

Notes for Residents and Providers

Starting a Note

Depending on your office's workflow, notes are typically started by either the provider or the clinical staff. Either way, the process is the same.

When you first log into Allscripts, you should default to your **Daily Schedule**.

The screenshot shows the Allscripts EHR interface. At the top, there's a navigation bar with options like 'Daily', 'Clinical Desktop', 'New Note', 'Task List', 'Appointments', 'Patient Lists', 'Provider Schedules', 'Worklist', and 'Documents'. Below this, patient information for 'Test, Dina' is displayed, including age (40 Years), sex (F), DOB (05/10/1971), and MRN (110331192113533). The 'Daily Schedule' section is active, showing a table of appointments for '01 Jul 2011'. The table has columns for 'N', 'A', 'Pt Loc', 'Pt Status', 'Time', 'Patient', 'MRN', 'Type', 'Dur', 'Tasks', and 'Comments'. The row for 'Test, Dina' at 10:30 AM is highlighted, and a red circle is drawn around a small note icon in the 'A' column. A yellow arrow on the left points to the text 'Start here.'.

\$	N	A	Pt Loc	Pt Status	Time	Patient	MRN	Type	Dur	Tasks	Comments
	Arr				08:00 AM	Test,Clamantha	110519174445780	0	15	3	
	Arr		G55A Exam Rm	Provider Ready	08:15 AM	Test,Kaelynn	110519175340223	0	15	0	peds
	Arr				08:30 AM	Test,Cleveland	110519174900623	0	15	6	
	Arr				09:00 AM	Test,Curtis	110331192539560	0	15	23	
	Arr				09:30 AM	TEST,DAISY D	050000002033902	0	15	69	
	Arr				10:00 AM	Test,Daphne	110505205116067	0	15	2	
	Arr				10:30 AM	Test,Dina	110331192113533	0	15	6	
	Arr				11:00 AM	Test,Dino	110525075702543	0	15	5	
	Arr				11:30 AM	TEST,DONALD	050000002033901	0	15	50	

Take note: To avoid *duplicate* notes, you should always enter the patient's chart through the Daily Schedule. If a note has already been started for the patient's visit, you will see the note icon  next to the Check-In status 

If a note has not been started, then the field will be blank and you can begin a new note.

To begin a new note, double click on the patient's name, and you will be taken to the **Clinical Desktop**, or the Patient's "Open Chart."

The screenshot shows the Allscripts EHR interface. The top navigation bar includes 'Daily', 'Clinical Desktop', 'New Note', 'Task List', 'Appointments', 'Patient Lists', 'Provider Schedules', 'Worklist', and 'Documents'. The 'New Note' button is circled in red. Below the navigation bar, the patient's name 'Test, Cleveland' is circled in red. The patient's details are displayed: Age: 58 Years, Sex: M, DOB: 09/09/1952, PCP: Cup, John, MRN: 110519174900623, Allergies: Yes, Pri Ins: Other: Security: No Restricted Data. The 'New Note' button is also circled in red. The interface displays various tabs like 'Meds', 'Allergies', 'Orders', and 'Appointments'. The 'Meds' tab is active, showing a list of current medications. The 'Vital Signs/Findings' tab is also visible, showing a table of vital signs for 28 Jun 2011 and 02 Jun 2011.

Item Name	Graph	28 Jun 2011	02 Jun 2011
Systolic	<input type="checkbox"/>	110	189
Diastolic	<input type="checkbox"/>	70	74
Temperature	<input type="checkbox"/>	98 F	98.5 F
Heart Rate	<input type="checkbox"/>		87
Pulse Quality	<input type="checkbox"/>		Normal

From the **Clinical Toolbar** button, click on the drop-down arrow next to the Note button and select New Note, or by clicking on the **New Note Tab** on the HTB.

The close-up screenshot shows the 'New Note' button in the Clinical Toolbar, which is circled in red. A dropdown menu is open, showing options: 'Goto Note', 'Start New Note', and 'Close Note'. The 'Start New Note' option is also circled in red. A blue callout box with a black border contains the text: 'A new note can be started by clicking on either location.' The background shows the patient's name 'Test, Cleveland' and other patient details.

The Note Selector screen should appear. From this screen, you should choose the type of note you intend to create.

The screenshot shows the 'Note Selector' window for a patient named 'Test, Cleveland 58 YO M DOB: 09Sep1952'. The window title is 'Note Selector' and the appointment is for '7/1/2011'. The 'Style' section has four radio buttons: 'Note', 'V10 Note', 'Unstructured' (which is circled in red and pointed to by a blue callout box saying 'Choose Unstructured for ACOG forms'), and 'Admin Forms'. The 'Specialty' dropdown is set to 'Internal Medicine'. The 'Visit Type' dropdown is set to 'Established' and is open, showing a list of visit types including 'Office Visits' (which is highlighted). The 'Chief Complaint' section is currently empty, with a link to 'Add/Remove Chief Complaints'. There are 'OK' and 'Cancel' buttons at the bottom right.

