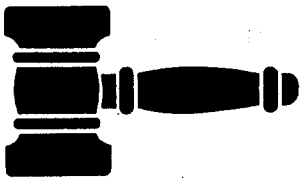
LEHIGH VALLEY HOSPITAL

Medical Staff Progress Notes

November

1997
Volume 9
Number 11

In This Issue . . .



From the President

> If we are to live together in peace, we must come to know each other better.
>
> Lyndon Baines Johnson

This is it! November, 1997. The month that Muhlenberg Hospital Center and Lehigh Valley Hospital merge into Lehigh Valley Health Network. Obviously, this event will have a dramatic effect on our medical culture here at Lehigh Valley Hospital. It's going to take a lot of frank discussion and negotiating for the medical staffs of each institution to make this a peaceful and fruitful evolution.

I must report that the impending merger was the stimulus for one of the most open exchanges we have had during our Medical Executive Committee discussion sessions! A lot of hopes and concerns came to the table that night.

It is because of this, then, that Troika feels we should have a special meeting of physicians and administrators from both institutions in the format of the Medical Staff Administrative Exchange developed by John Castaldo. Members of the Lehigh Valley Hospital/Muhlenberg Hospital Medical Staff Merger Committee will be available to both listen to concerns and answer your questions. While I am quite sure this event will foster better understanding on the part of Lehigh Valley Hospital physicians about the medical staff leadership at Muhlenberg Hospital Center, I am also sure it will help educate your leadership in the matters that concern you most. Two dates have been selected for these exchange sessions. The first session will be held on Monday, November 10, from 5:30 to 6:30 p.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78. The second will be on Tuesday, November 11, from 5:30 to 6:30 p.m., in Rooms 1 and 2 of the Banko Community Center at Muhlenberg Hospital Center. I invite/encourage as many members of our staff to be present and participate!

We have also been notified that JCAHO will be visiting December 15-19. I remind you that, for the first time, interviewers will be randomly selecting physicians for questioning, not limiting themselves to Department Chairs. Medical Staff Services will be making our "cheat sheets" available to everyone -- even if we have to hand them out in the parking lot and hospital entrances that week. Please be prepared to wow these JCAHOites during their stay at Lehigh Valley Hospital.

Finally, we are entering the holiday season this month. Hard to believe it can be Thanksgiving already when it was 80° just a few short weeks ago. The folks in Medical Staff Services and Troika wish you and your families a very Happy Thanksgiving!

Robert X. Murphy, Jr., MD
President, Medical Staff

Health Status at the Time of Reappointment to the Medical Staff

The biennial reappointment process for the Medical Staff will begin in February, 1998. As part of that process, physicians are required to answer questions related to their health status.

While certain health-related questions have always been a part of the reappointment application, the Medical Executive Committee and the Board of Trustees recently approved the addition of a question and a guideline form intended to facilitate appropriate communications and treatment, if necessary, between the Medical Staff member and his or her private physician. This form was developed over a period of several months with extensive input from many physicians on the Medical Staff. The Medical Executive Committee felt strongly that physicians have a right to confidentiality in obtaining treatment from their private physicians, however, it was also felt strongly that physicians have a responsibility to themselves, their patients, and their co-workers to seek treatment when affected by certain medical conditions. By being required to answer certain questions, the Medical Staff member is held accountable for seeking appropriate treatment, but since the guidelines form is shared only with the member's private physician, his or her confidentiality is maintained.

Please note that while **ALL** health-related questions on the application form must be answered and returned to Medical Staff Services, the guidelines form is only to be shared between the Medical Staff member and his or her private physician and **SHOULD NOT** be returned to the Medical Staff Office with the application.

Please make arrangements now to have your physical performed by your private physician between now and February, utilizing this new guidelines form. ***A copy of the new guidelines form is attached to the newsletter on Page 15.***

For your information, the questions appearing on the application are as follow:

1) Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform your professional or medical staff duties appropriately? No [ ] Yes [ ] (If yes, please provide details on a separate sheet of paper.)

