

2013
EDITION

Dearest Class of 2016,

We are extremely excited to be your new classmates and are delighted to welcome you to the CCRMC family. All those things you've been told about the trials and growth you'll go through during Residency—well, they're true. But we also believe that training here is a singular experience and adventure that you will look back on with fondness and wonderment.

What you hold in your hand is a tradition started by the Residents of yore that we carry on today. It is not intended to be a repository of physicianship. You already have that in you. Consider this the CCRMC version of a Lonely Planet®, a guide meant to facilitate your desire to experience, grow, and learn.

Of course, don't forget that this guide is nothing compared to the resources that surround you: your fellow Residents, Attendings, Nurses and other Staff!

Happy Trails!

THE 2013 SCOOP TEAM

p.s. We welcome any feedback or suggestions you may have about this document. Please also store those thoughts in the back of your own mind—they will come in handy when you design next year's Scoop!

Table of Contents

Communication

Phone Numbers	5
Important Codes	6
Resident Contacts.....	7
Staff Contacts	8

Hospital Procedure

Signout.....	9
Admissions	10
Discharges	11
Hospital Transfers.....	12
Deaths	13

On-Call Handbook

Medications.....	14
Frequent Floor Calls	16
Surgery	19
Pediatrics	21
Obstetrics.....	24

Insurance Issues

Undocumented Patients.....	25
----------------------------	----

Phone Numbers

Hospital - Main Line (925) 370-5200

Wards		Other Areas (Cont'd)	
3B - Emergency Dept	5973	GI Lab	5358
3D - ICU	5660	Interventional Radiology	4831
3D - ICU Work Room	5676,5677	Laboratory - General	5390
3E - IMCU	5666	Laboratory - Microbiology	4413
4A - Telemetry	5780	Laboratory - Public Health	5775
4B - Medical	5630	Medical Records	5207/5210
4B - Work Room	4475	MRI	4234/5320
4C - Psych Inpatient	5389	Nuclear Medicine	4158
5A - Resident Work Room	5620, 5622	Nutrition	5380
5A - L&D	5608	Emily 313, Katie 100, Kristin 184	
5B - Post-Partum	5613	OR	5340
5B - Nursery	5615	OR Scheduler	5645
5 - Peds Office	4613	PACU	5349
5D - MedSurg	5650	Pathology	5400
5D - Work Room	5303,5502	Pharmacy - Inpatient	5256/4017
Other Areas		Pharmacy - Outpatient	5245
Antepartum Testing (ATC)	5950	Pharmacy - Clinical Pharmacist	5668
Blood Bank	4414	Physical Therapy Office	4765
CT Tech	4324	Radiology - Ultrasound	5335
CT Radiologist	5808	Radiology - X-ray	5320
EKG	5585	Radiology - X-ray Tech	4833
Echo	4354	Radiology - File room	4828

Social Work & Discharge Planning

ICU & IMCU	Ext/Pgr	OB/Post-Partum	Ext/Pgr
Per Diem	5491/228	Rita Barouch	5444/339
4A		Vickey Dominguez	5486/151
Marsha Krinsky	5587/390	Float	
4B		Felice Hoeft-Laden	5060/194
Rm 2-6: Marsha Krinsky	See 4A	Discharge Planning	
Rm 8-20: Grace Roberge	5488/774	IMCU/ICU: Cheri Mohay	5078/985
Rm 22-34: Rani Visweswaran	5487/774	4B: Hillary Small	5308/442
5D		5D: Sara Miller	5183/274
Rm 2-8,10-12,22,26,28:		5D: Mary List	5647/985
Cynthia Fullwood-Fleck	5787/564		
Rm 14-20,24,30-34:		Financial Planning	5570
Okee Nwadiqo	5489/432		

Outside Numbers

Night Pharmacy	(866) 503-4443
Poison Control	(800) 222-1222
IT Help	(925) 957-7272
UCSF HIV Warmline	(800) 933-3413
EPIC Help Desk	7400

Transfer Centers

UCSF	(415) 353-5166
UC Davis	(916) 734-8200
Stanford	(650) 723-4696
CA Pacific Med Ctr	(888) 637-2762
Diablo Nephrology	(925) 686-1230

Residency Administration

Kristin Moeller	5464
JoAnn Valencia	5036
Tami Sloan	5045
Ernestine Cuyler	5216

Important Numbers — CODES

Don't get locked out again!

- ★ For some of the key pads hit # after the code... If you flub and need to start over, hit '**
- ★ General number to most doors, including 3rd floor call rooms = **2451(#) or Room Number SDRAWKCAB (BACKWARDS)**

Hospital Codes

Second Floor		Fourth Floor	
OR Stairwell	6330(#)	4A Conference Room	5444(*)
OR Locker Area	2451	4B Doors	2500
Third Floor		Fifth Floor	
ER	1542(#)	Resident Lounge	5355
ER Break Room	5170	OB OR Suite	5515
ER Ambulance Door	5150	OB Call Room	9055
ER Supply Room	1414	Peds Office	5515
ICU	6318	Nursery	5515
IMCU	6318	5C Clean Utility	2451
IMCU Med Room	3135	Ground Floor	
Call Rooms	2451	Medical Records	6616
Psych ED (CSU)	5150(#), 77325, 2500	South Entrance	2451#

Building 1 & Campus

Building 1		Library	
General	6380	Front Door	2451(#)
Noon Conference	3344(#)	Mailroom	2451
Miscellaneous			
Cafeteria	002451	Pathology Building	2451
Computer Lab	6555(*)		

