Consults and Referrals

Use the PHSKC Consult and Referral Form to document this activity and keep a copy in the chart. For consults with the Family Planning Medical Director, please refer to the Family Planning Medical Director Consultation Information. Provider referral lists are kept on the internal PHSKC clinical program intranet under the titles of gynecology and vasectomy referral lists. These lists are updated semi-annually by the Family Planning Program using PHSKC provider recommendations; reflecting historical referral patterns. A listing on the referral list does not imply an endorsement or that a PHSKC provider must use these lists, they are only a resource and represent only a partial list of the providers in the entire area. The lists are not appropriate for client use and it is recommended the PHSKC Consult and Referral Form be completed and a client should be given the option of 2 to 3 different referral provider options.

Referral Follow-up
When a client is referred for a consultation the chart should be assigned to a staff member to follow-up. Staff should verify the referral appointment was kept, that a record of the referral recommendations is returned to our department, and the provider is alerted of the results or if the client does not keep the appointment.

Primary Care Referrals
If the client does not have a primary care provider, then utilization of the PHSKC primary care clinic system should be considered. If a client has a condition which necessitates referral, it is possible to refer to the primary care clinic provider first and then that system can manage the referral process or perhaps become the end provider for the referral problem. An extensive document describing referral resources for the breast evaluation and referral into the PHSKC system is linked here (Primary Care Referral Information).

Harborview Women's Clinic Referrals
For referrals to Harborview Medical Center, the Information About Referral to Harborview Medical Center Patient Handout should be used. There is also a handout on Harborview Medical Center Payment Options available. If you are referring a client emergently, then call the Urgent Care Clinic, part of the Emergency Department, at 206-731-5867. They do not make appointments. If you are referring the client for a gynecology evaluation or women's clinic consult, then call 206-731-3367 to make an appointment. If the client needs a procedure like a tubal ligation schedule the procedure through the patient care coordinator, at 206-731-8597 and fax information to 206-731-8038. The staff must also leave the patient information including age, language, and preferably several phone number choices and times to contact the person. The patient care coordinator must arrange the appointment with the patient directly. Sometimes it works to have the health department clinic RN/MA call and help arrange it especially if interpretation is needed. Send paper copies of pertinent records and the referral with the patient as well so the patient knows why they are being referred and she can carry records to her appointment if FAXed materials are lost.

Coverage and Access

Medicaid
If a visit is greater than 50% family planning, the encounter should be recognized as a Program 28 visit on the Encounter Form and this form and the instructions for completion of the encounter form are available as a resource from PHSKC public folders.

Women whose medical care was paid by Medical Assistance during pregnancy are eligible for family planning services and supplies for an additional 10 months beyond the 60-day post pregnancy period. The family planning services extension covers the following:

- Family planning annual service package (includes pap smear, physical exam, family planning counseling, and contraceptive method).
- Non-prescription, over-the-counter products like male and female condoms, contraceptive cream, film, foam, gel, and suppositories
- Sterilization – vasectomy or tubal ligation
- STD services are only covered under the Family Planning Only program when related to a BCM, for example chlamydia infection treatment prior to IUD insertion.

If the client becomes pregnant and requests an abortion, the Family Planning Only coupon does not cover abortions. The client can be referred to the client services specialist or to the CSO to request eligibility determination for the full medical package.

Take Charge
Take Charge is a 5 year Medicaid program (7/2001 to 7/2006) for Washington State residents lacking health insurance family planning benefits whose family income is at or below 200% of the federal poverty level. The Take Charge website can be used to check for program updates http://fortress.wa.gov/dshs/maa/familyplan/TCfront.html. Take Charge cards and brochures can be ordered using the DSHS Publications Order Form or through the DSHS website at http://www.wa.gov/dshs/dshsforms/index.html. People currently covered by Medical Assistance are not eligible, as family planning is included in their health care package. A Washington State resident is determined by intent to remain in Washington. For example, a student from another state that intends to reside here permanently or for an indefinite period of time then becomes a resident. But if the student states “I am here for the school year only and will return to my home state” would not qualify.

Approved applicants may use their Take Charge coverage to get family planning services and birth control methods at an approved Take Charge family planning provider, local pharmacy, or surgical center. These services and methods include:

- An annual exam (no sooner than every 10 months)
- Family planning reproductive health education and risk reduction counseling
- All federal Food and Drug Administration approved birth control methods, devices, and supplies
- Non-prescription, over-the-counter products like male and female condoms, contraceptive cream, film, foam, gel, and suppositories

- Sterilization – vasectomy or tubal ligation (once sterilization is done, coverage ends at the end of that coverage year)

Consumer Hot Line for Insurance Company Questions/Concerns
If a client has insurance questions, these numbers may help. The State Office of Insurance Commissioner has set up a special, toll-free hot-line for consumers that are designed to assist consumers with questions, concerns, or disagreements with insurance companies.

The Consumer Hot Line – 1-800-562-6900 – is staffed from 7 a.m. to 7 p.m. Insurance experts for different kinds of policies, including health, life, homeowner and auto, can help with complaints or questions involving coverage.

The Consumer Hot Line can also assist the public with filing formal claims against insurance companies. For further information, contact the Consumer Hot Line at 1-800-562-6900, or call the Office of the Insurance Commissioner at 360-753-3613.

Reproductive Health Access Reporting
The Reproductive Health Access Report is to document instances in which women have difficulty accessing Family Planning Services due to the changing health care environment, particularly difficulties arising out of managed care in Washington State. This project can help accurately describe the issue and direct advocacy efforts to decrease barriers to reproductive health care.

You can help by submitting the Reproductive Health Access Form whenever a client tells you she experienced *any* trouble getting the services she wanted or needed. Please complete the form and send to Maria Wood; Clinical Services, Family Planning Program; 999 Third Avenue, Suite 1200; Seattle, WA 98104-4039. We will keep a record of the event and if appropriate, forward to the state insurance commissioner's office and/or possibly contact the woman to try and resolve the problem.

Coverage Question
"I have signed up for First Steps and now want an abortion will this change my medical coverage?"

Answer
"It's okay to change your status! Your pregnancy medical coverage coupon can be used to pay for a termination or for pregnancy care and it does not matter what you said to them at the time you applied. Even if you said that you were planning to continue the pregnancy at the time you applied that's ok, it can still be used for either service. The staff at DSHS has worked with many pregnant women that have changed their plans after applying for coverage.

After your termination, you will need to notify them (DSHS) that you've had a "change of circumstance"; you will have full medical coverage for yourself while you are pregnant and for 60 days after the termination. If you need to go to the doctor or to the dentist now is a good time to do that since it will be paid for; your coupon will change to "family planning only" 60 days after your termination.

Family Planning coupon will be good for 10 more months of coverage; it pays for any birth control method you choose even ones that you can get at the drug store like condoms or spermicides.

If you have other questions you can call DSHS at 1-877-980-9131. You can ask questions and you don't have to identify yourself.

We understand that getting services like this can be difficult emotionally as well as time consuming. Please don't hesitate to contact us again if you have more questions or need help."

