DH WALKER OFFLOADING DEVICE - Eligibility Checklist

Note: This form must be completed by the WCS and submitted for approval along with the Non-Formulary Medical Supply Order Form, via HPG to ESC SUPPLY (Limit 1 x only DH Walker per patient)

Patient Name:_____ **BRN#:** _____

Date: _____ **Depot requested:** _____

Contact # to advise when DH Walker is at depot for pickup _____

******NOTE******

IRREMOVABLE CONTACT CASTS ARE A BETTER OPTION THAN A REMOVABLE CAST WALKER

Reason for DH Walker Request	
Pre-TCC: patient will be attending clinic for application of irremovable TCC TCC pathway assessment complete ☐ Yes ☐ No Approximate date TCC to be initiated _____	☐ Yes ☐ No
Patient not eligible for Total Contact Cast (TCC) at this time, if eligibility changes, patient treatment will include the irremovable Total Contact Cast Pathway to enhance healing	☐ Yes ☐ No
Patient preference: health teaching provided on risks to wound healing if DH Walker removed and patient walks on affected foot (even one step)	☐ Yes ☐ No
Post TCC wound healing: should be worn for 2-4 weeks to enhance remodeling of healed tissue prior to wearing orthotics • Continue to wear DH Walker intermittently throughout the day as foot adjusts to orthotic • Any sign of redness at wound site patient should immediately stop wearing shoe/orthotic, use DH walker in the interim and have shoe/orthotic reassessed. • Keep DH walker on hand in case re-ulceration occurs	☐ Yes ☐ No
If any of the below are answered "Yes", DH Walker is contraindicated and primary care provider follow-up is required	
1. Active untreated infection	☐ Yes ☐ No
2. Vascular status not adequate for healing (ABPI < 0.5)	☐ Yes ☐ No
3. Unable to eliminate risk for falls with offloading device	☐ Yes ☐ No
Clinical Assessment	
A comprehensive lower leg assessment was completed by a Wound Care Specialist prior to request for DH Walker ☐ Yes ☐ No Date of assessment:_____ Results: ABPI Rt_____Lt_____ or TBI Rt_____Lt_____	
Patient has interdisciplinary team in place that is appropriate; including Diabetes Education Program (DEP) visits in place, if not seen within last 6 months	☐ Yes ☐ No

Patient Name:_____ BRN: _____

Patient has resources in place to assess footwear as part of a holistic care plan	☐ Yes ☐ No
If patient requires assistance with footwear/orthotic resources, assistance has been resourced	☐ Yes ☐ No
Psychosocial	
Patient's goal is to heal the wound and understands and agrees to lifestyle modifications for this goal to be achieved: e.g. uses offloading device as prescribed, optimizes nutrition, smoking cessation, good hygiene.	☐ Yes ☐ No
Patient/family can be taught to self-manage the DH Walker	☐ Yes ☐ No

Clinician – Reason to stop offloading device

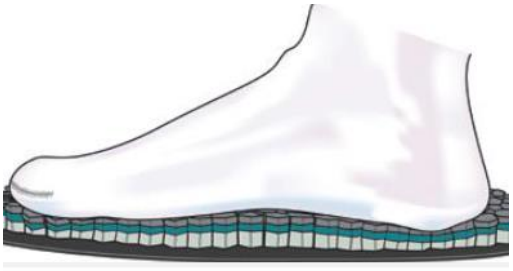
- ☐ Wound is deteriorating
- ☐ New onset of wound infection (until infection had been treated)
- ☐ Uncontrolled or excessive bleeding from debridement
- ☐ Uncontrolled pain
- ☐ Non adherence
- ☐ Patient is at risk for falls and unable to safely ambulate

DH Walker Ordering Information (Limit of 1x only order)

Size	Shoe Size (men)	Shoe Size (Women)
X-Small	**2 to 4**	**3.5 to 5.5**
Small	**4.5 to 7**	**6 to 8**
Medium	**7.5 to 10.5**	**8.5 to 11.5**
Large	**10.5 to 12.5**	**11.5 to 13.5**
X-Large	**12.5 +**	**13.5 +**

Replacement Parts

Rationale for replacement part required:

Size	Softgood (inner liner)	Insoles
X-Small		
Small		
Medium		
Large		
X-Large		
X-Large Soft Good Liner Extension (if circumference is a concern) WSKG-10cm		

_____ _____

Signature of WCS Nurse/Designation **Print Name**