Wound Healing Center

HYPERBARIC PATIENT RISK SCREEN WORKSHEET

Patient ID_____

Do you have a history of:	Yes	No	Comments
Optic Neuritis			
Cataracts			
Recent eye surgery			
Ear problems			Describe:
Ear reconstructive surgery			
Sinus problems			Describe:
Seizure			
Asthma			
Bronchitis			
Emphysema			
Pneumothorax			Treated: [ ] Yes [ ] No
Tuberculosis			
Other lung problems			
Hypertension			
Congestive heart failure			Ejection fraction:
Pacemaker			Brand/Pressure rating:
Any implanted device			Brand/Pressure rating:
Dialysis			If yes, type and schedule:
Current pregnancy			
Claustrophobia			
Diabetes			Type and medication(s):
Currently using these medications:			
a. Disulfiram (Antabuse®)			Last date drug was taken:
b. Mafenide acetate (Sulfamylon®)			
Cancer:			
a. Surgery			Type and date:
b. Radiation therapy			If yes, dose received:
c. Chemotherapy			
If yes, did you receive:			
a. Doxorubicin (Adriamycin®)			Last date administered:
b. Cisplatin (Platinol AQ®)			Last date administered:
c. Bleomycin (Blenoxane®)			Last date administered:
Congenital spherocytosis			
Current nicotine use:			
a. Smoking			
b. E-cigarettes/Vaping			
c. Nicotine patch			

COMMENTS:_____

_____

_____

_____

_____

Interviewer Signature _____Date / Time: _____

Wound Healing Center

HYPERBARIC TREATMENT ORDERS

Patient ID:_____

HYPERBARIC TREATMENT ORDERS (check all that apply)

[ ] 1. Lung sounds are to be auscultated prior to every treatment by staff and PRN as indicated by signs or symptoms of respiratory compromise. Notify hyperbaric provider of abnormal lung sounds.

[ ] 2. Tympanic membranes are to be viewed prior to every treatment by staff and PRN as indicated by signs or symptoms of barotrauma. Notify hyperbaric provider of signs or symptoms of barotrauma.

[ ] 3. Vital signs pre and post each treatment.
   a. If systolic blood pressure is <100 mmHg, provide patient with fluids by mouth and reassess in 15 minutes. If still <100 mmHg, notify hyperbaric provider.
   b. If systolic blood pressure is >180 mmHg or diastolic blood pressure is >100 mmHg, notify hyperbaric provider for orders.
   c. If temperature is 100°F or greater, give 650 mg acetaminophen and notify hyperbaric provider for further orders.

[ ] 4. Finger stick blood glucose levels are to be obtained pre and post each treatment for patients with diabetes.
   a. If glucose is <100 mg/dL, hold treatment, provide patient with nutritional supplement, and recheck in 15 minutes. If still <100 mg/dL, notify hyperbaric provider.
   b. If glucose is >300 mg/dl on three consecutive days, hold treatment and notify hyperbaric provider for orders.

[ ] 5. If patient exhibits signs or symptoms of sinusitis, shortness of breath, difficulty breathing, nausea, vomiting, and/or diarrhea, hold treatment and notify hyperbaric provider.

[ ] 6. If patient exhibits signs or symptoms of anxiety or claustrophobia, notify hyperbaric provider for orders.

[ ] 7. Hyperbaric oxygen therapy orders (choose one from each section):
   a. [ ] Wound Treatment Profile One: [2.0 ATA] x [90 minutes] without air breaks
      [ ] Wound Treatment Profile Two: [2.0 ATA] x [90 minutes] with 5 min air breaks every 30 min
      [ ] Wound Treatment Profile Three: [2.5 ATA] x [90 minutes] with 5 min air breaks every 30 min
      [ ] Other: _____
   b. [ ] Once a day
      [ ] Twice a day
      [ ] Three times a day
   c. [ ] Emergent condition (no treatments should be missed – document any variance in notes.)
      [ ] Non-emergent condition (periodic treatments may be missed)
   d. _____ treatments then re-evaluate for continuation, change, or termination of therapy.

[ ] 8. During the course of hyperbaric oxygen therapy:
   [ ] Provide _____(decongestant nasal spray) 2 puffs in each nare as needed prior to treatment to aid in pressure equalization.
   [ ] Other: _____

[ ] 10. Daily - Discharge when discharge criteria met or cleared by hyperbaric provider.

Provider Signature:_____Date / Time:_____

Wound Healing Center

PROVIDER HYPERBARIC TREATMENT NOTE

Patient ID:

Date of Treatment:

Diagnosis/indication for hyperbaric oxygen therapy:

- ☐ Acute thermal burn
- ☐ Air/gas embolism
- ☐ Carbon monoxide poisoning
- ☐ Central retinal artery occlusion
- ☐ Clostridial myositis/myonecrosis
- ☐ Compromised graft/flap
- ☐ Crush injury/acute traumatic ischemia
- ☐ Decompression sickness
- ☐ Delayed radiation injury
- ☐ Diabetic ulcer of lower extremity
- ☐ Intracranial abscess
- ☐ Necrotizing soft tissue infection
- ☐ Osteomeyelitis (refractory)
- ☐ Severe anemia
- ☐ Sudden sensorineural hearing loss
- ☐ Other:

Location/symptoms:

Treatment number: _____ of _____ (under current treatment plan)
Treatment profile: _____ ATA; 100% oxygen for ☐ 90 minutes ☐ _____ minutes
Air breaks: ☐ none ☐ 5 minutes air breathing every 30 minutes ☐ other: _____
Decompression rate: ☐ standard ☐ over 15 minutes ☐ other: _____

Pre-procedure:

Vital signs: ☐ within limits of department policy ☐ other (see comments below)

Pulmonary status: ☐ clear bilaterally ☐ other (see comments below)

Ear status: ☐ clear bilaterally ☐ other (see comments below)

Patient cleared for hyperbaric oxygen therapy: ☐ yes ☐ no

Comments:

Post-procedure:

Patient tolerated treatment: ☐ well ☐ other (see comments below)

Vital signs: ☐ within limits of department policy ☐ other (see comments below)

Pulmonary status: ☐ N/A ☐ clear bilaterally ☐ other (see comments below)

Ear status: ☐ N/A ☐ clear bilaterally ☐ other (see comments below)

Hyperbaric treatment plan: ☐ no change ☐ stop treatments (see comments below) ☐ other (see comments below)

Comments:

☐ I certify that I supervised and was immediately available throughout this hyperbaric treatment.

☐ Wound/problem re-assessed today (see follow-up visit note).

Provider signature Date / Time

Wound Healing Center

HYPERBARIC TREATMENT RECORD

Patient ID _____ Date _____

Pre-treatment Medical Check

TIME	BP	Pulse	Resp	Temp	Glucose	Lungs clear to auscultation [ ] yes [ ] see comments
	Interventions: [ ] none [ ] see comments				Glucometer ID	TMs negative for barotrauma [ ] yes [ ] see comments

Comments:

Nurse Signature / Date / Time: _____

Pre-treatment Safety Check

NO	YES			NO	YES	
		Patient grounded				Eyes: Hard contact lenses absent
		Air break mask present and functioning				Ears: Hearing aids/earplugs absent
		Clothing issued by wound center				Mouth: Dentures/partials absent
		Pockets empty				Hair: Spray/oil/wigs absent
		Underwear/bra absent				Face: Cosmetics absent
		Socks/booties absent				Body: Vaseline/lotion/oils absent
		Matches/lighters/cigarettes/e-cigarette absent				Body: Jewelry absent
		Phone absent				Body: Heat patches absent
		Electronic devices absent				Body: Medication patches absent
		Warming devices absent				Body: Petroleum dressings absent
		Alcohol products absent				Bed: Prohibited items absent

If 'NO' is selected, this item must be cleared by the Hyperbaric Safety Director.

Comments:

Chamber Operator Signature / Date / Time: _____

Hyperbaric Treatment

Date of current physician order: _____ ☐ Verify patient consent is in the chart

Physician Treatment Order		**Chamber ID:** _____				
Tx Pressure (ATA)	Tx Length (min)	Start Time	Reached Press	1st Air Break Start	1st Air Break End	Total Time (min)
Air Breaks ☐ None ☐ 5min every 30min ☐ Other:_____		2nd Air Break Start	2nd Air Break End	Reduced Press	End Time	

Adverse Reactions: ☐ none - if any present, document intervention(s) in comments
☐ diff equalizing ear(s) ☐ diff equalizing sinus ☐ confinement anxiety ☐ seizure ☐ other (see comments)

Comments:

Chamber Operator Signature / Date / Time: _____

Post-treatment Medical Check

TIME	BP	Pulse	Resp	Temp	Glucose	Lungs clear to auscultation [ ] yes [ ] see comments
	Interventions: [ ] none [ ] see comments				Glucometer ID	TMs negative for barotrauma [ ] yes [ ] see comments

Comments:

Nurse Signature / Date / Time: _____

Wound Healing Center

DISCHARGE EYE INSTRUCTIONS

Now that you have finished your course of hyperbaric oxygen treatments, you may have some questions about your vision.

