

## Pixalere – Downtime Forms

### How To Use

The forms below are for clinical use in the event of a Pixalere system outage (downtime). Print and complete assessments during a Pixalere system downtime. Update Pixalere with any patient assessments after service has been restored.

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**Appendix A: Ankle Pressure Index Guide**

## Dopplex Ankle Pressure Index (API) Guide

Ankle Pressure (mmHg)

		40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200		
Brachial Pressure (mmHg)	230	17	20	22	24	26	28	30	33	35	37	39	41	43	45	48	50	52	54	57	59	61	63	65	67	70	72	74	76	78	80	83	85	87	230	
	225	18	20	22	24	27	29	31	33	36	38	40	42	44	47	49	51	53	56	58	60	62	64	67	69	71	73	76	78	80	82	84	86	89	91	225
	220	18	20	23	25	27	30	32	34	36	39	41	43	45	48	50	52	55	57	59	61	64	66	68	70	73	75	77	80	82	84	86	89	91	220	
	215	19	21	23	26	28	30	33	35	37	40	42	44	47	49	51	53	56	58	60	63	65	67	70	72	74	77	79	81	84	86	88	91	93	215	
	210	19	21	24	26	29	31	33	36	38	40	43	45	48	50	52	55	57	60	62	64	67	69	71	74	76	79	81	83	86	88	90	93	95	210	
	205	20	22	24	27	29	32	34	37	39	41	44	46	49	51	54	56	59	61	63	66	68	71	73	76	78	80	83	85	88	90	93	95	98	205	
	200	20	23	25	28	30	33	35	38	40	43	45	48	50	53	55	58	60	63	65	68	70	73	75	78	80	83	85	88	90	93	95	98	1.00	200	
	195	21	23	26	28	31	33	36	38	41	44	46	49	51	54	56	59	62	64	67	69	72	74	77	79	82	85	87	90	92	95	97	1.00	1.03	195	
	190	21	24	26	29	32	34	37	39	42	45	47	50	53	55	58	61	63	66	68	71	74	76	79	82	84	87	89	92	95	97	1.00	1.03	1.05	190	
	185	22	24	27	30	32	35	38	41	43	46	49	51	54	57	59	62	65	68	70	73	76	78	81	84	86	89	92	95	97	1.00	1.03	1.05	1.08	185	
	180	22	25	28	31	33	36	39	42	44	47	50	53	56	58	61	64	67	69	72	75	78	81	83	86	89	92	94	97	1.00	1.03	1.06	1.08	1.11	180	
	175	23	26	29	31	34	37	40	43	46	49	51	54	57	60	63	66	69	71	74	77	80	83	86	89	91	94	97	1.00	1.03	1.06	1.09	1.11	1.14	175	
	170	24	26	29	32	35	38	41	44	47	50	53	56	59	62	65	68	71	74	76	79	82	85	88	91	94	97	1.00	1.03	1.06	1.09	1.12	1.15	1.18	170	
	165	24	27	30	33	36	39	42	45	48	52	55	58	61	64	67	70	73	76	79	82	85	88	91	94	97	1.00	1.03	1.06	1.09	1.12	1.15	1.18	1.21	165	
	160	25	28	31	34	38	41	44	47	50	53	56	59	63	66	69	72	75	78	81	84	88	91	94	97	1.00	1.03	1.06	1.09	1.13	1.16	1.19	1.22	1.25	160	
	155	26	29	32	35	39	42	45	48	52	55	58	61	65	69	71	74	77	81	84	87	90	94	97	1.00	1.03	1.06	1.10	1.13	1.16	1.19	1.23	1.26	1.29	155	
	150	27	30	33	37	40	43	47	50	53	57	60	63	67	70	73	77	80	83	87	90	93	97	1.00	1.03	1.07	1.10	1.13	1.17	1.20	1.23	1.27	1.30	1.33	150	
	145	28	31	34	38	41	45	48	52	55	59	62	66	69	72	76	79	83	86	90	93	97	1.00	1.03	1.07	1.10	1.14	1.17	1.21	1.24	1.28	1.31	1.34	1.38	145	
	140	29	32	36	39	43	46	50	54	57	61	64	68	71	75	79	82	86	89	93	96	1.00	1.04	1.07	1.11	1.15	1.19	1.22	1.26	1.30	1.33	1.37	1.41	1.43	140	
	135	30	33	37	41	44	48	52	56	59	63	67	70	74	78	81	85	89	93	96	1.00	1.04	1.07	1.11	1.15	1.19	1.22	1.26	1.30	1.33	1.37	1.41	1.44	1.48	135	
130	31	35	38	42	46	50	54	58	62	65	69	73	77	81	85	88	92	96	1.00	1.04	1.08	1.12	1.15	1.19	1.23	1.27	1.31	1.35	1.38	1.42	1.46	1.50	1.54	130		
125	32	36	40	44	48	52	56	60	64	68	72	76	80	84	88	92	96	1.00	1.04	1.08	1.12	1.16	1.20	1.24	1.28	1.32	1.36	1.40	1.44	1.48	1.52	1.56	1.60	125		
120	33	38	42	46	50	54	58	63	67	71	75	79	83	88	92	96	1.00	1.04	1.08	1.13	1.17	1.21	1.25	1.29	1.33	1.38	1.42	1.46	1.50	1.54	1.58	1.63	1.67	120		
115	35	39	43	48	52	57	61	65	70	74	78	83	87	91	96	1.00	1.04	1.09	1.13	1.17	1.22	1.26	1.30	1.35	1.39	1.43	1.48	1.52	1.57	1.61	1.65	1.70	1.74	115		
110	36	41	45	50	55	59	64	68	73	77	82	86	91	95	1.00	1.06	1.09	1.14	1.18	1.23	1.27	1.32	1.36	1.41	1.45	1.50	1.55	1.59	1.64	1.68	1.73	1.77	1.82	110		
105	38	43	48	52	57	62	67	71	76	81	86	90	95	1.00	1.05	1.10	1.14	1.19	1.24	1.29	1.33	1.38	1.43	1.48	1.52	1.57	1.62	1.67	1.71	1.76	1.81	1.86	1.90	105		
100	40	45	50	55	60	65	70	75	80	85	90	95	1.00	1.05	1.10	1.15	1.20	1.25	1.30	1.35	1.40	1.45	1.50	1.55	1.60	1.65	1.70	1.75	1.80	1.85	1.90	1.95	2.00	100		
95	42	47	53	58	63	68	74	79	84	89	95	1.00	1.05	1.11	1.16	1.21	1.26	1.32	1.37	1.42	1.47	1.53	1.58	1.63	1.68	1.74	1.79	1.84	1.89	1.95	2.00	2.05	2.11	95		
90	44	50	56	61	67	72	78	83	89	94	1.00	1.06	1.11	1.17	1.22	1.28	1.33	1.39	1.44	1.50	1.56	1.61	1.67	1.72	1.78	1.83	1.89	1.94	2.00	2.06	2.12	2.17	2.22	90		

