



ALBERTA AIDS TO DAILY LIVING (AADL) ASSESSMENT FORM FOR COMPRESSION STOCKINGS

Section 1: Client Data

Name (Last)	(First)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth Year Month Day	Client Phone Number Area Code ()
Mailing Address			City/Town/Village	Postal Code

Section 2: Client Assessment

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Vein Surgery	<input type="checkbox"/> Cardiac Bypass	<input type="checkbox"/> Smoke
<input type="checkbox"/> IDDM	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Malignancy / Tumor	<input type="checkbox"/> Arthritis
<input type="checkbox"/> NIDDM	<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Family Hx of Leg Ulcers	<input type="checkbox"/> Hx of Blood Clots	<input type="checkbox"/> C.H.F.
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Orthostatic Hypotension	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hx of Leg Ulcers	
<input type="checkbox"/> Hx of Cellulitis	<input type="checkbox"/> Hx of Yeast Infections	<input type="checkbox"/> Impaired Cognition	No. of Pregnancies: _____	

Right Leg (check most appropriate)	Left Leg (check most appropriate)
Pain: <input type="checkbox"/> Deep palpation <input type="checkbox"/> Relieved with elevation <input type="checkbox"/> "knife like" <input type="checkbox"/> Intermittent claudication <input type="checkbox"/> Pain at rest <input type="checkbox"/> ↑ with elevation <input type="checkbox"/> Pain at night Comments: _____ _____ _____	Pain: <input type="checkbox"/> Deep palpation <input type="checkbox"/> Relieved with elevation <input type="checkbox"/> "knife like" <input type="checkbox"/> Intermittent claudication <input type="checkbox"/> Pain at rest <input type="checkbox"/> ↑ with elevation <input type="checkbox"/> Pain at night Comments: _____ _____ _____
Edema: <input type="checkbox"/> BK <input type="checkbox"/> A/K <input type="checkbox"/> SACRAL Location: _____ Description: _____ <input type="checkbox"/> ↓ in AM <input type="checkbox"/> ↑ in PM	Edema: <input type="checkbox"/> BK <input type="checkbox"/> A/K <input type="checkbox"/> SACRAL Location: _____ Description: _____ <input type="checkbox"/> ↓ in AM <input type="checkbox"/> ↑ in PM
Skin: <input type="checkbox"/> Varicosities <input type="checkbox"/> Hemosiderin staining <input type="checkbox"/> Lipodermatosclerosis <input type="checkbox"/> Dermatitis/cellulitis <input type="checkbox"/> Atrophie blanche <input type="checkbox"/> Hairless, thin, shiny <input type="checkbox"/> Dependent rubor/ blanching on elevation <input type="checkbox"/> ↓ Capillary refill time <input type="checkbox"/> Cool/Cold <input type="checkbox"/> Nails: thick, yellow, brittle Comments: _____ _____ _____	Skin: <input type="checkbox"/> Varicosities <input type="checkbox"/> Hemosiderin staining <input type="checkbox"/> Lipodermatosclerosis <input type="checkbox"/> Dermatitis/cellulitis <input type="checkbox"/> Atrophie blanche <input type="checkbox"/> Hairless, thin, shiny <input type="checkbox"/> Dependent rubor/ blanching on elevation <input type="checkbox"/> ↓ Capillary refill time <input type="checkbox"/> Cool/Cold <input type="checkbox"/> Nails: thick, yellow, brittle Comments: _____ _____ _____
Right Ankle = _____ Pedal = _____ Leg: Brachial Brachial Optional: Sensation (use 5.07 monofilament) <input type="radio"/> - Absent <input checked="" type="radio"/> - Present _____ / 10 	Left Ankle = _____ Pedal = _____ Leg: Brachial Brachial Optional: Sensation (use 5.07 monofilament) <input type="radio"/> - Absent <input checked="" type="radio"/> - Present _____ / 10 

If pressure index < 0.8 or > 1.2, do NOT apply compression. Refer client back to physician for further assessment. Clients with ABI's NOT in therapeutic range must have approval for compression by a GP or Vascular specialist.

Section 3: Additional Information

Section 4: Authorizer Information

Authorizer No.	Last Name	First Name	Assessment Date
Phone Number Area Code ()	Fax Number Area Code ()	Signature	