Wound and Skin Discharge Summary Form

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

- Complete for all clients who are transferred to another facility. Keep original on chart, copy to receiving facility
- When discharged home, and Home Care (HC) involved, send copy of form to HC
- If client admitted to a facility from home while receiving HC, Case Coordinator to send a copy of the form
- Facility staff may request form from HC Case Coordinator
- Complete all areas; if area not applicable, record N/A and initial

Initial when done	
	1. Identify risk factors for skin breakdown (eg. immobility, nutrition, moisture issues, pressure, relevant lab results) Braden Score: _____ Record date last completed: _____ and attach copy.
	2. Details of pressure points (note condition of skin over bony prominences)
	3. Current plan/recommendation to minimize pressure, friction and shear: • Type of mattress - _____ • Type of seating - _____ • Current transfer techniques - _____ • Other - _____
	4. History of injuries/ulcers, skin conditions in past:
	5. If Pressure injury(s) present: a. Stage: _____ b. Site, size, type wound products used, freq of dressing change: _____ c. Wound Assessment and Treatment Form – copied & included d. If Stage 2, 3, 4 or Unstageable **Date reported:** _____ If not reported why? _____
	6. If other wounds: a. Type, location, dressing type and frequency, goal (healing, non-healing and non-healable.) b. Wound Assessment and Treatment Form – copied & included
	7. Pain management: _____ _____
	8. Client and family response/adherence to prevention and treatment plan: _____ _____

Completed by_____ Date_____