



VOLUME 4: MEDICAL SERVICES	Date Created: May 5, 2009
CHAPTER 27B	Next Revision: January 1, 2010
PHYSICIAN ASSISTANT PROCEDURE	Attachments: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

I. GENERAL REQUIREMENTS

A. Hiring of Physician Assistants

Physician Assistants may be hired into the California Prison Health Care Services (CPHCS) as civil servants or as contract employees. The hiring process for Physician Assistants shall follow established State laws and departmental standards. The physician manager at each institution, (Chief Medical Officer or Chief Physician and Surgeon) shall obtain approval from the Headquarters Credentialing Unit prior to making a permanent job offer to Physician Assistant applicants.

B. Education, Experience, and Certification

All Physician Assistants hired by CPHCS (civil service and contract employees) shall possess the following:

- Current California Physician Assistant license

Other desirable qualifications include:

- Current Basic Life Support certification
- At least two (2) years of relevant primary care experience; for specialized facilities (e.g., women's prison), the 2 years of primary care experience can be substituted with other relevant experience (e.g., women's health)
- National certification as a Physician Assistant (PA-C) from the National Commission on Certification of Physician Assistants (NCCPA)
- Possession of a DEA registration number within one year of hire.

C. Delegation of Services Agreement

Physician Assistants employed by CPHCS may provide medical services consistent with the Physician Assistant's education, training, and experience, for which they are deemed competent, and which are delegated in writing by a supervising physician. The supervising physician must delegate in writing those medical services to be performed by the Physician Assistant (see Attachment A, Delegation of Services Agreement). The Delegation of Services Agreement shall be retained on file for the duration of employment.

D. Orientation

All Physician Assistants (civil service and contract employees) shall attend new employee orientation at their assigned institution. Orientation shall include pertinent information regarding the work environment as well as job expectations. A copy of the duty statement shall be provided to all newly hired Physician Assistants during clinical orientation (see Attachment B, Physician Assistant Duty Statement).

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E. Scope

Pursuant to a signed Delegation of Services Agreement, Physician Assistants working in CPHCS may perform the following functions within their specialty area, consistent with their experience and credentialing: assessment, diagnosis, management and treatment of episodic illness and chronic illness, as well as health promotion and general evaluation of health status, including but not limited to ordering laboratory procedures, x-rays and physical therapies, recommending diets, and referring patients to specialty clinics when indicated.

F. Setting

Physician Assistants working in CPHCS may provide health care services to inmates in Reception Centers, Ambulatory Care Clinics, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Outpatient Housing Units, Correctional Treatment Centers (CTC), General Acute Care Hospitals (GACH), Hospice Units, and other clinical settings as determined by the Chief Medical Officer or designee. The Physician Assistant also may act as first or second assistant in surgery under the supervision of a qualified physician and surgeon.

The physician manager shall ensure that each Physician Assistant is properly credentialed and receives appropriate privileges. Only those Physician Assistants with appropriate credentials and privileges may provide care in licensed inpatient settings. Credentialing and privileging for practice in licensed inpatient settings shall be in accordance with the Title 22 regulations. When providing care in an inpatient setting, the Physician Assistant shall closely collaborate with the clinical supervisor who shall be the physician of record.

In extreme, unforeseen circumstances and when deemed medically necessary for the preservation of life and limb, Physician Assistants may provide emergency health care services consistent with their training and experience, in others areas of the institution or off grounds as necessary.

G. Consultation

Physician consultation shall be obtained as specified by the supervising physician and under the following circumstances:

- Whenever situations arise which go beyond the competence, scope of practice, or experience of the Physician Assistant;
- Whenever patient conditions fail to respond to the treatment plan in an appropriate timeframe;
- Any rare or unstable patient condition;
- Any patient condition that does not fit the commonly accepted diagnostic pattern for a disease or disorder;
- Any unexplained physical examination or historical finding;
- At the Physician Assistant's or supervising physician's request; and
- All emergency situations after initial stabilization.

Whenever a physician is consulted, a notation including the date, time, and physician's name, shall be recorded in the Unit Health Record (UHR).

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All patient consultations or treatment related to new or recurrent diagnosis of depression, anxiety, or any other mental health condition or diagnosis shall immediately be referred to the Mental Health Department at the institution. Whenever a Physician Assistant makes a mental health referral, a notation to that effect shall be made in the patient's UHR.

H. Patient Records

The Physician Assistant shall be responsible for the preparation of a complete medical record for each patient encounter. All information relevant to patient care shall be recorded in the UHR (e.g., assessments, diagnoses, treatment plans, procedure notes, and discharge notes). Each time the Physician Assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the Physician Assistant shall also enter the name of the supervising physician who is responsible for the patient. When the Physician Assistant transmits a verbal order, he or she shall also state the name of the supervising physician responsible for the patient.

I. Supervision

The physician manager at each institution shall be responsible for ensuring that Physician Assistants receive adequate supervision. Appropriately qualified physicians may provide clinical supervision to Physician Assistants. Physician consultation shall be available at all times, either on-site, by telephone, or via electronic device, and no physician shall supervise more than four (4) Physician Assistants at one time.

