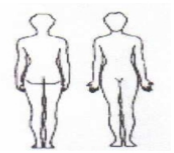
Pressure Ulcer/Wound Assessment Record

 Posterior Anterior	**Diagram of Wound** (undermining, tunneling, sinus, wound base)	**Name:** **Address:** **Age:** **Diagnosis:** **Other:**		
Date	**Initial Assessment**			
Braden Score – Date, interventions				
Location of wound				
Stage *(1, 2, 3, 4, X)*				
Length/width (cm)				
Depth (cm)				
Undermining/Tunnelling (cm) *(Use clock to describe)*				
Wound base *(**Pink** – epithelialization; **Red** – granulating; **Yellow** – slough; **Black** – necrotic/eschar; **Green** – infected; Hypergranulation) % of each*				
Ulcer margins				
Exudate *(Serous, Blood, Purulent)*				
Odour				
Culture *(date)*				
Periwound skin *(Normal, Macerated, Dry, Eczema, Cellulitic, Edematous, Other)*				
Sensation				
Pain Assessment				
Interventions (mattress, overlay cushion)				
Debridement: Yes/No Type				
Referrals: RD/ET/Wound Specialist/OT/PT				
Comments				
Treatment appropriate Yes/No Indicate Treatment:				
Changes in treatment/Care Plan Revised *(date)*				
Nurse's signature				