

# NEXTGEN NEPHROLOGY WORKFLOW DEMONSTRATION

This example works through a sample adult nephrology encounter. In this demonstration, the patient has been seen by other USA HSF providers, so most basic history will already be entered into the chart, though we'll touch upon updating this information as well.

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	DuffyK, Example001/...	Communication
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, Example001	

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

NextGen EMR: BooBoo Quagmire MRN: 000000007767 DOB: 01/04/1962 (Female) Age: 52 years 2 months - 03/23/2014 04:27 PM: "\*USA Intake"

File Edit Default View Tools Admin Utilities Window Help

Logout Print Clear Update USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Labos PAG Medications Templates Documents Images Orders Problems Appo Close

BooBoo Quagmire (F) DOB: 01/04/1962 (52 years) Weight: 156.00 lb (70.76 Kg) Allergies: (2) Problems: (4) Diagnoses: (1) Medications: (0)

Address: 555 Knock Knee Drive Mobile, AL 36604 MRN: 000000007767 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...  
Contact: (251) 555-1234 (Home) Insurance: BCBS OF ALABAMA Emergency Phone: Referring:  
NextMD: No Pharmacy 1: LINCOLN PHARM... Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM: "\*USA Intake"

Specialty select a specialty Visit Type select a visit type

Care Guidelines Global Days Panel Control: Toggle Cycle

General Established patient New patient Historian

Vital Signs Reason for Visit Medications Allergies

Patient History

- New Lock Search
- 03/23/2014 04:27 PM
  - 03/03/2014 03:38 PM
    - \*Intake
    - \*USA Intake
    - \*USA SOAP
  - 03/02/2014 03:35 PM
  - 03/01/2014 03:25 PM
  - 02/28/2014 03:22 PM
  - 02/27/2014 03:14 PM
  - 02/26/2014 04:45 PM
  - 02/25/2014 05:05 PM
  - 02/20/2014 09:10 AM
  - 02/14/2014 03:56 PM

Ready NGDev USA Health Services Foundation rduffy CAP NUM SCRL 03/23/2014

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 **Nephrology**.

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

The screenshot displays a medical software interface for a patient named BooBoo Quagmire (F), DOB: 03/04/1962 (52 years), Weight: 156.00 lb (70.76 Kg). The patient's address is 555 Knock Knee Drive, Mobile, AL 36684. The MRN is 000000007767, and the insurance is BCBS OF ALABAMA. The patient's specialty is currently set to "select a specialty" and the visit type is "select a visit type".

Two picklist windows are open:

- Ngkbn Get Dbpicklist Items**: A window showing a list of specialties. The list includes: Allergy & Immunology, Behavioral Health, Cardiology, Care Management, Dermatology, Family Practice, Gastroenterology, Gastroenterology ASC, General Surgery, Gynecology, Internal Medicine, Nephrology, Neurology, Neurosurgery, Obstetrics, Oncology, Ophthalmology, Orthopedics, and Otolaryngology. The "Nephrology" option is highlighted.
- Ngkbn Udp Visit Types**: A window showing a list of visit types. The list includes: Chart Abstraction, Chart Update - GYN, Colposcopy Visit, Consult, Endometrial Bx Visit, No-Show, Nurse Visit, Office Visit - GYN, Patient Communication, Pessary Visit, Post-Operative Visit, Pre-Operative Visit, and Preventive Medicine. The "Office Visit - GYN" option is highlighted.

The interface also shows a navigation pane on the left, a search bar at the top right, and a taskbar at the bottom with the date 03/23/2014.

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 she'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**. This patient is new to us, so we'll make that change.

BooBoo Quagmire (F)    DOB: 01/04/1962 (52 years)    Weight: 156.00 lb (70.76 Kg)    Allergies: (2)    Problems: (4)    Diagnoses: (1)    Medications: (0)

Address: 555 Knock Knee Drive  
Mobile, AL 36604  
Contact: (251) 555-1234 (Home)

MRN: 000000007767  
Insurance: BCBS OF ALABAMA  
NextMD: No

Emergency Relation:  
Emergency Phone:  
Pharmacy 1: LINCOLN PHARM...

PCP: DUFFY, ROBERT LAMAR ...  
Referring:  
Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM : "Intake" x

Specialty ▼ Nephrology    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:

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

The screenshot displays a medical software interface for a patient named BooBoo Quagmire (F). The patient's information includes DOB: 01/04/1962 (52 years), Weight: 156.00 lb (70.76 Kg), and MRN: 000000007767. The interface features a top navigation bar with various icons and a central patient information section. Below this, there are several tabs: 'Alerts' (highlighted with a green circle), 'Sticky Note' (highlighted with a green circle and a magenta diamond icon), and others like 'Referring Provider', 'HIPAA', 'Advance Directives', and 'Screening Summary'. The main content area shows a navigation bar with tabs for 'Intake', 'Histories', 'SOAP', 'Finalize', and 'Checkout'. The 'Intake' tab is currently selected. The interface also displays various clinical indicators like TOB, HTN, DM, and CAD.

We can tell by the appearance of the **Alert** button that there is no Alert. But the magenta color & solid diamond tell us there is a **Sticky Note**. To review it, 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 note that the patient is the mother of one of the Family Medicine nurses.



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 area containing the text "USAFM nurse Gretchen's mother.". 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 "Comments:" label.

When done click **Save & Close**.

Other times a sticky note would be a temporary notice, like **Ask about Tdap next visit. RL Duffy 4/13/13**. 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.

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 herself.

BooBoo Quagmire (F)    DOB: 01/04/1962 (52 years)    Weight: 156.00 lb (70.76 Kg)    Allergies: (2)    Problems: (4)    Diagnoses: (1)    Medications: (0)

Address: 555 Knock Knee Drive    MRN: 000000007767    Emergency Relation:    PCP: DUFFY, ROBERT LAMAR ...  
Mobile, AL 36604    Insurance: BCBS OF ALABAMA    Emergency Phone:    Referring:     
Contact: (251) 555-1234 (Home)    NextMD: No    Pharmacy 1: LINCOLN PHARM...    Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM : "\*Intake" x

Relationship of historian: x

- 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

Historian:



Note the PCP.

USA FAMILY MEDICINE | DUFFY, ROBERT LAMAR MD

BooBoo Quagmire (F) | DOB: 01/04/1962 (52 years) | Weight: 156.00 lb (70.76 Kg) | Allergies: (2) | Problems: (4) | Diagnoses: (1) | Medications: (0)

Address: 555 Knock Knee Drive  
Mobile, AL 36604  
Contact: (251) 555-1234 (Home)

MRN: 000000007767  
Insurance: BCBS OF ALABAMA  
NextMD: No

Emergency Relation:  
Emergency Phone:  
Pharmacy 1: LINCOLN PHARM...

PCP: DUFFY, ROBERT LAMAR ...  
Referring:  
Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM : '\*Intake' x

Specialty ▾ Nephrology | Visit Type ▾ Office Visit

Intake | Histories | SOAP | Finalize | Checkout

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

Care Guidelines | Global Days

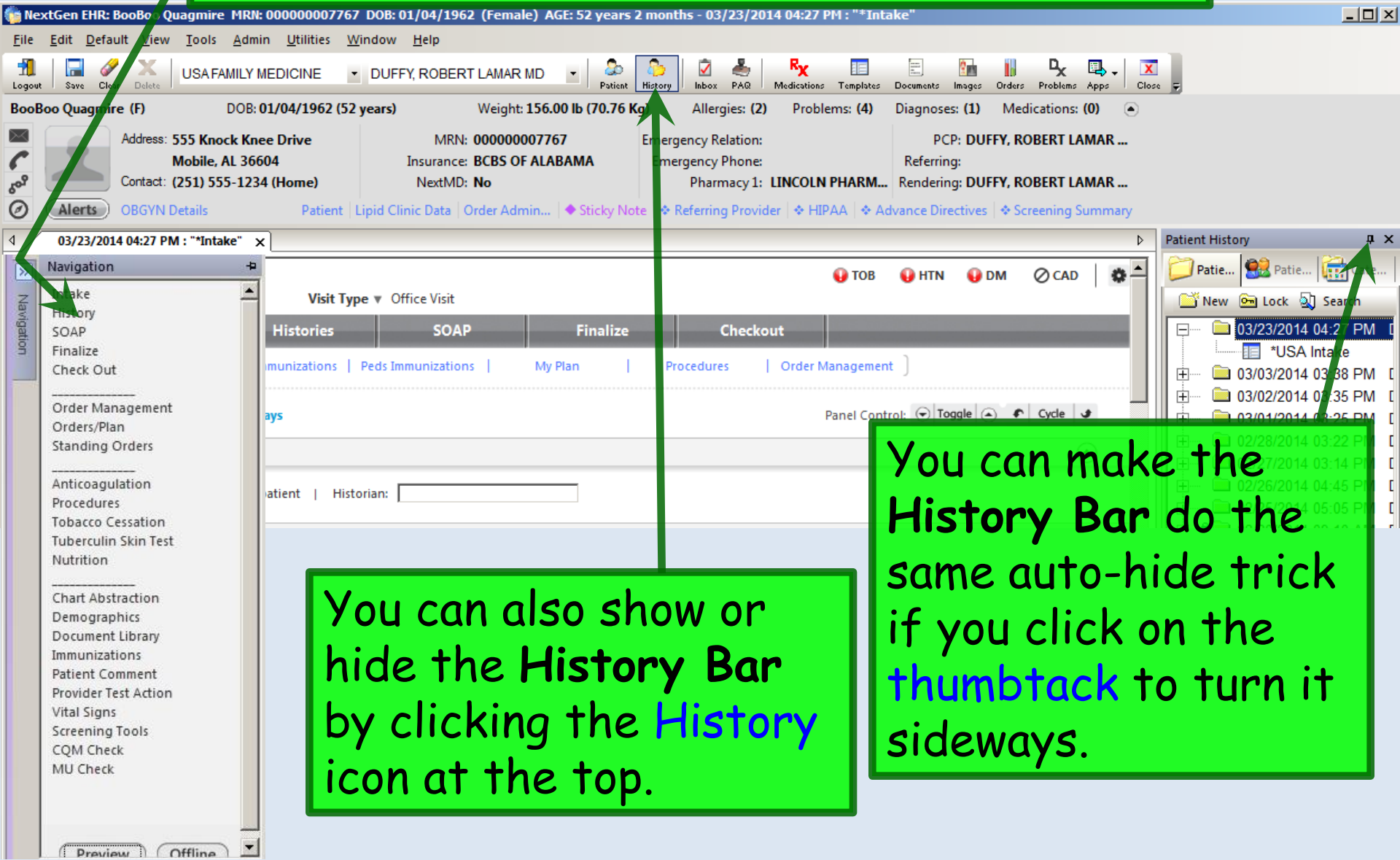
Panel Control: Toggle | Cycle

General

Established patient | New patient | Historian

If this needs to be changed, click **Patient**, which opens the Patient\_demographics template. (We don't need to do that here.)

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.



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.

You can collapse the Information Bar down to a narrower strip if desired; that is particularly helpful on the small-screened laptops. Click [this button](#).

Care Guidelines    Global Days    Panel Control: Toggle    Cycle

General

Established patient     New patient    Historian:

Reason for Visit

- Do not launch HPI
- anemia
  - chronic kidney disease
  - diabetes
  - edema
  - education
  - ESRD
  - hyperparathyroidism
  - hypertension
  - kidney stones
  - proteinuria
  - renal failure
  - urinary problems
- Additional / Manage

The nurse will probably next enter Vital Signs. It would be more convenient if that section were at the top of this template. So if it's not there already, let's move it there. Click on the [Vital Signs heading bar](#), & drag it up over Reason for Visit. (It can be a little touchy to make the drag work right, you'll eventually get it.)

Vital Signs

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
------	---------	---------	-----	----	-------	-------------	----------	---------------	-----	------------	----------

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

BooBoo Quagmire (F)    DOB: 01/04/1962 (52 years)    Weight: 156.00 lb (70.76 Kg)    Allergies: (2)    Problems: (4)    Diagnoses: (1)    Medications: (0)

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

03/23/2014 04:27 PM : "\*\*Intake" x

Specialty ▾ Nephrology    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:

**Vital Signs**

Health Promotion Plan | History | Graph

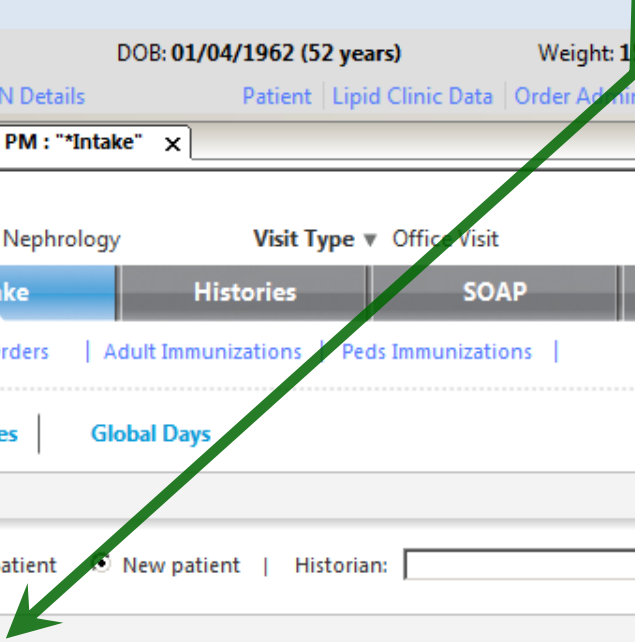
Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
------	---------	---------	-----	----	-------	-------------	----------	---------------	-----	------------	----------

Add    Edit    Remove

**Reason for Visit**

Do not launch HPI

anemia    chronic kidney disease    diabetes



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

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

**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  
Pulse: /min  Regular  Irregular  
Position:  Sitting  Standing  Lying  
Side:  Right  Left  
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:

Navigation: Clear For Add Delete Save Close

Data used in this example:

Ht 66 inches, measured today.

Wt 199 lbs, dressed without shoes.

T 97.7, orally.

BP 158/94 sitting, left arm, manual adult cuff.

HR 80.

Resp 16.

BMI of 32.12 will be calculated.

When done, click Save then Close.

Vital signs now display.

03/23/2014 04:27 PM : ""USA Intake" x

### General

Established patient  New patient | Historian:

### 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
5:12 PM	199.00	66.00	32.12	90.265	167.64	158/94	80	16	97.7	36.5			

### Reason for Visit

Do not launch HPI

- anemia
- chronic kidney disease
- diabetes
- edema
- education
- ESRD
- hyperparathyroidism
- hypertension
- kidney stones
- proteinuria
- renal failure
- urinary problems

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 is here to get established for **chronic kidney disease**, so click that.

Additional / Manage

Diagnostics

Show All

If you don't see the complaint you need, click **Additional/Manage**. Scroll through the list in the popup to make more selections.

**Reason for Visit**

Do not launch HPI

anemia  
**chronic kidney disease**  
diabetes  
edema  
education  
ESRD  
hyperparathyroidism  
hypertension  
kidney stones  
proteinuria  
renal failure  
urinary problems

**Chief Complaint**  
chronic kidney disease

**Reason For Visit**

Select your reasons for visit

- chronic kidney disease
- diabetes
- difficulty urinating
- DM/HTN
- DM/lipids
- dysuria
- edema
- fever
- frequency of urination
- headache
- hypercalcemia
- hyperlipidemia
- hyperparathyroidism
- hypertension
- hypocalcemia
- incontinence
- kidney concerns (peds)
- kidney infection
- kidney stones
- nocturia

Reason(s) for visit

Follow up  
chronic kidney disease

Follow up  
swelling

Follow up

Follow up

Follow up

Follow up

If you still don't see what you need, just type it in the next open box. In this example she is also complaining of **swelling**, so we'll type that in.

When done, click **Save & Close**.

The Reasons for Visit you've entered display.

### Reason for Visit

Do not launch HPI

- anemia
- chronic kidney disease
- diabetes
- edema
- education
- ESRD
- hyperparathyroidism
- hypertension
- kidney stones
- proteinuria
- renal failure
- urinary problems

Additional / Manage

#### Chief Complaint

chronic kidney disease  
swelling

#### History of Present Illness

[Intake Comments](#)

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

### Intake Comments

CKD followed by MD OOT; he was mentioning possible dialysis soon. Just moved to town. Saw FM last month & got meds refilled, but missed F/U appt. Feet have been swelling worse in last 3-4 wks.

**Save & Close**

Cancel

[Comment](#)

No medications

Medications reconciled

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



## Reason for Visit

 Do not launch HPI[◆ Intake Comments](#)

anemia Chief Complaint History of Present Illness

chronic kidney disease chronic kidney disease

diabetes swelling


Moving down the **Intake Tab**, we come to **Medications**. She confirms she's actually taking everything listed here, & nothing else, so click the **Medications reconciled** checkbox. (A detailed review of the Medication Module is provided in another lesson.)

Additional / Manage

Diagnostics

Show All

## Medications

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

Medication	Sig	Description
furosemide 20 mg tablet	1	daily in AM
Lantus Solostar 100 unit/mL (3 mL) Sub-Q Insulin Pen	18 units	each evening
lisinopril 10 mg tablet	1	daily

If you have questions about the meds 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.

General

Established patient | **New patient** | Historian:

Vital Signs **Vital Signs Outside Normal Range**

Reason for Visit

Medications

Allergies

Next, review allergies. Our patient states this list is correct & complete, so click the **Reviewed, no change** box.

Comment  No known allergies  Allergies added today  **Reviewed, no change**

Allergen	Reaction	Medication Name	Comment
GLUCORAL HYDRATE	Speaks in tongues		
PEANUT	Heebee Geebies		

Now let's move to the Histories Tab.

Add Update

Orders

- View of All Orders
- Labs
- Diagnostics
- Office Services
- View Immunizations Due
- Procedures
- Referrals

Status	Ordered	Order	Timeframe	Comments
--------	---------	-------	-----------	----------

Add Edit

A detailed review of data entry on the **Histories Tab** is included in another lesson, so in this example we'll keep it simple.

BooBoo Quagmire (F)    DOB: 01/04/1962 (52 years)    Weight: 199.00 lb (90.26 Kg)    Allergies: (2)    Problems: (4)    Diagnoses: (1)    Medications: (3)

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

03/23/2014 04:27 AM "USA Histories" x

Specialty ▼ Nephrology    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

**Problem List 4**

Show chronic     Show only tracked problem

Problem Description	Side	Notes	Added	Reviewed
Open cleft glaucoma				
Primary HTN				
Tobacco abuse				
Type II diabetes mellitus w/o complication				

Refresh    Add    Edit

The nurse notes that the **Risk Indicators** have been configured, displaying her HTN, DM, & tobacco abuse.

**OBGYN Detail** can be reviewed as desired/pertinent.

Navigation

Specialty ▾ Nephrology    Visit Type ▾ Office Visit

TOB    HTN    DM    CAD    ⚙

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** 4

Show chronic     Show my tracked problem     No active problems     Reviewed

Problem Description	Side	Notes	Addtl
Open cleft glaucoma	Bilateral	Seeing Dr. Jones. Well-controlled w/ drops.	1
Primary HTN			
Tobacco abuse			
Type II diabetes mellitus w/o complication			

Refresh    **Add**    Edit

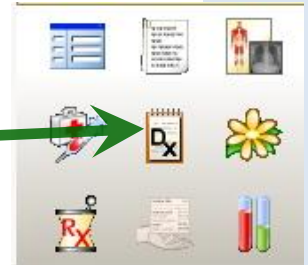
The nurse reviews the **Chronic Conditions**. The patient has shown her old notes including a GFR of 40, so the nurse astutely realizes CKD belongs on this list. Click **Add**.

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', 'Preferences', 'Show All Statuses' (with a dropdown arrow), 'Show My Tracked Problems Only', and 'Show Chronic Problems Only'. A status bar below the toolbar says '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 toolbar with buttons: 'Add Problem', 'Re-Code', 'Resolve', 'Set Chronic', 'Delete', 'Resources', 'View/Add Notes', 'View History', and 'Reconcile'. Below this toolbar are three links: 'Add to Billing ICD List', 'Add to My Tracked Problems', and 'Remove from My Tracked Problems'. A green box on the left contains text with an arrow pointing to the 'Problem List' tab. Another green box in the middle contains text with an arrow pointing to a 'Dx' icon in a tic-tac-toe board. A third green box at the bottom contains text with an arrow pointing to the 'Add Problem' button.

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](#).



A review of diagnosis search is covered in the Histories lesson. We'll search for & select **Chronic kidney disease stage 3**.