Hep B Vaccine in Family Planning Clinics

- Family Planning staff can administer Hep B injections regardless of the client's age.
- Consult the Immunization Manual Guidelines for more information on Hep B.
- Medicaid Fee-for-Service does cover Hep B so clients with this coverage will not be charged for Hep B.
- Family Planning Only and Take Charge DO NOT cover Hep B so clients will be charged on the sliding fee scale for the vaccine and the administration fee.
- Self-pay clients 19 years old and younger will receive state-supplied vaccine at no charge. However, there is $15 administration fee that will be charged when the Hep B code is entered in Signature. This fee slides depending on the client's pay status.
- Self-pay clients 20 years old and older (including those who have coverage that does not include Hep B) will receive purchased vaccine. These clients will be charged for the vaccine and the administration fee. The vaccine will slide to the cost of the vaccine, which is currently $24. The $15 admin fee can slide to zero depending on the client's pay status.
- As with all services at PHSKC, services will not be denied due to a client's inability to pay. When the client is charged for Hep B, the charge will be entered in their account.

Delayed Physical Examination for Hormonal Contraception

Background
The following guidelines developed by PPWW support the practice of allowing a woman to delay a pelvic exam during a contraceptive visit:

Improved access to hormonal contraception: Patients would be able to access hormonal contraception as needed, without the delay of a full annual exam. The patient would be able to experience the advantages that hormonal contraception provides, over the other less effective contraceptive methods.

Education: Women may be able to learn more in a relaxed session, without the pressure of having to undergo a pelvic exam. Patients may also gain more information about women's health if they perceive that the pelvic exam is not tied directly to birth control and their access to it.

In the more than 40 years since the approval of birth control pills, the standards for prudent medical practices regarding hormonal contraceptives have evolved. An article by Stewart et al. (published in *JAMA* in 2001; 285: 2232-2239) lists recommendations for prescribing hormonal contraceptives by these national and international organizations:

Organization	Pelvic/Physical Exam
US Food and Drug Administration	Physical exam may be deferred if requested by the woman and deemed appropriate by the clinician. (1994)
US Agency on International Development	Pelvic exam is not necessary for safe use of combined oral contraceptives. (1994)
Planned Parenthood Federation of America	Pelvic exam may be deferred for up to 3 months, with blood pressure and history taken, along with breast exam. (1996)
World Health Organization	Pelvic exam is not necessary for safe use of combined oral contraceptives. (1994)
International Planned Parenthood Federation	Physical exam is not routinely required; careful medical history is taken. (1995)
American College of Obstetricians and Gynecologists	Pelvic exam is not necessary prior to initiating oral contraceptives in teenagers. (1999)

The FDA OCP labeling states the following:

> "It is good medical practice for all women to have annual history and physical examination, including women using oral contraceptives. The physical examination, however, may be deferred until after initiation of oral contraceptives if requested by the woman and judged appropriate by the clinician. The physical examination should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including cervical cytology, and relevant laboratory tests. In case of undiagnosed, persistent or recurrent abnormal vaginal bleeding, appropriate measures should be conducted to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules should be monitored with particular care."

Rationale
There are several reasons for a delayed pelvic examination. Primarily it allows flexibility and a client-centered approach to the provision of contraceptive services. Clients may have had an examination at another clinic and the need for immediate examination with our program may not be feasible, deemed needed, or even paid for by insurance. The client may be menstruating and it is preferable to delay the pelvic examination until she is more comfortable and until the pap test and other necessary tests can be obtained. Some clients are afraid of pelvic examinations and a delay may be indicated to give more time for education and reassurance. Other women may come to the clinic before the initiation of sexual activity and delaying a pelvic examination through an intact hymenal ring is frequently desirable, since there are no risks of STD or cervical cancer. As well some clients may be unable to wait in the clinic that day for an examination or a clinician may not be immediately available. A client may request a delayed examination for any reason.

Nineteen percent of women getting contraception chose a delayed pelvic visit at Planned Parenthood of Western Washington (PPWW) from 7/01 to 3/02 and a survey of 207 of these women yielded this information:

- 16 percent stated that they had never had a pelvic exam.
- 56 percent indicated that they had had a pelvic exam within the last year.
- 8 percent stated that they had avoided hormonal birth control because of the pelvic exam requirement.
- 91 percent stated their intention to have a pelvic exam within the next year – 33 percent of these with a private provider.

Policy
To provide hormonal contraceptives with an optional pelvic exam when:

- Extensive education takes place, covering STIs, birth control, and the importance of the pelvic exam.
- STI and pregnancy urine testing should still be offered.
- Personal and family history is reviewed by a provider and the vital signs are taken.
- The exam has been done elsewhere during the past year, with records obtained or documented.
- An exam within six months is strongly encouraged.
- The clinician exercises medical judgment.
- The clinician updates the patient's care annually.
- After six months without an exam, an extension is permitted, with a disclaimer or waiver by signing the Specific Birth Control Method Informed Consent Form.

Procedure
- Women requesting a delayed pelvic examination prior starting hormonal contraceptives must register, sign the same consents for care, and complete the **Family Planning Medical History Form** which is reviewed by a medical provider.
- Counsel the client about the benefits of a physical examination and testing for STD and cancer.
- Include the danger signs, risks, and benefits of the contraceptive method chosen.
- Review the FDA package insert and educational handout materials with the client.
- A prescribing provider reviews the entire history and records weight and blood pressure.

- Strongly consider HCG testing if irregular or delayed menses, especially in teens.
- Consider urine CT screening if under age 25.
- If there are no special risk factors, the practitioner may prescribe three cycles of pills or a DMPA injection using the Contraceptive guidelines.
- Hormonal contraception users should be strongly encouraged to undergo examination especially if their menses is irregular, even if virginal, and the American College of OBGYN recommends all women (even virgins) be examined by age 21 or after 3 years of sexual activity when younger than 21 to detect treatable precancerous conditions. In addition there is evidence that long term users of the OCP may have increased risks of cervical cancer.
- At remote sites or when no clinician is available on-site, the prescription may be given over the phone by a clinician to the clinic RN who does the counseling and testing of the client.
- The clinician must countersign the verbal order in the chart when next at the clinic site.
- Dispensing cannot be done without a prescription and prescriptions can only be written or given verbally by licensed providers with prescribing authority.
- When the client returns, complete the examination, and exam documentation then prescribe the continuing contraceptive method for the year or as indicated by the guidelines.
- If client presents after three months and again wants the delayed pelvic option, this may be given with careful documentation of counseling regarding the benefits of an exam. Document in the chart, the client understands that she may have a pre-cancer of the cervix or a STD that could cause infertility, and is refusing screening.
- After six months the client cannot get further hormonal prescriptions without signing the **Specific Birth Control Method Informed Consent Form**, documenting her formal refusal of examination. The refusal of exam must be documented every year the client continues to receive hormonal contraceptives by both progress notes and the signed consent form.

Documentation of Family Planning Visits

History Documentation

The PHSKC Department Policy and Procedures manual chapter titled "Medical Record Documentation Policy" are to be followed by PHSKC clinics. PHSKC retains records for 10 years after the last visit for adults and for up to 21 years after the last visit for a minor. What follows in this chapter are specific items to the Family Planning Program.

Health History: Clients complete a Female or Medical History Form or Male FP/STD visit form at the initial exam or first visit to the clinic and with every annual exam. It is reviewed as appropriate, dated, and signed by the practitioner managing the visit. Each item checked by the client on the history form should have comments or notes written beside or in the progress notes. If a Spanish version of the history form is used to assist in data collection, the information must be transcribed on to the correct English form or the Spanish with English translation version of the form can be used. The program requires an English medical history as documentation for billing and to share with other English speaking providers.

Use the Female Contraceptive/STD Visit Form for new or annual visits to document exam services. The male exam is part of the Male Family Planning/STD Visit Form, and should be used for all male visits. For female visits, the Female Contraceptive Visit Form should be used to document the exam and treatment in the context of a contraceptive visit. For clients under age 18 it is important to address and document discussion regarding parental / family involvement. Minors can give consent for contraceptive and STD healthcare, however, if there are questions, consult the Ability of Minors to Consent to Health Care Summary of Legal Requirements. A plain progress note is appropriate for other visits. The Family Planning Flow Sheet should be kept current with each visit to allow a quick summary of vital statistics like blood pressure, weight, pap results, and birth control method history.

Standard medical terminology and abbreviations are to be used when documenting Family Planning patient visits. The approved PHSKC Charting Abbreviations List is available for reference.

Use forms or other appropriate documentation for each specific contraceptive method as indicated in the Family Planning Practice Guidelines. When using the forms if an entire section of the form is to be left blank, then a single line should be struck across the section. The provider billing for the visit is responsible for signing the entire visit note or form and by signing the provider signifies their agreement with any other documentation done by others on the form, such as vital signs or medications used collected by an RN, MA, or health educator as designated by the provider.

All clients seen by the Family Planning program should sign the Family Planning Consent Form at their initial visit. This form has a second side to address hormonal methods which only females would sign. Clients need to sign this consent form at their initial visit and if there is ever a change

in their status as a returning client, such as two years since their last visit, which will revert them to a new patient again, then they will need to resign the consent form for family planning. All procedures require consent forms specific for the treatment to be signed. If the client requires a Birth Control Method Specific Informed Consent Form**,** then it should be re-signed at each annual visit, as that is the time of the annual prescription for the specific method.

Pregnancy Screening: Use the Pregnancy Detection section of the guidelines to complete the Pregnancy Screening Form for visits involving pregnancy testing to document counseling, exam results, follow-up plan, and/or verification of pregnancy for insurance purposes.

ROS Review

A review of systems for a level 4 or 5 visit needs to include 10 body systems. The Female Contraceptive Visit Form allows the documentation of the ROS using a list of ROS to prompt the provider to address the appropriate systems if appropriate. A circle around the system on the form indicates this specific system was addressed in the history and symptoms were absent unless indicated otherwise by notes. Systems are listed below and include the following subsets of specific symptoms queried for their absence or presence.

- Constitutional: night sweats, fatigue or weakness, weight gain or loss, fevers or chills
- Integumentary/skin: hair loss, skin rash or growth, bleeding or bruising
- Gastrointestinal: stomach pain, constipation, vomiting, nausea, diarrhea, heartburn, black stools
- Genitourinary: pain with sex, painful periods, heavy period bleeding, vaginal odor or discharge, bladder pain, incontinence, frequency, blood in urine, urgency
- Breast: pain, discharge, lumps
- Neurological: psychiatric, numbness, shaking, depression/anxiety
- Cardiovascular: chest pain or palpitations
- Respiratory: shortness of breath, cough, coughing up blood
- Ears/Mouth/Nose/Throat: hearing loss, ear pain or ringing or buzzing, problems with teeth or gums
- Eyes: double vision, eye pain, wear glasses or contacts
- Musculoskeletal: arm or leg swelling, joint pain or joint swelling or stiffness

Exam Findings Documentation

When using the Family Planning approved forms in the exam section the option of checking a box labeled normal is provided. The box indicating a normal finding on the exam must correlate with the following descriptions and variations or abnormal findings need to be documented with text.

Female Exam Forms

General Exam

- Thyroid, normal: symmetric, smooth, non-enlarged, no nodularity
- Breasts, normal: symmetric, smooth, no discreet masses or lumps, no adenopathy or nipple discharge
- Heart, normal: regular rate and rhythm, no murmurs appreciated
- Lungs, normal: clear to auscultation without wheezes or rales
- Abdomen, normal: non-tender, no masses, no hepatosplenomegaly
- Skin, normal: no suspicious nevi, lesions, or rashes seen; extremities without

abnormalities

Pelvic Exam

- Lymph nodes, normal: no groin adenopathy or enlargement appreciated
- Vulva/vagina, normal: adult female maturation, no lesions, no suspicious nevi, normal BUS (bulbo-urethreal-skene glands) and no urethral caruncle or prolapsed epithelium, estrogenized, vaginal rugae, pink & moist
- Discharge, normal: discharge clear, white, or scant without odor or purulence
- Cervix, normal: no lesions or mucopus, ectopy appropriate for age and parity, non-tender
- Uterus, normal: symmetric, smooth, firm, mobile, non-tender & non-enlarged
- Adnexae, normal: non-tender, no masses palpated
- Rectal, normal: spincter intact, no masses felt, stool if checked negative for blood

Chart Stickers

Do Not Destroy Sticker: The purpose of the Unique Retention Sticker is to mark the medical record of clients getting an implant or device inserted by our clinic, like the IUD or Implant, so these records will not be destroyed. The chart may be purged and taken to storage but it cannot be destroyed for 15 years after the date of insertion of the device even if the device is removed. The Pharmacy Implant & Intrauterine System Log sheets are also to be stored for 15 years in the event of a product alert or recall. Product liability suits may be filed up to 15 years after product usage, which may require finding old records to find out if the client got an implant, which is being recalled, for example.

1. Label the charts of:
   - IUD users when PHSKC has performed the insertion.
   - Contraceptive implant user when PHSKC has performed the insertion.
   - Patients with colposcopy and CIN II/III biopsy result performed by PHSKC. We need to have this information kept until the patient is 65 years or older after which time the possibility of cervical cancer is very low.
2. Mark charts by folding sticker over the edge of the chart so it can be seen while on the medical record shelf so opposite the number side of chart. The " Unique Retention Sticker" should show on the outside of the chart while the information is hidden on the inside of the chart.
3. Put the date of the IUD or implant insertion, or biopsy date as indicated. If the sticker is used for other charts to avoid purging write the reason and date after other.
4. Example of sticker available from the warehouse.

Unique Retention	**IUD**: ☐ T380A ☐ LngIUS Date_____ **Implant**: ☐ Implanon ☐ Other Date_____ **Other**: _____

Allergy Sticker: The Allergy Sticker should be affixed to the problem list and the outside of any chart of a patient with a declared allergy. At every healthcare visit, patients should be queried regarding allergies and any new allergy should be recorded on the problem list. Print the stickers on a sheet of labels (Avery Yellow Fluorescent Labels 5972, 1" x 2 5/8").

Allergy Alert

_____

Urine Dip Results Sticker: This sticker can be affixed to the progress notes to document the in clinic lab result of the urine dip analysis. Here is an example of the sticker:

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50	Neg +	Normal 1	Neg Sml Mod	Normal 50 100	Neg Tr 30	Neg Pos	Neg Tr	5 6 7	1.000 1.005 1.010 1.015

Print the stickers on a sheet of labels (Avery Shipping Label 5163, 2" x 4") which should be white.

Telephone Triage Documentation

Registered Nurses do the *assessment and planning* for triage calls, using the nursing process.

The triage nurse is identified at each site, including when regular staff is gone. Triage decisions are based on assessment, pertinent medical history, patient response to symptoms and generally result in following disposition:

- Emergency..... 911 or send to ER
- Urgent-see ASAP/same day ..... Call back <1 hour
- Non-urgent-see within 1-3 days ..... Call back <4 hours
- Safe to treat at home-give home care info. ..... Call back <4 hours

All calls where health care advice is given are documented on the appropriate form Triage Form. The original copy is placed chronologically in the medical record in the program notes with tape on the top and bottom of form so cannot be lost. The NCR copy is retained chronologically in a confidential file for 3 months and then shredded. This NCR copy may be used for several activities: follow-up log, to demonstrate legal compliance, QA activities, and Utilization Review.

Whenever possible, the Medical Record is consulted before assessment and planning of chief complaint is completed (with the caller) and documented on Telephone Triage form or directly into medical record.

Documentation for telephone triage is complete, concise, signed and dated (including time call came in and time call is returned) and follows documentation guidelines for essential elements.

RN's assess Triage slips at minimum 1X/hour. Acute symptoms/illness calls are returned when noted ASAP. Non-urgent calls for health care information are returned within four hours. Examples: general home-care questions, calls for pharmacy refills, lab tests, routine follow-up calls.

Situations which require follow-up by nurse or provider are documented as such and calls are returned within time frame stated.

Triage calls will be monitored by PHSS regularly for skill, customer service, and timeliness.

Average talk time of a telephone call to assess and make recommendation (triage) is six minutes. (Benchmark)

Sexual Assault and Domestic Violence

39% of American women have experienced domestic violence or sexual assault at some point in their lifetimes (Collins, et al., 1999). Survivors of abuse have more chronic physical and mental health problems and suffer from more injuries than women who have never experienced abuse (Hendricks-Matthews, 1993). From the immediate threat to physical safety posed by domestic violence, to the long-term health consequences caused by sexual assault, violence against women represents a major public health concern. Providers may not know that their patients have experienced abuse because they do not routinely ask about current or past abuse. Research shows that patients want their providers to ask these questions, and that they believe their providers can help with these problems. Fortunately, Title X-supported clinics inquire about domestic violence at a much higher rate than do other clinics. More than 80% of clinicians at Title X clinics report that either verbal or written screening occurs routinely at their clinics, as opposed to less than 40% of a general sample of clinicians (Friedman, 1992; CDC, 2004) Provider knowledge of current or past sexual assault and domestic violence are imperative to the proper diagnosis, treatment and clinical management of patients.

Health Consequences of Sexual Assault and Domestic Violence

It is important to remember that individual responses to domestic violence and sexual assault will vary. More severe symptoms for childhood sexual assault survivors are associated with abuse onset at an early age, abuse by a parent, extended or frequent abuse, or use of force. Symptoms may be less severe or persistent if victims felt support from important persons in their life or if they posses certain inherent resiliency factors. General sequelae associated with sexual assault and domestic violence are listed below (Hendricks-Matthews, 1993).

Emotional
- Anxiety and panic attacks
- Lowered self-esteem
- Fear and phobias
- Anger

Cognitive
- Hallucinations
- Flashbacks and intrusive memories
- Dissociation

Interpersonal
- Sexual dysfunction
- Revictimization proneness

Somatic
- Insomnia
- Nightmares
- Nausea, gagging or vomiting
- Chronic pelvic pain
- Stomach pain
- Eating disorders
- Chronic illnesses that defy medical diagnosis

Behavioral
- Substance abuse
- Impaired social function
- Personality disorders
- Aggressive and antisocial behaviors
- Suicidal tendencies

Effects of Sexual Assault and Domestic Violence on Reproductive Health and Pregnancy

Childhood sexual assault can have long-term consequences for women's reproductive health. Gynecological problems such as chronic pelvic pain, dyspareunia, vaginismus and non-specific vaginitis are commonly reported. Sexual interest and sexual functioning may also be impacted, ranging from a lack of interest in sex or an inability to achieve orgasm, to sexual activity with multiple partners and involvement in prostitution. Childhood sexual assault is also significantly associated with adolescent pregnancy and increased STD rates, including HIV (ACOG, 2000). Domestic violence places women at risk of unintended pregnancy and STD exposure, as their partners may control their access to birth control and reproductive health information. Furthermore pregnant women are at a higher risk of domestic violence than women who are not pregnant (Straus and Gelles, 1990). Young pregnant women are at an even higher risk (Hedin and Janson, 2000; Parker et al, 1994)

How to Ask About Sexual Assault and Domestic Violence

- Never ask about DV or SA in front of others - If you can't ask her alone, don't ask
- Ask *all* women
- Normalize questions; find a way to ask that feels comfortable for you

- Begin with a **framing statement** explaining that you ask everyone. Many women who have experienced abuse may believe that you can "see it on them." The framing statement reassures them that this is not true. One example might be:

  "*Domestic violence and sexual assault are major health issues for women. Because so many women have experienced abuse, I ask all my patients these questions.*"

- Ask questions that are **behavior-specific**. For instance:

  "*Have you ever been forced into sexual acts as an adult or a child?*"

  "*Has your partner ever pushed, hit, kicked, or physically hurt you? Has he/she ever forced you to engage in sexual activities?*"

  "*Has your partner ever put you down, said hurtful things, or threatened you?*"

Instead of:

"*Have you ever been sexually assaulted or raped?*"

"*Has your partner ever abused you?*"

If a client discloses abuse to you, document it in the chart and offer referrals. Offer all clients the option to call the Domestic Violence Hotline, at 1(800) 562-6025, or the Sexual Assault Resource Line, at 1(888) 99VOICE (1-888-998-6423). An advocate from these agencies can offer counseling, safety planning, and resources. The hotlines are also available for professional consultation. Further information is listed below about documenting, making a CPS call, and working with clients in currently abusive relationships.

Documenting Sexual Assault, Domestic Violence and Child Abuse

- Document any domestic violence, sexual assault or child abuse in the progress notes of the chart.
- Document information of general clinical importance in the general progress notes for the visit, such as recent sexual assault, or history of sexual assault which is affecting current health.
- If extensive notes are needed, such as CPS calls, or documentation of an incident, document this on a separate sheet from any other notes, with a reference to the note containing the abuse information in the general progress note. As with other sensitive information, this allows confidentiality to be maintained. When medical history is requested from another clinic, these more extensive notes should be excluded. Similarly, if abuse information must be shared with another agency, medical history should be excluded. Providers' best judgment must be used in weighing clinical importance against confidentiality of the client when sharing chart information.
- When documenting calls made to CPS or law enforcement, including the name of the intake worker, what was reported, and any follow-up calls made.

Providing Clinical Services to Sexual Assault Survivors

Gynecological and obstetric procedures may be traumatic, triggering memories of past abuse. These include procedures such as vaginal, rectal and breast examinations, being connected to intravenous lines and lab monitors, and the experience of giving birth. Survivors may react to these events with anxiety or panic attacks or may dissociate completely. When working with a survivor of sexual assault, it is important to thoroughly explain procedures in advance, ask permission to touch her, and affirm her ability to stop the exam at any time. Other techniques to help ease her fear and prevent dissociation include: maintaining eye contact, allowing her to control the pace of the examination, talking her through the examination, and allowing her to have support people present.

Working with Clients in Currently Abusive Relationships

When working with clients who are currently in abusive relationships, it is important to discuss strategies to increase their safety and the safety of their children. Although it is tempting to advise the client to leave the relationship, this may not be the safest option at the moment. She will leave when she is ready and able to do so. However, we can help develop strategies to minimize harm to the client and the client's children. Ask the client:

- Where is her partner now? Returning when?
- Does she feel safe to go home today?
- Does she feel comfortable calling 911 in an emergency?
- What concerns does she have for her children's safety?
- What is the plan if future violence occurs?
- If one thing could be done to support you, what would it be?

If she does not feel safe to go home today, discuss her options. If her partner is in the lobby, she may want to call 911 from the clinic. Help her facilitate this process. If she is at the clinic alone, she may have someone she can stay with, or may be able to go to a shelter. Offer to let her call the Domestic Violence or the Sexual Assault Resource Line from the clinic phone. An advocate may be able to provider her with more thorough safety planning and discuss her options with her.

If it is safe for her to take written materials with her, offer the Domestic Violence Safety Plan Pocket Guide. These cards can be ordered from DSHS (publication # 22-276X) online at: https://fortress.wa.gov/prt/printwa/wsprt/default.asp

Making a CPS Report

Public Health employees are mandated to report suspected abuse or neglect of children under the age of 18 to Children's Protective Services, at 1(800) 562-5624. This includes, but is not limited to:

- Disclosure from a child or parent that a child is being abused or neglected by an adult
- Suspicious or unexplained injuries
- Disclosure of domestic violence that lead you to suspect that children in the house may be being abused (note: domestic violence does NOT always indicate child abuse)
- Disclosure of a significant age difference between an adolescent client and her/his partner (click here for guidelines – links to "reporting guidelines" section within this document)

It is important to let your client make the CPS call herself if she is willing and able (adults AND adolescents). For more information on crimes that require a CPS report, see "Abuse and Neglect Reporting for Children and Vulnerable Adults" (http://publichealth/policy/famplan/mandated-reporting.ppt)

Information that will need to be included in a CPS report, if possible, includes:

- Name, address, and date of birth of the child
- Name and address of the child's parents, stepparents, guardians, or other persons having custody of the child
- Any injuries or description of neglect or sexual abuse
- Any evidence of previous injuries, including their nature and extent

Emergent Rape

If a client presents with a rape that has occurred within the last 96 hours, and would like a rape exam, refer to Harborview at (206) 521-1800, or other local hospital. Not all clients will be interested in receiving a rape exam – it is important that the client make this decision totally on her own. The purpose of a rape exam is to gather forensic evidence for prosecution of a criminal case.

If the client would like to speak with someone immediately about her assault, allow her to use a phone to call the Sexual Assault Resource Line, at 1 (888) 998-6423. A trained counselor can help her discuss her options and can address her immediate trauma. Be helpful and supportive with the client, and make sure to maintain her confidentiality. Your help and support at this time will contribute to her healing from this trauma.

If the client is not interested in receiving a rape exam at a facility where forensic evidence can be collected, she should be offered emergency contraception and STD testing and treatment. She should be spared from an appreciable wait in the waiting area. Consideration might be given to completing registration data in the examination room. Maximum emotional support should be provided and all efforts should be made to minimize additional emotional trauma. It is our function to be non-judgmental and to provide care that is emotionally and medically appropriate.

Offer emergency contraception if it has been less than or 120 hours from assault. Also offer STD prophylaxis and treat as for positive GC and CT. Consider hepatitis B immunization, referral for HBIG, and possible HIV prophylaxis medication if high risk assault (anal, multiple assailants, or assailants known to use IV drugs or from endemic areas).

Adolescents

Adolescents may present with recent rape, current or past childhood sexual assault, or sexual exploitation or coercion. It can be confusing to know how to best help an adolescent, and what information must be reported to CPS. Adolescents may react to sexual assault in a number of ways. They may be very distraught, or may seem completely unfazed. They may withdraw from all sexual activity, or may engage in sexual activity with multiple partners. It is important to remember that all of these reactions are normal, and all clients who have experienced sexual assault should be offered resources to help in their healing process.

Some adolescent clients seeking reproductive health care may be have partners who are significantly older. They may be uncomfortable and feel pressured in these relationships, or may be very happy. Regardless of their feelings for their partner, in Washington State it is illegal for adolescents under the age of 16 to be involved with partners who are significantly older. Specific age differences are listed on the following page under "Reporting Guidelines."

Providers must notify CPS if clients are victims of child abuse or neglect, including the sexual crimes detailed in the "Reporting Guidelines" section of this document. Again, it is important to let adolescent clients know that a CPS call will be made, and to allow them to make the call if they are willing. These crimes must be reported to CPS even if the adolescent states that the sexual contact was consensual. Washington State does not recognize the ability of a minor to consent under these circumstances.

If an adolescent has been abused or assaulted by a peer of the same age, you are also mandated to report this to CPS. Let the adolescent know that what has happened to her is not acceptable, and that she has every right to call the police on her own behalf if she chooses. Of course, she should also be referred to appropriate services, and should be allowed to call the domestic violence or sexual assault resource lines.

Reporting Guidelines

In addition to reporting any suspected child abuse or neglect, there are several laws outlining specific age differences which constitute criminal sexual abuse.

Child Molestation is sexual contact with a person who is much younger than the offender; Rape of a Child is intercourse with a person who is much younger than the offender. There are three degrees, depending on the ages of the victim and the offender. Child Molestation and Rape of a Child are both felony crimes. *RCW 9A.44.073; RCW 9A.44.076; RCW 9A.44.079; RCW 9A.44.083; RCW 9A.44.086; RCW 9A.44.089*

- First Degree – victim is less than 12; offender is at least 24 months older than the victim for rape, or 36 months older for child molestation
- Second Degree – victim is 12 or 13; offender is at least 36 months older than the victim
- Third Degree – victim is 14 or 15; offender is at least 48 months older than the victim

Furthermore, Sexual Misconduct with a Minor is intercourse or sexual contact with a person who is 16 or 17 by a perpetrator *who is in a significant relationship* to the minor (for example, a coach, teacher, nurse, boss, counselor), and *who abuses a supervisory position* within that relationship in order to engage in such behavior. Sexual Misconduct with a Minor in the first degree is a felony; second degree is a gross misdemeanor.

