Diabetic Foot Care Assessment Results

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Provider Name: [Insert Provider Name]

Facility: [Insert Facility Name]

Assessment Summary

The following results were obtained during the diabetic foot care assessment conducted on [Insert Date]:

1. Sensation Evaluation

Monofilament Test: [Pass/Fail]

vibration Test: [Pass/Fail]

2. Visual Inspection

Skin Integrity: [Normal/Abnormal]

Presence of Calluses: [Yes/No]

Ulcers/Wounds: [Yes/No]

3. Circulation Assessment

Pulses Palpated: [Dorsalis Pedis/Posterior Tibial/Absent]

Capillary Refill Time: [Normal/Delayed]

Recommendations

[Insert recommendations based on assessment results]

Follow-Up Appointment

Next appointment scheduled for: [Insert Date]

Provider Signature

[Insert Provider Signature]