Wound Assessment and Treatment Form

Addressograph Label
Client Label
DOB mm/dd/yyyy
PHIN/MHSC#
HRN

Wound Location: _____ Wound Type/Cause: _____

Goal of Wound Care	**Pressure Injury Stage**
☐Healing ☐Non Healing ☐ Non Healable	☐Stage 1 ☐Stage 2 ☐Stage 3 ☐Stage 4 ☐Unstageable

Wound ____ of _____	**Date**					
	Time					
Exudate amount	none					
	scant					
	small					
	moderate					
	large					
Exudate type	sanguinous					
	sero-sang					
	serous					
	purulent					
	other					
Odor	yes/no					
Cleansing	18g/30ml or bottle					
	solution					
Wound base status (describe in %)	eschar					
	slough					
	granulation					
	pink					
	epithilialization					
Wound edge	attached					
	unattached					
	punched out					
	irregular					
	callous					
	rolled					
Periwound	intact					
	maceration					
	erythema					
	induration					
	dryness					
	scaling					
	edema					
	blistered					
	callous					
Wound size (measure weekly and prn if changes)	length					
	width					
	depth					
	undermining					
	tunnelling					
Dressing Selection (list products used)						
Circle: Clean No Touch **or** Sterile Technique						
Temperature	affected/unaffected					
Packing Length	cm out/in					
Pain	?/10					
See Integrated Progress Note (IPN)						
See Photo						
Nurse's initials						

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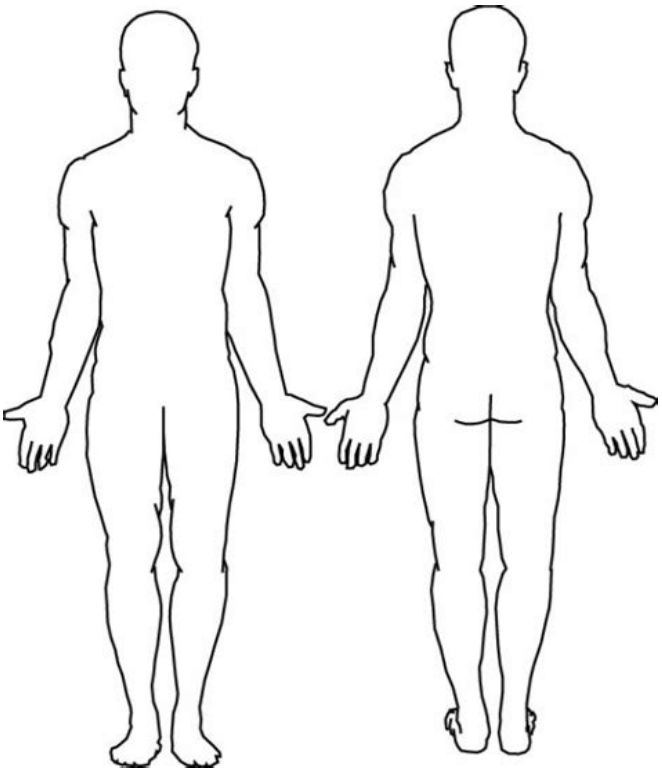
EXUDATE AMOUNT:	**none** = no measurable exudate, wound tissues dry **scant** = wound tissues moist **small** = wound tissues wet, drainage involves ≤25% of dressing **moderate** = wound tissues saturated, drainage involves > 25% to <75% of dressing **large** = wound tissues bathed in fluid, drainage involves >75% of dressing	
EXUDATE TYPE:	**serous** = thin, watery, clear **sanguinous** = bloody, thin, bright red	**serosanguinous** = thin, watery, pale red to pink **purulent** = thin or thick, opaque tan to yellow or green
ODOR:	**yes** = present following cleansing	**no** = absent following cleansing
WOUND BED STATUS: NB: describe in percentages	**epithelialization** = pink/purple new tissue **granulation tissue** = pebbled, beefy, moist, firm **eschar** = black, may be soft or firm	**pink** = salmon colored, firm, moist **slough** = yellow or white, may be soft or firm
PERIWOUND EDGE:	**attached** = level with wound base **regular** = well-defined edges (arterial) **callous** = hyperkeratotic or callous growth **rolled** = wound edge has a rolled under appearance (often chronic wound)	**unattached** = higher than wound base (has depth) **irregular** = poorly-defined (venous)
PERIWOUND STATUS:	**maceration** = white hyperkeratosis, indicates excessive moisture **erythema** = redness **edema** = fluid accumulation in surrounding tissues	**induration** = abnormal firmness of tissues **callous** = thick build-up of skin
WOUND SIZE:	**length** = (longest) x width (at right angles to length) x depth **tunneling & undermining** = indicate location via 12h clock, client's head is 12 o'clock	

Date: _____

Location of wound: indicate frontal or dorsal view



Draw diagram of wound and/or indicate location of wound on diagram. On grid use a dotted line to indicate undermining/tunneling. Measure with sterile applicator to determine the depth of undermining/tunneling.