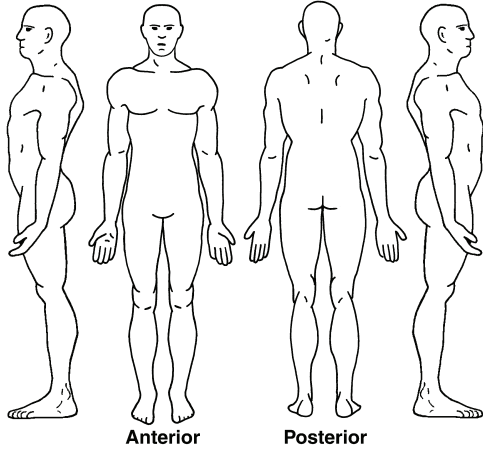


NON-PRESSURE SKIN CONDITION REPORT

DIRECTIONS: Fill in the appropriate boxes and spaces. Complete one form for each skin condition.

IDENTIFY SITE ON DIAGRAM BELOW



DATE FIRST OBSERVED: _____

SITE/LOCATION: (Identify on body forms) _____

CONDITION IS:

- Surgical Non-surgical Skin tear Abrasion Bruise Burn
- Venous/Stasis ulcer Arterial ulcer Diabetic ulcer Laceration
- Moisture-Associated Skin Damage (MASD)
- Other: _____



DATE	EXUDATE TYPE
	<input type="radio"/> None <input type="radio"/> Serous <input type="radio"/> Serosanguineous <input type="radio"/> Purulent

SIZE IN CM (Length x Width)	EXUDATE AMOUNT
	<input type="radio"/> None <input type="radio"/> Light <input type="radio"/> Moderate <input type="radio"/> Heavy

DEPTH (cm)	ODOR
	<input type="radio"/> None <input type="radio"/> Slight <input type="radio"/> Foul

NOTES:

Date Physician Notified: _____ Date Family Notified: _____

Date Dietary Notified: _____ Plan of Care Updated: Yes No

Signature/Title: _____

	Tunneling _____ (cm)
	Undermining _____ (cm)

TISSUE TYPE
<input type="radio"/> Epithelial <input type="radio"/> Granulation <input type="radio"/> Slough <input type="radio"/> Necrotic (Eschar)

SURROUNDING SKIN COLOR
<input type="radio"/> Normal <input type="radio"/> Pink <input type="radio"/> Bright red <input type="radio"/> White/Gray pallor <input type="radio"/> Dark red/Purple <input type="radio"/> Black/Brown

SURROUNDING TISSUE/WOUND EDGES
<input type="radio"/> Normal <input type="radio"/> Peripheral tissue edema <input type="radio"/> Maceration <input type="radio"/> Hardness/Induration <input type="radio"/> Rolled edges

CULTURE SENT
<input type="radio"/> Yes - Date: _____ Results: _____ <input type="radio"/> No

PROGRESS
<input type="radio"/> Improved <input type="radio"/> No Change <input type="radio"/> Worsened <input type="radio"/> Healed

TREATMENT
<input type="radio"/> Continue current treatment <input type="radio"/> Treatment changed

PAIN
Is resident experiencing pain related to wound? <input type="radio"/> Yes - See Pain Flow Sheet <input type="radio"/> No

DATE	EXUDATE TYPE
	<input type="radio"/> None <input type="radio"/> Serous <input type="radio"/> Serosanguineous <input type="radio"/> Purulent

SIZE IN CM (Length x Width)	EXUDATE AMOUNT
	<input type="radio"/> None <input type="radio"/> Light <input type="radio"/> Moderate <input type="radio"/> Heavy

DEPTH (cm)	ODOR
	<input type="radio"/> None <input type="radio"/> Slight <input type="radio"/> Foul

NOTES:

Date Physician Notified: _____ Date Family Notified: _____

Date Dietary Notified: _____ Plan of Care Updated: Yes No

Signature/Title: _____

	Tunneling _____ (cm)
	Undermining _____ (cm)

TISSUE TYPE
<input type="radio"/> Epithelial <input type="radio"/> Granulation <input type="radio"/> Slough <input type="radio"/> Necrotic (Eschar)

SURROUNDING SKIN COLOR
<input type="radio"/> Normal <input type="radio"/> Pink <input type="radio"/> Bright red <input type="radio"/> White/Gray pallor <input type="radio"/> Dark red/Purple <input type="radio"/> Black/Brown

SURROUNDING TISSUE/WOUND EDGES
<input type="radio"/> Normal <input type="radio"/> Peripheral tissue edema <input type="radio"/> Maceration <input type="radio"/> Hardness/Induration <input type="radio"/> Rolled edges

CULTURE SENT
<input type="radio"/> Yes - Date: _____ Results: _____ <input type="radio"/> No


PROGRESS
<input type="radio"/> Improved <input type="radio"/> No Change <input type="radio"/> Worsened <input type="radio"/> Healed


TREATMENT
<input type="radio"/> Continue current treatment <input type="radio"/> Treatment changed


PAIN
Is resident experiencing pain related to wound? <input type="radio"/> Yes - See Pain Flow Sheet <input type="radio"/> No

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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NON-PRESSURE SKIN CONDITION REPORT (Cont'd.)

DATE	EXUDATE TYPE <input type="radio"/> None <input type="radio"/> Serous <input type="radio"/> Serosanguineous <input type="radio"/> Purulent		Tunneling _____ (cm) Undermining _____ (cm)
SIZE IN CM (Length x Width)	EXUDATE AMOUNT <input type="radio"/> None <input type="radio"/> Light <input type="radio"/> Moderate <input type="radio"/> Heavy	TISSUE TYPE <input type="radio"/> Epithelial <input type="radio"/> Granulation <input type="radio"/> Slough <input type="radio"/> Necrotic (Eschar)	
DEPTH (cm)	ODOR <input type="radio"/> None <input type="radio"/> Slight <input type="radio"/> Foul	SURROUNDING SKIN COLOR <input type="radio"/> Normal <input type="radio"/> Pink <input type="radio"/> Bright red <input type="radio"/> White/Gray pallor <input type="radio"/> Dark red/Purple <input type="radio"/> Black/Brown	
NOTES: _____ _____ _____ _____ _____	SURROUNDING TISSUE/WOUND EDGES <input type="radio"/> Normal <input type="radio"/> Peripheral tissue edema <input type="radio"/> Maceration <input type="radio"/> Hardness/Induration <input type="radio"/> Rolled edges		
	CULTURE SENT <input type="radio"/> Yes - Date: _____ Results: _____ <input type="radio"/> No		
	PROGRESS <input type="radio"/> Improved <input type="radio"/> No Change <input type="radio"/> Worsened <input type="radio"/> Healed		
	TREATMENT <input type="radio"/> Continue current treatment <input type="radio"/> Treatment changed		
	PAIN Is resident experiencing pain related to wound? <input type="radio"/> Yes - See Pain Flow Sheet <input type="radio"/> No		
Date Physician Notified: _____	Date Family Notified: _____		
Date Dietary Notified: _____	Plan of Care Updated: <input type="radio"/> Yes <input type="radio"/> No		
Signature/Title: _____			

DATE	EXUDATE TYPE <input type="radio"/> None <input type="radio"/> Serous <input type="radio"/> Serosanguineous <input type="radio"/> Purulent		Tunneling _____ (cm) Undermining _____ (cm)
SIZE IN CM (Length x Width)	EXUDATE AMOUNT <input type="radio"/> None <input type="radio"/> Light <input type="radio"/> Moderate <input type="radio"/> Heavy	TISSUE TYPE <input type="radio"/> Epithelial <input type="radio"/> Granulation <input type="radio"/> Slough <input type="radio"/> Necrotic (Eschar)	
DEPTH (cm)	ODOR <input type="radio"/> None <input type="radio"/> Slight <input type="radio"/> Foul	SURROUNDING SKIN COLOR <input type="radio"/> Normal <input type="radio"/> Pink <input type="radio"/> Bright red <input type="radio"/> White/Gray pallor <input type="radio"/> Dark red/Purple <input type="radio"/> Black/Brown	
NOTES: _____ _____ _____ _____ _____	SURROUNDING TISSUE/WOUND EDGES <input type="radio"/> Normal <input type="radio"/> Peripheral tissue edema <input type="radio"/> Maceration <input type="radio"/> Hardness/Induration <input type="radio"/> Rolled edges		
	CULTURE SENT <input type="radio"/> Yes - Date: _____ Results: _____ <input type="radio"/> No		
	PROGRESS <input type="radio"/> Improved <input type="radio"/> No Change <input type="radio"/> Worsened <input type="radio"/> Healed		
	TREATMENT <input type="radio"/> Continue current treatment <input type="radio"/> Treatment changed		
	PAIN Is resident experiencing pain related to wound? <input type="radio"/> Yes - See Pain Flow Sheet <input type="radio"/> No		
Date Physician Notified: _____	Date Family Notified: _____		
Date Dietary Notified: _____	Plan of Care Updated: <input type="radio"/> Yes <input type="radio"/> No		
Signature/Title: _____			

DATE	EXUDATE TYPE <input type="radio"/> None <input type="radio"/> Serous <input type="radio"/> Serosanguineous <input type="radio"/> Purulent		Tunneling _____ (cm) Undermining _____ (cm)
SIZE IN CM (Length x Width)	EXUDATE AMOUNT <input type="radio"/> None <input type="radio"/> Light <input type="radio"/> Moderate <input type="radio"/> Heavy	TISSUE TYPE <input type="radio"/> Epithelial <input type="radio"/> Granulation <input type="radio"/> Slough <input type="radio"/> Necrotic (Eschar)	
DEPTH (cm)	ODOR <input type="radio"/> None <input type="radio"/> Slight <input type="radio"/> Foul	SURROUNDING SKIN COLOR <input type="radio"/> Normal <input type="radio"/> Pink <input type="radio"/> Bright red <input type="radio"/> White/Gray pallor <input type="radio"/> Dark red/Purple <input type="radio"/> Black/Brown	
NOTES: _____ _____ _____ _____ _____	SURROUNDING TISSUE/WOUND EDGES <input type="radio"/> Normal <input type="radio"/> Peripheral tissue edema <input type="radio"/> Maceration <input type="radio"/> Hardness/Induration <input type="radio"/> Rolled edges		
	CULTURE SENT <input type="radio"/> Yes - Date: _____ Results: _____ <input type="radio"/> No		
	PROGRESS <input type="radio"/> Improved <input type="radio"/> No Change <input type="radio"/> Worsened <input type="radio"/> Healed		
	TREATMENT <input type="radio"/> Continue current treatment <input type="radio"/> Treatment changed		
	PAIN Is resident experiencing pain related to wound? <input type="radio"/> Yes - See Pain Flow Sheet <input type="radio"/> No		
Date Physician Notified: _____	Date Family Notified: _____		
Date Dietary Notified: _____	Plan of Care Updated: <input type="radio"/> Yes <input type="radio"/> No		
Signature/Title: _____			

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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