- First Degree – intercourse; offender is at least 60 months older than the victim
- Second Degree – sexual contact; offender is at least 60 months older than the victim

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Education

Client Contraception Education All clients should be informed or educated about all contraceptive methods. A good flip book brochure on choosing a birth control method is available in English and Spanish through the Washington State DOH (can use the DOH Forms and Publications Request Order Form and request DOH Pub 930-101 4/02 and Fax to 360-664-2929) and other contraceptive education materials method and brochures can be ordered from the PHSKC warehouse using the FP Brochure Distribution Center Order Form. The DSHS STD Educational Materials Order Form can also be used to order STD materials (360-236-3460 if questions) or their website http://www.doh.wa.gov/chf/STD/publications.htm. The Office of Population Affairs Publications Clearinghouse Order Form is another source of free materials on birth control methods.

All clients sign on registration the Family Planning Consent Form. As appropriate PHSKC brochures and handouts on the specific contraceptive methods should be shared with clients and the chart note should document which materials were shared with the client. Any client receiving a contraceptive requiring a prescription and medication should be given the FDA approved patient package insert for the medication to read as part of the discussion on the risks and benefits of a method.

The risks of estrogen containing methods include the following warning signs and symptoms: severe abdominal pain; severe chest pain or shortness of breath; severe headaches; eye problems such as blurred vision, or loss of vision, and severe leg pain (calf or thigh). Women also need information regarding common hormonal side effects and these include: nausea; spotting between periods (breakthrough bleeding); depression; breast tenderness; headaches; changes in sex drive; worsening in acne; high blood pressure; darkening of the skin on the face.

All clients should be counseled about the need for barrier protection against sexually transmitted diseases, the mechanism of disease transmission, and how to evaluate their sexual practices and their contraceptive method as to the need for STD protection and for HIV/STD prevention including choices such as abstinence and mutually monogamous relationships.

All clients should be told of how to access local health care if emergent or after hours care when needed. Use the Education, Counseling, and Risk Reduction Form to document contraceptive education and counseling once a year (no sooner than a 10 month interval). Vaccine recommendations for adolescents and adults can be found at website: http://www.cdc.gov/nip/recs/adult-schedule.pdf

When using the FP/STD Female Visit Form providers will indicate education and counseling topics discussed with clients by checking boxes on the visit form. The descriptions of the content and points discussed for the topics are provided below.

1. Contraception: counseling about contraception as a global topic, specific method could be indicated, what method or methods discussed at the visit, contraceptive planning, method brochure or contraceptive choices flipbook could be supplied to the client. Specific information about a method is taken from the specific guidelines for each method individualized for the specific client.

2. How to start and how to use a method includes working with the woman on what she wants, does she want a Sunday start, to start the day of the visit, or perhaps to start with her next menses. Often the package for the pills or the method will be brought into the room and the woman will be shown how to remove the pills from the package, how to place the method like the patch, how to dispose of the used ring; these are all examples of how explicit the instructions can be and they are from the method chapters of the guidelines.

3. Back up method for 1 or 2 weeks. We circle if 1 or 2 weeks recommended for back up. We assess risk and need for back up contraception, ask if partner will use condoms or withdrawal, abstinence promoted as most effective, we remind women that they should be prepared, and provide ECP if important to their back up method plan.

4. EC availability/use/side effects to provide the information about it being available, can get from a pharmacy or a clinic, may also include discussion about how to use ECP and the common side-effects as presented in the EC chapter.

5. Advance provision ECP means women can be prescribed the packages to use in the future if the condom breaks or other unprotected sex. Women are advised to return to get a replacement package when needed.

6. Refused Advance provision ECP prescription indicates the woman typically identified by the provider as at risk for needing the ECP, such as a condom user, was offered an advance prescription but did not want to actually get it from the clinic that day.

7. BCM specific consent form was used and the topic on the form discussed as specified with the patient.

8. Estrogen side effects and thrombosis danger signs presented and discussed to the client along with the package insert from the prescription to include: breast tenderness, nausea for typical estrogen side effects and hair loss, acne, weight changes for possible progestin side effects. The serious risk of a blood clot could present with symptoms of severe or new headaches or visual changes, chest pain, shortness of breath, abdominal pain, or leg pain along with a leg or foot swelling.

9. Preconception counseling is identifying a client is at risk for possible pregnancy, either because she wants to get pregnant or is at risk for pregnancy, this can involve sharing the handout on this topic, folic acid necessity, screening for risks as discussed in the guidelines.

10. ECRR teaching done and form completed at this visit. The details of how to conduct an education, counseling, and risk reduction intervention are addressed in a document on the PHSKC health educator webpage.

11. STD/HIV prevention include the promotion of abstinence or mutual monogamy as the only 100% method, the importance of both male and female condoms, how to use the male condom to prevent breakage (sufficient lubrication, space at the tip, use prior to contact, and removal before loss of erection), screening partners, risk factors, sexual practices, the information and specific content of these messages comes from the

PHSKC STD guideliens, and many of these discussion can include brochures available from DOH on these topics.

12. Substance use addressed as an issue, identified this could be a problem for the client, specific history collected and discussed, risks of progression to other use, impairment of judgment, and health risks.

13. Tobacco cessation counseling as specified in the clinical guidelines.

14. Dietary education provided regarding the importance of calcium for bone health, iron if anemia, and weight reduction if obesity. All of these have specific handouts on the guidelines website and can be used to direct the content of the information.

15. Family involvement/Relationship safety involve the asking about the these issues, collecting the information, reminding the client that family will find out and should be involved often in family planning decisions and support. Identification of domestic violence or safety concerns, use of the guideline information about this topic and can help provide a safety plan and the state card/800 number.

16. Cervical cytology/HPV education regarding the importance of cervical cancer screening individualized for the woman and in context of her testing results. HPV or human papilloma virus information can be shared using the patient handout and the information from both the cervical cancer screening and STD guidelines.

17. Breast cancer self-exam/ screening information shared with the client using the guidelines. How to perform a self breast exam is often demonstrated on the client during a clinical breast exam. Referral for mammogram screening if indicated can be part of the visit and done using the breast guidelines.

Examination of Family Planning Clients

Physical Exam

A physical exam involves a systematic evaluation of the body incorporating the techniques of inspection, palpation, percussion, and auscultation. Several excellent books have been published which describe examination assessment techniques and screening procedures in depth. Clinicians conducting health exams should rely on such texts as reference guides if needed.

The physical exam should be brief, yet complete, with an emphasis on those areas suggested by history. Professional judgement should be used in determining if part of the exam should be omitted or postponed if situations necessitate (i.e. lack of privacy, client refuses). For a visit for a specific problem, the exam should be directed at the systems related to that problem.

The following is a general outline for the physical exam. This outline lists the specific systems or areas which should be examined and the types of observations which are important to each area. It is not intended to be all-inclusive.

General Physical: Provide on initial and Family Planning annual exams.

