Orthotist Referral & Treatment
Diabetic/Neuropathic Foot Offloading

Orthotist Clinic:_____

Client Information
Name:
PHN:
DOB:

Referral

To be completed by Physician/NP/NSWOC/WC

Client's Diagnosis: ☐ **Type 1 Diabetes** ☐ **Type 2 Diabetes** ☐ **Non-Diabetic Neuropathy** **Date of Diagnosis:** _____ YYYY/MMM

Charcot Deformity Noted: ☐ **Yes** ☐ **No** **If yes:** ☐ **Acute** ☐ **Stable** ☐ **Left Foot** ☐ **Right Foot** ☐ **Bilateral**

History of Previous Diabetic/Neuropathic Foot Ulcer: ☐ **Yes** ☐ **No** **Amputation:** ☐ **Yes** ☐ **No** **If yes: Date:** _____ YYYY/MMM

Foot Ulcer#1: **Date of Onset:** _____ YYYY/MMM/DD

Wound Treatment Start Date: _____ YYYY/MMM/DD **Closure Date:** ☐ **Anticipated:** _____ YYYY/MMM/DD ☐ **Actual:** _____ YYYY/MMM/DD

Off-loading Device: ☐ **TCC** ☐ **Boot:** _____ ☐ **Shoe:** _____

Start Date: _____ YYYY/MMM/DD ☐ **Other:** _____

Foot Ulcer#2: **Date of Onset:** _____ YYYY/MMM/DD (if more than two ulcers see Additional Foot Ulcers pg. 2)

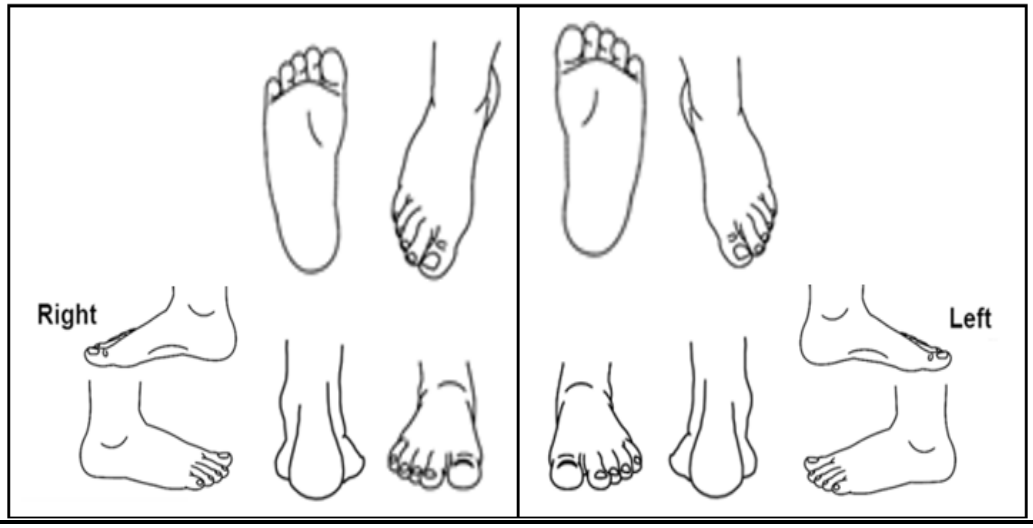
Wound Treatment Start Date: _____ YYYY/MMM/DD **Closure Date:** ☐ **Anticipated:** _____ YYYY/MMM/DD ☐ **Actual:** _____ YYYY/MMM/DD

Off-loading Device: ☐ **TCC** ☐ **Boot:** _____ ☐ **Shoe:** _____

Start Date: _____ YYYY/MMM/DD ☐ **Other:** _____

Location of Diabetic Foot Ulcer (DFU) or Neuropathic Foot Ulcer (NFU):

Mark:
- **Current DFU(s)/NFU(s) with an X & identify as #1, #2**
- **Previous ulcers with a P & identify as #1, #2**
- **Amputation(s) with a black dot**



Contact client via:

☐ **Phone** ☐ **Text** ☐ **Email** _____

HA: _____ **Clinic/Health Unit/LTC Site:**_____ **Phone#:**_____

Date: _____ YYYY/MMM/DD **Signature:**_____ **Print:**_____

Circle: Physician/NP/NSWOC/WC

Treatment Plan

To be completed by Orthotist

Notable anatomical deformities to the foot and leg:

□ **Rocker bottom deformity**

□ **Gastroc equinus**

□ **Plantarflexed rays**

□ **Structural limitus**

□ **Functional limitus**

□ **Other (describe):**_____

_____

Treatment: (*these devices <u>are not</u> covered by PharmaCare)

□ **Over the counter modified insole***

□ **Off the shelf arch support***

□ **AFO/Crow/patellar tendon bearing brace***

□ **Orthopedic footwear**

□ **Modified orthopedic footwear:**

□ **Rocker soles** □ **External lifts** □ **Sole flare/ buttress** □ **Internal excavation** □ **Other:** _____

□ **Custom foot orthoses**

□ **Custom made footwear**

□ **Other as per practitioner assessment:** _____

_____

Date: _____ **Signature:**_____**Print:**_____

YYYY/MMM/DD

Additional Foot Ulcers

To be completed by Physician/NP/NSWOC/WC if needed

Foot Ulcer#3: Date of Onset: _____

YYYY/MMM/DD

Wound Treatment Start Date: _____ **Closure Date:** □ **Anticipated:** _____ □ **Actual:** _____

YYYY/MMM/DD YYYY

Off-loading Device: □ **TCC** □ **Boot:** _____ □ **Shoe:** _____

Start Date: _____ □ **Other:** _____

YYYY/MMM/DD

Foot Ulcer#4: Date of Onset: _____

YYYY/MMM/DD

Wound Treatment Start Date: _____ **Closure Date:** □ **Anticipated:**_____ □ **Actual:** _____

YYYY/MMM/DD YYYY/MMM/DD YYYY/MMM/DD

Off-loading Device: □ **TCC** □ **Boot:** _____ □ **Shoe:** _____

Start Date: _____ □ **Other:** _____

YYYY/MMM/DD

Date: _____ **Signature:**_____

YYYY/MMM/DD