Client Name: _____

DOB: _____

PHN: _____

*OR ADDRESSOGRAPH/LABEL* Year: _____

_____
(Facility)

# WOUND ASSESSMENT & TREATMENT FLOW SHEET (WATFS) 

## WOUND TREATMENT PLAN

| **Treatment Plan**<br>**Leave in place for ONE week whenever possible** | **Document Rationale for change**<br>**as per agency policy on WATFS or Notes** | Date Initiated | Initials | Date D/C | Initials |
|---|---|---|---|---|---|
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Reference: *Wound Assessment Guideline Decision Support Tool (DST)*. Adapted from VCHA Wound Care Assessment Tool (2009)

(Facility)

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