Lower Limb Ulcer Assessment Form

Developed from the Clinical Practice Guideline for VLUs 2025: Assessment (Emily Haesler, Ed.). Hong Kong ETA, NZWCS, WA, WHS Singapore. Intended for HCPs trained in leg assessment. Not a substitute for clinical judgment. NZWCS is not liable for outcomes resulting from the use of this form.

Date:	Department:	Name of Assessor/Role:
Surname: Pronouns: Ethnicity: Address: Phone or email: NOK/contact:	First name: NHI No: DOB: Occupation:	ACC Number: *Activate if not completed* Injury Date: Referred by: GP/NP: Phone or email: Specialists involved in care:

EXPECTATIONS AND SUPPORT

Persons and/or family-whānau expectations:

Current living situation / family-whānau support/involvement:

RELEVANT HISTORY

Lower leg wound history & previous leg ulcer/s or slow to heal wounds: when and how wound(s) developed, recurrent ulcer, past and current wound/skin treatments, including compression.

Mobility and Gait Assessment: Assess mobility, gait, mobility aids used. Assess calf muscle pump function, foot/ankle range of motion

Health Related Quality of Life & Wellbeing: Document how wound and/or symptoms affect daily activities and quality of life. Use culturally appropriate models of care e.g. Te Whare Tapa Whā model.

Relevant bloods test results: e.g. iron studies, HbA1c, urea and electrolytes, serum albumin, lipids, liver and thyroid function, CRP, B-type natriuretic peptide (BNP)

Alcohol / Recreational Drugs / Smoking / Vaping:

Relevant Medical / Surgical History: e.g. lower leg surgery or trauma, skin or wound malignancies, autoimmune or inflammatory skin or wound disorders, lymphoedema, self-harm, depression.

Medications: Prescribed, over the counter and alternative therapies.

Nutrition: daily food and fluid intake, validated tool e.g. Mini Nutrition Assessment (MNA), BMI, altered bowel habits, non-planned weight loss

Venous History	Arterial History
☐ Confirmed venous disease diagnosis	☐ Confirmed arterial disease diagnosis
☐ Familial history of varicose veins, venous insufficiency and/or venous ulcers	☐ Familial history of peripheral arterial disease (PAD), heart disease, or stroke or TIAs
☐ Pulmonary embolism	☐ Heart failure
☐ L or R Deep vein thrombosis (DVT)	☐ Stroke-TIAs
☐ L or R Phlebitis lower leg	☐ Hypertension
☐ L or R Venous interventions (e.g. varicose vein surgery)	☐ L or R Arterial surgical interventions (e.g. angioplasty, CABG)
☐ Obesity	☐ Abdominal obesity
☐ Multiple pregnancies	☐ Diabetes mellitus
☐ Reduced mobility	☐ Preeclampsia or gestational diabetes
☐ L or R Reduced foot dorsi-plantar flexion	☐ Chronic kidney disease
☐ L or R Fracture/trauma or surgery to the leg (e.g. hip or knee replacements)	☐ Vasculitis
☐ Lifestyle factors (e.g. prolonged standing/ sitting, IV drug use on leg)	☐ Rheumatoid arthritis
	☐ Lifestyle factors (e.g. smoking, sedentary, high cholesterol)

PAIN ASSESSMENT

Current pain management (pharmacological and non-pharmacological):

What provokes or improves pain:
Quality: consider neuropathic, nociceptive or mixed pain descriptors
Radiates or localised: **Severity** 1 to 10:
Time: when it starts / how long it lasts:

Venous Pain	L	R	**Arterial Pain**	L	R
Pain improved or relieved with limb elevation	☐	☐	Intermittent claudication *crampy calf, thigh or buttock pain occurs during exercise, especially walking (immobility will obscure symptoms)*	☐	☐
Legs feel heavy, tired, or achy at the end of the day or after standing/sitting for long periods	☐	☐	Rest / night pain worse with limb elevation and reduced or relieved when dependant or standing	☐	☐

EXAMINATION: ***Do not base diagnosis on the presence of any signs or symptoms in isolation***

Left limb length: below knee to heel cm =	Right limb length: below knee to heel cm =
Left ankle cm = left calf cm =	Right ankle cm = right calf cm =

