MARVIX AI

BURN & TRAUMA WOUND CARE SOAP NOTE TEMPLATE

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE / SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

REFERRAL SOURCE

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

CARE SETTING: OUTPATIENT WOUND CLINIC / BURN CLINIC / TRAUMA CLINIC / INPATIENT / EMERGENCY / SKILLED NURSING FACILITY / HOME HEALTH

PRIMARY CARE PROVIDER, IF APPLICABLE

SURGEON / TRAUMA PROVIDER, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY BURN OR TRAUMA WOUND CONCERN

Primary burn or trauma wound-related reason for the visit in the patient's own words when possible — burn injury, traumatic wound, laceration, abrasion, avulsion, crush injury, post-operative wound, delayed healing, infection concern, dressing management, pain, drainage, scar concern, or wound follow-up...

S SUBJECTIVE

3 PATIENT-REPORTED INJURY HISTORY, WOUND SYMPTOMS & FUNCTIONAL IMPACT

3a INDICATION, MECHANISM & CIRCUMSTANCES

Reason for Burn / Trauma Wound Evaluation (initial evaluation, wound follow-up, burn assessment, traumatic wound care, delayed healing, infection concern, debridement, dressing change, graft or flap follow-up, scar management, post-hospital or post-operative wound care):

Mechanism of Injury (thermal, scald, flame, contact, chemical, electrical, friction, radiation, blast, crush, laceration, puncture, abrasion, avulsion, bite, fall, motor vehicle collision, work-related injury, surgical trauma):

Date and Circumstances of Injury (date and time of injury, location of the injury event, setting, occupational or environmental exposure, protective equipment, first aid performed, whether emergency care was received):

Wound Onset and Course (when the wound began, progression since injury; whether improving, worsening, stable, recurrent, or non-healing; any change in wound size, depth, drainage, odor, color, or pain):

3b INJURY CHARACTERISTICS & SYMPTOMS

Burn Characteristics, if applicable (burn source, estimated exposure duration, temperature or chemical involved, affected body areas, total body surface area, depth estimate, blistering, eschar, circumferential involvement, inhalation injury concern):

Trauma Wound Characteristics (laceration, abrasion, puncture, avulsion, crush injury, hematoma, open fracture concern, foreign body concern, contamination, tissue loss, exposed tendon / bone / hardware, whether repair or surgery was performed):

Pain and Sensory Symptoms (pain severity, quality, frequency, duration, triggers, dressing-related pain, neuropathic pain, numbness, tingling, hypersensitivity, reduced sensation, pain response to treatment):

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

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

3c TREATMENT HISTORY, FUNCTION & HEALING BARRIERS

Prior Evaluation and Treatment (emergency care, burn center evaluation, trauma surgery evaluation, wound cleansing, irrigation, sutures or staples, debridement, grafting, flap repair, antibiotics, tetanus prophylaxis, pain medication, topical therapy, dressings, compression, splinting, physical or occupational therapy):

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

Functional Impact (mobility, range of motion, work, sleep, ADLs, hand function, walking, transfers, clothing, footwear, hygiene, pain control, quality of life):

Risk Factors for Poor Healing (diabetes, peripheral arterial disease, venous disease, neuropathy, smoking, malnutrition, immunosuppression, steroid use, renal disease, edema, infection, contamination, delayed presentation, repeated trauma, poor wound care access):

Tetanus / Immunization Status (tetanus vaccination status, booster date, whether tetanus prophylaxis was provided):

Pertinent Negatives (fever, rapidly spreading redness, severe worsening pain, numbness or weakness, circumferential tightness, impaired perfusion, inhalation symptoms, chest pain, dyspnea, uncontrolled bleeding, exposed bone or tendon, systemic illness):

ROS BURN / TRAUMA WOUND REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Wound pain, tenderness, swelling, bleeding, drainage, odor, or itching	
Redness, warmth, blistering, eschar, necrosis, or delayed healing	
Fever, chills, fatigue, malaise, or systemic infection symptoms	
Numbness, tingling, weakness, reduced sensation, or impaired movement	
Shortness of breath, cough, hoarseness, soot exposure, or inhalation injury symptoms if burn-related	

