MA Manual Revised 2/20/2015

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Accreditation Preparedness

REMEMBER!!!!

Always ask when you are not sure. There is <u>NEVER</u> a stupid question.

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. _____

Location of Manuals

Policy and Procedure Manual _____

Forms Manual _____

Emergency Protocols _____

Life/Safety Manual (Blue) _____

Emergency Preparedness Manual (Red) _____

These manuals are located in each office in hard copy and/or available on the Corporate Intranet. It is each employee's responsibility to know and follow the applicable policies and procedures pertaining to their job.

Remember, if you have <u>any</u> questions, just ask!

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Tornado Safe Areas
Attach Map Here

MMG EMERGENCY CODES

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

For Emergencies call . . . 9-1-1

Directory of On-Site Phone Extensions

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Inventory
Location of Office, Forms, Medical & Pharmaceutical Supplies

Sample of Policy and Procedure
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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

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- 3001 – Treatment Interventions Not Applicable to MMG
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- 3315 – Care of a Severed Extremity
- 3320 – Sexual Assault
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- 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

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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 of 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

Priority Status: ❑ **Routine** ❑ **STAT**	**Medication Refill:** ❑ **Yes** ❑ **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

Priority Status: ❑ **Routine** ❑ **STAT**	**Medication Refill:** ❑ **Yes** ❑ **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

Priority Status: ❑ **Routine** ❑ **STAT**	**Medication Refill:** ❑ **Yes** ❑ **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

MM-141
Rev. 3/09

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

McLaren MEDICAL GROUP		**Policy Title:**	Appointment Scheduling
Effective Date:	1/1/2008	**Policy Number:**	2300
Review Date:		**Category:**	Business/Leadership
Revised Date:	5/28/2014	**Oversight Level:**	
Administrative Responsibility:	MMG Directors and MMG President/CEO		
Interpretation:	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:

Code	Appointment Length
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:

Code	Appointment Length
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-CONCURENT 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: _____

_____

_____

_____

☐ See attached patient registry report ☐ See attached e-prescription list

☐ See attached test results ☐ No test results available

Request for:

Office Visit Type

☐ Initial consultation
☐ Follow-up
☐ Pre-Certification
☐ Evaluate
☐ Evaluate/Treat
☐ Other _____

Appointment time preference

☐ A.M.
☐ P.M.
☐ 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.

Office Use Only:

Date follow up letter received from Specialist: _____
Reason patient did not keep appointment: _____
Date patient completed Specialist evaluation: _____

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.

McLaren MEDICAL GROUP		**Policy Title:**	Patient Care Assessment
Effective Date:	10/96	**Policy Number:**	3325
Review Date:	11/26/02	**Category:**	Clinical
Revised Date:	9/10/13	**Oversight Level:**	2
Administrative Responsibility:	Ambulatory Quality Improvement Committee		
Interpretation:	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 9/12/2013
(Original signed policy on file in MMG Practice Management)
Margaret Dimond — Date
President/Chief Executive Officer

Michael Ziccardi, D.O. 9/12/2013
(Original signed policy on file in MMG Practice Management)
Michael Ziccardi, Jr., D.O. — Date
Medical Director

Previous Revision Dates/Supercedes Policy: 11/6/2012
1/06 / 4-26-05/10.17

McLaren MEDICAL GROUP		**Policy Title:**	Responding to Life-Threatening Emergencies
Effective Date:	10/96	**Policy Number:**	3305
Review Date:		**Category:**	Clinical
Revised Date:	8/5/14	**Oversight Level:**	2
Administrative Responsibility:	Operations Managers		
Interpretation:	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.

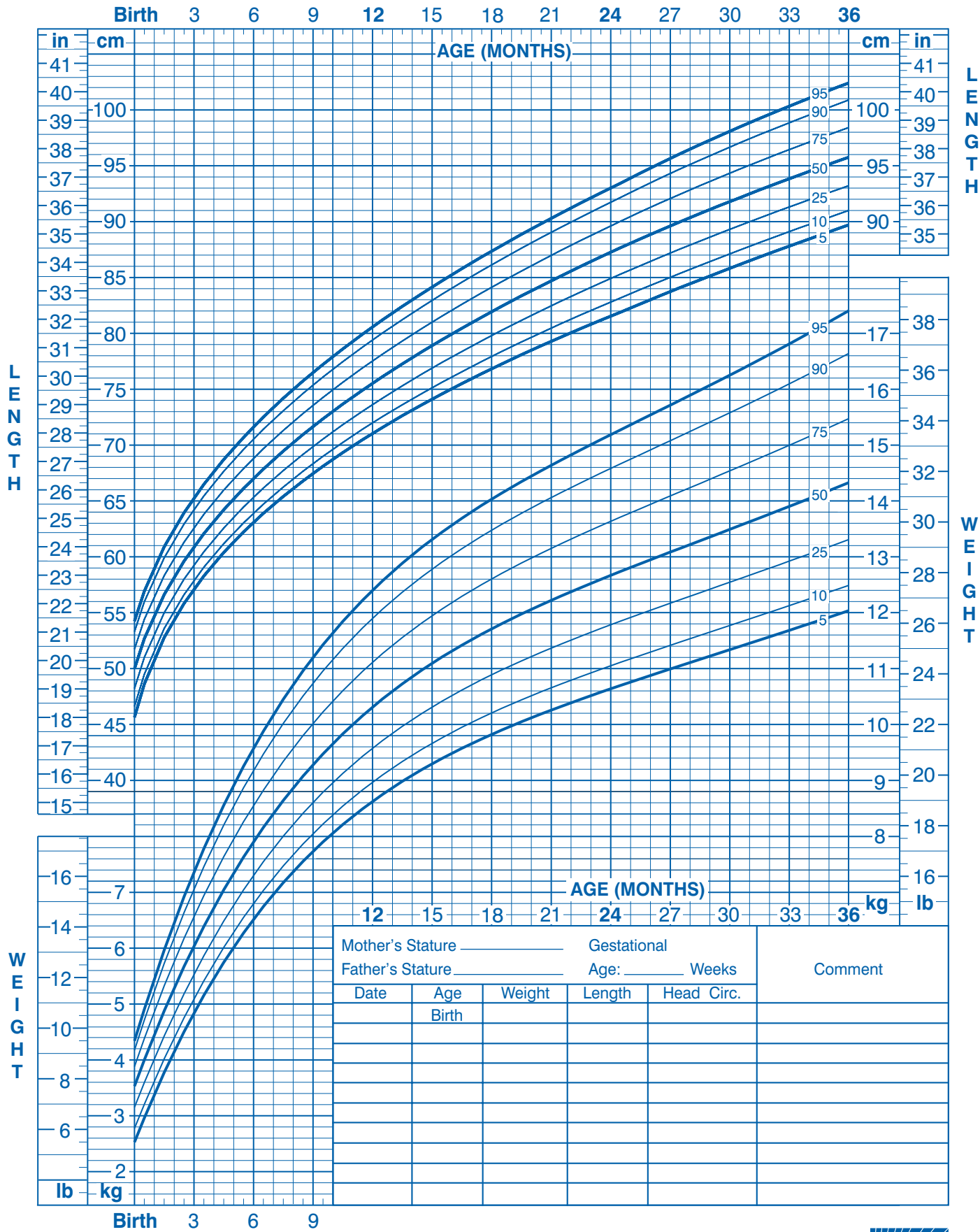
Rooming Patients

- 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

CDC
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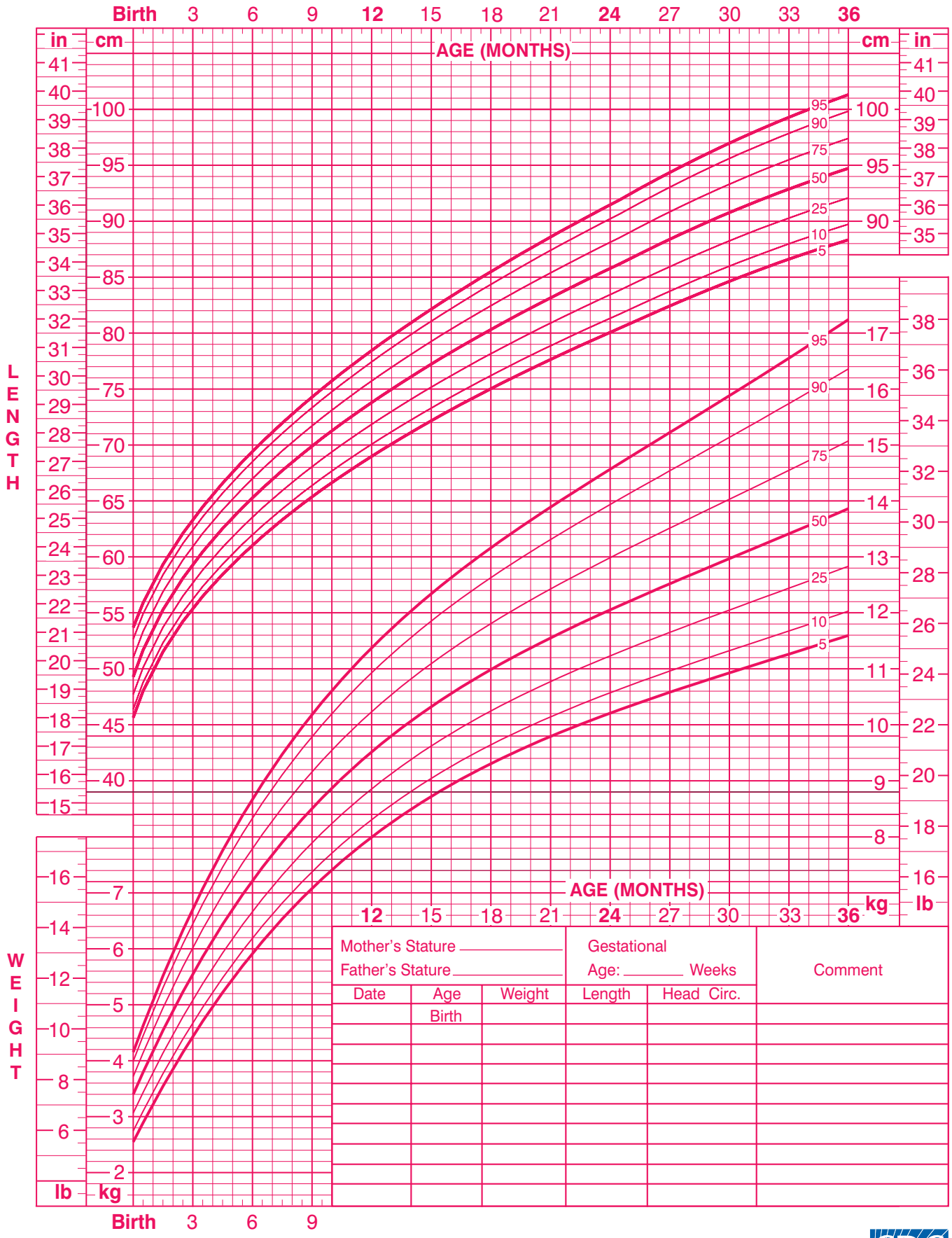
Birth to 36 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Mother's Stature _____

Father's Stature _____

Gestational Age: _____ Weeks

Date	Age	Weight	Length	Head Circ.	Comment
	Birth				

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

CDC
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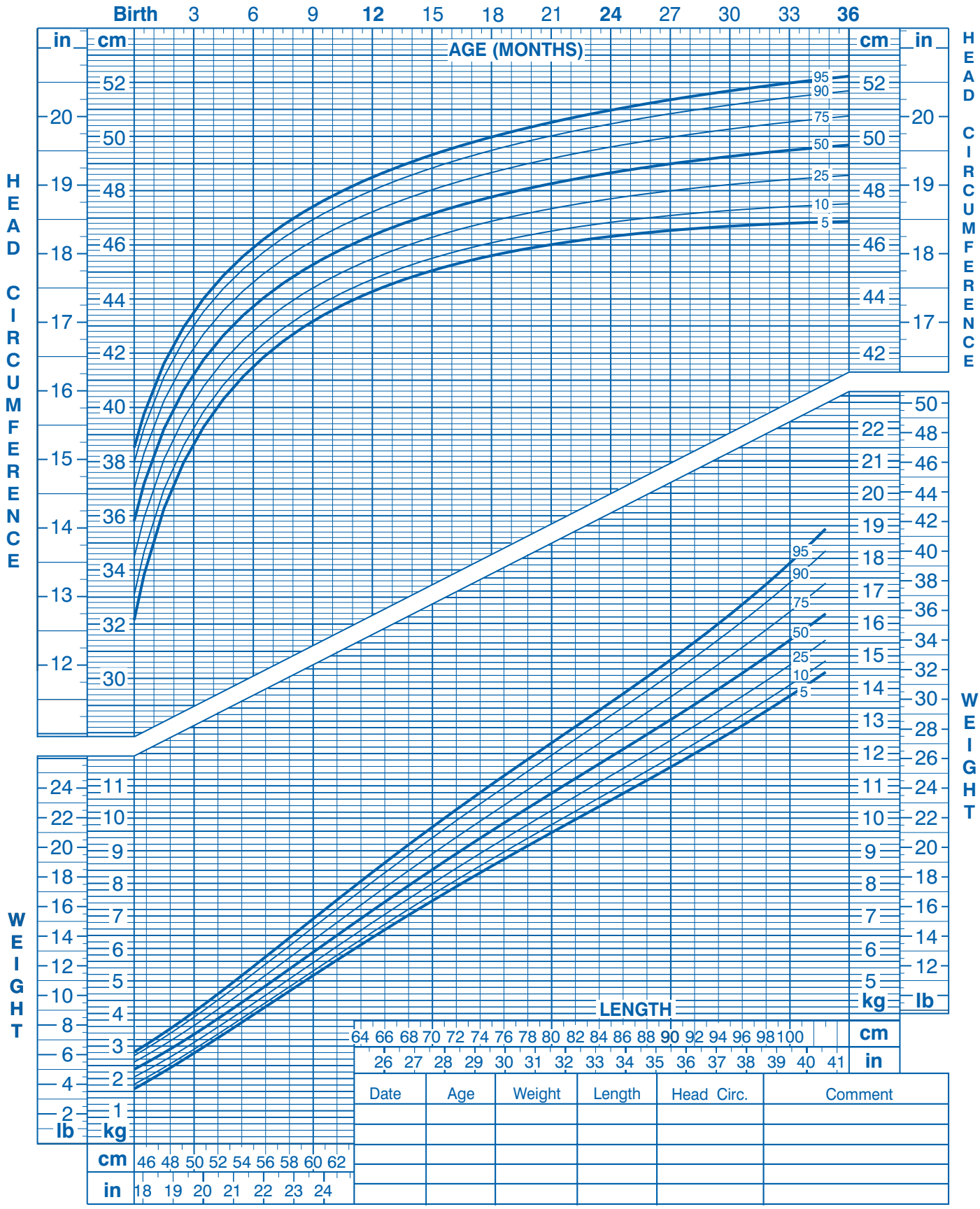
Birth to 36 months: Boys
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



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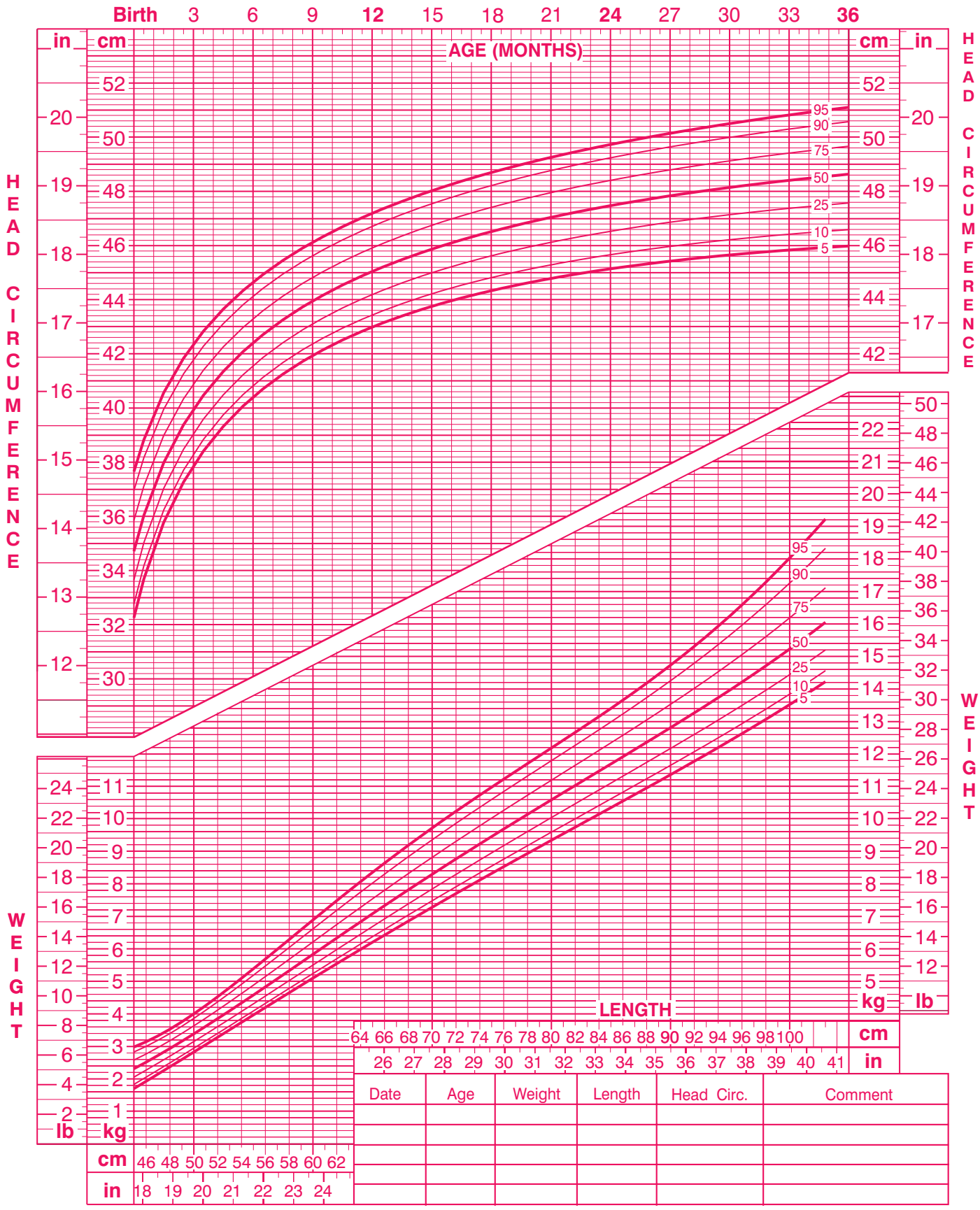
Birth to 36 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



cm 64 66 68 70 72 74 76 78 80 82 84 86 88 90 92 94 96 98 100

in 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41

Date	Age	Weight	Length	Head Circ.	Comment

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

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2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

