Calls about sick children: Launching your own triage system

By Barton D. Schmitt, MD

Here's what you need to know to get a telephone triage system up and running in your office. Second of two parts.

Pediatricians who delegate daytime calls about sick children to an office nurse alleviate a major frustration of pediatric practice, save money, and increase parent satisfaction by ensuring that calls are returned more quickly and reliably than they can be by a busy doctor. A properly trained triage nurse can handle most sick-child calls safely using protocols.

The first article in this series outlined an office triage system for daytime calls, including the basics of protocols and call documentation. This article describes how to hire and train a triage nurse, limit medical liability, deal with cost and capitation issues, and help parents adapt. For a discussion of nurse-staffed medical call centers that handle after-hours calls, see the article by Andrew J. Schuman, MD, on page 75.

Hiring and training a telephone nurse

Once you have established protocols and documentation procedures, the next step in setting up a telephone triage system is to hire and train a nurse to manage phone calls.

The right nurse. A pediatric RN with more than two years in pediatric practice is a good choice. Experience with infants and toddlers is helpful since most calls are about this age group. A calm, reassuring voice quality is also desirable.

Many offices hire LPNs rather than RNs to reduce costs.[1] Since the telephone triage nurse works closely with the physician, this is probably a safe practice. Physician assistants or nurse practitioners are overtrained for the telephone triage role.

Printed materials. Provide the triage nurse with printed protocols, which she can study on her own time to learn about the triage process. Learning goes more quickly if the protocols list the reasons behind each decision. One protocol book (*Pediatric Telephone Protocols*[2]) includes a user's guide that makes the manual more self-instructional. Some physicians have the nurse restrict her practice initially to the top 10 to 20 symptoms reported by patients (Table 1). Most of these involve common infections of the respiratory and gastrointestinal systems. Twelve symptoms account for 60% of sick-child calls

THE AUTHOR is Professor of Pediatrics at the University of Colorado School of Medicine and Director of General Consultative Services and Medical Director, After-Hours Call Center, The Children's Hospital, Denver. He is a member of the Editorial Board of *Contemporary Pediatrics*.

August 1998

and 25 account for 90% of calls.[3] (In areas with year-round warm weather, insect bites, swimmer's ear, and sunburn may be added.)

Targeted teaching. Training needs to target the following areas specifically:

■ *Choosing the most appropriate protocol.* Learning how to do this is often difficult since many protocols require the user to consider a list of related triage protocols before choosing and entering one of them. The most specific protocol that applies to the patient provides the most pertinent triage and advice. Someone choosing the cough protocol, for example, may be reminded to determine whether the asthma protocol is appropriate for this caller.

■ *Evaluating the caller's diagnosis.* Although callers can report symptoms, the caller's diagnosis of a disease shouldn't be accepted until it has been compared to a list of diagnostic criteria contained within the protocol (chickenpox, for example).

■ *Recognizing subtle serious symptoms.* Such symptoms, which require immediate attention, include any sickness in a newborn, a swollen or tender testicle, severe dysphagia, or symptoms that suggest unobserved poisonings or foreign body aspiration.

■ *Recognizing high-frequency safe symptoms.* These symptoms, which don't require an office visit if the nurse is able to provide appropriate reassurance to the caller, include yellow nasal discharge, yellow sputum, green stools, and "high" fever.

TABLE 1

Top 20 pediatric symptoms (in order of frequency)

1. Fever
2. Vomiting
3. Earache
4. Sore throat
5. Cold symptoms
6. Cough
7. Diarrhea
8. Head trauma symptoms
9. Abdominal pain
10. Bone/muscle trauma symptoms
11. Eye—with pus
12. Crying child
13. Skin trauma
14. Croup symptoms
15. Rashes, widespread, cause unknown
16. Ear—pulling at
17. Symptoms of immunization reactions
18. Constipation
19. Chickenpox symptoms
20. Asthma attack

Source: Poole SR, Schmitt BD, et al[3]

Experienced nurse trainers. After book learning, the best learning occurs while actually taking calls rather than in a classroom setting. A trainer or preceptor is essential. You may already have such an experienced nurse in your office, or you may be able to hire the services of one from a nearby medical call center or large group practice. By listening to calls through a "Y" connector or speaker phone, the trainee can observe the experienced nurse manage calls and complete log sheets for one shift. Most trainees then need to take calls themselves under the supervision of the experienced nurse for two shifts.

Over the following two or three months, either the experienced nurse or the physician needs to be readily available for additional training. Most offices require nurses to take all calls by protocol for at least six months. After that, you can assume that the nurse has memorized some of the protocols for routine symptoms. She can then look at the protocols selectively for unfamiliar or uncommon symptoms or when she is uncertain what to do next.

Interviewing skills. In addition to providing appropriate triage and advice, the telephone nurse must satisfy the caller. This requires good interviewing technique. The nurse should identify herself by name and try to use the name of the parent and child. Her voice must be calm, and she must convey that she is receptive to the call (for example, by saying "How can I help you?"). She needs to be a good listener initially, becoming more focused and directive only after a minute or so has passed. She must provide practical home care advice as well as reassurance about the child's condition, especially if the caller is anxious. She should give explanations and instructions in simple terminology and state clearly the reasons for which the

caller must call back. The nurse should be the child's advocate, suggesting whatever is in his best interest, and always try to help the caller, even if the caller is being difficult.

Call response time. A main complaint of callers is lack of immediate access to the doctor's office. If callbacks are delayed more than 30 minutes, some parents may need to leave for work. Others may be angry when the call is returned. Calls should be taken directly by the triage nurse (via the receptionist) when possible. If not, callbacks should be made quickly. Too many busy signals mean that your office needs more phone lines. There should be at least one incoming line per physician. If your office uses an automatic taped message, it should be no longer than 20 seconds. Before placing a caller on hold, first ask if he or she has a serious problem.

The most effective way to avoid telephone traffic jams is to have the triage nurse available in the office one or two hours before it opens, especially on Monday mornings. This time was previously known at the "telephone hour." Inform parents by office newsletter or other handout that during the first two hours of each day the phone lines are available only for parents with sick children. This will go a long way toward helping working parents whose child has become ill during the night. Some large groups may need extra triage nurses during the morning hours. Allowing parents to request an appointment directly from the receptionist also cuts down on backed-up calls.

Rx

Take-home message

The best way to avoid telephone traffic jams is to have the triage nurse available for sick-child calls one to two hours before the office opens, especially on Mondays.

Productivity. The average length of a triage call should be about four minutes.[1] Maximum call length should be six minutes. Some calls require a secondary call to a pharmacy, which adds another two or three minutes. A minimum of 10 calls per hour is a reasonable goal. This excludes calls to the receptionist for appointments only. Callback time for urgent calls should be less than 10 minutes. Average wait time for nonurgent callbacks should be 10 to 15 minutes. Additional staffing is needed if nonurgent calls can't be returned within 30 minutes.

To increase productivity and save time, the nurse should:

- Give appointments on demand without triage. There's no need to triage if the parents have already self-triaged. The triage nurse should be able to make appointments easily without transferring the call back to the receptionist.
- Keep triage brief. Focus the caller and try to determine the most serious symptom. Stop asking questions as soon as you get a positive answer.
- Keep advice brief, especially if the patient will be seen that day.
- Use printed aids such as dosage charts for common OTC drugs and lists of phone numbers for all local pharmacies (this can simply be a copy of the Yellow Pages listings).
- Use brief documentation. Many nurses find it difficult to write less and state "per protocol" for advice. For most calls, document only on a log sheet rather than in the chart. Don't pull charts for routine documentation.
- Avoid the tendency to provide telephone therapy. If the caller is requesting information about a complex problem, such as bedwetting, mail or fax the person an information sheet on the subject rather than try to explain it by phone. Some offices establish an endpoint for calls: If you can't solve the problem in five minutes, have the patient come in.

