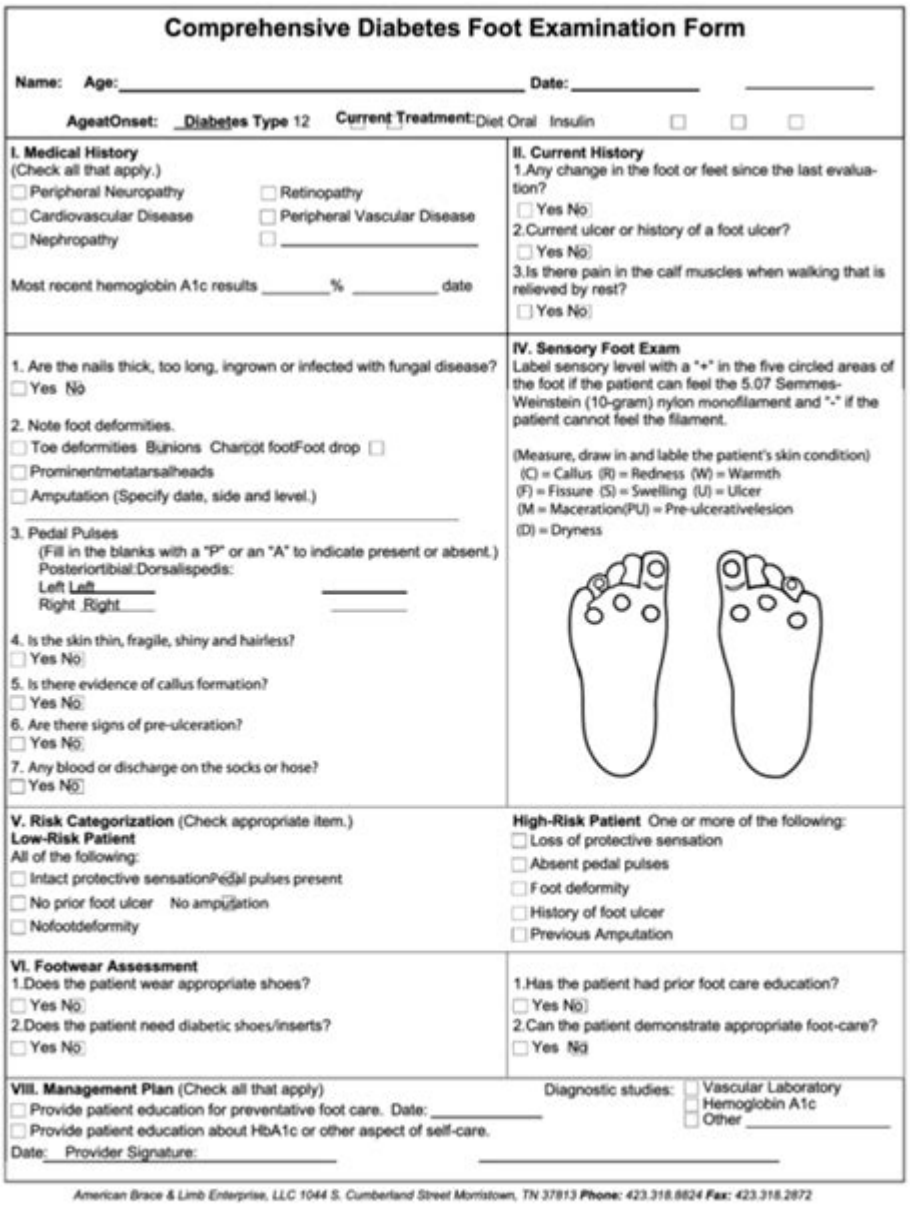
Diabetic Foot Exam Documentation Example



Comprehensive Diabetes Foot Examination Form

Name: Age: Date:

AgeatOnset: Diabetes Type 12 Current Treatment: Diet Oral Insulin

I. Medical History
(Check all that apply.)
- Peripheral Neuropathy
- Retinopathy
- Cardiovascular Disease
- Peripheral Vascular Disease
- Nephropathy
- _____

Most recent hemoglobin A1c results _____% _____ date

II. Current History
1. Any change in the foot or feet since the last evaluation? Yes No
2. Current ulcer or history of a foot ulcer? Yes No
3. Is there pain in the calf muscles when walking that is relieved by rest? Yes No

1. Are the nails thick, too long, ingrown or infected with fungal disease? Yes No

2. Note foot deformities.
- Toe deformities Bunions Charcot foot Foot drop
- Prominent metatarsal heads
- Amputation (Specify date, side and level.)