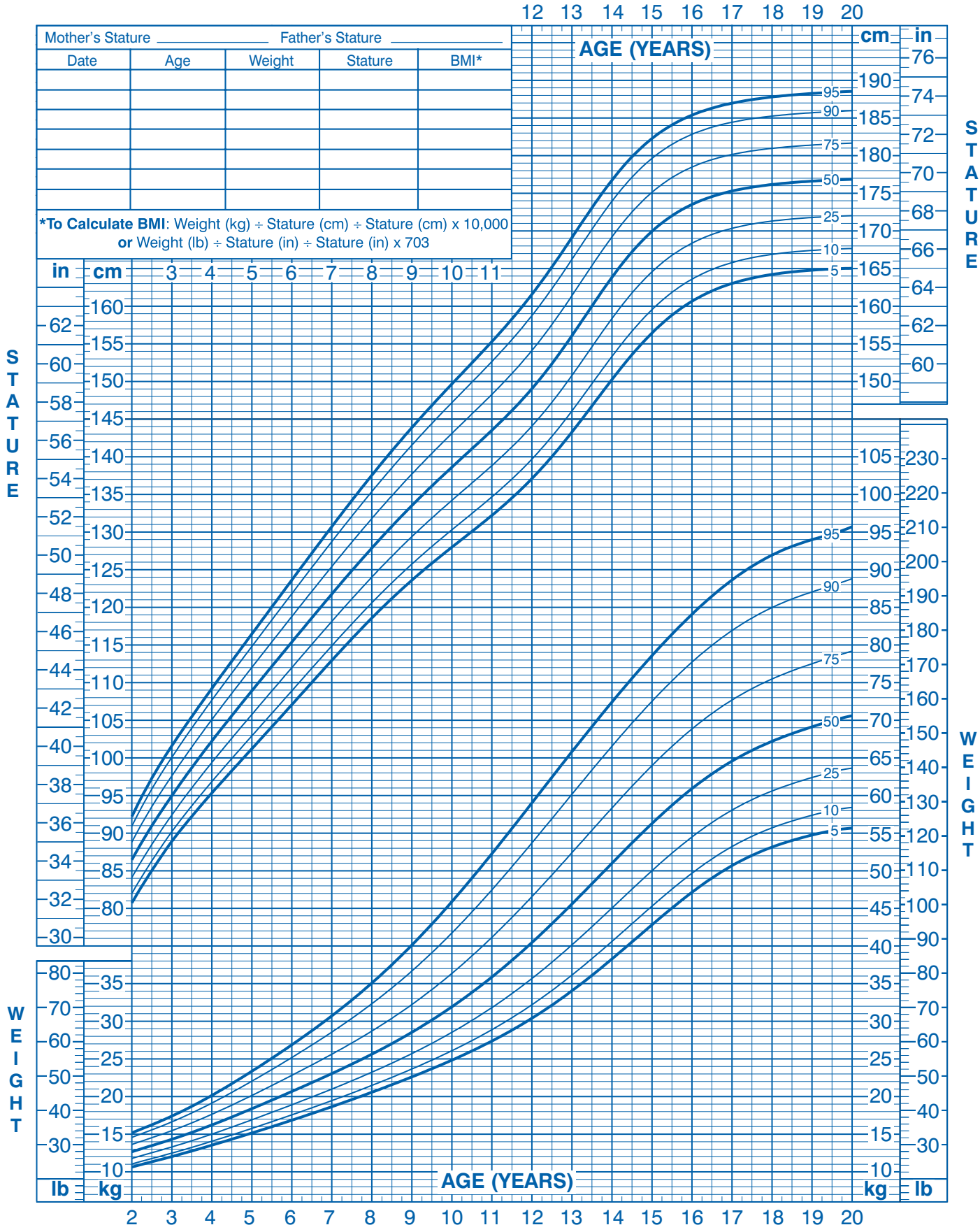
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
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http://www.cdc.gov/growthcharts

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2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

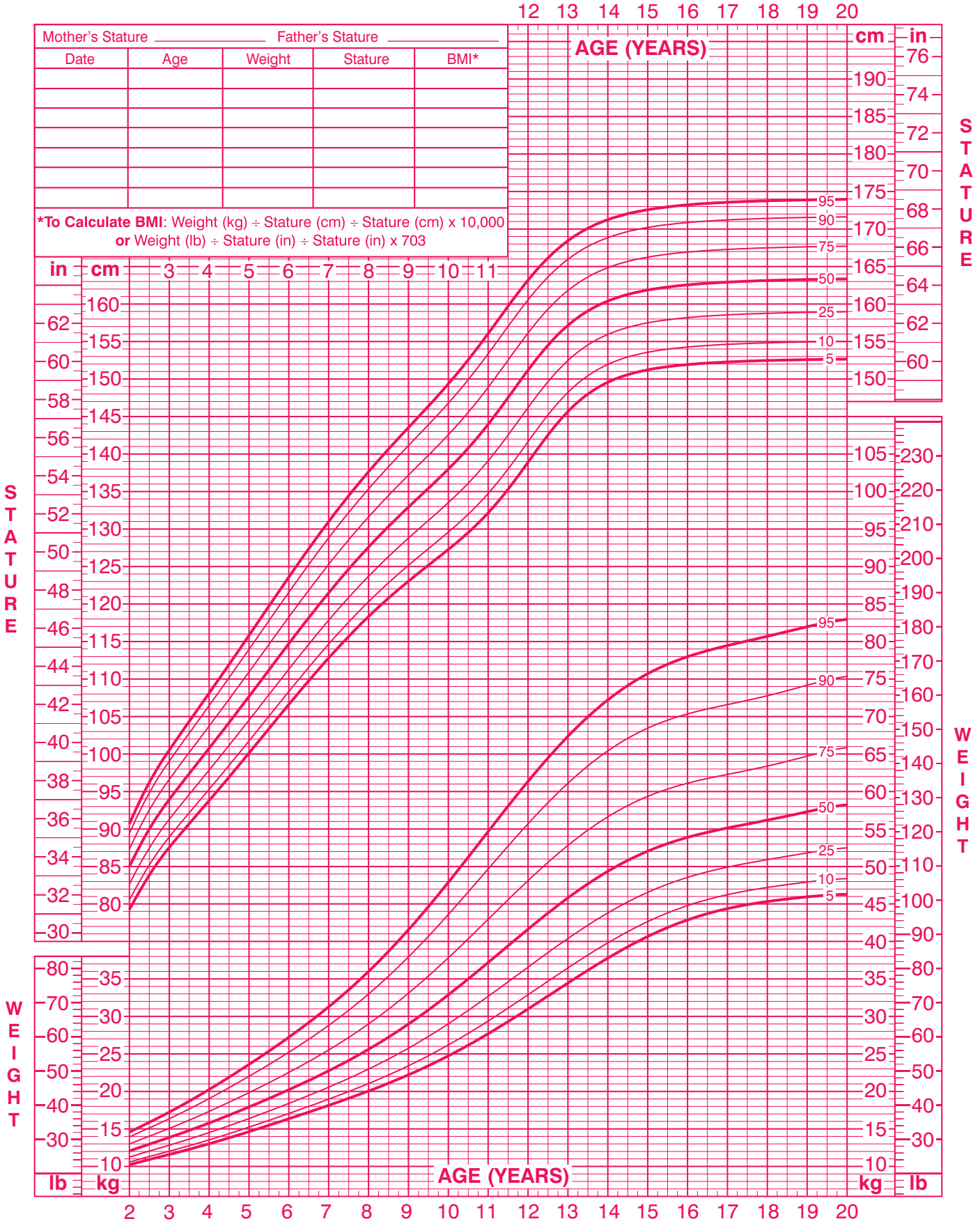
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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http://www.cdc.gov/growthcharts

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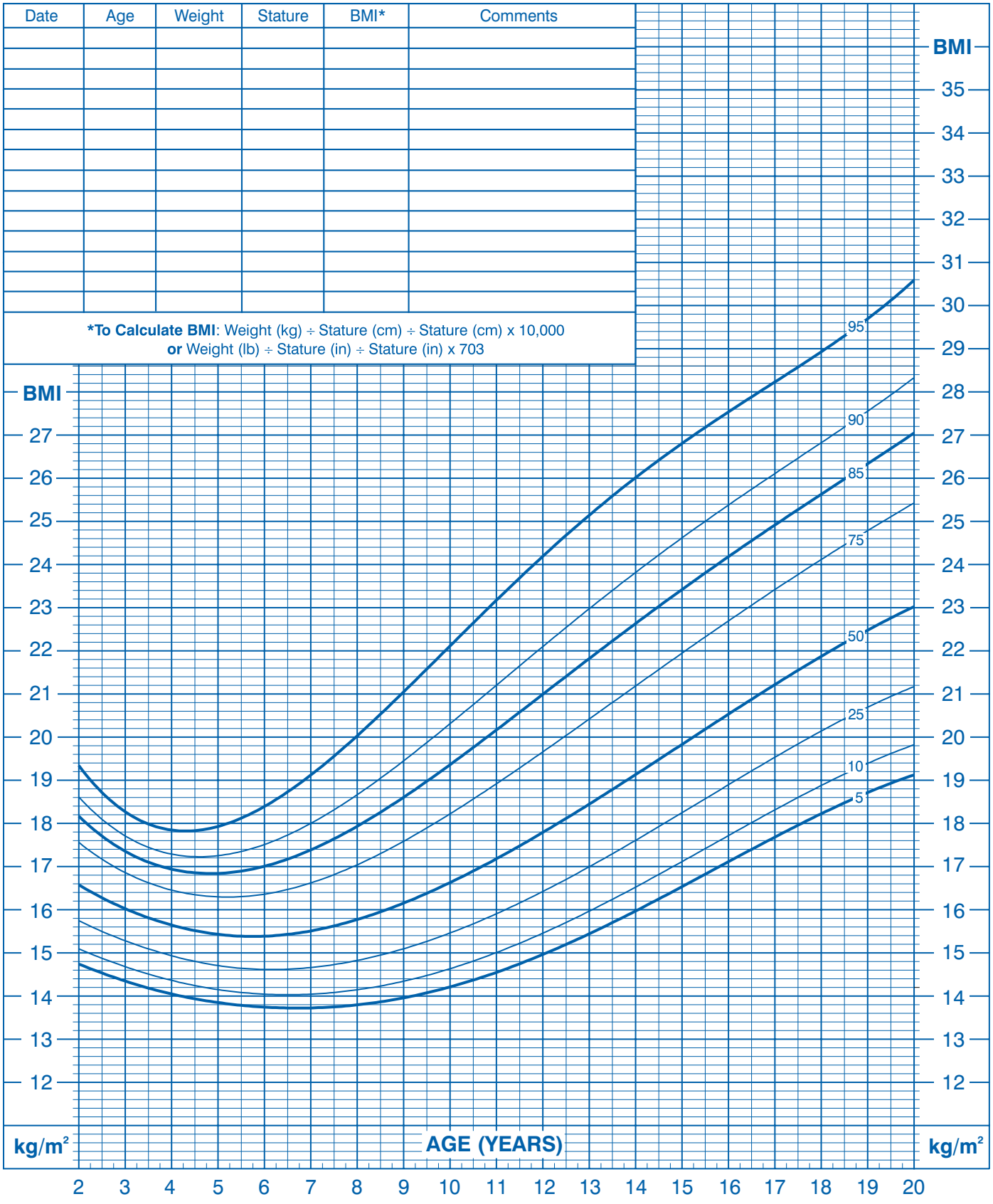
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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CDC
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2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

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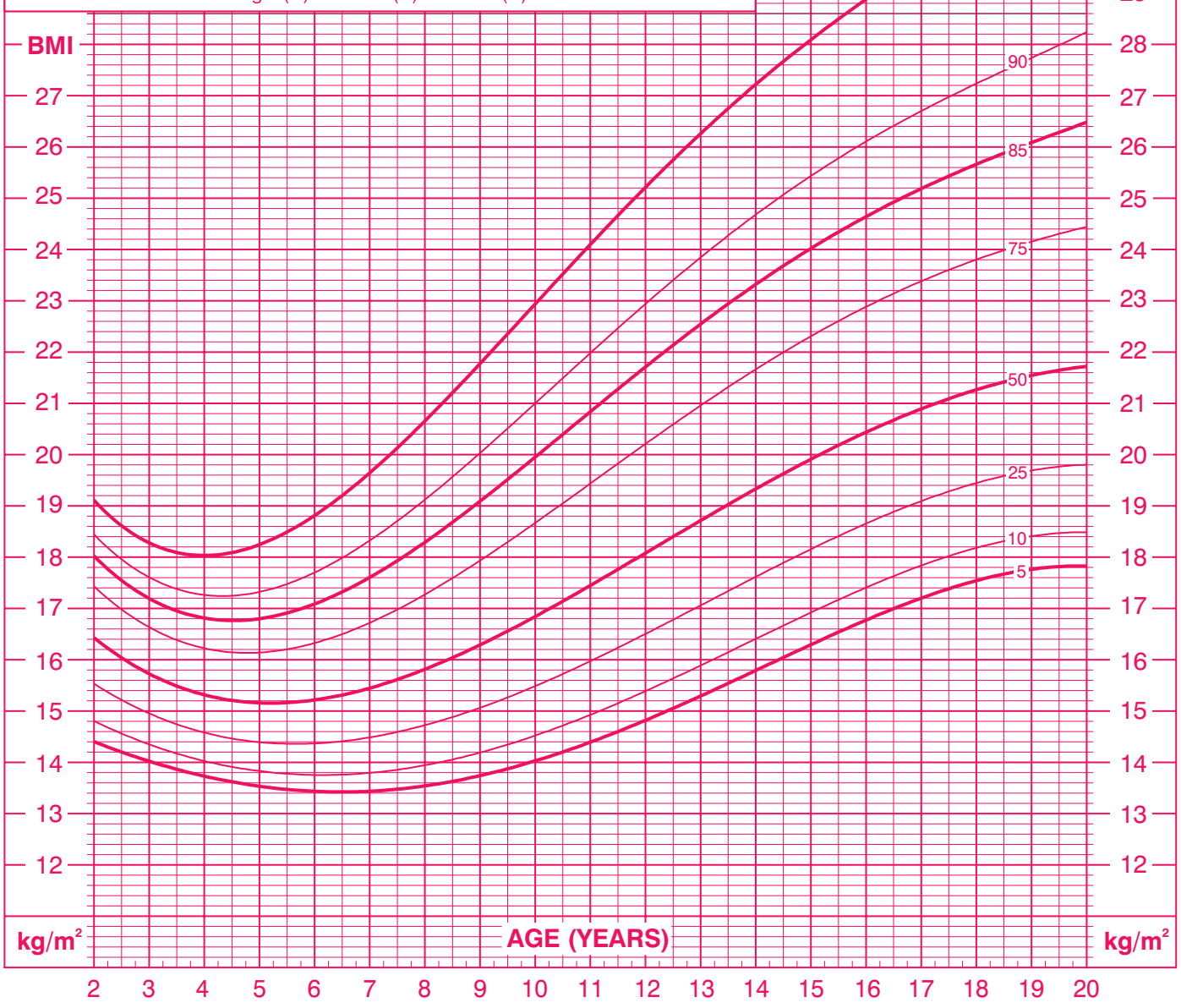
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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http://www.cdc.gov/growthcharts

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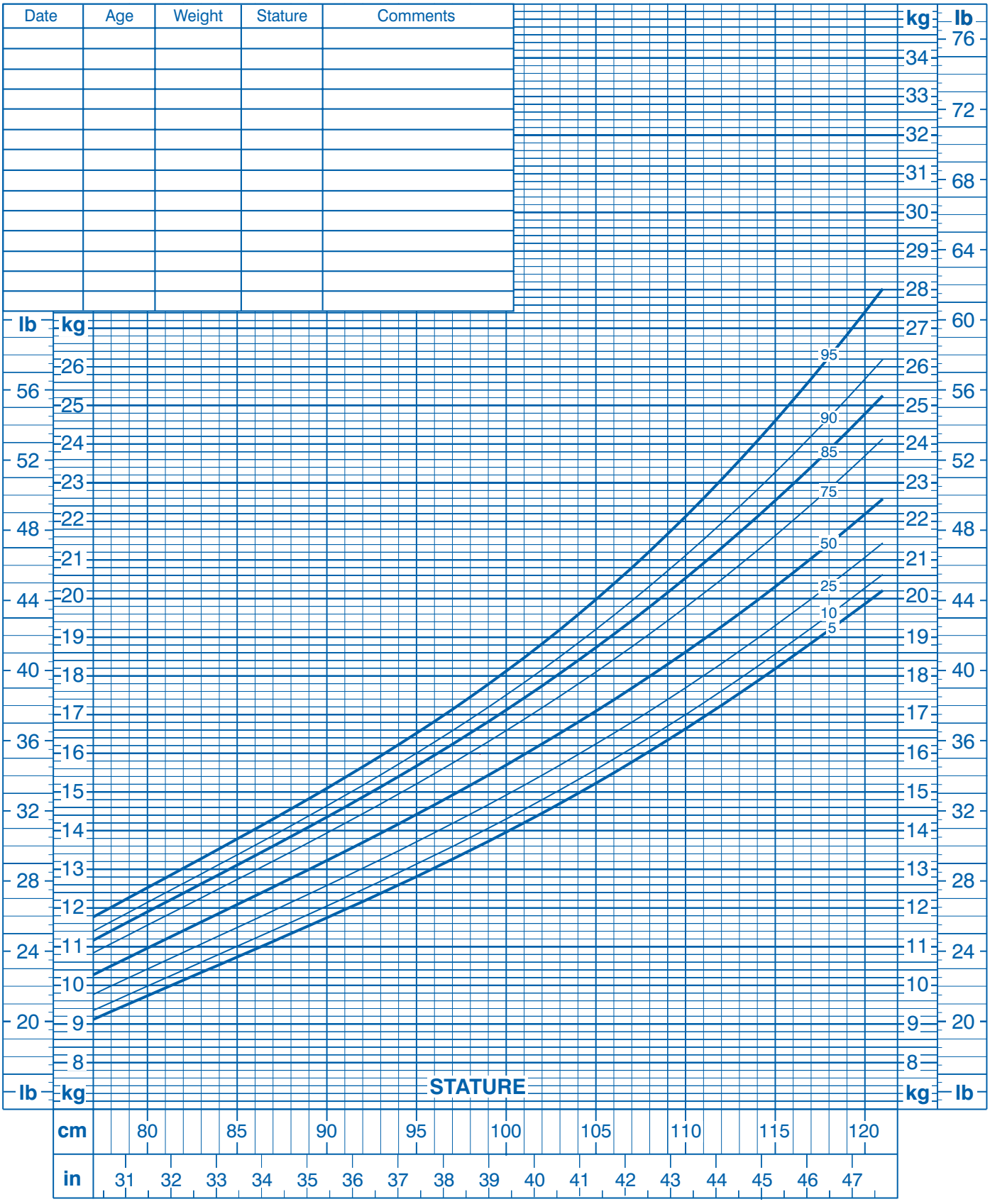
NAME _____

RECORD # _____

Weight-for-stature percentiles: Boys

Date	Age	Weight	Stature	Comments



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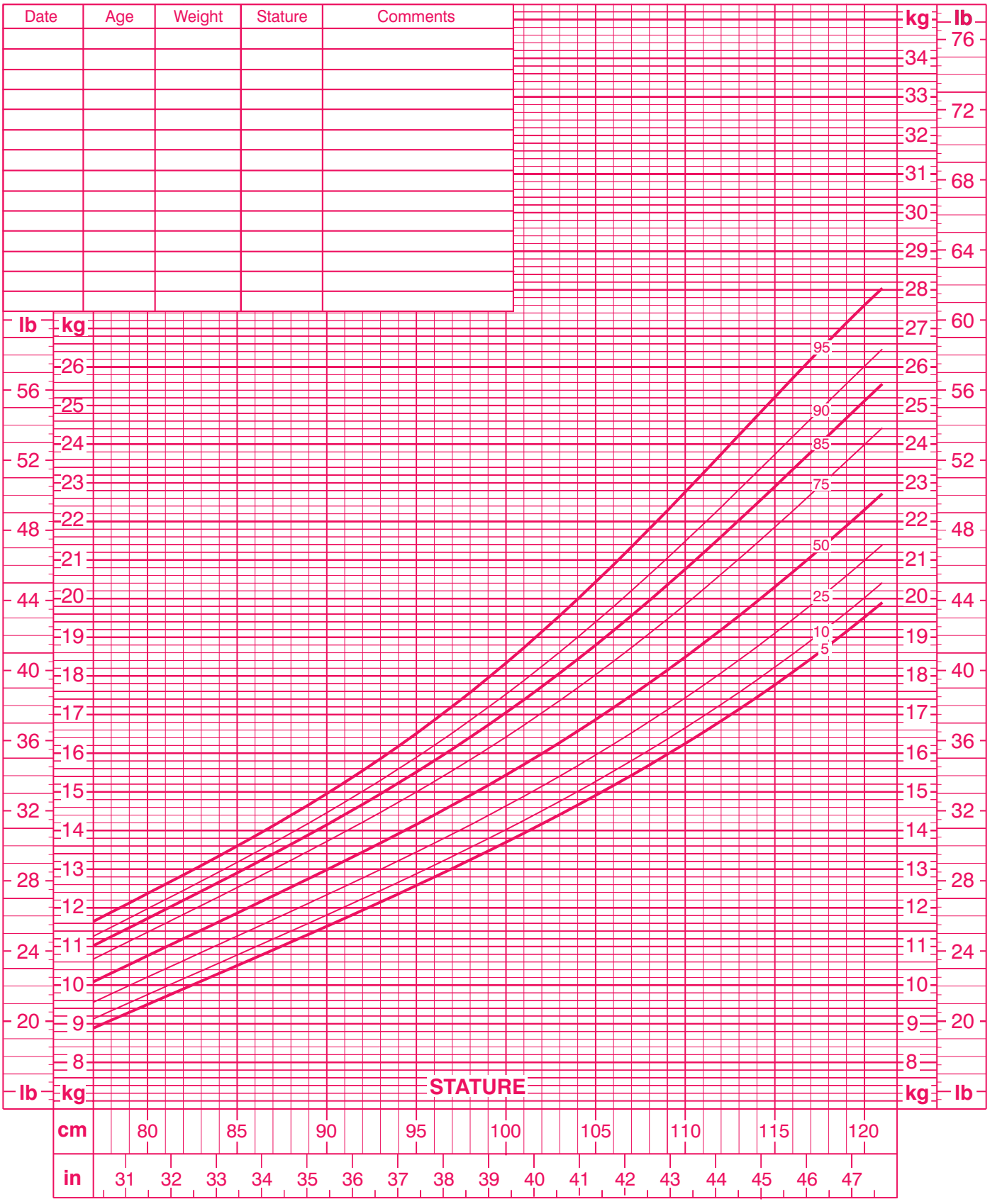
NAME _____

RECORD # _____

Weight-for-stature percentiles: Girls

Date	Age	Weight	Stature	Comments



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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: *no complaints*
implants lumps pain nipple discharge

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_____

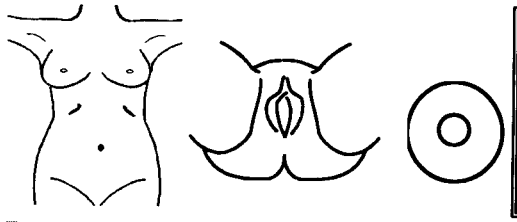
Social Hx smoker _____ ppd ETOH use_____

Family Hx _____

PHYSICAL EXAM

General Appearance
__no acute distress
__alert
__mild / moderate / severe distress_____
__anxious / lethargic_____

BREAST EXAM
__nml appearance
__nml contour
__non-tender
__no discharge
__no axillary adenopathy
__see diagram_____
__masses / dimpling_____
__flattening_____
__inverted nipples_____
__fibrocystic changes_____
__implants_____



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

PELVIC EXAM
__nml external genitalia
__nml urethral meatus
__nml speculum exam
(vagina, cervix)
__nml bimanual exam
(uterus, adnexal, urethra, bladder)

☐ pap collected
__*traditional*
__*thin prep*

__see diagram_____
__ulcerations_____
__vaginal discharge_____
__atrophic mucosa_____
__cervicitis_____
__Nabothian cysts_____
__cerv. motion tenderness_____
__adnexal tenderness / mass (R / L)_____
__uterine tenderness / enlargement / gravid_
__hysterectomy_____
__cystocele / rectocele_____
__prolapse_____

Name:_____ __New __Est.
DOB:_____ SS#:_____
Age:_____ Wt:_____ Ht:_____in BP_____ BMI_____
Temp:_____ *T R A O* RR:_____ Pulse_____ SaO_2_____
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_____

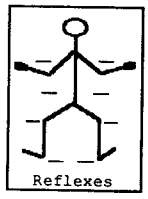
RECTAL
__non-tender
__heme neg stool
__nml anus
__nml sphincter tone
__black / bloody / heme pos. stool_____
__tenderness / mass / nodule_____
__hemorrhoids_____

BACK
__nml inspection
__nml ROM
__CVA tenderness (R / L)_____
__kyphosis_____
__scoliosis_____

SKIN
__nml color, no rash
__nml temp, dry
__skin rash_____
__warmth / erythema / lymphangitits_____
__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 palsy
__weakness / sensory loss
__depressed mood / affect


Reflexes

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
Low Risk Cervical Neoplasm
Worried Well Woman
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_____ Hemoccult___ 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_2_____

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*

_____ ***MD / DO***

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*
testicles *pain / swelling / rash*
inguinal mass
initiation difficulty
frequent urination
nocturia x_____
incontinence *stress / urge / mixed*
#____ 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_____

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
sore throat_____
nasal drainage / congestion_____
visual disturbances_____

SKIN / MS
rash_____
back pain_____
leg swelling_____

NEURO / PSYCH
headache_____
sleep disturbances_____
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
__alert
__mild / moderate / severe distress_____
__anxious / lethargic_____

ENT

__nml ENT inspection
__nml pharynx
__nasal drainage_____
__nasal mucosal edema_____
__pharyngeal erythema / exudate_____

NECK

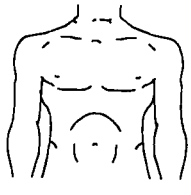
__nml inspection
__nml thyroid
__thyromegaly_____
__lymphadenopathy (R / L)_____
__JVD present_____
__carotid bruits_____

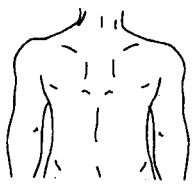
RESPIRATORY

__no resp. distress
__chest non-tender
__see diagram_____
__wheezing / rales / rhonchi_____

CVS

__reg. rate & rhythm
__no murmur
__no gallop
__irregular rhythm_____
__extrasystoles *occasional / frequent*_____
__tachycardia / bradycardia _____
__PMI displaced laterally_____
__murmur grade ___ /6 *sys / dias*
__gallop (S3 / S4)_____





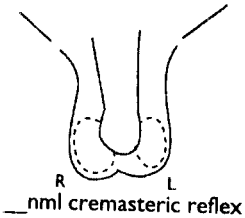
T=tenderness R=rebound
m=mild mod=moderate
sv=severe
Example- Tsv
indicates severe tenderness.

Name:_____ __New __Est.
DOB:_____ SS#:_____
Age:_____ Wt:_____ Ht:_____in BP_____ BMI_____
Temp:_____ *T R A O* RR:_____ Pulse_____ SaO_2_____
Nurse / MA Sig_____

Pt. Name_____

ABDOMEN
__soft, non-tender
__nml bowel sounds
__no organomegaly
__tenderness_____
__abnml bowel sounds / bruits_____
__hepatomegaly / splenomegaly / mass_____

GENITALS
__nml inspection
__nml palp of testicles



__nml cremasteric reflex
__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 _____

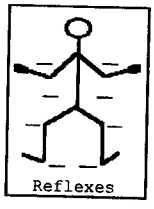
RECTAL
__nml rectal tone
__nml stool color
__heme neg stool
__nml prostate
__black / bloody / heme pos. stool_____
__prostate tenderness_____
__prostate enlarged / nodule_____

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_____	Hemoccult____	_____
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 / 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_2*_____

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*

_____ ***MD / DO***

McLAREN AMBULATORY CARE CENTER

MEDICATION LIST

Name of Pharmacy:	Telephone:	Name of Pharmacy:	Telephone:
1.	1.	3.	3.
2.	2.	4.	4.

ALLERGIES/REACTIONS (Drugs, Dyes, Latex, etc.)			ALLERGIES/REACTIONS (Drugs, Dyes, Latex, etc.)		
Date	Allergen	Reaction	Date	Allergen	Reaction

DATE	NAME OF MEDICATION/STRENGTH	FREQUENCY	REFILLS	DATE DC'D	STAFF SIGNATURE

Alternate Contact for Patient:

_____

Telephone: ( ) _____

MEDICATION LIST

Patient Name:

Date of Birth:

McLAREN AMBULATORY CARE CENTER

MEDICATION LIST

Name of Pharmacy:	Telephone:	Name of Pharmacy:	Telephone:
1.	1.	3.	3.
2.	2.	4.	4.

ALLERGIES/REACTIONS (Drugs, Dyes, Latex, etc.)			ALLERGIES/REACTIONS (Drugs, Dyes, Latex, etc.)		
Date	Allergen	Reaction	Date	Allergen	Reaction

Medication	Date					
Staff Signature						

Alternate Contact for Patient:

_____

Telephone: ( ) _____

MM-34525 (5/10)

MEDICATION LIST

Patient Name:

Date of Birth:

Your Health
Your Choice

MY ADVANCE DIRECTIVE

McLaren
MEDICAL GROUP

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 <u>select only one choice.</u> 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: _____

Other Specific Instructions

I want my patient advocate to follow the specific instructions I have written and signed below. These instructions may complement in further detail or limit the General and Specific Instructions described on the preceding page.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My Signature _____

Donation of My Organs or Tissue:
(Check one choice only and draw a line through the statements that you do not want.)

☐ I wish to donate any organs or tissue if possible.

☐ I wish to donate only the following organs or parts if possible (name the specific organs or tissue):

_____

☐ I do not want to donate any organ or tissue.

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 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.

McLaren Medical Group

PROGRESS NOTES

DATE/TIME	NOTATIONS (Patient's symptoms / complaints; physical findings; assessment; plan of treatment; disposition / follow-up)

PATIENT NAME:

DATE OF BIRTH:

PROGRESS NOTES

MM-34389 (8-13)

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:
❑	B-12 Injection & Administration	Medicare does not pay for this service for your condition	$37.00
❑	Chest X-ray	Medicare does not pay for this service for your condition	$87.00
❑	EKG, complete	Medicare does not pay for this service for your condition	$61.00
❑	Hemoccult	Medicare does not pay for this service for your condition	$16.00
❑	Urinalysis	Medicare does not pay for this service for your condition	$15.00
❑	PAP Smear	Medicare does not pay for this service as often as this	$70.00
❑	GYN Exam	Medicare does not pay for this service as often as this	$119.00
❑			
❑			
❑			
❑			

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.

Options: Check only one box. We cannot choose a box for you.

❑ **OPTION 1.** 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 **I can appeal to Medicare** 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.

❑ **OPTION 2.** I want the _____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

❑ **OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

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.

Signature:	**Date:**

PAGE TWO ADDITIONAL GUIDELINES

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: _____

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:_____

Patient Name:

Date of Birth:

McLaren Ambulatory Care Center, McLaren Occupational Health/Convenient Care Center

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

LESION #1 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

____,____-____Vicryl sub-Q

____,____-____Simple nylon/prolane

____,____-____Mattress nylon/prolane

Surgical margin _____cm
Specimen YES/NO
( ) sent to pathology

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

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

____,____-____Vicryl sub-Q

____,____-____Simple nylon/prolane

____,____-____Mattress nylon/prolane

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

AUTO ACCIDENT ☐ WORKER'S COMPENSATION ☐

Date of Accident/Injury _____

Occupation _____ Disability _____

DATE	TREATMENT

Patient Name:

Date of Birth:

AUTO ACCIDENT/WORKER'S COMPENSATION

MM-34338 (6/06)

McLaren Ambulatory Care Center

PRE-OPERATIVE CLEARANCE CONSULTATION*

***requires completion of all highlighted areas**

Request made by _____ ☐ M.D. ☐ D.O. on _____ (Date)

Reason: _____

_____

_____

_____

_____

Allergies: _____

Current Medications: _____

_____

Past Medical History (check √ if present) or ☐ None

- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction
- ☐ Irregular Heart Beat
- ☐ Congestive Heart Failure
- ☐ Peripheral Vascular Disease
- ☐ Murmur
- ☐ Pacemaker/ICD
- ☐ COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Ulcers
- ☐ CVA
- ☐ Transient Ischemic Attack
- ☐ Seizures

Diabetes Mellitus
- ☐ Type I
- ☐ Type II

Thyroid
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Bleeding Disorders

_____ Pregnancies

_____ Deliveries

☐ Other _____

Past Surgical History _____

_____

Social History

- ☐ Occupation _____
- ☐ Smoking _____
- ☐ Drugs _____
- ☐ Alcohol _____
- ☐ Abuse (Psychosocial) _____

Family History

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Malignant Hyperthermia

Review of Systems
(check √ if present)
or
☐ None

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

Patient Name:

Date of Birth:

PRE-OPERATIVE CLEARANCE CONSULTATION

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:

PRE-OPERATIVE CLEARANCE CONSULTATION

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)

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 ≥30 kg/m^2) • Previous ID of elevated impaired FBS or GTT … or any two of the following: • Overweight (BMI ≥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: _____
_____
_____
_____

Tobacco use: _____
Alcohol use: _____
Drug use: _____
Medications, supplements, vitamins: _____
_____
_____
_____
_____

Medical and social history

Past personal illnesses, injuries, operations	Date	Hospitalized?

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)

☐ Alcoholism	☐ Cancer	☐ High Cholesterol	☐ Seizures
☐ Anemia, Sickle Cell	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Arthritis	☐ Heart Disease	☐ Obesity	☐ Thyroid Disease
☐ Bleeding Disorders	☐ Liver Disease	☐ Kidney Disease	☐ Tuberculosis

Notes:

Is the patient on a special diet? Why? _____

Detection of cognitive impairment: _____
_____

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

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

Hearing loss screen

1. Do you have trouble hearing the television or radio when others do not? Yes ☐ No ☐
2. 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 ☐

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

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:

Preventive screen (frequency)	Coverage	Previously tested (If yes, when?)	Scheduled for screenings (5 to 10 years)
Bone Mass Measurements (every 24 months)	Medicare patients at risk for developing Osteoporosis		
Cardiovascular Screening Blood Tests (every 5 years) – **Lipid panel** – **Cholesterol** – **Lipoprotein** – **Triglycerides**	All asymptomatic Medicare patients (12-hour fast is required)		
Colorectal Cancer Screening – **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		
Diabetes Screening Tests (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)		
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (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)		
Glaucoma Screening (annually for patient ins 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		
Prostate Cancer Screening (annually) – **Digital rectal exam** – **Prostate specific antigen test**	All male patients 50 or older		
Screening Pap Tests and Pelvic Examination (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		
Screening Mammography (annually)	All female patients 40 or older		
Vaccines – **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: □ Well Visit - Last Complete Exam: / / **Current pain:** □ **no** □ **yes** **Severity of Pain:** 0 1 2 3 4 5 6 7 8 9 10 (Circle)

_____
_____
_____

PFSH: □ **See History Form in front of chart dated:** ____/ ____/ _____
Social History: □ **No change** **Tobacco?** □ **Yes** □ **No** **ETOH?** □ **Yes** □ **No** **Drugs?** □ **Yes** □ **No** _____
Family History: □ **No Change** _____
Medical History: □ **No Change** _____

ROS: □ **Constitutional** □ **ENT** □ **Cardiovascular** □ **Respiratory** □ **GI** □ **Musculoskeletal** □ **Skin/Breast**
□ **Neuro** □ **Psych** □ **Endocrine** □ **Hematologic** □ **GU** □ **Allergic/Immunologic** □ **Eyes/Head**

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

Objective

√ = examined & normal X = abnormal w/ explanation

	Skin		
	Lymph nodes		
	Neck		
	Eyes		
	ENT		
	C/V		
	Abd / Gastro		
	Respiratory		
	Chest / Breasts		
	Back		
	Genitalia		
	Neurologic		
	Psych		
	Extremities / Hips		
	Extremities / upper		

IMP/Dx/Plan:
_____
_____
_____
_____

ORDERS: □ **Oral Meds:** _____ □ **Injection** _____
□ **Rapid Strep**_____ □ **UA** _____ □ **02 Sat**_____ □ **EKG** □ **X-Ray of** _____**- Views:** _____
□ **Lab:** _____ □ **Other:** _____ **done by:** _____

RTO _____ **Days / Weeks / Months / Years / if worsens or no improvement / after tests / PRN** **Educational Material Given:** □ **Yes** □ **No**
Provider names: _____**Time spent with patient** _____ **estimated counseling time** _____ □ **consult**

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:	DOB	AGE	SEX				
JANE DOE	05/26/1975	33	F				
ADDRESS:				TIME IN	TIME OUT	MEANS OF ARRIVAL	NEW__
123 TEST ST							EST__
CITY	STATE	ZIP CODE		PRIMARY PHYSICIAN			
FLINT	MI	48507					
DOCTOR	DR#	TELEPHONE		GROUP	CONTRACT #	EMPLOYER	
BECK BRIAN DO	100	810-252-2552					
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_____

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

SIGNATURE:_____

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 (INCLUDE 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

APT REASON: COLLECTION CODE

Name: DOB Age Sex

Address:
1255 SUMMER AVENUE

City State Zip Code
MI

Doctor DR# Telephone

Primary Insurance Secondary Insurance

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

AUTO __

X	DESCRIPTION	CODE
	SURGICAL PROCEDURES	
__	INCISION&DRAINAGE, SIMP*	10060
__	INCIS&REMOV FORE BODY SIM*	10120
__	PUNCTURE ASPIRATION*	10160
__	SIMPLE REPAIR SUPERFICIAL WOUNDS BODY 2.5CM - LESS*	12001
__	SIMPLE REPAIR SUPERFICIAL WOUNDS BODY 2.6CM - 7.5CM*	12002
__	SIMPLE REPAIR SUPERFICIAL WOUNDS FACE 2.5CM - LESS*	12011
__	SIMPLE REPAIR SUPERFICIAL WOUNDS FACE 2.6CM - 5.0CM*	12013
__	INITIAL TREATMENT 1ST DEG BURN ONLY LOCAL TREAT REQ	16000
__	DRESS AND/OR DEBRIDEMENT INITIAL OR SUBS, SMALL*	16020
__	DRESS AND/OR DEBRIDEMENT INITIAL OR SUBS MEDIUM*	16025
__	REMOV FOREIGN BODY MUSCLE OR TENDON SHEATH SIMPLE*	20520
__	INJECTION TENDON SHEATH LIGAMENT, GANGLION CYST*	20550
__	TRIG PT INJEC 1-2 MUS GRP*	20552
__	TRIG PT INJEC 3/+ MUS GRP*	20553
__	APPLICATION OF SHORT ARM SPLINT FORARM TO HAND	29125
__	APP. OF FINGER SPLINT	29130
__	APPLICATION OF SHORT LEG SPLINT, CALF TO FOOT	29515
__	REMOVAL FOREIGN BODY EXT. EYE CONJUNCTIVAL SUPERFIC*	65205
__	REMOVAL FOREIGN BODY EXT. EYE CORNEAL W/O SLIT LAMP*	65220
__	REMOVAL FOREIGN BODY EXT. EYE CORNEAL W/ SLIT LAMP*	65222
__	REMOVAL IMPACTED CERUMEN ONE OR BOTH EARS	69210

X	RADIOLOGY	CODE
__	RADIOLOGIC EXAM SINUSES PARANASAL COMPLETE MIN 3V	70220
__	RADIOLG EXAM SKULL <4V	70250
__	RADIOLG EXAM SKULL MIN 4V	70250
__	RADIOLG EXAM CHEST SING V	71010
__	RADIOLG EXAM CHEST 2V	71020
__	RADIOLG EXAM RIBS UNIL 2V	71100
__	RADIOLG EXAM RIBS BILA 3V	71110
__	RADIOL EXAM SPN CERV 2/3V	72040
__	RADIOL EXAM SPN CERV 4V	72050
__	RADIOL EXAM SPN CERV CMPL	72052
__	RADIOLG EXAM SPN THOR 2V	72070
__	RADIOLG EXAM SPN LUMBO-SACRAL 2 OR 3V	72100
__	RADIOLG EXAM SPN LUMBO-SACRAL MIN 4V	72110

X	DESCRIPTION	CODE
	RADIOLOGY (CONT'D)	
__	RADIOLG EXAM PELV 1/2V	72170
__	RADIOLG EXAM SACCRUM & COCCYX MIN 2V	72220
__	RADIOLG EXAM CLAV CMPL	73000
__	RADIOLG EXAM SHOULDER COMPLETE MIN 2V	73030
__	RADIOLG EXAM HUMEROUS MIN 2 VIEW	73060
__	RADIOLG EXAM ELBOW COMPLETE MIN 3V	73080
__	RADIOLG EXM FOREARM 2V	73090
__	RADIOLG EXAM WRIST COMPLETE MIN 3V	73110
__	RADIOLG EXM HAND MN 3V	73130
__	RADIOLG EXAM FINGER($) MINIMUM 2V	73140
__	RADIOLG EXM HIP UNIL 1V	73500
__	RADIOLG EXM HIP CMP 2V	73510
__	RADIOLG EXAM PUMAR 2V	73550
__	RADIOLG EXAM KNEE 1/2V	73560
__	RADIOLG EXAM KNEE 3V	73564
__	RADIOLG EXAM KNEE 4/+V	73564
__	RADIOLG EXAM TIBIA & FIBULA 2V	73590
__	RADIOLG EXM ANKL MN 3V	73610
__	RADIOLG EXM FOOT MN 3V	73630
__	RADIOLG EXAM CALCANEUS MINIMUM 2V	73660
__	RADIOLG EXM TOES MN 2V	73660
__	RADIOLG EXAM ABDOMEN, ANTEROPOSTERIOR & ADD. OBLIQUE/ CONE V	74010
__	AC JOINTS	73050

X	PATH/LAB	CODE
__	INFLUENZA STRIPS	87804
__	URINALYSIS NON-AUTOMAT WITHOUT MICROSCOPY	81002
__	BLOOD OCCULT FECES 1-3 SIMULTAN DETERMINATION	82270
__	GLUCOSE QUANTITATIVE BLOOD REAGENT STRIP	82948
__	GLUCOSE BLOOD BY GLU-COSE MONITORING DEVICE	82962
__	GONADOTROPIN CHORIONIC (HCG) QUALITATIVE	84703
__	MONO TEST	86308
__	STREP (RAPID)	87880QW
__	URINE PREG TST VIS CLR	81025
__	BLOOD OCCULT FECES SINGLE DIGITAL	82272QW
__	CULT CHLAMYDIA WET MT	87110
__	TISSUE EXAM by KOH SKIN/HAIR/NAILS	87220

X	DESCRIPTION	CODE
	VACCINES, TOXOIDS**	
__	INFLUENZA VIRUS VACCINE SPLIT VIRUS 6-35 MOS	90657
__	INFLUENZA VIRUS VACCINE SPLIT VIRUS 3YRS & UP	90658
__	INFLUENZA VIRUS VACCINE LIVE INTERNASAL USE	90660
__	TETANUS TOXOID	90703
__	TETANUS&DIPHTHER (TD) 7YRS+	90718
	** CODES 90471-90472 MUST BE REPORTED IN ADDITION TO THE VACC. AND TOXOID CODE(S) 90476-90749.	
__	THERAP OR DIAGNOS INJECTION	96372

X	MEDICAL SERVICES	CODE
__	EKG ROUTINE, 12 LEADS W/ INTERPRETATION & REPORT	93000
__	EKG TRACING ONLY W/O INTERPRETATION & REPORT	93005
__	PRESSURIZED/NONPRESSURIZED INHALATION TREATMENT	94640
__	UNLISTED PULMONARY SERVICE OR PROCEDURE	94799
__	PROFES SERVICE FOR ALLERGEN IMMUNOTHERAPY SINGLE INJECT	95115
__	HANDLING AND/OR CONVEYANCE OF SPECIMINE	99000
__	POSTOPERATIVE FOLLOW-UP VISIT FOR DOCUMENTATION PURPOSES ONLY	99036
__	OFFICE SERV EMERGENCY BASIS	*99058
__	URG CARE GLOB FEE - BCN&HAP	S9083

X	E-SCRIBE	CODE
__	E-SCRIBE USED FOR ALL RX	G8443
__	E-SCRIBE NOT USED TODAY	G8445
__	NARC/CNTRL SUB PRESCRIBED	G8446
__	STATE/FED LAW REQUIRES PHONE OR PRINT RX	G8446
__	PATIENT ASKED FOR PHONE/PRINT RX	G8446
__	PHARMACY CAN'T RECEIVE ELECTRONIC RX	G8446

X	NEW PATIENTS	CODE
__	NEW PATIENT OFFICE VISIT PROBLEM FOCUSED	99201
__	NEW PATIENT OFFICE VISIT EXPANDED PROBLEM FOCUSED	99202
__	NEW PATIENT OFFICE VISIT DETAILED	99203
__	NEW PATIENT OFFICE VISIT COMPREHENSIVE	99204

X	ESTABLISHED PATIENTS	CODE
__	ESTABLISHED PATIENT, OFFICE VISIT PROBLEM FOCUSED	99212
__	ESTABLISHED PATIENT, OFFICE VISIT EXPAN PROBLEM FOCUSED	99213
__	ESTABLISHED PATIENT, OFFICE VISIT DETAILED	99214

X	DESCRIPTION	CODE
	OTHER SERVICES/SUPPLIES	
__	SPORTS PHYSICAL	GC100
__	NURSE VISIT NO CHG	GC002
__	MARRIAGE COUNSELING	
__	SPLY VITAMIN A CREAM	
__	PREGNANCY KIT	
__	SPLY WRIST SPLINT	GC500
__	SPLY WRST SPLINT UNI	GC501
__	SPLY FINGER SPLINT	GC502
__	SPLY ANKLE SPLINT	GC503
__	SPLY ARM SLING WITH THUMB LOOP	GC505
__	SPLY ARM SLING W/CST	GC506
__	SPLY KNEE IMMOBIL	GC507
__	SPLY ACE WRAPS	GC510
__	SPLY MISC OVRD PRICE	GC200
__	BLOOD DRAW	36415
__	SUTURE REMOVAL	

X	INJECTIONS	CODE
__	ROCEPHIN PER 250MG	J0696
__	CLAFORAN PER G	J0698
__	COMPAZINE TO 10MG	J0780
__	DEPO-MEDROL 20MG	J1020
__	DEPO-MEDROL 40MG	J1030
__	DEPO-MEDROL 80MG	J1040
__	BENADRYL TO 50MG	J1200
__	TORADOL PER 15MG ____UNITS (1UNIT = 15MG)	J1885
__	LASIX TO 20 mg >20mg __units	J1940
__	LINCOCIN TO 300MG	J2010
__	NUBAIN PER 10MG	J2300
__	NORFLEX TO 60MG	J2360
__	PHENERGAN TO 50MG	J2550
__	TIGAN TO 200MG	J3250
__	KENALOG 10MG __units	J3301
__	VISTARIL TO 25MG	J3410
__	SOLU-MEDROL TO 40mg	J2920
__	LEUPROLIDE	J1950

X	PREVENTATIVE MEDICINE	CODE
__	ADMIN/INTERP HEALTH RISK ASSES INSTRUMENT INCL FAA 2ND&3RD CLASS EXAM	99420
__	UNLISTED PREVENTATIVE MEDICINE EXAM INCL FAA 1ST CLASS PHYS EXAM	99429

ACCOUNT STATUS

CHARGE - $

PAYMENT - $

METHOD

_ CASH _CHECK _ CHARGE CARD

PLEASE NOTE: CODING BOOKS SHOULD ALWAYS BE REFERENCED FOR MORE SPECIFICITY IN
*SERVICE INCLUDES SURGICAL PROCEDURE 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:
  - ☐ 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:
  - ☐ Right *(Circle Grade)* Active Regressed/Stable
  - ☐ 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 ☐

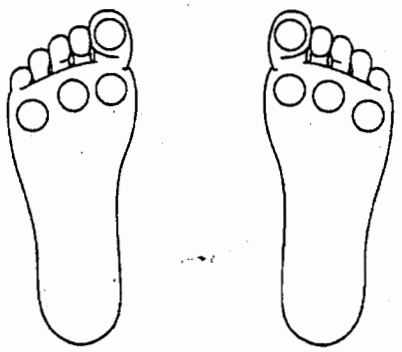
II. Foot Exam

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.)*



Right Foot Left Foot

Step 1 Step 2

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

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

Annual Tests (Date)									
Action Plan									
Spirometry									

Medications									
Rescue Meds:									
B-Agonist									
Controller Meds:									
Inhaled Corticosteroid									
Other:									

Miscellaneous (Date)									
Flu Vaccine									
Pneumonia Vaccine									
Pulmonary Referral									

Referrals/Comments: _____

PATIENT NAME:

DATE OF BIRTH:

MCLAREN AMBULATORY CARE CENTER

CHRONIC DISEASE MANAGEMENT FLOWSHEET

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

ANNUAL TESTING **(Date)**									
Total Cholesterol									
HDL									
LDL									
Triglycerides									
CBC									
UA									
Electrolytes									
BUN									
Creatinine									
Magnesium									
Glucose									

MISCELLANEOUS **(Date)**									
Influenza Vaccine									
Pneumonia Vaccine									
Tetanus									

DIABETES **(Date)**									
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

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

CAD (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									

MEDICATIONS (Date)									
B-Blockers									
ACE/ARB									
Antithrombim									
Antilipemic									

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

MEDICATIONS (Date)									
B-Blockers									
ACE/ARB									
Diuretic									

PATIENT NAME:

DATE OF BIRTH:

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

04/18/2013
Date

Michael Ziccardi, Jr., DO
(Original signed policy on file in MMG Practice Management)
Michael Ziccardi, Jr., DO
Medical Director

04/18/2013
Date

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

McLaren MEDICAL GROUP		**Policy Title:**	Waived Diagnostic Testing
Effective Date:	4/1999	**Policy Number:**	3420
Review Date:	4/30/2002	**Category:**	Clinical
Revised Date:	03/04/2014	**Oversight Level:**	2
Administrative Responsibility:	All Operations Managers and Human Resources personnel		
Interpretation:	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.
7.4. "CLIA and Quality Assurance," (n.d.), 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 Hemoccult
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

McLaren MEDICAL GROUP		Waived Diagnostic Testing – Appendix A	
Policy Title:	Waived Diagnostic Testing – Appendix A	**Policy Number:**	3420
Policy Number:	3420, Appendix A	**Category:**	Clinical
Standard Effective Date:	3/4/2014	**Oversight Level:**	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

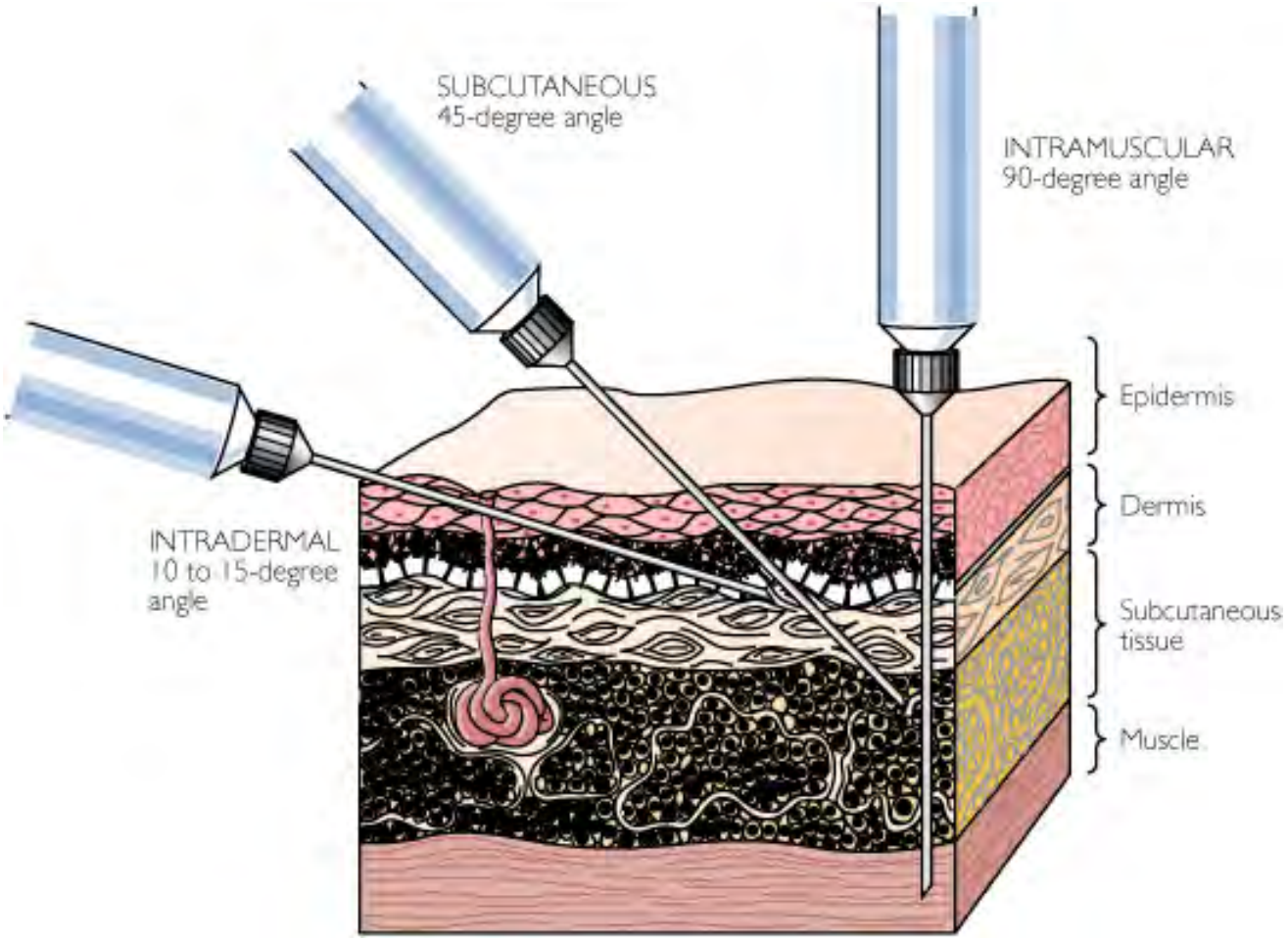
WAIVED TEST QUALITY CONTROL LOG

Practice Site: _____

Date	Kit Name	Kit Lot #	Developer #	Manufacturer's Expiration Date	QC Pass/Fail	Staff Signature

QC log is retained for 8 years.

Injection Types



Seven Rights of Medication Administration

Right **Patient**
Right **Medication**
Right **Dosage**
Right **Time**
Right **Delivery** (correct equipment i.e. SC VS IM)
Right **Technique** (prepare with aseptic technique, aspirate before inject)
Right **Reason**

McLaren MEDICAL GROUP		**Policy Title:**	Medication Administration
Effective Date:	10/96	**Policy Number:**	4115
Review Date:		**Category:**	Medication
Revised Date:	5/7/2013	**Oversight Level:**	2
Administrative Responsibility:	Operations Managers		
Interpretation:	Operations Managers		

1. Purpose
To provide accuracy in patient identification when administering medications; to apply appropriate technique as ordered by the physician.

2. Scope
All physicians, physician assistants, nurse practitioners and all other clinical staff

3. Definitions
3.1. Cleansing Agents – Material used to cleanse the skin such as alcohol sponges, Betadine swabs, etc.

3.2. Sponges – Material used to moisten, wipe or clean the skin such as cotton balls or gauze pads.

3.3. Medication – includes vaccines.

4. Policy
4.1.Physician Assistants, Nurse Practitioners, Registered Nurses, Licensed Practical Nurses and Medical Assistants shall administer medication under the direction of the physician in accordance with their scope of practice and use at least two patient identifiers (patient name and date of birth) for accuracy in patient identification. All injectable medications will be reviewed with the written order for drug and dosage with a second staff member. When a multi-dose vial is used, the syringe will be labeled with the name of the drug and dosage using a label.

5. Procedure
5.1. Injections

5.1.1. Equipment

5.1.1.1. Proper size needle and syringe

5.1.1.2. Band-Aid

5.1.1.3. Medication as ordered

5.1.1.4. Use appropriate cleansing material

5.1.2. Preparation of equipment

5.1.2.1. Wash hands.

5.1.2.2. Open package containing syringe and needle, and assemble as needed.

5.1.2.3. Maintain sterility of needle by replacing needle cap using one hand technique or using a safety-lok syringe.

5.1.2.4. Read drug label and compare with order.

5.1.2.5. If drug label and medicine order are identical and correct, proceed to open drug containers as follows:

5.1.2.5.1. Ampule

5.1.2.5.1.1. Wrap neck of ampule with gauze; break by grasping each end of ampule and exerting pressure away from you.

5.1.2.5.1.2. Discard small end of top.

5.1.2.5.1.3. Attach filter or filtered needle to syringe.

5.1.2.5.1.4. Insert tip of needle into remainder of ampule and withdraw desired dosage.

5.1.2.5.1.5. Read label again.

5.1.2.5.1.6. Compare it with ordered amount.

5.1.2.5.1.7. Once again check order with the ampule.

5.1.2.5.1.8. Label syringe with name of drug and dosage using label.

5.1.2.5.2. Vial: (Diluent)

5.1.2.5.2.1. Mix according to package instructions.

5.1.2.5.2.2. Pull back on plunger to empty syringe to desired dosage, air is now in syringe.

5.1.2.5.2.3. Wipe rubber stopper of vial with cleansing agent.

5.1.2.5.2.4. Insert needle through clean stopper.

5.1.2.5.2.5. Inject air into vial from syringe.

5.1.2.5.2.6. Remove needle from vial.

5.1.2.5.2.7. Inject diluent solution into medication vial by inserting needle through cleansed rubber stopper.

5.1.2.5.2.8. Withdraw excess air from medication vial and remove needle.

5.1.2.5.2.9. Gently rotate or shake according to instructions to properly dissolve and mix the medication.

5.1.2.5.3. Vial with powder (Mix-O-Vial)

5.1.2.5.3.1. Mix according to package instructions.

5.1.2.5.3.2. Pull back on plunger of empty syringe to desired dosage.

5.1.2.5.3.3. Wipe rubber stopper of vial with cleansing agent.

5.1.2.5.3.4. Insert needle through clean stopper.

5.1.2.5.3.5. Inject air.

5.1.2.5.3.6. Withdraw desired dosage.

5.1.2.5.3.7. Read label and order or correct medication and dosage.

5.1.2.5.3.8. Label syringe with name of drug and dosage using label

5.1.2.5.4. Pre-filled syringes

5.1.2.5.4.1. Compare order and pre-filled syringe.

5.1.2.5.4.2. Remove protective cap from needle.

5.1.2.5.4.3. Evacuate syringe as necessary to desired dosage.

5.1.2.5.4.4. Replace needle cap.

5.1.2.5.4.5. Compare order and medication for correct medication. (Note: All injectable medications will be verified with a second staff member. The original order will be compared with the drug and dosage. The second staff member will cosign the administration record.)

5.1.3. Preparation of patient.

5.1.3.1. Verify correct patient with two patient identifiers (name and date of birth)

5.1.3.2. Put on gloves

5.1.3.3. Determine correct selection of site for injection

5.1.3.4. Inspect syringe to be sure it is free of air

5.1.3.5. After area is cleansed, remove needle covering and maintain sterility

5.1.3.6. Insert needle

5.1.3.7. Inject contents of syringe

5.1.3.8. Cover injection site with sponge and withdraw needle quickly

5.1.4. Injection techniques

5.1.4.1. Intradermal

5.1.4.1.1. To place small amounts of material between the skin layers; use a 25-27-gauge needle.

5.1.4.1.2. Make sure the bevel of the needle is up and the angle is almost parallel to the skin’s surface.

5.1.4.2. Subcutaneous

5.1.4.2.1. Use a 22 gauge or smaller needle.

5.1.4.2.2. Use a 45-degree angle.

5.1.4.3. Intramuscular

5.1.4.3.1. Use a 90 degree angle

5.1.4.4. After care

5.1.4.4.1. Patient

5.1.4.4.1.1. Observe for drug reaction.

5.1.4.4.2. Equipment

5.1.4.4.2.1. DO NOT RECAP NEEDLE.

5.1.4.4.2.2. Dispose of syringe and needle in specified sharps containers.

5.1.4.4.3. At the time of opening a new multi-dose medication vial, the staff will date the vial with the discard date. The vial will expire 28 days from the date opened. Any evidence of contamination will warrant discarding sooner. A visual check of stopper and contents (cloudiness or presence of floaters) will be done to determine evidence of contamination, particularly if a significant time period has lapsed since opening (reference opening date).

5.2. Inhaled Bronchodilators

5.2.1. Equipment

5.2.1.1. Nebulizer machine

5.2.1.2. Nebulizer tubing

5.2.1.3. Nebulizer mouthpiece and flex tubing

5.2.2. Preparation of Equipment

5.2.2.1. Wash hands

5.2.2.2. Open premixed vial or bullet and dump into mouthpiece reservoir

5.2.2.3. Connect mouthpiece to the nebulizer tubing and connect the nebulizer tubing to the nebulizer machine

5.2.3. Procedure

5.2.3.1. Verify identity of patient using two identifiers (name and date of birth)

5.2.3.2. Explain procedure to the patient

5.2.3.3. Turn on nebulizer machine; ask patient to inhale aerosolized medication through mouth only, using deep slow breaths

5.2.3.4. Continue this procedure until all the medication has evaporated, usually 10 minutes

5.2.4. Post Procedure

5.2.4.1. Check the patient for complaints

5.2.4.2. Inform physician that treatment is completed and advise if there are any patient complaints

5.2.5. Documentation

5.2.5.1. Document the procedure in the respective patient's medical record as well as the status of the patient.

6. Exceptions

Utilizing Medicare guidelines for Influenza and Pneumococcal Vaccinations, an individual may receive the vaccines without a physician's order and without physician supervision, irrespective of insurance carrier involved.

7. References

7.1. Fundamental Nursing Skills and Concepts, Eighth Edition, 2005, Chapter 34.

7.2. Alliance for Immunization in Michigan (current AIM Kit)

7.3. CMS – National Coverage Decision Policy PHYS-040.

8. Appendix

8.1. Appendix A – How to Administer Intramuscular (IM) Injections

8.2. Appendix B – How to Administer Subcutaneous (SC) Injections

8.3. Appendix C – How to Administer Intramuscular (IM) and Subcutaneous (SC) Injections

9. Approvals

Margaret Dimond	6/11/2013
(Original signed policy on file in MMG Practice Management)	
Margaret Dimond President/Chief Executive Officer	Date

Michael Ziccardi, D.O.	6/11/2013
(Original signed policy on file in MMG Practice Management)	
Michael Ziccardi, D.O. Medical Director	Date

Ambulatory Quality Improvement Committee: 5/7/2013

Previous Revision Dates/Supercedes Policy:
10/5/10; 5-4-10 Not applicable

How to Administer Intramuscular (IM) Injections

Administer these vaccines by the intramuscular (IM) route: Diphtheria-tetanus (DT, Td) with pertussis (DTaP, Tdap); *Haemophilus influenzae* type b (Hib); hepatitis A (HepA); hepatitis B (HepB); human papillomavirus (HPV); inactivated influenza (TIV); meningococcal conjugate (MCV); and pneumococcal conjugate (PCV). Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPSV) either IM or SC.

Patient age	Injection site	Needle size
Newborn (0–28 days)	Anterolateral thigh muscle	⅝"* (22–25 gauge)
Infant (1–12 months)	Anterolateral thigh muscle	1" (22–25 gauge)
Toddler (1–2 years)	Anterolateral thigh muscle	1–1¼" (22–25 gauge)
	Alternate site: Deltoid muscle of arm if muscle mass is adequate	⅝–1"* (22–25 gauge)
Children (3–18 years)	Deltoid muscle	⅝–1"* (22–25 gauge)
	Alternate site: Anterolateral thigh muscle	1–1¼" (22–25 gauge)
Adults 19 years and older	Deltoid muscle of arm	1–1½"*† (22–25 gauge)
	Alternate site: Anterolateral thigh muscle	1–1¼" (22–25 gauge)

*A ⅝" needle may be used only if the skin is stretched tight, the subcutaneous tissue is not bunched, and injection is made at a 90° angle.

†A ⅝" needle is sufficient in adults weighing <130 lbs (<60 kg); a 1" needle is sufficient in adults weighing 130–152 lbs (60–70 kg); a 1–1½" needle is recommended in women weighing 152–200 lbs (70–90 kg) and men weighing 152–260 lbs (70–118 kg); a 1½" needle is recommended in women weighing >200 lbs (>90 kg) or men weighing >260 lbs (>118 kg).

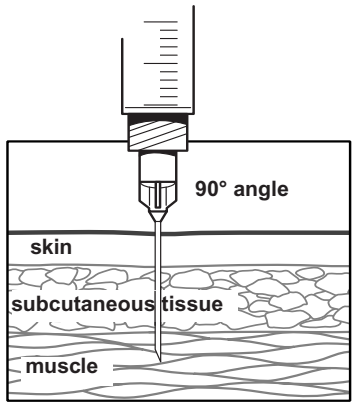
Needle insertion

Use a needle long enough to reach deep into the muscle.

