
This Quick Reference Guide (QRG) reviews the workflow for Documenting Lymphedema.

Complete Initial Evaluation Documentation

➤ From the Patient List in Cerner:

STEP 1: Double-click the appropriate patient's name.

STEP 2: Click  AdHoc.

- The Ad Hoc Charting window opens.

STEP 3: Select the **OT Lymphedema Evaluation** check box in the Outpatient Therapy folder.

STEP 4: Click .

- The Charting screen displays.

NOTE: It is best practice to complete the patient history prior to documenting the lymphedema measurements.

NOTE: You should not open the Lymphedema Measurements or Wound sections until the measurements have been documented in iView.

STEP 5: Click **Lymphedema History** in the left-hand list.

STEP 6: Review and document any lymphedema history information, as necessary.

STEP 7: Click **Surgery History** in the left-hand list.

STEP 8: Document any previous surgery for the patient, as necessary.

STEP 9: Click **Prior Lymphedema Treatment** in the left-hand list.

STEP 10: Document any past treatment for the patient, as necessary.

STEP 11: Click **Compression** in the left-hand list.

STEP 12: Document any compression garments the patient is using, as necessary.

STEP 13: Click **Axillary Web Syndrome** in the left-hand list.

STEP 14: Document the appropriate details for the patient.

STEP 15: Click the  Save icon.

- You return to the Ad Hoc Charting Window.

Document Lymphedema Measurements in iView

➤ From the your patient's Interactive View and I&O screen:

STEP 1: Click the **Lymphedema** navigator band.

STEP 2: Click the appropriate lymphedema option for your patient in the left-hand list.

STEP 3: Double-click the lymphedema type cell for the current date and time.

STEP 4: Click the appropriate measurement interval.

STEP 5: Fill out the flowsheet with the appropriate information, if necessary.

NOTE: **If appropriate, complete documentation for the Unaffected Baseline area, including its Laterality, Circumference Locations, and Circumferences.**

STEP 6: Click the  **Sign** icon.

NOTE: **If necessary, you can document any wound information by doing the following:**

- Click the Rehab Wound View navigator band.
- Click the Dynamic Group icon. This is the square icon in the Incision/Wound/Skin cell.
- Complete the wound documentation in the Dynamic Group window that displays.
- Click OK.
- Click the most current Abnormality Type cell for a wound location.
- Select the appropriate abnormality type(s) for the wound; then click the X Close button.
- Fill in information in the resultant cells, as needed.
- Repeat steps e-g for any remaining wound locations.
- Click the Sign icon.

Review and Sign an Existing Lymphedema Evaluation

➤ From your patient's Form Browser screen:

STEP 1: Right-click the patient's **OT Lymphedema Evaluation**; then click **Modify**.

- The Charting screen opens.

NOTE: **Previously completed lymphedema documentation can be viewed here. To view the patient's measurements, open the Lymphedema Measurements section. To view the patient's wound information, open the Wound section.**

STEP 2: Complete any remaining required documentation, if necessary.

STEP 3: Click the  **Sign** icon.

NOTE: **The Evaluation form now displays as complete with an addendum because you signed it.**

Complete Daily Documentation for a Lymphedema Patient

Completing Daily Documentation requires you to integrate the workflows of the three previous sections of this QRG. First, complete any required sections in the Daily Documentation form. Then, document current measurement and wound information in iView. Finally, review and sign the daily lymphedema documentation you recorded.

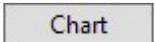
From the Patient List window:

STEP 1: Double-click the appropriate patient's name.

STEP 2: Click  AdHoc.

- The Ad Hoc Charting window opens.

STEP 3: Select the **OT Lymphedema Daily Documentation** check box in the Outpatient Therapy folder.

STEP 4: Click .

STEP 5: Complete the required sections of the form, if necessary.

STEP 6: Navigate to iView to complete the measurement and wound documentation.

- If necessary, refer to the Document Lymphedema Measurements in iView section of this QRG to complete this step.

STEP 7: Return to the patient's Daily Documentation form; then sign the sheet.

NOTE: If necessary, refer to the Review and Sign an Existing Lymphedema Evaluation section of this QRG to complete this step. Note that you should select the OT Lymphedema Daily Documentation form rather than the OT Lymphedema Evaluation form.

STEP 8: Click the  Sign icon.

- You return to the Ad Hoc Charting window.

STEP 9: Chat the Progress Note, Discharge Summary, and Missed Therapy Minutes forms, as necessary.

NOTE: You can forward lymphedema documentation to a provider by using the Menu to navigate to the Documentation or Notes page.

NOTE: You can review which forms have been signed by clicking the Multi-Patient Task List. Any form that has been started but not signed displays in your list.