

Student Provider Document Creation in Cerner

Introduction

Student Providers include medical, PA, and NP students.

Student Providers will be allowed to document in the Electronic Medical Record (EMR) in one of two ways:

A. Student providers may create notes that are primarily educational in nature, which will fall under the Note Type of **Student Provider Note** as cataloged in the Cerner EMR. All student providers are allowed to use this method.

B. Student providers may function as scribes for their supervising licensed providers. The supervising provider will be the author of record for the note, which will be cataloged in the Cerner EMR by the type of note created (e.g., Internal Medicine Progress Note, Pediatrics Office Clinic Note, History and Physical, etc.). The explicit goal of this method is to provide the most meaningful educational experience possible for the student provider in clinical settings where the Student Provider Note method would less-effectively facilitate this experience. First and second year medical students are NOT allowed to use this method.

Student providers will be instructed at the beginning of each clinical rotation which method is to be employed, or if this decision will be left up to each supervising provider. The **Student Provider Note** method will be the default unless the student provider is explicitly instructed to utilize the **Student Provider As Scribe** method.

There are two approaches to creating notes in Cerner Millennium: Dynamic Documentation (AKA DynDoc) and PowerNote. The newer DynDoc method will be used in most cases, while there are some clinical settings where PowerNote will still be used in at least the near future. Students will be told on each clinical rotation which approach to follow. Other lessons will go into detail about each of these approaches. Illustrations below use the DynDoc approach.

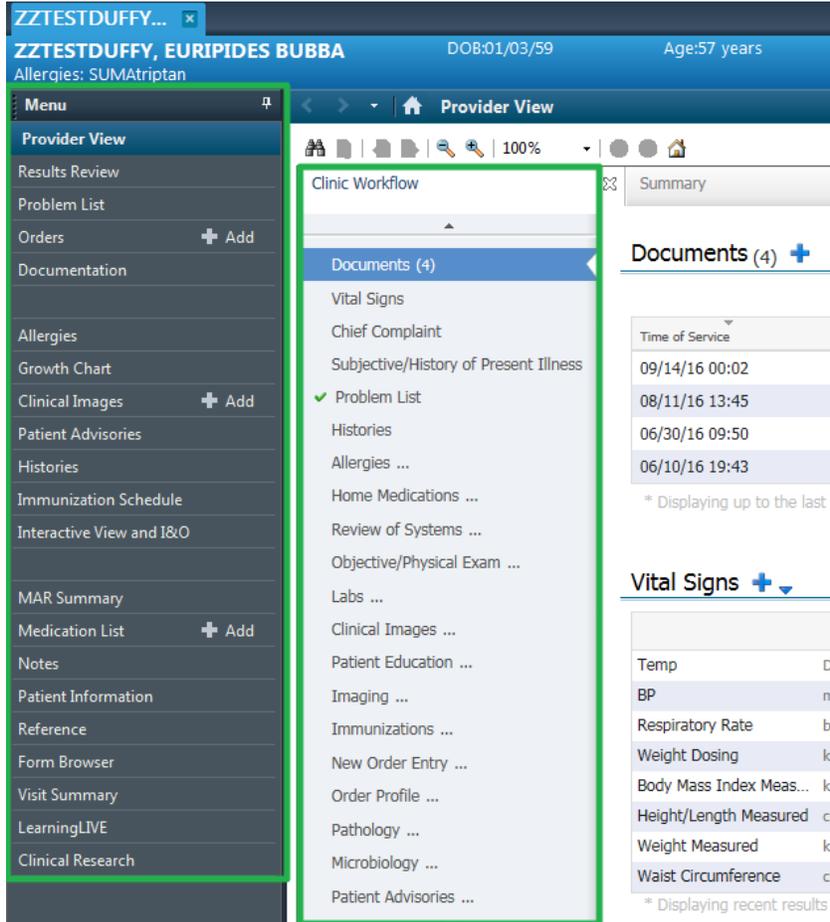
STUDENT PROVIDER NOTE METHOD

This approach creates primarily educational notes, though attendings may choose to reference the review of systems and past family/social/medical history from the student provider's note if desired. Residents are NOT to reference student provider notes; residents are expected to create original documentation.

This method will be the norm on rotations that include student providers, residents, and attendings.

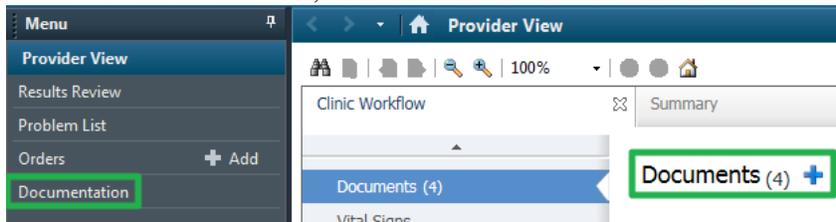
Student providers will participate in the "gathering" of structured data, just like other staff members. This includes information like allergies, current medications, past

medical/surgical/family/social history, etc., which can be accessed via the Table of Contents Menu or via workflow tabs:

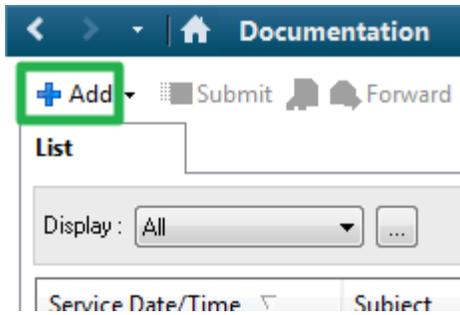


(In the future, some of this information may actually be directly entered by the patient, via patient portal or tablet devices in the office.)

