San Francisco General Hospital
Family Health Center
Pediatrics

FAMILY HEALTH CENTER
Registered Nurse

Medical Screening and

Standardized Procedures
Table of Contents

Authorization List Page 3
Introduction Page 4
Standardized Procedure Registered Nurse in the Family Health Center Page 5
Protocol #1 Medical Screening Exam Page 8
Protocol #2 Assessment and Management of Shortness of Breath with Wheezes Page 10
Protocol #3 Assessment and Management of Nausea, Vomiting, Diarrhea Page 12
Protocol #4 Assessment and Management of Abdominal Pain Page 14
Protocol #5 Assessment and Management of Febrile Seizures Page 16
Protocol #6 Assessment and Management of Urinary Tract Infection Page 18
Protocol #7 Assessment and Management of Fever Page 20
Protocol #8 Assessment and Management of suspected fractures Page 22
Protocol #9 Assessment and Management of Lacerations Page 24

Distribution List:
Copy 1: Nurse Medical Screening Area
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San Francisco General Hospital
Family Health Center
Pediatrics

Family Health Center Registered Nurse
Standardized Procedures and Protocols

The following Registered Nurses have reviewed the standardized procedures and have
demonstrated competency as Registered Nurses working the Family Health Center.
They are authorized to practice in the Family Health Center under the Standardized
Procedures and Protocols contained in this manual:

Rachel Abdel, RN
Ricardo Atengco, RN
Sherri Barnes, RN
Jennifer Chiu, RN
Chit Lee Chong, RN
Mario Flores, RN
Yvon Forsyth, RN
Glenn Foster, RN
Cynthia Gozun, RN
Besilda Mandipat, RN
Isela Mosteiro, RN
Kathleen Noonan, RN
Sara Paredes, RN
Carla Peguese, RN
Venus Peralta, RN
Jessenia Ramirez, RN
Sara Sullivan, RN
Josefina Tolosa, RN
Linda Truong, RN
Sujatha Vasudevan, RN

Hali Hammer, Ronald Labuguen, MD
Acting Medical Director, Family Health Center

Date

Olga Ivanco, RN
Nurse Manager, Family Health Center

Date

Updated: xx/xx/xxxx
San Francisco General Hospital  
Family Health Center  

Medical Screening Examination and  
Standardized Procedures:  
Registered Nurse  

Introduction

The following protocols are the policies and guidelines for the care provided to pediatric patients at the Family Health Center by the Registered Nurse (RN). Since it is impossible to anticipate every clinical situation or presenting chief complaint that may arise, it is expected that the Attending Physician, Nurse Practitioner, and/or Physician Assistant consultation may be warranted. The RN will consult the Attending Physician and/or other aforementioned providers by using their nursing clinical judgment. In general, the RN shall function within the scope of practice as specified in the State of California Nurse Practice Act.

The Standardized Procedures were developed with assistance from the following:

1. Implementation of Standardized Procedures. Position Statement of the California Nurse Association
2. Standardized Procedure Work Sheet, State of California Board of Registered Nursing, Department of Consumer Affairs.
San Francisco General Hospital  
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE ~ REGISTERED NURSE

Title: Registered Nurse in the Family Health Center

I. Policy Statement
   A. It is the policy of San Francisco General Hospital Medical Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Registered Nurses, Physicians, Administrators and other Affiliated Staff and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

   B. A copy of the signed procedures will be kept in an operational manual in the Family Health Center and on file in the credentialing liaison Medical Staff Office.

II. Functions to be performed

   The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. The RN provides interdependent functions that overlap the practice of medicine. These overlapping functions require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the RN to seek physician consultation.
III. Circumstances Under Which RN May Perform Function

A. Setting
The Registered Nurse may perform the following standardized procedure functions in the Family Health Center consistent with their experience and training.