The physician manager's responsibility is to:

- Delegate, if appropriate, the clinical supervision of Physician Assistants to appropriately qualified physicians based on approved ratios;
- Ensure that all physicians assigned to provide clinical supervision to Physician Assistants receive adequate orientation to their role and responsibilities;
- Ensure that a copy of the Delegation of Services Agreement Between Supervising Physician(s) and Physician Assistant is signed by each Physician Assistant and supervising physician, and is retained on file for the duration of employment;
- Ensure that all Physician Assistants (civil service and contract employees) receive new employee orientation in accordance with institutional guidelines;
- Ensure that all Physician Assistants (civil service and contract employees) receive adequate orientation to their job responsibilities;
- Ensure that each Physician Assistant complies with all department policies, procedures, and standards;
- Ensure that UHR reviews are completed for each Physician Assistant within established timeframes as specified in this policy; and
- Complete probationary reports and annual performance evaluations for each Physician Assistant as identified in this policy.

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J. Evaluation of Clinical Competence

Initial Evaluation

Initial evaluation of clinical competence for civil service and contract Physician Assistants shall be provided as follows:

- For the first month following employment, the supervising physician or designee shall meet with the Physician Assistant at least weekly to review the practitioner's clinical care. Evaluation shall include a review of at least five percent (5%) of the medical records for patients treated by the Physician Assistant. The supervising physician shall select for review those cases which, by diagnosis, patient complaint, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;
- After the first month of employment the supervising physician or designee shall select, review, sign and date at least five percent (5%) of the medical records for patients treated by the Physician Assistant. This review must be completed within 30 days of treatment;
- The physician manager shall ensure that three (3) probationary reports are completed thoroughly and in a timely manner for all civil service Physician Assistants;
- Informal consultations shall occur as deemed necessary and as mutually agreed upon by the supervising physician and Physician Assistant; and
- Contract Physician Assistants shall be evaluated at least as often as civil service Physician Assistants, utilizing the methods identified above.

Ongoing Evaluation

- At least weekly, the designated physician manager at each institution shall meet with Physician Assistants to discuss clinical practice issues;
- A peer review process shall be utilized to monitor compliance with current practice standards;
- The physician manager shall ensure that an Individual Development Plan (IDP) is completed annually for all civil service Physician Assistants that have satisfactorily completed probation; and
- Areas requiring increased proficiency as determined by initial or routine evaluation shall be reassessed by the physician supervisor at appropriate intervals until an acceptable skill level is achieved.

K. On-Call

Physician Assistants may be scheduled to provide "on-call" services in all areas of the institutions, except the GACH. Physician Assistants, Nurse Practitioners, and rank and file physicians shall be scheduled on an equal basis, with no individual or group receiving preferential treatment.

Physician Assistants scheduled "on-call" shall be available by phone or other electronic means, and be available to return to the institution if necessary. Physician Assistants scheduled "on-call" shall provide primary care services and determine appropriate disposition for patients. When a Physician Assistant is "on-call," a physician manager (Chief Physician and Surgeon, Chief Medical Officer or Regional Medical Director) shall be available on-site, by telephone, or via electronic device to provide supervision and

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clinical support. Physician Assistants "on-call" shall be compensated in accordance with the Bargaining Unit 19 Memorandum of Understanding.

Reviewed and Approved By:

Steven Ritter, D.O.

Chief Physician Executive (A)



5/26/09

Name

Date

ATTACHMENT A
Delegation of Services Agreement
Between Supervising Physician(s) and Physician Assistant
(Title 16, California Code of Regulations, Section 1399.540)

This Delegation of Services Agreement ("Agreement") is entered into between the physicians whose signatures appear below (each of which shall be referred to herein as "Supervising Physician"), and _____, PA/PA-C ("PA"). The purpose of this Agreement is to comply with the requirements of Title 16, Article 4, of the California Code of Regulations, hereinafter referred to as the "Physician Assistant Regulations."

Section 1399.540 of the Physician Assistant Regulations state, in pertinent part, that "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant." In accordance with Section 1399.540 of the Physician Assistant Regulations, the Supervising Physician hereby delegates the performance of certain medical services to the above-named PA. The Supervising Physician(s) shall provide clinical supervision to the PA in accordance with Section 1399.545 of the Physician Assistant Regulations.

1. QUALIFICATIONS

- a) _____ Physician Assistant, graduated from
(Name of PA)

Physician assistant training program on
(Name of PA Training Program)

(Date)
- b) _____ is licensed by the California Physician Assistant
(Name of PA)
Committee and current licensure expires on _____
(Date)

2. AUTHORIZED SERVICES

- a) The PA is authorized by the physician(s) whose name(s) and signature(s) appear below to perform all the tasks set forth in subsections (a), (b), (c), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, subject to the limitations and conditions described in this Agreement or established by Supervising Physician(s) in any applicable protocols or otherwise.

- b) As required by Section 1399.540 of the *Physician Assistant Regulations*, A PA may only provide those medical services which he or she is competent to perform and which are consistent with the PA's education, training and experience. A PA shall consult with the Supervising Physician(s) or another qualified health care practitioner regarding any task, procedure or diagnostic problem which the PA determines exceeds his or her level of competence, or shall refer such cases to the Supervising Physician or another appropriate practitioner.
- c) The PA shall perform delegated medical services under the supervision of the Supervising Physician(s) as specified in the *Physician Assistant Regulations*, this Agreement, any applicable protocols, and the specific instructions of the Supervising Physician(s).
- d) As required by Section 1399.546, each time a PA provides care for a patient and enters his or her name, signature, initials, or computer code on the patient's record or written order, a PA shall also enter the name of the Supervising Physician responsible for the patient.

