GIPPSLAND REGIONAL WOUND ASSESSMENT CHART

UR: DOB:
SURNAME: GIVEN:
Residential address:
Locality: Postcode:
Phone (home): Mobile:

USE LABEL IF AVAILABLE

DATE	/ /	**WOUND LOCATION**		**WOUND NO**	

ALLERGIES / SENSITIVIES :

WOUND HISTORY (Approximate wounding date, Mechanism of injury, Previous treatment etc)

WOUND TYPE

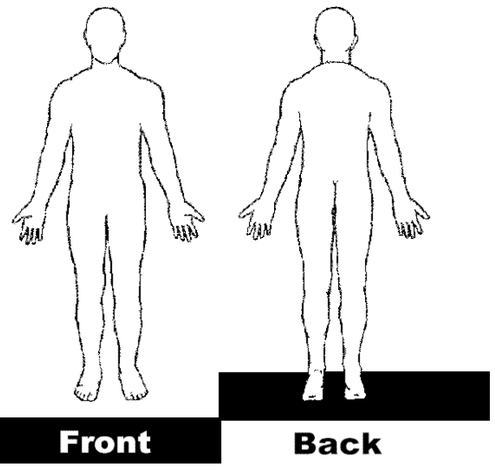
☐ Acute – Surgical / Crush / Burn / Trauma	☐ Lymphatic / Cellulitis with no previous ulcer
☐ Atypical - Malignancy / Irradiation	☐ Undiagnosed wound
☐ Fistula / Abscess / Pilonidal sinus / Drain tube	☐ Diagnosed wound (Pyoderma Gangrenosum; Mycobacterium Ulcerans)

Pressure Injury Classification	ISTAP Skin Tear Classification	Lower Limb Ulcer
☐ Stage I	☐ Type 1 - No skin loss	☐ Leg Ulcer – Arterial
☐ Stage II	☐ Type 2 - Partial flap loss	☐ Leg Ulcer – Venous
☐ Stage III	☐ Type 3 - Full flap loss	☐ Leg Ulcer – Mixed disease
☐ Stage IV		☐ Neuro / Ischaemic ulcer
☐ Unstageable		☐ Neuropathic
☐ Suspected deep tissue injury (SDTI)		☐ Undiagnosed leg ulcer

FACTORS AFFECTING HEALING

☐ Diabetes	☐ Smoking	☐ Cardiovascular disease (CCF / PAD / IHD)
☐ Autoimmune (Rheumatoid Arthritis)	☐ Anaemia	☐ Medications
☐ Poor Nutrition	☐ Respiratory Disease	☐ Lymphoedema
☐ Other :		

WOUND LOCATION



REFERRALS	DATE
☐ Wound Management CNC	
☐ Medical (GP / Surgeon)	
☐ Podiatrist	
☐ Dietitian	
☐ Diabetic Nurse Educator	
☐ Physiotherapist	
☐ Other	

INVESTIGATIONS	DATE
☐ HbA1c	
☐ ABPI/TBPI/TSP	
☐ Wound swab	
☐ Duplex Ultrasound Arterial / Venous	
☐ Medication review	
☐ Radiology	
☐ Other (list)	

NAME, SIGNATURE AND DESIGNATION

Date: / /

WOUND ASSESSMENT CHART

WOUND REGIME

AFFIX LABEL HERE

DATE: **NURSE SIGNATURE:** **DRESSING FREQUENCY:**
DEBRIDEMENT FREQUENCY: **DEBRIDEMENT MODE:** Autolytic ☐ Mechanical ☐ Sharp ☐ Nil ☐
Dressing regime (Cleansing, dressings, offloading and compression regime)

Rationale for changing this regime:

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WOUND LOCATION:

	ASSESSMENTS	**Date:**					
Exudate Amount	Nil	0					
	Low – up to 7 days wear	+					
	Mod – up to 2-3 days wear	++					
	Heavy – less than 24 hours wear	+++					
	Exudate increasing	✓					
Exudate type	Nil	✓					
	Serous	✓					
	Haemoserous	✓					
	Sanguineous	✓					
	Purulent	✓					
Wound bed tissue	Healed (epithelial) / Intact suture line	%					
	Granulation	%					
	Slough	%					
	Eschar	%					
	Other Eg. Tendon/bone - list						
	Hypergranulation	✓					
	Red friable / bleeding tissue	✓					
	Epithelial bridging	✓					
	Granulation pocketing	✓					
Debridement: Autolytic (A) Mechanical (M) Sharp (S)							
Edges and Periwound	Healthy / Intact	✓					
	Macerated (M) / Excoriated (E)	✓					
	Oedema	✓					
	Dry (D) / Scaly (S) / Callous (C)	✓					
	Rolled Edges	✓					
	Erythema (E), Heat (H), Odour (O)						
Weekly Monitoring	Length x Width x Depth (cm)						
	Undermined (cm at o'clock)						
	Traced	✓					
	Photographed	✓					
	Circumference	**Right** ankle / calf (cm)	/	/	/	/	/
		Left ankle / calf (cm)	/	/	/	/	/
	Increase in wound size or circumference	✓					
Pain	Pre dressing pain (Rate 1 – 10)						
	Procedural pain (Rate 1 – 10)						
	Post dressing pain (Rate 1 – 10)						
	Increase in wound pain or new pain	✓					
	ALERT	***Shaded areas indicate that biofilm based wound management is required due to increased bioburden, infection and /or potential biofilm formation***					
	Dressing regime changed (Yes / No)						
		INITIAL					

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WOUND LOCATON:

/	/	/	/	/	/	/	/	/
/	/	/	/	/	/	/	/	/
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