Insert needle at a 90° angle to the skin with a quick thrust.

(Before administering an injection, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.¶)

Multiple injections given in the same extremity should be separated by a minimum of 1", if possible.

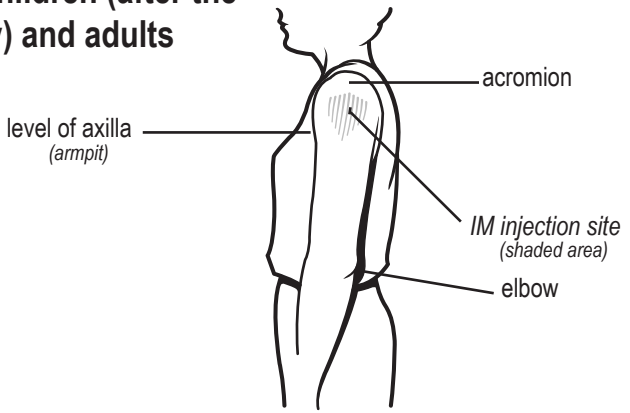


¶CDC. "ACIP General Recommendations on Immunization" at www.immunize.org/acip

IM site for infants and toddlers

Insert needle at a 90° angle into the anterolateral thigh muscle.

IM site for children (after the 3rd birthday) and adults



Insert needle at a 90° angle into thickest portion of deltoid muscle — above the level of the axilla and below the acromion.

Technical content reviewed by the Centers for Disease Control and Prevention, February 2009.

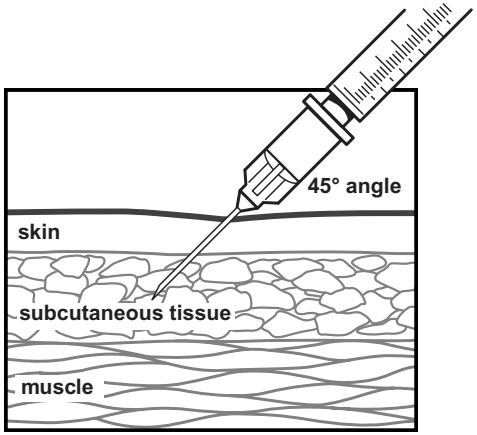
www.immunize.org/catg.d/p2020.pdf • Item #P2020 (2/09)

How to Administer Subcutaneous (SC) Injections

Administer these vaccines by the subcutaneous (SC) route: MMR, varicella, meningococcal polysaccharide (MPSV), and zoster (shingles [Zos]). Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPSV) vaccines either SC or IM.

Patient age	Injection site	Needle size	Needle insertion
Birth to 12 mos.	Fatty tissue over the anterolateral thigh muscle	⅝" needle, 23–25 gauge	Pinch up on subcutaneous (SC) tissue to prevent injection into muscle. Insert needle at 45° angle to the skin. (Before administering an injection, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.*) Multiple injections given in the same extremity should be separated by a minimum of 1".
12 mos. and older	Fatty tissue over anterolateral thigh or fatty tissue over triceps	⅝" needle, 23–25 gauge	

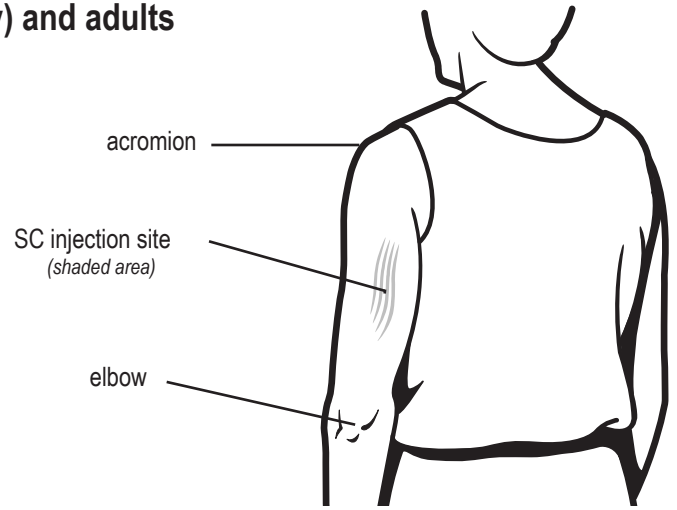
*CDC. "ACIP General Recommendations on Immunization" at www.immunize.org/acip



SC site for infants

Insert needle at a 45° angle into fatty tissue of the anterolateral thigh. Make sure you pinch up on SC tissue to prevent injection into the muscle.

SC site for children (after the 1st birthday) and adults



Insert needle at a 45° angle into the fatty tissue over the triceps muscle. Make sure you pinch up on the SC tissue to prevent injection into the muscle.

Technical content reviewed by the Centers for Disease Control and Prevention, February 2009.

www.immunize.org/catg.d/p2020.pdf • Item #P2020 (2/09)

How to Administer IM and SC Injections to Adults

Intramuscular (IM) Injections

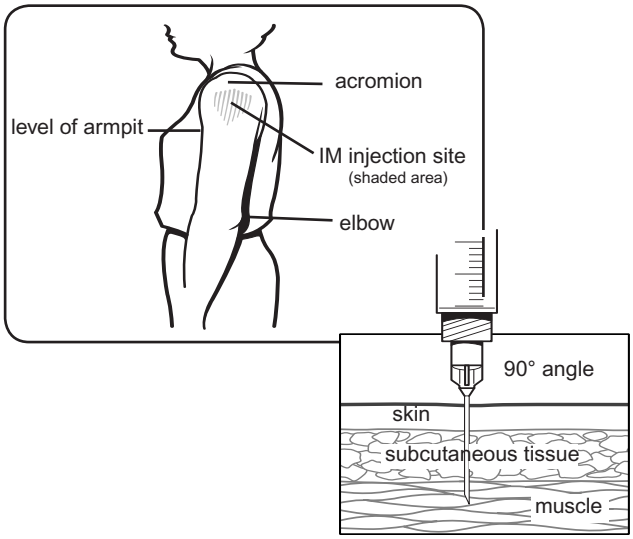
Administer these vaccines via IM route:
Tetanus, diphtheria (Td), or with pertussis (Tdap); hepatitis A; hepatitis B; human papillomavirus (HPV); trivalent inactivated influenza (TIV); and meningococcal conjugate (MCV). Administer polio (IPV) and pneumococcal polysaccharide vaccine (PPSV) either IM or SC.

Injection site:
Give in the central and thickest portion of the deltoid—above the level of the armpit and below the acromion (see the diagram).

Needle size:
22–25 gauge, 1–1½" needle *(see note at right)*

Needle insertion:

- Use a needle long enough to reach deep into the muscle.
- Insert the needle at a 90° angle to the skin with a quick thrust.
- Separate two injections given in the same deltoid muscle by a minimum of 1".



Note: A ⅝" needle is sufficient in adults weighing <130 lbs (<60 kg); a 1" needle is sufficient in adults weighing 130–152 lbs (60–70 kg); a 1–1½" needle is recommended in women weighing 152–200 lbs (70–90 kg) and men weighing 152–260 lbs (70–118 kg); a 1½" needle is recommended in women weighing >200 lbs (>90 kg) or men weighing >260 lbs (>118 kg). A ⅝" (16mm) needle may be used only if the skin is stretched tight, the subcutaneous tissue is not bunched, and injection is made at a 90-degree angle.

Subcutaneous (SC) Injections

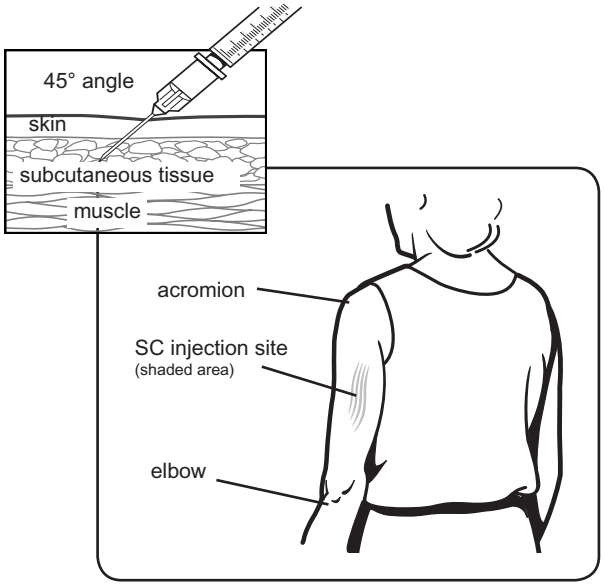
Administer these vaccines via SC route:
MMR, varicella, meningococcal polysaccharide (MPSV), and zoster (shingles). Administer polio (IPV) and pneumococcal polysaccharide vaccine (PPSV) either SC or IM.

Injection site:
Give in fatty tissue over the triceps (see the diagram).

Needle size:
23–25 gauge, 5/8" needle

Needle insertion:

- Pinch up on the tissue to prevent injection into the muscle. Insert the needle at a 45° angle to the skin.
- Separate two injections given in the same area of fatty tissue by a minimum of 1".



Adapted by the Immunization Action Coalition, courtesy of the Minnesota Department of Health

Technical content reviewed by the Centers for Disease Control and Prevention, February 2009.

www.immunize.org/catg.d/p2020A.pdf • Item #P2020A (2/09)

McLaren MEDICAL GROUP		**Policy Title:**	Immunizations
Effective Date:	10/96	**Policy Number:**	4110
Review Date:	1/7/2014	**Category:**	Medication
Revised Date:	1/7/2014	**Oversight Level:**	2
Administrative Responsibility:	Operations Managers		
Interpretation:	Operations Managers		

1. Purpose

To maintain the health of MMG patients and prevent childhood diseases in MMG pediatric patients.

2. Scope

Physicians, clinical staff, applicable patients

3. Definitions

3.1. Patient identifiers – two references used to accurately identify a patient, namely, patient name and date of birth.

4. Policy

4.1. MMG will adequately immunize its patients following appropriate guidelines to ensure quality of care and patient safety.

4.2. An MA may appropriately administer a vaccine under the supervision of a physician.

5. Procedure

5.1. Storage of vaccines:

5.1.1. All vaccines (except Varicella) are located in refrigerators designated for medications.

5.1.2. Varicella is stored in the freezer at five (5) degrees Fahrenheit.

5.1.3. Vaccines are segregated in the medication refrigerator.

5.1.3.1. Vaccines For Children (VFC) vaccines are separated from private stock.

5.2. At time of administration:

5.2.1. All vaccines are administered in the volume recommended in current Centers for Disease Control Guidelines.

5.2.2. Patient is appropriately identified utilizing two patient identifiers.

5.2.3. Physician will evaluate patient prior to administration of vaccine, if deemed necessary.

5.2.4. Patient or parent (guardian) will read the information handout (namely, the Vaccine Information Statement or VIS) relative to respective vaccine to be administered.

5.2.5. Physician will discuss the possible side effects of the vaccine.

5.2.6. Patient or parent (guardian) will provide consent to administer vaccine. If declining, patient/parent must sign required waiver.

5.3. Following administration:

5.3.1. Provide patient or parent (guardian) with copy of, or update to, immunization record. The following information is given: name of patient; vaccine administered, date, and physician's name.

5.3.2. Document appropriately on the Vaccine Administration Record (VAR) and in the progress notes. The VAR includes the following information: name of patient, vaccine administered, date, age of patient, site of injection, expiration date, vaccine manufacturer, lot number, publication date of Vaccine Information Sheet, and name of person who administered vaccine.

6. Exceptions

6.1. Instances where vaccines are medically contraindicated, or a parent (guardian) has expressed an objection to having patient vaccinated.

7. References

7.1. Recommended Childhood Immunization Schedule, United States, Centers for Disease Control National Immunization Program

7.2. FORM: MM-157 Vaccine Administration Record (for adults)

7.3. FORM: MM-34079 Vaccine Administration Record (for children and teens)

8. Appendix

None

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, Jr., D.O.
Medical Director
4/1/2014
Date

Ambulatory Quality Improvement Committee: 1/7/2014

Previous Revision Dates/Supercedes Policy: 5/4/2010
3-30-04 / Not applicable

McLaren Ambulatory Care Center

IMMUNIZATION WAIVER

Vaccine-preventable diseases are still with us. In many cases, they cause disability or death. Immunizations are one of our most cost effective measures to protect children from harmful disease. An individual who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. A child may be subject to exclusion from the school or program, if the local and/or state public health authority advises exclusion as a disease control measure.

I object to to receiving the following vaccines: _____, _____
(First & Last Name) (Birthdate)

- ❑ Diphtheria, Tetanus, acellular Pertussis (DTaP) vaccine
- ❑ Diphtheria, Tetanus, (DT or Td) vaccine
- ❑ *Haemophilus influenzae* type B (Hib) vaccine
- ❑ Hepatitis A vaccine
- ❑ Hepatitis B vaccine
- ❑ Influenza
- ❑ HPV (male/female)
- ❑ Measles, Mumps, Rubella (MMR) vaccine
- ❑ Meningococcal vaccine
- ❑ Pneumococcal vaccine
- ❑ Polio
- ❑ Tdap
- ❑ Varicella (chickenpox) vaccine
- ❑ Zoster
- ❑ Other _____

My provider has explained to me and I understand the following:

- The **purpose** of the recommended vaccination
- The **risks and benefits** of the recommended vaccination
- A **possible consequence** of not allowing my child to receive the recommended vaccination is contracting the illness the vaccine is intended to prevent.
- My Provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention (CDC) have all strongly recommended that the vaccine(s) be given.

The health care provider has answered all of my questions.

Name: (PRINT) _____

Signature _____ Date: _____

Relationship (If other than Patient)

Witness: _____

Patient Name:

Date of Birth:

IMMUNIZATION WAIVER

McLaren MEDICAL GROUP		**Policy Title:**	Medication, Vaccine, and Specimen Storage and Maintenance
Effective Date:	10-1-1996	**Policy Number:**	4100
Review Date:		**Category:**	Medication
Revised Date:	06/10/2014	**Oversight Level:**	2
Administrative Responsibility:	Office Management Team		
Interpretation:	Safety Officer; Operations Managers		

1. **Purpose**

To preserve the integrity of medications, vaccines and specimens stored in refrigerators and freezers by maintaining appropriate temperatures; to ensure patient safety.

2. **Scope**

All refrigerators and freezers used in MMG practice sites for storing medications, vaccines and specimens.

3. **Definitions**

3.1 Medications – Any pharmaceutical that may be administered to a patient.
3.3 Specimens – Laboratory specimens, including appropriately contained blood and body fluids, which must be preserved by refrigeration until transport.
3.4 Vaccines – Includes vaccines either purchased or acquired through the Vaccines for Children Program (VFC)
3.5. Data logger – records and monitors temperatures.

4. **Policy**

4.1 Temperature monitoring

4.1.1 The temperature of the refrigerators storing medications and vaccines will be monitored using a data logger in glycol .
4.1.2 Specimen refrigerator s will be monitored each day the practice is open to ensure temperatures required to preserve specimens are maintained.
4.1.3 Freezer and refrigerator temperatures will be recorded on the Daily Refrigerator Log in compliance with Michigan Department of Community Health Rules and minimum standards.
4.1.4 Monitoring will be performed at the monitoring frequency and maintained in the ranges designated in the AIM toolkit.
4.1.5 Each refrigerator and freezer will have a calibrated thermometer present. This will be placed in the warmest part of the refrigeration unit.

4.1.6 Refrigerators and freezers storing vaccines MUST have water bottles in the refrigerator and freezer packs in the freezer (Vaccines For Children requirement).
4.1.8 Thermometers used in refrigerators and freezers storing vaccines must be of a model approved by the Vaccines For Children program.
4.1.9 The Daily Refrigerator Log will be posted on the door of each refrigeration unit that contains Medications, Vaccines, or Specimens.
4.1.10 the Data logger or certified thermometer will be read twice daily and recorded, with a data report run each Monday.

4.2 Storage –

4.2.1 The Vaccine Storage and Handling (Post On Refrigerator) statement from the AIM Toolkit or VFC Resource Book will be posted on the front of each refrigerator storing vaccines.
4.2.2 Never mix the contents of a designated refrigerator. (MEDICATIONS ONLY - maintain only medications – no food or specimens and LABORATORY SPECIMENS ONLY – may only contain blood, body fluids, or tissue samples – no medications, vaccines, or food)
4.2.3 Each refrigerator and freezer will be labeled “MEDICATIONS ONLY” or “LABORATORY SPECIMENS ONLY”

4.3 Inventory

4.3.1 Inventory will be conducted on a monthly basis as a minimum.
4.3.2 Inventory will be placed so that those medications that will expire first are used first.
4.3.3 Inspection/inventory will be documented each month as required by regional hospital accreditation standards.

4.4 Cleaning Refrigerator

4.4.1 Refrigerators are to be kept clean and spills are to be wiped up immediately.
4.4.2 If ice accumulation in the freezer is greater than ¼ inch, it should be defrosted and cleaned.
4.4.3 During the thawing and cleaning of a refrigerator, all contents should be moved and placed in another refrigerator.
4.4.4 A notation will be made on the Daily Refrigerator Log indicating the date cleaned.

