Health Services
LOS ANGELES COUNTY

REGISTRATION

SECTION A PATIENT'S INFORMATION

Has the patient been here before or at any other LA County Hospital or Clinic? ❑ *YES* ❑ *NO*

_____ _____ _____
First Name Middle Name Last Name

_____/_____/_____ _____ _____-_____-_____ _____
Date of Birth Country of Birth Social Security Number Mother's Maiden Name

Sex: ❑ *Male* ❑ *Female*

Race (Check all that apply): ☐ American Indian/Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Ethnicity (Check all that apply): ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Address: _____ Apt#: _____
(Street)

City: _____ State: _____ Zip Code: _____

Home Phone # (_____) _____ -_____ Cell Phone # (_____) _____ -_____

E-mail Address _____@_____ Communication by email? ❑ *YES* ❑ *NO*

Preferred language to discuss health care: _____ Religion (if any): _____

Marital Status: ❑ *Single* ❑ *Married* ❑ *Widow* ❑ *Divorced* ❑ *Legally Separated*

SECTION B EMERGENCY CONTACT

Person to notify in case of emergency: _____ _____
Full Name Relationship to Patient

Primary Phone # (_____) _____ -_____ Secondary Phone # (_____) _____ -_____

Address: _____ City: _____ State: _____ Zip Code: _____

If you are admitted to the Hospital would you like to receive visitors? ❑ *YES* ❑ *NO*

SECTION C HEALTH INSURANCE

Check all that apply and complete:

- ❑ ***MEDI-CAL*** – Client Index Number (CIN): _____ Health Plan Name: _____
- ❑ ***MEDICARE*** – Health Insurance Claim (HIC) #: _____ Medicare Advantage? ❑ *YES* ❑ *NO*
- ❑ ***OTHER INSURANCE*** – Insurance Name: _____ Policy Number: _____
- ❑ ***MY HEALTH LA*** – MHLA Member Number: _____

Primary Care Doctor or Clinic Name: _____

For Staff Use Only. Date of Visit: _____

_____
Registration Staff / Number

DHS-OPA ER-REG FM1 01/17/17

PLACE LABEL WITH NAME / MRN & FIN HERE:

NAME:
MRN:
FIN:

Penicillin Desensitization Interagency
Patient Referral Form Attachment B

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

PATIENT INFORMATION: PATIENT ID #: _____

Patient Name: _____

Address: _____

_____

Mother's Maiden Name: _____

SSN: _____ Sex: ◯ Male ◯ Female

Patient Phone: _____ DOB: _____

Referral Date: _____ Date of patient's last visit: _____

MEDI-CAL Number:_____

Payor Source: ◯ GR ◯ PPP ◯ Medi-Cal ◯ Other

Weeks Gestation:

Gravida: _____ Para: _____

LMP _____ EDC: _____

REFERRING ORGANIZATION'S INFORMATION

Organization's Name/Clinic: _____ Provider Name: _____

Address: _____

Provider's Phone #: _____ Provider's FAX #: _____

Contact Person/Case Manager/PHN: _____ PHN Phone #: _____

REFERRAL INFORMATION: ◯ Routine ◯ Urgent ◯ Emergent

Diagnosis:

Diagnosis Code:

Treatment recommended:

Severity of Allergy (describe):

☐ PCN allergy since year:_____

Relevant history/physical findings/current therapy/medication: ☐ see attached notes

Relevant Medical Documentation: ☐ see attached lab results ☐ progress notes

Signature: _____

Date: _____

UTILIZATION REVIEW PROCESS: for LAC+USC Use Only

☐ Approved for service/clinic

☐ Deferred with the following studies before appointment:

☐ Denied. Does not meet referral criteria. Reason:

Signature: _____ Date: _____

Print name: _____

Timeframe for appointment: ☐ <1 week ☐ 1-6 weeks

APPOINTMENT:

Clinic: _____ Date: _____ Time: _____

Clinic Location: _____ Given by: _____

Patient Information Imprint Area

NAME:

MRN:

FIN:

PLEASE FAX THIS FORM TO DHSP NURSING (213)749-9621 or EMAIL: EDL-DPH_DHSP_Nursing@ph.lacounty.gov

