

PPC2: PATIENT TRACKING AND REGISTRY FUNCTIONS

Element D: Organizing Clinical Data:

1. Problem List in EMR

Chart for [redacted] - CareRevolution Today's Date: 05/20/2010

Chart Modules Specified View View Tools Help

DOB: [redacted] / [redacted] / [redacted] Patient #: [redacted] Encounter Date: 05/20/2010
Phones: Home: [redacted] Allergies: Multiple Exist Chart #: [redacted] Encounter Location: None
Insurance: No Insurance

Encounters Vitals Problems Orders Misc Index Patient Alerts Overview

Problems Current On: 05/20/2010

Select Problem for Details:

Identified	Description
05/13/2010	THORACIC RADICULOPATHY T8
05/13/2010	MAJOR DEPRESSION, SINGLE EPIS
04/21/2010	OSTEOARTHRITIS
04/21/2010	ORTHOPEDIC DISORDERS OF THE
04/21/2010	ESSENTIAL HYPERTENSION BENIG
03/24/2010	DEPRESSION
03/09/2010	memory lapses or loss
02/23/2010	CONJUNCTIVITIS ACUTE RIGHT EY
02/23/2010	ALLERGIC RHINITIS
02/23/2010	EMPHYSEMA
02/23/2010	URINARY TRACT INFECTION
02/23/2010	ASTHMA INTERMITTENT
02/16/2010	fainting (syncope)
02/16/2010	SINUS BRADYCARDIA

Details for New or Selected Problem

Problem: [redacted]
Code: [redacted]
Date Identified: [redacted] Modified: [redacted]
Medicin Desc: [redacted]
Status: [redacted]
Evaluation: [redacted]
Condition: [redacted]
Evolution: [redacted]
Examiner: [redacted]
Comments: [redacted]

2 & 3. Over-the-counter medications, supplements, and alternative therapies are added to medication lists. All medications are listed for chronic and short-term prescriptions.

Medications

Patient Information
 Patient #: [REDACTED] DOB: [REDACTED] Home Ph: [REDACTED] Insurance: [REDACTED]
 Encounter Date: 05/13/2010 Gender/Age: [REDACTED] Chart #: None Work Ph: [REDACTED]

Options Interactions Vitals Medication History

Current Medication Summary

Add Current Delete Renew Discontinue Details Print ERx Drug Info Sign Off Edit Edit Log Req Hx Map WDR

Prescribed	Medication N...	Sig	R...	Prescriber	Expiration	Pharmacy	Pharmacy P...	Ren...	Map
05/13/2010	Hospice Care	SIG: every 24 hours ...	S		N/A	W			?
05/13/2010	Provigil 200 m...	SIG: 1 tab(s) orally fo...	5		11/08/2010	W			
04/21/2010	lactulose 10 g...	SIG: 15 mL orally 2 ti...	4		09/17/2010	W			
04/21/2010	Phenergan 2...	SIG: 1 tab(s) orally e...	1		N/A	W			
04/21/2010	Veramyst 27...	SIG: 1 spray(s) in eac...	3		08/18/2010	W			
04/06/2010	Lasix 20 mg L...	SIG: 1 tab(s) orally o...	2		07/04/2010	W			
04/06/2010	oxybutyrin 5...	SIG: 1 tab(s) orally 2...	4		N/A	M			*
03/08/2010	Ventolin HFA...	SIG: 2 puff(s) inhaled...	5		N/A	V			
01/21/2010	Aricept 10 mg...	SIG: 1 tab(s) orally o...	5		N/A	V			*
12/07/2009	gabapentin 3...	SIG: 3 cap(s) orally o...	4		N/A	M			*
Unknown	levothyroxine...	SIG: 1 tab(s) orally o...	L		N/A				
12/07/2009	Omnaris	SIG: 2 sprays ea no...	7		N/A	W		1	?
07/29/2009	metoprolol 50...	SIG: 1 tab(s) orally o...	4		N/A	M		3	*
05/27/2009	Januvia	SIG: 1 tab(s) orally o...	4		N/A	MT			*
05/27/2009	Lotrel 10 mg...	SIG: 1 cap(s) orally o...	4		N/A	ML		3	*
05/22/2009	aspirin 81 mg...	SIG: 1 tab(s) chewed...			N/A				
Unknown	Prilosec OTC...	SIG: 1 tab(s) orally o...		Outside Pro...	N/A				
Unknown	niacinamide...	SIG: 1 cap(s) orally o...		Outside Pro...	N/A				
Unknown	Vitamin C ca...	SIG: 1 cap(s) orally o...		Outside Pro...	N/A				
Unknown	omega-3 poly...	SIG: 3 cap(s) orally 3...		Outside Pro...	N/A				

