Date: [Date]

To: [Facility Name / Director of Nursing]
From: [Wound Care Clinic Name / Provider Name]
Re: Transfer of Care / Post-Treatment Summary

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Service: [Date]

Wound Assessment

Wound Location: [e.g., Left Sacrum, Right Lateral Malleolus]
Wound Type: [e.g., Pressure Injury Stage IV, Diabetic Foot Ulcer]
Measurements: [Length] cm x [Width] cm x [Depth] cm
Wound Bed Description: [e.g., % Granulation, % Slough, % Eschar]
Exudate: [e.g., Serosanguinous, Purulent, Minimal/Moderate/Heavy]

Procedure/Treatment Performed

Debridement: [Select: Sharp, Enzymatic, Autolytic, or N/A]
Topical Medications Applied: [List medications used]
Primary Dressing: [List dressing type]
Secondary Dressing: [List dressing type]

Current Orders & Recommendations

Dressing Change Frequency: [e.g., Daily, Every 3 days, PRN]
Cleaning Solution: [e.g., Normal Saline, Wound Cleanser]
Specific Instructions: [e.g., Offloading instructions, compression wrap details]

Plan of Care

- Continue current dressing orders until next clinic visit.
- Monitor for signs of infection (redness, warmth, increased pain, foul odor).
- Follow-up appointment scheduled for: [Date/Time].

Provider Signature: _____

Contact Number: [Clinic Phone Number]