



Wolf EMR Practitioner User Guide

for British Columbia

Wolf EMR 2016.1.6

Issue 02.05

Revised August 19, 2016.

© TELUS Corporation. All rights reserved.

Wolf EMR[®] EMR software and related products and services are owned by TELUS Corporation.
Wolf EMR[®] EMR and TELUS Health[®] are registered trademarks of TELUS Corporation.

The patients, practitioners, and circumstances depicted within this manual are fictitious. Any resemblance of any sample data or screenshots to any actual person, whether living or dead, is purely coincidental and unintentional.

Table of Contents

Getting Started with Wolf EMR.	1
About this guide	1
Getting help	1
Accessing Wolf EMR user guides and online help.	2
Accessing the Wolf EMR Community Portal	2
Contacting Wolf EMR Support	3
Requesting additional instructor led training	3
TELUS Health EMR User Conference	4
Wolf EMR basics	5
Logging into Wolf EMR	6
Changing your Password	6
Setting up TELUS Wolf EMR self-service password reset	7
Help! I forgot my password	8
Locking Wolf EMR.	9
Shutting down your computer	9
Provider WorkDesk Overview.	11
Opening the WorkDesk.	11
Viewing your to-do list.	12
Viewing your active messages	12
Viewing your active patient follow-ups	13
Viewing your general clinical tasks	14
Viewing your schedule	16
Viewing and entering patient clinical data	17
Viewing a patient from your appointment list	18
Opening and viewing a patient's chart from your WorkDesk.	19
Opening the Quick Entry Form from your WorkDesk	19
Using WorkDesk menu options	20
Reviewing patient investigations and documents	23
Importing electronic investigation results and reports	23
Managing new patients added with investigation imports	27
Reviewing electronic investigations	32
Viewing your electronic investigations.	32
Graphing investigations	34
Adding notes to investigations	35
Moving an investigation to another patient's chart (Administrators)	36
Reviewing your faxed, scanned, and imported documents.	37

Viewing your incoming documents	38
Adding notes and markups to a document	44
Adding notes and markups directly on a document	45
Adding notes to a document's properties	47
Modifying document properties	47
Sharing documents on the Patient Portal	49
Moving a document to another patient's record	50
Deleting a document	51
Responding to electronic investigations and documents	51
Managing INR results (Physician-managed)	55
Viewing a patient's Anticoagulation Summary Sheet	55
Graphing a patient's INR results	57
Modifying a patient's INR test and anticoagulation medication instructions	58
Managing patient INR communications	59
Notifying your front end staff to contact a patient for INR instructions	59
Responding to an INR "Call Patient" message (nurses and MOA's)	60
Billing for INR management	62
Managing INR results (Nurse-managed)	63
Creating an INR Practice Search	63
Viewing the daily INR summary report	65
Viewing a patient's Anticoagulation Summary Sheet from an INR report	65
Graphing a patient's INR results from an INR report	66
Modifying a patient's INR test and anticoagulation medication instructions	66
Managing patient INR communications	66
Indicating that the patient has been notified of changes	67
Reminding yourself to contact a patient at a later time	67
Notifying another user or group to contact a patient	67
Addressing your INR "Call Patient" tasks	68
Billing for INR management - nurse managed	68
Viewing a patient's investigations and documents during their visit	68
Viewing un-reviewed investigations and documents from a patient's medical record	68
Viewing a patient's investigations history	69
Graphing investigations from patient records	71
Viewing a patient's documents	73
Sharing documents via the Patient Portal	75
Printing investigations and documents	77
Printing investigations	77
Printing a single investigation result	77
Printing all results for one investigation value	77
Printing investigation graphs	78
Printing PDF documents	78

Clinic communications and tasks	79
Creating messages	79
Creating messages regarding patients	79
Using the Address Book (NWT only)	84
Creating a message that is not associated with a patient	87
Follow-up tasks	89
To Come In (TCI) tasks	93
Managing your messages and tasks	95
Viewing your messages	95
Updating or modifying your messages	99
Completing your messages	100
Viewing your Follow-up tasks	101
Updating or modifying your Follow up tasks	104
Completing your Follow-up tasks	105
Managing messages and tasks for a specific patient	105
Viewing a patient's active Messages and Follow Ups	105
Viewing a patient's historic Messages and Follow Ups	107
Reactivating a patient's completed Messages and Follow-up tasks	108
Communicating with patients via the Patient Portal	109
Sending messages to patients	109
Verifying that a patient has viewed a message	111
Removing a message from the Patient Portal	112
Viewing messages from patients	112
Covering absent practitioners' messages and tasks	114
Setting up coverage for users	114
Identifying the coverage status of practitioners	115
Visit encounter notes - GP	117
Starting SOAP notes	117
Starting SOAP notes for patients without booked appointments	121
SOAP Form overview	122
SMART Patient Banner overview	123
Information in the SMART Patient Banner	124
Name	125
Demographics	125
Resources	125
Contact Information	127
Smoking Status	128
Vitals	129
Care Team	131
Notification bar	131
Overview of the SOAP Form toolbar	133

Overview of the SOAP form	134
SOAP Form view and action links	136
Entering visit notes in the SOAP form	139
Entering SOAP Form visit notes using shortcuts and templates	142
Using SOAP templates	142
Using the History Builder	144
Using Exam templates	148
Using SMART exams	150
Auto-Replace text	159
Using Auto-replace	159
Creating Auto-Replace text	160
Editing Auto-Replace text	162
Using pictures	162
Managing incomplete visit notes	165
Setting internal privacy restrictions on visit notes	167
Restricting access to a visit record	167
Removing restrictions on patient records	168
Viewing a restricted patient record	169
Visit encounter notes - Specialists	171
Starting consult letter visit notes	171
Starting consult letters for patients without booked appointments	175
SMART Patient Banner overview (on CPP)	177
Information in the SMART Patient Banner	177
Name	178
Demographics	179
Resources	179
Contact Information	181
Smoking Status	182
Vitals	183
Care Team	185
Notification bar	185
Consult Letter Examination window overview	187
Consult Letter SMART Patient Banner	188
Consult Letter Examination toolbar	189
Overview of the Consult Letter form	190
Consult Letter Examination form quick action links	192
Entering visit notes in the consult letter form	194
Entering visit notes using shortcuts and templates	198
Consult letter templates	198
Structured Exam templates	200
Using SMART exams	202

Auto-Replace text	.212
Printing and faxing consult letters.	.212
Printing or faxing a basic consult letter	.212
Printing or faxing consult letters using SMART Forms	.213
Creating consult letter templates	.215
Adding pick list items (check box selections) to consult letter templates .	.218
Pulling patient data into consult letter templates.	.218
Editing consult letter templates	.219
Managing incomplete visit notes	.221
Setting internal privacy restrictions on visit notes	.223
Restricting access to a visit record.	.223
Removing restrictions on patient records	.224
Viewing a restricted patient record	.225
 Creating prescriptions and managing medications	 .227
Creating basic prescriptions	.227
Initiating prescriptions	.227
Searching for medications to prescribe	.228
Searching for medications by name	.228
Searching for medications by category	.230
Searching for medications by targeted system	.231
Entering prescription details	.232
Reviewing drug interaction warnings.	.235
Requesting PharmaCare Special Authority for prescriptions.	.237
Prescribing multiple medications	.240
Creating prescriptions for special situations	.241
Prescribing PRNs	.242
Prescribing compound medications	.243
Prescribing variable doses	.244
Prescribing medical devices and other non-medication treatments	.244
Prescribing medical devices and other non-medication therapies using SMART Forms (Optional)	.245
Prescribing over-the-counter (OTC) and intravenous medications	.246
Reprinting prescriptions	.247
Medication favourites	.247
Adding medication favourites	.248
Using medication favourites	.248
Modifying the order of your medication favourites	.249
Modifying medication favourites	.250
Modifying prescriptions	.250
Editing prescriptions	.251
Discontinuing medications	.252

Discontinuing medications due to adverse reactions	253
Refilling prescriptions	254
Refilling prescriptions	254
Resuming an inactive medication	255
Managing staff-initiated refill requests	256
Electronic requisitions and forms (SMART forms)	259
Using SMART forms	259
Referencing previously completed SMART forms	264
SMART form favourites	265
Using your favourite SMART forms	266
Hiding SMART forms	266
Order Sets	268
Using Order Sets	268
Printing patient labels	269
Sending and managing referrals.	271
Initiating referrals	271
Creating and sending referral letters	278
Creating a basic referral letter	278
Creating a referral letter using the Referral Letter Composer	280
Referral Letter Composer templates	289
SMART Form-based referral letters	290
Creating referral letters using a SMART Form	290
Customizing your Referral Letter SMART Form	292
Managing your referrals.	293
Managing your referrals using the Referral List	293
Managing a patient's referrals from their Medical Summary	296
Updating referral status'	297
Managing the External Consultant list.	299
Adding and Editing consultants while creating a referral.	299
Adding a new consultant	300
Editing a consultant	301
Favourite consultants	302
Adding consultants to your favourites list.	302
Modifying consultants on your favourites list	303
eReferrals.	304
Sending eReferrals	304
Monitoring the status of eReferrals (accepted / declined)	305
Viewing and responding to declined eReferrals	306
Viewing and responding to accepted eReferrals	306

Sending and receiving messages, consult letters, and other documents to and from consultants.	307
Receiving messages, and other documents	307
Sending messages, and other documents	308
Quick Referrals.	310
Starting a Quick Referral	311
Configuring customized Quick Referrals	312
Specialized visits.	315
Prenatal visits	315
Viewing a patient's pregnancy status	316
Viewing and editing a patient's obstetrical history	316
Opening the Prenatal Record.	318
Calculating an estimated due date and gestational age based on LMP	319
Recording gestational age based on ultrasound and calculating EDD	321
Recording Prenatal Record notes on the first visit	321
Recording Prenatal Record notes on subsequent prenatal visits	326
Calculating a patient's Prenatal Risk Score	330
Recording prenatal visit notes	332
Viewing a Fundus Height Growth chart	334
Linking documents to the Prenatal Record	334
Linking documents to the Prenatal Record as patient handouts	335
Linking documents to the Prenatal Record as ultrasound images	336
Accessing documents linked to the Prenatal Record	336
Accessing patient handouts linked to the Prenatal Record	337
Accessing ultrasound images linked to Prenatal Records.	338
Printing and faxing the prenatal record	340
Attaching the prenatal record to a referral	340
Entering delivery details and closing the prenatal record	341
Recording clinical notes for WCB visits	342
WCB forms	342
WCB report types and tabs	342
Printing forms	343
Opening the WCB Report Manager	343
Opening the WCB Report Manager for a patient with a booked appointment	343
Opening WCB Report Manager for patients without booked appointments	344
Starting and completing WCB First Reports	344
Starting and completing WCB Progress Reports.	355
Completing regular SOAP visit notes at the same time as WCB reports	357
Finishing incomplete WCB Reports for individual patients	359
Tracking and managing incomplete WCB Reports for all patients.	360

Viewing previously billed (old) WCB reports	.361
Viewing previously billed (old) WCB reports for individual patients	.361
Viewing previously billed (old) WCB reports for all of your patients	.362
Recording clinical notes for pediatric patients	.362
Entering patient birth information	.362
Viewing patient growth charts	.363
Attaching growth charts to referrals	.367
Completing Rourke Baby Record exams	.368
Responding to incoming referrals (Specialists)	.371
Viewing incoming referrals	.371
Responding to faxed/mailed referrals	.373
eReferrals	.377
Opening and viewing eReferrals	.377
Responding to eReferrals	.379
Accepting eReferrals	.379
Declining eReferrals	.380
Requesting more information from the referring practitioner	.382
Importing patient medical information from eReferrals	.382
Sending messages and documents back and forth to referring practitioners	.384
Sending messages and documents	.384
Receiving messages, and other documents	.387
Viewing and recording patient medical history (Medical Summary)	.389
Opening a patient's Medical Summary	.389
Opening the Medical Summary from the SMART patient banner	.389
Opening the Medical Summary for patients on your appointment schedule	.390
Opening the medical summary for patients who do not have an appointment booked	.391
Medical Summary window overview	.392
Medical summary toolbar	.392
Medical Summary window tabs	.394
Medical Summary window navigation buttons	.395
Problems	.395
Recording problems	.395
Using problem favourites	.399
Recording problems using favourites	.400
Adding problems to your favourites list	.401
Using problem tags	.403
Adding problems using tags	.404
Assigning tags to problems	.404
Viewing and editing problems	.406

Medications	408
Viewing patient medications.	408
Viewing and editing encounter notes	410
Allergies and intolerances	414
Recording allergies and intolerances	414
Viewing and editing allergies and intolerances.	418
Vaccinations.	420
Recording vaccinations	420
Recording refused vaccinations	427
Recording group vaccinations	427
Viewing and modifying vaccinations	430
Creating vaccination recommendations	431
Stopping vaccination recommendations.	433
Recognizing when a patient is due for vaccinations.	433
Producing immunization reports	434
Recording and viewing blood type.	435
Procedures and surgeries	436
Recording procedures and surgeries	436
Using Procedure favourites (available only to select clinics).	438
Recording procedures and surgeries using favourites	439
Adding procedures to your favourites list.	441
Using Procedure tags (some clinics only)	443
Recording procedures and surgeries using tags	443
Assigning tags to procedures.	444
Viewing and editing procedures and surgeries	446
Recording and viewing social history	447
Harmful substances and other risks.	452
Recording and viewing smoking history	452
Viewing and recording alcohol history.	455
Viewing and recording other risks.	457
Family history	460
Recording family history problems	460
Viewing and editing family history details.	462
Appointment Scheduler overview.	465
Opening the Scheduler.	465
Viewing and navigating the Scheduler	466
Viewing the schedule by day, week, or month	466
Viewing your schedule in week view	467
Viewing your schedule in month view	467
Viewing all default practitioners' schedules in day view.	467
Viewing a specific date in the Scheduler.	467

Navigating the schedule by day	.468
Navigating the schedule by a specific number of days	.468
Navigating the schedule by weeks	.469
Navigating the schedule by months	.469
Navigating back to today's schedule	.470
Setting up practitioner schedules	.470
Setting the number of practitioner schedules to display	.470
Selecting default practitioner schedules to display	.471
Creating practitioner groups	.472
Viewing a practitioner group	.473
Deleting a practitioner group	.473
Modifying a practitioner group	.473
Changing practitioner group members	.474
Changing the name of a practitioner group	.474

Getting Started with Wolf EMR

Wolf EMR is a comprehensive practice management system that integrates patient medical records (which includes medical history, visit notes, investigations, medical reports and other documents, referrals, rules (reminders), and more), appointment scheduling, clinical task management, intra-office communications, and billing functions. Wolf EMR does more than replace your filing cabinets; it allows you to perform patient searches, create reports, produce financial statements, view patient statistics, and perform complex billing analysis.

The seamless software integration allows you to navigate between patient records, tasks, billing, and appointments without losing your place.

About this guide

This guide documents Wolf EMR features and workflows from the perspective of a front end staff member. Content is specific to activities that most front end staff members perform on a regular basis. More advanced functionality (for example, around reporting) is documented in feature-specific guides and in Wolf EMR Online Help.

Getting help



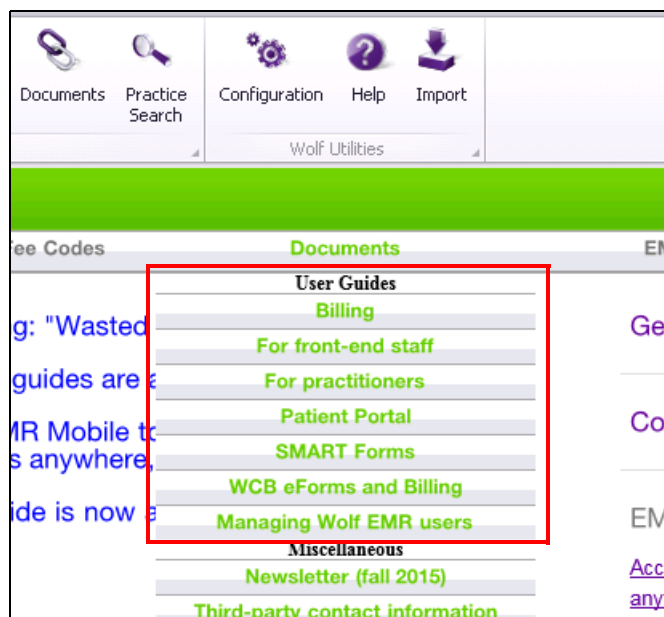
View recorded webinar: [Finding answers to your Wolf EMR questions](#)

There is an abundant amount of information that you will be trained on and there are further advanced functions that are not covered during your implementation training. For this reason, be sure to take advantage of the numerous learning resources available to Wolf EMR users.

Accessing Wolf EMR user guides and online help

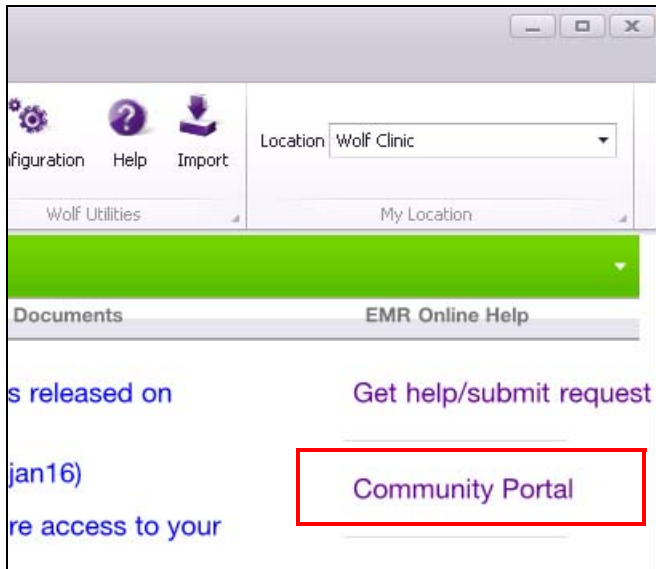
To view the Wolf EMR Online Help, on the Wolf EMR Launch page, click **Help** (). Alternatively, if you need help while performing a particular task, on your keyboard, press **F1**. For some windows, the EMR opens the help topic specific to the window you are currently in.

You can also refer to the various role-based and feature-based Wolf EMR user guides, which you can access from the Wolf EMR Launch page, in the **Documents** drop-down list, or from the Guides Available topic of the online Help.



Accessing the Wolf EMR Community Portal

Through the Wolf EMR Community Portal you can access an extensive amount of free learning resources including articles, PDF user guides, handouts (work instructions), training videos, collaborative forums, and Q and A. To access the Community Portal, on the Wolf EMR Launch page, click **Community Portal**.



You can also access the Community Portal from any device by going to:

<https://telushealthcommunity.force.com/wolfcommunity>

Note: The first time you log into the Community Portal, you will be required to set up a Community Portal account.

Contacting Wolf EMR Support

If you cannot find the answer to your question, contact the Wolf EMR support team:

- For issues requiring immediate assistance, call **1-866-879-9653 (Option 1)**
- For less immediate issues, you can contact support via email to **WolfEMR.support@telus.com** or via the **Cases** page of the [Wolf EMR Community Portal](#)
- For general how-to questions, you can post a question on the **Q&A** page of the [Wolf EMR Community Portal](#)

Requesting additional instructor led training

Even for the most computer-savvy person, there is a lot of information to absorb during EMR implementation training. You may find it helpful to have a Learning Specialist return to your office several months after go-live to:

- Re-assess your workflow and provide tips and tricks for using the system more efficiently
- Train you on how to perform more advanced tasks
- Work with each staff member to ensure everyone has a thorough grasp of the Wolf EMR functionality necessary to do their job with ease

TELUS Health also offers many 1-4 hour training courses that cover intermediate and advanced functionality. Once you are comfortable with the basics, take advantage of these courses to raise your EMR use to the next level. These courses are offered onsite or via webinar.

To arrange further training, contact the Client Care Team at **1-866-879-9653 (Option 4)**, via e-mail at **Accounts.WolfEMR@telus.com**, or Create a Case on the **Cases** page of the [Wolf EMR Community Portal](#).

TELUS Health EMR User Conference

Each year TELUS Health hosts a user conference, where you learn how to make the most of your EMR and gain insight into the advances being made to Wolf EMR. The conference offers a series of presentations, workshops, and peer networking opportunities.

Keep an eye on the Wolf EMR Launch page for information about the User Conference.

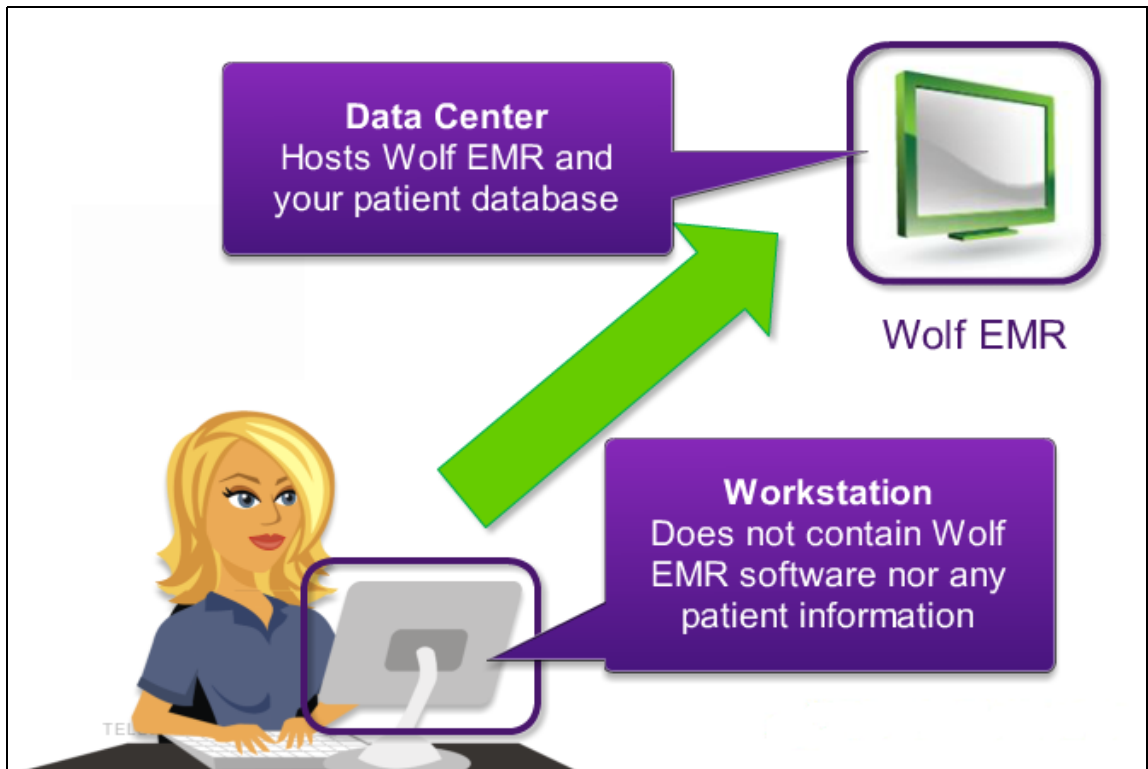
Wolf EMR basics



View video tutorial:

- [Signing into and out of Wolf EMR](#)

To access Wolf EMR, your workstation links to a remote system on the Wolf EMR data center. The data center hosts the Wolf EMR program and your patient database. Your clinic computers do not contain any patient information. Your workstation simply acts as a window into a system that contains your EMR data.



A Wolf EMR data center link is installed on all computers in your clinic. If your computer does not have the Wolf EMR data center link, please talk to a user at your site who has Wolf EMR administrative authority. Your system administrator can make arrangements to have the link added.

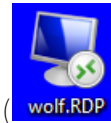
If you are accessing Wolf EMR for the first time, your temporary password is pre-set in the system and is provided to you, along with your username, by your system administrator or your TELUS Health learning specialist. You secure your password by changing it. Going forward you should never disclose your password to anyone.

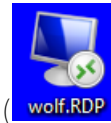
Logging into Wolf EMR

How you log into Wolf EMR depends on if you are logging in from a PC or from a Sunray computer. When you log in, Wolf EMR opens in a remote desktop. Keep in mind that in this view, the Windows **Start** menu and toolbar is for the remote desktop (not your workstation).

PC

To log into Wolf EMR from a PC:



1. On your desktop, double-click the Wolf EMR data center link (). A Microsoft Windows login window displays.

2. In the **User name** field, enter your username.

Note: If another user's name is already populated, click **Use another account**. You can now enter your own username.

3. In the **Password** field enter your temporary password, and then press **Enter**. You are now logged into the data center with Wolf EMR open.

Sunray

To log into Wolf EMR from a Sunray:

1. Slide your card into the Sunray card reader with the chip end inserted first. Your computer activates automatically.
2. Enter your username and password. The remote desktop opens with Wolf EMR open.

Changing your Password

If this is your first time accessing Wolf EMR, using a temporary password, you should change your password immediately. Wolf EMR prompts you to change your password regularly. How often you are required to change your password depends on current provincial guidelines, and on custom settings programmed by your system administrator.

If your password is compromised, you can manually change your Wolf EMR password at any time.

To change your password:



1. On the data center, click **Start** () and then, in the Start menu, click **Windows Security**.

2. In the list of Windows Security options, click **Change a Password**.

3. In the **Old password** field, enter your current (or temporary) password.
4. In the **New password** field, enter your new password, and then in the **Confirm password** field, enter your new password again.



Your password must:

- Be at least 8 characters in length
- Contain at least one number
- Contain at least one upper case letter

Note: You can use special characters such as #, *, or _

5. Press **Enter**.

Setting up TELUS Wolf EMR self-service password reset

Are you notorious for forgetting passwords? If so, now is the time to enrol for TELUS Wolf EMR self service password reset (free). If you forget your password, you will be able to reset your password by answering 3 personalized questions.

To enrol for TELUS Wolf EMR self service password reset:

1. On the data center desktop, click **Start** () and then, in the Start menu, click **All Programs > Tools4ever > SSRPM > Enrollment Wizard > Enrollment Wizard** (). The TELUS WolfEMR Password Reset Enrollment Wizard opens.
2. Click **Next**.

3. In the **Question 1** area, select a question and provide an answer.

TELUS WolfEMR Password Reset Enrollment Wizard - Define question 1 (of 4)

Please select a question and provide an answer.

Question 1

Question:

Answer:

Confirm:

*Please note that

Please click on the

In what city did you meet your spouse/significant other?

In what city or town did your mother and father meet?

In what town was your first job?

What is the first name of the boy or girl that you first kissed?

What is the middle name of your youngest child?

What is the name of your favorite childhood friend?

What is your fathers middle name?

What is your maternal grandmother's maiden name?

What is your mother's maiden name?

What is your oldest sibling's birthday month and year? (e.g., January 1900)

What is your oldest sibling's middle name?

What school did you attend for sixth grade?

What street did you live on in third grade?

What was the last name of your third grade teacher?

What was the make of your first car?

What was the name of your first pet?

What was the name of your first stuffed animal?

What was your childhood nickname?

What was your childhood phone number including area code? (e.g., 000-000-0000)

4. Click **Next**.
5. In the **Question 2** area, select a question and provide an answer.
6. In the **Question 3** area, create a custom question and answer, and then confirm your answer.
7. Click **Next**. A dialog box displays with the following message: "Congratulations! You have enrolled successfully into the Self Service Reset Password Management program!"

Help! I forgot my password

If you have forgotten your password, or have been locked out of the EMR due to too many failed login attempts, you can reset your password, without contacting the TELUS Health Wolf EMR support team, only if you have enrolled in TELUS Wolf EMR self service password reset. See ["Setting up TELUS Wolf EMR self-service password reset" on page 7](#).



If you have not set yourself up for TELUS Wolf EMR self service password reset and you have forgotten your password, you must contact the TELUS Health Wolf EMR support team to have your password reset. See ["Contacting Wolf EMR Support" on page 3](#).

The steps to reset your password depend on the type of workstation you are on. Click an option below to view the applicable steps:

- [I'm a Sunray user](#) (I insert a card to log into Wolf EMR)
- [I'm a PC user](#)

Locking Wolf EMR

If you leave your computer for more than a few moments, you should lock Wolf EMR. This way, no unauthorized users can access patient data, and other staff members cannot mistakenly enter data under your name. How you lock Wolf EMR depends on if you are using a PC or a Sunray computer.

PC

To lock Wolf EMR from a PC workstation:

1. On the data center, click **Start** () and then, in the Start menu, click **Windows Security**.
2. Click **Lock this computer**.



Caution: Locking the Wolf EMR remote computer does not lock your entire workstation. If you have other files or applications running on your workstation, those may still be accessible. To lock your PC workstation:

1. Minimize the Wolf EMR remote desktop window.
2. On your keyboard, press **Ctrl + Alt + Delete**, and then select **Lock Computer**.

Note: You can also use the keyboard shortcut: Press the **Microsoft key + L**.

Sunray

To lock Wolf EMR from a Sunray workstation, simply slide your card out of the card reader. The computer logs out automatically.

Shutting down your computer

When you shut down your computer, you should manually close Wolf EMR before you log out of the remote desktop.

To shut down your computer:

1. Close Wolf EMR using one of the following procedures:

- If you have the Wolf EMR Launch page open, click , and then select **Close all Wolf EMR Applications**.
 - If you have another Wolf EMR window open, on the task bar at the bottom of the desktop, right-click , and then select **Close Window**.
2. Close the remote computer: On the remote computer's task bar, click **Start** () , and then click **Log off**.
 3. Shut down your workstation.

Provider WorkDesk Overview

This chapter introduces you to the provider WorkDesk, where a majority of your daily work is completed in the EMR.

Through the WorkDesk, you can:

- View and enter data into patient records.
- Review your patient investigations (labs), and other received reports and documents.
- Communicate with front-end staff, and providers in your clinic.
- Add, monitor, and update your clinical tasks, messages, follow up items, referrals, and appointments.

Opening the WorkDesk

To open the WorkDesk:

On the Wolf EMR Launch page, click **WorkDesk** (). The EMR opens the WorkDesk.

Janna S, MD PhD FRCPC Wednesday - March 2, 2016 2:10 pm

No Investigations No Unreviewed Documents No Rule Matches 1 Current Message 130 Follow-ups No Patients Booked

Messages **Appointments**

Current Messages: ☒ Sign Out

Date	Patient/To	From
19-Jun-2013 12:04	Janna S	Janna S

Tasks **Patient**

Medical Summary Quick Entry Demographics

Investigation Results

- No Unreviewed New Electronic Investigation Results
- No Unreviewed New Documents
- No New Manual Results to be Reviewed
- No Rule Matches (level 5) found in last 7 days. Total rule matches = 0

Referrals

- No Letters Due Within The Next Week (No Letters - Total)
- No Letters to Edit
- No Incoming Consults No Declined eReferrals
- No Incoming Referrals

Patient Records

- No Incomplete Visit Records

Current Follow Up Tasks: ☒ Sign Out

Date	Patient/To	From
24-Nov-2015	H, Wes	Janna S
24-Nov-2015	W, Krystina	Janna S
11-Nov-2015	H, Taunya	Janna S
19-Oct-2015	H, Morris	Janna S
04-Oct-2015	W, Lahoma	Janna S
28-Jul-2015	W, Lahoma	Janna S
15-May-2015	C, Forrest	Janna S
04-Apr-2015	H, Patria	Janna S
05-Feb-2015	H, Patria	Janna S
30-Jan-2015	B, Charlott	Janna S
01-Jan-2015	L, Maryanne	Janna S
01-Jan-2015	B, Bob	Janna S
27-Dec-2014	V, Adrienne	Janna S

First 50 of 130 Follow Ups shown



Tip: When the WorkDesk opens, the EMR displays the WorkDesk icon () in the toolbar at the bottom of your screen.

You can quickly navigate back to the Launch page at any time by clicking the

Launch page icon () (located on the toolbar at the bottom of your screen.)

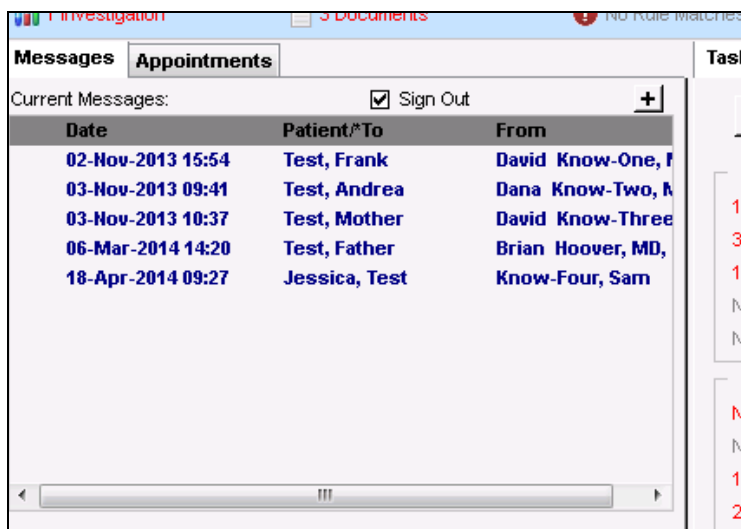
Viewing your to-do list

The following sections describe the different areas of your WorkDesk you can use to view and track items on your to-do list.

Viewing your active messages

Wolf EMR contains a messaging system for inter-office communications. You can send, receive, and forward messages just as you do with regular e-mail.

You can view and create messages from the **Messages** area on your WorkDesk. You can view your active messages in the top left area of the WorkDesk window.

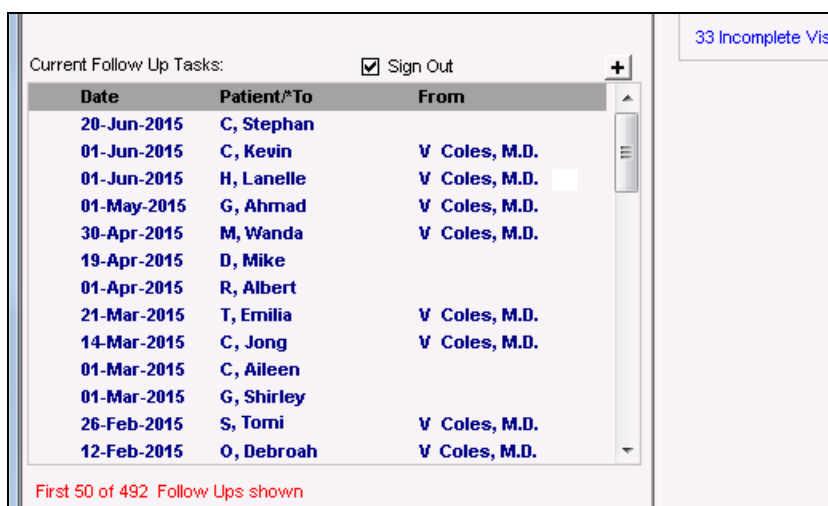


Viewing your active patient follow-ups

You can view and create follow-up tasks from the **Follow Up Tasks** area on your WorkDesk. Follow-up tasks are similar to messages; however, they are created primarily to:

- Remind you to call a patient.
- Serve as a reminder in a patient's record for you to talk to the patient about a particular test result, treatment option, or other matters pertaining to the patient's health.

You can view your follow-up tasks below the **Messages** area in WorkDesk window..



Viewing your general clinical tasks

You can view a list of your clinic tasks from the **Tasks** tab on your WorkDesk. You can view links to lists of patients requiring specific actions.

The screenshot shows the 'Tasks' tab selected in the top navigation bar. The interface includes a header with status indicators: '2 Current Messages', '492 Follow-ups', and '5 Patients Booked'. Below the navigation tabs, there are three main sections: 'Medical Summary', 'Quick Entry', and 'Demographics'. The 'Investigation Results' section displays '13 New Electronic Investigation Results', '2 New Documents', and '190 Patients Overdue for Preventive Procedures Outside Guidelines'. The 'Referrals' section shows 'No Letters Due Within The Next Week', 'No Letters to Edit', 'No Incoming Consults', and 'No Incoming Referrals'. The 'Patient Records' section indicates '33 Incomplete Visit Records' and 'No Incomplete WCB Reports'. The 'Refill Requests' section shows 'No Refills to be Approved'. The 'Patient Status' section includes a 'Change Patient Status' link and lists 'No Acute Care Patients Registered', 'No Long Term Care Patients Registered', 'No House Bound Patients Registered', and 'No Maternity Patients Registered'.

The Tasks tab contains five main sections:

- Investigation Results
- Referrals
- Patient Records
- Refill Requests
- Patient Status

The following table lists the information you can review and tasks you can perform in the five main sections on the **Tasks** tab.

Task section	You can:
Investigation Results	■ View and sign-off on investigation (lab) results. ■ View and sign-off on scanned and faxed reports. ■ View patients flagged for automated reminders, including overdue preventive care procedures and investigations.
Referrals	■ Review, accept, decline incoming referrals (specialists). ■ View the status of outgoing referrals.
Patient Records	■ View and open your incomplete patient visit notes. ■ View and open incomplete WCB Reports.
Refill Requests	■ Review, and respond to prescription refill requests passed on by your front end staff (originating from pharmacies or patients).
Patient Status	■ View lists of your special patient groups, including: ■ Acute care patients ■ Long term care patients ■ House bound patients ■ Maternity patients ■ Change the status of a patient to add the patient to, or remove a patient from one of the listed groups.



Tip: Customizing your task list

You can choose what outstanding tasks display in the **Tasks** area of the WorkDesk. All possible tasks display by default, but you can hide tasks to simplify your view.

To hide tasks on your WorkDesk **Tasks** area:

1. On the menu bar of the WorkDesk, click **Configure > Configure WorkDesk**



(). The EMR displays the WorkDesk User Preferences window.

2. On the **General** tab, in the **Label Visibility** area, clear the **Apply Clinic Setting** check box.

3. Clear the **User Setting** check box beside all tasks you do not want to display in your **Tasks** area.

4. Click

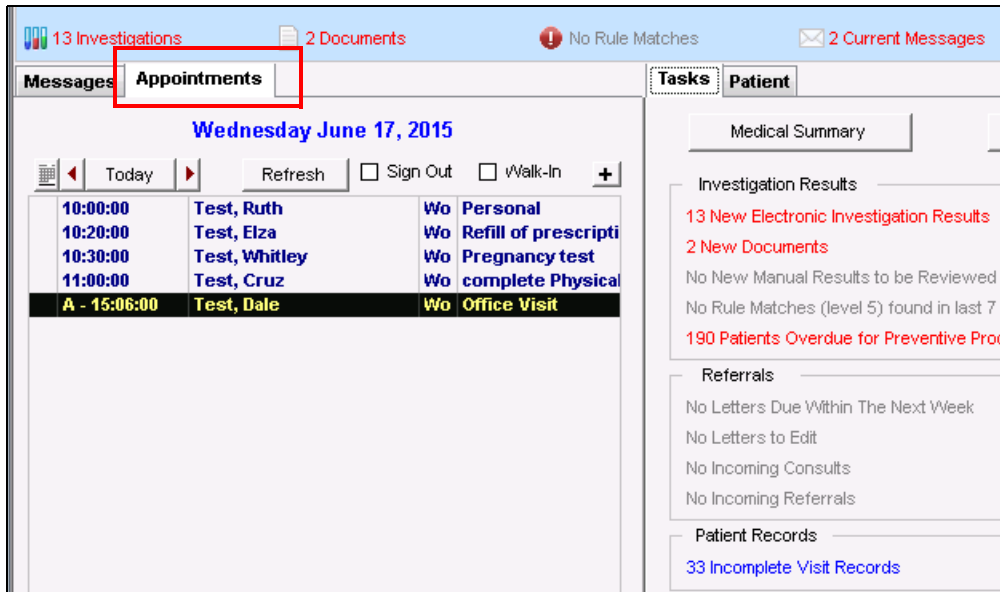


Viewing your schedule

On the WorkDesk, you can view, and add your appointments for a day.

To view your appointments:

Above the **Messages** area, click the **Appointments** tab.



Tip: To navigate back to your WorkDesk messages, click the **Messages** tab.

To navigate your appointments list:

1. To jump forward or back one day at a time, click **Forward** (🔴) or **Back** (⬅️) on either side of **Today**. The EMR jumps a day forward/back with each click.
2. To navigate back to today, click **Today**.
3. To view your list of appointments for a specific date, click 📅, and then on the calendar, double-click the date.
4. To include the appointment schedule of a provider you are covering for, select the **Sign Out** check box.
5. To refresh the list to reflect any new or cancelled appointments, click **Refresh**.

Viewing and entering patient clinical data

The following sections provide an overview of the various ways that you can view and enter patient clinical data from the WorkDesk. Your instructor will cover these topics in detail later in the course.

Viewing a patient from your appointment list

From your appointment list you can view, and add clinical data for listed patients.

To open a scheduled patient's record:

1. On the **Appointments** tab of the WorkDesk, navigate to the date the patient is booked for (if the patient is booked for a date other than today). See ["Viewing your schedule" on page 16](#).
2. Single-left-click the patient. The EMR opens the **Patient** tab of the Workdesk.

The screenshot shows the 'Patient' tab for a patient named Amy Test. The interface includes a header with patient demographics (Born 15-May-1981 (33), Sex F, PHN 12345-1234), a 'Caregiver' section (Test, Bill), and a 'Status' section (N/A). Below this is a 'Home address' section (222 Test Street SE, Calgary AB T2T 2T2) and a 'Work' section ((111) 111-1111). A 'Vitals' section displays BMI (20.6), Weight (56kg), BP (120/80), and other measurements. A 'No Follow Ups' and 'No Vaccinations' status is shown. The main area is divided into two panes. The left pane shows a list of visit notes with dates and descriptions, including 'Office Visit', 'test assessment', and 'UNAVAILABLE DUE TO SECURITY RESTRICTIONS'. The right pane shows a summary of medical information, including 'LAST PREVENTIVE CARE RESULTS', 'ALLERGIES' (penicillins - Anaphylaxis), 'PATIENT : " TEST, AMY "', 'CURRENT MEDICATIONS' (Atorvastatin, Naproxen, Warfarin), 'ACTIVE PROBLEMS' (Diabetes Mellitus), 'INACTIVE PROBLEMS' (Meningitis Meningococcal), 'NOTED PROCEDURES' (Vasectomy), 'LATEST DOCUMENTS' (e-MS Referral Letter, CT Procedures Use Form-AB Medical Summary Pap), 'NOTED FAMILY HISTORY' (Mother), and 'VACCINATION RECORD' (flu vaccine).

The **Patient** tab displays:

- A list of the patient's visit notes (both complete and incomplete).
- A summary of the patient's important medical information.
- The **SMART Patient Banner**: Located at the top of any window of the patient's medical record, the **SMART Patient Banner** provides a summary of the patient's demographic information, recent vitals and measurements, status, and care team.



The **Patient** tab acts as an entry point to the patient's medical record. From this page, you can access all of a patient's medical information, create encounter notes, and perform a number of actions in the patient's record.

3. To view the patient's full medical record, click anywhere on the **SMART Patient Banner** at the top of the window. The EMR displays the patient's **Medical Summary**.

Opening and viewing a patient's chart from your WorkDesk

If a patient is not booked for an appointment, you cannot open their chart from your appointments list. Instead, you can open and view a patient's medical record from the **Tasks** tab on the WorkDesk.

To open a patient's medical record from your WorkDesk:

1. At the top of the **Tasks** area on your WorkDesk, click **Medical Summary**. The EMR displays the Patient Search window.
2. Search for the patient and then, in the search results list, double-click the patient's name. The EMR displays the Medical Summary window with the patient's chart information.

The **Medical Summary** contains all of the patient's medical information categorized in easy to navigate tabs.

Medical Summary

Test, Bradley Born **26-Nov-1983 (31)** Sex **M** PHN **9999 999 999** Status **N/A**

Home address: 123 Test Avenue, Cobble Hill BC L0A 3J3 Home Cell Work: (111) 111-1111

BMI: 21.2 0 d Weight: 65kg 0 d BP: 120/80 0 d Pri: Veta Coles, M.D.

No Inv. No Docs No Rules No Messages No Follow Ups No Vaccinations

Print Chart Custom Report Request Chart Change Log

Current Hx Past Hx Personal Hx Communication Investigations Documents Referrals

Problems

<<Add New Problem>>

Nausea hematemesis, R flank pain
Colonoscopy
Depression
Personality Disorder Narcissistic ?

Current Medications

<<Add New Medication>>

Lithium (Lithium Carbonate CAP) 300 mg i PO BID

Encounters

Date	Type	Description
18-Jun-2015	I	Office Visit
05-Sep-2012	C	Depression
05-Sep-2012	C	Counselling
05-Sep-2012	C	Bipolar Affective Disorder
03-Sep-2012	C	msg This is a message
03-Sep-2012	C	msg This is a message
08-Aug-2012	C	msg This is a message
21-Jul-2012	P	RP Private pay
05-Jul-2012	P	RP Counselling
04-Jul-2012	C	Depression
30-Jun-2012	P	RP Private pay
23-Jun-2012	P	RP Private pay
18-Jun-2012	C	Depression

Vaccinations

<<Add Vaccination>>
<<Vaccination Schedule>>

☐ Primary Immunizations Completed

Blood Type:

Allergies

<<Add New Allergy>>

cipralext

Opening the Quick Entry Form from your WorkDesk

Using the Quick Entry Form, you can enter patient medical history information including social information, medical problem list, medications, allergies, and surgeries. You can open the **Quick Entry Form** in the **Tasks** area of your WorkDesk.

To access the **Quick Entry Form** from your WorkDesk:

1. On the **Tasks** tab of the WorkDesk, click **Quick Entry**. The EMR displays the Patient Search window.
2. Search for the patient and then, in the search results list, double-click the patient's name. The EMR displays the **Quick Entry Form** window.

