

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**.

Start here.

Test,Dina
 Select Patient

Age: 40 Years **DOB:** 05/10/1971 **H Phone:** (412)555-5555 **FYI:**
Sex: F **PCP:** Allscripts, Provider **MRN:** 110331192113533 **Security:** No Restricted Data
Allergies: NKA **Pri Ins:** TRI STATE BENEFIT SOLUTIONS **Other:**

Daily Schedule [Arrived, Pending and Rescheduled](#) [Personalize](#)

Provider: Allscripts,Provider **All** **AM:** 9 **PM:** 0 **Total:** 9 **Last Updated:** 07/01/2011 10:13 AM

Date: 01 Jul 2011 Sun Mon Tue Wed Thu Fri Sat

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



Patient Insurance: TRI STATE BENEFIT SOLUTIONS

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

User: qarlandbr **Site:** Oullien Physicians K Insp... **Enc Date:** 01 Jul 2011 10:30 AM **Enc Type:** Appointment

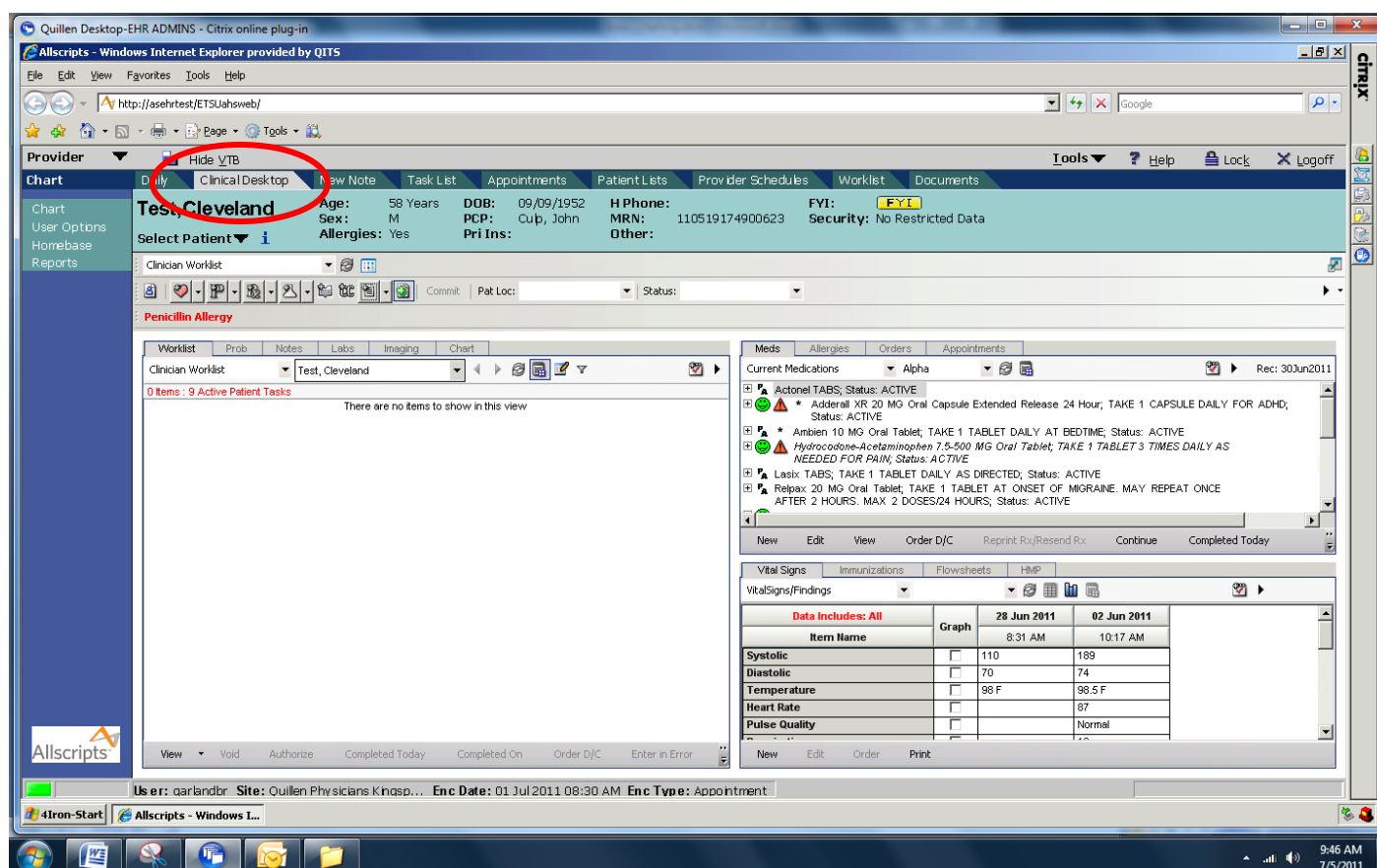
4Iron-Start Allscripts - Windows I...

