SHIFA CLINIC FACT SHEET

Staff

- Maria and Evelin—Administrative front desk
- Tammy – Food pantry coordinator
- Edelin – Volunteer coordinator
- Lupe – Office manager
- Hailey – Primary care PA
- Mercedes – Primary Care NP
- Helen—Primary Care NP
- Dr. Khan – OB/GYN MD
- Dr. Rayburn – OB/GYN MD
- ****REMEMBER… IF YOU DO NOT KNOW THE ANSWER TO SOMETHING OR DO NOT KNOW WHAT TO DO, DO NOT HESITATE TO ASK FELLOW STUDENTS OR OTHER ADMINISTRATIVE STAFF****

Patient Encounter

- Monday/Wednesday/Friday – Primary Care
- Tuesday/Thursday – OB/GYN (respectively)
- The first Wed and Thurs of every month are switched, Wednesday is GYN and Thursday is Diabetes day
- Students are to take every patient to the back and get a weight (and urine on OB days), room the patients and obtain vital signs.
- ALWAYS ask patients if they speak English or have a translator to call prior to initiating the visit. **PATIENTS ARE REQUIRED TO HAVE A TRANSLATOR FOR EVERY ENCOUNTER. GOOGLE TRANSLATE IS NOT PERMITTED. This leads to miscommunication, misunderstanding and poor patient care. If patients do not have a translator please inform Lupe, Evelin or Maria to come back to the room and speak to the patient**
- Complete HPI and PE with patients while in the room
    - On OB days PE includes fundal height and fetal heart tones
    - REFER TO THE SHIFA PRENATAL CHEAT SHEET FOR PERTINENT QUESTIONS AND PROPER OB CARE
- Present patient visit to provider of the day
- Discuss patient case and come up with game plan (ensure you and the provider have the same understanding for the plan so you can properly document this in the patient chart)
- Bring patient to the front desk and inform Maria/Evelin when their follow up appointment is, if they need to get labs done prior to their next visit.

Charting

- New Patients:
    - Ensure that intake information is completed on initial visits (PMH, allergies, family history, social history, sexual orientation/preferences)
    - OB patients → ALWAYS CREATE AN OB EPISODE. This is where you will input the patients LMP, initial ultrasound date for accurate EDD dating. This is also where you will upload urine dipstick, FH, and FHT results from the visit.

- Established Patients:
    - Ensure medication list is updated
    - Document HPI, ROS, PE and A+P.
    - In each A+P, make sure you clearly show that the note was documented by you
        - Ex. “Documented by First Last, PA-S
- Make sure all charts are completed and orders are signed prior to leaving clinic. On family medicine days, Hailey will sign her own orders. On OB/GYN days you will need to sign the orders because Dr. Khan does not always sign off her charts that same day.
- All vaccinations need to be documented in the A+P
- All new diagnoses need to be “pushed over” to the problem list by selecting the back arrow under that diagnosis
- **PATIENT PHARMACY AND LABCORP NEED TO BE ADDED INTO EVERY CHART**
- All urine dipsticks, pregnancy tests, and fingerstick blood glucose levels done in office need to be documented as **POINT OF CARE** testing under the orders tab in the A+P
- Medication refills (whether sent to pharmacy or dispensed from our internal pharmacy) need to be documented in A+P

Vaccinations

- **ASK EVERY PATIENT (SEPT-MAR) IF THEY WOULD LIKE A FLU SHOT IF IT IS NOT ALREADY DOCUMENTED IN THEIR CHART**
- If they have already received tha vaccination from an alternate source, insure that is updated in their vaccinations
- Vaccinations requiring prior application
    - Shingrix
    - Gardasil
    - TDAP
    - Pneumovax
- The only vaccine that DOES NOT require application is INFLUENZA vaccine
- Influenza vaccine requires daily tally on the vaccine refridgerator
- Confirm with Edelin prior to giving any vaccine (other than flu)
- All vaccinations need to be documented in the A+P as administered/declined
    - Ex. ICD10: “administration of influenza vaccination” or “declined influenza vaccination”
- TDAP vaccination to be applied for on the initial OB visit
- TDAP vaccine to be given after 28 week pregnancy visit
- LOT# and EXP date can be found on the vaccine vial

Pharmacy

- Medication refills (whether sent to pharmacy or dispensed from our internal pharmacy) need to be documented in A+P
- Medication orders are to be signed by students on OB/GYN days and Fridays
- Every medication dispensed from our pharmacy needs to be documented in the pharmacy computer
- Every Nexplanon/IUD needs to be documented in the LARC section in the pharmacy computer
- Patients are to call the clinic for refills when they have ~7-10d left of their prescription
- Provide patients with GoodRx coupons before they leave!

Consent Forms

- All Nexplanon/IUD insertion and removal need to have signed consent prior to the procedure
- Nexplanon insertion consent form is located inside the device box
- IUD insertion/removal and Nexplanon removal consent forms are located in the blue binder

Labs

- Labs can be sent via Athena in the A+P section and patients can go to labcorp to have blood drawn
- Sending specimens to the lab requires documentation on lab slips
- Most labs are found on the Primary Care slips (CMP, CBC, HgbA1C, Lipids, etc). Chlaymida/Gonorrhea/Trichomonas and Group B swab are also on the primary care lab slip even though they are common labs we order on OB days
- Gynecology lab slips are used to send pap smears
    - Check off: Pap smear with Rfx to ASC-US, Cervix, Thin Prep, Bruh/Spatula or cervical broom depending on what probes you use
- Patients are to get their lab work drawn fasted
- We offer prenatal genetic screening after the 12 week visit, which students complete in office and give to Maria at the front desk.
    - Patients receive a card from the box that they can use to get their results as early as 2 weeks, or we discuss results at their next visit
- **ALWAYS REVIEW PATIENTS LABS WITH THE PATIENT AND DISCUSS THEIR VALUES/MEANINGS.**

Check out/ Front Desk Requests

- Inform Marie and Evelin how long until patient follow up, if it is in clinic or telehealth, and if labs need to be completed prior to the next visit
- Inform front desk of any referalls we are sending the patient to
- Inform the patient that most referrals/imaging are going to be out of pocket cost but we do have options for patient assistance to help cover the cost, that they can inquire about at the front desk
- Patients are to call the clinic for refills when they have ~7-10d left of their prescription
- Inform patients that their medicine may not be available to pick up at the pharmacy until later that evening (orders sometimes don't get signed until the end of the day)
- The earliest they can go get their labs done is the morning after their appointment (needs to be fasting). But we usually want patients to get their labs done AT LEAST A WEEK PRIOR to their next visit.
- Patients have 3 days to pick up their medicine from our pharmacy if we refill it via phone call/telephone
- Provide patients with GoodRx coupons before they leave!
- **IF PATIENTS DO NOT GET LABS DONE PRIOR TO NEXT VISIT THEY WILL HAVE TO PAY A FEE**
- **PHARMACY AND LAB CORP NEED TO BE UPDATED IN PATIENT CHART PRIOR TO CHECK OUT**

Telehealth via Doc Response

- Provider logins as listed below or on the whiteboard in the student workspace.
- The login link is provided here: https://clinic.docresponse.com/apps/control/facility/login
- Charting is the same for a telehealth visit (PE is shortened due to lack of examination)

Dot Phrases/ Text Macros

- These can be found on the whiteboard in the student workspace. These will autopopulate a template for your basic physical exam findings, diabetes HPI, or CCPN colonoscopy referral.
- You will need to add .fullpe and .briefpe to your text macros by going to: “Settings → Text Macros → User: hlibengood. Section: PE → Copy)

Shifa Prenatal Cheat Sheet

Weeks 4 to 28 of pregnancy. Go for one checkup every 4 weeks (once a month).
Weeks 28 to 36 of pregnancy. Go for one checkup every 2 weeks (twice a month).
Weeks 36 to 41 of pregnancy. Go for one checkup every week (once a week).

