

Wound Assessment Tool

Last Name _____ First Name _____ Assessment Date _____

SS# _____

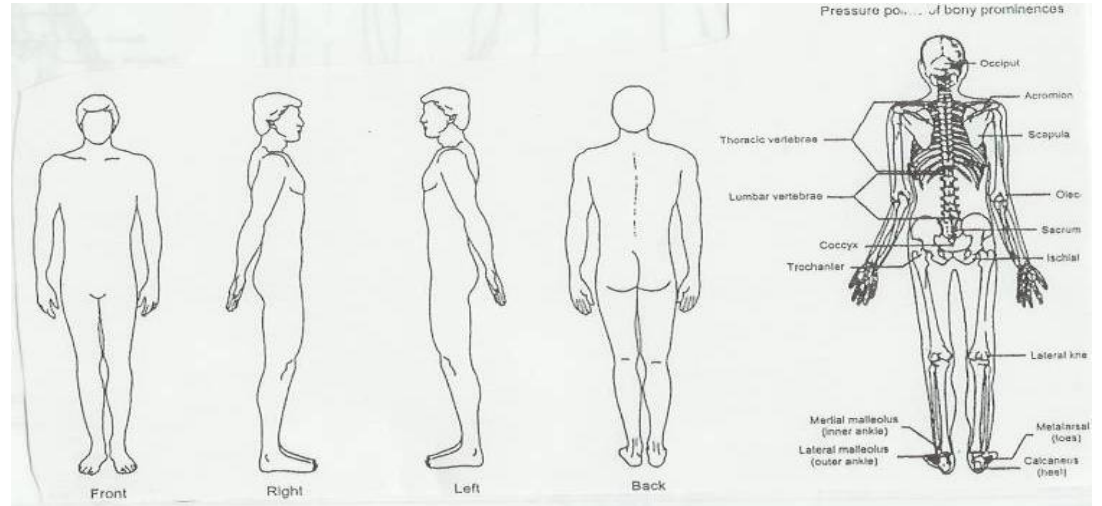
Medicaid# _____

Height _____

Weight _____

Diet _____

Locate and Number all wound areas. If there are more than three (3) wound areas, use a second sheet. Use the same wound area numbers for Continued Stay Reviews.



Is the Client compliant with their interventions? If not, explain:

Is the client currently using any pressure relief device? No Yes If yes, explain _____
 Specialized wound-healing device? No Yes If yes, explain _____

Comments and Pertinent Wound History:

Date	Lab Test	Findings
	Hemoglobin	
	Hematocrit	
	Albumin	
	WBC	
	Wound Culture	
	Blood Culture	

Category	Type	Status
Wound	A. Surgical	PTW (Partial Thickness Wound) Loss of epidermis and partial loss of dermis
	B. Arterial	
Pressure Ulcer Stage	C. Ulcer	FTW (Full Thickness Wound) Tissue destruction extending through the dermis involving the subcutaneous layer and may involve muscle/bone
	D. Diabetic Neuropathic	
	E. Traumatic	
	F. Other	
Pressure Ulcer Stage	1. Stage I	Nonblanchable Redness Blister/Partial Thickness Exposed Subcutaneous Tissue Exposed Muscle/Bone
	2. Stage II	
	3. Stage III	
	4. Stage IV	

Wound Assessment Tool

Last Name _____ First Name _____ Assessment Date _____

Wound - Current Status *(Make copies of this page. Complete one page for each wound)*

Wound/Ulcer #	Assessment Date:	Source(s) of Information: <input type="checkbox"/> Wound Nurse Note <input type="checkbox"/> Progress Note <input type="checkbox"/> Lab <input type="checkbox"/> Clinical Staff <input type="checkbox"/> Other _____	
Type: <input type="checkbox"/> Surgical <input type="checkbox"/> Arterial <input type="checkbox"/> Pressure Ulcer <input type="checkbox"/> Stasis Ulcer <input type="checkbox"/> Diabetic Neuorpathic <input type="checkbox"/> Traumatic <input type="checkbox"/> Other _____			
Status: <input type="checkbox"/> PTW <input type="checkbox"/> FTW			
Size (current measurement): Length: _____ Width: _____ Depth: _____			
Stage (if pressure ulcer): <input type="checkbox"/> (I) Nonblanchable Redness <input type="checkbox"/> (II) Blister/Partial Thickness <input type="checkbox"/> (III) Exposed Subq <input type="checkbox"/> (IV) Exposed Muscle/Bone			
If Stage III or IV: <input type="checkbox"/> Undermining <input type="checkbox"/> Tunneling		Clock Location:	Depth:
Wound Base Color: <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Other: _____		Wound Condition: <input type="checkbox"/> Eschar <input type="checkbox"/> Slough <input type="checkbox"/> Other: _____	
Drainage: <input type="checkbox"/> None <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Purulent			
Odor: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Foul			
Current Treatment			Date Started
Previous Treatment			Date Started
Infection, if applicable <input type="checkbox"/> No <input type="checkbox"/> Yes			Date Diagnosed
Type of Culture	Results of Culture		Date of Culture
Additional Comments <i>(If this is a concurrent review, discuss wound changes since admission)</i>			

Assessor Signature _____

Date _____ Page _____ of _____

Wound Assessment Tool

Last Name _____ First Name _____ Assessment Date _____

Wound Onset - Current Status (complete this section if instructed by DDM)

Make copies of this page. Complete one page for each wound.

Wound/Ulcer #	Assessment Date:	Source(s) of Information: <input type="checkbox"/> Wound Nurse Note <input type="checkbox"/> Progress Note <input type="checkbox"/> Lab <input type="checkbox"/> Clinical Staff <input type="checkbox"/> Other _____	
Type: <input type="checkbox"/> Surgical <input type="checkbox"/> Arterial <input type="checkbox"/> Ulcer <input type="checkbox"/> Diabetic Neuorpathic <input type="checkbox"/> Traumatic <input type="checkbox"/> Other _____			
Status: <input type="checkbox"/> PTW <input type="checkbox"/> FTW			
Size (current measurement): Length: _____ Width: _____ Depth: _____			
Stage (if pressure ulcer): <input type="checkbox"/> (I) Nonblanchable Redness <input type="checkbox"/> (II) Blister/Partial Thickness <input type="checkbox"/> (III) Exposed Subq <input type="checkbox"/> (IV) Exposed Muscle/Bone			
If Stage III or IV: <input type="checkbox"/> Undermining <input type="checkbox"/> Tunneling		Clock Location:	Depth:
Wound Base Color: <input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Slough <input type="checkbox"/> Eschar			
Drainage: <input type="checkbox"/> None <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Purulent			
Odor: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Foul			
Infection, if applicable <input type="checkbox"/> No <input type="checkbox"/> Yes			Date Diagnosed
Type of Culture	Results of Culture		Date of Culture
Additional Comments			

Assessor Signature _____

Date _____ Page _____ of _____