South West **LHIN**

Offloading Device Eligibility Checklist

Patient Name:_____ **BRN/HCN#**:_____

Device Provided (circle):

TCC EZ **TCC Cutimed** **DH Walker** **Aircast** **Darco Othowedge**

Darco Heelwedge **Darco Medsurg** **Other:**

Recurrent wound? ☐ Yes ☐ No **If yes, was patient using offloading?** ☐ Yes ☐ No

Is the patient currently receiving home and community care services? ☐ Yes ☐ No

Device Initiated

Date: _____

Please fax form to 1-833-243-8532

Please answer the following in regards to the patients Diabetic Foot Ulcer (DFU)

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/Physician 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

Consent

☐ The patient consents to this information being stored with the South West Local Health Integration Network where it will be used for the purpose of evaluating and improving care and related services.

Wound Closed

Date Closed_____

Please fax form to 1-833-243-8532

Signature (Provider) Print Name (Provider) Date (dd/mm/yy)

_____ _____ _____

IMPORTANT - Please fax form to SW LHIN 1-833-243-8532 **THANK YOU**