



EAST TENNESSEE STATE
UNIVERSITY

QUILLEN ETSU PHYSICIANS

Module 5: Notes

Provider Training Module
Allscripts Touchworks EHR

Quillen EHR Team
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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).

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 displays a clinical software interface with a navigation bar at the top containing tabs: Daily, **Clinic Desktop**, New Note, Worklist, Task List, Batch Sign, Appointments, Patient Lists, and Provider Schedules. Below the navigation bar, the patient's name 'SUPERUSER, FLASH' is prominently displayed and circled in red. To the right of the name, patient details are shown: PCP (Other), MRN (001000643529101), Security (No Restricted Data), FYI (FYI), and H Phone ((423)123-4567). A red banner on the right indicates 'MED & NON-MED ALLERGIES'. Below this, the 'Daily Schedule' section is active, showing 'Arrived, Pending and Rescheduled' appointments. The provider is set to 'ALLSCRIPTS,Provider' and the date is '25 May 2018'. The schedule table includes columns for appointment status, time, patient name, MRN, type, duration, tasks, and comments. The entry for 'SUPERUSER, FLASH' at 08:15 AM is highlighted in blue, and the status 'RrProvider Ready' is circled in red.

\$	N	TC	SO	CCS	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	00100064351760	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	00100064365540	AC	15	3	ACUTE PAIN - LASHER
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr	G59 Exam	RrProvider Ready	07:30 AM	SUPERUSER, ERNIE	00100064365620	5	15	2	CONSULT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:00 AM	SUPERUSER, CATWOM	00100064351680	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	00100064352910	69	15	2	POST OP SAHAWNEH
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			10:00 AM	SUPERUSER, WASP	00100064353740	NP	15	3	NP LIVINGSTON

NEW NOTE TAB

The screenshot displays a medical software interface. At the top, a navigation bar contains several tabs: 'Daily', 'Clinical Desktop', 'New Note' (highlighted with a red circle), 'Worklist', 'Task List', 'Batch Sign', 'Appointments', 'Patient Lists', and 'Provider Schedules'. Below this, the patient's name 'SUPERUSER, ERNIE' is prominently displayed in the 'Patient Banner' area. To the right of the name, there is a 'Patient Banner' label and a 'NO KNOWN ALLERGIES' status. The interface also shows the patient's date of birth (01-Jan-1979), gender (F), and other identifiers like PCP (Aiken, Todd) and MRN (001000643656201). The main content area is divided into several sections: 'All Notes' (showing 74 of 279 chart items), 'Current Orders' (showing no items), and various other tabs like 'Flowsheets', 'HMP/Reminders', 'Growth Chart', 'Vital Signs', 'Meds', 'Med Flowsheet', 'Orders', 'Allergies', and 'Immunizations'. The 'New Note' tab is highlighted in red, indicating the current active 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 'SUPERUSER, Emie' (01-Jan-1979, 39 years, F). The appointment date is '25-May-2018'. The interface includes a 'Create New' section with radio buttons for 'Note' (selected), 'Unstructured', and 'Admin Forms'. There are dropdown menus for 'Specialty' (Internal Medicine), 'Visit Type' (currently showing '<< Please select a Visit Type >>'), and 'Owner' (ALLSCRIPTS, Provider). A search icon is next to the 'Appt Type' field. A list of visit types is displayed, including Behavioral Health, Chart Documentation, Communication, Consult Visits, Follow-Up Visits, Health Maintenance, Nursing Visits, Office Visits (highlighted), Post-Op Visits, Procedures, Psych Visits, Diabetes/Nutrition Education Record, Nutrition Visit, and PreOp Clearance. A secondary list of note types is also visible, including 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, and Worker's Comp. The status bar at the bottom shows 'Enc Date: 25 May 2018 07:30 AM' and 'Enc Type: Appointment'.

Ensure that correct appointment date in upper right.

NOTE IN "EDIT" MODE

The screenshot shows an EHR interface in 'EDIT' mode. The top header displays patient information: SUPERUSER, Emie 01-Jan-1979 (39 years) F. A yellow arrow points to this header with the label 'Patient Name, age and DOB'. To the right, another yellow arrow points to 'Appointment: 25-May-2018' with the label 'Appointment date/visit type'. Below the header is a 'Clinical Toolbar' with various icons, highlighted by a red box and a blue arrow labeled 'Clinical Toolbar'. The main workspace is divided into several sections:

- Table of Contents:** A vertical list on the left side, highlighted by a red box and a blue arrow labeled 'Table of Contents'. It includes categories like Preventive, Health Management, Chief Complaint, Reason For Visit, Active Problems, History of Present Illness, Review of Systems, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies, and Immunizations.
- Clinical Desktop:** The central area showing a 'Preventive' section with a table of items. A blue arrow labeled 'Clinical Desktop' points to this area. The table has columns for 'Item Name' and 'Quality Measure'. Items include 'Have you ever had a...', 'Have you had a flu shot this...', and 'Have you had colorectal...'. Below this is a 'PHQ-9' section.
- Note Authoring Workspace (NAW):** A blue box at the bottom of the main workspace labeled 'Note Authoring Workspace (NAW)'.
- Problem List:** A table on the right side, highlighted by a red box, listing medical problems. It has columns for 'Name' and 'ICD-10'. Problems are categorized into 'Active', 'Chronic', and 'Acute'. Examples include 'Anxiety' (F41.9), 'Elevated blood pressure reading' (R03.0), 'Foot pain' (M79.673), 'Generalized continuous abdominal...' (R10.84), 'Major neurocognitive disorder' (F03.90), 'Malignant essential hypertension' (I10), 'Primary insomnia' (F51.01), 'Probable major neurocognitive...' (G30.9), 'Recurrent major depression...' (F33.9), 'Chest pain' (R07.9), 'History of Chronic pain syndrome' (G89.4), 'History of nausea and vomiting' (Z87.898), 'History of recurrent urinary tract...' (Z87.440), and 'History of Positive urine pregnancy...' (Z32.01).

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
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
health maintenance/risks
Health Maintenance
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...

The screenshot displays a medical software interface for a patient's record. At the top right, it shows "Appointment: 25-May-2018". Below this, there are several red text alerts: "Iodine Allergy", "Latex Allergy", "Patient does not speak English", "Patient has a caregiver", and "Pt likes people, with salt and pepper". The main area is divided into several sections. On the left is a "Table of Contents" with various categories like "Patient History", "Social History", "Family History", "Surgical History", and "Current Meds". The "Active Problems" section is highlighted with a yellow box. In the center, a table lists the patient's active problems, categorized into "Chronic" and "Acute". On the right, a "Problem List" window is open, showing a list of active problems. A yellow callout box points to the "Active Problems" section with the text: "...that section will open up so that you can document your information." Another yellow callout box at the bottom points to the "Output Template" section with the text: "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." The "Output Template" section shows a table with columns for "Output Template" and "CC" (Check/Uncheck).

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	041.01	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

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

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 software interface with a top toolbar containing icons for various functions and a 'Commit' button. Below the toolbar are tabs for 'Note', 'Appointments', and 'Health Management Plan'. The main area is divided into several panes. On the left, there is a navigation tree with categories like 'Active Problems', 'Past Medical History', 'Social History', etc. The central pane shows a form with sections for 'Reason For Visit', 'Active Problems', 'History of Present Illness', and 'Review of Systems'. On the right, there is a 'Clinical Desktop' pane with tabs for 'Immunizations', 'Allergies', 'Chart Viewer', 'Flowsheets', and 'Vitals'. The 'Chart Viewer' tab is active, showing a list of notes and appointments organized by specialty and date. At the bottom, there is a status bar with buttons for 'View', 'Recompile', 'Sign', 'Copy Forward', 'Security Codes', 'Audit', 'Save & Close', 'Save', and 'Close'.

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 in a medical software interface. The status is 'Needs Input'. The interface includes a sidebar with navigation options and a main table of care team members.

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

Buttons: Add Provider/Agency, Add Patient Caregiver/Resource

Task: Hide Show All Hide All

Output Template: CC

- Established
- Referral Letter
- Return to Work Letter

View: 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 such as 'Health Management', 'Chief Complaint', 'Reason For Visit', 'Active Problems', 'Past Medical History', 'Social History', 'Family History', 'Surgical History', and 'Current Meds'. 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'. A row for 'Mammogram...' is highlighted in yellow. The 'To Do' column for this row contains the text '* Due: 17Apr2015', which is circled in red. A context menu is open over this cell, with the 'Order' option highlighted in blue. A red arrow points from the circled text to the 'Order' option. A text box at the bottom of the screenshot provides instructions on how to use this feature.

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.

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 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.

Active Problems

Name	ICD-10
...ure reading	F41.9
...ure reading	R03.0
...us abdominal...	M79.673
... disorder	R10.84
... disorder	F03.90
... hypertension	I10
... cognitive...	F51.01
...ression...	G30.9
	F33.9

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)

Active Problems

Name	ICD-10
Health Maintenance/Risks	
Health Maintenance	
Past Medical History	
Chronic	
History of Chronic pain syndrome	G89.4
History of nausea and vomiting	Z87.898
History of recurrent urinary tract...	Z87.440
Acute	
History of Positive urine pregnancy...	Z32.01

Output Template | CC

- Established
- Referral Letter
- Return to Work Letter

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

FORMS

The screenshot shows a medical software interface with a sidebar on the left containing a tree view of medical categories. The 'Depressive Disorders' category is highlighted with a red box. The main window displays the 'Depressive Disorders (Brief)' form, which is also highlighted with a red border. 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 symptom and associated symptom has a 'Y/N' checkbox. The bottom toolbar contains buttons for 'View', 'Recompile', 'Sign', 'Spell Check', 'Copy Forward', 'Show Uncopied Form Data', 'Save & Close', 'Save', and 'Close'.

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: None

Interval Symptoms: None

Lifestyle:

Medications: None

New

Denie

Memory Loss Adherent Side Effects

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" for a patient named "ALLSCRIPTS, Cardiologist". The form is in "Needs Input" status. On the left, a navigation pane lists sections like "Chief Complaint", "Active Problems", "Review of Systems", "Past Medical History", "Social History", and "Family History". The "Review of Systems" section is expanded to show "Complete-Female".

At the top right of the form, there are two buttons: "All Normal" and "Previous Exam". A red box highlights these buttons. A yellow callout box points to the "All Normal" button with the following text:

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.

The main form area contains a list of symptoms and checkboxes for each system. A red arrow points from the "All Normal" button to the "Nasal Discharge" checkbox. The "Nasal Discharge" checkbox is checked, and the "Nosebleeds" checkbox is also checked. The "Palpitations" checkbox is checked. The "Chest Pain" checkbox is unchecked. The "As Noted in HPI" checkbox is unchecked. The "Nosebleeds" and "Nasal Discharge" checkboxes are also checked. The "Palpitations" checkbox is checked. The "Chest Pain" checkbox is unchecked. The "As Noted in HPI" checkbox is unchecked.

At the bottom of the form, there is a list of systems and their status:

- Endocrine: negative.
- Hematologic/Lymphatic: negative.
- Past Medical History
- Social History

A blue callout box on the right side of the form lists the following text:

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.

The bottom of the form has a footer with the following text: "View Recompile Sign Copy Forward Security Codes Audit Save & Close Save Cl 8".

HISTORY SECTIONS

The screenshot displays a medical chart interface with a sidebar on the left and a main content area on the right. The sidebar contains several sections, with 'Active Problems' and 'Past Medical History' highlighted in yellow. The main content area shows a 'Review of Systems' section, followed by 'Past Medical History' which is expanded to show 'Chronic' and 'Acute' categories. The 'Chronic' category lists 'History of Anxiety Disorder NOS 300.00', 'History of Asthma 493.90', 'Hypertension 401.9', and 'History of Permanent Pacemaker Placement'. The 'Acute' category lists 'History of Chest Pain 786.50'. Below the 'Past Medical History' section, there are buttons for 'New', 'Edit', 'Show', 'Show All', and 'Hide All'. The 'Show' button is highlighted with a red box. The sidebar also includes sections for 'Health Management', 'Chief Complaint', 'Reason For Visit', 'History of Present Illness', 'Diabetes Type II (Follow-U)', 'Hyperlipidemia (Follow-Up)', 'Review of Systems', 'Complete-Female', 'Social History', 'Family History', 'Surgical History', 'Current Meds', 'Allergies', 'Immunizations', 'Vitals', 'Physical Exam', 'Procedure', 'Patient Summary', 'Referral Letter', 'New Patient', and 'Return to Work Lett...'. The bottom of the interface has a 'View' button and a row of buttons: 'Recompile', 'Sign', 'Copy Forward', 'Security Codes', 'Audit', 'Save & Close', 'Save', and 'Close'.

Health Management

Chief Complaint

Reason For Visit
Reason For Visit - IM

Active Problems

History of Present Illness
Colorectal Cancer
Diabetes Type II (Follow-U)
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...

Review of Systems

Past Medical History

Type

Chronic

History of Anxiety Disorder NOS 300.00
History of Asthma 493.90
Hypertension 401.9
History of Permanent Pacemaker Placement

Acute

History of Chest Pain 786.50

New Edit **Show** Show All Hide All

Social History

Past Medical History

Social History

Family History

Surgical History

Current Meds

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

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 [Icons]

	Name	ICD-9	Managed By
Chronic			
<input type="checkbox"/>	History of Bilateral Pheochromocytoma	227.0	
<input type="checkbox"/>	History of depression	V11.8	
<input type="checkbox"/>	History of headache	V13.89	
<input 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 type="checkbox"/>	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

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

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-Injecti

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 displays 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), Arthrocentesis, Nebulizer Treatment, Adult Skin Lesion Excision, Wart Destruction, Abdominal Ultrasound, Electrocardiogram (ECG), Cerumen Removal, Orthopedic Aspiration-Injecti, Results/Data, Assessment, Discussion/Summary, Plan, Medication Changes and Ins, Attending Note, and Attending Note. The main window shows a 'Procedure' form titled 'Trigger Point Injection (General)'. A context menu is open over the 'Procedure' section 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 at the top right explains that notes are set to pull in the top 10 procedures and that users can right-click on section headers to add forms. An orange callout box at the bottom right 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

The screenshot shows the 'Note Form Selector' window with a search filter set to 'skin'. The table below lists various procedure forms. The 'Foreign Body Removal-Skin' form is selected, and its checkbox is checked. A yellow callout box provides instructions on how to use the window.

	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...	10-Dec-2014	<input type="checkbox"/>
<input type="checkbox"/>	Skin Lesion Biopsy/Excision/Destu...							-2011	Allscripts Cli...	16-Apr-2012	<input type="checkbox"/>
<input type="checkbox"/>	Skin Lesion Biopsy/Excision/Destu...							-2011	Garland, Bri...	28-Jun-2016	<input type="checkbox"/>
<input type="checkbox"/>	Skin Lesion Biopsy-Excision-Destu...							-2019	Garland, Bri...	07-Nov-2019	<input type="checkbox"/>
<input type="checkbox"/>	Skin Procedure Location Detail							-2007	Allscripts Cli...	26-Jan-2011	<input type="checkbox"/>
<input type="checkbox"/>	Skin Test and Challenge Procedure							2013	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.

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.*

Advanced Result Citation

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 04:00
- Microalbumin / Creatinine Ratio, Urine (Random); Ordered by ALLSCRIPTS, Provider; 14Jul2015 04:00
- Lipid Panel; Ordered by ALLSCRIPTS, Provider; 14Jul2015 04:00
- Hemoglobin A1C; Ordered by ALLSCRIPTS, Provider; 14Jul2015 04:00
- Thyroid Stimulating Hormone; Ordered by ALLSCRIPTS, Provider; 13Jul2015 13:00
- CBC Automated Differential; Ordered by ALLSCRIPTS, Provider; 08Jul2015 08:00
- Comprehensive Metabolic Panel; Ordered by ALLSCRIPTS, Provider; 08Jul2015 08:00
- Vitamin B12; Ordered by ALLSCRIPTS, Provider; 08Jul2015 08:00
- 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

Results/Data

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

Assessment

Assessed

Foot pain (M79.673)

Primary insomnia (F51.01)

Chest pain (R07.9)

Results/Data

Assessment

Summary/Care Plan

Output Template

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

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 for a note titled "Health Management/Reminders". The status is "Needs Input". The left sidebar lists various note sections, with "Assessment" highlighted in a red box. The main window displays the "Assessment" section, which is divided into "Assessed" and "Unassessed" categories. The "Assessed" category contains three items: "Foot pain" (M79.673), "Primary insomnia" (F51.01), and "Chest pain" (R07.9). The "Unassessed" category contains one item: "Anxiety" (F41.9). A yellow callout box highlights the "Assessed" section with the following text: "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." The toolbar includes icons for adding, deleting, and moving items, as well as a "P" icon for adding a diagnosis.

Name	ICD-10	Managed By
Assessed		
Foot pain	M79.673	
Primary insomnia	F51.01	
Chest pain	R07.9	
Unassessed		
Anxiety	F41.9	
Recurrent major depression resistant...	F33.9	

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

- 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: 04 Jun 2018
- IM Plan

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

Health Management

Plan

IM Plan:

Attending Note

Return to Work

View 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 shows an EHR note editor window titled "Note Health Management/Reminders". The status is "Needs Input" and the provider is "ALLSCRIPTS, Provider". The interface is divided into several sections:

- Left Panel (Table of Contents):** A list of sections including 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. Below this is an "Output Template" section with checkboxes for "Acute" (checked) and "Referral Letter".
- Main Content Area:** Contains sections for "Chief Complaint" (with a "Lock" button and a message "There are no items to show in this view."), "Chief Complaint Details", "Referring Provider", and "Active Problems" (listing conditions like "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)").
- Bottom Panel:** A preview of the "Chief Complaint" section with fields for "Chief Complaint:", "Referring Provider:", and "Reason For Visit:". Below this is a toolbar with buttons: "View", "Recompile", "Sign", "Spell Check", "Copy Forward", "Show Uncopied Form Data", "Save & Close", "Save", and "Close". The "Save" button is highlighted with a red box.

A large red arrow points from the top of the "Active Problems" section down to the "Save" button in the bottom toolbar.

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

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

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
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 headache

VIEWING YOUR NOTE

The screenshot shows a software window titled "Note Output" with a teal header. The patient information bar includes "SUPERUSER, Ernie 01-Jan-1979 (39 years) F" and "Appointment: 25-May-2018". Below this, a status bar shows "Established" (with a dropdown arrow), "Owner: ALLSCRIPTS, Provider", and "Status: Needs Input" (with a checkmark and menu icon). The main content area is titled "Established" and contains the following sections:

- 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)

At the bottom of the window is a grey bar with a "Close" button highlighted by a red rectangle. Other buttons include "Sign", "Audit", "Document Hx", "Task", "Attach to Result", "Print", "Fax", and "Invalidate".

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

The screenshot displays a medical software interface. At the top, there's a toolbar with various icons and a status bar showing 'Commit', 'Pat Loc G59 Exam Rm', 'Status Provider Ready', and 'Update'. Below this is a 'Note' header for 'Health Management/Reminders' with a status of 'Needs Input'. A sidebar on the left lists various medical procedures and templates. The main area shows a note with a 'Note Signature' dialog box overlaid. The dialog box contains the following fields: 'User Name' (livingstona), 'Password' (empty), 'Sig Type' (Author), and a checked 'Make Final' checkbox. Below these fields is a table for 'Carbon Copy Recipients' with columns for 'Recipient Name', 'Role', and 'Note Output'. The dialog box has 'OK' and 'Cancel' buttons at the bottom. In the background, the 'Sign' and 'Save & Close' buttons in the toolbar are highlighted with red boxes.

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 Task: **Co-Sign Note**

ALLSCRIPTS, Provider 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](#) [Clinical Desktop](#) [New Note](#) [Worklist](#) [Task List](#) [Batch Sign](#) [Appointments](#) [Patient Lists](#) [Provider Schedules](#)

SEARCH SUPERUSER, CATWOMAN PCP ALLSCRIPTS, Resident Other
 MRN 001000643516801 Security No Restricted Data
 FYI FYI H Phone (423)123-4567

Med & Non-Med Allergies
 Directives Signature On File

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

Patient Insurance: BLUE SHIELD OF TN BLUECARE

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

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!

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.

PCP ALLSCRIPTS, Resider
MRN 001000643516801
FYI FYI

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

Select Patient -- W

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 displays the EHR interface with the 'New Note' tab highlighted in red. Below it, the 'Note Selector' dialog box is open. The dialog box header shows the patient name 'ALLSCRIPTS, Chris' and date '10-Mar-1976 (42 years) M'. A search bar on the right contains the text 'Telephone Call: 04-Jun-2018'. The 'Create New' section has three radio buttons: 'Note' (selected), '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 set to 'Communication Note (co-sign)'. Below this, there is an 'Incomplete Notes' section with a dropdown menu. The 'Chief Complaint' section is expanded, showing a link 'Add/Remove Chief Complaints' and a message 'There are no items to show in this view'. At the bottom of the dialog box are 'OK' and 'Cancel' buttons.

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:  Type:

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

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

Provider: [dropdown] Status: Needs Input

Save & Close Save Close

Active Problems

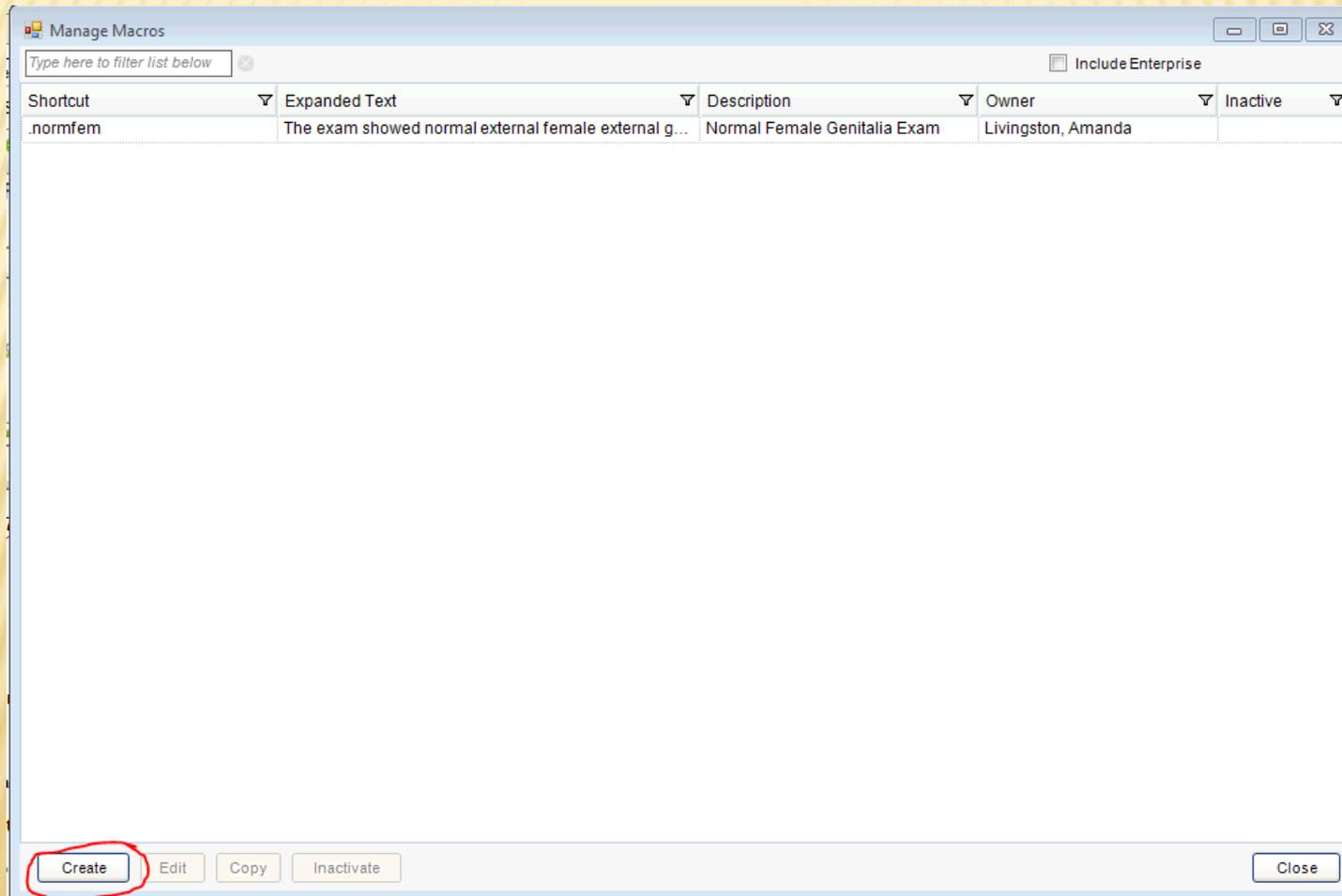
Type: [dropdown] Rec: Needed [dropdown] [dropdown] [dropdown]

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

MACRO CREATION

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

Create



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

MACRO COMPONENTS



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



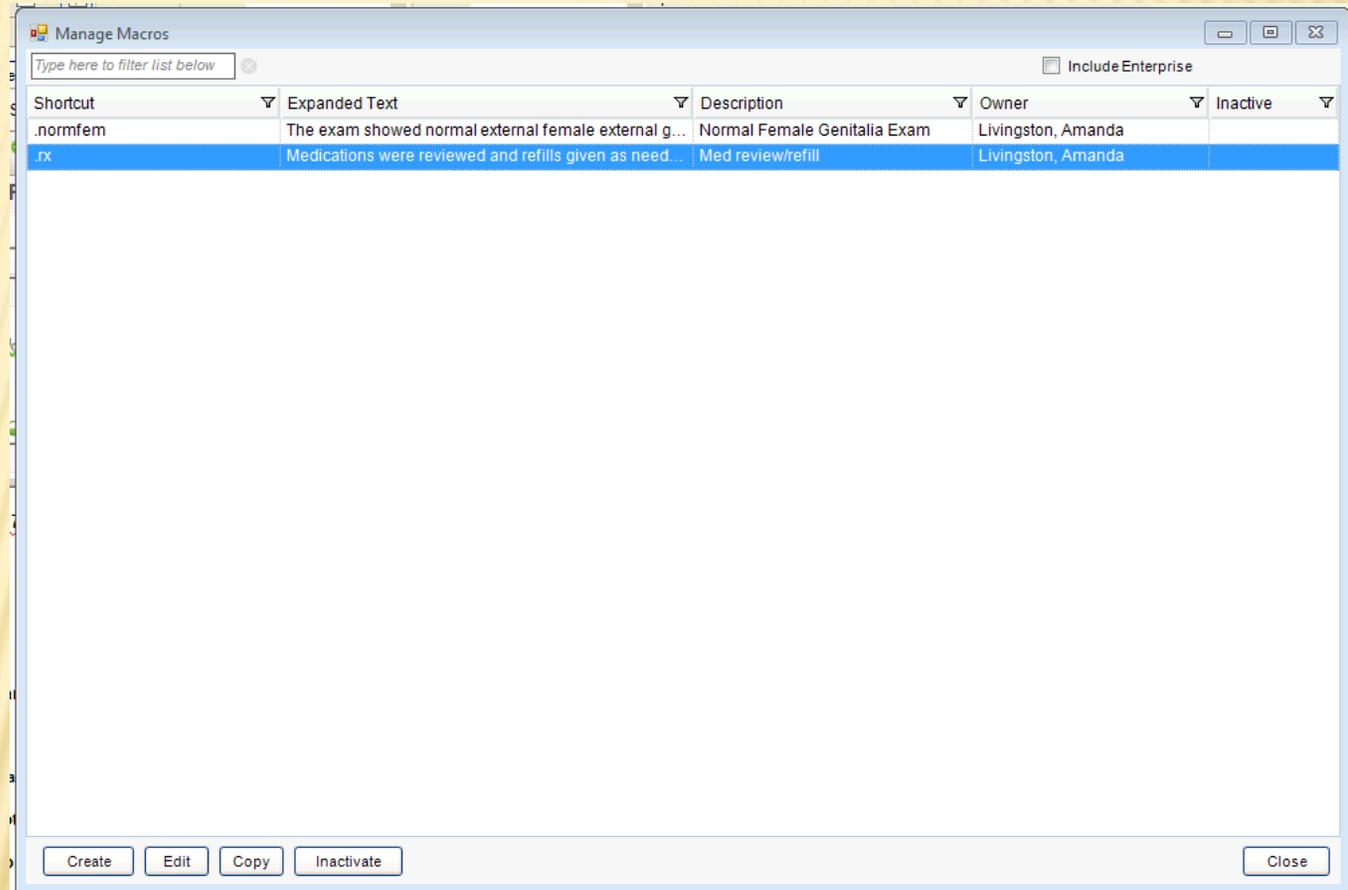
2. **Description** will explain what the macro is for.



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

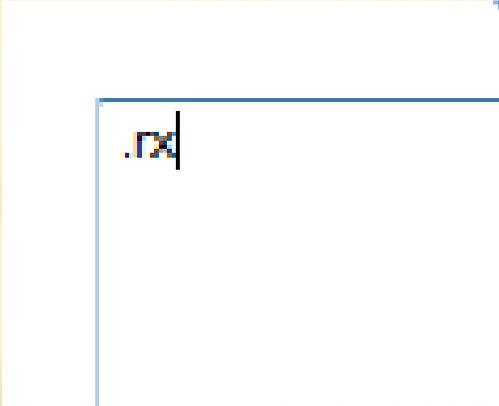
SAVE YOUR MACRO

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.

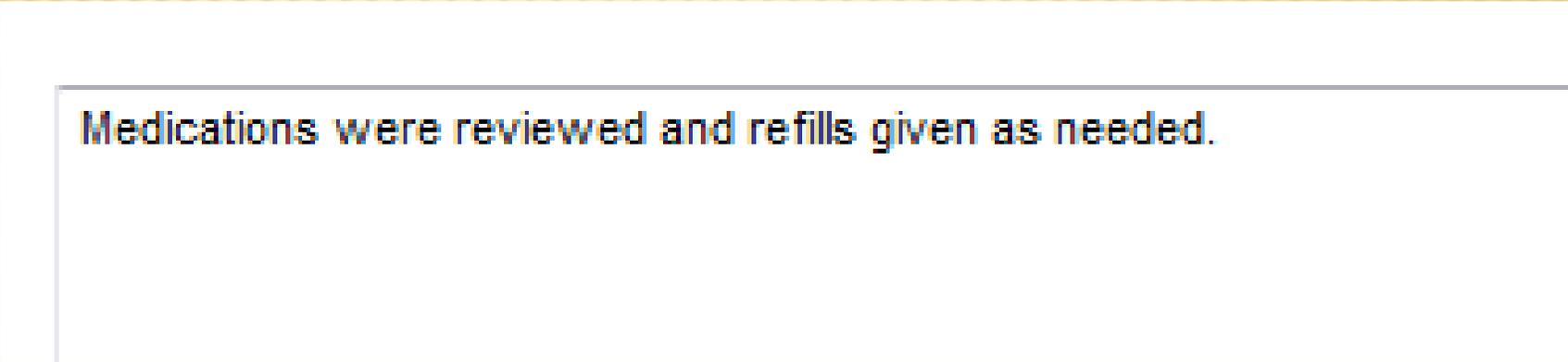


TO ADD MACRO IN ALLSCRIPTS

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.