**WOUND ASSESSMENT & TREATMENT FLOWSHEET**

(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  
- [ ] Skin Tear  
- [ ] Other

If Pressure Ulcer, chart one stage only and date.  
- [ ] Stage 1  
- [ ] Stage 2  
- [ ] Stage 3  
- [ ] Stage 4  

If change, chart new stage and date.  
- [ ] Stage X (unstageable)  
- [ ] Stage SDTI (Suspected Deep Tissue Injury)

**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:**  

<table>
<thead>
<tr>
<th>Location</th>
<th>Month/Year</th>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length</td>
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<td>Width</td>
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<td></td>
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<tr>
<td>Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus Tract #1 Depth</td>
<td></td>
<td></td>
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<tr>
<td>Location (o’clock)</td>
<td></td>
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<tr>
<td>Sinus Tract #2 Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location (o’clock)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undermining #1 Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location (o’clock)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undermining #2 Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location (o’clock)</td>
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</tbody>
</table>

**Wound Measurements in cm**  
- Head
- Toe
- Undermining/Sinus Tract
  - Location corresponds to face of clock with patient’s head at 12 o’clock position

**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**  

- [ ] None
- [ ] Scant/small
- [ ] Moderate
- [ ] Large/copious

**INITIALS**

Reference: Wound Assessment Guideline Decision Support Tool (DST)  
Adapted from VCHA Wound Care Assessment Tool (2009)
# WOUND ASSESSMENT & TREATMENT FLOWSHEET

## Wound Location:
- **Month/Year (mm/yy):**
- **Day:**
- **Time:**

### Exudate Type
- [ ] Serous
- [ ] Sanguineous
- [ ] Purulent
- [ ] Other:

### Odour
- Odour present after cleansing
  - [ ] Yes
  - [x] No

### Wound Edge
- [x] Attached (flush w/ wound bed or "sloping edge")
- [ ] Non-Attached (edge appears as a "cliff")
- [ ] Rolled (curled under)
- [ ] Epithelialization

### Peri-wound Skin
- [x] 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

### Packing Count
- Any depth 1 cm or greater, count packing pieces

### Treatment
- Treatment done as per Treatment Plan

### VISIT COUNT (Home Care Nursing Only)
- INITIALS

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## WOUND TREATMENT PLAN

Leave plan in place for ONE week whenever possible. Document rationale for change on the Progress Notes

<table>
<thead>
<tr>
<th>Date Initiated</th>
<th>Initials</th>
<th>Date D/C</th>
<th>Initials</th>
</tr>
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<tbody>
<tr>
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