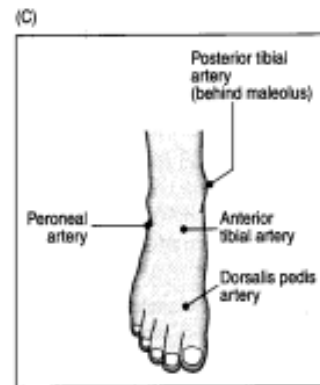
**Appendix B: ABI Measurement Worksheet**

Date: \_\_\_\_\_ Wound Location (if applicable) \_\_\_\_\_

Brachial Systolic Readings	Right Arm	Left Arm
Highest reading of the two arms is used to calculate ABI		

Dorsalis Pedis* Systolic Readings	Right Ankle	Left Ankle
Highest reading for each leg is used to calculate ABI		

Posterior Tibialis* Systolic Readings	Right Ankle	Left Ankle
Highest reading for each leg is used to calculate ABI		



\*Use the peroneal/fibular artery if you are unable to determine the other two ankle systolic readings.

**Calculation of ABI:**

Right leg:  $\frac{\text{Highest Right Ankle reading}}{\text{Highest Brachial reading}}$  \_\_\_\_\_ = \_\_\_\_\_ (Rt Leg ABI)


Left leg:  $\frac{\text{Highest Left Ankle reading}}{\text{Highest Brachial reading}}$  \_\_\_\_\_ = \_\_\_\_\_ (Lt Leg ABI)

Signature: \_\_\_\_\_

ABI Next Due \_\_\_\_\_

Pixalere Basic Lower Limb Assessment Worksheet		
Date	Name	PixID#
Parameters	Right Lower Limb	Left Lower Limb
Missing Limbs or Digits	<input type="checkbox"/> Leg above knee <input type="checkbox"/> Leg below knee <input type="checkbox"/> Foot partial <input type="checkbox"/> Foot all <input type="checkbox"/> Great toe <input type="checkbox"/> Second toe <input type="checkbox"/> Third toe <input type="checkbox"/> Fourth toe <input type="checkbox"/> Fifth toe <input type="checkbox"/> Not applicable	<input type="checkbox"/> Leg above knee <input type="checkbox"/> Leg below knee <input type="checkbox"/> Foot partial <input type="checkbox"/> Foot all <input type="checkbox"/> Great toe <input type="checkbox"/> Second toe <input type="checkbox"/> Third toe <input type="checkbox"/> Fourth toe <input type="checkbox"/> Fifth toe <input type="checkbox"/> Not applicable
Skin Colour	<b>Lower Leg:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black	<b>Lower Leg:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black
	<b>Foot:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black	<b>Foot:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black
	<b>Toes:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black	<b>Toes:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black
Skin Warmth	<b>Lower Leg:</b> <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold	<b>Lower Leg:</b> <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold
	<b>Foot:</b> <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold	<b>Foot:</b> <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold
	<b>Toes:</b> <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold	<b>Toes:</b> <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold
Circulation      Pulses by Palpation	<b>Dorsalis Pedis:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable	<b>Dorsalis Pedis:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable
	<b>Posterior Tibial:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable	<b>Posterior Tibial:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable
Capillary Refill ≤3 sec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Capillary Refill ≥3 sec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Pixalere Basic Lower Limb Assessment Worksheet <small>con't</small>		
Parameters	Right Lower Limb	Left Lower Limb
Range of Motion	<b>Knee:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <b>Ankle:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <b>Great Toe:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	<b>Knee:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <b>Ankle:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <b>Great Toe:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
Edema	<b>Location</b> <input type="checkbox"/> Foot <input type="checkbox"/> Up to ankle <input type="checkbox"/> Up to midcalf <input type="checkbox"/> Up to knee <input type="checkbox"/> Up to groin <input type="checkbox"/> No visible edema	<b>Location</b> <input type="checkbox"/> Foot <input type="checkbox"/> Up to ankle <input type="checkbox"/> Up to midcalf <input type="checkbox"/> Up to knee <input type="checkbox"/> Up to groin <input type="checkbox"/> No visible edema
	<b>Severity</b> <input type="checkbox"/> +1 Trace 2mm pitting <input type="checkbox"/> +2 Moderate 4mm pitting <input type="checkbox"/> +3 Deep 6mm pitting <input type="checkbox"/> +4 Very deep 8mm pitting <input type="checkbox"/> Non-pitting <input type="checkbox"/> None noted	<b>Severity</b> <input type="checkbox"/> +1 Trace 2mm pitting <input type="checkbox"/> +2 Moderate 4mm pitting <input type="checkbox"/> +3 Deep 6mm pitting <input type="checkbox"/> +4 Very deep 8mm pitting <input type="checkbox"/> Non-pitting <input type="checkbox"/> None noted
Sleep Position		
Circumference Measurements	10cm up from heel: _____ cm 30cm up from heel: _____ cm	10cm up from heel: _____ cm 30cm up from heel: _____ cm
Skin Appearance	<input type="checkbox"/> Dry/flaky <input type="checkbox"/> Itchy <input type="checkbox"/> Rash present <input type="checkbox"/> Fragile <input type="checkbox"/> Weepy <input type="checkbox"/> Hairless <input type="checkbox"/> Mottled <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Blister(s) present <input type="checkbox"/> Wound(s) present <input type="checkbox"/> None of the above	<input type="checkbox"/> Dry/flaky <input type="checkbox"/> Itchy <input type="checkbox"/> Rash present <input type="checkbox"/> Fragile <input type="checkbox"/> Weepy <input type="checkbox"/> Hairless <input type="checkbox"/> Mottled <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Blister(s) present <input type="checkbox"/> Wound(s) present <input type="checkbox"/> None of the above
Sensation	<input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Crawling <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> None of the above	<input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Crawling <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> None of the above
Pain	<input type="checkbox"/> Ache <input type="checkbox"/> Knife-like <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Non verbal response <input type="checkbox"/> No pain	<input type="checkbox"/> Ache <input type="checkbox"/> Knife-like <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Non verbal response <input type="checkbox"/> No pain
Comments		
Signature/Designation		

