



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

June 2020

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.

Navigation Bar: Daily, Clinical Desktop, New Note, Worklist, Task List, Batch Sign, Appointments, Patient Lists, Provider Schedules

Patient Information: SUPERUSER, FLASH
PCP: Other
MRN: 001000643529101
Security: No Restricted Data
FYI: FYI
H Phone: (423)123-4567
MED & NON-MED ALLERGIES

Daily Schedule: Arrived, Pending and Rescheduled
Provider: ALLSCRIPTS,Provider
Date: 25 May 2018
AM: 6, PM: 0, All: 6
Last Updated: 06/04/2018 3:39 PM

\$	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 includes 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 information section shows the name **SUPERUSER, ERNIE**, birth date 01-Jan-1979 (39y) F, and PCP Aiken, Todd. The **Patient Banner** section on the right displays the patient's name and a **NO KNOWN ALLERGIES** status. The main content area is divided into several sections: a top bar with icons and a status bar showing 'Commit', 'Pat Loc: G59 Exam Rm', 'Status: Provider Ready', and 'Updated: 3:35 PM'. Below this, there are tabs for 'Problem', 'Notes', 'Labs', 'Radiology', 'Procedures/Pathology', 'Chart', and 'Worklist'. The 'Notes' tab is selected, showing a list of chart items under the heading '74 of 279 Chart Items (3 Invalid and 190 Audit Items) - Filters Applied'. The list includes items like 'Acute (Acute) - ALLSCRIPTS, Provider, Enc: 25-May-2018 - Appointment - ALLS', 'Established (Established) - ALLSCRIPTS, Provider, Enc: 16-Nov-2017 - Chart U', 'ACOG Flowsheets - ALLSCRIPTS, Provider, Enc: 15-Nov-2017 - Chart Update -', 'sTWS Forms - Livingston, Amanda; Enc: 09-Nov-2017 - Chart Update - Livingst', 'sOMR PCP - Livingston, Amanda; Enc: 09-Nov-2017 - Chart Update - Livingston', 'Follow-Up (Follow-Up) - Livingston, Amanda; Enc: 08-Nov-2017 - Chart Update -', 'New Patient (New Patient) - Livingston, Amanda; Enc: 08-Nov-2017 - Chart Upd', 'Follow-Up (Follow-Up) - Livingston, Amanda; Enc: 23-Oct-2017 - Chart Update -', 'Communication Note (no co-sign) (Communication Note (no co-sign)) - Laiwala,', and 'Medication Management with Office Visit (Medication Management with Office Vi'. On the right side of the 'Notes' tab, there are sections for 'Flowsheets', 'HMP/Reminders', 'Growth Chart', 'Vital Signs', 'Meds', 'Med Flowsheet', 'Orders', 'Allergies', and 'Immunizations'. The 'Orders' section is currently empty, displaying '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. At the top, it displays 'SUPERUSER, Emie 01-Jan-1979 (39 years) F' and 'Appointment: 25-May-2018'. Below this, there are three radio buttons for 'Style': 'Note' (selected), 'Unstructured', and 'Admin Forms'. There are two dropdown menus: 'Specialty:' with 'Internal Medicine' selected, and 'Visit Type:' with '<< Please select a Visit Type >>' selected. The 'Visit Type' dropdown is open, showing a list of options: 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. To the right of the 'Visit Type' dropdown, there is a second dropdown menu with a list of note types: 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. At the bottom of the window, it says 'Enc Date: 25 May 2018 07:30 AM Enc Type: Appointment'.

Specialty: Internal Medicine

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

Owner: ALLSCRIPTS, Provider

Chief Complaint

Add/Remove Chief Complaints

There are no items to show in

OK

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

Ensure that correct appointment date in upper right.

NOTE IN "EDIT" MODE

The screenshot displays a medical software interface in "EDIT" mode. The top status bar shows "SUPERUSER, Emie 01-Jan-1979 (39 years) F" and "Appointment: 25-May-2018". A yellow arrow points from the patient information to the label "Patient Name, age and DOB". Another yellow arrow points from the appointment date to the label "Appointment date/visit type". Below the status bar is a "Clinical Toolbar" with various icons, highlighted by a red box and a blue arrow. The main workspace is divided into several panels. On the left is a "Table of Contents" panel, highlighted by a red box and a blue arrow, listing sections 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". The central panel shows the "Preventive" section with a table of items to be reviewed, including "Have you ever had a...", "Have you had a flu shot this...", "Have you had colorectal...", "Mammogram: who...", "Last Pap smear?", "Pap Smear: where / when?", "DXA (bone) scan done in last...", and "Have you had a diabetic...". A blue arrow points from this panel to the label "Clinical Desktop". Below the "Preventive" section is a "PHQ-9" section. On the right is a "Vitals" and "Immunizations" panel, highlighted by a red box, showing a list of active and acute conditions with their ICD-10 codes. At the bottom is a "Note Authoring Workspace (NAW)" panel, highlighted by a red box and a blue arrow, containing checkboxes for "Established", "Referral Letter", and "Return to Work Letter".

Patient Name, age and DOB

Appointment date/visit type

Clinical Toolbar

Table of Contents

Clinical Desktop

Note Authoring Workspace (NAW)

TABLE OF CONTENTS

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

Chart and Note View

Health Management

Chief Complaint

Reason For Visit

Reason For Visit - IM

Active Problems

History of Present Illness

Cough

Hypertension (Follow-Up)

Diabetes Type II (Follow-Up)

Review of Systems

Complete-Female

Past Medical History

Social History

Family History

Surgical History

Current Meds

Allergies

Immunizations

Vitals

Physical Exam

General Multi-System - Inter

☒ Acute

☐ Clinical Summary

Chief Complaint

Reason For Visit

Table of Contents

Section Heading

Form

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

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

Established ☒ ALLSCRIPTS, Provider Status: Needs Input

Table of Contents

- Note
- Established ☒ ALLSCRIPTS, Provider
- Patient Team
 - Health Management
 - HM Check
 - Health Maintenance Checklis
 - Chief Complaint
 - Chief Complaint
 - Reason For Visit
 - General RFV
 - Active Problems**
 - History of Present Illness
 - History of Present Illness
 - Review of Systems
 - Complete-Female
 - Past Medical History
 - No new statement - PMH
 - Social History
 - No new statement - SH
 - Family History
 - No new statement - FH
 - Surgical History
 - No new statement - Surgical
 - Current Meds
- Output Template
 - ☒ Established
 - ☐ Referral Letter
 - ☐ Return to Work Letter

Active Problems

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

...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.

CLINICAL DESKTOP/NAW

The screenshot displays the Clinical Desktop/NAW interface. At the top is a toolbar with icons for various functions and a status bar with 'Commit', 'Pat Loc', and 'Status' dropdowns. The main workspace is divided into several panes. On the left, a 'Note' pane shows a list of medical history items under 'Active Problems'. In the center, a 'Reason For Visit' pane is visible. On the right, a 'Chart Viewer' pane displays a list of notes and appointments, including '25May2012 - Appointment' and '23May2012 - Appointment'. A large orange callout box with an arrow pointing to the right pane contains the text: '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.' A yellow callout box with an arrow pointing to the bottom section of the interface contains the text: 'The Note Authoring Workspace (NAW) is where your text will populate as you document on the forms above.' The bottom section shows the 'Active Problems' and 'History of Present Illness' fields.

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

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

NOTE SECTIONS – PATIENT CARE TEAM

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

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

Left Sidebar:

- Note
- Established
- ALLSCRIPTS, Provider
- Status: Needs Input
- Patient Care Team**
- Health Management**
- HM Checklist
- Health Maintenance Checklis
- Chief Complaint
- Reason For Visit
- General RFV
- Active Problems**
- History of Present Illness
- Review of Systems
- Complete-Female
- Past Medical History**
- No new statement - PMH
- Social History**
- No new statement - SH
- Family History**
- No new statement - FH
- Surgical History**
- No new statement - Surgical
- Current Meds**

Main Content Area:

Patient Care Team

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

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

Task Hide Show All Hide All

Bottom Section:

