

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			

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

Assessment:

Alteration in comfort related to allergic reaction/anaphylactic reaction

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.
- 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: _____
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Education/Intervention: Instructed on treatment provided, patient to wear allergy bracelet, 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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