Community Health Centre Scheduling (SCH) Tipsheet

The steps below are the quick steps to book an appointment (clinic visit) for a patient in Community Wide Scheduling.

1. Choose **Community Wide Scheduling** from the main Desktop then choose **Scheduler Desktop**.
2. If prompted choose the appropriate database: Kitikmeot, Kivalliq, Qikiqtaalak.
1. Choose Appt Book from the right hand side to switch to Book mode.
2. Enter RE.CHC as the resource group for Resolute Health Centre.
3. Navigate to the day on the calendar you want to process using the Go To Day button.

To book a new appointment:

1. Click in one of the 3 slots for the time you want to book the appointment. Click **Book**.
2. When prompted for appointment type – Enter **RE** and press **Enter** to view the available visit types for Resolute.
3. At the patient prompt – type the complete name of the patient you are searching for. The format is as follows: LASTNAME,FIRSTNAME.
4. When prompted for Sex and Birthdate, click **cancel** to continue the patient search.
5. A list of patients will appear with that exact name. Select the patient you are looking for. If you do not see your patient in the list, you can use the buttons on the right to search by birthdate or healthcare #.
6. When prompted – choose **New Visit**.
7. Enter the **Visit Reason** and double-check the Date and Time are correct.
8. Click **SAVE**.

To edit an existing appointment (change date, time and/or reason for visit):

1. Click the patient's name or time slot you want to edit.
2. Click the **Edit** button from the right side of the screen.
3. Choose **Edit Appointment** when prompted.
4. Make the appropriate changes – *a. you can update the visit reason, b. you can specify a new date and time.*
5. If you change the date and/or time you will need to specify a **Reschedule Reason**. Use the arrow to see a list of options and choose the most appropriate response.
6. Click **SAVE** and a confirmation of the new appointment date and time will appear. Click **Close**.

The steps below are the quick steps to perform an Admissions **Clinical** Registration. Please see CHC Reg and HIM Manual for full explanations.

1. Depending on access, follow either path mentioned below:
    a. **Admissions** > **Registration Management Desktop**
    b. **Registration**
2. From the right-hand toolbar choose **Registration**
3. At the Type prompt enter **Clinical**
4. At the Form prompt enter **Long**
5. In the columns below the Account Number Search, enter the **Birthdate**. The format is **DDMMYY**
6. Select **okay** at the bottom of the screen.
7. A list of patients will appear with that birthdate. Select the patient you are looking for.
8. An Account Lookup will appear showing all previous accounts created. Cancel out of this screen as you are creating a new account. Select **Cancel** at the bottom right of the screen.
9. Enter **REG-CL** at the **Reg Category** prompt.
10. Go to the **Provider Tab**
11. At the **Attending Doctor** field, enter the Clinician.
12. Go to the **Visit Tab**
13. Complete the **Service Date**
14. Complete the **Service Time**
15. Complete the **Location**. RE will take you to the Resolute Bay locations.
16. Complete the **Reason for Visit**
17. Select **Save** at the bottom of the screen.
18. If labels are required, at the Print Admission Form Screen, enter "N" for all formats except for Community Health Centre Labels. At this prompt enter "Y" and in the Printer column enter **RE REC01**
19. At the last screen showing the Medical Record Number and Account Number, hit close.

The steps below are the quick steps to perform an Admissions **Clinical** Registration for the New Patient. Please see CHC Reg and HIM Manual for full explanations.

1. Depending on access, follow either path mentioned below:
    a. **Admissions** > **Registration Management Desktop**
    b. **Registration**
2. From the right-hand toolbar choose **Registration**.
3. At the Type prompt enter **Clinical**.
4. At the Form prompt enter **Long**.
5. In the columns below the Account Number Search, enter the **Birthdate**. The format is **DDMMYY**.
6. If you get the message **"Patient Not Found"**, that means the patient is never registered in the system and you need to create the New Patient.
7. In the columns below the Account Number Search, enter the **Name**. The format is **LASTNAME,FIRSTNAME**. Press Enter key.
8. Enter the Birthdate and Sex in Medical Record Search box and click on **OK** button.
9. A list of patients will appear. Click on **New Patient** button at the bottom.
10. Enter **REG-CL** at the **Reg Category** prompt.
11. Enter **City, Province** and **Home Phone** number.
12. Go to the **Language** tab.
13. Enter "Y/N" in **"Does the patient require an Interpreter?"** field.
14. Go to **Insurance** tab.
15. Enter **P-NUHP** in Mnemonic field for NU resicents, and press enter key. Information will default in Detail tab.
16. Go to the **Provider Tab**.
17. At the **Attending Doctor** field, enter the Clinician.
18. Go to the **Visit Tab**.
19. Complete the **Service Date**.
20. Complete the **Service Time**.
21. Complete the **Location**. NJ will take you to the Naujaat locations.
22. Complete the **Reason for Visit**.
23. Select **Save** at the bottom of the screen.
24. If labels are required, at the Print Admission Form Screen, enter "N" for all formats except for Community Health Centre Labels. At this prompt enter "Y" and in the Printer column enter **xx REC02**.
25. At the last screen showing the Medical Record Number and Account Number, hit close.

