

**PRIMARY CARE SERVICES GUIDELINES
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PRIMARY CARE SERVICES GUIDELINES

I. Overview

A. Expansion of Primary Care in the Tennessee Department of Health (TDOH)

- As of 7-1-05, the Tennessee General Assembly authorized the Tennessee Department of Health to initiate a statewide expansion of primary care services to uninsured Tennesseans.
- Prior to the expansion of primary care, there were 18 counties providing primary care.
- As of January 2007, 48 counties and 54 sites were open for primary care services.
- With the expansion of primary care, 240 new positions were created statewide. These included RN's, NP's, MD's, Nurse Assistants, Office Assistants, & Pharmacy Technicians.

B. Definition of Primary Care in the TDOH

- Primary Care in the TDOH includes outpatient management of non-critical acute episodic illness, chronic illness, and preventive health care.
- Target Service Group –
 - Age 19 through 64, uninsured.
 - Patients with Medicare Part A only (hospital coverage only) – see page 2, Section II.D. (Not including age 65+ who are eligible for Medicare Part B).
 - Patients with commercial insurance who are uninsured for specified conditions.
- Some regions serve as primary care providers (PCP's) for the TennCare population and they will follow TennCare guidelines for care provided.
- Some health departments serve as Federally Qualified Health Centers (FQHC's) and they will follow federal mandates for patients served.

C. Definition of Primary Care Services for Reporting Purposes in TDOH

- For purposes of Data Monitoring through CUBES, primary care is defined as all services provided to a patient which include at least one service provided by an Advanced Practice Nurse (APN) or MD in primary care sites.
- See Appendix A for map of Rural Health Department Primary Care sites.

D. Integration of Primary Care and Public Health

- Traditional public health services may also be offered to patients who receive primary care services, if applicable. In some clinics, those services may be provided by the primary care provider. In other clinics, patients are referred to a different provider for traditional public health services.
- Traditional public health services will continue to follow their respective program guidelines.
- Traditional public health services may include the following:
 - EPSDT
 - Family Planning
 - Communicable Disease
 - Maternal and Child Health
 - Children's Special Services
 - Breast and Cervical Cancer Screening
 - WIC

II. Administration

A. Fees

- Primary Care Services for private pay adults will incur a minimum office visit fee of \$5 (sliding scale does not apply). The minimum fee does not apply to recheck visits (code 3734).
- Procedure(s) and/or supplies are charged according to the PTBMIS fee assigned to the CPT code (sliding scale does apply).
- Drugs dispensed will incur a \$2 fee (sliding scale does apply).
- See Appendix A for the original minimum fee directive.

B. Medical Record

- The primary care medical record will be consistent across the state for primary care sites.
- See Appendix A for Primary Care Medical Record Standards.

C. Scheduling Guidelines

- Open Access – MD/NP schedule has all appointment slots as same day call-ins or walk-ins. (Use is optional)
- Modified Open Access – MD/NP schedule has specified appointment slots as same day call-ins or walk-ins. Other appointments may be made a month ahead or several months ahead (this varies according to the clinic site). (Use is optional)
- Follow-up Appointments - A follow-up system must be in place for primary care patients with chronic conditions (ie: patient tracking or statement stating that follow-up appointment is made at end of patient visit, etc.).

D. Medicare Patients

- Medicare Part A covers patients for hospitalization only. For all other health care services, they are considered to be uninsured. They are without insurance for acute, chronic, or preventive health care. It is doubtful that you would have a large number of this type patient in your health departments. However, if such a patient presents to the health department requesting primary care services, it is acceptable for them to be seen.
- Patients who have Medicare Part B or Part C must see a Medicare provider.

E. Uninsured Conditions

- Patients with commercial insurance who are uninsured for specified conditions may present to the Health Department clinic. It is doubtful that you would have a large number of this type patient in your health departments. However, if such a patient presents to the health department requesting primary care services, it is acceptable for them to be seen.

F. Appointment Cards

- Appointment Cards may be used at the discretion of the region.
- Following is an example of an appointment card ordered through Property and Procurement in a business card format. The State Seal may need to be shifted to the left and the other information shifted up to provide more space. Information is to be limited to nine lines. The Business Card Standard mentions the use of only seven (7) lines (1.b), but that did not take into consideration e-mail, cell phones, and pagers. If there is a special reason to use more than nine lines, submit to the Publications Committee.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
NAME OF REGION
NAME OF COUNTY HEALTH DEPARTMENT

Address
Address
Address

Phone:
Fax

Appointment For: _____
Date: _____ Time: _____

G. Patient Education Information

- A publication authorization number is not needed for the purchase of pre-printed brochures that are used “as is” with no modifications. These types of brochures also do not require Forms and Publications Committee Review. This also applies to online information obtained from an approved website. (Approved websites are determined by the State Primary Care Director – see Appendix A.)

H. Cell Phones

- Cell Phones may be purchased for the primary care nurse practitioners and physicians in each region. These phones are not for personal use.
- Each cell phone must be assigned to one individual person/region.
- To order more phones, a letter is required from the regional director to the Commissioner of Health. This letter should go to the Fiscal Office in the Bureau of Health Services. Please include a list of persons to whom the cell phones will be assigned, their RACF#, and their office contact information.
- If you need to reassign the phones, please notify the Fiscal Office in the Bureau of Health Services. Please include a list of persons to whom the cell phones will be assigned, their RACF#, and their office contact information.
- Fiscal staff in Bureau of Health Services will process cell phone bills.
- Please refer to the Department of Health Cellular Phone Policies and Procedures Manual and to the Department of Health Information Technology Policy entitled, Communication Devices Usage Policy. (For additional information, see Appendix A)

III. Personnel

- Orientation – All new staff should have an orientation that includes all aspects of public health. (See Public Health Nursing Orientation & Practice Manual.)
- Sample Job Plans (See Appendix B)
- Continuing Education – Offer CEU/CME when possible. (including local, regional, and state events/meetings)
- CME/Educational Resources/Publications Guide (See Appendix B)

- Bureau of Health Services Organizational Chart (See Appendix B)

IV. Operations

A. Supply/Equipment List

- Clinic supply/equipment needs will vary according to the expertise of the MD/NP and according to the population served.
- A suggested list of supplies and equipment that may be needed to set up a primary care clinic may be found in Appendix C.

B. Pharmacy

- Refills of up to 12 months are at the discretion of MD/NP. If insured patient, refills must meet insurance guidelines.
- Computer generated prescriptions are an option in primary care sites.
- Primary care clinicians are encouraged to use a judicious approach to controlled substance prescribing as directed by their respective regional medical director.
- Health Department pharmacies and clinics cannot mail prescriptions to patients under current Tennessee law and licensing by the Board of Pharmacy.
- Health Department pharmacies and clinics have no DEA license and cannot dispense controlled substances. This includes sample medications.
- Testosterone is a controlled substance prescribed in the HIV program. Patients may bring their vial into the health department for staff to administer, but the vial may not be stored onsite.
- The Drug Maintenance and Dispensing Policy (including sample medication requirements) is found in Bureau Policy 8.3 (See Appendix C).
- Tennessee State Law pertaining to prescriptions (See Appendix C for TCA, Sections 63-6-236, 63-7-123, and 63-7-126.)
- Medications listed on the Primary Care Formulary are available through each regional pharmacy for use in each primary care site (See Appendix C).
- Title X medications may only be dispensed to Title X patients (Family Planning). See Regional Pharmacist or Maternal Child Health Director for current listing.
- Pharmacy assistance programs may be used as needed.
- **Adult Immunizations Guidance:**
 - Effective May 26, 2006, physicians and nurse practitioners in health department clinics are authorized to order for their adult patients (aged 19 and older) vaccines recommended for them by the Centers for Disease Control and Prevention (CDC). This policy applies to adult patients being seen by a physician or nurse practitioner; it does not alter conditions for administration of vaccines by public health nursing protocols.
 - Effective July 8, 2009, additional federal funds have been made available to purchase vaccines for adults. Some of the funds are one-time only and will end in late 2010. Please refer to this memo in Appendix C.
 - According to the May 26, 2006 directive, vaccines are approved under either of the following conditions:
 1. The vaccine is recommended for the patient according to the current Recommended Adult Immunization Schedule published by the CDC (www.cdc.gov/nip/recs/adult-schedule.htm). The Tennessee Immunization Program will distribute the schedule

and CDC recommendations for any new adult vaccines published between the annual updates of the schedule.

2. The vaccine for the adult patient is required by state law for school entry (e.g., MMR).
- Patients requesting vaccines for the following reasons should continue to be referred to outside providers, unless contractual arrangements exist to provide these services at the health department:
 1. Vaccines recommended for international travel purposes only.
 2. Hepatitis B vaccines recommended for the patient only because of his/her occupation.
 3. Vaccines recommended or required by an institution that are not recommended for the patient according to the CDC or required by state law for school entry.
 - **Funding and Charges:**

The state immunization program will continue to provide federally-funded tetanus-containing vaccines for children and adults, and hepatitis B vaccine administered to the sexual and household contacts of mothers enrolled in the Perinatal Hepatitis B Program. Other funds must be used to purchase all non-tetanus-containing vaccines for routine use in adults aged 19 years and older. Also please see Appendix C for Memo dated July 8, 2009 – Federally Funded Vaccines for Adults.
 - **Purchasing Procedures:**

Non-tetanus-containing vaccines may be purchased directly by the pharmacists or procurement staff through the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) through Cardinal Health; patients will be charged for these vaccines on a sliding scale (exception below). Please call Cardinal Health Specialty Pharmaceutical Distribution at 866-677-4844 to purchase contracted vaccines that are available through MMCAP. Their operating hours are M-F 7am - 6pm, Central Time. In an emergency after hour's situation, call the same phone number and you will be directed on how to page the on-call representative.
 - **EXCEPTIONS TO THE ABOVE:**
 - **Influenza:** Directives concerning influenza vaccine charges will be distributed separately each year.
 - Please see Appendix C for Memo dated July 8, 2009 – Federally Funded Vaccines for Adults
 - **Guidance to Providers:** Questions on the CDC/ACIP adult immunization recommendations may be directed to the Tennessee Immunization Program (615-741-7247).
 - **Contract and Purchasing Guidance:** If pharmacist or procurement staff has questions on the contract and purchasing, please contact State Pharmacist (615-253-2311)

C. Labwork

- MD/NP providers will order labwork as appropriate based on current standards of care. Non-contracted labwork may require prior approval by regional primary care director.
- Each clinic must develop a procedure for timely review and tracking of lab results.
- The sliding fee scale will be applied to lab costs.
- Optional Use:

- Commonly ordered labs may be compiled into a quick reference “encounter form”. (See Appendix C for an example)

D. Diagnostics

- MD/NP providers will order/recommend diagnostics as appropriate based on current standards of care.
- Each clinic must develop a procedure for timely review and tracking of diagnostic test results.
- Limited diagnostic tests are available in the health department clinics and the sliding fee scale will apply. Patient is financially responsible for diagnostic tests done outside the health department.

E. After Hours Call

- Each region will have a procedure in place for after hours telephone call coverage.

V. Practice

A. Protocol

- **The approved Advanced Practice Nurse Protocol for Primary Care Services is the textbook Ferri’s Clinical Advisor, by Fred F. Ferri.** Each primary care site should have the current copy of this textbook available in the clinic (no older than two years). Obsolete protocol textbooks should be removed from the clinic area (ideally, they should be discarded). Obsolete protocol textbooks are kept in the Central Office indefinitely. The Physicians and APN’s will review and sign the protocol signature sheet on an annual basis. (See Appendix D for an example of a protocol signature sheet.)
- Additional required medical resources for each primary care clinic are as follows:
 - Contraceptive Technology – current version
 - PDR – current year OR current Epocrates (must update Epocrates regularly)
 - ICD-9 coding book – current year
 - CPT coding book – current year
 - PTBMIS Coding Manual – current version
 - USPSTF Guide to Preventive Health Services
 - Epidemiology and Prevention of Vaccine-Preventable Diseases – current version
 - CDC-STD Treatment Guidelines – current version
 - A current reference book for Laboratory Tests & Diagnostic Procedures
 - Red Book Report of the Committee on Infectious Diseases
 - Program Specific Manuals/Guidelines – most current versions
 - Primary Care Services Guidelines
 - Public Health Nursing Orientation and Practice Manual
 - PHN Protocol
 - Lab Services
 - Infection Control
 - Quality Management
 - TB Guidelines
 - STD Guidelines
 - Family Planning Clinical Guidelines and Prenatal Services Guidelines
 - Tennessee Breast and Cervical Screening Program Manual
 - Children’s Special Services Guidelines (CSS)
 - Child Health Manual
 - WIC Manual
 - Other pertinent manuals
- Additional recommended medical resources are as follows:

- Clinical Guidelines in Family Practice, by Uphold and Graham
- WHO Medical Eligibility Criteria for Contraceptive Methods
- Sanford Guide to Antimicrobial Therapy
- Nelson's Textbook of Pediatrics
- Harriett Lane
- Disabled License Plate Application:
 - Per Amended TCA Title 38, Chapter 8 and Title 55, Chapter 21, Certified Nurse Practitioners and physician assistants may certify statements of disability or deafness for an individual's application for an appropriate registration, license plate, placard, or decal from the Department of Revenue (as long as the tasks are expressly included in the written protocol developed jointly by the supervising physician and the nurse practitioner or physician assistant).
 - The Tennessee Department of Health Primary Care Protocol allows for Certified Nurse Practitioners and Physician Assistants to certify statements of disability or deafness as indicated above.

B. Documentation

- See Public Health Nursing Orientation & Practice Manual for description of SOAP format (Section II-7, Documentation).
- All patient care office visit notes will follow the SOAP format as outlined below.
 - Subjective
 - Objective
 - Assessment
 - Plan
- Medication Documentation
 - See Tennessee State Law Pertaining to Prescriptions (Appendix C – Pharmacy)
 - All medication orders must be documented on the progress note AND/OR on the Problem List/Medication Summary (PH 3567)

C. Coding

- Program codes are explained in the PTBMIS Coding Manual.
- Patients aged 19 and 20 years who receive primary care services should be coded as CH on Encounter Sheet.
- Office Visits and Procedure Codes are explained in both the PTBMIS Coding Manual and the current CPT Code Book.
- Diagnosis codes are detailed in both the current ICD-9 Book and the PTBMIS Coding Manual.
- See www.AAFP.org for AAFP Short and Long list of ICD-9 codes.

D. Advance Directives

- Advance Directives are required for individuals 18 years and older who are assigned by an MCO to the health department to receive primary care.
- Advance Directives are recommended but optional for uninsured primary care patients.
- A signed Advance Directive form should be filed in the patient chart in the Administration Section.
- Forms are available online at <http://health.state.tn.us/boards/advancedirectives/index.htm>, go to the Department of Health, link to featured topics, select Advance Directives and print copies as needed. (Also available in Spanish. See Appendix D for an example of an Advance Directive form.)

E. Reference Manuals

- Primary Care Providers should review the following manuals:
 - Primary Care Services Guideline
 - PHN Protocol
 - Public Health Nursing Orientation and Practice Manual
 - Lab Services
 - Infection Control
 - Epidemiology and Prevention of Vaccine-Preventable Diseases
 - PTBMIS Codes
 - Quality Management
 - HSA Policy and Procedure
 - TB Guidelines
 - STD Guidelines
 - Family Planning Clinical Guidelines and Prenatal Services Guidelines
 - Tennessee Breast and Cervical Screening Program Manual
 - Regional Policies and Procedures
 - CSS Guidelines
 - Child Health Manual
 - WIC Manual
 - Other pertinent manuals

F. Patient Dismissal

- Primary care patients may be dismissed from primary care services at the discretion of the regional health officer. They should be notified via certified letter and they should be given a 30 day notice.

VI. Rules and Regulations

A. Licensure and Credentialing

- RN/APN/MD license is current.
- NP Certificate of Fitness and NP Certification are current.
- NPI number. (Application available online at <https://nppes.cms.hhs.gov> or by calling 1-800-465-3203.)
- MD/APN DEA number is current.
- Please see Public Health Nursing Orientation & Practice Manual, Appendix B, Practice, P.B-1-185 for Rules and Regulations regarding Nurse Practitioners, Physician Preceptors, Prescription Writing, Clinical Supervision, Certification, and Practice.

B. Chart Review/Peer Review

- Each region is encouraged to develop a method for peer review of both APN's and MD's.

SECTION VII

APPENDICES

APPENDIX A

ADMINISTRATION

- **Minimum Fee**
- **Primary Care Site Map**
- **Medical Record Standards**
- **Tennessee Department of Health Cell Phone Policies and Procedure Manual**
- **Tennessee Department of Health Information Technology Policy**
- **Patient Education Website Listing**

Minimum Fee

ORIGINAL MINIMUM FEE DIRECTIVE

Memorandum

Date: September 26, 2005

To: Regional Clerical Consultants
Regional System Administrators

From: Pat Honigman, HSA

Subject: Minimum Fee for Primary Care visits
Effective October 1, 2005

Recently the Regional Directors made the decision to begin charging a minimum fee of \$5.00 per visit for Primary Care services (visits coded to program codes WH or MH) provided to **Private Pay Adults**. This \$5.00 minimum will be in addition to the charges for any drugs or supplies dispensed during the visit. The necessary PTBMIS changes will be in place to enable this minimum fee to be implemented beginning October 1, 2005.

The minimum fee for Primary Care will work like this:

Adults: For **private pay adults receiving Primary Care services**, the services would be coded to Program code WH (Women’s Health) or MH (Men’s Health), Payor 6, and would slide as far as appropriate, based on income and family size. When the visit is complete, the encounter would be entered in PTMIS and updated. The system will calculate the charges and apply the appropriate sliding scale. At this point, prior to finalizing the encounter, the check out clerk will enter the command MINF WH (for women) or MINF MH (for men) in the command line of the encounter screen, and press “enter”. The system will then calculate the difference between what the patient owes for services received (based on sliding scale) and the \$5.00 minimum fee. The difference (if any) would be added to the charges, making the total due for the visit at least \$5.00. If the patient’s charges, after sliding scale is applied, are already more than the minimum fee, the clerk will get the message “Patient has met minimum”; at this point they can go ahead and finalize the encounter. The cost of any drugs dispensed during the visit (shown on the Pay 6 screen in addition to the charges from the encounter for the visit itself), would slide according to income, as usual.

