Surgical Dressing Information Worksheet

Patient: _____TEL: _____

Address: _____

Physician: _____ Date of Evaluation: _____

Description of Wound

	Wound # _____	Wound # _____	Wound # _____	Wound # _____
Type of Wound	_____	_____	_____	_____
Location	_____	_____	_____	_____
Size (l x w) (cm)	_____	_____	_____	_____
Depth (cm)	_____	_____	_____	_____
Stage (I-IV)	_____	_____	_____	_____
Amount of Drainage	_____	_____	_____	_____
Date/Type Debridement*	_____	_____	_____	_____

Dressings Used	(a) (b) (c) (d)	(a) (b) (c) (d)	(a) (b) (c) (d)	(a) (b) (c) (d)
	— — — —	— — — —	— — — —	— — — —
	— — — —	— — — —	— — — —	— — — —
	— — — —	— — — —	— — — —	— — — —
	— — — —	— — — —	— — — —	— — — —

(a) = Dressing reference # from table below (All Primary and Secondary dressings used for each wound)
(b) = Quantity used per dressing change
(c) = Frequency of dressing change
(d) = How many days do you anticipate using these dressings? **

Dressing Ref #	Dressing Brand Name	Size	HCPCS#

Source of Information used to complete this form:
_____ Nursing Home Records _____ Home Care Records _____Physician Office Records
_____ Other (specify) _____

I certify that I obtained the information in this form from the stated source and that the original records are available for review:

_____ _____ _____
Print Name Signature Date
Phone Number: _____

* Debridement initiates uses of the Surgical Dressing policy ONLY and is not required with every dressing change.
** Medicare requires you to estimate an anticipated length of time of use (no. of days) for each dressing.
This should coincide with scheduled wound assessments so that dressing appropriateness is assessed at the same time.

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