Outlying Clinics

Pittsburg	2008
Antioch	6410
Martinez	6380
West County	Badge
Concord	0913*

Important Numbers — RESIDENTS

	PGY-1	PAGER	CLINIC	EMAIL
PAGER PREFIXES	Allison Berger	689	WCHC	abberger@ccfamilymed.com
(Inside CCRMC): 555 - ***	Elizabeth Berryman	883	MTZ	eberryman@ccfamilymed.com
(Outside CCRMC): (925) 346 - 4***	Christina Gomez-Mira	574	CHC	cgomezmira@ccfamilymed.com
	Kathy Hamlin	670	PHC	jhamlin@ccfamilymed.com
	Christine Henneberg	356	MTZ	chenneberg@ccfamilymed.com
GROUP PAGERS	Kendra Johnson	873	WCHC	kjohnson@ccfamilymed.com
All Residents 179	Christy Martinez	654	PHC	cmartinez@ccfamilymed.com
Inpatient Residents 440	Tamara McBride	743	MTZ	tmcbride@ccfamilymed.com
FPC/TLC 600	Jennifer Owen	880	MTZ	jowen@ccfamilymed.com
PGY-1 890	Mana Pirnia	773	MTZ	mpirnia@ccfamilymed.com
PGY-2 891	Jon Powell	332	WCHC	jpowell@ccfamilymed.com
PGY-3 887	Marcie Richmond	149	PHC	mrichmond@ccfamilymed.com
	Neal Sheran	079	WCHC	nsheran@ccfamilymed.com
	Kaitlyn Van Arsdell	051	CHC	kvanarsdell@ccfamilymed.com
SERVICE PAGERS				
House Officer 901				
FMS/Admit 674				
	PGY-2	PAGER	CLINIC	EMAIL
TRAVIS RESIDENTS	Ashley Ballard	942	PHC	aballard@ccfamilymed.com
Medicine 747	Kimberly Butler	930	MTZ	kbutler@ccfamilymed.com
Nurserv 907	Stephanie Cheng	947	MTZ	scheng@ccfamilymed.com
EMAIL LISTS	L. Emily Cotter	946	WCHC	ecotter@ccfamilymed.com
____@ccfamilymed.com	Danielle Draper	996	MTZ	ddraper@ccfamilymed.com
All Residents	Stephen Merjavy	992	MTZ	smerjavy@ccfamilymed.com
residents@	J. Travis Nelson	975	WCHC	tnelson@ccfamilymed.com
Class of 2014 (PGY-3)	John Parr	953	MTZ	jparr@ccfamilymed.com
class2014@	David Piccinati	943	AHC	dpiccinati@ccfamilymed.com
Class of 2015 (PGY-2)	Brent Porteous	957	MTZ	bporteous@ccfamilymed.com
class2015@	Mena Ramos	927	CHC	mramos@ccfamilymed.com
Class of 2016 (PGY-1)	Erin Stratta	991	PHC	estratta@ccfamilymed.com
class2016@	Tina Toosky	984	WCHC	ttoosky@ccfamilymed.com
Chief Residents	Lauren Wondolowski	941	PHC	lwondolowski@ccfamilymed.com
chiefs@				
Scheduler				
schedule@				
	PGY-3	PAGER	CLINIC	EMAIL
	Jon Froyd	857	CHC	jfroyd@ccfamilymed.com
	Christina Hamilton	865	MTZ	chamilton@ccfamilymed.com
	Jessica Hamilton	258	CHC	jhamilton@ccfamilymed.com
	Geena Jester	870	MTZ	gjester@ccfamilymed.com
	Abby Luensmann	840	MTZ	aluensmann@ccfamilymed.com
	Joe Mega†	842	WCHC	jmega@ccfamilymed.com
	Monika Mehrens	270	AHC	mmehrens@ccfamilymed.com
	Rohan Radhakrishna	207	MTZ	rradhakrishna@ccfamilymed.com
	Jeana Radosevich†	843	MTZ	jradosevich@ccfamilymed.com
	Abby Rardin†	876	PHC	arardin@ccfamilymed.com
	Jay Reinking	845	NRHC	jreinking@ccfamilymed.com
	Leah Schweid	846	PHC	lschweid@ccfamilymed.com
	James Walls‡	879	WCHC	jwalls@ccfamilymed.com
	Courtney Wright	847	MTZ	cwright@ccfamilymed.com

† = Chief Resident

‡ = Scheduling Chief

Important Numbers — STAFF

Ahmed (Gero-psych) 402	Freedman (Med) 091	Navel 777
Applegate (ICU) 375	Goheen 571	Newfield (OB) 689
Arpajirakul 323	Graham (Med) 995	Ortho tech (Pat) 582
Bader (ortho) 895	Gynn (Surg) 820	Patty Hennigan 504
Bannwart (FMS) 759	Haglund (FMS) 527	Peds on call: 733
Barrios (FMS) 320	Hay (OB) 043	Pham 314
Beach (FMS) 748	Hennigan 504	Psych Consult 652
Beaton 580	Hiner (heme/onc) 223	Quiñones (FMS) 929
Beck (OB) 284	James (ortho) 506	Raphael (Surg) 584
Berguer (Surg) 299	Johnson (Med) 589	Reif (GI) 517
Berletti (OB) 204	Katie (dietary) 100	Robello 549
Bhandari (Med) 057	Keller (OB) 705	Robello 550
Bhatt 521	Kim (path) 328	Saffier 334
Bliss (OB) 286	Kleinerman (Uro) 573	Safianoff (pulm) 233
Bondi-Boyd 579	Kuhl (ID) 053	Sandler (FMS) 229
Brody (Med) 568	Kuruvilla (ICU) 598	Schaplow (FMS) 358
Carey, Joe (FMS) 679	Lee, Becky (FMS) 250	Sinha (ortho) 835
Cavallaro (OB) 156	Lee, Dan (FMS) 667	Sobel (ER) 322
Cheng, Siri 719	Lee, Dave 562	Speech 553
Cominos (FMS) 177	Lee, John 226	Stanger, Kali 324
Curtis (FMS) 268	Lehman, Tara (OB) 707	Stone (rheum) 337
510-375-5352 (cell)	Levin (Med) 784	Stromberg (CHF) 410
Dao (OB) 405	Liebig (radiology) 495	Sullivan (Med) 554
Diaz (ICU) 331	ext 5336	Sutherland (Med) 127
Dosanjh, A (plast) 154	Lockhart (OB) 970	Thedinger (Med) 416
(415) 309-5611 (cell)	Loeliger (OB) 922	Tornabene (Med) 751
Echols (Psych) 643	Longstroth 552	Tsang 326
Emily (dietary) 313	MacDonald (FMS) 368	Tzvieli (Med) 321
Feirabend (OB) 415	Macedo (OB) 725	Urcuyo 329
Fentress 199	Madrigal 596	Weiss 347
Ferguson 575	Mahar (cards) 597	Yasul 152
Ferris (Inf Ctrl) 263	McCormick (hem/onc) 882	
Fish 187	McIlroy 303	
Forman (GI/ICU) 365	McNeil 306	
	Moeller (FMS) 060	
	Montandon 792	

qPatient qDay

Signout saves lives. It is a Joint Commission requirement that we verbally sign out each patient to the oncoming resident. It is also extremely helpful to the House Officer who takes care of your patients through the night. The expectation is that you signout ICU/IMCU patients to the ICU resident as close to 17:00 as possible. The sooner you signout your patients the sooner you don't need to respond to pages!!!!

