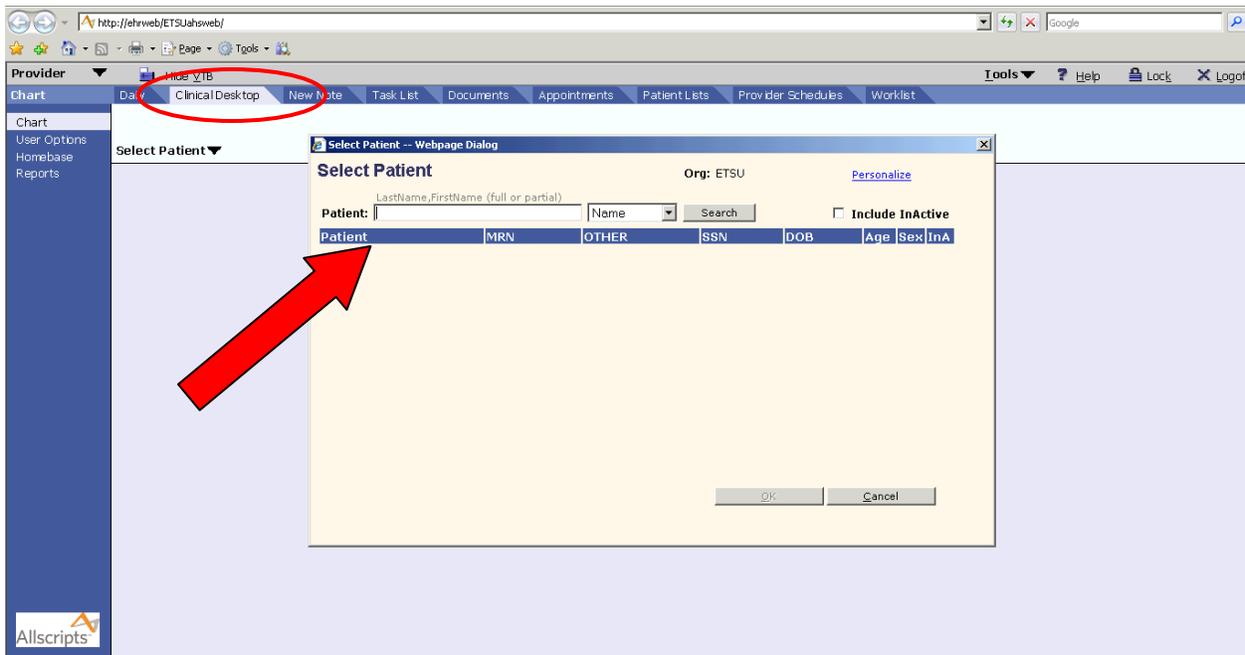


Preloading

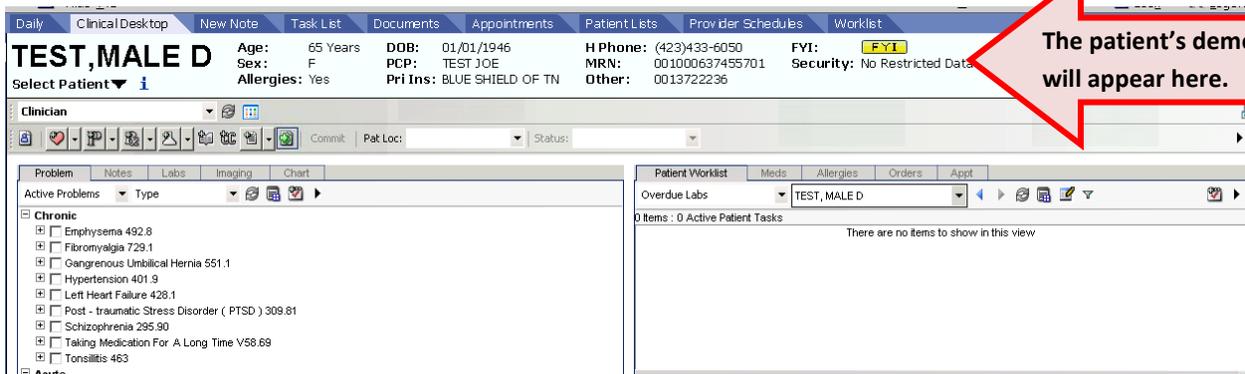
Preloading your patients' charts is highly recommended before their visit. Not only does preloading allow you to practice in the Allscripts EHR system, but your encounter time with the patient will also be cut down, as preloading is time consuming, especially for new users and/or patients with long medical histories and multiple medications.

Accessing the patient's chart

First, click on the Clinical Desktop tab on the horizontal toolbar and search for your patient.

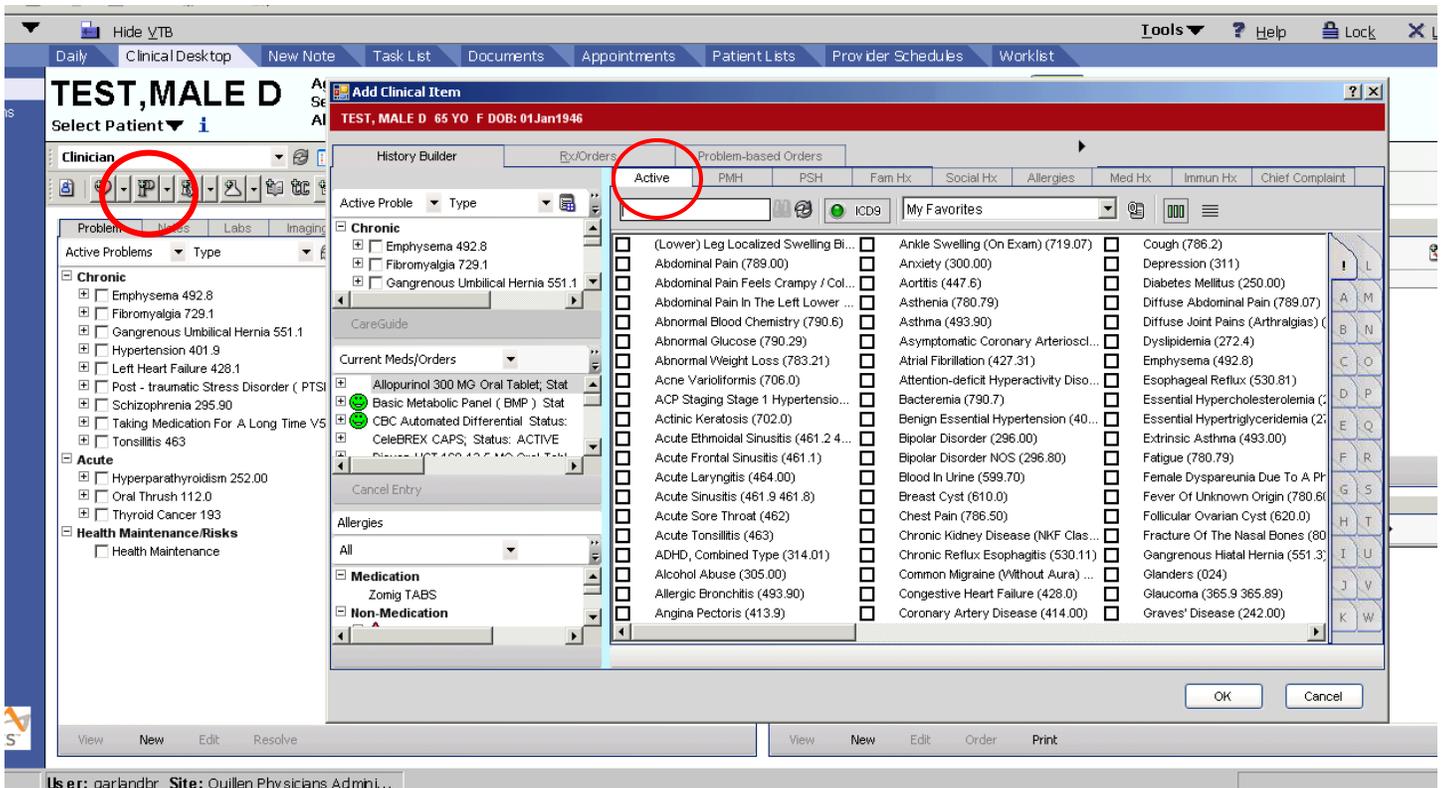


Make sure the correct patient was pulled into the patient banner.

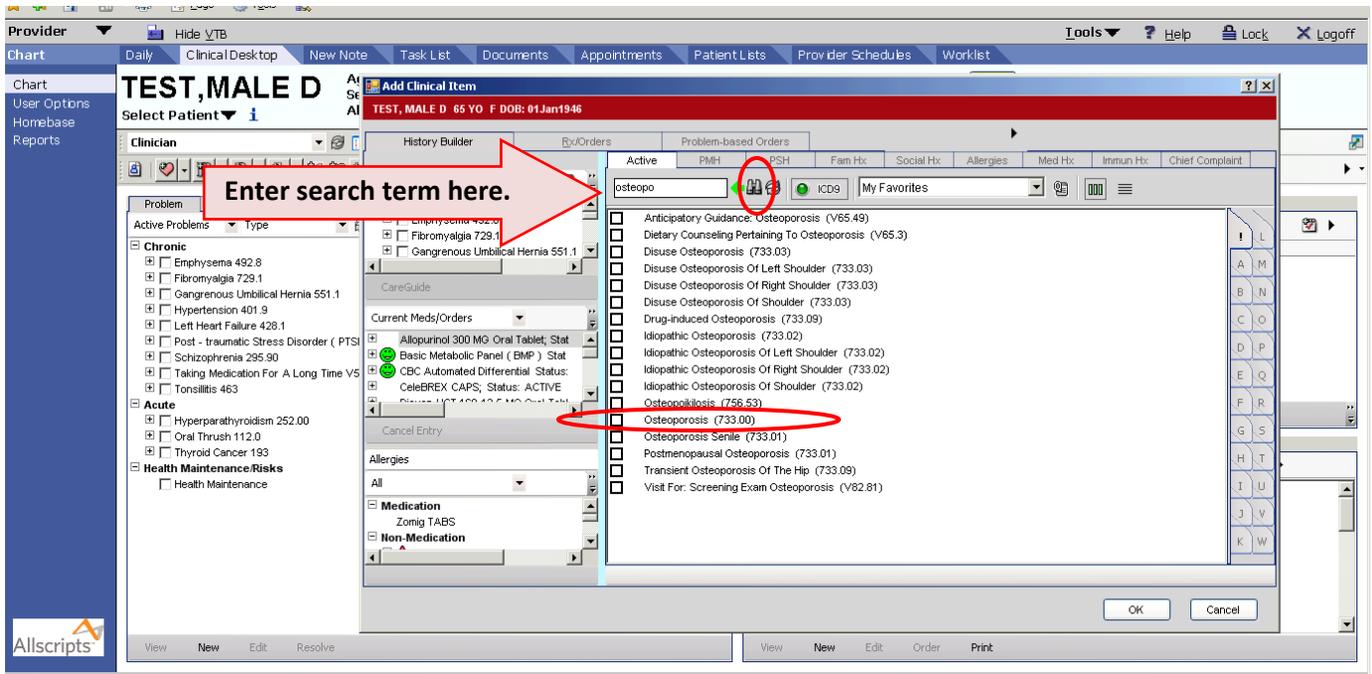


Preloading Basics

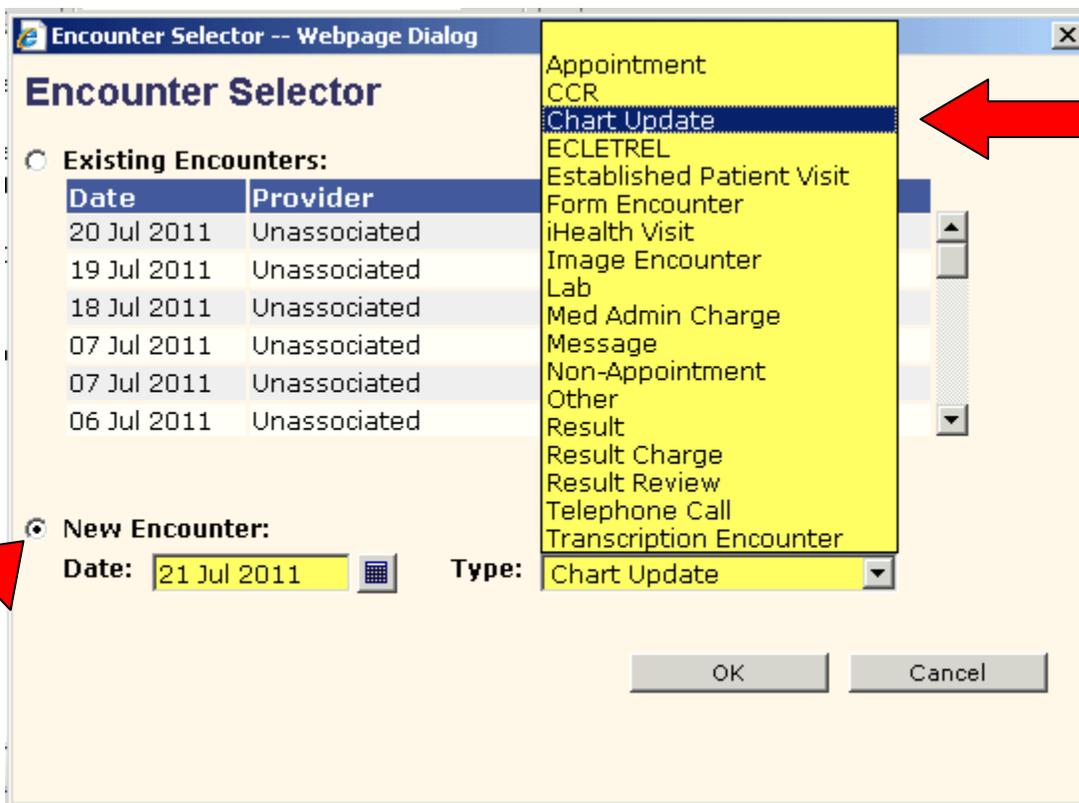
To begin preloading, click on the “P” icon on the Clinical Toolbar , which will pull up your “Add Clinical Items” screen (ACI). By default, you will be brought up under the “Active” tab, where you will add the patient’s active problems.



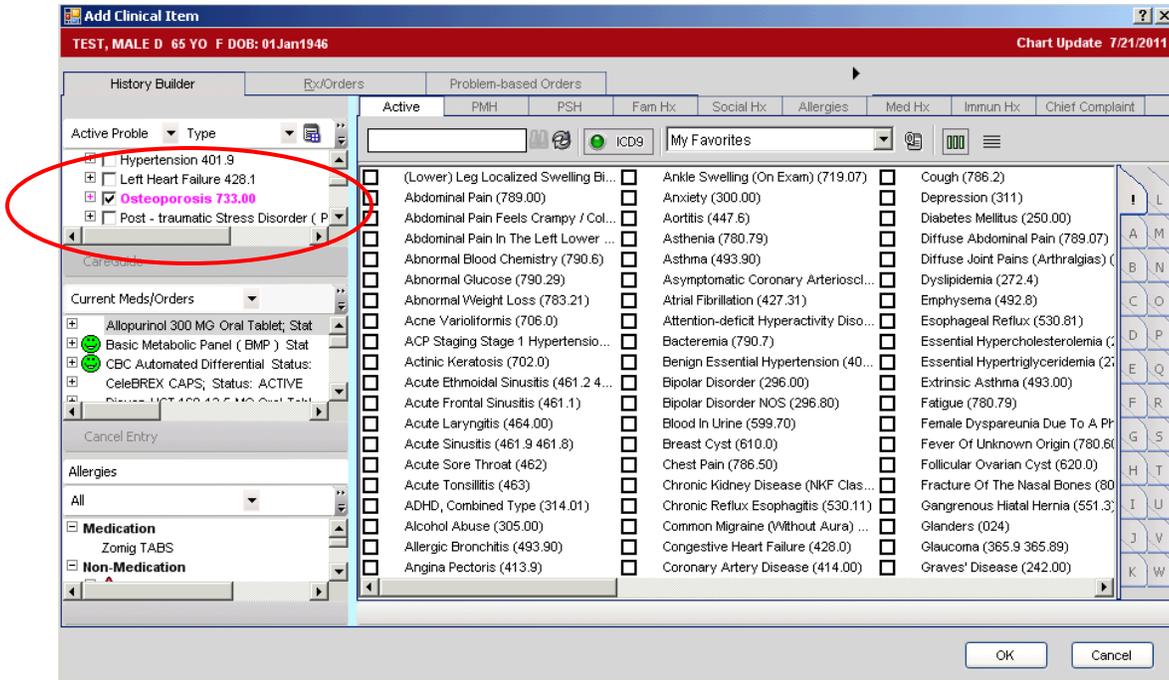
Search for the patient’s active problem by typing in the first few letters of the problem and click on the binoculars.  In the example below, we are adding osteoporosis. A list of problems which contain your search criteria will appear. Check the box next to the appropriate problem.



When you are preloading charts, after you select the first problem on each patient, an encounter form dialogue box pops up, prompting you to select the encounter type. Choose “New Encounter” and “Chart Update.” Then click “Ok.”



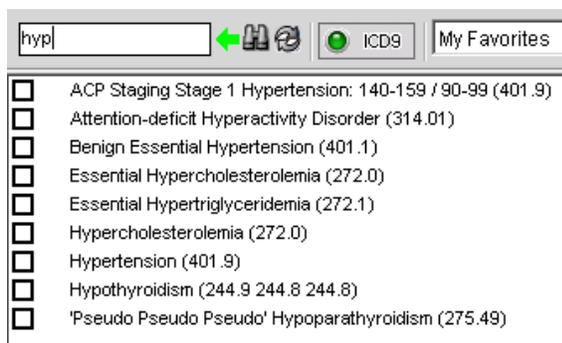
Notice that the problem you selected has been added to the history building section in the top left-hand corner and is written in magenta. This color indicates that the problem has not yet been saved.



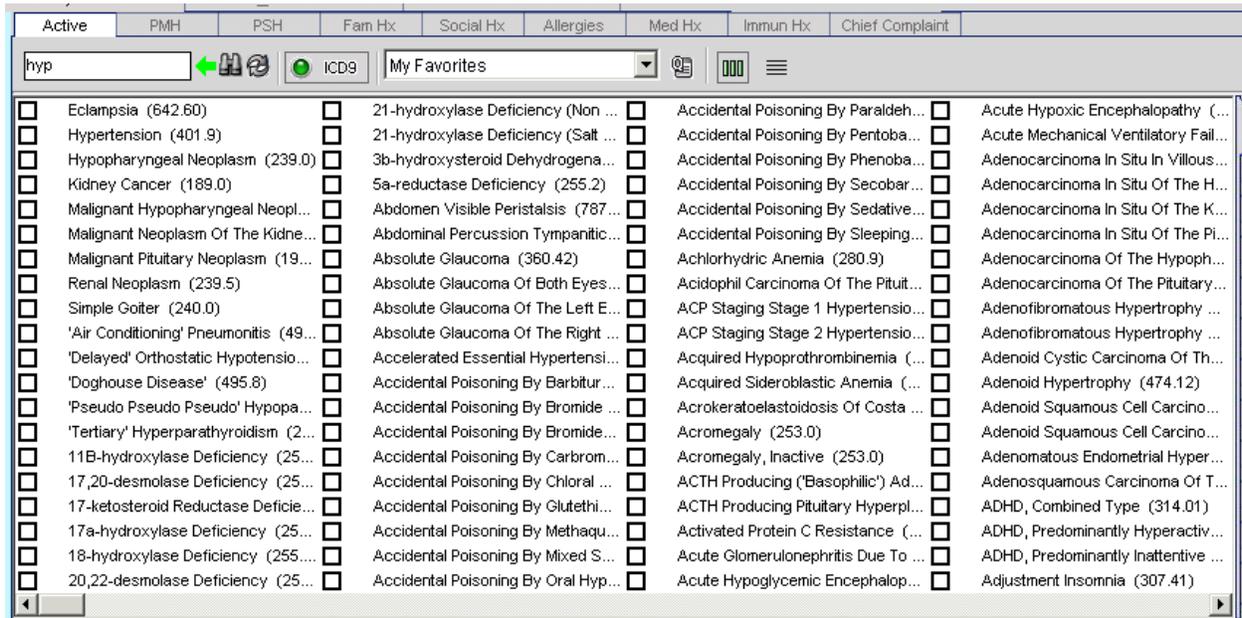
Searching Tips

When searching for a problem, notice that before you click on the binoculars, as you type in the letters of your search term, the list of problems begins narrowing. However, keep in mind that you are pulling from your Favorite Items list at this point. In order to search the master list of problems in Allscripts, you must click on the binoculars. When searching for hypertension, for example:

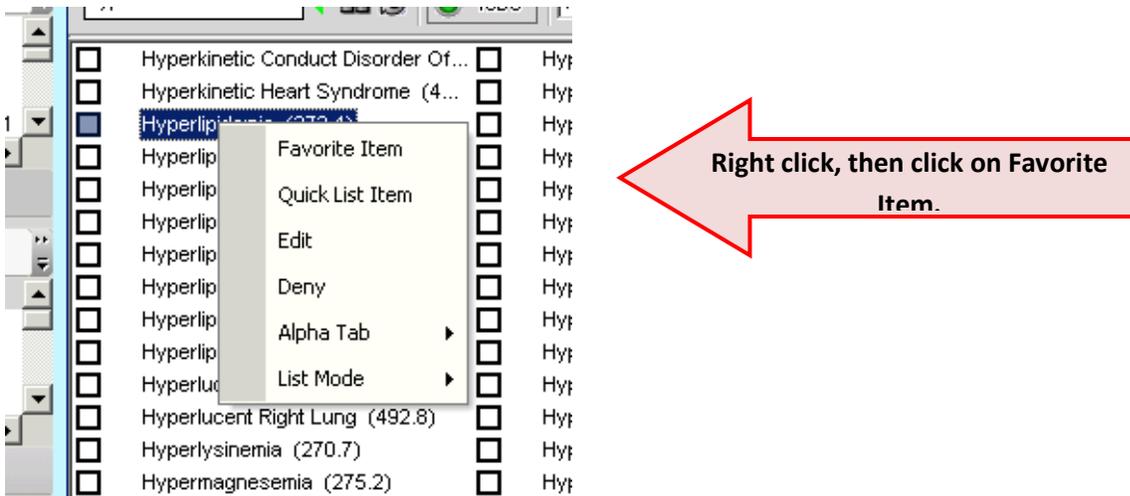
List before clicking the binoculars:



List after clicking the binoculars:



To add an item to your list of favorites, simply search for the item, and right click on it. Click on “Favorite Item” and a check box will appear, indicating the item is in your favorites.



You can add up to 200 items to your Favorites List. In addition to your Favorites List, you can also compile a “Quicklist.” You can add 50 items to your “Quicklist,” and when doing so, the item is automatically added to your Favorite Items list.

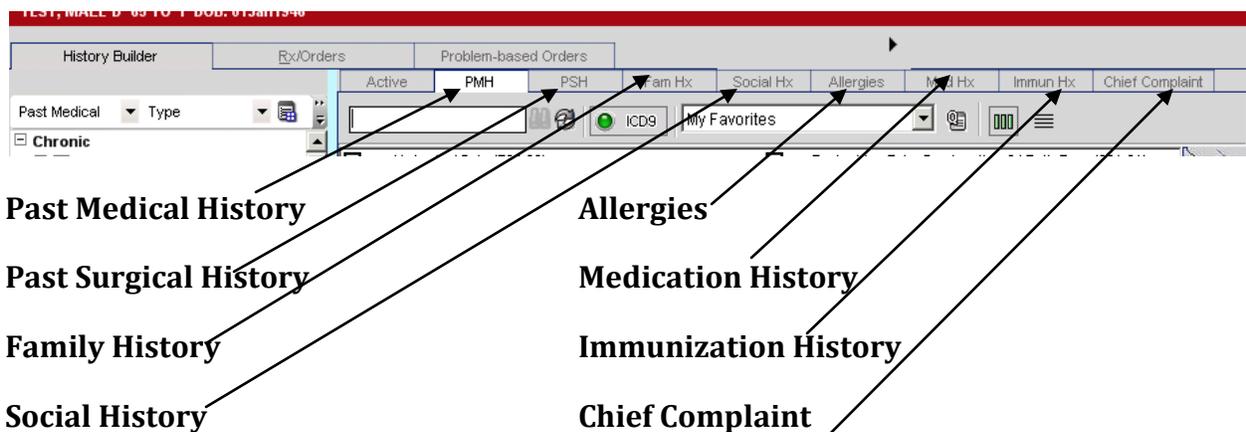
The process of adding to the Quicklist is the same as the above illustration for adding Favorite Items; simply click on Quicklist when you right click on the problem.

To access your Quicklist, click on the “Q” button next to the search box.



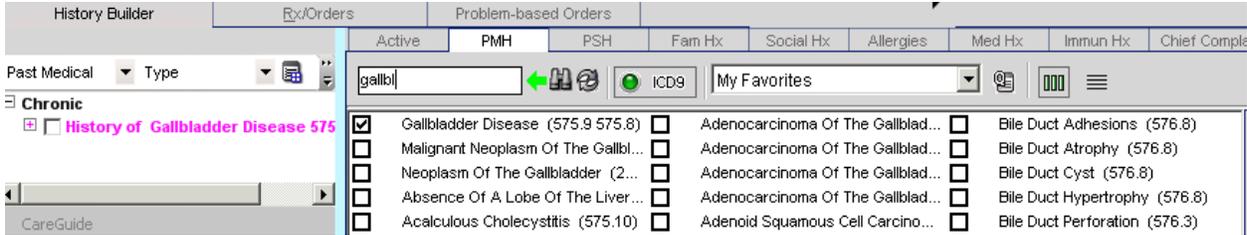
Adding Additional Items and Details

Additional medical items and details about those items are added through the ACI box as well. Click on the appropriate tab across the top of the box in order to locate the type of item you would like to add.



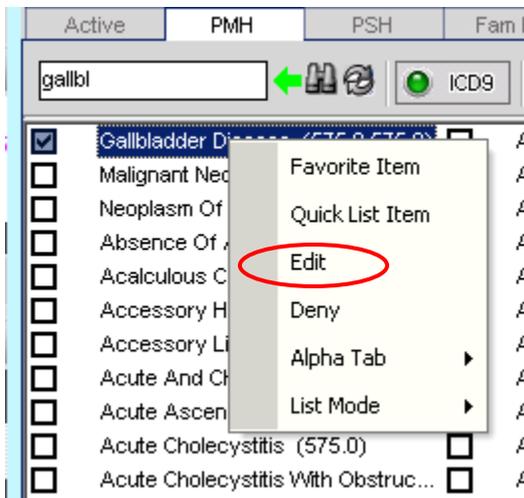
Once you have clicked on the appropriate tab, simply type in the search box and click on the binoculars.

In the example below, the user added a history of gallbladder disease to the patient's past medical history by clicking on the Past Medical History (PMH) tab and searching for gallbladder.



A history of gallbladder disease is added to the Past Medical History list in the top left-hand corner. Once again, the item is in magenta until it has been saved to the chart.

To add details about an item, right click on the item and select Edit.



A Problems Detail box will pop up. Within this box, you can add details about the particular item you have selected. In the example below, the user wants to document the Onset Date of the patient's gallbladder disease, as well as the severity and who has managed it.

Problem Details

TEST, MALE D 65 YO F DOB: 01Jan1946 Chart Update 7/21/2011

Gallbladder Disease ICD-9: 575.9

Annotations

History

Problem Details **Status:** Resolved

Chronic
 Acute
 Health Maint
 Include in PMHx
 Include in Active
 Last Assessed:

Onset Date 
Resolve Date: 

Description

Clin Progress:
 Category: History of
 Laterality:

Managed by: 
 Severity:
 Secondary to:

Provider
 Referring Provider
 Link Unverified Problem:

Clicking on the calendar icon  next to the Onset Date pulls up a calendar box in which you can select the onset date. Notice that you can choose “Approximately” if the patient was unsure about the onset date.

Select a Date and specific Time

Time period:

On
 Before
 After
 Approximately

Before next appointment
 With next appointment

Postoperative
 Preoperative

interval Postoperative
interval Preoperative

Never
 Childhood
 Unknown
 Adolescence

Date:

July 2011						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

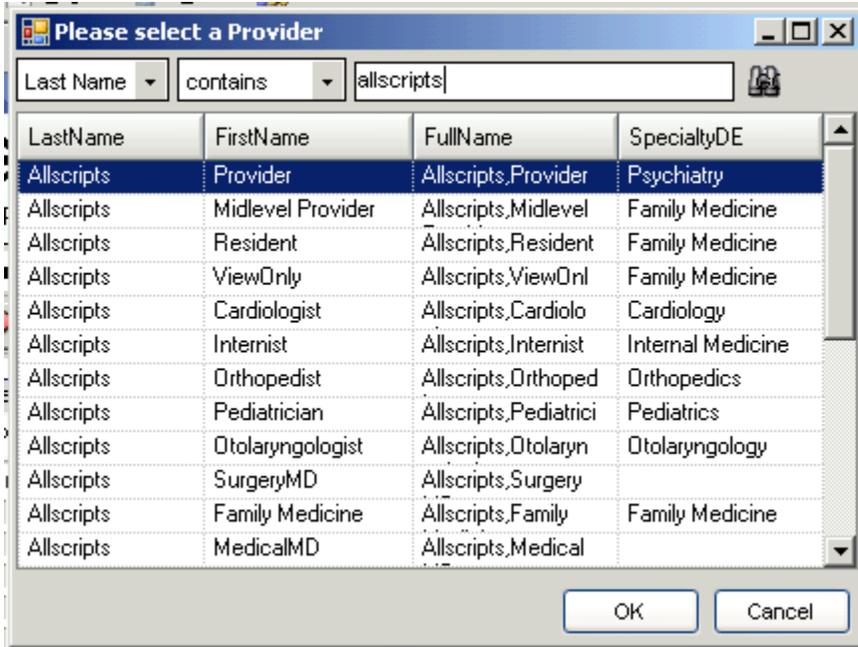
August 2011						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

Interval: weeks

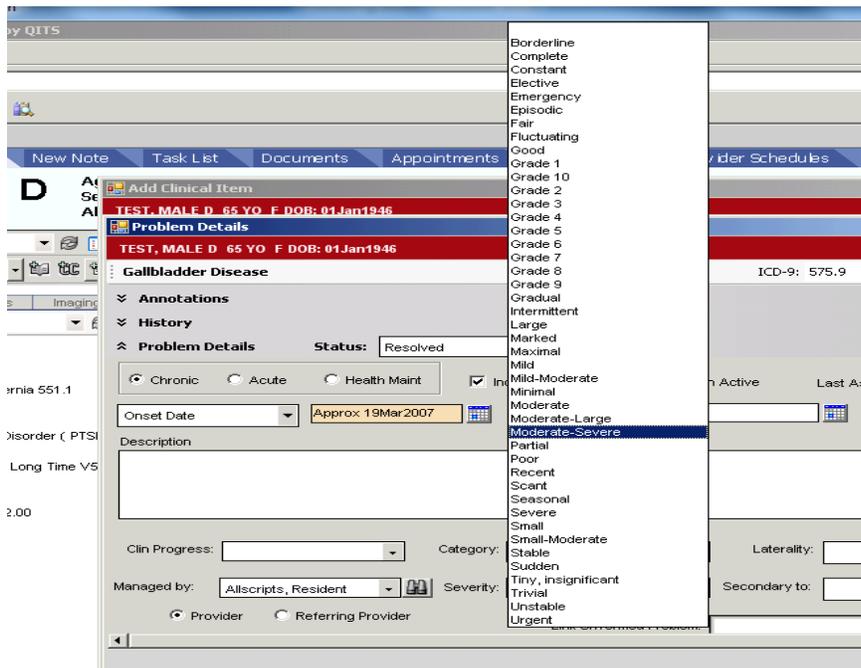
Jump: weeks

Selection: 21Jul2011

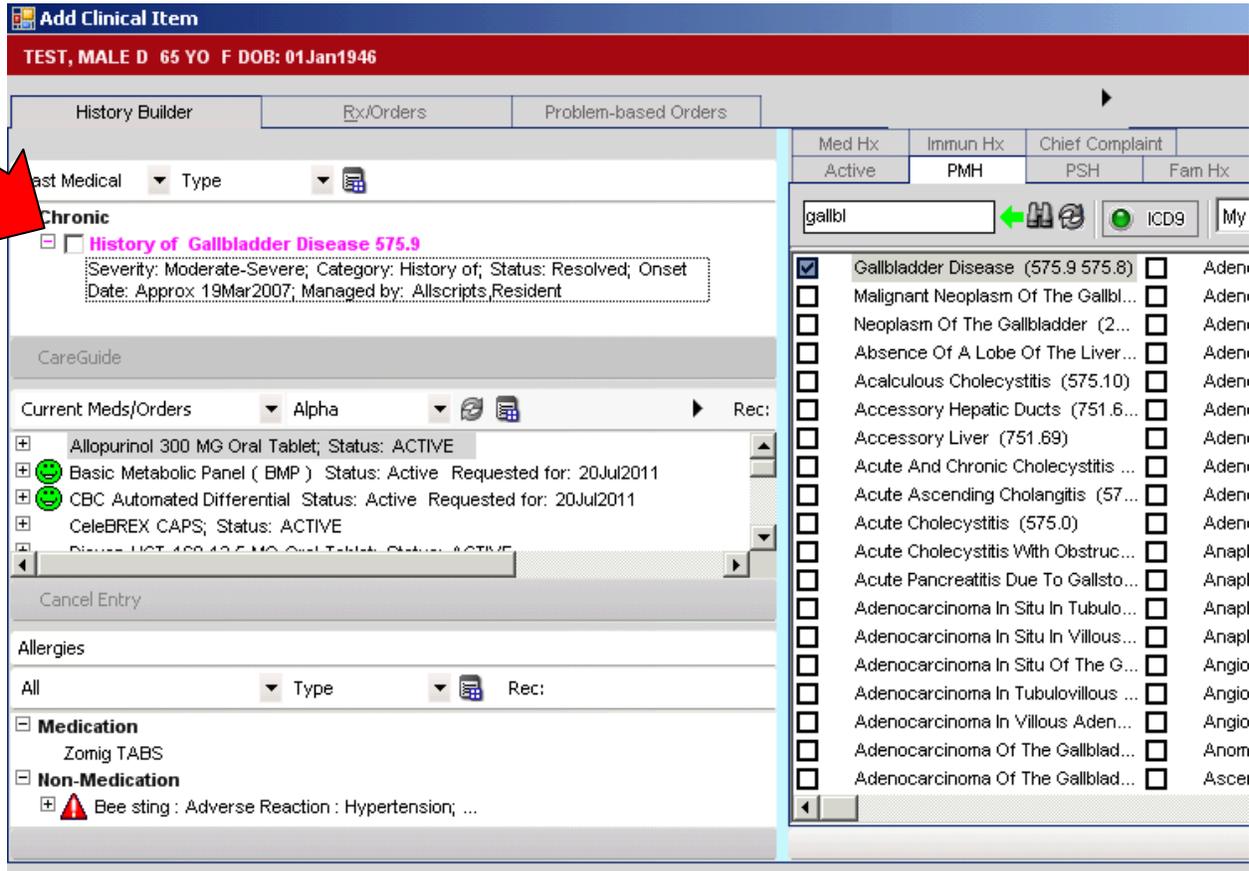
To add a managing provider, use the binoculars to search for the provider's last name. A list will populate from which you can choose the correct provider.



When adding details about the severity, you can use the drop-down menu, which contains a large list of descriptive choices.

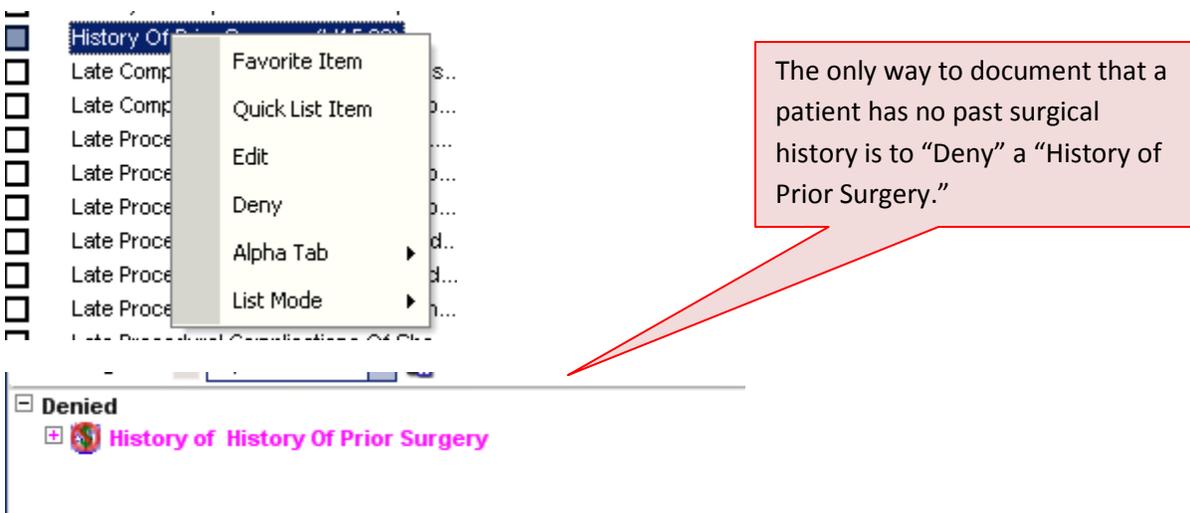
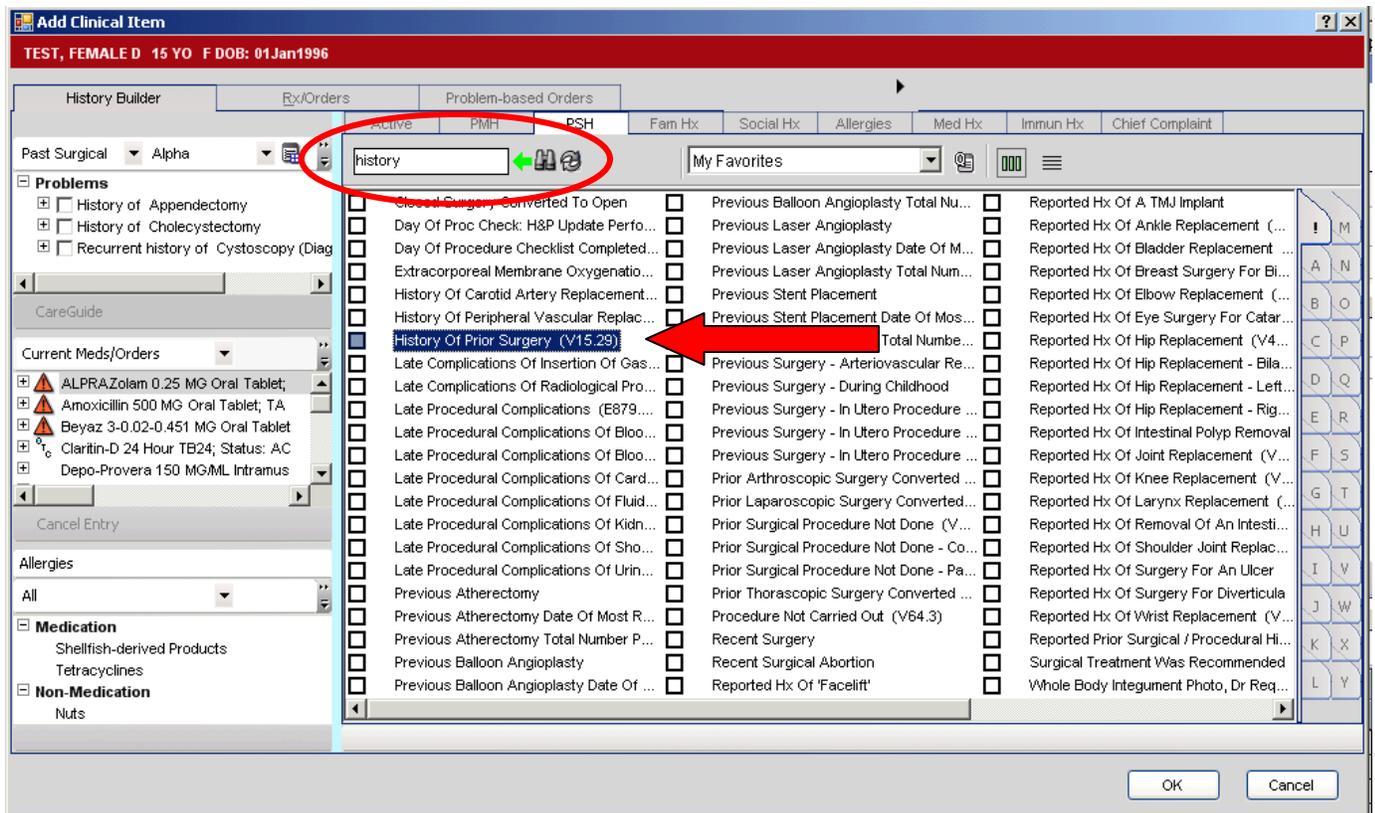


To view these details after they are added, click the plus (+) next to the problem in the left-hand corner. Doing so expands the description of the problem. This information is also available on the Clinical Desktop. Note that by default, past medical problems are automatically given the status of “Resolved.”



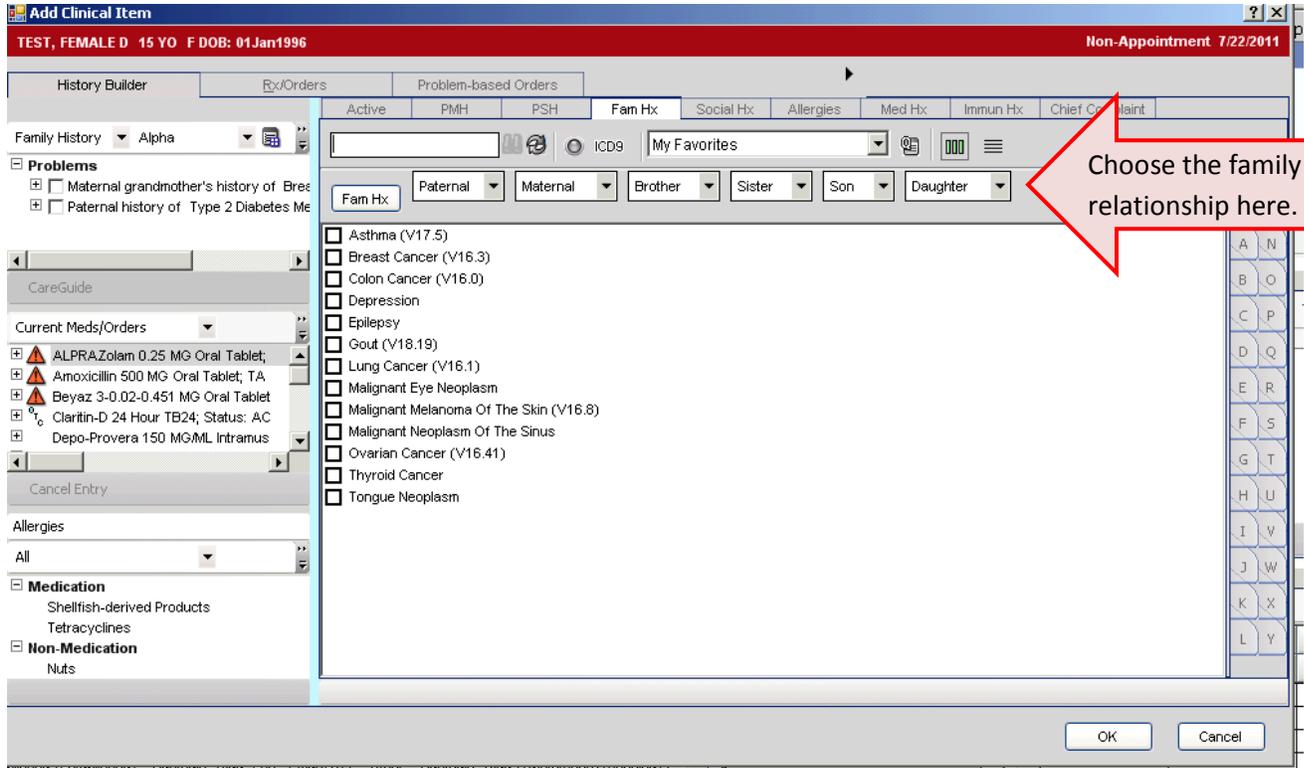
To document a **past surgery**, click on the PSH tab, and search the same way you would for a past medical problem. Check the box next to the correct surgical history and it will be added. To add details, right click on the item.

To document that the patient has **never had a surgery**, you will need to search for “History.” Select “History of Prior Surgery” and right click on it. Choose “Deny.”

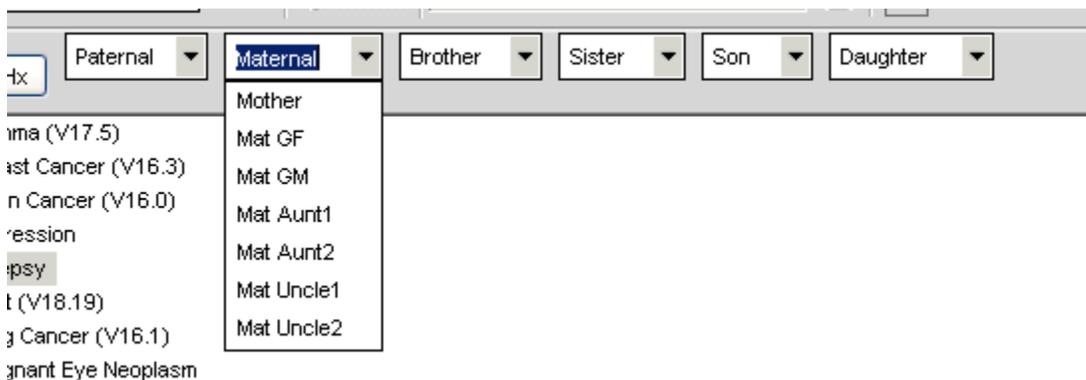


Any medical history item can be denied, but **don't check the box next to it** if you plan to deny it. Simply right click and deny it, and it will be placed in the "Denied" category of the chart. Checking the box first will not work for denied items.

Documenting a patient's **family history** is accomplished much the same way as other past medical history items, but you have additional pull down menus from which you must choose the family relationship.

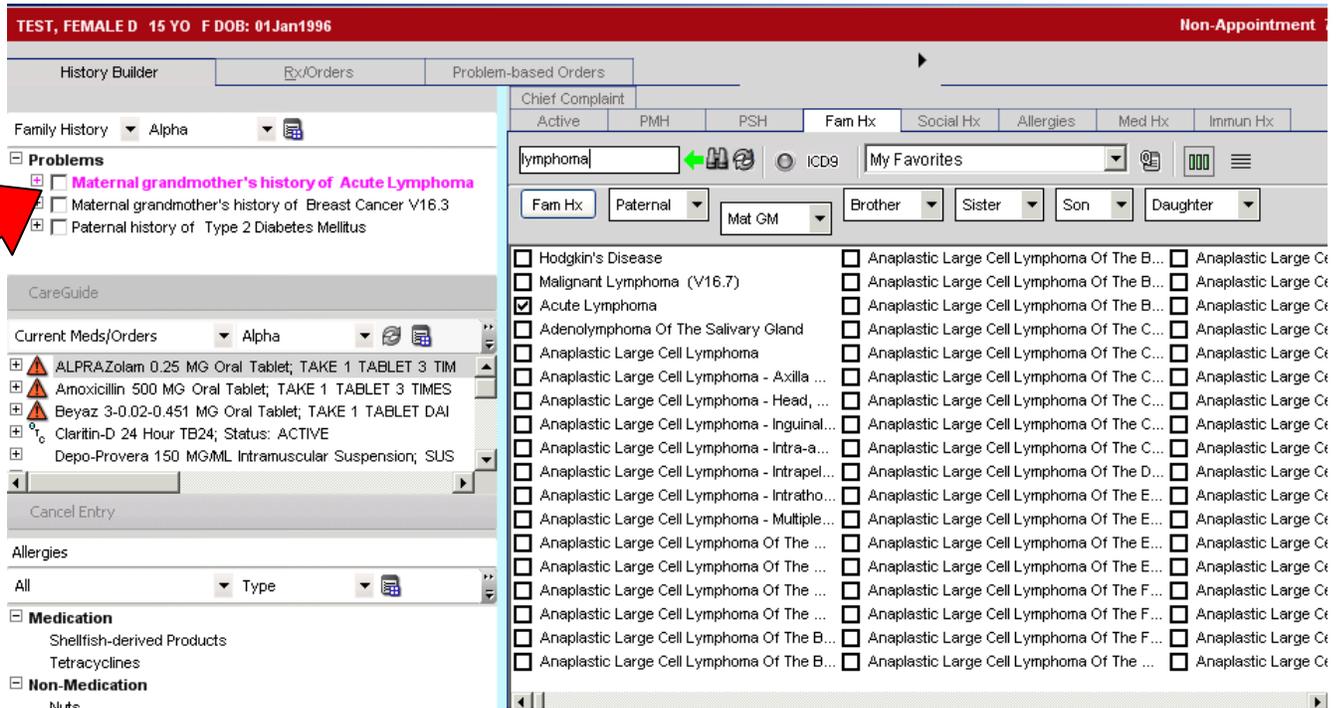


For example, to add a maternal grandmother's history of acute lymphoma, simply choose "Mat GM" from the "Maternal" drop-down menu first.

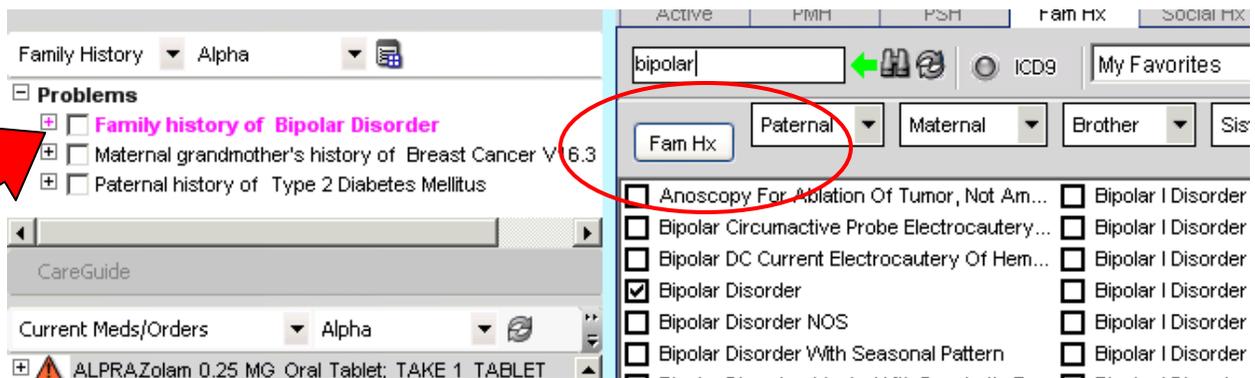


Search for "lymphoma" in the search box field.

The correct family history is added to the history builder.



If the exact family relationship is unknown, you can simply search for the problem without choosing the relationship and “Family History of . . .” is added. See below.

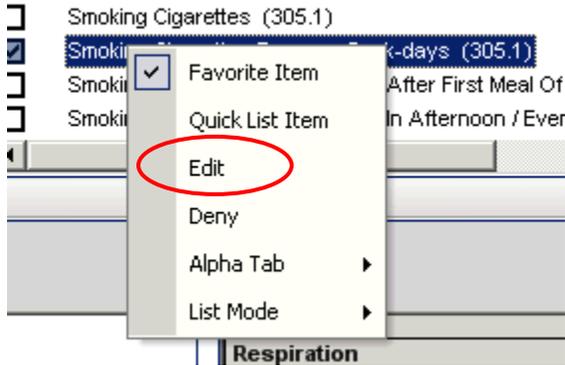


The **Social History** tab allows you to add a patient’s social information, or similar to the other tabs, enter information as denied.

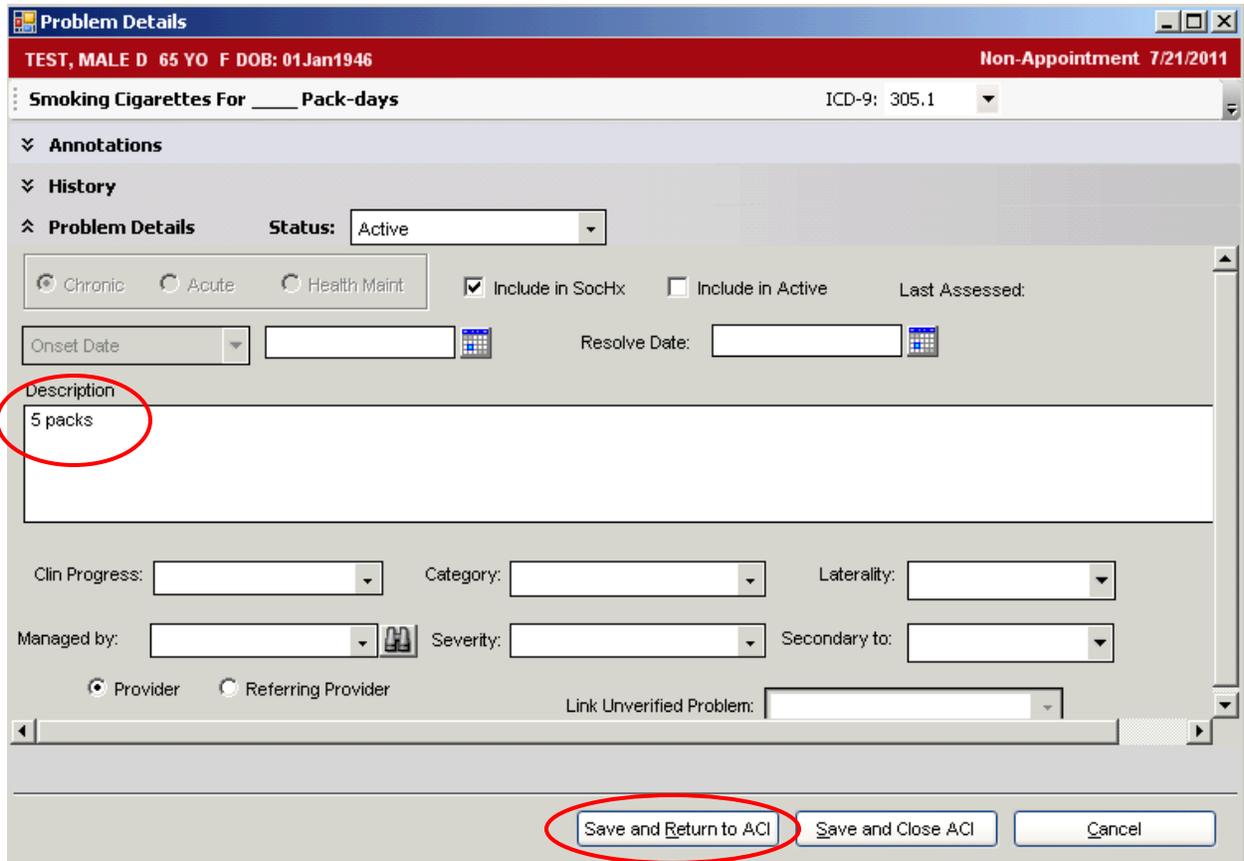
To add a history of smoking, search for “smoking” in the search box. You will be given several items to choose from, so you can be very specific in your documentation.

You can even document how many packs a day the patient smokes by checking “Smoking Cigarettes for __Pack-days,” right click to edit it, and then type in the number of packs in the description box.

Choose edit:



Type in the description box and click “Save and Return to ACI”:



The social history item then appears in the History Builder:

The screenshot shows the History Builder interface with the following components:

- Left Pane (Social History):**
 - Search: Alpha
 - Items:
 - Housing Toilet Facilities Outdoors
 - Living Aboard A Submarine
 - Smoking Cigarettes For ___ Pack-days 305.1** (highlighted with a red arrow)
 - 5 packs; Status: Active
- Right Pane (Search Results):**
 - Search: smoking
 - Results list:
 - Caregiver Sabotaging Efforts To Cope By Enabling Smoking
 - Chewing Nicotine-containing Substances
 - Chewing Nicotine-containing Substances Gum
 - Chewing Nicotine-containing Substances Tobacco
 - Cigars (___ A Day) (305.1)
 - Current Every Day Smoker (305.1)
 - Current Smoker (305.1)
 - Current Some Day Smoker (305.1)
 - Former Smoker (V15.82)
 - Leaving A Social Or Work Setting For A Cigarette
 - Marijuana By Prescription
 - Never A Smoker
 - Recent Increase In Cigarettes Per Day
 - Recently Stopping Smoking (V15.82)
 - Secondhand Tobacco Smoke In Home
 - Smoker, Current Status Unknown (305.1)
 - Smoking A Pipe
 - Smoking Cigarettes (305.1)
 - Smoking Cigarettes For ___ Pack-days (305.1)** (circled in red)
 - Smoking Cigarettes Starting Only After First Meal Of Day
 - Smoking Cigarettes Starting Only In Afternoon / Evening

When updating **Social and Family History**, it is helpful to know some “Keywords” to use in your search. By using these keywords, you will pull items grouped within certain categories:

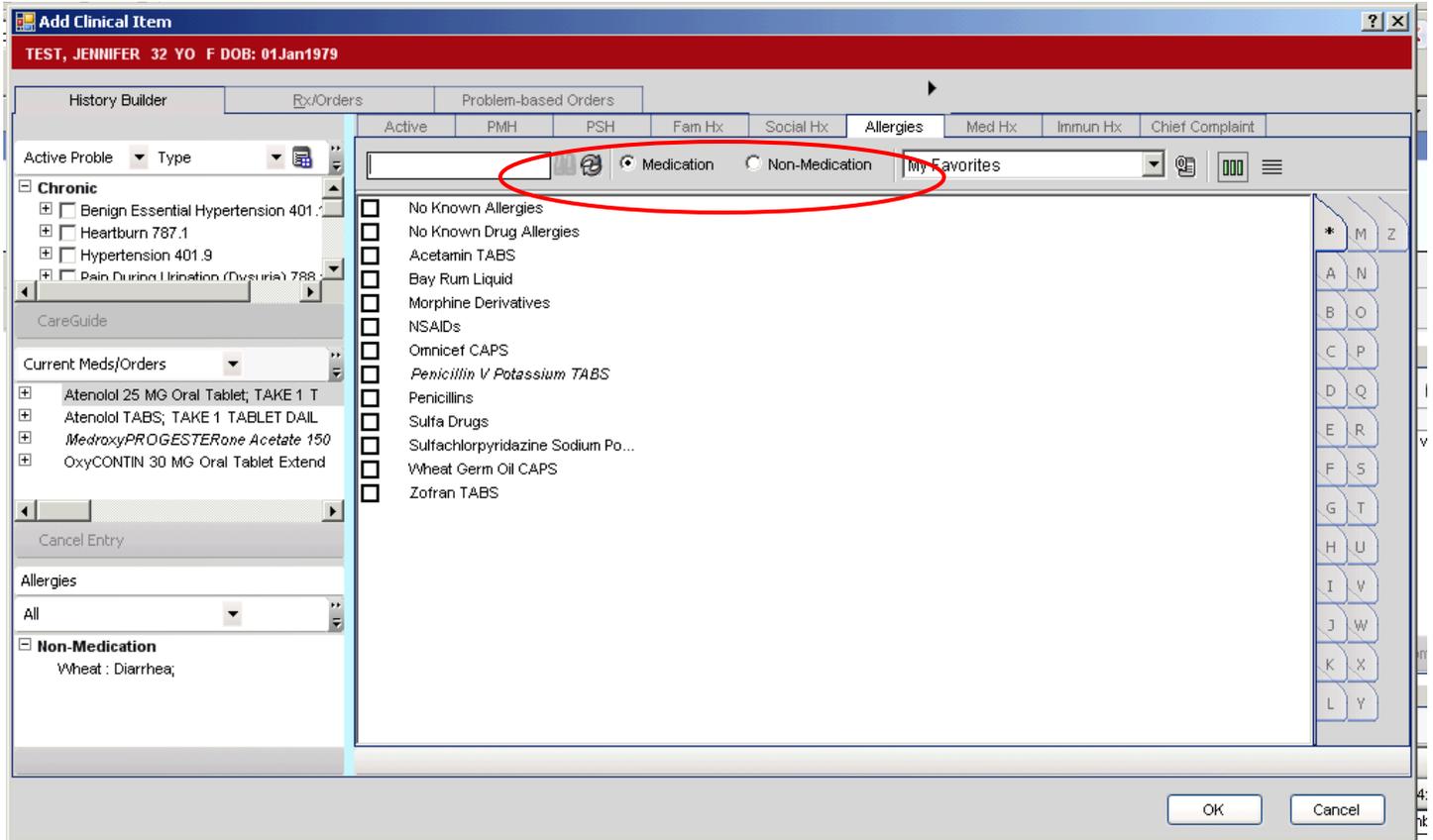
Social History Keywords

- | |
|------------|
| Behavior |
| Difficulty |
| Education |
| History |
| Housing |
| Job |
| Living |
| Never |
| Physical |
| Recent |
| Religious |
| Sexual |
| Sports |
| Travel |
| Unable |
| Using |

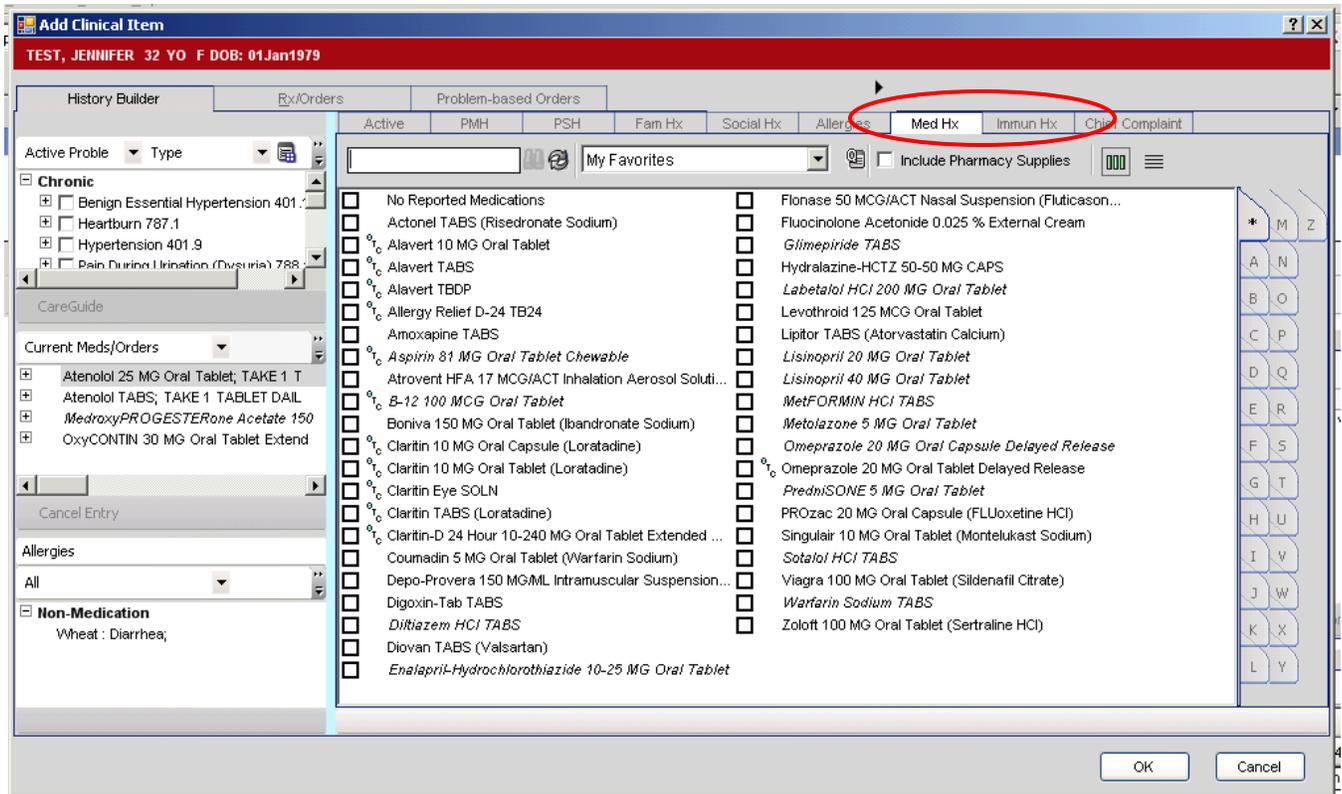
Family History Keywords

- | | |
|-----------|------------|
| Abuse | Illness |
| Alcohol | Immobility |
| Arthritis | None |
| Asthma | Peptic |
| Bleeding | Relation |
| Cancer | Seizure |
| Coronary | Smoking |
| Defects | Stress |
| Dementia | Standing |
| Diabetes | Stroke |
| Epilepsy | Surgery |
| Falls | Toxic |
| Fracture | Trauma |
| Heart | Travel |
| History | |
| Hyper | |

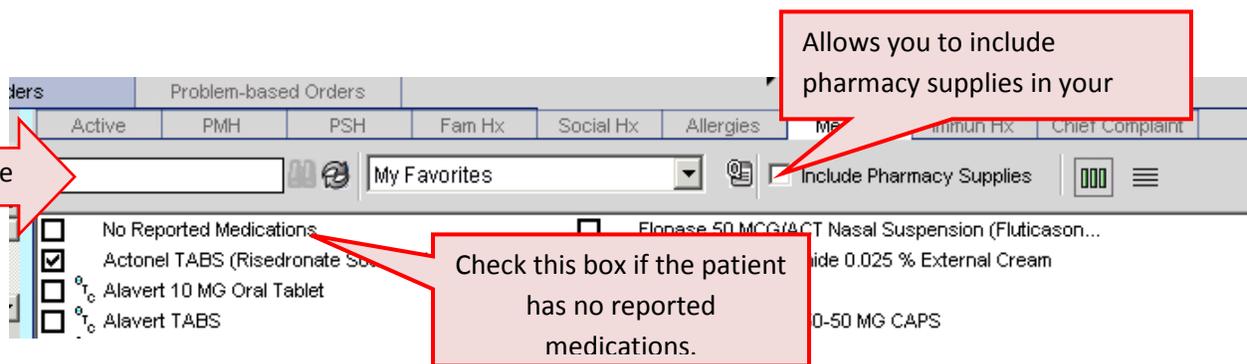
The **Allergies** tab permits users to enter two types of allergies – medication allergies and non-medication allergies. Before searching for the allergy, make sure the correct radio button is selected next to the type of allergy.



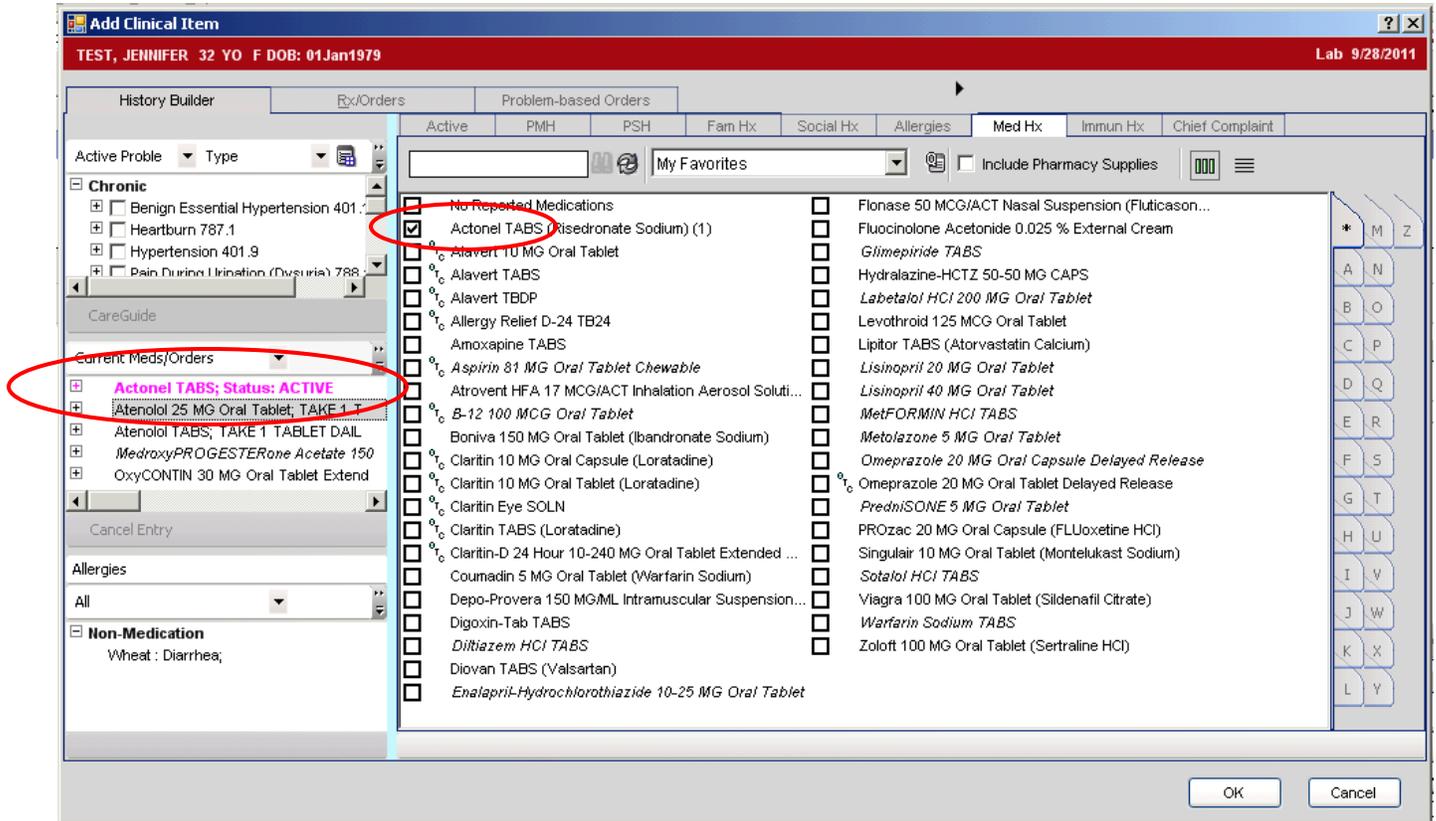
The **Medication History (Med Hx)** and **Immunization History (Immun Hx)** tabs are used to enter any past or current medications and immunizations for the patient. These tabs are not used for ordering medications or immunizations; they function only as a convenient location to preload or enter the patient's information.



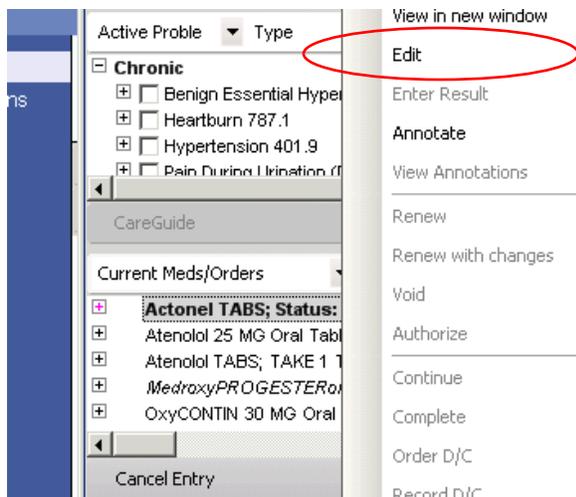
Search by typing in the name of the medication and clicking the binoculars. If the patient has no reported medications, check the box that says “No reported Medications.” If you would like to include pharmacy supplies in your search, make sure the “Include Pharmacy Supplies” is checked.



Click the box next to the medication that needs to be added and it is automatically put in the Current Medications list (Note: It will be in magenta font until it is “Committed.”)



If the medications needs to be edited (for example, the patient is no longer taking it). Right click and choose Edit.



The Medication Details screen will pop up and allows you to document the history of the medication.

Medication Details

TEST, JENNIFER 32 YO F DOB: 01Jan1979 Lab 9/28/2011

Order Entry [] Record w/o Ordering [x]

Actonel TABS Link to: [0]

Co-Pay and Coverage Detail

▲ Sig Status... Active; Change Status here.

SIG: Personal New Structured New Free Text Dosage Calculator

ALL There are no items to show in this view

Enter a Sig if desired.

Days: [] Qty: [] EA Refill: [0] Evaluate [] DAW [] Save as default for selected SIG [x]

Record RxBenefit: None Split Rx []

Additional Details

Pharmacy Instructions: [] Cite Result []

Ordered By: [] []

Managed By: [] Supervised By: [] Auth: Not Required

Rx Date: [] Expires: [] Therapy Start: [] End: []

Replaced: [] Link Unverified Order: []

Save and Return to ACI Save and Close ACI Cancel

You can link the medication to an active problem, document the Sig, and change the status.

Actonel TABS Link to: [0]

Change Status

TEST, JENNIFER 32 YO F DOB: 01Jan1979 Lab 9/28/2011

Change Status To: Complete

As Of: Complete

Defer For: [0]

For medications such as antibiotics, a completed status and date of completion can be documented.

OK Cancel

For Immunizations, after searching and selecting the Immunization to document, the Details screen will pop up for documenting the Date/Time, as well as any other information that might be helpful, such as who administered it.

Immunization Details

TEST, JENNIFER 32 YO F DOB: 01Jan1979 Lab 9/28/2011

Order Entry Record Administration Record w/o Ordering

DTP - HIB Link to: [0]

To Be Done: Status: Complete

Administration Details:

Series: [] Route: [] Date/Time: [] 

Dose: [] Site: [] Admin By: [] 

Manufacturer: [] NDC: []

Lot: [] Exp: [] 

Consent Obtained with this Administration Previously Obtained: []

Vaccine Information Statement (VIS)

DTP - HIB

Vaccine Information Statement provided with this administration? Yes No

Vaccine Information Statement Publication date: [] 

Date of last Vaccine Information Statement provided: []

Charging

Code	Display Name	When to Charge	Units	Time Based
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Save and Return to ACI Save and Close ACI Cancel