

## Wound Assessment

**Pressure Ulcer / Wound Description:**

Wound ID Number: \_\_\_\_\_ of \_\_\_\_\_  
 Wound Type:  Pressure  Surgical  Vascular  Diabetic  
 Other \_\_\_\_\_

Location: \_\_\_\_\_

Stage:  Deep Tissue Injury  I  II  III  IV  
 Unstageable

Dimensions: Length \_\_\_\_\_ cm  
 (head to toe)  
 Width \_\_\_\_\_ cm  
 (side to side)  
 Depth \_\_\_\_\_ cm

Undermining \_\_\_\_\_ cm  
 @ \_\_\_\_\_ o'clock

Tunneling/Sinus Tracts \_\_\_\_\_ cm  
 @ \_\_\_\_\_ o'clock

**Wound base description:**

Granulation: \_\_\_\_\_  
 Necrotic: \_\_\_\_\_  
 Eschar: \_\_\_\_\_  
 Slough: \_\_\_\_\_  
 Epithelial: \_\_\_\_\_

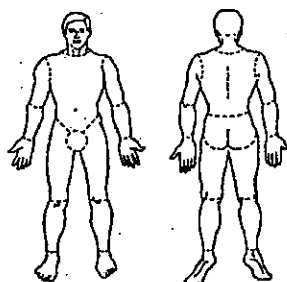
**Drainage:**

Amount:  none  scant  moderate  copious  
 Appearance:  serous  serosanguineous  
 purulent  Other \_\_\_\_\_  
 Odor:  none  present (describe) \_\_\_\_\_

**Wound edges:** (up to 4 cm from edge of wound)

light pink  deep red  purple  
 macerated  calloused  
 Other \_\_\_\_\_

Pain associated to wound (pain scale description) \_\_\_\_\_



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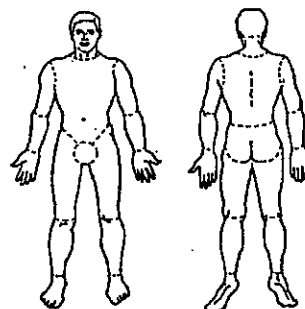
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**Wound Photo Checklist:**

- Clean wound with saline, blot dry.
- Drape patient for privacy with wound exposed and clearly visible.
- Place measurement guide next to wound.
- Turn camera flash off.
- Adjust zoom to normal position (DO NOT USE ANY ZOOM ADJUSTMENTS)
- Mount photo to Wound Assessment Sheet
- Notify physician if wound has new eschar, necrotic tissue or other signs of deterioration.
- Delete patient's photos from camera after printing for chart.

\_\_\_\_\_  
 Nurse Signature/Date/Time

\_\_\_\_\_  
 Physician Signature/Date/Time



Wound Assessment

Wound ID number: <u>    </u> of <u>    </u> (example: 1/1 or 1/3)	<b>Mount Wound Photo Here</b>
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Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