B. Scope of Supervision Required
1. The RN is responsible and accountable to the Family Health Center Nurse Manager and Medical Director or physician designee.
2. Overlapping functions are to be performed in areas, which allow for a consulting physician to be available to the RN, by phone or in person, including but not limited to the clinical area.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
   a) Emergency conditions requiring prompt medical intervention
   b) Upon the request of the patient, parents, registered nurse, or physician

IV. Requirements for the Registered Nurse

A. Experience and Education
1. Active California Registered Nurse license
2. Current Basic Life Support certification

B. Special Training
1. Possess an unrestricted California license as a Registered Nurse.
2. Successfully completion of the medical screening training and orientation program including protocol specific training as described in the orientation program (including Telephone advice for pediatrics)
3. Successful completion of the Health Stream through the Department of Education and Training.
4. Possess effective interpersonal communications skills.

C. Evaluation of the Registered Nurse competence in performance of standardized procedures
1. Initial: at the conclusion of the standardized procedure training the Nurse Manager or designee will assess the RN’s ability to perform the procedures.
   a. Successful completion of the RN orientation program
   b. Successful completion of the medical screening skills checklist
   c. Successful completion of Nurse Manager or designee review of accuracy and completeness of documentation for actual patient cases (minimum of ten)
2. Annual: Nurse Manager or designee will evaluate the RN's competence through an annual performance appraisal and skills competency review
along with feedback from colleagues, physicians, direct observation and/or chart review.

3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, or designee at appropriate intervals until acceptable skill level is achieved. This evaluation may include chart reviews.

V. Development and Approval of Standardized Procedure

A. Method of Development
Standardized procedures are developed collaboratively by the registered nurses, nurse managers, physicians, and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval
The CIDP, and Credentials, Medical Executive, and the Joint Conference Committees must approve all standardized procedures prior to the implementation.

C. Review Schedule
The standardized procedures will be reviewed every three years by the registered nurses, nurse managers, and medical director and as practice changes.

D. Revisions
All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.
Protocol #1: Medical Screening Examination

A. DEFINITION
This protocol covers the medical screening examination (MSE) performed in the Family Health Center. The MSE is an examination performed by a qualified Registered Nurse, on all patients who present to the FHC seeking care. This examination may range from a brief to a detailed examination, involving all the laboratory, x-ray, and consultative resources available within SFGH’s range of services, so that it is possible to reasonably determine whether an emergency medical condition exists or not.

B. DATA BASE
1. Subjective Data
   a. Statement of chief complaint.
   b. Patient history and signs and symptoms relevant to disease process/injury and organ system affected.
   c. Pain assessment to include onset, location and intensity (0-10 scale).
   d. Pertinent past medical history, medications, and allergies.
   e. Current immunizations status for the children and any additional surface trauma.
   f. Any treatments used prior to arrival.

2. Objective Data
   a. Limited physical exam appropriate for the presenting complaint, which may include but not be limited to:
      • Vital signs (rectal temp if <2years)
      • Oxygen saturation
      • Level of consciousness
      • Safety Risk Factors
      • Assessment of symptoms of pregnancy or possible labor including term gestation, as appropriate.
      • Degree of pain and or discomfort (mild, moderate, severe, on a scale of 0 – 10).
      • Emotional state
      • Skin signs
      • Physical appearance, size and location of injuries, sensation, as appropriate
      • Ability to ambulate and assessment of gait, as appropriate
      • Disease and age appropriate radiological studies
C. Assessment  
Consistent with subjective and objective findings and status of disease process/ injury.

D. Plan  
1. Treatment  
   a. Age appropriate screening tests and/or diagnostic tests for the purpose of disease identification.  
   b. Immunization update  
   c. Determination of triage category; emergent, urgent, or non-urgent.  

2. Patient conditions requiring Attending Consultation  
   a. Acute decompensation of patient situation  
   b. Unexplained historical, physical or laboratory findings  
   c. Upon request of patient, patient’s family, RN or provider  

3. Education  
   a. Patient or family education and counseling appropriate to diagnosis including treatment modalities, medications and activities.  

