

NEXTGEN WORKFLOW DEMONSTRATION

Well Child Visit

This demonstration works through a sample well child visit, introducing the new user to the general workflow.

This has been prepared for EHR 5.8 & KBM 8.3, though some older templates may appear when they do not adversely affect the presentation. Subsequent updates may display cosmetic & functional changes.

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

Work Flow [Duffy, Robert L]

Appointments 02/20/2013 Duffy

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

Tasks All Tasks Refills Test Results Questions

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

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

Patient Portal

- Communications
 - Inbox
 - Outbox
 - Drafts
 - Archived
- Prescriptions
 - Inbox
 - Outbox
 - Archived
- Appointments
 - Inbox
 - Outbox
 - Archived
- Online Forms
 - Inbox

Offline

Compose Remove + To Do + To Chart Chart

Always begin by performing the 4-Point check.

Patient

Location

Provider

Date

Specialty ▼ select a specialty

Visit Type ▼ select a visit type

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*.

The screenshot shows a medical chart for Wyman Quagmire (M) with MRN 000000007774 and DOB 01/12/2012. The chart is open to the Intake Tab for a visit on 03/20/2014 at 05:33 PM. The interface includes a menu bar (File, Edit, Default, View, Tools, Admin, Utilities, Window, Help), a toolbar with icons for Logout, Save, Clear, Delete, Patient, History, Inbox, PAR, Medications, Templates, Documents, Images, Orders, Problems, Apps, and Close. The patient information section displays the patient's name, DOB, address (8 Trail Mix Trail, Mobile, AL 36604), MRN, insurance (MEDICAID OF ALABAMA), and provider (DUFFY, ROBERT LAMAR MD). The chart area shows a list of visits with columns for Specialty and Visit Type, both of which have red text indicating they need to be selected. The Patient History panel on the right shows a list of visits, including the current one. The bottom status bar displays 'Ready' and various system information.

Click in the **Specialty** box & pick **Pediatrics**.

Then click in the **Visit type** box & pick from the list; select **Well Child**.

The screenshot displays a medical software interface for a patient named Robert Lamar Duffy. The patient's information includes their address (8 Trail Mountain Trail, Mobile, AL 36604), MRN (00000007774), and insurance (MEDICAID OF ALABAMA). The interface shows a visit on 03/20/2014 at 05:33 PM. Two windows are open: 'Ngkbn Get Dbpicklist Items' and 'Ngkbn Udp Visit Types'. The 'Ngkbn Get Dbpicklist Items' window shows a list of medical specialties, with 'Pediatrics' selected. The 'Ngkbn Udp Visit Types' window shows a list of visit types, with 'Well child' selected. A green box on the right contains a note for family medicine users.

Note to Family Medicine users:
You can now do a **Well Child** from the **Family Practice** specialty.

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail MRN: 000000007774 Emergency Relation: PCP:
Mobile, AL 36004 Insurance: **MEDICAID OF ALABAMA** Emergency Phone: Referring:
Contact: NextMD: **No** Pharmacy 1: Rendering: **DUFFY, ROBERT LAMAR ...**

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

03/20/2014 05:33 PM : "*USA Intake" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake | Histories | SOAP | Finalize | Checkout

Birth History | 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:

You can select a **Historian** from the picklist that appears if you click in that box. Here we'll pick **mother**.

The screenshot displays a patient record for Wyman Quagmire (M), DOB: 01/12/2012 (26 months 8 days). The patient's address is 8 Trail Mix Trail, Mobile, AL 36604. The MRN is 000000007774, and the insurance is MEDICAID OF ALABAMA. The emergency relation is unknown, and the emergency phone number is not provided. The referring provider is DUFFY, ROBERT LAMAR ...

The interface includes a navigation bar with options like Patient, Clinic Data, Order Admin..., Sticky Note, Referring Provider, HIPAA, Advance Directives, and Screening Summary. The patient's visit type is Well child, and the global days are TOB, HTN, DM, and CAD.

A picklist titled "Relationship of historian:" is open, showing a list of relationships. The "mother" option is highlighted with a green arrow. The "Patient" option in the navigation bar is also highlighted with a green arrow, indicating that clicking it opens the Patient_demographics template.

Other options in the picklist include: aunt, brother, daughter, daughter-in-law, father, father-in-law, foster child, foster parent, friend, granddaughter, grandfather, grandmother, grandson, mother-in-law, neighbor, nephew, niece, self, significant other, sister, son, son-in-law, spouse, step daughter, step parent, step son, and uncle.

Also note the **PCP**. To add this, click **Patient**, which opens the **Patient_demographics** template.

Since Dr. McFaden is no longer with us, we'll change the PCP by clicking in the **PCP** field.

Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Emergency Relation:

PCP:

Emergency Phone:

Referring:

Pharmacy 1:

Rendering: **DUFFY, ROBERT LAMAR ...**

Note Referring Provider HIPAA Advance Directives Screening Summary

Patient Information

First name: Wyman

Middle name:

Last name: Quagmir

Previous last name:

Nickname:

Country of birth:

Race: Black or /

Panel Control: Toggle Cycle

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

date: 01/12/2012

Sex: M

Language: English

Ethnicity: Not Hispanic or Latino

Status: single

Name:

Religion:

Type:

Contact Information

Address History

PCP/Insurance/Pharmacy

PCP:

First visit: / /

Last visit: / /

Referred by:

Insurance:

MEDICAID OF ALABAMA

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

Wyman Quagmire (M)

DOB: 01/12/2012 (26 months 8 days)

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

Diagnoses: (1) Medications: (0)



Address: 8 Trail Mix Trail
Mobile, AL 36604

MRN: 00000007774
Insurance: **MEDICAID OF ALABAMA**
NextMD: **No**

Emergency Relation:
Emergency Phone:
Pharmacy 1:

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

Alerts

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

03/20/2014 05:33 PM : **USA Intake Patient Demographics

Panel Control: Toggle Cycle

Patient Information

Social Security Number

First name:

Middle name:

Last name: Suffix:

Previous last name:

Nickname:

Country of birth:

Race:

Birth date: Sex:

Preferred language:

Ethnicity:

Marital status:

Spouse name:

Religion:

Blood type:

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

First visit: Last visit: Next visit:

Referred by:

Insurance:

You can select a **Historian** from the picklist that appears if you click in that box. Here we'll pick **mother**.

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 3 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail MRN: 000000007774 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Mobile, AL 36604 Insurance: MEDICAID OF ALABAMA Emergency Phone: Referring: Rendering: DUFFY, ROBERT LAMAR ...
Contact: NextMD: No Pharmacy 1:

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

Relationship of historian: [X] A Intake" [X]

Navigation

Visit Type ▼ Well child

TOB HTN DM CAD

Histories SOAP Finalize Checkout

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

Panel Days

Panel Control: [Toggle] [Cycle]

new patient | Historian: []

Chief Complaint | History of Present Illness

Intake Comments

Close

- 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

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail Mobile, AL 36604 MRN: 000000007774 Insurance: **MEDICAID OF ALABAMA** NextMD: **No** Emergency Relation: Emergency Phone: Pharmacy 1: PCP: **DUFFY, ROBERT LAMAR ...** Referring: Rendering: **DUFFY, ROBERT LAMAR ...**

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

03/20/2014 05:33 PM : "*USA Intake" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines Global Days

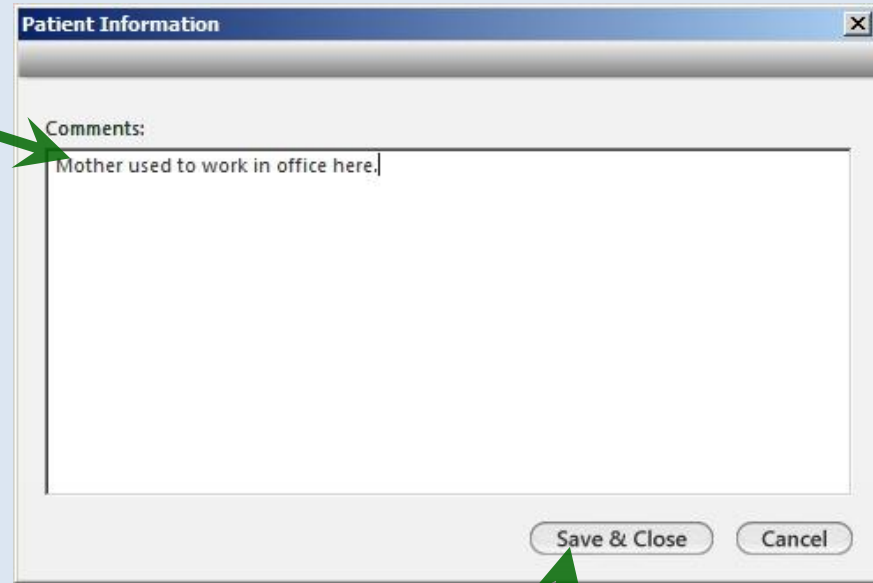
Panel Control: Toggle Cycle

General

Established patient New patient | Historian: []

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

Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We've entered here that the mother used to work here.



The screenshot shows a window titled "Patient Information" with a close button (X) in the top right corner. Below the title bar is a "Comments:" label followed by a text input area containing the text "Mother used to work in office here.". At the bottom right of the window are two buttons: "Save & Close" and "Cancel". A green arrow points from the text box on the left to the text input area, and another green arrow points from the text box on the right to the "Save & Close" button.

When done click **Save & Close**.

Other times a sticky note would be a temporary notice, like **At next visit confirm 15 mo Prevnar was given—don't see it listed. Duffy 3/20/14.** It's good to put your name & date on such things; otherwise, you may not know if they're still pertinent when you see them in the future. And you should delete such sticky notes when they're no longer meaningful.

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail MRN: 000000007774 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Mobile, AL 36604 Insurance: **MEDICAID OF ALABAMA** Emergency Phone: Referring: Rendering: DUFFY, ROBERT LAMAR ...
Contact: NextMD: **No** Pharmacy 1:

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

03/20/2014 05:33 PM : "*USA Intake" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines Global Days Panel Control: Toggle Cycle

General

Established patient

Reason for Visit

Do not launch HPI Intake Comments

rash Chief Complaint History of Present Illness
URI
fever

Now click Alerts.

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

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

Additional comments can be typed as well.

• Suicide/Homicide Risk ⓘ

Date	Instrument	Severity	Completed By

Additional comments:

Cardiology Alerts

Alert	Start Date	StopDate	#

OPH Alerts: Note:

Alert	Note

This gives you the opportunity to indicate several noteworthy alerts about the patient. For demonstration purposes we'll click Deaf.

Click Save & Close when you're done.

The Alerts button turns red when there is an entry.

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail MRN: 000000007774 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Mobile, AL 36604 Insurance: MEDICAID OF ALABAMA Emergency Phone: Referring:
Contact: NextMD: No Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

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

03/20/2014 05:33 PM : "*USA Intake" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail MRN: 000000007774 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Mobile, AL 36604 Insurance: MEDICAID OF ALABAMA Emergency Phone: Referring:
Contact: NextMD: No Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

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

03/20/2014 05:33 PM : "*USA Intake" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

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

NextGen EHR: Wyman Quagmire MRN: 000000007774 DOB: 01/12/2012 (Male) AGE: 26 months 8 days - 03/20/2014 05:33 PM : ""USA Intake"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Deletes USA CHILDRENS MEDICA DUFFY, ROBERT LAMAR MD Patient History Inbox P&R Medications Templates Documents Images Orders Problems Apps Close

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: Unknown Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail Mobile, AL 36604 MRN: 000000007774 Insurance: MEDICAID OF ALABAMA Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...

Contact: Emergency Phone: Referring: DUFFY, ROBERT LAMAR ...

NextMD: No Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

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

Navigation

Intake
History
SOAP
Finalize
Check Out

Order Management
Orders/Plan
Standing Orders

Anticoagulation
Procedures
Tobacco Cessation
Tuberculin Skin Test
Nutrition

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

Visit Type Well child

TOB HTN DM CAD

Histories SOAP Finalize Checkout

ing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

ays

Panel Control: Toggle Cycle

Patient | Historian:

Patient History

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

New Lock Search

03/20/2014 05:33 PM DUFFY, R

*USA Intake

Ready

NGDev1 USA Health Services Foundation rlduffy CAP NUM SCRL 03/20/2014

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

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: **Unknown** Problems: (0) Diagnoses: (1) Medications: (0)

Address: 8 Trail Mix Trail
Mobile, AL 36604

MRN: 000000007774
Insurance: MEDICAID OF ALABAMA
NextMD: No

Emergency Relation:
Emergency Phone:
Pharmacy 1:

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

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

03/20/2014 05:33 PM : "*USA Intake" x

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](#).

Established patient New patient Historian:

Reason for Visit ▲

- Do not launch HPI
- rash
 - URI
 - fever
 - ear pain
 - ADD/ADHD
 - cough
 - asthma
 - congestion
 - injury
 - abdominal pain
 - pediatric subspecialties
- Additional / Manage

Chief Complaint

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

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Allergies: Unknown Problems: (0) Diagnoses: (1) Medications: (0)

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

03/20/2014 05:33 PM : "*USA Intake" x

Specialty: Pediatrics Visit Type: Well child

Intake Histories SOAP Finalize Checkout

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

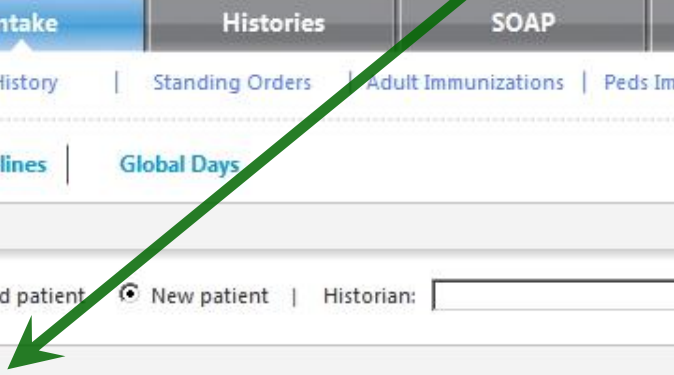
Add Edit Remove

Reason for Visit

Do not launch HPI

rash URI fever

Intake Comments



To enter Vital Signs, click Add.

