

Client Name: _____

SSN#: _____

Medicaid #: _____

Height: _____

Weight: _____

Diet: _____

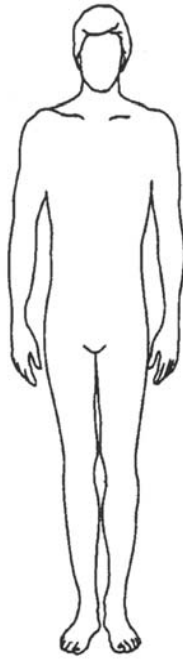
Assessment Date: _____

Signature of Assessor: _____

Please locate and number all wound areas.

If there are more than three areas please use a second sheet.

Please use the same wound area numbers for a Continued Stay Review.



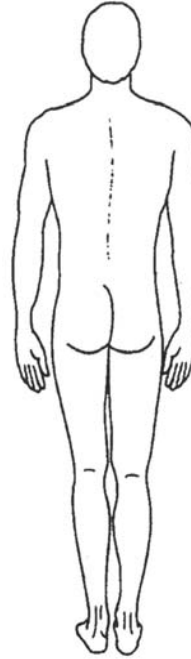
Front



Right

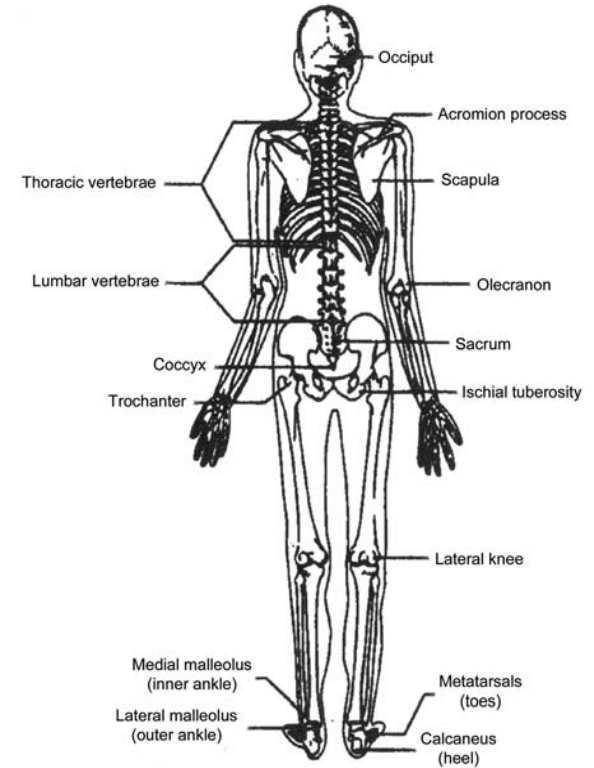


Left



Back

Pressure points of bony prominences



Wound/Ulcer # Size (cm): Undermining/Tunneling (Stage III/IV)	Date of Onset: _____ Length: _____ Width: _____ Depth: _____ <input type="checkbox"/> Clock Location and Depth _____	Wound/Ulcer # Size (cm): Undermining/Tunneling (Stage III/IV)	Date of Onset: _____ Length: _____ Width: _____ Depth: _____ <input type="checkbox"/> Clock Location and Depth _____	Wound/Ulcer # Size (cm) Undermining/Tunneling (Stage III/IV)	Date of Onset: _____ Length: _____ Width: _____ Depth: _____ <input type="checkbox"/> Clock Location and Depth _____
Wound Base Color	<input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Slough <input type="checkbox"/> Eschar	Wound Base Color	<input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Slough <input type="checkbox"/> Eschar	Wound Base Color	<input type="checkbox"/> Pink <input type="checkbox"/> Red <input type="checkbox"/> Slough <input type="checkbox"/> Eschar
Drainage	<input type="checkbox"/> None Serous <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Purulent	Drainage	<input type="checkbox"/> None Serous <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Purulent	Drainage	<input type="checkbox"/> None Serous <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Purulent
Odor	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Foul	Odor	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Foul	Odor	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Foul
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	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	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

Client Name: _____ Assessment Date: _____

Please categorize the wounds using these terms.

Category	Type	Status	Date	Lab Test	Findings
Wound	A. Surgical	PTW (Partial Thickness Wound) Loss of epidermis and partial loss of dermis		Hemoglobin	
	B. Arterial Ulcer			Hematocrit	
	C. Venous Ulcer	FTW (Full Thickness Wound) Tissue destruction extending through the dermis involving the subcutaneous layer, and may involve muscle/bone.		Albumin	
	D. Diabetic - Neuropathic Ulcer			WBC	
	E. Traumatic			Wound Culture	
	F. Other			Blood Culture	
Is the client compliant with their interventions? If not, please explain: _____					
Pressure Ulcer Stage	Stage I	Nonblanchable Redness Blister/Partial Thickness Exposed Subcutaneous Tissue Exposed Muscle/Bone Slough/Eschar _____ _____	Is the client currently using any pressure relief device or specialized wound-healing device? If yes, please explain: _____		
	Stage II		_____		
	Stage III		_____		
	Stage IV		_____		
	Other		Comments and pertinent wound history: _____		

Wound/Ulcer #1	Date Started	Previous TX	Results:	Date Started	Current TX:	Results:	Infection, if applicable -
Type: _____ Status: _____ Stage: _____			<input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> Resolved			<input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> Resolved	Date: _____ Type of Culture: _____ Results of Culture: _____
Wound/Ulcer #2	Date Started	Previous TX	Results:	Date Started	Current TX:	Results:	Infection, if applicable -
Type: _____ Status: _____ Stage: _____			<input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> Resolved			<input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> Resolved	Date: _____ Type of Culture: _____ Results of Culture: _____
Wound/Ulcer #3	Date Started	Previous TX	Results:	Date Started	Current TX:	Results:	Infection, if applicable -
Type: _____ Status: _____ Stage: _____			<input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> Resolved			<input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> Resolved	Date: _____ Type of Culture: _____ Results of Culture: _____