10:13 AM 7/1/2011

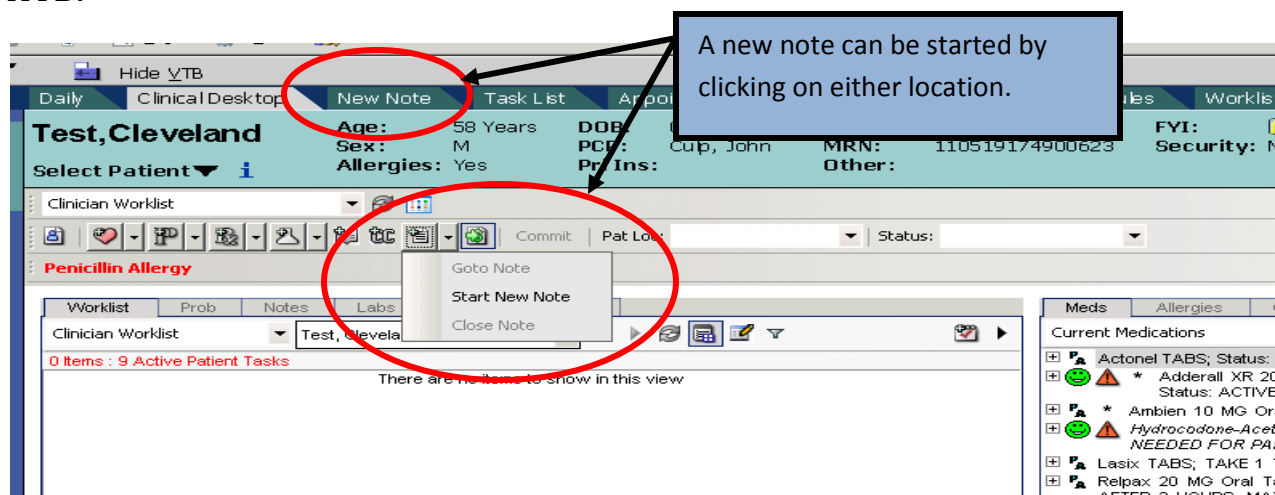
Take note: To avoid *duplicate* notes, you should always enter the patient's chart through the Daily Schedule. If a note has already been started for the patient's visit, you will see the note icon  next to the Check-In status  Arr

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."



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 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 has a red header bar with the patient's name and an 'Appointment 7/1/2011' label. Below the header, there are four radio buttons for 'Style': 'Note' (selected), 'V10 Note', 'Unstructured' (circled in red), and 'Admin Forms'. A blue callout box points to the 'Unstructured' option with the text 'Choose Unstructured for ACOG forms'. To the left of the 'Style' buttons, two yellow arrows point to the 'Style' label and the 'Unstructured' radio button. Below the 'Style' buttons, there are dropdown menus for 'Specialty' (set to 'Internal Medicine') and 'Visit Type' (set to 'Established'). A yellow arrow points to the 'Visit Type' dropdown. Below these, there is a section for 'Incomplete Notes' with a warning icon and a button to 'Add/Remove Chief Complaints'. A yellow arrow points to this section. The main area of the window is empty, with a message 'There are no items to show in t'. At the bottom right, there are 'OK' and 'Cancel' buttons. A dropdown menu is open for 'Visit Type', showing options: 'Communication', 'Consult Visits', 'Follow-Up Visits', 'Health Maintenance', 'Nursing Visits', 'Office Visits' (highlighted), 'Procedures', 'ACOG Forms', 'Geriatric Evaluation & Management', and 'PreOp Clearance'. A second dropdown menu is open for 'Office Visits', showing options: 'Acute', 'Established', 'Hospital Follow-Up', and 'New Patient'.