Height/length measurements:

Enter Vital Signs. (Details are reviewed in a separate exercise.)

Growth percentile: [Growth Chart](#)

Unobtainable:

Waist:
Height: Weight: Hip Ratio:

Patient Refused:

BSA calculation: [BSA Plan](#)
 kg/m²

[Audiometry Exam](#)

[Vision Screening](#)

[Orthostatic Vital Signs](#)

BSA: m² [Calculate](#)

Head/Waist/Hip/ circumference:

Data used in this example:

Ht 35 inches, measured today.
Wt 30.4 lbs, dressed with shoes.
T 98.9, ear.
BP 100/60 sitting, right arm, sitting.
HR 88.
Resp 16.

LMP date:

- Premenopausal
- Perimenopausal
- Postmenopausal

Pain scale:

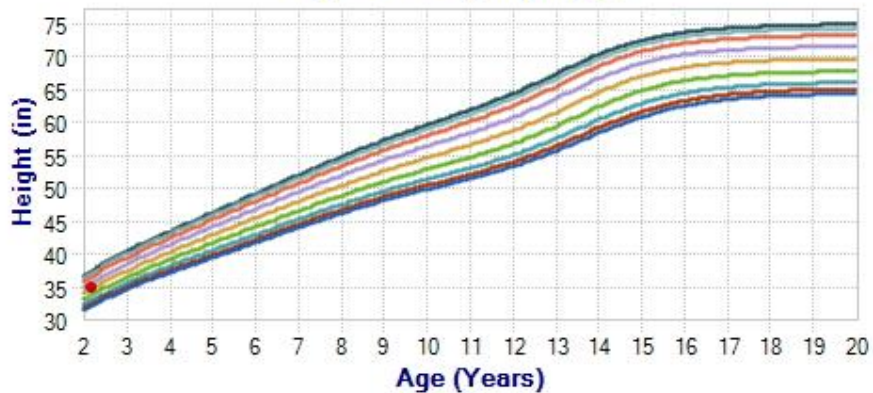
Pain score: [i](#) Method:

Measured date: Time:
06/15/2014 7:34 PM

Measured by:
 Robert L. Duffy

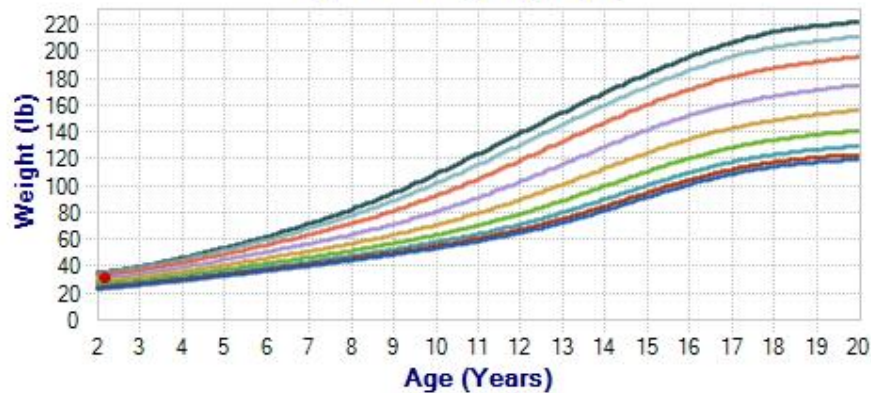
Click Save, then Growth Charts to display growth charts.

Age vs. Height (Boys)



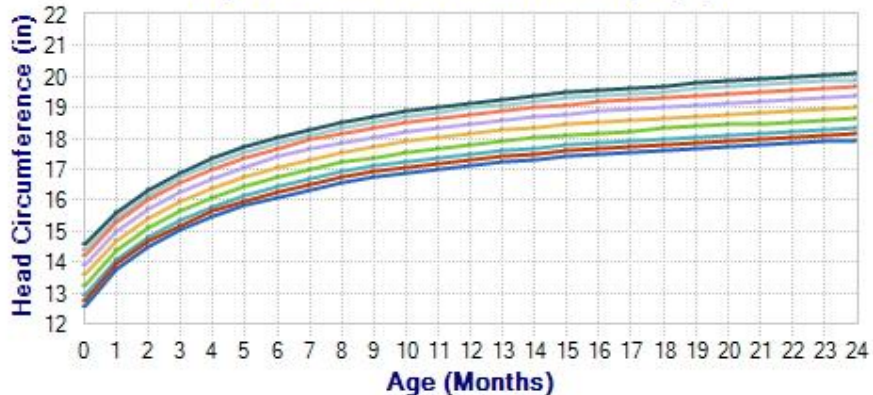
- Patient
- 3%
- 5%
- 10%
- 25%
- 50%
- 75%
- 90%
- 95%
- 97%

Age vs. Weight (Boys)



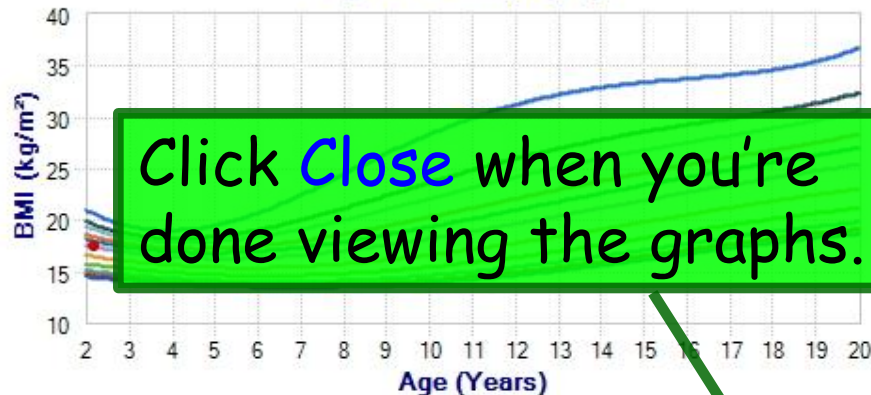
- Patient
- 3%
- 5%
- 10%
- 25%
- 50%
- 75%
- 90%
- 95%
- 97%

Age vs. Head Circumference (Boys)



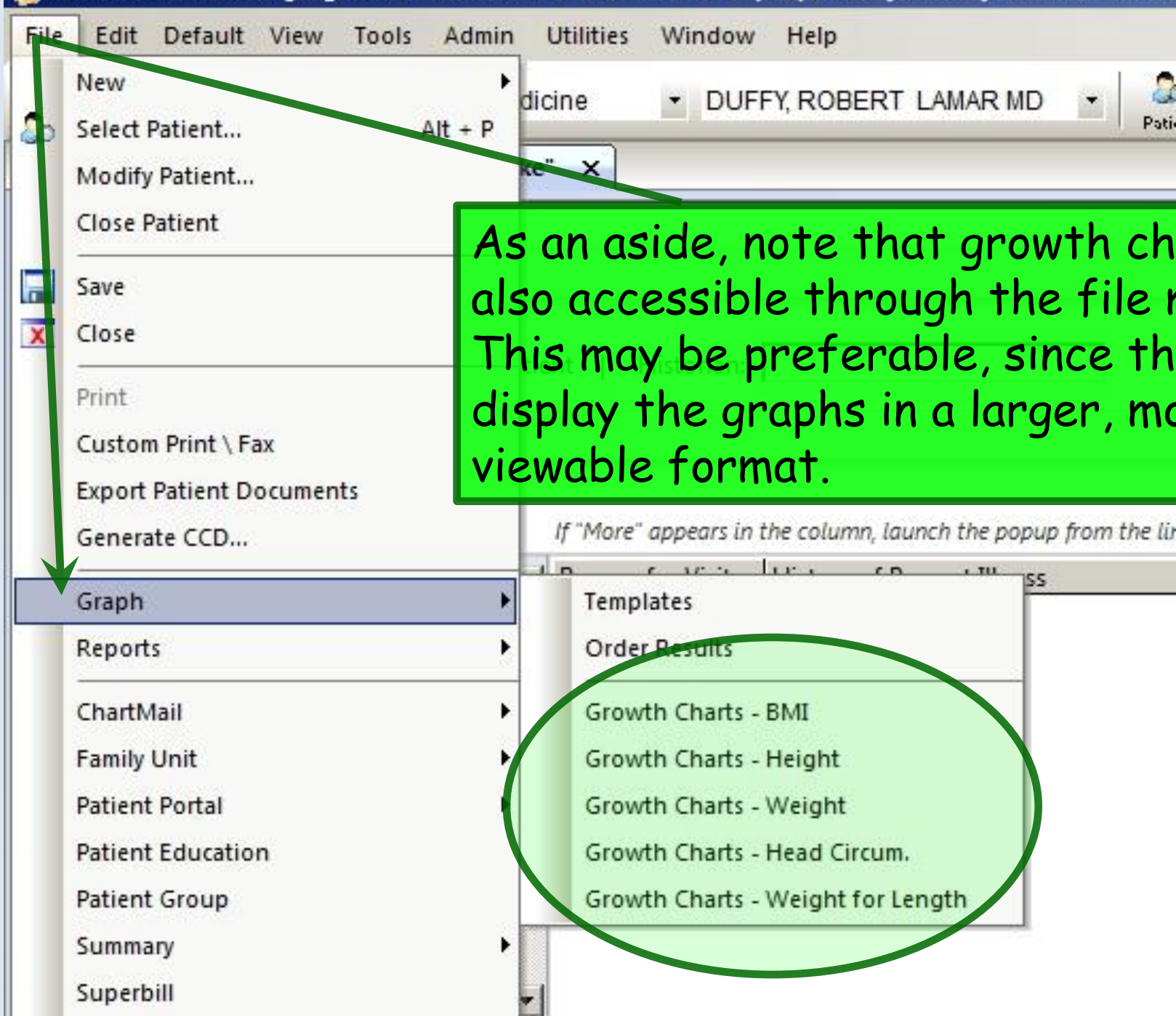
- 3%
- 5%
- 10%
- 25%
- 50%
- 75%
- 90%
- 95%
- 97%

Age vs. BMI (Boys)



Click **Close** when you're done viewing the graphs.

Close



As an aside, note that growth charts are also accessible through the file menu. This may be preferable, since this will display the graphs in a larger, more easily viewable format.

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

Head/Waist/Hip/ circumference:

Head: in cm Waist: in cm Hip: in cm

Temperature:

F C Site:

Blood pressure and pulse:

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

Respiration and

Respiration: /min Pulse Ox: %
Pulse Ox: Room Amb Resu
Pulse Ox measured: Pre-treatment Post-treatment

Pain scale:

Pain score: Method:

Comments:

Growth percentile: [Growth Chart](#)

Waist
Height: Weight: Hip Ratio:

BMI/BSA calculation:

BMI: kg/m² [BMI Plan](#)
BSA: m²

Unobtainable:
 Patient Refused:

[Audiometry Exam](#)
[Vision Screening](#)
[Orthostatic vital Signs](#)

When age-appropriate, the nurse would also perform **Audiometry & Vision Screening** through these links.

LMP date:
 Premenopausal
 Perimenopausal
 Postmenopausal

Measured date: Time:

Measured by:

Tone Audiometry - PE

Reason for Test: Quick Note: Apply Save

Hearing loss Screening

Frequency:

500 hz:	1 khz:	2 khz:	3 khz:	4 khz:	<input type="radio"/> Pass <input type="radio"/> Fail
Right:					
Left:					<input type="radio"/> Pass <input type="radio"/> Fail

Comments:

Submit audiometry test to Superbill

Procedure: Code:

Assessment: Code: Status:

Save & Close

Enter results in whatever manner your machine gives them to you.

If you don't plan to bill for the hearing test, clear this checkbox.

Tone Audiometry - PE

Reason for Test: Quick Note: Apply Save

Hearing loss Screening

Frequency:

500 hz:	1 khz:	2 khz:	3 khz:	4 khz:	<input type="radio"/> Pass <input type="radio"/> Fail
Right:	25 dB	25 dB	25 dB	25 dB	
Left:	25 dB	25 dB	25 dB	25 dB	<input type="radio"/> Pass <input type="radio"/> Fail

Comments:

Submit audiometry test to Superbill

Save & Close Cancel

But if you do want to submit to superbill, you'll need to pick a reason for the test.

Reason for Test:

 Hearing loss
 Screening

Frequency:

	500 hz:	1 khz:	2 khz:	3 khz:	4 khz:
Right:	25 dB	25 dB	25 dB		25 dB
Left:	25 dB	25 dB	25 dB		25 dB

Comments:

 Submit audiometry test to Superbill

Quick Notes: Apply

A search list with some likely choices appears. For hearing loss, you'll see some likely options.

 Enter search term

Search

All Diagnoses
 Patient's Diagnoses
 Patient's Chronic Diagnoses
 Favorites
 My List - Importe
 Favorite 2
 Categories

Clinical Description and ICD Code	Billing Description
Unspecified hearing loss 389.9	Unspecified hearing los
Unspecified hearing loss, bilateral H91.93	Unspecified hearing los
Unspecified hearing loss, left ear H91.92	Unspecified hearing los
Unspecified hearing loss, right ear H91.91	Unspecified hearing los
Other examination of ears and hearing V72.19	EXAM EARS & HEARING
Encounter for examination of ears and hearing with other abnormal findings Z01.118	Encntr for exam of ears
Encounter for routine child health examination without abnormal findings Z00.129	Encntr for routine child
Encounter for health supervision and care of founding Z76.1	Encounter for health su
Encounter for examination of ears and hearing without abnormal findings Z01.10	Encounter for exam of e
Encounter for hearing conservation and treatment V72.12	HEARING CONSERVATN,
Encounter for hearing conservation and treatment Z01.12	Encounter for hearing c
Encounter for hearing examination following failed hearing screening Z01.110	Encounter for hearing e
Encounter for hearing examination following failed hearing screening V72.11	HEARING EXAM-FAIL SCI

15 rows returned

Select

Cancel

For screening you probably want to pick routine child health examination or Other examination of ears and hearing.

Unfortunately, you may get nagged about diagnosis & superbill submission even if you don't want to charge for the test & you clear the checkboxes. Sigh....

Data entry, diagnosis, & superbill considerations are analogous on the **Vision Screening** popup.

Vision Screening - PE [X]

Quick Note:

Visual Acuity:

	Corrected:	Uncorrected:
OD:	20/20	
OS:	20/25	
OU:	20/20	

Unobtainable:

Vectograph: Pass Fail Unobtainable

Corrective lenses: No Yes

Comments: [Ishihara Test for Color Blindness](#)

Submit vision screening to Superbill

Procedure: Code:

Assessment: Code: Status:

Note there is a link to display a color vision screen.

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

Head/Waist/Hip/ circumference:

Growth percentile: [Growth Chart](#)

Height: Weight: Hip Ratio:

BMI/BSA calculation: [BMI Plan](#)

BMI: kg/m² BSA: m²

Unobtainable:
 Patient Refused:

[Audiometry Exam](#)
[Vision Screening](#)

Note about failed hearing & vision screens: With all of the red vital sign alerts popping up everywhere, it is intuitive to believe that you'll get an alert if the hearing or vision tests are abnormal. *That is, unfortunately, not the case.* Nurses need to include this fact in the Intake Comments or verbally communicate it to the provider to help keep this from being overlooked.

Providers, note that the hearing & vision results are posted to your physical exam, so you'll get a chance to notice it there—just later than you might be expecting.

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

Head/Waist/Hip/ circumference:

Head: in cm Waist: in cm Hip: in cm

Temperature:

F C Site:

Blood pressure and pulse:

Systolic: Diastolic:

/ mm/Hg

Pulse: Pulse pattern: Regular Irregular

/min

Position:

Sitting Standing Lying

Side:

Right Left

Site:

Method:

Manual Automatic Home monitor Pediatric Adult Large Thigh

Cuff size:

Respiration and Pulse Ox:

Respiration: /min

Pulse Ox Rest:

Pulse Ox: Room air Oxygen - Method:

Pulse Ox measured: Pre-treatment Post-treatment

Pain scale:

Pain score:

Method:

Comments:

Growth percentile: [Growth Chart](#)

Height: Weight: Hip Ratio:

BMI/BSA calculation: [BMI Plan](#)

BMI: kg/m²

BSA: m²

Unobtainable:

Patient Refused:

[Audiometry Exam](#)

[Vision Screening](#)

[Orthostatic Vital Signs](#)

Note that other VS, such as head or waist circumference, can be entered when age-appropriate.

When done click [Save](#) then [Close](#).

Measured date:

Time:

Measured by:

Vital signs now display.

Care Guidelines | Global Days

Panel Control: Toggle Cycle

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	Wt%	Ht%	Pain level	Comments
7:09 PM	30.4	35.00	17.45	13.789	88.90	100/60	88	16	98.9	37.2		70	57		

Add Edit Remove

Reason for Visit

Do not launch HPI

- rash
- URI
- fever
- ear pain
- ADD/ADHD
- cough
- asthma
- congestion
- injury
- abdominal pain
- pediatric subspecialties

Chief Complaint

Now enter Chief Complaints, or Reasons for Visit. The most common complaints used in each clinic will appear on this list. In addition to the WCC, his mother asks about his stuffy nose, so click **congestion**.

Additional / Manage

Diagnostics Show All

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake

Histories

SOAP

Finalize

Checkout

Birth History

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

Reason for Visit

Do not launch HPI

[Intake Comments](#)

- rash
- URI
- fever
- ear pain
- ADD/ADHD
- cough
- asthma
- congestion**
- injury
- abdominal pain
- pediatric subspecialties

Chief Complaint
congestion

History of Present Illness

Congestion is added as a complaint

The Well Child Visit complaint is implied (& may actually display automatically), but to demonstrate adding another complaint you don't see listed, click **Additional/Manage**.

[Additional / Manage](#)

Diagnostics

Show All

Reason For Visit



Select your reasons for visit

- ear pain
- eye problems
- fatigue
- fatigue (chronic)
- fever
- flu-like symptoms
- follow up on lab test(s)
- foot ulcer
- gastroenteritis
- genital lesion
- GERD
- gout
- headache
- hearing loss (peds)
- heart disease
- heart disease (follow up)
- heartburn
- heavy periods
- hematomas
- HIV
- HIV (follow up)
- hoarseness
- hot flashes
- hyperlipidemia
- hyperlipidemia (follow up)
- hypertension
- hypertension (follow up)

Reason(s) for visit

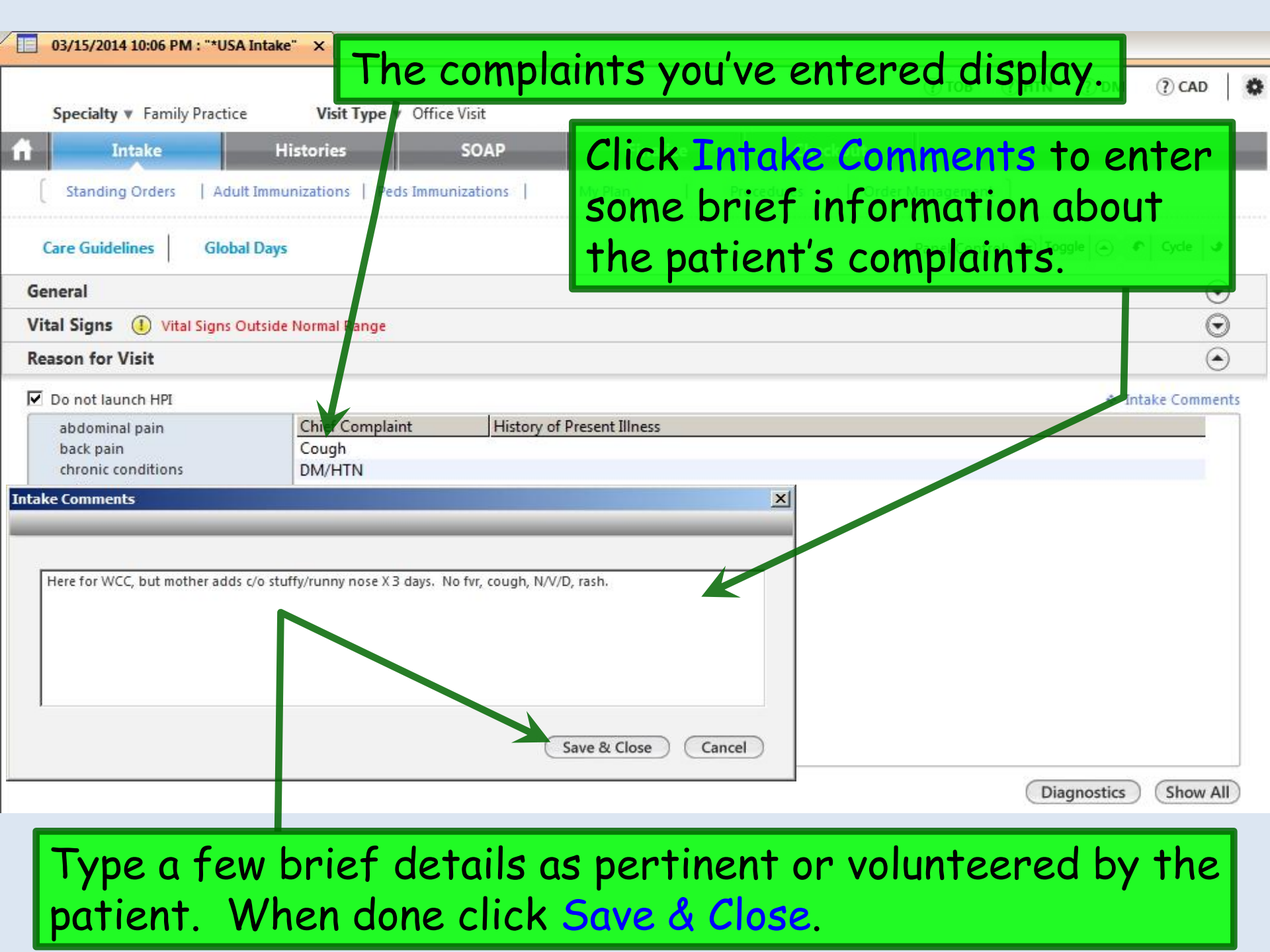
Follow up
congestion

Follow up

Follow up

Scroll through the list to look for other complaints. If you don't see what you need, just click in the next open box & type it; here we'll type **Well Child Check**.

When done click **Save & Close**.



The complaints you've entered display.

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

Intake Comments

Here for WCC, but mother adds c/o stuffy/runny nose X 3 days. No fvr, cough, N/V/D, rash.

Save & Close Cancel

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

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

03/20/2014 05:33 PM : "**USA Intake" x

Specialty ▼ Pediatrics Visit Type ▼ Well child

Intake Histories SOAP Finalize Checkout

Birth History 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: mother

Vital Signs

Reason for Visit

Medications

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

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

Add/Update **Reconcile**

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

Last Audit	Status	Medication Name	Generic Name	Start Date	Stop Date	Sig	Original Start
Status: Active (1 item)							
	Active	loratadine 5 mg/5 mL Oral Soln	LORATADINE	03/20/2014		1 tsp daily as needed for runny nose, d...	03/20/2014

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

In this example, our patient is taking:

Loratadine 5 mg/5 mL, 1 tsp daily as needed for runny nose, drainage.

Add this medication, then close the Med Module to return to the Intake Tab.

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

Click the **Medications reconciled** checkbox.

[Care Guidelines](#)[Global Days](#)

General

Vital Signs

Reason for Visit

Medications

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

Medication

Sig Description

loratadine 5 mg/5 mL Oral Soln

1 tsp daily as needed for runny nose, drainage.

Add/Update

Reconcile

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

Specialty ▾ Pediatrics

Visit Type ▾ Well child



Intake

Histories

SOAP

Finalize

Checkout

Birth History

Standing Orders

Adult Immunizations

Peds Immunizations

My Plan

Procedures

Order Management

Care Guidelines

Global Days

Panel Control: ⌵ Toggle ⌶ ↺ Cycle ↻

General

Vital Signs

Reason for Visit

Medications

Patient status: Transitioning into care Summary of care received

✦ Comment

 No medications Medications reconciled

Medication

Sig Description

loratadine 5 mg/5 mL Oral Soln

1 tsp daily as needed for runny nose, drainage.

Next, review allergies. He has no allergies, just click the **No allergies** box.

Add/Update

Reconcile

Allergies

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

Allergen

Reaction

Medication Name

Comment

If there had been any allergies, you would click the **Add** button, as reviewed in the separate Allergies demonstration.

Add

Update

Specialty ▾ Pediatrics Visit Type ▾ Well child

Home Intake Histories SOAP Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines Global Days

Panel Control: [Dropdown] Toggle [Dropdown] [Dropdown] Cycle [Dropdown]

General	[Dropdown]
Vital Signs	[Dropdown]
Reason for Visit	[Dropdown]
Medications	[Dropdown]
Allergies	[Dropdown]
Orders	[Dropdown]

The nurse might next review vaccinations, which you could do by clicking **Immunizations**.



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

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

Add Edit

03/20/2014 05:33 PM : "*USA Intake" 03/20/2014 05:33 PM : "Immunization - Pediatric" X

Pediatric Adult

Alert: Detail document Reviewed, no changes Reviewed, updated Last updated/detailed doc: //

New Order... Refresh Print Fax... Historical... Exclusions... Web Links

Show Ages Given Include Exceptions Pending Only Error Only

The **Immunization - Pediatric** template opens; it now interacts with the **Order Module** for managing vaccinations. We hope that at least some interaction with the Alabama ImmPRINT vaccination registry materializing soon. There will be other lessons demonstrating the vaccination workflow.

We'll close the **Immunization - Pediatric** template & move to the **Histories Tab**.

Specialty ▾ Pediatrics

Visit Type ▾ Well child

Home Intake **Histories** SOAP Finalize Checkout

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

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

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

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl

Notice that Birth History can be entered here. Click **Birth History**.

Refresh Add Edit

- Detailed document
- Reviewed
- History unobtainable

Last detailed doc date:
[Comments](#)

Hospital course
 Vitamin K injection: No Yes
 Hep B vaccine: No Yes
 Hearing test: Pass Fail

Antenatal
 Maternal age: EDC: Marital status: Lives with FOB: No Yes
 Gravida: Para: Ab: Living:
 Prenatal care given: No Yes
 Maternal blood type: Rh pos Rh neg
 Ultrasound results: Normal Abnorm
 Group B strep screen: Neg Pos
 Antenatal labs: No Yes
 Maternal illness/complications: No Yes
 Maternal infections: No Yes

Infant blood type: Rh pos Rh neg Coombs:
 Jaundice: No Yes Peak bilirubin level: mg/dL

Enter Birth History as known/relevant. When done, save & close the template, returning to the Histories Tab.