4. Follow-up  
   As indicated and appropriate to patient health status and diagnosis.  

E. Record Keeping  
All information relevant to patient care will be recorded in the medical record or LCR as appropriate. EMTALA logs to be completed.
Protocol #2: Shortness of Breath with Wheezes (Asthma)

A. DEFINITION
This protocol covers the initial assessment and management of children with shortness of breath and wheezes seen by Registered Nurses (RN) in the Family Health Center.

Indications: Shortness of breath with confirmed wheezing and history of asthma.

B. DATA BASE
1. Subjective Data
   a. Review history and signs and symptoms of asthma/COPD.
   b. Pertinent past medical history, current medications and allergies.
   c. Characteristics of shortness of breath and associated symptoms (cough, fever, chills).
   d. Any treatments used prior to arrival.

2. Objective Data
   a. Perform focused physical exam relevant to respiratory disease:
      • Auscultate lung sounds bilaterally.
      • Note respiratory rate, depth, and work of breathing.
      • Stridor or audible wheezing, nasal flaring, grunting, retractions.
   b. Measure vital signs every 30 minutes throughout stay in clinic or more frequently, as indicated.
   c. Place on pulse oximetry and measure SpO₂, keep O₂ Sat >94%.
   d. Skin signs, color, temperature, moisture, and capillary refill.
   e. Obtain temperature every 1 hour (rectal if < 2 years) or more frequently, as indicated.

C. Assessment
Consistent with subjective and objective findings and status of disease findings.

D. Plan
1. Treatment
   a. Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO₂ > 94%.
   b. Administer nebulized albuterol sulfate 2.5-5 mg for children over 12 years old every 20 minutes for 3 doses combined with ipratropium bromide (atrovent) 500 mcg.
      For children 3-12 years old give 0.15mg/kg albuterol sulfate every 20 minutes for 3 doses (minimum 2.5mg) combined with ipratropium bromide (atrovent) 125-250 mcg.
      **For children <3 years old, provider consultation is required prior to initiating treatment with medications.**
   c. Portable chest film or send patient to X-ray for PA and lateral of
c. Transport to Children’s Health Center (6M) or Emergency Department as directed by provider.

2. Consultation with physician for altered vital signs:
   
   **Child 0 – 12 months**
   
   - HR > 200, < 80
   - SPO₂ < 94%
   - RR > 60, < 20

   **Child 1 – 6 years**
   
   - HR > 180, < 60
   - SPO₂ < 94%
   - SBP < 75
   - RR > 60, < 20

   **Child > 6 years**
   
   - HR > 150, < 50
   - SPO₂ < 94%
   - SBP < 80
   - RR > 50, < 10

3. Education
   
   a. Patient education and counseling appropriate to disease process.
   
   b. Asthma education to be done by Health Workers from the Asthma Clinic.

4. Follow-up
   
   Primary care provider as indicated and appropriate to diagnosis.

E. Record Keeping
   
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol #3: **Assessment and Management of Nausea, Vomiting and Diarrhea**

**A. DEFINITION**
This protocol covers the initial assessment and management of patients with related symptoms seen by Registered Nurses in the Family Health Center.

Indications:
- Diarrhea > 24 hours
- No urination > 24 hours
- Abdominal pain > 4 hours
- Dysuria
- Fevers
- Vomiting > 12 hours (<6 months)
  
  > 24 hours (6 months to 2 years)
  > 48 hours (> 2 years old)

