



Wound Care/ Assessment Visit Note

Patients name:

Location of care:

Wound Location	Site 1:	Site 2:
Type ( burn, surgical, venous, traumatic, pressure)		
Stage (if applicable)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Length /width / depth (cm)	L _____ x W _____ x D _____	L _____ x W _____ x D _____
Tunneling ( separation of fascia leading to formation of sinus)	<input type="checkbox"/> yes <input type="checkbox"/> no _____ cm _____ cm _____ o'clock	<input type="checkbox"/> yes <input type="checkbox"/> no _____ cm _____ cm _____ o'clock
Undermining ( erosion under the edge of the wound )	<input type="checkbox"/> yes <input type="checkbox"/> no _____ cm _____ o'clock to _____ o'clock	<input type="checkbox"/> yes <input type="checkbox"/> no _____ cm _____ o'clock to _____ o'clock
Eschar ( thick, leathery, necrotic tissue)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Slough ( loose, stringy, necrotic)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Wound color	<input type="checkbox"/> pink <input type="checkbox"/> red <input type="checkbox"/> yellow <input type="checkbox"/> black	<input type="checkbox"/> pink <input type="checkbox"/> red <input type="checkbox"/> yellow <input type="checkbox"/> black
Drainage – type	<input type="checkbox"/> serous <input type="checkbox"/> serosanguinous <input type="checkbox"/> purulent <input type="checkbox"/> bloody	<input type="checkbox"/> serous <input type="checkbox"/> serosanguinous <input type="checkbox"/> purulent <input type="checkbox"/> bloody
Drainage – color	<input type="checkbox"/> clear <input type="checkbox"/> pink <input type="checkbox"/> yellow <input type="checkbox"/> cream <input type="checkbox"/> green	<input type="checkbox"/> clear <input type="checkbox"/> pink <input type="checkbox"/> yellow <input type="checkbox"/> cream <input type="checkbox"/> green
Drainage – amount	<input type="checkbox"/> trace <input type="checkbox"/> small <input type="checkbox"/> moderate <input type="checkbox"/> large <input type="checkbox"/> copious	<input type="checkbox"/> trace <input type="checkbox"/> small <input type="checkbox"/> moderate <input type="checkbox"/> large <input type="checkbox"/> copious
Surrounding skin	<input type="checkbox"/> WNL for race <input type="checkbox"/> inflamed <input type="checkbox"/> macerated <input type="checkbox"/> rash <input type="checkbox"/> denuded <input type="checkbox"/> indurated	<input type="checkbox"/> WNL for race <input type="checkbox"/> inflamed <input type="checkbox"/> macerated <input type="checkbox"/> rash <input type="checkbox"/> denuded <input type="checkbox"/> indurated
PAIN ( SCALE 0 -10)		
Intervention	Cleansed with:  Dressing:	Cleansed with:  Dressing:
Assessment of teaching: <input type="checkbox"/> Verbalized full understanding <input type="checkbox"/> Verbalized moderate understanding <input type="checkbox"/> Verbalized minimal understanding <input type="checkbox"/> no understanding of knowledge	Assessment of training:  <input type="checkbox"/> competent <input type="checkbox"/> minimal coaching <input type="checkbox"/> coaching and assistance <input type="checkbox"/> unable to perform	MD Contacted: <input type="checkbox"/> yes <input type="checkbox"/> no  Date of Next Visit: _____  Frequency of Visits: _____

