

HEMORRHOIDS

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ New Onset Chronic

History:

Last bowel movement: _____ Color/Consistency: _____

History of dietary habits: _____

History of fluid intake/restriction: _____

History of laxative use: Yes No Comments: _____

History of hemorrhoids: Yes No Comments: _____

History of anal sex: Yes No Comments: _____

History of bleeding: Yes No Comments: _____

Pain: Yes No Pain scale: (0-10) _____

Associated Symptoms:

- | | | | | |
|---------------------------------------|-----------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> None | <input type="checkbox"/> Small amount | <input type="checkbox"/> Moderate amount | <input type="checkbox"/> Large amount |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Itching | <input type="checkbox"/> Burning | <input type="checkbox"/> Straining with stool |

Objective Data: (clinically indicated VS)

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

Rectal area	<input type="checkbox"/> External protrusion	<input type="checkbox"/> No external protrusions	<input type="checkbox"/> Inflammation
	<input type="checkbox"/> Torn skin tissue	<input type="checkbox"/> Bleeding around anal area	<input type="checkbox"/> Edema
	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Purulent discharge	<input type="checkbox"/> Vesicles

(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:

- Significant rectal bleeding

Refer to Medical Provider If:

- | | |
|--|--|
| <input type="checkbox"/> Anal warts or fissure | <input type="checkbox"/> Patient is HIV positive |
| <input type="checkbox"/> No improvement after one week | <input type="checkbox"/> Suspected syphilis, gonorrhea or herpes |

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

Assessment:

- Alteration in elimination related to hemorrhoids

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.
- Hemorrhoidal suppositories rectally 3 times a day for 4 days, especially in the morning and at night after bowel movement

OR

- Hemorrhoidal ointment 3 times a day for 4 days, especially in the morning and at night after bowel movement
- Psyllium (i.e. Fiber Tabs) 2 tablets each evening for 30 days with 8 oz of water
- Hydrocortisone cream 1% 3 times a day for 3 days, especially in the morning and at night after bowel movement for symptomatic relief of itching to affected area.
- Education/Intervention: Instructed to exercise, increase water intake to 8 glasses daily/fibrous foods, avoid straining when passing stool, limit prolonged sitting or standing, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

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

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

Name
(Last, First)

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