The steps below are the quick steps to perform an Admissions **Recurring** Registration. Please see CHC Reg and HIM Manual for full explanations.

1. Depending on access, follow either path mentioned below:
    a. Admissions > Registration Management Desktop
    b. Registration
2. From the right-hand toolbar choose Registration.
3. At the Type prompt enter Recurring.
4. At the Form prompt enter Long.
5. In the columns below the Account Number Search, enter the Birthdate. The format is DDMMYY.
6. Select okay at the bottom of the screen.
7. A list of patients will appear with that birthdate. Select the patient you are looking for.
8. An Account Lookup will appear showing all previous accounts created. **If there is a previously existing registration, you would be looking for a REG RCR account to the location of RE.MH**. If such an account exists, cancel out of the screen and go to the Revisit Functionality (see steps below). If the account is not there, cancel out of this screen and continue as you are creating a new account. Select Cancel at the bottom right of the screen.
9. Enter REG-RCR at the Reg Category prompt.
10. Go to the Provider Tab.
11. At the Attending Doctor field, enter the Clinician.
12. Go to the Visit Tab.
13. Complete the Service Date.
14. Complete the Service Time.
15. Complete the Location. WC will take you to the Whale Cove locations.
16. Complete the Reason for Visit.
17. Select Save at the bottom of the screen.
18. If labels are required, at the Print Admission Form Screen, enter "N" for all formats except for Community Health Centre Labels. At this prompt enter "Y" and in the Printer column enter RE.REC01.
19. At the last screen showing the Medical Record Number and Account Number, hit close.

Revisit Functionality Steps

Follow the steps below if the patient has an existing REG RCR registration to the location of RE.MH.

1. From the right-hand toolbar choose Revisit.
2. Enter the Birthdate. The format is DDMMYY.
3. Select the REG RCR account with a location of RE.MH.
4. Enter the Service Date.
5. Enter the Service Time.
6. Enter the Attending Physician.

Area	Registration Performed By	Registration Type	Location	Reason for Visit	Labels Each Visit
CHN Visit	Front Desk Clerk Interpreters	REG CLI	RE CHC **Attending: CHN the patient will be seeing (if known) or SCHP**	Generic For example, Sick Clinic, Well Woman Clinic, Well Man Clinic, Prental Clinic, Chronic Disease Clinic, Well Child Clinic, Emergency	Y
Lab	Front Desk Clerk Interpreters	REG CLI	RE LAB **Attending: CHN who placed the Lab orders on the paper requisition or SCHP**	Generic For example, For Bloodwork	N
X-Ray	Front Desk Clerk Interpreters	REG CLI	RE DI	Generic For example, For X-ray	N
Mental Health	Front Desk Clerk Interpreters	REG RCR ***** With Re-visit for subsequent visits**	RE MH	Generic For example, Mental Health Appointment	Y
Telehealth	Front Desk Clerk Interpreters	REG CLI	RE TH	State the Telehealth Session. For example, Pediatrician	Y
Occupational Therapy	Front Desk Clerk Interpreters	REG RCR **For Telehealth OT Visit, either do a new registration *or* re-visit the existing REG RCR registration.**	RE RH OT	Generic For example, To see OT	Y

Physiotherapy	Front Desk Clerk Interpreters	REG RCR **For Telehealth PT Visit, either do a new registration or re-visit the existing REG RCR registration.**	RE RH PT	Generic For example, To see PT	Y
Speech Language Therapy	Front Desk Clerk Interpreters	REG RCR **For Telehealth SLP Visit, either do a new registration or re-visit the existing REG RCR registration.**	RE RH SLP	Generic For example, To see SLP	Y
Audiology	Front Desk Clerk Interpreters	REG RCR **For Telehealth AUD Visit, either do a new registration or re-visit the existing REG RCR registration.**	RE RH AUD	Generic For example, To see AUD	Y

Community Health Centre (CHC) Ordering Tipsheet

The steps below are the quick steps to order a Consult, Referral, Lab or X-ray order. Please see CHC OM Manual for full explanations.

1. Choose **Provider Care Manager** in the iEHR.
2. Choose **Patient Lists** from the right-hand sidebar to search for the patient and specific visit / account. (Search by DOB – format is **DDMMYY**)
3. Once you have selected the appropriate visit/account you can click on the **Orders** button on the right.
4. This will show the patient's Current Orders if there are any. To enter new orders, click the **New Orders** button at the top.
5. Click on **Category Groups** or **Name** to begin your search for the test you would like to order. Category Groups allows you to view all of the available tests. Name allows you to type in the test with your keyboard if you know the name.
6. Once you've found the test you would like to order, tick the checkbox next to it.
7. Repeat steps 5 and 6 for each test you would like to order. Once you have selected all of your tests click **Next** at the bottom of the screen.
8. You will now see a list of all the tests you've ordered. If any of them have a red edit button, you will be required to click this button and fill out the required fields. Required fields are indicated by an asterix (*).
9. Once you've completed all required fields click **OK** at the bottom of the screen. You will notice that the edit button is now no longer red. Repeat step 8 for all the tests you are ordering.
10. Once the required fields from all tests have been completed you can click **OK** at the bottom to submit your orders.
11. A final review screen will show you all the tests you are ordering. Please review this list and if satisfied press **Save** at the bottom. You will be prompted to enter your PIN.
12. Depending on the tests ordered – lab labels, x-ray requisitions and consults will print to the appropriate printers.

