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**A. ADDITIONAL IMMUNIZATION INFORMATION ..... 7.010**

- 5 Rights of medication administration
- Vaccines & Routes of Administration
- How to Administer Intramuscular (im) Injections
- How to Administer Subcutaneous (sc) Injections
- Emergency Supplies and Equipment
- Pharmacy Policy 3.03B, Labeling of Medications

**TIPS ON SAFEGUARDING YOUR VACCINE SUPPLY**  
(Refer to Vaccine Storage and Handling Toolkit)

**B. LIST OF STANDARD ABBREVIATIONS ..... 7.020**

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# ANAPHYLAXIS

## SUBJECTIVE

### History of:

- Ingestion of medication or recent injection, often within minutes
- Recent insect bite or sting
- Food consumption
- Previous allergic reaction

### Symptoms may include:

- Headache
- Anxiety/feeling of impending doom
- Difficult breathing/tightness in throat and chest, wheezing
- Feeling faint
- Localized or generalized pruritus
- Swelling of hands, feet, face and tongue

## OBJECTIVE

- Weak, irregular, and rapid pulse (above 100 beats per minute)
- Rapid and shallow respirations
- Fall in blood pressure
- Patient apprehensive and perspiring heavily, may be confused
- Lips, tongue, and eyelids are frequently swollen
- Hives, rash, erythema present
- Cyanosis of the lips and nail beds
- Labored breathing and wheezing (wheezes are heard throughout chest)
- Nasal discharge, nasal congestion, change in voice quality, sensation of throat closure or choking, shortness of breath

## ASSESSMENT

Anaphylactic reaction

## PLAN

There are **NO** absolute contraindications to epinephrine use in anaphylaxis:

- Initiate emergency response system
- Place patient in supine position
- Assure adequate airway - administer CPR if indicated
- Question regarding most recent weight
- Administer aqueous epinephrine 1:1000 **INTRAMUSCULAR** according to Emergency Drug chart
- May repeat epinephrine dosage every 5-15 minutes, if necessary
- Administer Benadryl IM according to Emergency Drug Chart
- Observe closely for signs of continuing shock, airway obstruction, convulsions, and coma

- Administer oxygen, 4-6 liters per minute by nasal catheter or cannula, or 6-12 liters by mask
- Transport via ambulance as soon as possible and send report of care given

## ANAPHYLAXIS EMERGENCY DRUG CHART

### Epinephrine Dose

**Recommended dose is 0.01 mg/kg body weight up to 0.5 mg maximum dose.**

**May be repeated every 5–15 minutes for a total of 3 doses.**

Age group	Range of weight (kg)*	Range of weight (lb)	1 mg/mL injectable (1:1000 dilution); <u>INTRAMUSCULAR</u> Minimum dose: 0.05 mL
1–6 months	4–8.5 kg	9–19 lb	0.05 mL (or mg)
7–36 months	9–14.5 kg	20–32 lb	0.1 mL (or mg)
37–59 months	15–17.5 kg	33–39 lb	0.15 mL (or mg)
5–7 years	18–25.5 kg	40–56 lb	0.25 mL (or mg)
8–10 years	26–34.5 kg	57–76 lb	0.3 mL (or mg)
11–12 years	35–45 kg	77–99 lb	0.4 mL (or mg)
13 years & older	46+ kg	100+ lb	0.5 mL (or mg) – maximum

**NOTE:** Dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.

### Diphenhydramine (commonly known as Benadryl)

#### Injectable 50mg/ml INTRAMUSCULAR

Age group	Range of weight (kg)*	Range of weight (lb)	Dose 50 mg/ml	INTRAMUSCULAR
7–36 months	9–14.5 kg	20–32 lb	10–15 mg/dose	0.3 ml
37–59 months	15–17.5 kg	33–39 lb	15–20 mg/dose	0.4 ml
5–7 years	18–25.5 kg	40–56 lb	20–25 mg/dose	0.5 ml
8–12 years	26–45 kg	57–99 lb	25–50 mg/dose†	1.0 ml
13 years & older	46+ kg	100+ lb	50 -100 mg/dose†	2.0 ml

**NOTE:** Dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.

†According to AAP's *Red Book*, for children age ≥12 years, the diphenhydramine maximum single dose is 100 mg.

**WEIGHT CONVERSION:**

1 kg = 2.2 lbs

1 lb = 0.45 kg

**References**

Community Health Services Policy #3.4A

Campbell, RL., MD, PhD, Kelso, JM, MD. Anaphylaxis: Emergency treatment. In: UpToDate, Walls, RM, MD, FRCPC, FAAEM (Ed), UpToDate, Waltham, MA, accessed on June 9, 2016.

Medical management of vaccine reactions in children and teens, <http://www.immunize.org/catg.d/p3082a.pdf> accessed February 26, 2016

Simons, F., MD, FRCPC. Anaphylaxis: Rapid Recognition and Treatment. In: UpToDate, Feldweg, A., (Ed), UpToDate, Waltham, MA, 2016

## Community Located Vaccination Clinics

The Emergency Protocols below for Anaphylaxis and Syncope are to be used during community located vaccination clinics

### ANAPHYLAXIS

#### SUBJECTIVE

##### History of:

- Recent injection, often within minutes
- Previous allergic reaction

##### Symptoms may include:

- Headache
- Anxiety/feeling of impending doom
- Difficult breathing/tightness in throat and chest, wheezing
- Feeling faint
- Localized or generalized pruritus
- Swelling of hands, feet, face and tongue

#### OBJECTIVE

- Weak, irregular, and rapid pulse (above 100 beats per minute)
- Rapid and shallow respirations
- Fall in blood pressure
- Patient apprehensive and perspiring heavily, may be confused
- Lips, tongue, and eyelids are frequently swollen
- Hives, rash, erythema
- Cyanosis of the lips and nail beds
- Labored breathing and wheezing (wheezes are heard throughout chest)
- Nasal discharge, nasal congestion, change in voice quality, sensation of throat closure or choking, shortness of breath

#### ASSESSMENT

- Anaphylactic reaction

#### PLAN

- There are **NO** absolute contraindications to epinephrine use in anaphylaxis:
- Initiate emergency response system
- Place patient in supine position
- Assure adequate airway - administer CPR if indicated
- Question regarding most recent weight
- Administer aqueous epinephrine 1:1000 INTRAMUSCULAR according to Emergency Drug Chart A
- May repeat epinephrine dosage every 5-15 minutes, if necessary

## EMERGENCY DRUG CHART

Aqueous Epinephrine (Adrenaline) = 0.01 ml./kg. IM

### Epinephrine Dose

**Recommended dose is 0.01 mg/kg body weight up to 0.5 mg maximum dose.**

**May be repeated every 5–15 minutes for a total of 3 doses.**

Age group	Range of weight (kg)*	Range of weight (lb)	1 mg/mL injectable (1:1000 dilution); <u>INTRAMUSCULAR</u> Minimum dose: 0.05 mL
1–6 months	4–8.5 kg	9–19 lb	0.05 mL (or mg)
7–36 months	9–14.5 kg	20–32 lb	0.1 mL (or mg)
37–59 months	15–17.5 kg	33–39 lb	0.15 mL (or mg)
5–7 years	18–25.5 kg	40–56 lb	0.25 mL (or mg)
8–10 years	26–34.5 kg	57–76 lb	0.3 mL (or mg)
11–12 years	35–45 kg	77–99 lb	0.4 mL (or mg)
13 years & older	46+ kg	100+ lb	0.5 mL (or mg) – max.

**NOTE:** Dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.

## SYNCOPE/VASOVAGAL REACTION/COMMON FAINT

### SUBJECTIVE

#### Symptoms may include:

- Nausea
- Lightheadedness
- Roaring in ears sensation
- Dimming vision

#### History to establish cause:

Gather as much information as possible from patient, family/friend(s), or bystanders

- What was the person doing prior to the injection?
- What were the prodromal symptoms (i.e., nausea, lightheadedness etc.)?
- Are there any predisposing factors (i.e., age, chronic disease, fasting)?
- Are there any precipitating factors (i.e., a painful or fearful procedure)?
- What did others witness?
- Were there any signs of seizure?

**OBJECTIVE**

Diaphoresis  
Loss of color (pale/ashen)  
Loss of consciousness and postural tone

**ASSESSMENT**

Syncope – Possible Vasovagal Reaction

**PLAN**

Assure airway, breathing, and circulation  
Remove any inciting stimuli (stress, pain, fear, etc.)  
Elevate legs, loosen tight clothing such as a tie or belt  
Monitor vital signs  
When there is immediate recovery, review history and refer patients with any significant findings to a primary care provider  
Initiate emergency response (call EMT/911) if recovery is not complete within minutes  
Continue to check vital signs, assure airway, breathing, and circulation until EMT arrives  
Give report to EMT team

**REFERENCES**

Community Health Services Policy #3.4A

<http://www.mayoclinic.org/diseases-conditions/vasovagal-syncope/diagnosis-treatment/treatment/txc-20184861>, accessed May 17, 2016.

Simons, F., MD, FRCPC. Anaphylaxis: Rapid Recognition and Treatment. In: UpToDate, Feldweg, A., (Ed), UpToDate, Waltham, MA, 2016

## **BASIC INFERTILITY SERVICES**

### **GENERAL INFORMATION**

Infertility is defined as the failure of a couple to achieve a pregnancy after 12 months or longer of regular unprotected intercourse **OR** after 6 months for women:

- over age 35
- with oligomenorrhea (infrequent or very light menstruation)
- history of known/suspected uterine/tubal disease or endometriosis
- with a partner known to be subfertile (the condition of being less than normally fertile though still capable of effecting fertilization)

Both partners should be evaluated concurrently (recommendation of American Society for Reproductive Medicine, ASRM)

### **SUBJECTIVE**

- Reproductive life plan
- Sexual health assessment
- Complete medical history
  - Medical conditions associated with reproductive failure such as:
    - ✓ thyroid disorders or other endocrine disorders
    - ✓ PCOS
    - ✓ Hirsutism
  - Pelvic/abdominal pain
  - Dyspareunia
  - Galactorrhea
- Childhood disorders
- Family history of infertility
- Reproductive history
  - Review menstrual history
  - How long has client been trying to achieve pregnancy?
  - Coital frequency/timing
  - Fertility awareness
  - Previous evaluations/treatments
  - Gonadal toxin exposure including heat (men)

### **OBJECTIVE**

Height, weight, BMI (optional)

### **ASSESSMENT**

Infertility/sub-fertility

### **PLAN**

Refer patient to health department or private physician or APN for a complete infertility based physical exam

Refer to current CDC guidelines and recommendations regarding Zika virus risk and prevention:

- Has the client or the client's partner (s) travelled to an area with Zika virus?
- Has the client had other recognized risks of exposure?
  - ✓ Provide referral for pregnant women with exposure or symptomatic clients with exposure
- Provide Zika virus information and discuss recommendations for:
  - ✓ avoiding mosquito bites,
  - ✓ preventing sexual transmission
  - ✓ delaying pregnancy
  - ✓ access to contraception

### Health Teaching

Educate about “peak” fertility days (refer to Fertility Awareness protocol 2.090)

- Clear, stretchy cervical mucus
- Vaginal intercourse every 1-2 days following end of menses
- Discourage ETOH, recreational drugs, smoking
- Encourage weight loss if obese

### Preventative Health Recommendations

Advise client of the importance of recommended related family planning preventative health screening and testing.

#### Females:

- Cervical Cytology (pap smear) refer to PHN Protocol 2.020 for screening guidelines
- Genital exam should accompany cervical cancer screening
- Clinical Breast Examination:
  - ACOG recommends annual CBE for women ages 19 and older.
- Mammography:
- USPSTF recommends screening mammography for women ages 50-74 every other year.

#### Males:

Examination of the genitals of adolescent **males** should be conducted to document normal growth and development; exam should include palpation of inguinal nodes, scrotal contents, penis and peri-anal region as well as inspection of skin & hair

### REFERENCES:

- Centers for Disease Control and Prevention. Providing Quality Family Planning Services. Recommendations of CDC and the U.S. Office of Population Affairs. MMWR. April 25, 2014.
- Curtis, M. et al. (2014) Glass' Office Gynecology. Seventh Edition. Philadelphia: Wolters Kluwer Health.

## FERTILITY AWARENESS-BASED METHODS (FAM)

### GENERAL INFORMATION

Fertility awareness-based methods can be provided by deferred exam.

There are five different types of fertility awareness-based methods. Couples may elect to use more than one of these at a time. The methods are:

Fertility Awareness-based Method	Synopsis
Calendar Method	The calendar rhythm method requires that a woman keep a record of the length of 6-12 menstrual cycles. Find the longest and shortest of your past menstrual cycles. Subtract 18 from the number of days in the shortest cycle to find the first fertile day. Subtract 11 from the number of days in the longest cycle to find the last fertile day. To prevent pregnancy, avoid unprotected intercourse from the first through the last days identified as fertile.
Standard Days Method	The standard days method is only for women whose menstrual cycles are 26 to 32 days long. On days 8 to 19, avoid unprotected intercourse. To simplify this method, the client may use a specially designed, color-coded string of beads, brand name CycleBeads®.
Two Day Method	Until a woman can say, "I do not have vaginal secretions today and I did not have secretions yesterday", she must consider herself fertile.
Billings Ovulation Method	This ovulation method relies on assessment of the cervical mucus by look, touch, and by the feeling of wetness at the vulva.
Symptothermal Method	The symptothermal method is a method that combines observation of cervical mucous with basal body temperature (BBT).

### SUBJECTIVE

Collect and review medical history including obstetric and gynecologic history with emphasis on the menstrual cycle preferable for the previous 6-12 months.

Screening components for contraceptive services include:

- Medical history
- Reproductive life plan
- Sexual health assessment

### OBJECTIVE

- Pregnancy test (if clinically indicated)
- Height, Weight, BMI (optional)

**PLAN**

- Provide necessary health teaching to use method correctly and consistently
- Provide client with method specific instructions. Resources are available at <http://fpntc.org/training-and-resources/contraceptive-fact-sheets>. A Spanish version is available at <http://www.cardeaservices.org/resourcecenter/contraceptive-fact-sheets-Spanish>. You may also use previously approved instructions.
- Document 3-4 of the Title X Office of Population Affairs required health teaching/counseling topics during each family planning visit until instruction in all required topics is complete.
- Chlamydia and gonorrhea screening
  - Screen all sexually active women aged  $\leq 25$  years for chlamydia AND gonorrhea annually
  - Screen all sexually active women  $\geq 26$  years with risk factors for chlamydia AND gonorrhea.
    - Risk factors include; a new partner; more than one sex partner; a partner who has other concurrent partners; or a partner who has a sexually transmitted infection
- Refer to current CDC guidelines and recommendations regarding Zika virus risk and prevention:
  - Has the client or the client's partner (s) travelled to an area with Zika virus?
  - Has the client had other recognized risks of exposure?
    - ✓ Provide referral for pregnant women with exposure or symptomatic clients with exposure
  - Provide Zika virus information and discuss recommendations for:
    - ✓ avoiding mosquito bites,
    - ✓ preventing sexual transmission
    - ✓ delaying pregnancy
    - ✓ access to contraception
- Offer condoms for improved STI protection
- Offer ECP as indicated
- Advise client when to return to the clinic for visit with provider

**Preventative Health Recommendations**

Clients are no longer required to have an examination to receive most contraceptive methods. However, the client must be advised of the importance of the recommended related family planning preventative health screening and testing.

