

Total Contact Casting (TCC) Treatment and Assessment Form

<input type="checkbox"/>	Initial Report	<input type="checkbox"/>	1 Week Reassessment	<input type="checkbox"/>	3 Week Reassessment	<input type="checkbox"/>	6 Week Reassessment	<input type="checkbox"/>	8 Week Reassessment	<input type="checkbox"/>	Discharge
--------------------------	----------------	--------------------------	---------------------	--------------------------	---------------------	--------------------------	---------------------	--------------------------	---------------------	--------------------------	-----------

Site:	<input type="checkbox"/> Chatham-Kent	<input type="checkbox"/> Sarnia Lambton	<input type="checkbox"/> Windsor Essex
-------	---------------------------------------	---	--

Date:	
-------	--

Patient Name:		BRN:	
---------------	--	------	--

Address:		Postal Code:	
----------	--	--------------	--

Assessing Clinician:		Agency:	
----------------------	--	---------	--

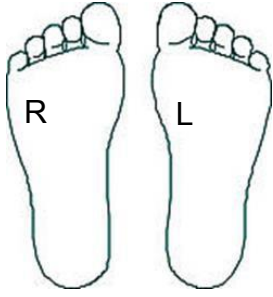
Care Coordinator:		Extension:	
-------------------	--	------------	--

Step 1: Indicate if any of the following contraindications are present:

<input type="checkbox"/> Infection	<input type="checkbox"/> Eschar in wound	<input type="checkbox"/> Vascular status not adequate for healing. Ankle Brachial Index (ABI) < 0.5	<input type="checkbox"/> Untreated osteomyelitis (bone infection) with copious drainage, edema
<input type="checkbox"/> Neuropathic ulcers with exposure of deep structure tendon, joint capsule, bone	<input type="checkbox"/> Ulcer that is deeper than it is wide	<input type="checkbox"/> Non-compliance with visits or protocol	<input type="checkbox"/> Allergy to the casting material
<input type="checkbox"/> Excess leg or foot swelling and fragile skin	<input type="checkbox"/> Patient's foot does not fit in boot; calf exceeds cast size limit	<input type="checkbox"/> Unable to eliminate risk for falls	

Nurse to follow up with the physician regarding a plan to address the contraindications as TCC is not appropriate at this time.

Step 2: All of the following requirements must be met:

<input type="checkbox"/> Diabetic Foot Ulcer	<input type="checkbox"/> Non-infected diabetic foot ulcer	<input type="checkbox"/> Under the care of a primary care provider	<input type="checkbox"/> Verbal consent for TCC provided by patient; aware of need for compliance
Location of Ulcer: 	<input type="checkbox"/> Responsible for care/ownership of Total Contact Cast Boot	<input type="checkbox"/> Verbal consent for referral to Diabetes Education Program (DEP) if last referral > 6 months	<input type="checkbox"/> Able to access Nursing Clinic for treatment
	Patient has adequate vascular supply. ABPI: or TBI: If clinician questions vascular supply, refer to vascular specialist prior to casting.		<input type="checkbox"/> Patient has been provided Emergency Removal Instruction Card

Patient Name:

BRN:

Step 3: To be completed at initial application and after reapplication at week 1, 3, 6 and 8

Check all that apply	Date:					
		Initial	1 Week	3 Week	6 Week	8 Week
Assess for adequate blood supply (ABI <0.5), inadequate (refer to vascular specialist)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Debridement of necrotic/eschar tissue required before TCC application		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing Change as required. Apply TCC		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinician Initials:						

Step 4: Considerations for Discontinuation of TCC:

Check all the apply	Date					
		Initial	1 Week	3 Week	6 Week	8 Week
Wound is deteriorating		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No progression towards healing (e.g. <50% in 4 weeks)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New onset wound infection		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncontrolled or excessive bleeding from debridement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncontrolled pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-compliance (walking without boot, getting cast wet, refusal to attend DEP/CCDC)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient is at risk for falls due to the TCC or is not able to safely ambulate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinician Initials:						

Step 5: Wound Assessment

	Date	Length x width x depth (cm)	Appearance of wound and exudate amount	% of Healing	Clinician Name
Initial					
1 Week					
3 Week					
6 Week					
8 Week					

Considerations for Extension of TCC beyond 8 weeks:

Clinical Rationale:	Two week discharge plan:
---------------------	--------------------------

TCC MUR sent to Physician/Practitioner Yes No