Leg Ulcer Assessment Form

This form has been developed by the NZWCS www.nzwcs.org.nz and is to be used in conjunction with the Australian and NZ Clinical Practice Guideline for Prevention and Management of Venous Leg Ulcers http://www.awma.com.au/publications/2011_awma_vlug.pdf The NZWCS does not take any responsibility for any outcomes through using this form. The form is for competent healthcare professionals (HCPs) trained in leg ulcer assessment and does not replace the HCPs clinical judgement in each individual case.

Surname: First name: Preferred name: NHI No: DOB: Address: Telephone: Email:	Ethnic group: NOK & Telephone: Occupation: ACC Number: Injury Date:
Department: Name of Assessor: Date: Assessor Role:	GP & Telephone: Referred by: Specialists involved in care:

HISTORY – Clinical, Pain & Leg Ulcer

Patient visit expectations:

Current community & family support:

Presenting problem & ulcer/s location:
** Consider specialist referral if past history skin/wound malignancy*

Current Ulcer History	*Past Ulcer History*
Presenting ulcer is recurrent: Y / N Duration of current ulcer: How leg ulcer occurred: **Consider spontaneous, trauma, eczema, not wearing compression hosiery*	Past history of ulcers: Y / N Approx. time to heal: circle <6wks / 6-12wks / >12wks Time since last ulcer: < 12wks / 12wks-6months / >6 months

Previous leg ulcer treatments / compression hosiery adherence:

Gait assessment:

**Consider client walks normally striking heel to toe / shuffles / mobilises independently or uses an aid*

Nutrition:

**Discuss daily food / fluid intake. Consider BMI and using a validated nutritional assessment tool e.g. MNA*

Medications:

**Consider drugs that may affect healing: Immunosuppressant's, Cytotoxics, Anti-rheumatics, Nicotine, Corticosteroids, NSAIDs*
**Consider alternative therapies used*

Known allergies / sensitivities:

**Consider drug, food, latex, creams, wound care products*

Alcohol type / amount:
Recreational drug type / amount:
Smoking history:

Identified quality of life (QOL) including psychosocial issues: e.g.: spiritual, cultural beliefs, odour, pain, exudate, lack of sleep, reduced mobility affecting physical function, depression, anxiety, social situation, affecting employment, ADLs, domestic violence
Pain:

**Consider use of a validated QOL assessment tool per guidelines. *Consider pain questions: Provokes what causes it, what makes it better?, Quality description of the pain, Radiates localised, moves?, Severity on a scale of 1-10, Time when did it start, how long it lasts?*

Date: Surname: NHI:

EXAMINATION of the Leg & Ulcer

Possible Pain in Venous Disease	L	R	**Possible Pain in Arterial Disease**	L	R
Pain improved or relieved with limb elevation	❑	❑	Intermittent claudication *crampy calf, thigh or buttock pain that occurs during exercise, especially walking (immobility may obscure symptoms).*	❑	❑
Legs feel heavy, tired, or achy at the end of the day or after standing/sitting for long periods	❑	❑	Rest / night pain (worse with limb elevation) *pain is eased by hanging leg down or standing on cold surface*	❑	❑

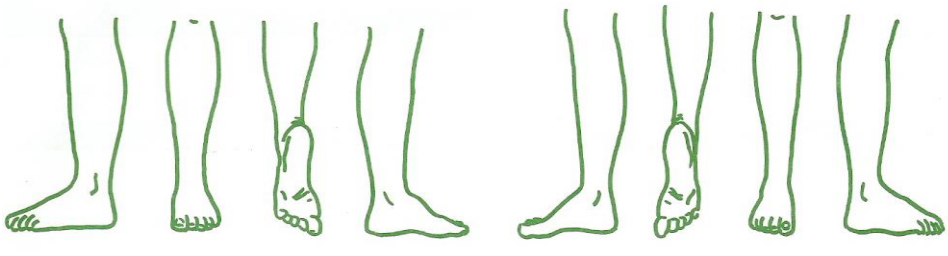
Clinical Indicators Venous Disease	L	R	**Clinical Indicators Arterial Insufficiency**		
Deep venous thrombosis	❑	❑	Heart disease		❑
Previous vein surgery	❑	❑	High blood pressure		❑
Hx phlebitis	❑	❑	Diabetes		❑
Hx episodes chest pain/haemoptysis or PE	❑		Hx of stroke or TIAs		❑
Lower leg fracture/trauma or surgery	❑	❑	Nicotine **consider smoking cessation support*		❑
Reduced mobility/calf pump **test dorsi/plantar flexion*	❑	❑	Elevated cholesterol		❑
Prolonged standing/sitting occupation/s: Y/N			Past arterial surgery/intervention *e.g. CABG, angioplasty*		❑
Number of pregnancies:					
Overweight: Y/N					
Family history of varicose veins/ulcers: Y/N					