PENICILLIN DESENSITIZATION REFERRAL FLOWCHART FOR CFS & CLINIC SERVICES

(Ensuring Treatment of Syphilis in Pregnancy)

INITIAL CONSULT FOR PCN DESENSITIZATION FOR PREGNANT PERSONS

CS/CFS STAFF (i.e., Clinic Intake Nurse/Provider/CFS Physician/CFS Public Health Nurse/STD Clinic Staff or PHI)

1) Staff must check Casewatch (CW) for incident and ensures assignment to a CFS PHN; not assigned call (213)368-7441 or e-mail: EDL-DPH_DHSP_Nursing@ph.lacounty.gov to open a CW incident and ensure assignment to a CFS PHN.
2) Assigned CFS PHN contacts the DHSP-Clinical Guidance & Nursing Unit PHN at ***(213) 368-7441*** for consultation. Program staff sends PCN Desensitization Referral Packet for completion. Information required: patient's medical history i.e., syphilis diagnosis, hx of PCN allergic reaction, prenatal care, LMP and EDC.
3) CS/CFS Staff completes the PCN Desensitization Referral Packet: Request for Medical Record Number (Attachment A), Interagency Referral Form (Attachment B), submits Labs/Progress notes.

COMPLETED PCN DESENSITIZATION REFERRAL PACKET

1) CFS Staff sends the PCN Desensitization Referral Packet (Attachments A, B), patient's PMD progress notes and serologic test results (RPRs, TPPAs) from outside clinics as well as patient ORCHID MRN and FIN via fax to DHSP at ***(213) 749-9621***. or e-mail: EDL-DPH_DHSP_Nursing@ph.lacounty.gov
2) DHSP CGN PHN reviews the PCN Desensitization referral packet & appropriate paperwork. The DHSP PHN confirms that patient requires penicillin therapy and has history consistent with a penicillin allergy.

(FYI) ONLY DHSP INTERNAL PROCESS FOR SETTING UP HOSPITAL ADMISSION/ALLERGY & IMMUNOLOGY APPOINTMENTS

1) **DHSP CGN PHN:** Contacts LAC+USC OB or Triage & Allergy and Immunology Dept. to alert the admission of a High or Medium Priority case and await instruction for admission/appt. *Please Note: A & I Appointments may be a 2 Visit Process or visit maybe done via Telehealth. If admitted patient usually stays 24 hours-prepare pt. for overnight stay.*
2) DHSP CGN PHN: Gives instruction/updates the CFS PHN of agreed date/time of appointment or admission to the hospital.

ON DAY OF APPOINTMENT OR ADMISSION

The CFS PHN:

1) Ensures patient's safe transport to LAC+USC Medical Center and makes it to her appointment on time. (Request Uber through DHSP if needed)
2) Ensures patient is sent to LAC-USC with copies of paperwork and copy of LAC USC Map. Ensure seamless admission/appointment.
3) Ensures CFS accompanies pt. and meets the DHSP-STD PHN outside of the LAC+USC INPATIENT Tower. Only required if patient is unreliable needs support.

The DHSP STD PHN:

1) Assesses in Orchid to ensure seamless admission/appointment.
2) Ensures CFS accompanies pt. and meets the DHSP-STD PHN outside of the LAC+USC INPATIENT Tower. Only required if patient is unreliable needs support.
   A/I Evaluation Appointments go to: OPD 3 M 40 if indicated, or Admission go to: LAC+USC INPATIENT Tower: OB Triage 3H for PCN Desensitization.

*****OB Triage Staff/ A & I facilitate admission process If patient is admitted stays are for at least 24 hours.**

AFTER APPOINTMENT OR DISCHARGE

The CFS PHN:

1) Confirms patient's discharge plan i.e., follow-up appointments, prescription for oral penicillin etc. Knows if additional treatment needed and where additional treatment will be given. Depending on if truly allergic to PCN or not pt. maybe he asked to return to A & I Clinic, hospital or go to STD Clinic for follow up treatment.
2) Ensures patient is safely transported back to her residence. **(Request Uber if needed)**
3) Updates the DHSP STD PHN of outcome, discharge instructions and other pertinent information, or patient BA's.