# Data Collection for Skin/Wound Assessment Form

## Section 1 - General Information

- **Individual Name**: 
- **Program Name**: 
- **Entered By**: 
- **Reported By**: 
- **Date**: 
- **Notification Level**: Low, Medium, High

## Section 2 - Skin/Wound Information

- **Event Time**: 
- **Body Part(s)**: 
- **Photo**: Attached, Photo Date:
- **Wound Type**: Abrasion, Bruises, Decubitus, Dermal ulcer, Hematoma, Laceration, Perineal irritation, Rash, Skin tear, Surgical Incision, None
- **Wound Stage**: Nonblanchable erythema, Blister with skin break, Damage to Subcutaneous, Damage to muscle, tendon, bone, Healed, If Other:
- **Wound Size**: Length (cm), Width (cm), Depth (cm)
- **Wound Base Color**: Beige, Black, Pink, Red, Yellow, If Other:
- **Surrounding Skin**: Intact, Non Intact
- **Skin Color**: Normal, Purple, Red, White
- **Skin Tone**: Hard, Normal, Soft, Swollen
- **Wound Infection**: Yes, No
- **Link to Infection Tracking**: (If 'Yes' then you can add to Infection Tracking form in the Therap System)
- **Drainage**: Color: Bloody, Purulent, Purulent-Pus, Serosanguineous-Serum & Blood, Serous, Serous-Watery, Serosanguineous, Amount: None, Scant, Small, Moderate, Large, Odor: Full, None, Treatment/Dressing: Aquacell, Dry Dressing, Gel, Hydrocolloid, Normal saline, If Other:

## Comments

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**Note:** Required fields are marked with an asterisk (*)