It is possible that during your course of hyperbaric treatments, especially if you received more than 20 treatments, you might have experienced some changes in your vision. If you wear glasses or contact lenses, DO NOT throw away your old lenses since your vision may return to what it was before your treatments began. In most cases this is temporary and should return to normal within 3-4 months.

If you had any cataracts when you started your hyperbaric oxygen treatments, they may have permanently changed. This will require a visit to your eye doctor to confirm. If you or your vision specialist has any questions, we would gladly discuss them. Please call us at _____ for more information.

Wound Healing Center

DISCHARGE EAR INSTRUCTIONS

Since you have finished your hyperbaric oxygen treatments at this time, we would like to remind you about the care needed for your ears while the pressure equalizing tubes are in place.

Continue to follow the instructions given by physician who inserted the tubes in your ears until your next follow-up with that doctor. Those instructions are probably to insert cotton balls with a small amount of petroleum jelly into the outer canals if you might get water into your ears, like when you are swimming, bathing, showering, or washing your hair. Don't forget to remove the cotton balls when you finish. The physician who inserted the tubes may have issued ear plugs for use instead of the cotton balls.

If you will no longer be receiving hyperbaric oxygen treatments, the pressure equalizing tubes can either be removed or left to fall out naturally. The physician who inserted the tubes will help you make that decision.

If you anticipate further hyperbaric treatment, you may want to leave your tubes in place. Again, the tubes will fall out naturally, but you will need to continue to protect your ear canals from water until you are sure they have fallen out.

Wound Healing Center

NEW PATIENT ASSESSMENT

Patient ID

VITAL SIGNS					
BP	PULSE	RESP	TEMP	BL GLUCOSE	GLUCOMETER ID
AGE	HEIGHT: actual / stated		WEIGHT: actual / stated		

CHIEF COMPLAINT
PROBLEM:
DATE OF ONSET:
CAUSE:
PREVIOUS TREATMENT:

HISTORY AND CO-MORBID CONDITIONS					
Head, Eyes, Ears, Nose, Throat	**Yes**	**No**	**Renal**	**Yes**	**No**
Blurred/double vision			Kidney/bladder disease		
Cataracts			Transplant recipient		
Eye problems			Urinary incontinence		
Ear problems			Dialysis		
Hearing loss			*Type:*		
Other:			*Shunt location:*		
			Schedule:		
Pulmonary	**Yes**	**No**	*Treatment location:*		
Reactive airway diseases:			Other:		
Asthma			**Neuromuscular**	**Yes**	**No**
Bronchitis			Loss of sensation in lower extremities		
Emphysema			Problems with ambulation		
Tuberculosis			Spinal cord injury		
Chronic Obstructive Pulmonary Disease			Multiple sclerosis		
Other:			Other:		
Cardiovascular	**Yes**	**No**	**Diabetes**	**Yes**	**No**
Hypertension			Finger stick blood glucose _____ Time_____		
Angina			Diagnosed		
Infarction			*Type 1*		
Heart failure			*Type 2*		
Arrhythmia			*Gestational*		
Cardiovascular accident / TIA			Duration of diagnosis		
Heart bypass / angioplasty			Treatment regimen		
Lower extremity bypass / angioplasty			Recurrent hosp/ER visits for diabetes		
Claudication			Complications:		
Rest pain			*Amputation*		
Ischemia/gangrene			*Retinopathy*		
Phlebitis			*Nephropathy*		
Distal extremity swelling			*Neuropathy*		
Other:			*Vascular disease*		
			Vascular disease		
			Previous diabetes education? Date		

Abdominal/Gastrointestinal	Yes	No
Diagnosis jaundice / hepatitis		
Difficulty for more than 1 week with:		
Chewing / unable to eat		
Swallowing		
Vomiting		
Diarrhea		
Bowel continence		
Unplanned weight loss (>10 lbs) in last 4		
months		
Diagnosis malnutrition/malabsorption		
Special diet *(specify)*		
Other:		