Pixalere Advanced Lower Limb Assessment Worksheet		
Date	Name	PixID#
Parameter	Right Lower Limb	Left Lower Limb
Doppler: Dorsal Pedis	<input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Triphasic <input type="checkbox"/> Not Audible <input type="checkbox"/> Biphasic <input type="checkbox"/> Monophasic	<input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Triphasic <input type="checkbox"/> Not Audible <input type="checkbox"/> Biphasic <input type="checkbox"/> Monophasic
Doppler: Posterior Tibial	<input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Triphasic <input type="checkbox"/> Not Audible <input type="checkbox"/> Biphasic <input type="checkbox"/> Monophasic	<input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Triphasic <input type="checkbox"/> Not Audible <input type="checkbox"/> Biphasic <input type="checkbox"/> Monophasic
<b>Ankle Brachial Index</b> *Use Peroneal pulse only if Dorsal Pedis and/or Posterior Tibial pulses are unavailable  ** In Pixalere, please chart if unable to compress arteries in the Comments text box	Dorsal Pedis Pressure: Posterior Tibial Pressure: Brachial Pressure: Peroneal Pressure*: ABI Score: Unable to compress arteries** <input type="checkbox"/>	Dorsal Pedis Pressure: Posterior Tibial Pressure: Brachial Pressure: Peroneal Pressure*: ABI Score: Unable to compress arteries** <input type="checkbox"/>
<b>Toe Brachial Pressure Index</b>	Toe Pressure: Brachial Pressure: TBI Score:	Toe Pressure: Brachial Pressure: TBI Score:
<b>Semmes-Weinstein Monofilament Test</b> 	<input type="checkbox"/> 1 <sup>st</sup> Digit <input type="checkbox"/> 3 <sup>rd</sup> Digit <input type="checkbox"/> 5 <sup>th</sup> Digit <input type="checkbox"/> 1 <sup>st</sup> MTH <input type="checkbox"/> 3 <sup>rd</sup> MTH <input type="checkbox"/> 5 <sup>th</sup> MTH <input type="checkbox"/> Medial <input type="checkbox"/> Lateral <input type="checkbox"/> Heel <input type="checkbox"/> Dorsum ___ / ___ Score	<input type="checkbox"/> 1 <sup>st</sup> Digit <input type="checkbox"/> 3 <sup>rd</sup> Digit <input type="checkbox"/> 5 <sup>th</sup> Digit <input type="checkbox"/> 1 <sup>st</sup> MTH <input type="checkbox"/> 3 <sup>rd</sup> MTH <input type="checkbox"/> 5 <sup>th</sup> MTH <input type="checkbox"/> Medial <input type="checkbox"/> Lateral <input type="checkbox"/> Heel <input type="checkbox"/> Dorsum ___ / ___ Score
<b>Nail/Foot Care Provided</b>	<input type="checkbox"/> Washed (prior to nail care) <input type="checkbox"/> Filed (regular) <input type="checkbox"/> Filed (rotary tool) <input type="checkbox"/> Trimmed (clippers) <input type="checkbox"/> Trimmed (nippers) <input type="checkbox"/> Trimmed (rotary tool) <input type="checkbox"/> Thinning nails (rotary tool) <input type="checkbox"/> Reduce callus (rotary tool) <input type="checkbox"/> Nail Treatment (ingrown toenail) <input type="checkbox"/> Nail Treatment (anti-fungal applied) <input type="checkbox"/> Cleansed (after nail care) <input type="checkbox"/> Moisturized <input type="checkbox"/> Sock/Footwear applied <input type="checkbox"/> Other: Comments:	<input type="checkbox"/> Washed (prior to nail care) <input type="checkbox"/> Filed (regular) <input type="checkbox"/> Filed (rotary tool) <input type="checkbox"/> Trimmed (clippers) <input type="checkbox"/> Trimmed (nippers) <input type="checkbox"/> Trimmed (rotary tool) <input type="checkbox"/> Thinning nails (rotary tool) <input type="checkbox"/> Reduce callus (rotary tool) <input type="checkbox"/> Nail Treatment (ingrown toenail) <input type="checkbox"/> Nail Treatment (anti-fungal applied) <input type="checkbox"/> Cleansed (after nail care) <input type="checkbox"/> Moisturized <input type="checkbox"/> Sock/Footwear applied <input type="checkbox"/> Other: Comments:
<b>Positive Stemmer's Sign</b>	Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Present: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Limb Shape</b>	<input type="checkbox"/> Champagne-bottle shaped leg <input type="checkbox"/> Wasted calf muscle <input type="checkbox"/> None of the above	<input type="checkbox"/> Champagne-bottle shaped leg <input type="checkbox"/> Wasted calf muscle <input type="checkbox"/> None of the above


Pixalere Advanced Lower Limb Assessment Worksheet <small>con't</small>		
Parameter	Right Lower Limb	Leg Lower Limb
Foot Assessment	<input type="checkbox"/> Bunion(s) <input type="checkbox"/> Callus(es) <input type="checkbox"/> Cracks/fissures <input type="checkbox"/> Corn(s) <input type="checkbox"/> Plantar's wart(s) <input type="checkbox"/> Dropped metatarsal head(s) <input type="checkbox"/> Hammertoe(s) <input type="checkbox"/> Crossed toes <input type="checkbox"/> Cracks between toes <input type="checkbox"/> Abnormal skin dryness <input type="checkbox"/> Acute Charcot <input type="checkbox"/> Chronic Charcot <input type="checkbox"/> None of the above Comments:	<input type="checkbox"/> Bunion(s) <input type="checkbox"/> Callus(es) <input type="checkbox"/> Cracks/fissures <input type="checkbox"/> Corn(s) <input type="checkbox"/> Plantar's wart(s) <input type="checkbox"/> Dropped metatarsal head(s) <input type="checkbox"/> Hammertoe(s) <input type="checkbox"/> Crossed toes <input type="checkbox"/> Cracks between toes <input type="checkbox"/> Abnormal skin dryness <input type="checkbox"/> Acute Charcot <input type="checkbox"/> Chronic Charcot <input type="checkbox"/> None of the above Comments:
Toe Nail Assessment	<input type="checkbox"/> Incorrect length - short <input type="checkbox"/> Incorrect length - long <input type="checkbox"/> Ingrown nail(s) <input type="checkbox"/> Thin <input type="checkbox"/> Brittle <input type="checkbox"/> Thickened nail(s) <input type="checkbox"/> Ridged <input type="checkbox"/> Discoloured <input type="checkbox"/> Involuted nail(s) <input type="checkbox"/> Ram's Horn formation <input type="checkbox"/> Fungal infection <input type="checkbox"/> None of the above Comments:	<input type="checkbox"/> Incorrect length - short <input type="checkbox"/> Incorrect length - long <input type="checkbox"/> Ingrown nail(s) <input type="checkbox"/> Thin <input type="checkbox"/> Brittle <input type="checkbox"/> Thickened nail(s) <input type="checkbox"/> Ridged <input type="checkbox"/> Discoloured <input type="checkbox"/> Involuted nail(s) <input type="checkbox"/> Ram's Horn formation <input type="checkbox"/> Fungal infection <input type="checkbox"/> None of the above Comments:
<b>Skin Assessment</b> (see Basic Assessment: Skin for additional information)	<input type="checkbox"/> Blanching on elevation <input type="checkbox"/> Dependent rubor <input type="checkbox"/> Hemosiderin staining <input type="checkbox"/> Woody fibrosis <input type="checkbox"/> Venous dermatitis <input type="checkbox"/> Atrophie blanche <input type="checkbox"/> Contract dermatitis/pruritis <input type="checkbox"/> Ankle flare <input type="checkbox"/> Varicosities <input type="checkbox"/> Hyperkeratosis <input type="checkbox"/> Papillomatosis <input type="checkbox"/> None of the above	<input type="checkbox"/> Blanching on elevation <input type="checkbox"/> Dependent rubor <input type="checkbox"/> Hemosiderin staining <input type="checkbox"/> Woody fibrosis <input type="checkbox"/> Venous dermatitis <input type="checkbox"/> Atrophie blanche <input type="checkbox"/> Contract dermatitis/pruritis <input type="checkbox"/> Ankle flare <input type="checkbox"/> Varicosities <input type="checkbox"/> Hyperkeratosis <input type="checkbox"/> Papillomatosis <input type="checkbox"/> None of the above
<b>Pain</b> (see Basic Assessment: Pain for additional information)	<input type="checkbox"/> With deep palpation <input type="checkbox"/> Relieved with elevation <input type="checkbox"/> Relieved with rest <input type="checkbox"/> Relieved with dependent position <input type="checkbox"/> Intermittent claudication <input type="checkbox"/> Pain at night <input type="checkbox"/> No pain	<input type="checkbox"/> With deep palpation <input type="checkbox"/> Relieved with elevation <input type="checkbox"/> Relieved with rest <input type="checkbox"/> Relieved with dependent position <input type="checkbox"/> Intermittent claudication <input type="checkbox"/> Pain at night <input type="checkbox"/> No pain
Comments		
Signature/Designation		

Pixalere Basic Upper Limb Assessment Worksheet		
Date	Name	PixID#
Parameters	Right Upper Limb	Left Upper Limb
<b>Missing Limbs or Digits</b>	<input type="checkbox"/> Arm above elbow <input type="checkbox"/> Arm below elbow <input type="checkbox"/> Hand partial <input type="checkbox"/> Hand all <input type="checkbox"/> Thumb <input type="checkbox"/> Second finger <input type="checkbox"/> Third finger <input type="checkbox"/> Fourth finger <input type="checkbox"/> Fifth finger <input type="checkbox"/> Not applicable	<input type="checkbox"/> Arm above elbow <input type="checkbox"/> Arm below elbow <input type="checkbox"/> Hand partial <input type="checkbox"/> Hand all <input type="checkbox"/> Thumb <input type="checkbox"/> Second finger <input type="checkbox"/> Third finger <input type="checkbox"/> Fourth finger <input type="checkbox"/> Fifth finger <input type="checkbox"/> Not applicable
<b>Skin Colour</b>	<b>Arm:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black	<b>Arm:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black
	<b>Hand:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black	<b>Hand:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black
	<b>Fingers:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black	<b>Fingers:</b> <input type="checkbox"/> Pale <input type="checkbox"/> Flesh/tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black
<b>Skin Warmth</b>	<b>Lower Arm:</b> <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	<b>Lower Arm:</b> <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot
	<b>Hand:</b> <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	<b>Hand:</b> <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot
	<b>Fingers:</b> <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	<b>Fingers:</b> <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot
<b>Circulation</b> <b>Pulses by Palpation</b>	<b>Radial:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable	<b>Radial:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable
	<b>Brachial:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable	<b>Brachial:</b> <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable
<b>Capillary Refill ≤3 sec</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Capillary Refill ≥3 sec</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No


Pixalere Basic Upper Limb Assessment Worksheet <small>con't</small>		
Parameter	Right Upper Limb	Left Upper Limb
Range of Motion	Elbow: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	Elbow: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
	Wrist: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	Wrist: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
	Thumb: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	Thumb: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
Edema	Location <input type="checkbox"/> Hand <input type="checkbox"/> Up to wrist <input type="checkbox"/> Up to elbow <input type="checkbox"/> Up to shoulder <input type="checkbox"/> No visible edema	<input type="checkbox"/> Hand <input type="checkbox"/> Up to wrist <input type="checkbox"/> Up to elbow <input type="checkbox"/> Up to shoulder <input type="checkbox"/> No visible edema
	Severity <input type="checkbox"/> Non-pitting <input type="checkbox"/> +1 Trace 2mm pitting <input type="checkbox"/> +2 Moderate 4mm pitting <input type="checkbox"/> +3 Deep 6mm pitting <input type="checkbox"/> +4 Very deep 8mm pitting <input type="checkbox"/> None noted	<input type="checkbox"/> Non-pitting <input type="checkbox"/> +1 Trace 2mm pitting <input type="checkbox"/> +2 Moderate 4mm pitting <input type="checkbox"/> +3 Deep 6mm pitting <input type="checkbox"/> +4 Very deep 8mm pitting <input type="checkbox"/> None noted
Circumference Measurements	Wrist : _____ cm Forearm: _____ cm	Wrist : _____ cm Forearm: _____ cm
Skin Appearance	<input type="checkbox"/> Dry/flaky <input type="checkbox"/> Itchy <input type="checkbox"/> Rash present <input type="checkbox"/> Fragile <input type="checkbox"/> Weepy <input type="checkbox"/> Hairless <input type="checkbox"/> Mottled <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Blister(s) present <input type="checkbox"/> Wound(s) present <input type="checkbox"/> None of the above	<input type="checkbox"/> Dry/flaky <input type="checkbox"/> Itchy <input type="checkbox"/> Rash present <input type="checkbox"/> Fragile <input type="checkbox"/> Weepy <input type="checkbox"/> Hairless <input type="checkbox"/> Mottled <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Blister(s) present <input type="checkbox"/> Wound(s) present <input type="checkbox"/> None of the above
Sensation	<input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Crawling <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> None of the above	<input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Crawling <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> None of the above
Pain	<input type="checkbox"/> Ache <input type="checkbox"/> Knife-like <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Nonverbal response <input type="checkbox"/> No pain	<input type="checkbox"/> Ache <input type="checkbox"/> Knife-like <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Nonverbal response <input type="checkbox"/> No pain
Comments		
Signature/Designation		


Pixalere Mobility Assessment Worksheet		
Date	Patient Name	PixID#
<b>Mobility Assessment</b>		
Weight Bearing	<input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full	
Balance	<input type="checkbox"/> Steady <input type="checkbox"/> Unsteady	
Calf Muscle Pump	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired	
Mobility Aids (Check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Crutches <input type="checkbox"/> Brace <input type="checkbox"/> Cane <input type="checkbox"/> Prosthesis <input type="checkbox"/> Splint	
	<input type="checkbox"/> Walker – no wheels <input type="checkbox"/> Walker – 2 wheels <input type="checkbox"/> Walker – 4 wheels <input type="checkbox"/> Scooter <input type="checkbox"/> Wheelchair	
Gait Pattern		
Walking Distance		
Walking Endurance		
<b>Footwear</b>		
Indoor Footwear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Outdoor Footwear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Orthotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Function</b>		
Muscle Tone	<input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Flat	
	<input type="checkbox"/> Low <input type="checkbox"/> Flaccid	
Arches	<input type="checkbox"/> High <input type="checkbox"/> Normal <input type="checkbox"/> Flat	
Foot Supination	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Foot Pronation	<input type="checkbox"/> Yes <input type="checkbox"/> No	

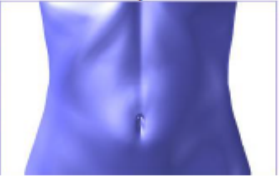
Pixalere Mobility Assessment Worksheet <small>con't</small>		
Parameters	Active	Passive
Dorsiflexion	<input type="checkbox"/> Normal Range of Motion <input type="checkbox"/> Normal strength <input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Decreased strength	<input type="checkbox"/> Normal Range of Motion <input type="checkbox"/> Normal strength <input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Decreased strength
Plantarflexion	<input type="checkbox"/> Normal Range of Motion <input type="checkbox"/> Normal strength <input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Decreased strength	<input type="checkbox"/> Normal Range of Motion <input type="checkbox"/> Normal strength <input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Decreased strength
Great Toe	<input type="checkbox"/> Normal Range of Motion <input type="checkbox"/> Normal strength <input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Decreased strength	<input type="checkbox"/> Normal Range of Motion <input type="checkbox"/> Normal strength <input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Decreased strength
	Right	Left
Proprioception	<input type="checkbox"/> Intact <input type="checkbox"/> Impaired	<input type="checkbox"/> Intact <input type="checkbox"/> Impaired
Comments		
Signature/Designation		

Pixalere Wound Assessment Worksheet		
Date	Name	PixID#
**One wound per worksheet**	Etiology:	Goal of Care: <input type="checkbox"/> Heal <input type="checkbox"/> Maintain <input type="checkbox"/> Monitor/Manage
Assessment Type	<input type="checkbox"/> Full Assessment <input type="checkbox"/> Partial Assessment <input type="checkbox"/> Phone Visit <input type="checkbox"/> Not Assessed	
*Mark wound is located as 'A', 'B', etc 	<b>Recurrent</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Scale 0-10
	<b>Dimensions</b> Length (cm): Width (cm): Depth (cm):	Pain Comments
	<b>Undermining</b> (Use clock face as reference) Site #1:                      Depth: Site #2:                      Depth:	
	<b>Sinus Tract</b> (Use clock face as reference) Site #1:                      Depth: Site #2:                      Depth:	
	<b>Fistula</b>	
<b>Wound Bed</b> Total % must = 100%	<input type="checkbox"/> Superficial pink, red                      % <input type="checkbox"/> Non-granulation tissue                      % <input type="checkbox"/> Granulation tissue                      % <input type="checkbox"/> Slough                      % <input type="checkbox"/> Eschar – dry, stable                      % <input type="checkbox"/> Eschar – soft, boggy                      % <input type="checkbox"/> Bone                      % <input type="checkbox"/> Tendon                      % <input type="checkbox"/> Foreign body                      % <input type="checkbox"/> Not visible                      % <input type="checkbox"/> No open wound                      % <input type="checkbox"/> Fully epithelialized                      % <input type="checkbox"/> Fully callused                      % <input type="checkbox"/> Hematoma                      % <input type="checkbox"/> Epithelial islands                      % <input type="checkbox"/> Blister                      % <input type="checkbox"/> Weepy skin                      % <input type="checkbox"/> Scab                      % <input type="checkbox"/> Visible graft                      % <input type="checkbox"/> Friable                      % <input type="checkbox"/> Malignant tissue                      % <input type="checkbox"/> Fungating tissue                      % <input type="checkbox"/> Hypergranulation tissue                      % <input type="checkbox"/> New tissue damage                      % <input type="checkbox"/> Underlying tissue structure(s)                      % <input type="checkbox"/> Biochemical wound product                      % <input type="checkbox"/> Not Assessed                      %	

Pixalere Wound Assessment Worksheet <small>con't</small>	
Exudate	<input type="checkbox"/> Nil <input type="checkbox"/> Serous <input type="checkbox"/> Sanguineous <input type="checkbox"/> Purulent <input type="checkbox"/> Other <input type="checkbox"/> Not Assessed
Exudate Amount	<input type="checkbox"/> None <input type="checkbox"/> Scant <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large/Copious <input type="checkbox"/> Not Assessed
Odour (After wound cleansing)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Assessed
Wound Edge	<input type="checkbox"/> Diffuse <span style="float: right;"><input type="checkbox"/> Hypergranulation</span> <input type="checkbox"/> Demarcated <span style="float: right;"><input type="checkbox"/> Callused</span> <input type="checkbox"/> Attached <span style="float: right;"><input type="checkbox"/> Scarred</span> <input type="checkbox"/> Not attached <span style="float: right;"><input type="checkbox"/> Not applicable</span> <input type="checkbox"/> Epithelializing <span style="float: right;"><input type="checkbox"/> Not assessed</span> <input type="checkbox"/> Rolled
Peri-Wound Skin	<input type="checkbox"/> Intact <span style="float: right;"><input type="checkbox"/> Rash</span> <input type="checkbox"/> Dry <span style="float: right;"><input type="checkbox"/> Blister</span> <input type="checkbox"/> Fragile <span style="float: right;"><input type="checkbox"/> Bruised</span> <input type="checkbox"/> Macerated <span style="float: right;"><input type="checkbox"/> Edema</span> <input type="checkbox"/> Excoriated/denuded <span style="float: right;"><input type="checkbox"/> Boggy</span> <input type="checkbox"/> Weepy <span style="float: right;"><input type="checkbox"/> Callused</span> <input type="checkbox"/> Tape tear <span style="float: right;"><input type="checkbox"/> Increased warmth</span> <input type="checkbox"/> Indurated <2cm <span style="float: right;"><input type="checkbox"/> Indurated 2cm or &gt;</span> <input type="checkbox"/> Erythema <2cm <span style="float: right;"><input type="checkbox"/> Erythema 2cm or &gt;</span> <input type="checkbox"/> Not Assessed
Treatment and Treatment Comments	
Care Plan Revisions	
Frequency of Change/Next Visit	
Progress Note (PN)	
Referral to WCC:	<input type="checkbox"/> No <input type="checkbox"/> Yes (Urgent) <input type="checkbox"/> Yes (Clinical Review)
Signature/Designation	

Pixalere Incision Assessment Worksheet		
Date	Name	PixID#
** one incision per worksheet**	Etiology	Goal of Care <input type="checkbox"/> To Heal
Assessment Type	<input type="checkbox"/> Full Assessment <input type="checkbox"/> Partial Assessment <input type="checkbox"/> Phone Visit <input type="checkbox"/> Not Assessed	
*Mark incision location as a "1", "2", etc. 	Post-Op Management: <input type="checkbox"/> Not Applicable <input type="checkbox"/> Afebrile <input type="checkbox"/> Lungs clear <input type="checkbox"/> No calf pain <input type="checkbox"/> Drinking well <input type="checkbox"/> Eating well <input type="checkbox"/> Bowels moving <input type="checkbox"/> Voiding well <input type="checkbox"/> Not Assessed <input type="checkbox"/> Concerns Noted: See Progress Notes	Surgical Procedure
		Date of Surgery
		Surgeon
Pain	Scale of 0-10	Pain Comments
Incision Status	<input type="checkbox"/> Approximated <input type="checkbox"/> Fully epithelialized <input type="checkbox"/> Tenuous <input type="checkbox"/> Not Assessed <input type="checkbox"/> Gaping* (if gaping, please fill out Wound Assessment Flowchart)	
Closure Method(s) Insitu	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Sutures <input type="checkbox"/> Staples <input type="checkbox"/> Retention Sutures <input type="checkbox"/> Steri-Strips <input type="checkbox"/> Surgigluce <input type="checkbox"/> Not Assessed	
Exudate	<input type="checkbox"/> Nil <input type="checkbox"/> Serous <input type="checkbox"/> Sanguineous <input type="checkbox"/> Other <input type="checkbox"/> Purulent <input type="checkbox"/> Not Assessed	
Exudate Amount	<input type="checkbox"/> None <input type="checkbox"/> Scant <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large <input type="checkbox"/> Not Assessed	
Peri-Incisional Skin	<input type="checkbox"/> Intact <span style="float: right;"><input type="checkbox"/> Edematous</span> <input type="checkbox"/> Rash <span style="float: right;"><input type="checkbox"/> Blisters</span> <input type="checkbox"/> Bruised <span style="float: right;"><input type="checkbox"/> Increased warmth</span> <input type="checkbox"/> Indurated <2cm <span style="float: right;"><input type="checkbox"/> Indurated 2cm or &gt;</span> <input type="checkbox"/> Erythema <2cm <span style="float: right;"><input type="checkbox"/> Erythema 2cm or &gt;</span> <input type="checkbox"/> Not Assessed	
Treatment and Treatment Comments		
Care Plan Revisions		
Frequency of Change/Next Visit		
Progress Note (PN)		
Referral to WCC:	<input type="checkbox"/> No <input type="checkbox"/> Yes (Urgent) <input type="checkbox"/> Yes (Clinical Review)	
Signature/Designation		

Pixalere Tube/Drain Assessment Worksheet		
Date	Name	PixID#
*one tube/drain per worksheet*	Etiology:	Goal of Care: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> To Be Determined
Assessment Type	<input type="checkbox"/> Full Assessment <input type="checkbox"/> Partial Assessment <input type="checkbox"/> Phone Visit <input type="checkbox"/> Not Assessed	
*Mark where drain is located as a "1", "2", etc. 	Type of Drain	Surgery
	Tube/Drain Changed <input type="checkbox"/> Yes Date: Changed By:  <input type="checkbox"/> Not Applicable	Date of Surgery
	Tube/Drain Sutured <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Surgeon
Pain	Scale of 0-10:	Pain Comments:
Measurements	Feeding Tube Length (cm.mm): _____ (Long Tube Only)	
Drainage Amount	_____ ml in _____ hours or time from _____ to _____	
Drainage Characteristics	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Serous <input type="checkbox"/> Clear <input type="checkbox"/> Sanguineous <input type="checkbox"/> Cloudy <input type="checkbox"/> Purulent <input type="checkbox"/> Bile <input type="checkbox"/> Yellow <input type="checkbox"/> Odourous <input type="checkbox"/> Green <input type="checkbox"/> Mucousy <input type="checkbox"/> Not Assessed	
Tube/Drain Site	<input type="checkbox"/> Intact <input type="checkbox"/> Eroded <input type="checkbox"/> Hypergranulated <input type="checkbox"/> Not Assessed	
Peri-Tube/Drain Site	<input type="checkbox"/> Intact <input type="checkbox"/> Excoriated <input type="checkbox"/> Fragile <input type="checkbox"/> Rash <input type="checkbox"/> Macerated <input type="checkbox"/> Increased warmth <input type="checkbox"/> Excoriated <input type="checkbox"/> Indurated <2cm <input type="checkbox"/> Indurated 2cm or > <input type="checkbox"/> Erythema <2cm <input type="checkbox"/> Erythema 2cm or > <input type="checkbox"/> Not Assessed	
Treatment and Treatment Comments		
Care Plan Revisions		
Frequency of Change/Next Visit		
Progress Note (PN)		
Referral to WCC:	<input type="checkbox"/> No <input type="checkbox"/> Yes (Urgent) <input type="checkbox"/> Yes (Clinical Review)	
Signature/Designation		

Pixalere Ostomy Assessment Worksheet		
Date	Name	PixID#
*one ostomy per worksheet*	Etiology:	Goal of Care: <input type="checkbox"/> Permanent <input type="checkbox"/> Established <input type="checkbox"/> Temporary <input type="checkbox"/> To Be Determined
Assessment Type	<input type="checkbox"/> Full Assessment <input type="checkbox"/> Partial Assessment <input type="checkbox"/> Phone Visit <input type="checkbox"/> Not Assessed	
*Mark where ostomy is located 	<b>Ostomy Type</b> <b>Fecal Diversion:</b> <input type="checkbox"/> Ileostomy <input type="checkbox"/> Koch Pouch <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileal Anal Pouch – Stage 1 <input type="checkbox"/> Jejunostomy <input type="checkbox"/> Ileal Anal Pouch – Stage 2 <input type="checkbox"/> Cecostomy <input type="checkbox"/> Ileal Anal Pouch – Stage 3  <b>Urinary Diversion:</b> <input type="checkbox"/> Urostomy/Ileal Conduit <input type="checkbox"/> Indiana Pouch <input type="checkbox"/> Neobladder/Studer <input type="checkbox"/> Mitrofanoff	
Stoma Construction	<input type="checkbox"/> New <input type="checkbox"/> Revision <input type="checkbox"/> Loop <input type="checkbox"/> End <input type="checkbox"/> Double Barrel <input type="checkbox"/> Other:	
Devices In Situ	<input type="checkbox"/> Rod/Bridge <input type="checkbox"/> Stent(s)	
Stoma Shape	<input type="checkbox"/> Oval <input type="checkbox"/> Round	
Dimensions	Length (mm):                  Width (mm):                  or Diameter (mm):	
Stoma Appearance Total % must = 100%	<input type="checkbox"/> Pink/Red	%
	<input type="checkbox"/> Dusky	%
	<input type="checkbox"/> Purple/Maroon	%
	<input type="checkbox"/> Slough	%
	<input type="checkbox"/> Necrotic	%
	<input type="checkbox"/> Moist <input type="checkbox"/> Edematous <input type="checkbox"/> Trauma <input type="checkbox"/> Stenosed	
Stoma Os	<input type="checkbox"/> Centered <input type="checkbox"/> Tilted <input type="checkbox"/> Off-centered <input type="checkbox"/> Skin level	
Stoma Height	<input type="checkbox"/> Raised <input type="checkbox"/> Retracted <input type="checkbox"/> Flush <input type="checkbox"/> Prolapsed (>2cm)	
Mucocutaneous Junction <small>(Point where epidermis and mucosa merge) *Separated: Use clock face as reference</small>	<input type="checkbox"/> Intact: with Sutures <input type="checkbox"/> Intact: fully epithelialized <input type="checkbox"/> Suture granuloma <input type="checkbox"/> Separated*    *Site 1:                  Depth:                  *Site 2:                  Depth:	
Peristomal Skin	<input type="checkbox"/> Intact <input type="checkbox"/> Rash – Fungal <input type="checkbox"/> Erythema <input type="checkbox"/> Rash – Contact Dermatitis <input type="checkbox"/> Indurated <input type="checkbox"/> Rash – Folliculitis <input type="checkbox"/> Excoriated <input type="checkbox"/> Rash – Allergy <input type="checkbox"/> Denuded <input type="checkbox"/> Pseudo-verrucous lesions <input type="checkbox"/> Macerated <input type="checkbox"/> Malignant lesion <input type="checkbox"/> MARS! <input type="checkbox"/> Peristomal psoriasis <input type="checkbox"/> Bruised <input type="checkbox"/> Pyoderma gangrenosum <input type="checkbox"/> Wound <input type="checkbox"/> Caput Medusae	
Urine Characteristics	<input type="checkbox"/> Clear <input type="checkbox"/> Concentrated <input type="checkbox"/> Mucous shred <input type="checkbox"/> Cloudy <input type="checkbox"/> Clots <input type="checkbox"/> Sediment <input type="checkbox"/> Malodourous	
Urine Colour	<input type="checkbox"/> Pale yellow <input type="checkbox"/> Yellow <input type="checkbox"/> Amber <input type="checkbox"/> Orange <input type="checkbox"/> Pink <input type="checkbox"/> Red	
Stool Characteristics	<input type="checkbox"/> Flatus <input type="checkbox"/> Mucous <input type="checkbox"/> Watery <input type="checkbox"/> Mushy <input type="checkbox"/> Pasty <input type="checkbox"/> Semi-formed <input type="checkbox"/> Hard <input type="checkbox"/> Fomed <input type="checkbox"/> Other:	
Stool Colour	<input type="checkbox"/> Brown <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Clay <input type="checkbox"/> Bloody	
Mucous Fistula: Fistula Drainage	<input type="checkbox"/> Clear <input type="checkbox"/> Mucousy <input type="checkbox"/> Fecal <input type="checkbox"/> Malodourous <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large <input type="checkbox"/> Not Assessed	

<b>Mucous Fistula: Peri-Fistula Skin</b>	<input type="checkbox"/> Intact <input type="checkbox"/> Erythema <input type="checkbox"/> Indurated <input type="checkbox"/> Excoriated <input type="checkbox"/> Macerated <input type="checkbox"/> Rash																												
<b>Abdominal Contours/Pouching Concerns</b>	<table border="0"> <tr> <td><input type="checkbox"/> Rounded</td> <td><input type="checkbox"/> Stoma ostomy filled</td> </tr> <tr> <td><input type="checkbox"/> Flabby</td> <td><input type="checkbox"/> Stoma flush</td> </tr> <tr> <td><input type="checkbox"/> Distended</td> <td><input type="checkbox"/> Stoma retracted</td> </tr> <tr> <td><input type="checkbox"/> Loose/wrinkly</td> <td><input type="checkbox"/> Stoma prolapsed</td> </tr> <tr> <td><input type="checkbox"/> Pendulous</td> <td><input type="checkbox"/> Proximity bony prominence</td> </tr> <tr> <td><input type="checkbox"/> Soft</td> <td><input type="checkbox"/> Proximity umbilicus</td> </tr> <tr> <td><input type="checkbox"/> Hard</td> <td><input type="checkbox"/> Proximity incision</td> </tr> <tr> <td><input type="checkbox"/> Parastomal hernia</td> <td><input type="checkbox"/> Proximity wound</td> </tr> <tr> <td><input type="checkbox"/> Skin crease/fold</td> <td><input type="checkbox"/> Proximity drain</td> </tr> </table>	<input type="checkbox"/> Rounded	<input type="checkbox"/> Stoma ostomy filled	<input type="checkbox"/> Flabby	<input type="checkbox"/> Stoma flush	<input type="checkbox"/> Distended	<input type="checkbox"/> Stoma retracted	<input type="checkbox"/> Loose/wrinkly	<input type="checkbox"/> Stoma prolapsed	<input type="checkbox"/> Pendulous	<input type="checkbox"/> Proximity bony prominence	<input type="checkbox"/> Soft	<input type="checkbox"/> Proximity umbilicus	<input type="checkbox"/> Hard	<input type="checkbox"/> Proximity incision	<input type="checkbox"/> Parastomal hernia	<input type="checkbox"/> Proximity wound	<input type="checkbox"/> Skin crease/fold	<input type="checkbox"/> Proximity drain										
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<input type="checkbox"/> Soft	<input type="checkbox"/> Proximity umbilicus																												
<input type="checkbox"/> Hard	<input type="checkbox"/> Proximity incision																												
<input type="checkbox"/> Parastomal hernia	<input type="checkbox"/> Proximity wound																												
<input type="checkbox"/> Skin crease/fold	<input type="checkbox"/> Proximity drain																												
<b>Pouching System Change</b>	Pain with pouch change (0 to 10 or N/A): <input type="checkbox"/> Intact <input type="checkbox"/> Changed – teaching <input type="checkbox"/> Changed – routine <input type="checkbox"/> Change - leaked																												
<b>Self Care Progress</b>	<table border="0"> <tr> <td><input type="checkbox"/> Viewed teaching video</td> <td><input type="checkbox"/> Cleansing the peristomal skin</td> </tr> <tr> <td><input type="checkbox"/> Education booklet(s)</td> <td><input type="checkbox"/> Measuring the stoma</td> </tr> <tr> <td><input type="checkbox"/> UOA visitor</td> <td><input type="checkbox"/> Cutting the flange</td> </tr> <tr> <td><input type="checkbox"/> Lesson with family</td> <td><input type="checkbox"/> Applying ostomies as per management plan</td> </tr> <tr> <td><input type="checkbox"/> Viewed stoma</td> <td><input type="checkbox"/> Attaching secondary urinary drainage system</td> </tr> <tr> <td><input type="checkbox"/> Viewed emptying pouch</td> <td><input type="checkbox"/> Measuring output (ileostomy only)</td> </tr> <tr> <td><input type="checkbox"/> Viewed pouch change</td> <td><input type="checkbox"/> Sexual concerns discussed</td> </tr> <tr> <td><input type="checkbox"/> Viewed flange change</td> <td><input type="checkbox"/> Colostomy irrigations</td> </tr> <tr> <td><input type="checkbox"/> Participated with emptying pouch</td> <td><input type="checkbox"/> Ileal Anal Pouch bowel training</td> </tr> <tr> <td><input type="checkbox"/> Participated with pouch change</td> <td><input type="checkbox"/> Ileal Anal Pouch perianal skin maintenance</td> </tr> <tr> <td><input type="checkbox"/> Participated with flange change</td> <td><input type="checkbox"/> Not assessed</td> </tr> <tr> <td><input type="checkbox"/> Independent with emptying pouch</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Independent with pouch change</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Independent with flange change</td> <td></td> </tr> </table>	<input type="checkbox"/> Viewed teaching video	<input type="checkbox"/> Cleansing the peristomal skin	<input type="checkbox"/> Education booklet(s)	<input type="checkbox"/> Measuring the stoma	<input type="checkbox"/> UOA visitor	<input type="checkbox"/> Cutting the flange	<input type="checkbox"/> Lesson with family	<input type="checkbox"/> Applying ostomies as per management plan	<input type="checkbox"/> Viewed stoma	<input type="checkbox"/> Attaching secondary urinary drainage system	<input type="checkbox"/> Viewed emptying pouch	<input type="checkbox"/> Measuring output (ileostomy only)	<input type="checkbox"/> Viewed pouch change	<input type="checkbox"/> Sexual concerns discussed	<input type="checkbox"/> Viewed flange change	<input type="checkbox"/> Colostomy irrigations	<input type="checkbox"/> Participated with emptying pouch	<input type="checkbox"/> Ileal Anal Pouch bowel training	<input type="checkbox"/> Participated with pouch change	<input type="checkbox"/> Ileal Anal Pouch perianal skin maintenance	<input type="checkbox"/> Participated with flange change	<input type="checkbox"/> Not assessed	<input type="checkbox"/> Independent with emptying pouch	<input type="checkbox"/> Other	<input type="checkbox"/> Independent with pouch change		<input type="checkbox"/> Independent with flange change	
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<b>Care Plan Revisions</b>																													
<b>Frequency of Change/Next Visit</b>																													
<b>Progress Note (PN)</b>																													
<b>Referral to WCC:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (Urgent) <input type="checkbox"/> Yes (Clinical Review)																												
<b>Signature/Designation</b>																													