

# Diabetic Foot Care Fax Back Report

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Fax # \_\_\_\_\_

	<b>Assessment</b> (Boxes checked if applicable. Results not within normal limits indicated in narrative comments)
<b>Vascular status:</b>	Pedal pulses <input type="checkbox"/> 4(bounding) <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0(absent)
	<b>Comments:</b>
<b>Neurological status:</b>	<input type="checkbox"/> Intact, bilaterally <input type="checkbox"/> At risk (see comments)
	<b>Comments:</b>
<b>Integumentary status:</b>	<input type="checkbox"/> No lesions, bilaterally
	<b>Comments:</b>
<b>Current Podiatric Rx's:</b>	<input type="checkbox"/> None
<b>Diabetic Foot Wear Indicated?</b>	<input type="checkbox"/> Yes (see comments) <input type="checkbox"/> No restrictions
	<b>Comments:</b>
<b>Other Notes:</b>	

Progress note to follow?     Yes     No    Follow- up interval \_\_\_\_\_

Podiatric Physician Name (please print) \_\_\_\_\_

Podiatric Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_