3. DRUG ORDERS

- a) The PA may administer or provide medication to a patient, or issue a drug order, orally or in writing in a patient's chart or drug order form, subject to the conditions and limitations as set forth in Section 3502.1 of the Business and Professions Code, this Agreement, any applicable protocols as described in subsection (b) below, or the specific instructions of the Supervising Physician. Such medications may include Controlled Substances in schedules II through V. The PA may sign for the request and receipt of samples of drugs specified in the protocols in subsection (b) below.
- b) Drug orders shall either be based on protocols established or adopted by the Supervising Physician(s), or shall be approved by the Supervising Physician for the specific patient prior to being issued or carried out. Notwithstanding the foregoing, all drug orders for Controlled Substances shall be approved by the Supervising Physician for the specific patient prior to being issued or carried out.
- c) The Supervising Physician shall review, countersign, and date the medical record of any patient for whom a PA issues or carries out a drug order for a Schedule II Controlled Substance within seven days.

4. EMERGENCY TRANSPORT AND BACKUP

- a) In a medical emergency requiring the services of a hospital emergency room, the PA shall activate the institution's internal emergency medical response system to have the patient transported to an outside facility.
- b) In the event that the Supervising Physician is not available when needed, the PA may call and/or refer patients to other authorized physicians as designated by the Supervising Physician, or as otherwise deemed appropriate by the PA.

5. SUPERVISION REQUIRED

The PA will be supervised in accordance with the written supervisor guidelines required by Section 1399.545 of the *Physician Assistant Regulations*.

6. SUPERVISING PHYSICIAN'S RESPONSIBILITIES

a) The Supervising Physician(s) shall remain electronically available at all times while the PA is performing medical services, unless another approved supervising physician who has signed a Delegation of Services Agreement for the PA is so available.

b) To the extent required by Section 4(c) above, the Supervising Physician shall review, countersign, and date within seven (7) days the medical record of any patient for whom the PA issues or carries out a drug order for a Schedule II Controlled Substance. For other patients, Supervising Physician shall utilize one or more of the following mechanisms to supervise the PA, as required by Section 1399.545 of the *Physician Assistant Regulations*.

Examination of the patient by the Supervising Physician the same day as care is given by the PA.

The Supervising Physician shall review, audit, and countersign every medical record written by the PA within 30 days of the encounter.

The Supervising Physician shall audit the medical records of at least five percent (5%) of the patients managed by the PA under protocols that shall be adopted by Supervising Physician and the PA, pursuant to Section 1399.545(e)(3) of the *Physician Assistant Regulations*. The Supervising Physician shall select for review those cases, which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

c) If the PA is operating under interim approval, the Supervising Physician shall review, sign, and date the medical records of all patients cared for by the PA within seven (7) days if the Supervising Physician was on the premises when the patient was diagnosed or treated. If the Supervising Physician was not on the premises at the time, he or she shall review, countersign, and date such medical records within 48 hours of the time the medical services were provided.

7. PROTOCOLS

This Agreement does not constitute the protocols required by Section 3502.1 of the Business and Professions Code or, if applicable, Section 1399.545(e)(3) of the *Physician Assistant Regulations*. Such protocols are on file at the practice site and may incorporate by reference appropriate medical texts.

8. NO THIRD PARTY BENEFICIARIES

This Agreement shall not be construed as creating rights in or obligations to any third party. It is the intent of the parties solely to fulfill the requirements of the *Physician Assistant Regulations* for a Delegation of Services Agreement and for the mechanisms to be used by the Supervising Physician in supervising the PA.

_____ Physician Assistant	_____ Date
_____ Supervising Physician	_____ Dated

ATTACHMENT B

CALIFORNIA PRISON HEALTH CARE SERVICES (CPHCS)

PHYSICIAN ASSISTANT DUTY STATEMENT

JOB TITLE: PHYSICIAN ASSISTANT – CORRECTIONAL FACILITY (CF)
DIVISION: HEALTH CARE SERVICES
DEPARTMENT: MEDICAL

DEFINITION:

Under the direction of a supervising physician, the Physician Assistant (CF) provides routine primary care services to the adult male and female inmate population, including assessment, diagnosis, management, and treatment of episodic, and chronic illness, as well as health promotion and general evaluation of health status. Primary care services to be provided by a Physician Assistant (CF) must be delegated in writing by the supervising physician. Primary care services may be provided in Reception Centers, Outpatient Housing Units, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Correctional Treatment Centers, General Acute Care Hospitals, Hospice Units, and other clinical settings as determined by the Health Care Manager (HCM) or designee. The Physician Assistant (CF) also may act as the first or second assistant in surgery under the supervision of an approved supervising physician.

DUTIES:

80% Responsible for the evaluation and treatment of inmates by carrying out the following functions:

1. Obtain relevant medical histories. Perform physical examinations based on age and history.
2. Conduct preventive screening procedures based on age and history.
3. Formulate the appropriate differential diagnosis based upon the history, physical examination and clinical findings.
4. Develop and implement appropriate treatment plans that include:
 - Ordering appropriate diagnostic tests (laboratory, x-rays, electrocardiograms, etc.;
 - Identifying and ordering appropriate pharmacologic agents, adhering to the CPHCS statewide formulary whenever possible;
 - Identifying non-pharmacologic interventions;
 - Making appropriate referrals to other health professionals (mental health, specialty services, dentistry, etc.) and community agencies upon release from CPHCS;
 - Consulting with a Supervising Physician on-site or via electronic means as clinically indicated;
 - Developing a patient education plan that promotes inmate-patient participation in the plan of care;
 - Counseling and educating patients on health behaviors, self-care skills, and treatment options.

