Good Foot Forward

Provider Referral Form

Eligibility:

1. **No access to foot care (i.e. no extended health benefits or ability to pay privately).**
2. **Moderate Risk Criteria** with or without loss of protective sensation as per the assessment & triage tool.

Date of Referral *(dd-mm-yyyy)*	Please fax completed forms to Good Foot Forward Fax # **705-797-2921**

Last Name (legal)	First Name (legal)
Preferred Name (last, first)	DOB (dd-mm-yyyy)
Indigenous Self-Identification: ☐First Nation (Status) ☐First Nation (non-Status) ☐Métis ☐Inuit Other:__________________	
Gender ☐Male ☐Female ☐Non-binary/Prefer not to disclose ☐Unknown	
Address:	
Phone Number:	
Health Card Number:	VC:

Patient Information
☐Type 1 Diabetes ☐Type 2 Diabetes ☐No Diabetes
Peripheral Arterial Disease ☐Yes ☐No

Provider Information
Assessment and Triage Form Completed ☐Yes ☐No
Referring provider's name (physician, NP, diabetes educator, nurse, etc.):
Physician/Nurse Practitioner Name:
Physician/Nurse Practitioner Office Phone:
Physician/Nurse Practitioner Office Address:

If you have questions, please email: goodfoot@rvh.on.ca

Please do not send any personal health information to this email address

Good Foot Forward

Foot Risk Assessment & Triage Form

The Good Foot Forward Program will only take referrals for people who fall under moderate risk criteria.

If the following information is unknown, please leave blank and fax the referral.

Risk Features *(check all that apply)* **(✓)**

Out of Scope - Low Risk

► Routine annual foot exam & diabetes education

In Scope - Moderate Risk Criteria with or without Loss of Protective Sensation

☐Callus/Corn/Fissure/Crack *(not bleeding or draining)*

☐Inadequate foot care - missing, sharp, unkept, thickened, long or deformed toenails

☐Inadequate footwear ☐Infected ingrown toenail

☐Sensation of numbness/tingling/throbbing/burning

► **Refer to Foot Care Provider: Good Foot Forward Program or Chiropody**

Foot Care Managed by Good Foot Forward Program or Chiropody

In Scope - Moderate Risk Criteria - Loss of Protective Sensation at one or more of sites on the foot as pictured, **PLUS** any of the following:

☐Prior history of Diabetic Foot Ulcer *(ulcer in remission)* and or amputation

☐Decreased range of motion at ankle or toe joint ☐Foot Deformities

☐Inadequate footwear requiring therapeutic/custom footwear ☐Altered structure

► **Refer to Good Foot Forward or Chiropody**

Foot Care Managed by Good Foot Forward Program or Chiropody

Out of scope please make referrals as appropriate

High Risk Criteria - Patient presents with **one or more** of the following:

Blister, fissure or crack *(bleeding or draining)* and or hemorrhagic callus

Diabetic Foot Ulcer

Redness over structural deformity of the foot / toes related to pressure

Signs of arterial insufficiency *(PAD; ischemia),* cool skin with pallor, cyanosis or mottling, dependent rubor

One or more pedal pulses not palpable or audible

Inappropriate footwear causing pressure and/or skin breakdown

Refer to:

► **Chiropody**

► **Home and Community Care** for wound care if required

► **Infectious Disease** for consultation if warranted

► **Vascular Surgeon** if appropriate

Managed by Primary Care

Out of scope please make referrals as appropriate

Urgent Risk Criteria - Patient presents with **one or more** of the following:

Infection - draining Diabetic Foot Ulcer and/or wet gangrene

Red, hot, painful joint, or acute Charcot foot

Acute onset of pain in a previously insensate foot

Absent pedal pulses with cold white painful foot or toes

► **Primary Provider Initiates antibiotic therapy** guided by Best Practice Guidelines

► **Offload the affected foot**

► **Refer to the appropriate health care provider** based on the patient assessment findings *(i.e Vascular Surgeon if absent pedal pulses on auscultation)*

► **Home and Community Care** for wound care if required

► **May Require Acute Care Admission**

Comments		
Date Faxed *(dd-mm-yyyy)*	Name	Signature

(Rev2023-12)