MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
DIRECTORATE OF MEDICAL SERVICES PATIENT FORMS	NAVHOSPPNCLAINST 5213.6B	01 Oct 2015

LOCAL FORM TITLE *(Optional)*
ACUTE UNCOMPLICATED DYSURIA OR URGENCY IN WOMEN

Date: _____ Time: _____

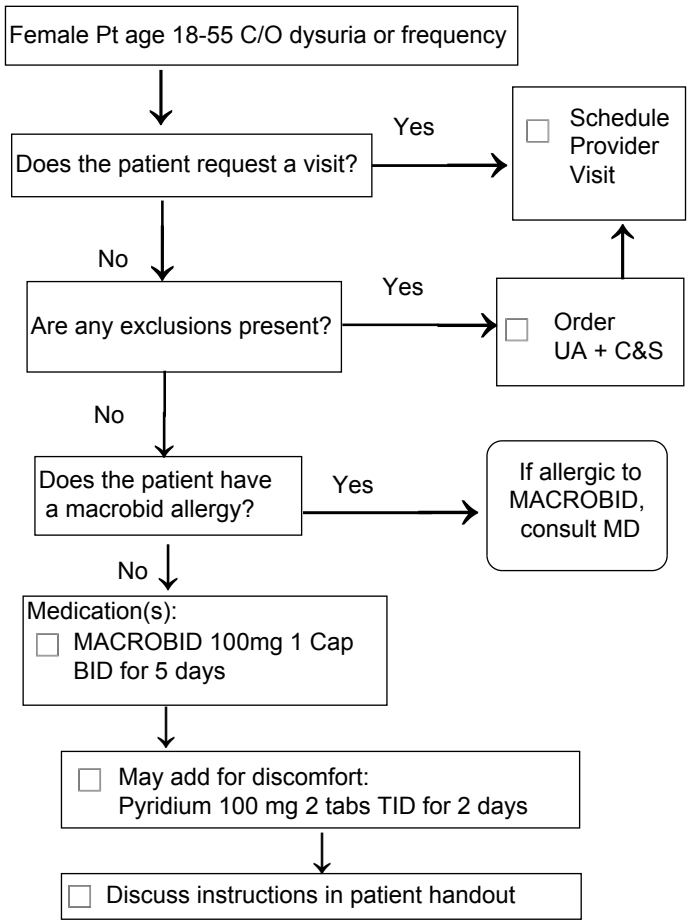
Chief Complaint: _____

Current Medications: _____

Medication Allergies: _____

EXCLUSIONS

	Yes	No
1. Fever, documented (>100.4ºF or 38ºC)	☐	☐
2. Nausea, vomiting, abdominal pain Slight tenderness over bladder area is not an exclusion)	☐	☐
3. Known pregnancy or think you might be pregnant	☐	☐
4. Immunocompromised (receiving immunosupressive medication or has condition)	☐	☐
5. Symptoms > 7 days	☐	☐
6. Symptoms of vaginitis (vaginal discharge, vaginal irritation)	☐	☐
7. Recent or persistent urinary stone disease	☐	☐
8. Chronic renal or urologic abnormalities other than stress incontinence	☐	☐
9. Gross hematuria in women > 50 years old	☐	☐
10. Been treated for UTI within last 2 weeks or 2 or more in last 12 months	☐	☐
11. Had a catheterization or other urologic procedure in last 3 months	☐	☐
12. Been discharged from the hospital or nursing home in last 3 months	☐	☐
13. Diabetics with last A1C > 9	☐	☐



If exclusions present, appointment Date: _____

Time: _____

RN Printed Name _____ RN Signature _____ Date / Time _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	