



QUILLEN ETSU PHYSICIANS

Module 5: Notes

Clinical Staff and Provider Training
Module

Quillen EHR Team
Phone: (423) 282-6122, Option 1
Email: EHRmail@qetsu.org

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Opening a note started by someone else

In most of the clinics, the nurse will start the note for the provider. She/he will open the note, put in the chief complaint and possibly a reason for visit, and then save and close the note. Once the note has been started, it will appear on your Daily Schedule with a “note”  con in the “N” field. To begin documentation on your patient, **make sure** that the Pt Status is set to **Provider Ready**, and then **double click the note icon** to open your note in “edit” mode. (Slide 7 shows you the “edit” mode)

Daily Clinical Desktop New Note Task List Documents Appointments Patient Lists Provider Schedules Worklist

SUPERUSER,BATMAN Age: 24 Years DOB: 01/01/1989 H Phone: (423)123-4567 FYI: **FYI**
 Sex: F PCP: Chastain, David Other: Security: No Restricted Data
 Allergies: Yes Pri Ins: BLUE SHIELD OF TN MRN: 001000643517601

Select Patient  

Daily Schedule [Arrived](#), [Pending](#), [Rescheduled](#), [No Show](#) [Personalize](#)

Provider: ALLSCRIPTS,Resident  AM: 6 PM: 0 Total: 6 Last Updated: 04/22/2013 3:41 PM 

Date: 17 Jun 2013  Sun Mon Tue Wed Thu Fri Sat 

\$	N	TC	CS	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
				Arr			08:00 AM	SUPERUSER,AQUAMAN	001000643536601	0	15	70	Migraines
				Arr	Exam 3	Provider Ready	08:15 AM	SUPERUSER,BATMAN	001000643517601	0	15	69	F/U from surgery
					NSH		08:30 AM	SUPERUSER,CATWOMAN	001000643516801	0	15	97	UTI
				Arr			08:45 AM	SUPERUSER,DAREDEVIL	001000643532501	0	30	78	Infected foot
					Pen		09:00 AM	SUPERUSER,FLASH	001000643529101	0	15	54	Dizziness
					Pen		09:30 AM	SUPERUSER,SPIDERMAN	001000643519201	0	45	56	New patient

Starting Your Own Note

If the nurse does not start the note for you (or if you are clinical staff), once he/she changes the status to **Provider Ready** (or **Nurse Ready**), double click on the patient's name. This takes you to the Clinical Desktop.

The screenshot displays a clinical software interface. At the top, a navigation bar includes tabs for 'Daily', 'Clinical Desktop', 'New Note', 'Task List', 'Documents', 'Appointments', 'Patient Lists', 'Provider Schedules', and 'Worklist'. The 'Clinical Desktop' tab is circled in red. Below the navigation bar, the patient's name 'SUPERUSER,BATMAN' is displayed in large, bold letters, also circled in red. To the right of the name, patient details are shown: Age: 24 Years, DOB: 01/01/1989, H Phone: (423)123-4567, FYI: FYI, Sex: F, PCP: Chastain, David, Other: Security: No Restricted Data, Allergies: Yes, Pri Ins: BLUE SHIELD OF TN, MRN: 001000643517601. Below the patient information, there is a 'Daily Schedule' section. The provider is set to 'ALLSCRIPTS,Resident' and the date is '17 Jun 2013'. The schedule table shows appointments for Monday, June 17, 2013. The 'Provider Ready' status for the 08:15 AM appointment with SUPERUSER,BATMAN is circled in red.

\$	N	TC	CS	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:00 AM	SUPERUSER,AQUAMAN	001000643536601	0	15	70	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr	Exam 3	Provider Ready	08:15 AM	SUPERUSER,BATMAN	001000643517601	0	15	69	F/U from surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		NSH		08:30 AM	SUPERUSER,CATWOMAN	001000643516801	0	15	97	UTI
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:45 AM	SUPERUSER,DAREDEVIL	001000643532501	0	30	78	Infected foot
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Pen		09:00 AM	SUPERUSER,FLASH	001000643529101	0	15	54	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Pen		09:30 AM	SUPERUSER,SPIDERMAN	001000643519201	0	45	56	New patient

New note tab

TEST, FRANKENSTEIN
Age: 35 Years Sex: F DOB: 03/03/1979 MRN: 001000647052001
Allergies: Med & Non Med PCP: Bochtis, Melania FYI: FYI
HPhone: (423)111-1111

Patient Banner

ETSU - Clinician

Iodine Allergy Latex Allergy Patient does not speak English Patient has a caregiver Pt likes people, with salt and pepper

Problem List

Name	ICD-9	Managed By
Active		
Acute frontal sinusitis	461.1	AL
Acute upper respiratory infection	465.9	Garland, Bridget
Attention deficit disorder of adult	314.00	
Bipolar disorder	296.80	
Cancer	199.1	Garland, Bridget
Community acquired pneumonia	486	Garland, Bridget
Diabetes mellitus	250.00	
Hungry bone syndrome	275.5	Garland, Bridget
Nontoxic multinodular goiter	241.1	
Ophthalmoplegia internuclearis	378.86	Garland, Bridget
Pain, abdominal	789.00	
Health Maintenance	V70.0	
Past Medical History		
History of Acute tonsillitis	463	Garland, Bridget
History of Bilateral Pheochromocytoma	227.0	
History of depression	V11.8	
History of headache	V12.00	

Current Medications None Alpha Rec: 15Aug2013

- Amphetamine-Dextroamphetamine 30 MG Oral Tablet (Adderall 30 MG Oral Tablet); TAKE 1 TABLET DAILY AS DIRECTED; Last Rx: 15Aug2013; Status: ACTIVE - Retrospective Authorization Ordered
- HumaLOG 100 UNIT/ML Subcutaneous Solution; USE AS DIRECTED; Therapy: 28May2014 to (Last Rx:28May2014); Status: ACTIVE - Retrospective Authorization Ordered
- Insulin Syringe; USE AS DIRECTED; Therapy: 28May2014 to (Complete:25Sep2014); Last Rx:28May2014; Status: UNAUTHORIZED - Requires Authorization Ordered
- Pioglitazone HCl - 45 MG Oral Tablet (Actos 45 MG Oral Tablet); TAKE 1 TABLET ONCE DAILY; Last Rx:12Jun2014; Status: ACTIVE - Retrospective Authorization Ordered

Callout: Make sure the patient's name is in the Patient Banner, and then click on the New Note tab

Note Selector

The Note Selector screen allows you to choose the type of note you are going to create. Your specialty and name should auto-populate in the **Specialty** and **Owner** fields. Click the drop down next to **Visit Type** and choose the note type. We suggest you talk to your preceptor about what note type to choose.

The screenshot shows the 'Note Selector' application window. At the top, a red header bar displays patient information: 'TEST, FRANKENSTEIN 34 YO F DOB: 03Mar1979' and 'Chart Update 4/22/2013'. Below the header, there are radio buttons for 'Style': 'Note' (selected), 'V10 Note', 'Unstructured', and 'Admin Forms'. The 'Specialty' dropdown is set to 'Internal Medicine' and the 'Owner' dropdown is set to 'ALLSCRIPTS, Provider'. The 'Visit Type' dropdown is open, showing a list of options: Behavioral Health, Communication (highlighted), Consult Visits, Follow-Up Visits, Health Maintenance, Nursing Visits, Office Visits, Post-Op Visits, Procedures, Geriatric Evaluation & Management, and Medical Student Note. A secondary dropdown menu is open for 'Communication', listing: Communication Regarding Patient, Nurse Telephone Note, Patient Letter, Provider Telephone Note (highlighted), Results Note, and Results Note w/o Labs. The 'Incomplete Notes' field contains '<< Choose an incomplete Note. >>'. The 'Chief Complaint' section is empty, showing 'There are no items to show in t'. At the bottom, there are 'OK' and 'Cancel' buttons.

NOTE IN "EDIT" MODE

Patient Name, age and DOB: TEST, FRANKENSTEIN 35 YO F DOB: 03Mar1979

Appointment date/visit type: Chart Update 06/13/2014

Clinical Toolbar: Includes icons for various clinical actions.

Clinical Desktop: Main workspace showing the **Patient Care Team** table.

Care Team ...	Role	Relations	Lock
Woodside,...		Family...	C
BERTOLI...			K
KINGSPORT...		Internal...	K
Mary Test	Care Giver	Daughter	

Table of Contents: Sidebar menu with categories like Patient Care Team, Health Management, HM Checklist, Chief Complaint, Reason For Visit, Active Problems, History of Present Illness, Review of Systems, Past Medical History, Social History, Family History, Surgical History, and Current Meds.

Note Authoring Workspace (NAW): Bottom section with **Output Template** (Established, Clinical Summary, Referral Letter) and **CC** (Patient Care Team, Health Management, HM Checklist).

Problem List: Right sidebar showing a list of active and past medical conditions.

Active: Acute frontal sinusitis, Acute upper respiratory infecti, Attention deficit disorder of adu, Bipolar disorder, Cancer, Community acquired pneumor, Diabetes mellitus, Hungry bone syndrome, Nontoxic multinodular goiter, Ophthalmoplegia internuclearis, Pain, abdominal, Health Maintenance.

Past Medical History: History of Acute tonsillitis, History of Bilateral Pheochrom, History of depression, History of headache, History of hypertension.

Footer: View, Recompile, Sign, Spell Check, Copy Forward, Security Codes, Audit, eReply, Save & Close, Save, Close, New, Edit, Active, Reso6

TABLE OF CONTENTS

Table of Contents

Section Heading

Form

The **Table of Contents** contains all the sections of the note, and any associated forms. The forms will always be indented beneath the section heading. It is suggested that you use the **Table of Contents** to scroll through your note. To navigate, simply scroll down until you reach the desired section.

Health Management
Chief Complaint
Reason For Visit
Reason For Visit - IM
Active Problems
History of Present Illness
Cough
Hypertension (Follow-Up)
Diabetes Type II (Follow-Up)
Review of Systems
Complete-Female
Past Medical History
Social History
Family History
Surgical History
Current Meds
Allergies
Immunizations
Vitals
Physical Exam
General Multi-System - Inter
Acute
Clinical Summary
Chief Complaint
Reason For Visit

Chart and Note View
SUPERUSER, BATMAN 24 YO F DOB: 01Jan1989
Appointment 6/17/2013
Updated: 3:41 PM
Status: Needs Input
Immunizations
Allergies
Chart Viewer
Flowsheets
Vitals
Problem
Meds/Orders
Labs
Imaging
Active Problems
Type
Show All Hide All New Order
mplaint
For Visit
roblems
ement
View Recompile Sign Copy Forward Security Codes Audit Save & Close Save Close New Edit CareGuide Resolve

TABLE OF CONTENTS

As you click on each section header in the Table of Contents...

Chart Update 06/13/2014

Commit Pat Loc Status

Iodine Allergy Latex Allergy Patient does not speak English Patient has a caregiver Pt likes people, with salt and pepper

Note

Established ALLSCRIPTS, Provider Status: Needs Input

Active Problems

Type	Name	ICD-9	Managed By	Last Asses
Chronic				
	Attention deficit disorder of adult	314.00		12Jun20
	Bipolar disorder	296.80		
	Cancer	199.1	Garland, Bridget	
	Community acquired pneumonia		Garland, Bridget	
	Diabetes mellitus	250.00		
	Hungry bone syndrome	275.5	Garland, Bridget	
	Nontoxic multinodular goiter	241.1		14Apr20
	Ophthalmoplegia internuclearis	378.86	Garland, Bridget	14Apr20
	Pain, abdominal	789.00		06Jun20
Acute				
	Acute frontal sinusitis	461.1	ALLSCRIPTS, Provider...	29Apr20
	Acute upper respiratory infection	465.9	Garland, Bridget	14Apr20

...that section will open up so that you can document your information.

Output Template CC

Established

Referral Letter

Return to Work Letter

Active Problem

History of Present Illness

Review of Systems

Recompile Sign

This section contains the "outputs" that are available for this note type. There will always be one - the main note (in this case, "Established"). Some note types will also have a referral or consult letter. If you want one of these outputs to be created, simply check the box before signing the note.

Clinical desktop/naw

The pane on the right-hand side of the page contains all the components of the **Clinical Desktop**. So, from within the note, you can view the patient's Problem list, the Meds/Orders, Labs, Imaging, Allergies, and all of the notes (on the Chart Viewer tab), as well as the Flowsheets, Vitals and Immunizations. Just click the appropriate tab to view the patient's information.

The **Note Authoring Workspace (NAW)** is where your text will populate as you document on the forms above.

The screenshot shows a clinical desktop interface with a top toolbar, a patient information bar (Commit, Pat Loc, Status), and a main workspace. On the left, there are tabs for Note, Appointments, and Health Management Plan. Below these are various patient information sections like Active Problems, Past Medical History, Social History, etc. The main workspace is divided into a top section for form-based data (Reason For Visit, Active Problems, History of Present Illness, Review of Systems, Past Medical History) and a bottom section for text entry (Active Problems, History of Present Illness, Review of Systems). On the right, there are tabs for Immunizations, Allergies, Chart Viewer, Flowsheets, and Vitals. The Chart Viewer tab is active, showing a list of notes by specialty, including Adolescent Medicine, Cardiology, and Endocrinology. Two callout boxes with arrows point to the right-hand pane and the bottom text entry area.

Note Sections - patient care team

The Patient Care Team is a section where clinical staff can enter members of the patient's care team - other physicians, home health companies, and even family members/caregivers.

Note

Established | ALLSCRIPTS, Provider | Status: Needs Input

Patient Care Team

Health Management

- HM Checklist
 - Health Maintenance Checklis
- Chief Complaint
 - Chief Complaint
- Reason For Visit
 - General RFV
- Active Problems**
- History of Present Illness
 - History of Present Illness
- Review of Systems
 - Complete-Female
- Past Medical History**
 - No new statement - PMH
- Social History**
 - No new statement - SH
- Family History**
 - No new statement - FH
- Surgical History**
 - No new statement - Surgical
- Current Meds**

Output Template | CC

- Established
- Referral Letter
- Return to Work Letter

Task Hide Show All Hide All

Care Team ...	Role	Relationship	Specialty	Comments
Woodside,...			Family...	C
BERTOLI...				K
BRASHEAR...				J
SUMMERS...			Internal...	K
KINGSPORT...				K
Mary Test	Care Giver	Daughter		

Recompile Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close

Note Sections - Health Management

The screenshot displays a medical software interface with a sidebar on the left containing various patient care team sections like 'Health Management', 'Active Problems', and 'Past Medical History'. The main window shows a 'Health Management' section with a table of items. The table has columns for 'Item', 'Sch...', 'G...', 'Most Recent', 'Date', and 'To Do'. One row, 'Mammogram...', is highlighted in yellow. A red circle highlights the 'To Do' column for this row, which contains the text '* Due: 17Apr2015'. A red arrow points from this text to a context menu that is open, showing options like 'New', 'Defer', 'Stop Deferral', 'D/C', 'Done Today', 'Last Done', 'Order', and 'Record As Admin'. The 'Order' option is highlighted in blue.

Item	Sch...	G...	Most Recent	Date	To Do
Mammogram...	Q 1...	New	negative	17Apr2014	* Due: 17Apr2015

The Health Management section is where you will find reminders that have been set up for this patient. If you see an order that is due, you can order directly from here. Simply right click in the **To Do** column, and click **Order**.

Note Sections - Chief Complaint

TEST, FRANKENSTEIN 35 YO F DOB: 03Mar1979

Internal Medicine Note View

Iodine Allergy Latex Allergy Patie

Note

Established ALLSCRIPTS, Provider Status: Needs Input

Patient Care Team

Health Management

- HM Checklist
- Health Maintenance Checklis
- Chief Complaint**
- Chief Complaint
- Reason For Visit
- General RFV

Active Problems

- History of Present Illness
- History of Present Illness
- Review of Systems
- Complete-Female

Past Medical History

- No new statement - PMH

Social History

- No new statement - SH

Family History

- No new statement - FH

Surgical History

- No new statement - Surgical

Current Meds

Output Template

	CC
<input checked="" type="checkbox"/> Established	
<input type="checkbox"/> Referral Letter	
<input type="checkbox"/> Return to Work Letter	

HM Checklist

Chief Complaint

- Belching

New Resolve Hide Show All Hide All

Chief Complaint

Chief Complaint Details:

The next section is the Chief Complaint. If your nurse has added a CC, it will show here.

You can add a new CC by simply clicking on New on the toolbar under the Chief Complaint section. Most note types also have a free-text form for more detailed documentation.

View Recompile Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close

HPI Note Forms

Note

Established ALLSCRIPTS, Provider

Patient Care Team

Health Management

- HM Checklist
- Health Maintenance Checklis
- Chief Complaint**
- Chief Complaint
- Reason For Visit
- General RFV

Active Problems

- History of Present Illness**
- History of Present Illness
- HM Adult Female
- Belching**
- Review of Systems
- Complete-Female
- Past Medical History**
- No new statement - PMH
- Social History**
- No new statement - SH
- Family History**
- No new statement - FH
- Surgical History**

Output Template CC

- Established
- Referral Letter
- Return to Work Letter

Screening:

Belching:

Review of Systems

Past Medical History

Recompile Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close

Both the Chief Complaint and the Active Problem sections are designed to pull forms into the HPI section of the note. When your nurse adds a Chief Complaint before opening the note, the HPI form will be available when you open your note.

To get the form(s) to pull in after the note has been opened, add a Chief Complaint or Active problem, and then click the **Recompile** button.

Recompile

Forms

To add a new problem, click “P” on the Clinical Toolbar (or New on the gray toolbar). The Active Problems are “billable” items. Items that are added here, or checked on the Clinical Desktop, will appear in the Assessment section of the note.

Chronic

Name	ICD-9	Managed By	Last Asses:
Attention deficit disorder of adult	314.00		12 Jun 2013
Bipolar disorder	296.80		13 Jun 2013
Community acquired pneumonia	488.4	Carolyn, Pickett	28 Jun 2013
Diabetes mellitus			
Nontoxic multinodular goiter			
Ophthalmoplegia			
Pain, abdominal			

Acute

Acute frontal sinusitis			
Acute upper respiratory infection			

Active

- Acute frontal sinusitis
- Acute upper respiratory infection
- Attention deficit disorder of adult
- Bipolar disorder
- Cancer
- Community acquired pneumonia
- Diabetes mellitus
- Nontoxic multinodular goiter
- Ophthalmoplegia internuclearis
- Pain, abdominal
- Health Maintenance

Past Medical History

- History of Acute tonsillitis
- History of Bilateral Pheochromocytoma
- History of depression
- History of headache
- * History of hypertension
- History of migraine headaches

Output Template

CC
Established
Referral Letter
Return to Work Letter

History of Present Illness

Acute Mania:
Bipolar Disorder (Brief):
Review of Systems
Past Medical History

Recompile Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close

Forms

Chart and Note View

Commit Pat Loc: Status:

Note Appointments Health Management Plan

New Patient ALLSCRIPTS, Provider Status: Needs Input

Health Management

Chief Complaint

Reason For Visit

Reason For Visit - IM

Active Problems

History of Present Illness

Colorectal Cancer

Diabetes Type II (Follow-Up)

Hyperlipidemia (Follow-Up)

Review of Systems

Complete-Female

Past Medical History

Social History

Family History

Surgical History

Current Meds

Allergies

Immunizations

Vitals

Physical Exam

General Multi-System Exam

Procedure

Trigger Point Injection (Gene

Arthrocentesis

Patient Summary

Referral Letter

New Patient

Return to Work Lett...

Hyperlipidemia (Follow-Up) Brief Comprehensive All Normal Previous History

Hyperlipidemia Follow-up

Status:

Good Stable Poor

Comorbid Illnesses:

None CAD Carotid Disease

Diabetes Mellitus PVD Tobacco Use

Hypertension

Interval Events:

None

Interval Symptoms:

	New	Denies	Resolved	Improved	Stable	Worse
Chest Pain	<input type="checkbox"/>	<input type="radio"/>				
Claudication	<input type="checkbox"/>	<input type="radio"/>				
Muscle Pain	<input type="checkbox"/>	<input type="radio"/>				
Muscle Weakness	<input type="checkbox"/>	<input type="radio"/>				
Other	<input type="checkbox"/>	<input type="radio"/>				

Associated Symptoms:

Focal Neuro Deficit Memory Loss

Lifestyle:

Symptoms:

Hyperlipidemia (Follow-Up):

Symptoms:

Review of Systems

Past Medical History

View Recompile Sign Copy Forward Security Codes Audit Save & Close Save Close New Edit

The forms are used to document specific information related to the patient's complaints. Keep in mind, if you do not click on any items on the form, it will not appear in your note. Also, the forms have a LOT of choices – but you only need to document relevant items. Feel free to ignore the rest.

Forms

Clicking the boxes on the forms will populate the text at the bottom of the page (called the Note Authoring Workspace).

The screenshot shows a medical form titled "Hyperlipidemia Follow-up". The form includes sections for Status, Comorbid Illnesses, Interval Events, Interval Symptoms, Lifestyle, and Medications. A yellow callout box highlights a small radio button next to a checkbox in the "Interval Events" section, stating: "Clicking on the small radio button (looks like a degree symbol) next to a checkbox will open up a **details form** which provides more options for charting."

The "Details form" pop-up window is titled "Details form" and contains the following sections:

- Onset Mode:** Gradual, Sudden
- Severity:** Mild, Moderate, Severe
- Location / Laterality:** Substernal, Epigastric, Anterior Mid-Chest, Infrascapular, Sub-Xiphoid
- Table:**

	Bilateral	Right	Left
Anterior Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Quality / Character:** Aching, Burning, Dull, Heavy, Pleuritic, Pressure-Like, Sharp, Squeezing, Stinging, Tight
- Radiation / Laterality:** No Radiation, Neck, Jaw, Back

At the bottom of the form, there is a "Note Authoring Workspace" containing the following text:

Diabetes Type II (Follow-Up):
Symptoms: |
Hyperlipidemia (Follow-Up): The patient states her hyperlipidemia has been stable since the last visit. | Comorbid Illnesses: diabetes mellitus and hypertension. |
Symptoms: |
Review of Systems

Buttons for "Clear", "OK", and "Cancel" are visible at the bottom of the "Details form" window.

Forms

Some of the forms will have an **All Normal** and/or **Previous Exam** option. Clicking the All Normal button will populate negative/normal text for ALL of the systems. The Previous Exam button will pull in all items from the last exam.

The screenshot shows a medical form titled "Complete-Female" with a status of "Needs Input". The form is organized into sections: Constitutional, Eyes, and a section with checkboxes for "Established" and "Clinical Summary".

Constitutional

- Negative
- As Noted in HPI
- Fever
- Feeling Poorly
- Chills
- Feeling Tired/Fatigue

Eyes

- Negative
- As Noted in HPI
- Eye Pain
- Eyesight Problems
- Red Eyes
- Discharge From Eyes

Other symptoms:

- As Noted in HPI
- Nosebleeds
- Nasal Discharge
- As Noted in HPI
- Chest Pain
- Palpitations

Buttons: "All Normal" and "Previous Exam" are located in the top right corner of the form area.

Yellow Callout Box:

Be VERY careful using the All Normal button. Using this option frequently is a HUGE red flag to our auditors. Of note, you can click the All Normal button, and then go back and uncheck the systems that are abnormal, and document the specific information as needed for those sections.

Blue Callout Box (Listed Findings):

- Complete-Female:
- Constitutional: negative.
- Eyes: negative.
- ENT: negative.
- Cardiovascular: negative.
- Respiratory: negative.
- Gastrointestinal: negative.
- Genitourinary: negative.
- Musculoskeletal: negative.
- Integumentary: negative.
- Neurological: negative.
- Psychiatric: negative.
- Endocrine: negative.
- Hematologic/Lymphatic: negative.

Form Footer: View, Recompile, Sign, Copy Forward, Security Codes, Audit, Save & Close, Save, Cl

History sections

The screenshot displays a medical software interface with a sidebar on the left and a main content area. The sidebar contains several sections: 'Health Management', 'Chief Complaint', 'Reason For Visit', 'Active Problems' (highlighted in yellow), 'History of Present Illness', 'Diabetes Type II (Follow-U)', 'Hyperlipidemia (Follow-Up)', 'Review of Systems', 'Complete-Female', 'Past Medical History' (highlighted in yellow), 'Social History', 'Family History', 'Surgical History', 'Current Meds', 'Allergies', 'Immunizations', 'Vitals', 'Physical Exam', 'Procedure', and a list of checkboxes at the bottom. The main content area shows 'Review of Systems', 'Past Medical History' (expanded to show 'Chronic' and 'Acute' sub-sections), and 'Social History'. A red box highlights the 'Show', 'Show All', and 'Hide All' buttons. A yellow text box on the right explains that these sections auto-populate from previous notes.

The "historical" sections of the chart are designed to auto-populate from previous notes. So, for example, the history items that you entered on your patient during their first visit will automatically pull into the note on subsequent visits. These sections include: **Active Problems, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies, and Immunizations.** All or some of the items in these sections can be hidden if you do not want them in your note.

Hiding items

Use the “Show,” “Show All,” “Hide,” and “Hide All” options to pull only relevant items into your note. If the items are **grayed out**, they are hidden. If they are **black**, they will appear in your note. In this example, I’ve clicked on 3 items, and then clicked “show.” Only those items will appear in my finished note. It does not erase them from the patient’s chart, however. The next time you open a note, all items will pull in.

^ Past Medical History Edit Mode of Note

Type [dropdown] [icons]

	Name	ICD-9	Managed By
Chronic			
<input checked="" type="checkbox"/>	History of Bilateral Pheochromocytoma	227.0	
<input checked="" type="checkbox"/>	History of depression	V11.8	
<input checked="" type="checkbox"/>	History of headache	V13.89	
<input checked="" type="checkbox"/>	* History of hypertension	V12.59	Garland, Br
<input checked="" type="checkbox"/>	History of migraine headaches	V12.49	
<input checked="" type="checkbox"/>	History of Hungry bone syndrome	275.5	Garland, Br
Acute			
<input checked="" type="checkbox"/>	History of Acute tonsillitis	463	Garland, Br

← [scroll bar]

New Edit CareGuide Resolve Show Show All Hide All

Past Medical History

- History of depression (V11.8)
- History of headache (V13.89)
- History of hypertension (V12.59)
 - Will increase lisinopril to 10 mg daily. Followup in 2 weeks.

Social History

- Current every day smoker (305.1)
 - 1ppdx 10 years
- Drinks beer
- Never a smoker

Family History

- Family history of Alcohol Abuse
- Family history of Drug use during pregnancy
- Family history of obesity (V18.19)

Finished Note

Note Sections - Current Meds

Hyperlipidemia (Follow-Up)

- Review of Systems
- Complete-Female
- Past Medical History
- Social History
- Family History
- Surgical History
- Current Meds**
- Allergies
- Immunizations
- Vitals

Physical Exam

- General Multi-System Exam

Procedure

- Trigger Point Injection (Gene
- Arthrocentesis
- Nebulizer Treatment, Adult
- Skin Lesion Excision
- Wart Destruction
- Electrocardiogram (ECG)
- Abdominal Ultrasound
- Cerumen Removal
- Orthopedic Aspiration-Injecti

Results/Data

- Patient Summary
- Referral Letter
- New Patient
- Return to Work Lett...

Family History

Surgical History

Current Meds

Alpha Rec: 16Apr2013

- ⚠ Amoxicillin 200 MG/5ML Oral Suspension Reconstituted; TAKE 1 TEASPOONFUL EVERY 12 HOURS DAILY; Therapy: 01Apr2011 to (Evaluate:18Apr2013); Last Rx:16Apr2013; Status: ACTIVE - Retrospective Authorization
Ordered; For: Health Maintenance (V70.0); Rx By: ALLSCRIPTS,Provider; Dispense: 2 Days ; #:12 ML; Refill: 0; Faxed To: TouchWorks Test Pharmacy; Last Updated By: Logan,Jennifer
- Atorvastatin Calcium 40 MG Oral Tablet; TAKE 1 TABLET DAILY AT BEDTIME; Therapy: 03Aug2012 to (Evaluate:29Jul2013); Last Rx:03Aug2012; Status: ACTIVE - Retrospective Authorization

New Edit View Order D/C Add On Orders Completed Today Completed On Hide

Allergies

All Type

- Medication
 - ⚠ Brilinta TABS
- Non-Medication
 - Shellfish

Current Meds

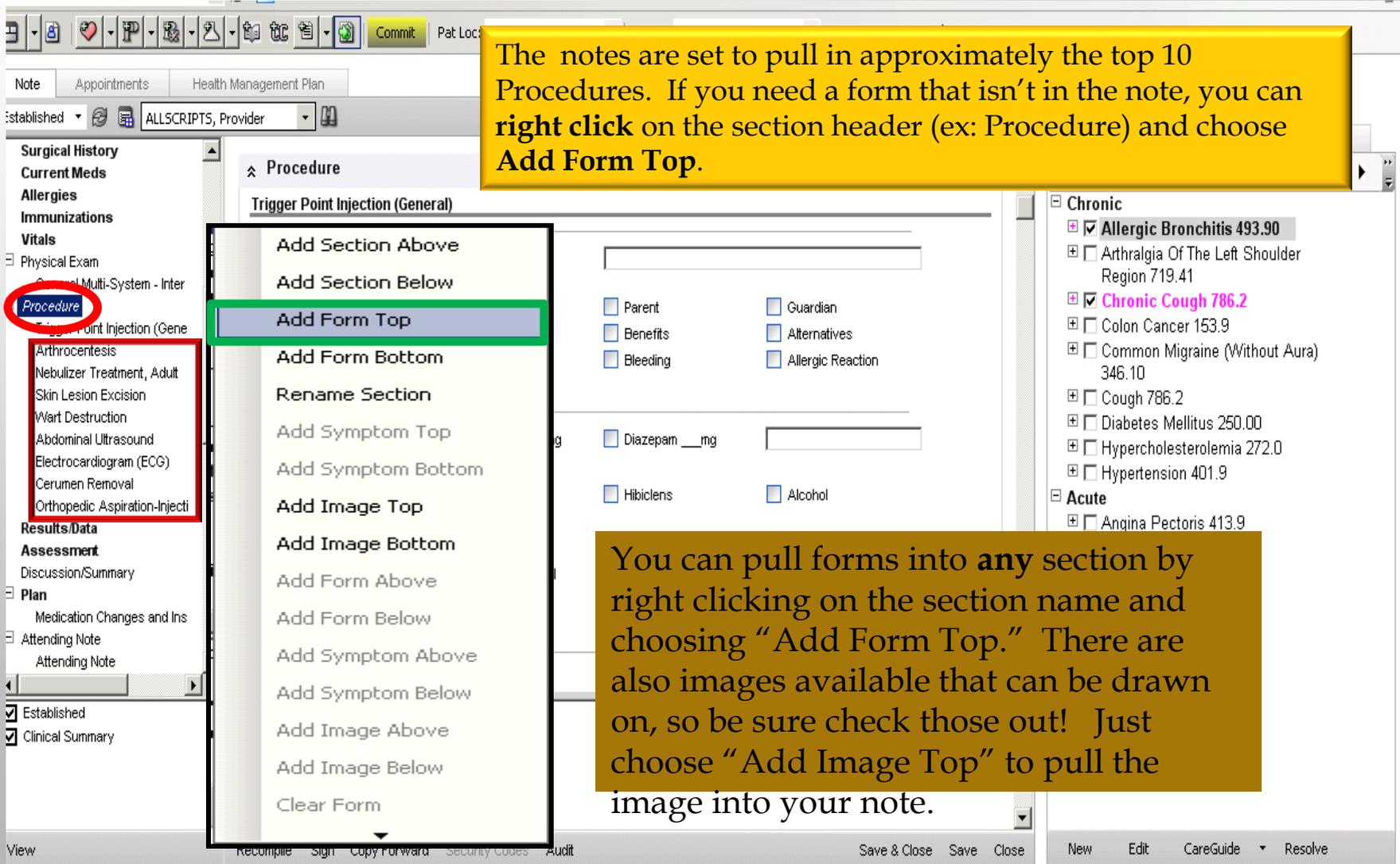
Allergies

The "Current Meds" are the medications that the patient was on when the note was started. Any new meds that you prescribe during the visit will appear in the **Plan** section.

View Recompile Sign Copy Forward Security Codes Audit Save & Close Save Close

Note Sections - Procedures

The notes are set to pull in approximately the top 10 Procedures. If you need a form that isn't in the note, you can **right click** on the section header (ex: Procedure) and choose **Add Form Top**.



You can pull forms into **any** section by right clicking on the section name and choosing "Add Form Top." There are also images available that can be drawn on, so be sure check those out! Just choose "Add Image Top" to pull the image into your note.

Note Sections - Procedures

Form Selector

cardiac <Filter by Form Type> Procedure Internal Medicine

Form Display name	Sex	Age	Type	Section	Specialty	Created By	Date Created	Modified By	Date Mo
<input type="checkbox"/> Abdominal Ultrasound			PROC	Procedure	Adolescent...	Logan, Jennifer	4/13/2011	Garland, B...	3/14/20
<input type="checkbox"/> Anoscopy			PROC	Procedure	Family Medi...	Allscripts Clinica...	1/16/2008	Logan, Je...	12/7/20
<input type="checkbox"/> Anoscopy Findings Detail			PROC	Procedure	Family Medi...	Allscripts Clinica...	1/16/2008	Logan, Je...	12/7/20
<input type="checkbox"/> Arthrocentesis			PROC	Procedure	Family Medi...	Allscripts Clinica...	10/25/2007	Logan, Je...	8/19/20
<input type="checkbox"/> Bilat S4 and S5 Nerve Root Blocks			PROC	Procedure	Family Medi...	Allscripts Clinica...	7/15/2009	Logan, Je...	12/7/20
<input type="checkbox"/> Bladder Catheterization			PROC	Procedure	Family Medi...	Allscripts Clinica...	6/9/2009	Logan, Je...	12/8/20
<input type="checkbox"/> Bladder Flow Rate Study			PROC	Procedure	Family Medi...	Allscripts Clinica...	6/7/2009	Logan, Je...	12/8/20
<input checked="" type="checkbox"/> Cardiac Stress - Sx			PROC	Procedure	Cardiology,...	Allscripts Clinica...	11/1/2008	Logan, Je...	12/7/20
<input type="checkbox"/> Cardiac Stress ECG - Post-Stress			PROC	Procedure	Cardiology,...	Allscripts Clinica...	11/1/2008	Logan, Je...	12/7/20
<input type="checkbox"/> Cardiac Stress ECG - Pre-Stress			PROC	Procedure	Cardiology,...	Allscripts Clinica...	11/1/2008	Logan, Je...	12/7/20
<input type="checkbox"/> Cast Application Details			PROC	Procedure	Emergency...	Allscripts Clinica...	9/15/2008	Logan, Je...	12/7/20
<input type="checkbox"/> Caudal Epidural Steroid Injection			PROC	Procedure	Family Medi...	Allscripts Clinica...	7/15/2009	Logan, Je...	12/8/20
<input type="checkbox"/> Cervix Image			PROC	Procedure	Family Medi...	Allscripts Clinica...	9/11/2007	Logan, Je...	12/7/20
<input type="checkbox"/> Colonoscopy			PROC	Procedure	Gastroente...	Allscripts Clinica...	10/27/2009	Logan, Je...	12/8/20
<input type="checkbox"/> Colposcopy Multiple Vaginal Locations			PROC	Procedure	Family Medi...	Allscripts Clinica...	11/4/2009	Logan, Je...	12/8/20

Cardiac Stress - Sx

Once you right click on the section and choose Add Form Top, the Form Selector box pulls up. Search for the form you want, then check the box next to the desired form and click OK.

OK Cancel

Note Sections - Results/Data

The Results/Data section will pull in the patient's labs for the previous month.

Pt likes people, with salt and pepper

The screenshot shows a clinical desktop interface with a patient's lab results. The 'Results/Data' section is highlighted, and a context menu is open over a specific lab result, with 'Cite selected' highlighted in red.

Results/Data

Complete

Urinalysis (DIPSTICK ONLY) (UA) Toteja, Vandana Final 06Jun2014 11:32AM

Test	Result	Flag	Reference
Color	yellow		
Specific Gravity	0.5	A	

Context Menu:

- View
- View in New Window
- Document Hx
- Edit
- Attach To Result
- Send to Portal
- New
- Print
- Fax
- Clinical Exchange Document
- Cite selected**
- Advanced Result Situation
- Show Audit Items
- Show Invalid Items
- Show CED-Auto Export
- Personalize

To pull in a lab that is outside of the 1-month parameter, simply right click on the desired lab on the Clinical Desktop, and choose **Cite Selected**.

Note Sections - Assessment

TEST, FRANKENSTEIN 35 YO F DOB: 03Mar1979

Internal Medicine Note View

Commit Pat Loc Status

Iodine Allergy Latex Allergy Patient does not speak English Patient has a caregiver Pt likes people, with salt and pepper

Note

Established ALLSCRIPTS, Provider Status: Needs Input

Name	ICD-9	Managed By	Last Ass
Assessed			
<input checked="" type="checkbox"/> Acute frontal sinusitis	461.1	ALLSCRIPTS, Provider...	29Apr
Onset Date: 07Apr2013 Description: Infected nasal cavities....			
<input checked="" type="checkbox"/> Ophthalmoplegia internuclearis	378.86	Garland, Bridget	14Apr
<input checked="" type="checkbox"/> * History of hypertension	V12.59	Garland, Bridget	14Apr
<input type="checkbox"/> Nontoxic multinodular goiter	241.1		14Apr

The Assessment section shows the patient's Active Problems. **Make sure** that you check the boxes of any diagnoses that you assessed at the visit, and uncheck any items that were not assessed. You can also add a diagnosis at this point, by clicking on the "P" on the toolbar.

It's **really** important for billing purposes that the items you assessed are placed in order of importance. To do this, simply click on the item you need to move and drag it into place. Currently, we are still utilizing superbills, so the assessed problems in your note need to match the problems you list on the encounter form (superbill). The order also needs to match.

Note Sections - Plan

TEST, JENNIFER 35 YO F DOB: 01Jan1979

Internal Medicine Note View

Review before release of medical records

Note

Established ALLSCRIPTS, Provider Status: Needs Input

Assessment

- Plans & Patient Instructions**
- Resident Attestation
- Medication Changes and Inst
- PQRS - Preventive Care - Fa
- Summary
- Attending Note
- Return to Work
- Letter Greeting
- Letter Closing
- Signatures

Plans & Patient Instructions

Problem Rec: 28May2014 Lock

- 1 year Follow up - Follow-up Status: Hold For - Scheduling Requested for: 13Jun2014
- Referrals
 - Psychiatry Referral Evaluation and Treatment - Status: Hold For - Scheduling Requested for: 13Jun2014
- Health Maintenance
 - Orders
 - DXA Bone Densitometry Status: Hold For - Scheduling Requested for: 13Jun2014

New Edit Authorize All View Show Hide All Show Impression

To order the patient's prescriptions, etc., just click on the **beaker button** on the Clinical Toolbar, (like you did from the Clinical Desktop in the previous module) or click on the **New** button on the gray toolbar. This will take you to the ACI screen, where you can order all of the items.

Output Template CC

- Established
- Referral Letter
- Return to Work Letter

Plans & Patient Instructions

Resident Attestation: |

Medication Changes and Instructions: |

PQRS - Preventive Care - Family Medicine: |

Summary

View Recompile Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close

Note Sections - ordering

Add Clinical Item

TEST, JENNIFER 35 YO F DOB: 01Jan1979 Non-Appointment 06/13/2014

History Builder **Orders**

Problem - based Rx Med Admin Immun Lab Rad Procs Findings FU/Ref Instruct Supplies

Send To Retail TouchiWorks Test Pharmacy

My Favorites On Record w/o Ordering Pharmacy Supply

- No Reported Medications
- HumaLOG 100 UNIT/ML Subcutaneous Solution
- Lisinopril 20 MG Oral Tablet
- Unable To Obtain

Recognize this screen? This is where you will do all of your ordering. It's important that you get all of the ordering completed **before** the patient leaves, as this information will show up on the Clinical Summary, which is given to the patient at check out.

DUR Alerts: Drug-Drug (0) | PAR (0) | Disease (0) | Dup Therapy (0) | Dose (0)

OK Cancel

Viewing Your Note

Review before release of medical records Do not prescribe Loratab, BG, Internal Med

Note
Acute ALLSCRIPTS, Provider Status: Needs Input

Health Management

Item	Sched...	Goal	Most Recent	Date	To Do	Incompl...
Personal history of asthma						
Eye Exam	Q 1 year		Complete Eye Exam	20A...	Due:...	
Health Maintenance						
Colonoscopy	Q 5...	New	Complete	07J...	Due:...	
Hemoglobin A1C	Q 6...		Complete	25A...	Due:...	
Mammogram (Screening)	Q 2...	New	Complete	06M...	Due:...	

Hide Show All Hide All New Order

Chief Complaint
Reason For Visit

Output Template CC

- Referral Letter
- Acute
- Return to Work Letter

View

Once you've finished inputting the sections of the note, you're going to want to view it. (In fact, you can view it at any point during the process). Simply click on **View** on the toolbar at the bottom of the screen.

Current Orders Labs Appointments
Allergies Vitals Immunizations
Problem Medications Chart Viewer

All Problem List

Active

- Abdominal rigidity
- Cluster headache
- Common migraine without aura
- Delusional disorder
- Diastolic hypertension
- Generalized anxiety disorder
- Hernia, inguinal
- Health Maintenance

Past Medical History

- History of Aborta/Miscarriages 1
- * History of Anxiety
- Common migraine without aura
- History of Dementia
- History of Gravida 3
- H/O degenerative disc disease
- H/O urinary disorder
- History of atrial fibrillation
- History of harkache

Edit Active Resolve

Viewing Your Note

Note Output

TEST, JENNIFER 35 YO F DOB: 01Jan1979

Acute ▾ Owner: ALLSCRIPTS, Provider Status: Needs Input

Acute

Health Management

Personal history of asthma
Eye Exam; every 1 year; Last 20Aug2013; Next Due: 20Aug2014; Active

Health Maintenance
Colonoscopy; every 5 years; Last 07Jan2014; Next Due: 07Jan2019; Active
Hemoglobin A1C; every 6 months; Last 25Apr2014; Next Due: 25Oct2014; Active
Mammogram (Screening); every 2 years; Last 06Mar2014; Next Due: 06Mar2016; Active

Active Problems

Chronic

1. Abdominal rigidity (789.40)
2. Cluster headache (339.00)
3. Common migraine without aura (346.10)
4. Delusional disorder (297.1)
5. Diastolic hypertension (401.9)
6. Hernia, inguinal (550.90)

Health Maintenance/Risks

7. Generalized anxiety disorder (300.02)

Past Medical History

Chronic

- History of Aborta/Miscarriages 1
- History of Anxiety (300.00)
 - Anxiety is improved. Feels almost normal.
- Common migraine without aura (346.10)
- History of Dementia (294.20)
- History of Gravida 3
- H/O degenerative disc disease (V13.59)
- H/O urinary disorder (V13.00)
- History of atrial fibrillation (V12.59)
- History of backache (V13.59)

≡ Annotate

Sign Audit **Close** Document Hx eReply Attach to Result

To make changes to your note, click **Close** and return to the Edit mode. (This page is a "Read-Only" type screen and can't be edited.)

Signing a Note

The screenshot displays a medical software interface with a 'Note Signature' dialog box open. The dialog box contains the following fields: 'User Name' with the value 'twresident', 'Password' with a masked field, and 'Sig Type' set to 'Author'. There is also a 'Make Final' checkbox. The 'OK' and 'Cancel' buttons are at the bottom of the dialog. In the background, the 'Health Management' section is visible, showing a list of problems and a 'Most Recent' table. At the bottom of the screen, the 'Sign' button in the toolbar is highlighted with a red box. Another red box highlights the 'Save & Close' button in the bottom right corner.

Note Signature

User Name: twresident

Password: [Masked]

Sig Type: Author

Make Final

OK Cancel

Most Recent

Problem	Status
Diabetes	Complete
Hemo	Complete
Health M	Complete
CBC M	Complete
Colon	Complete

View Recompile **Sign** Copy Forward Security Codes Audit **Save & Close** Save Close

When you're ready to sign off on your note, click "Sign" on the toolbar. You will get a Note Signature box which will ask for a password. (This is your Allscripts password.)

Once you've finished reviewing your note, and it's complete, you will want to sign it. Residents will need to send it to their preceptor for review and finalization. If you are NOT finished with the note, but need to get out of it and go on to another patient, you will click "Save & Close," instead of "Sign."

Co-sign note task

Once you click OK on the Signature Box, residents (and nurses, if they are creating a note that needs to be finalized by an attending MD) will get a **Co-Sign Note** task.

Task Details

Task: Filters

1 Not about a patient 2 Concerning patient [R] TEST,FRANKENSTEIN

Assign To: User Team Task: Co-Sign Note

Priority: Routine Status: Active

Comment:

1. Change the radio button to "User."

2. Click the "All" button and search by last name for your attending physician. (Once you have searched for their name once, they will be available in the drop-down list)

Text Templates...

Activate: 25 Apr 2013 4:52 PM Overdue: 02 May 2013 4:52 PM

Create Notify Task When: Complete Overdue

Notify: ALLSCRIPTS_Resident All Priority: Routine

Delegate OK Cancel

After you have put your **attending physician's** name in the Assign To: field, click OK. There is no need to type anything in the Comment section. (When your attending double clicks on this task, it will take him/her directly into the note to be signed and finalized.)

Return to daily schedule

Provider ▼ Hide YTB Tools ▼ ? Help 🔒 Lock ✕ Logoff

Chart | Daily | Clinical Desktop | New Note | Task List | Documents | Appointments | Patient Lists | Provider Schedules | Worklist

TEST, FRANKENSTEIN Age: 34 Years DOB: 03/03/1979 H Phone: (423)111-1111 FYI: FYI
 Sex: F PCP: ALLSCRIPTS, Provider Other: Security: No Restricted Data
 Allergies: Yes Pri Ins: ACORDIA NATIONAL MRN: 001000647052001

Select Patient ▼ i ⚠

Daily Schedule [Arrived, Pending, Rescheduled, No Show](#) Personalize

Provider: ALLSCRIPTS, Resident AM AM: 6 PM: 0 Total: 6 Last Updated: 06/28/2013 9:16 AM 🔄

Date: 17 Jun 2013 📅 Sun Mon Tue Wed Thu Fri Sat 🔍 ⏪ ⏩

\$	N	TC	CS	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:00 AM	SUPERUSER,AQUAMAN	001000643536601	0	15	105	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:15 AM	SUPERUSER,BATMAN	001000643517601	0	15	96	F/U from surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NSH			08:30 AM	SUPERUSER,CATWOMAN	001000643516801	0	15	118	UTI
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:45 AM	SUPERUSER,DAREDEVIL	001000643532501	0	30	100	Infected foot
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pen			09:00 AM	SUPERUSER,FLASH	001000643529101	0	15	76	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pen			09:30 AM	SUPERUSER,SPIDERMAN	001000643519201	0	45	59	New patient

If you aren't automatically routed back to the Daily Schedule after you have closed your note, go ahead and click on the Daily tab to return to your schedule. You are ready to move on to the next patient!

Patient Insurance: Test Allscripts

Patient Profile...
Appt Details...
Patient Appts...
Print Sched...
Print Chart...
New Task...

User: lqani Site: Administration Enc Date: 28 Jun 2013 09:06 AM Enc Type: Chart Update Done

4Iron-Start | Allscripts - Windows Inte... | Allscripts - Windows I...

Starting a note

Most of the time, you will be doing notes on patients who are on your schedule. But, from time to time, you'll want to create a telephone note on a patient who isn't on your schedule. To document a note in this situation, click "Select Patient" on the banner, and choose "Search." A "Select Patient" box will appear. Search for your patient by **Last Name, First Name**. Click Search. Highlight the patient's name and click Enter.

The screenshot shows a medical software interface. The top navigation bar includes 'Provider', 'Chart', 'Daily', 'Clinical Desktop', 'New Note', 'Task List', 'Documents', 'Appointments', and 'Patient Lists'. The main area displays patient information for 'TEST, FRANKENSTEIN', including Age (34 Years), Sex (F), Allergies (Yes), and DOB (03/03/1979). The 'Select Patient' dropdown menu is circled in red, and the 'Search' option is also circled in red. A 'Select Patient' dialog box is open, showing a search for 'allscri, b' and a table of results.

Select Patient (Org: ETSU) [Personalize](#)

Partial LN, Optional Partial FN, Optional Full DOB or YOB

Patient: Name Search Include InActive

Patient	MRN	Other	SSN	DOB	Age	Sex	InA
Allscripts, Betsy	ZZZAHS04	1234567		18 Mar 1946	67Y	F	N
Allscripts, Brad	ZZZAHS03	1234567		08 Mar 1980	33Y	M	N

New Note tab

Once the patient is in the Banner, click on the New Note tab. Choose your Visit Type. Click OK

Daily Clinical Desktop **New Note** Task List Batch Sign Appointments Patient Lists Provider Schedules Worklist

TEST, JENNIFER Age: 35 Years DOB: 01/01/1979 MRN: 001000651937501
Sex: F PCP: FYI: FYI
Allergies: Med Only HPhone: (423)456-7890

Select Patient ▼ i - !

Note Selector

TEST, JENNIFER 35 YO F DOB: 01Jan1979 Non-Appointment 04/16/2014

Create New

Style: Note V10 Note Unstructured Admin Forms

Specialty: Family Medicine Visit Type: << Please select a Visit Type >>

Owner: ALLSCRIPTS, Provider

⚠ Incomplete Notes: << Choose an incomplete Note. >>

⌵ Chief Complaint

[Add/Remove Chief Complaints](#)

There are no items to show in t

- Chart Documentation
- Communication**
- Consult Visits
- Follow-Up Visits
- Health Maintenance
- Nursing Visits
- Office Visits
- Prenatal Visits
- Procedures
- ACOG Note
- Emergency Note
- Home Visit
- Postpartum Visit
- PreOp Clearance
- SBIRT Note
- Well Woman Visit

- Alden Letter
- Bowers Letter
- Communication Regarding Patient
- Letter to Patient
- Nurse Telephone Note
- Patient Letter
- Pillion/Smith Letter
- Provider Telephone Note**
- Results Note
- Results Note (JCFM)
- Results Note w/o Labs

OK Cancel

You have now completed all of
the required modules for
Allscripts EHR training.