OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

MSRM 140117.01.2.7
(R 2/20)

DANDRUFF

Subjective Data: **Allergies:** _____

Chief complaint: _____

_____

Onset:_____ ❑ New Onset ❑ Recurrence ❑ Constant

Current treatment/medications:

Previously treated by health care provider:	❑ Yes	❑ No	
Over the counter medication	❑ Yes	❑ No	Describe:_____
Prescription medication	❑ Yes	❑ No	Describe:_____

Associated Symptoms:

❑ Itching ❑ Flaking ❑ Patchy hair loss

Objective Data: (clinically indicated VS)

BP _____Pulse _____ Resp. _____ Temp. _____ Wt._____O_2 sats._____ FSBS: _____

Degree of flaking	❑ Minimal	❑ Mild	❑ Extensive			
Scalp	❑ Normal	❑ Redness	❑ Swelling			
Lesions	❑ None	❑ Flat	❑ Raised	❑ Weeping	❑ Scabbing	❑ Ulceration
Associated irritation	❑ None	❑ Ears	❑ Shoulders	❑ Neck	❑ Face	

REFER TO HEALTH CARE PROVIDER IF: *If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

❑ Ulceration, lesions, scabbing
❑ Signs of infection
❑ Previous treatment by health care provider
❑ Unresponsive to above treatment

Health Care Provider: _____ **Time Notified:** _____ **Orders Received for Treatment:** ❑ Yes ❑ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

❑ Check in assessment only for health care providers visit.
❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
❑ Selenium Sulfide 1% (dandruff shampoo) 3 times per week for 30 days PRN or till bottle is empty.
❑ Education/Intervention: Instructed to keep hands away from face/area, use own towels and linens, decrease frequency of shampooing and rinse well, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

_____

_____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

Inmate Name
(Last, First)

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