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1. Access the Tracking window: **Clinical, Practice Management, or Billing tab > Schedule button > Tracking radio button.**
2. Select the patient.
3. Click the **Room** drop-down and select from the list.
4. Click the **Visit Status** drop-down and select from the list.
5. Right-click on the appointment and select **Open well visit.** A confirmation window displays.
6. Click **Yes** to apply the template.

Note: Always confirm the correct template before selecting Yes. If incorrect, select No and choose the correct Well Visit template by clicking the **Complete List** button located in Interval Hx. Select the correct template by clicking the paperclip.

Encounter Visit

1. Access the Tracking window: **Clinical, Practice Management, or Billing tab > Schedule button > Tracking radio button.**
2. Select the patient.
3. Click the **Room** drop-down and select from the list.
4. Click the **Visit Status** drop-down and select from the list.
5. Right-click on the appointment and select **Open encounter.** A confirmation window displays.
6. Click **Yes** to apply the template.

Note: Always confirm the correct template before selecting Yes. If incorrect, select No and choose the correct Encounter Visit template by clicking the **Complete List** button located in CC/HPI/ROS. Select the correct template by clicking the paperclip.

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Add Vital Signs and Growth Measurements

Vital Signs

1. From within the Patient Chart, Encounter or Well Visit Note, click **Vitals/Growth**.
2. Click the **New** button.
3. Complete the fields below in the **Standard Measurements** group.
Note: When entering Vitals, you can use the Tab key on your keyboard or click in each field to move through the information.
 - a. **Date/time taken:** Defaults to the date and time you clicked the New button.
 - b. **Temp method:** Select a radio button. The default is set in System Preferences.
 - c. **Temperature:** Type a number or click the drop-down and select from the number pad.
 - d. **BP systolic:** Type a number or click the drop-down and select from the number pad.
 - e. **BP diastolic:** Type a number or click the drop-down and select from the number pad.
 - f. **BP method:** Select a radio button. The default is Sit/Stand.
 - g. **Pulse (heart rate):** Type a number or click the drop-down and select from the number pad.
 - h. **Respiratory rate:** Type a number or click the drop-down and select from the number pad.
4. (*Optional*) Complete the fields below in the **Other Measurements** group.
 - **Pulse ox:** Type a number or click the drop-down and select from the number pad. Add additional comments in the text field to the right.
 - **Peak flow:** Type a number or click the drop-down and select from the number pad. Add additional comments in the text field to the right.
 - **Severity of pain:** Click the drop-down and select from the list. Add additional comments in the text field to the right.
5. Click the **Save** button.

Growth Measurements



1. Click the **New** button.
2. Complete the following fields:
 - a. **Measure date:** Defaults to the date and time you clicked the New button.
 - b. **Stature/Length:** Type a number or click the drop-down and select from the number pad.
 - c. **Weight:** Type a number or click the drop-down and select from the number pad.

- d. (Optional) **Head circumference:** Type a number or click the drop-down and select from the number pad.
 - e. (Optional) **Mid-Parental Height:** Type a number or click the drop-down and select from the number pad.
3. Click the **Save** button.

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Add an Allergy

1. From within the Patient Chart, Encounter or Well Visit Note, click **Allergies**.
2. Click the **New** button.
3. Complete the following fields:
 - a. **Subsection: Medication Allergy** is the default selection. To change, click the drop-down and choose from the list
 - b. **Status: Active** is the default selection. To change, select the **Tracking** or **Resolved** radio button.
 - c. (Optional) **Onset date:** Defaults to the date you clicked the New button. To change, type a date or click the drop-down and select from the calendar.
 - d. **Medication (required for Medication allergy):**
 - i. Type the full or partial name of the medication and select the **Ellipsis** button or press the **Enter** key.
 - ii. Choose the medication from the list.
 - iii. Click the **OK** button.