Note Types

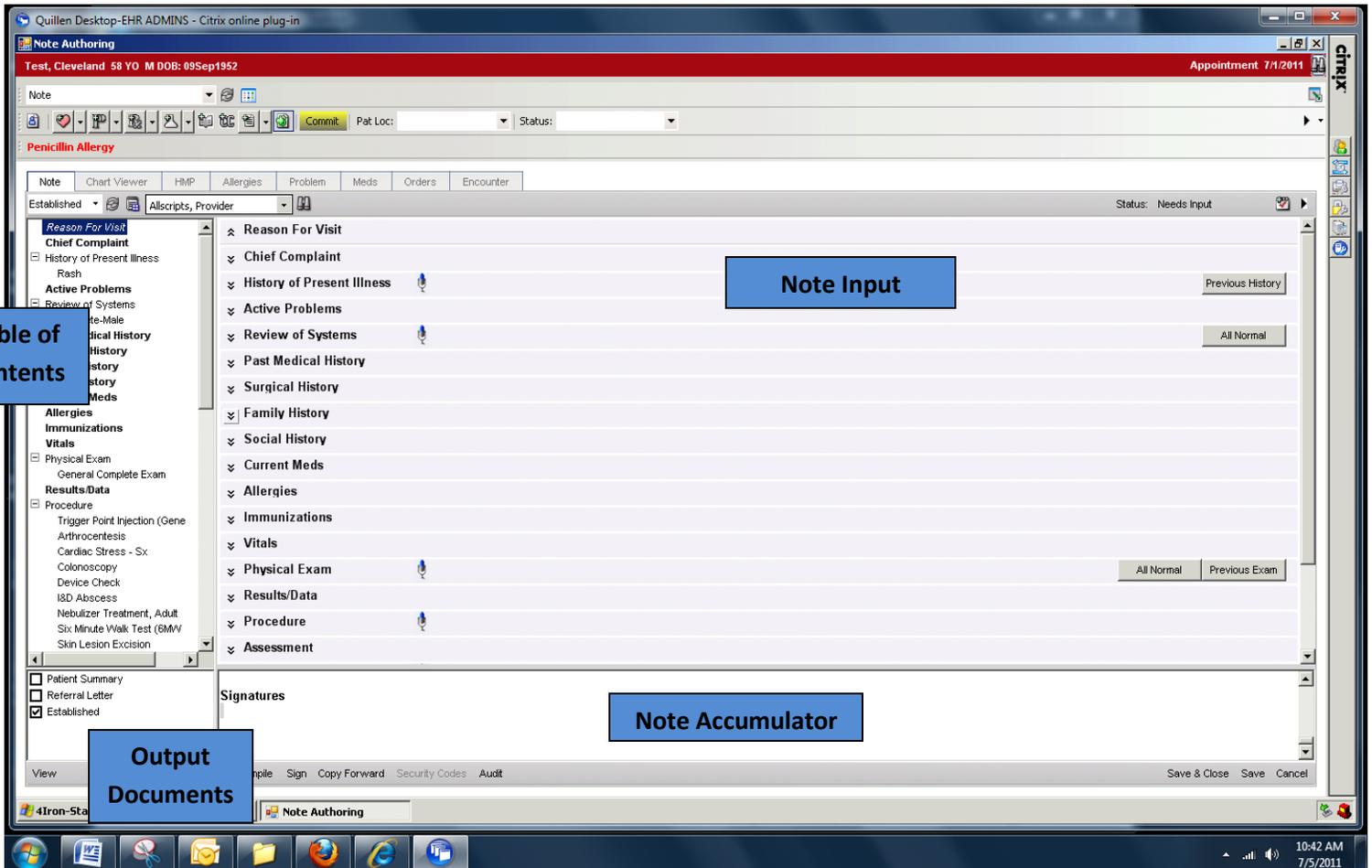
Style: By default, the structured *Note* button is selected. You may also choose *Unstructured* if you need an ACOG form.

Specialty: This menu defaults to the current user's specialty, but you can search for other active specialties if desired.

Visit Type: From the drop down menu, you should select the type of clinical visit you wish to document.

Chief Complaint: You can add or remove a chief complaint if desired. Chief complaints will automatically generate Note input (i.e. pull in auto-configured forms for the History of Present Illness and Physical Exams sections).

Once the note type has been selected from the Note Selector, the **Note Authoring Workspace (NAW)** displays, where you will document your patient encounter. [The NAW is opened in a separate window to allow users to toggle between the chart and the note.]



Entering Information

There are multiple methods for entering information into a Note, but the **recommended way is to use the *note forms and cited information***. Doing so allows for capture of discreet data for research, statistics, flowsheets, etc.

To use a **Note Form**:

After the Note Selector Screen has been completed (from the instructions above), and the NAW space is open, **review the Chief Complaint and Active Problems** to see if these are accurate. (The forms generated automatically into the note are based on the chief complaint and/or active problems.)

To **add** an active problem, from the Clinical Toolbar, click on the “Add New

Problem” button.



The ACI displays, defaulting to the History Builder tab and the “Active” sub-tab.

- In the search field, type in the active problem (skin rash, for example) and click the binoculars. Locate the problem and double click.
- The item is added and appears in a magenta color. The Problem Details box opens.
- Check the box next to “Include in PMHx” if appropriate.
- Click the calendar next to the onset date and choose accordingly (note that “approximately” can also be selected next to the date).
- In the Description box, you can free text any other details that need to be documented.
- Click on “Save and Return to ACI” if you need to add more or “Save and Close.”
- To view any added details, in the Viewer on the left, single-click the plus sign next to the problem to expand and view.

To **remove** an active problem, from the active problems list, right click on the problem and click on edit.

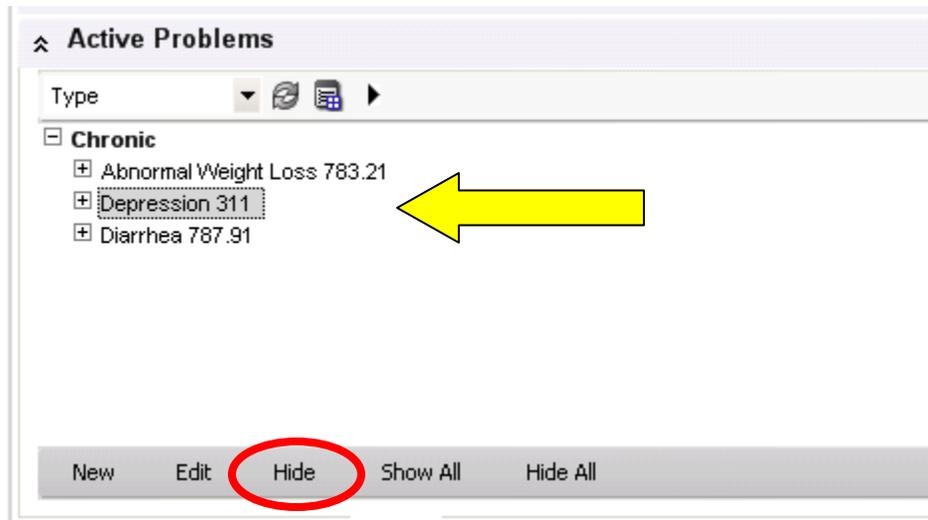
- The Problems Details box opens. In the drop down menu next to status, click on “Resolved.”
- Click on the calendar next to the resolved date and select the date the problem was resolved.