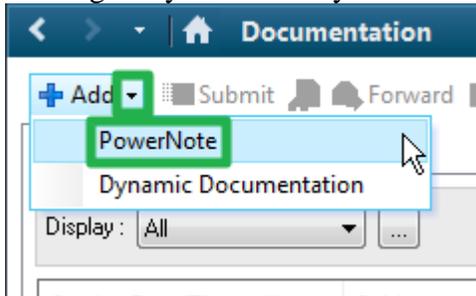
When it is time to create a visit note (inpatient or outpatient), begin by opening the **Documentation** section, either on the Table of Contents or a workflow tab:



In most venues, we'll be using the DynDoc method of note creation. Begin by clicking **+Add**:

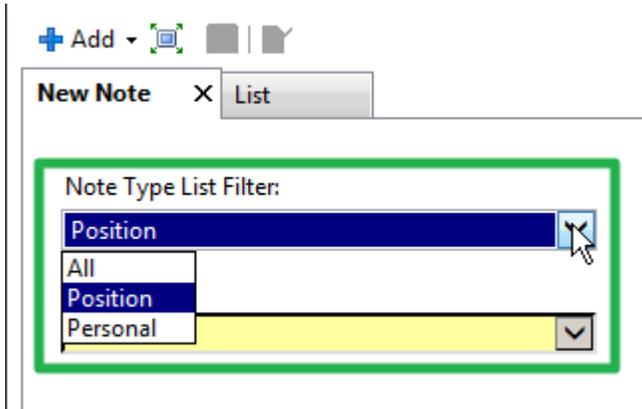


In a few venues, PowerNote will be used for the near future. (You'll be instructed to do this on rotations where this is expected.) To create a PowerNote, notice that the dropdown arrow next to **+Add** gives you the ability to create a PowerNote:

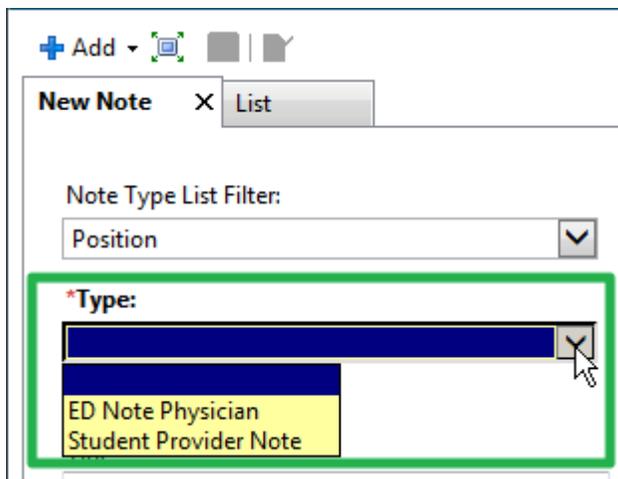


But for the rest of this illustration, we'll use DynDoc.

After clicking **+Add**, a New Note tab will open. The **Note Type List Filter** may be set to **Position**:



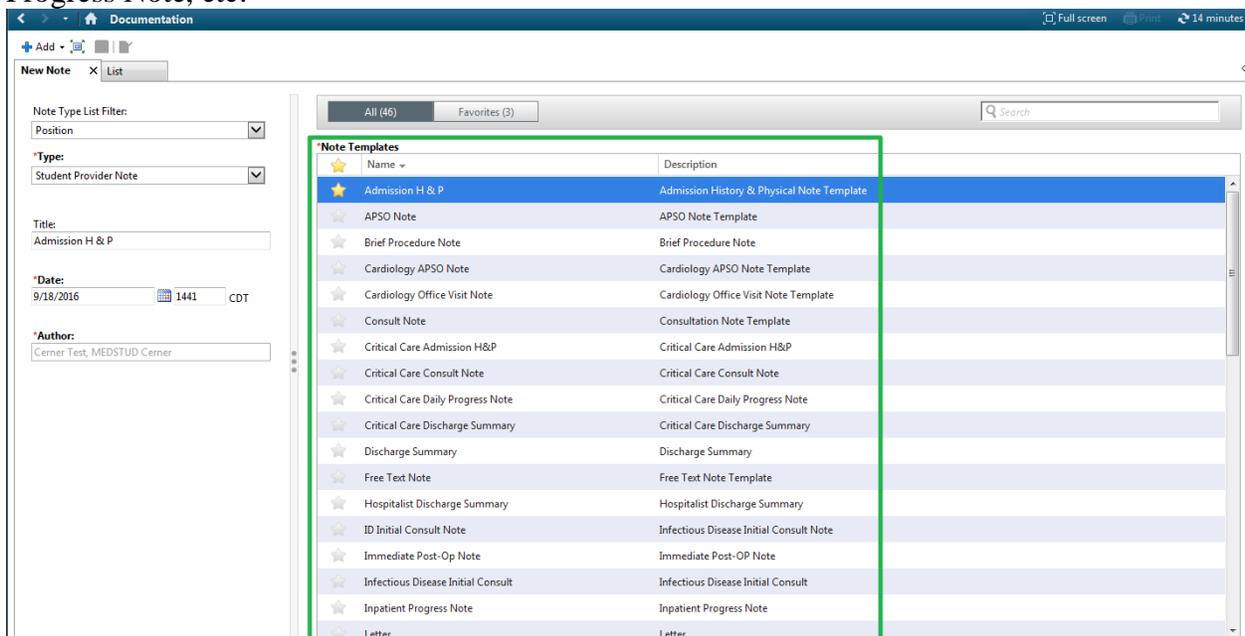
This gives you a very short list of **Type** options:



For this method of documentation, select **Student Provider Note**. (If the **Note Type List Filter** is set to **All** you'll see a much longer list, which is sometimes necessary, but you can still find **Student Provider Note**.)

Note Type helps categorize notes on document lists; think of them as file folder tabs for things like Pediatrics Office Visit Note, History and Physical, Discharge Summary, etc. In this case, student provider's documents will be filed under the category of **Student Provider Note**.

To the right is a list of available **Note Templates**. As the name implies, these are templates that determine the structure or layout of the note. Examples are Admission H&P, Office Visit Note, Progress Note, etc:



You'll have to scroll down to see all of the possibilities.

At first it's hard to keep **Note Type** and **Note Template** straight. To reiterate, **Note Type** is the heading the note is filed under; **Note Template** is the structure or layout of the note.

