Advanced Foot & Nail Care Assessment & Treatment Flow Sheet

Name:

DOB: MRN:

Assessment*

This assessment is used in conjunction with the client's High-Risk Foot & Nail Assessment (baseline) Date Done:_____

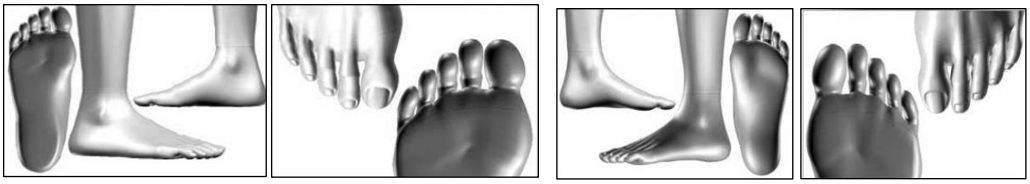
Year (XXXX)	**Month/Day** (MMM/DD)				
	Time (HH:MM)				
Parameters Lower Leg, Foot, Toes & Nails	**Limb**	**Left**	**Right**	**Left**	**Right**
Skin & Nail Integrity Y (Yes) / N (No)	As per baseline				
	Nails correct length				
Colour Y (Yes) / N (No)	As per baseline				
Warmth (Circulation) Y (Yes) / N (No)	As per baseline				
	Posterior Tibial Pulse present				
	Dorsalis Pedis Pulse present				
	Cap Refill less than 3 seconds				
Movement Y (Yes) / N (No)	As per baseline				
Sensation Y (Yes) / N (No)	As per baseline				
	Pain during day				
	Pain at night				
	Signature				

Treatment

Date (MMM/DD):

Area of Concern (use A, B, C to indicate areas of concern)

Right **Left**



Care Provided (use ✓ to indicate care done)

☐ Nails trimmed/filed ☐ Tyloma reduction ☐ Heloma reduction ☐ Verruca reduction

☐ Offloading ☐ Skin care ☐ Teaching ☐ Referral

Other:

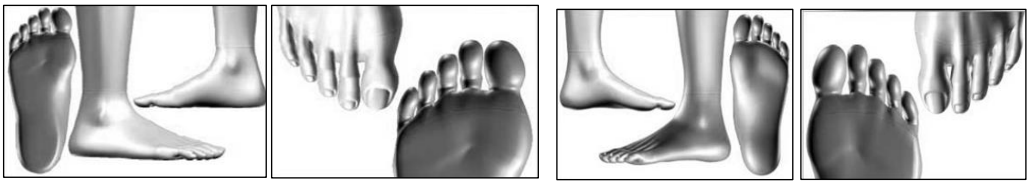
Comments:

Signature:

Date (MMM/DD):

Area of Concern (use A, B, C to indicate areas of concern)

Right **Left**



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☐ Other:

Comments:

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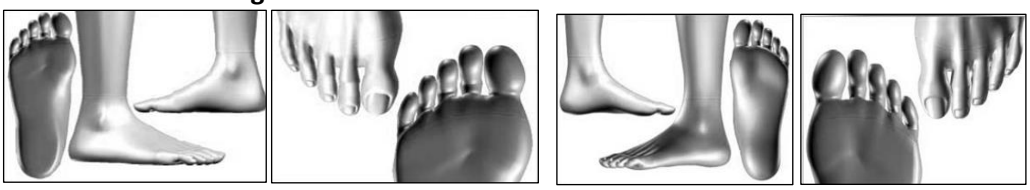

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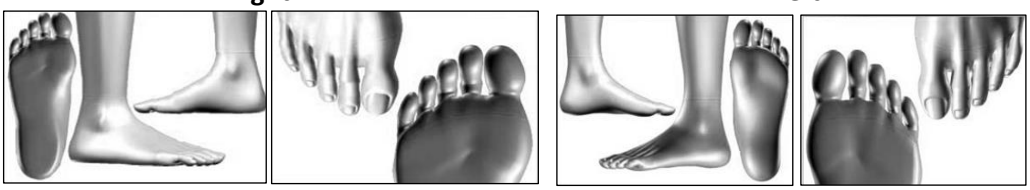

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