

This guide will help you complete a chart for a Nutrition Assessment / RD Visit

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.

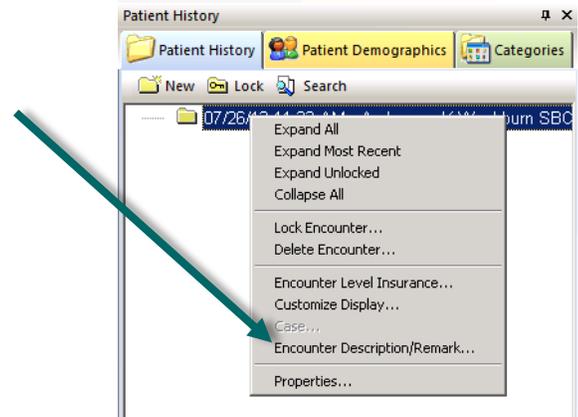
I. Opening the Encounter

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

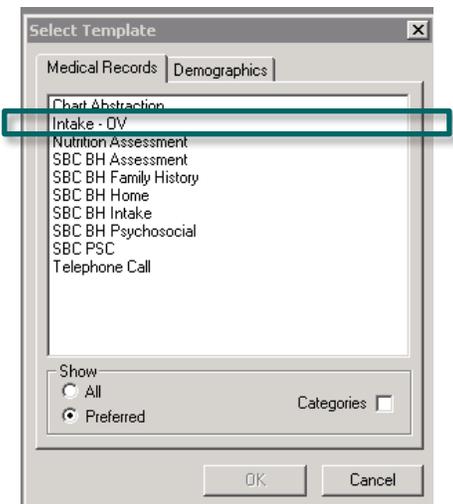
1. Right-click on the encounter and select *Encounter Description/Remark*



2. Type *RDV* for Nutrition/RD visit.

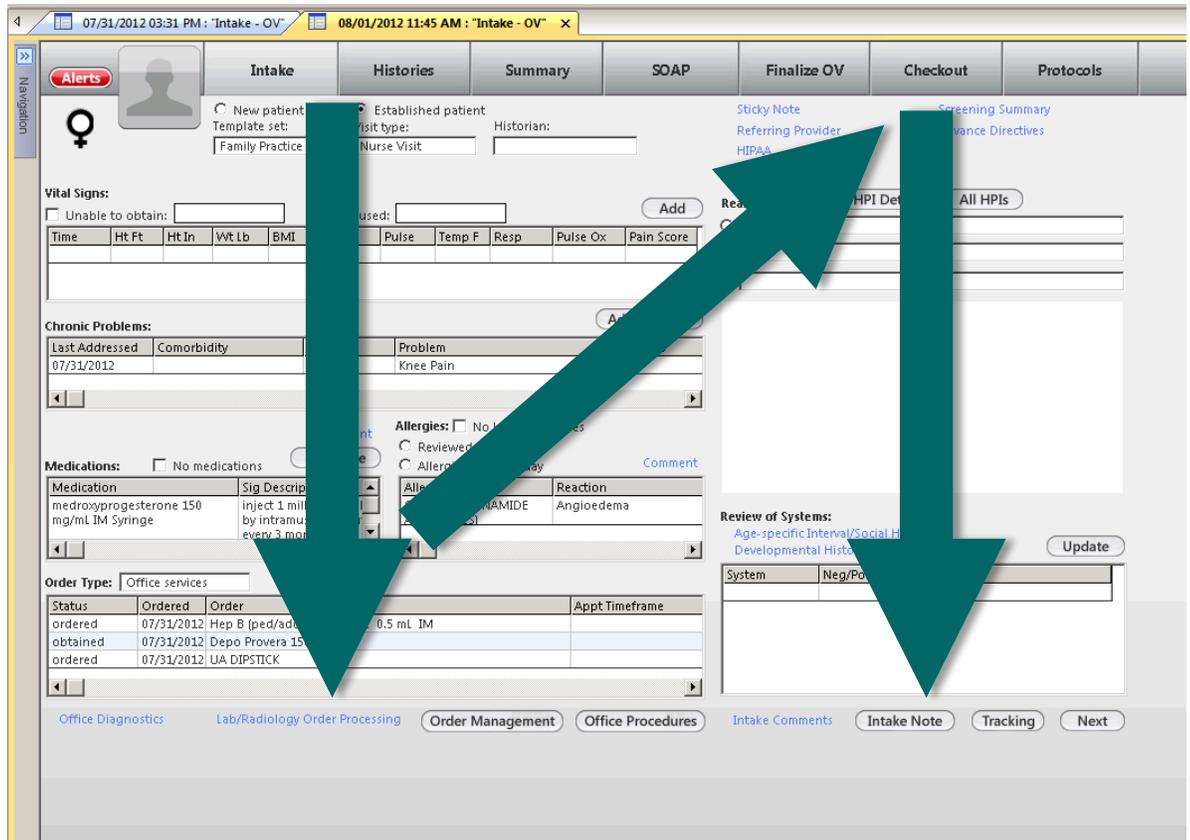
C. Open Intake – OV Template

1. Click on the *Template*  button either at the bottom of the *Patient History* window or on the EHR toolbar.
2. Choose *Intake - OV* from the *Select Template* window

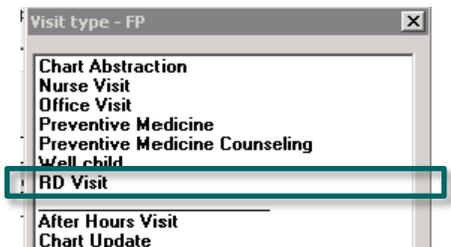


II. Intake Screen

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



A. Visit Type: Select RD Visit



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.

Vital Signs:

Unable to obtain: Refused:

Time	Ht Ft	Ht In	Wt Lb	BMI	BP	Pulse	Temp F	Resp	Pulse Ox	Pain Score

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.

- a. Height
- b. Weight
- c. Temp
- d. BP
- e. Heart Rate
- f. Position
- g. Side
- h. Method
- i. Cuff Size

"Pediatric Vital Signs over 2 Years" - [New Record]

ALERTS:

Unobtainable: Patient Refused:

Measured By: Brian T. May Time: 12:16 PM

Measured Date: 08/01/2012 LMP: / /

Height: 5 ft 8 in 68.00 total in

Weight: 145 lb kg

Temperature: 98.5 F 0 C

Blood Pressure: 140 sys mm/Hg 60 dias

Heart Rate: 172 /min

Respiration: /min

Pulse Ox Rest: %

Pulse Ox Amb: %

Pain Score: 0

Head Circum: in cm

Waist Circum: in cm

Hip Circum: in cm

FIo² Room Air % L/min

Peak Flow: L/min Pre-tx Post-tx

Last Measured: 07/31/2012 measured today carried forward

Context: Dressed with shoes Dressed without shoes

Site:

Position: sitting standing lying

Side: right left

Site:

Method: manual automatic

Cuff Size: pediatric adult large thigh

Pulse Pattern: regular irregular

Pulse Ox: Pre-tx Post-tx

Method:

Waist Hip Ratio:

Delivery Method:

Method:

Comments:

Metric to Standard
Standard to Metric

1 2 3
4 5 6
7 8 9
0 . CL
NEXT

BMI: 22.04 kg/m²
BMI Plan

BSA: m²
Calculate

height: 93
weight: 83
BMI: 66

Audiometry Exam
Growth Charts
Vision Screening

Clear For Add Delete Save Close

3. Ensure the BMI has been calculated
4. Click on *Save* and then *Close*

F. Office Diagnostics

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

Medications: No medications Allergies added today

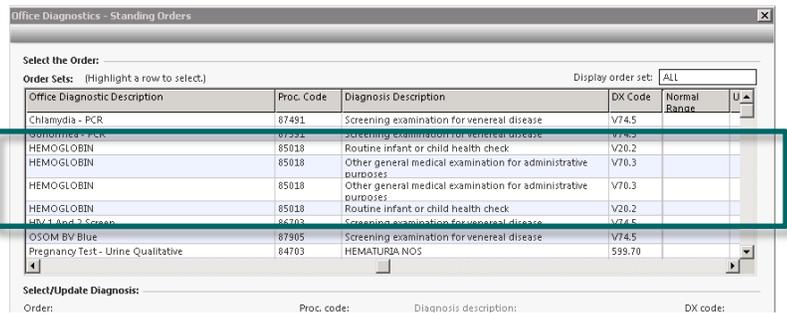
Medication	Sig	Description	Allergen	Reaction
Benadryl Allergy 25 mg Tab	take 2 tablet (50MG)	oral route every 4 - 6 hours as needed	SULFA(SULFONAMIDE ANTI-BIOTICS)	Angioedema

Order Type: Office services

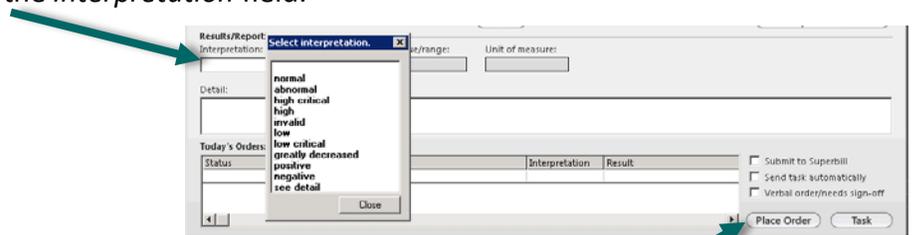
Status	Ordered	Order	Appt Timeframe
ordered	08/28/2012	Gonorrhea - PCR	
ordered	08/28/2012	Chlamydia - PCR	
obtained	08/21/2012	Chlamydia - PCR	
result received	08/18/2012	HEMOGLOBIN	

[Office Diagnostics](#) [Lab/Radiology Order Processing](#)

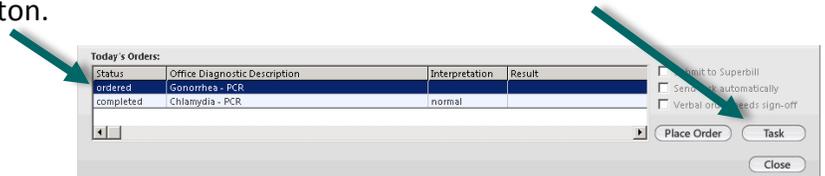
1. The SBC common procedures are listed first. Make sure to select the correct *Office Diagnostic* with the correct *Diagnosis Description* by double-clicking on the pair.



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



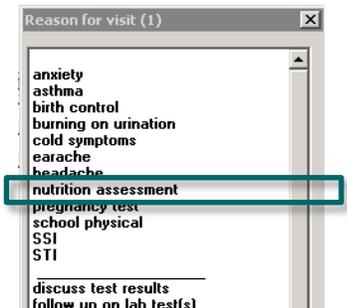
3. Click on the *Place Order* button. Your order and its status will appear in the *Today's Orders* field.
4. If you need to task someone to complete a procedure, select the order in *Today's Orders* and click on the *Task* button.



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

G. Reason for Visit

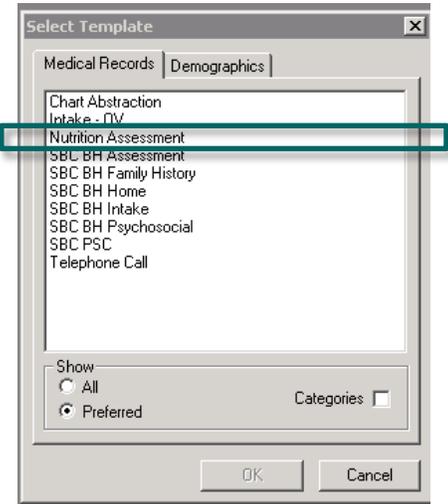
1. Click on a blank *Reason for Visit* field and select *nutrition assessment*.
2. Add any necessary comments for each reason.



III. Nutrition Assessment

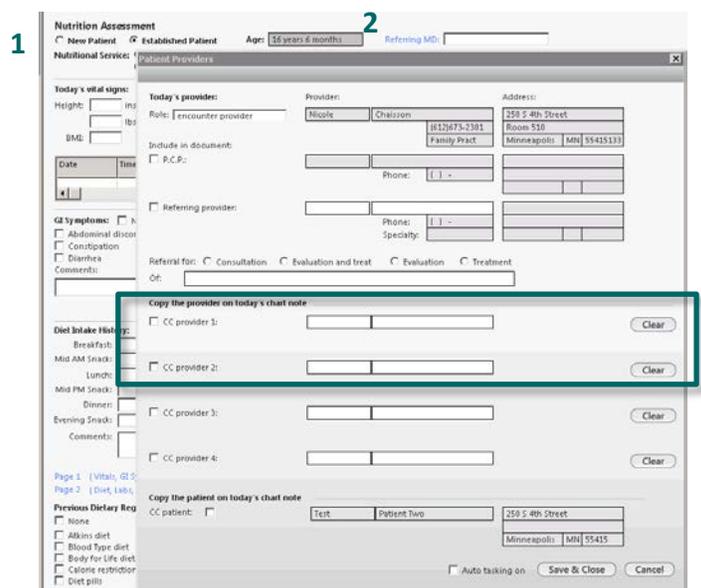
A. Open Nutrition Assessment Screen

1. Click on the *Template*  button either at the bottom of the *Patient History* window or on the EHR toolbar.
2. Choose *Nutrition Assessment* from the *Select Template* window



B. Nutrition Assessment

1. Select *New* or *Established Patient* (this will probably already be selected for you).
2. Click on the *Referring MD* link.
 - a. Enter any necessary information including if you want the Referring Provider to be copied on your chart note.



- b. Click on the *Save & Close* button.

3. *Nutritional Services*: Select the proper service.

Nutritional Service: Diabetes Self Management training Nutritional counseling by physician Nurse visit
 Nutritional Therapy, initial Nutritional Therapy, reassessment

Today's vital signs: _____ **Weight history:** _____

C. Page 1: Vitals, GI Symptoms, Diet Hx

1. Vitals

- If vitals were taken today, they will be listed here.
- To find previous vitals, click on the left navigation bar and select *Record Vital Signs*. You will see a list of all vitals taken on the patient.
- Enter the vitals you want to use here and click on the *Save* button.

2. Weight History

Enter the appropriate data and comments.

Weight history:
 Weight gain: _____ lbs _____ time
 Weight loss: _____ lbs _____ time
 No weight changes _____ time

Comments:

3. GI Symptoms

Either select *No symptoms* or check the appropriate boxes for each symptom.

GI Symptoms: No symptoms

Abdominal discomfort Dysphagia Nausea
 Constipation Flatulence Reflux
 Diarrhea Heartburn Vomiting

Comments:

No Yes
 Calcium Dietary sources _____ mg/day
 Supplement _____ mg/day
 Contraindication: _____

Vitamin D Supplement
 Adequate sunlight exposure

Multivitamin Daily Occasionally
 Folic acid Daily Occasionally

4. Diet Intake History

Enter the appropriate information.

Diet Intake History:

					Time	AM	PM	Not
Breakfast:						<input type="radio"/>	<input type="radio"/>	
Mid AM Snack:						<input type="radio"/>	<input type="radio"/>	
Lunch:						<input type="radio"/>	<input type="radio"/>	
Mid PM Snack:						<input type="radio"/>	<input type="radio"/>	
Dinner:						<input type="radio"/>	<input type="radio"/>	
Evening Snack:						<input type="radio"/>	<input type="radio"/>	
Comments:	<input type="text"/>							

D. Page 2: Diet, Labs, Meds, Allergies, Activity

1. Previous Dietary Regimens

Either select *None* or check the appropriate boxes for each.

Previous Dietary Regimens:

None

Atkins diet Exercise Low Sugar

Blood Type diet High Protein diet South Beach diet

Body for Life diet Low Carb diet Zone diet

Calorie restriction Low Fat diet Weight Watchers diet

Diet pills Low Sodium diet

Comments:

2. Medications and Allergies Review

a. Check the *Reviewed Nutritional Related Meds*

Medications: Reviewed Nutritional Related Meds

Medication	Sig Description	Start D	Ingredient/Allergen	Allergy Type	Brand Name
Gildess FE 1 mg-20 mcg tablet	take 1 tablet by oral route every day	09/17/	SULFA(SULFONAMIDE ANTIBIOTICS)	Specific Allergen Group	
Gildess FE 1 mg-20 mcg tablet	take 1 tablet by oral route every day	09/14/			

Allergies: No known allergies

b. Either check the *No known allergies* box or double-click the white field to add an allergy.

3. Weight and Activity Factors

Ideal Body Weight: lbs **% Ideal Body Weight:** % **Basal Metabolic Rate:** calories

Activity Factor:

Sedentary (little or no exercise)

Lightly Active (light exercise/sports 1-3)

Moderately Active (moderate exercise/sports 3-5)

Very Active (hard exercise/sports 6-7 days/week)

Extra Active (very hard exercise/sports/physical)

Click to calculate weight loss factor

Basal Metabolic Rate w/Activity Factor: calories

Basal Metabolic Rate w/Weight Loss Factor: calories

- Enter data in the *Ideal Body Weight* fields.
- Activity Factor*: Select the proper option.
- Check the *Click to calculate weight loss factor* box.

E. Assessment, Recommendations, Plan

1. Assessment

ASSESSMENT:	Status:	Details:	Add or Update Assessment	Add Common Assessment

a. Click on the *Add or Update Assessment* link.

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

The screenshot shows the 'Add or Update Assessment' window. At the top, there are fields for 'Today's concerns/reason for visit:' with 'musculoskeletal pain' and 'URI' entered. Below this are sections for 'Diagnosis History', 'Active Chronic Problems', and 'My List'. The 'Today's assessments:' section contains a table with columns for 'Clear', 'Today's Assessments', 'Code', 'Status', 'Axis', and 'Details'. A green arrow points to the first empty row in this table. To the right of the table are buttons for 'Add Assessment to: Chronic List' and 'My List', and 'Add' buttons. At the bottom are 'Add Common Assessment', 'Sort DX', 'Save & Close', and 'Cancel' buttons.

c. 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.

i. Select the appropriate category and double-click on the diagnosis from the list.

The screenshot shows the 'Select Diagnosis' dialog box. It has fields for 'Description:', 'User Desc.', 'Diagnosis Key:', 'ICD9 Code:', and 'Cat. Desc.'. The 'Cat. Desc.' dropdown is open, showing a list of categories with asterisks in front of them, such as '*Allergy', '*Breast', '*Cardiovascular', etc. A green arrow points to the 'Cat. Desc.' dropdown. On the right side of the dialog are 'OK', 'Cancel', 'Clear', and 'Search' buttons, along with a 'Key Terms' field.

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

The screenshot shows the 'Today's assessments:' table. The first row contains 'Panic disorder without agoraphobia' with code '300.01'. A green arrow points to the 'Add' button in the 'Add Assessment to: Chronic List' column for this row. Another green arrow points to the 'Add' button in the 'Add Assessment to: My List' column. The table has columns for 'Clear', 'Today's Assessments', 'Code', 'Status', 'Axis', and 'Details'. To the right of the table are 'Diff. DX' buttons and 'Add' buttons for both 'Chronic List' and 'My List'. At the bottom are 'Add Common Assessment' and 'Sort DX' buttons.

e. 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*.

f. Repeat these steps until all diagnoses have been entered.