Note: At this time, Order Sets should not be utilized at the Community Health Centres. The orders will not flow to the correct modules (Lab and ITS).

Diagnostic	X-ray to be done today in Resolute Bay	Entered into MEDITECH
	X-ray to be done in the future in Resolute Bay	Paper
	X-ray to be done in Iqaluit	Paper and fax to Iqaluit (QGH)
	Ultrasound Order	Entered into MEDITECH
	CT Order	Entered into MEDITECH
	Mammo Order	Entered into MEDITECH
	MRI Order	Paper and fax to TOH
	ECG Order	Paper
	Holter Monitor Order	Paper

Laboratory	Lab Orders performed at QGH and vial drawn today in Resolute Bay	Entered into MEDITECH
	Lab Orders performed at QGH and vial to be drawn in the future	Paper. **Order entered into MEDITECH on the day vial is drawn**
	Lab Orders sent to Dynacare	Entered into MEDITECH
	Micro Orders performed at QGH and taken today in Resolute Bay	Entered into MEDITECH
	Micro Orders performed at QGH and sample to be taken in the future	Paper. **Order Entered into MEDITECH the day sample is acquired**
	Micro Orders sent to Dynacare	Entered into MEDITECH

Consults	Family Practice Consult	Entered into MEDITECH
	Specialty Clinic Consult	Entered into MEDITECH
	Mental Health Consult	Entered into MEDITECH
	Public Health/TB Consult (currently no specific TB position; done by CHN's)	Entered into MEDITECH
	Rehab Consult	Entered into MEDITECH
	Dietitian Consult	Entered into MEDITECH
	Respiratory Therapy (rare if ever)	Entered into MEDITECH
	Social Services Consult	Paper

Imaging and Therapeutic Services Tipsheet for Resolute Bay X-ray

Below are the steps to follow once the Order Management Requisition appears on the X-ray printer and the x-ray has been completed.

1. **Imaging and Therapeutic Services**

2. **Receptionist Desktop**
   - The Department of DI will default in.
   - Select Save.
   - Tick the box next to the correct patient.
   - Select Arrival Time from the right-hand toolbar. **This step is important to ensure the requisition prints at Rankin Inlet Diagnostic Imaging.** The Arrival Time can be the same as the Service Time.
   - Select OK.
   - The ITS Requisition will print at QGH Diagnostic Imaging.

3. **Technologist Desktop**
   - Tick the box next to the correct patient.
   - Select Record Exam from the right-hand toolbar. **This step is important as it allows the Radiologist's report to come back into the iEHR.**
   - Complete the following fields:
     - Status – Taken
     - Start Date – Day the x-ray was done.
     - Start Time – Same as the Arrived Time.
     - End Date – Day the x-ray was done.
     - End Time – When the x-ray was finished. Fifteen minutes can be added to the Start Time.
     - Tech 1 – Who did the x-ray.
     - Departed Time – Same as End Time.
     - Select Save

The steps below are the quick steps to view patients with booked appointments out of territory.

1. Choose **Community Wide Scheduling** from the main Desktop then choose **Scheduler Desktop**.
2. When prompted choose the appropriate database: Kitikmeot, Kivalliq, Qikiqtaalak.
3. At the patient prompt – type the complete name of the patient you are searching for. The format is as follows: LASTNAME,FIRSTNAME
4. When prompted for Sex and Birthdate, click **cancel** to continue the patient search.
5. A list of patients will appear with that exact name. Select the patient you are looking for. If you do not see your patient in the list, you can use the buttons on the right to search by birthdate or healthcare #.
6. Now that you've selected your patient, you will see a list of appointments (if there are any) on this screen. Each appointment will display the date, time, status, duration and type. Appointment types prefixed with **OT** indicate the appointment is **O**ut of **T**erritory.
7. To view more details about a specific appointment, click the check-box next to the appointment and then click the **View** button.
8. Once viewing more specific appointment details you will have access to view Reason for Visit, Scheduler Notes and Patient Instructions.
9. Click **Close** to close this appointment and return back to the **Patient Desktop**.

