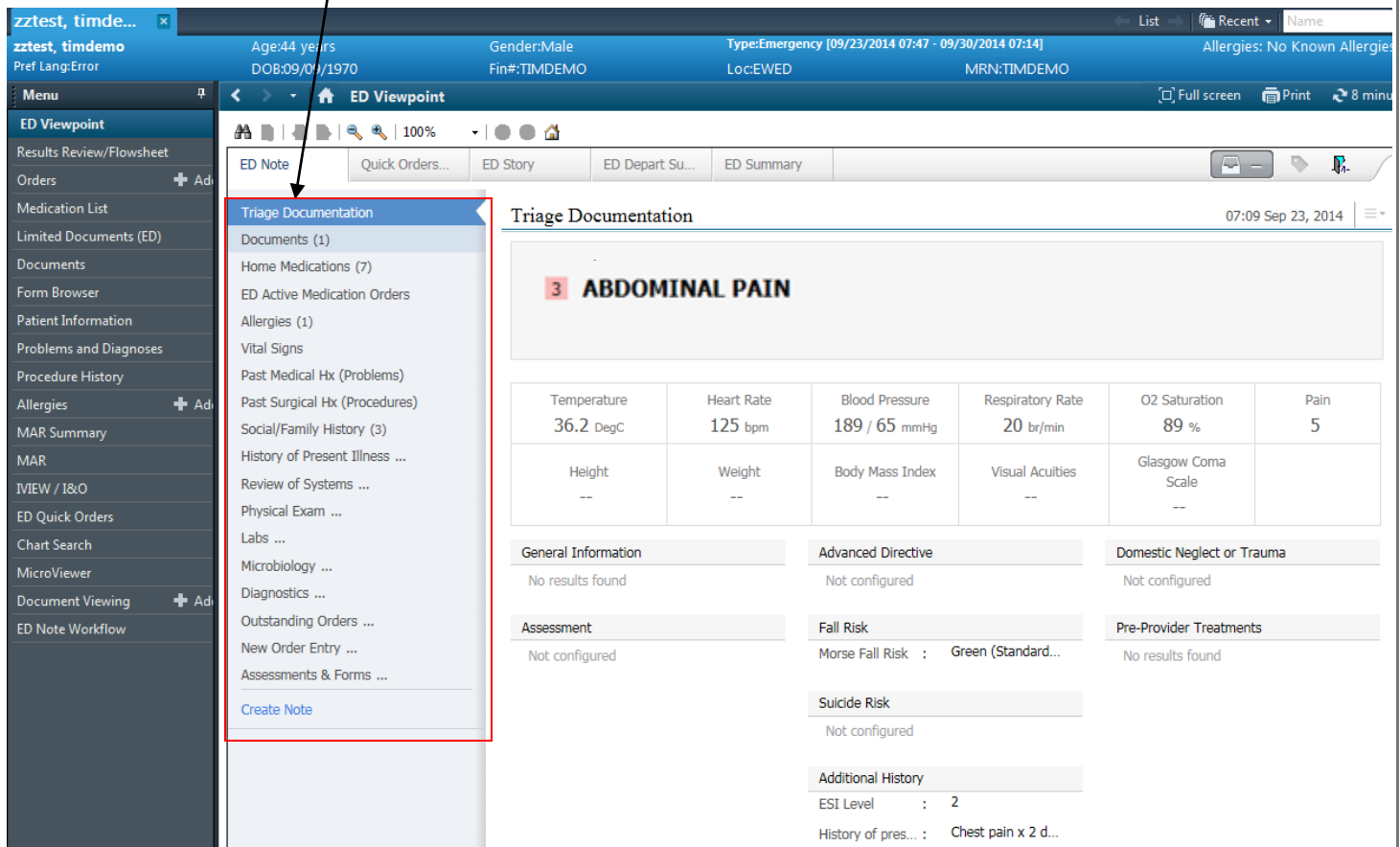


Documentation Workflow

The new Documentation workflow page will make the creation of your notes a by-product of your normal workflow.

1. Launch Dragon before accessing a patient's chart, so that it may load while you are reviewing the chart.
2. From the patient list, open the patient's chart.
3. The **ED Viewpoint** will open to the ED Note Workflow.
4. On the left is the **Workflow**.



The screenshot displays the ED Viewpoint interface for a patient named Timdemo. The left sidebar contains a menu with various options, including 'Triage Documentation' which is highlighted with a red box. The main content area shows the 'Triage Documentation' workflow for 'ABDOMINAL PAIN' on 07:09 Sep 23, 2014. The workflow includes a table of vital signs and a series of assessment sections.

Temperature	Heart Rate	Blood Pressure	Respiratory Rate	O2 Saturation	Pain
36.2 DegC	125 bpm	189 / 65 mmHg	20 br/min	89 %	5

Height	Weight	Body Mass Index	Visual Acutities	Glasgow Coma Scale
--	--	--	--	--

General Information
No results found

Advanced Directive
Not configured

Domestic Neglect or Trauma
Not configured

Assessment
Not configured

Fall Risk
Morse Fall Risk : Green (Standard...)

Pre-Provider Treatments
No results found

Suicide Risk
Not configured

Additional History
ESI Level : 2
History of pres... : Chest pain x 2 d...

5. Click on each item to jump to that section. You can also scroll down the page to review each section in the workflow.

Sections in Workflow

Documents

Documents provides a list of previous signed electronic documents for this visit based on the timeframe selected.

Click on the Note Type to open and view the document.

The list defaults to most recent document on top, but the timeframe can be changed.

Documents (9)

Selected visit | Last 24 hours | Last 48 hours | More ▾

☐ My notes only ☐ Group by encounter | Display: Facility defined view ▾

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
Progress Note	Progress Note Basic	Ali MD, Mohammed	04/01/14 13:29	Ali MD, Mohammed	04/01/14 13:33
Progress Note	Medicine - CCHP	Uzelac MD, Giovanna L. (resident)	03/31/14 17:27	Uzelac MD, Giovanna L. (resident)	03/31/14 17:32
Progress Note	Progress Note Basic	MDPilot, Test	03/31/14 16:35	MDPilot, Test	03/31/14 16:37

Pane View

Documents (3)

Selected visit: Last 48 hours | Last 24 hours | Last 1 weeks | More ▾

☐ My notes only ☒ Group by encounter | Display: Facility defined view ▾

Progress Note MDPilot5, Test 04/16/14 13:52	<p>Progress Note 04/16/14 12:14</p> <p>Progress Note</p> <p><u>Subjective</u></p> <p><u>Objective/Physical Exam</u></p> <p><u>Vitals & Measurements</u></p> <p>GENERAL: [awake], [well-developed, well-nourished], [comfortable]</p> <p>HEAD/EYES: [normocephalic, atraumatic], [normal lids and conjunctiva], [pupils equal], [extraocular muscles intact]</p> <p>EARS/NOSE/THROAT: [normal external ears/nose], [normal tympanic membranes], [normal oropharynx]</p> <p>NECK: [supple], [full range of motion], [no masses], [no thyromegaly]</p> <p>CARDIOVASCULAR: [normal S1/S2], [regular rate and rhythm], [no murmur/gallop/rub]</p> <p><u>Lab Results</u></p> <p>/</p> <p>1.0 \</p> <p>300</p> <p><u>Labs</u></p> <p>HGB 9.4 G/DL 04/15/2014 13:30 EDT (Low)</p>
Progress Note MDPilot5, Test 04/16/14 13:26	
Progress Note MDPilot3, Test 04/16/14 12:14	

On the Pane view, use down arrow on keyboard or click the note name to move from note to note, to review like paper chart.

Click on Pane Icon to view the documents like a paper chart.

Visible on Documentation Workflow:

ED Notes
H&P
Consults
OP reports
Stress/Cath and GI reports
Discharge Summaries

To see additional documents, click the section header.

Sections in Workflow

Triage Documentation

Triage Documentation provides a quick summary of Triage information in an easy to read view.

Based on the Triage Nursing Documentation for this visit, it includes:

- Chief complaint: This is the Triage Chief complaint.
- Vital signs: Most recent set
- General Information: such as mode of arrival
- Advanced Directive choices
- Domestic Neglect or Trauma details
- Assessment from Triage
- Fall Risk
- Pre-Provider Treatments
- Suicide Risk
- Pregnancy information
- Additional History, like the Acuity level and HPI.

Triage Documentation				12:11 Nov 04, 2014	
3 ABDOMINAL PAIN					
Temperature 36.8 DegC	Heart Rate 95 bpm	Blood Pressure 122 / 73 mmHg	Respiratory Rate 16 br/min	O2 Saturation 98 %	Pain 9
Height --	Weight 66.3 KG	Body Mass Index --	Visual Acuities --	Glasgow Coma Scale --	Fetal Heart Tones --
General Information		Advanced Directive		Domestic Neglect or Trauma	
No results found		Not configured		Not configured	
Assessment		Fall Risk		Pre-Provider Treatments	
Not configured		Morse Fall Risk : Green (Standard Risk)		No results found	
		Suicide Risk		Pregnancy	
		Not configured		Not configured	
		Additional History			
		ESI Level : 3			
		History of present i...: Pt c/o R sided abd p...			

Sections in Workflow

Home Medications

Home Medications carry over from Encounter to Encounter. Although Home Meds may be documented by the ED, ensure they are accurate and do not contraindicate, as this list will populate in your note.

Home Medications (7)

Medication	Last Dose Date/Time	Compliance	Compliance Comments
Rx: albuterol 90 mcg/inh inhalation aerosol with adapter 2 PUFF, Inhalation, Q4H, 1 EA, PRN: Wheezing/SOB	--	--	--
Hx: Aspirin	--	--	--
Hx: GLIPIzide.	--	--	--
Rx: Levaquin 500 mg oral tablet 500 MG, 1 TAB, PO, Q24H, 06/18/14 16:19 7 TAB	--	--	--

To see if the Med History has been updated for this visit, see the Status in the ED Active Medication Orders section below.

ED Active Medication Orders

Medications for the selected visit are displayed in the following categories:




- Scheduled
- Continuous
- Administered in last 12 hours

ED Active Medication Orders

For the full list of medications and administrations, click the ED Active Medication Orders heading to view the MAR Summary screen.

Scheduled (0)
Continuous (0)
Administered (0) Last 12 hours

Status: Complete
Last Documented: 09/23/2014 08:13
Last Documented By: Shiuh MD, Timothy Y.


Status:  Meds History  Adm. Meds Rec  Disch. Meds Rec

Medication Reconciliation Status is easy to determine on the workflow.

- Meds History (Home Medications)
- Adm. Meds Rec
- Disch. Meds Rec

 = Completed

 = In Progress

 = Not Started

Hover over the status to see the Date/ Time and person who completed the Med Rec. To complete reconciliation or view the med rec screens, click the status.

Sections in Workflow

When performing Med Rec, confirm that the information on the right side is correct and that the order includes:

- Name
- Dosage
- Route
- Frequency

Order Reconciliation: Admission - ZZTEST, PHYSDOC6

ZZTEST, PHYSDOC6 Age: 28 years Gender: Female Type: Inpatient [01/24/2014 07:39 - <No - Discharge da... Allergies: No Known Allergies
DOB: 01/24/1986 Fin#: 3800100074 Loc: CSA; 5A01; B MRN: 2800100056

+ Add | Manage Plans Status: ☒ Meds History ☐ Adm. Meds Rec ☐ Disch. Meds Rec

Orders Prior to Reconciliation			Orders After Reconciliation		
Order Name/Details	Status		Order Name/Details	Status	
Medications					
acetaminophen (Acetaminophen (Tylenol)) (Ace... 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever	Ordered	<input checked="" type="radio"/>	acetaminophen (Acetaminophen (Tylenol)) (Ace... 650 MG, 2 TAB, PO, Q4H, PRN: Pain Scale - Mild 1-3/Fever	Ordered	<input checked="" type="radio"/>
AMLOdipine (AMLOdipine.) 0 Refill(s)	Documented	<input type="radio"/>			<input type="radio"/>
aripiprazole (Abilify) 0 Refill(s)	Documented	<input type="radio"/>			<input type="radio"/>
CAPTOpriL (CAPTOpriL) 0 Refill(s)	Documented	<input type="radio"/>			<input type="radio"/>
carvedilol (Carvedilol (Coreg)) (Carvedilol 6.25 MG, 1 TAB, PO, BID	Documented	<input checked="" type="radio"/>	carvedilol (Carvedilol (Coreg)) (Carvedilol 6.25 M... 6.25 MG, 1 TAB, PO, BID	Ordered	<input checked="" type="radio"/>
carvedilol (Coreg)	Documented	<input type="radio"/>			<input type="radio"/>
levofloxacin (LevoFLOxacin (Levaquin)) (LevoFL... 750 MG, 1 TAB, PO, Daily	Ordered	<input checked="" type="radio"/>	levofloxacin (LevoFLOxacin (Levaquin)) (LevoFL... 750 MG, 1 TAB, PO, Daily	Ordered	<input checked="" type="radio"/>
levothyroxine (Levoxyl)	Documented	<input type="radio"/>			<input type="radio"/>
metoprolol (metoprolol XL (Toprol-XL)) 25 MG, PO, Daily	Ordered	<input checked="" type="radio"/>	metoprolol (metoprolol XL (Toprol-XL)) 25 MG, PO, Daily	Ordered	<input checked="" type="radio"/>
nitroglycerin (Nitroglycerin (Nitrostat) SL Tab) 0.3 MG, SL, Q 5Min, PRN: Chest pain-MR x2	Ordered	<input checked="" type="radio"/>	nitroglycerin (Nitroglycerin (Nitrostat) SL Tab) 0.3 MG, SL, Q 5Min, PRN: Chest pain-MR x2	Ordered	<input checked="" type="radio"/>
omeprazole (omeprazole.) 0 Refill(s)	Documented	<input type="radio"/>			<input type="radio"/>
ondansetron (Ondansetron ODT (Zofran ODT)) (O... 4 MG, 1 SL TAB, PO, Q8H, PRN: Nausea/Vomiting	Ordered	<input checked="" type="radio"/>	ondansetron (Ondansetron ODT (Zofran ODT)) (O... 4 MG, 1 SL TAB, PO, Q8H, PRN: Nausea/Vomiting	Ordered	<input checked="" type="radio"/>
piperacillin-tazobactam (Piperacillin-Tazobacta... 4.5 G, 200 ML/HR, IV, Q8H	Ordered	<input checked="" type="radio"/>	piperacillin-tazobactam (Piperacillin-Tazobacta... 4.5 G, 200 ML/HR, IV, Q8H	Ordered	<input checked="" type="radio"/>
topiramate (Topamax)	Documented	<input type="radio"/>			<input type="radio"/>
zolpidem (Zolpidem (Ambien)) (Zolpidem 5 Mg T... 2.5 MG, 0.5 TAB, PO, QHS, PRN: Insomnia	Ordered	<input checked="" type="radio"/>	zolpidem (Zolpidem (Ambien)) (Zolpidem 5 Mg T... 2.5 MG, 0.5 TAB, PO, QHS, PRN: Insomnia	Ordered	<input checked="" type="radio"/>

Details

0 Missing Required Details 7 Unreconciled Order(s) Reconcile And Sign Cancel

Allergies

Modify Allergies by selecting section header or add an allergy by clicking the plus sign.

Allergies (1) + All Visits

Name	Severity	Reaction	Reaction Type	Onset	Source	Comments
NKA	--	--	Allergy	--	--	--

Allergies

Mark All as Reviewed

+ Add | Modify | ☐ No Known Allergies | ☐ No Known Medication Allergies | ☒ Reverse Allergy Check | Display: **Active**

D...	Substance	Category	Reactions	Seve...	Type	C...	Est. Onset	Reaction S...	Updated By	Source	Reviewed	I...
NKA		Drug			Allergy			Active	06/05/201...		06/25/20...	

Vital Signs

This section only shows vitals from the current encounter. To view vitals from previous encounters, click the header to change the search criteria.

