Wound Status Assessment Table

Primary Diagnosis:	Client ID# _____ .
	Name: _____ .
	D.O.B _____ .
	Address: _____ .
	Completed By: _____ .
	Phone Number: _____ .

Assessment Date	Wound #1	Wound #2	Wound #3	Wound #4
Type of wound (decubitus, diabetic, peripheral vascular disease, traumatic)				
Wound Site				
Wound size (L x W x D in cm)				
Wound bed (necrotic %, fibrous %, granulation %)				
Wound Tunneling (direction and depth. ie,1 o'clock, 2 o'clock)				
Exudate amount (25%, 50%, 75%, 100%)				
Exudate type (serous, sanguineous, purulent)				
Odour/infection (faint, moderate, strong)				
Type and size of dressings used.				
Frequency of dressing change (q days, q2 days, q 3 days, etc)				
Anticipated healing time				

Date: _____   **Signature:** _____

Fax to First Nations Medical: 1-866-600-1041