Wound Assessment form

Date: Patient Name:

Patient ID: Assessor Name:

Patient

Age: years

Weight: kgs

Gender: ○ Male ○ Female

Nutrition status: ○ Well nourished ○ Malnourished

Mobility status: ○ Good Mobility ○ Bad Mobility

Smoking: ○ Yes ○ No

If yes, how many/day:

Alcohol: ○ Yes ○ No

If yes, units/week:

Co-morbidities: ☐ Venous disease ☐ Arterial disease

☐ Diabetes ☐ Anaemia

Other:

Medications:

Allergies:

ABPI (*done*): ○ Yes ○ No

If yes,measurement:

Date:

Wound description

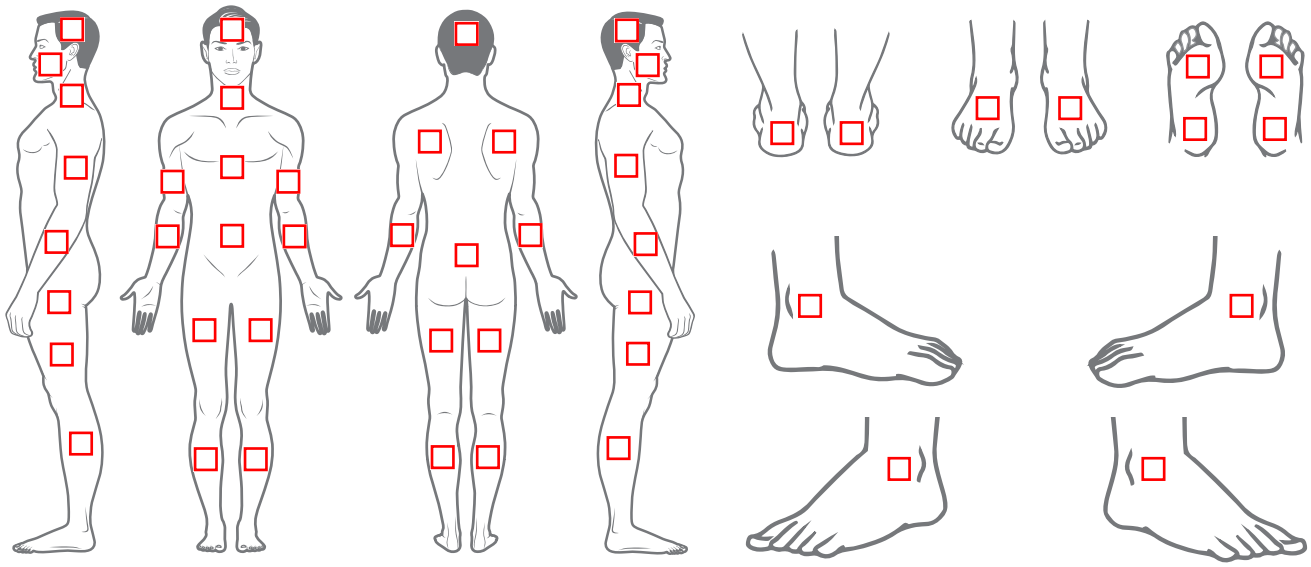
Wound type(s):

Duration of wound(s):

Previous treatment(s):

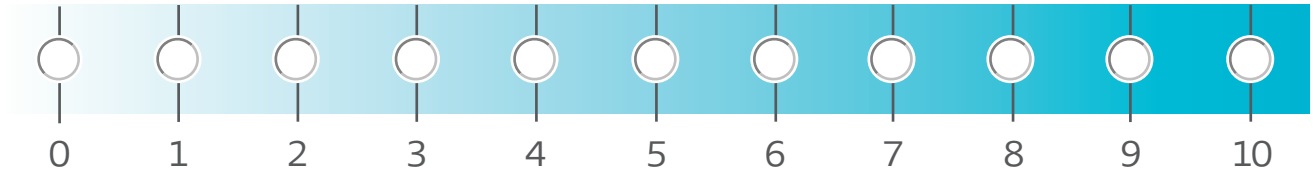
Size: length mm width mm depth mm

Wound location(s):



Information about location(s):