1st trimester: week 1-12
2nd trimester: week 13-26
3rd Trimester: 27- end

ALWAYS ASK
-year/ sex/ date/ route of delivery/ of previous pregnancy
-weight of baby/ complications (type in pregnancy problem list)

All patients should have initial labs (there is an initial OB labs lab order set in the HER that Dr. Khan made just for OB patients on their initial visit)

MSAFP (spinal defects in baby, structural)

Weight gain:
If Normal weight prior to pregnancy: 25-35lb
If Overweight: 15-25lb
If Obese: 11-20lb

If Underweight: 28-40lb

Normal: 40 weeks/280 days
Premature: < 37 weeks

Tdap: for 27 weeks onward

UPDATE THE OB EPISODE IN THE CHART FOR EACH PATIENT!!! Dr. Khan is adamant about the OB episode being updated and correct!

Initial Prenatal:

Health History
Confirm pregnancy; first-trimester ultrasound is most reliable
LMP
Health conditions: depression, diabetes, HTN, overweight, vaccinations
Medications: prescription, OTC, supplements, herbal products
Allergies: medications
Pregnancy History: G T P A L
Gravida, Term (37+), Preterm (20-37), Abortion/Miscarriage, Living
Menstrual history:
Recently normal, spotting
Smoking/alcohol/drugs
Stress and coping
Safety at home and work: chemicals, cats, abuse, physical labor
Diet: vegetarian/vegan, etc.

Physical Exam:
height & weight to determine weight gain needed
Look at thyroid
Blood tests, blood pressure, urine: syphilis, hep B, HIV, RH factor, H&H
BP, urine: test for preeclampsia (HTN and protein in urine, after 20 weeks, before GHTN)
Preeclampsia: swelling, weight gain, abdominal pain, severe headache
Pap smear: If indicated, test for HPV, chlamydia, gonorrhea
Vaccinations: flu shot
EDD: need LMP, early ultrasound
Prenatal vitamin: 600 mcg folic acid; prevents NTDs (cleft lip/ palate)

Prenatal Checkups:

Weight, BP
FHT (starting at 10-12 weeks via doppler; fetascope 18-20 weeks) 20 weeks can hear with stethoscope?!
Measure uterine fundus (starting at 20 weeks, umbillicus)
U/S (18-20 weeks)
Glucose screening (24-28 weeks)
TDAP vaccine (27-36 weeks): prevents pertussis
GBS (35-37 weeks)
Pelvic exam: cervical changes
Baby's movement: about 20 weeks

Initial visit:

-Confirm pregnancy via transvaginal u/s; first trimester is best
-Initial labs (CBC, Rh/ABO (blood type), antibody screen: rubella, rubella immunity, RPR/VDRL: syphillus, Hepatitis B surface antigen);
-HIV based on RF
-Pap if routine
-STD (CT, GC, Wet Mount)
-urinalysis
-CF/ TSH; BS; sickle cell; toxo

12 weeks

-Review previous labs
-Repeat labs that were abnormal
-N&V gone

16 weeks

-Can feeling quickening
-Schedule routine second trimester u/s
-AFP Quad screening (optional) --
-Uterus halfway between symphysis and pelvis
- those two blood tests, need u/s, AFP (extra cost),

20 weeks:

-Review quad screening results and u/s
-Quickening (movement) should start
-Uterus at umbillicus

24-28 weeks:

-Gestational diabetes (1hr GTT/3hr)
if at risk can test earlier than 24 weeks
obesity, HTN, fam hx of diabetes, previous large infant (4,000g+), unexplained fetal death, hx of GDM
-Rh - testing and Rhogam (28 weeks & whenever blood mixes IE amniocentesis, abortion, maternal trauma)
-TDAP at 28 weeks.
-Repeat H&H w/ platelets.
-Preterm labor precautions
-Braxton-Hicks contractions: Do not increase with intensity or frequency, slows with rest, do not cause cervical changes; uterus responds in weights

32, 34 week visit
-Set up pediatrician, talk about breastfeeding, CBE classes, fetal movement (kick counts) daily
-Kick counts: 10 movements in one hour while lying still; after meals is the best time to monitor due to increased glucose for baby; report decrease or change in movement

Birthing Plan
-can go to any hospital if they go into natural birth (MUSC, roper st francis, east cooper)
-only induction/ cs-section bonsecure roper st francis in West Ashley

