



EAST TENNESSEE STATE  
UNIVERSITY

# QUILLEN ETSU PHYSICIANS

## Module 5: Notes

Provider Training Module  
Allscripts Touchworks EHR

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

June 2018

# 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 the following elements:

- Navigation Bar:** Clinical Desktop, New Note, Worklist, Task List, Batch Sign, Appointments, Patient Lists, Provider Schedules.
- Patient Information:** SUPERUSER, FLASH (circled in red), PCP, MRN 001000643529101, Security No Restricted Data, H Phone (423)123-4567.
- Buttons:** MED & NON-MED ALLERGIES (red), Personalize.
- Daily Schedule:** Arrived, Pending and Rescheduled. Provider: ALLSCRIPTS,Provider. Date: 25 May 2018. Day: FRI.
- Table:**

\$	N	TC	SO	CC	S	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"/>	<input type="checkbox"/>	Arr			07:00 AM	SUPERUSER, BATMAN	00100064351760	NP	15	1	NP GALLBLADDER
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			07:15 AM	SUPERUSER, BERT	00100064365540	AC	15	3	ACUTE PAIN - LASHER
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr	G59 Exam	RrProvider Ready	07:30 AM	SUPERUSER, ERNIE	00100064365620	5	15	2	CONSULT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:00 AM	SUPERUSER, CATWOMAN	00100064351680	FU	15	1	FOLLOW UP WOUND
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			08:15 AM	SUPERUSER, FLASH	00100064352910	69	15	2	POST OP SAHAWNEH
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arr			10:00 AM	SUPERUSER, WASP	00100064353740	NP	15	3	NP LIVINGSTON

# NEW NOTE TAB

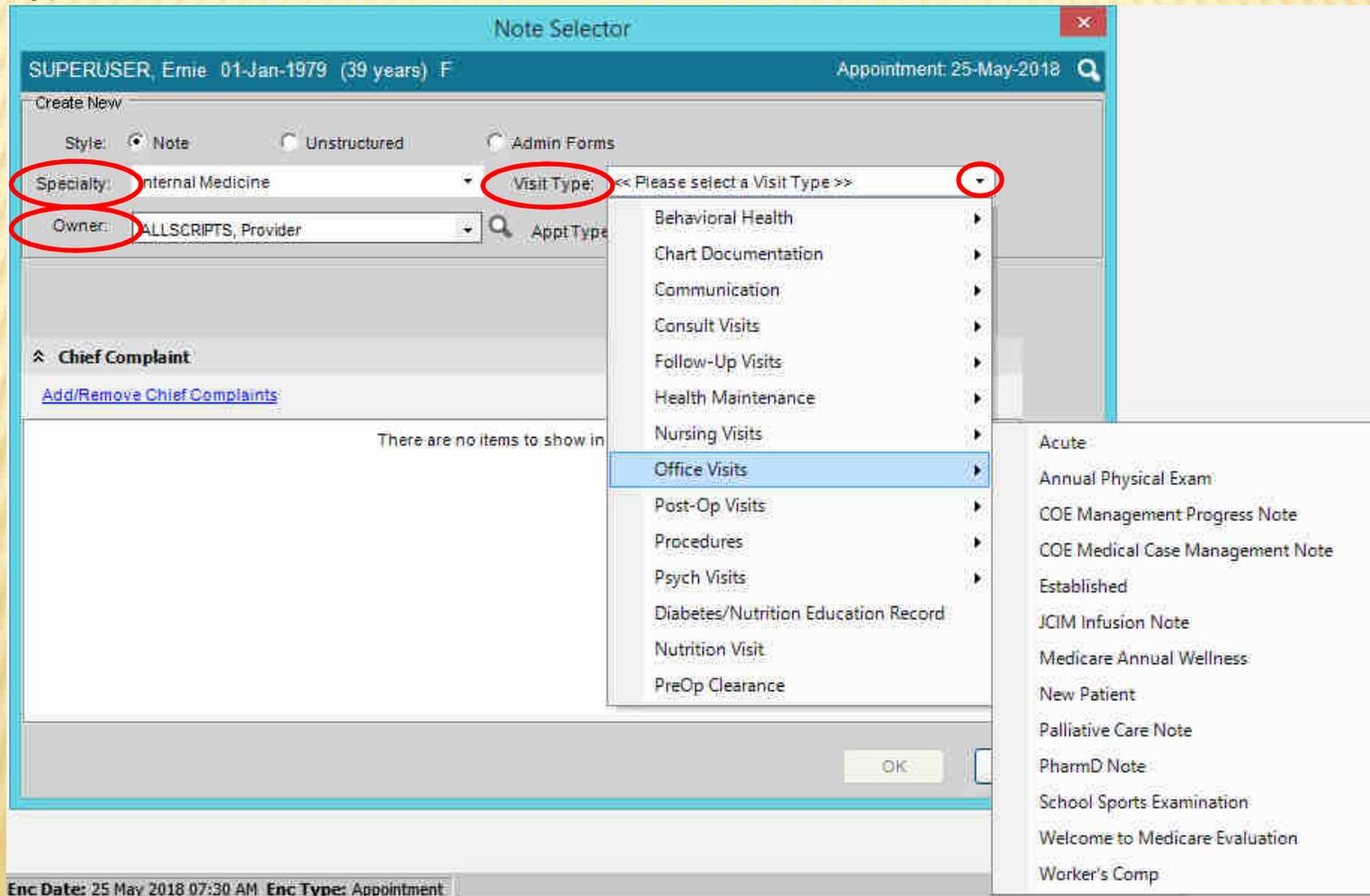
The screenshot shows a clinical software interface with the following elements:

- Navigation Bar:** Includes tabs for 'Clinical Desktop' (highlighted with a red circle), 'New Note', 'Worklist', 'Task List', 'Batch Sign', 'Appointments', 'Patient Lists', and 'Provider Schedules'.
- Patient Banner:** Displays patient information for 'SUPERUSER, ERNIE', including PCP 'Aiken, Todd', MRN '001000643656201', and a 'NO KNOWN ALLERGIES' status.
- Toolbar:** Contains various icons for clinical actions and a 'Commit' button.
- Notes Tab:** 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', and 'ACOG Flowsheets - ALLSCRIPTS, Provider, Enc: 15-Nov-2017 - Chart Update -'.
- Right Panel:** Contains tabs for 'Flowsheets', 'HMP/Reminders', 'Growth Chart', 'Vital Signs', 'Meds', 'Med Flowsheet', 'Orders', 'Allergies', and 'Immunizations'. The 'Orders' tab is active, showing 'Current Orders' and a message: '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.



# NOTE IN "EDIT" MODE

The screenshot shows an EHR interface in 'EDIT' mode. The top status bar displays 'SUPERUSER, Emie 01-Jan-1979 (39 years) F' on the left and 'Appointment: 25-May-2018' on the right. A yellow arrow points from the patient information to the appointment date. Below the status bar is a 'Clinical Toolbar' with various icons. The main workspace is divided into several sections:

- Table of Contents:** A vertical list on the left side of the main workspace, including categories like Preventive, Health Management, Chief Complaint, Reason For Visit, Active Problems, History of Present Illness, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies, and Immunizations.
- Clinical Desktop:** The central area showing a 'Preventive' section with a table of items. A blue arrow points from this section to the right.
- Note Authoring Workspace (NAW):** A section at the bottom of the main workspace containing 'Preventive', 'Health Management/Reminders', and 'Chief Complaint' sections.
- Problem List:** A table on the right side of the interface listing various medical conditions with their ICD-10 codes. The table is organized into 'Active' and 'Acute' sections.