Vital Signs + Selected visit: **Latest+** Selected visit: Last 6 months More

	Aug 8, 2013 07:06	Jul 24, 2013 13:08	Jul 17, 2013 13:44	Jun 25, 2013 18:55
Temp	36.0	--	--	36.8
BP	--	--	--	163 [2] 89
HR	--	--	--	93
Respiratory Rate	--	--	--	20
Pulse Ox	--	--	--	98
Oxygen Source ED	--	--	--	Nasal Cannula

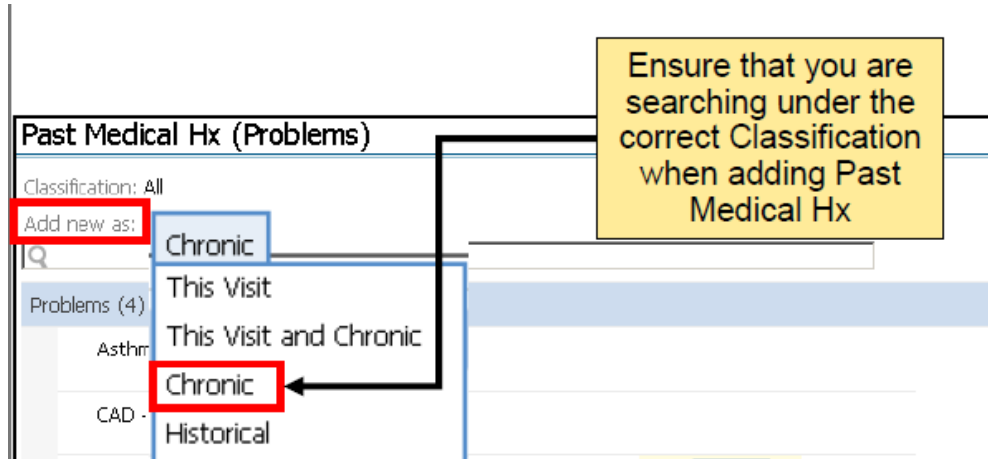
Display defaults to most recent vitals, but the timeframe can be changed.

Sections in Workflow

Past Medical Hx (Problems)

Past Medical Hx (Problems) is a combined list of Past Medical History and Problems.

To add Past Medical History and Problems, change the “Add New As”, located above the Search field, to Chronic.



Past Medical Hx (Problems)

Classification: All

Add new as: **Chronic**

Problems (4)

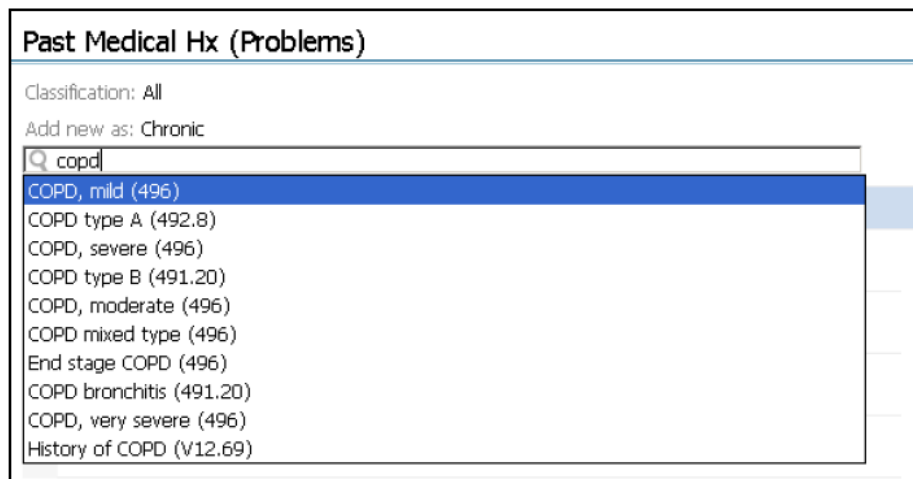
- Asthma
- CAD - Coronary artery disease
- HTN - Hypertension
- ...

Chronic
This Visit
This Visit and Chronic
Chronic
Historical

Ensure that you are searching under the correct Classification when adding Past Medical Hx

In the Search field, type the problem. This will begin yielding results from which you can choose.

Click the appropriate problem.



Past Medical Hx (Problems)

Classification: All

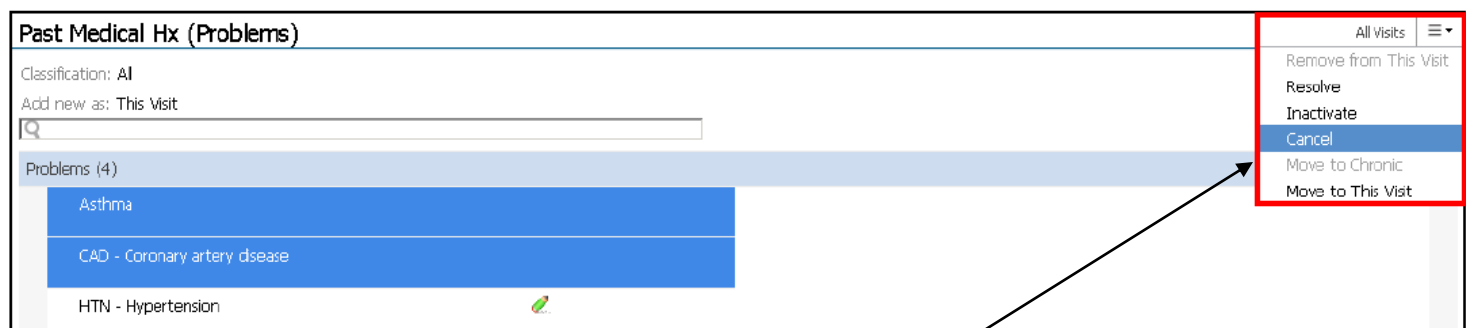
Add new as: Chronic

Q copd

- COPD, mild (496)**
- COPD type A (492.8)
- COPD, severe (496)
- COPD type B (491.20)
- COPD, moderate (496)
- COPD mixed type (496)
- End stage COPD (496)
- COPD bronchitis (491.20)
- COPD, very severe (496)
- History of COPD (V12.69)

Remove a problem

Click the problems you wish to remove. The items selected will turn blue.



Past Medical Hx (Problems)

Classification: All

Add new as: This Visit

Q

Problems (4)

- Asthma**
- CAD - Coronary artery disease**
- HTN - Hypertension

All Visits

- Remove from This Visit
- Resolve
- Inactivate
- Cancel**
- Move to Chronic
- Move to This Visit

Select the icon on the top right corner and select Cancel or Resolve.

Sections in Workflow

Past Surgical Hx (Procedures)

Past Surgical Hx (Procedures) is a list of past procedures.

To add a new past surgical history, click the header.

Past Surgical Hx (Procedures) (3)

All Visits | ▾

Procedure	Surgeon	Implant	Date
4 Procedures (3)			
Other Irrigation of Wound	--		08/19/13
Appendectomy	--		--
Hernia repair	--		--

Procedure History

Procedure

Mark all as Reviewed

Procedures

+ Add Modify Display

Procedure

Appendectomy

Hernia repair

Other Irrigation of Wound

8/19/2013

Location

Last Reviewed

Code

132967011

84078018

96.59

Click the Add plus sign to add a new Hx or Double click on existing Procedures to modify

Return to the workflow by clicking the back arrow.

Remove a procedure

Make sure that you are not currently attempting to add a problem.

On the main Procedure History window, right click on the procedure you wish to remove. Then select, **Remove Procedure**.

Procedure History

Procedure

Mark all as Reviewed

Procedures

+ Add Modify Display: Active

Procedure

Appendectomy

Hernia repair

Other Irrigation of Wound

/19/2013

Location

Last Reviewed

Code

132967011

84078018

96.59

Add Procedure

Modify Procedure

View Details

Remove Procedure

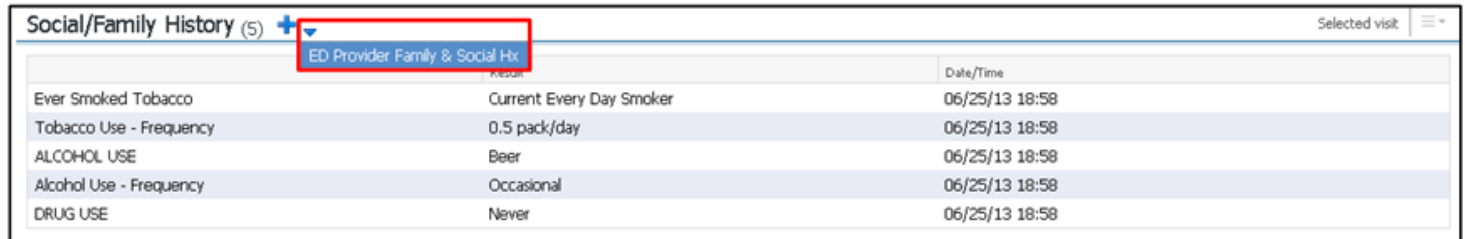
Add to Favorites...

