

Institution: _____

Encounter Form: Hemorrhoids

Name: _____ CDCR# _____ DOB _____ Date/Time _____

Fill in the blanks and check all that apply

SUBJECTIVE:

Chief Complaint: _____

Date and time of onset: _____

Describe symptoms: Itching Burning
 Bleeding Irritation

Pain: Location: _____

What makes the pain better: _____

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

Prior history of: Hemorrhoids Constipation
 Diarrhea GI illness (including liver disease)
 Anal sex or instrumentation Other _____

Chronic illness: _____

Allergies: _____

Current medications: _____

OBJECTIVE:

VS: BP _____ Temp: _____ Pulse: _____ Resp. _____

Visual inspection of anal area reveals:
 Trauma Rash Papules Redness
 Edema Skin Tags Hemorrhoids Warts
 Abscess Fissures Fistula Bleeding
 Drainage Open wounds/lesions

ASSESSMENT:

Impaired tissue integrity evidenced by/related to: _____

Pain evidenced by/related to: _____

PLAN:

MD referral completed: (circle) NO / YES If yes: _____

STAT (moderate to severe pain, discharge, bleeding, abscess, open lesions, condylomata, evidence of trauma, or history of anal sex or instrumentation)

Urgent Routine

Orders received by phone from Physician-On-Call.

Physician called (name / time) _____

Physician responded (time) _____

RECTAL ITCHING/erythema and/or mild discomfort with or without hemorrhoids or open lesions:

Sitz bath 20 min. TID PRN pain/itching while symptoms persist.

Warm compresses to area QID PRN pain/itching while symptoms persist.

Hydrocortisone Cream 1%: apply to affected area no more than 3-4 times/day while symptoms persist.

External hemorrhoids accompanied by mild bleeding with bowel movements:

Warm compress to area QID PRN while symptoms persist.

Phenylephrine 0.25% suppository PRN per rectum itching/burning/pain after each bowel movement while symptoms persist; not to exceed 4 times/day.

Sitz bath 20 min. TID while symptoms persist.

Docusate Sodium 100mg 1-3 softgels PO QD x 14 days and while hemorrhoids persist.

Calcium Polycarbophil 625 mg PO QD x 30 days and while symptoms persist.

All other symptoms: Refer patient to a physician on a STAT, Urgent, or Routine basis as appropriate.

EDUCATION:

Assess the patient's potential for understanding the health information to be provided.

Provide patient education consistent with the assessment of the condition.

Document the education provided and the patient's level of understanding in the health record.

Refer the patient to other resources as needed. Document all referrals in the health record.

Advise the patient to resubmit a CDC 7362, Health Care Request Form, if symptoms persist.

Signature / Title

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DISPOSITION

Time released: _____

Condition on release: _____

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

Person/time contacted: _____

Time/Mode of transfer: _____

ERV contacted (time) _____

ERV arrived (time) _____

Additional Comments: _____

Signature / Title

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