WOUND ASSESSMENT& TREATMENT FLOWSHEET

Client Name: _____

DOB: _____

PHN: _____

OR ADDRESSOGRAPH/LABEL

Year: _____

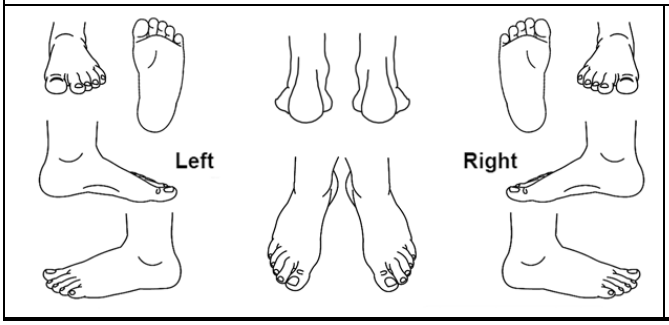
Wound Date of Onset_____

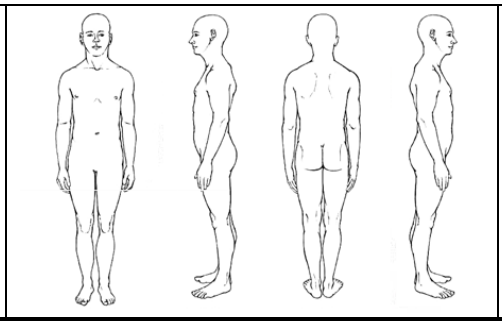
(Please fill out ONE form per wound) **Goal of Care:** ☐ To Heal ☐ To Maintain ☐ To Monitor / Manage

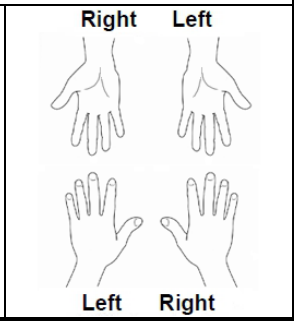
Wound Type/Etiology (if known)
☐ Pressure ☐ Venous ☐ Arterial ☐ Diabetic ☐ Surgical 2^0 Intention ☐ Skin Tear ☐ Other

If Pressure Ulcer, chart one stage only and date. If change, chart new stage and date.
☐ Stage 1 _____ (dd/mm) ☐ Stage 2 _____ (dd/mm) ☐ Stage 3 _____ (dd/mm) ☐ Stage 4 _____ (dd/mm)
☐ Stage X (unstageable) _____ (dd/mm) ☐ Stage SDTI (Suspected Deep Tissue Injury) _____ (dd/mm)

MARK LOCATION OF WOUND/ULCER WITH AN ARROW OR AN "X"







Legend:	**X** or **Blank Space =** Not Applicable (as per agency)	✓= Assessed/Completed	**PN =** See Progress Notes

Wound Location:	Month/Year *mm/yy* Day										
	Time										
Weekly/PRN — **Wound Measurements in cm** (*Head* clock: 12 1 2 3 4 5 6 7 8 9 10 11; *Toe*; Undermining/ Sinus Tract: Location corresponds to face of clock with patient's head at 12 o'clock position)	Length										
	Width										
	Depth										
	Sinus Tract #1 Depth										
	Location (o'clock)										
	Sinus Tract #2 Depth										
	Location (o'clock)										
	Undermining #1 Depth										
	Location (o'clock)										
	Undermining #2 Depth										
	Location (o'clock)										
Wound Bed: Total % must = 100%	% Pink/Red										
	% Granulation (red pebbly)										
	% Slough										
	% Eschar										
	% Foreign body (sutures, mesh, hardware)										
	% Underlying structures (fascia, tendon, bone)										
	% Not visible										
	% Other:										
Exudate Amount [✓] one	None										
	Scant/small										
	Moderate										
	Large/copious										
	INITIALS										

Reference: *Wound Assessment Guideline Decision Support Tool (DST)*
Adapted from VCHA Wound Care Assessment Tool (2009)

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OR ADDRESSOGRAPH/LABEL Year: _____

Wound Location:	Month/Year *mm/yy* Day										
	Time										
Exudate Type [✓] all that apply	Serous										
	Sanguineous										
	Purulent										
	Other:										
Odour	Odour present after cleansing **Y**es or **N**o										
Wound Edge [✓] all that apply	Attached (flush w/ wound bed or "sloping edge")										
	Non-Attached (edge appears as a "cliff")										
	Rolled (curled under)										
	Epithelialization										
Peri-wound Skin [✓] all that apply	Intact										
	Erythema (reddened) in cm										
	Indurated (firmness around wound) in cm										
	Macerated (white, waterlogged)										
	Excoriated/Denuded (superficial loss of tissue)										
	Callused										
	Fragile										
	Other:										
Wound Pain (10 = worst)	Scored from 10 point analogue Pain Scale See Pain Assessment for details	10	10	10	10	10	10	10	10	10	10
Packing Count	Any depth 1cm or greater, count packing pieces Out										
	In										
Treatment	Treatment done as per Treatment Plan										
	INITIALS										
	VISIT COUNT (Home Care Nursing Only)										

WOUND TREATMENT PLAN

Leave plan in place for ONE week whenever possible. Document rationale for change on the Progress Notes	Date Initiated	Initials	Date D/C	Initials

Reference: *Wound Assessment Guideline Decision Support Tool (DST)*
Adapted from VCHA Wound Care Assessment Tool (2009)