Examples:

	Pt. 0% pay	Pt. 25% pay	Pt. 50% pay	Pt. 100% pay
Charges for Visit, Procedures & Labs	\$10.00	\$10.00	\$10.00	\$10.00
Pt. Charge after slide	0	\$2.50	\$5.00	\$10.00
Minimum fee applied	<u>\$5.00</u>	<u>\$2.50</u>	<u>0</u>	<u>0</u>
Total for visit	\$5.00	\$5.00	\$5.00	\$10.00
\$4 Drugs disp.w/slide	<u>0</u>	<u>\$1.00</u>	<u>\$2.00</u>	<u>\$4.00</u>

Primary Care Services Guidelines
May 18, 2010

Total patient charges	\$5.00	\$6.00	\$7.00	\$14.00
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Children: For Private Pay children receiving Primary Care services (applicable to existing primary care sites), the services would be coded to Program Code CH (Child Health) and would slide based on family income as usual. No minimum fee would be applied. The cost of any drugs dispensed would be in addition to the charges for the visit, as usual.

Other Programs/Payers: The MINF command would only be used when entering encounters for **Adult Private Pay patients receiving Primary Care services**. Services related to other programs, such as Family Planning, STD, TB, etc. would continue to be coded to those program codes and would continue to slide just as they do now. No minimum fee would apply.

The minimum fee will only apply to Private Pay patients. If the patient has insurance coverage, the third party payor will continue to be coded on the encounter and billed for the services received, as usual, even if the services received are Primary Care services.

The minimum fee for Adult Private Pay Dental services will continue to be \$10.00. There will be no change in the way this works. The MINF DN command will continue to apply the \$10.00 minimum fee for these services and the Dental procedure codes ending in "A" should continue to be coded on encounters for adult private pay patients receiving dental services.

Please share this information with the appropriate staff in your region, in preparation for implementation of the Primary Care Minimum Fee on October 1. I will be happy to try to answer any questions you may have about this process.

Primary Care Site Map

Primary Care Medical Record Standards

PRIMARY CARE MEDICAL RECORD STANDARDS

Tennessee Department of Health

Standard #1: Consistency

The primary care medical record will be consistent across the state for primary care sites. The use of the primary care medical record in non-primary care sites is a regional decision and regional standards variations must be documented for Quality Management Review.

Standard #2: Order

The primary care medical record will be organized in chronological order under each divider. Chronological order refers to filing the oldest note on bottom and most recent note on top.

Beginning on the date these standards go into effect in the region, when a patient with an existing record visits the health department for services, record dividers indicating “Old Record” will be placed on top of each side of the record. From that visit forward, the record will be formatted as specified in this document with all documentation being placed above the “Old Record” dividers. Prior to placing the “Old Record” dividers, active Immunization Clinic Record forms, WIC, or growth charts should be pulled from the chart and placed in the appropriate section of the newly formatted record. Other pertinent information may be brought forward and placed in the appropriate section of the newly formatted record.

Standard #3: Forms Revisions/Additions

Any additional primary care forms and/or revisions to existing forms must be approved by the following:

1. Regional Primary Care Director
2. State Primary Care Director
3. State medical record forms committee (if this committee is in existence)
4. State Forms/Publications Committee for approval and for PH#.

Any forms to be piloted must have written approval from the Medical Director of Clinical Services and Disease Management.

Standard #4: TennCare MCO Regions Only

When the health department is notified that a new patient has been assigned for gatekeeper/primary care provider (PCP) services, the health department will complete a short registration screen in the computer and specify that the tracking system generate a welcome letter to the patient explaining the preventive services that TennCare covers and encouraging them to make an appointment before they get sick. If the patient has not made an appointment within 30 days from the date of first tracking letter, another appointment tracking letter is sent. Information concerning the 1-800 number for after hours care will be included in this letter.

PRIMARY CARE MEDICAL RECORD STANDARDS

Standard #5:

Approved forms are:

Adult/Adolescent Physical Examination (PH#3564)
Anticoagulation Checklist (PH#3917) (optional)
Consent for Procedure (PH#3914) and Consent for Procedure Spanish Version (PH#3914S)
Diabetes Care Checklist (PH#3915) (optional)
Growth Charts (as appropriate) (PH#1539, 1540, 1541, and 1542)
Health Questionnaire (PH#3566) and Health Questionnaire Spanish Version (PH#3566S)
Immunization Clinic Record (PH#3570)
Problem List / Medication Summary form (PH#3567)
Progress Note (PH#3564 for Adults, PH#3565 for Child Health, and PH#1746/1726c progress notes)
STD medical record form, PH#1592 (optional form)
TB drug screen and monitor form, PH#2040 (optional form)
Well Child Visit (PH#3565) (used by TennCare Primary Care Providers)

Standard #6:

Dividers to be used are:

Administration
Consults
Diagnostics
History
Old Record
Progress Notes
WIC

Optional Dividers to be used are:

Dental
Care Coordination
CDC
Family Planning (those regions currently using)
Prenatal

Standard #7: Approved Primary Care Medical Record forms, chart dividers, and order of the chart are as follows:

○ LEFT SIDE OF THE RECORD

1. Problem List and Medication Summary, PH#3567 (filed on top of dividers)
2. Diabetes Checklist, PH#3915 (optional form, filed under Problem List)
3. Anticoagulation Checklist, PH#3917 (optional form, filed under Problem List)
4. **DIAGNOSTICS DIVIDER**
Reports filed in chronological order.

PRIMARY CARE MEDICAL RECORD STANDARDS

5. CONSULTS DIVIDER

Examples: Copies of reports received from other providers
Copies of old records from other providers
Copies of prescriptions from other providers
Etc.

6. ADMINISTRATION DIVIDER

Examples: Consents
Referral requests
Income information
Release of information
Advance directives

Note: The particular order in which information in the administrative section of the record is filed is not mandated by the state standard, but should be established by Regional policy.

7. OLD RECORD DIVIDER

o RIGHT SIDE OF THE RECORD

1. Immunization Clinic Record, PH#3570, (filed on top of dividers)
2. Growth Chart, PH#1539-1542 (filed under Immunization Clinic Record)

3. PROGRESS NOTES DIVIDER

- TB drug screen and monitor form, PH#2040 (optional form)
- STD medical record form, PH#1592 (optional form)
- Adolescent/adult physical examination form, PH #3564
- Well child visit form, PH#3565
- Progress note form, PH#1746 or #1726c
- See Comments Section.

4. HISTORY DIVIDER

- Progress note sheet for history updates, PH #1746/1726c
- Health Questionnaire form, PH #3566

5. WIC DIVIDER

6. OPTIONAL DIVIDERS:

- DENTAL
- CARE COORDINATION
- PRENATAL
- CDC
 - o If CDC divider is used, STD form PH#1592 and TB Form PH#2040 filed here.
- Family Planning (those regions currently using)
- See Comments Section.

7. OLD RECORD DIVIDER

PRIMARY CARE MEDICAL RECORD STANDARDS

COMMENTS

- 1) **Health Questionnaire:** Health Department services requiring the Health Questionnaire include physical exams, family planning services, chronic care, and acute care, including STD and TB treatment. If the only service(s) a patient receives are immunization-only visits and/or TB skin tests-only, the Health Questionnaire is not required. At the provider's discretion, the questionnaire may be used for patients in for other visits, such as pregnancy tests. One form will be used regardless of age or sex of patient and regardless of which program the patient is accessing. This form will be filed behind the History divider.
- 2) **Progress Notes:** Visits will be documented in SOAP format in chronological order in the "Progress Note" Section of the record. Forms used may be PH#3564 for Adults, PH#3565 for Child Health, and PH#1746/1726c progress notes.
- 3) **TB and STD forms:** If the TB and STD forms are being used, these will be in chronological order on top of the progress notes unless the CDC divider is used.
- 4) **Follow-up or Urgent care visits:** Follow-up or Urgent care visits will be documented in SOAP format on the progress note (PH#1746/1726c) or physical exam forms PH#3564 for Adults, or PH#3565 for Child Health.
- 5) **FP dividers** are not currently on state contract. These will need to be ordered locally at this time. You are encouraged to incorporate family planning documentation into the progress notes section instead of having a separate section. However if your region is currently using the FP Divider, you may continue to do so.

Standard #8: Following this page are examples of the approved forms and instructions for each, with the exception of the forms listed below:

WIC Child's Record – PH#3542
Progress Notes – PH1746/1726C
Growth Charts – PH1539-PH1542

(These accepted forms are not available electronically at this time.)



ADOLESCENT/ADULT PHYSICAL EXAMINATION (11 years and older)

Interpretation (if applicable) provided by:							PCP:		
CHIEF COMPLAINT:							LMP:		
VITAL SIGNS:		Ht.	Wt.	BMI	Temp	Pulse	Resp	BP	
ROS (APN / MD only)	N	AB	Comments:		Medical History Reviewed <input type="checkbox"/>	Immunizations Assessed <input type="checkbox"/>			
1. General									
2. Eyes									
3. ENT/mouth									
4. Resp									
5. CV									
6. GI									
7. GU									
8. Musculoskeletal									
9. Skin									
10. Breast									
11. Neurologic									
12. Endocrine									
13. Blood/lymph									
14. Immunologic									
15. Psych									
CURRENT MEDICATIONS			PHYSICAL EXAM	N	AB	Comments:			
<input type="checkbox"/> See Medication Form (PH 3567)			1. General			Nutritional Assessment:			
			2. Skin						
			3. Head						
			4. Eyes R _____ L _____ Both _____						
			5. Ears R ____ L ____ (Hearing: P = pass; F = Fail)						
RISK ASSESSMENT	At Risk	Not At Risk	6. Nose						
Cholesterol			7. Mouth/Throat						
Tuberculosis			8. Neck/Thyroid						
Dev. Screen			9. Breast						
IN HOUSE TESTS	Neg	Pos	10. Lungs						
Urine pregnancy			11. Back						
Stool Hemocult			12. Heart						
Rapid Strep			13. Circulatory						
Urine Dipstick			14. Abdomen						
			15. External Genitalia						
			16. Internal Genitalia						
Glucose			17. Rectal						
			18. Neurological						
Hemoglobin			19. Musculoskeletal						
			20. Extremities						
<input type="checkbox"/> Liquid Based Pap <input type="checkbox"/> Conventional Pap <input type="checkbox"/> GC/Chlamydia <input type="checkbox"/> Saline Prep prn <input type="checkbox"/> KOH Prep prn									
Wet Prep results:									

Tennessee Department of Health
Adolescent/Adult Physical Examination, PH 3564
Instructions for Completion (Rev. June 2009)

PURPOSE: This record will be used to document any physical exam when completed for individuals 11 years and older, family planning exams, and to document extensive office visits at providers' discretion. Examples include: EPSDT, school physicals, primary care problem visits, other physicals, etc.

EXPLANATION AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner; if not available the name and chart number should be printed in this area.

Interpretation: Document use of an interpreter and name.

Primary Care Provider: Document name of medical provider assigned by MCO or who provides most of the medical care.

Chief Complaint: Document the reason for visit, including patient complaints.

LMP: Document beginning date of last normal menses.

Vital Signs: Obtain appropriate measures for age/condition/program guidelines and document results.

ROS: The provider completing the physical exam will do a review of systems as appropriate for type of exam (complete physical or assessment of specific symptoms/condition) and document by checking appropriate boxes (N or AB). Note abnormal findings in the adjoining comment section (each finding should correspond to the number listed beside each system).

Medical History Reviewed/Immunizations Assessed: Placing a check mark in the box indicates that assessment was completed.

Current Medications: Document any prescription or over the counter medications. Document method of contraception. Include vitamins and other supplements/herbals. Instead of listing chronic medications here, provider may check the box "See Medication Form (PH3567) and document medications there.

Physical Exam: Must be an unclothed physical exam for EPSDT. Eyes sensory exam must be documented as R (right), L (left), and Both. Ears sensory exam must be documented as "hearing" R (right) and L (left).

Document normal or abnormal physical findings by checking the appropriate boxes (N or AB). Note abnormal findings in the adjoining comment section (each finding should correspond to the number listed beside each system).

Indicate if Pap, GC/Chlamydia, and Wet Prep tests were done by placing a check mark in the appropriate box .

Document findings of wet prep, if done.

Nutritional Assessment: WIC and/or EPSDT Requirement. Document review of food intake (a 24 hour diet recall is not required) and indicate if adequate or not.

Risk Assessment: Required for EPSDT. Assess risk factors according to periodicity schedule (cholesterol, tuberculosis, developmental screening) and counsel according to protocol. (PHN and/or APN Protocol) Placing a check mark in the box indicates that assessment was completed. Indicate positive or negative for each risk assessment by checking appropriate box (At Risk or Not At Risk). Risk factors identified will be reflected in Assessment and Plan.

In House Tests (lab work): Complete as appropriate for age, risk factors, and condition. Document results as indicated on this form and/or PTBMIS and/or by initialing and dating lab slip.

Back of Page:

Socialization and Education/Anticipatory Guidance: Required for EPSDT Exam. Document the areas discussed.

Continuation: Use to continue documentation from any other section on the form.

Assessment: Document a concise statement of findings. For EPSDT, include findings from the physical and developmental assessment.

Plan: Document plan of action based on assessment, referrals, timeframe and reason for return visits. Check appropriate boxes for referral, including Letter to PCP box. (required for EPSDT).

Counseling and Education: Per PHN Protocol only. A check mark placed in the counseling/education according to protocol box will indicate that patient has received counseling appropriate for problems indicated in Assessment and Plan

Signature/Title and Date: The professional who completes this exam should sign name and title (first initial and last name). This signature indicates that all the information pertaining to this visit has been reviewed. Document the date the exam was done.

OFFICE MECHANICS AND FILING: The completed form should be permanently attached in the medical record according to medical record organization guidelines. It should be updated as appropriate.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a).

Tennessee Department of Health
Anticoagulation Flowsheet PH# 3917
Instructions for Completion

PURPOSE:

This form will be used to track medication dosages and labwork for primary care health department patients who are on anticoagulation therapy. Labwork to monitor on this form will be the International Normalized Ratio (INR). Medication to monitor on this form will be Coumadin (warfarin).

EXPLANATION AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner; if not available the name and chart number should be printed in this area.

Indication for anticoagulation: Place a checkmark in the box beside the diagnosis requiring anticoagulation.

Target INR: place a checkmark in the box beside the target range for INR for this patient.

Start date: Document the date the patient started Coumadin/warfarin.

Therapy Duration: Document the length of time patient is expected to be on Coumadin/warfarin.

Date: Record the date when documenting INR and Coumadin/warfarin dosage.

Current Dose: Record the Coumadin/warfarin dosage the patient is taking when INR is done.

INR: Record the INR results.

Complications: Record any complications the patient is having with Coumadin/warfarin.

New Dose: Record the prescribed dosage of Coumadin/warfarin after reviewing the INR results.

Next INR: Record the date or timeframe for the next INR to be obtained.

Initial: The health care professional should initial to indicate who is completing the flowsheet.

USED BY: Health Care Providers / Health Department Staff

OFFICE MECHANICS AND FILING: The form should be permanently attached in the medical record according to medical record organization guidelines and updated as appropriate.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a).



CONSENT FOR PROCEDURE

Name of Procedure: _____

I, _____, patient or legal guardian for _____, (patient) consent to allow _____ to perform the above procedure. I have been informed about my condition and the recommended diagnostic, medical or surgical procedure that is named above has been explained to me. I understand that there can be complications such as, but not limited to the following:

I am aware that in the practice of medicine, unexpected complications or other risks may occur. I also understand that during the course of the proposed procedure, unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

I understand that there are alternatives to the procedure, such as the following:

I understand that, having read this form and talked with the health care provider, my signature below acknowledges that I voluntarily give my authorization and consent to performance of the procedure.

Patient (or person authorized to sign for patient)

Date

Witness

Date

Etiqueta



DEPARTAMENTO DE SALUD DE TENNESSEE
Oficina de Servicios de Salud

CONSENTIMIENTO PARA UN PROCEDIMIENTO

Nombre del procedimiento: _____

Yo, _____, paciente o tutor legal de
_____, (paciente) doy mi
consentimiento para permitir que _____
me practique el procedimiento arriba mencionado. Me han informado sobre mi afección
y me han dado una explicación del procedimiento diagnóstico, médico o quirúrgico
recomendado, arriba mencionado. Comprendo que puede haber complicaciones, tales
como las que se dan a continuación, pero sin limitarse a ellas:

Reconozco que en la práctica de la medicina ocurren complicaciones inesperadas u otros
riesgos. Comprendo también que durante el transcurso del procedimiento propuesto,
pueden surgir condiciones inesperadas requiriendo la realización de procedimientos
adicionales, y doy mi autorización para que se realicen dichos procedimientos.
Reconozco, además, que no se me han dado garantías ni promesas acerca de los
resultados de procedimiento o tratamiento alguno.

Comprendo que existen alternativas al procedimiento, a saber:

Comprendo que, después de leer este documento y hablar con el proveedor de servicios
médicos, mi firma más abajo da constancia de mi autorización y consentimiento
voluntario a que me hagan el procedimiento.

Paciente (o persona autorizada a firmar por el paciente)

Fecha:

Testigo
PH3914S

Fecha:

Tennessee Department of Health
Consent for Procedure –PH3914
Instructions for Completion

PURPOSE:

This form will be used for documentation of informed consent for procedures performed in the health department clinic for which there is not otherwise a specific approved consent form. For example, this form could be used when there is burning, freezing, or cutting of skin and/or when there is shedding of more than a trace of blood.

EXPLANATION AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner; if not available the name and chart number should be printed in this area.

Date: The date should be recorded when the patient gives informed consent to perform the procedure.

Informed Consent: Informed consent must include the following elements:

- Explanation of the nature of the procedure
- Risks/benefits of the procedure (including possible complications)
- Alternatives to the procedure and their risks/benefits

USED BY: Health Care Providers / Health Department Staff

OFFICE MECHANICS AND FILING: The form should be permanently attached in the medical record according to medical record organization guidelines and updated as appropriate.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a).

Label



TENNESSEE DEPARTMENT OF HEALTH
Bureau of Health Services

DIABETES CARE CHECKLIST

ENCOUNTER DATE							
BLOOD PRESSURE < 130/80							
WT or BMI (BMI Goal < 30)							
SMOKING CESSATION							
ASPIRIN DAILY							
ACE INHIBITOR OR ARB							
QUARTERLY							
HgbA1C < 7%							
REVIEW PT'S GLUCOSE LOG							
SELF MANAGEMENT GOALS							
VISUAL FOOT INSPECTION							
ANNUAL							
CHOLESTEROL (Goal < 200)							
TRIGLYCERIDES (Goal < 150)							
LDL (Goal < 100 mg/dl)							
HDL (Goal > 40)							
URINE MICROALBUMIN/CREAT. RATIO							
SERUM CREATININE							
GFR (calculated)							
FOOT EXAM W/MONOFILAMENT							
DILATED EYE EXAM REFERRAL							
DENTAL EXAM REFERRAL							
INFLUENZA VACCINE							
PERIODIC							
PNEUMONIA VACCINE							
TETANUS VACCINE							
TB SCREENING							
EKG							
PERIODIC EDUCATION							
PATIENT EDUCATION-ON SITE							
DIABETES EDUCATION/REFERRAL							
NUTRITION MANAGEMENT							
PHYSICAL ACTIVITY/WEIGHT MGT.							
SELF-GLUCOSE MONITORING							
MEDICATION (oral agents/insulin)							
COMPLICATIONS							
MENTAL HEALTH (assess/refer prn)							
PROVIDER INITIALS							

√=DONE OR ADDRESSED
LEAVE BLANK IF NOT DONE OR ADDRESSED.

PH3915 Rev. 07/09

Tennessee Department of Health
Diabetes Care Checklist PH-3915
Instructions for Completion

PURPOSE:

This record will be used to track diabetes care for those patients who present to the Health Department for primary care with a diagnosis of Diabetes.

EXPLANATION AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner; if not available the name and chart number should be printed in this area.

Date: The date should be recorded when any procedure on the checklist has been completed or addressed. Documentation of actual values in the checklist is optional (Values may be documented in the office visit note).

Documentation:

Education provided could be a hand-out and/or verbal.

√= Done or Addressed – checkmark indicates that this procedure was either done at this visit or addressed in some way. Details will be documented in the office visit note.

Leaving the box blank indicates this was not done or addressed at this visit.

Initial: The provider should initial at the bottom of the column to indicate who is completing/reviewing the checklist.

Blank areas: These areas may be used to document other information to be tracked.

USED BY: Health Care Providers / Health Department Staff

OFFICE MECHANICS AND FILING: The form should be permanently attached in the medical record according to medical record organization guidelines and updated as appropriate.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a).

Rev September 22, 2006

HEALTH QUESTIONNAIRE



*Patient
Label*

TENNESSEE DEPARTMENT OF HEALTH

Bureau of Health Services

Person Completing form: Patient Other _____ (specify relationship to client)

GENERAL HEALTH/SAFETY QUESTIONS ABOUT PATIENT (Please answer all that apply)

Primary language of family members/guardian:		<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced
				Highest Grade Completed: _____
<input type="checkbox"/> Public Water Supply	<input type="checkbox"/> Other Water Supply	<input type="checkbox"/> Guns in the home	<input type="checkbox"/> Physical/Sexual abuse	
<input type="checkbox"/> Wear seat belt/car seat	<input type="checkbox"/> Smoke detectors in home	<input type="checkbox"/> Regular Exercise	<input type="checkbox"/> Your mother took hormones (DES) while pregnant with you	

TOBACCO USE	SUBSTANCE USE	VACCINE HISTORY
<input type="checkbox"/> Smoke Cigarettes	<input type="checkbox"/> Alcohol	Last Tetanus: _____
How many a day: _____	How much, how often _____	Flu Vaccine: _____
<input type="checkbox"/> Past Smoker		Pneumo Vac: _____
Date stopped: _____		MMR: _____
How frequently: _____	<input type="checkbox"/> Drugs	Hepatitis B _____
Date stopped: _____	(Street/IV) _____	
<input type="checkbox"/> Chew/Dip		
<input type="checkbox"/> Past Chew/Dip		
<input type="checkbox"/> Exposure to 2 nd hand smoke		
Where (car, house) _____		

ADVANCE DIRECTIVES FOR HEALTH CARE (AGE 18 AND ABOVE ONLY)

Have you finalized any advance health directives? (examples—living will, durable power of attorney, organ donation, “do not resuscitate” instructions)

YES NO If not, would you like information? YES NO Information Given YES NO

FAMILY MEDICAL HISTORY OF PATIENT (Please check appropriate box of family member for all that apply)

ARE YOU ADOPTED? YES NO UNKNOWN

	ARE YOU ADOPTED?						ARE YOU ADOPTED?				
	Father	Mother	Father's Parents	Mother's Parents	Brother Sister		Father	Mother	Father's Parents	Mother's Parents	Brother Sister
Anemia						Kidney Disease					
Cancer (specify type)						Glaucoma					
Diabetes						Bleeding Disorder					
Heart Disease/Attack						Sickle Cell Trait					
High Cholesterol						Mental Illness					
Stroke						Epilepsy/Seizures					
High Blood Pressure						Birth Defects					
Lung Disease						Other					

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<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sexual Transmitted Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney/Bladder Disease	<input type="checkbox"/> Sickle Cell Disease/Trait
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Liver Disease/Hepatitis	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Birth Defect	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Lung Disease/Tuberculosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Fainting	<input type="checkbox"/> Measles	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Thyroid Disease/Goiter
<input type="checkbox"/> Bowel/Stomach Problems	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mumps	<input type="checkbox"/> Vision Problems:
		<input type="checkbox"/> Physical Activity Limitations	<input type="checkbox"/> Wears Glasses or Contacts
<input type="checkbox"/> Other (list):			

SURGERIES	DATE	HOSPITALIZATIONS/INJURIES	DATE

FOR CHILDREN UNDER 6 YEARS OF AGE ONLY				
Birth Weight	Birth Length	<input type="checkbox"/> Vaginal Birth	<input type="checkbox"/> C-Section	<input type="checkbox"/> Premature Birth (less than 36 weeks)
<input type="checkbox"/> Pregnancy Complications:			<input type="checkbox"/> Delivery Complications:	
<input type="checkbox"/> Mother's Number of Prenatal Visits:		<input type="checkbox"/> Hospital Newborn Metabolic Screening		<input type="checkbox"/> Hospital Newborn Hearing Screening
Hospital of Birth:			Length of Hospital Stay:	
Attends Day Care (Name):				

Initial History reviewed with the client by:

STAFF SIGNATURE/TITLE _____ DATE _____

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FOR FAMILY PLANNING PATIENTS (* APPLIES TO BOTH MALE/FEMALE)

Reproductive Health Questions	Answer	Reproductive Health Questions	Answer
Age at time of first period		*Have you had problems with any methods?	
Do you have a period every month?		How many times have you been pregnant?	
Average number of days menstrual bleeding		How many pregnancies resulted in a live birth?	
Is your bleeding heavy, medium, or light?		How many pregnancies ended in miscarriage?	
Do you have cramps with your period?		How many pregnancies ended in stillbirth?	
What medicine do you take for cramps?		How many pregnancies ended in abortion?	
*Have you ever had sex?		How many cesarean births have you had?	
*How old were you the first time you had sex?		Did you have any problems during a pregnancy?	
*How many sex partners have you had?		When was your last delivery?	
*How many sex partners have you had in the past 6 months?		Did you have a check up after your last delivery?	
*Does your sex partner use IV street drugs?		Are you breastfeeding?	
*Does your sex partner have sex with other women?		What was the birth weight of your smallest baby?	
*Does your sex partner have sex with men?		What was the birth weight of your largest baby?	
*Has your sex partner ever been in prison?		*Have you ever had an STD?	
*Has your partner(s) ever had an STD?		*Have you ever been diagnosed with HIV/AIDS?	
*Has your partner(s) ever had HIV?		*Have you ever had an AIDS test?	
*Have you ever experienced sexual or physical abuse?		When was your last Pap smear done?	
When, if ever, would you like to be pregnant?		Was your last Pap smear normal?	
*How many children would you like to have?		Have you ever had an abnormal Pap smear?	
*How do you prevent pregnancy now?		If you've had an abnormal Pap, when was that?	
*What method of birth control do you want today?			
*What other methods of birth control have you tried?			

Initial History reviewed with the client by: _____ DATE _____
 STAFF SIGNATURE/TITLE _____

DO NOT WRITE BELOW THIS LINE - FOR STAFF USE ONLY

At top of column, put date of counseling. Then sign your initials across from the topic under the date column. Ideally, cover no more than 3-4 topics per visit. Cover different required topics each visit until all required topics and other topics are reviewed. Repeat only as needed.

Family Planning Required Topics	Date:	Date:	Date:	Date:	Date:	Date:
Family involvement/Teens/1 st visit						
Sexual coercion/Teens/1 st visit						
Health dept. services & clinic routine						
Why test or screen?						
Tests and exam results						
All FP methods/abstinence/ECPs						
Informed consent/details of method						
24-Hour Emergency Care						
ABC of HIV Prevent. & HIV testing						
STDs & STD prevention						
Breast (♀)/Testicular (♂) self-exam						
Referral counseling done as needed						
Other Topics						
Nutrition/weight/folic acid/calcium						
High risk sexual & lifestyle behaviors						
ETOH, drugs, smoking cessation						
Domestic violence/personal safety						
Reproductive health plan/spacing						
♂ & ♀ anatomy and physiology						
Immunizations/Td every 10 years						
Pregnancy test results w/ counseling						
Bicycle, car/seatbelt & firearm safety						

PH 3566 Rev 04/10

CUESTIONARIO DE SALUD



Patient

Label

DEPARTAMENTO DE SALUD DE TENNESSEE
Oficina de Servicios de Salud

Persona que completa el formulario: Paciente Otra _____ (especificar la relación con el cliente)

PREGUNTAS GENERALES SOBRE LA SALUD Y SEGURIDAD DEL PACIENTE (Marque todo lo que corresponda)		
Idioma principal de los miembros de la familia o del tutor:		<input type="checkbox"/> Inglés <input type="checkbox"/> Español <input type="checkbox"/> Otro (especificar):
<input type="checkbox"/> Soltero <input type="checkbox"/> Casado <input type="checkbox"/> Viudo <input type="checkbox"/> Separado <input type="checkbox"/> Divorciado	Nivel de educación más alto completado:	
<input type="checkbox"/> Suministro público de agua <input type="checkbox"/> Otro suministro de agua	<input type="checkbox"/> Armas en casa	<input type="checkbox"/> Maltrato físico o abuso sexual
<input type="checkbox"/> Uso de asiento y cinturón de seguridad en el auto	<input type="checkbox"/> Detectores de humo en casa	<input type="checkbox"/> Ejercicio regular <input type="checkbox"/> Su madre tomó hormonas (DES) cuando estaba embarazada de usted
CONSUMO DE TABACO <input type="checkbox"/> Fuma cigarrillos Cuántos al día: _____ <input type="checkbox"/> Fumó en el pasado Fecha en que dejó de hacerlo: _____ <input type="checkbox"/> Masca o chupa Frecuencia: _____ <input type="checkbox"/> Mascó o chupó en el pasado Fecha en que dejó de hacerlo: _____ <input type="checkbox"/> Fumador pasivo Lugar (auto, casa) _____	CONSUMO DE SUSTANCIAS <input type="checkbox"/> Alcohol Cantidad y frecuencia _____ <input type="checkbox"/> Drogas (IV u otras) Cantidad y frecuencia _____	ANTECEDENTES DE VACUNACIÓN Última antitetánica: _____ Antigripal: _____ Antineumocócica: _____ SPR (triple vírica): _____ Hepatitis B: _____
VOLUNTADES ANTICIPADAS DE ATENCIÓN MÉDICA (SOLO MAYORES DE 18 AÑOS)		
¿Completó algún documento de voluntades anticipadas? (por ejemplo: testamento vital, poder notarial duradero, donación de órganos, instrucciones de "no reanimar")		
<input type="checkbox"/> Sí <input type="checkbox"/> NO Si la respuesta es no, ¿desea información? <input type="checkbox"/> Sí <input type="checkbox"/> NO Información proporcionada <input type="checkbox"/> Sí <input type="checkbox"/> NO		

ANTECEDENTES MÉDICOS DE LA FAMILIA DEL PACIENTE (Marque el cuadro del familiar para todo lo que corresponda)											
¿ES USTED ADOPTADO? <input type="checkbox"/> SÍ <input type="checkbox"/> NO <input type="checkbox"/> NO LO SABE											
	Padre	Madre	Abuelos paternos	Abuelos maternos	Hermano /hermana		Padre	Madre	Abuelos paternos	Abuelos maternos	Hermano /hermana
Anemia						Enfermedad renal					
Cáncer (especificar tipo)						Glaucoma					
Diabetes						Trastorno hemorrágico					
Cardiopatía o ataque cardíaco						Rasgo drepanocítico					
Colesterol alto						Enfermedad mental					
Derrame cerebral						Epilepsia o convulsiones					
Alta presión sanguínea						Anomalías congénitas					
Enfermedad pulmonar						Otro					

PH#3566S MODIF. 04/10

ANTECEDENTES MÉDICOS DEL PACIENTE (Marque todo lo que corresponda)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Varicela | <input type="checkbox"/> Colesterol alto | <input type="checkbox"/> Problemas sexuales |
| <input type="checkbox"/> Ansiedad | <input type="checkbox"/> Depresión | <input type="checkbox"/> VIH/SIDA | <input type="checkbox"/> Enfermedad de transmisión sexual |
| <input type="checkbox"/> Artritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Enfermedad renal o de vejiga | <input type="checkbox"/> Anemia o rasgo drepanocítico |
| <input type="checkbox"/> Asma | <input type="checkbox"/> Trastorno de la alimentación | <input type="checkbox"/> Enfermedad hepática o hepatitis | <input type="checkbox"/> Enfermedad de la piel |
| <input type="checkbox"/> Anomalía congénita | <input type="checkbox"/> Epilepsia o convulsiones | <input type="checkbox"/> Enfermedad pulmonar o tuberculosis | <input type="checkbox"/> Derrame cerebral |
| <input type="checkbox"/> Trastorno sanguíneo | <input type="checkbox"/> Desmayos | <input type="checkbox"/> Sarampión | <input type="checkbox"/> Pensamientos suicidas |
| <input type="checkbox"/> Coágulo sanguíneo | <input type="checkbox"/> Enfermedad de vesícula biliar | <input type="checkbox"/> Problemas de salud mental | <input type="checkbox"/> Enfermedad tiroidea o bocio |
| <input type="checkbox"/> Problemas estomacales o intestinales | <input type="checkbox"/> Problema auditivo | <input type="checkbox"/> Migraña | <input type="checkbox"/> Úlceras |
| <input type="checkbox"/> Enfermedad del seno | <input type="checkbox"/> Cardiopatía o ataque cardíaco | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venas varicosas |
| <input type="checkbox"/> Cáncer | <input type="checkbox"/> Alta presión sanguínea | <input type="checkbox"/> Paperas | <input type="checkbox"/> Problemas de la vista: |
| | | <input type="checkbox"/> Limitaciones de actividad física | <input type="checkbox"/> Usa anteojos o lentes de contacto |

Otro (especificar):

CIRUGÍAS	FECHA	HOSPITALIZACIONES O LESIONES	FECHA

SOLO PARA MENORES DE 6 AÑOS

Peso al nacer	Tamaño al nacer	<input type="checkbox"/> Parto vaginal	<input type="checkbox"/> Cesárea	<input type="checkbox"/> Parto prematuro (menos de 36 semanas)
<input type="checkbox"/> Complicaciones del embarazo:		<input type="checkbox"/> Complicaciones del parto:		
<input type="checkbox"/> Número de visitas prenatales de la madre:		<input type="checkbox"/> Examen metabólico del recién nacido en hospital	<input type="checkbox"/> Examen auditivo del recién nacido en hospital	
Hospital de nacimiento:			Duración de la estancia en el hospital:	
Asiste a cuidados de guardería (nombre):				

Initial History reviewed with the client by:
STAFF SIGNATURE/TITLE _____ **DATE** _____

PARA LOS PACIENTES DE PLANIFICACIÓN FAMILIAR (*SE APLICA A HOMBRES Y MUJERES)

Preguntas sobre salud reproductiva	Respuesta	Preguntas sobre salud reproductiva	Respuesta
Edad en la primera menstruación		*¿Ha tenido problemas con algún método?	
¿Tiene una menstruación cada mes?		¿Cuántas veces ha estado embarazada?	
Días en promedio que dura la menstruación		¿En cuántos embarazos el bebé nació vivo?	
¿Tiene menstruaciones abundantes, medias o leves?		¿Cuántos embarazos terminaron en aborto espontáneo?	
¿Tiene cólicos con la menstruación?		¿En cuántos embarazos el bebé nació muerto?	
¿Qué medicamento toma para los cólicos?		¿Cuántos embarazos terminaron en aborto provocado?	
*¿Ha tenido alguna vez una relación sexual?		¿Cuántos partos por cesárea ha tenido?	
*¿A qué edad tuvo su primera relación sexual?		¿Ha tenido problemas durante algún embarazo?	
*¿Cuántas parejas sexuales ha tenido?		¿Cuándo fue su último parto?	
*¿Cuántas parejas sexuales ha tenido en los últimos 6 meses?		¿Se hizo una revisión después de su último parto?	
*¿Consume su pareja drogas por vía intravenosa?		¿Está usted lactando?	
*Su pareja sexual, ¿tiene relaciones sexuales con otras mujeres?		¿Cuál fue el peso al nacer de su bebé más pequeño?	
*Su pareja sexual, ¿tiene relaciones sexuales con hombres?		¿Cuál fue el peso al nacer de su bebé más grande?	
*¿Ha estado su pareja sexual alguna vez en prisión?		*¿Ha tenido alguna vez una ETS?	
*Su pareja o parejas, ¿han tenido alguna vez una ETS?		*¿Le han diagnosticado alguna vez VIH o SIDA?	
*Su pareja o parejas, ¿han tenido alguna vez VIH?		*¿Alguna vez le han hecho la prueba del SIDA?	
*¿Alguna vez ha sido usted víctima de maltrato físico o abuso sexual?		¿Cuándo le hicieron su última prueba de Papanicolau?	
¿Cuándo le gustaría embarazarse, si lo desea?		¿Fue normal el resultado de su última prueba de Papanicolau?	
*¿Cuántos hijos le gustaría tener?		¿Alguna vez ha tenido un resultado anormal en su prueba de Papanicolau?	
*¿Cómo evita actualmente el embarazo?		¿Cuándo tuvo un resultado anormal en su prueba de Papanicolau?	
*¿Qué método anticonceptivo desea ahora?			
*¿Qué otros métodos anticonceptivos ha usado?			

Initial History reviewed with the client by:

STAFF SIGNATURE/TITLE _____ DATE _____

NO ESCRIBA DEBAJO DE ESTA LÍNEA: PARA USO DEL PERSONAL ÚNICAMENTE

At top of column, put date of counseling. Then sign your initials across from the topic under the date column. Ideally, cover no more than 3-4 topics per visit. Cover different required topics each visit until all required topics and other topics are reviewed. Repeat only as needed.

Family Planning Required Topics	Date:	Date:	Date:	Date:	Date:	Date:
Family involvement/Teens/1 st visit						
Sexual coercion/Teens/1 st visit						
Health dept. services & clinic routine						
Why test or screen?						
Tests and exam results						
All FP methods/abstinence/ECPs						
Informed consent/details of method						
24-Hour Emergency Care						
ABC of HIV Prevent. & HIV testing						
STDs & STD prevention						
Breast (♀)/Testicular (♂) self-exam						
Referral counseling done as needed						
Other Topics						
Nutrition/weight/folic acid/calcium						
High risk sexual & lifestyle behaviors						
ETOH, drugs, smoking cessation						
Domestic violence/personal safety						
Reproductive health plan/spacing						
♂ & ♀ anatomy and physiology						
Immunizations/Td every 10 years						
Pregnancy test results w/ counseling						
Bicycle, car/seatbelt & firearm safety						

HEALTH QUESTIONNAIRE, PH 3566

Instructions for Completion (Rev. 3/19/10)

PURPOSE: This form may be used by all patients being seen in the health department for whom a health questionnaire is required, including Family Planning, Primary Care, Communicable Disease, etc. It is mandatory for Primary Care Services. This form is to be used to gather information from the patient or parent regarding general health, family medical history, past medical history, decisions about advance directives, and to document Family Planning counseling. This form is to be completed by the patient/parent. Health Care provider must review any risk factors or medical problems indicated on the form and provide appropriate counseling. If there is any indication that the patient/parent is unable to complete the form, staff will provide assistance. The health care provider must review, sign and date the form.

EXPLANATIONS AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner; if not available, the name and chart number should be printed in this area.

General Health/Safety Questions about Patient: Review this section, place checks in appropriate boxes, and complete all blank areas. Areas of special importance to document include primary language of family members and vaccine history/update.

Advance Directives for Health Care: This is only required for individuals 18 years and older who are assigned by an MCO to the Health Department to receive primary care.

Family Medical History of Patient: Review this section and place checks in appropriate boxes.

Medical History of Patient: Review this section, place checks in appropriate boxes, and complete any blank areas.

For Children Under Six Years of Age: Review this section, place checks in appropriate boxes, and complete all blank areas. Areas of special importance to document include Hospital Newborn Metabolic Screening and Hospital Newborn Hearing Screening.

For Family Planning Patients: Review this section and complete all blank areas for females/all pertinent blank areas for males. This section is required for Family Planning patients and is optional for all other patients.

Staff Use Only section: This section is for staff use only and should be used to document topics covered pertaining to Family Planning. At top of "date" column, write date of counseling, then sign initials across from the topic under the "date" column. Ideally, cover no more than 3-4 topics per visit. Cover different required topics each visit until all required topics and other topics are reviewed. Repeat only as needed. This section is required for Family Planning patients and is optional for all other patients.

Provider Signature/Title and Date: Signature (first initial and last name) and title indicates that the questionnaire was reviewed and appropriate health education provided. Document date the history was reviewed.

History Comments & Updates: Use to document updates or changes in history on subsequent visits. Each entry should be dated with signature and title of professional obtaining the information. History should be reviewed and updated at least annually.

USED BY: Patient and Health Care Provider

OFFICE MECHANICS AND FILING: This form should be permanently attached in the medical record according to medical record organization guidelines.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a).



TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

CHILD IMMUNIZATION CLINIC RECORD

PATIENT ID:

HEALTH DEPARTMENT ADDRESS:

Medical Alert

Allergies: _____

Other: _____

VACCINE	#	Age	Vac/VIS/ ISS Given	Inject. Site	Mftr.	Lot #	VIS/ISS Rev. Date
<input type="checkbox"/> DTaP <input type="checkbox"/> DTaP/HBV/IPV <input type="checkbox"/> DT <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
	4						
	5						
<input type="checkbox"/> IPV <input type="checkbox"/> OPV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
	4						
<input type="checkbox"/> Hib <input type="checkbox"/> Hib/HBV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
	4						
<input type="checkbox"/> Hep B <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
<input type="checkbox"/> Hep A <input type="checkbox"/>	1						
	2						
<input type="checkbox"/> Pneumococcal Conjugate <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
<input type="checkbox"/> Varicella <input type="checkbox"/>	1						
	2						
<input type="checkbox"/> MMR <input type="checkbox"/>	1						
	2						
<input type="checkbox"/> Menomune <input type="checkbox"/> Menactra	1						
<input type="checkbox"/> Influenza <input type="checkbox"/>							
<input type="checkbox"/> Other <input type="checkbox"/>							

TB Skin Test: (initial indicates TB skin test read according to PHN protocol)

Test	Given	Initial	Read	Results	Initial	Test	Given	Initial	Read	Results	Initial
PPD						PPD					

Provider's Signature: (signature indicates immunization/PPD given according to PHN protocol)

SIGNATURE	Date	SIGNATURE	Date	SIGNATURE	Date	SIGNATURE	Date



TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

ADULT IMMUNIZATION CLINIC RECORD

PATIENT ID:

HEALTH DEPARTMENT ADDRESS:

Medical Alert

Allergies: _____

Other: _____

VACCINE	#	Age	Vacc./VIS/ ISS Given	Inject. Site	Mftr.	Lot #	VIS/ISS Rev. Date
<input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
	4						
<input type="checkbox"/> MMR <input type="checkbox"/>	1						
	2						
<input type="checkbox"/> Hep B <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
<input type="checkbox"/> Hep A <input type="checkbox"/>	1						
	2						
<input type="checkbox"/> Menomune <input type="checkbox"/> Menactra	1						
<input type="checkbox"/> Pneumococcal <input type="checkbox"/> <input type="checkbox"/>	1						
	2						
	3						
<input type="checkbox"/> Influenza <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
<input type="checkbox"/> Other <input type="checkbox"/>							

TB Skin Test: (initial indicates TB skin test read according to PHN protocol)

Test	Given	Initial	Read	Results	Initial	Test	Given	Initial	Read	Results	Initial
PPD						PPD					
PPD						PPD					

Provider's Signature: (signature indicates immunization/PPD given according to PHN protocol)

SIGNATURE	Date	SIGNATURE	Date	SIGNATURE	Date	SIGNATURE	Date

Patient ID:

Tennessee Department of Health

Problem List and Medication Summary, PH 3567

Instructions for Completion (Rev. 03/07)

PURPOSE/INSTRUCTIONS: This form is to be used to record allergies, chronic or recurrent problems/diagnosis, and long term medications both prescription and over the counter. It may also be used to document special diet information.

Relevant new information must be added to this form at each and every patient visit by the individual that provides any primary care service.

Every primary care medical record will have a completed Problem List and Medication Summary by the end of the patient's second visit.

EXPLANATION AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner, if not available the name and chart number should be printed in this area.

Date: The date should indicate when the chronic problem was diagnosed if known.

Problem: Document disease or condition.

ICD-9 Code: Document ICD-9 code.

Onset and Resolved: Record dates if applicable.

Medications/Diet Dates: List date when medication was started and date discontinued when applicable. Refill information may also be documented (optional). Dates regarding diets may also be documented (optional).

USED BY: Health Care Providers.

OFFICE MECHANICS AND FILING: This form should be permanently attached in the medical record according to medical record organization guidelines.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a).

AGE	SOCIALIZATION	EDUCATION/ANTICIPATORY GUIDANCE	ADDITIONAL COMMENTS/DOCUMENTATION
1-6 Mo.	<input type="checkbox"/> Mobiles	<input type="checkbox"/> Car Seat	
	<input type="checkbox"/> Talking/music	<input type="checkbox"/> Falling	
	<input type="checkbox"/> Eye contact	<input type="checkbox"/> Temp. taking	
	<input type="checkbox"/> Rattles, soft toys, mirrors	<input type="checkbox"/> Bath Safety	
	<input type="checkbox"/> Encourage vocalization	<input type="checkbox"/> Childproof home	
	<input type="checkbox"/> Baby at table for meals	<input type="checkbox"/> Teething, gum, tooth care	
	<input type="checkbox"/> Toys easy to grasp	<input type="checkbox"/> Fire safety	
7-15 Mo.	<input type="checkbox"/> Reward desired behavior	<input type="checkbox"/> Stranger	
	<input type="checkbox"/> Peek-a-boo/patty cake	<input type="checkbox"/> First dental visits (6 mo -1 yr.)	
	<input type="checkbox"/> Parent away, child's anxiety	<input type="checkbox"/> Burn safety	
	<input type="checkbox"/> Body parts	<input type="checkbox"/> Outdoors hazards	
	<input type="checkbox"/> Use of cup and spoon	<input type="checkbox"/> Pet safety	
	<input type="checkbox"/> Encourage security object	<input type="checkbox"/> Choking foods	
	<input type="checkbox"/> Encourage speech	<input type="checkbox"/> Childproof Mother's purse/home	
	<input type="checkbox"/> Reading, songs	<input type="checkbox"/> Climbing	
		<input type="checkbox"/> Toddler car seat	
		<input type="checkbox"/> Poisons, Ipecac	
18 Mo.-3 yr.	<input type="checkbox"/> Reading, songs, pictures	<input type="checkbox"/> Tooth care	
	<input type="checkbox"/> Encourage exploring	<input type="checkbox"/> Day care	
	<input type="checkbox"/> Experiences away from home	<input type="checkbox"/> Accidents	
	<input type="checkbox"/> Toilet training	<input type="checkbox"/> Tooth brushing	
	<input type="checkbox"/> Negativism	<input type="checkbox"/> Sleep/bath patterns	
	<input type="checkbox"/> Give simple choices	<input type="checkbox"/> Saying "no"	
	<input type="checkbox"/> Consistent discipline	<input type="checkbox"/> Encourage active play	
	<input type="checkbox"/> Parent's needs	<input type="checkbox"/> Day care	
	<input type="checkbox"/> Encourage recall, recent events	<input type="checkbox"/> Stranger	
	4-6 Yr.	<input type="checkbox"/> Riding toys	<input type="checkbox"/> Stranger
<input type="checkbox"/> Simple chores		<input type="checkbox"/> Seat belts	
<input type="checkbox"/> Recognize coins, colors		<input type="checkbox"/> Answer/ help by phone	
<input type="checkbox"/> Scissors, coloring		<input type="checkbox"/> Teach name, address, phone number	
<input type="checkbox"/> Self hygiene		<input type="checkbox"/> Secure matches, weapons	
<input type="checkbox"/> Shoe tying		<input type="checkbox"/> Teach to avoid assault	
<input type="checkbox"/> Negotiation skills		<input type="checkbox"/> Encourage active play	
<input type="checkbox"/> Games with rules		<input type="checkbox"/> Safe outdoor play areas	
<input type="checkbox"/> Toilet trained		<input type="checkbox"/> Street crossing	
<input type="checkbox"/> Respect for authority		<input type="checkbox"/> Bike, water safety	
<input type="checkbox"/> School readiness			
<input type="checkbox"/> Avoid blaming, guilt			
7-10 Yr.		<input type="checkbox"/> Telling time	<input type="checkbox"/> Bike safety
	<input type="checkbox"/> Simple errands	<input type="checkbox"/> Water safety	
	<input type="checkbox"/> Practice complex directions	<input type="checkbox"/> Stranger	
	<input type="checkbox"/> Homework	<input type="checkbox"/> Street/ assault safety	
	<input type="checkbox"/> Promote self esteem	<input type="checkbox"/> Alternative responsible adult	
	<input type="checkbox"/> Encourage peer interaction	<input type="checkbox"/> Limit TV	
	<input type="checkbox"/> Encourage special interests	<input type="checkbox"/> Cardiovascular exercise	
	<input type="checkbox"/> Age appropriate limits	<input type="checkbox"/> Prepare for puberty	
	<input type="checkbox"/> Age appropriate responsibilities	<input type="checkbox"/> Hair, skin care	
	<input type="checkbox"/> Allow / cope with mood swings	<input type="checkbox"/> Substance abuse	
	<input type="checkbox"/> Allow privacy	<input type="checkbox"/> Car safety	

Counseling and education provided in accordance with PHN protocols

Signature/Title: _____ Date: _____

PURPOSE: This record is to be used to document a physical exam when completed for a child from birth through 10 years of age. The only exception will be if the service provided is a family planning exam, in which case the adult physical form, PH 3564 will be used.

EXPLANATION AND DEFINITIONS:

Label: A computer generated patient label should be placed in the upper left-hand corner; if not available the name and chart number should be printed in this area.

Subjective: Document the reason for visit, including patient complaints (provider signature not required). The professional completing the physical exam will do a review of systems and document in the subjective area.

Primary Care Physician: Document name of medical provider assigned by MCO/or who provides most of the medical care.

Interpreter: Document use of an interpreter.

Allergies: List all allergies circled or written “in Red” including medications and others such as mold, grass, etc. If no drug allergies, document no known drug allergies (NKDA).

Current Medication: Document any prescription and over the counter medications that are taken on a regular basis.

Measures (vital signs): Obtain as appropriate for age and document results.

Tests (lab work): Complete as appropriate for age and risk factors and document. Results may be documented using PTBMIS or by initialing and dating lab slip.

Risk Assessment: Risk Factors will be assessed (cholesterol, lead poisoning, tuberculosis, developmental screening) and counseling provided according to PHN protocol. Placing a check mark in the box indicates that assessment was completed. Indicate positive or negative for each risk assessment by checking appropriate box (Y or N). Risk Factors identified will be reflected in Assessment & Plan.

Unclothed Physical Exam: Document normal or abnormal physical findings by checking the appropriate boxes (N or AB). Note abnormal findings in the comment section (indicating number of abnormal physical finding).

Nutritional assessment: Document review of child’s food intake (a 24 hour diet recall is not required) indicating adequate or inadequate for age.

Assessment: Document a concise statement of findings including physical and developmental assessment.

Plan: Document a plan of action based on assessment, referrals, timeframe, and reason for return visits. Check appropriate boxes for referral, including Letter to PCP box.

Socialization and Education/Anticipatory Guidance: Document the areas discussed and/or observed.

Continuation area: Use to document any additional information or comments regarding the visit.

Counseling and Education: A check mark placed in the counseling/education according to protocol box will indicate that patient has received counseling appropriate for problems indicated in Assessment and Plan.

Signature/Title and Date: The professional who completes this exam should sign name and title (first initial and last name). This signature indicates that all the information pertaining to this visit has been reviewed. Document the date the exam is done.

USED BY: Health Care Providers

OFFICE MECHANICS AND FILING: The completed visit record should be permanently attached in the medical record in chronological order according to medical record organization guidelines.

RETENTION TIME: The form must be retained in the medical record for 10 years after the date of last service and in accordance with HSA policy for Retention of Medical Records (5.3.a)..

Cell Phone Policies

STATE OF TENNESSEE



DEPARTMENT OF HEALTH CELLULAR PHONE POLICIES AND PROCEDURES MANUAL

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CELLULAR PHONE ISSUANCE

It is the policy of the Department of Health that cellular telephones shall be issued and assigned to a departmental employee or office on an as needed basis and only after approval by the Commissioner of Health. Since cellular telephone usage is more costly than a conventional telephone, usage shall be limited to those purposes and conditions set forth in the Rules and Regulations Section of this Manual. The monitoring of cellular telephone usage shall be in compliance with procedures set forth in this Manual.

RULES AND REGULATIONS

- The permanent assignment of cellular phones to employees shall be minimized. Cellular phones may be assigned to a pool if properly justified. When phones are pooled, they may be flexibly assigned to staff as the need arises.
- State-owned cellular telephones are for State business only. Calls should be kept at a minimum to control costs and cellular phones should not be used when access to regular (landline) telecommunications is available. Non-business calls are permitted only in emergency situations.
- Other than the Commissioner, cellular phones will only be assigned to employees when: 1) the safety of the employee, the public safety or State property is at risk, or; 2) a majority of the employee's time is spent in locations where landline telephones are not available (i.e. in vehicles), or; 3) time sensitive communications is essential.
- State travel regulations state that "Department heads may authorize employees to use their personal cellular phones to conduct official business." In that regard, employees will be reimbursed for official business cellular phone calls only based on procedures established or approved by the Department of Finance and Administration.
- If a state-owned cellular phone is broken, malfunctioning, lost or stolen, it is the responsibility of the person or program to which it is assigned to report it to the Department of Health Telecommunications Coordinator immediately.
- When an employee terminates employment with the Department of Health, their cellular phone must either be transferred to a new employee or returned to the Telecommunications Coordinator, it cannot be taken with an employee to another department. If a cellular phone is transferred to another employee the Telecommunications Coordinator must be notified immediately.

MONITORING AND MAINTAINING

It is the responsibility of each cellular phone user to monitor the use of their cellular phone.

Any cellular phone used by multiple employees must have a log kept by the supervisor documenting the following:

Name of User	Date of Use	Number Called	Purpose

These logs must be kept by the supervisor for a minimum of three years as directed by Internal Audit.

Each month a copy of the section's cellular phone bill will be sent to their director. This bill must be reviewed and approved by the user(s) and their immediate supervisor. A review of the bill should ensure that the charges made by authorized employees are reasonable and necessary, and that there is follow-up of any discrepancies found.

If discrepancies are found, a written explanation of error or abuse should be noted on the approval form. Quarterly reports of cellular phone usage will be prepared by the Telecommunications Coordinator and sent to the Commissioner for review.

Once the monitoring is completed the approval form should be returned to the Telecommunications Coordinator in a timely manner.



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
APPROVAL OF
CELLULAR PHONE BILL**

Our bill has been reviewed to ensure that the charges made by authorized employees are reasonable and necessary, and that there has been a follow-up of any discrepancies found.

<u>Billing Date</u>	<u>Phone Number</u>	<u>User(s) Signature</u>	<u>Supervisor Signature</u>	<u>Date</u>
-------------------------	---------------------	------------------------------	---------------------------------	-------------

DISCREPANCIES FOUND:

EXPLANATION:

ACTION TAKEN:

Please make checks payable to: TREASURER-STATE OF TENNESSEE

**Please return completed form, attached information, and any reimbursements to:
Tennessee Department of Health
Fiscal Services
10th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
ATTENTION: Sonya Pedigo**

State of Tennessee Department of Health

Information Technology Policies

Policy Title: Communication Devices Usage Policy

Effective Date: March 19, 2008

Revision Date: March 19, 2008

Approved: *Susan Rogers MD, RD*

Application: Applies to all Tennessee Department of Health (TDOH) employees and contractor personnel (hereinafter referred to as "users") whose access to or use of cellular telecommunications devices and services, blackberries, calling cards and Virtual Private Network accounts that is funded by the State or is available through equipment owned or leased by the State.

Authority: Health Executive Management Advisory Committee

Purpose: The purpose of this policy is to establish guidelines to govern use of communication devices by users.

Policy: It is the policy of TDOH to use communication device resources to carry out the missions of the Department and to promote efficiency and improved communications with our internal and external customers. Communication device resources are provided to users who meet prescribed eligibility requirements as described in this policy. The use of these resources is intended for the benefit of state government and for carrying out TDOH business.

The Department expects users to exercise good judgment and common sense in the workplace to avoid abuse and inappropriate use of communication device resources. The following list, although not all-inclusive, provides some examples of unacceptable uses:

- Private or personal for-profit activities. This includes use of communication devices for private purposes such as marketing or business transactions and any activity meant to foster personal gain;

- Unauthorized not-for-profit business activities. This includes the conducting of any non-governmental-related fund raising or public relations activities such as solicitation for religious and political causes; and
- Use for, or in support of, unlawful/prohibited activities as defined by federal, state, and local laws or regulations. Illegal activities relating to communication device usage include, but are not limited to:
 - Delivery of threatening, offensive or harassing communications which contains defamatory, abusive, obscene, profane, sexually oriented, threatening, racially offensive, or otherwise biased, discriminatory language; and
 - Violation of state or agency regulations prohibiting sexual harassment.

Procedures: All communication device resources issued to users in the performance of their duties shall be department owned or leased. Communication devices are to be used only by the person to whom they are issued and cannot be transferred to other users without approval from the Office for Information Technology Services Telecommunication section. Communication devices that are no longer required due to termination or change of job status must be returned to the Telecommunications Section upon departure. These procedures ensure that the Bureaus and Offices maintain a current and accurate inventory of the communication devices assigned to it.

Although personal use of TDOH-provided communication device resources is not the intended benefit, TDOH recognizes that incidental personal usage may occur. Therefore, the Bureau and Office managers are responsible for monitoring the communication device usage. This will include, but not be limited to, reviewing usage “exception reports” available from Finance and Administration and taking appropriate action on usage exceptions identified and communicated on a periodic basis from the Office of Internal Audit. Should personal use be considered excessive or inappropriate, costs incurred due to this personal usage will be the responsibility of the user. In such circumstances, charges incurred for personal use must be reimbursed by the user to the department on a timely basis.

Bureau or Office managers are responsible for educating users about appropriate communication device procedures. However, in emergency situations managers may grant exceptions to these policies.

Eligibility and Acquisition: Communication device service will be assigned to users whose need for voice or data services are essential to their job classification and not for the convenience of the user. All requests for cellular phone service must be submitted on the “Telecommunications Request Form”, found on the Office for Information Technology Services intranet page. This request must include justification for the need of communication device. Justification should contain information that explains how the communication device will benefit TDOH. All requests for communication devices must have approval from the user Bureau or Office Director.

TDOH Management Responsibilities: User billing records are subject to review by the appropriate supervising authority. It is the responsibility of the Bureau or Office Director provide for a routine examination of the communication device billing to ensure proper use of equipment.

User Responsibilities: Use of communication devices is a privilege. This constitutes the acceptance of responsibilities and obligations that are subject to state government policies and federal, state, and local laws. State of Tennessee contracts shall not be used to obtain communication devices for personal use. Misuse or abuse of communication devices may result in access being revoked. Misuse or abuse of communication devices is subject to the appropriate disciplinary action under the authority of TCA §8-30-202 and §8-30-326 and as described in the Rules of the Tennessee Department of Human Resources 1120-10-06, Examples of Disciplinary Offenses. Users may be subject to limitations on their use of communication device resources as determined by the appropriate supervising authority.

Communication device transmissions, such as cell phones, are not secure. Therefore, employees must use discretion in relaying confidential information. Reasonable precautions shall be made by the user to prevent equipment theft and damage. If a communication device is stolen, a police report must be filed to account for the loss of state property. If a communication device is lost, stolen, or damaged, the Office for Information Technology Services, Telecommunications Section must be notified for replacement or repair. Users are responsible for reimbursing TDOH for lost, stolen, or damaged cell phones if due to user negligence. Communication devices that are no longer required due to termination or change of job status must be returned to the Telecommunications Section.

Guidelines: It shall be the responsibility of the Office for Information Technology Services to maintain a master inventory of all Communication Devices used by the TDOH for inventory and billing services by the Bureau of Administrative Services. Therefore, it is imperative that Bureaus and Offices inform the Office for Information Technology Services of any change in physical location of a communication device or any inappropriate usage.

Definitions: Communication devices means cellular phones, Blackberry voice and data devices, telephone calling cards, 3G wireless service, VPN accounts, RAP accounts, and pagers.

References: Tennessee Code Annotated, Section 4-3-5501, et seq., effective May 10, 1994.
Tennessee Code Annotated, Section 10-7-512, effective July 1, 2000.
Tennessee Code Annotated, Section 10-7-504, effective July 1, 2001.
State of Tennessee Security Policies.

Patient Education Website Listing

PRIMARY CARE PATIENT EDUCATION WEBSITES

Originated AUGUST 9, 2007

The following websites are for use by health department personnel and their patients. (These have not been approved for use in community events – that would require Forms/Publication approval and assignment of a PH number.)

<http://health.state.tn.us/tobaccoquitline.htm>

www.aafp.org

www.acog.net

www.ahcmedia.com

www.cancer.gov

www.cdc.gov

www.changingdiabetes-us.com

www.diabetes.org

www.digestive.niddk.nih.gov

www.ebm-guidelines.com

www.familydoctor.org

www.fda.gov/womens

www.fpnotebook.com

www.healthyroadsmedia.org

www.immunize.org

www.jama.ama-assn.org

www.knowmenopause.com

www.mayoclinic.com

www.mdconsult.com

www.medicalcenter.osu.edu/patientcare/patient_education

www.medlineplus.gov

www.menshealthnetwork.org

www.nih.gov

www.nlm.nih.gov

www.nurses4tobaccocontrol.org

www.patient.co.uk

www.pdr.net

www.PPARX.org

www.survivorshipguidelines.org

www.youngwomenshealth.org/index.html

PRIMARY CARE PATIENT EDUCATION WEBSITES

-continued-

Added 1-4-08

www.medlineplus.gov

www.drugs.com (<http://www.drugs.com/>)

Added 1-25-08

<http://health.nih.gov/>

<http://medicalcenter.osu.edu/patientcare/healthinformation/education>.

<http://www.americanheart.org>

Added 12-23-08

<http://health.state.tn.us/consumers.htm>

Added 2-23-09

<http://www.bddiabetes.com/us/>

Added 9-25-09

<http://www.hcvadvocate.org/>

Added 3-25-10

<http://www.hcvadvocate.org/hepatitis/factsheets.asp>

<http://www.liverfoundation.org/education/downloads>

Added 4-14-10

www.hemochromatosis.org

The Hemochromatosis Information Center

www.kidney.org

Kidney Foundation

www.lungusa.org

American Lung Association

www.nhlbi.nih.gov

National Heart Lung Blood Institute

www.patientedu.org

Pri-Med Patient Handouts

www.ramusa.org

Primary Care Services Guidelines
May 18, 2010

APPENDIX B

PERSONNEL

- Sample Job Plans
- CME Online Resource List
- Bureau of Health Services Organizational Chart

Sample Job Plans

**RN-2
Nurse Practitioner
M.D.
Regional Nurse Practitioner**

RN-2 Job Plan

EXAMPLE - JOB PERFORMANCE PLAN – RN-2

(For System 2/3 only)

Print Employee's Name

Print Supervisor's Name

MAJOR JOB RESPONSIBILITY		BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
5199	Performs Direct Client/Patient Services	<ul style="list-style-type: none"> A. Always utilizes the nursing process to assess, plan, implement and evaluate nursing services. B. Always utilizes current nursing protocols, standards, and sound professional judgment in nursing practice. C. Health teaching/counseling and anticipatory guidance are always relevant to the client/patient needs. D. All pertinent client/patient information is documented completely, accurately, legibly and in a timely manner utilizing SOAP format, regionally approved abbreviations, etc., according to current documentation policy.
5199	Performs Case Management Activities	<ul style="list-style-type: none"> A. Always collects pertinent and program-required information to enroll and follow clients. B. Plan of care always reflects involvement of the client/patient in its development. C. Strategies for planning quality care reflect collaboration with other team members and appropriate community agencies. D. Continually seeks opportunities to educate all persons about TennCare services and resources. E. Maintains appropriate documentation; submits encounters in a timely fashion. F. Always assesses client/patient readiness for case closure and discharges from care as a result of monitoring, reassessment, or any other form of client ineligibility. G. Arranges transportation for patients as needed; may provide transportation upon supervisor's approval; always follows regional policy regarding appropriate safety precautions.
9999	Participates in Continuing Education/Staff Development Activities	<ul style="list-style-type: none"> A. Always attends all scheduled in-service programs and other approved learning activities. B. Actively participates in staff conferences. C. Nursing practice reflects continued learning. D. Participates in peer review as assigned and supports departmental goal of continuous quality improvement.

Reviewer's Signature

Date

Employee's Signature

Date

Supervisor's Signature

Date

EXAMPLE - JOB PERFORMANCE PLAN – RN-2

(For System 2/3 only)

Print Employee's Name

Print Supervisor's Name

MAJOR JOB RESPONSIBILITY	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
5199 Utilizes Epidemiological Methods for Communicable Disease Control	A. Appropriate action to curtail spread of disease is always implemented. B. Performs functions as assigned during disease outbreaks or other epidemiological activities. C. Performs emergency support functions upon notification by, and under the direction of, local, regional, or central office supervisors (Emergency Response Coordinators) in the event of community disasters. Always functions according to PHN Protocol, American Red Cross Protocol, or health officer direction within scope of training and practice in all situations. D. Work practices reflect compliance with current infection control guidelines, universal precautions, respiratory precautions, to prevent spread of disease to clients, employees and community.

Reviewer's Signature

Date

Employee's Signature

Date

Supervisor's Signature

Date

Nurse Practitioner Job Plan

Example - Job Performance Plan - Nurse Practitioner

(For System 2/3 only)

Print Employee's Name

Print Supervisor's Name

MAJOR JOB RESPONSIBILITY	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
5153 Serves as a Professional Role Model within the Agency	<ul style="list-style-type: none"> A. Pursues continuing education, in-service education and self-directed learning activities to maintain a high level of practice. B. Nursing practice reflects evidence of continued learning. C. Consistently uses unscheduled or "slack" time productively. D. Consistently displays effective problem solving skills in patient care management and clinic management.
5136 Utilizes Community Resources	<ul style="list-style-type: none"> A. Collaborates with other community resources in providing service to clients/patients. B. Provides, when possible, information and services upon request from community individuals and agencies. C. Seeks out community resources to meet specific client/patient needs.
5152 Develops Own Protocol	<ul style="list-style-type: none"> A. Protocol is developed within agency policies. B. Protocol is developed in collaboration with physician preceptor. C. Protocol is reviewed, revised if needed, and signed at least annually.
5154 Participates in Quality Assurance Activities	<ul style="list-style-type: none"> A. Utilizes a systematic method of monitoring practice. B. Always participates in peer review on a regularly scheduled basis. C. Always participates in corrective action, if appropriate. D. Meets at regular intervals with physicians to evaluate clinic practice. E. Records are always in orderly fashion for weekly record review by physician preceptor.
5199 Cooperating With Co-workers	<ul style="list-style-type: none"> A. Willingly and efficiently covers the work for others during lunchtime, or other absences. B. Responds courteously to others when they seek help. C. Works harmoniously with other staff. Provides useful input and shares responsibility for group decisions. D. Offers helpful suggestions for improving work operations. E. Creates and maintains constructive interpersonal relationships that promote task accomplishment. Communicates in a positive manner with all staff members and other fellow employees. F. Always volunteers all pertinent work related information to other staff members. G. Helps in welcoming and putting new employees at ease and in training them to become productive employees. Answers questions patiently and volunteers useful information.

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

Example - Job Performance Plan - Nurse Practitioner

(For System 2/3 only)

Print Employee's Name

Print Supervisor's Name

MAJOR JOB RESPONSIBILITY	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
<p>9999 Confidentiality of Patient Records and Information</p> <p>9999 Productivity Guidelines</p> <p>9999 Emergency Response</p> <p>9999 Medical Provider in health department clinics</p>	<p>A. Always handles patient records to assure that strict confidentiality is maintained in accordance with Bureau Policy 5.2.</p> <p>B. Always limits access to patient records to only those persons employed by or assigned to local and regional clinics who need patient-specific information to perform their duties.</p> <p>C. Always assures that scheduling and registration procedures protect confidentiality. No interviews of a confidential nature are conducted so that they can be overheard by other patients or uninvolved staff.</p> <p>A. Average at least 29 Relative Value Units for any 7.5-hour workday.</p> <p>B. Average an appropriate ratio of Relative Value Units for any day worked that is less than 7.5 hours.</p> <p>A. Always responds to and reports immediately if called upon by local, regional or central office supervisors, as part of a coordinated emergency response by the Department of Health.</p> <p>A. Examines, diagnoses, and treats patients in health department clinics</p> <ol style="list-style-type: none"> 1. Assesses preventive and acute care needs 2. Obtains relevant medical history 3. Performs physical exam in accordance with health needs and history 4. Analyzes clinical data to establish appropriate diagnosis and management 5. Assures complete, accurate, and prompt documentation of history, physical examination, assessment, plan, procedures performed, and medication prescribed 6. Properly counsels patients, family members, and care givers 7. Provides medical consultation to any health department patient within scope of practice and health department guidelines 8. Facilitates referral of health department patients to other medical providers as indicated by limitations in health department services 9. Participates in rotation of on-call duties of the health department 10. Performs routine primary care clinic procedures if appropriately trained

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

Example - Job Performance Plan - Nurse Practitioner

(For System 2/3 only)

Print Employee's Name

Print Supervisor's Name

MAJOR JOB RESPONSIBILITY	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
<p style="margin-left: 40px;">9999 Attendance and Punctuality</p>	<p>A. Always begins work on or before scheduled time even during inclement weather conditions (except for illness or other circumstances beyond the control of the employee).</p> <p>B. Notifies nursing supervisor as quickly as possible when unable to work as scheduled.</p> <p>C. Never leaves work prior to the scheduled quitting time without approval of supervisor.</p> <p>D. Always returns from breaks and lunch at the scheduled time.</p>

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

M.D. Job Plan

EXAMPLE - JOB PERFORMANCE PLAN - PHYSICIAN

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
----------------------------	--

9999. Medical provider and supervisor in health department clinics

- A. Examines, diagnoses and treats patients in health department clinics
 - 1. Assess preventive and acute care needs
 - 2. Obtains relevant medical history
 - 3. Performs physical exam in accordance with health needs and history
 - 4. Analyzes clinical data to establish appropriate diagnosis and management
 - 5. Assures complete, accurate, and prompt documentation of history, physical examination, assessment, plan, procedures performed, and medication prescribed
 - 6. Properly counsels patients, family members and caregivers
 - 7. Provides medical consultation to any health department patient within scope of practice and health department guidelines
 - 8. Facilitates referral of health department patients to other medical providers as indicated by limitations in health department services
 - 9. Participates in rotation of gatekeeper on-call duties of the health department
 - 10. Performs routine primary care clinic procedures if appropriately trained.
- B. Supervises and directs nurse clinicians, nurse practitioners, and staff nurses in the provision of clinical preventive and therapeutic care.
 - 1. Directly observes provision of care by all nurse clinicians and practitioners at least quarterly; observes new staff nurse performing physical assessment within 3 months of assignment
 - 2. Provides medical supervision to family planning nurse practitioners, including chart reviews
 - 3. Documentation of clinical observation is recorded in personnel file
 - 4. Reviews 20% of nurse clinician's charts within 30 days of service
- C. Maintains knowledge of current principles and practices of medicine
 - 1. Achieves 20 hours of continuing medical education (category I) per 2 year
 - 2. Attends a major update in primary care or area of specialty once per 3 years
 - 3. Educates medical staff recording new developments in preventive and therapeutic care

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

PR-0134

EXAMPLE - JOB PERFORMANCE PLAN - PHYSICIAN

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
----------------------------	--

9999. Leadership in Public Health Services

- A. Participates in overall activities of the health department
 - 1. Actively contributes to setting and achieving the goals of county health department
 - 2. Attends staff meetings with nursing supervisor, office manager and county director.
- B. Strives to assure that quality health services are available to, accessible to, and utilized by persons in need within the catchment area.
 - 1. Keeps informed of services available from health care providers in the area
 - 2. Reviews health statistics and health services utilization with county director and nursing supervisor yearly
- C. Establishes and maintains effective working relationships with local health care professionals, hospitals, teaching institutions and other health care agencies/organizations.
 - 1. Participates in developing recommendations to elected officials and boards of health regarding promulgation of new public health laws and regulations when directed to do so
 - 2. Facilitates outreach to new physicians in the community
 - 3. Encourages community physicians to report notifiable diseases
 - 4. Participates in the health planning activities of the county through health councils or other similar community organization

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

PR-0134

EXAMPLE - JOB PERFORMANCE PLAN - PHYSICIAN

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
----------------------------	--

9999. Development and implementation of departmental policy and procedures

- A. Medical protocol development
 - 1. Protocols are reviewed and signed at least annually
 - 2. Participates in development of protocols for public health nurses and advance practice nurses
 - 3. Serves effectively as a consultant for staff and clearly communicates clinical expertise
 - 4. Assures that protocol is consistent with high quality medical practice
- B. Recruitment
 - 1. Identifies and refers prospective practitioners to the Regional Health Officer
 - 2. Keeps informed of vacant positions
 - 3. Participates in recruitment and orientation of new clinicians and physicians

0020. Participating in the employee job performance planning and evaluation program

- A. Conducting the employee job performance planning and evaluation program
 - 1. Adheres to schedule of evaluations
 - 2. Seeks active input of reviewer(s) prior to discussing evaluation with employee

9999. TDH & EEO/Affirmative Action Policy

- A. Compliance with TDH & EEO/Affirmative Action Policy
 - 1. No breach of policy is reported

9999. Confidentiality of patients and their records

- A. Confidentiality of patients and their records
 - 1. No breach of policy is reported

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

PR-0134

EXAMPLE - JOB PERFORMANCE PLAN - PHYSICIAN

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
----------------------------	--

9999. Productivity Guidelines

- A. Average at least 25 Relative Value Units for any 7 1/2 hour workday
- B. Average an appropriate ratio of Relative Value Units for any day worked that is less than 7 1/2 hours

9999. Disaster Response

- A. Always responds to and reports immediately if called upon by local, regional, or central office supervisors, as part of a coordinated emergency response by the Department of Health.