- Click on “Ok.” These will be removed from the active problems list and put into the past medical history.

To add details about a problem, from the active problems or past medical history list, right click on the problem and click on “Edit.”

- The Problems Details box opens. Click in the details box.
- Free text the details that you would you like to add.
- Click on “Ok.” These will be added to the active problem. *(Note: Free text will not appear in the note, only in the problems detail box.)*

To hide or show an active problem, click on “Active Problems” from the Table of Contents. Highlight the active problem that needs to be hidden or shown, then click on “Show” or “Hide” from the gray toolbar. You can also choose to “Show All” or “Hide All” from the gray toolbar. This workflow can also be applied to all of the Note Sections (see below for information about the other Note Sections).



NOTE SECTIONS

History of Present Illness

Next, click on the “History of Present Illness” from the Table of Contents. The active problem forms will appear in the note input section.

- Yes “Y” and No “N” buttons appear for the provider to select.
- Use the radio buttons to add details about the problem.

^ History of Present Illness 

Ankle Swelling

Y N Ankle Swelling

^ Associated Symptoms:

<input type="checkbox"/> Y <input type="checkbox"/> N Ankle Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Ankle Pain <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Ankle Redness	<input type="checkbox"/> Y <input type="checkbox"/> N Dyspnea <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Ankle Warmth	<input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Distention	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Fatigue <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Rash <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Weight Gain <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Ulcers <input type="radio"/>

Review of Symptoms

Under this section, the provider can use the forms provided for a review of symptoms. These forms are populated by gender.

- Yes “Y” and No “N” buttons appear for the provider to select.
- Use the radio buttons to add details about the problem.

^ Review of Systems 

Complete-Female

^ Constitutional Normal

<input type="checkbox"/> Y <input type="checkbox"/> N Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Feeling Poorly	<input type="checkbox"/> Y <input type="checkbox"/> N Recent Weight Gain (___ Lbs)
<input type="checkbox"/> Y <input type="checkbox"/> N Chills	<input type="checkbox"/> Y <input type="checkbox"/> N Feeling Tired	<input type="checkbox"/> Y <input type="checkbox"/> N Recent Weight Loss (___ Lbs) <input type="radio"/>

^ Eyes Normal

<input type="checkbox"/> Y <input type="checkbox"/> N Eye Pain <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Eyesight Problems <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Dry Eyes <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Red Eyes <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Discharge From Eyes <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Eyes Itch <input type="radio"/>

^ ENT Normal

<input type="checkbox"/> Y <input type="checkbox"/> N Earache <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Nosebleeds <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Loss Of Hearing <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Nasal Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N Hoarseness

^ Cardiovascular Normal

<input type="checkbox"/> Y <input type="checkbox"/> N Heart Rate Is Slow <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Leg Claudication <input type="radio"/>
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Rate Is Fast	<input type="checkbox"/> Y <input type="checkbox"/> N Palpitations <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Lower Ext Edema

^ Respiratory Normal

<input type="checkbox"/> Y <input type="checkbox"/> N Shortness Of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N Cough <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N Orthopnea
<input type="checkbox"/> Y <input type="checkbox"/> N Wheezing <input type="radio"/>	<input type="checkbox"/> Y <input type="checkbox"/> N SOB on Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N PND

Make sure to save frequently by clicking on “Save” in the lower right-hand corner of the NAW.

Medical History

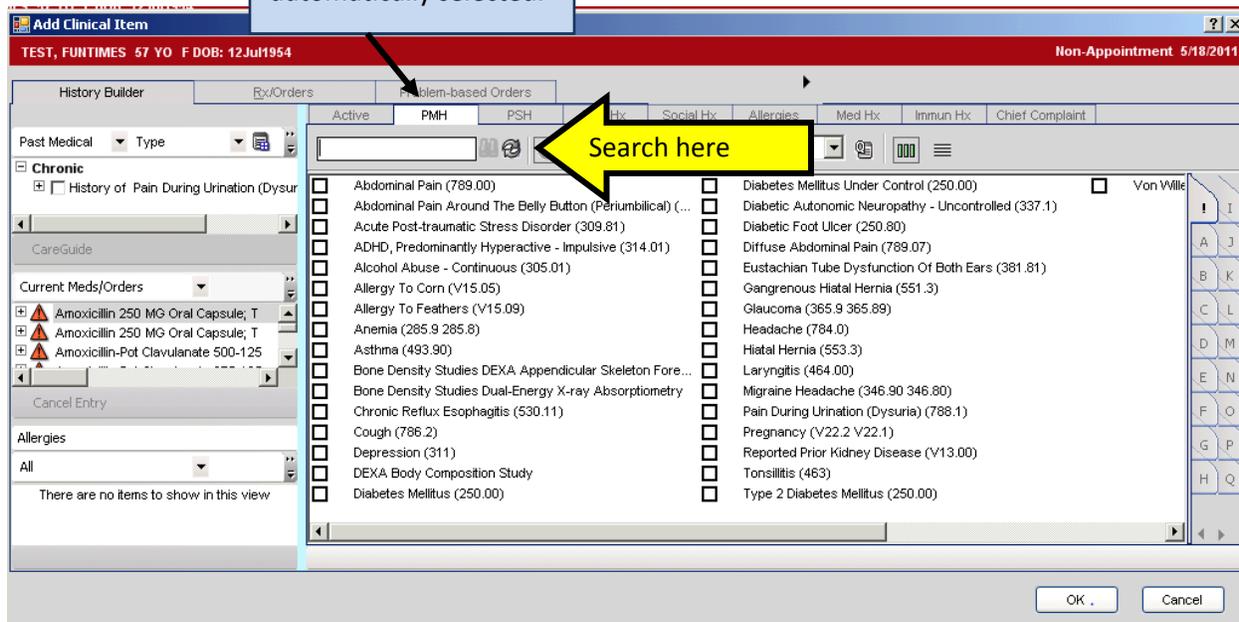
Past Medical History and **Family History** can also be added and updated if desired. Click on the appropriate heading from the Table of Contents.

