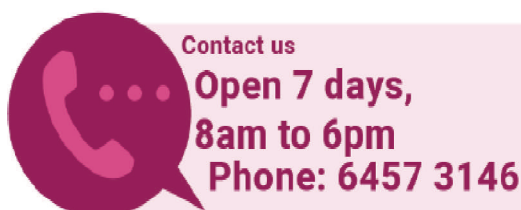




Residential Care Line

6 Steps to Wound Assessment & Referral



Step 1: Provide Essential Details

- Referrer name and position
- Facility
- Resident name and DOB
- GP details / aware of referral?

Step 2: Provide the wound history

- Location & how long wound has been present
- Cause of wound
- Classification if skin tear or pressure injury
- Current dressing plan, including frequency

Step 3: Describe the wound

- Measurements: (head to toe), width, depth, circumference; any undermining or tracking?
- Wound bed e.g. percentage of granulating / slough / necrotic / epithelial tissue
- Wound edges e.g. rolled, flat, macerated (wet / white), dehydrated (dry)

Step 4: Describe the exudate

- Level: none, low, moderate, high
- Type: serous (clear), haemoserous (pink / clear), sanguineous (bright red blood) purulent (pus)

Step 5: Describe the surrounding skin

- Is it: healthy / red / macerated (wet / white) / dry / eroded / is there skin loss?

Step 6: Check for infection

- Local: erythema (redness), local warmth, malodour, healing delay, increased pain, increased exudate, oedema (swelling)
- Systemic: febrile, confusion, delirium, increased drowsiness, cellulitis, malaise, decreased appetite, increased leukocytes

Please use the above structure to guide your assessment. Please scroll down to the next page to complete our referral form. Once completed, please send to RCL@health.wa.gov.au with their Medication chart, Past medical history and current wound photo. If you have any concerns or questions, please call RCL on 6457 3146 0800HRS – 1800HRS, 7 days a week.

REFERRAL FOR WOUND MANAGEMENT

Residential Care Line

Date of referral:		Facility Name:		Facility number:	
Resident name:				DOB: ____/____/____	
GP Name:				GP aware of referral: ☐ YES ☐ NO	
GP Number:					
AHD / ACP / GoC: ☐ YES ☐ NO				Date completed: ____/____/____	
CNM name:					
CNM aware of referral: ☐ YES ☐ NO					
Name of referrer:					
Description					
Wound: (incl. location)				Re-referral: ☐ YES ☐ NO	
Status: (click) ☐ 1st referral ☐ Deteriorating ☐ Static ☐ Improving					
Aetiology			Duration		
Skin tear classification			Pressure injury classification		
Previous Hx of wounds:					
Other specialist / clinic / services involved +/- current care plan from specialist:					
Wound assessment					
Measurement		Wound bed		Wound edges [Click]	
Width	mm	Granulation	%	☐ Rolled	
Length	mm	Slough	%	☐ Flat	
Depth	mm	Necrotic	%	☐ Macerated	
Circumference	mm	Epithelialising	%	☐ Dry	
Exudate [Click relevant]					
Level	☐ Dry ☐ Low		Type	☐ Serous ☐ Haemoserous	
	☐ Medium ☐ High			☐ Sanguineous ☐ Purulent	
Surrounding skin [Click relevant]					
☐ Healthy ☐ Macerated ☐ Erythema ☐ Eroded ☐ Dry ☐ Skin loss					
Symptoms of Infection [Click relevant]					
If the resident is experiencing systemic infection signs, RCL would suggest an urgent GP review.					
Local	☐ Erythema ☐ Local warmth		Systemic	☐ Febrile ☐ Confusion	
	☐ ↑ Exudate ☐ Malodour			☐ Delirium ☐ Malaise	
	☐ ↑ Pain ☐ Pocketing			☐ ↑ Drowsiness ☐ ↓ Appetite	
	☐ Oedema ☐ Healing delay			☐ Cellulitis ☐ ↑ Leukocytes	
Wound Management Plan					
Cleanser:	Moisturiser / barrier	Primary dressing:	Secondary dressing:	Fixation:	Frequency: