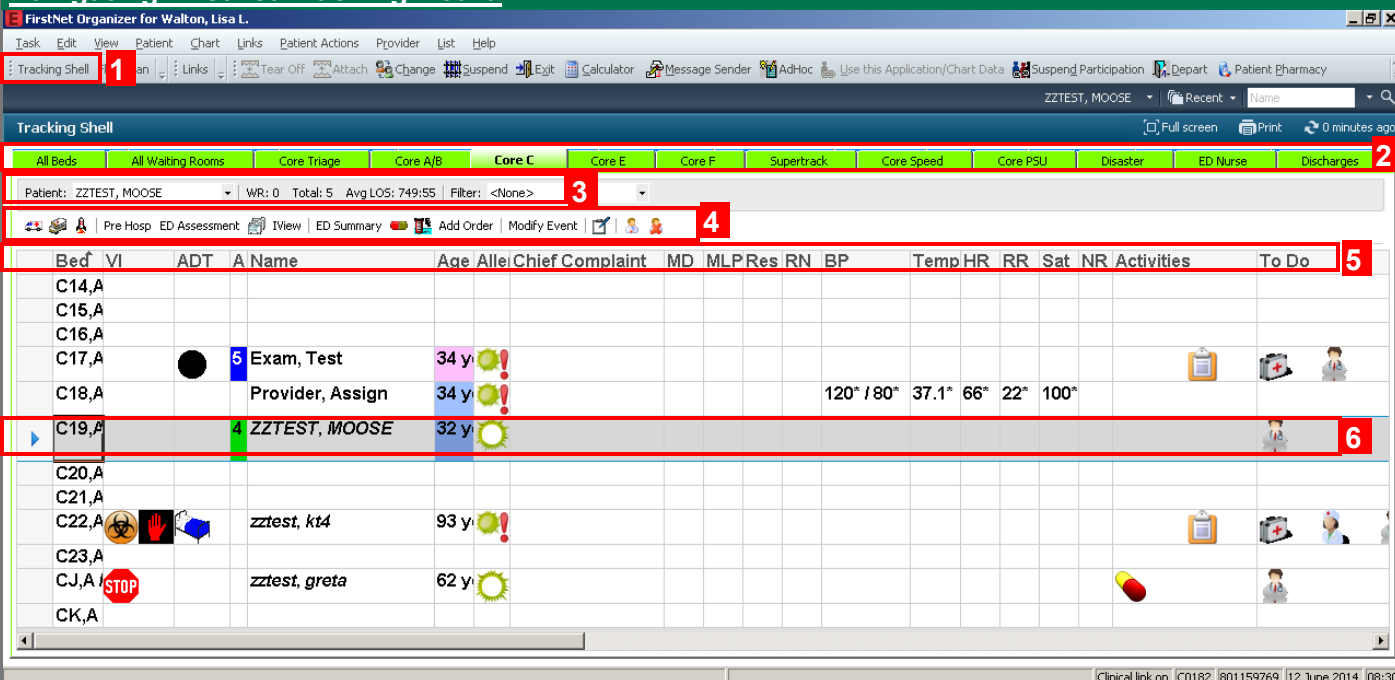


## What is FirstNet?

A monitoring and tracking system that serves as the hub of all patient activity and is key to improving patient throughput.

## Navigating FirstNet Tracking Board



### 1. Organizer Toolbar: Two new buttons:

- **Tracking Shell:** Opens the Tracking Board

### 2. Tracking List Tabs: Based on your current location, you will only see tabs for that location. Click on different tabs to view different groups of patients.

### 3. Metrics:

- **Patient:** Name of patient the user currently has selected.
- **WR:** Number of patients in waiting room
- **Total:** Total Number of patients checked in
- **Avg LOS:** Average length of stay for the total number of patients.
- **Pre-configured filters:** Use to view only your assigned patients. Sets back to the default option when you log out.

### 4. FirstNet Toolbar: Most common functions can be performed by selecting a patient from the Tracking List (left-clicking their name) and clicking the appropriate button from this toolbar.

### 5. Tracking List Columns: Specific columns on the Tracking List to display tasks, activities and relevant information for providers. Click on the column heading to sort the board by that column.

### 6. Rows: Each row represents a room and once a patient is assigned to that room, relevant patient information is displayed.

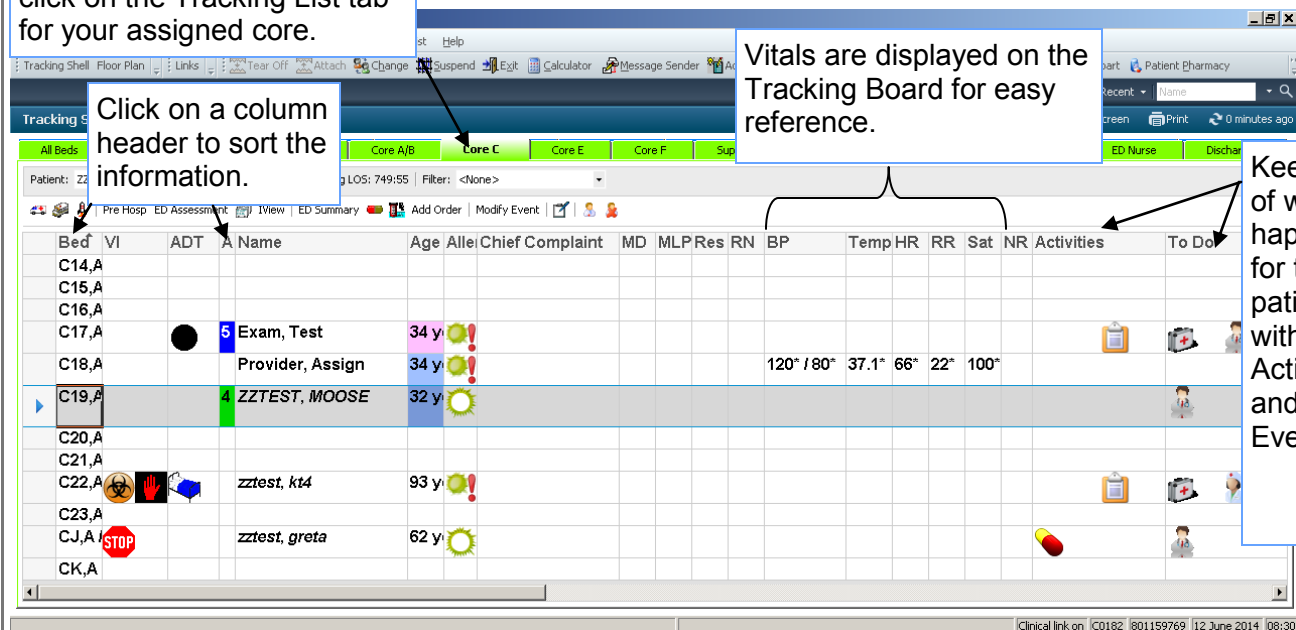
## Tracking Board

Track patients by location; click on the Tracking List tab for your assigned core.

Click on a column header to sort the information.

Vitals are displayed on the Tracking Board for easy reference.










Keep track of what's happening for the patient with Activities and Events.







## Tracking Columns

Bed	Bed Assignment	Events	Tasks to be completed for this patient
Sign	Indicates the status of provider documentation	Temp	Vitals: Temperature
Name	Patient's name	BP	Vitals: Blood pressure
Age	Patient's age and sex (blue for male, pink for female)	HR	Vitals: Heart Rate
A	Allergies	RR	Vitals: Respiratory Rate
Reason for Visit	Patient stated reason for visit	Sat	Vitals: O <sub>2</sub> saturation
Comments	Comments section	NR	Nurse Review
DR	Assigned MD	Meds	Number of meds
NP	Assigned NP	Lab	Number of labs ordered / completed
PA	Assigned PA	Rad	Number of rads ordered / completed
RN	Assigned RN	EKG	EKG status
MA	Assigned MA	LOS (Room)	How long patient has been in room
Tech	Assigned Nurse Tech	PCP	Patient's PCP
Activities	Documentation required for patient	Attending Phys	Name of Attending added in Soarian

## FirstNet Toolbar

	Pre-Arrive Patient	Opens the Pre-arrival window to pre-arrive a patient in the system
	Pre-Arrival Actions	Used to attach a Pre-Arrival to a patient
	Downtime Registration	Used to register patients in the event of a downtime
	Medication List	Open the Medication List tab of the patient's chart
	MAR	Opens FirstNet in the MAR Summary view
Add Order	Add Order	Opens the Add order window, which you can use to add an order to a patient
<b>MAU Workflow</b>	MAU Workflow	Opens the ED Summary window, which give you a quick overview of documented information
Modify Event	Modify event	Allows you to modify an order or task that need to be completed in the ED
Depart	Discharge Process	Opens the Depart Process dialog box
	Assign Provider	Assigns yourself to the selected patient based on your provider role
	Unassign Provider	Unassign yourself from the selected patient
	Provider Check in	Checks a provider in to the system if the automatic check in does not work
	Provider Checkout	Checks a provider out of the system and allows them to reassign patients to a different provider

## Sign

	No Documentation Started
	Two Document Tracking (Attending/Resident)
	Document created and saved, but not signed
	Document signed (Auth verified)

## Activities

Activities are items which require documentation.

When an activity is due for a patient, the system displays a notification icon in the **Activities** column.

Icon Name	Icon
Medications	
Patient Care	
Assessment	
Other	

Double-click the icon to open the Document Activities dialog box.


















## Events

Events are time-stamped activities that occur during a patient's visit, used to communicate the status of the activities for a patient.

Events are depicted with icons and are visible in the columns on each tracking list.


On the Tracking Board, hover over the event to see what the icon represents.

To Do	To Do (Tech)	Orders	Med Lab	Rad	EKG S
			2	2/0	2/0/0
Time 06/17/2014 13:11	Event Document Home Meds	Status Request	Duration(HH:MM) 24:11	User SYSTEM, SYSTEM	

Events Column						NR Column		Allergies Column	
	MAU Intake		POC Urine		EKG		Nurse Review		No Allergy information documented
	Vitals		POC HCG		Oxygen Admin				No Known Allergies
	Dr Exam		Urine Collect		Pulse Ox Check				Known Allergies
	Specimen Collect		POC Blood						No Known Medication Allergies
						Labs Column			
							Labs Completed		


## Provider Check-in

These settings should only have to be configured the first time you check-in.


1. Click the **Provider Check-in** icon. 
2. In the Provider Check in window, your name appears as Provider.
3. In the Provider Role box, select from the dropdown: **MAU Doctor**.
4. In the Default Relation box, select from the dropdown: **Doctor**
5. Select a color. This is identify you on the Tracking Board.
6. Ensure the Available Provider and Available Reviewer boxes are checked.
7. Click **OK** to complete the check in process.

The screenshot shows the 'Provider Checkin' dialog box. It contains fields for 'Provider' (Walton, Lisa L.), 'Display Name' (LW), and 'Provider Role' (ED Provider). There are also fields for 'Default Location', 'Default Relation' (Emergency Physician), and 'Provider Comment'. A checkbox for 'Associated Provider Color' is checked, with a green color swatch. Below these are sections for 'Available Teams', 'Assigned Teams', and 'Assigned Team Locations'. At the bottom, there are checkboxes for 'Available Provider' and 'Available Reviewer', both of which are checked. The 'OK' button is highlighted with a red box and the number 7.

## Assigning Patients

1. Highlight a patient on the Tracking Board.
2. From the First Net toolbar, click the Assign Provider button. 
3. You are now assigned to the patient based on the provider role you selected when you checked in to FirstNet. You'll see your name in the RN column.

## Unassigning Patients

1. Highlight a patient on the Tracking Board.
2. From the First Net toolbar, click the Unassign Provider button. 
3. The patient is now available for another provider.

## Room the patient

Select the exam room to which you are taking the patient.

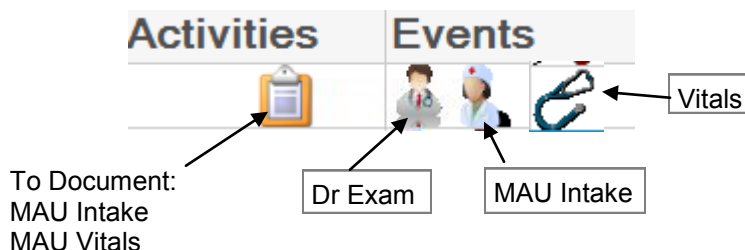
1. Double click on the WR in the Bed column next to the patient name.
2. In the Select a Location window, **double click the exam room** in which you want to move the patient.
3. Click **OK**.
4. The patient's location under the bed column will display the Exam room you selected.



The screenshot shows a window titled 'Select a location for ZZTRAIN, MADDY'. It contains a list of exam rooms: Exam 1, A (0), Exam 2, A (0), Exam 3, A (0), Exam 4, A (0), Exam 5, A (0), Exam 6, A (0), Exam 7, A (0), Exam 8, A (0), Exam 9, A (0), Exam 10, A (0), Trauma, A (0), and WR (4). The 'WR (4)' option is selected. At the bottom are 'OK' and 'Cancel' buttons.

## Intake Documentation

After the patient is registered, Events and Tasks automatically fire in FirstNet under the Activities and Events columns.



1. Double-click the Assessments (clipboard) icon in a patient's Activities column.

2. MAU Intake and MAU Vitals Assessments are listed. Check the box(es) next to the assessment you want to complete and select **Document**.

Document Activities

ZZTRAIN, MADDY Age:58 years DOB:03/01/1958 MRN:2800109416 Patient Portal: No \*\* Allergies Not R...  
Pref Lang: English Type:Urgent Care 3800113966 Loc:MAU STAR Weight:

Refresh

Medications (0)

Patient Care (0)

Assessments (2)

Other (0)

Medications (0)

Patient Care (0)

Assessments (2)

MAU Vitals  
09/18/2016 13:24, Order placed due to patient arrival to the Medical Aid Unit; Vital Signs - MAU

MAU Intake  
09/18/2016 13:24, Order placed due to patient arrival to the Medical Aid Unit; MAU Intake

Other (0)

Show completed tasks

Not Done Document Cancel

3. The Triage & Arrival Information Power Form will open. When complete, click **Sign Form**. After the assessment is signed, other tasks/events begin to appear on the Tracking Board.

## Sections of the Intake form

There are two pages to the Form: MAU Intake and Home Medications (see the left menu).

If the patient has been seen at other CCHS location, some documented information may pull forward. Enter any known or required (in yellow) information in each part of the form.

Use the scroll bar on the right to move down the form.