**Females:**

Cervical Cytology (pap smear) refer to PHN Protocol 2.020 for screening guidelines

Genital exam should accompany cervical cancer screening

Clinical Breast Examination:

ACOG recommends annual CBE for women ages 19 and older.

Mammography:

USPSTF recommends screening mammography for women ages 50-74 every other year.

**Males:**

Examination of the genitals of adolescent **males** should be conducted to document normal growth and development; exam should include palpation of inguinal nodes, scrotal contents, penis and peri-anal region as well as inspection of skin & hair

**REFERENCES**

Contraceptive Technology, Robert A. Hatcher, M.D., et al., Twentieth Revised Edition, 2011.  
"Family Planning Clinical Guidelines" Tennessee Department of Health, January 2011

A Pocket Guide to Managing Contraception, Hatcher, R.A., Nelson, A.L., Ziemann, M. et. al.,  
Tiger, Georgia: Bridging the Gap Foundation, 2010.

[www.cyclebeads.com](http://www.cyclebeads.com)

Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of  
Population Affairs MMWR/ Vol. 63 / No. 4 April 25, 2014

## PRECONCEPTION HEALTH SERVICES

### GENERAL INFORMATION

Preconception describes any time that a woman of reproductive potential is at risk of becoming pregnant or when a man is at risk for impregnating his female partner. Preconception health-care services aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcomes through prevention and management.

### SUBJECTIVE

Medical history

Female client	Male client	Female and Male
<ul style="list-style-type: none"> <li>- history of poor birth outcomes</li> <li>- preterm or cesarean delivery</li> <li>- miscarriage and stillbirth</li> <li>- medicines that are known teratogens</li> </ul>	<ul style="list-style-type: none"> <li>- medical/surgical history that might impair reproductive health</li> <li>- history of reproductive failures</li> <li>- conditions that can reduce sperm quality (i.e.obesity, diabetes,varicocele)</li> </ul>	<ul style="list-style-type: none"> <li>- Reproductive life plan</li> <li>- Sexual health assessment</li> <li>- Environmental exposures, hazard and toxins</li> <li>- Genetic conditions</li> <li>- Immunization history</li> <li>- Depression</li> <li>- Intimate partner violence</li> </ul>

### OBJECTIVE

Height, weight, BMI (optional)

Blood pressure

For female and male clients with a sustained BP > 135/80 (treated or untreated), refer client to primary care physician for diabetes screen

### ASSESSMENT

Preconception care/counseling

### PLAN

For women: Folic acid 0.4 to 0.8 mg daily

Refer to current CDC guidelines and recommendations regarding Zika virus risk and prevention:

- Has the client or the client's partner (s) travelled to an area with Zika virus?
- Has the client had other recognized risks of exposure?
  - ✓ Provide referral for pregnant women with exposure or symptomatic clients with exposure
- Provide Zika virus information and discuss recommendations for:
  - ✓ avoiding mosquito bites,
  - ✓ preventing sexual transmission
  - ✓ delaying pregnancy
  - ✓ access to contraception

Management/referral as indicated for:

- Hypertension
- Diabetes
- Depression
- Intimate partner violence
- Tobacco/ETOH/drug use
- Immunizations

**REFERENCES:**

Center for Disease Prevention. "U.S. Medical Eligibility Criteria for Contraceptive Use." MMWR, Vol. 59, June 18, 2010.

MMWR, Providing Quality Family Planning Services, Recommendations of CDC and the U.S. Office of Population Affairs, April 25, 2014/63(04)

# PREGNANCY TEST

## GENERAL INFORMATION

Patients requesting pregnancy tests at the Health Department should be tested on that day and only deferred if absolutely necessary.

## SUBJECTIVE

Screening components for pregnancy testing and counseling includes:

Appropriate history

Date of LMP

History of unprotected coitus since LMP

Symptoms of pregnancy and date symptoms appeared:

Breast tenderness

Fatigue

Nausea

Urinary frequency

## OBJECTIVE

Positive or negative urine pregnancy test

## ASSESSMENT

Pregnancy test positive, pregnancy intended

Pregnancy test positive, pregnancy unintended

Pregnancy test negative, pregnancy desired

Pregnancy test negative, pregnancy not desired

## PLAN

- Discuss test results clearly and objectively.
- Refer to health department APN or MD for pelvic exam as indicated
- Chlamydia and gonorrhea screening
  - Screen all sexually active women aged  $\leq 25$  years for chlamydia AND gonorrhea annually
  - Screen all sexually active women  $\geq 26$  years with risk factors for chlamydia AND gonorrhea.
    - Risk factors include; a new partner; more than one sex partner; a partner who has other concurrent partners; or a partner who has a sexually transmitted infection
- Refer to current CDC guidelines and recommendations regarding Zika virus risk and prevention:
  - Has the client or the client's partner (s) travelled to an area with Zika virus?
  - Has the client had other recognized risks of exposure?

- ✓ Provide referral for pregnant women with exposure or symptomatic clients with exposure
- Provide Zika virus information and discuss recommendations for:
  - ✓ avoiding mosquito bites,
  - ✓ preventing sexual transmission
  - ✓ delaying pregnancy
  - ✓ access to contraception

**If pregnancy test is positive and pregnancy is desired**

- Provide an estimation of gestational age
- Inform client about normal signs/symptoms of pregnancy
- Provide initial prenatal counseling including
  - Importance of early prenatal care
  - Importance of nutrition, prenatal vitamins, and folic acid
- Stress importance of good dental care during pregnancy and refer if applicable
- Discuss appropriate vaccinations and offer if available
- Enroll or refer eligible clients to WIC, HUGS, and Presumptive TennCare
- If patient is not eligible for Presumptive TennCare, refer patient to other prenatal care resources
- Advise patient to discuss prescription and OTC medication use with the prescribing physician or OB.
- Advise patient to avoid
  - Smoking including e-cigarettes
  - Alcohol and substance use
  - Fish containing high mercury (shark, swordfish, king mackerel, or tilefish)
- Discuss impact of STI on pregnancy, offer STI screening including HIV
- Review signs/symptoms of ectopic pregnancy or threatened abortion including bleeding, spotting, or acute lower abdominal pain
- Provide infant care information/counseling
  - ✓ Discuss prevention of sleep related deaths and SIDS. Discuss and provide “ABC’s of Safe Sleep” handout included at the end of this protocol. Encourage parents to share ABC’s with all other caregivers of the newborn.

**If the pregnancy test is positive and the pregnancy is not desired:**

- Provide factual non-biased counseling and referral for the following patient requested options
  - Parenting
  - Adoption
  - Termination
- Provide a list of area and community resources for those options requested by the patient.
- Discuss the timetable for decision-making (obtaining pregnancy termination during the first trimester).
- Consider whether or not a mental health referral is needed.

If pregnancy test is **negative** and pregnancy is **not desired**

- Offer contraceptive services/counseling

If pregnancy test is **negative** and pregnancy is **desired**:

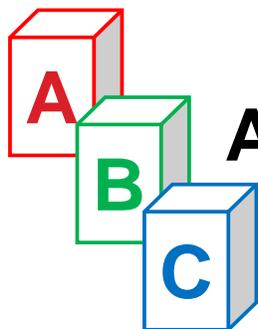
- Discuss reproductive life plan
- Refer to preconception health services protocol 2.105
- Offer basic infertility services (if indicated)

## **REFERENCES**

U.S. Department of Health and Human Services, Public Health Service, Health Service Administration, Bureau of Community Health Services Program, *Program Guidelines For Project Grants For Family Planning*, 2001.

