

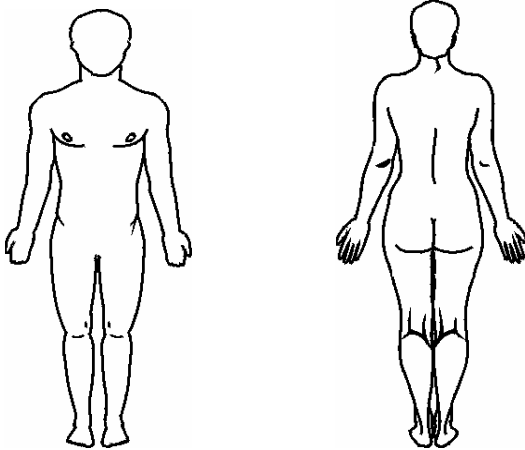
## WOUND ASSESSMENT SHEET

Patient's Name .....  
 Number .....  
 Ward / Department.....  
 Consultant/G.P. ....

Type of wound: (e.g. pressure ulcer, leg ulcer)

Known allergies to wound care products:

**Body area affected (sketch the wound or mark on chart. Add date and written description as needed)**



Date (dd/mm/yy)					
<b>Wound dimensions:</b> L x B x D (approx. in cms) Tracing Yes/No Photograph Yes/No					
<b>Wound bed:</b> E = Epithelialisation G = Granulation S = Sloughy N (H/S) = Necrotic (hard/ soft) Other – please specify Please indicate the % of each of the above in the wound bed to make a total of 100%					
<b>Exudate:</b> What colour? Any odour?  What amount? ( low, med, high)					
<b>Infection:</b> Signs of possible infection present? Yes/No ( i.e. delayed healing, bleeds easily, erythema, heat, unexpected tenderness, odour, localised oedema, discoloured wound bed)  Swab taken? Yes/No      Date:					
<b>Infection confirmed?:</b> Yes / No / Awaiting results Treatment?					
<b>Condition of surrounding skin:</b> H = Healthy D = Dry Ec = Eczema E = Erythema M = Macerated If any of the above are present, please state maximum distance from wound in cms.					
<b>Wound edges:</b> H = Healthy O = Oedematous O/G = Over granulated					
<b>Pain at wound site:</b> C = Continuous I = Intermittent DC = only at dressing changes N = None Patient's perception of pain: mild, moderate, severe?					
<b>Signature</b> <b>Name and designation</b>					

Summary of action and Treatment Plan

Signature (and print name):

Time:

Date:

Band:

Summary of action and Treatment Plan

Signature (and print name):

Time:

Date:

Band:

Summary of action and Treatment Plan

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