



## TABLE OF CONTENTS

### **SITE ORIENTATION**

Map of Office  
Location of Fire Extinguishers  
Location of Flush Lights  
Location of Manuals  
Tornado Safe Areas  
Emergency Codes  
Directory of On-Site Phone Extensions  
Fan Out  
Location of Inventory  
Sample of Policy and Procedure Manual Table of Contents

### **CUSTOMER SERVICE**

Telephone Etiquette  
Voicemail  
Patient Messages  
Triaging Phone Calls  
Phoning in Prescriptions  
Patient Call-Backs

### **CONFIDENTIALITY**

Confidentiality Overview  
Telephone Messages  
Confidential Communications  
Valid Authorizations

### **SUPPORT SERVICES**

Comment Codes  
Referral/Consultation Request Forms  
Use of Office Equipment  
Telephone, Copier, Fax  
Computer Application

## **PATIENT CARE ASSESSMENT**

Responding to Life-Threatening Emergencies

### **PATIENT CARE**

Rooming Patients

Clinical Forms:

- Growth Chart Examples
- T-Chart Table of Contents
- T-Chart Examples
- Medication List
- Medication List Tracking Format
- Advance Directive Form
- Progress Notes
- ABN
- Pain Management Agreement
- Consent for Office Procedure
- Auto/Worker's Compensation
- Pre-Op Clearance Consultation Form
- Refusal to Consent to Treatment/Transport
- "Welcome to Medicare" Exam
- Sports Physical
- Router
- Diabetic Management
- Asthma Management
- Chronic Disease

Documentation in the Medical Record

Do Not Use List

Vital Signs

Patient Measurements

Injections

- Intramuscular
- Subcutaneous
- Intradermal
- Injection Documentation
- Avoiding Dangers of Incorrect Injecting Technique
- Dangers of Incorrect Injecting Technique
- Seven "Rights" of Dispensing Medication

Vaccines

- Medication Administration
- Immunization Schedules
- Vaccine Administration Record – Adult
- Vaccine Administration Record – Children
- Refrigerator/Freezer Log
- Immunization Waiver

Flu Consent Form  
Flu VIS  
CLIA Waived Testing/Lab Procedures  
Waived Diagnostic Test Policy  
Procedures and Set-Up  
Nebulizer Treatments  
Pulse-Ox  
Pulmonary Function Testing  
Arthrocentesis  
Cryosurgery  
Cyst Removal  
Incision and Drainage  
Ingrown Toenail Remval  
Laceration Repair  
Mole/Skin Tag Removal  
Pap/Pelvic Exam  
Rectal Exam/Hemoccult  
Suture/Staple Removal  
EKG  
Eye Tray/Wash Station  
Hearing Tests  
Tympanogram  
Visual Acuity  
Sports Physical

**OB/GYN**

Procedures and Set-Up  
Fetal Heart Tones  
Ultrasound GYN Exam  
Ultrasound OB Exam  
Amniocentesis  
Fetal Non-Stress Test  
Colposcopy  
Cryosurgery  
Endometrial Biopsy  
LEEP

Forms

GYN History and Examination  
Colposcopy Report

**MISCELANEOUS**

Biohazard  
O2 Tank Care  
Nasal Cannula and Mask

Infection Control

Other Control Logs

Spore Check Log for Autoclave

Ok Sterilization Strips Record

Sample Medications

Who to Call For Assistance

Miscellaneous Help Sheet

Most Frequently Misspelled Words

Most Commonly Misspelled Medication List

ISMP's List of Confused Drug Names

ISMP's List of Error Prone Abbreviations, Symbols and Doses

Medical Math Study Guide

Accreditation Preparedness

**REMEMBER!!!**

**Always ask when you are not sure. There is NEVER a stupid question.**



**MEDICAL GROUP**

**MEDICAL ASSISTANT REFERENCE**

**Acknowledgement Form**

**Name (please print):** \_\_\_\_\_  
Last First Middle Initial

**Name of Office:** \_\_\_\_\_

**I have been in-serviced on the Medical Assistant Reference and  
received my personal copy of the reference.**

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**In-Serviced By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Site Orientation**

Map of Office – Attach Here

## Location of Fire Extinguishers

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

## Location of Flash Lights

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_
13. \_\_\_\_\_
14. \_\_\_\_\_
15. \_\_\_\_\_





**Tornado Safe Areas  
Attach Map Here**

## MMG EMERGENCY CODES

CODE NAME	EVENT
<b>CODE RED</b>	FIRE
<b>CODE BLUE</b>	CARDIAC ARREST - ADULT
<b>CODE WHITE</b>	CARDIAC ARREST - CHILD
<b>CODE LITTLE BLUE</b>	RESPIRATORY/CARDIAC ARREST – INFANT
<b>CODE WEATHER (WATCH/WARNING)</b>	SEVERE WEATHER
<b>CODE PINK</b>	INFANT ABDUCTION
<b>CODE PURPLE</b>	CHILD ABDUCTION
<b>CODE SILVER</b>	HOSTAGE SITUATION
<b>CODE YELLOW</b>	BOMB THREAT
<b>CODE ORANGE (INTERNAL/EXTERNAL)</b>	HAZARDOUS MATERIAL INCIDENT
<b>CODE TRIAGE ALERT</b>	EMERGENCY/DISASTER ALERT
<b>CODE TRIAGE (INTERNAL/EXTERNAL)</b>	DISASTER INCIDENT
<b>CODE GRAY</b>	VIOLENT/COMBATIVE INDIVIDUAL

For Emergencies call . . . 9-1-1

## **Directory of On-Site Phone Extensions**

## Fan-Out



## **Sample of Policy and Procedure Table of Contents Most Applicable to MA's**

### 1000 – ETHICS/RIGHTS/RESPONSIBILITIES

- 1005 – Adult Abuse/Neglect
- 1010 – Child Abuse/Neglect
- 1015 – Advance Directives
- 1030 – Discharging Patient from Physician/Office/Network
- 1031 – Management of No-Shows

### 3000 – CLINICAL

- 3001 – Treatment Interventions Not Applicable to MMG
- 3205 – Poison Control
- 3220 – Reportable Diseases
- 3305 – Responding to Life-Threatening Emergencies
- 3310 – Management of Patients “Dead on Arrival” / Unexpected Deaths
- 3315 – Care of a Severed Extremity
- 3320 – Sexual Assault
- 3325 – Patient Care Assessment
- 3330 – Care Planning
- 3335 – Animal Bites
- 3340 – Pain Management
- 3345 – Medication/Product Recall
- 3355 – Pre-Operative Verification
- 3360 – Potassium Sensitivity Testing
- 3405 – HIV Counseling and Testing
- 3410 – Patient Notification of Abnormal Test Results
- 3415 – Identification/Transport of Specimens
- 3420 – Waived Diagnostic Testing
- 3440 – Laboratory Techniques
- 3470 – Tracking Patient Test Results
- 3475 – Provider Performed Microscopy
- 3485 – Exam of Urine Sediment – Microscopy
- 3490 – Wet Prep and Wet Prep with KOH
- 3500 – Skin/Nail Potassium Hydroxide (KOH) Prep
- 3520 – Verbal Orders

### 4000 – MEDICATION

- 4100 – Medication and Vaccine Storage
- 4105 – Allergy Injections
- 4110 – Immunizations
- 4115 – Medication Administration
- 4120 – Controlled Substance Procurement

- 4125 – Medication Samples
- 4130 – Dispensing of Pre-Packaged Medications
- 4150 – Prescription Security
- 4160 – TB Skin Testing

5000 – INFECTION CONTROL

- 5100 – Laundry Processing
- 5105 – Management of Lice
- 5110 – Shelf Life for Disposable Supplies
- 5115 – Sterilization
- 5120 – Thermometers
- 5130 – Standard (Universal) Precautions
- 5135 – Isolation
- 5140 – Management of Scabies
- 5145 – Latex Sensitivities/Allergies (Related to Patients)

6000 – MEDICAL RECORDS/HIPAA

- 6100 – Designation of a Privacy Officer
- 6105 – Valid Authorizations
- 6110 – Identifying Protected Health Information (PHI)
- 6115 – De-Identifying PHI
- 6120 – Use and Disclosure of Minimum Necessary PHI
- 6125 – Amendments to PHI
- 6130 – Providing Notice of Privacy Practices
- 6140 – Patients' Rights to Access PHI
- 6145 – Requests for Restrictions
- 6150 – Accounting of Disclosures
- 6155 – Employee General Awareness Training of Privacy/Security of Health Information
- 6160 – Business Associate Relationships
- 6165 – Uses & Disclosures of PHI for Marketing
- 6185 – Technology Resources
- 6220 – Management of Clinical Records
- 6230 – Documentation in Clinical Records
- 6295 – Purging/Retention of Medical Records
- 6300 – Consent for Treatment
- 6310 – Completion of Clinical Record Documentation
- 6315 – Updating Patient Information
- 6320 – Transfer of Clinical Information
- 6325 – Master Patient Index
- 6335 – Dictation/Transcription of Reports
- 6340 – Forms Approval/Usage
- 6365 – Charges for Depositions and Various Paperwork
- 6370 – Social Security Number Privacy/Use
- 6375 – Allscripts Downtime

## BLUE MANUAL – LIFE/SAFETY MANAGEMENT

- 7100 – Security
- 7105 – Hazardous Materials and Waste Management Plan
- 7110 – Infectious Waste Management Plan
- 7120 – Utility Management Plan
- 7125 – Medical Equipment Management Plan
- 7130 – Emergency Preparedness Management Plan
- 7135 – Safety Plan
- 7140 – Life Safety Management Plan
- 7145 – Suspicious Packages

## RED MANUAL – EMERGENCY PREPAREDNESS

- 7300 – Disaster Plan/Corporate
- 7305 – External Disaster
- 7306 – Safe Water Management
- 7310 – Severe Weather
- 7315 – Tornado Instructions
- 7400 – Fire Plan
- 7410 – Alarm Systems
- 7501 – Emergency Codes
- 7510 – Ambulance Transfer of Patients to Hospital
- 7600 – Bomb Threat
- 7700 – Evacuation Policy
- 7905 – Pandemic Influenza Plan
- 7320 – National Incident Management System

## 8000 – HUMAN RESOURCES/EMPLOYEE HEALTH

- 8120 – Employee Communicable Diseases
- 8130 – Occupational Health Services
- 8150 – Student Trainees/Educational Observers

## 9000 – PERFORMANCE IMPROVEMENT PLAN AND PROCEDURES

- 9100 – Performance Improvement Plan
- 9200 – Procedures for Site Review
- 9220 – Sampling Case Methodology
- 9230 – Peer Review Process
- 9300 – Clinical Documentation Guidelines
- 9310 – Pediatric Immunizations
- 9320 – Adolescent Immunization Monitor
- 9330 – CHF Monitor
- 9340 – Diabetes Mellitus Monitor
- 9350 – Asthma
- 9360 – Pediatric Preventative Monitor
- 9370 – Adult Preventative



- 9380 – Colorectal Screenings/Abnormal
- 9390 – Cervical Cancer Screenings/Abnormal
- 9400 – Abnormal Breast Screenings/Follow-Up
- 9140 – Prenatal Care Standards
- 9420 – Patient Education
- 9430 – Convenient Care Medical Records
- 9440 – Occupational Musculoskeletal/Injury
- 9770 – Patient Satisfaction Survey Complaints
- 9800 – Reporting Patient Safety Occurrences and Serious Occurrence Process

# **Telephone Etiquette**

## **Voicemail**

- Should be checked at least twice daily to ensure timely response to messages.

## **Patient Messages**

- Use the appropriate phone message sheet (in forms manual.)
- Take patients' name, date of birth, phone number, pharmacy phone number, and all information the patient gives you in the message for the provider.
- Inform the patient when they should expect a return call.
- Pull the patients' chart and attach the message on the front.
- Put the chart in the appropriate place for the provider to answer.

## **Triaging Phone Calls**

- Calls will be relayed to clinical staff immediately if the receptionist has any question regarding the severity of the issue. All messages of an urgent nature are given directly to the provider.

## **Phoning in Prescriptions**

- You must have a signed approval from the provider.
- You must have the provider's name, address, phone number and NPI number before calling the pharmacy.
- Give the pharmacist all the information for the prescriptions (patient name, drug, quantity, dosage and refills.)
- The pharmacist will let you know if they have any questions.
- Document in the patient's medical record in all applicable places.
- Call the patient to inform them that their prescription has been called in to the pharmacy.

### **Patient Call Backs**

- Read the message to verify that you understand the call back BEFORE you call the patient.
- Call the patient. You must verify the patient (first and last name) and date of birth or last 4 digits of their social security number if available. If the patient is not available, only leave a message if the person to whom you are speaking is listed on the Confidential Communications form.
- Give them the response to their original question.
- Ask them if they understand the answer, or if they have any further questions.
- If more questions are asked, you must fill out a new message request.
- If no other questions are asked you may document all information in the patient record and file the chart.
- Call back messages should be checked periodically throughout the day to ensure a quick response to our patients.

# Confidentiality

## Confidentiality Overview

Every American enjoys a fundamental right to privacy. Confidentiality and privacy are terms often used interchangeably in reference to medical data. Privacy is the right to be left alone. Medical confidentiality is a special case of the right to privacy. Confidentiality simply means keeping a secret. We want to ensure that our patients have an environment where they can continue an open dialogue with their providers without fear that their intimate information will be revealed. This is crucial to patient care.

The **four ways** that patient confidentiality is most often violated are through:

- Print or electronic patient-related information that is left exposed where visitors or unauthorized individuals can see it
- Discussions of patient information in a public place or with inappropriate, unauthorized individuals
- Unauthorized people hearing patient-sensitive information
- Records that are accessed for the wrong reasons or by inappropriate individuals

*You can help to prevent violations of patient confidentiality by keeping the following points in mind:*

**When dealing with written or computerized information, ask yourself, “Who is able to read this?”**

- Turn computer screens inward
- Keep printed material hidden
- Keep patient forms and records face down on desk
- Monitor the duplication and transmission of records on fax machines, photocopiers and printers
- When sending a confidential fax, call first to notify the recipient
- Never leave photocopiers unattended when duplicating confidential materials
- Always put unwanted copies of reports with protected health information in the confidential bins or shredder; **never put in regular trash**

**Every time you communicate medial information when the patient is not present, ask yourself, “To whom am I speaking?”**

- Ask in advance if you can confirm appointments and leave messages (Confidential Communications Form)
- Confirm appointment in a generic way; give no specific information
- Never leave details in a message
- Never give details to a third party

**When speaking about patients, ask yourself, “Who else can hear what I’m saying?”**

- Don’t announce full names or specific information
- Speak softly so that others do not accidentally overhear confidential or embarrassing information
- If you can, find a more private place to discuss patient information

**Whenever you access medical records, ask yourself, “How am I using these records?”**

- Do not reveal your password to anyone, and do not post your password near your computer
- When you don’t recognize staff members who request records, ask them for identification
- Never leave file rooms unlocked or unattended
- Never leave computer files open; they may provide access to unauthorized users

<b>Priority Status:</b> <input type="checkbox"/> Routine <input type="checkbox"/> STAT		<b>Medication Refill:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date/Time:	Physician:	Patient Name/Date of Birth:	
Caller's Name/Telephone:		Pharmacy Name/Telephone:	
Concern/Problem:			
Disposition/Instructions/Orders:			
Taken By:		Provider's Signature	

McLaren Ambulatory Care Center  
 McLaren Occupational Health and/or Convenient/Prompt Care Center

**TELEPHONE MESSAGE**

<b>Priority Status:</b> <input type="checkbox"/> Routine <input type="checkbox"/> STAT		<b>Medication Refill:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date/Time:	Physician:	Patient Name/Date of Birth:	
Caller's Name/Telephone:		Pharmacy Name/Telephone:	
Concern/Problem:			
Disposition/Instructions/Orders:			
Taken By:		Provider's Signature	


McLaren Ambulatory Care Center  
 McLaren Occupational Health and/or Convenient/Prompt Care Center

**TELEPHONE MESSAGE**

<b>Priority Status:</b> <input type="checkbox"/> Routine <input type="checkbox"/> STAT		<b>Medication Refill:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date/Time:	Physician:	Patient Name/Date of Birth:	
Caller's Name/Telephone:		Pharmacy Name/Telephone:	
Concern/Problem:			
Disposition/Instructions/Orders:			
Taken By:		Provider's Signature	

McLaren Ambulatory Care Center  
 McLaren Occupational Health and/or Convenient/Prompt Care Center

**TELEPHONE MESSAGE**

		<b>Policy Title:</b>	Confidential Communications
<b>Effective Date:</b>	4/14/03	<b>Policy Number:</b>	6135
<b>Review Date:</b>		<b>Category:</b>	Medical Records/HIPAA
<b>Revised Date:</b>	5/15/13	<b>Oversight Level:</b>	2
<b>Administrative Responsibility:</b>		Privacy Officer; MMG Compliance Committee	
<b>Interpretation:</b>		Privacy Officer	

### 1. Purpose

To ensure compliance with applicable law regarding confidential communications by McLaren Medical Group (MMG) and its physician practice sites.

### 2. Scope

MMG Workforce

### 3. Definitions

3.1. Covered entity - MMG as a health care provider.

3.2. Individual - person who is the subject of information.

3.3. Protected Health Information (PHI) - any information that is collected, transmitted, created and/or maintained in any form or medium (electronic, paper, or oral) by MMG.

3.3.1. PHI relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; and the past, present, or future payment for the provision of healthcare to an individual.

3.3.2. PHI includes, but is not limited to, diagnoses, diagnostic reports, procedures, progress notes, radiological films, medications, billing documents, physician or location (if such information leads one to know or infer a diagnosis, etc.)

3.3.3. PHI is any information that either identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual (encounter number, Social Security Number, address, picture, etc.).

3.4. Workforce - employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity. (Employees include physicians and allied health professionals.)

#### 4. Policy

4.1. MMG will accommodate reasonable requests by individuals to receive confidential communications of PHI from MMG by alternative means or at alternative locations. Furthermore, individuals will be allowed to authorize a) the use of answering machines for transmittal of messages and b) the sharing of PHI with other designated individuals.

#### 5. Procedure

5.1. Individual shall make the request for a confidential communication in writing.

5.2. Individual will not be required to give reason for request.

5.3. Applicable data will be entered into the billing system as a "CC" note:

5.3.1. alternative address and/or telephone number will be documented in full

5.3.2. "AM-OK" will be entered for authorization to leave messages on an answering machine

5.3.3. "Share PHI" will be entered for authorization to share information with other individuals

5.4. Designated staff member will complete bottom portion of Confidential Communications form labeled, FOR OFFICE USE ONLY, to support patient request.

5.5. Copies of requests will be sent to the Privacy Officer when alternative address and/or telephone are requested.

5.6. Updates to Confidential Communications forms

5.6.1. Do not cross out any information on an obsolete Confidential Communications form; merely, make a note (**clearly visible**) on form such as, "Information no longer effective, see CC form dated \_\_\_\_\_."

5.6.2. Maintain obsolete form in patient record if any questions should later arise.

5.6.3. Be sure that CC notes in computer are **updated** to reflect current information in effect.

#### 6. Exceptions

6.1. Additional addresses/telephone numbers (along with permanent address/telephone) are not applicable.



6.2. Only the respective patient should receive his/her PHI when it is sensitive in nature, even if authorization to use answering machine or share PHI was previously given by patient.

**7. References**

7.1. FORM - Confidential Communications MM-132

7.2. Federal Register - 45 CFR 164.522(b)(1)

7.3. Instructions for entering "CC" notes into the billing system

**8. Appendix**

None

**9. Approvals**

***Margaret Dimond***

*(Original signed policy on file in MMG Practice Management)*

**Margaret Dimond**  
President/Chief Executive Officer

**5/28/2013**

**Date**

**Previous Revision Dates/Supercedes Policy: 7/20/10**  
04/2008 / Not applicable

**McLaren Medical Group**  
**CONFIDENTIAL COMMUNICATIONS**

I request that all communications to me of my protected health information be sent or made to me at the alternative means or alternative locations, as follows:

Alternative address: \_\_\_\_\_

Alternative telephone: \_\_\_\_\_

I authorize the practice of leaving a message on my answering machine/voice mail:  Yes  No

**FOR APPOINTMENT REMINDERS ONLY:**

1) Use cell phone:  Yes \_\_\_\_\_  No

2) Use e-mail:  Yes \_\_\_\_\_  No

I authorize the release of my protected health information over the telephone to the following individuals:

Name of person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number: Home \_\_\_\_\_ Work \_\_\_\_\_

Name of person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number: Home \_\_\_\_\_ Work \_\_\_\_\_

Name of person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number: Home \_\_\_\_\_ Work \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

---

**FOR OFFICE USE ONLY:**

Agrees to patient's request for confidential communications

Does not agree to patient's request for confidential communications.

Comments: \_\_\_\_\_


\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name:

Date of Birth:

		<b>Policy Title:</b>	Appointment Scheduling
<b>Effective Date:</b>	1/1/2008	<b>Policy Number:</b>	2300
<b>Review Date:</b>		<b>Category:</b>	Business/Leadership
<b>Revised Date:</b>	5/28/2014	<b>Oversight Level:</b>	
<b>Administrative Responsibility:</b>	MMG Directors and MMG President/CEO		
<b>Interpretation:</b>	MMG Operations Managers		

### 1. Purpose

To more effectively schedule appointments that enhances patient satisfaction and provider productivity.

### 2. Scope

MMG workforce

### 3. Definitions

3.1. Appointment type - type of appointment requested and the duration of time necessary for the visit.

3.2. Comment code - reason behind appointment type; further explains what appointment type consists of, where necessary.

3.3. Protocol Book - individualized parameters per provider by which a scheduler is guided to make an appointment.

3.4. Resource code - number assigned to a provider; if an established patient, resource code will refer to patient's primary care provider.

### 4. Policy

4.1. Appointment schedules are scheduled in a consistent manner across MMG.

4.2. Appointment types and time increments are assigned as indicated:

<u>Code</u>	<u>Appointment Length</u>
EPHY	40 or 45 Minutes * with Director approval only
EST	10 or 15 minutes
EXP	20 or 30 minutes
INJ	5 minutes
NEW	20 or 30 minutes
NPD	10, 20, or 30 minutes
NUR	10, 15, or 20 minutes
PHY	15 or 30 minutes

PAP	15 or 30 minutes
PRO	30 or 60 minutes
SD	5 minutes
TOC	20 or 30 minutes
WCC	20 or 30 minutes
WTM (Welcome to Medicare)	15 or 30 minutes
WLNS (Medicare Wellness visit)	15 or 30 minutes

4.3. The following appointment types and times are used consistently for OB/GYN:

<u>Code</u>	<u>Appointment Length</u>
NEW or NOB	10, 20, or 30 minutes
EST	10, 15, or 20 minutes
OBC	10 or 15 minutes
PAP	10, 15, 20, or 30 minutes
COLP	30 minutes
CONS	30 minutes
NST (stress test)	15 minutes
PRO	30 minutes
TOC	20 or 30 minutes

4.4. Additional appointment scheduling codes are allowed under the following circumstances:

- There are documented compelling business reasons for adding codes.
- The medical and administrative leaders of the specialty or region support the addition.
- The addition is approved by the Regional Operations Director.
- The additional codes are implemented consistently throughout the specialty or region.

4.5. Appointments are scheduled in accordance with steps outlined in the Horizon Practice Plus Manual.

4.6. All appointments are scheduled using Horizon Practice Plus (McKesson); staff should not schedule appointments on paper and later transfer to Horizon Practice Plus.

4.7. No shows and cancellations are accounted for in the Horizon Practice Plus system on the same day that they occur.

4.8. Operations Managers (or a designee) are expected to provide the most up-to-date availability information for all providers in their respective sites.

4.9. Same Day Appointments (SD) - will be scheduled throughout the day, at the provider's discretion, and book simultaneously with other scheduled visits.

4.10. Nurse Visits (NUR) may not be scheduled on the provider's schedule.

## 5. Procedure

### 5.1. Preliminary Information known to MMG management

5.1.1. Each clinic manager will standardize information that will provide easy access to information when a call is received.

5.1.2. Emergency calls (such as, chest pain, shortness of breath, drug overdose or any other life threatening issue) are immediately transferred to an **actual** person (no voice mails) at the respective provider's site.

5.1.3. Physicals and non-emergency appointments are scheduled in the next available time slot in accordance with MMG policies.

### 5.2. Registration of patients

5.2.1. Pre-register new patients prior to their appointment; complete all screens with as much information as you can obtain.

5.2.2. Confirm the following with the patient:

- Correct spelling of name; verify if patient may have any other names in the system
- Date of birth; for a child's one-year check-up, verify that the the child is at least a year and a day old at the time of visit
- Address
- Insurance; confirm that both the Patient Registration Screen and the Insurance Screen have up-to-date information (such as, address and telephone number)
- When scheduling an annual pap, complete physical examination, or a mammogram, verify that at least a year and a day has passed since the last exam/study because some insurance companies may not cover if earlier.

5.2.3. If there are address or telephone number changes, update on **ALL** billing system screens.

### 5.3. "Collection" Verification

5.3.1. Check "notes present"; indicate in notes that patient was informed of a balance.

5.3.2. Do not turn away a patient if sick.

5.4. Assign appropriate resource codes

5.4.1. For *established* patients, indicate patient's primary care provider for the resource code; update resource code when patient changes primary care provider (PCP).

5.4.2. For *new* patients, use resource codes located on the Scheduling Screen.

5.5. Assign appropriate appointment type, comment code

5.5.1. Determine appropriate appointment type

5.5.2. Assign a comment code (see Appendix A) on extended reason line; if no applicable comments code, briefly state reason for visit on extended reason line.

5.6. Reminders to patients following registration

5.6.1. Inform the patient and document on the extended reason line the following:

- Bring current x-rays
- Current medications (with strength, dosage, frequency as listed on bottles)
- Mammogram order
- Arrival time 15 minutes prior to appointment time for completion of paperwork (applies to new patients)
- Fasting state, when applicable
- Minors (17 years of age and younger) must have parent or legal guardian accompany minor patient
- Bring in insurance card(s)
- Bring photo ID
- Inform patient that any co-pays are paid on date of service
- Remind patient of any current balance and critical balance

5.7. The following abbreviations are utilized in communications with MMG offices relative to disposition of an appointment:

- CA = cancelled
- NA = no answer/not available
- LMA = left a message with an adult
- LMR = left a message on a recorder
- OK = talked to patient; appointment is okay
- TT = talked to.....

5.8. Prior to contacting a patient, refer to CC notes (Confidential Communications) for appropriate/authorized contact information.

5.9. Special issue - *Provider not at the site*

- 5.9.1. Do NOT tell the patient to call the hospital and have their provider paged.
  - 5.9.2. Check other providers' schedules first to determine if any have an available appointment for patients that need to see a provider.
  - 5.9.3. Offer patient an appointment with another provider.
  - 5.9.4. Document in notes, if patient refuses to go elsewhere.
- 5.9. Special issue - *Provider's schedule booked for the day*
- 5.9.1. Check for any last minute cancellations.
  - 5.9.2. Place patient in provider's next available appointment time, if patient can wait. If an alternate provider is available, offer that choice to the patient.
  - 5.9.3. For Managed Care patients
    - If patient is ill and needs to see a provider, suggest patient speak with the provider's MA; offer to make the call.
    - Suggest an appointment with another provider who has an opening.
  - 5.9.4. If off-site provider's schedule is full, offer to call the off-site for the patient to determine if you can get the patient an appointment.
  - 5.9.5. If not able to get patient worked in or provide with an appointment within 48 hours, suggest a Convenient/Prompt Care Center to the patient; reference the Insurance List.
- 5.10. Cancellations
- 5.10.1 Cancel appointment and reschedule, if requested.
  - 5.10.2. Follow Provider Protocol.
  - 5.10.3. Call the provider's office to inform of the cancellation.
  - 5.10.4. Enter reason for cancellation into the computer.
- 5.11. Discharged patients who request an appointment
- 5.11.1 Refer to computer notes to determine status of discharge (that is, physician, site, or network)

- Physician discharge - patient can see other physicians in the same site.
- Site discharge - patient cannot see any provider in respective site; would need to select another MMG site.
- Network discharge - patient cannot see any provider at any MMG site except as noted under "Exceptions."

5.11.2. Check date of discharge to establish if the required 30 days has passed.

5.11.3. If within 30 days and the nature of the visit is an emergency, schedule the patient.

5.12. For patients discharged from the network, proceed as follows:

5.12.1. Advise the patient that you are not able to schedule an appointment for them because they are discharged from the MMG network of sites.

5.12.2. Refer patient to their insurance company to aid them in finding a non-MMG provider that accepts their insurance.

5.12.3. Refer patient to the respective Operations Manager (give specific name) at the site where the discharge took place, if patient is insistent on speaking with someone regarding the discharge.

5.13. Customer Service with Appointment Scheduling

5.13.1. Customer Service standards are upheld by the following actions:

- Offering to call patient back, if the computer system is inoperable.
- Offering to make appointments for patients when they are referred for additional services.
- Providing cross-site and cross-department scheduling performed by staff who have demonstrated competency for respective site or department.
- Offering to call patient back, if busy with other patients.
- Never asking the patient to call back.
- Returning all calls before the end of the business day.
- Sending recall notices when the schedule is not available.

