



EAST TENNESSEE STATE  
UNIVERSITY

# QUILLEN ETSU PHYSICIANS

Module: Notes

Non Ordering Staff Training Module  
Allscripts Touchworks EHR

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

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# 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 \$, N, TC, SO, CCS, A, Pt, Loc, Pt Status, Time, Patient, MRN, Type, Dur, 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
	✓	✓				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
		✓				Arr	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 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, including 'All Notes' with a list of chart items, and 'Current Orders' which currently shows '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 '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', 'Unstructured', and 'Admin Forms'. The 'Specialty' is set to 'Internal Medicine' and the 'Owner' is 'ALLSCRIPTS, Provider'. The 'Visit Type' dropdown is open, showing a list of options including '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', and 'PreOp Clearance'. A secondary dropdown is visible on the right, listing specific note types such as '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 'Enc Date' is '25 May 2018 07:30 AM' and the 'Enc Type' is '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' and 'Appointment: 25-May-2018'. A yellow arrow points from the patient name to the text 'Patient Name, age and DOB', and another yellow arrow points from the appointment date to the text 'Appointment date/visit type'. Below the header is a 'Clinical Toolbar' with various icons, highlighted by a blue arrow. The main workspace is divided into several sections:

- Table of Contents:** A vertical list on the left side of the main workspace, highlighted by a red box and a blue arrow. 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 containing a 'Preventive' section with a table of items and a 'PHQ-9' section. A blue arrow points from the 'Clinical Desktop' label to this area.
- Note Authoring Workspace (NAW):** A section at the bottom of the main workspace, highlighted by a red box and a blue arrow. It contains a 'Preventive' section with a 'Quality Measure' dropdown and a 'PHQ-9' section with a 'Data Includes: Current Encounter' dropdown.
- Problem List:** A panel on the right side, highlighted by a red box, showing a list of active and acute problems with their ICD-10 codes. It includes categories like 'Active', 'Chronic', and 'Acute'.

At the bottom of the interface, there are buttons for 'View', 'Recalculate', 'Sign', 'Spell Check', 'Copy Forward', 'Show Encrypted Form Data', 'Save & Close', and 'New', 'Edit', 'Resolve'.

# 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  
Chief Complaint  
Reason For Visit

Appointment: 25-May-2018

Immunizations  
Allergies  
Chart Viewer  
Flowsheets  
Vitals  
Problem  
Meds/Orders  
Labs  
Imaging  
Active Problems  
Type

Status: Needs Input

There are no items to show in this view

Show All Hide All New Order

Complaint  
For Visit  
Problems  
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...

Appointment: 25-May-2018

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

ALLSCRIPTS, Provider Status: Needs Input

**Active Problems**

Type	Name	ICD-9	Managed By	Last Asses
<b>Chronic</b>				
	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
<b>Acute</b>				
	Acute frontal sinusitis	461.1	ALLSCRIPTS, Provider...	29Apr20
	Acute upper respiratory infection	465.9	Garland, Bridget	14Apr20

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

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.

Output Template CC

- Established
- Referral Letter
- Return to Work Letter

# CLINICAL DESKTOP/NAW

The screenshot shows the Clinical Desktop/NAW interface. At the top, there is a toolbar with icons for various functions and a status bar with 'Commit', 'Pat Loc', and 'Status' buttons. The main workspace is divided into several panes:

- Left Pane:** A navigation tree with categories like 'Active Problems', 'Past Medical History', 'Social History', 'Family History', 'Surgical History', 'Current Meds', 'Allergies', 'Immunizations', and 'Vitals'. Under 'Active Problems', there are sub-items like 'History of Present Illness', 'Review of Systems', 'Complete-Female', etc.
- Center Pane:** The 'Reason For Visit' section, currently showing 'Active Problem'. It has a 'Type' dropdown and lists 'Chronic' (Colon Cancer, Common M, Diabetes M, Hyperchole, Hypertensio) and 'Acute' (Angina Pec) conditions.
- Right Pane:** A list of notes and appointments, organized by specialty. It includes sections for 'Adolescent Medicine', 'Cardiology', and 'Endocrinology', with specific dates and appointment types listed.