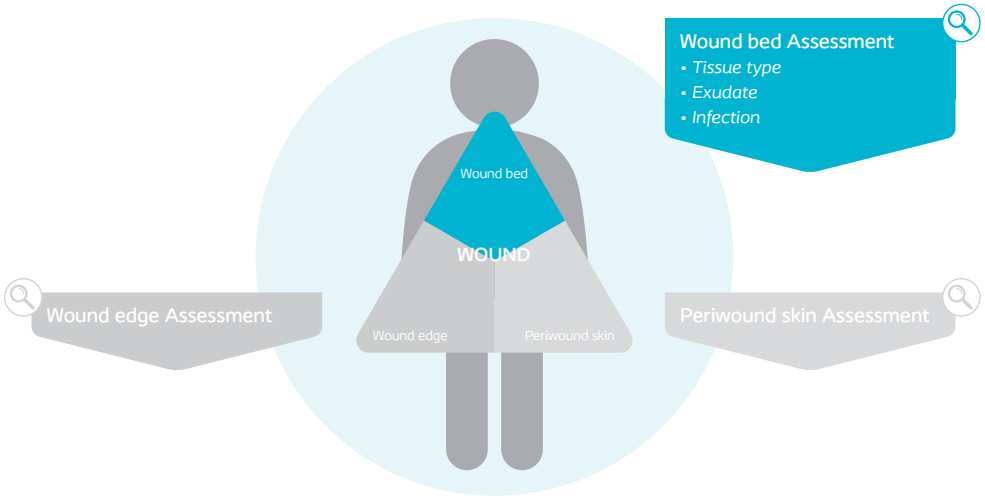
Pain level:



No pain Moderate pain Worst pain

If any pain, is it: ○ Constant ○ At dressing changes

Wound bed assessment



Wound bed Assessment

Tissue type

Nectotic ☐ %
Sloughy ☐ %
Granulating ☐ %
Epithelialising ☐ %

Exudate

Level ○ Dry ○ Low ○ Medium ○ High

Type ☐ Thin/watery ☐ Cloudy ☐ Thick ☐ Purulent
☐ Clear ☐ Pink/red

Infection

Local

- ☐ Increased pain
- ☐ Erythema
- ☐ Oedema
- ☐ Local warmth
- ☐ Increased exudate
- ☐ Delayed healing
- ☐ Friable granulation tissue
- ☐ Malodour
- ☐ Pocketing

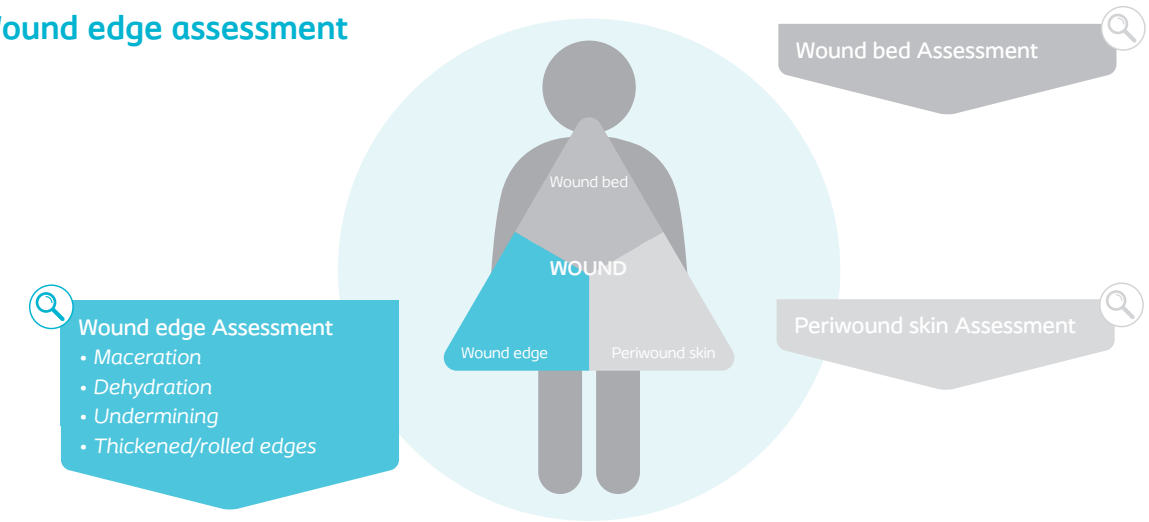
Spreading/systemic

- ☐ Increased erythema
- ☐ Pyrexia
- ☐ Abscess/pus
- ☐ Wound breakdown
- ☐ Cellulitis
- ☐ General malaise
- ☐ Raised WBC count
- ☐ Lymphangitis

