FLOYD PRIMARY CARE

Physician Assistants Functions Request

_____ _____

Applicant Name Supervising Physician

_____ _____

Title Department

Please check patient care functions requested and note the degree of supervision, ***direct*** or ***indirect****,* by each.

Patient Care Functions	**Direct**	**Indirect**	**Approved**
HOSPITAL DUTIES			
1. Obtain history and perform physical exam			
2. Order routine tests such as: CBC, urinalysis, X-rays, EKGs **(to be countersigned by the responsible physician**)			
3. Check-up of established patients			
4. Perform and dictate discharge summary			
5. Perform and dictate history and physical exam			
6. Administration of medication such as: a. Intramuscular b. Intravenous c. Subcutaneous d. Rectal e. Blood transfusion f. Chemotherapy g. Other			
7. Entries on progress notes			
8. Admit patient to service of physician			
9. Make rounds for physician			
10. Drawing of venous blood**, NOT** to include femoral vein			
11. Drawing of venous blood, to include femoral vein		**XXXXXX**	
12. Writing pre-op and post-op orders on charts **(to be countersigned by the responsible physician)**			
13. See patients in Emergency Room			
MEDICAL PROCEDURES			
1. Application and removal of plaster		**XXXXXX**	
2. Apply and set up traction		**XXXXXX**	
3. Insertion of intravenous needles and catheters			
4. Insertion of Foley catheter			
5. Cardiopulmonary resuscitation **(EMERGENCY – NO MD AVAILABLE)**			
6. Insertion of nasal gastric tubes			
7. Insert nasogastric tubes and perform gastric lavage			
8. Insertion of endotracheal tubes **(EMERGENCY ONLY)**			
SURGICAL PROCEDURES			
1. Suture of minor laceration			
2. Removal of sutures			

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Applicant

Patient Care Functions	Direct	Indirect	Approved
3. Closing of incisions			
4. Perform First Assistant's duties			
5. Assist with minor surgical procedures in the presence of attending physician			

PLEASE USE ADDITIONAL SHEET FOR ADDITIONAL PATIENT CARE FUNCTIONS, DOCUMENTATION, AND COMMENTS.

Date _____ _____
Signature of Applicant

Date _____ _____
Signature of Supervising Physician

APPROVED FPC:

_____ _____
FPC Date

BOARD APPROVAL: _____ *YES* _____ *NO* _____
Date