

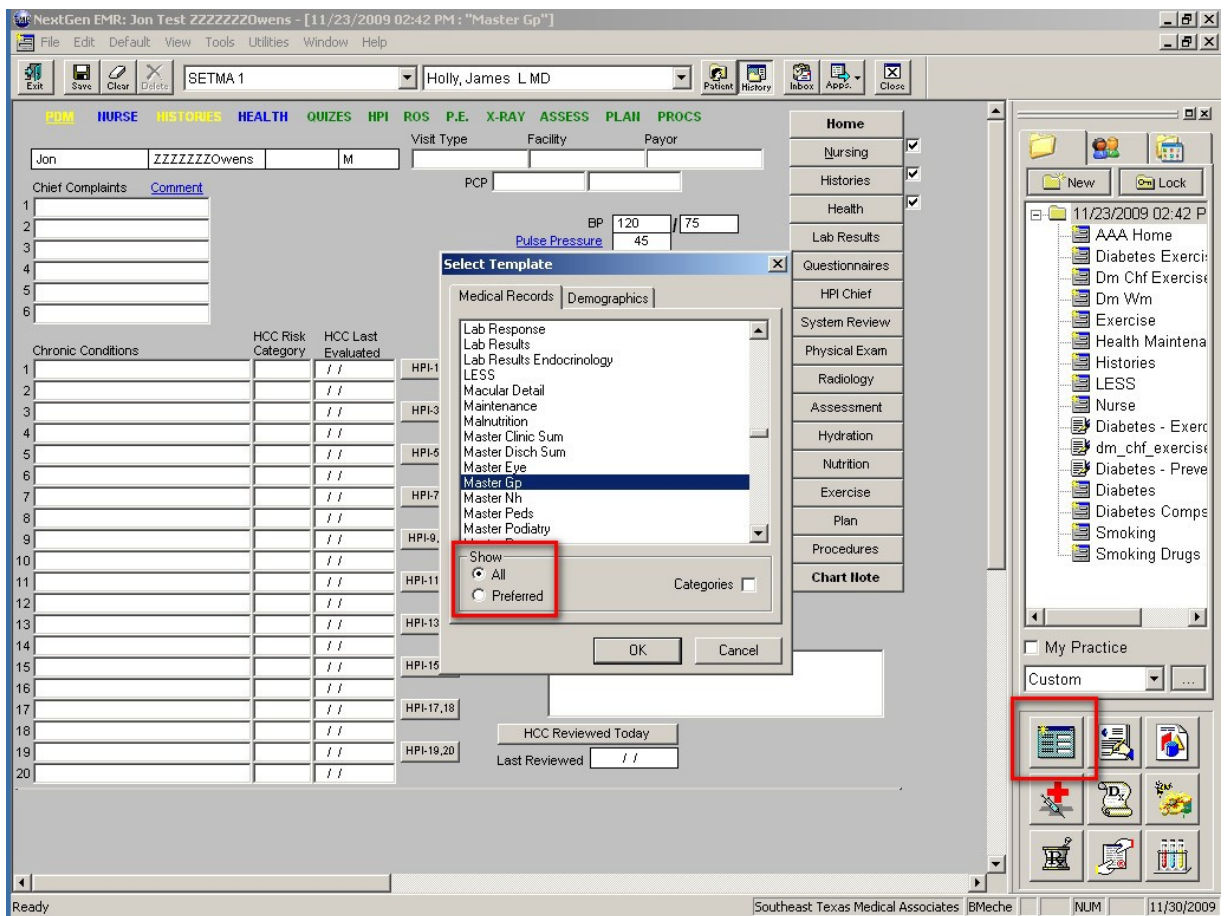
# Master GP Suite of Templates

The Master GP is the basic patient evaluation and/or history and physical examination tool in SETMA's suite of NextGen templates. It is accessed in several ways:

- **AAA Home** – in the third line by clicking on the hyperlink entitled Master GP.

The screenshot displays the SETMA Medical Associates, LLP patient portal. At the top left is the logo. The patient information section includes fields for Patient Name (Jon ZZZZZZOwe), Sex (M), Age (3), and DOB (08/03/2009). Below this are fields for Home Phone, Work Phone, and Patient's Code Status. A navigation menu follows, with 'Master GP' highlighted in a red box. Other menu items include 'Nursing Home', 'Ophthalmology', 'Pediatrics', 'Physical Therapy', 'Podiatry', 'Rheumatology', 'Daily Progress', 'Admission Orders', 'Discharge', 'Insulin Infusion', 'Colorectal Surgery', 'Pain Management', 'Exercise', 'CHF Exercise', 'Diabetic Exercise', 'Drug Interactions', 'Smoking Cessation', 'Hydration', 'Nutrition', 'Guidelines', 'Lab Future', and 'Lab Results'. A 'Disease Management' section lists conditions like Acute Coronary Syn, Angina, Asthma, CHF, Diabetes, Headaches, Hypertension, Lipids, and Cardiometabolic Risk Syndrome. On the left, there are fields for Patient's Pharmacy, Phone, and Fax, along with buttons for 'Rx Sheet - Active', 'Rx Sheet - New', 'Rx Sheet - Complete', and 'Home Health'. The main content area features two tables: 'Pending Referrals' and 'Archived Referrals - Do not use for new referrals', both with columns for Status, Priority, Referral, and Referring Provider. A 'Referral History' link is present. On the right, a 'Chart Note' sidebar contains buttons for 'Return Info', 'Return Doc', 'Email', 'Telephone', 'Records Request', and 'Transfer of Care Doc'.

- **Main Tool Bar** – by clicking on the **Template** button (top left button) at the bottom right of the screen and finding Master GP in the alphabetical list of templates. If the Master GP is not listed in your **Template Preference List**, you can add it.



Review these documents for more information on Main Tool Bar, [Setting Preferences](#)

**Once the Master GP template is opened, the Main Tool Bar should be closed.**

- If you need to look at a previous visit, add a medication or allergy, review the laboratory work you will need to open the Main Tool Bar again by clicking on the Toggle Main Tool Bar button on the Top Tool Bar.
- Also, if you need to use Work Flow, you will need to open it through the Top Tool Bar.

Review these documents for more information on the Top Tool Bar ,Main Tool Bar, Toggle Main Tool Bar and the Work Flow button on the Top Tool Bar.

**Documentation on the Master GP Suite of templates is done by:**

1. Clicking in boxes
2. Checking boxes
3. Activating buttons
4. Type in comment boxes

**When a box appears, documentation will be by:**

1. Pick lists which appear when you left click on your mouse with your cursor in the box. Pick lists can be searched on by typing the first letter in the name of the element you wish to add to your encounter note.

NextGen EMR: Jon Test ZZZZZZZOwens - [11/23/2009 02:42 PM: "Master Gp"]

File Edit Default View Tools Utilities Window Help

SETMA 1 Holly, James L MD

PDM NURSE HISTORIES HEALTH QUIZES HPI ROS P.E. X-RAY ASSESS PLAN PROCS

Jon ZZZZZZZOwens M

Chief Complaints [Comment](#)

1  
2  
3  
4  
5  
6

Chronic Conditions

1  
2  
3  
4  
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15  
16  
17  
18  
19  
20

IMChief Complaint

- \* Coumadin Management
- \* Diabetes Management
- abdominal pain
- aches
- altered bowel habits
- anxiety
- belching
- bleeding
- bloating
- blood in stool
- blood pressure check
- breast tenderness
- chest pain
- cold intolerance
- congestion
- constipation
- cough
- cramping
- delusions
- depression
- diabetes
- diarrhea
- dizziness
- dribbling
- dry mouth
- dryness
- ear ache
- ear drainage
- edema
- emotional instability
- excessive thirst
- fatigue
- fever
- flu
- food sticking
- frequency of urination
- gas
- hair loss
- hallucinations
- headache
- heartburn
- heat intolerance
- heavy periods
- hesitancy of urination
- hot flashes

BP 120 / 75

Pulse Pressure 45

Temp 98.60

Pulse 85.00

Resp 20

wt. lbs 200.00

BMI 27.22

Body Fat

BMR

Cardiac Risk Ratio

Fall Risk Assessment //

Functional Assessment //

Pain Assessment //

Alert

Allergies

Comments

E-Mail Note

Telephone

Vitals/Time

Nursing Home Patient

HIPAA

HCC Reviewed Today

Last Reviewed //

Home

- Nursing
- Histories
- Health
- Lab Results
- Questionnaires
- HPI Chief
- System Review
- Physical Exam
- Radiology
- Assessment
- Hydration
- Nutrition
- Exercise
- Plan
- Procedures
- Chart Note

1  
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20

Ready Southeast Texas Medical Associates BMeche NJM

NextGen EMR: Jon Test ZZZZZZOWens - [11/23/2009 02:42 PM: "Master Gp"]

File Edit Default View Tools Utilities Window Help

SETMA 1 Holly, James L MD

PDM NURSE HISTORIES HEALTH QUIZES HPI ROS P.E. X-RAY ASSESS PLAN PROCS

Visit Type Facility Payor

Jon ZZZZZZOWens M

PCP

BP 120 / 75  
Pulse Pressure 45

Home  
Nursing   
Histories   
Health   
Lab Results

Chief Complaints [Comment](#)

1  
2  
3  
4  
5  
6

Chronic Conditions	HCC Risk Category
1 AA Metabolism Disorder	RxHCC
2 Abd Pain LLQ	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	///
17	///
18	///
19	///
20	///

HPI-17,18  
HPI-19,20

HCC Reviewed Today  
Last Reviewed ///

**Diagnosis Code Mstr**

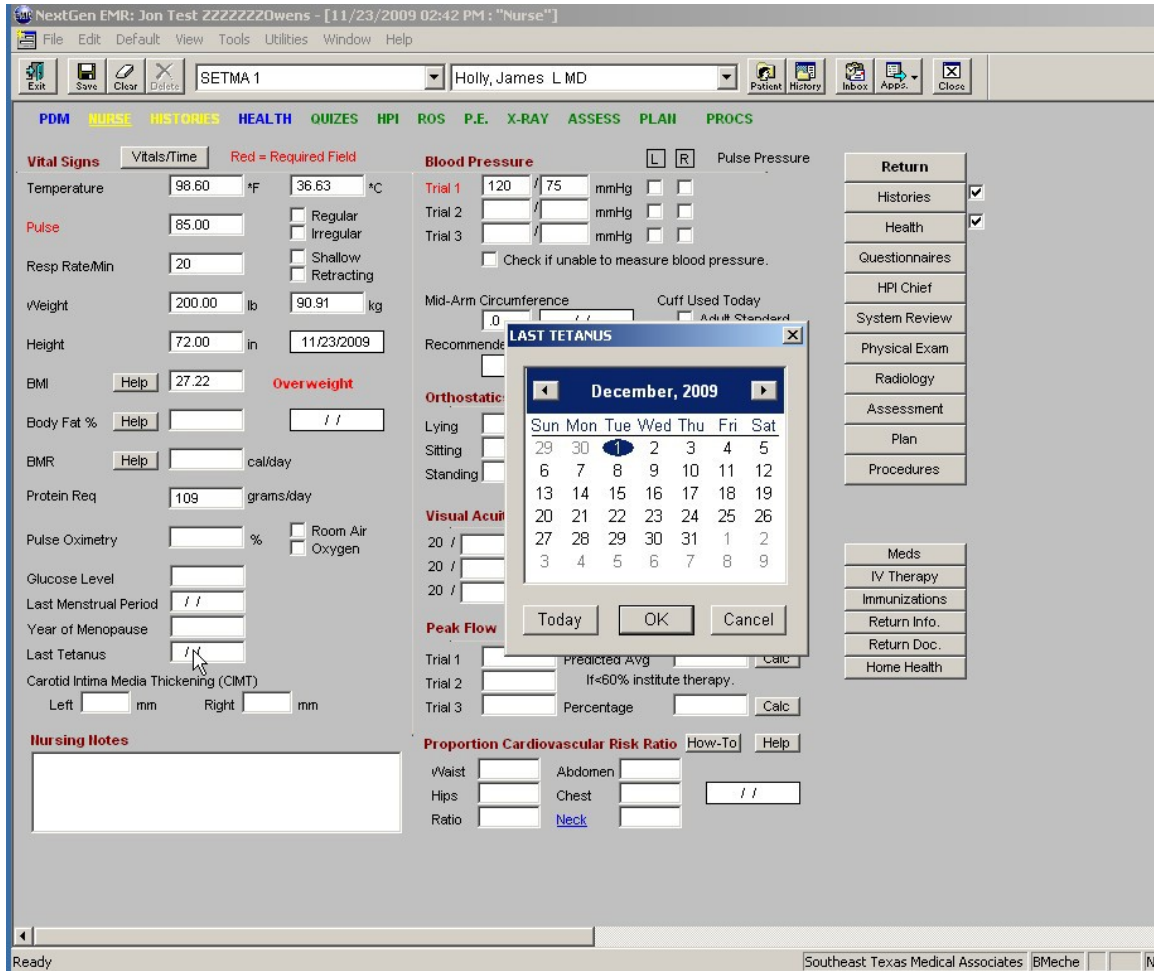
Description	Icd9cm Code Id	User Description
AA Branched Chain Dis Maple Syrup Urine	2703	RxHCC
AA Disorders Specified	2708	RxHCC
AA Disorders Unspecified	2709	RxHCC
AA Elev Homocysteine	2704	RxHCC
AA Fanconi Syncrome	2700	RxHCC
AA Histidine Metabolism Disturbance	2705	RxHCC
AA Metabolism Disorder	2702	RxHCC
AA Phenylketonuria	2701	RxHCC
AA Straight-chain Glucoglycinuria	2707	RxHCC
AA Urea Cycle Metabolism Disturbance	2706	RxHCC
Abd Pain Epigastric	78906	
Abd Pain Generalized	78907	
Abd Pain LLQ	78904	
Abd Pain LUQ	78902	
Abd Pain Periumbilical	78905	

Refresh OK Cancel

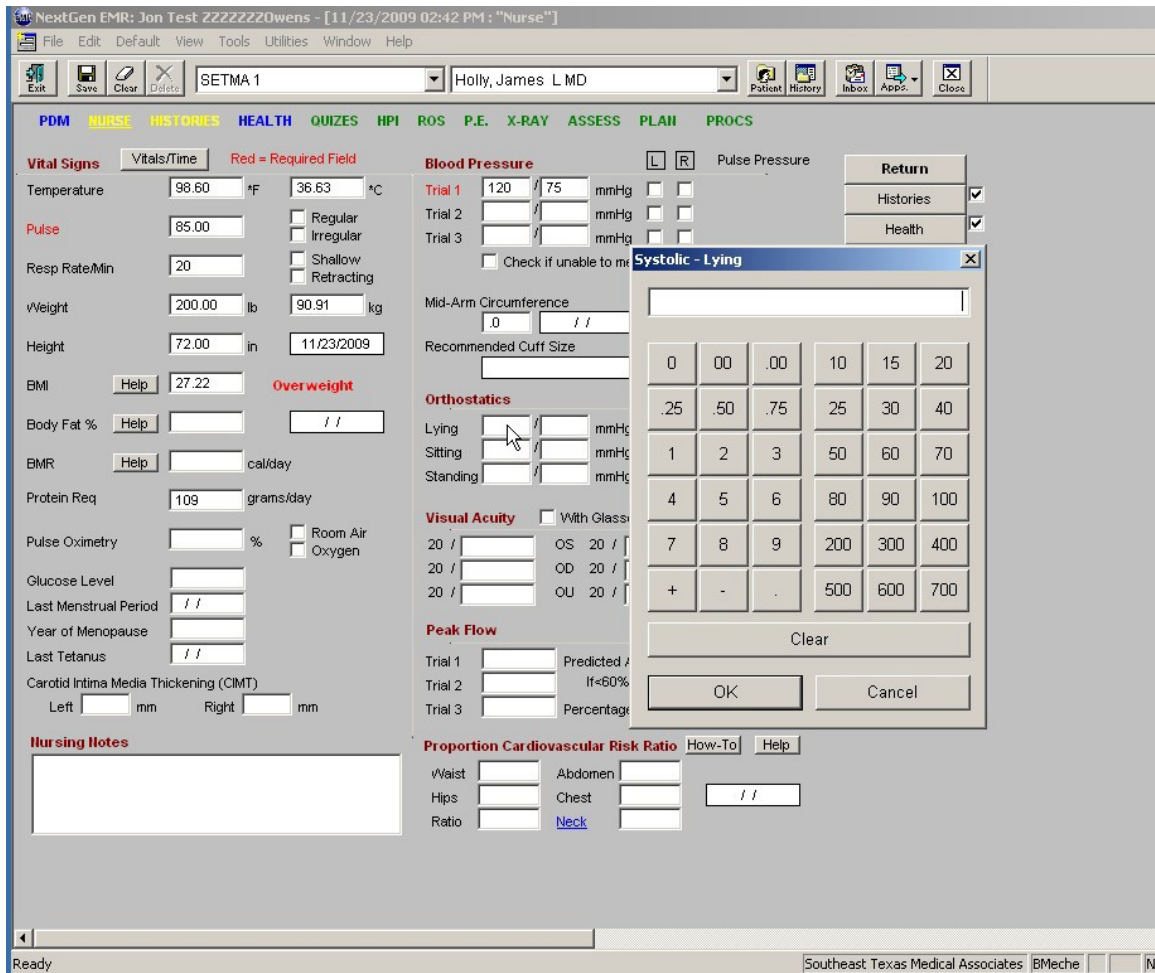
1 2702  
2 78904  
3  
4  
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20