Community Health Centre Orders by Facility Tipsheet

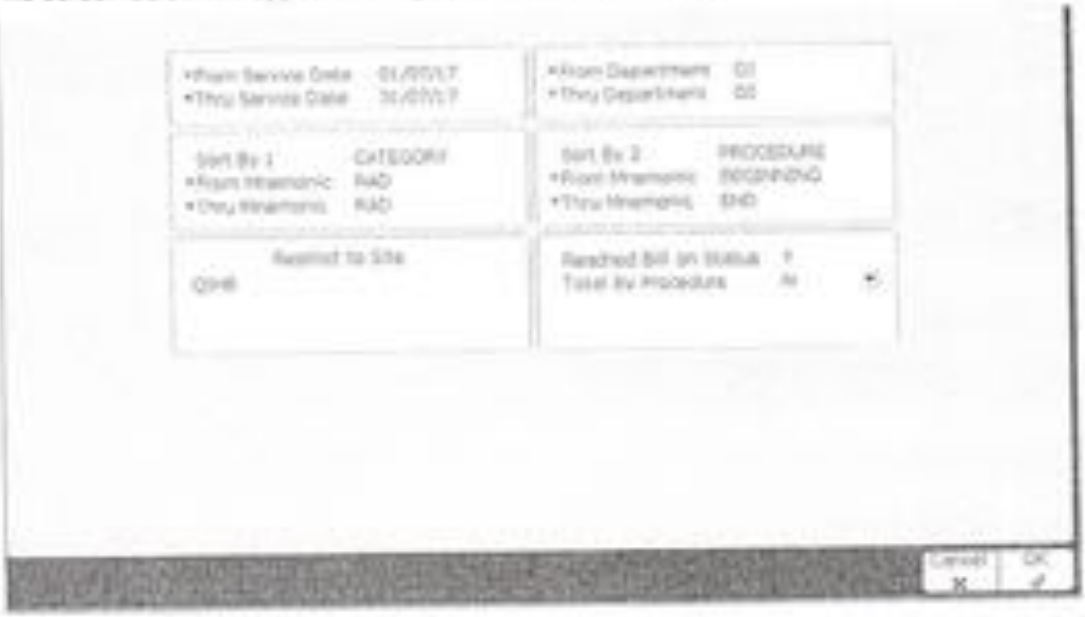
The steps below show how to run the Orders by Facility Report.

1. From the main Desktop – Reports > Orders by Facility. You will be prompted with the screen below. Below are the options to complete the various fields:
    a. Facility:
        i. QI for Qikiqtaaluk
        ii. KV for Kivalliq
        iii. KI for Kitikmeot
        iv. QR for Resolute Bay
        v. KS for Sanikiluaq.
    b. Category: This is the category of orders you are looking for. Examples would be as follows:
        i. CONS – Physician Consults/Speciality Clinics
        ii. CONSFP – Family Practice Consult
        iii. REF.REHAB – Referral – Rehab
        iv. REF.RT – Referral – Respiratory
        v. REFDIET – Referral – Dietitian
    c. Order Date – Select the dates you want
    d. Order Location – Select the site two letter prefix. For example, Qikiqtarjuaq is QI and Clyde River is CR
    e. Select the Print button at the bottom of the screen.

f. You will be prompted with the screen below. Select "OK" at the bottom of the screen and you will get the report.

The steps below outline the process to follow for pulling the monthly Imaging and Therapeutic Services (X-ray) statistics from the iEHR.

1. From your main Desktop, follow the path below:
   - Imaging and Therapeutic Services > Statistics and Searches > Statistics > Departmental > Patient Count
2. The screen below will appear. Complete the fields as follows:



   - From Service Date and Thru Service Date: select the dates you want.
   - From Department and Thru Department: DI
   - Sort by 1: Category with From Mnemonic and Thru Mnemonic being RAD
   - Sort by 2: Procedure with From Mnemonic and Thru Mnemonic being Beginning to End
   - Restrict to Site: Select your site. The above example shows Hall Beach.
   - Reached Bill on Status: Y
   - Total by Procedure: N
3. Select OK at the bottom right of the screen. You can then preview and subsequently print the report if necessary.

SOAP Notes Basics

The **SOAP note** (an acronym for **subjective**, **objective**, **assessment**, and **plan**) is a problem/issue oriented method of documentation. **SOAP** is a simple, logical means of organizing written information. It provides consistency in documentation and makes it easier to review a chart for specific information.

Subjective = subjective data (e.g., how does the patient/client feel?), any information you receive from the patient (history of present illness, past medical history, etc)

The patient's complaint or issue; this is a very brief statement by the patient (quoted). The history or stated experienced symptoms are recorded in the patient's own words and includes history, onset, and duration, alleviating and aggravating factors. The patient/client should be asked directed questions about any complaints – current or reportedly resolved -- and ask appropriate follow-up questions and document all responses.

Subjective comments made by the patient/client may range from no complaints ("I feel great") to specific current complaints ("I've had a headache for 3 days") to complaints that took place in the interim but have resolved ("3 weeks ago I had diarrhea for a couple of days"). For an infant's record, the subjective component would include the mother's (or caretaker's) observations.

Objective = objective data (e.g., results of the physical exam/assessment, relevant vital signs, measurements), any data, whether in the form of a physical finding during your exam/assessment, or lab results

The objective component includes measurements, findings from physical examinations/assessments and results from diagnostic tests.

