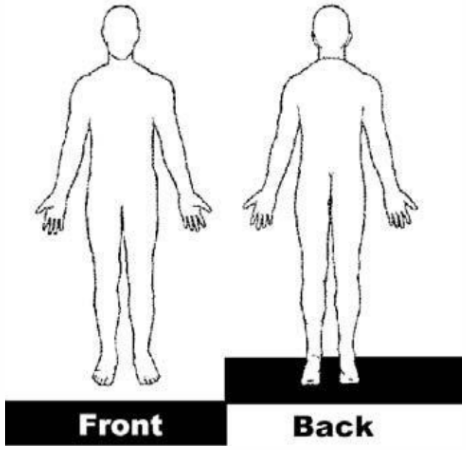
WOUND DOCUMENTATION

This form can be photocopied on paper to take into the isolation room for bedside wound documentation.

The form can be photographed and submitted to an EMR for documentation similar to a photograph (if allowed by facility policy), then the paper discarded in the isolation room. Additional documentation can be completed outside the isolation room and photos (wound and/or documentation sheet) can be referenced per facility policy.

Please refer to the WOCN Society Recommendations for Wound Assessment & Photo Documentation in Isolation for more details.



ASSESSMENT	WOUND #	WOUND #	WOUND #
LOCATION (BE SPECIFIC, USE IMAGES ABOVE TO MARK BY NUMBER)			
MEASUREMENTS (LXWXD, IN CM) IMAGINE CLOCK FACE OVER WOUND			
DRAINAGE (NONE, SCANT, MINIMAL, MODERATE, HEAVY)			
DRAINAGE CONSISTENCY & COLOR: THIN/THICK, OPAQUE/CLEAR, WHITE/YELLOW/TAN/BROWN/RED/OTHER			
WOUND EDGES: FLAT, ELEVATED, EDEMATOUS, ROLLED			
PERIWOUND SKIN: NORMAL & WARM, RED (<5CM) & WARM, RED (>5CM) & HOT, PALE & COOL TO TOUCH**			

** DO NOT REMOVE PPE TO "TOUCH" THE SKIN. IF THIS PARAMETER ISN'T ASSESSED, DOCUMENT THIS DEVIATION FROM THE ASSESSMENT (ON THIS FORM OR LATER IN THE RECORD AFTER EXITING PATIENT'S ROOM).

Wound Ostomy and Continence Nurses Society®