PAINFUL URINATION
(example – Urinary Tract Infection)

Subjective Data:

Allergies: __________________________
Onset:_________________________________  □ New Onset □ Chronic □ Recurrence

History:

Sexually transmitted disease:  □ None □ Gonorrhea □ Syphilis □ Herpes □ Chlamydia
Diabetic: □ Yes □ No  FSBS: ________

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) ______

Objective Data: (clinically indicated VS)

BP_______________  Pulse_______________  Resp. _______________  Temp. ______________  Wt.________________

Abdomen: □ Soft □ Slightly firm □ Rigid □ Distended

Bowel sound: □ Normal □ Hyperactive □ Hypoactive □ Absent

Mucus membrane: □ Moist □ Dry □ Parched

Turgor: □ Normal □ Decreased

Urine: □ Dark □ Cloudy □ Bloody □ Foul order

Appearance: □ Mild distress □ Moderate □ Severe distress

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

□ Inmate unable to void
□ Inmate unable to ingest fluids
□ Temperature > 101
□ Inmate has vomiting associated with other symptoms

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.

□ Dipstick urine abnormal
□ Suspected gonorrhea, chlamydia, syphilis, or pyelonephritis
□ Inmate has costo-vertebral angle tenderness
□ Inmate has history of kidney stones

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 medical providers visit.
□ Assessment completed. Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation.
□ Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days PRN OR
□ Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days PRN
□ Clean catch urine specimen (critical in females)
□ Dip-stick urine
□ Increase fluids to at least 2 liters unless history of CHF / Pulmonary edema
□ Education/Intervention: Instructed to increase fluid intake, void every 2-3 hours, 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________________________ DOC #