

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
DENTAL - TOOTHACHE

MSRM 140117.01.46
(R-6/11)

Subjective Data:

Allergies: _____

Chief complaint: _____

Location of tooth: _____

Onset: _____ New Onset Constant Intermittent

Associated symptoms:

Jaw pain Earache Sore throat Sinus

Pain: scale: (0-10) _____

Contributing Factors Related to Pain:

Eating Drinking Chewing Hot Cold Air

Objective Data: (clinically indicated VS)

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

Visual evidence of tooth decay:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Redness surrounding affected tooth:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Swelling surrounding affected tooth:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Visual evidence of external swelling:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Pus surrounding affected tooth:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Evidence of trauma / injury to jaw:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Tooth positive to percussion:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Appearance:	<input type="checkbox"/> No distress <input type="checkbox"/> Mild distress <input type="checkbox"/> Moderate distress <input type="checkbox"/> Severe distress	

NOTIFY DENTIST/RN IMMEDIATELY IF:

- Signs of infection (swollen gums and jaw, severe redness, isolated pain)
- Post extraction profuse bleeding the second day post extraction site pain
- Severe tooth pain that is not relieved by Ibuprofen or acetaminophen
- Accidents with painful / fractured teeth, bleeding, or if offender cannot close mouth

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

Assessment:

- Alteration in comfort related to tooth pain

Plan:

Nursing Intervention Routine:

- Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4days

OR

- Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days
- Send request with documentation of assessment to Dentist

Progress Note: _____

Offender Education:

- Instructed on proper oral hygiene care, 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)

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