Note: You do not need to select the correct form/strength of the medication.
 - e. (Optional) **Allergy group:**
 - i. Click the **Ellipsis** button.
 - ii. Type the full or partial name of the allergy in the **Allergy Code** field.
 - iii. Click the **Search** button.
 - iv. Select the allergy and click the **Select** button.
 - f. **Problem:**
 - i. Type the full or partial name of the allergy and press the **Enter** key or drop-down arrow.
 - ii. Choose the allergy from the list.
 - g. (Optional) **ICD code:** Type the description or code and press the **Enter** key or click the drop-down arrow and choose from the list.
 - h. (Optional) **Refer/coord:** Click the **Address book** button  or the **Patient Coordination** button  and select.

- i. *(Optional)* **Stage/severity**: Click the drop-down arrow and select from the list.
 - j. *(Optional)* **Symptoms**: Click the drop-down arrow and select from the list.
 - k. *(Optional)* **Notes**: Type notes related to the allergy.
 - l. **Visibility: Any staff member** is the default selection. To change, click the drop-down arrow and select from the list.
4. Click the **Save** button.

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Add a Medication

1. From within the Patient Chart, Encounter or Well Visit Note, click **Medications**.
2. Click the **New** button.
3. Complete the following fields:
 - a. **Purpose: Med - reference only** is the default selection. To change, click the drop-down arrow and select from the list.
 - b. *(Optional)* **Primary DX**:
 - i. Type the full or partial name of the diagnosis and press the **Enter** key or click the drop-down arrow and select the diagnosis from the list.
 - ii. Click the **Select** button.
 - c. **Type: Standard Medication** is the default selection. To change, click the drop-down arrow and select from the list.
 - d. **Drug**:
 - i. Type the full or partial name of the medication and press the **Enter** key or click the drop-down arrow and select the medication from the list.
 - ii. Click the **OK** button.
 - e. **Include in chronic medication list**: Select this checkbox if the medication is ongoing.
 - f. **Rx start date**: Defaults to the date you clicked the New button. If unknown, highlight and click the **Delete** button or click the drop-down arrow and select **Clear**.
 - g. *(Optional)* **Rx end date**: Date calculated using the Rx Start Date and Days Supply.
4. Click the **Save** button.





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Add History

Past Medical History

1. From within the Patient Chart, Encounter or Well Visit Note, click the **History** button.
2. Click the **Past Medical** tab.
Note: If previous past medical history was entered, the selections display in the Past Medical window.
3. To see additional history questions, select the **Show all questions** checkbox.
4. Make selections for Past Medical History by clicking once for + (Positive), twice for - (Negative) or three times for **N/A**.

Family History

1. From within the Patient Chart, Encounter or Well Visit Note, click **History**.
2. Click the **Family** tab.
3. Confirm the **Genetic mother** and **Genetic father**. If not selected, click the drop-down and choose from the list.
Note: The selected patient's Genetic mother and Genetic father are entered and set in Family Contacts.
4. Click the **Add** button  at the bottom of the window.
5. Complete the following fields.
 - a. **Family Member:** Click the drop-down arrow and select from the list.
 - b. **+/-:** Default to + (Positive). Click in the + / - field to change the selection.
 - c. **Problem:** Click the **Problem** button  or type the full or partial name of the problem and press the **Search** button .
 - d. *(Optional)* **SNOMED:** This field is populated by the selected problem.
 - e. *(Optional)* **Dx Age:** Click the drop-down arrow and select from the list.
 - f. *(Optional)* **Notes:** Type notes related to the selected family member's problem.
6. Click the **Save** button .

Social History

1. From within the Patient Chart, Encounter or Well Visit Note, click **History**.
2. Click the **Social** tab.
Note: If previous social history was entered, the selections display in the Social window.
3. To see additional history questions, click the **Show all questions** checkbox.
4. Make selections for Social History by clicking once for + (Positive), twice for - (Negative) or three times for **N/A**.

Newborn History

1. From within the Patient Chart, Encounter or Well Visit Note, click **History**.
2. Click the **Newborn** tab.

Note: If previous newborn history was entered, the selections display in the Newborn window.

3. To see additional history questions, click the **Show all questions** checkbox.
4. Make selections for Newborn History by clicking once for **+** (Positive), twice for **-** (Negative) or three times for **N/A**.

Birth Info

1. From within the Patient Chart, Encounter or Well Visit Note, click **History**.
2. Click the **Birth Info** tab.

Note: Always follow your Practice policy on what information to complete in the fields below.

3. Complete the following fields:
 - **Birth time:** Type a time or click the up/down arrows to change the time.
 - **Part of multiple birth:** Click this checkbox if part of a multiple birth.
 - **Apgars:** Click in the field and type the Apgars score.
 - **Gestational Age:** Click the drop-down arrow and select from the list
 - **Synagis indicated:** Click the checkbox if Synagis indicated.
 - **Type of delivery:** Click the drop-down arrow and select from the list.
 - **Feeding:** Click the drop-down arrow and select from the list.
 - **Infant blood type:** Click the drop-down arrow and select from the list.
 - **Coombs:** Click the drop-down arrow and select from the list.
 - **Hearing screen:** Click the drop-down arrow and select from the list.
 - **Newborn screen #:** Click in the field and type the Newborn screen number.
 - **Adopted/at:** If adopted, select the checkbox and enter the age in months the patient was adopted in the months field.
 - **Birth Location:** Complete the fields in this section by clicking the drop-down and selecting from the list.
 - **Birth Measurements:** Complete the fields in this section by typing a number or clicking the drop-down and select from the number pad.
 - **Discharge Measurements:** Type a **Discharge Date** or select from the calendar. Complete **Length, Weight** and **Head Circum** by typing a number or clicking the drop-down and select from the number pad.

Maternal/Pregnancy History

1. From within the Patient Chart, Encounter or Well Visit Note, click **History**.

2. Click the **Maternal/Pregnancy** tab.

Note: Always follow your Practice policy on what information to complete.

3. *(Optional)* **Maternal Blood Type / Tests:** Complete the fields in this section by clicking the drop-down and selecting from the list.
4. *(Optional)* **Family of Origin:** Complete the **Marital status** and **Parent relationship** by clicking the drop-down and selecting from the list. Complete **Mother/Father ethnicity** and **Mother's maiden name** by typing in the field.

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Add Clinical Documentation

Well Visit: Visit Info

1. From an open Well Visit Note, click **Visit Info**.
2. Review and make edits, as necessary, to the **Accompanied by** field.
3. *(Optional)* **Telehealth:** Complete the fields below
 - a. **Provider Location:** Click the drop-down arrow and select from the list.
 - b. **Patient Location:** Click the drop-down arrow and select from the list.

Note: Once the Provider Location and Patient Location fields are completed, the Place of Service field updates to **Telehealth**.

Well Visit: Interval History/ROS

1. From an open Well Visit Note, click **Interval Hx**.

Note: Always follow your Practice policy on what information to complete in the fields below.
2. **Interval History:** The age-specific template questions display in this field. Click in the field to change the responses or add additional information.
3. **ROS:** Questions and/or Symptoms are set to Pert. Click once for **Reports**, twice for **Denies** or three times for **Skip**.

Note: If you set a ROS question or symptom as Skip the question is removed from selection for the visit.

Encounter: Visit Info

1. From an open Encounter Note, click **Visit Info**.
2. Review and make edits, as necessary, to the **Accompanied by** field.
3. *(Optional)* **Independent historian:** Click the drop-down arrow and select from the list or click in the field and type who is providing patient history to the provider.

Note: This field is used in the MDM calculation.

