ASSESSMENT TOOL TO IDENTIFY PATIENT AT RISK OF PRESSURE ULCER

Ward : _____

Date of transfer in : _____

Date/time of assessment : _____

ASSESSMENT DONE BY (WRITE FULL NAME): _____

A. Pressure Area Scores

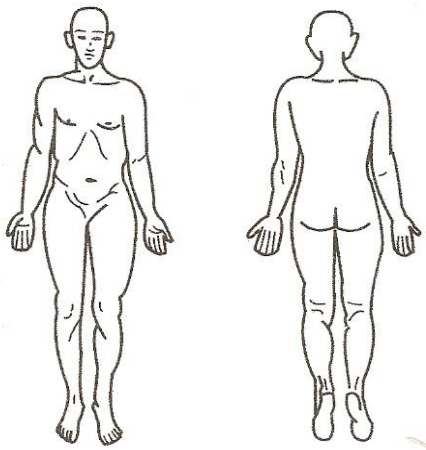
CRITERIA	SCORES				
	1	2	3	4	Score/Criter
AGE	< 50 yr	50 - 59 yr	60 - 69 yr	> 70 yr	
MOBILITY	Fully mobile	Mobile with help	Severely restricted	Bed/chair bound	
MENTAL CONDITION	Alert	Apatheic/depressed	Confused/Uncooperative	Paralysed/Comatose	
WEIGHT	Normal	Obese	Emanciated	Recent/rapid weight loss	
NUTRITION	Normal	Poor Appetite/small intake	Fluids only/restricted	Artificial feeding	
CONTINENCE	Continent	Sometimes	Usually	Double incontinence	
				TOTAL SCORE	

B. Staging of Pressure Ulcer

	ULCER STAGING	
Stage 0		Intact skin with no erythema or redness
Stage 1		Erythema does not disappear within half an hour after applied pressure is relieved.
Stage 2		Skin blister or superficial skin break at epidermis or dermis level.
Stage 3		Full thickness involving loss of subcutaneous tissue
Stage 4		Extending through muscles or bone

C. Numerical Location (Pl. Tick)

Sacral	Scapula	Iliac crest	Heel	Others
1	2	3	4	5



* ear, occiput, malleolus, elbow etc.

Date/Time	Ulcer Assessment						Remarks	Staff Name
	Size	Location	Ulcer Status					
			Clean	Slough	Pus	Necrotic		