Collagen Vascular/Arthritic Disease	Yes	No
Osteoarthritis		
Collagen vascular disease		
Systemic lupus erythematosus		
Rheumatoid arthritis		
Scleroderma		
Mixed		
Other:		

Cancer	Yes	No
History		
Diagnosis		
Location		
Treatment		
Surgery		
Radiation therapy		
Chemotherapy		
Other:		

Orthopedic	Yes	No
Trauma		
Bony deformities		
History of osteomyelitis		
Mobility deficit		
Other:		

Dermatologic	Yes	No
Dermatitis		
Eczema		
Rashes		
Malignancy		
Other:		

Hematologic	Yes	No
Anemia		
Bleeding/clotting disorders		
Sickle cell disease		
Immunologic disorders		
Other:		

Substance Use	Yes	No
Caffeine:		
Alcohol: # of years		
Smoking:		
Pack / day use: < 0.5 < 1 < 1.5 < 2 > 2		
Years: < 5 < 10 < 15 < 20 < 25 < 30 _____		
Pack years = num of packs X num of years		
Pack Years:		
Other substance:		
Other substance:		
Other substance:		

PSYCHOSOCIAL

	Lives alone		Other:
	With spouse		Supervised living:
	Other family		Extended care facility:

Current Services	Caregiver
Home health Agency:	Name:
Mental health/retardation services	Relationship:
Hospice	Phone #
Rehabilitation services	Transportation available, Describe:

Barriers to Receiving Care	Anticipated Discharge Needs
Religious	Return to prior living situation
Financial	Home health services
Other:	Durable medical equipment
	Inpatient rehabilitation services
	Skilled nursing facility/Intermediate care facility
	Other:

Social Needs
Food, clothing, or shelter needs (if checked, consult social services department)
Support systems are lacking or cannot be identified (if checked, consult social services department)
Suspected abuse/neglect (if checked, consult social services department or notify appropriate authority)
Patient unable to care for self and no identified assistance (if checked, consult social services department)
Other:

☐ Wound(s) present. Complete a Visit Note with Wound Description record.

RN Signature _____ Date / Time_____

Wound Healing Center

VISIT NOTE

Patient ID: _____

VITAL SIGNS:	BP	PULSE	TEMP	RESP	BLOOD GLUCOSE	GLUCOMETER ID
Repeat						

Interventions for VS

PAIN ASSESSMENT (0 – 10): _____ (if >0, complete a Pain Assessment Record)

PATIENT HOSPITALIZED SINCE LAST VISIT: ❑ No ❑ Yes, reason:

CHANGE(S) IN MEDICAL CARE FROM OTHER PROVIDERS: ❑ No ❑ Yes (update Problem List)

CHANGE(S) TO MEDICATIONS: ❑ No ❑ Yes (update Problem List)

COORDINATION OF CARE: ❑ No ❑ Yes, what?

DISCHARGE PLANNING:

❑ Home health visits ❑ Physical therapy ❑ Orthotics/shoes ❑ Nutrition
❑ Pain management ❑ Community resources ❑ Compression stockings ❑ Pressure risks
❑ Other:

NURSING EDUCATION (mark all that apply below)

WHO: ❑ Patient ❑ Family ❑ Caregiver

HOW: ❑ Verbal ❑ Written ❑ Demo

COMPREHENSION: ❑ Patient / family / caregiver verified instruction ❑ Unable to assess comprehension

COMPLIANCE ISSUES	DIABETIC EDUCATION	WOUND CARE	HEALTH EDUCATION
❑ Present & on time ❑ Calling about absence ❑ Following tx plan ❑ Following instructions ❑ Smoking cessation ❑ Other:	❑ Diet control for healing ❑ Diet control for BS ❑ Foot care ❑ Daily foot inspection ❑ Proper shoes ❑ Obtaining orthotics ❑ Creating new wounds ❑ Other:	❑ Wound care instructions ❑ Drsg dry & intact ❑ Off loading ❑ Elevation ❑ NPWT instructions ❑ Creating new wounds ❑ Maintaining compression ❑ Recognize changes in skin integrity ❑ Other:	❑ Pain control ❑ Disease processes ❑ HBO orientation ❑ Medication issues ❑ Smoking cessation ❑ Personal hygiene ❑ Nutrition ❑ Supplemental vitamins ❑ Foot care ❑ Other:

COMMENTS:

Scheduled follow-up:

EXTRA STAFF USED: ❑ No ❑ Yes, how many? ____

TOTAL STAFF TIME: ❑ 1-9 ❑ 10-19 ❑ 20-29 ❑ 30-39 ❑ 40+ min

❑ This was a Nurse Only visit

Nurse Signature _____ Date / Time _____

Patient ID: _____

WOUND DESCRIPTION		
WOUND #: _____ WOUND LOCATION:		
CONDITION OF OLD DRESSING	DRAINAGE ON OLD DRESSING	ODOR ON OLD DRESSING
❑ Intact ❑ Strike-through noted ❑ Saturated with: ❑ Removed prior to arrival ❑	❑ Serous (clear) ❑ Small amount ❑ Sanguinous ❑ Moderate ❑ Sero-sanguinous ❑ Copious ❑ Purulent Color: Green Red Yellow Brown	❑ None ❑ Mild Odor ❑ Foul Odor
COMPLAINTS OR PROBLEMS W DRESS	WOUND CLEANSED WITH	IRRIGANT
	❑ Soap and water ❑	❑ NS ❑ Other:
WOUND BED TISSUE	PERI-WOUND SKIN	CURRENT PAIN ASSESSMENT
❑ Granulation: Pale Red Dark ❑ Fibrin/ slough ❑ Necrotic/ eschar ❑ Bone ❑ Tendon/ muscle ❑	❑ New epithelialization ❑ Macerated ❑ Callus ❑ Cyanotic ❑ Dry/ scaly ❑ Edema ❑ Other: ❑ Erythema ❑ Indurated	0 – 10 : _____ (if >0, complete a Pain Assessment Record) PAIN INTERVENTION ❑ No ❑ Yes (if yes, document on Pain Assessment Record)
MEASUREMENTS:	UNDERMINING:	TUNNELING
Length _____cm Width _____cm Depth _____cm	Depth _____cm Direction_____ o'clock	Depth _____cm Direction_____ o'clock
CULTURE: ❑ No ❑ Swab ❑ Tissue	PHOTO TAKEN: ❑ No ❑ Yes	

NEW DRESSING					
Products	Primary Drsg	Compression	Secured With	Periwound Care	N.P.W.T.
❑ 0.9%Saline ❑ Saline Gel ❑ Enzymatic: ❑ Other:	Secondary Drsg	❑ 4-layer ❑ 3-layer ❑ Unna ❑ ❑	❑ Netting ❑ Tape ❑ ❑ ❑		❑ Black ❑ Silver ❑ White ❑ Cont. suc. ❑ Inter. suc. ❑ Press:

WOUND DESCRIPTION		
WOUND #: _____ WOUND LOCATION:		
CONDITION OF OLD DRESSING	DRAINAGE ON OLD DRESSING	ODOR ON OLD DRESSING
❑ Intact ❑ Strike-through noted ❑ Saturated with: ❑ Removed prior to arrival ❑	❑ Serous (clear) ❑ Small amount ❑ Sanguinous ❑ Moderate ❑ Sero-sanguinous ❑ Copious ❑ Purulent Color: Green Red Yellow Brown	❑ None ❑ Mild Odor ❑ Foul Odor
COMPLAINTS OR PROBLEMS W DRESS	WOUND CLEANSED WITH	IRRIGANT
	❑ Soap and water ❑	❑ NS ❑ Other:
WOUND BED TISSUE	PERI-WOUND SKIN	CURRENT PAIN ASSESSMENT
❑ Granulation: Pale Red Dark ❑ Fibrin/ slough ❑ Necrotic/ eschar ❑ Bone ❑ Tendon/ muscle ❑	❑ New epithelialization ❑ Macerated ❑ Callus ❑ Cyanotic ❑ Dry/ scaly ❑ Edema ❑ Other: ❑ Erythema ❑ Indurated	0 – 10 : _____ (if >0, complete a Pain Assessment Record) PAIN INTERVENTION ❑ No ❑ Yes (if yes, document on Pain Assessment Record)
MEASUREMENTS	UNDERMINING	TUNNELING
Length _____cm Width _____cm Depth _____cm	Depth _____cm Direction_____ o'clock	Depth _____cm Direction_____ o'clock
CULTURE: ❑ No ❑ Swab ❑ Tissue	PHOTO TAKEN: ❑ No ❑ Yes	

NEW DRESSING					
Products	Primary Drsg	Compression	Secured With	Periwound Care	N.P.W.T.
❑ 0.9%Saline ❑ Saline Gel ❑ Enzymatic: ❑ Other:	Secondary Drsg	❑ 4-layer ❑ 3-layer ❑ Unna ❑ ❑	❑ Netting ❑ Tape ❑ ❑ ❑		❑ Black ❑ Silver ❑ White ❑ Cont. suc. ❑ Inter. suc. ❑ Press:

Nurse Signature _____ Date / Time _____

Wound Healing Center

PROVIDER DEBRIDEMENT NOTE

Patient ID:

Date of Procedure: **Time of Procedure:**

☐ Medical history reviewed
☐ Procedure explained by myself, patient indicates understanding and verbalizes authorization to proceed with treatment
☐ New consent for procedure signed **OR** ☐ Consent for treatment on file in medical record
☐ Pain assessment performed pre and post-procedure (see nursing notes)
☐ Time-out taken prior to procedure

WOUND # _____ LOCATION:
Why is this debridement necessary?

Pre-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Anesthesia: ☐ none ☐ lidocaine _____ % local injection ☐ lidocaine gel topical ☐ Other: _____

Procedure note:
Under clean conditions, the area was prepped and draped. ☐ Selective **OR** ☐ Excisional debridement was performed.
Wound area debrided: _____ cm^2, which is approximately _____ % of total wound area.
Instrument(s) used: ☐ sterile # _____ blade ☐ forceps ☐ curette ☐ other: _____
Tissue removed: ☐ epidermis/dermis ☐ subcutaneous tissue ☐ muscle ☐ bone ☐ tendon/ligament
Description of tissue: ☐ necrotic ☐ devitalized ☐ fibrous ☐ eschar ☐ other: _____
Specimen disposition: ☐ N/A ☐ sent for pathology ☐ sent for culture and sensitivity

Post-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Bleeding:
Controlled by: ☐ N/A ☐ direct pressure ☐ pressure bandage ☐ chemical cautery ☐ sutures ☐ other: _____
Estimated blood loss: ☐ none ☐ minimal ☐ moderate ☐ heavy

Dressing: ☐ a moist wound dressing was applied ☐ other:

WOUND # _____ LOCATION:
Why is this debridement necessary?

Pre-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Anesthesia: ☐ none ☐ lidocaine _____ % local injection ☐ lidocaine gel topical ☐ Other: _____

Procedure note:
Under clean conditions, the area was prepped and draped. ☐ Selective **OR** ☐ Excisional debridement was performed.
Wound area debrided: _____ cm^2, which is approximately _____ % of total wound area.
Instrument(s) used: ☐ sterile # _____ blade ☐ forceps ☐ curette ☐ other: _____
Tissue removed: ☐ epidermis/dermis ☐ subcutaneous tissue ☐ muscle ☐ bone ☐ tendon/ligament
Description of tissue: ☐ necrotic ☐ devitalized ☐ fibrous ☐ eschar ☐ other: _____
Specimen disposition: ☐ N/A ☐ sent for pathology ☐ sent for culture and sensitivity

Post-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Bleeding:
Controlled by: ☐ N/A ☐ direct pressure ☐ pressure bandage ☐ chemical cautery ☐ sutures ☐ other: _____
Estimated blood loss: ☐ none ☐ minimal ☐ moderate ☐ heavy

Dressing: ☐ a moist wound dressing was applied ☐ other:

WOUND # _____ LOCATION:
Why is this debridement necessary?

Pre-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Anesthesia: ☐ none ☐ lidocaine _____ % local injection ☐ lidocaine gel topical ☐ Other: _____

Procedure note:
Under clean conditions, the area was prepped and draped. ☐ Selective **OR** ☐ Excisional debridement was performed.
Wound area debrided: _____ cm^2, which is approximately _____ % of total wound area.
Instrument(s) used: ☐ sterile # _____ blade ☐ forceps ☐ curette ☐ other: _____
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Description of tissue: ☐ necrotic ☐ devitalized ☐ fibrous ☐ eschar ☐ other: _____
Specimen disposition: ☐ N/A ☐ sent for pathology ☐ sent for culture and sensitivity

Post-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Bleeding:
Controlled by: ☐ N/A ☐ direct pressure ☐ pressure bandage ☐ chemical cautery ☐ sutures ☐ other: _____
Estimated blood loss: ☐ none ☐ minimal ☐ moderate ☐ heavy

Dressing: ☐ a moist wound dressing was applied ☐ other:

WOUND # _____ LOCATION:
Why is this debridement necessary?