5. Document all assessments and care provided for each patient contact, maintaining detailed, legible, and confidential medical records in accordance with Department policies and procedures.
6. Monitor patients to determine the effectiveness of the plan of care. Reassess and modify the plan of care as necessary to achieve medical and health goals.
7. Conduct patient rounds in the inpatient setting.
8. Perform pre-parole evaluations.
9. Perform administrative segregation clearances.
10. Perform evaluations of patients to determine their suitability or fitness for vocational/education programs.
11. Complete CDC Form 128-C in accordance with department policy.
12. Perform other duties related to patient care as assigned by the Health Care Manager or designee.

10% Respond to medical emergencies in the clinics, Outpatient Housing Units, Correctional Treatment Center, General Acute Care Hospital, or off grounds as necessary. Conduct emergency examinations on injured staff and provide First Aid care.

10% Participate in multidisciplinary care conferences and professional practice group meetings (e.g., Peer Review, Continuous Quality Improvement, Pharmacy and Therapeutics, etc.) Assist in updating policies and standards as necessary. Attend continuing education seminars necessary to maintain licensure and certification requirements.

Physician Assistant

Date Reviewed

Supervising Physician's Signature

Date Reviewed

ATTACHMENT C
CALIFORNIA PRISON HEALTH CARE SERVICES
REFERENCE BOOKS FOR PHYSICIAN ASSISTANTS

Two (2) copies of each of the following textbooks shall be maintained in the Physician Assistant Resource Library

California Department of Corrections and Rehabilitation Formulary

Cecil Textbook of Medicine (Two Volume with CD-ROM), Goldman, L., (2001).
21st Edition, W.B. Saunders Company

Clinical Guidelines in Family Practice, Uphold, C., Graham, M., (2003).
Barmarrae Books

Clinical Practice in Correctional Medicine, Puisis, M., (2006).
2nd Edition, Mosby-Yearbook Inc.

Current Emergency Diagnosis & Treatment, Stone, C.K., Humphries, R.L. (2004).
McGraw-Hill Companies, Inc.

Current Medical Diagnosis, McPhee, S.J., Papadakis, M.A., Tierney Jr., L.M. (2007).
Forty-Sixth Edition, McGraw-Hill Companies, Inc.

Current Obstetric & Gynecological Diagnosis and Treatment (2002).
9th Edition, McGraw-Hill Companies, Inc.

Current Surgical Diagnosis & Treatment, Way, L.W., Dpherty, G.M. (2002).
McGraw-Hill/Appleton & Lange

Ferri's Clinical Advisor 2006: Instant Diagnosis and Treatment
(Text with CD-ROM for Windows), Ferri, F. , Mosby-Yearbook, Inc.

Guide to Clinical Preventive Services: Report to the U.S. Preventive Services Task Force,
3rd Edition, January 2002

Guidelines to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force,
U.S. Public Health, 2005

Outpatient Medicine, Fihn, S.D., DeWitt, D.E., (1997).
2nd Edition, W.B. Saunders Company

Physician's Desk Reference, 2006 Library Edition.
60th Edition, Medical Economics, Inc.

Textbook of Primary Care Medicine, Noble, J., (2000).
3rd Edition, Mosby-Yearbook Inc.

Tintinalli's Emergency Medicine: A Comprehensive Guide, (2004).
6th Edition, McGraw-Hill Companies, Inc.

Washington Manual of Medical Therapeutics, Washington University (2007).
32nd Edition, Lippincott Williams & Wilkens

ATTACHMENT D
CALIFORNIA PRISON HEALTH CARE SERVICES
NURSE PRACTITIONER AND PHYSICIAN ASSISTANT
STANDARDIZED PROCEDURES

The attached Standardized Procedures may be provided by Physician Assistants consistent with the Physician Assistant's education, training, and experience, for which they are deemed competent, and which are delegated in writing by a supervising physician.

ATTACHED STANDARDIZED PROCEDURES:

- D-1 PRIMARY CARE**
- D-2 URGENT/ACUTE CARE**
- D-3 TERTIARY CARE**
- D-4 FURNISHING DRUGS AND DEVICES**
- D-5 PATIENT SPECIFIC PROTOCOL - SCHEDULE II AND SCHEDULE III
CONTROLLED SUBSTANCES**
- D-6 PROCEDURES AND MINOR SURGERY**
- D-7 PRENATAL CARE**

ATTACHMENT D-1
CALIFORNIA PRISON HEALTH CARE SERVICES
NURSE PRACTITIONER AND PHYSICIAN ASSISTANT
STANDARDIZED PROCEDURE: PRIMARY CARE

A. Definition

This protocol covers the procedure for age-appropriate health care management in clinics, Reception Centers, and inpatient units. Scope of care includes assessment, diagnosis, management and treatment of episodic illness and chronic illness, as well as health promotion and general evaluation of health status.

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Reception Centers, Hospice Unit, Correctional Treatment Centers (CTC), and the Outpatient Housing Unit (OHU).
2. Supervision: Per department policy for Nurse Practitioners/Physician Assistants.

C. Database

1. Subjective Data:
 - a. Screening: age appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatment, and review of systems.
 - b. Ongoing/Continuity: review of symptoms and history of relevant to the disease process or presenting complaint.
 - c. Pain history to include onset, location, and intensity.
2. Objective Data:
 - a. Physical exam consistent with history and clinical assessment of the patient.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

D. Diagnosis

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g., stable, unstable, uncontrolled).

