ASSESSMENT FORMAT FOR PRESSURE SORE

Name of Patient _____ Age _____ Sex _____
Date _____Time _____ Number of pressure ulcers _____Diagnosis_____

A	**Anatomic Location Of Wound**	**Specific Location**	
	1. Sacrum	R	L
	2. Heel R L	R	L
	3. Trochanter R L	R	L
	4. Lateral malleolus R L	R	L
	5. Ishcium R L	R	L
	6. Elbow R L	R	L
	AGE OF WOUND _____ days or _____ months client has had the pressure ulcer		
S	**S. SIZE** _____ cm length _____ cm width _____ cm depth		
	SHAPE (Check one)	YES	NO
	1. Oval		
	2. Round		
	3. Other		
	STAGE Check One)	YES	NO
	1. Stage I		
	2. Stage II		
	3. Stage III		
	4. Stage IV		
	5. Unable to determine stage; ulcer is necrotic		

S	**SINUS TRACT, TUNNELING, UNDERMINING**		
	1. Sinus tract, tunneling (narrow tracts under the skin at _____o'clock		
	2. Undermining (bigger area [than tunneling] of tissue destruction area is more like a cave than a tract		
E	**E. EXUDATE**		
	Color	YES	NO
	a. Serous		
	b. Serosanguineous		
	c. Sanguineous		
	Amount	YES	NO
	a. Scant		
	b. Moderate		
	c. Large		
	Consistency	YES	NO
	a. Clear		
	b. Purulent		
S.	**SEPSIS**	YES	NO
	a. Local infection		
	b. Systemic		
	c. None		
S.	**SURROUNDING SKIN**	YES	NO
	a. Dark		
	b. Discolored		
	c. Erythematous		
	d. Intact		
	e. Swollen		
	f. Other/s_____ _____ _____		

M.	**MARGINS**	YES	NO
	a. Attached (edges are connected to the sides of the wound)		
	b. Not attached (edges are not connected to the sides of the wound)		
	c. Rolled (edges appear rounded or rolled over)		
	MACERATION	YES	NO
	a. Present		
	b. Not Present		
E.	**ERYTHEMA**	YES	NO
	a. Present		
	b. Not Present		
	EPITHELIAZATION	YES	NO
	a. Present		
	b. Not Present		
	ESCHAR (necrotic tissue)	YES	NO
	a. Yellow slough		
	b. Black		
	c. Soft		
	d. Hard		
	e. Stringy		
	Area around eschar is:	YES	NO
	a. Dry		
	b. Moist		
	c. Reddened		
N.	**NECROTIC TISSUE**	YES	NO
	a. Present		
	b. Not Present		
	NOSE	YES	NO
	a. Odor present		
	b. Odor not present		

	NEOVASCULARIZATION (blood vessels are visible)	YES	NO
	a. Present		
	b. Not present		
T.	**TISSUE BED**	YES	NO
	a. Granulation tissue present		
	b. Not present		
	TENDERNESS TO TOUCH	YES	NO
	a. No pain		
	b. Pain present:		
	o On touch		
	o Anytime		
	o Only when performing ulcer care		
	Patient getting pain medication		
	a. Yes		
	b. No		
	TENSION	YES	NO
	a. Tautness, hardness present		
	b. Not present		
	TEMPERATURE	YES	NO
	a. Skin warm to touch		
	b. Skin cool to touch		
	c. Normal		

_____

Signature of Assessor ***(MD/ROD/RN)***

Date: