Subjective Data:

Allergies: ________________________________

Chief complaint: ____________________________

Current problems: (list) ____________________________________________________________

Current medications: (list) ________________________________________________________

Has your condition improved, deteriorated, or remained the same since you last saw the health care provider?

☐ N/A  ☐ improved  ☐ deteriorated  ☐ remained the same

Current medication(s): _____________________________________________________________

Are you experiencing any problems with your current medications?

☐ N/A  ☐ Yes  ☐ No  If “Yes” Explain: ________________________________________________

Are you experiencing any new health care/dental/optometric/mental health problems since arriving to the facility?

☐ Yes  ☐ No  If “Yes” Explain: _____________________________________________________

Objective Data: (clinically indicated VS)

BP _______ Pulse _________ Resp. _________ Temp. _______ Wt. _______ O₂ sats. _______ FSBS: _______

If the inmate is experiencing any new medical/dental/optometric/mental health problems or deteriorating conditions since arriving to facility refer to appropriate Nursing Protocol or Referral to Health Care Provider.

☐ Complains of deteriorating condition
☐ Presence of abnormal findings
☐ Complains of severe pain
☐ Unexplained clinical abnormalities
☐ Abnormal vital signs, Temp >101, Pulse > 100 or < 50, Appears in acute distress
☐ Persistent or progressively worse symptoms

Plan: Interventions: (check all that apply)

☐ Requires referral to health care/dental/optometric/mental health provider
☐ Requires further nursing evaluation - Nursing Protocol
☐ No unexplained clinical abnormalities, signs and symptoms of illness, follow-up sick call PRN
☐ Education/Intervention: Instructed inmate to follow-up sick call if experiencing any signs and symptoms that warrant treatment, sick call process and medication refills. Inmate verbalizes understanding of instructions

Progress Note: ________________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Health Care Provider Signature/Credentials: ___________________________ Date: ______ Time: ______

RN/LPN Signature/Credentials: ___________________________ Date: ______ Time: ______

Inmate Name (Last, First) DOC #