Difficulty walking, using the affected limb, performing ADLs, working, or sleeping

Dressing adherence issues, supply barriers, or home care concerns

Hyperglycemia, poor appetite, smoking, or other healing 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, hydration status, nutritional appearance, ability to participate in wound care, overall clinical condition):

Cardiovascular / Vascular (pulses, capillary refill, limb temperature, edema, perfusion, cyanosis, pallor, signs of vascular compromise when the wound involves an extremity):

Pulmonary (breath sounds, work of breathing, oxygen requirement, cough, hoarseness, soot exposure findings, respiratory concerns when inhalation injury is possible):

5b NEUROLOGIC, MUSCULOSKELETAL & SKIN

Neurologic (sensation, motor function, weakness, numbness, neuropathic symptoms, pain response, neurovascular status distal to the wound):

Musculoskeletal / Functional (range of motion, joint involvement, contracture risk, splint status, tendon function, gait, hand function, weight-bearing status, mobility limitations):

Skin / Soft Tissue (surrounding skin condition, erythema, edema, maceration, blistering, eschar, necrosis, cellulitis, bruising, hematoma, scar formation, contracture, graft or flap status, additional wounds):

WA BURN / TRAUMA WOUND ASSESSMENT

6 DESCRIBE EACH BURN OR TRAUMA WOUND SEPARATELY & PRECISELY

WOUND NUMBER

LOCATION AND LATERALITY

INJURY TYPE AND SUSPECTED ETIOLOGY

DATE FIRST ASSESSED, IF KNOWN

LENGTH × WIDTH × DEPTH

BURN DEPTH (SUPERFICIAL / PARTIAL-THICKNESS / DEEP PARTIAL-THICKNESS / FULL-THICKNESS)

ESTIMATED TOTAL BODY SURFACE AREA, IF APPLICABLE

EXUDATE AMOUNT, COLOR, CONSISTENCY, ODOR

WOUND PHOTOGRAPHS OBTAINED, IF APPLICABLE

COMPARISON TO PRIOR MEASUREMENTS AND APPEARANCE

Wound bed tissue type (epithelialization, granulation, slough, eschar, necrosis, exposed tendon, exposed bone, exposed joint, exposed hardware, graft or flap tissue):

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

Wound edges (attached, irregular, macerated, rolled, undermined); periwound condition:

Blistering, eschar, char, foreign material, contamination, or devitalized tissue:

Bleeding or friability; signs of infection, ischemia, compartment concern, or deep tissue involvement:

Pain with wound care or palpation; range of motion or contracture limitation related to wound location:

CL BURN / TRAUMA CLASSIFICATION, IF APPLICABLE

7 CLASSIFICATION

BURN TYPE: THERMAL / SCALD / FLAME / CONTACT / CHEMICAL / ELECTRICAL / FRICTION / RADIATION / OTHER

BURN DEPTH

TOTAL BODY SURFACE AREA INVOLVED

CIRCUMFERENTIAL BURN STATUS

INHALATION INJURY CONCERN

ELECTRICAL INJURY CONCERN

CHEMICAL EXPOSURE DETAILS AND DECONTAMINATION STATUS

TRAUMA WOUND TYPE: LACERATION / ABRASION / PUNCTURE / AVULSION / CRUSH / DEGLOVING / BITE / SURGICAL OR TRAUMATIC OPEN WOUND

CONTAMINATED OR DIRTY WOUND STATUS

SCAR OR CONTRACTURE RISK

Involvement of face, hands, feet, genitalia, perineum, major joints, or airway risk areas:

Exposed tendon, bone, joint, capsule, hardware, or graft material:

Need for burn center, trauma surgery, plastic surgery, hand surgery, or orthopedic evaluation:

PR PROCEDURES PERFORMED

8 BURN OR TRAUMA WOUND PROCEDURES THIS VISIT

Wound cleansing or irrigation · Selective debridement · Excisional debridement · Non-selective debridement · Blister management · Eschar management · Foreign body removal · Laceration repair follow-up · Suture or staple removal · Wound culture collection · Negative pressure wound therapy application or change · Skin substitute or graft application · Compression dressing or wrap application · Splint application · Burn dressing change · Scar or contracture assessment · Wound photography or measurement

PROCEDURE NAME

INDICATION

WOUND LOCATION AND LATERALITY

CONSENT OBTAINED

ANESTHESIA, IF USED

INSTRUMENTS USED

TISSUE REMOVED

IRRIGATION / CLEANSING PERFORMED

FOREIGN MATERIAL REMOVED

BLEEDING / HEMOSTASIS

POST-PROCEDURE 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, glucose, HbA1c, renal function, albumin, prealbumin, nutrition markers, coagulation studies, CK if crush or electrical injury concern, infection-related labs):

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

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

Vascular / Perfusion Studies (ABI, TBI, arterial duplex, venous duplex, Doppler exam, $TcPO_2$, skin perfusion pressure, angiography, other perfusion studies when healing or limb viability is a concern):

Burn / Trauma Records (emergency department records, burn center notes, trauma surgery notes, operative reports, graft or flap records, discharge summaries, prior wound measurements and photos):

Prior Records Reviewed (wound clinic notes, surgical notes, home health notes, therapy notes, infectious disease notes, medication history, immunization records, prior imaging and lab reports):

A ASSESSMENT

10 BURN & TRAUMA WOUND CLINICAL INTERPRETATION

Primary burn or trauma wound diagnosis or working diagnosis. Wound type, location, severity, depth, and healing status. Wound progression compared with prior visit. Presence or absence of infection, ischemia, necrosis, eschar, foreign body, exposed structure, graft or flap compromise, or functional limitation. Burn-specific risk including depth progression, contracture risk, scarring, circumferential involvement, inhalation injury concern, electrical injury concern, or need for burn center referral. Trauma-specific risk including contamination, retained foreign body, tendon / joint / bone involvement, crush injury, open fracture concern, or delayed healing. Healing barriers including diabetes, vascular disease, smoking, malnutrition, edema, immunosuppression, infection, repeated trauma, or adherence issues. Need for debridement, antibiotics, imaging, culture, surgical evaluation, therapy, splinting, grafting, compression, scar management, or higher level of care...

P PLAN

11 BURN & TRAUMA WOUND MANAGEMENT BY PROBLEM

Wound cleansing and dressing plan (dressing type, topical agents, frequency, who will perform dressing changes). Debridement or wound procedure plan. Burn care plan (topical antimicrobial or burn dressing, blister and eschar management, edema control, pain control, range-of-motion preservation, scar prevention, burn center referral). Trauma wound care plan (irrigation, foreign body evaluation, closure status, suture or staple management, immobilization, splinting, evaluation for deeper structure involvement). Infection management plan. Pain management plan. Functional and rehabilitation plan (range-of-motion exercises, splinting, hand therapy, physical therapy, occupational therapy, mobility support, contracture prevention, return-to-work guidance). Scar and contracture prevention plan (moisturization, massage, compression garments, silicone therapy, sun protection, splinting). Tetanus and immunization plan. Nutrition and healing plan. Home care and supply plan. Referral and coordination 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, suture or staple removal, burn depth reassessment, graft or flap monitoring, scar and contracture assessment, therapy progress, surgical referral follow-through):

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 / BURN OR TRAUMA WOUND TREATMENT

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

BURN TREATMENT CODE(S), IF APPLICABLE

DEBRIDEMENT CODE(S), IF APPLICABLE

WOUND REPAIR / SUTURE REMOVAL 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

SPLINT / DRESSING / COMPRESSION 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: BURN & TRAUMA WOUND CARE / WOUND CARE / SURGERY

DATE

TIME