U.S. Department of Health and Human Services, Public Health Service, Standards of Compliance for Abortion-Related Services in Family Planning Service Projects, *Federal Register* 58(23), February 5, 1993.

Centers for Disease Control and Prevention. MMWR. Providing Quality Family Planning Services. Vol. 63, No. 4. April 25, 2014.



## ABC's of Safe Sleep

Babies should sleep...

### Alone

- Not with an adult, another child, or pets
- Not with pillows or stuffed toys
- Not with crib bumpers
- Room-sharing\* is recommended

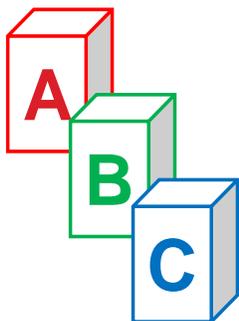
### On their Back

- Not on their side
- Not on their stomach

### In a Crib

- Not in an adult bed
- Not on a couch or sofa
- Not in a chair

\*The American Academy of Pediatrics recommends having the infant sleep in the same room as the parent(s) on a separate sleep surface (crib or other similar surface). Evidence suggests that this arrangement decreases the risk of Sudden Infant Death Syndrome (SIDS) by up to 50%.



## El ABC del sueño seguro

Los bebés deben dormir...

### A solas

- No con un adulto, ni con otro niño, ni con una mascota
- Sin cojines ni muñecos de peluche
- Sin protectores en la cuna
- Se recomienda compartir la habitación\*

### Boca arriba

- No de lado
- No boca abajo

### En una Cuna

- No en la cama de un adulto
- No en un diván, ni en un sofá
- No en una silla

\*La American Academy of Pediatrics (la Academia estadounidense de pediatría) recomienda que el lactante duerma en la misma habitación que los padres sobre una superficie aparte (cuna o superficie similar). Se ha comprobado que esto logra disminuir hasta el 50% el riesgo de muerte súbita del lactante (SIDS, *Sudden Infant Death Syndrome*).

## PROGESTIN-ONLY PILLS

### GENERAL INFORMATION

Progestin only pills are taken daily without a pill/hormone free interval.

### SUBJECT

Medical history  
Reproductive life plan  
Sexual health assessment

### OBJECTIVE

Pregnancy test (if clinically indicated)  
Height, weight, BMI (optional)

### ASSESSMENT

A current medical history should be taken for each client. The history must be negative for U.S. Medical Eligibility Criteria categories 3 and 4 to dispense without an exam.

Refer to the Summary Chart of U. S. Medical Eligibility Criteria for Contraceptive Use in Family Planning Reference section 2.170.

Appropriate to being or continue progestin-only oral contraceptive.

### PLAN

PHN follows the ongoing plan of care written by the examiner or RN initiates progestin only hormonal contraception via Quick Start Protocol.

- Document name, dosage, route, and frequency of the progestin-only oral contraceptive chosen.
- Document number of cycles given
- PHN must consult with health department APN/MD to obtain an order to continue chosen method beyond 6 months
- Provide necessary health teaching to use method correctly and consistently.
- Provide client with method specific instructions. Resources are available at <http://fpntc.org/training-and-resources/contraceptive-fact-sheets>. A Spanish version is available at <http://www.cardeaservices.org/resourcecenter/contraceptive-fact-sheets-Spanish>. You may also use previously approved instructions.
- Document 3-4 of the Title X Office of Population Affairs required health teaching/counseling topics during each family planning visit until instruction in all required topics is complete.
- Chlamydia and gonorrhea screening
  - Screen all sexually active women aged  $\leq 25$  years for chlamydia AND gonorrhea annually
  - Screen all sexually active women  $\geq 26$  years with risk factors for chlamydia AND gonorrhea.

- Risk factors include; a new partner; more than one sex partner; a partner who has other concurrent partners; or a partner who has a sexually transmitted infection
- Offer condoms for improved STI protection.
- Offer condoms and/or contraceptive foam or film for use as back-up protection against unintended pregnancy
- Offer ECP as indicated
- Advise client when to return to the clinic for a visit with provider

### **Health Teaching**

Document necessary health teaching regarding emergency warning signs:

- A** Abdominal pain – severe (as might be seen with liver disease, gallbladder disease, ectopic pregnancy)
  - C** Chest pain - severe, (cough, shortness of breath or sharp pain on inhalation as might be seen with heart attack or pulmonary embolism)
  - H** Headache - severe, dizziness, weakness, or numbness, especially if one-sided (as might be seen with migraine or stroke especially with numbness, muscle weakness, or visual changes)
  - E** Eye disturbances vision loss or blurring, also speech problems (as might be seen with retinopathy or stroke)
  - S** Severe leg pain in calf or thigh (as might be seen with thrombophlebitis)
- Consult APN or physician for complications and warning signs and for side effects that have not responded to standard treatments

### **Preventative Health Recommendations**

Clients are no longer required to have an examination to receive most contraceptive methods. However, the client must be advised of the importance of the recommended related family planning preventative health screening and testing.

#### **Females:**

Cervical Cytology (pap smear) refer to PHN Protocol 2.020 for screening guidelines

Genital exam should accompany cervical cancer screening

Clinical Breast Examination:

ACOG recommends annual CBE for women ages 19 and older.

Mammography:

USPSTF recommends screening mammography for women ages 50-74 every other year.

### **REFERENCES**

Hatcher, R. et al. Contraceptive Technology, Twentieth Revised Edition. New York: Ardent Media 2011.

“Family Planning Clinical Guidelines”, Tennessee Department of Health, January 2011.

Hatcher, R. A., Nelson, A. L., Ziemann, M., et. al., A Pocket Guide to Managing Contraception, Tiger, Georgia: Bridging the Gap Foundation 2015.

Center for Disease Control and Prevention, US Medical Eligibility Criteria for Contraceptive Use, MMWR, Vol. 59, June 18, 2010.

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age	Menarche to <20 yrs: <sup>2</sup>												
	Menarche to <20 yrs: <sup>2</sup>												
	Menarche to <18 yrs: <sup>1</sup>												
	Menarche to <18 yrs: <sup>2</sup>												
	Menarche to <18 yrs: <sup>1</sup>												
	Menarche to <40 yrs: <sup>2</sup>												
	Menarche to <40 yrs: <sup>1</sup>												
	Menarche to >45 yrs: <sup>1</sup>												
	Menarche to >45 yrs: <sup>2</sup>												
	Menarche to >45 yrs: <sup>1</sup>												
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease <sup>†</sup>	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer <sup>†</sup>												
	i) Current	1		4		4		4		4		4	
ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3		
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
d) >42 days postpartum					1*		1*		1*		2*		
Cervical cancer	Awaiting treatment	4	2	4	2	2	2	2	1	1	2	2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (compensated)	1		1		1		1		1		1	
	b) Severe <sup>†</sup> (decompensated)	1		3		3		3		3		4	
Cystic fibrosis <sup>‡</sup>		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (first-degree relatives)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
ii) Without prolonged immobilization	1		1		1		1		1		2		
f) Minor surgery without immobilization	1		1		1		1		1		1		
Depressive disorders		1*		1*		1*		1*		1*		1*	

