



**Ontario Health atHome geko™ Wound Therapy Device Eligibility Checklist and  
Assessment Tool**

**\*\* This form must accompany the WCS assessment and the non-formulary request \*\***

**Patient Name:** \_\_\_\_\_ **BRN:** \_\_\_\_\_

<b>Eligibility Criteria</b>		
Wound Location: _____ Number of Wounds: _____		
Wound Etiology: _____ Confirmed by: _____		
Largest Wound Measurement: L _____ cm x W _____ cm x D _____ cm		
1	Has evidenced-based wound care been applied for a minimum of 28 days with less than 30 % healing noted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Clinical Assessment</b>		
2	Lower leg assessment done, no signs/symptoms of ischemia noted; ABPI > 0.5 or TBPI > 0.64 <b>Results:</b> ABPI: Lt: _____ Rt: _____ or TBPI Lt: _____ Rt: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Attempts to improve nutrition for optimal wound healing: ie dietician consult	<input type="checkbox"/> Yes or N/A <input type="checkbox"/> No
4	Localized or deep infection is addressed – no unresolved osteomyelitis	<input type="checkbox"/> Yes or N/A <input type="checkbox"/> No
5	If diabetic, blood glucose levels are in normal range or being addressed	<input type="checkbox"/> Yes or N/A <input type="checkbox"/> No
6	If compression therapy is indicated, the patient has been in compression for at least 14 days prior to geko™ initiation	<input type="checkbox"/> Yes or N/A <input type="checkbox"/> No
7	Skin is intact with no dermatitis in the geko™ application sites	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Psychosocial Criteria</b>		
8	Patient/family can be taught to self-manage the device and are agreeable to do so	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Patient's goal is healing of the wound and agrees to necessary lifestyle changes in order for this goal to be achieved (e.g. offloading, agrees to compression, optimizes nutrition, smoking cessation, good hygiene, diabetes education program, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Physician/Nurse Practitioner</b>		
10	Primary Care Practitioner is aware and agrees to plan of care	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Exclusion Criteria</b>		
11	Patient is older than 19 years of age	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If any of the following develop/occur, geko™ therapy will be discontinued</b>		
➤ No improvement in wound is seen at 28 days (four weeks) of treatment		
➤ Active dermatitis in area of application		
➤ Development of a DVT or PE during the treatment period		
➤ Poor adherence to wound care plan/therapy or not using geko™ as advised		
➤ Poor adherence to offloading devices or compression therapy (failure to treat-the-cause)		

\_\_\_\_\_  
Signature of WCS/Prescriber

\_\_\_\_\_  
Print Name and Designation

\_\_\_\_\_  
Date