Hindmarsh Shire Council

Grampians Region HACC Program

Foot Care Program Screening Tool

hacc home and community care

A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

Date of Screening:	Client Name:	Date of Birth:
Address:		Agency ID Number:

If you are providing a service to a client and notice any of these 'red flag' symptoms to their limbs or toes please discuss your concern with the client and report to your supervisor.

*Feet are hot to touch	*Swollen with pain	*Sores/ulcers that are slow to heal e.g. longer than 2 to 3 weeks
*Colour is blue/black/red	*Sores with pus or other discharge	

1. General Information:

Does the client have a podiatrist that they see as needed? Name ..... ☐ Yes ☐ No

Does the client cut their own nails? ☐ Yes ☐ No

What do they use to cut their nails? Please tick: ☐  ☐  ☐ 

If NO, who does cut them? .....

2. General Health:

a. Does the client have impaired vision? ☐ Yes ☐ No ☐ Unsure

b. Do they have health problems such as diabetes, arthritis, poor circulation, sensation? ☐ Yes ☐ No ☐ Unsure

Problem: .....

c. Have they fallen or tripped in the last three months? ☐ Yes ☐ No ☐ Unsure

d. Do they take any of the following medications: ☐ Yes ☐ No ☐ Unsure
Warfarin, Methotrexate, Prednisolone, Insulin, Metformin

3. Self Care and Skin Care:

a. Is the client able to reach their feet? ☐ Yes ☐ No

b. Does the client have swollen feet? ☐ Yes ☐ No

c. Do they complain of ☐ numbness, ☐ cramps or ☐ pins and needles in their feet or legs? ☐ Yes ☐ No
(Please tick the problem(s) they report)

d. Are the feet clean and dry between the toes? ☐ Yes ☐ No

e. Is the skin dry & scaly? ☐ Yes ☐ No

i. Does the client use a skin cream? Details: ..... ☐ Yes ☐ No

i. Any rubs, blisters or excessive redness of the skin? ☐ Yes ☐ No

ii. Does the client apply anything to this area? Details: ..... ☐ Yes ☐ No

j. Are there callous or cracks present? Yes / No

k. Are there any markings on the feet such as: chilblains, warts, corns, moles, tinea (etc). ☐ Yes ☐ No

Please describe what you observe; ask how long has it been there and whether a Doctor, Nurse or Podiatrist have viewed it and draw it on the foot chart on the next page.

Developed in collaboration with Northern Grampians Foot Care Project, Ballarat Foot Care Project and Grampians Region Foot Care Project, 2013/14.

4. Nail care

a. Are the nails thickened? ☐ Yes ☐ No

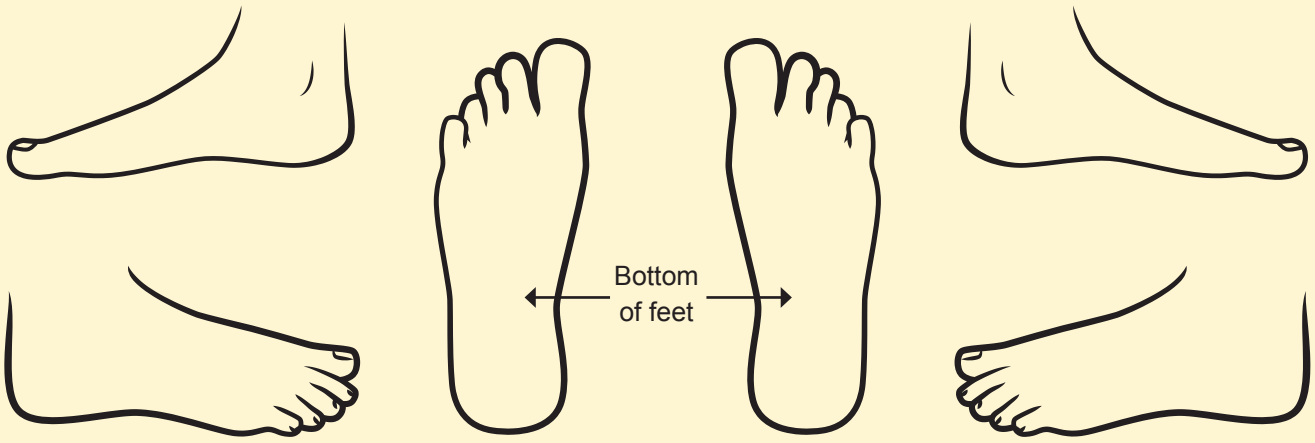
b. Are the nails excessively curved? ☐ Yes ☐ No

c. Are there any ingrowing toenails present? ☐ Yes ☐ No

d. Are there any fungal nails present? ☐ Yes ☐ No

Instruction for personal care worker: If the client answers yes to any of the above questions in Sections Two, Three or Four - ask them if they have seen a podiatrist in the last six months or regularly attend a podiatrist – if the answer is NO then ask them would they like you to talk to your supervisor about a podiatrist assessment. Report the outcome of this discussion to your supervisor within the working week.

Please complete the 'feet' tool diagram to describe where areas of concern have been identified.



Right Foot **Left Foot**

Are there any other comments you would like to make which will assist either your own team or the podiatrist? Example: specific instructions for the coordinator to add to the clients Support (Care) plan: such as client preferences e.g.: client's foot likes/dislikes such as 'client likes her foot cream put on when she is dressed and not in the bathroom'

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Personal Care Worker Signature .....

Print name ..... Date ...../...../.....

Client name: ..... Client signature: ..... Date: ...../...../.....

Action Taken: .....

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Whom By:

Name ..... Position ..... Date ...../...../.....

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