Name	ICD-10
<b>Active</b>	
Chronic	
Anxiety	F41.9
Elevated blood pressure reading	R03.0
Foot pain	M79.673
Generalized continuous abdominal...	R10.84
Major neurocognitive disorder	F03.90
Malignant essential hypertension	I10
Primary insomnia	F51.01
Probable major neurocognitive...	G30.9
Recurrent major depression...	F33.9
Acute	
Chest pain	R07.9
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

# 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.



# CLINICAL DESKTOP/NAW

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

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

The screenshot shows a software interface with a top toolbar containing icons for various functions and buttons for 'Commit', 'Pat Loc', and 'Status'. Below the toolbar are several tabs: 'Note', 'Appointments', and 'Health Management Plan'. The 'Note' tab is active, showing a patient record for 'ALLSCRIPTS, Provider'. On the left, there is a navigation pane with categories like 'Active Problems', 'Past Medical History', 'Social History', etc. The main area is divided into sections for 'Reason for Visit', 'Active Problems', 'History of Present Illness', and 'Review of Systems'. On the right, there is a 'Clinical Desktop' pane with tabs for 'Immunizations', 'Allergies', 'Chart Viewer', 'Flowsheets', and 'Vitals'. The 'Chart Viewer' tab is active, displaying a list of notes and appointments, including '25May2012 - Appointment' and '04Aug2012 - Appointment'. At the bottom, there is a status bar with buttons for 'View', 'Recompile', 'Sign', 'Copy Forward', 'Security Codes', 'Audit', 'Save & Close', 'Save', and 'Close'.

# NOTE SECTIONS – PATIENT CARE TEAM

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

The screenshot displays the 'Patient Care Team' section within a medical software interface. The interface includes a sidebar on the left with navigation options such as 'Health Management', 'Active Problems', 'Past Medical History', and 'Current Meds'. The main area shows a table of team members with columns for Name, Role, Relationship, Specialty, and Comments. Two buttons, 'Add Provider/Agency' and 'Add Patient Caregiver/Resource', are highlighted with a red box. The bottom of the screen shows an 'Output Template' section and a status bar with various action buttons.

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

# NOTE SECTIONS – HEALTH MANAGEMENT

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

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

- New
- Defer
- Stop Deferral
- D/C
- Done Today
- Last Done
- Order**
- Record As Admin

# NOTE SECTIONS – CHIEF COMPLAINT

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

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

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

Note

Established    ALLSCRIPTS, Provider    Status: Needs Input

**Patient Care Team**

**Health Management**

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

**Active Problems**

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

**Past Medical History**

- No new statement - PMH

**Social History**

- No new statement - SH

**Family History**

- No new statement - FH

**Surgical History**

- No new statement - Surgical

**Current Meds**

**Output Template**    CC

- Established
- Referral Letter
- Return to Work Letter

HM Checklist

Chief Complaint

- Belching

New    Resolve    Hide    Show All    Hide All

Chief Complaint

Chief Complaint Details:

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

# HPI NOTE FORMS

Note

Established ALLSCRIPTS, Provider

**Patient Care Team**

**Health Management**

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

**Active Problems**

- History of Present Illness**
- History of Present Illness
- HM, Adult Female
- Belching**
- Review of Systems
- Complete-Female

**Past Medical History**

- No new statement - PMH

**Social History**

- No new statement - SH

**Family History**

- No new statement - FH

**Surgical History**

**Output Template** CC

- Established
- Referral Letter
- Return to Work Letter

Screening:

**Belching:**

Review of Systems

**Past Medical History**

New Resolve Hide Show All Hide All

**Chief Complaint**

**Chief Complaint Details:**

**Reason For Visit**

View **Recompile** Sign Spell Check Copy Forward Security Codes Audit eReply Save & Close Save Close 1.2

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. At the top, a toolbar contains a 'P' icon circled in red with an arrow pointing to it. Below the toolbar, a list of 'Active Problems' is shown, with 'Chest pain' highlighted in pink and a paper icon next to it, with an arrow pointing to it. At the bottom, a 'Recompile' button is circled in red. A yellow callout box is overlaid on the right side of the screen.

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.

# FORMS

Health Management/Reminders

Acute - ALLSCRIPTS, Provider Status: Needs Input

Save & Close Save Close

**Depressive Disorders (Brief)** Brief Comprehensive Previous History

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:

Permanent history:

Language Line:

Depressive Disorders (Brief):

Review of Systems

Active Problems

Output Template CC

Acute Referral Letter

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).

