



# HARBOR - UCLA MEDICAL CENTER

## Affiliating Resident Questionnaire

Instructions: **ALL SECTIONS OF THIS FORM MUST BE COMPLETED.** Please complete this form and fax to the Graduate Medical Education office two weeks prior to the rotation start date along with the resident's HIPAA certificate, Code of Conduct exam & acknowledgment, medical license, DEA, and ECFMG certificate (if applicable). All these forms are available on the *Visiting Resident - Check in* section of our website at: [www.Harbor-UCLA.org](http://www.Harbor-UCLA.org) House Staff must register with Graduate Medical Education/Medical Administration by visiting room 8E8 on the first day of a rotation between 8:30 AM and 5:00 PM. Questions should be referred to the Graduate Medical Education Office (310) 222-2911. **FAX # (310) 782-8599**

**Sending Hospital:** \_\_\_\_\_ **Department:** \_\_\_\_\_

**Will be sending resident:** \_\_\_\_\_ **to Harbor-UCLA Medical Center**  
Name

**Department or Service:** \_\_\_\_\_ **Physician's NPI#:** \_\_\_\_\_

**Affiliation dates will be:** \_\_\_\_\_ **to** \_\_\_\_\_  
Month/Day/Year Month/Day/Year

If a scheduling change occurs, i.e., change of date or cancellation, an adjusted form must be completed and turned in to the GME Office.

**Physician's Home Address:** \_\_\_\_\_  
Street Address City, State Zip Code

**Phone: Home**(\_\_\_\_) \_\_\_\_\_ **Pager**(\_\_\_\_) \_\_\_\_\_ **Work**(\_\_\_\_) \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Postgraduate Year Level:** \_\_\_\_\_  
(PGY 1,2, etc.)

**Medical School:** \_\_\_\_\_ **Month/Year Graduated:** \_\_\_\_\_

**International Medical Graduates: ECFMG Certificate#** \_\_\_\_\_ **Date Issued:** \_\_\_\_\_ Copy required

**Check here if not licensed**  **Code of Conduct** Copy required  **HIPAA Certification** Copy required

**California Medical License #** \_\_\_\_\_ **Exp Date:** \_\_\_\_\_ Copy required

**Physician DEA #** \_\_\_\_\_ **Exp Date:** \_\_\_\_\_ Copy required

**Person to notify in case of emergency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Your Program Director's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*I have received, read, and understand the attached information regarding Hospital Policies.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR OFFICE USE ONLY:**

**ZZ** \_\_\_\_\_ **T** \_\_\_\_\_  
Physician ID # Parking/meals Issued Pharm. Reg. Date

Lname, Fname



GAIL V. ANDERSON, JR., M.D., M.B.A.  
MEDICAL DIRECTOR

TECLA A. MICKOSEFF  
CHIEF EXECUTIVE OFFICER

## **“IMPORTANT HOSPITAL POLICES TO MAKE EVERYONE’S LIFE BETTER”**

### **MEDICAL RECORDS**

1. **Legibility** – Physicians must sign their name and print their name with Physician I.D. number unless a legible ink stamp of the physician’s full name is used.
2. **Correcting errors** – draw one line through the erroneous entry. Write the word “error” above the line followed by your initials, date and time.
3. **Dates and Times:** All orders and entries dated and timed.
4. **Late entries** – Designate the entry or note at “Late entry”. Date and time the note as the time when the note is actually written. Do not try and squeeze the entry in between previous entries in the medical record.
5. **Informed Consents** – Must be witnessed and signed appropriately. Be sure to use interpreter/ Spanish form when appropriate. Make sure to use informed consents for administration of blood products and radiocontrast material.
6. **Timeliness of Documentation** - All reports and notes must be completed in a timely manner: *Histories & Physicals* – 24 hours; *Progress Notes* – daily; *Operative Reports* – immediately post-op; *Discharge summaries* – ASAP after discharge
7. **Signing Orders** - Verbal orders – must be signed immediately; Phone orders – within 24 hours
8. **Pain assessments** (use 1-10 scale); **Reassessments** (for patients previously identified as having pain; use the same pain scale and document an appropriate intervention)
9. **Utilization Management:** Indicate patient’s need for continuing hospitalization; avoid terms such as “status quo”, “looks good”, “home soon”. Good example, “The patient requires continued acute hospitalization for evaluation and management of severe hypoxemia”.
10. **“Range Orders”** (e.g. 1-2 tabs q 4-6 hrs) are not permitted; **“prn” medication orders** must include the both frequency and indication.
11. **Patient Confidentiality** – avoid patient care discussions in public areas; do not take confidential patient information home with you.
12. **Conscious Sedation / Restraints** - use and fully complete the hospital forms. The forms are located at all clinical work stations.

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES - HARBOR-UCLA MEDICAL CENTER  
(310) 222-2903; FAX (310) 782-8599

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**PATIENT SAFETY**

1. **Communication:** Unapproved abbreviations
2. **Patient Identification** – remember to use a “Time Out” before all invasive procedures or administration of blood products. The “Time Out” must be documented in the medical record.
3. **General Safety:** All Codes, by color
4. **Fire Safety:** Please review the nearest fire alarms, extinguishers and exits; understand “RACE” and “PASS”
5. **Preventing Infections:** Remember to wash your hands before and between patient contacts.
6. **Read backs:** Nurses should read back to physicians any verbal or phone orders given; lab or nursing staff should request the housestaff to repeat the critical results back to them.
7. **Risk Management** –Please promptly report medication and other medical errors by completing an “Event Notification Form”.
8. **Housestaff Supervision** – All procedures to be performed under the supervision of Attendings or supervising residents, unless previously deemed “competent” to perform procedure at hand by Program Director.

**OTHER**

**Autopsies** – Autopsies provide valuable training and feedback regarding patient care. Please obtain consent for autopsy when appropriate.

**Patient Advocate** - Please direct patients with complaints or special needs to Julie Flynn, ext 2151.