3. Pedal Pulses
(Fill in the blanks with a "P" or an "A" to indicate present or absent.)
Posterior tibial: Dorsalis pedis:
Left Left
Right Right

4. Is the skin thin, fragile, shiny and hairless? Yes No
5. Is there evidence of callus formation? Yes No
6. Are there signs of pre-ulceration? Yes No
7. Any blood or discharge on the socks or hose? Yes No

IV. Sensory Foot Exam
Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 Semmes-Weinstein (10-gram) nylon monofilament and "-" if the patient cannot feel the filament.

(Measure, draw in and lable the patient's skin condition)
(C) = Callus (R) = Redness (W) = Warmth
(F) = Fissure (S) = Swelling (U) = Ulcer
(M = Maceration(PU) = Pre-ulcerativelesion
(D) = Dryness

V. Risk Categorization (Check appropriate item.)

Low-Risk Patient
All of the following:
- Intact protective sensation Pedal pulses present
- No prior foot ulcer No amputation
- No foot deformity

High-Risk Patient One or more of the following:
- Loss of protective sensation
- Absent pedal pulses
- Foot deformity
- History of foot ulcer
- Previous Amputation

VI. Footwear Assessment
1. Does the patient wear appropriate shoes? Yes No
2. Does the patient need diabetic shoes/inserts? Yes No

1. Has the patient had prior foot care education? Yes No
2. Can the patient demonstrate appropriate foot-care? Yes No

VIII. Management Plan (Check all that apply)
- Provide patient education for preventative foot care. Date: _____
- Provide patient education about HbA1c or other aspect of self-care.

Diagnostic studies:
- Vascular Laboratory
- Hemoglobin A1c
- Other _____

Date: Provider Signature: _____

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Diabetic foot exam documentation example is crucial for healthcare providers to ensure comprehensive patient care and to maintain accurate medical records. This documentation serves as an essential tool in the prevention and management of diabetic foot complications, which can lead to severe outcomes, including amputations. In this article, we will explore the significance of diabetic foot exams, the components of thorough documentation, and provide a detailed example of how to document a diabetic foot exam effectively.

Understanding the Importance of Diabetic Foot Exams

Diabetes can lead to a variety of complications, and one of the most concerning is diabetic foot disease. High blood sugar levels can cause nerve damage (neuropathy) and poor blood circulation, increasing the risk of foot ulcers and infections. Regular foot exams are essential for early detection of potential problems, allowing for timely interventions that can prevent serious complications.

Key Reasons for Conducting Regular Diabetic Foot Exams

1. Early Detection of Foot Problems: Regular exams can identify issues like neuropathy, calluses, or infections before they become serious.
2. Patient Education: These exams provide an opportunity to educate patients on proper foot care and the importance of regular check-ups.
3. Reduction in Amputation Risk: Early intervention can significantly reduce the risk of foot ulcers and subsequent amputations.
4. Monitoring Progression: Documenting foot exams helps track any changes over time, assisting in the management of the patient’s overall health.

Components of Diabetic Foot Exam Documentation

Accurate documentation of a diabetic foot exam is essential for ensuring continuity of care and meeting legal and insurance requirements. A well-structured documentation format should include the following components:

1. Patient Identification Information

- Name: Full name of the patient
- Date of Birth: To confirm the patient’s age
- Medical Record Number: Unique identifier in the healthcare system

2. Date of Exam

- Clearly indicate the date when the foot exam was conducted.

3. Medical and Diabetic History

- Duration of Diabetes: Years since diagnosis
- Type of Diabetes: Type 1 or Type 2
- Complications: Any known complications related to diabetes, such as neuropathy, retinopathy, or cardiovascular issues.

4. Medications

- List all medications the patient is currently taking, including insulin and oral hypoglycemics.

5. Foot Examination Findings

This section should be detailed and include:

- Visual Inspection:
- Skin condition: Check for color changes, dryness, cracks, or infections.
- Deformities: Note any bunions, hammertoes, or other structural changes.
- Calluses or Corns: Document any areas of thickened skin.

- Sensory Examination:
- Monofilament Test: Document the results of the 10g monofilament test to assess protective sensation.
- Tuning Fork Test: Use a 128 Hz tuning fork to evaluate vibratory sensation.

- Vascular Assessment:
- Pulses: Check dorsalis pedis and posterior tibial pulses, noting any abnormalities.
- Capillary Refill: Document the time it takes for color to return after pressing on a toe.

6. Patient Education Provided

- Note any education given regarding foot care, such as:
- Daily foot inspections
- Proper footwear recommendations
- Importance of blood sugar control

7. Follow-Up Recommendations

- Outline the frequency of future foot exams based on the current findings and the patient’s risk level.

Example of Diabetic Foot Exam Documentation

Here is a sample documentation for a diabetic foot exam:

Patient Identification Information
- Name: John Doe
- Date of Birth: 01/15/1955
- Medical Record Number: 123456

Date of Exam: 10/15/2023

Medical and Diabetic History
- Duration of Diabetes: 15 years
- Type of Diabetes: Type 2
- Complications: Mild neuropathy, no history of foot ulcers or amputations

Medications:
- Metformin 500 mg BID
- Insulin Glargine 10 units at bedtime

Foot Examination Findings:
- Visual Inspection:
- Skin: Dry, no cracks or lesions noted.
- Deformities: No bunions or hammertoes present.
- Calluses: Mild callus formation noted on the left heel.

- Sensory Examination:
- Monofilament Test: Sensation intact on all tested sites.
- Tuning Fork Test: Vibration sense intact at the great toe.

- Vascular Assessment:
- Dorsalis Pedis Pulse: 2+
- Posterior Tibial Pulse: 2+
- Capillary Refill: <2 seconds

Patient Education Provided:
- Instructed on daily foot inspections and proper footwear.
- Advised to maintain tight blood sugar control to prevent complications.

Follow-Up Recommendations:
- Schedule next foot exam in 6 months or sooner if any foot problems arise.

Conclusion

In conclusion, proper **diabetic foot exam documentation examples** are a vital aspect of diabetes care that can significantly impact patient outcomes. By maintaining detailed and accurate records, healthcare providers can ensure that they are providing the best possible care for their patients. Regular

foot exams, coupled with thorough documentation, are essential in preventing complications associated with diabetic foot disease. Ensuring that patients are educated and aware of their foot health is equally important in promoting long-term well-being.

Frequently Asked Questions

What is a diabetic foot exam and why is it important?

A diabetic foot exam is a clinical assessment performed to identify any foot complications in individuals with diabetes, such as neuropathy, ulcers, or infections. It is important because early detection of foot issues can prevent serious complications, including amputations.

What key components should be included in the documentation of a diabetic foot exam?

Documentation should include the patient's history, visual inspection findings, sensory and vascular assessments, any ulcers or lesions noted, and the patient's education regarding foot care practices.

How often should a diabetic foot exam be performed?

The American Diabetes Association recommends that individuals with diabetes should have a comprehensive foot exam at least once a year, while those with a history of foot ulcers or neuropathy should be examined more frequently.

What specific findings should be documented during a diabetic foot exam?

Findings such as skin integrity, presence of calluses or corns, foot deformities, pulses in the feet, temperature differences, and any signs of infection or ulceration should be documented.

What is the role of patient education in diabetic foot exam documentation?

Patient education is crucial and should be documented, including instructions on daily foot care, the importance of proper footwear, signs of complications to watch for, and when to seek medical help.

What tools or assessments are commonly used during a diabetic foot exam?

Common tools include monofilaments for sensory testing, tuning forks for vibration sensation, Doppler ultrasound for assessing blood flow, and visual

inspection for ulcers or skin changes.

How can electronic health records improve diabetic foot exam documentation?

Electronic health records (EHRs) can improve documentation by providing standardized templates for foot exams, facilitating easy tracking of patient history, and improving communication among healthcare providers regarding patient care.

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