Setting up a quality improvement system

The best risk-management measures are to use the best triage protocols available, hire excellent nurses, and provide excellent training.[4] Most quality improvement relies on continuing nurse education. The physician should:

- Be available between patients for questions about calls.

Continued on page 54

TABLE 2

Quality assurance checklist

Written documentation on telephone log sheets

Nurse's name _____

Patient's name _____ **Date of call** _____

1. Legible handwriting	Yes ☐	No ☐
If not, comment: _____		
2. Patient registration complete	Yes ☐	No ☐
If not, comment: _____		
3. Symptoms and protocol		
Duration of symptom is recorded	Yes ☐	No ☐
Protocol used is recorded	Yes ☐	No ☐
Box checked that protocol questions were asked	Yes ☐	No ☐
Protocol is appropriate for symptoms	Yes ☐	No ☐
If not, comment: _____		
4. Disposition		
Reasonable disposition per protocol	Yes ☐	No ☐
If not, comment: _____		
If patient is to be seen, the reason is recorded	Yes ☐	No ☐
5. Drug dosage		
If OTC or prescription drug is recommended, the dosage is clearly recorded	Yes ☐	No ☐
If not, comment: _____		
6. Comments section		
If present, the comments are clear and helpful	Yes ☐	No ☐
If not, comment: _____		
7. Time per call		
Three times are recorded	Yes ☐	No ☐
Call lasted _____ minutes, which is reasonable	Yes ☐	No ☐

■ Monitor all log sheets of all calls taken by new triage nurses for at least two weeks or until you are satisfied that the nurse's judgment and documentation are reliable. Review the log sheets with the nurse before she leaves each day.

■ Thereafter, do spot checks of selected calls at least once a week. It's a good idea to review high-risk calls such as those concerning infants less than 90 days old and abdominal pain. Table 2 provides a sample of a quality assurance checklist for more formal performance reviews.

■ Discuss any errors you detect with the triage nurse.

■ Provide the triage nurse with articles from the pediatric literature that relate to telephone triage (the risks of salmonella diarrhea from pet reptiles, for example)

■ Provide ongoing targeted training on topics such as preferred OTC drugs for various symptoms. This can be done at weekly lunch meetings.

■ Review any complaints from callers and discuss your findings with the triage nurse.

Limiting liability

The main cause of lawsuits related to telephone calls is damage from delayed diagnosis and treatment.[5] Potential causes of harmful delays include:

■ A caller with a life-threatening emergency can't get through

■ The triage nurse doesn't refer a child with an emergent condition into the office immediately

■ The triage nurse tells the parents of a child with a life-threatening emergency to come into the office by car instead of referring them to emergency medical services (EMS)

■ The triage nurse refers a child into the office immediately, but the parent doesn't bring her in and claims we didn't tell them to come in.

Recognizing true emergencies. Every person who takes part in the telephone intake process needs to be alert for true emergencies. The parent's common sense will recognize most life-threatening situations, and the parent will usually call 911 without prompting. When a parent who needs EMS calls the doctor's office by mistake, the receptionist or triage nurse needs to reroute the call. If the office uses an audiotaped message, the first comment on the tape must be, "If this is a true emergency, hang up and

call 911." The receptionist needs to have a simple list of obvious life-threatening or major emergencies to refer to (Table 3). Before putting someone on hold, the receptionist must ask "Is this an emergency?" and listen to the reply.

The triage nurse must be well trained in recognizing all life-threatening emergencies (including subtle ones such as shock) and know how to reroute them quickly to 911, send them to the emergency department, or involve an office physician, sometimes by pager. She also needs to be adept at recognizing and dealing with urgent and semiurgent calls that are not emergencies. Table 4 presents a checklist for the triage nurse of emergency and urgent calls. The office protocols need to have an EMS (911) disposition category for all serious symptoms.

Preventing lawsuits. Proactive measures targeted to counteract the most common causes of lawsuits are the best way to prevent them.[6,7] The triage nurse must adhere to these essential risk-management measures:

- If a serious problem is possible, have the patient seen in the office. Always be ready to lower the threshold for seeing patients.
- Keep a log of every incoming sick-child call that is handled by a nurse. This log can substantiate that you weren't called if a parent falsely states that she or he did call. All calls to the receptionist for appointments will be logged only in the appointment book.
- Always ask about active chronic disease. The caller may assume your office already knew about the chronic condition or fail to see the connection between the symptom and the underlying disease.
- Don't accept the caller's diagnosis without ascertaining the symptoms.
- Document the recommended disposition of all calls that are triaged by a nurse. This will counteract any false accusation that the patient wasn't referred to the office immediately. Most lawsuits relate to delayed referral for medical care.
- Document instructions to the caller concerning when to call the office again. Encourage all callers to call back if the patient's condition worsens or any complications occur. Also advise them to call back if the problem persists too long—vomiting longer than two days or fever longer than three days, for example.
- Document prescribed drug dosages, including dosages of OTC drugs. This is especially important in the first two or three years of life when dosage errors can have greater repercussions. Also have the caller repeat the dosage, because communication errors are common with numbers.
- Allow the caller to override the protocol and have the child seen in the office. Unlike after-hours visits, office visits need to be client-driven. Initiate a callback on any patient who worries you or the parent, such as a child with croup or head injury.

TABLE 3

EMS (911) checklist for the receptionist

Purpose: *To identify obvious life-threatening emergency calls*

Response: *Redirect these calls to EMS (911) immediately*

Severe breathing problems

Breathing stopped

Choking and unable to breathe or turning blue

Difficulty breathing following a bee sting, medication, or foods (concern for severe allergic reaction or anaphylaxis)

Severe bleeding

Blood is pumping or spurting from the wound

Blood is pouring out and can't be stopped with direct pressure

Severe neck injury (advise caller not to move the child until EMS arrives)

Seizure or convulsion in progress (hasn't stopped)

Can't wake up child (unconscious or in a coma)

Handling physician callbacks

The calls on the physician nonurgent callback list are generated mainly by the telephone nurse. The size of the list is thus inversely proportional to the amount of responsibility delegated to the office nurse. The list also includes follow-up calls requested by the doctor. Most of these are one-day follow-ups on patients seen for potentially serious problems—a 2-month-old baby with vomiting, for example. The following guidelines can help increase the efficiency of physician callbacks:

- Make callbacks in clusters—every two to three hours, for ex-

Continued on page 62

TABLE 4

Emergency/urgent call checklist for the triage nurse

Purpose: *To identify incoming calls that are potential emergencies or urgent problems*

Response: *Emergency calls will be returned within 5 minutes (some may have to be referred to EMS [911])*
Urgent calls will be returned within 15 minutes

Emergency calls

Difficulty breathing (choking, stopped breathing, weak breathing, stridor, cyanosis, or other signs of respiratory distress)

Possible anaphylaxis (difficulty breathing or swallowing after medicine, bee sting, food, or other possible allergen)

Severe bleeding

Neurological symptom from any cause (seizure, loss of consciousness, fainting, hard to awaken, confusion, altered mental status, stiff neck)

Poisoning, drug overdose

Foreign body (inhaled, choking on, or swallowed)

Neck trauma

Eye trauma

Electric shock

Near drowning

Suicide threat or attempt

Urgent calls

All other trauma (not neck or eye)

Asthma, wheezing, or croup (with no mention of difficulty breathing)

All other foreign bodies (ear, nose, vagina) except slivers

Bleeding (including blood in vomit or stool) unless bleeding has stopped

Burns, except sunburn

Bites (animal, snake, spider, marine animal, bee, yellow jacket), except insect (mosquito, fly) or tick bites