- **Presenting Complaint:** will fill in from Soarian's reason for visit
- **Presenting History of Present Illness:** Free text the patient's description of present illness  
\*REQUIRED\*
- **New vs Established-** Use the answer on the New vs Established patient form provided by the front desk and make the appropriate selection here. \*REQUIRED\*
- **Pain:** Indicate the Pain Scale Used, type the Pain Level, identify the Pain Location, Laterality, Quality, Radiates and Radiation
- **Allergies:**



- If patient does not have any allergies, click No Known Allergies. Then click OK on the next screen.
- If patient has No Known Medication allergies, click No Known Medication Allergies The click OK on the next screen.
- If allergies are documented, review with the patient. If there are no changes, Click Mark All as Reviewed.
- If patient does not have allergies documented, click the Add button.
  1. In the Search field, type the name of the allergy (example peanut) and click Search (or Press Enter)
  2. Choose from the displayed list by double clicking the name or highlighting it once and pressing Select.
  3. The name will appear under Substance.
  4. From the Category dropdown, select the category of allergy.
  5. Under Reaction Type, Allergy will default, but you can choose from anything on the list as appropriate (example, intolerance, Side Effect.).
  6. To enter a reaction symptom under Reaction symptoms, click in the field under Add Free text and move back to the Search field on the left and type an reaction (example, hives). Double click the symptom. It moves under Reaction symptoms
  7. Under Allergy details, you can add a severity by choosing from the dropdown.
  8. Under Comments, you can add additional information about this allergy.
  9. Click OK if you are only adding one allergy.
  10. Click New.. if you are adding additional allergies, then repeat process.

## Sections of the Intake form (continued)

- Past Medical History:** A quick pick of common problems is listed (in yellow) and one must be selected to complete this form.

- If conditions are listed under Problems, review the list with the patient. If there are no changes, select check the box next to Problem list Reviewed & Up to Date.
- If no conditions are listed, check the box next to any of the appropriate problems on the quick pick list.
- If the problem is not on the quick pick list, click the blue plus sign next to Add under Problems.
  - Type the problem in the yellow field. Click the binoculars to search.
  - A list of possible matches appear in the Problem Search window. Select from the list. Click OK to close the search window..
  - Click OK to save the problem, or click OK & New to save the problem and add another.

- Alternatively, you can click the Folders button to see a quick list of problems categorized by system. Double click to add it, then click OK.



## Sections of the Intake form (continued)

- **Past Surgical History:** Review the list with the patient and Mark all as Reviewed if correct.
  - If the list needs to be updated or no procedures are listed, click the blue plus sign to add.
    1. Type the procedure in the yellow field. Click the binoculars to search.
    2. A list of possible matches appear in the Procedure Search window. Select from the list. Click OK.
    3. Add additional information such as the date of the procedure, or the age at which it was performed and any comments.
    4. Click OK.
    5. Alternatively, you can click the Folders button to see a quick list of procedures categorized by system. Double click to add it, then click OK.

**Past Surgical Procedures**

Procedure	Laterality	Procedure Date	Location	Last Reviewed	Code

**\*Procedure**  ☐ Free Text

Laterality:  Provider:  ☐ Free Text

Display As:  At: Age  Date  Comments:

Location:  ☐ Free Text

OK OK & Add New Cancel

Up Home Favorites **Folders** Folder: Folders

- **Social History:** Tobacco Use documentation is required. Click the circle next to the appropriate option. Then complete any other information.

**Social History**

<b>Ever Used Tobacco</b> <ul style="list-style-type: none"> <li><input type="radio"/> Current Every Day Smoker</li> <li><input type="radio"/> Current Some Day Smoker</li> <li><input type="radio"/> Smoker, Current Status Unknown</li> <li><input type="radio"/> Former Smoker</li> <li><input type="radio"/> Never Smoker</li> <li><input type="radio"/> Unknown if Ever Smoked</li> <li><input type="radio"/> Heavy Tobacco Smoker</li> <li><input type="radio"/> Light Tobacco Smoker</li> </ul>	<b>Tobacco Frequency</b> <ul style="list-style-type: none"> <li><input type="radio"/> &lt; 0.5 pack/day</li> <li><input type="radio"/> 0.5 pack/day</li> <li><input type="radio"/> 1 pack/day</li> <li><input type="radio"/> 1.5 packs/day</li> <li><input type="radio"/> 2 packs/day</li> <li><input type="radio"/> 2.5 packs/day</li> <li><input type="radio"/> 3 packs/day</li> <li><input type="radio"/> &gt; 3 packs/day</li> <li><input type="radio"/> Other:</li> </ul>	
<b>Alcohol Frequency</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Occasional</li> <li><input type="checkbox"/> Moderate</li> <li><input type="checkbox"/> Heavy</li> <li><input type="checkbox"/> Weekends Only</li> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Other:</li> </ul>	<b>Drug Use</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Never</li> <li><input type="checkbox"/> Quit</li> <li><input type="checkbox"/> Cocaine</li> <li><input type="checkbox"/> Heroin</li> <li><input type="checkbox"/> Marijuana</li> <li><input type="checkbox"/> Methamphetamines</li> <li><input type="checkbox"/> Prescription drug</li> <li><input type="checkbox"/> Other:</li> </ul>	<b>Drug Frequency</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Occasional</li> <li><input type="checkbox"/> Moderate</li> <li><input type="checkbox"/> Heavy</li> <li><input type="checkbox"/> Weekends Only</li> <li><input type="checkbox"/> Other:</li> </ul>

## Sections of the Intake form (continued)

- Family History:** Check the boxes next to any of the appropriate issues from this Quick Pick list.

Family History							
<input type="checkbox"/> AAA	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cerebral Aneurysm	<input type="checkbox"/> DVT	<input type="checkbox"/> MI - Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other:	
<input type="checkbox"/> Aortic dissection	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> PE	<input type="checkbox"/> Non contributory		

- Pregnancy:** If the patient is pregnant, indicate that here, as well as the LMP.

Pregnancy	
<b>LMP</b> <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="radio"/> Unknown <input type="radio"/> Hysterectomy <input type="radio"/> Other:	<b>Pregnant?</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure

- Depression screening:** **\*\*REQUIRED\*\*** The answers you input will calculate a score for Initial Depression Screening Score. If higher than X, a task will fire for the provider to complete the PHQ9 assessment.

Depression Screening		
How often have you been bothered by the below symptoms over the last two weeks?		
<b>Little Interest, Pleasure in Activities</b> <input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half the days <input type="radio"/> Nearly every day	<b>Feeling Down, Depressed, Hopeless</b> <input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half the days <input type="radio"/> Nearly every day	<b>Initial Depression Screening Score</b> <input type="text"/>

- Public Health Screening:** **\*\*REQUIRED\*\*** Ask the question about travel and document the answer.

Public Health Screening	
Has the patient traveled or been in contact with anyone who has traveled in the past 21 days to a country that has an identified emerging infectious disease?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to obtain

## Sections of the Intake form (continued)

Click the **Home Medications** band on the left navigation menu of the form. The Medication List on the patient's chart opens.

To document the home medication, click **Document Medication by Hx**.

- On the tool bar, click the **Patient Pharmacy** button.

1

+ Add | External Rx History | Rx Plans (0): Error | Patient Pharmacy

Medication History

☐ No Known Home Medications ☐ Unable To Obtain Information

- If the pharmacy has been identified, it will be listed on the Patient Preferred tab.
- If it needs to be changed, right click on the Pharmacy name and select remove.
- If there is no Pharmacy on file, the window default to the Search tab.
  - Move to the Search tab.
  - In the Search field, type the name of the Pharmacy.
  - Type in a City, State and/or zip code. Then click Search.
  - Right click on the correct Pharmacy and select **Add to Patient Preferred**.
  - The pharmacy will now appear on the Patient Preferred tab.
  - Click Close.

**Patient Preferred Pharmacies**

**ZZTRAIN, MADDY** Age: 58 years DOB: 03/01/1958 MRN: 2800109416 Patient Portal: No \*\* Allergies Not Rec...  
 Pref Lang: English Type: Urgent Care 3800113966 Loc: MAU STAR Weight:

The default pharmacy is displayed in the Patient Preferred tab with bold text.

**Patient Preferred** Search

Pharmacy Name	Address	Cross-Street	City	State	Zip Code
<b>CVS Pharmacy # 3738</b>	4298 HIGHWAY 1		REHOBOT...	DE	19971

Pharmacy Name: cvs  
 Address:  
 City:  
 State: DE  
 Zip Code:  
 Phone:

Pharmacy Type: ☒ Retail ☐ Mail Order ☐ Specialty ☐ 24-hour ☐ Long-term Care

Search

☐ Remember search options

Close

- If no Home Medications are listed and the patient is not taking any medications, you can click **No Known Home Medications** under Medication History in the toolbar. If the patient is unable to verify information with you, you could click **Unable to obtain**.

2





+ Add | External Rx History | Rx Plans (0): Error | Patient Pharmacy

Medication History

☐ No Known Home Medications ☐ Unable To Obtain Information

## Sections of the Intake form (continued)

3. Ask the patient if it is okay to pull information from their pharmacy about any current prescriptions. In the toolbar, click **External Rx History**.

 Add | 
  External Rx History ▾ | 
 Rx Plans (0): Error ▾ | 
  Patient Pharmacy 
  Medication History 
 ☐ No Known Home Medications 
 ☐ Unable To Obtain Information






3

- a. From the dropdown, Click Import. Then click Consent Granted.
- b. This pulls in the external medications in a side by side view with current medications and allows you to convert an external med to a home med. You must review the lists with the patient or family.
- c. Use the side by side to verify the information with the patient or family. Start with what's documented. Identify anything in External Rx History that is not documented as a home medication, indicated by the orange burst icon. Hover over the medication for more information about it.

Document Medication by Hx

THOMAS, DOUGLAS Age: 75 years Gender: Male Type: Emergency [07/08/2015 11:25 - 07/08/2015 13:35] Allergies: No Known Allergies  
 DOB: 02/26/1940 Fin#: 3800108350 Loc: CED; MAIN MRN: 2800105793 Weight:





















UNIC+III code

+ Add | 
  External Rx History ▾ | 
 Rx Plans (0): In Process 
  Medication History 
 ☐ No Known Home Medications 
 ☐ Unable To Obtain Information 
 ☐ Use Last Compliance 
 Reconciliation Status: 
  Meds History 
  Admission 
  Discharge








**External Rx History**

Display: Last 24 Months ☒ Show Individual Instances Disclaimer: ⓘ

This Rx history contains prescription records provided by community pharmacies and pharmacy benefits managers (PBM's). Such Rx history may be incomplete and prescriber should not rely solely on this Rx history data to make any clinical decisions. It is the responsibility of the prescriber to validate and verify the information directly with the patient or via other appropriate means.

Order Name/Details	Last Fill	Add As
<b>Refresh to get latest external medication history</b>		
XARELTO 20mg TK 1 T PO D V Date Written: 06/10/2014 Quantity: 90 TAB Pharmacy: WALGREENS Prescriber: NOTTINGHAM, WILLIAM	10/16/2014	 
XARELTO	10/15/2014	 
AMLODIPINE BESYLATE 10MG TABLETS TK 1 T PO QD	09/17/2014	 
CLOPIDOGREL 75MG TABLETS TK 1 T PO QD	09/17/2014	 
FUROSEMIDE 40MG TABLETS TK 1 T PO D	09/17/2014	 
HYDRALAZINE 25MG TABLETS (ORANGE) TK 1 T PO BID	09/17/2014	 
PRAVASTATIN 40MG TABLETS TK 1 T PO QHS	09/17/2014	 
WARFARIN SOD 7.5MG TABLETS (YELLOW) TK 1 T PO D	09/17/2014	 
CLOPIDOGREL 75MG TABLETS TK 1 T PO D	08/06/2014	 
WARFARIN SOD 7.5MG TABLETS (YELLOW) TK 1 T PO QD	08/06/2014	 

**Document Medication by Hx**

Order Name/Details	Last Dose Date/Time	Information Source	Compl
Last Documented On 07/22/2015 09:01 (Walton, Lisa L.)			
<b>Home Medications</b>			
 clopidogrel (Plavix 75 mg oral tablet)			
 hydrALAZINE (hydrALAZINE.)			
 pravastatin (Pravachol 40 mg oral tablet)			
 FUROSemide (Lasix 40 mg oral tablet)			
 rivaroxaban (Xarelto 20 mg oral tablet)			
 aspirin (aspirin 81 mg oral tablet)			
 traMadol (traMADol 50 mg oral tablet)			

- d. Click the Add as scroll icon to convert the external med to the home med list. On the Order Sentence window, click None, then OK to bring over the med name. If you have additional details you can fill them in. The med will list as Pending Home Meds until you click the Document History button.
- e. On the right side of the screen, one of two icons will appear next to the medication.
  - Prescription icon: electronic prescription from previous encounter whether in ER or inpatient.
    - If patient is still taking, do nothing.
    - If finished the script, right click and select Complete.
  - Scroll icon: indicates a medication from previous history (not a prescription from a previous encounter).
    - If patient still taking but needs to change, choose Modify.
    - If not still taking, chose delete.

## Sections of the Intake form (continued)

4. To add new Home Medications, click the Add blue plus sign.

4

+ Add | External Rx History | Rx Plans (0): Error | Patient Pharmacy | Medication History | No Known Home Medications | Unable To Obtain Information

- A list of common medications will appear in alphabetical order. You can locate and select the medication from the list.
- For faster searching, in the Search field, type the name of the medication.
- Results should begin to display as you type.
- Click once on the Medication that most closely matches the information the patient gave you. (it is being added to the list behind this window.)
- Search for additional medications.
- Click Done.
- On the Pending Home Medication list, for each medication, review/complete the Dose, Route of Administration, Frequency. Click each field to make selections from pre-defined options.

Document Medication by Hx

Order Name	Status	Details	Last Dose Date/Time	Information Source	Compliance	Compliance Comments
Medication history has not yet been documented. Please document the medication history for this patient encounter.						
Pending Home Medications						
ibuprofen	Document	0 Refill(s)				

**Details for ibuprofen**

Details | Order Comments | Compliance

Dose	Route of Administration	Frequency	Duration	Dispense	Refill
					0

PRN:

Requested Refill Date:  09/18/2016

Start Date/Time:  1522

Stop Date/Time:

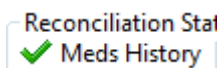
Special Instructions:


Type Of Therapy: ☐ Acute ☒ Maintenance


0 Missing Required Details

Leave Med History Incomplete - Finish Later | Document History | Cancel

- Click the Compliance tab for each medication to indicate the medication status, who supplied the information and the last dose date/ time.
- When finished, click **Document History** button.
- On the MAU Intake form, the medications are listed, and the Meds History Reconciliation Status icon changes to a green check mark to indicate complete.



- When complete, click the green check mark  in the upper left corner to sign the form.
- If only the MAU Intake Assessment was selected, you will return to the Document Activities window and see that the Assessment has been completed. Click Cancel to close the window.
- The clipboard under Activities will be removed, as well as the MAU intake icon from the Events column.

NOTE: If Home Medications need to be updated after completing the MAU Intake form, click the patient row and then the Medication List icon  in the toolbar on the Tracking Board. Then click Document Medication by Hx.

## Sections of the Vitals Form

### MAU Vitals

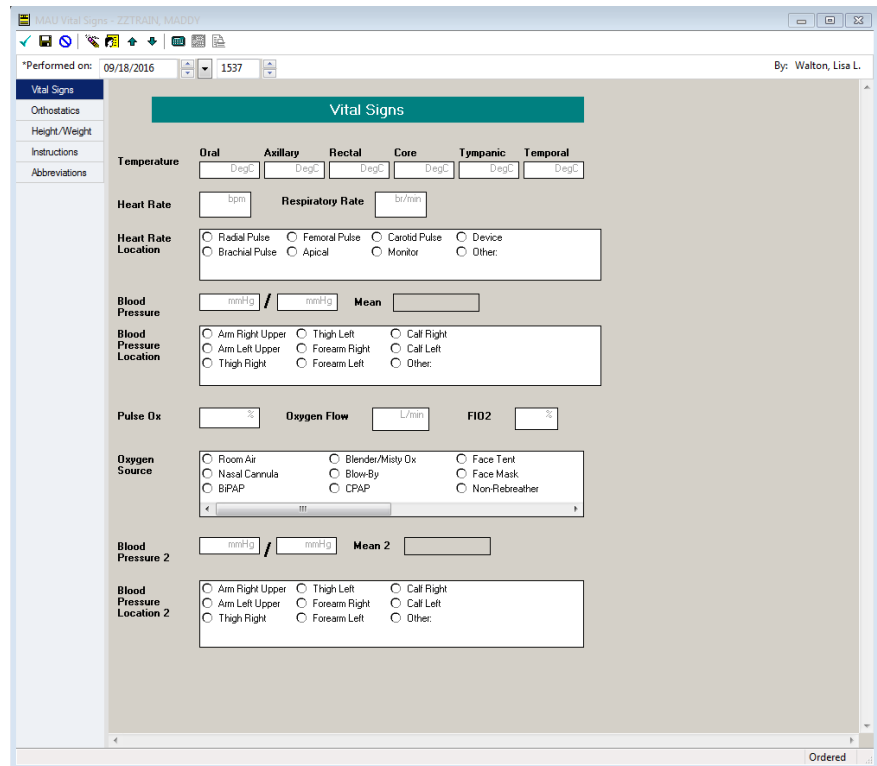
After checking the box and clicking Document, the Vital Signs PowerForm will open.

There are three pages on this form (see left menu):

- Vital Signs
- Orthostatics
- Height/Weight


1. On Vital Signs, document the vitals that you take.

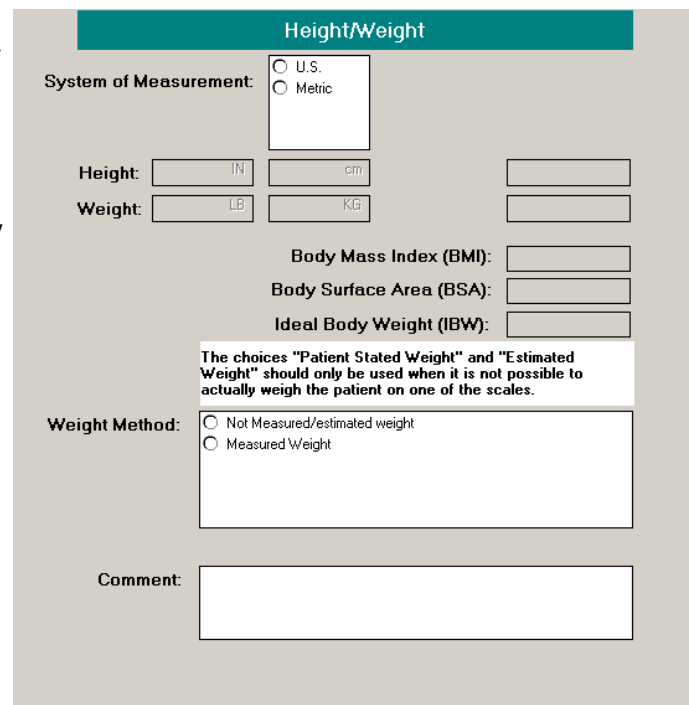
2. If you need to document Orthostatics vitals, click the Orthostatics navigation band on the menu on the left of the form.



3. To document Height/ Weight, click the Height/ Weight navigation band in the menu on the left of the form.

- Select the System of measurement: US or Metric.
- Type the Height and Weight in the correct units. The measurement will automatically convert to the other unit of measurement and will calculate BMI, BSA and IBW.
- Select the Weight Method.

5. When complete, click the green check mark  in the upper left corner to sign the form.
















- ◆ The assessments will be removed from the list on the Document Activities screen. Click Cancel to close the window.
- ◆ The clipboard under Activities will have dropped, as well as the Vitals icon from the Events column.
- ◆ Documented Vitals will be displayed under the Temp, BP, HR, SAT.

## Tasks That Require Documentation

Some tasks are driven by the Activities column and open a PowerForm where documentation can be completed. Once documentation is complete, the icon or item will automatically be removed.

1. An icon will display in the **Events** column indicating the type of task to be performed.
2. After the test has been completed, double-click the Clipboard icon under the Activities column to open the Document Activities dialog box.
3. Under the Patient Care section, check the box next to the test.
4. Click **Document**.
5. The **PowerForm for the test** displays. Document the results. Click Sign.
6. In the Document Activities box, the task under Assessments is removed from the list.
7. The icon will automatically be removed from the Events column.

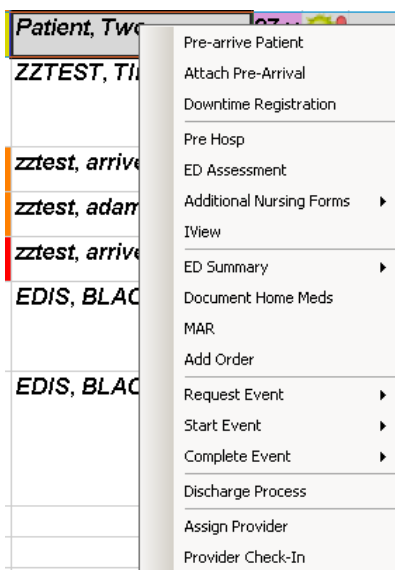
Task	Icon	Trigger	How to Complete
MAU Intake		Fires on Arrive	PowerForm
MAU Vitals		Fires on Arrive	PowerForm
POC Blood Glucose		Order	PowerForm
POC HCG		Order	PowerForm
POC Urine		Order	PowerForm
POC Strep		Order	PowerForm
POC Rapid Flu		Order	PowerForm
POC Hgb		Order	PowerForm
POC Occult Blood Stool		Order	PowerForm
POC Mono		Order	PowerForm
Oxygen Admin		Order	PowerForm
Pulse Ox		Order	PowerForm
MD Exam		Fires on Rm Assign	Assign Provider
Crutches/ Crutch Walking	No icon	Order	Task/Document (Chart Done)

## Accessing Patient's Chart

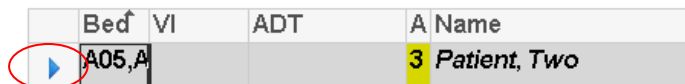
*Tip: If you see a patient name in italics, it means someone else on the tracking board has the same last name. Use caution in selecting the correct patient.*

You can review/access other parts of the patient's chart any of the following ways:

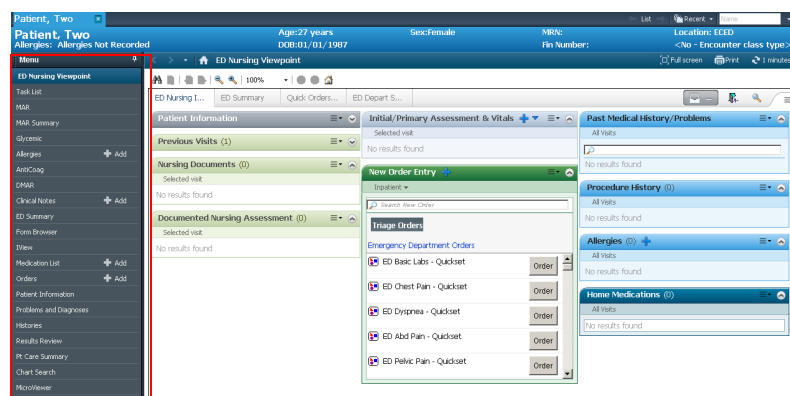
1. Right click on the patient name.
2. Select the task or chart option from the dropdown list.



1. Double click on the first cell of the patient row to open the chart.



2. The chart defaults to MAU Workflow
3. Click on the desired tab in the Menu on the left.



1. Click **Chart** in the top toolbar.

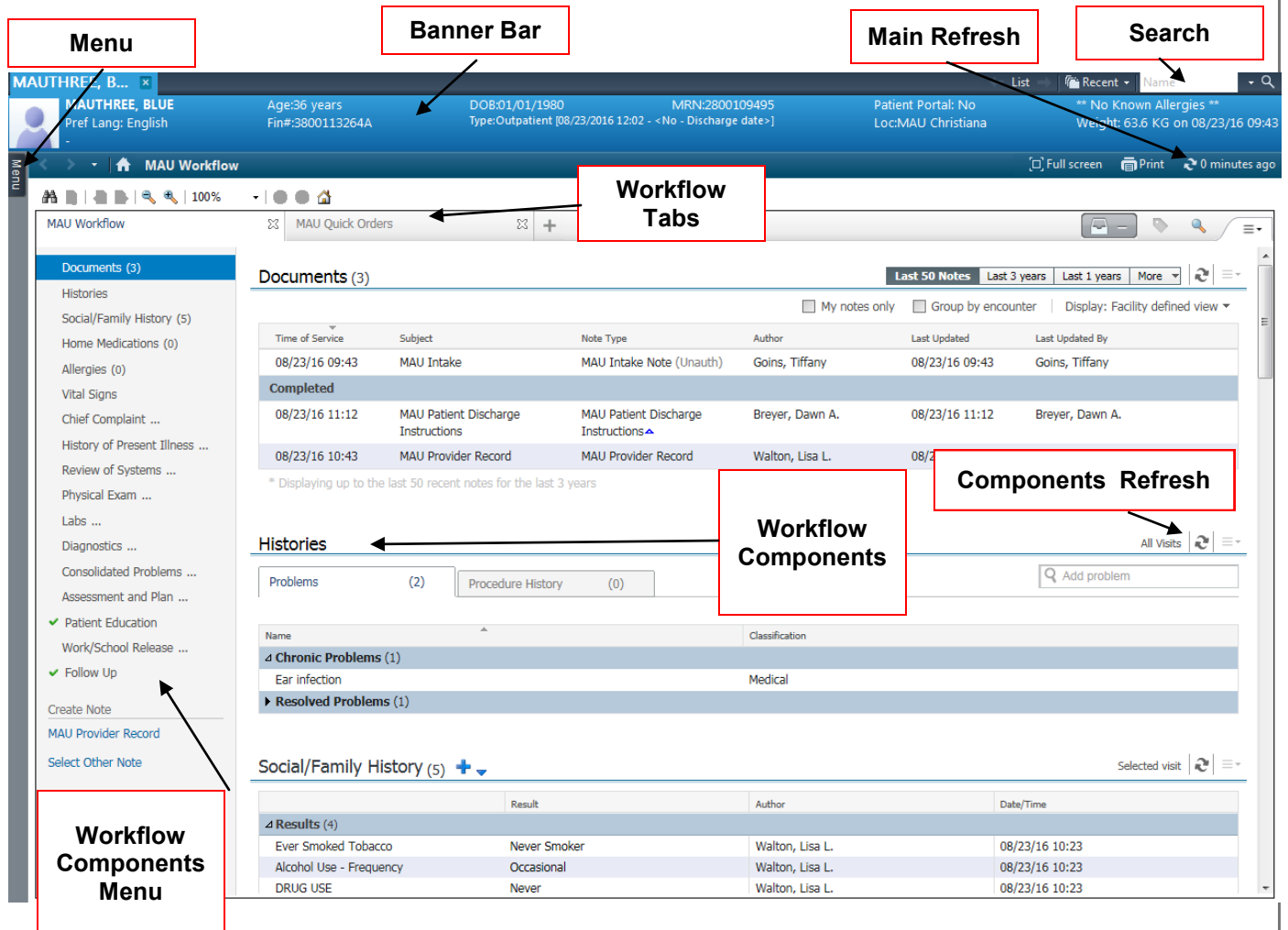


2. A drop down list appears to choose where in the chart you'd like to go.



## MAU Workflow

The MAU Workflow is a streamlined collection of all pertinent information for this patient's visit.



The screenshot shows the MAU Workflow interface for patient MAUTHREE, B. The interface includes a top banner bar with patient information, a left menu, a main content area with workflow tabs, and a right sidebar with components refresh and workflow components.

**Menu**: Located on the left side of the interface, containing various patient information categories like Documents, Histories, Social/Family History, etc.

**Banner Bar**: The top blue bar displaying patient details: MAUTHREE, B., Age: 36 years, DOB: 01/01/1980, MRN: 2800109495, Patient Portal: No, Loc: MAU Christiana, Weight: 63.6 KG on 08/23/16 09:43.

**Main Refresh**: A button in the top right corner of the banner bar.

**Search**: A search bar in the top right corner of the banner bar.

**Workflow Tabs**: A tab labeled 'MAU Quick Orders' located below the banner bar.

**Components Refresh**: A button in the right sidebar, labeled 'All Visits'.

**Workflow Components**: A section in the right sidebar containing 'Problems' (2) and 'Procedure History' (0).

**Workflow Components Menu**: A button in the left menu, labeled 'Create Note', 'MAU Provider Record', and 'Select Other Note'.

**Documents (3)**: A table showing recent documents:

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
08/23/16 09:43	MAU Intake	MAU Intake Note (Unauth)	Goins, Tiffany	08/23/16 09:43	Goins, Tiffany
08/23/16 11:12	MAU Patient Discharge Instructions	MAU Patient Discharge Instructions	Breyer, Dawn A.	08/23/16 11:12	Breyer, Dawn A.
08/23/16 10:43	MAU Provider Record	MAU Provider Record	Walton, Lisa L.	08/23/16 10:43	Walton, Lisa L.

