
This Quick Reference Guide (QRG) reviews how to document required admission documentation.

Common Buttons & Icons



Back Arrow icon



Add icon

Enter Required Admission Documentation

Admissions require specific documentation that activate other areas of a patient's chart. If certain sections are not completed, issues can occur during the admission visit process.

After you have reviewed intake documentation from the referral source, follow this guide to document your patient's admission.

➤ From the **Today** screen:

STEP 1: Tap your patient's **VISIT TYPE** link. Your patient's chart opens.

STEP 2: Tap **Start Visit** near the top of the screen.

STEP 3: Tap the **Admission | Status** tile. The Admission & Status window opens.

STEP 4: Document the **Admission and Status** information as needed.

NOTE: Consider the following while completing documentation.

- A patient's status designation describes the circumstances of their admission or discharge. The status can activate other required sections in a patient's chart, such as Visit Frequencies.
- The STATUS DATE field displays the current date by default; however, you can change this if needed. This date should match the date you admit or discharge the patient.
- The ACUITY field will be activated if an OASIS is needed for the patient.

STEP 5: Tap the **Back Arrow** icon. You return to your patient's chart screen.

STEP 6: Tap the **Payers | Authorizations** tile. The Payers | Authorizations screen opens.

STEP 7: Confirm that the patient's insurance information in the system matches their insurance card.

STEP 8: Verify the number of visits that have been authorized under the Authorization section.

STEP 9: When your review is complete, tap the **Back Arrow** icon until you return to the patient's chart screen.

STEP 10: Tap the **Care Team** tile. The Care Team screen displays.

STEP 11: Verify that you are listed as the Admitting Clinician in the Care Team list.

NOTE: If you are not listed as the Admitting Clinician, follow these steps to add yourself.

- a. Tap **Admitting Clinician** in the Care Team list.
- b. Tap the **ASSIGNED TO ROLE** drop-down arrow.
- c. Search for your name using the **Search** field; then tap your name.
- d. If the relationship is no longer active, set an **End Date**.

STEP 12: Update any other Care Team roles, if needed.

STEP 13: Tap **CODE Status** in the Care Team list.

STEP 14: Tap the **ASSIGNED TO ROLE** drop-down arrow; then tap the appropriate CODE for your patient

STEP 15: Tap the **Back Arrow** icon. Your patient's chart screen appears.

STEP 16: Tap the **Family | Friends** tile. The Family and Friends screen opens.

STEP 17: Add or update any Family or Friends information for your patient, as needed.

NOTE: Use the **Add** icon at the bottom-right of the screen to add new Family/Friend information.

STEP 18: Tap the **Back Arrow** icon. Your patient's chart screen appears.

STEP 19: If needed, complete documentation for any other required sections as determined by your patient's status.

STEP 20: Tap **End Visit**.

From the Office of Clinical Informatics

[Insert Title]

[Month Day, Year]

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For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at:
207-973-7728 or 1-888-827-7728.