**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  Intrascapular

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

Clear OK Cancel

**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 interface. On the left is a sidebar with a tree view containing sections like 'Health Management', 'Chief Complaint', 'Active Problems', 'Review of Systems', 'Past Medical History', 'Social History', and 'Family History'. The 'Review of Systems' section is expanded, and 'Complete-Female' is selected. The main area displays the 'Complete-Female' form with checkboxes for 'Negative' and 'As Noted in HPI' for various systems: Constitutional (Negative checked), Eyes (Negative checked), Endocrine (Negative), Hematologic/Lymphatic (Negative), and Past Medical History (Social History). At the top right of the form are two buttons: 'All Normal' and 'Previous Exam'. A red box highlights these buttons. A yellow callout box with a red arrow points to the 'All Normal' button, containing a warning about its use. A blue-bordered box on the right contains a list of system names followed by 'negative.', corresponding to the systems in the form.

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

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

# HISTORY SECTIONS

The screenshot displays a medical software interface with a sidebar on the left and a main content area. The sidebar contains several sections, with 'Active Problems' and 'Past Medical History' highlighted in yellow. The main content area shows a 'Review of Systems' section, followed by a 'Past Medical History' section. Under 'Past Medical History', there are two sub-sections: 'Chronic' and 'Acute'. 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 the 'Past Medical History' section, there are buttons for 'New', 'Edit', 'Show', 'Show All', and 'Hide All'. The 'Show', 'Show All', and 'Hide All' buttons are highlighted with a red box. Below these buttons is a 'Social History' section. At the bottom of the interface, there are buttons for 'View', 'Recompile', 'Sign', 'Copy Forward', 'Security Codes', 'Audit', 'Save & Close', 'Save', and 'Close'. A yellow callout box on the right side of the screenshot 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 [Icons]

Name	ICD-9	Managed By
<b>Chronic</b>		
History of Bilateral Pheochromocytoma	227.01	
History of depression	V11.8	
History of headache	V13.89	
• History of hypertension	V12.59	Garland, Br
History of migraine headaches	V12.49	
History of Hungry bone syndrome	275.5	Garland, Br
<b>Acute</b>		
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

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

Allergies

Medication

- Brilinta TABS

Non-Medication

- Shellfish

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 – ASSESSMENT

The screenshot shows a medical software interface for a patient note. The top bar indicates the note is for 'ALLSCRIPTS, Provider' and has a status of '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 explains that the Assessment section shows active problems and that users should check boxes for assessed diagnoses and uncheck for unassessed ones. It also notes that diagnoses can be added by clicking the 'P' on the toolbar.

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

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

# NOTE SECTIONS - PLAN

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

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

**Toolbar:** Home, Patient, Rx, Beaker, Print, Copy, Paste, Commit, Pat Loc: G59 Exam Rm, Status: Provider Ready, Updated: 3:35

**Note:** Health Management/Reminders

**Established:** ALLSCRIPTS, Provider | Status: Needs Input

**Plan:**

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

**IM Plan:**

**Health Management:**

**Plan:**

- IM Plan:
- Attending Note
- Return to Work

**Output Template:**

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

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

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

- Left Sidebar (Table of Contents):**
  - Chief Complaint (highlighted)
  - Referring Provider
  - Reason For Visit
  - Pediatrics Reason For:
  - History of Present Illness
  - History of Present Illnes
  - Language Line
  - Depressive Disorders (
  - Review of Systems
  - Active Problems
  - Past Medical History
    - No new statement - PM
  - Surgical History
    - No new statement - Sur
  - Family History
    - No new statement - FH
  - Social History
    - Pets
    - No new statement - SH
  - Current Meds
  - Allergies
  - Immunizations
  - Vitals
    - Growth Percentiles
  - Physical Exam
    - Pediatric Exam
  - Procedure
- Output Template** (Table):

Output Template	CC
<input checked="" type="checkbox"/> Acute	<input type="checkbox"/>
<input type="checkbox"/> Referral Letter	<input type="checkbox"/>

- Main Content Area:**
- Chief Complaint:** A large text area containing "There are no items to show in this view." with a "Lock" button.
- Chief Complaint Details:** A text input field.
- Referring Provider:** A text input field.
- Active Problems:** A list of chronic conditions:
  - 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)
  - Severe recurrent major depression (E33.2)
- Bottom Section:** A summary of the note with fields for "Chief Complaint:", "Referring Provider:", and "Reason For Visit".
- Bottom Bar:** Contains 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.

