Home and Community Care geko™ Wound Therapy Device Eligibility Checklist

***This form must accompany the Special Authorization Form**

Patient Name: _____ BRN#:_____

Wound Assessment		
Wound Etiology: _____ Location:_____ Age of Wound: _____ Largest Wound Measurement: L _____cm x W_____cm x D _____cm Circle One: Healable Non Healing Non Healable		
Wound Care Team		
1.	Has a Dietitian been consulted for nutritional assessment and dietary recommendations?	☐ Yes ☐ No
2.	Has a Physiotherapist been consulted for calf muscle pump activation/strengthening and gait assessment?	☐ Yes ☐ No
Clinical Assessment		
3.	Lower leg assessment done, no signs/symptoms of ischemia noted **Results: ABPI Rt: Lt:**	☐ Yes ☐ No
4.	Localized or deep Infection is addressed; (No unresolved osteomyelitis).	☐ Yes ☐ No
5.	If Diabetic, HgA1C tested in the past 3 months is < 10.	☐ Yes ☐ No
6.	If Diabetic Foot Ulcer or Pressure Injury, appropriate offloading or pressure redistribution is in place or being addressed.	☐ Yes ☐ No
7.	If a Venous Leg Ulcer, appropriate compression has been initiated using: _____(list compression therapy)	☐ Yes ☐ No
8.	Skin is intact with no dermatitis	☐ Yes ☐ No
Psychosocial		
9.	Patient/family can be taught to self-manage the device.	☐ Yes ☐ No
10.	Patient agrees to the clinic first approach when possible.	☐ Yes ☐ No
11.	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, agrees to compression, optimizes nutrition, smoking cessation, good hygiene.	☐ Yes ☐ No
Physician/ Nurse		
12.	Primary Care Practitioner is aware and agrees with plan for patient.	☐ Yes ☐ No
Exclusion Criteria		
13.	Patient is less than 19 years of age	☐ Yes ☐ No

Reasons to stop geko™ Wound Therapy device:

- ☐ No Improvement is seen at **28 days (4 weeks)**;
- ☐ Active dermatitis in area of application
- ☐ Development of a DVT or pulmonary embolism
- ☐ Poor adherence to best practices

Contraindications/Precautions:

- ☐ Pacemaker or implanted electrical device
- ☐ History of CHF
- ☐ Recent history of DVT
- ☐ Pregnancy

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

_____ _____ _____