Output Template CC

- Established
- Referral Letter
- Return to Work Letter

Patient Care Team

Health Management

HM Checklist

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

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 10

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

The screenshot shows a medical software interface with several key areas highlighted by red circles and arrows:

- Clinical Toolbar:** A red circle highlights the 'P' icon, with an arrow pointing to it from the text: "To add a new problem, click 'P' on the Clinical Toolbar (or New on the gray toolbar)." The 'New' icon on the gray toolbar is also circled in red.
- Active Problems Section:** A red circle highlights the 'New' button in the 'Active Problems' section. An arrow points to the 'Chest pain' problem in the list, with text explaining: "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."
- Recompile Button:** A red circle highlights the 'Recompile' button at the bottom of the interface.
- Left Sidebar:** A red box highlights 'Chest Pain (Brief)' under the 'Active Problems' section.

The main window displays a list of active problems, including 'Elevated blood pressure reading', 'Foot pain', 'Generalized continuous abdominal pain', 'Major neurocognitive disorder', 'Malignant essential hypertension', 'Primary insomnia', 'Probable major neurocognitive disorder', and 'Recurrent major depressive disorder'. The 'Chest pain' problem is highlighted in pink.

The right sidebar shows a list of ICD-10 codes, including F41.9, R03.0, M79.673, R10.84, F03.90, I10, F51.01, G30.9, and F33.9.

The bottom of the interface shows a menu bar with options: View, Recompile, Spell Check, Copy Forward, Show Uncopied Form Data, Save & Close, Save, and Close.

FORMS

The screenshot shows a medical software interface with a sidebar on the left containing a tree view. The tree view has the following items: Chief Complaint, Reason For Visit, History of Present Illness, Language Line, **Depressive Disorders** (highlighted with a red box), Review of Systems, Active Problems, Past Medical History, Surgical History, Family History, Social History, Pets, Current Meds, Allergies, Immunizations, Vitals, Physical Exam, and Procedure. The main window displays the 'Depressive Disorders (Brief)' form, which is also highlighted with a red box. The form includes sections for Reason for Visit, Visit Type, Depression Type, Last Visit, Symptoms, Problem Details, Associated Symptoms, Suicide / Homicide Risk, Current Treatment, and Pertinent History. The bottom status bar contains buttons for View, Recompile, Sign, Spell Check, Copy Forward, Show Uncopied Form Data, Save & Close, Save, Close, and a New button.

Depressive Disorders (Brief)

Reason for Visit:

Visit Type

Medication Management Acute Exacerbation Follow-Up - From Acute Care

Follow-Up - Routine Clinic Follow-Up - From Hospitalization Worsening Symptoms

Depression Type

Last Visit:

Symptoms:

Symptoms

None Y/N Sense of Failure Y/N Weight Gain

Currently Experiencing Y/N Poor Concentration Y/N Poor Sleep

Y/N Loss of Interest Y/N Indecisiveness Y/N Hypersomnia

Y/N Depressed Mood Y/N Guilt Y/N Headaches

Y/N Hopelessness Y/N Psychomotor Retardation Y/N Irritability

Y/N Crying Spells Y/N Appetite Change

Y/N Fatigue Y/N Weight Loss

Problem Details

Associated Symptoms

None Y/N Psychotic Symptoms Y/N Eating Disorder Symptoms

Y/N Anxiety Symptoms Y/N OCD Symptoms Y/N Panic Symptoms

Y/N Manic Symptoms

Suicide / Homicide Risk:

Current Treatment:

Pertinent History:

Language Line:

Depressive Disorders (Brief):

Review of Systems

Active Problems

Output Template CC

Acute CC

Referral Letter CC

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

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

FORMS

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

The screenshot displays the 'Hyperlipidemia Follow-up' form and its associated 'Details' form.

Hyperlipidemia Follow-up Form:

- Status:** Radio buttons for 'Good' and 'Stable'. 'Stable' is selected.
- Comorbid Illnesses:** Checkboxes for 'None', 'Diabetes Mellitus' (checked), 'Hypertension' (checked), 'CAD', and 'PVD'.
- Interval Events:** A checkbox for 'None' and a small radio button (circled in red).
- Interval Symptoms:** A checkbox for 'None'.
- Lifestyle:** Radio buttons for 'Y' and 'N'.
- Medications:** Radio buttons for 'Y' and 'N'.