Ready Southeast Texas Medical Associates BMeche NUM 12/0

2. Date Pads which appear when you left click on your mouse with your cursor in the box.

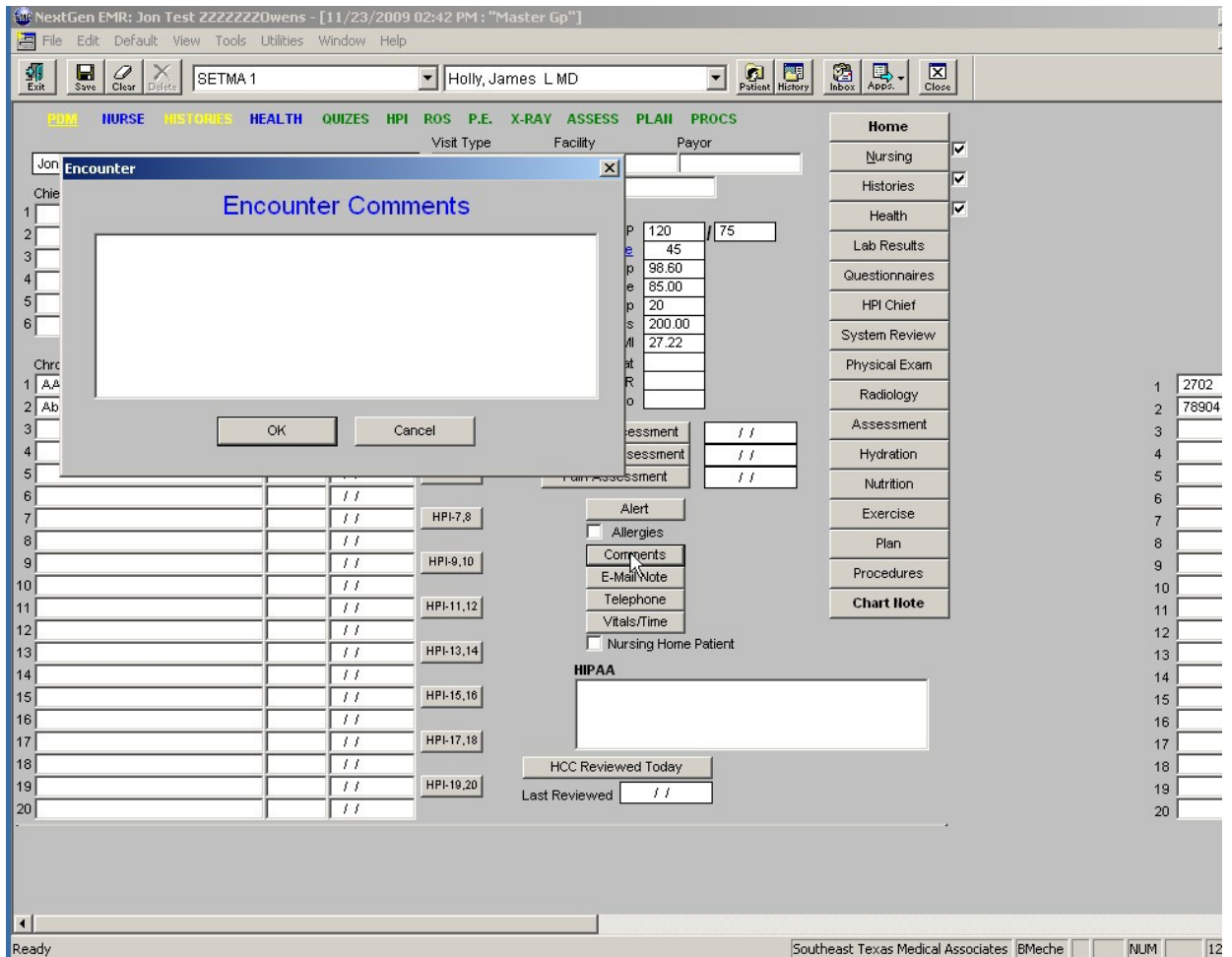


- Number Pads which appear when you left click on your mouse with your cursor in the box.





- Using free texts by typing in comment boxes. It is also possible to use voice recognition with NextGen, but SETMA is not present doing this.



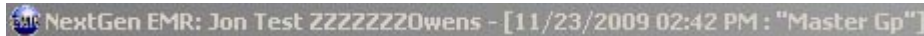


## Patient Data Master Template

**Patient Data Master is the name of the first template in the GP Master Suite of templates.**

At the top of the Patient Data Master and at the top of all other templates in the Master GP suite of templates, you will find:

### 1. Title Bar



### 2. Menu Bar



### 3. Top Tool Bar



### 4. SETMA's Navigation Bar with twelve icons which correspond with the navigation buttons to the right of the screen.



### 5. SETMA's Navigation Buttons down the right hand side of the screen which corresponds with the buttons on SETMA's Navigation Bar.

- a. There are seventeen **SETMA Navigation Buttons**.
- b. Until the Main Tool Bar is toggled closed the vertical right-hand navigation buttons are hidden.
- c. When the Main Tool Bar is closed, they appear.

<b>Home</b>	
Nursing	<input checked="" type="checkbox"/>
Histories	<input checked="" type="checkbox"/>
Health	<input checked="" type="checkbox"/>
Lab Results	
Questionnaires	
HPI Chief	
System Review	
Physical Exam	
Radiology	
Assessment	
Hydration	
Nutrition	
Exercise	
Plan	
Procedures	
<b>Chart Note</b>	

## Content of the Patient Data Master

Across the top of the template, just under SETMA's navigation bar, you will find the following information:

- The patient name, age, sex and
- The Visit type, facility where the services were delivered and the payor.

Beneath this are three columns which contain the following information:

### Column 1:

#### Chief Complaint

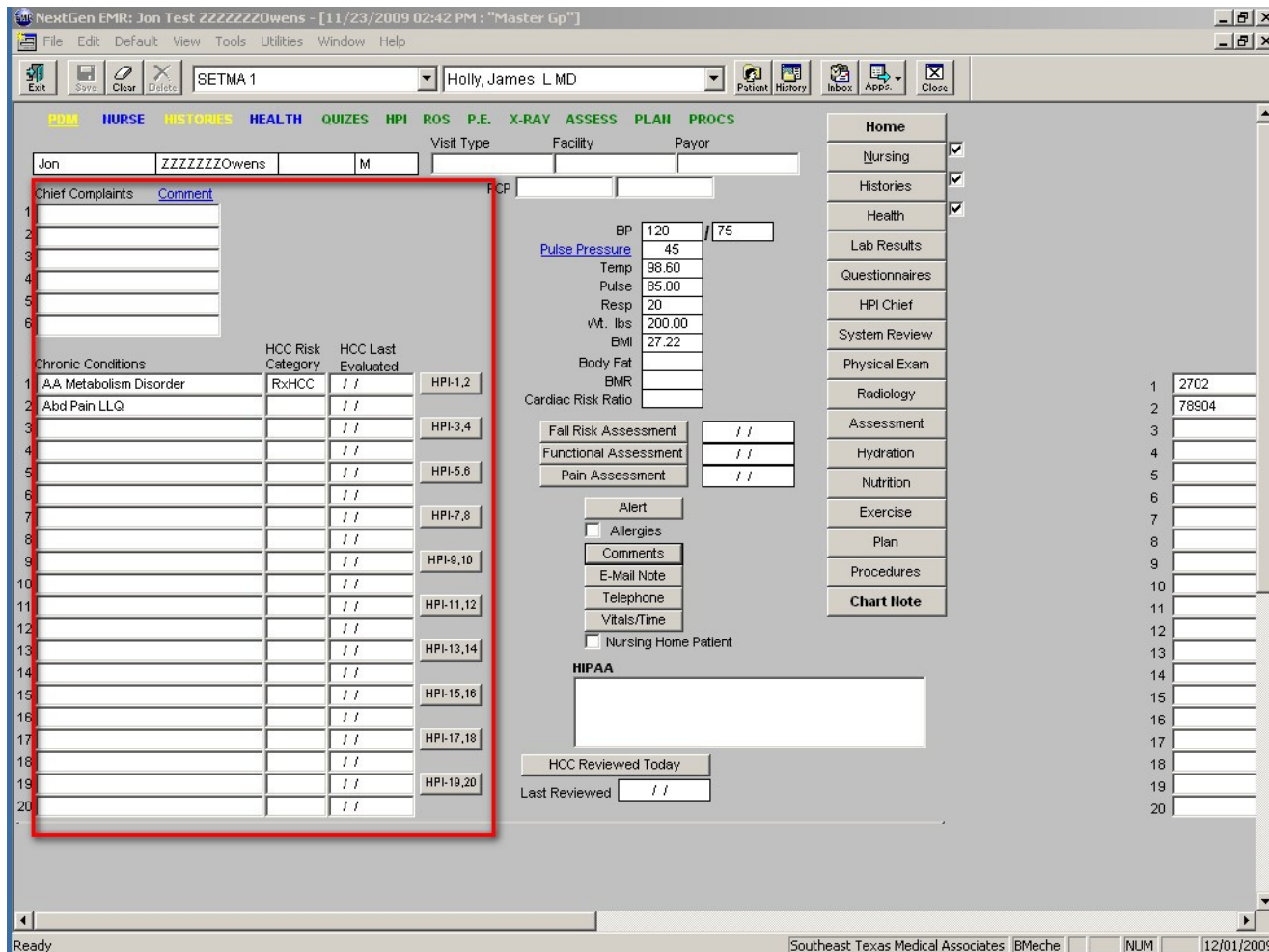
- By left clicking in the space provided, a pick list appears with common presentation complaints.
- The chief complaint should almost always be a single word or short phrase for a symptom such as, pain, shortness of breath, fainting, etc. The details about the chief complaint will be gathered under the history of present illness (HPI).
- To the right of the title "Chief Complaint" there is a "comment" box. This allows for typing in more details if appropriate.
- Where possible, the data should be collected in structured fields so that it can be analyzed and/or audited for quality and for disease management purposes.
- The chief complaint fields are built in Medical Record template fields which means that the data does not copy forward to subsequent visits, i.e., the chief complaint must be entered at every visit.

#### Chronic Conditions

- This essentially represents what was classically the patient's problem list.
- These conditions are added by left clicking in the space and picking the **diagnoses from the ICD-9 code list** which appears.
- The ICD-9 code list can be searched in several ways.
- This list needs to be updated regularly.
- **Remember**, if you type in diagnoses, they will not work with Charge Posting
- **Remember**, if a chronic condition displays both the ICD-9 Code description and number, it must be changed so that it will work with charge posting.
- Beside each Chronic condition box there is a **HPI (History of Present Illness)** button which allows you to update the status of a patient's chronic conditions.

- In order to bill Medicare, the patient must have a legitimate Chief Complaint.
- If they do not have a chief complaint, i.e., they are coming for a “follow-up” or “check-up,” ect., reviewing 3-4 chronic conditions and their status will qualify you for at least a 99213 E&M code even without a chief complaint.

For more information, see [Finding ICD-9 Codes](#), [E & M Codes](#), [Charge Posting](#), [Chronic Conditions](#)



## Column 2:

There is a display of the vital signs, which pulls over automatically from the nursing template.

**Note:** If the BMR is not displayed on the Patient Data Master, you need to go to the Nursing template (which is the second button on SETMA’s navigation bar to the right of the screen).

1. In the space for BMR (which is midway down the first column on the left hand side of the Nursing template), left click on your mouse.
2. This will display a pop-up which allows you to select an activity level for the patient, which automatically calculates the patient’s BMR.
3. Then click OK.
4. The BMR will now be displayed on the Patient Data Master and the chart note.

**Beneath the vitals signs are seven functions which are either in a button or a check box; they are:**

**Alert** – this interacts with the alert template which has 25 different special circumstances in relationship to the patient. Included is the fact that the patient has been fired from the practice or is deaf or is blind, etc. If there is a large red X by the Alert box, you can click on the button to find out what the alert means.

**Allergies** – this is a check box which notes that the patient’s medication allergies have been entered here. When checked, a pop-up is launched which allows for the noting of the patient’s medication allergies. Remember, this does not interact with the Medication Module and the patient’s allergies must also be entered in the Allergy Module on the Main Tool Bar.

**Comments** – this is a box where you can type in comments about this visit. There are many comment boxes through the Master GP Suite, this one particularly relates to general comments about the patient encounter such as: “Patient accompanied by parents, or daughter, or son, etc.

**E-Mail Note** – this allows you to send an e-mail anyone about this patient concerning follow-up, referrals or others management issues. When you access this function, a pop-up appears requesting directions for attachments. Typically, you would click “this template,” which will then allow the recipient to go to Work Flow and open this patient’s chart easily.

**Telephone** – this launches the telephone template for documenting a telephone message from or to this patient.

**Vitals/time** – this launches a display of the patient’s vitals signs from all visits in NextGen. This is a useful tool to look for patterns or trends.

**Nursing Home Patient** – this is a check box where a patient can be designated as a nursing home patient.

**Beneath these six buttons, across the bottom of the template, are hyperlinks to:**

- Nursing Home
- Pediatrics
- Physical Therapy
- Admission Orders

File Edit Default View Tools Utilities Window Help

Southeast Texas Medical Associ Collection, Accounts

**PHYS** NURSE HISTORIES HEALTH QUIZES HPI ROS P.E. X-RAY ASSESS PLAN PROCS

Visit Type Facility Payor

Test Dummy 48 Years M

Chief Complaints [Comment](#)

1  
2  
3  
4  
5  
6

Chronic Conditions

1	Addison's Disease 255.4	HPI-1,2
2	Amputation Leq Below Knee	
3	Diabetes Mellitus Manif Typ II	HPI-3,4
4		
5		HPI-5,6
6		
7		HPI-7,8
8		
9		HPI-9,10
10		
11		HPI-11,12
12		
13		HPI-13,14
14		
15		HPI-15

BP [ ] / [ ]

Temp [ ]

Pulse [ ]

Resp [ ]

Wt. lbs [ ]

BMI [ ]

Body Fat [ ]

BMR [ ]

Cardiac Risk Ratio [ ]