4.5 Vaccine Ordering

4.5.1 All Vaccines for Children vaccines will be ordered using the process outlined in the Aim Toolkit or VFC Resource Book .

4.6 All VFC vaccines will follow the VFC Lost/ Wasted/ Borrowed Policy

5. **Procedure**

5.1 The temperature of each refrigerator and freezer is to be measured and documented as required on the Daily Refrigerator Log.

5.2When temperatures in the "gray zone" or outside the recommended ranges are recorded, staff will:

5.2.1Gather information about length of time temperature below normal, lowest or highest temperature reached and completes an Occurrence Report (MHCC-10057)

5.2.2 Contact manufacturer to determine whether medications/vaccines are usable or must be disposed of and follow directions appropriately according to Emergency Response Worksheet

5.2.3 Complete the Emergency Response Worksheet; attach to Occurrence Report; send to MMG Safety Officer

5.2.4Contact the Laboratory Director of the subsidiary hospital to determine how specimens should be handled, if applicable

5.2.5 Notify the supervisor initially and then contact maintenance company to reset/repair the refrigerator.

5.2.6 If necessary, move medications, vaccines and other contents to an alternate storage area (another refrigerator, cooler, etc.).

5.3 Temperature logs/charts will be filed at the end of the month and maintained per the record retention policy.

5.4Operations Managers will arrange to provide emergency storage of vaccines/medications in the event of a prolonged power outage or refrigerator failure. Emergency contact numbers should be easily accessible.

6. **Exceptions**

None

7. References

7.1. http://www.aimtoolkit.org/vaccine-storage-handling.php

7.2. Public Health Code -P.A. 368 of 1978 Part 92 (MCL 333.9201 *et seq.)* – Immunizations

7.3 Vaccines for Children Resource book, http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4914-211079--,00.html

7.4. FORM: Occurrence Report – MHCC-10057

8. Appendix

8.1. Appendix A - Temperature Logs

9. Approvals

Mark O'Halla

(Original signed policy on file in MMG Practice Management)
Mark O'Halla
Interim President/Chief Executive Officer

6/23/2014
Date

Michael Ziccardi, D.O.
(Original signed policy on file in MMG Practice Management)
Michael Ziccardi, D.O.
Medical Director

7/1/2014
Date

Forms Committee: approved 9/20/2013
Ambulatory Quality Improvement Committee: approved

Previous Revision Dates/Supersedes Policy:
7/29/05, 5/4/2010, 11/21/11 – Not applicable

Document temperatures when you arrive and before you leave for the day. Keep temperature logs on file for at least three years. Take IMMEDIATE action if your temperature check shows the current temperature in the shaded area!

Fahrenheit (º F) Temperature Log **Month/Year:** _____ **PIN:** _____

REFRIGERATOR 35-46º F																							* FREEZER ≤ 5º F						Calibration / Comments
Day of Month	Time		Staff Initials	MIN MAX	≥49	48	47	46	45	44	43	42	41	40	39	38	37	36	35	34	33	≤-32	MIN MAX	≥8	7	6	5	4	≤3	
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Instructions: Place an "X" in the box that corresponds with the temperature (column), day of the month, and am or pm (rows) for your temperature check. For freezer temps <3º, please record the actual temperature. Enter your initials and the time you monitored the temperature in the appropriate boxes. When calibrating your thermometers, if the discrepancy is more than 3º F from the reading on the calibrated/certified thermometer, make adjustments and document the action. Store frozen vaccine at -58º F to 5º F. MIN/MAX temperatures should be documented once every morning when the clinic opens. Record the miniumun temperature under MIN and the maximum temperature under MAX. If you have a digital data logger record the MIN/MAXtemperatures on the log for both refrigerator and freezer units. If the temperature recorded is in the shaded area, TAKE ACTION, and follow your emergency response plan. 1/22/2013

Document temperatures when you arrive and before you leave for the day! Keep temperature logs on file for at least 3 years!
Take IMMEDIATE action if your temperature check shows the current temperature in the shaded area!!

Celsius (^{O}C) Temperature Log

Month/Year: **PIN:**

REFRIGERATOR 2 - 8^{O}C																* FREEZER ≤-15^{O}C											Calibration / Comments
Day of Month	Time	Staff Initials		MIN MAX	≥11	10	9	8	7	6	5	4	3	2	1	0	≤-1	≥-12	-13	-14	-15	-16	-17	-18	-19	≤-20	MIN MAX	
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Instructions: Place an "X" in the box that corresponds with the temperature (column), day of the month, and am or pm (rows) for your temperature check. For freezer temps <-20^{o}, please record actual temperature. Enter your initials and the time you monitored the temperature in the appropriate boxes. When calibrating your thermometers, if the discrepancy is more than 1.5^{o}C from the reading on the calibrated/certified thermometer, make adjustments and document the action. Store frozen vaccine at -50^{o}C to -15^{o}C.

McLaren Ambulatory Care Center

IMMUNIZATION WAIVER

Vaccine-preventable diseases are still with us. In many cases, they cause disability or death. Immunizations are one of our most cost effective measures to protect children from harmful disease. An individual who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. A child may be subject to exclusion from the school or program, if the local and/or state public health authority advises exclusion as a disease control measure.

I object to to receiving the following vaccines: _____, _____
(First & Last Name) (Birthdate)

- ❑ Diphtheria, Tetanus, acellular Pertussis (DTaP) vaccine
- ❑ Diphtheria, Tetanus, (DT or Td) vaccine
- ❑ *Haemophilus influenzae* type B (Hib) vaccine
- ❑ Hepatitis A vaccine
- ❑ Hepatitis B vaccine
- ❑ Influenza
- ❑ HPV (male/female)
- ❑ Measles, Mumps, Rubella (MMR) vaccine
- ❑ Meningococcal vaccine
- ❑ Pneumococcal vaccine
- ❑ Polio
- ❑ Tdap
- ❑ Varicella (chickenpox) vaccine
- ❑ Zoster
- ❑ Other _____

My provider has explained to me and I understand the following:

- The **purpose** of the recommended vaccination
- The **risks and benefits** of the recommended vaccination
- A **possible consequence** of not allowing my child to receive the recommended vaccination is contracting the illness the vaccine is intended to prevent.
- My Provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention (CDC) have all strongly recommended that the vaccine(s) be given.

The health care provider has answered all of my questions.

Name: (PRINT) _____

Signature _____ Date: _____

Relationship (If other than Patient)

Witness: _____

Patient Name:

Date of Birth:

IMMUNIZATION WAIVER

McLaren Medical Group

INFLUENZA CONSENT FORM

Last Name: _____ First Name :_____ Sex: ❑ Male ❑ Female

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Primary Care Provider (PCP): _____

Not all individuals requesting the flu vaccine can safely be immunized against influenza. Please complete the following questions to evaluate any contraindication:

For any YES response: If active patient at this site, review with the provider. Otherwise, refer the patient back to their PCP.

❑ I have reviewed and authorize vaccine administration. Provider Signature_____ Date_____Time____

1.	Have you ever had a severe reaction to a previous influenza vaccine? Describe: _____	❑ Yes	❑ No
2.	Are you allergic to eggs, chicken feathers, chicken or chicken dander?	❑ Yes	❑ No
3.	Are you allergic to Thimerosal (a mercury derivative found in contact lens solution and Merthiolate)?	❑ Yes	❑ No
4.	Are you allergic to Latex?	❑ Yes	❑ No
5.	Do you have a fever or active illness?	❑ Yes	❑ No
6.	Are you pregnant?	❑ Yes	❑ No
7.	Do you have a past history of Guillain-Barre Syndrome?	❑ Yes	❑ No
8.	Have you received another type of vaccine in the past fourteen (14) days?	❑ Yes	❑ No
9.	Are you under the age of eighteen (18)?	❑ Yes	❑ No
10.	Are you currently receiving blood thinners such as coumadin, aspirin or heparin?	❑ Yes	❑ No

Influenza vaccine is composed of dead influenza viruses and will not give you the flu. It is given by injection. As with any medication, there are risks and possible side effects/reactions. Side effects of influenza vaccine are generally mild in adults and occur within 6-12 hours after vaccination and can persist for one or two days. These reactions consist of soreness of the injection site, fever, chills, muscular aches and, in rare cases, even death. **If you should have a reaction, CONTACT YOUR PRIMARY CARE PROVIDER.**

Having received influenza vaccine information (dated 8/19/14) and informed consent, I hereby agree to release and hold McLaren Medical Group, its employees, agents and representatives harmless from further responsibility with regard to my receiving the injections.

I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request the flu vaccine to be given to me or to the person named for whom I am authorized to sign.

_____ _____

Signature: Patient or Authorized Representative (Relationship) **Date**

FOR MEDICARE PATIENTS ONLY

I request that this provider be paid authorized Medicare benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits for related services. I understand that I am responsible for the charges if my Medicare coverage is not appropriate. Medicare Number _____

Patient Signature _____ ❑ Payment to Patient ❑ Payment to Provider

❑ We were unable to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your primary care provider.

Site of injection: ❑ Right Deltoid ❑ Left Deltoid ❑ Right Anterolateral Thigh ❑ Left Anterolateral Thigh

Lot #: _____ Manufacturer: _____ Expiration Date: _____

Given by:_____ Date: _____ Time: _____

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

- Sclapel
- 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.

McLaren Medical Group

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 our 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 Currette
- 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.

McLaren MEDICAL GROUP		**Policy Title:**	Wet Prep and Wet Prep with KOH
Effective Date:	05/01/2002	**Policy Number:**	3490
Review Date:		**Category:**	Clinical
Revised Date:	05/01/2012	**Oversight Level:**	2
Administrative Responsibility:	Operations Managers/Directors		
Interpretation:	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*, 22nd 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

Signature:

PHYSICIAN ASSESSMENT

History of Present Illness: ❑ Questionnaire / ROS reviewed

EXAMINATION:

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

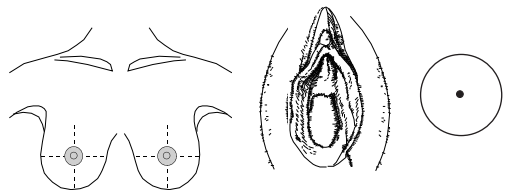
Urethra meatus WNL ❑ Y ❑ N

Urethra WNL ❑ Y ❑ N Cervix WNL ❑ Y ❑ N

Bladder WNL ❑ Y ❑ N Uterus WNL ❑ Y ❑ N

Vagina WNL ❑ Y ❑ N Adnexa WNL ❑ Y ❑ N

DIAGRAMS:



Date of Last:

Pap: Mamm: Bone Density:

NOTES/ASSESSMENT/PLAN:

Time: _____ mins. ❑ 50% of time counseling

PATIENT NAME:

DATE OF BIRTH:

Signature of Provider Date/Time

McLAREN MEDICAL GROUP

COLPOSCOPY REPORT

Date: _____ LMP:_____

Patient Referred By: _____

Allergies:_____

_____

Meds: _____

_____

VITALS

WT: _____ HT: _____ BP: _____ T: _____ P: _____ R:_____

HISTORY

☐ STD

- ☐ Chlamydia ☐ Gonorrhea
- ☐ Herpes ☐ HPV
- ☐ Syphilis

☐ Past history of abnormal pap

☐ Smoker

☐ Periods ☐ Regular ☐ Irregular

Days of flow _____

Cycle length _____

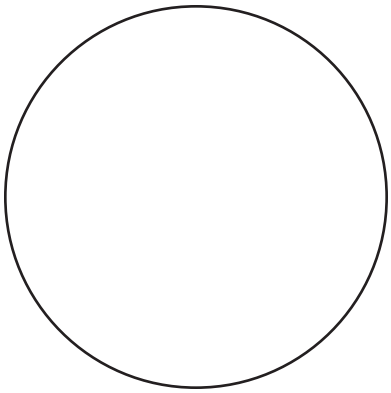
Flow ☐ Heavy ☐ Med ☐ Light

☐ Bleeding

- ☐ Intermenstrual
- ☐ Postcoital

☐ Current oral contraceptive use

_____ (Number of) sexual partners



BIOPSY SITE:

COLPOSCOPY _____

- ☐ Normal
- ☐ Abnormal
  - • ☐ Location _____
  - • ☐ Biopsy Site _____
  - • ☐ Mosaicism _____
  - • ☐ Punctuation _____
  - • ☐ A W change _____
  - • ☐ Irregular vessel _____
  - • ☐ Squamocolumnar site _____
- ☐ Endocervical curettage _____
- ☐ Transformation zone seen
- ☐ Transformation zone not seen

IMPRESSION:

FOLLOW-UP:

_____

Chaperone

_____

Physician Date/Time

MM-164 (8/13)

COLPOSCOPY REPORT

Patient Name:

Date of Birth:

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

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)
Erythematosus (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!*® and the *ISMP Medication Safety Alert!*® 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
aceta**ZOLAMIDE**	aceto**HEXAMIDE**
acetic acid for irrigation	glacial acetic acid
aceto**HEXAMIDE**	aceta**ZOLAMIDE**
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	Altocor
Afrin (oxymetazoline)	Afrin (saline)
Afrin (saline)	Afrin (oxymetazoline)
Aggrastat	argatroban
Aldara	Alora
Alkeran	Leukeran
Alkeran	Myleran
Allegra	Viagra
Alora	Aldara
ALPRAZolam	**LORA**zepam
Altocor	Advicor
amantadine	amiodarone
Amaryl	Reminyl
Ambisome	amphotericin B
Amicar	Omacor
Amikin	Kineret
a**MIL**oride	am**LODIP**ine
amiodarone	amantadine

Drug Name	Confused Drug Name
am**LODIP**ine	a**MIL**oride
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	**RABE**prazole
Asacol	Os-Cal
Atacand	antacid
Atrovent	Natru-Vent
Avandamet	Anzemet
Avandia	Prandin
Avandia	Coumadin
AVINza	**INV**anz
AVINza	Evista
Axert	Antivert
aza**CITID**ine	aza**THIO**prine
aza**THIO**prine	aza**CITID**ine
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
INSTITUTE FOR SAFE MEDICATION PRACTICES
www.ismp.org

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
dexmethylphenidate	methadone
Diabenese	Diamox
Diabeta	Zebeta
Diamox	Diabenese
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
dimenhyDRINATE	diphenhydrAMINE
diphenhydrAMINE	dimenhyDRINATE
Dioval	Diovan
Diovan	Dioval
Diovan	Zyban
Diovan	Darvon
Diprivan	Diflucan
Diprivan	Ditropan
disopyramide	desipramine
Ditropan	Diprivan
DOBUTamine	DOPamine
DOPamine	DOBUTamine
Doribax	Zovirax
Doxil	Paxil
DOXOrubicin	DAUNOrubicin
DOXOrubicin	DOXOrubicin liposomal
DOXOrubicin	IDArubicin
DOXOrubicin liposomal	DOXOrubicin
Dulcolax (bisacodyl)	Dulcolax (docusate sodium)
Dulcolax (docusate sodium)	Dulcolax (bisacodyl)
DULoxetine	FLUoxetine
Durasal	Durezol
Durezol	Durasal
Duricef	Ultracet
Dynacin	Dynacirc
Dynacirc	Dynacin
edetate calcium disodium	edetate disodium
edetate disodium	edetate calcium disodium
Effexor	Effexor XR
Effexor XR	Effexor
Enbrel	Levbid
Engerix-B adult	Engerix-B pediatric/adolescent
Engerix-B pediatric/adolescent	Engerix-B adult
Enjuvia	Januvia
ePHEDrine	EPINEPHrine
EPINEPHrine	ePHEDrine
Estratest	Estratest HS
Estratest HS	Estratest
ethambutol	Ethmozine
Ethmozine	ethambutol
Evista	AVINza
factor IX complex, vapor heated	coagulation factor IX (recombinant)
Fanapt	Xanax
Femara	Femhrt

Drug Name	Confused Drug Name
Femhrt	Femara
fentaNYL	SUFentanil
Fioricet	Fiorinal
Fiorinal	Fioricet
flavoxATE	fluvoxaMINE
Flonase	Flovent
Flovent	Flonase
flumazenil	influenza virus vaccine
FLUoxetine	PARoxetine
FLUoxetine	DULoxetine
FLUoxetine	Loxitane
fluvoxaMINE	flavoxATE
Folex	Foltx
folic acid	folinic acid (leucovorin calcium)
folinic acid (leucovorin calcium)	folic acid
Foltx	Folex
fomepizole	omeprazole
Foradil	Fortical
Foradil	Toradol
Fortical	Foradil
gentamicin	gentian violet
gentian violet	gentamicin
glacial acetic acid	acetic acid for irrigation
glipiZIDE	glyBURIDE
glyBURIDE	glipiZIDE
Granulex	Regranex
guaiFENesin	guanFACINE
guanFACINE	guaiFENesin
HBIG (hepatitis B immune globulin)	BabyBIG
Healon	Hyalgan
heparin	Hespan
Hespan	heparin
HMG-CoA reductase inhibitors ("statins")	nystatin
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
hydrALAZINE	hydrOXYzine
HYDROcodone	oxyCODONE
Hydrogesic	hydrOXYzine
HYDROmorphone	morphine

