**Pediatric MA Pre-Visit Planning**

09/05/2018

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| **Progress Note Prep**  (template goes in when patient arrives) | Document the following have been performed under **HPI** -  Screening:  1.Pre-Visit Planning  2.Preventative Care Visits  3.Patient Portal Education |
| **Social History** | Document whether social history needs to be obtained from the family in **Chief Complaint**.  Administer Social History Questionnaire and enter results under **Social History -** **Family Social Characteristics, Social Determinants of Health,** and **Social Functioning Age 4 and up** |
| **Labs**  (lead, cbc, chlamydia) | Document any labs due in **Chief Complaint** section of progress note.  1. lead/CBC are included in 12 and 24 month well baby templates  2. chlamydia and gonorrhea urine screening age 13+ |
| **Vaccines**  (use KIDSNET as needed) | Document vaccines due in **Chief Complaint** section of progress note.  (routine vaccines are included in templates 2 mo-5yo) |
| **Developmental Screening**  **(**at 9 mo., 18 mo., 24 mo., 30 mo.) | Document SWYC needed in **Chief Complaint** section of progress note.  Enter patient info into the Patient Tools application on practice tablet.  Document SWYC results under **HPI – Screening** in progress note |
| **Depression Screening**  (at age 13+) | Document PHQ Screening needed in **Chief Complaint** section of progress note.  PHQ-2/PHQ-9 Questionnaire given on laminated sheet to teens aged 13+, responses are then entered into note by MA under **HPI - Screening** |
| **Birth Info** | Birth history entered under **HPI** newborn:  Birth weight, discharge weight, BF or bottle, birth hospital, c-section or vaginal delivery, first Hep B dose transcribed |
| **Audiometry** | Document hearing screening needed in **Chief Complaint** section of the progress note.  Done at age 4, 5, 6, 8, and 10  Document results under **Treatment – Lab** section of the progress note |
| **Patient Education** | Choose age appropriate well child/baby education and portal access info from **Education** tab in the **Treatment** section of the progress note and publish to portal or print to hand to parent/patient. |
| **Follow Up Appointments** | Schedule next year’s annual PE and print the appointment card to give to parent/patient. |

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| **Visit Type** | **MA Duties** |
| **Sick Visits** | temp, O2 sat as needed for cough, strep swab if with sore throat/fever/HA/nausea |
| **Diarrhea/Vomiting** | weight, temp |
| **Headache** | BP, questionnaire |
| **Concussion** | temp, O2 sat, BP |
| **Med Check** | weight, height, BP |
| **Weight Check** | weight, height |
| **Babies<3 months old** | weight |
| **Asthma** | ACT questionnaire |
| **New ADHD/DPN/Oral Contraceptives** | weight, height, BP, schedule follow up as directed by MD |

**Nurse Care Manager / Care Coordinator Pre-Visit Planning**

NCM/CC will check schedule for High-Risk patientsthe days or week ahead and enter one of the following into the **Chief Complaint:**

1. NCM/CC - No case management needed-all services in place-if any changes please advise <*insert NCM or CC name*>
2. NCM/CC - <*insert NCM or CC name*> to meet with patient/family
3. NCM/CC – Please ask patient/family about <*insert care plan actions and/or goals*> This has not worked very well so far, we are going to revisit a better strategy for when the NCM/CC is not physically available to gather this information herself.