# VIEWING YOUR NOTE

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

Note Acute ALLSCRIPTS, Provider Status: Needs Input

**Health Management**

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

Hide Show All Hide All New Order

Chief Complaint

Reason For Visit

**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 backache

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

The screenshot shows a software window titled "Note Output" with a light blue header. Below the header, patient information is displayed: "SUPERUSER, Ernie 01-Jan-1979 (39 years) F" and "Appointment: 25-May-2018". A status bar below shows "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" with sub-sections "Chronic" (listing 9 items including Anxiety, hypertension, and depression) and "Acute" (listing "10. Chest pain (R07.9)"); and "Past Medical History" with a sub-section "Chronic" (listing "• History of Chronic pain syndrome (G89.4)"). At the bottom, a toolbar contains buttons for "Sign", "Audit", "Document Hx", "Task", "Attach to Result", "Print", "Fax", "Invalidate", and "Close". The "Close" button is highlighted with a red rectangular box.

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

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

Results/Data  
Assessment

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

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

Output Template | CC

Established  
Referral Letter  
Return to Work Letter

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

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

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

# CO-SIGN NOTE TASK

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

**Task Details**

Task Filters

1 Not about a patient  2 Concerning patient SUPERUSER,ERNIE

Assign To:  User  Team

Task: Co-Sign Note

Priority: Routine Status: Active

ALLSCRIPTS, Provider

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

# RETURN TO DAILY SCHEDULE

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

**SEARCH** SUPERUSER, CATWOMAN    PCP ALLSCRIPTS, Resident    Other    **MED & NON-MED ALLERGIES**  
 MRN 001000643516801    Security No Restricted Data    Directives Signature On File  
 FYI FYI    H Phone (423)123-4567

**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 checked="" 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. Click Search. Highlight the patient's name and click OK.

Org: ETSU

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

Patient:  Name

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 EHR interface with the 'New Note' tab selected. The patient information for Chris Allscripts is displayed. The 'Note Selector' dialog box is open, showing the following details:

- Patient: ALLSCRIPTS, Chris 10-Mar-1976 (42 years) M
- Search: Telephone Call: 04-Jun-2018
- Style:  Note,  Unstructured,  Admin Forms
- Specialty: Internal Medicine
- Visit Type: Communication Note (co-sign)
- Owner: ALLSCRIPTS, Provider
- Incomplete Notes: << Choose an incomplete Note. >>
- Chief Complaint: Add/Remove Chief Complaints
- Message: There are no items to show in this view.
- Buttons: OK, Cancel

# MACROS

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

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

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

# HOW TO CREATE A MACRO

Click the macro button.