Details Form:

- Onset Mode:** Radio buttons for 'Gradual' and 'Sudden'.
- Severity:** Radio buttons for 'Mild', 'Moderate', and 'Severe'.
- Location / Laterality:** Checkboxes for 'Substernal', 'Epigastric', 'Anterior Mid-Chest', 'Infrascapular', and 'Sub-Xiphoid'.
- Table:**

	Bilateral	Right	Left
Anterior Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Quality / Character:** Checkboxes for 'Aching', 'Burning', 'Dull', 'Heavy', 'Pleuritic', 'Pressure-Like', 'Sharp', 'Squeezing', 'Stinging', and 'Tight'.
- Radiation / Laterality:** Checkboxes for 'No Radiation', 'Neck', 'Jaw', and 'Back'.

A yellow callout box points to the small radio button in the 'Interval Events' section, stating: "Clicking on the small radio button (looks like a degree symbol) next to a checkbox will open up a details form which provides more options for charting."

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 "Constitutional" section includes "Negative", "Fever", "Chills", "Feeling Poorly", and "Feeling Tired/Fatigue". The "Eyes" section includes "Negative", "Eye Pain", "Red Eyes", "Eyesight Problems", and "Discharge From Eyes". The "Nosebleeds" and "Nasal Discharge" sections are also visible. A red arrow points from the "All Normal" button in the top right corner to the "Nasal Discharge" section. A yellow callout box on the left side of the form contains 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.

A blue-bordered box on the right side of the form contains 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 form also includes a sidebar on the left with sections like "Health Management", "Chief Complaint", "Reason For Visit", "Active Problems", "History of Present Illness", "Review of Systems", "Past Medical History", "Social History", and "Family History". The "Review of Systems" section is currently selected, and the "Complete-Female" option is highlighted. The bottom of the form has a status bar with buttons for "View", "Recompile", "Sign", "Copy Forward", "Security Codes", "Audit", "Save & Close", "Save", and "Cancel".

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: 'Health Management' (with 'Chief Complaint' and 'Reason For Visit'), 'Active Problems' (highlighted with a yellow box), 'Past Medical History' (highlighted with a yellow box), 'Social History', 'Family History', 'Surgical History', 'Current Meds', 'Allergies', 'Immunizations', and 'Vitals'. The 'Active Problems' section lists 'Colorectal Cancer', 'Diabetes Type II (Follow-U', and 'Hyperlipidemia (Follow-Up'. The 'Past Medical History' section lists 'History of Present Illness', 'History of Anxiety Disorder NOS 300.00', 'History of Asthma 493.90', 'Hypertension 401.9', and 'History of Permanent Pacemaker Placement'. The 'Social History' section is also visible. The main content area shows a 'Review of Systems' section, followed by 'Past Medical History' (with a 'Type' dropdown), 'Chronic' (with 'History of Anxiety Disorder NOS 300.00', 'History of Asthma 493.90', 'Hypertension 401.9', and 'History of Permanent Pacemaker Placement'), and 'Acute' (with '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 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'.

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

HIDING ITEMS

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

^ Past Medical History Edit Mode of Note

Type [dropdown] [icon] [icon] [icon] [icon] [icon]

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

New Edit CareGuide Resolve Show Show All Hide All

Past Medical History

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

Social History

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

Finished Note

Family History

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

NOTE SECTIONS – CURRENT MEDS

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

Note | Appointments | Health Management Plan

New Patient | ALLSCRIPTS, Provider | Status: Needs Input

Hyperlipidemia (Follow-Up)