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Drug Name	Confused Drug Name
hydrOXYzine	Hydrogesic
hydrOXYzine	hydrALAZINE
IDArubicin	DAUNOrubicin
IDArubicin	DOXOrubicin
Inderal	Adderall
indinavir	Denavir
inFLIXimab	riTUXimab
influenza virus vaccine	flumazenil
influenza virus vaccine	tuberculin purified protein derivative (PPD)
Inspra	Spiriva
INVanz	AVINza
iodine	Lodine
Isordil	Plendil
ISOtretinoin	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 subsalcylate)	Kaopectate (docusate calcium)
Kaopectate (docusate calcium)	Kaopectate (bismuth subsalcylate)
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
KlonoPIN	cloNIDine
Kuric	Carac
Kwell	Qwell
LaMICtal	LamISIL
LamISIL	LaMICtal
lamiVUDine	lamoTRIgine
lamoTRIgine	lamiVUDine
lamoTRIgine	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
levETIRAcetam	levOCARNitine
levETIRAcetam	levofloxacin
levOCARNitine	levETIRAcetam
levofloxacin	levETIRAcetam
levothyroxine	lamoTRIgine
levothyroxine	Lanoxin
Lexapro	Loxitane
Lexiva	Pexeva
Lipitor	Loniten
Lipitor	ZyrTEC
lithium carbonate	lanthanum carbonate
Lodine	codeine
Lodine	iodine
Loniten	Lipitor
Lopressor	Lyrica
LORazepam	ALPRAZolam
LORazepam	clonazePAM
LORazepam	Lovaza
Lotronex	Protonix
Lovaza	LORazepam
Lovenox	Levemir
Loxitane	Lexapro
Loxitane	FLUoxetine
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

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Materna	Matulane
Maxzide	Microzide
Menactra	Menomune
Menomune	Menactra
Mephyton	methadone
Metadate	methadone
Metadate CD	Metadate ER
Metadate ER	Metadate CD
Metadate ER	methadone
met**FORMIN**	metro**NIDAZOLE**
methadone	dexmethylphenidate
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
metro**NIDAZOLE**	met**FORMIN**
Mevacor	Benicar
Micronase	Microzide
Microzide	Maxzide
Microzide	Micronase
midodrine	Midrin
Midrin	midodrine
mifepristone	misoprostol
Miralax	Mirapex
Mirapex	Miralax
misoprostol	mifepristone
morphine	**HYDRO**morphone
morphine - non-concentrated oral liquid	morphine - oral liquid concentrate
morphine - oral liquid concentrate	morphine - non-concentrated oral liquid
Motrin	Neurontin
MS Contin	Oxy**CONTIN**
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-Synephrine (oxymetazoline)	Neo-Synephrine (phenylephrine)
Neo-Synephrine (phenylephrine)	Neo-Synephrine (oxymetazoline)
Neulasta	Lunesta
Neulasta	Neumega
Neumega	Neupogen
Neumega	Neulasta
Neupogen	Neumega
Neurontin	Motrin
Neurontin	Noroxin
Neutra-Phos-K	K-Phos Neutral
Nex**AVAR**	Nex**IUM**
Nex**IUM**	Nex**AVAR**
ni**CAR**dipine	**NIFE**dipine
NIFEdipine	ni**CAR**dipine
NIFEdipine	ni**MOD**ipine
ni**MOD**ipine	**NIFE**dipine
Norcuron	Narcan
Normodyne	Norpramin
Noroxin	Neurontin
Norpramin	Normodyne
Norvasc	Navane
Novo**LIN**	Humu**LIN**
Novo**LIN**	Novo**LOG**
Novo**LIN** 70/30	Novo**LOG** Mix 70/30
Novo**LOG**	Huma**LOG**
Novo**LOG**	Novo**LIN**
Novo**LOG** FLEXPEN	Novo**LOG** Mix 70/30 FLEXPEN
Novo**LOG** Mix 70/30 FLEXPEN	Novo**LOG** FLEXPEN
Novo**LOG** Mix 70/30	Novo**LIN** 70/30
nystatin	HMG-CoA reductase inhibitors ("statins")
Occlusal-HP	Ocuflox
Ocuflox	Occlusal-HP
OLANZapine	**QUE**tiapine
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	car**BAM**azepine
oxy**CODONE**	**HYDRO**codone

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oxyCODONE	OxyCONTIN
OxyCONTIN	MS Contin
OxyCONTIN	oxyCODONE
PACLitaxel	PACLitaxel protein-bound particles
PACLitaxel protein-bound particles	PACLitaxel
Pamelor	Panlor DC
Pamelor	Tambocor
Panlor DC	Pamelor
paregoric (camphorated tincture of opium)	opium tincture
PARoxetine	FLUoxetine
PARoxetine	piroxicam
Patanol	Platinol
Pavulon	Peptavlon
Paxil	Doxil
Paxil	Taxol
Paxil	Plavix
PEMEtrexed	PRALAtrexate
Peptavlon	Pavulon
Percocet	Darvocet
Percocet	Procet
Pexeva	Lexiva
PENTobarbital	PHENobarbital
PHENobarbital	PENTobarbital
Pilocar	Dilacor XR
piroxicam	PARoxetine
Platinol	Patanol
Plavix	Paxil
Plendil	Isordil
pneumococcal 7-valent vaccine	pneumococcal polyvalent vaccine
pneumococcal polyvalent vaccine	pneumococcal 7-valent vaccine
Polycitra	Bicitra
PRALAtrexate	PEMEtrexed
Prandin	Avandia
Precare	Precose
Precose	Precare
prednisoLONE	predniSONE
predniSONE	prednisoLONE
PriLOSEC	Pristiq
PriLOSEC	PROzac
Priscoline	Apresoline
Pristiq	PriLOSEC
probenecid	Procanbid
Procan SR	Procanbid
Procanbid	probenecid
Procanbid	Procan SR
Procardia XL	Protain XL

Drug Name	Confused Drug Name
Procet	Percocet
Prograf	PROzac
propylthiouracil	Purinethol
Proscar	Provera
Protain XL	Procardia XL
protamine	Protonix
proton pump inhibitors	ARIPiprazole
Protonix	Lotronex
Protonix	protamine
Provera	Proscar
Provera	PROzac
PROzac	Prograf
PROzac	PriLOSEC
PROzac	Provera
Purinethol	propylthiouracil
QUEtiapine	OLANZapine
quiNIDine	quiNINE
quiNINE	quiNIDine
Qwell	Kwell
RABEprazole	ARIPiprazole
Razadyne	Rozerem
Recombivax HB	Comvax
Regranex	Granulex
Reminyl	Robinul
Reminyl	Amaryl
Renagel	Renvela
Renvela	Renagel
Reprexain	ZyPREXA
Restoril	RisperDAL
Retrovir	ritonavir
Rifadin	Rifater
Rifamate	rifampin
rifampin	Rifamate
rifampin	rifaximin
Rifater	Rifadin
rifaximin	rifampin
RisperDAL	Restoril
risperiDONE	rOPINIRole
Ritalin	ritodrine
Ritalin LA	Ritalin SR
Ritalin SR	Ritalin LA
ritodrine	Ritalin
ritonavir	Retrovir
riTUXimab	inFLIXimab
Robinul	Reminyl
rOPINIRole	risperiDONE

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Drug Name	Confused Drug Name
Roxanol	Roxicodone Intensol
Roxanol	Roxicet
Roxicet	Roxanol
Roxicodone Intensol	Roxanol
Rozerem	Razadyne
Salagen	selegiline
Sand**IMMUNE**	Sando**STATIN**
Sando**STATIN**	Sand**IMMUNE**
saquinavir	**SINE**quan
saquinavir (free base)	saquinavir mesylate
saquinavir mesylate	saquinavir (free base)
Sarafem	Serophene
selegiline	Salagen
Serophene	Sarafem
SEROquel	**SERO**quel XR
SEROquel	Serzone
SEROquel	**SINE**quan
SEROquel XR	**SERO**quel
sertraline	cetirizine
sertraline	Soriatane
Serzone	**SERO**quel
Sinemet	Janumet
SINEquan	saquinavir
SINEquan	**SERO**quel
SINEquan	Singulair
SINEquan	Zonegran
Singulair	**SINE**quan
sita**GLIP**tin	**SUMA**triptan
Solu-**CORTEF**	Solu-**MEDROL**
Solu-**MEDROL**	Depo-Medrol
Solu-**MEDROL**	Solu-**CORTEF**
Sonata	Soriatane
Soriatane	Loxitane
Soriatane	sertraline
Soriatane	Sonata
sotalol	Sudafed
Spiriva	Inspra
Sudafed	sotalol
Sudafed	Sudafed PE
Sudafed PE	Sudafed
SUFentanil	fenta**NYL**
sulf**ADIAZINE**	sulfa**SALA**zine
sulf**ADIAZINE**	sulfi**SOXAZOLE**
sulfa**SALA**zine	sulf**ADIAZINE**
sulfi**SOXAZOLE**	sulf**ADIAZINE**
SUMAtriptan	sita**GLIP**tin

Drug Name	Confused Drug Name
SUMAtriptan	**ZOLM**itriptan
Symbyax	Cymbalta
Tambocor	Pamelor
Taxol	Taxotere
Taxol	Paxil
Taxotere	Taxol
TEGretol	**TEG**retol XR
TEGretol	Tequin
TEGretol	**TREN**tal
TEGretol XR	**TEG**retol
Tequin	**TEG**retol
Tequin	Ticlid
Testoderm TTS	Testoderm
Testoderm TTS	Testoderm with Adhesive
Testoderm with Adhesive	Testoderm
Testoderm with Adhesive	Testoderm TTS
Testoderm	Testoderm TTS
Testoderm	Testoderm with Adhesive
tetanus diptheria toxoid (Td)	tuberculin purified protein derivative (PPD)
Thalomid	Thiamine
Thiamine	Thalomid
tia**GAB**ine	ti**ZAN**idine
Tiazac	Ziac
Ticlid	Tequin
ti**ZAN**idine	tia**GAB**ine
TNKase	Activase
TNKase	t-PA
Tobradex	Tobrex
Tobrex	Tobradex
TOLAZamide	**TOLBUT**amide
TOLBUTamide	**TOLAZ**amide
Topamax	Toprol-XL
Toprol-XL	Topamax
Toradol	Foradil
t-PA	TNKase
Tracleer	Tricor
tra**MAD**ol	tra**ZOD**one
tra**ZOD**one	tra**MAD**ol
TRENtal	**TEG**retol
tretinoin	**ISO**tretinoin
Tricor	Tracleer
tromethamine	Trophamine
Trophamine	tromethamine
tuberculin purified protein derivative (PPD)	influenza virus vaccine
tuberculin purified protein derivative (PPD)	tetanus diptheria toxoid (Td)
Tylenol	Tylenol PM

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Tylenol PM	Tylenol
Ultracet	Duricef
val**ACY**clovir	val**GAN**ciclovir
Valcyte	Valtrex
val**GAN**ciclovir	val**ACY**clovir
Valtrex	Valcyte
Varivax	VZIG (varicella-zoster immune globulin)
Vesanoid	Vesicare
Vesicare	Vesanoid
Vexol	Vosol
Viagra	Allegra
Videx	Bidex
vin**BLAS**tine	vin**CRIS**tine
vin**CRIS**tine	vin**BLAS**tine
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	Zyr**TEC**
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)	Zy**PREXA** Zydis
Zestril	Zegerid
Zestril	Zetia
Zestril	Zy**PREXA**
Zetia	Bextra
Zetia	Zebeta
Zetia	Zestril
Ziac	Tiazac
Zocor	Cozaar
Zocor	Zyr**TEC**
ZOLMitriptan	**SUMA**triptan
Zonegran	**SINE**quan
Zostrix	Zovirax
Zovirax	Doribax
Zovirax	Zyvox
Zovirax	Zostrix
Zyban	Diovan
Zy**PREXA**	Cele**XA**
Zy**PREXA**	Reprexain
Zy**PREXA**	Zestril
Zy**PREXA**	Zyr**TEC**
Zy**PREXA** Zydis	Zelapar (Zydis formulation)
Zyr**TEC**	Lipitor
Zyr**TEC**	Zantac
Zyr**TEC**	Zocor
Zyr**TEC**	Zy**PREXA**
Zyr**TEC**	Zyr**TEC**-D
Zyr**TEC** (cetirizine)	Zyr**TEC** Itchy Eye Drops (ketotifen fumarate)
Zyr**TEC**-D	Zyr**TEC**
Zyr**TEC** Itchy Eye Drops (ketotifen fumarate)	Zyr**TEC** (cetirizine)
Zyvox	Vioxx
Zyvox	Zovirax

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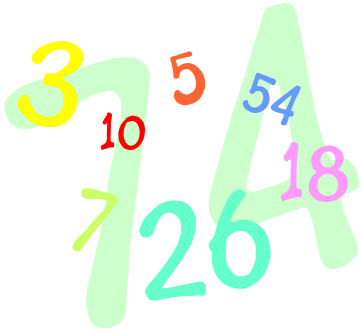
Medication Math

Study Guide



With
Practice Test

McLaren
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) = $\frac{1{,}000\ mg}{1\ g}$
Amount on Hand (H) x Conversion Factor (C) = Answer

$$\mathbf{5\ \cancel{g} \times \frac{1{,}000\ mg}{1\ \cancel{g}} = 5{,}000\ mg}$$

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) = $\frac{1{,}000\ mg}{1\ g}$
Formula: (H) x (C) = Answer

$$\mathbf{25.8\ \cancel{g} \times \frac{1{,}000\ mg}{1\ \cancel{g}} = 25{,}800\ mg}$$

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) x (C) = Answer

Injectable medications*:
Ordered Dose (D) x Dose on Hand (H) = Answer
(Provider's order x equivalent value = Answer)
(**D) x (H) = 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

$$\textbf{3 tablets} \times \frac{\textbf{0.4 mg}}{\textbf{1 tablets}} = \textbf{1.2 mg}$$

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 ~~mg~~ x $\frac{\textbf{1 mL}}{\textbf{5 ~~mg~~}}$ = 5 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 ~~lb~~ x $\frac{\textbf{1 kg}}{\textbf{2.2 ~~lb~~}}$ = 19.5 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 or 91 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 kg or 27.3 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 kg x 2.2 lb = 55 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 = $\frac{10 \text{ mL}}{1 \text{ g}}$

$$0.5 \text{ g} \times \frac{10 \text{ mL}}{1 \text{ g}} = 5 \text{ mL}$$

McLaren MEDICAL GROUP

Environment of Care Readiness Checklist

Date:_____
Department:_____
Completed By:_____
Red Indicates Know TJC Problem Areas

Instructions: ***Complete ONE checklist per month. Keep original. Send copies to You're Immediate Supervisor by 1st of the month & to Sue Walker EOC coordinator.***

Element Inspected Where Applicable	N/A	OK	NOT OK		If "Not OK", Action Taken Comment REQUIRED
Emergency warning devices:					
• Emergency plan staff awareness (can verbalize response to Fire, Tornado, Evacuation, Disaster)					
• Exit Signs illuminated and Emergency Exit Lights Operational (Battery Operated) (**Make sure arrows point only toward exit.)**					
• 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**)					
Personal protective equipment and clothing available and used as needed					
Materials handling, storage, and disposal:					
• Laundry bags not overfilled **(2/3 full is max, no odors)**					
• No items within 18" from ceiling					
• Patient care items stored more than 6" from floor and away from water, heat and electrical outlets					
• O2 tanks stored properly - no more than 11/room & in cart **(Empty and full O2 tanks segregated, secured)**					
Crash Cart checks completed DAILY, O2 tank & regulator available **(Lock secure, defib. strip run daily, only 1 month worth of logs in book)**					
Operations involving hazardous materials and processes:					
• SDS - Available on Intranet **(Make sure employees know how to access SDS info and why)**					
• Biohazard bags are available & in appropriate container					
• **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. • Black box dated when put in use					
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)**					
No stained, displaced or missing ceiling tiles					
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. :					
• No food or drink in patient care areas or nursing stations					
• Refrigerator temp logs up to date *(not required for Staff Only food fridges)* **(Refrigerator checks twice a day if used for vaccination storage)**					
• All open containers in refrigerator dated					
Illumination: All bulbs operational; All lights turned on/off					
Fire protection equipment and hazards:					
• Smoke detectors, alarms functioning (Outpt. Only)					

• Check all fire extinguishers up to date: **(Fire extinguishers checked monthly with full date of monthly inspection date, ex: 01-03-14) & initial. Annual Hole Punch**					
• Fire doors **latch and close properly**					
• Do not block medical gas shut offs or electrical panels					
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					
No torn exam tables or chairs					
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. If door locks does everyone have the key.					
HFAP Manual Chapter 31.00.00 Outpatient services 2014 With tabs					
CHECK ALL EXPERATION DATES: NOTHING EXPIRED- liquids, blood tubes, chemicals (Specifically, Cidex OPA & 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					

Notes or
Concerns:_____

_____