X Alert

Allergies

Comments

E-Mail Note

Telephone

Vitals/Time

Nursing Home Patient

Nursing Home Pediatrics Physical Therapy Admission Orders

Home

Nursing

Histories

Health

Lab Results

Questionnaires

HPI Chief

System Review

Physical Exam

Radiology

Assessment

Hydration

Nutrition

Exercise

Plan

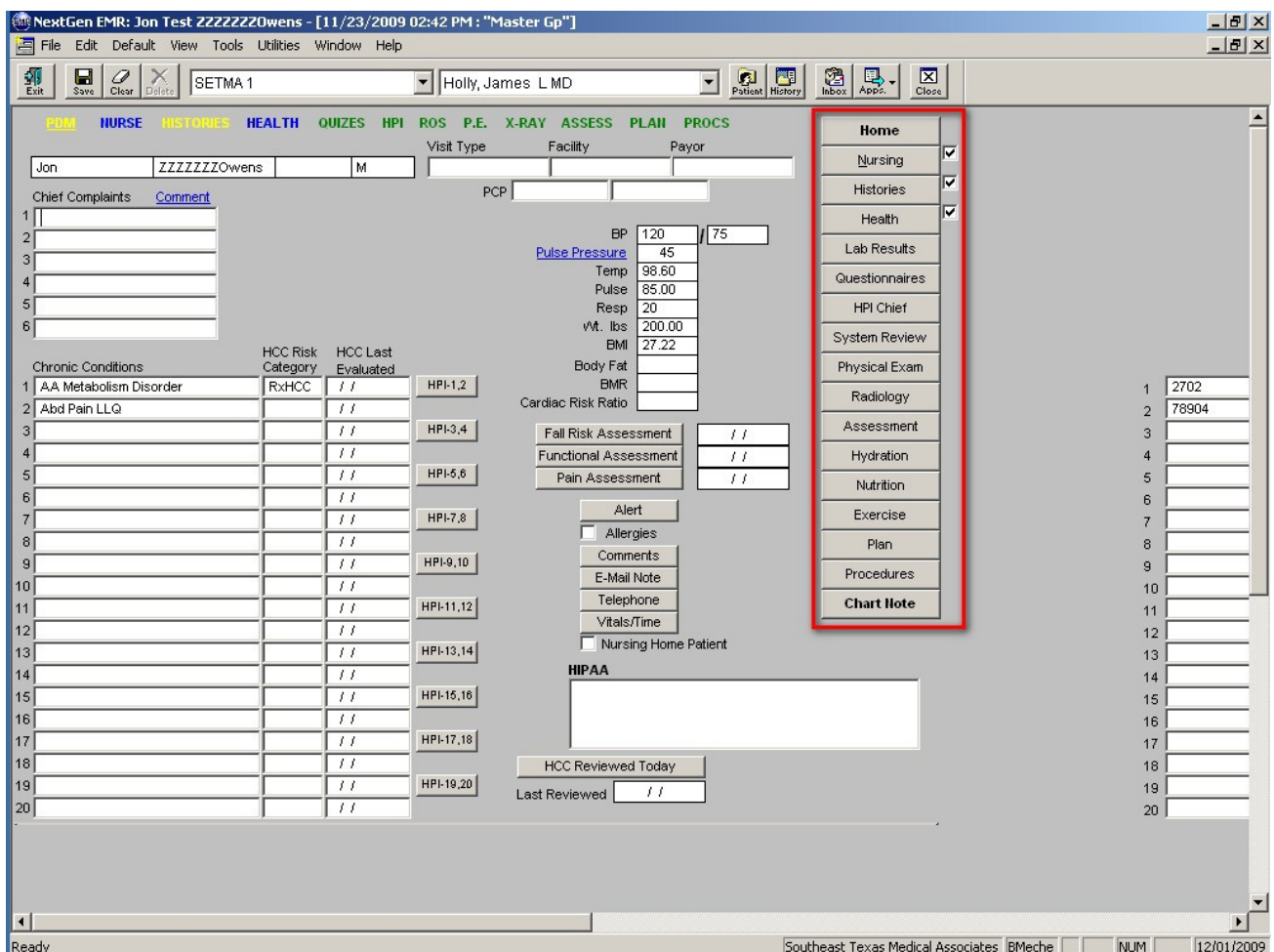
Procedures

**Chart Note**

### Column 3:

This is SETMA's Navigation Bar and represents seventeen buttons which launch:

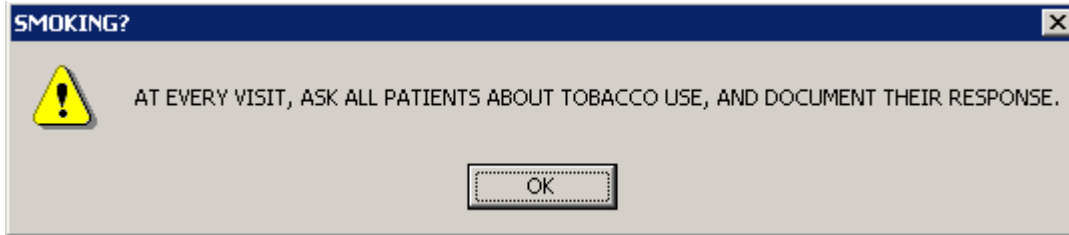
- Home – this takes you back to AAA Home which is the starting point for all navigation.
- Nursing
- Histories
- Health
- Lab Results
- Questionnaires
- HPI
- Systems Review
- Physical Exam
- Radiology
- Assessment
- Hydration
- Nutrition
- Exercise
- Plan
- Procedure
- Chart Note





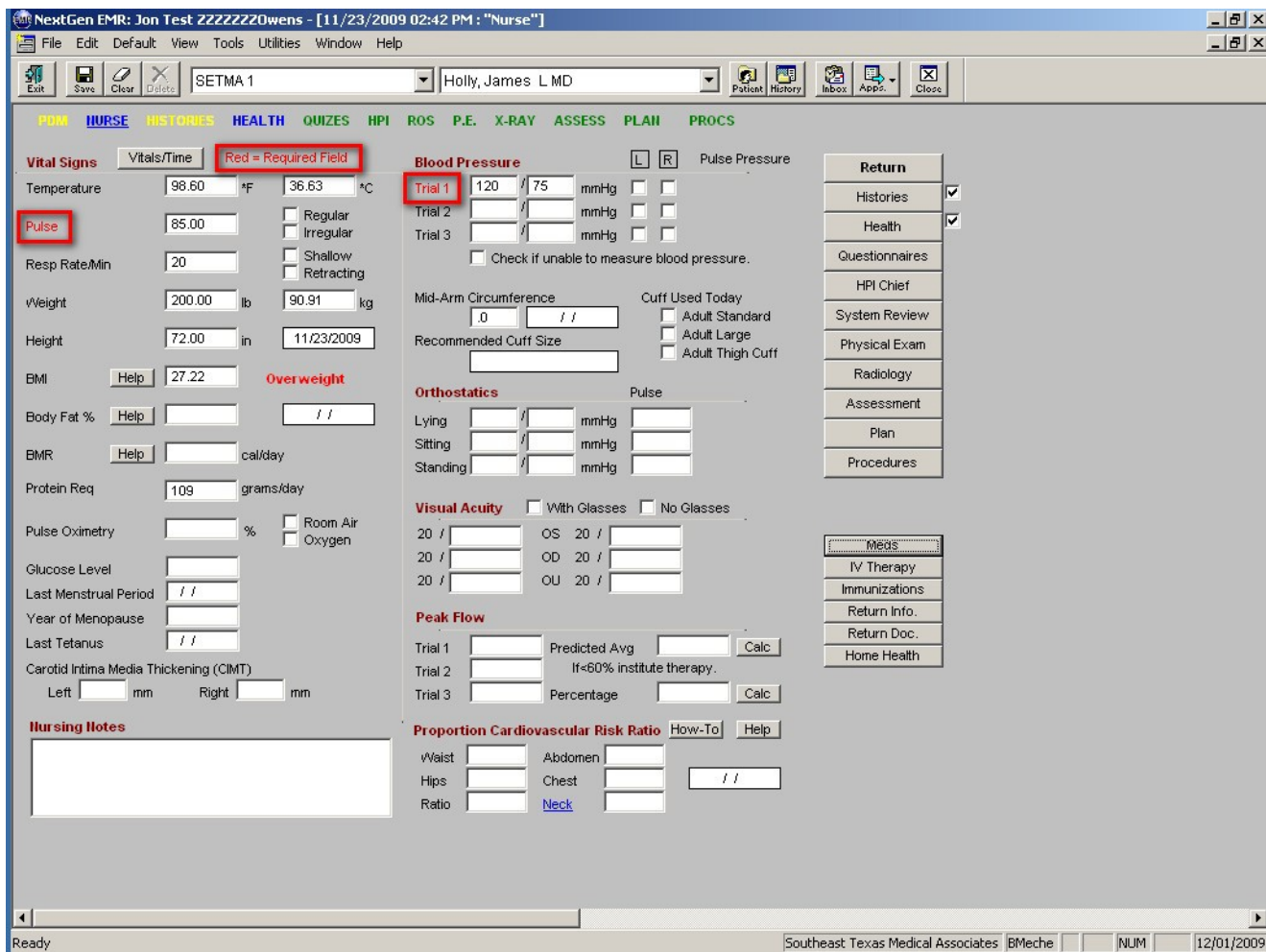
## Nursing Template

When the Nursing Template launches, a pop-up appears which states: **At Every Visit, Ask Every Patient, About Tobacco Use and Document Their Answer.** While this is a part of the LESS Initiative, this older function has been left here because of the important of confronting every patient with the issue of tobacco use.



All of the patient's vital signs are displayed here. The key points are:

1. The following vital signs are required: blood pressure and pulse. These are needed to complete other functions in our preventive health initiatives and therefore are **required fields** which mean that before you can proceed they must be completed.

A screenshot of the NextGen EMR interface for a patient named Jon Test ZZZZZZ0wens. The interface shows various tabs like "VITALS", "HISTORIES", "HEALTH", etc. The "VITALS" tab is active, displaying a form for entering patient data. Red boxes highlight the "Pulse" field and the "Blood Pressure" section. The "Blood Pressure" section includes fields for "Trial 1", "Trial 2", and "Trial 3", with "Trial 1" containing the value "120". Other fields include "Temperature", "Resp Rate/Min", "Weight", "Height", "BMI", "Body Fat %", "BMR", "Protein Req", "Pulse Oximetry", "Glucose Level", "Last Menstrual Period", "Year of Menopause", "Last Tetanus", "Carotid Intima Media Thickening (CIMT)", "Orthostatics", "Visual Acuity", "Peak Flow", and "Proportion Cardiovascular Risk Ratio". A "Return" sidebar on the right lists various medical actions like "Histories", "Health", "Questionnaires", etc. The status bar at the bottom indicates "Ready" and "Southeast Texas Medical Associates | BMeche | NJM | 12/01/2009".

2. The following are in **demographic fields** which means that the information in these fields copies forward to the next visit:
  - a. Height
  - b. Body Fat Percent
  - c. Waist -- there is a help button which gives instructions for how to properly measure the patient's waist size.
  - d. Hips
  - e. Abdomen
  - f. Chest
  - g. **Neck** – a neck circumference of greater than 16 for a woman and 17 for a man places the patient at increased risk for sleep apnea.
  
3. The following automatically calculate:
  - a. **BMI** – this automatically calculates when the weight and height are added to the patient encounter.
  - b. **BMR** – you must click in the BMR box with the left mouse and assign an activity level. The BMR then auto calculates
  - c. **Protein Requirement** – this lets you know how many grams of protein this patient should have each day. Even if the patient is trying to lose weight which will require a caloric-restricted diet, they should still get this many grams of protein.
  - d. **Ratio for cardiovascular risk** – this is automatically calculated and is a function of the relationship between the waist and hips.

*Note:* The help button entitled Proportion Cardiovascular Risk Ratio states in part: Ideally, women should have a waist-to-hip ratio of 0.8 or less and ideally, men should have a waist-to-hip ratio of 0.95 or less.
  
4. The following help buttons given details about each subject and appear on the Nursing Template:
  - a. BMI
  - b. Body Fat
  - c. BMR
  - d. Cardiovascular Risk
  
5. At the top of the template there is the ability to look at **Vital Signs Over Time** which is the same as the function on the Patient Data Master.

NextGen EMR: Jon Test ZZZZZZDwens - [11/23/2009 02:42 PM : "Nurse"]

File Edit Default View Tools Utilities Window Help

SETMA 1 Holly, James L MD

PBM **NURSE** HISTORIES HEALTH QUIZES HPI ROS P.E. X-RAY ASSESS PLAN PROCS

**Vital Signs** Vitals/Time Red = Required Field

Temperature 98.60 °F 36.63 °C

**Pulse** 85.00  Regular  Irregular

Resp Rate/Min 20  Shallow  Retracting

Weight 200.00 lb 90.91 kg

Height 72.00 in 11/23/2009

BMI  27.22 Over weight

Body Fat %  //

BMR  cal/day

Protein Req 109 grams/day

Pulse Oximetry %  Room Air  Oxygen

Glucose Level

Last Menstrual Period //

Year of Menopause

Last Tetanus //

Carotid Intima Media Thickening (CMT)  
Left mm Right mm

**Nursing Notes**

**Blood Pressure**  L  R Pulse Pressure

Trial 1 120 / 75 mmHg

Trial 2 / / mmHg

Trial 3 / / mmHg

Check if unable to measure blood pressure.

Mid-Arm Circumference .0 //

Cuff Used Today  Adult Standard  Adult Large  Adult Thigh Cuff

Recommended Cuff Size

**Orthostatics** **Pulse**

Lying / / mmHg

Sitting / / mmHg

Standing / / mmHg

**Visual Acuity**  With Glasses  No Glasses

20 / / OS 20 / /

20 / / OD 20 / /

20 / / OU 20 / /

**Peak Flow**

Trial 1 / / Predicted Avg / /

Trial 2 / / If <60% institute therapy.

Trial 3 / / Percentage / /

**Proportion Cardiovascular Risk Ratio**

Waist / / Abdomen / /

Hips / / Chest / /

Ratio / / [Neck](#) / /

**Return**

- Histories
- Health
- Questionnaires
- HPI Chief
- System Review
- Physical Exam
- Radiology
- Assessment
- Plan
- Procedures

**Meas**

- IV Therapy
- Immunizations
- Return Info.
- Return Doc.
- Home Health

Ready Southeast Texas Medical Associates BMeche

NextGen EMR: Jon Test ZZZZZZDwens - [11/23/2009 02:42 PM : "Vitals"]

File Edit Default View Tools Utilities Window Help

SETMA 1 Holly, James L MD

**Vitals Over Time**

Date	Systolic 1	Diastolic 1	Pulse	Weight (lb)	BMI	Body Fat %	Waist (in)	Hips (in)	Abdomen (in)	Ri
11/23/2009 02:42 PM	120	75	85.00	200.00	27.22					

6. When the **peak flow meter** is used, there are two buttons with “calc” which stands for “calculate.” When clicked these will automatically calculate the “**Predicted Average**” and the “**Percent**” for this patient.

## Health (Health Maintenance) Template

This is a summary of the Preventive Health and Interval Health care received by the patient. At the top of this template, after the Title Bar, the Menu Bar, the Top Tool Bar and SETMA’s Tool Bar, there is the following information:

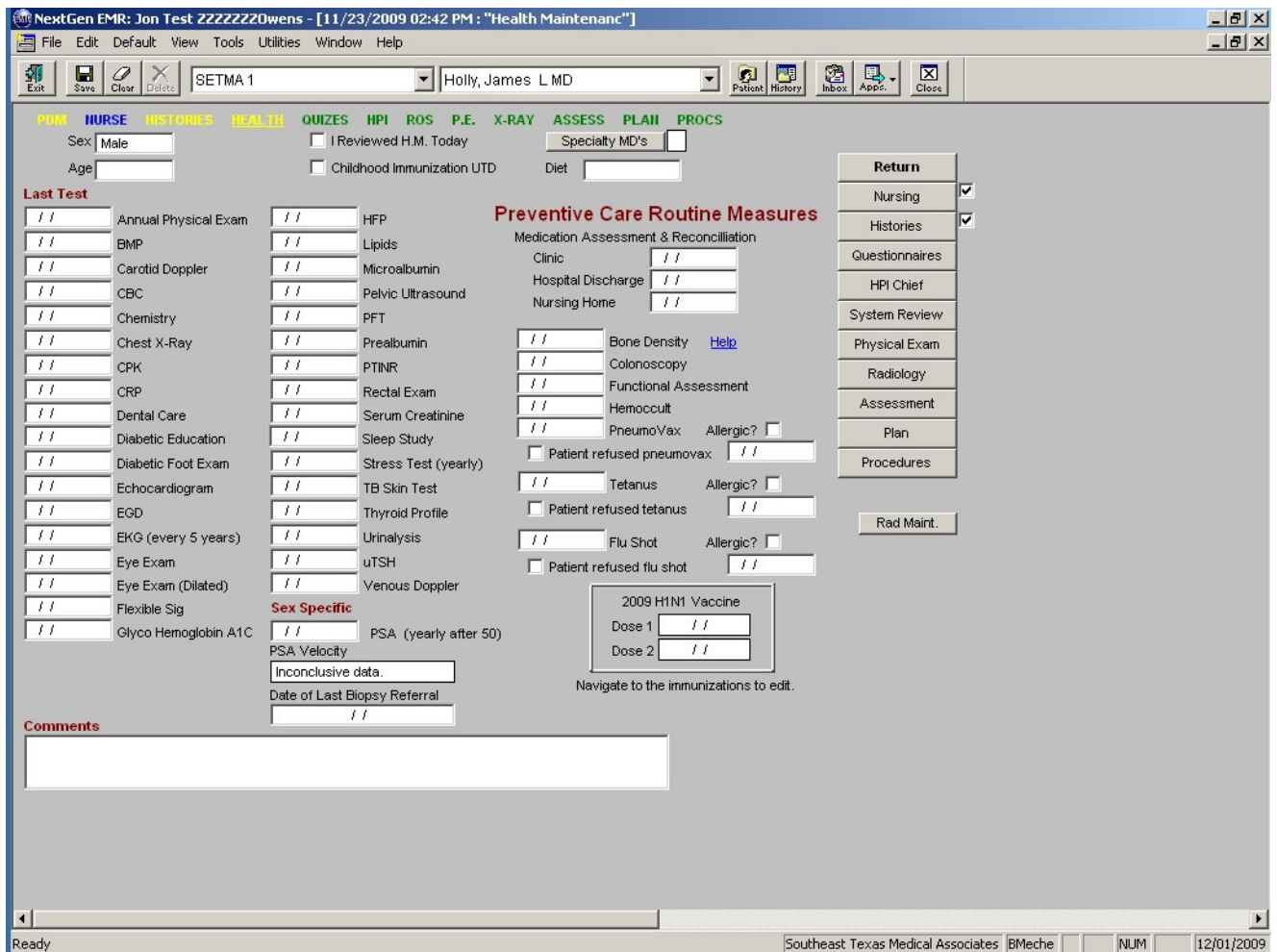
- Sex
- Age
- **I Reviewed H.M. Today** – this is a check box which allows you to document that you reviewed this template during the current encounter. If this box is checked, the Health Maintenance data will print on your chart note.
- **Childhood Immunization UTD (Up to Date)** – a check box for documenting a summary statement about immunizations.
- **Specialty MDs** – this is a button which launches a pop-up where it is possible to document the names and specialties of other physicians who treat this patient.
- Diet
- **Dental Care** – an important issue in general health and particularly in diabetic care is dental hygiene. This documents when the patient last saw a dentist.

There are 36 parameters which are routinely tracked for both male and female and there are sex specific measures. These parameters are automatically captured when the data is generated through NextGen, but can and should be manually inputted if the care was received elsewhere.

The **Comment Box** at the bottom of the screen is a demographic field which means that any data which is placed there will copy forward to future visits.

At the right, there is a list of SETMA’s Navigation Buttons

*Note:* Just beneath, SETMA’s Navigation Button, there is button entitled **Rad Maint**. When accessed this launches a summary of the most recent x-rays on this patient in 21 categories. This function is also launched from the Radiology Template.



## History Template

This template documents many elements of the patient's past medical and surgical history. Its content and organization include three columns with additional material across the bottom of the template:

### Column 1:

A check box to indicate that you have reviewed the patient's past history during the current encounter. When this box is checked the information on this template will copy to the chart note.

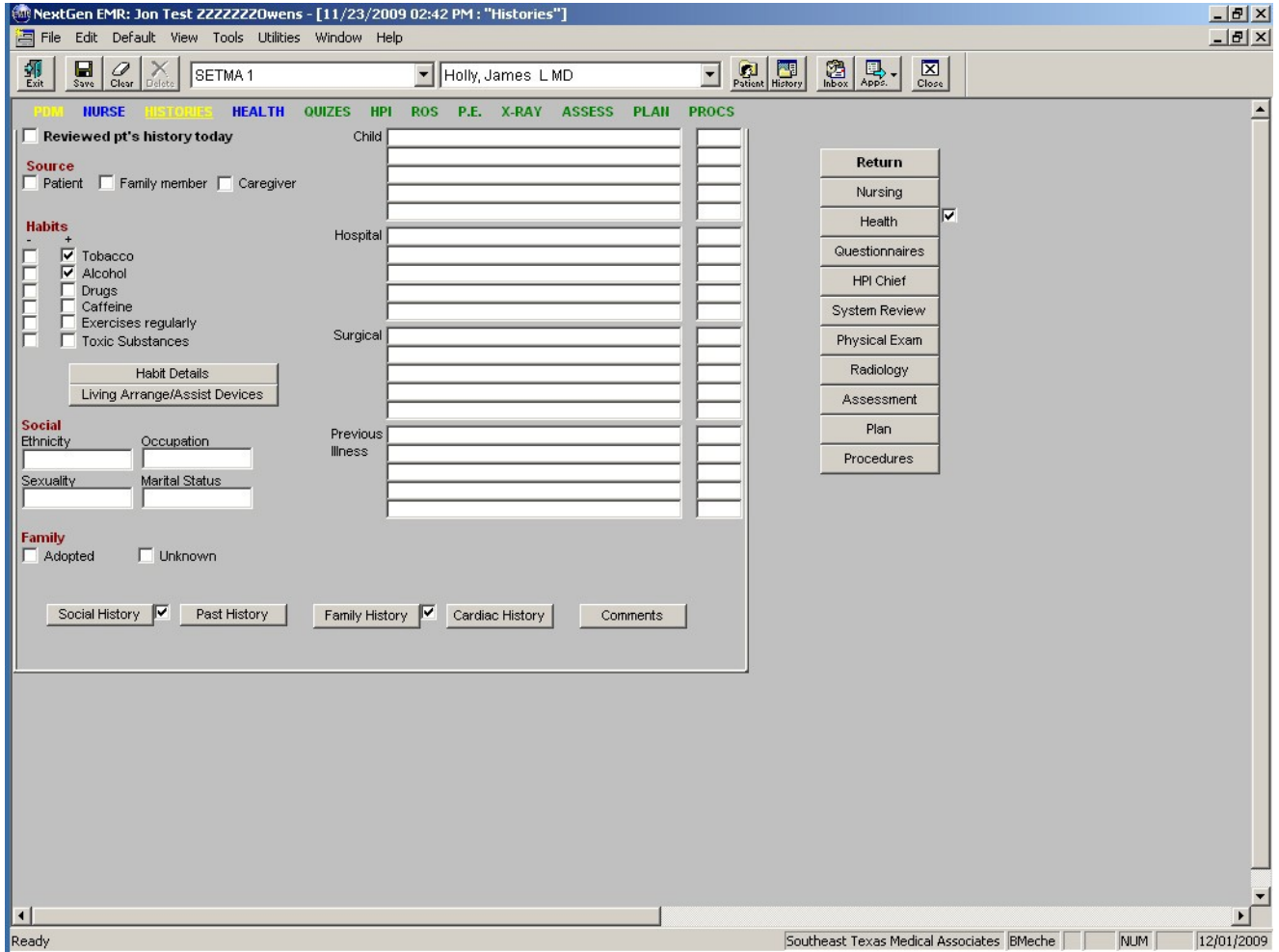
**Source** – this documents who gave the information contained on the history template. It is possible to indicate that more than one person gave the information.

**Current habits** – gives the ability to document the use of or the exposure to:

1. Tobacco
2. Alcohol
3. Drugs
4. Caffeine
5. Exercises Regularly
6. Toxic Substances

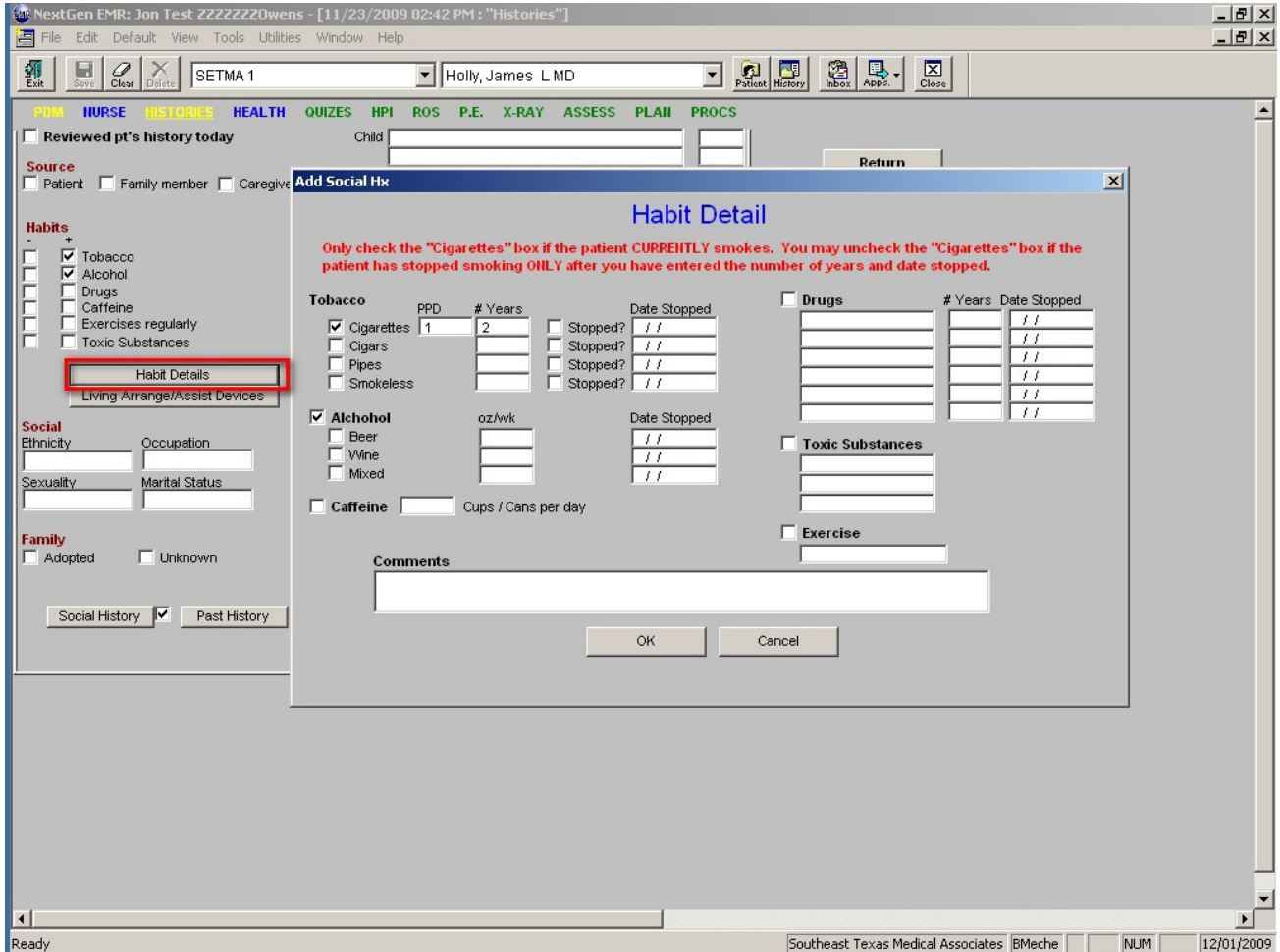
To the right of these six functions is a button entitled **Previous Habits**. This allows for the documentation of the prior use of tobacco, alcohol, drugs, and the exposure to toxic substances and exercise.

Also to the right of these six functions is a button entitled **Living Arrangements and Assistive Devices** which launches a pop-up where it is possible to give details about with whom the patient lives and in what kind of dwelling and also any special devices (wheelchair, walker, braces, splints they use and/or whether they have a hearing, etc.:

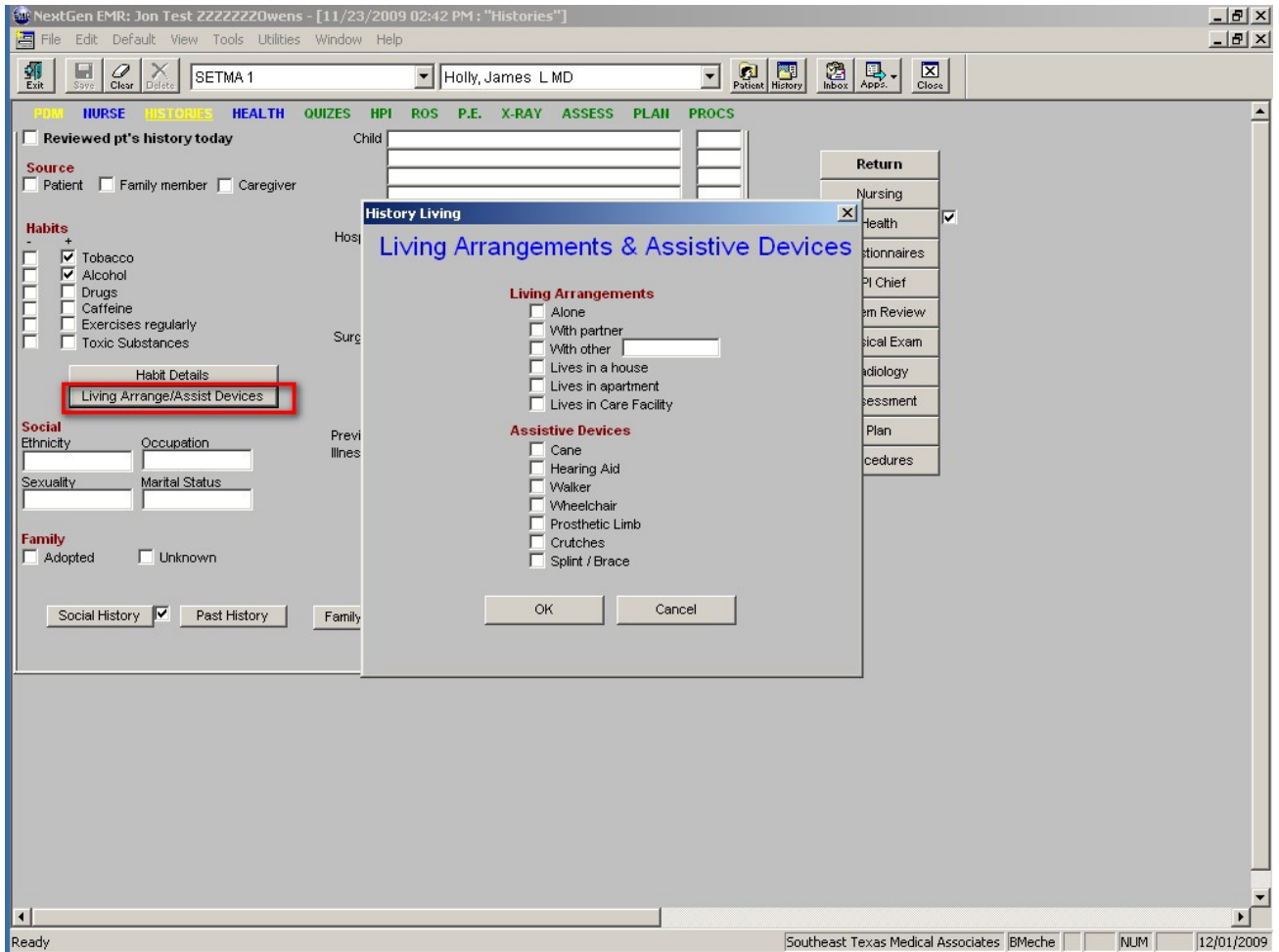


**Social** – this is the place to document the patient’s

1. Ethnicity
2. Occupation
3. Sexuality
4. Marital Status

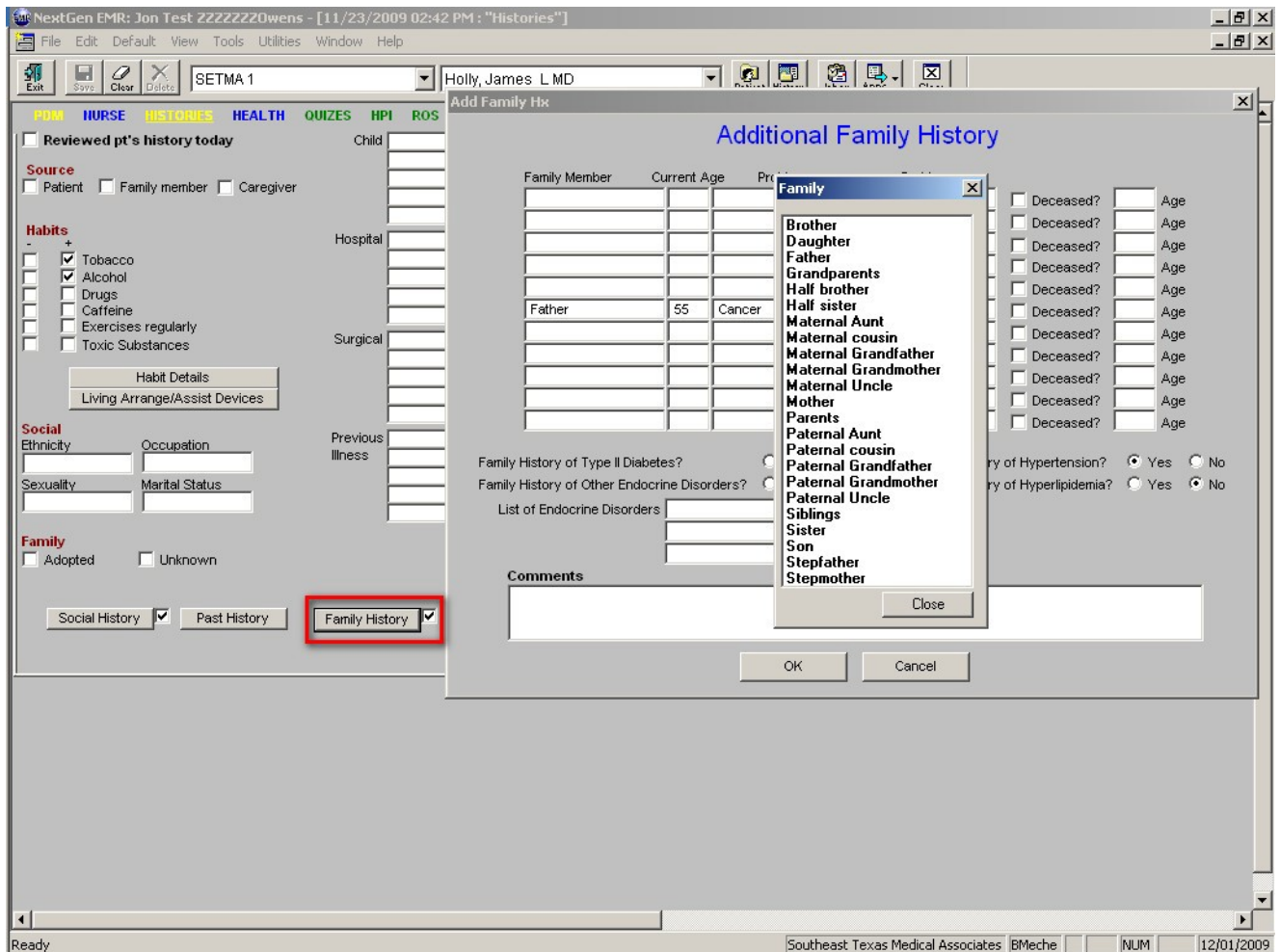






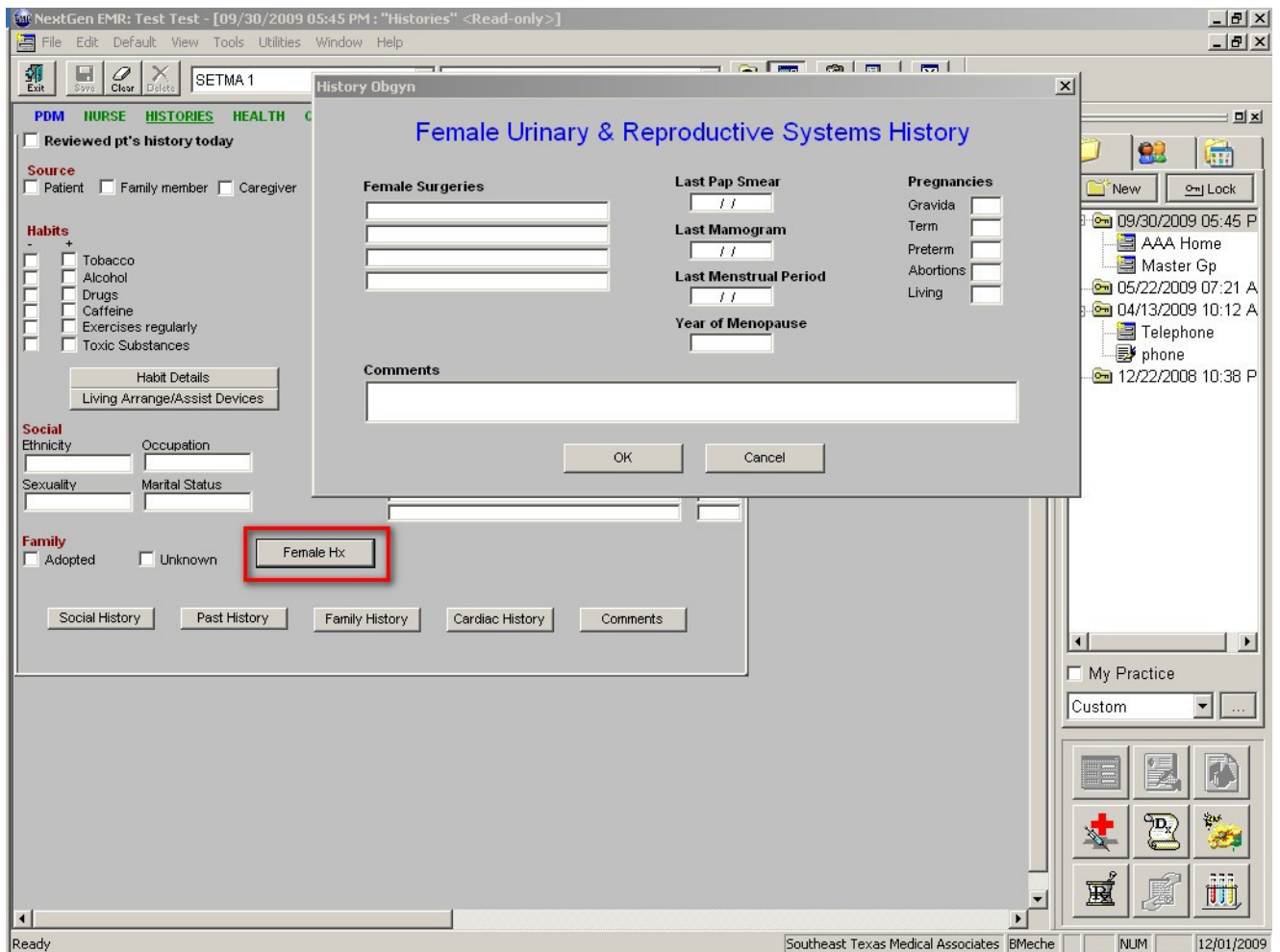
**Family History** with two check boxes to document the limitations on collecting a family history of:

1. Adopted
2. Unknown



If the patient is a female you will see just to the right of the above family history section, a button entitled **Female History**. This allows for documentation of:

- Females Surgeries
- Last Pap Smear – which is interactive with the Health Maintenance Template
- Last Mammogram – which is interactive with the Health Maintenance Template
- LMP (Last Menstrual Period)
- Pregnancies (Gravida, Term, Preterm, Abortions, Living)
- Comments Box

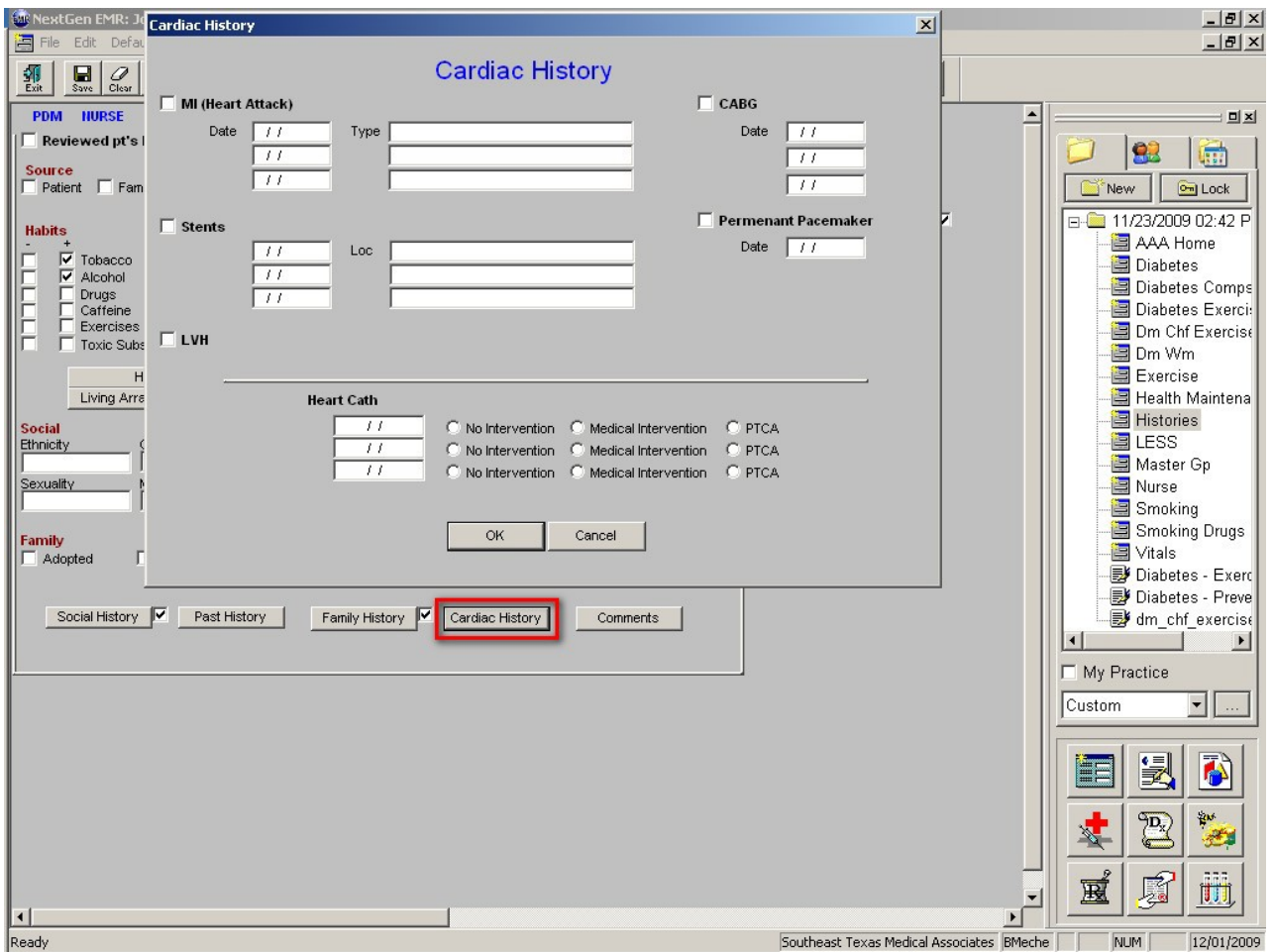


**Six boxes for the collection of family history including**

1. Relationship
2. Current Age
3. Problem
4. State of Health
5. Deceased
6. Age at death

**Extension of family history with five buttons for:**

1. Extended Social History
2. Extended Surgical History
3. Extended Family History
4. Cardiac History – when completed the information contained here interacts with other functions in the EMR including Framingham Risk and others.



5. Comments – this allows for free text to be typed in for additional details which do not fit with the boxes above.

## Column 2:

Boxes for documentation of:

1. Child
2. Hospital
3. Surgical
4. Previous Illnesses

### Column 3 – SETMA’s Navigation Bar

1. Return
2. Nursing
3. Health
4. Questionnaires
5. HPI
6. System Review
7. Physical Exam
8. Radiology
9. Assessment
10. Plan
11. Procedures

### Lab Results Template

- When this template is opened, automatically the current and/or most recent lab work will be imported into this template.
- Once the process is completed, it is possible to complete a document which can be printed and given to the patient.
- Also, once the process is completed and without producing the document, this information will now print on your chart note for this current encounter.

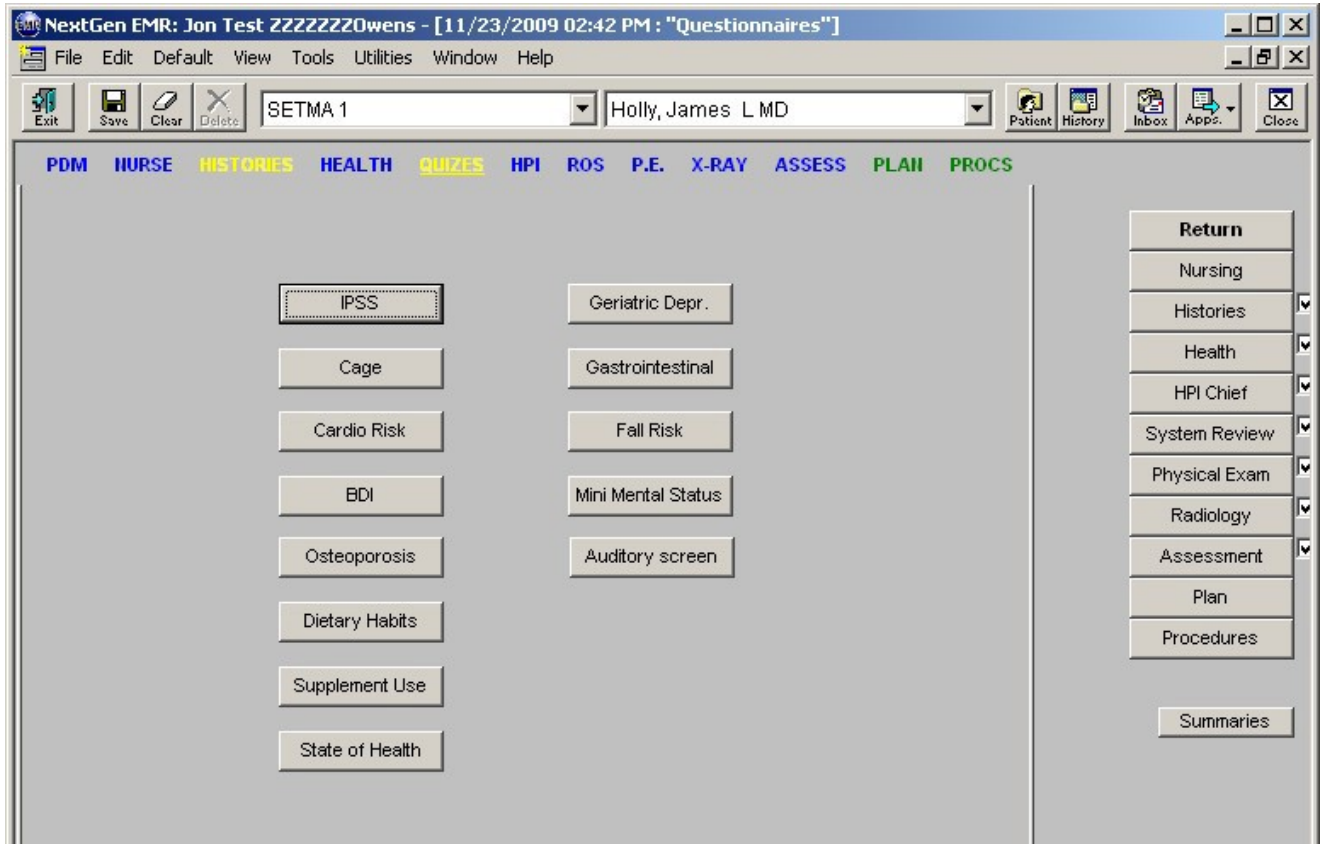
### Lab Results

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Return
Document

Scroll down for more... Common Neurology Orders

# Questionnaires Template



This template has 13 questionnaires which can be accessed and completed; they are:

- **AUA -- American Urological Symptom Index** – A score, a scale and a result are given. It is also possible to compare prior results with today’s result.

**American Urological Symptom Index**

<p>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?</p> <p>Over the past month, how often have you had to urinate again less than 2 hours after your finished urinating?</p> <p>Over the past month, how often have you found you stopped and started again several times when you urinated?</p> <p>Over the past month, how often have you found it difficult to postpone urination?</p> <p>Over the past month, how often have you had a weak urinary stream?</p> <p>Over the past month, how often have you had to push or strain to begin urination?</p> <p>Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?</p>	<p><b>Score</b></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><b>Score Indications</b> 0 - 7 Mild 8 - 19 Moderate 20 - 35 Severe</p> <p>Total Score <input type="text"/></p> <p>Indication <input type="text"/></p>	<p><b>Scoring guide</b></p> <p>Not at all 0</p> <p>Less than 1 time in 5 1</p> <p>Less than half the time 2</p> <p>About half the time 3</p> <p>More than half the time 4</p> <p>Almost always 5</p>
--	--	--

**If changes are made, please re-calculate total score and indication.**

- **CAGE Questionnaire for Alcoholism** – A score and a scale are given.

**Cage Questionnaire**

[Return](#)

The CAGE questionnaire is an inexpensive, brief interview that can be used in the process of taking a routine medical history. It indicates the following four questions.

1. Have you ever felt the need to *cut down* on your drinking?       yes    no

2. Have you ever been *annoyed* by criticism of your drinking?       yes    no

3. Have you ever felt *guilty* about your drinking?       yes    no

4. Have you ever had a morning *eye-opener* after a night of drinking?       yes    no

**Patients who answer yes to two or more of the questions have a high risk for having alcoholism. The positive predictive value of two affirmative responses has been reported to be 80 to 100%.**



- **Framingham Cardiovascular Risk** – this also triggers from many other places as well.

### Framingham Cardiovascular Risk Assessment

Last Updated/Reviewed

Date of Birth  Sex

**Return**

Summary

**Stroke Risk Factor Prediction**

The Stroke Risk Factor Prediction is for male and female patients between the ages of 54 and 86 with SBP ranges Male: 95-213, Female: 95-204

Age	<input type="text" value="3"/>	Pts.	<input type="text" value="0"/>
SBP	<input type="text"/>	Pts.	<input type="text"/>
HYP RX	<input type="text"/>	Pts.	<input type="text"/>
Diabetes	<input type="text"/>	Pts.	<input type="text"/>
CIGS	<input type="text"/>	Pts.	<input type="text"/>
CVD	<input type="text"/>	Pts.	<input type="text"/>
AF	<input type="text"/>	Pts.	<input type="text"/>
LVH	<input type="text"/>	Pts.	<input type="text"/>

**Coronary Heart Disease Risk Factor Prediction**

The CHD Risk Factor Prediction is for patients between the ages of 20 and 60. The algorithm assesses the patient's 10 Year CHD risk based on age, systolic blood pressure, HDL cholesterol, total cholesterol, Diabetes, smoking, and LVH.

Age	<input type="text" value="3"/>	Pts.	<input type="text"/>
SBP	<input type="text"/>	Pts.	<input type="text"/>
<input type="checkbox"/> treated <input type="checkbox"/> untreated			
HDL - C:	<input type="text"/>	Pts.	<input type="text"/>
Total - C:	<input type="text"/>	Pts.	<input type="text"/>
Diabetes	<input type="text"/>	Pts.	<input type="text"/>
CIGS	<input type="text"/>	Pts.	<input type="text"/>
LVH	<input type="text"/>	Pts.	<input type="text"/>

Point Total

10 Year Risk  Percent

points

**Key For Symbols**

SBP - Systolic blood Pressure	AF - History of atrial fibrillation
HYP RX - Under anti-hypertensive therapy	LVH - Left ventricular hypertrophy on ECG
Diabetes - History of diabetes	HDL-C = HDL-Cholesterol
CIGS - Smokes cigarettes	Total - C = Total Cholesterol
CVD - History of myocardial infarction, angina pectoris, coronary insufficiency, intermittent claudication or congestive	

**Interpretation**

- **BDI Depression Scale** – A score, a scale and a summary with past results are given. A link with the Psych Examination is also present.

### BDI Depression Scale

**1**  I do not feel sad.  
 I feel sad.  
 I am sad all the time and I can't snap out of it.  
 I am so sad or unhappy that I can't stand it.

**3**  I do not feel like a failure.  
 I feel I have failed more than the average person.  
 As I look back on my life, all I can see is a lot of failures.  
 I feel I am a complete failure as a person.

**5**  I don't feel particularly guilty.  
 I feel guilty a good part of the time.  
 I feel quite guilty most of the time.  
 I feel guilty all of the time.

**7**  I don't feel disappointed in myself.  
 I am disappointed in myself.  
 I am disgusted with myself.  
 I hate myself.

**9**  I don't have any thoughts of killing myself.  
 I have thoughts of killing myself, but I would not carry them out.  
 I would like to kill myself.  
 I would like to kill myself if I had the chance

**11**  I am more irritated now than I ever am  
 I get annoyed or irritated more easily than I used to.  
 I feel irritated all the time now.  
 I don't get irritated at all by the things that used to irritate me.

**13**  I make decisions about as well as I ever could.  
 I put off making decisions more than I used to.  
 I have greater difficulty in making decisions than before.  
 I can't make decisions at all anymore.

**15**  I can work about as well as before.  
 It takes extra effort to get started at doing something.  
 I have to push myself very hard to do anything.  
 I can't do any work at all.

**17**  I don't get tired more than usual.  
 I get tired more easily than I used to.  
 I get tired from doing almost anything.  
 I am too tired to do anything.

**19**  I haven't lost much weight, if any, lately.  
 I have lost more than 5 pounds.  
 I have lost more than 10 pounds.  
 I have lost more than 15 pounds.

**21**  I have not noticed any recent change in my interest in sex.  
 I am less interested in sex than I used to be.  
 I am much less interested in sex now.  
 I have lost interest in sex completely.

**2**  I am not particularly discouraged about the future.  
 I feel discouraged about the future.  
 I feel I have nothing to look forward to.  
 I feel that the future is hopeless and that things cannot improve

**4**  I get as much satisfaction out of things as I used to.  
 I don't enjoy things the way I used to.  
 I don't get real satisfaction out of anything anymore.  
 I am dissatisfied or bored with everything.

**6**  I don't feel I am being punished.  
 I feel I may be punished.  
 I expect to be punished.  
 I feel I am being punished.

**8**  I don't feel I am any worse than anybody else.  
 I am critical of myself for my weaknesses or mistakes.  
 I blame myself all the time for my faults.  
 I blame myself for everything bad that happens.

**10**  I don't cry any more than usual.  
 I cry more now than I used to.  
 I cry all the time now.  
 I used to be able to cry, but now I can't cry even though I want to.

**12**  I have not lost interest in other people.  
 I am less interested in other people than I used to be.  
 I have lost most of my interest in other people.  
 I have lost all of my interest in other people.

**14**  I don't feel I look any worse than I used to.  
 I am worried that I am looking old or unattractive.  
 I feel that there are permanent changes in my appearance that make me look unattractive.  
 I believe that I look ugly.

**16**  I can sleep as well as usual.  
 I don't sleep as well as I used to.  
 I wake up 1-2 hours earlier than usual and find it hard to go back to sleep.  
 I wake up several hours earlier than I used to and cannot go back to sleep.

**18**  My appetite is no worse than usual.  
 My appetite is not as good as it used to be.  
 My appetite is much worse now.  
 I have no appetite at all anymore.

**20**  I am no more worried about my health than usual.  
 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.  
 I am very worried about physical problems and it's hard to think of much else.  
 I am so worried about my physical health that I cannot think

**Return**

Psych Evaluation

**TOTAL**

A score of less than 13 indicates minimal depression.

A score of 14 to 19 indicates mild depression.

## Psychological Evaluation

**Patient feels**

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Nervous
<input type="checkbox"/>	<input type="checkbox"/>	Jittery
<input type="checkbox"/>	<input type="checkbox"/>	Upset
<input type="checkbox"/>	<input type="checkbox"/>	Frightened
<input type="checkbox"/>	<input type="checkbox"/>	Worried
<input type="checkbox"/>	<input type="checkbox"/>	Restless

**Answers reflect moods and feelings nearly every day during any 2 week period.**

<input type="checkbox"/>	<input type="checkbox"/>	Depressed most of the day
<input type="checkbox"/>	<input type="checkbox"/>	Less interest or pleasure in activities most of the day
<input type="checkbox"/>	<input type="checkbox"/>	Significant weight gain or weight loss even when not dieting
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia or excessive sleepiness
<input type="checkbox"/>	<input type="checkbox"/>	Decrease or increase in appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive activity or slowed activity
<input type="checkbox"/>	<input type="checkbox"/>	Feels tired or has loss of energy
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of worthlessness or guilt
<input type="checkbox"/>	<input type="checkbox"/>	Difficult to make decisions or concentrate
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts, plans, or attempts
<input type="checkbox"/>	<input type="checkbox"/>	Do you do anything to hurt yourself, ie cutting or burning

**Patient expresses or demonstrates the following.**

<input type="checkbox"/>	<input type="checkbox"/>	Currently in psychotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Past psychotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalized for psychiatric reasons
<input type="checkbox"/>	<input type="checkbox"/>	Patient feels that individual counseling would be beneficial prior to beginning treatment
<input type="checkbox"/>	<input type="checkbox"/>	Has experienced major trauma such as physical, mental, sexual, or child abuse
<input type="checkbox"/>	<input type="checkbox"/>	Currently has significant stress in life (other than weight)
<input type="checkbox"/>	<input type="checkbox"/>	Period of elevated mood or irritable mood lasting at least one week or causing hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Seriousness of mood
<input type="checkbox"/>	<input type="checkbox"/>	History of obsessive compulsive disorder
<input type="checkbox"/>	<input type="checkbox"/>	Repetitive thoughts or ideas which seem uncontrollable
<input type="checkbox"/>	<input type="checkbox"/>	Repetitive activities or actions which seem uncontrollable

**Comments**

- **Osteoporosis Risk Questionnaire** – A score, a scale and a summary are given.

## Osteoporosis Risk Questionnaire

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Do you have gum disease or excessive tooth decay?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you drink 5 or more cups of coffee or soft drinks a day?
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you smoke one or more packs of cigarettes a day?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you drink more than two ounces of alcohol a day?
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you avoided milk and dairy products?
<input type="checkbox"/>	<input type="checkbox"/>	6. Are you female?
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you Caucasian or Asian?
<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have a fair complexion?
<input type="checkbox"/>	<input type="checkbox"/>	9. Are you under 110 pounds?
<input type="checkbox"/>	<input type="checkbox"/>	10. Have any of your relatives suffered a broken hip or shoulder when past the age of 45?
<input type="checkbox"/>	<input type="checkbox"/>	11. Have relatives lost height as they grew older?
<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have thyroid problems, epilepsy, rheumatoid arthritis, insulin-dependent diabetes, mellitus or chronic liver problems?
<input type="checkbox"/>	<input type="checkbox"/>	13. Have you taken corticosteroids for a prolonged period?
<input type="checkbox"/>	<input type="checkbox"/>	14. Have your menstrual periods stopped (natural or surgical), become infrequent, or, if menopausal, have you avoided taking female hormones ( estrogen )?

- **Dietary Habits -- What Are Your Current Eating Habits** – this evaluates patients on whether their eating habits contribute to inflammation in the body. A score and a result are given.

**Quiz Cur Eating** [X]

## What are Your Current Eating Habits?

Rationale: Highly processed foods - those most commonly eaten - contain many pro-inflammatory substances. If you are not careful about what you eat, you likely consume large amounts of pro-inflammatory foods.

**Eating Habits at Home**

- Do you cook with corn, peanut, sunflower, safflower, or soy (as opposed to olive or grapeseed oil)?
- Do you eat prepackaged microwave meals that provide a full meal (as opposed to only frozen vegetables) more than once a week?
- Do you eat any foods packaged in boxes, such as ready-to-eat cereals, flavored rices, meat extenders, and other boxed foods more than once a week?
- When you eat at home, do you use bottled salad dressings that contain soy or safflower oil or partially hydrogenated fats (as opposed to olive oil)? Check the label.
- Do you eat pasta, bread, or pizza (one, some, or all three) daily?
- Do you eat baked goods such as cookies, coffee cakes, other cakes, doughnuts, packaged brownies, cakes, or similar food products at least once a week?
- Do you use margarine instead of butter?
- Do you eat a lot of hamburgers?
- Do you dislike eating fish?
- Do you drink regular (sweetened) soft drinks or add sugar to your coffee or tea?

**Eating Habits at Restaurants**

- Do you eat at fast-food restaurants such as McDonald's, Burger King, KFC, Taco Bell, or others at least once a week?
- Do you eat at a Chinese restaurant more than once a week?
- Do you eat breaded and fried fish or deep-fried shrimp more than once every week or two?
- Do you eat french fries?
- Do you eat mostly beef?
- If you eat beef, is hamburger your favorite type?
- Do you order soft drinks when you eat out?

Total

points

[OK] [Cancel]

- **Supplement Use -- What Nutritional Supplements Do You Take?** – Intends to uncover evidence of treatment of inflammation in the body. A score and a result are given.

The screenshot shows a window titled "Quiz Cur Supp" with a close button in the top right corner. The main heading is "What Nutritional Supplements Do You Take?". Below the heading is a paragraph: "Taking individual supplements indicates that you care about preserving your health, and taking specific anti-inflammatory supplements suggest that you are already trying to prevent or reverse an inflammatory disorder." This is followed by instructions: "Do not include any supplements found in multivitamins or any type of once-a-day supplement. These questions refer only to stand-alone supplements." There are six checkboxes with corresponding questions: "Do you take any supplements such as fish oil, salmon oil, omega-3, EPA, DHA, or GLA?", "Do you take vitamin E supplements?", "Do you take vitamin C supplements?", "Do you take glucosamine or chondroitin supplements?", "Do you take devil's claw, green tea, Pycnogenol, grape seed extract, or quercetin supplements?", and "Do you take herbal supplements such as St. John's wort, ginseng, ginkgo, or any other?". Below the questions is a "Total" label above a text input field, followed by the word "points". At the bottom are "OK" and "Cancel" buttons.



- **State of Health – What is your current Health?** – A questionnaire which guides you to determine whether or not you have active inflammation in your body. A score and a result are given.

**Quiz Cur Health** [X]

## How Is Your Current Health?

Have you been diagnosed with one of the following conditions, regardless of whether you are taking medications for treatment?

<input type="checkbox"/> AIDS or HIV Infection	<input type="checkbox"/> Inflammatory bowel disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Celiac disease or gluten intolerance	<input type="checkbox"/> Eczema, psoriasis, or frequent sunburn
<input type="checkbox"/> Coronary artery (heart) disease	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Diabetes or elevated blood sugar	<input type="checkbox"/> Ulcerated varicose veins
<input type="checkbox"/> Gingivitis or Periodontitis	<input type="checkbox"/> A recent physical injury - by accident, or through sports/athletics, or via a severe sunburn
<input type="checkbox"/> Hepatitis	

Do you have any consistently stiff or aching joints, such as those in your fingers or knees?

Does your body feel stiff when you get out of bed in the morning?

If you are overweight by ten pounds or less, do you carry all or most of the fat in your abdomen?

If you are obese (more than twenty pounds over your ideal weight), do you carry all or most of the extra fat around your abdomen?

Is your nose stuffed up or runny a lot of the time?

Do you get injured (anything from serious bruises to broken bones) several or more times a year because of accidents, the nature of your work, or athletic activities?

Have you been hospitalized for surgery during the past twelve months?

Do you smoke or chew tobacco products?

Do you get frequent colds or flu?

Do you have seasonal allergies, such as pollen or molds?

Do you have any sores or rashes that don't seem to go away?

Total

points

[OK] [Cancel]

- **Geriatric Depression Scale** – a score and result are given.

## Geriatric Depression Scale

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Are you basically satisfied with your life?
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you dropped many of your activities or interests?
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you feel that your life is empty?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you often get bored?
<input type="checkbox"/>	<input type="checkbox"/>	5. Are you hopeful about the future?
<input type="checkbox"/>	<input type="checkbox"/>	6. Are you bothered by thoughts you cannot get out of your head?
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you in good spirits most of the time?
<input type="checkbox"/>	<input type="checkbox"/>	8. Are you afraid that something bad is going to happen to you?
<input type="checkbox"/>	<input type="checkbox"/>	9. Do you feel happy most of the time?
<input type="checkbox"/>	<input type="checkbox"/>	10. Do you often feel helpless?
<input type="checkbox"/>	<input type="checkbox"/>	11. Do you often get restless and fidgety?
<input type="checkbox"/>	<input type="checkbox"/>	12. Do you prefer to stay at home, rather than going out and doing new things?
<input type="checkbox"/>	<input type="checkbox"/>	13. Do you frequently worry about the future?
<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel that you have more problems with memory than most?
<input type="checkbox"/>	<input type="checkbox"/>	15. Do you think that it is wonderful to be alive now?
<input type="checkbox"/>	<input type="checkbox"/>	16. Do you often feel downhearted and blue?
<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel pretty worthless the way you are now?
<input type="checkbox"/>	<input type="checkbox"/>	18. Do you worry about the past?
<input type="checkbox"/>	<input type="checkbox"/>	19. Do you find life very exciting?
<input type="checkbox"/>	<input type="checkbox"/>	20. Is it hard for you to get started on new projects?
<input type="checkbox"/>	<input type="checkbox"/>	21. Do you feel full of energy?
<input type="checkbox"/>	<input type="checkbox"/>	22. Do you feel that your situation is hopeless?
<input type="checkbox"/>	<input type="checkbox"/>	23. Do you think that most people are better off than you are?
<input type="checkbox"/>	<input type="checkbox"/>	24. Do you frequently get upset over little things?
<input type="checkbox"/>	<input type="checkbox"/>	25. Do you frequently feel like crying?
<input type="checkbox"/>	<input type="checkbox"/>	26. Do you have trouble concentrating?
<input type="checkbox"/>	<input type="checkbox"/>	27. Do you enjoy getting up in the morning?
<input type="checkbox"/>	<input type="checkbox"/>	28. Do you prefer to avoid social gatherings?
<input type="checkbox"/>	<input type="checkbox"/>	29. Is it easy for you to make decisions?
<input type="checkbox"/>	<input type="checkbox"/>	30. Is your mind as clear as it used to be?



- **GI Questionnaire**

### GI Questionnaire

<input type="checkbox"/> Heartburn / indigestion	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Hx of ulcers in the past	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Chronic vague diffuse abdominal pain	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Epigastric pain/ discomfort relieved by food	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Diarrhea	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Constipation	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Alternating diarrhea and constipation	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Recent loss of appetite	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Nausea / vomiting	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Blood in / around stool	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Complaint of hemorrhoids/rectal pain	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Positive family hx of colon cancer	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Persistent difficulty / pain in swallowing	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Recent loss of weight	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Gradual, left lower quadrant pain radiating to back	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Recurrent, severe, cramping abdominal pain (colic)	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Passing excessive gas	Since:	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Hx of gastric or bowel surgery	Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Comments:**

**Previous treatment Hx:**

- **Fall Risk Assessment** – A Score and result are given.

12/01/2009

## Fall Risk Assessment

1. Level of Consciousness/Mental Status

 Alert  
 Disoriented  
 Intermittent Confusion

2. History of Falls (In past 3 months)

 No Falls  
 1-2 Falls  
 3 or more Falls

3. Ambulation/Elimination Status

 Ambulatory/Continent  
 Chair Bound (Requires restraints and assist with elimination)  
 Ambulatory/Incontinent

4. Vision Status (With or without glasses)

 Adequate  
 Poor  
 Legally Blind

5. Gait/Balance Instructions

 Gait/Balance Normal  
 Balance problem while standing  
 Balance Problem while walking  
 Decreased muscular coordination  
 Requires usage of assistive devices (i.e. cane, w/c, walker, furniture)  
 Jerking or unstable when making turns  
 Change in gait pattern when walking through the doorway

6. Systolic Blood Pressure (Between lying and standing)

 No noted drop  
 Drop LESS THAN 20 mm Hg  
 Drop MORE THAN 20 mm Hg

7. Medications Instructions

 NONE of these medication taken currently or within last 7 days  
 Takes 1-2 of these medications currently and/or within last 7 days  
 Takes 3-4 of these medications currently and/or within last 7 days  
 Change in medication or dosage in last five days

8. Predisposing Diseases Instructions

 None present  
 1-2 present  
 3 or more present

**Total Score**  Past Scores

**Total score above 10 indicates HIGH**

Return

Guidelines

12/01/2009

## Fall Risk Assessment

1. Level of Consciousness/Mental Status

 Alert  
 Disoriented  
 Intermittent Confusion

2. History of Falls (In past 3 months)

 No Falls  
 1-2 Falls  
 3 or more Falls

3. Ambulation/Elimination Status

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 Gait/Balance Normal  
 Balance problem while standing  
 Balance Problem while walking  
 Decreased muscular coordination  
 Requires usage of assistive devices (i.e. cane, w/c, walker, furniture)  
 Jerking or unstable when making turns  
 Change in gait pattern when walking through the doorway

6. Systolic Blood Pressure (Between lying and standing)

 No noted drop  
 Drop LESS THAN 20 mm Hg  
 Drop MORE THAN 20 mm Hg

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 NONE of these medication taken currently or within last 7 days  
 Takes 1-2 of these medications currently and/or within last 7 days  
 Takes 3-4 of these medications currently and/or within last 7 days  
 Change in medication or dosage in last five days

8. Predisposing Diseases Instructions

 None present  
 1-2 present  
 3 or more present

**Total Score**  Past Scores

**Total score above 10 indicates HIGH**

Return

Guidelines

### Guidelines for Fall Precaution

**Inpatient/Nursing Home**

 Perform and record Neuro vital signs every  hours for 48 hours.  
 Pharmacy Review  
 CBC  
 BMP  
 Urinalysis  
 EKG  
 Consult Physical Therapy  
 Apply Lap Buddy when up in chair.  
 Apply Pelvic Restraint when up in chair.  
 Notify family of application of and rationale for restraint device.  
 Implement Nursing Fall Precaution Protocol PRN.  
 Consult Optometry

**Outpatient**

 Patient cautioned about increased risk of falls.  
 Patient cautioned to gain their balance and stability before beginning to walk after standing up.  
 Prescribed cane use.  
 Prescribed four pronged cane use.  
 Prescribed four legged walker.  
 Recommend walking only with assistance.  
 Prescribed wheelchair use.  
 Referral to PT for evaluation for physical therapy.  
 Referral to PT for evaluation for motorized wheelchair.  
 Home Health evaluation for safety.  
 Recommend commode and bathtub device for mobility.

OK

Cancel

- **Mini Mental Status Examination** – A score a scale and a result are given.

**Mini-Mental State Examination (MMSE)**

<p>Max Score</p> <p>5</p> <p>5</p> <p>3</p> <p>5</p> <p>3</p> <p>2</p> <p>1</p> <p>3</p> <p>1</p> <p>1</p> <p>1</p> <p>Max Total 30</p>	<p>Score</p> <p><b>Orientation</b></p> <p><input type="text"/> What is the (year) (season) (date) (day) (month)? <i>One point for each correct response.</i></p> <p><input type="text"/> Where are we: (state) (county) (town or city) (hospital) (floor)? <i>One point for each correct response.</i></p> <p><b>Registration</b></p> <p><input type="text"/> Name 3 common objects (eg. "apple,table, penny"). <i>One point for each correct response.</i></p> <p>Count trials and record. Trials: <input type="text"/></p> <p><b>Attention &amp;</b></p> <p><input type="text"/> Serial 7's, backwards. <i>One point for each correct response.</i> Stop after 5 answers. Alternatively, spell "WORLD" backwards. <i>One point for each correct response.</i></p> <p><b>Recall</b></p> <p><input type="text"/> Ask for the 3 objects repeated above. <i>One point for each correct response.</i></p> <p><b>Language</b></p> <p><input type="text"/> Name a pencil and a watch.</p> <p><input type="text"/> Repeat the following: "No ifs, ands, or buts."</p> <p><input type="text"/> Follow a 3-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." <i>One point for each part correctly executed.</i></p> <p><input type="text"/> Read and obey the following: CLOSE YOUR EYES.</p> <p><input type="text"/> Write a sentence.</p> <p><input type="text"/> Copy the following design.</p> <p><input type="text"/> SCORE</p>	<p><b>Trigger Symptoms Indicative of Dementia:</b> <input type="button" value="Return"/></p> <p><i>Does the person have increased difficulty with any of the activities listed below?</i></p> <p><input type="checkbox"/> Learning and retaining new information. For example: is more repetitive; has more trouble remembering recent conversations, events, appointments; more frequently misplaces objects.</p> <p><input type="checkbox"/> Handling complex tasks. For example: has more trouble following a complex train of thought, performing tasks that require many steps such as balancing a checkbook or cooking a meal.</p> <p><input type="checkbox"/> Reasoning ability. For example: is unable to respond with reasonable plan to problems at work or home, such as knowing what to do if the bathroom is flooded; shows uncharacteristic disregard for rules of social conduct.</p> <p><input type="checkbox"/> Spatial ability and orientation. For example: has trouble driving, organizing objects around the house, finding his or her way around familiar places.</p> <p><input type="checkbox"/> Language. For example: has increasing difficulty with finding the words to express what he or she wants to say and with following conversations.</p> <p><input type="checkbox"/> Behavior. For example: appears more passive and less responsive; is more irritable than usual; is more suspicious than usual; misinterprets visual or auditory stimuli.</p> <p>In addition to failure to arrive at the right time for appointments, the clinician can look for difficulty discussing current events in an area of interest and changes in behavior or dress.</p> <p>It might also be helpful to follow up on areas of concern by asking the patient or family members relevant questions.</p> <p><i><b>*Positive findings in any of these areas generally indicate the need for further assessment for the presence of dementia.</b></i></p>
---	--	---

**KEY QUESTIONS IN THE DEMENTIA HISTORY:**

Duration of symptoms?   day(s)  week(s)  month(s)  year(s)

Abrupt onset  Gradual onset

Continuous deterioration  Stepwise deterioration

- **Auditory Screen – Hearing Loss Recognition Questionnaire** – A score and scale are given.

**Hearing Loss Recognition Questionnaire**

Trouble hearing over the telephone.

Trouble following the conversation when two or more people are talking at the same time.

People complain that TV volume is up too high.

Have to strain to understand conversation.

Trouble hearing in a noisy background.

Find yourself asking people to repeat themselves.

Many people you talk to seem to mumble or not speak clearly.

You misunderstand what others are saying and respond inappropriately.

Trouble understanding the speech of women and children.

People get annoyed because you misunderstand what they say.

Total

**A total of three or more indicates referral for evaluation is advised.**

## HPI Chief Template

This template allows for the documentation of details of the patients History of Present Illness. This is organized in relationship to the patient's chief complaint or chief complaints. The elements of the HPI are:

- Location
- Radiation
- Quality
- Frequency
- Duration
- Quality
- Aggravated by
- Relieved by
- Associated Symptoms
- Pertinent Negatives
- Comments – a place to add free text if an important details does not allow for documentation in one of the fields above.

**Note:** For a Chief Complaint and/or a History of Present Illness to contribute to your Evaluation and Management Code, you must have four or more elements of the HPI completed for each Chief Complaint.

On the template are display spaces for three Chief Complaints which automatically copy from the Patient Data Master.

To the lower right on the HPI Template is a button entitled HPI 2, which allows for documentation of the History of Present Illness for three additional Chief Complaints, allowing for the documentation of six chief complaints at each encounter.

**SETMA's Navigation Buttons** are presented to the right of the template represent the means of moving back and forth, in and out, of one template to another.

	Chief Complaint 1	Chief Complaint 2	Chief Complaint 3
Location			
Radiation			
Quality			
Frequency			
Duration			
Severity			
Change			
Context			
Aggravated by			
Relieved by			
Associated Sx			
Pertinent Negatives			
Comments			

**Master GP**

- Nursing
- Histories
- Health
- Questionnaires
- System Review
- Physical Exam
- Radiology
- Assessment
- Plan
- Procedures

HPI 2

# Systems Review (ROS) Template

The content of the ROS Template is in four columns.

[PDM](#)
[NURSE](#)
[HISTORIES](#)
[HEALTH](#)
[QUIZES](#)
[HPI](#)
[ROS](#)
[P.E.](#)
[X-RAY](#)
[ASSESS](#)
[PLAN](#)
[PROCS](#)

**Chief Complaints**


**Chronic Conditions**

AA Metabolism Disorder
Abd Pain LLQ

**Source of Information**

Patient  
 Family member  
 Caregiver  
 Chart (hospital setting)

**Allergies**  
 Double-click below to add/edit patient allergies.

Allergy	Date of Onset

Patient's allergies reviewed/updated today.

Positive

Constitutional
Self Monitoring
Eyes
HENMT
Cardiac
Respiratory
Gastrointestinal
Urinary/Repr.
Musculoskeletal
Integumentary
Neuro
Psychiatric
Psych Eval
Endocrine
Hematology

**Master GP**

Nursing
Histories
Health Maint.
Questionnaires
HPI Chief
Physical Exam
Radiology
Assessment
Plan
Procedures

Summary  
Questionnaire Summary Data

**Comments**

--

**Column 1:**

This brings into the ROS Template the Chief Complaints and the Chronic Conditions from the Patient Data Master

**Column 2:**

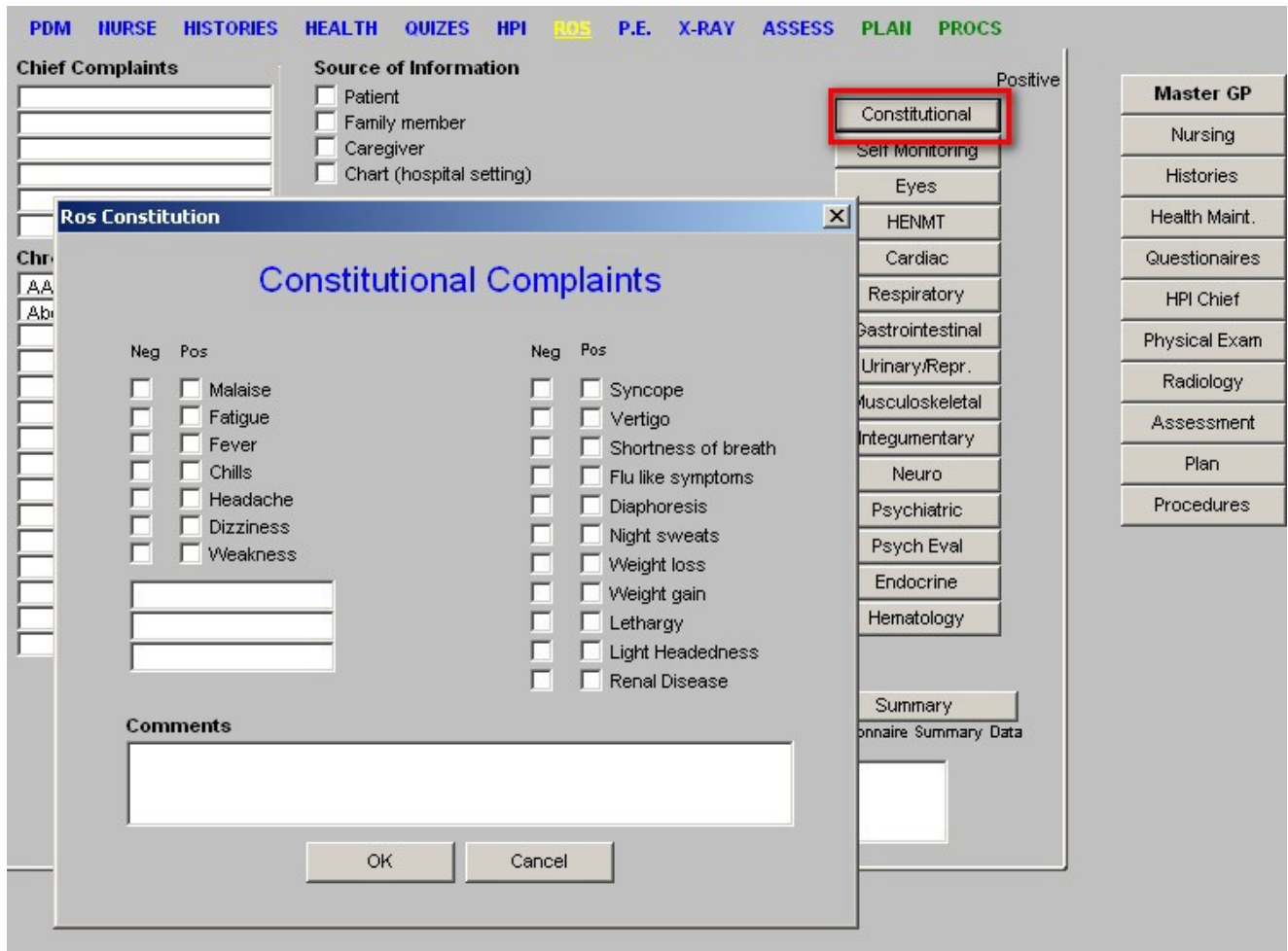
From the History Template, this brings the source of the material being documented. That source can be multiple, i.e., the patient and a family member and/or care giver.

**Summary Button** – this presents a summary of the results of any and all Questionnaires which have been completed on this patient.

**Column 3:**

There are fourteen buttons with the names of 14 different body systems which can be reviewed. Documentation is with check boxes, number pads and calendar pads.

**Note:** The Constitution ROS should be completely filled out on EVERY patient seen in the clinic, ER, Hospital, Nursing Home or elsewhere.





## Column 4:

SETMA's **Navigation Buttons** which carry you through the Master GP Suite of Templates.

## Physical Examination Template

This template is also organized in four columns.

The screenshot displays the Physical Examination Template interface. At the top, a navigation bar includes buttons for PDM, NURSE, HISTORIES, HEALTH, QUIZES, HPI, ROS, P.E. (highlighted in yellow), X-RAY, ASSESS, PLAN, and PROCS. The main area is divided into four columns:

- Column 1:** Chief Complaints (a vertical stack of six text input fields) and Source of Information (checkboxes for Patient, Family member, and Caregiver).
- Column 2:** Chronic Conditions (a vertical stack of ten text input fields, with the first two containing "A.A Metabolism Disorder" and "Abd Pain LLQ").
- Column 3:** A vertical stack of buttons for physical examination systems: Constitution, Head / Face (highlighted with a dashed border), Eyes, Ears, Nasopharynx, Neck / Thyroid, Respiratory/Thorax, Cardiovascular, Breast, Abdomen / GI, Genitourinary, Rectal, Back, Musculoskeletal, Neurological, Integumentary, and Psychiatric. A "Foot" button with a checked checkbox is located at the bottom right of this column.
- Column 4:** Master GP (a vertical stack of buttons: Nursing, Histories, Health, Questionnaires, HPI Chief, System Review, Radiology, Assessment, Plan, and Procedures).

## Column 1:

This brings into the Physical Examination Template the Chief Complaints and the Chronic Conditions from the Patient Data Master

## Column 2:

### Vital Signs Button:

This carries you back to the **Nursing Template** for review of the patient's Vital Signs.

**Note:** To have the **Vital Signs** appear on the chart note, you must access this button even if you have already reviewed the patient's vital signs on the Patient Data Master and/or the Nursing Template. This brings from the History Template, the source of the material being documented. That source can be multiple, i.e., the patient and a family member and/or care giver.

