

In addition to the standard Adı Pediatric Admit Workflow will iı	mit workflow com nclude Social and	ponents (see the H&P job aid for more information), the Family History controls and a special Admit H&P note.
Social History		
<ul> <li><u>Adding Social History</u></li> <li>1. On the Admit workflow, click</li> <li>2. Click the Social History tab.</li> <li>3. Click the blue plus sign next</li> <li>4. Categories are displayed procession</li> </ul>	the Histories hea to Add.	ader. <u>Histories</u>
<ul> <li>in blue rows. Click the plus sign next to the category to expand.</li> <li>5. Check the box, click the circle or free text next the appropriate options to enter required details.</li> <li>6. Scroll down to complete all appropriate sections.</li> <li>7. When finished, click OK at bottom of screen.</li> </ul>	Exercise  Home/Environment  Lives with:  Living situation:  Home equipment:  Alcohol abuse in household:	Alone Siblings Agency(s)/Others notified: Yes Children Significant other Yather Spouse Mother Other: Agencies notified: Free text boxed CPAP/BPAP Respiratory treatments Elevator Special bed Feeding tube Gucose monitoring Waker/Cane Verhiator Other: No Succose monitoring Waker/Cane Veter Concern for family members at home: Yes Oxygen Other: No Veter Other: No
The information is displayed on the Social History tab within Histories.	Procedure Social History Family H Mark all as Reviewed Social Add Modify Display: Category Abbreviated/Brief Social Hx: House Environment House Environment Employment/School Exercise Nutrition/Health Substance Abuse Tobacco	All
<ul> <li><u>Modifying Social History</u></li> <li>1. Click the category row in the</li> <li>2. Right click and select Modify</li> <li>3. Make modifications you war boxes in the form.</li> <li>4. Click OK.</li> <li><u>Removing Social History</u></li> <li>1. Click the category row in the window.</li> </ul>	e Social History wi y ht using the e Social History	▼       Indow.       House Environment       Employment/School       Exercise       Nutrition/Health       Substance Abuse       Tobacco       Sexual       Other
2. Right click and select Remo	ve	
On the Admit Workflow, the information is displayed on the Social History tab of the Histories component.	Histories Procedure History (0 Category	Family History (0)       Social (3)       Pregnancy (0)         Details       Lives with: Father       Lives with: Siblings       Lives In Split level home
Hover over an item for details.	House Environment Nurtition/Health	Concerns about house/environment No Recent travel No Pets at home Cat Type of diet: Breast

L



Far	nily Histo	ry									
1.	On the Ad	nit workflow,	click the Hi	stories hea	ader.						
2. 3	Use the ch	eck boxes to	indicate if f	amily histo	orv is Neo	ative	Unknow	n Unable	e to Obtain or l	Patient Adopte	be
0.	Family			anny mote		uuve,	Children				1
	🕂 Add	Modify	Display: Family M	lember View (Posit	tive Only)	•	Negative	🔲 Unknown	🔲 Unable to Obtain	Patient Adopted	
4.	To add far	nily history, cl	ick the blue	e plus sign	next to A	dd.					
		Procedure Social	I History Family His	tory							
		Add Family History									
		Last Update: 08/21	1/2015 12:23 by Waltor	), Lisa L. 📃 Focus M	ode				<ul> <li>Add Family Member</li> </ul>	5b	
Rel	ationships	-		<ul> <li>Relationship</li> </ul>	Father I	<b>Nother</b>	Brother	Sister		<u> </u>	
				Name H. Health Status	ANDOFF1, HAN	IDOFF1,	-	-		=	
		🛛 QuickList		9							
		🖯 Behavioral		۹,							
		Alcoholism Drug abuse		-							
		Drug addictio	on	-							
	onditions -	Eating disord	ler	-							
		Suicidal beha	avior	-							
		🖯 Cardiovascul	lar	۹,			·				
		Aortic valve	disorder	-							
		Cardiovascul	lar disease	-						•	
		✓ Add Gr	roup						OK Cance		
5	Relationsh	ins are displa	wed in colu	mns							
0.	a. To remo	ve a relation	ship, right c	lick on the	blue rela	tionsh	ip and se	elect Ren	nove.		
	b To add	a family mem	ber click A	dd Family	Member						
	Select t	he relationshi	p to add. If	t will displa	iv as a ne	w colu	ımn.				
	c. To add	details for a r	elationship.	click on it	. Add	🔳 Updat	e Family Member - Fat	her		×	
	Name a	nd Birthdate.	You can al	so indicate	e if this	First Name	2	Last Name:	Sex:	Birth: Date	
	family n	nember is dec	ceased. The	e name wil	l display	Decea	sed	Age at Death:	Age Cause of De	• * /** /** * *	
	below th	ne relationshi	р.					0	•		]
										OK Cancel	
6.	Conditions	are displayed	d in rows, o	rganized b	by catego	ry.					
	a. Quick L	<b>.ist</b> allows yo	u to group f	together va	arious cor	ndition	s that are	e commo	n– your freque	ent diagnosis fo	or
	example	<b>)</b> .									
	• 10	add condition	ns under Qu	IICK LISt, Cl	ick the m	agnity	ing glass		st		
	• IN6	e list of condit	tions are dis	splayed in	aipnabeti	cal or	ler. Seretek l	Ded			
	• LOC			condition		lo ine -	Scratch	Pau.			
	• VVI	en you nave		ndor the (	S, CIICK UI	∧. ∽ataa	00/				
	• 110		vili uispiay t			caley	Ory.				
	b. Catego	ies can be or	pened/close	ed by clicki	na the +/·	- next t	to the na	me.			
	Need to	add another	condition u	nder a cat	egorv?						
	Clic	k the magnif	ying glass r	next to the	category	name					
	• On	the Condition	n Search wi	ndow, type	e the con	dition r	name in t	the Searc	ch field.		
	• Do	uble click the	condition o	n the Resi	ult List.						

Click OK.



## **Family History**

### Adding Family History

To add history for family members:

- 1. Mark as Negative:
  - a. If a condition is negative for all family members, click the minus sign (-) in the column to the right of the condition. A minus sign will appear for each family member.
  - b. To mark a condition as Negative for an individual family member, find the condition row, and under the Family member column, click the Negative (or white) column. The system adds a minus (-) sign.
- 2. Mark as Positive:
  - a. To mark as Positive, find the condition row, and under the Family Member, click the Positive (or blue) column. The system adds a plus (+) sign. *Note: if a condition is marked as positive, the condition changes to bold.*
  - b. Double click the + sign to add as many details as you have information for.

	Relationship	Father		
	Name			
	Health Status		•	
🛛 Cardiovascular	۹			44
Aortic valve disorder	-	- 🗲		1D
Cardiovascular disease	-			
Chest pain	-	-		22
Deep vein thrombosis	-	-	F	20
Acute deep venous thrombosis	-	-	+	3e

Clear

Behavioral

Alcoholism

### 3. Add secondary conditions:

- a. Click on the plus sign for a condition.
- b. On the Update Family Member window, to view/select secondary conditions for the primary condition, click **Show Conditional Details**.
- c. Select the condition(s).
- d. Click OK.
- e. On the Family History tab, the secondary condition is displayed under the primary condition. Mark as positive.
- f. To remove the secondary condition, right click it and select Remove.
- 4. To mark the entire history for an individual family member as Unknown or Negative, select it from the Health Status dropdown under the relationship.
   5. To remove a mark, right click on the minus or plus sign and select Clear.
- 5. To remove a mark, right click on the minus or plus sign and select Clear.
- 6. When finished documenting history, click **OK** at bottom of screen.

The information is displayed on the Family History tab	Procedure Social History Family History Mark all as Reviewed								
within Historias	- Family								
within thistories.	🕂 Add 🗹 Modify Dis	play: Condition View	•		Negative	Unknown Unable to 01	btain 📃 Patient Adopted		
	Last Update: 08/21/2015 12:23 by Wal	lton, Lisa L.							
	Condition A	Age of Onset	Last Reviewed	Course	Life Cycle	Severity			
	ADD - Attention deficit disorder								
	Brother		08/21/2015						
	Alcoholism		00/21/2010						
	Father		08/21/2015						
	Emotional problems								
	5.4		00.001.00015						

Change the way the information is displayed by selecting the view.

- Condition View: organized by condition with positive family members listed below
- **Family Member View (All):** organized by Family Member and Positive/Negative documented conditions.
- **Family Member View (Pos):** organized by Family Member with only Positive documented conditions.

Display:	Condition View
	Condition View
Walton, Li	Family Member View (All)
	Family Member View (Positive Only)



## **Family History**

On the Admit Workflow, the information is displayed on the Family History tab of the Histories component. Change the way the information is displayed by clicking the menu and selecting the view.

Histories				All Visits  2		
ſ			~	Condition View		
Social History (2)	Family History (4)	Procedure	e History (0)	Family Member Vi	iew	
Condition		Family Me	ember			
⊿ Behavioral					Condition	/iew
Alcoholism		Father				
Emotional problems		Father				
▲ Endocrine/Metabolic						
Thyroid disorder		Mother				
⊿ Neurologic						
ADD - Attention deficit	disorder	Brother				
Histories						
Thistories						
Social History (2	) Family History	(4)	Procedure Histo	ory (0) (0)	Family Men	nber View
Family Member			Condition			
Brother			ADD - Attentior	n deficit disorder		
Father			Alcoholism E	Emotional probler	ms	
Mother			Thyroid disorde	er		
<ul> <li>wing/Modifying Family make any changes to a. If history exists ar</li> <li>b. Right click on a ro c. Click Add to add in d. When finished, cli</li> </ul>	I <u>y History</u> Family History, clio nd there are no cha ow and select Modi new information. ick OK at bottom of	ck the H inges aff fy Famil f screen	istories heade ter reviewing, y History to ch	er. Then click th click Mark All a nange existing	e Family History as Reviewed. information.	tab.
Procedure Social History Family History						
Mark all as Reviewed						
Family 🕂 Add 🗹 Modify Display:	Condition View	•		Negative	Unknown Unable to Obtain	in 🔲 Patient Adopted
Last Update: 08/21/2015 12:23 by Walton, Lis	a L.					
Condition Age	of Onset 🛄 Last Revi	ewed	Course	Life Cycle	Severity	
Brother Alcoholism	08/21/20	115				
<b>F</b> 4						
Emotional problems	08/21/20	15				
Father Emotional problems Father Thyroid disorder	08/21/20	115				



# Pediatric History and Physical Note Template

- 1. After documenting on the Admit workflow, click Create Note.
- 2. The New Note screen opens.
- 3. From the Type dropdown, select **H&P**.
- 4. Verify the Date and Time matches your Date and Time of Service (you may backdate if making a late entry).
- 5. Under Note Templates, click **Peds H&P**.
  - Favorites: It is recommended to make this a favorite. Click the star next to the template name. The template will be added to the Favorites folder. On future note creation, click on the Favorites tab to select the Peds H&P.

#### 6. Click **OK** .

New Note X List					4 ۵
Note Type List Filter:			All (54) Favorites (1)	Q Search	
*Type:	•	Note T	emplates		_
H&P V		<u> </u>	Name +	Description	<u> </u>
Title:			OB Triage H&P	OB Trage H&P	
Peds H&P		- 92	Pediatrics Progress Note	Pediatrics Progress Note	
*5.4		*	Peds H&P	Peds H&P	
Date: 09/03/2015		*	Procedure Note	Procedure Note	
			Procedure Note Bedside	Procedure Note Freetext	
*Author:	•	*	Progress Note Basic	Daily Progress Note Basic	
waiton, Lisa L.	•		Progress Note	Blank Progress Note	
		×	Progress Note Hospitalist	Hospitalist Progress Note	
			Progress Note I&O	Progress Note I&O	
		*	Progress Note I&O Med List	Progress I&O and Med List	E
			Progress Note ICU	Progress Note ICU	
		×	Progress Note Med List	Progress Note with Medication List	
			Progress Note Nephrology	Progress Note Nephrology	
		*	Progress Note Ortho	Ortho Progress Note	
			Progress Note Post Surgical	Post Surgical Progress Note	
		4	Dragrass Note Phaymotology	Dragress Note Decumentalizary	-
				OK Cancel	

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Tahoma       Size       Image: Size       Size       Image: Size       Image: Si	
Pediatric History and Physical         DOB 06/01/2015 FIN 3800108094 MRN 2800105607 Location C4A/4A13/A       8       Problem List/Past Medical History         Og/03/2015 09:42       Orgoing No chronic problems Historical No qualifying data       9       Perinatal History         Chief Complaint Newborn, Vag Del 37+ Week Gest. GBS Neg, 4 lbs 14.99 oz Image       9       Perinatal History         Historian: [Name & Relationship to Patient]       10       Procedure/Surgical History	
DDB 06/01/2015 FIN 3800108094 MRN 2800105607 Location C4A/4A13/A       8       Problem List/Past Medical History         09/03/2015       Ongoing       No chronic problems         09/03/2015       No qualifying data         Chief Complaint C C C C       9         Newborn, Vag Del 37+ Week Gest. GBS Neg, 4 lbs 14.99 oz C       9         Historical       No qualifying data         Historian: [Name & Relationship to Patient]       10	
Date and Time of Service       8       Problem List/Past Medical History         09/03/2015       Orgoing       No dynamic         09:42       No qualifying data         Chief Complaint       9       Perinatal History         Newborn, Vag Del 37+ Week Gest. GBS Neg, 4 lbs 14.99 oz X       9       Perinatal History         Historian: [Name & Relationship to Patient]       10       Procedure/Surgical History	
Chief Complaint       Chief Complaint       Perinatal History         Newborn, Vag Del 37+ Week Gest. GBS Neg, 4 lbs 14.99 oz       9         History of Present Illness       9         Historian: [Name & Relationship to Patient]       10         Procedure/Surgical History	
History of Present Illness Historian: [Name & Relationship to Patient] 10 Procedure/Surgical History	
Historian: [Name & Relationship to Patient]  10  Procedure/Surgical History	
11 Home Medications No qualifying data available	
Review of Systems Constitutional: no fever/chills, no diaphoresis, no weakness, no recent illness Eyes/ENT: no vision problems, no sore throat Cardiovascular: no chest pain, no papitations	
Respiratory: no shortness of breath, no cough       13       Social History         GI/GU: no abdominal pain, no nausea, no vomiting, no diarrhea, no black stools, no problems urinating       13       Social History         Musculoskeletal/Skin/Lymph: no myalgias, no arthraigias, no rashes, no gland swelling       Family History       Family History	
Physical Exam Drug abuse: Mother. Drug addiction: Mother (Dx at 18).	
Vitals with Min/Max     15       T:37.3(Oral) HR:140 RR:66     15	
No results found	
Chaperone: [Name & Relationship to Patient]         H&H Only         06/24/15           HGB         12.0 G/DL HCT         35.0 %	12:08
BUN         06/22/15           General: comfortable, alert, well-hydrated         BUN         66 mg/dL           Head: normocephalic, anterior fontanelle open/soft         Creatinine Blood Level         06/22/15:           Eyes/Ears/Nose/Throat: tympanic membranes normal, oropharynx clear         CRT         3.50 mg/dL           Neck: supple. no hymphadenopathy         CRT         3.50 mg/dL	13:26 13:26
Cardiac: regular rate/rhythm, no murmurs, well perfused Lungs: clear to auscultation, no wheezes/rales/rhonchi Abdomen: soft, non-tender, non-distended, no masses, no organomegaly, normal bowel sounds Genitourinary: normal external genitalia Extremities: no cyanosis/clubbing/edema Neurologic: no focal deficits, motor/sensation intact, normal tone, brisk tendon reflexes	
Assessment/Plan	
Neonatal withdrawal symptoms from maternal use of drugs of addiction Continue medications and monitor	
ote Details: H&P, Walton, Lisa L, 09/03/2015 09:42, Peds H&P	& Close

- 1. Patient Demographics DOB, FIN, MRN, Location
- 2. Date and Time of Service when the note is created.
- 3. Chief Complaint pulls in from Workflow, but there is a free text section under it here to provide additional information.
- 4. **History of Present Illness:** Pulls in HPI documentation from Workflow; includes Historian and Interpretation/ Interpreter information; can free-text.
- 5. Review of Systems: Pulls in ROS documentation from Workflow; can free text
- 6. **Physical Exam:** Includes: Vitals and Measurements, Ht., Wt., BMI if > 1 yr old, option to document patient Chaperone, Pulls in PE documentation from Workflow
- 7. Assessment/Plan: Pulls in the selected problems and documentation from the Assessment/Plan on workflow.
- Problem List/ Past Medical History: Pulls in documented Ongoing (Chronic) Problems and Historical (past visit) problems.
   Perinatal History: If less than 1 year, pulls in Delivery info, complications, Premature at X weeks.
- 10. **Procedure/ Surgical History:** Pulls in documented procedures or surgeries
- 11. Home Medications: Pulls in documented Home Medications.
- 12. Allergies: Pulls in documented Allergies
- 13. Social History: Pulls in Social History documented using Social History tab.
- 14. Family History: Pulls in Family History documented using Family History tab.
- 15. Immunizations: Free-text
- 16. Lab results: Displays Labs for the last 24 hours across encounters, displays fishbone labs and Bili trend for the last 7 days across encounters.
- 17. Diagnostics: Free-text

In free text sections, you can type, dictate with Dragon microphone, use auto-text, or use Dragon commands.