Diabetic Foot Risk Assessment

**Risks Identified by Screener**

- **HIGH**
  - Previous ulceration
  - Previous amputation
  - Renal replacement therapy
  - Neuropathy and Peripheral Arterial Disease (PAD) together
  - Neuropathy in combination with callus and/or deformity
  - PAD in combination with callus and/or deformity.

- **Refer for initial Assessment**
  - within 2-4 weeks from Podiatric Foot Protection Service (FPS).
  - Thereafter 1-2 monthly review.
  - Provider Name & contact phone Number

- **Moderate**
  - Single risk factor present;
  - Deformity
  - Neuropathy
  - Peripheral Arterial Disease (PAD)

- **Refer for Initial Assessment**
  - within 6-8 weeks from Podiatric FPS.
  - Thereafter 3-6 months Review.
  - Provider Name & Contact phone number.

- **LOW**
  - No risk factors present except callus alone

- **Annual Screening by suitably trained HCP. (HCA – Consultant)**
  - Written and Verbal education
LOW RISK: - No Risk factors. Annual Foot Screening by suitably trained HCP

- Pulses present
- No loss of sensation
- No deformity

Callus alone is considered low risk

How to do an annual foot check:

- Remove shoes and socks/ stockings
- Test foot sensations using 10g monofilament or vibration with a tuning fork
- Palpate foot pulses
- Inspect for any deformity
- Inspect for significant callus
- Check for signs of ulceration
- Ask about any previous ulceration
- Inspect footwear
- Ask about any pain (Rest or walking)
- Tell patient how to look after their feet and provide written information
- Tell patient their risk status and what it means. Explain what to look out for and provide emergency contact numbers
MODERATE RISK

Refer to a specialist podiatrist or member of the foot protection service (FPS) and request an assessment within 6-8 weeks.

• Thereafter they should be assessed every 3-6 months in addition to their annual assessment, by a specialist podiatrist or a member of the FPS.

• Assess feet and lower limbs, then agree a tailored treatment plan.

• Provide written and verbal education with emergency contact numbers.

• Refer for special intervention if/when required.

• Liaise with other healthcare professionals e.g. GP as necessary.

MODERATE RISK

• Deformity or
• Neuropathy (loss of sensation) or
• Peripheral arterial disease.

Deformity
HIGH RISK

- Previous ulceration or previous amputation or on renal replacement therapy (dialysis or transport) or

- Neuropathy (loss of sensation) and lower limb peripheral arterial disease together or

- neuropathy in combination with callus and/or deformity or lower limb peripheral arterial disease in combination with callus and/or deformity

Foot Ulcer

Neuro-Ischaemic foot
Foot Screening Tests

1. NEUROPATHY

Monofilament testing

Use a 10g (5.07 Semmes-Weinstein) monofilament. (Sites to be tested as recommended by International Working Group for the Diabetic Foot)

Apply the monofilament perpendicular to the skin surface with sufficient force to cause the filament to bend or buckle. The total duration of the approach, skin contact, and removal of the filament should be approximately 2 seconds. Apply the filament to healthy skin, do not use on callus, scar or necrotic tissue. Do not allow the filament to slide across the skin or make repetitive contact at the test site. Ask the patient if pressure applied (yes/no). Repeat this application twice at the same site, but alternate this with at least one “sham” application, in which no filament is applied (total three questions per site). Protective sensation is present at each site if the patients correctly answer two out of three applications. Protective sensation is absent with two out of three incorrect answers, and the patient is then considered to be at risk of ulceration.

The nylon filament can be wiped with an antiseptic wipe between patients, and if used continuously all day (not more than 10 patients tested) will need to rest for 24 hours for the filament to recover. The average lifetime use is about 6 months so should be replaced.

2. VASCULAR ASSESSMENT

Identify if the arterial supply to the foot is reduced (by the absence of foot pulses, signs of tissue ischaemia or symptoms of intermittent claudication).

The vascular evaluation should include palpation of the pedal pulses. Do this for both pulses on both feet. The dorsalis pedis pulse can be found in the groove between the first and second metatarsal bones. The posterior tibial pulse can be found behind the medial malleolus, one third of the distance from the medial malleolus to the bottom of the heel. Absence of either pulse means the foot is at risk and of significant concern if neither pulse is palpable. If the pulse is not palpable due to the presence of oedema in the foot, Doppler testing can be performed by a trained individual to assess blood supply.

3. DEFORMITY

Identify deformities or problems of the foot (including bony deformities, dry skin or fungal infection) that may put it at risk. Identify Foot Deformity
### SECTION 1: PATIENT DEMOGRAPHIC DETAILS

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### SECTION 2: REFERRER INFORMATION

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