4. Our EMR allows us to design templates for age-appropriate risk-factors (12 mo Well Child Check):

Spec

Prefix Modifier Result Status Episode Onset Duration

CC / HPI Recommended Labs SICK HPI PE Anticipatory Guidance Free Text - Link Outline View

The Chief Complaint is:

SOURCE OF INFORMATION:

Patient Y N

Mother Y N

Father Y N

Another Person (No permission) Y N

Another Person Y N

Permission to treat patient obtained.

STRESSORS

Recent Emotional Stress Y N D

Chronic Emotional Stress Y N D

Psychosocial Support Y N D

Violent Behavior in home Y N D

Birth Control Method Y N D

SUPPORT SYSTEM

Family has adequate support system Y N

Family does not have an adequate support system Y N

NUTRITION

Breast-feeding? Y N

times per day

Bottle-feeding? Y N

Formula oz q day - Brand:

Weaned To Cup At Age (months) Y N

Regular Table Foods Started At Age (months) Y N

Difficulty feeding solid foods? Y N D

WIC Services Y N D

Dietary History Y N

Milk - Type and Amount:
Juice - Amount:
Fruit:
Vegetables:
Meat:

PROBLEMS

Constipation (Describe) Y N D

Sleep Problems? Y N D

Discussed Concerns RE: Dev/Behav Y N

No Concerns RE: Dev/Behav Y N

Delayed Dev. Milestones Y N D

Developmental

Bangs Objects Together Y N

Drinks From A Cup Y N

Feeds Self With Fingers Y N

Pulls Self To Standing Position/cruises Y N

Plays Peek-a-boo Y N

Says Mama Or Dada Specifically Y N

Says 3 Additional Words Y N

Waves Bye-Bye Y N

Pincer Grasp Y N

Walks Holding Onto Furniture Y N

Stands Well Alone Y N

Walks Unassisted Y N

DENTAL EDUCATION

Tooth Brushing Y N

Dental Visits - Dentist Referral Y N

Fluoride Y N

MASTER

Encounter (F) 12 Month Checkup

SBIRT screen for 18 and older:

SBIRT Brief Screen

1. Have you smoked cigarettes or used other tobacco products in the past 3 years? Y N
2. On average, how many days per week do you drink alcohol?
3. On a typical day when you drink, how many drinks do you have?
4. What is the maximum number of drinks you have had on any given day in the last month?
5. Do you use prescription drugs for reasons other than prescribed, more frequently than prescribed, or any illicit drugs? Y N

POSITIVE - Referral to SBIRT Educator Y SIGNATURE: PF type in your name

Positive Brief Screens: A yes answer to question 1 or 5 is a positive screen, or if patient is under the age of 21 Questions 2, 3, and 4 will depend on the quantity or frequency. These questions are based on the following guidelines:
 Men may be at risk for alcohol related problems if their alcohol consumption exceeds 14 standard drinks per week or more than 4 drinks per day.
 Women may be at risk if they have more than 7 standard drinks per week or more than 3 drinks per day.
 Men and women 65 and older may be at risk for alcohol related problems if they have more than 7 standard drinks per week or more than 2 drinks per day.