Key:	
1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC		
		I	C	I	C	I	C	I	C	I	C	I	C	
Diabetes	a) History of gestational disease	1		1		1		1		1		1		
	b) Nonvascular disease													
	i) Non-insulin dependent	1		2		2		2		2		2		
	ii) Insulin dependent	1		2		2		2		2		2		
	c) Nephropathy/retinopathy/neuropathy <sup>‡</sup>	1		2		2		3		2		3/4*		
d) Other vascular disease or diabetes of >20 years' duration <sup>‡</sup>	1		2		2		3		2		3/4*			
Dysmenorrhea	Severe	2		1		1		1		1		1		
Endometrial cancer <sup>†</sup>		4	2	4	2	1	1	1	1	1	1	1		
Endometrial hyperplasia		1		1		1		1		1		1		
Endometriosis		2		1		1		1		1		1		
Epilepsy <sup>†</sup>	(see also Drug Interactions)	1		1		1*		1*		1*		1*		
Gallbladder disease	a) Symptomatic													
	i) Treated by cholecystectomy	1		2		2		2		2		2		
	ii) Medically treated	1		2		2		2		2		3		
	iii) Current	1		2		2		2		2		3		
	b) Asymptomatic	1		2		2		2		2		2		
Gestational trophoblastic disease <sup>†</sup>	a) Suspected GTD (immediate postevacuation)													
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*		
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*		
	b) Confirmed GTD													
	i) Undetectable/non-pregnant β-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	1*	
	ii) Decreasing β-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	1*	
	iii) Persistently elevated β-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	1*	
	iv) Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	1*	
	Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1	1*
		b) Migraine												
i) Without aura (includes menstrual migraine)		1		1		1		1		1		2*		
ii) With aura	1		1		1		1		1		4*			
History of bariatric surgery <sup>†</sup>	a) Restrictive procedures	1		1		1		1		1		1		
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1		
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2		
	b) Past COC related	1		2		2		2		2		3		
History of high blood pressure during pregnancy		1		1		1		1		1		2		
History of Pelvic surgery		1		1		1		1		1		1		
HIV	a) High risk for HIV	2	2	2	2	1	1*	1	1*	1	1*	1	1	
	b) HIV infection							1*	1*	1*	1*	1*	1*	
	i) Clinically well receiving ARV therapy	1	1	1	1								If on treatment, see Drug Interactions	
ii) Not clinically well or not receiving ARV therapy <sup>†</sup>	2	1	2	1									If on treatment, see Drug Interactions	

**Abbreviations:** C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA=depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring. † Condition that exposes a woman to increased risk as a result of pregnancy. ‡ Please see the complete guidance for a clarification to this classification: [www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm](http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm).

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (properly taken measurements)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100 <sup>†</sup>	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	1		1		1		2		2		2/3*	
Ischemic heart disease <sup>‡</sup>	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations <sup>‡</sup>		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma <sup>‡</sup>	1		3		3		3		3		4	
	b) Malignant <sup>‡</sup> (hepatoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a) With prolonged immobility	1		1		1		2		1		3	
	b) Without prolonged immobility	1		1		1		2		1		1	
Obesity	a) Body mass index (BMI) ≥30 kg/m <sup>2</sup>	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥30 kg/m <sup>2</sup>	1		1		1		2		1		2	
Ovarian cancer <sup>‡</sup>		1		1		1		1		1		1	
Parity	a) Nulliparous	2		2		1		1		1		1	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a) Past												
	i) With subsequent pregnancy	1	1	1	1	1	1	1	1	1	1	1	1
	ii) Without subsequent pregnancy	2	2	2	2	1	1	1	1	1	1	1	1
	b) Current	4	2*	4	2*	1	1	1	1	1	1	1	1
Peripartum cardiomyopathy <sup>‡</sup>	a) Normal or mildly impaired cardiac function												
	i) <6 months	2		2		1		1		1		4	
	ii) ≥6 months	2		2		1		1		1		3	
	b) Moderately or severely impaired cardiac function	2		2		2		2		2		4	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	2*		2*		1*		1*		1*		1*	
	c) Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum (nonbreastfeeding women)	a) <21 days					1		1		1		4	
	b) 21 days to 42 days												
	i) With other risk factors for VTE					1		1		1		3*	
	ii) Without other risk factors for VTE					1		1		1		2	
	c) >42 days					1		1		1		1	
Postpartum (in breastfeeding or non-breastfeeding women, including cesarean delivery)	a) <10 minutes after delivery of the placenta												
	i) Breastfeeding	1*		2*									
	ii) Nonbreastfeeding	1*		1*									
	b) 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c) ≥4 weeks	1*		1*									
	d) Postpartum sepsis	4		4									

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
	b) Not on immunosuppressive therapy	1		1		1		2		1		2	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver <sup>‡</sup>	1		1		1		1		1		1	
Sexually transmitted diseases (STDs)	a) Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1		1		1		1	
	b) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	2	2	2	2	1		1		1		1	
	c) Other factors relating to STDs	2*	2	2*	2	1		1		1		1	
Smoking	a) Age <35	1		1		1		1		1		2	
	b) Age ≥35, <15 cigarettes/day	1		1		1		1		1		3	
	c) Age ≥35, ≥15 cigarettes/day	1		1		1		1		1		4	
Solid organ transplantation <sup>‡</sup>	a) Complicated	3	2	3	2	2		2		2		4	
	b) Uncomplicated	2		2		2		2		2		2*	
Stroke <sup>‡</sup>	History of cerebrovascular accident	1		2		2	3	3		2	3	4	
Superficial venous disorders	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial venous thrombosis (acute or history)	1		1		1		1		1		3*	
Systemic lupus erythematosus <sup>‡</sup>	a) Positive (or unknown) antiphospholipid antibodies	1*	1*	3*		3*		3*	3*	3*		4*	
	b) Severe thrombocytopenia	3*	2*	2*		2*		3*	2*	2*		2*	
	c) Immunosuppressive therapy	2*	1*	2*		2*		2*	2*	2*		2*	
	d) None of the above	1*	1*	2*		2*		2*	2*	2*		2*	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis <sup>‡</sup> (see also Drug Interactions)	a) Nonpelvic	1	1	1	1	1*		1*		1*		1*	
	b) Pelvic	4	3	4	3	1*		1*		1*		1*	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*		3*		2*		2*	
Uterine fibroids		2		2		1		1		1		1	
Valvular heart disease	a) Uncomplicated	1		1		1		1		1		2	
	b) Complicated <sup>‡</sup>	1		1		1		1		1		4	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		1		2		2		2		1	
	b) Heavy or prolonged bleeding	2*		1*	2*	2*		2*		2*		1*	
Viral hepatitis	a) Acute or flare	1		1		1		1		1		3/4*	2
	b) Carrier/Chronic	1		1		1		1		1		1	1
Antiretroviral therapy	Fosamprenavir (FPV)	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b) Lamotrigine	1		1		1		1		1		3*	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampin or rifabutin therapy	1		1		2*		1*		3*		3*	
SSRIs		1		1		1		1		1		1	
St. John's wort		1		1		2		1		2		2	

**Updated July 2016.** This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm>. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

## **ORAL HEALTH RISK ASSESSMENT & FLUORIDE VARNISH**

### **General Information**

The bacteria associated with dental caries have been identified as Streptococcus Mutans. The presence of these bacteria along with certain foods allows the process of decay to begin on the tooth surface. Untreated decay progresses through stages of tooth destruction. As the decay progresses, the affected area becomes larger.

Tooth decay (cavities) is one of the most common chronic conditions of childhood in the United States. Dental care is the most common unmet health need in most communities. Primary care providers should incorporate oral health into their practices.