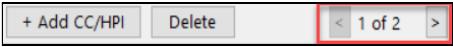
4. (Optional) **Assisted by translator:** Select the checkbox to indicate a translator assisted the provider.
5. (Optional) **Telehealth:** Complete the fields below
 - a. **Provider Location:** Click the drop-down arrow and select from the list.
 - b. **Patient Location:** Click the drop-down arrow and select from the list.

Note: Once the Provider Location and Patient Location fields are completed, the Place of Service field updates to **Telehealth**.

Encounter: CC/HPI/ROS

1. From an open Encounter Note, click **CC/HPI/ROS**.

Note: Always follow your Practice policy on what information to complete in the fields below.
2. **CC:** The template complaint displays in this field. Click in the field to type additional information.
3. **HPI:** The template HPI questions display in this field. Click in the field to complete or type additional information.
4. Click the **+ Add CC/HPI** button to add an additional CC/HPI without layering another template. Or, if an additional template will be layered, click into the All Templates field and search for and select the template.

Note: When more than one CC/HPI is added, the toggle button is used to navigate through what has been applied to the Encounter. To remove an added CC/HPI, click the **Delete** button after confirming you are on the correct form .
5. **ROS:** Questions and/or Symptoms may be set to Reports or Denies by the template. All other Questions and/or Symptoms relevant to the complaint are set to Pert. Click once for **Reports**, twice for **Denies** or three times for **Skip**.

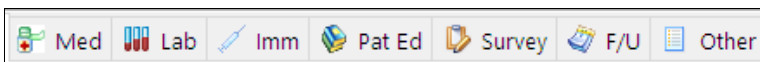
Note: If you set a ROS question or symptom as Skip, the question is removed from selection for the visit.

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Add and Complete Tasks

Add a Task from the Order Worksheet

1. From within an Encounter Note click **Orders**, or from within a Well Visit Note, click **Plan/Orders**. The Worksheet Summary populates by the template and by what is entered into each tab of the worksheet:




- Note:** Med, Pat Ed, F/U, and Other are not typically entered by clinical staff.
2. To add a task for a **Lab**:
 - a. Click the **Lab** tab.

- b. If the lab is listed, select the **Add** checkbox.
 - c. If the lab is not listed:
 - i. Click the **Add** button.
 - ii. Type the test name in the **Diagnostic Test Name** field.
 - iii. Select the test.
 - iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
 - v. Confirm that the **Add** checkbox is selected.
 - vi. Click the **Save** button.
 - d. Repeat the above procedures to add other diagnostic tests.
 - e. Click the **Create** button.
 - f. Click the **OK** button to create a task for the diagnostic test.
3. To add a task for an **Immunization**:
- a. Click the **Imm** tab.
 - b. If the vaccine is listed, click the radio button in the **Tdy** column.
 - c. If the vaccine is not listed:
 - i. Click the **Add** button.
 - ii. Type the name of the vaccine in the **Vaccine Name** field.
 - iii. Select the vaccine.
 - iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
 - v. Click the **Save** button.
 - d. Repeat the above procedures to add other vaccines.
 - e. Click the **Create** button.
 - f. Click the **OK** button to create a task for the vaccine.
4. To add a task for a **Survey**:
- a. Click the **Survey** tab.
 - b. If the survey is listed, select the **Add** checkbox.
 - c. If the survey is not listed:
 - i. Click the **Add** button.
 - ii. Type the name of the survey in the **Survey Name** field.
 - iii. Select the survey.
 - iv. Confirm the **Department**. Click the drop-down arrow if you need to change it.
 - v. Click the **Save** button.
 - d. Repeat the above procedures to add other surveys.

- e. Click the **Create** button.
- f. Click the **OK** button to create a task for the survey.

Complete a Task from the Tracking Window

1. Access the Tracking window: **Clinical, Practice Management, or Billing tab > Schedule button > Tracking radio button.**
2. Select a patient.
3. Click the **Tasks** button .
4. Double-click to select and complete the task.

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