NHS
Enfield Community Services

Leg Ulcer Assessment Form

This Assessment Form should be used as part of the holistic assessment of patients with a leg ulcer. It in no way replaces clinical judgement. Where space is limited use the continuation sheets at the back.

PART 1. DEMOGRAPHIC DETAILS

Ethnic Code:		**First Language:**	
NHS No: RIO No: Patient's Title: (please circle) Dr Mr Mrs Ms Miss Patient's Name: Address: Postcode: Tel no: DOB: Age: Sex: M / F Occupation (past if retired):		GP's Name: Surgery: Postcode: Tel no: Fax no: DN/PN/Named Nurse: Address: Tel no: Fax no:	
Next of Kin: Relationship: Address: Tel no:		Date of Assessment: Location of Assessment: Name of Assessor: Signature of Assessor: Source of Referral: (please circle) GP PN DN HOSPITAL OTHER If "other", please state:	

PLEASE NOTE: Clinical Findings from the holistic and ulcer assessment must be considered along with the ABPI when making a decision about treatment.

NURSING DIAGNOSIS OF LEG ULCER AETIOLOGY (please circle):

VENOUS ARTERIAL MIXED TRAUMATIC MALIGNANT DIABETIC RHEUMATOID OTHER

If **"other"** please state:

The assessment and treatment plan has been discussed with the patient and they have indicated that they understand and agree to the treatment plan? YES / NO

Name Of Assessor: Signature Of Assessor:

Signature Of Patient: Date:

PART 2: GENERAL PATIENT ASSESSMENT

Past Medical History:	Current Medication + Dose:

Known drug allergies:

Allergies to dressings/topical preparations (including rubber):

Temperature: Pulse: Blood Pressure Urinalysis:	Weight: Height: Body Mass Index: Blood Sugar Level: Blood Results:

VENOUS RELATED RISK FACTORS	RIGHT	LEFT
Deep Vein Thrombosis	YES/NO	YES/NO
Past Surgery	YES/NO	YES/NO
Past Venous Surgery	YES/NO	YES/NO
Lower Leg Fractures	YES/NO	YES/NO
Orthopaedic Surgery	YES/NO	YES/NO
Thrombophlebitis	YES/NO	YES/NO
Varicose Veins	YES/NO	YES/NO
Prior Venous Ulceration	YES/NO	YES/NO
Multiple Pregnancies	YES/NO	
Any Prolonged Periods Of Bed Rest (↑ 4 Days)	YES/NO	

ARTERIAL RELATED RISK FACTORS	RIGHT	LEFT
Peripheral Vascular Disease	YES/NO	YES/NO
Arterial Surgery	YES/NO	YES/NO
Rheumatoid Arthritis	YES/NO	YES/NO
Intermittent Claudication	YES/NO	YES/NO
Diabetes Mellitus	YES/NO	
Angina	YES/NO	
Ischaemic Heart Disease	YES/NO	
Myocardial Infarction	YES/NO	
Trans.Ischaemic Attack	YES/NO	
Cva (Stroke)	YES/NO	
Smoker (amount and duration)…….	YES/NO	
Hypertension	YES/NO	
Hypercholesterolaemia	YES/NO	

VENOUS RELATED SIGNS / SYMPTOMS	RIGHT	LEFT
Varicose Veins	YES/NO	YES/NO
Pigmentation (Brown Staining)	YES/NO	YES/NO
Induration (Hard Woody Feeling In Skin)	YES/NO	YES/NO
Varicose Eczema	YES/NO	YES/NO
Atrophe Blanche	YES/NO	YES/NO
Ankle Flare	YES/NO	YES/NO
Oedema	YES/NO	YES/NO
Itching over Varices	YES/NO	YES/NO
Ulcer over Malleolus	YES/NO	YES/NO
Ulcer within Gaitor area	YES/NO	YES/NO
Aching or heaviness In legs	YES/NO	YES/NO

ARTERIAL RELATED SIGNS / SYMPTOMS	RIGHT	LEFT
Capillary Refill Time ↑ 3 secs	YES/NO	YES/NO
Dusky Skin Colour on foot	YES/NO	YES/NO
Foot/Toes Blanche when raised Above hip level	YES/NO	YES/NO
Cold foot	YES/NO	YES/NO
Loss Of Hair on leg	YES/NO	YES/NO
Atrophic, shiny skin on shin	YES/NO	YES/NO
Muscle wasting in calf/ thigh	YES/NO	YES/NO
Thickened toe nails	YES/NO	YES/NO
Ulcers on toes	YES/NO	YES/NO
Gangrene on toes	YES/NO	YES/NO
Loss of pedal pulses	YES/NO	YES/NO
Pain In Lower Legs/Foot when raised	YES/NO	YES/NO

Is there any family history of the above?

