

This guide will help you complete a chart for most clinical visits (excluding SSI).

Note: The following procedures should be considered **required to complete a patient's chart**. Providers are encouraged to add additional information as needed in the chart.

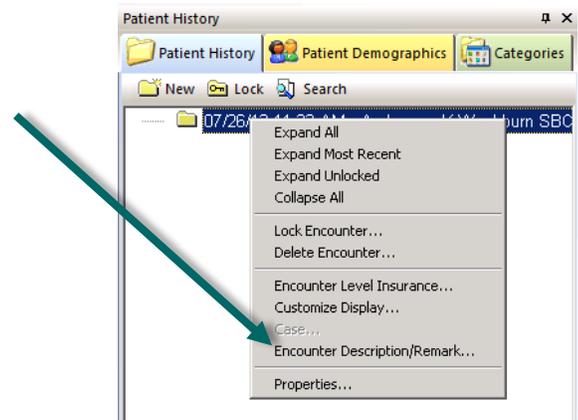
I. Opening the Encounter

A. Perform the 6-Point Check See EHR How-to Guide 2

Note: Only chart on encounters that have already been created from a visit check-in. Do not create an encounter in the EHR for a visit.

B. Create Remark

1. Right-click on the encounter and select *Encounter Description/Remark*



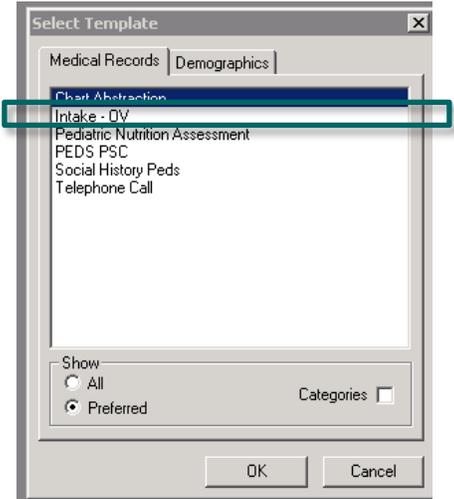
2. Depending on the type of visit, enter one of the following codes:

Type of Visit	Code
Acute – Established	ATE
Acute – New	ATN
Family Planning – Established	FPE
Family Planning – New	FPN
Explanation of Services	EOS
Health Ed	HED
Immunization Only	IMZ
Lab Only	LOV
Physical Exam	PEX
Sports Physical	SPE
Vitals Only	VIT

C. Open Intake – OV Template

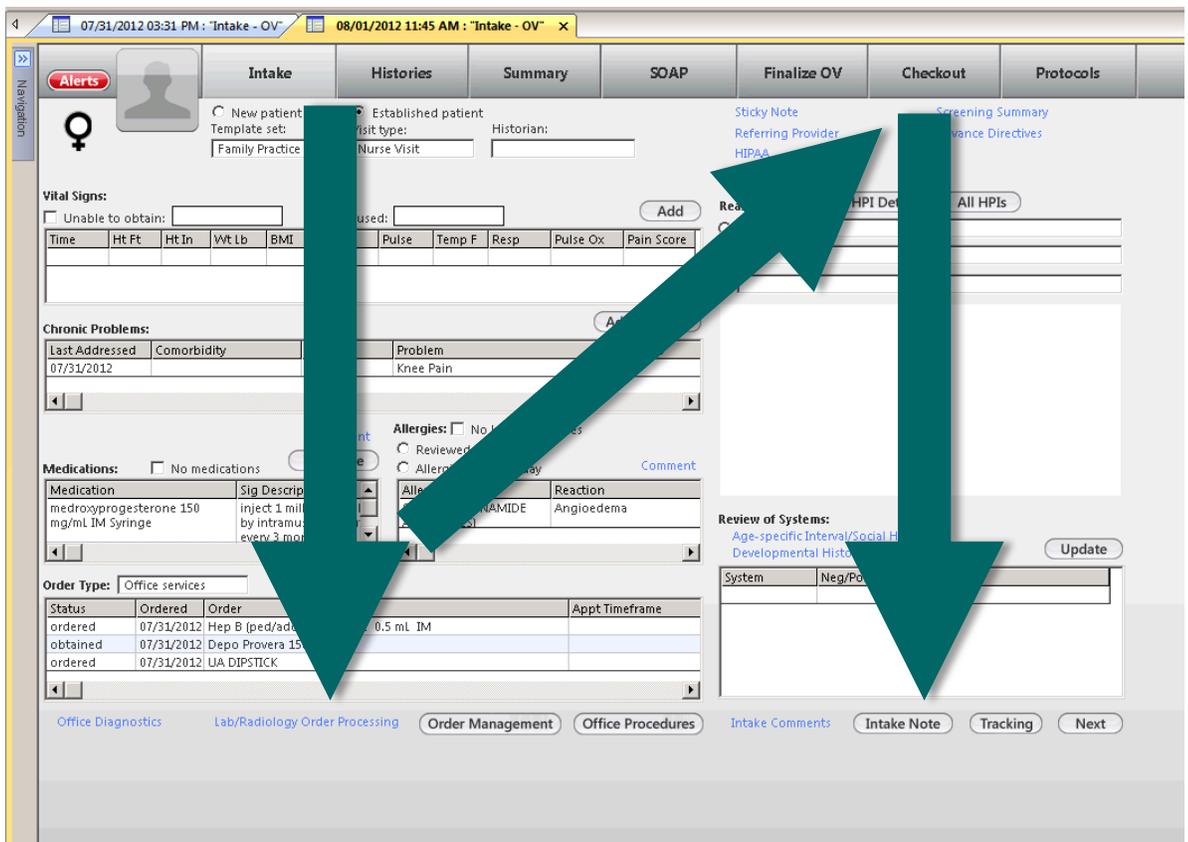
1. Click on the *Template*  button either at the bottom of the *Patient History* window or on the EHR toolbar.