RN initial \_\_\_\_\_ Date: \_\_\_\_\_





Skilled Nursing Intermittent Visit Progress Notes

**Patient Name:** \_\_\_\_\_

<b>Purpose of Visit:</b>	<b>Assessment of Teaching:</b>	<b>Assessment of Training:</b>
<input type="checkbox"/> Physical Assessment	<input type="checkbox"/> Verbalizes full understanding	<input type="checkbox"/> Competent - full knowledge and ability
<input type="checkbox"/> Wound Care	<input type="checkbox"/> Verbalizes moderate understanding - needs reinforcement	<input type="checkbox"/> Able to demonstrate with minimal coaching only
<input type="checkbox"/> Teaching/Care Instructions	<input type="checkbox"/> Verbalizes minimal understanding - needs basic teaching	<input type="checkbox"/> Able to demonstrate with coaching and assistance
<input type="checkbox"/> Procedures (specify) _____	<input type="checkbox"/> No understanding or knowledge	<input type="checkbox"/> No knowledge of ability
<input type="checkbox"/> Discharge visit		

**Patient/Caregiver Comments:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Assessment:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Procedure/Teaching:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Plans/Recommendations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MD Contacted:**  Yes  No **If yes, reason:** \_\_\_\_\_

**Signature/Date/Time:** \_\_\_\_\_ **Next Visit Scheduled For** \_\_\_\_\_



Initial Pain Assessment Tool

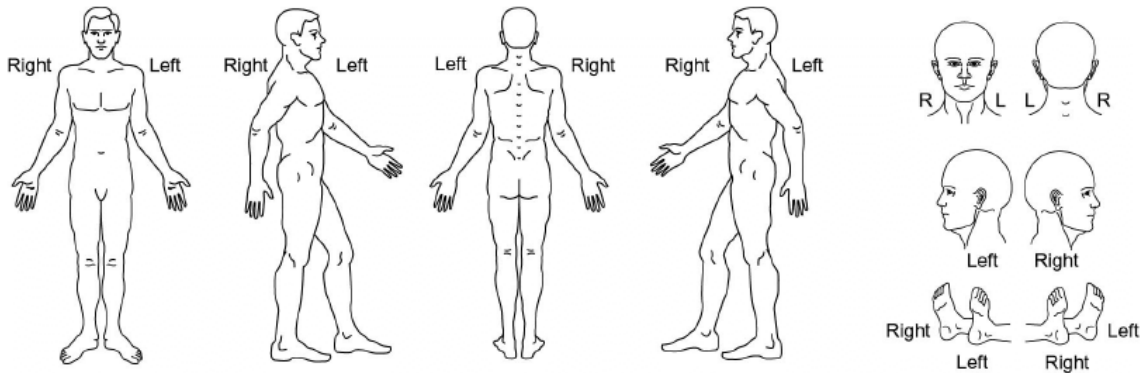
Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Room: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

Nurse: \_\_\_\_\_

1. Location: Patient or nurse marks drawing



2. Intensity: Patient rates the pain. Scale used: \_\_\_\_\_

Present: \_\_\_\_\_

Worst pain gets: \_\_\_\_\_

Best pain gets: \_\_\_\_\_

Acceptable level of pain: \_\_\_\_\_

3. Quality: (Use patients own words, e.g., prick, ache, burn, throb, pull, sharp) \_\_\_\_\_

4. Onset, duration, variations, rhythms: \_\_\_\_\_

5. Manner of expressing pain: \_\_\_\_\_

6. What relieves the pain? \_\_\_\_\_

7. **What causes or increase the pain?** \_\_\_\_\_

8. **Effects of pain:** (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) \_\_\_\_\_

Sleep \_\_\_\_\_

Appetite \_\_\_\_\_

Physical activity \_\_\_\_\_

Relationship with others (e.g., irritability) \_\_\_\_\_

Emotions (e.g., anger, suicidal, crying) \_\_\_\_\_

Concentration \_\_\_\_\_

Other \_\_\_\_\_

9. **Other comments:** \_\_\_\_\_

10. **Plan:** \_\_\_\_\_



### Medication Profile

Client Name: \_\_\_\_\_ Allergies: \_\_\_\_\_  
MD Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date	Route	Medication	Dosage	Frequency

### OTC or Herbal Medication

Date	Route	Medication	Dosage	Frequency