Properties...

Sections in Workflow

Social/ Family History

This data is captured by ED Nurses during ED Assessment. Ensure the date and time are for a current visit.
If you need to add additional Social/Family History details, click the drop down arrow.
Select **ED Provider Family & Social Hx**.

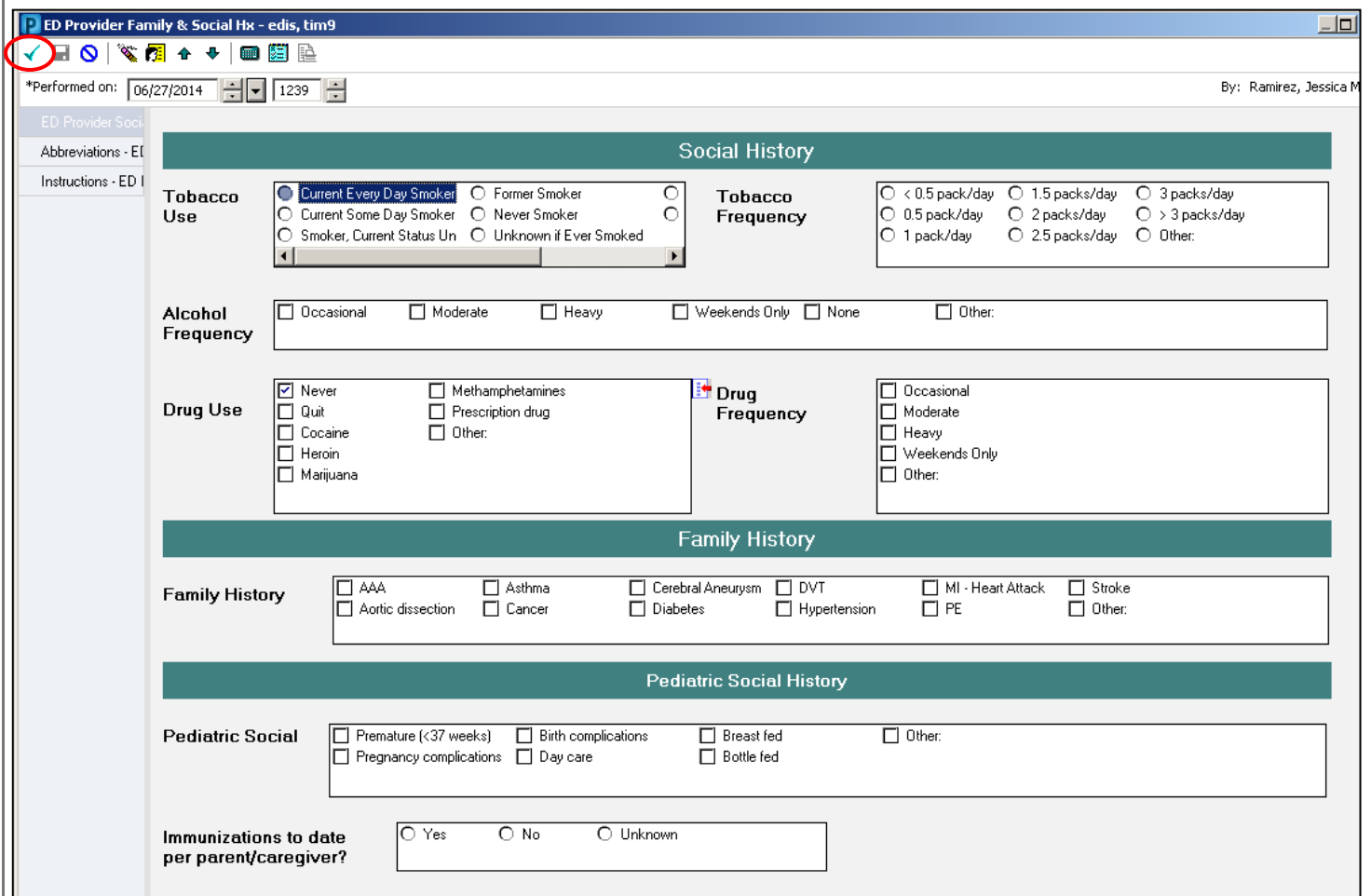


The screenshot shows a dropdown menu for 'Social/Family History (5)'. The selected option is 'ED Provider Family & Social Hx', which is highlighted with a red box. Below the dropdown, a table displays the following data:

	Medication	Date/Time
Ever Smoked Tobacco	Current Every Day Smoker	06/25/13 18:58
Tobacco Use - Frequency	0.5 pack/day	06/25/13 18:58
ALCOHOL USE	Beer	06/25/13 18:58
Alcohol Use - Frequency	Occasional	06/25/13 18:58
DRUG USE	Never	06/25/13 18:58

This opens the Social and Family History form. Complete the additional information.

Sign by clicking the green check mark on the top left corner of the form.



The screenshot shows the 'ED Provider Family & Social Hx - edis, tim9' form. The form is titled 'Social History' and contains the following sections:

- Tobacco Use:** Radio buttons for ☒ Current Every Day Smoker, ☐ Former Smoker, ☐ Current Some Day Smoker, ☐ Never Smoker, ☐ Smoker, Current Status Un, and ☐ Unknown if Ever Smoked.
- Tobacco Frequency:** Radio buttons for ☐ < 0.5 pack/day, ☐ 0.5 pack/day, ☐ 1 pack/day, ☐ 1.5 packs/day, ☐ 2 packs/day, ☐ 2.5 packs/day, ☐ 3 packs/day, ☐ > 3 packs/day, and ☐ Other.
- Alcohol Frequency:** Check boxes for ☐ Occasional, ☐ Moderate, ☐ Heavy, ☐ Weekends Only, ☐ None, and ☐ Other.
- Drug Use:** Check boxes for ☒ Never, ☐ Quit, ☐ Cocaine, ☐ Heroin, ☐ Marijuana, ☐ Methamphetamines, ☐ Prescription drug, and ☐ Other.
- Drug Frequency:** Check boxes for ☐ Occasional, ☐ Moderate, ☐ Heavy, ☐ Weekends Only, and ☐ Other.
- Family History:** Check boxes for ☐ AAA, ☐ Aortic dissection, ☐ Asthma, ☐ Cancer, ☐ Cerebral Aneurysm, ☐ Diabetes, ☐ DVT, ☐ Hypertension, ☐ MI - Heart Attack, ☐ PE, ☐ Stroke, and ☐ Other.
- Pediatric Social History:** Check boxes for ☐ Premature (<37 weeks), ☐ Birth complications, ☐ Breast fed, ☐ Bottle fed, ☐ Pregnancy complications, ☐ Day care, and ☐ Other.
- Immunizations to date per parent/caregiver?** Radio buttons for ☐ Yes, ☐ No, and ☐ Unknown.

Sections in Workflow

History of Present Illness

History of Present Illness

Tahoma 12 [Rich Text Editor Icons]

To add your History of Present Illness documentation for this update, you can:

- Free text
- Auto text
- Dragon

The documentation will auto-save after a short period of time, but you can also click **Save**.
What you add here will display in the note.

Save

Review of Systems

Review of Systems

Selected visit | [Menu Icon]

Font Size [Rich Text Editor Icons]

To add your Review of Systems documentation for this update, you can use:

- Auto text
- Dragon

Save

Physical Exam

Physical Exam

Selected visit | [Menu Icon]

Font Size [Rich Text Editor Icons]

To add your Physical Exam documentation for this update, you can use:

- Auto text
- Dragon

Save

1. Use Dragon commands to add:
 - a template of multi-system exam information
 - a macro of an individual system
2. Use the Dragon **Tab Forward** key, the F3 key on keyboard or say "**Next field**" to move to each bracketed field and dictate your findings.
3. If you have to complete a selection field in the template or auto-text (by adding an X to select a choice), be sure to use a capital X.
4. When complete, press the Accept Defaults key on the Dragon mic to remove the brackets.

Sections in Workflow

Labs

This section defaults to the latest labs resulted for this encounter.

Change the search criteria by selecting the look back options for this encounter.