Two callout boxes provide additional information:

- Orange Callout Box:** Points to the right pane and states: "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."
- Yellow Callout Box:** Points to the center pane and states: "The **Note Authoring Workspace (NAW)** is where your text will populate as you document on the forms above."

At the bottom, there is a footer with 'View', 'Recompile', 'Sign', 'Copy Forward', 'Security Codes', 'Audit', 'Save & Close', 'Save', and 'Close' buttons.

# 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.

**Patient Care Team**

Lock  Show Inactive

Add Provider/Agency Add Patient Caregiver/Resource

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

**Patient Care Team**

**Health Management**

**HM Checklist**

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 1.0

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
<b>Chest pain</b>	<b>R07.9</b>
Health Maintenance/Risks	
Health Maintenance	
<b>Past Medical History</b>	
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

# 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 divided into several sections, each with a list of symptoms and checkboxes for "Y" (Yes) or "N" (No). The "All Normal" button is highlighted in a red box, and the "Previous Exam" button is also highlighted. A yellow callout box explains the "All Normal" button, and a blue callout box lists the resulting negative findings for various systems.

**Health Management**  
Chief Complaint  
Reason For Visit  
Reason For Visit - IM  
Active Problems  
History of Present Illness  
Angina (Follow-Up)  
Review of Systems  
**Complete-Female**  
Past Medical History  
Social History  
Family History

**Complete-Female** [All Normal] [Previous Exam]

**^Constitutional**  
 Negative  As Noted in HPI  
 Fever  Feeling Poorly  
 Chills  Feeling Tired/Fatigue

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

As Noted in HPI  
 Nosebleeds  
 Nasal Discharge

As Noted in HPI  
 Chest Pain  
 Palpitations

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

**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.

View Recompile Sign Copy Forward Security Codes Audit Save & Close Save Cl4

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.

# HISTORY SECTIONS

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

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

# HIDING ITEMS

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

^ Past Medical History Edit Mode of Note

Type [dropdown] [icons]

	Name	ICD-9	Managed By
<b>Chronic</b>			
<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
<b>Acute</b>			
<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

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-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 – 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
- 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

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 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"/>

View Recompile Sign Spell

10 of 281 Chart Items (4 Invalid and 191 Audit Items) - Filters Applied

- Drug Screen, Urine ( UDS ) - Done: 15-Nov-2017 - Livingston, A
- Result Note (Result Note) - ALLSCRIPTS, Provider; Enc: 14-Jul-
- Result Note (Result Note) - ALLSCRIPTS, Provider; Enc: 14-Jul-
- Microalbumin / Creatinine Ratio, Urine ( Random ) - Done: 14-Jul-
- Lipid Panel ( Lipid Profile ) - Done: 14-Jul-2015 - ALLSCRIPTS, Provider;
- Hemoglobin A1C - Done: 14-Jul-2015 - ALLSCRIPTS, Provider;
- Thyroid Stimulating Hormone ( TSH ) - Done: 13-Jul-2015 - ALL-
- CBC Automated Differential - Done: 08-Jul-2015 - ALLSCRIPTS, Provider;
- Comprehensive Metabolic Panel ( CMP ) - Done: 08-Jul-2015 - A-
- Vitamin B12 - Done: 08-Jul-2015 - ALLSCRIPTS, Provider; Enc:

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 patient note. The top bar indicates the patient is 'Established' and the provider is 'ALLSCRIPTS, Provider'. 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' section contains three items: 'Foot pain' (M79.673), 'Primary insomnia' (F51.01), and 'Chest pain' (R07.9). The 'Unassessed' section contains one item: 'Anxiety' (F41.9). A yellow callout box provides instructions on how to manage these items.

Name	ICD-10	Managed By
<b>Assessed</b>		
Foot pain	M79.673	
Primary insomnia	F51.01	
Chest pain	R07.9	
<b>Unassessed</b>		
Anxiety	F41.9	
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. If you don't assess or bill, don't do this.

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 orders from provider's show up. You can also free text your plan.

