California Correctional Health Care Services

Institution: _____

Encounter Form: Earache

Name:_____ CDC#_____ DOB_____ Date/Time _____

Fill in the blanks and check all that apply

SUBJECTIVE:

Chief Complaint: _____

Date and time of onset:_____

Ear Involved: ❑ Right ❑ Left ❑ Both

Pain: Scale of 0-10 (0=no pain 10=worst pain) _____

Area of pain: _____

Quality of pain: _____

What makes it better? _____

What makes it worse? _____

Accompanying Symptoms:

❑ Itching ❑ Decreased hearing ❑ Drainage (describe)

_____

History of: ❑ Recent URI ❑ Chills/fever

❑ Chronic ear problems

Chronic illnesses: _____

Allergies: _____

Current medications: _____

_____

OBJECTIVE:

VS: Temp_____ Pulse_____ Resp____ B/P_____

	Right Ear	Left Ear
External ear and meatus:	❑ Normal ❑ Redness ❑ Swelling ❑ Cerumen ❑ Foreign body ❑ Tenderness	❑ Normal ❑ Redness ❑ Swelling ❑ Cerumen ❑ Foreign body ❑ Tenderness
Drainage	❑ None ❑ Bloody ❑ Purulent ❑ Serous	❑ None ❑ Bloody ❑ Purulent ❑ Serous
Tympanic Membrane	❑ Intact ❑ Pearly gray ❑ Dull ❑ Red ❑ Bulging ❑ Retracted ❑ Obscured ❑ Fluid	❑ Intact ❑ Pearly gray ❑ Dull ❑ Red ❑ Bulging ❑ Retracted ❑ Obscured ❑ Fluid

Adenopathy: ❑ yes ❑ no

Mastoid pain: ❑ yes ❑ no

Hearing Acuity	❑ Normal ❑ Reduced ❑ Absent	❑ Normal ❑ Reduced ❑ Absent

ASSESSMENT:

❑ Pain as evidenced by/related to:

_____

_____

❑ Alteration in sensory/perception, auditory, as evidenced by/related to:_____

PLAN:

❑ If inspection of the ear canal reveals retracted tympanic membrane and/or fluid behind the tympanic membrane refer patient to physician **STAT**.

❑ If the patient presents with a temperature $\geq$ 101.5 F and/or bulging tympanic membrane, refer to a physician **STAT**.

❑ If inspection of the ear canal reveals a bulging or newly perforated tympanic membrane, or purulent drainage refer patient to physician **STAT**.

❑ If the patient complains of severe ear pain and hearing loss, refer the patient to a physician **STAT.**

❑ If the patient is diabetic with purulent ear drainage, refer the patient to a physician **STAT.**

For ear pain without fever or with fever less than 101.5:

❑ Apply warm compresses to ear PRN.

❑ Acetaminophen 325mg 2 tabs PO Q4-6 hours PRN pain while symptoms persist; not to exceed 12 tabs in 24 hours. **or**

❑ Ibuprofen 200mg 1-2 tabs PO Q4-6hrs PRN pain while symptoms persist; not to exceed 6 tabs in 24 hrs

❑ Chlorpheniramine 4mg 1 tab PO Q4-6 hours PRN nasal congestion while symptoms persist; not to exceed 24mg/day x 3 days

❑ Instruct patient to follow-up in RN clinic in 48 hours if symptoms persist.

Cerumen impaction:

❑ Administer Carbamide Peroxide 6.5% Otic Solution: instill 5 to 10 drops into external ear canal, then insert a cotton plug x 30 minutes.

❑ Using an otic syringe, gently flush the ear with lukewarm water and hydrogen peroxide mixture.

❑ Follow-up with RN in 48 hours. If impaction is not fully removed and symptoms persist, repeat the procedure.

_____

Signature / Title

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Fill in the blanks and check all that apply

Additional comments:_____

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DISPOSITION

Time released: _____

Condition on release: _____

- ❑ Returned to housing unit
- ❑ Housing reassignment to: _____
- ❑ Referred for clinic follow-up: ❑ Physician ❑ RN
- ❑ Referred to higher level of care: (specify)

_____

Person/time contacted: _____

Time/Mode of transfer: _____

ERV contacted (time)

_____

ERV arrived (time)

_____

List name(s) of RN Protocols used: _____

_____

Signature / Title

EDUCATION:

- ❑ Assess patient's potential for understanding the health information to be provided.
- ❑ Provide patient education consistent with the assessment of the condition.
- ❑ Evaluate the patient's level of understanding and document all patient education on the encounter form or a progress note.
- ❑ Refer patient to other resources as needed.
- ❑ Document referrals in the patient's unit health record.
- ❑ Advise the patient to resubmit a Health Care Request Form (CDCR 7362) if symptoms persist.

Patient instructed in:

- ❑ Use of medication ❑ Avoid putting anything in ears
- ❑ Resubmit a Health Care Service Request Form (CDC 7362) if there is a change in hearing acuity; or _____

1. Disability Code:	2. Accommodation:	3. Effective Communication:
☐ TABE score ≤ 4.0	☐ Additional time	☐ P/I asked questions
☐ DPH ☐ DPV ☐ LD	☐ Equipment ☐ SLI	☐ P/I summed information
☐ DPS ☐ DNH	☐ Louder ☐ Slower	**Please check one:**
☐ DNS ☐ DDP	☐ Basic ☐ Transcribe	☐ Not reached* ☐ Reached
☐ Not Applicable	☐ Other*	*See chrono/notes

4. Comments: _____