OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

MSRM 140117.01.7.3
(R-4/19)

GENITAL DISCHARGE - MALE

Subjective Data: **Allergies:** _____

Chief complaint: _____

Onset:_____ ❑ Chronic ❑ Recurrence

History:

Sexually transmitted disease: ❑ None ❑ Gonorrhea ❑ Syphilis ❑ Herpes ❑ Chlamydia ❑ Venereal warts

Antibiotic therapy: When: _____ Name of medication: _____

Last sexual intercourse: _____

Associated Symptoms:

❑ Burning / painful urination	❑ Frequency	❑ Urgency	❑ Dribbling	❑ Inability to void
❑ Foul odor to urine	❑ Back pain	❑ Abdominal pain	❑ Painful ejaculation	

Objective Data: (clinically indicated VS)

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

Genitalia	Skin	Urine	Mouth
❑ Normal	❑ Rash	❑ Clear	❑ Ulcers
❑ Ulcers	❑ Other lesions	❑ Cloudy	❑ Purulent tonsils
❑ Warts/skin tags		❑ Dark	❑ Exudate
❑ Clear discharge		❑ Foul odor	

CONTACT HEALTH CARE PROVIDER/RN IMMEDIATELY IF: *Health care provider must be called if not on site or if after clinic hours.*

❑ Temp > 101

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.*

❑ Any discharge or genital lesions are present

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

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.
❑ Clean catch urine specimen.
❑ Prepare for urethral culture if discharge present and ordered by health care provider.
❑ Education/Intervention: Instructed to protect scrotal or groin area, avoid strenuous physical activity, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

_____

_____

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

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

Inmate Name
(Last, First)

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