

GENITAL DISCHARGE - FEMALE

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ New Onset Chronic Recurrence

History:

Sexually transmitted disease: None Gonorrhea Syphilis Herpes Chlamydia Venereal warts

Antibiotic therapy: When: _____ Name of medication: _____

Last sexual intercourse: _____ Last menstrual period: _____ Last vaginal infection: _____

Associated Symptoms:

Change in voiding: Burning / painful urination Frequency Urgency Dribbling Inability to void

Lumbosacral back pain or mid-abdominal pain: Yes No If "Yes" describe: _____

Radiation of pain: Yes No If "Yes" describe: _____ Pain scale: (0-10) _____

Itching Foul odor Burning Redness Edema Discharge: Describe: _____

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____

Abdomen:	<input type="checkbox"/> Soft	<input type="checkbox"/> Slightly firm	<input type="checkbox"/> Rigid	<input type="checkbox"/> Distended
Bowel sound:	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Hypoactive	<input type="checkbox"/> Absent
Mucus membrane:	<input type="checkbox"/> Moist	<input type="checkbox"/> Dry	<input type="checkbox"/> Parched	
Turgor:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased		
Urine:	<input type="checkbox"/> Clear	<input type="checkbox"/> Dark	<input type="checkbox"/> Cloudy	<input type="checkbox"/> Bloody <input type="checkbox"/> Foul odor
Appearance:	<input type="checkbox"/> No distress	<input type="checkbox"/> Mild distress	<input type="checkbox"/> Moderate distress	<input type="checkbox"/> Severe distress

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:

- Temp > 101
- Abdominal pain

Refer to Medical Provider If:

- Any discharge or genital lesions are present
- Frequent recurrence
- Offender not responding to interventions

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

- Alterations in comfort related to genital infection

Plan:

Nursing Intervention Routine:

- Clean catch urine specimen
- Dip-stick urine
- Anti-fungal vaginal cream or suppositories (This will require an order from the medical provider)
- Hydrocortisone cream 1% 2 times a day for 7 days to external vaginal area for symptomatic relief of itching or perineal irritation – issue one tube

Progress Note: _____

Offender Education:

- Instructed on proper hygiene care, methods to reduce irritation, medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

DOC #