MOBILITY:

FULLY MOBILE PARTIALLY MOBILE MOBILE WITH AIDS IMMOBILE (please circle)

Does the patient walk heel to toe? YES / NO

Ankle movement: **LEFT:** MOBILE REDUCED FIXED (please circle)
RIGHT: MOBILE REDUCED FIXED (please circle)

Is patient able to elevate legs? YES / NO

Does patient sleep in bed? YES / NO

Please note: If mobility is affected consider referral to Physiotherapist.

PART 3: PAIN ASSESSMENT

Does the patient have pain? At night? At rest? On movement? Is sleep disturbed?	YES / NO YES / NO YES / NO YES / NO YES / NO	Patient's own description of pain:
What helps to relieve pain? Current pain relief:		What makes the pain worse? **Please note:** If appropriate use the "Patient/Carer/Professional Pain Monitoring Form."
Has the pain become worse during the last 2 weeks? Does the patient experience night pain in the lower limbs? Does hanging leg(s) down help relieve the pain? Has the pain affected the patient's activities of daily living? (if yes explain how)		YES / NO YES / NO YES / NO YES / NO

PAIN ANALOGUE SCALE

0= NO PAIN 1=MILD PAIN 2=MODERATE PAIN 3=SEVERE PAIN 4=VERY SEVERE PAIN 5= WORST EVER PAIN

(Tick appropriate box)	**0**	**1**	**2**	**3**	**4**	**5**	CONSTANT	INTERMITTENT
DAY								
NIGHT								
AT DRESSING CHANGE								

PART 4: NUTRITION

Does the patient eat a well balanced diet? Does the patient have a reduced appetite? Does patient appear: FRAIL /UNDERWEIGHT/ NORMAL/ OVERWEIGHT (please circle) Is patient well hydrated? (test skin turgor, moist tongue, colour & concentration of urine) Has there been weight loss in the last 3 months? If YES, is weight loss deliberate? If YES, how much weight loss? Over what period of time? Is this significant for the patient? Dietician referral indicated? (include details & date of referral)	YES / NO YES / NO YES / NO YES / NO YES / NO YES / NO YES / NO	• *If initial assessment highlights any deficits complete a MUST assessment* • *If weight loss is significant do a full nutritional assessment and refer to Dietician / GP.* • *Overweight patients may also benefit from dietician referral for weight reducing advice*. **Problems noted:**

PART 5: CONDITION OF FEET

Does patient receive podiatry treatment? YES / NO (If yes, give details where)

Does patient need podiatry care? YES / NO (If yes, give details of advice/referral)

Condition of feet/toes/nails (include number of toes, skin condition, deformities etc.)

RIGHT FOOT:

LEFT FOOT:

PART 6: PSYCHOLOGICAL ASSESSMENT

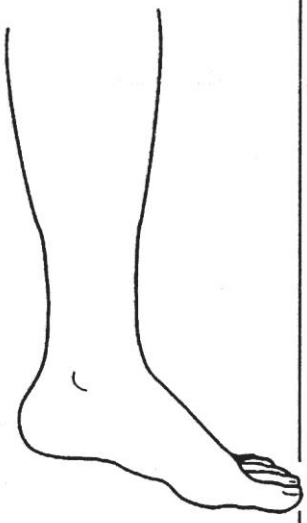
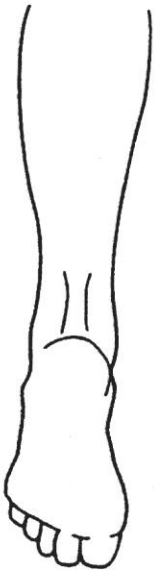
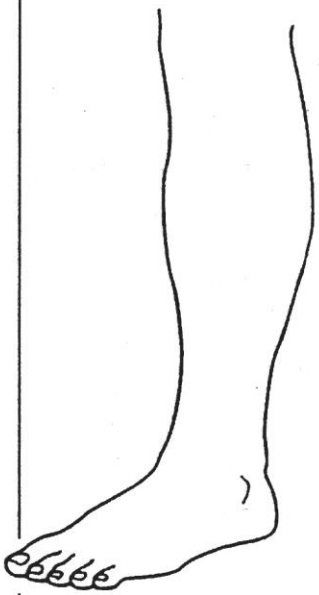
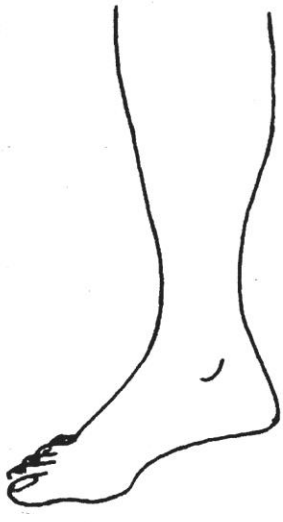
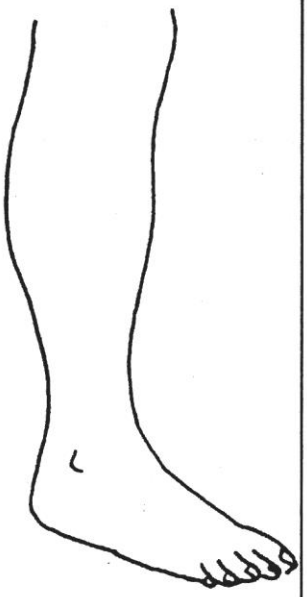
Include details of the following in this section: motivation, embarrassment, anxiety level, indifference, depression, coping strategies. Also any psychological impairment that may affect concordance with treatment e.g. dementia, learning difficulties, lifestyle choices. Also detail any behavioural problems that may impact on treatment and drug/alcohol dependency.
SUPPORT & SOCIAL NETWORK i.e. Family structure, carers, ability to assist with patient care, hobbies, interests, Social Services input. Detail attitudes and any avoidance of social activities due to leg ulcer.
What are the patient's priorities for care?

PART 7: ULCER HISTORY

	RIGHT LEG / FOOT	LEFT LEG / FOOT
How did ulcer start?		
Duration of present ulcer:		
Time since first ulcer appeared:		
Number of episodes of ulceration:		
Previous treatments; successful and unsuccessful.		
Time free from ulcers:		
How long did previous ulcer(s) take to heal?		
Who is treating present ulcer?		
Current dressing regime?		
Ankle Circumference (cms) Calf Circumference (cms)		

PART 8: DIAGRAM OF ULCER POSITION

Please number ulcer(s) on diagrams below i.e.1,2,3,4

	LEFT MEDIAL VIEW	POSTERIOR VIEW	ANTERIOR VIEW	LEFT LATERAL VIEW
LEFT LEG				
	RIGHT MEDIAL VIEW	**ANTERIOR VIEW**	**POSTERIOR VIEW**	**RIGHT LATERAL VIEW**
RIGHT LEG				

PART 9: ULCER DESCRIPTION (record details of additional ulcers and subsequent wound assessments on the Trusts wound chart and attach to this Leg Ulcer Assessment Form)

	ULCER 1	ULCER 2	ULCER 3	ULCER 4
Date				
Site of ulcer				
Measurements in cms (width and length)	W=	W=	W=	W=
	L=	L=	L=	L=
Depth (superficial, dermal, deep dermal, tendon exposed, bone Exposed etc.)				
Edges of ulcer (shallow, rolled, punched out. Detail shape of ulcer i.e. regular or irregular)				
Type of tissue in ulcer bed (necrotic, sloughy, granulating, epithelialising. Infected. Calculate in % of total wound)				
Appearance of ulcer bed (black, yellow, red, pink, green)				
Exudate (Slight, Moderate, Copious. Indicate strike through how many layers of dressing)				
Colour of exudate				
Malodourous	YES / NO	YES / NO	YES / NO	YES / NO
Signs of infection (redness, inflammation, purulent discharge, pyrexia, patient unwell				
Microbiology swab taken (include date)	YES / NO	YES / NO	YES / NO	YES / NO
Result of microbiology swab + resistance + sensitivities				
Ulcer traced (retrace ulcer every 4-6 weeks. If no improvement re-evaluate care)	YES / NO	YES / NO	YES / NO	YES / NO
Ulcer photographed	YES / NO	YES / NO	YES / NO	YES / NO

PART 10: CONDITION OF SURROUNDING SKIN

	ULCER 1	ULCER 2	ULCER 3	ULCER 4
Skin intact	YES / NO	YES / NO	YES / NO	YES / NO
Dry eczema	YES / NO	YES / NO	YES / NO	YES / NO
Wet eczema	YES / NO	YES / NO	YES / NO	YES / NO
Cellulitis (red, swollen, hot, painful)	YES / NO	YES / NO	YES / NO	YES / NO
Induration (hard feeling)	YES / NO	YES / NO	YES / NO	YES / NO
Skin excoriated from exudate	YES / NO	YES / NO	YES / NO	YES / NO
Dry and flaky skin	YES / NO	YES / NO	YES / NO	YES / NO
Macerated, white, wet skin	YES / NO	YES / NO	YES / NO	YES / NO
Brown staining	YES / NO	YES / NO	YES / NO	YES / NO

PART 11: DOPPLER ASSESSMENT

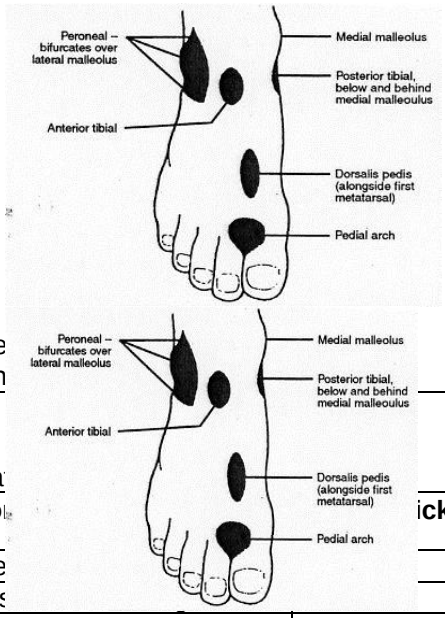
Record the position of the patient during the procedure (circle appropriate): lying flat / reclining at …… (insert approximate degree) sitting upright with legs raised / sitting with legs at downward angle

- Ideally patient should be lying supine for **20** minutes prior to commencing assessment. If patient cannot lie flat, record how far they can recline. Unreliable readings may occur if the patient is upright or legs are lowered.
- Take the systolic brachial pressure in both arms and at least **3** of the following points:

Use Doppler for all pulses including brachial	**RIGHT**	**LEFT**	Record sounds (e.g. tri-phasic bi-phasic / mono-phasic) **RIGHT**	Record sounds (e.g. tri-phasic bi-phasic / mono-phasic) **LEFT**
BRACHIAL				
DORSALIS PEDIS				
ANTERIOR TIBIAL				
POSTERIOR TIBIAL				
PERONEAL				
A.B.P. I *			* ANKLE BRACHIAL PRESSURE INDEX	

CALCULATION: HIGHEST ANKLE PRESSURE = ABPI

HIGHEST BRACHIAL PRESSURE



*If ABPI is between 0.8 and 1.2 and sounds are bi or tri-phasic and venous disease is diagnosed as the underlying aetiology, compression is indicated.
*If ABPI is less than 0.8 and venous disease is the underlying aetiology use compression therapy with caution.
If ABPI is less than 0.7 refer patient for vascular assessment.
*NB: If the patient is diabetic, possible calcification of medial artery wall may give
For more information please refer to the Trust's Leg Ulcer Management Guidelin

PART 12: REFERRALS

Please Note: Referrals should be discussed & agreed with GP/Consultant and pa

Referral To Specialist Indicated? (tick type of referral and record date referred)	**Please tick**	**Reaso**	**ick**
Tissue Viability Service Referral		Initial Assessme	
Vascular Referral		Follow Up Asses	
Dermatology Referral		Duplex Scan	
Diabetic Referral		Vascular Assessment	
Plastic Surgery Referral		Biopsy Of Ulcer	
Podiatry Referral		Advice	
Leg Ulcer Clinic Referral		X-Ray	
Diabetic Nurse Specialist Referral		Skin Grafting	
Physiotherapy Referral		Shared care	
Dietician Referral			
Lymphoedema Service			
Other		Other (please specify)	