5199. Cooperating with co-workers

- A. Willingly and efficiently covers the work for others during lunchtime or other absences.
- B. Responds courteously to others when they seek help
- C. Works harmoniously with other staff
- D. Provides useful input and shares responsibility for group decisions
- E. Offers helpful suggestions for improving work operations
- F. Creates and maintains constructive interpersonal relationships that promote task accomplishments
- G. Communicates in a positive manner with all staff members and other fellow employees
- H. Always volunteers all pertinent work-related information to other staff members
- I. Helps in welcoming and putting new employees at ease and training them to become productive
- J. Answers questions patiently and volunteers useful information

0001. Attendance and punctuality

- A. Always begins work on or before the scheduled time even during bad weather conditions (except for illness or circumstances beyond the control of the employee)
- B. Always notifies work unit as quickly as possible when ill and clearly explains the illness
- C. Never leaves work prior to scheduled quitting time without permission from the supervisor
- D. Always returns from meals and breaks at the scheduled time.

Reviewer's Signature Date

Employee's Signature Date

Supervisor's Signature Date

PR-0134

Regional Nurse Practitioner Job Plan

EXAMPLE - JOB PERFORMANCE PLAN – Regional NP Primary Care Director

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
----------------------------	--

5123. Administers/Supervises Primary Care Program Activities	5123A. Develops realistic plans for program activities 5123B. Coordinates implementation of plans with local, regional, and state personnel. 5123C. Monitors program activities on a regularly scheduled basis. 5123D. Delegates specific responsibilities according to identified need and staff competency. 5123E. Collaborates with appropriate staff relative to budgetary matters and local staffing patterns.
--	---

5122. Coordinates Program Activities that Impact on Primary Care	5122A. Collaborates with program staff in planning patient activities 5122B. Periodically monitors/reviews nursing activities in program areas. 5122C. Facilitates problem solution in specific problem areas when identified.
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5117. Provides Professional Nursing Guidance	5117A. Always utilizes protocols, standards, and sound professional nursing judgement in assisting others. 5117B. Interprets rules and regulations, policies and procedures, and other information to nursing staff. 5117C. Always applies current nursing principles. 5117D. Promotes the use of the nursing process.
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5152. Develops Protocol	5152A. Protocol is developed within agency policies. 5152B. Protocol is developed in collaboration with physician preceptor. 5152C. Protocol is reviewed, revised if needed, and signed at least annually.
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0032. Preparation of Reports	0032A. Reports requested by senior managers are prepared as needed and within agreed-upon time schedules. 0032B. Information provided in reports is thoroughly reviewed to insure accuracy. 0032C. Recommendations or conclusions are logically developed and supported or explained, and alternatives noted when possible. 0032D. Written reports are clear and concise, appropriate for the intended audience, and contain all relevant information.
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5151. Serves as a Resource Person to Other	5151A. Shares knowledge and expertise with other health team members and/or students when requested.
--	--

Reviewer's Signature

Date

Employee's Signature

Date

Supervisor's Signature

Date

PR-0134

Primary Care Services Guidelines

May 18, 2010

EXAMPLE - JOB PERFORMANCE PLAN – Regional NP Primary Care Director

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
Public Health Personnel	5151B. Helps develop and conduct in-service educational programs when requested. 5151C. Provides planned orientation for staff and students. 5151D. Information regarding continuing education and in-service programs is available to staff. 5151E. Arranges for staff attendance at approved continuing education and in-service programs.
5153. Serves as a Professional Role Model Within the Agency	5153A. Pursues continuing education, in-service education, and self-directed learning activities to maintain a high level of practice. 5153B. Nursing practice reflects evidence of continued learning. 5153C. Consistently uses unscheduled or "slack" time productively. 5153D. Consistently displays effective problem-solving skills in patient care management.
5136. Utilizes Community Resources	5136A. Collaborates with other community resources in providing services to patients. 5136B. Provides, when possible, information and services upon request from community individuals and agencies. 5136C. Seeks out community resources to meet specific patient needs.
5147. Assesses Health Needs of Patient	5147A. A relevant medical history is always obtained. 5147B. The health hazards in the patient's immediate environment are always identified. 5147C. The cultural patterns, economic status, and family resources influencing the patient's health are always identified. 5147D. All appropriate laboratory specimens are collected from the patient. 5147E. Always evaluates patient's ability to comprehend teaching/counseling. 5147F. Specific patient risk factors are always identified. 5147G. Always analyzes clinical data to establish appropriate diagnosis and management.
5130. Plans for Patient Services	5130A. Plan of care always meets identified health problems and diagnosis. 5130B. The strategies for planning quality care reflect collaboration with other team members and appropriate community

Reviewer's Signature

Date

Employee's Signature

Date

Supervisor's Signature

Date

PR-0134

EXAMPLE - JOB PERFORMANCE PLAN – Regional NP Primary Care Director

(For System 2/3 only)

Employee's Name

Print Supervisor's Name

Major Job Responsibilities	BEHAVIORS OR WORK OUTCOMES CHARACTERISTIC OF EXCEPTIONAL PERFORMANCE
	agencies when needed. 5130C. Plan of care always reflects involvement of the patient in its development. 5130D. Plan of care is revised according to the changing needs of the patient. 5130E. Plan of care is always consistent with current public health nursing standards and protocols, and physician orders.
5148. Implements Patient Plans	5148A. Always carries out nursing action in a safe manner according to current nursing principles and concepts. 5148B. Patient services are always delivered according to public health standards/protocols. 5148C. Always recognizes when assistance is needed to carry out a plan. 5148D. Health teaching/counseling is always relevant to the patient's needs. 5148E. All pertinent patient information is documented completely, accurately, legibly, and in a timely fashion. 5148F. Informed consent forms are always signed and dated. 5148G. Consistently refers patients to appropriate medical services that exceed the scope of their practice.
9999 Confidentiality of Patient Records and Information	9999A. Always handles patient records to assure that strict confidentiality is maintained in accordance with Bureau Policy 5.2. 9999B. Always limits access to patient records to only those persons employed by or assigned to local and regional clinics who need patient-specific information to perform their duties. 9999C. No interviews of a confidential nature are conducted so that they can be overheard by other patients or uninvolved staff.
9999. Emergency Preparedness	9999A. Always responds to and reports immediately if called upon by local, regional, or central office supervisors, as part of a coordinated emergency response by the Department of Health. 9999B. Maintains the Mid-Cumberland Regional Office emergency kit. 9999C. Coordinates the requirements for annual emergency drills in the local health departments.

Reviewer's Signature

Date

Employee's Signature

Date

Supervisor's Signature

Date

PR-0134

Primary Care Services Guidelines

May 18, 2010

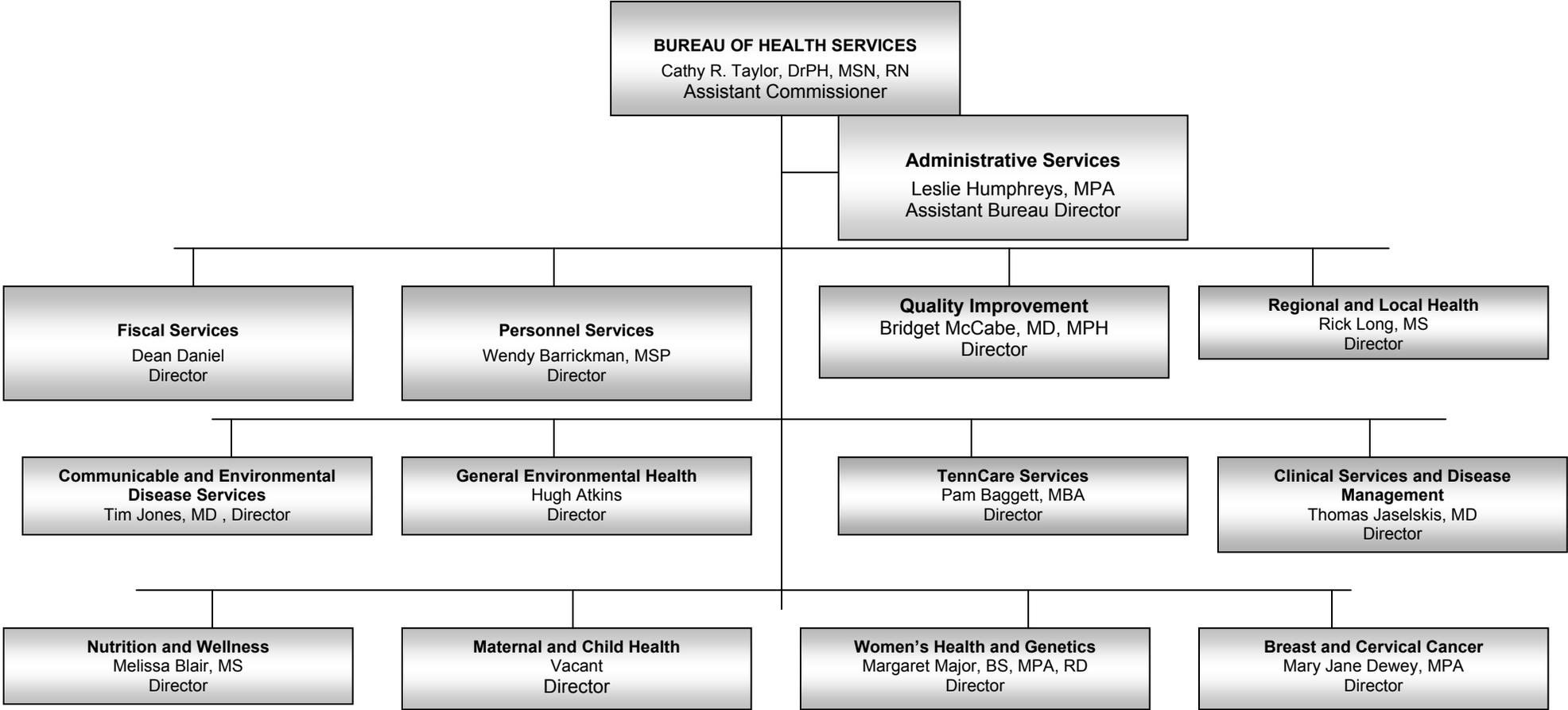
CME Online Resource List

CME Online Resource List

www.academycme.org
<http://cme.amcancersoc.org>
www.advanceweb.com
www.baylorcme.org
www.cardiovillage.com
[www.cdc.gov.mmwr/cme/conted.html](http://www.cdc.gov/mmwr/cme/conted.html)
www.cemedicus.com
www.clevelandclinicmeded.com
www.clinicianreviews.com
www.cliniciansCME.com
www.cmeondiabetes.us
www.cmelist.com
www.cme.nejm.org (The New England Journal of Medicine)
www.ConsultantLive.com
www.CMEzone.com
<http://com.etsu.edu/cme>
www.diabetesroundtable.com
<http://education.cmellc.com>
www.freecme.com
www.GIcme.com
www.gynob.emory.edu rtc
www.hopkinscme.org
www.mc.vanderbilt.edu/nursing/CE/index.html
www.medconnect.com
www.mededtoday.com
www.medscape.com
<http://medsitecme.com>
www.minimed.com/professionals/continuingeducation.html
CME.NACCME.com
www.ndei.org (ndei is the acronym for National Diabetes Education Incentive)
www.netnpa.com
www.osteoporosiscme.org
www.powerpak.com
www.PrincetonCME.com
www.ppscme.org
www.pri-med.com/south
www.t2b2.org
www.TheGut.org
www.USPharmacist.com
WesternSchools.com
www.womenshealthpc.com

Bureau of Health Services Organizational Chart

**TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES (11-1-09)**



APPENDIX C

OPERATIONS

- Supply/Equipment List
- Pharmacy
 - Drug Maintenance and Dispensing Policy, Bureau Policy 8.3
 - Tennessee State Law Pertaining to Prescriptions
 - TCA 63-7-126 Advanced Practice Nurses
 - TCA 63-7-123 Certified Nurse Practitioners
 - TCA 63-6-236 Drug Prescriptions
 - Primary Care Formulary
- Labwork
 - Optional Quick Reference Lab Encounter Form

Supply List

OPTIONAL SUPPLY LIST FOR A PRIMARY CARE CLINIC

Adhesive Bandage Strip, 1" x 3"
Adhesive Strip Bandage, 1" x 3", flexible fabric
Adhesive Surgical Tape
Alcohol Prep Pad
Autoclave Tape
Bandage, Adhesive Strip, Jr, 3/8" x 1"
Bandage, Roll, Gauze, 3" x 4"
Burn Packs
Butterfly Wing, Blood Collector, 23g x 3/4"
Butterfly Wing, Blood Collector, 25g x 3/4"
Chek-Stixs, 25/btl
Cold Pack
Cotton Applicator Stick
Cotton Ball, 1"
CPR Pocket Mask
Disposable CPR Mouth Shield
Elastic Bandage, "Rubber", 3" x 5 yd
Elastic Bandage, "Rubber", 4" x 5 yd
Exam Gloves, Latex Free
Exam Gown, Disposable
Exam Sheets, 40" x 60"
Exam Table Paper, 18"
Exam Table Paper, 21"
Gauze Bandage Roll
Gauze Bandage, 3" x 4 yd
Gauze Bandage, 4" x 4 yd
Gauze Nasal Packing
Glucometer Control Solution
Glucose Tests Strips
Hemocult Kits
Inflatable Splints
Kleenspec Disp. Diagnostic Otoscope Specula
Kleenspec Disp. Diagnostic Otoscope Specula, 4mm
Lancets, 1.8 mm
Latex Gloves, Size 6.5
Latex Gloves, Size 7
Latex Gloves, Size 7.5
Latex Gloves, Size 8
Link 2 Strep 25 (B-4340904) Microcuvettes
Microscope slide covers
Microscope slides
Mono spot lab tests
Multi-Stixs
Non-Adherent Pad, 2" x 3"
Paper Adhesive Tape, 1" x 10 yd
Pregnancy Test Kits, 50 tests/kit
Sani Cloth Germicidal
Scissors, Bandage, 5 1/2"
Sharps Container, 8 qt.
Sling, Large
Sling, Medium
Sling, Small
Sling, X-Large
Sling, X-Small
Specimen Cups
Sponge, IV, 2" x 2"
Steri-strips, 1" x 5"
Steri-strips, 1/2" x 4"
Steri-strips, 1/4" x 1 1/2"
Steri-strips, 1/4" x 3"
Steri-strips, 1/4" x 4"
Steri-strips, 1/8" x 3"
Storage Jars (set of 5 sundry jars)
Surgical Sponge, 12 ply, 4" x 4"
Surgical Sponge, 2" x 2"
Surgical Sponge, 4" x 4"
Surgical Sponge, 4" x 4"
Surgical Sponge, 8 ply, 4" x 4"
Suture Removal Set
Suturing Supplies
Syringe, Insulin, 27g x 1/2"
Syringe, Tuberculin, 1cc, 27g x 1/2"
Syringes, retractable, 3cc, 21g x 1 1/2"
Syringes, retractable, 3cc, 22g x 1"
Syringes, retractable, 3cc, 23g x 1"
Syringes, retractable, 3cc, 25g x 1"
Syringes, retractable, 3cc, 25g x 5/8"
Telpha Pads
Thermometers
Tongue Depressor, 6"
Urine Catheter Tray - 14 French Cath
Vaseline gauze

Clinical Guidelines in Family Practice by
Uphold and Graham
Ferri's Clinical Advisor, Ferri

Equipment List

OPTIONAL EQUIPMENT LIST FOR A PRIMARY CARE CLINIC

Accessory Pack for Emergency Carts	Hyfrecator
AED	Hyfrecator accessories
Aeromist Plus Compressor/Nebulizer	Microlux II Microscope
Aeromist Plus Compressor/Nebulizer (Latex Free)	Microscope Bulbs
AudioScope - Welch Allyn	Oxygen Tank
Autoclave, sterilizer	Pulse Oximeter - Compact w/o Memory
Automatic Vital Sign Monitor - Large	SECA Digital Scale-Weight & Height Rod
Automatic Vital Sign Monitor - Standard	Spirometer Machine
Calibration Syringes for Spirometer	Stethoscope
Centrifuge	Taylor Percussion Hammer, 7 1/2"
Cuvettes	Vision Tester
Ear Hook/Spoon	W/A Diagnostic Wall Mount System
Ear Irrigation Syringe (100m)	W/A Ophthalmoscope Head for Wall Mt System
EKG Machine	W/A Otoscope Heads
Emergency Carts, 4 drawer	Welch Allyn Kleenspec Disposable Vaginal
Exam Light	Speculum, Medium, Pederson
Exam Table - General Purpose	Speculum, Small, Pederson
Glucometer - EvenCare Starter Kit	Verruca Freezer
HemoCue	Wheelchair, 19" wide
HemoCue Glucose 201	Wood's Lamp

Pharmacy

Drug Maintenance and Dispensing Policy

Drug Maintenance and Dispensation -- 8.3

Department of Health Pharmacy Policy - 8.3.d

Issued: November 24, 2003



Last Changed: New Policy on November 24, 2003

Signature:

By: Wendy J. Long, MD, Director
Bureau of Health Services

POLICY

The Regional Pharmacies are licensed as a Distributor with the Tennessee Board of Pharmacy and are under the direct supervision of a registered pharmacist. The pharmacist shall be responsible for maintaining, securing and accounting for medications in the regional pharmacy. The pharmacist will direct the management of inventories in the local health departments and supervise the implementation of the policy. Pharmacists and Local Health Departments shall adhere to internal control standards.