- Choose *Intake - OV* from the *Select Template* window



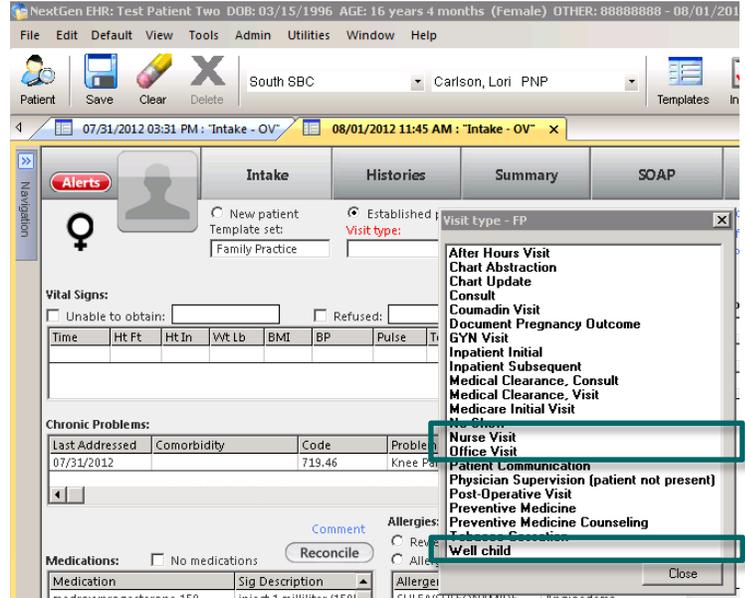
II. Intake Screen

In any template, you always work in columns – left column top to bottom, then right column top to bottom.

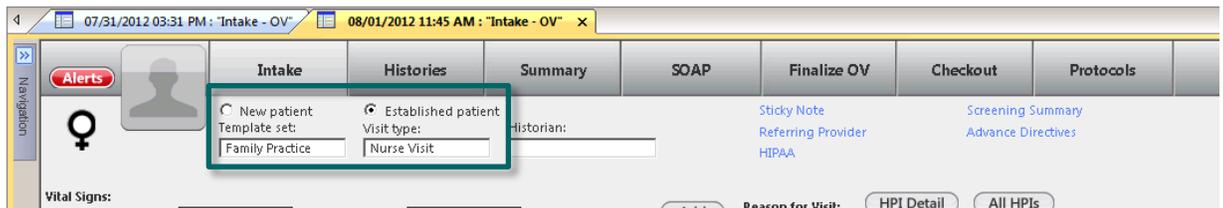


A. Select the Visit Type

You will usually select *Nurse Visit*, *Office Visit* or *Well Child* (physical exams)



B. Select *New patient* or *Established patient* (this may already be selected for you)

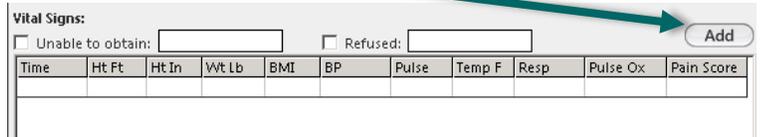


C. Ensure *Family Practice* is selected as the Template Set

D. If a health alert has been established for this patient, the *Alerts* button will be red. Click on it to view or add alerts.

E. Vital Signs

1. Click Add or double-click in the white grid.



Hint: You can add multiple vital screenings per encounter by clicking on the *Add* button.

2. Enter the following by either using the keypad or typing them in and using the *Tab* key.

- Height
- Weight
- Temp
- BP
- Heart Rate
- Position
- Side
- Method
- Cuff Size

The screenshot shows the 'Pediatric Vital Signs over 2 Years' form. It includes fields for patient information (Name: Brian T. May, Date: 08/01/2012), vitals (Height: 5 ft 8 in, Weight: 145 lb, Temp: 98.5 F, BP: 140/60), and physical exam options (Position: sitting, Side: right, Method: automatic). A keypad is on the right. A blue box highlights 'Audiometry Exam', 'Growth Charts', and 'Vision Screening'. A red box highlights the 'Calculate' button. A green box highlights the 'Reconcile' button in the Medications section.

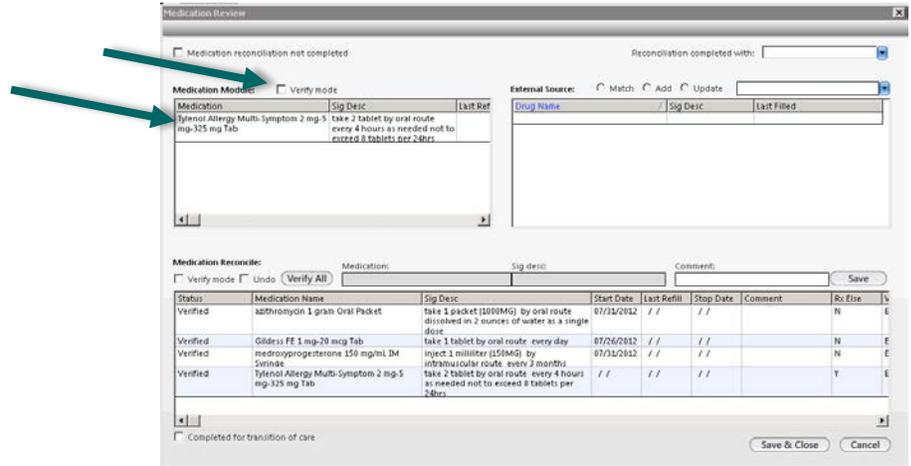
- Ensure the BMI has been calculated
- If performing a physical exam, you can record the hearing and vision screenings here.
- Click on Save and then Close

F. Medication Reconciliation & Verification

- If the patient is not using any medications, check the *No Medications* box
- If you need to add medications the patient is **currently** using, go to the Med Module. *See How-to Guide 4.*
- If medications are already listed, click on the *Reconcile* button.

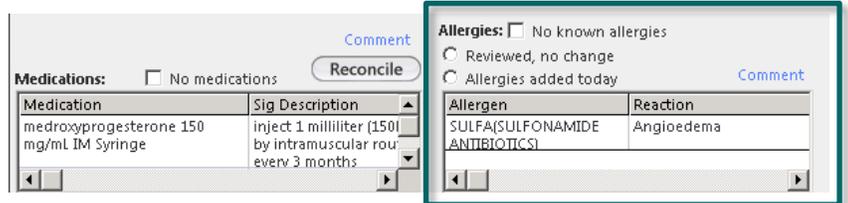
The screenshot shows the Medication Reconciliation section. It includes a 'Medications' table with columns for Medication, Sig, and Description. A table of 'Allergies' is also visible. A red arrow points to the 'No medications' checkbox, a green arrow points to the 'Reconcile' button, and a blue arrow points to the 'Comment' button.

- Click on *Verify Mode* in the *Medication Module* section.
- Click on the Med you have verified. It will drop into the *Medication Reconcile* section.
- Click on the *Save & Close* button.



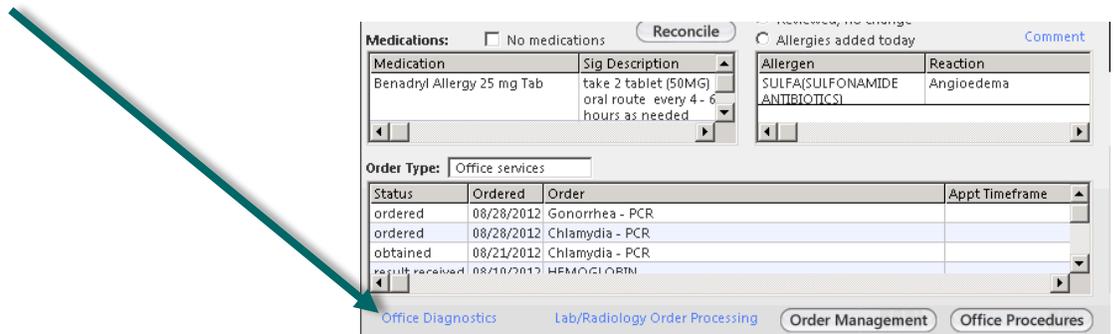
G. Allergy Verification

- If the patient has no known allergies, check the *No known allergies* box
- If there are allergies listed, either check *Reviewed, no change* or *Allergies added today*.
- If you are adding allergies, double-click in the white grid and perform an allergy search.



H. Office Diagnostics

If you know upon intake that the patient will need labs or office procedures performed, click on the link.



- The SBC common procedures are listed first. Make sure to select the correct *Office Diagnostic* with the correct *Diagnosis Description* by double-clicking on the pair.

Office Diagnostic Description	Proc. Code	Diagnosis Description	DX Code	Normal Range
Chlamydia - PCR	87491	Screening examination for venereal disease	V74.5	
Gonorrhea - PCR	87591	Screening examination for venereal disease	V74.5	
HEMOGLOBIN	85018	Routine infant or child health check	V20.2	
HEMOGLOBIN	85018	Other general medical examination for administrative purposes	V70.3	
HEMOGLOBIN	85018	Other general medical examination for administrative purposes	V70.3	
HEMOGLOBIN	85018	Routine infant or child health check	V20.2	
HIV 1 And 2 Screen	86703	Screening examination for venereal disease	V74.5	
OSOM BV Blue	87905	Screening examination for venereal disease	V74.5	
Pregnancy Test - Urine Qualitative	84703	HEMATURIA NOS	599.70	

- The order you selected will now appear in the *Select/Update Diagnosis* section.
 - If you are performing the procedure on the spot, you can add the result by clicking on the *Interpretation* field.

- Click on the *Place Order* button. Your order and its status will appear in the *Today's Orders* field.
- If you need to task someone to complete a procedure, select the order in *Today's Orders* and click on the *Task* button.

Status	Office Diagnostic Description	Interpretation	Result
ordered	Chlamydia - PCR		
completed	Chlamydia - PCR	normal	

- Click on *Close* to return to *Intake - OV*.

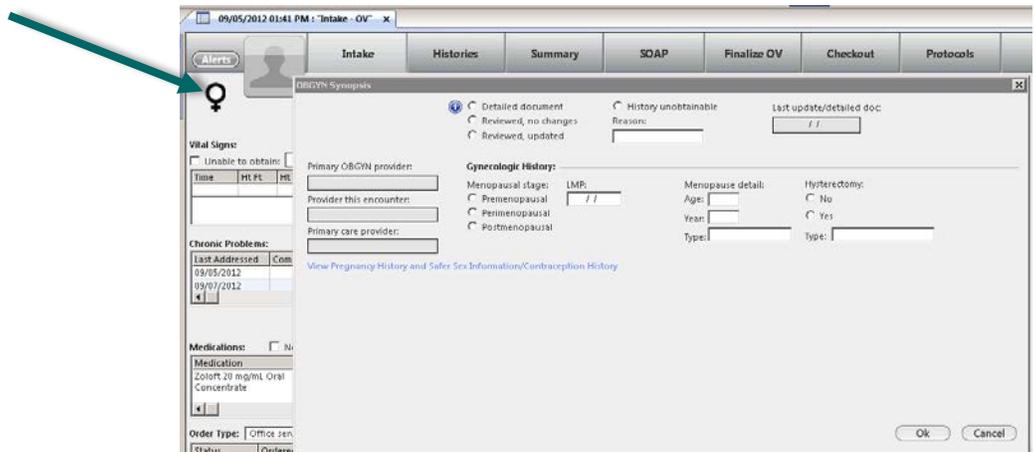
I. Reason for Visit

- Click on a blank *Reason for Visit* field and select at least one reason for visit from the pick list.
- Add any necessary comments for each reason.

Note: You can free-text in the fields provided, but it is strongly recommended to select one from the pick list.

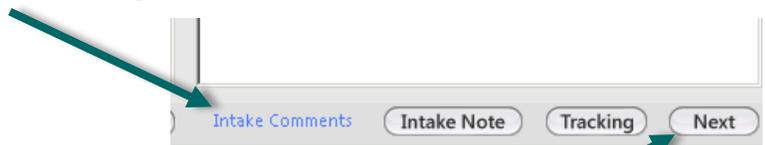
J. OBGYN Synopsys

If applicable, you can click on the symbol below to get the *OBGYN Synopsys* screen for females.



K. Intake Comments

Click this link to add any notes for the Rendering Provider to view before the exam.



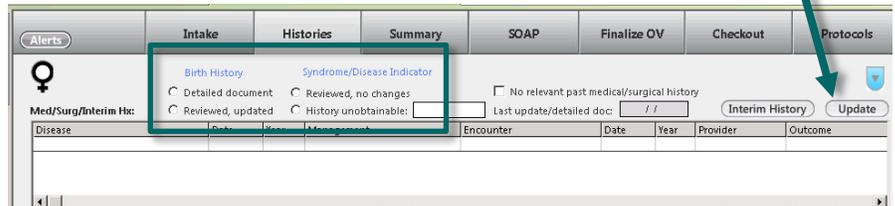
L. Click on the *Next* button at the bottom of the screen or the *Histories* tab at the top.

III. Histories Screen

A. Med/Surg/Interim History

Each patient submits a Personal Health History form at the beginning of each year. This information needs to be entered into the EHR.

1. If you are entering the history for the first time, select *Detailed document* and then click on the *Update* button.
2. If you are updating the history, select *Reviewed, updated* and then click on the *Update* button.



3. If the history is already added and there are no changes, select *Reviewed, no changes*.

B. Family History

1. If you are entering the family history for the first time, select *Detailed document* and then click on the *Update* button.
2. If you are updating the history, select *Reviewed, updated* and then click on the *Update* button.

3. If the history is already added and there are no changes, select *Reviewed, no changes*.

C. Social History

1. If you are entering the social history for the first time, select *Detailed document* and then click on the *Update* button.
2. If you are updating the history, select *Reviewed, updated* and then click on the *Update* button.

3. If the history is already added and there are no changes, select *Reviewed, no changes*.
4. Make sure the Smoking Status is current.

D. Confidential Info

1. Click on the *Confidential Info* button under *Social History*.
2. Enter all confidential health history (alcohol & drug use, sexual history, abuse, etc)

E. School Info

1. Ensure the school information is correct or add it for the first time.

F. Intake Note

If you wish to view the Intake note, you can run it by clicking on the button.

- G. Click on the *Next* button or the *Summary* tab at the top.

IV. Summary Screen

A. Chronic Problems

1. If you have a chronic problem to add, click the *Add Problem* button.

Last Addressed	Comorbidity	Code	Problem	Comments
07/31/2012		719.46	Knee Pain	

2. If there are existing problems, click the *Address* button.

- B. Click on the *Next* button at the bottom of the screen or the *SOAP* tab at the top.

V. SOAP Screen

A. Intake Comments

Click this link to view any notes from the MA or RN during the Intake.

B. Reason for visit

1. Add any additional reasons that have come up in the exam.
2. Check the *F/U* box if this is a follow-up appointment for the reason for visit.

C. HPI Detail

1. For each reason for visit, click on the *HPI Detail* button and complete the questions you would normally ask in an appointment

Hint: See the Advanced Training section of this guide on how to make this screen easier to use.

2. Add any necessary comments for each reason.

D. Review of Systems

1. *ROS Defaults*: Select one if applicable
2. If all other systems are negative, check the *All others negative* box
3. Click on the *Update* button to review or make changes.

Hint: See the Advanced Training section of this guide on how to make this screen easier to use.

E. Physical Exam

If performing a physical exam or sports physical exam, follow these steps.

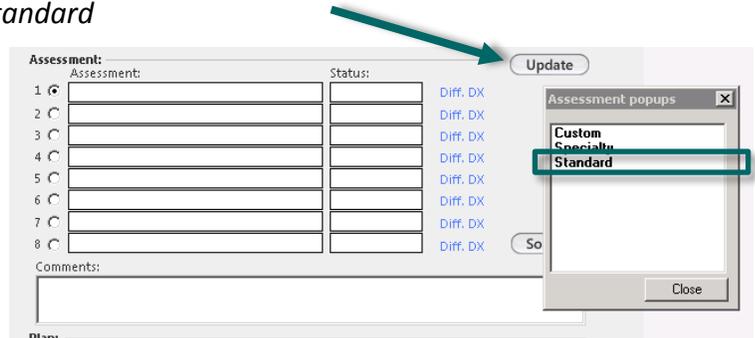
1. Click on the *Physical Exam* link

Hint: See the Advanced Training section of this guide on how to make this screen easier to use.