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

Physical Exam

- General Multi-System Exam

Procedure

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

The screenshot displays the ETSU medical software interface. On the left, a sidebar contains various note sections: Allergies, Immunizations, Vitals, Physical Exam, Procedure, and Assessment. The 'Results/Data' section is highlighted with a red box. In the center, the 'Results/Data' section is active, showing a message: 'There are no items to show in this view. Data Includes: Last 1 Month'. A red box highlights the 'Advanced Result Citation' button. A dialog box titled 'Results Citation Selection' is open, showing a list of lab results with checkboxes. The first item, 'Drug Screen, Urine', is checked. The dialog also displays patient information: 'SUPERUSER, Ernie 01-Jan-1979 (39 years) F : 25-May-2018'. On the right, a list of lab results is visible, including 'Drug Screen, Urine (UDS) - Done: 15-Nov-2017 - Livingston, A', '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', and 'Vitamin B12 - Done: 08-Jul-2015 - ALLSCRIPTS, Provider; Enc:'. At the bottom, a yellow box contains text explaining how to pull in labs outside the 1-month parameter.

Results/Data

Advanced Result Citation

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

Results Citation Selection

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

Result Citation Selection

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

OK Cancel

Assessment

Assessed

Foot pain (M79.673)

Primary insomnia (F51.01)

Chest pain (R07.9)

Results/Data

Assessment

Summary/Care Plan

Output Template CC

- ☒ Established
- ☐ Referral Letter
- ☐ Return to Work Letter

View Recompile Sign Spell

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

NOTE SECTIONS – ASSESSMENT

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

Name	ICD-10	Managed By
Assessed		
Foot pain	M79.673	
Primary insomnia	F51.01	
Chest pain	R07.9	
Unassessed		
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.

Note Health Management/Reminders

Established ALLSCRIPTS, Provider Status: Needs Input

Plan

Problem Rec: Done Lock

- ☐ Chest pain
 - ☐ Follow-ups
 - 1 month Follow up - Follow-up Status: Hold For - Scheduling Requested for: 04Jun2018
- ☐ Elevated glucose
 - ☐ Medications
 - ePA Start: Glucose Test Strips; provide one unit
- ☐ Referrals
 - Dietitian Referral Evaluation and Treatment cut cards Status: Hold For - Scheduling Requested for: 04Jun2018
- ☐ Recurrent major depression resistant to treatment
 - ☐ Orders
 - Lithium - Summary Status: Active Requested for: 04 Jun 2018

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

IM Plan

Health Management Review/Plan

Output Template CC

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

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

VIEWING YOUR NOTE

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

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

Note Acute ALLSCRIPTS, Provider Status: Needs Input

Health Management

- Chief Complaint
- Reason For Visit
- Reason For Visit - IM
- Active Problems**
- History of Present Illness
- Review of Systems
- Complete-Female
- Past Medical History**
- No new statement - PMH
- Social History**
- No new statement - SH
- Family History**
- No new statement - FH
- Surgical History**
- No new statement - Surgical
- Current Meds**
- Allergies**
- Immunizations**
- Vitals

Health Management

Item	Sched...	Goal	Most Recent	Date	To Do	Incompl...
Personal history of asthma						
Eye Exam	Q 1 year		Complete	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

- Referral Letter
- Acute
- Return to Work Letter

View

Current Orders Labs Appointments

Allergies Vitals Immunizations

Problem Medications Chart Viewer

All Problem List

Active

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

Past Medical History

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

Edit Active Resolve

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

VIEWING YOUR NOTE

The screenshot shows a software window titled "Note Output". At the top, it displays patient information: "SUPERUSER, Ernie 01-Jan-1979 (39 years) F" and "Appointment: 25-May-2018". Below this, there are tabs for "Established", "Owner: ALLSCRIPTS, Provider", and "Status: Needs Input". The main content area is divided into sections: "Chief Complaint" with a list of "1. Bad Breath" and "2. Hot Flashes"; "Active Problems" which is further divided into "Chronic" (listing 9 items including Anxiety, blood pressure, foot pain, abdominal pain, neurocognitive disorder, hypertension, insomnia, Alzheimer's disease, and depression) and "Acute" (listing "10. Chest pain (R07.9)"); and "Past Medical History" with a "Chronic" section listing "History of Chronic pain syndrome (G89.4)". At the bottom, there is a toolbar with buttons: "Sign", "Audit", "Document Hx", "Task", "Attach to Result", "Print", "Fax", "Invalidate", and "Close". The "Close" button is highlighted with a red rectangle.

