

PATIENT INFORMATION

Patient's Name (last, first, MI): _____

Patient's DOB: / / SS# - -

PHYSICIAN'S GOAL FOR THERAPY

Was the Physician's goal for therapy met? Yes No*

*If No, why not? _____

DISCHARGE ASSESSMENT [Indicate when Invia® Wound Therapy has been discontinued and the outcome.]

Therapy Discharge Date: / /

Wound #1

Wound Location: _____

Wound Status (Check all that apply.)

<input type="checkbox"/> Adequate granulation	<input type="checkbox"/> Patient in hospital	<input type="checkbox"/> Wound unresponsive	<input type="checkbox"/> Pain
<input type="checkbox"/> Wound healed	<input type="checkbox"/> Delayed primary closure	<input type="checkbox"/> Patient non-compliant	<input type="checkbox"/> Patient expired
<input type="checkbox"/> Wound sutured closed	<input type="checkbox"/> Tunnel dimensions decreased or closed	<input type="checkbox"/> Undermining improved or resolved	
<input type="checkbox"/> 4 months of treatment completed	<input type="checkbox"/> Other (please describe)		

Final wound measurements Date: / / Length: cm Width: cm Depth: cm

Wound #2 [Complete only if a second wound was treated.]

Wound Location: _____

Wound Status (Check all that apply.)

<input type="checkbox"/> Adequate granulation	<input type="checkbox"/> Patient in hospital	<input type="checkbox"/> Wound unresponsive	<input type="checkbox"/> Pain
<input type="checkbox"/> Wound healed	<input type="checkbox"/> Delayed primary closure	<input type="checkbox"/> Patient non-compliant	<input type="checkbox"/> Patient expired
<input type="checkbox"/> Wound sutured closed	<input type="checkbox"/> Tunnel dimensions decreased or closed		
<input type="checkbox"/> 4 months of treatment completed	<input type="checkbox"/> Other (please describe)		

Final wound measurements Date: / / Length: cm Width: cm Depth: cm

Print name title and employer of individual providing information: _____

Phone: _____ Date: / /

Thank you for completing this form.

For Armscare Use Only:	Information taken verbally by _____ from _____
	_____ on _____ at _____

(caregiver) Date: mm dd yyyy (time)