Labs

Selected visit: **Latest*** Selected visit Last 24 hours More

	Mar 11, 2014 11:25
Chemistry	
NA	↓123
K	3.5
CL	112
TOTAL CO2	↑33
BUN	↓3
CRT	↑3.00
GFR Group	See B
eGFR African-American	↑32
eGFR Non African-American	↑26
ANION GAP	see C
CA	↑11.0
Hematology	
CBC w/ Diff	See Below
WBC	4.0
HGB	↓11.0

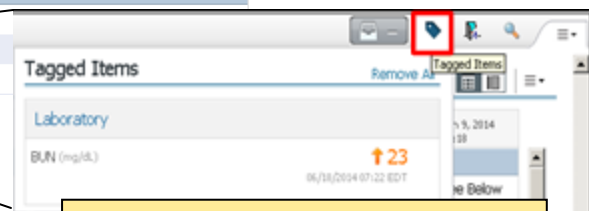
Hover over a result to see more information.

TOTAL CO2: 33 MMOL/L
Date/Time: 03/11/2014 11:25
Status: Auth (Verified)
Normal Low: 24
Normal High: 32
Critical Low: --
Critical High: --

Labs that will automatically pull into the note include:

Fishbone Labs: CBC/BMP, Troponin, BNP, D-dimer, Mg, Ca, LFT's, Lipase, Ammonia, Lactate, TSH, PT/INR, PTT, Sed Rate/CRP, Type/Rh, HCG Quant, ASA, Tylenol, ETOH, Valproic, Depakote, Phenytoin, Lithium, Urine Studies: UA, HCG, Urine Tox

Any additional lab results you wish to include in your note can be Tagged by **right clicking** on the result and clicking **Tag**.



The tag icon at the top of the Documentation workflow page turns blue, indicating a tagged result. These results will then pull into your note.

To view labs from past encounters, click the **Labs** Heading. The Results Review Flowsheet will open. Change the search criteria to see past encounters.

Results Review

Flowsheet VS + Resp Flowsheet GI/HVIS/Periop Rehab Svcs Nursing RRT Advisory Flowsheet MicroViewer OB-Perinatal Peds-Perinatal

Flowsheet: All Results Flowsheet Level: ALLRESULTSECT As Of 14:15 Table Group List

25 June 2013 18:53 - 27 June 2014 14:15 (Admit to Current)


Navigator	Results	06/26/2014 09:37	06/25/2014 08:57	10/01/2013 22:24	09/26/2013 08:37
<input checked="" type="checkbox"/> Chemistry	Chemistry				
<input checked="" type="checkbox"/> Hematology	BMP Status				
	Electrolytes Status				
	GLU				

Sections in Workflow

Microbiology

View results by selecting the Microbiology Heading to open the MicroViewer or clicking on the Order name (in blue) to open the full report.

Microbiology (22)

Order	Susceptibility	Growth	Organism(s)	Source/Site	Collected	Last Updated	Status
Urine Cult		CULTURE NEG	--	Urine, Straight Catheter	05/28/14 16:08	05/30/14 07:46	Completed
Blood Cult		CULTURE NEG	--	Blood, Central Line	05/28/14 15:50	06/02/14 18:11	Completed
Wound Cult		SMEAR NEG/CULTURE POS	Serratia marcescens, Enterococcus faecalis, Staphylococcus spp. (coagulase negative)	Abdomen	05/28/14 15:50	06/02/14 10:48	Completed

Urine Culture w Gram. - Accession: **061000061.7**

Micro Reports Specimen Action List

Urine Culture w Gram. - 06 October 2014 10:05 -
System, Lab Autogenerated

Gram Stain FINAL
REPORT 10/06/14 11:09

Rare WBC's
Few gram positive rods suggestive of
Lactobacillus

Urine Culture (includes gram) FINAL
REPORT 10/07/14 09:14

1,000-10,000 cfu/mL gram positive growth

MicroViewer

Forward Copy Preview Related Results

Orders

Display Order Start Date Between

All Orders 03/30/2014 07/30/2014

Customize View Previous Order Next Order

Collect Date/Time	Order	Growth Ind:	Organism	Status	Last Update Date/Time	Source/Body Site	Freetext Source
06/28/2014 07:25	Blood Culture			Preliminary	06/28/2014 07:25	Blood, Peripheral	
06/28/2014 07:23	Blood Culture			Order			

Sections in Workflow

Diagnostics

The Diagnostic Tests and Imaging Orders for the selected visit will be displayed, but the timeframe can be changed.

Diagnostics (4)

Selected visit Last 24 hours Last 3 days More ▾

Name	Reason For Exam	Resulted	Last Updated	Status
Diagnostic Tests (0)				
No results found				
Imaging (4)				
Chest PA and Lat	--	03/04/14 08:58	--	Ordered
CT Abd,Pelvis w/wo Contrast	--	02/24/14 07:05	02/24/14 07:27	Auth (Verified)
Chest PA and Lat	--	02/24/14 07:05	02/24/14 07:29	Auth (Verified)
Chest PA and Lat	--	01/27/14 10:07	--	Unauth

Clicking an **Auth (Verified)** report opens the Final report.

Clicking an **Unauth** report opens the Result Details window with more information about the order.

Document Viewer - ZZTEST, PHYSDOC6 - 2800100056

*** Final Report ***

5400480
Name: ZZTEST, PHYSDOC6
DOB: 01-24-1986 Gender: F
Med Rec#: 2800100056
Financial#: 3800100074
Location: Christiana Hospital
Ordering Phys: SHIUH, TIMOTHY Y. MD
CC Physician:
Study: CHEST PA AND LATERAL VIEWS
Service Date: 02-24-2014 07:06:00
The heart is normal in size and configuration. Both lungs are expanded and are clear.

IMPRESSION: NORMAL CHEST

ALAN EVANTASH, MD
(Electronically Signed)
Dict/trans: Ae/ Ae
TR: 02-24-2014 07:29:00
VE: 02-24-2014 07:29:00

Result type: Chest PA and Lat
Result date: 24 February 2014 07:05
Status: Auth (Verified)
Document Title: 5400480
Performed by: Evantash MD, Alan on 24 February 2014 07:29
Verified by: Evantash MD, Alan on 24 February 2014 07:29
Encounter info: 3800100074, CHR Inpatient, 01/24/2014 -

Tag

Highlight any specific section of the report and click Tag to insert this information into your Progress note.

Result Details - ZZTEST, PHYSDOC6

Result History

Value	Valid From	Valid Until
Exam Completed	01/28/2014 11:01	Current
Ordered	01/28/2014 11:01	01/28/2014 11:01

Result Action List

Chest PA and Lateral

Exam Completed

Date/Time 27 January 2014 10:07
Contributor System RIS
Accession Number 22064263
Status Unauth
[Trend](#)

2515475514 Forward... Print... Close

Tagging can be used in:

- Documents
- Diagnostics
- Lab Results

Sections in Documentation Workflow

Outstanding Orders

Outstanding orders are orders which have not been completed yet.

Outstanding Orders (1)

Last 24 hours for the selected visit



	Status	Ordered
CBC with diff	Ordered	04/03/14 11:00

Hover over the order for more information, like who placed the order.

Order: CBC with diff

Order Details: Once, Stat 04/07/2014 09:42, Lab Draw

Order Comments:

3 ml Purple top - Adult

Purple top tubes (EDTA) must contain a minimum of two (2) ml blood and not be clotted or hemolyzed.

0.3 ml Purple microtainer - Pediatric/Neonate

Fill peds microtainer to 1st line. Prefer 2nd line.

Order Date/Time: 04/07/2014 09:42

Start Date/Time: 04/07/2014 09:42

Status: Ordered

Ordered by: Shih MD, Timothy Y.

New Order Entry

New Order Entry allows you to quickly add an order from the workflow.

New Order Entry +

Inpatient ▾

Personal Shared

Favorites

Gen General Admission w/modules MD5000 EKM

Surg_Ortho Total Joint Replacement-LWR MD3140

Pulm Pneumonia, Community Acquired Pneumonia MD5159

CBC with diff Once, Stat

CBC with diff Daily TIMED, Morning Rounds 0500 -0800, for 5 DAY

Orders may be displayed by a list of your favorites.
To order, simply click the Order button next to the order name. The button turns dark gray.

To access the Quick Orders screen click the New Order Entry heading or the plus sign for the order window.