Multiply answers for questions 2 and 3 together. Positive screen if:
 Greater than 14 for men
 Greater than 7 for women
 Greater than 7 for men and women age 65 and older

Teen Screen:

PRESCREEN FOR TEENS

During the last 12 months, did you:

1. Did you drink any alcohol (more than a few sips)? Y N
2. Smoke any marijuana or hashish? Y N
3. Use anything else to get high? Y N

--"Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or huff.

SCORING: If "No" to all three questions, only ask question 1 on the CRAFFT. If "Yes" to any of the prescreen questions, then ask entire CRAFFT.

CRAFFT

1. Have you every ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs? Y N
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? Y N
3. Do you ever use alcohol or drugs while you are by yourself alone? Y N
4. Do you ever forget things you did while using alcohol or drugs? Y N
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use? Y N
6. Have you gotten into trouble while you were using alcohol or drugs? Y N

SCORING: 2 or more positive items indicate the need for further assessment.

Anticipatory Guidance: Alcohol Use Y Referred To [Free Text] Y Discussed Talking w/Parent Y

Anticipatory Guidance: Illicit Drug Use Y Patient Refusal Y

SIGNATURE: PF type in your name

Geriatric Screen:

GERIATRIC SCREENING		YES	NO
SECTION 1 GERIATRIC DEPRESSION SCALE: (Click to put heading in the Note)		<input type="checkbox"/>	<input type="checkbox"/>
1. Are you basically satisfied with your life?		<input type="checkbox"/>	<input type="checkbox"/>
2. Are you in good spirits most of the time?		<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel happy most of the time?		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you think it is wonderful to be alive now?		<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel full of energy?		<input type="checkbox"/>	<input type="checkbox"/>
SECTION 2			
6. Are you afraid that something bad is going to happen to you?		<input type="checkbox"/>	<input type="checkbox"/>
7. Do you often get bored?		<input type="checkbox"/>	<input type="checkbox"/>
8. Do you often feel helpless?		<input type="checkbox"/>	<input type="checkbox"/>
9. Do you prefer to stay at home, rather than going out and doing new things?		<input type="checkbox"/>	<input type="checkbox"/>
11. Do you feel that your life is empty?		<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel like you have more problems with memory than most?		<input type="checkbox"/>	<input type="checkbox"/>
12. Do you feel pretty worthless the way you are now?		<input type="checkbox"/>	<input type="checkbox"/>
13. Have you dropped many of your activities and interests?		<input type="checkbox"/>	<input type="checkbox"/>
14. Do you feel that your situation is hopeless?		<input type="checkbox"/>	<input type="checkbox"/>
15. Do you think that most people are better off than you are?		<input type="checkbox"/>	<input type="checkbox"/>

Count up number of NO's in this section.

Count up the number of YES's in this section.

SIGNATURE: PF type in your name

Total the number of NO's in section 1 and the total number of YES's in section 2, click 'Y', put the score in and add the date.
REPEAT THE SCORE IN CORRESPONDING BOX TO DESCRIBE SYMPTOMS

Depression Screening Onset
 Negative for Symptoms
 No Significant Symptoms
 Mild to Moderate Symptoms
 Clinically Significant Symptoms

Score 0
 Score 1 - 5
 Score 6 - 10
 Score 11 - 15

5. Structured Template for Progress Note:

HPI 1	HPI 2	HPI 3	Trauma	ROS - General	ROS 1	ROS 2	ROS 3	Gen. PE - LINKS	PE 1	PE 2	PE 3-LINKS	Free Text	Outline View
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Smoking <input type="checkbox"/> <input type="checkbox"/></p> <p>Interpreter used to communicate with patient <input type="checkbox"/></p> <p>History of Present Illness</p> <div style="border: 1px solid gray; height: 40px; width: 100%;"></div> <p>Previous Medication Caused Problems <input type="checkbox"/></p> <p>Recently Stopped Taking Medication <input type="checkbox"/></p> <p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Systemic Symptoms <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Weight Change <input type="checkbox"/> <input type="checkbox"/> Decrease In Appetite <input type="checkbox"/> <input type="checkbox"/> Increased Appetite (polyphagia) <input type="checkbox"/> <p>Psychosocial</p> <p>Psychosocial Support <input type="checkbox"/></p> <p>Physical Abuse in home <input type="checkbox"/></p> </div> <div style="width: 30%;"> <p>HEAD/EYES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head Symptoms <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> Eye Symptoms <input type="checkbox"/> <input type="checkbox"/> Vision Problem <input type="checkbox"/> <input type="checkbox"/> Pain in the Eyes <input type="checkbox"/> <input type="checkbox"/> Purulent Eye Discharge <input type="checkbox"/> <input type="checkbox"/> Red Eyes <input type="checkbox"/> <p>ENT</p> <ul style="list-style-type: none"> <input type="checkbox"/> ENT Symptoms <input type="checkbox"/> <input type="checkbox"/> Hearing Loss <input type="checkbox"/> <input type="checkbox"/> Earache <input type="checkbox"/> <input type="checkbox"/> Ear Discharge <input type="checkbox"/> <input type="checkbox"/> Rhinorrhea <input type="checkbox"/> <input type="checkbox"/> Epistaxis <input type="checkbox"/> <input type="checkbox"/> Nasal Stuffiness <input type="checkbox"/> <input type="checkbox"/> Sinus Pain <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> Hoarseness <input type="checkbox"/> <input type="checkbox"/> Sore Throat <input type="checkbox"/> <input type="checkbox"/> Neck Symptoms <input type="checkbox"/> <input type="checkbox"/> Swollen Glands <input type="checkbox"/> <p style="text-align: center;">Asthma Severity Assessment Form</p> </div> <div style="width: 30%;"> <p>BREAST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Symptoms <input type="checkbox"/> <input type="checkbox"/> Breast Pain <input type="checkbox"/> <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> <input type="checkbox"/> Breast Lump <input type="checkbox"/> <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> CV Symptoms <input type="checkbox"/> <input type="checkbox"/> Chest Pain <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Leg Claudication <input type="checkbox"/> <input type="checkbox"/> Orthopnea <input type="checkbox"/> <input type="checkbox"/> PND <input type="checkbox"/> <input type="checkbox"/> Edema <input type="checkbox"/> <p>PULMONARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pulmonary Symptoms <input type="checkbox"/> <input type="checkbox"/> Feeling Congested <input type="checkbox"/> <input type="checkbox"/> Dyspnea <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> Coughing Up Sputum <input type="checkbox"/> <input type="checkbox"/> Hemoptysis <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> </div> </div> <div style="margin-top: 10px; display: flex; justify-content: flex-end; gap: 10px;"> Asthma Severe Persistent <input type="checkbox"/> Asthma Moderate Persistent <input type="checkbox"/> Asthma Mild Persistent <input type="checkbox"/> Asthma Mild Intermittent <input type="checkbox"/> </div>													

6. Age appropriate screening tool for developmental testing

CC / HPI | SICK HPI | PE | Anticipatory Guidance | Free Text - Link | Outline View

The Chief Complaint is:

SOURCE OF INFORMATION:

Patient

Mother

Father

Another Person (No permission)

Another Person

. Permission to treat patient obtained:

Breast-feeding?

times per day

Difficulty Breast-feeding?

Bottle-feeding?

Formula oz q day - Brand:

Difficulty Bottle-feeding?

WIC Services

Is rice cereal introduced?

STRESSORS

Recent Emotional Stress

Chronic Emotional Stress

Psychosocial Support

Violent Behavior in home

Birth Control Method

PROBLEMS

Constipation (Describe)

Sleep Problems?