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.]

The screenshot displays the 'Note Authoring' window for a patient named 'Test, Cleveland 58 YO M DOB: 09Sep1952' with an appointment on 7/1/2011. The interface includes a 'Table of Contents' on the left sidebar, a main 'Note Input' area, and a 'Note Accumulator' at the bottom. The 'Table of Contents' lists various medical history sections, including 'Reason For Visit', 'Chief Complaint', 'History of Present Illness', 'Active Problems', 'Review of Systems', 'Past Medical History', 'Surgical History', 'Family History', 'Social History', 'Current Meds', 'Allergies', 'Immunizations', 'Vitals', 'Physical Exam', 'Results/Data', 'Procedure', 'Assessment', 'Patient Summary', 'Referral Letter', and 'Established'. The 'Note Input' area is a large text field for entering patient information. The 'Note Accumulator' is a section for accumulating notes. The 'Signatures' section is at the bottom of the main area. The bottom of the window shows a taskbar with various application icons and a system clock indicating 10:42 AM on 7/5/2011.

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.

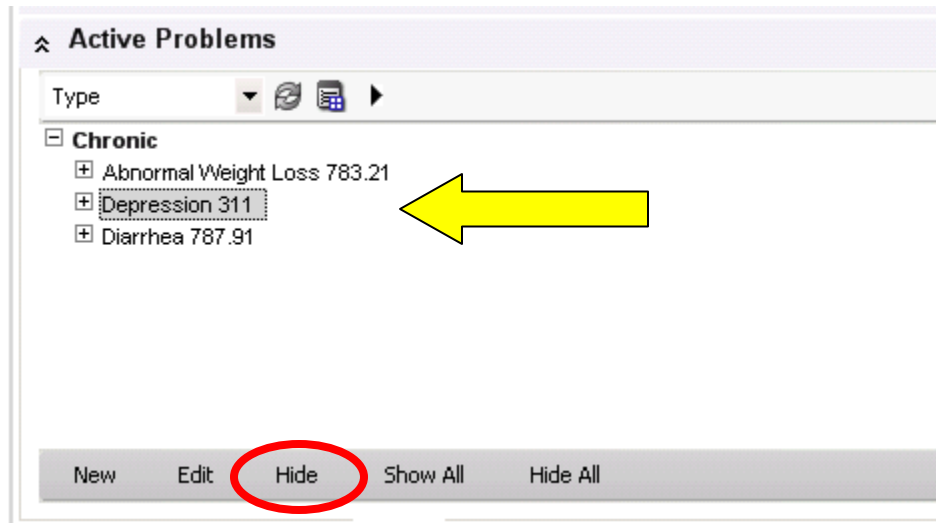
- The Problems Details box opens. In the drop down menu next to status, click on “Resolved.”
- Click on the calendar next to the resolved date and select the date the problem was resolved.

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

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

Eyes ☐ Normal

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

ENT ☐ Normal

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

Cardiovascular ☐ Normal

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

Respiratory ☐ Normal

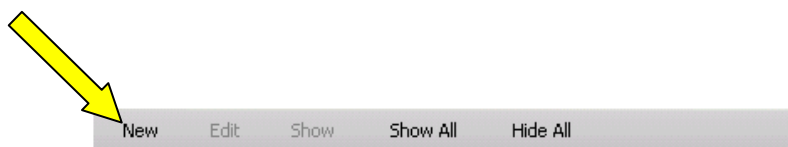
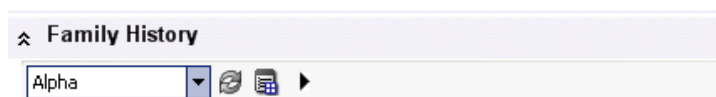
<input checked="" type="radio"/> Y <input type="radio"/> N Shortness Of Breath	<input checked="" type="radio"/> Y <input type="radio"/> N Cough	<input checked="" type="radio"/> Y <input type="radio"/> N Orthopnea
<input checked="" type="radio"/> Y <input type="radio"/> N Wheezing	<input checked="" type="radio"/>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