The ccLink process

1. Signoff notes should be updated by the primary team by 17:00 daily!
2. Find the "MEDICINE SIGN-OFF" field within ccLink
3. Use the premade smartphrases:
 - a. **".floorsignout"** for floor patients
 - b. **".icusignout"** for ICU/IMCU patients
4. If the HO fails to receive a page or phone call from the departing resident, the HO should page the attending on the service to ask if there were any outstanding issues and to have the opportunity to ask questions about the service.

Hospital Admissions

GUIDELINES

Your pager rings '5973'. This means you got an admission! You should call back as soon as possible to talk to the admitting ED Physician and then go to assess the patient quickly (whether or not you start the admission). **Resident are expected to assess (not necessarily admit) the patient within 30 minutes.** Make your own evaluation of the patient's level of care — if you believe the patient may be at a higher level of acuity, do not hesitate to discuss this with an attending or senior resident.

Admission Staffing

- All admissions performed by an Intern must be presented to either a Senior Resident or Attending.
- **Family Medicine Service**: All patients are presented to FMS registrar on call.
- **Medicine**: Patients to the general medical floor (e.g., Ward 4B) may be presented to a Senior Resident. All others (IMCU/ICU/Telemetry (4A)) must be presented to an Attending
- **Labor & Delivery**: All admissions to L&D are presented to the attending on call. All triages (even non-admitted) must also be presented.

Medication Reconciliation

This is an area of frequent errors that can jeopardize patient safety. The ED Nurse is supposed to be in charge of inputting patient medications into the system, but you must also verify them yourself.

Admission Orders

1. Click the "Admission" tab on the left
2. Click "med rec sign and hold" to complete admission orders
3. Go through process per your training
4. Use the premade smartsets (ie. Medicine Admission, ICU Admission) and other smartsets as applicable (Insulin sliding scale, high potency pain meds)
5. Sign! Because you're a real doctor now.

*******If the pt is going to board in the ER you will need to release orders that you want acted on before transfer (ask a friend for help how to do this).*******

Hospital Discharges

GUIDELINES

Discharge summaries need to be completed AS SOON AS POSSIBLE – you never know when a pt will bounce back to the ED.

Use the smartphrase “.stardischarge”

The discharge summary should give an idea of why the patient was admitted, what happened during the hospitalization, the conclusions made, and ideas for follow up and future management. Be succinct and explain the thoughts underlying the patient’s care.

Medications MUST be included in your discharge summary. Think about what you would need to care for the patient in the clinic, or on a subsequent ER visit.

For discharge orders type “discharge” into *order set* and choose medicine or FMS.

Follow-up

Interdisciplinary rounds are a great time to help coordinate the care your patients will need on discharge. Use this time wisely and also consider going to other floors your patients may be on.

If you feel the patient is at high risk for readmission, consider scheduling a home visit. You can page Dr. Lynn Stromberg (pager 410) to arrange home follow-up, especially for those who congestive heart failure (CHF), poor health literacy with complex medical problems, and the elderly. Patients at skilled nursing facilities (SNF’s) are not appropriate patients for Dr. Stromberg. For CHF patients, be sure to include the discharge weight (or dry weight) in your discharge summary.

Uninsured Patients

Occasionally we will get uninsured patients who do not qualify for the County Health Plan or MediCal (especially undocumented patients), and therefore have no coverage for follow-up or medications. Please be sure to discharge these patients with medications that they can afford. This may mean choosing unusual medication regimens, or less than ideal choices that are nonetheless better than no medications at all. The Walmart and Target \$4 lists can be accessed both from their pharmacy websites as well as the Epocrates drug formularies. Patients can also utilize CostCo Pharmacy (whose prices are often less than Walgreens) even if they are not members.

Furthermore, all pts (regardless of insurance status) are guaranteed one specialist follow up after discharge.

Hospital Transfers

THIS IS SOMETHING YOUR ATTENDING SHOULD HELP YOU WITH

1. Once you have decided that you need to transfer your patient to another hospital for services we do not provide, contact the discharge planner who can assist you with identifying possible accepting hospitals based on patient insurance, as well as assisting with contact information.
2. Call the Transfer Center and tell them you have a patient you would like to transfer. That person (typically a nurse) will walk you through the information they need. If (s)he decides they can accept, you will be given the physician contact information for clinician acceptance.
3. Contact the accepting physician. Lead with the reason for your transfer and what service the patient needs (e.g., I have a 65 year-old poorly controlled diabetic with uremia who I need to transfer for dialysis). The accepting physician usually will ask for the information (s)he wants.
4. Once you get acceptance, notify the discharge planner, who will arrange for transport as well as a pile of paperwork for you to complete.
5. You will need to complete all patient paperwork including transfer summary and medication reconciliation. Social work usually will gather images, diagnostic reports for transport, but it may be good to verify this. Remember, you can get a CD of all pt images prior to transfer from the third floor radiology reception desk.

Transfer Centers

CA Pacific Medical Center	(888) 637-2762
Doctor's Medical Center (Ask for Nursing Supervisor)	(510) 970-5000
John Muir Medical Center - Concord (Ask for Nursing Supervisor)	(925) 682-8200
Stanford University	(650) 723-4696
UCSF	(415) 353-5166
UC Davis	(916) 734-8200

Deaths

Although often the patient's nurse has already made the determination that the patient has died, a physician must make the official pronouncement. California Health and Safety Code Sections 7180 and 7181 establish two methods of pronouncing death:

- Determine that there has been irreversible cessation of circulatory and respiratory functions. Generally this condition is satisfied when no heart beat or breath sounds are heard after approximately sixty (60) seconds of auscultation.
- Two physicians determine that brain death has occurred. In this case, the official time of death is the time that the second physician confirms brain death. This generally will not need to be done on the floor.

Once you have pronounced a pt:

- Note the **Time of Death**
- **Notify the family if not present** (even if middle of night)
- Write a **Death Note**. Deceased pts also need DC summaries (this can be done by the primary team if you are HO).
- Sign the paperwork nursing will give you to complete
 - Nursing will also take care of contacting other agencies
- In almost every case in the hospital, **the coroner does NOT need to be contacted**. Reasons for contacting the coroner include undetermined cause of death; death that took place outside of medical care; suspected suicide; injury or accident; death caused by crime.

If family is present at an expected death, offer condolences and ask if they have any questions. If they have a funeral home chosen, they need to sign the official paperwork to give permission to release the body. In any unexpected or not-straightforward death, offer an autopsy to the family (e.g., in a scenario of an unexpected code blue).

If family is absent, discuss with the nursing supervisor or charge nurse how long the patient can be held in his or her bed until the family can arrive. Call the primary family member and inform of a "change in status." Ask if they can come to the hospital. You can say that the condition is "critical." This is done primarily for safety reasons with driving. If they ask if the patient has expired, you can say yes.

You may ALWAYS ask for the assistance of other residents/attendings in speaking with family members if you would be more comfortable. If family sounds distraught on the telephone, consider asking if they can have a friend or neighbor drive.

Note: All intubations and lines must be left in place for an autopsy and family should be forewarned of tubing, etc., before entering the room. If they do want an autopsy, the next of kin must sign the official paperwork. If they decline, have nursing staff prepare the patient for the family.

General Advice

1. When in doubt, ask the ICU resident. They are there to help, teach, and back you up when you need it. Also, the ER doctors are knowledgeable and always willing to give you advice. Finally, the on-call registrars are getting paid to back us up – call them if needed. The bottom line is, you are not alone!
2. Your job is not to solve all of the patient's problems overnight. Sometimes you have to gently set expectations of nurses, patients, and patient's families regarding what your role is when you are covering for an entire hospital full of patients.
3. You have a ton of responsibilities when you are on call, do your best to triage – it will get easier over time. Here is your list of included expectations as house officer:
 - a. Crosscover nursery, all of the 4th and 5th floor (excluding OB/Post partum)
 - b. Neonatal resuscitation for OB response calls (stat C-sections)
 - c. Admissions
 - d. Assisting the surgeon for overnight cases
 - e. Procedures (per resident preference)

COCKTAILS

Everyone's favorite, especially on call

Haldol Cocktail (B-52): Caution in the elderly or demented. For the agitated patient: Haldol 5 mg IM + Ativan 2 mg IV/IM + Diphenhydramine 25 mg IV/IM (or Cogentin 1 mg IV/IM).

Diphenhydramine/Cogentin protect against the extrapyramidal effects of Haldol.

GI Cocktail: For the patient whose stomach pain is keeping him/her and you awake at night... Be sure the pain is GI and not cardiac before giving! Maalox 30

mL + Viscous lidocaine 10 mL ± Donnatal 10 mL...also known as GI Lizard

Banana Bag: Can be ordered directly in EPIC (type BANANA). For the patient who's had too many cocktails. Prevent Wernicke-Korsakoff: In 1 L NS, add Thiamine 100 mg + 1 mg Folic acid, Multivitamin 1 amp, MgSO₄ 3 grams.

Unclogging a G-tube: Unclog with 2 tablets pancrelipase (Viokase) and 1 tablet bicarbonate (650 mg), crushed in 5 to 15 mL of lukewarm water. Run through the G-tube.

Unclogging a PICC: Alteplase 2mg

PAIN MEDICATION

Pain medication is likely the most common call... and, sometimes, the most challenging.

First, ask the nurse for an assessment of the patient's pain. Take a look at the MAR and see what the patient has been receiving. Is this drug-seeking behavior? Is this new worrisome pain that needs to be worked up? Be sure to check sign off notes for suggestions from the primary team and to make sure you don't write for IV meds when they are trying to avoid them!

Writing a onetime order and having the primary team reassess in the morning is usually ok – you don't know the patient like they do. Think about whether there is an anxiety component and consider benzos if so.

Strongly consider going to see the patient – this can give you the best perspective on the patient's pain. Sometimes, all they need is some reassurance!

The On-Call Guidebook — Frequent Floor Calls

Mild pain:

Acetaminophen 650mg PO/PR q 6 hours
(max daily dose 4g or 2-3g in liver dysfunction)

Ibuprofen 600mg po q6-8 hours (avoid in pre/post-op patients due to bleeding risk, avoid in renal dysfunction)

Moderate pain:

Norco or Percocet 1-2 tabs q4 hours (max daily dose limited by Acetaminophen)

Toradol 30mg IV q6 hours (avoid in patients with bleeding risk, PUD, liver disease, renal disease, CAD – should have normal creatinine)

Severe pain: (overall, should be managed by the primary team – avoid starting recurring doses):

Morphine 1-2 mg IV is a good start

Dilaudid 0.5-1mg IV or 1-2 mg po

If starting a PCA, use the preset “usual” doses and **avoid using a basal rate!**

Consider trying a combination of agents, especially to help you get through the night (ie. Toradol + Morphine + Tylenol)

**Here is a brief conversion list –
Use it wisely!**

1 tab Vicodin (5 mg HYDROcodone/500 mg Tylenol) = 1 tab Norco (5 mg HYDROcodone/325 mg Tylenol)

1 tab Percocet (5 mg OXYcodone/325 mg Tylenol) = 1.5 tab Vicodin (5/500)

5 mg PO morphine = 1 tab Vicodin (5/500)

3 mg PO morphine = 1 mg IV morphine

4 mg PO Dilaudid (HYDROmorphine) = 1 mg IV Dilaudid (HYDROmorphine)

1 mg IV morphine = 0.01 mg (10 mcg) IV Fentanyl

7 mg IV morphine = 1 mg IV Dilaudid (HYDROmorphine)

Methadone is VERY long acting and shouldn't be changed unless you know what you are doing - it is beyond the scope of The Scoop.

¡Opiates are constipating! – “the same hand that writes for opiates writes for DSS”

CHEST PAIN

1. Go evaluate the patient
2. STAT EKG
3. Oxygen
4. Chew 325 mg ASA
5. SL nitro 0.4 mg q 5 min x 3
6. 2 mg morphine for pain
7. If you suspect cardiac ischemia, call ICU resident to transfer patient to a monitored bed and order cardiac enzymes STAT.

Numbers 1-3 are usually done regardless of what your suspicion is for etiology of the chest pain. If it's a patient on 4A you may want to go ahead and order the NTG while on the phone... then go assess the patient.

Consider repeat EKG if suspicious of ischemic etiology, call ICU resident PRN. Remember to look at old EKGs for comparison (your attending will ask for these.)

RESPIRATORY DISTRESS:

Go assess the patient! Your assessment of lung sounds may be very different than the nurse's. What's the etiology? Asthma? CHF? Pneumonia? PE? Oversedation?

You can always call RT... they are great about giving good advice (Nebs, BiPAP, etc.)

If you're concerned about worsening CHF...consider CXR and LASIX

If CO2 retainer... be very careful when administering O2

If oversedation...consider narcan

If anxious...reassurance and POSSIBLY Ativan once evaluated

ALWAYS CONSIDER GETTING AN ABG! IT OFTEN CLARIFIES THE PICTURE!

jLow threshold for calling a RRT!

AGITATION/ANXIETY:

Use caution using anti-cholinergics (benadryl) or benzos in the elderly/demented/delirious

Why is the patient agitated – sometimes it's a symptom... under-medicated for pain? Demented? Sundowning? Drug-seeking? Over medicated? Anxiety? Withdrawing? Air-hunger?

Go visit the patient to evaluate the situation if you have not seen the patient previously.

First try talking to the patient, and encourage the nurses to try re-directing – it works!

Sometimes benadryl 25mg IV/PO may suffice for sedation, you can also offer temazepam (Restoril) 15mg

Ativan 1-2 mg IV/PO q 2-6 hours PRN will do the trick (0.5 mg in frail/elderly)

However, benzos can actually worsen delirium in the elderly... Strongly consider haldol for these patients.

Haldol 1-2.5 mg PO/IM q 4 PRN... is a good start. If patient is still agitated you can increase dose and frequency (IV not available unless in ICU/IMCU). Check the QT_c for recurring orders.

BLEEDING:

Assess patient... is it severe or just post-operative oozing? Stat CBC if anything more than a small ooze, consider checking coags.

Check vitals and consider IVF... if hemodynamically unstable... LR wide-open and call ICU resident/registrar PRN.

If severe or baseline Hgb is already on the low side <7-8, type and cross match several units of blood - call ICU resident/registrar PRN.

Nurses will call you about platelets: OK to give heparin or lovenox if platelets >50,000. Check baseline, if acute drop consider holding the dose

BLOOD PRESSURE:

jFirst check the baseline and compare! Then have RN recheck BP.

HIGH: Is the patient in pain? Anxious? These are the most common, treat these first.

Was the patient on meds as an outpatient that were not started or the wrong dose was started?

Go with shorter acting medicines. (NTG paste ½ inch to chest q6, clonidine 0.1 BID, captopril 12.5 po TID, hydralazine 10mg PO Q6 - All can be used PRN SBP>160-180.)

What's the patient's HR? Can they tolerate a beta-blocker? 25 mg metoprolol? 30 mg diltiazem? Or nitropaste? This can be applied and quickly wiped off if BP falls too low.

jONCE AGAIN, CHECK THE BASELINE!

LOW: Dehydration? Ask about urine output

The On-Call Guidebook — Frequent Floor Calls

Trying a little fluid bolus and seeing if the patient responds is usually a good start

NS 500 mL or 1L (more caution if NO urine output or CHF)

Med Check... is the patient on a bunch of blood pressure meds?

If really low... Trendelenberg and call ICU resident to eval with you, with likely transfer to the ICU for pressors.

CHEMSTICKS/INSULIN: “THE PATIENT’S SUGAR IS...”

Part of the sliding scale insulin order says “call HO if sugar is over...” Usually this is not a big deal... patients often run high while hospitalized, especially when they’re on steroids.

Ask what the highest step is on their sliding scale insulin and give that, or that + 2 units. Ask them to recheck in 2 hours and to give you a call... this is just so you know that the glucose level is going down... Don’t give extra insulin at the 2 hour re-check, because it takes 3 hours for the prior regular insulin dose to take full effect.

If the glucose is sky-high (>500) and not responding you may consider checking a basic panel to evaluate bicarb/anion gap and r/o DKA. If they are in DKA they’ll need to be transferred to the ICU/IMCU for an insulin drip. If the patient is consistently high you may need to bump them up to a higher level on the SSI order.

FEVER (>100.4F, 38C)

Get more information:

1st: what is the trend; low or high fever?

Constantly febrile or first one?

2nd: get complete set of vitals; remember SIRS

- Not worried: +/- lactate
- Worried (SIRS or new fever): lactate, blood culture, CBC
- Really worried (septic, pt looks bad): lactate, CBC, UA, urine culture, blood culture, CXR, +/- CMP, +/- ABG, +/- transfer
- If septic but known source and patient already being treated you usually don’t have to obtain a full sepsis w/u, however consider reculturing patient if > 24 hours since last blood culture.
- usually do not have to change abx on a patient for isolated fever (consider broadening if septic)

INSOMNIA:

Use with caution in the elderly!

Benadryl 25-50 mg PO/IV x 1

Trazodone 50-100 mg PO x 1

Zolpidem (Ambien) 5-10 mg PO x1
(elderly or hepatic impairment may consider 5mg)

Temazepam (Restoril) 15 mg PO x 1,
may repeat in 45 minutes if insomnia persists

ITCHING:

Benadryl 25-50 mg PO/IV q6-8 PRN OR
Atarax 25-50 mg (max 100mg) PO q6-8 PRN

The On-Call Guidebook — Frequent Floor Calls

INTRAVENOUS FLUIDS:

LR or NS at 125mL/hour is always a safe bet... careful in little old people or CHF (go a little slower – like 75mL/hr).

For diabetics, if NPO use D5LR or D5NS.

If you're trying to rehydrate/bolus someone, NS or LR 500mL-1000 mL

Check latest potassium, if low, add 20mEq KCl per liter IVF. If Na low consider NS over LR.

CONSTIPATION:

Docusate 250mg PO BID

MOM 5mL QID PRN

Senna 50mg***

Miralax 17gm daily

Lactulose 15-30mL up to three times daily

NAUSEA

Ondansetron 4-8mg IV q6h PRN

Phenergan (promethazine) 12.5mg or 25mg TD or IV q6h PRN

Reglan (metoclopramide) 10mg *** up to QID

Compazine (prochlorperazine) 5-10mg *** TID

ELECTROLYTES

First, why they are abnormal: Not enough? Too much? Renal failure? DKA? Low Mg?

Hyperkalemia (EKG!): Kayexalate 15gm 1-4x daily

K scary high: Calcium gluconate, insulin w/ glucose, albuterol, sodium bicarbonate

“THE FAMILY/PATIENT WANTS TO TALK TO A DOCTOR...”

Yeah, that's you! This usually means that the nurses have already exhausted their own resources to explain things. Or, there is a conflict between the nurse and the patient, and you get to be the intermediary. This puts you into a bad situation... you know virtually nothing about the patient/situation and you're supposed to make it better. YIKES! The main thing is to stay calm and think of yourself as the calming/reassuring presence in the situation. Read a little from the chart and learn from the nurse what exactly has happened before you were called and what the patient/family expects from you. Then go talk with the family or patient. Emphasize that you want to help, remind them that you are not the primary doctor so you may not be able to answer all of their questions, but do your best to answer what you can. Usually these situations turn out fine... the family/patient appreciates seeing “a doctor” and you can tide them over until the morning when the primary team is available.

Serum K	KCl to give IV or PO
3.7-3.8	20
3.5-3.6	40
3.3-3.4	60
3.1-3.2	80
≤3.0	100

Serum Mg ²⁺	MgSO ₄ to give IV
1.8-1.9	1
1.6-1.7	2
1.4-1.5	3
1.2-1.3	4
<1.2	5

Soaked Dressings

Post-op patients often have drainage from their wounds. The nurses will call you if they find a dressing is saturated. This is something you should always go look at. You can do some triaging over the phone by asking for vitals. If hypotensive/tachycardic, you know you need to get there faster. Things that should worry you:

- Frank bleeding from a wound or coming out of a drain (JP or Blake drain)
- Hemodynamic instability
- Bleeding from an unidentifiable location, i.e. from inside the abdomen.

Things you can do:

- If grossly unstable, remember ABC's (CAB's): confirm IV access, fluids, order type and cross to transfuse blood, consider FFP, platelets etc, transfer to ICU (consult with ICU resident or attending/surgeon on call)
- If stable but concerning, check serial CBC's to follow hemoglobin, more frequent vitals
- Pressure dressing, cautery (in equipment cart on the floor)
- If very slow oozing (most commonly the case), just reinforce the dressing with more gauze

NGT/Dobhoff placement confirmation

Nurses can place NG and Dobhoff tubes but MDs confirm position. You may be asked to confirm placement before they can be used to give meds, tube feeds, etc.

Dobhoff: tip should be in duodenum, as it is often used for tube feeds. Confirm by making sure you see it cross the midline on X-ray

NG tube: tip should be in stomach, confirm by making sure it goes below diaphragm. It may also curve around the stomach and can cross the midline a little.

NGT clamp trials/residuals

When you think you are starting to have return of bowel function, gastric secretions will go downward as nature intended, instead of sitting in the stomach waiting to be sucked out by the NG tube. To prove to yourself that this is happening, and that it is safe to remove the NG tube, you can do a clamp trial. This involves clamping the tube for 4-6 hours, then hooking it back up to suction to see how much fluid is left in the stomach (the "residual" fluid). Each surgeon has a different definition of "passing" the trial.

- Weiss: 150ml after 3 hours
- Gynn: 200ml after 4 hours

If the residual fluid is less than the defined amount, you can remove the NG tube, and will likely see enough return of bowel function to avoid further need for an NG.

Post-Op Fever

Immediate (within hours of surgery): meds or blood products given during procedure, trauma prior to or as part of surgery, infection present before surgery, malignant hyperthermia (rare), atelectasis (debated)

Acute (within first week post-op): nosocomial infections

- Surgical site infection (SSI), specific to abd surgeries: deep abd abscess
- Pneumonia: risk factors include atelectasis, poor lung expansion due to pain, altered mental status or NG tube increasing risk for aspiration
- UTI: risk factors include Foley catheters, urinary retention, GU procedures

Subacute (1-4 weeks post-op): central line infections, C.diff, drug reactions (antibiotics), thrombophlebitis, DVT, PE. Keep in mind that the most likely causative bacteria changes as the patient is hospitalized longer and exposed to more antibiotics.

“My patient hasn’t peed in ____ hours”

Post-op patients can have urinary retention related to anesthesia. Urine output can also be a marker of hydration status, renal function, and tissue perfusion. In most post-op patients, options include:

- Fluid bolus if other signs of dehydration (tachycardia with hypotension)
- Wait a little bit longer.
- Ask the nurse to insert a Foley, and if she gets >300ml out, leave it in place.

“My patient hasn’t pooped in ____ days”

Post-op patients (especially post-abdominal surgery patients) often have this problem. While the pain meds they get post-op can be constipating, other more dangerous things should be high on your differential, especially if they have abdominal pain or distention—namely ileus or bowel obstruction. Options if worrisome pt:

- Reverse diet or make NPO
- Abdominal series, or KUB with upright and supine views: this will show bowel distension, air-fluid levels, etc. It can be hard to tell the difference between SBO and ileus with one film, but it can tell you GI function isn’t normal.
- If you see distention on the abd series, or if the patient has a lot of pain, you can place an NG (nasogastric) tube to drain whatever is in the stomach. This can alleviate the distention, pressure, and pain.

Ulcer Staging

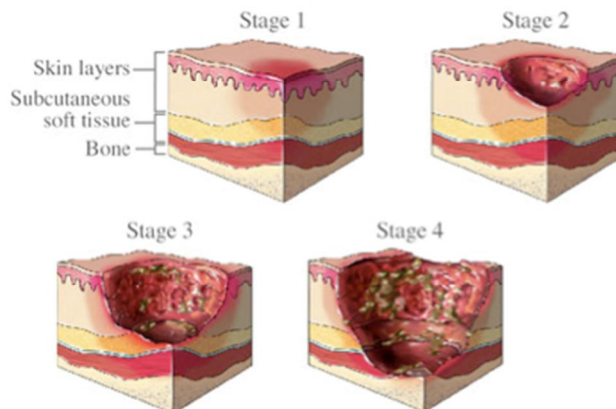
It is important to document ulcers, both new and pre-existing, and the initial documentation has to involve an MD.

Stage 1: Intact skin with nonblanchable redness of a localized area

Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough

Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but not bone, tendon or muscle

Stage 4: Full thickness skin loss with exposed bone, tendon or muscle.



**** If you get paged about a C-section or an OB response team is called, you're expected to go. Yes, we know that the floor is busy and there are always ER admissions to do, but admissions shouldn't come before C-sections. As long as the patient in the ER is stable, it's okay to go up to the nursery and then come back and finish the admission.****

As far as other calls, most of you will handle nursery calls before you do nursery. Generally speaking, have a very low threshold to call the pediatrician. Unless you totally feel comfortable with the order you are giving the nurse, call the pediatrician (pager 733) to run the question by them. Avoid just telling the nurse to call the pediatrician. You'll learn a ton more if you try to come up with a plan, assess the baby if needed, and then call the pediatrician yourself.

We have 2 levels of nursery at CCRMC. Level 1 (the opposite of trauma center designations) is baby at mom's bedside (most of our patients). Level 2 is the nursery. Babies go to the nursery if there are any concerning issues, risk factors, etc. We do NOT have a level 3 nursery (NICU), so babies will get transferred to CHO if they need that level of care.