2) Are you currently taking medication/under other therapy for a condition which affects or is reasonably likely to affect your ability to perform your professional or medical staff duties? No [ ] Yes [ ] (If yes, please provide details on a separate sheet of paper.)

3) Most recent physical examination: Date ____/_____/_____

4) Have you had the appropriate screening/testing, immunization, as indicated, and medical follow-up for selected infectious diseases as provided for in attached guidelines? (Note: **DO NOT** return completed guideline form.) No [ ] Yes [ ]

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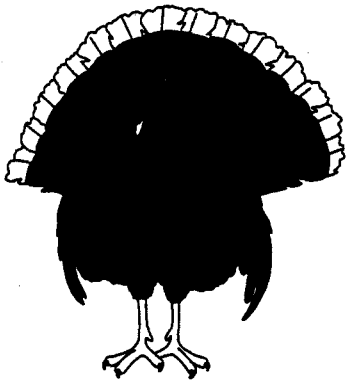
5) Did that physical examination disclose, identify, note or refer to any physical or mental health condition that affects or is reasonably likely to affect your ability to perform your professional or medical staff duties appropriately? No [ ] Yes [ ] (If yes, please provide details on a separate sheet of paper.)

If you have any questions regarding this issue, please contact Rita M. Mest, Director, Medical Staff Services, at 402-8900.



Medical Records News

History & Physical Reports

There has been an increase in the number of history and physical reports from previous admissions being utilized on patients' medical records at the time of their readmission.

In conjunction with JCAHO standard PE.1.6.1.1, "if a history and physical examination has been performed within 30 days before an admission, a durable, legible copy of this report may be used in the patient's record, provided any changes that may have occurred since the last admission are recorded in the medical record at the time of the admission."

Medical Staff Bylaws state, "For elective or outpatient procedures, pre-admission history and physical examinations must be performed by a credentialed member of the medical, allied health or residency staff within 30 days prior to admission. A completed history and physical examination shall in all cases be dictated or documented in the medical record no later than 24 hours after admission of patient."

History and physical examinations not meeting the guidelines listed above will be returned to the clinician for appropriate documentation.

If you have any questions regarding this issue, please contact Sue Cassium, Operations Manager, at 402-4451.

Observation Guidelines

Observation guidelines were developed at the request of the Medical Record Committee to ensure that all patients are assigned the correct status on admission.

A physician's order is required and must include the appropriate status of the patient. Medical necessity is the key to assigning patient status.

The following guidelines should be helpful when determining patient status:

Observation vs. Inpatient Status

Criteria for Observation

Observation status is usually 24 hours or less. (Not to exceed 48 hours or more than one overnight stay per HCFA).

Observation status may be considered in instances where medical necessity for acute care cannot be determined without diagnostic and clinical workup.

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At any time during the observation period, but no longer than 24 hours, if the patient's condition warrants or diagnostic results demonstrate that acute care is medically necessary, the patient may be transferred to inpatient status.

If patient's clinical situation improves, or if workup reveals no need for continued hospitalization, patient may be discharged from observation status with appropriate outpatient follow-up arrangements.

A simpler way to determine which status to order for a patient:

If it is reasonably expected that a patient will require a hospital stay of 24 hours or less, order Observation status.

If it is reasonably expected that a patient will require a hospital stay of more than 24 hours, order Inpatient status.

Reimbursement should not be a deciding factor when determining patient status. It must be determined by **medical necessity**. All payors have different pay schedules, rules and regulations regarding patient status, but the **ALL** require that appropriate patient status is based on **medical necessity**.

A Physician's Order is required for all admissions and transfers in status. Careful monitoring of patients in Observation is necessary to be sure that either the status is appropriately changed or the patient is discharged within the required timeframe.

Observation vs. Ambulatory Status

Criteria

An Ambulatory Procedure is typically a procedure in which the patient is expected to be discharged after a reasonable period of recovery and an overnight stay is not anticipated.

If, due to a change in patient's condition in which **medical necessity** warrants further monitoring and/or treatment, patient may be transferred to Observation status if the anticipated stay will be less than 24 hours.