Medications during pregnancy:

Stayed in NICU: No Yes
 Stayed in nursery: Days: Reason:

Confidential Info.

Labor and delivery
 Type of delivery:
 SGA AGA LGA
 PROM AROM hrs
 Apgar score:
 1 min: 5 min: 10 min:

Birth defects: No Yes
 State screening done: No Yes Abnormality:
 Medication given: No Yes
 Circumcised: No Yes
 Turner's syndrome Down's syndrome

Time of birth: Hour: Mins: AM PM Meconium: No Yes
 Time of birth: Hours of labor:

Discharge
 Feeding history: Breast Bottle Both
 Formula type:
 Discharge date: Time: Hour: Mins: AM PM
 Discharge time: Discharge weight: lbs oz

Gestational age at birth: wks days Premature Resuscitation: No Yes
 Birth weight: lbs oz kgs
 Length: in cm
 Head circ: in cm

Social service referral: No Yes
 Adoption: No Yes
 Follow up phone call made: Date: Time:
[Newborn Call Template](#)

Specialty **New.** Visit Type Well child

New.

Intake **Histories** SOAP Finalize Checkout

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

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

Panel Control: Toggle Cycle

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl

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

Old.

Refresh Add Edit

Intake **Histories** Summary

Sticky Note | Referring Provider | HL

Chronic Conditions

Reviewed

Problem	Comments

Add

Specialty ▾ Pediatrics

Visit Type ▾ Well child

Home Intake **Histories** SOAP Finalize Checkout

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

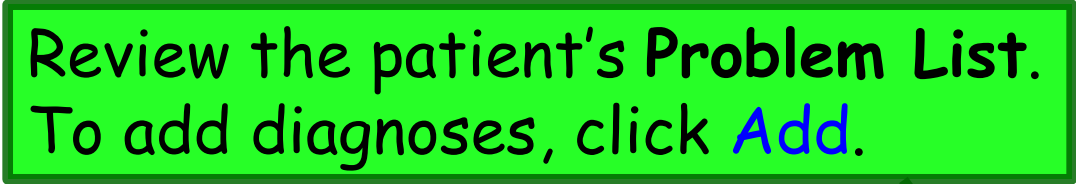
Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

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

Problem List 0

Show chronic Show my tracked problem

No active problems Reviewed

Problem Description	Side	Notes	Addl
			

Refresh Add Edit

The screenshot shows the 'Problems' module interface. At the top, there are two tabs: 'Problem List' (which is selected and highlighted with a green box) and 'Billing ICD List'. Below the tabs is a toolbar with buttons for 'Refresh', 'Preferences', and a dropdown menu for 'Show All Statuses'. There are also two checkboxes: 'Show My Tracked Problems Only' and 'Show Chronic Problems Only'. Below the toolbar, there is a section labeled '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 for 'Add Problem', 'Re-Code', 'Resolve', 'Set Chronic', 'Delete', 'Resources', 'View/Add Notes', 'View History', and 'Reconcile'. Below this toolbar are three more buttons: 'Add to Billing ICD List', 'Add to My Tracked Problems', and 'Remove from My Tracked Problems'.

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

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



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

Problems

Problem List | Billing ICD List

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

No Active Problems

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition
------------	-------------	----------------------	---------	---------------------

🔍 Allergic rhinitis Search

Description	Fully Specified Name	Concept Id
Allergic rhinitis	Allergic rhinitis	61582004
Rhinitis due to pollen allergy	Allergic rhinitis due to pollen	21719001
Allergic rhinitis due to animal dander	Allergic rhinitis due to animal dander	429195002
AR - Allergic rhinitis	Allergic rhinitis	61582004
Allergic rhinitis due to allergen	Allergic rhinitis	61582004
Allergic rhinitis due to pollen	Allergic rhinitis	925003
Allergic rhinitis due to food	Allergic rhinitis due to food	441978001
Allergic rhinitis due to grass pollens	Allergic rhinitis due to grass pollens	91926003
Allergic rhinitis due to pollen	Allergic rhinitis due to pollen	9729000
Allergic rhinitis due to pollens	Allergic rhinitis due to pollen	21719001
Allergic rhinitis due to tree pollens	Allergic rhinitis due to tree pollens	91927006
Allergic rhinitis due to weed pollens	Allergic rhinitis due to weed pollens	91928001

36 rows returned

Add to My Tracked Problems Select Cancel

A review of diagnosis search is covered in the Histories lesson. As an example, we'll add allergic rhinitis & return to the Histories Tab.

These problems now display. Note the Problems count on the Info Bar now shows 1.

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 1

Show chronic Show my tracked problem

No active problems **Reviewed**

Problem Description	Side	Notes
Allergic rhinitis		

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

Medical/Surgical/Interim

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

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

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Weight: 30.40 lb (13.79 Kg) Allergies: (1) Problems: (1) Diagnoses: (1) Medications: (1)

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

03/20/2014 05:33 PM : "USA Histories" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

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 1

Show chronic Show my tracked problem

Problem Description	Side	Notes
Allergic rhinitis		

History Review

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

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

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

Save & Close Cancel

Refresh Add Edit

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

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

[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** 1 Show chronic Show my tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl
Allergic rhinitis			

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
------------------	------	------------	------------	------	------	----------------	---------

We don't have any episodic medical illnesses to enter, so that panel has been collapsed. But our patient had an umbilical hernia repair in 2013.

Click the **Hernia repair, umbilical** checkbox.

- Specialty:
- Medical**
- Surgical**
- To add comments, click manage. Date:
- Adenoidectomy
 - Appendectomy
 - Blood transfusion
 - Dental surgery
 - Hernia repair, inguinal
 - Hernia repair, umbilical** [Manage](#)
 - Lymph node biopsy/excision
 - Tonsillectomy
 - Umbilical hernia repair
 - Other

[Add To Grid](#) [Clear](#)

Past Medical History Grid

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

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

[Save & Close](#) [Cancel](#)

The Histories lesson goes into more detail about adding items here, but for this example just click **Add To Grid**, then **Save & Close**.

Specialty ▼ Pediatrics Visit Type ▼ Well child

This history now displays.

Finalize

Checkout

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

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

 Panel Control: ▼ Toggle ▲ ↺ Cycle ↻
Problem List 1
 Show chronic Show my tracked problem

 No active problems Reviewed

Problem Description	Side	Notes	Addtl
Allergic rhinitis			

Refresh

Add

Edit

Medical/Surgical/Interim
 No relevant past medical/surgical history

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

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Umbilical hernia		01/12/2012	Hernia repair, umbilical		2013		

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

Refresh

Interim History

Add

Edit

Remove

Diagnostic Studies

Family



Specialty ▾ Pediatrics Visit Type ▾ Well child

🏠
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** 1 ⌵
- Medical/Surgical/Interim** ⌵
- Diagnostic Studies** ⌵
- Family** 🏠 ⌵

No relevant family history
 Adopted - no family history known
 [👤 Copy from Family Member](#)
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
<div style="position: relative; width: 100%; height: 100%;"> <div style="position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%); background-color: #00ff00; padding: 10px; border: 2px solid #00ff00; border-radius: 10px;"> <p style="color: #0000ff; font-size: 24px; margin: 0;">Click Add.</p> </div> </div>							

Add Edit Remove

Specialty:

No family history of:

Relationship:

Family member name:

Alive and well Deceased

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Birth defects*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Obesity	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Strabismus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>

Enter this Family History:
 His mother is alive & well.
 His father has migraines.
 His sister has asthma.
 (Family History is covered in detail in the Histories lesson.)
 When done click **OK**.

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
Father				Migraines		N	
Mother		N		Alive and well			
Sister				Asthma		N	

Specialty ▾ Pediatrics

Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

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

Care Guidelines | Global

These additions display in the grid.


Toggle ↻ ↺ Cycle ↻

Problem List 1

Medical/Surgical/Interim

Diagnostic Studies

Family

 No relevant family history Adopted - no family history known  Copy from Family MemberAll 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
Father				Migraines		N	
Mother		N		Alive and well			
Sister				Asthma		N	

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

Add

Edit

Remove

Social

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

Substances Tobacco	Encounter Date:Time
▶ Relationships Home Environment Education Nutrition Comment Diet History Environmental	

Developmental History

Confidential History

Add

- Tobacco
- Relationships
- Home Environment
- Education
- Nutrition/Elimination
- Comments
- Adult Social History

Detailed doc
 Age: 2 years 2 months
 Preferred language: English
Child Care:
 Provider:
 Mother
 Father
 Grandparent
 Sibling
 Nanny

Relationships:
 Resides with:
 Primary:
 The patient lives with:
 Time spent: []
 Secondary:
 []
 Time spent: []
 Parent/guardian relationship:
 []

Tobacco Exposure:
 Smokers at home? No Yes

The Social History popup appears. Note that there are several headings on the left, corresponding to the Social History pilltabs we just saw; we start out on the Relationships heading. We'll enter the following information:

Daycare 5 days a week.
 Lives with mother & father, who are married.
 He's the 2nd child, having 1 sibling.
 There are no smokers at home.

Maternal depression screening performed
 Maternal depression screening result discussed

Marital status: [married]

Siblings: how many? [1] Birth order: [2nd]

Relationship with sibling(s): []

Eye contact with family: No Yes

Cooperative with teachers: No Yes

Has enough friends: No Yes

Has friends of both sexes: No Yes

Concerns about relationship with family/friends/others: No Yes

- Tobacco
- Relationships
- Home Environment
- Education
- Nutrition/Elimination
- Comments
- Adult Social History

Detailed document Reviewed, updated Reviewed, no changes History unobtainable

Age: Historian: Last updated/detailed doc:

Note the **Adult Social History** link. This gives you the chance to toggle to & from the adult version of the social history—particularly useful for adolescents. You can also directly access Tobacco history for adolescents.
(The Histories lesson gives a demonstration of entering adult-type social history.)
Now move to the **Home Environment** heading.

Preferred language:

Child Care:

Provider:

Mother

Father

Grandparent

Sibling

Nanny

Relationships:

Resides with:

Primary:

Time spent:

Secondary:

Time spent:

Parent/guardian relationship / Occupation

Tobacco Exposure:

Smokers at home? No Yes

- Tobacco
- Relationships
- Home Environment
- Education
- Nutrition/Immunization
- Comments
- Adult Social History

Detailed document
 Reviewed, updated
 Reviewed, no changes
 History unobtainable

Age:
 Historian:
 Last updated/detailed doc:

Preferred language:

Hand dominance: Right Left Ambidextrous

Home Environment:

Neighborhood:

Housing Status:

Home type:

Home age:

Home affords adequate privacy: No Yes

Home affords adequate safety: No Yes

Water source: Municipal

Is water chlorinated? No Yes

Is water fluoridated? No Yes

Is there lead in home? No Yes

Safety:

Uses bike/skating helmet: No Yes

Car restraints: Car seat: face rear
 Booster
 None
 Car seat: face front
 Seat belt

Carbon monoxide detector: No Yes

Smoke detectors: No Yes

Radon in home: No Yes Untested Treated

Pool/spa at home: No Yes

Pets/animals at home: No Yes
 Type of animals:

Firearms in the home: No Yes

Enter details to the degree they're known or pertinent.

Data used in this example:

- Municipal water.
- Car seat face rear.
- Has smoke & CO detectors.
- Hedgehogs at home.

Now move to Education.

Save & Close

Cancel

- Tobacco
- Relationships
- Home Environment
- Education
- Nutrition/Elimination
- Comments
- Adult Social History

Detailed document
 Reviewed, updated
 Reviewed, no changes
 History unobtainable

Age:
 Historian:
 Last updated/detailed doc:

Preferred language:

Education:

School name:

Grade in school:

Grades earned:

Performing: Below grade level
 At grade level
 Above grade level

Likes school: No Yes True

Suspended or expelled: No Yes

Learning disability: No Yes

Special needs: No Yes

Gifted program: No Yes

College prep: No Yes

High school graduate: No Yes

Enter details to the degree they're known or pertinent.

Data used here:

Doesn't take naps.

Doesn't sleep with parents.

Sleeps through night.

Sleep:

Takes naps: No Yes

Sleeps with parents: No Yes

Sleeps through the night: No Yes

Minimum 8.5 hrs sleep nightly: No Yes

Nightmares/sleep problems: No Yes

Activity:

Hours per day:

Exercise/sports:

TV/computer games:

Internet:

Recent Travel:

Out of state

Out of country

Now move to Nutrition/Elimination.

- Tobacco
- Relationships
- Home Environment
- Education
- Nutrition/Elimination**
- Comments

Detailed document Reviewed, updated Reviewed, no changes History unobtainable

Nutrition:

No concerns Nutrition concerns: WIC referral: No Yes

Liquid:

Ozs/day: Type of liquid

Milk:

Juice:

Water:

Soda:

Drinks from:

Bottle Cup

Breast: Duration:

Elimination:

Bladder:

No concerns

Concerns:

Wet diapers/day:

Color:

Toilet trained: No Yes Day only

Problems: No Yes

Age trained: months

Bowel:

No concerns

Concerns:

BMs/day:

Color:

Consistency:

Toilet trained: No Yes

Problems: No Yes

Age trained: months

Dental Care:

No concerns

Last visit:

Concerns:

Caries: No Yes

Erosion: No Yes

Disease: No Yes

Topical fluoride applied: No Yes

By whom:

Date received:

Uses pacifier

Again enter as much detail as desired.

Data used here:
Bladder & bowel training in progress,
going well.
No dental concerns; had check
2/4/14.

Now move to **Comments**.



- Tobacco
- Relationships
- Home Environment
- Education
- Nutrition/Elimination
- Comments
- Adult Social History

Comments:

You can enter further comments here that didn't fit well under the other headings.

This gives you a good place to free-type other social history notes.

Save & Close Cancel

When done click **Save & Close**.

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake **Histories** SOAP Finalize Checkout

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

You can click on the left-side headings to display many of the details in the grid (though you may have to open the popup to view everything).

- Problem List 1
- Medical/Surgical/Inte
- Diagnostic Studies
- Family
- Social

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

Substances	Encounter Date:Time	03/20/2014 05:33 PM
Tobacco	Primary residence	The patient lives with mother and father.
► Relationships	Parent status	married
Home Environment	Number siblings	1
Education	Child Care Provider	0
Nutrition	Days/week	0
Comment	Child Care Provider	0
Diet History	Days/week	0
Environmental	Child Care Provider	0
	Days/week	0
	Child Care Provider	0

Developmental History Confidential History Add

Note there's also a link to **Developmental History** here. Some clinics may have the nursing staff enter all or part of this, while providers also have an opportunity to review or update this on the **SOAP Tab**. We'll go ahead & demonstrate entry here.

Click **Developmental History**.

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

Substances	Encounter Date:Time	03/20/2014 05:33 PM
Tobacco	Primary residence	The patient lives with mother and father.
► Relationships	Parent status	married
Home Environment	Number siblings	1
Education	Child Care Provider	0
Nutrition	Days/week	0
Comment	Child Care Provider	0
Diet History	Days/week	0
Environmental	Child Care Provider	0
	Days/week	0
	Child Care Provider	0
	Days/week	0
	Child Care Provider	0
	Days/week	0

Developmental History

Confidential History

Add

Child Development Record

Child Development History

Patient: Ipitania Quagmire

Age: 3 Years 5 Months

Document: C Age Appropriate

Development Milestones:

1 Month

Pass- 0

Fail- 0

[Details](#)

6 Months

Pass- 0

Fail- 0

[Details](#)

15 Months

Pass- 0

Fail- 0

[Details](#)

18 Months

Pass- 0

Fail- 0

[Details](#)

2 Years

Pass- 0

Fail- 0

[Details](#)

Other screenings (results in grid below)

Reviewed

[Add New](#)

[Print](#)

3 Years

Pass- 13

Fail- 0

[Details](#)

4 Years

Pass- 0

Fail- 0

[Details](#)

5 Years

Pass- 0

Fail- 0

[Details](#)

Screening Tool Results

Date Of Test	Screening Name	Results	Score	Scanner	Rep

If we've been seeing this child since birth, all of the developmental screens through the last visit will display. For this example click [Details](#) under 2 Years.

Note that the results of other developmental screens can also be entered.

Inquire about each milestone & click the appropriate Pass/Fail box, adding comments as necessary. When done, click *Save & Close*.

Peds Child Development 2 Years

2 Years

Pass All

	Pass:	Fail:	Comments:
2 word sentences	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Acts worried if you are sad	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Follows 2 part verbal command	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Gets along with family	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Helps dress self	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Holds cup in one hand	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Jumps w/both feet	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Kicks a ball	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Removes clothes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Runs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Scribbles	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Throws overhand	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Walks stairs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Summary:
Pass- 13
Fail- 0

If you select the **Child Development History** tab, you can review a history of all previous screens.

03/20/2014 05:33 PM : "USA Histories" | 03/20/2014 05:33 PM : "Child Dev. Hx" X

Child Development Record | **Child Development History**

Patient: Wyman Quagmire Age: 2 Years 2 Months Document

Select Filtering Properties for Milestones: Detailed History

Age Group: Final Status: Start Status: Category:

Age Group	Age At Test	Milestone	Date Of Test	Final Status	Start Status	Category	Comment
2 Years	21 Months 2 Weeks	Scribbles	04/17/2013	pass		fine_motor	
2 Years	21 Months 2 Weeks	Jumps w/both feet	04/17/2013	pass		gross_motor	
2 Years	21 Months 2 Weeks	Runs	04/17/2013	pass		gross_motor	
2 Years	21 Months 2 Weeks	Kicks a ball	04/17/2013	pass		gross_motor	
2 Years	21 Months 2 Weeks	Throws overhand	04/17/2013	pass		gross_motor	
2 Years	21 Months 2 Weeks	Walks stairs	04/17/2013	pass		gross_motor	
2 Years	21 Months 2 Weeks	Holds cup in one hand	04/17/2013	pass		gross_motor	
2 Years	21 Months 2 Weeks	Follows 2 part verbal command	04/17/2013	pass		language	
2 Years	21 Months 2 Weeks	2 word sentences	04/17/2013	pass		language	

Developmental Screenings:

Date Of Test	Screening Name	Results	Score	Scanned Report	Comments

When done close the **Developmental templates** & return to the **Histories Tab**.

Specialty ▾ Pediatrics


Visit Type ▾ Well child

[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:

- Problem List** 1
- Medical/Surgical/Interim**
- Diagnostic Studies**
- Family** 
- Social**

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

Substances	Encounter Date:Time	03/20/2014 05:33 PM
Tobacco	Primary residence	The patient lives with mother and father.
▶ Relationships	Parent status	married
Home Environment	Number siblings	1
Education	Child Care Provider	0
Nutrition	Days/week	0
Comment	Child Care Provider	0
Diet History	Days/week	0
Environmental	Child Care Provider	0
	Days/week	0
	Child Care Provider	0

To generate a summary of the medical history & any notes entered by the nurse today, click **Intake Note**.

TX Text

Arial 12 B I U [List Bullets] [List Numbered] [List Discs] [List Squares] [List Triangles] 100%

PATIENT: Wyman Quagmire
 DATE OF BIRTH: 01/12/2012
 DATE: 03/20/2014 5:33 PM
 HISTORIAN: mother
 VISIT TYPE: Well child

The Intake Note is created. Now close this & go back to the Histories Tab.

This 2 year 2 month old male presents with well child check.

History of Present Illness

1. congestion
2. Well Child Check

Problem List:

Problem Description	Onset Date	Chronic	Notes
Allergic rhinitis		Y	

Family History


Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death
Father				Migraines		N
Mother		N		Alive and well		
Sister				Asthma		N

SOCIAL HISTORY

Preferred language is English.
 MARITAL STATUS/FAMILY/SOCIAL SUPPORT
 Currently single.
 HOME ENVIRONMENT/SAFETY
 Carbon monoxide detector at home.
 Uses car seat: face rear

Specialty ▾ Pediatrics

Visit Type ▾ Well child

? TOB ? HTN DM ? CAD 



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 1

Medical/Surgical/Interim

Diagnostic Studies

Family

Social

History Review

Substances
Toxicology
Relationships
Home
Education
Nutrition
Compliance
Diet
Environment

As an aside, note there are Risk Indicators visible at the top of each template, which can be configured as appropriate. This usually won't be pertinent for young children, but with older children & adolescents it may be appropriate to configure these indicators, as described in the Histories lesson. We won't go through that in this example.

Developmental History

Confidential History

Add

Intake Note

Specialty ▾ Pediatrics Visit Type ▾ Well child

? 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 1

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

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

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

Substances	Encounter Date:Time	03/20/2014 05:33 PM
Tobacco	Primary residence	The patient lives with mother and father.
Relationships	Parent status	married
Home Environment	Number siblings	1
Education	Child Care Provider	0
Nutrition	Days/week	0
Comment	Child Care Provider	0
Diet History	Days/week	0
Environmental	Child Care Provider	0
	Days/week	0
	Child Care Provider	0

Developmental History Confidential History Add

Intake Note

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

Appointment date: 02/21/2014

Today's date: 02/24/2014

Appointment information:

9:00 AM DUFFY MD, ROBERT LAMAR Reason:

Room:

Status:

Ngkbn Get Dbpicklist Items [X]

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

Refresh OK Cancel

Patient Tracking:

Appt Time	Room

Appointment date shown.

Today's Patient Tracking

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

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

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

Patient Tracking:

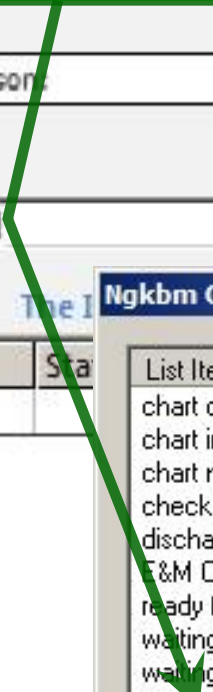
Appt Time	Room	Sta

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: Wyman Quagmire MRN: 000000007774 DOB: 01/12/2012 (Male) AGE: 26 months 8 days

File Edit Default View Tools Admin Utilities Window Help

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Weight: 30.40 lb (13.79 Kg) Allergies: (1) Problems: (1) Diagnoses: (1) Medications: (1)

Address: 8 Trail Mix Trail Mobile, AL 36604 MRN: 000000007774 Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
 Contact: Insurance: MEDICAID OF ALABAMA Emergency Phone: Referring: ...
 NextMD: No Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

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

03/20/2014 05:33 PM "USA Home Page" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

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

HPI's	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Plans	03/20/2014	7:09 PM	98.9	100/60	88	16	35.00	30.40	17.45				

Immunizations Growth History Physical Exams Vitals Medications Allergies Labs Diagnostics Office Procedures Procedures Referrals Office Labs Past Medical/Surgical History

Patient History

- New Lock Search
- 03/20/2014 05:33 PM [
 - *USA Intake
 - Medication
 - Problem
 - Immunization - Pec
 - USA Histories
 - Pregnancy/Birth Hi
 - *USA Home Page
 - *USA SOAP
 - Child Dev. Rec
 - Child Dev. Hx
 - intake_note

Ready NGDevl USA Health Services Foundation rlduffy CAP NUM SCRL 03/20/2014

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

NextGen EHR: Wyman Quagmire MRN: 000000007774 DOB: 01/12/2012 (Male) AGE: 26 months 8 days

File Edit Default View Tools Admin Utilities Window Help

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Weight: 30.40 lb (13.79 Kg) Allergies: (1) Problems: (1) Diagnoses: (1) Medications: (1)

Address: 8 Trail Mix Trail Mobile, AL 36604 MRN: 000000007774 Insurance: MEDICAID OF ALABAMA Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Contact: NextMD: No Emergency Phone: Referring: ...
Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

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

03/20/2014 05:33 PM : *USA Home Page

Specialty Pediatrics Visit Type Well child

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

HPI's Plans
Immunizations Growth History Physical Exams Vitals Medications Allergies Labs Diagnostics Office Procedures Procedures Referrals Office Labs Past Medical/Surgical

Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
03/20/2014	7:09 PM	98.9	100/60	88	16	35.00	30.40	17.45				

TOB HTN DM CAD

Patient History
New Lock Search
03/20/2014 05:33 PM
*USA Intake Medication Problem Immunization - Pec USA Histories Pregnancy/Birth Hi *USA Home Page *USA SOAP Child Dev. Rec Child Dev. Hx intake_note

Ready NGDevil USA Health Services Foundation rlduffy CAP NUM SCRL 03/20/2014

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** (if used).

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.

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

03/20/2014 05:33 PM: "*USA Home Page" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

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
HPI's	03/20/2014	7:09 PM	98.9	100/60	88	16	35.00	30.40	17.45				

HPI's
Plans
Immunizations
Growth History
Physical Exams
Vitals
Medications
Allergies
Labs
Diagnostics
Office Procedures
Procedures
Referrals
Office Labs
Past Medical/Surgical History

Patient History

- 03/20/2014 05:33 PM
 - *USA Intake
 - Medication
 - Problem
 - Immunization - Pec
 - USA Histories
 - Pregnancy/Birth Hi
 - *USA Home Page
 - *USA SOAP
 - Child Dev. Rec
 - Child Dev. Hx
 - intake_note

Custom

Ready

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

The Problem List is viewable & editable here.

Care Guidelines | Global Days

Panel Control: ▾ Toggle ⏪ ⏩ Cycle ↻

Medical Chart Summary

Problem List 1

Show chronic Show my tracked problems No active problems Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Clinical Status	Provider	Location	Notes
	Allergic rhinitis		Y	N		DUFFY, ROBERT LAMAR	USA CHILDRENS MEDICAL CENTER	

Refresh Add Edit

History Summary

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

Confidential

History Review

No relevant past medical/surgical history

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

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type
Umbilical hernia		01/12/2012	Hernia repair, umbilical		2013	

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

Add Edit Remove

Allergies

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

Allergen	Reaction	Medication Name	Comment
----------	----------	-----------------	---------

NO KNOWN ALLERGIES

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.

[Add](#) [Update](#)

Medications

Patient status: Transitioning into care Summary of care received

[Comment](#) No medications Medications reconciled

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

loratadine 5 mg/5 mL Oral Soln	1 tsp daily as needed for runny nose, drainage.
--------------------------------	---

[Add/Update](#) [Reconcile](#)

Vital Signs

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

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

7:09 PM	98.9	100/60	88	16	35.00	30.40	13.789	17.45					
---------	------	--------	----	----	-------	-------	--------	-------	--	--	--	--	--

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

File Edit Default View Tools Admin Utilities Window Help

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

Wyman Quagmire (M) DOB: 01/12/2012 (26 months 8 days) Weight: 30.40 lb (13.79 Kg) Allergies: (1) Problems: (1) Diagnoses: (1) Medications: (1)

Address: 8 Trail Mix Trail Mobile, AL 36604 MRN: 000000007774 Insurance: MEDICAID OF ALABAMA Emergency Relation: PCP: DUFFY, ROBERT LAMAR ...
Contact: NextMD: No Emergency Phone: Referring: ...
Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

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

03/20/2014 05:33 PM : "*USA Home Page" x

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

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

Care Guidelines | Global Days

Medical Chart Summary

HPT's	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Plans	03/20/2014	7:09 PM	98.9	100/60	88	16	35.00	30.40	17.45				

Patient History

- 03/20/2014 05:33 PM
 - *USA Intake
 - Medication
 - Problem
 - Immunization - Pec
 - USA Histories
 - Pregnancy/Birth Hi
 - *USA Home Page
 - *USA SOAP
 - Child Dev. Rec
 - Child Dev. Hx
 - intake_note

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

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.

Specialty ▾ Pediatrics Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

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

Reason for Visit

Introduction:

This 2 year 2 month old male presents for congestion and Well Child Check.

Do not launch HPI

Intake Comments

Reason for Visit	History of Present Illness
congestion	
Well Child Check	

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 **congestion**.

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.

Onset: 13 Days

Severity: mild moderate severe incapacitating

Status: improving no change worse resolved

Frequency: persistent intermittent occasional

other negatives:

other positives:

comments:

history of allergies recent cold sick contacts at daycare sick family member

Aggravated by: nothing

Relieved by: nothing

<input type="checkbox"/> allergens	<input type="checkbox"/> lying down	other negatives: <input type="text"/>	<input type="checkbox"/> antihistamines	<input type="checkbox"/> OTC analgesics	other negatives: <input type="text"/>
<input type="checkbox"/> cold air	<input type="checkbox"/> smoke	other positives: <input type="text"/>	<input type="checkbox"/> bulb suction	<input type="checkbox"/> humidifier	other positives: <input type="text"/>
<input type="checkbox"/> exertion		comments: <input type="text"/>	<input type="checkbox"/> decongestants	<input type="checkbox"/> saline nose drops/spray	comments: <input type="text"/>
			<input type="checkbox"/> OTC cough syrup	<input type="checkbox"/> throat lozenges	

Associated Symptoms/Pertinent Negatives:

<input type="checkbox"/> chills/rigors	<input type="checkbox"/> difficulty sleeping	<input type="checkbox"/> fussiness	<input type="checkbox"/> otalgia:	<input type="checkbox"/> rhinitis	<input type="checkbox"/> No associated symptoms
<input checked="" type="checkbox"/> cough	<input checked="" type="checkbox"/> dyspnea	<input type="checkbox"/> headache	<input type="checkbox"/> pharyngitis	<input type="checkbox"/> sinus pressure	<input type="checkbox"/> No pertinent negatives
<input type="checkbox"/> decreased appetite	<input type="checkbox"/> facial pain	<input type="checkbox"/> hemoptysis	<input checked="" type="checkbox"/> postnasal drainage	<input type="checkbox"/> sputum	<input type="checkbox"/> All others negative
<input type="checkbox"/> decreased fluid intake	<input type="checkbox"/> fatigue	<input type="checkbox"/> myalgia	quality: <input type="text"/>		other negatives: <input type="text"/>
<input type="checkbox"/> decreased urine output	<input checked="" type="checkbox"/> fever				other positives: <input type="text"/>

Comments:

And you can save & reuse presets.

Review of Systems:

Constitutional	Respiratory	Immunological	HEENT	Integumentary
<input type="checkbox"/> chills/rigors	<input checked="" type="checkbox"/> cough	<input type="checkbox"/> asthma	<input checked="" type="checkbox"/> nasal congestion	<input checked="" type="checkbox"/> rash
<input type="checkbox"/> fatigue	<input type="checkbox"/> dyspnea	<input type="checkbox"/> environmental allergies	<input type="checkbox"/> otalgia	
<input checked="" type="checkbox"/> fever	<input type="checkbox"/> hemoptysis	Gastrointestinal	<input type="checkbox"/> pharyngitis	
<input type="checkbox"/> night sweats	<input type="checkbox"/> pleuritic pain	<input checked="" type="checkbox"/> diarrhea	<input checked="" type="checkbox"/> postnasal drainage	
<input type="checkbox"/> weight loss	<input type="checkbox"/> wheezing	<input checked="" type="checkbox"/> nausea	<input checked="" type="checkbox"/> rhinitis	
		<input checked="" type="checkbox"/> vomiting		

Office Labs: Office Diagnostics

<input type="checkbox"/> Rapid RSV	<input type="checkbox"/> Rapid influenza	<input type="checkbox"/> Rapid strep
Diagnosis: <input type="text"/> Code: <input type="text"/>	Diagnosis: <input type="text"/> Code: <input type="text"/>	Diagnosis: <input type="text"/> Code: <input type="text"/>

(Labs ordered here will not upload to lab module)

Place Order OK Cancel

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

Concern: Severity: Mild Moderate Severe Incapacitating Other: Frequency: Constantly Daily Weekly Randomly Other: E & M coding information: ⓘ

Onset: ⓘ

Duration: ⓘ Location:

Aggravated by: Relieved By:

- Acute
 Chronic

✦ [Review of Test\(s\)](#)

HPI: Filter: Summary Phrase

In for WCC. No concerns about diet. Day care 5 days a wk; gets along well w/ others. Potty training coming along well.

If you had clicked on the **Well Child Check Reason for Visit**, you would see the **Generic Free Form HPI Popup**. This is a good place to review any little questions the parent has, especially when there are not other major complaints to discuss.

When done click **Save & Close**.

This field is limited to 9000 characters.

Entries from the HPI popups display on the SOAP Tab.

03/20/2014 05:33 PM - "HSA SOAP" x

Specialty v Pediatrics Visit Type v Well Child

Intake Histories **SOAP** Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations M Plan Procedures Order Management

Care Guidelines Global Days Panel Control: Toggle Cycle

Reason for Visit

Introduction:

This 2 year 2 month old male presents for congestion and Well Child Check.

Do not launch HPI [Intake Comments](#)

Reason for Visit	History of Present Illness
congestion	Onset: 3 Days ago. The severity of the problem is moderate and has not changed. Symptoms are associated with history of allergies. Associated symptoms include nasal congestion, postnasal drainage and rhinitis. Pertinent negatives include cough, dyspnea, fever and rash.
Well Child Check	In for WCC. No concerns about diet. Day care 5 days a wk; gets along well w/ others. Potty training coming along well.

rash
URI
fever
ear pain
ADD/ADHD
cough
asthma
congestion
injury
abdominal pain
pediatric subspecialties

Additional / Manage

Diagnostics Comments

Specialty ▾ Pediatrics

Visit Type ▾ Well child

Intake

Histories

SOAP

Finalize

Checkout

Birth History

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 (though for a Well Child Check this is less of an issue).

Specialty ▾ Pediatrics

Visit Type ▾ Well child

Comments about HPI Popups:

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

Specialty ▾ Pediatrics

Visit Type ▾ Well child

Intake Histories SOAP Finalize Checkout

Birth History Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management

Care Guidelines Global Days

Panel Control: Toggle Cycle

Reason for Visit

Introduction:

This 2 year 2 month old male presents for congestion and Well Child Check.

Do not launch HPI

Intake Comments

	Reason for Visit	History of Present Illness
rash URI fever ear pain ADD/ADHD cough asthma congestion injury abdominal pain pediatric	congestion	Onset: 3 Days ago. The severity of the problem is moderate and has not changed. Symptoms are associated with history of allergies. Associated symptoms include nasal congestion, postnasal drainage and rhinitis. Pertinent negatives include cough, dyspnea, fever and rash.
	Well Child Check	In for WCC. No concerns about diet. Day care 5 days a wk; gets along well w/ others. Potty training coming along well.

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

congestion

My Phrases

1. Nasal congestion over the last 3 days, w/ runny nose, puffy eyes. No fvr, sore throat, cough, rash. Has had allergies in the past, so mom wasn't sure if this was allergies or a cold.

Well child check

My Phrases

2. Potty training going well. Gets along w/ other kids in day care. Eats wide assortment of table foods.

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 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." (Obviously, there is some redundant documentation here for the sake of illustration.)

Introduction:

This 2 year 2 month old male presents for congestion and Well Child Check.

Do not launch HPI

rash
URI
fever
ear pain
ADD/ADHD
cough
asthma
congestion
injury
abdominal pain
pediatric subspecialties

Reason for Visit	History of Present Illness
congestion (comments)	Nasal congestion over the last 3 days, w/ runny nose, puffy eyes. No fvr, sore throat, cough, rash. Has had allergies in the past, so mom wasn't sure if this was allergies or a cold.
congestion	Onset: 3 Days ago. The severity of the problem is moderate and has not changed. Symptoms are associated with history of allergies. Associated symptoms include nasal congestion, postnasal drainage and rhinitis. Pertinent negatives include cough, dyspnea, fever and rash.
Well Child Check (comments)	Potty training going well. Gets along w/ other kids in day care. Eats wide assortment of table foods.
Well Child Check	In for WCC. No concerns about diet. Day care 5 days a wk; gets along well w/ others. Potty training coming along well.

Additional / Manage

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.

Reason for Visit

Review of Systems

System	Neg/Pos	Findings
Constitutional	Negative	Fever.
ENMT	Positive	Nasal congestion, Post-nasal drainage, Rhinitis.
Respiratory	Negative	Cough and dyspnea.
GI	Negative	Diarrhea, nausea and vomiting.
Integumentary	Negative	Rash.
Allergic/Immunc	Positive	Animals at home (Animals include hedgehogs).



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

Developmental History

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 **Pediatrics 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.

Pediatric - ROS

ROS defaults:  

System	Neg	Pos	All neg		
Constitutional	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Chills	<input type="radio"/> Decreased activity	<input type="radio"/> Decreased appetite	<input checked="" type="radio"/> Fever		
<input type="radio"/> Fussiness	<input type="radio"/> Irritability	<input type="radio"/> Lethargy	<input type="radio"/> Weight gain		
<input type="radio"/> Weight loss	Other positives: <input type="text"/>				
Other negatives: <input type="text"/>					
HEENT	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Dysphagia	<input type="radio"/> Ear discharge	<input type="radio"/> Esotropia	<input type="radio"/> Eye discharge		
<input type="radio"/> Eye redness	<input type="radio"/> Headache	<input type="radio"/> Hearing loss	<input checked="" type="radio"/> Nasal congestion		
<input checked="" type="radio"/> Otagia	<input checked="" type="radio"/> Pharyngitis	<input type="radio"/> Rhinorrhea	<input checked="" type="radio"/> Sneezing		
<input type="radio"/> Tearing	<input type="radio"/> Vision loss	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Respiratory	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input checked="" type="radio"/> Dyspnea	<input type="radio"/> Stridor	<input type="radio"/> Use of accessory muscles	<input checked="" type="radio"/> Cough		
<input type="radio"/> Known TB exposure	TB risk factors: <input type="text"/>				
<input type="radio"/> Sputum	<input type="radio"/> Wheezing	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Cardiovascular	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Chest pain	<input type="radio"/> Irregular heartbeat/palpitations	<input type="radio"/> Syncope	Other positives: <input type="text"/>		
Other negatives: <input type="text"/>					
Vascular	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Cool extremity	<input type="radio"/> Cyanosis	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Gastrointestinal	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Abdominal pain	<input type="radio"/> Constipation	<input checked="" type="radio"/> Diarrhea	<input type="radio"/> Nausea		
<input type="radio"/> Reflux	<input checked="" type="radio"/> Vomiting	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Genitourinary	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Decreased urine output	<input type="radio"/> Dysuria	<input type="radio"/> Enuresis	<input type="radio"/> Flank pain		
<input type="radio"/> Foul urine odor	<input type="radio"/> Hematuria	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Reproductive	<input type="radio"/>	<input type="radio"/>			
<input type="radio"/> Circumcised	<input type="radio"/> Penile discharge	<input type="radio"/> Scrotum testicular mass	<input type="radio"/> Scrotum testicular pain	Other positives: <input type="text"/>	
Other negatives: <input type="text"/>					
Metabolic/Endocrine	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Polydipsia	<input type="radio"/> Polyuria	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Neuro/Psychiatric	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Inappropriate interaction	<input type="radio"/> Behavioral changes	<input checked="" type="radio"/> Inconsolable	<input type="radio"/> Difficulty concentrating		
<input type="radio"/> Distorted body image	<input type="radio"/> Self conscious	Other positives: <input type="text"/>			
Other negatives: <input type="text"/>					
Integumentary	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Acne	<input type="radio"/> Pruritus	<input checked="" type="radio"/> Rash	<input type="radio"/> Skin lesion	Other positives: <input type="text"/>	
Other negatives: <input type="text"/>					
Musculoskeletal	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Bone pain	<input type="radio"/> Joint pain	<input type="radio"/> Joint swelling	<input type="radio"/> Muscle weakness		
<input type="radio"/> Myalgia	Other positives: <input type="text"/>				
Other negatives: <input type="text"/>					
Hematologic	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Easy bleeding	<input type="radio"/> Easy bruising	<input type="radio"/> Lymphadenopathy	<input type="radio"/> Petechiae	Other positives: <input type="text"/>	
Other negatives: <input type="text"/>					
Immunological	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		
<input type="radio"/> Allergic rhinitis	<input type="radio"/> Environmental allergies	<input checked="" type="radio"/> Food allergies	<input type="radio"/> Urticaria	Other positives: <input type="text"/>	
Other negatives: <input type="text"/>					

When done click **Save & Close**.

Your new entries display.

You can also directly access other system-specific HPI popups from here.

The screenshot shows a medical software interface. At the top, there are navigation tabs: Birth History, Standing Orders, Adult Immunizations, Peds Immunizations, My Plan, Procedures, and Order Management. Below these are Care Guidelines and Global Days. A 'Reason for Visit' section is visible. The main area is titled 'Review of Systems' and contains a table with columns for System, Neg/Pos, and Findings. A sidebar on the left lists various medical systems. A 'Developmental History' button is located at the bottom right.