E. Plan

1. Treatment:
 - a. Age appropriate screening tests and/or diagnostic studies for purposes of disease identification.
 - b. Initiation or adjustment of medication per Furnishing Drugs and Devices protocol.

- c. Immunization update.
 - d. Referral to specialty clinics and supportive services as needed.
2. Patient Conditions Requiring Physician Consultation:
- a. Whenever situations arise which go beyond the competence, scope of practice, or experience of the Nurse Practitioner/Physician Assistant.
 - b. Whenever patient condition fails to respond to the treatment plan in an appropriate timeframe.
 - c. Acute decompensation of patient condition.
 - d. Any patient condition that does not fit the commonly accepted diagnostic pattern for a disease or disorder.
 - e. Unexplained historical, physical or laboratory findings.
 - f. Upon the request of the Nurse Practitioner/Physician Assistant or Physician.
 - g. Initiation or change of medication other than those in the formulary.
 - h. Problem requiring hospital admission or potential hospital admission.
 - i. When ordering complex imaging studies or procedures.
3. Education:
- a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g., diet, exercise).
 - b. Anticipatory guidance and safety education that is age and risk factor appropriate.
4. Follow-up:
As indicated and appropriate to patient health status and diagnosis.

F. Record Keeping

All information related to patient care shall be documented in the Unit Health Record. Documentation shall be patient-specific and include but not be limited to assessment, diagnosis, laboratory tests/diagnostic studies, treatment plan, procedure notes, patient education, and discharge notes. Physician consultation and/or referral shall be noted in the patient's chart (including the physician's name).

**RECORD OF PHYSICIAN ASSISTANTS AUTHORIZED
TO PERFORM STANDARDIZED PROCEDURE:
PRIMARY CARE**

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
DEA#

DATE

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
DEA#

DATE

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
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DATE

ATTACHMENT D-2
CALIFORNIA PRISON HEALTH CARE SERVICES
NURSE PRACTITIONER AND PHYSICIAN ASSISTANT
STANDARDIZED PROCEDURE: URGENT/ACUTE CARE

A. Definition

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unfamiliar, unstable, or complex conditions.

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Triage Treatment Area (TTA), Outpatient Housing Units (OHU), and Correctional Treatment Centers (CTC).
2. Supervision: Per department policy for Nurse Practitioners/Physician Assistants.

C. Database

1. Subjective Data:
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
2. Objective Data:
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

D. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes. May include a statement of current status of disease (e.g., stable, unstable, uncontrolled).

E. Plan

1. Treatment:
 - a. Common acute problems: perform diagnostic studies for the purposes of disease identification.
 - b. Initiation or adjustment of medication per Furnishing Drugs and Devices protocol.
 - c. Referral to physician, specialty clinics, and supportive services as needed. Supervising physician is notified if his/her name is used on a referral to a specialty physician or department.

- d. For uncommon, unfamiliar, unstable, or complex conditions consult a physician regarding evaluation, diagnosis, and/or treatment plan. Management of the patient is either in conjunction with a supervising physician or by complete referral to a community provider and/or facility.
2. Education:
 - a. Patient education including treatment modalities.
 - b. Discharge information and instructions.
3. Follow-up:

As indicated and appropriate to patient health status and diagnosis.

F. Record Keeping

All information related to patient care shall be documented in the Unit Health Record. Documentation shall be patient-specific and include but not be limited to assessment, diagnosis, laboratory tests/diagnostic studies, treatment plan, procedure notes, patient education, and discharge notes. Physician consultation and/or referral shall be noted in the patient's chart (including the physician's name).

RECORD OF PHYSICIAN ASSISTANTS
AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:
URGENT/ACUTE CARE

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
DEA#

DATE

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
DEA#

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PHYSICIAN ASSISTANT
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PHYSICIAN ASSISTANT LICENSE#
DEA#

DATE

ATTACHMENT D-3
CALIFORNIA PRISON HEALTH CARE SERVICES
NURSE PRACTITIONER AND PHYSICIAN ASSISTANT
STANDARDIZED PROCEDURE: TERTIARY CARE

A. Definition

This protocol covers the procedure for patients who present with acute, life threatening conditions including but not limited to respiratory or cardiac arrest.

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Triage Treatment Area (TTA), Outpatient Housing Units (OHU), and Correctional Treatment Centers (CTC).
2. Supervision: Per department policy for Nurse Practitioners/Physician Assistants.

C. Database

1. Subjective Data:
 - a. Brief history, including precipitating event or mechanism of injury if applicable, and review of symptoms relevant to the presenting complaint.
 - b. Pertinent past medical history, hospitalizations/injuries, allergies, current medications, and tetanus immunization status if applicable.
2. Objective Data:
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory tests as indicated.

D. Diagnosis

Assessment of data from subjective and objective findings. May include a statement of current status (e.g., stable or unstable).

E. Plan

1. Treatment:
 - a. Initial evaluation and stabilization of the patient with concomitant notification of and immediate management by a physician. Initial treatment may include all modalities of Advanced Cardiac Life Support.
 - b. Transfer to higher level of care as indicated.
2. Education:

Patient education consistent with the assessment of the condition.
3. Follow-up:

As indicated and appropriate to patient health status and diagnosis.

F. Record Keeping

All information related to patient care shall be documented in the Unit Health Record. Documentation shall be patient-specific and include but not be limited to assessment, diagnosis, treatment, procedures, and final disposition. Physician consultation and/or referral shall be noted in the patient's chart (including the physician's name).