Dental oral health risk assessments and referrals are recommended for every child

There has been a well-documented decline in dental caries in children in the United States, which has been attributed to widespread use of various forms of fluoride. The use of fluoride varnish, a high-concentration of fluoride in a small amount, when painted directly onto the teeth contributes to this decline.

Even people living in communities where water supplies are fluoridated benefit from exposure to fluoride found in toothpaste, mouth rinses, professionally applied fluoride, and in foods processed in cities where water supplies are fluoridated (i.e., the “halo” phenomenon).

The use of topical fluoride application is one alternative means of providing protection to the teeth of children 0 months old to 21<sup>1</sup> years of age who are at risk for dental caries.

Proper application technique reduces the possibility that a patient will swallow varnish during its application and limits the total amount of fluoride swallowed as the varnish wears off the teeth over several hours.

A combination of various types of fluoride use (e.g. optimally fluoridated water, prescription fluoride supplements, and professionally applied topical fluoride) reduces dental caries significantly more than any one method alone.

No published evidence indicates that professionally applied fluoride varnish is a risk factor for enamel fluorosis for children 0 through 8 years of age.

Applying the fluoride varnish to any and all tooth surfaces reduces the risk of decay.

A helpful tip for applying fluoride varnish to the teeth of young children is to sit knee-to-knee with parent or caregiver, and have the child lay their head in the health care provider’s lap.

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<sup>1</sup> Topical application of fluoride varnish is safe for the prenatal patient

**SUBJECTIVE**

Age 0 – 21 years of age, with teeth present

ASK about oral health risk factors and symptoms of oral disease:

- Mother, primary caregiver, or sibling have active decay
- Lack of adequate fluoride exposure
- Continual bottle/sippy cup use with fluid other than water
- Frequent snacking
- Special health care needs
- Does the family have a Dental Home
- Low socioeconomic status
- Condition(s) impairing saliva flow
- Drink fluoridated water

**OBJECTIVE**

Look for signs of oral health risk or active disease:

- Obvious Decay
- White, chalky spots on teeth
- Restorations (fillings) Present
- Visible Plaque Accumulation
- Gingivitis
- Healthy Teeth

**ASSESSMENT**

**(MUST BE PERFORMED BY RN)**

Never apply varnish without first performing an oral assessment (an assessment may not always warrant varnish application)

- ✓ High risk
  - Obvious Decay
  - Restorations (fillings) present
  - White chalky spots/decalcifications
- ✓ Medium risk
  - Plaque Accumulation
  - Gingivitis
- ✓ Low Risk
  - Has a dental home
  - Brushes twice daily

**PLAN**

Public Health Nurse (RN) performs dental oral health risk assessment

Plan is the same regardless of risk status, (high, medium or low):

- Fluoride varnish should be applied at a minimum of twice annually but may be applied as often as every 3 months once teeth are present
  - ✓ Maximum 0.25ml-primary dentition (baby teeth, milk teeth)
  - ✓ Maximum 0.40ml-mixed and permanent dentition (big teeth, adult teeth)

- Provide home care instructions and stress importance of following instructions
- Provide active referral to a dentist (dental home)

### **Health Teaching:**

- Patient can leave immediately after application
- Child should not brush for 4 hours
- Eat a soft diet for 4 hours
- Avoid hot drinks and products containing alcohol (beverages, oral rinses) for 4 hours
- Instruct parent/guardian on the correct care of child's teeth until the next day
- Provide parent/guardian with appropriate information sheet for care of child's teeth following fluoride varnish application
- Instruct parent or guardian on the need for additional applications of fluoride varnish
- Counsel parent/guardian to closely supervise tooth brushing by young children in order to prevent their ingestion of fluoride toothpaste and to ensure that only very small quantities (pea-sized amounts) are used (so as to reduce the risk of dental fluorosis)
- Counsel parent/guardian regarding the risks that contributes to dental decay
- Instruct parent/guardian about proper diet and feeding habits, as well as the daily care of the child's teeth to contribute to the prevention of dental decay

### **Follow-Up:**

Provide dental oral health risk assessment at least twice annually.

Based upon oral health screening and risk assessment, fluoride varnish applied twice per year is optimal for children at minimal and normal risk.

At the nurses discretion, more frequent application (as often as every 3 months) may be recommended for children at high risk such as those with no community water fluoridation and/or lack of available dental services.

### **Contraindications**

- Ulcerative gingivitis and stomatitis (trench mouth)
- Known allergies or reactions to colophony (Rosin- the sap or sticky substance that comes from pine and spruce trees. Found in cosmetics, adhesives, medicines, and chewing gum).
- Professional fluoride application within the past 3 months
- Low risk children who consume optimally fluoridated water or receive routine fluoride treatments through a dental office

### **REFERENCE**

Tenn. Code Ann. § 63-5-109

Hagan JF, Shaw JS, Duncan PM, eds. 2008 *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third edition. Elk Grove Village, IL: American Academy of Pediatrics.

American Academy of Pediatrics, Tennessee Chapter. Education, EPSDT and Coding-Oral Health. June 2015. [www.tnaap.org](http://www.tnaap.org)

Centers for Disease Control and Prevention. Division of Oral Health-Children's Oral Health. November 10, 2014. [www.cdc.gov/oralhealth](http://www.cdc.gov/oralhealth)

# EARLY, PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

## Background

The Early Periodic Screening, Diagnosis and Treatment (EPSDT)\* service is a comprehensive and preventive child health program for individuals under the age of 21.

What is an EPSDT?

- **Early** – Assessing a child’s health early in life so that potential diseases and disabilities can be identified or prevented in the early stages, when they can be most effectively treated;
- **Periodic** – Assessing a child’s health at periodic and age appropriate intervals to assure continued healthy development;
- **Screening** – Performing age appropriate tests and procedures to identify conditions requiring closer medical/mental health or dental attention;
- **Diagnosis** – Performing appropriate diagnostic tests when a risk is identified; and
- **Treatment** – Providing referral for treatment services needed to control, correct, or reduce identified physical and mental problems.

Federal law requires all under-21 aged Medicaid recipients, which includes TennCare recipients, to have access to these services. EPSDT is designed to improve primary health for children under age 21 with emphasis on preventive care.

The American Academy of Pediatrics (AAP) has developed a comprehensive set of health supervision guidelines to direct well child care at each EPSDT visit. These guidelines follow the Bright Future recommendations and are summarized in the AAP’s Periodicity Schedule. Public Health Nurse’s perform EPSDT following the periodicity schedule

## SUBJECTIVE

Parent and/or child presents to health department for EPSDT exam and/or other services and an EPSDT exam is offered

## OBJECTIVE

Child is eligible for EPSDT exam

## ASSESSMENT

Perform the 7 components of the EPSDT exam as outlined below.

The seven components of EPSDT exams are:

1. Comprehensive Health (Physical and Mental) and Developmental History
  - a) Initial and Interval History
  - b) Developmental/Behavioral Assessment  
(use current Dept of Health screening and scoring tools)

\*Follow these same guidelines for all child health wellness exams

2. Comprehensive Unclothed Physical Exam (RN or APN only)
3. Vision Screening
4. Hearing Screening
5. Laboratory
6. Immunizations
7. Health Education/Anticipatory Guidance

## **PLAN**

Discuss findings of exam with caregiver and/or child.

Refer all abnormal findings to the patient's PCP or dental home as appropriate.

For patients with TennCare, send the Primary Care Provider (PCP) letter with results of the patient exam.

## **REFERENCES**

Hagan JF, Shaw JS, Duncan PM, eds. 2008. *Bright Futures: Guidelines for Health supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics.