## 6. Exceptions

6.1. Patients who have been discharged from the MMG primary care network may still see specialists in the network or in any Convenient/Prompt Care Center.

## 7. References

- 7.1. Individual Protocol Books
- 7.2. Resource Codes



7.3. Horizon Practice Plus Manual

**8. Appendix**

8.1. Appendix A - Comment Codes

**9. Approvals**

***Mark S. O'Halla***

*(Original signed policy on file in MMG Practice Management)*

**Mark O'Halla**  
**President/Chief Executive Officer**

**6/23/2014**

**Date**

***Michael Ziccardi, D.O.***

*(Original signed policy on file in MMG Practice Management)*

**Michael Ziccardi, Jr., D.O.**  
**Medical Director**

**6/10/2014**

**Date**

**Previous Revision Dates/Supercedes Policy: 1/16/2014 / 5/28/2013 / 7/18/2012  
4-29-2009 / 8-1-2008 / 7/18/2012**

## COMMENT CODES

2YR	NOT SEEN IN 2 YEARS
ACU	ACUTE APPT/SAME DAY
COL	COLONOSCOPY
COLP	COLPOSCOPY
CRY	CRYOSURGERY
E15	ESTABLISHED PT MED REFILL
E30	NEW PT TO PROVIDER TO ESTABLISH CARE
EMG	EMG-UPPER OR LOWER
EST	ESTABLISHED PATIENT
EXP	MULTIPLE PROBLEMS
IMM	IMMUNIZATIONS
INJ	INJECTION
IOB	INITIAL OB
LAB	LAB VISIT
NEW	NEW PATIENT
NFI	NEW FEMALE INCONTINENCE
NOB	NEW OB PATIENT
NOR	NORPLANT
NPD	NEW PATIENT TO THE PROVIDER
NPY	NEW PATIENT YEARLY
NUR	NURSE VISIT
OBC	OB CHECK/POSTPARTUM
OMT	OSTEOPATHIC MANIPULATIVE THERAPY
OVG	GERIATRIC PATIENTS (OVER 60 YEARS OLD)
P17	PHYSICAL FOR PATIENT 17 AND YOUNGER
P18	PHYSICAL FOR PATIENT 18 AND OLDER
PAP	ANNUAL PAP
PHY	PHYSICAL
POE	PRE-OP EXAM
POP	POST-OP EXAM
PSY	DEPRESSION
RCK	RECHECK
SD	SAME DAY
SIG	SIGMOID
SPH	SPORTS PHYSICAL
SRG/FRM	SURGERY AND ROOM-CONCURRENT SCHEDULING
SUR	SURGERY
TRA	TRAVEL CLINIC
VAS	VASECTOMY
WLB	WELL BABY VISIT

**McLaren Medical Group  
REFERRAL/CONSULTATION REQUEST**

To: Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_

Referred to you from provider \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date of Referral: \_\_\_\_\_ Patient needs appointment with you within: \_\_\_\_\_ days/weeks

Insurance Type: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

History/diagnostic testing completed/therapeutic measures tried: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> See attached patient registry report | <input type="checkbox"/> See attached e-prescription list |
| <input type="checkbox"/> See attached test results            | <input type="checkbox"/> No test results available        |

Request for:	<b>Office Visit Type</b>		<b>Appointment time preference</b>
	<input type="checkbox"/> Initial consultation	<input type="checkbox"/> Evaluate	<input type="checkbox"/> A.M.
	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Evaluate/Treat	<input type="checkbox"/> P.M.
	<input type="checkbox"/> Pre-Certification	<input type="checkbox"/> Other _____	<input type="checkbox"/> None

Signature of referring provider (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Appointment Date/Time: \_\_\_\_\_ \*\* Please notify us immediately if our patient does not keep their appointment

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE OBSERVE THE FOLLOWING GUIDELINES:**

- Please use McLaren facilities for all tests, treatments, and procedures.
- Contact the Primary Care Physician if further visits/testing is needed before the appointment is made.
- Use Network Formulary when prescribing medicines.
- Send consultation report and any applicable test results to Primary Care Physician within seven (7) days of service.

<p><b>Office Use Only:</b></p> <p>Date follow up letter received from Specialist: _____</p> <p>Reason patient did not keep appointment: _____</p> <p>Date patient completed Specialist evaluation: _____</p>
--

Patient Name:
Date of Birth:

## USE OF OFFICE EQUIPMENT

Copier – Will be demonstrated on site, see manufacturer instructions for more information.

Fax – Will be demonstrated on site, see manufacturer instructions for more information.

Scanner – Will be demonstrated on site, see manufacturer instructions for more information.

## COMPUTER/APPLICATIONS

Horizon Practice Plus/HPP/PLUS – MMG's Practice Management System for patient registration, appointment scheduling and billing. Requires User ID and password.

POLCI – MMG's previous billing system.


Allscripts – MMG's Electronic Medical Record's (EMR) system. Requires User ID and password.

MCIR – Michigan Care Improvement Registry. Link to the State of Michigan for immunization records. Requires User ID and password.

PIE – Patient Information Exchange. Access to hospital, laboratory and radiology records. Requires User ID and password.

Web-denis – Link to Blue Cross and Blue Shield of Michigan for eligibility verification. Requires User ID and password.

Intranet – Corporate Intranet has links to all corporate subsidiaries and partners (Office Depot, MCIR, Web-denis, etc.) Policy and Procedure Manuals, Corporate Phone Directories, and other resources are also available here.

		<b>Policy Title:</b>	Patient Care Assessment
<b>Effective Date:</b>	10/96	<b>Policy Number:</b>	3325
<b>Review Date:</b>	11/26/02	<b>Category:</b>	Clinical
<b>Revised Date:</b>	9/10/13	<b>Oversight Level:</b>	2
<b>Administrative Responsibility:</b>	Ambulatory Quality Improvement Committee		
<b>Interpretation:</b>	Clinical Managers		

### 1. Purpose

To collect and analyze data for the purpose of diagnosing the patient's problems and/or needs that are within the scope of the medical staff; to establish a staff/patient relationship which includes mutual involvement in planning his/her care.

### 2. Scope

MMG providers and clinical staff.

### 3. Definitions

3.1. Initial assessment - an evaluation of patient's health status based on documentation of history, health risks, cultural/spiritual needs, and learning disabilities.

3.2. Process - continuous and systematic method of gathering data and identifying needs/problems.

### 4. Policy

4.1. Assessments are completed on all patients initially and annually to determine care, treatment, and services to meet the patient's needs.

4.2. Assessments are accurately written, promptly completed, properly filed, and accessible to the provider.

### 5. Procedure

5.1. Based on the patient's condition, information gathered in the initial assessment will include:

- 5.1.1. a physical assessment
- 5.1.2. a psychological assessment
- 5.1.3. a social assessment
- 5.1.4. nutrition and hydration status
- 5.1.5. functional status

5.1.6. social, spiritual, and cultural variables that would influence the patient's and family members' perception of grief, for patients who are receiving end-of-life care

5.1.7. the patient's perception of the effectiveness of, and any side effects related to, medications

- 5.1.8. a pain assessment
- 5.1.9. fall risk
- 5.1.10. adult abuse and neglect
- 5.1.11. special learning needs

5.2. Adult abuse and neglect information is assessed and documented annually.

5.3. When clinically indicated, based on the patient's plan of care or changes in the patient's condition, information gathered in a reassessment will include:

- 5.3.1. The patient's perception of the effectiveness of, and any side effects related to, medications.
- 5.3.2. a pain assessment for patients who are at risk

5.4. Process

5.4.1. Assessment techniques will include:

- 5.4.1.1. review of forms filled out by the patient
- 5.4.1.2. interview
- 5.4.1.3. examination
- 5.4.1.4. discussion with family members, if applicable
- 5.4.1.5. review of various reports, including consultation, laboratory, and radiology.

5.4.2. Documentation for the initial encounter will include:

- 5.4.2.1. vital signs, reason for visit, presence or absence of pain, allergies, and any immediate signs/symptoms
- 5.4.2.2. normal as well as abnormal facts
- 5.4.2.3. seven dimensions of a symptom: location, quantity, quality, frequency, what alleviates it, chronology, when and where did it happen, and other related symptoms
- 5.4.2.4. medical data, laboratory findings, x-ray, and data from other services to the patient
- 5.4.2.5. fall risk

5.4.3. Documentation for encounters after the initial will include:

- 5.4.3.1. patient problems; changes in status of initially identified problems/needs considering health/safety hazards; allergies; abnormal signs/symptoms; assistance with activities of daily living (ADL's); social or behavioral problems affecting patient's illness/recovery
- 5.4.3.2. additional problems/needs experienced by the patient
- 5.4.3.3. progress notes will reflect ongoing assessment
- 5.4.3.4. include teaching needs for the patient
- 5.4.3.5. utilize patient/family strengths in formulating approaches to meet problem/needs
- 5.4.3.6. adult abuse and neglect
- 5.4.3.7. fall risk screening is completed annually

5.4.4. All entries are timed, dated and signed by the provider.

**6. Exceptions**

6.1. None.

**7. References**

7.1. Healthcare Facilities Accreditation Program (2012-2013), *Accreditation Requirements for Healthcare Facilities*.

7.2. Joint Commission (July 1, 2012), *Accreditation Requirements*.

7.3. P/P 3340 Pain Management

**8. Approvals**

***Margaret Dimond***

*(Original signed policy on file in MMG Practice Management)*

**Margaret Dimond**  
President/Chief Executive Officer

9/12/2013

Date

***Michael Ziccardi, D.O.***

*(Original signed policy on file in MMG Practice Management)*


**Michael Ziccardi, Jr., D.O.**  
Medical Director

9/12/2013

Date

Previous Revision Dates/Supercedes Policy: 11/6/2012

1/06 / 4-26-05/10.17

		<b>Policy Title:</b> Responding to Life-Threatening Emergencies
<b>Effective Date:</b>	10/96	<b>Policy Number:</b> 3305
<b>Review Date:</b>		<b>Category:</b> Clinical
<b>Revised Date:</b>	8/5/14	<b>Oversight Level:</b> 2
<b>Administrative Responsibility:</b>	Operations Managers	
<b>Interpretation:</b>	Operations Managers	

### 1. Purpose

To provide effective artificial ventilation and circulation when a patient's respirations and/or heart have ceased to function by using CPR.

### 2. Scope

All MMG Physicians, Nurse Practitioners, Physicians Assistants, Medical Assistants and other qualified personnel

### 3. Definitions

3.1. Cardiopulmonary resuscitation (CPR) - restoration of cardiac output and pulmonary ventilation following cardiac arrest and apnea, using artificial respiration and closed chest massage.

3.2. Qualified clinical staff member - MMG workforce with current BLS certification

3.3. Life threatening conditions may include the following but are not limited to:

3.3.1. chest pain

3.3.2. severe active bleeding from any source

3.3.3. severe vomiting or diarrhea

3.3.4. acute shortness of breath

3.3.5. faints or complains of "feeling faint"

3.3.6. severe pain

3.3.7. convulsions

3.3.8. fresh burns

3.3.9. obvious fracture or dislocation

3.3.10. active labor

### 4. Policy

4.1. All MMG Physicians, Nurse Practitioners, Physician Assistants, Medical Assistants, and other designated staff will maintain current BLS certification. Newly hired clinical staff will be required to successfully complete the BLS certification process during the first 90 days of employment.



4.2. Individuals presenting with a life threatening condition or cardiac and/or respiratory arrest will be resuscitated and stabilized prior to the determination of the patient's insurance status or their ability to pay.

4.3. An individual suffering cardiac or respiratory arrest will receive immediate resuscitation using BLS protocol.

## **5. Procedure**

5.1. When a patient presents with a life threatening condition clinical staff (including a provider) will be immediately summoned.

5.2. The patient will be assessed by the provider to determine if the patient can be appropriately treated on site or transported to an alternate care setting.

5.3. If the patient is in cardio-pulmonary arrest, a qualified clinical staff member will initiate CPR per BLS protocol. BLS protocol will be continued until EMS staff arrives on the scene.

5.4. In the event of cardio-pulmonary arrest or if the patient is determined to be unstable, the staff will activate Emergency Medical Services (EMS) via 911.

5.5. Care will be transferred to the EMS staff by the physician, nurse practitioner, or physician assistant. Pertinent verbal/written medical information will be provided to EMS staff.

5.6 If the patient conditions warrants, he/she may be transported to an alternate care setting via car by family/companion.

5.7. Documentation

5.7.1. All details of the event will be documented in patient's medical record, including advanced directives and disposition.

## **6 Exceptions**

6.1 Applicable Advance Directives dictate otherwise

## **7 References**

None

## **8 Appendix**

8.1 Appendix A - Emergency Guidelines

9 Approvals

***Mark S. O'Halla***

*(Original signed policy on file in MMG Practice Management)*

---

Mark O'Halla  
Interim President/CEO

**8/20/2014**

---

Date

***Michael Ziccardi, D.O.***

*(Original signed policy on file in MMG Practice Management)*

---

Michael Ziccardi, Jr., DO  
Senior Medical Director

**9/9/2014**

---

Date

Previous Revision Dates/Supercedes Policy: 1/2006  
June 2004/10.4



## EMERGENCY GUIDELINES

### GENERAL

1. In the event a patient presents with, or appears to have, one of the following conditions while awaiting treatment, clinical staff will be immediately summoned:

Life threatening conditions include but are not limited to the following:

- a. chest pain
  - b. severe active bleeding from any source
  - c. severe vomiting or diarrhea
  - d. acute shortness of breath
  - e. faints or complains of "feeling faint"
  - f. severe pain
  - g. convulsions
  - h. fresh burns
  - i. obvious fracture or dislocation
  - j. active labor
2. Patients presenting with known or suspected infectious disease will be isolated according to P/P 5135.
  3. Clinical staff/physician will assess the patient's condition and determine if the patient can be appropriately treated on site.

### OFFICE STAFF

1. Alert clinical staff in the event of occurrence described in number one above.
2. Attend to family/companion.
3. Register patient if able to stabilize the patient onsite.

### CLINICAL STAFF

1. Obtain a brief history, initiate a physical assessment and document findings in the patient's medical record.
2. Alert physician when possible.
3. Determine if the patient can be appropriately treated on site or transported to an alternate care setting; activate Emergency Medical Services as appropriate.
4. If the patient is unstable, initiate treatment until the ambulance arrives.
5. If the patient's condition warrants, he/she may be transported to an alternate care setting via car by family/companion.
6. Send appropriate medical information, including advance directives (if available), with the patient.
7. Document disposition of the patient in the medical record.

## Rooming Patients

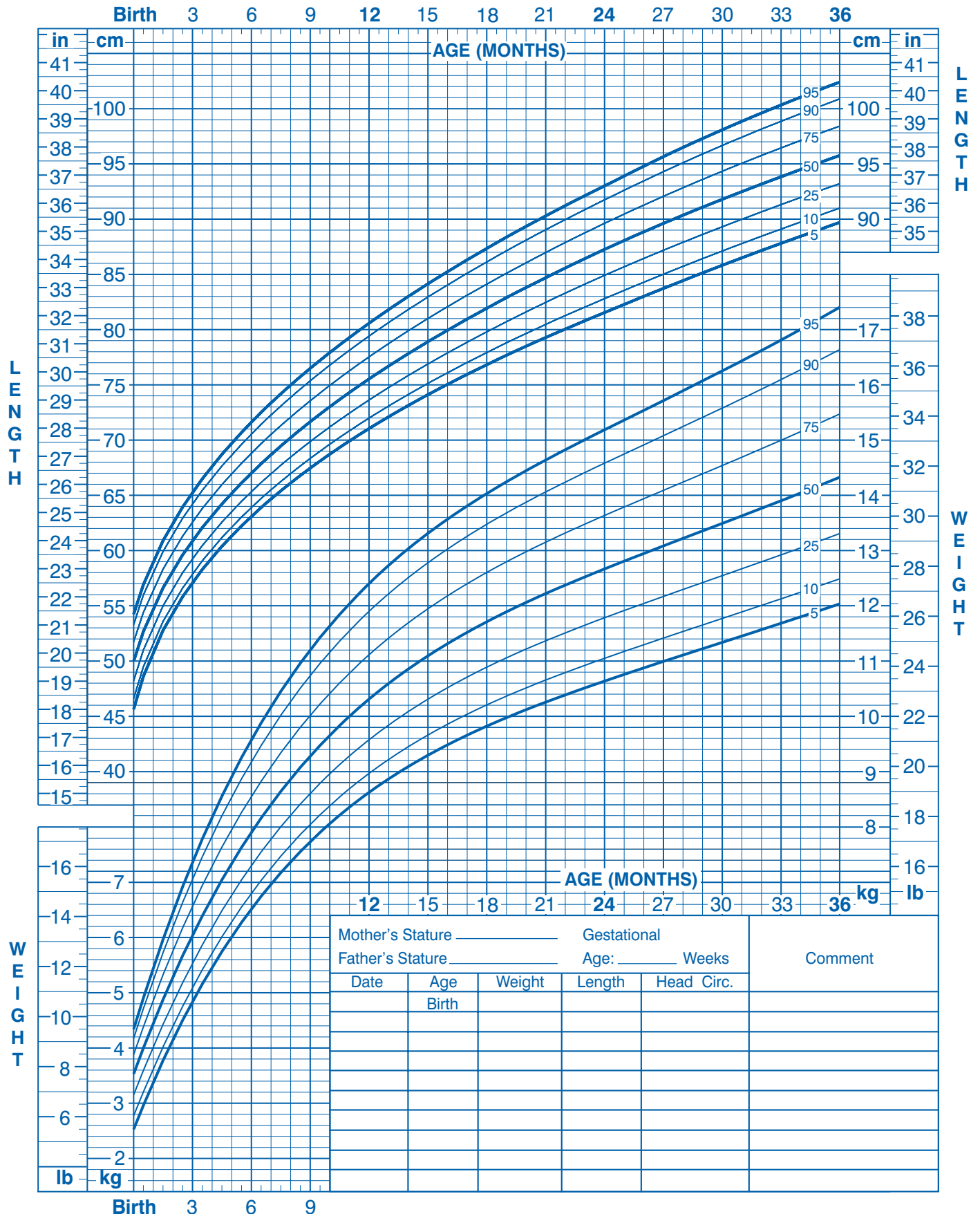
- ❖ Call patient from waiting room, using only first or last name if possible.
- ❖ Greet patient and escort them to the patient care area.
- ❖ Obtain height and weight for patient. Proceed to exam room.
- ❖ Obtain vital signs (blood pressure, pulse, respirations and temperature.)
- ❖ Select appropriate chart within EMR.
- ❖ Complete HMP (Health Management Plan), update as needed.
- ❖ Enter vital signs into EMR.
- ❖ Add/modify clinical items including history, Rx/orders and problems.
- ❖ Review all information that is updated above.
- ❖ Start a new note in the EMR according to visit type/chief complaint.

# Birth to 36 months: Boys

## Length-for-age and Weight-for-age percentiles

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 4/20/01).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). <http://www.cdc.gov/growthcharts>

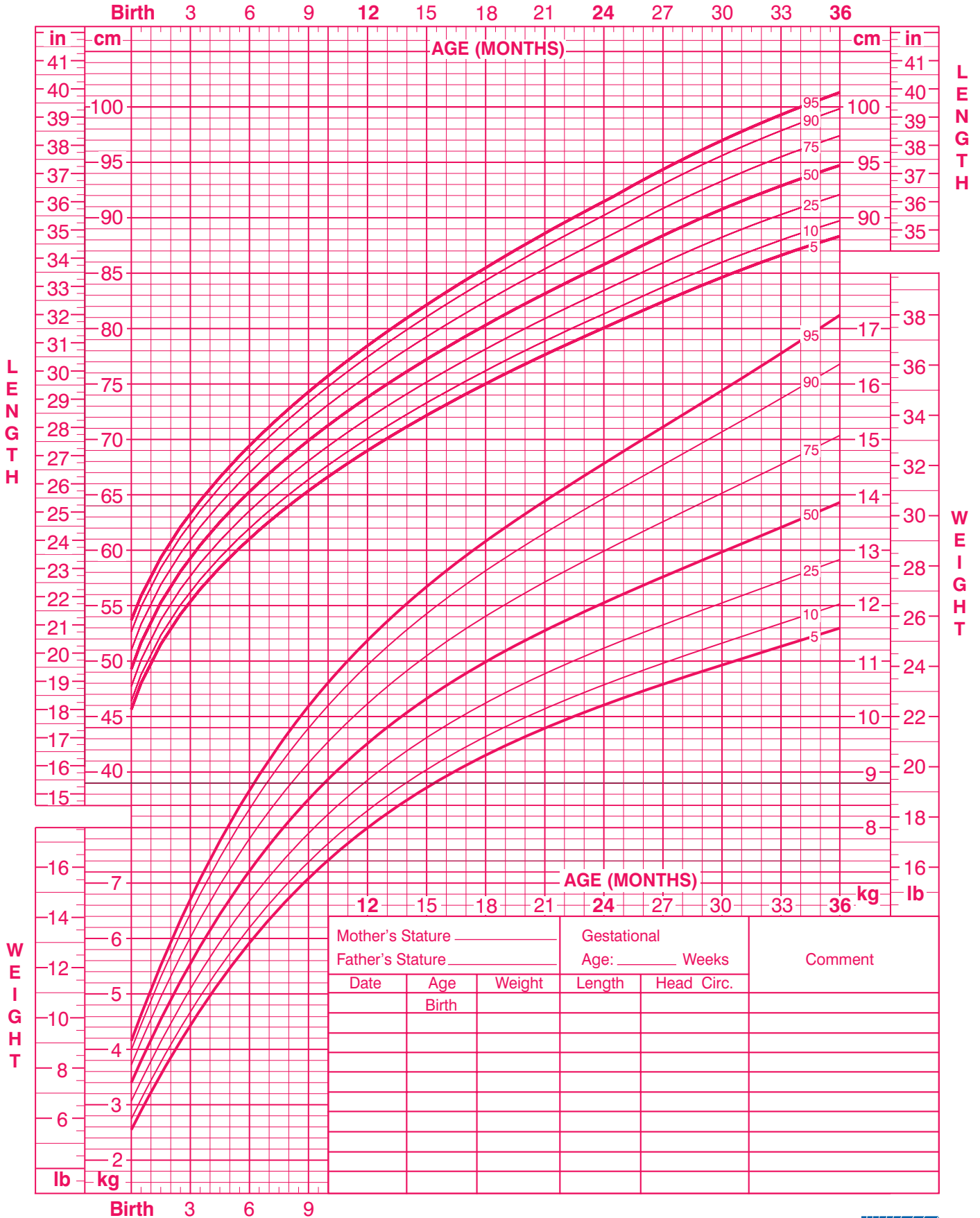


# Birth to 36 months: Girls

## Length-for-age and Weight-for-age percentiles

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 4/20/01).  
 SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>



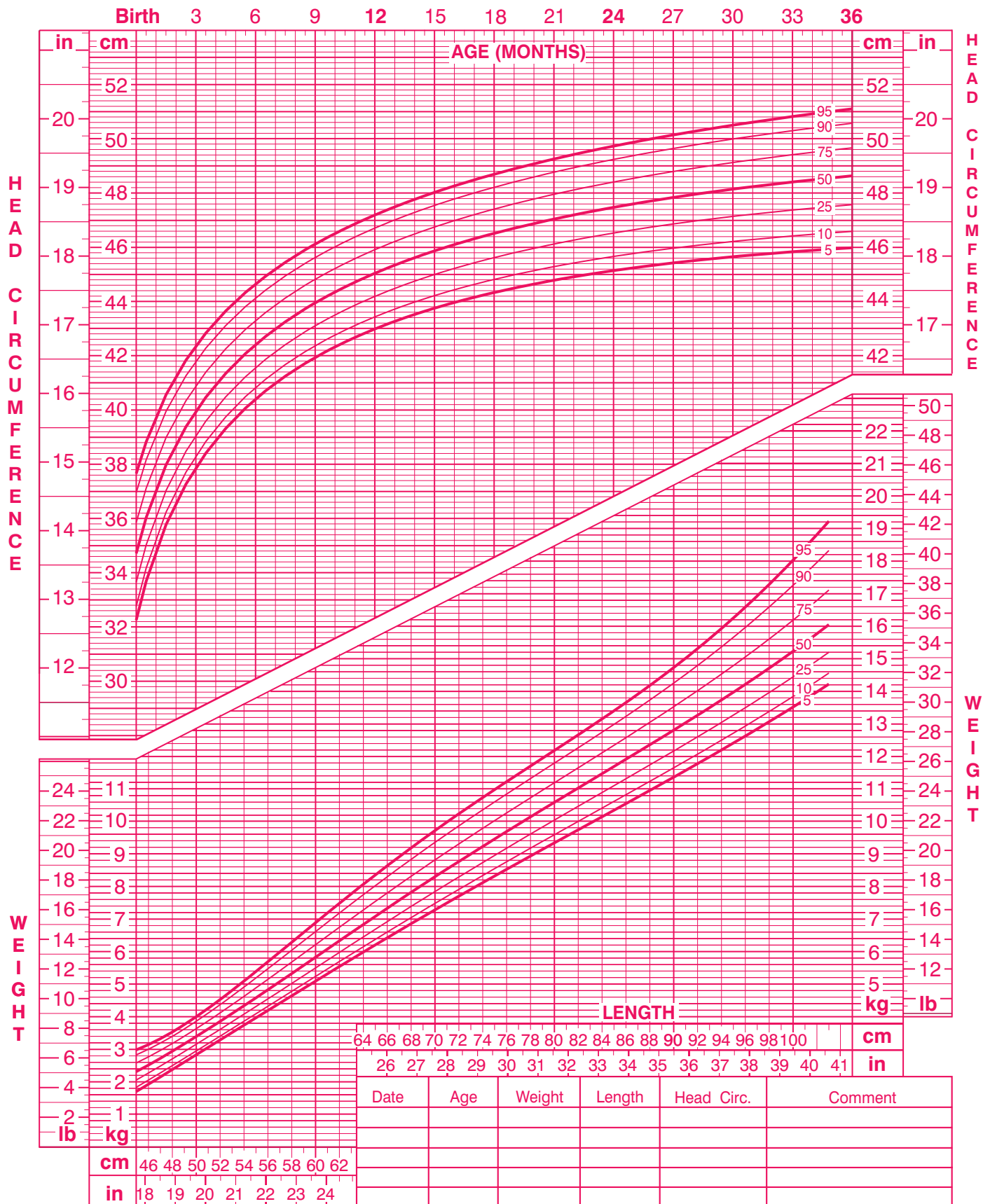


# Birth to 36 months: Girls

## Head circumference-for-age and Weight-for-length percentiles

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). <http://www.cdc.gov/growthcharts>



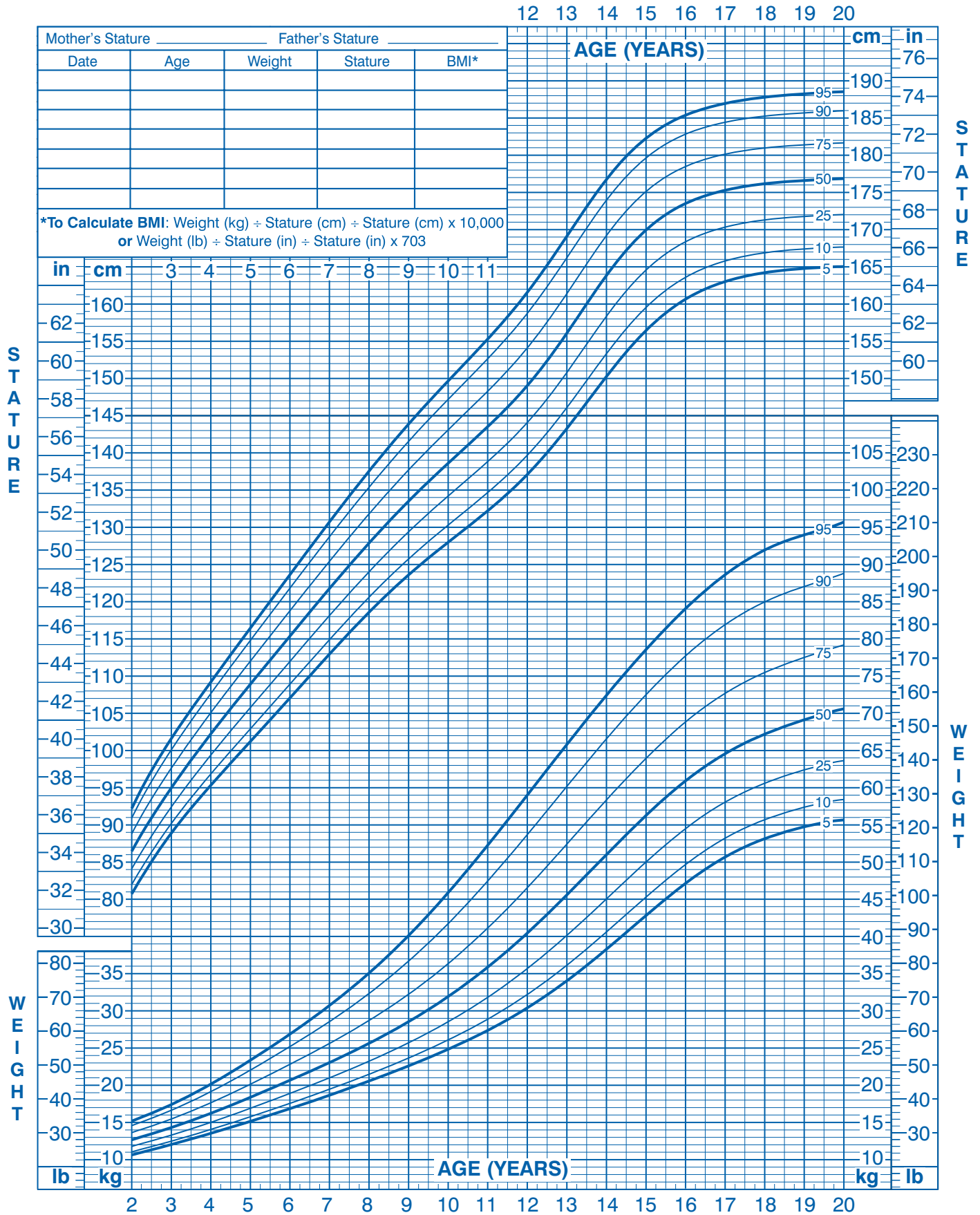


# 2 to 20 years: Boys

## Stature-for-age and Weight-for-age percentiles

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 11/21/00).  
 SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>

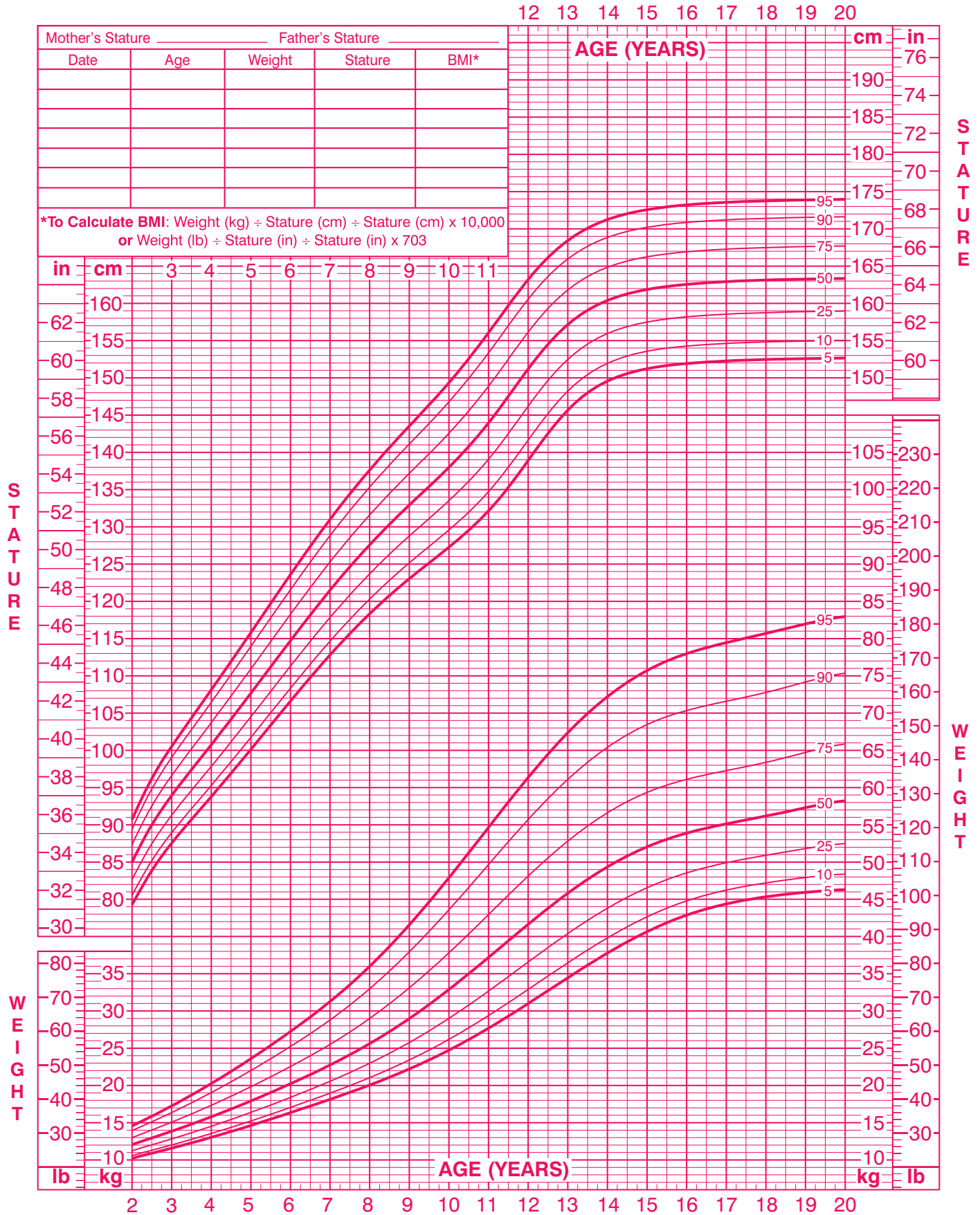


# 2 to 20 years: Girls

## Stature-for-age and Weight-for-age percentiles

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 11/21/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>



SAFER • HEALTHIER • PEOPLE™

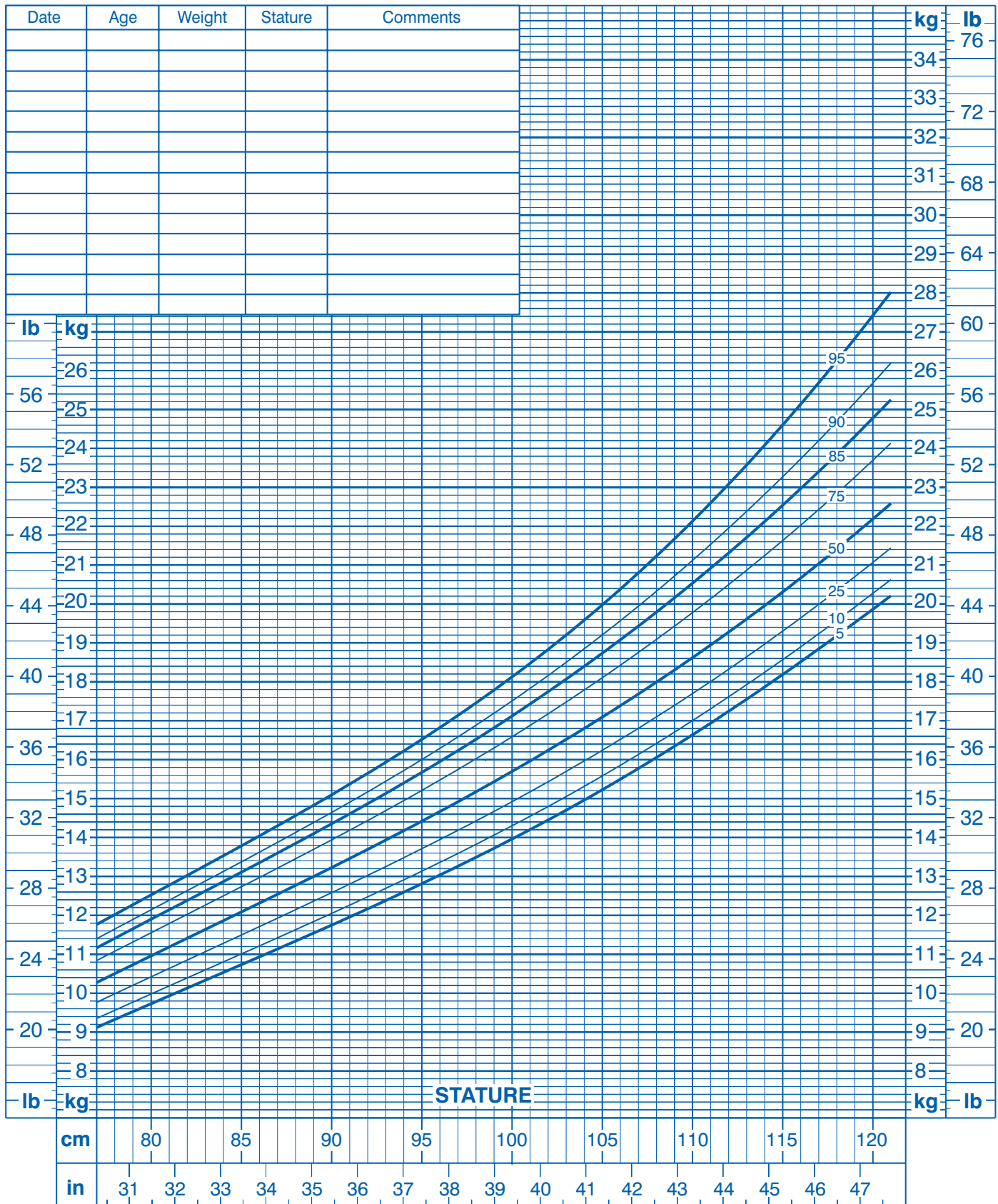




NAME \_\_\_\_\_

RECORD # \_\_\_\_\_

# Weight-for-stature percentiles: Boys

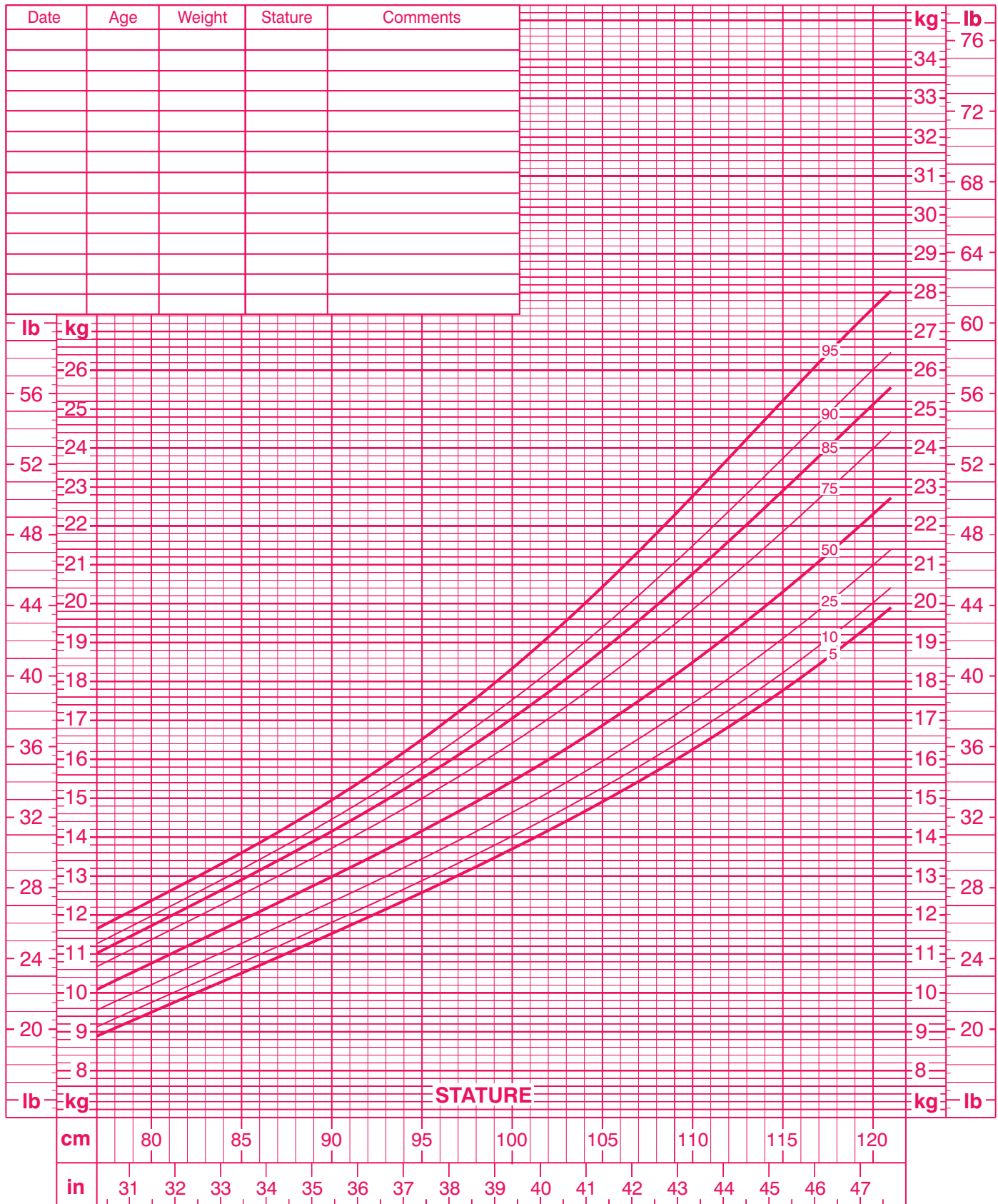


Published May 30, 2000 (modified 10/16/00).  
 SOURCE: Developed by the National Center for Health Statistics in collaboration with  
 the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_

# Weight-for-stature percentiles: Girls



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). <http://www.cdc.gov/growthcharts>



SAFER • HEALTHIER • PEOPLE™

52 McLaren Medical Management, Inc.  
**PHYSICIAN RECORD**  
**Well Female Check**

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

HISTORIAN: patient spouse other \_\_\_\_\_  
 reason for visit: \_\_\_\_\_

**chief complaint:**

well check request for contraceptives estrogen replacement  
 > 3yrs since last pap child bearing age increased risk for cancer

**HPI**

**breast history:**

implants \_\_\_\_\_ lumps \_\_\_\_\_ pain \_\_\_\_\_ nipple discharge \_\_\_\_\_ *no complaints*

**ob / gyn history:**

database reviewed / updated \_\_\_\_\_ unchanged \_\_\_\_\_

age menarche \_\_\_\_\_ G \_\_\_\_\_ P \_\_\_\_\_ M \_\_\_\_\_ A \_\_\_\_\_  
 •menses LMP \_\_\_\_\_ nml abnml \_\_\_\_\_  
 cycle frequency regular / irregular \_\_\_\_\_  
 cycle length every \_\_\_\_\_ days, \_\_\_\_\_ month  
 flow length \_\_\_\_\_ days heavy / mod / light  
 # \_\_\_\_\_ pads / tampons per day  
 pain / cramping minimal / mild / mod / severe \_\_\_\_\_  
 mood changes marked / minimal \_\_\_\_\_

•contraception avoid / rhythm / IUD / BCP / condoms / spermicide

•menopause age \_\_\_\_\_ natural / oophorectomy / hysterectomy  
 last pap > 7 yrs ago DES exposure in utero

**sexual history:**

heterosexual / homosexual / bisexual \_\_\_\_\_  
 sexual activity vaginal / oral / anal / unprotected \_\_\_\_\_  
 age of onset < 16 / ≥ 5 sexual partners in lifetime  
 sexual dysfunction no orgasm / painful intercourse / loss of interest  
 known exposure or Hx of STD \_\_\_\_\_

**urinary history:**

no complaints \_\_\_\_\_  
 frequent urination \_\_\_\_\_  
 nocturia x \_\_\_\_\_  
 initiation difficulty \_\_\_\_\_  
 incontinence stress / urge / mixed \_\_\_\_\_  
 # \_\_\_\_\_ pads / Depends \_\_\_\_\_

**Patient Concerns:**

Similar symptoms previously \_\_\_\_\_

Recently seen by doctor office / ER / hospitalized \_\_\_\_\_

**ROS**

**CONST**

fatigue \_\_\_\_\_  
 weight loss / gain \_\_\_\_\_  
**PULMONARY / CVS**  
 cough \_\_\_\_\_  
 trouble breathing \_\_\_\_\_  
 chest pain \_\_\_\_\_

**GI**

abdominal pain \_\_\_\_\_  
 nausea / vomiting \_\_\_\_\_

**ENT / EYES**

nasal drainage / congestion \_\_\_\_\_  
 visual disturbances \_\_\_\_\_

**SKIN / MS**

rash \_\_\_\_\_  
 back pain \_\_\_\_\_  
 leg swelling \_\_\_\_\_

**NEURO / PSYCH**

headache \_\_\_\_\_  
 blackout \_\_\_\_\_  
 anxiety / depression \_\_\_\_\_

reviewed and updated: \_\_\_\_\_ Past Hx \_\_\_\_\_ Family Hx \_\_\_\_\_ Social Hx

Location: \_\_\_\_\_ in chart \_\_\_\_\_ Date: \_\_\_\_\_

**Past Hx** \_\_\_\_\_ negative \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_ NKA \_\_\_\_\_

**CURRENT MEDS:** \_\_\_\_\_ none \_\_\_\_\_

**Social Hx** smoker \_\_\_\_\_ ppd ETOH use \_\_\_\_\_

**Family Hx** \_\_\_\_\_

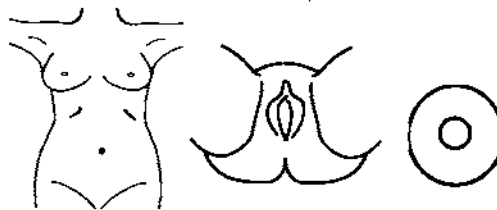
**PHYSICAL EXAM**

**General Appearance**

\_\_\_\_\_ no acute distress \_\_\_\_\_ mild / moderate / severe distress \_\_\_\_\_  
 \_\_\_\_\_ alert \_\_\_\_\_ anxious / lethargic \_\_\_\_\_

**BREAST EXAM**

\_\_\_\_\_ nml appearance \_\_\_\_\_ see diagram \_\_\_\_\_  
 \_\_\_\_\_ nml contour \_\_\_\_\_ masses / dimpling \_\_\_\_\_  
 \_\_\_\_\_ non-tender \_\_\_\_\_ flattening \_\_\_\_\_  
 \_\_\_\_\_ no discharge \_\_\_\_\_ inverted nipples \_\_\_\_\_  
 \_\_\_\_\_ no axillary adenopathy \_\_\_\_\_ fibrocystic changes \_\_\_\_\_  
 \_\_\_\_\_ implants \_\_\_\_\_



T=tenderness  
 R=rebound  
 m=mild  
 mod=moderate  
 sv=severe  
**Example:** Tsv  
 indicates severe  
 tenderness.

**PELVIC EXAM**

\_\_\_\_\_ see diagram \_\_\_\_\_  
 \_\_\_\_\_ nml external genitalia \_\_\_\_\_ ulcerations \_\_\_\_\_  
 \_\_\_\_\_ nml urethral meatus \_\_\_\_\_ vaginal discharge \_\_\_\_\_  
 \_\_\_\_\_ nml speculum exam \_\_\_\_\_ atrophic mucosa \_\_\_\_\_  
 (vagina, cervix) \_\_\_\_\_ cervicitis \_\_\_\_\_  
 \_\_\_\_\_ nml bimanual exam \_\_\_\_\_ Nabothian cysts \_\_\_\_\_  
 (uterus, adnexal, urethra, bladder) \_\_\_\_\_ cerv. motion tenderness \_\_\_\_\_  
 \_\_\_\_\_ adnexal tenderness / mass ( R / L ) \_\_\_\_\_  
 \_\_\_\_\_ uterine tenderness / enlargement / gravid \_\_\_\_\_  
 \_\_\_\_\_ hysterectomy \_\_\_\_\_  
 \_\_\_\_\_ cystocele / rectocele \_\_\_\_\_  
 \_\_\_\_\_ prolapse \_\_\_\_\_

pap collected  
 \_\_\_\_\_ traditional  
 \_\_\_\_\_ thin prep

Name: \_\_\_\_\_ New \_\_\_\_\_ Est \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Age: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_ in BP \_\_\_\_\_ BMI \_\_\_\_\_

Temp: \_\_\_\_\_ T R A O RR: \_\_\_\_\_ Pulse \_\_\_\_\_ SaO<sub>2</sub> \_\_\_\_\_

Nurse / MA Sig \_\_\_\_\_

Pt. Name \_\_\_\_\_

**ENT**

\_\_ nml ENT inspection  
\_\_ nml pharynx

\_\_ nasal drainage  
\_\_ nasal mucosal edema  
\_\_ pharyngeal erythema / exudate

**NECK**

\_\_ nml inspection  
\_\_ nml thyroid

\_\_ thyromegaly  
\_\_ lymphadenopathy ( R / L )  
\_\_ JVD present  
\_\_ carotid bruits

**RESPIRATORY**

\_\_ no resp. distress  
\_\_ nml breath sounds  
\_\_ chest non-tender

\_\_ wheezing  
\_\_ rales / rhonchi

**CVS**

\_\_ reg. rate & rhythm  
\_\_ no murmur  
\_\_ no gallop

\_\_ irregular rhythm  
\_\_ extrasystoles ( occasional / frequent )  
\_\_ tachycardia / bradycardia  
\_\_ murmur grade \_\_ / 6 sys / dias  
\_\_ gallop ( S3 / S4 )

**ABDOMEN**

\_\_ soft, non-tender  
\_\_ nml bowel snds  
\_\_ no organomegaly

\_\_ tenderness  
\_\_ abnml bowel sounds / bruits  
\_\_ hepatomegaly / splenomegaly / mass

**RECTAL**

\_\_ non-tender  
\_\_ heme neg stool  
\_\_ nml anus  
\_\_ nml sphincter tone

\_\_ black / bloody / heme pos. stool  
\_\_ tenderness / mass / nodule  
\_\_ hemorrhoids

**BACK**

\_\_ nml inspection  
\_\_ nml ROM

\_\_ CVA tenderness ( R / L )  
\_\_ kyphosis  
\_\_ scoliosis

**SKIN**

\_\_ nml color, no rash  
\_\_ nml temp, dry

\_\_ skin rash  
\_\_ warmth / erythema / lymphangitis  
\_\_ abnml pigmentation  
\_\_ abnml growths

**EXTREMITIES**

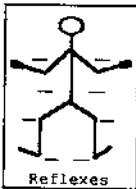
\_\_ non-tender  
\_\_ no pedal edema  
\_\_ nml pulses

\_\_ calf tenderness  
\_\_ pedal edema  
\_\_ pulse deficit  
\_\_ varicose veins

**NEURO / PSYCH**

\_\_ oriented x3  
\_\_ CN's nml as tested  
\_\_ no motor / snsry deficit  
\_\_ nml reflexes  
\_\_ nml mood / affect

\_\_ disoriented  
\_\_ to: person / place / time  
\_\_ facial droop / EOM paisy  
\_\_ weakness / sensory loss  
\_\_ depressed mood / affect



**OFFICE TESTS**

**EKG MONITOR STRIP** \_\_ NSR \_\_ Rate \_\_\_\_\_  
EKG \_\_ NML  Interp. by me  Reviewed by me Rate \_\_\_\_\_  
\_\_ NSR \_\_ nml intervals \_\_ nml axis \_\_ nml QRS \_\_ nml ST/T  
not / changed from: \_\_\_\_\_

**CLINICAL IMPRESSION**

Well Woman                      Worried Well Woman  
Low Risk Cervical Neoplasm      High Risk Cervical Neoplasm

**TREATMENT PLAN**

\_\_ return to work / school in \_\_\_\_\_ days / weeks  
\_\_ Immunizations: Td Tdap Zoster Pneumovax Influenza Gardasil  
\_\_ colonoscopy date completed: \_\_\_\_\_

**LABS & X-RAYS**

CBC \_\_\_\_\_ UA \_\_\_\_\_ Fecal occult \_\_\_\_\_ serum / urine  
CMP \_\_\_\_\_ Urine dip \_\_\_\_\_ Hemocult \_\_\_\_\_ POS NEG  
H. Pylori \_\_\_\_\_ KOH \_\_\_\_\_ blood \_\_\_\_\_ GC / Chl \_\_\_\_\_  
Lipid panel \_\_\_\_\_ MAU \_\_\_\_\_ HIV \_\_\_\_\_  
TSH \_\_\_\_\_ Wet mount \_\_\_\_\_

**XRAYS** \_\_ NML  Interp. by me  Reviewed by me  
**KUB Upright abd 3-view CXR pa lat ap**  
\_\_ nml / NAD \_\_ nml bowel gas pattern \_\_ no free air \_\_ no mass  
\_\_ no infiltrates \_\_ nml heart size \_\_ nml mediastinum

\_\_ reviewed / discussed with patient  
\_\_ labs / radiology / diagnostic studies / old records

**CONSULTS / REFERRALS**

**DISCHARGE MEDICATIONS / INSTRUCTIONS**  see med log

\_\_ counseling / instructions provided  
\_\_ risks / benefits / side effects of medications discussed

**Discharge Vitals**  
BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ Temp \_\_\_\_\_ SaO<sub>2</sub> \_\_\_\_\_

**FOLLOW-UP PLANS**

\_\_ will see in office in \_\_\_\_\_ Day / Week / Month  
\_\_ assessment and plan reviewed with patient  
\_\_ patient questions answered  
\_\_ patient agrees to follow-up as directed

**HEALTH EDUCATION / COUNSELING / SCREENS**

Counseled patient regarding:  
\_\_ Labs                      \_\_ Diagnosis                      \_\_ Follow-up  
\_\_ Weight reduction      \_\_ Diet and exercise      \_\_ Alcohol cessation  
\_\_ Substance abuse      \_\_ Family planning      \_\_ Sexual health / STD  
\_\_ Self breast exams      \_\_ Dental health      \_\_ Risk factors modif.  
\_\_ Osteoporosis prevention      \_\_ Injury prevention  
\_\_ Annual eye exam  
\_\_ Smoking cessation counseling provided time spent \_\_\_\_\_ mins  
    Discussed plan / triggers / challenges / risk / Rx given \_\_\_\_\_  
\_\_ Screens completed fall weight mammogram immunization \_\_\_\_\_

Total face-to-face time: \_\_\_\_\_ minutes  
\_\_ > 50% of visit dominated by counseling



54 McLaren Medical Management, Inc.  
**PHYSICIAN RECORD**  
**Well Male Check**

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

HISTORIAN: patient spouse other \_\_\_\_\_

reason for visit: \_\_\_\_\_

chief complaint: \_\_\_\_\_  
 well check request for sterilization

**HPI**

**gu history:** \_\_\_\_\_ no complaints  
 penis pain / swelling / rash frequent urination  
 testicles pain / swelling / rash nocturia x \_\_\_\_\_  
 inguinal mass incontinence stress / urge / mixed  
 initiation difficulty # \_\_\_\_\_ pads / Depends

**sexual history:** \_\_\_\_\_  
 heterosexual / homosexual / bisexual  
 sexually active vaginal / oral / anal / unprotected  
 sexual dysfunction no orgasm / painful intercourse / loss of interest  
 known exposure or hx of STD \_\_\_\_\_

**ROS**

CONST	ENT / EYES
fatigue _____	sore throat _____
weight loss / gain _____	nasal drainage / congestion _____
	visual disturbances _____
PULMONARY / CVS	SKIN / MS
cough _____	rash _____
trouble breathing _____	back pain _____
chest pain _____	leg swelling _____
	NEURO / PSYCH
GI	headache _____
abdominal pain _____	sleep disturbances _____
nausea / vomiting _____	anxiety / depression _____

reviewed and updated: \_\_\_ Past Hx \_\_\_ Family Hx \_\_\_ Social Hx  
 Location: \_\_\_ in chart \_\_\_ Date: \_\_\_\_\_

Past Hx \_\_\_ negative \_\_\_\_\_

ALLERGIES: \_\_\_ NKA \_\_\_\_\_

CURRENT MEDS: \_\_\_ none \_\_\_\_\_

Social Hx smoker \_\_\_\_\_ ppd ETOH use \_\_\_\_\_

Family Hx \_\_\_\_\_

**PHYSICAL EXAM**

**General Appearance**  
 \_\_\_ no acute distress \_\_\_ mild / moderate / severe distress  
 \_\_\_ alert \_\_\_ anxious / lethargic

**ENT**  
 \_\_\_ nml ENT inspection \_\_\_ nasal drainage  
 \_\_\_ nml pharynx \_\_\_ nasal mucosal edema  
 \_\_\_ pharyngeal erythema / exudate

**NECK**  
 \_\_\_ nml inspection \_\_\_ thyromegaly  
 \_\_\_ nml thyroid \_\_\_ lymphadenopathy ( R / L )  
 \_\_\_ JVD present  
 \_\_\_ carotid bruits

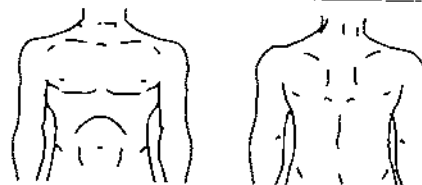
**RESPIRATORY**  
 \_\_\_ no resp. distress \_\_\_ see diagram  
 \_\_\_ chest non-tender \_\_\_ wheezing / rales / rhonchi

**CVS**  
 \_\_\_ reg. rate & rhythm \_\_\_ irregular rhythm  
 \_\_\_ no murmur \_\_\_ extrasystoles occasional / frequent  
 \_\_\_ no gallop \_\_\_ tachycardia / bradycardia  
 \_\_\_ PMI displaced laterally  
 \_\_\_ murmur grade \_\_\_ / 6 sys / dias  
 \_\_\_ gallop ( S3 / S4 )

Patient Concerns: \_\_\_\_\_

Similar symptoms previously \_\_\_\_\_

Recently seen by doctor office / ER / hospitalized \_\_\_\_\_



T=tenderness R=rebound  
 m=mild mod=moderate  
 sv=severe  
 Example- Tsv  
 indicates severe tenderness.

Name: \_\_\_\_\_ New \_\_\_ Est. \_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Age: \_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_ in BP \_\_\_\_\_ BMI \_\_\_\_\_

Temp: \_\_\_\_\_ T R A O RR: \_\_\_\_\_ Pulse \_\_\_\_\_ SaO<sub>2</sub> \_\_\_\_\_

Nurse / MA Sig \_\_\_\_\_

**ABDOMEN**

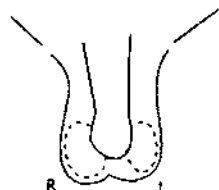
soft, non-tender  
nml bowel sounds  
no organomegaly

tenderness  
abnml bowel sounds / bruits  
hepatomegaly / splenomegaly / mass

**GENITALS**

nml inspection  
nml palp of testicles

urethral discharge  
testicular tenderness ( R / L )  
epididymal tenderness  
circumcised / uncircumcised  
scrotal swelling ( R / L )  
hernia mass ( R / L )  
examined while standing  
herpes-like lesion(s)  
inguinal lymphadenopathy  
hydrocele



nml cremasteric reflex

**RECTAL**

nml rectal tone  
nml stool color  
heme neg stool  
nml prostate

black / bloody / heme pos. stool  
prostate tenderness  
prostate enlarged / nodule

**BACK**

nml inspection

CVA tenderness ( R / L )  
scoliosis

**SKIN**

nml color, no rash  
warm, dry

skin rash  
abnml pigmentation  
abnml growths

**EXTREMITIES**

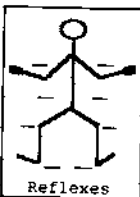
non-tender  
no pedal edema  
nml pulses

calf tenderness  
pedal edema  
decreased pulse(s)  
varicose veins

**NEURO / PSYCH**

oriented x3  
nml CN's as tested  
no motor / snsry deficit  
nml reflexes  
nml mood / affect

disoriented  
to: person / place / time  
facial droop / EOM palsy  
weakness / sensory loss  
depressed mood / affect



**OFFICE TESTS**

**EKG MONITOR STRIP** NSR Rate  
EKG NML Interp. by me Reviewed by me Rate  
NSR nml intervals nml axis nml QRS nml ST/T  
not / changed from: \_\_\_\_\_

**CLINICAL IMPRESSION**

Well Man \_\_\_\_\_ Worried Well Man \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT PLAN**

return to work / school in \_\_\_\_\_ days / weeks  
Immunizations: Td Tdap Zoster Pneumovax Influenza  
colonoscopy date completed: \_\_\_\_\_

**LABS & X-RAYS**

CBC \_\_\_\_\_ Lipid panel \_\_\_\_\_ Fecal occult \_\_\_\_\_ urine culture \_\_\_\_\_  
CMP \_\_\_\_\_ TSH \_\_\_\_\_ Hemocult \_\_\_\_\_  
H. Pylori \_\_\_\_\_ UA \_\_\_\_\_ blood \_\_\_\_\_ GC / Chl \_\_\_\_\_  
Urine dip \_\_\_\_\_ PSA \_\_\_\_\_ RPR \_\_\_\_\_  
**XRAYS** NML Interp. by me Reviewed by me  
**KUB Upright abd 3-view CXR pa lat ap**  
nml / NAD nml bowel gas pattern no free air no mass  
no infiltrates nml heart size nml mediastinum

reviewed / discussed with patient  
labs / radiology / diagnostic studies / aid records

**CONSULTS / REFERRALS**

**DISCHARGE MEDICATIONS / INSTRUCTIONS**  see med log

counseling / instructions provided  
risks / benefits / side effects of medications discussed

**Discharge Vitals**  
BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ Temp \_\_\_\_\_ SaO<sub>2</sub> \_\_\_\_\_

**FOLLOW-UP PLANS**

will see in office in \_\_\_\_\_ Day / Week / Month  
will see in office in \_\_\_\_\_ Day / Week / Month  
assessment and plan reviewed with patient  
patient questions answered  
patient agrees to follow-up as directed

**HEALTH EDUCATION / COUNSELING / SCREENS**

Counseled patient regarding:  
Labs \_\_\_\_\_ Diagnosis \_\_\_\_\_ Follow-up \_\_\_\_\_  
Weight reduction \_\_\_\_\_ Diet and exercise \_\_\_\_\_ Alcohol cessation \_\_\_\_\_  
Sexual health / STD \_\_\_\_\_ Testicle self exams \_\_\_\_\_ Family planning \_\_\_\_\_  
Risk factors modification \_\_\_\_\_ Substance abuse \_\_\_\_\_ Dental health \_\_\_\_\_  
Injury prevention \_\_\_\_\_ Osteoporosis prevention \_\_\_\_\_ Annual eye exam \_\_\_\_\_  
Smoking cessation counseling provided time spent \_\_\_\_\_ mins  
Discussed plan / triggers / challenges / risk / Rx given \_\_\_\_\_  
Screens completed fall weight immunization \_\_\_\_\_

Total face-to-face time: \_\_\_\_\_ minutes visit dominated by counseling  
> 50% of visit dominated by counseling





# *Your Health Your Choice*



## **MY ADVANCE DIRECTIVE**



### **Introduction**

This document expresses my preferences about my medical care if I cannot communicate my wishes or make my own health care decisions. I want my family, doctors, other healthcare providers, and anyone else concerned with my care to follow my wishes. For this reason, I give my patient advocate permission to share this document with doctors, hospitals, and health care providers that provide care to me. Likewise, health care providers with whom I have given this document may share it with other providers involved in my care. Any document created before this is no longer legal or valid.

My name: \_\_\_\_\_

My date of birth: \_\_\_\_\_

My address: \_\_\_\_\_

My telephone number: \_\_\_\_\_ My cell: \_\_\_\_\_

Date document completed: \_\_\_\_\_

VERSION 10/17/13

## MY CHOICE FOR MY PATIENT ADVOCATE

If I am unable to communicate my wishes and health care decisions due to illness or injury, or if my health care providers have determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions.\* My patient advocate must follow my health care instructions in this document and any other instructions I have given to them and must make decisions that are in my best interest.

I, \_\_\_\_\_ choose the person named below to be my primary Patient Advocate:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

If I cancel my primary patient advocate's authority, or if my primary patient advocate is not willing, able, or reasonably available to make a health care decision for me, I name as my alternative patient advocate (in the order listed):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

## **My Healthcare Instructions**

### General Instructions

When I am unable to speak for myself, I want my Patient Advocate to be able to:

- Make choices for me about my medical care or services, such as testing, medications, surgery, hospitalization, and hospice care. If treatment has been started, he or she can keep it going or have it stopped depending upon my specific instructions (see section on next page) or, if I have included no specific instructions, my best interest;
- Interpret any instructions I have given in this form (or in other discussions) according to his or her understanding of my wishes, values, and beliefs;
- Review and release my medical records and personal files as needed for my medical care;
- Participate in deciding arrangements for my medical care, treatment and hospitalization in Michigan or any other state, as he or she thinks appropriate;
- Determine which health professionals and organizations may provide my medical treatment.

### **Mental Health Advance Directive**

Michigan law gives individuals the right to complete an advance directive for their mental health treatment. Please contact your local community mental health agency (Genesee Health System) to learn of your rights regarding a mental health advance directive and for assistance in preparing the document.

### Specific Instructions for Life Sustaining Treatment (optional)

I give my patient advocate permission to make the following decisions regarding my preferences for my health care and request my health care providers honor them should I become unable to communicate or make my own choices. I understand that I can choose one of the three (3) instructions regarding life-sustaining treatment listed on the next page. If I choose one, I will sign my name below my choice. I understand I do not have to pick any of these choices if I do not wish to do so. With any choice, I understand that reasonable measures will be taken to keep me comfortable and free from pain as much as possible.

Life sustaining treatment is any medical device or procedure that increases your life expectancy by restoring or taking over a vital bodily function. This includes antibiotics and other medications, a breathing machine (ventilator), surgery, CPR, dialysis, and receiving food, water and other liquids through tubes.

**You may select only one choice. 1) Check the choice you wish, 2) sign your name below your choice and 3) cross out the choices you do not want. Specific instructions pertaining to your choice may be outlined on the following page.**

**Choice #1**

I want to stop or withhold treatments that might be used to keep my body alive longer, if any of these conditions exist:

If it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends, and environment;

I am close to death;

I am terminally ill and these treatments would only artificially keep me alive longer;

I am in a coma and/or have severe, permanent brain damage and am not expected to recover;

The burdens of the medical treatment outweigh the benefits.

***This Choice is my wish for treatment. I understand this decision could or would allow me to die.***

**If this Choice is your wish for treatment, sign here:** \_\_\_\_\_

**Choice #2**

I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes is irreversible. Once my doctor concludes I am permanently unconscious, I do not want life-sustaining treatment to be given or continued.

***This Choice is my wish for treatment. I understand this decision could or would allow me to die.***

**If this Choice is your wish for treatment, sign here:** \_\_\_\_\_

**Choice #3**

I want my life to be prolonged as long as possible. I wish for life-sustaining treatments to be provided until my doctor and patient advocate agree that such treatments are harmful or no longer helpful.

***This Choice is my wish for treatment.***

**If this Choice is your wish for treatment, sign here:** \_\_\_\_\_





## **My Hopes and Wishes (Optional but Encouraged)**

An individual's responses regarding their hopes and wishes have been shown to improve the patient advocate's ability to guide the healthcare decision making process.

I want my patient advocate and loved ones to know my following thoughts and feelings:

1. The things that make life most worth living to me are:

---

---

---

---

---

2. My beliefs about when life would be no longer worth living:

---

---

---

---

---

3. My choices about specific medical treatments, if any (this could include your wishes regarding ventilators, dialysis, antibiotics, tube feedings, etc.):

---

---

---

---

---

4. My thoughts and feelings about how and where I would like to die:

---

---

---

---

---

5. If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (Family members, pets, rituals, prayers, music, etc.):

---

---

---

---

---

6. Religious affiliation:

I am of the \_\_\_\_\_ faith, and am a member of  
\_\_\_\_\_ faith community in (city) \_\_\_\_\_.

Please attempt to notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

---

---

---

---

---

7. Other wishes/instructions:

---

---

---

---

---

---

---

---

---

---

---

---

# Making My Advance Directive Legal

## Patient Signature

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

---

## Witness Statement and Signature

I know this person to be the individual identified in the Patient Advocate form. I believe him or her to be of sound mind and at least eighteen (18) years of age. I personally saw him or her sign this form, and I believe that he or she did so voluntarily and without duress, fraud, or undue influence. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Patient Advocate or alternative appointed by the person signing this document.
- Not the spouse, parent, child, grandchild, brother or sister of the person signing this document.
- Not directly financially responsible for the person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee of a health care or insurance provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

### Witness Number 1:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

---

### Witness Number 2:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

---

## MY PATIENT ADVOCATE'S ACCEPTANCE

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

The person named above has asked you to serve as his or her Patient Advocate (or as an alternate or "back up" Patient Advocate).

Before agreeing to take on that responsibility and signing this form, please carefully read:

1. A copy of the form the person filled out entitled "My Choice for My Patient Advocate" and;
2. The document entitled "A Brief Guide to Advance Care Planning," which provides important information and instructions.

**Most importantly, take the time to talk to the person choosing you as Patient Advocate so that you can gain the knowledge you need to allow you to make the decisions he or she would want made.**

If you are willing to accept the role of Patient Advocate, please read and sign the following statement. Your signature does NOT need to be witnessed or notarized.

I accept the patient's selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the patient as indicated in the "My Choice for Patient Advocate" form (or in other written or spoken instructions from the patient).

I also understand and agree that:

- a. This appointment shall not become effective unless the patient is unable to participate in medical or mental health treatment decisions, as applicable.
- b. I will not exercise powers concerning the patient's care, custody, medical or mental health treatment that the patient - if the patient were able to participate in the decision - could not have exercised on his or her own behalf.
- c. I cannot make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant if that would result in the patient's death, even if these were the patient's wishes.
- d. I can make a decision to withhold or withdraw treatment which would allow the patient to die only if he or she has expressed clearly that I am permitted to make such a decision, and understand that such a decision could or would allow his or her death.
- e. I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.
- f. I am required to act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.
- g. The patient may revoke his or her appointment of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.
- h. The patient may waive the right to revoke a designation as to the power to exercise mental health treatment decisions, and if such waiver is made, the patient's ability to revoke as to certain mental health treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
- i. I may revoke my acceptance of my role as Patient Advocate any time and in any manner sufficient to communicate an intent to revoke.

- j. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Michigan Public Health Code, 1978 PA 368, MCL 333.20201

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the person the patient has designated as the alternate Patient Advocate. The alternate Patient Advocate is authorized to act until I become available to act.

**Patient Advocate**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Alternative Patient Advocate**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Alternative Patient Advocate**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (*Print or Type*): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

## NEXT STEPS

Now that you have completed your health care directive, you should also take the following steps.

- Give your patient advocate a copy of your health care directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your patient advocate is, and what your wishes are.
- Give a copy of your health care directive to your doctors. Make sure your wishes are understood and will be followed.
- Keep a copy of your health care directive where it can be easily found and accessed.
- If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the “Five D’s” occur:
  - Decade – when you start each new decade of your life.
  - Death – whenever you experience the death of a loved one.
  - Divorce – when you experience a divorce or other major family change.
  - Diagnosis – when you are diagnosed with a serious health condition.
  - Decline – when you experience a significant decline or deterioration of an existing health condition especially when you are unable to live on your own.

A copy of your advance directive will be provided to Michigan Health Connect as an electronic record. Genesee County health providers, who are subject to strict privacy laws under HIPAA, may access these records only if they have a valid medical reason pertaining to your treatment. If you do not want your advance directive stored with Michigan Health Connect you may opt out by obtaining a form from their website at [www.michiganhealthconnect.org](http://www.michiganhealthconnect.org) or phoning them at 877-269-7860.

**Copies of this document have been given to:**

Primary Patient Advocate      Name: \_\_\_\_\_

Alternative Patient Advocate      Name: \_\_\_\_\_

Alternative Patient Advocate      Name: \_\_\_\_\_

Health Care Provider/Clinic

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

*If your wishes change, fill out a new health care directive form and tell your agent, your family, your doctor, and everyone who has copies of your old health care directive forms.*

# EXAMPLE :

Medication	Date	2
1	3	4
	5	6

- KEY:**
- 1 Name of Medication (i.e., Altace)
  - 2 Date
  - 3 Strength (i.e., 2.5 mg)
  - 4 Dosage with frequency (i.e., one tab qd)
  - 5 Quantity (i.e., 30)
  - 6 Refills (i.e., 3)





**McLAREN COMMUNITY MEDICAL CENTER - GRAND BLANC**  
**2313 E. Hill, Grand Blanc, MI 48439**  
**(810) 953-6400**

**Notifier(s):**

**Patient Name:**

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

Checked Items Only:	Items or Services:	Reason Medicare May Not Pay:	Estimated Cost:
<input type="checkbox"/>	B-12 Injection & Administration	Medicare does not pay for this service for your condition	\$37.00
<input type="checkbox"/>	Chest X-ray	Medicare does not pay for this service for your condition	\$87.00
<input type="checkbox"/>	EKG, complete	Medicare does not pay for this service for your condition	\$61.00
<input type="checkbox"/>	Hemocult	Medicare does not pay for this service for your condition	\$16.00
<input type="checkbox"/>	Urinalysis	Medicare does not pay for this service for your condition	\$15.00
<input type="checkbox"/>	PAP Smear	Medicare does not pay for this service as often as this	\$70.00
<input type="checkbox"/>	GYN Exam	Medicare does not pay for this service as often as this	\$119.00
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p><b>Options: Check only one box. We cannot choose a box for you.</b></p> <p><input type="checkbox"/> <b>OPTION 1.</b> I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but <b>I can appeal to Medicare</b> by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</p> <p><input type="checkbox"/> <b>OPTION 2.</b> I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b></p> <p><input type="checkbox"/> <b>OPTION 3.</b> I don't want the _____ listed above. I understand with this choice I am <b>not responsible for payment</b>, and I cannot appeal to see if Medicare would pay.</p>
--

**Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>Signature:</b>	<b>Date:</b>
-------------------	--------------

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

- 1) An ABN, to be effective, must be completed **before** being given to the beneficiary.
- 2) Notifier must enter the first and last name of the beneficiary receiving the notice, and middle initial should also be used if on the beneficiary's Medicare (HICN) card.  
*Notifier is name of physician who will be contacted for questions.*
- 3) Delivery of an ABN occurs when the beneficiary or authorized representative (i.e., the person acting on the beneficiary's behalf) both has received the notice and can comprehend its contents. All notices must include an explanation written in lay language of the physician's or supplier's reason for believing the items or services will be denied payment. ***With the delivery of an ABN, billing should be entered along with a –GA modifier.***

***a) A –GY modifier shall be used when no ABN is required because service is never a covered benefit. Examples of such services would be: routine physicals; lab. x-ray, EKG when signs/symptoms (not present) are documented as reason for service; and cosmetic surgery (i.e., removal of skin tags).***

- 4) Common items or services will be pre-printed on the ABN for consistency in use by MMG offices. Accurate and complete documentation, as presented in CMS guidelines, will include clear checking of the items or services in question with the reason and cost information. Please note the following:
  - Beneficiary should be able to match particular items or services with the applicable reason and cost information
  - “Blank” boxes are available to allow for less commonly performed procedures
  - *Desktop Reference (Advance Beneficiary Notice of Noncoverage) under Physician Billing Update on Intranet is available for further clarification.*
- 5) Some examples of non-covered services where an ABN is not necessary include:
  - Preventive medicine services (99381-99397)
  - Routine foot care
  - Most immunizations (for example, tetanus, Rotavirus, HPV, Zoster).***A –GY modifier would be used in above cases as well.***
- 6) Medicare will pay for a screening Pap smear and pelvic examination only once every two years unless the beneficiary is considered to be at high risk for cancer under the following guidelines set by Medicare:
  - Early onset of sexual activity (under 16 years of age)
  - Multiple sexual partners (five or more in a lifetime)
  - History of sexually transmitted disease (including HIV)
  - Fewer than three (3) negative Pap smears or any abnormal Pap smear within the previous seven (7) years

- Exposed daughter of a woman who took DES during pregnancy.
- 7) A single ABN can cover up to a year of repetitive treatment if the ABN identifies all the items and services the physician believes Medicare won't pay. An example would be a series of lab tests, or B12 injections at regular intervals.
  - 8) When a patient who is capable of signing an ABN refuses to do so, and still wants the services listed on the ABN, the physician or supplier can annotate the form, with the signature of a witness, that the beneficiary received notice but refused to sign the form, and can submit the claim with a –GA modifier (waiver of liability statement on file) indicating that an ABN was given.
    - If a beneficiary chooses to receive some, but not all of the items or services that are the subject of the ABN, items and services that patient does not wish to receive may be crossed out, if done in a way that also clearly strikes reason and cost information that correspond solely to that care; otherwise, a new ABN must be prepared.
  - 9) Giving ABNs to beneficiaries under great duress is not permitted, regardless of the particular treatment setting or location.
  - 10) A copy of the signed ABN is given to the beneficiary immediately after the beneficiary signs it. Office must retain the original notice on file. ***Third copy will be attached to the router for billing purposes.***
  - 11) It is never permissible to add items or services after the beneficiary or representative has signed the notice. The ABN is only effective for items and services clearly described on the notice at the time it is signed by the beneficiary or representative.**
  - 12) See Addendum for guidance relative to “other” services and corresponding documentation that would be required. ***You must comply with this required documentation and not modify in any way.***

McLaren Ambulatory Care Center  
**CONTROLLED MEDICINES AGREEMENT**

**The purpose of this Agreement is to prevent any misunderstandings about certain medicines that you will be taking. This is to assist both you and your doctor in complying with the law regarding controlled medicines.**

**TERMS OF THE AGREEMENT:**

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my doctor will stop prescribing controlled medicines.

I will communicate fully with my doctor about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve the symptoms.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., and agree that I may be tested for use of controlled substances at any time.

I will not share, sell or trade my medicine with anyone.

I will not attempt to obtain any controlled substances, including opioid medicines, controlled stimulants, or anti-anxiety medicines, from any other doctor without coordination of care between doctors.

I will safeguard my medicine from loss or theft. I understand my doctor may not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my medicine, I understand my doctor will discuss this with me and may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of controlled medicines. I agree to these additional controls, which I understand include limitations on my supply of controlled medicines.

I agree that refills of my prescriptions for controlled medicines will be made only at the time of an office visit or during regular office hours because an evaluation of my circumstance or condition must be made. No refills will be available during evenings or on weekends.

I agree to use \_\_\_\_\_ Pharmacy, located at \_\_\_\_\_, for filling prescriptions for all of my controlled medicines.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medicine for a period of time.

**I understand that any provisions not followed in this Agreement could be grounds for discharge from care.**

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding these medicines have been adequately answered. A copy of this Agreement has been given to me.

This Agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Patient: \_\_\_\_\_ Physician: \_\_\_\_\_

Authorized Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_

**CONTROLLED MEDICINES  
AGREEMENT**

MM-21 (1/09)

PATIENT  
NAME:  
  
DATE OF  
BIRTH:

**McLaren Ambulatory Care Center  
PARENT CONTROLLED MEDICINES AGREEMENT**

**The purpose of this Agreement is to prevent any misunderstandings about certain medications that your child will be taking. This is to assist both you and your doctor in complying with the law regarding controlled medicines.**

**TERMS OF AGREEMENT:**

I understand that my child's doctor is bound by certain state and federal laws when prescribing controlled medicines. While these laws seem inconvenient to me, I understand that they are ultimately intended to protect my child's safety, health, and privacy.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my child's doctor will stop prescribing controlled medicines for my child.

I will communicate with my child's doctor about the character and intensity of my child's symptoms, the effect of the symptoms on my child's daily life, and how well the medicine is helping to control the symptoms.

I will be vigilant in assuring that my child does not use any illegal controlled substances, including marijuana, cocaine, etc. and agree that my child may be tested for use of controlled substances at any time.

I will not use, share, sell, or trade my child's medication at any time.

I agree that I will administer the medication exactly as the doctor prescribed it and make no changes to the dose, nor discontinue the medication, without instruction from my child's doctor.

I will not attempt to obtain any controlled medications for my child from any other doctor without coordination of care between doctors.

I will safeguard my child's prescription and my child's medication from loss or theft. I understand that my child's doctor may not replace lost, misplaced, or stolen medicines. If I have trouble with safeguarding my child's medicine, I understand my doctor will discuss this with me and may elect to remove my child from therapy with controlled medicines.

I understand that refills of my child's medication will be made only at the times of office visits, or during regular office hours if I call 5 business days ahead of time with a refill request. I understand that after I have called for a refill request, I should call the office the day I plan to pick it up to be sure that the physician has had the opportunity to write the prescription. I understand that refills are NOT available after office hours, on weekends, or through an on-call physician.

I understand that I may be asked for photo ID when picking up my child's prescription. I understand that I may leave written permission for some other adult designee (over age 18) to pick up my child's prescription and that the designee may be asked to provide photo ID when picking up my child's prescription.

**I understand that any provisions not followed in this Agreement could be grounds for discharge from care.**

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding these medicines have been adequately answered. A copy of this Agreement has been given to me.

This Agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Patient: \_\_\_\_\_ Physician \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_

**PARENT CONTROLLED MEDICINES  
AGREEMENT**

MM-170 (6011)

Patient Name:

Date of Birth:

**CONSENT FOR OFFICE PROCEDURE**  
(Other than Routine Care)

I hereby authorize and consent to the performance of the following procedure \_\_\_\_\_

by or under direction of Dr. \_\_\_\_\_

at \_\_\_\_\_ on \_\_\_\_\_  
(Facility's name) (Date of procedure)

I further consent to the performance of any additional procedures during the course of my procedure which the physician or his designee judges necessary or desirable to correct the existing condition or any other unhealthy condition which they may discover.

I have been advised by my physician about alternatives to the procedure suggested, but I believe that the procedure suggested is the procedure I should have.

My physician has advised me fully about the nature of the procedure and the risks involved. I realize that neither the physician nor the facility can guarantee any result.

I have read this authorization and understand it.

**NOTE TO PATIENT:** YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND AGREED TO THE ABOVE, THAT THE PROCEDURE(S) HAS (HAVE) BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR PHYSICIAN, THAT YOU HAVE ALL THE INFORMATION YOU DESIRE, AND THAT YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE(S) MENTIONED ABOVE.

DATE/TIME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

RELATIONSHIP (IF OTHER THAN PATIENT): \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_

Signature of physician by which it is affirmed that the informed consent of the patient, or duly authorized agent, has been obtained to the outlined above.

DATE/TIME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Time of pre-procedure Time out: _____	
____ Patient identified	
____ Operative site(s) verified/marked	
____ Procedure verified	
_____ Patient Signature	_____ Date/Time
_____ Physician Signature	_____ Date/Time

_____ Patient Name
_____ Date of Birth:

McLaren Medical Group  
**REPORT OF SURGICAL PROCEDURE**

PROCEDURE \_\_\_\_\_

PREOPERATIVE DIAGNOSIS #1 \_\_\_\_\_  
#2 \_\_\_\_\_

POSTOPERATIVE DIAGNOSIS #1 \_\_\_\_\_  
#2 \_\_\_\_\_

SKIN PREP IN STERILE FASHION \_\_\_\_\_  
ANESTHESIA ( ) none ( ) 1% lidocaine ( ) 1% lidocaine w/epi ( ) marcaine 0.25% ( ) other

TOTAL AMOUNT OF ANESTHESIA ADMINISTERED \_\_\_\_\_

1 2 3 4 5 6 7 8 9 >10 LESIONS

1 2 3 4 5 6 7 8 9 >10 LESIONS

LESION #1 Site \_\_\_\_\_  
Method:  
( ) excision with \_\_\_\_\_  
( ) loop cautery  
( ) shave  
( ) punch  
( ) cryo  
( ) destruction \_\_\_\_\_  
Specimen size \_\_\_\_\_

LESION #2 Site \_\_\_\_\_  
Method:  
( ) excision with \_\_\_\_\_  
( ) loop cautery  
( ) shave  
( ) punch  
( ) cryo  
( ) destruction \_\_\_\_\_  
Specimen size \_\_\_\_\_

Hemostasis via:  
( ) silver nitrate  
( ) electrocautery  
( ) aluminum chloride  
Estimated blood loss \_\_\_\_\_ mL  
Single/multi-layer closure

Hemostasis via:  
( ) silver nitrate  
( ) electrocautery  
( ) aluminum chloride  
Estimated blood loss \_\_\_\_\_ mL  
Single/multi-layer closure

\_\_\_\_\_, \_\_\_\_\_ - \_\_\_\_\_ Vicryl sub-Q

\_\_\_\_\_, \_\_\_\_\_ - \_\_\_\_\_ Vicryl sub-Q

\_\_\_\_\_, \_\_\_\_\_ - \_\_\_\_\_ Simple nylon/prolane

\_\_\_\_\_, \_\_\_\_\_ - \_\_\_\_\_ Simple nylon/prolane

\_\_\_\_\_, \_\_\_\_\_ - \_\_\_\_\_ Mattress nylon/prolane

\_\_\_\_\_, \_\_\_\_\_ - \_\_\_\_\_ Mattress nylon/prolane

Surgical margin \_\_\_\_\_ cm  
Specimen YES/NO  
( ) sent to pathology

Surgical margin \_\_\_\_\_ cm  
Specimen YES/NO  
( ) sent to pathology

Wound care instructions were given to patient. Wound was dressed with appropriate ointment prior to release. Patient instructed to call with any questions and/or problems. Patient to follow up as scheduled for post-operative care. Patient tolerated procedure well.

PATIENT TO RETURN TO CLINIC IN \_\_\_\_\_ DAYS.

PROVIDER'S SIGNATURE \_\_\_\_\_

DATE/TIME \_\_\_\_\_

Patient Name:

Date of Birth:





McLaren Ambulatory Care Center

PRE-OPERATIVE CLEARANCE CONSULTATION\*

\*requires completion of all highlighted areas

Request made by \_\_\_\_\_  M.D. on \_\_\_\_\_  
 D.O. (Date)

Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_

Past Medical History (check  if present) or  None

- |  |  |   |                                |
|--|--|---|--------------------------------|
| <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Asthma                    | Diabetes Mellitus                               |                                |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Tuberculosis              | <input type="checkbox"/> Type I                 | _____ Pregnancies              |
| <input type="checkbox"/> Myocardial Infarction       | <input type="checkbox"/> GERD                      | <input type="checkbox"/> Type II                | _____ Deliveries               |
| <input type="checkbox"/> Irregular Heart Beat        | <input type="checkbox"/> Hepatitis                 | Thyroid   | <input type="checkbox"/> Other |
| <input type="checkbox"/> Congestive Heart Failure    | <input type="checkbox"/> Ulcers                    | <input type="checkbox"/> Hypothyroidism         | _____                          |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> CVA                       | <input type="checkbox"/> Hyperthyroidism        | _____                          |
| <input type="checkbox"/> Murmur                      | <input type="checkbox"/> Transient Ischemic Attack | <input type="checkbox"/> Cancer                 |                                |
| <input type="checkbox"/> Pacemaker/ICD               | <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Chronic Kidney Disease |                                |
| <input type="checkbox"/> COPD                        |  | <input type="checkbox"/> Bleeding Disorders     |                                |

Past Surgical History \_\_\_\_\_  
\_\_\_\_\_

Social History

- |   |   |
|---|---|
| <input type="checkbox"/> Occupation _____ |   |
| <input type="checkbox"/> Smoking _____    | <input type="checkbox"/> Drugs _____                |
| <input type="checkbox"/> Alcohol _____    | <input type="checkbox"/> Abuse (Psychosocial) _____ |

Family History

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer             |   |

Review of Systems

(check  if present)  
or  
 None

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Nausea/Vomiting    | <input type="checkbox"/> Altered Bowel Habits    |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Altered Bladder habits  |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Dyspepsia/Dysphagia     |
| <input type="checkbox"/> Sore Throat         | <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Anorexia/Weight Loss    |
| <input type="checkbox"/> Fever/Chills        | <input type="checkbox"/> Hearing Problems   | <input type="checkbox"/> Fatigue/Weakness        |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Light-headedness   | <input type="checkbox"/> Weakness in Extremities |

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PHYSICAL EXAMINATION (Explain any abnormalities under "Other"):**

Vital Signs:     Reviewed     Other \_\_\_\_\_

HEENT:         Normal         Other \_\_\_\_\_

Neck:          Normal         Other \_\_\_\_\_

Breast:         Normal         N/A         Other \_\_\_\_\_

Thorax:        Normal         Other \_\_\_\_\_

Heart:         Normal         Other \_\_\_\_\_

Lungs:         Normal         Other \_\_\_\_\_

Abdomen:      Normal         Other \_\_\_\_\_

Genitalia:     Normal         N/A         Other \_\_\_\_\_

Pelvic:         Normal         N/A         Other \_\_\_\_\_

Rectal:        Normal         N/A         Other \_\_\_\_\_

Extremities:  Normal         Other \_\_\_\_\_

Neuro:         Normal         Other \_\_\_\_\_

**Pertinent Labs, X-Rays, EKG:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Findings:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Cleared for surgery:**     Yes     No

Comments: \_\_\_\_\_

\_\_\_\_\_

**Report sent to:** \_\_\_\_\_ Date/Time: \_\_\_\_\_

Signature \_\_\_\_\_ Date/Time: \_\_\_\_\_  
Physician

Patient Name:

Date of Birth:

**McLaren Ambulatory Care Center  
McLaren Occupational Health/Convenient Care Center  
REFUSAL TO CONSENT TO MEDICAL TREATMENT/TRANSPORT**

This is to certify that I, \_\_\_\_\_, a rational and competent individual, a patient at \_\_\_\_\_  
Name of Patient Name of Facility

on \_\_\_\_\_, am refusing one of the below categories against the advice of the physician:  
Date of Service

- 1. Tests: \_\_\_\_\_  
\_\_\_\_\_
- 2. Procedures: \_\_\_\_\_  
\_\_\_\_\_
- 3. Treatments: \_\_\_\_\_  
\_\_\_\_\_
- 4. Left against \_\_\_\_\_  
Medical advice: \_\_\_\_\_

I acknowledge that I have been informed of the risk involved as a result of failure to consent to the tests, procedures, treatments or leaving against medical advice, and hereby release the physician and the care center from all responsibility and liability for any ill effects that may result from this refusal. I understand that this refusal could include adverse effects arising because my physician will be unable to reach a timely, correct, or accurate diagnosis of my condition, and thereby resulting in my physician's inability to promptly or correctly render treatment appropriate to my condition.

- 5. Refusal to be \_\_\_\_\_  
Transported: \_\_\_\_\_

I acknowledge that I have been informed of the risk involved in refusing to be transported by ambulance which may include advanced cardiac life support, intravenous support and paramedic treatment. I hereby release the ambulance company, physician and this medical care facility from all responsibility for any ill effects which may result in my decision.

\_\_\_\_\_  
(Signature of Patient) (Time) (Date)

\_\_\_\_\_  
(Signature of Physician) (Signature of Witness)

If patient is unable to sign due to a question of competence or is a minor, complete the following: (If the patient is a minor or the patient is legally incompetent, please obtain the signature of the legal guardian, patient advocate or closest available relative.)

Patient is unable to sign because \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Signature of Witness) (Signature of Parent / Legal Guardian / Patient Advocate)

**REFUSAL TO CONSENT TO**

Patient Name:

Date of Birth:

## ADDITIONAL INFORMATION

### FOR FRONT OFFICE STAFF:

1. Obtain appropriate information when scheduling a patient for a “Welcome to Medicare” visit.
  - a. Are you a new Medicare beneficiary?
  - b. What is the effective date for Part B on your health insurance card?
2. Confirm with patient that they are wanting a “Welcome to Medicare” exam, as opposed to a regular physical exam.

### FOR MA/PROVIDER:

1. Have appropriate form available for completion.
2. If the service is performed more than once in a lifetime or after the patient’s first 12 months of Medicare Part B enrollment, an Advance Beneficiary Notice (ABN) must be signed by the patient in advance of the service.

### FOR PROVIDER:

1. A comprehensive medical and social history will identify modifiable risk factors for disease; a family history will identify hereditary diseases or diseases that otherwise place the patient at increased risk for disease.
2. Identifying depression and other mood disorders does not have to be done by using a standardized depression screening tool. This would be too cumbersome to use in a short office visit. The U.S. Preventive Services Task Force (USPSTF) recommends two questions for this screening, both of which are included on our form. If an affirmative answer to either, then a patient would be identified as needing further evaluation for depression.
3. There is a lot of leeway with the review of functional ability and level of safety. According to the American Geriatric Society, there are two tests that should trigger further patient evaluation. If your patient has previously received treatment for a fall, or if your patient takes longer than 30 seconds for an “Up & Go” test. (Have the patient stand up from a chair, walk three meters, turn around, walk back to the chair and sit down.) If the patient takes longer than 30 seconds or seems unsteady, the test is

considered positive for increased fall risk. For the hearing evaluation, simply question patients about their hearing function.

4. The physical exam is extremely focused. Height, weight, blood pressure, visual acuity, and measurement of body mass index are the only required components. Use of a Snellen chart is appropriate for vision.
5. End-of-life planning is a required service upon the beneficiary's consent. This planning is information provided to the beneficiary regarding:
  - a. The beneficiary's ability to prepare an Advance Directive in the case that an injury or illness causes the beneficiary to be unable to make healthcare decisions, and
  - b. Whether or not the physician is willing to follow the beneficiary's wishes as expressed in the Advance Directive.
6. EKG results need to be incorporated into the patient's medical record. If the patient is sent to another facility for the EKG, the order must read "EKG as part of the Welcome to Medicare Physical."
7. There should be evidence of brief education, counseling and referral to address any pertinent health issues identified during the first five elements of the exam. Time required for this step will vary depending on the problems discovered.
8. Maintenance of a written plan regarding separate preventive care services covered by Medicare Part B. It is important to understand the Medicare policy on these services before counseling the patient. Some are covered at 100% of the Medicare allowable charge, and some are covered at 80%. Some services are covered only if medically indicated.

**FOR BILLING:**

1. Use the following valid Medicare Initial Preventive Physical Exam Codes (HCPCS):
  - a. **G0402** – Initial preventive physical exam; face to face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
  - b. **G0403** – EKG, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.
  - c. **G0404** – EKG, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.

- d. **G0405** – EKG, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination.
2. If a sick chief complaint is addressed, you may bill any level of E/M (99201-99205 or 99212-99215) with the “Welcome to Medicare” code; add modifier -25 to the E/M code. You must document that portion of the visit on the appropriate MMG form (or dictate.)
3. For female patients, you may also bill the breast and pelvic screening exam code (G0101) and the screening pap smear (Q0091) if you document the 7 of 11 genitourinary bullets and document that the pap was obtained. If you provide this service, you can bill this in addition to the “Welcome to Medicare” code. You must document this service on the appropriate MMG form (or dictate.) **REMINDER: If providing the screening breast/pelvic and pap smear service, obtain the Medicare ABN due to frequency guidelines.**
4. For male patients, the prostate screening exam code (G0102) is bundled into the “Welcome to Medicare” code. This is NOT separately billable, but if done it must be documented separately on the appropriate form (or dictated.)
5. Any diagnostic tests provided at the time of the “Welcome to Medicare” exam MUST be documented and billed separately.

McLaren Medical Group  
"Welcome to Medicare" Exam

Medicare B eligibility date: \_\_\_\_\_ Date of exam: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

**MEDICAL/SOCIAL HISTORY**

**Past personal illnesses or injuries:**

Injury or illness	Date	Hospitalized?

Drug allergies: \_\_\_\_\_

Tobacco use: \_\_\_\_\_

Alcohol use: \_\_\_\_\_

Drug use: \_\_\_\_\_

**Medications, supplements and vitamins:**

\_\_\_\_\_  
\_\_\_\_\_

**Social history notes (including diet and physical activities):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family history notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DEPRESSION SCREEN**

- 1. Over the past two weeks, have you felt down, depressed or hopeless?  Yes  No
- 2. Over the past two weeks, have you felt little interest or pleasure in doing things?  Yes  No

**FUNCTIONAL ABILITY/SAFETY SCREEN**

- 1. Was the patient's timed Up & Go test unsteady or longer than 30 seconds?  Yes  No
- 2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money?  Yes  No
- 3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?  Yes  No
- 4. Have you noticed any hearing difficulties?  Yes  No

Hearing evaluation: \_\_\_\_\_

**A "yes" response to any of the questions regarding depression or function/safety should trigger further evaluation.**

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Visual acuity: L \_\_\_\_\_ R \_\_\_\_\_ Body Mass Index: \_\_\_\_\_

**ELECTROCARDIOGRAM**

Referral or result: \_\_\_\_\_

**Evaluations/referrals based on history, exam and screening:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADVANCE DIRECTIVE**

- Patient has  does not have  info given  Physician willing to follow Advance Directive

continued 

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



**McLaren Medical Group**  
**“Welcome to Medicare” Exam**

**COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES**

Service	Limitations	Recommendation	Scheduled
Vaccines • Pneumococcal • Influenza • Hepatitis B (if medium/high risk)	No deductible/no co-pay  Medium/high-risk factors: • End-stage renal disease • Patients with hemophilia who received Factor VIII or IX concentrates • Clients of institutions for the mentally retarded • Persons who live in the same house as a carrier of Hepatitis B virus • Homosexual men • Abusers of illicit injectable drugs		
Mammogram			
Pap and pelvic exams			
Prostate cancer screening • Digital rectal exam (DRE) • Prostate specific antigen (PSA)			
Colorectal cancer screening • Fecal occult blood test • Flexible sigmoidoscopy • Screening colonoscopy • Barium enema	Exempt from Part B deductible.		
Diabetes self-management training	Requires referral by treating physician for patient with diabetes or renal disease.		
Bone mass measurements	Requires diagnosis related to osteoporosis or estrogen deficiency.		
Glaucoma screening			
Medical nutrition therapy for diabetes or renal disease	Requires referral by treating physician for patient with diabetes or renal disease.		
Cardiovascular screening blood tests • Total cholesterol • High-density lipoproteins • Triglycerides	Order as a panel if possible.		
Diabetes screening tests • Fasting blood sugar (FBS) or glucose tolerance test (GTT)	Patient must be diagnosed with one of the following: • Hypertension • Dyslipidemia • Obesity (BMI $\geq 30$ kg/m <sup>2</sup> ) • Previous ID of elevated impaired FBS or GTT ... or any two of the following: • Overweight (BMI $\geq 25$ but $< 30$ ) • Family history of diabetes • Age 65 years or older • History of gestational diabetes or birth to baby weighing more than 9 pounds		
Abdominal aortic aneurysm screening • Sonogram	Patient must be referred through this exam and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria: • Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime • Anyone with a family history of abdominal aortic aneurysm • Anyone recommended for screening by the U.S. Preventive Services Task Force		

Provider's Signature \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient Name:

Date of Birth:

McLaren Medical Group  
**Medicare First Annual Wellness Visit**

**Patient's name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Part B eligibility date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of exam:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Allergies:** \_\_\_\_\_

**Medical and social history**

Past personal illnesses, injuries, operations	Date	Hospitalized?

**Tobacco use:** \_\_\_\_\_  
**Alcohol use:** \_\_\_\_\_  
**Drug use:** \_\_\_\_\_  
**Medications, supplements, vitamins:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current list of patient's providers and suppliers**

Name	Specialty	Reason

**Height:** \_\_\_\_\_  
**Weight:** \_\_\_\_\_  
**BMI:** \_\_\_\_\_  
**BP:** \_\_\_\_\_  
**Visual acuity:** L \_\_\_\_\_ R \_\_\_\_\_  
 \_\_\_\_\_:

**Family history** (check those that apply)

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia, Sickle Cell	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Obesity	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis

**Notes:**

**Is the patient on a special diet? Why?** \_\_\_\_\_

**Detection of cognitive impairment:** \_\_\_\_\_

**Depression screen** (ask the following questions, check the response)

- Over the last two weeks, have you felt down, depressed or hopeless? Yes  No
- Over the last two weeks, have you felt little interest or pleasure in doing things? Yes  No

**Hearing loss screen**

- Do you have trouble hearing the television or radio when others do not? Yes  No
- Do you have to strain or struggle to hear/understand conversations? Yes  No

Patient Name:

Date of Birth:

**Function screen**

- 1. Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances, or other activities of daily living? Yes  No
- 2. Do you live alone? Yes  No

**Home safety screen**

- 1. Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? Yes  No
- 2. Does your home LACK grab bars in bathrooms, handrails on stairs and steps? Yes  No
- 3. Does your home LACK functioning smoke alarms? Yes  No

**Risk for falls screen**

- 1. Was the patient unsteady or take longer than 30 seconds during the timed “get up and go” test? Yes  No

<b><u>ACTION ITEMS:</u></b> Information in the patient’s history and checking any yes response to the above screening questions should trigger further evaluation(s).		
<b>Evaluation/referral based on screening</b>	<b>Scheduled appointment (dates, physician, etc.)?</b>	<b>Notes</b>

**Advanced care planning**

- 1. Patient Consent: “I consent to discuss end-of-life issues with my healthcare provider.”

\_\_\_\_\_

Patient/Guardian Signature Date

- 2. Patient already has executed an Advance Directive. Yes  No
- 3. If no, patient was given an opportunity to execute an Advance Directive today? Yes  No
- 4. Physician Statement: “This individual has the ability to prepare an Advance Directive.” Yes  No
- 5. Physician has completed a physician order for life-sustaining treatment, or similar document of reflecting the patient’s wishes for an advanced care plan. Yes  No
- 6. Physician is willing to follow the patient’s wishes. Yes  No

**Notes:**

Patient Name:
Date of Birth:

<b>Preventive screen (frequency)</b>	<b>Coverage</b>	<b>Previously tested (If yes, when?)</b>	<b>Scheduled for screenings (5 to 10 years)</b>
<b>Bone Mass Measurements</b> (every 24 months)	Medicare patients at risk for developing Osteoporosis		
<b>Cardiovascular Screening Blood Tests</b> (every 5 years) – Lipid panel – Cholesterol – Lipoprotein – Triglycerides	All asymptomatic Medicare patients (12-hour fast is required)		
<b>Colorectal Cancer Screening</b> – Flexible sigmoidoscopy (4 years, or once every 10 years after a screening colonoscopy) – Screening colonoscopy (every 24 months at high risk; every 10 years not at high risk) – Fecal occult blood test (annually) – Barium enema (every 24 months at high risk; every 4 years not at high risk)	– Medicare patients age 50 and up – Screening colonoscopy: Those at high risk; no minimum age – No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the patient is at high risk		
<b>Diabetes Screening Tests</b> (2 screening tests per year for patient diagnosed with pre-diabetes; 1 screening per year if previously tested, but not diagnosed with pre-diabetes or if never tested)	Medicare patients with certain risk factors for diabetes or diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible for benefit)		
<b>Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy</b> (Up to 10 hours of initial training within a continuous 12-month period; subsequent years up to 2 hours of follow-up training each year after initial year)	Medicare patients at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes (must certify DSMT need)		
<b>Glaucoma Screening</b> (annually for patient in one of the high risk groups)	Patients with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and up		
<b>Prostate Cancer Screening</b> (annually) – Digital rectal exam – Prostate specific antigen test	All male patients 50 or older		
<b>Screening Pap Tests and Pelvic Examination</b> (annually if high-risk, or childbearing age with abnormal Pap test within past 3 years; every 24 months for all other women)	All female Medicare patients		
<b>Screening Mammography</b> (annually)	All female patients 40 or older		
<b>Vaccines</b> – Pneumococcal (once in a lifetime) – Seasonal Influenza (once per flu season in the fall or winter) – Hepatitis B (scheduled dosages required)	All Medicare patients – May provide additional pneumococcal vaccinations based on risk and provided that at least 5 years have passed since previous dose – Hepatitis B, if medium/high risk		

Provider signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Patient Name:

Date of Birth:

**EXAM FORM: Completing this form is not required for the Wellness Visit, but is voluntary.**

**Subjective: C/O:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_  
**HPI:** \_\_\_\_\_ **Current pain:**  no  yes **Severity of Pain:** 0 1 2 3 4 5 6 7 8 9 10 (Circle)

3) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

52 \_\_\_\_\_  
 \_\_\_\_\_

√ = normal X = abnormal other than stated in HPI - explanation

**Objective**

√ = examined & normal X = abnormal w/ explanation

	Skin		
	Lymph nodes		
	Neck		
	( <input type="checkbox"/> HV		
	( <input type="checkbox"/> 17		
	& 9		
	Abd / Gastro		
	Respiratory		
	Chest / Breasts		
	Back		
	Genitalia		
	Neurologic		
	Psych		
	( <input type="checkbox"/> WHP WPM ISV		
	( <input type="checkbox"/> WHP WPM XSSHU		

**IMP/Dx/Plan:**

**ORDERS:**

**Oral Meds:** \_\_\_\_\_ **Injection** \_\_\_\_\_  
 Rapid Strep \_\_\_\_\_  02 Sat \_\_\_\_\_  EKG \_\_\_\_\_  X-Ray of \_\_\_\_\_ - Views: \_\_\_\_\_  
 Lab: \_\_\_\_\_  Other: \_\_\_\_\_ done by: \_\_\_\_\_

5 2 \_\_\_\_\_ D V \_\_\_\_\_ H N V 0 R M V \_\_\_\_\_ H D V \_\_\_\_\_ R U H V R U R I P S U R Y H P H W D I M U M W W 3 5 1 \_\_\_\_\_ ( G X F D M R D O D M U D O l ven:  HV  No  
**Provider names:** \_\_\_\_\_ **Time spent with patient** \_\_\_\_\_ **estimated** FRX V H Q \_\_\_\_\_ M P H B B B B B B B B B B FR V X O V

Provider signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Patient Name:

Date of Birth:

McLaren Ambulatory Care Center  
McLaren Occupational Health/Convenient Care Center

**ACKNOWLEDGEMENT OF SPORTS PHYSICAL**

I, \_\_\_\_\_, acknowledge that the physical examination performed  
(name of parent/legal guardian)  
on my son/daughter, \_\_\_\_\_, is a limited examination only to  
(name of son/daughter)  
determine readiness for sports participation. It is not meant to be a substitute for a comprehensive  
health maintenance examination. If such a comprehensive examination is desired, I understand that  
an appointment for same must be scheduled in advance.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Patient Name:

Date of Birth:

VISIT DATE APPT TIME PATIENT MSR

08/21/08

NAME: JANE DOE DOB: 05/26/1975 AGE: 33 SEX: F

ADDRESS: 123 TEST ST CITY: FLINT STATE: MI ZIP CODE: 48507 TIME IN TIME OUT MEANS OF ARRIVAL NEW EST PRIMARY PHYSICIAN DOCTOR: BECK BRIAN DO DR#: 100 TELEPHONE: 810-252-2552 GROUP CONTRACT # EMPLOYER PRIMARY INSURANCE SECONDARY INSURANCE AUTHORIZED BY

CHIEF COMPLAINT:

REASON FOR VISIT

HT WT B/P P R TEMP. LMP PREGNANT? LAST TETANUS

ALLERGIES MEDS

(PFSH) PAST MED HISTORY: FAMILY HISTORY: CANCER DIABETES HEART DISEASE LUNG DISEASE/TB LIVER DISEASE KIDNEY DISEASE HYPERTENSION OTHER SOCIAL HISTORY: TOBACCO ALOCHOL SUB ABUSE OTHER

REVIEW OF SYSTEMS (ROS)

CONSTITUTIONAL (GENERAL SYMPTOMS):

FEVER CHILLS SWEATS FATIGUE SLEEPLESS HEADACHE DIZZINESS WEAKNESS LOSS OF APPETITE WEIGHT LOSS/GAIN

EYES: DRAINAGE REDNESS ITCHING BLURRING DOUBLE VISION ACUITY L20/ R20/

EARS, NOSE, THROAT, MOUTH: PAIN/PRESSURE (AREAS) CONG/DRAIN (AREAS) SNEEZING DEC HEARING BAD BREATH

OTHER

RESPIRATORY: SHORTNESS OF BREATH COUGH WHEEZING BLOODY SPUTUM CONGEST/HEAVINESS IN CHEST OTHER

CARDIOVASCULAR: CHEST PAIN/PRESSURE IRREGULAR/RAPID BEAT JAW/SHOULDER/ARM PAIN EXCESS SWEATING POOR COLOR SWELLING/FLUID RETENTION OTHER

GASTROINTESTINAL: INDIGESTION NAUSEA VOMITING GAS DIARRHEA CONSTIPATION BLOOD IN STOOL BLOOD IN VOMIT HEMORRHOIDS PAIN OTHER

GENITOURINARY: BURNING/PAINFUL URINATION FREQUENCY NIGHT URINATION BLOOD IN URINE GENITAL SORES VAG/PEN DISCH PELVIC PAIN ITCHING BLEEDING OTHER

MUSCULOSKELETAL: BODY ACHE STIFF (AREA) SWELL JOINT PAIN (AREA) WARMTH OTHER

SKIN AND/OR BREAST: WOUNDS (AREA) SORES (AREA) DRYNESS ITCHING RASHES DISCOLORATION TIGHTENING OTHER SIGNATURE:

PSYCHIATRIC: STRESS DEPRESSION ANXIETY AGITATION OTHER

ENDOCRINE: THYROID HEAT OR COLD INTOL EXCESS SWEATING THIRST HUNGE OTHER

HEMATOLOGIC/LYMPHATIC: SWOLLEN GLANDS TENDER GLAND OTHER ALLERGIC/IMMUNOLOGIC: RESP DISTRESS HIVES ITCHIN DIFF SWALLOWING SWELLING NEUROLOGICAL: TINGLING (AREA) NUMBNESS PARALYSIS

REVIEW OF DOCUMENTATION ABOVE: (PHYSICIAN TO INITIAL EACH SECTION AFTER REVIEW) VITALS PFSH ROS

PHYSICAL EXAMINATION (DESCRIPTION OF FINDINGS)

GENERAL APPEARANCE: N ABN NOT EXAMINED

EYES: N ABN NE

EARS: N ABN NE

NOSE: N ABN NE

THROAT: N ABN NE

MOUTH: N ABN NE

NECK: N ABN NE

RESPIRATORY: N ABN NE

CARDIOVASCULAR: N ABN NE

CHEST (BREASTS): N ABN NE

ABDOMEN/GASTROINTESTINAL: N ABN NE

GENITOURINARY: N ABN NE

LYMPH: N ABN NE

MUSCULOSKELETAL: N ABN NE

SKIN: N ABN NE

NEUROLOGICAL: N ABN NE

PSYCHIATRIC: N ABN NE

LAB TESTS, X-RAYS/RESULTS

DIAGNOSIS

TREATMENT PLAN (INCLUDES INSTRUCTIONS FOR FOLLOW-UP CARE)/FINAL DISPOSITION

LEFT AGAINST MEDICAL ADVICE

PROVIDER'S NAME (PLEASE PRINT)/SIGNATURE

DATE

Visit Date Appt Time Patient MSR

MCLAREN

1. \_\_\_\_\_  
 APT REASON: COLLECTION CODE  
 Name: DOB Age Sex 2. \_\_\_\_\_  
 Address: 3. \_\_\_\_\_  
 1255 SUMMER AVENUE  
 City State Zip Code 4. \_\_\_\_\_  
 MI  
 Doctor DR# Telephone  
 Primary Insurance Secondary Insurance 5. \_\_\_\_\_  
 AUTO 6. \_\_\_\_\_