RECORD OF PHYSICIAN ASSISTANTS
AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:
TERTIARY CARE

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
DEA#

DATE

PHYSICIAN ASSISTANT
PHYSICIAN ASSISTANT LICENSE#
DEA#

DATE

PHYSICIAN ASSISTANT
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PHYSICIAN ASSISTANT LICENSE#
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ATTACHMENT D-4

CALIFORNIA PRISON HEALTH CARE SERVICES

NURSE PRACTITIONER AND PHYSICIAN ASSISTANT

STANDARDIZED PROCEDURE: FURNISHING DRUGS AND DEVICES

A. Definition

This protocol covers the procedure for Nurse Practitioners/Physician Assistants furnishing drugs or devices. "Furnishing is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure." The ordering of drugs and devices includes the initiation, discontinuation and/or renewal of prescription medications and/or over-the-counter equivalents.

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Reception Centers, Hospice Unit, Correctional Treatment Centers (CTC), and the Outpatient Housing Unit (OHU).
2. Supervision: Physician supervision required. The physician must be available at least by telephone.
3. Patient Conditions:
Nurse Practitioners who possess a current furnishing number may furnish or order drugs and devices incidental to the provision of:
 - Family planning services
 - Routine health care rendered to essentially healthy persons
4. Other:
Nurse Practitioners/Physician Assistants may furnish Schedule II through Schedule V controlled substances when in possession of a Drug Enforcement Administration (DEA) registration number.

Physician Assistants must obtain advance approval (specific to the patient being treated) from a supervising physician prior to issuing drug orders for non-formulary drugs.

In addition, Physician Assistants must obtain advance approval from a supervising physician before writing a drug order for Schedule II through Schedule V controlled substances, unless the Physician Assistant has completed an education course that covers controlled substances and, the course meets standards approved by the Physician Assistant Committee.

C. Database

1. Subjective Data:
 - a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments and substance abuse history.

- b. No personal and/or family history, which is an absolute contraindication to use of the drug or device.
 - c. Pain history to include onset, location, and intensity.
2. Objective Data:
- a. Physical exam consistent with history and clinical assessment of the patient.
 - b. Laboratory and imaging evaluation to indicate or contraindicate use of the drug or device if necessary.

D. Diagnosis

Assessment data consistent with use of drug or device. No absolute contraindications to use of the drug or device.

E. Plan

1. Treatment:
- a. Initiate, adjust, discontinue, and/or renew medication and devices included on, but not limited to the attached formulary. Use lowest effective dosage per pharmaceutical references. The Nurse Practitioner/Physician Assistant name and furnishing/DEA number shall be included on all prescription transmittal order forms.
 - b. Orders for Schedule IV and V controlled substances shall not exceed 90 days in duration.
 - c. For chronic conditions such as acute, intermittent but recurrent pain, or continuous chronic pain the treatment plan shall be established in collaboration with a physician.
 - d. Monitor the effectiveness of the prescribed drug or device.
2. Patient Conditions Requiring Physician Consultation:
- a. Non-responsiveness to appropriate therapy.
 - b. Unusual or unexpected side effects.
 - c. Initiation or change of medication other than those in the formulary.
 - d. Unexplained historical, physical or laboratory findings.
 - e. Upon the request of the Nurse Practitioner/Physician Assistant or Physician.
3. Education:
- a. Provide education on why medication is being prescribed, expected outcomes, side effects, and precautions.
 - b. Provide instruction to the patient on how to take the medication or use the device correctly. Communicate effectively and appropriately based upon the patient's primary language spoken.
4. Follow-up:
- As indicated and appropriate to patient health status and diagnosis.

F. Record Keeping

All information related to patient care shall be documented in the Unit Health Record. Documentation shall be patient-specific and include but not be limited to assessment, diagnosis, name of the drug (or device), condition for which the drug or device is prescribed, dose, route, frequency, quantity, number of refills authorized, patient education, and timeframe for follow-up. For controlled substances the name, title, signature, and Drug Enforcement Administration (DEA) registration number of the Nurse Practitioner/Physician Assistant shall be included on the prescription transmittal order form. Physician consultation and/or referral shall be noted in the patient's chart (including the physician's name).

**RECORD OF PHYSICIAN ASSISTANTS
AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:
FURNISHING DRUGS AND DEVICES**

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ATTACHMENT D-5
CALIFORNIA PRISON HEALTH CARE SERVICES
NURSE PRACTITIONER AND PHYSICIAN ASSISTANT
STANDARDIZED PROCEDURE: PATIENT SPECIFIC PROTOCOL –
SCHEDULE II AND SCHEDULE III CONTROLLED SUBSTANCES

A. Definition

This protocol covers the procedure for Nurse Practitioners/Physician Assistants furnishing or ordering drugs classified as Schedule II and Schedule III controlled substances. Schedule II and Schedule III controlled substances must be furnished in accordance with a patient-specific protocol. "A patient-specific protocol is a protocol contained within a standardized procedure that specifies which categories of patients may be furnished this class of drugs."

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Specialty Clinics, Yard Clinics, Sick Call Clinics, Chronic Care Clinics, Hospice Unit, Correctional Treatment Centers (CTC), and the Outpatient Housing Unit (OHU).
2. Supervision: Physician supervision required. The physician must be available at least by telephone.
3. Patient Conditions:
Schedule II and Schedule III controlled substances may be ordered for patients in the following categories:

Category Examples

Respiratory	Marked cough; injury
Dermatology	Shingles; dermal injuries
Musculoskeletal	Marked strain, sprain or fracture; marked arthritis Inflammatory disorders
Neurological	Headache, marked myofascial pain or neuropathies
EENT	Severe pain from EENT infection or injury
GU	Urinary calculi
Post-operative pain	

4. Other:
Nurse Practitioners/Physician Assistants must possess a current Drug Enforcement Administration (DEA) registration number in order to furnish controlled substances.