Note Output

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

Established Owner: ALLSCRIPTS, Provider Status: Needs Input

Established

Chief Complaint

1. Bad Breath
2. Hot Flashes

Active Problems

Chronic

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

Acute

10. Chest pain (R07.9)

Past Medical History

Chronic

- History of Chronic pain syndrome (G89.4)

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

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

SIGNING YOUR NOTE

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

Note | Health Management/Reminders

Established | ALLSCRIPTS, Provider | Status: Needs Input

Save & Close | Save

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

Results/Data
Assessment

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

Plan

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

Output Template | CC

Established
Referral Letter
Return to Work Letter

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

Note Signature

User Name: livingstone

Password:

Sig Type: Author

☒ Make Final

Carbon Copy Recipients:

Recipient Name	Role	Note Output
There are n		

OK | Cancel

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

☐ 1 Not about a patient ☒ 2 Concerning patient SUPERUSER,ERNIE

Assign To: ☒ User ☐ Team

Task: **Co-Sign Note**

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

Comment:

Text Templates...

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

Create Notify Task When: ☐ Complete ☐ Overdue

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

☐ Delegate **Reactivate** **OK** **Cancel**

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

SUPERUSER, CATWOMAN
01-Jan-1979 (39y) F

PCP ALLSCRIPTS, Resident
MRN 001000643516801
FYI FYI

Other
Security No Restricted Data
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
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.

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

Header: **SUPERUSER, CATWOMAN** PCP ALLSCRIPTS, Resider MRN 001000643516801 FYI FYI

Patient: 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 shows the Allscripts software interface. At the top, a navigation bar includes tabs for 'Daily', 'Clinical Desktop', 'New Note' (highlighted with a red circle), 'Worklist', 'Task List', 'Batch Sign', 'Appointments', 'Patient Lists', and 'Provider Schedules'. Below this, a patient banner for 'Allscripts, Chris' (10-Mar-1976, 42y) M is displayed, along with fields for PCP, MRN (ZZZAH506), FYI, Other (1234567), Security (No Restricted Data), and H Phone ((802)555-1116).

The main window is titled 'Note Selector' and contains the following elements:

- A header bar with patient information: 'ALLSCRIPTS, Chris 10-Mar-1976 (42 years) M' and a search field containing 'Telephone Call: 04-Jun-2018' (highlighted with a red box).
- A 'Create New' section with three radio buttons: 'Note' (selected), 'Unstructured', and 'Admin Forms'.
- Two dropdown menus: 'Specialty:' set to 'Internal Medicine' and 'Owner:' set to 'ALLSCRIPTS, Provider'.
- A 'Visit Type:' dropdown menu set to 'Communication Note (co-sign)' (highlighted with a red box).
- An 'Incomplete Notes:' section with a dropdown menu showing '<< Choose an incomplete Note. >>'.
- 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 bottom right, there are 'OK' and 'Cancel' buttons.

ENCOUNTER SELECTOR


Encounter Selector -- Webpage Dialog

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

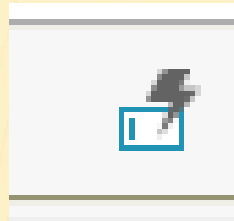
A macro is a shortcut that you create that when entered into the system will automatically expand into a larger phrase or series of phrases. A macro can be used to automatically enter simple, repetitive phrases including commonly used sentences and instructions in your documentation.

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

vider Status: Needs Input

Save & Close Save Close

Active Problems

Type

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

MACRO CREATION

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

Create

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

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

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

MACROS

Create New Macro

Owner: Livingston, Amanda

Shortcut: Alphanumeric only

Description: << Show Merge Fields

Medications were reviewed and refills given as needed.

