

**DIABETES MULTIDISCIPLINARY FOOT REFERRAL CRITERIA**

* **RED, HOT, SWOLLEN FOOT WITH OR WITHOUT PAIN**
* **DIABETIC FOOT ULCERATION NOT IMPROVING IN 4 WEEKS**
* **DETERIORATING DIABETIC FOOT ULCERATION**
* **RECURRENT DIABETIC FOOT ULCERATION ON SAME SITE WITHIN LAST 12 MONTHS**
* **NECROSIS**
* **BONE VISIBLE OR PROBED IN WOUND BED**
* **WOUND WITH A SCORE OF ≥3 ON SINBAD WOUND CLASSIFICATION SYSTEM**

|  |  |  |  |
| --- | --- | --- | --- |
| SINBAD WOUND CLASSIFICATION SYSTEM | | | |
| CLINICAL DOMAIN | CONDITION | | SCORE |
| **S**ITE | FORE FOOT | | 0 |
| HINDFOOT | | 1 |
| **I**SCHAEMIA | PEDAL BLOOD FLOW INTACT(at least one pulse palpable) | | 0 |
| CLINICAL EVIDENCE OR REDUCE PEDAL BLOOD FLOW | | 1 |
| NEUROPATHY | PROTECTIVE SENSATION INTACT | | 0 |
| PROTECTIVE SENSATION LOST | | 1 |
| **B**ACTERIAL INFECTION | NONE PRESENT | | 0 |
| PRESENT | | 1 |
| **A**REA | ULCER < 10 MM² | | 0 |
| ULCER ≥ 10 MM ² | | 1 |
| DEPTH | ULCER CONFINED TO SKIN AND SUBCUTANNEOUS TISSUE | | 0 |
| ULCER REACHING MUSCLE TENDON OR DEEPER | | 1 |
| Highest score 6 | | TOTAL |  |
| Adapted from Ince et al (2008) | | | |

**IF REFERRING TO DIABETES FOOT CLINIC PLEASE ENSURE PHOTOGRAPH, WOUND SWAB, FOOT SCREENING, INCLUDING PULSES, AND DIABETES BLOODS ARE UP-TO-DATE**

**If a person requires patient transport to clinic please note on the referral form for an appropriate appointment slot to be given.**

**If a person cannot physically attend clinic please note in medical history to allow treatment to be discussed at Diabetes Foot Multidisciplinary Team meeting or remote consultation where possible.**

**Please note clinic runs on Wednesday afternoons in DGRI Outpatients only.**



**DIABETES MULTIDISCIPLINARY FOOT CLINIC REFERRAL**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT DETAILS | | | | | | | |  | | | | | | | | | |
| FULL NAME |  | | | | | | | | | | | | | | | | |
| ADDRESS |  | | | | | | | | | | | | | | | | |
| POSTCODE |  | | CHI |  | | | | | | TRANSPORT REQUIRED Y/N | | | | | |  | |
| REASON FOR REFERRAL | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| REFERRAL CATEGORY | | | | | | | | PLEASE MARK WITH X | | | | | | | | | |
| IF URGENT PLEASE SPECIFY REASON BELOW | | | | | | | | ROUTINE | | |  | | SOON |  | URGENT | |  |
|  | | | | | | | | | | | | | | | | | |
| IF A WOUND IS PRESENT PLEASE COMPLETE | | | | | | | |  | | | | | | | | | |
| DURATION OF WOUND (WEEKS) | | | | |  | | | SINBAD SCORE (SEE OVER) | | | | | | | |  | |
| IS BONE VISIBLE OR PROBED IN WOUND (Y/N) | | | | | | |  | | | | | | | | | | |
| WOUND DIMENSIONS (mm) | | | | | | | LENGTH | |  | WIDTH | | |  | DEPTH | |  | |
| RELEVENT MEDICAL HISTORY | | | | | | | |  | | | | | | | | | |
| PERIPHERAL VASCULAR DISEASE Y/N | | | | | |  | | PERIPHERAL NEUROPATHY Y/N | | | | | | | |  | |
| RECENT X-RAY/MRI Y/N | | | | | |  | | ABLE TO ATTEND OUTPATIENTS Y/N | | | | | | | |  | |
| CURRENT /RECENT ANTIBIOTICS  TYPE AND DOSE | | | | | |  | | | | | | | | | | | |
| OTHER | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| REFERRER DETAILS | | | | | | | |  | | | | | | | | | |
| NAME |  | | | | | | | DESIGNATION | | | |  | | | | | |
| SIGNATURE |  | | | | | | | DATE | | | |  | | | | | |
| CONTACT PHONE / EMAIL | |  | | | | | | | | | | | | | | | |
| PLEASE FORWARD COMPLETED REFERRALS TO DIABETES FOOT TEAM  dg.podclin@nhs.scot | | | | | | | | | | | | | | | | | |