- Height - provided on initial visit, repeat at age 18 and 24.
- Weight
- Blood pressure, (Pulse for IUD insertion and temperature if infection check)
- Inspect oropharynx and tongue (only if oral symptoms or tobacco user)
- Visualize and palpate thyroid
- Lung auscultation (Only if pulmonary symptoms present or age<21)
- Heart auscultation (Only on initial exam or if cardiac symptoms or age<21)
- Palpation of abdomen to feel for masses and enlarged or tender liver
- Breast examination and palpation for nipple discharge, masses or abnormality and assess axillary and supraclavicular lymph nodes.
- Entire body skin inspection for suspicious nevi, skin lesions, or rashes.

Genital Exam: Provide on initial, annual, and infection check exams. If STD evaluation, refer also to PHSKC STD Clinical Guidelines.

Female:
Use Female Medical Exam Form.

- External genital skin, labial structures, urethra, glands, inspect and palpate
- Speculum exam of vaginal mucosa and ectocervix
- Consult STD guidelines (http://www.metrokc.gov/health/apu/std/std-clinicalguidelines.doc). for specimen collection instructions. The order for specimen collection should be as follows:
  1. Vaginal secretions: pH, saline wet mount, KOH sniff test, and microscopic evaluation for fungal elements (KOH or Gram stain).

2. Endocervical secretions for culture or other approved test for N. gonorrhoeae (or urethra if cervix is absent) and test for C. trachomatis (or urethra if cervix is absent).
3. Cervical cytology (consult Cervical Cancer Screening section of the Guidelines). Always use both the spatula and cytobrush. If mucopurulent endocervical discharge is present, it is preferable to defer cytology test until cervicitis has resolved.

- Bimanual exam to palpate vaginal walls, cervix, uterus, and adnexa
- Rectovaginal exam after age 50 for stool giauac or if adnexal mass or pain concerns
- If a virgin, not sexually active, with no STD or menstrual complaints or symptoms, then the pelvic exam may be delayed until the age of 21 using the Delayed Pelvic Guidelines. After the age of 21, for hormonal prescriptions, patient is strongly advised to have a pelvic exam. However, the client may choose to sign a Birth Control Specific Informed Consent Form to refuse.
- For the chart carefully document counseling regarding the benefits of an exam and the reasons for exam refusal. Cervical cancer screening should be initiated by 3 years after sexual coitarche or by age 21.
- Adolescents still benefit from breast exam to detect masses, anomalies, and development.
- The Feminine Hygiene Menstrual Product **or** Female Anatomy handouts can be offered to patients, and if appropriate, the Bacterial Vaginosis**,** Trichomonas**, or** Yeast Patient Handouts.

Male
Refer to PHSKC STD clinical practice guidelines (http://www.metrokc.gov/health/apu/std/std-clinicalguidelines.doc). Use Male Medical Exam Form. Use the Male Anatomy and Testicular Exam handouts as needed.

Specimens
All specimens sent should be logged on the Lab Test Tracking Log so that tracking can be done to ensure timely results and follow-up

Reportable Diseases: If a reportable disease is discovered during a Family Planning patient visit, the health care provider must report the case to the appropriate Public Health Department within the allotted time. Please refer to the Reportable Disease List for more information or view the Washington State DOH website at (http://www.doh.wa.gov/notify/).

Scheduling Clients

Exam priorities are listed below. This list is only to help guide scheduling and to give examples of appropriate Program 28 visits.

1. OCP and injection refills for established patients not due for annual exam.

2. Annual exams for renewal of their birth control method.

3. New exams to begin contraception.

4. Post abortion or post partum clients with contraception needs.

5. OCP and injection refills for new patients that will need to get records but not an exam.

6. Emergency Contraception prescription and possible contraception start/exam.

7. Pregnancy detection testing, exam, and possible contraception if terminating.

8. Implant, IUD, or sterilization (male or female) consults.

9. Contraceptive method questions.

10. Women asking for pap testing alone. Ask if contraception method needed, if not, consider referral to the Breast and Cervical Health Program or other community site.

11. STD concerns, vaginal discharge, recent exposure to partner with an STD.

12. HIV testing.

13. Abdominal, pelvic, urinary, or breast complaints. If it is a new client and that is the primary reason for the visit request, then the RN should screen the call, however, it is likely the person will be referred elsewhere because we are a categorical family planning STD program. Unless these complaints relate to contraception or STD services, coming to our clinic is inappropriate and not in the patient's best interest as we do not have the resources (for example, ultrasound).

14. The encounter form cannot be coded to Program 28 unless the visit documentation has proof that contraceptive or STD management services were provided. For example, a visit that was only for a urinary tract infection in a married, monogamous woman with a history of sterilization would have little reason to code under Program 28. For that matter, even her pap smear would not fit this criteria.

Pharmacy

Pharmacy Guidelines for Program 28

1. Dispensing at the site can only be paid for by Program 28 if the medication, dose, and packaging (# of pills per bottle) is on the current approved PHSKC Family Planning Program Formulary.
2. Providers can write prescriptions for these medications instead of dispensing if compensation requires a pharmacist to dispense the medication for payment; such is the case with some insurance prescription policies.
3. A provider can always offer clients prescriptions for medications or amounts that are not on our formulary and the client can then purchase the medication at a local pharmacy.
4. Sites will maintain their family planning program pharmaceutical supplies using the family planning program order forms once a month and stocking the amounts determined as reasonable for the specific site for a one month supply of each medication. In case of a drug recall consult the Pharmaceutical Recall Policy.

Maintenance of the Dispensary at Non-Pharmacy Sites

1. Stocking:
   Only items on the approved Family Planning Program Formulary List are to be stocked at non-pharmacy/dispensary sites. No other items will be included without approval from the Family Planning Medical Director or the Chief of Pharmacy**.** Pharmacy Medication Stickers for the approved medications are supplied by the pharmacy as needed and when updates occur. Family Planning staff should determine the amount to stock at each site. We recommend that you review your stock on a weekly basis and compare it with the amount needed for a one-month supply. Pharmacy staff will work with you to determine the schedule for ordering at your site. It is important to be aware of medication expiration dates and to return any stock to the pharmacy expiring soon. Be careful to keep the stock with the designated stickers to avoid dispensing a product with a sticker that does not have the corresponding Lot # or Expiration Date. Each dispensary site should have a designated clinic staff person (can be MA or RN usually) as a pharmacy contact person to work with the pharmacy on stocking, ordering, and supplies.

2. Ordering:
   Submit all orders for Family Planning pharmaceuticals for the non-pharmacy/dispensary sites on the Family Planning Program 28 Pharmacy Medication Order Form or Clinic Stock Order Form, which are kept on the PHSKC intranet site.

3. Dispensing:
   The medication labels have 4 stickers to facilitate dispensing. Please adhere the large patient prescription sticker with the patient's name and provider name to the medication, the next sticker should go at the bottom of the encounter form as it has the encounter number and NDC number (and fits at the bottom of the page), the next and the thinnest sticker is for the medication sheet in the patient chart, and finally the last sticker on is fixed on the medication dispensing log in the pharmacy (even though it may overlap slightly on the prior

sticker) as this sticker has the expiration date, Lot #, and all other important information needed to record for in the event of a product recall. If you have a Spanish speaking client, an additional Spanish label for medication instructions, in Spanish is available, if this label covers the english label completely then it is very important to write the lot # on the Spanish label. It may be easier to place the Spanish instructions on a separate sheet of paper and give that to the client. Log all medication dispensed for Family Planning clients at non-pharmacy/dispensary sites on the Family Planning Medication Dispensing Log. The log sheets can be shredded after 24 months. The medication and prescription information should then be recorded on the Medication List in the chart with allergies clearly flagged using the Allergy Sticker.