**B. DATA BASE**
1. **Subjective Data**
   - Review history and signs and symptoms related to dehydration
     1. Last oral intake
     2. Tearing (note with or without crying)
     3. Fever, chills (rectal temp if < 2 years of age)
     4. Frequency of urination in last 24 hours
   - Pertinent past medical history, current medications and allergies.
   - Characteristics of any pain location, quality, and intensity (0 – 10) and associated symptoms (abdominal cramping, fever, chills).
   - Any treatments used prior to arrival.
   - Travel history
2. **Objective Data**
   - Perform focused physical exam relevant to dehydration.
   - Skin signs: color, temperature, moisture, and capillary refill
   - Laboratory evaluation:
     1. CBC
     2. Urine dipstick
     3. Obtain full set of vitals and redo every 30 minutes 2 times (rectal temperature if <2)

**C. Assessment**
Consistent with subjective and objective findings. Assessment of status of disease process.

**D. Plan**
1. **Treatment**
   - Save any stool samples.
   - Transfer to patient care area for evaluation by provider.
2. Patient conditions requiring immediate Attending Consultation
   a. HR > 130
   b. BP < 90
   c. RR > 45
   d. SpO₂ < 92%
   e. Temperature:
      ▪ <6 months  >38C
      ▪ 6-12 months, >38.5C
      ▪ >12 months ≥ 39C
   f. No urination in 24 hours

3. Education
   a. Patient or family education and counseling appropriate to disease process and document findings on a Progress note for inclusion in the medical record.

4. Follow-up
   a. If the patient’s concern does not require provider evaluation and the assessment is reassuring, document findings on a progress note for inclusion in the medical record.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol # 4: Assessment and Management of Abdominal Pain

A. DEFINITION

This protocol covers the initial assessment and management of children with abdominal pain which may include but not limited to vomiting and diarrhea seen by Registered Nurses in the Family Health Center.

Indications:
1. Vomiting more than two times a day.
2. Diarrhea/loose stool watery, mucousy > 24 hours.
3. Vital signs suggesting hemodynamic instability (HR > 120 or SBP < 90).
4. Orthostatic vital signs or dizzy when standing.
5. Severe abdominal pain > 24 hours.

B. DATA BASE

1. Subjective Data
   a. Review history and signs and symptoms suggestive of volume loss:
      1. Frequency, amount, and color of emesis.
      2. Frequency, amount, and color of stool and urine.
   b. Pertinent past medical history, current medications and allergies.
   c. Characteristics of any pain location, quality, and intensity (0 – 10) and associated symptoms (abdominal pain, fever or chills).
   d. Any treatments used prior to arrival.

2. Objective Data
   a. Perform focused physical examination relevant to gastrointestinal disorders.
   b. Ascultate bowel sounds and note abdominal distension.
   c. Measure vital signs every 30 minutes times 2. Include orthostatic vital signs unless HR > 120 or SBP < 90.
   d. Place on pulse oximetry and measure SpO₂ > 94%.
   e. Obtain temperature (rectal if < 2 years).
   f. Obtain urine sample, clean catch if possible. May need first stream specimen.

C. Assessment

Consistent with subjective and objective findings and assessment of status of disease process.

D. Plan

1. Treatment
   a. Request order from physician for anti-emetic or anti-pyretic medication if indicated.
   b. Save stool sample if having diarrhea.
   c. Transport to the Children’s Health Center or the Emergency Department as directed by the provider.
2. Patient conditions requiring Attending Consultation
   a. HR > 130
   b. SBP < 90
   c. RR > 45
   d. SpO₂ < 92%
   e. Temperature:
      - <6 months >38°C
      - 6-12 months, >38.5C
      - >12 months > 39°C
   f. Altered mental status with GCS < 13 (Keep Glasgow scale accessible in the binder on the unit)
   g. Vomiting more than two times in Acute Care Clinic prior to being seen by provider

3. Education
   a. Patient or family education appropriate to diagnosis appropriate to disease process.

4. Follow-up
   As indicated and appropriate to diagnosis including treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol #5: Assessment and Management of Febrile Seizures

A. DEFINITION
This protocol covers the initial assessment and management of children who present following a febrile seizure seen by the Registered Nurse in the Family Health Center.