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

Medical History

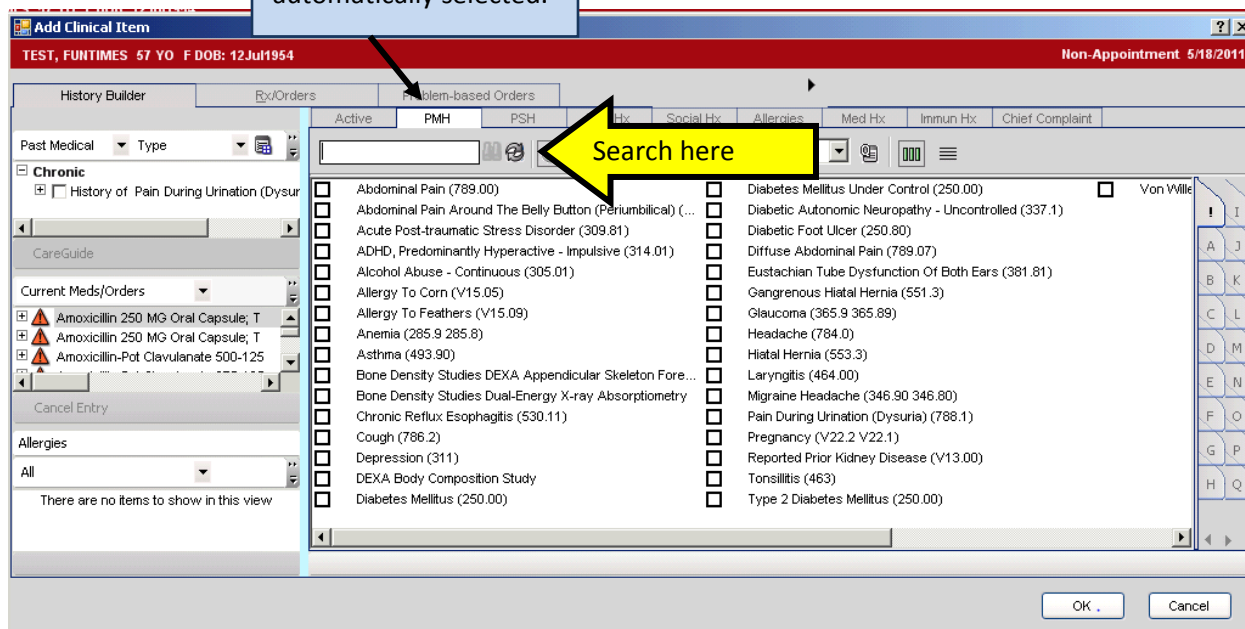
Past Medical History and **Family History** can also be added and updated if desired. Click on the appropriate heading from the Table of Contents.

Select “New” from the gray toolbar.

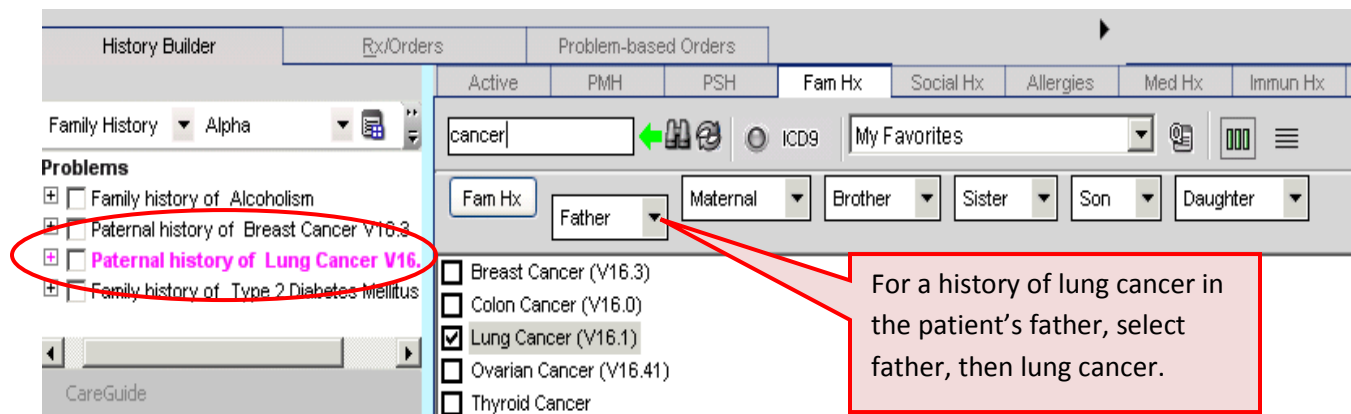


The “Add Clinical Item” window shows where the provider can select the specific problem.

Notice that the Past Medical History tab is automatically selected.

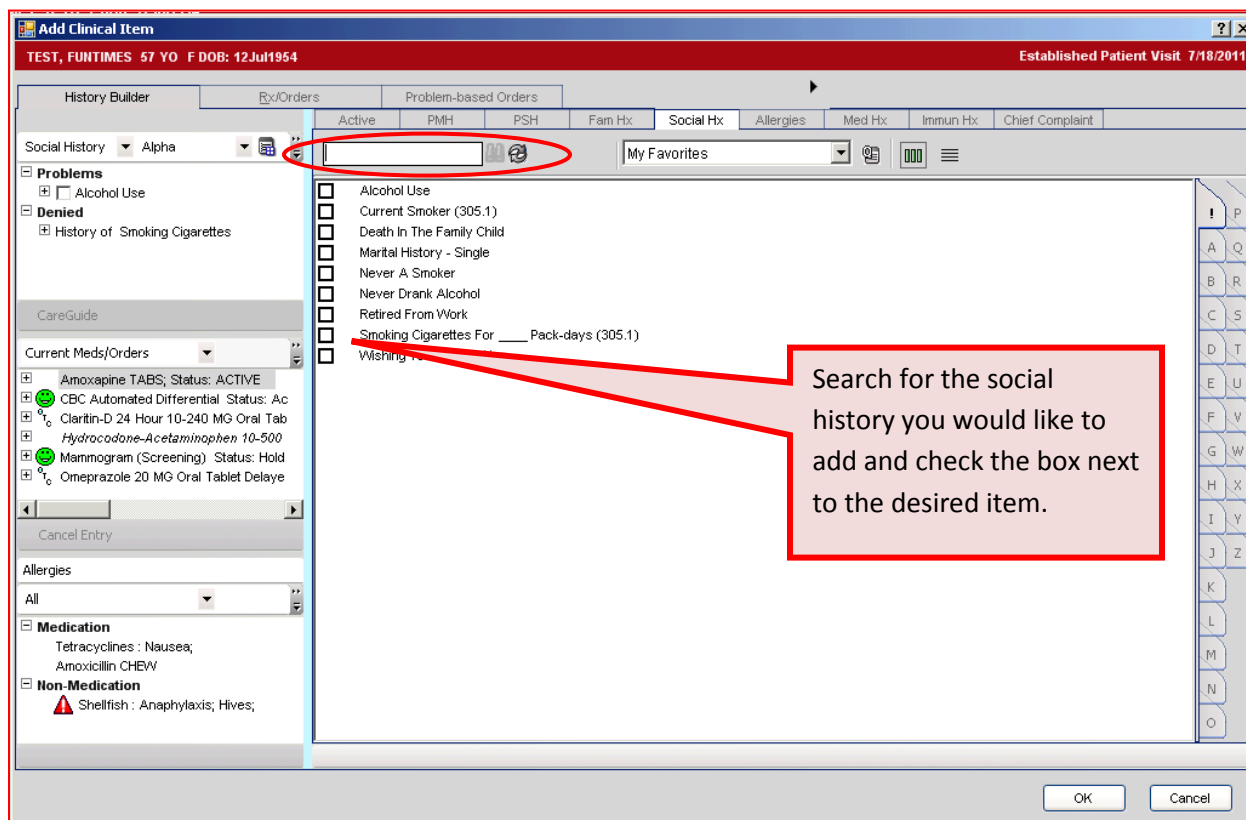


Family history can also be easily categorized by using the family relationship drop-down field. First select the family member for which the history is to be recorded, then select the problem.

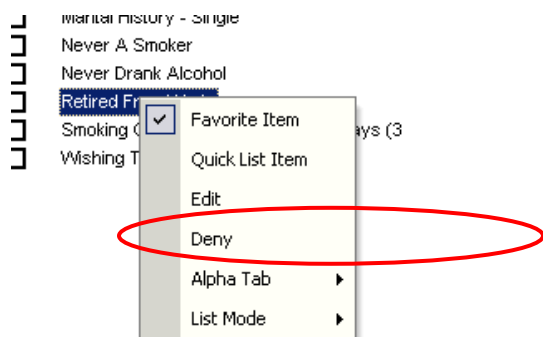


Social History

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.

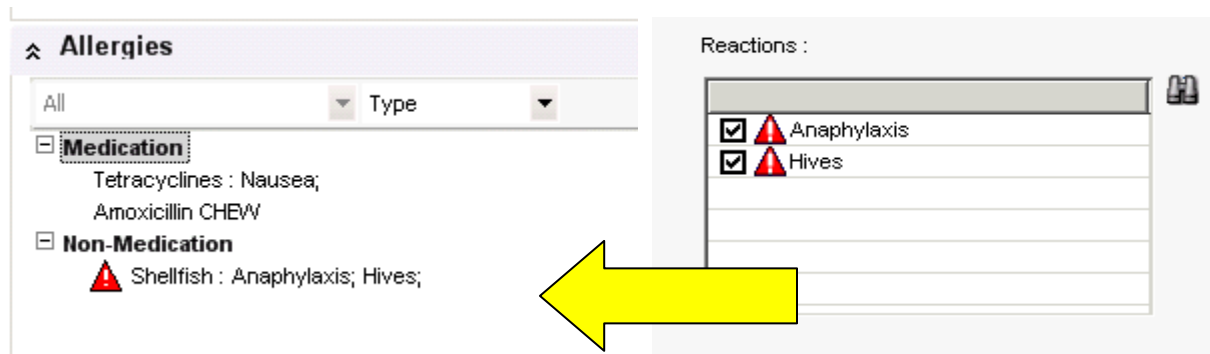
Current Medications, Allergies, Immunizations, Vitals

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		<input type="radio"/> Brief <input checked="" type="radio"/> Comprehensive	
General Multi-System Exam			
^ Constitutional			
General Appearance:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
^ Head and Face			
Examination of the Head and Face:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Palpation of the Face and Sinuses:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
^ Eyes			
Inspection of Conjunctiva and Lids:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Examination of Pupils and Irises:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Ophthalmoscopic Examination:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
^ Ears, Nose, Mouth, and Throat			
External Inspection of Ears and Nose:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Otoscopic Examination:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Assessment of Hearing:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Inspection of Nasal Mucosa, Septum, and Turbinates:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Inspection of Lips, Teeth, and Gums:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
Examination of Oropharynx:	<input type="radio"/> Normal <input type="radio"/> Abnormal <input style="width: 150px;" type="text"/>		
^ 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.

The screenshot shows the 'Results/Data' section of a medical software interface. At the top, there is a header 'Results/Data' with a small icon. Below it, a dropdown menu is set to 'All Results' and a red status bar indicates 'Data Includes: Last 1 Entries'. The main area displays a list of results:

- 20Jun2011 03:41PM
 - Prothrombin Time (PT) - Fingerstick (FM)
 - Prothrombin Time 0
 - INR 2.5
- 20Jun2011 03:39PM
- 20Jun2011 03:35PM
- 14Dec2010 01:52PM

 At the bottom, a gray toolbar contains buttons: 'Show', 'Show All', 'Hide All', 'Remove Cited View', and 'New'.

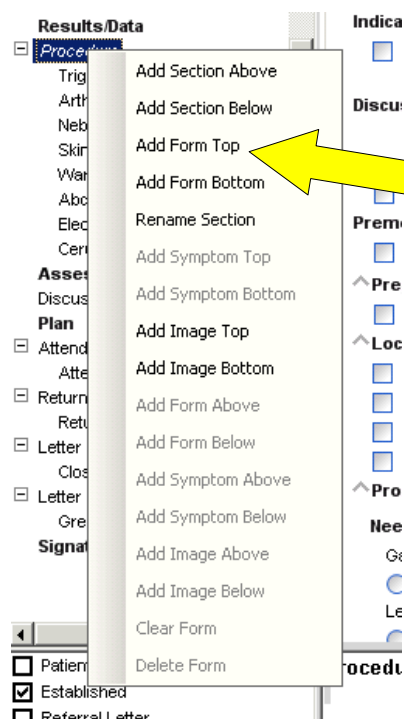
Procedure forms are also available in the Results/Data section. These are typically populated by the note type selected.

The screenshot shows the 'Procedure' form in a medical software interface. On the left, a sidebar lists various sections: 'Immunizations', 'Vitals', 'Physical Exam', 'General Multi-System Exam', 'Results/Data', 'Procedure', 'Trigger Point Injection (General)', 'Arthrocentesis', 'Nebulizer Treatment, Adult', 'Skin Lesion Excision', 'Wart Destruction', 'Abdominal Ultrasound', 'Electrocardiogram (ECG)', and 'Cerumen Removal'. The 'Results/Data' section is circled in red. The main area displays the 'Procedure' form for 'Trigger Point Injection (General)'. The form includes sections for:

- Procedure:** A checkbox for 'Injection Of Trigger Point(s)'.
- Indication:** Checkboxes for 'Pain' and 'Spasm'.
- Discussed:** Checkboxes for 'Patient', 'Parent', 'Guardian', 'Risks', 'Benefits', and 'Alternatives'.
- Complications:** Checkboxes for 'Infection', 'Bleeding', and 'Allergic React'.
- Premedication:** A checkbox for 'Consent Obtained'.

 The 'Cerumen Removal' option in the sidebar is highlighted with a blue background.

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

The 'Form Selector' dialog box displays a table of forms. The 'Form Display Name' column is circled in red. The table lists various medical procedures and their associated specialties and patient demographics.





Form Display Name	Type	Section	Specialty	Sex	Age
<input type="checkbox"/> 17 Section Image	PROC	Procedure			
<input type="checkbox"/> 18 Trigger Point Injection	PROC	Procedure			
<input type="checkbox"/> Abdominal Ultrasound	PROC	Procedure	Family Medicine,Internal Medi...		
<input type="checkbox"/> Amniocentesis	PROC	Procedure	Family Medicine,Internal Medi...	Female	
<input type="checkbox"/> Ankle-Brachial Index (ABI)	PROC	Procedure			
<input type="checkbox"/> Anoscopy	PROC	Procedure	Family Medicine,Gastroenter...		
<input type="checkbox"/> Anoscopy Findings Detail	PROC	Procedure	Family Medicine,Gastroenter...		
<input type="checkbox"/> Antenatal Nonstress Test (NST)	PROC	Procedure	Obstetrics/Gynecology,Obst...	Female	
<input type="checkbox"/> Apex	PROC	Procedure	Cardiology,Family Medicine,J...		
<input type="checkbox"/> Apical Anterior	PROC	Procedure	Cardiology,Family Medicine,J...		
<input type="checkbox"/> Apical Inferior	PROC	Procedure	Cardiology,Family Medicine,J...		
<input type="checkbox"/> Apical Lateral	PROC	Procedure	Cardiology,Family Medicine,J...		
<input type="checkbox"/> Apical Septal	PROC	Procedure	Cardiology,Family Medicine,J...		
<input type="checkbox"/> Arthrocentesis	PROC	Procedure	Family Medicine,General Sur...		
<input type="checkbox"/> Artificial Insemination	PROC	Procedure	Obstetrics/Gynecology,Obst...	Female	

OK Cancel

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**
- ☒ **Plan**
- ☐ Discussion/Summary
- ☐ Attending Note
- ☐ Return to Work
- ☐ Letter Closing
- ☐ Letter Greeting
- ☐ Signatures



Results/Data

Procedure

Assessment

Discussion/Summary

Plan

Alpha  

☐ Amoxapine 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 NEEDED
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

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.

Plan

Alpha

- ☐ 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

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

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

View

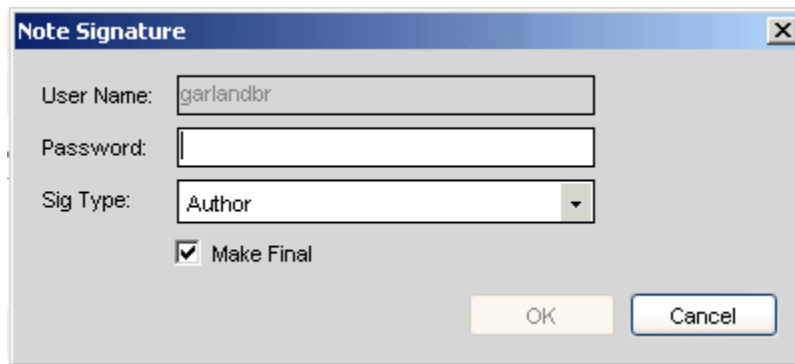
4iron-Start Allscripts - Windows Inte... N... ring

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.

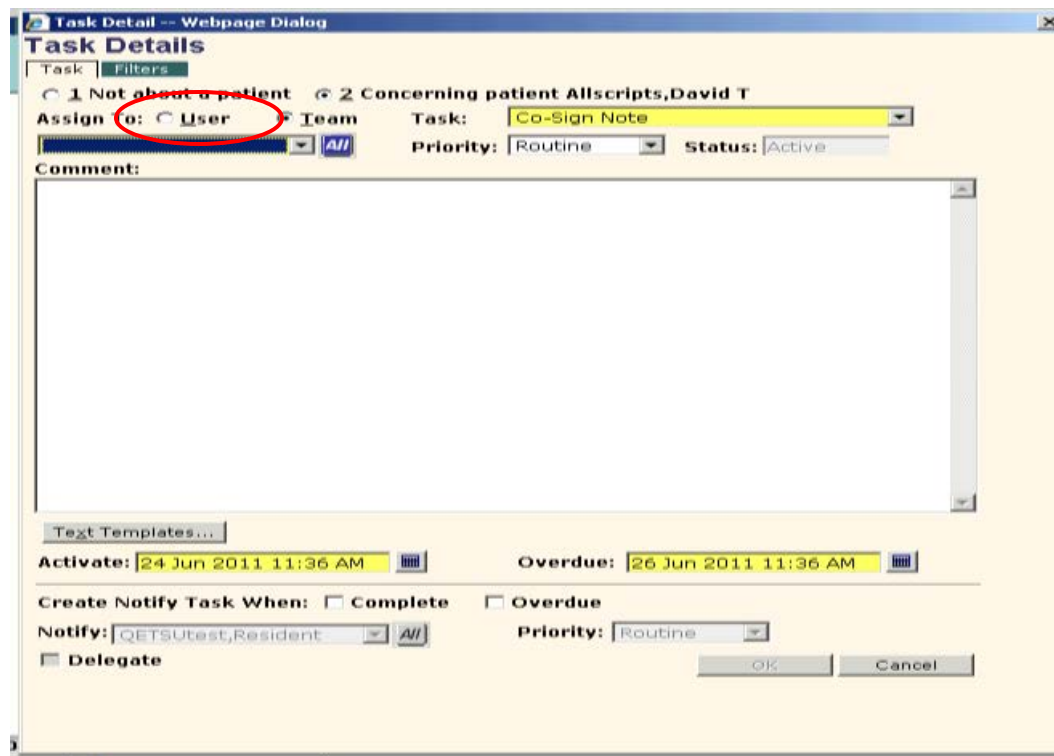
You will receive a dialogue box either prompting you for your password, or indicating that a password is not required (dependent on the amount of time you have been in the system).



The "Note Signature" dialog box contains the following fields and controls:

- User Name:** A text field containing the value "garlandbr".
- Password:** An empty text field.
- Sig Type:** A dropdown menu currently set to "Author".
- Make Final:** A checked checkbox.
- Buttons:** "OK" and "Cancel" buttons at the bottom right.

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



The "Task Detail -- Webpage Dialog" window displays the following information:

- Task Details:**
 - Task:** "Filters" (selected)
 - Assign to:** "User" (circled in red), with "Team" as an alternative option.
 - Task:** "Co-Sign Note" (dropdown menu)
 - Priority:** "Routine" (dropdown menu)
 - Status:** "Active" (dropdown menu)
- Comment:** A large text area for adding comments.
- Text Templates...** button.
- Activate:** "24 Jun 2011 11:36 AM" (calendar icon)
- Overdue:** "26 Jun 2011 11:36 AM" (calendar icon)
- Create Notify Task When:**
 - ☐ Complete
 - ☐ Overdue
- Notify:** "QETSUtest,Resident" (dropdown menu)
- Priority:** "Routine" (dropdown menu)
- Delegate:** A checked checkbox.
- Buttons:** "OK" and "Cancel" buttons at the bottom right.

- 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. 