

### Physician/Provider Pressure Ulcer Determination & Diagnosis - POA and HA

- If Present** Risk Factors associated with pressure ulcer risk for development and/or diagnosis
- Cognitive Impairment Diagnosis \_\_\_\_\_
  - Ambulation/Mobilization Impairment (motor and/or sensory) Diagnosis \_\_\_\_\_
  - Nutritional/Hydration Impairment Diagnosis \_\_\_\_\_
  - Incontinence/Moisture (too wet/too dry) Impairment Diagnosis \_\_\_\_\_
  - Contact with medical devices (i.e., braces, orthotics, cannulas, tubing), and/or any object in contact with the body.

**General Medical Conditions & Medications that have a co-morbidity effect on pressure ulcer development and/or healing.**

Analysis of Body Systems

- |   |  |
|---|--|
| <input type="checkbox"/> Integumentary    | <input type="checkbox"/> Neurological            |
| <input type="checkbox"/> Cardiovascular   | <input type="checkbox"/> Musculoskeletal         |
| <input type="checkbox"/> Respiratory      | <input type="checkbox"/> Hematologic/Immunologic |
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Endocrine               |
| <input type="checkbox"/> Genitourinary    | <input type="checkbox"/> Reproductive            |
| <input type="checkbox"/> Medications      |  |

Comments \_\_\_\_\_  
 \_\_\_\_\_

**Existing Wound Diagnosis**

1. Pressure Ulcer

Depth

- Deep Tissue Injury (ICD-9-Code 707.25)
- Stage I (ICD-9 Code 707.21)
- Stage II (ICD-9 Code 707.22)
- Stage III (ICD-9 Code 707.23)
- Stage IV (ICD-9 Code 707.24)
- Unstageable (ICD-9 Code 707.25)
- Unspecified (ICD-9 Code 707.20)

Location

- Unspecified (ICD-9-Code 707.00)
- Elbow (ICD-9 Code 707.01)
- Upper back, shoulder blade (ICD-9 Code 707.02)
- Lower back (ICD-9 Code 707.03)
- Hip (ICD-9 Code 707.04)
- Buttocks (ICD-9 Code 707.05)
- Ankle (ICD-9 Code 707.06)
- Heel (ICD-9 Code 707.07)
- Other site (ICD-9 Code 707.09)

Indicators

- Y Indicates the condition was present on admission.
- W Affirms the provider has determined, based on data and clinical judgement, that it is not possible to document when the onset of the conditions occurred.
- N Indicates the condition was not present on admission.
- U Indicates the documentation is insufficient to determine if the condition was present at the time of admission.

**Wound** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

- 2. History of closed (repaired) Stage III, IV, Unstageable pressure ulcer. Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 3. Arterial (ischemic)  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 4. Venous Stasis  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 5. Lymphedema  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 6. Neuropathic  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 7. Trauma  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 8. Surgical  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_
- 9. Other  Partial Thickness  Full Thickness Location \_\_\_\_\_  
 Comment \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_