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

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

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

**Plan**  
IM Plan:   
**Attending Note**  
**Return to Work**

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

# 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 software interface for editing a note. The window title is "Note Health Management/Reminders". The status bar at the top indicates "Acute" and "ALLSCRIPTS, Provider" with a search icon and "Status: Needs Input". The main content area is divided into sections: "Chief Complaint" (with a "Lock" button), "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 window, there is a toolbar with buttons for "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, and a red arrow points to it from the right side of the screen.

# 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

**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

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.

# VIEWING YOUR NOTE

Note Output

SUPERUSER, Ermie 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)

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

The screenshot shows a medical software interface with a 'Note Signature' dialog box open. The dialog box contains the following fields and options:

- User Name: livingstona
- Password: [Empty field]
- Sig Type: Author
- Make Final
- Carbon Copy Recipients: [Empty list]

The background interface shows a patient note with a toolbar containing the following buttons: View, Recompile, Sign, Spell Check, Copy Forward, Show Uncopied Form Data, Save & Close, Save, and Close. The 'Sign' and 'Save & Close' buttons 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 preceptor's name in the Assign To: field, click OK. There is no need to type anything in the Comment section. (When your preceptor 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.

Org: ETSU

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

Patient:  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 a medical software interface. At the top, a navigation bar includes tabs for 'Daily', 'Clinical Desktop', 'New Note', 'Worklist', 'Task List', 'Batch Sign', 'Appointments', 'Patient Lists', and 'Provider Schedules'. The 'New Note' tab is highlighted with a red circle. Below the navigation bar, patient information for 'Allscripts, Chris' is shown, including the date '10-Mar-1976 (42y) M' and various identifiers like 'PCP', 'MRN ZZZAHS06', and 'FYI'. A 'Note Selector' dialog box is open, showing the patient's name and date. A search bar at the top right of the dialog contains 'Telephone Call: 04-Jun-2018' and is highlighted with a red box. Below the search bar, 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)' and is highlighted with a red box. Below this, there is an 'Incomplete Notes' section with a dropdown menu. At the bottom of the dialog, 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'. At the very bottom of the dialog 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

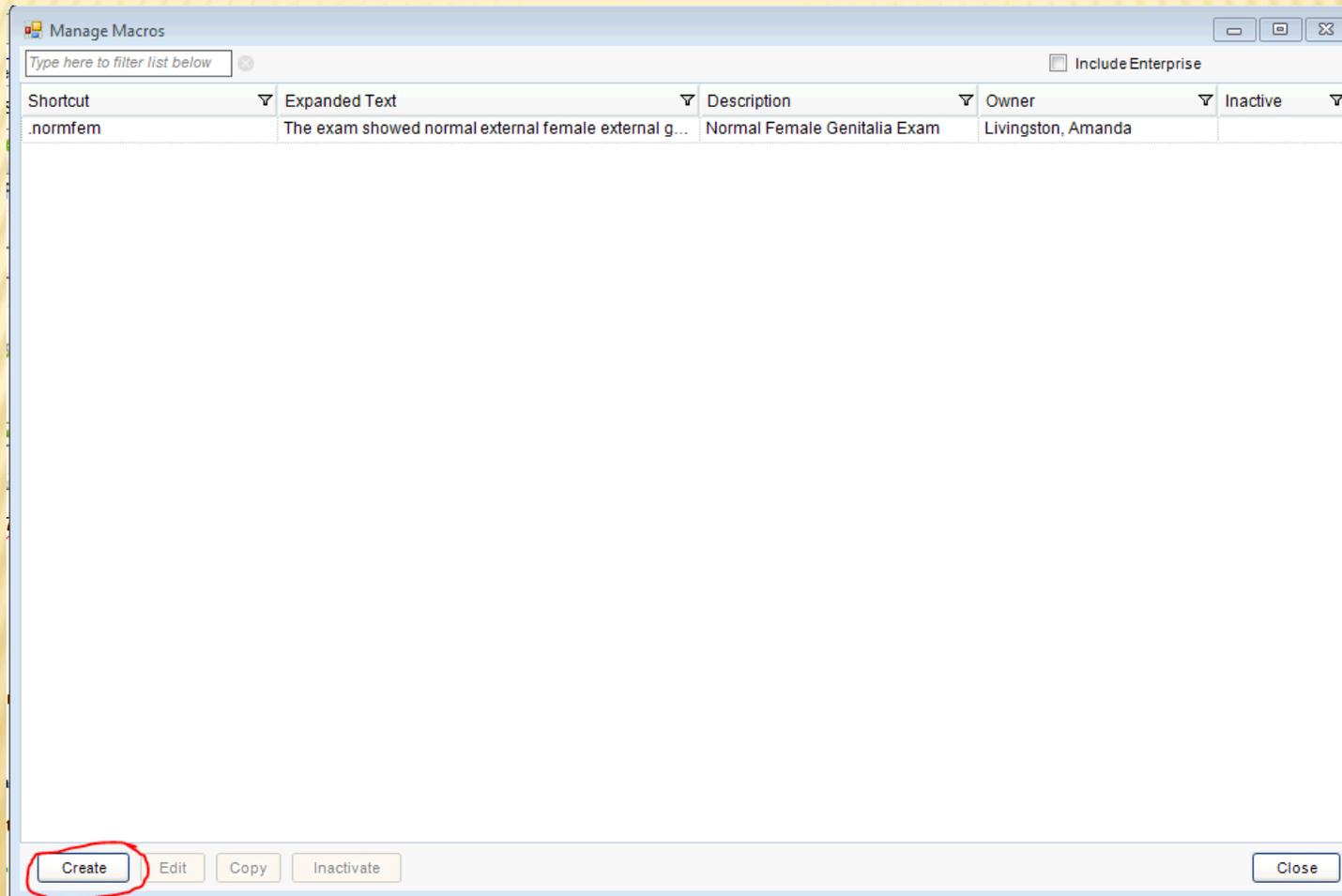
Type: [dropdown] Rec: Needed [filter] [checkbox] [menu]