Pre-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Anesthesia: ☐ none ☐ lidocaine _____ % local injection ☐ lidocaine gel topical ☐ Other: _____

Procedure note:
Under clean conditions, the area was prepped and draped. ☐ Selective **OR** ☐ Excisional debridement was performed.
Wound area debrided: _____ cm^2, which is approximately _____ % of total wound area.
Instrument(s) used: ☐ sterile # _____ blade ☐ forceps ☐ curette ☐ other: _____
Tissue removed: ☐ epidermis/dermis ☐ subcutaneous tissue ☐ muscle ☐ bone ☐ tendon/ligament
Description of tissue: ☐ necrotic ☐ devitalized ☐ fibrous ☐ eschar ☐ other: _____
Specimen disposition: ☐ N/A ☐ sent for pathology ☐ sent for culture and sensitivity

Post-procedure:
Measurements: _____ cm Length X _____ cm Width X _____ cm Depth
Necrotic tissue: _____ % Granulation tissue: _____ % New epithelialization: _____ %
Pictures taken: ☐ yes ☐ no

Bleeding:
Controlled by: ☐ N/A ☐ direct pressure ☐ pressure bandage ☐ chemical cautery ☐ sutures ☐ other: _____
Estimated blood loss: ☐ none ☐ minimal ☐ moderate ☐ heavy

Dressing: ☐ a moist wound dressing was applied ☐ other:

Patient ☐ did ☐ did not tolerate the procedure well.

Additional debridements ☐ were not performed ☐ were performed (see additional debridement note)

Additional Comments:

Provider signature Date / Time

Wound Healing Center

PROVIDER FOLLOW-UP VISIT NOTE

Patient ID:	**Date of Visit:**

Current Complaint / Illness:

History of Present Illness

☐ no changes ☐ changes (describe):

☐ medications reviewed
☐ no changes since last visit ☐ changes (describe):

☐ lab results / diagnostic studies reviewed (describe):

Physical Exam

☐ vital signs reviewed
☐ stable ☐ unstable (describe):

☐ glucose control reviewed
☐ controlled ☐ uncontrolled (describe):

☐ pain reviewed
☐ no intervention ☐ intervention (describe):

☐ weight reviewed
☐ no change ☐ weight gain/loss (describe):

Wound description:	**Wound # _____**	**Wound # _____**	**Wound # _____**	**Wound # _____**
Location				
Etiology				
Dimensions in cm	☐ see nursing notes	☐ see nursing notes	☐ see nursing notes	☐ see nursing notes
Undermining / tunneling	☐ N/A ☐ see nursing notes	☐ N/A ☐ see nursing notes	☐ N/A ☐ see nursing notes	☐ N/A ☐ see nursing notes
% granulation tissue				
Tissue color / texture				
% new epithelialization				
Drainage				
Odor				
Peripheral skin				
Infection / inflammation				
Exposed structures				

☐ **Procedure performed** (see Wound Care Procedure Note)

☐ New problem/wound identified (describe):

☐ Review of prior external note(s) X ____
☐ Review of the result(s) of each unique test X ____
☐ Ordering of each unique test X ____
☐ Assessment requiring an independent historian(s)
☐ Independent interpretation of a test performed by another person (not separately reported)
☐ Discussion of management or test interpretation with external person (not separately reported)

Total time: _____ minutes. (Only your personal spent on this patient on the day of the visit, including non-face-to-face time)

Treatment Plan

☐ no changes ☐ changes (describe):

Additional Comments:

Provider signature Date / Time

STAFF MEETING

DATE:

Roster of attendance:	Meeting chair:

Standard agenda item categories

☐ Safety ☐ Outcomes ☐ Patient satisfaction ☐ Communication

Description of issue:

Action taken/Plan of action:

Point of contact for this issue:

☐ Issue resolved ☐ Requires followup Followup date:

Standard agenda item categories

☐ Safety ☐ Outcomes ☐ Patient satisfaction ☐ Communication

Description of issue:

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