Subjective Data:  

Chiefs complaint: ____________________________________________

Onset: __________

☐ Right eye  ☐ Left eye  ☐ Both eyes  Type of foreign body: (If known)_________

☐ Exposure to allergens/chemicals (type)_________________________________________________________________________

☐ Glasses  ☐ Contact lens

Associated Symptoms:

☐ Itching  ☐ Burning  ☐ Tearing  ☐ Unable to tear  ☐ Blurred vision  ☐ Seeing spots  ☐ Photo sensitivity

☐ Pain scale (0-10) __________

Objective Data: (Clinically indicated VS)

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

<table>
<thead>
<tr>
<th>Visual</th>
<th>Pupils</th>
<th>Eyes</th>
<th>Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>OS _______</td>
<td>☐ Equal</td>
<td>☐ Redness</td>
<td>☐ No distress</td>
</tr>
<tr>
<td>OD _______</td>
<td>☐ Unequal</td>
<td>☐ Inflamed</td>
<td>☐ Mild distress</td>
</tr>
<tr>
<td>OU _______</td>
<td>☐ PERRLA</td>
<td>☐ Edema</td>
<td>☐ Moderate distress</td>
</tr>
</tbody>
</table>

Discharge (Color/amount):

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EYE EMERGENCY: IMMEDIATE EMERGENCY CARE AND TRANSFER WITHOUT DELAY AND CONTACT HEALTH CARE PROVIDER:

☐ Imbedded object or Penetrating injuries

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

☐ Sudden change in visual acuity

☐ Foreign body not easily removed

☐ Continued pain after removal of foreign body

☐ Any eye complaint not readily associated with foreign body

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.

☐ Rinse eye at eye wash station or with optometric normal saline. Notify Health Care Provider/RN if ineffective.

☐ If object moves and it appears that it can be removed easily, remove object by sweeping inner aspect of upper lid with lower lashes or with moist cotton tipped applicator.

☐ Re-check and document appearance and visual acuity.

☐ If suspected corneal abrasion use fluorescein paper (Note: only nurses with documented training on fluorescein paper may perform this procedure)

☐ Artificial tears instill 2 drops in affected eye 4 times a day for 7 days PRN for relief of burning and dryness.

☐ Eye patch for comfort.

☐ Education/Intervention: Instructed not rub/touch eyes, s/s of infection, 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 #