



EAST TENNESSEE STATE
UNIVERSITY

QUILLEN ETSU PHYSICIANS

Module 5: Notes

Provider Training Module
Allscripts Touchworks EHR

Quillen EHR Team
Phone: (423) 282-6122, Option 1

June 2020

MODULE INSTRUCTIONS

There are a total of 5 modules that need to be completed prior to the on-site training. It is **REQUIRED** that you complete all of the modules **PRIOR** to training.

These modules are intended to serve two purposes: as an introduction to the system, and as a reference. The modules are very detailed. As such, we don't expect you to retain all of the information in the slides before training; however, we encourage you to print the PDFs, as you will be able to refer back to them as you begin to use the system.

Training will consist mainly of mock practice sessions, so a basic knowledge of the system prior to training is essential. If you have any problems completing these modules, please contact the EHR team. (Contact info is on Slide 1 of each module).

OFFICIALS & MOLE PARTICIPATED BY MURKIN

started, it will appear on your Daily Schedule with a “note”

Provider: ALLSCRIPTS,Provider



STARTING YOUR OWN NOTE

If your nurse does not start your note for you, once he/she changes the status to **Provider Ready**, double click on the patient's name. This takes you to the Clinical Desktop.

The screenshot shows a clinical software interface. At the top, there is a navigation bar with tabs: Daily, Clinical Desktop, New Note, Worklist, Task List, Batch Sign, Appointments, Patient Lists, and Provider Schedules. The 'Daily' tab is selected. Below the navigation bar, the patient's name 'SUPERUSER, FLASH' is displayed, along with their MRN (001000643529101) and other details. A red box highlights the 'MED & NON-MED ALLERGIES' section. Below this, the 'Daily Schedule' section is shown, with a dropdown menu for 'Provider' set to 'ALLSCRIPTS,Provider'. The date is '25 May 2018'. The schedule table lists appointments for the day, with the status 'RrProvider Ready' circled in red for the appointment at 07:30 AM with SUPERUSER, ERNIE.

\$	N	TC	SO	CCS	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
							Arr	07:00 AM	SUPERUSER, BATMAN	00100064351760	NP	15	1	NP GALLBLADDER
							Arr	07:15 AM	SUPERUSER, BERT	00100064365540	AC	15	3	ACUTE PAIN - LASHER
						G59 Exam	RrProvider Ready	07:30 AM	SUPERUSER, ERNIE	00100064365620	5	15	2	CONSULT
							Arr	08:00 AM	SUPERUSER, CATWOM	00100064351680	FU	15	1	FOLLOW UP WOUND
							Arr	08:15 AM	SUPERUSER, FLASH	00100064352910	69	15	2	POST OP SAHAWNEH
							Arr	10:00 AM	SUPERUSER, WASP	00100064353740	NP	15	3	NP LIVINGSTON

NEW NOTE TAB

The screenshot shows a medical software interface with the following elements:

- Top Navigation Bar:** Contains tabs for Daily, Clinical Desktop, **New Note** (highlighted with a red circle), Worklist, Task List, Batch Sign, Appointments, Patient Lists, and Provider Schedules.
- Patient Information:** Displays the patient name **SUPERUSER, ERNIE**, birth date **01-Jan-1979 (39y) F**, and other details like PCP **Aiken, Todd**, MRN **001000643656201**, and H Phone **(423)123-4567**.
- Patient Banner:** An orange box on the right side of the patient information section containing the text **Patient Banner** and **NO KNOWN ALLERGIES**.
- ETSU - Clinician:** A section below the patient information showing the clinician's name and various icons for different medical functions.
- Navigation Bar:** A row of icons for different medical functions, including a red circle icon, a heart icon, a person icon, a document icon, a magnifying glass icon, and a plus icon.
- Commit:** A button labeled **Commit**.
- Pat Loc:** A dropdown menu showing **G59 Exam Rm**.
- Status:** A dropdown menu showing **Provider Ready**.
- Updated:** A text field showing **3:35 PM**.
- Notes Tab:** The **Notes** tab is selected, showing a list of chart items. The list includes items like **Acute (Acute) - ALLSCRIPTS, Provider, Enc: 25-May-2018 - Appointment - ALLS**, **Established (Established) - ALLSCRIPTS, Provider, Enc: 16-Nov-2017 - Chart U**, **ACOG Flowsheets - ALLSCRIPTS, Provider, Enc: 15-Nov-2017 - Chart Update -**, **sTWS Forms - Livingston, Amanda; Enc: 09-Nov-2017 - Chart Update - Livingst**, **sOMR PCP - Livingston, Amanda; Enc: 09-Nov-2017 - Chart Update - Livingston,**, **Follow-Up (Follow-Up) - Livingston, Amanda; Enc: 08-Nov-2017 - Chart Update -**, **New Patient (New Patient) - Livingston, Amanda; Enc: 08-Nov-2017 - Chart Upd**, **Follow-Up (Follow-Up) - Livingston, Amanda; Enc: 23-Oct-2017 - Chart Update -**, **Communication Note (no co-sign) (Communication Note (no co-sign)) - Laiwala,**, and **Medication Management with Office Visit (Medication Management with Office Vi**.
- Flowsheets Tab:** The **Flowsheets** tab is selected, showing a list of items like **Vital Signs**, **Meds**, **Med Flowsheet**, **Orders**, **Allergies**, and **Immunizations**.
- Current Orders:** A section showing **Current Orders** with a dropdown menu for **Type** and **Alpha**. Below this, it says **There are no items to show in this view.**

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. 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' window for a patient named Emie, born 01-Jan-1979 (39 years), Female. The appointment is scheduled for 25-May-2018. The 'Style' is set to 'Note'. The 'Specialty' is 'Internal Medicine' and the 'Owner' is 'ALLSCRIPTS, Provider'. The 'Visit Type' dropdown is open, showing a list of options. A red circle highlights the 'Visit Type' dropdown, and a red arrow points from a text box to the 'Appointment: 25-May-2018' field. The 'Chief Complaint' section is empty, with a message 'There are no items to show in'. The 'Enc Date' is 25 May 2018 07:30 AM and the 'Enc Type' is Appointment.

Specialty: Internal Medicine

Owner: ALLSCRIPTS, Provider

Visit Type: << Please select a Visit Type >>

- Behavioral Health
- Chart Documentation
- Communication
- Consult Visits
- Follow-Up Visits
- Health Maintenance
- Nursing Visits
- Office Visits
- Post-Op Visits
- Procedures
- Psych Visits
- Diabetes/Nutrition Education Record
- Nutrition Visit
- PreOp Clearance

Acute

Annual Physical Exam

COE Management Progress Note

COE Medical Case Management Note

Established

JCIM Infusion Note

Medicare Annual Wellness

New Patient

Palliative Care Note

PharmD Note

School Sports Examination

Welcome to Medicare Evaluation

Worker's Comp

Enc Date: 25 May 2018 07:30 AM Enc Type: Appointment

Ensure that correct appointment date in upper right.

NOTE IN "EDIT" MODE

The screenshot displays a medical software interface in "EDIT" mode. The interface is divided into several sections, with annotations highlighting key components:

- Patient Information:** Located at the top, it includes the patient's name, age, and date of birth (DOB), as well as the appointment date and visit type.
- Clinical Toolbar:** A horizontal bar containing various icons for clinical actions, such as adding new problems, medications, or orders.
- Table of Contents:** A vertical list on the left side of the screen, providing a quick overview of the note's structure, including sections like Preventive, Health Management, Chief Complaint, Reason For Visit, Active Problems, History of Present Illness, Review of Systems, Complete-Female, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies, and Immunizations.
- Clinical Desktop:** The central workspace where the clinical note is authored. It includes a "Preventive" section with a "Data Includes: Current Encounter" button, a table of items (e.g., "Have you ever had a...", "Have you had a flu shot this...", "Have you had colorectal..."), and a "PHQ-9" section.
- Note Authoring Workspace (NAW):** A section at the bottom of the Clinical Desktop, used for managing the note's content and structure.
- Vitals and Immunizations:** A section on the right side of the screen, displaying vital signs and immunization records.

The interface also features a "Commit" button, a "Save & Close" button, and a "Close" button. The status bar at the bottom indicates the current state of the note and the user's actions.

TABLE OF CONTENTS

SUPERUSER, Emie 01-Jan-1979 (39 years) F Appointment: 25-May-2018

Chart and Note View

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

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.

Show All Hide All New Order

mplaint

For Visit

roblems

ement

Health Maintenance/Risks

☐ Health Maintenance

New Edit CareGuide Resolve

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

TABLE OF CONTENTS

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

The screenshot displays a medical software interface. At the top right, it says 'Appointment: 25-May-2018'. Below this, there are several tabs: 'Allergies', 'Vitals', 'Immunizations', 'Problem', 'Medications', and 'Chart Viewer'. The 'Problem' tab is selected, showing a list of 'Active' problems. On the left side, there is a 'Table of Contents' with various sections like 'Patient History', 'Social History', 'Family History', 'Surgical History', 'Current Meds', 'Output Template', and 'CC'. The 'Active Problems' section is highlighted in the Table of Contents. A yellow callout box points to this section, stating: '...that section will open up so that you can document your information.' Below the Table of Contents, there is a section for 'Output Template' with checkboxes for 'Established', 'Referral Letter', and 'Return to Work Letter'. The 'Established' checkbox is checked. A yellow callout box points to this section, stating: '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.'

Type	Name	ICD-9	Managed By	Last Asses
Chronic	Attention deficit disorder of adult	314.00		12Jun20
Chronic	Bipolar disorder	296.80		
Chronic	Cancer	199.1	Garland, Bridget	
Chronic	Community acquired pneumonia	041.01	Garland, Bridget	
Chronic	Diabetes mellitus	250.00		
Chronic	Hungry bone syndrome	275.5	Garland, Bridget	
Chronic	Nontoxic multinodular goiter	241.1		14Apr20
Chronic	Ophthalmoplegia internuclearis	378.86	Garland, Bridget	14Apr20
Chronic	Pain, abdominal	789.00		06Jun20
Acute	Acute frontal sinusitis	461.1	ALLSCRIPTS, Provider...	29Apr20
Acute	Acute upper respiratory infection	465.9	Garland, Bridget	14Apr20

CLINICAL DESKTOP/NAW

The screenshot displays the Clinical Desktop/NAW interface. At the top is a toolbar with icons for various functions and buttons for 'Commit', 'Pat Loc', and 'Status'. Below the toolbar are tabs for 'Note', 'Appointments', and 'Health Management Plan'. The left sidebar contains a list of medical history categories: Active Problems, Review of Systems, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies, Immunizations, and Vitals. The main workspace is divided into sections for 'Reason For Visit', 'Active Problems', 'History of Present Illness', 'Review of Systems', and 'Past Medical History'. The right sidebar shows a list of notes organized by specialty, including Adolescent Medicine, Cardiology, and Endocrinology. Two callout boxes provide additional information: an orange box explains that the right-hand side contains components of the Clinical Desktop, and a yellow box explains that the Note Authoring Workspace (NAW) is where text is populated into the forms.

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.

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.

The screenshot shows the 'Patient Care Team' section of a medical software interface. The interface includes a sidebar with various note sections, a main content area for the Patient Care Team, and a bottom section for output templates and a task bar.

Note
Established ALLSCRIPTS, Provider Status: Needs Input

Patient Care Team

Lock

☐ Show Inactive

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

Task Hide Show All Hide All

Output Template CC

☒ Established

☐ Referral Letter

☐ Return to Work Letter

Patient Care Team

Health Management

HM Checklist

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

NOTE SECTIONS – HEALTH MANAGEMENT

The screenshot displays the 'Health Management' section of a medical software interface. On the left, a sidebar lists various patient care team sections, including 'Health Management', 'HM Checklist', 'Chief Complaint', 'Reason For Visit', 'Active Problems', 'Past Medical History', 'Social History', 'Family History', 'Surgical History', and 'Current Meds'. The main area shows a table with columns: Item, Sch..., G..., Most Recent, Date, and To Do. A row for 'Mammogram...' is highlighted, showing 'Q 1...', 'New', 'negative', and '17Apr2014' in the 'To Do' column. A red circle highlights the 'To Do' column for this entry, which shows '* Due: 17Apr2015'. A right-click context menu is open over this entry, with the 'Order' option highlighted. An orange text box explains that users can order directly from here by right-clicking and selecting 'Order'.

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

SUPERUSER, Emie 01-Jan-1979 (39 years) F

Tip: Allscripts considers Chief Complaints to be symptoms, rather than diagnoses. For this reason, the CC selection is limited and includes items such as wheezing, shortness of breath, and swelling, rather than asthma, COPD, and edema.

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

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

HM Checklist

Chief Complaint

☒ Belching

New

Resolve

Hide

Show All

Hide All

New
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

HM Checklist

Chief Complaint

☒ Belching

New Resolve Hide Show All Hide All

Chief Complaint

Chief Complaint Details:

Reason For Visit

Screening:

Belching:

Review of Systems

Past Medical History

View **Recompile** Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close 1.4

Both the Chief Complaint and the Active Problem sections are designed to pull forms into the HPI section of the note. The HPI forms are added when the problem is Assessed or the Chief Complaint is added in the ACI.

To get the form(s) to pull into the note, add a Chief Complaint or assess an Active problem, and then click the **Recompile** button.

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.

If the Active Problem was added at a previous visit, and you want the form to pull into the note, click the paper icon in the Active Problem section (which assesses the problem for today’s visit), and then click **Recompile**. The form will pull into the HPI section.

Left Sidebar (Tree View):

- Preventive
- Health Management
- Chief Complaint
- Reason For Visit
 - Reason For Visit - IM
- Active Problems**
- History of Present Illness
 - History of Present Illness
 - Foot Pain
 - Sleep Disorders (Brief)
 - Insomnia (Brief)
 - Insomnia (Follow-Up)
 - Bad Breath
 - Hot Flashes
 - Chest Pain (Brief)**
 - Nausea
- Review of Systems
 - Complete-Female
- Past Medical History
 - No new statement - PM
- Social History
 - No new statement - SH

Bottom Left (Output Template):

CC

☒ Established ☐ Referral Letter ☐ Return to Work Letter

Central Workspace:

Active Problems

- Elevated blood pressure reading R03.0
- Foot pain
- Generalized continuous abdominal pain
- Major neurocognitive disorder
- Malignant essential hypertension
- Primary insomnia
- Probable major neurocognitive disorder
- Recurrent major depressive disorder
- Chest pain**

Past Medical History

Chronic

- History of Chronic pain syndrome (G89.4)
- History of nausea and vomiting (Z87.898)
- History of recurrent urinary tract infection (Z87.440)

Acute

- History of Positive urine pregnancy test (Z32.01)

Bottom Right (Buttons):

New Edit CareGuide Resolve Hide Show All Hide All

Right Sidebar (Table):

Name	ICD-10
Elevated blood pressure reading	R03.0
Foot pain	M79.673
Generalized continuous abdominal pain	R10.84
Major neurocognitive disorder	F03.90
Malignant essential hypertension	I10
Primary insomnia	F51.01
Probable major neurocognitive disorder	G30.9
Recurrent major depressive disorder	F33.9

Bottom Right (Buttons):

New Edit Resolve

FORMS

The screenshot shows a medical software interface. On the left is a sidebar with a tree view containing categories like 'Chief Complaint', 'Reason For Visit', 'History of Present Illness', 'Depressive Disorders' (highlighted with a red box), 'Review of Systems', 'Active Problems', 'Past Medical History', 'Surgical History', 'Family History', 'Social History', 'Current Meds', 'Allergies', 'Immunizations', 'Vitals', 'Physical Exam', and 'Procedure'. The main window displays the 'Depressive Disorders (Brief)' form, which is also highlighted with a red box. The form includes sections for 'Reason for Visit', 'Visit Type', 'Depression Type', 'Last Visit', 'Symptoms', 'Problem Details', 'Associated Symptoms', 'Suicide / Homicide Risk', and 'Current Treatment'. Each section contains various checkboxes and radio buttons for data entry. At the bottom, there is a status bar with buttons for 'View', 'Recompile', 'Sign', 'Spell Check', 'Copy Forward', 'Show Uncopied Form Data', 'Save & Close', 'Save', 'Close', and a 'New' button with an information icon.

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).

Hyperlipidemia Follow-up

Status:

☐ Good ☒ Stable

Comorbid Illnesses:

☐ None ☐ CAD

☒ Diabetes Mellitus ☐ PVD

☒ Hypertension

Interval Events: ☒ (circled)

☐ None

Interval Symptoms:

☐ None

Lifestyle: ☐

Medications: ☐

Details form

Onset Mode:

☐ Gradual ☐ Sudden

Severity:

☐ Mild ☐ Moderate ☐ Severe

Location / Laterality:

☐ Substernal ☐ Anterior Mid-Chest ☐ Sub-Xiphoid

☐ Epigastric ☐ Infrascapular

	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 ☐ Pleuritic ☐ Stinging

☐ Burning ☐ Pressure-Like ☐ Tight

☐ Dull ☐ Sharp

☐ Heavy ☐ Squeezing

Radiation / Laterality:

☐ No Radiation ☐ Jaw ☐ Back

☐ Neck

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

Note Authoring Workspace

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" within a software interface. The sidebar on the left lists various sections: Health Management, Chief Complaint, Reason For Visit, Active Problems, History of Present Illness, Angina (Follow-Up), Review of Systems (highlighted with a red box), Complete-Female (highlighted with a red box), Past Medical History, Social History, Family History, and Sexual History. The main content area is titled "Complete-Female" and has two buttons at the top right: "All Normal" and "Previous Exam", both highlighted with red boxes. Below these buttons, there are several sections with checkboxes and "Y/N" buttons: Constitutional (Negative, Fever, Chills, As Noted in HPI, Feeling Poorly, Feeling Tired/Fatigue), Eyes (Negative, Eye Pain, Red Eyes, As Noted in HPI, Eyesight Problems, Discharge From Eyes), Nosebleeds, Nasal Discharge, Chest Pain, and Palpitations. A red arrow points from the "All Normal" button to the summary box on the right. The summary box, outlined in blue, lists the following: 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. At the bottom of the form, there are buttons for View, Recompile, Sign, Copy Forward, Security Codes, Audit, Save & Close, Save, and Clk8.

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.

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.

HISTORY SECTIONS

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] [icon] [icon] [icon] [icon] [icon]

	Name	ICD-9	Managed By
Chronic			
+ [icon]	History of Bilateral Pheochromocytoma	227.0	
[icon]	History of depression	V11.8	
[icon]	History of headache	V13.89	
[icon]	* History of hypertension	V12.59	Garland, Br
+ [icon]	History of migraine headaches	V12.49	
+ [icon]	History of Hungry bone syndrome	275.5	Garland, Br
Acute			
[icon]	History of Acute tonsillitis	463	Garland, Br

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

Finished Note

Family History

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

NOTE SECTIONS – CURRENT MEDS

Commit | Pat Loc: G59 Exam Rm | Status: Provider Ready | Updated: 3:35 PM

Note | Appointments | Health Management Plan

New Patient | ALLSCRIPTS, Provider | Status: Needs Input

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-Inject

Results/Data

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

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

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

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.

NOTE SECTIONS – PROCEDURES

The screenshot shows a medical software interface with a sidebar on the left containing various note sections: Surgical History, Current Meds, Allergies, Immunizations, Vitals, Physical Exam, Procedure (highlighted with a red circle), Results/Data, Assessment, Discussion/Summary, Plan, and Attending Note. The main area displays the 'Procedure' section header for 'Trigger Point Injection (General)'. A context menu is open over this header, listing options such as 'Add Section Above', 'Add Section Below', 'Add Form Top' (highlighted with a green box), 'Add Form Bottom', 'Rename Section', 'Add Symptom Top', 'Add Symptom Bottom', 'Add Image Top', 'Add Image Bottom', 'Add Form Above', 'Add Form Below', 'Add Symptom Above', 'Add Symptom Below', 'Add Image Above', 'Add Image Below', and 'Clear Form'. A yellow callout box explains that notes are set to pull in the top 10 procedures and that users can right-click on the section header to add forms. An orange callout box explains that forms can be pulled into any section by right-clicking on the section name and choosing 'Add Form Top', and that images can also be added using 'Add Image Top'.

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

skin <Filter by Form Type> Procedure My Favorites

	Form Display Name	Sex	Age	Type	Section	Specialty	Created By	Date Created	Modified By	Date Modified	Is
<input type="checkbox"/>	Additional Skin Debridement Site D...			PROC	Procedure	Podiatry	Allscripts Cli...	23-Mar-2011	Allscripts Cli...	10-Dec-2014	<input type="checkbox"/>
<input type="checkbox"/>	Allergy Skin Testing			PROC	Procedure	Allergy/Immunology	Logan, Jen...	12-Jul-2013	Logan, Jen...	12-Jul-2013	<input type="checkbox"/>
<input type="checkbox"/>	Eyelid Lesion Excision			PROC	Procedure	Ophthalmology	Livingston,...	19-Feb-2020	Livingston,...	19-Feb-2020	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Foreign Body Removal-Skin			PROC	Procedure		Allscripts Cli...	28-Mar-2011	Garland, Bri...	02-Apr-2020	<input type="checkbox"/>
<input type="checkbox"/>	Foreign Body Removal-Skin			PROC	Procedure		Allscripts Cli...	16-Feb-2010	Garland, Bri...	02-Apr-2020	<input type="checkbox"/>
<input type="checkbox"/>	Skin Debridement			PROC	Procedure	Podiatry	Allscripts Cli...	20-Apr-2011	Allscripts Cli...	10-Dec-2014	<input type="checkbox"/>
<input type="checkbox"/>	Skin Excision Detail			PROC	Procedure		Allscripts Cli...	12-Sep-2007	Allscripts Cli...	10-Dec-2014	<input type="checkbox"/>
<input type="checkbox"/>	Skin Excision Detail						-2011	Allscripts Cli...	Allscripts Cli...	10-Dec-2014	<input type="checkbox"/>
<input type="checkbox"/>	Skin Lesion Biopsy/Excision/Destru...						-2011	Allscripts Cli...	Allscripts Cli...	16-Apr-2012	<input type="checkbox"/>
<input type="checkbox"/>	Skin Lesion Biopsy/Excision/Destru...						-2011	Garland, Bri...	Garland, Bri...	28-Jun-2016	<input type="checkbox"/>
<input type="checkbox"/>	Skin Lesion Biopsy-Excision-Destru...						-2019	Garland, Bri...	Garland, Bri...	07-Nov-2019	<input type="checkbox"/>
<input type="checkbox"/>	Skin Procedure Location Detail						-2007	Allscripts Cli...	Allscripts Cli...	26-Jan-2011	<input type="checkbox"/>
<input type="checkbox"/>	Skin Test and Challenge Procedure						2013	Logan, Jen...	Logan, Jen...	28-Feb-2013	<input type="checkbox"/>

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.

☒ Foreign Body Removal-Skin

Switch to Structured Content View

OK Cancel

NOTE SECTIONS – RESULTS/DATA

The Results/Data section will pull in the patient's labs for the previous month for MEAC clinics. *Family Medicine doesn't automatically pull in any labs.*

The screenshot displays a medical software interface with a sidebar on the left containing various note sections: Allergies, Immunizations, Vitals, Physical Exam, Procedure, and Assessment. The 'Results/Data' section is highlighted in the sidebar. The main window shows the 'Results/Data' section with a message: 'There are no items to show in this view. Data Includes: Last 1 Month'. A red box highlights the 'Advanced Result Citation' button. A dialog box titled 'Results Citation Selection' is open, showing a list of lab results with checkboxes. The first item, 'Drug Screen, Urine', is checked. The dialog also displays patient information: 'SUPERUSER, Ernie 01-Jan-1979 (39 years) F : 25-May-2018'. The 'Assessment' section is visible below the 'Results/Data' section, listing 'Foot pain (M79.673)', 'Primary insomnia (F51.01)', and 'Chest pain (R07.9)'. The 'Output Template' section is at the bottom left, showing 'Established' as the selected template.

Results/Data

Advanced Result Citation

There are no items to show in this view. Data Includes: Last 1 Month

Results Citation Selection

SUPERUSER, Ernie 01-Jan-1979 (39 years) F : 25-May-2018

Result Citation Selection

- ☒ Drug Screen, Urine; Ordered by Livingston, Amanda; 15Nov2017
- ☐ Microalbumin / Creatinine Ratio, Urine (Random); Ordered by
- ☐ Lipid Panel; Ordered by ALLSCRIPTS, Provider; 14Jul2015 04:
- ☐ Hemoglobin A1C; Ordered by ALLSCRIPTS, Provider; 14Jul20
- ☐ Thyroid Stimulating Hormone; Ordered by ALLSCRIPTS, Provid
- ☐ CBC Automated Differential; Ordered by ALLSCRIPTS, Provide
- ☐ Comprehensive Metabolic Panel; Ordered by ALLSCRIPTS, Pr
- ☐ Vitamin B12; Ordered by ALLSCRIPTS, Provider; 08Jul2015 04
- ☐ GYN Flowsheet; Ordered by Logan, Jennifer; 18Jul2010 12:00
- ☐ GYN Flowsheet; Ordered by Logan, Jennifer; 31Jan2008 12:00
- ☐ GYN Flowsheet; Ordered by Logan, Jennifer; 18Aug2000 12:00

OK Cancel

Assessment

Assessed

Foot pain (M79.673)

Primary insomnia (F51.01)

Chest pain (R07.9)

Results/Data

Assessment

Summary/Care Plan

Output Template

CC

☒ Established

☐ Referral Letter

☐ Return to Work Letter

View

Recompile Sign Spell

To pull in a lab that is outside of the 1-month parameter, simply choose **Advanced Result Citation** then check the box for the lab you want pulled into the note. This is only available for labs completed by ETSU laboratory.

NOTE SECTIONS – ASSESSMENT

The screenshot shows a medical software interface. On the left, a sidebar lists various note sections: Wart Destruction, Abdominal Ultrasound, Electrocardiogram (EC), Cerumen Removal, Orthopedic Aspiration-I, Sacroiliac Joint Injectio, Epley Maneuver, Results/Data, **Assessment** (highlighted with a red box), Summary/Care Plan, Care Plan, Summary of Visit, Discussion and Summa, Plan, IM Plan, Attending Note, Attending Note, Return to Work, Return to Work, and Letter Greeting. The main area is titled 'Assessment' and contains a table of patient problems.

Name	ICD-10	Managed By
Assessed		
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot pain	M79.673	
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Primary insomnia	F51.01	
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain	R07.9	
Unassessed		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety	F41.9	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recurrent major depression resistant...	F33.9	

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

The Plan section is where you are going to order all the items for the patient; such as prescriptions, labs, radiology, follow-up visits, referrals and patient education.

To order the patient's prescriptions or labs, etc., just click on the Rx or beaker button on the Clinical Toolbar or the New button on the gray toolbar. This will take you to the ACI screen, where you can order all of the items.

Plan

Problem | Rec: Done | Lock

- Chest pain**
 - Follow-ups**
 - 1 month Follow up - Follow-up Status: Hold For - Scheduling Requested for: 04Jun2018
 - Elevated glucose**
 - Medications**
 - ePA Start: Glucose Test Strips; provide one unit
 - Referrals**
 - Dietitian Referral Evaluation and Treatment cut cards Status: Hold For - Scheduling Requested for: 04Jun2018
 - Recurrent major depression resistant to treatment**
 - Orders**
 - Lithium Status: Active Requested for: 04Jun2018

View **New** Verify/Add Record D/C Temp Defer Edit Hide

IM Plan

Health Manage

Plan

IM Plan: ☐ **Attending Note**

Return to Work

Recompile Sign Spell Check Copy Forward Show Uncopied Form Data Save & Close Save Close

NOTE SECTIONS – ORDERING

Add Clinical Item

SUPERUSER, Emie 01-Jan-1979 (39 years) F Appointment: 25-May-2018

History Builder **Orders**

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

Send To Retail TouchWorks Test Pharmacy

Entering For: ALLSCRIPTS,Provider Supervised By:

My Favorites ON Record w/o Ordering Pharmacy Supp

☐ No Reported Medications
☐ OBDM

Problems

Active Problems Rec: Done

Chest pain
Elevated blood pressure reading
Elevated glucose
Foot pain

Medications

Current Medications Rec: Done

Filter: Current Encounter (e.g. only items entered / edi

Unauthorized - Requires Signature
Glucose Test Strips; provide one u

DUR Alerts: Drug-Drug (0) | PAR (0) | Disease (0) | Dup Therapy (0) | Dose (0) | Adult Dose Range Checking is not available.

OK Cancel

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.

SAVE YOUR NOTE

It is important to save your note often when working. This will create iterations that can be retrieved by the EHR team in case the note crashes or you lose internet connectivity.

The screenshot displays an EHR interface for creating a note. The top bar shows 'Note' and 'Health Management/Reminders'. Below this, there's a search bar with 'ALLSCRIPTS, Provider' and a status indicator 'Status: Needs Input'. The main content area is divided into a left sidebar and a right pane. The sidebar lists various medical history sections like 'Chief Complaint', 'Reason For Visit', 'History of Present Illness', 'Active Problems', 'Past Medical History', 'Surgical History', 'Family History', 'Social History', 'Current Meds', 'Allergies', 'Immunizations', 'Vitals', 'Physical Exam', and 'Procedure'. The right pane shows the 'Chief Complaint' section with a 'Lock' button and a message 'There are no items to show in this view.' Below this, there are sections for 'Chief Complaint Details', 'Referring Provider', and 'Active Problems'. The 'Active Problems' section lists several conditions: 'Chronic Abnormal fasting glucose (R73.01)', 'Diabetic ketoacidosis associated with diabetes mellitus due to underlying condition (E08.10)', 'Generalized anxiety disorder (F41.1)', 'Hospital discharge follow-up (Z09)', 'Nasal congestion (R09.81)', and 'Severe recurrent major depression (F33.2)'. At the bottom of the interface, there's a toolbar with buttons for 'View', 'Recompile', 'Sign', 'Spell Check', 'Copy Forward', 'Show Uncopied Form Data', 'Save & Close', 'Save', and 'Close'. A red arrow points to the 'Save' button.

VIEWING YOUR NOTE

Commit Pat Loc G59 Exam Rm Status Provider Ready Updated: 3:35 PM

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

Note Acute ALLSCRIPTS, Provider Status: Needs Input

Health Management

Problem

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

Current Orders Labs Appointments

Allergies Vitals Immunizations

Problem Medications Chart Viewer

All Problem List

Name

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 hachache

Edit Active Resolve

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.

VIEWING YOUR NOTE

The screenshot shows a software window titled "Note Output". At the top, it displays patient information: "SUPERUSER, Ernie 01-Jan-1979 (39 years) F" and "Appointment: 25-May-2018". Below this, there are tabs for "Established", "Owner: ALLSCRIPTS, Provider", and "Status: Needs Input". The main content area is divided into sections: "Chief Complaint" with a list of "1. Bad Breath" and "2. Hot Flashes"; "Active Problems" which is further divided into "Chronic" (a list of 9 conditions including Anxiety, Elevated blood pressure, Foot pain, etc.) and "Acute" (a list of 1 condition: Chest pain); and "Past Medical History" which includes "Chronic" (a list of 1 condition: History of Chronic pain syndrome). At the bottom, there is a toolbar with buttons: "Sign", "Audit", "Document Hx", "Task", "Attach to Result", "Print", "Fax", "Invalidate", and "Close". The "Close" button is highlighted with a red rectangle.

Note Output

SUPERUSER, Ernie 01-Jan-1979 (39 years) F Appointment: 25-May-2018

Established Owner: ALLSCRIPTS, Provider Status: Needs Input

Established

Chief Complaint

1. Bad Breath
2. Hot Flashes

Active Problems

Chronic

1. Anxiety (F41.9)
2. Elevated blood pressure reading (R03.0)
3. Foot pain (M79.673)
4. Generalized continuous abdominal pain (R10.84)
5. Major neurocognitive disorder (F03.90)
6. Malignant essential hypertension (I10)
7. Primary insomnia (F51.01)
8. Probable major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance (G30.9,F02.81)
9. Recurrent major depression resistant to treatment (F33.9)

Acute

10. Chest pain (R07.9)

Past Medical History

Chronic

- History of Chronic pain syndrome (G89.4)

Annotate

Sign Audit Document Hx Task Attach to Result Print Fax Invalidate **Close**

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 YOUR NOTE

Commit | Pat Loc G59 Exam Rm | Status Provider Ready | Update

Note | Health Management/Reminders

Established | ALLSCRIPTS, Provider | Status: Needs Input

Save & Close | Save

Wart Destruction
Abdominal Ultrasound
Electrocardiogram (EC
Cerumen Removal
Orthopedic Aspiration-I
Sacroiliac Joint Injectio
Epley Maneuver

Results/Data
Assessment

Summary/Care Plan
Care Plan
Summary of Visit
Discussion and Summa

Plan
IM Plan
Attending Note
Attending Note
Return to Work
Return to Work
Letter Greeting
Greetings
Letter Closing

Output Template | CC

Established
Referral Letter
Return to Work Letter

View | Recompile | Sign | Spell Check | Copy Forward | Show Uncopied Form Data | 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 SUPERUSER,ERNIE

Assign To: ☒ **User** ☐ Team

ALLSCRIPTS, Provider

Task: **Co-Sign Note**

Priority: **Routine** Status: **Active**

Comment:

Text Templates...

Activate: **04 Jun 2018 5:07 PM** Overdue: **11 Jun 2018 5:07 PM**

Create Notify Task When: ☐ Complete ☐ Overdue

Notify: **Livingston, Amanda** Priority: **Routine**

☐ Delegate

1. Change the radio button to "User."

2. Click the "magnifying glass" 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)

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

Daily Schedule Arrived, Pending and Rescheduled ☐ AM: 6 ☐ PM: 0 ☒ All: 6 [Personalize](#)

Provider: ALLSCRIPTS, Provider Last Updated: 06/04/2018 5:11 PM

Date: 25 May 2018

SUN	MON	TUE	WED	THU	FRI	SAT	Today							
\$	N	TC	SOC	CS	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			07:00 AM	SUPERUSER, BATMAN	001000643517601	NP	15	1	NP GALLBLADDER
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			07:15 AM	SUPERUSER, BERT	001000643655401	AC	15	3	ACUTE PAIN - LASHER
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr	G59 Exam Rm	Provider Ready	07:30 AM	SUPERUSER, ERNIE	001000643656201	5	15	2	CONSULT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:00 AM	SUPERUSER, CATWOMAN	001000643516801	FU	15	1	FOLLOW UP WOUND
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:15 AM	SUPERUSER, FLASH	001000643529101	69	15	2	POST OP SAHAWNEH
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			10:00 AM	SUPERUSER, WASP	001000643537401	NP	15	3	NP LIVINGSTON

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: BLUE SHIELD OF TN BLUECARE

[Edit Clin Summary](#)
[Patient Profile...](#)
[Appt Details...](#)
[Patient Appts...](#)
[Print Sched...](#)
[Print Chart...](#)
[New Task...](#)

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 on the "magnifying glass." A "Select Patient" box will appear. Search for your patient by **Last Name, First Name** or **DOB**. Click Search. Highlight the patient's name and click OK.

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

SUPERUSER, CATWOMAN PCP ALLSCRIPTS, Resider
MRN 001000643516801
FYI FYI

01-Jan-1979 (39y) F | i x u

Select Patient -- W

Select Patient Org: ETSU

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

Patient: allscripts Name Search

Patient	MRN	Other	SSN
... Allscripts, Alan	120710142609537		
... ALLSCRIPTS, ALLISON	001000774664701		XXX
... ALLSCRIPTS, AMBER	001000774638101		XXX
... ALLSCRIPTS, BETSY	001000774665401		XXX

NEW NOTE TAB

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

The screenshot shows the 'New Note' tab selected in the top navigation bar. The patient information at the top includes 'Allscripts, Chris', '10-Mar-1976 (42y) M', and various identifiers like PCP, MRN (ZZZAH506), and H Phone ((802)555-1116). The 'Note Selector' window is open, displaying the patient's name and date. The 'Create New' section has three radio buttons: 'Note' (selected), 'Unstructured', and 'Admin Forms'. Below these are dropdown menus for 'Specialty' (Internal Medicine), 'Owner' (ALLSCRIPTS, Provider), and 'Visit Type' (Communication Note (co-sign)). A red box highlights the 'Visit Type' dropdown. To the right, a search bar shows 'Telephone Call: 04-Jun-2018'. Below the 'Create New' section is an 'Incomplete Notes' section with a dropdown menu. At the bottom, there is a 'Chief Complaint' section with a link 'Add/Remove Chief Complaints' and a message 'There are no items to show in this view'. The 'OK' and 'Cancel' buttons are at the bottom right.

ENCOUNTER SELECTOR

Encounter Selector

☒ Existing Encounters:

Date	Provider	Type
15May2020 9:15 AM	Alshunnaq, Dina	Appointment
15May2020 9:15 AM		Chart Update
11May2020 4:10 PM	Alshunnaq, Dina	Non-Appointment
11May2020 4:06 PM	Alshunnaq, Dina	Non-Appointment
08Nov2019 10:56 AM		Chart Update
08Nov2019 10:56 AM		Chart Update

☐ New Encounter:

Date: 18 May 2020

Type:

- Broadmore Visit
- Chart Update
- Home Visit
- Image Encounter
- Lab
- Medication Update
- Message
- Non-Appointment
- Result
- Rx Change
- Rx Renewal
- Telephone Call

Cancel

The Encounter Selector opens when the note isn't attached to an appointment, like a telephone call. Click New Encounter radio button and choose a Type.

MACROS

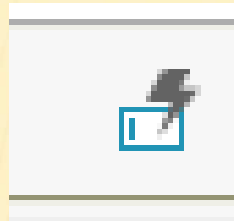
A macro is a shortcut that you create that when entered into the system will automatically expand into a larger phrase or series of phrases. A macro can be used to automatically enter simple, repetitive phrases including commonly used sentences and instructions in your documentation.

Macros that are inserted without editing may contain elements that were not asked or examined during the specific patient encounter. Physicians need to be certain that the medical record accurately reflects the patient encounter.

More documentation does not equal a higher E/M level. E/M levels are determined by the nature of the presenting complaint, History, Physical Exam and Medical Decision Making. Evaluation and treatment must be medically necessary and appropriate.
(from <https://www.acep.org/Clinical---Practice-Management/EMR-EHR-FAQ/>)

HOW TO CREATE A MACRO

Click the macro button.



Health Management/Reminders

vider Status: Needs Input

Save & Close Save Close

Active Problems

Type Rec: Needed Lock

	Name	ICD-10	Managed By	Last Assessed
Chronic				
	Chronic kidney disease, stage 3 to stage 5	N18.3	+	30Jun2017 Maguire, Jose
	Diabetes	E11.9		30Jun2017 Maguire, Jose
	Hypertension	I10		22Jun2017 Panta, Utsab...
	Thoracic outlet syndrome	G54.0		22Jun2017 Panta, Utsab...
	Warts	B07.9		29Jun2017 Crooks, Christ
Acute				

MACRO CREATION

A Macros Edit box will appear for you to begin creating. Click Create.

Create

The screenshot shows a 'Manage Macros' dialog box with a table of macros. The 'Create' button at the bottom left is circled in red.

Shortcut	Expanded Text	Description	Owner	Inactive
.normfem	The exam showed normal external female external g...	Normal Female Genitalia Exam	Livingston, Amanda	

Buttons at the bottom: Create (circled in red), Edit, Copy, Inactivate, Close.

MACROS

Create New Macro

Owner: Livingston, Amanda

Shortcut: Alphanumeric only

Description: << Show Merge Fields

Medications were reviewed and refills given as needed.

Verify Merge Fields Spell Check Save Cancel

1 2 3

MACRO COMPONENTS



1. **Shortcut** will allow you to put in your short phrase for your macro.



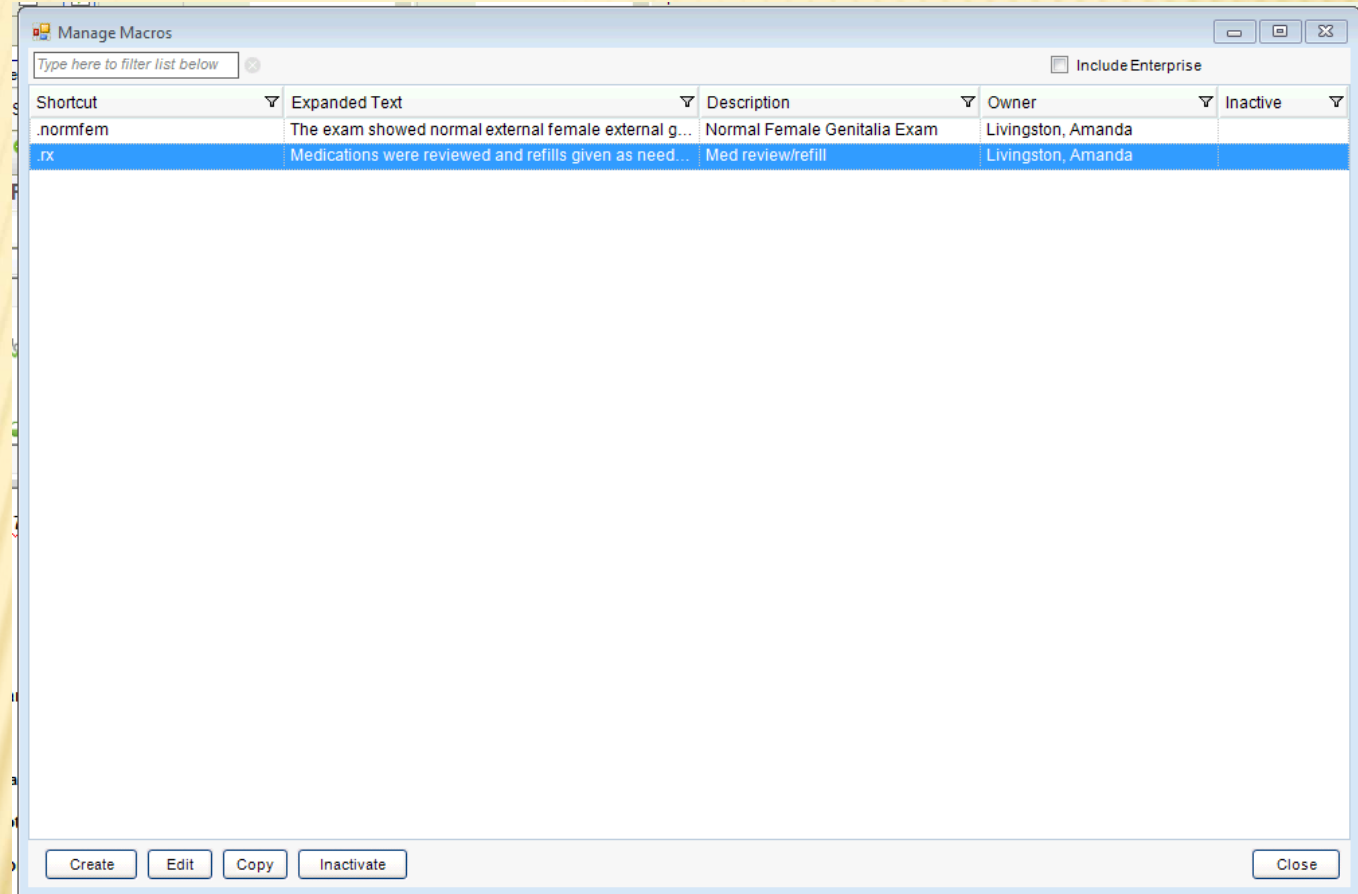
2. **Description** will explain what the macro is for.



3. Information placed into the text field will be distributed in the area your macro is placed.

SAVE YOUR MACRO

Save your macro.
The new macro will
be added to your
Manage Macros list.
From this window,
you can Create, Edit,
and Inactivate.
They are not
removed easily from
the system.



TO ADD MACRO IN ALLSCRIPTS

To add, just type whatever your shortcut name is wherever you want your macro to populate. Be sure to begin with the period. Enter the macro shortcut. Then click the enter key on your keyboard.



.rx



Medications were reviewed and refills given as needed.

You have now completed all of
the required modules for
Allscripts EHR 17.1 training.
Please be sure to complete the
quiz by following the link beneath
the modules.