Regurgitation

Excessive Crying

Diaper Rash

SUPPORT SYSTEM

Family has adequate support system

Family does not have an adequate support system

Discussed Concerns RE: Dev/Behav

No Concerns RE: Dev/Behav

Delayed Dev. Milestones

Developmental

Gaze Follows Past Midline

Vocalizes

Attentive To Voices

Laughs

Rolls From Front Onto Back

Brings Hands Together

Controls Head/Neck

Reaches For Objects

Uses Arms To Push Chest Off Surface

DENTAL EDUCATION

Pacifiers

Propping Up Bottle

Tooth Brushing / Cleaning

Teething

Fluoride

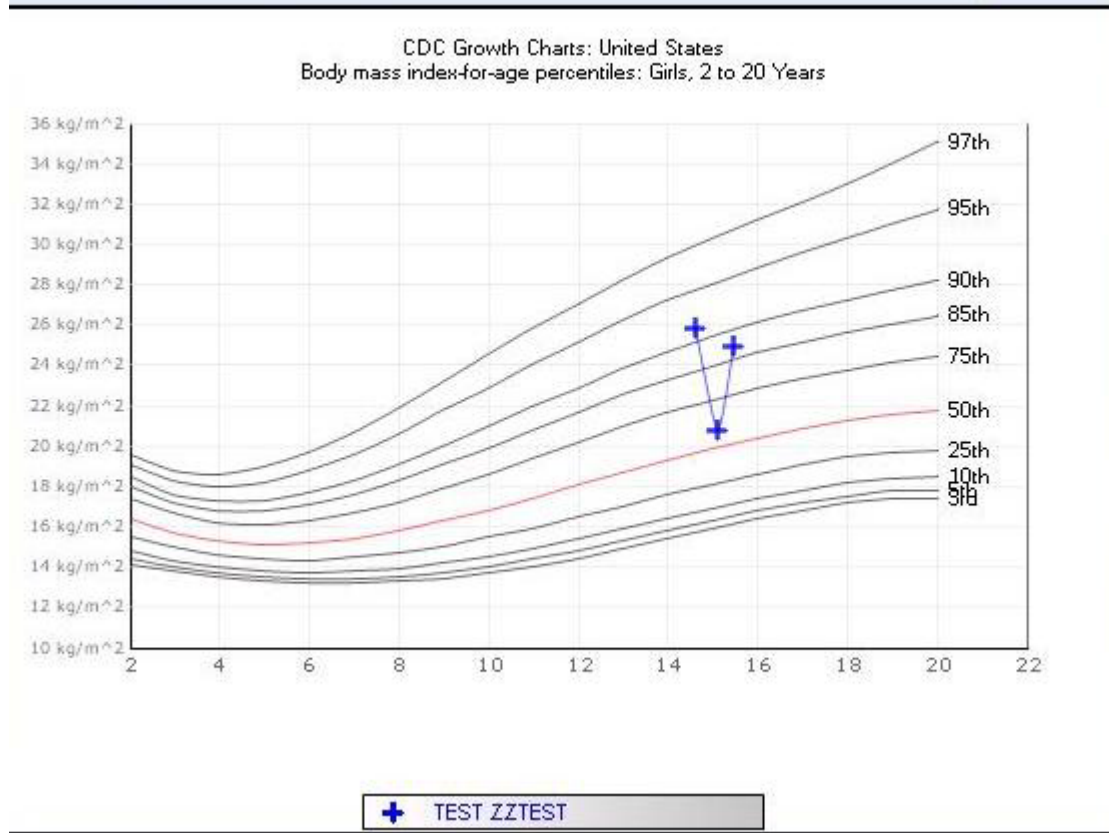
MASTER

Encounter (C) 4 Month Checkup

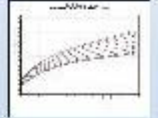
7. Growth Charts are available for height, weight, head circumference and BMI if < 18 yrs

TEST ZZTEST (#23127) Age: 15Yrs, 7Mos

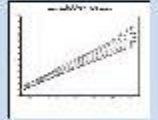
Print Chart



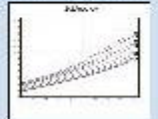
Weight By Age (Birth to 36 months)



Weight By Length (Birth to 36 months)



Weight By Stature (2 to 20 years)



Stature By Age (2 to 20 years)

