# Wound Assessment and Evaluation Form

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>D.O.B</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td>Date of Initial Assessment</td>
</tr>
<tr>
<td>Name of Assessor</td>
<td>Team</td>
</tr>
</tbody>
</table>

Mark location with an X and number each wound

## Body Diagram

### Front

### Back

## Feet Diagram

### Right

### Left

## Type of Wounds

<table>
<thead>
<tr>
<th>Traumatic Wound</th>
<th>Foot Ulcer</th>
<th>Surgical Wound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn / Scald</td>
<td>Fungating Lesion</td>
<td>Lower Limb Wound – Consider Leg Ulcer Care Pathway</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>Consider completing Waterlow Assessment Tool</td>
<td>Other -</td>
</tr>
</tbody>
</table>

## How the wound developed:

Duration of wound:

Factors which could delay healing: *(Please circle relevant box)*

<table>
<thead>
<tr>
<th>Poor Nutrition Status</th>
<th>Y N</th>
<th>Diabetes</th>
<th>Y N</th>
<th>Anaemia</th>
<th>Y N</th>
<th>Low Serum Albumin</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Y N</td>
<td>Immobility</td>
<td>Y N</td>
<td>Smoking</td>
<td>Y N</td>
<td>Incontinence</td>
<td>Y N</td>
</tr>
<tr>
<td>Circulatory Disease</td>
<td>Y N</td>
<td>Allergies</td>
<td>Y N</td>
<td>Oedema</td>
<td>Y N</td>
<td>Chemotherapy</td>
<td>Y N</td>
</tr>
</tbody>
</table>

Significant Medical History

Significant Medication / Allergies
Using the Wound Exudate Continuum

<table>
<thead>
<tr>
<th>Volume</th>
<th>Viscosity</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>5</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
</tr>
<tr>
<td>Low</td>
<td>1</td>
</tr>
</tbody>
</table>

When reviewing the wound, the exudate on the dressing and present in the wound should be assessed. Any wound assessed as having both high viscosity and high volume of wound exudate would score a full 10 points and be regarded as giving serious concern. It is likely that there may be spreading infection. Any wound scoring 6 points would be regarded as requiring regular review. It may be that this finding is entirely consistent with the treatment applied e.g. the liquefying of wound slough. The wound may previously have scored higher and as such a score of 6 would indicate an improvement. Where a wound previously scored as 2-4 points and then increases to 6 points may be showing early signs of Critical Colonisation or the development of outright infection and should be treated appropriately.

Using the Wound Infection Continuum

The Wound Infection Continuum is a simple sliding scale which can be used as an aid to clinical decision-making regarding the level of bacterial colonisation of a wound.

The four key levels are:

**Colonisation**
The normal state for a wound healing by secondary intention. A reduction in the wound size over a two week period would suggest an acceptable level of colonisation.

**Critical Colonisation**
Characterised by delayed healing, with the possible presence of malodour and increased exudate production. However, the wound does not present as if locally infected.

**Local Infection**
Presents with similar symptoms to spreading infection but is localised to the wound and shows no signs of spreading.

**Spreading Infection**
Characterised by Spreading redness > 2cm from wound margins, High exudate levels, pain, malodour, heat.

This is the most severe and can be life-threatening.

**Pain analogue scale**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1 – 2</th>
<th>3 – 4</th>
<th>5 – 6</th>
<th>7 – 8</th>
<th>9 – 10</th>
<th>Constant</th>
<th>Intermittent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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At dressing change D/C

Please record the highest score on assessment template

If the pain score is above 4 consider undertaking a more comprehensive assessment using
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**Pain / Analgesia**
- Pain Score: D / N / DC
- Analgesia prescribed?

**Tissue type on wound bed**
- Necrotic Black
- Slough Yellow
- Granulation Red
- Epithelialisation
- Other

**Wound Dimensions** — Always calculate wound size - Width = West to East / Length = North to South
- Widest Width
- Longest Length
- Deepest Depth
- Undermining / Sinus

**Wound progressing?**
- Y / N / Static

**Photograph / Traced**
- P / T

**Consent obtained?**

**Wound exudate level / type**
- Continuum score
- Serous
- Haemoserous
- Purulent

**Peri – wound skin**
- Macerated
- Dry
- Oedematous
- Erythema
- Excoriated
- Healthy
- Eczema Wet/Dry

**Signs of infection**
- Increased size
- Increased pain
- Increased exudate
- Increased odour
- Cellulitis
- Friable Bleeding

**Treatment**
- Irrigation / Other
- Topical application
- Primary dressing
- Secondary dressing
- Frequency

**Signature**

**Progress / Comments** – Please date and sign