Health Management/Reminders

Provider: [dropdown] Status: Needs Input

Save & Close Save Close

### Active Problems

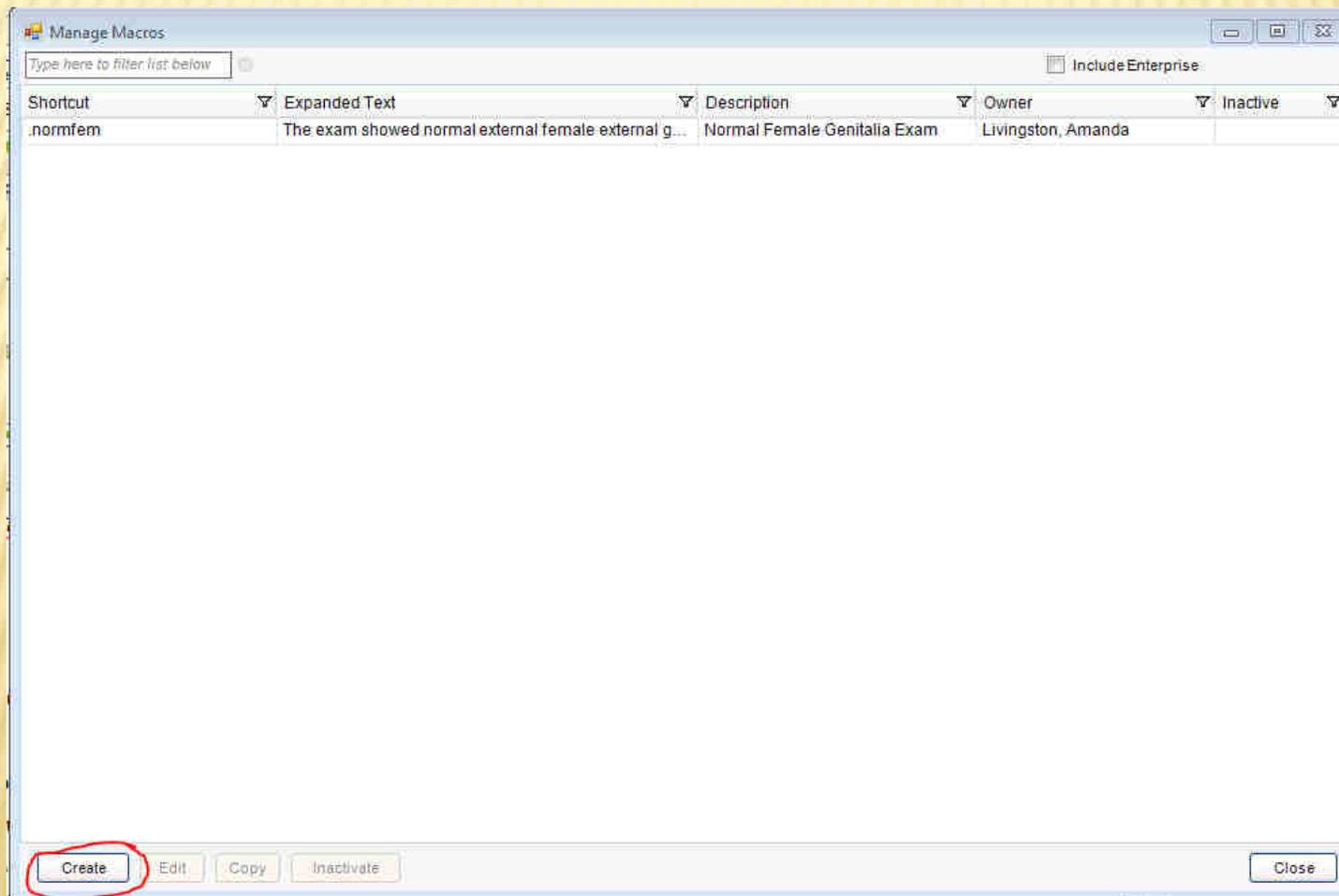
Type: [dropdown] Rec-Needed [dropdown] [dropdown] [dropdown]

