Subjective Data:
Chief complaint:
Onset: ☐ New Onset  ☐ Recurrence  Activity at onset: __________________________

Type of pain:
☐ Dull  ☐ Intermittent  ☐ Constant  ☐ Throbbing  ☐ Achy  ☐ Sharp  ☐ Pressure
☐ Pain with wt. bearing  ☐ Pain without wt. Bearing  Pain scale: (0-10) __________

Associated symptoms:
☐ Bruising  ☐ Swelling  ☐ Deformity  ☐ Tender to touch
☐ Able to walk immediately after injury  ☐ Able to walk when examined
☐ Numbness: Describe __________________________  ☐ Tingling: Describe __________________________

Objective Data: (clinically indicated VS)
BP _______ Pulse _______ Resp. _______ Temp. _______ Wt. _______ O2 sats. _______ FSBS: _______

<table>
<thead>
<tr>
<th>Pulses (distal to injury)</th>
<th>Skin temp (distal to injury)</th>
<th>Capillary Refill</th>
<th>Appearance of injury</th>
<th>Range of Motion</th>
<th>Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>Normal</td>
<td>Brisk - &lt; 2 seconds</td>
<td>Deformity</td>
<td>Full</td>
<td>No distress</td>
</tr>
<tr>
<td>Absent</td>
<td>Warm</td>
<td>Sluggish - &gt; 2 seconds</td>
<td>Discoloration</td>
<td>Slightly decreased</td>
<td>Mild distress</td>
</tr>
<tr>
<td></td>
<td>Cool</td>
<td></td>
<td>Edema</td>
<td>Greatly decreased</td>
<td>Moderate distress</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bruising</td>
<td>Crepitus with motion</td>
<td>Severe distress</td>
</tr>
</tbody>
</table>

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IN ALL CASES OF SPRAIN FOLLOWING FIRST AID TREATMENT: Health care provider must be called if not on site or if after clinic hours.
☐ Injuries are present that suggest need for x-ray or further assessment (i.e. joints)

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.
☐ No response to interventions

Meets Ottowa criteria for x-ray
☐ Tenderness at posterior edge of lateral malleolus
☐ Tenderness at lateral edge of mid foot
☐ Inability to walk immediately and when examined (regardless of limping)
☐ No response to 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.
☐ Apply cold compresses/ice packs for 20 minutes every 3 hours while awake for first 24 hours and then either cold or warm compresses for additional 24 hours.
☐ Immobilization of area for no longer than 3 days, crutches as needed for ambulation for no longer than 3 days.
☐ Local heat after acute phase resolution – compresses.
☐ Analgesic Balm to affected area QID for 7 days PRN.
☐ 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.
☐ Activity restrictions may be indicated for a period of time until the inmate can be evaluated by the health care provider.
☐ Crutches issued. Aides to Impairment Appliance Record completed and signed by inmate.
☐ Splint, sling, ace wrap, crutches should be considered where appropriate.
☐ Rest and elevation for 3 days (medical lay-in / restrictions if indicated).
☐ Medical lay-in / restrictions.
☐ Education/Intervention: Instructed to avoid heavy lifting, strenuous work/activity until problem resolved, 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 #