INDIGESTION

Subjective Data:

Chief complaint: _______________________

Onset: __________________________

Pain scale: (0-10) __________

History:

Last bowel movement: ___________

Color/Consistency: _______________________

Dietary habits: _________________________________________________________________________

Fluid intake/restriction: _____________________________________________________________________________

Recent wt. change:  □ Yes □ No  When: ____________________________________________________________

Gallbladder disease:  □ Yes □ No  When: ____________________________________________________________

Recent Abd. surgery:  □ Yes □ No  When: ____________________________________________________________

Appendicitis:  □ Yes □ No  When: ____________________________________________________________

Ulcers:  □ Yes □ No  When: ____________________________________________________________

Current medications: ________________________________________________________________________________

Associated symptoms:

□ Burning  □ Belching  □ Gas  □ Flatulence  □ Bloating  □ Discomfort in upper stomach / chest

Objective Data: (clinically indicated VS)

BP __________ Pulse _________ Resp. ________ Temp. ________ Wt. ________ O2 sats. ________ FSBS: ________

Abdomen □ Soft □ Firm  □ Tender to  □ Distended

Bowel sounds □ Normal □ Hyperactive □ Hypoactive □ Sluggish □ Absent

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

□ Onset is sudden and abnormal vital signs or problem exists or recurrence

□ Symptoms suggesting cardiac origin

□ Symptoms unrelieved by nursing 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.

□ Calcium Carbonate (i.e. Alcalak, Tums): chew 2 tablets four times a day (after meals and at bedtime) for 3 days PRN.

□ Education/Intervention: Instructed to avoid spicy foods, foods that increase symptoms: caffeine, nicotine, ASA eat small meals, chew slowly and thoroughly, increase water intake to 8 glasses daily/fibrous foods, not to lie down at least 2 hours after eating, 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 #