Select “New” from the gray toolbar.

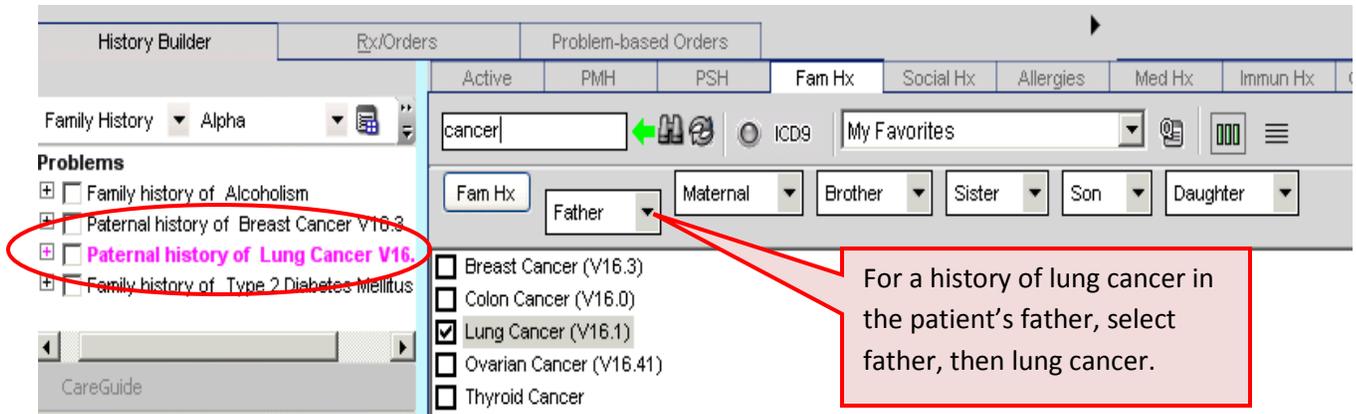


The “Add Clinical Item” window is where the provider can select the specific problem to add to the patient’s history.

Notice that the Past Medical History tab is automatically selected.

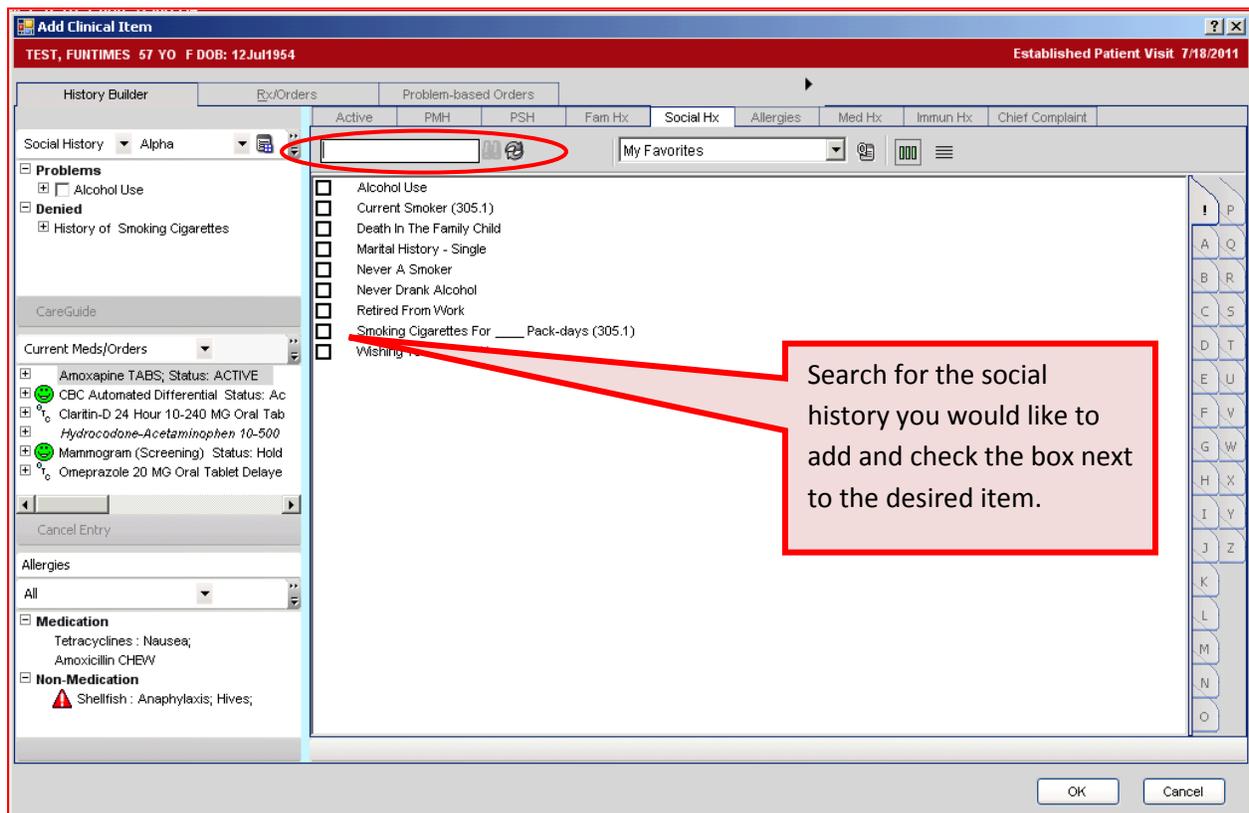


Family history can also be easily categorized by using the family relationship drop-down field. First select the family member for which the history is to be recorded, then select the problem.

