

Allergic Reaction/Anaphylactic Emergency

Subjective Data: _____ **Allergies:** _____
Chief complaint: _____

Type of reaction:

<input type="checkbox"/> Itching	<input type="checkbox"/> Feelings of weakness	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Skin redness (rash/hives)	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Known allergen exposure	Describe: _____	

Current medication(s): _____

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ Peak Flow _____ O₂ sats. _____

Respiration	Lung Sounds	Skin	LOC	Swelling	Appearance
<input type="checkbox"/> Even	<input type="checkbox"/> Clear	<input type="checkbox"/> Warm	<input type="checkbox"/> Awake	<input type="checkbox"/> Tongue	<input type="checkbox"/> No distress
<input type="checkbox"/> Uneven	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Pink	<input type="checkbox"/> Alert	<input type="checkbox"/> Throat	<input type="checkbox"/> Mild distress
<input type="checkbox"/> Labored	<input type="checkbox"/> Wheezes	<input type="checkbox"/> Cool	<input type="checkbox"/> Oriented X____	<input type="checkbox"/> Facial	<input type="checkbox"/> Moderate distress
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Diminished	<input type="checkbox"/> Pale	<input type="checkbox"/> Confused	<input type="checkbox"/> Extremities	<input type="checkbox"/> Severe distress
<input type="checkbox"/> Shallow	<input type="checkbox"/> Rales	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Generalized	
<input type="checkbox"/> Deep		<input type="checkbox"/> Mottled	<input type="checkbox"/> Comatose		
<input type="checkbox"/> Use of accessory muscles		<input type="checkbox"/> Diaphoretic			

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IN ALL CASES OF ALLERGIC REACTION/ANAPHYLACTIC EMERGENCY:

Refer to Medical Provider if: Acute Emergency

Anticipate medical providers need for the following: Intubation/airway management, IV access .9% normal saline, Epinephrine 1:1000 SC, CPR, Notify emergency department

Emergency department notification time: _____ Transport time: _____

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

Assessment:

Alteration in comfort related to allergic reaction/anaphylactic reaction

Plan:

Nursing Intervention Routine:

Give Benadryl 50 mg p.o. or IM as soon as possible (this will require an order from the medical provider)

Provide IV access (if clinically indicated) (this will require an order from the medical provider)

Encourage increase fluids

Re-evaluate frequently for at least the next 4 hours

Record ER assessment/treatment, copy and send to emergency department with patient

VS every 5 –10 minutes until transported:

Time: _____ BP _____ Pulse: _____ Resp: _____ Temp: _____ O₂ Sats: _____

Time: _____ BP _____ Pulse: _____ Resp: _____ Temp: _____ O₂ Sats: _____

Time: _____ BP _____ Pulse: _____ Resp: _____ Temp: _____ O₂ Sats: _____

Progress Note: _____

Offender Education:

Instructed on treatment provided, patient to wear allergy bracelet, 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)

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