Fever higher than 105° F (not caller's statement of "high fever")

Infant under 3 months of age with fever or acting sick (not diaper rash, cradle cap, constipation, cord care, or feeding concerns)

Severe pain (especially in the abdomen, head, or chest)

Possible dehydration

Purple rash (purple spots or dots)

Heat exhaustion or stroke

Hypothermia (body temperature lower than 95° F)

Psychosocial emergencies (sexual assault, child abuse, domestic violence)

ample. You may wish to block off 15 minutes every two hours on your schedule to return calls. If you save all the calls until the end of the day, you may find that some involve patients who need to be seen, or you may end up leaving the office late.

- Instruct the office nurse to give the parent an approximate time at which to expect a callback from the doctor. This prevents frustration from inordinate waiting.
- Have the patient's chart available for callbacks since most calls require a notation. Others require information about drugs and dosages prescribed earlier, especially for patients with chronic disease.
- Take steps to prevent unnecessary phone calls from demanding parents. A few parents will speak only to the physician, even though they are not calling about an emergency or complex problem. It is up to the doctor to correct this misunderstanding. The office nurse can indicate that the physician is busy and will call back later. She can then say, "Perhaps I could help you in the meantime." If the parent does not accept this offer, call back later and discuss his or her concern. After meeting the caller's needs, you can add: "This could have been handled by the advice nurse. She is well trained and knows when I am needed. Please talk with her in the future about this type of problem. It will save you time."

Promoting cost effectiveness

The main cost savings in an office telephone triage program come from delegating this task to an RN

or LPN rather than having the doctor do it. In Denver, RNs with four years of training cost $13 to $14 per hour in office practice. (RNs working in after-hours programs are paid more because of the undesirable hours.) LPNs with two years of training cost $9 to $10 per hour. Delegating telephone triage to a physician assistant or pediatric nurse practitioner is not only inappropriate but also more costly. Phone calls are a necessary evil and an expected free service by most families. Since they are an unreimbursed expense, they never make money for the practice.

Additional savings on phone service come from having a receptionist make appointments for patients who don't need to speak with the nurse, from handling calls efficiently, and from keeping each phone call to a minimal required time. Reducing the overall volume of unnecessary incoming calls also helps, but it requires ongoing parent education and is usually difficult to accomplish.

Dealing with capitation

Capitation with a set reimbursement per patient makes every office visit an expense rather than a profit. While the physician can't control the number of incoming phone calls, he or she can control how they are handled. To serve more patients within a set amount of office hours under capitation, the physician needs to decrease office visits by increasing telephone contacts and other forms of education. This is called demand management.

℞ Take-home message

Only about 30% of incoming calls during office hours currently result in patients being cared for at home. Theoretically, this percentage can be doubled to 55% or 60%.

Once capitation covers more than 40% of patients in a practice, demand management requires that very few callers be given an appointment by the receptionist automatically. Instead, a nurse will triage most calls. More patients will be observed at home for two hours rather than automatically seen in the office. More prescriptions will be called in by protocol. More instructions will be faxed to parents at home.

In after-hours systems where nurses triage all incoming calls by protocol, we know that approximately 20% of patients need to be seen immediately, 25% can be seen in the office the next day, and 55% can be cared for at home.[3] Currently, only about 30% of incoming calls during office hours result in patients being cared for at home.[1] Theoretically, this percentage can be doubled to 55% or 60%.

Caller satisfaction will always be very important, even under capitation. Parents must be allowed to override the protocol during the day. Fortunately, there are natural disincentives to coming into the doctor's office, namely travel time, babysitter arrangements, and copayments. When callers say that they want an appointment, the triage nurse can ask, "Would you like to see if I can save you an office visit?" If the caller declines and comes in for an unnecessary visit, the advantages of telephone triage will become apparent or can be emphasized at the end of the visit. Parents of a firstborn often require several needless office visits before they can substitute telephone reassurance for the reassuring physical examination.

Reducing unnecessary calls

Self-triage and self-care are the answers to unnecessary calls and office visits. The following techniques have proved effective in encouraging parents to handle minor problems at home:

- Encourage parents to read before calling. Give home care instruction sheets for common illnesses in advance. During an office visit for an acute illness, again redirect the parent to the instruction sheets.
- Give parents dosage charts to be kept at home for common OTC medicines.
- Provide access to a telephone advice service, such as the Parent Advice Line, which has 275 one- to two-minute messages, and can be reached by means of a special

Continued on page 70

telephone number in each community. Hospitals or health plans usually pay the costs of the advice line.

■ Encourage parents to actively participate in their child's health at every encounter.

Helping parents adapt

Parents who are accustomed to calling their pediatrician's office and talking to the doctor may be reluctant to talk to the triage nurse. They need to be reassured that the nurse has been carefully trained and uses protocols, that she works closely with and has direct access to the physician, and that she has the advantage of being more available to handle their calls. These issues can be dealt with in a flyer, brochure, or office newsletter. It's often helpful to include the nurse's picture and information about her previous training and experience.

Most parents can easily be taught to use the telephone system you decide on. Providing them with an information sheet about the system at their first office visit will improve compliance. The sample telephone policy statement on the facing page outlines the telephone system that has been described thus far. You can use it as a template for writing your own parent information sheet.

Reviewing the start-up checklist

As you plan your office telephone triage system keep the following checklist in mind:

■ ***Choose a protocol system.*** Writing your own is too time-consuming. Review the protocols you've chosen and modify them as needed.

■ ***Establish a documentation system.*** Keep track of all sick-child calls on a log sheet. Choose a system from the three types of log sheets described in the previous article. Require that the triage nurse record the recommended disposition. Allow space to check off when standard advice is given per protocol. Transfer the information to the chart only in selected cases.

■ ***Set up a training system for the telephone triage nurse.*** Provide a minimum of three days of training by an experienced nurse. If you are reluctant to transfer this responsibility, start small by teaching the triage nurse to cover all calls about the top 10 symptoms and how to select the correct protocol.

■ ***Establish an ongoing quality improvement process.*** Regular discussions between you and the triage nurse about unusual or difficult calls usually suffice.

Summing up

An office pediatrician can safely delegate over 90% of daytime parent phone calls to a triage nurse. The phone lines for appointments and advice should be staffed at least one hour before the office opens to deal with the large volume of early morning calls. The receptionist takes care of callers who simply want to make an appointment and refers other calls to the telephone nurse for triage or advice. The triage nurse should also be able to schedule appointments quickly when necessary.

The triage system must include a procedure for handling emergencies. When uncertainty exists as to whether the office can handle a specific type of potential emergency, the physician should become involved in the decision-making process. □

The author is grateful to Drs. Vince DiMaria and Nick Tschetter for their careful reviews of this manuscript. He would also like to thank the following large pediatric group practices in metropolitan Denver, which completed the surveys and provided the data that made this article possible:

Academy Park Pediatrics
Arapahoe Park Pediatrics
Aurora Pediatrics & Associates
Arvada Pediatrics
Centennial Valley Pediatrics
Cherry Creek Pediatrics
Children's Medical Center
Creekside Pediatrics
Greenwood Pediatrics
Littleton Pediatrics Medical Center
Mountain Land Pediatrics
Pediatrics at DTC