36-40 weekly visits
-GBS (35-37 weeks)
*swab the lateral and posterior walls of labia and rectum = culture comes back in about 2 days
-Repeat H&H with platelets PRN depending on earlier results
-Baby begins to settle into the pelvis; mom may feel "the drop" aka lightening
-Hospital selection: where, when, what to take
-Assessing fetal position
-Prenatal record to hospital
-Cervical checks for effacement and dilation
-36 weeks uterus below xiphoid process
-40 weeks uterus drops
-5:1:1 – contractions come every 5 minutes, last 1 minute each for 1 hour

40+
-Post-term talk
-Fetal surveillance as indicated (NST, BPP)
-Refer for delivery
-If patient is not showing signs of cervical effacement or dilation at 39 weeks, go ahead and let the front desk know to schedule an induction for the patient. If the patient ends up going into spontaneous labor that is great.. but if not, they will have an appointment established for induction

Education points:
-Avoid hot-tubs/saunas
-Avoid smoking/second-hand smoke
-Sex is safe for uncomplicated pregnancies
-Air travel safe until 36 weeks
-Travel in car for no longer than 5-6 hours; move frequently
-Exercise HR less than 140 bpm; uncomplicated
-Risk for falls due to center of gravity
-Avoid cat litter boxes
-Encourage plenty of fresh fruits and vegetables, lean meat

Postpartum:
-General coping/adjustment
-Sexual activity/planning method desired
-Breast engorgement or breastfeeding concerns
-Lochia can happen up to 35 days; return of menses varies (up to 18 months for those breastfeeding)

4-6 weeks post-partum
-episiotomy non-tender, well-healed
-vaginal rugae normal appearance
-cervical os should be closed
-uterus back to normal size
-Pelvic exam, depression, breastfeeding, bleeding, contraception

Hx preterm labor
-Baby aspirin at 12 weeks daily
-Makena injections 16-37 weeks

Genetic Screening:

Why:
Preparation for any upcoming problems + piece of mind
Indications:
Advanced maternal age (> 35)
Previous child with chromosomal abnormality, fam hx of CA,

Types:
Screening: all of these are screening, if abnormal → amniocentesis
Diagnostic testing: amniocentesis!
Combined first TM
9-13 weeks, imaging + blood testing together (US and nuchal translucent + BHcg (free or total)
Nuchal translucent- 3-4 mm= down syndrome, big structure on back of neck= cystic hygroma
BHcg + PAPPa- Increase BHcg plus low PAPPa= down syndrome
Triple/quad
16-18 weeks- serum testing
Triple: AFP, hCG, unconjugated estriol
Quad: same + inhibin A
Multiple of median (MOM)- serum level constantly changing→ standardized formula = 1.0= normal
Integrated testing
Full: 1st and 2nd Tm combined + quad
Serum: all labs excluding NT
Step wise sequential- high risk pt can opt out and instead received genetic counseling & amniocentesis, low risk can continue
Contingent- high risk→ amniocentesis
Full integrated
Everything

Variables:
Gestational age determination- error is the most common reason for false positive
BPD, femur length & abdominal circumference- 2nd trimester measurements
Crown – in 1st trimester
Prior pregnancy history-
Maternal age-

TDap- 26 weeks onward, to cover baby- takes 2 weeks

High Glucose levels
- Start glucose logs
- Can start Metformin 500 mg BID (more compliant in patients)
- Insulin dosage can be expensive and requires patients to go to MUSC for check-ups

General: Well nourished, well developed in NAD. HEENT: Atraumatic, normocephalic.
Neck: Neck supple, non-tender without lymphadenopathy, masses or thyromegaly.
CV: No edema.
Pulmonary: Normal respiratory rate and effort, no use of accessory muscles.
Abdomen: Normoactive bowel sounds. Soft, nondistended, nontender. No guarding or rebound tenderness. No masses, pulsations or hernias.
Skin: Warm, dry. Well healing ~12 cm horizontal scar in hypogastric region of abdomen
MSK: Normal spinal curvature. FROM spine and extremities. No joint erythema or tenderness. **Neurological:** CN II-XII intact. Normal Gait
Psychiatric: Well groomed, appropriate mood and affect. Alert and oriented to person, place, and time.

ROS:
CP, h/a, dizziness, intense fatigue, n/v/d/c, edema, abd pain, bleeding, discharge, fever, chills, weight loss, flank pain, hematuria, burning/pain w/ urination.