Assessment = assessment (e.g., what is the client's status?), diagnoses derived from the history and objective data

Assessment combines the subjective information gathered during the interview with the patient/client and the objective findings of the physical exam/assessment and consolidates them into a short assessment: "This is a 26-year old woman here for a routine HPTN microbicide study visit; there are no clinical problems today" or "This is a 22-year old pregnant woman, 26 weeks gestation by physical exam, here for a non-study visit due to chief complaint of increased nausea for 1 week and vomiting for 2 days" or "This is a 46-year old HIV-infected man here for routine HPTN study visit with increased fatigue and pallor; blood smear is positive for malaria."

Plan = plan (e.g., does the plan stay the same? is a change needed?), what you intend to do about the diagnoses from your assessment; what the clinician will do for the patient/client

SOAP Notes Basics

This is what the health care provider will do to treat the patient's concerns - such as ordering further diagnostics, consulting other providers, procedures performed, medications given and education provided. A note of what was discussed or advised with the patient as well as timings for further review or follow-up are generally included.

Often the Assessment and Plan sections are grouped together.

Example of a Nursing Focus note using the SOAP format:

Focus: Respiratory
S: Patient complaining of shortness of breath.
O: Respiratory Rate 44. Upon auscultation decreased air entry LLL.
A: Patient in moderate respiratory distress.
P: Physician notified. Ventolin aerosol ordered.

References:

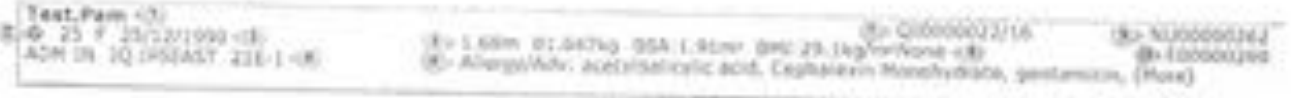
1. College of Registered Nurse of British Columbia Practice Support: Nursing Documentation. https://www.crnbc.ca/downloads/151.pdf
2. http://en.wikipedia.org/wiki/SOAP_note
3. http://www.scrubnotes.com/2007/08/how-to-write-historyphysical-or-soap.html

Resolute Bay Online Nursing Documents		
Naming Convention	Note/Template	Comments
CHC Nursing Note	Note	Complex note
CHC Soap Note	Note	Simple note. To be used when no vital signs or point of care tests documented.
Newborn Flow Sheet	Note	
CHC Lice Check	Note	
KV Immunization	Template	To be used for non-Well Baby Immunizations: Flu Clinic
KV Sexual Health	Template	
KV Smoking Cessa Assess	Template	
KV TB Assessment	Template	N.B. This can be put in a Pending Status following 1st visit/screen
KV Travel Clinic	Template	To be used for patient's receiving travel immunizations
KV Well Baby Record 02 Months KV Well Baby Record 04 Months KV Well Baby Record 06 Months KV Well Baby Record 09 Months KV Well Baby Record 12 Months KV Well Baby Record 15 Months KV Well Baby Record 18 Months KV Well Baby Record 2-3 Years KV Well Baby Record 4-5 Years KV Well Baby Record Birth - 1 mth	Templates	Immunizations are tracked on these templates. Immunizations still need to be tracked on the Immunizations Card.

EMR- Patient Header

The patient header appears whenever a patient specific routine is opened.

Always review the patient header upon opening any routine to ensure you have the correct patient selected. Immediately hover the mouse over the patient name and then proceed to working in the chart.



1. Patient name: Last name, first name
2. The symbol contains basic information about Allergies, Height and Weight and if the patient requires an interpreter.

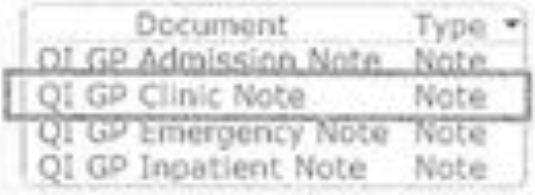
3. Age, sex and birthday
4. Registration status, Location and Room and Bed Number
5. Height/Weight, BSA and BMI
6. Allergies/Adverse Reactions
7. Account Number (QI0000075/12)
8. Health Card Number (if not documented, the word "None" appears)
9. Medical Record Number (NU00000281), also known as the NU Number
10. EMR Number (E0000028). The GON does not currently reference this number for any reason.

