



AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
**Pressure Injury Assessment and Documentation**  
 (Pressure Injury Numbering from  
 Nursing Services Basic Injury Assessment)  
**Use one form per pressure injury described.**

DATE OF SERVICE
CASE MANAGER NAME
RN NAME

**Section 1. Client Information (Completed by DSHS or AAA Staff, RN, and/or Contractor)**

CLIENT NAME	DATE OF BIRTH	CLIENT ACES ID	CLIENT PROVIDER ONE ID
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**Pressure Injury Description**

1. PRESSURE INJURY NUMBER From form 13-780 (pictorial diagram)	2. LOCATION DESCRIPTION
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3. PRESSURE INJURY CLASSIFICATION  
 Staging (check one):  1  2  3  4  
**or (check one of the following):**  
 Unstageable:  
 Suspected deep tissue injury reason:

4. MEASUREMENT OF WOUND  
 Length:          cm    Width:          cm    Depth (visual estimate):          cm

5. TUNNELING <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, describe:	UNDERMINING <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, describe:
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6. A. WOUND EXUDATE: (% SATURATION OF DRESSING)

<input type="checkbox"/> None: (0%)	<input type="checkbox"/> Minimal: (<25% Saturation of Dressing)
<input type="checkbox"/> Moderate: (26-75% Saturation of Dressing)	<input type="checkbox"/> Heavy: (>75% Saturation of Dressing)

B.

<input type="checkbox"/> Serous: (Thin, Watery, Clear)	<input type="checkbox"/> Sanguineous: (Bloody)
<input type="checkbox"/> Purulent: (Thin or Thick, Opaque, Tan/Yellow)	<input type="checkbox"/> Serosanguineous: (Thin Watery, Pale Red/Pink)

7. WOUND BED  
 Granulation  Slough  Necrotic  
 Comments:

8. ODOR  
 No  Yes. If yes, describe:

9. PAIN SCALE  
 NO PAIN  0  1  2  3  4  5  6  7  8  9  10 WORST PAIN IMAGINABLE

10. SURROUNDING SKIN  
 Erythema  Edema  Warm  Induration (hard)  Other:  
 Comments:

Pressure Injury Documentation, Pages          of

RN SIGNATURE	DATE	PRINTED RN NAME
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11. RN POST PRESSURE INJURY ASSESSMENT RECOMMENDATIONS TO DSHS CASE MANAGER (INCLUDING TREATMENT AND/OR RECOMMENDATIONS FOR HCP FOLLOW-UP, ADDITIONAL TREATMENT OR CARE NEEDS AND/OR RECOMMENDED CHANGES TO SERVICE PLAN