REFERENCES

1. Schmitt BD: Survey of 12 large pediatric group practices: How sick-child calls are managed. January 1997 (unpublished data)
2. Schmitt BD: *Pediatric Telephone Protocols.* Littleton, CO: Decision Press, 1994 (revised 1998) (Office Version 1998 available from American Academy of Pediatrics Publications, 800-433-9016; After-Hours Version 1998 available from Decision Press, 5121 Pinyon Dr, Littleton, CO 80123)
3. Poole SR, Schmitt BD, et al: After-hours telephone coverage: The application of an area-wide telephone triage and advice system for pediatric practices. *Pediatrics* 1993;92:1
4. Bergman DA: Quality improvement: Buzz words or boon? *Pediatr Rev* 1993;13:208
5. Katz HP, Wick W: Malpractice, meningitis, and the telephone. *Pediatr Ann* 1991;20:85
6. Isaacman DJ, Verdile VP, Kohen FP: Pediatric telephone advice in the emergency department: Results of a mock scenario. *Pediatrics* 1992;89:35
7. Yanovski SZ, Yanovski JA, Malley JD, et al: Telephone triage by primary care physicians. *Pediatrics* 1992;89:701

FOR PARENTS

About our office telephone policy

Emergency calls (day or night)

- Call 911 (emergency medical services) for life-threatening emergencies in which your child may require resuscitation (your child is not breathing, is choking severely, is unconscious, or is having seizures, for example).
- Call our office for minor emergencies such as dehydration, difficulty breathing, wounds that need suturing, or fractures. When you call in, always state clearly, "This is an emergency." Do not let the answering service or office staff put you on hold.
- For poisonings, call the poison control center at _____.

Calls about sick children during office hours

We see sick children by appointment only. Our office hours are:

Weekdays _____ to _____, Saturday _____ to _____, and _____, Sunday _____ to _____.

The telephone nurse is available to take your calls _____ minutes before the office opens.

If your child is sick and you want the doctor to see him, call ahead for an appointment so you won't have to wait. Try to call us about sick children during early morning office hours.

All medical calls are screened by a telephone nurse who has been specially trained to make decisions about which patients need to be seen by the doctor and how to provide home care for children who don't need to be seen. If the nurse can't help you, she will ask you to bring your child to the office or have your physician call you back.

If the office staff is busy and can only take a message, ask for an approximate callback time. While waiting for a callback, try to keep your line open. If your call isn't returned within 60 minutes after the predicted callback time, call again. In general, we try to return calls within 15 minutes. Keep in mind that Monday mornings are the busiest time.

Working parents with sick children

We keep appointments open during the last hour of the day for sick children who need to be seen after school or day care. Make sure your babysitter or day-care center understands that they should call you before 3 p.m. if your child becomes ill. If you think your child may need to be seen the same day, please call before our office closes.

Well-child questions

We are happy to provide you with the health information you need to be a better parent. Please place calls about behavior questions or other well-child issues during weekday office hours. The best time to call is usually early afternoon, when our switchboard is least busy.

Prescription refills

We phone in prescription refills to pharmacies only during office hours because we need to have your child's chart handy to check on dosages and disease status. Plan ahead so you don't run out of important medicines. Always have the phone number of your pharmacy handy when you call the office.

Nighttime (after-hours) calls

After office hours, call us only for emergencies or urgent problems that can't wait until morning. Calls about mild illnesses can usually wait. We need to keep our line open at night for urgent calls. After office hours your calls will be received by an answering service and transferred to your physician or the telephone nurse who is covering your physician's calls. The doctor or nurse will usually return your call within 15 minutes. If you do not receive a callback within one hour in a nonemergency situation, please call again.

Weekend and holiday calls

If your child becomes ill or is injured during a weekend or holiday, call our answering service. If possible, call before noon so we can plan the day. After 5 p.m., limit calls to emergencies or other urgent problems that can't wait until morning.

Please have the following information available when you call (except in emergencies):

- Your child's main symptoms
- Any chronic disease or health problem your child has
- Your child's temperature if she is sick
- Your child's approximate weight (for calculating drug dosages)
- The names and dosages of any medicines your child is taking
- Your pharmacy's telephone number
- Your questions (it's a good idea to write them down)

Always have a pencil and paper handy to take down instructions, and have your child nearby, in case you need to check something about her condition.