

WOUND CHECK / SUTURE REMOVAL

1. Age	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Reason for visit <input type="checkbox"/> Wound check <input type="checkbox"/> Suture removal <input type="checkbox"/> Other:	4. Provider instructed patient to return in ____ days
5. Mechanism of injury		6. Date of injury	7. Provider who initially saw the patient
8. Problems the patient is experiencing			
a. Signs of infection <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Pus <input type="checkbox"/> Yes <input type="checkbox"/> No	d. Redness <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Pain at the site <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," rate: 1 2 3 4 5 6 7 8 9 10			
f. Other Problems <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain:			
9. Physical examination			
a. Sutures? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many? _____		b. Staples? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many? _____	c. Steri-strips? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Dermabond? <input type="checkbox"/> Yes <input type="checkbox"/> No			
e. Signs of infection <input type="checkbox"/> Yes <input type="checkbox"/> No	f. Skin well healed <input type="checkbox"/> Yes <input type="checkbox"/> No	g. Pus <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Erythema <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
i. Swelling <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
10. Assessment/Plan <i>(Initial those that were completed.)</i>			
a. _____ Sutures removed		e. _____ Patient instructed to return to the _____ clinic	
b. _____ Steri-strips placed		in ____ days.	
c. _____ Bandage applied		f. _____ Precautions were given to watch for signs of infection.	
d. _____ Topical antibiotic applied. Type:		g. _____ Handout given to patient.	
11. Other comments:			
11a. Forwarded to provider for review and comments <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Provider's orders: <i>(If item 11a is "Yes".)</i>			
PROVIDER <i>(Signature & Title -- only if item 11a is "Yes".)</i>		DEPARTMENT/SERVICE/CLINIC	DATE
NURSE <i>(Signature & Title)</i>		DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*