

EMR Web Training Script

Course:	Trauma Office Visit
Learning Objective:	To show an entire Trauma office visit including adding Problems to the Patient's Problem List
Video Length:	8 minutes, 4 seconds

The purpose of this video is to show an entire Trauma office visit including adding problems to the patient's problem list.

To find the office visit you must first find the patient chart. Simply look at the schedule and double click on the name of the Patient.

Go to the documents tab and double click the correct visit.

Notice the patient's vital signs, medication allergies and current medications have been updated by the nursing staff.

Scroll down to see information on the patient's injuries, operations and procedures.

On the left hand side is the list of inserted forms to choose from.

Start by double clicking on the Physical Exam.

Choose the appropriate tab. Document using the drop-down menus or the free-text fields.

Click the Next Form button to open the Wound Check form.

Use the check boxes and free text fields to document the wound and any action taken to dress it.

Close the Wound Check form find the Assessment and Plan on the list and double click on it.

Notice the quick text suggestions for use in the Assessment and Plan text box. Don't forget to use lower case letters and click the spacebar to activate.

The other quicktext being shown were created for this training video. The EMR video titled 'quicktext' gives step by step instructions on how to create some for your own personal use in the EMR.

Now type the details in the Assessment & Plan and the Trauma Diagnosis box.

Patient instructions should be typed here and should be in laymen's terms to ensure the patient understands.

Select the orders tab. To give the patient a new medication, click the Trauma Medications button, choose the medication from the drop down list and be sure to fill in the patient instructions. Narcotics will still be handwritten for the patient on a prescription pad and documented in the electronic chart. Fill in the quantity and number of refills, choose handwritten as the prescribing method and click ok.

To refer a patient for a consultation click the Referrals button, choose the type of referral and notice that it appears in this box above.

In order for the clinic to consider the referral, a diagnosis code must be associated. First, check the list of potential diagnoses. To add one, simply click the new button, Click the Reference List button and type the diagnosis keyword. Keep it simple here using partial

words and avoiding phrases like “of the”. Use the scroll bar to the right and select the diagnosis and click ok. Choose the onset date and click ok. It is now on the potential diagnosis list. To put a secondary diagnosis in, simply perform these steps again. Click new, click the Reference List button and type the diagnosis keyword. Use the scroll bar to the right and select the diagnosis and click ok. Choose the onset date and click ok again.

You will now see that they are both on the potential diagnosis list for use. Highlight the diagnosis and click the arrow button to attach it to the order. Highlight the second diagnosis and click the arrow again. To see both codes simply hover your cursor over the diagnosis box.

When finished, click the sign orders button. This will send the order straight to the printer.

Select the Excuse tab, choose which excuse and fill in the blanks. Click the “completed by” button to add your name as the signature.

Select the OT/PT tab, click the orders button and after a few seconds the OT/PT/SLP form opens up. Select the appropriate tab, fill in the blanks and when finished, click the MD sign button – which sends the order to the printer.

Find the Assessment and Plan form on the list and double click to reopen it. Now select the Disposition tab. Choose the buttons which apply to this patient, fill in the blanks as needed and finally be sure to print the Patient Care Summary Sheet.

Close the A&P form. Click the End Update button, make sure the preceptor is in the provider field and the Route to section, and then select the Hold Document button.

The Preceptor will then open the office visit, read your documentations, make comments and place a signature on the document making it a permanent record.