Swab taken: ○ Yes ○ No

If yes, result: *Date:*

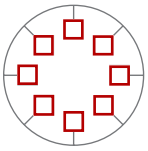
Wound edge assessment



Wound edge Assessment

Maceration ☐ Undermining ☐

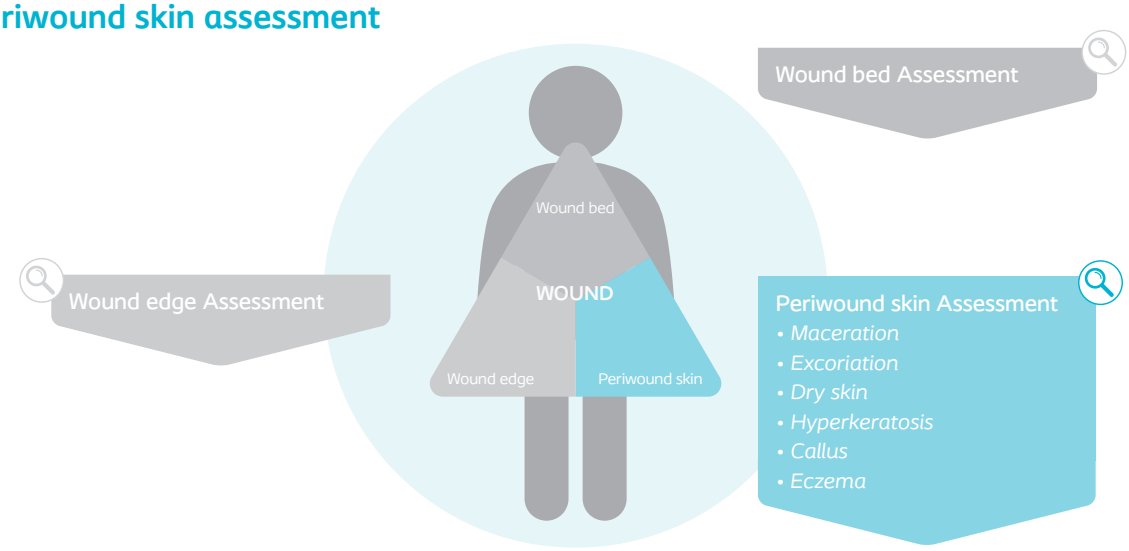
Dehydration ☐ Rolled edges ☐



Mark position of undermining

Extent: ____ cm

Periwound skin assessment



Periwound skin Assessment

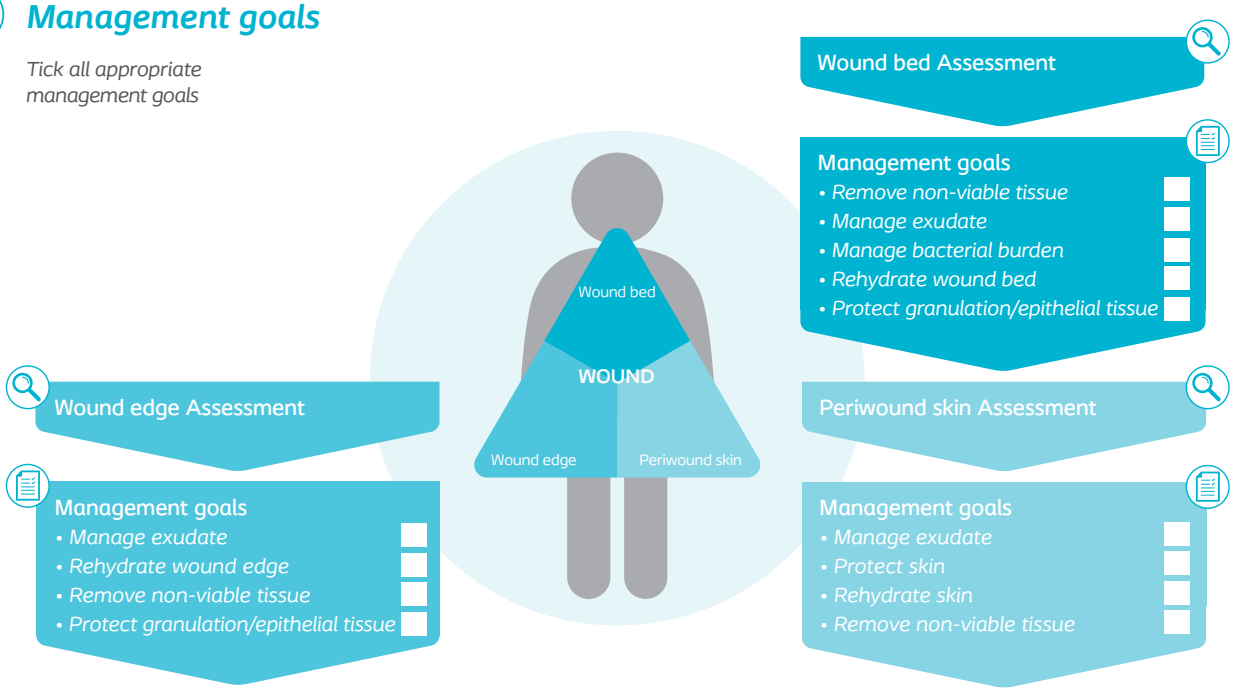
Maceration ☐	cm	Hyperkeratosis ☐	cm
Excoriation ☐	cm	Callus	cm
Dry skin	cm	Eczema	cm

Status

Is the wound: ○ N/A- First visit ○ Deteriorating ○ Static ○ Improving

Management goals

Tick all appropriate management goals



Wound Management Goals

Type all management goals:

Treatment choice

Treatment: _____

Dressing type/name: _____

Reason for choosing dressing: _____

Follow up plan

Date of next visit:

Main objective at next visit:

Date of reassessment:

Refferal needed: ○ Yes ○ No

If yes, to who: *Date:*

Coloplast