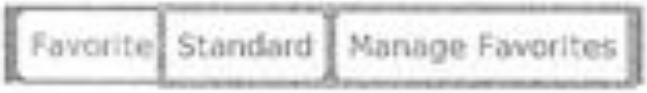
Documenting a note from PCM

1. From the patients EMR
   a. Click "Select Visits"
   b. Select your visit to add documentation
   c. Click "Document"

2. Use the Footer buttons to select "New"

3. Select the appropriate note category (ie. QI GP Clinic Note, QI GP Emergency Note, etc.) or select the note category using the footer buttons Standard & Manage Favourites





Once favorites are managed the first time they take for all patients

Documenting a note from PCM

4. Use the first line (approximately 20 characters) as your title/diagnosis

5. When finished documenting select "OK" in the bottom right corner to put in your PIN to save

You can use detail to back date/time your note

You can also add saved data and Text using the footer buttons

Back Date and Time Notes

1. When note is open select "Detail" on the left hand side of the window

2. Select the drop down arrow and choose the date and time to back date your note to and select ok

3. When you are finished with your note select save and enter your PIN

You cannot back date or back time before the registration date/time

You can also free text the date or time

Undo Note

1. Click EMR Notes tab and then select note to be undone

2. Select the Undo footer button

3. Specify your undo reason and save

Note will be removed from the EMR and status will change to Cancel

How to print a Referral

1. After the order has been placed, click "History".
2. Select the referral you want to print.

3. When the "View Order Detail" screen appears; click "Print" on the bottom of the page.

4. If any printers are listed click the "X" to remove them (Unless it is the printer you require).

5. Complete the following information;
   a. **Output Format**: Select "Clinical Data-Full Page"
   b. **Destination:** Select the printer you wish to print, Ex: IQ.ER02
   c. **Copies**: Number of Copies.

How to print a Referral

6. Click "Ok" to print.

Allergies/AdvReaction – Adding, Editing, Removing

Editing/Removing

1. On the patients EMR select summary tab from the right hand side and then the Edit button on the Allergy section

2. Make sure the header button "Edit" is still selected
   a. Place a check mark on the allergy you are looking at
   b. Make any changes using the available options or select the Remove footer button to remove the allergy/AdvReaction
3. Select save in the bottom right corner when finished

You can select multiple listings to remove more than one at a time

You can change multiple listings and save when finished

Allergies/AdvReaction – Adding, Editing, Removing

New (adding)

1. Make sure the "New" header button is selected
   a. In the Search For field type the name of the allergy
   b. Select the appropriate allergy ****if allergy is not listed type the full name and use the "Add As Uncoded" to still list the Allergy but no cross checking will be made****
   c. Select the red Edit button to specify the reaction
2. Select save in the bottom right corner when finished

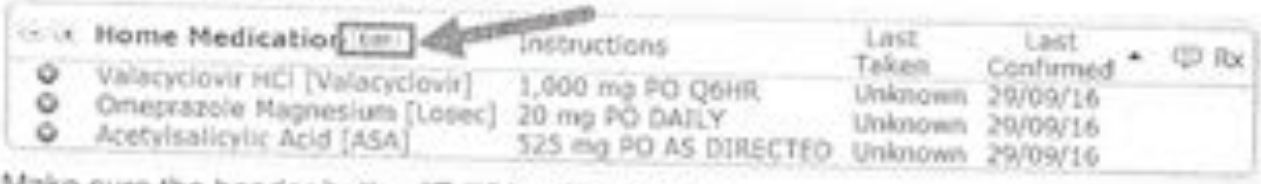
You can add multiple items and select the reactions when you are done and save when finished all

Home Medications – Editing, Adding New Med

Editing

You can also edit the medication fields while following the confirm/discontinue steps

1. On the patients EMR select summary tab from the right hand side and then the Edit button on the Home Medication section.



2. Make sure the header button "Edit" is still selected
   a. Place a check mark on the medication you are looking to edit
   b. Make any changes using the available options

