RECOVERY CARE WOUND CARE SUMMARY

Member Name: _____

HAP #:

Date Evaluated				
Location of Wound				
Size: Length, width, depth, measured 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 **Amount:**				
Stage: I-IV (See key below)				
TREATMENT PLAN:				

Stage Key (Pressure Ulcers Only) 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), 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 uder the wound edges may be present.

** **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 Recovery Care 313-664-8880