Often, you'll only need to use a small handful of **Note Templates**. You can click the **Star** to add them to your Note Template **Favorites** list:

All (46) Favorites (3)

***Note Templates**

★	Name ▾
★	Admission H & P
★	APSO Note
★	Brief Procedure Note

When you click on the **Favorites** tab, you'll see a shorter list with just your Favorites:

All (46) Favorites (3)

***Note Templates**

★	Name ▾	Description
★	Admission H & P	Admission History & Physical Note Template
★	Office Visit Note	Office Visit Note Template
★	Progress Note	Daily Progress Note Template

Whether using the **All** or the **Favorites** tabs, double-click the template you wish to use. In this example, we'll use **Office Visit Note**:

All (46) Favorites (3)

***Note Templates**

★	Name ▾	Description
★	Admission H & P	Admission History & Physical Note Template
★	Office Visit Note	Office Visit Note Template
★	Progress Note	Daily Progress Note Template

The note will generate. Often there are sections with all of the “structured data,” seen here on the right, and other sections with all of the information specific to this visit, here seen on the left:

Information that has been entered on the workflow tabs will display under appropriate headings. But you don't *have* to enter anything in those workflow tabs—you can generate the note, and directly add the information here, via typing, AutoText, or potentially via voice transcription. We'll flesh out some information for this example:

If you're interrupted or need to work on something else, you can **Save** the note and come back to it. But when you're done, click **Sign/Submit**.

In the following window, select the attending, either by searching or use of the **Recent** or **Favorites** contacts lists:

Sign/Submit Note

*Type: Student Provider Note Note Type List Filter: Position

*Author: Cerner Test, MEDSTUD Cerner Title: Office Visit Note *Date: 9/18/2016 1441 CDT

Forward Options

Favorites Recent Relationships

Contacts	Recipients
Default Name	Default Name Comment Sign Review/CC
<input checked="" type="checkbox"/> Cerner Test, Drfamilymed02 C... Unspecified - Physician - Famil...	<input checked="" type="checkbox"/> Duffy MD, Robert Lamar Primary Care Physician, Attending P...
<input checked="" type="checkbox"/> Cerner Test, Eddr Cerner Unspecified - Physician - Emer...	
<input checked="" type="checkbox"/> Cerner Test, Physosp Cerner Unspecified - Physician - Hosp...	
<input checked="" type="checkbox"/> Cerner Test, Physim Cerner Unspecified - Physician - IM	
<input checked="" type="checkbox"/> Cerner Test, Physpcp Cerner Covering Physician - Physician ...	
<input checked="" type="checkbox"/> Duffy MD, Robert Lamar Primary Care Physician, Attending...	

Submit Cancel

You might instead select a resident, if instructed to do so by rotation supervisors/instructors.

After that click **Submit**, and the student provider is done.

We'll now review the supervising provider's workflow to sign off this note

The student provider's note will come to your inbox:

Sign X

Communicate Open Message Journal Sign All Review All Forward Only Select Patient Select All

Patien Name	Assigned	Author	Create Date	Description	Description-Subject	Due Date	From
ZZTESTDUFFY, EURIPIDES BU...	Duffy MD, Rob...	Cerner Test, MEDSTUD Cerner	9/18/2016 3:22:37 PM CDT	Student Provider Note	Student Provider Note - Office Visit Note		Cerner Test, MEDSTUD C...
ZZTESTDUFFY, BATHSHEEBA S...	Duffy MD, Rob...	Cerner Test, RESIDENTI Cerner	9/17/2016 11:57:00 AM CDT	Family Practice Office Clin...	Family Practice Office Clinic Note - Office Visit Note		Cerner Test, RESIDENTI C...
ZZTESTDUFFY, ANASTHASIA G...	Duffy MD, Rob...	Cerner Test, RESIDENTI Cerner	9/13/2016 7:04:15 PM CDT	Family Practice Office Clin...	Family Practice Office Clinic Note - Office Visit Note		Cerner Test, RESIDENTI C...
EDUMAT, NANCY	Duffy MD, Rob...	Cerner Test, Physosp Cerner	9/9/2016 9:26:19 AM CDT	History and Physical	History and Physical - Admission H & P		Cerner Test, Physosp Ce...
ZZTESTDUFFY, BABYBERTHA B...	Duffy MD, Rob...	Cerner Test, RESIDENTI Cerner	8/25/2016 3:48:43 PM CDT	Family Practice Office Clin...	Family Practice Office Clinic Note - Office Visit Note		Cerner Test, RESIDENTI C...
ZZTESTDUFFY, ANASTHASIA G...	Duffy MD, Rob...	Cerner Test, RESIDENTI Cerner	8/25/2016 3:36:59 PM CDT	Progress Note Generic	Progress Note Generic - SOAP Note: Simple		Cerner Test, RESIDENTI C...
THIRDDITEST, FIFTEEN	Duffy MD, Rob...	Cerner Test, Physosp Cerner	8/24/2016 1:31:28 PM CDT	Progress Note Generic	Progress Note Generic - Free Text Note		Cerner Test, Physosp Ce...
THIRDDITEST, FOUR	Duffy MD, Rob...	Cerner Test, Physosp Cerner	8/24/2016 12:01:50 PM C...	Radiation Therapy Progr...	Radiation Therapy Progress Note - APSO Note		Cerner Test, Physosp Ce...
ZZTEST, BIANCA	Duffy MD, Rob...	Cerner Test, HMMGR Cerner	8/23/2016 1:17:29 PM CDT	Stress ECG	Stress ECG -		
THIRDDITEST, THIRTEEN	Duffy MD, Rob...	Cerner Test, Physosp Cerner	8/23/2016 12:00:26 PM CDT	History and Physical	History and Physical - Admission H & P IT# Testing		Cerner Test, Physosp Ce...
ZZTEST, KENYETTA	Duffy MD, Rob...	Cerner Test, Physosp Cerner	8/11/2016 3:49:51 PM CDT	Admission Note Physician	Admission Note Physician - Pediatric Intensive Care...		Cerner Test, Physosp Ce...
ZZTESTDUFFY, DOORNOBIA B...	Duffy MD, Rob...	Cerner Test, MEDSTUD Cerner	7/21/2016 4:59:53 PM CDT	Medical Student Note	Medical Student Note - General Admission H&P		Cerner Test, MEDSTUD Ce...
ZZTEST, BIANCA	Duffy MD, Rob...	Duffy MD, Robert Lamar	7/15/2016 1:40:08 PM CDT	Coding Query	Coding Query		Cerner Test, HMMGR C...

