



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:** _____


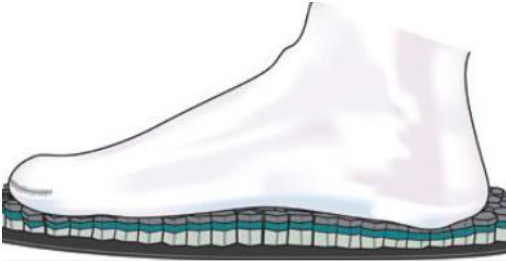
Contact # to advise when DH Walker is at depot for pickup _____

******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 <input type="checkbox"/> Yes <input type="checkbox"/> No Approximate date TCC to be initiated _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient preference: health teaching provided on risks to wound healing if DH Walker removed and patient walks on affected foot (even one step)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post TCC wound healing: should be worn for 2-4 weeks to enhance remodeling of healed tissue prior to wearing orthotics <ul style="list-style-type: none"> 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 	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Vascular status not adequate for healing (ABPI < 0.5)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Unable to eliminate risk for falls with offloading device	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Assessment	
A comprehensive lower leg assessment was completed by a Wound Care Specialist prior to request for DH Walker <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Name: _____ BRN: _____

Patient has resources in place to assess footwear as part of a holistic care plan		<input type="checkbox"/> Yes <input type="checkbox"/> No
If patient requires assistance with footwear/orthotic resources, assistance has been resourced		<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient/family can be taught to self-manage the DH Walker		<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinician – Reason to stop offloading device		
<input type="checkbox"/> Wound is deteriorating <input type="checkbox"/> New onset of wound infection (until infection had been treated) <input type="checkbox"/> Uncontrolled or excessive bleeding from debridement <input type="checkbox"/> Uncontrolled pain <input type="checkbox"/> Non adherence <input type="checkbox"/> 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