Skilled Nursing Facility Wound Care Documentation Form

HealthSpring℠

Fax this completed form to 855-662-7969.

Member name _____ **Authorization number** _____

Facility name _____ **Facility contact** _____

Initial evaluation status	**Date of update**				
	Wound assessment				
	Type: Pressure or surgical				
	Location				
	Stage				
	Measurement (cm)				
	Drainage: Type, amount, odor				
	Slough				
	Eschar				
	Type of dressing change				
	Frequency of dressing change				
	Other interventions (diet, positioning devices)				
	Wound assessment				
	Type: Pressure or surgical				
	Location				
	Stage				
	Measurement (cm)				
	Drainage: Type, amount, odor				
	Slough				
	Eschar				
	Type of dressing change				
	Frequency of dressing change				
	Other interventions (diet, positioning devices)				
Comments					