System	Neg/Pos	Findings
Constitutional	Negative	Fever.
ENMT	Positive	Nasal congestion, Post-nasal drainage, Rhinitis, Sneezing.
ENMT	Negative	Otalgia and pharyngitis.
Eyes	Positive	Tearing.
Eyes	Negative	Eye redness.
Respiratory	Negative	Cough and dyspnea.
Gastrointestinal	Negative	Diarrhea, nausea, vomiting.
Psychiatry	Negative	Unstable.
Integumentary	Negative	Rash.
Allergic/Immune	Negative	Food allergies.

Developmental History

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.

Review of Systems

Also note you can open up the **Developmental History** from here, to either review nurse's entries or add further data.

- Constitutional
- HEENT
- Respiratory
- Cardiovascular
- Vascular
- Gastrointestinal
- Genitourinary
- Reproductive

Constitutional	Negative	Fever.
Respiratory	Positive	Nasal congestion, Post-nasal drainage, Rhinitis, Sneezing.
Eyes	Positive	Tearing.
Eyes	Negative	Eye redness.
Respiratory	Negative	Cough and dyspnea.
GI	Negative	Diarrhea, nausea and vomiting.

Continuing down the **SOAP** tab, you can review the **Vital Signs** again. You can add another entry, review a history of previous readings, or see them in graph form.

Developmental History

Vital Signs

Health Promotion Plan | History | Graph

Time	Temp (F)	BP	Pulse	Respiration	Ht (in)	Wt (lb)	Wt (kg)	BMI	Pulse Ox Rest	Head Circ (in)	BSA	Pain level	Comments
7:09 PM	98.9	100/60	88	16	35.00	30.40	13.789	17.45					

You'll next move down to the **Physical Exam** section.

Add Edit Remove

Physical Exam

One Page Exam	Exam	Findings	Details
---------------	------	----------	---------

- Constitutional
- Eyes
- Ears

First notice the **Office Diagnostics** button. That would give you a chance to review things like rapid strep, RSV, & flu tests that your nurse may have done for you. 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.

There is no such data entered in this example.

The screenshot shows a software interface for a 'Physical Exam'. On the left, there is a vertical list of body systems: One Page Exam, Constitutional, Eyes, Ears, Nose | Mouth | Throat, Neck | Thyroid, Respiratory, Cardiovascular, Abdomen, Genitourinary, Skin | Hair, Musculoskeletal, Neurological, and Psychiatric. Below this list is an 'Additional' section. The main area of the interface has three tabs: 'Exam', 'Findings', and 'Details'. The 'Exam' tab is currently selected. In the bottom right corner of the interface, there is a button labeled 'Office Diagnostics'. A green arrow points from the text above to this button.

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**.

03/20/2014 05:33 PM : "**USA SOAP" x

Physical Exam

One Page Exam
Constitutional
Eyes
Ears
Nose | Mouth | Throat
Neck | Thyroid
Respiratory
Cardiovascular
Abdomen
Genitourinary
Skin | Hair
Musculoskeletal
Neurological
Psychiatric
Additional

Exam Findings Details

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.

Physical Exam

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

Exam	Findings	Details



I'm going to click the Open Preset icon & double-click on **PEFullNIToddler-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
- PEFullNIToddler-RLD

Refresh OK Cancel

Your exam displays. You can select aspects of the exam from the menu on the left, & modify findings as necessary for the individual patient. Here I'll click on the **Nose|Mouth|Throat** exam to change my findings.

03/20/2014 05:33 PM : "**USA SOAP" x

Physical Exam

One Page Exam
Constitutional
Eyes
Ears
Nose | Mouth | Throat
Neck | Thyroid
Respiratory
Cardiovascular
Abdomen
Genitourinary
Skin | Hair
Musculoskeletal
Neurological
Psychiatric

Additional

Exam	Findings	Details
Constitutional	*	Level of distress - no acute distress. Overall appearance - age appropriate.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal.
Ears	*	Canal - Right: No excess wax or inflammation, Left: No excess wax or inflammation. TM - Right: Benign, Left: Benign.
Nasopharynx	*	Nares - Right: Clear, Left: Clear. Oropharynx - No redness or drainage.
Neck Exam	Normal	Inspection - Normal.
Respiratory	Normal	Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Murmurs - None.
Abdomen	Normal	Inspection - Normal. Anterior palpation - Normal. No abdominal tenderness.
Psychiatric	Normal	Behavior appropriate for age.

Office Diagnostics

- Constitutional
- Head/Face
- Eyes
- Ears
- Nose/Mouth/Throat
- Neck/Thyroid
- Lymphatic
- Breast
- Respiratory/Thorax
- Cardiovascular
- Vascular
- Abdomen
- Genitourinary
- Rectal
- Skin/Hair
- Back/Spine
- Musculoskeletal
- Jointman
- Soft Tissue
- Extremities
- Neurological
- Psychiatric

Select all normal

Nose:

External nose:	<input type="checkbox"/> Normal		
Nares: R:	<input type="checkbox"/> Normal	discharge - clear	
L:	<input type="checkbox"/> Normal	discharge - clear	
Mucosa:	<input type="checkbox"/> Normal		

Sinuses:

Septum:	<input type="checkbox"/> Normal		
Sinuses: R:	<input type="checkbox"/> Normal		
L:	<input type="checkbox"/> Normal		
Turbinates: R:	<input type="checkbox"/> Normal		
L:	<input type="checkbox"/> Normal		
Adenoids:	<input type="checkbox"/> Normal		

Mouth:

Lips/teeth/gums:	<input type="checkbox"/> Normal		
Tongue:	<input type="checkbox"/> Normal		
Buccal mucosa:	<input type="checkbox"/> Normal		
Salivary glands:	<input type="checkbox"/> Normal		
Breath odor:	<input type="checkbox"/> None		

Throat:

Palate & uvula:	<input type="checkbox"/> Normal		
Tonsils:	<input type="checkbox"/> Normal		
Oropharynx:	<input type="checkbox"/> Normal	No redness or drainage	
Gag reflex:	<input type="radio"/> Present	<input type="radio"/> Absent	

Larynx:

Epiglottis:	<input type="checkbox"/> Normal		
Arytenoids:	<input type="checkbox"/> Normal		
Vocal cords:	<input type="checkbox"/> Normal		

Comments:

I'll change these entries to discharge - clear.

You can go directly to any other system to make further entries.

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.



03/20/2014 05:33 PM : "*USA SOAP" x

Physical Exam

Exam	Findings	Details
Constitutional	*	Level of distress - no acute distress. Overall appearance - age appropriate.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal.
Ears	*	Canal - Right: No excess wax or inflammation, Left: No excess wax or inflammation. TM - Right: Benign, Left: Benign.
Nasopharynx	*	Nares - Right: discharge - clear, Left: discharge - clear. Oropharynx - No redness or drainage.
Neck Exam	Normal	Inspection - Normal.
Respiratory	Normal	Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Murmurs - None.
Abdomen	Normal	Inspection - Normal. Anterior palpation - Normal. No abdominal tenderness.
Psychiatric	Normal	Behavior appropriate for age.

One Page Exam
Constitutional
Eyes
Ears
Nose | Mouth | Throat
Neck | Thyroid
Respiratory
Cardiovascular
Abdomen
Genitourinary
Skin | Hair
Musculoskeletal
Neurological
Psychiatric
Additional

Office Diagnostics

Physical Exam

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

P. Exam

1. Assessment ROUTIN CHILD HEALTH EXAM (V20.2).

Moving to the bottom of the **SOAP** tab, we'll document assessments & plans. Since this is a well child check, Routine Child Health Exam has already been added as the 1st diagnosis.

To document plans/counseling regarding the WCC, click the **Well Visit** button.

 Resident-Attending discussion took place Attending saw patient

Well Visit

Consent

Procedure Scheduling

Add/Update

Remove

✦ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

There are numerous anticipatory guidance items listed. You may wish to check several off as you discuss them.

Peds Plan 2 Years

Assessment:
Description: Code:

Orders:
 Hematocrit
 Hemoglobin
 Lead

Immunizations

Anticipatory guidance:

- Bedtime rituals
- Begin toilet training when child is ready
- Child care
- Consistent limit setting/discipline
- Dental care
- Encourage opportunities for physical activity
- Encourage self expression/express feelings
- Follow 1-2 step commands
- Limit TV viewing to no more than 1-2 hours/day
- Listen and respond to child
- Model appropriate language
- Moving from crib to bed
- Napping
- Night terrors/wakening
- Play and peer contacts
- Praise good behavior/respect
- Representational play/hiding games
- Self-comforting behavior
- Social interaction at meals
- Speech development/read to child daily

Diet:

- 3 meals/day; 2-3 snacks/day
- Allow toddler to decide how much to eat
- Eat meals as a family
- Iron-fortified foods
- No bottle
- Nutritious snacks
- Self feeding
- Vitamin and fluoride supplements

Other:

Safety:

- Aspiration
- Bathing
- Bicycle helmet use
- Car safety (use age appropriate seat in back seat facing forward)
- Caution about hot liquids, cigarette ashes
- Choking (toys, food, small objects)
- Drowning (tubs, toilets, pools)
- First aid knowledge
- Guns (unload/lock up)
- Home child proofing
- Insect protection
- Limit sun exposure/use of sunscreen
- Microwave-heated food
- Pets/animals
- Poison (Poison Control Center info)
- Smoke detectors
- Supervise play
- Teach hand washing
- Water temperature less than 120 degrees F

There is also room to add further comments at the bottom.

Comments: Handout given

2% milk is a good choice for a lower fat milk for the whole family.

Assessment:

Description: Code:

Orders:


- Hematocrit
- Hemoglobin
- Lead



Immunization ordering & completion may be done in several different ways, depending on clinic policies. If you choose to request vaccines verbally, nurses can order, document, & charge for them at the same time using the **Immunization templates & Order Module**. Another alternative is to click here to access the age-appropriate order set from those resources.

 Praise good behavior/respect Representational play/hiding games Self-comforting behavior Social interaction at meals Speech development/read to child daily TV and screen timeOther:

Comments

 Poison (Poison Control Center info) Smoke detectors Supervise play Teach hand washing Water temperature less than 120 degrees F

His vaccines are up-to-date, & it's not flu vaccine season, so we don't need to order any immunizations. Click **Save & Close**.

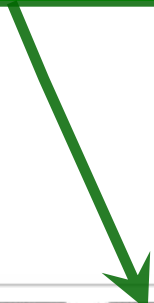
Physical Exam

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	ROUTIN CHILD HEALTH EXAM (V20.2).
----	------------	-----------------------------------

To add further diagnoses, click the **Add/Update** button.



Resident-Attending discussion took place Attending saw patient

[Well Visit](#) [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. congestion 2. Well Child Check

(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
ROUTIN CHILD HEALTH EXAM	V20.2

Add Common Assessment | Diagnosis Code Lookup

Clinical Problems

Show Chronic Show My Tracked problems No active problems

Description	Onset Date
Allergic rhinitis	

My Favorites Favorites Category:

All Filter:

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

Dx description: Code: Status: Site:

Impression: Differential Dx:

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

Add/Update

Today's Assessments

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.

Today's Concerns/Reason for Visit:

1. congestion 2. Well Child Check

(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
Allergic rhinitis, cause unspecified	477.9
ROUTIN CHILD HEALTH EXAM	V20.2

Clinical Problems

Show Chronic

Description	Code	Onset Date
Allergic rhinitis		

My Favorites

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

Here I've added Allergic rhinitis by clicking on it on the Clinical Problems list.

Add Common Assessment | Diagnosis Code Lookup

Dx description: Code: Status: Site:

Impression: Differential Dx:

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

Add/Update

Today's Assessments

#	Description(code) Status Site	Impression/Differential Dx
1	ROUTIN CHILD HEALTH EXAM (V20.2)	
2	Allergic rhinitis, cause unspecified (477.9)	

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

Save & Close

Sort

Remove

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

Assessment/Plan Expanded View 

#	Description	Code	Status
1	ROUTIN CHILD HEALTH EXAM	V20.2	
2	Allergic rhinitis, cause unspecified	477.9	

Selected Assessment: Allergic rhinitis, cause unspecified

Add

Edit

Sort DX

Remove

Impression/Comments:

My Phrases



Differential Diagnosis:

My Phrases



(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

Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.

Provider Details:

My Phrases

Common Phrases

Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

Record your plans here. You can type and/or use **My Phrases** for instructions you give repeatedly throughout the day. (Setup of **My Phrases** is discussed in the User Personalization demo.)

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	ROUTIN CHILD HEALTH EXAM	V20.2	
2	Allergic rhinitis, cause unspecified	477.9	

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

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

Plan Details

Previous Patient Details | Previous Provider Details | Health Promotion Plan

Patient Details:

My Phrases

Common Phrases

Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.

Provider Details:

My Phrases

Common Phrases

Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

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

Today's Orders:

When done click **Save & Close**.

Save & Close

Cancel

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	ROUTIN CHILD HEALTH EXAM (V20.2).
2.	Assessment	Allergic rhinitis, cause unspecified (477.9).
	Patient Plan	Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.
	Provider Plan	Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

Your assessments & plans display. (Though you don't see the output of the Well Visit plan popup here, everything you documented will be included in the visit note.)

Resident-Attending discussion took place Attending saw patient

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

To complete his prescriptions click **Meds**.

Provider Comm. **Meds** Procedures Patient Plan Visit Document Document Library EM Coding Dictation

03/20/2014 05:33 PM : **USA SOAP** Rx Medications Module x

White Grid Preferences 26 months 9 day Old Male Weighing 30.40 lb | 13.79 Kg

Last Audit	Status	Medication Name	Generic Name	Start Date	Stop Date	Sig	Original Start
Status: Active (1 item)							
	Active	loratadine 5 mg/5 mL Oral Soln	LORATADINE	03/20/2014		1 tsp daily as needed for runny nose, d...	03/20/2014

Prescribe New Print Send Renew Interactions Stop Resources Dose Range Delete Eligibility Medication History Reconcile

loratadine 5 mg/5 mL Oral Soln Max. daily dose not checked - U

Sig: 1 tsp daily as needed for runny nose, drainage. [Remove Sig](#) [Edit Sig...](#)

Quantity: 6 Units: Fluid Ounce Refills: 11 Dispense As Written Prescribed Elsewhere Source:

Start: 03/20/2014 Stop: 03/21/2014 Duration: PRN Reason:

Comments: *This field is for nonclinical comments to the pharmacist. Any additional clinical instructions for this prescription should be added using the 'Additional Instructions' segment of the Sig Builder.*

Problem:

Accept Cancel

Medication Module details are reviewed in another lesson.

