

**MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA**

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE <b style="text-align: center;">WOUND CARE</b>	OTSG APPROVED (Date)
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1. Temperature	2. Wound pain No pain > 0 1 2 3 4 5 6 7 8 9 10 < Worst imaginable	3. Edema (If "Yes," describe.) <input type="checkbox"/> Yes <input type="checkbox"/> No
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4. Wound information					
Location <i>a</i>	Size <i>b</i>	Wound base <i>c</i>	Peri wound tissue <i>d</i>	Exudate <i>e</i>	
Location:	Width _____ cm Length _____ cm Depth _____ cm Sinus tract: <input type="checkbox"/> Yes <input type="checkbox"/> No Location:	<input type="checkbox"/> Graduation ____ % <input type="checkbox"/> Eschar ____ % <input type="checkbox"/> Slough ____ % <input type="checkbox"/> Not visible ____ %  Color: <input type="checkbox"/> N/A <input type="checkbox"/> Red <input type="checkbox"/> Yellow <input type="checkbox"/> Pink <input type="checkbox"/> Black <input type="checkbox"/> White	<input type="checkbox"/> Intact <input type="checkbox"/> Macerated <input type="checkbox"/> Edematous <input type="checkbox"/> Erythema <input type="checkbox"/> Warm <input type="checkbox"/> Denuded  Comments:	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Scant <input type="checkbox"/> Large <input type="checkbox"/> Small <input type="checkbox"/> Copious	Color: <input type="checkbox"/> N/A <input type="checkbox"/> Sero-Sanguinous <input type="checkbox"/> Purulent <input type="checkbox"/> Serous <input type="checkbox"/> Bloody Odor: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
If burn: <input type="checkbox"/> 1st degree <input type="checkbox"/> 2d degree	Undermining: <input type="checkbox"/> Yes <input type="checkbox"/> No Location:		Comments:	Comments:	

5. Functional limitations - Client:  No limitations/willing  Unwilling  Unable due to:

6. Functional limitations - Caregiver:  N/A  Unwilling  Unable due to:

7. Dressing change, if required:

8. Nursing interventions  
 Wound status as above  Signs and/or symptoms of infection as above  Wound care done  Wound teaching instructions given  
 Handout given to patient (specify):

9. Client outcome  
 No change in wound  Wound is improving  Wound is deteriorating  No signs or symptoms of infection present  
 Signs and/or symptoms of infection are:  Local  Systemic

10. Plan  
 No change in wound care  Call MD  New MD orders  If new infection develops, call primary care provider (see information below)  
 [ Provider's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ ]

11. Nurse's recommendation:  
 No further need to see patient concerning the treatment of this wound.  
 Patient is instructed to return to the \_\_\_\_\_ clinic within \_\_\_\_\_ (time frame).

12. Care coordination:  Nurse  MD

13. Endurance:  Satisfactory  Poor

14. Other comments:

15. Doctor's orders:

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)	<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT
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