South West **LHIN**

Specialty Site Offloading Device Eligibility Checklist

Patient Name:_____ HCN#:_____

Device (circle) **TCC** **DH Walker** **Aircast** Date applied: _____

Recurrence wound? ☐ Yes ☐ No If yes, was patient using offloading? ☐ Yes: orthotics ☐ Yes: RCW ☐ No

If any of the below are answered "yes", Total Contact Casting (TCC) is contraindicated and physician follow up required. Removable Cast Walker (RCW) may be appropriate based on clinical assessment.

1.	Active infection.	☐ Yes ☐ No
2.	Eschar in the wound.	☐ Yes ☐ No
3.	Untreated osteomyelitis with copious drainage.	☐ Yes ☐ No
4.	Vascular status not adequate for healing (ABPI < 0.5).	☐ Yes ☐ No
5.	Neuropathic ulcer with exposure of deep structure tendon, joint capsule, bone.	☐ Yes ☐ No
6.	Excessive leg or foot swelling a fragile skin.	☐ Yes ☐ No
7.	Ulcer that is deeper than it is wide.	☐ Yes ☐ No
8.	Patient's foot does not fit in boot; calf exceeds cast size limit.	☐ Yes ☐ No
9.	Unable to eliminate risk for falls with offloading device.	☐ Yes ☐ No
10.	Allergy to casting material.	☐ Yes ☐ No
11.	Patient does not consent to device or need for frequent visits with offloading device application.	☐ Yes ☐ No

Clinical Assessment

12.	Diabetic Foot Ulcer Comprehensive Assessment completed.	☐ Yes ☐ No
13.	Primary Care Provider order received.	☐ Yes ☐ No
14.	Diabetic Foot Risk Assessment completed ☐ Yes ☐ No Score: _____	
15.	Location of the Wound: _____ Largest Wound Measurement: L _____cm x W_____cm x D _____cm	
16.	Results ABPI: Rt: Lt: or TBPI: Rt: Lt:	
17.	Patient has an interdisciplinary team in place that is appropriate including Diabetes Education Program (DEP) visits in place.	☐ Yes ☐ No
18.	Specialty site referral initiated.	☐ Yes ☐ No

Psychosocial

19.	Patient/family can be taught to self-manage the device and provided with emergency removal instruction card.	☐ Yes ☐ No
20.	Patient agrees to attend the Flex Clinic for care.	☐ Yes ☐ No
21.	Patient's goal is to heal the wound and understands and agrees to lifestyle modifications for this goal to be achieved: e.g. uses offloading device as prescribed, optimizes nutrition, smoking cessation, good hygiene.	☐ Yes ☐ No

Physician/ Nurse

Reasons to stop offloading device:

- ☐ No Improvement is seen at **28 days (4 weeks)**; or wound stalls in spite of best practice > 30days
- ☐ Wound is deteriorating
- ☐ New onset of wound infection
- ☐ Uncontrolled or excessive bleeding from debridement
- ☐ Uncontrolled pain
- ☐ Non-adherence (walking without boot, getting cast wet, refusal to attend DEP)
- ☐ Patient is at risk for falls and unable to safely ambulate

Wound Closed

Date Closed: _____

***Please Fax form to 1-866-675-0885 once wound has closed

Signature of ET /WCS Nurse/ Designation _____ Print Name _____ Date (dd/mm/yy) _____

South West LHIN fax number: 1-866-675-0885