Here we would renew/prescribe meds as necessary & ERx them. He'll just continue to use OTC loratadine, so we'll close the med module & return to the **SOAP** Tab.

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	ROUTIN CHILD HEALTH EXAM (V20.2).
2.	Assessment	Allergic rhinitis, cause unspecified (477.9).
	Patient Plan	Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.
	Provider Plan	Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

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

 Resident-Attending discussion took place Attending saw patient

Well Visit

Consent

Procedure Scheduling

Add/Update

Remove

Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

You have several options for generating a school excuse.

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

General

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

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

Letters

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

Assessments and Tools

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

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	ROUTIN CHILD HEALTH EXAM (V20.2).
2.	Assessment	Allergic rhinitis, cause unspecified (477.9).
	Patient Plan	Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.
	Provider Plan	Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

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

Well Visit

Consent

Procedure Scheduling

Add/Update

Remove

✦ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

03/20/2014 05:33 PM : "*USA SOAP" 03/20/2014 05:33 PM : Document "Patient Plan" x

TX Text

Segoe UI 10 B I U 100% L ¶ A S x₂ x²

PATIENT PLAN FOR 03/21/2014
Name: Wyman Quagmire
Date of Birth: 01/12/2012
Date of Visit: 03/21/2014
Visit Type: Well child
Location: USA FAMILY MEDICIN

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

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

Primary Care Provider: ROBERT LAMAR DUFFY MD

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

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	ROUTIN CHILD HEALTH EXAM (V20.2).
2.	Assessment	Allergic rhinitis, cause unspecified (477.9).
	Patient Plan	Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.
	Provider Plan	Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

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

Well Visit

Consent

Procedure Scheduling

Add/Update

Remove

Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

03/20/2014 05:33 PM : **USA SOAP** 03/20/2014 05:33 PM : Document "Master_Im" x

TX Text

Segoe UI 10 B I U 100% L ¶ A x₂ x²

PATIENT: Wyman Quagmire
DATE OF BIRTH: 01/12/2012
DATE: 03/20/2014 05:33 PM
VISIT TYPE: Well child

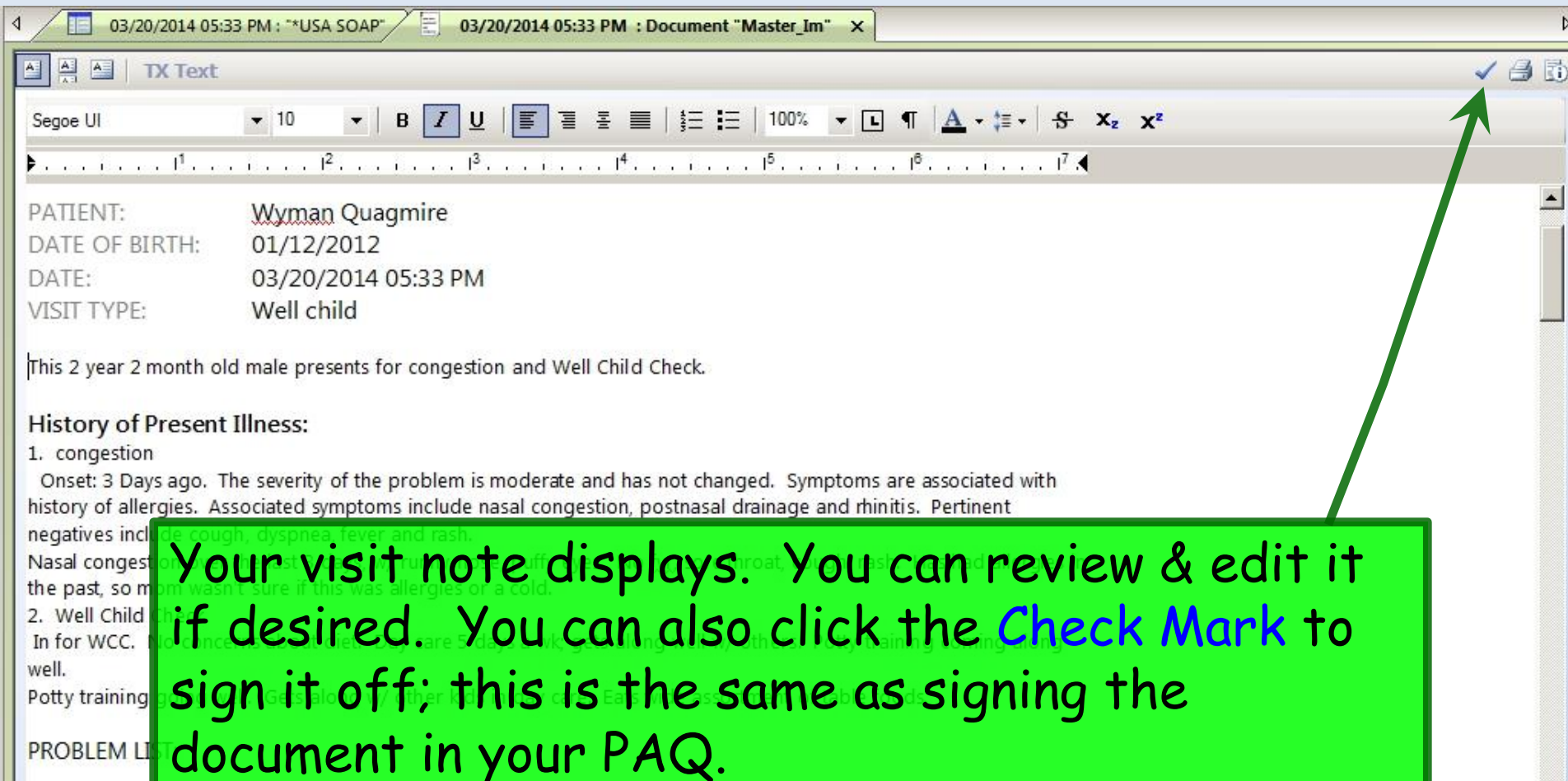
This 2 year 2 month old male presents for congestion and Well Child Check.

History of Present Illness:

1. congestion
Onset: 3 Days ago. The severity of the problem is moderate and has not changed. Symptoms are associated with history of allergies. Associated symptoms include nasal congestion, postnasal drainage and rhinitis. Pertinent negatives include cough, dyspnea, fever and rash.

2. Well Child Check
In for WCC. Mom wasn't sure if this was allergies or a cold.

PROBLEM LIST



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**.

Navigation

- Navigation
- Internal
- History
- SOAP
- Finalize
- Check Out
- > Order Management
- > Orders/Plan
- > Standing Orders
- > Standing Orders
- Anticoagulation
- Procedures
- Tobacco Cessation
- Tuberculin Skin Test
- Nutrition
- Chart Abstraction
- Demographics
- Document Library
- Immunizations
- Patient Comment
- Provider Test Action
- Vital Signs
- Screening Tools
- CQM Check
- MU Check

Preview Offline

Discussion took place Attending saw patient Well Visit Consent Procedure Scheduling Add/Update Remove

Consent



Meds



Procedures



Patient Plan

Visit Document

Document Library



EM Coding



Dictation

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	ROUTIN CHILD HEALTH EXAM (V20.2).
2.	Assessment	Allergic rhinitis, cause unspecified (477.9).
	Patient Plan	Avoid any identified allergens--& watch for things that you think could be aggravating the problem. Continue loratadine 5 mg (1 tsp) daily as needed for drainage, sneezing, watery/puffy eyes. Call if not doing well enough. Otherwise, vaccines are up to date; plan on next well child visit in 1 yr.
	Provider Plan	Discussed possibly adding Singulair, but mother wants to see how he does as springtime progresses, which is fine.

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

Well Visit

Consent

Procedure Scheduling

Add/Update

Remove

✦ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

Specialty Pediatrics Visit Type Well child

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

E&M coding is reviewed in another lesson. But for a well child check it's simple. The program knows the patient's age, & whether he's new or established, so just click Calculate Code.

General Established 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

Table with 7 columns: New patient, Established, Consultation, Preventive new, Preventive established, Preventive counseling, Post Op. Rows include codes like 99201-99205, 99211-99215, 99241-99245, 99381-99387, 99391-99396, 99401-99404, 99024, 59425, 59426.

Behavioral Health:

90791 (Initial eval, no med services) 90792 (Initial eval, w/ med services) 90846 (Family/Couple therapy, w/o patient)

Specialty Pediatrics Visit Type Well child

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 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

The calculated code is acceptable, so 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: 99382

Modifier(s):

Calculate Code Submit Code

CQM Check

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

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

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

Select your attending & click Add User(s).

03/20/2014 05:33 PM : "USA SOAP" 03/20/2014 05:33 PM : Select Task Recipients

Today's Assessment
Provider Sign Off
Physician Sign Off Request:
 Submit to supervising physician for review
Supervising Physician Sign Off:
 I have reviewed and agree with the diagnosis and treatment plan

Evaluation and Management Coding
Medical Decision Making View MDM Guidelines | View Risk Table
 Straight forward Low complexity
 Moderate complexity High complexity

Evaluation and Management Code
Visit code: 99382
Modifier(s):
Calculate Code Submitted
CQM Check
Calculated EM code: 99382
Submitted code: 99382
Calculated eRx code:
Submitted eRx code:

Available Users / Workgroups:
Favorites
Workgroups
+ EHR Core Group (Core Group)
+ FMC Attending Team (Attending Team)
+ FMC Attendings (Physicians)
+ FMC Blue Team (Blue Team e-Rx R)
+ FMC Front Office (Front Office)
+ FMC Green Team (Green Team e-R)
+ FMC Medical Records (Medical Re)
+ FMC Mid-Level (Mid-Level Provider)
+ FMC Momcare Case Worker (Social
+ FMC Nursing (Nurses)
+ FMC Nursing Blue (Blue Nursing Te
+ FMC Nursing Red (Red Nursing Te
+ FMC Nursing White (White Nursing
+ FMC Red Team (Red Team e-Rx R)
+ FMC Referral Department (Referral:
+ FMC Residents

Task Recipients:
Name Type

Add User(s)
Add Group(s)
Remove
Clear

New Group Delete Modify OK Cancel

Then click OK.

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

The screenshot displays the NextGen EHR interface for a patient named Wyma Ouamire. The main window shows encounter details for 03/20/2014 05:33 PM, including a list of encounters with codes like 99201 through 99205. A context menu is open over the encounter folder, listing options such as 'Expand All', 'Lock Encounter...', and 'Properties...'. A green arrow points from the text box to the 'Properties...' option in the menu. The interface also includes sections for 'Physician Sign Off Request', 'Supervising Physician Sign Off', and 'Evaluation and Management Coding'.

Physician Sign Off Request:
 Submit to supervising physician for review

Supervising Physician Sign Off:
 I have reviewed and agree with the diagnosis and treatment plan

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):
Total counsel time (minutes): [Counseling Details](#)

Evaluation and Management Code

Visit code:
Modifier(s):

Submitted

Calculated EM code:
Submitted code:

Calculated eRx code:
Submitted eRx code:

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

New patient:	Established:	Consultation:	Preventive new:	Preventive establish:
<input type="radio"/> 99201	<input type="radio"/> 99211	<input type="radio"/> 99241	<input type="radio"/> 99381	<input type="radio"/> 99391
<input type="radio"/> 99202	<input type="radio"/> 99212	<input type="radio"/> 99242	<input type="radio"/> 99382	<input type="radio"/> 99392
<input type="radio"/> 99203	<input type="radio"/> 99213	<input type="radio"/> 99243	<input type="radio"/> 99383	<input type="radio"/> 99393
<input type="radio"/> 99204	<input type="radio"/> 99214	<input type="radio"/> 99244	<input type="radio"/> 99384	<input type="radio"/> 99394
<input type="radio"/> 99205	<input type="radio"/> 99215	<input type="radio"/> 99245	<input type="radio"/> 99385	<input type="radio"/> 99395
			<input type="radio"/> 99386	<input type="radio"/> 99396
			<input type="radio"/> 99387	<input type="radio"/> 99397

Behavioral Health:
 90791 (Initial eval, no med services)
 90792 (Initial eval, w/ med services)
 90832 (Psychotherapy, 30 minutes)
 90846 (Family/Couple therapy)
 90847 (Family/Couple therapy)

Context Menu:
Expand All
Expand Most Recent
Expand Unlocked
Collapse All
Lock Encounter...
Delete Encounter...
Encounter Level Insurance...
Customize Display...
Case...
Encounter Description/Remark...
Properties...

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

The resident doctor clicks the Supervisor dropdown arrow & selects the attending.

Claims | Marketing | Properties | History

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

Then click OK to close the popup.

Complaints: [text]
Date Last Seen: [calendar]
Admit Date: [calendar]
Discharge Date: [calendar]
Initial Treatment Date: [calendar]
Facility: [dropdown]
Encounter Types: Billable: Clinical
 Print Encounter On Statements Patient is Homebound
Case: [text] Case Date: [calendar]
Service Type: [dropdown]

Specialty ▾ Pediatrics

Visit Type ▾ Well child

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 (1)				
Patient Education (3)				
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 Well Child Visit
demonstration.

Monday is an awful way to spend 1/7 of your week.

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