**Wound Record**  
**Weekly Wound Assessment**  
(Use a separate sheet for each wound site)

### Patient Information:
- **Name**: ____________________________  
- **Risk Factors**
  - Incontinence/moisture  
  - Altered nutritional status  
  - Altered sensory perception  
  - Activity limitation  
  - Impaired Mobility bed/chair  
  - Other (describe)_____________________
- **Room #**: _________________________

### Site:

<table>
<thead>
<tr>
<th>Date Acquired</th>
<th>Date (Pressure only)</th>
<th>Stage</th>
<th>Size (cm) LxWxD</th>
<th>Tissue Appearance</th>
<th>Wound Appearance</th>
<th>Wound Edge Appearance</th>
<th>Drainage (Type/amt/color)</th>
<th>Wound pain (Y/N)</th>
<th>Response to Treatment</th>
<th>Nurse's Signature</th>
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**Site Key**
- **Head**
  - Lower Ext
  - Lateral Ankle
- **Trunk**
  - Medical Ankle
  - Heel
  - Other (specific)
- **Sacrum**
  - Other (specific)
- **Trochanter**
- **Ischial Tuberosity**

**Tissue Appearance**
- Granulation
- Epithelialization
- Necrotic
- Slough/Eschar
- Other (describe)

**Wound Appearance**
- S- Sinus tract
- T - Tunneling
- U - Undermining

**Wound Edge Erythema**
- E-Erythema
- I - Induration
- M-Maceration
- Other (describe)

**Drainage Key**
- S-Serous
- SS-Serosanguinous
- P-Purulent
- Amt-Sm.Med.Lg.
- Color (describe)
- Odor- (describe)

**Suspected Deep Tissue Injury**: Intact skin with non-blanchable redness of a localized area. Darkly pigmented skin may not have visible blanching.

**Stage 1**: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

**Stage 2**: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

**Stage 3**: A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.

**Stage 4**: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

**Unstageable**: Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.