Sections in Documentation Workflow

New Order Entry– Quick Search

You can also search for an order on the workflow.
Type the order details into the Search field.

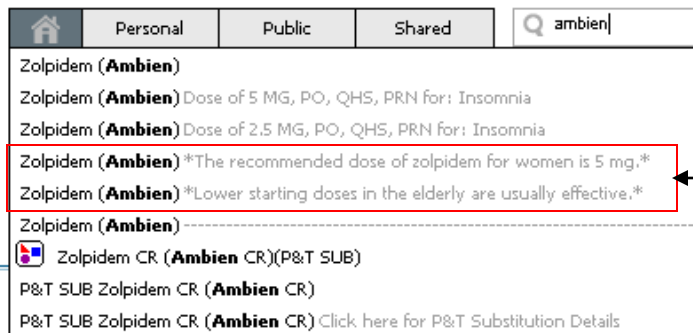


Being as specific as possible will return the most correct order:

1. Type the order, dosage, route and frequency.
2. Select the correct order from the list.

New Order Entry +

Inpatient ▾



Use caution!!

Order sentences that begin with an * are not real orders.
Do not select these orders on this screen.

As you make your selections, the Order Inbox in the upper right of the Workflow page turns green and counts the number of orders. Click the **Order inbox**. The **Orders for Signature** window appears.



Orders for Signature (1)

Zolpidem (Ambien)

Dose of 2.5 MG, PO, QHS, PRN for: Insomnia



☐ Show Diagnosis Table

Sign

Save

Modify

Cancel

Click **Sign** to complete the order.

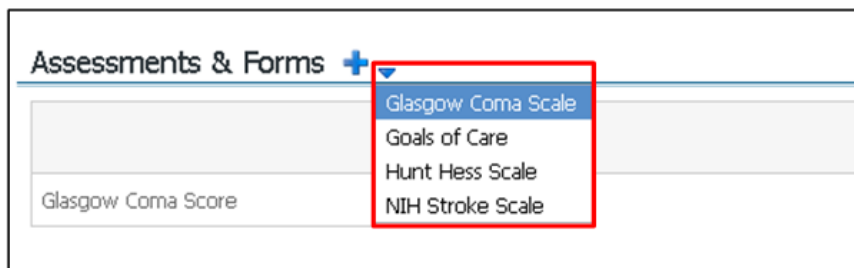
Change order information by clicking **Modify**.

Remove the order by hovering over the order and clicking the X that appears.

Sections in Documentation Workflow

Assessments & Forms

Click the down arrow to view the forms that are available. Select the form from the list.

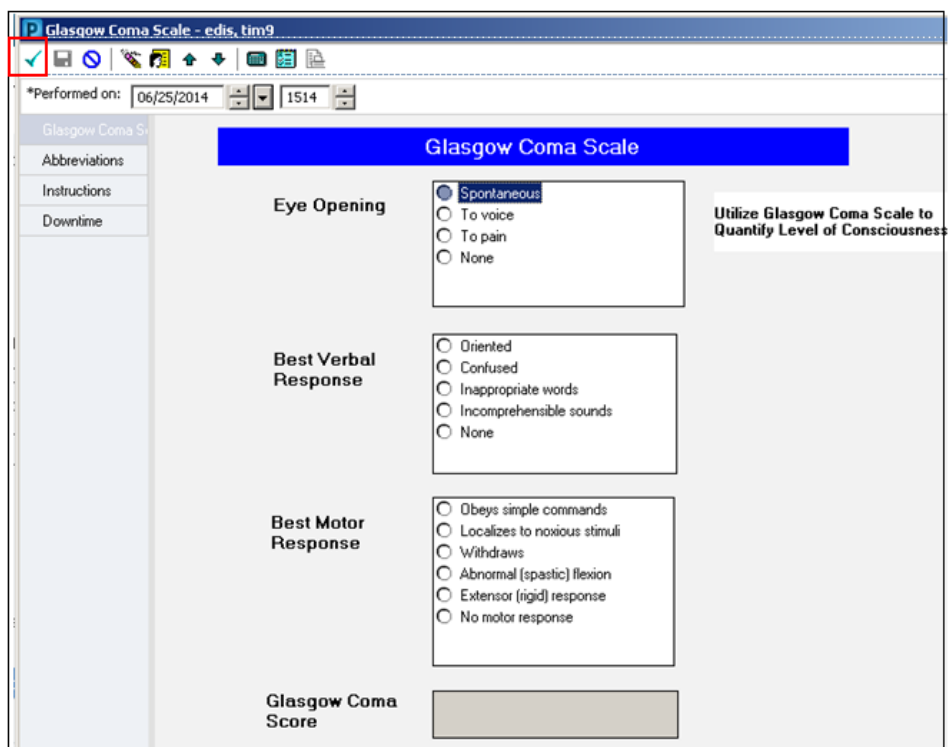


Assessments & Forms +

- Glasgow Coma Scale
- Goals of Care
- Hunt Hess Scale
- NIH Stroke Scale

Glasgow Coma Score

Fill out the details and sign the form by clicking the green check mark.



Glasgow Coma Scale - edis, tim9

*Performed on: 06/25/2014 1514

Glasgow Coma Scale

Eye Opening

- ☒ Spontaneous
- ☐ To voice
- ☐ To pain
- ☐ None

Best Verbal Response

- ☐ Oriented
- ☐ Confused
- ☐ Inappropriate words
- ☐ Incomprehensible sounds
- ☐ None

Best Motor Response

- ☐ Obeys simple commands
- ☐ Localizes to noxious stimuli
- ☐ Withdraws
- ☐ Abnormal (spastic) flexion
- ☐ Extensor (rigid) response
- ☐ No motor response

Glasgow Coma Score

Utilize Glasgow Coma Scale to Quantify Level of Consciousness

Create Note

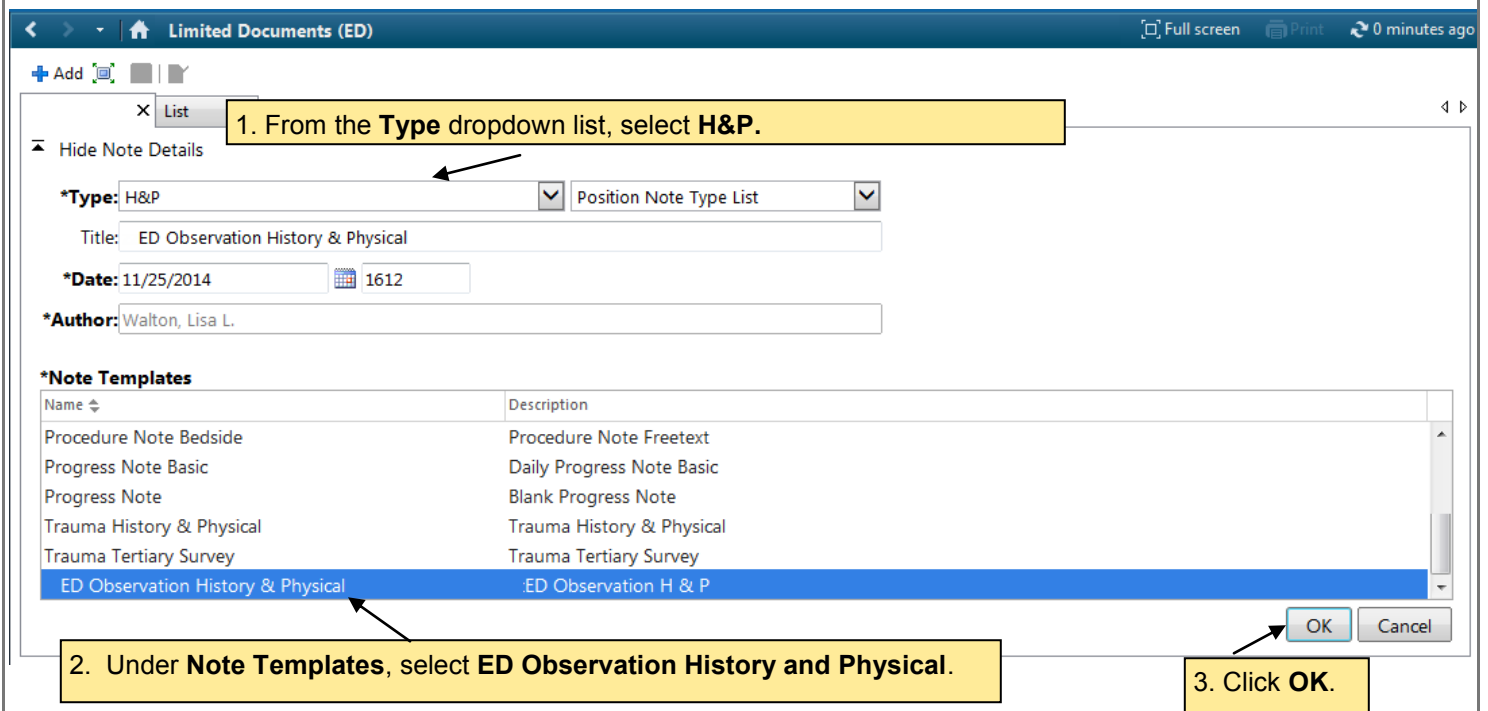
Review of Systems
Physical Exam
Labs
Microbiology (0)
Diagnostics (3)
Outstanding Orders (4)
New Order Entry
Assessments & Forms (0)

Create Note

Now that your review and documentation are complete, click **Create Note**.