Associated Changes in the Leg	L	R	**Associated Changes in the Leg**	L	R
Evidence of healed ulcers	❑	❑	Evidence of scars from revascularisation	❑	❑
Telangiectasias *spider veins 0.1-1mm diameter*	❑	❑	Intermittent claudication	❑	❑
Reticular veins *dilated blue/green veins 1-3mm diameter*	❑	❑	Limb cool to touch	❑	❑
Varicose veins	❑	❑	Surrounding skin shiny & taut	❑	❑
Eczema (dry or wet)	❑	❑	Weak or absent pedal / leg pulses	❑	❑
Pedal / ankle / leg oedema **circle**	❑	❑	Toe amputation/s (review underlying cause)	❑	❑
Lipodermatosclerosis *fibrosed skin above ankle*	❑	❑	Positive Beurger's test *supine position with limb elevated foot pallor occurs (note degree this occurs), and foot rubor on dependency*	❑	❑
Inverted champagne-bottle shaped leg	❑	❑			
Ankle flare *distended veins foot arch or ankle*	❑	❑			
Haemosiderin *reddish brown pigmentation due to haemosiderin deposits*	❑	❑			
Atrophie blanche *ivory/white depressed atrophic plaques with prominent red blotching*	❑	❑			

Venous Ulcer Location & Characteristics	L	R	**Arterial Ulcer Location & Characteristics**	L	R
Shallow	❑	❑	Punched out appearance	❑	❑
Moist	❑	❑	Minimal wound exudate unless infected	❑	❑
Irregular wound edges	❑	❑	Prone to infection	❑	❑
Ruddy granulation tissue	❑	❑	Poorly perfused wound bed *pale, non-granulating and/or necrotic tissue*	❑	❑
Wound exudate moderate to high	❑	❑			
May be odorous	❑	❑	Ulcers located on toes, heels, and bony prominences of the foot **check for inter-digital ulcers*	❑	❑
Ulcers located anterior to medial malleolus or pretibial area *(lower third of leg)*	❑	❑			

Additional relevant past history:

Draw location of wound/s



Left Leg Right Leg

INVESTIGATIONS to Support Diagnosis

The ankle-brachial pressure index (ABPI) identifies arterial insufficiency and should be used to screen all ulcers, and performed by trained and competently assessed healthcare professionals.

Baseline BP			
Pulse examination (- absent / + present) **Palpable pulses alone are insufficient to rule out arterial disease*			
Left dorsalis Pedis (DP):		Right dorsalis Pedis (DP):	
Left posterior tibial (PT):		Right posterior tibial (PT):	
**Consider palpating popliteal and femoral pulses if DP/PT absent*			
Left popliteal		Right popliteal	
Left femoral		Right femoral	

Ankle-Brachial Pressure Index **Do not attempt if DVT, cellulitis or severe pain present or critical limb ischemia*

Left	**Recordings (mmHg)**	**Sounds / Comments**	**Right**	**Recordings (mmHg)**	**Sounds / Comments**
Brachial			Brachial		
DP			DP		
PT			PT		

Results:	**Left leg =**	**Right leg =**
ABPI = Highest pressure from DP or PT for each leg / Highest brachial pressure obtained for both arms		Reason if unable to complete ABPI:

Diagnosis

L R *consider specialist referral to vascular surgeon*

- ❑❑ Venous leg ulcer *ABPI 0.8–1.2 with characteristics of venous aetiology* CEAP Classification: ☐
- ❑❑ Mixed venous / arterial *ABPI 0.6-0.8*
- ❑❑ Arterial leg ulcer *ABPI < 0.6*
- ❑❑ Atypical ulcer
- ❑❑ Arterial calcification *ABPI >1.2*

CEAP classification to evaluate and classify venous disease:
C0 No signs of venous disease / C1 Telangiectasias or reticular veins / C2 Varicose veins / C3 Presence of oedema
C4a Eczema or pigmentation / C4b Lipodermatosclerosis or atrophie blanche / C5 Evidence of a healed VLU / C6 Active VLU

Atypical ulcer characteristics: None/minimal venous and arterial ulcers characteristics, extreme pain, oedema, unusual ulcer appearance or atypical distribution, suspicion of malignancy, deterioration in ulcer or necrotic tissue present, ulcer not healed in three months.