**Histories**: A section containing 'Problems' (2) and 'Procedure History' (0).

**Social/Family History (5)**: A table showing social and family history results:

Result	Author	Date/Time
Ever Smoked Tobacco	Walton, Lisa L.	08/23/16 10:23
Alcohol Use - Frequency	Walton, Lisa L.	08/23/16 10:23
DRUG USE	Walton, Lisa L.	08/23/16 10:23

## MAU Workflow

### Documents

*Not all Documents types will display here.*

You'll see the last 50 documents for the past 3 years (across encounter) of these types:

- H&P
- Consults
- Discharge Summary and Planning
- ED Documents
- OP reports

Check **Group by Encounter (A)** to sort the documents by encounter and make it easier to distinguish which notes belong with which encounter.

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
Emergency A	06/15/15				
06/15/15 13:42	ED Teaching Physician Record	ED Teaching Physician Record	McGhee DO, Jonathan D.	06/15/15 15:10	McGhee DO, Jonathan D.
06/15/15 13:40	ED Physician Record - Resident/PA	ED Physician Record	Hansen DO, Michael J.(resident)	06/15/15 16:24	Hansen DO, Michael J.(resident)
Inpatient A	05/19/15				
05/22/15 11:03	Ongoing Discharge Planning Assessment	Ongoing Discharge PlanningAssessmentNot e	Elwood, Laura	05/22/15 11:03	Elwood, Laura
05/20/15 11:08	CV 2D ECHO W/CF AND DOP	Transthoracic Echocardiogram	Marmo DO, Vincent J.	05/20/15 15:28	Marmo DO, Vincent J.
05/20/15 10:40	Pulmonary Consult Note	Consult	Stewart MD, Jeffrey I.	05/20/15 11:08	Stewart MD, Jeffrey I.
05/20/15 07:22		H&P	Burkhart-Smith PA-C, Colleen E.	05/20/15 07:23	Burkhart-Smith PA-C, Colleen E.
05/19/15 15:19	Advance Directives Assessment	Advance Directives Assessment	Dignan, Erin E.	05/19/15 15:19	Dignan, Erin E.
05/19/15 13:58	Ongoing Discharge Planning Assessment	Ongoing Discharge PlanningAssessmentNot e	Morris, Elaine	05/19/15 13:58	Morris, Elaine
05/19/15 13:56	Initial Discharge Planning Assessment	Initial Discharge PlanningAssessmentNot e	Morris, Elaine	05/19/15 13:56	Morris, Elaine

Use the Display filter to selectively limit the document that display. Click the **Display** dropdown (B).

Uncheck **Facility defined view**.

Check the boxes next to the type of documents you want to display. Then click **Apply**.

Only those documents types will display.

To see all available documents again, click the display dropdown and click Reset All and Apply.

Click on a document once to open a preview directly in the workflow.

When previewing a document on the workflow, you can also tag from the document. Highlight the information you wish to include in your note and then select the Tag button.

The items will be available to move into your note when you create it.

## MAU Workflow

### Home Medications

A list of all documented home medications taken by a patient, including medication from previous hospital visits.

Verify the list has been updated this encounter.

Medication reconciliation status bar

- Green check mark next to Meds History (A) indicates the list was verified this visit.
- Can launch Discharge Meds Rec by clicking the link (B). Refer to the Discharge Med Rec section later in this document.

Home Meds/Med Rec/Rx (2) All Visits

\*
A
B

Status: ✓ Meds History | i Admission | i Outpatient

Medication	Last Dose Date/Time	Compliance	Compliance Comments
aspirin (aspirin 81 mg oral tablet) 81 MG, 1 TAB, PO, Daily, 0 Refill(s)	--	--	--
omega-3 polyunsaturated fatty acids (Fish Oil 1000 mg oral capsule) 1,000 MG, 1 CAP, PO, TID, 90 CAP, 0 Refill(s)	--	--	--

Sign

### Histories

Problems Tab: [Manages Chronic Problems \(Past Medical History\)](#)

A list of Chronic (ongoing) and Resolved (resolved chronic) Problems. Items entered in Intake form will display here.

Click on a problem to open the preview pane.

- Use Modify to change problem details.
- Use Resolve to make the problem historical, not ongoing; it will move the problem to the Resolved section.
- Use Cancel to remove it as a chronic problem.
- Use the X to close the preview.

**Histories** All Visits

Problems (6)
Procedure History (1)
Family History (0)
Social History (0)
Pregnancy (0)

Name	Classification
<b>4 Chronic Problems (4)</b>	
Chronic kidney disease stage 3	Medical
Dementia	Medical
HTN - Hypertension	Medical
Hypercholesterolemia	Medical
<b>4 Resolved Problems (2)</b>	
Absolute anemia	Medical
Leg laceration	Medical

Modify
Resolve
Cancel
✕

**Hypercholesterolemia**

Onset Date: --

Problem Type: Chronic

Status: Active

Classification: Medical

Confirmation: Confirmed

You can add new chronic problems by using **Add problem** search field.

## MAU Workflow

### Histories

**Procedures Tab: Manages Past Procedures (Past Surgical History)**

A list of any documented past procedures (Past Surgical History).

Add a procedure by using the search field.

- Type the name of the procedure.
- If you don't know the specifics of the procedure, there's an option to add it as free text.

**You MUST click Save to add a procedure on the workflow.**

**Histories** All Visits

Problems (0) Procedure History (1) Family History (0) Social History (0) Pregnancy (0)

ICD9

Procedure Surgeon Implant

4 Procedures (1)

pacemaker insertion	--	
---------------------	----	--

Other and Unspecified Hysterectomy  
Laparoscopic Total Abdominal Hysterectomy  
Other and Unspecified Vaginal Hysterectomy  
Other and Unspecified Subtotal Abdominal Hysterectomy  
[Add "hysterectomy" as free text](#)

### Social/ Family History

Review and validate existing information added from Social/ Family History Form.

If information needs to be added or updated:

- Click arrow next to heading.
- Select **Provider Family & Social Hx.**

**Social/Family History (3)** Selected visit

	Result	Date/Time
4 Results (3)		
Ever Smoked Tobacco	Never Smoker	06/15/15 13:46
Alcohol Use - Frequency	None	06/15/15 13:46
DRUG USE	Never	06/15/15 13:46
4 Forms (0)		
No results found		

- Update information on the Power Form.
- Click the green check mark to Sign.

It is added to the workflow and will pull into your note under Social and Family History.

**4** → **Provider Family & Social History - ROGERS, ARLENE**

\*Performed on: 09/04/2015 1048 By: Walton, Lisa L.

**Social History**

**Tobacco Use**

☒ Current Every Day Smoker ☐ Heavy Tobacco Smoker  
☐ Current Some Day Smoker ☐ Light Tobacco Smoker  
☐ Smoker, Current Status Un  
☐ Former Smoker  
☐ Never Smoker  
☐ Unknown if Ever Smoked

**Tobacco Frequency**

☐ < 0.5 pack/day ☐ 3 packs/day  
☐ 0.5 pack/day ☐ > 3 packs/day  
☐ 1 pack/day ☐ Other:  
☐ 1.5 pack/day  
☐ 2 pack/day  
☐ 2.5 pack/day

**Years Smoked**

**Pack Years**

**Alcohol Frequency**

☐ Occasional ☐ Moderate ☐ Heavy ☐ Weekends Only ☐ None ☐ Other:

**Drug Use**

☐ Never ☐ Marijuana ☐ Methamphetamines  
☐ Quit ☐ Cocaine ☐ Prescription drug  
☐ Heroin ☐ Other:

**Drug Frequency**

☐ Occasional ☐ Other:  
☐ Moderate  
☐ Heavy  
☐ Weekends Only

**Social History Comments**

**Family History**

**Family History**

☐ AAA ☐ Asthma ☐ Cerebral Aneurysm ☐ DVT ☐ MI - Heart Attack ☐ Stroke  
☐ Aortic dissection ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ PE ☐ Other:

**Family History Comments**

## MAU Workflow

### Allergies

Displays any documented allergy information

You can add and modify allergies directly in the workflow.

1. Type the allergy into the Add Allergy field.
2. Select the Allergy category.
3. Click Save.

Substance	Severity	Reactions	Reaction Type
No Known Medication	--	--	Allergy
Strawberry	Mild	Hives	Allergy
Peanut	--	--	--

**Strawberry**

Reactions: Add reaction

Hives

Severity: Mild | Reaction Type: Allergy

\* Category: Food

Status: Active | Reason:

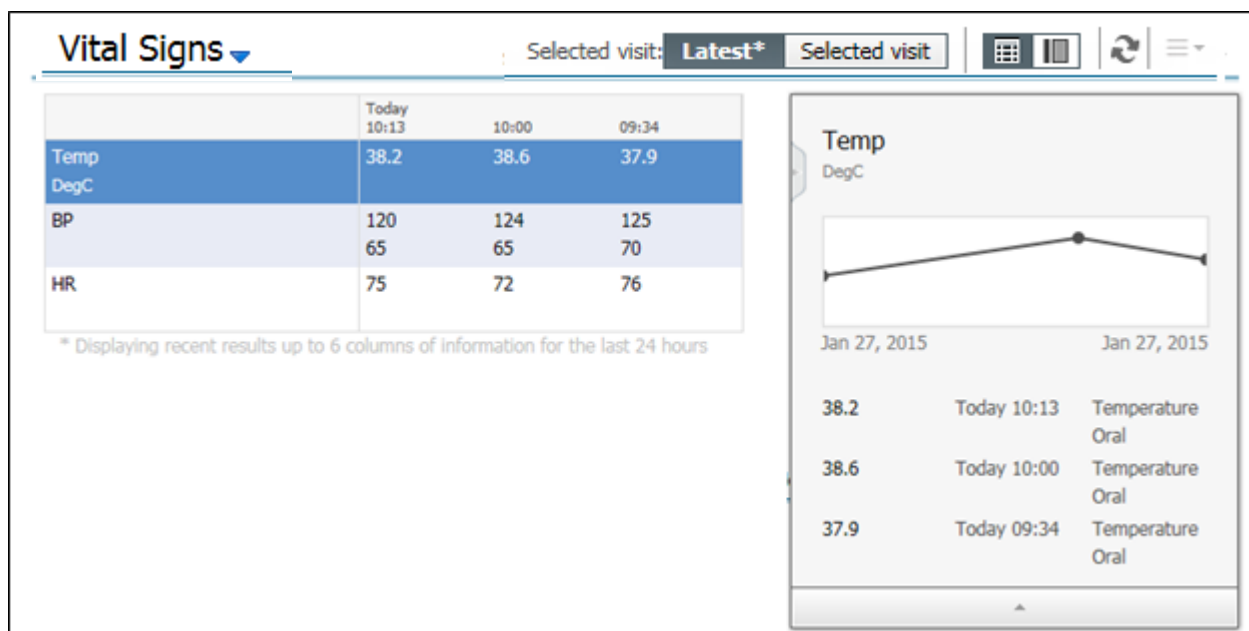
4. Once added, view the detail pane for more information by clicking on the allergy.
5. To change information about that allergy, click Modify.
6. Change information in the fields provided.
7. Click Save to save changes; click Cancel to discard Changes.

### Vital Signs

Displays vital signs documented during this visit

To see set of vitals or lab results over time, click on the row to display graph.

To add a new set of vitals, click the blue down arrow next to the heading Vital Signs. Then select Vitals Signs from the list. Complete the form and click the green



## MAU Workflow

### Chief Complaint

Free text section to provide the patient's chief complaint, preferably in their own words, or the reason for the encounter.

#### Chief Complaint

Selected visit | [X] | [↺] | [≡]

Font - Size -
 
 [List Icon] [Link Icon] [B] [I] [U] [A+] [Align Left] [Align Center] [Align Right] [Justify] [Text Color]

Save

### History of Present Illness

Free text section to provide a detailed characterization of the patient's current problem. Use Dragon/ macros/ auto-text/ free-text to add the information.

#### History of Present Illness

Selected visit | [X] | [↺] | [≡]

Font - Size -
 
 [List Icon] [Link Icon] [B] [I] [U] [A+] [Align Left] [Align Center] [Align Right] [Justify] [Text Color]

Save

### Review of Systems

Documentation of systems reviewed. Use Dragon/ macros/ auto-text/ free-text to add the information.

#### Review of Systems

Selected visit | [X] | [↺] | [≡]

Font - Size -
 
 [List Icon] [Link Icon] [B] [I] [U] [A+] [Align Left] [Align Center] [Align Right] [Justify] [Text Color]

Save

### Physical Exam

Section for your observations during the physical exam. Use Dragon macros, dictate or free text your findings.

#### Physical Exam

Selected visit | [X] | [↺] | [≡]

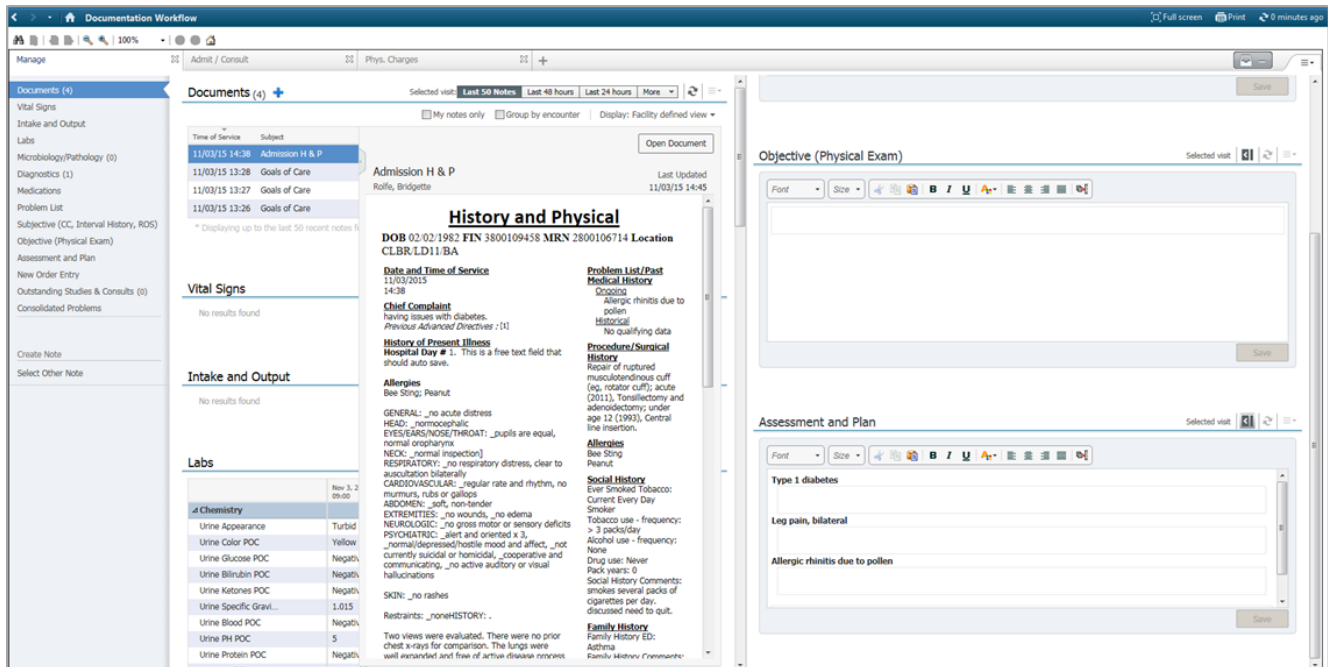
Font - Size -
 
 [List Icon] [Link Icon] [B] [I] [U] [A+] [Align Left] [Align Center] [Align Right] [Justify] [Text Color]


Save

## MAU Workflow

### Increase documentation efficiency by using split screen view

When using a horizontal 24 inch monitor, document on the right side of screen while reviewing chart information on the left. For example, you can review previous notes in preview mode on the left and dictate your new information on the right; no need to scroll down the workflow.