History and Physical

To create your History and Physical, complete the following:



1. From the **Type** dropdown list, select **H&P**.

*Type: H&P Position Note Type List

Title: ED Observation History & Physical

*Date: 11/25/2014 1612

*Author: Walton, Lisa L.

*Note Templates

Name	Description
Procedure Note Bedside	Procedure Note Freetext
Progress Note Basic	Daily Progress Note Basic
Progress Note	Blank Progress Note
Trauma History & Physical	Trauma History & Physical
Trauma Tertiary Survey	Trauma Tertiary Survey
ED Observation History & Physical	ED Observation H & P

2. Under **Note Templates**, select **ED Observation History and Physical**.

3. Click **OK**.

The History and Physical displays.

History and Physical

Limited Documents (ED) Full screen Print 0 minutes ago

+ Add

ED Observation History & ... X List

Calibri 14

ED Observation History and Physical

DOB 04/18/1942 FIN MRN Location ECOB/0066/01

Date and Time of Service
12/09/2014
09:06

Basic Information
Triage Chief Complaint:
hypertension at work

History / Exam limited by: ☐

History of Present Illness

Review of Systems

Physical Exam
Vitals & Measurements
Most Recent Vitals within past 8 hrs, as of 12/09/14 09:06
T:36.9(Oral) HR:63 RR:16 BP:156/49 Pulse O₂:100% Source:Room Air ---

Assessment/Plan

Problem List
Chronic
Anemia
Diabetes mellitus type 1
High blood pressure
Hyperlipidemia

Procedure/Surgical History
hysterectomy (01/01/1990).

Home Medications
Home
atorvastatin 40 mg oral tablet, 40 MG, 1
hydrochlorothiazide 12.5 mg oral capsule
PO, Daily
lisinopril 20 mg oral tablet, 20 MG, 1 TAB
metformin 500 mg oral tablet, 500 MG,
Norvasc 10 mg oral tablet

Allergies
NKA

Social/Family History
SOCIAL HISTORY
Ever Smoked Tobacco: Former Smoker
Alcohol use - frequency: None
Drug use: Never

Lab Results (within the last 12 hours)

TROP T <0.01 NG/ML

Urine Studies

U APPEAR	12/09/14 03:52
U COLOR	CLEAR
U SP GR	P.YEL
U PH	1.013
U LEUK	5.5 pH units
U NITRITE	POSITIVE
U Protein Dipstick	Negative
U GLUCOSE	100mg/dl mg/dL
U KETONES	1gm/dl mg/dL
U UROBILIN	Negative mg/dL
U BILI	Normal mg/dL
U BLOOD	Negative
U WBC	Negative /UL
U BACTERIA	11-20 /HPF
U RBC	RARE /HPF
U EPT SQAM	0-2 /HPF
	0-5 /HPF
	12/09/14 03:52
U SP GR	1.013
U PH	5.5 pH units

Diagnostic Results

Radiology
MRI Brain. (ordered 12/08/14 23:52)
2D Echo w Color Flow & Spectral Doppler (ordered 12/08/14 23:53)
CT Head wo Contrast (ordered 12/08/14 21:32)
MRA Head wo Contrast (ordered 12/09/14 03:48)
MRA Neck wo Contrast (ordered 12/09/14 03:48)
MRI Brain wo Contrast (ordered 12/09/14 03:47)

Annotations:

- Date and Time of Service: Date and Time the note is created.
- Basic Information Triage Chief Complaint: Triage Chief Complaint pulls in from ED documentation, but there is a free text section under it here to provide additional information.
- History / Exam limited by: If history or exam could not be performed, indicate why here.
- History of Present Illness: HPI and ROS are free text sections. If you documented in the workflow, the information will display here.
- Physical Exam: Under Physical Exam, the most recent vitals within 8 hours will pull in. A free-text section allows you to document. If you documented in the workflow, the information will display here.
- Assessment/Plan: Under Assessment/Plan, the active and prioritized diagnoses will display. Document the plan of care for each diagnosis on each date of service.
- Problem List: Problem List displays Past Medical Hx.
- Procedure/Surgical History: Procedure/ Surgical History displays Past Procedure Hx.
- Home Medications: Home Medications pulls in the last documented medication history, but refer to workflow for Med Rec status.
- Allergies: Documented Allergies pull in.
- Social/Family History: Social/ Family History documented from ED pulls in.
- Lab Results (within the last 12 hours): Lab results from the last 12 hours pull. CBC and Chemistries present in Fishbone format. Urine Studies pull in and display the date of result.
- Diagnostic Results: Diagnostics results, like Radiology and EKG, are pulled in.

Add H&P Assessment statement:
Dragon Command: **ED Obs Macro**
Auto-text: **=edobs_assessment**

Note Details: H&P, Walton, Lisa L, 12/09/2014 09:06, zzED Observation History & Physical

Sign/Submit Save Save & Close Cancel

Adding tagged text

1. To add the Tagged Text to the History and Physical, click and hold the Tagged Text.
2. Then drag it to the desired section of the note.

Tagged Text

5400480 01/27/2014 05:05 ...

IMPRESSION: NORMAL CHEST.

IMPRESSION: NORMAL CHEST.

ED Observation History and Physical

Subjective
28 year old female admitted to the emergency department last evening with chest pain. Patient was diagnosed with hypertension. Patient was initially in substantial pain, but is now resting comfortably and without distress.

Objective/Physical Exam

Vitals & Measurements
T: 37.6 (Oral) HR: 80 RR: 21 Pulse O₂: 99%

GENERAL: Acute chest pain, diarrhea, nausea
HEAD: [normocephalic]
EYES/EARS/NOSE/THROAT: [pupils equal, extraocular muscles intact, no scleral icterus, normal pharynx]
NECK: [normal inspection]
RESPIRATORY: [no respiratory distress, clear to auscultation bilaterally]
CARDIOVASCULAR: [regular rate and rhythm, no murmurs, rubs or gallops]
ABDOMEN/GU: [soft, non-tender, no organomegaly, no masses, normal bowel sounds]
EXTREMITIES: [non-tender, normal range of motion, no edema/swelling]
NEUROLOGIC: [alert and oriented x 3, no gross motor deficits, no gross sensory deficits, cranial nerves intact]
SKIN: [no rashes]

Assessment/Plan

CAD (coronary artery disease)
☐
Ordered: CBC with diff

Sys hypertension
☐
Ordered: CBC with diff

Insomnia
☐
Ordered: zolpidem, Dose of 2.5 MG = 0.5 TAB, PO, QHS, PRN for: Insomnia, Order Start: 04/04/2014 10:38

Lab Result
HGB 11.0 G/DL 03/11/2014 11:25 EDT (Low)

Fishbone Labs

MAR 11 11:25

\ L 11.0 /
4.0 _____ 150
/ 45.0 \

Diagnostic Results
IMPRESSION: NORMAL CHEST. [1]

[1] 5400480: Satti MD, Sudhakar R. 01/27/2014 05:05 EST

3. A footnote appears, attributing the tagged information to the original document.

Refreshing/Free text fields/Deleting



Parts of the note, like Lab Result can be refreshed to import the most recent information. Hover over the title and click the **Refresh** icon that displays.

Add a free text field to document additional information. Hover over the title and click the **Insert Free Text field** icon. *Information added here does not update on the Documentation Workflow.*

Sections can be deleted if that information is not pertinent to your progress note. Hover over the title and click the **Delete** icon that displays.

Completing your note

- Once you have completed your note, click **Sign & Submit**. No more changes can be made.
 - To save the information without closing or signing, click **Save**.
 - To save the information and close the note without signing, click **Save & Close**.
 - Click **Cancel** to discontinue the note.
2. The Signed and Saved note will display in the patient's chart under Documents.

Sign/Submit Save Save & Close Cancel

Documents (11) +

Selected visit Last 24 hours Last 48 hours More

☐ My notes only ☐ Group by encounter | Display: Facility defined

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
H&P	ED Observation History & Physical	Walton, Lisa L.	12/09/14 09:51	Walton, Lisa L.	12/09/14 09:52

3. If you had Saved and Closed, the note would indicate (In Progress) and could be opened and modified.

Documents (2)

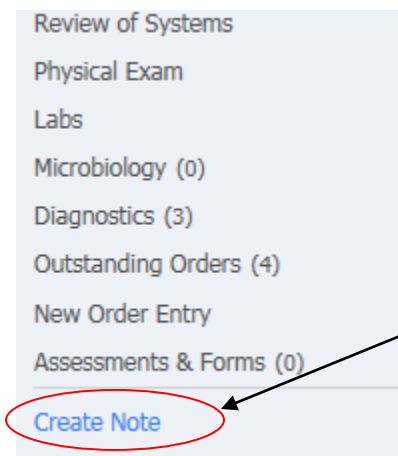
Last 1 years Last 6 months Last 2 years More

☐ My notes only ☐ Group by encounter | Display: Facility defined view

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
H&P (In Progress)	zED Observation History & Physical	Walton, Lisa L.	12/09/14 09:51	Walton, Lisa L.	12/09/14 09:52
Completed					
ED Physician Record	ED Physician Record	Shiuh MD, Timothy Y.	09/23/14 08:10	Shiuh MD, Timothy Y.	09/23/14 08:24

Discharge Note

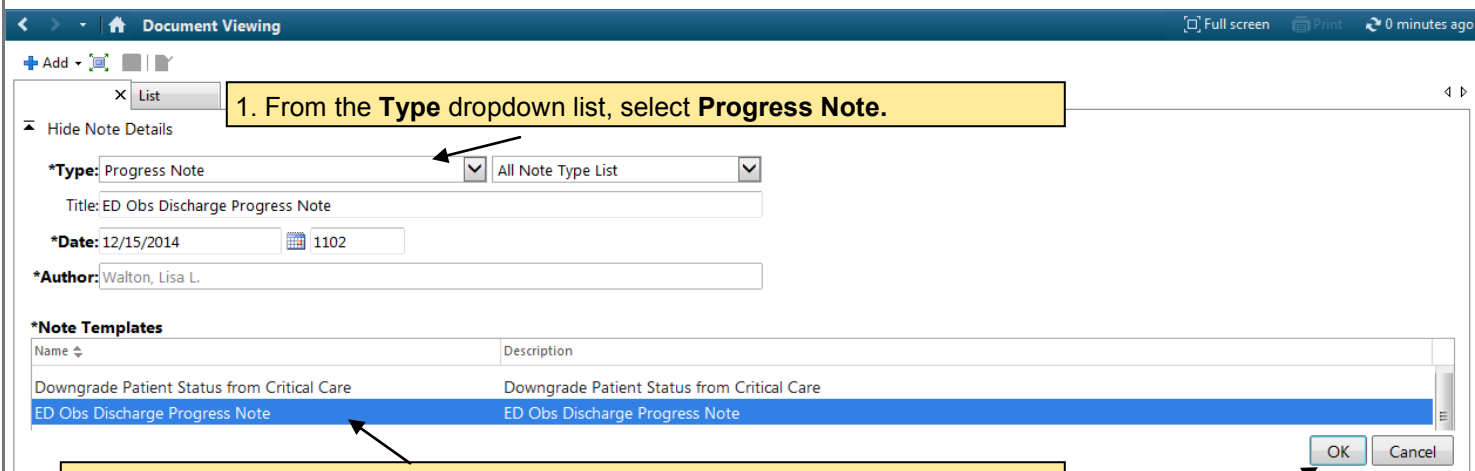
After the Depart process has been completed, you can create a Discharge Note. Click Create Note on the Workflow.



A vertical list of menu items in a light blue box. The items are: Review of Systems, Physical Exam, Labs, Microbiology (0), Diagnostics (3), Outstanding Orders (4), New Order Entry, Assessments & Forms (0), and Create Note. The 'Create Note' item at the bottom is circled in red.

Now that your review and documentation are complete, click **Create Note**.

To create your Discharge Note, complete the following:



A screenshot of a web application window titled 'Document Viewing'. The window has a toolbar with 'Full screen', 'Print', and '0 minutes ago' options. Below the toolbar is a 'List' tab. The main content area is titled 'Hide Note Details' and contains several fields: '*Type:' with a dropdown menu set to 'Progress Note', 'Title: ED Obs Discharge Progress Note', '*Date:' with a calendar icon and the date '12/15/2014', and '*Author:' with the name 'Walton, Lisa L.'. Below these fields is a table titled '*Note Templates' with two columns: 'Name' and 'Description'. The table has two rows: 'Downgrade Patient Status from Critical Care' and 'ED Obs Discharge Progress Note'. The 'ED Obs Discharge Progress Note' row is highlighted in blue. At the bottom right of the form are 'OK' and 'Cancel' buttons.


1. From the **Type** dropdown list, select **Progress Note**.

2. Under **Note Templates**, select **ED Obs Discharge Progress Note**.


3. Click **OK**.

The Discharge Note displays.

Document Viewing Full screen Print 5 minutes ago

+ Add 

ED Observation Discharge N... List

Tahoma 12 

ED Observation Discharge Progress Note

Date and Time of Service
12/09/2014
15:38

Admit Date/Time: 12/08/2014 23:55
Discharge Date/Time: 12/09/2014 14:36
Length of Stay: Hours: 14 **Minutes:** 42

Reason for Hospitalization

Outcome of Hospitalization

Subjective

Objective/Physical Exam
Vitals & Measurements
No results found

Assessment/Plan
Final Impression: COPD exacerbation, NSTEMI (non-ST elevated myocardial infarction), Anemia,
Disposition: Discharge Order. Home, self care, 06/06/2014 13:16
Disposition: Discharge Order. Home, self care, 06/06/2014 13:17

Patient Instructions:
Patient Education Provided: Anemia, FAQs, Acute Coronary Syndrome, Chronic Obstructive Pulmonary Disease
Followup providers and additional instructions given to patient:
Roger Kerzner, 2 - 7 days,
Follow up with primary care provider, 2 - 7 days,
Patient was given prescriptions for:
Plavix 75 mg oral tablet (clopidogrel) 75 MG, by mouth, Every day, Telephone - Called to Pharmacy
Coreg 12.5 mg oral tablet (carvedilol) 12.5 MG, by mouth, 2 Times A Day, Telephone - Called to Pharmacy

Discharge Medications Please refer to the Patient Discharge Instructions for a list of reconciled medications.

Condition at Discharge

Note Details: Walton, Lisa L., 12/09/2014

Sign/Submit Save Save & Close Cancel

Date and Time the note is created.

Under the Date and Time, the Length of Stay will be calculated, based on the Admit time of Obs status to when the Discharge order is written.

Reason for hospitalization and Outcome of Hospitalization are free-text fields.

Subjective and Objective/ Physical Exam have free-text sections. If you documented in the workflow, the information will display here.

Under Objective, vitals documented in the last 8 hours will pull in.

Under Assessment/Plan, the Final Impression/ Disposition will pull in from Depart information, including Patient Education instructions.

Medication Reconciliation should be completed prior to creating this note, so the statement here refers to the Discharge instructions for list of reconciled meds.

Condition at Discharge is a free-text field for your documentation.

Completing your note

- Once you have completed your note, click **Sign & Submit**. No more changes can be made.
 - To save the information without closing or signing, click **Save**.
 - To save the information and close the note without signing, click **Save & Close**.
 - Click **Cancel** to discontinue the note.
- The Signed and Saved note will display in the patient's chart under Documents.

Sign/Submit

Save

Save & Close

Cancel