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

# 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.



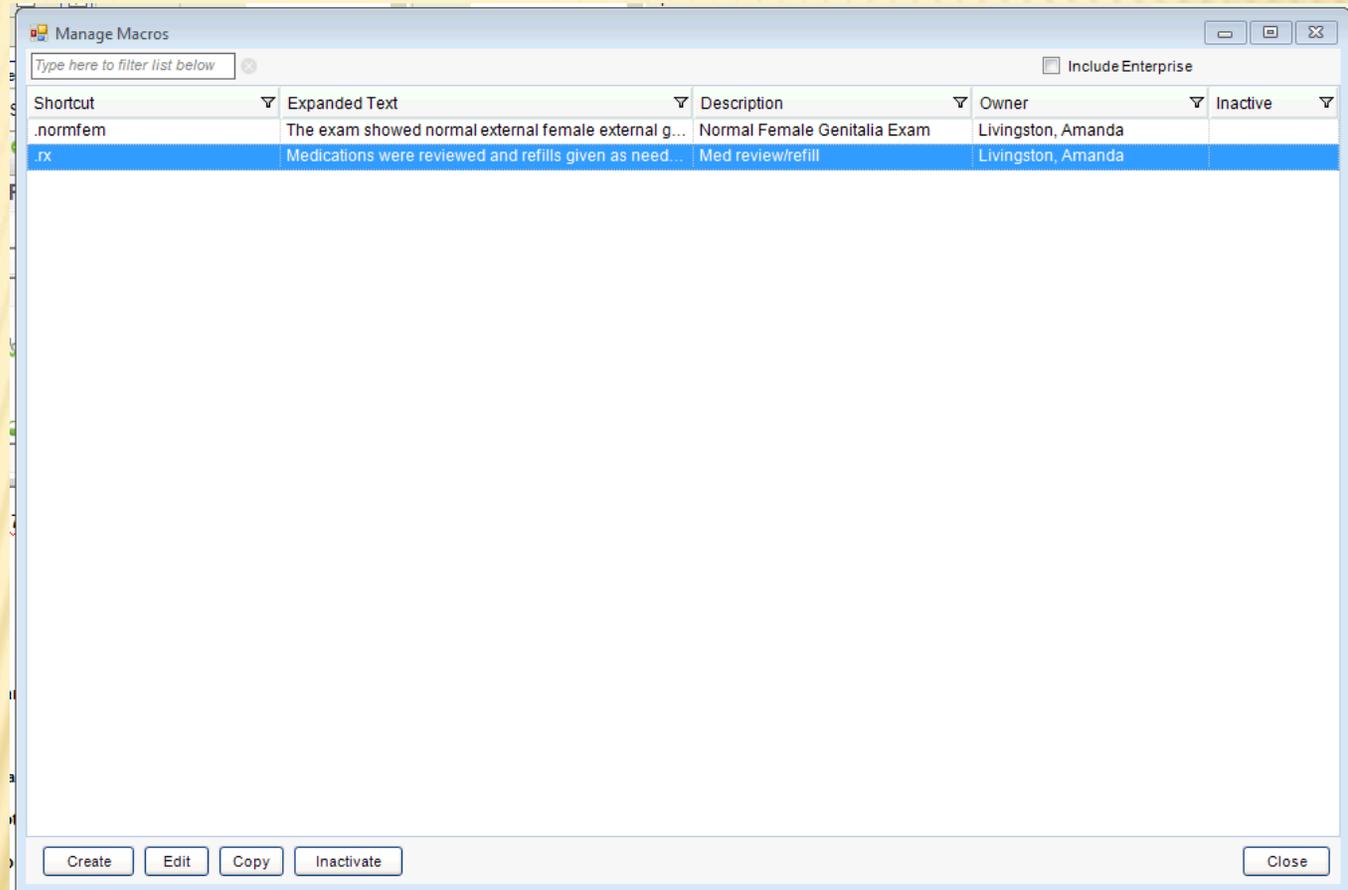
2. **Description** will explain what the macro is for.



