NORTON Children's Gynecology

Policies and Procedures

Welcome to Norton Children's Gynecology! We are proud to be the only practice in Kentucky dedicated to the unique gynecology needs of children, adolescents and young women under the age of 21. All of our providers are trained in pediatric and adolescent gynecology specialty care.

This letter is to explain our office policies and practices designed to provide you with the best quality care.

1. Confidentiality: Kentucky state law requires that adolescents have access to confidential services in regards to sexuality, sexually transmitted disease screening, treatment and pregnancy and mental health screening. We encourage all of our patients to have open communication wither their parents/guardians. However, in order to ensure all of our patient's health care needs are being met, we provide patients an opportunity to discuss concerns in private, and use this time provide education on these issues.

2. No Show Policy: No shows are a huge burden to our practice. We ask that you notify us 48 hours before your scheduled appointment if you need to cancel or reschedule. If you have more than 3 no shows or a history of late cancellations you will be dismissed from the practice. You may also be charged a $25.00 fee for no showing to or cancelling your appointment in less than 24 hours.

3. Late Policy: We ask you to be on time for your appointments. You need to leave a little extra time for parking, as well as paperwork. If you are late we will reschedule your appointment in order to keep the office on schedule for the other patients who arrived on time.

4. Appointment Arrival Time: If you are a new patient to our practice or are scheduled for an annual check, you need to be at the office 30 minutes prior to your appointment time. This will allow enough time to complete the necessary paperwork before your appointment. If you are an established patient to our practice, please arrive 15 minutes prior to your appointment time for follow-up paperwork.

5. We will not be able to do hospital consults at hospitals outside the Norton system. If you experience an emergency situation and need to go to the emergency room go to the nearest Norton Children's Hospital facility if 18 and under. If over the age of 18, please go to the closest Norton Hospital including Norton Audubon, Norton Women's and Children's, Norton Downtown, or Norton Brownsboro. Make sure to let the emergency room doctor know you are a patient in our practice, so they can contact us for necessary follow-up care.

6. On-Call Physicians: One of the physicians from our practice is on call after regular office hours. The on-call physician is for emergencies. If you have questions regarding non-emergent issues, medications, need prescription refills, or appointments you will need to call during business hours of 8:00am-4:30pm or use My Chart to send us correspondence.

Please sign that you have read and understand the office policies.

Signature: _____

Date: _____

Patient Visit Information Sheet

Name: _____ **Age:** _____ **DOB:** _____

Email Address: _____

1. What is the reason for your visit today?

☐Birth Control	☐Annual Exam	☐Irregular Periods
☐Painful Periods	☐Heavy Periods	☐Vaginal Irritation
☐Vaginal Discharge	☐Pelvic Pain	☐Breast Problem
☐Lichen Sclerosis	☐Ovarian Cyst	☐Endometriosis
☐STD Screening	☐Post-Op Visit	☐Follow-Up

☐Other *(Please Specify)*_____

2. If you are here for an annual visit, have you visited or are you planning to visit your primary care doctor this year for a wellness visit? _____

3. Who is accompanying the patient? _____

4. Please list any allergies (latex, drugs) _____

_____

5. What pharmacy do you use *(Please list Name, City, and Street Address or Phone)*

_____

6. Please list what medications you are currently taking:

Drug Name	Dosage

7. Patient Symptomatic History *(Please check if you are currently experiencing…)*

☐Fever/Chills	☐Frequent Urination	☐Breast Pain
☐Weight Loss or Gain	☐Painful Urination	☐Nipple Discharge
☐Changes in Sleep	☐Leaking Urine	☐Breast Mass/Lump
☐Heart Problems	☐Bedwetting >5yrs. old	☐Eczema
☐Fainting	☐Muscle Spasms	☐Rash
☐Asthma	☐Loss of Appetite	☐Unwanted Hair Growth
☐Coughing	☐Nausea/Vomiting	☐Acne
☐Shortness of Breath	☐Constipation	☐Vaginal Discharge
☐Anemia	☐Abdominal Pain	☐Vaginal Bleeding
☐Bleeding Problems	☐Diarrhea	☐Thyroid Problems
☐Pubic Hair Development	☐Breast Development	☐Diabetes
☐High Blood Pressure	☐High Cholesterol	☐Migraines/Headaches
☐Sports Injury	☐Anxiety/Depression	☐Seizures

☐Other *(Please Specify)*_____

_____

For Office Use Only:

WT: _____

HT: _____

BP: _____ /_____

P: _____

T: _____

LMP: _____

Cell: _____

Gardasil: ☐**1** ☐**2** ☐**3**

Flu Vaccine: ☐**Y** ☐**N**

8. **Does patient have her period?** ☐No ☐Yes – At what age did patient start? _____

9. **Patient Surgical History**

☐Ear Tubes ☐Wisdom Teeth ☐Tonsils ☐Adenoids ☐Cosmetic Surgery ☐Appendix ☐Hernia Repair ☐Fracture
☐Other _____

10. **Patient/Family Medical History** *(Please check if patient or anyone in patient's family have/had any of the following medical conditions. Some will not apply to the patient, but could to a family member. If you have filled this history out in the past year and there have been no changes, please check no changes at the bottom.)*

Relationship	Alcohol Abuse	Anemia	Anxiety	Arthritis	Asthma	Birth Defects	Bladder Problems	Blood Clot/Transfusion	Bowel/Stomach Problem	Cancer	Depression	Developmental Delay	Diabetes	Drug Abuse	Early Death	Endometriosis	Headaches	Heart Disease	Hepatitis	High Blood Pressure	High Cholesterol	Liver Disease	Mental/Psychiatric Disorder	Migraines	Ovarian Cyst	Polycystic Ovaries	Seizure Disorder	Sickle Cell Trait/Disease	Stroke	Thyroid Disease	VonWillebrand Disease
Patient																															
Mother																															
Father																															
Sister																															
Brother																															
Maternal Aunt																															
Maternal Uncle																															
Paternal Aunt																															
Paternal Uncle																															
Maternal Grandmother																															
Maternal Grandfather																															
Paternal Grandmother																															
Paternal Grandfather																															

☐Adopted ☐Family History Unknown ☐Maternal Family History Unknown ☐Paternal Family History Unknown ☐No Changes

Is there any additional information about today's visit, family history, or current living situation we should be aware of? _____
_____

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Parent Questionnaire

1. **Do you have any concerns about your child's health, weight or nutrition?** ☐Yes ☐No
   Please describe: _____
   _____

2. **Have there been any changes or stresses for your family in the last year?** ☐Yes ☐No
   Please describe: _____
   _____

3. **Have you noticed any changes in your child's behavior, such as unusual anger or irritability, withdrawal, secrecy, sadness, depression, or problems at home or school?** ☐Yes ☐No
   Please describe: _____
   _____

4. **Do you think smoking, drinking, or drugs are a problem for anyone in your family?** ☐Yes ☐No
   Please describe: _____
   _____

5. **Is your child exposed to violence in your home or community?** ☐Yes ☐No
   Please describe: _____
   _____

6. **What are some of your child's strengths and talents?**_____
   _____

7. **Would you like help with talking to your child about puberty, menstrual periods, sex, drugs, alcohol, smoking, bullying or any other social issues?** ☐Yes ☐No
   Please describe: _____
   _____

8. **Is there anything *you* would like to discuss with the nurse or doctor today?** ☐Yes ☐No
   Please describe: _____
   _____

9. **Can we share your answers to any of the questions above with your child?** ☐Yes ☐No
   Please describe: _____
   _____

10. **Primary Care Physician: _____ Phone: _____**

11. **Who referred you? Name: _____ Phone: _____**

12. **List other doctors or mental health counselors your child has seen in the last year:**

    Name: _____ Phone: _____

    Name: _____ Phone: _____

    Name: _____ Phone: _____

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Are You Getting Enough CALCIUM?

