Allergic Reaction/Anaphylactic Emergency

Subjective Data: **Allergies:** _____

Chief complaint: _____

_____

Type of reaction:

❑ Itching	❑ Feelings of weakness	❑ Difficulty breathing
❑ Skin redness (rash/hives)	❑ Shortness of breath	❑ Difficulty swallowing
❑ Known allergen exposure	Describe:_____	

Current medication(s): _____

Objective Data: (clinically indicated VS)

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

Respiration	Lung Sounds	Skin	LOC	Swelling	Appearance
❑ Even	❑ Clear	❑ Warm	❑ Awake	❑ Tongue	❑ No distress
❑ Uneven	❑ Rhonchi	❑ Pink	❑ Alert	❑ Throat	❑ Mild distress
❑ Labored	❑ Wheezes	❑ Cool	❑ Oriented X___	❑ Facial	❑ Moderate distress
❑ Unlabored	❑ Diminished	❑ Pale	❑ Confused	❑ Extremities	❑ Severe distress
❑ Shallow	❑ Rales	❑ Cyanotic	❑ Lethargic	❑ Generalized	
❑ Deep		❑ Mottled	❑ Comatose		
❑ Use of accessory muscles		❑ Diaphoretic			

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IN ALL CASES OF ALLERGIC REACTION/ANAPHYLACTIC EMERGENCY: *Health care provider must be called if not on site or if after clinic hours.*

Anticipate health care 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:** _____ **Transported by:** _____
Health Care Provider: _____ **Time Notified:** _____ **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.
- ❑ Give Benadryl 50 mg p.o. or IM as soon as possible **(this will require an order from the health care provider)**
- ❑ Provide IV access (if clinically indicated) **(this will require an order from the health care 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: _____ O_2 Sats: _____
Time: _____ BP _____ Pulse: _____ Resp: _____ Temp: _____ O_2 Sats: _____
Time: _____ BP _____ Pulse: _____ Resp: _____ Temp: _____ O_2 Sats: _____

❑ Education/Intervention: Instructed on treatment provided, patient to wear allergy bracelet, 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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