X DESCRIPTION	CODE	X DESCRIPTION	CODE	X DESCRIPTION	CODE	X DESCRIPTION	CODE
<b>SURGICAL PROCEDURES</b>		<b>RADIOLOGY (CONT'D)</b>		<b>VACCINES, TOXOIDS**</b>		<b>OTHER SERVICES/SUPPLIES</b>	
INCISION&DRAINAGE, SIMP*	10060	RADIOLOG EXAM PELV 1/2V	72170	INFLUENZA VIRUS VACCINE		SPORTS PHYSICAL	GC100
INCIS&REMOV FORE BODY SIM*	10120	RADIOLOG EXAM SACCRUM &		SPLIT VIRUS 6-35 MOS	90657	NURSE VISIT NO CHG	GC002
PUNCTURE ASPIRATION*	10160	COCCYX MIN 2V	72220	INFLUENZA VIRUS VACCINE		MARRIAGE COUNSELING	
SIMPLE REPAIR SUPERFICIAL		RADIOLOG EXAM CLAV CMPL	73000	SPLIT VIRUS 3YRS & UP	90658	SPLY VITAMIN A CREAM	
WOUNDS BODY 2.5CM - LESS*12001		RADIOLOG EXAM SHOULDER		INFLUENZA VIRUS VACCINE		PREGNANCY KIT	
SIMPLE REPAIR SUPERFICIAL		COMPLETE MIN 2V	73030	LIVE INTERNASAL USE	90660	SPLY WRIST SPLINT	GC500
WOUNDS BODY 2.6CM - 7.5CM*12002		RADIOLOG EXAM HUMEROUS		TETANUS TOXOID	90703	SPLY WRST SPLINT UNIGC501	
SIMPLE REPAIR SUPERFICIAL		MIN 2 VIEW	73060	TETANUS&DIPH THER (TD) 7YRS+	90718	SPLY FINGER SPLINT	GC502
WOUNDS FACE 2.5CM - LESS*12011		RADIOLOG EXAM ELBOW		** CODES 90471-90472 MUST BE		SPLY ANKLE SPLINT	GC503
SIMPLE REPAIR SUPERFICIAL		COMPLETE MIN 3V	73080	REPORTED IN ADDITION TO THE VACC.		SPLY ARM SLING	
WOUNDS FACE 2.6CM - 5.0CM*12013		RADIOLOG EXM FOREARM 2V	73090	AND TOXOID CODE(S) 90476-90749.		WITH THUMB LOOP	GC505
INITIAL TREATMENT 1ST DEG		RADIOLOG EXAM WRIST		THERAP OR DIAGNOS INJECTION	96372	SPLY ARM SLING W/CSTGC506	
BURN ONLY LOCAL TREAT REQ16000		COMPLETE MIN 3V	73110			SPLY KNEE IMMOBIL	CC507
DRESS AND/OR DEBRIDEMENT		RADIOLOG EXM HAND MN 3V	73130			SPLY ACE WRAPS	GC510
INITIAL OR SUBS, SMALL*	16020	RADIOLOG EXAM FINGER(S)				SPLY MISC OVRD PRICECC200	
DRESS AND/OR DEBRIDEMENT		MINIMUM 2V	73140	<b>X MEDICAL SERVICES</b>	<b>CODE</b>	BLOOD DRAW	36415
INITIAL OR SUBS MEDIUM*	16025	RADIOLOG EXM HIP UNIL 1V73500		BKG ROUTINE, 12 LEADS	93000	SUTURE REMOVAL	
REMOV FOREIGN BODY MUSCLE		RADIOLOG EXM HIP CMP 2V	73510	W/ INTERPRETATION & REPORT			
OR TENDON SHEATH SIMPLE*	20520	RADIOLOG EXAM FUMAR 2V	73550	BKG TRACING ONLY W/O	93005		
INJECTION TENDON SHEATH		RADIOLOG EXAM KNEE 1/2V	73560	INTERPRETATION & REPORT			
LIGAMENT, GANGLION CYST*	20550	RADIOLOG EXAM KNEE 3V	73564	PRESSURIZED/NONPRESSURIZED	94640	<b>X INJECTIONS</b>	<b>CODE</b>
TRIG PT INJEC 1-2 MUS GRP*20552		RADIOLOG EXAM KNEE 4/+V	73564	INHALATION TREATMENT		ROCEPHIN PER 250MG	J0696
TRIG PT INJEC 3/+ MUS GRP*20553		RADIOLOG EXAM TIBIA &		UNLISTED PULMONARY SERVICE	94799	CLAFORAN PER G	J0698
APPLICATION OF SHORT ARM		FIBULA 2V	73590	OR PROCEDURE		COMPazine TO 10MG	J0780
SPLINT FORARM TO HAND	29125	RADIOLOG EXM ANKL MN 3V	73610	PROFES SERVICE FOR ALLERGEN	95115	DEPO-MEDROL 20MG	J1020
APP. OF FINGER SPLINT	29130	RADIOLOG EXM FOOT MN 3V	73630	IMMUNOTHERAPY SINGLE INJECT		DEPO-MEDROL 40MG	J1030
APPLICATION OF SHORT LEG		RADIOLOG EXAM CALCANEUS		HANDLING AND/OR	99000	DEPO-MEDROL 80MG	J1040
SPLINT, CALF TO FOOT	29515	MINIMUM 2V	73660	CONVEYANCE OF SPECIMINE		BENADRYL TO 50MG	J1200
REMOVAL FOREIGN BODY EXT.		RADIOLOG EXM TOES MN 2V	73660	POSTOPERATIVE FOLLOW-UP VISIT FOR		TORADOL PER 15MG	UNITS
EYE CONJUNCTIVAL SUPERFIC*65205				DOCUMENTATION PURPOSES ONLY	99036	(1UNIT = 15MG)	J1885
REMOVAL FOREIGN BODY EXT.		RADIOLOG EXAM ABDOMEN,		OFFICE SERV EMERGENCY BASIS	+99058	LASIX TO 20 mg	
EYE CORNEAL W/O SLIT LAMP*65220		ANTEROPOSTERIOR & ADD.		URG CARE GLOB FEE - BCN&HAP	S9083	>20mg units	J1940
REMOVAL FOREIGN BODY EXT.		OBLIQUE/ CONE V	74010			LINCOICIN TO 300MG	J2010
EYE CORNEAL W/ SLIT LAMP*65222		AC JOINTS	73050	<b>X E-SCRIBE</b>	<b>CODE</b>	NUBAIN PER 10MG	J2300
REMOVAL IMPACTED CERUMEN				E-SCRIBE USED FOR ALL RX	G8443	NORFLEX TO 60MG	J2360
ONE OR BOTH EARS	69210	<b>X PATH/LAB</b>	<b>CODE</b>	E-SCRIBE NOT USED TODAY	G8445	PHENERGAN TO 50MG	J2550
		INFLUENZA STRIPS	87804	NARC/CNTRL SUB PRESCRIBED	G8446	TIGAN TO 200MG	J3250
<b>X RADIOLOGY</b>	<b>CODE</b>	URINALYSIS NON-AUTOMAT		STATE/FED LAW REQUIRES	G8446	KENALOG 10MG	unitsJ3301
RADIOLOGIC EXAM SINUSES		WITHOUT MICROSCOPY	81002	PHONE OR PRINT RX		VISTARIL TO 25MG	J3410
PARANASAL COMPLETE MIN 3V70220		BLOOD OCCULT FECES 1-3		PATIENT ASKED FOR	G8446	SOLU-MEDROL TO 40mg	J2920
RADIOLOG EXAM SKULL <4V70250		SIMULTAN DETERMINATION	82270	PHONE/PRINT RX		LEUPROLIDE	J1950
RADIOLOG EXAM SKULL MIN 4V70250		GLUCOSE QUANTITATIVE		PHARMACY CAN'T RECEIVE	G8446		
RADIOLOG EXAM CHEST SING V71010		BLOOD REAGENT STRIP	82948	ELECTRONIC RX		<b>X PREVENTATIVE MEDICINE</b>	<b>CODE</b>
RADIOLOG EXAM CHEST 2V 71020		GLUCOSE BLOOD BY GLU-				ADMIN/INTERP HEALTH	99420
RADIOLOG EXAM RIBS UNIL 2V71100		COSE MONITORING DEVICE	82962	<b>X NEW PATIENTS</b>	<b>CODE</b>	RISK ASSES INSTRUMENT	
RADIOLOG EXAM RIBS BILA 3V71110		GONADOTROPIN CHORIONIC		NEW PATIENT OFFICE VISIT	99201	INCL PAA 2ND&3RD CLASS EXAM	
RADIOL EXAM SPN CERV 2/3V72040		(HCG) QUALITATIVE	84703	PROBLEM FOCUSED		UNLISTED PREVENTATIVE	
RADIOL EXAM SPN CERV 4V 72050		MONO TEST	86308	NEW PATIENT OFFICE VISIT	99202	MEDICINE EXAM	99429
RADIOL EXAM SPN CERV CMPL72052		STREP (RAPID)	87880QW	EXPANDED PROBLEM FOCUSED		INCL FAA 1ST CLASS PHYS EXAM	
RADIOLOG EXAM SPN THOR 2V 72070		URINE PREG TST VIS CLR	81025	NEW PATIENT OFFICE VISIT	99203		
RADIOLOG EXAM SPN LUMBO-		BLOOD OCCULT		DETAILED			
SACRAL 2 OR 3V 72100		FECES SINGLE DIGITAL	82272QW	NEW PATIENT OFFICE VISIT	99204		
RADIOLOG EXAM SPN LUMBO-		CULT CHLAMYDIA WET MT	87110	COMPREHENSIVE			
SACRAL MIN 4V 72110		TISSUE EXAM by KOH					
		SKIN/HAIR/NAILS	87220	<b>X ESTABLISHED PATIENTS</b>	<b>CODE</b>	ACCOUNT STATUS	
				ESTABLISHED PATIENT, OFFICE	99212	CHARGE - \$	
				VISIT PROBLEM FOCUSED			
				ESTABLISHED PATIENT, OFFICE	99213	PAYMENT - \$	
				VISIT EXPAN PROBLEM FOCUSED			
				ESTABLISHED PATIENT, OFFICE	99214	METHOD	
				VISIT DETAILED		CASH	CHECK
						CHARGE CARD	

PLEASE NOTE: CODING BOOKS SHOULD ALWAYS BE REFERENCED FOR MORE SPECIFICITY IN  
 \*SERVICE INCLUDES SURGICAL PROCEDURES ONLY+ADD-ON CODE (USE WITH E/M CODE)



**MCLAREN AMBULATORY CARE CENTER  
DIABETIC RETINOPATHY EVALUATION**

**Patient: Please present this form to your eye care professional to assist in coordinating your Diabetic Management Care program**

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Date of Exam: \_\_\_\_\_ Health Plan ID: \_\_\_\_\_

**Primary Care Physician Information**

Physician: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: **MI** Zip: \_\_\_\_\_

**FINDINGS**

- No diabetic retinopathy is found in either eye. **OR**
- RETINAL EXAM ABNORMALITIES DETECTED, AS FOLLOWS:
- Background changes noted in:
- |   |  |          |        |
|---|--|----------|--------|
| <input type="checkbox"/> Right (Circle Grade) | Mild   | Moderate | Severe |
|   | Clinically significant diabetic macular edema? | Yes      | No     |
- Left (Circle Grade)
- |  |          |        |
|--|----------|--------|
| Mild   | Moderate | Severe |
| Clinically significant diabetic macular edema? | Yes      | No     |
- Proliferative changes noted in:
- |   |        |                  |
|---|--------|------------------|
| <input type="checkbox"/> Right (Circle Grade) | Active | Regressed/Stable |
| <input type="checkbox"/> Left (Circle Grade)  | Active | Regressed/Stable |

**FOLLOW UP**

- Routine follow-up exam is recommended in one year. **OR**
- Follow-up of abnormalities in my office is recommended in \_\_\_\_\_ (timeframe).
- Referral to Dr. \_\_\_\_\_ is recommended in \_\_\_\_\_ (timeframe).
- Cataracts or Glaucoma detected **OR** laser treatment is needed. Letter to follow.

Thank you for referring this patient for diabetic retinal evaluation.  
Sincerely,

\_\_\_\_\_  
Practitioner's Signature  
\_\_\_\_\_  
Practitioner's Printed Last Name

**Please fax or mail this document to the patient's Primary Care Physician identified above**

## McLAREN AMBULATORY CARE CENTER DIABETIC FOOT SCREENING

### I. Current History

1. Any change in the foot since the last evaluation?  
Yes  No
2. Current ulcer or history of a foot ulcer?  
Yes  No
3. Any foot pain since last evaluation?  
Yes  No

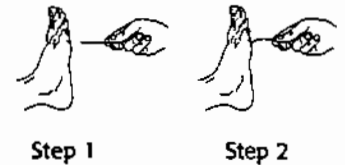
### II. Foot Exam

1. Are the nails thick, too long, or ingrown?  
Yes  No
2. Note foot deformities:  
 Callous/Corn  
 Toe deformities  
 Bunions (Hallus valgus)
3. Open wound? Yes  No
4. Amputation:  
\_\_\_\_\_ (site)
5. Other gross deformity?  
Yes  No

### III. Pedal Pulses

	Right	Left
Posterior tibial:	+ / -	+ / -
Dorsalis pedis:	+ / -	+ / -

**IV. Sensory Foot Exam** (Touch the filament to all sites circled on the drawing. Place a "+" in the circle if the patient feels the filament at that site and a "-" if the patient cannot feel the filament.)



1. Hold the 5.07 Semmes-Weinstein (10 gram) nylon filament by the handle and touch to the skin of the patient's foot for 1-2 seconds. Touch alongside of, and NOT directly on, an ulcer, callous, or scar.
2. Push to make the filament bend.

### V. Risk Categorization and Management Plan (Check the appropriate boxes)

#### Low Risk Patient

All of the following:

- No prior foot ulcer
- No severe deformity
- No amputation
- Pedal pulses present
- Intact protective sensation

- Educate patient to check feet daily
- Re-evaluate in six months

#### High Risk Patient

One or more of the following:

- History of foot ulcer
- Severe foot deformity
- Prior amputation
- Absent pedal pulses
- Loss of protective sensation

- Educate patient to check feet daily
- Refer to:  Podiatrist  
 Vascular Lab  
 Vascular Surgeon  
 Orthopedist  
 Other
- Re-evaluate in \_\_\_\_\_ months

Comments:

---

---

---

---

---

---

---

---

---

---

Signature \_\_\_\_\_

Date \_\_\_\_\_

PT. NAME \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**McLAREN AMBULATORY CARE CENTER  
PERSISTENT ASTHMA MANAGEMENT**

**Smoker:**  Yes  No Date Ceased: \_\_\_\_\_

2nd Hand exposure  Yes  No

<b>Each Visit (Date)</b>									
Asthma Education									
Smoking Education/Rx									
Peak Flow Meter									

<b>Annual Tests (Date)</b>									
Action Plan									
Spirometry									

<b>Medications</b>									
Rescue Meds:									
B-Agonist									
Controller Meds:									
Inhaled Corticosteroid									
Other:									

<b>Miscellaneous (Date)</b>									
Flu Vaccine									
Pneumonia Vaccine									
Pulmonary Referral									

Referrals/Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PATIENT NAME:
DATE OF BIRTH:

**MCLAREN AMBULATORY CARE CENTER  
CHRONIC DISEASE MANAGEMENT FLOWSHEET**

<b>EACH VISIT</b>	<b>(Date)</b>									
Height										
Weight										
BMI										
Blood Pressure										
Lifestyle Changes :										
a) Diet										
b) Exercise										
Smoking Status :										
a) Education										
b) RX										

<b>ANNUAL TESTING</b>	<b>(Date)</b>									
Total Cholesterol										
HDL										
LDL										
Triglycerides										
CBC										
UA										
Electrolytes										
BUN										
Creatinine										
Magnesium										
Glucose										

<b>MISCELLANEOUS</b>	<b>(Date)</b>									
Influenza Vaccine										
Pneumonia Vaccine										
Tetanus										

<b>DIABETES</b>	<b>(Date)</b>									
Education : Diet, Exercise, Foot Self Exam, Etc.										
Review Daily Blood Glucose Records										
HgA1C										
Microalbumin										
Foot Exam										
Monofilament Exam										
Dilated Eye Exam										
Endocrinologist Referral										

PATIENT  
NAME:

DATE OF  
BIRTH:

**MCLAREN AMBULATORY CARE CENTER  
CHRONIC DISEASE MANAGEMENT FLOWSHEET**

<b>CARDIAC HISTORY</b>	Yes	Date	No			Yes	No
Angina					Comorbid Disease:		
Previous MI					Hypertension		
Stent					Hyperlipidemia		
Bypass					Diabetes		
Angioplasty					Sedentary Lifestyle		


<b>CAD</b>	(Date)								
CAD Education:									
a.) Low Saturated Fat Diet									
b.) Exercise									
c.) Salt Restriction									
d.) Monitoring Home BP									
e.) Omega 3/Fish Oil									
f.) Aspirin (if appropriate)									
Imaging Studies									
Cardiologist Referral									

<b>MEDICATIONS</b>	(Date)								
B-Blockers									
ACE/ARB									
Antithrombin									
Antilipemic									

<b>CHF</b>	(Date)								
CHF Education:									
a.) Daily Weights									
b.) Salt Restriction									
c.) Fluid Restriction									
Echocardiogram/Ejection Fraction									
Cardiologist Referral									

<b>MEDICATIONS</b>	(Date)								
B-Blockers									
ACE/ARB									
Diuretic									

PATIENT  
NAME:  
  
DATE OF  
BIRTH:

		<b>Policy Title:</b>	Documentation in the Clinical Record
<b>Effective Date:</b>	10/96	<b>Policy Number:</b>	6230
<b>Review Date:</b>		<b>Category:</b>	Medical Records/HIPAA
<b>Revised Date:</b>	4/18/2013	<b>Oversight Level:</b>	2
<b>Administrative Responsibility:</b>	Ambulatory Quality Improvement Committee, Directors, Operations Managers		
<b>Interpretation:</b>	Compliance Officer		

### 1. Purpose

To provide necessary guidelines for documentation in the patient record that facilitate effective and safe patient healthcare in the MMG practices; additionally, to ensure the clinical record contains information sufficient to serve as legal documentation and to meet applicable federal regulations and state licensing guidelines.

### 2. Scope

MMG workforce

### 3. Definitions

3.1. Ambiguous - an entry that could be interpreted in more than one way.

3.2. Legible - characteristic of an entry that can be clearly and easily read.

3.3. Clinically-oriented individuals - physician, physician assistant, nurse, medical assistant, midwife.

### 4. Policy

4.1. Documentation in the clinical record will uphold the guidelines established in MMG's Clinical Guidelines. Furthermore, documentation will be in accordance with professionally recognized standards of clinical record management.

Only clinically-oriented individuals involved in the direct care of the patient will be authorized to make entries in the clinical record. A countersignature by the primary care physician will appear where applicable

4.2. Entries that are non-clinical in nature and related to indirect patient care such as; failed appointments, telephone messages, etc., will be the responsibility of those staff members so designated.

### 5. Procedure

5.1. Document services in the clinical record at the time the service is provided.

5.1.1. Record entries in chronological order in the appropriate section of the record.

5.1.1.1. Document “no shows” in the context of progress notes to apprise physician and/or staff members of patient’s non-compliance; subsequent follow-up will be conducted, where necessary, and appropriately documented.

5.1.2. Entries include complete date (day/month/year) and where applicable, time.

5.1.3. Authenticate entries appropriately.

5.1.3.1. Author signs entry with, as a minimum, first initial, last name and title.

5.1.3.2. If initials are used, a dated Signature List will be required where an individual will sign his full name and title along with initials for reference in the identification of author of entry when needed.

5.1.3.3. Signature/initial stamps will not be used.

5.1.4. Indicate missed notations or addendum documented at a later time as “out of sequence,” “late entry,” or “addendum”; give reason for additional information.

5.2. Documentation must be clear, concise, and objective.

5.2.1. Prohibit use of derisive or derogatory terms, phrases or comments related to the patient.

5.2.2. Do not document professional debates, incident reports, staffing issues, disagreements, reports relating to other individuals, and policies.

5.2.3. Remarks critical of the care or services provided by others should not be included in the clinical record.

5.3. All entries must be legible.

5.3.1. An entry should be clearly and easily read by two healthcare professionals other than the author of the entry.

5.3.2. Entries must be in black ink; they can also be typewritten or computer generated.

5.3.3. Pencils or erasable ink pens shall never be used in documenting information in a patient’s record.

5.4. Use of abbreviations, acronyms, and symbols

5.4.1. Providers of care will abide by the regional hospital's "DO NOT USE" List All other abbreviations (and symbols) will be deemed acceptable, if they can be substantiated as approved abbreviations.

5.5. Corrections in the clinical record will be appropriately documented by the author.

5.5.1. Draw single line through entry.

5.5.2. Make correction either above or near original entry to accurately reference action taken.

5.5.3. Initial and date correction.

## 6. Exceptions

None

References None

Appendix NONE

## 7. Approvals

*Margaret Dimond*

*(Original signed policy on file in MMG Practice Management)*

Margaret Dimond  
President/CEO

*Michael Ziccardi, Jr., DO*

*(Original signed policy on file in MMG Practice Management)*

Michael Ziccardi, Jr., DO  
Medical Director

04/18/2013


Date

04/18/2013

Date

Previous Revision Dates/Supersedes Policy: 8/14/07  
2-24-04 / 8.8.3



		<b>Policy Title:</b>	Waived Diagnostic Testing
<b>Effective Date:</b>	4/1999	<b>Policy Number:</b>	3420
<b>Review Date:</b>	4/30/2002	<b>Category:</b>	Clinical
<b>Revised Date:</b>	03/04/2014	<b>Oversight Level:</b>	2
<b>Administrative Responsibility:</b>	All Operations Managers and Human Resources personnel		
<b>Interpretation:</b>	Operations Managers		

### 1. Purpose

To maintain proper Waived Diagnostic Testing at McLaren Medical Group (MMG) Physician Offices; to perform proper controls for accuracy in results for Waived Diagnostic Testing performed in all MMG Physician Offices.

### 2. Scope

All clinical staff

### 3. Definitions

3.1. Waived test - is a simple laboratory examination and procedure that the FDA has cleared for home use, has a simple and accurate methodology, or poses no reasonable risk of harm to the patient if done incorrectly

3.2. CLIA - Clinical Laboratory Improvement Amendments of 1988; this statute/law defines a laboratory as any facility which examines human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings; any facility that meets this definition must have the appropriate CLIA certificate to perform laboratory tests such as a Certificate of Waiver that allows the performance of tests granted waived status by the CDC.

3.3. Lab Director – is a physician designated at each office site.

### 4. Policy

4.1. MMG offices shall follow the procedures outlined to ensure that proper Waived Diagnostic Testing is performed.

### 5. Procedure

5.1. The regional MHCC affiliate Medical Center's Director of Laboratory Services will act as a resource for the MMG waived testing program.

5.2. Competency training is done with all personnel involved in the direction, supervision, and performance of waived diagnostic testing upon hire. This includes a color blindness test at the new-hire health assessment. Personnel are then annually

evaluated for competency. All paperwork for competency is retained by Human Resources, with a copy for the provider's office.

5.3. Written information for the lab area will include all of the following: current package insert for each type of test performed, quality control log, a copy of this policy, certificates for all staff members who are trained to perform CLIA waived testing, and a copy of the Ready?, Set?, Test! Booklet from the CDC.

#### 5.4. Lab Kits

5.4.1. Kits are stored according to manufacturer's instructions.

5.4.2. Kits are dated when opened with the "open date".

5.4.3. Kits are discarded when expired.

5.4.4. Kits are used according to current manufacturer instructions.

#### 5.5. Quality Control

5.5.1. Quality control procedures are as directed by the manufacturer.

5.5.2. Quality control results are documented in the Quality Control Book.

5.5.3. Information on each kits is logged, upon opening, to include date the kit was opened, kit name, kit lot number, manufacturer's expiration date, and staff signature in the event of a recall.

5.5.4. Quality control records are retained for eight years.

5.6. Quality Control Failures - in the event of a quality control failure, follow the instructions on the package insert. If there are no directions on the package insert, repeat the test and notify site management.

## 6. Exceptions

None

## 7. References

7.1. 42 CFR 493.15(b)(1-3)

7.2. 42 CFR 493.1105

7.3. Howerton, Devery et al, "Good Laboratory Practices for Waived Testing Sites," *MMWR*, (11/11/05)/54(RR13); 1-25 or at [www.cdc.gov/mmwr/preview/mmwrhtml/rr5413a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5413a1.htm).

7.4. "CLIA and Quality Assurance," (n.d.), [www.aafp.org](http://www.aafp.org).

## 8. Appendices

8.1 Appendix A - Approved Waived Tests

8.2 Appendix B - Waived Test Quality Control Log

9. Approvals

***Mark S. O'Halla***

*(Original signed policy on file in MMG Practice Management)*

**Mark S. O'Halla**  
**Acting President/CEO**

**4/7/2014**

**Date**

***Michael Ziccardi, D.O.***

*(Original signed policy on file in MMG Practice Management)*


**Michael Ziccardi, D.O.**  
**Medical Director**

**4/1/2014**

**Date**

**Previous Revision Dates/Supercedes Policy:**

- 4/26/2005, 1/2006, 7/15/2011; Policy # 12.4
- Appendix A - QuickVue One-Step Strep A Test
- Appendix B - QuickVue One-Step hCG-urine Test
- Appendix C - Glucometer Test
- Appendix D - SKD Hemocult
- Appendix E - Bayer Multistix Urinalysis
- Appendix F - QuickVue Influenza Test
- Appendix G - Hemoglobin A1C Test
- Appendix H - Urine for Microalbumin
- Appendix I - H. Pylori gII Test
- Appendix J - Mono-Plus Test

		Waived Diagnostic Testing - Appendix A	
<b>Policy Title:</b>	Waived Diagnostic Testing - Appendix A	<b>Policy Number:</b>	3420
<b>Policy Number:</b>	3420, Appendix A	<b>Category:</b>	Clinical
<b>Standard Effective Date:</b>	3/4/2014	<b>Oversight Level:</b>	2

**I. PURPOSE**

To identify the waived diagnostic tests approved for use at McLaren Medical Group practice locations.

**II. Approved Waived Tests**

- Blood Glucose Monitoring
- Fecal Occult Blood/Hemoccult
- Glycosylated Hemoglobin (Hgb A1C)
- HCG, Urine
- Helicobacter Pylori
- Hemoglobin
- Infectious Mononucleosis Antibodies (Mono)
- Influenza A/B
- Microalbumin
- Mononucleosis
- PT/INR
- Respiratory Syncytial Virus
- Streptococcus, Group A
- Urine Dipstick to include creatinine, protein



## Procedures and Set-Up

### Nebulizer (Aerosol) Treatments:

- Explain procedure to patient.
- Attach disposable tubing.
- Add medication prescribed by provider.
- Instruct patient on how to use.
- Turn machine on.
- Monitor patient while they are doing the treatment.
- When completed, dispose of tubing in biohazard container.

### Pulse-Ox

- Instruct patient to be still for 3-4 minutes before taking reading.
- Place monitor on patient's finger.
- Record the reading in the EMR.

### Pulmonary Function Test

- Ask patient if they have had this procedure before. If not, explain procedure to patient.
- Give instructions to patient on how to do the test, demonstrating with the disposable mouthpiece still sealed in the bag.
- Enter patient data into machine.
- Patient should do the test standing.
- Have the patient do the test 3 times. Machine will determine the best reading.
- Dispose of mouthpiece in biohazard container.
- Replace the PFT in the dock or connect to computer to print out report.
- Place completed report on chart and mark on router.

### Arthrocentesis

#### Set-Up

- Needles (Provider's preference)
- Numbing agent (Lidocaine/Marcaine)
- Betadine swabs
- Alcohol pads
- Culturettes
- Band-Aids
- Sterile 4x4's
- Sterile gloves for provider

#### Procedure

- Assist provider as instructed.

## **Cryosurgery**

### **Set-Up**

- Cryo Tank
- 4x4's
- Lubricating Gel
- Sterile Cryo Tips
- Supplies vary by site

### **Procedure**

- Assist provider as instructed.

## **Cyst Removal**

### **Set-Up**

- Needle/Syringe
- Numbing agent
- Sutures
- Scissors
- Hemostat
- Biopsy bottles
- Betadine
- Sterile Dressing
- Sterile Gloves

### **Procedure**

- Assist provider as instructed.

## **Incision and Drainage**

### **Set-Up**

- Needle/Syringe
- Numbing agent
- Razor (if necessary)
- Scalpel
- Culturettes
- Specimen containers
- Betadine
- Sterile field
- Sterile gloves
- Sterile dressing

### **Procedure**

- Assist provider as instructed.

## **Ingrown Toenail Removal**

### **Set-Up**

- Needle/Syringe
- Numbing agent
- Scalpel/Clippers
- Other toenail removal instruments or kit (scissors, hemostats, English anvil)
- Toe tourniquet
- Culturettes
- Betadine
- Sterile field
- Sterile dressing

### **Procedure**

- Assist provider as instructed.

## **Laceration Repair**

### **Set-Up**

- Sterile water
- Betadine
- Needle/Syringe
- Numbing agent
- Sutures
- Hemostat
- Pick-Ups
- Scissors
- Sterile gloves
- Sterile dressing
- Sterile field

### **Procedure**

- Assist provider as instructed.

## **Mole/Skin-Tag Removal**

### **Set-Up**

- Needle/Syringe
- Razor (if necessary)
- Numbing agent
- Sutures
- Hemostats
- Pick-Ups
- Scissors
- Punch biopsy



- Scalpel
- Betadine
- Sterile field (4x4's included)
- Sterile dressing
- Specimen bottles

#### Procedure

- Assist provider as instructed.
- Ask provider if specimens need to be sent to laboratory.

### **Pap/Pelvic Exam**

#### Set-Up

- Gloves
- Disposable speculum
- Light
- Spatula/Brush
- Pap test specimen container (type used is determined by lab associated with patient's insurance)
- Have vaginal cultures available
- Lubricating gel
- Hemoccult cards

#### Procedure

- Instruct patient to undress according to exam being performed (well-woman vs. pelvic only or repeat pap.)
- Assist provider as instructed.

### **Rectal Exam/Hemoccult**

#### Set-Up

- Gloves
- Hemoccult card
- Developer
- Lubricating gel

#### Procedure

- Instruct patient to undress according to exam.
- Assist provider as instructed.

### **Suture Removal/Staple Removal**

#### Set-Up

- Staple remover/suture removal kit
- Peroxide

- Antibiotic ointment
- Steri-strips
- Glue

#### Procedure

- Check area for infection.
- Clean area with peroxide.
- Remove sutures/staples as directed by provider.
- Apply antibiotic ointment.
- Apply steri-strips/glue as directed by provider.

#### **EKG**

- Instruct patient to remove clothing from the waist up.
- Attach tabs on patient's body. (Clean area where tabs will be applied and shave if necessary.)
- Connect electrodes.
- Enter patient information.
- Begin EKG.
- Remove tabs from patient.
- Put the final EKG report on the chart with an EKG interpretation form and notify provider.
- Replace EKG machine in correct storage.
- Make sure machine is plugged in.

## EKG INTERPRETATION

Ventricular Rate:

P-R Interval:

QRS Duration:

Axis Deviation:

Interpretation:

Provider's Signature: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Patient Name:

Date of Birth:

### **Eye Tray/Wash Station**

- Be aware of location of Eye Tray/Eye Washing Station.
- Check to be sure that the water is a comfortable temperature. (If station uses bottled water, change distilled water monthly.)
- Wash patient's eyes per instructions from provider.

### **Hearing Tests**

- Reference copy of manufacturer instructions for machine on site for accurate use.
- Record results in EMR.

### **Tympanogram**

- Reference copy of manufacturer instructions for machine on site for accurate use.
- Record results in EMR.

### **Visual Acuity**

- Instruct patient to stand 20 feet from chart.
- Have patient perform test with both eyes.
- Instruct patient to perform test with left eye covered. (Use eye paddle.)
- Instruct patient to perform test with right eye covered, reading backwards, right to left.
- Test using color bar.
- Record results in EMR. (Note with or without corrective lenses.)

### **Sports Physical**

- Use Sports Physical form. Fill out completely.
- Take vital signs.
- Perform vision test. (Note with or without corrective lenses.)
- Perform urinalysis.
- Provider will do exam.

## **OB/GYN Procedures and Set-Up**

### **Fetal Heart Tones**

- Using Doppler, obtain fetal heart tones and document in EMR.
- Please see site specific instructions.

### **Ultrasound GYN Exam**

- Explain procedure to patient.
- Enter patient data into ultrasound machine.
- Prepare vaginal probe with probe cover.
- Instruct patient to undress from the waist down. Provide drape sheet.
- Assist provider as instructed.

### **Ultrasound OB Exam**

- Explain procedure to patient.
- Enter patient data into ultrasound machine.
- Prepare abdominal probe unless patient is less than 10 weeks gestation. Typically vaginal probe is used for early OB exams.
- Instruct patient to undress accordingly. Provide drape sheet.
- Assist provider as instructed.

### **Amniocentesis**

#### **Set-Up**

- Needle with 10cc syringe
- 3 specimen containers
- Betadine
- Fenestrated drape

#### **Procedure**

- Explain procedure to patient. Obtain signature on consent form.
- Enter patient data into ultrasound machine.
- Call for pick-up.

## **Fetal Non-Stress Test**

- Bring patient into NST room.
- Instruct patient to lie back on table.
- Attach all monitors to patient.
- Turn on recording device.
- Instruct patient to push button when fetal movement is felt.
- The provider will then check the patient while they are on the machine.