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



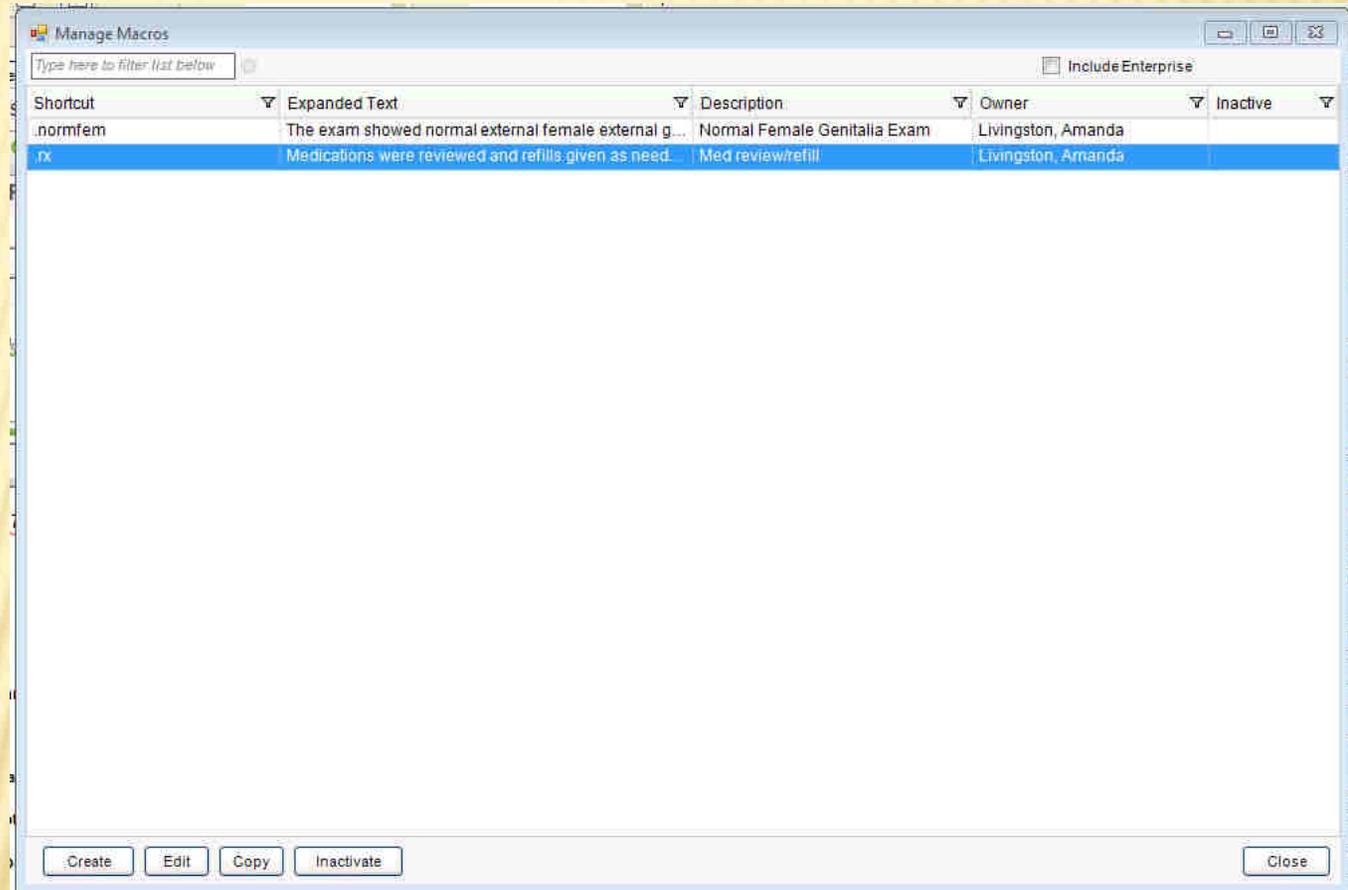
2. **Description** will explain what the macro is for.



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

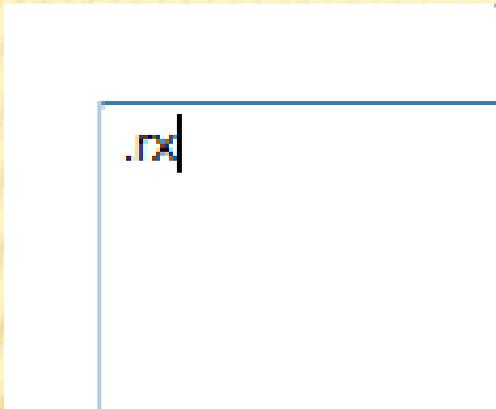
# SAVE YOUR MACRO

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. Then your enter key on your keyboard.



Medications were reviewed and refills given as needed.

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