Inpatient status should be considered if the patient's condition warrants extensive workup and/or treatment in which a stay of more than 24 hours is anticipated.

A physician's order is required, and **medical necessity** documented, in order to change patient status.

A status change may not be made for the convenience of the patient, physician or hospital.

If you have any questions regarding this issue, please contact Arlene Lampart, Technical Manager, Medical Records, at 402-5035.

Illegible Handwriting

Physicians with illegible handwriting continue to be a chronic problem in that subsequent caregivers are unable to decipher orders, notes, etc., and are also unable to identify the physician's name so that he or she could be contacted to clarify the documentation. While various other measures have been tried in the past, they have not been successful. The medical record currently has a "Initial and Signature Record" (Form # NSG-25) on which other caregivers print their names and write their signatures. At its October meeting, the Medical Executive Committee approved the policy whereby those physicians who are identified as having illegible handwriting will be required to print their names and write their signatures on this sheet as well. The Medical Record Committee will now make a recommendation to the Medical Executive Committee to require those identified physicians with illegible handwriting to utilize the "Initial and Signature Record" on all of their patients medical records.

If you have any questions regarding this issue, please contact Zelda Greene, Director, Medical Records, at 402-8330.

Infection Control Briefs

Tuberculosis

Screening and early identification, as well as essential communication are all critical elements to a successful Tuberculosis (TB) exposure control program. Patients with signs and symptoms of TB continue to be introduced into the patient care environment without proper barrier precautions being taken, putting personnel, patients and visitors at risk for acquiring the disease. These occurrences can be prevented with the use of the tuberculosis screening tool at all points of entry (clinics, admitting, emergency rooms, GI lab, pre-admission testing, etc.). Communication from the physician regarding the patient's TB status to the departments processing the patient for testing or admission is also essential.

Documentation of Pneumonia

Conducting surveillance for cases of ventilator associated pneumonia (VAP) and providing feedback to appropriate personnel is a critical measure in the prevention of nosocomial pneumonia. The Infection Control Department conducts surveillance on nosocomially acquired VAPs providing rates of infection for the critical care units. Paramount to the collection of accurate data following the Centers for Disease Control's definition of pneumonia is the physician's diagnosis of pneumonia. Clear chart documentation by the clinician of the patient's pulmonary findings and status will assist the Infection Control Department in providing accurate VAP data and providing feedback on appropriate rate information.

Post Exposure Protocol

Administrative Policy #6300.25, "HIV Antibody Testing of Members of the Medical Staff," details the procedures required when a member of the Medical Staff has sustained an occupational exposure to blood or body fluid. Occupational exposures must be handled according to Pennsylvania Legislation Act 148, which protects the confidentiality rights of patient and health care providers. Employee Health Services and Infection Control are available on call 24 hours a day to assist a Medical Staff member through the process in a strictly confidential and expeditious manner. A hotline, 402-STIK, is also in place which has a recorded message detailing the steps to take when an exposure occurs.

Infection Control Week Celebrated

Handwashing was the topic of Infection Control week celebrated in October. Hospital staff were reminded of this critical practice through a variety of displays, messages, quizzes and interactive activities which showcased the importance of handwashing in reducing the carriage of bacteria on health care workers' hands. Physicians play an integral role in patient care and, therefore, handwashing compliance before and after patient contact, as with other members of the health care team, is imperative!

Mark Your Calendar!