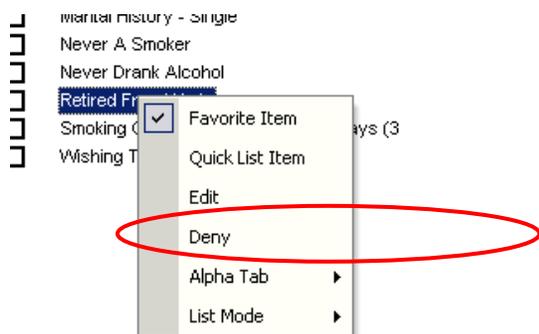


Social History

Social history can also be added to the note from the NAW by clicking on “New” from the gray toolbar and the “Add Clinical Item” box appears. (See **Medical History** above.)



Right clicking on the item allows you to “edit” it and add additional details you would like to document.



In the example below, the provider has documented details about the patients’ retirement from work.

A screenshot of the 'Problem Details' window in a medical software. The window title is 'Problem Details' and it shows patient information: 'TEST, FUNTIMES 57 YO F DOB: 12Jul1954' and 'Established Patient Visit 7/18/2011'. The 'History' section is expanded to 'Problem Details', showing the status as 'Active'. The 'Description' field contains the text: 'Retired from Party City as a balloon consultant. Pt. feels isolated since retiring.' A yellow arrow points to this text. At the bottom, the 'Save and Return to ACI' button is circled in red. Other buttons include 'Save and Close ACI' and 'Cancel'.

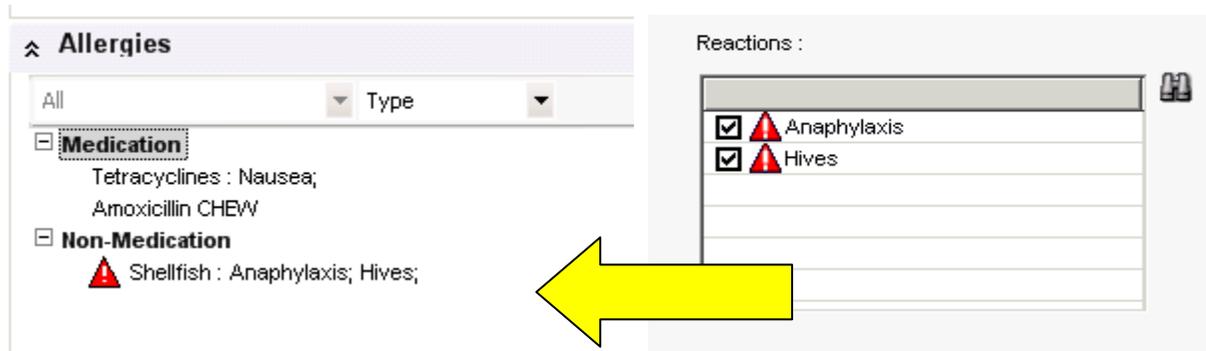
Current Medications, Allergies, Immunizations, Vitals

Similar to Medical History, Current Medications, Allergies, Immunizations, and Vitals can all be viewed and/or edited within the Note if needed.

Current medications can be ordered, updated, completed, ordered discontinued, shown, and hidden by choosing the appropriate choice from the gray toolbar.



Allergies are distinguished between *medication* allergies and *non-medication* allergies. The red triangle indicates there is information about severe reactions to an allergy.



Immunizations and **Vitals** can be viewed from the note, and the provider can opt to hide or show these in the note.

Immunizations

	1	2	3	4	5	6
Varicella						
Rabies	01 Jul 2011					
Tetanus	11 Jul 2011					

Hide Show All **Hide All** Remove Cited View

Vitals

Vital Signs

Data Includes: Current Encounter		18 Jul 2011
Item Name	4:38 PM	
Temperature	98.6 F	
Heart Rate	78	
Systolic	180	
Diastolic	20	
Height	5 ft 8 in	
Weight	170 lb	
BMI	25.85 kg/m2	

Show Show All **Hide All** Remove Cited View New

Physical Exam

The physical exam is populated by a form generated by the note type. The provider can choose to complete a brief or comprehensive exam, choose “All

Physical Exam All Normal Previous Exam

General Multi-System Exam Brief Comprehensive All Normal Previous Exam

General Multi-System Exam

^ Constitutional

General Appearance: Normal Abnormal

^ Head and Face

Examination of the Head and Face: Normal Abnormal

Palpation of the Face and Sinuses: Normal Abnormal

^ Eyes

Inspection of Conjunctiva and Lids: Normal Abnormal

Examination of Pupils and Irises: Normal Abnormal

Ophthalmoscopic Examination: Normal Abnormal

^ Ears, Nose, Mouth, and Throat

External Inspection of Ears and Nose: Normal Abnormal

Otoscopic Examination: Normal Abnormal

Assessment of Hearing: Normal Abnormal

Inspection of Nasal Mucosa, Septum, and Turbinate: Normal Abnormal

Inspection of Lips, Teeth, and Gums: Normal Abnormal

Examination of Oropharynx: Normal Abnormal

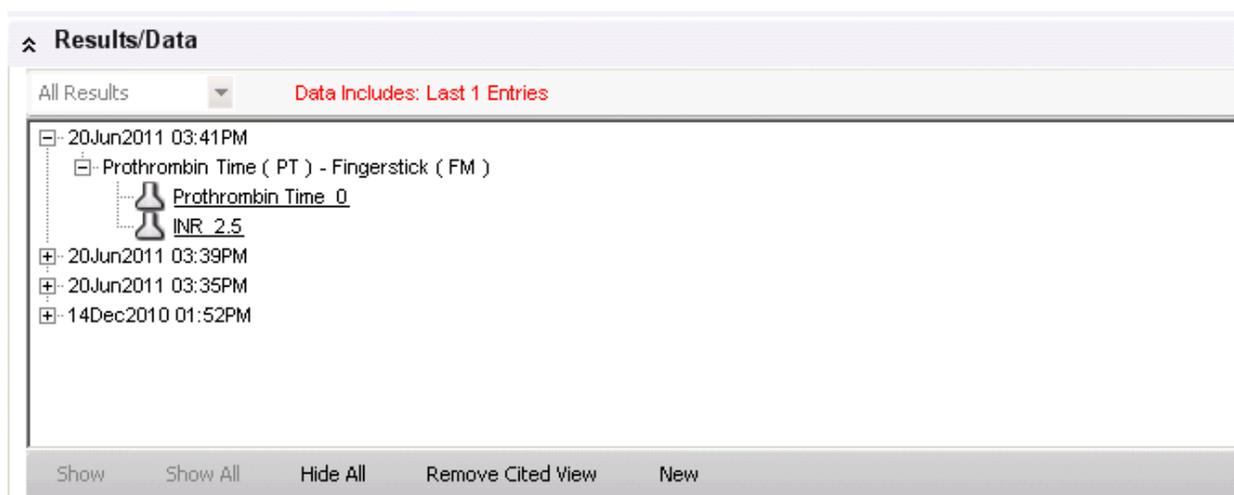
^ Neck

Normal,” or populate the form using “Previous Exam.”

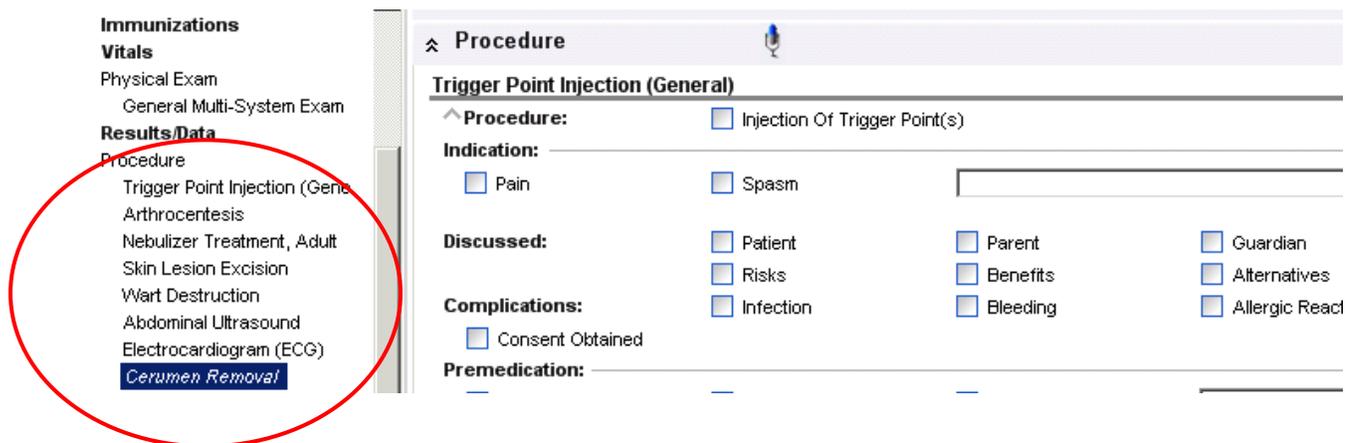
Use these shortcuts if a comprehensive exam is not needed, or the previous exam can be used.

Results/Data

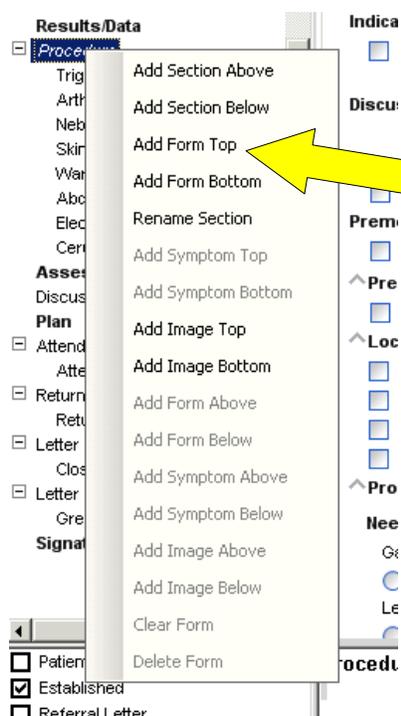
The Results/ Data section contains recent labs or tests that may have been ordered/performed on the patient. You may also order a new lab or tests from the gray toolbar. If you prefer these not to show up in your note, simply select “Hide All” from the gray toolbar.



Procedure forms are also available in the Results/Data section. These are typically populated by the note type selected.

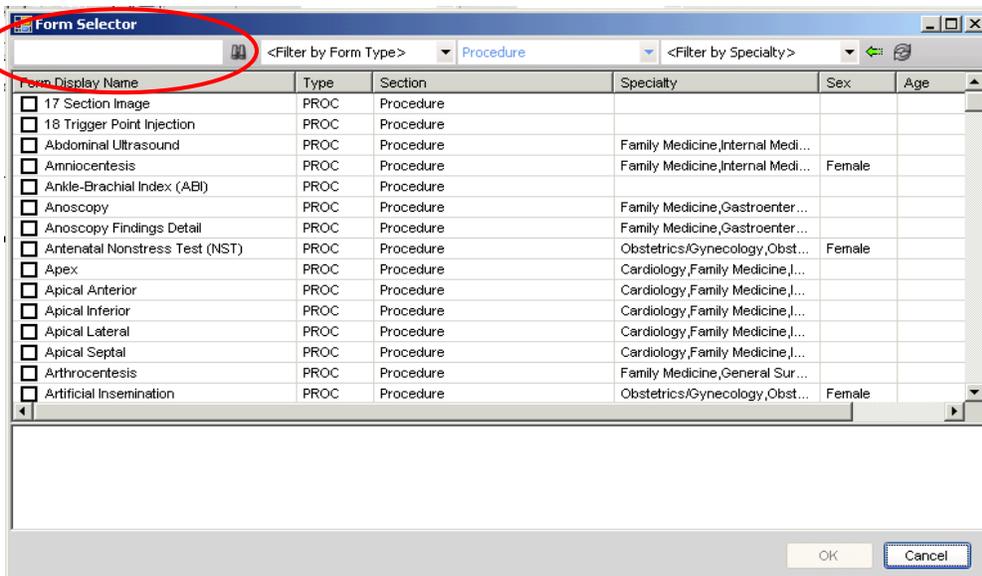


If at any point in your note you would like to **add a form** that is not automatically generated, right-click in the table of contents on the section to which you would like to add the form.



Select “Add Form Top” and a search box will appear from which you can search for a form.

Form Selector



Assessment

The Assessment section allows you to document what active problems you assessed and didn't assess. Simply check or uncheck the box next to the problem. You can also add new problems or edit problems from the gray toolbar.

Assessment

Assessed

- Assessed
 - Chest Pain 786.50
- Unassessed
 - Abdominal Pain 789.00
 - Ankle Swelling (On Exam) 719.07
 - Atrial Fibrillation 427.31
 - Esophageal Reflux 530.81
 - Health Maintenance V70.0
 - Pain During Urination (Dysuria) 788.1
 - Type 2 Diabetes Mellitus - Uncomplicated, Uncontrolled 250.02

New Edit CareGuide Show

Discussion/Summary and Plan

The **Discussion/Summary** section allows the provider to free text any information pertinent to the patient's visit that hasn't been documented or needs to be addressed outside of a form.

Note Chart Viewer HMP Allergies Problem Meds Orders Encounter

Established Garland, Bridget

Results/Data

- Procedure
 - Nebulizer Treatment, Adult
 - Skin Lesion Excision
 - Wart Destruction
 - Abdominal Ultrasound
 - Electrocardiogram (ECG)
 - Cerumen Removal
- Assessment
 - Discussion/Summary
- Plan
 - Attending Note
 - Return to Work
 - Letter Closing
 - Letter Greeting
 - Signatures

Results/Data

Procedure

Assessment

Discussion/Summary

Plan

Alpha

- Amoxicapine TABS; Status: DISCONTINUED
Recorded; Dispense: 0 Days ; #: Sufficient; Refill: 0; Record; Last Updated By: Garland,Bridget
- Claritin-D 24 Hour 10-240 MG Oral Tablet Extended Release 24 Hour; TAKE 1 TABLET DAILY
Recorded; Dispense: 0 Days ; #: Sufficient; Refill: 0; Record; Last Updated By: Garland,Bridget
- Hydrocodone-Acetaminophen 10-500 MG Oral Tablet; TAKE 1 TABLET 4 TIMES DAILY AS A
Ordered; For: Abdominal Pain (789.00); Rx By: Davis,Chris; Dispense: 2 Days ; #6; Refill: 0; T

New Edit View Order D/C Completed Today Hide Show All

Attending Note

Return to Work

Letter Closing

Letter Greeting

Signatures

Discussion/Summary

Plan

View Recompile Sign Copy Forward Security Codes Audit

You can enter free text into this field for your discussion/summary.

The **Plan** section is automatically populated by any updates on medications (a new script, a discontinue, etc.), as well as any orders for labs, images, or procedures. The section also automatically populates with any follow-ups or referrals that you order.

The screenshot shows a 'Plan' window with a search bar containing 'Alpha'. Below the search bar, there is a list of medications with their status and details:

- Amoxapine TABS; Status: DISCONTINUED
Recorded; Dispense: 0 Days ; #: Sufficient; Refill: 0; Record; Last Updated By: Garland,Bridget
- Cardiology Referral Consult Only Referral Status: Hold For - Scheduling Requested for: 20Jul2011**
Ordered; For: Chest Pain (786.50); Ordered By: Garland, Bridget Performed:
- Claritin-D 24 Hour 10-240 MG Oral Tablet Extended Release 24 Hour; TAKE 1 TABLET DAILY AS DIRECTED; Status: DISCONTINUED
Recorded; Dispense: 0 Days ; #: Sufficient; Refill: 0; Record; Last Updated By: Garland,Bridget
- Follow-up visit in 2 days Follow Up Follow-up Status: Hold For - Scheduling Requested for: 20Jul2011**
Ordered; For: Chest Pain (786.50); Ordered By: Garland, Bridget Performed: Due: 30Jul2011
- Hydrocodone-Acetaminophen 10-500 MG Oral Tablet; TAKE 1 TABLET 4 TIMES DAILY AS NEEDED FOR PAIN; Status: DISCONTINUED

At the bottom of the window, there is a toolbar with the following options: New, Edit, View, Order D/C, Completed Today, Hide, Show All, Hide All.

Finishing and Signing the Note

The last sections of the note include options for an attending note, return to work note, letter greetings and closings, and signatures. These are optional for each provider and site.

- Attending Note**
Attending Note
- Return to Work**
Return to Work
- Letter Closing**
Closing
- Letter Greeting**
Greetings
- Signatures**

If you plan to send your note out as a letter, the greeting and closing are added by clicking on the appropriate section and selecting the type of each you would like to use, for instance, a referral greeting or consult greeting.

Closing

Letter Closing

Referral
 Consult

⤴ **Letter Greeting** 

Greetings

Letter Greeting

Referral Consult

⤵ **Signatures**

Closing: Thank you very much for seeing this patient. If you have any questions, please do not hesitate to contact me.
Letter Greeting

Greetings: I am referring FUNTIMES TEST to you for further evaluation. My most recent evaluation follows:

Notice that the Greeting and Closing are populated in the Note Accumulator.

At any point while you are in the note, you can choose to view your note by clicking on “View” in the bottom left hand corner of your note.

⤴ **Letter Greeting** 

Greetings

Letter Greeting

Referral Consult

⤵ **Signatures**

Closing: Thank you very much for seeing this patient. If you
Letter Greeting

Greetings: I am referring FUNTIMES TEST to you for furthe
Signatures

Print | Mail | Sign | Copy Forward | Security Codes | Audit

Patient Summary
 Established
 Referral Letter
 Return to Work Lett...

View

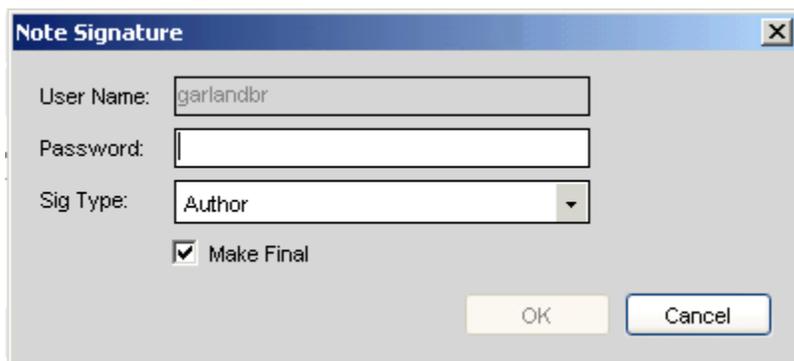
Windows Taskbar: Iron-Start | Allscripts - Windows Inte... | ...ring

Outputs also need to be selected if you would like to send the note out.

Signing Your Note

Once you have finished authoring your note and have reviewed it, you should sign it by clicking on the “Sign” option in the gray toolbar at the bottom of the screen.

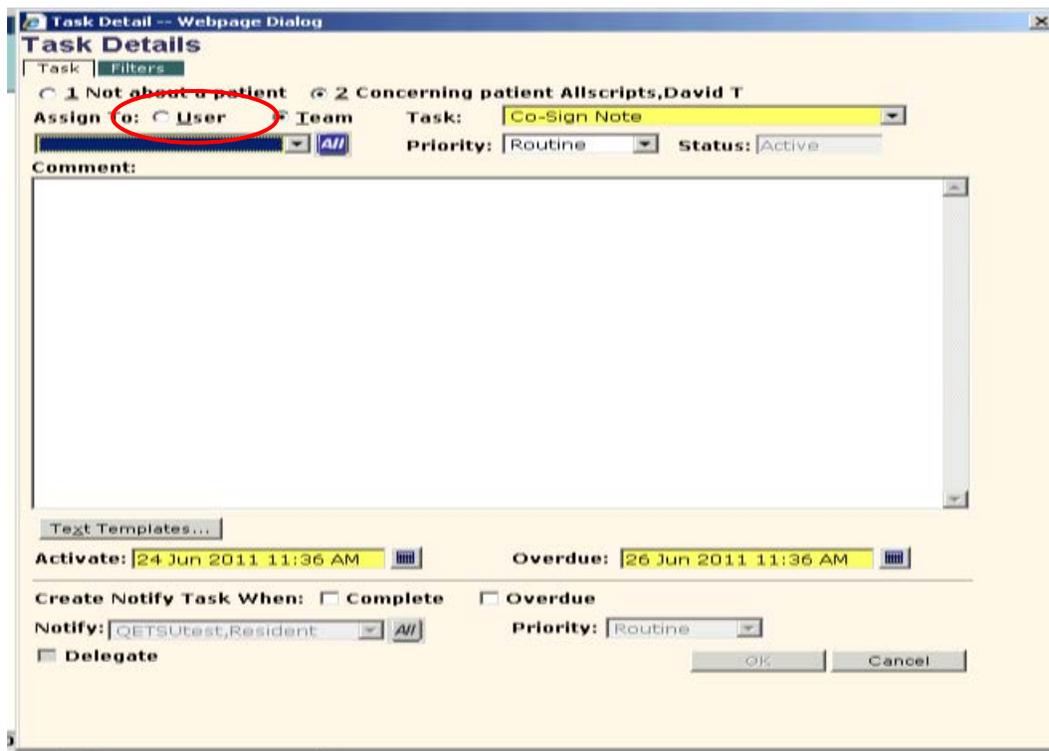
You will receive a dialogue box either prompting you for your password, or indicating that a password is not required (dependent on the amount of time you have been in the system).



The image shows a dialog box titled "Note Signature". It contains the following fields and controls:

- User Name:
- Password:
- Sig Type: (dropdown menu)
- Make Final
- OK button
- Cancel button

Residents will receive an additional box requesting that a task be sent to their preceptor to review the note and finalize it.



The image shows a "Task Detail -- Webpage Dialog" window. It contains the following information:

- Task: (dropdown menu)
- Priority: (dropdown menu)
- Status: (dropdown menu)
- Assign to: User Team
- Comment:
- Activate: (calendar icon)
- Overdue: (calendar icon)
- Create Notify Task When: Complete Overdue
- Notify: (dropdown menu)
- Priority: (dropdown menu)
- Delegate
- OK button
- Cancel button

- They should click on the “User” radio button, and pull in their preceptor’s name using the blue “All” button (they should only have to do this the first time—the preceptor’s name should automatically populate on subsequent notes).
- Once they pull the preceptor’s name in, they can just click “OK.” This will send a Co-Sign Note task to the preceptor, alerting them to the fact that the resident has signed the note and it is ready for finalization.

Please take note:

1. Residents need to put their own name in the Owner field in the Note Selector box when first creating the note. If the resident forgets to put their own name in as the owner, the preceptor will receive both the Finish Note task (if the resident saves and closes the note before signing it), and the Co-Sign Note task.
2. The Finish Note task will not automatically disappear once the preceptor finalizes the note. It will need to be removed manually.
3. Since the preceptor will only get a task once the resident has SIGNED the note. The resident will begin to get tasks on patients whose notes have not been signed, but the preceptor will only receive ONE task regarding the resident’s notes--the Co-Sign Note task.
4. Once the preceptor signs the note, and the note has been finalized, the green checkmark will appear on the note icon on the Daily Schedule. 