

## DIRECTIONS FOR WOUND/SKIN CARE REPORT

To assist you in completing the Wound/Skin Care Report, please read the directions listed below. Review the previous information in the Consumer's Corner section as needed. If experiencing more than one wound or ulcer, use a separate Progress Report for each.

1. Progress Report For: Enter your name.
  2. Week #. Enter the date for which you are monitoring care.
  3. Wound/Ulcer Type. Enter the type of wound. Refer to the chart titled "Wound Types" posted in Consumer's Corner (acute wound, arterial ulcer, chronic wound, diabetic ulcer, full-thickness wound, laceration, partial-thickness wound, pressure ulcer, venous stasis ulcer).
  4. Physician 1. Enter the name of the primary physician providing your care.
  5. Phone. Enter the phone number for the primary physician providing your care.
  6. Physician 2. Enter the name of additional physician, or care giver, providing your care.
  7. Phone. Enter the phone number for the additional physician providing your care.
  8. Date. Enter the date you are recording your information.
  9. Fever. Circle "yes" if you have a fever, circle "no" if you do not have a fever. Enter your temperature.
  10. Redness. Enter "yes" if the area appears red, enter "no" if no redness is apparent. If applicable, circle the up arrow (↑) if there is increased redness from your previous documentation, circle the down arrow (↓) if there is decreased redness from your previous documentation.
  11. Swelling. Enter "yes" if swelling is apparent, enter "no" if swelling is not apparent. If applicable, circle the up arrow (↑) if there is increased swelling from your previous documentation, circle the down arrow (↓) if there is decreased swelling from your previous documentation.
  12. Hardness. Enter "yes" if the area around the wound is hard to the touch, enter "no" if the area does not feel hard to the touch. If applicable, circle the up arrow (↑) if there is increased hardness from your previous documentation, circle the down arrow (↓) if there is decreased hardness from your previous documentation.
  13. Bleeding. Enter "yes" if bleeding is apparent, enter "no" if there is no bleeding. If applicable, circle the up arrow (↑) if there is increased bleeding from your previous documentation, circle the down arrow (↓) if there is decreased bleeding from your previous documentation.
  14. Drainage. Enter "yes" if the wound/ulcer is draining any fluid (for example, blood, pus, etc.), enter "no" if there is no drainage apparent.
  15. Type. Enter the type of drainage:
    - Clear. This is called "serous," which is clear, watery plasma.
    - Bloody. This is called "sanguineous," which is fresh bleeding.
    - Slightly pink. This is called "serosanguineous," which consists of plasma and red blood cells.
    - Cloudy. This is called "purulent," which is thick, white blood cells and living or dead organisms, possibly with a yellow, green, or brown color that can suggest the type of infecting organism.
- If applicable, circle the up arrow (↑) if there is increased drainage from your previous documentation, circle the down arrow (↓) if there is decreased drainage from your previous documentation.
16. Odor. Enter "yes" if odor is present, enter "no" if there is no odor. If applicable, circle the up arrow (↑) if there is increased odor from your previous documentation, circle the down arrow (↓) if there is decreased odor from your previous documentation. A pungent, strong, foul, fecal, or musty odor suggests infection.
  17. Pain. Enter "yes" if you have pain around the wound or ulcer area, enter "no" if there is no pain. If applicable, circle the up arrow (↑) if there is increased pain from your previous documentation, circle the down arrow (↓) if there is decreased pain from your previous documentation. Pain may indicate infection, underlying tissue destruction that isn't visible, or vascular insufficiency. No pain may indicate nerve destruction or neuropathy.
  18. Color. Circle 'R' for red, 'Y' for yellow, 'B' for black, or 'M' for mixed or a variation of more than one color apparent. Color should always be documented. Color is important and used to distinguish viable tissue from nonviable tissue. Color may also guide treatment. If other colors are apparent, for example, pink, gray, or white, document these colors as well. There may be something within the wound bed that needs attention.

19. Measurements. Size is determined by measuring length, width, and depth, usually in centimeters (cm), or by measuring volume. Consistent vocabulary and consistent units of measure are essential when documenting and describing wound measurements.

- Length and width. Take a linear measurement from wound edge to wound edge. Establish landmarks. For example, look at the wound as if it were the face of a clock. The top of the wound (12 o'clock) would be toward your head. The bottom of the wound would be the opposite end (6 o'clock). Width can be measured from side to side (3 o'clock to 9 o'clock). You can also trace your wound. Use a permanent marker to trace your wound onto a transparent paper. If pain is present, avoid this option. Also avoid getting the marker on the wound. Keep the papers in a plastic bag for reference.

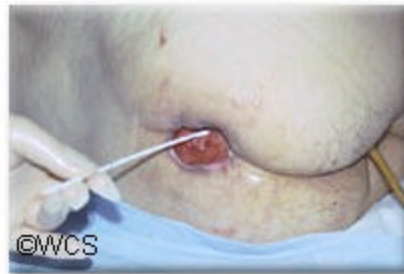


length



width

- Depth. Measure the visible surface to the deepest point in the wound. If the depth varies, take measurements of different areas. See “Measuring wound depth” below.



depth

- Tunneling. Both the direction and the depth of tunneling should be documented. This is tissue destruction underlying intact skin. See “Measuring wound tunneling” below.



tunneling

If applicable, circle the up arrow (↑) if there is an increase in size from your previous documentation, circle the down arrow (↓) if there is a decrease in size from your previous documentation.

Upon your next visit to your health care provider, share this information so you can take charge and play an active role in managing your care.

WOUND/SKIN CARE REPORT FOR: \_\_\_\_\_

Date:			Physician 1:				Physician 2:			
Wound/Ulcer Type:			Phone:				Phone:			
Date:										
Fever:	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	Yes No Temp: ___°	
Redness:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Swelling:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Hardness:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Bleeding:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Drainage:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
Drainage Type	C B SP CL	C B SP CL	C B SP CL	C B SP CL	C B SP CL	C B SP CL	C B SP CL	C B SP CL	C B SP CL	
<u>C</u> = Clear <u>B</u> = Bloody <u>SP</u> = Slightly Pink <u>CL</u> = Cloudy										
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Odor:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Pain:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	
More or less	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	
Color:	R Y B M	R Y B M	R Y B M	R Y B M	R Y B M	R Y B M	R Y B M	R Y B M	R Y B M	
<u>R</u> =Red (clean, healthy tissue) <u>Y</u> =Yellow (slough/fibrinous tissue) <u>B</u> =Black (presence of eschar) <u>M</u> =Mixed (two/+ colors in wound)										
<i>If possible, include your wound measurements to assist your health care provider in evaluating the progress of your wound. Measurements should be taken in a consistent manner and by a consistent caregiver. To learn how to measure, see section 19 in the "Directions for Wound/Skin Care Report." Also, check with your health care provider.</i>										
Measurements In centimeters: Length, Width, Depth, Tunneling	L: W: D: T:	L: W: D: T:	L: W: D: T:	L: W: D: T:	L: W: D: T:	L: W: D: T:	L: W: D: T:	L: W: D: T:	L: W: D: T:	
Size:	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	↑ ↓	

If a support surface (specialty bed) or pressure relieving device was ordered, what type of surface or device is it?

\_\_\_\_\_ Date of first use: \_\_\_\_\_

Notes and observations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_