**WOUND CARE MEASUREMENT AND ASSESSMENT**

**PAIN**

Is patient experiencing pain related to wound? □ Yes □ No □ Unable to communicate

Non-verbals demonstrated: □ Diaphoresis □ Grimacing □ Moaning/Crying □ Guarding □ Irritability □ Anger □ Tense □ Restlessness □ Change in vital signs □ Other:

Pain Location (site(s) specify):

Nature of pain (specify):

Frequency: □ Episodic □ Continuous Date healed: __________ / ______ / ______

Intensity: (using scales below)

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Hurt</td>
</tr>
<tr>
<td>2</td>
<td>Hurts Little Bit</td>
</tr>
<tr>
<td>4</td>
<td>Hurts Little More</td>
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<tr>
<td>6</td>
<td>Hurts Even More</td>
</tr>
<tr>
<td>8</td>
<td>Hurts Whole Lot</td>
</tr>
<tr>
<td>10</td>
<td>Hurts Worst</td>
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</tbody>
</table>


0-10 Numeric Pain Intensity Scale

Present level of pain _______ Worst pain gets _______ Best pain gets _______ Acceptable level of pain _______

**LOCATION (ANATOMICAL SITE):______

WOUND TYPE (“✓” below):

□ Pressure Ulcer: Stage

□ Arterial □ Venous □ Diabetic □ Surgical □ Other:

Size (cm) (LxW):______ Depth (cm):______

Tunneling (cm):______

Undermining (cm):______

Date first observed:______ Granulation %:______

EXUDATE:

□ Odor: □ None □ Slight □ Moderate □ Foul

□ Type: □ None □ Bloody □ Serosanguineous □ Purulent/Foul

□ Amt: □ None □ Scant □ Small □ Moderate □ Large □ Copious

SURROUNDING SKIN COLOR:

□ Normal for skin □ Epithelial tissue □ Granulation tissue □ Slough □ Black/brown (eschar)

WOUND EDGES/SURROUNDING TISSUE:

□ Normal for skin □ Peripheral tissue edema □ Maceration □ Hardness/induration □ Rolled edges

Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones it may appear with persistent blue or purple hue.

Stage 2: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Unstageable – Non-removable dressing: Known but not stageable due to non-removable dressing/device.

Unstageable – Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar.

Unstageable – Deep tissue: Suspected deep tissue injury in evolution.

**CLINICIAN SIGNATURE:____________________________ DATE:_________________________**
### PAIN

Is patient experiencing pain related to wound?  
- Yes  
- No  
- Unable to communicate  

Non-verbals demonstrated:  
- Diaphoresis  
- Grimacing  
- Moaning/Crying  
- Guarding  
- Irritability  
- Anger  
- Tense  
- Restlessness  
- Change in vital signs  

**Pain Location**:  
- Site(s) specify: ____________________________________________________________  

**Nature of pain (specify)**: ____________________________________________________  

**Frequency**:  
- Episodic  
- Continuous  

**Intensity**: (using scales below)  

<table>
<thead>
<tr>
<th>Intensity</th>
<th>No Hurt</th>
<th>Hurts Little Bit</th>
<th>Hurts Little More</th>
<th>Hurts Even More</th>
<th>Hurts Whole Lot</th>
<th>Hurts Worst</th>
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**0-10 Numeric Pain Intensity Scale**  

<table>
<thead>
<tr>
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<th>Moderate Pain</th>
<th>Worst Possible Pain</th>
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</table>

Present level of pain_____  
Worst pain gets_____  
Best pain gets_____  
Acceptable level of pain_____

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### WOUND CARE MEASUREMENT AND ASSESSMENT

**LOCATION (ANATOMICAL SITE):** ____________________________________________________________  

**WOUND TYPE (“✓” below):**  
- Pressure Ulcer: Stage__________________________  
- Arterial  
- Venous  
- Diabetic  
- Surgical  
- Other:  

**Size (cm) (LxW):** ____________________________________________________________  
- Depth (cm):  
- Tunnelling (cm):  
- Undermining (cm):  

**Date first observed:** ____________________  
Granulation %:__________________________  

**EXUDATE:**  
- Odor:  
  - None  
  - Slight  
  - Moderate  
  - Foul  
- Type:  
  - None  
  - Bloody  
  - Serosanguineous  
  - Purulent/Foul  
- Amt:  
  - None  
  - Scant  
  - Small  
  - Moderate  
  - Large  
  - Copious

**WOUND BED:**  
- Normal for skin  
- Epithelial tissue  
- Granulation tissue  
- Slough  
- Black/brown (eschar)  

**SURROUNDING SKIN COLOR:**  
- Normal for skin  
- Pink  
- Bright red  
- White/gray pallor  
- Dark red/purple  
- Black/brown  

**WOUND EDGES/SURROUNDING TISSUE:**  
- Normal for skin  
- Peripheral tissue edema  
- Maceration  
- Hardness/induration  
- Rolled edges

**Stage 1:**  
- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hue.

**Stage 2:**  
- Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

**Stage 3:**  
- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

**Stage 4:**  
- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

**Unstageable – Non-removable dressing:** Known but not stageable due to non-removable dressing/device.

**Unstageable – Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar.

**Unstageable – Deep tissue:** Suspected deep tissue injury in evolution.

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**CLINICIAN SIGNATURE:** ____________________  
**DATE:** ____________________

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**WOUND CARE MEASUREMENT AND ASSESSMENT**

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**NAME–Last First Middle Attending Physician Room/Bed**

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