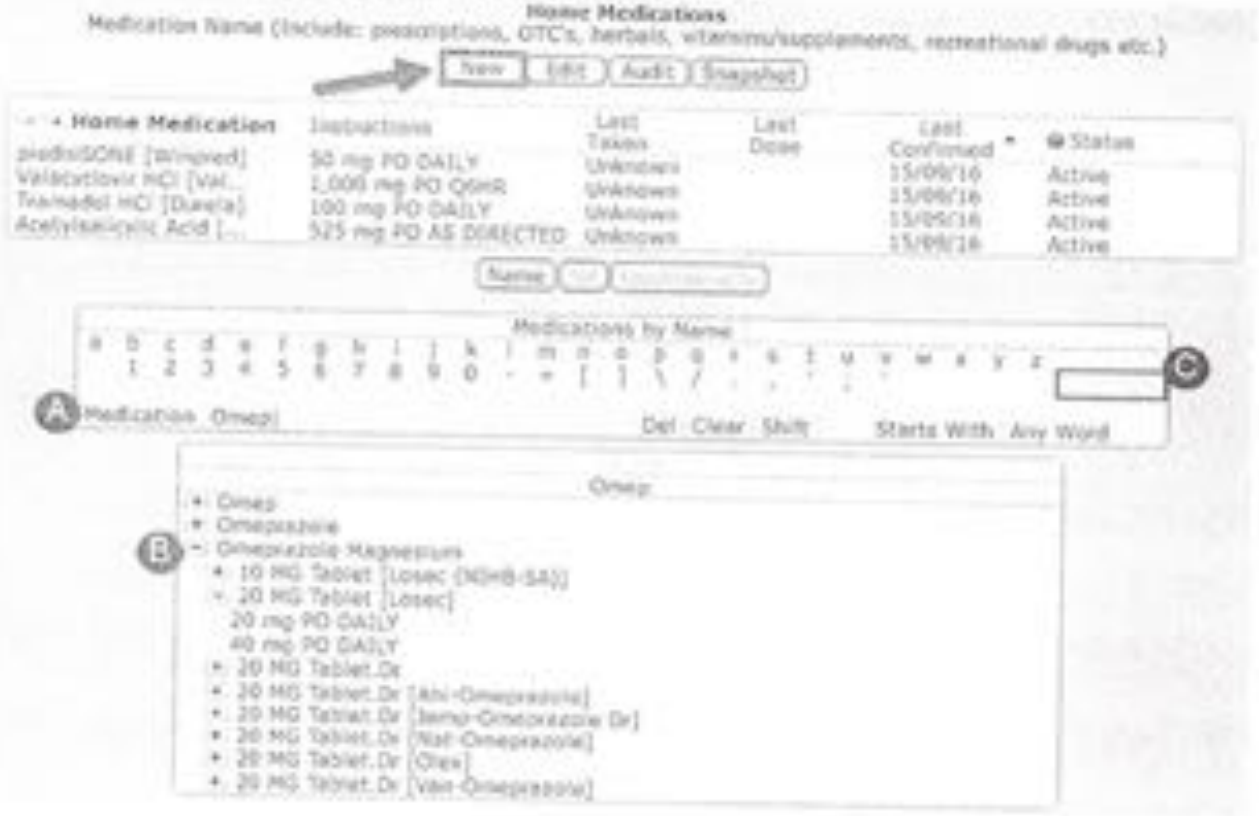
3. Select "Save" in the bottom right corner when finished

You can change multiple listings and add meds then save when finished

Home Medications – Editing, Adding New Med

New Med

1. Make sure the "New" header button is selected
   a. In the Medication field type the name of the medication
   b. Select the appropriate medication and use the + symbols to take the options down until there are no more + symbol options and select a line of medication you want (ie. 20 mg PO DAILY)
   c. If the medication is not available you can type out the full name of the medication and add it with the "Any Med" option (you will have to manually fill out all fields and no cross checking is done.)



Home Medications – Editing, Adding New Med

2. On the newly added medication
   a. Make sure to fill out the Dose, Units, Route, and frequency if not already done so as you will not be able to confirm it for future visits
   b. Last Taken is mandatory so make sure to fill this out
   c. Complete source

3. Click "Save" to complete

Home Medications – Discontinuing and Confirming

1. From the "Summary" tab on the EMR select the Edit button under the Home Medication section

If not needing to discontinue anything skip to step 3

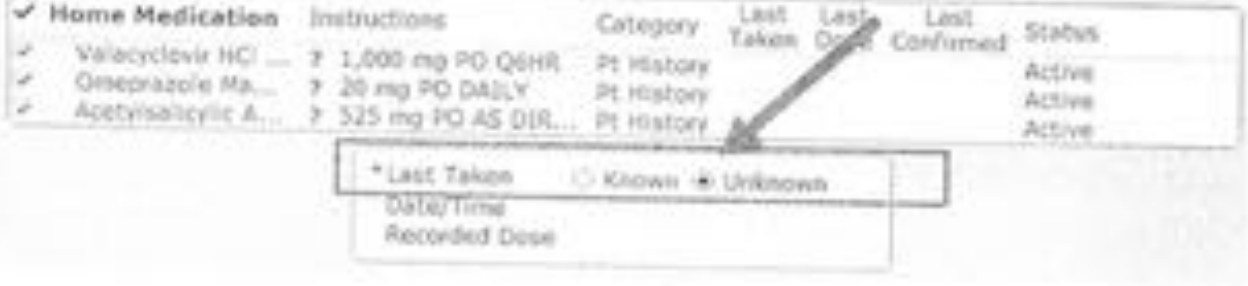
2. On the next screen select any medications you would like to discontinue and use the "Discontinue" footer button, enter your reason for discontinuing and select ok

Home Medications – Discontinuing and Confirming

You can also make changes to any medications before confirming them (see editing tip sheet)

