

Central Kansas Podiatry Associates

Patient Name: _____ Date: _____ Record #: _____

PERIODIC COMPREHENSIVE DIABETIC FOOT EVALUATION (CDFE) (For Physician Use)

Patient seen at Central Kansas Podiatry Assoc. for a comprehensive diabetic foot education (CDFE).

Patient was last seen for foot care: / / Last CDFE was: / /

Interim complaints: _____

Name of MD/DO treating diabetes: _____

Date last seen: _____ Last FBS: _____ HbA1C: _____

Past Medical/Surgical History: _____

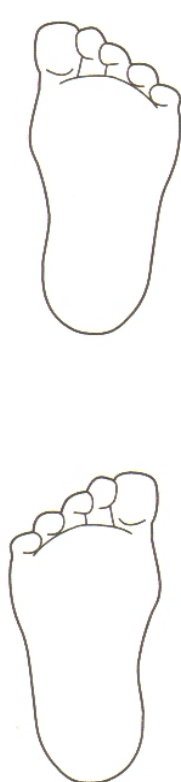
Current medications: _____

Drug Allergies: _____

Review of Systems:

Ortho:	(-) Joint aches/pain	(-) Deformities	(-) Stiffness	(-) Weakness					
Dermatitis:	(-) Skin Rash	(-) Pruritus	(-) Nail changes	(-) Scaling	(-) Dryness				
Neuro:	(-) Numbness	(-) Tingling	(-) Paresthesia	(-) Dysesthesia	(-) Hypesthesia				
Vascular:	(-) Claudication	(-) Night cramps	(-) Edema	(-) Temp.changes	(-) Hair growth	(-) Rubor	(-) Thinning of skin		
Endocrine	(-) Polyuria	(-) Polydipsia	(-) Polyphagia						

Notes:



Physical Exam:

Orthopedic	LEFT	RIGHT
<i>Digital Deformities (including hallux valgus)</i>	(--) Hammertoes 1 2 3 4 5 (--) Bunions	(--) Hammertoes 1 2 3 4 5 (--) Bunions
<i>Equinus</i>	(--) present	(--) present
<i>Plantarflexed metatarsal</i>	1 2 3 4 5	1 2 3 4 5
<i>Previous amputations</i>		
<i>Other:</i>		

Dermatological	LEFT	RIGHT
<i>Tinea pedis</i>	(--) present (--) scaly (--) red	(--) present (--) scaly (--) red
<i>Xerosis</i>	(--) present	(--) present
<i>Skin Fissures</i>	(--) present (--) Ulceration (--) Infection	(--) present (--) Ulceration (--) Infection
<i>Onychomycosis</i>	1 2 3 4 5 1-5 L	1 2 3 4 5 1-5 R
<i>Onychocryptosis</i>	1 2 3 4 5 1-5 L	1 2 3 4 5 1-5 R
<i>Interdigital spaces</i>	(--) maceration (--) debris (--) 1 2 3 4	(--) maceration (--) debris (--) 1 2 3 4
<i>Other:</i>		
Neurological		
<i>Vibration perception test</i>		
<i>Loss of protective sensation-SWMT 5.07</i>	/5	/5
<i>Soft Touch</i>	<i>Intact Diminished Absent</i>	<i>Intact Diminished Absent</i>
<i>Sharp/dull</i>	<i>Intact Diminished Absent</i>	<i>Intact Diminished Absent</i>
Vascular		
<i>Dorsalis Pedis</i>	0 1 2 3 4 / 4	0 1 2 3 4 / 4
<i>Posterior Tibial</i>	0 1 2 3 4 / 4	0 1 2 3 4 / 4
<i>Capillary Refill Time</i>	1 2 3 4 5	1 2 3 4 5
<i>Edema</i>	0 1 2 3 4	0 1 2 3 4
<i>Hair growth</i>	(--) present (--) diminished (--) absent	(--) present (--) diminished (--) absent
<i>Varicosities</i>	(--) present (--) bronze (--) torturous	(--) present (--) bronze (--) torturous
Footwear		
<i>Type of shoe</i>	tie/velcro slip-on sandal	tie/velcro slip-on sandal
<i>Fit</i>	tight loose good	tight loose good
<i>Shoe condition and wear patterns</i>	(--) heel (--) forefoot	(--) heel (--) forefoot
<i>Foreign bodies in shoes</i>	(--) present	(--) present
<i>Innersoles, orthotics</i>		
<i>Other:</i>		

<input type="checkbox"/> (0) N Neuropathy - Annual	<input type="checkbox"/> (1) Neuropathy – Semi-Annual	<input type="checkbox"/> (2) Neuropathy, PVD and/or deformity - Quarterly	<input type="checkbox"/> (3) Previous Ulcer or amputation – monthly to every 2 months
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Education and Counseling provided:		Yes	No
General	Explanation of systemic Risks of diabetes and importance of proper glucose control		
	Explanation of dangers of neuropathy and loss of “the gift of pain”		
	Counseling on risk stratification and exam frequency		
Diabetic Foot Education	Explanation of high pressure areas, risks and offloading solutions		
	Review proper foot care instructions		
Medications	Review of current medications		
Other			

Prescriptions Ordered: _____ Other: _____

Referred to: _____ Next Exam: _____
 (physician's name)

Reason: _____ Diagnostic Studies: _____

Patient Visit Time in: _____ Time Out: _____ Signature: _____
 Print Name: _____

Supervising Physician Acknowledgement: Above are the Findings for the above-referenced patient. Please acknowledge your agreement with these findings and sign below. Please mail or fax this back to us with the attached Supervising Physician's Statement and keep a copy of both forms in the patient's chart. After signed please fax to 316-264-5516. Thank You!	Signature: _____
	Print Name: _____
	Date: _____