Planning, Implementation & Evaluation

Treatment Objectives:

Management Plan / Review Date:

**Consider: if venous aetiology the 'Leg Ulcer Clinical Pathway' (www.nzwcs.org.nz) provides a six-week time-line and records all interventions and variances that may affect healing. This information can be used to improve patient outcomes and service delivery.*

Professionals need to be trained and competent in the application of compression bandaging

Compression Therapy	**Left Leg**	**Right Leg**
Circumferences (cm)	left ankle = left calf=	right ankle= right calf=
Compression system used:		

Client Education (as appropriate):

- ❑ *What is a Venous Leg Ulcer
- ❑ * Treating Venous Leg Ulcers & Maintaining Leg Health
- ❑ * Preventing Venous Leg Ulcers

*Available from http://www.nzwcs.org.nz/lower-limb-ulcers

Other:

- ❑ Safety: when to remove compression
- ❑ Nutrition / weight management
- ❑ Pain management
- ❑ Diabetes *consider referral to relevant Teams*
- ❑ Smoking Cessation

Referrals Activated from the Consultation (cc GP):
Consider Vascular referral for surgical intervention to prevent venous leg ulcer recurrence according to your organisations criteria.

Wound Nurse Practitioner/ CNS		Vascular Consultant		Dermatologist	
Physiotherapist		Dietician		Occupational Therapist	
Podiatrist		Vascular Lab		Orthotics	
Diabetes Nurse Specialist		Other		Other	
Other		Other		Other	

Date:	Surname:			NHI:	
Wound & Skin Assessment					
Ulcer Location					
Wound Dimensions					
Max length x width cm					
Max depth cm					
Wound Depth √ post cleaning & debridement					
Superficial: epidermis/upper dermis					
Partial: skin loss up to lower dermis					
Full thickness: to subcut tissue					
Full thickness: muscle, tendon, joint capsule or bone					
Unable to determine necrosis or slough					
Wound Tissue √ post cleaning/debridement (approx % of colours) *Alert yellow: document if fat, tendon or bone (consider x-ray to exclude osteomyelitis)*					
Necrotic (black)					
Slough (yellow)					
Granulating (red) state if unhealthy					
Overgranulated (red / raised)					
Epithelialising (pink)					
Other describe:					
Exudate Colour √ & Volume: Dry, Moist, Wet (no strikethrough), Saturated (strikethrough) or Leaking.					
Serous (clear, amber)	**Volume**	**Volume**	**Volume**	**Volume**	**Volume**
Haemoserous (blood stained)					
Sanguineous (heavily blood stained)					
Cloudy, milky or creamy					
Other describe:					
Odour: No / Yes					
Infection Suspected: No / Yes					
Wound Swab: No / Yes					
ABs commenced: No / Yes					
Wound Edge (e.g.: normal, punched-out, rolled, undermined, irregular)					
Describe:					
Surrounding Skin e.g.: Normal, Inflamed, Macerated, Oedematous, Eczema wet/dry, Fragile, Skin stripping, Hard, Cool, Heat. Colour: e.g. red, white, brown					
Describe:					
Pain Grade (1-10) & describe pain e.g. shooting/burning/stabbing = nerve damage OR throbbing, gnawing, aching = tissue damage; NB: may be mixed					
Pre dressing					
During dressing					
Post dressing					
Describe / Location					
Analgesia required for wound care					
TX Objectives: **H**eal, **M**aintenance (healing not realistic), **A**bsorption, **D**ebridement, **R**ehydration, **M**icrobial **C**ontrol, ↓**P**ain, ↓**Od**our, ↓**O**edema, **Pr**otection etc:					
List:					
Product Selection					
Primary Dressing					
Secondary Dressing					