1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE / SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

REFERRAL SOURCE

VISIT TYPE: WOUND CARE CONSULTATION / FOLLOW-UP / PROCEDURE VISIT

CARE SETTING: OUTPATIENT WOUND CLINIC / INPATIENT / SKILLED NURSING FACILITY / HOME HEALTH / TELEHEALTH

PRIMARY CARE PROVIDER, IF APPLICABLE

SPECIALIST / SURGEON, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY WOUND-RELATED CONCERN

Primary wound-related reason for the visit in the patient's own words when possible — non-healing wound, pressure injury, diabetic ulcer, venous ulcer, arterial ulcer, surgical wound, traumatic wound, burn, infection concern, wound drainage, wound pain, dressing management, or wound follow-up...

S SUBJECTIVE

3 PATIENT-REPORTED WOUND HISTORY, SYMPTOMS & TREATMENT RESPONSE

3a INDICATION, ONSET & WOUND COURSE

Reason for Wound Care Evaluation (initial wound evaluation, wound follow-up, worsening wound, delayed healing, infection concern, debridement, dressing change, compression therapy, offloading, post-surgical wound care, wound closure planning):

Wound Onset and Course (when the wound began; cause or suspected cause — traumatic, surgical, pressure-related,

diabetic, vascular, infectious, burn-related, or spontaneous; whether improving, worsening, stable, recurrent, or non-healing):

Wound Location and Laterality (exact anatomic site, laterality, wound number if multiple, relationship to pressure points, surgical sites, bony prominences, footwear, prosthetics, braces, or devices):

3b WOUND SYMPTOMS, DRAINAGE & INFECTION

Wound Symptoms (pain, tenderness, drainage, odor, bleeding, swelling, redness, warmth, itching, numbness, tingling, maceration, necrosis, skin breakdown, change in wound appearance):

Drainage / Exudate History (amount, color, consistency, odor, frequency of dressing saturation, change in drainage pattern):

Infection Symptoms (fever, chills, increased pain, erythema, warmth, purulent drainage, foul odor, edema, streaking, wound enlargement, delayed healing, systemic symptoms, prior cellulitis or osteomyelitis):

3c TREATMENT HISTORY, FUNCTION & HEALING BARRIERS

Prior Wound Treatment (dressings, topical agents, compression therapy, offloading, antibiotics, debridement, grafts, negative pressure wound therapy, hyperbaric oxygen therapy, surgery, vascular intervention, home health wound care):

Dressing and Home Care Adherence (dressing change frequency, caregiver or home health involvement, adherence to wound care instructions, supply access, hygiene, bathing practices, barriers to care):

Functional Impact (walking, transfers, footwear, work, sleep, activities of daily living, pain control, mobility, quality of life):

Risk Factors for Poor Healing (diabetes, peripheral arterial disease, venous insufficiency, neuropathy, pressure exposure, immobility, malnutrition, smoking, edema, obesity, immunosuppression, renal disease, steroid use, chemotherapy, radiation, infection, poor glycemic control):

Vascular / Neuropathy Symptoms (claudication, rest pain, cold extremity, numbness, tingling, loss of protective sensation, edema, varicose veins, skin discoloration, prior vascular testing or intervention):

Nutrition and Metabolic Factors (appetite, protein intake, weight change, hydration, albumin / prealbumin, glycemic control, nutrition support):

Pertinent Negatives (fever, chills, rapidly spreading redness, severe pain, necrosis, exposed bone, new numbness, rest pain, systemic illness, acute limb ischemia symptoms):

ROS WOUND CARE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Wound pain, tenderness, drainage, bleeding, odor, or itching	
Redness, warmth, swelling, maceration, necrosis, or skin breakdown	
Fever, chills, fatigue, or systemic infection symptoms	
Numbness, tingling, neuropathy symptoms, or decreased sensation	
Claudication, rest pain, cold extremity, edema, or vascular symptoms	
Difficulty walking, transferring, wearing footwear, or performing ADLs	
Hyperglycemia, poor appetite, weight change, or nutrition concerns	
Dressing adherence, supply issues, or home care barriers	

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
HEART RATE	RESPIRATORY RATE
OXYGEN SATURATION	WEIGHT
BMI	PAIN SCORE

5a GENERAL, VASCULAR & PULMONARY

General Appearance (distress level, mobility, nutritional appearance, hygiene, ability to participate in wound care, overall clinical condition):

Cardiovascular / Vascular (pulses, capillary refill, limb temperature, edema, varicosities, skin discoloration, dependent rubor, pallor with elevation, signs of venous disease, signs of arterial insufficiency):

Pulmonary (respiratory status when relevant to overall healing, oxygenation, or hyperbaric therapy eligibility):

5b EXTREMITIES, NEUROLOGIC & SKIN

Extremities (edema, deformity, amputation status, Charcot changes, contractures, pressure points, footwear, braces, prosthetics, offloading devices, mobility limitations):

Neurologic (sensation, protective sensation, monofilament testing, vibration sense, proprioception, neuropathy findings, motor function):

Skin (periwound skin condition, dermatitis, maceration, callus, cellulitis, hemosiderin staining, lipodermatosclerosis, pressure-related skin changes, fungal changes, additional wounds):

WA WOUND ASSESSMENT

6 DESCRIBE EACH WOUND SEPARATELY & PRECISELY

WOUND NUMBER

LOCATION AND LATERALITY

WOUND TYPE OR SUSPECTED ETIOLOGY

DATE FIRST ASSESSED, IF KNOWN

LENGTH × WIDTH × DEPTH

STAGE OR GRADE, IF APPLICABLE

EXUDATE AMOUNT, COLOR, CONSISTENCY, ODOR

WOUND PHOTOGRAPHS OBTAINED, IF APPLICABLE

Undermining and tunneling, including clock-face location and depth:

Wound bed tissue type (granulation, slough, eschar, epithelialization, exposed tendon, exposed bone, exposed hardware):

Wound edges (attached, rolled, undermined, callused, macerated, irregular):

Periwound condition:

Bleeding or friability; signs of infection or inflammation:

Pain with wound care or palpation:

Comparison to prior measurements and appearance:

CL PRESSURE INJURY / ULCER CLASSIFICATION, IF APPLICABLE

7 WOUND CLASSIFICATION

PRESSURE INJURY STAGE

DIABETIC FOOT ULCER GRADE / CLASSIFICATION, IF USED

VENOUS LEG ULCER FEATURES

ARTERIAL ULCER FEATURES

NEUROPATHIC ULCER FEATURES

SURGICAL WOUND STATUS

TRAUMATIC WOUND FEATURES

BURN DEPTH, IF APPLICABLE

Presence of exposed bone, tendon, muscle, joint capsule, hardware, or graft material:

Concern for osteomyelitis, ischemia, abscess, necrosis, or deep infection:

PR PROCEDURES PERFORMED

8 WOUND PROCEDURES THIS VISIT

Selective debridement · Excisional debridement · Non-selective debridement · Callus paring · Incision and drainage · Wound culture collection · Negative pressure wound therapy application or change · Skin substitute or graft application · Compression wrap application · Total contact cast application · Dressing change · Suture or staple removal · Wound photography or measurement

PROCEDURE NAME

INDICATION

WOUND LOCATION AND LATERALITY

CONSENT OBTAINED

ANESTHESIA, IF USED

INSTRUMENTS USED

TISSUE REMOVED

BLEEDING / HEMOSTASIS

POST-PROCEDURE WOUND MEASUREMENTS

DRESSING APPLIED

Technique:

Patient tolerance and complications, if any:

L LABORATORY AND DIAGNOSTIC RESULTS

9 RESULTS REVIEWED OR ORDERED

Laboratory Studies (CBC, CMP, ESR, CRP, HbA1c, albumin, prealbumin, glucose, renal function, nutrition markers, inflammatory markers, infection-related labs):

Microbiology (wound culture, tissue culture, blood culture, antibiotic sensitivities, prior resistant organisms, pending culture results):

Imaging (X-ray, MRI, CT, ultrasound, bone scan, tagged WBC scan; imaging for osteomyelitis, abscess, foreign body, gas, fracture, deep infection):

Vascular Studies (ABI, TBI, arterial duplex, venous duplex, toe pressures, $TcPO_2$, skin perfusion pressure, angiography, vascular intervention reports):

Pathology (biopsy results, malignancy evaluation, inflammatory dermatosis findings, atypical wound pathology):

Prior Records Reviewed (wound clinic notes, surgical notes, vascular records, podiatry records, infectious disease notes, home health notes, hospital records, medication history, prior wound measurements and photos):

A ASSESSMENT

10 WOUND CARE CLINICAL INTERPRETATION

Primary wound diagnosis or working diagnosis. Wound type, location, severity, and healing status. Wound progression compared with prior visit. Presence or absence of infection, ischemia, necrosis, pressure injury, edema, neuropathy, osteomyelitis concern, or exposed structure. Healing barriers including diabetes control, vascular insufficiency, venous disease, pressure, offloading nonadherence, malnutrition, smoking, immunosuppression, edema, or inadequate wound care supplies. Adequacy of current dressing and wound care plan. Need for debridement, culture, antibiotics, imaging, vascular evaluation, offloading, compression, grafting, negative pressure therapy, surgery, or higher level of care...

P PLAN

11 WOUND CARE MANAGEMENT BY PROBLEM

Wound cleansing and dressing plan (dressing type, topical agents, frequency, who will perform dressing changes). Debridement plan (performed today, deferred, repeated, or referred for surgical debridement). Infection management plan (culture, antibiotics, imaging, infectious disease referral, cellulitis monitoring, osteomyelitis evaluation, urgent escalation). Offloading plan (footwear modification, diabetic shoes, inserts, total contact cast, walker boot, heel protector, pressure redistribution surface, repositioning, activity limitation). Compression and edema plan. Vascular evaluation plan. Diabetes and metabolic optimization plan. Nutrition plan. Pain management plan. Advanced therapy plan (negative pressure wound therapy, skin substitutes, grafting, hyperbaric oxygen therapy, biologic dressings, surgical closure). Home care and supply plan. Patient education...

F FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose (wound measurement reassessment, dressing response, debridement, infection monitoring, culture or imaging review, vascular evaluation follow-up, offloading or compression assessment, advanced therapy planning):

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

PROCEDURE TIME, IF APPLICABLE

COUNSELING / COORDINATION OF CARE TIME

RECORDS REVIEW TIME, IF APPLICABLE

HOME HEALTH / SUPPLY COORDINATION TIME, IF APPLICABLE

BASIS FOR BILLING: TIME-BASED / MDM / PROCEDURE-BASED / WOUND MEASUREMENT AND TREATMENT

E/M LEVEL, IF APPLICABLE: 99203 / 99204 / 99205 / 99213 / 99214 / 99215

DEBRIDEMENT CODE(S), IF APPLICABLE

WOUND PROCEDURE CODE(S), IF APPLICABLE

SKIN SUBSTITUTE / GRAFT CODE(S), IF APPLICABLE

NEGATIVE PRESSURE WOUND THERAPY CODE(S), IF APPLICABLE

COMPRESSION / CAST / DRESSING CODE(S), IF APPLICABLE

PRIMARY ICD-10 DIAGNOSIS CODE + DESCRIPTION

SECONDARY ICD-10 DIAGNOSIS CODE(S), IF APPLICABLE

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY: WOUND CARE	DATE	TIME