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

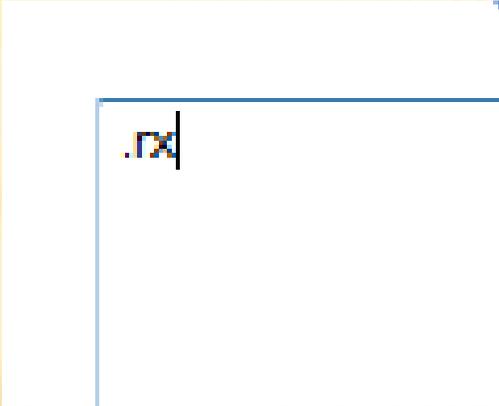
# SAVE YOUR MACRO

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.

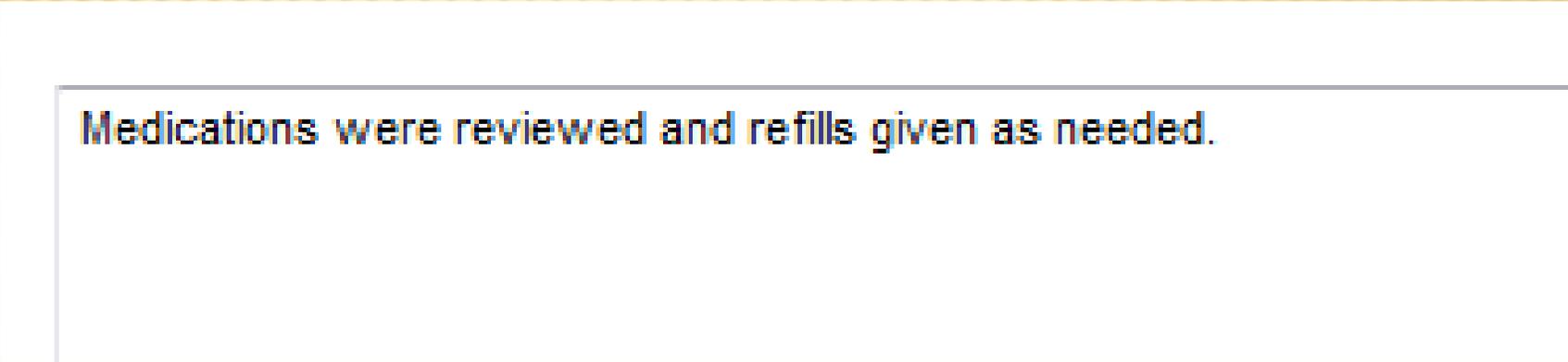


# TO ADD MACRO IN ALLSCRIPTS

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.