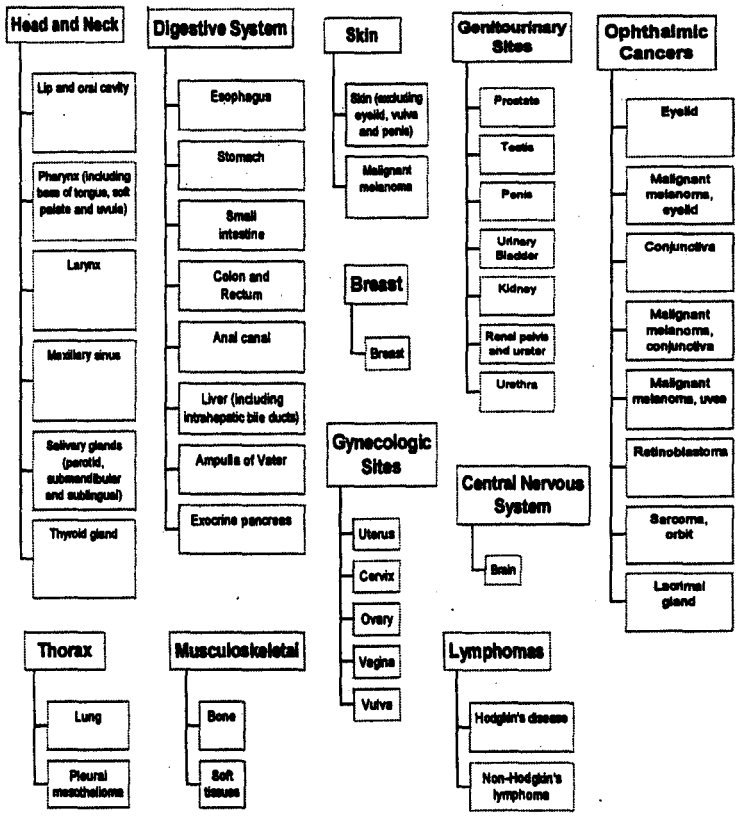
♦ **Annual Meeting**

All employees and physicians are invited to attend the Lehigh Valley Hospital and Health Network annual meeting.

WHEN: **Wednesday, December 3, at 4 p.m.**
WHERE: **Lehigh Valley Hospital Cedar Crest & I-78 Auditorium**

Cancer Staging Sheets

As a reminder, in May 1997, the hospital began using cancer staging sheets to assign clinical and/or pathologic stage to 46 organ sites to which the American Joint Committee on Cancer's staging rules apply. (American Joint Committee on Cancer, ***Manual for Staging of Cancer*** 1992, 4th edition, J.B. Lippincott Co.) Physician participation, with documentation of participation, in the staging process is a requirement for accreditation by the Commission on Cancer. Cancer staging sheets are available for the following sites:



The Cancer Committee has developed and approved the following process to comply with the Commission on Cancer's staging requirement. Staging must be performed by the attending physician for patients having a medical record at the time of the cancer diagnosis (primary tumor). The diagnosis may be made by specimen (positive pathology or cytology), radiologic finding, direct visualization and/or clinical impression. When the histologic specimen supports the assignment of T, N, M classification, that classification is included within the body of the pathology report.

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Site specific staging sheets, located on all patient care units, in Medical Records (physicians' work room) and Tumor Registry, should be completed and signed by the attending (treating) physician prior to the patient's discharge. The appropriate boxes for T, N, M, stage grouping and staging classification should be checked, and the sheet signed and dated. If the current admission is not associated with the initial diagnosis of malignancy (i.e., patient was previously diagnosed and staged), the box indicating that this admission is for an established diagnosis (readmission) should be checked. In this case, restaging is not done. Cancer staging sheets are kept behind the Operative Report (and before the Pathology Report) in the medical record.

Patients' medical records will be reviewed after discharge for the presence and completeness of cancer staging sheets. Absent/incomplete staging sheets will result in a chart deficiency. The deficient chart will be returned to the attending physician for completeness as defined in the Medical Staff Bylaws. Cancer staging sheet deficiencies will be managed by the Medical Record Department along with other record deficiencies.

If you have any questions about staging or the use of the staging sheets, please contact Robert D. Riether, MD, Chairperson, Cancer Committee, at 433-7571; Andrea Geshan, RN, Manager, Tumor Registry, at 402-0526; or Brenda Dwinal, CTR, Tumor Registry, at 402-0520.

Prostatic Acid Phosphatase

A review of the clinical relevance of various methods for the quantitation of acid phosphatase has confirmed that the measurement of **Prostatic Acid Phosphatase** in human serum or plasma by microparticle immunoassay is the preferred method. This methodology is more precise and specific than the conventional **Enzymatic** acid phosphatase test for the quantitation of prostatic acid phosphatase.

Therefore, effective October 15, 1997, Health Network Laboratories discontinued the routine performance of the **Enzymatic** acid phosphatase assay (CPT code 84060). The lab now offers the **Prostatic Acid Phosphatase** test (CPT code 84066), which utilizes the Abbott microparticle enzyme immunoassay methodology.

As a physician, if you determine that an enzymatic acid phosphatase is medically necessary for the treatment of your patient, please be specific in your order using the term **"Enzymatic Acid Phosphatase."** This will ensure that the specimen is referred for the appropriate methodology.

If you have any questions regarding this issue, please contact Jan Gushen, Manager, Lab-Client Services, at 402-4436.

Microsurgery/Laser Lab Changes Name

As a result of evolution and time, the nomenclature identifying the Microsurgery/Laser Laboratory no longer reflects the department's true depth of its functions and responsibilities. Therefore, effectively immediately, the Microsurgery/Laser Laboratory will change its name to **Advanced Clinical Technologies Department**. This new name identifies the department's activities and functions more clearly and allows for future growth, development, utilization and diversification in this rapidly-evolving healthcare environment.

Since its inception in 1979, the **Advanced Clinical Technologies Department** has played an important role in providing education/training, research opportunities, and clinical support to physicians, residents, medical students, nursing staff, and other science and health care professionals. The department has introduced and promoted the technologies and techniques of reconstructive microsurgery, laser surgery and treatments, laparoendoscopic surgery, thoracoscopic surgery, "other" endoscopic surgical techniques, the ATLS Laboratory Sessions and research related to these applications.

For more information about the department, please contact David Rice, Director, at 402-8977.

Epilepsy Trial

Neurosciences Research of the Lehigh Valley Hospital is continuing recruitment for an Epilepsy trial. Please consider referring patients with:

- Complex partial seizures with or without generalization
- Receiving up to two anti-epileptic drugs
- At least one break through seizure per 28 days

This trial is:

- Add on
- Double blind
- Three month drug trial with extension

For more information, contact:

- Neurosciences Research, (610) 402-9830

Coordinators:

- Joan Longenecker, RN, and Nancy Eckert, RN

Investigators:

- John Margraf, MD, and Alexander Rae-Grant, MD

Library News

OVID Training

To schedule a one-on-one OVID (MEDLINE) training session, contact Barbara Iobst in the Health Sciences Library, Cedar Crest & I-78, at 402-8408.

New Additions to the Library Collection

The following books were recently acquired by the Health Sciences Library at 17th & Chew:

Prenatal Diagnosis & Reproductive Genetics
Author: Jeffrey Kuller, et al.
Call No. QZ 50 K96 1996

Psychiatric Clinics of North America
Topic: Suicide
Guest Editor: J. John Mann
Volume 20, Number 3, September 1997

The Low Back Pain Handbook: A Practical Guide for the Primary Care Clinician
Author: Andrew Cole, et al.
Call No. WE 39 C689L 1997

The Family Practice Handbook, 3rd ed.
Author: Mark Graber, et al.
Call No. WB 39 F1985 1997

The following book were recently added to the Health Sciences Library at Cedar Crest & I-78:

Maingot's Abdominal Operations, 10th ed.
Editor: Michael Zinner, et al.
Call No. WI 900 M225 1997

The ICU Book, 2nd ed.
Author: Paul Marino
Call No. WX 218 M3395i 1997

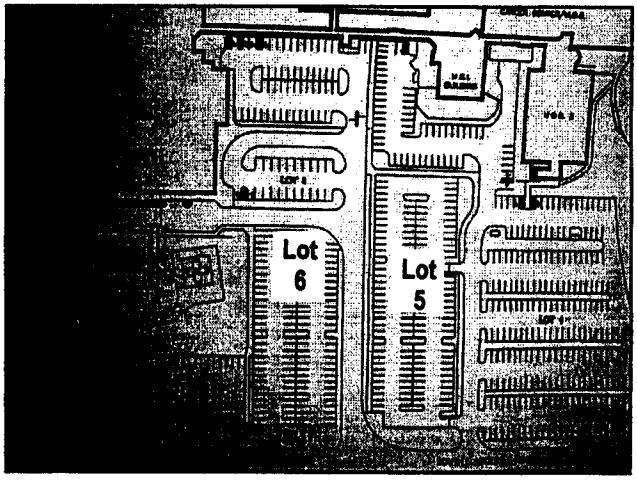
Urologic Oncology
Author: Joseph Osterling, et al.
Call No. WJ 160 U7843 1997

