OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

MSRM 140117.01.7.2
(R-2/20)

GENITAL DISCHARGE - FEMALE

Subjective Data: **Allergies:** _____

Chief complaint: _____

Onset:_____ ❑ New Onset ❑ Chronic ❑ Recurrence

History:

Sexually transmitted disease:	❑ None	❑ Gonorrhea	❑ Syphilis	❑ Herpes	❑ Chlamydia	❑ Venereal warts

Antibiotic therapy: When: _____ Name of medication: _____

Last sexual intercourse: _____ Last menstrual period: _____ Last vaginal infection: _____

Associated Symptoms:

Change in voiding: ❑ Burning / painful urination ❑ Frequency ❑ Urgency ❑ Dribbling ❑ Inability to void

Lumboscaral back pain or mid-abdominal pain: ❑ Yes ❑ No If "Yes" describe:_____

Radiation of pain: ❑ Yes ❑ No If "Yes" describe: _____ Pain scale: (0-10)

❑ Itching ❑ Foul odor ❑ Burning ❑ Redness ❑ Edema ❑ Discharge: Describe: _____

Objective Data: (clinically indicated VS)

BP _____Pulse _____ Resp. _____ Temp. _____ Wt._____O_2 sats._____ FSBS: _____

Abdomen:	❑ Soft	❑ Slightly firm	❑ Rigid	❑ Distended
Bowel sound:	❑ Normal	❑ Hyperactive	❑ Hypoactive	❑ Absent
Mucus membrane:	❑ Moist	❑ Dry	❑ Parched	
Turgor:	❑ Normal	❑ Decreased		
Urine:	❑ Clear	❑ Dark	❑ Cloudy	❑ Bloody ❑ Foul odor
Appearance:	❑ No distress	❑ Mild distress	❑ Moderate distress	❑ Severe distress

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: *Health care provider must be called if not on site or if after clinic hours.*

❑ Temp > 101 ❑ Foul odor
❑ Abdominal pain

REFER TO HEALTH CARE PROVIDER IF: *If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

❑ Any discharge or genital lesions are present
❑ Frequent recurrence
❑ Inmate not responding to interventions

Health Care Provider: _____ **Time Notified:** _____ **Orders Received for Treatment:** ❑ **Yes** ❑ **No**

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

❑ Check in assessment only for health care providers visit.
❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
❑ Clean catch urine specimen.
❑ Dip-stick urine.
❑ Anti-fungal vaginal cream or suppositories. **(This will require an order from the health care provider)**
❑ Hydrocortisone cream 1% 2 times a day for 10 days PRN to external vaginal area for symptomatic relief of itching or perineal irritation.
❑ Education/Intervention: Instructed on proper hygiene care, methods to reduce irritation, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

_____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

Inmate Name
(Last, First)

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