PENNSYLVANIA
Department of State

For questions about this website, please **Click Here to send an E-Mail**, or to contact your Board directly, **Click Here.**

Click the X at the upper right corner to close this window and return to the list of licensees.

Person Information

Name: JAMES NUNCIE ANASTI

Address Information

Address(city state zipcode): Bethlehem PA 18015

License Information

Type:	Medical Physician and Surgeon	**Secondary Type:**		**Number:**	MD056874L
Profession:	Medicine	**Status:**	Active		
Issue Date:	8/30/1995	**Expires:**	12/31/2012	**Last Renewed:**	11/16/2010

Discipline Action History

No disciplinary actions were found for this license.

The Information above is considered primary source for verification of license credentials.

myLicense Renewal Question Responses
License Number: MD056874L
Name : JAMES NUNCIE ANASTI

Online Submission Date : 12/12/2004 9:08:47AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing juristiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you provide health care services to patients within the Commonwealth of PA?	Y
If yes, is the percentage of patients that you provide care for in the Commonwealth 20% or more of your practice?	Y
Do you maintain current medical professional liability insurance in the Commonwealth?	N
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

Online Submission Date : 10/3/2012 12:16:49AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	N
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing juristiction?	N
Have you met your current CE requirements?	N
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	N
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@state.pa.us
www.dos.state.pa.us/med

November 12, 2009

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

JAMES NUNCIE ANASTI 9849
ST LUKE'S HOSPITAL DEPT OF OB/GYN
801 OSTRUM STREET
BETHLEHEM PA 18015

RE: MD056874L

RE: Continuing Education Audit

Dear Licensee:

The State Board of Medicine received your response to the continuing medical education audit being conducted. The information provided has been reviewed and this hereby certifies your compliance with the continuing medical education requirement for the January 1, 2007 – December 31, 2008 biennial renewal period.

Should you have any questions, please contact the Board.

Sincerely,

State Board of Medicine

Passed

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@state.pa.us
www.dos.state.pa.us/med

October 15, 2009

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

JAMES NUNCIE ANASTI 9849
ST LUKE'S HOSPITAL DEPT OF OB/GYN
801 OSTRUM STREET
BETHLEHEM PA 18015

RE: MD056874L

NOV 05 2009

Dear Doctor:

You have been randomly selected for audit of the continuing education hours claimed for the renewal of your physician and surgeon license through December 31, 2008. The State Board of Medicine requires completion of 100 hours of AMA PRA Category 1 or 2 hours of continuing education as outline below:

- Twenty (20) credit hours must be completed in AMA PRA Category 1 activities.
- The remaining eighty (80) credit hours may be completed in either Category 1 or Category 2 approved activities.
- A minimum of 12 hours of the 100 must be completed in activities related to patient safety or risk management and may be completed in either Category 1 or 2.
- Details regarding continuing education accepted as Category 1 and 2 can be found on the Board's web site at www.dos.state.pa.us/med.

You must now submit **copies** of your continuing education documentation totaling a minimum of 100 hours for the renewal period 1/1/07 through 12/31/08. When submitting Category 1 hours, copies should be 8 ½" x 11" and must include your name, name of sponsor, course title, date of completion and number and category of CME credits awarded. **Do not submit** registration receipts, course agendas, or activity sheets. These do not provide all the information necessary to determine eligibility as outlined above. If you no longer have your certificates, you must contact the course provider for duplicates. **THE DOCUMENTATION SUBMITTED WILL NOT BE RETURNED.**

Please complete the verification statement below and return this entire page with copies of your continuing education documentation **no later than 30 days from the date of this audit notice**. If you were exempt from the CME requirement during the required time period, please complete and return this audit notice with documentation of your exemption.

Failure to satisfactorily comply with this audit request will result in a referral to the Professional Compliance Office, which may result in disciplinary proceedings under **Section 41 (6) of the Medical Practice Act of 1985 (63 P.S. 422.41 (6).** Thank you for your cooperation.

Sincerely,
State Board of Medicine

VERIFICATION STATEMENT

I have attached copies of approved continuing education for programs I completed during the licensure period 1/1/07 through 12/31/08.

Signature (Required) Nov 2 2009
Date

Person Info
Name: JAMES NUNCIE ANASTI
Address Info

Street Address: ST LUKE'S HOSPITAL DEPT OF OB/GYN 801 OSTRUM STREET

Email: [redacted]

Phone [redacted]

Fax

City Bethlehem

State PA

Zipcode 18015

Country 82

County Northampton

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
Have you met your current CE requirements?	N

Education Information

No education records

Employment Information

No employment records

remarks
Remarks:
Continuing Education Information

No CE Course records

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

Official Use Only

M D - 0 5 6 8 7 4

A N A S T R N E

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

JAMES NUNCIE ANASTI
[redacted]

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1998. TO RE. THROUGH DECEMBER 31, 2000, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OF MONEY ORDER IN THE AMOUNT OF $1. PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 P CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1998. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES	NO	
X	X	1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW.
( )	X	2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?
( )	X	3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)
( )	X	4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.
( )	X	5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?
( )	X	6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE _____ DATE 10-15-98

00080880

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

Official Use Only 026471

M D 0 5 6 8 7 4 L

A N A S T R N E W

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA 17105-8414

JAMES NUNCIE ANASTI
[redacted]

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 2000. TO RENEW YO
THROUGH DECEMBER 31, 2002, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF $12
PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 PER
CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 2000. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK
UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE HER
PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE
DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE
REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIA
OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS
ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO

( ) (X) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED) IN ANY OTHER JURISDIC
TION? IF YES, LIST EACH ONE.

( ) (X) 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY
SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?

( ) (X) 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT
VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE,
INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL
COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)

( ) (X) 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION
FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.

( ) (X) 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU
OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?

( ) (X) 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR
PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS, PLACE AN "X" IN THE BLANK TO THE RIGHT.
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE
SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE [signature] DATE 12-21-00

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st.medicine@state.pa.us
www.dos.state.pa.us/bpoa

Please complete and submit the following information for the physician assistant you supervise regarding granting approval for him/her to prescribe or dispense Schedule II controlled substances, provided that they possess a valid DEA registration.

Please note that ORIGINAL signatures are required.

PLEASE PRINT

Name of Primary Supervisor

Written Agreement #MX

Name of Physician Assistant

License #MA

Will Schedule II controlled substances be prescribed and/or dispensed by the above named physician assistant?

Yes ☐ No ☒

Signature of Supervisor

Supervisor's License #MD

Date

If these privileges are being granted and once our records have been updated, you will be notified in writing that those privileges have been added to the written agreement for the physician assistant listed above.

#K/0301810302

49-106 (REV. 3/02)

030110 0302

STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-2391

COURIER ADDRESS:
STATE BOARD OF MEDICINE
124 PINE STREET
HARRISBURG PA 17101

MXOOKIS7
AnastAPPL

Trans. No. _____
Amount _____
Date _____

APPLICATION FOR REGISTRATION AS A PHYSICIAN ASSISTANT SUPERVISOR

INSTRUCTIONS - If written agreement and drug list (if applicable) are identical for supervisors, submit one application for each physician assistant. Complete and sign t application. Attach fee and written agreement along with drug list, if applicable.

FEE - $35.00 for each application with one primary and one substitute physician assistant supervisor. An additional $5.00 fee is due for each additional substitute supervisor listed.

MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." FEE IS NOT REFUNDABLE.

NOTE: A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR FINAN INSTITUTION, REGARDLESS OF REASON FOR NON-PAYMENT.

PLEASE PRINT OR TYPE ALL INFORMATION

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR NAME/LICENSE NUMBER: OK

Anast James Nuncie MD-056874 L
LAST FIRST MIDDLE LIC. NO.

PHYSICIAN ASSISTANT NAME/CERTIFICATION NUMBER: OK

Bloom Jill E MA-001973L
LAST FIRST MIDDLE CERT NO.

PRACTICE ADDRESS 63 N Franklin St
STREET

Wilkes Barre PA 18701
CITY STATE ZIP CODE

PRACTICE TELEPHONE (570) 824-8921

49-106 (REV. 3/02)

Primary Physician Assistant Supervisor must complete:

List Specialties: Obstetrics/Gynecology, Reproductive Endocrinology

Do you hold a membership in any American Boards of Medical Specialties
YES X NO

If Yes, list Board(s): American Board of Obstetrics and Gynecology
American Board of Reproductive Endocrinology

If you have hospital staff privileges, indicate hospital name(s):
St. Luke's Hospital - Bethlehem PA

VERIFICATION

I will direct and exercise supervision over the named physician assistant in accorda[illegible] rules and regulations of the State Board of Medicine. I verify that I have reviewed the [illegible] Practices Act and Regulations of the State Board of Medicine. I recognize that I am [illegible] comply with all the provisions of the Act and Regulations including those provi[illegible] **require me to notify the Board of the termination of my agreement to supervise the p[illegible] assistant.** I recognize that I retain full professional and legal responsibili[illegible] performance of the physician assistant and the care and treatment of the physician [illegible] patients.

I verify that the statements in this application, written agreement and ar[illegible] applicable) are true and correct to the best of my knowledge, information and be[illegible] understand that false statements are made subject to the penalties of 18 Pa. C.S. [illegible] relating to unsworn falsification to authorities and may result in the suspension or [illegible] of my registration.

The physician assistant identified in this application will only assist the primary [illegible] assistant supervisor and substitute physician assistant supervisor(s) listed [illegible] application. This physician assistant will only provide medical services to the pati[illegible] the care of the primary and substitute supervisor(s) named in this application.

Signature of Primary Physician Assistant Supervisor _____ Date 09-26-02

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

[illegible]nature _____ Date _____ MD# _____

[illegible]e of Substitute Physician Assistant Supervisor _____

[illegible] _____ Date _____ MD# _____

[illegible] sheets with additional [illegible]

030118 0362

49-106 (REV. (3/02)

WRITTEN AGREEMENT

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

PHYSICIAN ASSISTANT SIGNATURE

INSTRUCTIONS: Please provide the following information for questions 1 and 2 on 8 1/2 X 11 sheets and attach to this form. Number each section on the attachment. The information on this agreement must be identical for all supervisors listed on page 2.

1. Describe the functions/tasks to be delegated to the physician assistant, including the manner in which the physician assistant will be assisting each named physician, instructions for the use of the physician assistant in the performance of delegated functions/tasks and medical regimens to be administered or relayed by the physician assistant.

2. Describe the time, place and manner of supervision and direction you will provide the physician assistant, including the frequency of personal contact with the physician assistant.

3. Identify the location and practice setting(i.e. hospital, private practice, group practice, etc.) where the physician assistant will serve.

Family Planning clinic

4. The name(s) of physician(s) who is/are willing to act as a substitute physician assistant supervisor in your absence are all listed on page 2 of this application ?
YES _____ NO _____

5. Will the physician assistant prescribe and dispense drugs?
YES X NO _____ If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? YES _____ NO X (NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances)

NOTE: The Regulations of the State Board of Osteopathic Medicine do not permit a physician assistant to prescribe or dispense drugs when practicing under the supervision of an osteopathic physician.

RECEIVED
OCT 28 2002
Medical Licensing Boards

49-306 (REV. 7/02)

PRESCRIBING AND DISPENSING DRUGS BY PHYSICIAN ASSISTANT

Print or type name

James N Anastasi Jr MD — Jill E Bloom

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR — PHYSICIAN ASSISTANT

If you answered "YES" to question number 5 in the written agreement, please check those categories which the physician assistant will be permitted to prescribe and dispense drugs.

1. Categories from which a physician assistant may prescribe and dispense without limitation are as follows:

   ___ (i) Antihistamines.
   X (ii) Anti-infective agents.
   X (iii) Cardiovascular drugs.
   X (iv) Contraceptives - for example, foams and devices.
   ___ (v) Diagnostic agents.
   ___ (vi) Disinfectants - for agents used on objects other than skin.
   ___ (vii) Electrolytic, caloric and water balance.
   ___ (viii) Enzymes.
   ___ (ix) Antitussives, expectorants and mucolytic agents.
   ___ (x) Gastrointestinal drugs.
   ___ (xi) Local anesthetics.
   X (xii) Serums, toxoids and vaccines.
   X (xiii) Skin and mucous membrane agents.
   X (xiv) Smooth muscle relaxants.
   ___ (xv) Vitamins.

2. Categories from which a physician assistant may prescribe and dispense subject to exclusions and limitations listed:

   ___ (i) **Autonomic drugs.** Drugs excluded under this category: Sympathomimetic (adrenergic) agents.
   ___ (ii) **Blood formation and coagulation.** Drugs excluded under this category:
   (A) Anti-coagulants and coagulants.
   (B) Thrombolytic agents.
   ___ (iii) **Central nervous system agents.** Drugs excluded under this category:
   (A) General anesthetics.
   (B) Monoamine oxidase inhibitors.
   ___ (iv) **Eye, ear, nose and throat preparations.** Drugs limited under this category: Miotics and mydriatics used as eye preparations require specific approval from the physician assistant supervisor for a named patient.
   X (v) **Hormones and synthetic substitutes.** Drugs excluded under this category:
   (A) Pituitary hormones and synthetics.
   (B) Parathyroid hormones and synthetics.

PLEASE NOTE:

Categories from which a physician assistant may not prescribe or dispense are as follows:

(i) Antineoplastic agents.
(ii) Dental agents.
(iii) Gold compounds.
(iv) Heavy metal antagonists.
(v) Oxytocics.
(vi) Radioactive agents.
(vii) Unclassified therapeutic agents.
(viii) Devices.
(ix) Pharmaceutical aids.

030118.0367

Planned Parenthood®
of North East Pennsylvania

P.O. Box 013, Trexlertown, PA 18087-0013
610-481-0401 Fax 610-481-0406

JOB DESCRIPTION

JOB TITLE: Clinician

DEPARTMENT: Patient Services

RESPONSIBLE TO: Center Manager (Administrative)
Medical Director (Medical)

GENERAL RESPONSIBILITIES:
Function in an expanded role in the provision and promotion of health care for women and men by collaboration with the Medical Director and following Planned Parenthood of North East Pennsylvania's (PPNEP) Protocols of Practice. Participate in a team approach to patient care.

SPECIFIC DUTIES:

Takes and/or reviews and interprets a complete health history, including obstetric, gynecological, sexual, contraceptive, medical, surgical, family health and psychosocial and records findings accurately, legibly and succinctly.

Performs physical examinations with special emphasis on the reproductive system including heart and lung assessment, thyroid, abdominal, breast and pelvic examination, pregnancy sizing and appropriate screening procedures, interprets finding of examination and records same.

Prescribes and provides appropriate contraceptive methods and/or treatments for specified medical conditions following protocols and tailored to the clients' maintenance.

Provides relevant health instruction to include family planning, STD prevention, genetics, nutrition, sexual counseling and principles of health promotion maintenance.

Consults with Medical Director or designated community gynecologist, or refers clients with abnormal findings or in need of further care according to clinical judgment and protocols of practice.

Responsible for follow-up pertaining to referrals, medical problems, lab tests, etc. with staff assistance.
Assists Center Manager and Health Care Assistants to ensure smooth operation of the service, i.e., record keeping, laboratory testing, clerical functions, and maintenance of facilities.

Supports PPNEP's required staff productivity levels.

Assists with orientation/training of new staff and/or students.

Participates in departmental committees (clinician, Q.A.) which affect or determine policies related to the delivery of reproductive health care to the consumer.

Participates in departmental meetings (clinician and affiliate medical committees) which affect and determine policies related to the role of the clinician.

Establishes contact with other community health providers.

Maintains continuing education requirements for licensure.

Practices in accordance with agency and PPFA Medical Standards and Guidelines

Maintains cardiopulmonary resuscitation certification.

Assists with abortion services and accepts call duties, as needed.

Assists with prenatal services as needed.

Responsible for regular periodic medical in-service and medical supervision of non clinical staff at center.

QUALIFICATIONS:
Licensed or certified as a nurse practitioner, nurse midwife, or physicians assistant in the state of Pennsylvania. Training in a recognized program or its equivalent. Experience in reproductive in reproductive health care, including STDs, contraceptives, pregnancy sizing, and options counseling essential. Experience in male examination desirable. Malpractice coverage assumed by clinician if individual coverage required by the state (e. CNMs). Must be willing to

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work some evenings and/or Saturdays. Must have a commitment to and interest in providing quality reproductive health care including family planning and abortion services.

I have received copy of this job description. I understand and accept the responsibilities and duties that it describes. My signature does not constitute a contract for any term, and neither PPNEP nor I am obliged to any specific term of employment.

I support the mission* of PPNEP and, regardless of my personal beliefs, I agree to assist in the provision of all services provided by PPNEP as requested.

Signed:_____

Date:_____

*MISSION STATEMENT

Planned Parenthood of North East Pennsylvania shall protect and promote an environment that ensures that individuals have universal access to quality reproductive health care and the freedom of choice to determine their reproductive needs.

Revised 4/99
4/01

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Clinicians at PPNEP practice under standing Protocols of Practice. The supervising physician will be available by telephone consultation whenever necessary. The supervising physician will attend at minimum quarterly quality management meetings with all clinicians and do on site audits with physician assistant in attendance.

XVII. FORMULARY OF MEDICATIONS

1. Rule out Drug Allergies when prescribing; document as "Denies Allergies" or "NKDA".

2. PPNEP clinicians may prescribe Oral Contraceptives 50 mcg or less and Emergency Hormonal Contraception.

3. Clinicians may prescribe hormone replacement therapy in accordance with the protocols of practice.

Medication/Brand	Type	Dosage/Active Ingred.
Acl-jel*	cream	
Acyclovir (Zovirax) *	oral	200 mg
Aldara*	topical cream	
Amino Cerv *	Vaginal cream	Urea 8.34%; Sodium Propinase 0.5%; Methionine 0.83%; Cystine 0.35%; Inosdal 0.83%
Ampicillin *	oral	500 mg & 3.5 gm
Anaprox *	oral	275 mg & 550 mg
Azithromycin* (Zithromax)	oral	150 mg. tablets; 1 G powder for suspension
Bellergal*	Oral	
Boric Acid*	capsule	
Ceftriaxone	IM	250 mg or 125 mg
Cefixime (Suprax)	oral	400 mg
Cleocin*	vaginal cream	5 gm (1 applicator)
Ciprofloxacin	oral	500 mg

Medication/Brand	Type	Dosage/Active Ingred
Compazine*	oral	10 mg
Condylox (Podofilox)*	topical	0.5%
Denavir*	topical	1%
Depo Provera	IM	150 mg
Dicloxicillin*	oral	250 mg & 500 mg
Diflucan*	oral	150 mg
Doxycycline	oral	100 mg
Dramamine*	oral	50 mg
Erythromycin *	oral	500 mg
Estring*	vaginal ring	
Estinyl *	oral	20mcg
Famvir*	oral	250 mg
Femstat Prefill *	cream	Butoconazole Nitrate 2%
Ferrous Sulfate * or		
Feosol Spansules *	oral	300 mg
Flagyl*	oral	375 mg
Flagyl ER*	oral	750 mg
Floxin*	oral	200 mg BID X 3d
Fosamax*	oral	10 mg
Keflex*	oral	500 mg
Lotrisone*	topical	

Medication/Brand	Type	Dosage/Active Ingred
Lunelle	IM	5ml
Macrobid*	oral	1 BID
Metronidazole	oral	250 mg and 500 mg
Metrogel-Vaginal*	vaginal gel	5 gm (1 applicator)
Mirena IUD*		
Monural*	oral	3 g
Motrin *	oral	400 mg
Nitrofurantoin *	oral	50 mg
Ofloxacin	oral oral oral	400 mg 300 mg 200 mg
Podophillox *	local	0.5% solution
Ponstel *	oral	250 mg
Promethazine(Phenergan)*	oral	25 mg
Provera*	oral	2.5 mg; 5 mg; 10 mg
Pyridium *	oral	200 mg
RID	topical	Pyrethrum extract 33% Piperonyl Bioxide 4.0%
Scabies Medication* (Lindane, Permethrin Cream) per CDC guidelines		
Spectinomycin	IM	2 gm
Sulfatrim DS *	oral	160 mg trimethoprim 800 mg sulfamethoxazole
Terazol 7 *	cream	Terconazole, 0.4%

Terazol 3 *	suppository	Terconazole, 80 mg

Medication/Brand	Type	Dosage/Active Ingred
Tetracycline	oral	500 mg
Tigan *	oral	250 mg
Trichloracetic Acid	local	85% solution
Vagisec *	douche	Polyoxyethylene nonylphenol / 5.25 mg
Valtrex*	oral	500 mg, 1000 mg
Zyban *		

* available to patients by prescription only

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49-106 (REV. (3/02)

Primary Physician Assistant Supervisor Must complete:

List Specialties Obstetrics/Gynecology ; Reproductive Endocrinology

Do you hold a membership in any American Boards of Medical Specialties
YES X NO

If yes, list Board(s) American Board of Obstetrics and Gynecology
American Board of Reproductive Endocrinology

If you have hospital staff privileges, indicate hospital name(s).
St Lukes Hospital, Bethlehem PA

VERIFICATION

I will direct and exercise supervision over the named physician assistant in accordance rules and regulations of the State Board of Medicine. I verify that I have reviewed the Practice Act and Regulations of the State Board of Medicine. I recognize that I am obli comply with all the provisions of the Act and Regulations including those provisi require me to notify the Board of the termination of my agreement to supervise the p assistant. I recognize that I retain full professional and legal responsibility performance of the physician assistant and the care and treatment of the physician ass patients.

I verify that the statements in this application, written agreement and drug (i applicable) are true and correct to the best of my knowledge, information and bel understand that false statements are made subject to the penalties of 18 Pa. C.S. Secti relating to unsworn falsification to authorities and may result in the suspension or re of my registration.

The physician assistant identified in this application will only assist the primary p assistant supervisor and substitute physician assistant supervisor(s) listed i application. This physician assistant will only provide medical services to the patient the care of the primary and substitute supervisor(s) named in this application.

Signature of Primary Physician Assistant Supervisor _____ Date 04-26-02

Name of Substitute Physician Assistant Supervisor Mark S. Lobo MD

Signature _____ Date 11/14/02 MD# 040926 PA

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

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(Attach 8 1/2 x 11 sheets with additional names if needed.)

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49-106 (REV. (3/02)

WRITTEN AGREEMENT

PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

PHYSICIAN ASSISTANT SIGNATURE

INSTRUCTIONS: Please provide the following information for questions 1 and 2 on 8 1/2 x 11 sheets and attach to this form. Number each section on the attachment. The information on this agreement must be identical for all supervisors listed on page 2.

1. Describe the functions/tasks to be delegated to the physician assistant, including the manner in which the physician assistant will be assisting each named physician, instructions for the use of the physician assistant in the performance of delegated functions/tasks and medical regimens to be administered or relayed by the physician assistant.

2. Describe the time, place and manner of supervision and direction you will provide the physician assistant, including the frequency of personal contact with the physician assistant.

Identify the location and practice setting(i.e. hospital, private practice, group practice, etc.) where the physician assistant will serve.

Family Planning clinic

4. The name(s) of physician(s) who is/are willing to act as a substitute physician assistant supervisor in your absence are all listed on page 2 of this application ?
YES X NO ____

Will the physician assistant prescribe and dispense drugs?
YES X NO ____ If yes, please complete page 4.

If yes, will Schedule III, IV and/or V controlled substances be prescribed and dispensed? YES ____ NO X (NOTE: Physician Assistants are not permitted to prescribe Schedule I and II controlled substances.)

NOTE: The Regulations of the State Board of Osteopathic Medicine do not permit a physician assistant to prescribe or dispense drugs when practicing under the supervision of an osteopathic physician.

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Planned Parenthood®
of North East Pennsylvania

P.O. Box 613, Trexlertown, PA 18087-0013
610-481-0491 Fax: 610-481-0486

A clinician at PPNEP working under standing Protocols of Practice can:

- Take and/or review and interpret a complete health history, including obstetric, gynecological, sexual, contraceptive, medical, surgical, family health and psychological information.
- Records findings accurately, legibly and succinctly.
- Performs physical examinations with special emphasis on the reproductive system, including heat and lung assessment, thyroid, abdominal, breast and pelvic examination, pregnancy sizing and appropriate screening procedures.
- Interprets finding of examination and records same.
- Prescribes and provides appropriate contraceptive methods and/or treatments for specified medical conditions following protocols and tailored to the client.
- Consults Medical Director or designated community gynecologist or refers clients with abnormal findings or in need of further care according to clinical judgment and standing orders.
- Responsible for follow-up pertaining to referrals, medical problems, lab tests etc with staff assistance.

Follows is a sample of part of the Standing orders which the Physician assistant uses to reach decisions and institute care plans for PPNEP clients.

Question # 4:
The supervising physician will be available by telephone consultation whenever necessary. The supervising physician will attend at minimum quarterly quality management meetings with all clinicians and do on site audits with physician assistant in attendance.

V. **Medical Screening & Evaluation**

A. The medical record/database must:

1. contain sufficient information to identify the patient, justify the diagnosis or clinical impression, and warrant treatment;

2. be updated at least annually, or more often if problems develop;

3. use lay terms if a self-history is used;

4. be verified by a staff member.

B. A history necessary to determine the presence or absence of high risk factors relative to the patient's age should be obtained.

1. Rule Out Drug Allergies when Prescribing; Document as "Denies Allergies" or "NKDA"

The physical examination for comprehensive patients must include:

1. height (for initial visit only) and annually for midlife women;

2. weight;

3. blood pressure;

4. thyroid palpation;

5. heart and lung;

6. inspection of extremities;

7. Breast exams may include the following components:

a. Inspection (observation) of the breasts for asymmetry, abnormal superficial vascular pattern, dimpling, fixation to the chest wall, peau d'orange;

b. bilateral breast inspection and palpation in the sitting position, including observation for galactorrhea;

c. lymph node exam of the axillae and supraclavicular areas;

d. repeat bilateral breast palpation in the supine position;

e. when the breast examination done at the affiliate is not completely normal, findings must be fully documented;

including a diagram of breast abnormalities and a narrative description of same.

8. abdominal palpation, to include liver palpation for patients taking oral contraceptives, and including (for pregnant patients) palpating the abdomen downward toward the pubic bone to check for fundal height;

9. pelvic exam, including inspection of the external genitalia, cervix and vagina, bimanual examination, and rectal exam as appropriate. Infection control procedures must be observed, including changing the gloves between the vaginal and rectal exams;

10. Rectal exam for women over 40 and others at clinician discretion.

C. Routine Laboratory Tests Ordered and Interpreted as Indicated:

1. Wet smear

2. Pap smear

3. Gonorrhea screen (DNA probe)

4. Hematocrit/hemoglobin

5. Urine dipstick

- If urine dipstick for protein is 2+ or greater for 2 more visits and patient is asymptomatic, get clean catch mid-stream and recheck with ChemStrip.
- If sugar is present, refer for evaluation, if not already under the care of MD, may order an FBS.
- See Section VI. G. UTI

6. Urinalysis

7. Pregnancy test (urine and serum)

- Perform urine pregnancy test.
- May estimate length of gestation if patient requests and as scheduling permits, and at clinician discretion.

- Must refer if:

  1. Fibroids;

  2. Palpable adnexal mass;

  3. Uterine position makes size difficult to determine;

  4. Marked discrepancy between size and gestation age from LMP;

  5. Suspected ectopic pregnancy.

REFER TO ER IMMEDIATELY

- A pregnant patient complaining of severe pain or if an ectopic pregnancy is suspected may not be examined, but referred immediately to a private physician or to an emergency room.

- If in the course of a pregnancy verification an STD which could cause post abortal endometritis is found, a note may be given to the patient to give to the abortion or prenatal provider documenting the findings or treat in accordance with CDC guidelines.

8. High risk Studies (Cholesterol, CHD profile)

9. Fasting Blood Sugar

   - as appropriate consider weight, family history, history of gestational diabetes

10. Liver Profile (SGOT, SGPT, gamma GT, LDH)

11. Prolactin Level

12. Thyroid Function Studies (T3, T4, TSH)

13. Bacterial cultures & sensitivity

14. Complete Blood Count

15. ChemScreen (SMAG or HYCEL)

Patients with breast implants must be referred to a radiologist with experience in performing mammography on such women.

3. TB Tine Tests

a. TB Tine tests may be done on full or limited service patients.

b. Tine test is done on inner aspect of forearm. Forearm should be cleansed with alcohol and allowed to air dry. Pronged applicator is then applied to cleansed area.

c. Test should be read within 72 hours of administration. Any erythema or raised area should be interpreted as positive and referral given.

E. Diagnosis, Treatment and Special Instructions

The following must be documented in the medical record:

1. diagnostic and therapeutic orders, observations, clinical findings and action(s) taken;

2. notations about follow-up;

3. documentation of referral;

4. notation of any telephone calls made either by or to a patient regarding medical problems.

F. Deferred Pap/Pelvic Exam

Pap smears and pelvic exams may be deferred in virginal women with normal bleeding history. The Pap smear may be done at the first annual visit following onset of intercourse.

G. Delayed Pap/Pelvic Exam

The Pap smear and pelvic exam may be delayed and the patient offered up to 3 cycles of oral contraceptives when the clinician feels that doing a Pap would not provide optimum results, e.g., menses, post-partum, post-abortion, recent intercourse or douching. See Section II Hormonal Contraceptive Use, B 4, unless patient is being seen as a limited service (HOPE).

VI. Drivers License and Pre-Employment Physical

A. The medical portion of the driver's license applications and working papers may be filled out by the clinician for PPNEP patients or as a limited service. Clinician registration numbers must be filled in the appropriate areas.

B. Pre-employment physicals may be completed for PPNEP patients at the discretion of the clinician, based on requirements of the physical.

1. Patients must either be or become comprehensive service patients.

2. Exams must be completed to the best of our ability, with the resources available (i.e., eye exams, gross hearing ability etc.)

3. Any portion of the exam form that we are unable to complete must be so documented.

VII. Smoking Cessation

Clinicians may counsel patients on smoking cessation and recommend:

A. over the counter aids such as habitrol or nicorette gum

B. Zyban 150 mg Daily x 3 days, then 300 mg (150 mg BID) for not longer than 12 weeks.

VIII. HIV + patients

Women who are known to be HIV seropositive may be provided any reproductive health care service at the affiliate. The patient must be told:

A. in addition to routine services, management of reproductive tract manifestations of HIV disease only will be offered at the affiliate;

B. referrals for continuing care will be given if conditions progress beyond affiliate management capacity;

C. primary care for non-reproductive manifestations of HIV infection **must** be obtained by referral elsewhere, preferably by a health care provider experienced in the care for HIV positive individuals;

D. See Section V, Infectious Conditions.

IX. STI Screening

Patients will be screened for STIs as indicated. See Section V, Infectious Conditions.

X. Recommendations/Referrals and Follow-Up

A. Definitions

1. Recommendation:

   a. A suggestion to obtain a routine screening procedure when no abnormality has been identified (e.g., routine screening cholesterol or mammography); or,

   b. A suggestion to follow up on a minor health problem.

2. Referral – advice to obtain a consultation or test when a specific need (a problem or abnormality, present or suspected) is identified (e.g., indicated ultrasound or mammography, management of headaches, diabetes).

B. Follow-Up Procedures

1. For both recommendations and referrals there must be:

   a. An alternate mechanism of contact established and documented on the medical record if the patient has requested confidentiality be maintained. Patients must be informed that confidentiality may be broken if they cannot be contacted when a life-threatening condition is suspected or detected;

   b. A listing of agencies, physicians, and hospitals to which patients may be directed or referred.

      1) A medical condition or complication considered to be outside the domain of PPNBP;

      2) Additional evaluation or medical service requested by the patient;

      3) Routine screening procedure.

2. For recommendations:

   a. A referral form does not have to be given.

   b. The recommendation must be documented in the medical record.

   c. The patient should be questioned/reminded when s/he returns to the center.

3. For referrals:

a. A referral must be given be given when an out-of- affiliate referral is from an essential service or for the management of an emergent condition (Level 1 or 2). If the condition is to be managed within the PPNEP, a referral form does not have to be given. All patients must be tracked through a reliable follow-up system.

b. All referrals must be documented on the medical record. All referrals **must** be categorized and followed up as below and as identified in the protocols specific to that condition.

c. There must be an established reminder system to assure timely follow up (e.g., notebook log) with a detailed description of the system/procedures in the protocols.

d. There must be a readily identifiable reminder on the chart ("tickler"), placed in a prominent place so that anyone looking at the chart for any reason (e.g., supply visit, telephone call) can take appropriate action.

e. For patients being referred out-of-affiliate for care, three referral sources should be given when possible.

C. Referral Management – refer to chart.

D. Documentation

1. Referral Forms – A signed and dated copy must be maintained in the medical record.

2. Chart – Must contain:

a. Documentation of all recommendations or referrals made;

b. Why a referral was made;

c. A copy of the signed and dated referral form;

d. Consent to release information to the referral source;

e. Documentation of patient education materials given;

f. All attempts and contacts with the patient or referral source (with copies of any written communications);

g. All visits;

h. Documentation of appointments not kept or patient noncompliance. In circumstances where the patient will not receive care as recommended, the patient must sign a release before further clinical services can be provided – Release When Test/Service/Consultation Will Not Be Obtained as Recommended (1RL).

For level 1 and 2 referrals, a readily identifiable reminder on the chart ("tickler") placed in a prominent place so that any one looking at the chart for any reason (e.g., supply visit, telephone call) can take appropriate action.

E. Staff – There must be documentation in the personnel file of each staff person who has patient contact that orientation was provided regarding that person's responsibility related to the follow up of referrals.

F. Quality Management

1. The referral/follow-up system should be audited at least annually to assure that referrals are followed up as required and in a timely fashion.

2. Consumer feedback is encouraged and feedback obtained should be considered when updating the list of consultations.

3. The patient needing referral should be asked if she has her own physician; if she does not, she should be provided with a list of at least three names of suitable and competent medical providers that have verified their choice of being a PPNEP referral source and have been proven competent in their respective specialty.

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CONDITION	PATIENT NOTIFICATION	REFERRAL PROCEDURE	CONFIRMATION OF CARE
Level 1 - Acute* (e.g., suspected ectopic, acute abdomen, thromboembolic event, acute PID, hemorrhage, STIs)	At time of visit. -or- Emergency phone call from patient.	Give referral form at visit; -or- Send referral form. Transfer to ER or Hospital; -or- With patient's consent, help patient make appt., if necessary. "Tickler" on chart.	Call patient at least once within 48 hours. If no contact, must make two more telephone attempts within next 48 hours. If no response to telephone attempts, must send one letter. If no response to letter, follow up when patient returns to clinic. With patient's consent, request feedback from referral source.
Level 2 - Potentially serious or life-threatening* (e.g., abnormal Pap smear, dominant breast mass, adnexal mass, potential malignancy)	At time of visit, -or- Within PPFA designated time period for abnormal test results. Also see specific Standards.	If out-of-affiliate, give referral form at visit; -or- send referral form. Initiate tracking system for all in-affiliate and out-of-affiliate referrals. With patient's consent, help patient make appt., if necessary. "Tickler" on chart.	Request feedback from patient -make three attempts at contact within 90 days of referral, two of which must be in writing. If no response to letters, follow up when patient returns to clinic. With patient's consent, request feedback from referral source. If, when contacted, patient has not gone for referral, advise again as to importance. Follow up when patient returns to clinic. Sign release as indicated in specific Standards.

* The aggressiveness of follow-up shall depend on the potential seriousness of the problem.

In addition to minimizing the number of partners, STI risk may be reduced by avoiding certain high risk behaviors. This includes:

A. unprotected sexual contact with persons who have a genital discharge, genital warts, ulcerative genital lesions, or clinical or laboratory evidence of HIV or hepatitis B virus (HBV) infection;

B. unprotected anal intercourse or oral-anal sex;

C. genital contact with oral cold sores.

The AIDS epidemic had led to a heightened awareness regarding the importance of barrier contraceptives in preventing the spread of STIs. Even if a person uses effective continuous contraception, including oral contraceptives or sterilization, the use of latex condoms must be advocated when engaging in any at risk sexual behavior. Information and education on effective condom use should be given.

C. MEDICAL EVALUATION

1. History

Although the emphasis may vary, the following questions should be considered in any patient being evaluated for a possible STI:

a. nature of complaints: onset, character, intensity, course, aggravating factors;

b. history of previous episodes or similar complaints or conditions: diagnosis, treatment, response to treatment;

c. history of other STIs: number of episodes, dates, response to treatment;

d. present sexual practices: number of partners, use of barrier contraceptives, physical sites of sexual contact;

e. attempts at self-treatment: antibiotics, vaginal medications, douches;

f. health status of partners: STI symptoms, diagnoses, recent treatments;

g. present method of contraception; percentage of time that method was correctly used;

h. last menstrual period; possibility of pregnancy; presence of pregnancy symptoms;

i. drug allergies, side effects, or reactions;

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D. PHYSICAL EXAMINATION

1. A complete history and physical exam must be completed using STI forms for history and physical.

2. Male and female clients may receive the following services and laboratory tests:

   a. Inspection of skin, face, trunk, forearms, and palms

   b. Inspection of oral mucosa

   c. Inspection of pubic hair for lice and nits

   d. Palpation of inguinal and femoral areas, as well as cervical, epitrochlear, and axillary nodes for lymphadenopathy

   e. Serologic test for syphilis

   f. Risk reduction counseling including evaluation for possible AIDS and HIV antibody screening (If possibly symptomatic for AIDS, client must be referred for appropriate evaluation.)

   g. DNA amplification test for Chlamydia and gonorrhea

3. Female clients may also receive the following services and laboratory tests:

   a. inspection of external genitalia, perineum, and anus

   b. examination of vagina and cervix, using a speculum

   c. bi-manual pelvic exam including rectal exam when indicated

   d. endocervical culture for gonorrhea and Chlamydia

   e. wet smear of vaginal secretions as indicated for diagnosis of trichmoniases, bacterial vaginosis, monilial vaginitis

   f. evaluation for possible PID and/or purulent endocervical discharge, culture as indicated

   g. Pap smear if not done within the past 12 months

   h. A client may be treated presumptively for contact to an STI