Wound Assessment & Plan of Care Sheet

Assessment date_____

Patient Name_____**Date of Birth**_____

Address_____**Phone #**_____

Wound Assessment

	Wound Number	1	2	3	4
*	**Wound Type**	□ Surgical or □Debrided	□ Surgical or □Debrided	□ Surgical or □Debrided	□ Surgical or □Debrided
*	**Diagnosis**				
*	**Stage/Thickness**				
*	**Wound Location**				
*	**Wound Length**	cm	cm	cm	cm
*	**Wound width**	cm	cm	cm	cm
*	**Wound Depth**	cm	cm	cm	cm
	Sinus Tract (Tunneling)	□Yes____cm □No	□Yes____cm □No	□Yes____cm □No	□Yes____cm □No
*	**Drainage Amount (exudate)**	□None □Small □Moderate □Large	□None □Small □Moderate □Large	□None □Small □Moderate □Large	□None □Small □Moderate □Large
*	**Drainage Color (exudate)**	□Serous □Purulent □Yellow □Green □Serosanquineous	□Serous □Purulent □Yellow □Green □Serosanquineous	□Serous □Purulent □Yellow □Green □Serosanquineous	□Serous □Purulent □Yellow □Green □Serosanquineous
*	**Infection Present**	□Yes □No	□Yes □No	□Yes □No	□Yes □No
	Eschar	□None □ Partial Coverage □ Full Coverage	□None □ Partial Coverage □ Full Coverage	□None □ Partial Coverage □ Full Coverage	□None □ Partial Coverage □ Full Coverage
	Granulation Tissue	□ None □ Pale/Gray □Pink □ Red □Hypergranulation	□ None □ Pale/Gray □Pink □ Red □Hypergranulation	□ None □ Pale/Gray □Pink □ Red □Hypergranulation	□ None □ Pale/Gray □Pink □ Red □Hypergranulation
*	**Debridement Preformed**	□ Autolytic □Chemical □Mechanical □Surgical	□ Autolytic □Chemical □Mechanical □Surgical	□ Autolytic □Chemical □Mechanical □Surgical	□ Autolytic □Chemical □Mechanical □Surgical
*	**Date of Last Debridment**				

Plan of Care

	1	2	3	4
Frequency of Changes				
Primary Dressing				
Number of Dressings Per Change				
Cover With:				
Number of Dressings Per Change				
Secure With:				
Number of Dressings Per Change				
Duration of The Above Treatment	□1 Week □ 2 Weeks □1 Month □Other_____	□1 Week □ 2 Weeks □1 Month □Other_____	□1 Week □ 2 Weeks □1 Month □Other_____	□1 Week □ 2 Weeks □1 Month □Other_____

Patient Next Appointment: □1 Week □ 2 Weeks □1 Month □Other_____ □ Discharged

Assessment Proformed By:_____**Date**_____

(Signature & Title)

Physician:_____ **Date:**_____