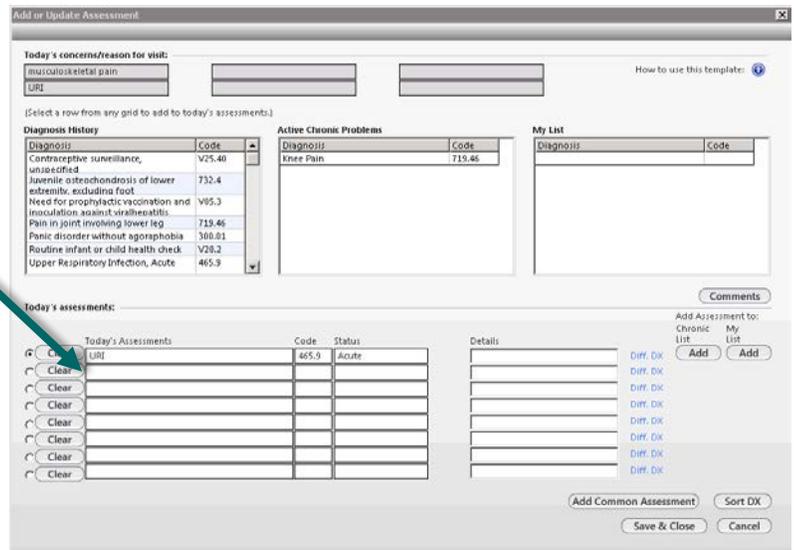
2. Complete only what you performed in the exam. For more detail, click any of the blue links.
3. You can view or enter the hearing and vision screenings.
4. When finished, click on the *Save & Close* button.

F. Assessments

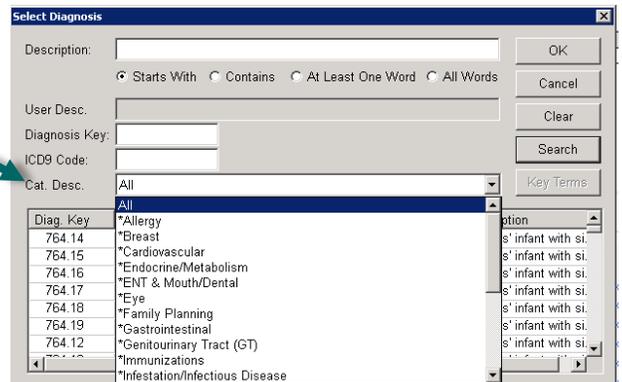
1. Click on *Update* and choose *Standard*



2. Click on an empty *Today's Assessments* field



3. In the *Cat. Desc.* dropdown field, you will find several categories with an * in front of them. These are the SBC diagnosis categories on the Encounter Fee Ticket.
 - a. Select the appropriate category and double-click on the diagnosis from the list.



4. If the assessment is chronic, click on the *Add* button.

Clear	Today's Assessments	Code	Status	Axis	Details
<input checked="" type="radio"/>	Panic disorder without agoraphobia	300.01			
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					
<input type="radio"/>					

5. Click on the *Status* field and select the appropriate option.
You can also add details or comments to each assessment.

Hint: If this is a diagnosis you use frequently, click on the *Add* button under *My List*.

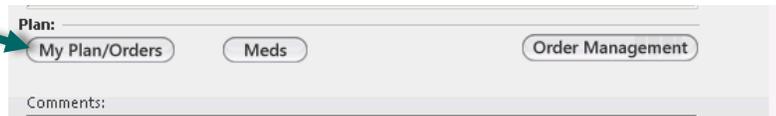
6. Repeat these steps until all diagnoses have been entered.
7. Click on the *Save & Close* button.
8. On the *SOAP* Screen, you can add comments for each diagnosis by clicking on the radio button next to the assessment and then typing in the *Comments* field.

Assessment:	Status:
<input checked="" type="radio"/> Pain in joint involving lower leg	
<input type="radio"/>	

Comments:

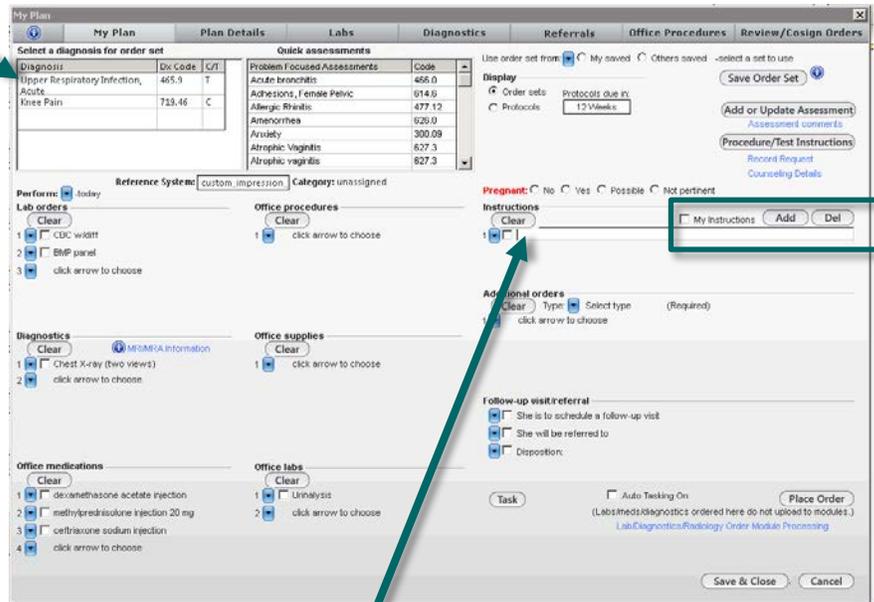
VI. My Plan

Click on *My Plan/Orders* on the SOAP Screen



A. Instructions

1. Click on a diagnosis



2. Enter Instructions for each diagnosis if applicable.

Hint: Click the *My Instructions* box and click the *Add* button to save any common instructions for this diagnosis to use for future encounters.