Werner and Ingbar's the Thyroid: A Fundamental and Clinical Text, 7th ed.
Author: Lewis Braverman, et al.
Call No. WK 200 W492 1996

Physician Parking

Effective October 20, both Lot 6 (Physicians' Parking) and Lot 5 (adjacent to Lot 6) will be accessible to physicians at any time.

Please refer to the diagram at right for easy reference.



Congratulations!

William W. Frailey, Jr., MD, Division of General Surgery, and **Charles J. Scagliotti, MD,** Division of General Surgery/Trauma-Surgical Critical Care, were notified by the American Board of Surgery that they successfully completed the recertification process and are now recognized as recertified in Surgery.

Ross N. Futerfas, MD, Division of Pulmonary Medicine, has satisfied the requirements of the American Board of Sleep Medicine and has become certified in the specialty of Sleep Medicine.

Ian M. Gertner, MD, Chief, Division of Neonatology, was the recipient of the Physician Service Award which was presented at the Star Celebration held on Friday, October 3, at the Holiday Inn, Fogelsville. The purpose of the award is to recognize a physician who consistently demonstrates exceptional customer service characteristics.

Albert J. Peters, DO, Chief, Section of Reproductive Endocrinology & Infertility, was one of 225 resident educators to receive the 1997 Council on Resident Education in Obstetrics and Gynecology National Faculty Award for Excellence in Resident Education. This award was created to allow OB/GYN residency programs to give their outstanding faculty nationwide recognition.

Dictated Radiology Reports . . .

are now accessible to physicians through the Lanier System. The following instructions have been corrected. To use the system, follow the instructions below:

- Dial one of the following extensions – 5631, 5632, 5633, 5634, or 5635
- Press "#" and "1"
- Enter your four-digit physician number preceded by "50" if you are a staff physician or "48" if you are a resident
- Enter the transcription destination code:
  - "1" for Radiology transcription
  - "2" for LVDI transcription
  - "3" for LMIC transcription
- To review the dictated report using the accession number, press "1" followed by six zeroes and the six-digit accession number
- To review the dictated report using the medical record number, press "3" followed by six zeroes and the six-digit medical record number
- The system will start with the most recent dictation. Press "5" to go to the next dictation on the same patient.

Please note: Due to space constraints, voice reports are only held on the Lanier system for five days.

If you have any questions regarding this issue, please contact Valerie Hunsicker, Operations Coordinator, at 402-0393.

Papers, Publications and Presentations

Mehrzad Bozorgnia, MD, General Surgery resident, presented his paper, "End-Stage Renal Disease and Infrainguinal Bypass Grafting: Is It Appropriate?" at the 19th Annual Scientific Meeting of the Delaware Valley Vascular Society which was held September 25 in Philadelphia. Co-authors of the paper include **Gary G. Nicholas, MD**, Chief, Division of Vascular Surgery; **James F. Reed III, PhD**, Director of Health Studies; and **Susan A. Nastasee, BS**, Department of Surgery.

Kevin J. Farrell, MD, Chief, Section of Burn, and **Madge E. Ellis, MD**, former Surgical resident and Burn fellow, will be presenting their paper, "Preoperative Angioplasty in Burn Patients," at the Southern Medical Association's 10th Annual Regional Burn Seminar to be held December 5-7 in Chapel Hill, NC. Co-authors of the paper include **D. Lynn Morris, MD**, Chief, Division of Cardiology, and **W. John Edmiston, MD**, former Surgical resident.

