








This Quick Reference Guide (QRG) reviews the workflow for Performing a Patient Intake.

Common Buttons & Icons

	Add drop-down arrow
	Mark all as Reviewed button
	Add button
	Sign and Return icon
	Back-Arrow icon
	Sign icon
	All Visits drop-down arrow
	Ambulatory View icon

Document the Comprehensive Intake Form

➤ **From the Ambulatory Organizer:**

STEP 1: Click the patient's name. The patient's chart opens on Ambulatory View.

STEP 2: Click Vital Signs in the Ambulatory Nursing workflow menu.

STEP 3: Click the Add drop-down arrow.

STEP 4: Click Ambulatory Comprehensive Intake Form.

STEP 5: The intake form displays defaulting to the Summary section. Adjust Visit Date & Time using the up and down arrow icons or the drop-down arrow icon to access the calendar, as needed.

NOTE: **When documenting in the Ambulatory Comprehensive Intake Form:**

- You can navigate through the various sections of the intake form using the menu along the left margin.
- Document different sections of the Comprehensive Intake Form as appropriate for your practice.
- Sections with a red asterisk indicates that there are required fields for documentation, which display in yellow.

STEP 6: Click the appropriate Primary Language radio button.

STEP 7: Click the appropriate Patient Communication Preference radio button; then click Submit within the box.

STEP 8: Enter an accident description in the Accident Description field, as needed.

STEP 9: Document the Vital Signs fields, as needed.

NOTE: **At a minimum, the patient's blood pressure and weight must be documented for each visit, and their height must be documented at least one time. This helps prevent any errors when medications are prescribed.**

STEP 10: Scroll down to the Pain section of the form.

STEP 11: Click the Pain Present drop-down arrow.

STEP 12: Click the appropriate selection.

STEP 13: Document the various pain information, as appropriate.

STEP 14: Click Nursing HPI in the Form menu.

STEP 15: Enter your documentation in the Nursing HPI field.

NOTE: **Nursing HPI is a free text field for documenting additional information not gathered in other areas of the chart. Do not change the font or use special characters within this field.**

STEP 16: Click Advanced Directive in the Form menu.

NOTE: **Required fields for documentation display in yellow.**

STEP 17: Click the appropriate answer for Does Patient have an Advance Directive.

STEP 18: Click the appropriate answer for any other corresponding questions for Advance Directive.

NOTE: **A check mark displays next to Advance Directive once all required documentation is complete.**

STEP 19: Click CPC + Health Status Evaluations in the Form menu and document, if needed.

STEP 20: Click Depression Screening in the Form menu.

NOTE: **The PHQ-2 questionnaire is required for all patients 18 or older.**

STEP 21: Document the PHQ-2 questionnaire, as needed.

NOTE: **If the patient's score is greater than zero, the PHQ-9 and Depression Screen Plan are required to be completed.**

STEP 22: Click **Procedure History** in the Form menu.

NOTE: The history sections need to be reviewed and updated at every visit.

STEP 23: Click **Mark all as Reviewed** if there are no changes or click **Add** to document new procedures.

STEP 24: Click **Social History** in the Form menu.

NOTE:

- **Tobacco documentation is required for all patients 18 years or older.**
- **If the patient is a smoker, cessation education or counseling information is required, and tobacco must be listed on the patient's problem list.**
- **Social history documentation carries over from encounter to encounter, so you can see the last time each history was documented under the Last Reviewed column. If it's been done recently, this can prevent having to ask questions again.**
- **To make modifications to previous documentation, click Modify.**

STEP 25: If there are no changes needed, click Mark all as Reviewed.

STEP 26: Click Family History in the Form menu.

STEP 27: Click Mark all as Reviewed if there are no changes or click Add to document new history.

STEP 28: Click OB/GYN History in the Form menu and document, if needed.

STEP 29: Click Psychosocial in the Form menu and document, if needed.

STEP 30: Click Religious/Spiritual/Cultural in the Form menu and document, if needed.