JAUNDICE (THE MOST COMMON CALL...BY FAR)

"Doctor, Babyboy Smith has a bilirubin of 14. What do you want to do?"

1. Is it a **manual** ("skin") bilirubin or a **serum** bilirubin measurement?
 - a. You want a serum level.
2. Is the bilirubin level direct or indirect?
 - a. The first time a bilirubin is drawn you should make sure there is a direct and total

bilirubin to know that you are not missing hepatobiliary diseases. (Many times the direct bili is flagged as high – check to see if it's over 20% of total bilirubin).

- b. Subsequent bilirubin levels can just be total bilirubin.
3. How many hours old is the infant
 - a. The hours-age of the child determines the threshold for treatment (see phototherapy chart).
4. Is the infant pre-term?
 - a. Pre-term infants younger than 35 weeks use a different chart that is NOT in this booklet.
 - b. Call the peds attending on call.
5. Treatment
 - a. Look at the bilirubin chart below for treatment
 - b. Ask the nurse if there are any of listed risk factors and plot accordingly.
 - c. Any bilirubin level above the appropriate line means the baby gets phototherapy and a serum re-check in the morning. Call the peds attending on call and let them know.
 - d. It is important to remember that the guidelines are to be followed fairly strictly. Don't be the one to go outside of the guidelines, let the peds attending do that if they wish.
 - e. If you are below the appropriate line, order a re-check for the morning. If you are anywhere close to the line, order a serum bili for the morning. Otherwise, a manual might be ok per your discretion.

Remember Bilitool.org if you find it hard to see the little lines in this book.

NORMAL VITAL SIGNS FOR TERM NEWBORNS:

Because it's embarrassing when the nurse calls to tell you that the baby's RR is 65 and you can't remember what normal is.

RR 30-60 HR 100-160 SBP 50-70

FEVER

1. Make sure that baby was re-checked after taking off some of baby's clothes and placing him/her skin-to-skin for 20 minutes.
2. Are there any risk factors for sepsis (Chorioamnionitis, pre-term, prolonged ROM)?
 - a. If so, go ahead and order the standard sepsis screen (CBC, Blood Cultures, possibly a CRP) and call the peds attending to discuss starting prophylactic antibiotics.
 - b. If there aren't risk factors you can often get away with re-checking the temperature in 30 minutes. If you aren't sure, just call the Peds attending – that is what they are there for.
3. Standard Antibiotics are
 - a. **Ampicillin** 100mg/kg q12 hours
 - b. **Gentamicin** 4 mg IV q24 hours + Gent trough before 3rd dose

HYPOTHERMIA

1. Make sure that baby was re-checked after placing him/her skin-to-skin for 20 minutes
2. Is baby still hypothermic?
 - a. Transfer the baby to the nursery to be placed in the warmer
 - b. Call the peds attending to let them know

- c. Consider sepsis workup (get risk factors and discuss with peds attending)

TACHYPNEA (RR>60 OR E/O DISTRESS)

1. Go see the patient
2. Call the Peds attending.
3. DDX = Retained Lung Fluid (Transient Tachypnea of the Newborn or TTN),
4. RDS, Sepsis, Meconium Aspiration Syndrome, Hypovolemia, Acidosis, Pneumothorax, Congenital heart disease.

POLYCYTHEMIA (HIGH HEMATOCRIT)

1. Is it real?
 - a. Often hematocrits are first done with a heelstick, which can be artificially concentrated (high) if the infant's heel had to be squeezed a lot to get the blood sample.
 - b. Normal newborn Hct = 42-64%
 - c. Were there risk
 - i. Infant of diabetic mother
 - ii. Delayed cord clamping
 - iii. Dehydration (usually >48 hrs old)
 - iv. Intrauterine hypoxia 2/2 placental insufficiency – IUGR, preeclampsia, maternal smoking/cocaine/meth, maternal heart disease
 - v. Symptoms of hyperviscosity syndrome: jitteriness, plethora, irritability, emesis, poor feeding, jaundice, hypoglycemia
2. Management
 - a. Check a "central" or venous hematocrit, blood glucose.
 - b. Consider getting a serum bilirubin and calcium.
 - c. Call the peds attending.

EMESIS/ABDOMINAL DISTENSION

1. Babies do spit up
2. Bilious emesis (bright yellow or green) is always worrisome until proven otherwise. If an infant has true bilious emesis, they need urgent pediatric surgical evaluation. DO NOT WAIT.
3. Worry about ischemic bowel (AKA necrotizing enterocolitis or NEC)
 - a. Risk factors for fetal hypoxia?
 - b. Is baby's belly getting distended per a nursery RN who has been checking serially?
 - c. Has baby gotten an abdominal x-ray yet?
4. Ask yourself the simple questions like "does baby have an anus?"
5. Consider when you want to call the peds attending, before you order studies or after. Just remember that the peds attending might want to add a study to your order set, and if that study is a lab you don't want to have to stick the baby twice.

HYPOGLYCEMIA

1. General points
 - a. Hypoglycemia is a glucose of less than 40-45 in any aged infant
 - b. Symptoms of hypoglycemia include apnea, hypotonia, irritability, tachypnea, poor feeding, tremors/jitteriness, temperature instability, seizures, lethargy, tachypnea
 - c. Being born to a diabetic mother is the biggest risk factor by far.
 - d. Other causes are perinatal stress, sepsis, asphyxia, polycythemia (extra RBCs eat up more glucose), shock, IUGR/SGA infant, premature infants. There are also congenital inborn errors of

metabolism and hormonal problems that can cause it but these are much more rare.

2. What to do
 - a. Has the test been repeated? Has plasma glucose been sent to the lab?
 - b. The nurses will often respond to the low glucose level by giving them breast milk or formula and then re-checking before they call you.
 - c. If the blood glucose doesn't increase nicely by feeding, call the Peds attending and make a plan for oral vs. IV glucose and a likely transfer to the nursery.

OTHER NURSERY INFO:

Sepsis: Ampicillin and Gentamicin for all babies with mothers with chorioamnionitis, funny behavior, etc. If Mom is GBS + without antibiotics or GBS status is unknown, order a sepsis screen. This is a CBC-D and blood cultures. When blood cultures are negative for 48 hours then ampicillin and gentamicin may be discontinued. Do not forget to do this because they draw blood for a gentamicin level before AND after the third dose, so baby gets stuck unnecessarily if you forget.