B. My Phrases

1. Click on the *Plan Details* tab.



2. Add either *My Phrases* or *Common Phrases* to each diagnosis

Hint: See the Advanced Training section of this guide on how to make this screen easier to use.

C. Labs

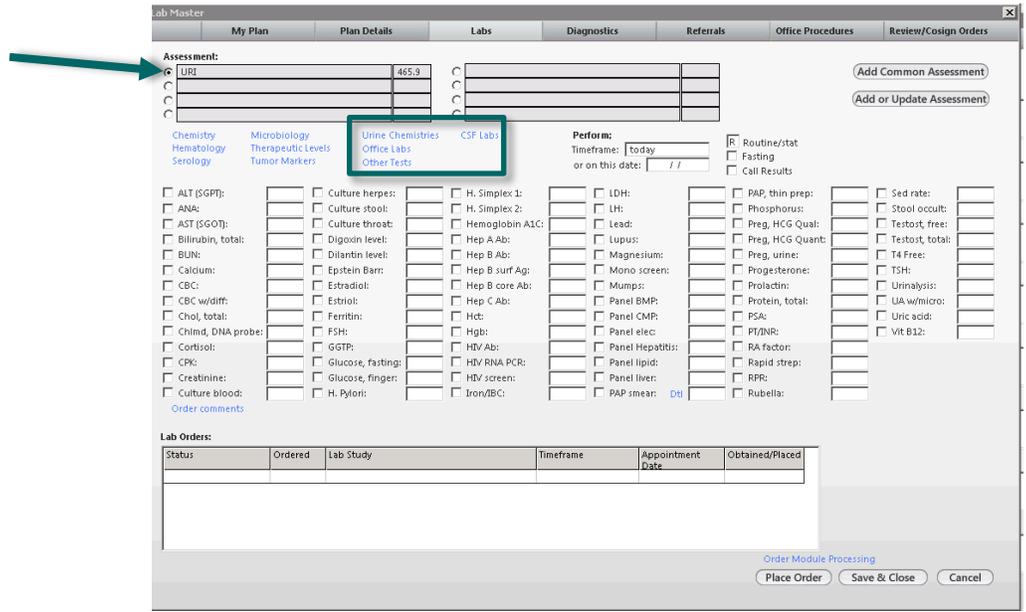
If there are additional labs needed that were not ordered at intake, follow this procedure.

1. Click on the *Labs* tab.



2. Click on the diagnosis you are ordering a lab.
 - a. Click on *Office Labs* and select the correct lab.
 - b. If you need a different lab, select one of the blue links to find the lab you need.

Note: Injections and tests are under the *Office Procedures* tab.



3. Click on the *Place Order* button.

Note: If you are performing the lab on the spot, see page 6 of this guide for office diagnostics or *EHR How-to Guide 5: Orders & Labs*.

D. Office Procedures

1. Click on the *Office Procedures* tab.



- For each diagnosis, add the corresponding office procedure.

Hint: Depo injection is under *Miscellaneous*. Also click on *Injection*.

- Click on the *Place Order* button.

E. Referrals

If you need to refer the patient to another provider either within or outside of the SBC, follow these steps.

- Click on the *Referrals* tab.

- Select the correct To: category (most likely *Specialty/specialist name/site*)
- Select the Specialty.

4. Select or type in the provider you are referring.
5. Add any other pertinent information

F. Click on *Save & Close*

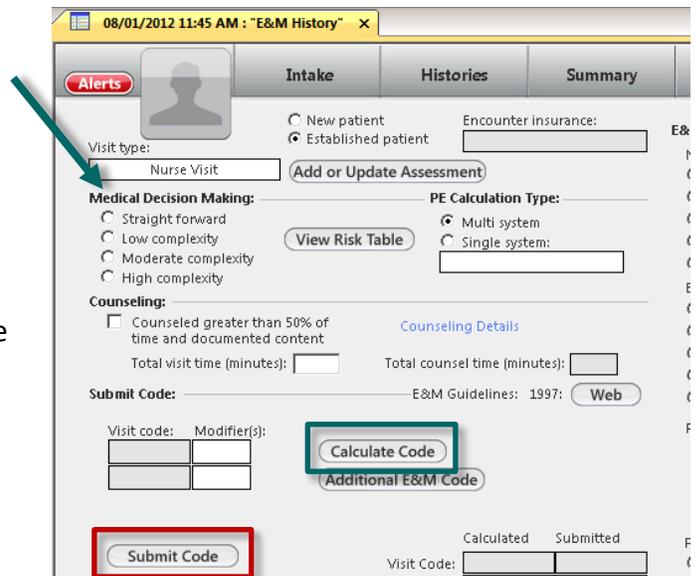
 This is a good time to enter medications. See *EHR How-to Guide 4: Medication Module*.
This is also a good time to enter immunizations. See *EHR How-to Guide 5: Labs & Order Management*.

- G. On the *SOAP* screen, click on the *Next* button at the bottom of the screen or the *Finalize OV* tab at the top.