Q chronic kidney disease

Search

Description	Fully Specified Name	Concept Id
Chronic kidney disease	Chronic renal impairment	236425005
<b>Chronic kidney disease stage 3</b>	<b>Chronic kidney disease stage 3</b>	<b>433144002</b>
Chronic kidney disease stage II	Chronic kidney disease stage 2	431856006
Chronic kidney disease stage two	Chronic kidney disease stage 2	431856006
Stage 2 chronic kidney disease	Chronic kidney disease stage 2	431856006
Chronic kidney disease stage 1	Chronic kidney disease stage 1	431855005
Chronic kidney disease stage 2	Chronic kidney disease stage 2	431856006
Chronic kidney disease stage five	Chronic kidney disease stage 5	433146000
Chronic kidney disease stage four	Chronic kidney disease stage 4	431857002
Chronic kidney disease stage I	Chronic kidney disease stage 1	431855005
Chronic kidney disease stage III	Chronic kidney disease stage 3	433144002
Chronic kidney disease stage three	Chronic kidney disease stage 3	433144002
Chronic kidney disease, stage 2	Chronic kidney disease stage 2	431856006

Results are limited to top 100. Consider refining search.

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	Problem S
<b>Active</b>					
<b>Chronic kidney disease stage 3</b>					
433144002	Chronic kidney disease stage 3	Chronic kidney disease stage 3	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Active
<b>Essential hypertension</b>					
59621000	Primary HTN	Essential hypertension	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Active
<b>Open-angle glaucoma</b>					
<b>Tobacco dependence syndrome</b>					
<b>Type II diabetes mellitus without complication</b>					

Click **Set Chronic**, then clear the **Onset Date** checkbox, since we don't really know what that is.

Click the **Accept** button, then close the **Problems Module** to return to the **Histories Tab**.

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

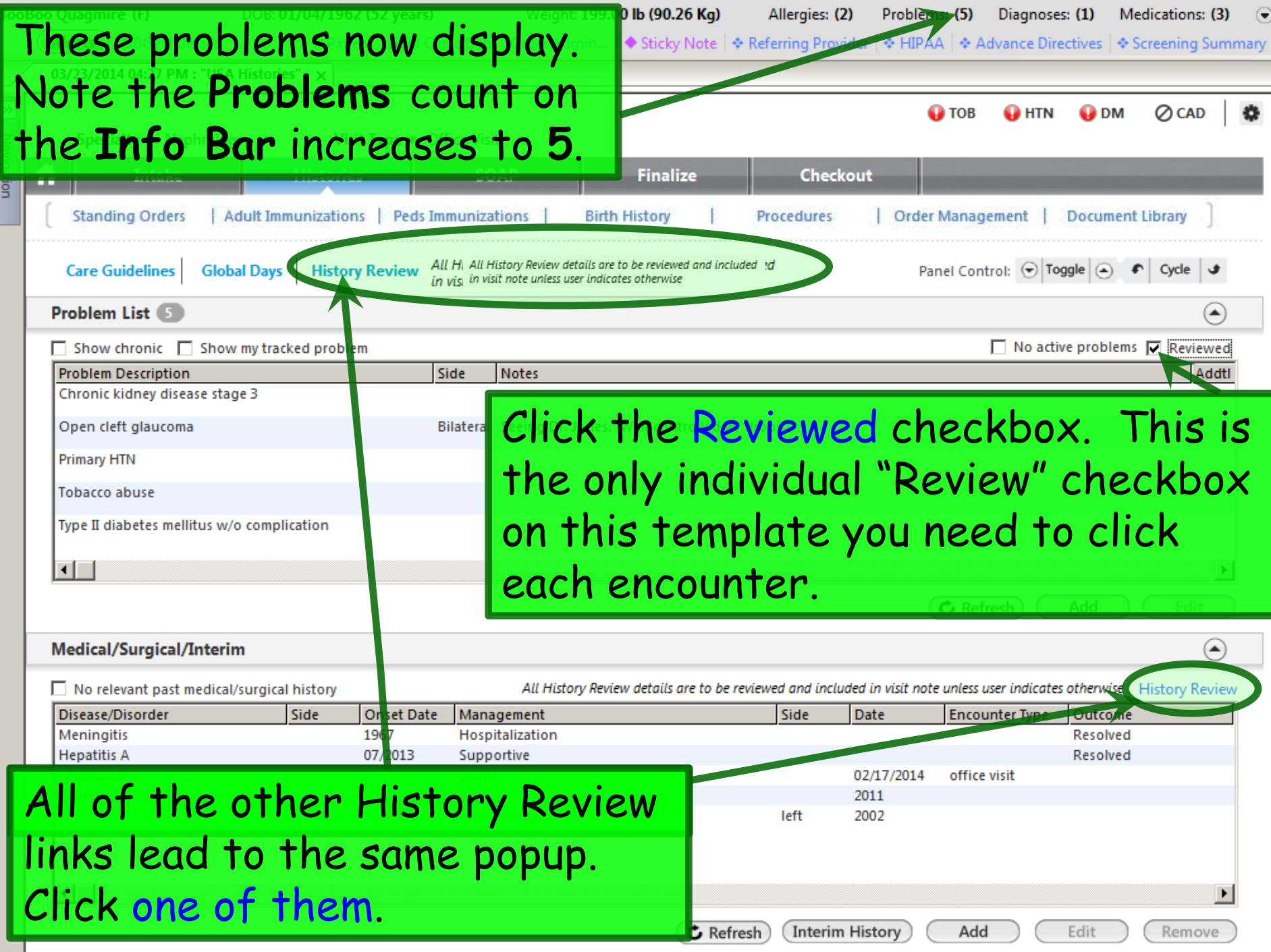
Concept Id: 431856006

Description: Chronic kidney disease stage 2 | Fully Specified Name: Chronic kidney disease stage 2

Onset Date:  03/23/2014 | Resolved Date:  03/23/2014 | Last Addressed:

Resolved By: | Resolved Reason:

These problems now display. Note the Problems count on the Info Bar increases to 5.



History Review

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

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

History Review



BooBoo Quagmire (F)    DOB: 01/04/1962 (52 years)    Weight: 199.00 lb (90.26 Kg)    Allergies: (2)    Problems: (5)    Diagnoses: (1)    Medications: (3)

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

03/23/2014 04:27 PM : "USA Histories" x

Specialty ▾ Nephrology    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 in

Panel Control: Toggle    Cycle

**Problem List** 5

Show chronic     Show my tracked problem

Problem Description	Side	Notes
Chronic kidney disease stage 3		
Open cleft glaucoma	Bilateral	Seeing Dr. Jo
Primary HTN		
Tobacco abuse		
Type II diabetes mellitus w/o complication		

**History Review**

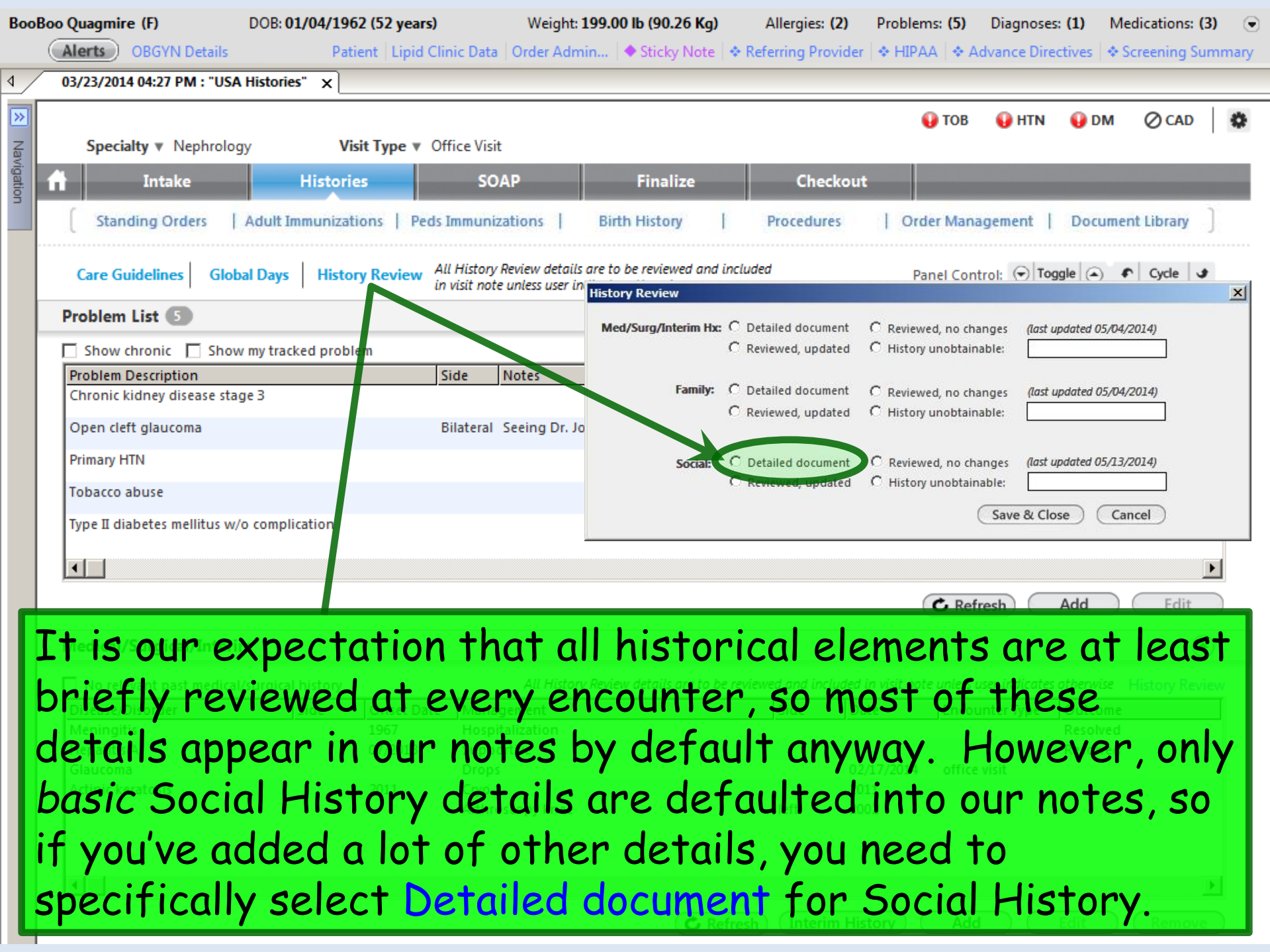
Med/Surg/Interim Hx:  Detailed document     Reviewed, no changes (last updated 05/04/2014)  
 Reviewed, updated     History unobtainable:

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 review **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. There is nothing to add.

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:

**Problem List** 5

Show chronic  Show my tracked problem

No active problems  Reviewed

Problem Description	Side	Notes	Adtl
Chronic kidney disease stage 3			
Open cleft glaucoma	Bilateral	Seeing Dr. Jones. Well-controlled w/ drops.	1
Primary HTN			
Tobacco abuse			
Type II diabetes mellitus w/o complication			

**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
Meningitis		1967	Hospitalization				Resolved
Hepatitis A		07/2013	Supportive				Resolved
Glaucoma			Drops		02/17/2014	office visit	
Actinic keratosis		2011	Cryo		2011		
			Arthroscopy knee	left	2002		

Specialty ▾ Nephrology

Visit Type ▾ Office Visit



Intake

Histories

SOAP

Finalize

Checkout

Now move to the Family History. We have nothing to add.

## 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
				No family history of Alcoholism		N	
				No family history of Diabetes mellitus		N	
Father		Y		Coronary artery disease		N	
Father				Hypertension		N	
Mother							
Mother							
Sister							

Then move to Social History. We can review some details by selecting the left side navigation.

## Social

 History Review
  Last documented
  All
 

Substances

 Tobacco

 Alcohol/Caffeine

Statuses

Lifestyle

Occupation

Comment

Diet History

Environmental

Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
02/26/2014	Yes	Cigarette	Heavy tobacco smoker	1 Packs	35.00	

Encounter Date:Time

To review further details or to make additions click the **Add** button.

Add

- ❖ Tobacco
- ❖ Alcohol/Caffeine
- ❖ Statuses
- ❖ Lifestyle
- ❖ Occupation
- ❖ Comments
- ❖ Diet History
- ❖ Environmental



Save &amp; Close

Panel Control: ▼ Toggle ▲ ↺ Cycle ↻

## Tobacco Use

Have you ever used tobacco?  No/never  Yes  Unknown [Exclusions](#) Reviewed Updated: 03/23/2014

## Smoking Tobacco Use

Tobacco type:	Use daily:	Usage per day:	Years used:	Pack year:	Age started:	Age stopped:
<input checked="" type="checkbox"/> Cigarette	<input checked="" type="checkbox"/>	1 Packs	35	35.00		
<input type="checkbox"/> Cigarillo	<input type="checkbox"/>	cigarillos				
<input type="checkbox"/> Cigar	<input type="checkbox"/>	cigars				
<input type="checkbox"/> Pipe	<input type="checkbox"/>	pipes				

## Non-Smoking Tobacco Use

Tobacco type:	Use daily:	Usage per day:	Years used:	Age started:	Age stopped:
<input type="checkbox"/> Chewing	<input type="checkbox"/>	units			
<input type="checkbox"/> Smokeless	<input type="checkbox"/>	units			
<input type="checkbox"/> Snuff	<input type="checkbox"/>	units			

Review & update as necessary. Here we have nothing to add, so we'll click the Reviewed checkbox, then Save & Close.

Encounter Date	Tobacco Type	Usage Per Day	Years Used	Pack Year	Status	Age Started	Age Stopped
02/26/2014	Cigarette	1 Packs	35.00	35.00	Heavy tobacco smoker		

## Efforts To Quit Tobacco

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

Tobacco type:	Month:	Day:	Year:	Longest tobacco free:	Cessation method:	Relapse reason:
<input type="text"/>	Quit:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add Update Clear

Specialty ▾ Nephrology

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



## 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
				No family history of Alcoholism		N	
				No family history of Diabetes mellitus		N	
Father		Y					
Father				Coronary artery disease		N	
Father				Hypertension		N	
Father		Y		Cancer, lung	65	Y	
Mother				Irritable bowel disease		N	
Mother				Asthma		N	
Sister				Cancer breast	40	N	

Add

Edit

Remove

## Social

## History Review

## Substances

- Tobacco
- Alcohol/Caffeine

## Statuses

- Lifestyle
- Occupation
- Comment
- Diet History
- Environmental

Let's say the clinic has standing orders to perform a urinalysis on all patients, & a sugar on all diabetics. Click the **Standing Orders** link, which can be found in several locations.

Developmental History

Confidential History

Add

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 interface. A table lists various lab orders. A popup window titled 'Ngkbn Dbp Ofc Orderset Types' is open, displaying a list of order set types. A green arrow points from the 'Display order set' box in the main application to the 'Office Tests' option in the popup.

**Office Services**

Panel Control: Toggle [Icons]

**Office Services 0**

Orders  
(Highlight a row to select) Display category: ALL

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		RUDD-CHARLES SYNDROME
ALL	Antigen therapy services, single/mult antigen			
ALL	Assay, albumin, urine, microalbumin, semiquan			
ALL	Assay, blood PKU			

Diagnosis

\*Order: [Text Box]

\*Diagnosis: [Text Box]

Results/Report

Interpretation: [Text Box] Details

Clinical indication: [Text Box]

Details: [Text Box]

Today's Orders  Submit to Superbil

Status	Office Diagnostic Description	Side

**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

**Diagnostic History Entry 0**

Save & Close Cancel

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

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 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		LIRINARY FRFOLIFNCY	788.41	ni

Diagnosis

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

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

Results/Report

Interpretation:       Normal value/range:       [Details](#)

Clinical indication:

Details:

Today's Orders

Sort By: Summary Phrase My Phrases Manage My Phrases

Interpretation      Result      Performed By      Cl

Quick Task      Place Order      Update

Save & Close      Cancel

Diagnostic History Entry 0

**Value**

156

7 8 9 +  
4 5 6  
1 2 3  
0 . -

Clear

OK Cancel

**Enter 156 mg/dL, then click OK.**

Office Services 0Display 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.



In a similar manner, we'll find **Urinalysis, dipstick**. Here we'll be presented with a popup to enter U/A results. When done click **OK**, then **Close**.

**Urine Dipstick**  Normal  See detail

<b>Color</b> <input checked="" type="radio"/> light yellow <input type="radio"/> yellow <input type="radio"/> dark yellow <input type="radio"/> amber <input type="radio"/> bloody	<b>Glucose</b> <input type="radio"/> negative <input type="radio"/> 100 mg/dl <input checked="" type="radio"/> 250 mg/dl <input type="radio"/> 500 mg/dl <input type="radio"/> 1000 mg/dl <input type="radio"/> 2000> mg/dl	<b>Bilirubin</b> <input checked="" type="radio"/> negative <input type="radio"/> small <input type="radio"/> moderate <input type="radio"/> large	<b>Ketones</b> <input checked="" type="radio"/> negative <input type="radio"/> trace <input type="radio"/> small <input type="radio"/> moderate <input type="radio"/> large <input type="radio"/> very large	<b>Specific Gravity</b> <input type="radio"/> 1.000 <input type="radio"/> 1.005 <input checked="" type="radio"/> 1.010 <input type="radio"/> 1.020 <input type="radio"/> 1.025 <input type="radio"/> 1.030	<b>Blood</b> <input checked="" type="radio"/> negative <input type="radio"/> trace non-hem <input type="radio"/> mod. non-hem <input type="radio"/> trace <input type="radio"/> small <input type="radio"/> moderate <input type="radio"/> large
<b>pH</b> <input type="radio"/> 5.5 <input checked="" type="radio"/> 6.0 <input type="radio"/> 6.5 <input type="radio"/> 7.0 <input type="radio"/> 7.5 <input type="radio"/> 8.0 <input type="radio"/> 8.5	<b>Albumin</b> <input type="radio"/> negative <input type="radio"/> trace <input checked="" type="radio"/> small <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+	<b>Urobilinogen</b> <input type="radio"/> normal <input checked="" type="radio"/> 2 mg/dl <input type="radio"/> 4 mg/dl <input type="radio"/> 8 mg/dl	<b>Nitrite</b> <input checked="" type="radio"/> negative <input type="radio"/> positive	<b>Leukocytes</b> <input checked="" type="radio"/> negative <input type="radio"/> trace <input type="radio"/> small <input type="radio"/> moderate <input type="radio"/> large	

Ok Cancel

Quick Task Place Order Update

Save & Close Cancel

Specialty Nephrology

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

Allergies

Orders

Lab/Radiology Order Processing Order Management Immunizations Standing Orders Task

View of All Orders

Status Ordered Order Timeframe Comments

Labs

Diagnostics

Office Services

View Immunizations Data

Procedures

Referrals

Now click **Generate Intake Note** using the button at the bottom of the **Intake** or **Histories** Tab.

Add

Edit

Review of Systems

Generate Intake Note

TX Text

Segoe UI 10 B I U [List Icons] 100%

PATIENT: BooBoo Quagmire  
DATE OF BIRTH: 01/04/1962  
DATE: 03/23/2014 4:27 PM  
VISIT TYPE: Office Visit

History of Present Illness:  
1. chronic kidney disease  
2. swelling

Intake Comments: CKD followed by MD OOT; he was mentioning possible dialysis soon. just moved to town. Saw FM last month & got meds refilled, but missed F/U appt. Feet have been swelling worse in last 3-4 wks.

Problem List:

Problem Description	Onset Date	Chronic	Notes
Tobacco abuse		Y	
Open cleft glaucoma		Y	
Type II diabetes mellitus w/o complication	01/01/2009	Y	
Primary HTN		Y	
Chronic kidney disease stage 3		Y	

Family History

Relationship	Family Member Name	Deceased

03/23/2014 04:27 PM [Folder] \*Intake  
\*USA Intake  
Medication  
USA Histories  
intake\_note

03/03/2014 03:38 PM [Folder]  
03/02/2014 03:35 PM [Folder]  
03/01/2014 03:25 PM [Folder]  
02/28/2014 03:22 PM [Folder]  
02/27/2014 03:14 PM [Folder]  
02/26/2014 04:45 PM [Folder]  
02/25/2014 05:05 PM [Folder]  
02/20/2014 09:10 AM [Folder]  
02/14/2014 03:56 PM [Folder]

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

Close this, returning you to the Intake Tab.

BooBoo Quagmire (F)    DOB: 01/04/1962 (52 years)    Weight: 199.00 lb (90.26 Kg)    Allergies: (2)    Problems: (5)    Diagnoses: (1)    Medications: (3)

Address: 555 Knock Knee Drive    MRN: 000000007767    Emergency Relation:    PCP: DUFFY, ROBERT LAMAR...  
Mobile, AL 36604    Insurance: BCBS OF ALABAMA    Emergency Phone:    Referring:     
Contact: (251) 555-1234 (Home)    NextMD: No    Pharmacy 1: LINCOLN PHARM...    Rendering: DUFFY, ROBERT LAMAR...

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

03/23/2014 04:27 PM : "\*USA Intake" x

Specialty ▾ Nephrology    Visit Type ▾ Office Visit

TOB    HTN    DM    CAD

Intake    Histories    SOAP    Finalize    Checkout

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

The patient is ready for the provider. On the re-expanded Info Bar & click the Tracking icon.

Care Guide    Global Data    Panel    Audit    Control

General    Vital Signs    Reason for Visit    Medications    Allergies    Orders

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				

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:

[Empty Room Input Box]

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

Patient Tracking:

Appt Time	Room

Appointment date shown.

Refresh

OK

Cancel

Task

EHR Appointments

Save & Close

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:** Attended (Entries uploaded on "Save and Close".)

**Patient Tracking:**

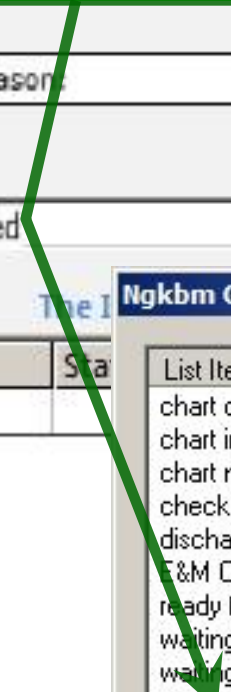
Appt Time	Room	Sta

**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

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



**Today's Patient Tracking** [Close]

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.**



Task   EHR Appointments   **Save & Close**   Cancel

Patient

Location

Provider

Date

NextGen EHR: BooBoo Quagmire MRN: 00000007767 DOB: 01/04/1962 (Female) AGE: 52 years 2 months - 03/23/2014 04:27 PM: "\*USA Home Page"

File Edit Default View Tools Admin Utilities Window Help

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

BooBoo Quagmire (F) DOB: 01/04/1962 (52 years) Weight: 199.00 lb (90.26 Kg) Allergies: (2) Problems: (5) Diagnoses: (1) Medications: (3)

Address: 555 Knock Knee Drive Mobile, AL 36604 MRN: 00000007767 Insurance: BCBS OF ALABAMA Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...  
 Contact: (251) 555-1234 (Home) NextMD: No Emergency Phone: Referring: ...  
 Pharmacy 1: LINCOLN PHARM... Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM: "\*USA Home Page"

Specialty Nephrology 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

Medical Chart Summary

Allergies	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Assessment History	03/23/2014	5:12 PM	97.7	158/94	80	16	66.00	199.00	32.12				
Clinical Guidelines	02/26/2014	4:49 PM	98.9	120/84	88	16	66.00	156.00	25.18				
Communication History	02/25/2014	5:02 PM	98.0	128/88	88	16	66.00	156.00	25.50				

Navigation: Home Intake Histories SOAP Finalize Checkout

Patient History: Patie... Patie... Cate...  
 New Lock Search  
 03/23/2014 04:27 PM  
 \*Intake  
 \*USA Intake  
 Medication  
 USA Histories  
 intake\_note  
 03/03/2014 03:38 PM  
 03/02/2014 03:35 PM  
 03/01/2014 03:25 PM  
 02/28/2014 03:22 PM  
 02/27/2014 03:14 PM  
 02/26/2014 04:45 PM  
 02/25/2014 05:05 PM

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



BooBoo Quagmire (F) DOB: 01/04/1962 (52 years) Weight: 199.00 lb (90.26 Kg) Allergies: (2) Problems: (5) Diagnoses: (1) Medications: (3)

Address: 555 Knock Knee Drive Mobile, AL 36604  
Contact: (251) 555-1234 (Home)  
MRN: 00000007767 Insurance: BCBS OF ALABAMA NextMD: No  
Emergency Relation: Emergency Phone: Pharmacy 1: LINCOLN PHARM...  
PCP: DUFFY, ROBERT LAMAR ... Referring: Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM : "\*USA Home Page" x

Specialty Nephrology 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

Medical Chart Summary

Allergies Assessment History Clinical Guidelines Communication History Diagnostics Family History HPI's Labs Medications Office Labs Office Procedures Past Medical/Surgical History Patient Provider Physical Exams Plans

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

03/23/2014 5:12 PM 97.7 158/94 80 16 66.00 199.00 32.12

02/26/2014 4:49 PM 98.9 120/84 88 16 66.00 156.00 25.18

02/25/2014 5:06 PM 99.0 133/86 88 16 66.00 158.00 28.50

02/27/2014 03:14 PM

03/01/2014 03:25 PM

02/28/2014 03:22 PM

02/26/2014 04:45 PM

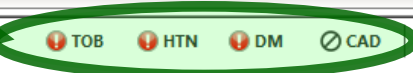
02/25/2014 05:05 PM

Custom

Ready

NGDevil USA Health Services Foundation rlduffy CAP NUM SCRL 03/23/2014

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', 'OBGYN Details', 'Patient', 'Lipid Clinic Data', 'Order Admin...', 'Sticky Note', 'Referring Provider', 'HIPAA', 'Advance Directives', and 'Screening Summary'. Below this, the patient's name and date are shown: '03/23/2014 04:27 PM: \*\*USA Hom Page'. The main area is divided into sections: 'Specialty' (Nephrology), 'Visit Type' (Office Visit), and a row of buttons for 'Intake', 'Histories', 'SOAP', 'Finalize', and 'Checkout'. Below these are 'Care Guidelines' and 'Global Days'. A 'Medical Chart Summary' section is visible, with a table of vital signs. A green arrow points from the text above to the 'Histories' button. Another green arrow points from the text below to the 'Pulse' column in the table. On the right, a 'Patient History' sidebar shows a tree view of folders for various dates and times, with a green arrow pointing to the '03/23/2014 04:27 PM' folder. At the bottom, there is a 'Ready' status bar and a date '03/23/2014'.

	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Allergies	03/23/2014	5:12 PM	97.7	158/94	80	16	66.00	199.00	32.12				
Assessment History	03/23/2014	5:12 PM	97.7	158/94	80	16	66.00	199.00	32.12				
Clinical Guidelines	03/23/2014	5:12 PM	97.7	158/94	80	16	66.00	199.00	32.12				
Communication History	02/25/2014	5:06 PM	99.0	133/86	88	16	66.00	158.00	25.50				
Diagnostics													
Family History													
HPI's													
Labs													
Medications													
Office Labs													
Office Procedures													
Past Medical/Surgical History													
Patient Providers													
Physical Exams													
Plans													

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

The Problem List is viewable & editable here.

Specialty ▾ Nephrology

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



### Medical Chart Summary

### Problem List 5

Show chronic  Show my tracked problems

No active problems  Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Clinical Status	Provider	Location	Notes
	Tobacco abuse		Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	
	Open cleft glaucoma		Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	Seeing Dr. Jones. Well-controlled w/ drop
	Type II diabetes mellitus w/o complication	01/01/2009	Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	
	Primary HTN		Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	

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

No relevant past medical/surgical history

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

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

- Medical
- Surgical/mgmt
- Interim
- Social
- Family
- Diagnostic

## Allergies

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

Allergen	Reaction	Medication Name	Comment
CHLORAL HYDRATE	Speaks in tongues		
PEANUT	Heebee Geebies		

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.

## Medications

Patient status:  Transitioning into care
  Summary of care received

[Comment](#)
 No medications
  Medications reconciled

Medication	Sig	Description
furosemide 20 mg tablet	1	daily in AM
Lantus Solostar 100 unit/mL (3 mL) Sub-Q Insulin Pen	18 units	each evening
lisinopril 10 mg tablet	1	daily

Add/Update

Reconcile

**Vital Signs**
⚠ Vital Signs Outside Normal Range
[History](#) | [Graph](#)

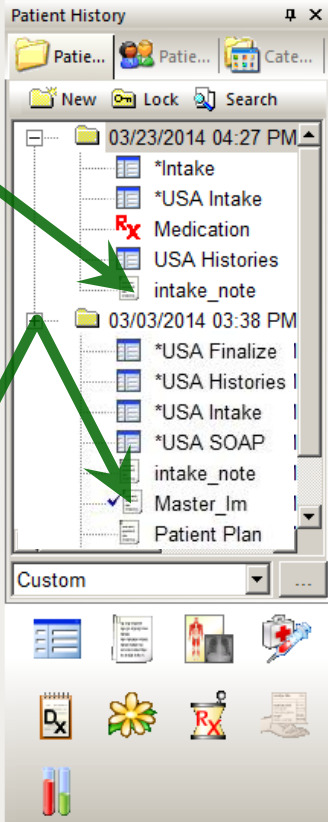
Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
5:12 PM	66.00	199.00	32.12	158/94	80	16	97.7				

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.

Patient History

- Patie...
- Patie...
- Cate...
- New Lock Search
- 03/23/2014 04:27 PM
  - \*Intake
  - \*USA Intake
  - Medication
  - USA Histories
  - intake\_note
- 03/03/2014 03:38 PM
  - \*USA Finalize
  - \*USA Histories
  - \*USA Intake
  - \*USA SOAP
  - intake\_note
  - Master\_Im
  - Patient Plan

Custom



Medical Chart Summary

	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Allergies													
Assessment History	03/23/2014	5:12 PM	97.7	158/94	80	16	66.00	199.00	32.12				
Clinical Guidelines	02/26/2014	4:49 PM	98.9	120/84	88	16	66.00	156.00	25.18				
Communication History	02/25/2014	5:06 PM	99.0	133/86	88	16	66.00	158.00	25.50				
Diagnostics													
Family History													

You could also review the **Master\_Im** (visit note) from the last visit with the PCP.

NextGen EHR: BooBoo Quagmire MRN: 00000007767 DOB: 01/04/1962 (Female) AGE: 52 years 2 months - 03/23/2014 04:27 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 PAQ Medications Templates Documents Images Orders Problems Apps Close

BooBoo Quagmire (F) DOB: 01/04/1962 (52 years) Weight: 199.00 lb (90.26 Kg) Allergies: (2) Problems: (5) Diagnoses: (1) Medications: (3)

Address: 555 Knock Knee Drive Mobile, AL 36604 MRN: 00000007767 Insurance: BCBS OF ALABAMA Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...  
Contact: (251) 555-1234 (Home) NextMD: No Emergency Phone: Referring: ...  
Pharmacy 1: LINCOLN PHARM... Rendering: DUFFY, ROBERT LAMAR ...

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

03/23/2014 04:27 PM: "\*USA Home Page"

Specialty Nephrology 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

Medical Chart Summary

	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Allergies													
Assessment History	03/23/2014	5:12 PM	97.7	158/94	80	16	66.00	199.00	32.12				
Clinical Guidelines	02/26/2014	4:49 PM	98.9	120/84	88	16	66.00	156.00	25.18				
Communication History	02/25/2014	5:06 PM	99.0	133/86	88	16	66.00	158.00	25.50				
Diagnostics													
Family History													
HPI's													
Labs													
Medications													
Office Labs													
Office Procedures													
Past Medical/Surgical History													
Patient Providers													
Physical Exams													
Plans													

Ready NGDev| USA Health Services Foundation rlduffy | CAP NUM SCRL 03/23/2014

Patient History

- 03/23/2014 04:27 PM
  - \*Intake
  - \*USA Intake
  - Medication
  - USA Histories
  - intake\_note
- 03/03/2014 03:38 PM
- 03/02/2014 03:35 PM
- 03/01/2014 03:25 PM
- 02/28/2014 03:22 PM
- 02/27/2014 03:14 PM
- 02/26/2014 04:45 PM
- 02/25/2014 05:05 PM

Custom

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

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

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

Care Guidelines | Global Days | Panel Control: [Toggle] [Cycle]

Reason for Visit

Introduction:  
This 52 year old female presents for chronic kidney disease and swelling.

Do not launch HPI

Intake Comments

Reason for Visit	History of Present Illness
anemia	chronic kidney disease
chronic kidney disease	swelling
diabetes	
edema	
education	
ESRD	
hyperparathyroidism	
hypertension	
kidney stones	
proteinuria	
renal failure	

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 **chronic kidney disease**.

Diagnostics | Comments

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

Information

Concerns

Date of initial visit: 03/23/2014

Date of diagnosis: Month: Year:

Severely: moderate

Current pain scale:

- Stable
- Improving
- Worsening
- Remission
- Relapsed
- Clinically free of disease

**Initial Symptoms:**

- Fatigue
- Hypertension
- Low back pain
- Swelling of foot/ankle
- Other:
- Hematuria
- Lethargy
- Shortness of breath
- Weakness
- None

**Secondary To:**

- Diabetes Type I
- Diabetic nephropathy
- IGA
- Membranous nephropathy
- Other:
- Diabetes Type II
- Hypertension
- Interstitial nephritis
- Multiple myeloma
- None

**Associated Symptoms/Pertinent Negatives:**

- No associated symptoms
- No pertinent negatives
- All others are negative

- |                                      |                                           |                                        |                                    |                                   |                                   |
|--------------------------------------|-------------------------------------------|----------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="radio"/> No             | <input type="radio"/> Yes                 | <input type="radio"/> No               | <input type="radio"/> Yes          | <input type="radio"/> No          | <input type="radio"/> Yes         |
| <input type="radio"/> Abdominal pain | <input type="radio"/> Chills              | <input type="radio"/> Dysuria          | <input type="radio"/> Insomnia     | <input type="radio"/> Mouth sores | <input type="radio"/> Nausea      |
| <input type="radio"/> Anorexia       | <input type="radio"/> Constipation        | <input type="radio"/> Fatigue          | <input type="radio"/> Night sweats | <input type="radio"/> Pallor      | <input type="radio"/> Petechiae   |
| <input type="radio"/> Bleeding       | <input type="radio"/> Cough               | <input type="radio"/> Fever            | <input type="radio"/> Vomiting     | <input type="radio"/> Weight gain | <input type="radio"/> Weight loss |
| <input type="radio"/> Bone pain      | <input checked="" type="radio"/> Diarrhea | <input type="radio"/> Headache         |                                    |                                   |                                   |
| <input type="radio"/> Bruising       | <input type="radio"/> Dizziness           | <input type="radio"/> Hives            |                                    |                                   |                                   |
| <input type="radio"/> Chest pain     | <input type="radio"/> Dyspnea             | <input type="radio"/> Increased thirst |                                    |                                   |                                   |

And you can save & reuse presets.

Comments:

When done click **Save & Close**.

Save & Close Cancel



Entries from the HPI popups display on the SOAP Tab.

Specialty | Nephrology

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

### Reason for Visit

Introduction:

This 52 year old female presents for chronic kidney disease and swelling.

Do not launch HPI

[Intake Comments](#)

	Reason for Visit	History of Present Illness
anemia chronic kidney disease diabetes edema education ESRD hyperparathyroidism hypertension kidney stones proteinuria renal failure urinary problems	chronic kidney disease           swelling	The patient presents with chronic kidney disease. The initial visit date was 03/23/2014. The patient reports the severity is moderate. The condition is stable. Initial symptoms include hypertension and swelling of foot/ankle. Secondary symptoms include diabetes type II and hypertension. Pertinent negatives include diarrhea, fever, rash and vomiting.
<hr/> Additional / Manage		

Diagnostics Comments

Specialty ▼ Nephrology

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

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.

## 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; sometimes you can't even recognize whether you performed the visit or if it was done by one of your colleagues.

Specialty ▾ Nephrology

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

Reason for Visit

Introduction:

This 52 year old female presents for chronic kidney disease and swelling.

Do not launch HPI

Intake Comments

	Reason for Visit	History of Present Illness
anemia	chronic kidney disease	The patient presents with chronic kidney disease. The initial visit date was 03/23/2014. The patient reports the severity is moderate. The condition is stable. Initial symptoms include hypertension and swelling of foot/ankle. Secondary symptoms include diabetes type II and hypertension. Pertinent negatives include diarrhea, fever, rash and vomiting.
chronic kidney disease	swelling	
diabetes		
edema		
education		
ESRD		
hyperparathyroidism		
hypertension		
kidney failure		
proteinuria		
renal failure		
urinary		

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

chronic kidney disease

My Phrases

1. Referred to get estab w/ nephrologist after moving to area. Family Medicine's recent notes reviewed, along w/ some records from prev nephrologist in Pensacola, showing GFR of 40, Cr. 3.7. Also has DM & HTN, not optimally controlled. Was out of meds, & just had them refilled at FM. Smoker. No recent eye care.

swelling

My Phrases

2. Worsening swelling in legs over last month; thinking back, she says it's actually worsened over last 4-6 mos

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 52 year old female presents for chronic kidney disease and swelling.

Do not launch HPI

- anemia
- chronic kidney disease
- diabetes
- edema
- education
- ESRD
- hyperparathyroidism
- hypertension
- kidney stones
- proteinuria
- renal failure
- urinary problems

Additional / Manage

Reason for Visit	History of Present Illness
chronic kidney disease	The patient presents with chronic kidney disease. The initial visit date was 03/23/2014. The patient reports the severity is moderate. The condition is stable. Initial symptoms include hypertension and swelling of foot/ankle. Secondary symptoms include diabetes type II and hypertension. Pertinent negatives include diarrhea, fever, rash and vomiting.
chronic kidney disease (comments)	Referred to get estab w/ nephrologist after moving to area. Family Medicine's recent notes reviewed, along w/ some records from prev nephrologist in Pensacola, showing GFR of 40, Cr. 3.7. Also has DM & HTN, not optimally controlled. Was out of meds, & just had them refilled at FM. Smoker. No recent eye care.
swelling	
swelling (comments)	Worsening swelling in legs over last month; thing back, she says it actually worsened over last 4-6 mos.

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 ▾ Nephrology      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]

Reason for Visit

**Review of Systems**

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

System	Neg/Pos	Findings
Constitutional	Negative	Fever.
GI	Negative	Diarrhea and vomiting.
Integumentary	Negative	Rash.
Reproductive	Positive	The patient is post-menopausal (Occurred at age 48).

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 **Nephrology - ROS**.

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.

Nephrology - ROS

ROS Defaults:

**Constitutional:**  
 All neg  
**Neg Pos**  
 Chills  
 Fatigue  
 Fever  
 Weight loss  
 Other:

**HEENT:**  
 All neg  
**Neg Pos**  
 Bleeding gums  
 Dysphagia  
 Ear drainage  
 Ear pain  
 Epistaxis  
 Hearing loss  
 Hoarseness  
 Mouth ulcers  
 Ringing in ears  
 Snoring  
 Visual loss  
 R  L  Bilateral  
 Legally blind  
 Blurred vision  
Corrective:  
 Glasses  
 Contacts  
 Both  
 Radial keratotomy  
 LASIK  
 Other:

**Respiratory:**  
 All neg  
**Neg Pos**  
 Cough  
 Dyspnea  
 Hemoptysis  
 Known TB exposure  
 Wheezing  
 Other:

**Cardiovascular:**  
 All neg  
**Neg Pos**  
 Chest pain  
 Edema  
 Leg swelling  
 Palpitations  
 Syncope  
 Other:

**Gastrointestinal:**  
 All neg  
**Neg Pos**  
 Abdominal pain  
 Change in appetite  
 Constipation  
 Diarrhea  
 Heartburn  
 Hematemesis  
 Nausea  
 Rectal bleeding  
 Vomiting  
 Other:

**Metabolic/Endocrine:**  
 All neg  
**Neg Pos**  
 Goiter  
 Increased thirst  
 Uncontrolled hunger  
 Other:

**Genitourinary:**  
 All neg  
**Neg Pos**  
 Dysuria  
 Hematuria  
 Urinary frequency  
 Urinary incontinence  
 Other:

**Reproductive:**  
 All neg  
**Neg Pos**  
 Abnormal Pap  
 Breast discharge  
 Breast lump  
 Dysmenorrhea  
 Dyspareunia  
 Hot flashes  
 Menorrhagia  
 Vaginal discharge  
 Other:

**Neurological:**  
 All neg  
**Neg Pos**  
 Dizziness  
 Focal weakness  
 Gait disturbance  
 Headache  
 Memory loss  
 Nervousness  
 Paralysis  
 Paresthesia  
 Seizures  
 Speech disturbances  
 Other:

**Psychiatric:**  
 All neg  
**Neg Pos**  
 Anxiety  
 Depression  
 Insomnia  
 Other:

**Integumentary:**  
 All neg  
**Neg Pos**  
 Hives  
 Itching  
 Mole changes  
 Rash  
 Ulcer  
 Other:

**Musculoskeletal:**  
 All neg  
**Neg Pos**  
 Back pain  
 Body aches  
 Calf tenderness  
 Joint swelling  
 Limited joint motion  
 Other:

**Hematologic/Lymphatic:**  
 All neg  
**Neg Pos**  
 Anemia  
 Easy bleeding  
 Easy bruising  
 Other:

**Immunologic:**  
 All neg  
**Neg Pos**  
 Environmental allergies  
 Food allergies  
 Hay fever  
 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.

03/23/2014 04:27 PM : "\*USA SOAP" x

Specialty: Nephrology Visit Type: Office Visit

TOB HTN DM CAD

Panel Control: Toggle Cycle

Reason for Visit

Review of Systems

System	Neg/Pos	Findings
Constitutional	Positive	Fatigue.
Constitutional	Negative	Fever.
ENMT	Negative	Otalgia.
Eyes	Negative	Vision loss.
Respiratory	Negative	Cough and dyspnea.
Cardio	Positive	Edema, Leg swelling.
Cardio	Negative	Chest pain, irregular heartbeat/palpitations and syncope.

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

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.

Specialty ▾ Nephrology

Intake | History

Standing Orders | Adult Immunization

Care Guidelines | Global Days

Reason for Visit

Review of Systems

Vital Signs ⚠ Vital Signs Outside Normal Range

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain Level	Comments
5:12 PM	66.00	199.00	32.12	158/94	80	16	97.7				

Health Promotion Plan | History | Graph

Add Edit Remove

Physical Exam

- One Page Exam
- Constitutional
- Eyes
- Nose | Mouth | Throat
- Neck | Thyroid
- Lymphatic
- Respiratory
- Cardiovascular
- Vascular
- Abdomen
- Skin | Hair
- Musculoskeletal
- Extremities
- Psychiatric

Exam | Findings | Details

You'll next move down to the Physical Exam.

Specialty ▾ Nephrology

Visit Type ▾ Office Visit

First notice the **Office Diagnostics** button. That gives you a chance to review things like urinalyses, pregnancy tests, etc., that your nurse may have done for you through standing orders. Even though you had the chance to review those on the **Home Tab**, it may be that the results weren't available yet when you first went into the room.

Add

Edit

Remove

## Physical Exam



One Page Exam  
Constitutional  
Eyes  
Nose | Mouth | Throat  
Neck | Thyroid  
Lymphatic  
Respiratory  
Cardiovascular  
Vascular  
Abdomen  
Skin | Hair  
Musculoskeletal  
Extremities  
Psychiatric

Exam	Findings	Details
------	----------	---------

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

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

## Results/Report

Interpretation: Normal value/range: Unit of measure: 

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 **Save & Close**.

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

Add Edit Remove



- One Page Exam
- Constitutional
- Eyes
- Nose | Mouth | Throat
- Neck | Thyroid
- Lymphatic
- Respiratory

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.

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
5:12 PM	66.00	199.00	32.12	158/94	80	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 **PEFullNIFemale-RLD**, a preset I've previously saved as my starting point for a typical normal exam for an adult female. 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

- PEFullNAdultMale-RLD
- PEFullNIFemale-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 **One Page Exam**.

Reason for Visit

Review of Systems

Vital Signs  Vital Signs Outside Normal Range

Physical Exam



Exam	Findings	Details
Constitutional	*	Overall appearance - In no acute distress.
Ears	*	Canal - Right: No excess wax or inflammation, Left: No excess wax or inflammation. TM - Right: Benign, Left: Benign.
Nasopharynx	*	Oropharynx - No redness or drainage.
Neck Exam	Normal	Palpation - Normal. Thyroid gland - Normal.
Breast	Normal	Inspection - Bilateral: Normal. Palpation - Bilateral: Normal.
Respiratory	Normal	Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Abdomen	Normal	No abdominal tenderness.
Genitourinary	Normal	No suprapubic tenderness.
Extremity	Normal	No edema.
Neurological	*	Sensory - Grossly normal. Motor - Grossly normal.

Default:



◆ **Constitutional**

Level of distress:  Normal

Nourishment:  Normal

◆ **Head/Face**

Facial features:  Normal

Eyebrows:  Normal

Skull:  Normal

Hair:  Normal

◆ **Eyes**

Normal

◆ **Ears** ◆ **Nose/Mouth/Throat**

Pinna: R  Normal

L  Normal

External nose:  Normal

Lips/teeth/gums:  Normal

◆ **Cardiovascular**

Heart Sounds:  Normal S1  Normal S2 Murmur:  None Jugular vein: HT:  cm

Heart rate:  Regular rate  Tachycardia Degree of tilt:

Rhythm:  Regular  Regularly irregular  Irregularly irregular

JVD:  Absent  Present

◆ **Vascular**

Bruits Absent Location: Severity:

Carotids:

Abdominal, upper:

Pulses Normal Right: Left:

Dorsalis pedis:

Posterior tibial:

◆ **Extremities** ◆ **Diabetic Foot Exam**

Edema:  No  Yes Location: Side: Severity: Type:

Cyanosis:  No  Yes

Clubbing:  Absent  Present

Fistula:  No  Yes

◆ **Musculoskeletal**

Extremities overview:  Normal

Gait:  Normal

◆ **Neurological**

Cranial nerves:  II - XII grossly intact  I grossly intact [◆ Details](#)

DTRs:  Normal

Sensory:  Normal

◆ **Psychiatric**

No Yes

Oriented to time, place, person and situation   Poor judgement

Appropriate mood and affect:   Poor insight

Memory loss

Comments:  Carry forward comments

Using this popup and/or the system popups, edit your entry to reflect today's findings. For this example I'll just change Edema to **Yes**. 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.

Review of Systems

Vital Signs

Physical Exam

One Page Exam

Constitutional

Ears

Nose | Mouth | Throat

Neck | Thyroid

Lymphatic

Respiratory

Cardiovascular

Vascular

Abdomen

Skin | Hair

Musculoskeletal

Extremities

Psychiatric

Additional

Exam	Findings	Details
Constitutional	*	Overall appearance - In no acute distress.
Ears	*	Canal - Right: No excess wax or inflammation, Left: No excess wax or inflammation. TM - Right: Benign, Left: Benign.
Nasopharynx	*	Oropharynx - No redness or drainage.
Neck Exam	Normal	Palpation - Normal. Thyroid gland - Normal.
Breast	Normal	Inspection - Bilateral: Normal. Palpation - Bilateral: Normal.
Respiratory	Normal	Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Abdomen	Normal	No abdominal tenderness.
Genitourinary	Normal	No suprapubic tenderness.
Extremity	*	Edema.
Neurological	*	Sensory - Grossly normal. Motor - Grossly normal.

Reason for Visit



Review of Systems



Vital Signs



Physical Exam



Assessment/Plan



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. chronic kidney disease 2. swelling

(Select a row from any grid to add to Today's Assessments)  Add Assessments on 1-clickDiagnosis History  Show Chronic only

Diagnosis Description	Code
Abscess	682.9

[Add Common Assessment](#) | [Diagnosis Code Lookup](#)

Clinical Problems

 Show Chronic  Show My Tracked problems  No active problems

Description	Onset Date
Chronic kidney disease stage 3	
Open cleft glaucoma	
Primary HTN	

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

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. (Details are covered in another lesson.)

Today's Concerns/Reason for Visit

1. chronic kidney disease 2. swelling

(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
Abscess	682.9
Chronic kidney disease, Stage III (moderate)	585.3
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00
Unspecified essential hypertension	401.9

Clinical Problems

Show Chronic  Show My Tracked problems  No active problems

Description	Onset Date
Chronic kidney disease stage 3	
Open cleft glaucoma	
Primary HTN	

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

Today's Assessments

#	Description(code)	Status	Site	Impression
1	Chronic kidney disease, Stage III (moderate) (585.3)			
2	Unspecified essential hypertension (401.9)			
3	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00)			

Here I've made a few selections from the Clinical Problems list.

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.

# 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	Chronic kidney disease, Stage III (moderate)	585.3	
2	Unspecified essential hypertension	401.9	
3	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00	
4	Tobacco use disorder	305.1	

Selected Assessment: Chronic kidney disease, Stage III (moderate)

- Add
- Edit
- Sort DX
- Remove

Impression/Comments:

My Phrases

[Empty text area for Impression/Comments]

Differential Diagnosis:

My Phrases

[Empty text area for Differential Diagnosis]

(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

Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.

Provider Details:

- My Phrases
- Common Phrases

May increase lisinopril later, but I want to look at lab first. Further plans when lab back.

Record your plans. While you can type your instructions here, you can also use **My Phrases** to greatly reduce your work for things you say repeatedly. (Setup of **My Phrases** is discussed in the User Personalization demo.)

- 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	Chronic kidney disease, Stage III (moderate)	585.3	
2	Unspecified essential hypertension	401.9	
3	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	250.00	
4	Tobacco use disorder	305.1	

**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.**

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

Patient Details: My Phrases Common Phrases

Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.

Provider Details: My Phrases Common Phrases

May increase lisinopril later, but I want to look at lab first. Further plans when lab back.

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

Today's Orders:

**When done click Save & Close.**

Manage My Phrases Save & Close Cancel

Reason for Visit

Review of Systems

Vital Signs

Physical Exam

Assessment/Plan

Your assessments & plans display.



<ul style="list-style-type: none"> <li>Assessments</li> <li>My Plan</li> <li>A/P Details</li> <li>Labs</li> <li>Diagnostics</li> <li>Referrals</li> <li>Office Procedures</li> <li>Review/Cosign Orders</li> <li>View Immunizations</li> <li>Office Diagnostics</li> <li>Physical Therapy Orders</li> <li>Health Promotion Plan</li> </ul>	1.	Assessment	Chronic kidney disease, Stage III (moderate) (585.3).
		Patient Plan	Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.
		Provider Plan	May increase lisinopril later, but I want to look at lab first. Further plans when lab back.
	2.	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.
	3.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
	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 her prescriptions. Click **Meds**.



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

Last Audit	Status	Medication Name	Generic Name	Start Date	Stop Date	Sig	Original Start
Status: Active (3 items)							
	Active	furosemide 40 mg tablet	FUROSEMIDE	03/23/2014		1 each AM	03/23/2014
	Active	Lantus Solostar 100 unit/mL (3 mL) Sub-...	INSULIN GLARGINE HUM.REC.ANLOG	03/23/2014		18 units each evening	03/23/2014
	Active	lisinopril 10 mg tablet	LISINOPRIL	03/23/2014		1 daily	03/23/2014

Medication Module details are reviewed in another lesson.

We've changed furosemide to 40 mg daily, & we'll ERx that, then return to the SOAP Tab.

[Prescribe New](#)
[Print](#)
[Send](#)
[Renew](#)
[Interactions](#)
[Stop](#)
[Resources](#)
[Dose Range](#)
[Delete](#)
[Eligibility](#)
[Medication History](#)
[Reconcile](#)

furosemide 40 mg tablet

Sig: 1 each AM [Remove Sig](#) [Edit Sig...](#)

Quantity:  Units:  Refills: 
 Dispense As Written

Start:  03/23/2014 Stop:  03/24/2014 Duration: 
 Prescribed Elsewhere Source:

PRN Reason:

Problem:  [Add...](#)

Comments:

Provider:

Location:

Note: [Add Note...](#)

Formulary Data:

[Last Renewed:](#) [Times Renewed:](#) [Full History](#) [DUR History](#) [Dispense History](#) [Additional Prescription Detail](#)



Reason for Visit

Review of Systems

Vital Signs

Physical Exam

Assessment/Plan

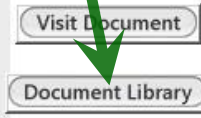
- Assessments
- My Plan
- A/P Details
- Labs
- Diagnostics
- Referrals
- Office Procedures
- Review/Cosign Orders
- View Immunizations
- Office Diagnostics
- Physical Therapy Orders
- Health Promotion Plan

1.	Assessment	Chronic kidney disease, Stage III (moderate) (585.3).
	Patient Plan	Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.
	Provider Plan	May increase lisinopril later, but I want to look at lab first. Further plans when lab back.
2.	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.
3.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
4.	Assessment	Tobacco use disorder (305.1).

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



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

Reason for Visit

Review of Systems

Vital Signs

Physical Exam

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	Chronic kidney disease, Stage III (moderate) (585.3).
	Patient Plan	Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.
	Provider Plan	May increase lisinopril later, but I want to look at lab first. Further plans when lab back.
2.	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.
3.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
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 <a href="http://www.alabamaquitnow.com">www.alabamaquitnow.com</a> or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, <a href="http://www.lung.org/stop-smoking">www.lung.org/stop-smoking</a> , or 800-586-4872.

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
Provider  
Comm.

Meds



Procedures

Patient  
Plan

Visit Document

Document Library



EM Coding



Dictation

TX Text

Segoe UI 10 B I U

## PATIENT PLAN FOR 03/24/2014

Name: BooBoo Quagmire

Date of Birth: 01/04/1962

Date of Visit: 03/24/2014

Visit Type: Office Visit

Location: USA FAMILY MEDICINE

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

REASON(S) FOR VISIT

chronic kidney disease, s

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Chronic kidney disease, Stage II (moderate) (585.3)
	Patient Plan	Discuss importance of blood glucose and blood pressure control. Follow-up if blood pressure is not controlled. Get lab work today: CMP, P, C
2.	Assessment	Unspecified essential hypertension (401.9)
	Patient Plan	Continue with current treatment. Inspect feet daily, as well as wounds at any other location. Follow-up if wounds do not appear to be

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

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. Also, you actually have 3 business days to generate this, so patients could just be informed that it will be available then.

Reason for Visit

Review of Systems

Vital Signs

Physical Exam

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	Chronic kidney disease, Stage III (moderate) (585.3).
	Patient Plan	Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.
	Provider Plan	May increase lisinopril later, but I want to look at lab first. Further plans when lab back.
2.	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.
3.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00).
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 <a href="http://www.alabamaquitnow.com">www.alabamaquitnow.com</a> or 800-784-8669. A wealth of information & assistance is also available at the American Lung Association, <a href="http://www.lung.org/stop-smoking">www.lung.org/stop-smoking</a> , 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

TX Text

Segoe UI

10

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U

PATIENT: BooBoo Quagmire  
DATE OF BIRTH: 01/04/1962  
DATE: 03/23/2014 04:27 PM  
VISIT TYPE: Office Visit

This 52 year old female presents for chronic kidney disease and swelling.

#### History of Present Illness:

1. chronic kidney disease

The patient presents with chronic kidney disease. The initial visit date was 03/23/2014. The patient reports the severity is moderate.

The condition is stable, initial symptoms include hypertension and swelling of foot/ankle. Secondary symptoms include proteinuria, hematuria, and polyuria. Referred to nephrologist after moving to area. Family Medicine's recent notes reviewed, along w/ some records from nephrologist in Pensacola, showing GFR of 40, Cr. 3.7. Also has Diabetes, HbA1c not optimally controlled. Well controlled w/ insulin.

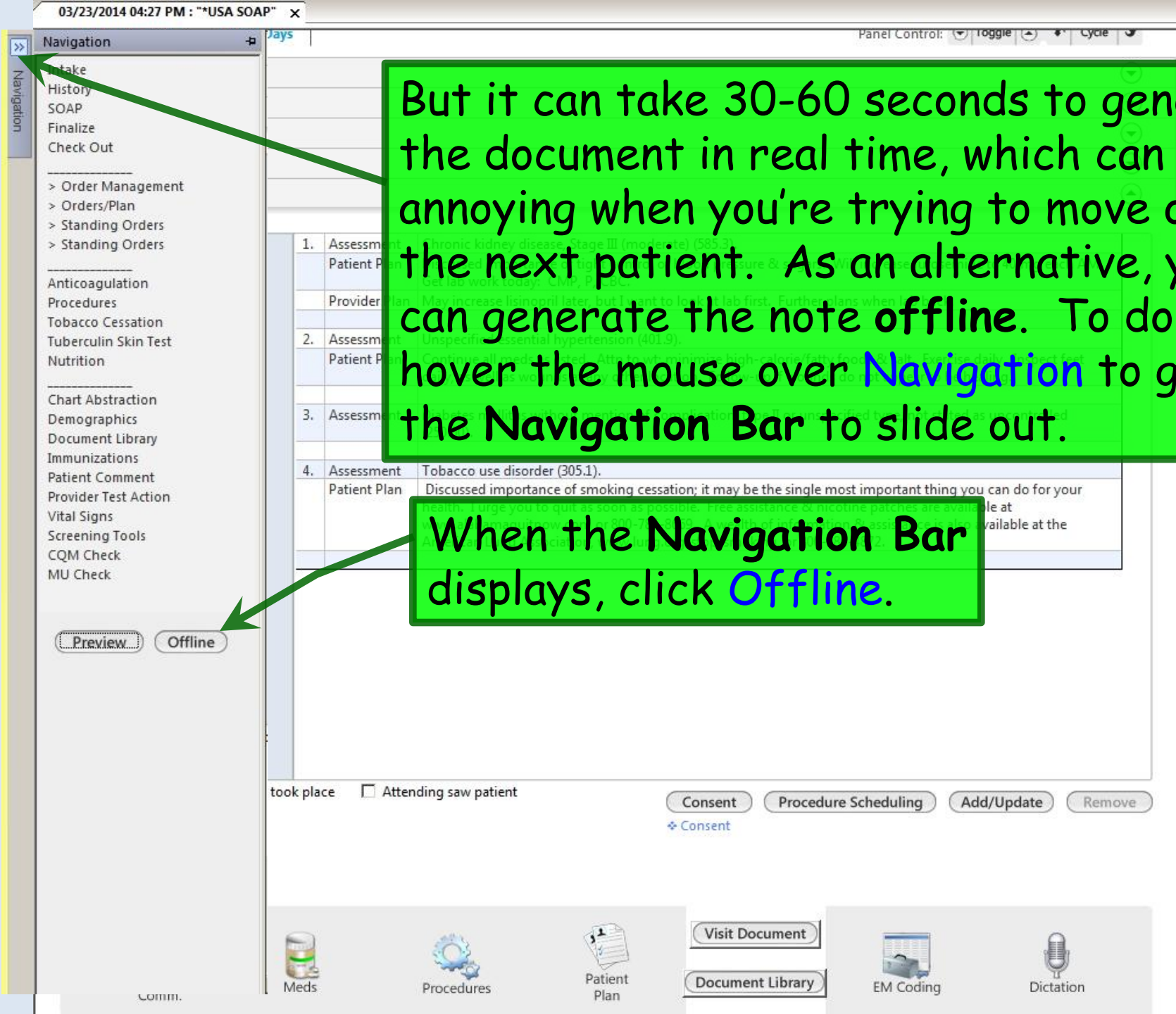
2. swelling

Worsening swelling of feet/ankles, this swelling is worse in the morning. Intake of salt and fluid restricted. On diuretics. Just moved to town. Saw FM last month & got started on diuretics. Swelling have been swelling worse in last 3-4 wks.

#### PROBLEM LIST:

Problem Description	Onset Date	Chronic	Notes
Tobacco abuse		Y	
Open cleft glaucoma		Y	Seeing Dr. Jones. <u>Well-controlled w/ drops.</u>

Your visit note displays. You can review & edit it if desired. You can also click the **Check Mark** to sign it off; this is the same as signing the document in your PAQ.



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**.

Reason for Visit

Review of Systems

Vital Signs

Physical Exam

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

1.	Assessment	Chronic kidney disease, Stage III (moderate) (585.3).
	Patient Plan	Discussed importance of tight control of blood pressure & sugars. Will increase furosemide to 40 mg each AM. Get lab work today: CMP, P, CBC.
	Provider Plan	May increase lisinopril later, but I want to look at lab first. Further plans when lab back.
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	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.
3.	Assessment	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (250.00)

Now move to the **Finalize Tab**. You can do this by navigating back to the top & clicking the **Finalize Tab**, but if you're at the bottom of the **SOAP Tab**, there is a shortcut to get there directly. Click **EM Coding**.

 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



Specialty Nephrology

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

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:

- 99201 99202 99203 99204 99205

Established:

- 99211 99212 99213 99214 99215

Consultation:

- 99241 99242 99243 99244 99245

Preventive new:

- 99381 99382 99383 99384 99385 99386 99387

Preventive established:

- 99391 99392 99393 99394 99395 99396 99397

Preventive counseling:

- 99401 99402 99403 99404

Post Op:

- 99024

Prenatal:

- 59425

Visit 4-6:

- 59426

Visits greater than 6:

- 59426

Behavioral Health:

- 90791 (Initial eval, no med services)

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

Specialty Nephrology

Visit Type Office Visit

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

PE Type: Multi system  Single system  E&M Guidelines1997: Web

Today's Assessment

Provider Sign Off

Physician Sign Off Request:

Submit to supervising physician for review

If the calculated code is acceptable to you, click **Submit 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: 99203

Modifier(s):

Calculate Code

Submit Code

CQM Check

Calculated EM code: 99203

Submitted code:

Calculated eRx code:

Submitted eRx code:

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

New patient:

- 99201
- 99202
- 99203
- 99204
- 99205

Established:

- 99211
- 99212
- 99213
- 99214
- 99215

Consultation:

- 99241
- 99242
- 99243
- 99244
- 99245

Preventive new:

- 99381
- 99382
- 99383
- 99384
- 99385
- 99386
- 99387

Preventive established:

- 99391
- 99392
- 99393
- 99394
- 99395
- 99396
- 99397

Preventive counseling:

- 99401
- 99402
- 99403
- 99404

Post Op:

- 99024

Prenatal:

- 59425

Visits greater than 6:

- 59426

Behavioral Health:

- 90791 (Initial eval, no med services)
- 90792 (Initial eval, w/ med services)

- 90846 (Family/Couple therapy, w/o patient)

Specialty ▾ Nephrology

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 (3)
  - Patient Education
  - Physical Therapy

Requisition

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 Nephrology Visit demonstration.

Ham and eggs. A day's work for a chicken,  
a lifetime commitment for a pig.