Discharge:

- 2 day stay if vaginal birth,
- 3 days if Cesarean section
- Early d/c can happen after 24 hours for NSVD as long as baby is perfect and there are no risk factors or social issues.

1. R/O Labor at Term

- Reactive NST
- SVE, if <4cm, and not ruptured, ? Walk vs Home
- Check vertex with sono
- If 40+ weeksà check AFI
- Check active GBS (good for 5wk). If not, collect.

2. R/O PTL (in this order) (Ask recent trauma, intercourse, hydration, recent illness, sick contacts)

- Send UA/UCx
- FFN @ North if <34wks (**No gel & prior to SVE**)
- SSE: send GBS/GC/CT, do wet mount
- SVE (repeat in 2 hours, unnecessary if nl CL)
- If CTX on TOCO give IVF
- Cervical length if < 30wk GA
- If <34wk GA, consider giving Beta (12mg IM q24hr x2)

3. Decreased Fetal Movement

- Reactive NST (28 to 32wk: 10x10) (>32wk: 15x15)
- BPP (show mom baby moving, document mom now feels baby moving)
- DC home with kick counts (4 kick in 1hr, if not kick in 1st hour, lay on left side and drink juice, if not kick return to triage)

4. R/O ROM

- SSE - check pooling/nitrazine/ferning
- Check AFI
- Wet mount, GC/CT
- If ROM and GBS+ or GBS unknown with + risk factor, then start PCN
- Do not perform VE if PPROM <34wks**

5. Elevated BPs: ask about S/Sx PEC

- Serial BPs (Q15min), check DTRs, lung exam
- Check BP range in PNC and intake PNC BP @ __GA
- PEC labs: CBC, Chem7, LFTs, LDH, Uric acid (prior to delivery and only once), **Straight Cath** U/A, UCx, +/- coags, admit labs (on hold)
- Push Meds if Urgency/Emergency (≥ 3 BP >160/110)
- If not admitted, consider d/c with 24hr UProtein & UCx collection. Pt to return for BP check with collection.

6. Vaginal Bleeding: Previa vs Abruptio vs Other (In this Order)

- Check Vitals for stability, IV access, O2 and IVF
- Check FH
- Ask about recent intercourse/infections
- Abdominal exam: uterine tenderness/tetany
- Sono for placental location**
- SSE: if no evidence of previa then do cultures, wet mt, eval whole genital tract for VB source
- Labs to R/o Abruptio: CBC, T&S or T&C, fibrinogen, coags, Kleihauer-Betke, +/- UTox
- Transfer to L&D for deliver if unstable
- RH-: Rhogam.
- If s/p Trauma and not in labor, admit for 23hr observation

7. Asthma

- Check Peak Flow prior to and after neb treatment
- Neb x3 with albuterol and ipratropium q20min
- Solumedrol if not resolved with Albuterol
- +/- ABG

8. Hyperemesis/Gastroenteritis

- D5 1/2 NS
- Reglan/phen/±compazine/±zofran combo, IV/PR (multiple medications is the key)
- Labs: CBC, UA, Amy/Lip, Chem 20, TFTs
- Inquire about weight loss, sick contacts, weird food
- PO challenge - if failed, admit
- Give Rx: Reglan (warn about torticollis) q 6 hrs around clock x 3 days then PRN, Vitamin B6 qD, Compazine PR q12

9. DKA (ie, there is an anion gap)

- FS: if >250, start NS + Insulin drip ~7u/hr
- When FS <250, switch to D5 1/2NS + Potassium and Slow Insulin drip to 1-2u/hr
- Monitor FS q Hr.
- Labs: UA, CBC, Chem 20, Serum Ketones
- If No anion gap, just hydrate with NS.

COUNTY CARE FOR UNDOCUMENTED PATIENTS

- ★If your patient has a financial class code 'PK' or 'PQ', that patient is **UNDOCUMENTED**.
- ★If you have an inpatient who *needs more than 1 follow-up specialty clinic visit*, e-mail **Dr. David Goldstein** (Chief Medical Officer) and explain the circumstances
- ★Inpatients with *diagnosed breast or cervical cancer* qualify for Medi-Cal for 18 months. Talk to **financial counseling**.
- ★Inpatients with *life-threatening conditions* may qualify for Medi-Cal via PRUCOL (Proof of Residence Under Color of Law). Examples include renal failure requiring dialysis, persistent vegetative state, diagnosed cancer. Patients must disclose immigration status. Talk to **financial counseling**.

COMMUNITY HEALTH CENTERS

- ★Inpatients *without specialty clinic needs* should be referred to community health centers (e.g., Brookside, La Clinica de la Raza). Do not arrange follow-up for undocumented patients within our system as they will end up lost to care.
- ★Community Health Centers provide primary care **ONLY**. The **county pays for 3 visits per patient**, with an option to renew. Community clinics bill the county. Labs and imaging are not covered.

WOMEN'S HEALTH

- ★All pregnant women in California regardless of residency status are granted Restricted MediCal (Code TR). TR stays in effect until the second calendar month after giving birth. This means that women may have anywhere from 4 to 8 weeks of post-partum care (e.g., if the delivery happened at the beginning of June, the patient should be covered until the end of July (~ 8 weeks). However, if the delivery occurred at the end of June, the patient will also be covered until the end of July (~ 4 weeks).
- ★Post-partum patients who are losing insurance should be referred to a **FamilyPACT**. - County clinics in Concord, Richmond, Pittsburg, Martinez, La Clinica in Concord, Planned Parenthood are participating members. FamilyPACT provides free STD testing, Pap smears, contraception, and services that "Protect reproductive health by helping patients take care of themselves so that they can have a healthy baby when ready."
- ★**Women must have reproductive potential to be eligible for FamilyPACT.** Post-menopausal women and women who have undergone a sterilization procedures (e.g., tubal ligation) are not eligible for FamilyPACT.

NON-EMERGENCY SURGERY

- ★Inpatients who need non-emergency surgery should be referred to **Community Health Centers**, which can make a referral to **Operation Access**, a service that provides free non-emergency, outpatient surgeries (e.g. hernia repair, knee procedures, cataract, diagnostic colonoscopy) at John Muir and Kaiser.

MEDICATIONS

- ★**Target and Walmart \$4 formularies** cover most common medications (not pain medications, insulin, or most psych meds)
- ★Please be sure to discharge undocumented patients with medications **THEY CAN AFFORD**, as they are otherwise uncovered.
- ★You can search their websites or download their formularies from Epocrates

Good
Luck!!!

Notes