Paul Frassinelli, MD, Chief Surgical Resident; **Megan Werner**, medical student at Brown University; **James F. Reed III, PhD**, Director of Health Studies; and **Charles J. Scagliotti, MD**, Division of General Surgery/Trauma-Surgical Critical Care, co-authored a paper, "Laparoscopic Cholecystectomy Alleviates Pain in Patient with Acalculous Biliary Disease," which was accepted for publication in the journal, ***Surgical Laparoscopy & Endoscopy***.

E. James Frick, MD, General Surgery resident; **Mark D. Cipolle, MD, PhD**, Chief, Section of Trauma Research; **Michael D. Pasquale, MD**, Chief, Division of Trauma/Surgical Critical Care; **Thomas E. Wasser, MEd**, Department of Community Health & Health Studies; **Michael Rhodes, MD**, Chairman, Department of Surgery, Medical Center of Delaware, and **Susan A. Nastasee, BS**, Department of Surgery, co-authored the paper, "Outcome of Blunt Thoracic Aortic Injury in a Level I Trauma Center: An 8-Year Review," which was accepted for publication in the ***Journal of Trauma***.

Arvind K. Gupta, MD, Internal Medicine resident, presented a paper, "Relationship Between Hepatitis C Virus Viral Load and HIV Viral Load: A Case Control Study," at the 37th Interscience Conference on Antimicrobial Agents and Chemotherapy held September 28 to October 1 in Toronto, Canada. The paper was co-authored by **Margaret L. Hoffman-Terry, MD**, Division of Infectious Diseases.

Dona C. Hobart, MD, Chief Surgical Resident, won the Residents Paper Competition Award at the 19th Annual Scientific Meeting of the Delaware Valley Vascular Society held September 25 in Philadelphia. Her paper, "Carotid Endarterectomy: Reduced Resource Utilization Using a Clinical Management Protocol," was co-authored by **Gary G. Nicholas, MD**, Chief, Division of Vascular Surgery, and **James F. Reed III, PhD**, Director of Health Studies.

Lester Rosen, MD, Associate Chief, Division of Colon/Rectal Surgery, was invited to speak at the October 12-17 meeting of the American College of Surgeons in Chicago, Ill. He presented "Guidelines for Colorectal Cancer Screening in Average Risk Individuals" and participated in a post-graduate panel discussion regarding medical and surgical treatment for colorectal cancer.

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday from noon to 1 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Topics for November include:

November 4 - **Treatment Options for Acute Stroke** will be presented by Eric Raps, MD, Director, Stroke & Neuro Intensive Care, Department of Neurology, University of Pennsylvania, Philadelphia, Pa.

November 11 - **Kidney Transplant Update, LVH** will be presented by Craig Reckard, MD, Chief, Transplantation Surgery, Lehigh Valley Hospital

November 18 - **Anatomic Basis of Low Back Pain** will be presented by Carson Schneck, MD, Professor of Anatomy and Diagnostic Imaging, Temple University School of Medicine, Philadelphia, Pa.

November 25 - **Anti-Coagulation Strategies** will be presented by Geno J. Merli, MD, Clinical Professor of Medicine, and Director, Division of Internal Medicine, Thomas Jefferson University Hospital, Philadelphia, Pa.

For more information, please contact Evalene Patten in the Department of Medicine at 402-1649.

Department of Pediatrics

November 14 - **Update in Pediatric Obesity** will be presented by Andrew Tershakovec, MD, Director, Weight Management Program; Director, Home Parenteral Nutrition Program; Division of Gastroenterology and Nutrition, Children's Hospital of Philadelphia.

Pediatric conferences begin at noon and are held in the hospital's Auditorium at 17th & Chew. For more information, contact Kelli Ripperger in the Department of Pediatrics at 402-2540.