Name: _____ **Date:** _____ **Age:** _____

1. On average, how many 8 oz. glasses of milk (whole, reduced-fat, skim, or lactose-free) do you drink?
   ☐*less than one glass per day* ☐*1 glass per day*
   ☐*2 glasses per day* ☐*more*
2. On average, how often do you eat a serving (1/2 cup, cooked) of deep-green vegetable (broccoli, kale, collard greens, etc.)?
   ☐ *daily* ☐*3X a week* ☐*weekly* ☐*never*
3. On average, how often do you eat a serving (1 oz.) of hard cheese (Parmesan, Cheddar, Swiss, etc.)?
   ☐ *daily* ☐*3X a week* ☐*weekly* ☐*never*
4. On average, how often do you eat a serving (1 cup) of yogurt?
   ☐ *daily* ☐*3X a week* ☐*weekly* ☐*never*
5. On average, how often do you eat a serving (1/2 cup; approximately 1 large scoop) of premium or low-fat ice cream?
   ☐ *daily* ☐*3X a week* ☐*weekly* ☐*never*
6. How often do you eat any calcium-fortified foods such as cereals, juice, cottage cheese, or breakfast bars?
   ☐ *daily* ☐*3X a week* ☐*weekly* ☐*never*
7. On average, how often do you eat a serving (3 oz.) of canned salmon or sardines (including bones)?
   ☐ *daily* ☐*3X a week* ☐*weekly* ☐*never*
8. How many alcoholic beverages do you have in an average day?
   (One alcoholic beverage = 5 oz. of wine, 12 oz. of beer, 1.5 oz. of hard liquor)
   Wine: ☐*1* ☐*2* ☐*More* *Beer:* ☐*1* ☐*2* ☐*More*
   Liquor: ☐*1* ☐*2* ☐*More*
9. Do you take any multivitamin supplements? ☐*Yes* ☐*No*
10. Do you take a calcium supplement? ☐*Yes* ☐*No*
    *If yes, what type?*_____ *No. Tabs/Day* _____

Calculating Calcium Intake

Using the answers to the questionnaire on the left, multiply the number of servings for each question by the number of milligrams provided then add it up for an estimated calcium intake.

1. No. of glasses x 300 _____
2. No. of servings x 150 _____
3. No. of ounces x 200 _____
4. No. of cups x 400 _____
5. No. of ½ cups x 85 _____
6. No. of servings x 200 _____
7. No. of servings x 150 _____
9. No. of tabs x mg/tab _____
10. No. of tabs x mg/tab _____

DAILY TOTAL _____

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Are You Getting Enough CALCIUM?

Age Group	Suggested daily calcium intake
Infants	
(Birth to 6 months)	210 milligrams
(7 months to 1 year)	270 milligrams
Children	
(1 to 3 years)	500 milligrams
(4 to 8 years)	800 milligrams
Teens and young adults	
(9 to 18 years)	1,300 milligrams

Adults	Suggested daily calcium intake
Women	
(31 to 50 years)	1,000 milligrams
(51 years and older)	1,200 milligrams
Postmenopausal Women	
(on estrogen)	1,200 milligrams
(not on estrogen)	1,500 milligrams
Pregnant/Lactating Women	
(all ages)	1,200 milligrams

Where you'll find it...

Food Items	Milligrams
Milk	
Milk (2%), 8 ounces	315 milligrams
Milk (Skim), 8 ounces	302 milligrams
Milk (Whole), 8 ounces	291 milligrams
Low-fat Chocolate, 8 ounces	287 milligrams
Buttermilk, 8 ounces	285 milligrams
Breast milk, 8 ounces	79 milligrams
Yogurt	
Nonfat yogurt, 8 ounces	452 milligrams
Low-fat yogurt, 8 ounces	415 milligrams
Yogurt with fruit, 8 ounces	345 milligrams
Yogurt Drink, 8 ounces	186 milligrams
Frozen yogurt, ½ cup	90 milligrams
Cheese	
Goat cheese (hard), 1 ounce	254 milligrams
Part-skim mozzarella, 1 ounce	183 milligrams
American cheese, 1 ounce	174 milligrams
Low-fat cottage cheese, 1 cup	155 milligrams
Feta cheese, 1 ounce	140 milligrams
Grated parmesan cheese, 1 tbs.	69 milligrams

Food Items	Milligrams
Fish	
Sardines with bones, 3 ounces	370 milligrams
Canned salmon with bones, 3 ounces	180 milligrams
Vegetables	
Collards, 1 cup	357 milligrams
Turnip greens, 1 cup	200 milligrams
Kale, 1 cup	179 milligrams
Broccoli (cooked), 1 cup	178 milligrams
Okra (cooked), 1 cup	176 milligrams
Dandelion greens, 1 cup	147 milligrams
Mustard greens, 1 cup	103 milligrams
Other	
Vegetable lasagna, 1 piece	450 milligrams
Orange-juice, 8 ounces	300 milligrams
Cheese pizza, 1 slice	290 milligrams
Chocolate pudding, ½ cup	161 milligrams
Rice pudding, ½ cup	152 milligrams
Vanilla ice-cream, ½ cup	113 milligrams
Chocolate ice-cream, ½ cup	106 milligrams