WOUND CARE SUMMARY

Member Name _____ **Member ID #** _____

Date evaluated				
Wound location				
Size Length, width, depth (in centimeters)				
Tissue color Pink (granulating); yellow (slough); black (necrotic)				
Condition of surrounding skin: Intact; fragile; red; hard purple; open				
Odor None; foul; mild; sweet				
Drainage Serosanguinous; serous; bleeding; purulent; none				
Drainage amount				
Stage: I-IV (see key below)				
Treatment plan				

Stage Key (Staging applies to pressure ulcers only and not vascular wounds)

Stage 1: Intact skin that is pink or reddened and does not blanch upon touch.
Stage 2: Cracked, blistered or open areas of the top layer of skin. The pressure ulcer is shallow in depth. May appear as abrasion or blister.
Stage 3: Injury through several layers of skin, including subcutaneous tissue. Ulcer has some depth. May be able to visualize muscle fascia. Wound tissue may be pink (granulation), y yellow (slough), or black (necrotic). Tunneling under the wound edges (undermining) may be present.
Stage 4: Injury through all layers exposing muscle, tendon, and bone. Wound base may be pink, yellow, or black. Tunneling under the wound edges may be present.

Note: When eschar (thick, black, leathery tissue) is present, accurate staging of the pressure ulcer is not possible until the eschar has sloughed or the wound has been debrided.

Please fax completed form to HAP Inpatient Rehab/SNF Team at (313) 664-5820.