

Wound Care and Hyperbaric Medicine

Admission Assessment, 1 of 4

Patient Name

REFERRAL SOURCE

Primary Care Physician:
PCP Address:
Referred by:

HISTORY OF CHRONIC WOUND

Where is the wound:
When did the wound start:
How did the wound start:
Has the wound ever healed: Yes No Almost
Doctors who helped care for the wound:
What type of treatments have been tried:
What type of dressings have been tried:
Has surgery been tried: Yes No
How do you clean your wound:
How do you dress your wound (gauze, bandages, etc):
How often do you change the wound dressing:

SOCIAL HISTORY

Are you: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)
Do you drink alcohol? Yes No Type: Frequency:
Do you use tobacco? Yes No Type: Frequency:
Do you use recreational drugs? Yes No Type: Frequency:

CURRENT APPLIANCES/PROTEHSES

<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Hearing Aid
<input type="checkbox"/> Dentures (full)	<input type="checkbox"/> Dentures (Partial)	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Ostomy	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> None	<input type="checkbox"/> Crutches	<input type="checkbox"/> Cane
<input type="checkbox"/> Other		

WOUND PAIN

	Low	High
Are you in pain? Yes No	0 1 2 3 4 5 6 7 8 9 10	
Pain location:	How long does pain last? Constant Occasional	
Describe pain: Throbbing Stabbing Burning		
How is it relieved? Pills Elevation Dangling		

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Patient Name _____

NUTRITIONAL ASSESSMENT

Without trying, I have lost more than 10 pounds in the last 2-3 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
My appetite is:	<input type="checkbox"/> Poor, < ½ of meals	<input type="checkbox"/> Fair, 50-75% of meals	<input type="checkbox"/> Good, 75-100% of meals
I have nausea, vomiting or diarrhea for over 4 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
I have chewing or swallowing problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
I have diabetes and:	<input type="checkbox"/> have not had education about diet	<input type="checkbox"/> do not follow a diabetic diet	

FUNCTIONAL ASSESSMENT

Bathing – either sponge bath, tub bath or shower:		
<input type="checkbox"/> I need no help bathing	<input type="checkbox"/> I need help with only certain areas	<input type="checkbox"/> I can't bathe without help
Dressing – get clothes from closets and drawers, including underclothes, outer garments, and using fasteners (including braces, if worn):		
<input type="checkbox"/> I can get completely dressed without help	<input type="checkbox"/> I can get completely dressed except for shoes	<input type="checkbox"/> I cannot dress without help
Toileting – going to the bathroom for bowel and urine elimination; cleaning self afterward:		
<input type="checkbox"/> I can go to the bathroom without help	<input type="checkbox"/> I need help going to the bathroom	<input type="checkbox"/> I do not use the bathroom
Transfer:		
<input type="checkbox"/> I can get in and out of bed and chairs without help	<input type="checkbox"/> I need help to get in and out of chairs and bed	<input type="checkbox"/> I do not get out of bed
Continence:		
<input type="checkbox"/> I control urination and bowel movements by myself	<input type="checkbox"/> I have occasional accidents	<input type="checkbox"/> A catheter is used; I am unable to control myself
Feeding:		
<input type="checkbox"/> I can eat without help	<input type="checkbox"/> I need help at times with meals	<input type="checkbox"/> I need help feeding myself; I am fed by tubes or IV lines

SKIN BREAKDOWN/RISK ASSESSMENT

Sensory perception (ability to respond to discomfort)			
1 – none	2 – very limited (painful stimuli)	3- slightly limited	4- no problem
Exposure of skin to moisture			
1 – constant	2- usually	3 – occasional	4 – no problem
Physical activity			
1- bedfast	2 – chairfast	3 – walks occasionally	4 – no problem
Mobility			
1 – immobile	2 – very limited	3 – slightly limited	4 – no problem
Nutrition			
1 – very poor	2 – inadequate <50%	3 – adequate but ↓	4 – excellent
Friction/shear			
1 – problem (needs mod/max help to move)	2 – potential problem(needs some help to move)	3 – no problem (moves by self)	

TOTAL SCORE: _____ Score of ≤ 16 = high risk

REVIEW OF SYSTEMS

Circle problems you have had or have now.

General:	fatigue, weight loss, night sweats, hot flashes, hair loss, recent chemotherapy or radiation, cancer
HEENT:	headache, neck stiffness, loss of consciousness, corrective lenses, reduced vision, blindness, ringing in ears, hearing loss, nose bleeds, sore throat, dentures, hoarseness, loss of teeth, glaucoma, cataracts, trouble swallowing, bleeding behind the eye
Respiratory:	asthma, bronchitis, shortness of breath, pneumonia, difficulty breathing, wheezing, coughing, emphysema, TB, COPD
Cardiac:	chest pain, CHF, MI, pacemaker, circulation problem, hypertension, hypotension, irregular rhythm, leg swelling, varicose veins, history of blood clots
Gastro-Intestinal:	nausea, vomiting, diarrhea, constipation, difficulty swallowing, bloody stools, abdominal pain, cirrhosis, colon polyps or cancer, Crohn's disease, diverticulitis, ulcerative colitis, hepatitis, GI bleeding, ulcers, heartburn, GERD, hiatal hernia
Genito-Urinary:	incontinence, difficulty passing urine, frequent urination, bloody urine, prostate enlargement, prostate cancer, prostate inflammation, kidney infections, bladder infections, vaginal discharge, pelvic pain, birth control, possible pregnancy, renal disease, burning, dialysis
Musculo-Skeletal:	fractures, scoliosis, osteoporosis, rheumatoid arthritis, osteoarthritis, leg pain at rest, leg pain walking, change in appearance of feet or toes
Neurological:	tremors, numbness, weakness, anesthesia, paraesthesia, slurring, stroke, dementia, seizures, TIA, Parkinson's disease, change in memory, trouble with balance, dizziness, headache, tingling
Female Hx:	breast masses, breast cancer, breast fibrocystic disease, ovarian cysts, ovarian cancer, menopause
General Systems:	anemia, bleeding disorder, hyperthyroidism, hypothyroidism, diabetes, lupus, collagen vascular disease, AIDS or other autoimmune disorder,

FAMILY HISTORY

List any known medical problems or cause of death and age:

Mother
Father

QUESTIONS OR COMMENTS

 Please write any problems you may be having regarding your wound.

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MEDICAL HISTORY

<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Arthritis (osteo/rheumatoid)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> TB
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Depression	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Stomach problems	<input type="checkbox"/> Other	

SURGICAL HISTORY

Procedure	Year	Procedure	Year

MEDICATIONS

Name	Dose	Freq.	Name	Dose	Freq.

ALLERGIES/REACTION

Patient Signature/Date _____

Staff Signature/Date _____

REVIEW DATE AND SIGNATURE