Asaro, A., MD. (2016). Pediatric Physical Assessment Training [PowerPoint Training presentation]. TN Department of Health.

## TUBERCULOSIS, CASE OR SUSPECT (INITIAL VISIT)

### SUBJECTIVE

Symptoms may include the following:

Cough >2 weeks	Chills
Hemoptysis	Night sweats
Chest pain	Weight loss
Fever	Fatigue
Referral from physician	

### OBJECTIVE

Productive cough	Respirations normal or labored
Thin, pale	Documented weight loss
HIV status	Jaundice, yellow eyes
Positive or negative tuberculin skin test (TST)	
Positive, negative or indeterminate IGRA (Indeterminate should be repeated)	
Positive or negative smear, cultures, or culture pending	
Abnormal chest X-ray	
Other diagnostic tests/results	

Baseline measurement from TB clinic to include CMP, CBC with platelets and differential, and HIV. (Routine laboratory monitoring for toxicity is generally not needed in individuals with normal baseline.)

Clinical information from other providers, hospital

### ASSESSMENT

Tuberculosis suspect (culture report not available)

Tuberculosis case (culture report or nucleic acid amplification test result is positive, indicate site of infection)

Latent Tuberculosis Infection (LTBI)

### PLAN

**Have patient wear surgical mask if symptomatic; nurse must wear n-95 mask**

#### Initial Nursing Assessment:

- Face to face contact will be made within 24 hours of notification of new infectious (sputum smear positive or cavitary on chest x-ray) TB suspect/case; this contact may be in the home, office, hospital, or other facility
- Explain contact investigation and begin identify contacts
- Face to face contact visit will be made within 3 working days of notification of a newly diagnosed case or suspect who is:

sputum smear negative,  
 culture pending or culture positive,  
 abnormal chest x-ray non-cavitary

- Records should be obtained within 24 hours of report of suspect

### **Conduct Home Assessment:**

If the initial visit is not a home visit, nurse should make a home visit to assess the home environment within 3 working days from notification; preferably the home visit should be made prior to patient's discharge from hospital, but no later than 24 hours after discharge from a hospital (see TB Guidelines)

Nurse must ensure that no immunosuppressed persons or children <4 years of age are in the home if an infectious patient is being discharged home

### **Provide Screening Evaluation:**

- Consider psychosocial, cultural background, and language/literacy level
- Provide interpreter services as needed
- Complete TB/LTBI Risk Assessment Tool (if not done previously) and evaluate history, including onset and duration of symptoms and signs for TB (as listed above) Evaluate for possible pregnancy, discuss birth control options. Advise female patients to avoid pregnancy while receiving TB treatment and to report any possibility of pregnancy to provider as soon as possible.
- Screen for any contraindications to anti-tuberculosis drugs (using PH 2040, Screening and Monitoring Forms)
- Observe patients and family's ability and availability of resources to cope, adherence to medications regimen, and compliance with follow-up
- If being treated by private physician, obtain record of physical exam, chest X-ray report, significant lab tests (sputum cultures, liver functions, and WBC) and medication orders
- Ascertain whether MD will follow or if Health Department to follow; if Health Department to follow, refer to TB Clinic
- Assure that a focused physical exam and chest X-ray have been performed by TB clinic MD/NP; if not done, refer back to TB clinic
- Begin contact investigation
- If patient is hospitalized, notify hospital of isolation discharge requirements
- If patient is discharged from hospital, obtain and send copy of all records (notes, lab, and radiology reports, physician orders, and medication sheets) to regional TB clinic

### **Obtain and Document the Following Information:**

Physician referral of suspect, case, or orders for anti-TB drugs

Known contacts

HIV status/other TB risk factors

PPD skin test history (including measurement) or previous IGRA test (including dates and results)

Previous history of –

- Tuberculosis disease
- TB infection (LTBI)
- Administration of anti-TB medications

Symptoms including –

- Date of first symptom
- Weakness, weight loss, anorexia
- “Flu-like” episode, chills, fever
- Productive cough, chest pain, blood in sputum
- Night sweats

Other health problems including –

- HIV or immunosuppression
- Diabetes mellitus
- Liver or kidney disease
- History of alcohol or drug abuse
- Current medications (including OTCs and herbal medicines)
- LMP
- Allergies
- Other evaluation by private MD, other providers, or health care facility
- Special patient needs

**Treatment:**

- Instruct on home isolation precautions until no longer infectious, or place patient on isolation if indicated
- Measure height, weight, and vital signs initially.
- Obtain weight and vital signs monthly

**Directly observed therapy (DOT) is the standard of care for all TB cases**

Issue anti-tuberculosis drugs as prescribed by TB clinic physician (only those medications approved by TB clinic MD may be issue)

If on ETHAMBUTOL perform visual acuity (Snellen chart) and Red/Green color discrimination monthly; if patient wears glasses, check vision with glasses and note this in record

If STREPTOMYCIN or an AMINOGLYCOSIDE (Capreomycin, Amikacin) is to be used, obtain BUN and creatinine; patient should be questioned at baseline and monthly about possible hearing loss or tinnitus, and monitor vestibular function using the Romberg at baseline and monthly

At treatment initiation, if not drawn in TB clinic, draw CMP, CBC with platelets and differential and HIV (if not known); all labs to be reviewed by the TB physician

Issue 3 sputum containers, dated and numbered (if pulmonary TB or to rule out pulmonary TB) with instructions for collecting in AM

Collect first sputum specimen in clinic in person by sputum induction using 3% sodium chloride.

Issue patient 2 prelabeled and dated cans for use the next 2 consecutive days for natural sputum

collection

Complete all required fields on lab requisition

DOT worker should pick up sputums at home on the day of collection for mailing to the lab from the local health department

### **Perform Contact Investigation (see TB Guidelines)**

- All high-risk contacts should be tested within 7 working days
- Completion of initial medical assessments of high-risk contacts should be completed within 10 working days of contact identification.
- Document all contact information on PH 1631, “TB Contact Record”

NOTE: IGRA test is preferred for baseline testing for contacts  $\geq 5$  years of age.

All contacts should receive an IGRA or TST if they have a documented negative PPD or IGRA history.

- All high-risk contacts (from all environments) that have a positive IGRA or Positive TST are to have a chest X-ray and evaluation by an MD or APN.
- Contacts that have an initial negative TST or IGRA but are at risk of progression to active TB (i.e., children < 4, immunosuppressed persons, pregnant women, dialysis patients, HIV+, etc.) are to have a chest X-ray and evaluation by an MD or APN as soon as possible.
- All contacts with an initial negative IGRA or TST should have a repeat IGRA or TST at 8-10 weeks after contact is broken (last exposure) with the suspect/case; only one IGRA or TST is needed if contact has been broken for more than 10 weeks when initially tested.

NOTE: Use consistent method of testing for evaluation of a contact

Example:

- if IGRA is drawn initially, then at 8-10 weeks, IGRA will be repeated
- if Tubersol PPD is placed initially, then at 8-10 weeks, a second PPD will be placed using Tubersol
- if Aplisol PPD is placed initially, then at 8-10 weeks, a second PPD will be placed using Aplisol
- Any contact that has an **indeterminate** IGRA is to be retested within 1-2 weeks.
- Consult with regional TB nurse/physician for preventative therapy on ALL children who are close contacts of infectious or potentially infectious cases of TB, regardless of skin test results.
- Document on contact record (PH 1631).
- When contact investigation is completed, send a copy of PH 1631 to Regional TB office.

### **Provide Follow-up**

- ✓ If patient is being followed by Health Department TB physician, schedule monthly return appointments to TB clinic.
- ✓ If patient is being followed by a private provider, schedule monthly visit with PHN to issue medication(s) and document any medication side effects.
- ✓ Obtain monthly office visit medical record notes from private provider prior to monthly PHN visit at health department.

