**PERSONAL DETAILS**

**Date of registration** - DD/MM/YYYY

**Reference number** - 20170523001

**Name- …………………………………………………………………….**

**Date of birth -** DD/MM/YYYY

**Age** - ………………………………………

**Gender** – M F

**Address**- ………………………………………………………………………….

………………………………………………………………………….

**Contact number** – …………………………………………………………………………..

…………………………………………………………………………..

**DISEASE SUMMARY**

**Laterality** R L B/L

**Onset**  Traumatic

Post infection

Spontaneous

Post cellulitis

**Duration ……………………………………………..**

**Ulcer type -** Venous ulcer

Neuropathic Ulcer

Neuroischaemic ulcer

Ischaemic ulcer

Other

Vasculitis

Infections

**Venous Ulcer**

SFL

EVLT

SPD

DM Yes No

If yes Duration ……………………………..

Diet control Yes No

OHA Yes No

Insulin Yes No

**Neuropathic, Ischaemic and Neuroischaemic ulcers**

**RISK FACTORS AND COMORBIDITIES**

Pulse status

|  |  |  |
| --- | --- | --- |
| Pulse | R | L |
| Femoral | Yes/No | Yes/No |
| Popliteal | Yes/No | Yes/No |
| PTA | Yes/No | Yes/No |
| DPA | Yes/No | Yes/No |

PVD Yes No

Intermittent claudication Yes No

Rest pain Yes No

Right / Left / Bi lateral

Neuropathy yes No (if yes)

Monofilament test R - L-

Foot deformities

|  |  |  |
| --- | --- | --- |
|  | R | L |
| High arch |  |  |
| Flat foot |  |  |
| Claw toes |  |  |
| Hallux valgus |  |  |
| Charcot’s foot |  |  |

DM Yes No

If yes Duration ……………………………..

Diet control Yes No

OHA Yes No

Insulin Yes No

Dyslipidaemia Yes No

Hypertension Yes No

Smoking Yes No

Cardiac disease Yes No

Cerebral Vascular accidents Yes No

**OTHER**

**Wound biopsy Yes No**

**TREATMENT**

Date DD/MM/YYYY

Wound dressing Atrauman Ag

Acticoat

Vaseline

Biatain Ag

Biatain

Iodosorb

Oxoferin

Vac dressing

Gel - Intrasite or Metro gel

Other

Oral medications Antibiotics

Co-amoxiclav

Clindamycin

Flucloxacillin

Ciprofloxacin

Metranidazole

Doxycycline

Linezolid

Other

Duration:

Analgesics Yes No

Debridement yes No

Duration ………………………………………………….

FBS …………………………………………………………………

HBA1C …………………………………………………………………

Notes ………………………………………………………………………………………………………..

Cost per visit : ……………………………………………………

Image 1

Image 3

Image 2