

Wound Assessment

Patient: _____ A&O X: _____ Phone: _____

Living Arrangement: _____ Caregiver: _____ Hrs: _____

Caregiver Name: _____ Relation: _____ Phone: _____

Patient Goals: _____

Wt _____ Ht _____ Age _____ Temp _____ RR _____ O2% _____ HR _____ B/P _____ Pain: C _____ L _____ H _____
Aching Burning Numbness Dull Sharp Stabbing Tender Throbbing Constant Intermittent Radiating Location: _____

Allergies: NKDA PCN SULF ASA IODINE CODINE MSO4 TAPE LATEX

Other: _____

PMH: _____

IDDM PVD PAD CAD HTN CHF COPD HLD DEPRESSION ANXIETY

DM L _____ H _____ (IC) STOOL URINE MGT: _____

Assessments indicated: Wound 24 Hour ADL Recall 24 Hour Diet Recall Medications

Wound Type: Arterial Burn DFU PI Trauma Vascular Other: _____

Location: 1) _____ 2) _____ 3) _____

M: 1) _____ x _____ x _____ UT _____ 2) _____ x _____ x _____ UT _____ 3) _____ x _____ x _____ UT _____

Location: 4) _____ 5) _____ 6) _____

M: 4) _____ x _____ x _____ UT _____ 5) _____ x _____ x _____ UT _____ 6) _____ x _____ x _____ UT _____

Wound Care: _____

PCP Name: _____ PCP Number: P _____ F _____

PCP Location: _____ Last Visit Date: _____ Next Visit: _____

Surgeon: _____ PCP Number: P _____ F _____

Last Visit Date: _____ Next Visit Date: _____

Other Physicians: _____

Orders: _____

Supplies / DME: _____