Checklist for the identification of foot problems

Clients Name: _____ DOB: _____

Does the client have swollen feet?	Yes ☐	No ☐
Is the colour of the client's feet blue/black?	Yes ☐	No ☐
Does the client have sores or ulcers that haven't healed in 2-3 weeks?	Yes ☐	No ☐
Does the client complain of night cramps or do they sit up to sleep (eg. In a recliner)?	Yes ☐	No ☐
Does the client complain of numbness in their feet?	Yes ☐	No ☐
Does the client have health problems such as diabetes or arthritis?	Yes ☐	No ☐
Does the client trip or fall often?	Yes ☐	No ☐
Does the client have a visual impairment?	Yes ☐	No ☐
Does the client get someone else to cut their toenails because they are unable to do it themselves?	Yes ☐	No ☐

IF THE ANSWER TO ANY OF THESE QUESTIONS IS YES, THE CLIENT NEEDS TO BE ASSESSED BY A PODIATRIST

Please complete the information over the page & return to the Assessment Officer today with a NGSC Incident/Concern Form

Created 3/8/14
Date for review: June 2015

Does the client see a podiatrist? Yes ☐ No ☐

Podiatrist/ Podiatry Service? _____

Does the client have a podiatry appointment? Yes ☐ No ☐

If yes, when is the appointment?

Date: _____ Time: _____

If no, will the client make the appointment? Yes ☐ No ☐

DCW Name: _____ Date: _____