Pamela E. Houghton, PT, PhD

Pressure Ulcer Assessment Form

Date: _____

Name: _____ Date of Birth: _____ Age: _____

MEDICAL HISTORY

Current Conditions:

1. _____
2. _____
3. _____
4. _____

□ CHF □ Heart Arrhythmia □ Hypertension □ Heart Attack □ Stroke

□ Lung Disease □ Renal disease □Gastrointestinal disease

□ Obesity □ ↑ Thyroid □ Diabetes: ___# yrs; insulin:___ Oral Glucose: _____

Recent Serious Illnesses/Hosp/Surgeries:

_____ Date_____

_____ Date_____

_____ Date_____

Medications attached list? □

Recent Changes : _____

□ Steroid _____ □ NSAIDS_____

□ Immunosuppress _____ □ Antibiotics _____

Other _____ _____

Neurological Disease: _____ Date of Onset:_____ Level:_____

Motor Loss: _____

Spasticity: _____

Sensory Loss:_____

Consciousness/Cognition: _____

Continence: Yes/No Problems: _____

Bowel Manage: _____

Bladder Program: _____

Mobility:

bed mobility:_____ dependence: _____

transfers: type_____ _____ dependence: _____

Nutrition: Body Wt: _____ lbs; _____ Ht. Recent Weight Loss: _____

Special Diet: _____ Protein: _____ Vitamins: _____

Name: _____ Date: _____

Pain:

Location: _____ Type: _____ VAS: ____ ↑ increase _____ ↓ decrease _____
_____ ↑ increase _____ ↓ decrease _____

Location: _____ Type: _____ VAS: ____ ↑ increase _____ ↓ decrease _____
_____ ↑ increase _____ ↓ decrease _____

Current Management: _____
_____

PSYCHOSOCIAL ISSUES

Smoking: ____presently _____past quit: _____ # pack yrs._____

Support/Help:_____

Finances:_____ Insurance?_____

Stress:_____

Sleep Disturb:_____ Night Pain: ____ Nocturia:____

Quality of Life: Delighted – Terrible (0-10): _____

Have you had to change your lifestyle as a result of this ulcer: _____

_____

_____

Do you feel that you no longer able to do the things you would like to do: _____

_____

_____

Motivation/Adherence: _____

_____

Cardiff Wound Impact: _____

PRESSURE RELIEF:

EQUIPMENT

Bed: _____ How old_____ Supplier:_____

Chair: manual/electric: _____ How old? _____ Supplier: _____

Cushion: _____ How old? _____ Supplier: _____

Other surfaces: _____ How old? _____ Supplier: _____

Other surfaces: _____ How old? _____ Supplier: _____

Comments: _____

_____

Name: _____ Date: _____

Pressure Relieving Strategies:

Describe what patient/caregivers are currently doing: _____

_____

Transfer Ax**:** _____

_____

What is working/not working: _____

_____

_____

Patient Activity

Occupation: _____

Hobbies:_____ _____

Daily Activities : _____

Exercise: _____

□ Complete a 1-3 day diary to determine positions and activities over 24 hour period
Amt Standing: _____ hrs Siting _____ hrs Lying: _____ hrs ____ # Tsfs

Objective Assessment

Lab Tests

HbA1C: _____ Fasting Blood Glucose Albumin/Prealbumin: _____ TLC: _____

Hbg (Anemia): _____ Iron Profile: _____ TIBC: _____ HCt: _____

CRP: _____ ESR: _____ TSH: _____ BUN: _____

Other: _____ Other:_____

Other: _____ Other:_____

Sensation (Sharp/Dull): ◯ Normal Decreased (local): _____
Absent below (level): _____

Perfusion (if LE Wound):

Vitals: Pulse; _____ Blood Pressure: ____ / _____ Resp: _____

(L) ABI Dorsal Pedal: _____ / _____ = _____ ?Manual: Y / N □ Mono □ Biphasic □ Triphasic

(R) ABI Dorsal Pedal: _____ / _____ = _____ ?Manual: Y / N □ Mono □ Biphasic □ Triphasic

Name: _____ Date: _____

Wound History

History of Ulcers:_____

_____

Location: _____ Date of Onset: _____

Description of Onset (mechanism/cause):_____

Previous Treatments (eg. Estim, NPWT, Advanced wound care products, skin grafts)_____

Current Dressing Protocol:

Since: _____ (date last reviewed by wound care specialist)

Cleansing: _____

Packing: _____

Exudate management: _____

Cover: _____

Secure: _____

Skin Prep: _____

Moisturizer: _____

Frequency of Dressing Changes:_____

Changed by: _____

Directed by_____

Issues: _____

_____

Allergies: _____

Name: _____ Date: _____

ANALYSIS

Patient Goals

1. _____
2. _____
3. _____
4._____

Factors Contributing to Delaying Healing

□ **Friction/Shear:**	□ **FootWear:**	□ **glucose regulation**	□ **Edema**
□ **Unrelieved Pressure**	□ **Wound Moisture**	□ **Bioburden**	□ **Nutrition**
□ **Wound Oxygenation**	□ **Metabolism**	□ **Medications**	□ **Spasms**
□ **Cardiovascular Disease**	□ **PVD**	□ **Denervation**	□ **Immobility**

□ **Foot Biomechanics** Other: _____ Other: _____

Comments

Health Condition:_____
_____

Address underlying cause(s); _____
_____

Wound Environment (Dressing Protocol):_____
_____

Practical Issues: _____
_____

PLAN (Things to do)

1._____
2. _____
3. _____

DATE FOR RE-ASSESSMENT: _____

_____ _____
Signed Date