STEP 31: Click ID Risk Screen in the Form menu and document, if needed.

STEP 32: Click STEADI Fall Risk (Pt age 65 or older) in the Form menu.

NOTE: **STEADI Fall Risk is required annually for all ambulatory patients 65 and older.**

STEP 33: Document the questions, as appropriate.

NOTE: **If the patient answers "Yes" to any of the STEADI Fall Risk questions, the Timed Up and Go (TUG) sub-form opens. Enter the patient's time in the Timed Up and Go Test Time field; then click the Sign and Return icon to return to the Intake form.**

STEP 34: Click **Additional Measurements** in the Form menu and document, if needed.

STEP 35: Click **Additional Vitals** in the Form menu and document, if needed.

STEP 36: Click **Review of Systems** in the Form menu.

STEP 37: Document this section, if appropriate.

NOTE: When documenting the Review of Systems section:

- To document the patient's review of systems was negative, click Yes for All Ros negative.
- Be careful using the Negative radio button, only use it if you have asked all questions for that section.
- To document one of the questions as yes in a section:
- Click Negative to clear the documentation for the section.
- Click the No header.
- Click the Yes cell for the question.

STEP 38: Click CCSSRS Screen in the Form menu and document, if needed.

STEP 39: Click IADL in the Form menu and document, if needed.

STEP 40: Click Education Needs in the Form menu and document, if needed.

STEP 41: Click Food Insecurity in the Form menu and document, if needed.

STEP 42: Click Social Needs Screening in the Form menu and document, if needed.

STEP 43: Click Med Management Documentation in the Form menu.

STEP 44: Document the appropriate fields.

NOTE: When documenting in the Med Management Documentation section:

- If this needs to be documented between visits, a PowerForm can be accessed from AdHoc.
- Once this information is documented in a PowerForm, it will flow into IView.

STEP 45: Click **Oswestry Disability Index** in the Form menu and document, if needed.

NOTE: It is important to complete this section in its entirety to generate the index score.

STEP 46: Click **Influenza Vaccine Questions** in the Form menu.

STEP 47: Document the appropriate fields.

STEP 48: Click the **Sign** icon once the form is completed.

NOTE: A Pending Actions alert populates when you have the search field open for a procedure or problem history documentation. Go back to that section and click OK to close it. Then you will be able to sign the form.

Document Chief Complaint

➤ **From the Ambulatory Organizer:**

STEP 1: Click the patient's name. The patient's chart opens on Ambulatory View.

STEP 2: Click Chief Complaint in the Amb Nursing workflow menu.

STEP 3: Enter the patient's chief complaint in the Chief Complaint free text field.

NOTE: This can be updated throughout the visit as needed.

STEP 4: Click Sign in the Chief Complaint component.

Review Vital Signs

➤ **From the Ambulatory View screen:**

STEP 1: Click **Vital Signs** in the Amb Nursing workflow menu.

STEP 2: Review the vital signs.

NOTE: When documenting vital signs:

- Click a filter button or the All Visits drop-down arrow at the top of the component to change the range of viewable data, as needed.
- Click the Ambulatory View icon to display results in a condensed view.

Access the Results Legend

➤ **From the Vital Signs component:**

STEP 1: Click the Vital Signs component header.

STEP 2: Click Options from the top tool bar.

STEP 3: Click Results Legend at the bottom of the list.

STEP 4: Click Close.

STEP 5: Click the Back-Arrow icon to return to the workflow page.

View Vital Signs Graph

➤ **From the Vital Signs Component:**

STEP 1: Click the vital sign name field of the one you want to graph.

NOTE: The default view is the range you currently have selected.

Document Additional Vital Signs

➤ **From the Vital Signs Component in the patient's chart:**

STEP 1: Click the Add drop-down arrow.

STEP 2: Click Repeat Vitals Form.

STEP 3: Document the appropriate fields.

STEP 4: Click the Sign icon when completed.