Physician Assistants must obtain advance approval (specific to the patient being treated) from a supervising physician prior to issuing drug orders for

Schedule II through Schedule V controlled substances, unless the Physician Assistant has completed an education course that covers controlled substances and, the course meets standards approved by the Physician Assistant Committee.

C. Database

1. Subjective Data:
 - a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments and substance abuse history.
 - b. No personal and/or family history, which is an absolute contraindication to use of the drug.
 - c. Pain history to include onset, location, and intensity.
2. Objective Data:
 - a. Physical exam consistent with history and clinical assessment of the patient.
 - b. Laboratory and imaging evaluation to indicate or contraindicate use of the drug if necessary.

D. Diagnosis

Assessment data consistent with use of the drug or device. No absolute contraindications to use of the drug or device.

E. Plan

1. Treatment:
 - a. Initiate, adjust, discontinue, and/or renew medication. Limit quantity of tablets as appropriate to the condition being treated. Orders for controlled substances shall not exceed 90 days in duration.
 - b. Monitor the effectiveness of the medication.
2. Patient Conditions Requiring Physician Consultation:
 - a. Non-responsiveness to appropriate therapy.
 - b. Unusual or unexpected side effects.
 - c. Unexplained historical, physical or laboratory findings.
 - d. Upon the request of the Nurse Practitioner/Physician Assistant or Physician.
3. Education:
 - a. Provide education on why medication is being prescribed, expected outcomes, side effects, and precautions.
 - b. Provide instruction to the patient on how to take the medication correctly. Communicate effectively and appropriately based upon the patient's primary language spoken.
4. Follow-up:

As indicated and appropriate to patient health status and diagnosis.

F. Record Keeping

All information related to patient care shall be documented in the Unit Health Record. Documentation shall be patient-specific and include but not be limited to assessment, diagnosis, name of the medication, condition for which medication is prescribed, dose, route, frequency, quantity, number of refills authorized, patient education, and timeframe for follow-up. The name, title, signature, and DEA registration number of the Nurse Practitioner/Physician Assistant shall be included on the prescription transmittal order form. Physician consultation and/or referral shall be noted in the patient's chart (including the physician's name).

RECORD OF PHYSICIAN ASSISTANTS
AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:
PATIENT SPECIFIC PROTOCOL - SCHEDULE II AND SCHEDULE III
CONTROLLED SUBSTANCES

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ATTACHMENT D-6

CALIFORNIA PRISON HEALTH CARE SERVICES NURSE PRACTITIONER AND PHYSICIAN ASSISTANT

STANDARDIZED PROCEDURE: PROCEDURES AND MINOR SURGERY

A. Definition

This protocol covers the process to be utilized by Nurse Practitioners/Physician Assistants when performing minor surgical procedures.

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Specialty Clinics, and Triage Treatment Area (TTA).

2. Supervision: Per department policy for Nurse Practitioners/Physician Assistants.

3. Patient Conditions:

Minor surgical procedures performed by Nurse Practitioners/Physician Assistants shall be limited to the following:

- Casting, simple
- Chemical or electrocautery of external, non-facial, non-malignant lesions less than 1 cm in size (e.g., warts)
- Epidermal cyst removal (non-facial) less than 3 cm in size
- Incision and drainage of non-facial abscess less than 5 cm in size
- Suture non-facial lacerations less than 5 cm in size
- Mole removal (non-facial)
- Punch or shave biopsy
- Toenail removal

4. Other:

The Nurse Practitioner/Physician Assistant must complete appropriate training and satisfactorily demonstrate competence prior to performing the above procedure(s) independently. Competency shall be assessed by the supervising physician through direct observation of the Nurse Practitioner/Physician Assistant performing the above procedure(s).

A physician consult shall be obtained prior to applying any casting.

C. Database

1. Subjective Data:

- a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies.

2. Objective Data:

- a. Physical exam appropriate to presenting symptoms.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

D. Diagnosis

Assessment of subjective and objective data to identify disease processes.

E. Plan

1. Treatment:
 - a. Physician consultation shall be obtained before applying any casting.
 - b. Patient consent shall be obtained before procedure is performed.
 - c. The Nurse Practitioner/Physician Assistant shall follow standard medical technique for the procedures as described in department approved reference books.
 - d. All moles and biopsy specimens shall be sent to the Pathologist for analysis.
 - e. Initiation or adjustment of medication per Furnishing Drugs and Devices protocol.
 - f. Referral to physician, specialty clinics, and supportive services as needed.
2. Patient Conditions Requiring Physician Consultation:
 - a. Acute decompensation of patient situation
 - b. Unexplained historical, physical or laboratory findings
 - c. Uncommon, unfamiliar, unstable, and/or complex patient conditions
 - d. Upon the request of the Nurse Practitioner/Physician Assistant or Physician
 - e. Initiation or adjustment of medication other the those in the formulary
 - f. Problem requiring hospital admission or potential hospital admission
 - g. When ordering complex imaging studies or procedures
3. Education:

Discharge information and instructions.
4. Follow-up:

As indicated and appropriate to patient health status and diagnosis.