Leg and Ulcer Examination

Venous Leg Changes	L	R	**Arterial Leg Changes**	L	R
Evidence of healed ulcers	☐	☐	Callused feet	☐	☐
Reddish brown hyperpigmentation/haemosiderin deposit *may present darker brown/black in darker skin tones*	☐	☐	Dystrophic toenails	☐	☐
			Healed ulcers or scars from revascularisation	☐	☐
Venous eczema/dermatitis (circle: wet or dry)	☐	☐	Lower limb muscle atrophy	☐	☐
Dilated and/or torturous superficial varicose veins	☐	☐	Pale, bluish or dark reddish skin, in darker skin tones dark blue or brownish	☐	☐
Reticular veins and/or telangiectasias *may not be visible in darker skin tones*	☐	☐			
			Dry skin	☐	☐
Atrophie blanche *May present as pale pink/ivory or loss of pigmentation in dark skin tones*	☐	☐	Positive Buerger's test *supine position with limb elevated foot pallor occurs, and foot rubor on dependency*	☐	☐
Corona phlebectatica (ankle flare) *dilated veins medial or lateral foot arch or ankle region*	☐	☐	Weak or absent pedal / leg pulses	☐	☐
			Lower limb/foot cool or cold	☐	☐
Lipodermatosclerosis *skin induration and fibrosis*	☐	☐	Capillary Refill Time >3 sec: *assess in a warm setting*	☐	☐
Altered leg shape *inverted "champagne bottle"*	☐	☐	Toe amputation/s (review underlying cause)	☐	☐
Decreased calf muscle pump function	☐	☐	Loss of hair on the feet and legs	☐	☐
Oedema: pedal, ankle and/or lower leg	☐	☐			

Consider other causes of oedema: toe oedema (consider lymphoedema), above knee oedema (consider heart/renal/liver failure), medications, infection, limb dependency, and low albumin.
If skin does not improve using emollients or medicated creams, such as topical steroid, consider fungal skin infection.

Wound & Peri-Wound Examination

Venous Wound	L	R	**Arterial Wound**	L	R
Lower third of leg (gaiter) pretibial / medial malleolus	☐	☐	Lower leg or foot/toes (check for inter-digit wounds)	☐	☐
Peri-wound maceration, pruritus and skin scale, hyperkeratosis	☐	☐	Pale, poorly perfused wound and peri-wound area	☐	☐
			Regular wound edges or punched out appearance	☐	☐
Irregular shaped wound edges, often shallow	☐	☐	Necrotic tissue, slough or gangrene	☐	☐
Moist or wet wound bed, high exudate	☐	☐	Full thickness wounds that may show bone and/or tendon	☐	☐
Ruddy granulation tissue, slough or fibrinous tissue	☐	☐			

INVESTIGATIONS to Support Diagnosis

Perform ankle brachial index [ABI] on both limbs. AVOID in critical limb ischaemia, untreated DVT, acute cellulitis, or severe leg pain. Excess oedema may give false readings. In these situations, or arterial calcification, consider TBI and/or absolute systolic toe pressure (ASTP). If unable to assess TBI/ASTP refer to relevant specialists for further investigations. Calculate ABI for both DP and PT pulse sites if there is a wide variation in readings. Seek further advice for wide variations in brachial and foot systolic pressures.

Pulse examination (- absent / + present) **Palpable pulses alone are insufficient to rule out arterial disease*
Pulses may be weaker or non-palpable if significant oedema or obesity. Massage oedema from pulse site to aid palpation or auscultation. If pedal pulses non palpable assess popliteal and femoral pulses.

Left Leg	**Palpable**	**Signals Mono, bi or triphasic**	**Readings mmHg**	**Right Leg**	**Palpable**	**Signals Mono, bi or triphasic**	**Readings mmHg**
Brachial				Brachial			
Doralis Pedis (DP)				Dorsalis Pedis (DP)			
Posterior Tibial (PT)				Posterior Tibial (PT)			
Left leg ABI result				Right leg ABI result			
ABI = Highest mmHg from DP or PT for each leg / Highest brachial mmHg obtained for both arms				Reason if unable to complete ABI:			
Popliteal (palpable/signal)				Popliteal (palpable/signal)			
Femoral (palpable/signal)				Femoral (palpable/signal)			
Loss of Protective Sensation (LOPS): assess for LOPS to the feet (safety for compression / risk of injury) use a monofilament or the Ipswich Touch Test.							
LOPS left foot				LOPS right foot			

ABI Interpretation:	TBI Interpretation:	ASTP Interpretation:
☐ Normal 0.9-1.4 (1.3 in people with diabetes mellitus or kidney disease) ☐ Some arterial disease <0.9 ☐ Arterial occlusive disease <0.6 ☐ Calcified arteries >1.4 (>1.3 in people with diabetes mellitus or kidney disease)	☐ Normal value > 0.7 ☐ Borderline value 0.6—0.7 ☐ Abnormal value <0.6 ☐ Mild arterial disease 0.4—0.59 ☐ Moderate arterial disease 0.2—0.39 ☐ Severe arterial disease: < 0.2	☐ Normal value: > 95 mmHg ☐ Higher risk of arterial disease: < 70 mmHg ☐ High risk of non-healing wound: < 30 mmHg

DIAGNOSIS

If a diagnosis is not clear, differentials should be documented, and further assessment/investigations or referrals made to determine aetiology. ABI, TBI and ASTP results should not be considered in isolation when either diagnosing peripheral arterial disease or evaluating the person's suitability for compression therapy. Urgent Vascular referral is advised in the presence of arterial clinical signs and symptoms.

L R

☐☐ Venous leg ulcer ABPI 0.8–1.4 or 1.3 in people with diabetes or kidney disease) with characteristics of venous aetiology *CEAP Classification:

☐☐ Mixed venous/arterial ABPI 0.6-0.8

☐☐ Arterial leg ulcer ABPI < 0.6

☐☐ Arterial calcification ABPI >1.4 or 1.3 in people with diabetes or kidney disease

☐☐ Atypical ulcer

*CEAP classification of venous disease severity:

C0 No signs of venous disease / C1 Telangiectasias or Reticular Veins / C2 Varicose veins / C3 Oedema / C4 Skin changes secondary to CVI / C4a Pigmentation or Eczema / C4b Lipodermatosclerosis or Atrophie Blanche / C4c Corona Phlebectatica (ankle flare) / C5 Healed VLU / C6 Active VLU

PLANNING & IMPLEMENTATION

Lower compression can be used with caution for people with an ABI from 0.5 to 0.8 in the absence of arterial signs and symptoms
Higher compression can be used for ABI readings 0.8-1.4
Seek advice when applying compression in people with arterial calcification in the absence of arterial signs and symptoms

Identify goals of care with patient, family/whānau: e.g. healable wound, maintenance, relevant referrals. Consider the individuals health needs.

Compression System / Plan:
Consider the individuals health literacy and cognition. Assess support systems and family-whānau knowledge and adherence to the treatment plan, consider increased supports or package of care if identified.

Provide Education and Offer Relevant Educational Resources:

☐ Venous Leg Ulcers: treating and preventing	☐ Safety: when to remove compression
☐ Donning and doffing hosiery	☐ Nutrition
☐ Exercise	☐ Pain management / debridement
☐ Skin care	☐ Smoking Cessation
☐ Wound care / signs of wound infection	☐ Other:

Referrals Activated from the Consultation (cc GP/NP):

☐ Wound CNS	☐ Vascular – vascular lab	☐ Dietician
☐ Vascular CNS / NP	☐ Surgical	☐ Occupational Therapist
☐ Podiatrist	☐ Orthotics	☐ Physiotherapist
☐ Diabetes Nurse Specialist	☐ Dermatologist	☐ Other

NOTES:

EVALUATION

Follow-Up Schedule: Establish and record a follow-up schedule to monitor progress and adjust treatment as needed. Include a clear plan and timeline if wound/s are not progressing as expected and refer early if identified.

Wound / Skin Assessment & Treatment

Wound Location:					
Wound Size: Consider wound photography and/or electronic documentation if available					
Max length x width cm or cm2					
Max depth cm / undermining					
Wound Tissue: post cleaning/debridement (approx. % of colours). Document fat, tendon or bone (consider x-ray to exclude osteomyelitis)					
Necrotic (black)					
Slough (yellow)					
Granulation (red)					
Hypergranulation					
Epithelialisation (pink)					
Other describe					
Wound Edge: level, raised, rolled, undermined, punched out, irregular					
Describe					
Surrounding Skin: colour (e.g. red, pale), temperature, oedema, induration, macerated, excoriated, weeping, eczema, callus, hyperkeratosis					
Describe					
Exudate Type and Volume: Dry, Moist, Wet (no strikethrough), Saturated (strikethrough), Leaking					
Serous (clear, pale yellow, thin)		**Volume**		**Volume**	
Haemoserous (blood stained)					
Sanguineous (heavily blood stained)					
Serosanguineous (light pink, thin, and watery)					
Seropurulent (yellow, tan, or light green, thin)					
Purulent (yellow, green, or brown, thick)					
Odour: No / Yes					

Wound Pain (1-10) & describe pain e.g. shooting/burning/stabbing = nerve damage OR throbbing, gnawing, aching = tissue damage					
Describe					
Pre-dressing 0-10					
During dressing 0-10					
Post dressing 0-10					
Analgesia for wound care					

Assess for local or spreading infection

☐ **Subtle signs local infection**: hypergranulation, friable granulation, increased exudate, delayed healing, or classic signs: erythema, local warmth, swelling, increasing wound pain or malodour, breakdown. Treat: topical antiseptics/antimicrobial dressings

☐ **Spreading and/or systemic infection symptoms**: spreading erythema >2cm from wound edge, lymphangitis, fever, new malaise or lethargy. Treat ASAP with oral antibiotics or assess for IVI antibiotics and hospitalisation especially in compromised people. Perform a wound swab (Levine technique) to provide guidance on antibiotic therapy.

☐ **Wound swab** ☐ **Antibiotics commenced**

Treatment Objectives: e.g. heal, maintenance (healing not realistic), exudate management, debridement, rehydration, microbial/biofilm control, ↓pain, ↓odour, ↓oedema, skin integrity					
List:					
Product Selection					
Primary Dressing					
Secondary Dressing					
Compression System					
Evaluation date					