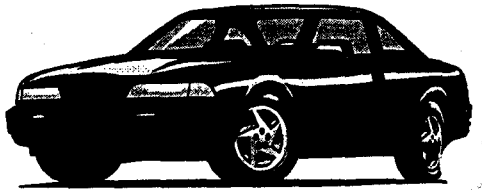
Medical Staff Forum

The Medical Staff Transition Team, comprised of leaders from the Lehigh Valley Hospital (LVH) and Muhlenberg Hospital Center (MHC) Medical Staffs, has been established to identify, prioritize and recommend the process for solution of issues related to medical staff issues and the merger of LVH and MHC. Members of this group would like to meet with interested physicians from both Medical Staffs to listen to their concerns about the merger.

Two forums have been scheduled for this purpose: **Monday, November 10**, beginning at 5:30 p.m., in the Auditorium at Lehigh Valley Hospital (Cedar Crest I-78); and **Tuesday, November 11**, at 5:30 p.m., in Rooms 1 and 2 of the Banko Community Center on the campus of Muhlenberg Hospital Center.

The members of the Medical Staff Transition Team are very interested in hearing your thoughts and opinions, and hope you will be able to attend.

FREE Valet Parking is available to ALL patients coming to the hospital or to their physician's office located in one of the medical office buildings at Cedar Crest & I-78. Office managers and staff are asked to encourage their patients to use the service when they are scheduling appointments.



Who's New

Medical Staff

Address Change

Theodore H. Gaylor, MD
1251 S. Cedar Crest Blvd.
Suite 110
Allentown, PA 18103-6297

Nercy Jafari, MD
451 Chew Street
Suite 304
Allentown, PA 18102-3423

H. Christina Lee, MD
95 Highland Avenue
Suite 100
Bethlehem, PA 18017
(610) 868-8600
FAX: (610) 868-8700

Practice Change

Jamie D. Paranicas, MD
The Heart Care Group, PC
3340 Hamilton Blvd.
Allentown, PA 18103-4598
(610) 433-6442
FAX: (610) 776-6645

New Fax Number

Judith N. Barrett, MD
Primary Care Associates in the LV, PC
FAX: (610) 432-6517

Tuberculosis

I. History

Positive Skin Test:	Yes [ ]	No [ ]
Personal History of T.B.	Yes [ ]	No [ ]

II. If yes, check the appropriate spot for any symptoms you may be experiencing:

1.	Fatigue; Malaise	Yes [ ]	No [ ]
2.	Unexplained weight loss	Yes [ ]	No [ ]
3.	Anorexia (loss of appetite)	Yes [ ]	No [ ]
4.	Fever (usually at night)	Yes [ ]	No [ ]
5.	Night sweats (drenching proportions)	Yes [ ]	No [ ]
6.	Cough	Yes [ ]	No [ ]
7.	Hemoptysis (spitting up blood)	Yes [ ]	No [ ]

III. PPD Skin Test - Purified Protein Derivative Intermediate Strength

Positive PPD Skin Test
- reaction of 10mm or more of induration in a health care worker with normal immune function.
- reaction of 5mm or more of induration in a person with compromised immune function and/or persons who have had recent close contact with persons who have active TB.

Doubtful PPD Skin Test - reaction of 5mm through 9mm of induration in a person with normal immune function.

Recent Skin Test Converter - a person whose PPD skin test has increased by at least 6mm within the last 12 months, from less than 10mm to more than 10mm.

Hepatitis B

I. History

Prior Immunization:	Yes [ ]	No [ ]
Personal History of Hepatitis B:	Yes [ ]	No [ ]

II. If immunization history positive, check antibody titer as indicated.
If personal history negative, evaluate for active disease including HB_SA_g as indicated.

If no, skip to III.

III. Immunization as indicated.

Addendum - CDC recommends, but does not require, the following:

1. Annual influenza immunization.
2. Rubeola immunization for susceptible individuals born after 1956.

LEHIGH VALLEY
HOSPITAL

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

Non-Profit Org.
U.S. Postage
PAID
Allentown, PA
Permit No. 1922

Medical Staff Progress Notes **is published monthly to inform the Lehigh Valley Hospital Medical Staff and employees of important issues concerning the Medical Staff. Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at 402-8590.**
Lehigh Valley Hospital is an equal opportunity employer.
M/F/H/V