B. DATA BASE
1. Subjective Data
   a. Review history and signs and symptoms of febrile seizures.
   b. Pertinent past medical history, current medications and allergies.
   c. Characteristics of seizure activity, post-ictal state.
   d. Any treatments used prior to arrival.

2. Objective Data
   a. Perform focused medical examination relevant to seizure activity:
      1. Check of level of responsiveness.
   b. Measure vital signs in triage (obtain rectal temperature if < 2 years of age)
   c. Place on pulse oximetry to ensure SpO2 saturation > 94%.

C. Assessment
Assessment consistent with subjective and objective findings and assessment of status of disease process.

D. Plan
1. Treatment
   a. Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO2 > 94%.
   b. Administer Acetaminophen or Ibuprofen as prescribed by provider for fever > 39 C (102.2 F).
   c. Transport to Children’s Health Center (6M) or Emergency Department as directed by provider.

2. Patient conditions requiring Attending Consultation
   a. HR > 130
   b. SBP < 90
   c. SpO2 < 92% on room air, prior to any supplemental oxygen
   d. RR > 45
   e. Altered mental status

3. Education
   a. Patient or family education appropriate to diagnosis including treatment modalities, medications and activities.
4. Follow-up
   Primary Care Provider as indicated as appropriate to diagnosis including
treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or
   LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol #6: Assessment and Management of Urinary Tract Infection

A. DEFINITION
This protocol covers the initial assessment and management of children with urinary tract infection seen by the Registered Nurse in the Family Health Center.

B. DATA BASE
1. Subjective Data
   a. Review history and signs and symptoms of painful urination.
   b. Characteristics of urination problems, smell, hydration status.
   c. Pertinent past medical history, hospitalizations, current medications and allergies.
   d. Any treatments used prior to arrival.

2. Objective Data
   a. Perform focused physical examination relevant to urinary tract infections.
      1. Diaper count
   b. Measure vital signs and include pain assessment (rectal temperature if < 2 years of age).

C. Assessment
Assessment consistent with subjective and objective findings and assessment of disease processes.

D. Plan
1. Treatment
   a. Abdominal examination (tenderness in area)
   b. Urine collection for urine analysis, clean catch if possible.
   c. Transport to Children’s Health Center (6M) or Emergency Department as directed by provider.

2. Patient conditions requiring Attending Consultation
   a. HR > 130
   b. SBP < 90
   c. RR > 45
   d. Altered mental status
   e. Temperature:
      • <6 months >38C
      • 6-12 months, >38.5C
      • >12 months >39C
   f. Urine dipstick with (+) hemoglobin, Protein-trace, (+) leukocytes

3. Education
   a. Patient or family education and counseling appropriate to disease process.
4. Follow-up
   Primary Care Provider as indicated and as appropriate to diagnosis including treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol # 7: Assessment and Management of Fever with Rash

A. DEFINITION
This protocol covers the initial assessment and management of children with generalized rash and fever seen by Registered Nurses in the Family Health Center. To prevent the transmission of chicken pox, measles, meningococcus and other infections in the waiting room and other clinical areas.

B. DATA BASE
1. Subjective Data
   a. Review history and signs and symptoms of fever with or without rash.
   b. Characteristics of rash, redness of skin, generalized over body.
   c. Characteristics of fever, irritability, fussiness.
   d. Pertinent past medical history, hospitalizations, current medications and allergies. Exposure to someone with the same symptoms.
   e. Any treatments used prior to arrival.
   f. Hydration status: drinking fluids and wet diapers.
   g. Travel history.

2. Objective Data
   a. Perform focused physical examination relevant to fevers and rash.
   b. Measure vital signs and include pain assessment. (Rectal temperature if < 2 years of age).