### Column 3:

#### A series of 18 buttons on which a thorough physical examination can be documented.

- **Constitution** – this should be completed on every patient at every visit or encounter. The BMI is documented here and automatically chooses the level of obesity if any.
- **Head/Face** – there is a help button on this pop-up which gives the function of the cranial nerves and allows documentation of their functional status.
- **Eyes** – there is a tracking of a dilated eye exam (required annually on diabetics) and a routine eye examine done without dilation by the primary provider.
- Ear --
- Nasopharynx
- **Neck/Thyroid** – there is opportunity for documenting the brachial plexus evaluation on this neck template.
- **Respiratory/Thorax** – on this template there is a place to document if the patient has “rales” – this interacts with the CHF quality of care standards.
- **Cardiovascular** – peripheral edema is also documented here.
- **Breast** – by clicking the check box at the top of the template, you update the health maintenance template for breast examination.
- Abdomen/GI
- **Genitourinary** – this is a sex specific examination, i.e., it is different for males and females.
- **Rectal** – there is a check box which updates the health maintenance for last rectal exam.
- **Back** – there is a help button which gives the normal range of motion for each joint.
- Musculoskeletal
- **Neurological** – there are two pop-ups on this template in addition to the data which is collected on the template: one is for Cranial Nerves (the same as the one of Head/Face) and the other for Motor function.
- Integumentary
- **Psychiatric** – this is a larger template and requires scrolling to see all documentation opportunities.
- **Foot** – this has three pop-ups which are important:
- **Extremity Examination**
- **Monofilament neuro-exam of the foot** – also gives instructions on how to do monofilament examination.
- **Risk Assessment** – this requires documenting the pulses, sensory status, deformity, ulcer, and amputations. When those entries are made by check boxes, activate the “calculation” button which will execute a plan of care for foot care, particularly important for the diabetic. This will print on the chart note.

#### Column 4:

SETMA's Navigation Buttons which carry you through the Master GP Suite of Templates.

#### Radiology Template

- This is a list of 22 buttons each of which launches a pop-up on which the x-ray results for the designated procedure can be documented.
- The **Rad Maint** button, which appears just under the title Radiology, launches a pop-up which gives a summary of the most recent radiographic studies in 21 categories done in the clinic on this patient.
- Once the template for this encounters x-rays are completed, you need to click the **Document Button** in order to produce a document of your x-ray report. The **Document Button** appears at the bottom of SETMA's Navigation Buttons on the **Radiology Template**.



## Column 1:

### Assessments –

- This is the place for you to document your conclusions about the patient’s diagnoses.
- The pick list on the Assessment section of this template is SETMA’s collection of almost 8,000 ICD-9 codes.
- For directions on how to find ICD-9 Codes see the tutorial on [Finding ICD-9 Codes](#).
- The Assessment listed here are in **Medical Records Fields** which means that do not copy forward.
- However, if you are completing a follow-up evaluation from a previous visit or from a discharge from the hospital, you can add the assessments from a previous visit by doing the following:
  1. Open the Main Tool Bar
  2. Look in the window where all the patient’s encounters are documented.
  3. Find the encounter date which has the assessment you are interested in copying.
  4. Expand the information in that date by clicking on the + just to the left of the encounter date.
  5. Find the word Assessment under that date.
  6. Highlight that Assessment by right clicking on your mouse
  7. Keeping the mouse depressed
  8. Drag the Assessment forward today’s visit and drop it over the date of today’s visit.
  9. You will be asked whether you want to copy this material today’s visit; answer, “yes.”
  10. Now the old assessment is on your present note.

**Note:** Once you open the Assessment Template on the present encounter, you cannot “click and drag” an assessment from a previous visit. You must bring the previous assessment forward before opening the current encounters assessment template.

The “click and drag” function is extremely valuable as if you are following up on seven problems, you do not have to re-enter them, you simply “click and drag” and then update the status.

Once you have completed the Assessments for today’s encounter, you need to place a status by each of the assessments. That is done by clicking on the box next to the assessment and selecting the appropriate status, i.e., acute, chronic, improved, etc.

**Note:** If you do not select the diagnosis from the ICD-9 Code list, your assessment will not work with charge posting, which is very important. See both [Finding ICD-9 Codes](#) and [Charge Posting Tutorials](#).

**Note:** The automatic advancement of your cursor is from Assessment box to the status box to the next Assessment box. This is different from the Chronic Conditions described below as the automatic advancement of your cursor is from the Assessment Box to Assessment box and from the Status Box to the next Status Box. The logic of this will become obvious to you.

Chronic Conditions

This is similar to the old Problem lists which we tried to maintain in our paper charts. As those problem lists, so this Chronic Conditions list, it:

- Needs routine maintenance,
- Adding and eliminating problems and as they appear and/or are resolved.

*Note:* If the ICD-9 Code which is in the Chronic Problem List appears with its description and its number, it will not work with charge posting. All of the old ICD-9 Codes which have the description and the number, MUST be changed to the new system where only the description appears and the number only appears when you use the chart posting function. Typing in diagnoses will not work with charge posting as there will be no ICD-9 number linked with the description you type in to the Chronic Conditions or Assessments boxes.

- To the right of the Chronic Conditions are HPI buttons which allow you to document the status and relevant activity of the Chronic conditions.

See [Chronic Conditions](#) for more information

At the bottom of the first column is a **Comment Box** which allows you to make any additional Assessment comments which do not fit into the above format.

## Column 2

There are three buttons entitled:

- Diagnosis Categories
- Dx Categories Abbrev
- Abbrevs in Descriptions

These are helps to finding ICD-9 Codes. For an explanation of these see [Finding ICD-9 Codes](#).

## Column 3

The Chief Complaints are brought forward from the Patient Data Master

At the bottom of this column is a **General Comments Box**.

## Column 4

SETMA's Navigation Buttons

Hydration Template, Nutrition Template, Exercise Template

These three buttons link with the templates by the same name. For tutorials on their use, see [Hydration Assessment](#), [Nutrition](#), [Exercise Prescription](#).

## Plan Template

This is one of the most important templates in our entire Suite. Understanding and using it properly is critical to your success in using SETMA's presentation of NextGen.

### The Organization and Structure

The top of the template has the same structure as all others with one very important difference. The following are the same:

- Title Bar
- Menu Bar
- Top Tool Bar
- SETMA's Navigation Bar

Here is the difference; beneath these four bars is a new set of navigation tools which we will call **Charge Posting Bar**. This bar consists of nine links which operate the Charging Posting Function.

They are:





**Column 1:**

- **Acute Dx** – this is the same as the Assessments on the Assessment Template and copies forward from that template. Additional Assessments can be added from the Plan Template, however, unless the Assessment template has been opened, the Patient’s Assessments will not print on the chart note.
- **Chronic Conditions** – this is the same as on the Patient Data Master and the Assessments Template.

The screenshot displays a software interface for patient management. At the top, there are navigation tabs: PDM, NURSE, HISTORIES, HEALTH, QUIZES, HPI, ROS, P.E., X-RAY, ASSESS, PLAN, and PROCS. Below these are sub-tabs for Immunizations, Injections, Present Lab (Endocrinology, Rheumatology), Future Lab (Endocrinology, Rheumatology), Procedures (Surgery), Radiology (Sutures), and Eval & Mgmt.

On the left side, there are checkboxes for 'All', 'SETMA', and 'Unspecified'. A 'Today I Reviewed' section includes checkboxes for 'Current and previous lab' and 'Current and previous x-rays'. Below this is a table for 'Acute Dx' with columns for 'Acute Dx' and 'HCC Risk Cat'. A red box highlights this table and the 'Chronic Dx' table below it, which has columns for 'Chronic Dx' and 'HCC Risk Cat'. The 'Chronic Dx' table contains entries like 'A.A Metabolism Disorder' and 'Abd Pain LLQ'.

The main area contains several sections: 'Plan' with input fields for 'Acute Care Followup', 'Routine Interval Follow-up', 'Diet', and 'Exercise'; 'Education/Instructions' with a text area; 'Lab Results' with a dropdown for 'Endocrinology'; 'Pending Referrals' with a table with columns 'Status', 'Priority', 'Referral', and 'Referring Provider'; and 'Archived Referrals - Do not use for new referrals' with a similar table. There are also buttons for 'Superbill', 'Plan Summary', 'Rx Sheet', 'Help Desk', 'Clinic Follow-Up Call', and 'Hospital Follow-Up Call'. On the right side, there is a 'Master GP' section with a list of services (Nursing, Histories, Health, Questionnaires, HPI chief, System Review, Physical Exam, Radiology, Assessment, Procedures) each with a checked checkbox. At the bottom right, there is a 'Physician Consulted' checkbox and input fields.

**Column 2:**

At the top of column 2, there are two check boxes, which state “Today I have reviewed:

- Current and previous lab
- Current and previous X-rays

Beneath that there is a designation Extended Plan of Care with a button associated. When executed this button launches a pop-up which enables a provider to document an extensive plan of care.

The screenshot displays the 'PLAN' tab in the EPM software. At the top, navigation tabs include PDM, NURSE, HISTORIES, HEALTH, QUIZES, HPI, ROS, P.E., X-RAY, ASSESS, PLAN, and PROCS. Below these are sub-tabs for Immunizations, Injections, Present Lab (Endocrinology, Rheumatology), Future Lab (Endocrinology, Rheumatology), Procedures (Surgery), Radiology (Sutures), and Eval & Mgmt. A 'Home' button is in the top right.

A red box highlights the 'Today I Reviewed' section, which contains three checkboxes:
 

- All
- SETMA
- Unspecified

 To the right of these are two checkboxes:
 

- Today I Reviewed:  Current and previous lab
- Current and previous x-rays
- Current medications

The interface includes several data entry areas:
 

- Acute Dx** and **HCC Risk Cat** tables.
- Chronic Dx** table with entries: 'A.A Metabolism Disorder' (RxHCC) and 'Abd Pain LLQ'.
- Education/Instructions** section with a text area containing 'Smoking cessation discussed'.
- Lab Results** section with a link to 'Endocrinology'.
- Pending Referrals** table with columns: Status, Priority, Referral, Referring Provider.
- Archived Referrals - Do not use for new referrals** table with columns: Status, Priority, Referral, Referring Provider.

On the right side, there is a 'Master GP' sidebar with a list of services and checkboxes:
 

- Nursing
- Histories
- Health
- Questionnaires
- HPI chief
- System Review
- Physical Exam
- Radiology
- Assessment
- Procedures

At the bottom right, there is a 'Physician Consulted' checkbox and a text input field.

### Column 3

In this column there are two functions related to follow-up care.

- First there is the acute follow-up.
- Then there is Routine Interval Follow-up.
- The concept is this.
- If you need to see the patient in six months for cholesterol follow-up, you put that follow-up in the Routine Interval Follow-up.
- If you need to see the patient back in three weeks for low back pain, you put that in acute follow-up.
- 

This means that if the patient is seen five times between the present visit and a Routine Interval Follow-up in six months, the patient will not be lost to follow-up for the Routine visit.

**Diet** – this documents the patient diet and interacts with other parts of the record

**Exercise** – this allows documentation of the patient’s exercise habit.

**Beneath these two fields are five buttons:**

- **Superbill** – while SETMA utilizes electronic chart posting and chart capture, this function allows the provider to create a copy of the superbill to see if it was done correctly. It is not necessary to complete this function in order to make charge posting work.
- **Plan Summary** – this creates a document which summaries briefly the plans executed on this patient visit.
- **Rx Sheet** – this creates a list of the patient’s medication which should be given to them at each visit.
- **Help Desk** – this provides billing information which is never used.
- **Chart Note** – this creates the chart note.

Beneath these five buttons are two columns of four buttons per column

**First column:**

- Billing – this is for the back office and should not be used by clinical staff.
- Comments – a space for free text additions to the plan of care.
- Education – this launches a list of articles which are been generated by SETMA providers. It is different than the Education Module in NextGen which is launched from the Menu Bar under File – Education. Also, there is a wealth of education information at [Your Life Your Health](#).
- Medi-legal – this launches the following:
  1. Waiver
  2. Tx Release
  3. Patient Notification
  4. Advanced Directive Under 18
  5. Advanced Directive Over 18

## Second Column

- **PT Prescription** -- this links the provider to Golden Triangle Physical Therapy's (GTPT) prescription which is documented in GTPT's Physical Therapy Suite of Templates.
- **Preceptor** – this launches a pop-up where a preceptor for a student or other trainee can document their oversight.
- **Return Doc** – this creates the return to work or school document.
- **Work Return** – this allows for documentation of the details required for a return to work or school document.

The screenshot displays the EPM software interface. At the top, there are navigation tabs: PDM, NURSE, HISTORIES, HEALTH, QUIZES, HPI, ROS, P.E., X-RAY, ASSESS, PLAN, and PROCS. Below these are sub-tabs for Immunizations, Injections, Present Lab, Future Lab, Procedures, Radiology, and Eval & Mgmt. A 'Home' button is located in the top right corner. A 'Master GP' sidebar on the right contains checkboxes for Nursing, Histories, Health, Questionnaires, HPI chief, System Review, Physical Exam, Radiology, Assessment, and Procedures. The main content area is divided into several sections: 'Acute Dx' and 'Chronic Dx' (with 'Additional Acute Assessments' link), 'Plan', 'Education/Instructions', 'Lab Results' (with 'Endocrinology' link), 'Pending Referrals' (table), and 'Archived Referrals - Do not use for new referrals' (table). A red box highlights a set of buttons: 'Comments', 'Education', 'Med-Legal', 'PT Prescription', 'Preceptor', 'Return Doc', and 'Work Return'. The 'PT Prescription' button is the primary focus of the document.

Across the bottom is access to the **Referral Template** by double clicking in the space provided. For a tutorial on how to use the Referral Template, [click on this link](#).

## Column 4

### SETMA's Navigation Buttons

#### Physician Consulted

When the check box is clicked it launches a list of SETMA physicians who can be consulted by nurse practitioners or other providers. This allows for the documentation of your having discussed the care of the patient with another provider.

The screenshot displays a medical software interface with a 'Provider Mstr' dialog box open. The dialog box contains a table of physicians with columns for 'Last Name' and 'First Name'. Below the table are 'Refresh', 'OK', and 'Cancel' buttons. In the background, the main interface shows a 'Physician Consulted' checkbox checked and highlighted with a red box. Other visible elements include navigation tabs at the top (PDM, NURSE, HISTORIES, HEALTH, QUIZES, HPI, ROS, P.E., X-RAY, ASSESS, PLAN, PROCS), a 'Home' button, and various clinical data entry fields.

Last Name	First Name
Abbas	Asad
Abdullah	Nabeel
Abi Hanna	Pierre
Abochamah	Dia
Abraham	Aleyamma
Achanta	Venkata
Achilles	Jackson
Adkins	Charles
Adyanthaya	Ajit
Afra	Sohail
Agricola	Dennis
Agurdine	Dr
Agustin	Gilberto
Agustin	Gilberto
Ahmad	Sharin

Status	Priority	Referral	Referring Provider

Status	Priority	Referral	Referring Provider



## **Procedures Template**

This template has 24 buttons which launch various tools for the documentation of:

- Cerumen removal
- Cryotherapy
- Debridement
- Digital Block
- Electrocardiogram
- I&D
- Joint Injection
- Nail Removal
- Skin Biopsy
- Stress Report
- Suture Removal
- Wound Repair

### **Special Procedures:**

- Bone Density
- Carotid Doppler
- CPET
- Echocardiogram
- Elec Stim Therapy 1
- Elec Stim Therapy 2
- PFT
- Rhinolaryngoscope
- Stress Test
- Venous Doppler
- Colon Rectal Surgery
- Breast Biopsy

PDM NURSE HISTORIES HEALTH QUIZES HPI ROS P.E. X-RAY ASSESS PLAN **PROCS**

## Procedures

Cerumen Removal	<input type="checkbox"/>
Cryotherapy	<input type="checkbox"/>
Debridement	<input type="checkbox"/>
Digital Block	<input type="checkbox"/>
Electrocardiogram	<input type="checkbox"/>
I and D	<input type="checkbox"/>
Joint Injection	<input type="checkbox"/>
Nail Removal	<input type="checkbox"/>
<b>Skin Biopsy</b>	<input type="checkbox"/>
Stress Report	<input type="checkbox"/>
Suture Removal	<input type="checkbox"/>
Wound Repair	<input type="checkbox"/>

**Special Procedures**

Bone Density	<input type="checkbox"/>
Carotid Doppler	<input type="checkbox"/>
CPET	<input type="checkbox"/>
Echocardiogram	<input type="checkbox"/>
Elec Stim Therapy 1	<input type="checkbox"/>
Elec Stim Therapy 2	<input type="checkbox"/>
Holter	<input type="checkbox"/>
PFT	<input type="checkbox"/>
Rhinolaryngoscope	<input type="checkbox"/>
Stress Test	<input type="checkbox"/>
Venous Doppler	<input type="checkbox"/>

Tissue Biopsy

Colorectal Surgery

Breast Biopsy

**Return**

Nursing

Histories

Health

Questionnaires

HPI Chief

System Review

Physical Exam

Radiology

Assessment

Plan

**Procedure Note**

Once the procedure has been documented in each of these functions, the Document button at the bottom of SETMA's Navigation Buttons should be clicked. This creates the document for these procedures.