

CONTUSIONS

Subjective Data:

Allergies: _____

Chief complaint: _____

Location: _____ Size: _____

Pain Scale: (0-10) _____

Objective Data: (clinically indicated VS)

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

Offender on anticoagulants (warfarin, aspirin, heparin etc.) Yes No

Contusion	<input type="checkbox"/> Deformity	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Swelling
Pulse (distal)	<input type="checkbox"/> Able to palpate	<input type="checkbox"/> Unable to palpate	
Neurological	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	
Movement	<input type="checkbox"/> No limitation in movement	<input type="checkbox"/> Limitation in movement (describe) _____	
Appearance:	<input type="checkbox"/> No distress	<input type="checkbox"/> Mild distress	<input type="checkbox"/> Moderate distress <input type="checkbox"/> Severe distress

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/medication required)

NOTIFY MEDICAL PROVIDER IMMEDIATELY IF:

- Deformity is present
- Impaired neurological/vascular status
- Mechanism of injury suggesting hidden trauma

If head contusion follow Head Trauma Protocol - MSRM 140117.01.39

Refer to Medical Provider If:

- Marked swelling is present
- Condition not responding to intervention

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

Assessment:

- Alteration in skin integrity and comfort related to injury-contusion

Plan: Nursing Intervention Routine: (Check all that apply)

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
- Consider immobilization of injury with splint or ace wrap for no more than 3 days
- Apply ice to the affected area to reduce swelling 24 to 48 hours
- Consider crutches if lower extremity
- Medical lay-in/Restrictions
- Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days
- OR**
- Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days
- Education/Intervention: Instructed signs and symptoms to warrant further treatment (loss of sensation, increase swelling, decrease ROM, medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

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

Offender Name
(Last, First)

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