## **Colposcopy**

### **Set-Up**

- Colposcope
- Disposable speculum
- Fox swabs
- Betadine
- Vinegar solution
- Specimen bottles
- Endocervical Curette
- Cervical biopsy forceps
- Silver nitrate
- Maxipad

### **Procedure**

- Explain procedure to patient. Obtain signature on consent form.
- Instruct patient to undress from the waist down.
- Assist provider as instructed.
- Label all specimens as directed by provider.
- Instruct patient to get dressed.
- Give post-op instruction to patient.
- Clean room.

## **Cryosurgery**

### **Set-Up**

- Cryo tank
- 4x4's
- Lubricating gel
- Sterile cryo tips

### **Procedure**

- Assist provider as instructed.

## **Endometrial Biopsy**

### **Set-Up**

- Disposable speculum
- Dilator
- Betadine
- Fox swabs
- Endometrial pipette
- Single tooth tenaculum
- Specimen bottles

### **Procedure**

- Explain procedure to patient. Obtain signature on consent form.
- Instruct patient to undress from the waist down.
- Assist provider as instructed.
- Label specimens as instructed.

## **LEEP**

### **Set-Up**

- Betadine
- Cervical block needle
- Numbing agent
- LEEP loops
- Cautery
- Grounding pad
- Specimen bottles
- Long neck tweezers

### **Procedure**

- Explain procedure to patient. Obtain signature on consent form.
- Instruct patient to undress from the waist down.
- Assist provider as instructed.
- Label specimens as instructed.

## **PAP/Pelvic Exam**

- Gloves
- Disposable speculum
- Spatula/brush
- Pap test specimen container
- Lubricating gel

### **Rectal Exam/Hemoccult/iFOBT**

- Gloves
- Hemoccult card
- Developer
- Lubricating gel

### **UA for Protein/Glucose**

- Dip test strip in urine sample.
- Record results in patient's OB record on the EMR and log on sheet in lab.


### **Multistix UA**

- Dip test strip in urine sample.
- Record results on Waived Diagnostic Test reporting form to be scanned into EMR.

### **Pregnancy Test**

- Perform according to manufacturer instructions.
- Record results in EMR.



		<b>Policy Title:</b>	Wet Prep and Wet Prep with KOH
<b>Effective Date:</b>	05/01/2002	<b>Policy Number:</b>	3490
<b>Review Date:</b>		<b>Category:</b>	Clinical
<b>Revised Date:</b>	05/01/2012	<b>Oversight Level:</b>	2
<b>Administrative Responsibility:</b>	Operations Managers/Directors		
<b>Interpretation:</b>	Clinical Managers		

### 1. Purpose

To evaluate vaginal secretions using microscopic examination.

### 2. Scope

MMG physicians and providers performing this procedure

### 3. Definitions

None

### 4. Policy

Examination of a wet prep shall be performed by a provider using bright-field or phase contrast microscopy.

### 5. Procedure

#### 5.1. Equipment

- 5.1.1. Vial for vaginal sample
- 5.1.2. Sterile swab
- 5.1.3. Glass microscope slide and cover slip
- 5.1.4. Disposable pipette
- 5.1.5. Microscope
- 5.1.6. Disposable gloves

#### 5.2. Reagents

- 5.2.1. Potassium Hydroxide (KOH)
- 5.2.2. Storage: Store at room temperature

5.2.3. Quality Control: Check the KOH expiration date prior to use. Discard KOH if the solution contains an increased number of precipitates.

5.2.4. 0.9% NaCl; check for expiration date prior to use.

5.2.5. Storage: Store at room temperature

5.3. Specimen Collection shall be performed by the provider.

5.4. Slide Preparation

5.4.1. Wet Prep

5.4.1.1. Place smear on slide.

5.4.1.2. Transfer a drop of the chosen reagent onto a slide. Place a cover slip gently on the slide.

5.5. Microscopic examination shall be performed by the provider.

5.6. Documentation - document test results in the patient's chart.

## 6. Exceptions

None

## 7. References

7.1. McPherson, R.A. & Pincus, M. R., *Henry's Clinical Diagnosis and Management by Laboratory Methods*, 22<sup>nd</sup> ed., 2011.

## 8. Appendix

None

## 9. Approvals

***Margaret Dimond***

*(Original signed policy on file in MMG Practice Management)*

**Margaret Dimond**  
President/CEO

June 12, 2012

Date

***Michael Ziccardi, Jr., D.O.***

*(Original signed policy on file in MMG Practice Management)*

**Michael Ziccardi, Jr., D.O.**  
Medical Director

June 12, 2012

Date

Previous Revision Dates/Supersedes Policy: 03/20/2007

Not applicable / 12.19

McLaren Medical Group  
**GYNECOLOGICAL HISTORY & EXAMINATION**

NURSING ASSESSMENT

DATE \_\_\_\_\_

AGE \_\_\_\_\_

VITALS:                      Height:                      Weight:                      B/P:                      T:                      P:                      R:

Chief Complaint	_____
_____	LMP
_____	<b>Signature:</b>

**History of Present Illness:** \_\_\_\_\_  Questionnaire / ROS reviewed

**EXAMINATION:**

Date of Last: \_\_\_\_\_  
 Pap:                      Mamm:                      Bone Density: \_\_\_\_\_

Vital Signs reviewed  General Appearance \_\_\_\_\_

Orientation     time     place     person

Mood/Affect     normal     depressed  
                           anxious     agitated

**Neck:** Neck/Thyroid

**RESPIRATORY:** WNL  Y  N

**CARDIOVASCULAR:** WNL  Y  N

**BREASTS:** Symmetrical     Y  N

Discharge  Y  N    Lump/masses  Y  N

Nipples     Everted     Inverted

Other \_\_\_\_\_

**GASTROINTESTINAL:** Liver/spleen

Abdominal masses / tenderness  Y  N

Hernia     Y  N

Rectum /Anus WNL  Y  N    **Hemoccult**  Pos.  Neg.

**LYMPHATIC:** Neck     non-palpable

Axilla     non-palpable    Groin     non-palpable

**PELVIC:** External genitalia

Urethra meatus WNL  Y  N

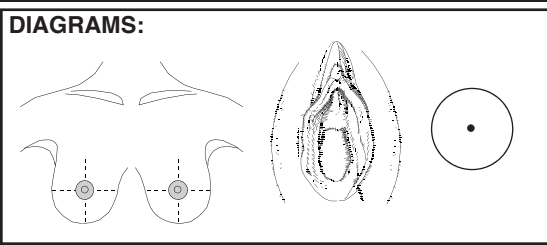
Urethra WNL  Y  N    Cervix WNL  Y  N

Bladder WNL  Y  N    Uterus WNL  Y  N

Vagina WNL  Y  N    Adnexa WNL  Y  N

**NOTES/ASSESSMENT/PLAN:**

P  
H  
Y  
S  
I  
C  
I  
A  
N  
A  
S  
S  
E  
S  
S  
M  
E  
N  
T



Time: \_\_\_\_\_ mins.     50% of time counseling

PATIENT NAME:  
 DATE OF BIRTH:

Signature of Provider \_\_\_\_\_ Date/Time \_\_\_\_\_



## **Biohazard**

Sharps containers  
Biohazard red bags  
Biohazard storage

- Know locations, where stored
- Empty in-room biohazard containers at least weekly
- Change sharps containers when contents reach the “full” line (2/3 full)

## **O2 Tank Care**

- Check weekly to ensure tank is full and operational. Record on log.

## **Nasal Cannula and Mask**


- All masks are disposable and should be disposed of in biohazard container.

## **Infection Control**

- Storage of cleaning supplies – see management for location of all supplies.
- Contaminated materials clean-up, chemical spill clean-up, bodily fluid clean-up – See Policy and Procedure Manual.
- Notice of Occurrence forms (needle sticks and occupational injuries – See management for location.
- MSDS book location – Located on Intranet.
- Disinfect and operate autoclave, sterilize instruments/Cidex – See management for location and instructions.

## **Other Control Logs**

- Attest/Autoclave/Spore Check
- Refrigerator Temperature Log
- Freezer Temperature Log

		Policy Title:	Medication Samples
Effective Date:	10/96	Policy Number:	4125
Review Date:		Category:	Medication
Revised Date:	8/16/2013	Oversight Level:	2
Administrative Responsibility:	MMG President/CEO and Directors		
Interpretation:	MMG Compliance Officer		

**1. Purpose**

To provide administrative guidelines relative to sample medication management that support patient safety and improve the quality of care, treatment, and services rendered to patients.

**2. Scope**

MMG practice sites.

**3. Definitions**

None

**4. Policy**

4.1. All sites that are part of McLaren Medical Group (MMG) are NOT allowed to maintain a sample medication management system.

**5. Exceptions**

None

**6. References**

None

**7. Appendix**

None

**8. Approvals**

***Margaret Dimond***

*(Original signed policy on file in MMG Practice Management)*

**Margaret Dimond**  
President/Chief Executive Officer

**8/16/2013**

**Date**

**Previous Revision Dates/Supersedes Policy**

11-11-09 / 12-05 / Not applicable

## Who to Call for Assistance

- Patient Emergencies – 911
- Physical Security- 911
  
- Anthelio Help Desk – 810.424.8400
- McLaren University Password Reset – 810.342.1205 or 810.342.1050
- MMG Compliance Hot Line – 810.342.1088
- MMG Privacy Officer – 810.342.1513
- MMG Security Officer – 810.342.1541
- MyMcLaren Password Reset – Human Resources Contact
- Patient Billing Questions – 866.814.9536 or 810.342.6505
- Physician Billing – 810.624.1063
- Webdennis Help Desk – 877.258.3932
  
- Communication Barriers – See Enclosed Policy PP 2135
- Patient Rights Complaint Process – See Enclosed Policy PP 1040
- Patient Satisfaction Survey Complaints – See Enclosed Policy PP 9700
- Service Recovery – See Enclosed Policy PP 2310
- Work Related Injuries – See Enclosed Policy PP 8130

## Miscellaneous Helpers

### Most frequently misspelled words in medicine

#### A

Accommodation – Note the 2 c's and 2 m's

Afferent vs. Efferent

Ascites (sounds like uh-sight-ees)

Aphagia vs. Aphasia

Asymmetry ans Symmetry

Auscultation (sounds like oss-cull-tashun)

#### B

Basilar (not basilar – bay-sill-urh)

Barbiturates (sounds like bar-bit-your-uhts)

Branchial vs. Brachial

#### C

Callus (noun) vs. Callous (adjective)

Catheterization

Chalazion (sounds like kuh-laz-ee-on)

Circumferential

Chlamydia (sounds like kluh-mid-ee-uh)

Cord vs. Chord

Cor (heart) vs. Core (center)

#### D

Debridement (sounds like dee-breed-ment)

Dependent vs. Dependant

Diaphragm (not diaphram)

Dyspareunia (sounds like diss-pair-ee-oo-knee-uh)

#### E

Enuresis vs. Anuresis

Elicit vs. Illicit

Epididymis (sounds like epee-did-ee-mus)

Erythematous (sounds like arith-uh-mutt-oss-is)



Exacerbated vs. Exasperated

## **G**

Gamma (note 2 m's) – gamma globulin is two words

Gas, gases, gassy – gaseous

## **I**

Ileum vs. Ilium – (one is the gut & the other bone)

Insufflate (sounds like in-sue-flate)

## **M**

Malacia (sounds like muhl-ace-ee-uh) – not malasia

Mucus (noun) vs. Mucous (adjective)

Myxedema (sounds like mix-id-eema)

## **O**

Occur – Occurring – Occurrence

Ophthalmology

## **P**

Paroxysmal (sounds like pair-ox-is-muhl)

Perfusion vs. Profuion

Perineal vs. Peroneal

Persistent

Petechia (sounds like peh-teek-ee-uh) or the plural Petechiae

Plane vs. Plain

Pleurisy

Polyposis

Prostate vs. Prostrate

Pruritis

Pterygium (sounds like tuhr-idg-ee-um)

## **R**

Regime vs. Regimen

## **S**

Sagittal (not saggital)

Scalene (from scalenus) – not scaline

Scarring

Seborrheic

Serotonin

Senile

Shotty lymph nodes

Suppuration

**T**

Tonsil

Trachea

**V**

Vesicle vs. Vesical

**X**

Xerosis

## Most commonly misspelled medications

### **Analgesics**

Codeine  
Darvocet  
Vicodin  
Fiorcet  
Xylocaine

### **Anti-Inflammatories**

Toradol  
Naprosyn  
Voltaren  
Aleve

### **Anti-Histamines**

Phenergan  
Benadryl  
Claritin  
Dimetapp  
Seldane  
Allegra

### **Heart Medication**

Procardia  
Dyazide  
Hydrodiuril  
Cardizem  
Tenoretic

### **Antibiotics**

Penicillin  
Amoxicillin  
Augmentin  
Erythromycin  
Lincocin  
Cephalosporin  
Cortisporin  
Flagyl  
Ancef  
Cipro  
Zithromax  
Biaxin

### **Miscellaneous**

Hydrocortisone  
Triamcinolone  
Vancenase  
Zovirax  
Pyridium  
Epinephrine  
Synthroid  
Betadine  
Insulin  
Estrogen  
Tetanus

### **Stomach Medication**

Tagamet  
Pepcid  
Axid  
Zantac  
Compazine

# ISMP's List of *Confused Drug Names*

This list of confused drug names, which includes look-alike and sound-alike name pairs, consists of those name pairs that have been published in the *ISMP Medication Safety Alert!*<sup>®</sup> and the *ISMP Medication Safety Alert!*<sup>®</sup> Community/Ambulatory Care Edition. Events involving these medications were reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP).

We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies such as: using both the brand and generic names; including the purpose of the medication on prescriptions; configuring computer selection screens to prevent look-alike names from appearing consecutively; and changing the appearance of look-alike product names.

Updated through June 2011

Drug Name	Confused Drug Name
Abelcet	amphotericin B
Accupril	Aciphex
acetaZOLAMIDE	acetoHEXAMIDE
acetic acid for irrigation	glacial acetic acid
acetoHEXAMIDE	acetaZOLAMIDE
Aciphex	Accupril
Aciphex	Aricept
Activase	Cathflo Activase
Activase	TNKase
Actonel	Actos
Actos	Actonel
Adacel (Tdap)	Daptacel (DTaP)
Adderall	Inderal
Adderall	Adderall XR
Adderall XR	Adderall
Advair	Advicor
Advicor	Advair
Advicor	Altacor
Afrin (oxymetazoline)	Afrin (saline)
Afrin (saline)	Afrin (oxymetazoline)
Aggrastat	argatroban
Aldara	Alora
Alkeran	Leukeran
Alkeran	Myleran
Allegra	Viagra
Alora	Aldara
ALPRAZolam	LORazepam
Altacor	Advicor
amantadine	amiodarone
Amaryl	Reminyl
Ambisome	amphotericin B
Amicar	Omacor
Amikin	Kineret
aMILoride	amLODIPine
amiodarone	amantadine

Drug Name	Confused Drug Name
amLODIPine	aMILoride
amphotericin B	Abelcet
amphotericin B	Ambisome
Anacin	Anacin-3
Anacin-3	Anacin
antacid	Atacand
Antivert	Axert
Anzemet	Avandamet
Apresoline	Priscoline
argatroban	Aggrastat
argatroban	Orgaran
Aricept	Aciphex
Aricept	Azilect
ARIPiprazole	proton pump inhibitors
ARIPiprazole	RABEprazole
Asacol	Os-Cal
Atacand	antacid
Atrovent	Natru-Vent
Avandamet	Anzemet
Avandia	Prandin
Avandia	Coumadin
AVINza	INVanz
AVINza	Evista
Axert	Antivert
azaCITIDine	azaTHIOprine
azaTHIOprine	azaCITIDine
Azilect	Aricept
B & O (belladonna and opium)	Beano
BabyBIG	HBIG (hepatitis B immune globulin)
Bayhep-B	Bayrab
Bayhep-B	Bayrho-D
Bayrab	Bayhep-B
Bayrab	Bayrho-D
Bayrho-D	Bayhep-B
Bayrho-D	Bayrab

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



## ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name
Beano	B & O (belladonna and opium)
Benadryl	benazepril
benazepril	Benadryl
Benicar	Mevacor
Betadine (with providone-iodine)	Betadine (without providone-iodine)
Betadine (without providone-iodine)	Betadine (with providone-iodine)
Bextra	Zetia
Bicillin C-R	Bicillin L-A
Bicillin L-A	Bicillin C-R
Bicitra	Polycitra
Bidex	Videx
Brethine	Methergine
Brevibloc	Brevital
Brevital	Brevibloc
buPROPion	busPIRone
busPIRone	buPROPion
Capadex [non-US product]	Kapidex
Capex	Kapidex
Carac	Kuric
captopril	carvedilol
carBAMazepine	OXcarbazepine
CARBOplatin	CISplatin
Cardura	Coumadin
carvedilol	captopril
Casodex	Kapidex
Cathflo Activase	Activase
Cedax	Cidex
ceFAZolin	cefTRIAxone
cefTRIAxone	ceFAZolin
CeleBREX	CeleXA
CeleBREX	Cerebyx
CeleXA	ZyPREXA
CeleXA	CeleBREX
CeleXA	Cerebyx
Cerebyx	CeleBREX
Cerebyx	CeleXA
cetirizine	sertraline
chlordiazePOXIDE	chlorproMAZINE
chlorproMAZINE	chlordiazePOXIDE
chlorproMAZINE	chlorproPAMIDE
chlorproPAMIDE	chlorproMAZINE
Cidex	Cedax
CISplatin	CARBOplatin
Claritin (loratadine)	Claritin Eye (ketotifen fumarate)
Claritin-D	Claritin-D 24
Claritin-D 24	Claritin-D

Drug Name	Confused Drug Name
Claritin Eye (ketotifen fumarate)	Claritin (loratadine)
Clindesse	Clindets
Clindets	Clindesse
clomiPHENE	clomiPRAMINE
clomiPRAMINE	clomiPHENE
clonazePAM	cloNIDine
clonazePAM	LORazepam
cloNIDine	clonazePAM
cloNIDine	KlonoPIN
Clozaril	Colazal
coagulation factor IX (recombinant)	factor IX complex, vapor heated
codeine	Lodine
Colace	Cozaar
Colazal	Clozaril
colchicine	Cortrosyn
Comvax	Recombivax HB
Cortrosyn	colchicine
Coumadin	Avandia
Coumadin	Cardura
Cozaar	Colace
Cozaar	Zocor
cycloSERINE	cycloSPORINE
cycloSPORINE	cycloSERINE
Cymbalta	Symbyax
DACTINomycin	DAPTOmycin
Daptacel (DTaP)	Adacel (Tdap)
DAPTOmycin	DACTINomycin
Darvocet	Percocet
Darvon	Diovan
DAUNOrubicin	DAUNOrubicin citrate liposomal
DAUNOrubicin	DOXOrubicin
DAUNOrubicin	IDArubicin
DAUNOrubicin citrate liposomal	DAUNOrubicin
Denavir	indinavir
Depakote	Depakote ER
Depakote ER	Depakote
Depo-Medrol	Solu-MEDROL
Depo-Provera	Depo-subQ provera 104
Depo-subQ provera 104	Depo-Provera
desipramine	disopyramide
dexamethylphenidate	methadone
Diabinese	Diamox
Diabeta	Zebeta
Diamox	Diabinese
Diflucan	Diprivan
Dilacor XR	Pilocar

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name
Dilaudid	Dilaudid-5
Dilaudid-5	Dilaudid
<b>dimenhyDRINATE</b>	<b>diphenhydrAMINE</b>
<b>diphenhydrAMINE</b>	<b>dimenhyDRINATE</b>
Dioval	Diovan
Diovan	Dioval
Diovan	Zyban
Diovan	Darvon
Diprivan	Diflucan
Diprivan	Ditropan
<b>disopyramide</b>	<b>desipramine</b>
Ditropan	Diprivan
<b>DOBUTamine</b>	<b>DOPamine</b>
<b>DOPamine</b>	<b>DOBUTamine</b>
Doribax	Zovirax
Doxil	Paxil
<b>DOXRubicin</b>	<b>DAUNORubicin</b>
<b>DOXRubicin</b>	<b>DOXRubicin liposomal</b>
<b>DOXRubicin</b>	<b>IDARubicin</b>
<b>DOXRubicin liposomal</b>	<b>DOXRubicin</b>
Dulcolax (bisacodyl)	Dulcolax (docusate sodium)
Dulcolax (docusate sodium)	Dulcolax (bisacodyl)
<b>DULOxetine</b>	<b>FLUoxetine</b>
Durasal	Durezol
Durezol	Durasal
Duricef	Ultracet
Dynacin	Dynacirc
Dynacirc	Dynacin
<b>edetate calcium disodium</b>	<b>edetate disodium</b>
<b>edetate disodium</b>	<b>edetate calcium disodium</b>
Effexor	Effexor XR
Effexor XR	Effexor
Enbrel	Levbid
Engerix-B adult	Engerix-B pediatric/adolescent
Engerix-B pediatric/adolescent	Engerix-B adult
Enjuvia	Januvia
<b>ePHEDrine</b>	<b>EPINEPHrine</b>
<b>EPINEPHrine</b>	<b>ePHEDrine</b>
Estratest	Estratest HS
Estratest HS	Estratest
<b>ethambutol</b>	Ethmozine
Ethmozine	<b>ethambutol</b>
Evista	<b>AVINza</b>
<b>factor IX complex, vapor heated</b>	<b>coagulation factor IX (recombinant)</b>
Fanapt	Xanax
Femara	Femhrt

Drug Name	Confused Drug Name
Femhrt	Femara
<b>fentaNYL</b>	<b>SUFentanyl</b>
Fioricet	Fiorinal
Fiorinal	Fioricet
<b>flavoXATE</b>	<b>fluvoxAamine</b>
Flonase	Flovent
Flovent	Flonase
<b>flumazenil</b>	<b>influenza virus vaccine</b>
<b>FLUoxetine</b>	<b>PARoxetine</b>
<b>FLUoxetine</b>	<b>DULOxetine</b>
<b>FLUoxetine</b>	Loxitane
<b>fluvoxAamine</b>	<b>flavoXATE</b>
Folex	Foltx
<b>folic acid</b>	<b>folinic acid (leucovorin calcium)</b>
<b>folinic acid (leucovorin calcium)</b>	<b>folic acid</b>
Foltx	Folex
<b>fomepizole</b>	<b>omeprazole</b>
Foradil	Fortical
Foradil	Toradol
Fortical	Foradil
<b>gentamicin</b>	<b>gentian violet</b>
<b>gentian violet</b>	<b>gentamicin</b>
<b>glacial acetic acid</b>	<b>acetic acid for irrigation</b>
<b>glipiZIDE</b>	<b>glyBURIDE</b>
<b>glyBURIDE</b>	<b>glipiZIDE</b>
Granulex	Regranex
<b>guaiFENesin</b>	<b>guanFACINE</b>
<b>guanFACINE</b>	<b>guaiFENesin</b>
HBIG (hepatitis B immune globulin)	BabyBIG
Healon	Hyalgan
<b>heparin</b>	Hespan
Hespan	<b>heparin</b>
<b>HMG-CoA reductase inhibitors ("statins")</b>	<b>nystatin</b>
HumaLOG	HumuLIN
HumaLOG	NovoLOG
HumaLOG Mix 75/25	HumuLIN 70/30
Humapen Memoir (for use with HumaLOG)	Humira Pen
Humira Pen	Humapen Memoir (for use with HumaLOG)
HumuLIN	NovoLIN
HumuLIN	HumaLOG
HumuLIN 70/30	HumaLOG Mix 75/25
Hyalgan	Healon
<b>hydrALAZINE</b>	<b>hydrOXYzine</b>
<b>HYDRocodone</b>	<b>oxyCODONE</b>
Hydrogesic	<b>hydrOXYzine</b>
<b>HYDRomorphone</b>	<b>morphine</b>

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name
hydr <b>OX</b> zine	Hydrogesic
hydr <b>OX</b> zine	hydr <b>AL</b> ZINE
<b>IDA</b> rubicin	<b>DAUNO</b> rubicin
<b>IDA</b> rubicin	<b>DOXO</b> rubicin
Inderal	Adderall
indinavir	Denavir
in <b>FLIX</b> imab	ri <b>TUX</b> imab
influenza virus vaccine	flumazenil
influenza virus vaccine	tuberculin purified protein derivative (PPD)
Inspira	Spiriva
<b>INV</b> anz	<b>AVIN</b> za
iodine	Lodine
Isordil	Plendil
<b>ISO</b> tretinoin	tretinoin
Jantoven	Janumet
Jantoven	Januvia
Janumet	Jantoven
Janumet	Januvia
Janumet	Sinemet
Januvia	Enjuvia
Januvia	Jantoven
Januvia	Janumet
K-Phos Neutral	Neutra-Phos-K
Kaopectate (bismuth subsalicylate)	Kaopectate (docsate calcium)
Kaopectate (docsate calcium)	Kaopectate (bismuth subsalicylate)
Kadian	Kapidex
Kaletra	Keppra
Kapidex	Capadex [non-US product]
Kapidex	Capex
Kapidex	Casodex
Kapidex	Kadian
Keflex	Keppra
Keppra	Kaletra
Keppra	Keflex
Ketalar	ketorolac
ketorolac	Ketalar
ketorolac	methadone
Kineret	Amikin
Klono <b>PIN</b>	clo <b>NID</b> ine
Kuric	Carac
Kwell	Qwell
La <b>MIC</b> tal	Lam <b>ISIL</b>
Lam <b>ISIL</b>	La <b>MIC</b> tal
lami <b>VUD</b> ine	lamo <b>TRI</b> gine
lamo <b>TRI</b> gine	lami <b>VUD</b> ine
lamo <b>TRI</b> gine	levothyroxine

Drug Name	Confused Drug Name
Lanoxin	levothyroxine
Lanoxin	naloxone
lanthanum carbonate	lithium carbonate
Lantus	Lente
Lariam	Levaquin
Lasix	Luvox
Lente	Lantus
leucovorin calcium	Leukeran
Leukeran	Alkeran
Leukeran	Myleran
Leukeran	leucovorin calcium
Levaquin	Lariam
Levbid	Enbrel
Levemir	Lovenox
lev <b>ETIRA</b> cetam	lev <b>OCARN</b> itine
lev <b>ETIRA</b> cetam	levofloxacin
lev <b>OCARN</b> itine	lev <b>ETIRA</b> cetam
levofloxacin	lev <b>ETIRA</b> cetam
levothyroxine	lamo <b>TRI</b> gine
levothyroxine	Lanoxin
Lexapro	Loxitane
Lexiva	Pexeva
Lipitor	Loniten
Lipitor	Zyr <b>TEC</b>
lithium carbonate	lanthanum carbonate
Lodine	codeine
Lodine	iodine
Loniten	Lipitor
Lopressor	Lyrica
<b>LOR</b> azepam	<b>ALPRA</b> Zolam
<b>LOR</b> azepam	clonaze <b>PAM</b>
<b>LOR</b> azepam	Lovaza
Lotronex	Protonix
Lovaza	<b>LOR</b> azepam
Lovenox	Levemir
Loxitane	Lexapro
Loxitane	<b>FLU</b> oxetine
Loxitane	Soriatane
Lunesta	Neulasta
Lupron Depot-3 Month	Lupron Depot-Ped
Lupron Depot-Ped	Lupron Depot-3 Month
Luvox	Lasix
Lyrica	Lopressor
Maalox	Maalox Total Stomach Relief
Maalox Total Stomach Relief	Maalox
Matulane	Materna

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name
Materna	Matulane
Maxzide	Microzide
Menactra	Menomune
Menomune	Menactra
Mephyton	methadone
Metadate	methadone
Metadate CD	Metadate ER
Metadate ER	Metadate CD
Metadate ER	methadone
metFORMIN	metroNIDAZOLE
methadone	dexamethylphenidate
methadone	ketorolac
methadone	Mephyton
methadone	Metadate
methadone	Metadate ER
methadone	methylphenidate
Methergine	Brethine
methimazole	metolazone
methylphenidate	methadone
metolazone	methimazole
metoprolol succinate	metoprolol tartrate
metoprolol tartrate	metoprolol succinate
metroNIDAZOLE	metFORMIN
Mevacor	Benicar
Micronase	Microzide
Microzide	Maxzide
Microzide	Micronase
midodrine	Midrin
Midrin	midodrine
mifepristone	misoprostol
Miralax	Mirapex
Mirapex	Miralax
misoprostol	mifepristone
morphine	HYDRomorphine
morphine - non-concentrated oral liquid	morphine - oral liquid concentrate
morphine - oral liquid concentrate	morphine - non-concentrated oral liquid
Motrin	Neurontin
MS Contin	OxyCONTIN
Mucinex	Mucomyst
Mucinex D	Mucinex DM
Mucinex DM	Mucinex D
Mucomyst	Mucinex
Myleran	Alkeran
Myleran	Leukeran
naloxone	Lanoxin
Narcan	Norcuron