4. We can only dispense and administer medications obtained and stored by our system. If a client presents with a medication such as a contraceptive injection we cannot administer this medication as we do not know how it was stored or in some cases it is not even a FDA approved drug.

Dispensing Documentation

The state board of pharmacy requires pharmacy records to be kept for 2 years. It is important to track medications dispensed and the manufacturer in case of a Class I drug recall where patients need to be notified. For all medications even if only a sample, it is necessary to know which manufacturer and lot number was dispensed to which patient. The logbook allows for that check without having to pull all the charts. Alternately, an electronic report can be run on a specific pre-pack dispensed to each patient at a pharmacy site and the charts can be pulled to check that the sticker with the identifying information was noted.

Prescription Laws

1. Verbal prescriptions to the pharmacy – It is legal for a practitioner with prescriptive authority to verbally give a prescription order to a pharmacist, with the exception of Schedule II narcotics. Designated agents of a prescribing practitioner may also give verbal prescription orders to a pharmacist after having received the order, either written or orally (see prescribing through a third party).

2. Prescribing through a third party – A practitioner with prescriptive authority can designate a person who may phone in prescriptions to a pharmacy. This person can be a nurse or even a receptionist in the clinic. This person cannot, however, authorize medication refills or medications without express permission, either written or oral, of the prescribing practitioner. If a verbal order is taken, written documentation in the patient's chart needs to reflect the full name of the prescribing practitioner and the exact prescription as dictated. The chart entry should be co-signed by the practitioner within 30 days with a separate entry on the day of the co-signing stating the verbal order, for example "Consulted on June 13, 2001 regarding need for refill of oral contraceptive pills. Gave prescription for Orthocyclen 3 packages as documented in the June 13, 2001 note." Written prescriptions may be completed by a third party but must be signed by a practitioner with prescribing authority.

Prescription and Dispensing Chart Documentation

The prescription can be documented on a prescription pad and given to the client for an outside pharmacy. Alternately, the prescription can be documented by adhering the medication sticker (includes medication name, dose, lot number, and expiration date) to the Medication List in the

chart. If a free sample is dispensed the same documentation must be done in the dispensing log and patient chart. The provider must sign with a legal signature (initial of first name, last name, and title), date, and supply the dosing schedule. Most of our medications come with a sticker, which supplies most of this information, and the sticker should be placed on the medication sheet. In the progress notes or on the visit form, a statement can be made, "see med sheet," for the prescriptions prescribed and dispensed for that visit. If prescribing a year of injections or OCPs, the medication sheet or the Female Family Planning / STD visit form can reflect the 13 pill packages or every 12-week dosing for 1 year. Alternately, the entire prescription can be written into the progress note. The Drug Reactions Handout is available for patients to help warn of side effects or problems when prescribing multiple medications. To prescribe more than a 28 day supply for outside pharmacies or DSHS of OCP, write the prescription for #84 pills with 3 refills.

Reporting Problems to the FDA

Any problems like allergic responses, site or product problems, or unusual reactions or problems detected while using the medications used by Family Planning patients should be reported to the Family Planning Medical Director and to the FDA. You may call the FDA at 1-800-FDA-1088 or fill out the form online at http://www.fda.gov/medwatch/report/hcp.htm. A copy of this form is to be given to the Site Supervisor to forward to the Downtown Pharmacy and Chief of Pharmacy.

Transfer Clients

Between Health Department Clinics
Ideally when a client transfers to a different clinic within the health department there will be time to obtain the medical records before the visit. In this case, care is continued at the new site as appropriate. Ascertain if the client plans to return to the former site, in which case the records should be returned to that site.

Clients who appear at a site different from their usual site within the health department can usually be managed by contacting the other site within the health department. When that site is closed so records can not be obtained, the client should be handled as appropriate for the current medical problem. If the client needs a refill of contraceptives, usually only three cycles can be given until the clinician can assure that the client does not have an outstanding medical problem, such as an abnormal pap test or an untreated infection.

Satellite sites which have staff only part-time may make a list of clients needing medical follow-up and send a copy to the primary clinic in that district, in case the client contacts the primary clinic when the satellite clinic is closed. Include client number and nature of the outstanding problem. If records indicate the annual has been done and the client has no problems, then contraceptives to complete the year can be provided at the primary clinic.

Transfer Clients from HMC-STD Clinics for Ongoing Contraception
Clients seen in the STD program may be started on oral contraceptives and are ordinarily given 3 cycles of pills with a referral to one of the Family Planning/STD Clinics. They will have had only a brief history and exam taken. The Pap test may not have been done if she had an infection. To get ongoing contraceptive care they need to:

1. Complete paper work including the medical history forms, consents, and all required registration materials.
2. Perform the remaining parts of the physical examination including weight, height, blood pressure, hematocrit, thyroid, and breast examination.
3. Can call the cytology lab for a verbal report. If the pap results were abnormal, contact the HMC/STD program and obtain a copy of the report.
4. Arrange for any other follow-up that may be indicated. Review use of the contraceptive method and any problems. If appropriate, prescribe sufficient medication if needed to complete one year.

Transfer Clients (Outside Health Department for Contraception)
Ordinarily transfer clients are considered new clients and need a complete examination and history taken. Transfer clients may request waiver of the complete examination for circumstances such as having recent complete examination elsewhere, being post-partum, moving, no longer able to afford private care, unable to pay insurance co-pay, or underinsurance or non-coverage of contraception.

Transfer clients continuing oral contraceptives, who are not getting the complete exam on the first visit, may be prescribed one to three cycles of pills pending receipt of records. This is the Delayed Pelvic option which can be reviewed by consulting that section of the guidelines. Similarly, transfer clients continuing injection contraception may be given one injection pending receipt of their records. The transfer client must still register, sign any required consent and history forms. A practitioner reviews the history, and weight and blood pressure are taken. A provider evaluation and medical history review occurs with documentation. Then the prescription for pills or injection is given.

Once records are received, transfer clients requesting pill or DMPA refills must:

- Have results of their physical examination reviewed by the practitioner and any required physical completed as necessary;
- Have results of laboratory tests reviewed by the practitioner. If the Pap test was not normal, a copy of the laboratory report should be obtained and reviewed;
- Have contraceptives ordered in the chart by the practitioner;
- A transfer client is charged for the time needed to review and document her medical history and examination, as needed, to provide contraceptive care. If a pelvic is necessary, an initial exam should be done.
- If client then refuses examination, consult the Delayed Pelvic Exam section of the guidelines.
- Clients who choose to have annual examinations outside our system, to continue obtaining pharmaceutical supplies, should be strongly counseled to consider having at least every other gynecologic annual exam with our program to enhance the provision of her contraceptive care.