APPLICABILITY

This policy applies to all Regional Pharmacies and all Counties.

PURPOSE

To provide internal control standards for all regional pharmacies and local health departments.

PROCEDURE



Control Environment

1. The Regional Pharmacist will maintain records in the Regional Pharmacy that will show the following: drugs ordered by Regional Pharmacy, drugs received by the Regional Pharmacy, stock levels of drugs at the Regional Pharmacy using a perpetual inventory system, and drugs issued to clinic sites. These records shall be maintained for a period of 3 years. See TCA 63-10-405 (B).
2. Clinics are responsible for keeping records showing receipt and movement of drugs for a period of 1 year.
3. The Regional Pharmacist will periodically review the quantity on hand and usage in each clinic and send the appropriate quantity of drugs to the clinics based on usage and the clinic requests.
4. Any drugs shipped to clinics from the Regional Pharmacy will be entered into the system at the region prior to shipment. Any drugs received from any other source will not be on the system until the Regional Pharmacy is notified. It is the responsibility of

the clinic staff to advise the Regional Pharmacy of receipt of these drugs.

5. Drugs in storage are grouped by lot number and expiration date so that the stock with the shortest expiration date may be distributed first.
6. All outdated drugs are removed from stock immediately and placed in a separate area. If credit can be received, drugs are sent to Nashville or the manufacturer. Clinics must notify Regional Pharmacy if drugs are removed from stock or transferred to another clinic so that PTBMIS inventory can be adjusted.
7. Health Officers, Nurse Practitioners, Public Health Nurses, and Licensed Practical Nurses are the only staff authorized to dispense drugs and related pharmaceutical supplies. All prescription drugs must be labeled prior to dispensing with the patient's name, physician, date, drug name, dose, amount dispensed, instructions and expiration date (if applicable). Only child proof, amber containers shall be used for drugs which are repackaged.
8. All drugs issued will be recorded through the pharmacy module of PTBMIS. The computer will keep a perpetual inventory of all drugs. No drugs shall be dispensed that would expire within the dates of treatment.
9. When there is a drug recall, the Regional Pharmacist will check the regional pharmacy inventory records to see if this particular drug has been received by the pharmacy. If so, the nurse supervisor in each clinic will be contacted immediately to see if they have any in stock. In the event they do, the nurse supervisor will return it to the regional pharmacy where it will be processed as indicated in the recall notification.



Control Activities

1. The Nurse supervisor at the clinic is responsible for the inventory, procurement, storage, handling, and issuing of all drugs. She may use appropriate staff to assist her in carrying out her duties. The packing slips received with the drugs should be checked and any discrepancies noted on the slip and the Regional Pharmacy should be notified if a discrepancy is found. If the packing slip matches what was received, it should be signed and maintained with the Drug Room records.
2. Access to the Regional Pharmacy and drug rooms is secured by use of locks and/or alarm systems and/or security guards.
3. The regional pharmacy shall be kept secured at all times in the absence of the pharmacist or pharmacy assistant/technician. Any key(s) for access to the drug room at each local health department at all times will be in possession of the personnel designated to access the drug room.
4. In the event of loss of said key, the person responsible will immediately notify their supervisor and, to prevent possible unauthorized access, have a new lock installed on the drug room door.
5. All medications shall be stored according to manufacturer recommendations in a locked cabinet or drug room with access limited to persons designated to have access. All medications must be kept in this room(s) except when in use during operational hours. All drugs are to be returned to this room at the end of the working day. The Nurse Supervisor is responsible for the security and control of all drugs and related pharmaceutical supplies. A refrigerator/freezer shall be available for storage of

medications, which require refrigeration/freezing.



Monitoring

1. The Regional Pharmacist will make periodic physical inventories at the Regional Pharmacy and reconcile these with the inventories and records of drugs delivered and received. HSA Policy 2.3 Segregation of Duties will be observed to the extent possible
2. It shall be the responsibility of the Nurse Supervisor or his/her designee to inspect, on a monthly basis, the expiration date of all drugs stored in the drug room of the local health department. When expired drugs are found in stock, he/she will remove them from stock and place them in a container in the drug room, which will be marked "OUT OF DATE - DO NOT ISSUE." These should be destroyed or returned at the Pharmacist's direction.
3. Local Health Departments will conduct a physical inventory of all drugs at least semi-annually. All differences between perpetual inventory and physical count will be analyzed to determine if corrective action is indicated. These differences and corrective action will be forwarded to the Regional Director, Regional Pharmacist, Regional Nursing Director, and the County Director and County Nursing Supervisor of the county affected.
4. An annual inventory of drugs and medical supplies will be performed in the Regional Pharmacy at the date specified by Central Office personnel in Nashville.

REFERENCE DOCUMENTS

1. Tennessee Code Annotated TITLE 63 PROFESSIONS OF THE HEALING ARTS: CHAPTER 10 PHARMACY : PART 4 PHARMACY PRACTICE : 63-10-405. Approval of drugs dispersed by department of health or local health departments
2. RULES OF THE TENNESSEE BOARD OF PHARMACY, CHAPTER 1140-3, STANDARDS OF PRACTICE, 1140-3-.06 Labeling Requirements
3. HSA Policy 2.3 Segregation of Duties

OFFICE OF PRIMARY RESPONSIBILITY

Office of the Medical Director, Bureau of Health Services, (615)741-7305

Tennessee State Law Pertaining to Prescriptions

TCA 63-7-126. Advanced practice nurses. —

(a) “Advanced practice nurse” means a registered nurse with a master's degree or higher in a nursing specialty and national specialty certification as a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist.

(b) Nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists holding such education and practice credentials shall apply to the board for a certificate to practice as an advanced practice nurse including authorization to use the title “advanced practice nurse” or the abbreviation “APN”. No other person shall assume such title or use such abbreviation or any other words, letters or signs to indicate that the person using the same is an advanced practice nurse.

(c) An applicant for a certificate to practice as an advanced practice nurse shall pay an initial fee as set by the board as well as a biennial renewal fee as set by the board.

(d) A nurse practitioner, nurse anesthetist, nurse midwife or clinical nurse specialist who holds a Tennessee registered nurse license in good standing and current national specialty certification in the advanced practice specialty shall be eligible for a certificate to practice as an advanced practice nurse on May 22, 2002, and shall be exempt from the requirement of a master's degree or higher in the nursing specialty if licensed in Tennessee and holding national specialty certification prior to July 1, 2005.

(e) Nothing in this section shall be interpreted to alter or change the current law as it existed on May 22, 2002, regarding prescriptive rights, supervision, or scope of practice for nurse anesthetists regulated under this title, nurse midwives as described in § [56-7-2407](#), clinical nurse specialists, or certified nurse practitioners as defined in § [63-7-123](#). Nor shall anything in this section be interpreted to allow any board or other entity to promulgate rules that would alter or change the law as it existed on May 22, 2002, regarding such prescriptive rights, supervision, or scope of practice.

[Acts 2002, ch. 768, § 1; 2003, ch. 111, § 1.]

TCA 63-7-123. Certified nurse practitioners — Drug prescriptions — Temporary certificate — Rules and regulations. —

(a) The board shall issue a certificate of fitness to nurse practitioners who meet the qualifications, competencies, training, education and experience, pursuant to § [63-7-207](#)(14), sufficient to prepare such persons to write and sign prescriptions and/or issue drugs within the limitations and provisions of § [63-1-132](#).

(b) (1) A nurse who has been issued a certificate of fitness as a nurse practitioner pursuant to § [63-7-207](#) and this section shall file a notice with the board, containing the name of the nurse practitioner, the name of the licensed physician having supervision, control and responsibility for prescriptive services rendered by the nurse practitioner, and a copy of the formulary describing the categories of legend drugs to be prescribed and/or issued by the nurse practitioner. The nurse practitioner shall be responsible for updating this information.

(2) The nurse practitioner who holds a certificate of fitness shall be authorized to prescribe and/or issue controlled substances listed in Schedules II, III, IV and V of title [39](#), chapter 17, part 4, upon joint adoption of physician supervisory rules concerning controlled substances pursuant to subsection (d).

(3) (A) Any prescription written and signed or drug issued by a nurse practitioner under the supervision and control of a supervising physician shall be deemed to be that of the nurse practitioner. Every prescription issued by a nurse practitioner pursuant to this section shall be entered in the medical records of the patient and shall be written on a preprinted prescription pad bearing the name, address, and telephone number of the supervising physician and of the nurse practitioner, and the nurse practitioner shall sign each prescription so written. Where the preprinted prescription pad contains the names of more than one (1) physician, the nurse practitioner shall indicate on the prescription which of those physicians is the nurse practitioner's primary supervising physician by placing a checkmark beside or a circle around the name of that physician.

(B) Any handwritten prescription order for a drug prepared by a nurse practitioner who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription. The handwritten prescription order must contain the name of the

prescribing nurse practitioner; the name and strength of the drug prescribed; the quantity of the drug prescribed, handwritten in both letters and numerals; instructions for the proper use of the drug; and the month and day that the prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing nurse practitioner must sign the handwritten prescription order on the day it is issued, unless the prescription order is:

(i) Issued as a standing order in a hospital, a nursing home or an assisted care living facility as defined in § [68-11-201](#); or

(ii) Prescribed by a nurse practitioner in the department of health or local health departments, or dispensed by the department of health or a local health department as stipulated in § [63-10-205](#).

(C) Any typed or computer-generated prescription order for a drug issued by a nurse practitioner who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription order. The typed or computer-generated prescription order must contain the name of the prescribing nurse practitioner; the name and strength of the drug prescribed; the quantity of the drug prescribed, recorded in letters or in numerals; instructions for the proper use of the drug; and the month and day that the typed or computer-generated prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing nurse practitioner must sign the typed or computer-generated prescription order on the day it is issued, unless the prescription order is:

(i) Issued as a standing order in a hospital, nursing home or an assisted care living facility as defined in § [68-11-201](#); or

(ii) Prescribed by a nurse practitioner in the department of health or local health departments, or dispensed by the department of health or a local health department as stipulated in § [63-10-205](#).

(D) Nothing in this section shall be construed to prevent a nurse practitioner from issuing a verbal prescription order.

(4) The nurse practitioner shall maintain a copy of the protocol the nurse practitioner is using at the nurse practitioner's practice location and shall make the protocol available upon request by the board of nursing, the board of medical examiners or authorized agents of either board.

(c) (1) The board may issue a temporary certificate of fitness to a registered nurse who:

(A) Is licensed to practice in Tennessee;

(B) Has a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills that includes three (3) quarter hours of pharmacology instruction or its equivalent; and

(C) Has applied for examination and/or is awaiting examination results for national certification as a first-time examinee in an appropriate nursing specialty area.

(2) Such temporary certificate shall remain valid until the examination results are obtained. The holder of a temporary certificate issued under the provisions of this subsection (c), who has not received the results of the examination, shall work only under the supervision and control of a certified nurse practitioner or physician.

(d) Any rules that purport to regulate the supervision of nurse practitioners by physicians shall be jointly adopted by the board of medical examiners and the board of nursing.

[Acts 1980, ch. 851, § 4; T.C.A., § 63-760; Acts 1985, ch. 120, § 9; 1992, ch. 822, § 1; 1994, ch. 569, § 2; 1995, ch. 358, § 1; 1996, ch. 659, § 2; 1997, ch. 507, § 2; 1998, ch. 842, §§ 2, 3; 2003, ch. 259, § 1; 2004, ch. 678, § 9; 2005, ch. 12, § 4.]

TCA 63-6-236. Drug prescriptions. —

(a) Any handwritten prescription order for a drug prepared by a physician or surgeon who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription. The handwritten prescription order must contain the name of the

prescribing physician or surgeon; the name and strength of the drug prescribed; the quantity of the drug prescribed, handwritten in both letters and numerals; instructions for the proper use of the drug; and the month and day that the prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician or surgeon must sign the handwritten prescription order on the day it is issued, unless the prescription order is:

(1) Issued as a standing order in a hospital, a nursing home or an assisted care living facility as defined in § [68-11-201](#); or

(2) Prescribed by a physician or surgeon in the department of health or local health departments, or dispensed by the department of health or a local health department as stipulated in § [63-10-205](#).

(b) Any typed or computer-generated prescription order for a drug issued by a physician or surgeon who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the typed or computer-generated prescription order. The prescription order must contain the name of the prescribing physician or surgeon; the name and strength of the drug prescribed; the quantity of the drug prescribed, recorded in letters or in numerals; instructions for the proper use of the drug; and the month and day that the typed or computer-generated prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician or surgeon must sign the typed or computer-generated prescription order on the day it is issued, unless the prescription order is:

(1) Issued as a standing order in a hospital, nursing home or an assisted care living facility as defined in § [68-11-201](#); or

(2) Prescribed by a physician or surgeon in the department of health or local health departments, or dispensed by the department of health or a local health department as stipulated in § [63-10-205](#).

(c) Nothing in this section shall be construed to prevent a physician or surgeon from issuing a verbal prescription order.

[Acts 2004, ch. 678, § 5; 2005, ch. 12, § 3.]

Primary Care Formulary

Primary Care Formulary
Tennessee Department of Health

ITEM
Acyclovir 400mg
Albuterol Aerosol 90 mcg
Albuterol Nebulizer .083%
Allopurinol 300 mg
Amitriptyline 10 mg*
Amoxicillin 250 mg
Amoxicillin/Clavulanic Acid
Antacid Liquid
Azithromycin 250 mg Dosepack
Bacitracin Ointment
Bicillin LA 1.2MU
Ceftriaxone 500 mg Inj.
Cefuroxime Axetil 500 mg
Cephalexin 500 mg
Ciprofloxacin 500mg
Clindamycin Caps 150 mg
Clonidine 0.1 mg
Cortisporin Otic Susp
Dexamethasone 4mg/ml Inj.
Diphenhydramine 25 mg
Doxycycline 100 mg
Fluconazole 150 mg
Fluoxetine 20 mg*
Furosemide 40 mg
Gemfibrozil 600 mg
Gentamicin Opth Soln
Glyburide 5 mg
Guaifenesin DM syrup
Guaifenesin 100mg/5ml syrup
Hepatitis A Vaccine
Hepatitis B Vaccine
Hydralazine 50 mg
Hydrochlorothiazide 25mg
Hydrocortisone Oint 2.5%
Hydrocortisone Cream 1%
Hydroxyzine Pam 25 mg caps
Hydroxyzine HCl 25mg/ml Inj.
Ibuprofen 600 mg
Influenza Vaccine

ITEM
Isosorbide Dinitrate 10 mg
Kenalog – 40 Inj.
Lidocaine 1% Inj.
Lisinopril 10 mg
Lisinopril 20 mg
Lovastatin 40 mg
Mebendazole Chew Tab 100 mg
Medroxyprogesterone 5 mg
Metformin 500 mg
Metoprolol 50 mg
Metronidazole 500 mg
Meningococcal Vaccine
MMR II (Meas/Mump/Rub) Vaccine
Neo/Gram/PolyB Eye Gtts
Nitrofurantoin (macro)
Novolin N
Novolin R
Novolin 70/30
Permethrin Creme Rinse
Permethrin Cream 5%
Phenytoin ER 100 mg
Pneumococcal Vaccine
Potassium Chloride 10meq
Prednisone 5 mg
Promethazine Tab 25 mg
Promethazine Inj. 25mg/ml
Promethazine Supp 25 mg
Ranitidine 150 mg
Silver Sulfadiazine Cream
TMP/SMZ DS Tabs
Tramadol 50 mg
Trazadone 50 mg*
Triamterene/Hydrochlorothiazide
Triple Antibiotic Opth Oint
Varicella Vaccine
Verapamil 80 mg
Verapamil XR 240 mg

**Antidepressants*

Primary Care Immunization Memo



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
IMMUNIZATION PROGRAM
CORDELL HULL BUILDING, 4TH FLOOR
425 - 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37247-4911

Date: July 8, 2009

To: Rural and Metro Regional Directors, Health Officers, Nursing Directors, Pharmacists

From: Tom Jaselskis, MD, *Medical Director, Bureau of Health Services* and
Kelly L. Moore, MD, MPH, *Medical Director, Immunization Program*

Re: Federally funded vaccines for adults now available for specific recipients

Background:

As a result of the availability of federal funds, including one-time federal American Recovery and Reinvestment Act (ARRA, “stimulus”) funds, the following vaccines may now be purchased through orders placed on the appropriate form provided by the Tennessee Immunization Program (TIP). The federally funded vaccines may be administered to recipients under the circumstances specified. The specified no-charge code must be used in PTBMIS and only an administration fee may be charged to the recipient.