C. Assessment
Assessment consistent with subjective and objective findings. Assessment of disease process.

D. Plan
1. Treatment
   a. Examination of body for generalized redness, papular or Petechiae.
   b. Assess child for general conditions (runny nose, high fever, pink eye, cough, loss of appetite, altered mental status)
   c. Isolate patient in room away from other patients.
   d. Urine collection for urine analysis, clean catch if possible.
   e. Transport to Children’s Health Center or Emergency Department as directed by provider.

2. Patient conditions requiring Attending Consultation
   a. HR > 130
   b. SBP < 90
   c. RR > 45
   d. Urine dipstick with (+) hemoglobin, Protein-trace, (+) leukocytes
   e. Temperature:
      - <6 months >38°C
3. Education
   a. Patient or family education and counseling appropriate to the disease process.

4. Follow-up
   Primary Care Provider as indicated and as appropriate to diagnosis including treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol #8: Assessment and Management of Suspected Fractures

A. DEFINITION
This protocol covers the initial assessment and management of children with suspected fractures seen by the Registered Nurse in the Family Health Center.

B. DATA BASE
1. Subjective Data
   a. Review of chief complaint.
   b. Patient history, signs and symptoms of relevant findings.
   c. Pain assessment using scale of (0 to 10)
   d. Any treatment used prior to arrival.
   e. Recent visits to provider

2. Objective Data
   a. Limited physical examination appropriate for suspected fractures.
   b. Ability to move extremities or ambulate.
   c. Perfusion of extremity and circulation, movement and sensation distal to injury

C. Assessment
Consistent with subjective and objective findings and status of disease process/injury.

D. Plan
1. Treatment
   a. Apply ice
   b. To be determined by provider based on age of patient, severity of fracture and type of fracture.
   c. Transport to the Emergency Department if further treatment options are needed as directed by provider.

2. Patient conditions requiring Attending Consultation
   a. Initiation of pain control measures.
   b. Initiation of radiological studies per Medical Screening assessment.
   c. Reporting to Child Protective Services if findings are positive.

3. Education
   a. Patient or family education appropriate to diagnosis including treatment modalities, medications and activities.

4. Follow-up
   Primary Care Provider as indicated as appropriate to diagnosis including treatment, medication and activities.
E. Record Keeping
Documentation of radiological study ordered. All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.
Protocol #9  Assessment and Management of Laceration

A. DEFINITION
This protocol covers the initial assessment and management of children with lacerations seen by Registered Nurses in the Family Health Center,

Indications:
1. Lacerations < 5 cm involving fingers, hands or scalp.
2. Vital signs suggesting hemodynamic instability (HR > 130 or SBP < 90)

B. DATA BASE
1. Subjective Data
   a. Review history and signs and symptoms suggestive of volume loss (frequency and amount)
   b. Pertinent past medical history
   c. Current medications, allergies
   d. Any treatment or medications prior to arrival.
   e. Date and time of injury.
2. Objective Data
   a. Perform physical examination of laceration site, depth, width, location and bleeding.
   b. Pain assessment using scale of (0 to 10)
   c. Measure vital signs with pain scale.
   d. Skin signs, color, temperature, moisture, and capillary refill if laceration is on extremities.

C. Assessment
Consistent with subjective and objective findings and assessment of status of disease process.

D. Plan
1. Treatment
   a. Age appropriate screening tests and/or diagnostic tests for the purpose of disease identification.
   b. Immunization update
   c. Obtain vitals every 30 minutes while in clinic.
2. Patient conditions requiring Attending Consultation
   a. If laceration > 5 cm transport to the Emergency Department for suturing. In consultation with provider.
   b. If laceration < 5 cm support provider with suture procedure or consult with provider regarding appropriateness of treatment in the clinic.
   c. Unexplained historical, physical or laboratory findings.
   d. Upon request of patient, parent's, RN or physician.
3. Education
   a. Patient or family education and counseling appropriate to diagnosis including treatment, medication and activities.

4. Follow-up
   Primary Care Provider as indicated as appropriate to diagnosis including treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate. Completion of EMTALA logs as appropriate.