California Correctional Health Care Services

Encounter Form: Respiratory Distress

Institution: _____

Name:_____ CDC#_____ DOB_____ Date/Time _____

Fill in the blanks and check all that apply

SUBJECTIVE:

Chief Complaint: _____
Date and time of onset: _____
Activity at time of onset _____
Pain: Scale of 0-10 (0=no pain 10=worst pain) _____
Area of pain: _____
Is SOB accompanied by chest pain ❑ yes ❑ no
Symptoms: ❑ SOB ❑ wheezing
❑ air hunger ❑ dyspnea

Recent exposure to ❑ dust ❑ fumes ❑ chemicals
❑ Other _____
Allergies: _____
Hx. of recent respiratory infection ❑ yes ❑ no
History of ❑ asthma ❑ COPD ❑ bronchitis
❑ tuberculosis ❑ heart disease
❑ Other chronic diseases: _____
_____
Smoker ❑ yes ❑ no
Current medications: _____
_____

OBJECTIVE:

❑ Airway, breathing and circulation present.
❑ Awake, alert, oriented to person, place, time

Time	BP	Pulse	Resp.	O2 Sat.	Peak flow

General appearance:
- ❑ SOB
- ❑ Dyspnea
- ❑ Cyanosis
- ❑ Tachypnea
- ❑ Too breathless to speak in sentences
- ❑ Stridor
- ❑ Nasal flaring
- ❑ Signs of choking
- ❑ Use of accessory muscles
- ❑ Restlessness
- ❑ Pallor
- ❑ Diaphoresis
- ❑ Other: _____
- ❑ Jugular venous distention
- ❑ Tracheal deviation

Lungs Sounds

Upper Right	Upper Left
❑ Clear	❑ Clear
❑ Wheezes	❑ Wheezes
❑ Crackles	❑ Crackles
❑ Diminished	❑ Diminished
Lower Right	**Lower Left**
❑ Clear	❑ Clear
❑ Wheezes	❑ Wheezes
❑ Crackles	❑ Crackles
❑ Diminished	❑ Diminished

Heart sounds: ❑ Regular ❑ Irregular

ASSESSMENT:

❑ Impaired gas exchange related to/ evidenced by: ____
_____
❑ Ineffective breathing pattern related to /evidenced by:
_____
❑ Inability to sustain spontaneous ventilation related to / evidenced by: _____

PLAN:

❑ **STAT** referral to physician (for severe bronchospasm)
Physician (name/time): _____
Physician Responded (time):_____
❑ Orders received by phone from POC
❑ Airway, breathing and circulation maintained
❑ Place on pulse oximeter
❑ O2 given via ❑ cannula ❑ rebreather mask
O_2 at 2-6 L/minute via nasal cannula or 15L/ minute via mask to maintain oxygen saturation ≥ 90%.
❑ IV started Sodium Chloride Intravenous Solution (0.9%) at(time)_____ in (location) _____ with(needle) _____ to run at_____
❑ Monitor cardiac rate and rhythm with EKG machine or cardiac monitor
❑ Monitor vital signs, level of consciousness, and pulse oximeter readings every five minutes until transferred to outside facility.
❑ Prepare to transfer to outside facility or admit to a facility capable of providing a higher level of care.
❑ Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to receiving facility

_____
Signature / Title

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EDUCATION:

- ❑ Assess 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 on the emergency care flow sheet.
- ❑ Refer patient to other resources as needed. Document all referrals on the emergency care flow sheet.
- ❑ Advise patient to utilize urgent/emergent process to access medical care if symptoms recur

DISPOSITION

Time released: ______________________________

❑ Condition on release: ______________________

❑ Referred for follow-up

❑ Physician clinic ❑ RN clinic

Referred to higher level of care: (specify) ______________

Watch Commander notified ____________________

Transport team arrived ______________________

❑ Records faxed to facility

Ambulance contacted (time)______________________

Ambulance arrived (time) ______________________

Time/Mode of transfer: ______________________

Additional Comments:

Name of RN protocol(s) used:_____________________

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Signature / Title

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: ____