VII. Finalize OV

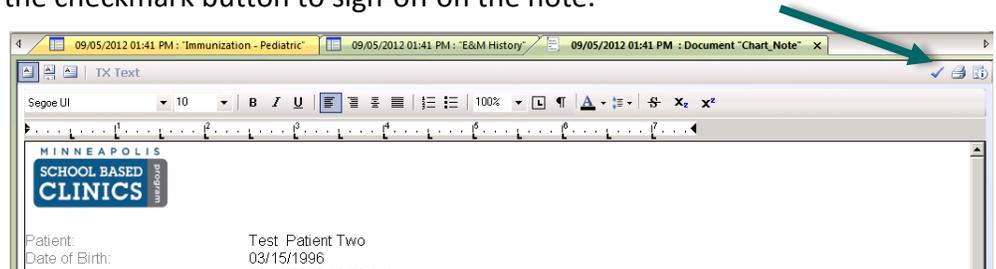
A. Calculate Visit Coding

6. Select the appropriate *Medical Decision Making* option if applicable.
7. Click on the *Calculate Code* button
8. Ensure the code provided is correct. If it's not, select from the list of codes on the right.
9. **Click on the *Submit Code* button.**
Submitted will appear if the code went through successfully.



B. Chart Note

1. The Chart Note will automatically run.
2. View the note to ensure everything is complete. If you are a Rendering Provider, you can click on the checkmark button to sign-off on the note.



3. Close the note when finished.

C. Provider Sign-off

If you are a First Consulting provider (non-rendering), your chart note will automatically go to your Rendering Provider for sign-off. If there is a reason you want the Rendering Provider to actually go through the chart to make sure she is aware of something done, check the *Submit to supervising physician* for review box.

Provider Sign Off:
 Physician sign off request:
 Submit to supervising physician for review
 Supervising physician sign off:
 I have reviewed and agree with the diagnosis and treatment plan

Note: If you are a Rendering Provider and received this chart in your tasks, this is where you would sign-off on the chart by checking the *I have reviewed and agree with the diagnosis and treatment plan* box.

D. Finalize Buttons

Several buttons appear at the end of this screen for your use.

Documents: View detailed E&M History
 Chart Note Patient Plan Referral Request Consult Thank You
 Summary Note Work/School Excuse Brief Quick Parent Excuse
 CC: Providers Patient Portal Upload Tracking Next

1. **Chart Note:** you can run the Chart Note again.
2. **Patient Plan:** run this document to print and give to the patient.
3. **Referral Request:** If you requested a referral in the My Plan, click this button to print or send the request document.
4. **Consult Thank You:** If you were a referring provider, click on this to run the consult document.
5. **Work/School Excuse Brief:** Click on this to print an excuse from school, gym or other physical activity.

E. Click on the *Next* button at the bottom of the screen or the *Checkout* tab at the top.

VIII. Checkout

- A. Review each field to make sure everything looks correct.
- B. Check the appropriate boxes under *Given to Patient/Verified*.

Given to Patient/Verified:

Yes	Refused	Comments:	Yes	Refused	Comments:
<input type="checkbox"/>	<input type="checkbox"/>	Lab orders: (1)	<input type="checkbox"/>	<input type="checkbox"/>	Referrals:
<input type="checkbox"/>	<input type="checkbox"/>	Diagnostic tests:	<input type="checkbox"/>	<input type="checkbox"/>	Educational materials:
<input type="checkbox"/>	<input type="checkbox"/>	Medication(s):	<input type="checkbox"/>	<input type="checkbox"/>	Follow up(s) scheduled:
<input type="checkbox"/>	<input type="checkbox"/>	Office Services ordered:	<input type="checkbox"/>	<input type="checkbox"/>	Procedure:
<input type="checkbox"/>	<input type="checkbox"/>	Transportation arranged:	<input type="checkbox"/>	<input type="checkbox"/>	Patient Plan:

Time: _____ Type: _____ Company/name: _____ Exp: ____/____/____
 Checked out by: Brian T. May Code Submitted: 99211
 Lab/Radiology Order Processing Tracking Task Patient Portal Upload

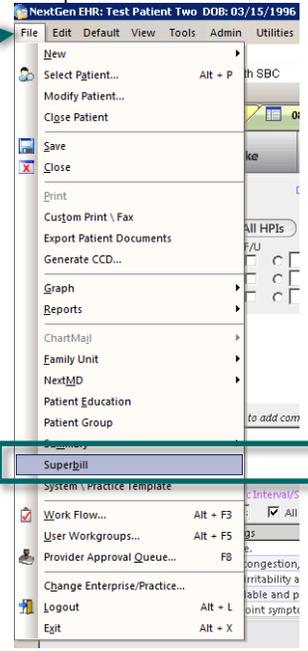
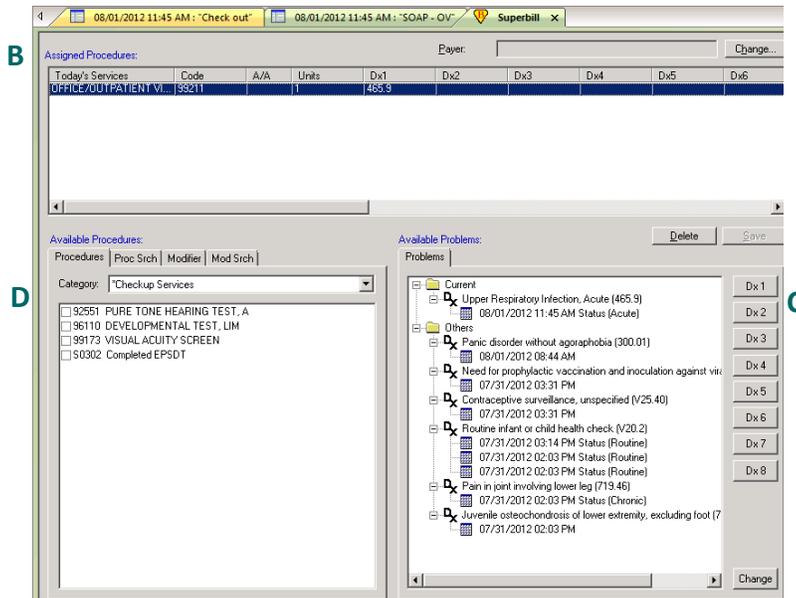
C. If you need to task a provider on this chart, you can do it here.