All tetanus-containing vaccines (Td, Tdap) and routine vaccines administered to children younger than 19 years (except HPV for fully insured girls) remain federally funded. This memo addresses both sustained routine vaccine policy changes and the time-limited adult immunization campaign to be conducted as part of the ARRA stimulus funding. All ARRA funded vaccines must be ordered by the end of September 2010.

Note: All vaccines administered to persons of any age need to be documented on the IU screen of PTBMIS in both metro and regional health departments, in accordance with existing state policy. The state Department of Health has begun a process to migrate adult immunization records into the state immunization information system (SIIS – “the immunization registry”); those not documented on the IU screen cannot be transferred to SIIS.

The new categories of federally funded vaccines are listed below (those marked “ARRA” are expected to be discontinued once ARRA funds end in late 2010):

1. MMR (measles, mumps, rubella). PTBMIS code: MMR

- a. Adults (19 or older) needing this vaccine to meet state college entry requirement (discontinue MMC code)
- b. Adults with medical indications for MMR (e.g., a woman of childbearing age susceptible to rubella)

**NOT federally funded: MMR for adult travelers, occupational health (e.g., not for persons whose employer requires it – that is the employer’s responsibility)*

2. Adult hepatitis B vaccine (complete 3-dose series). PTBMIS code: HBF

- a. All at-risk contacts of a person with acute or chronic hepatitis B (e.g., household contact, sexual contact, or needle-sharing). Self-reported contact is acceptable – verification not required.
 - b. All persons with medical indication for hepatitis B vaccination (end-stage renal disease, dialysis, HIV, or chronic non-hepatitis B liver disease)
 - * *Those sites already participating in the limited special CDC hepatitis B prevention program will continue unchanged*
- 3. Adult hepatitis A vaccine.**
- a. All persons for whom it is indicated as post-exposure prophylaxis: 1 dose only **PTBMIS code HAZ**
 - b. All persons with medical indication (such as chronic liver disease, receive clotting factor): 2-dose series **PTBMIS code HAM**
 - **NOT federally funded: HAV for adult travelers, occupational health (employer’s obligation)*
- 4. Varicella vaccine (2-dose series). PTBMIS code: VVF**
- a. Adults without insurance coverage for whom it is medically indicated (susceptible – see ACIP definition or PHN protocol for details)
 - **NOT federally funded: Varicella vaccine for adult travelers, insured adults, occupational health (employer’s obligation)*
- 5. Pneumococcal Polysaccharide Vaccine (PPSV) PTBMIS code: PPS**
- a. For children <19 years with medical conditions that put them at high risk. The ACIP specifies risk factors for children for whom both PCV (conjugate vaccine) and PPSV is recommended. See PHN protocol for details.
 - b. (ARRA) For previously unvaccinated adults 19 through 64 years and Medicare ineligible with medical risk factors (see protocol for detail, includes all significant chronic illness, all smokers, all adults with asthma)
- 6. Haemophilus influenzae type B vaccine (Hib). PTBMIS code: HI4 or HI3 as appropriate – same as child**
- a. May be used for adults ≥ 19 who have a medical indication for the vaccine (e.g., sickle cell, leukemia, HIV or splenectomy). These indications are rare, but adults would get 1 dose of the same vaccine children receive.
- 7. Herpes Zoster (“shingles”) vaccine. PTBMIS code: ZOF**
- a. (ARRA) May be used for established primary care clinic patients only at this time. Ages 60 through 64 or Medicare ineligible if over 64. (*Note: Continue to use code ZOS – with a \$150 charge – for state or locally purchased Zoster vaccine for adults outside this eligible group*)
- 8. Tetanus, diphtheria and pertussis (Tdap) vaccine. PTBMIS code: TDP**
- a. *Already* covered for adults under age 65 – ARRA funds will be used through 2010 to support the increased use of Tdap in an active campaign to give pertussis protection of adults who live with or care for infants under age one year.

Labwork

Optional Quick Reference Lab Encounter Form

EXAMPLE

PTBMIS CODE	TEST NAME	TYPE of TUBE	LAB CORP CODE	PRICE
82024	ACTH (adrenocorticotrophic hormone)	L (freeze)	004440	60.50
82088	Aldosterone level, 24 hour urine	24 hour urine	004291	68.30
82150	Amylase	S	001396	13.00
86038	ANA screen with reflex titer <i>(if screen is positive it reflexes to titer panel)</i>	S <i>reflex</i>	164962 <i>(screen only)</i> <i>(titer panel)</i>	10.00 86.00
80048	Basic Metabolic Panel <i>(includes BUN, BUN/creatinine ratio, calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium)</i>	S	322758	2.30
82247	Bilirubin, Total	S (refrigerate)	001099	8.90
82607F	B12 & folate panel	S (refrigerate)	000810	16.50
86140	C reactive protein (quantitative)	S	006627	18.40
86304	CA 125	S (refrigerate)	002303	43.20
82310	Calcium, total (serum)	S	001016	1.60
85025	CBC with differential, automated	L	005009	2.50
85027	CBC without differential, automated	L	028142	2.45
82378	CEA	S (refrigerate)	002139	30.20
82390	Ceruloplasmin	R <i>(See directions)</i>	001560	19.90
87075C	Clostridium Difficile Culture	Stool swab <i>(not stool in cup)</i>	008045	23.80
80053	Comprehensive Metabolic Panel <i>(includes basic panel components plus: Albumin, alkaline phos, ALT, AST, total bilirubin, globulin (calculated) total protein)</i>	S	322000	2.90
82525	Copper	See dir.	001586	67.00
82533	Cortisol, total (serum)	S (refrigerate)	004051	28.10
82550	CPK, total serum	S (refrigerate)	001362	8.90
82552	CK isoenzymes <i>(includes CK-BB, CK-MB, CK-MM)</i>	S (freeze)	002154	25.90
82565	Creatinine (serum)	S	001370	8.90
82570	Creatinine (random urine) without protein	See dir.	013672	12.60
87086	Culture, AEROBIC <i>(urine ONLY)</i> / <i>(i.e. urine C&S)</i> <i>With reflex to S00001(at additional cost) if UA is positive</i>	Gray top	008847	10.00

PTBMIS CODE	TEST NAME	TYPE of TUBE	LAB CORP CODE	PRICE
87184	Antibiotic susceptibility of positive urine culture	-reflex-	S00001	5.00
87070L	Culture, AEROBIC (wound, ulcer, abscess, eye, conjunctiva or other ocular source ONLY) <i>With reflex to 87077 and 87186 (at additional cost of each) if culture is positive</i>	Aerobic swab kit	008649	12.00
87070UR	Culture, AEROBIC (nasopharynx, nares, upper respiratory, throat, ear ONLY)	Aerobic swab kit	008342	22.90
87075	Culture ANAEROBIC (should be used rarely)	Anaerobic swab kit	008904	46.90
87077	Organism identification if positive aerobic culture	-reflex-	008664	29.10
87186	Antibiotic susceptibility if positive aerobic culture	-reflex-	008680	28.90
85379	D-Dimer (FDP Quantitative)	See dir.	115188	30.00
80162	Digoxin level	R (refrigerate)	007385	27.30
80185	Dilantin (phenytoin) level, total	R or G (refrigerate)	007401	10.00
80051	Electrolyte panel	S	303754	1.90
82670	Estradiol	S (refrigerate)	004515	50.80
82728	Ferritin	S (refrigerate)	004598	6.50
83001	FSH	S	004309	31.00
82947	Glucose, fasting	S	001032	1.60
83036	Hemoglobin A1C	L	001453	5.00
80074	Hepatitis panel, acute (Includes Hep A IgM, Hep B Surface antigen, Hep B Core IgM antibody, Hepatitis C antibody)	S – 2 tubes (refrigerate)	322744	30.00
86704	Hep B Core Antibody	S (refrigerate)	006718	8.00
86705	Hepatitis B Core IgM Antibody	S (refrigerate)	016881	8.00
86706	Hep B Surface Antibody, Qualitative	S (refrigerate)	006395	8.00
87340	Hep B Surface Antigen screening <i>With reflex to 87341(at additional cost) if positive</i>	S (refrigerate)	006510	6.00
87340R	Hep B Surface Antigen confirmation	-reflex-	-reflex-	

PTBMIS CODE	TEST NAME	TYPE of TUBE	LAB CORP CODE	PRICE
87902	Hepatitis C Genotype	L (freeze)	550475	494.75
87522	Hepatitis C virus RNA, Quantitative	L (freeze)	550080	125.00
86803	Hep C Surface Antibody	S (refrigerate)	143991	8.00
86677	H Pylori IgG (qualitative)	S	162289	34.20
83527	Insulin, free & total	S (refrigerate)	140350	43.70
83525	Insulin, total	S (refrigerate)	004333	20.70
83540	Iron, total	S	001339	1.60
83550	Iron binding capacity, total iron, %sat.	S	001321	8.00
83655	Lead - Child	L microtainer	717009	21.40
82491L	Levetiracetam (Keppra) level	R,frozen see instructions	716936	117.25
83690	Lipase	S (refrigerate)	001404	6.00
80061	Lipid panel with LDL:HDL ratio	S	235010	4.50
80178	Lithium level	S (refrigerate)	007708	10.00
80076	Liver panel/Hepatic Function Panel (includes AST, ALT, albumin, alkaline phosphatase, direct bilirubin, total bilirubin, total protein)	S (refrigerate)	322755	2.20
83002	LH (lutening hormone)	S	004283	30.10
83735	Magnesium, serum	S	001537	6.00
6517	Microalbumin, urine random	See dir.	140285	35.90
83516M	Mitochondrial antibody	R (refrigerate)	006650	34.70
86308	Mononucleosis test	S	006189	17.80
83970	Parathyroid hormone, intact (PTH)	S (freeze) See directions	015610	20.00
80184	Phenobarbital level	R or G (refrigerate)	007823	30.30
84132	Potassium	S	001180	8.90
84703	Pregnancy (serum) HCG qualitative	S (refrigerate)	004556	8.00
84144	Progesterone (serum)	S (refrigerate)	004317	38.90
84146	Prolactin level	S (refrigerate)	004465	38.90
84156	Protein (24 hour urine) without creatinine	See dir.	003277	10.20
85610	Prothrombin time with INR	Light blue	005199	3.25
84153	PSA, total	S (refrigerate)	010322	8.00

PTBMIS CODE	TEST NAME	TYPE of TUBE	LAB CORP CODE	PRICE
80069	Renal function panel (includes albumin, calcium, carbon dioxide, chloride, creatinine, glucose, phosp., potassium, sodium, BUN)	S	322777	10.70
85045	Reticulocyte Count	L (refrigerate)	005280	6.50
86431	Rheumatoid factor, quantitative	S	006502	11.70
80299RF	Rifampin level	###	810931	147.00
86235S	(Scleroderma) Antiscleroderma antibodies	S	018705	90.75
85652	Sedimentation rate, erythrocyte	L (refrigerate)	005215	8.70
84295	Sodium	S	001198	1.60
84480	T3 Total	S	002188	10.00
84439	T4 (thyroxine) free	S (refrigerate)	001974	29.00
84436	T4 Total	S (refrigerate)	001149	1.50
80156	Tegretol (carbamazepine) level	R or G (refrigerate)	007419	10.00
84403	Testosterone, total	S (refrigerate)	004226	45.20
80198	Theophylline	R or G (refrigerate)	007336	29.40
83550	Total Iron Binding Capacity (TIBC)	S	001321	8.00
84478	Triglycerides	S	001172	1.60
82491T	Trileptal (oxcarbazepine) level	R or L (refrigerate)	716928	43.20
84443	TSH	S (refrigerate)	004259	4.00
84550	Uric acid, serum	S	001057	1.60
88112	Urine cytology	Cytology transport kit	009068	117.00
80164	Valproic acid (depakane level)	R or G (refrigerate)	007260	10.00

Most frequently ordered labs

Labs restricted to patients who are approved for and have agreed to outpatient Hepatitis C treatment

Special Instructions; please note

PLEASE NOTE: if a test has “reflex” associated with it that means that if the test ordered is positive or “out of range”, a 2nd (reflex) test will automatically be done. If the 2nd reflex test is done then an additional lab code must be added to the patient’s encounter because the 2nd test incurs additional charges. The nursing supervisor must be notified if the reflex test is done so that the patient encounter can be CENC and the additional test added.

Revised December 14, 2009

IN HOUSE or STATE LAB TESTING/PROCEDURES

PTBMIS CODE	TEST NAME	PRICE
	IN HOUSE Procedures/tests	
93000	EKG	23.36
85018	Hemoglobin	3.55
82270	Fecal occult (3 samples)	5.15
82272	Fecal occult (one sample)	5.15
82948	Glucose, fingerstick	4.75
94640	Inhalation treatment	14.34
82044	Microalbumin (urine) – Greene Co. only	7.11
81025	Pregnancy test	9.86
84703J	Pregnancy test JOHN DEERE only	11.46
85610IH	Prothrombin Time (PT/INR)	5.91
94760	Pulse oximetry	2.93
86403	Rapid strep	15.41
87210	Smear, wet mount, simple stain	6.71
81015	Urinalysis, microscopic	4.75
81002	Urinalysis, w/o microscopy (dip)	3.95
	STATE LAB TESTING	
GENP	Genprobe (put in LOE)	98.08
87252	Herpes culture	40.16
86701	HIV (put in LOE)	12.41
NEWB	Newborn screening	
87177	Ova & parasite (stool)	11.93
86592	RPR	5.37
85660	Sickle cell (Meharry)	
87045	Stool culture (enteric)	14.69
87116 or SPUT	TB sputum	16.73
	OTHER SPECIAL CODES	
A4206	Insulin syringes, box of 100	14.40
A425301	True track glucometer strips #100	32.00
E0570	Nebulizer compressor	27.00

12/14/09

APPENDIX D

PRACTICE

- **Protocol Signature Sheet Example**
- **Advanced Directives Forms Example**

Protocol Signature Sheet Example

EXAMPLE

ADVANCED PRACTICE NURSE PROTOCOL SIGNATURE LIST

_____ REGION

We the undersigned accept the responsibility of patient care. We recognize that the nurse practitioner's scope of practice is dependent upon the complexity and severity of the condition, and the clinical training of the practitioner. We agree to provide patient care within our individual scope of practice, utilizing Ferri's Clinical Advisor: Instant Diagnosis and Treatment. This resource has been jointly reviewed and agreed upon by both the precepting physician and the nurse practitioner(s). Any exceptions or exclusions of specific protocols will be so indicated as below and on said page(s) and signed by both the physician and the nurse practitioner. This protocol expires one year from the date of signatures. It shall be renewed and signed annually and is subject to revision at anytime.

Regional Medical Director

Date

Initials

Regional Nurse Practitioner/Primary Care Director

Date

Initials

Regional Nursing Director

Date

Initials

MD

Date

Initials

MD

Date

Initials

Advanced Practice Nurse

Date

Initials

Advanced Practice Nurse

Date

Initials

EXAMPLE
Primary Care Protocol Signature Sheet

ADDENDUM

NURSE PRACTITIONER PROTOCOL
TENNESSEE DEPARTMENT OF HEALTH

_____ REGION

_____ County/Site

This protocol has been jointly prepared by Nurse Practitioner and Medical Preceptors and is approved for use by Nurse Practitioners in the _____ Region.

The health providers whose signatures are below agree that this protocol establishes the standard for Nurse Practitioner Services for those conditions included in the protocol. This protocol expires in one year from the date of signatures. It will be renewed or revised and signed at least annually and more frequently as deemed necessary.

_____ NP has specialized knowledge and training in

and has been authorized by _____ MD to perform this procedure and/or function.

PHYSICIAN

NURSE PRACTITIONER

Name, Title, Date

Name, Title, Date

EXAMPLE
PRIMARY CARE PROTOCOL SIGNATURE SHEET
 _____ **REGION**

The following resources are accepted as medical protocol for the standards of care for advanced practice nurses (RN-ES, APN’s) serving clients in the Family Planning (FP) or Tennessee Breast and Cervical Screening Program (TBCSP). The health providers whose names are signed below 1) agree that this protocol establishes the standard of care for FP/TBCSP services and 2) agree to provide patient care within each individual’s scope of practice. A current copy of each resource shall be available at each site. This protocol will be reviewed, renewed, and signed annually.

Resources

- Contraceptive Technology, Hatcher, R. A., et.al ,Ardent Media Inc., New York, NY.
- Sexually Transmitted Diseases Treatment Guidelines, Center for Disease Control and Prevention, Atlanta, GA. (<http://www.cdc.gov/std/treatment/>)
- Managing Contraception For Your Pocket, Zieman, M., Hatcher, R. A., et. al., Tiger, GA, Bridging the Gap Foundation.
- Family Planning Clinical Guidelines “Guidance for Providing Title X Family Planning Services in Tennessee”, Tennessee Department of Health Bureau of Health Services,
- World Health Organization, Medical Eligibility Criteria for Contraceptive Use, World Health Organization, Geneva (see Family Planning Clinical Guidelines) (http://www.maqweb.org/iudtoolkit/policies_guidelines/whomec.pdf)
- PHN Protocol Manual
- Tennessee Breast and Cervical Screening Program (TBCSP) Program Manual

Regional Medical Director	Date	MD	Date
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Regional Nursing Director	Date	APN	Date
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Regional Primary Care Director/Coordinator	Date	APN	Date
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Advanced Directives Forms Example

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these items as you want**):

- Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

- CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes No
- Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
Yes No
- Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes No
- Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Yes No

PLEASE SIGN ON PAGE 2

Page 1 of 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

Any organ/tissue My entire body Only the following organs/tissues: _____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

*Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.*

APPOINTMENT OF HEALTH CARE AGENT
(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

Alternate:

Name

Name

Address

Address

City State Zip Code

City State Zip Code

() _____
Area Code Home Phone Number

() _____
Area Code Home Phone Number

() _____
Area Code Work Phone Number

() _____
Area Code Work Phone Number

() _____
Area Code Mobile Phone Number

() _____
Area Code Mobile Phone Number

Patient's name (please print or type) Date

Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above.
I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005