**For patients with active TB:**

- Ensure DOT as ordered by physician until regimen is completed
- Assess for side effects each time DOT is given
- Weigh at every TB clinic visit
- Assess LMP at every TB clinic visit. If patient has missed menses, perform pregnancy test and notify TB clinician.
- Ensure baseline labs and sputum culture results are in chart
- Report any symptoms suggesting toxicity promptly to the treating physician and obtain appropriate lab specimens as ordered
- If on ETHAMBUTOL, perform monthly vision checks including visual acuity and color red/green discrimination
- If on STREPTOMYCIN or an AMINOGLYCOSIDE (Capreomycin, Amikacin), perform monthly Romberg and hearing evaluation (see TB Guidelines)
- Repeat liver testing if indicated (underlying liver disease, alcohol use symptoms) or as ordered by physician
- Issue sputum containers (set of 3) at least monthly but should be more frequently if patient is infectious; three sputum cultures must be obtained at one month and two months as ordered by physician (document reason if unable to obtain and notify Regional TB clinic), remind physician to order at 2 months if not done
- Sputum cultures must be done every month until patient has 3 consecutive negative cultures for 2 consecutive months
- When culture sent to outside labs, contact private provider or lab to ensure culture and sensitivity are ordered and that culture isolate is sent to state lab
- Send a copy of completed drug monitoring sheet to the regional TB clinic monthly
- Ensure TB clinic is aware of all culture and sensitivity results

**Provide Referral:**

- Current medication intolerance and/or adverse reactions
- Abnormal laboratory findings
- Pregnancy
- Non-adherence

**REFERENCES**

- CDC. Core curriculum on TB: What the Clinician Should Know, 5<sup>th</sup> Ed., 2011.
- CDC. [Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC](#) *MMWR* 2005; 54 (No. RR-15, 1-37)
- CDC. [Guidelines for Using the QuantiFERON–TB Gold Test for Detecting \*Mycobacterium tuberculosis\* Infection, United States](#) *MMWR* 2005; 54 (No. RR-15, 1-37)
- CDC. Mantoux Tuberculosis Skin Testing Facilitator Guide. <http://www.cdc.gov/tb/education/Mantoux/part2.htm>
- CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. *MMWR* 2000;49:1-51.
- CDC. [Updated Guidelines for Using Interferon Gamma Release Assays to Detect \*Mycobacterium tuberculosis\* Infection — United States, 2010](#) *MMWR* 2010; 59 (RR-5); 1-25
- Reichman LB, and Hershfield ES, eds. Tuberculosis: A Comprehensive International Approach, 2000; Vol. 144.
- Report of the Committee on Infectious Diseases*. Elk Grove Village, IL Tennessee Department of Health Tuberculosis Guidelines, 2004

## INACTIVATED SEASONAL INFLUENZA VACCINE (IIV)

### GENERAL INFORMATION

#### **General Recommendations for Seasonal Influenza Vaccination:**

Inactivated injectable influenza vaccine (IIV) is produced in 3 ways: in eggs (e.g., Fluzone® and others), in cell culture from seed strains grown in eggs (Flucelvax®) and recombinant influenza vaccine grown in culture without the use of eggs (RIV, FluBlok®). For the 2016-17 season, CDC does not recommend the use of live-attenuated influenza vaccine (LAIV) due to U.S. studies showing little to no effectiveness in the previous three seasons. IIV options may contain either three or four strains of influenza virus; the additional benefit of the fourth strain cannot be predicted. CDC expresses no preference for any influenza vaccine product for the 2016-17 season.

All 2016-2017 IIV options contain an unchanged A/California/7/2009 (H1N1)-like virus, a new A/Hong Kong/4801/2014 (H3N2)-like virus, and a B/Brisbane/60/2008-like (Victoria lineage) virus. Quadrivalent vaccines also contain a B/Phuket/3073/2013-like (Yamagata lineage) virus.

Children 6 months through 8 years who have had 2 or more total doses of trivalent or quadrivalent influenza vaccine as of July 1, 2016, only need one dose for 2016-17. The two previous doses do not need to have been given during the same season or consecutive seasons. **Previous doses of Flumist should be counted as valid doses.** Children 6 months through 8 years who have previously received 0-1 dose of seasonal influenza vaccine, or have an unknown history, need two doses of vaccine to be fully protected for the 2016-2017 season.

Begin vaccinating patients as soon as vaccine arrives for the season; delaying vaccination **is not** recommended.

#### **Centers for Disease Control and Prevention (CDC) recommendations:**

CDC recommends annual influenza vaccine for ALL persons without medical contraindications, aged 6 months or older. NEW 2016-17: Based on new published studies, the ACIP no longer considers egg allergy a precaution or contraindication to influenza vaccination with any vaccine, with the caveat that persons with a history of serious egg allergy (more than just hives) should be vaccinated in a health department or medical setting where someone is capable of responding to an allergic reaction and not in an off-site (e.g., school) clinic. Egg-allergic patients should be observed for 20 minutes, just like all other vaccine recipients, for signs of acute allergic reactions.

#### **Contraindications (should not receive influenza vaccine):**

- Children less than 6 months of age.
- History of severe allergic reaction to any component of the vaccine.

**Precautions:**

Persons with history of Guillain-Barré syndrome within 6 weeks of administration of a previous dose of influenza vaccine (refer for further evaluation, this is not a contraindication)

Persons having moderate to severe acute febrile illness (until illness resolves)

Persons with a severe egg allergy (any serious symptom other than hives only) should be vaccinated in the health department or other clinic setting under the supervision of a healthcare provider who is able to recognize and manage severe allergic conditions. Do not administer IIV to these patients in off-site (e.g., school/community) clinics.

**PLAN**

- Have recipient, parent, or guardian read Vaccine Information Statement (VIS)
- Counsel regarding benefits and side effects
- Administer vaccine injection according to manufacturer's recommendation
- Remind that seasonal influenza vaccine is recommended annually.
- Advise the parent or guardian of recipients less than 9 years of age to return for a second dose in 4 weeks if the child has not previously received at least 2 doses of injectable or Flumist seasonal influenza vaccine before July 1, 2016. Count previous doses of Flumist as valid doses.
- Advise to wait in clinic 20 minutes after injection
- Record manufacturer and lot number of the vaccine administered, date, name, address, and title of person administering vaccine
- Instruct patient to contact Health Department if adverse reaction occurs (complete appropriate VAERS form)

**Recommended Schedule and Dosage of Seasonal Inactivated Influenza Vaccine (IIV):**

Age Group	Influenza Vaccination Status	Dosage Schedule
Children 6 months through 35 months	Has <b>not</b> had at least 2 seasonal influenza vaccine doses before July 1, 2016 <b>or not sure</b>	2 doses (each dose 0.25 ml, IM) at least 4 weeks apart
	<b>Has had</b> 2 or more seasonal influenza vaccine doses before July 1, 2016	1 dose (0.25 ml, IM for Fluzone®)
Children 36 months through 8 years	Has <b>not</b> had at least 2 seasonal influenza vaccine doses before July 1, 2016, <b>or not sure</b>	2 doses (each dose 0.5 ml, IM) at least 4 weeks apart
	<b>Has had</b> 2 or more seasonal influenza vaccine doses before July 1, 2016	1 dose (0.5 ml, IM)
All others 9 years and up	Not relevant	1 dose (0.5 ml, IM)

**REFERENCES**

Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices, United States, 2016–17 Influenza Season. <http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf> Last accessed August 25, 2016.

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