IX. Superbill

A. Go to *File* and select *Superbill*.

B. Assigned Procedures

1. Ensure the proper office coding and diagnosis appear here.
2. If the proper diagnosis doesn't appear, select it from the *Available Problems* section.



C. Available Problems

1. The diagnosis history for the patient is listed here. If a diagnosis is missing from a service in the *Assigned Procedures* list, first click on the service in the *Assigned Procedures*.
2. Then under *Available Problems*, find the diagnosis you want to add and click on the *Dx 1*, *Dx 2* or *Dx 3* buttons depending on where you want the diagnosis to appear.
3. You should now see the diagnosis in the *Assigned Procedures* section.

D. Available Procedures

You will want to add any special visit CPT codes that are typically found on the front of the Encounter Fee Ticket.

1. Select the proper category with an * in front of it (these are the same categories listed on the front of the Encounter Fee Ticket).
2. Click on the box next to the code you want to add.

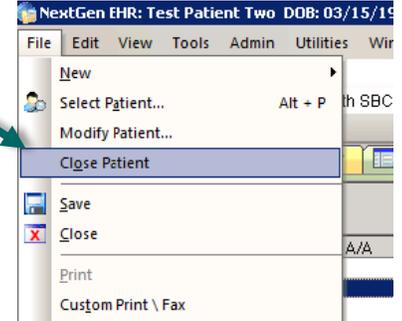
Note: For physical exams, you will need to add every code under **Checkup Services*.

3. The selected procedures should now appear in the *Assigned Procedures* section.

A. Click on the *Save* button on the EHR toolbar.

B. Click on *File* and select *Close Patient*

Note: You have 10 days to complete these steps before the encounter locks.



Advanced Training: Memorizing Templates

This section is not required, but offers extra tips on how to customize certain templates for easier use.

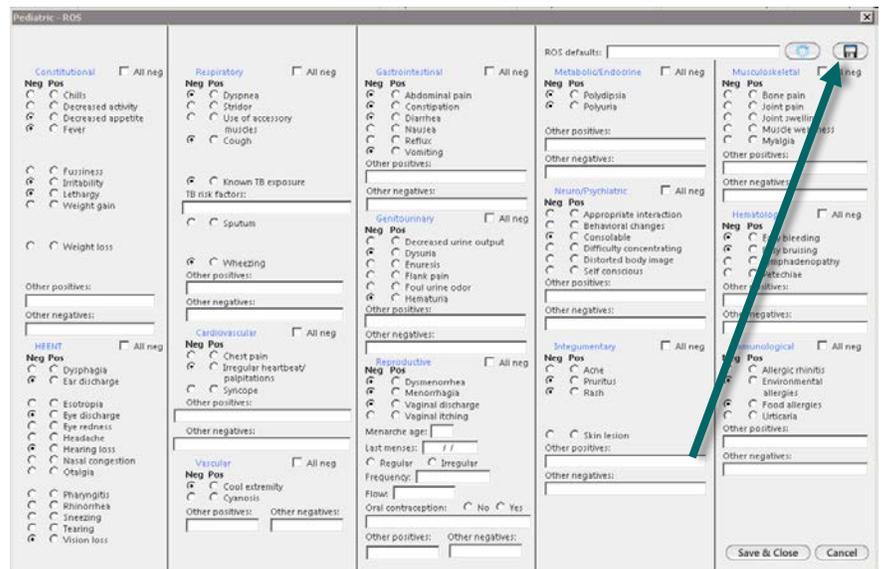
I. Template Memorization



If a template or screen has these icons in the upper right-hand corner, you can save the data you've entered as a memorized data set. You can then use this set on any patient without having to reenter the data.

A. Enter the data.

Hint: If you want to set up some data sets up without charting on an actual patient, search for *Patient, Test* or *Patient, Test Two* and create your data sets under one of these fake patients.



B. Click on the *Quick Save* button

- C. In the Default Set Name, enter the name of your data set

Examples: SPE normal Female, Review of Systems Normal Male, Eyes Normal.

- D. Click on *Save & Close*

- E. The next time you chart on a patient and want to use your memorized data set, click on the



button and double-click on the set you want to use. The data will then automatically fill in the template.

- F. Review and change any data that does not apply to the patient.

II. My Phrases

Instead of re-typing the same notes and recommendations repeatedly, you can create saved phrases relevant to a diagnosis.

- A. Open *My Plan/Orders* under the *SOAP* screen.
B. Click on the *Plan Details* tab.



- C. Click on the *Manage My Phrases* button.

- D. Click on *Add new or copy highlighted phrase*.
E. Click on *My Phrase Type* and choose the appropriate type (usually HPI).
F. In the *My Phrase* field, type the phase you want to use.
G. Click on *Add*.

Congrats! You are now done with this How-to Guide.