PRURITIC LESIONS/SCALING
(example-Athlete's Foot (Tinea Pedis))

Subjective Data:

Chief complaint: ____________________________

Allergies: _______________________

Onset: ____________________________

□ New Onset □ Reoccurrence □ Constant

Affected area: □ Left foot □ Right foot □ Bilateral feet

Associated Symptoms:

□ Itching □ Burning □ Diabetic □ Pain

Pain scale (0-10) ______________

Current treatment/medications:

Over the counter □ Yes □ No

Describe: ____________________________________________________________

Prescription □ Yes □ No

Describe: ____________________________________________________________

Objective Data: (clinically indicated VA)

BP _______________ Pulse _______________ Resp. _______________ Temp. _______________ Wt. _______________

□ Rash □ Pruritic cracking □ Scaling □ Inflammation □ Crusting □ Red streaks

□ Dry □ Drainage □ Odor □ Blisters □ Discoloration □ Edema

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.

□ Worsening of condition after treatment started

□ Allergy to Antifungal agent-documented

□ Presence of secondary infection

□ Suspected underlying infection

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 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.

□ Tolnaftate cream to affected area twice daily for 30 days PRN.

OR

□ Tolnaftate powder to affected area twice daily for 30 days PRN.

□ Assign nursing protocol to Infectious Disease nurse if positive for athlete’s foot

□ Education/Intervention: Instructed on hygiene - care of feet, signs and symptoms of secondary infection, 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) DOC #