

PowerChart Progress Notes

Tip Sheet: Documenting Consults

May 23, 2014

Issue: I need to document a consultation. How do I do that?

Resolution: Physicians may use Option 1 or 2 below. Mid-level providers should use Option 2 below.

Option #1: For Physicians (only)

Digitally dictate Full Consult using phone, then document Dictation Job number via Brief Consult Note.

1. Use the Dictation phone line to dictate your consult. You will be given a Dictation Job Number.
2. In PowerChart, open the workflow and click **Create Note**.
3. Select Type: **Consult**.
4. Select Note Template: **Brief Consult Note**.
5. Title the note with your specialty: Consult Note- <Specialty>
6. In the note, type auto-text **=dictation** and click Enter.

Brief Consult Note

Date and Time of Service
05/23/2014
12:05
=d|

Rea=dictation *sult

Date and Time of Service

05/23/2014

12:05

Dictation Job Number _|

7. The Auto text **Dictation Job Number_** displays.
8. Type or Dragon the dictation job number provided on the phone.

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Option #2: For Physicians and Mid-level providers

Document Full Consult via Consult Note

1. In PowerChart, open the workflow and click **Create Note**.
2. Select Type: **Consult**.
3. Title the note with your specialty: Consult Note- <Specialty>
4. Select Note Template: **Consult Note**.
5. Click **OK**.

The screenshot shows the 'Document Viewing' window in PowerChart. The 'List' tab is active. Under 'Hide Note Details', the following fields are visible: '*Type:' set to 'Consult', 'Title:' set to 'Consult Note-SCCC', and '*Date:' set to '5/23/2014' with a calendar icon and the number '1445'.

6. The Consult Note displays.

The screenshot shows the 'Consult Note' form. The title 'Consult Note' is centered at the top. The form is divided into several sections:

- Date and Time of Service:** 05/23/2014, 14:46
- Chief Complaint:** A free text field for Chief Complaint documentation is provided.
- Reason for Consult:** Document your full Consultation under Reason for Consult.
- History of Present Illness:**
- Review of Systems:**
- Physical Exam:** Vitals & Measurements: T: 37.2 (Oral) HR: 88
- Assessment/Plan:** Under Assessment/Plan, document for the diagnosis for which you consulted. Hover over any unrelated diagnosis name and click the [X] to remove it from your note.
- Additional Recommendations or Comments:**
- Past Medical History:** Chronic: No chronic problems
- Procedure/Surgical History:**
- Home Medications:**
 - Inpatient:** acetaminophen - CODEINE (Tylenol with Codeine #3) 300/30, 30 MG, 1 TAB, PO, Q4H, PRN; Aspirin Chew Tab, 81 MG, 1 CHTAB, PO, Daily; ATENolol (Tenormin), 50 MG, 1 TAB, PO, Daily; FUROsemide (Lasix), 40 MG, 1 TAB, PO, BID
 - Home:** Arthritis Pain 500 mg oral tablet; aspirin 81 mg oral delayed release capsule, 81 MG, 1 CAP, PO, Daily; atenolol 50 mg oral tablet, 50 MG, 1 TAB, PO, Daily
- Allergies:** penicillin (rash)
- Social/Family History:** No qualifying data available.
- Lab Results:**
- Diagnostic Results:**
- I&O:**

7. When finished documenting, select **Sign/Submit**.
8. Mid-level providers should then forward the note to the Attending Physician.