F. Record Keeping

Patient visit, consent forms, and other procedure specific information shall be documented in the patient's chart. Physician consultation and/or referral shall be noted in the patient's chart (including the physician's name).

RECORD OF PHYSICIAN ASSISTANTS
AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:
PROCEDURES AND MINOR SURGERY

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ATTACHMENT D-7
CALIFORNIA PRISON HEALTH CARE SERVICES
NURSE PRACTITIONER AND PHYSICIAN ASSISTANT
STANDARDIZED PROCEDURE: PRENATAL CARE

A. Definition

This protocol covers the procedure for the routine prenatal care for pregnant inmates-patients.

B. Circumstances Under Which the Nurse Practitioner/Physician Assistant May Perform These Functions

1. Setting: Ambulatory Care Clinics, Yard Clinics, Sick Call Clinics, and Outpatient Housing Units (OHU).
2. Supervision: Per department policy for Nurse Practitioners/Physician Assistants.

C. Database (Initial Visit)

1. Subjective Data:
 - a. Screening: complete age appropriate history including but not limited to: menstrual history, obstetrical history, medical history including past illnesses, surgeries, current use of medications, habits, family history, psychosocial history, allergies, and current concerns.
 - b. Symptoms relevant to the prenatal health process.
2. Objective Data:
 - a. Complete physical examination, including internal gynecologic exam and bimanual exam.
 - b. Initial prenatal laboratory work to include complete blood count, urinalysis, Pap test, blood type and Rh factor, antibody screening for Rh antibody, Rubella titer, Hepatitis viral screening, testing for sexually transmitted diseases.
 - c. Diagnostic studies based on information provided on the Hollister Maternal/Newborn Record System form.

D. Diagnosis

Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with subjective and objective findings.

E. Plan

1. Treatment Plan:
 - a. Routine prenatal examinations shall be done at the following intervals:
 1. Every four (4) weeks during the first trimester and up to 24-26 weeks gestation
 2. Every three (3) weeks up to 30 weeks gestation
 3. Every two (2) weeks up to 36 weeks gestation
 4. Weekly after 36 weeks gestation up until delivery

- b. Routine prenatal examination shall include:
 1. Questioning the patient about any present problems
 2. Weighing the patient
 3. Blood pressure
 4. Urinalysis for protein, glucose, and albumin
 5. Measurement of the uterine fundus
 6. Auscultation of the fetal heart with fetoscope or dopitone, or both
 7. Determination of the position of the fetus if possible
 8. Physical examination for edema
 - c. Glucose screen for gestational diabetes at 24 to 28 weeks or initial visit if history is positive for diabetes. Plasma glucose value > 160 mg/dL requires glucose tolerance test.
 - d. Hematocrit should be repeated at 28 to 36 weeks and at the following visit if the patient's previous reading was below 36%.
 - e. Immunization update. Repeat Rh antibody titer at 26 to 28 weeks gestation. If patient is Rh-negative administer Rhogam.
 - f. Additional diagnostic studies shall be ordered based on information provided on the Hollister Maternal/Newborn Record System forms.
 - g. Refer to Specialty Clinics and supportive services as needed (e.g., Medical Social Worker for Case Management, Dentist, HIV counseling and testing, etc).
 - h. Initiate prenatal vitamins, iron, and folic acid per Furnishing Drugs and Devices protocol.
 - i. Positively identified pregnant inmate-patient's shall be provided with the following:
 1. Two (2) extra cartons of milk, two (2) extra servings of fresh fruit, and two (2) extra servings of fresh vegetables daily. Additional nutrients may be ordered as necessary.
 2. Comprehensive Accommodation Chrono (CDCR Form 7410) for any indicated medical clearances or restrictions.
 - j. The Supervising Obstetrician shall examine all prenatal patients at 36 weeks gestation.
2. Patient Conditions Requiring Physician Consultation:
- a. Whenever situations arise which go beyond the competence, scope of practice, or experience of the Nurse Practitioner/Physician Assistant.
 - b. No fetal heart tones heard by 22 weeks gestation.
 - c. The patient feels no movement by 22 weeks, or none for one (1) week at any time after this.
 - d. Blood pressure above 140/90 mm Hg on two checks after bed rest.
 - e. Patient has albuminuria or persistent edema.
 - f. Patient has glycosuria, proteinuria, or symptoms of pyelonephritis.
 - g. Hematocrit is below 33%.
 - h. Lack of regular fetal growth.
 - i. If the Nurse Practitioner/Physician Assistant questions the position of the fetus (e.g., breech or transverse lie) or any time the Nurse Practitioner/Physician Assistant is in doubt about the patient's status.

- j. Uterus size is 2 weeks greater or smaller than expected from estimated weeks of gestation.
- k. Upon the request of the Nurse Practitioner/Physician Assistant or Supervising Obstetrician.
 - 1. Significant condylotomy or herpes develop.
- 3. Education:
 - a. Normal process and progression of pregnancy
 - b. Psychosocial issues related to pregnancy
 - c. Pregnancy information pamphlets and other pertinent material
 - d. Signs and symptoms of complications
 - e. Fetal kicks, stages of labor
 - f. Pain management during labor and delivery
- 4. Follow-up:
 - As indicated in above treatment plan.

F. Record Keeping

All information related to prenatal care shall be documented in the Unit Health Record. Physician consultation and referral for support services shall be noted in the patient's chart.

RECORD OF PHYSICIAN ASSISTANTS
AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:
PRENATAL CARE

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