Drug Name	Confused Drug Name
Natru-Vent	Atrovent
Navane	Norvasc
Neo-Syneprine (oxymetazoline)	Neo-Syneprine (phenylephrine)
Neo-Syneprine (phenylephrine)	Neo-Syneprine (oxymetazoline)
Neulasta	Lunesta
Neulasta	Neumega
Neumega	Neupogen
Neumega	Neulasta
Neupogen	Neumega
Neurontin	Motrin
Neurontin	Noroxin
Neutra-Phos-K	K-Phos Neutral
NexAVAR	NexIUM
NexIUM	NexAVAR
niCARDipine	NIFEdipine
NIFEdipine	niCARDipine
NIFEdipine	niMODipine
niMODipine	NIFEdipine
Norcuron	Narcan
Normodyne	Norpramin
Noroxin	Neurontin
Norpramin	Normodyne
Norvasc	Navane
NovoLIN	HumuLIN
NovoLIN	NovoLOG
NovoLIN 70/30	NovoLOG Mix 70/30
NovoLOG	HumaLOG
NovoLOG	NovoLIN
NovoLOG FLEXPEN	NovoLOG Mix 70/30 FLEXPEN
NovoLOG Mix 70/30 FLEXPEN	NovoLOG FLEXPEN
NovoLOG Mix 70/30	NovoLIN 70/30
nystatin	HMG-CoA reductase inhibitors ("statins")
Occlusal-HP	Ocuflox
Ocuflox	Occlusal-HP
OLANzapine	QUETiapine
Omacor	Amicar
omeprazole	fomepizole
opium tincture	paregoric (camphorated tincture of opium)
Oracea	Orencia
Orencia	Oracea
Orgaran	argatroban
Ortho Tri-Cyclen	Ortho Tri-Cyclen LO
Ortho Tri-Cyclen LO	Ortho Tri-Cyclen
Os-Cal	Asacol
OXcarbazepine	carBAMazepine
oxyCODONE	HYDRocodone

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



## ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name	Drug Name	Confused Drug Name
oxy <b>CODONE</b>	Oxy <b>CONTIN</b>	Procet	Percocet
Oxy <b>CONTIN</b>	MS Contin	Prograf	<b>PRO</b> zac
Oxy <b>CONTIN</b>	oxy <b>CODONE</b>	propylthiouracil	Purinethol
<b>PAC</b> Litaxel	<b>PAC</b> Litaxel protein-bound particles	Proscar	Provera
<b>PAC</b> Litaxel protein-bound particles	<b>PAC</b> Litaxel	Protain XL	Procardia XL
Pamelor	Panlor DC	protamine	Protonix
Pamelor	Tambacor	proton pump inhibitors	<b>ARIP</b> iprazole
Panlor DC	Pamelor	Protonix	Lotronex
paregoric (camphorated tincture of opium)	opium tincture	Protonix	protamine
<b>PAR</b> oxetine	<b>FLU</b> oxetine	Provera	Proscar
<b>PAR</b> oxetine	piroxicam	Provera	<b>PRO</b> zac
Patanol	Platinol	<b>PRO</b> zac	Prograf
Pavulon	Peptavlon	<b>PRO</b> zac	Pri <b>LOSEC</b>
Paxil	Doxil	<b>PRO</b> zac	Provera
Paxil	Taxol	Purinethol	propylthiouracil
Paxil	Plavix	<b>QU</b> Etiapine	<b>OLAN</b> zapine
<b>PEM</b> Etrexed	<b>PRAL</b> atrexate	qui <b>NID</b> ine	qui <b>NINE</b>
Peptavlon	Pavulon	qui <b>NINE</b>	qui <b>NID</b> ine
Percocet	Darvocet	Qwell	Kwell
Percocet	Procet	<b>RAB</b> Eprazole	<b>ARIP</b> iprazole
Pexevea	Lexiva	Razadyne	Rozerem
<b>PENT</b> obarbital	<b>PHEN</b> obarbital	Recombivax HB	Comvax
<b>PHEN</b> obarbital	<b>PENT</b> obarbital	Regranex	Granulex
Pilocar	Dilacor XR	Reminyl	Robinul
piroxicam	<b>PAR</b> oxetine	Reminyl	Amaryl
Platinol	Patanol	Renagel	Renvela
Plavix	Paxil	Renvela	Renagel
Plendil	Isordil	Reprexain	<b>ZyPREXA</b>
pneumococcal 7-valent vaccine	pneumococcal polyvalent vaccine	Restoril	Risper <b>DAL</b>
pneumococcal polyvalent vaccine	pneumococcal 7-valent vaccine	Retrovir	ritonavir
Polycitra	Bicitra	Rifadin	Rifater
<b>PRAL</b> atrexate	<b>PEM</b> Etrexed	Rifamate	rifampin
Prandin	Avandia	rifampin	Rifamate
Precare	Precose	rifampin	rifaximin
Precose	Precare	Rifater	Rifadin
predniso <b>LONE</b>	predni <b>SONE</b>	rifaximin	rifampin
predni <b>SONE</b>	predniso <b>LONE</b>	Risper <b>DAL</b>	Restoril
Pri <b>LOSEC</b>	Pristiq	risperi <b>DONE</b>	<b>rOPINI</b> Role
Pri <b>LOSEC</b>	<b>PRO</b> zac	Ritalin	ritodrine
Priscoline	Apresoline	Ritalin LA	Ritalin SR
Pristiq	Pri <b>LOSEC</b>	Ritalin SR	Ritalin LA
probenecid	Procanbid	ritodrine	Ritalin
Procan SR	Procanbid	ritonavir	Retrovir
Procanbid	probenecid	ri <b>TUX</b> imab	in <b>FLIX</b> imab
Procanbid	Procan SR	Robinul	Reminyl
Procardia XL	Protain XL	<b>rOPINI</b> Role	risperi <b>DONE</b>

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



## ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name	Drug Name	Confused Drug Name
Roxanol	Roxicodone Intensol	<b>SUM</b> Atriptan	<b>ZOLM</b> triptan
Roxanol	Roxicet	Symbyax	Cymbalta
Roxicet	Roxanol	Tambocor	Pamelor
Roxicodone Intensol	Roxanol	Taxol	Taxotere
Rozerem	Razadyne	Taxol	Paxil
Salagen	<b>selegiline</b>	Taxotere	Taxol
Sand <b>IMMUNE</b>	Sando <b>STATIN</b>	<b>TEG</b> retol	<b>TEG</b> retol XR
Sando <b>STATIN</b>	Sand <b>IMMUNE</b>	<b>TEG</b> retol	Tequin
<b>saquinavir</b>	<b>SINE</b> quan	<b>TEG</b> retol	<b>TREN</b> tal
<b>saquinavir (free base)</b>	<b>saquinavir mesylate</b>	<b>TEG</b> retol XR	<b>TEG</b> retol
<b>saquinavir mesylate</b>	<b>saquinavir (free base)</b>	Tequin	<b>TEG</b> retol
Sarafem	Serophene	Tequin	Ticlid
<b>selegiline</b>	Salagen	Testoderm TTS	Testoderm
Serophene	Sarafem	Testoderm TTS	Testoderm with Adhesive
<b>SERO</b> quel	<b>SERO</b> quel XR	Testoderm with Adhesive	Testoderm
<b>SERO</b> quel	Serzone	Testoderm with Adhesive	Testoderm TTS
<b>SERO</b> quel	<b>SINE</b> quan	Testoderm	Testoderm TTS
<b>SERO</b> quel XR	<b>SERO</b> quel	Testoderm	Testoderm with Adhesive
<b>sertraline</b>	<b>cetirizine</b>	<b>tetanus diphtheria toxoid (Td)</b>	<b>tuberculin purified protein derivative (PPD)</b>
<b>sertraline</b>	Soriatane	Thalomid	Thiamine
Serzone	<b>SERO</b> quel	Thiamine	Thalomid
Sinemet	Janumet	<b>tiaGAB</b> ine	<b>tiZAN</b> idine
<b>SINE</b> quan	<b>saquinavir</b>	Tiazac	Ziac
<b>SINE</b> quan	<b>SERO</b> quel	Ticlid	Tequin
<b>SINE</b> quan	Singulair	<b>tiZAN</b> idine	<b>tiaGAB</b> ine
<b>SINE</b> quan	Zonegran	TNKase	Activase
Singulair	<b>SINE</b> quan	TNKase	<b>t-PA</b>
<b>sitaGLIP</b> tin	<b>SUM</b> Atriptan	Tobradex	Tobrex
Solu- <b>CORTEF</b>	Solu- <b>MEDROL</b>	Tobrex	Tobradex
Solu- <b>MEDROL</b>	Depo-Medrol	<b>TOLAZ</b> amide	<b>TOLBUT</b> amide
Solu- <b>MEDROL</b>	Solu- <b>CORTEF</b>	<b>TOLBUT</b> amide	<b>TOLAZ</b> amide
Sonata	Soriatane	Topamax	Toprol-XL
Soriatane	Loxitane	Toprol-XL	Topamax
Soriatane	<b>sertraline</b>	Toradol	Foradil
Soriatane	Sonata	<b>t-PA</b>	TNKase
<b>sotalol</b>	Sudafed	Tracleer	Tricor
Spiriva	Inspra	<b>traMAD</b> ol	<b>traZOD</b> one
Sudafed	<b>sotalol</b>	<b>traZOD</b> one	<b>traMAD</b> ol
Sudafed	Sudafed PE	<b>TREN</b> tal	<b>TEG</b> retol
Sudafed PE	Sudafed	<b>tre</b> tinoin	<b>ISO</b> tre <sup>t</sup> inoin
<b>SUF</b> entanil	<b>fenta</b> NYL	Tricor	Tracleer
<b>sulfADIAZINE</b>	<b>sulfa</b> SALazine	<b>tromethamine</b>	Trophamine
<b>sulfADIAZINE</b>	<b>sulfi</b> SOXAZOLE	Trophamine	<b>tromethamine</b>
<b>sulfa</b> SALazine	<b>sulfADIAZINE</b>	<b>tuberculin purified protein derivative (PPD)</b>	<b>influenza virus vaccine</b>
<b>sulfi</b> SOXAZOLE	<b>sulfADIAZINE</b>	<b>tuberculin purified protein derivative (PPD)</b>	<b>tetanus diphtheria toxoid (Td)</b>
<b>SUM</b> Atriptan	<b>sita</b> GLIPtin	Tylenol	Tylenol PM

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.



ISMP's List of *Confused Drug Names*

Drug Name	Confused Drug Name
Tylenol PM	Tylenol
Ultracet	Duricef
valACYclovir	valGANciclovir
Valcyte	Valtrex
valGANciclovir	valACYclovir
Valtrex	Valcyte
Varivax	VZIG (varicella-zoster immune globulin)
Vesanoid	Vesicare
Vesicare	Vesanoid
Vexol	Vosol
Viagra	Allegra
Videx	Bidex
vinBLAStine	vinCRIStine
vinCRIStine	vinBLAStine
Viokase	Viokase 8
Viokase 8	Viokase
Vioxx	Zyvox
Viracept	Viramune
Viramune	Viracept
Vosol	Vexol
VZIG (varicella-zoster immune globulin)	Varivax
Wellbutrin SR	Wellbutrin XL
Wellbutrin XL	Wellbutrin SR
Xanax	Fanapt
Xanax	Zantac
Xeloda	Xenical
Xenical	Xeloda
Yasmin	Yaz
Yaz	Yasmin
Zantac	Xanax
Zantac	ZyrTEC
Zavesca (escitalopram) [non-US product]	Zavesca (miglustat)
Zavesca (miglustat)	Zavesca (escitalopram) [non-US product]
Zebeta	Diabeta

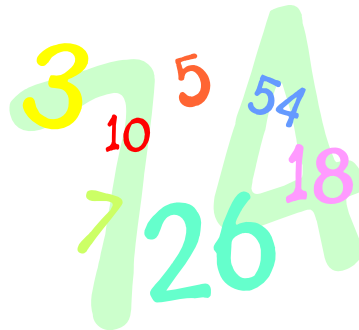
Drug Name	Confused Drug Name
Zebeta	Zetia
Zegerid	Zestril
Zelapar (Zydis formulation)	ZyPREXA Zydis
Zestril	Zegerid
Zestril	Zetia
Zestril	ZyPREXA
Zetia	Bextra
Zetia	Zebeta
Zetia	Zestril
Ziac	Tiazac
Zocor	Cozaar
Zocor	ZyrTEC
ZOLMitriptan	SUMATriptan
Zonegran	SINEquan
Zostrix	Zovirax
Zovirax	Doribax
Zovirax	Zyvox
Zovirax	Zostrix
Zyban	Diovan
ZyPREXA	CeleXA
ZyPREXA	Reprexain
ZyPREXA	Zestril
ZyPREXA	ZyrTEC
ZyPREXA Zydis	Zelapar (Zydis formulation)
ZyrTEC	Lipitor
ZyrTEC	Zantac
ZyrTEC	Zocor
ZyrTEC	ZyPREXA
ZyrTEC	ZyrTEC-D
ZyrTEC (cetirizine)	ZyrTEC Itchy Eye Drops (ketotifen fumarate)
ZyrTEC-D	ZyrTEC
ZyrTEC Itchy Eye Drops (ketotifen fumarate)	ZyrTEC (cetirizine)
Zyvox	Vioxx
Zyvox	Zovirax

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. Brand name products appear in black; generic/other products appear in red.

© ISMP 2011. Permission is granted to reproduce material with proper attribution for internal use within healthcare organizations. Other reproduction is prohibited without written permission from ISMP. Report actual and potential medication errors to the ISMP National Medication Errors Reporting Program (ISMP MERP) via the Web at [www.ismp.org](http://www.ismp.org) or by calling 1-800-FAIL-SAF(E).

# Medication Math

## *Study Guide*



*With  
Practice Test*



**MEDICAL GROUP**

Medication Administration in the  
Ambulatory Care Setting

## *Introduction:*

Upon completion of the Medication Administration module and Medication Math Study Guide, the learner will complete an online quiz.

- Medication administration requires accurate math skills, every drug, every time!
- The inability to accurately calculate drug dosages may lead to fatal outcomes.
- Medication math requires practice.
- Best practice requires the use of a Master Formula for dosage calculations.

## **The Seven Rights of Medication Administration**

- Right **Patient**
- Right **Medication**
- Right **Dose**
- Right **Time**
- Right **Route**
- Right **Reason**
- Right **Documentation**

## **The Essentials of Medication Administration**

- Stop and clarify if you are not 100% certain!
- Identify the **right patient** using two patient identifiers (i.e. name and date of birth).
- Determine if the patient has any allergies.
- Prepare the **right dose** of the **right medication**.
- Never give a medication that has been prepared by someone else.
- Always label the syringe with the name and dosage of the drug.
- Always label multi-dose vials with the 28-day discard date, the time opened, and your initials.
- Ensure that a second clinical staff member reviews your medication dose, and records the check in the EMR or on the paper chart.
- Administer the drug at the **right time** as ordered by the provider.
- Administer the drug using the **right route**.
- The **right reason** must always be reviewed.
- Include the **right documentation** in the EMR or on the paper chart.

## Familiarize Yourself with the Following Units of Measurement

### Units of Measurement

1 cc	=	1 mL
1 teaspoon	=	5 mL
1 tablespoon	=	15 mL
1 fluid ounce	=	30 mL
1 liter	=	1,000 mL
1 g	=	1,000 mg
1,000 g	=	1 kg
1 kilogram	=	2.2 lb

## Master Formula for Calculating Medication

**Amount on Hand (H) x Conversion Factor (C) = Answer**

## Using the Master Formula

As an example, let's determine how many milligrams would be equal to 5 grams.

We know that 1 gram (g) = 1,000 milligrams (mg). *This is the equivalent value or Conversion Factor.*

We can then convert grams to milligrams.

Amount on Hand (H) = 5 g

Conversion Factor (C) =  $\frac{1,000 \text{ mg}}{1 \text{ g}}$

Amount on Hand (H) x Conversion Factor (C) = Answer

$$\cancel{5 \text{ g}} \times \frac{1,000 \text{ mg}}{\cancel{1 \text{ g}}} = 5,000 \text{ mg}$$

---

**Sample Problem:** You have 25.8 g of medication, how many mg is this equivalent to?

Amount on Hand (H) = 25.8 g

Conversion Factor (C) =  $\frac{1,000 \text{ mg}}{1 \text{ g}}$

**Formula:** (H) x (C) = Answer

$$\cancel{25.8 \text{ g}} \times \frac{1,000 \text{ mg}}{\cancel{1 \text{ g}}} = 25,800 \text{ mg}$$

## Caution Regarding Decimal Points

A misplaced decimal point will cause the patient to receive the wrong dosage of medication. Always double check your decimal points!

Make sure to put a “0,” in front of all dosages of medication less than one. For example, 0.5 mL should always be written with the “0,” in the lead. *Never write, .5 mL, as this could be misinterpreted.*

## Master Formulas for Non-injectable and Injectable Medications

### Non-injectable medications:

Ordered Dose (D) x Conversion Factor (C) = Answer

*(Provider's order x equivalent value = Answer)*

$$(D) \times (C) = \text{Answer}$$

### Injectable medications\*:

Ordered Dose (D) x Dose on Hand (H) = Answer

*(Provider's order x equivalent value = Answer)*

$$(D) \times (H) = \text{Answer}$$

\*Note: Some medication vials are prepared as concentrations. For example, if the vial states 100 mg/1 mL, this means that for every one (1) mL of medication that you draw up into your syringe, you will have the equivalent of 100 mg of medication.

---

### Sample Problem – Non-injectable Medication:

Nitroglycerin is supplied in tablet form. The concentration per **tablet** is **0.4 mg**. If you administered **3 tablets** as your order, how many **mg** of nitroglycerin has the patient received?

In this example, the conversion factor (equivalent value) is 0.4 **mg** per one (1) **tablet**. The dose administered (provider's order) is **3 tablets**.

Ordered Dose (D) x Dose on Hand (H) = Answer

$$3 \cancel{\text{tablets}} \times \frac{0.4 \text{ mg}}{1 \cancel{\text{tablets}}} = 1.2 \text{ mg}$$

---

**Sample Problem – Injectable Medication:**

The provider orders 25 **mg** of xylocaine for injection. How many **mL** should you administer if your medication is supplied in a 5 **mg/ml** concentration?

**Formula:** Ordered Dose (provider's order) x Conversion Factor (equivalent value) = Answer

Ordered Dose = 25 mg

Conversion factor =  $\frac{1 \text{ mL}}{5 \text{ mg}}$

$$25 \text{ mg} \times \frac{1 \text{ mL}}{5 \text{ mg}} = 5 \text{ mL}$$

### Converting Pounds to Kilograms

**Sample Problem:** In pediatrics we often need to convert the patient's weight from pounds (lb) to kilograms (kg), in order to calculate medication dosages.

As an example, let's determine how many **kg** are equal to 43 **lb**?

**Formula:** Amount on Hand (H) x Conversion Factor (C) = Answer

Amount on Hand (H) = 43 lb

Conversion Factor (C) =  $\frac{1 \text{ kg}}{2.2 \text{ lb}}$

$$43 \cancel{\text{ lb}} \times \frac{1 \text{ kg}}{2.2 \cancel{\text{ lb}}} = 19.5 \text{ kg}$$



## Medication Math Practice Questions Worksheet

*For the following two questions, the medication you have on hand is supplied in 5 mg/2 mL concentration.*

1. The provider orders 50 **mg** of medication. How many **mL** will you administer?
2. The provider orders 35 **mg** of medication. How many **mL** will you administer?

*For the following two questions, the acetaminophen tablets you have on hand are supplied in 500 mg/1 tab.*

3. A patient has an order for 1,000 **mg** of acetaminophen. How many **tablets** will you administer?
4. A patient has an order for 500 **mg** of acetaminophen. How many **tablets** will you administer?

*Convert the following.*

5. 200 lb = \_\_\_\_\_ kg
6. 60 lb = \_\_\_\_\_ kg
7. 3 teaspoons = \_\_\_\_\_ mL
8. 2 fl. oz = \_\_\_\_\_ mL
9. 25 kg = \_\_\_\_\_ lb
10. 0.5 L = \_\_\_\_\_ mL

11. 0.25 g = \_\_\_\_\_ mg
12. 0.75 kg = \_\_\_\_\_ g
13. 2 tablespoons = \_\_\_\_\_ mL

***Solve the problems below:***

14. You have an order for a 150 **mg** injection of Depo-Provera. The medication vial is available in 300 **mg/2 mL**. How many **mL** will you administer to the patient?
  
15. The provider creates an order for a 100 mg injection of Depo-Testosterone. The vial is available in 200 **mg/1 mL**. How many **mL** will the provider administer to the patient?
  
16. You have an order for a 0.5 **g** injection of an antibiotic. The vial is available in 1 **g/10 mL**. How many **mL** will you administer to the patient?

## Answers to Practice Test:

1. 20 mL
2. 14 mL
3. 2 tabs
4. 1 tab
5. 90.9 kg
6. 27.3 kg
7. 15 mL
8. 60 mL
9. 55 lb
10. 500 mL
11. 250 mg
12. 750 g
13. 30 mL
14. 1 mL
15. 0.5 mL
16. 5 mL

Medical Math Practice Questions  
Worksheet Calculations

1. D = 50 mg  
C = 5 mg/2 mL

$$50 \text{ mg} \times \frac{2 \text{ mL}}{5 \text{ mg}} = 20 \text{ mL}$$

2. D = 35 mg  
C = 5 mg/2 mL

$$35 \text{ mg} \times \frac{2 \text{ mL}}{5 \text{ mg}} = 14 \text{ mL}$$

3. D = 1,000 mg  
C = 500 mg/1 tablet

$$1,000 \text{ mg} \times \frac{1 \text{ tab}}{500 \text{ mg}} = 2 \text{ tabs}$$

4. D = 500 mg  
C = 500 mg/1 tablet

$$500 \text{ mg} \times \frac{1 \text{ tab}}{500 \text{ mg}} = 1 \text{ tab}$$

5. H = 200 lb  
C = 2.2 lb = 1 kg

$$200 \text{ lb} \times \frac{1 \text{ kg}}{2.2 \text{ lb}}$$

$$200/2.2 = 90.9 \text{ or } 91 \text{ kg}$$

6. H = 60 lb  
C = 2.2 lb = 1 kg

$$60 \text{ lb} \times \frac{1 \text{ kg}}{2.2 \text{ lb}}$$

$$60/2.2 = 27.27 \text{ kg or } 27.3 \text{ kg}$$

7. H = 3 teaspoons (t)  
C =  $\frac{1 \text{ teaspoon}}{5 \text{ mL}}$

$$3 \text{ t} \times \frac{5 \text{ mL}}{1 \text{ t}} = 15 \text{ mL}$$

8. H = 2 fl. oz  
C =  $\frac{30 \text{ mL}}{1 \text{ fl. oz}}$

$$2 \text{ fl. oz} \times \frac{30 \text{ mL}}{1 \text{ fl. oz}} = 60 \text{ mL}$$

9. H = 25 kg  
C = 2.2 lb = 1 kg

$$25 \text{ kg} \times \frac{2.2 \text{ lb}}{1 \text{ kg}}$$

$$25 \text{ kg} \times 2.2 \text{ lb} = 55 \text{ kg}$$

10. H = 0.5 L  
C =  $\frac{1,000 \text{ mL}}{1 \text{ L}}$

$$0.5 \text{ L} \times \frac{1,000 \text{ mL}}{1 \text{ L}} = 500 \text{ mL}$$

11. H = 0.25 g  
C =  $\frac{1,000 \text{ mg}}{1 \text{ g}}$

$$0.25 \text{ g} \times \frac{1,000 \text{ mg}}{1 \text{ g}} = 250 \text{ mg}$$

12. H = 0.75 kg  
C =  $\frac{1,000 \text{ g}}{1 \text{ kg}}$

$$0.75 \text{ g} \times \frac{1,000 \text{ g}}{1 \text{ kg}} = 750 \text{ mg}$$

13. H = 2 tablespoons (T)  
C =  $\frac{15 \text{ mL}}{1 \text{ T}}$

$$2 \text{ T} \times \frac{15 \text{ mL}}{1 \text{ T}} = 30 \text{ mL}$$

14. D = 150 mg  
C =  $\frac{300 \text{ mg}}{2 \text{ mL}}$

$$150 \text{ mg} \times \frac{2 \text{ mL}}{300 \text{ mg}} = 1 \text{ mL}$$

15. D = 100 mg  
C =  $\frac{200 \text{ mg}}{1 \text{ mL}}$

$$100 \text{ mg} \times \frac{1 \text{ mL}}{200 \text{ mg}} = 0.5 \text{ mL}$$

16. D = 0.5 g  
C =  $\frac{10 \text{ mL}}{1 \text{ g}}$

$$0.5 \text{ g} \times \frac{10 \text{ mL}}{1 \text{ g}} = 5 \text{ mL}$$



# MEDICAL GROUP

## Environment of Care Readiness Checklist

Date: \_\_\_\_\_  
 Department: \_\_\_\_\_  
 Completed By: \_\_\_\_\_

**Instructions:** Complete ONE checklist per month. Keep original. Send copies to You're Immediate Supervisor by 1<sup>st</sup> of the month & to Sue Walker EOC coordinator.

**Red Indicates Know TJC Problem Areas**

Element Inspected Where Applicable	N/A	OK	NOT OK	If "Not OK", Action Taken Comment REQUIRED
<b>Emergency warning devices:</b>				
<ul style="list-style-type: none"> <li>Emergency plan staff awareness (can verbalize response to Fire, Tornado, Evacuation, Disaster)</li> </ul>				
<ul style="list-style-type: none"> <li>Exit Signs illuminated and Emergency Exit Lights Operational (Battery Operated) (Make sure arrows point only toward exit.)</li> </ul>				
<ul style="list-style-type: none"> <li>Passage ways are clear and Exits are not blocked (No items plugged in while in hallway, no hallway storage. No beds or equipment storage in hallways)</li> </ul>				
Personal protective equipment and clothing available and used as needed				
<u>Materials handling, storage, and disposal:</u>				
<ul style="list-style-type: none"> <li>Laundry bags not overfilled (2/3 full is max, no odors)</li> </ul>				
<ul style="list-style-type: none"> <li>No items within 18" from ceiling</li> </ul>				
<ul style="list-style-type: none"> <li>Patient care items stored more than 6" from floor and away from water, heat and electrical outlets</li> </ul>				
<ul style="list-style-type: none"> <li>O2 tanks stored properly - no more than 11/room &amp; in cart (Empty and full O2 tanks segregated, secured)</li> </ul>				
Crash Cart checks completed DAILY, O2 tank & regulator available (Lock secure, defib. strip run daily, only 1 month worth of logs in book)				
<u>Operations involving hazardous materials and processes:</u>				
<ul style="list-style-type: none"> <li>SDS - Available on Intranet (Make sure employees know how to access SDS info and why)</li> </ul>				
<ul style="list-style-type: none"> <li>Biohazard bags are available &amp; in appropriate container</li> </ul>				
<ul style="list-style-type: none"> <li>Sharps containers are secured to the wall and not overfilled. Date box with discard date, which is 90 days from the date of implementation. Dispose of box after 90 days or when ¾ full.</li> </ul>				
<ul style="list-style-type: none"> <li>Black box dated when put in use</li> </ul>				
Confidential Patient Information is protected (No identifying patient information in trash)				
Walking and working surfaces clear of debris/obstructions (Hallways clear, no decorations on fire doors, nothing taped to bare walls – only posted on bulletin board)				
<b>No stained, displaced or missing ceiling tiles</b>				
Stairwells are clean and well lighted (No storage in stairwells/fire exits)				
Electrical Systems hazard; check for frayed cords, all items plugged in				
Health and sanitation provision in food preparation, eating areas, restrooms, etc. :				
<ul style="list-style-type: none"> <li>No food or drink in patient care areas or nursing stations</li> </ul>				
<ul style="list-style-type: none"> <li>Refrigerator temp logs up to date (not required for Staff Only food fridges) (Refrigerator checks twice a day if used for vaccination storage)</li> </ul>				
<ul style="list-style-type: none"> <li>All open containers in refrigerator dated</li> </ul>				
Illumination: All bulbs operational; All lights turned on/off				
<u>Fire protection equipment and hazards:</u>				
<ul style="list-style-type: none"> <li>Smoke detectors, alarms functioning (Outpt. Only)</li> </ul>				

<ul style="list-style-type: none"> <li>Check all fire extinguishers up to date: (Fire extinguishers checked monthly with full date of monthly inspection date, ex: 01-03-14) &amp; initial. Annual Hole Punch</li> </ul>					
<ul style="list-style-type: none"> <li>Fire doors <b>latch and close properly</b></li> </ul>					
<ul style="list-style-type: none"> <li><b>Do not block medical gas shut offs or electrical panels</b></li> </ul>					
Calibration and maintenance records up to date (Look for inventory sticker from Biomed)					
Flashlights checked and functioning					
First Aid Kits supplied – no outdated supplies (Outpt. Only)					
Cupboards under sinks contain nothing or are locked					
<b>No torn exam tables or chairs</b>					
Locks on Receptionist windows/Lobby Doors any Medical Records or confidential materials in an unsecured place?					
Is all staff wearing their ID Badge? Patient Rights badge					
Do patient bathroom have wireless door bells with sign posted. <b>If door locks does everyone have the key.</b>					
HFAP Manual Chapter 31.00.00 Outpatient services 2014 With tabs					
<b>CHECK ALL EXPIRATION DATES: NOTHING EXPIRED- liquids, blood tubes, chemicals (Specifically, Cidex OPA &amp; test strips, blood tubes, glucose test strips, medications) DO NOT USE IF PAST EXPIRATION DATE. MULTI-USE ITEMS: Label with discard date of 28 days from opening</b>					

Notes or

Concerns: \_\_\_\_\_  
 \_\_\_\_\_