- g. Click on the *Save & Close* button. Your assessments will now appear on the Nutrition Assessment screen.

2. Recommendations

- a. Enter any recommendations and goals you wish to assign.

RECOMMENDATIONS:

Appropriate Calorie Level:

Appropriate Carbohydrate servings:

Appropriate Protein Level:

Other Dietary Modifications:

Exercise:

Type:

Frequency: Duration:

Goals:

Education Recommendations:

Educational Materials provided:

- b. Click on the *Calculate Calorie Level* button.

3. Plan

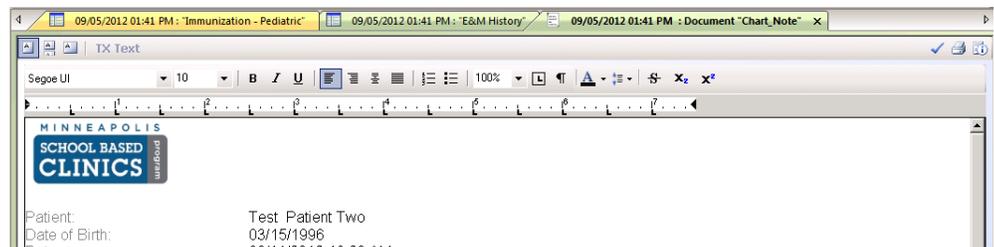
- a. *Follow Up:* Select the proper follow-up time period

F. Preview Nutrition Assessment Document

1. Click on the *Preview OV* button at the bottom of the screen.



2. View the note to ensure everything is complete.



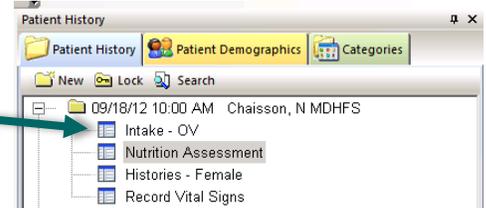
3. Close the note when finished.

IV. Referrals

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

A. Click on the *History* button on the EHR Toolbar.

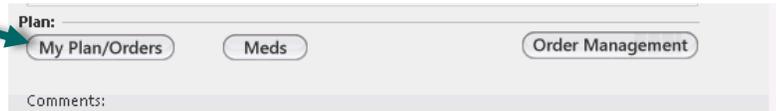
B. Under the Encounter you are currently charting under (Perform the 6-point Check), click on *Intake – OV*.



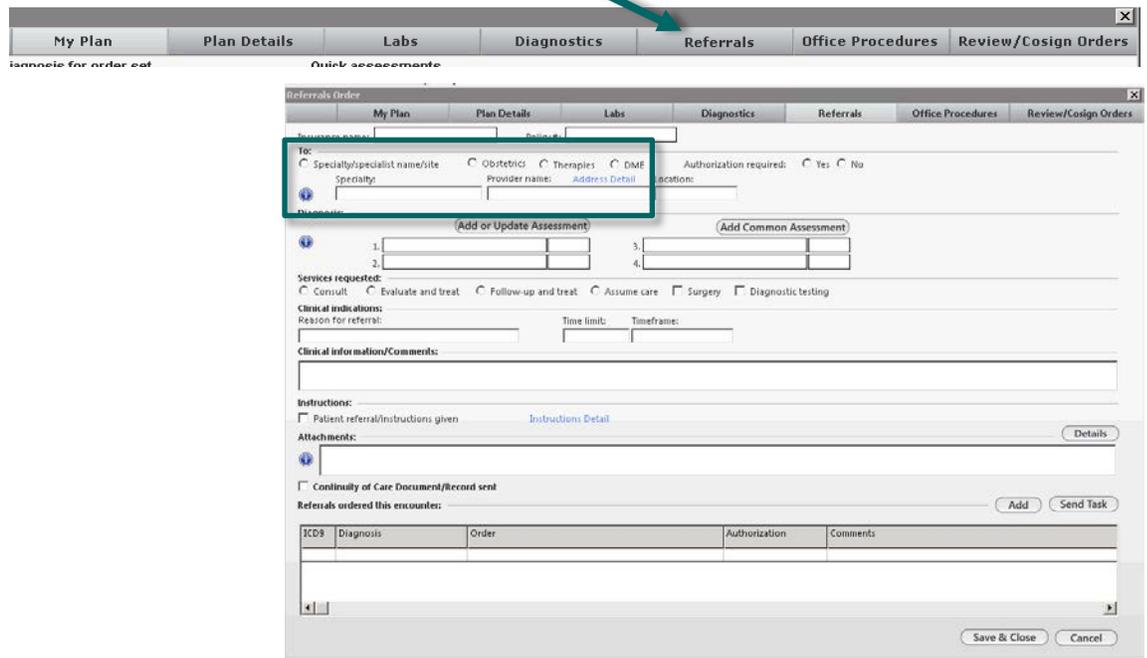
C. Click on the *SOAP* tab.



