NOTE: this pathway is not exhaustive; there are many steps within a workflow, and not all are referenced here.

1. Understand pathogenesis and patient presentation/chief complaint and history of present illness
   a. Venous hypertension
      i. Due to abnormal calf muscle pump
         1. Incompetent veins/valves
         2. Acquired
      3. Congenital
      4. Muscle dysfunction
      5. Decreased mobility
   ii. Venous pooling
      1. Leukocytes become trapped and release proteolytic enzymes, which lead to formation of free radicals that damage tissue
   2. Dilatation of veins

2. Document patient history
   a. Prior history of venous disease
   b. Trauma
   c. Deep venous thrombosis
   d. Pregnancy
   e. Congestive heart failure
   f. Family history of venous disease/ulcers
   g. Obese
   h. Elderly
   i. Female

3. Document physical examination
   a. Irregular borders
   b. Good granulation tissue
   c. Moderate/heavy exudates
   d. Edema
   e. Periwound hyperpigmentation and scaling
   f. Lipodermatosclerosis
   g. Mild/moderate pain
   h. Varicosities
   i. Atrophie blanche

j. Scarring
k. Ankle-brachial index
l. Location
   i. Medial legs

4. Document wound assessment
   a. Etiology
   b. Qualitative information
      i. Anatomical location
      ii. Classification using clinical signs, etiology of venous disease (congenital or primarily or secondarily acquired), anatomic distribution (superficial, perforating, and/or deep veins), and pathologic condition (obstruction and/or reflux) or Clinical-Etiology-Anatomy-Pathophysiology classification
      iii. Edema or swelling of tissues
      iv. Exudate
      v. Odor
      vi. Pain
      vii. Periwound skin
      viii. Type of tissue exposed
      ix. Wound bed description and wound color
      x. Wound margin condition
      xi. Photograph of the wound
      xii. Surface area of wound
      xiii. Wound depth and undermining
   c. Quantitative information
      i. Ankle and calf circumference (for vascular parameters)
      ii. Undermining or tunneling wound size

5. Perform and document procedure, if warranted
6. Document treatment completed
7. Document provider orders
8. Document patient education
9. Order other tests based on patient presentation (review your local coverage determination policies to determine which studies are reasonable and necessary)
10. Provide discharge instructions
11. Reconcile signatures and work completed