*** Preliminary Report ***

Chief Complaint
Cough

Assessment/Plan
Pharyngitis

History of Present Illness
57 year old male with 4 day history of cough, sore throat, runny nose, aching, & subjective fever. No N/V/D. The cough is mild & non-productive, but the sore throat has worsened by the day. Appetite down. History of allergic rhinitis, which sometimes causes a mild cough. Continues to smoke.

Review of Systems
Constitutional: [No measured fever].
ENMT: [Clear nasal drainage; worsening sore throat].
Respiratory: [Mild cough. No dyspnea].
Cardiovascular: [No chest pain, palpitations, or edema].
Gastrointestinal: [No abdominal pain, diarrhea, nausea, or vomiting].
Genitourinary: [No dysuria].
Neuro: [No dizziness, headache, or focal weakness].
Integumentary: [No pruritus or rash].
Musculoskeletal: [No joint pain or neck/back pain; generalized muscle aching].
Hema/Lymph: [No lymphadenopathy].

Physical Exam
Vitals & Measurements
T: 37.0 °C (Tympanic) HR: 80 (Peripheral) RR: 16 BP: 140/80 HT: 175.5 cm WT: 71 kg (Measured) BMI: 23

Problem List/Past Medical History
Allergic rhinitis
Migraines
Historical
No historical problems

Procedure/Surgical History
Procedure on ankle (ORIF right ankle.)

Medications
amitriptyline 50 mg oral tablet, 50 mg, 1 tabs, Oral, HS
fluticasone 50 mcg/inh nasal spray, 1 sprays, Nasal, BID

Allergies
SUMATriptan (Flushing)

Social History
Alcohol
Current user, 1-2 times per week
Employment/School
Employed, Work/School description: Crime scene eradicator..

Exercise
Minutes per day: 30. Days per week: 7. Physical Activity Intensity: Moderate. Exercise type: Running.

Home/Environment
Lives with Spouse. Marital Status of Patient if Patient Independent Adult:

In general, Student Provider Notes are not considered part of the official medical record, and are just here to be discussed/reviewed with the student for educational purposes. After doing so, the resident or the attending simply signs them off as you would any other note.

Residents may sometimes be asked to assist in this teaching function. However, residents are NOT to use any part of Student Provider Notes as part of their own documentation; residents should create their own notes separately.

When attendings are working directly with student providers, with no resident involved, the most straightforward workflow is to do the same thing: Don't reference the student provider note at all, and create your own note separately.

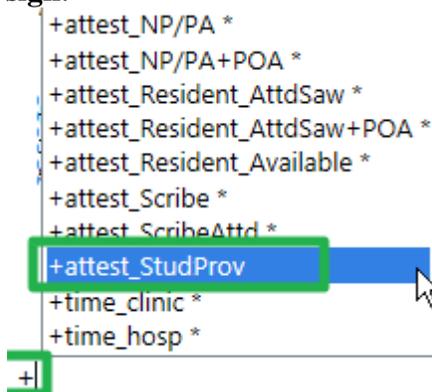
However, it is permissible for attendings to reference certain portions of a Student Provider Note to support the attending's documentation. The allowed sections are:

Review of systems

Past medical, family, and social histories.

HPI, physical exam, and assessment/plan sections of the note must be documented independently by the attending. (Structured data like med and allergy lists will be automatically incorporated into the note if used in the chosen document template.)

If an attending chooses to reference these permissible Student Provider Note sections, the attending must apply the proper attestation, which can be called up via AutoText by typing the + sign:



Select **+attest_StudProv***, which adds this statement:

Attending Attestation: I have reviewed the student provider's documentation of the review of systems and past, family and social histories. I have performed and documented all other elements of the service. See my separate note, with any exceptions and/or additions I have made to the student-documented elements. |

But again, you only need to do this if the attending is creating his/her own note, and wishes to reference the student provider's ROS/PFSH. If you're not doing that, simply sign off the note without adding an attestation.

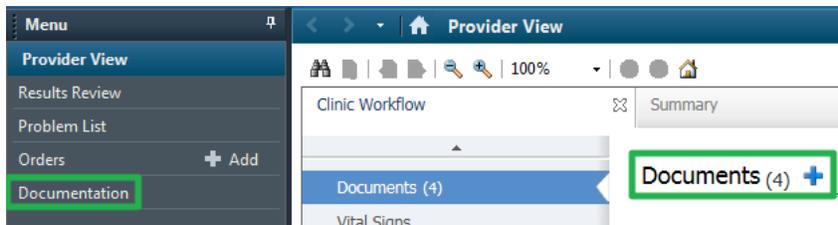
STUDENT PROVIDER AS SCRIBE METHOD

In some settings the above approach may not be especially practical. This is particularly true when student providers are working directly with attendings, with no residents involved. In these cases, we allow the option for the student provider to function as a scribe for the attending, to afford the student provider a more hands-on educational experience. Student providers will be instructed whether or not this method will be used at the onset of each clinical rotation, and/or by the supervising provider. Student providers will never, however, function as scribes for residents.

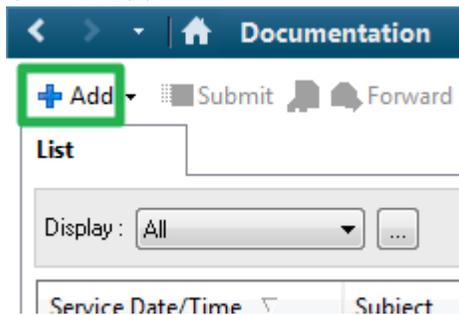
As before, the student provider may participate in the gathering and entering into the EMR of structured data elements—past medical history including medication and allergy lists, social history, and family history. The student provider may also assist the supervising provider in the navigation of the EMR and the location and retrieval of information.

Typical workflow might be for the student provider to see the patient, collect, and document structured data elements listed above. The student provider could then discuss history of present illness with the patient, perform a physical exam, and think through an assessment and plan—but *not yet document these HPI, PE, and A&P items*. The student provider would next present the patient to the supervising provider, and then go into the room with the supervising provider as HPI, PE, and A&P are confirmed and further clarified. After the supervising provider has ascertained these details, the supervising provider will instruct the student provider to document these items as discussed, using the Note Type instructed. An illustration follows utilizing Dynamic Documentation; if using PowerNote, while the note creation method will be different, the attestation steps will be the same.

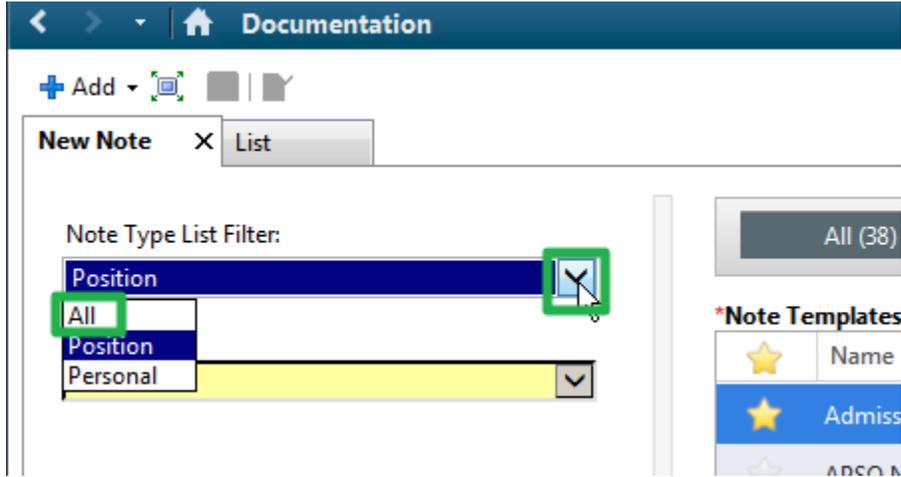
Having received those instructions, the student provider begins documentation as before, through the **Documents** or **Documentation** link on the workflow tab or Table of Contents:



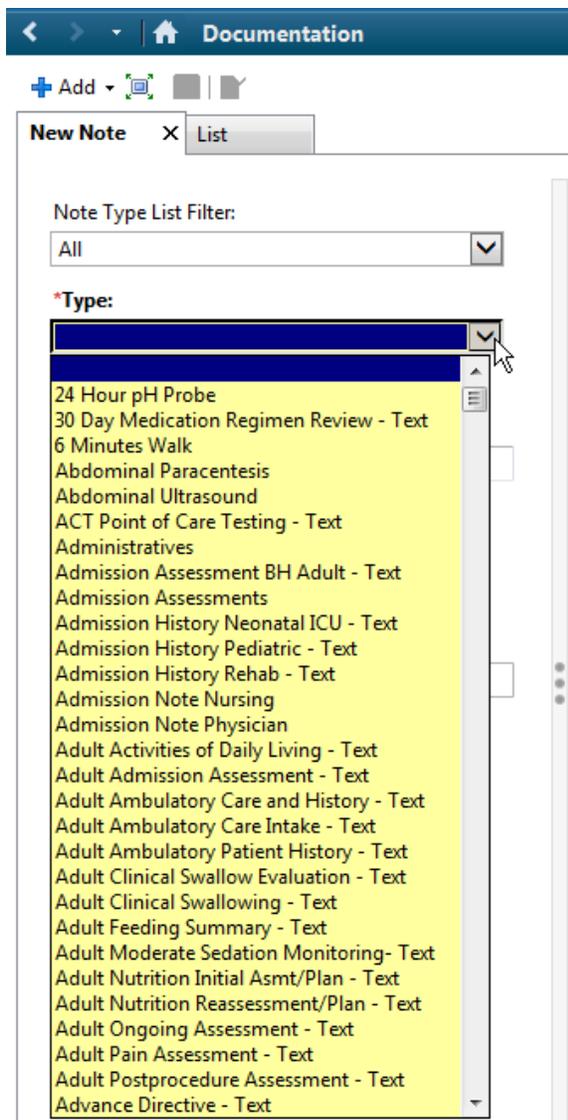
Click **+Add**:



After clicking +Add, a New Note tab will open. If necessary, set the **Note Type List Filter** to **All**:

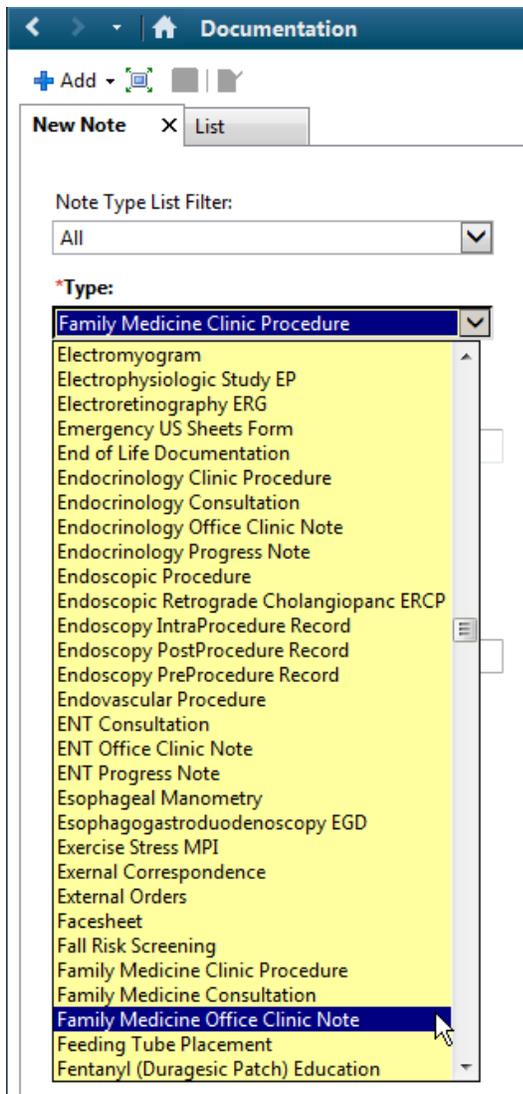


The **Type** list will be very long:



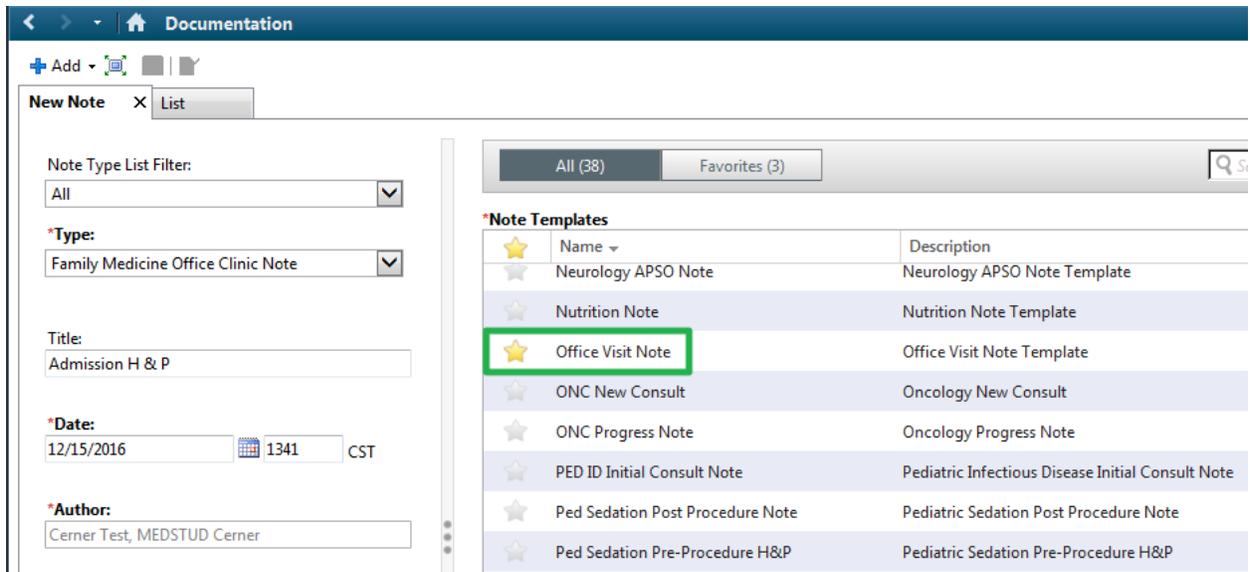
~~~~~  
*TIP:* See the **Note Type** lesson for a way to create a short Personal Note Type List for Note Types you use frequently.  
~~~~~

For this example, we'll say the student provider is working with an attending in the Family Medicine office, and the attending instructs to use the **Family Medicine Office Clinic Note**. Rather than scrolling through the long list, type **fam**, and you'll jump down to that part of the list, where you'll only need to scroll a couple clicks more to select **Family Medicine Office Clinic Note**:



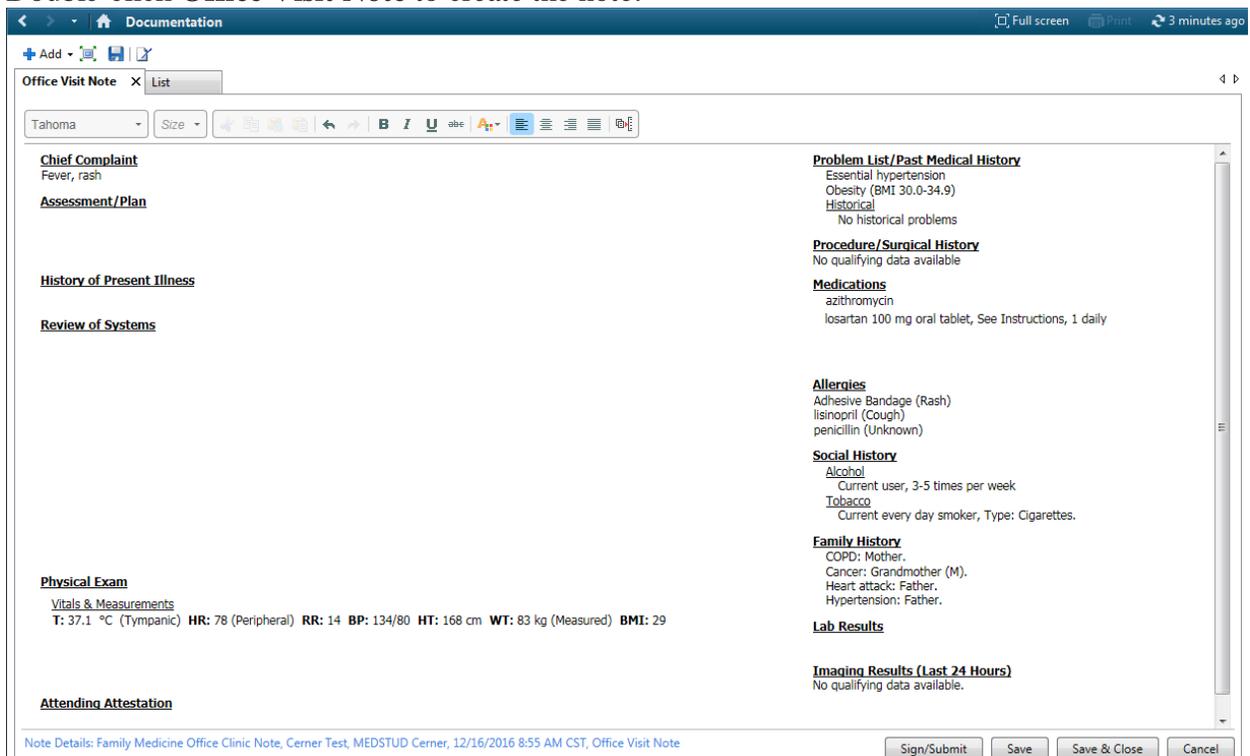
Double-click that.

The student provider will be instructed which template to use to construct the note. In this example we'll use the **Office Visit Note** template:



In the example above we've also clicked the **Star**, to add it to your favorites so you can find it faster the next time.

Double-click **Office Visit Note** to create the note:



The start of the note is generated. Many note templates will contain all of the “structured data” parts of the medical record, such as the problem list, med list, allergies, and past medical/family/social history. Often those will be the items on the right side of the chart, with notes specific to today’s encounter on the left. On the left, the review of systems might be

complete if it was done earlier by the staff or student provider, but the HPI, physical exam, and assessment/plan sections will be blank, since the student provider has only just now been instructed what to document there by the supervising provider.

The student provider adds the necessary data as jointly discussed with the supervising provider. (Details of DynDoc creation are covered in other training materials.):

The screenshot shows a web-based medical documentation interface. The main content area is titled 'Office Visit Note' and contains a patient's medical history and physical exam findings. The right-hand sidebar provides a structured overview of the patient's record, including historical problems, surgical history, medications, allergies, social history, family history, lab results, and imaging results. The interface includes a rich text editor at the top and a navigation bar at the bottom with buttons for saving and submitting the note.

If you're interrupted or need to work on something else, you can **Save** the note and come back to it later. But when the note is complete, scroll down to the **Attestation** area. Type **+a**, which will bring up the list of attestations we use:

Physical Exam

Vitals & Measurements

T: 37.1 °C (Tympanic) HR: 78 (Periphera

- General: [In modest distress]
- HENT: +attest_NP/PA *
- Neck: +attest_NP/PA+POA *
- Lun: +attest_Res_AttdAvail *
- Hea: +attest_Res_AttdAvailOnsite *
- Abd: +attest_Resident_AttdSaw *
- Ext: +attest_Resident_AttdSaw+POA *
- Neu: +attest_Scribe *
- Skir: +attest_ScribeAttd *
- Mus: +attest_StudProv *
- Atte: +attest_StudProvScribe *

+a]

Double-click **+attest_StudProvScribe**, to add this statement:

Attending Attestation

I am recording for, and in the presence of, Dr. (INSERT PROVIDER NAME)

Note Details: Family Medicine Office Clinic Note, Cerner Test, MEDSTUD Cerner, 12/16/20

Change (INSERT PROVIDER NAME) to your supervising provider. Then click **Sign/Submit**:

Skin: [Dusky macular rash on torso, upper arms, thighs. Numerous crusted papules suggestive of resolving insect bites.]
Musculoskeletal: [Diffuse muscle & joint pains, but no frank effusions noted.]

Attending Attestation

I am recording for, and in the presence of **Dr. Duffy.**

Note Details: Family Medicine Office Clinic Note, Cerner Test, MEDSTUD Cerner, 12/16/2016 8:55 AM CST, Office Visit Note

Sign/Submit Save Save & Close Cancel

This brings up the **Sign/Submit** screen:

The screenshot shows the 'Sign/Submit Note' window. At the top, there are dropdown menus for 'Type' (Family Medicine Office Clinic Note) and 'Note Type List Filter' (All). Below these are fields for 'Author' (Cerner Test, MEDSTUD Cerner), 'Title' (Office Visit Note), and 'Date' (12/16/2016 0855 CST). A 'Forward Options' section includes 'Favorites', 'Recent', and 'Relationships' tabs, along with a search bar for 'Provider Name'. The 'Contacts' list on the left includes several entries, with 'Duffy MD, Robert Lamar' selected. The 'Recipients' table on the right is currently empty. A message at the bottom states: 'Select at least one Recipient as a signer before you Submit.' Buttons for 'Submit' and 'Cancel' are at the bottom right.

★	Default	Name	Comment	Sign	Review/CC
★	<input checked="" type="checkbox"/>	Cerner Test, Drfamilymed02 C...			
★	<input checked="" type="checkbox"/>	Unspecified - Physician - Famil...			
★	<input checked="" type="checkbox"/>	Cerner Test, Eddr Cerner			
★	<input checked="" type="checkbox"/>	Unspecified - Physician - Emer...			
★	<input checked="" type="checkbox"/>	Cerner Test, Physhosp Cerner			
★	<input checked="" type="checkbox"/>	Unspecified - Physician - Hosp...			
★	<input checked="" type="checkbox"/>	Cerner Test, Physim Cerner			
★	<input checked="" type="checkbox"/>	Unspecified - Physician - IM			
★	<input checked="" type="checkbox"/>	Cerner Test, Physpcp Cerner			
★	<input checked="" type="checkbox"/>	Unspecified - Physician - Prim...			
★	<input checked="" type="checkbox"/>	Duffy MD, Robert Lamar			
★	<input checked="" type="checkbox"/>	Primary Care Physician, Attend...			

Add your supervising attending, either through searching, your recent contacts list, or favorites:

Sign/Submit Note

*Type: Family Medicine Office Clinic Note Note Type List Filter: All

*Author: Cerner Test, MEDSTUD Cerner Title: Office Visit Note *Date: 12/16/2016 0855 CST

Forward Options

Favorites Recent Relationships Provider Name

Contacts	Recipients																								
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<input checked="" type="checkbox"/>	Duffy MD, Robert Lamar Primary Care Physician, Attending P...		<input checked="" type="radio"/>	<input type="radio"/>																					

Submit Cancel

Then click **Submit**, and the student provider is done.

We'll now review the **Attending's workflow to sign off this note**

The student provider's note will come to your inbox:

Message Center

Inbox Summary

Sign x

Communicate Open Message Journal Sign All Review All Forward Only Select Patient Select All

Patient Name	Assigned	Author	Create Date	Description	Description-Subject	Due Date	From
ZZCERT, FM-ONE	Duffy MD, Ro...	Cerner Test, MEDSTUD Cerner	12/16/2016 9:54:03 AM C...	Family Medicine Office C...	Family Medicine Office Clinic Note - Office Visit ...		Cerner Test, MEDSTUD
ZZCERT, EEM-TEST	Duffy MD, Ro...	CPDI Service, CPDI Service C...	12/12/2016 2:15:25 PM C...	Consultation Note Generic	Consultation Note Generic -		Wislow Consultant, Kri
ZZTEST, MC	Duffy MD, Ro...	Cerner Test, Drped01 Cerner	12/7/2016 11:40:42 AM C...	Pediatrics Office Clinic N...	Pediatrics Office Clinic Note - Office Visit Note		Cerner Test, Drped01

* Preliminary Report *

Chief Complaint
Fever, rash

Assessment/Plan
Scrub typhus
Discussed with patient & wife. CBC, BMP, immunofluorescence studies, CXR today. Given the Wikileaks reports of tetracycline resistance in SE Asia, will start azithromycin. Fluids, diet as tolerated; acetaminophen for fever & body aches. Advised that this is not contagious to others. Call or return to clinic if developing shortness of breath, protracted vomiting, intractable fever, significantly worsening headaches, or changes in mentation. Otherwise, recheck 1 wk.

Problem List/Past Medical History
Essential hypertension
Obesity (BMI 30.0-34.9)
Historical
No historical problems

Procedure/Surgical History
No qualifying data available

Medications

Double-click the sign-off request to open it in a new window:

Sign x FORWARDED SIGN DOC: ZCZCERT, FM-ONE x

Forward Only Print Select Patient Mark Unread Inb_x View Summary View

ZCZCERT, FM-ONE DOB:07/16/80 Age:36 years Dose Wt:Error **Modify** Sex:Male MRN:100004086 Attending:Duffy MD, Robert Lamar
 Allergies: penicillin, Adhesive Bandage, li... Error Isolation:Error Clinic FIN: 1200291940 [Visit Dt: 12/7/2016 8:53 AM] Visit Reas...Loc:Family Medicine Error

*** Preliminary Report ***

Chief Complaint
Fever, rash

Assessment/Plan
Scrub typhus
Discussed with patient & wife. CBC, BMP, immunofluorescence studies, CXR today. Given the Wikileaks reports of tetracycline resistance in SE Asia, will start azithromycin. Fluids, diet as tolerated; acetaminophen for fever & body aches. Advised that this is not contagious to others. Call or return to clinic if developing shortness of breath, protracted vomiting, intractable fever, significantly worsening headaches, or changes in mentation. Otherwise, recheck 1 wk.

History of Present Illness
36 year old male who developed fever to 103, headache, myalgias, nausea, nonproductive cough, & loose stools yesterday upon return from a mission trip to the East Asian island of Abductistan. Prior to this he recalls a dusky red rash & numerous insect bites. No vomiting, dysuria, sore throat reported. None of the rest of the party had similar symptoms, but he's not been in contact with them after their return. No sexual contacts on the trip. No similar illnesses in the past, & medical history has been remarkable mainly for smoking & HTN. Slight relief with acetaminophen.

Review of Systems
Constitutional: [Positive fever].
ENMT: [No nasal drainage or sore throat].
Respiratory: [Nonproductive cough; no dyspnea].

Problem List/Past Medical History
Essential hypertension
Obesity (BMI 30.0-34.9)
Historical
No historical problems

Procedure/Surgical History
No qualifying data available

Medications
losartan 100 mg oral tablet, See Instructions, 1 daily
azithromycin 250 mg daily

Allergies
Adhesive Bandage (Rash)
lisinopril (Cough)
penicillin (Unknown)

Social History

You can review the note here if you like. To sign off the note, click the **Modify** button at the top, shown above. That opens the note in a manner where you can review it further, and add further notes, deletions, or corrections as necessary via typing, AutoText, or Dragon transcription.

When done, place your cursor in the **Attestation** section under the student provider's line:

Attending Attestation ← ×

I am recording for, and in the presence of, Dr. Duffy.

I

Type **+a** to bring up the attestation AutoTexts, and double-click **+attest_ScribeAttd**:

General: [In modest distress].
 HENT: [Ear canal without excessive wax] or inflamma
 Neck: +attest_NP/PA * s, but there
 Lung: +attest_NP/PA+POA * clearing with
 Heart: +attest_Res_AttdAvail * murmur].
 Abdo: +attest_Res_AttdAvailOnsite *
 Extre: +attest_Resident_AttdSaw *
 Neu: +attest_Resident_AttdSaw+POA * deficits. Bala
 Skin: +attest_Scribe * er arms, thig
 Mus: +attest_Scribe * pains, but ne
 +attest_ScribeAttd *
 +attest_StudProv *
 +attest_StudProvScribe *
 I am recording for, and in the presence of, Dr. Duffy.
 +a

This inserts the attending attestation line needed to be paired with the student provider's line to comply with requirements for scribed documentation. (This same attestation is used when working with an employed scribe as well.):

Attending Attestation
I am recording for, and in the presence of, Dr. Duffy.
The documentation recorded herein accurately and completely reflects the services I personally performed and the decisions made by me, in compliance with regulatory requirements.]

Note Details: Family Medicine Office Clinic Note, Cerner Test, MEDSTUD Cerner, 12/16/2016 8:55 AM CST, Unauth, Office Visit Note

Sign/Submit Save Save & Close Cancel

When done, click **Sign/Submit**. The **Sign/Submit** window opens. You can create a letter, or forward the note to other providers if desired. But when done, click **Sign** to complete the sign-off process:

When viewed on a document list, the attestation and electronic signature for both the student provider and supervising provider will display:

Attending Attestation
 I am recording for, and in the presence of, Dr. Duffy.
 The documentation recorded herein accurately and completely reflects the services I personally performed and the decisions made by me, in compliance with regulatory requirements.

Signature Line
 Electronically Signed on 12/16/16 04:30 PM

Duffy MD, Robert L

Electronically Signed on 12/16/16 09:54 AM

Cerner Test, MEDSTUD Cerner

Result type: Family Medicine Office Clinic Note
 Result date: December 16, 2016 08:55 CST
 Result status: Auth (Verified)
 Result title: Office Visit Note
 Performed by: Duffy MD, Robert L on December 16, 2016 16:30 CST
 Verified by: Duffy MD, Robert L on December 16, 2016 16:30 CST
 Encounter info: 1200291940, Family Medicine, Clinic, 12/07/16 - 12/07/16

(Yes, it would be nice if each person's signature fell directly under that person's attestation, but it just doesn't work out that neatly. But all the required elements are there, and that's what's most important.)

A FEW WORDS ABOUT ORDERS

Regardless of how notes are created, student providers are allowed to "propose" (AKA "pend") orders if directed to do so by the supervising provider. Such orders are not visible to staff, and thus are not executable, until they have been signed off by the supervising provider.

It is left to the clinical rotation's policies and/or the supervising provider's preference as to whether to employ this workflow. In reality, in most cases the attending (or residents when available) will likely be able to directly place orders as fast or faster than they could sign off a student provider's proposed orders, especially using Quick Orders or Favorites.

During a downtime scenario when a paper order process has been implemented, student providers will not be allowed to propose orders.