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



E. Click on the *Referrals* tab.



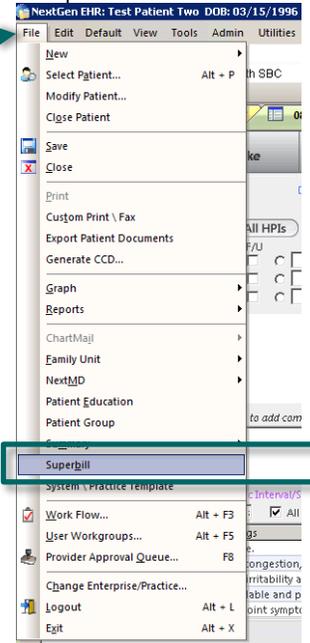
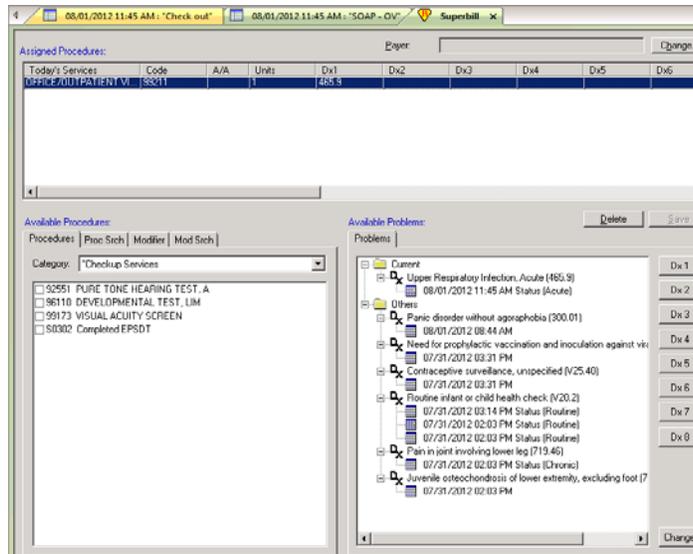
1. Select the correct To: category (most likely *Specialty/specialist name/site*)
2. Select the Specialty.
3. Select or type in the provider you are referring.
4. Add any other pertinent information
5. **Click on *Save & Close***

V. 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

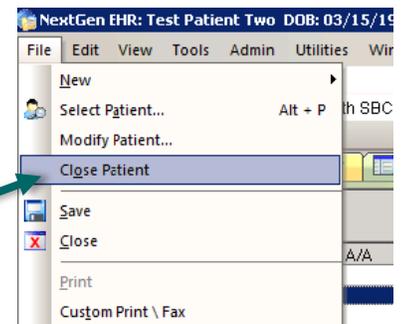
You will want to add any special visit CPT codes that are typically found on the front of the Encounter Fee Ticket including the Nutrition Visit Codes.

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

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

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

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



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