Name & address of specialist to whom the patient has been referred:

Date:

Comments:

PART 13: TREATMENT PLAN (also select appropriate care plan)

	ULCER 1	ULCER 2	ULCER 3	ULCER 4
Clean ulcer with:				
Dress ulcer with: • primary dressing				
• secondary dressing				
Dressing secured with:				
Apply compression? YES/NO (please indicate)				
Type of compression system e.g. 4 layer, short stretch or long stretch bandages or hosiery.				
Name components of compression bandage / retention aid / hosiery prescribed: (name all layers including padding bandages and crepe)	1. 2. 3. 4.	1. 2. 3. 4	1. 2. 3. 4	1. 2. 3. 4
Frequency of Renewal:				
Dressing:				
Bandage/Hosiery:				
Please note: If no improvement is seen in the ulcer within 4 weeks then review treatment and consider referral to the Tissue Viability Service.				

PART 14: CARE OF SURROUNDING SKIN

	RIGHT LEG	LEFT LEG
Wash skin with:		
Moisturise skin with:		
Comments:		

PART 15: ONGOING ASSESSMENTS (All patients wearing compression should have a repeat ABPI every 3-6 months.)

3 MONTH ASSESSMENT

Patients lying position:	Assessment completed by: Date:				
Blood Pressure (use Stethoscope)	**L**	**R**		**L**	**R**
Brachial Pressure (use Doppler)			Ankle Circumference		
Record Three of the following pressures:			Calf Circumference		
			For Hosiery: state **Class**		
Dorsalis Pedis			Size:		
Anterior Tibial			Make:		
Posterior Tibial			Open or Closed Toe		
Peroneal			Standard / Made To Measure?		
ABPI			Classification: British / European		

Referral to a specialist indicated? YES/NO	**Referred to:**
Date:	

6 MONTH ASSESSMENT

Patients lying position:	Assessment completed by: Date:				
Blood Pressure (use Stethoscope)	**L**	**R**		**L**	**R**
Brachial Pressure (use Doppler)			Ankle Circumference		
Record Three of the following pressures:			Calf Circumference		
			For Hosiery state Class:		
Dorsalis Pedis			Size:		
Anterior Tibial			Make:		
Posterior Tibial			Open or Closed Toe		
Peroneal			Standard / Made To Measure?		
ABPI			Classification: British / European		

Referral to a specialist indicated? YES / NO	**Referred to:**
Date:	

9 MONTH ASSESSMENT

Patients lying position:	Assessment completed by: Date:				
Blood Pressure (use Stethoscope)	**L**	**R**		**L**	**R**
Brachial Pressure (use Doppler)			Ankle Circumference		
Record Three of the following pressures:			Calf Circumference		
			For Hosiery state Class:		
Dorsalis Pedis			Size:		
Anterior Tibial			Make:		
Posterior Tibial			Open or Closed Toe		
Peroneal			Standard / Made To Measure?		
ABPI			Classification: British / European		

Referral to a specialist indicated? YES / NO	**Referred to:**
Date:	

12 MONTH ASSESSMENT

Patients lying position:	Assessment completed by: Date:				
Blood Pressure (use Stethoscope)	**L**	**R**		**L**	**R**
Brachial Pressure (use Doppler)			Ankle Circumference		
Record Three of the following pressures:			Calf Circumference		
			For Hosiery state Class:		
Dorsalis Pedis			Size:		
Anterior Tibial			Make:		
Posterior Tibial			Open or Closed Toe		
Peroneal			Standard / Made To Measure?		
ABPI			Classification: British / European		

Referral to a specialist indicated? YES / NO	**Referred to:**
Date:	

CONTINUATION SHEET

(Use this section to document extra observations or details that would not fit on the assessment form and to summarise and outline management plan. Supplement with Care Plans where necessary)

Date	Comments	Signature

CONTINUATION SHEET

DATE	COMMENTS	SIGNATURE