

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
DENTAL - TOOTHACHE

MSRM 140117.01.46
(R-12/15)

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

Assessment:

- Alteration in comfort related to tooth pain

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

- Check in assessment only for provider visit.
 Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
 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
 Education/Intervention: Instructed on proper oral hygiene care, 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)

DOC #