Verify Merge Fields Spell Check Save Cancel

1 2 3

MACRO COMPONENTS



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



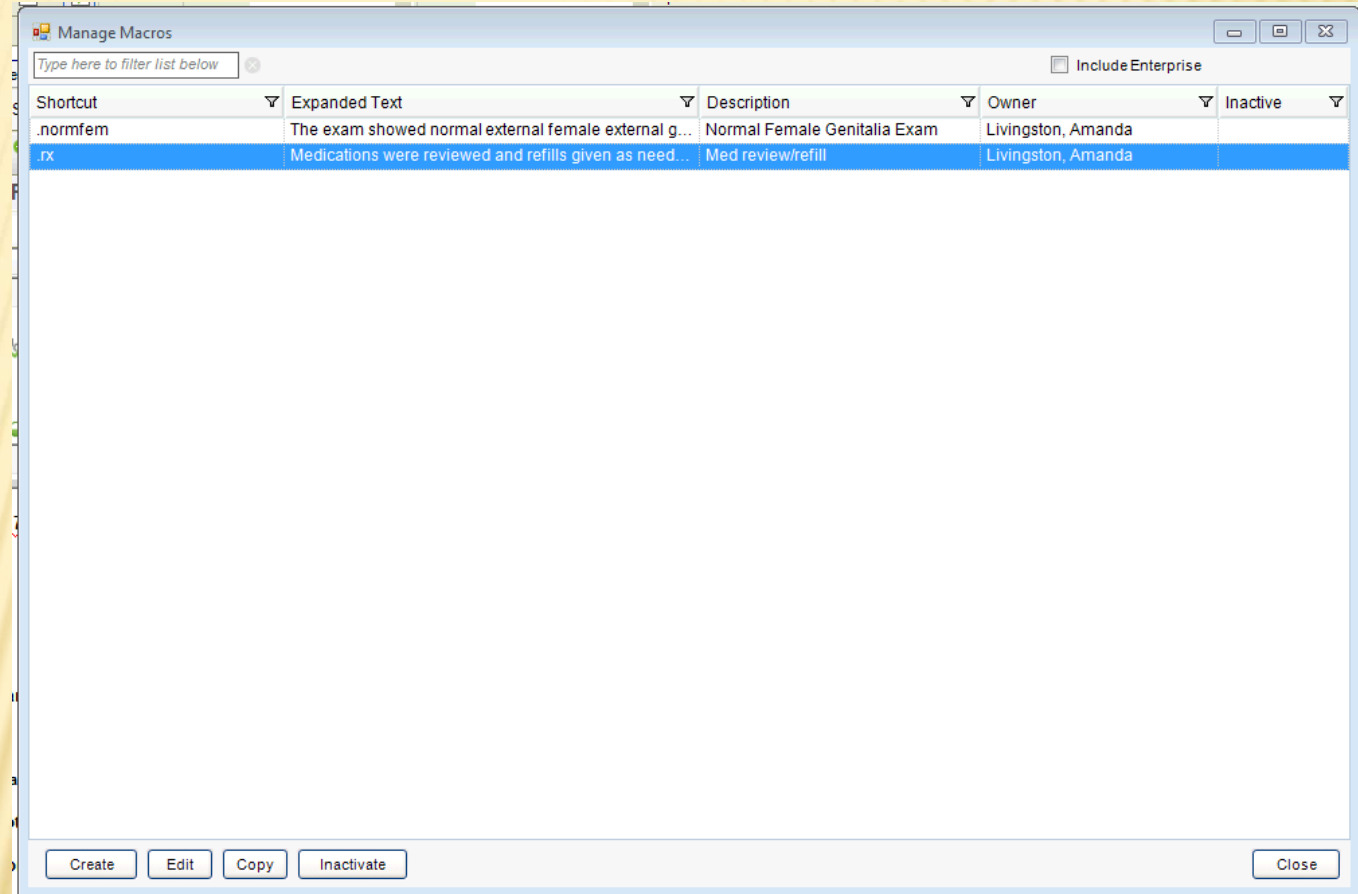
2. **Description** will explain what the macro is for.



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

SAVE YOUR MACRO

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



TO ADD MACRO IN ALLSCRIPTS

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

A screenshot of a text input field with a blue border. Inside the field, the text ".rx" is typed in a monospaced font, and a vertical cursor is positioned at the end of the text.

.rx

A screenshot of a text area with a light gray border. It contains a single line of text: "Medications were reviewed and refills given as needed." The text is in a monospaced font.

Medications were reviewed and refills given as needed.