Saint Elizabeth
Well beyond health care

WOUND Medical Update Report

Client Name _____ Date of Birth_____ BRN_____

Diagnoses _____ Allergies _____

Current Status: (check all that apply)

Wound: □ Pressure □ Diabetic Foot □ Venous □ Venous/Arterial □ Surgical □Pilonidal □ Burn □ Other _____

□ New □ Recurrent □ Healing □ Maintenance □ Non-Healing

IP Team involvement: □ ET □ Wound Resource Nurse □ PT □ OT □ RD □ Chiropodist □ Pedorthotist □ Other_____

Assessment

Deep Tissue Infection: □ Suspected □ Confirmed **Local Infection (critical colonization)**: □ Suspected □ Confirmed

Osteomyelitis: □ Suspected □ Confirmed □ **Antibiotic Resistant Organisms:** □ MRSA □ VRE □ Other _____

Infection Management: □ Parenteral antibiotics □ Oral antibiotics □ Topical Antimicrobial Management

Wound Related Pain (0-10): _____ **Odour:** □ Yes □ No **Edema**: □ No □ Yes Location: _____

Lower Leg Assessment: □ N/A ABPI: Left _____ Right _____ Date: _____ Vascular Studies: □ Done □ Requested

Wound Measurements: Length _____ Width _____ Depth _____ Volume _____ % change in volume (from initial) _____

Undermining: (describe)_____ _____ Sinus Tract: (describe) _____

Wound Base: □ Granulation (%____) □ Slough (%____) □ Eschar (%____) □ Bone □ Tendon/Ligament Other: _____

Exudate: □ Sero-Sanguinous □ Serous □ Sanguinous □ Purulent □ Dry □ Moist □ Wet/Saturated

Periwound: □ Intact □ Macerated □ Erythema □ Indurated □ Denuded □ Other _____

Current Wound Treatment:

Dressing Frequency: □ Daily □ Q2 Days □Q3 Days □Q4 Days □ Q5 Days □Q6 Days □ 1x Week □ Biweekly □ Other _____

Additional: □ Client following plan: □Yes □No □Teaching towards self-management* □ Client able to self-manage*

Evidence Based Treatment Recommendations:

Request: □ Compression:_____ □ C&S wound swab □ Antibiotics □ Bone Scan □ X-Ray □ Vascular Studies

□ Blood Work _____ □ Vascular Study Results □ Lab Work Results Other:_____

Signature/Designation _____Print Name _____Date_____

Health Care Provider Response/Orders: **□ Implement evidence/assessment based treatment**

During apt. Packing removed □ Packing inserted □

Signature/Designation _____Print Name _____Date_____

Please fax response to Saint Elizabeth at: _____ Phone number: _____

***Our goal is to promote independence, with regular nursing visits to assess, *if* the patient is capable.**