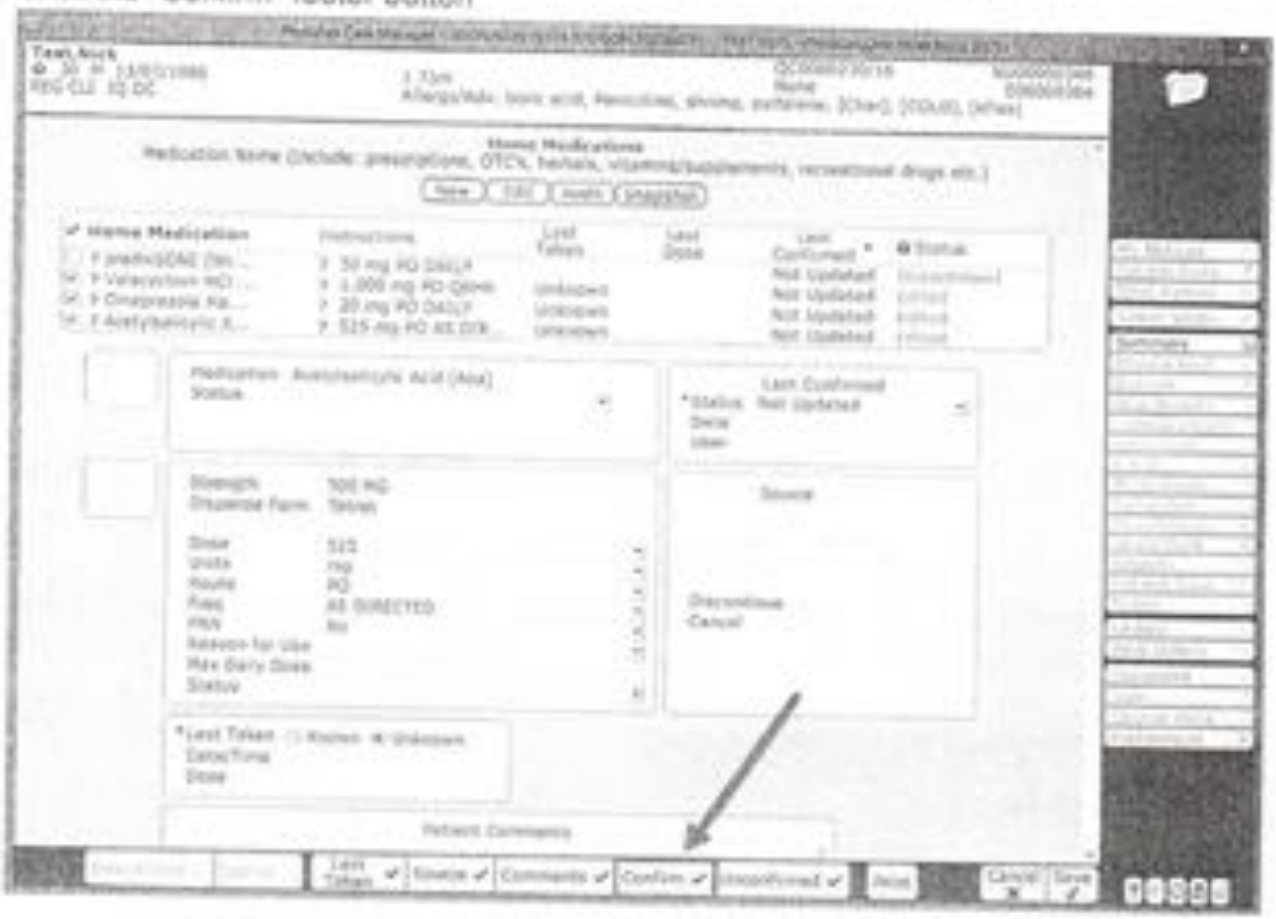
3. Once back at Home Medications confirm them by
   a. Selecting the medications that were not discontinued
   b. Select "Last Taken" footer button

4. Select "Unknown" on the Last Taken line or "known" if applicable



Home Medications – Discontinuing and Confirming

5. Click the "Confirm" footer button



6. When finished select "Save" in the bottom right corner

Saved Data in Note Documentation

While in the EMR of the desired patient, click Document→New → choose the preferred note type (narrative, text, or blank note)

Note:

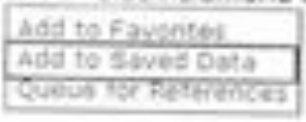
If blank note is selected, please indicate diagnoses on the first line then proceed with the note

After completing your note, you can incorporate information such as blood work ordered for the current visit, clinical panels /vital signs, and laboratory results into the note.

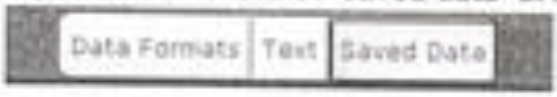
To add saved data

1. Minimize the note but DO NOT save it
2. Click on orders→new orders. Identify/select and edit desired orders accordingly. Then enter your unique PIN to submit the orders
3. After submitting the order, the orders defaults to the current order header tab. Click on the "+" sign beside current order to expand your orders.

4. Under "**status**", right click on the order (s) you wish to place in the patient note and select "**Add to Saved Data**". A black diamond should appear.



5. Return/maximize the patient note and click "**saved data**" at the footer



6. A list of items you previously selected to be saved to data will display with a check mark to the left of them. You can deselect an item by simply clicking on the check mark. Click "**Insert**" at the bottom footer.

Saved Data in Note Documentation

7. To add clinical panel/vital signs, and laboratory results to note: While in patients EMR, identify the items you wish to add. To add items to save data, right click in the desired field and a black diamond should appear.

8. When all items have been inserted your note should appear similar to the image below.

9. Click "OK" to save the note

Note:

- Remember always to save documented data
- If the assessment is exited without saving, all documentation is lost