Red Flags for Orthotic Prescribing

Contraindications, Cautions and When to Refer

Orthotics are generally safe and well-tolerated, but certain clinical presentations represent contraindications, significant cautions, or indications for specialist referral before prescribing. This reference covers the key red flags organised by clinical category — to support safe, appropriate prescribing decisions.

1 Absolute Contraindications

ABSOLUTE CONTRAINDICATIONS — Seek Specialist Input Before Prescribing

The following presentations require specialist assessment and/or management before standard orthotic prescribing proceeds. Prescribing without appropriate assessment in these cases carries risk of harm.

Condition	Why it is a Contraindication	Required Action
Active Charcot Neuroarthropathy (acute phase)	Active bone destruction and joint disintegration — standard orthotics apply pathological load to a structurally failing foot. Risk of catastrophic structural collapse.	Total contact cast (TCC) or offloading boot — specialist/vascular/diabetic foot team management. Orthotics only in stable/reconstructed Charcot.
Acute Deep Vein Thrombosis (DVT) confirmed or suspected	Pressure from orthotic may dislodge thrombus. Calf pain, swelling, warmth after immobility — DVT must be excluded first.	Urgent medical referral. Do not apply orthotics until DVT excluded or adequately treated.
Active peripheral arterial disease (critical ischaemia)	Severely compromised circulation — any localised pressure risks ischaemic ulceration or tissue necrosis. ABPI <0.5.	Vascular surgery referral. Wound/vascular MDT management. Orthotic prescribing only with specialist input and ABPI guidance.
Acute infection / cellulitis of the foot	Active infection with swelling — pressure devices contraindicated until infection resolved. Risk of spreading infection or masking deterioration.	Treat infection first. Defer orthotic prescribing until resolution confirmed.
Unhealed / active plantar ulceration	Standard orthotics cannot safely manage active ulcers — total contact casting or bespoke offloading devices required with specialist oversight.	Wound care MDT. Specialist offloading device. Refer to diabetic foot clinic if diabetic ulceration.
Suspected malignancy involving foot/ankle	New bone pain, night pain, unexplained swelling, constitutional symptoms — orthotic prescribing should not precede diagnosis.	Urgent imaging and oncology/orthopaedic referral. Do not prescribe orthotics until diagnosis confirmed.

2 Significant Cautions

SIGNIFICANT CAUTIONS — Prescribe with Modification and Close Follow-Up

The following presentations do not preclude orthotic prescribing but require modified approach, specialist material selection, and careful monitoring.

Condition	Clinical Concern	Modified Approach
Diabetic peripheral neuropathy	Reduced pain sensation — pressure injuries may go undetected. High risk of ulceration if orthotic fit is suboptimal.	Accommodative total contact device; Plastazote Grade 1 top cover; gradual wear-in; weekly skin checks initially; specialist footwear required.
Peripheral arterial disease (moderate; ABPI 0.5–0.8)	Reduced tissue perfusion — pressure tolerance significantly lower than normal.	Soft accommodative shell only; no rigid modifications; frequent review; podiatric/vascular co-management.
Rheumatoid arthritis (active synovitis / joint involvement)	Active inflammation — joint instability, subluxation, erosions. Standard orthotic may apply load to compromised structures.	Soft/accommodative shell; offloading priority; avoid rigid modifications over affected joints; podiatric/rheumatology liaison.
Paediatric growth plates (see M12)	Significant modifications applied to developing bone — risk of overcorrection affecting normal development.	Conservative prescription; growth monitoring; avoid aggressive posting; review every 3–6 months.
Post-surgical foot/ankle	Altered anatomy; healing tissues; changed biomechanics post-reconstruction.	Consult surgeon before prescribing; wait for surgical clearance; prescription based on post-surgical foot morphology.
Severe fixed deformity (rigid cavus, Charcot stable)	Rigid deformity cannot be corrected — standard prescriptions risk pressure injury.	Accommodative / total contact approach; bespoke footwear may be required; no corrective modifications.
Oedema (lymphoedema / cardiac / venous)	Variable foot volume — orthotics fitted in oedematous state may be too tight when oedema reduces, or cause pressure when oedema increases.	Fit at consistent time of day; address oedema management; volume-adjustable footwear; frequent review.
Cognitive impairment / inability to report discomfort	Cannot self-report pressure, pain, or poor fit — tissue damage may go undetected.	Involve carers; very gradual introduction; frequent skin checks; conservative prescription.

3 Referral Indicators

Finding	Urgency	Refer To
Suspected Charcot (acute red/hot/swollen foot in neuropathic patient)	URGENT — same day	Diabetic foot clinic / vascular/orthopaedic team
Suspected DVT	URGENT — same day	Emergency department / GP for urgent imaging
Critical limb ischaemia (cold, pallor, pulseless)	EMERGENCY	Emergency department immediately
Active plantar ulceration (diabetic or neuropathic)	URGENT	Diabetic foot clinic / wound care
Suspected bone tumour (night pain, swelling, constitutional symptoms)	URGENT — within days	Orthopaedic/oncology
Progressive neurological deficit (foot drop, rapidly increasing weakness)	URGENT	Neurology / spinal surgery
PTTD Stage IIb or above (fixed deformity, surgical candidate)	Routine-urgent	Orthopaedic foot and ankle surgeon
Paediatric talipes / complex congenital deformity	Routine	Paediatric orthopaedics
Charcot stable (reconstruction phase)	Routine	Orthotist / specialist bespoke footwear service

4 Safe Prescribing Checklist

ALWAYS ASSESS VASCULAR AND NEUROLOGICAL STATUS

Before any orthotic prescription, basic vascular (capillary refill, pedal pulses, ABPI if indicated) and neurological (10g monofilament, vibration, two-point discrimination) assessment should be completed and documented. This is non-negotiable in diabetic, elderly, and at-risk patients.

DOCUMENT YOUR CLINICAL REASONING

Record the clinical indication, assessment findings, prescription rationale, and any red flags identified or excluded. If a caution is present and you are proceeding, document why and what precautions have been taken. This protects the patient and the clinician.

REVIEW IS PART OF THE PRESCRIPTION

Red flag categories require shorter review intervals — typically 2–4 weeks for high-risk patients vs 6–8 weeks for standard MSK. At every review, inspect the skin for pressure areas before assessing biomechanical outcomes.