

# The Diabetic Foot in Nova Scotia Referral Algorithm

## ● LOW RISK

- Provide **Low Risk** Diabetic Foot Information Sheet
- Provide Patient Foot Care Path

### Foot Care Management and Follow Up by:

- GP
- NP
- Diabetes Educator
- Foot Care Nurse

*(Care by a Foot Specialist is not required for the Low Risk Diabetic Foot)*

**Foot Assessment**  
Annually

## ▼ MODERATE RISK

- Provide **Moderate Risk** Diabetic Foot Information Sheet
- Provide Patient Foot Care Path

### Referral to and Management by:

#### Findings

Skin Abnormalities

Structural Deformities

Vascular Problems

Loss of Protective Sensation

#### Foot Specialist\*

GP/Foot Care Nurse/Podiatrist/Dermatologist

GP/Podiatrist/Orthopedics/Plastics (Pedorthist for footwear problems)

GP/Endocrinologist/Internist/Podiatrist/Vascular Surgeon

GP/Endocrinologist/Internist/Podiatrist/Neurologist

*(Referral for advanced assessment and management should be arranged within 1 to 2 weeks)*

**Foot Assessment**  
Every 4 to 6 months  
*(or as assessed by above)*

## ● HIGH RISK

- Provide **High Risk** Diabetic Foot Information Sheet
- Provide Patient Foot Care Path

### Refer to Foot Specialist\*/Team *(\*As per Moderate Risk)*

#### Manage as indicated for:

- Pressure Off-Loading
- Wound Care
- Vascular Insufficiency
- Antibiotic Therapy

#### Skin Breakdown or Active Ulcer:

- Refer within 24 hours

**Foot Assessment**  
Every 1 to 4 months  
**Skin Breakdown/Active Ulcer**  
Every 1 to 4 weeks

### Strategies to Prevent Diabetic Foot Problems

- Promote daily foot inspections (self/caregiver).
- Provide proper foot care/foot wear education.
- Encourage smoking cessation.
- Reinforce the importance of optimal diabetes management.
- Perform routine foot risk assessment (health professional), including monofilament testing.