This icon  indicates documentation components that can be moved to the right (i.e., Chief Complaint, History of Present Illness, Review of Systems, Physical Exam and Assessment and Plan). **Click the icon to move the component to the right. You'll only need to set this up once.**

**\*\*Note:** Move the components in the order in which you want them to display on the right.

On the left, the component heading will remain and you can click the icon to move the component back. The same icon displays on the right side component to easily move it back to the left.



On the workflow, you can drag the moved component headings to the bottom of the list so they don't interfere with your left side review.

**Tip:** Don't pin the navigation menu so that you have more room on your screen for documentation.

It should look like this so the menu will auto-hide when you are not hovering over it.



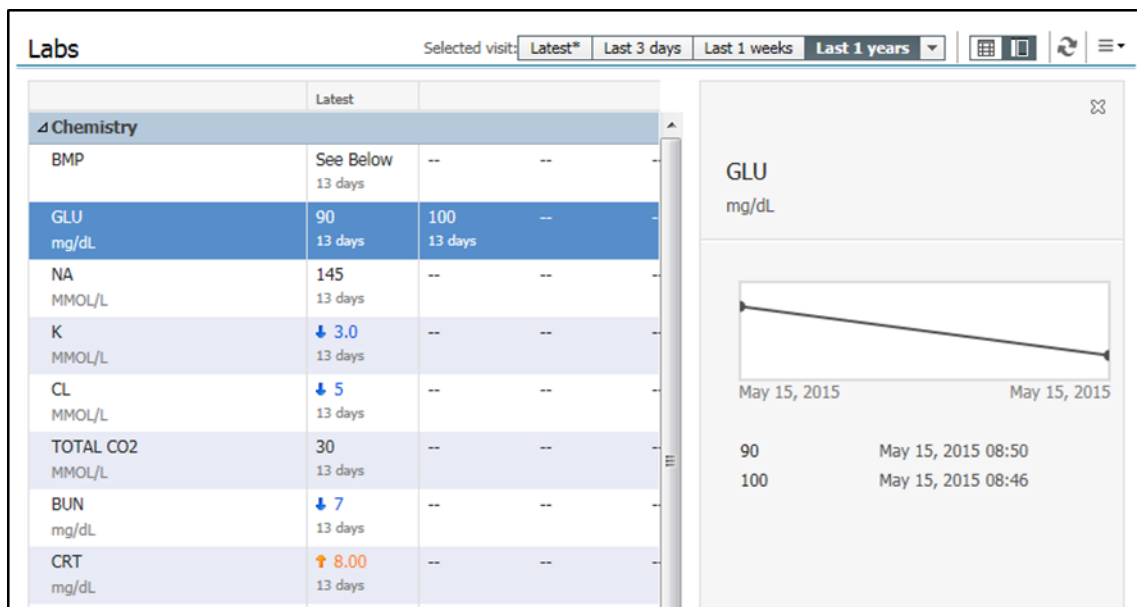
## MAU Workflow

### Labs

Displays **results across encounters**. **POC testing resulted in office will pull into your note automatically**. Functionality such as graphing, previewing, and multi-select tagging are available.

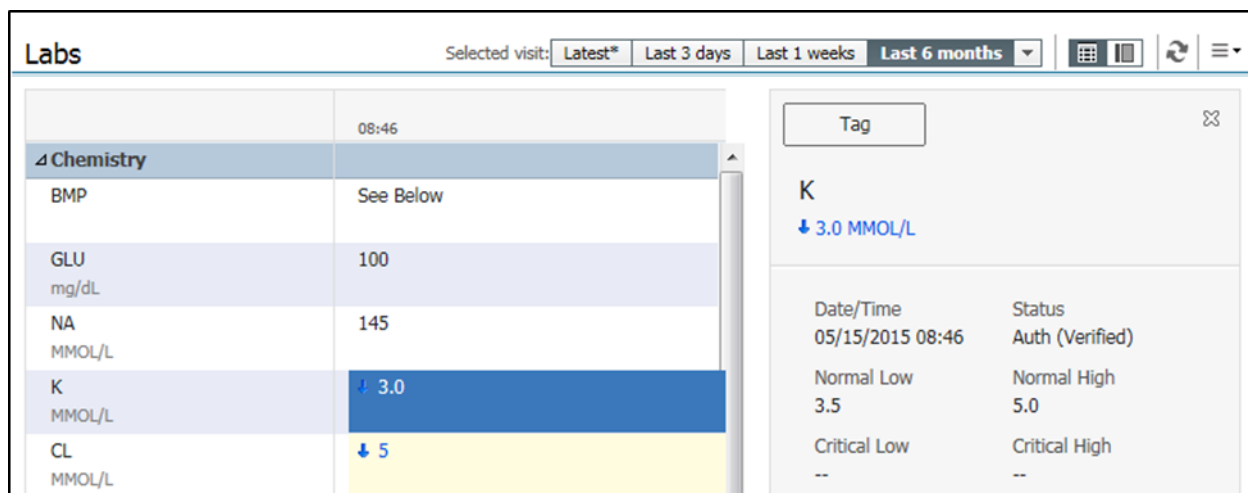
To view a set of labs over time, click on the test name to display graph.

To close the preview, click the test name again or click the X.



To see information about a single result, click on the result to open the Detail pane.

You can tag a single result by right clicking the value and clicking Tag.





## MAU Workflow

### Multi- select Lab results

You can select multiple results and tag once.

To select multiple results that are displayed next to each other, click the first result, then press Shift and click the last result.

All results between the first and last are highlighted and selected for tagging. Right click and select Tag.

	Latest	
<b>Chemistry</b>		
BMP	See Below 13 days	--
GLU mg/dL	90 13 days	100 13 days
NA MMOL/L	145 13 days	--
K MMOL/L	3.0 13 days	--
CL MMOL/L	5 13 days	--

To select multiple results that are separated in the table, click the first result, press and hold Ctrl and click the other results you wish to tag. Right click and select Tag.

	Latest			
<b>Chemistry</b>				
BMP	See Below 6 days	--	--	--
GLU mg/dL	90 6 days	100 6 days	--	--
NA MMOL/L	145 6 days	--	--	--
K MMOL/L	3.0 6 days	--	--	--

### Diagnostics

Displays the last 3 months of results across encounter.

Click on a report to open it and tag information, if needed.

Name	Reason For Exam	Resulted	Last Updated	Status
<b>Radiology (0)</b>				
No results found				
<b>Imaging (0)</b>				
No results found				
<b>General Radiology (0)</b>				
No results found				
<b>CT (0)</b>				
No results found				
<b>MRI (0)</b>				
No results found				
<b>Ultrasound/Vascular (0)</b>				
No results found				
<b>Cardiovascular (0)</b>				
No results found				
<b>GI Lab (0)</b>				
No results found				
<b>Pulmonary (0)</b>				
No results found				
<b>EEG/EMG (0)</b>				
No results found				

## MAU Workflow

### Consolidated Problems

In both the Admit and Manage workflows, the Consolidated Problems section has been redesigned to make it easier to add and manage problems; both Chronic (past medical history) and This Visit (problems/working diagnoses being addressed this encounter).

*Tip: When you first access the new list, change the Classification filter to All (from Medical and Patient Stated) by clicking the arrow next to the Classification and clicking All. This allows you to view all problems. Once you make this selection, it will remain selected for you.*

**Consolidated Problems**

Classification: **All** | All Visits | [Refresh] | [Menu]

Add new as: **This Visit** | [Search] Problem name

Name	Classification	Actions
-- ▾ Paroxysmal atrial fibrillation	Medical	[This Visit] [Chronic]
Hypertension	Medical	[This Visit] [Chronic] [Resolve]
▴ <b>Historical</b>		[Show Previous Visits] <input type="checkbox"/>
Hypercholesteremia	Medical	[This Visit] [Chronic]

- ◇ This Visit and Chronic problems display at the top of the list (A).
- ◇ Historical problems (problems from previous encounters, not chronic) can be viewed by clicking the triangle next to historical (B).

The Actions column makes managing problems easier.

#### In the This Visit and Chronic section:

- Blue indicates an active, current selection. To remove it, hover over it. A blue line appears, which means remove the selection. Click to remove.  
*Note: This removes/cancels the problem from the Problem list, not just your note. You could remove another provider's problem, so use with caution.*
- White indicates a choice. Hover over a white choice and it turns blue. Click it to make it active.
- Resolve will only display for chronic problems. Clicking it will move the problem to the historical section.

**Actions**

[This Visit] [Chronic]

[This Visit] [Chronic]

[This Visit] [Chronic]

[Show Previous Visits]

[This Visit] [Chronic]

#### In the Historical section:

White indicates a choice to select.

Gray indicates a the status of the problem before it was resolved (made historical) You may click to renew the status back to an ongoing chronic problem.

#### Add a new problem

Next to Add new as: choose This Visit or This Visit and Chronic. Then, begin typing in the search field. A list of possible results appears. Click on the desired problem.

Add new as: **This Visit** | [Search] asthma

- Asthma (493.90)
- Classifica FH: asthma (V17.5)
- Medica FHx: asthma (V17.5)
- Medica Hay asthma (493.00)
- Medica Wood asthma (495.8)

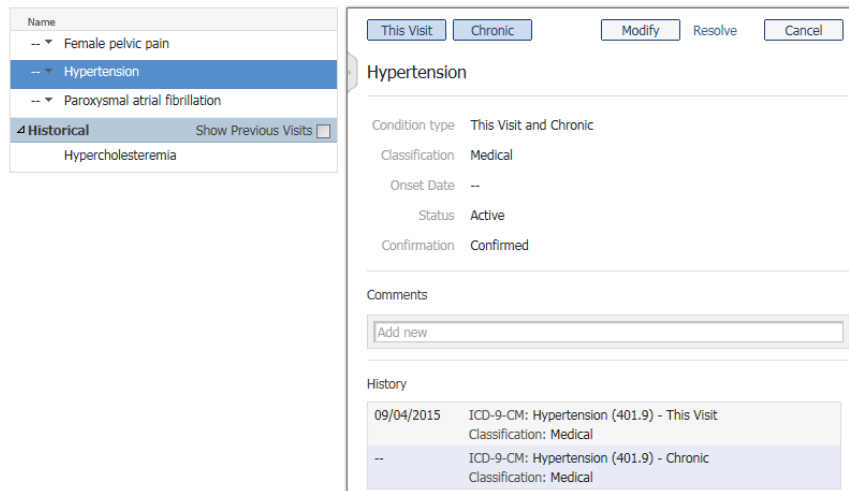
## MAU Workflow

The problem preview pane allows you to quickly see details of the problem without leaving the workflow. Click on a problem to view the preview pane.

When you preview Chronic Problems you will have action options.

- Use **This Visit** and **Chronic** buttons to change status.
- **Modify** allows you to make changes to a Chronic problem directly in the workflow.
- **Resolve** will move the problem to Historical.

Click the problem again to close the preview.

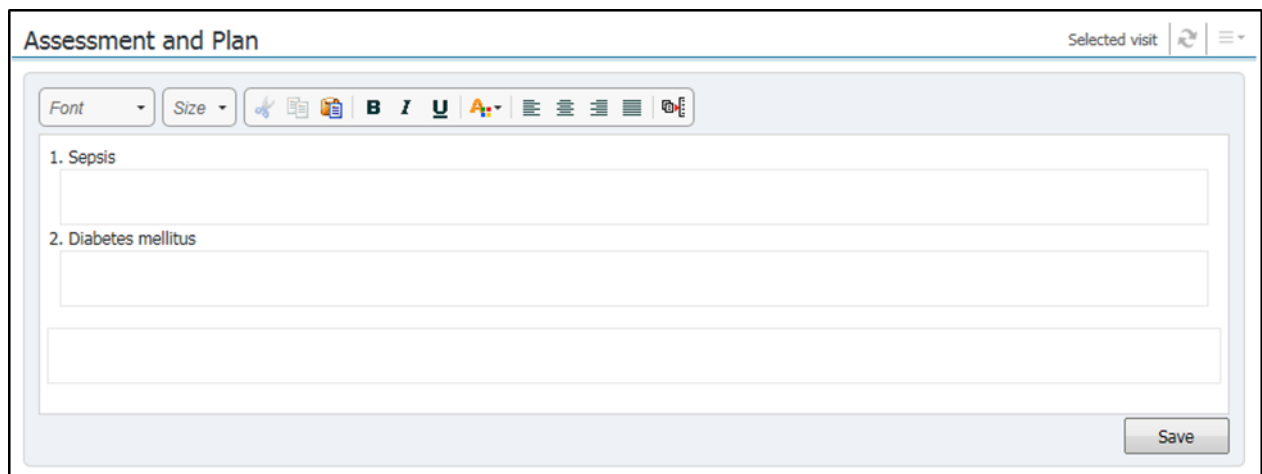


The screenshot shows the 'Hypertension' problem preview pane. At the top, there are buttons: 'This Visit', 'Chronic', 'Modify', 'Resolve', and 'Cancel'. Below these, the problem name 'Hypertension' is displayed. The 'Condition type' is 'This Visit and Chronic', 'Classification' is 'Medical', 'Onset Date' is '--', 'Status' is 'Active', and 'Confirmation' is 'Confirmed'. There is a 'Comments' section with an 'Add new' button. Below that is a 'History' section showing two entries: '09/04/2015 ICD-9-CM: Hypertension (401.9) - This Visit Classification: Medical' and '-- ICD-9-CM: Hypertension (401.9) - Chronic Classification: Medical'. To the left of the preview pane, a list of problems is visible, with 'Hypertension' selected.

## Assessment and Plan

As you manipulate the problems list, the Assessment and plan section updates real time and pulls in each This Visit problem. This allows you to document your plan of care for each directly in the workflow. When you create your note, all documentation will pull into the Assessment/Plan section of the note automatically under the problem.

- Don't want to include a problem in your note? Hover over the problem name and click the X.  
*Tip: If you removed a problem from Assessment and Plan by mistake, click the main refresh button to bring the problems back.*
- In the box below each problem, use Dragon and Auto-text to dictate your plan..  
*Tip: To quickly move from field to field, press the tab key on the keyboard or the Tab forward button on the Dragon microphone.*



The screenshot shows the 'Assessment and Plan' section. At the top, there is a 'Selected visit' button and a refresh icon. Below this is a rich text editor with a toolbar containing options for Font, Size, Bold, Italic, Underline, Text Color, Background Color, Bulleted List, Numbered List, Indent, Outdent, and Link. The editor contains two numbered items: '1. Sepsis' and '2. Diabetes mellitus', each followed by a large text area for documentation. A 'Save' button is located at the bottom right of the editor.

- Click **Save** when finished.

## MAU Workflow

### Patient Education

**\*\*REQUIRED to complete prior to discharge\*\***

The Patient Education section allows you to select appropriate education for your patients post-discharge.

Based on the diagnosis, a list of suggested patient education will default.

To add the education, click on the name once. It will be added to the “Added Education” field.

Patient Education + 🔍 ⌵

---

Education Medication Leaflets
English ▼

Suggestions Custom Education Favorites

All Suggestions	Suggestions based on all this visit problems	
Hypertension	Coronary Artery Disease, Risk Factors	☆ Microalbumin Test
	DASH Eating Plan	☆ Myocardial Infarction
	Heart Attack	☆ Myoglobin Test
	Heart Attack, Easy-to-Read	☆ Potassium (K) Test
	Heart Disease Prevention	☆ Triglycerides Test
	How to Take Your Blood Pressure, Easy-to-Read	☆ Urine Metanephrines Test
	Hypertension	☆
	Hypertension, Easy-to-Read	☆
	Lipid Profile Test	☆
	Managing Your High Blood Pressure	☆

Added Education

No added Education

Added Medication Leaflets

No added medication leaflets

You can also save education as Favorites. Click on the star next to the title and select Personal Favorites. Then, you can click the Favorites button to see the list of those you have selected

## MAU Workflow

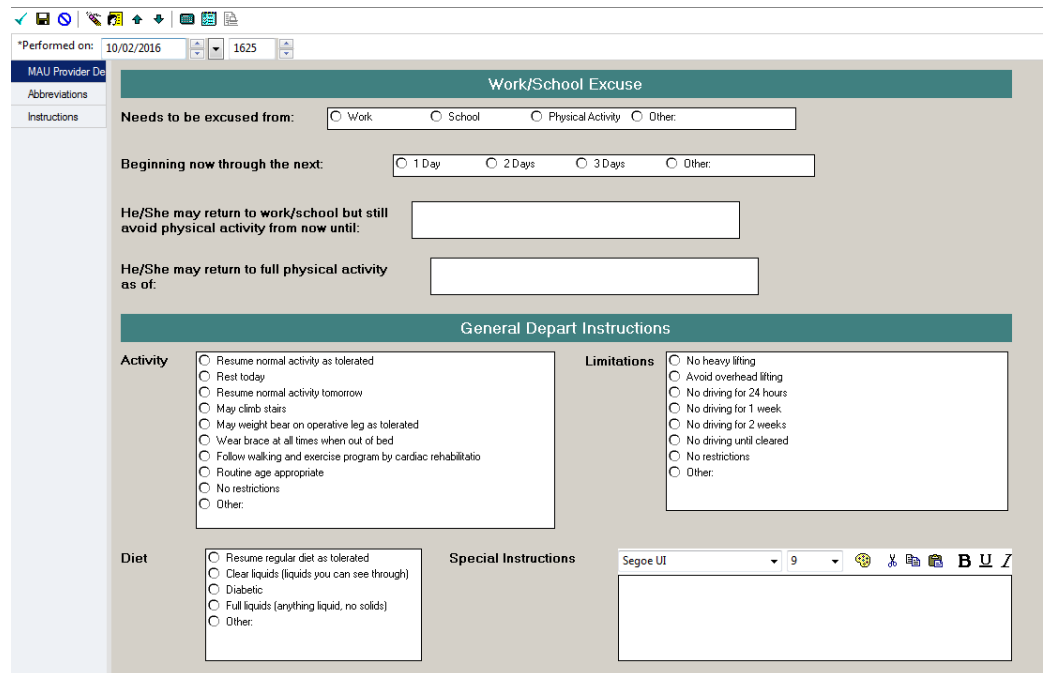
### Work/School Release

If a Work/School Release note is needed, or general depart instructions need to be included in the Discharge Instructions, click the blue dropdown arrow next to Work/School Release. Select MAU Provider Depart.

Work/School Release + ▾

No results found

On the PowerForm, complete the needed fields. When finished, click the green check mark in the upper left corner to sign and save.



The screenshot shows the 'Work/School Excuse' form. At the top, it says '\*Performed on: 10/02/2016' and '1625'. The form is divided into several sections:

- Needs to be excused from:** Radio buttons for Work, School, Physical Activity, and Other.
- Beginning now through the next:** Radio buttons for 1 Day, 2 Days, 3 Days, and Other.
- He/She may return to work/school but still avoid physical activity from now until:** A text input field.
- He/She may return to full physical activity as of:** A text input field.
- General Depart Instructions:**
  - Activity:** Radio buttons for Resume normal activity as tolerated, Rest today, Resume normal activity tomorrow, May climb stairs, May weight bear on operative leg as tolerated, Wear brace at all times when out of bed, Follow walking and exercise program by cardiac rehabilitation, Routine age appropriate, No restrictions, and Other.
  - Limitations:** Radio buttons for No heavy lifting, Avoid overhead lifting, No driving for 24 hours, No driving for 1 week, No driving for 2 weeks, No driving until cleared, No restrictions, and Other.
  - Diet:** Radio buttons for Resume regular diet as tolerated, Clear liquids (liquids you can see through), Diabetic, Full liquids (anything liquid, no solids), and Other.
  - Special Instructions:** A text input field.

### Follow Up

**\*\*REQUIRED to complete prior to discharge\*\***

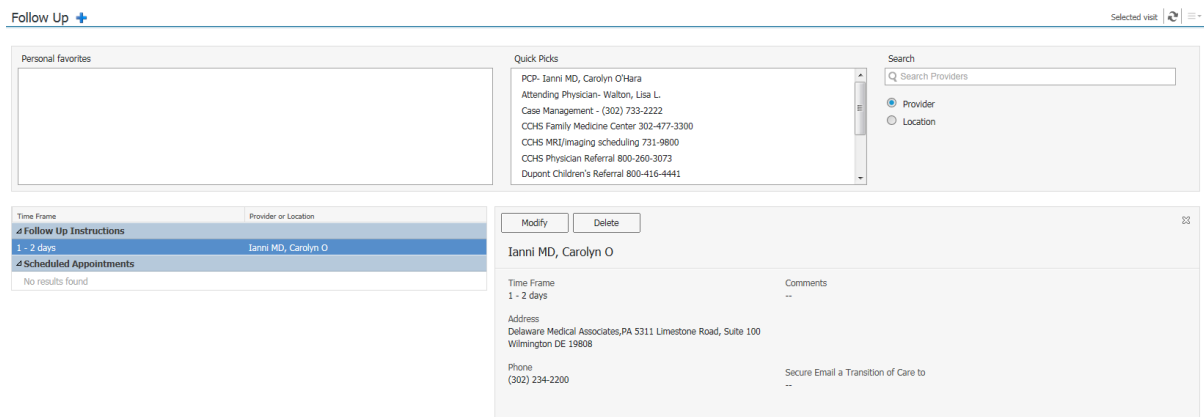
The Follow Up section provides Quick Picks of follow up providers and timeframes. This information will display in the Discharge Instructions.

Under Quick Picks the name of the patient's PCP (if identified) will be listed, as well as several other types of follow-up.

To choose the follow-up provider, click on the name.

If you need to change the details of the follow-up, click Modify.

The change the information, including the Timeframe and any pre-defined comments you wish to add.



The screenshot shows the 'Follow Up' section. It includes a 'Personal favorites' list, a 'Quick Picks' list, and a 'Search' bar. The 'Quick Picks' list shows:

- PCP: Ianni MD, Carolyn O'Hara
- Attending Physician- Walton, Lisa L.
- Case Management - (302) 733-2222
- COHS Family Medicine Center 302-477-3300
- COHS MRI/imaging scheduling 731-9800
- COHS Physician Referral 800-260-3073
- Dupont Children's Referral 800-416-4441

Below the list, there are 'Modify' and 'Delete' buttons. The 'Time Frame' is set to '1 - 2 days'. The 'Provider or Location' is 'Ianni MD, Carolyn O'. The 'Comments' field is empty. The 'Address' is 'Delaware Medical Associates, PA 5311 Limestone Road, Suite 100, Wilmington DE 19808'. The 'Phone' is '(302) 234-2200'. The 'Secure Email a Transition of Care to' field is empty.

## MAU Workflow

### Discharge Med Rec

**\*\*REQUIRED to complete prior to discharge\*\***

Prior to discharging the patient, you should perform discharge medication reconciliation to indicate of any medication should be stopped and to order any prescriptions for the patient.

- On the MAU workflow, click on the Home Medications/Med Rec/Rx component.
- Click the Outpatient link.

- On the Order Reconciliation: Outpatient window, the left side shows any home meds and meds administered during the visit. The right side will display any meds you add to be taken after discharge.

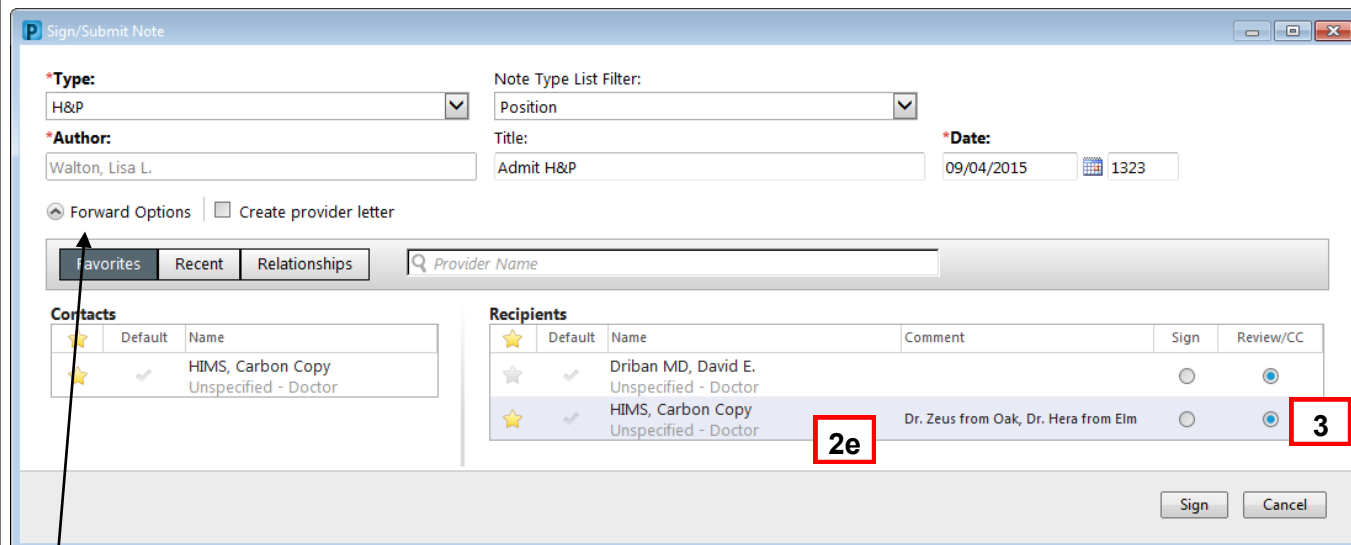
- If you want the patient to stop taking a medication, click the circle under the column with the red square, next to the medication.
- If you want to prescribe a new medication, click the Add button. Select from the list or search for the medication.
- After adding it, associate the correct diagnosis.
- Select the Routing for the prescription by clicking the dropdown next to Send To:. The patient's preferred pharmacy should be listed. You could also select to print the prescription.
- Click Reconcile and Sign to finish.

## MAU Workflow

### Carbon Copy (CC)

You will now have the ability to send a copy of your notes to other providers directly from FirstNet. A list of providers and groups/ practice related to CCHS is pre-loaded.

After you click Sign/Submit, this window appears.



**Sign/Submit Note**

\*Type: H&P Note Type List Filter: Position

\*Author: Walton, Lisa L. Title: Admit H&P \*Date: 09/04/2015 1323

☒ Forward Options ☐ Create provider letter

favorites Recent Relationships

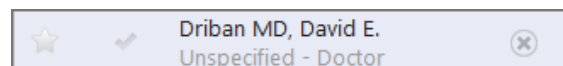
★	Default	Name
★	✓	HIMS, Carbon Copy Unspecified - Doctor

★	Default	Name	Comment	Sign	Review/CC
★	✓	Driban MD, David E. Unspecified - Doctor		<input type="radio"/>	<input type="radio"/>
★	✓	HIMS, Carbon Copy Unspecified - Doctor	Dr. Zeus from Oak, Dr. Hera from Elm	<input type="radio"/>	<input checked="" type="radio"/>

Sign Cancel

*Note: You may need to click the arrow next to Forward options to expand the section.*

- Type the name of the provider you wish to copy in the Provider Name field.
  - If there is only one provider by that name, it will automatically be added to the Recipients list.
  - If there is more than one provider by that name, you can choose the correct provider on the provider Selection window.
  - If the provider you entered is not available, no name or selection window will appear.
- For providers who are not on our list, the HIMS team can carbon copy the note.
  - To send the name of the provider to the HIMS team, type HIMS in the provider name window.
  - Select **HIMS, Carbon Copy** from the list.
  - On the Recipient list, HIMS, Carbon Copy is added. Click the star to save it as a favorite so you don't have to search for it again. The next time you need to use HIMS, Carbon copy, under Contacts, you simply click the Blue plus sign next to the name.
  - To add the name of the provider you would like HIMS to send copies to, double click in the column under Comment.
  - Type at least the name of the provider you wish to copy. You can enter the address and/or phone number if you know it.
  - If there is more than one provider to cc, type all of the names, separated by a comma.
- Be sure the **Review/CC circle** is filled in.  
*(Mid-level providers should check carefully, as your option defaults to Sign.)*
- You can remove a provider from your recipient list, by hovering over the name and clicking the X.
- Click **Sign**.



## MAU Workflow

### Carbon Copy (CC)- continued

Carbon Copy can also be completed from Message Center when signing a forwarded document.

You can see if anyone has already been sent the document by opening the Action List.

- Click and hold on the line between the note and the Action Pane.
- Slide up to open the Action List.

- Check the box next to Additional Forward actions.
- Ensure the Action is set to Review.
- Type the name of the provider in the To: field.
- If it is an external provider not on the list, type HIMS, Carbon Copy. In the comments section, enter the name and information of the provider.
- Click OK.

**History and Physical**  
 DOB 09/08/1944 FIN      MRN      Location ECED/C19/A  
 Date and Time of Service  
 08/15/2015  
 16:17  
 Assessment/Plan  
 Anemia  
 Dementia

**Problem List/Past Medical History**  
 Ongoing  
 Chronic kidney disease stage 3  
 Dementia  
 Historical  
 HTN - Hypertension  
 Hypercholesterolemia  
 Procedure/Surgical History  
 pacemaker insertion, suture.  
 Medications  
 Home Medications (6) Active  
 AggRENOX 1 CAP, PO, BID  
 atorvastatin.  
 Calcium with Vitamin D . PO

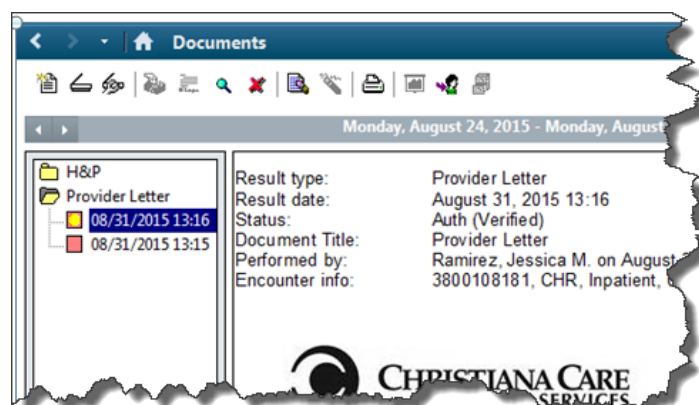
Action	Performed By	Performed Date	Action Status	Comment	Proxy Personnel	Requested By	Requested Date	Request Comment
Sign	Resident, Test	08/15/2015 16:18	Completed					
Perform	Resident, Test	08/15/2015 16:18	Completed					
Review	HIMS, Carbon Copy		Completed			Resident, Test	08/15/2015 16:18	Dr. Zeus from Olympus, Dr. Hera fr
Sign	Walton, Lisa L.		Requested			Resident, Test	08/15/2015 16:18	

**Action Pane**  
 Sign ☐ Refuse Reason:   
 Additional Forward Action: Review To: (Limit 5) Druban MD, David E.   
 Comments: (Limit 255)   
 Next OK OK & Next

## Provider Letter

When you use HIMS, Carbon Copy to carbon copy an external provider not in the PowerChart database, HIMS will create a Provider Letter to send with your document. It displays to whom the document was sent via fax/U.S. mail.

You will see this provider letter under **Documents> Provider Letter**. There will be one Letter per carbon copied provider. Double click to open and view details.



Health Information Management Services  
4755 Ogletown-Stanton Road  
Newark, DE 19718  
(302) 733-1128 or (302) 733-1070

Timothy Shih,  
123 Street Address  
City, State

Dear Timothy Shih,

Enclosed is the Document related to the stay of JESSICA IPASS. If you have problems with this transmission, please contact the HIMS department at Christiana Care at the telephone number listed above.

If you have received this transmission in error, please notify the HIMS department immediately by telephone and return the original transmission to us at the above address.

Attached: 08/31/15 H&P

Sincerely,

Christiana Care Health Services

**Notice:** This transmission is intended only for the use of the provider to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. The recipient of this information is prohibited from disclosing the information to any other party and is required to destroy the information after the need has been fulfilled.

Name: IPASS, JESSICA

Page 1 of 1

DOB: 04/04/2015



## MAU Workflow

### Refusing a Note

In some cases, you may receive a document in your Message Center inbox that you feel should not be there.

1. Refuse a document by clicking the **Refuse** circle.
2. Click the dropdown next to reason.
3. Select a reason for refusal from the list.
4. Click OK or OK and Next.

<p>Not Entered as Communicated Signed by another provider Addendum created, Merge Reports Incomplete report Redictated Forwarded to other provider to sign Do not follow this patient Unable to Complete Wrong document type Wrong Provider/Physician Wrong visit date/FIN</p>		<p>Lasix 20 mg oral tablet 20 MG = 1 TAB, PO, Daily</p> <p><b>Allergies</b> Nuts</p> <p><b>Social History</b> Ever Smoked Tobacco: Never Smoker Alcohol use - frequency: None Drug use: Never Family History ED: Cancer, Hypertension</p>
<p><b>Action Pane</b></p> <p> <input type="radio"/> Sign         <input checked="" type="radio"/> Refuse         Reason: <span style="border: 1px solid black; padding: 2px;">Wrong Provider/Physician</span> </p> <p> <input type="checkbox"/> Additional Forward Action: <span>Review</span> To: <span>(Limit 5)</span> <span>PDF</span> </p> <p>         Comments: <span>(Limit 255)</span> </p>		
<p style="text-align: right;"> <span>Next</span> <span>OK</span> <span>OK &amp; Next</span> </p>		

## MAU Workflow

### MAU Quick Orders

The Quick Orders tab is a list of commonly ordered tests, procedures, medications and E&M charges. **Before completing an order, you must add a diagnosis.**

The screenshot shows the MAU Quick Orders interface with several tabs visible: E&M, POC, Lab, Radiology, Medications - In Office, and Consolidated Problems. The E&M tab is active, displaying a list of orders including 99201 NEW PATIENT OFFICE VISIT, PROBLEM FOCUSED PP MAU, 99202 NEW PATIENT OFFICE VISIT, EXPANDED PROBLEM FOCUSED PP MAU, 99203 NEW PATIENT OFFICE VISIT, DETAILED PP MAU, 99204 NEW PATIENT OFFICE VISIT, COMPREHENSIVE PP MAU, 99205 NEW PATIENT OFFICE VISIT, COMPLEX PP MAU, 99211 ESTABLISHED PATIENT VISIT, MINIMAL PP MAU, 99212 ESTABLISHED PATIENT VISIT, FOCUSED PP MAU, 99213 ESTABLISHED PATIENT VISIT, EXPANDED PP MAU, 99214 ESTABLISHED PATIENT VISIT, DETAILED PP MAU, 99215 ESTABLISHED PATIENT VISIT, COMPLEX PP MAU, 99224 POST OPERATIVE VISIT INCL. GLOBAL PP, 99429 SCHOOL/CAMP PHYSICALS PP, and No Charge - MAU. The POC tab shows orders like Blood Glucose-Point of Care, HCG Urine, Point of Care, Hgb, Point of Care, MAU Mono POC, MAU Rapid Flu POC, Occult Blood Stool Point of Care, Oxygen, Peak Flow, Pulse Ox (Check), Strip A (Rapid Screening) Point of Care, and Urine Dipstick, Point of Care. The Lab tab shows Affirm Vaginal, HSV Culture, RSV & Influenza A/B PCR, Wound Culture, Aerobic, includes Gram, Viral Culture, and UA. The Radiology tab shows ACJ Pain, Ankle Left AP/Lat/Obl Pain, Ankle Right AP/Lat/Obl Pain, Facial Bones & Orbits, Facial Bones 3 View, Femur Left AP/Lat, Femur Right AP/Lat, Foot Left AP/Lat/Obl, Foot Right AP/Lat/Obl, Hip Lateral w Pelvis Left, Hip Bilateral, Knee Left AP/Lat, Knee Right AP/Lat/Patella, Knee Right AP/Lat, Knees Bilateral AP Standing, Leg: Tibia/Fibula Left, Leg: Tibia/Fibula Right, Mandible Bilateral, Nasal Bones, Sinuses, Skull, Sternum, TMJ, and Toe Left Great (1st). The Medications - In Office tab shows Aluminum Hydroxide-Magnesium Hydroxide (Maalox) Susp- Ambulatory, D50 (Dextrose 50%- Ambulatory, dexaMETHasone (Decadron) Inj- Ambulatory, DICICLOmine (BENIV)- Ambulatory, DiphenhydramINE (Benadryl)- Ambulatory, DiphenhydramINE (Benadryl) Liquid- Ambulatory, Doxycycline (Vibramycin)- Ambulatory, ePINEphrine (Adrenalin) Nasal Solution- Ambulatory, ePINEphrine (EpiPen) Auto-Injector- Ambulatory, ePINEphrine Inj- Ambulatory, Fluorescein (Ful-Glo) Ophth Strip- Ambulatory, Glucose gel - Ambulatory, Guaifenesin (Robitussin) Liquid- Ambulatory, Guaifenesin-Dextromethorphan (Robitussin DM)- Ambulatory, Ibuprofen (Motrin / Advil)- Ambulatory, Influenza "High Dose" vaccine (65 YR+)- Ambulatory, and Influenza vaccine- Ambulatory. The Consolidated Problems tab shows All Visits, Classification: All, Add new as: This Visit, Priority, Problem, This Visit (1), Hypertension, Chronic (0), Record "No Chronic Problems", No results to display, Historical (1), Show Previous Visits, New Order Entry, Ambulatory - In Office (Made in Office), Search New Order, Personal, Favorites, and No Favorites Found.

To order, click once on the name of the order.

As you select orders, the order inbox will turn green and tally the number of orders. Click the green inbox.

The screenshot shows the MAU Quick Orders interface with the Lab and Radiology tabs visible. The Lab tab shows Affirm vaginal, HSV Culture, RSV & Influenza A/B PCR, Wound Culture, Aerobic, includes Gram, Viral Culture, and UA. The Radiology tab shows ACJ Pain, Ankle Left AP/Lat/Obl Pain, Ankle Right AP/Lat/Obl Pain, Facial Bones & Orbits, and Facial Bones 3 View. The Orders for Signature window is open, showing a list of orders for signature, including Ankle Left AP/Lat/Obl (Pain). The window has a green header and a table with columns for Order, Diagnosis, and Signature. The table shows one order: Ankle Left AP/Lat/Obl (Pain) with a diagnosis of (100) Hypertension. The window has buttons for Sign, Save, Modify, and Cancel.

Associate the order with the diagnosis by clicking in the column under the diagnosis. Then click Sign.

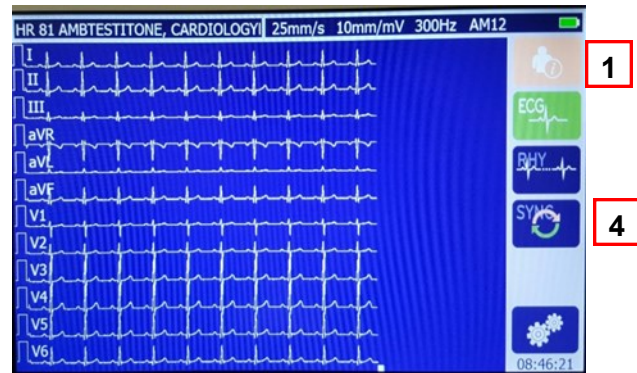
The order may require additional details to complete it. The Order sentence window will appear. Select from the list and then click OK.

The screenshot shows the Order Sentences window. The window has a title bar that says "Order Sentences". Below the title bar, it says "Order sentences for: Toe Left 2nd". There is a list of sentences: (None), Pain, Injury, Swelling, Post Reduction Fracture, Amputation Status, and Cellulitis. At the bottom of the window, there are buttons for Reset, OK, and Cancel.

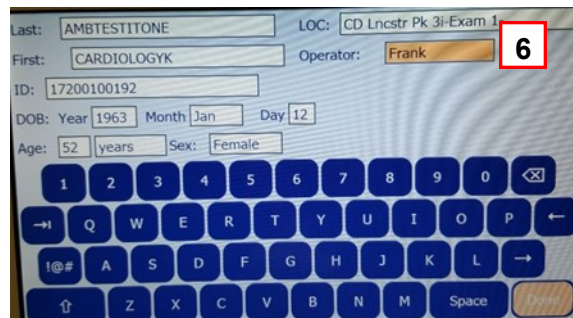
## EKG

### Sync Patient Information on the EKG machine

1. On the EKG machine, click the Orange tab.
2. Click the MWL (Modality Worklist) button.
3. Click on drop down next to query code and select location.
4. If the patient isn't displayed, click the Sync button. The Transmit screen will sync.
5. Highlight the patient name on the list.



6. In Operator box, type your 801#.
7. Select Done.



### Perform the EKG

1. Attach the leads to the patient.
2. On the EKG machine, select the ECG button.



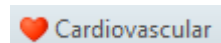
This begins capturing the EKG. It will display on the screen of the machine.

3. When you are satisfied with the EKG, click Transmit. The screen displays Transmission status 1 out of 1 EKG transmitted.
4. Click Done. This ends the EKG process.

## Performing an EKG

### Mark the EKG as completed in FirstNet

1. In the toolbar above the Tracking Board, click the Cardiovascular button.
2. On the Cardiovascular work list, find your patient.
3. Click once to highlight.
4. In the Steps sections, the status should be Completed under the Status column.
5. Right mouse click on the word Completed.
6. Click Edit Performing Information.



Steps				
Action	Status	Description	Performed Locat...	Performe
	Completed	EKG Acquisition		Tue, 09/13/2016 15:30
Edit	Saved	Edit Performing Information		Tue, 09/13/2016 15:30

7. In the Modify Performed Step box, add your name under Provider, if not defaulted.
8. Select OK. The Tech name will display under Performed by.

Modify Performed Step

Start Date

09/13/2016

1529

EDT

Stop Date

09/13/2016

1529

EDT

Provider

Walton, Lisa L.

OK

Cancel

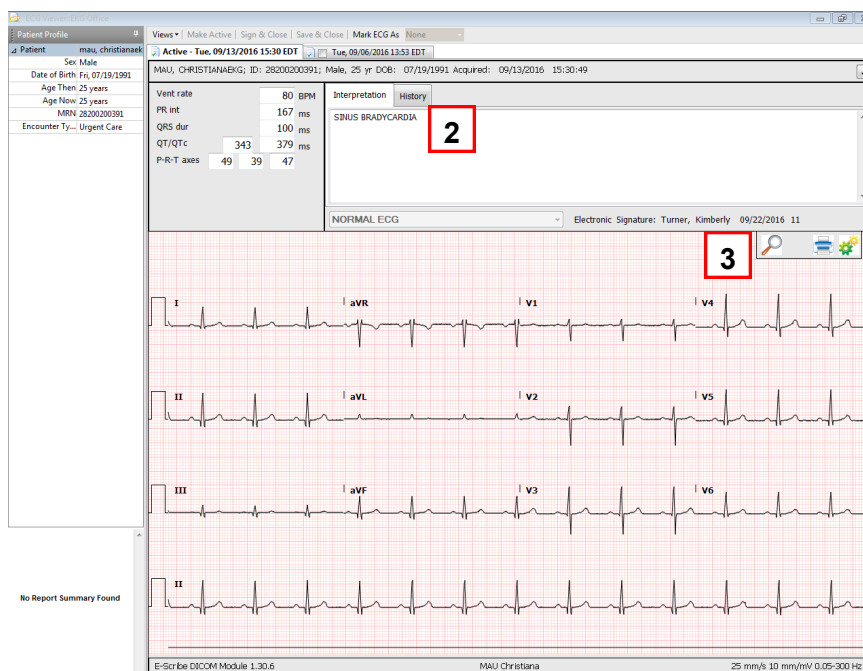
### Interpreting/ Signing the EKG

The status of EKGs will be displayed in the EKG column of the Tracking Shell. The column shows the number of ordered tests/number completed tests.

EKG
1/1
1/0

1. Double click on the status of 1/1 to see the transmitted EKG.

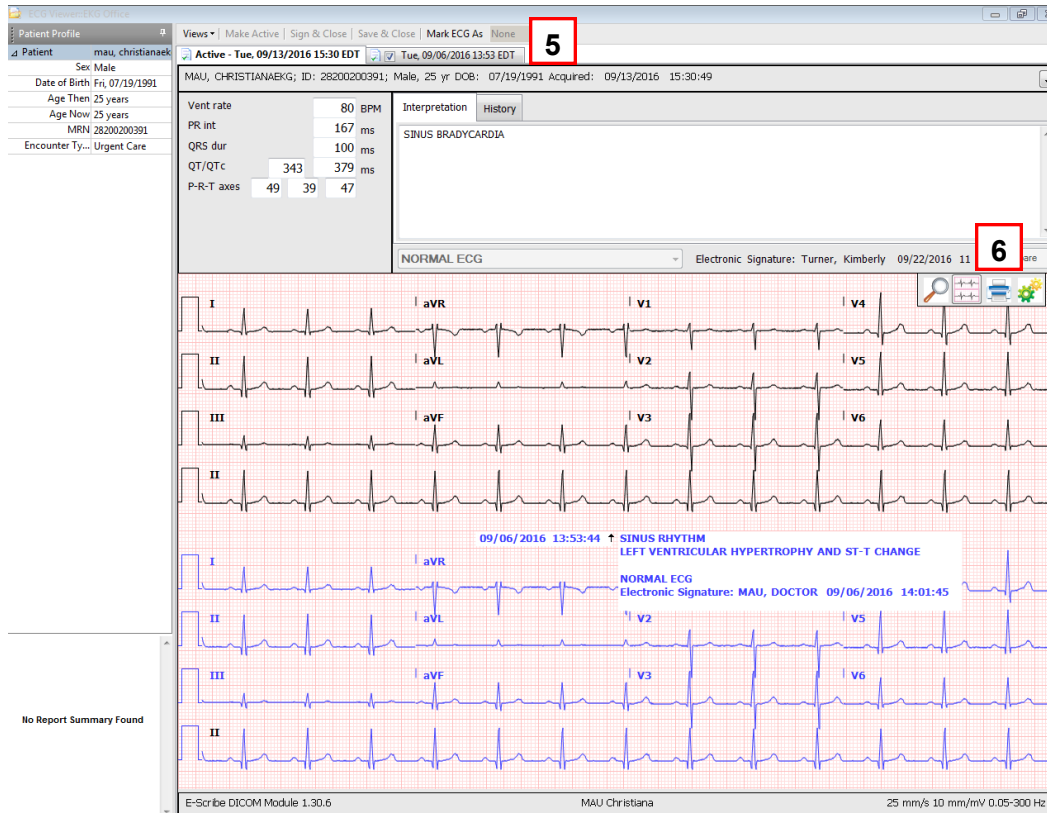
2. The ECGs for the patient are displayed in the viewer. Software generated interpretation will be listed under the Interpretation tab.
3. In the ECG Waveform toolbar, click the magnify button and position your pointer over the waveform to see a magnified view.
4. To add calipers, click, hold and drag along the waveform. Blue calipers will appear. Remove the calipers by right clicking and select Remove Calipers.



## Performing an EKG

### Interpreting/ Signing the EKG

5. To compare another ECG to the active ECG, check the box next to the previous.
6. Click the compare button. The previous EKG will be displayed under the current for comparison.






7. If necessary, edit the EKG interpretation in the Interpretation tab. Click the interpretation text to edit it directly. You can also view and edit information in the History tab.
8. You can also add a Normalcy indicator. Next to Mark ECG as, click the dropdown. Select from the list: None, Abnormal, Critical. Save as appropriate.
9. When you are done editing the EKG, click one of the following button options to save your changes and exit PowerChart EKG viewer:
  - Save and Close: Save the EKG and close PowerChart EKG viewer.
  - Ready to Sign and Close: Save the EKG as Ready to Sign and closes PowerChart EKG Viewer.
  - Sign and Close: Signs the EKG and closes PowerChart EKG Viewer.
  - Prelim and Close: performs a preliminary read on an EKG and closed PowerChart EKG viewer.
5. To change interpretation or add and addendum, right-click on the interpretation step and select Undo Completed.
6. Click the Print button to print the EKG (if needed).



## Medications




1. Hover over the number in the Med Column to see the actual orders.

Orders	Med	Lab	Rad	EKG	Stop	Provider	Nurse	Ancillary	Real Time Lo	Rm Time
  	4	10/0	2/0/0	1/0						18:37
<b>IV Medications</b> Sodium Chloride 0.9% 1,000 ML      Time: 06/19/2014 21:47      Order Status: Ordered      Departmental Status: Ordered      User: Shiuh MD, Timothy Y.										
<b>Scheduled Medications</b> Ondansetron 4 Mg Oral Disintegrating Tab      Time: 06/19/2014 21:48      Order Status: Ordered      Departmental Status: Ordered      User: Shiuh MD, Timothy Y. Hydromorphone 1 Mg Syr      Time: 06/19/2014 21:48      Order Status: Ordered      Departmental Status: Ordered      User: Shiuh MD, Timothy Y. Acetaminophen 325 Mg Tab      Time: 06/19/2014 21:47      Order Status: Ordered      Departmental Status: Ordered      User: Shiuh MD, Timothy Y.										



2. Double click in the **Meds** column to access MAR and see a list of all medications that were ordered.
3. Review orders before administering meds to patient. Confirm the medication you will administer matches what was ordered.

**Menu**  
ED Nursing Viewpoint  
Task List  
**MAR**  
MAR Summary  
Glycemic  
Allergies + Add  
AntiCoag  
DMAR  
Clinical Notes + Add  
ED Summary  
Form Browser  
Iview  
Medication List + Add  
Orders + Add

**MAR**  
12 September 2014 11:35 - 14 September 2014 11:35  
☒ Show All Rate Change Documen...  
**Time View**  
☒ Scheduled  
☒ Unscheduled  
☒ PRN  
☒ Continuous Infusions  
☒ Future  
☒ Discontinued Scheduled  
☒ Discontinued Unscheduled  
☒ Discontinued PRN  
☒ Discontinued Continuous Infusions

Medications	09/13/2014 4 11:33	09/13/2014 4 12:00
<b>Scheduled</b>		
 <b>albuterol (albuterol (PROVENTIL) Neb Soln...</b> Dose of 5 MG = 1 ML, Inhalation, Once, Order Start: 09/13/2014 11:33, Order Stop: 09/13/2014 11:33, NOW	<b>NOW</b>	
albuterol Neb		
 <b>AZITHromycin (AZITHromycin (Zithrom...</b> Dose of 500 MG, IV, Once, Order Start: 09/13/2014 12:00, Order Stop: 09/13/2014 12:00		<b>500 MG</b>
AZITHromycin		
 <b>cefTRIAXONE (cefTRIAXONE (Rocephin)) ...</b> Dose = 1 G, IV, Once, Order Start: 09/13/2014		<b>1 G</b>

4. After giving the med, document administration directly from MAR. Double click on the time column (should be listed as NOW).
5. In the Medication window, complete any required details (depending on the medication, some fields may be yellow and must be completed prior to signing).
6. You can also document if the medication was not given. Check the box next to Not Given and select a reason from the list.
7. Click the green check mark to sign.

**predniSONE (PredniSONE (Deltasone) - Ambulatory) (PredniSONE 20 Mg Tab)**  
Dose of 20 MG = 1 TAB, PO, Once, Order Start: 09/18/2016 15:56, Order Stop: 09/18/2016 15:56, NOW

\*Performed date / time: 09/18/2016 1558  
\*Performed by: Walton, Lisa L.

\*predniSONE: 20 MG Volume: 0 ml  
Diluent: <none> ml  
\*Route: PO Site:

☐ Not Given  
Reason:

Comment...

## Labs/ Rads

Hover over the column to see the actual orders.

The Lab and Rad columns show the number of **ordered tests/number of processing tests/ number of resulted tests**.

Lab	Rad	EKG	Stop	Provider	Nurse	Ancillary	Real Time	LoRm Time
1/0	2/0/0							
Order		Time		Order Status		Departmental Status		User
CBC with diff		06/02/2014 16:59		Ordered		Ordered		EDDoc, Test

Lab/ Rad

**Discharge (Depart)**

1. From the FirstNet toolbar, right click on the patient you wish to discharge.
2. Click **Discharge Process**.
3. The Depart Process window opens.
4. Ensure all of the Depart items are completed (there is not yellow).
7. Print the Discharge Instructions by clicking Print.
8. Explain the Discharge Instructions to the patient and get signature for chart scan.
9. Click the pencil next to Discharge patient.
10. The patient will then drop from the First Net Tracking Board.



## Results Callback Worklist

Review the list and call patients who have abnormal lab results (from CCHS).

1. Click the Results Callback Worklist in the toolbar.
2. Under Facility, click the dropdown arrow and select the Facility for which you are reviewing results. Click Submit.
3. Under Nurse units, click the dropdown and select the unit. Click Submit.
4. Click the Update List button.
5. On the Callback List tab, the total number of patients will be displayed.
6. The Patient Name, Result, Status, Comments and last updated will be displayed in columns.
7. Each row is a different patient.
8. To document the call to the patient, click the right facing arrow next to the patient name.
9. Information about the patient's results and callback information displays.

The screenshot displays the 'Results Callback Worklist' application. On the left, a list of patients is shown with expandable details. The main area shows a detailed view of a patient named 'PHENO'. The patient's information is displayed in a blue banner at the top (labeled A). Below this, the test name 'PHENO' and its normal range '(15.0-40.0) MG/L' are listed (labeled B). The test result '11.1 MG/L' is shown (labeled C). The date and time of the test, 'March 6, 2016 14:33', are displayed (labeled D). On the right side of the patient view, encounter details are listed, including 'Encounter Date and Location', 'Encounter Diagnostics', 'Encounter Provider', 'Allergies', 'Discharge Diagnosis', 'Encounter Treatment', 'Discharge Medications', and 'Home Medications' (labeled E). The 'Callbacks' tab is active, showing options to select 'No Answer', 'Left Message', or 'Patient Contacted'. A free text box is provided for additional information, and buttons for 'Cancel', 'Letter', and 'Sign' are at the bottom.

- A. The blue banner bar has information about the patient.
- B. The test name and normal range is listed
- C. Test result
- D. The date the test was completed is displayed.
- E. Encounter details are listed down the right side:
 

Encounter Date and Location	Discharge Diagnosis
Encounter Diagnostics	Encounter Treatment
Encounter Provider	Discharge Medications
Allergies	Home Medications
- F. The Callbacks tab lists the patient's Phone numbers and the PCP name and phone number. Options to select are:
  - No Answer
  - Left message
  - Patient Contacted
  - A free text box allows you to add additional information.

If you contacted the patient, and nothing else is required, you can check the No further action required box. Then click Sign. The patient is removed from the list. You can see them on the Completed Callbacks tab.

## Document Patient Refusal of Treatment

1. Select the patient from the Tracking List.
2. Double-click the Patient Care icon in the Activities column.
3. In the Document Activities window, click the check box next to the Patient Care that was not performed.
4. Click **Not Done** at the bottom of the window.
5. In the dialog box, select an option from the **Reason Not Done** dropdown (Patient Refused).
6. Click **Sign**.
7. Close the Document Activities box to return to the Tracking List.



**Document Activities**

testscript, cp      Age: 42 years      Sex: Male      MRN:      Location: ECED  
Allergies: Allergies Not Recorded      DOB: 11/11/1971      Fin Number:      <No - Encounter ...

Refresh

Medications (1)      Patient Care (1)      Assessments (4)      Other (0)

**Medications (1)**

☐ Nitroglycerin (Nitrostat) SL Tab  
Dose of 0.4 MG = 1 SLTAB, SL, Q\_5Min, PRN for: Chest pain-MR x3, Hold for SBP (mmHg) < 90, Order Start: 05/19/2014 06:46; nitroglycerin

☒ **Patient Care (1)**

☒ MRI Abdomen Consult  
ED / Results ED, Attn: Liver, Mass, Liver, Stretcher, 06/09/2014 09:04; MRI Safety Questionnaire

**Assessments (4)**

☐ ED Rad Order  
\*\*\* Routine; ED Rad Order

☐ Nitroglycerin (Nitrostat) SL Tab  
Dose of 0.4 MG = 1 SLTAB, SL, Q\_5Min, PRN for: Chest pain-MR x3, Hold for SBP (mmHg) < 90, Order Start: 05/19/2014 06:46; PRN Response

☐ Nitroglycerin (Nitrostat) SL Tab  
Dose of 0.4 MG = 1 SLTAB, SL, Q\_5Min, PRN for: Chest pain-MR x3, Hold for SBP (mmHg) < 90, Order Start: 05/19/2014 06:46; PRN Response

☐ Nitroglycerin (Nitrostat) SL Tab  
Dose of 0.4 MG = 1 SLTAB, SL, Q\_5Min, PRN for: Chest pain-MR x3, Hold for SBP (mmHg) < 90, Order Start: 05/19/2014 06:46; PRN Response

**Other (0)**

Not Done      Document      Cancel

**MRI Safety Questionnaire (Not Done) - testscript, cp**

\*Performed on: 06/16/2014 1036 By: Walton, Lisa L.

\*Reason Not Done: Patient/Family Refused

Comment: