

Community Clinician Record of Visit

To be completed at initial video-consultation only

CRITICAL ISCHAEMIA / SPREADING INFECTION must be referred immediately to On-Call Vascular Surgeon

Patient Details	Name & CHI or CHI label	Date of visit:
		Clinician Name:
		Profession:

Foot Ulcer Details	<u>New</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Deteriorating</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Non Healing</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Palliative</u> Y <input type="checkbox"/> N <input type="checkbox"/>
	<u>Post Surgical</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>In-remission</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Texas Classification</u>	
	<u>Location</u>		<u>Size (Length X Breadth)</u>	
	Duration	< 1 week <input type="checkbox"/>	1-4 weeks <input type="checkbox"/>	1-3 months <input type="checkbox"/>
		3-6 months <input type="checkbox"/>	>6 months <input type="checkbox"/>	>1year <input type="checkbox"/>

Current or Recent antibiotic use	Describe Treatment to Date:			
	Flucloxacillin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Metroidazole <input type="checkbox"/> Other (specify) <input type="checkbox"/>	Dosage	Duration	Date Started

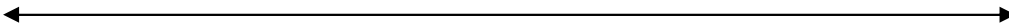
Professionals Involved	Previously known to:	<u>Foot MDT</u> Y <input type="checkbox"/> N <input type="checkbox"/>	Currently Known to:	<u>Foot MDT</u> Y <input type="checkbox"/> N <input type="checkbox"/>
		<u>Vascular</u> Y <input type="checkbox"/> N <input type="checkbox"/>		<u>Vascular</u> Y <input type="checkbox"/> N <input type="checkbox"/>
	Shared Care:	<u>District Nurse</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Practice Nurse</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Community Podiatry</u> Y <input type="checkbox"/> N <input type="checkbox"/>

Modified Wound Management	<u>Dressing</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Off-loading</u> Y <input type="checkbox"/> N <input type="checkbox"/>	<u>Antibiotics</u> Y <input type="checkbox"/> N <input type="checkbox"/>
	Outcome as a result of this consult:		
	<u>Foot MDT</u>		<u>Vascular</u>
	Face to Face	Y <input type="checkbox"/> N <input type="checkbox"/>	Face to Face Y <input type="checkbox"/> N <input type="checkbox"/>
	VC	Y <input type="checkbox"/> N <input type="checkbox"/>	
	Email Contact with Foot MDT	Y <input type="checkbox"/> N <input type="checkbox"/>	

COMMUNITY PODIATRIST VC EVALUATION

Name of Podiatrist		Patient ID	
Location / area		Postcode:	
Date		Time of arrival:	
Problems/delays		If yes, please describe the issue	
	Yes	No	
Arrival	<input type="checkbox"/>	<input type="checkbox"/>	
Set-up	<input type="checkbox"/>	<input type="checkbox"/>	
Connectivity	<input type="checkbox"/>	<input type="checkbox"/>	
Photography	<input type="checkbox"/>	<input type="checkbox"/>	
Video link	<input type="checkbox"/>	<input type="checkbox"/>	
Were images shared successfully?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Additional comments?			
Time of departure			

PATIENT VC SATISFACTION

How likely is it that you would recommend this service to others in a similar situation?												
<i>Not at all likely</i>	0	1	2	3	4	5	6	7	8	9	10	<i>Extremely likely</i>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
												
If there is anything you would like to: comment on please do so below												