

NEXTGEN WORKFLOW DEMONSTRATION

Adult Patient With Bronchitis, Hypertension, & Diabetes

This example works through a sample adult encounter on a patient with a combination of acute complaints & chronic problems. For demonstration purposes, it will be presented as if we're entering most of the data for the first time, as would be done with a new patient, or an established patient being seen for the first time using the EHR. On subsequent encounters the workflow would be more streamlined.

This has been prepared for EHR 5.8 & KBM 8.3. Subsequent updates may display cosmetic & functional changes.

Use the keyboard or mouse to pause, review, & resume as necessary.

Work Flow [Duffy, Robert L]

Appointments 02/20/2013 Duffy

Time	Room	Patient/Subject	Reason	Status
09:00 AM		Flinstone, Wilma/Follow U...		Attended
10:45 AM		RUBBLE, BARNEY/Follow U...		KEPT
11:15 AM		FLINSTONE, FRED/Follow ...		BOOKED

Tasks All Tasks Refills Test Results Questions

Due Date	Patient/Subject	Description
01/23/2013	Quagmire, Charlene/F...	Unable to find insurance inf...
01/23/2013	Quagmire, Charlene/L...	Unable to find insurance inf...
10/24/2012	TEST, DEBBIE/notified ...	Testing Advanced audit ...
10/19/2012	TEST, DEBBIE	ORT SHOULDER COMPLETE
08/22/2012	Horton, PedsAsthma003	
08/10/2012	Test, Mickey	
06/28/2012	BarnesB, Example002	
06/28/2012	Osborn, Example002	
06/28/2012	DuffyR, Examp...0017...	Communication
06/28/2012	BowenC, Example002	
06/28/2012	HepburnM, Example002	
06/28/2012	ColierK, Example002	
06/28/2012	BowenC, Example001...	Just bothering you.
06/27/2012	HortonT, IMEX001	
06/27/2012	MilteerH, IMEx001	
06/26/2012	BarnesC, Examp...001	

The nurse begins by double-clicking on the patient from her provider's appointment list.

Patient Portal

Communications

- Inbox
- Outbox
- Drafts
- Archived

Prescriptions

- Inbox
- Outbox
- Archived

Appointments

- Inbox
- Outbox
- Archived

Online Forms

- Inbox

From Subject Received

Offline

Compose Remove + To Do + To Chart Chart

Always begin by performing the 4-Point check.

Patient

Location

Provider

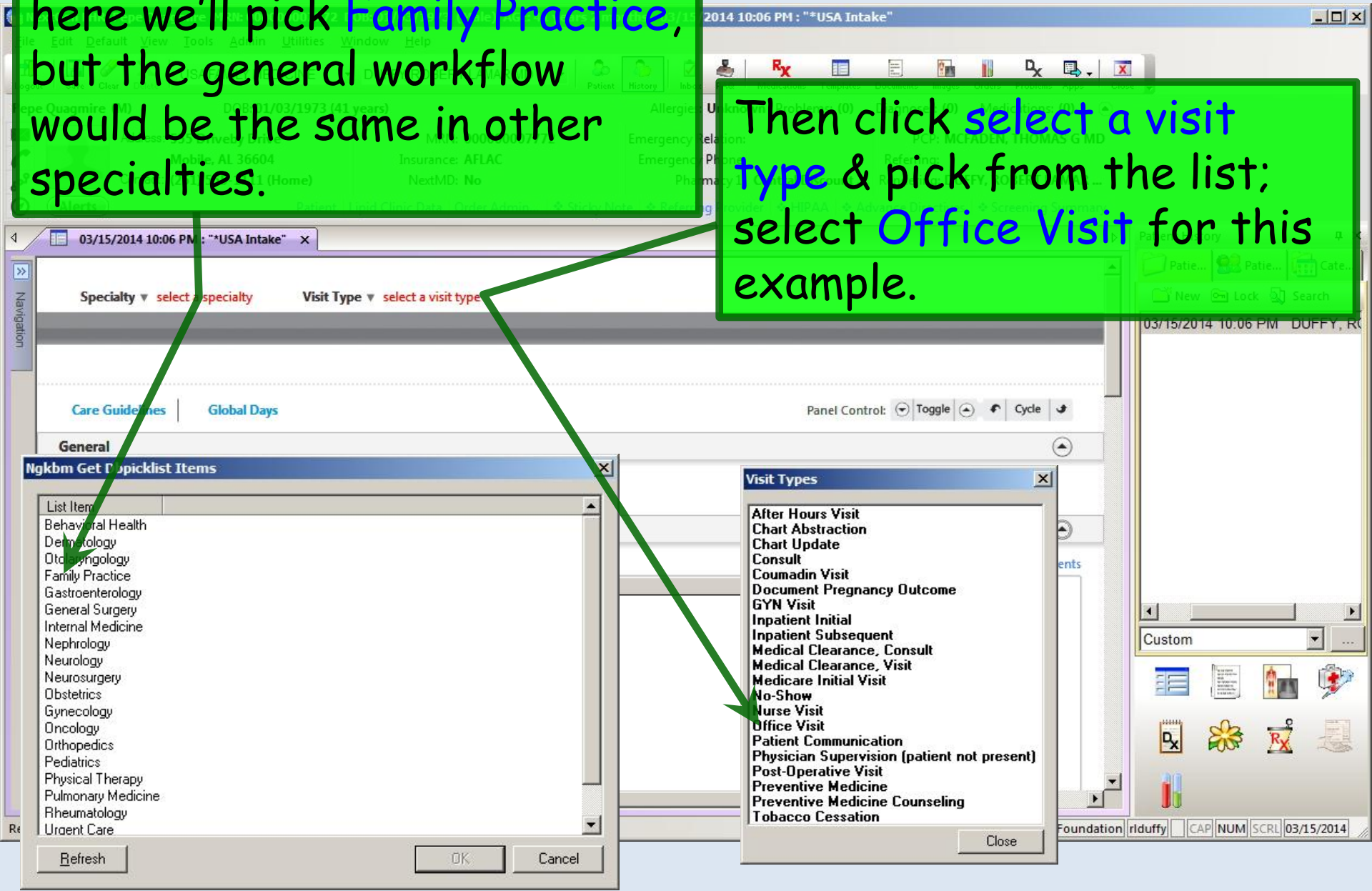
Date

The screenshot shows a medical software interface for a patient named Pepe Quagmire. The patient's information includes MRN: 00000000772, DOB: 01/03/1973 (Male), AGE: 41 years 2 months, and a visit date of 03/15/2014 10:06 PM. The provider is DUFFY, ROBERT LAMAR MD. The interface includes a navigation pane on the left, a main content area with a form, and a patient history pane on the right. The form has a header with 'Specialty select a specialty' and 'Visit Type select a visit type' in red text. Below this are sections for 'General' (Established patient, New patient) and 'Reason for Visit' (Do not launch HPI). The patient history pane shows a single entry for 03/15/2014 10:06 PM by DUFFY, ROBERT LAMAR MD.

When you first open the chart to the Intake Tab, you'll note some red text demanding attention:
Specialty *Select a specialty* & **Visit type** *Select a visit type*.

Click **select a specialty** & make a selection from the picklist; here we'll pick **Family Practice**, but the general workflow would be the same in other specialties.

Then click **select a visit type** & pick from the list; select **Office Visit** for this example.



Note whether the patient is listed as **New** or **Established**, since this sometimes needs to be changed. A patient seen elsewhere in the USA system might initially appear as **Established**, but if it's the first time he's been to your office, that would need to be changed to **New**. Conversely, if you've seen the patient before you started using the EHR, but today is the first visit in NextGen, you may need to change the encounter from **New** to **Established**, so we'll click **Established** here.

03/15/2014 10:06 PM : **USA Intake

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines Global Days Panel Control: Toggle Cycle

General

Established patient New patient Historian:

Reason for Visit

Do not launch HPI Intake Comments

asthma Chief Complaint History of Present Illness

It's always good to begin by noting whether there are any **Sticky Note** or **Alerts** entries.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 555 Driveby Drive Mobile, AL 36604 MRN: 000000007772 Insurance: **AFLAC** NextMD: **No** Emergency Relation: PCP: **MCFADEN, THOMAS G MD**

Contact: (251) 555-1111 (Home) Emergency Phone: Referring: **DUFFY, ROBERT LAMAR ...** Pharmacy 1: **Central Discount ...** Rendering: **DUFFY, ROBERT LAMAR ...**

Alerts **Sticky Note** Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : "*USA Intake" x

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management


Care Guidelines Global Days Panel Control: Toggle Cycle

General

Established patient New patient | Historian:

We can tell by their appearances that there are no **Sticky Notes** or **Alerts**. But for demonstration purposes, we'll enter some. Click **Sticky Note**.

Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We've entered here that this is one of our nurse's sister.



The screenshot shows a window titled "Patient Information" with a close button (X) in the top right corner. Below the title bar is a "Comments:" label followed by a text input field containing the text "Family Medicine nurse Broomhilda's sister.". At the bottom right of the window are two buttons: "Save & Close" and "Cancel". A green arrow points from the text box on the left to the text input field.

When done click **Save & Close**.

Other times a sticky note would be a temporary notice, like **Ask about Tdap next visit. RL Duffy 2/13/14**. It's good to put your name & date on such things; otherwise, you have no idea whether they're still pertinent when you see them in the future. And you should delete such sticky notes when they're no longer meaningful.

When a **Sticky Note** is present, the link will change to a magenta color with a solid diamond.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years)

Address: 555 Driveby Drive MRN: 000000007772
Mobile, AL 36604 Insurance: AFLAC
Contact: (251) 555-1111 (Home) NextMD: No

Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)

Emergency Relation: PCP: MCFADEN, THOMAS G MD
Emergency Phone: Referring: Rending: DUFFY, ROBERT LAMAR ...
Pharmacy 1: Central Discount ...

Alerts Patient Lipid Clinic Data Order Admin... **Sticky Note** Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 10:06 PM : "*USA Intake" x

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines Global Days Panel Control: Toggle Cycle

General

Established patient

Reason for Visit

Do not launch HPI Intake Comments

asthma Chief Complaint History of Present Illness
chest pain

Now click **Alerts**.

The alerts displayed apply to the latest encounter. In order to add new alerts, the most recent encounter should be unlocked.

- Abuse
- Active addiction
- Active Tuberculosis
- Adult protective services alert
- Ambulance transit required
- Bed-ridden
- Deaf
- Discharged from this practice
- Do not use this chart
- Drug seeking
- Hard of hearing, left ear
- Hard of hearing, right ear
- History of alcohol abuse
- History of drug addiction
- History of fainting
- History of fainting with phlebotomy
- Immunizations due
- Interpreter required
- Legally blind
- Medicare Care Management Performance patient
- Mute
- No blood/blood products
- No blood pressure right arm
- No blood pressure left arm
- No information to family
- No medication refills
- No medication refills until seen in office
- No narcotics
- No narcotics until seen in office
- No sexual information sharing except with patient
- Palliative care
- Patient has expired
- Resuscitation status
- Terminally ill
- Wheelchair required
- Work restrictions:
- Other:

Additional comments can be typed as well.

◆ Suicide/Homicide Risk ⓘ

Date	Instrument	Severity	Completed By

Additional comments:

Cardiology Alerts

Alert	Start Date	StopDate	#

OPH Alerts: Note: Add

Alert	Note

Remove Save & Close Cancel

This gives you the opportunity to indicate several noteworthy alerts about the patient. For demonstration purposes we'll click **Legally blind**. (Are there places where it is illegal to be blind? Man, that would be harsh.)

Click **Save & Close** when you're done.

The Alerts button turns red when there is an entry.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 555 Driveby Drive MRN: 000000007772 Emergency Relation: PCP: MCFADEN, THOMAS G MD
Mobile, AL 36604 Insurance: AFLAC Emergency Phone: Referring:
Contact: (251) 555-1111 (Home) NextMD: No Pharmacy 1: Central Discount ... Rendering: DUFFY, ROBERT LAMAR ...

Alerts Patient Lipid Clinic Data Order Admin... **Sticky Note** Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : "*USA Intake" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake Histories SOAP Finalize Checkout

When you remove entries the Sticky Note & Alerts return to their baseline appearance, as below.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 555 Driveby Drive MRN: 000000007772 Emergency Relation: PCP: MCFADEN, THOMAS G MD
Mobile, AL 36604 Insurance: AFLAC Emergency Phone: Referring:
Contact: (251) 555-1111 (Home) NextMD: No Pharmacy 1: Central Discount ... Rendering: DUFFY, ROBERT LAMAR ...

Alerts Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : "*USA Intake" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake Histories SOAP Finalize Checkout

You can select a **Historian** from the picklist that appears if you click in that box; you can also type in an entry. This is most pertinent if the patient is a child or adult unable to care for himself.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years)

Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)

MRN: 000000007772
Insurance: AFLAC
NextMD: No

Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Emergency Relation:
Emergency Phone:
Pharmacy 1: **Central Discount ...**

PCP: **MCFADEN, THOMAS G MD**
Referring:
Rendering: **DUFFY, ROBERT LAMAR ...**

Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:05 PM: "NUSA Intake" x

Relationship of historian:

- aunt
- brother
- daughter
- daughter-in-law
- father
- father-in-law
- foster child
- foster parent
- friend
- granddaughter
- grandfather
- grandmother
- grandson
- mother
- mother-in-law
- neighbor
- nephew
- niece
- self
- significant other
- sister
- son
- son-in-law
- spouse
- step daughter
- step parent
- step son
- uncle

Visit Type: Office Visit

Histories SOAP Finalize Checkout

Panel Control: Toggle Cycle

Intake Comments

Note the PCP.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 555 Driveby Drive MRN: 000000007772 Emergency Relation: PCP: MCFADEN, THOMAS G MD
Mobile, AL 36604 Insurance: AFLAC Emergency Phone: Referring: Rendering: DUFFY, ROBERT LAMAR ...
Contact: (251) 555-1111 (Home) NextMD: No Pharmacy 1: Central Discount ...

[Patient](#) [Lipid Clinic Data](#) [Order Admin...](#) [Sticky Note](#) [Referring Provider](#) [HIPAA](#) [Advance Directives](#) [Screening Summary](#)

03/15/2014 10:06 PM : "*USA Intake" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management

Care Guidelines | Global Days Panel Control: Toggle Cycle

General

Established patient New patient | Histori...

Reason for Visit

Do not launch HPI

If this needs to be changed, click **Patient**, which opens the **Patient_demographics** template.

Since Dr. McFaden is no longer with us, we'll change the PCP by clicking in the **PCP** field. (Don't worry—he's not dead, just moved on.)

(0) Diagnoses: (0) Medications: (0)
PCP: MCFADEN, THOMAS G MD
Referring:
Rendering: DUFFY, ROBERT LAMAR ...
Advance Directives Screening Summary

Patient Information

First name:
Middle name:
Last name:
Previous last name:
Nickname:
Country of birth:
Race:

Ngkbn Dbp All Providers

LastName	FirstName	PhysicianName	P
COHEN	MICHAEL	MICHAEL V COHEN MD	2
COLORADO	NATALIA	NATALIA COLORADO MD	2
COLPO	GYN	GYN COLPO	2
CONNELLY	ROSINA	ROSINA A CONNELLY MD	2
CONTRERAS	CARLO	CARLO M CONTRERAS MD	2
COX	JEFFREY	JEFFREY LAYNE COX MD	2
CREWS	LADONNA	LADONNA CREWS MD	2
CROOK	ERROL	ERROL D CROOK MD	2
CULPEPPER	GREGORY	GREGORY RYAN CULPEPPER MD	2
CURIEL	RAUL	RAUL CURIEL MD	2
De MELO	SILVIO	SILVIO W De MELO	2
DECOTIS-SMITH	DIANA	DIANA DECOTIS-SMITH MD	2
DELP	MEREDITH	MEREDITH R DELP DO	2
DELP	WILLIAM	WILLIAM DONOVAN DELP DO	2
DIPALMA	JACK	JACK A DIPALMA MD	2
DUFFY	ROBERT	ROBERT LAMAR DUFFY MD	2
DYESS	DONNA	DONNA LYNN DYESS MD	2
EDMOND	III IF	III IF EDMOND P&	2

Refresh OK Cancel

Panel Control: Toggle Cycle

Social Security Number

date: Sex:
language:
ethnicity:
status:
name:
religion:
type:

Contact Information

Address History

PCP/Insurance/Pharmacy

PCP:

First visit: Last visit: Next visit:
Referred by:
Insurance:

In the picklist that appears, scroll down to the desired choice; you can type the first few letters to jump down to that part of the alphabet. Here we'll double-click on **DUFFY**.

Pepe Quagmire (M)

DOB: 01/03/1973 (41 years)

Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)



Address: 555 Driveby Drive
Mobile, AL 36604
Contact: (251) 555-1111 (Home)

MRN: 00000007772
Insurance: **AFLAC**
NextMD: **No**

Emergency Relation:
Emergency Phone:
Pharmacy 1: **Central Discount ...**

PCP: **MCFADEN, THOMAS G MD**
Referring:
Rendering: **DUFFY, ROBERT LAMAR ...**

Alerts

Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : **USA Intake Patient Demographics X

Panel Control: Toggle Cycle

Patient Information

Social Security Number

First name: <input type="text" value="Pepe"/>	Birth date: <input type="text" value="01/03/1973"/> Sex: <input type="text" value="M"/>
Middle name: <input type="text"/>	Preferred language: <input type="text" value="English"/>
Last name: <input type="text" value="Quagmire"/> Suffix: <input type="text"/>	Ethnicity: <input type="text" value="Hispanic or Latino"/>
Previous last name: <input type="text"/>	Marital status: <input type="text" value="married"/>
Nickname: <input type="text"/>	Spouse name: <input type="text"/>
Country of birth: <input type="text"/>	Religion: <input type="text" value="Scientology"/>
Race: <input type="text" value="Hispanic"/>	Blood type: <input type="text"/>

Save the template (e.g., via **control-S**), then close the **Patient_Demographics** template. (If you don't save first, it'll remind you.)

First visit: Last visit: Next visit:

Referred by:

Insurance:

The Navigation Bar is normally hidden at the left; it will slide out if you hover over it. But you probably won't need it very often.

NextGen EHR: Pepe Quagmire MRN: 000000007772 DOB: 01/03/1973 (Male) AGE: 41 years 2 months - 03/15/2014 10:06 PM : ""USA Intake"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Deletes USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)

Address: 555 Driveby Drive MRN: 000000007772 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Mobile, AL 36604 Insurance: AFLAC Emergency Phone: Referring:
Contact: (251) 555-1111 (Home) NextMD: No Pharmacy 1: Central Discount ... Rendering: DUFFY, ROBERT LAMAR ...

Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

Navigation

Intake
History
SOAP
Finalize
Check Out

Order Management
Orders/Plan
Standing Orders

Anticoagulation
Procedures
Tobacco Cessation
Tuberculin Skin Test
Nutrition

Chart Abstraction
Demographics
Document Library
Immunizations
Patient Comment
Provider Test Action
Vital Signs
Screening Tools
CQM Check
MU Check

Visit Type Office Visit

Histories	SOAP	Finalize	Checkout
Immunizations	Peds Immunizations	My Plan	Procedures
Order Management			

Panel Control: Toggle Cycle

Patient | Historian: self

Patient History

Patie... Patie... Patie...

New Lock Search

03/15/2014 10:06 PM DUFFY, R...

*USA Intake

Ready

NGDevil USA Health Services Foundation rlduffy CAP NUM SCRL 03/15/2014

You can also show or hide the History Bar by clicking the History icon at the top.

You can make the History Bar do the same auto-hide trick if you click on the thumbtack to turn it sideways.

The Info Bar is collapsed, & Vital Signs are at the top.

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Alerts Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : "*USA Intake" x

Navigation: Home Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Pediatric Immunizations My Plan Procedures Order Management

Care Guidelines Global Days Panel Control: Toggle Cycle

General

Established patient New patient Historian: self

Vital Signs

Health Promotion Plan | History | Graph

Time	Wt lbs	Ht in	BMI	Wt kg	Ht cm	BP	Pulse	Resp	TempF	TempC	O-sat	Pain level	Comments

Add Edit Remove

Reason for Visit

Do not launch HPI

asthma chest pain depression

Intake Comments

To enter Vital Signs, click **Add**.

Enter Vital Signs. (Details are reviewed in another demo.)

"Adult Vital Signs" - [New Record]

Height/length measurements:
ft in total in cm Position: Standing Lying
Last Measured: // Measured today Carried forward

Weight measurement:
lb kg Context: Dressed with shoes Dressed without shoes

Temperature: F C Site:

Blood Pressure and pulse:
Systolic: / Diastolic: mm/Hg Position: Sitting Standing Lying Side: Right Left
Pulse: /min Regular Irregular Method: Manual Automatic Home monitor Pediatric Adult Cuff size:
Respiration and Pulse Ox:
Respiration: /min Pulse Ox Rest: % Pulse Ox Amb: %
Pulse Ox: Room air Oxygen - Method:
Pulse Ox measured: Pre-treatment Post-treatment
Pain scale:
Pain score: Method: HAQ-DI
Comments:

BMI/BSA calculation: Unobtainable:
BMI: kg/m²
BSA: m²

Peak Flow:
Method:

Measured date: Time:
25/15/2014 11:24 AM
Measured by:

Clear For Add Delete Save Close

Data used in this example:

Ht 73 inches, measured today.

Wt 199 lbs, dressed without shoes.

T 97.7, orally.

BP 167/123 sitting, left arm,
manual adult cuff.

HR 84.

Resp 16.

BMI of 26.25 will be calculated.

When done, click Save then Close.

Vital signs now display.

General

Established patient New patient | Historian: self

Vital Signs ! Vital Signs Outside Normal Range

[Health Promotion Plan](#) | [History](#) | [Graph](#)

Time	Wt lbs	Ht in	BMI	Wt kg	Ht cm	BP	Pulse	Resp	TempF	TempC	O-sat	Pain level	Comments
11:19 PM	199.00	73.00	26.25	90.265	185.42	167/123	84	16	97.7	36.5			

Add Edit Remove

Reason for Visit

Do not launch HPI

- abdominal pain
 - back pain
 - chronic conditions
 - cold symptoms
 - cough
 - diabetes (follow up)
 - earache
 - fever
 - headache
 - hypertension (follow up)
 - musculoskeletal pain
 - PAP test
 - rash
 - sore throat
- Additional / Manage

Chief Complaint

Now enter Chief Complaints, or Reasons for Visit. The most common complaints used in each clinic will appear on this list. Our patient has a cough, so click that.

The complaints you've entered display.

Click **Intake Comments** to enter some brief information about the patient's complaints.

The screenshot displays a medical software interface for a patient named "USA Intake". The top navigation bar includes "Specialty" (Family Practice) and "Visit Type" (Office Visit). Below this, there are tabs for "Intake", "Histories", and "SOAP". The "Intake" tab is active, showing a list of symptoms: abdominal pain, back pain, chronic conditions, and cold symptoms. A table below lists "Chief Complaint" (Cough, DM/HTN) and "History of Present Illness". A red warning icon indicates "Vital Signs Outside Normal Range". The "Reason for Visit" section has a checkbox for "Do not launch HPI" which is checked. An "Intake Comments" window is open, showing a text area with the following text: "Cough X3 days, gradually worsening, like bronchitis he's had before. No fever. Also needs med refills; has been out of Cozaar for last wk." Below the text area are "Save & Close" and "Cancel" buttons. At the bottom right of the interface, there are "Diagnostics" and "Show All" buttons.

Type a few brief details as pertinent or volunteered by the patient. When done click **Save & Close**.

Moving down the **Intake Tab**, we come to **Medications**. Since this is the first encounter documented in NextGen, we need to add the patient's meds. Click the **Add/Update** button.

03/15/2014 10:06 PM : "**USA Intake" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake | Histories | SOAP | Finalize | Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management

Care Guidelines | Global Days


Panel Control: ▾ Toggle ◀ ▶ Cycle ↻

General ▾

Vital Signs ▾

Reason for Visit ▾

Medications ▴

Patient status: Transitioning into care Summary of care received  Comment No medication Medications reconciled

Medication	Sig Description
------------	-----------------

Add/Update **Reconcile**

If there were no meds, you'd click the **No medications** box.

Medication Module

White Grid Preferences 41 year Old Male Weighing 199.00 lb | 90.26 Kg

Last Audit	Status	Medication Name	Generic Name	Start Date	Stop Date	Sig	Original Start
Status: Active (2 items)							
	Active	losartan 50 mg tablet	LOSARTAN POTASSIUM	03/15/2014		1 daily	03/15/2014
	Active	metformin 500 mg tablet	METFORMIN HCL	03/15/2014		1 twice daily	03/15/2014

A detailed discussion of the Medication Module is included in another lesson.

In this example, our patient is taking:


Losartan 50 mg daily.

Metformin 500 mg twice daily.

Add these medications, then close the Med Module to return to the Intake Tab.

Medications display (though sometimes they may not show until the template is refreshed).

Click the **Medications reconciled** checkbox.

Patient status: Transitioning into care Summary of care received  [Comment](#) No medications Medications reconciled

Medication	Sig Description
losartan 50 mg tablet	1 daily
metformin 500 mg tablet	1 twice daily

If you have questions about the medicines that you are unable to clarify with the patient, DON'T click the **Medications reconciled** checkbox. Instead, use the **Comment** link (or perhaps better, the **Intake Comments** link you used under **Reasons for Visit** above), and/or verbally tell the provider.

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines

Next, review allergies. If there are no allergies, just click the **No known allergies** box.

General
Vital Signs
Reason for Visit
Medications
Allergies

Comment No known allergies Allergies added today Reviewed, no change

Allergen	Reaction	Medication Name	Comment

Add Update

But our patient states he is allergic to tetracycline, so click **Add**.

Allergies entered here will not be checked against the current medication list.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Accupril (Quinapril) | <input type="checkbox"/> Demerol | <input type="checkbox"/> Latex | <input type="checkbox"/> Prevacid |
| <input type="checkbox"/> Accutane (Isotretinoin) | <input type="checkbox"/> Demerol | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Prilosec (Esomeprazole) |
| <input type="checkbox"/> Acyclovir | <input type="checkbox"/> Diabeta (Glyburide) | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Prinivil (Captopril) |
| <input type="checkbox"/> Actonel (Risedronate) | <input type="checkbox"/> Diovan (Lisinopril) | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Prolokin (Enbryol) |
| <input type="checkbox"/> Altace (Lisinopril) | <input type="checkbox"/> Dioxycillin | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Ranitidine |
| <input type="checkbox"/> Ampicillin | <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Sildenafil (Viagra) |
| <input type="checkbox"/> Amaryl (Glimepiride) | <input type="checkbox"/> Egg | <input type="checkbox"/> Micronase (Glyburide) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Augmentin (Amoxicillin) | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Minocin (Minocycline) | <input type="checkbox"/> Tagamet (Cimetidine) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Flagyl | <input type="checkbox"/> Morphine | <input type="checkbox"/> Tegretol (Carbamazepine) |
| <input type="checkbox"/> Bactrim (Sulfamethoxazole) | <input type="checkbox"/> Floxin | <input type="checkbox"/> Motrin (Ibuprofen) | <input type="checkbox"/> Tenormin (Atenolol) |
| <input type="checkbox"/> Biaxin | <input type="checkbox"/> Glucotrol (Glipizide) | <input type="checkbox"/> Naprosyn (Naproxen) | <input type="checkbox"/> Tetanus toxoid |
| <input type="checkbox"/> Carafate (Sucralfate) | <input type="checkbox"/> Heparin | <input type="checkbox"/> Neptazane | <input checked="" type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Ceclor (Cefaclor) | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Niacin | <input type="checkbox"/> Ticlid |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Inderal (Propranolol) | <input type="checkbox"/> Oxycodone | <input type="checkbox"/> Valium (Diazepam) |
| <input type="checkbox"/> Cephalosporins | <input type="checkbox"/> Indocin (Indomethacin) | <input type="checkbox"/> Peanut | <input type="checkbox"/> Vancomycin |
| <input type="checkbox"/> Cipro (Ciprofloxacin) | <input type="checkbox"/> Insulin (Animal) | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Vasotec |
| <input type="checkbox"/> Clinoril (Sulindac) | <input type="checkbox"/> Iodine or shellfish | <input type="checkbox"/> Percocet (Oxycodone) | <input type="checkbox"/> Zestril |
| <input type="checkbox"/> Contrast media (Ioversol) | <input type="checkbox"/> Keflex (Cephalexin) | <input type="checkbox"/> Persantine | <input type="checkbox"/> Zithromax |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Klonopin | <input type="checkbox"/> Plavix | <input type="checkbox"/> Zocor (Simvastatin) |
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Lasix (Furosemide) | <input type="checkbox"/> Phenytoin | <input type="checkbox"/> Zyloprim (Allopurinol) |
| <input type="checkbox"/> Darvon | | <input type="checkbox"/> Pravachol | |

Add the patient's allergy to tetracycline; he gets a moderate rash from it. (A detailed discussion of the Allergy Module is covered in a separate exercise.)
When done, click **Save & Close**.

Save & Close Cancel

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management

Care Guidelines | Global Data

Tetracycline now displays in the Allergies grid. Since this was just added, the Allergies added today bullet was selected.

General
Vital Signs
Reason for Visit
Medications
Allergies

Comment No known allergies Allergies added today Reviewed, no change

Allergen	Reaction	Medication Name	Comment
TETRACYCLINE	Rash		

Now let's move to the Histories Tab.

Add Update

Specialty **New.** Visit Type ▾ Office Visit

New.



Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: ▾ Toggle ⏪ ⏩ Cycle ↻

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

Problem Description Side Notes Addtl

A note to those transitioning from earlier versions of NextGen: The new Problem List replaces the old Chronic Conditions, due to Meaningful Use requirements. While some conversion may happen automatically, the old Chronic Conditions list may need to be reviewed & used to complete the new Problem List. See the What's New lesson for details.

Old.



Refresh Add Edit

Intake **Histories** Summary

Sticky Note | Referring Provider | HL

Chronic Conditions

Reviewed

Problem Comments

Add

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Home Intake **Histories** SOAP Finalize Checkout


Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: [Dropdown] Toggle [Left Arrow] [Right Arrow] Cycle [Refresh] [Undo]

Problem List 0 [Up Arrow]

Show chronic Show my tracked problem No active problems Reviewed

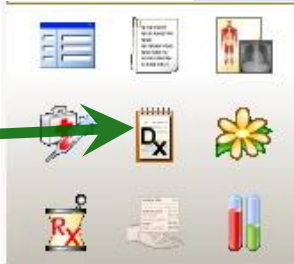
Problem Description	Side	Notes	Addl
			

Refresh Add Edit

The screenshot shows the 'Problems' module interface. At the top, there are two tabs: 'Problem List' (highlighted with a green box) and 'Billing ICD List'. Below the tabs is a toolbar with 'Refresh' (circular arrow icon), 'Preferences' (gear icon), 'Show All Statuses' (dropdown menu), and two checkboxes: 'Show My Tracked Problems Only' and 'Show Chronic Problems Only'. A status bar below the toolbar reads 'No Active Problems'. The main area is a table with columns: 'Concept Id', 'Description', 'Fully Specified Name', and 'Chronic'. At the bottom, there is a secondary toolbar with buttons: 'Add Problem' (plus icon), 'Re-Code', 'Resolve' (circular arrow icon), 'Set Chronic', 'Delete' (X icon), 'Resources' (globe icon), 'View/Add Notes', 'View History', and 'Reconcile'. Below this is another row of buttons: 'Add to Billing ICD List', 'Add to My Tracked Problems', and 'Remove from My Tracked Problems'.

The Problems Module opens, focused on the Problem List Tab.

This is sometimes called the Diagnosis Module because of the Dx Icon that will open it from the tic-tac-toe board.



To add a new problem, logically enough, click **Add Problem**.

The diagnosis search popup appears. Let's find glaucoma. Click in the **search field**, type **Diabetes mellitus type II**, then click **Search**.

Q Diabetes mellitus type II

Search

Description

Fully Specified Name

Concept Id

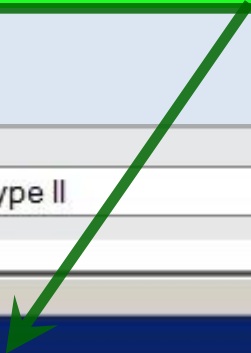
You could actually just type **diabetes** or some other smaller portion of the term you're looking for; it doesn't even require a complete word. The more you type, the shorter your results list, & the faster it will display. You'll quickly get a feel for how much to type to find your diagnosis without having to scroll through 100 results.

Add to My Tracked Problems

Select

Cancel

A list of results appears. We'll select **Diabetes mellitus type II** by double-clicking on it.



Q Diabetes mellitus type II

Search

Description	Fully Specified Name	Concept Id
Diabetes mellitus type II	Diabetes mellitus type 2	44054006
Diabetes mellitus type II with ulcer	Type II diabetes mellitus with ulcer	190389009
Type 2 diabetes mellitus	Diabetes mellitus type 2	44054006
Diabetes mellitus type 2 with ulcer	Type II diabetes mellitus with ulcer	190389009
Type 1 diabetes	Diabetes mellitus type 1	46635009
Type 1 diabetes mellitus	Diabetes mellitus type 1	46635009
Type 1 diabetic	Diabetes mellitus type 1	46635009
Type 1 DM	Diabetes mellitus type 1	46635009
Type 2 diabetes	Diabetes mellitus type 2	44054006
Type 2 DM	Diabetes mellitus type 2	44054006
Type I diabetes	Diabetes mellitus type 1	46635009
Type I diabetes mellitus	Diabetes mellitus type 1	46635009
Type I diabetic	Diabetes mellitus type 1	46635009

95 rows returned

Add to My Tracked Problems

Select

Cancel

Problems

Problem List | Billing ICD List

Refresh Preferences Show All Statuses Show My Tracked Problems Only Show Chronic Problems Only

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition
Active				
Diabetes mellitus type 2				
44054006	Diabetes mellitus type II	Diabetes mellitus type 2	<input type="checkbox"/>	<input type="checkbox"/>

The diagnosis appears on the **Active** problem list.

There are a lot of details that can be added below, some of which you may use, & some of which you may ignore.

Add Problem | Re-Code | Resolve | Set Chronic | Delete | Resources | View/Add Notes | View History | Reconcile

Add to Billing ICD List | Add to My Tracked Problems | Remove from My Tracked Problems

Accept Cancel

Concept Id: 44054006

Description: Diabetes mellitus type II Fully Specified Name: Diabetes mellitus type 2

Onset Date: 03/16/2014 Resolved Date: 03/16/2014 Last Addressed:

Resolved By: Resolved Reason:

Problem Status: Active Clinical Status:

Chronic: Recorded Elsewhere: Source: EHR

Secondary Condition:

Provider: ROBERT LAMAR DUFFY Location: USA FAMILY MEDICINE

Side: Site:

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition
Active				
Diabetes mellitus type 2				
44054006	Diabetes mellitus type II	Diabetes mellitus type 2	<input type="checkbox"/>	<input type="checkbox"/>

First look at **Onset Date**. Today's date is entered by default, but unless this is truly the first day this diagnosis is being made (usually *not* the case), you'll want to change this. If you know a date of onset, you can click the dropdown arrow to add one; you may need to approximate. But if you don't know the onset date or it is immaterial, just click the checkbox to clear it.

Add Problem		Re-Code	Resolve	Set Chronic	Delete	Resources	View/Add Notes	View History	Reconcile	
Add to Billing ICD List		Add to My Tracked Problems		Remove from My Tracked Problems						
Accept		Cancel								
Concept Id:	44054006									
Description:	Diabetes mellitus type II			Fully Specified Name: Diabetes mellitus type 2						
Onset Date:	<input checked="" type="checkbox"/> 03/16/2014	Resolved Date:	<input type="checkbox"/> 03/16/2014		Last Addressed:					
Resolved By:										
Problem Status:	Active		Clinical Status:							
Chronic:	<input type="checkbox"/>	Recorded Elsewhere:	<input type="checkbox"/>							
Source:	EHR									
Secondary Condition:	<input type="checkbox"/>									
Provider:	ROBERT LAMAR DUFFY			Location: USA FAMILY MEDICINE						
Side:										
Site:										

The very nature of a "Problem List" would seem to imply "chronic," but NextGen provides the option of distinguishing "chronic" from "not chronic"—though I'm not sure I'd go to the trouble to add something here that is not chronic.

Anyway, to indicate the diagnosis is chronic, click **Set Chronic** or the **Chronic** checkbox.

The screenshot shows the 'Problems' form in NextGen. The form is for a problem with Concept ID 44054006 and Description 'Diabetes mellitus type II'. The Onset Date is 03/16/2014 and the Resolved Date is also 03/16/2014. The Problem Status is 'Active'. The 'Chronic' checkbox is checked. The Provider is 'ROBERT LAMAR DUFFY' and the Location is 'USA FAMILY MEDICINE'. The 'Set Chronic' button is highlighted with a green arrow pointing from the text above.

Accept	Cancel				
Concept Id:	44054006				
Description:	Diabetes mellitus type II	Fully Specified Name:	Diabetes mellitus type 2		
Onset Date:	03/16/2014	Resolved Date:	03/16/2014	Last Addressed:	
Resolved By:		Resolved Reason:			
Problem Status:	Active	Clinical Status:			
Chronic:	<input checked="" type="checkbox"/>	Recorded Elsewhere:	<input type="checkbox"/>	Source:	EHR
Secondary Condition:	<input type="checkbox"/>	Provider:	ROBERT LAMAR DUFFY	Location:	USA FAMILY MEDICINE
Side:		Site:			

Problems

Problem List | Billing ICD List

Refresh Preferences Show All Statuses Show My Tracked Problems Only Show Chronic Problems Only

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition
Active				
Diabetes mellitus type 2				
44054006	Diabetes mellitus type II	Diabetes mellitus type 2	<input type="checkbox"/>	<input type="checkbox"/>

Add Problem Re-Code Resolve Set Chronic Delete Resources View/Add Notes View History Reconcile

Add to Billing ICD List Add to My Tracked Problems Remove from My Tracked Problems

Accept Cancel

Concept Id: 44054006

Description: Diabetes mellitus type II Fully Specified Name: Diabetes mellitus type 2

Onset Date: 03/16/2014 Resolved Date: 03/16/2014 Last Addressed:

Resolved By: Resolved Reason:

Problem Status: Active Clinical Status:

Chronic: Recorded Elsewhere: Source: EHR

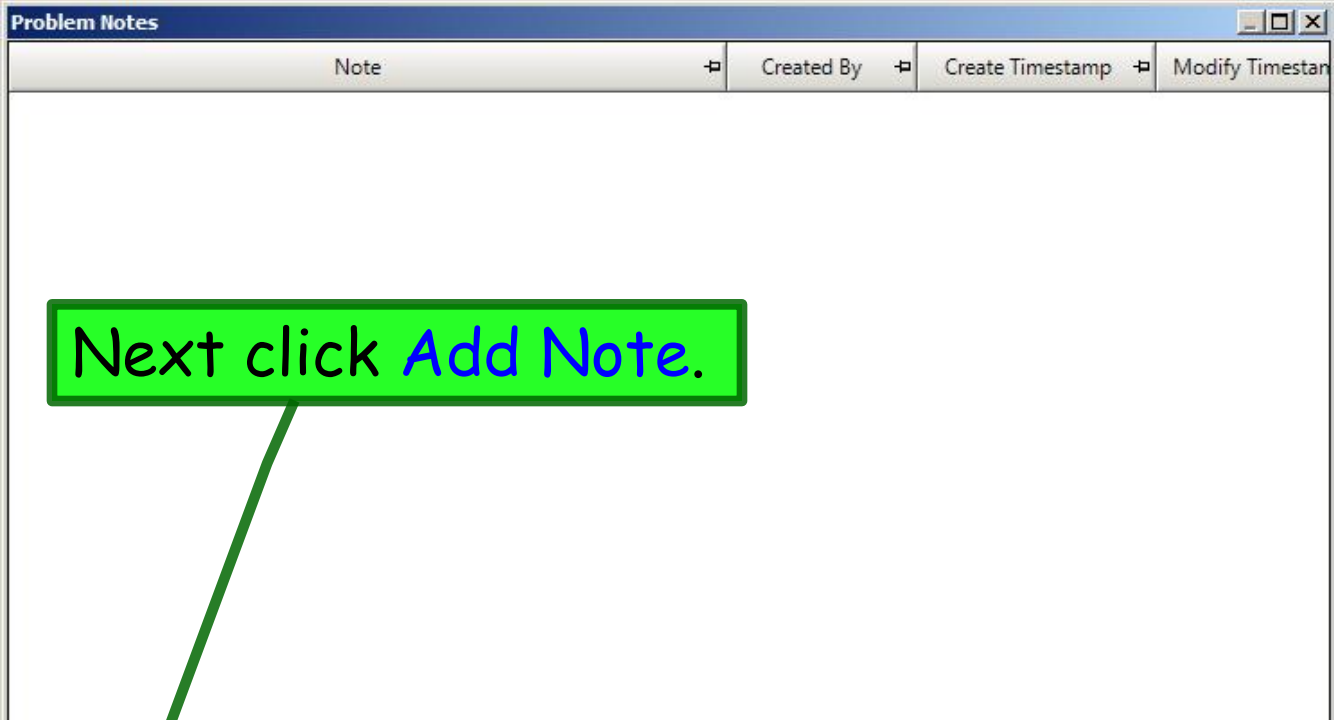
Secondary Condition:

Provider: ROBERT LAMAR DUFFY, Location: USA FAMILY MEDICINE

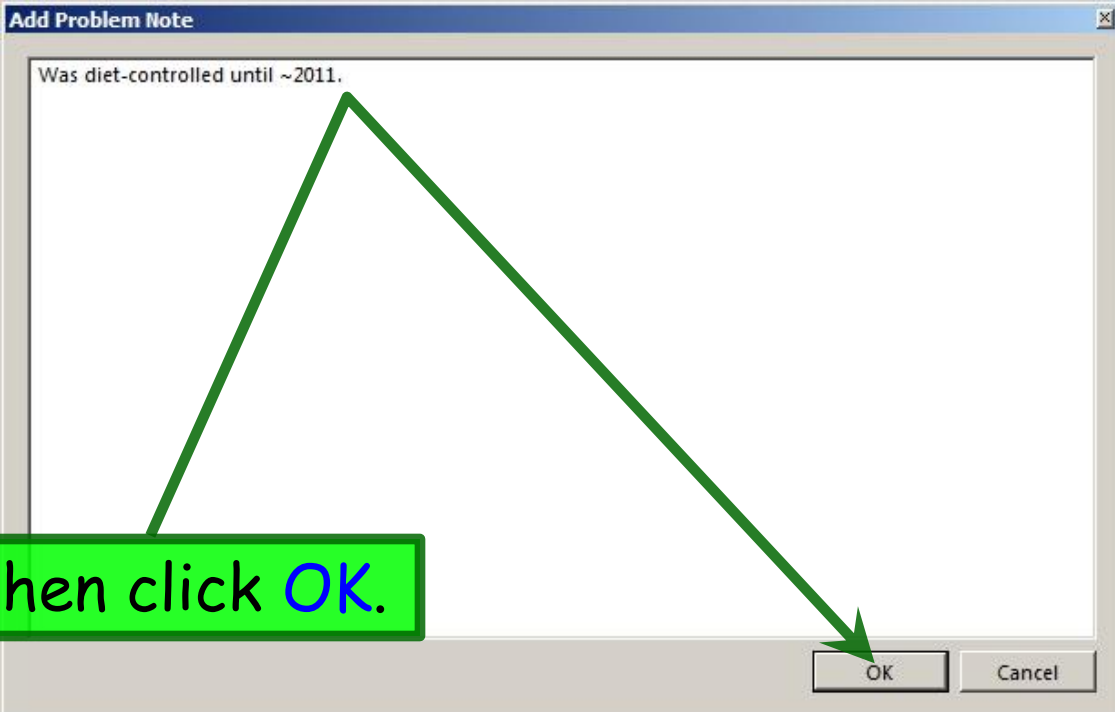
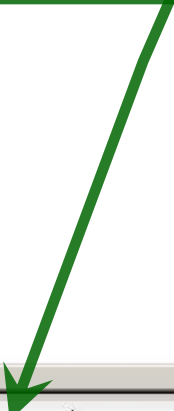
Side: Site:

When germane, you can specify **Side & Site**.

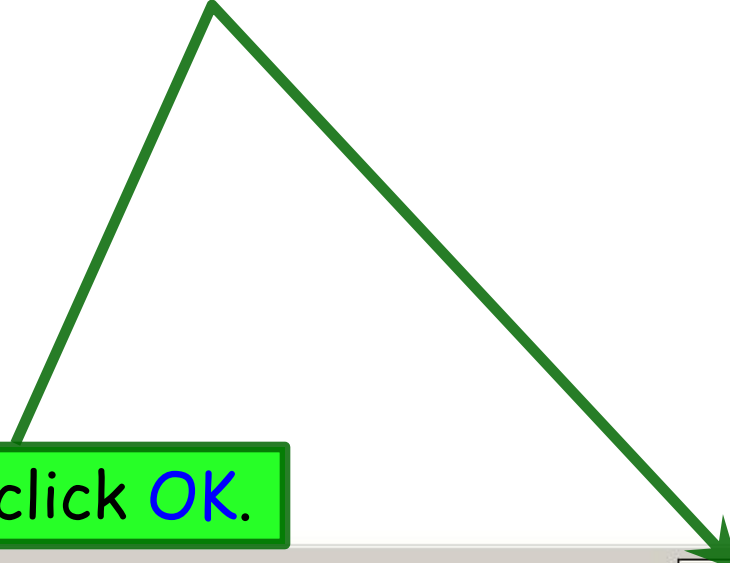
You can also add further details. Click **View/Add Notes**.



Next click **Add Note**.



Type your entry, then click **OK**.



Problem Notes

Note	Created By	Create Timestamp	Modify Timestamp
Was diet-controlled until ~2011.	Duffy, Robert L	3/16/2014 12:20:50 PM	3/16/2014 12:20:50 PM

Your entry displays. Note that you can update or delete a note.

When done, click **Close**.

⚙️ Add Note Update Note Delete Note Close

Problems

Problem List | Billing ICD List

Refresh Preferences Show All Statuses Show My Tracked Problems Only Show Chronic Problems Only

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition
Active				
Diabetes mellitus type 2				
44054006	Diabetes mellitus type II	Diabetes mellitus type 2	<input type="checkbox"/>	<input type="checkbox"/>

When you've addressed all the details you need to enter, click **Accept**. You can then add other diagnoses; I'll go ahead & add essential hypertension.

When done, click the **X** to close the **Problems Module**.

Add Problem Re-Code Resolve Set Chronic Delete Resources View/Add Notes View History Reconcile

Add to Billing List Add to My Tracked Problems Remove from My Tracked Problems

Accept **Cancel**

Concept Id: 44054006

Description: Diabetes mellitus type II Fully Specified Name: Diabetes mellitus type 2

Onset Date: 03/16/2014 Resolved Date: 03/16/2014 Last Addressed:

Resolved By: Resolved Reason:

Problem Status: Active Clinical Status:

Chronic: Recorded Elsewhere: Source: EHR

Secondary Condition:

Provider: ROBERT LAMAR DUFFY, Location: USA FAMILY MEDICINE

These problems now display.
Note the Problems count on
the Info Bar now shows 2.

Care Guidelines Global Days **History Review** All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Problem List 2

Show chronic Show my tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl
Diabetes mellitus type II		Was diet controlled until ~2011	
Essential hypertension			

Click the **Reviewed** checkbox. This is the only individual "Review" checkbox on this template you need to click each encounter.

Medical/Surgical/Interim

No relevant past medical/surgical history All History Review details are to be reviewed and included in visit note unless user indicates otherwise **History Review**

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
------------------	------	------------	------------	------	------	----------------	---------

All of the other History Review links lead to the same popup.
Click **one of them**.

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations Birth History Procedures Order Management Document Library

Care Guidelines Global Days History Review

All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Panel Control: Toggle Cycle

Problem List 2

Show chronic Show my tracked problem

Problem Description	Side	Notes
Diabetes mellitus type II		Was diet contr
Essential hypertension		

History Review

Med/Surg/Interim Hx: Detailed document Reviewed, no changes (last updated 05/04/2014)
 Reviewed, updated History unobtainable:

Family: Detailed document Reviewed, no changes (last updated 05/04/2014)
 Reviewed, updated History unobtainable:

Social: Detailed document Reviewed, no changes (last updated 05/13/2014)
 Reviewed, updated History unobtainable:

Save & Close Cancel

Refresh Add Edit

It is our expectation that all historical elements are at least briefly reviewed at every encounter, so most of these details appear in our notes by default anyway. However, only basic Social History details are defaulted into our notes, so if you've added a lot of other details, you need to specifically select **Detailed document** for Social History.

Now we'll enter other **Medical/Surgical/Interim** history. While the **Problem List** includes ongoing medical issues, the **Medical/Surgical/Interim** history is for isolated episodes of illness or events such as surgery. Click **Add**.

Problem List 2

Show chronic Show my tracked problem

No active problems Reviewed

Problem Description	Side	Notes	Addtl
Diabetes mellitus type II		Was diet-controlled until ~2011.	1
Essential hypertension			

Refresh Add Edit

Medical/Surgical/Interim

No relevant past medical/surgical history

All History Review details are to be reviewed and included in visit note unless user indicates otherwise [History Review](#)

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
------------------	------	------------	------------	------	------	----------------	---------

Refresh Interim History Add Edit Remove

Specialty:

Panel Control:

Medical

Surgical

To add comments, click manage.

Date:

Date:

Date:

Angioplasty

Appendectomy

Arthroscopy

Back surgery

Blood transfusion

CABG

Cardiac pacemaker

Carpal tunnel release

Cataract extraction

Cholecystectomy

Colectomy

Colostomy

Gastric bypass

Hernia repair

Hip replacement

Knee replacement

LASIK

ORIF

Thyroidectomy

Tonsillectomy

Other

Past Medical History Grid

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment
------------------	------	------------	------------	------	------	----------------	---------	---------

We don't have any episodic medical illnesses to enter, so that panel has been collapsed. But our patient had a left inguinal hernia repair in 2002.

Click the **Hernia repair** checkbox.

Specialty:

Panel Control:

Enter the year 2002.

Medical

Surgical

To add comments, click manage.

- Angioplasty
- Appendectomy
- Arthroscopy
- Back surgery
- Blood transfusion
- CABG
- Cardiac pacemaker
- Carpal tunnel release
- Cataract extraction
- Cholecystectomy

- Colectomy
- Colostomy
- Gastric bypass
- Hernia repair
- Hip replacement
- Knee replacement
- LASIK
- ORIF
- Thyroidectomy
- Tonsillectomy

Other

Date:

Date:

Date:

Manage

Past Medical History Grid

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment

To add further details, click **Manage**.

Manage Past Medical History

Disease/Disorder
Disease/disorder:

SNOMED code:

Onset date: / / Side:

Management
Management:

SNOMED code:

Date: / / 2002 Side:

Facility:

Provider: (Last) (First)

Outcome/Comments
Outcome:

Comments:
RLD 03/16/2014 -

Characters left: 984

A popup appears that allows you to associate a disease/medical problem with the surgery, along with other details, as you see demonstrated.

Manage Past Medical History

Disease/Disorder
Disease/disorder:

SNOMED code:

Onset date: / / 2002 Side:

Management
Management:

SNOMED code:

Date: / / 2002 Side:

Facility:

Provider: (Last) (First)

Outcome/Comments
Outcome:

Comments:
RLD 03/16/2014 -

Characters left: 984

When done click **Save to Grid & Close**.

Specialty:

Panel Control:

Medical

Surgical

To add comments, click manage.

Date:

Date:

Date:

- Angioplasty
- Appendectomy
- Arthroscopy
- [Back surgery](#)
- Blood transfusion
- CABG
- Cardiac pacemaker
- Carpal tunnel release
- Cataract extraction
- Cholecystectomy

- Colectomy
- Colostomy
- Gastric bypass
- Hernia repair
- Hip replacement
- Knee replacement
- LASIK
- ORIF
- Thyroidectomy
- Tonsillectomy
- Other

The hernia appears on the grid.

Past Medical History Grid

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment
Inguinal hernia	left	2002	Hernia repair	left	2002		successful	RLD 03/16/201

He also had an L4-5, L5-S1 discectomy & fusion in 2004 for degenerative lumbar problems. Click [Back surgery](#); note that it is a blue link instead of just a plain checkbox.

Here you see a short picklist of spinal procedures. More than one may be appropriate. Pick the best match; here we'll double-click **Discectomy, lumbar**.

The screenshot shows a 'Manage Past Medical History' window with a 'Management' tab. A modal dialog titled 'Ngkbn Get PMH Sec Diag' is open, displaying a list of diagnoses. A green arrow points to 'Discectomy, lumbar' in the list. The background window has fields for 'Disease/Disorder', 'SNOMED code', 'Onset date', 'Outcome/Comments', and 'Comments'. The 'Comments' field contains 'RLD 03/16/2014 -'. At the bottom left, it says 'Characters left: 984'. The dialog has 'Refresh', 'OK', and 'Cancel' buttons.

Diagnosis
Discectomy, cervical
Discectomy, lumbar
Discectomy, thoracic
Laminectomy
Laminotomy
Spinal fusion, cervical
Spinal fusion, lumbar
Spinal fusion, thoracic
Surgery, cervical spine
Surgery, lumbar spine
Surgery, thoracic spine

If there is just *nothing* here you can use, you can cancel out of this & type an entry.

Manage Past Medical History [X]

Disease/Disorder
Disease/disorder: [dropdown]
SNOMED code: [text]
Onset date: [] / [] / [] Side: []

Management
Management: [Discectomy, lumbar]
SNOMED code: [178618008]
Date: [] / [] / [] Side: []
Facility: []
Provider: (Last) [] (First) []

Outcome/Comments
Outcome: []
Comments: [RLD 03/16/2014 -]
Characters left: 984

[Save to Grid & Close] [Cancel]

As before, a popup allows you to enter details; note that I've expanded upon the management details.

Manage Past Medical History [X]

Disease/Disorder
Disease/disorder: [Lumbar disc degenerative disease]
SNOMED code: [26538006]
Onset date: [] / [] / [2004] Side: []

Management
Management: [L4-5, L5-S1 discectomy & fusion]
SNOMED code: []
Date: [] / [] / [2004] Side: []
Facility: []
Provider: (Last) [] (First) []

Outcome/Comments
Outcome: [improved]
Comments: [RLD 03/16/2014 -]
Characters left: 984

[Save to Grid & Close] [Cancel]

When done click **Save to Grid & Close**.

Specialty:

Panel Control:

Medical
Surgical

The additional entry displays.

- Appendectomy
- Arthroscopy
- Back surgery
- Blood transfusion
- CABG
- Cardiac pacemaker
- Carpal tunnel release
- Cataract extraction
- Cholecystectomy
- Colostomy
- Gastric bypass
- Hernia repair
- Hip replacement
- Knee replacement
- LASIK
- ORIF
- Thyroidectomy
- Tonsillectomy

Date: Other

Note that you can later select one of the grid entries & edit it.

Past Medical History Grid

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment
Lumbar disc degenerative disease		2004	L4-5, L5-S1 discectomy & fusion		2004		improved	RLD 03/16/201
Inguinal hernia	left	2002	Hernia repair	left	2002		successful	RLD 03/16/201

When you've entered everything you need, click **Save & Close**.

Specialty Family Practice Visit Type Office Visit

This history now displays.

Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | History Review

All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Panel Control: Toggle Cycle

Problem List 2

Show chronic Show my tracked problem

Problem Description	Side
Diabetes mellitus type II	
Essential hypertension	

More details about the Problem List & Past History are available in the Histories lesson.

Refresh Add Edit

Medical/Surgical/Interim

No relevant past medical/surgical history

All History Review details are to be reviewed and included in visit note unless user indicates otherwise History Review

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Lumbar disc degenerative disease		2004	L4-5, L5-S1 discectomy & fusion		2004		improved
Inguinal hernia	left	2002	Hernia repair	left	2002		successful

Now we'll use the collapsible panels to move down to the Family History.

Refresh Interim History Add Edit Remove

Diagnostic Studies

Family




Specialty ▾ Family Practice Visit Type ▾ Office Visit

Home Intake **Histories** SOAP Finalize Checkout

[Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library]

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: [Toggle] [Cycle]

- Problem List** 2
- Medical/Surgical/Interim
- Diagnostic Studies
- Family 

No relevant family history Adopted - no family history known

All History Review details are to be reviewed and included in visit note unless user indicates otherwise [History Review](#)

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments

Click Add.

Add Edit Remove

Family Health History

Specialty:

No family history of:

Relationship:

Family member name:

Alive and well Deceased

ADD/ADHD Onset age: Cause of death:
 Elevated lipids Onset age: Cause of death:
 Other Onset age: Cause of death:

Enter this Family History:
 His brother has hypertension.
 His mother died from alcoholism at age 52.
 (Family History is covered in detail in the Histories lesson.)
 When done click Save & Close.

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

These additions display in the grid.

Care Guidelines Global Days History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise Panel Control: Toggle Cycle

Problem List 2

Medical/Surgical/Interim

Diagnostic Studies

Family

No relevant family history Adopted - no family history known All History Review details are to be reviewed and included in visit note unless user indicates otherwise History Review

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
Brother				Hypertension		N	
Mother		Y	52	Alcoholism	52	Y	
Mother		Y	52				

Now move down to Social History & click the Add button.

Add Edit Remove

Social

(last updated 03/15/2014)

History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Last documented All

Substances	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
Tobacco							
Alcohol/Caffeine							
Statuses							
Lifestyle							
Occupation							
Comment							
Diet History							
Environmental							

Confidential History Add

- ◆ Tobacco
- ◆ Alcohol/Caffeine
- ◆ Statuses
- ◆ Lifestyle



Save & Close

Panel Control:



Toggle



Cycle



Tobacco Use



Enter this Social History:

He's smoked 1 pack per day for about 24 years; you advised smoking cessation & asked if he'd like to talk to the doctor today about help quitting. He declined. He drinks an average of 1 drink per day. He works as an accountant.

(Social History is covered in detail in the **Histories** lesson.)

When done click **Save & Close**.

Historical Use



Date	Tobacco type	Usage per day	Years used	Age started	Age stopped	Smoking status
03/15/2014	Cigarette	1 Packs	24.00	24.00		Heavy tobacco smoker 17

Efforts To Quit Tobacco



Have you ever tried to quit using tobacco? No/never Yes Unknown

Tobacco type:

Month: Day: Year:

Quit:

Longest tobacco free:

Cessation method:

Relapse reason:

Add

Update

Clear

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations Birth History Procedures Order Management Document Library

Care Guidelines Global Days History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Panel Control: Toggle Cycle

Problem List 2

Medical/Surgical/Interim

Diagnostic Studies

Family

Social

These details display in the grid.

History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise

(last updated 03/15/2014)

Last documented All

Substances	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
Tobacco	03/15/2014	Yes	Cigarette	Heavy tobacco smoker	1 Packs	24.00	
Alcohol/Caffeine							

But since we've just collected a history of smoking, let's expand the Problem List panel & add Tobacco Abuse.

Confidential History Add

I've done that, using the methods demonstrated earlier.

03/15/2014 10:06 PM : "USA Histories" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: ▾ Toggle ↶ ↷ Cycle ↻

Problem List 3

Show chronic Show my tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl
Diabetes mellitus type II		Was diet-controlled until ~2011.	1
Essential hypertension			
Tobacco abuse			

Refresh Add Edit

Also note the Tobacco Risk Indicator is now activated, since we recorded this in the Social History. Click the **Configure** button to complete the other Risk Indicators.

Risk Factors Config

No risk indicators

Tobacco:

Smoking status:

Tobacco use:

Tobacco cessation discussed 

Tobacco Usage:

Enc Date	Use	Type	Total Pk Yrs
03/15/2014	yes	Cigarette	24.00

Hypertension:

Yes No Unknown

Diabetes:

Yes No Unknown

CAD:

Yes No Unknown

Tobacco has already been addressed. Sometimes the other risk indicators will also be answered "yes" automatically if those diagnoses are previously documented on the **Chronic Condition List** or earlier encounters, but this doesn't work predictably, & no entry will be pre-populated as "no." So this will require some manual configuration the first time & upon any subsequent change.

Click the bullets for **Hypertension Yes**, **Diabetes Yes**, & **Coronary Artery Disease No**.

When done click **Save & Close**.

All Risk Indicators are now configured.

The screenshot shows a medical software interface. At the top, a green box contains the text "All Risk Indicators are now configured." with an arrow pointing to a row of four risk indicators: TOB, HTN, DM, and CAD. Below this, the interface shows a navigation bar with "Intake", "Histories", "SOAP", "Finalize", and "Checkout". Under "Histories", there are sub-links for "Standing Orders", "Adult Immunizations", "Peds Immunizations", "Birth History", "Procedures", "Order Management", and "Document Library". A "Care Guidelines" section is also visible, with a "History Review" link and a note: "All History Review details are to be reviewed and included in visit note unless user indicates otherwise". Below this is a "Problem List" section with 3 items. It includes checkboxes for "Show chronic", "Show only tracked problem", "No active problems", and "Reviewed". The table below lists three problems: "Diabetes mellitus type II" (with side and notes), "Essential hypertension", and "Tobacco abuse".

03/15/2014 10:06 PM : "USA Histories" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | History Review *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: Toggle Cycle

Problem List 3

Show chronic Show only tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl
Diabetes mellitus type II		Was diet-controlled until ~2011.	1
Essential hypertension			
Tobacco abuse			

Say the clinic has standing orders to perform a sugar on all diabetics, & a HbA1c on all diabetics who haven't had one in 3 months. Click the **Standing Orders** link, which can be found in several locations.

On the **Standing Orders** popup, click in the **Display order set** box. In the ensuing popup, double-click **Office Tests**.

The screenshot shows the 'Office Services' application window. The main window has a 'Display category' dropdown set to 'ALL'. A popup window titled 'Ngkbn Dbp Ofc Orderset Types' is open, showing a list of 'Txt Set Type' options: ALL, Body, Head/Spine, Lower Extremity, Office Meds, Office Tests, ORT, and Upper Extremity. A green arrow points from the 'Office Tests' option in the popup to the 'Display category' dropdown in the main window.

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
ALL	Allergen immunotherapy, 2+ injections	95117		
ALL	Allergen immunotherapy, one injection	95115		
ALL	Allergen immunotherapy, one injection	95115		BLDD, CHIEF SYMPTOME
ALL	Antigen therapy services, single/mult antigen			
ALL	Assay, albumin, urine, microalbumin, semiquan			
ALL	Assay, blood PKII			

Ngkbn Dbp Ofc Orderset Types

Txt Set Type

- ALL
- Body
- Head/Spine
- Lower Extremity
- Office Meds
- Office Tests
- ORT
- Upper Extremity

Refresh OK Cancel

Quick Task Place Order Update

Save & Close Cancel

Scroll down & find **Glucose blood test** associated with Diabetes...250.00. Select that, then click the **Details**.

The screenshot shows the 'Office Services' application window. A green arrow points from the text above to the 'Glucose blood test' row in the table. Another green arrow points from the 'Details' button to a 'Value' dialog box. A third green arrow points from the 'Value' dialog box to the 'OK' button. A green box contains the text: 'Enter 156 mg/dL, then click OK.'

Office Services

Panel Control: Toggle Cycle

Office Services 0

Orders
(Highlight a row to select)

Display category: Office Tests

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description	DX Code	De
Office Tests	Flu test, rapid	87804		FLU W RESP MANIFEST NEC	487.1	
Office Tests	Glucose blood test	82962		DMI WO CMP NT ST UNCNR	250.00	nu
Office Tests	Glucose blood test	82962		DMI WO CMP NT ST UNCNR	250.01	nu
Office Tests	Glucose blood test	82962		ABNORMAL GLUCOSE NEC	790.29	nu
Office Tests	Glucose blood test	82962		OTHER ALTER CONSCIOUSNES	780.09	nu
Office Tests	Glucose blood test	82962		LIRINARY FRFOLIFNCY	788.41	ni

Diagnosis

*Order: Glucose blood test Procedure code: 82962 Side:

*Diagnosis: DMI WO CMP NT ST UNCNR Dx code: 250.00 Status:

Results/Report

Interpretation: Details Normal value/range:

Clinical indication:

Details:

Today's Orders

Sort By: Summary Phrase My Phrases Manage My Phrases

Interpretation Result Performed By

Quick Task Place Order Update

Save & Close Cancel

Value

156

7 8 9 +

4 5 6

1 2 3

0 . -

Clear

OK Cancel

Office Services 0

Orders

(Highlight a row to select)

Display category:

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description	DX Code	De
Office Tests	Flu test, rapid	87804		FLU W RESP MANIFEST NEC	487.1	
Office Tests	Glucose blood test	82962		DMII WO CMP NT ST UNCNTR	250.00	nu
Office Tests	Glucose blood test	82962		DMI WO CMP NT ST UNCNTL	250.01	nu
Office Tests	Glucose blood test	82962		ABNORMAL GLUCOSE NEC	790.29	nu
Office Tests	Glucose blood test	82962		OTHER ALTER CONSCIOUSNES	780.09	nu
Office Tests	Glucose blood test	82962		URINARY FREQUENCY	788.41	nu

Diagnosis

*Order: Procedure code: Side: *Diagnosis: Dx code: Status:

Results/Report

Interpretation: Normal value/range: Unit of measure: Clinical indication: Sort By: Summary Phrase [My Phrases](#) | [Manage My Phrases](#)Details:

Today's Orders

 Submit to Superbill Verbal order/needs sign-off Send task automatically[Additional Orders](#) | [Task](#)

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl

Diagnostic History Entry 0

Click Submit to Superbill, then Place Order.

Office Services 1

Orders

(Highlight a row to select)

Display category: Office Tests

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description	DX Code	De
Office Tests	Glucose; quantitative, blood (except reagent strip)	82947				nu
Office Tests	Hemoglobin A1c	83036		DMII WO CMP NT ST UNCNTR	250.00	nu
Office Tests	Hemoglobin A1c	83036		DMI WO CMP NT ST UNCNTL	250.01	nu
Office Tests	Hemoglobin A1c	83036		ABNORMAL GLUCOSE NEC	790.29	nu
Office Tests	INR/PT	85610		LONG-TERM USE ANTICOAGUL	V58.61	nu
Office Tests	INR/PT	85610		HFMORRHAGE NOS	459.0	nu

Diagnosis

*Order: Hemoglobin A1c

Procedure code: 83036

Side:

*Diagnosis:

In a similar manner, enter a HbA1c of 7.4.
When done click **Close**.

Results/Report

Interpretation: see detail

Normal value/range:

Unit of measure:

Clinical indication:

Sort By: Summary Phrase [My Phrases](#) | [Manage My Phrases](#)

Details:

7.4

Today's Orders

 Submit to Superbill Verbal order/needs sign-off Send task automatically[Additional Orders](#) | [Task](#)

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl
completed	Glucose blood test		see detail	156	Robert L. Duffy	

Diagnostic History Entry 0

Medication	Directions
losartan 50 mg tablet	1 daily
metformin 500 mg tablet	1 twice daily

Ingredient	Reaction	Medication Name	Comr
TETRACYCLINE	Rash		

Add Reconcile Add

Orders

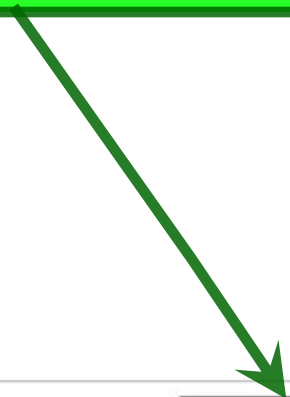
Status	Lab Order	Timeframe	Comments
completed	Glucose blood test		
completed	Hemoglobin A1c		
completed	Patient counseled on tobacco cessation.		

- ▶ All Orders (3)
- Labs
- Diagnostics
- Office Services (2)
- Immunizations
- Procedures
- Guidelines

Now click **Generate Intake Note** using the button at the bottom of the **Intake** or **Histories** Tab. (You might actually do this while waiting for the glucose & HbA1c results to appear.)

- Respiratory
 - Cardiovascular
 - Vascular
 - Gastrointestinal
 - Genitourinary
 - Reproductive
 - Metabolic | Endocrine
 - Neuro | Psychiatric
 - Dermatologic
 - Musculoskeletal
 - Hematologic
- Primary Care ROS - Male

Generate Intake Note



TX Text

Arial 12 B I U [List Icons] 100%

PATIENT: Pepe Quagmire
 DATE OF BIRTH: 01/03/1973
 DATE: 03/15/2014 10:06 PM
 HISTORIAN: self
 VISIT TYPE:

History of Present Illness:

1. Cough
2. DM/HTN

Intake Comments: Cough x 3 days, gradually worsening, like bronchitis he's had before. No fever. Also needs med refills; has been out of Cozaar for last wk.

Problem List:

Problem Description	Onset Date	Chronic	Notes
Essential hypertension		Y	
Tobacco abuse	01/01/1990	Y	
Diabetes mellitus type II		N	Was <u>diet-controlled</u> until ~2011.

PAST MEDICAL/SURGICAL HISTORY (Detailed)

Disease/disorder	Onset Date	Management	Date	Comments
Inguinal hernia	2002	Hernia repair	2002	RLD 03/16/2014 -

The **Intake Note** is created, summarizing all of the data you've just entered.

Close this, returning you to the **Intake Tab**.

Specialty ▾ Family Practice Visit Type ▾ Office Visit

TOB HTN DM CAD

Intake Histories SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management

Care Guidelines | Global Days Panel Control: Toggle Cycle

The patient is ready for the provider.
Re-expand the Info Bar & click the Tracking icon.

Lab/Radiology Order Processing | Order Management | Immunizations | Standing Orders | Task

Status	Ordered	Order	Timeframe	Comments
View of All Orders				
Labs				
Diagnostics				
Office Services				
View Immunizations Due				
Procedures				
Referrals				

Add Edit

Click in the Room box & select a room; alternately, you can just type a room number in the box.

Appointment date: 02/21/2014

Today's date: 02/24/2014

Appointment information:

9:00 AM DUFFY MD, ROBERT LAMAR Reason:

Room: []

Status:

Ngkbn Get Dbpicklist Items [X]

List Item
Checkout
Exam 1
Exam 2
Exam 3
Exam 4
Exam 5
Exam 6
Lab
Procedure room
Waiting room
X-ray

[Refresh] [OK] [Cancel]

Patient Tracking:

Appt Time	Room

Appointment date shown.

Today's Patient Tracking

Appointment date: 02/21/2014 Today's date: 02/24/2014

Appointment information:
9:00 AM DUFFY MD, ROBERT LAMAR Reason:

Room: Exam 1 **Status:** Attended (Entries uploaded on "Save and Close".)

Patient Tracking:

Appt Time	Room	Sta

Next, click in the **Status** box & select **waiting for provider**.

Ngkbn Get Dbpicklist Items

List Item
chart complete
chart incomplete
chart needs sign-off
checked out
discharged
F&M Code Submitted
ready for check-out
waiting for educator
waiting for nursing
waiting for provider
with nursing
with provider

Refresh OK Cancel

Today's Patient Tracking ✕

Appointment date: 02/21/2014

Today's date: 02/24/2014

Appointment information:

9:00 AM DUFFY MD, ROBERT LAMAR Reason:

Room: Exam 1

Status: waiting for provider

(Entries uploaded on "Save and Close".)

Patient Tracking:

The Inbox will update today's calendar and not the appointment date shown.

Appt Time ▾	Room	Status	Time	Documented By

When done click **Save & Close**.
The nurse can finish entering sugar & HbA1c results if necessary. But otherwise she is done & the patient is ready for the provider.



Task EHR Appointments **Save & Close** Cancel



Patient

Location

Provider

Date

The screenshot displays a medical software interface for a patient named Pepe Quagmire. The patient's information includes MRN: 00000007772, DOB: 01/03/1973 (Male), AGE: 41 years 2 months, and a visit on 03/15/2014 at 10:06 PM. The provider is identified as DUFFY, ROBERT LAMAR MD. The interface shows a navigation pane on the left with options like Intake, Histories, SOAP, Finalize, and Checkout. The main area displays a 'Medical Chart Summary' with a list of categories such as HPI's, Plans, Problem List, Medications, Allergies, Labs, Diagnostics, Vitals, Physical Exams, Office Procedures, Procedures, Referrals, Past Medical/Surgical History, Family History, and Tobacco Usage. A 'Patient History' pane on the right shows a list of appointments, with the selected one being 03/15/2014 10:06 PM. A green arrow points from the 'Date' label to the appointment date in the Patient History pane. Another green arrow points from the 'Patient' label to the patient's name in the top navigation bar. A third green arrow points from the 'Provider' label to the provider's name in the top navigation bar. A fourth green arrow points from the 'Location' label to the location dropdown menu in the top navigation bar. A large green box at the bottom contains the text: 'The provider then opens the chart from the appointment list & performs the 4-point check.'

The provider then opens the chart from the appointment list & performs the 4-point check.

NextGen EHR: Pepe Quagmire MRN: 000000007772 DOB: 01/03/1973 (Male) AGE: 41 years 2 months - 03/15/2014 10:06 PM : "**USA Home Page"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Weight: 199.00 lb (90.26 Kg) Allergies: (1) Problems: (3) Diagnoses: (0) Medications: (2)

Address: 555 Driveby Drive Mobile, AL 36604 MRN: 000000007772 Insurance: AFLAC Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Contact: (251) 555-1111 (Home) NextMD: No Emergency Phone: Referring: ...
Pharmacy 1: Central Discount ... Rendering: DUFFY, ROBERT LAMAR ...

Alerts Patient Lipid Clinic Data Order Admin Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : "**USA Home Page"

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Medical Chart Summary

HPI's Plans Problem List Medications Allergies Labs Diagnostics Vitals Physical Exams Office Procedures Procedures Referrals Past Medical/Surgical History Family History Tobacco Usage

TOB HTN DM CAD

Patient History

Patie... Patie... Cate...

New Lock Search

03/15/2014 10:06 PM

*USA Intake USA Histories Medication intake_note

Custom

Ready NGDevil USA Health Services Foundation rlduffy CAP NUM SCRL 03/17/2014

The provider generally starts on the Home Tab.
It's good to begin by looking for **Sticky Notes & Alerts**; there are none on this patient.
Also take note of the **Risk Indicators**.

You can select any of the headings on the left to view various aspects of the chart. In particular, this is a good place to look at Office Lab results or review previous vital signs.

The screenshot displays a medical software interface. At the top, there is a navigation bar with tabs for Alerts, Patient, Lipid Clinic Data, Order Admin..., Sticky Note, Referring Provider, HIPAA, Advance Directives, and Screening Summary. Below this is a patient information section with Specialty (Family Practice) and Visit Type (Office Visit). The main area is titled "Medical Chart Summary" and contains a table of vital signs. A navigation menu on the left lists various chart components, with "Vitals" selected. A patient history panel on the right shows a list of recent activities, including "USA Intake", "USA Histories", "Medication", and "intake_note".

HPI's	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Plans	03/15/2014	11:19 PM	97.7	167/123	84	16	73.00	199.00	26.25				

Note also you can use the collapsible panels or scroll down to see a lot more information.

The Problem List is viewable & editable here.

Care Guidelines

Global Days

Panel Control: ▾ Toggle ⏪ ⏩ Cycle ↻

Medical Chart Summary

Problem List 3

 Show chronic
 Show my tracked problems

 No active problems
 Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Clinical Status	Provider	Location	Notes
	Essential hypertension		Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	
	Tobacco abuse	01/01/1990	Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	
	Diabetes mellitus type II		N	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	Was diet-controlled until ~2011.

Refresh

Add

Edit

History Summary

History Review

All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Confidential

(last updated 03/15/2014)

 No relevant past medical/surgical history

Management	Side	Date	Encounter Type	Outcome	Disease/Disorder
L4-5, L5-S1 discectomy & fusion		2004		improved	Lumbar disc degenerative disease
Hernia repair	left	2002		successful	Inguinal hernia

Medical

- ▶ Surgical/mgmt

Interim

Social

Family

Diagnostic

Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.

Add

Edit

Remove



Allergies

[Comment](#) No known allergies Allergies added today Reviewed, no change

Allergen	Reaction	Medication Name	Comment
TETRACYCLINE	Rash		

Allergies, meds, vital signs, office labs—everything that can be found on the **Intake & Histories Tabs** can be reviewed & if necessary updated from this tab. Update

Medications

Patient status: Transitioning into care Summary of care received  [Comment](#) No medications Medications reconciled 

Medication	Sig	Description
losartan 50 mg tablet	1	daily
metformin 500 mg tablet	1	twice daily

Add/Update Reconcile

Vital Signs ! Vital Signs Outside Normal Range

[History](#) | [Graph](#)

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
11:19 PM	73.00	199.00	26.25	167/123	84	16	97.7				

Add Edit Remove

Orders

[Lab/Radiology Order Processing](#) | [Order Management](#) | [Immunizations](#) | [Standing Orders](#) | [Task](#)

Ordered	Status	Order	Timeframe	Comments
View of All Orders Labs				

NextGen EHR: Pepe Quagmire MRN: 000000007772 DOB: 01/03/1973 (Male) AGE: 41 years 2 months - 03/15/2014 10:06 PM : "*USA Home Page"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Pepe Quagmire (M) DOB: 01/03/1973 (41 years) Weight: 199.00 lb (90.26 Kg) Allergies: (1) Problems: (3) Diagnoses: (0) Medications: (2)

Address: 555 Driveby Drive Mobile, AL 36604 MRN: 000000007772 Insurance: AFLAC Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Contact: (251) 555-1111 (Home) NextMD: No Emergency Phone: Referring: ...
Pharmacy 1: Central Discount ... Rendering: DUFFY, ROBERT LAMAR ...

Alerts Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/15/2014 10:06 PM : "*USA Home Page"

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Medical Chart Summary

HPT's Plans Problem List Medications Allergies Labs Diagnostics Vitals Physical Exams Office Procedures Procedures Referrals Past Medical/Surgical History Family History Tobacco Usage

Date Title Temp F BP Pulse Respiration Ht In Wt Lb BMI BSA Pain Score HAQ Score Pulse

03/15/2014 11:05:00 AM 97.7 157/94 94 18.0 1.73 25.7

TOB HTN DM CAD

Patient History

Patie... Patie... Cate...

New Lock Search

03/15/2014 10:06 PM

*USA Intake
USA Histories
Medication
intake_note

Ready

NGDev| USA Health Services Foundation | rlduffy | CAP | NUM | SCRL | 03/17/2014

You can also just review the intake_note to see a summary as well. Regardless of the method chosen, the provider is responsible for reviewing & confirming this information, & updating it as necessary.

When you're done reviewing the chart, move to the SOAP tab.

Specialty Family Practice Visit Type Office Visit

Intake Historics SOAP Finalize Checkout

We'll start entering the HPI. First note that you can keep or edit this introductory line—or delete it all together.

Reason for Visit

Introduction:

This 41 year old male presents for Cough and DM/HTN.

Do not launch HPI

Intake Comments

	Reason for Visit	History of Present Illness
abdominal pain	Cough	
back pain	DM/HTN	
chronic conditions		
cold symptoms		
cough		
diabetes (follow up)		
earache		
fever		
headache		
hypertension (follow up)		
musculoskeletal pain		

If you didn't previously note them, you can review the nurse's Intake Comments.

Next, you have some options as to how to proceed. You can click on one of the Reasons for Visit to open the HPI Popup. We'll click cough.

Diagnostics Comments

Information on this HPI that has been pre-populated from another HPI must be changed on the original HPI to prevent conflicting documentation.

Concern:

Status:
 No change
 Improved
 Resolved
 Gradually worse

Frequency:
 Occasional
 Persistent
 Nocturnal only

Severity:   Onset:  

Quality of Cough:
 None Productive Green

Context:
 Allergies GERD symptoms Sick family member
 Heart failure Smoke exposure
 Known asthmatic Smoker

You can use picklists, checkboxes, & bullets to document elements of the HPI. You can type a little more info in the Comments box.

Aggravated By:
 Aspirin Laughing
 Cold air Lying down
 Exercise Stress

Relieved By:
 Decongestants Steroids
 Bronchodilators OTC cough syrup Tea with honey

Other:

Other:

Associated Symptom/Pertinent Negatives:

No associated symptoms
 No Yes
 Chills
 Cough
 Dyspnea
 Dyspnea on exertion
 Epistaxis

No pertinent negatives
 No Yes
 Fatigue
 Fever
 Heartburn
 Hemoptysis
 Hoarseness
 Nasal congestion
 Night sweats
 Pleuritic pain
 Post-nasal drainage
 Rhinitis

No Yes
 Sinus pressure
 Sore throat
 Weight loss
 Wheezing

Other associated symptoms:

Other pertinent negatives:

Comments:

No Yes
 History of allergies
 History of asthma

Has had several bouts of bronchitis in past similar to this.

Save & Close

Cancel

And you can save & reuse presets.

Information on this HPI that has been pre-populated from another HPI must be changed on the original HPI to prevent conflicting documentation.

Chronic Conditions

Last Addressed	Condition	Code	Additional Information
/ /	Benign essential hypertension	401.1	
/ /	Diabetes Mellitus Type 2,	250.00	

Vital Signs:

Home blood pressure range: Timeframe: [Blood Pressure Classification](#)
[] / [] / [] [] Add discrete home BP to vitals

Vital Signs Outside Normal Range (Double click on data grid to add new.)

Date	Time	Ht Ft	Ht In	Wt Lb	BMI	BP	Pulse Rate
04/13/2013	5:21 PM		73.00	199.00	26.25	167/123	84

Flowsheets Address

If you had clicked on the DM/HTN Reason for Visit, you would see the Chronic Conditions HPI Popup. There are good & bad things about this popup. The latest version is under review, & may be the subject of another lesson if it looks like it will be of value to our users.

Add History

Comments: []

Clinical Guidelines:

Show due within: []

Diabetes Hypertension	Guideline	Goal	Status	Due	Action
	ACEI		alternate	04/13/2013	Prescribed ARB
	Antiplatelet		not prescribed	04/13/2013	
	ARB		prescribed	04/13/2013	losartan 50 mg tablet
	Beta Blocker		not prescribed	04/13/2013	

Category: Guideline: Status: Action:

When done click **Save & Close**.

Update Save & Close Cancel

Entries from the HPI popups display on the SOAP Tab.

03/15/2014 10:06 PM : "**USA SOAP" x

Specialty ▾ Family Practice Visit Type ▾ Office Visit

TOB HTN DM CAD

Intake Histories **SOAP** Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Care Guidelines | Global Days

Panel Control: Toggle Cycle

Reason for Visit

Introduction:

This 41 year old male presents for Cough and DM/HTN.

Do not launch HPI ◆ Intake Comments

	Reason for Visit	History of Present Illness
abdominal pain back pain chronic conditions cold symptoms cough diabetes (follow up) earache fever headache hypertension (follow up) musculoskeletal pain PAP test rash sore throat	Cough	Severity: moderate. The patient describes the cough as productive (of green sputum). It occurs persistently. The problem has become gradually worse. Context: smoker. Associated symptoms include cough, nasal congestion, post-nasal drainage and rhinitis. Pertinent negatives include fever and sore throat. The patient does not have a history of allergies. Additional information: Has had several bouts of bronchitis in past similar to this.
Additional / Manage	DM/HTN	

Diagnostics Comments

Specialty ▾ Family Practice

Visit Type ▾ Office Visit

Intake

Histories

SOAP

Finalize

Checkout

Standing Orders

Adult Immunizations

Peds Immunizations

My Plan

Procedures

Order Management

Document Library

Care Guidelines

Global Days

Panel Control: Toggle Cycle

Reason for Visit

Comments about HPI Popups:

- HPI popups can present a rapid way to document key elements of the HPI if the user is very familiar with the popup.
- For some common complaints you may find yourself saying the same thing repeatedly throughout the day, & using presets may be of help there—though it takes some care not to inadvertently document erroneous or conflicting HPI details when the patient's story differs from the preset.
- And the elements you pick allow the coding assistant to help you bill for the visit—particularly useful for new patient encounters, which require all 3 billing elements.

Specialty ▾ Family Practice

Visit Type ▾ Office Visit

Comments about HPI Popups:

- But many users find the "pick & click" nature of using HPI popups tedious, slow, & frustrating—and distracting when trying to perform documentation in real time in the exam room.
- The Comments boxes on the HPI popups provide only a limited amount of space to type, which can vary from one to another, so that you never know when you're going to run out of space.
- And when entries from a series of "picks & clicks" are condensed into something resembling English, the result is often awkwardly-worded, not really reflecting any uniqueness of the story or the story-teller. Your eyes glaze over when you read it; often you can't even recognize whether you performed the visit or if it was done by one of your colleagues.

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

Reason for Visit

Introduction:

This 41 year old male presents for Cough and DM/HTN.

Do not launch HPI

Intake Comments

	Reason for Visit	History of Present Illness
abdominal pain	Cough	Severity: moderate. The patient describes the cough as productive (of green sputum). It occurs persistently. The problem has become gradually worse. Context: smoker. Associated symptoms include cough, nasal congestion, post-nasal drainage and rhinitis. Pertinent negatives include fever and sore throat. The patient does not have a history of allergies. Additional information: Has had several bouts of bronchitis in past similar to this.
back pain	DM/HTN	
chronic conditions		
cold symptoms		
cough		
diabetes (follow up)		
earache		
fever		
headache		
hypertension (follow up)		
musculoskeletal pain		
past medical history		
respiratory		
social history		
Additional / Manage		

There is an alternative many providers will find more comfortable than using the HPI popups. Click the Comments button.

Diagnostics Comments

Chief complaint/reason for visit:

Manage My Phrases

cough

My Phrases

1. Gradually worsening cough over last 3 days. Productive of green sputum. Nasal congestion, drainage. Some chills, no fvr. No sore throat, SOB, N/V/D. Still smoking. Feels similar to prev bouts of bronchitis.

DM/HTN

My Phrases

2. Needs med refills; out of losartan 1-2 wks, & sometimes misses doses anyway. Taking DM meds as listed. No recent eye exam. Checks feet; no sores. Not really following any specific diet. Lipid panel was done about 3 months ago; atorvastatin 10 Rx'd, but pt didn't get prescription.

3.

Here you have essentially unlimited space to type the story. Sketch it out with a few words & phrases in real time while interviewing the patient; flesh it out later if desired. You can jump from one complaint to another, just like patients do when telling their story. And you have access to **My Phrases**—a robust way to save & reuse text that you say repeatedly throughout the day. (Setup & use of **My Phrases** is covered in the User Personalization demonstration.)

When done click **Save & Close**.

Save & Close

Cancel

Your entries are displayed. Note that use of HPI popups & HPI Comments are not mutually exclusive. Especially for new patients you may wish to use the "pick & click" options on the HPI popups for coding purposes, but use HPI Comments to actually "tell the story."

Introduction:

This 41 year old male presents for Cough and DM/HTN.

Do not launch HPI

abdominal pain
back pain
chronic conditions
cold symptoms
cough
diabetes (follow up)
earache
fever
headache
hypertension (follow up)
musculoskeletal pain
PAP test
rash
sore throat

Additional / Manage

Reason for Visit	History of Present Illness
Cough	Severity: moderate. The patient describes the cough as productive (of green sputum). It occurs persistently. The problem has become gradually worse. Context: smoker. Associated symptoms include cough, nasal congestion, post-nasal drainage and rhinitis. Pertinent negatives include fever and sore throat. The patient does not have a history of allergies. Additional information: Has had several bouts of bronchitis in past similar to this.
Cough (comments)	Gradually worsening cough over last 3 days. Productive of green sputum. Nasal congestion, drainage. Some chills, no fvr. No sore throat, SOB, N/V/D. Still smoking. Feels similar to prev bouts of bronchitis.
DM/HTN	
DM/HTN (comments)	Needs med refills; out of losartan 1-2 wks, & sometimes misses doses anyway. Taking DM meds as listed. No recent eye exam. Checks feet; no sores. Not really following any specific diet. Lipid panel was done about 3 months ago; atorvastatin 10 mg Rx'd, but pt didn't get prescription.

Diagnostics

Comments

Working down the **SOAP** tab, you come to the **Review of Systems**. Note that some items that are shared with the HPI popups may already be documented. For an established patient, this may be all the ROS you wish to perform.

Specialty ▾ Family Practice Visit Type ▾ Office Visit

Intake Histories **SOAP** Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Care Guidelines | Global Days | Panel Control: Toggle Cycle

Reason for Visit

Review of Systems

System	Neg/Pos	Findings
Constitutional	Negative	Fever.
ENMT	Positive	Nasal congestion, Post-nasal drainage, Rhinitis.
ENMT	Negative	Sore throat.
Respiratory	Positive	Cough.

- Constitutional
- HEENT
- Respiratory
- Cardiovascular
- Vascular
- Gastrointestinal
- Genitourinary
- Reproductive
- Metabolic | Endocrine
- Neuro | Psychiatric
- Dermatologic
- Musculoskeletal
- Hematologic
- Immunologic
- One Page ROS - Male

If you need to record further ROS, a good place to start is with the one-screen ROS option you see, which is age & gender-specific. Click **One Page ROS - Male**.

Make additional entries as necessary. You can click on any system heading to take you to a more detailed ROS for that system. And you can save & reuse presets.

ROS-Male

Information on this ROS that has been pre-populated from a HPI must be changed on the HPI to prevent conflicting documentation.

ROS Defaults:

Constitutional All neg

Neg Pos

- Chills
- Fatigue
- Fever
- Malaise
- Night sweats
- Weight gain
- Weight loss
- Other:

HEENT All neg

Neg Pos

- Ear drainage
- Ear pain
- Eye discharge
- Eye pain
- Hearing loss
- Nasal drainage
- Sinus pressure
- Sore throat
- Visual changes
- Other:

Respiratory All neg

Neg Pos

- Chronic cough
- Cough
- Known TB exposure
- Shortness of breath
- Wheezing
- Other:

Cardiovascular All neg

Neg Pos

- Chest pain
- Claudication
- Edema
- Palpitations
- Other:

Gastrointestinal All neg

Neg Pos

- Abdominal pain
- Blood in stools
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting
- Other:

Genitourinary All neg

Neg Pos

- Dribbling
- Dysuria
- Hematuria
- Polyuria
- Slow stream
- Urinary frequency
- Urinary incontinence
- Urinary retention
- Other:

Reproductive All neg

Neg Pos

- Erectile dysfunction
- Penile discharge
- Sexual dysfunction
- Other:

Metabolic / Endocrine All neg

Neg Pos

- Cold intolerance
- Heat intolerance
- Polydipsia
- Polyphagia
- Other:

Neurological All neg

Neg Pos

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Tremors
- Other:

Psychiatric All neg

Neg Pos

- Anxiety
- Depression
- Insomnia
- Other:

Integumentary All neg

Neg Pos

- Brittle hair
- Brittle nails
- Hair loss
- Hirsutism
- Hives
- Pruritis
- Mole changes
- Rash
- Skin lesion
- Other:

Musculoskeletal All neg

Neg Pos

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain
- Other:

Hematologic / Lymphatic All neg

Neg Pos

- Easy bleeding
- Easy bruising
- Lymphadenopathy
- Other:

Immunologic All neg

Neg Pos

- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies
- Other:

All others negative

Save & Close **Cancel**

When done click **Save & Close**.

Your new entries display.

You can also directly access other system-specific ROS popups from here to make additions, changes, & deletions.

03/15/2014 10:06 PM : "*USA SOAP" x

TOB HTN DM CAD

Care Guidelines Global Days

Reason for Visit

Review of Systems

Panel Control: Toggle Cycle

System	Neg/Pos	Findings
Constitutional	Positive	Chills.
Constitutional	Negative	Fever.
ENMT	Positive	Nasal congestion, Nasal drainage, Post-nasal drainage, Rhinitis.
ENMT	Negative	Sore throat.
Respiratory	Positive	Cough.
Respiratory	Negative	Wheezing.
Cardio	Negative	Edema.

Constitutional
HEENT
Respiratory
Cardiovascular
Vascular
Gastrointestinal
Genitourinary
Reproductive
Metabolic | Endocrine
Neuro | Psychiatric
Dermatologic
Musculoskeletal
Hematologic
Immunologic

One Page ROS - Male

And you can save & reuse all of these entries, whether entered on the one-screen ROS or the system-specific ones, as discussed in the User Personalization demo.

Continuing down the **SOAP** tab, you can review the **Vital Signs** again. You'll receive notices about VS that are out of normal ranges—though that is sometimes a matter of interpretation depending upon the patient & circumstances.

The screenshot shows a medical software interface with a navigation bar at the top containing tabs for Intake, Histories, SOAP (selected), Finalize, and Checkout. Below the navigation bar are links for Standing Orders, Adult Immunizations, Peds Immunizations, My Plan, Procedures, Order Management, and Document Library. A secondary bar includes Care Guidelines, Global Days, and Panel Control options (Toggle, Cycle, etc.). The main content area is divided into sections: Reason for Visit, Review of Systems, and Vital Signs. The Vital Signs section has a red warning icon and text: "Vital Signs Outside Normal Range". Below this is a table of vital signs data. At the bottom right of the table are buttons for Add, Edit, and Remove.

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
11:19 PM	73.00	199.00	26.25	167/123	84	16	97.7				

Let's say we'd like to recheck that elevated blood pressure. Click **Add**.

Height/length measurements:

ft in total in cm Position: Standing Lying

BMI/BSA calculation:

BMI: kg/m² [BMI Plan](#)

Unobtainable:
 Patient Refused:

Record the pressure you measure, then click **Save, Close.**

Last measured: Measured today Carried forward BSA: m² Calculate

Weight measurement:

lb kg Context: Dressed with shoes Dressed without shoes

Temperature: F C Site:

Blood Pressure and pulse: **Blood pressure is elevated.**

Systolic: Diastolic: mm/Hg Position: Sitting Standing Lying Side: Right Left Site:
Pulse: /min Pulse pattern: Regular Irregular Method: Manual Automatic Home monitor Cuff size: Pediatric Adult Large Thigh

- Neck/Waist/Hip Circumference
- Audiometry Exam
- Vision Screening
- Orthostatic Vital Signs

Respiration and Pulse Ox:

Respiration: /min Pulse Ox Rest: % Pulse Ox Amb: %
Pulse Ox: Room air Oxygen - Method:
Pulse Ox measured: Pre-treatment Post-treatment

Peak Flow: L/min Pre-treatment Post-treatment
Method:

Pain scale:

Pain score: Method: [HAQ-DI](#)

Measured date: Time:
06/15/2014 5:32 PM

Comments:

Measured by:
Robert L. Duffy

Your additional blood pressure displays.

03/15/2014 10:06 PM : "**USA SOAP" x

Vital Signs ⚠ Vital Signs Outside Normal Range

[Health Promotion Plan](#) | [History](#) | [Graph](#)

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
6:03 PM				162/110							
11:19 PM	73.00	199.00	26.25	167/123	84	16	97.7				

[Add](#) [Edit](#) [Remove](#)

Physical Exam



- One Page Exam
- Constitutional
- Diabetic Foot Exam
- Ears
- Nose | Mouth | Throat
- Neck | Thyroid
- Breast
- Respiratory
- Cardiovascular
- Abdomen
- Genitourinary
- Skin | Hair
- Musculoskeletal
- Psychiatric

- Additional

Exam Findings Details

Now turn your attention to the physical exam section. First notice the **Office Diagnostics** button. Click **that**.

[Office Diagnostics](#)

Office Services 2

Orders

(Highlight a row to select)

Display category:

Order Category	Lab Name	Proc. Code	Side	Diagnosis Description
ALL	Allergen immunotherapy, 2+ injections	95117		
ALL	Allergen immunotherapy, one injection	95115		
ALL	Allergen immunotherapy, one injection	95115		BUDD-CHIARI SYNDROME
ALL	Antigen therapy services, single/mult antigen	95165		
ALL	Assay, albumin, urine, microalbumin, semiquan	82044		
ALL	Assay, blood PKU	84030		

Diagnosis

This gives you a chance to review any office tests the nurse did via clinic standing orders, if you didn't note them earlier. (Often the results might not have been ready when you first entered the room.) When done click **Close**.

Details:

Today's Orders

 Submit to Superbill Verbal order/needs sign-off Send task automatically [Additional Orders](#) | [Task](#)

Status	Office Diagnostic Description	Side	Interpretation	Result	Performed By	Cl
completed	Hemoglobin A1c		see detail	7.4	Robert L. Duffy	
completed	Glucose blood test		see detail	156	Robert L. Duffy	

Diagnostic History Entry 0

Physical Exam documentation is performed similarly to the ROS demonstrated above. You can directly access any system from the headings on the left, but you'll often want to start with the age & gender-specific **One Page Exam**.

Physical Exam

One Page Exam
Constitutional
Diabetic Foot Exam
Ears
Nose | Mouth | Throat
Neck | Thyroid
Breast
Respiratory
Cardiovascular
Abdomen
Genitourinary

Exam Findings Details

Add Edit Remove

Even better, start from a saved preset, as covered in the User Personalization lesson.

While you may well complete the physical exam documentation later after you're done working with the patient, for the ease of discussion I'll go ahead & do it now, illustrating the value of using saved preset exams.

Vital Signs ! Vital Signs Outside Normal Range

[Health Promotion Plan](#) | [History](#) | [Graph](#)

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
6:03 PM				162/110							
11:19 PM	73.00	199.00	26.25	167/123	84	16	97.7				

Add Edit Remove

Physical Exam



One Page Exam	Exam	Findings	Details
Constitutional			

I'm going to click the Open Preset icon & double-click on **PEFullNIAdult-RLD**, a preset I've previously saved as my starting point for a typical normal exam for an adult male. It includes items entered via the **One Page Exam** & some of the **system-specific exams**. (Details on setup of these presets are covered in the User Personalization demo.)

Ngkbn Td Dbp Filter

Set Name
PEFullNIAdult-RLD

Refresh OK Cancel

Office Diagnostics

Your default normal exam displays. Now let's change the respiratory exam to mention some abnormalities found today. Click on **Respiratory**.

03/15/2014 10:06 PM : "**USA SOAP" x

Physical Exam

One Page Exam
Constitutional
Diabetic Foot Exam
Ears
Nose | Mouth | Throat
Neck | Thyroid
Breast
Respiratory
Cardiovascular
Abdomen
Genitourinary
Skin | Hair
Musculoskeletal
Psychiatric

Additional

Exam	Findings	Details
Constitutional	Normal	Well developed.
Ears	*	TM - Right: Uninflamed, Left: Uninflamed.
Ears	Normal	Canal - Right: Normal, Left: Normal.
Nasopharynx	Normal	Oropharynx - Normal.
Respiratory	Normal	Inspection - Normal. Effort - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Murmurs - None.
Abdomen	Normal	Inspection - Normal. No abdominal tenderness.
Extremity	Normal	No edema.
Neurological	*	Sensory - NI except as otherwise noted. Motor - No focal deficits except as noted otherwise below. Balance & gait - Grossly normal.

Office Diagnostics

Respiratory - Physical Exam

- ◆ Constitutional
- ❖ Head/Face
- ❖ Eyes
- ◆ Ears
- ❖ Nose/Mouth/Throat
- ❖ Neck/Thyroid
- ❖ Lymphatic
- ❖ Breast
- ◆ Respiratory/Thorax
- ◆ Cardiovascular
- ❖ Vascular
- ◆ Abdomen
- ❖ Genitourinary
- ❖ Rectal
- ❖ Skin/Hair
- ❖ Back/Spine
- ◆ Musculoskeletal

Select all normal

Inspection:

	Side:	Location:	Findings:
<input type="checkbox"/> Normal			

Auscultation:

	Side:	Location:	Findings:
<input type="checkbox"/> Normal	bilateral	posterior	mild rhonchi clearing w/ cough

Palpation:

	Side:	Location:	Findings:
<input type="checkbox"/> Normal			

Percussion:

	Side:	Location:	Findings:
<input type="checkbox"/> Normal			

Chest wall tenderness:

	Side:	Location:	Findings:
<input type="checkbox"/> Absent			

Cough:

<input type="checkbox"/> Absent		
---------------------------------	--	--

Effort:

<input checked="" type="checkbox"/> Normal		
--	--	--

Comments:

Edit your entry to reflect today's findings. When done click **Save & Close**.

Save & Close Cancel

Your completed exam displays on the **SOAP** tab.

Using this combination of presets & editing of only specific pertinent findings, sometimes called **documentation by exception**, is a powerful & rapid way to record an accurate exam, customized to the way you want to say it.

02/28/2014 03:48 PM : "**USA SOAP" x

Physical Exam



	Exam	Findings	Details
One Page Exam	Constitutional	Normal	Well developed.
Constitutional	Ears	*	TM - Right: Uninflamed, Left: Uninflamed.
Diabetic Foot Exam	Ears	Normal	Canal - Right: Normal, Left: Normal.
Ears	Respiratory	*	Auscultation - Side: bilateral, Location: posterior, Findings: mild rhonchi clearing w/ cough.
Nose Mouth Throat	Respiratory	Normal	Effort - Normal.
Neck Thyroid	Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Murmurs - None. Extremities - No edema.
Breast	Abdomen	Normal	Inspection - Normal. No abdominal tenderness.
Respiratory	Extremity	Normal	No edema.
Cardiovascular	Neurological	*	Sensory - NI except as otherwise noted. Motor - NI except as otherwise noted. Balance & gait - Grossly nl.
Abdomen			
Genitourinary			
Skin Hair			
Musculoskeletal			
Psychiatric			
Additional			

Physical Exam

Assessment/Plan

Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals

Moving to the bottom of the **SOAP** tab, you might next perform any of several activities: Document assessments & plans, prescribe meds, order labs, plan X-rays, or request referrals.

For this exercise, let's address Assessment/Plan. Begin by clicking the **Add/Update** button.

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

↕ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

Today's Concerns/Reason for Visit:

1. Cough 2. DM/HTN

(Select a row from any grid to add to Today's Assessments) Add Assessments on 1-click

Diagnosis History Show Chronic only

Diagnosis Description	Code

Add Common Assessment | Diagnosis Code Lookup

Clinical Problems

Show Chronic Show My Tracked problems No active problems

Description	Onset Date
Diabetes mellitus type II	
Essential hypertension	
Tobacco abuse	01/01/1990

My Favorites Favorites Category: All Filter:

Description	Code
Benign essential hypertension	401.1
Coronary artery disease	414.00
Cough	786.2
CVA	434.91

Dx description: Code: Status: Site:

Impression: Differential Dx:

Mark diagnosis as chronic Add assessment to: Clinical problems My tracked problems My favorites

Add/Update

Today's Assessments

Description	Code	Status	Site	Impression/Differential Dx

A group of tabbed popups appears; let's call this the **Assessment-Plan Suite**. Here you have multiple ways to select diagnoses. The easiest involve picking something from the patient's previous **Diagnoses History**, the **Problems** list, or your **My Favorites** list.

Save & Close Sort Remove

Today's Concerns/Reason for Visit:

1. Cough 2. DM/HTN

(Select a row from any grid to add to Today's Assessments) Add Assessments on 1-click

Diagnosis History Show Chronic only

Diagnosis Description	Code
Acute bronchitis	466.0
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00
Tobacco use disorder	305.1
Unspecified essential hypertension	401.9

Clinical Problems

Show Chronic Show My Tracked problems No active problems

Description	Onset Date
Diabetes mellitus type II	
Essential hypertension	
Tobacco abuse	01/01/1990

My Favorites Favorites Category: All Filter:

Description	Code
Benign essential hypertension	401.1
Coronary artery disease	414.00
Cough	786.2
CVA	434.91

Add Common Assessment | Diagnosis Code Lookup

Dx description:

Impression:

Mark diagnosis as chronic Add assessment to Clinical problems My tracked

...and add some other diagnoses from the Problem List.

Today's Assessments

#	Description(code) Status Site	Impression/Differential Dx
1	Acute bronchitis (466.0)	
2	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00)	
3	Unspecified essential hypertension (401.9)	
4	Tobacco use disorder (305.1)	

Today's Concerns/Reason for Visit:

1. Cough 2. DM/HTN

(Select a row from any grid to add to Today's Assessments) Add Assessments on 1-click

Diagnosis History Show Chronic only

Diagnosis Description	Code
Acute bronchitis	466.0
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00
Tobacco use disorder	305.1
Unspecified essential hypertension	401.9

Clinical Problems

Show Chronic Show My Tracked problems No active problems

Description	Onset Date
Diabetes mellitus type II	
Essential hypertension	
Tobacco abuse	01/01/1990

My Favorites Favorites Category: All Filter:

Description	Code
Benign essential hypertension	401.1
Coronary artery disease	414.00
Cough	786.2
CVA	434.91

Add Common Assessment | Diagnosis Code Lookup

Dx description: Code: Status: Site:

Impression: Differential Dx:

Mark diagnosis as chronic Add assessment to: Clinical problems My tracked problems My favorites

Add/Update

Today's Assessments

#	Description(code) Status Site	Impression/Differential Dx
1	Acute bronchitis (466.0)	
2	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00)	
3	Unspecified essential hypertension (401.9)	
4	Tobacco use disorder (305.1)	

Now let's document some plans. The My Plan tab has some potential, but we're still investigating how well that can be applied to our practice setting. So let's move on to A/P Details.

Save & Close Sort Remove

Today's Assessments: (Select an assessment and enter the details below.)

Assessment/Plan Expanded View

#	Description	Code	Status
1	Acute bronchitis	466.0	
2	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00	
3	Unspecified essential hypertension	401.9	
4	Tobacco use disorder	305.1	

Record your plans here for each diagnosis. Maximize use of **My Phrases**, adding or editing notes here & there as needed for this specific patient. (Setup of **My Phrases** is discussed in the User Personalization demo.)

(Only the first 215 characters will be displayed in the Diagnosis Module.)

Plan Details

Previous Patient Details | Previous Provider Details | **Health Promotion Plan**

Patient Details:

My Phrases

Common Phrases

Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.

Provider Details:

My Phrases

Common Phrases

I suspect there is a component of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.

(Provider details will not print on the patient plan.)

Today's Orders:

[Empty text area for Today's Orders]

Manage My Phrases

Follow Up

Counseling Details

Save & Close

Cancel

Assessment Plan Details

Assessments | My Plan | A/P Details | **Labs** | **Diagnostics** | **Referrals** | Office Procedures | Cosign Orders

Today's Assessments: (Select an assessment and enter the details below.) Assessment/Plan Expanded View ⓘ

#	Description	Code	Status
1	Acute bronchitis	466.0	
2	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00	
3	Unspecified essential hypertension	401.9	

If we wanted to order X-rays or Referrals, we could do so using the Diagnostics or Referrals Tabs above. (We don't use the Labs Tab at present, since we have another way to place lab orders.) Those are covered in other lessons, so we won't do that on this encounter.

(Only the first 215 characters will be displayed in the Diagnosis Module.)

Plan Details

Previous Patient Details | Previous Provider Details | [Health Promotion Plan](#)

Patient Details: My Phrases Common Phrases

Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.

Provider Details: My Phrases Common Phrases

I suspect there is a component of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.

(Provider details will not print on the patient plan.)

Today's Orders:

When done click **Save & Close**.

Save & Close | Cancel

Assessment/Plan

Your assessments & plans display.

Assessments My Plan A/P Details Labs Diagnostics Referrals Office Procedures Review/Cosign Orders View Immunizations Office Diagnostics Physical Therapy Orders Health Promotion Plan	1.	Assessment	Acute bronchitis (466.0).
		Patient Plan	Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steam showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
		Provider Plan	I suspect there is a component of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
	2.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
	3.	Assessment	Unspecified essential hypertension (401.9).
		Patient Plan	Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing well, follow up in 2 wks.
		Provider Plan	discussed importance of
	4.	Assessment	Tobacco use disorder (305.1).
		Patient Plan	Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. I urge you to quit as soon as possible. Free assistance & nicotine patches are available at www.alabamaquitnow.com or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.

Let's complete his prescriptions. Click **Meds**.

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

✦ Consent



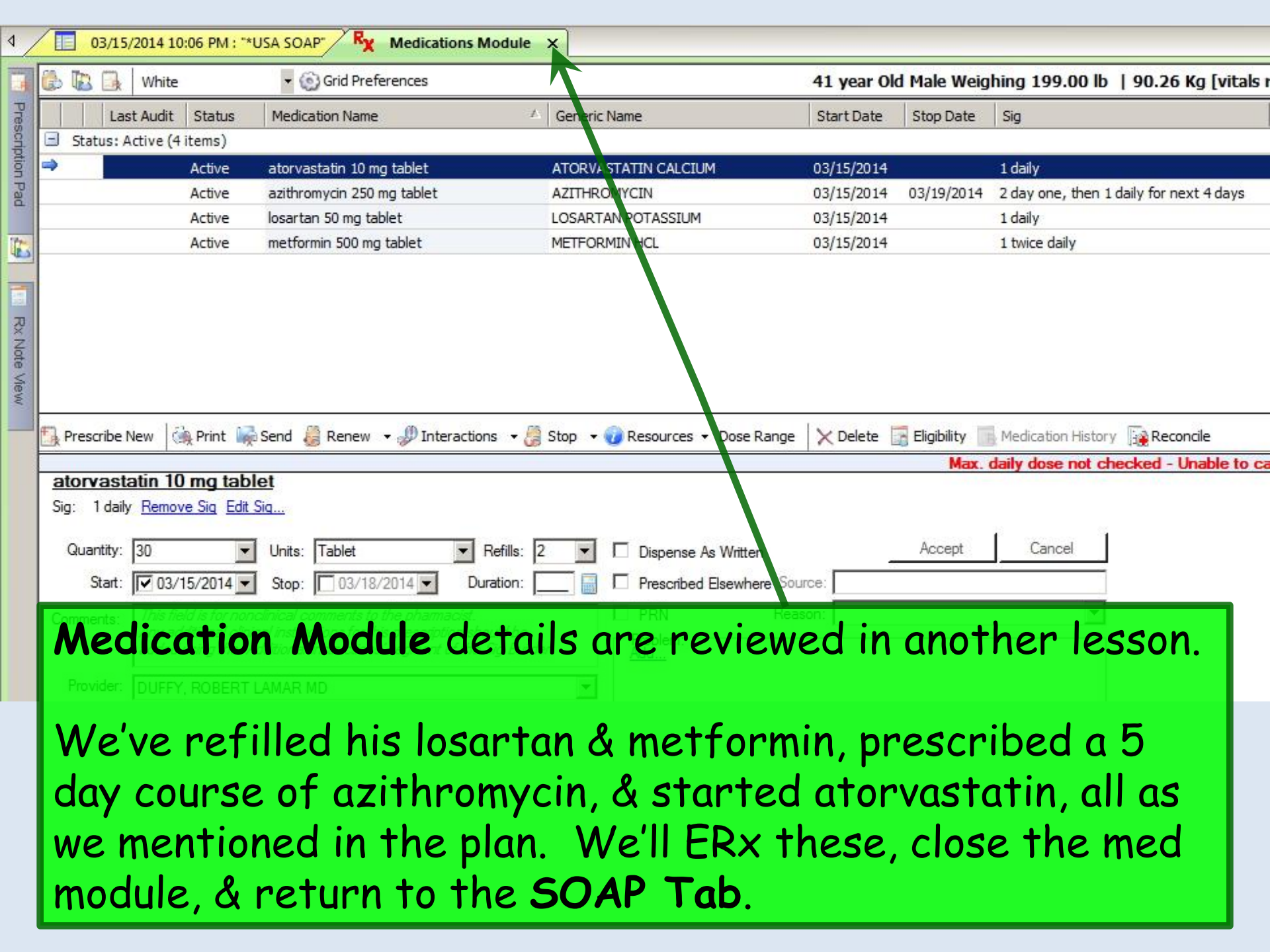
Visit Document

Document Library

Document

Library





atorvastatin 10 mg tablet

Sig: 1 daily [Remove Sig](#) [Edit Sig...](#)

Quantity: 30 Units: Tablet Refills: 2 Dispense As Written Prescribed Elsewhere Source:
Start: 03/15/2014 Stop: 03/18/2014 Duration:

Comments: PRN Reason:
Provider:

Medication Module details are reviewed in another lesson.
We've refilled his losartan & metformin, prescribed a 5 day course of azithromycin, & started atorvastatin, all as we mentioned in the plan. We'll ERx these, close the med module, & return to the **SOAP Tab**.

Assessment/Plan

Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan

1.	Assessment	Acute bronchitis (466.0).
	Patient Plan	Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
	Provider Plan	I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3.	Assessment	Unspecified essential hypertension (401.9).
	Patient Plan	Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing well, follow-up in 3 mos.
	Provider Plan	Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. Nicotine patches are available at our office & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.

The patient needs a work excuse, which might be generated by you or your nurse. Open the **Document Library**.

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

✦ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

You have several options for generating a work excuse.

05/28/2014 10:08 AM : "USA Document Library" x

General

After Hours Care Note
Chart Summary
Confidential Note
Controlled Substance Agreement, Full
Controlled Substance Contract, Brief
Counseling Notepad
Discharge Summary-Preliminary
Durable Medical Equipment Order
FreeText
Hospital-Clinic Continuity Note
Immunization Record

Lab Results-All
Lab Results-Last 30 Days
Medication List
Missed Appointment Reminder
Patient Plan
Safety Contract
Telephone Notes/Clinic Memos
Visit Note (Master Document)
Vital Signs History
Weight Loss Program Sheet

Letters

Letter About Patient
Letter To Patient
Letter From Consultant
Letter To Consultant
Work/School Excuse Note
Work/School Excuse Note-FM
Work/School Excuse Note-Peds
Work/School Status, Brief
Work/School Status, Detailed

Assessments and Tools

ACC/AHA ASCVD Risk Estimator
Behavioral Assessments & Tools
Edinburgh Postnatal Depression Scale
Generate Report Scoring
Mini Mental Status Exam
Pediatric Symptom Checklist
St. Louis Univ Mental Status Exam (SLUMS)
SLUMS Diagram Generate Report

Assessment/Plan

Assessments My Plan A/P Details Labs Diagnostics Referrals Office Procedures Review/Cosign Orders View Immunizations Office Diagnostics Physical Therapy Orders Health Promotion Plan	1.	Assessment	Acute bronchitis (466.0).
		Patient Plan	Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
		Provider Plan	I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
	2.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
	3.	Assessment	Unspecified essential hypertension (401.9).
		Patient Plan	Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing well, follow-up in 3 mo.
		Patient Plan	Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. Encouraged you to quit as soon as possible. Free assistance & nicotine patches are available at www.quitnow.com or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-580-4872.

One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click Patient Plan.

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

✦ Consent



Visit Document

Document Library



TX Text

Arial 10 B I U [List Icons] 100% [Font Color Icon] [Undo Icon] [Redo Icon] x₂ x²

[Ruler]

PATIENT PLAN FOR 03/18/2014
Name: Pepe Quagmire
Date of Birth: 01/03/1973
Date of Visit: 03/18/2014
Visit Type: Office Visit
Location: USA FAMILY MEDICINE

The Patient Plan generates. Click the **Printer icon** to print it, then return to the **SOAP Tab**.

Thank you for choosing us for your healthcare needs. The following is a summary of the outcome of today's visit and other instructions and information we hope you find helpful.

Primary Care Provider: ROBERT LAMAR DUFFY MD

TODAY'S VISIT

REASON(S) FOR VISIT

Cough, DM/HTN.

Assessment/Plan

It can be challenging from a time management standpoint to generate a **Patient Plan** before the patient leaves. This will become easier when we have expanded ways to electronically communicate with patients. In the meantime a strategy is to complete a very bare-bones assessment & plan, prescribe meds, then generate the **Patient Plan**. Print this for the patient, then flesh out the details later.

Assessment/Plan

Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan

1.	Assessment	Acute bronchitis (466.0).
	Patient Plan	Azithromycin 5 day course. Acetaminophen, fluids, rest, vaporizer/steamy showers, etc. Guaifenesin DM (generic over-the-counter) as needed for cough. Recheck if getting high/protracted fever, worsening cough/shortness of breath, or not resolving in 10-14 days. Work note for March 15-17; may return earlier if feeling better sooner, cough is improving, and temperature has been under 100 for 24 hrs.
	Provider Plan	I suspect there is a coomponent of early COPD here. We'll treat for bronchitis & recheck in 2 wks, which will also give us a chance to look at BP again. Consider spirometry at that time, w/ further plans as indicated.
2.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
3.	Assessment	Unspecified essential hypertension (401.9).
	Patient Plan	Continue all meds as listed. Attn to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Inspect feet daily, as well as wounds at any other location; follow-up if wounds do not appear to be healing. See eye doctor yearly; have them send us a note when you're seen. Checking your blood pressure at home, work, or pharmacy about once a month wouldn't be a bad idea. BP goal is under 140/90, so if it is running above that more often than not, recheck. If you're checking your sugars, contact us if they are frequently under 90 or over 200. If doing well, follow-up in 3 mos.
	Provider Plan	Discussed importance of smoking cessation; it may be the single most important thing you can do for your health. Encouraged to quit as soon as possible. Free assistance & nicotine patches are available at www.cancer.gov/quitnow.com or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, www.lung.org/stop-smoking, or 800-586-4872.

Now generate today's visit note.
One way to do this would be to
click **Visit Document**.

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

* Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

Navigation

- History
- SOAP
- Finalize
- Check Out

> Order Management

- > Orders/Plan
- > Standing Orders
- > Standing Orders

Anticoagulation

Procedures

Tobacco Cessation

Tuberculin Skin Test

Nutrition

Chart Abstraction

Demographics

Document Library

Immunizations

Patient Comment

Provider Test Action

Vital Signs

Screening Tools

CQM Check

MU Check

[Preview](#) [Offline](#)

But it can take 30-60 seconds to generate the document in real time, which can be annoying when you're trying to move on to the next patient. As an alternative, you can generate the note offline. To do this, hover the mouse over **Navigation** to get the **Navigation Bar** to slide out.

When the **Navigation Bar** displays, click **Offline**.

1.	Assessment	Acute bronchitis (466.0)	
	Plan		
	Provider Plan		
2.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	
3.	Assessment	Unspecified essential hypertension (401.9)	
	Plan		
	Provider		
4.	Assessment	Tobacco use disorder (305.2)	
	Patient		

ion took place Attending saw patient

[Consent](#) [Procedure Scheduling](#) [Add/Update](#) [Remove](#)

✦ Consent

[Meds](#) [Procedures](#) [Patient Plan](#) [Visit Document](#) [Document Library](#) [EM Coding](#) [Dictation](#)

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

General

Established patient New patient

Today's Assessment

Provider Sign Off

Physician Sign Off Request: Submit to supervising physician for review

E&M coding is reviewed in another lesson. For this exercise, click Moderate complexity for Medical decision making, then Calculate Code.

Evaluation and Management Coding

Medical Decision Making View MDM Guidelines | View Risk Table

Straight forward Low complexity Moderate complexity High complexity

Counseling Counseled greater than 50% of time and documented content

Total visit time (minutes): Counseling Details Total counsel time (minutes):

Evaluation and Management Code

Visit code: Modifier(s):

Calculate Code Submit Code

CQM Check

Calculated EM code:

Submitted code:

Calculated eRx code:

Submitted eRx code:

Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes

New patient:	Established:	Consultation:	Preventive new:	Preventive established:	Preventive counseling:	Post Op:
<input type="radio"/> 99201	<input type="radio"/> 99211	<input type="radio"/> 99241	<input type="radio"/> 99381	<input type="radio"/> 99391	<input type="radio"/> 99401	<input type="radio"/> 99024
<input type="radio"/> 99202	<input type="radio"/> 99212	<input type="radio"/> 99242	<input type="radio"/> 99382	<input type="radio"/> 99392	<input type="radio"/> 99402	Prenatal:
<input type="radio"/> 99203	<input type="radio"/> 99213	<input type="radio"/> 99243	<input type="radio"/> 99383	<input type="radio"/> 99393	<input type="radio"/> 99403	Visit 4-6:
<input type="radio"/> 99204	<input type="radio"/> 99214	<input type="radio"/> 99244	<input type="radio"/> 99384	<input type="radio"/> 99394	<input type="radio"/> 99404	<input type="radio"/> 59425
<input type="radio"/> 99205	<input type="radio"/> 99215	<input type="radio"/> 99245	<input type="radio"/> 99385	<input type="radio"/> 99395		Visits greater than 6:
			<input type="radio"/> 99386	<input type="radio"/> 99396		<input type="radio"/> 59426
			<input type="radio"/> 99387	<input type="radio"/> 99397		

Behavioral Health: 90791 (Initial eval, no med services)

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP **Finalize** Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

If the calculated code is acceptable to you, click **Submit Code**.

Panel Control: Toggle Cycle

Today's Assessment

Provider Sign Off

Physician Sign Off Request:

Submit to supervising physician for review

Residents will need to click **Submit to supervising physician for review**.

Evaluation and Management Coding

Medical Decision Making View MDM Guidelines | View Risk Table

Straight forward Low complexity

Moderate complexity High complexity

Total visit time (minutes): Counseling Details

Total counsel time (minutes):

Evaluation and Management Code

Visit code:

Modifier(s):

Calculated EM code:

Submitted code:

Calculated eRx code:

Submitted eRx code:

Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes

New patient:	Established:	Consultation:	Preventive new:	Preventive established:	Preventive counseling:	Post Op:
<input type="radio"/> 99201	<input type="radio"/> 99211	<input type="radio"/> 99241	<input type="radio"/> 99381	<input type="radio"/> 99391	<input type="radio"/> 99401	<input type="radio"/> 99024
<input type="radio"/> 99202	<input type="radio"/> 99212	<input type="radio"/> 99242	<input type="radio"/> 99382	<input type="radio"/> 99392	<input type="radio"/> 99402	<input type="radio"/> Prenatal:
<input type="radio"/> 99203	<input type="radio"/> 99213	<input type="radio"/> 99243	<input type="radio"/> 99383	<input type="radio"/> 99393	<input type="radio"/> 99403	<input type="radio"/> Visit 4-6:
<input type="radio"/> 99204	<input checked="" type="radio"/> 99214	<input type="radio"/> 99244	<input type="radio"/> 99384	<input type="radio"/> 99394	<input type="radio"/> 99404	<input type="radio"/> 59425
<input type="radio"/> 99205	<input type="radio"/> 99215	<input type="radio"/> 99245	<input type="radio"/> 99385	<input type="radio"/> 99395	<input type="radio"/> 99404	<input type="radio"/> Visits greater than 6:
			<input type="radio"/> 99386	<input type="radio"/> 99396		<input type="radio"/> 59426
			<input type="radio"/> 99387	<input type="radio"/> 99397		

Behavioral Health:

90791 (Initial eval, no med services)

90792 (Initial eval w/med services)

A resident also needs to view encounter properties to set the Supervising Physician for billing purposes. Right-click on the **encounter folder** & select **Properties** in the popup.

The screenshot displays a medical software interface. A window titled "Patient History" is open, showing a list of folders. A right-click context menu is open over a folder dated "03/15/2014 10:06 PM". The menu options include: Expand All, Expand Most Recent, Expand Unlocked, Collapse All, Lock Encounter..., Delete Encounter..., Encounter Level Insurance..., Customize Display..., Case..., Encounter Description/Remark..., and Properties... (highlighted with a green arrow). The background interface shows various tabs like "HTN", "DM", "CAD", and "Office Visit". Below the patient history, there are sections for "General" (Established patient, New patient), "Today's Assessment", "Provider Sign Off" (Physician Sign Off Request, Medicare Patient Incident Sign Off), and "Evaluation and Management Coding" (Medical Decision Making, Counseling).

Billable Date: 03/15/2014
Billable Time: 10:06 P
Occurrence Code: [dropdown]
State: [dropdown]
Onset Date: [calendar]
Onset Time: [dropdown]

General | Billing & Collections | Encounter Specifics | Claims | Marketing | Properties | History

Patient Type: [dropdown]
Condition Related to Employment: [checkbox]
Admit Date: [calendar]
Discharge Date: [calendar]
Initial Treatment Date: [calendar]
Facility: [dropdown]

Encounter Types: Billable: Clinical
 Print Encounter On Statements Patient is Homebound
Case: [text] Case Date: [calendar]
Service Type: [dropdown]

Providers
Rendering: MCFADEN, THOMAS G
Referring: [dropdown]
Referring Facility: [dropdown]
First Consulting: [dropdown]
Supervisor: [dropdown]
CONTRERAS, CARLO M
CREWS, LADONNA
CROOK, ERROL D
De MELO, SILVIO W
DIPALMA, ZACK A
DUFFY, ROBERT LAMAR
DYESS, DONNA LYNN
GANDY, ROY E

The resident doctor clicks the Supervisor dropdown arrow & selects the attending. In this example, we'll use Dr. Duffy.

Billable Date: 03/15/2014
Billable Time: 10:06 P
Occurrence Code: [dropdown]
State: [dropdown]
Onset Date: [calendar]
Onset Time: [calendar]

General | Billing & Collections | Encounter Specifics | Claims | Marketing | Properties | History

Patient Type: [dropdown] Condition Related to Employment
Remarks: [text area] Same/Similar Date: [calendar]
Complaints: [text area] Date Last Seen: [calendar]
Admit Date: [calendar] Discharge Date: [calendar] Initial Treatment Date: [calendar]
Facility: [dropdown]
Encounter Types: [dropdown] (Billable;Clinical)
 Print Encounter On Statements Patient is Homebound
Case: [text area] Case Date: [calendar]
Service Type: [dropdown]

Providers
Rendering: MCFADEN, THOMAS G
Referring: [dropdown]
Referring Facility: [dropdown]
First Consulting: [dropdown]
Supervisor: DUFFY, ROBERT LAMAR
Service Location: USA FAMILY MEDICINE

Incident-To Bill Encounter

Click OK to close the popup.

OK Cancel

Specialty Family Practice Visit Type Office Visit

Intake Histories SOAP Finalize **Checkout**

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

Today's Orders

Lab/Radiology Order Processing Task Immunizations

	Status	Lab Order	Timeframe	Comments
▶ Labs				
Diagnostics				
Referrals				
Office Services				
Procedures				
Follow up				
Medications (4)				
Patient Education				
Physical Therapy				

Requisition

Given to Patient

The Checkout Tab may be utilized by office staff to document completion of various orders, referrals, appointments, etc. The degree & manner of its use will be individualized to the workflow of each clinic.

This concludes the
NextGen Adult Visit demonstration.

Experience is something you often
don't get until just after you need it.

R. Lamar Duffy, M.D.
Associate Professor
University of South Alabama
College of Medicine
Department of Family Medicine