Using WorkDesk menu options



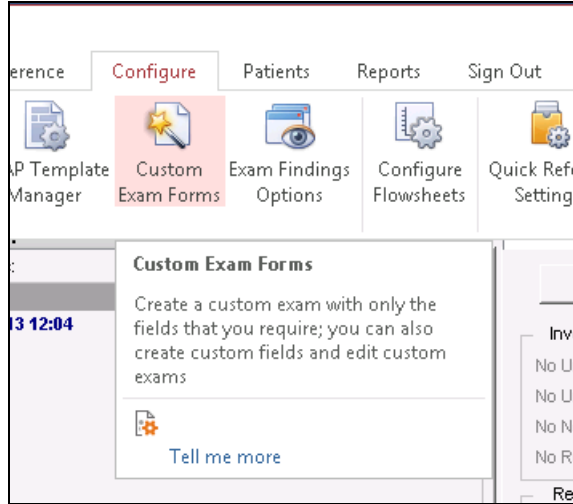
Video demonstration: [Wolf EMR 2016.1 WorkDesk enhancements](#)

Along the top of the WorkDesk window, there are a series of menu options. Here, you can perform a variety of actions, including customizations to the way your WorkDesk acts and looks.

When you click a menu, the EMR displays options for that menu in a horizontal ribbon.



If you are unsure of what a menu option is for, hover your cursor over the icon and a description pops up.



Reviewing patient investigations and documents

In this chapter, you learn how to review and manage:

- Lab and other investigation results that your clinic receives electronically
- Medical reports and other documents that come into your clinic via fax, mail, or direct import.

Importing electronic investigation results and reports

You can import electronic laboratory results, and other medical reports (depending on which feeds your clinic is set up for) for all providers in your clinic at once. Following import, you and other providers can then review and take action on received investigations.

To receive the most up-to-date results, import 3 times daily. Wolf EMR imports all electronic investigations released since the last import.



Note: Any Wolf EMR user can download electronic investigations, no matter their role or security access. However, each user who downloads investigations must be configured to do so.

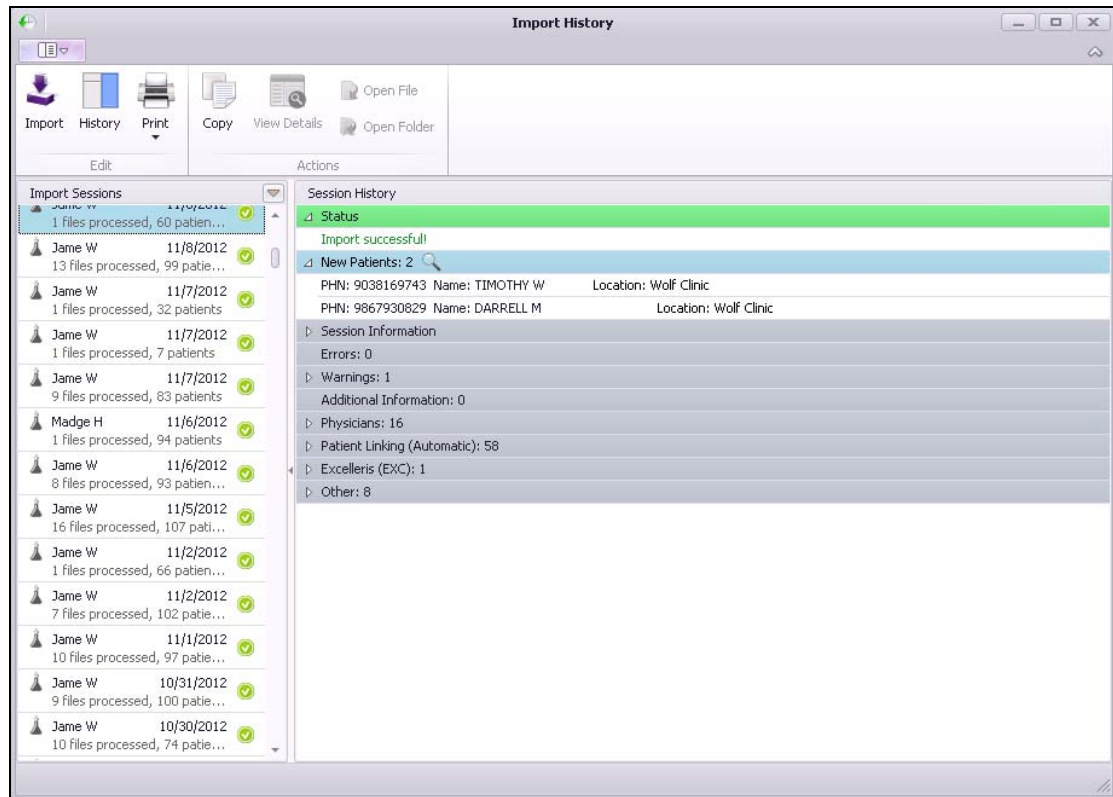


Tip: Assign specific users to be responsible for manually downloading lab investigations at similar times each day. This way you can ensure that lab downloads occur at regular intervals.

To import your clinic's electronic investigations:

1. On the Wolf EMR Launch page, click **Import** (). The EMR displays a dialog box with the following prompt: "Are you sure you would like to import new investigations at this time?"

- Click **Yes**. The EMR displays the Import History window. The EMR imports investigations and reports from all of the companies that you have Lab Import permission for, and displays the imported investigations in the Import History window.



The Import History window contains the following information:

- **Import Sessions:** A running list of users who have imported investigations, and on what dates and times those imports occurred.
- **Session History:** A status summary of your imports. Indicates if the current import is successful, and the total number of investigations imported. Also details information on new patients added with the most recent investigation import, including patient names, provincial health numbers, and clinic location (if your clinic has more than one clinic location).

3. If an investigation from the import belongs to a patient who cannot be identified in your system, the EMR opens the Patient Match Selection Form window. This window displays the imported patient information, and a list of possible patient matches below.

Patient In Import File

Last Name : **LAB**
 First Name : **BOY** Middle Name :
 PHN : **9433863162** PHN Ver.: DOB : **10-Jun-1996** Gender : **M** Home Phone : **4564564561**
 Address : **PO BOX 34, GIBSONS, BC** Add as New

Similar Patients Already On File:

Score	Last Name	First Name	Middle Name	PHN	Date of Birth	Gender	Most Recent Appointment	Total Number of Visits	Home Phone	Address	Location
70	DITEST-D	SAMUEL	THOMAS B	9433863162	30-Sep-1942	M		0		AB	Location 3

Perform one of the following actions:

- To match the investigation to a patient on the list, in the **Similar Patient Already On File** list, double-click the patient's name.
- To add the patient as a new patient in your system, click **Add as New**.



Note: If your clinic has multiple clinic locations, the patient is automatically assigned to the ordering physician's primary location. You can manually assign imported patients to another location if needed. See ["Managing new patients added with investigation imports" on page 27](#).

Once all unidentified patients are matched, the EMR displays the Import History window once more.

4. In the **Session History** area of the Import History window, review the status of your import to see if your import was successful or not.



Note: If there are any errors, the **Session History** window provides instructions to contact the Wolf EMR Support Team for further assistance.

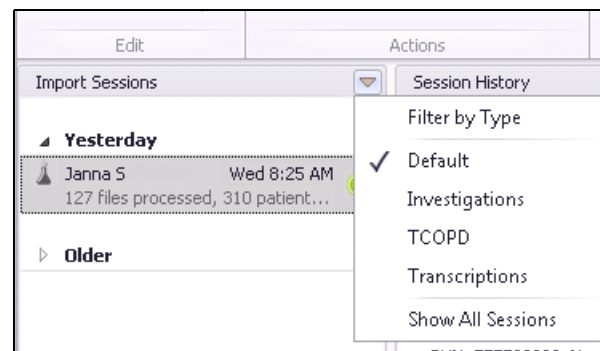


Viewing investigation import information for multiple locations:

If your clinic has multiple locations, by default you see investigation import information only for locations that you are assigned to.

To view import information for all clinic locations:

1. On the **Import Session** header, click the down arrow icon () . The EMR displays a list of filter options.

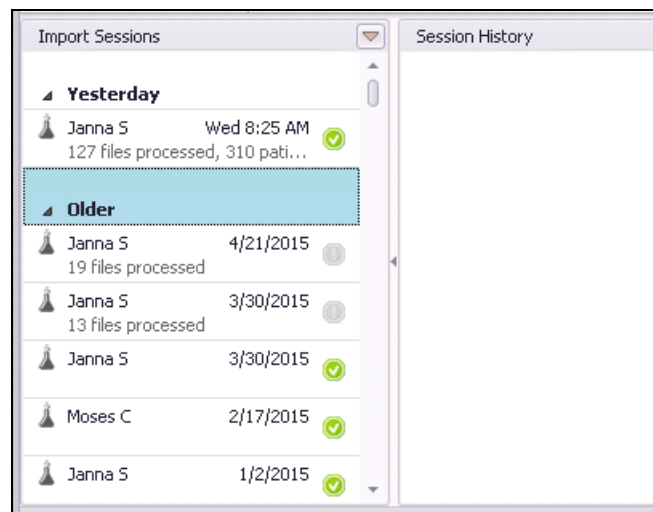


2. In the list of filter options, click **Show All Sessions**. The EMR displays import information for all clinic locations.

5. To view detailed information for a previous import, in the **Import Sessions** area, click the import. The EMR displays detailed information for the import in the **Session History** area.



Tip: If the import you want is not available in the list, click the arrow to the left of **Older**. The EMR displays a complete list of previous imports.

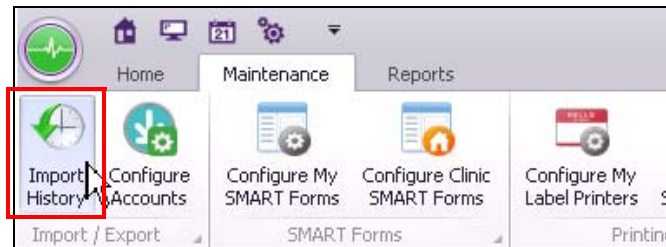


6. To expand the **Session History** area, click **History** (). The EMR hides the **Import Sessions** area.
7. To display the **Import Sessions** area, click **History** () once more.
8. When you finish reviewing the status of your import, click **Close** ().



Tip: If you want to view the Import History without importing investigations, you can access the Import History window from Wolf EMR Maintenance:

- On the Wolf EMR Launch page, and then click the **Maintenance** tab, and then click **Import History**.



Managing new patients added with investigation imports

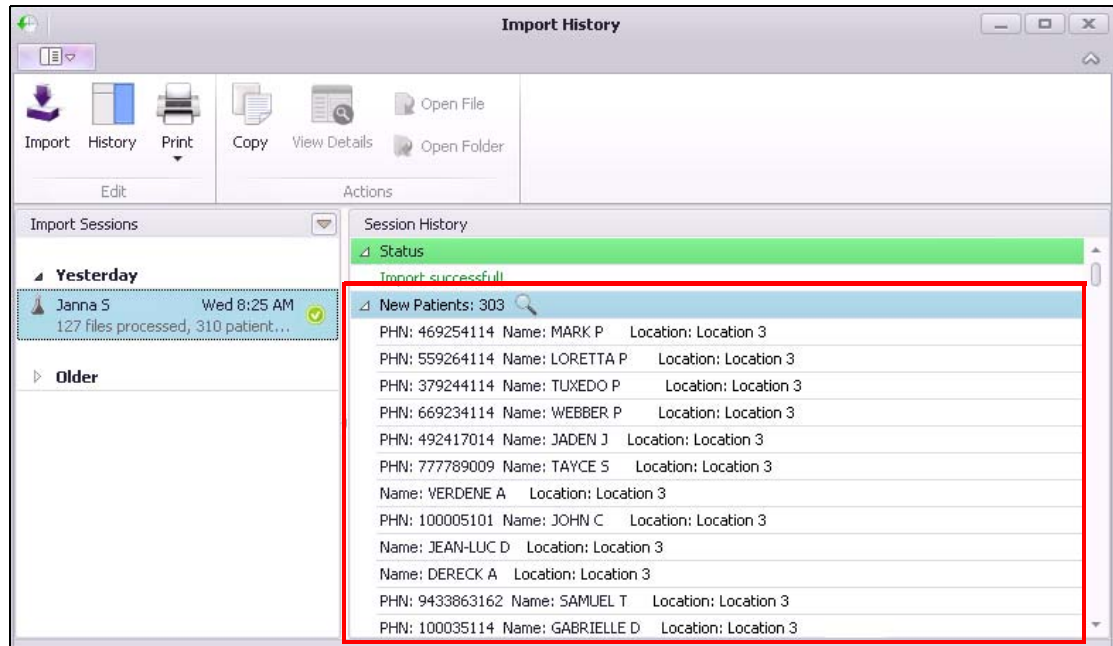
If you add patients with an investigation import (for example, if you receive labs for patients seen by a provider in hospital), from the Import History window, you can:

- Modify patient demographic information
- Deactivate the patients
- Assign the patients to a primary MD
- Assign the patients to a location
- Assign the patients to a care team
- Change the patients' status
- Create follow-up tasks for the patients

To manage patients that are added with an import:

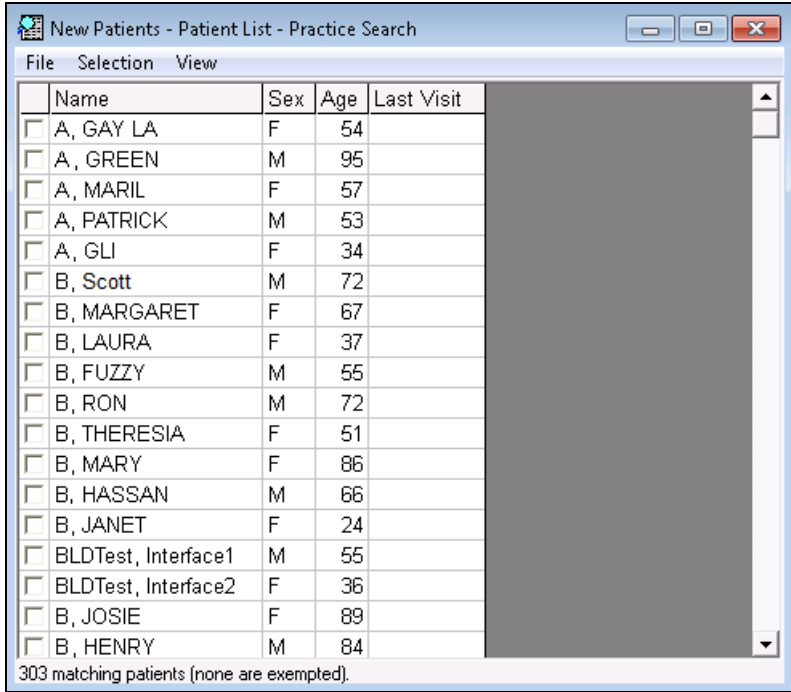
1. Open the Import History window, see [“Importing electronic investigation results and reports” on page 23](#).
2. In the **Import Session** area, click the import you want to view and manage new patients for. The EMR displays information for the selected import in the **Session History** area, including a list of patients added to your system with the import. The list includes each patient's:

- Name
- Provincial health number
- Clinic location the investigation was ordered from (displays only if your clinic has multiple clinic locations)



3. To view or modify a patient's demographic information, double-click the patient's name. The EMR displays the Patient Maintenance window.
4. To modify or deactivate the imported patients as a group:

- a) In the **Session History** area, on the **New Patients** header, click . The EMR opens a window displaying the list of new patients.

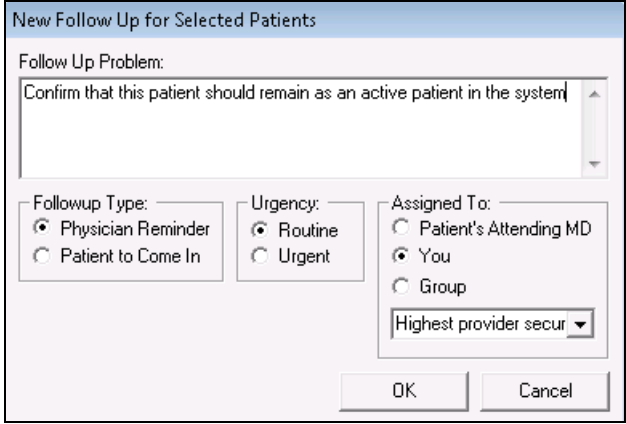


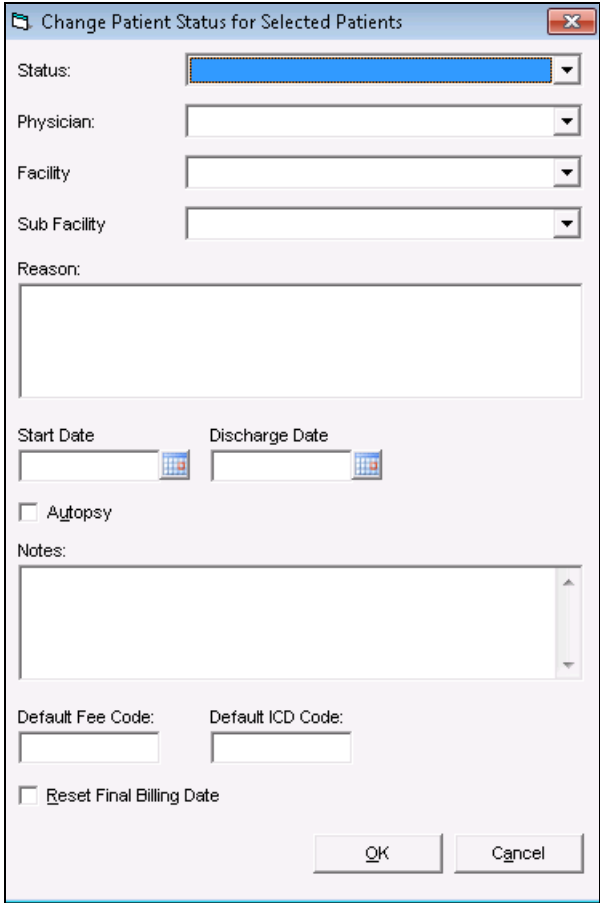
	Name	Sex	Age	Last Visit
☐	A, GAY LA	F	54	
☐	A, GREEN	M	95	
☐	A, MARIL	F	57	
☐	A, PATRICK	M	53	
☐	A, GLI	F	34	
☐	B, Scott	M	72	
☐	B, MARGARET	F	67	
☐	B, LAURA	F	37	
☐	B, FUZZY	M	55	
☐	B, RON	M	72	
☐	B, THERESIA	F	51	
☐	B, MARY	F	86	
☐	B, HASSAN	M	66	
☐	B, JANET	F	24	
☐	BLDTest, Interface1	M	55	
☐	BLDTest, Interface2	F	36	
☐	B, JOSIE	F	89	
☐	B, HENRY	M	84	

303 matching patients (none are exempted).

- b) Select the check box beside the patients you want to modify or deactivate, or to select all patients, click **Selection > Select All**.
- c) In the menu, click **Selection**. The EMR displays a list of actions you can perform on the selected patients.

d) Using the following table, select an action to perform on the patients.

Action	Description
Add to Followup List	To create a follow-up task for the selected patients: - Click Add to Followup List. The EMR displays the New Follow Up for Selected Patients window.  - Enter the following information, and then click OK: ■ Follow Up Problem: Enter a description for the follow up task. ■ Follow up Type: To assign the follow task(s) to a particular user or to a group, click Physician Reminder, or to create a to Come In task, click Patient to Come In. Note: For more information on To Come In (TCI) tasks, see "To Come In (TCI) tasks" on page 93. ■ Urgency: Click Routine or Urgent. ■ Assigned To: Click the user or group the task(s) are to be assigned to.
Assign Primary MD	To assign the patients a primary provider, click Assign Primary MD .
Assign Care Team	If your clinic has care teams set up in Wolf EMR, and you want to assign the patients to a particular care team, click Assign Care Team .
Update Default Location	If your clinic has multiple clinic locations, and you want to assign the patients to a particular location, click Update Default Location. Note: By default, patient's are assigned to the location that their investigations were ordered from.

Action	Description
Update Patient Status	To update the patients' status: - Click Update Patient Status. The EMR displays the Change Patient Status for Selected Patients window.  - In the status drop-down list, click the status. - Complete the remainder of the fields, and then click OK. Note: The information required depends on the status selection. Note: If the status you want is not available on the list, a user with administrator authority can add statuses as needed.
Deactivate Selected	To deactivate the patients, click Deactivate Selected .

5. To close the patient list, click **Close** (.

Reviewing electronic investigations

If your clinic receives lab and other investigation results electronically, your front end staff manually imports results several times daily. When investigations for your patients are imported, you are notified on your WorkDesk. From your WorkDesk, you can then view and respond to your electronic investigation results.

Viewing your electronic investigations

To view your electronic investigations:

1. On the WorkDesk, on the blue notification banner at the top of the window, click **<#> Investigations** (with **<#>** indicating the number of new results available). The EMR displays the Investigation/Document In Basket window with the following information displayed:
 - Your name selected on the **Practitioner** drop-down list.
 - All of your un-reviewed investigations listed in the left column.
 - The first un-reviewed investigation on your list displaying in the main area of the window.

Investigation/Document In Basket

H, Carol PHN: 999

Born: 05-Jul-1924 (90) Sex: M Status: N/A

3364 NW Fair Place, Grandhams BC H C W

Pr: Ray D, MD

Order New Lab Tests Quick Print

Reviewed Redirect To Come In Follow-up Message Patient Summary

☒ Electronic Investigation ☐ Hide Notes

☐ Documents

☐ Incoming Consults

☐ Incoming Referrals

Note:

☐ Declined eReferrals

Practitioner: Ray D, MD

☐ Signed Out

☒ New ☐ Corrected ☐ Abnormal

☐ Date

☒ Include Excellents Text Reports

☐ Patient

Patient: Carol H 999 Born 05-Jul-1924

Reported: 14-Nov-2012 13:20 Collected: 14-Nov-2012 08:41 Specimen Received: 14-Nov-2012 08:41

TSH (Status: Final)

TSH 2.5 (0.38-5.5) mU/L

TOTAL ABS NEUT = NEUTS + BANDS

14/Nov/12 H, Carol

14/Nov/12 J, Bobby

14/Nov/12 C, Zada

14/Nov/12 S, Leigh

14/Nov/12 K, Don

14/Nov/12 A, Emil

14/Nov/12 M, Emmett

13/Nov/12 H, Sharol

13/Nov/12 O, Debo

13/Nov/12 M, Sierra

13/Nov/12 S, Rasheed

08/Nov/12 K, Del

08/Nov/12 K, Del

TrnID: 12-168319033

Filler Order: 12-168319033-TSR-1

Sending Facility: LIFELABS

Sending Application: PATHL7



Excelleris Transcription Reports

If your clinic is set up to receive Transcription Reports from Excelleris electronically, these reports display in the **Electronic Investigations** area. Once you view an Excelleris Transcription Report however, it is saved in the **Documents** area in the patient's Medical Summary. See ["Viewing a patient's documents" on page 73](#).

- To review investigations for another provider, in the **Practitioner** drop-down list, click the provider's name.
- To filter your investigation results list, select one or more of the check boxes, using the following table as a reference:

Filter selection	Results
New (Default selection)	Displays electronic investigations that have not been reviewed.
Corrected	Displays electronic investigations flagged as corrections to previously received investigations.
Abnormal	Displays electronic investigations flagged as abnormal.
Date	Displays electronic investigations for a particular date. Enter a date, OR click  to select a date from a calendar.
Include Excelleris Test Reports	Displays reports you received from Excelleris.
Patient	Displays electronic investigations for a particular patient. Search for a patient using the Patient Search window, OR select a patient name from your list of electronic investigations.

- On the electronic investigations list, click a patient's name. The EMR displays the investigation on the right side of the window, and the patient's SMART patient banner at the top of the window.
- To view a patient's medical record as you review the patient's investigations, click on the SMART patient banner. The EMR displays the patient's Medical Summary, which contains information on:
 - Previous investigation results.
 - Previous medical reports (documents).
 - Problem list.
 - Family history.

6. To simplify your view of an electronic investigation, on the top of the Investigation/Document In Basket window, select the **Hide Notes** check box. The EMR hides the investigation notes.
7. If the result contains a blue link , click the link. The EMR opens the link in your default browser.



Tip: If you want to open the link in another browser (that is not currently set as your default browser), copy and paste the link into the browser you want:

1. highlight the link, and then on your keyboard, press **Ctrl + C** to copy the link.
2. Open the browser you want.
3. Click the address field, and then press **Ctrl + V** to paste the link.

8. To view a running list of a patient's previous results for a particular test, on the investigation click a numeric result, and then click **Patient Summery**. The EMR displays a Microsoft Word window, containing a running list of the patient's previous and current results.

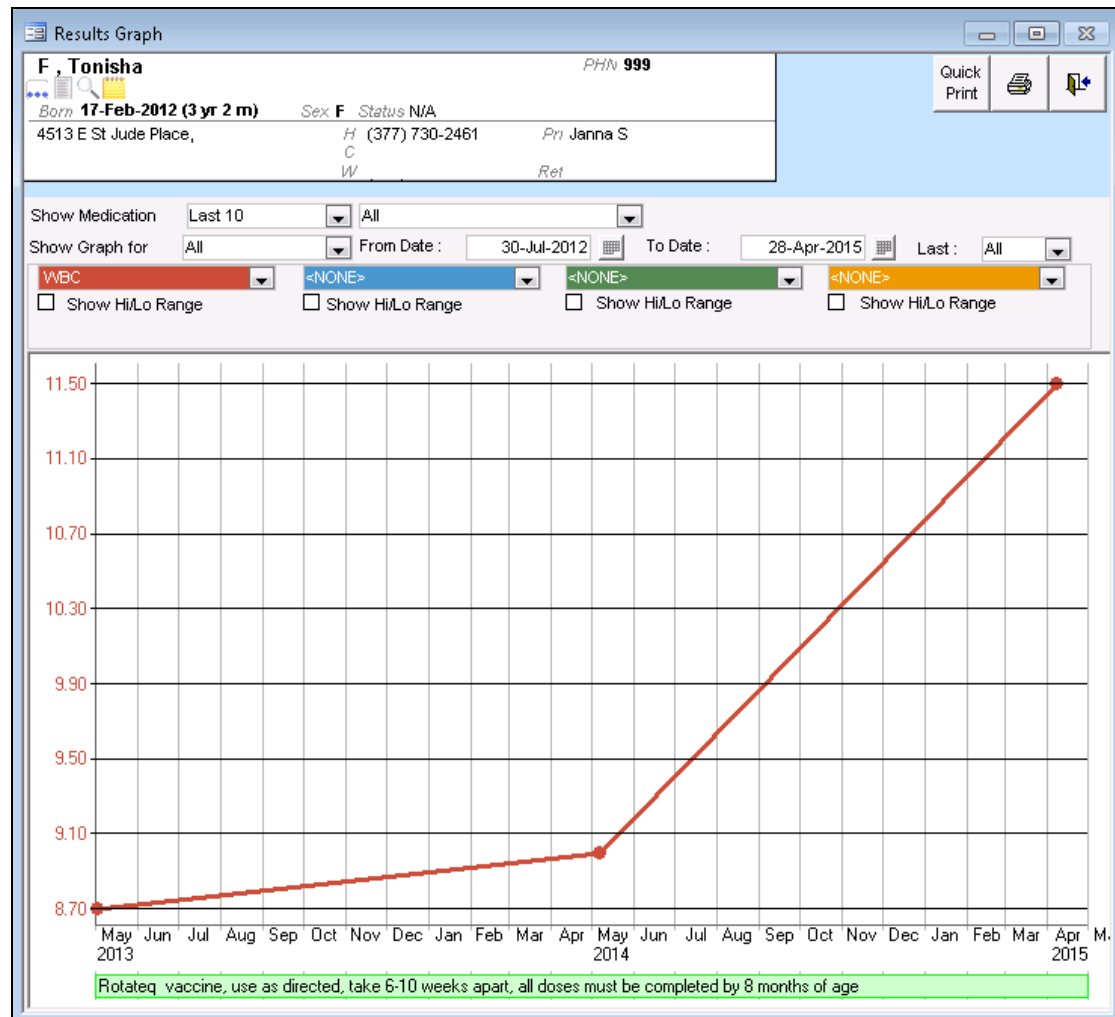
Graphing investigations

From the Investigation/Document In Basket window, you can view investigation results in the form of a graph. This way, you can identify trends and compare a current results to previous results.

To graph a numeric investigation result:

1. Double-click the result. The EMR displays the Results Graph window with a graph of the patient's current and previous results for the selected value. For more information on how to

view and manipulate the graph, see [“Graphing investigations from patient records”](#) on page 71.



Note: If the selected value is an INR, the results display in the Anticoagulation Summary Sheet. This way, you can manage a patient's anticoagulation medication changes right away. See [“Viewing a patient's Anticoagulation Summary Sheet”](#) on page 55.

Adding notes to investigations

You can append electronic investigations by adding notes.

To add notes to an investigation:

1. Open the Investigations/Documents In Basket. See [“Viewing your electronic investigations”](#) on page 32.

2. On your list of investigations, click the investigation you want to add notes to. The EMR displays detailed information about the selected investigation on the right side of the window.
3. At the top of the displayed investigation, in the **Note** field, enter your notes.

ation ☐ Hide Notes

Note:

☐ Declined Referrals

Patient: TonishaFuqua 9992404608 Born 17-Feb-2012
 Collected: 01-May-2013 15:49 Specimen Received: 01-May-2013 15:53

	RESULT	REFERENCE RANGE
COMPLETE BLOOD COUNT (Reviewed By JSS on 02-May-2013)		
HEMOGLOBIN	133	{106 - 145} g/L
HEMATOCRIT	0.39	{0.31 - 0.44} L/L
RBC	4.7	{3.5 - 5.6} 10E12/L
MCV	84	{71 - 90} fL
MCHC	339	{310 - 350} g/L
RDW	12.5	{11.0 - 16.0} %
PLATELET COUNT	331	{150 - 400} 10E9/L
WBC	8.7	{6.0 - 16.0} 10E9/L
NEUTROPHILS	2.0	{0.6 - 5.1} 10E9/L
LYMPHOCYTES	5.9	{2.7 - 12.0} 10E9/L

Moving an investigation to another patient's chart (Administrators)

If an electronic investigation is linked to the wrong patient's chart, you can move the investigation to the correct patient chart.



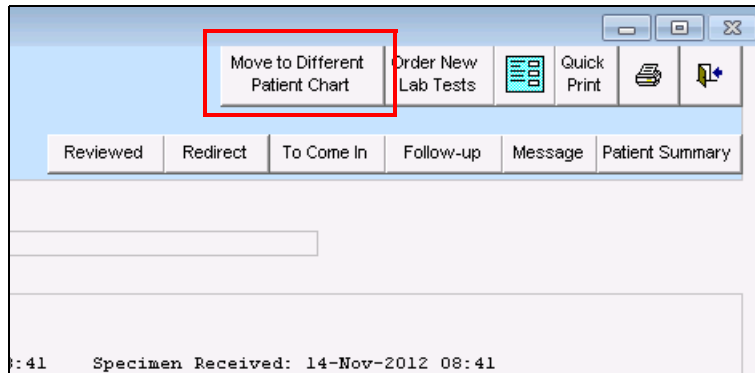
Note:

- Only users with administrative authority in Wolf EMR can move electronic investigation results and reports from one patient to another.
- When you move an investigation, if the investigation is an update to a previously received investigation, the original investigation is moved to the new patient's record as well.

To move an electronic investigation to another patient's chart:

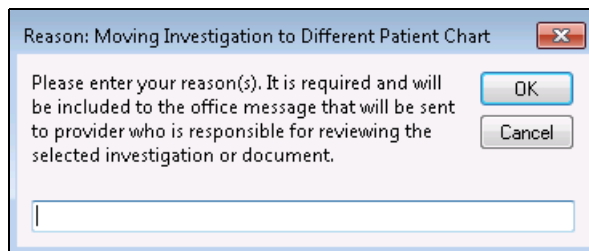
1. Open the Investigation/Document In Basket window. See [Step 1](#) in "Viewing your electronic investigations" on page 32.

- Click the investigation, and then click **Move to Different Patient Chart**.



The EMR displays the Patient Search window.

- Search for and select the patient you want to move the electronic investigation to. The EMR displays a dialog box asking for your reason for moving the investigation.



- Enter your reason, and then click **OK**. The EMR:
 - Moves the electronic investigation to the selected patient's chart.
 - Sends a message to you and to the ordering provider indicating that the investigation has been moved. (The message displays in your Messages List.)

Reviewing your faxed, scanned, and imported documents

Faxed, and mailed documents are scanned by your front end staff and manually imported into Wolf EMR.

As front end staff link documents to your patients, you are notified. You can then view and take action on each document.



Note: If you have electronic faxing set up in your clinic, your front end staff do not have to manually scan the documents, however, they still manually import the PDF documents into your Wolf EMR.

Viewing your incoming documents

When documents are linked to your patients, you are notified on your WorkDesk. You can then view any un-reviewed documents by clicking the notification.

To view your incoming documents:

1. On the WorkDesk, in the blue notification banner at the top of the window, click **<#> Documents** (with <#> indicating the number of new documents available). The EMR displays the Investigation/Document In Basket window with:
 - Your name selected on the **Practitioner** drop-down list.
 - A list of your un-reviewed documents displayed.

Date	Document Type	Keyword One	Keyword Two	Keyword Three	Content Type	Review Note	Patient
18-Jan-2016	Diagnostic Imaging O/R Report						T, Elvis
15-Jan-2016	Diagnostic Imaging MRI					Second opinion report	T, Yadira
11-Jan-2016	Surgical Pathology O/R Report						T, Loura



Tip: If you are viewing your electronic investigations, you can quickly navigate to your documents. In the top left of the Investigations/Documentation In Basket window, click **Documents**.

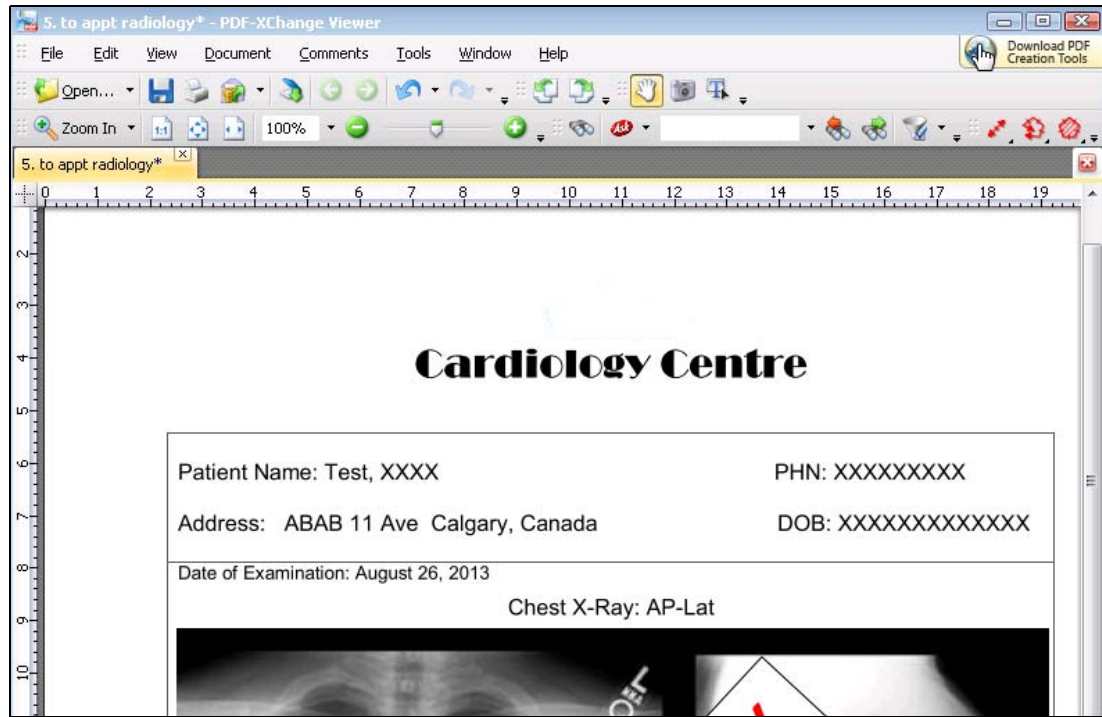
To navigate from your documents back to your electronic investigations, click **Electronic Investigation**.

2. To review documents for another provider, in the **Practitioner** drop-down list, click the provider's name. Otherwise, leave your name selected.
3. To filter the list of documents, use one or more of the options described in the following table.

Filter	Description
New (default selection)	To display only un-reviewed documents, select New .
Reviewed	To display only reviewed documents, select Reviewed .

Filter	Description
All Documents	To display both un-reviewed and reviewed documents, select All Documents .
Search Keywords	To display only documents containing specific keywords, in the Search Keywords field enter the Keyword(s). If you are entering multiple keywords, separate the keywords by a space and then, in the drop-down list to the right, select one of the following options: ■ AND: To indicate that matches must contain all keywords entered. ■ OR: To indicate that matches can contain either of the keywords entered.
Document Type	To display only documents with a specific document type assigned, in the Document Type drop-down list, select the document type.
Date	To display only documents that were received on a particular date: 1. Select the Date check box. 2. In the Date field, enter the date, or to select a date from a calendar, click .
Patient	To display only documents for a particular patient: 1. Select the Patient check box. The EMR displays the Patient Search window. 2. Search for and select the patient.

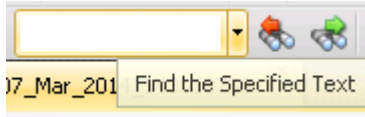
4. On your list of documents, double-click a document to view it. If the document is in PDF format (which most scanned/faxed documents are), the EMR displays the document in the PDF-XChange Viewer window.



Note: If the document is in a format other than a PDF, the EMR opens the appropriate application to display the document. For example, a word document opens in Microsoft Word.

- Using the PDF-XChange Viewer tools, modify the document to improve your view. The following table describes how to use common viewing tools:

Tool	How to use
Zoom 	- Click Zoom Out () to make the document smaller. - Click Zoom In () make the document larger. - Click and drag the marker, located between Zoom Out () and Zoom In (), to the left to zoom out, and to the right to zoom in.

Tool	How to use
Search 	To search a document for a specific word or phrase, 1. In the Find field, located to the left of the binocular icons, enter a search word or phrase, and then press Enter. The PDF XChange Viewer highlights all occurrences of the search term and displays the first occurrence. 2. To view the next occurrence of your search term, Click Find Next (). 3. To view the previous occurrence of your search term. Click Find Previous (. Note: A document is “searchable” only if it has Optical Character Recognition (OCR) applied to it.
Clockwise ()	Click to rotate the selected page of the document 90 degrees in a clockwise direction..
Counterclockwise ()	Click to rotate the selected page of the document 90 degrees in a counterclockwise direction.
Show grid ()	To display a grid over the document view, click View > Show Grid. The PDF XChange Viewer displays a grid over the document. Note: To customize the height and width of the grid lines. Click Edit > Preferences > Measurements.
Show ruler ()	To display a vertical and horizontal ruler, click View > Show Ruler
Distance tool ()	To measure the distance between two points on the document: 1. Click Tools > Measuring tools > Distance Tool. The PDF viewer displays a small cross-hair cursor. 2. Click the starting point and then click-and-drag the cursor to the ending point. 3. Click the end point to finish the measurement. The PDF viewer displays the distance measurements in a measuring tool dialog box.



Note: Some modifications you make to the document using the PDF-XChange Viewer tools are NOT saved. Edits that are not saved include:

- Zoomed view.
- Rotated view.

Edits that are saved include:

- Distance measurements.

6. To close the PDF xChange viewer, click **Close** ().
7. To view more information about a document (for example, if the document was received electronically and you want to view messages sent with the document):
 - a) In the list of documents, click the document, and then click **Document Properties**. The EMR displays the document properties window with associated notes displayed in the **Notes** area.

Document Properties




Document Properties

c:\WolfData\BogusData\scrambled.txt

Link to Referral

Link to Appointment

Document Date:

Document Linked:

07-Mar-2012

Keywords

MRI

Keywords

Keywords

Document Type

Diagnostic Imaging

Review Status:

Reviewed

Review Date:

07-Mar-2012 19:21

Notes:

Content Type:

HL7 Message Details:

*** NOT received electronically from data sources ***

Lemon, Jodi



Note: If the document was received via electronic import, the EMR displays additional document details and messages in the **HL7 Message Details** area.

You cannot modify this information.

- b) To close the Document Properties window, click **Save Document Settings and Close**

Form ()

Adding notes and markups to a document

You can add notes and mark-ups on a document directly, or add notes to the document's properties.

Adding notes and markups directly on a document



CAUTION: Notes added on a document directly are visible only when the document is open in the PDF-XChange Viewer.

To add notes and markups to a document:

1. Open the Investigation/Document In Basket window to view your un-reviewed documents. See [“Viewing your incoming documents” on page 38](#).
2. On your list of un-reviewed documents, double-click a document to view it. The EMR displays the document in the PDF-XChange Viewer window.
3. At the top of the PDF-xChange Viewer window, click **Tools**. The PDF-XChange Viewer displays a list of tool categories.
4. Click **Comment And Markup Tools**. PDF-XChange Viewer displays a list of comment and markup tools.
5. On the list of comment and markup tool, click the tool you want to use. The PDF-XChange Viewer enables the use the selected tool on the document.
6. Procedures on how to use some of the more commonly used tools are outlined in the table below:

Tool	How to use
Sticky Note 	To add a “sticky note” containing your comments: ■ Click Sticky Note Tool. The PDF viewer changes your cursor to a “sticky note cursor”. ■ Place the cursor where you want the note and click it. The PDF viewer displays a pop-up note. ■ Enter your notes into the light coloured area of the pop-up note.
Typewriter 	To add “typewriter-like” text directly onto the PDF: ■ Click Typewriter Tool. ■ Click the starting position for the text entry and then enter your note text. ■ Press Enter to start a new line.

Tool	How to use
Text Box 	To add a text box containing your comments: ■ Click Text Box Tool. The PDF viewer changes your cursor to a cross cursor. ■ Click to start a text box and drag down and to the right to expand the box. ■ Click inside the box and then enter your comments.
Callout ()	To add a text box with an arrow pointing to a selected location on the page: ■ Click Callout Tool. ■ Move your cursor to where you want the point of the arrow to display. ■ To expand the arrow and text box, click and then drag the resulting text box away from the click point. ■ Double-click inside the box, and then enter your comments. Note: You can adjust the dimensions of the text box and arrow as needed. Click the small boxes to grab and adjust the size.
Highlight Text 	To highlight selected text on the document: ■ Click Highlight Text Tool. The PDF viewer changes your cursor to a selection cursor. ■ Click and drag the selection cursor over the text to be highlighted. ■ Release your mouse button. The selected text displays with highlighted colour. Note: You cannot highlight image-based text. The document must have OCR applied.
Underline text 	To underline selected text on the document: ■ Click Underline Text Tool. The PDF viewer changes your cursor to a selection cursor. ■ Click and drag the selection cursor over the text to be underlined. ■ Release your mouse button. The selected text displays with an underline.



Note: All comments and mark-ups can be saved and then viewed when opened at a later time.



Note: Detailed information on how to use the PDF Viewer is available from the PDF window:

- In the PDF viewer click **Help > Contents**. The PDF viewer displays a link to the user guide web page called “**PDF-XChange Viewer Help File (English)**”.

7. On PDF-XChange Viewer, click **Close** (). If you made changes to the document, the EMR displays a dialog box with the following prompt: “The document [document name] was changed. Do you want to save changes before closing?”.
8. To save your comments and mark-ups, Click **Yes**.

Adding notes to a document's properties



Note: Notes added to a document's properties can be viewed in the **Documents** tab of the patient's Medical Summary without having to open the document. See [“Viewing a patient's documents” on page 73](#).

To add notes to a document's properties:

1. Open the Investigation/Document In Basket window. See [“Viewing your incoming documents” on page 38](#).
2. On the list of un-reviewed documents in the Investigation/Document In Basket window, click the document you want to add notes to.
3. In the **Notes** field at the top of the window, enter your notes.
4. Click .

Modifying document properties

Unlike electronic investigations, where results are automatically labelled, categorized, and assigned to the appropriate patient (based on healthcare number); Documents are manually viewed, assigned to a patient, and labeled/ categorized by your front end staff.

An unfortunate consequence of this manual process for importing documents, is that documents can be labeled or categorized inaccurately.

As you review your incoming documents, you can modify the following properties for a document if needed:

- Document type
- Document keywords
- Link to a referral - used only if the document is a consultant's report.

- Link to an appointment
- Notes
- Document date

To modify a document's properties:

1. Open the Investigation/Document In Basket window, and then view the document. See ["Viewing your incoming documents" on page 38](#).
2. Click **View Document Properties**. The EMR displays the Document Properties window.

3. Add or modify information in the Document Properties window, using the following table as a reference:

Field	Description
Link to Referral	To link the document to a specific referral, in the drop-down list, click the referral. Note: When you link a document to a referral, Wolf EMR assumes you are attaching the consultant's report and marks the referral as Completed .
Link to Appointment	To link the document to an appointment, in the drop-down list, click the appointment.
Document Date	Enter the date the document was written (date on document itself).

Field	Description
Document Linked	The EMR displays the date that the document was linked to the patient's record. Note: You cannot modify this information.
Keywords	In the drop-down list(s) click a keyword to identify the document. If the Keyword you want is not available, in the field, enter the Keyword. Note: Consistent keywords enable you to identify and search documents easier. Avoid entering a keyword manually unless absolutely necessary.
Document Type	In the drop-down list, click the document type.
Notes	Enter any notes regarding the document.

4. Click .

Sharing documents on the Patient Portal

If you share medical information with your patient's using the Patient Portal, incoming documents are not published to the Patient Portal automatically. Instead, you manually publish each document to the Patient Portal after you have viewed it.

To publish a document to the Patient Portal:

1. Open the Investigation/Document In Basket window, and then view the document. See ["Viewing your incoming documents" on page 38](#).

2. In your list of documents, click the document, and then click **View Document Properties**. The EMR displays the Document Properties window.

3. Select the **Publish to Portal** check box.

4. Click .



Note: If you no longer want to share the document on the Patient Portal, you can remove the document at any time by clearing the **Publish to Portal** check box.

Moving a document to another patient's record

If a document is attached to the wrong patient's record, you can un-link a document from a patient's record and send it back to the queue. Your front end staff can then re-link the document to the correct patient's record.

To unlink a document from a patient's record:

1. Open the Investigation/Document In Basket window, and then view the document. See ["Viewing your incoming documents" on page 38](#).

2. On the list of un-reviewed documents, click the document you want, and then click **View Document Properties**. The EMR displays the **Document Properties** window.
3. Click **Delete** (). The EMR displays a dialog box with the following prompt: "Click 'Yes' to move document to 'UnlinkedDocuments' folder, click 'No' to move document to 'DeletedDocuments' folder, click 'Cancel' to exit"
4. Click **Yes**. The EMR displays a dialog box with the following prompt: "Are you sure you want to unlink [document name] and move it to folder W:\Wolfdata\UnlinkedDocuments"
5. Click **Yes**. The EMR moves the document to the UnlinkedDocuments folder, and notifies your front end staff that there is a document in the UnlinkedDocuments folder.

Deleting a document

If a document is irrelevant to a patient's care, and you want to remove it both from the patient's record and from your system ("shred it"), you can delete a document.

To delete a document:

1. Open the Investigation/Document In Basket, and then view the document. See ["Viewing your incoming documents" on page 38](#).
2. On the list of un-reviewed documents, click the document, and then click **View Document Properties**. The EMR displays the **Document Properties** window.
3. Click **Delete** (). The EMR displays a dialog box with the following prompt: "Click 'Yes' to move document to 'UnlinkedDocuments' folder, click 'No' to move document to 'DeletedDocuments' folder, click 'Cancel' to exit".
4. Click **No**. The EMR displays a dialog box with the following prompt: "Are you sure you want to unlink [document name] and move it to folder W:\Wolfdata\DeletedDocuments."
5. Click **Yes**. The EMR removes the document from the patient's record and moves it to the 'Deleted Documents' folder.



If you delete a document in error, you can recover it from your **DeletedDocuments** folder.

Responding to electronic investigations and documents

After you view an electronic investigation or document, you can respond to it by marking it as reviewed ("signed-off"), or by initiating an action for it. Actions include:

- Redirecting to another provider

- Sending a request for the patient **To Come In**
- Sending a **Follow Up** task
- Sending a **Message**

To respond to your investigations and documents:

1. Perform one of the following actions:
 - To respond to an investigation, view the investigation result. See [“Viewing your electronic investigations” on page 32.](#)
 - To respond to a document, view the document. See [“Viewing your incoming documents” on page 38.](#)
2. On the top right corner of the Investigation/Document In Basket window, click an action, using the following table as a reference:

Option	Scenario(s)	Results
Reviewed	■ Result is normal. ■ You are CC'd on a result pertaining to a patient who belongs to a provider from another clinic.	■ The investigation/document no longer displays as “new” in your Investigation/Document In Basket. ■ The investigation/document posts to the Investigations or Documents tab of the patient's Medical Summary.
Redirect	■ Result pertains to a patient belonging to another provider in your clinic.	■ The investigation/document moves to another provider's Investigation/Document In Basket and disappears from yours. Note: You can only redirect labs to providers who are set up to receive labs in Wolf EMR.

Option	Scenario(s)	Results
To Come In	A patient has an abnormal result. You want to notify your staff to call-back the patient, and simultaneously create a reminder to yourself to discuss the result during the patient's next visit.	Both you <u>AND</u> your front end staff receive notifications to follow up with the patient: Front-end Staff: The patient displays on their Patient's To Notify list. (Prompting them to call the patient to come back for a follow up visit.) Provider: Patient displays on your follow-up list. (Prompting you to discuss the patient's test results when they come back for their follow-up visit.) - The Investigation/document posts to the Investigations or Documents tab of the patient's Medical Summary. - On the SMART Banner of the patient's medical record there is an indication that the patient has an outstanding follow-up item. - The investigation/document no longer displays as "new" in your Investigation/Document In Basket.
Follow up	A patient has an abnormal result, however, you know that the patient already has an appointment booked tomorrow. You want to remind yourself to discuss the result, but do not need to notify your front end staff to call-back the patient.	- A follow-up item displays on your's or another user's follow-up list depending on who you assign the Follow-up to. - Investigation or document no longer displays as "new" in your Investigation/Document In Basket. - The investigation/document posts to the Investigations or Documents tab of the patient's Medical Summary.

Option	Scenario(s)	Results
Message	You want to talk to a colleague about an investigation result before you act on it.	- A message displays on either your's or another user's message list depending on who you send the message to. - The investigation/document no longer displays as "new" in your Investigation/Document In Basket, - The investigation/document posts to the Investigations or Documents tab of the patient's Medical Summary.



Note: For more information on how to use and modify messages and tasks, see: ["Clinic communications and tasks" on page 79.](#)



Tip: If the options for **Reviewed**, **Redirect**, **To Come In**, **Follow Up**, or **Message** do not display, than this indicates that the results have already been reviewed, or were manually entered.

3. After you finish viewing and responding to your electronic investigation results and

documents, click **Save & Close** ()



Tip: If you mark an investigation as reviewed by mistake, you can "bring it back" if need be:

- In the filter list area of the Investigation/Document In Basket window, clear the **New** check box.
- Select the **Date** check-box, and then enter the date that the investigation came in on. The EMR displays all reviewed and un-reviewed investigations for the selected date.
- Send a message, or a follow-up task regarding the reviewed lab:
 - On the displayed investigation in the Investigation/Document In Basket window, right-click. The EMR displays the **SMART Menu**.
 - Click **New Message**, or **New Follow-up**.

Managing INR results (Physician-managed)

If you receive an INR result, using the Anticoagulation Summary Sheet, you can view and manage the patient's:

- INR history
- Anticoagulation medication instructions
- Follow-up instructions

You can access the Anticoagulation Summary Sheet directly from the INR result in the Investigation/Document In Basket window.



Note: **INR** stands for “International Normalized Ratio” and is used to determine the clotting tendency of the blood.

Viewing a patient's Anticoagulation Summary Sheet

To view a patient's anticoagulation summary sheet:

1. View your investigations. See [“Viewing your electronic investigations” on page 32](#).
2. On your list of investigations in the Investigation/Document In Basket window, click an investigation containing an INR result. The EMR displays the investigation on the right side of the window.
3. Double-click the numeric INR result. The EMR displays the patient's Anticoagulation Summary Sheet window.
4. On the Anticoagulation Summary Sheet, click the **Text** tab (if it is not already displayed). The EMR displays the following information:
 - **Previous Directions:** most recent Anticoagulation medication instructions given to the patient.
 - Current and historic INR results.
 - Anticoagulation medication dose and frequency at the time of each INR result.
 - INR follow-up instructions for each INR result.
 - Anticoagulation medication adjustment instruction for each INR result.

Anticoagulation Summary Sheet

B, Armand PHN 999

Born 18-Nov-1946 (68) Sex M Status N/A

8995 E Place, Hazelton BC H C W Pri N Joe, M.D.

Diagnosis: **Atrial Fibrillation Paroxysmal** View Current Anticoagulant Prescriptions

Most Recent Directions: 6mg daily

Initiation: Termination: Range: To:

Graph Text

INR Result and Adjustment	Follow Up	Patient Instructions and Callback Log
13-Nov-2012 2.7 Electronic Result 0 Adjustment	Called	
25-Oct-2012 1.7 Electronic Result 0 Adjustment	Called 25-Oct-2012 15:19	5 mg every day ... lab in 2 weeks
24-Aug-2012 2.4 Electronic Result 0 Adjustment	Called 25-Aug-2012 10:39	same dose ... 1 month
24-Jul-2012 2.0 Electronic Result 0 Adjustment	4 weeks Called 25-Jul-2012 22:07	same dose 1 month Follow Up: 4 weeks pt notified. 26jul2012. sc
28-Jun-2012 2.5 Electronic Result 0 Adjustment	Called 30-Jun-2012 12:47	same dose ... 2 weeks
		same dose 1 week



Note: If a patient has not received an INR result, the table appears blank.



Tip: A patient's most recent INR and corresponding anticoagulation medication dosage displays at the top of the table in blue.

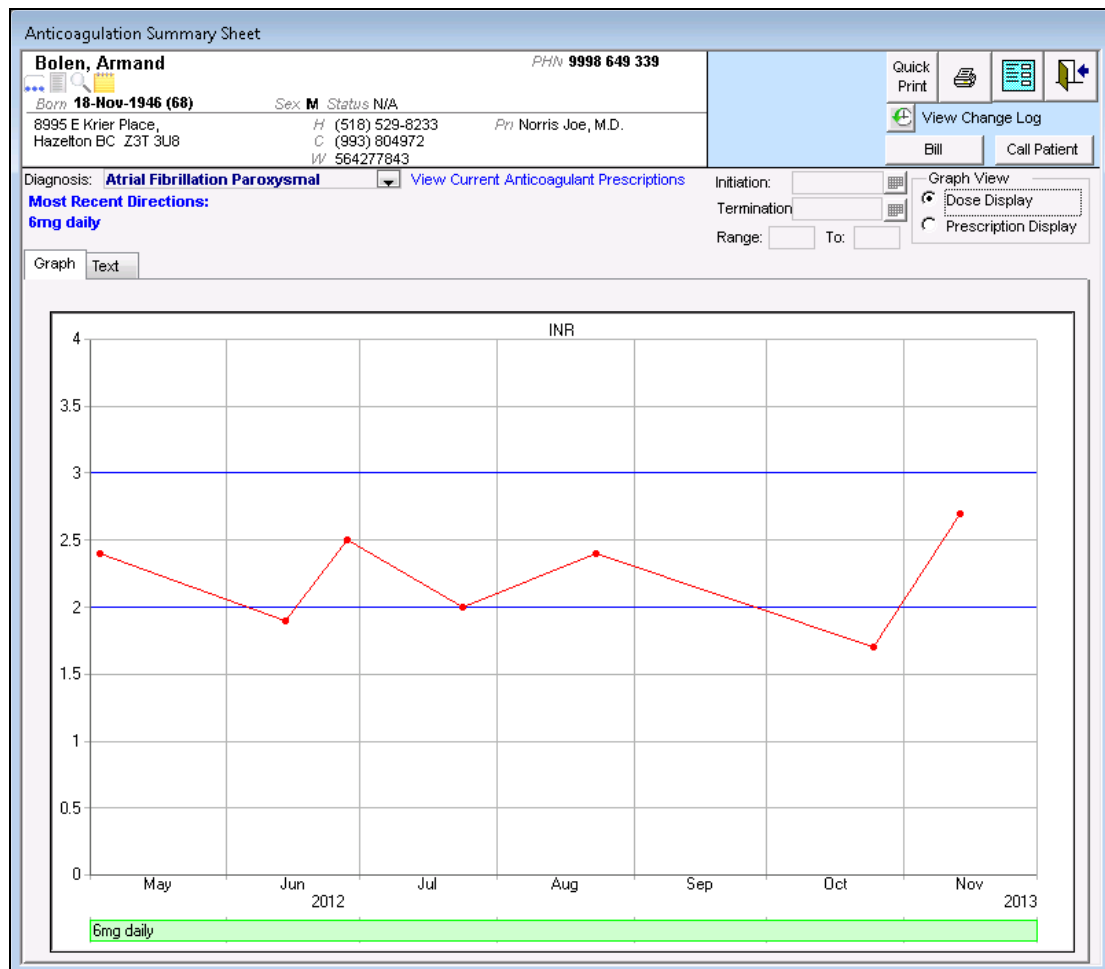
- To view the patient's latest anticoagulation medication prescription, click **View Current Anticoagulant Prescriptions**. The EMR displays the Anticoagulant Medication List window, with a the patient's current and historic anticoagulation prescriptions listed.

- When you are finished, click **Save & Close** ()

Graphing a patient's INR results

To graph a patient's INR results:

1. On the Investigation/Document In Basket window, open the patient's Anticoagulation Summary Sheet. See [“Viewing a patient's Anticoagulation Summary Sheet” on page 55.](#)
2. On the Anticoagulation Summary Sheet, click the **Graph** tab. The EMR displays a graph of the patient's current and historic INR results.



Note: Anticoagulation dosage information, displayed at the bottom of an INR graph, originates from the dosage instructions (“INR Result Adjustment” column) in the **Text** tab of the Anticoagulation Summary Sheet window.

3. To display the patient's anticoagulation medication details on the graph, click **Dose Display**. The EMR displays the patient's anticoagulation medication details at the bottom of the graph.

4. To display the patient's INR targets, in the **Range** fields at the top of the window, enter the "normal" or "goal" INR minimum and maximum value. The EMR displays horizontal blue lines on the graph at the minimum and maximum INR values entered.
5. To display the Hover your cursor over a data point on the INR graph. The EMR displays the exact INR value and date for the data point.
6. Click **Save & Close** () when you are finished.

Modifying a patient's INR test and anticoagulation medication instructions

To modify a patient's INR test and anticoagulation medication instructions:

1. Open a patient's Anticoagulation Summary Sheet. See ["Viewing a patient's Anticoagulation Summary Sheet" on page 55](#).
2. On the Anticoagulation Summary Sheet window, click the **Text** tab.
3. In the **Diagnosis** drop-down list, click the patient's associated diagnosis (if not already selected.)



Note: Only diagnosis' that have been previously added to the patient's problem list are available to select. To add a new diagnosis on the fly:

1. At the top of the problem list, click **<<Add New Problem>>**. The EMR displays the Problem List window.
2. In the Problem List window, enter a diagnosis. See ["Recording problems" on page 395](#).

4. In the top entry of the INR table, in the **Follow Up** drop-down list, click a recommended time until the next patient follow up visit.
5. To indicate that the patient is instructed to maintain their current anticoagulation medication dose, in the **INR Result and Adjustment** column, in the drop-down list, click **No Adjustment**. The EMR displays the text "Continue with Current Dose" in the **Patient Instructions and Callback Log** column.



Note: If this is the first time a patient's dose instructions are being adjusted on the Anticoagulation Summary Sheet, than you can only select **Adjust Anticoagulant**, and then enter the current instructions.

6. To indicate that the patient is instructed to change their current anticoagulation medication dose:
 - a) In the **INR Result and Adjustment** column, in the drop-down list, click **Adjust Anticoagulant**. The EMR displays the Enter new Anticoagulant dosage window.

- b) In the **New Dosage** field, enter the anticoagulation medication dosage directions.
- c) Click . The EMR displays the text “MEDICATION ADJUSTMENT: <medication name and dosage instructions>” in the **Patient Instructions and Callback Log** column.
7. To enter additional instructions to the patient, in the **Patient Instructions and Callback Log** column, enter the instructions (for example, “INR in 2 weeks”).
8. To indicate that the patient is to stop taking their anticoagulation medication indefinitely, in the **Termination** field at the top of the Anticoagulation Summary Sheet window, enter a termination date.
9. To close the Anticoagulation Summary Sheet, click **Save & Close** ().
10. Mark the INR result as reviewed:
 - a) On the Investigations/documents In basket window, in your list of investigations, click the INR patient's name. The EMR displays the INR result on the right.
 - b) Click **Reviewed**. The EMR removes the investigation from your new investigations list.

Managing patient INR communications

After you view a patient's INR results and indicate if, and how, anticoagulation medication dose is to be changed, the patient is informed of the new medication dose.

You can mark the patient as **Called** if you call the patient personally, or inform the patient during a schedule visit.

You can also send your front end staff a message to call the patient for you. In this case, the front end staff mark the patient as **Called** after the task is completed.

Notifying your front end staff to contact a patient for INR instructions

To notify your front end staff to contact a patient regarding INR instructions:

1. Open a patient's Anticoagulation Summary Sheet. See [“Viewing a patient's Anticoagulation Summary Sheet” on page 55](#).
2. Enter a patient's follow up, INR test, and medication instructions. See [“Modifying a patient's INR test and anticoagulation medication instructions” on page 58](#).
3. At the top of the Anticoagulation Summary Sheet window, click **Call Patient**. The EMR displays a New Message window for the patient, with text from the **Patient Instructions**

and **Callback Log** column of the Anticoagulation Summary Sheet displayed in the **Message** text area.

New Message For: Bolen, Armand

Message

Quick Print [Icons]

To: <<All Employees>>
 Physician C, Shaunda
 Staff D, Cory
 Patient E, Donna
 Group F, Elinore
 Multiple H, Madge
 M, Monte

From: Patient
 Consultant
 Family Member
 Clinic MD
 Staff
 Other

Clinic MD:
 B, Dewayne, M.D.

Re: Patient
 Other

B, Armand PHN: 999
 Born 18-Nov-1946 (68) Sex: M Status: N/A
 8995 E Place, H C Pri: N Joe, M.D.
 Hazelton BC W

Message:
 INR result : 2.7 (13-Nov-2012)
 Adjustment : Adjust Anticoagulant
 Dosage : 3mg daily
 Patient instructions :
 MEDICATION ADJUSTMENT: 3mg daily

Notes:

Response:
 Message Left
 No Answer
☐ Completed

Please Call Back
 Will Call Again
 For Your Information

Routine
 Important
 Urgent

- On the New Message window, in the **To** area, click the individual or group who you want the message to go to.



Best Practice: If several users in your clinic help with contacting INR patients, create a security group called INR. You can then address "Call Patient" messages to the INR group. For more information on setting up security groups, see the Wolf EMR Online Help.

- In the **Message** area, enter or modify the text of the message as needed.



- Click **Close & Save Message** (). The EMR sends the message to the recipient.

Responding to an INR "Call Patient" message (nurses and MOA's)

To respond to an INR "Call Patient" message:

1. On your **Current Messages** list in the **Message** area of your WorkDesk, double-click the INR-related message. The EMR displays the Message List window with the selected message displayed on the right side of the window.

The screenshot shows the 'Message List' window in an EMR system. The window has a title bar 'Message List' and a toolbar with icons for 'Show Filters', 'Quick Print', and others. Below the toolbar is a list of messages with columns: Date, Patient, To, From, and To. The selected message is dated 10-Sep-2014 14:35, from Test-R, INR, to Dana Know-Four, MD. The message content is displayed on the right side of the window. The message is a 'Routine Message' for 'Test-R, INR' entered by Dana Know-Four, MD on 10-Sep-2014 14:35. The message content includes: 'INR result : 3.3 (16-Oct-2013)', 'Adjustment : Adjust Anticoagulant', 'Dosage : Warfarin (Coumadin TAB) 1 mg i PO OD', 'Patient instructions :', and 'Follow Up: 1 week'. There are also fields for 'Notes' and 'Log' with a 'Completed' checkbox. On the right side of the message view, there are buttons for 'Completed', 'Message Left', 'No Answer', and 'ReDirect...'. The patient information on the right includes 'Test-R, INR', 'Born 10-Jun-1987 (27)', 'Sex: M', 'Status: N/A', and 'Pri: Rod Arreola, MD'.

Date	Patient	To	From	To
02-Nov-2013 15:54	Test, Frank	David Know-One, MD	All P	
03-Nov-2013 09:41	Test, Andrea	Dana Know-Two, MD	All P	
03-Nov-2013 10:37	Test, Mother	David Know-Three, MD	Dana	
06-Mar-2014 14:20	Test, Father	Brian Hoover, MD, FCF...	Dana	
18-Apr-2014 09:27	Jessica, Test	Know-Four, Sam	Dana	
10-Sep-2014 14:35	Test-R, INR	Dana Know-Four, MD	Dana	

Routine Message For Your Information

From: Dana Know-Four, MD
To: Dana Know-Four, MD

Test-R, INR

Born: 10-Jun-1987 (27) Sex: M Status: N/A
H C W Pri: Rod Arreola, MD
Fam Ret

Message: Entered by: Dana Know-Four, MD (10-Sep-2014 14:35)

INR result : 3.3 (16-Oct-2013)
Adjustment : Adjust Anticoagulant
Dosage : Warfarin (Coumadin TAB) 1 mg i PO OD
Patient instructions :
Follow Up: 1 week

Notes:

Log:

Completed: ☐

Completed
Message Left
No Answer
ReDirect...

2. Review the message and call the patient.
3. On the displayed message, right-click. The EMR displays the **SMART Menu** for the patient whom the message pertains to.
4. Click **View INR Summary**. The EMR displays the patient's Anticoagulation Summary Sheet window.
5. Click the **Text** tab, (if it is not selected already).
6. In the top entry in the table of INR results and anticoagulation medication instructions, click **Called**. The EMR posts the current date and time in the adjacent field.
7. Click **Save & Close** (). The EMR closes the Anticoagulation Summary Sheet window, and displays the INR message once more.
8. On the displayed INR message, click **Completed**. The EMR removes the message from your **Current Messages** list.

Billing for INR management

You can bill for INR management directly from the Anticoagulation Summary Sheet.

To Bill for INR management:

1. Open a patient's Anticoagulation Summary Sheet. See ["Viewing a patient's Anticoagulation Summary Sheet" on page 55](#).
2. On the top right of the Anticoagulation Summary Sheet window, click **Bill**. The EMR displays the Billing window, with the following information populated in the bill:

- Current MD's name
- Patient's name
- **Bill To:** Medical Services Plan BC
- **Fee code:** 43
- **ICD9 code:** 9642

*Payee #: 12345-

*Bill To: Medical Services Plan BC

*New Bill Patient: Test, Richard 37

*Fee Code / Desc: 43 *%Billed: 6.62% *%Locum: 100% %: 0%

43 - ANTICOAGULATION THERAPY

☐ Hospital ☐ MVA *Units: 1

*ICD9 Code / Desc: 9642 9642 - ANTICOAGULANTS

Service Location: A-Practitioners Office - In Community

Facility: <Unknown>

Buttons: Save, Save+New

3. Make additions or edits to the bill as needed, and then click **Save**.

4. To close the billing window, click **Close** (.

Managing INR results (Nurse-managed)

Nurses track and manage patient INR results and Anticoagulation medication adjustments in a different manner than providers do. Nurses monitor a daily report detailing new INR results that have come in for their providers.

From this report, nurses can open a patient's record and view and modify a patient's Anticoagulation Summary Sheet.



INR stands for “International Normalized Ratio” and is used to determine the clotting tendency of the blood.

Creating an INR Practice Search

To create an INR practice search:

1. On the Wolf EMR Launch Page, click **Practice Search** (). The EMR displays the Practice Search window.
2. Click **Make a New Search** (). The EMR displays a dialog box with the following prompt: “Are you sure that you want to clear the Current Search? This Operation cannot be undone.”
3. Click **Yes**.
4. In the top field, enter **Daily INR report** as the name of the search.
5. In the **Select Search Parameters** list, expand **History**.
6. Click **Lab Results (Any)**. The EMR displays a **History** criteria window on the right.
7. In the **of Type** drop down list, click **INR ***.
8. Clear the **With Value** check box.
9. Select the **Observed** check box.
10. In the **Observed** drop down list, leave **In Last** selected.

11. In the field to the right of the observed, enter **1**, and then in the drop down list, click **days**.



Tip: If you perform a search for INR results on a Monday, or following a holiday you can change the **Observed** options to “2 days” or more depending on how many days have passed since you last produced a report.

12. Click **Save Current Search** (📁). The EMR displays the **Save Current Search As** window.

13. Click **Save as New**. The EMR displays a dialog box with the following text: “Search was Saved Successfully”.



Tip: For more information on creating patient search criteria, see Wolf EMR Online Help.

Viewing the daily INR summary report



Note: Always complete an electronic investigation **Import** before viewing the Daily INR report. This way, you know that the report pulls all lab results released up until the moment the report is run.

To view the daily INR summary report:

1. On the Wolf EMR Launch page, click **Practice Search** (). The EMR displays the Practice Search window.
2. Click **Open Saved Search or Rule** (). The EMR displays the Open Saved Search or Rule window.
3. In the list of searches, click **Daily INR report**.
4. Click **Open Selected**. The EMR displays the Practice Search window, with the Daily INR report criteria displayed.



Tip: If you are viewing the Daily INR report more than 1 day after you have viewed the last Daily INR report, then adjust the practice search criteria to show patient's who have received INR results in 2 or more days:

- In the **History** criteria area, beside the **Observed** check box, change the value to **2**.

5. Click Show **Search Results as a Patient List** (). The EMR displays a list of patients who have received an INR result in the past 24hours.



Tip: You can adjust the columns you see in the produced report. To add a column:

- On the patient list, click **View > Column Options**.
- On the left side, click a view that contains the columns you want to see, OR click **Add**, to add a new view.
- To add a column to your report view, in the **View Columns** area, click Add.
- To remove a column from your report view, in the **View Columns** area, click **Remove**.

6. When you are finished viewing the report, click **Close** ().

Viewing a patient's Anticoagulation Summary Sheet from an INR report

To view a patient's Anticoagulation Summary Sheet:

1. Open the daily INR summary report. See [“Viewing the daily INR summary report” on page 65](#).
2. On the INR summary report, double-click a patient's name. The EMR displays the patient's Medical Summary.
3. On the Medical Summary window, right-click. The EMR displays the SMART Menu list.
4. On the SMART Menu list, click **View INR Summary**. The EMR displays the Anticoagulation Summary Sheet window.
5. View the Anticoagulation Summary Sheet. See [Step 4](#) to [Step 6](#) in [“Viewing a patient's Anticoagulation Summary Sheet” on page 55](#).

Graphing a patient's INR results from an INR report

To graph a patient's INR results from an INR report:

1. Open the patient's Anticoagulation Summary Sheet, see [“Viewing a patient's Anticoagulation Summary Sheet from an INR report” on page 65](#).
2. On the Anticoagulation Summary Sheet, click the **Graph** tab. The EMR displays a graph of the patient's current and historic INR results.
3. Modify your view of the graph as needed. See [Step 3](#) to [Step 6](#) in [“Graphing a patient's INR results” on page 57](#).

Modifying a patient's INR test and anticoagulation medication instructions

To modify a patient's INR test and anticoagulation medication instructions:

1. Open a patient's Anticoagulation Summary Sheet. See [“Viewing a patient's Anticoagulation Summary Sheet from an INR report” on page 65](#).
2. In the **Text** tab, enter instructions for medication adjustments and INR testing frequency. See [Step 3](#) to [Step 9](#) in [“Modifying a patient's INR test and anticoagulation medication instructions” on page 58](#).

Managing patient INR communications

After you view a patient's INR results and indicate if and how anticoagulation medication dose is to be changed, you can:

- Mark the patient as **Called** (if you call the patient personally)
- Remind yourself to inform the patient during an upcoming scheduled visit.
- Send yourself, another user, or a group of users a message to contact the patient.

Indicating that the patient has been notified of changes

To indicate that a patient has been notified of any follow up, INR test, or anticoagulation medication dose changes:

1. Open a patient's Anticoagulation Summary Sheet. See ["Viewing a patient's Anticoagulation Summary Sheet from an INR report" on page 65](#).
2. Click the **Text** tab, (if it is not selected already).
3. On the most recent entry in the table of INR results and anticoagulation medication instructions, click **Called**. The EMR posts the current date and time in the adjacent field.
4. Click **Save & Close** (). The EMR closes the Anticoagulation Summary Sheet window, and displays the INR message once more.

Reminding yourself to contact a patient at a later time

To remind yourself to contact a patient:

1. Open a patient's Anticoagulation Summary Sheet window. See ["Viewing a patient's Anticoagulation Summary Sheet from an INR report" on page 65](#).
2. Enter a patient's follow up, INR test, and medication instructions. See ["Modifying a patient's INR test and anticoagulation medication instructions" on page 66](#).
3. On the top of the Anticoagulation Summary Sheet window, click **Call Patient**. The EMR displays a New Message window, with text from the **Patient Instructions and Callback Log** column of the Anticoagulation Summary Sheet is displayed in the **Message** text area.
4. In the **To** lists of the New Message window, click your name.
5. In the Message area, enter or modify the text of the message as needed.
6. Click **Save & Close** (). The EMR adds the message to your WorkDesk message list.

Notifying another user or group to contact a patient

To notify another user or group of users to contact a patient:

1. Open a patient's Anticoagulation Summary Sheet window. See ["Viewing a patient's Anticoagulation Summary Sheet from an INR report" on page 65](#).
2. Enter a patient's follow up, INR test, and medication instructions. See ["Modifying a patient's INR test and anticoagulation medication instructions" on page 66](#).
3. On the top of the Anticoagulation Summary Sheet window, click **Call Patient**. The EMR displays a New Message window, with text from the **Patient Instructions and Callback Log** column of the Anticoagulation Summary Sheet is displayed in the **Message** text area.

4. In the **To** lists of the New Message window, click a specific user, or group.



Best practice: If several users in your clinic help with contacting INR patients, create a security group called INR. You can then address “Call Patient” messages to the INR group.

5. In the **Message** area, enter or modify the text of the message as needed.



6. Click **Save & Close** (). The EMR adds the message to your WorkDesk message list.

Addressing your INR “Call Patient” tasks

To respond to an INR “Call Patient” message, follow the procedure outlined in [“Responding to an INR “Call Patient” message \(nurses and MOA’s\)” on page 60.](#)

Billing for INR management - nurse managed

To bill for INR management:

1. Open a patient’s Anticoagulation Summary Sheet window. See [“Viewing a patient’s Anticoagulation Summary Sheet from an INR report” on page 65.](#)
2. Bill for INR management. See [Step 2 to Step 4 of “Billing for INR management” on page 62.](#)

Viewing a patient’s investigations and documents during their visit

When a patient returns for a follow up visit, you can view the patient’s current and historic investigations and documents in their Medical Summary.

Also, if a patient has un-reviewed investigations and documents, you can access them from any window of the patient’s medical record via the SMART banner.

When you view investigations and documents, you can print the results, and give them to the patient as a reference.

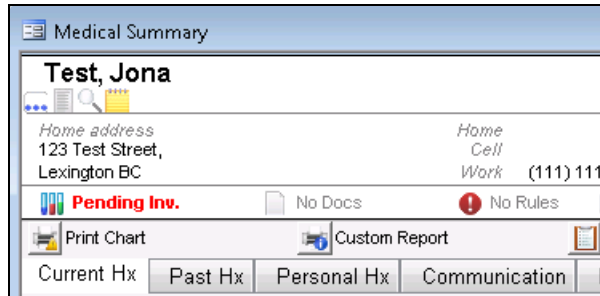
Viewing un-reviewed investigations and documents from a patient’s medical record



Best practice: Make sure you have no un-reviewed investigations or documents outstanding for a patient before or during a patient visit.

To view un-reviewed investigations or documents for a patient:

1. On any window of the patient's medical record (for example, the Medical Summary, SOAP form, or Consult letter form), in the SMART patient banner, identify if the words **Pending Inv.**, or **Unrev. Docs** are displayed.



Note: If you see **No Inv.** and **No Docs** displayed in the notification bar of the Medical Summary instead, this indicated that the patient has no un-reviewed Investigations or Documents.

2. If **Pending Inv.**, or **Unrev. Docs** is displayed, then click the links. The EMR displays the Investigation/Document In Basket window with the current patient's un-reviewed investigations (if **Pending Inv.** clicked), or documents (if **Unrev. Docs** clicked) displayed.
3. View un-reviewed investigations for your patient. See ["Viewing your electronic investigations" on page 32](#)
4. View un-reviewed documents for your patient. See ["Viewing your incoming documents" on page 38](#).
5. Respond to un-reviewed investigations and documents for your patient. See ["Responding to electronic investigations and documents" on page 51](#).

Viewing a patient's investigations history

In the **Investigations** tab of a patient's Medical Summary, you can search, view, and graph the patient's current and historical investigations.

To view a patient's electronic investigations:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Investigations** tab. The EMR displays a list of all of the patient's current and historic electronic investigations, with columns displaying the following information:
 - Observed (date of test)
 - Status
 - Test
 - Flag (if abnormal)

- Result
- Range (if provided by the sending lab facility)
- Facility (testing facility)
- Review Note

Manually entered investigations display under **Manual Results** in the bottom right corner.

Medical Summary

Test, Father Born: 20-Jun-1980 (34) Sex: M PHN: Status: Long Term Care Pa..

Home address: 1234 Frist Street, Calgary AB T5R4E3W Home Cell: (403) 999-8888 Work: BMI: 8.1 yr 4 m Weight: 2kg 1 yr 4 m BP: 160/90 1 wk 2 d Pri: Dana Know-Four, MD Fam: Ref: No Vaccinations

Unrev. Docs 3 Rules 5 Messages 7 Follow Ups

Print Chart Custom Report Request Chart Change Log NetCare

Current Hx Past Hx Personal Hx Communication Investigations Documents Referrals

Investigations

From Date: 15-Apr-2013 To Date: 07-Mar-2014 Status: << All >> Test: << All >> Type: << All >> Non-Graph

Observed	Status	Test	Flag	Result	Range	Facility	Review Note
07-Mar-2014	Final	Hgb		78 g/L	(-) g/L	Wolf	
17-Apr-2013	Final	Creatinine		79 umol/L	(-) umol/L	Wolf	
17-Apr-2013	Final	HgA1C		4 %	(-) %	Wolf	
15-Apr-2013	Final	Cholesterol		4.2	(-)	Wolf	

Preventive Care Procedures

<<Enter New Preventive Care Procedure Result>>

Manual Results

07-Mar-2014	Hgb	78 g/L
17-Apr-2013	Hemoglobin ...	4 %
17-Apr-2013	Creatinine	79 umc
15-Apr-2013	Cholesterol	4.2

3. To reorder the list of investigations, click a column header to order the list based on the column's contents.
4. To filter the list of investigations, use one or more of the filter options described in the following table.

Filter	How to use	Result
From Date	In the From Date field, enter a start date, or click  to select a date from a calendar.	The EMR displays electronic investigations from after the specified date.

Filter	How to use	Result
To Date	In the field, enter an end date, or click  to select a date from a calendar.	The EMR displays investigations for from before the specified date.
Status	In the drop-down list, click a status.	The EMR displays investigations with the selected status.
Test	In the drop-down list, click a test. Note: Only tests that the patient has received results for display on the list.	The EMR displays investigations for the selected test. Note: Only one test can be selected at a time.
Type	In the drop-down list, click an investigation type.	The EMR displays investigations for the selected test type.
Non-Graph	To view only reports that do not contain numeric values, select this check box.	The EMR displays investigations hat do not contain “graphable” values. For example, diagnostic reports with no numeric values associated.

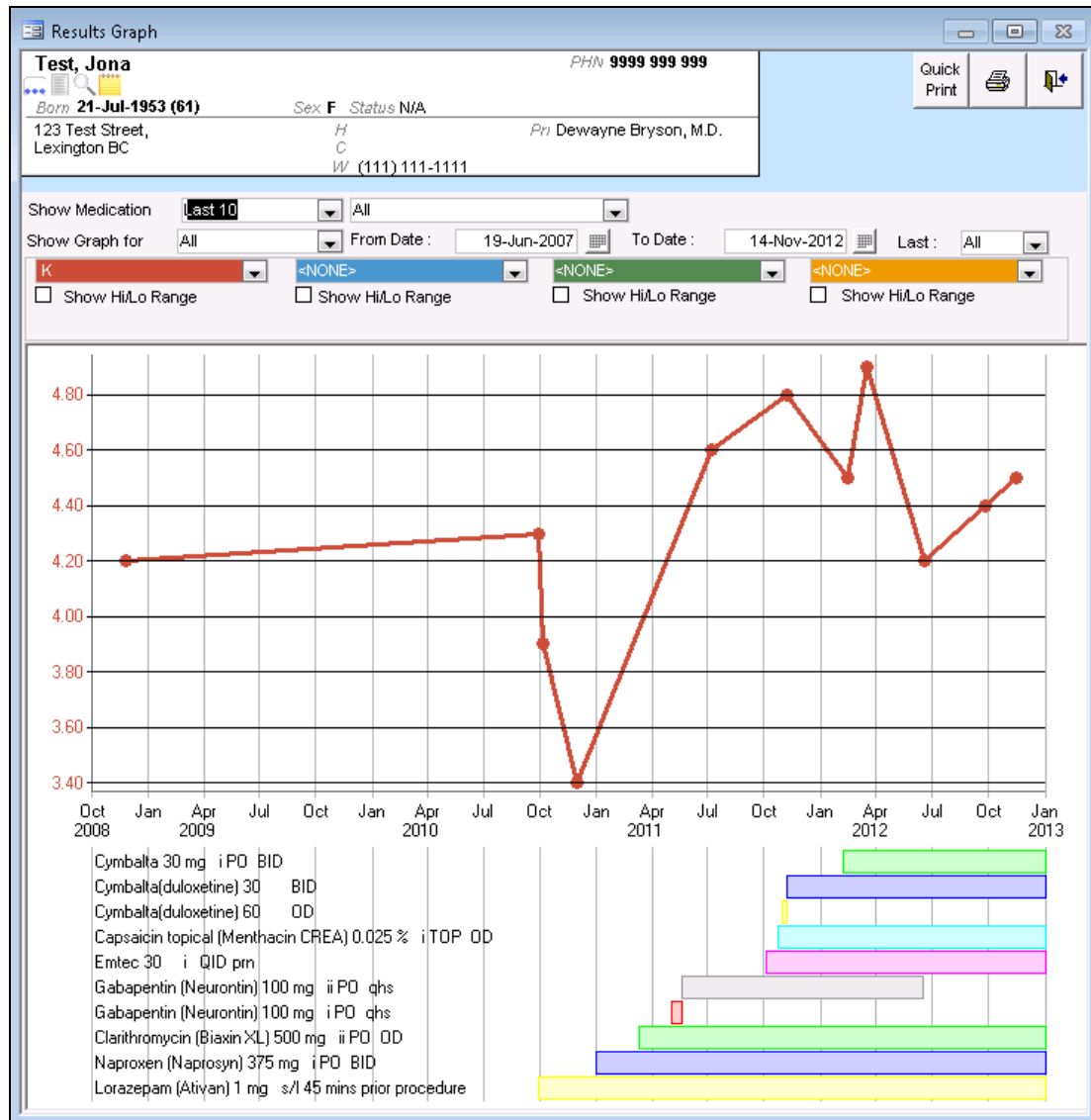
- On the investigations list, double-click an investigation to view it. The EMR opens the Investigation/Document In Basket window with the selected investigation displayed.

Graphing investigations from patient records

To graph an investigation from a patient's record:

- Perform one of the following actions:

- If you are viewing the **Investigations** tab of the patient's Medical Summary, in the patient's list of investigations, click the investigation, and then click **Graph** () (located on the top left of the **Investigations** tab). The EMR displays the Results Graph window with a graph of the selected value displayed.
- If you are viewing any other window related to the patient's medical record (for example, a SOAP note):
 - On the window, right click and then, in the SMART menu, click **View Clinical Graphs**. The EMR displays the Results Graph window.
 - In the red drop-down list, select the value you want to graph.



- To narrow the number or date-range of the graphed value(s), perform one of the following actions:
 - To narrow the date-range to 3 years, 1 year, 3 months, or 1 month, in the **Show Graph for** drop-down list click a time option. The EMR graphs investigations occurring within the period selected.
 - To display only values from a specific date, in the **From Date** field, enter a date, OR click  to select a date from a calendar. The EMR graphs investigations occurring after the date specified.

- To display only values up to a specific date, in the **To Date** field, enter a date, OR click  to select a date from a calendar. The EMR graphs investigations occurring before the date specified.
 - To display only a specific number of data points, in the **Last** drop-down list, click the number of data points you want to see.
3. To compare a patient's medication history to the graphed investigation values:
 - a) In the **Show Medication** drop-down list, click the number of medications you want to display.
 - b) In the drop-down list to the right of the **Show Medications** drop-down list, complete one of the following actions:
 - To display all the medications on the graph, click **All**.
 - To display only one medication on the graph, click the medication.
 4. To include graphs of the patient's vitals, and other lab values on the current graph:
 - a) In the blue drop-down list, click a value. The EMR graphs the value on the current investigation graph.
 - b) In the green and yellow drop-down lists, click other values you want to graph. The EMR graphs the values on the current investigation graph.



Note: Manually entered investigation results cannot be graphed.

Workaround: Users with administrative authority can make Manual Results "graphable" by converting them to electronic investigations in the Investigation Maintenance window (**Configuration > View > Patient Data Codes > Investigations.**)

Viewing a patient's documents

On a patient's medical record, you can search for, view, and modify documents pertaining to a patient. Documents include:

- Received scanned and faxed medical reports (for example, diagnostic imaging reports, and consult letters).
- Requisition forms, and other SMART forms created for the patient in Wolf EMR.
- Information sent as attachments on referral letters.
- Sent eReferrals. (Pertains only to clinics who send referrals using Wolf EMR eReferral.)
- Received eReferrals. (Pertains only to specialist clinics who receive Wolf EMR eReferrals.)

To view a patient's documents:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Documents** tab. The EMR displays a list of all of the patient's current and historic documents, with columns displaying the following information:
 - Date (of report)
 - Status
 - Document type
 - Keywords
 - Content type
 - Notes
 - MD
 - Review Date

Medical Summary

Test, Father Born: 20-Jun-1980 (34) Sex: M PHN: Status: Long Term Care Pa..

Home address: 1234 Frist Street, Calgary AB T5R4E3W Home Cell: (403) 999-8888 Work: BMI: 8 1 yr 4 m Weight: 2kg 1 yr 4 m BP: 180/90 1 wk 2 d Pri: Dana Know-Four, MD Fam: Ref:

No Inv. Unrev. Docs 3 Rules 5 Messages 7 Follow Ups No Vaccinations

Print Chart Custom Report Request Chart Change Log NetCare

Current Hx Past Hx Personal Hx Communication Investigations Documents Referrals

☐ Hide SMART Forms Document Type: <ALL> Search: AND View Document Properties

Date	Status	Document Type	Keyword One	Keyword Two	Keyword Three	Content Type	Notes	MD	Review Date
07-Mar-2014	Reviewed		Lab Req-AB Cg (2)						07-Mar-2014
07-Mar-2014	Reviewed		CPX - Female						07-Mar-2014
07-Mar-2014	Reviewed		Note - Message						07-Mar-2014
06-Mar-2014	Staff Revis		Consult Letter Co	WOLF.COMPOSER.			Marked as reviewed at cr		06-Mar-2014
06-Mar-2014	Reviewed	eReferral	e-MS	ReferralLetter				DK	06-Mar-2014
27-Aug-2013		Diagnostic Imaging	Cardiology Report						
27-Aug-2013		Incoming Referral	Cardiology Report						
18-Apr-2013	Reviewed	eReferral	e-MS	ReferralLetter				TG	18-Apr-2013
18-Apr-2013	Reviewed		Lab Req-AB Cg					TG	18-Apr-2013

3. To reorder the list of documents, click a column header to order the list based on the column's contents.

4. To filter the list of documents, use one or more of the filter options described in the following table.

Filter	Description
Hide SMART Forms	To view only documents that are not SMART forms, select this check box. Note: SMART Forms are most often requisition forms and referral letters created by your clinic. They do not typically contain results to be referenced.
Document Type	To view only a specific type of documents, in the drop-down list, click the document type. Note: Document Types are originally assigned by your front end staff.
Search	To view only documents containing a specific keyword, in this field, enter part, or all of, the keyword. The EMR filters the list to display documents with keywords containing the search term. Note: Keywords are originally assigned by your front end staff.

5. To view a document, on the documents list, double click the document. The EMR opens the document in an appropriate viewing window depending on the type of document it is:
- PDF documents (scanned and faxed documents): Open in PDF-XChange Viewer.
 - SMART Forms: Open in Microsoft Word.
 - Images: Open in Windows Photo Viewer.
 - eReferrals: Open in the Referral Letter Composer window.

Sharing documents via the Patient Portal

If you share health information with your patients via the Patient Portal, from the Medical Summary you can select what documents to share with a patient. The EMR does not automatically share a patient's documents on the Patient Portal.

To share a document with a patient via the Patient Portal:

1. On the patient's Medical Summary, click the **Documents** tab.

2. Click **Publish to Portal**.

The screenshot shows the EMR interface with a patient record for 'Okotoks AB U30 UBS'. The 'Documents' tab is selected. A table lists patient documents with columns: Date, Status, Document Type, Keyword One, Keyword Two, Keyword Three, Content Type, and Notes. The 'Publish to Portal' button is highlighted in a red box in the top right corner of the document list area.

Date	Status	Document Type	Keyword One	Keyword Two	Keyword Three	Content Type	Notes
26-May-2011	Reviewed		scrambled				
26-May-2011	Reviewed		scrambled				
26-May-2011	Reviewed		scrambled				
04-Mar-2011	Reviewed		scrambled				
30-Jun-2010	Reviewed		scrambled				
19-Feb-2009	Reviewed		scrambled				
09-Jan-2008	Reviewed		scrambled			pdf	
02-Jan-2008	Reviewed		scrambled				

The EMR displays the Publish documents to Patient Portal window with a list of the patient's documents.

The screenshot shows the 'Publish documents to Patient Portal' window for patient 'Test, Kasey'. It displays a list of documents with columns: Portal, Date, Status, Document, Keyword One, Keyword Two, Keyword Three, Content Type, Notes, MD, Review Date, and Notes To Patient. The 'Notes To Patient' column is currently empty.

Portal	Date	Status	Document	Keyword One	Keyword Two	Keyword Three	Content Type	Notes	MD	Review Date	Notes To Patient
☐	14-Nov-2012	Staff Review...		scrambled						14-Nov-2012	
☐	14-Nov-2012	Staff Review...		scrambled						14-Nov-2012	
☐	14-Nov-2012			scrambled	scrambled						
☐	13-Nov-2012	Reviewed		scrambled	scrambled				DB	13-Nov-2012	
☐	09-Nov-2012	Reviewed		scrambled	scrambled				DB	13-Nov-2012	
☐	23-Aug-2012	Reviewed		scrambled	scrambled				RS	24-Aug-2012	
☐	16-Aug-2012	Staff Review...		scrambled						16-Aug-2012	
☐	13-Aug-2012	Reviewed		scrambled	scrambled				DB	13-Aug-2012	
☐	31-Jul-2012	Staff Review...		scrambled	scrambled	scrambled				31-Jul-2012	
☐	30-Jul-2012	Reviewed		scrambled	scrambled				DB	30-Jul-2012	
☐	24-Jul-2012	Reviewed		scrambled	scrambled				DB	24-Jul-2012	
☐	23-Jul-2012	Reviewed		scrambled	scrambled				DB	07-Aug-2012	
☐	20-Jul-2012	Reviewed		scrambled	scrambled				DB	20-Jul-2012	
☐	17-Jul-2012	Reviewed		scrambled	scrambled				DB	18-Jul-2012	
☐	10-Jul-2012	Staff Review...		scrambled						10-Jul-2012	
☐	03-Jul-2012	Reviewed		scrambled	scrambled				DB	07-Jul-2012	
☐	09-Jun-2012	Staff Review...		scrambled	scrambled					09-Jun-2012	
☐	08-Jun-2012	Reviewed		scrambled	scrambled				DB	08-Jun-2012	
☐	01-Jun-2012	Staff Review...		scrambled						01-Jun-2012	
☐	30-May-2012	Staff Review...		scrambled						30-May-2012	
☐	28-May-2012	Reviewed		scrambled	scrambled				DB	31-May-2012	
☐	25-May-2012	Staff Review...		scrambled	scrambled					25-May-2012	

3. In the list of documents, select the check box beside documents you want to share.
4. To add notes to the patient regarding a particular document, in the **Notes to Patient** column, enter your notes to the patient.
5. When you finish, click **Close** (). The EMR displays a dialog box with the following message: "Selected document(s) have been published/updated via the Patient Portal".
6. Click **OK**.

Printing investigations and documents

If a patient wants a copy of their results, you can print a:

- Specific investigation
- Summary of current and historic results for a specific test
- Graph of a result value
- Document

Printing investigations

If you want to provide your patient with a written copy of their investigation results, you can print a single investigation result, or a summary of all results for a specific investigation type.

Printing a single investigation result

To print a single investigation result:

1. Open the patient's Medical Summary. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Investigations** tab. The EMR displays a complete list of the patient's current and historic electronic investigations.
3. On the list of investigations, double-click the investigation you want to print. The EMR displays the Investigation/Document In Basket with the selected investigation displayed.
4. Complete one of the following actions:

- To print the investigation on your default printer, click **Quick Print** ().
- To select a printer to print to, click **Print** ().

Printing all results for one investigation value

To print results (both previous and current) for one investigation value:

1. Open a patient's investigation in the Investigation/Document In Basket. See step 1 to step 3 of [“Printing a single investigation result” on page 77](#).
2. On the displayed investigation, click the specific value you want to print, (for example, WBC).
3. Click **Patient Summary** (located in the top right of the window). The EMR displays a summary of all of the patient's current and historic results in Microsoft Word.
4. On the Microsoft Word window, click **File**. The EMR displays a list of file options.

5. On the list of file options, click **Print**.

Printing investigation graphs

To print a graph of current and previous result values for an investigation:

1. View a graph of an investigation result. See ["Graphing investigations from patient records" on page 71](#).
2. At the top of the Investigation/Document In Basket window, click either:

- **Quick Print** (): The EMR sends the print job to your default printer to be printed.
- **Print** (): The EMR prompts you to select a printer to print to.

Printing PDF documents

To print a PDF document:

1. From the patient's Medical Summary, open the document. See ["Viewing a patient's documents" on page 73](#).
2. On the PDF-XChange Viewer window, click **Print** (). The EMR displays a Printer Selection window.
3. On the list of available printers, click a printer, and then click **Print**.

Clinic communications and tasks

In this chapter you learn how to create and manage messages and tasks. Wolf EMR contains an intra-office communication feature similar to e-mail. Using this feature, you can:

- Create messages for yourself and other clinic users
- Create follow-up tasks for yourself and other clinic users
- Manage all of your tasks and messages from a centralized location on your WorkDesk

Creating messages

You can create a message from your WorkDesk or from a patient's chart. You can create a message regarding a specific patient, or you can create a non-patient message.

Messages regarding patients are saved in patient charts, both in the **Communication** tab of the Medical Summary, and in the encounter list.

Creating messages regarding patients

To create a message regarding a patient:

1. Perform one of the following actions:
 - If you have any window of the patient's record open (for example, the SOAP form, Medical Summary, or Patient tab), right-click and then, on the SMART menu, click **New Message**.
 - If you do not have the patient's record open:
 - a) On the WorkDesk, in the **Messages** area, click **Enter New Message** (). The EMR displays a dialog box with the following prompt: "Patient Message? - SELECT YES, Intraoffice Message Not Related to a Patient - SELECT NO"
 - b) Click **Yes**. The EMR displays the Patient Search window.
 - c) Search for and select the patient.

The EMR displays the New Message window with:

- The **From** field defaulted to **Clinic MD**, and your name selected in the **Clinic MD** drop-down list.
- The **Re** field defaulted to **Patient**.
- The patient's SMART Patient Banner displayed in the middle of the window.

New Message For: Test, Father

Message

Quick Print [Icon] [Icon] [Icon] [Icon]

To: <<All MD's>>
 Physician: Doo, Devlin MD
 Staff: Know-Four, Dana MD
 Patient: Know-One, David MD
 Group: Know-Three, David MD
 Persons:

From: Patient
 Consultant
 Family Member
 Clinic MD
 Staff
 Other

Clinic MD:
 Dana Know-Four, MD

Re: Patient
 Other

Test, Father
 Born 20-Jun-1980 (34) Sex: M Status Long Term C...
 1234 Frist Street, H (403) 999-8888 Pri Dana Know-Four, MD
 Calgary AB T5R4E3W C Fam Ret

Please Call Back
 Will Call Again
 For Your Information

Routine
 Important
 Urgent

Message:

Notes:

Response: Message Left
 No Answer

☐ Completed



Best practice: Always double check the SMART patient banner on the message to ensure that you selected the correct patient. Once a message is sent, it is permanently associated with the selected patient's chart (you cannot delete it).



Note: You can also start a message as you review your investigations and documents: On the Investigations/Documents In Basket window, click **Message**. See ["Responding to electronic investigations and documents" on page 51](#).



Tip: To view detailed information about the patient you are creating a message for, in the middle of the New Message window, click the SMART patient banner. The EMR displays the patient's Medical Summary.

2. In the **To** area, click the type of recipient you want to send the message to. The EMR displays a list of associated users and user groups.

The following table describes the five user types available in the **To** list, and how they affect the user list you can choose from:

Recipient type	Result
Physician	All practitioners display. You can send a message a specific practitioner or to All MD's. Note: If you send a message to All MD's, only one message is created. After one of the recipients views and completes the message, it disappears from all other users' message lists.
Staff	All MOAs, and other front end staff display. You can send a message a specific staff member or to All Employees (all staff members). Note: If you send a message to All Employees, only one message is created. After one of the recipients views and completes the message, it disappears from all other users' message lists.
Patient	No user's receive the message on their message list, so NO users display in the list to the right. Instead, the message is attached to the patient's Medical Summary, and can be referenced and completed by any user from there. Note: Commonly used as “reminders” to perform tests or treatments on, or provide council to a patient during their next visit.
Group	All messaging groups display. If you send a message to a group, all users belonging to that group can view the message. By default, after one user completes the message, the message disappears from the message list of ALL group members. (For example, you send a message to all MOAs to perform a task, but you require that only one person completes the task.) If you want each user in the group to view and complete the message individually, select the Resolve groups to individual addresses check box. (For example, there is a staff meeting this week and you want all clinic members to know.) Note: For information on how to use and create messaging groups (security groups), see Wolf EMR Online Help.

Recipient type	Result
Multiple (AB and BC only)	All practitioners and front end staff display. Click each user you want to send the message to. Note: The message is sent to the selected users for each to view, and complete individually.
Multiple (NWT only)	When you click this option, the EMR displays the following: ■ Create a copy for each recipient check box (selected by default): The functionality of this check box is the same as that of the Resolve groups to individual addresses check box (when To: "Group" is selected); if this check box is not selected, then when any recipient marks the item as completed, it is marked as completed for all recipients. ■ Address Book button: Use the Address Book to select the recipient(s) of the message. See "Using the Address Book (NWT only)" on page 84.

3. Click the user or user group you want to send the message to.
4. To send the message on behalf of someone else:
 - a) In the **From** area, click the type of sender for the message. The EMR displays different fields, to the right of the **From** list, depending on your selection.
 - b) In the field to the right of the **From** list, specify a name or facility.

The following table describes the **From** options, and case examples for each.

Origin type	Input fields displayed	Purpose and case example
Patient	The EMR displays a Patient Search window. Search for the patient, and then double-click the patient's name.	Indicates that the recipient is to follow up with the patient directly. Example: A patient wants more information on diabetic programs available in your city. You don't have the information readily available now, so send you yourself a message to provide the information to the patient during their next visit.

Origin type	Input fields displayed	Purpose and case example
Consultant	The EMR displays a Consultant drop-down list. Search for and select a consultant's name.	Indicates that the recipient is required to contact a consultant. Example: A consultants office leaves you a phone message indicating that they require a patient's diagnostic reports before they can book an appointment. You send a message to your front end staff, requesting that they fax the reports to the consultant's office.
Family member	The EMR displays a Name and Phone text field. Enter the family member's name and phone number.	Indicates that the recipient is required to contact a patient's family member. Example: Your front end staff send you a message, requesting that you contact the daughter of one of your geriatric patient's.
Clinic MD	The EMR displays a Clinic MD drop-down list. Select your's or another practitioner's name.	Indicates that a clinic practitioner is the message sender, and that any replies are to be made to that sender.
Staff	The EMR displays a Staff drop-down list. Select a front-end-staff member's name.	Indicates that a front end staff member is the message sender, and that any replies are to be made to that sender.
Other	The EMR displays a Name and Phone text field. Enter the person's name or facility and phone number.	Indicates that the message recipient is to contact an individual or facility (that is not a consultant, or family member.) Example: You send a message to your front end staff requesting that they follow up with a diagnostic imaging centre on the status of a report you are waiting for.

- On the **Re** line, in the list to the right of the **SMART Patient Banner**, click one of the following options:
 - **Please call back**
 - **Will call again**
 - **For your information**
- In the **Priority** list, located below the **Re** line, click one of the following options:

- **Routine:** The EMR displays the message at the bottom of the recipient's message list.
- **Important:** The EMR displays the message in the recipient's message list in red, with an asterisk (*) in the first column, and lists the message above **Routine** messages in the list.
- **Urgent:** The EMR displays the message in the recipient's message list in red, with an exclamation mark (!) in the first column, and lists the message at the top of the list.



Note: If you select **Urgent**, the EMR displays an Urgent Message pop-up window on the WorkDesk of the recipient. The receiver must have the WorkDesk open in order to see the pop-up. This pop-up window re-appears about every 10 minutes for front end staff, and every 1 minute for practitioners, until the recipient completes the message.



Best practice: Mark a message as **Urgent** only if the recipient must address the message right away.

7. In the **Message** area, enter the text of your message.
8. If you have not performed any actions toward the completion of a task requested in the message, leave the **Notes**, and **Response** areas blank.



Note: The **Notes** and **Response** areas of the message are generally reserved for recipients to add notes on updates and actions they have done to complete a task.

If you do complete actions toward the task, then you can input your actions in the **Notes** and **Response** areas. The recipient can see and add to these notes.

9. Click **Save & Close** ()

Using the Address Book (NWT only)

When you create a message, you can use the Address Book to specify multiple message recipients.

To use the Address Book:

1. Start a message. See [Step 1.](#) in [“Creating messages regarding patients” on page 79.](#)

- In the **To** area, click **Multiple**. The EMR displays the **Create a copy for each recipient** check box (selected by default), and the **Address Book** button.

New Message For: Adcock, Amber

Message

To: **Address Book** **Multiple**

From: Patient
Consultant
Family Member
Clinic MD
Staff
Other

☒ Create a copy for each recipient

Re: Patient
Other

Adcock, Amber PHN: 9994587530
 Born 06-Nov-1992 (22) Sex: F Status: N/A
 2678 W Gating Place, H C Pri: Mitch Whited, MD, FRC...
 Drumheller AB T3P 6R3 W (529) 865-9077 Ret

Message:

Quick Print Print Cancel Save

Clinic MD: Mitch Cortez Whited, MD, FRCF

Please Call Back
Will Call Again
For Your Information

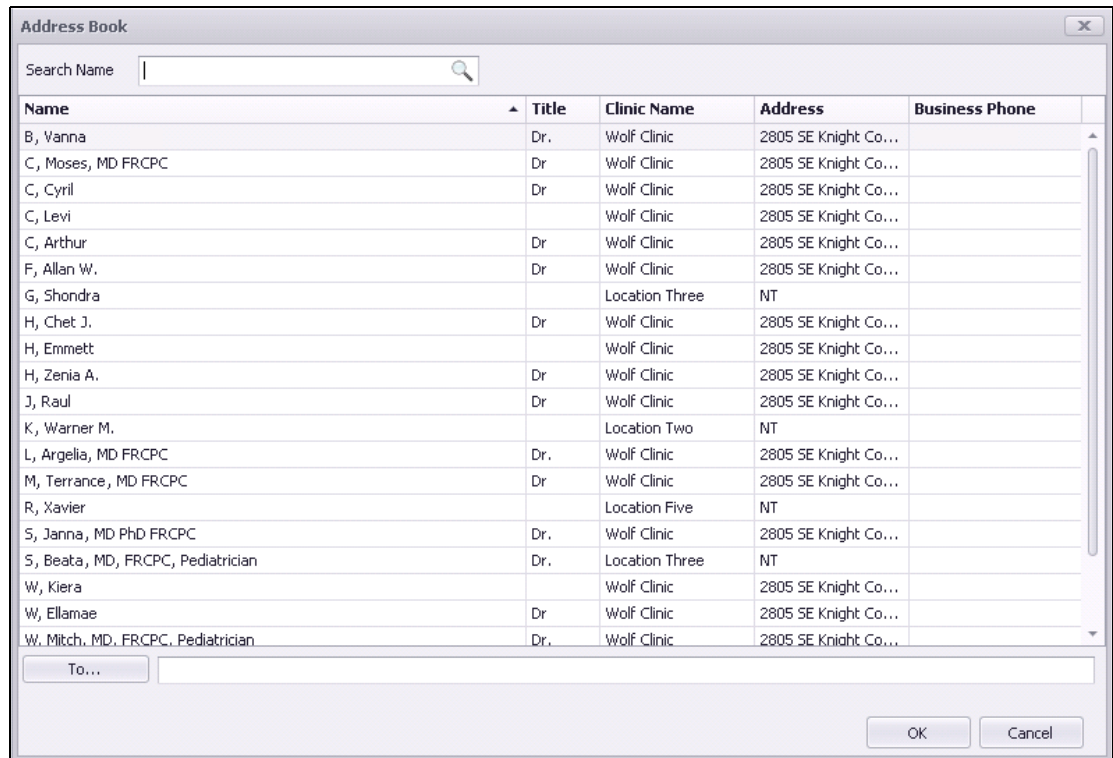
Routine
Important
Urgent



Note: If the **Create a copy for each recipient** check box is selected, each recipient views and completes the message individually.

- If you want the EMR to mark the message as completed for all recipients when any recipient marks the item as completed, clear the **Create a copy for each recipient** check box.

4. Click **Address Book**. The EMR displays the Address Book window with a list of all the active staff and practitioner users.

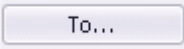


The Address Book window displays a table with the following columns: Name, Title, Clinic Name, Address, and Business Phone. Below the table is a 'To...' button and 'OK' and 'Cancel' buttons at the bottom right.

Name	Title	Clinic Name	Address	Business Phone
B, Vanna	Dr.	Wolf Clinic	2805 SE Knight Co...	
C, Moses, MD FRCPC	Dr	Wolf Clinic	2805 SE Knight Co...	
C, Cyril	Dr	Wolf Clinic	2805 SE Knight Co...	
C, Levi		Wolf Clinic	2805 SE Knight Co...	
C, Arthur	Dr	Wolf Clinic	2805 SE Knight Co...	
F, Allan W.	Dr	Wolf Clinic	2805 SE Knight Co...	
G, Shondra		Location Three	NT	
H, Chet J.	Dr	Wolf Clinic	2805 SE Knight Co...	
H, Emmett		Wolf Clinic	2805 SE Knight Co...	
H, Zenia A.	Dr	Wolf Clinic	2805 SE Knight Co...	
J, Raul	Dr	Wolf Clinic	2805 SE Knight Co...	
K, Warner M.		Location Two	NT	
L, Argelia, MD FRCPC	Dr.	Wolf Clinic	2805 SE Knight Co...	
M, Terrance, MD FRCPC	Dr	Wolf Clinic	2805 SE Knight Co...	
R, Xavier		Location Five	NT	
S, Janna, MD PhD FRCPC	Dr.	Wolf Clinic	2805 SE Knight Co...	
S, Beata, MD, FRCPC, Pediatrician	Dr.	Location Three	NT	
W, Kiera		Wolf Clinic	2805 SE Knight Co...	
W, Ellamae	Dr	Wolf Clinic	2805 SE Knight Co...	
W, Mitch, MD, FRCPC, Pediatrician	Dr.	Wolf Clinic	2805 SE Knight Co...	

5. **(Optional)** To search for a person, in the **Search Name** field, enter part of their name (first or last) or other information (for example, their specialty). As you enter the text, the EMR filters the list to display only matching recipients.
6. Specify the message recipients. Use any of the following methods:
- Click a person and press **Enter**. Repeat for each recipient.
 - Double-click a person. Repeat for each recipient.
 - To select more than one person, hold down the **Ctrl** key, click each person and then press **Enter**.
 - To select more than one person, click the first person, hold down the **Shift** key, click the last person and then press **Enter**.

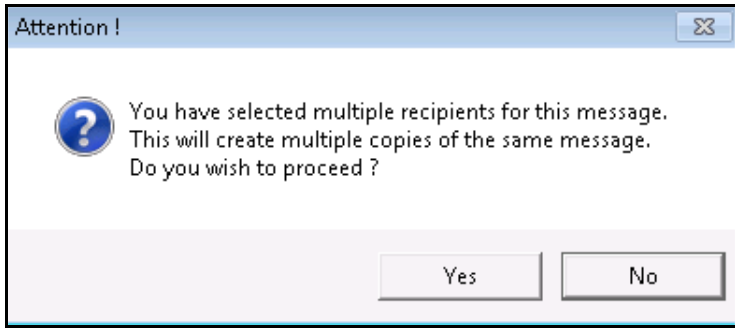


Tip: After you select your recipients, you can click **To** () instead of pressing **Enter**.

7. To remove a person from the recipients list, perform one of the following actions in the **To** field:
- Click a name and then, on your keyboard, press **Delete** or **Backspace**.

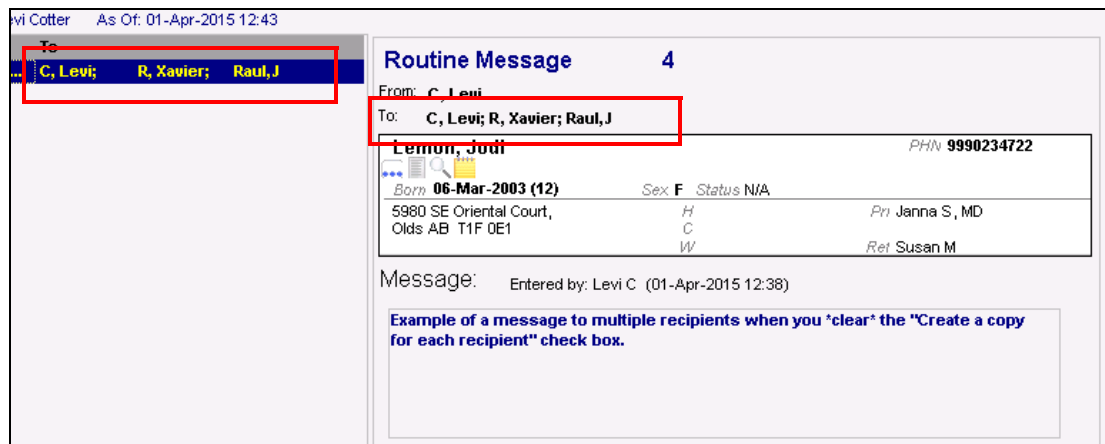
- Place your cursor to the right of the person's name and then, on your keyboard, press **Delete** or **Backspace**.
- 8. When you finish adding recipients, click **OK**. The EMR closes the Address Book window.
- 9. Complete the message. See [Step 4.](#) to [Step 9.](#) in “Creating messages regarding patients” on page 79.

 **Note:** If the **Create a copy for each recipient** check box was selected, the EMR displays the following dialog box:



10. Click **Yes**.

Note: When you use the “**To: Multiple**” option and you clear the **Create a copy for each recipient** check box, the **To** column and field show the recipients of the message.



vi Cotter As Of: 01-Apr-2015 12:43

To: C, Levi; R, Xavier; Raul, J

Routine Message 4

From: C, Levi

To: C, Levi; R, Xavier; Raul, J

Lemon, Judi PHN 9990234722

 Born 06-Mar-2003 (12) Sex F Status N/A
 5980 SE Oriental Court, H Pri Janna S, MD
 Olds AB T1F 0E1 C
 W Ret Susan M

Message: Entered by: Levi C (01-Apr-2015 12:38)

Example of a message to multiple recipients when you *clear* the "Create a copy for each recipient" check box.

Creating a message that is not associated with a patient

To send a message that is not associated to a patient:

1. In the **Messages** area of your WorkDesk, click **Send New Message** (). The EMR displays a dialog box with the following prompt: “Patient Message? - SELECT YES. Intra-office Message Not Related to a Patient - SELECT NO”.
2. Click **No**. The EMR displays the New Message window, with:

- The **From** field defaulted to **Clinic MD**, and your name selected in the **Clinic MD** drop-down list.
- The **Re** field defaulted to **Other**.
- **For Your Information**, selected on the **Re** line.

3. In the **To** area, in the list of recipient types, click the type of recipient you want to send the message to. The EMR displays a list of associated users, and user groups.
4. In the list of associated users or user groups, click the user(s) or user group you want to send the message to. For more information, see [Step 3. in "Creating messages regarding patients" on page 79](#). This table describes the different user types available in the **To** list, and how they affect the user list you can choose from.
5. The **From** field defaults to **Clinic MD** and your name appears in the **Clinic MD** drop-down list. To send the message on behalf of someone else:
 - a) In the **From** list, click the type of sender for the message. The EMR displays different fields, to the right of the **From** list, depending on your selection.
 - b) In the field to the right of the **From** list, specify a name or facility.
6. In the **Re** field, leave **Other** selected.
7. Complete the message as you would for a patient-related message. See [Step 5. to Step 9. in "Creating messages regarding patients" on page 79](#).

Follow-up tasks

Follow-up tasks are similar to messages in how they are created and used, however, they are created primarily to:

- Instruct or remind a staff member or practitioner to call a patient or schedule a return appointment (recall).
- Serve as a reminder in a patient's record for a practitioner to talk to the patient about a particular test result, treatment option, life style advice, or any other matter pertaining to the patient's health.



Note: Because Follow-up tasks serve a specific function, they have fewer options than Messages do. For example:

- Follow-up tasks cannot be sent to several users at once to complete individually. A Follow-up task can only be sent to a single user, or to a group in your system. As soon as one member of the recipient group views and completes the task, the task disappears from the Follow-up list of all group members.
- Follow-up tasks have fewer **From** options, than messages do. You cannot indicate that the message is originating from a patient, family member, consultant, or any other external source (unless written in the **Follow-up Reason** field).

To create a Follow-up task:

1. Start a Follow-up from the main area of your WorkDesk, or from a patient's record.

To start a follow-up from your WorkDesk:

- a) In the **Follow Up Tasks** area on your WorkDesk, click **Enter New Follow-up** (+). The EMR displays a dialog box with the following prompt: "Patient Follow-up?"
- b) To create a Follow-up regarding a patient, click **Yes**. The EMR displays the Patient Search window.
- c) Search for the patient and then, in the search results list, double-click the patient's name. The EMR displays the Follow-ups window.

To start a Follow-up from a patient's record:

- a) On any window of the patient's record (for example, the SOAP Note, Medical Summary, or Patient tab), right-click and then, in the SMART menu, click **New Follow-up**. The EMR displays the Follow-ups window.



Tip: You can also start a Follow-up:

- As you view your new investigations and documents. On the Investigations/ Documents In Basket window, click **Follow-up**. See [“Responding to electronic investigations and documents” on page 51](#).
- From a message. On the New Message window, click **Create New Follow**

Up Based on Message (.

Use case: You send a message to your front end staff to contact a patient regarding an abnormal lab result. Your front end staff call the patient but they discover that the patient has gone overseas for 3months. On the message, your

front end staff click **Create New Follow Up Based on Message** (). to create a follow-up task. They delay the due date of the task to 3 months from today.

The Follow-ups window displays with:

- The patient's **SMART Patient Banner** displayed at the top.
- Your name selected in the **To** list, by default.
- Your name selected in the **From** list, by default.
- The patient's next booked appointment date/time displayed beside **Next Appt.**

Follow-ups

Test, Father PHN

Born **20-Jun-1980 (34)** Sex **M** Status Long Term C...
 1234 Frist Street, H (403) 999-8888 Pn Dana Know-Four, MD
 Calgary AB T5R4E3W C Fam
 W Ret

To:
 Practitioner: **Doo, Devlin MD**
 Know-Four, Dana MD
 Know-One, David MD
 Know-Three, David MD
 Know-Two, Dana MD
 Locum, Goodouv. (Locum:Know-Four)
 Staff
 Group

From:
☒ Practitioner **Dana Know-Four, MD**
☐ Non-Practitioner

Follow-up Reason:

Select Follow-up Date:

Date for Follow-up: **18-Sep-2014**

Next Appt:

Notes:

☐ Follow Up Done

Routine
Urgent

Reminder
 Patient TCI For Follow Up



Best practice: Once a Follow-up is created it is permanently linked to the selected patient's chart (it cannot be deleted.) For this reason, always double check the SMART patient banner on the Follow-up to ensure that you selected the correct patient.



Tip: To view detailed information about the patient, at the top of the Follow ups window, click the SMART patient banner. The EMR displays the patient's Medical Summary.

2. In the **To** area, click the type of recipient you want to send the follow-up to. The EMR displays a list of associated users, and user groups.
3. Click the user or user group you want to assign the Follow-up to.

4. The following table describes the user types available in the **To** list, and how they affect the user list you can choose from.

Recipient type	Result
Practitioner	All practitioners display. Note: You can select only one practitioner.
Staff	All MOA's, and other front end staff display. Note: You can select only one front-end staff member.
Group	All security groups, programed into your system, display on the right. Note: For information on how to use and create security groups in Wolf EMR, see the Wolf EMR Online Help.



Sending a Follow-up to a group

If a Follow-up is sent to a group, all users belonging to that group can view the Follow-up, however, once the message is completed by one user, the Follow-up disappears from the Follow-up list of ALL group members.

If you want each user in the group to view and complete the task individually, Then create a message instead.

5. The **From** option defaults to **Practitioner** and your name is selected in the drop-down list. To send the follow-up on behalf of someone else:
- Click one of the following options:
 - **Practitioner:** The EMR displays a list of all practitioners in your clinic.
 - **Non-practitioner:** The EMR displays a list of all MOAs and front end staff in your clinic.
 - On the displayed list of users, click the sender's name
6. In the **Priority** list, click one of the following options:
- **Routine:** The EMR displays the Follow-up at the bottom of the recipient's Follow-up list.
 - **Urgent:** The EMR displays the Follow-up in the recipient's message list in red, with an exclamation mark(!) in the first column, and lists the Follow-up at the top of the list.



Best practice: Only mark Follow ups as **Urgent** if they must be addressed immediately.

If you select **Urgent**, an Urgent Follow up pop-up window displays on the WorkDesk of the recipient. This pop-up window re-appears about every 10min for front end staff, and every 1min for practitioners, until the recipient completes the message.

7. In the **Follow Up Reason** area, enter the problem, and reason for Follow-up.

8. If the due date for the Follow-up is any day other than today, complete one of the following actions:
 - To set the follow-up due date for a specific number of days, weeks, or months in the future:
 - a) In the **Select Follow-up Date** field, enter the number of days, weeks, months, or years that the Follow-up is due in.
 - b) In the **Follow-up Date** drop-down list, click either: days, weeks, months, or years. The EMR displays the calculated date, based on the **Follow-up Date** fields, in the **Date for Follow Up** field.
 - To select a specific follow up date, in the **Date for Follow Up** field, enter a date, or to select a date from a calendar, click .
9. In the **Follow-up Type** list to the right of Follow-up date, click **Reminder**.
10. In the **Notes** area, enter notes on any actions you have taken toward completing the Follow-up task. For example, "Informed patient during their visit that an MOA will contact them to book an appointment if results are abnormal"
11. Click **Save & Close** (). The Follow-up displays on the recipient(s) **Current Follow-up Tasks** list.

To Come In (TCI) tasks

A To Come In (TCI) task is a special type of Follow-up task used to order a patient to come in for a visit.

When you create a TCI task, two actions occur:

- Your MOA/Front end staff receive a notification to contact the patient and book an appointment (adding to their recall list).
- You receive a Follow-up task, reminding you what items to discuss, or actions to perform on the patient when they come in for their follow-up visit.

Following are some common instances you can use TCI tasks for:

- You want to follow up with a patient regarding an abnormal investigation result.
- You want to follow up with a patient regarding an over-due preventive care text. For example, an overdue pap smear, mammogram. or colonoscopy.

To Create a TCI task:

1. Open a new follow-up task for the patient. See [Step 1.](#) to [Step 10.](#) in “Follow-up tasks” on [page 89.](#)



Note: You can also start a To Come In task as you view your new investigations and documents. From the Investigations/Documents In Basket, click **To Come In.** See “[Responding to electronic investigations and documents](#)” on [page 51.](#)

2. On the Follow-ups window, in the follow up type list, click **Patient TCI for Follow Up.**

The EMR displays additional input fields in the bottom right of the window.

Follow-ups

Test, Father PHN

Born: 20-Jun-1980 (34) Sex: M Status: Long Term C... PHN: 1234 Frist Street, Calgary AB T5R4E3W H: (403) 999-8888 Pn: Dana Know-Four, MD C: Fam: W: Ret:

To: Doo, Devlin MD
Know-Four, Dana MD
Practitioner Know-One, David MD
Staff Know-Three, David MD
Group Know-Two, Dana MD
Locum. Goodouv. (Locum:Know-Four)

From: ☒ Practitioner Dana Know-Four, MD
☐ Non-Practitioner

Follow-up Reason:
Patient over-due for a colonoscopy.

Select Follow-up Date:
Date for Follow-up: 19-Sep-2014
Next Appt:

Reminder
Patient TCI For Follow Up

Routine
Urgent

Note:

Response Log:

☐ Follow Up Done

☐ Patient Notified ☐ Cancelled



Note: The additional input fields for TCI requests are for information you want to attach to the task for your front end staff.

3. Below the **Notes** area, click **Routine** or **Urgent** as the priority. The selection defaults to the priority set for the Follow-up. The EMR displays the selected priority on the MOA/Front end staff's **Users To Notify** list with the TCI task.

4. In the **Note** area, enter notes on any actions you have already taken toward completing the **Patient to Notify** task. For example, "Informed patient during their visit that an MOA will contact them to book an appointment if results are abnormal."



5. Click **Save & Close** (). The Follow-up displays:
 - On the MOA's/Front end staff's WorkDesk in the **Patients to Notify** list, as a notification to contact the patient to book the appointment.
 - In the Follow-up recipient's **Current Follow-up Tasks** list.
 - On the notifications bar of the patient's Medical Summary, as a reminder to address the Follow-up item with the patient during their appointment.

Managing your messages and tasks

You can manage your messages and follow-up tasks from your WorkDesk. You can:

- View your active and historic messages and tasks.
- Update or modify your messages and tasks.
- Complete your messages and tasks.
- Redirect your messages and tasks to other users.

Viewing your messages

You can view your messages from a list ordered by due date and priority. You can also reorder your list of messages by patient, sender, and receiver.

If your list of messages is extensive and you want to minimize your list to display only specific types of messages, you can filter your list of messages by sender, urgency, topic, and so on.

To view your messages:

1. The **Messages** area of your WorkDesk, displays your messages, listed chronologically in the following order:
 - Top: **Urgent** messages displayed in red, with an exclamation mark (!) in the first column.
 - Middle: **Important** messages displayed in red, with an asterisk (*) in the first column.
 - Bottom: **Routine** messages.

- In the **Messages** list, double-click a message. The EMR displays the **Message List** window, with the selected message displayed on the right, and your full list of messages displayed on the left.

Message List

Patient Message for Test, Baby

Signout Current Messages For: Dana Know-Four, MD As Of: 19-Sep-2014 14:12

Date	Patient/To	From	To
02-Nov-2013 15:54	Test, Frank	David Know-One, MD	All P
03-Nov-2013 09:41	Test, Andrea	Dana Know-Two, MD	All P
03-Nov-2013 10:37	Test, Mother	David Know-Three, MD	Dana
06-Mar-2014 14:20	Test, Father	Brian Hoover, MD, FCF...	Dana
18-Apr-2014 09:27	Jessica, Test	Know-Four, Sam	Dana
19-Sep-2014 14:12	Test, Baby	FAMILY: Mother Test: 4...	Dana

Routine Message Please Call

From: FAMILY: Mother Test: 444-444-4444
To: Dana Know-Four, MD

Test, Baby Daughter PHN

Born: 15-Jun-2014 (13 wk 5 d) Sex: F Status: N/A

123 Test Street, H C W Pri: Dana Know-Four, MD
Fam Ret

Message: Entered by: Dana Know-Four, MD (19-Sep-2014 14:12)

Mother has question regarding daughter's behavioural issues at pre-school.

Notes:

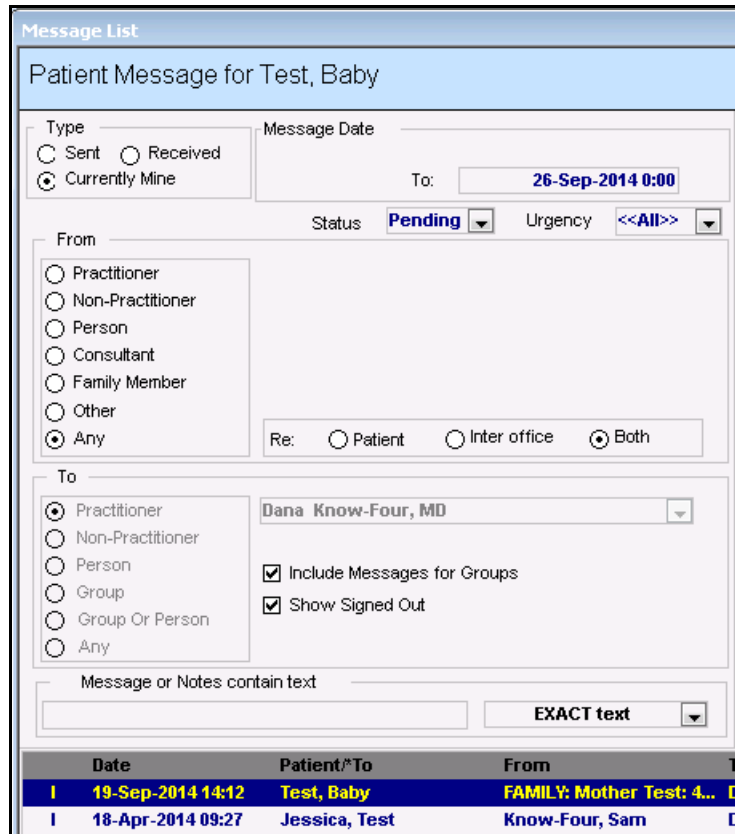
Log:

Completed: ☐

Completed
Message Left
No Answer
Redirect...

- To re-order your message list, click a column header. The EMR re-orders the list alphabetically or chronologically based on the column selected.

4. To address groups of messages at once, you can search for and view only specific types messages at a time. At the top of the Message List window, Click **Show Filters** (). The EMR displays filtering options on the left side of the window.



The following table describes your message filter options:

Filter	How to use
Type	Select one of the following options: ■ Sent: The EMR displays only active messages that you originally sent. ■ Received: The EMR displays only active messages you received. ■ Currently Mine: The EMR displays only active messages that are currently assigned to you.
Message Date	In the To field, enter a due date (using the format: DD-MMM-YYYY H:MM). The EMR displays only messages with due dates earlier than, or on the date entered.

Filter	How to use
Status	In the drop-down list, click one of the following options: ■ <<All>>: The EMR displays all of your current and historic messages. ■ Pending: The EMR displays all of your active messages (messages not yet marked as complete.) ■ Complete: The EMR displays all of your historic messages (messages that have been marked as complete.)
Urgency	In the drop-down list, click one of the following options: ■ <<All>>: The EMR displays messages with any priority level assigned. ■ Urgent: The EMR displays only messages with a priority level of Urgent. ■ Important: The EMR displays only messages with a priority level of Important. ■ Routine: The EMR displays only messages with a priority level of Routine.
From	In the From area, select the sender type. The EMR displays only messages that have the same sender type defined in their From area. The EMR also displays different drop-down lists and input fields to the right of the From sender type options, depending on your selection. Select and enter information into these fields to filter the list even further.
Re	In the Re area, select one of the following options: ■ Patient: The EMR displays only messages regarding a patient. ■ Inter office: The EMR displays only messages that are not linked to patients. ■ Both: The EMR displays both patient and non-patient related messages.
To	In the To area, select the type of receiver. The EMR displays only messages that have the same receiver type defined in their To area. The EMR also displays different drop-down lists and entry fields, depending on your selection. Select and enter information into these fields to filter the list even further.

Filter	How to use
Include Messages for Groups	■ To view messages that were sent to messaging groups you are a member of, select the Include Messages for Groups check box. ■ To view only messages that were sent to you directly (not through message groups), clear the Include Messages for Groups check box.
Show Signed Out	To view messages that belong to an absent practitioner you covering for, click Show Signed Out .
Message or Notes contain text	To view only messages that contain specific text in the Message or Notes area: 1. In the Message or Notes Contain Text field, enter a search term. 2. In the drop-down list to the right of the text field, click an option describing how closely the search term must match the actual message text.



Tip: You can specify multiple message list filter criteria simultaneously.

5. On the filtered message list, click a message. The EMR displays the selected message on the right.



Note: Once you filter the message list, it will remain filtered until you complete one of the following actions:

- Change the filter criteria.
- Close the Message List window.

6. When you finish viewing your messages, click **Save & Close** ()

Updating or modifying your messages

If you perform an action toward a message, but do not fully complete the task, you can update the message to document the actions you took.

Also, if you do not have enough time to address a message, or if you receive a message that does not pertain to you, you can redirect the message to another clinic user.

To update a message:

1. In the **Messages** area on your Workdesk, double-click the message you want to update. The EMR opens the Message List window with the message displayed on the right.
2. In the **Notes** area, enter the steps you have taken toward completing the task.
3. To indicate that you have called a patient, but did not talk to the patient directly, click one of the following options:
 - **Message Left:** The EMR displays the text “Message Left: [your name](current date and time)” in the **Log** area.
 - **No Answer:** The EMR displays the text “No Answer: [your name](current date and time)” in the **Log** area.
4. In the **Log** area, edit or enter text as necessary, to indicate your actions taken toward completing the task.
5. Perform one of the following actions:
 - If you are finished updating the message, click **Save & Close** (). The EMR saves your changes to the message and the message remains in your **Messages** list.
 - If you want to send the message to another user to complete:
 - a) At the bottom of the message, click **Redirect**. The EMR displays the Redirecting Patient Message window.
 - b) In the **To** field, click the user or group you want to redirect the message to.
 - c) In the **Notes** area, enter any additional notes or instructions to the receiver.
 - d) Click **Save & Close** (). The EMR removes the message from your **Current Messages** list, and adds the message to the receiver's **Current Messages** list.

Completing your messages

To complete a message:

1. In the **Messages** area on your Workdesk, double-click the message you want to complete. The EMR opens the Message List window with the message displayed on the right.
2. In the **Notes** area, enter any notes on steps you have taken toward completing the task.
3. Click **Completed**. If the message is a group-addressed message, the EMR displays a dialog box with the following prompt: “Completing this Message will cause the message to NOT display for other recipients of this message. Do you still want to Complete this message?”.

- To complete the message, click **Yes**. The EMR removes the message from your **Current Messages** list. The EMR also removes the message from the **Current Messages** list of all group members if the message was addressed to a group (without the **Resolve groups to individual Addressees** check box selected).

Viewing your Follow-up tasks

Similar to messages, you can view your follow-up tasks from a list ordered by due date and priority. You can also reorder your list of follow-up tasks by patient, sender, and receiver.

If your list of follow-up tasks is extensive, and you want to minimize your list to display only specific types of follow-up tasks, you can filter your list of follow-up tasks, by sender, urgency, topic, and so on.

To view your Follow-up tasks:

- The **Follow Up Tasks** area on your WorkDesk displays your follow-ups, listed chronologically by due date, with your **Urgent** follow-ups displayed in red at the top.
- In the **Follow Up Tasks** area, double-click a follow-up. The EMR displays the Follow-up List window, with the selected follow-up displayed on the right, and your full list of follow-ups displayed on the left.

Follow-ups

Follow-up List

☒ Signed Out
 Current Follow Ups for Dana Know-Four, MD

Date	Patient/To	From	To
18-Sep-2014	Test, Father	Dana Know-Four, MD	Dana Know-Four, MD
18-Sep-2014	Test, Father	Dana Know-Four, MD	Dana Know-Four, MD
16-Sep-2014	Test, Mother	Dana Know-Four, MD	Dana Know-Four, MD
16-Sep-2014	Test, Mother	Dana Know-Four, MD	Dana Know-Four, MD
11-Sep-2014	Test, Mother	Dana Know-Four, MD	Dana Know-Four, MD
11-Sep-2014	Test, Fred	Dana Know-Four, MD	Dana Know-Four, MD
11-Sep-2014	Test, Amy	Dana Know-Four, MD	Dana Know-Four, MD
11-Sep-2014	Jessica, Test	Dana Know-Four, MD	Dana Know-Four, MD
11-Sep-2014	Test, Jay	Dana Know-Four, MD	Dana Know-Four, MD
07-Mar-2014	Test, Father	Dana Know-Four, MD	Dana Know-Four, MD

Routine Follow Up
To: Dana Know-Four, MD

Test, Mother
PHN: 79827-4114

Born: 27-Oct-1970 (43) Sex: F Status: Long Term C...

1234 Frist Street, Calgary AB T5R4E3W H: (403) 999-8888 P: Dana Know-Four, MD C: Fam W: Ret

Follow-up Date: 16-Sep-2014

Request Patient to Come in For Refill For Warfarin (Coumadin TAB) 3 mg i PO OD

Last Appt: 12-Sep-2014 Next Appt:

Notes:

Request Patient TCI

Routine

Urgent

Note: TCI for Refill

Response Log:

☐ Patient Notified
 ☐ Cancelled

Completed

Redirect

Completed By:
 Completed Date:
 From: Dana Know-Four, MD
 Create Date: 2014-Sep-16 10:10:23



Note: If the selected follow-up originates from a TCI task, then the EMR displays additional fields/check boxes. These fields and check boxes are linked to the **Patients to Notify** task on the front end staff's WorkDesk. Any notes and selections you make here reflect on the **Patients to Notify** list.

- **Response log**
- **Note** (for the TCI)
- **Patient notified** check-box
- **Cancelled** check-box

3. To re-order your Follow-ups list, click a column header. The EMR re-orders the list alphabetically or chronologically based on the column selected.
4. To address groups of Follow-up tasks at once, you can search for and view only specific types of Follow-ups at a time. In the top of the Follow-ups window, Click **Show Filters**

(**Show Filters**). The EMR displays filtering options in the left side of the window.

Follow-ups

Follow-up List

Type
☐ Sent ☐ Received
☒ Currently Mine

Follow Up Date To: 27-Sep-2014

Status: Pending Urgency: <<All>>

From
☐ Practitioner <<ALL>>
☐ Non-Practitioner
☒ Person ☐ Show Inactive Users

To
☒ Practitioner Dana Know-Four, MD
☐ Non-Practitioner
☐ Person
☐ Group
☐ Group Or Person ☒ Include Follow Ups for Groups
☒ Show Signed Out

Date	Patient#To	From	To
18/Sep/2014	Test, Father	Dana Know-Four, MD	Dana Know-Four, MD
18/Sep/2014	Test, Father	Dana Know-Four, MD	Dana Know-Four, MD
16/Sep/2014	Test, Mother	Dana Know-Four, MD	Dana Know-Four, MD
16/Sep/2014	Test, Mother	Dana Know-Four, MD	Dana Know-Four, MD
11/Sep/2014	Test, Jay	Dana Know-Four, MD	Dana Know-Four, MD
07/Mar/2014	Test, Father	Dana Know-Four, MD	Dana Know-Four, MD

The following table describes your Follow-ups list filter options:

Filter	How to use
Type	Select one of the following options: ■ Sent: The EMR displays only active Follow-up tasks that you originally sent. ■ Received: The EMR displays only active Follow-up tasks that you have received. ■ Currently Mine: The EMR displays only active Follow-up tasks that are currently assigned to you.
Follow Up Date	In the Type area, select Received or Sent. (This enables the To field. The EMR also displays the From field.) In the To field, enter a due date (using the format: DD-MMM-YYYY H:MM). The EMR displays only Follow-up tasks with due dates earlier than, or on the date entered. To view follow-up tasks within a range of dates: In the From field, enter the start of the date range. In the To field, enter the end of the date range.
From	In the From area, select the sender type. The EMR displays only follow-up tasks that have the same sender type defined in their From area. The EMR also displays different drop-down lists and entry fields to the right of the From sender type options, depending on your selection. Select and input information into these fields in order to filter the list even further.
To	In the To area, click the receiver type. The EMR displays only Follow-up tasks that have the save receiver type defined in their To area. The EMR also displays different drop-down lists and entry fields to the right of the To receiver type options, depending on your selection. Select and input information into these fields in order to filter the list even further.
Include Follow Ups for Groups	■ To view follow up tasks that were sent to groups in which you are a member of, select the Include Follow Ups for Groups check box. ■ To only view Follow-up tasks that were sent to you directly (not to groups), clear the Include Follow Ups for Groups check box.

Filter	How to use
Show Signed Out	To view messages that belong to an absent practitioner you covering for, click Show Signed Out .



Tip: You can specify multiple Follow-up list filter criteria simultaneously.

- On the filtered Follow-ups list, click a follow-up. The EMR displays the selected follow-up on the right.



Note: Once you filter the Follow-ups list, it remains filtered until you complete one of the following actions:

- Change the filter criteria.
- Close the Follow-up List window.

- When you finish viewing your follow-up tasks, click **Save & Close** ().

Updating or modifying your Follow up tasks

If you complete some action toward a follow-up task, but do not fully complete the task, you can update the follow-up task to document the actions you take.

Also, if you do not have enough time to address a follow-up task, or receive a follow-up task that does not pertain to you, you can redirect the follow-up task to another clinic user.

To update a follow-up task:

- In the **Follow Up Tasks** area on your Workdesk, double-click the follow-up you want to update. The EMR opens the Follow-up List window with the follow-up displayed on the right.
- In the **Notes** area, enter the steps you have taken toward completing the task.
- Perform one of the following actions:

- If you are finished updating the follow-up, click **Save & Close** (). The EMR saves your changes to the follow-up and the follow-up remains in your **Follow Up Tasks** list.
- If you want to assign the follow-up task to another user to complete, follow the steps below:
 - At the bottom of the follow-up, click **Redirect**. The EMR displays the Redirect Patient Follow-up window.
 - In the **To** area, click the user, or group, you want to redirect the message to.
 - In the **Notes** area, enter any additional notes or instructions to the receiver.

- d) Click **Save & Close** (). The EMR removes the follow-up from your **Follow Up Tasks** list, and adds the follow-up to the receiver's Follow-up List.

Completing your Follow-up tasks

To complete your Follow-ups:

1. In the **Follow Up Tasks** area on your Workdesk, double-click the follow-up you want to complete. The EMR opens the Follow-up List window with the follow-up displayed on the right.
2. In the **Notes** area, enter the steps you have taken toward completing the task (optional).
3. Select the **Patient Notified** check box (if not selected already).



Note: A patient remains on the Front end staff's **Patients to Notify** list, until the **Patient Notified** check box is selected. If you have followed up with a patient on a follow-up item, then there is no need for the patient to remain on the **Patients to Notify** list. For this reason, always select the check box after you have completed the task.

4. Click **Completed**. If the follow-up is a group-addressed follow-up, the EMR displays a dialog box with the following prompt: "Completing this task will cause the task to NOT display for other recipients of this task. Do you still want to Complete this task?."
5. Click **Yes**. The EMR removes the task from your **Current Follow Up Tasks** list. The EMR also removes the message from the **Current Follow Up Tasks** list of all group members if the task was assigned to a group (without the **Resolve groups to individual Addressees** check box selected).

Managing messages and tasks for a specific patient

You can view at-a-glance if the patient has any outstanding active messages or follow-up tasks.

You can also view a patient's historic messages and follow-up tasks. If you happen to find that one of a patient's messages or follow-up tasks are marked as complete, but shouldn't be, then you can reactivate the message.

Viewing a patient's active Messages and Follow Ups

From a patient's Medical Summary, you can see at-a-glance if they have any active messages or Follow-up items. You can then view, update, and complete a patient's messages and Follow-up tasks from the Medical Summary.

To view a patient's active Messages and Follow-ups:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#).
2. To View active messages pertaining to a particular patient:

- a) On the Notification bar, below the SMART patient banner, click **# messages** () (where # = the number of active messages for the patient). The EMR displays the Messages For: [Patient name] window, with a list of the patients current (active) messages on the left side of the window.
- b) If the patient's list of active messages is extensive, and you want to search for a specific message or group of messages, click **Show Filters** () . The EMR displays filter options above the list of messages.



Note: The filters available are the same as the filters available when you view your complete list of active messages. For tips on how to use the various list filters, see ["Viewing your messages" on page 95](#).

- c) To view a specific message, on the patient's **Current Messages** list, click a message. The EMR displays the message details on the right side of the window.
- d) To update or modify a message, complete [Step 2](#). to [Step 5](#). in ["Updating or modifying your messages" on page 99](#).
- e) To complete a message, complete [Step 2](#). to [Step 4](#). in ["Completing your messages" on page 100](#).
- f) When you are finished, click **Save & Close** () .

3. To view active follow-ups pertaining to a specific patient:

- a) On the Notification bar, below the SMART Patient Banner, click **# Follow Ups** () (where # = the number of active follow-up tasks pertaining to the patient). The EMR displays the Follow-ups For: [Patient name] window, with a list of the patients current (active) Follow-ups on the left side of the window.
- b) If the patient's list of active follow-up tasks is extensive, and you want to search for a specific follow-up task or group of follow-up tasks, click **Show Filters**. The EMR displays filter options above the list of follow-up tasks.



Note: The filters available are the same as the filters available when you view your complete list of active follow-up tasks. For tips on how to use the various list filters, see ["Viewing your Follow-up tasks" on page 101](#).

- c) To view a specific Follow-up task, on the patient's **Current Follow-ups** list, click a Follow-up task. The EMR displays the Follow-up tasks details on the right side of the window.
- d) To update or modify a Follow-up task, complete [Step 2.](#) to [Step 3.](#) of ["Updating or modifying your Follow up tasks"](#) on page 104.
- e) To complete a Follow-up task, follow [Step 2.](#) to [Step 5.](#) of ["Completing your Follow-up tasks"](#) on page 105.

- a) When you are finished, click **Save & Close** ().

Viewing a patient's historic Messages and Follow Ups

To view a patient's active Messages and Follow-ups:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary"](#) on page 389.
2. Click the **Communications** tab. The EMR displays a list of active and completed Messages and follow-up tasks pertaining to the patient.



Note:

- A **C** beside the date indicates the message or follow-up task is complete.
- An **I** beside the date indicates the message or follow-up task is incomplete.

3. To view detailed information about a patient's historic message(s):
 - a) In the **Messages** list, double-click a completed message. The EMR displays the Messages For [Patient name] window, with the message open on the right and a full list of the patient's complete and incomplete messages on the left.
 - b) If the patient's list of messages is extensive, and you want to search for a specific message or group of messages, click **Show Filters** (). The EMR displays filter options above the list of messages.



Note: The filters available are the same as the filters available when you view your full list of active messages. For tips on how to use the various list filters, see ["Viewing your messages"](#) on page 95.

- c) When you are finished, click **Save & Close** ().
4. To view detailed information about a historic Follow-up task:

- a) In the Follow-ups list, double-click a follow-up. The EMR displays the Follow-ups for [Patient name] window, with the selected Follow-up displayed on the right and a full list of the patient's complete and incomplete follow-ups on the left.
- b) If the patient's list of Follow-up tasks is extensive, and you want to search for a specific follow-up task or group of follow-up tasks, click **Show Filters** (). The EMR displays filter options above the list of follow-ups.



Note: The filters available are the same as the filters available when you view your full list of active Follow-ups. For tips on how to use the various list filters, see ["Viewing your Follow-up tasks" on page 101](#).

- c) When you are finished, click **Save & Close** ().

Reactivating a patient's completed Messages and Follow-up tasks

To reactivate a completed Message or Follow-up for a patient:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#)
2. Click the **Communications** tab. The EMR displays a list of active and completed Messages and Follow-up tasks pertaining to the patient.
3. In the list of Messages, or Follow-ups, double-click the task you want to reactivate. The EMR displays the Messages for <Patient name> window, or the Follow-ups for <Patient name> window, with the selected message or follow-up task displayed on the right.
4. On the displayed message or follow-up task, clear the **Completed** check box. The EMR enables the **Redirect** button.
5. Click **Redirect**. The EMR displays a new message or follow-up task window with the task details duplicated from the original message or follow-up task.
6. In the **To** area, select the user or group you want the message or task to be assigned to.



Note: You can select your own name as a message or task recipient.

7. Edit or add information to any of the message or follow-up fields.

8. Click **Save & Close** ().

Communicating with patients via the Patient Portal

If your clinic is set up for Patient Portal messaging, you can:

- Send messages to patients
- Delete messages that were sent to patients
- Track if patients have viewed their messages
- Receive messages from patients (if you are a practitioner)

Sending messages to patients

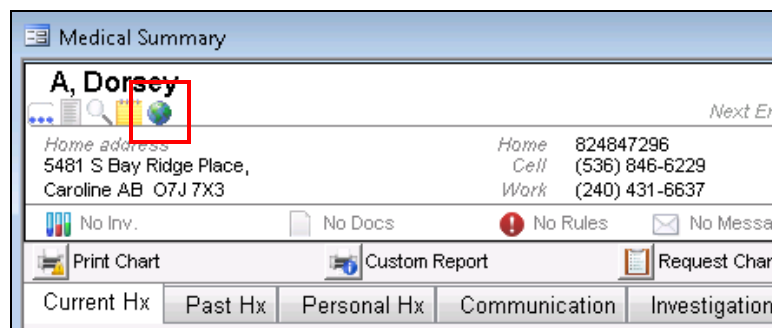
Any clinic user can send a message to a patient via the Patient Portal. When you send a message to a patient, you are indicated as the sender. You cannot send a message on behalf of another user. You send messages to patients using the same messaging system you use to send messages to clinic members in Wolf EMR.

When patients receive a Patient Portal message, they are notified by e-mail. Patients can then log into the Patient Portal to view their message(s).

To send a message to a patient via the Patient Portal:

1. Open any window of the patient's chart (for example, the Medical Summary, or a SOAP

note). If the patient is a Patient Portal user, the EMR displays a Patient Portal icon (🌐) in the SMART Patient Banner.



2. Right-click and then, in the SMART menu, click **New Message**. The EMR displays the New Message For: <patient name> window.
3. In the **To** area, click **Patient**. The EMR displays options for publishing the message to the Patient Portal.

New Message For: A. Dorsey

Message

To: Physician
Staff
Patient
Group
Multiple

☐ Publish to Portal

Regarding:

From: Patient
Consultant
Family Member
Clinic MD
Staff
Other

Clinic MD: S. Janna, MD

Re: Patient
Other

A. Dorsey PHN 9992
 Born 07-Jun-1994 (21) Sex M Status N/A
 5481 S Bay Ridge Place, H 824847296 Pn Mitch W, MD, FRC...
 Caroline AB 07J 7X3 C (536) 846-6229 W (240) 431-6637 Rel

**Please Call Back
Will Call Again
For Your Information**

**Routine
Important
Urgent**

Message:

Notes:

Response: Message Left
No Answer

☐ Completed



Note: If the Patient Portal messaging options do not display, the patient is likely not set up as a Patient Portal user. Ensure the Patient Portal icon (🌐) is displayed in the SMART patient banner.

4. Select the **Publish to Portal** check box. The EMR selects your name in the **From** area and changes the **From** area to be unavailable for editing.



Note: You cannot send messages on behalf of someone else.

5. In the **Regarding** field, enter the reason or subject for the message.
6. In the **Message** area, enter the message body.
7. Click **Close & Save Message** (📧). The EMR sends an e-mail to the patient indicating that a message is available in the Patient Portal. The patient can log into the Patient Portal to view the message. See ["Viewing messages from patients" on page 112](#).

Verifying that a patient has viewed a message

To verify that a patient has viewed their message:

1. Open the message:
 - a) Open the patient's Medical Summary.
 - b) Click the **Communications** tab. The EMR displays a list of the patient's completed and outstanding messages in the left pane.



Note: All Patient Portal messages are marked as complete as soon as they are sent to a patient (as indicated by a **C** to the left of the message).

- c) Double-click the message. The EMR displays the Patient Message for <patient name> window, with the selected message's details displayed in the right pane.

Messages For: Abrams, Dorsey

Patient Message for A, Dorsey

Current Messages For: A, Dorsey As Of: 16-Oct-2015 15:13

Date	From	To
C 16-Oct-2015 15:12	Janna S	Abrams, D
C 03-Dec-2007 16:19	Mitch C	Guillen, S
C 17-Aug-2005 15:00	Bosley, D	All Non-Providers

Routine Message 4

From: Janna S, MD PhD FRCP
To: A, Dorsey

A, Dorsey PHN 999

DOB: 07-Jun-1994 (21) Sex: M Status: N/A

5481 Ridge Place, H: 824847296 Pri: Mitch W, MD
Caroline AB 07J 7X3 C: (536) 846-8229
W: (240) 431-6637 Ref:

Message: Entered by: Janna Schreiber, MD PhD FRCP (16-Oct-2015 15:12)

re: rash
Hi Dorsey
Hope your rash is doing better today.
Sue

Notes:

Log: Message Opened: Dorsey A, dorsey (16-Oct-2015 15:13)
Email Sent: to Dorsey Abrams, Upplkumar@telus.com (16-Oct-2015 15:12)

Completed: ☒ Publish to Portal: ☒

Completed
Message Left
No Answer

2. In the **Log** area of the message, scroll down to view information on:

- When the message was sent and who sent the message
- The date and time that the message was opened

Log: Message Opened: Dorsey A, dorsey (16-Oct-2015 15:13)
Email Sent: to Dorsey A, U.kumar@telus.com (16-Oct-2015 15:12)

Completed: ☒ Publish to Portal: ☒

Completed
Message Left
No Answer

Removing a message from the Patient Portal

If you send a message in error (for example, if you send a message to the wrong member of a family), you can remove the message from the Patient Portal.

To remove a message from the Patient Portal:

1. Open the message:
 - a) Open the patient's Medical Summary.
 - b) Click the **Communications** tab. The EMR displays a list of the patient's completed and outstanding messages in the left pane.



Note: All Patient Portal messages are marked as complete as soon as they are sent to a patient (as indicated by a **C** to the left of the message).

- c) Double-click the message. The EMR displays the Patient Message for <patient name> window, with the selected message's details displayed in the right pane.
2. At the bottom of the message detail area, clear the **Publish to Portal** check box.

3. Click **Close Form** ().

Viewing messages from patients

At this time, only practitioners can receive Patient Portal messages from patients. When you receive a Patient Portal message, the message displays in your Wolf EMR messages list.

If you are a practitioner, and you do not want to manage messages originating from the Patient Portal, you can redirect patient portal messages to your front end staff.

To view Patient Portal messages from patients:

1. Open your outstanding Wolf EMR messages: Open the WorkDesk, and then on the blue banner (located at the top of the window), click **# Current Messages** (where **#** = the number of your outstanding messages). The EMR displays the Message List window.
2. In your list of outstanding messages, click a message that contains a patient name in the From column. The EMR displays:
 - The message title: **Patient Message for <patient name>** at the top of the window
 - The message contents in the right pane
 - Patient Portal" beside **Entered by:**

The screenshot shows the 'Message List' window. At the top, a blue banner displays 'Patient Message for A, Dorsey'. Below this is a table with columns: Date, Patient*To, From, and To. The first row shows a message from 'A, Dorsey' dated '16-Oct-2015 15:19'. To the right of the table, a 'Routine Message' pane shows details for 'A, Dorsey', including birth date '07-Jun-1994 (21)', sex 'M', status 'N/A', and contact information. Below the patient details, the 'Message:' section shows 'Entered by: A, Dorsey (Patient Portal)'. At the bottom right, there are buttons for 'Completed', 'Message Left', 'No Answer', and 'ReDirect...'.

3. Perform one of the following actions:
 - To redirect the message to another staff member, click **ReDirect**.
 - To mark the message as viewed and to remove the message from your list of outstanding messages, click **Completed**.



Note: If you want to send a reply to the patient, you cannot reply directly from the message. Instead, you must compose a new message to the patient. See [“Sending messages to patients” on page 109](#).

Covering absent practitioners' messages and tasks

If you, or another provider is absent from the clinic (for example, for vacation, or medical leave) you and other providers can easily cover the messages and tasks for the absent provider using the **Sign Out** feature. If you sign out another user, you automatically receive the users:

- Messages, and Follow-up tasks (if, on your **Current Messages** and **Current Follow Up Tasks** lists, you select the **Sign Out** check box).
- New Electronic investigation notifications.
- New document notifications.
- Refill requests.
- Appointments (if, on your **Appointments** list, you select the **Sign Out** check-box)

Setting up coverage for users

You can Sign Out, or “cover-for”, another practitioner for a defined period of time, and vica versa. Once set up, coverage starts and ends automatically.

To set up coverage for a practitioner:

1. On the top of your WorkDesk, click **Sign Out > Sign Out**. The EMR displays the SignOut window.

The screenshot shows the 'SignOut' window in the Wolf EMR. The 'Sign Out Type' section has 'Practitioner' selected. The 'User List' and 'Sign Out To:' lists are populated with various users and roles. The 'Coverage Starts' field shows '23-Sep-2014 16:52'. The 'Coverage Ends' section has 'Open ended' selected. A 'Notes:' field is present at the bottom right. A 'Coverage History' link is at the bottom left.

2. Under **Sign Out Type**, leave **Practitioner** selected.
3. In the **User List**, click the user to be covered (user who will be absent.)
4. In the **Sign Out To** list, click the user who will receive the absent user's messages and tasks.

5. In the **Coverage Starts** area, enter the date and time that the coverage is to start, or to select a date and time from a calendar, click .
6. On the **Calendar**, enter a coverage start time in the **HR**, **MIN**, and **AM/PM** fields.
7. Double-click the date that the coverage is to start (the first day that the user will be absent.) The EMR populates the selected date and time into the **Coverage Starts** field.
8. Under **Coverage Ends**, select one of the following options:
 - **Open ended**: The EMR forwards the absent user's messages to the covering user until you manually end the coverage.
 - **Until end of day**: The EMR forwards the absent user's messages to the covering user until the end of the **Coverage Starts** date.
 - **24 hours**: The EMR forwards the absent user's messages to the covering user for 24 hours after the **Coverage Starts** date and time.
 - **Calendar** (.

Identifying the coverage status of practitioners

If you are covering for a practitioner, or are being covered by another practitioner, you can see a notification on your WorkDesk during the time that the coverage is active.

To identify if you are signed-out or have signed-out another practitioner:

1. In the blue banner on the top of your WorkDesk, identify if one of the follow notifications is displayed:
 - "[provider name] is signed out to you until...": Indicates that you currently have another provider signed out (you are covering for another provider.)
 - "Currently signed out to [provider name] until...": Indicates that you are signed out by another provider.

- “You are covering multiple persons”: Indicates that you are covering for more than one user.

The screenshot shows the WorkDesk interface for Doctor One, M.D. A purple box highlights the text "Currently signed out to Bertrand, T" in the top right corner. Below the header, there are statistics: 10 Investigations, 10 Documents, 2 Rule Matches, 5 Current Messages, and 5 F. The main area is divided into two tabs: Messages and Appointments. The Messages tab is active, showing a list of current messages with columns for Date, Patient/To, and From. The Appointments tab is also visible, showing a list of appointments with columns for Date, Patient/To, and From.

Date	Patient/To	From
19-Aug-2011 13:44	T, Trenton	Jerald H, M.D
31-Aug-2011 16:05	B, Marylin	Jerald H, M.D
07-Sep-2011 15:16	H, Jon	Hattie R, RN
20-Sep-2011 15:38	F, Elizabet	Hattie R, RN
11-Jun-2014 10:48	* Doctor One, M.D.	Groce, D



Tip: If you are covering for multiple users over a period of time and want to view which users you are currently covering for:

On your WorkDesk, click **Sign Out > Sign Out History**. The EMR displays the Coverage History window, with:

- Your name selected in the **Sign Out To** field by default.
- A list of the practitioners you are currently covering for.

The screenshot shows the Coverage History window. It has a header "Coverage History" and a sub-header "Coverage History:". Below the header, there are filter options: User (set to <<ALL>>), Sign Out To (set to Doctor One, M.D.), Effective Date From (set to 26-Jun-2015), and End Date From (set to 27-Jun-2015). There is also a checkbox for "Show Inactive Users". Below the filter options, there is a table showing the coverage history.

User	Sign Out To	Effective Date Time	End Date Time
Ben Ashley, RN	Doctor One, M.D.	24-Jun-2015 18:03	
Dania Dykes, M.D.	Doctor One, M.D.	17-Jun-2015 18:05	30-Jun-2015 00:00

Visit encounter notes - GP

In Wolf EMR, you enter your visit notes using a structured SOAP form. From the SOAP form you can also:

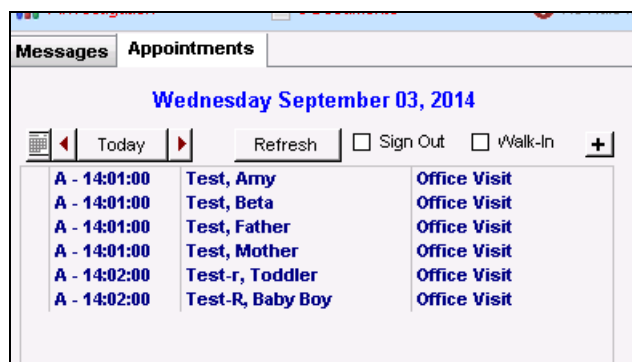
- View pertinent patient chart information. (For example, view a patient's recent lab results.)
- Perform actions in the patient's chart. (For example, prescribe a medication or refer the patient to a consultant.)
- Create basic patient bills

Starting SOAP notes

To begin a patient visit, open a SOAP note for the patient. On the SOAP note, you can enter your visit notes, view the patient's chart data, and perform actions on the patient's chart.

To open a SOAP Form for a patient:

1. On the WorkDesk, click the **Appointments** tab. The EMR displays a list of your appointments for today.



2. In the **Appointments** list, click the patient you want to start a SOAP note for.



Note: On the **Appointments** tab, you can view and select patients booked in future or on past days. Also, if a patient is not on your appointment list, but you want to start a new SOAP note for the patient, you can add the patient to your appointment list. For more information on how to:

- Navigate the appointments tab
- Add a patient to your appointment list

See [“Viewing your schedule” on page 16](#).

The EMR displays the **Patient** tab. The **Patient** tab contains the patient's **Cumulative Patient Profile (CPP)**, and includes:

- A list of the patient's previous and current encounters (office visits) that includes encounter date, status (**C** = complete, **I** = Incomplete, **P** = visit notes entered in a paper chart), attending physician, and visit type.



Note: The EMR assigns a status of **P** to an encounter if, in the attending practitioner's user profile, there is no start date entered in the **Other Data** tab, under **Use of Online Records**.



Tip: Visit notes created by you do not display initials under attending physician.

- A summary of important and recently added patient chart data.
- The **SMART Patient Banner**: Here, you can view a summary of the patient's demographic information, latest vitals and measurements, care team information, and more. See [“SMART Patient Banner overview” on page 123](#)

Tasks		Patient																																																																																								
Test, Mother																																																																																										
Home address 5980 SE Oriental Court, Olds AB T1F 0E1		Born: 06-Mar-1993 (23) Sex: F PHN: 9990234722 Status: N/A Arrived 237 mins BMI: 33.5 3 yr 3 m Weight: 68.1kg 3 yr 3 m BP: 98/60 3 yr 3 m Pri: Janna Schreiber, MD PhD FRCP Ref: Susan M. Kuhn																																																																																								
Pending Inv. No Docs No Rules 5 Messages No Follow Ups No Vaccinations																																																																																										
Templates:																																																																																										
<table border="1"> <thead> <tr> <th>Date</th> <th>Type</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>14-Mar-2016</td> <td>I</td> <td>Office Visit</td> </tr> <tr> <td>09-Jul-2013</td> <td>I</td> <td>F/U</td> </tr> <tr> <td>19-Jun-2013</td> <td>I</td> <td>msg This is a message</td> </tr> <tr> <td>22-Apr-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>25-Mar-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>13-Mar-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>16-Jan-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>15-Jan-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>15-Jan-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>09-Jan-2013</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>20-Nov-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>20-Nov-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>20-Nov-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>19-Nov-2012</td> <td>C</td> <td>Epistaxis and flushing</td> </tr> <tr> <td>29-Oct-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>11-Sep-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>11-Sep-2012</td> <td>C</td> <td>Good Response to Increase Med Dose.</td> </tr> <tr> <td>27-Aug-2012</td> <td>C</td> <td>review, multiple issues</td> </tr> <tr> <td>27-Mar-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>08-Mar-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>07-Mar-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>05-Mar-2012</td> <td>C</td> <td>review, multiple issues</td> </tr> <tr> <td>10-Jan-2012</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>04-Nov-2011</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>25-Sep-2011</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>06-Sep-2011</td> <td>C</td> <td>msg This is a message</td> </tr> <tr> <td>24-Aug-2011</td> <td>C</td> <td>social work contact</td> </tr> <tr> <td>24-Aug-2011</td> <td>C</td> <td>msg This is a message</td> </tr> </tbody> </table>		Date	Type	Description	14-Mar-2016	I	Office Visit	09-Jul-2013	I	F/U	19-Jun-2013	I	msg This is a message	22-Apr-2013	C	msg This is a message	25-Mar-2013	C	msg This is a message	13-Mar-2013	C	msg This is a message	16-Jan-2013	C	msg This is a message	15-Jan-2013	C	msg This is a message	15-Jan-2013	C	msg This is a message	09-Jan-2013	C	msg This is a message	20-Nov-2012	C	msg This is a message	20-Nov-2012	C	msg This is a message	20-Nov-2012	C	msg This is a message	19-Nov-2012	C	Epistaxis and flushing	29-Oct-2012	C	msg This is a message	11-Sep-2012	C	msg This is a message	11-Sep-2012	C	Good Response to Increase Med Dose.	27-Aug-2012	C	review, multiple issues	27-Mar-2012	C	msg This is a message	08-Mar-2012	C	msg This is a message	07-Mar-2012	C	msg This is a message	05-Mar-2012	C	review, multiple issues	10-Jan-2012	C	msg This is a message	04-Nov-2011	C	msg This is a message	25-Sep-2011	C	msg This is a message	06-Sep-2011	C	msg This is a message	24-Aug-2011	C	social work contact	24-Aug-2011	C	msg This is a message	NO KNOWN ALLERGIES PATIENT : ** LEMON, JODI ** CURRENT MEDICATIONS Melatonin 5 mg PO qhs PEG 3350 10 gm po od Topiramate (Topamax) 25 mg ii PO BID ACTIVE PROBLEMS Smith Magenis Syndrome financial stressors Astigmatism Noncompliance Appointments Headache Hypertriglyceridemia Obesity Seizure sleep disturbances global developmental delay behavioral challenges Constipation INACTIVE PROBLEMS Rectal Bleeding - NYD Pyelonephritis Polydipsia and polyuria LATEST DOCUMENTS 19-Jun-2013 Reviewed scrambled 13-Apr-2013 Reviewed scrambled 19-Mar-2013 Reviewed scrambled 13-Mar-2013 Staff Reviewed scrambled 15-Jan-2013 Reviewed scrambled NOTED FAMILY HISTORY	
Date	Type	Description																																																																																								
14-Mar-2016	I	Office Visit																																																																																								
09-Jul-2013	I	F/U																																																																																								
19-Jun-2013	I	msg This is a message																																																																																								
22-Apr-2013	C	msg This is a message																																																																																								
25-Mar-2013	C	msg This is a message																																																																																								
13-Mar-2013	C	msg This is a message																																																																																								
16-Jan-2013	C	msg This is a message																																																																																								
15-Jan-2013	C	msg This is a message																																																																																								
15-Jan-2013	C	msg This is a message																																																																																								
09-Jan-2013	C	msg This is a message																																																																																								
20-Nov-2012	C	msg This is a message																																																																																								
20-Nov-2012	C	msg This is a message																																																																																								
20-Nov-2012	C	msg This is a message																																																																																								
19-Nov-2012	C	Epistaxis and flushing																																																																																								
29-Oct-2012	C	msg This is a message																																																																																								
11-Sep-2012	C	msg This is a message																																																																																								
11-Sep-2012	C	Good Response to Increase Med Dose.																																																																																								
27-Aug-2012	C	review, multiple issues																																																																																								
27-Mar-2012	C	msg This is a message																																																																																								
08-Mar-2012	C	msg This is a message																																																																																								
07-Mar-2012	C	msg This is a message																																																																																								
05-Mar-2012	C	review, multiple issues																																																																																								
10-Jan-2012	C	msg This is a message																																																																																								
04-Nov-2011	C	msg This is a message																																																																																								
25-Sep-2011	C	msg This is a message																																																																																								
06-Sep-2011	C	msg This is a message																																																																																								
24-Aug-2011	C	social work contact																																																																																								
24-Aug-2011	C	msg This is a message																																																																																								
Filtered by: All providers Viewing 33 of 33 encounters		Filter Options																																																																																								

- On the list of encounters, double-click the encounter you want to start a SOAP note for. (In most cases this will be the incomplete (I) encounter listed at the top.)



Tip: You can filter the patient's encounter list to display only encounters with specific providers, or encounters with providers belonging to a specific security group. To filter the patient's encounter list:

1. Below the patient's encounter list, click **Filter Options**. The EMR displays the Encounter Filter Options window.

2. Perform one of the following actions:

- To view visits for a specific security group, click **Security Group** and then, in the drop-down list, select the security group you want.
- To view visits for specific providers, click **Selected providers** and then, in the list of providers, select the check box beside the provider(s) you want.

3. Click **Save**. The EMR filters the list and displays the filter criteria at the bottom of the visit list.

Date	Provider	Message
25-Sep-2011	C	msg This is a message
06-Sep-2011	C	msg This is a message
24-Aug-2011	C	social work contact
24-Aug-2011	C	msg This is a message

Filtered by: Selected providers
Viewing 33 of 33 encounters

Note: If you want to filter encounters, the Encounter filtering feature must be enabled for your clinic. For more information, contact the Wolf EMR Support Team. See ["Contacting Wolf EMR Support" on page 3](#).

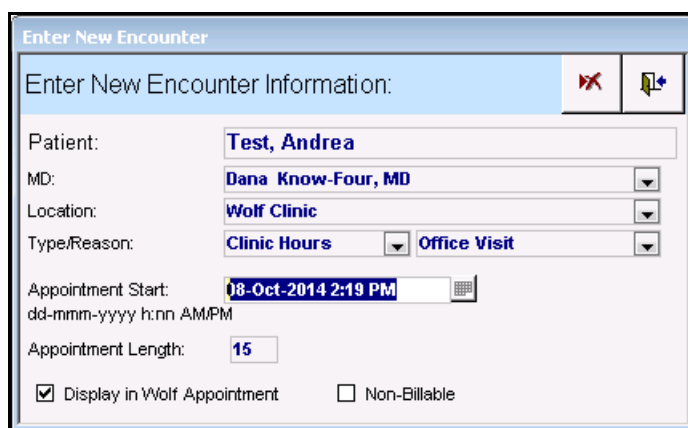
The EMR displays the Soap Note Examination window.

Starting SOAP notes for patients without booked appointments

You can start a SOAP note for a patient who does not have an appointment booked only if you add the patient to your appointment list first.

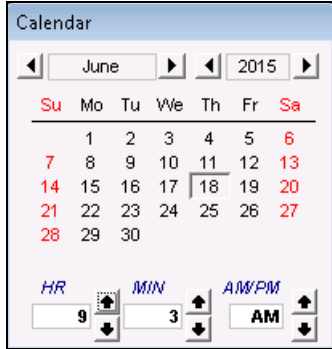
To start a SOAP note for a patient that does not have a booked appointment:

1. On the WorkDesk, click **Appointments** tab, and then navigate to the date you want to create the SOAP note for. See [“Viewing your schedule” on page 16](#).
2. On the **Appointments** tab, click **Enter New Encounter** (), and then in the Patient Search window, search for and select the patient you want. The EMR displays the Enter New Encounter Window, with the patient's name, MD, and clinic location pre-populated.



3. In the Enter New Encounter Information window, enter or modify information using the following table as a reference:

Field	Description
MD	Your name is entered by default. To make an appointment for another practitioner, in the drop-down list click the practitioner's name. Note: If your clinic has multiple locations, you can select only practitioners who are assigned to any of the locations that you are assigned to.
Location	If your clinic has multiple clinic locations, in the drop-down list, click the location you want to make the appointment for.
Type	Optionally, click the appointment type.
Reason	Optionally, click the appointment reason.

Field	Description
Appointment start	To modify the date and/or time of the appointment, click , and then on the calendar, select the time, and double click the date. 
Appointment Length	Enter the amount of time (in minutes) required for the visit.
Display in Wolf Appointment	To exclude the patient's appointment from the clinic appointment scheduler, clear this check box.
Non-Billable	To exclude the patient from the billing list, select this check box.

4. Click . The EMR displays the patient on your appointment list for the date and time you specified.

SOAP Form overview

The SOAP Form consists of four main areas in which you can view patient information, enter data, or perform various chart actions. These four areas are:

- The SMART Patient Banner
- The SOAP form toolbar
- The SOAP form
- Record Details

Soap Note Examination Date: 03-Jul-2015

SMART Patient Banner

Test, Grandfather Born 07-Feb-1952 (63) Sex M PHN 9999 999 999 Status N/A

Home address: 6146 NE Test Street, West Vancouver BC

Home (111) 111-1111 Cell (333) 333-3333 Work (222) 222-2222 x111

BMI Weight BP

Pri Shaquita C

No Inv. No Docs No Rules No Messages No Follow Ups No Vaccinations

Visit Search Change Log Print Quick Print

Record Details

SOAP Form

Soap Form Toolbar

Template Search: General Visit Template

CHIEF COMPLAINT

SUBJECTIVE

OBJECTIVE

EXAM General

BP Systolic: Pulse: Height: Units: cm in Temp: °C °F

BP Diastolic: RR: Weight: Units: kg lb

ASSESSMENT Text

PLAN

Plan items changed today

Medications: No Medication Changes.

Quick Referral Group: Investigation/Procedure:

Double Click To Set Up Quick Referral Settings

Documents: At A Glance, Cardiac Risk

No Current Medications, No Problems Noted, No Allergies Noted

Draw Picture, Apply Defaults

Order Labs, Prescribe Medication, Enter Vaccination, Create Referral

Payee Number: 44444, Insurer: Medical Services Plan BC, Fee Code: [dropdown]

Service Units / Service Time: [radio buttons], Service Units: [text box]

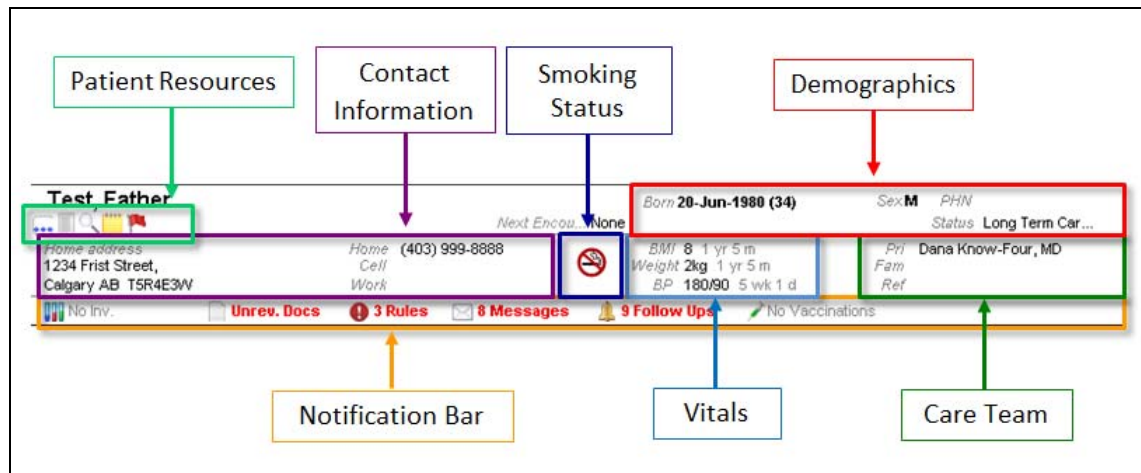
SMART Patient Banner overview

The SMART Patient Banner is located at the top of the SOAP Note Examination window. The SMART Patient Banner is also located at the top of most windows relating to a patient, including

- The Medical Summary
- The Cumulative Patient Profile (CPP) - displayed in the **Patient** tab of the WorkDesk
- On messages, follow-ups, and other tasks

Information in the SMART Patient Banner

The SMART Patient Banner contains a variety of patient information that you can view, at-a-glance in one convenient area. You can also easily edit some of the patient information, for example patient demographics.



The main areas of the SMART Patient Banner include:

- Name
- Demographics
- Patient Resources
- Contact Information
- Smoking Status
- Vitals
- Care Team
- Notification bar
- Medical Summary toolbar
- Navigation button

The following sections describe the main areas of the SMART Patient Banner

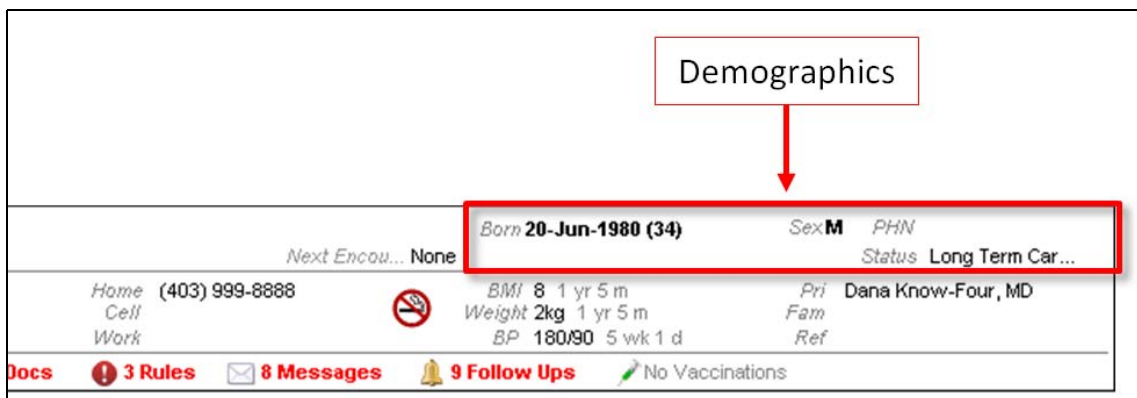
Name

The Name area is in the top left corner of the SMART Patient Banner. The Name area displays the patient's last name and first name separated with a comma. For example "Smith, Barbara."



Demographics

The Demographics area is in the top right corner of the SMART Patient Banner.



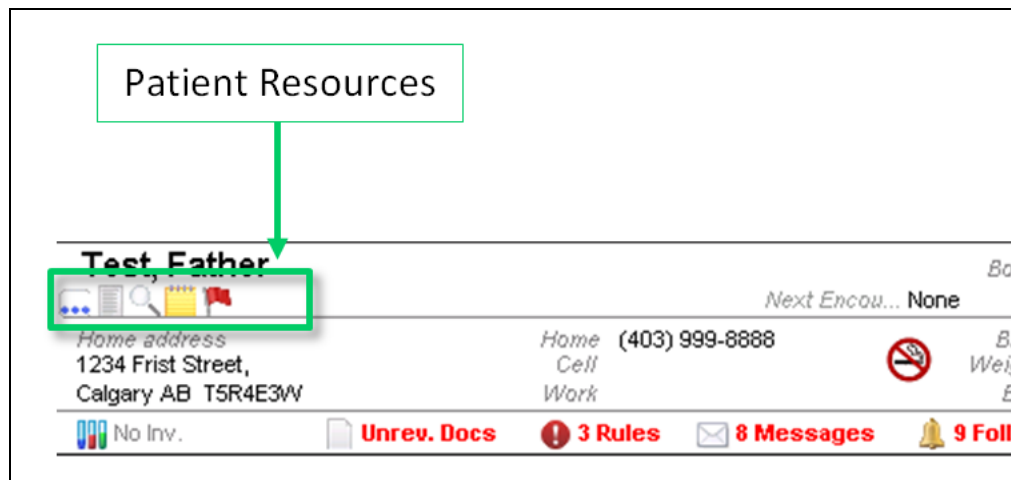
The Demographics area displays the following information:

- **Born:** The patient's date of birth. The age is shown in brackets beside the date.
- **Sex:** M/F
- **PHN:** Patient's PHN
- **Pregnant:** Displays if a patient is pregnant and how many weeks the patient is along in her pregnancy.
- **Status:** displays a patient's active Patient Status. For example, Homebound, Acute Care, Patient, or Left Practice.

Resources

The Patient Resources area is below the patient name in the SMART Patient Banner. The Patient Resources area of the SMART Patient Banner gives you easy access to more information about the patient. Some of the information is view-only; for example patient visit

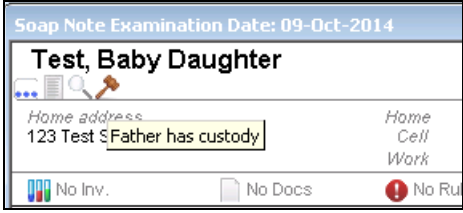
records or the patient photo. Other icons link you to other areas of the EMR where you can view and edit the information if necessary. For example, you can view and edit information in the Patient Maintenance window.



The Patient Resources area displays only icons that apply to the patient. For example, if there are no alerts for the patient, you do not see the Alerts icon. Similarly, if no notes exist for the patient, you do not see the Patient Notes icon.

The following table describes the icons you may see in the Patient Resources area.

Item	Description
View Patient Demographics Information 	Opens the Name/Adr/Phone tab in the Patient Maintenance window.
View Patient Visits 	Opens all summarized Visit Records for the patient.
Search Patient Visits 	Opens the Visit Record History window with a list of encounters to choose from, or you can use the Search function.
Patient Notes 	Opens the Notes tab in the Patient Maintenance window (if applicable).
Patient Photo 	Opens the patient's photo (if available).

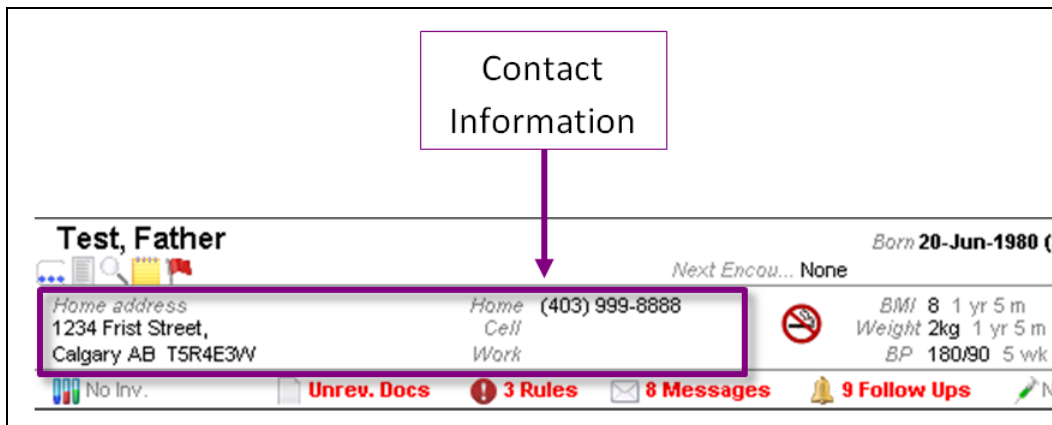
Item	Description
Alerts 	Opens alerts for the patient (if available).
Custody information 	The icon's ToolTip displays custody related text when you hover your cursor over the icon.  This icon displays if the Note field in the Custody Agreement area on the Name/Addr/Phone tab in the Patient Maintenance window is populated, and the patient is under the legal majority age for the province.
Patient Portal Status 	Opens Patient Maintenance to Portal Settings (if your clinic is set up for the Patient Portal).



Tip: If you want to open the patients' Medical Summary (medical chart), click anywhere on the SMART Patient Banner. The EMR opens the Medical Summary in a new window.

Contact Information

The Contact Information area is below the Patience Resources area in the SMART Patient Banner.



Contact Information

Test, Father Born 20-Jun-1980 (

Next Encou... None

Home address: 1234 Frist Street, Calgary AB T5R4E3W

Home (403) 999-8888

Cell

Work

BMI 8 1 yr 5 m

Weight 2kg 1 yr 5 m

BP 180/90 5 wk

No Inv. Unrev. Docs 3 Rules 8 Messages 9 Follow Ups

The Contact Information area displays the following information:

- **Home Address:** Patient's address
- **Phone Number(s):** Home, Cell, Work



Note:

- If available, caregiver information is displayed above the phone number.

Soap Note Examination Date: 09-Oct-2014	
Test, Baby Daughter	
Caregiver: Mr. Test, Irwan Arrived	
Home address 123 Test Street,	Home (111) 111-1111 Cell (222) 222-2222 Work
No Inv.	No Docs No Rules No Messages

- If the patient does not have an appointment today, or the appointment is finished, the next encounter date is displayed above the phone number. If the patient has a current appointment, the patient status, room number, and wait time is displayed.

Examination Date: 09-Oct-2014	
Baby Daughter	
Born 15-Jun-2013	
Caregiver: Mr. Test, Irwan In Room (E2) 1 min (14 mins)	
Home address 123 Test Street,	Home (111) 111-1111 Cell (222) 222-2222 Work
No Docs	No Rules No Messages 1 Follow Up

Smoking Status

The Smoking Status area is beside the Contact information area in the SMART Patient Banner.

Smoking Status	
Test, Father	
Born 20-Jun-1980 (34)	
Next Encou... None	
Home address 1234 Frist Street, Calgary AB T5R4E3W	Home (403) 999-8888 Cell Work
No Inv.	Unrev. Docs 3 Rules 8 Messages 9 Follow Ups

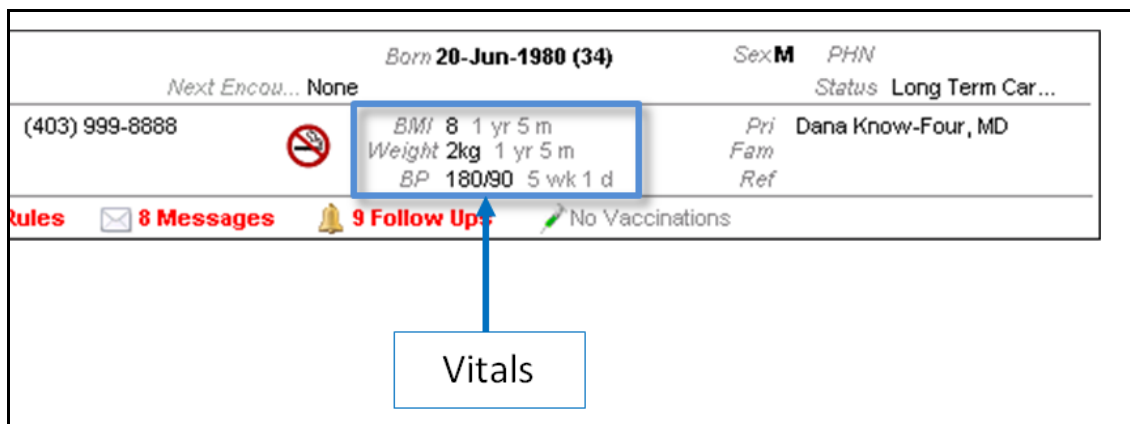
If the smoking status has been set, the smoking status appears as one of the following icons:

- Non-Smoker 

■ Smoker 

Vitals

The Vitals area is beside the Smoking Status area, and below the Demographics area in the SMART Patient Banner.



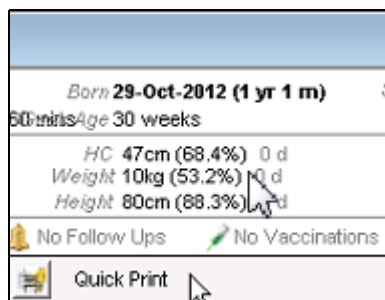
Next Encou... None		Born 20-Jun-1980 (34)	Sex M PHN
(403) 999-8888		BMI 8 1 yr 5 m Weight 2kg 1 yr 5 m BP 180/90 5 wk 1 d	Pri Dana Know-Four, MD Fam Ref
Rules	8 Messages	9 Follow Ups	No Vaccinations

Vitals

The vital information displayed depends on the age of the patient.

If a patient's age is 0 to 2 years old, the Vitals area displays the following fields, together with percentiles, if available:

- **HC:** Head Circumference
- **Weight**
- **Height**



Born 29-Oct-2012 (1 yr 1 m)	
Age 30 weeks	
HC 47cm (68.4%) 0 d	
Weight 10kg (53.2%) 0 d	
Height 80cm (88.3%) 0 d	
No Follow Ups	No Vaccinations
Quick Print	

If a patient's age is 2 to 19 years old, the Vitals area displays the following fields, together with percentiles, if available:

- **BMI:** Body Mass Index
- **Weight**

■ Height

<i>Born</i> 13-Jan-2010 (3 yr 9 m)	
<i>BMI</i>	14.2 (12.1%) 8 m 2 wk
<i>Weight</i>	14.3kg (44.4%) 8 m 2 wk
<i>Height</i>	100.5cm (83.3%) 8 m 2 wk
No Follow Ups	No Vaccinations
Change Log	Ne
Documents	Referrals

If a patient's age is 20+ years old, the following fields are listed:

- BMI
- Weight
- BP: Blood Pressure

<i>Born</i> 13-Mar-1969 (45)	
<i>BMI</i>	137.1 4 d
<i>Weight</i>	120lbs 4 d
<i>BP</i>	120/80 4 d



Note: Percentiles are based on the Canadian Dietitian (WHO) growth charts.



The time frame displays with each of the above measures. For example, a patient's BP is displayed as: BP 120/80 1y3m ago

Care Team

The Care Team area is beside the Vitals area, and below the Demographics area in the SMART Patient Banner.

Next Encou... None		Born 20-Jun-1980 (34)	Sex M PHN
(403) 999-8888		BMI 8 1 yr 5 m Weight 2kg 1 yr 5 m BP 180/90 5 wk 1 d	Status Long Term Car...
Rules		8 Messages	9 Follow Ups
No Vaccinations		Care Team	

The Care Team area displays the following information:

- **Primary MD:** Displays the default practitioner.
- **Family MD:** Displays if the patient has a family practitioner who is not the primary practitioner.
- **Referral MD:** Displays if the referring incoming practitioner is noted in Patient Maintenance.
- **Care Team:** Displays if the patient is assigned to a care team.



Tip: You can set your WorkDesk preferences to disable or enable the display of the above items:

- On the WorkDesk menu click **Configure > Configure WorkDesk > Miscellaneous** tab.

Notification bar

The Notification bar is below the Contact Information area in the SMART Patient Banner.

Test, Father		Born 20-Jun-1980 (34)		Sex M PHN
Home address 1234 Frist Street, Calgary AB T5R4E3W		Home (403) 999-8888	Cell	Work
No Inv.		Unrev. Docs	3 Rules	8 Messages
9 Follow Ups		No Vaccinations		

The Notification bar indicates how many investigations, rules, documents, and messages are available for the patient. The Notification bar also indicates how many follow ups and

vaccinations the patient is due for. Pending, un-reviewed, and recent items appear in red text. You can click any icon in the Notification bar to open the related area in the EMR. For example you can click the **Investigations** icon to open the Investigation In Basket window for the patient.

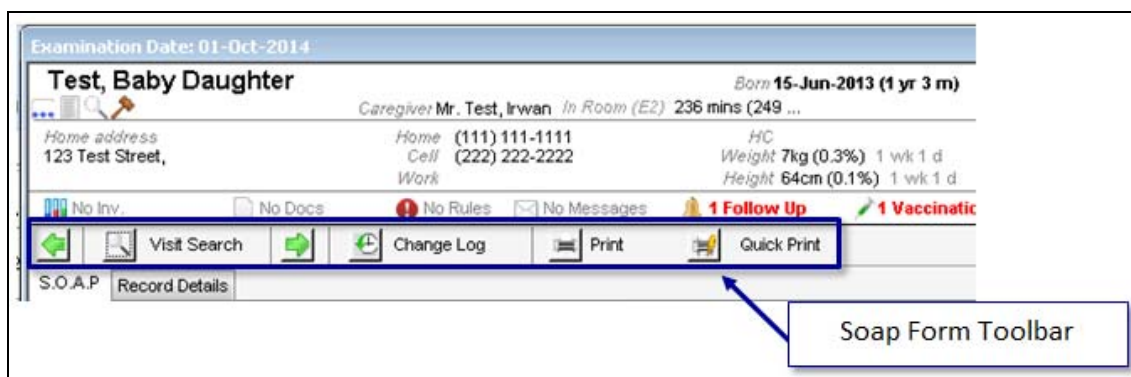
The following table describes the icons on the Notification bar.

Item	Description
Investigations 	■ Indicates how many pending investigations (Pending Inv.) or recent investigations (Recent Inv.) are that are available for the patient. Also indicates if there are no recent investigations for the patient (No Inv.). ■ Investigations are Electronic Lab or Report Submissions received by Wolf EMR. ■ You can view Excelleris text reports such as an Operative Report, or a Procedures Report from the Investigation In Basket. The EMR saves Excelleris text reports under the Documents tab in the patient's Medical Summary. ■ To view and manage the patient's un-reviewed investigations, click the icon.
Documents 	■ Indicates how many un-reviewed documents (Unrev. Docs.), or recent documents (Recent Docs) are that are available for the patient. Also indicates if there are no recent documents for the patient (No Docs). ■ Documents are scanned or faxed items that have been linked to the patient's record. ■ To view and manage a patient's un-reviewed documents, click the icon.
Rules 	■ Indicates how many rules the patient has been flagged for. Note: A rule is a search or an automated reminder that flags patients when they meet the defined criteria. For example, a patient can be flagged by a mammogram rule if the patient is over 40 years old and has not received a mammogram in 2 years. ■ To view and manage a patient's rule matches, click the icon.
Messages 	■ Indicates how many incomplete messages are related to the patient. ■ To view and manage the incomplete messages, click the icon.
Follow Ups 	■ Indicates how many incomplete follow-up tasks are related to the patient ■ To view and manage the incomplete follow-up tasks, click the icon.

Item	Description
Vaccinations 	■ Indicates how many vaccinations the patient is due for. ■ To view what vaccinations the patient is due for, click the icon.

Overview of the SOAP Form toolbar

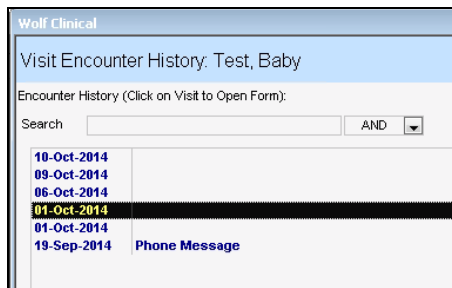
The SOAP Form toolbar is located below the Notification bar of the SMART Patient Banner.



Using the SOAP Form toolbar, you can find and view previous visit record notes, print the current visit note, or view a record of changes made to the current visit note.

The following table describes the icons on the SOAP Form toolbar.

Icon	Item	Description
	Previous Visit Record	Opens the patient's previous Visit Record.
	Next Visit Record	Opens the patient's next Visit Record.
	Visit Search	Displays a chronological list of the patient's past encounters in the Visit Encounter History window.



Icon	Item	Description
	Change Log	Displays a log of changes made to this visit record.
	Print	Displays the change printer properties window, enabling you to select a printer to print the visit record.
	Quick Print	Prints the visit record to your default printer.

Overview of the SOAP form

The SOAP Form is where you enter your visit notes and perform actions in the patient's chart. The SOAP Form contains text areas, drop-down lists, and check boxes for easy data entry. You can enter data into as much, or as little of the SOAP Form as you want.

The form also contains a variety of quick-links that you can use to view pertinent patient information (for example, patient lab results), or to perform common actions (for example, to prescribe a medication).

Soap Note Examination Date: 03-Jul-2015

Test, Grandfather Born: 07-Feb-1952 (63) Sex: M PHN: 9999 999 999 Status: N/A

Home address: 6146 NE Test Street, West Vancouver BC Home: (111) 111-1111 BMI: 22.2 x111 Weight: BP: No Messages No Follow Ups No Vaccinations

Visit Search Change Log Print Quick Print

S.O.A.P Record Details

Template Search: General Visit Template

CHIEF COMPLAINT (Visit Reason)

SUBJECTIVE (Subjective notes)
Open Hx Builder

OBJECTIVE (Objective notes)
EXAM: General
BP Systolic: Pulse: Height: Waist Circ: Length Units: cm in Temp: BP Diastolic: RR: Weight: BMI: Weight Units: kg lb

ASSESSMENT (Assessment notes)
Text

PLAN (Plan notes)
Plan items changed today
Medications: No Medication Changes.
Quick Referral Group: Investigation/Procedure:
Double Click To Set Up Quick Referral Settings

Billing entry
Payee Number: 44444
Insurer: Medical Services Plan BC
Fee Code:
Service Units / Service Time
Service Units: Service Time

The following table describes the main areas of the SOAP Form:

Area	Description
CHIEF COMPLAINT	In the text field, enter the patient's primary reason for seeing you, or select an option from the drop-down list.
SUBJECTIVE	- In the text area, enter your subjective notes. - To choose your subjective findings without having to type them, click Open Hx Builder. See "Using the History Builder" on page 144.
OBJECTIVE	- In the text area, enter your objective notes. - In the Exam area, enter data in the structured fields, drop-down lists, and check boxes.

Area	Description
ASSESSMENT	■ In the text area, enter your assessment notes. ■ In the search field, search for and select one or more diagnosis' for the visit.
PLAN	In the text area, enter your plan notes.
Billing (Optional)	If you do your own billing, or you want to send billing notes such as fee codes and service units to your billing staff, you can input billing information in the fields available here. Note: Information you enter in the Billing area carries-over to the Wolf EMR billing program, and populates the bills with the information you entered.

SOAP Form view and action links

Along the right side of the SOAP Form are a variety of links that enable you to view patient information, or perform actions on the patient's chart. The links are strategically placed, with each link located beside the area of the form you will likely be entering data in when you use the link.

Soap Note Examination Date: 03-Jul-2015

Test, Grandfather Born **07-Feb-1952 (63)** Sex **M** PHN **9999 999 999** Status **N/A**

Home address: 6146 NE Test Street, West Vancouver BC Home (111) 111-1111 Cell (333) 333-3333 Work (222) 222-2222 x111 BMI Weight BP

No Inv. No Docs No Rules No Messages No Follow Ups No Vaccinations

Visit Search Change Log Print Quick Print

S.O.A.P Record Details

Template Search: General Visit Template

CHIEF COMPLAINT

SUBJECTIVE Open Hx Builder

OBJECTIVE

EXAM General Draw Picture Apply Defaults

BP Systolic: Pulse: Height: Waist Circ: Length Units: cm in Temp: C F
BP Diastolic: RR: Weight: BMI Weight Units: kg lb

ASSESSMENT Text AND

PLAN

Plan items changed today Payee Number: 44444

Links to view patient information

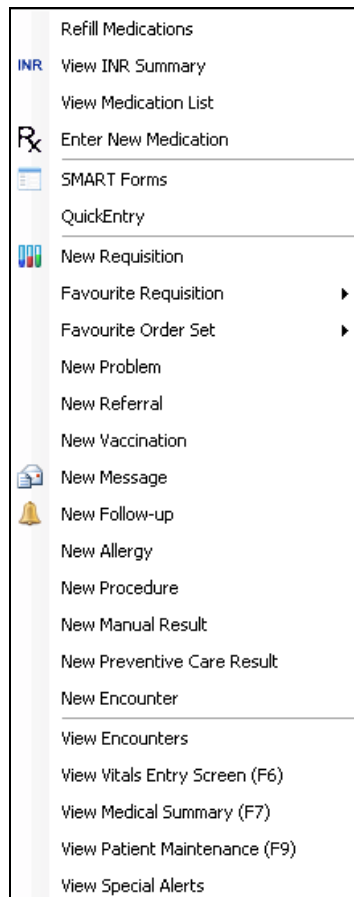
Links to perform actions

No Pending Follow-ups
Investigations
Labs
Documents
At A Glance
Cardiac Risk

No Current Medications
No Problems Noted
No Allergies Noted

Order Labs
Prescribe Medication
Enter Vaccination
Create Referral

To view a more detailed list of information you can view and actions you can perform from the patient's chart, right-click anywhere on the SOAP Form. The EMR displays the SMART Menu.



Tip: You can open the SMART menu from most windows related to a patient, including:

- The Patient tab (CPP)
- Messages and tasks regarding the patient
- The Medical Summary
- Referrals



Tip: You can customize the SMART menu so that only view and action items you use often are displayed. To customize your SMART Menu:

1. On the WorkDesk, click **Configure**. The EMR displays your WorkDesk user Preferences.
2. Click the **General** tab.
3. Click **Manage Right-Click** Menu.
4. Clear check boxes for menu items you do not want displayed on the SMART Menu.

Entering visit notes in the SOAP form

You can enter your patient visit notes using the SOAP form. In the SOAP form, you enter your subjective, objective, assessment, and plan notes into structured text areas, drop-down lists, and check boxes.

To enter a patient's visit notes in the SOAP Form:

1. Open the SOAP Form for the patient. See: ["Starting SOAP notes" on page 117](#).



Note: If an MOA, nurse, or other front end staff has entered a patient's vitals, and/or visit notes for this visit already, these notes display in the SOAP form. You can edit and add to these notes as needed.

2. In the **CHIEF COMPLAINT** field, enter a short description of the primary visit reason, or in the drop-down list, click the primary visit reason.
3. In the **SUBJECTIVE** field, enter your subjective finding notes.
4. In the **OBJECTIVE** field, enter your objective finding notes.
5. In the **EXAM** area:
 - a) Enter the patient's vitals and measurements in the available fields (if another clinical staff member has not done so already).



Note: To ensure you can graph and report on important patient vitals and other measurements, always enter this information into the appropriate fields in the Exam area. Avoid free-typing vitals and measurements into the **OBJECTIVE** text area.

- b) In the **Length Units**, **Weight Units**, and **Temp** areas, select the appropriate units of measurement.

- c) To graph a vital or measurement, beside the value you want to graph, click .



Tip: To view Growth Charts for pediatric patients, beside the weight and height values, click .



Note: The EMR displays information you enter into the **Exam** area as text below the **Objective** area.

6. In the **ASSESSMENT** area, enter the problem(s) the patient is seeing you for:
 - a) In the top field, enter all or part of a problem name or ICD9 diagnosis code.
 - b) Press **Enter**. The EMR displays a list of matching problems and codes.
 - c) In the results list, click a problem.
 - d) In the **Qualifier** field, enter the position (for example, right, left, front) or other qualifier information about the problem, or in the drop-down list, click a qualifier.
 - e) Click **Add to Assessment**. The EMR displays the selected problem in the **Structured** field.



Adding an Assessment diagnosis to a patient's problem list

If you want to effectively identify, track, and manage patients who have specific problems, always add important problems to a patient's problem list.

If the diagnosis is not on the patient's problem list already, you can add the diagnosis to the patient's problem list from the SOAP Form itself:

1. In the **Assessment** area, in the **Structured** field, click the diagnosis you want to add to the patient's problem list.
2. To the right of the **Assessment** area, click **Add to Problem list**.

- f) To add another diagnosis, repeat [Step 6](#)
7. In the **ASSESSMENT** area, in the text area, enter any additional assessment notes.
8. In the **PLAN** area, enter any notes on your plan for treatment, referrals, follow-up, etcetera.
9. To populate the patient's bill at this time:
 - a) In the **Insurer** drop-down list, click the insurer, individual, or company you want to bill.
 - b) In the **Fee Code** drop-down list, click a fee code that applies to the visit.



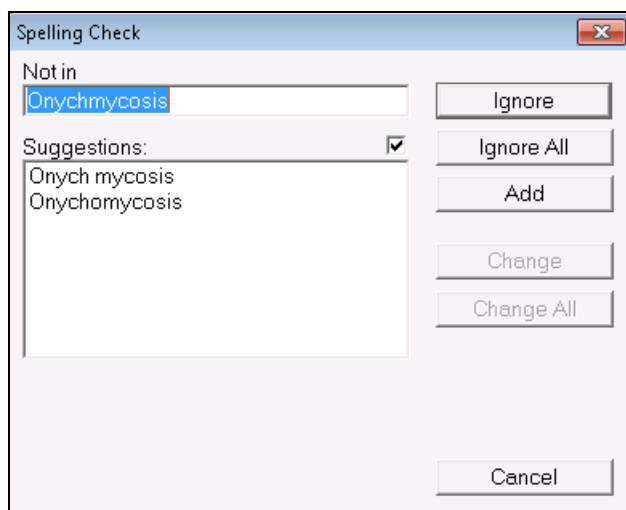
Note: You can enter only one service code in the SOAP form. If you want to add additional service codes, you must add them in the billing window. See the [Wolf EMR Billing User Guide](#).

c) In the **Service Units/Service Time** area, complete one of the following actions:

- To enter the number of service units, select **Service Units**, and then enter a number in the **Service Units** field.
- To enter a service time, select **Service time**, and then enter a start and end time in the **Service Start/End time** fields.

10. To check spelling in your SOAP note:

- a) On any text area (for example, the **SUBJECTIVE** text area), right-click.
- b) Click **Check Spelling**. If unidentified words are recognized, the EMR displays the Spelling Check window.



c) For each word identified, complete one of the following actions:

- To skip the word, click **Ignore**.
- To skip all instances of the word, click **Ignore All**.
- To change the word to a suggested option, in the **Suggestions** area, click a word, and then click **Change**.
- To change all occurrences of the word to a suggested option, in the **Suggestions** area, click a word, and then click **Change All**.
- To add the word to your dictionary, click **Add**.

11. When you are finished, Perform one of the following actions:

- To save the form, mark the visit as complete, and convert the form to read-only, click

Lock Form (.

- To add more information to the SOAP Form at a later time, click **Save & Close** (). The EMR saves your visit notes, but leaves the visit status as Incomplete. The SOAP form remains editable, and displays on your Incomplete Visit Notes list.

12. The EMR displays a dialog box with the following prompt: "Sign and Lock Record?"

13. To Lock the form, and mark it as complete, click **Yes**.



Note: No matter which closing option you choose, you are prompted to indicate if you want to lock the visit note.

A visit note is never truly "locked", you can always edit a locked note if needed.

Entering SOAP Form visit notes using shortcuts and templates

If you enter similar notes, sentences, or paragraphs for certain types of visits, you can use a variety of Wolf EMR template options to enhance your work efficiency.

In using templates for visit note entries, you also record your data in a more consistent manner, enhancing your ability to search for and report on data.

Wolf EMR template options include:

- SOAP Form templates
- Exam templates
- The History Builder
- Auto-Replace text
- Pictures

Using SOAP templates

A SOAP Template is a version of the SOAP form that is pre-populated with information specific to a certain type of visit. SOAP templates can have:

- The **Chief Complaint** field pre-populated with a visit reason.
- History Builder options customized to the visit type. (See ["Using the History Builder" on page 144](#))
- Information pre-entered in any of the text fields.
- A specific Exam template open. (See ["Using Exam templates" on page 148](#))

- A high-level problem added to the Assessment field (for example, Diabetes).



Chronic Disease Management (CDM) SOAP templates:

Wolf EMR contains numerous Chronic Disease Management (CDM) SOAP templates for you to use. The CDM templates structure the SOAP form around current disease-specific clinical guidelines.

CDM SOAP templates help you understand your patient base and focus on prevention when monitoring chronic disease patients. If you enter CDM visit data using appropriate SOAP templates, you can:

- View a patient's latest vitals and lab results on the visit note itself.
- Track patient trends, disease progress, and compliance for entire groups of patients diagnosed with a specific chronic disease (using Practice Search reports).
- Track a specific patient's treatment plan, disease progression, and compliance (using disease-specific flowsheets).
- Receive automated reminders for chronic disease patients who are due for specific tests, follow-up appointments, lifestyle advice, and treatments (using Rules).

CDM SOAP templates available in Wolf EMR include:

- Diabetes Mellitus Review
- Diabetes Mellitus (BCMA)
- Hypertension (CDM)
- COPD
- CHF (Cardiac Heart Failure)
- Chronic Kidney Disease (CDM)
- Depression (CDM)

To enter a patient's visit notes using a SOAP Template:

1. Open the SOAP Form for the patient. See: ["Starting SOAP notes" on page 117](#).
2. In the **Template Search** drop-down list, click the template you want. The EMR loads the template in the SOAP form and displays the template name at the top of the SOAP form.
3. If the SOAP Template is a CDM template:
 - a) In the **SUBJECTIVE** area, enter your notes using History Builder. See ["Using the History Builder" on page 144](#).

- b) In the **OBJECTIVE** area, enter your notes in the **EXAM** area. See [“Using Exam templates” on page 148](#).
4. Edit any other pre-populated information as necessary, and complete the remainder of the form as normal. See [“Entering visit notes in the SOAP form” on page 139](#).

Using the History Builder

Using the History Builder you can enter a patient's symptoms and other subjective notes by clicking items in a series of selections. The EMR translates your selections into written text..



IMPORTANT: Use the History Builder when entering notes for your chronic disease patients. The EMR can pull subjective notes only created using History Builder into Chronic Disease Management (CDM) Flowsheets.

To enter subjective notes using History builder:

1. Open the SOAP Form. See: [“Starting SOAP notes” on page 117](#).
2. In the **SUBJECTIVE** area, click **Open Hx Builder**. The EMR expands the **SUBJECTIVE** area to display the Hx Builder area, with:
 - Subjective note categories listed in the far left column
 - Subjective note choices for the selected category listed in the middle column
 - A text area on the right side of the window, displaying text that will populate the **SUBJECTIVE** area of the SOAP note.

3. In the list of symptom categories, click an option. The EMR displays a new column with a list of associated symptoms.

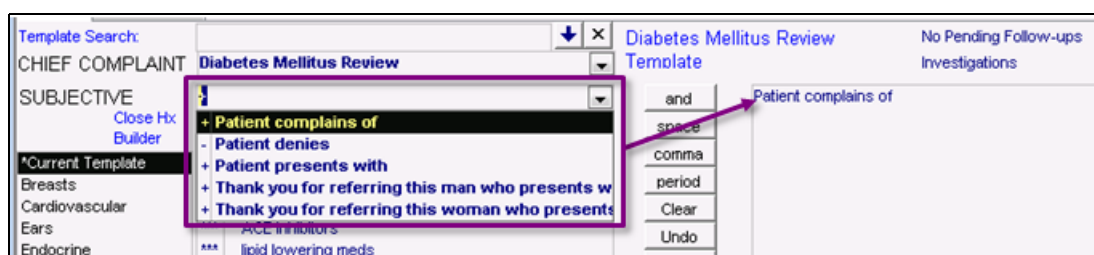


Note: If you are using a SOAP template, the symptom options that display for ***Current Template** are specific to the SOAP template.



Note: Do not click a symptom yet.

4. To change the pre-defined statement at the beginning of your subjective notes, for example to “Patient complains of...”, in the drop-down list beside the **SUBJECTIVE** tag, click a statement. The statement displays in the far right column prior to your notes.



5. Above the list of associated symptoms, complete one of the following actions:
- To indicate that the patient exhibits the symptom, click **Positives**.
 - To indicate that the patient does not exhibit the symptom, click **Negatives**.
6. To add details about onset of the symptom, for example “instant onset”, in the **Onset** drop-down list, click the option you want. The EMR displays the associated statement in the far right column.
7. In the column listing subjective note options, click the subjective note you want to add.



Tip: Subjective note options that contain three asterisks (***) pull information from the EMR. For example, if you select ***** <<LastLabHbA1C>>**, the EMR pulls the patient's latest Hemoglobin A1C result into the **SUBJECTIVE** notes.

The EMR:

- Enters the subjective note in the far right column, following the onset information you selected.

- Displays a positive (+) or negative (-) indicator beside the symptom in the list of subjective note options.

8. To add duration information about the selected symptom, for example “for 2 days”, in the **Duration** drop-down list, click an option. The EMR displays the associated statement in the far right column following the symptom you selected.
9. To add frequency information about the selected symptom, for example “intermittent”, in the **Frequency** drop-down list, click an option. The EMR displays the associated statement in the far right column following the selected symptom.
10. To add severity information about the selected symptom, for example “moderate”, in the **Severity** drop-down list, click an option. The EMR displays the associated statement in the far right column following the symptom you selected.
11. To add another symptom:
 - a) Indicate how you want your symptoms list structured in the **SUBJECTIVE** text area:
 - To display your symptoms as a horizontal list, click **space**. The EMR inserts a space in the right column, following the symptom you just entered
 - To display your symptoms as a sentence, click **comma**, **and**, or **period**, depending where in the sentence the next symptom is located. The EMR inserts a comma, the word “and”, or a period in the right column, following the symptom you just entered.
 - b) Repeat [Step 3](#) to [Step 10](#)



Note: Only symptoms categorized under ***Current Template** allow you to add list structure (space, comma, and, period), onset details, frequency details, or severity details.

For symptoms listed under all other categories, after you select a symptom, a **Comments** field displays instead. In the **Comments** field, manually enter any onset, frequency, and severity details.



Tips for adding symptoms

- If you enter a symptom in error, click **Undo**. The EMR clears the latest text entry in the far right column.
- To redo a symptom entry that you “undid” by accident, click **Redo**. The EMR re-enters the last text entry.
- If you want to edit contents in the text area (far right column), click the area. The text area becomes editable. You can now add, modify, and delete text as needed.



Removing symptoms that were entered in error

If you enter a symptom in error you must remove it from the text area (using **Undo**, or by manually deleting the text), and then “de-select” the symptom from the list of subjective options.

To “de-select” an option from the list of subjective options:

- Above the list of subjective options, click **Remove**, and then click the option you want to remove. The EMR removes the **+** or **-** indicator beside the option.

12. When you finish, click **Close Hx Builder**. The EMR displays the symptoms you selected in the Hx Builder within or directly below the **SUBJECTIVE** text area:

- ***Current Template** symptoms you selected display in the **Subjective** field itself.
- Symptoms you selected from other symptom categories display below the **SUBJECTIVE** field, and are grouped by category.



Editing your Hx Builder notes

You can edit subjective notes created with Hx Builder if necessary:

- If you have created symptom notes using the Hx Builder that display within the **Subjective** text field, you can edit these notes within the **Subjective** field itself.
- If you have created categorized symptom notes using the **Hx Builder** that display below the Subjective field, you can edit your symptom notes from the Hx Builder area. To edit symptom notes:
 1. Click **Open Hx Builder**. The EMR expands the Subjective area to display the Hx Builder area.
 2. Click the category of the specific symptom you want to edit.
 3. To delete a symptom, click **Remove**, and then click the symptom. The EMR removes the symptom from the column on the right.
 4. Add new, or modify symptoms as necessary.

Using Exam templates

You can enter objective visit notes using visit-specific templates called Exams. Exams contain fields specific to a particular problem or type of examination. For example, a **Back** structured examination template contains fields such as back flexion, back extension, and leg strength.

Wolf EMR contains numerous disease-specific Chronic Disease Management (CDM) structured examination templates that you can use to enter data. The CDM structured examination templates help you to understand your patient base and focus on prevention when monitoring chronic disease patients. If you enter CDM visit data using the appropriate templates, you can:

- Track patient trends, disease progress, and compliance for entire groups of patients diagnosed with a specific chronic disease (using Practice Search reports).
- Track a specific patient's treatment plan, disease progression, and compliance (using disease-specific flowsheets).
- Receive automated reminders for chronic disease patients who are due for specific tests, follow-up appointments, lifestyle advice, and treatments (using Rules).

The default **General Exam** that displays below the **OBJECTIVE** area of the SOAP Form (where you input the patient's vitals and measurements) is an example of a Structured Examination. Wolf EMR contains numerous other Exams that you can use for specialized visit types. For example, you can use the Diabetes Review or Rourke (pediatric) Structured Examinations.



Note: You can create your own customized Structured Exam templates if desired.

To enter notes using Exam templates:

1. Open the SOAP Form. See: [“Starting SOAP notes” on page 117](#).
2. In the **Objective** area, in the **Exam** drop-down list, select an exam. The EMR hides the General Exam, and displays the selected exam.

The screenshot shows the 'Diabetes Review' exam template. At the top, there's a dropdown menu for 'EXAM' set to 'Diabetes Review', with buttons for 'Close Exam', 'Draw Picture', and 'Apply Defaults'. The form is organized into several sections:

- Glucose and Lipid Data:** Patient Blood Glucose Range, Patient Lipid Risk, Hypoglycemic Episode Past Week.
- Vitals and Physical Measurements:** BP Systolic, BP Diastolic, Pulse, BMI, Height (cm/in), Weight (kg/lb).
- Cardiac and Renal Data:** HgA1C, Cholesterol, Triglycerides, Creatinine, Microalbumin, Albumin/Cr, Framingham Score.
- Neurological and Sensory Data:** S1, S2, S3, S4, Deep Tendon Reflexes, Vibration, Sensation, Pinprick, 10 g Monofilament Test.
- Other Data:** Carotid Bruit? (Right/Left), DP, PT, Last Ophthalmology Consult.
- Notes:** A large text area for additional notes.



Note: If you have selected a SOAP template, an Exam may already be open in the **OBJECTIVE** area of the SOAP Form.

3. Enter your exam data in the text fields, check boxes, and drop-down lists available in the Structured Exam template.



Tips for entering Exam data

- To view values that were previously entered in a specific field, double-click the field. The EMR displays a summary of values previously entered for the patient and the corresponding exam dates.
- To view a patient's Medical Summary (chart) while entering information into an exam, on your keyboard, press **F7**.

4. To insert pre-defined default values in the remainder of the fields, click **Apply Defaults**.
5. When you are finished, click **Close Exam**. The EMR displays a text summary of the information you entered below the **OBJECTIVE** text area, and defaults back to the General Exam template.



Editing an Exam after you have closed it

After you close an Exam the information you entered is visible as read-only text below the Objective area. You can, however, go back to the original exam and make edits at any time:

- Simply re-select the exam from the Exam drop-down list, and the Structured Examination displays with the information you entered.
- Edit the exam information as needed.

6. To use another Structured Exam template during the same visit, repeat [Step 2](#) to [Step 4](#)

Using SMART exams

For questionnaire-type diagnostic tools (such as mental health assessments) and for complex visit documentation (such as the Pain Management Functional Goals & Summary), you can enter data using specialized SMART forms called SMART exams. When you enter data using SMART exams:

- The EMR automatically calculates questionnaire scores.
- For questionnaire scores and other exam data: You can graph values and perform patient searches based on values.

Most Wolf EMR SMART exams also contain links to patient handouts and other physician resources related to specific diagnostic tools.

The following table lists and describes the SMART exams available in Wolf EMR.

Name	Description
Adult Mental Health Assessment SMART exams The Adult Mental Health SMART Exams are designed to support the British Columbia Practice Support Program (PSP) for mental health, however, these forms can also be used by providers from other provinces. The Adult Mental Health Assessment SMART exams incorporate the PSP mental health algorithm, questionnaires, patient handouts, and other physician resources.	
Adult Mental Health Assessments	Combines content from all other mental health SMART exams, and includes ■ Generalized Anxiety Disorder Questionnaire (GAD-7) ■ Patient Health Questionnaire-9 (PHQ-9) ■ Diagnostic Assessment Interview Questions ■ Self-Assessment Questionnaire ■ Montreal Cognitive Assessment Questionnaire (MoCA) ■ Standardized Mini-Mental State Exam (sMMSE) ■ Mood Disorder Questionnaire (MDQ) ■ Global Assessment of Functioning (GAF) Scale ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References Note: Use this SMART exam if you are managing several mental health disorders for a patient. Complete only the exam sections that apply to the patient.

Name	Description
Adult Mental Health Assessments - Anxiety	Contains mental health diagnostic tools and resources for anxiety, and includes: ■ Generalized Anxiety Disorder Questionnaire (GAD-7) ■ Self-Assessment Questionnaire ■ Montreal Cognitive Assessment Questionnaire (MoCA) ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References
Adult Mental Health Assessments - Cognitive Function	Contains mental health diagnostic tools and resources for cognitive function, and includes: ■ Montreal Cognitive Assessment Questionnaire (MoCA) ■ Standardized Mini-Mental State Exam (sMMSE) ■ Mood Disorder Questionnaire (MDQ) ■ Global Assessment of Functioning (GAF) Scale ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References

Name	Description
Adult Mental Health Assessments - Depression	Contains mental health diagnostic tools and resources for depression, and includes: ■ Patient Health Questionnaire-9 (PHQ-9) ■ Diagnostic Assessment Interview Questions ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References
Child and Youth Mental Health SMART exams The Child and Youth Mental Health SMART Exams are designed to support the British Columbia Practice Support Program (PSP) for child and youth mental health, however, these forms can also be used by providers from other provinces. The Child and Youth Mental Health SMART exams incorporate the PSP mental health algorithm, questionnaires, patient handouts, and other physician resources.	
Child & Youth Mental Health Visit	Designed for the screening of mental health conditions, and includes: ■ CYMH Historical Questions ■ Current Situations ■ 6 Item Kutcher Adolescent Depression Scale (KADS) ■ Screen for Child Anxiety Related Disorders ■ SNAP-IV (Parent & Teacher Versions)

Name	Description
Child and Youth Mental Health Screening	Designed for documenting ongoing mental health care, and includes: ■ Teen & Child Functional Assessments ■ 6 Item Kutcher Adolescent Depression Scale (KADS) ■ Tool for Assessment of Suicide Risk (TASR-Am) ■ Anxiety, Depression Medication Side-Effect Scale (sCKS) ■ Kutcher Side Effect Scale for ADHD Medications (KSES-A) ■ Clinical Global Impression - Improvement Scale (CGI) ■ Worry Reducing Prescription (WRP) ■ Mood Enhancing Prescription (MEP) ■ CYMH Support Plan ■ Family Mental Health Care Plan ■ Professional Mental Health Care Plan ■ CYMH Historical Questions ■ Instructions for accessing the Confident Parents Thriving Kids (BC) form ■ Psychotherapeutic Supports Used ■ Team-based Care Resources & Tools ■ References
Pain Management SMART exam The Pain Management SMART Exam is designed to support the British Columbia Practice Support Program (PSP) for the management of patients with chronic pain, however, these forms can also be used by providers from other provinces. The Pain Management SMART exam incorporates PSP tools, questionnaires, patient handouts, and other physician resources related to the management of pain.	

Name	Description
Pain Management	Includes: ■ Brief Pain Inventory ■ Urine Drug Screen ■ Red & Yellow Flags ■ Brief Pain Inventory (BPI) Questionnaire ■ Pain Disability Index (PDI) Questionnaire ■ Generic Body Exam ■ PHQ-9 & Gad-7 Questionnaires ■ Sleep Questionnaire ■ DN4 Screening Questionnaire ■ Pain Catastrophizing Scale (PCS) Questionnaire ■ Initiation Checklist ■ Opioid Risk Tool ■ D.I.R.E. Score ■ Initiation Trial Chart ■ PharmaNet Search confirmation ■ Opioid Switching Tool ■ Patient Termination Letter (Opioid Use) ■ Pain Management Functional Goals & Summary Handout ■ Brief Action Plan - Self Management ■ Pain Management Education Done confirmation ■ PSP Pain Management Algorithm ■ References and Additional Handouts

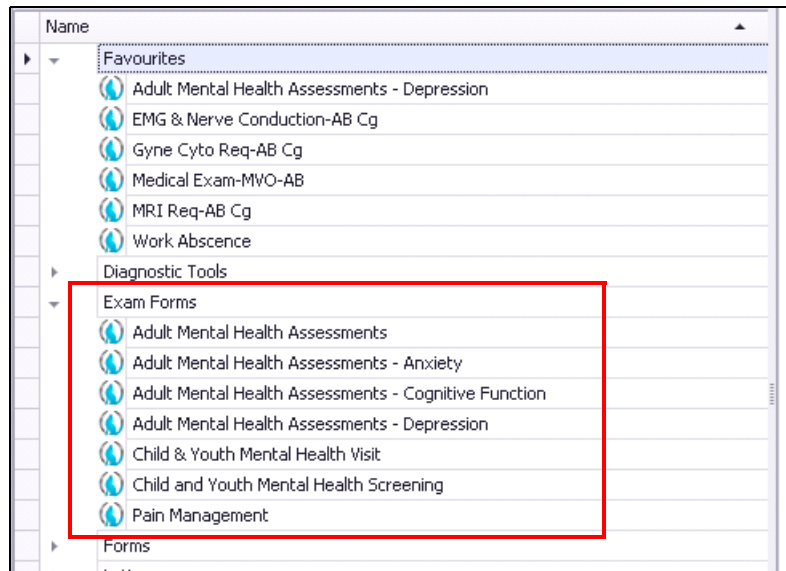


Note: You can access SMART exams only from the SOAP Note Examination window or from the Consult Letter Examination window (specialists), as the exam must be connected to a patient visit.

To use a SMART exam:

1. Open a SOAP form for the visit: See [“Starting SOAP notes” on page 117](#).

2. Right-click anywhere on the window and then, in the SMART menu, click **SMART Forms**. The EMR displays the Send to SMART form window.
3. In the left pane, expand the **Exam Forms** category, and then click the SMART exam you want.



The EMR previews the exam.



Tip: If you want to complete a number of mental health assessments from one window, select the **Mental Health Assessments** exam. This exam combines the anxiety, cognitive function, and depression exams.

4. Click **Send and Close** (), or in the list of SMART exams, double-click the exam. The EMR opens the SMART exam in Microsoft Word.

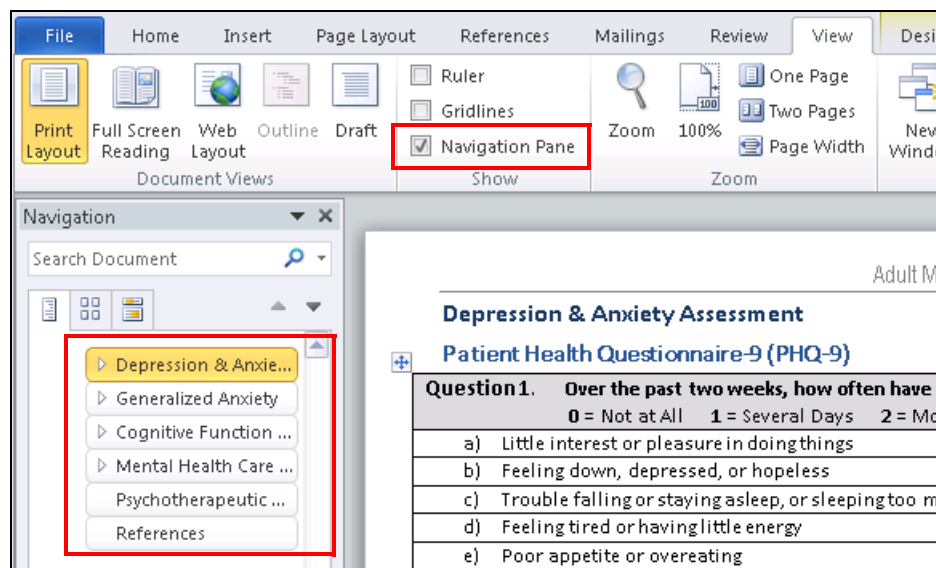
Adult Mental Health Assessments		19-Jul-2016
Depression & Anxiety Assessment		
Patient Health Questionnaire-9 (PHQ-9)		
Question 1. Over the past two weeks, how often have you been bothered by any of the following problems? 0 = Not at All 1 = Several Days 2 = More than half the days 3 = Nearly every day		
a) Little interest or pleasure in doing things		
b) Feeling down, depressed, or hopeless		
c) Trouble falling or staying asleep, or sleeping too much		
d) Feeling tired or having little energy		
e) Poor appetite or overeating		
f) Feeling bad about yourself, or that you are a failure or have let yourself or your family down		
g) Trouble concentrating on things, such as reading the newspaper or watching television		
h) Moving or speaking so slowly that other people could have noticed; or the opposite: being so fidgety or restless that you have been moving around a lot more than usual		
i) Thoughts that you would be better off dead, or of hurting yourself in some way.		
PHQ-9 Scoring Guide: 5-14 = Mild 15-19 = Moderate 20+ = Severe IMPORTANT: Enter the Calculated Score in the PHQ-9 Score to Document.		[Click for Result] PHQ-9 Score: 0
Question 2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		
		SELECT
Paper Copy : Click for PHQ-9 Questionnaire Patient Information: BC Depression Treatment Guide		Copyright Notice: PHQ 1999 Pfizer Inc. All rights reserved. PHQ-9 reproduced with permission by Med Access Inc

5. Enter data in the applicable area(s) of the SMART exam.



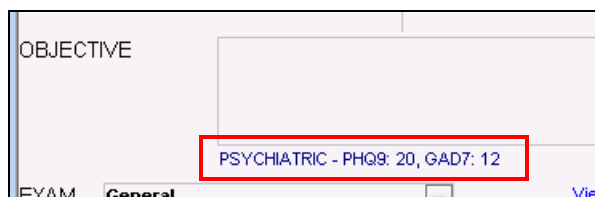
Tips for entering data in SMART exams:

- To calculate a questionnaire score, click **Click for Result**.
- If the exam has numerous sections, you can use the **Navigation** pane (left pane) to jump to specific sections.



- You do not have to enter data in every section of the SMART exam. Complete only the exam sections that apply to this visit

6. Click **Save** (), and then close the window. If you close and then reopen this visit's SOAP form, the calculated scores for the questionnaire(s) you completed display below the **OBJECTIVE** area.



FAQ: After I save and close the SMART exam can I go back and make edits?

After you save and close a SMART exam, you cannot open and edit the original exam. Instead, start a new version of the SMART exam (see [Step 1](#) to [Step 4](#)), and then re-enter data in the fields and questionnaires you want to modify. When you save the new SMART exam, the EMR overwrites the areas of the form where you entered data.

Auto-Replace text

Using the Wolf EMR auto-replace feature, you can quickly insert pre-defined words, phrases, and paragraphs into the SOAP Form. Auto-replace is especially useful to enter repetitive text you use often in patient visit notes, and to enter difficult-to-spell words (for example, "Onychomycosis" [a fungal nail infection]). You can also use auto-replace text in other areas of the Wolf EMR including:

- Messages and follow-ups
- Referrals letters
- Consult letters

Using Auto-replace

To use auto-replace text:

1. In any text field on the SOAP Form, click where you want the Replace Text to insert.
2. Enter a pre-defined Replace Term (for example, "tci"), and then press the **Space Bar** key. The EMR replaces the term you entered with the associated Replace Text (for example, "to come in").
3. Edit the inserted text as necessary.



Note: The replace term is NOT case sensitive, however, the capitalization you use when entering the term in your note IS important. For example, the Replace term of "tci" with Replace Text of "To Come In", inserts as follows:

- Entering "tci" will be replaced with "to come in"
- Entering "TCI" will be replaced with "TO COME IN"
- Entering "Tci" will be replaced with "To come in"



Turning off Auto-replace

If you do not want to use the Auto-replace feature in Wolf EMR, you can turn this feature off. This way, you do not risk your text being inadvertently replaced with auto-replace text.

To turn off auto-replace:

1. On your WorkDesk, click **Configure > Configure WorkDesk**. The EMR displays your WorkDesk User Preferences window.
2. Click the **Spell Check** tab.
3. Clear the **Apply Clinic Setting** check box (if it is currently selected).
4. Clear the **Auto replace** check box.

5. Click **Save & Close** ().

Creating Auto-Replace text

To create auto-replace text:

1. On your WorkDesk, click **Configure > Configure Workdesk**. The EMR displays the WorkDesk User Preferences window.
2. Click the **Spell Check** tab. The EMR displays auto-replace terms and associated text in the **Replace text word pairs** area, with:
 - Your personal auto-replace templates listed on the left.

- Clinic-wide auto-replace templates listed on the right.

WorkDesk User Preferences
WorkDesk Preferences for Dana Know-Four, MD

General | **Spell Check** | Message | Miscellaneous | Document Templates and Drawings Folders | Medications | Graph | Visit Exams

Spell Checker Preferences

User Setting: Use Spell Checker ☒ Auto replace ☒ Auto Correct ☐ Apply Clinic Setting ☐

Clinic Setting: Use Spell Checker ☒ Auto replace ☒ Auto Correct ☐

Alternate Main Dictionary: [Browse] Apply Clinic Setting ☒ [Browse]

Alternate Thesaurus: [Browse] Apply Clinic Setting ☒ [Browse]

Custom Dictionary: W:\Wolfdata\CustomDictionaries\know-four.dana.A2C [Browse] W:\Wolfdata\CustomDictionaries\ClinicCustomDicti [Browse]

Replace text word pairs

Replace	Replace Text
exam1	This is an exam for various problems due to a higugar diet faced in northa me
htn	hypertension
plan1	All systems are normal, recheck in 1 year.
	Thank you for seeing this

Replace	Replace Text
rc1	Recheck 1 month, sooner prn.
rc3	Recheck 3 months, sooner prn.
rc2w	Recheck 2 weeks, sooner prn.
rc2	Recheck 2 months, sooner prn.

3. Click **Add Replace text word pair** () . The EMR inserts an empty row on the Replace text word pairs list.
4. In the **Replace** column, enter the simple term to be typed (and replaced by the replace text you define later).



Note: A replace term can be used only once for the entire clinic, even if the term is used for a User-specific auto-replace template.



Tips for creating effective Replace Terms:

- The replace term is not case sensitive. You can enter all of your terms in lower case.
- Do not include any spaces or special characters in your replace term (for example, !#\$%*_+.). The Replace Text does not insert if either a space or special character is part of the term.
- If you have a large number of clinic staff who are creating auto-replace templates, consider adding your initials to the beginning of your replace terms. This way, each user can use a similar term, but with their own individualized replace text.

5. In the **Replace Text** column, enter the text you want inserted when the replace term is entered.

6. Click **Save & Close** ()



Note: Always create and save auto-replace text BEFORE opening the screen where the replace text will be used. For example, if you are in the process of creating a visit note, and, in the middle of the writing your notes you open the Configure WorkDesk screen and add a new replace text item, close and re-open the SOAP Form before you use the new replace term.

Editing Auto-Replace text

After you create an auto-replace term and text pair you can edit or delete your text as needed.



Note: If you do not have Administrator Authority in Wolf EMR, you can edit or delete only auto-replace text you created.

To edit or delete Auto-Replace text:

1. Open the WorkDesk User Preferences window, and then click the **Spell Check** tab. See [Step 1](#) to [Step 2](#) in “Creating Auto-Replace text” on page 160.
2. To edit a replace term or replace text, double-click the appropriate field, and then edit the text.
3. To delete an auto-replace text entirely:
 - a) On your auto-replace text list click the text you want to delete.
 - b) Click **Delete** (). The EMR displays a dialogue box with the following prompt: “Are you sure you want to delete <Auto-Replace text name>?”
 - c) To delete the Auto-Replace text click **Yes**. The EMR removes the Auto-Replace text from the list.

4. Click **Save & Close** ()

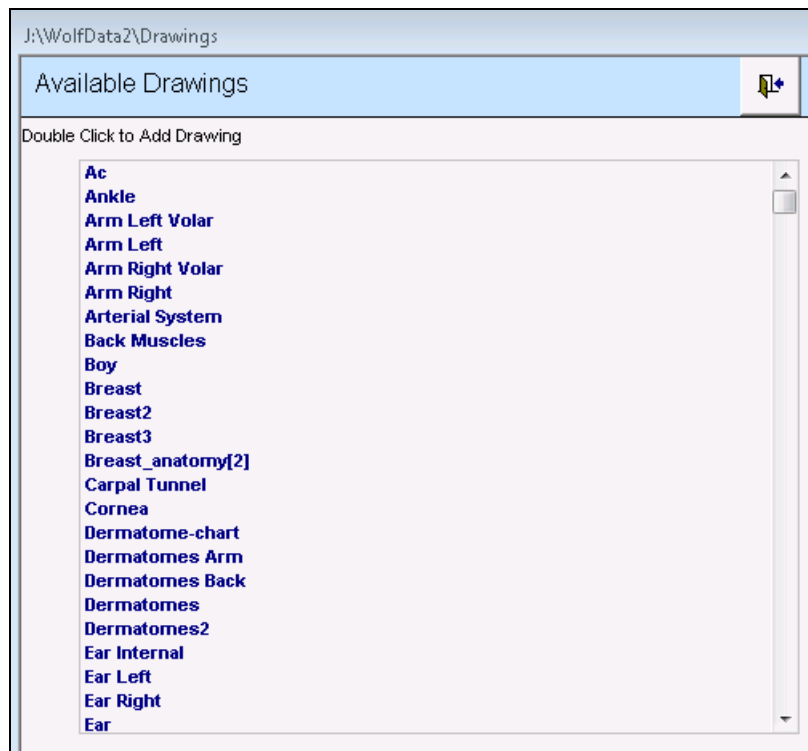
Using pictures

On the SOAP Form, you can select a medical picture and mark it up with lines, shapes, and text. You can highlight areas of symptoms, or injury without having to enter a long description to identify location.

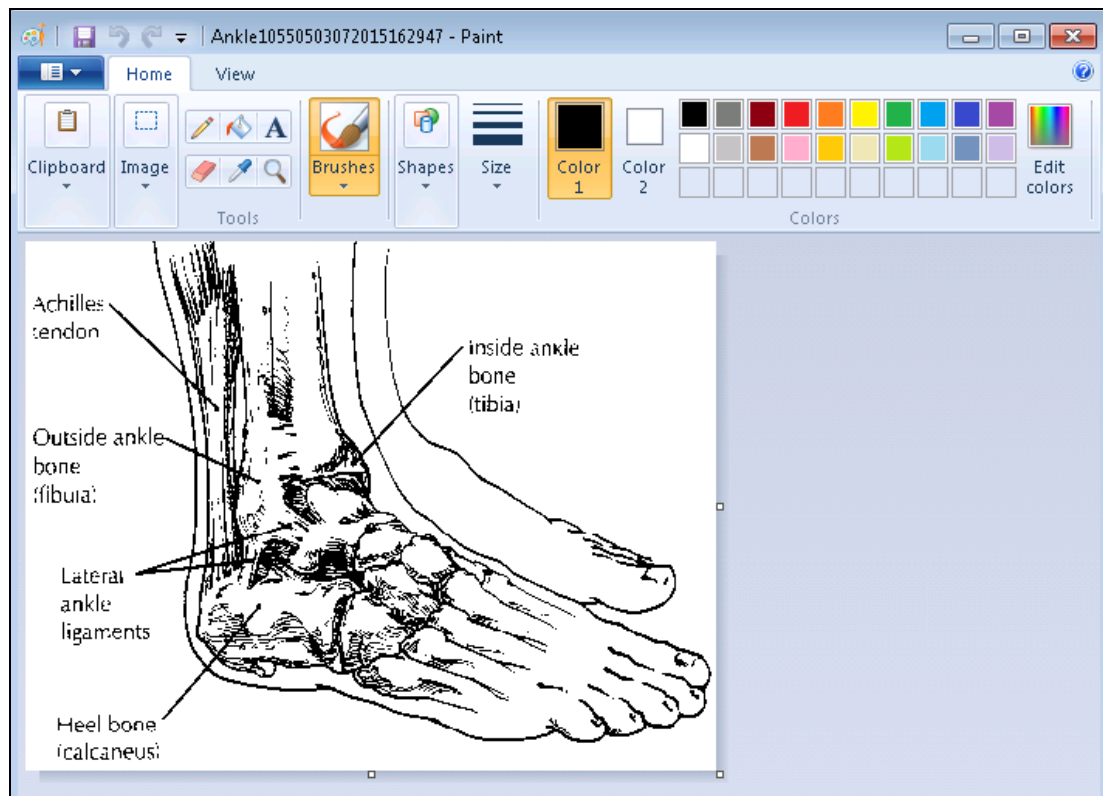
To insert and mark-up a picture:

1. Open the SOAP Form. See [“Starting SOAP notes” on page 117](#).

2. In the **OBJECTIVE** area, click **Draw Picture**. The EMR displays a window with a list of available drawings.



3. In the **Available Drawings** list, double-click the drawing you want. The EMR displays the selected drawing in Microsoft Paint.



4. Use the erase, draw, text, and shape features in Microsoft Paint to mark-up the document.

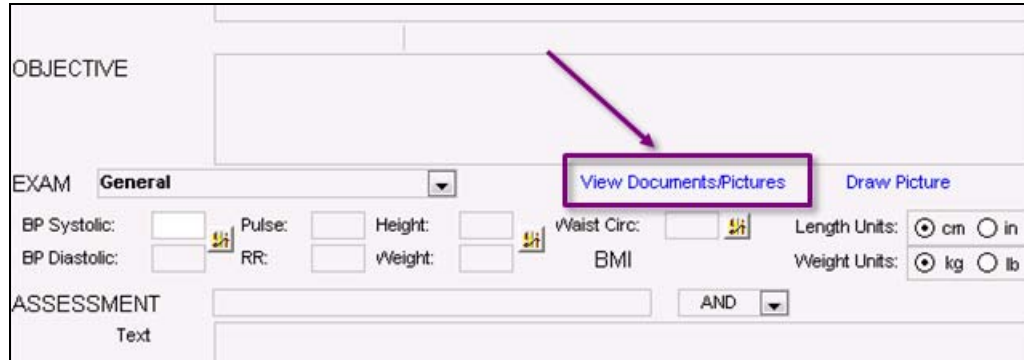


Tip: To view instructions on how to use the picture editing and mark-up tools in Microsoft Paint, on the top right corner of the Microsoft Paint window, click

Windows Help and Support ().

5. Click **Close** (). Microsoft Paint displays a dialog box with the following prompt: "Do you want to save changes to <picture name>?".

6. To save the picture click **Yes**. The EMR saves the picture in the **Documents** area of the patient's Medical Summary. The EMR also creates a link on the current SOAP Form called **View Documents/Pictures**. You can view the marked-up picture by clicking this link.



The screenshot shows a portion of an EMR SOAP form. At the top is the 'OBJECTIVE' section. Below it is the 'EXAM' section, which includes a 'General' dropdown menu. To the right of the 'General' dropdown is a red box containing the text 'View Documents/Pictures'. A red arrow points from the 'OBJECTIVE' section down to this red box. To the right of the red box is a 'Draw Picture' button. Below the 'EXAM' section are fields for 'BP Systolic', 'BP Diastolic', 'Pulse', 'RR', 'Height', 'Weight', 'Waist Circ', and 'BMI'. To the right of these fields are 'Length Units' (cm, in) and 'Weight Units' (kg, lb) dropdown menus. Below the 'EXAM' section is the 'ASSESSMENT' section, which includes a 'Text' field and an 'AND' dropdown menu.

Managing incomplete visit notes

In the old days of paper charting, you likely created a pile of patient charts you had to finish notes for. In Wolf EMR, your “pile” is located on the WorkDesk. Any time you save a SOAP note without locking it, the EMR adds the visit note to your **Incomplete Visit Record** list. From the **Incomplete Visit Record list**, you can go back and finish your notes at your convenience.

To view and finish your incomplete visit notes:

1. On your WorkDesk, in the **Tasks** tab, in the **Patient Records** area, click **# Incomplete visit Records** (where # is the number of your incomplete visit notes). The EMR displays the Incomplete Records window.

Incomplete Records

Test, Mother PHN 79827-4114

Born: 27-Oct-1970 (43) Sex: F Status: Long Term C...
 1234 Frist Street, Calgary AB T5R4E3W H (403) 999-8888 Pri Dana Know-Four, MD
 C Fam W Ret

☐ Include All Arrived Appointments

Patient Name	Appt Start	Visit Description
Test, Mother	06-Nov-2013 14:15	
Tapia, Twanna	06-Nov-2013 14:16	
Tarver, Tennie	06-Nov-2013 14:16	
Test, Scott	20-Nov-2013 19:58	<<PTFirst Name>> feels his mood can best
Test, Scott	30-Jan-2014 14:57	
Test, Delta	03-Mar-2014 11:40	
Test, Arm	03-Mar-2014 12:30	Pre Natal Form
Test, Delta	10-Mar-2014 11:00	* Diabetes Mellitus
Test, Scott	11-Mar-2014 10:10	
Test, Mother	11-Mar-2014 10:31	
Test, Father	11-Mar-2014 10:37	The 33 years old year old patient presents
Test, Amy	24-Mar-2014 16:22	
Test, Amy	26-Mar-2014 13:00	Pre Natal Form
Test, Amy	08-Apr-2014 08:43	
Test, Fred	09-Apr-2014 09:49	Right side Arm Pain
Test, Fred	09-Apr-2014 09:49	These are my subjective notes
Test, Hynke	14-Apr-2014 15:16	
Test, Amy	11-Jun-2014 15:07	
Test, Mother	17-Jul-2014 11:58	
Test, Mother	13-Aug-2014 09:00	
Test, Joy	13-Aug-2014 10:10	
Test, Father	03-Sep-2014 14:01	
Test, Mother	12-Sep-2014 19:26	
Test, Amy	08-Oct-2014 11:23	

2. To include incomplete visit notes for all arrived appointments, select the **Include All Arrived Appointments** check box.



Note: The **Incomplete Records** list displays, by default, only records that you have opened and then closed

3. In the list of incomplete visit records, double-click the visit record you want to complete. The EMR opens the Soap Note Examination window for the incomplete visit record.
4. Complete any unfinished areas on the SOAP Form. See [“Entering visit notes in the SOAP form” on page 139](#).
5. After you finish the visit note, click **Sign and Lock** (). The EMR displays a dialogue box with the following prompt: “Sign and Lock Record?”.
6. Click **Yes**. The EMR removes the record from your **Incomplete Records** list.

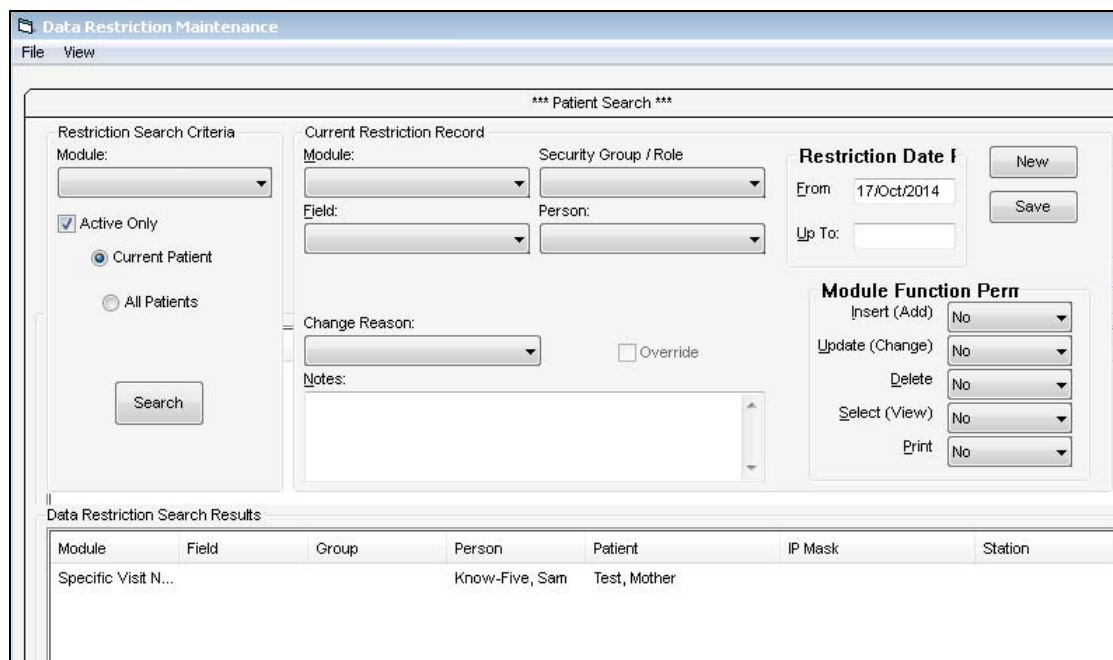
Setting internal privacy restrictions on visit notes

If a patient requests that you to keep their visit notes confidential from all, or some of your clinic staff members, you can restrict selected clinic users from accessing specific patient visit records.

Restricting access to a visit record

To restrict access to a visit record:

1. On any window of the patients chart (for example, the CPP, Medical Summary, or Consult Letter Examination form), on the SMART Patient Banner, click **View Patient Maintenance** (). The EMR displays the Patient Maintenance window.
2. On the Patient Maintenance menu, click **View > Patient Data Restrictions**. The EMR displays the Data Restriction Maintenance window.



Module	Field	Group	Person	Patient	IP Mask	Station
Specific Visit N...			Know-Five, Sam	Test, Mother		

3. In the **Current Restriction Record** area, in the **Module** drop-down list, click **Specific Visit Note**.

4. In the **Security Group/Role**, or **Person** drop-down list, click the group or individual user that you want to restrict access to.



Note: When you select a security group, role, or individual to restrict access to, the EMR displays an **Exception** area with your name selected by default. The person defined in the **Exception** area can access the patient record no matter what restrictions are placed on the record.

5. In **Restriction Date Range** area, leave the date in the **From** field as today's date, and leave the **Up To** field blank.
6. To enable restricted users to perform some actions on the restricted record, in the **Module Function Permissions** area, click **Yes** beside actions you want to enable.
7. In the **Restricted Data Record** drop-down list, click the visit note you want to restrict access to.
8. Click **Save**.
9. To add a restriction to another visit record, or restrict the same record to other users, repeat [Step 3 to Step 8](#)
10. When you are finished, click **Close** ().

Removing restrictions on patient records

If you add restrictions to a visit record in error, you or any other user can remove the restrictions at any time. When a visit record restriction is removed, the EMR tracks who removed the restriction in the transaction log.

To remove a restriction on a visit record:

1. Open the Data Restriction Maintenance window for the patient. See [Step 1 to Step 2](#) in ["Restricting access to a visit record" on page 167](#). The EMR lists any current restrictions on the patient's record in the **Data Restriction Search Results** area.

2. If the list of data restrictions for the patient is long, search for the visit note data restriction you want remove:
 - a) In the **Restriction Search Criteria** area, in the **Module** drop-down lists, click **Specific Visit Note**.
 - b) Click **Search**. The EMR filters the **Data Restriction Search Results** area to display only data restrictions related to specific visit records.
3. In the **Data Restriction Search Results** area, click the data restriction you want to remove. The EMR displays the restriction details.
4. In the **Restriction Date** area, enter today's date in the **Up To** field.
5. Click **Save**.

Viewing a restricted patient record

If you have been restricted access to view or perform an action on a specific patient's record, you can Unmask the record for yourself if needed.



Note: You cannot unmask records for other users.

1. Open the patient's Data Restriction Maintenance window, and then search for the restricted record you want to unmask. See [Step 1](#) to [Step 2](#) in "Removing restrictions on patient records" on page 168.
2. In the **Data Restriction Search Results** area, click the data restriction you want to remove. The EMR displays the restriction's details.
3. In the **Restriction Date** area, click **Unmask**. The EMR:
 - Enters tomorrow's date in the **Up To** field
 - Selects your name in the **Person** field
 - Defaults all selections in the **Module Function Permission** area to **Yes**
4. To unmask the patient record for longer than one day, in the **Up To** field enter the date you want access to the record until, or to unmask the record indefinitely, clear the field.
5. To enable yourself permission to perform only specific actions on the record, in the **Module Function Permission** area, select **No** beside actions you do not need access to perform.
6. Click **Save**. The EMR adds a new entry in the **Data Restrictions Search Results** area indicating:
 - That you have unmasked the record.

- The actions you have permission to perform.



Note: You cannot delete this entry. There is a permanent record indicating that you have unmasked the patient's restricted record.

Visit encounter notes - Specialists

This chapter covers how to enter patient visit notes using the consult letter form. On the consult letter form you can:

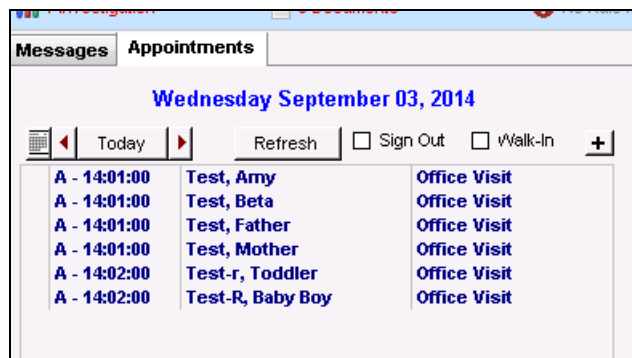
- Enter your visit notes in a letter format.
- Use letter templates to reduce the time it take to record visit information.
- View pertinent patient chart information (for example, view a patient's recent lab results).
- Perform actions on the patient's chart (for example, prescribe a medication).
- Print your visit notes as a consult letter.

Starting consult letter visit notes

If a patient's visit notes are to be printed/sent as a consult letter, you can enter your visit notes in a consult letter form. When you finish your visit notes, you can then print the notes as a consult letter.

To start a consult letter visit note:

1. On the WorkDesk, click the **Appointments** tab. The EMR displays a list of your appointments for today.



2. In the **Appointments** list, click the patient you want.



Note: On the **Appointments** tab, you can view and select patients booked for appointments on days other than today. Also, if a patient is not on your appointment list, but you want to start a new SOAP note for the patient, you can add the patient to your appointment list. See ["Starting consult letters for patients without booked appointments"](#) on page 175.

The EMR displays the **Patient** tab. The **Patient** tab contains the patient's **Cumulative Patient Profile (CPP)**, and includes:

- A summary of the patient's previous and current encounters. The list displays the encounter date, status (**C** = complete, **I** = Incomplete, **P** = visit notes entered in a paper chart), attending physician, and visit type for each visit listed.



Note: The EMR assigns a status of **P** to an encounter if, in the attending practitioner's user profile, there is no start date entered in the **Other Data** tab, under **Use of Online Records**.



Tip: Visit notes created by you do not display initials under attending physician.

- A summary of important and recently added data on the patient's chart.
- The **SMART Patient Banner**: Here, you can view a summary of the patient's demographic information, latest vitals and measurements, care team information, and more. (To be covered in greater detail later in this module.)

Tasks		Patient	
Test, Mother			
Home address 5980 SE Oriental Court, Olds AB T1F 0E1		Home Cell Work	
Pending Inv.		No Docs	
No Rules		5 Messages	
No Follow Ups		No Vaccinations	
Born: 06-Mar-1993 (23)			
Sex: F PHN: 9990234722			
Status: N/A			
BMI: 33.5 3 yr 3 m			
Weight: 68.1kg 3 yr 3 m			
BP: 98/60 3 yr 3 m			
Pri: Janna Schreiber, MD PhD FRCP			
Ref: Susan M. Kuhn			
Arrived 237 mins			
Templates:			
NO KNOWN ALLERGIES			
PATIENT : ** LEMON, JODI **			
CURRENT MEDICATIONS			
Melatonin 5 mg PO qhs			
PEG 3350 10 gm po od			
Topiramate (Topamax) 25 mg ii PO BID			
ACTIVE PROBLEMS			
Smith Magenis Syndrome			
financial stressors			
Astigmatism			
Noncompliance Appointments			
Headache			
Hypertriglyceridemia			
Obesity			
Seizure			
sleep disturbances			
global developmental delay			
behavioral challenges			
Constipation			
INACTIVE PROBLEMS			
Rectal Bleeding - NYD			
Pyelonephritis			
Polydipsia and polyuria			
LATEST DOCUMENTS			
19-Jun-2013 Reviewed scrambled			
13-Apr-2013 Reviewed scrambled			
19-Mar-2013 Reviewed scrambled			
13-Mar-2013 Staff Reviewed scrambled			
15-Jan-2013 Reviewed scrambled			
NOTED FAMILY HISTORY			
Filtered by: All providers			
Viewing 33 of 33 encounters			
Filter Options			

- On the list of office visits, click the office visit you want to start a consult letter form for (in most cases this is the incomplete (I) visit listed at the top), and then in the **Templates** drop-down list, click **Consult Letter**. The EMR displays the Consult Letter Examination window.

Consult Letter Examination Date: 16-Mar-2016

Test, Lindsay PHN: 9994568371

Born: 16-Mar-1999 (16) Sex: M Status: N/A
 7257 NE Knickerbocker Avenue, H 65251216 Pri: Beata S, MD
 Rockford AB F2D 8S1 C
 W (302) 856-6801 Ret

Referral Reason: **Prenatal** ...edit info

Select Template:

Double Click to Launch Template Paragraph:

Edit/New Template

Assessment:

Search: AND

Text:

List:

Order Labs
 Prescribe Medication
 Detailed Referral
 Set Billing defaults
 Structured Examinations:

Delete Assessment
 Add To Problem List
 Edit

Medications: **No Medication Changes.**

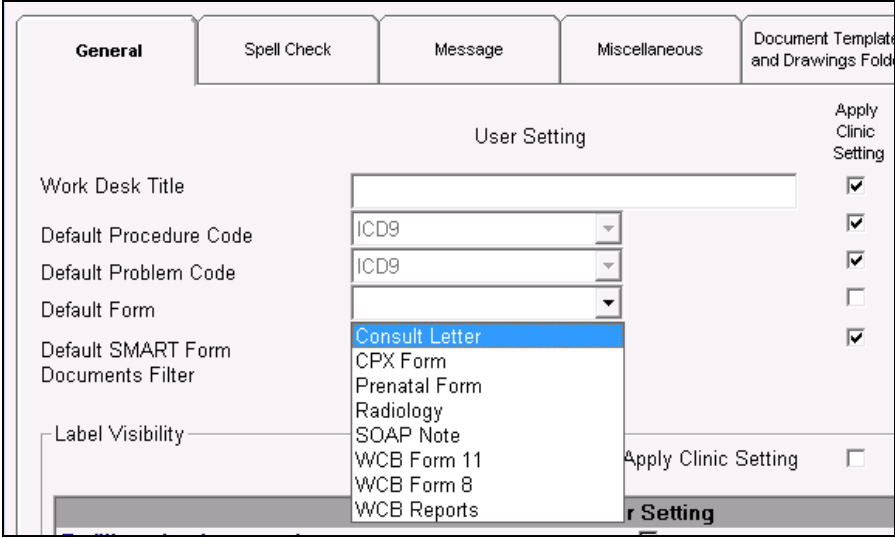
Quick Referral Group: Investigation/Procedure:



Tip: If you are a specialist and most of your notes are written in the form of a consult letter, then the consult letter form should be set as your default window for entering visit notes. When the consult letter form is set as your default, when you double-click a new encounter, the consult letter form window opens instead of the SOAP form.

To set the consult letter form as your default:

1. On your WorkDesk, click **Configure > Configure WorkDesk** (). The EMR displays the WorkDesk User Preferences window.
2. On the **General** tab, in the **Default Form** drop-down list, click **Consult Letter**.



The screenshot shows the 'WorkDesk User Preferences' window with the 'General' tab selected. The 'Default Form' dropdown menu is open, displaying a list of form options. 'Consult Letter' is the selected option. Other options include CPX Form, Prenatal Form, Radiology, SOAP Note, WCB Form 11, WCB Form 8, and WCB Reports. The 'Apply Clinic Setting' checkbox is checked.

3. Click **Save settings and exit** ().

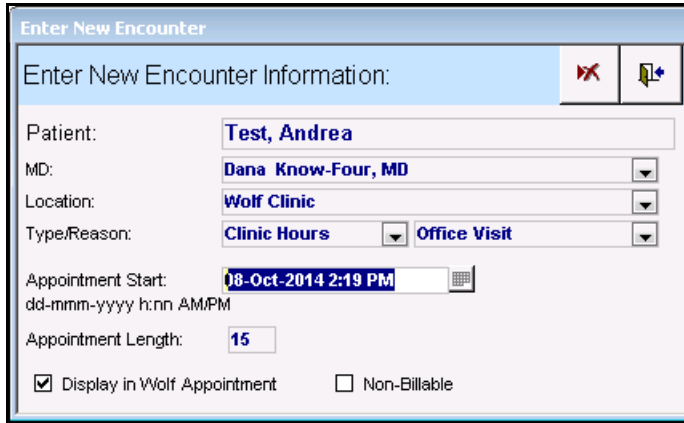
Starting consult letters for patients without booked appointments

You can open a consult letter form for a patient who does not currently have an appointment booked with you. Begin by adding the patient to your appointment list, and then start an encounter from your appointment list.

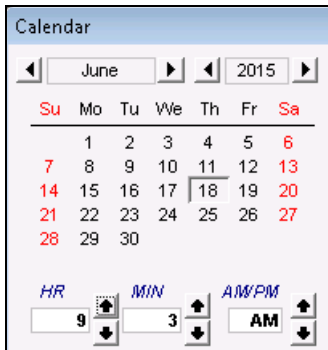
To start a consult letter for a patient that does not have a booked appointment:

1. On the Appointments tab of the WorkDesk, navigate to the date you want to create the consult letter for. See [“Viewing your schedule” on page 16](#).

2. On the **Appointments** tab, click **Enter New Encounter** (), and then in the Patient Search window, search for and select the patient you want. The EMR displays the Enter New Encounter Window, with the patient's name, MD, and clinic location pre-populated.



3. In the Enter New Encounter Information window, enter or modify information using the following table as a reference:

Field	Description
MD	Your name is entered by default. To make an appointment for another practitioner, in the drop-down list click the practitioner's name. Note: If your clinic has multiple locations, you can select only practitioners who are assigned to any of the locations that you are assigned to.
Location	If your clinic has multiple clinic locations, in the drop-down list, click the location you want to make the appointment for.
Type	Optionally, click the appointment type.
Reason	Optionally, click the appointment reason.
Appointment start	To modify the date and/or time of the appointment, click  , and then on the calendar, select the time, and double click the date. 

Field	Description
Appointment Length	Enter the amount of time (in minutes) required for the visit.
Display in Wolf Appointment	To exclude the patient's appointment from the clinic appointment scheduler, clear this check box.
Non-Billable	To exclude the patient from the billing list, select this check box.

- Click . The EMR displays the patient on your appointment list for the date and time you specified, and then opens the **Patient** tab for the selected patient.
- On the list of office visits, double-click the office visit you want to start a consult letter form for.

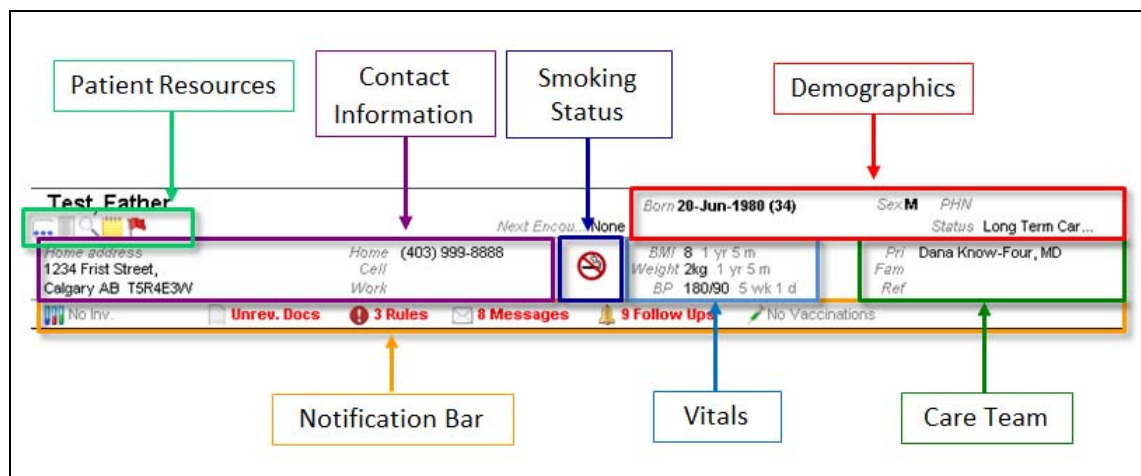
SMART Patient Banner overview (on CPP)

The SMART Patient Banner is located at the top of the Patient tab (CPP). The SMART Patient Banner is also visible at the top of most windows relating to a patient, including:

- The Medical Summary
- The Consult Letter form
- On messages, follow-ups, and other tasks

Information in the SMART Patient Banner

The SMART Patient Banner contains a variety of patient information that you can view, at-a-glance in one convenient area. You can also easily edit some of the patient information, for example patient demographics.



The main areas of the SMART Patient Banner include:

- Name
- Demographics
- Patient Resources
- Contact Information
- Smoking Status
- Vitals
- Care Team
- Notification bar
- Medical Summary toolbar
- Navigation button

The following sections describe the main areas of the SMART Patient Banner.

Name

The Name area is located in the top left corner of the SMART Patient Banner. The Name area displays the patient's last name and first name separated with a comma. For example "Smith, Barbara.

The screenshot shows a patient banner for "Test, Father". Below the name is a row of icons: a computer, a document, a magnifying glass, a calendar, and a flag. Underneath the icons is the "Home address" section, which displays "1234 Frist Street, Calgary AB T5R4E3W". To the right of the address, there is a partially visible "Home" section. At the bottom of the banner, there is a status bar with three colored bars (blue, green, red) and the text "No Inv.", followed by a document icon, the text "Unrev. Docs" in red, and a red circle with a white exclamation mark.

Demographics

The Demographics area is located in the top right corner of the SMART Patient Banner.

		Demographics	
		↓	
Next Encou... None		Born 20-Jun-1980 (34) Sex M PHN Status Long Term Car...	
Home (403) 999-8888		BMI 8 1 yr 5 m	Pri Dana Know-Four, MD
Cell		Weight 2kg 1 yr 5 m	Fam
Work		BP 180/90 5 wk 1 d	Ref
Docs 3 Rules 8 Messages 9 Follow Ups No Vaccinations			

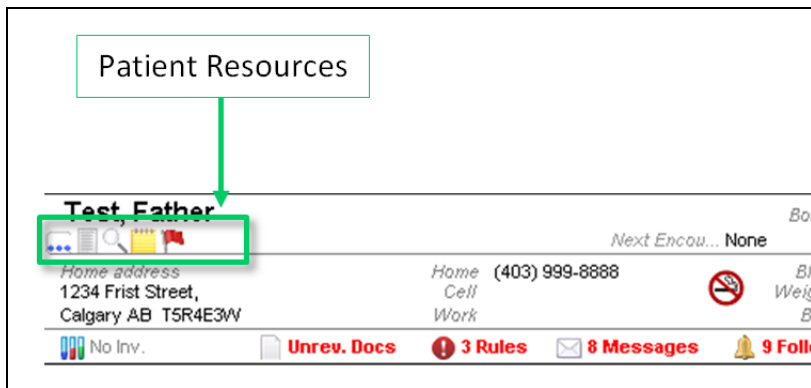
The Demographics area displays the following information:

- **Born:** The patient's date of birth. The age is shown in brackets beside the date.
- **Sex:** M/F
- **PHN:** Patient's PHN
- **Pregnant:** Displays if a patient is pregnant and how many weeks the patient is along in her pregnancy.
- **Status:** displays a patient's active Patient Status. For example, Homebound, Acute Care, Patient, or Left Practice.

Resources

The Patient Resources area is below the patient name in the SMART Patient Banner. The Patient Resources area of the SMART Patient Banner gives you easy access to more information about the patient. Some of the information is view-only; for example patient visit records or the patient photo. Other icons link you to other areas of the EMR where you can view

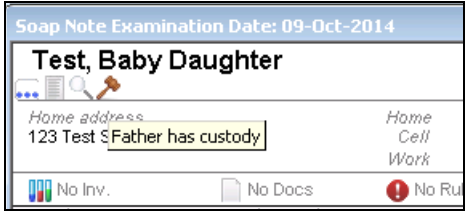
and edit the information if necessary. For example, you can view and edit patient demographic information in the Patient Maintenance window.



Note: The Patient Resources area displays only icons that apply to the patient. For example, if there are no alerts for the patient, you do not see the Alerts icon. Similarly, if no notes exist for the patient, you do not see the Patient Notes icon.

The following table describes the icons you may see in the Patient Resources area.

Icon	Item	Description
	View Patient Demographics Information	Opens the Name/Adr/Phone tab in the Patient Maintenance window.
	View Patient Visits	Opens all summarized Visit Records for the patient.
	Search Patient Visits	Opens the Visit Record History window with a list of encounters to choose from, or you can use the Search function.
	Patient Notes	Opens the Notes tab in the Patient Maintenance window (if applicable).
	Patient Photo	Opens the patient's photo (if available).
	Alerts	Opens alerts for the patient (if available).

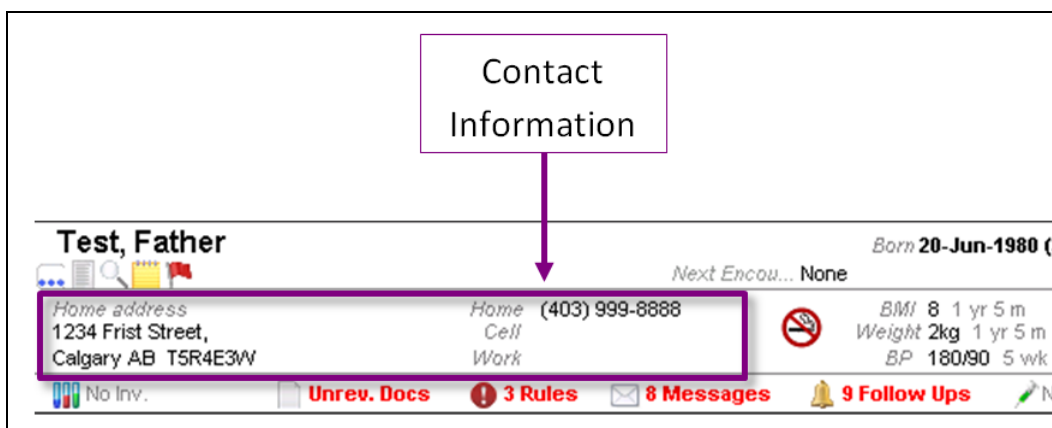
Icon	Item	Description
	Custody information	The icon's ToolTip displays custody related text when you hover your cursor over the icon.  This icon displays if the Notes field in the Custody Agreement area on the Name/Addr/Phone tab in the Patient Maintenance window is populated, and the patient is under the legal majority age for the province.
	Patient Portal Status	Opens Patient Maintenance to Portal Settings (if your clinic is set up for the Patient Portal).



Tip: If you want to open the patients' Medical Summary (medical chart), click anywhere on the SMART Patient Banner. The EMR opens the Medical Summary in a new window.

Contact Information

The Contact Information area is located below the Patience Resources area in the SMART Patient Banner.



Contact Information

Test, Father Born 20-Jun-1980 (

Next Encou... None

Home address: 1234 Frist Street, Calgary AB T5R4E3W

Home (403) 999-8888

Cell

Work

BMI 8 1 yr 5 m

Weight 2kg 1 yr 5 m

BP 180/90 5 wk

No Inv. Unrev. Docs 3 Rules 8 Messages 9 Follow Ups

The Contact Information area displays the following information:

- **Home Address:** Patient's address

■ **Phone Number(s):** Home, Cell, Work



Note:

- If available, caregiver information is displayed above the phone number.

Soap Note Examination Date: 09-Oct-2014	
Test, Baby Daughter	
Caregiver Mr. Test, Irwan Arrived	
Home address 123 Test Street,	Home (111) 111-1111 Cell (222) 222-2222 Work
No Inv.	No Docs No Rules No Messages

- If the patient does not have an appointment today, or the appointment is finished, the next encounter date is displayed above the phone number. If the patient has a current appointment, the patient status, room number, and wait time is displayed.

Examination Date: 09-Oct-2014	
Baby Daughter	
Caregiver Mr. Test, Irwan In Room (E2) 1 min (14 mins)	
Home address 123 Test Street,	Home (111) 111-1111 Cell (222) 222-2222 Work
	HC Weight 7kg (0.3%) Height 64cm (0.1%)
No Docs	No Rules No Messages 1 Follow Up

Smoking Status

The Smoking Status area is located beside the Contact information area in the SMART Patient Banner.

Smoking Status	
Test, Father	
Next Encou. None	
Home address 1234 Frist Street, Calgary AB T5R4E3W	Home (403) 999-8888 Cell Work
No Inv.	Unrev. Docs 3 Rules 8 Messages 9 Follow Ups

If the smoking status has been set, the smoking status appears as one of the following icons:

- Non-Smoker

- Smoker

Vitals

The Vitals area is located beside the Smoking Status area, and below the Demographics area in the SMART Patient Banner.

The screenshot shows a patient banner for a male born 20-Jun-1980 (34). The Vitals section, highlighted with a blue box, displays the following data:

BMI	8	1 yr 5 m
Weight	2kg	1 yr 5 m
BP	180/90	5 wk 1 d

Other visible information includes: Next Encou... None, Sex M, PHN (403) 999-8888, Status Long Term Car..., Pri Dana Know-Four, MD, Fam, Ref, 8 Messages, 9 Follow Ups, and No Vaccinations.

The vital information displayed depends on the age of the patient.

If a patient's age is 0 to 2 years old, the Vitals area displays the following fields, together with percentiles, if available:

- **HC:** Head Circumference
- **Weight**
- **Height**

The screenshot shows a patient banner for a male born 29-Oct-2012 (1 yr 1 m). The Vitals section displays the following data:

HC	47cm (88.4%)	0 d
Weight	10kg (53.2%)	0 d
Height	80cm (88.3%)	0 d

Other visible information includes: Age 30 weeks, No Follow Ups, No Vaccinations, and a Quick Print button.

If a patient's age is 2 to 19 years old, the Vitals area displays the following fields, together with percentiles, if available:

- **BMI:** Body Mass Index
- **Weight**

■ Height

<i>Born</i> 13-Jan-2010 (3 yr 9 m)	
<i>BMI</i>	14.2 (12.1%) 8 m 2 wk
<i>Weight</i>	14.3kg (44.4%) 8 m 2 wk
<i>Height</i>	100.5cm (83.3%) 8 m 2 wk
No Follow Ups	No Vaccinations
Change Log	New
Documents	Referrals

If a patient's age is 20+ years old, the following fields are listed:

- BMI
- Weight
- BP: Blood Pressure

<i>Born</i> 13-Mar-1969 (45)	
<i>BMI</i>	137.1 4 d
<i>Weight</i>	120lbs 4 d
<i>BP</i>	120/80 4 d



Note: Percentiles are based on the Canadian Dietitian (WHO) growth charts.



Note: The time frame displays with each of the above measures. For example, a patient's BP is displayed as: BP 120/80 1y3m ago

Care Team

The Care Team area is located beside the Vitals area, and below the Demographics area in the SMART Patient Banner.

Next Encou... None		Born 20-Jun-1980 (34)		Sex M	PHN
(403) 999-8888		BMI 8 1 yr 5 m Weight 2kg 1 yr 5 m BP 180/90 5 wk 1 d		Status Long Term Car...	
Rules		8 Messages		9 Follow Ups	
No Vaccinations					
				Care Team	

The Care Team area displays the following information:

- **Primary MD:** Displays the default practitioner.
- **Family MD:** Displays if the patient has a family practitioner who is not the primary practitioner.
- **Referral MD:** Displays if the referring incoming practitioner is noted in Patient Maintenance.
- **Care Team:** Displays if the patient is assigned to a care team.



Tip: You can set your WorkDesk preferences to disable or enable the display of the above items:

- On the WorkDesk menu click **Configure > Configure WorkDesk > Miscellaneous** tab.

Notification bar

The Notification bar is located below the Contact Information area in the SMART Patient Banner.

Test, Father		Born 20-Jun-1980 (34)		Sex M	PHN
Next Encou... None				Status Long Term Car...	
Home address 1234 Frist Street, Calgary AB T5R4E3W		(403) 999-8888		BMI 8 1 yr 5 m Weight 2kg 1 yr 5 m BP 180/90 5 wk 1 d	
Pri Dana Know-Four, MD		Fam		Ref	
No Inv.		Unrev. Docs		3 Rules	
8 Messages		9 Follow Ups		No Vaccinations	
				Notification Bar	

The Notification bar indicates how many new investigations, rules, documents, and messages are available for the patient. The Notification bar also indicates how many follow ups and

vaccinations the patient is due for. Pending, un-reviewed, and recent items appear in red text. You can click any icon in the Notification bar to open the related area in the EMR. For example you can click the **Investigations** icon to open the Investigation In Basket window for the patient.

The following table describes the icons on the Notification bar.

Icon	Description
	Investigations ■ Indicates if and how many pending investigations (Pending Inv.) or recent investigations (Recent Inv.) are available for the patient. Also indicates if there are no recent investigations for the patient (No Inv.). ■ Investigations are Electronic Lab or Report Submissions in Wolf. ■ You can view Excelleris text reports such as an Operative Report, or a Procedures Report from the Investigation In Basket. The EMR saves Excelleris text reports under the Documents tab in the patient's Medical Summary. ■ Click to open the Investigation In Basket.
	Documents ■ Indicates how many un-reviewed documents (Unrev. Docs.), or recent documents (Recent Docs) are available for the patient. Also indicates if there are no recent documents for the patient (No Docs). ■ Documents are generally items scanned in by the staff, or they are printed from the system. You may have some documents from certain regions come electronically into this area as well. Click to open the Documents In Basket.
	Rules ■ Indicates how many Rule Matches are available for that patient. A rule is a search or an automated reminder. which runs over night. ■ Click to open the Rule Matches screen.
	Messages ■ Indicates how many unread Messages are available for that patient. ■ Click to open the Message Viewer screen.
	Follow Ups ■ Indicates how many outstanding Follow-Ups the patient is due for. ■ Click to open the Follow-Ups screen.

Icon	Description
	Vaccinations ■ Indicates how many Vaccinations the patient is due for. ■ Click to open the Vaccination Schedule screen.

Consult Letter Examination window overview

The Consult Letter Examination window consists of three main areas where you can view patient information, enter data, or perform various chart actions. These three areas are:

- A simplified SMART Patient Banner
- The Consult Letter Examination toolbar
- The Consult Letter Examination form

The screenshot displays the 'Consult Letter SMART Patient Banner' and the 'Consult Letter Examination Form'. The banner at the top shows patient information for 'Test, Mother' (PHN 79827-4114), born 27-Oct-1970 (43), with address 1234 Frist Street, Calgary AB T5R4E3W. It also lists contact information: H (403) 999-8888, C (403) 999-8888, W (403) 999-8888, and care team members Dana Know-Four, MD (Pri), Fam (Fam), and Ret (Ret). The banner includes a 'SMART Patient Banner' label and a 'Consult Letter Examination Toolbar' with buttons for Log, Quick Print, and other functions.

The 'Consult Letter Examination Form' is the main area, containing sections for:

- Referral Reason:** A dropdown menu and a link to '...edit info'.
- Select Template:** A dropdown menu and a link to 'Double Click to Launch Template Paragraph'.
- Order Labs:** A link to 'Order Labs'.
- Prescribe Medication:** A link to 'Prescribe Medication'.
- Detailed Referral:** A link to 'Detailed Referral'.
- Set Billing defaults:** A link to 'Set Billing defaults'.
- Structured Examinations:** A dropdown menu.
- Assessment:** A section with 'Search', 'Text', and 'List' fields, and an 'AND' dropdown.
- Medications:** A text input field.
- Quick Referral Group:** A list of options: Massage Therapy, Acupuncture, Physiotherapy, Consultation, Medical Imaging, and Podiatry.
- Investigation/Procedure:** A text input field.
- Referrals:** A section with a link to 'Double Click To Set Up Quick Referral Settings'.
- Surgical Procedures:** A text input field.

Consult Letter SMART Patient Banner

In the Consult Letter SMART Patient Banner, you can view a summary of the patient's demographic information, care team information, patient status, and more. The Consult Letter SMART Patient Banner is a less detailed version of the SMART Patient Banner located at the

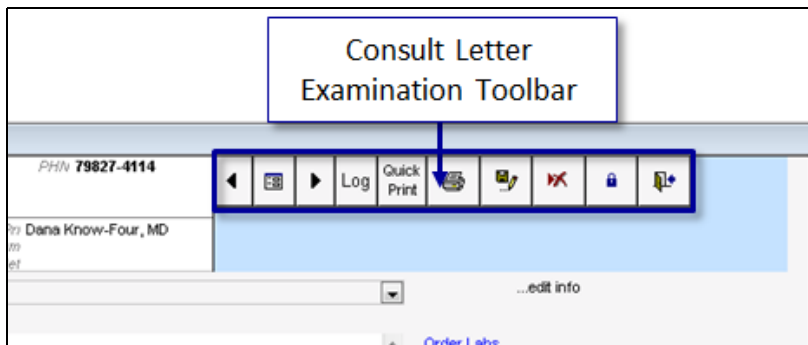
top of the Patient tab (patient's CPP). However, you can view much of the same information and can perform similar actions. See: [“SMART Patient Banner overview \(on CPP\)” on page 177](#).



Tip: If you want to open the patients' Medical Summary (medical chart), click anywhere on the SMART Patient Banner. The EMR opens the Medical Summary in a new window.

Consult Letter Examination toolbar

The Consult Letter Examination toolbar is located to the right of the SMART Patient Banner.

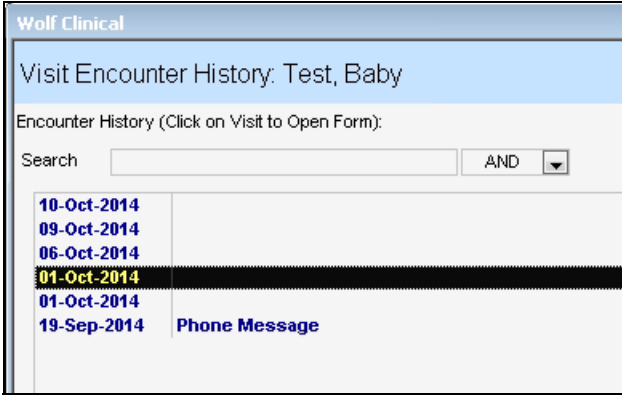


From the Consult Letter Examination toolbar, you can:

- Find and view previous visit record notes
- Print the current visit note
- View a record of changes made to the current visit note.
- Save and lock the visit record
- Delete the visit record

The following table describes the icons on the Consult Letter toolbar.

Icon	Description
	Previous Visit Record Opens the patient's previous Visit Record.
	Next Visit Record Opens the patient's next Visit Record.

Icon	Description
	Visit Search Displays a chronological list of the patient's past encounters in the Visit Encounter History window. 
	Change Log Displays a log of changes made to this visit record.
	Print Displays the change printer properties window, enabling you to select a printer to print the visit record.
	Quick Print Prints the visit record to your default printer.
	Save Current Visit Record as a Template Saves current visit in a SOAP form format. See "Visit encounter notes - GP" on page 117 .
	Delete Visit Record Permanently deletes the contents of the current visit record.
	Lock Current Visit Record Locks the record and marks it as Complete.

Overview of the Consult Letter form

The Consult Letter form is where you enter your visit notes and perform actions in the patient's chart. The form contains text areas for easy data entry. You can enter data into as much, or as little of the form as you want.

The form also contains a variety of quick-links that you can use to view pertinent patient information, such as patient lab results, or to perform common actions, such as prescribe a medication.

The screenshot shows the 'Consult Letter Examination' form for a patient named 'Test, Mother'. The form includes a header with patient details (Born: 27-Oct-1970 (43), Sex: F, Status: Long Term C..., PHN: 79827-4114) and a toolbar with icons for navigation and actions. The main form area is divided into several sections, each highlighted with a colored box and an annotation:

- Visit Reason** (Red box): A red arrow points to the 'Referral Reason:' dropdown menu.
- Visit notes (in the form of a consult letter)** (Purple box): A purple arrow points to the large text area for 'Select Template:'.
- Assessment notes** (Green box): A green arrow points to the 'Assessment:' section, which includes a search bar, a text area, and a list area.
- Treatment and referral history** (Orange box): An orange arrow points to the 'Medications' and 'Referrals' sections, which include a list of quick referral groups and a table for referrals.

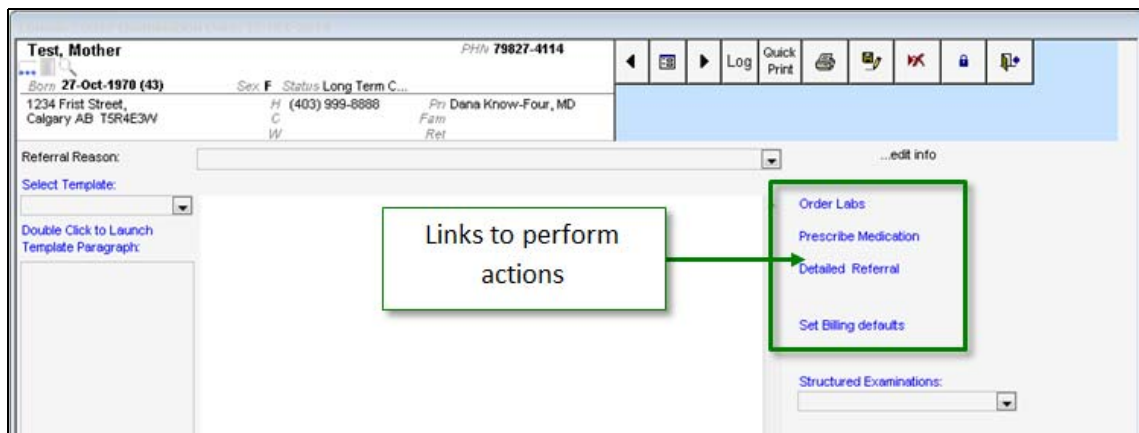
The following table describes the main areas of the Consult Letter Examination form:

Area	Description
Visit Reason (Referral Reason)	Enter the patient's primary reason for seeing you, or select an option from the drop-down list.
Visit notes	Enter the body of the a consult letter.

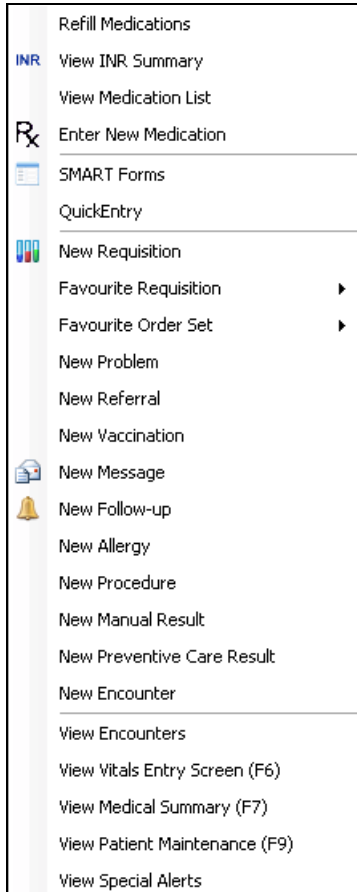
Area	Description
Assessment notes	- In the text area, enter your assessment notes. - In the Search field, enter the problem that the patient is visiting you for. Note: You can add one, or multiple diagnosis' for the visit.
Treatment and referral history	View at a glance a patient's treatment history, upcoming surgical procedures, and referral information. Medication Changes: Displays all medications that were added/alterd on today's date. Quick Referral Group: Displays your Quick Referral Groups. Investigation/Procedure: Displays investigations and procedures associated to a selected Quick Referral Group. Referrals: Displays any referrals made. Surgical Procedures: Displays any ordered surgical procedures.

Consult Letter Examination form quick action links

Along the right side of the Consult Letter Examination form are a variety of links that enable you to perform common actions on the patient's chart.



To view a more detailed list of information you can view and actions you can perform from the patient's chart, right-click anywhere on the Consult Letter Examination form. The EMR displays the SMART Menu.



Tip: You can right-click on most windows containing a patient's data to view the SMART Menu, including:

- The Patient tab (CPP)
- Messages and tasks regarding the patient.
- The Medical Summary.



Tip: You can customize the SMART menu so that only view and action items you use often are listed. To customize your SMART menu:

1. On your WorkDesk, click **Configure**. The EMR displays the WorkDesk user Preferences window.
2. Click the **General** tab.
3. Click **Manage Right-Click** Menu.
4. Clear check boxes for menu items you do not want displayed on the SMART Menu.

Entering visit notes in the consult letter form

You can enter a majority of your patient visit notes in the Consult Letter Examination form. Here, you can enter your notes in the form of a consult letter using the structured fields provided. A majority of your notes are written in the main text area, with your assessment notes entered in the lower aspect of the window.

To enter general visit notes into the Consult Letter Examination form:

1. Open the Consult Letter Examination Form for a patient. See: ["Starting consult letter visit notes" on page 171](#).
2. In the **Referral Reason** field, complete one of the following actions:
 - Enter a short description of the primary visit reason.
 - In the drop-down list, click a primary visit reason.
3. In the main text area, enter your visit notes in the form of a consult letter. (For example, start your notes with a statement such as "Thank you for referring your patient to our clinic regarding...".)
4. To enter a patient's basic vitals and measurements:
 - a) In the **Structured Exam** drop-down list, click **General**.
 - b) If another clinical staff member has not done so already, enter the patient's vitals and measurements.



Tip: If your front end staff have already entered vitals and measurements for the patient, the values display in the General Exam form.

- c) Select the appropriate length, weight, and temperature units.

- d) To graph a vital or measurement, beside the value, click .



Tip: For pediatric patients (under the age of 19yrs), if you graph weight or height, the EMR displays the pediatric Growth Charts.

- e) When you are finished, click **Close**(.



Note: To ensure that you can graph and report on important patient vitals and other measurements, enter this information in the appropriate fields of a Structured Examination. Avoid free-typing this information in the Consult Letter text area.

5. In the **Assessment** area, enter the problem(s) the patient is seeing you for:
 - a) In the **Search** field, enter all or part of a problem term or an ICD9 diagnosis code.
 - b) Press **Enter**. The EMR displays a list of matching problems.
 - c) On the results list, click a problem.
 - d) To enter a position (for example, right, left, front) or other qualifier information about the problem, in the **Qualifier** field, enter the qualifier, or in the drop-down list click an option.
 - e) Click **Add to Assessment**. The EMR displays the selected problem in the **List** field of the **Assessment** area.



Tip: If the problem is not on the patient's problem list already, you can add the problem to the patient's problem list from the **Assessment** area:

1. In the **List** field, click the problem..
2. To the right of the **Assessment** area, click **Add to Problem list**. The EMR displays a dialog box with the following prompt: "Register <selected problem> in patient's Problem List?"
3. Click **Yes**.

- f) To add another problem, repeat [Step 5](#).
6. If a selected ICD 9 description is not appropriate for your written impression, you can edit the Assessment description. To edit a selected assessment:
 - a) In the **List** field, click the assessment you want to edit. The EMR displays a list of action options to the right.

- b) Click **Edit**. The EMR displays the Visit Impression window.

- c) In the **Impression** field, edit the description.



- d) When you are finished, click .

7. In the **Assessment** area, in the **Text** field, enter any additional assessment notes.

8. To populate the patient's bill at this time:

- a) Click **Set Billing defaults**. The EMR displays the **Set Billing Default Values** window.

- b) In the **Insurer** drop-down list, click the insurer, individual, or company you want to bill.
- c) In the **Fee Code** field, enter part or all of the fee code number or description. The EMR filters the **Fee Code** drop-down list to display matching codes.
- d) In the **Fee Code** drop-down list, click the fee code you want.



Note: You can enter only one service code from the Consult Letter Examination form.

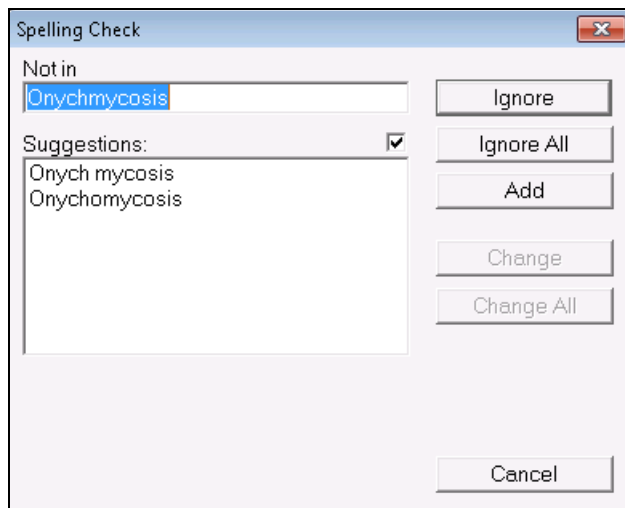
- e) In the **Service Units/Service Time** area, complete one of the following actions:
- To enter the number of service units, select **Service Units**, and then enter a number in the **Service Units** field.

- To enter a service time, select **Service time**, and then enter a start and end time in the **Service Start/End time** fields.

f) Click .

9. To check spelling in your consult letter:

- On the Consult Letter Examination window, left-click the text area you want to spell check.
- Right-click anywhere within the selected text area.
- Click **Check Spelling**. If unidentified words are recognized, the EMR displays the Spelling Check window.



d) For each word identified, complete one of the following actions:

- To skip the word, click **Ignore**.
- To skip all instances of the word, click **Ignore All**.
- To change the word to a suggested option, in the **Suggestions** area, click a word, and then click **Change**.
- To change all occurrences of the word to a suggested option, in the **Suggestions** area, click a word, and then click **Change All**.
- To add the word to your dictionary, click **Add**.

10. Perform one or more of the following actions:

- To print or fax the consult letter, see ["Printing and faxing consult letters" on page 212](#).
- To save the form, mark the visit as complete, and convert the form to read-only, click

Lock Current Visit Record ().

- To add more information to the consult letter form at a later time, click **Close Visit**



Record (). The EMR saves your visit notes, but leaves the visit status as Incomplete. The consult letter form remains editable, and displays on your Incomplete Visit Notes list.

11. The EMR displays a dialog box with the following prompt: "Sign and Lock Record?"

12. To Lock the form, and mark it as complete, click **Yes**.



Tip: No matter which closing option you choose, you are prompted to indicate if you want to lock the visit note.

A visit note is never truly "locked", you can go back and edit a locked note if needed.

Entering visit notes using shortcuts and templates

If you enter similar notes, sentences, or paragraphs for similar types of visits, you can use a variety of Wolf EMR template options to enhance your work efficiency.

In using templates for visit note entries, you also record your data in a more consistent manner, enhancing your ability to search for and report on data.

Wolf EMR template options include:

- Consult letter templates
- Structured Exam templates
- Auto-Replace text

Consult letter templates

Consult letter templates consist of a series of pre-written paragraphs. You can choose which paragraphs you want to include in each letter. Once you insert each paragraph into a consult letter, you can edit the paragraph as needed.

Paragraphs can also contain a series check box items. In paragraphs with check box items, you select which text items you want to include in the paragraph.

To use a consult letter template:

1. Open a Consult Letter form for a patient. See: ["Starting consult letter visit notes" on page 171](#).

2. In the **Select Template** drop-down list, click a template. The EMR lists the available template paragraphs.

Consult Letter Examination Date: 22-Oct-2014

Test, Father PHN

Born: 20-Jun-1980 (34) Sex: M Status: Long Term C...

1234 Frist Street, Calgary AB T5R4E3W H: (403) 999-8888 Pri: Dana Know-Four, MD
C Fam Ret

Referral Reason: **Diabetes Follow Up**

Select Template: **Diabetes visit**

Double Click to Launch Template Paragraph:

- Introduction
- Discussed
- Test Values
- Subjective
- Objective
- Plan

Edit/New Template

3. In the main text area, click where you want a paragraph to insert.
4. In the paragraph list, double-click a paragraph. The EMR:
 - Inserts the paragraph's text in the main text area.
 - Displays a list of available options to pick from, if the paragraph has check boxes associated with it.

Template Compile: Form

...
SUBJECTIVE:

Feels: well
Diet: Doing all that they think they can do for optimal nutrition
Exercise: Walking
Smoking: Continues to be a smoker

☒ Doing all that they think they can do for optimal nutrition
☐ Looking for nutritional advice
☐ insufficient fruit and vegetables
☐ excessive simple carbohydrates
☐
☐
☐
☐
☐

◀ ▶ Stop Finished

5. If a paragraph has check box options:

- a) On the Template Compile Form window, read the highlighted text on the left to understand what the check box selections pertain to.
- b) Select the check box beside each statement you want to include in the body of your consult letter.
- c) Complete one of the following actions:
 - To move to the next selection list for the paragraph, click **Next** (). If there are no more selection lists, the window closes and the EMR inserts your selected text in the main text area of the consult letter form.
 - To go back to the previous selection list for the paragraph, click **Previous** ().
 - To exit the selection window, click **Stop** (). The EMR inserts selected text for only the selection windows you viewed.
6. Edit the inserted paragraph text as needed.
7. To add another paragraph from the consult letter template, repeat [Step 3.](#) to [Step 6.](#)


Tips:

- Each paragraph inserts where your cursor is situated in the main text area. If you want a double space between each paragraph, press enter twice before inserting the next paragraph.
- You can insert paragraphs in any order you choose.

Structured Exam templates

Using Structured Exams, you can enter your exam findings in a series of pre-constructed check boxes, drop-down lists, and text fields. Structured Exams are especially useful for entering numeric data that you later want to search or report on.

The **General Exam** template (where you input the patient's vitals and measurements) is an example of a Structured Examination. Wolf EMR contains numerous other Structured

Examinations that you can use for specialized visit types. For example, you can use the Diabetes Review, or Rourke (pediatric) Structured Examinations.



Chronic Disease Management (CDM) Structured Exam templates:

Wolf EMR contains numerous Chronic Disease Management (CDM) Structured Exam templates for you to use. The CDM templates structure your notes around current disease-specific clinical guidelines.

CDM Structured Exam templates help you understand your patient base and focus on prevention when monitoring chronic disease patients. If you enter CDM visit data using appropriate Structured Exam templates, you can:

- View a patient's latest vitals and lab results on the visit note itself.
- Track patient trends, disease progress, and compliance for entire groups of patients diagnosed with a specific chronic disease (using Practice Search reports).
- Track a specific patient's treatment plan, disease progression, and compliance (using disease-specific flowsheets).
- Receive automated reminders for chronic disease patients who are due for specific tests, follow-up appointments, lifestyle advice, and treatments (using Rules).

CDM SOAP templates available in Wolf EMR include:

- Diabetes Mellitus Review
- Hypertension (CDM)
- COPD
- CHF (Cardiac Heart Failure)
- Chronic Kidney Disease (CDM)
- Depression (CDM)



Note: You can create your own customized Structured Exam templates if desired.

To use Structured Examination templates:

1. Open a Consult Letter Examination form for a patient. See [“Starting consult letter visit notes” on page 171](#).

- In the **Structured Exam** drop-down list, click an exam. The EMR displays the selected Structured Exam template in a new window.

- Enter your data in the available text fields, check boxes, and drop-down lists.

- When you are finished, click **Close** (Close button icon). The EMR saves your entered data.



Tip: You can go back to the original exam and make edits at anytime. Simply re-select the exam from the **Structured Exam** drop-down list, and the Structured Examination displays with the information you entered. Edit the information as needed.

- To use another Structured Exam template during the same visit, repeat [Step 2.](#) to [Step 4.](#) of this procedure.



IMPORTANT: Information entered in a structured examination is saved in the patient's encounter record, however, structured examinations DO NOT print with your consult letter, unless you print your consult using a SMART Form.

Using SMART exams

For questionnaire-type diagnostic tools (such as mental health assessments) and for complex visit documentation (such as the Pain Management Functional Goals & Summary), you can enter data using specialized SMART forms called SMART exams. When you enter data using SMART exams:

- The EMR automatically calculates questionnaire scores.
- For questionnaire scores and other exam data: You can graph values and perform patient searches based on values.

Most Wolf EMR SMART exams also contain links to patient handouts and other physician resources related to specific diagnostic tools.

The following table lists and describes the SMART exams available in Wolf EMR.

Name	Description
Adult Mental Health Assessment SMART exams The Adult Mental Health SMART Exams are designed to support the British Columbia Practice Support Program (PSP) for mental health, however, these forms can also be used by providers from other provinces. The Adult Mental Health Assessment SMART exams incorporate the PSP mental health algorithm, questionnaires, patient handouts, and other physician resources.	
Adult Mental Health Assessments	Combines content from all other mental health SMART exams, and includes ■ Generalized Anxiety Disorder Questionnaire (GAD-7) ■ Patient Health Questionnaire-9 (PHQ-9) ■ Diagnostic Assessment Interview Questions ■ Self-Assessment Questionnaire ■ Montreal Cognitive Assessment Questionnaire (MoCA) ■ Standardized Mini-Mental State Exam (sMMSE) ■ Mood Disorder Questionnaire (MDQ) ■ Global Assessment of Functioning (GAF) Scale ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References Note: Use this SMART exam if you are managing several mental health disorders for a patient. Complete only the exam sections that apply to the patient.

Name	Description
Adult Mental Health Assessments - Anxiety	Contains mental health diagnostic tools and resources for anxiety, and includes: ■ Generalized Anxiety Disorder Questionnaire (GAD-7) ■ Self-Assessment Questionnaire ■ Montreal Cognitive Assessment Questionnaire (MoCA) ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References
Adult Mental Health Assessments - Cognitive Function	Contains mental health diagnostic tools and resources for cognitive function, and includes: ■ Montreal Cognitive Assessment Questionnaire (MoCA) ■ Standardized Mini-Mental State Exam (sMMSE) ■ Mood Disorder Questionnaire (MDQ) ■ Global Assessment of Functioning (GAF) Scale ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References

Name	Description
Adult Mental Health Assessments - Depression	Contains mental health diagnostic tools and resources for depression, and includes: ■ Patient Health Questionnaire-9 (PHQ-9) ■ Diagnostic Assessment Interview Questions ■ Problem and Resource Lists ■ Problem List Action Plan ■ Mental Health Care Plan ■ Brief Action Plan - Self Management ■ Psychotherapeutic Supports Used ■ References
Child and Youth Mental Health SMART exams The Child and Youth Mental Health SMART Exams are designed to support the British Columbia Practice Support Program (PSP) for child and youth mental health, however, these forms can also be used by providers from other provinces. The Child and Youth Mental Health SMART exams incorporate the PSP mental health algorithm, questionnaires, patient handouts, and other physician resources.	
Child & Youth Mental Health Visit	Designed for the screening of mental health conditions, and includes: ■ CYMH Historical Questions ■ Current Situations ■ 6 Item Kutcher Adolescent Depression Scale (KADS) ■ Screen for Child Anxiety Related Disorders ■ SNAP-IV (Parent & Teacher Versions)

Name	Description
Child and Youth Mental Health Screening	Designed for documenting ongoing mental health care, and includes: ■ Teen & Child Functional Assessments ■ 6 Item Kutcher Adolescent Depression Scale (KADS) ■ Tool for Assessment of Suicide Risk (TASR-Am) ■ Anxiety, Depression Medication Side-Effect Scale (sCKS) ■ Kutcher Side Effect Scale for ADHD Medications (KSES-A) ■ Clinical Global Impression - Improvement Scale (CGI) ■ Worry Reducing Prescription (WRP) ■ Mood Enhancing Prescription (MEP) ■ CYMH Support Plan ■ Family Mental Health Care Plan ■ Professional Mental Health Care Plan ■ CYMH Historical Questions ■ Instructions for accessing the Confident Parents Thriving Kids (BC) form ■ Psychotherapeutic Supports Used ■ Team-based Care Resources & Tools ■ References
Pain Management SMART exam The Pain Management SMART Exam is designed to support the British Columbia Practice Support Program (PSP) for the management of patients with chronic pain, however, these forms can also be used by providers from other provinces. The Pain Management SMART exam incorporates PSP tools, questionnaires, patient handouts, and other physician resources related to the management of pain.	

Name	Description
Pain Management	Includes: ■ Brief Pain Inventory ■ Urine Drug Screen ■ Red & Yellow Flags ■ Brief Pain Inventory (BPI) Questionnaire ■ Pain Disability Index (PDI) Questionnaire ■ Generic Body Exam ■ PHQ-9 & Gad-7 Questionnaires ■ Sleep Questionnaire ■ DN4 Screening Questionnaire ■ Pain Catastrophizing Scale (PCS) Questionnaire ■ Initiation Checklist ■ Opioid Risk Tool ■ D.I.R.E. Score ■ Initiation Trial Chart ■ PharmaNet Search confirmation ■ Opioid Switching Tool ■ Patient Termination Letter (Opioid Use) ■ Pain Management Functional Goals & Summary Handout ■ Brief Action Plan - Self Management ■ Pain Management Education Done confirmation ■ PSP Pain Management Algorithm ■ References and Additional Handouts

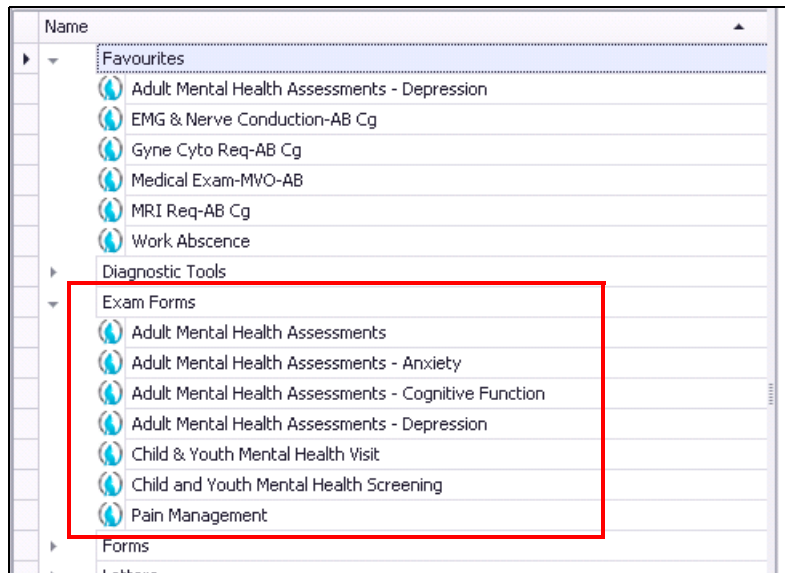


Note: You can access SMART exams only from the SOAP Note Examination window or from the Consult Letter Examination window (specialists), as the exam must be connected to a patient visit.

To use a SMART exam:

1. Open a Consult Letter form for the visit: See ["Starting consult letter visit notes" on page 171.](#)

2. Right-click anywhere on the window and then, in the SMART menu, click **SMART Forms**. The EMR displays the Send to SMART form window.
3. In the left pane, expand the **Exam Forms** category, and then click the SMART exam you want.



The EMR previews the exam.



Tip: If you want to complete a number of mental health assessments from one window, select the **Mental Health Assessments** exam. This exam combines the anxiety, cognitive function, and depression exams.

4. Click **Send and Close** (), or in the list of SMART exams, double-click the exam. The EMR opens the SMART exam in Microsoft Word.

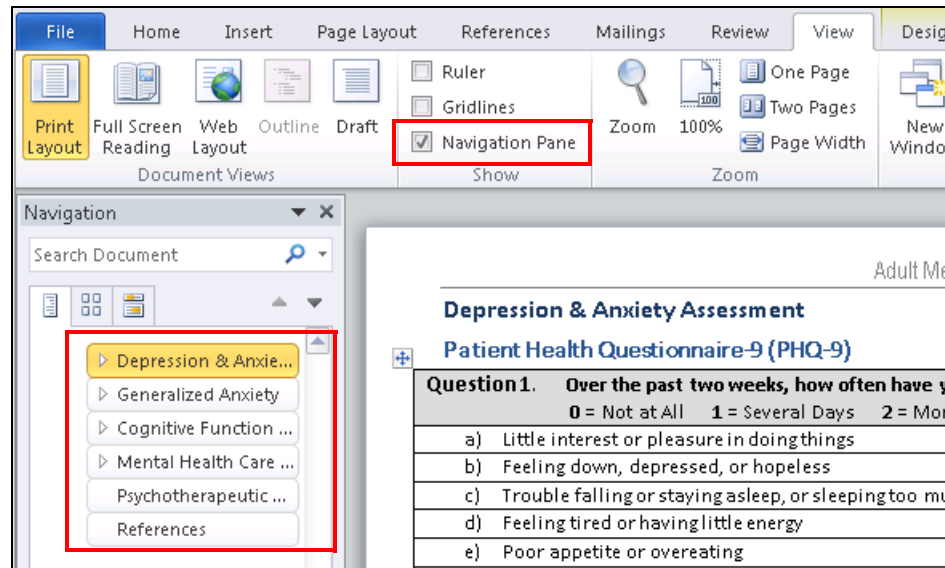
Adult Mental Health Assessments		19-Jul-2016
Depression & Anxiety Assessment		
Patient Health Questionnaire-9 (PHQ-9)		
Question 1. Over the past two weeks, how often have you been bothered by any of the following problems? 0 = Not at All 1 = Several Days 2 = More than half the days 3 = Nearly every day		
a) Little interest or pleasure in doing things		
b) Feeling down, depressed, or hopeless		
c) Trouble falling or staying asleep, or sleeping too much		
d) Feeling tired or having little energy		
e) Poor appetite or overeating		
f) Feeling bad about yourself, or that you are a failure or have let yourself or your family down		
g) Trouble concentrating on things, such as reading the newspaper or watching television		
h) Moving or speaking so slowly that other people could have noticed; or the opposite: being so fidgety or restless that you have been moving around a lot more than usual		
i) Thoughts that you would be better off dead, or of hurting yourself in some way.		
PHQ-9 Scoring Guide: 5-14 = Mild 15-19 = Moderate 20+ = Severe IMPORTANT: Enter the Calculated Score in the PHQ-9 Score to Document.		[Click for Result] PHQ-9 Score: 0
Question 2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		
		SELECT
Paper Copy : Click for PHQ-9 Questionnaire Patient Information: BC Depression Treatment Guide		Copyright Notice: PHQ 1999 Pfizer Inc. All rights reserved. PHQ-9 reproduced with permission by Med Access Inc

5. Enter data in the applicable area(s) of the SMART exam.



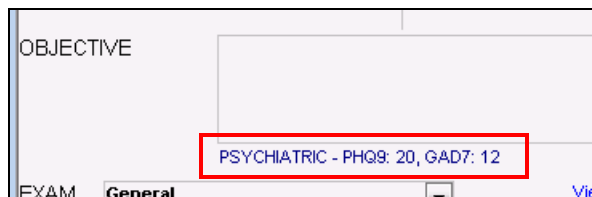
Tips for entering data in SMART exams:

- To calculate a questionnaire score, click **Click for Result**.
- If the exam has numerous sections, you can use the **Navigation** pane (left pane) to jump to specific sections.



- You do not have to enter data in every section of the SMART exam. Complete only the exam sections that apply to this visit

6. Click **Save** (), and then close the window. If you close and then reopen this visit's SOAP form, the calculated scores for the questionnaire(s) you completed display below the **OBJECTIVE** area.



FAQ: After I save and close the SMART exam can I go back and make edits?

After you save and close a SMART exam, you cannot open and edit the original exam. Instead, start a new version of the SMART exam (see [Step 1.](#) to [Step 4.](#)), and then re-enter data in the fields and questionnaires you want to modify. When you save the new SMART exam, the EMR overwrites the areas of the form where you entered data.

Auto-Replace text

Using the Wolf EMR auto-replace feature, you can quickly insert pre-defined words, phrases, and paragraphs into the Consult Letter form. Auto-replace is especially useful to enter repetitive text you use often in patient visit notes, and to enter difficult-to-spell words (for example, "Onychomycosis" [a fungal nail infection]). You can also use auto-replace text in other areas of the Wolf EMR including:

- Messages and follow-ups
- Referrals letters
- SOAP notes

For more information of using and customizing auto-replace text, see ["Auto-Replace text" on page 159](#).

Printing and faxing consult letters

You can print your consult letter as one of the following:

- A basic, un-formatted document, printed from the Consult Letter Examination window itself.
- A Word Document letter (SMART Form), enabling you to modify the appearance of the letter before printing.

Printing or faxing a basic consult letter

To print or fax a basic consult letter:

1. Enter your visit notes. See ["Entering visit notes in the consult letter form" on page 194](#) or ["Entering visit notes using shortcuts and templates" on page 198](#).
2. On the Consult Letter Examination window, complete one of the following actions:

- To print your consult letter on your default printer or fax machine, click **Quick Print**



- To select a printer or fax machine and set preferences before printing/faxing begins, click



The EMR prints your consult letter as a basic, un-formatted document.

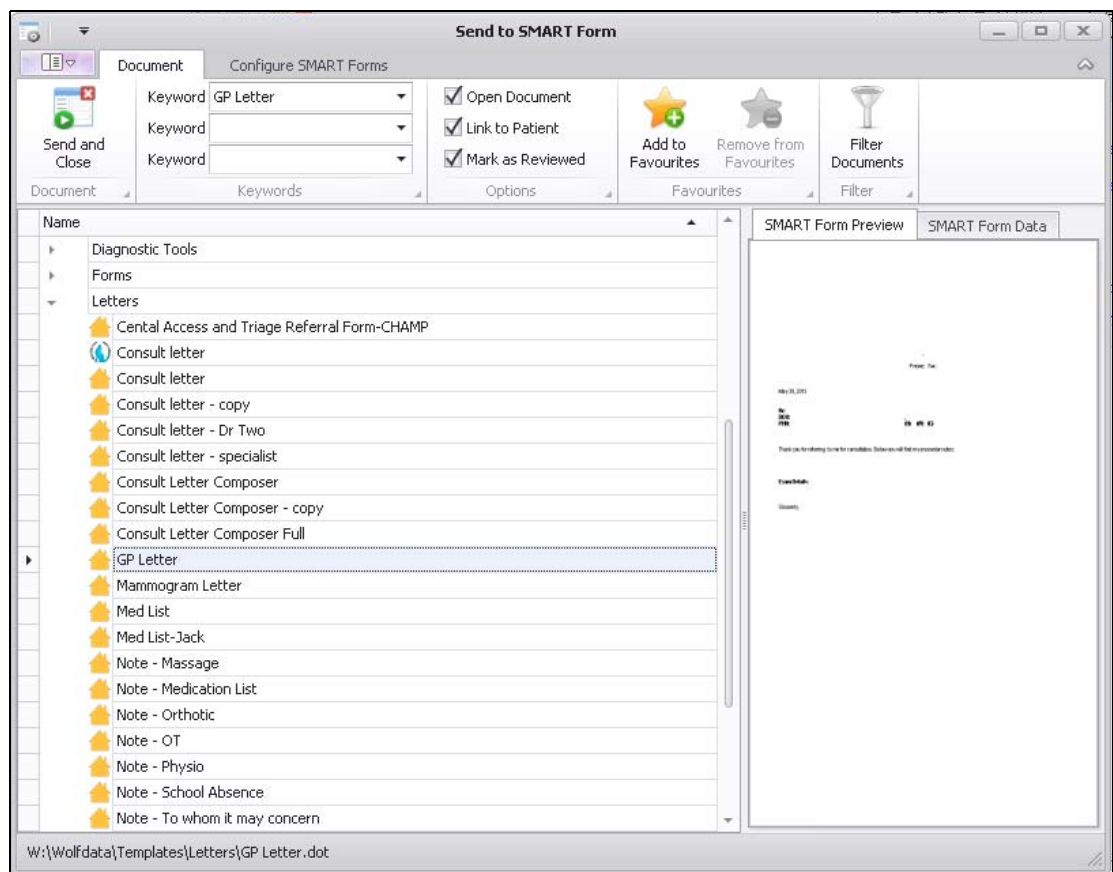
Printing or faxing consult letters using SMART Forms

If you want more options for formatting your letter, you can pull the data from the consult letter form into a Word Document template (SMART Form). You can then modify the letter before sending it. For example, you can add bullets, add a letterhead, or change the text font.

The SMART Form can also pull data you entered into Structured Exams during the patient visit.

To print or fax a consult letter using SMART Forms:

1. Enter your visit notes in the Consult Letter form. See [“Entering visit notes in the consult letter form” on page 194](#), or [“Entering visit notes using shortcuts and templates” on page 198](#).
2. Click **Lock** () to save your notes.
3. On the consult letter form, right-click and then, in the SMART Menu, click **SMART Forms**. The EMR displays the Send to SMART Form window.



4. In the left column of the window, expand **Letters**.

5. In the list of Letter SMART Forms, double-click **GP Letter**. The EMR opens a letter template in Word with your visit notes populated.



Note: If your clinic has a customized consult letter SMART form, select the customized SMART Form.



Tip: For information on how to create a customized letter SMART Form, see the Wolf EMR SMART Forms User Guide.

Dana Know-Four, MD
Wolf Clinic
 123 TEST DRIVE
 HIGH PRAIRIE, AB
 A5X 0G5
 PHONE: (111) 111-1111 Fax: (222) 222-2222

May 30, 2013

Re: Father Test
DOB: 20-Jun-1990
PHN:

1234 Frist Street
Calgary, AB T5R4E3W
(403) 999-8888

Thank you for referring Father to the Wolf Diabetic Centre.

DISCUSSED: Lack of targets for glucose and HbA1C, smoking cessation and activity increase and nutrition

LATEST TEST VALUES:
 HbA1C = 4 % (17-Apr-2013)
 Microalbumin/Creatinine Ratio = none on file
 Creatinine = 79 umol/L (17-Apr-2013)
 Cholesterol = none on file
 TG = none on file
 LDL = none on file
 HDL = none on file
 Last flu shot: - none on record.
 Home FBS: Lab FBS: none on file

SUBJECTIVE:
 Feels: well
 Diet: Looking for nutritional advice and insufficient fruit and vegetables
 Exercise: Walking, exercise classes, weight training and needs more minutes per week
 Smoking: working toward smoking cessation

Exam Details:
 Biometrics: Height: 175 cm, Weight: 65 kg, BMI: 21.3
 CNS: R Fundus: Normal, L Fundus: Normal
 CVS: S1: diminished, S2: loud, Murrur: None, S3: +, S4: +
 History: Lipid Risk: High
 Neuro: Feet: Cool, Vibration: decreased, Sensation: diminished: feet LT, Pinprick: mild decrease sensation
 Vitals: BP - 120/80, Pulse: 75

Sincerely,

6. Modify the letter as needed using the Microsoft Word tools available.

7. When you are finished, click **File > Print**. Microsoft Word displays the Print window.



8. Select the desired printer or fax machine, and then click **Print** (). The letter is printed or faxed on the selected machine.

9. Click **Save** (). The EMR saves the letter in the patient's Medical Summary in the **Documents** tab.

10. Click **Close** ().



Tip: If your front end staff print/send your consult letters for you, then send a message to your front end staff to indicate that the letter is ready for printing.

Use Auto-Replace text in your message to save you time. For example, you can create Auto-Replace text so that when you enter "pl" and the words "Please fax consult letter to referring physician." populate the message automatically.

Creating consult letter templates

To create a consult letter template:

1. Open the consult letter form for a test patient. See ["Starting consult letter visit notes" on page 171](#).

2. On the left side of the window, click **Edit/New Template**. The EMR displays the Visit Consult Template Builder window, with your name selected in the MD field.

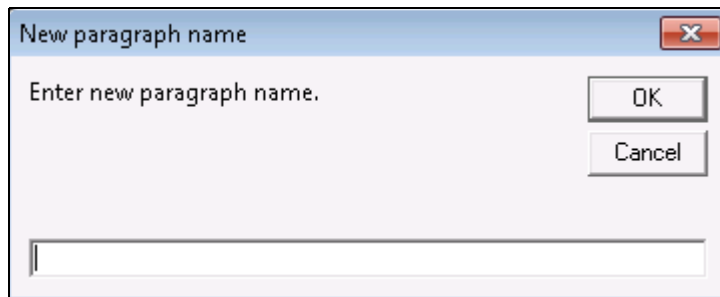


Note: Each physician has their own set of Consult Letter templates.

3. To create a consult letter template for another practitioner, in the **MD** drop-down list, click the practitioner's name, or to create a consult letter template for all practitioners, click **<<All MDs>>**.
4. Click **Add New Template** (). The EMR displays a dialog box with the following prompt: "Create a new template?".
5. Click **Yes**. The EMR displays the Template Name window.

6. In the **Template Name** field, enter a name for the template, and then click **OK**.

7. To add a paragraph, click **New Paragraph**. The EMR displays the New paragraph name window.



8. In the **New paragraph name** field, enter a descriptive name for the paragraph.



Tip: Consult letter templates are made up of a series of paragraphs. You can add as many or as few paragraphs as you want. When you use the template to write a consult letter, you can select which paragraphs you want to use or exclude, and select the order of the paragraphs.

If you split your template into more paragraphs, your template is more versatile.

9. In the main text area on the Visit Consult Template Builder window, enter text for the paragraph as you want it to appear in the consult letter.
10. To add additional paragraphs:
- Click **New Paragraph**. The EMR displays a dialogue box with the following prompt: "Save Changes?".
 - Click **Yes**.
 - Repeat [Step 8](#). and [Step 9](#).

11. When you are finished click **Close** (.

Adding pick list items (check box selections) to consult letter templates

If you want to choose from a list of options on your template, you can create check box selection options.

The screenshot shows a window titled "Template Compile : Form". On the left, there is a text area containing the following text:

...
SUBJECTIVE:
 Feels: well
 Diet: Doing all that they think they can do for optimal nutrition
 Exercise: Walking
 Smoking: Continues to be a smoker

On the right, there is a list of check box options:

- ☒ Doing all that they think they can do for optimal nutrition
- ☐ Looking for nutritional advice
- ☐ insufficient fruit and vegetables
- ☐ excessive simple carbohydrates
- ☐
- ☐
- ☐
- ☐
- ☐

At the bottom right, there are four buttons: a left arrow, a right arrow, "Stop", and "Finished".

When you use Consult Letter Templates for patient visits, the EMR translates check box selections into text on the consult letter itself.

To create check box selections:

1. Open the Visit Consult Template Builder window, and start a paragraph. See ["Creating consult letter templates" on page 215](#).
2. In the main text area on the Visit Consult Template Builder window, enter any "fixed" notes for the paragraph.
3. In the paragraph, click where you want selected check box items to insert.
4. Enter check box options using the following format: {Item 1|Item 2|Item 3}
 - For example: "Diet: {Doing all that they think they can do for optimal nutrition | Looking for nutritional advice | insufficient fruit and vegetables | excessive simple carbohydrates}."



CAUTION: For check box items, use letters and numbers only. Do not use any special characters such as _?,:.*> or the template will not work properly.

Check boxes are limited to a single sentence at most, as you cannot use periods or commas. Use simple statements only.

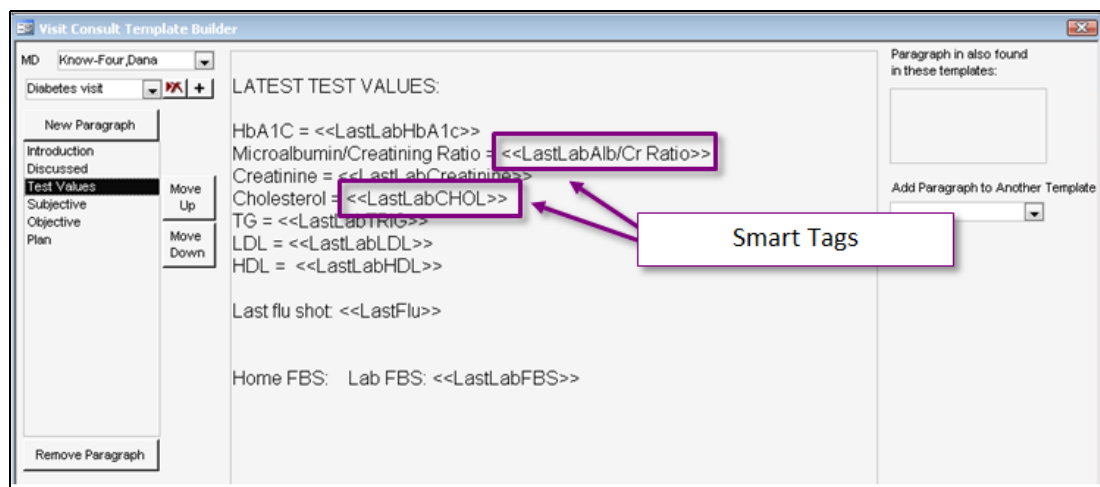
Pulling patient data into consult letter templates

Most information available in a patient's record can be pulled automatically into a consult letter using consult letter templates. For example, you can pull a patient's current medications, or

latest lab results. To program a consult letter template to automatically pull a specific patient information, inserting the appropriate **Smart Tag** in the place where you want the data to pull.

To add a Smart Tag to a consult letter template:

1. On the Wolf EMR Launch page, click **Help** (). The EMR displays the Wolf EMR Help window.
2. Click **Search** ().
3. In the **Search** field, enter the following text: "Smart Tag".
4. Press **Enter**. The EMR displays a list of matching topics.
5. In the list of topics, click **Smart Tags**. The EMR displays the Smart Tags help topic, with a list of available tags you can choose from.
6. Scroll through the list to find the appropriate Smart Tag, or click a letter to jump down to the selected area on the alphabetical list.
7. Open the Visit Consult Template Builder window and start a paragraph. See ["Creating consult letter templates" on page 215](#).
8. In the main text area on the Visit Consult Template Builder window, enter any "fixed" notes for the paragraph.
9. Enter the Smart Tag name in the place in the paragraph that you want the information to populate.



Editing consult letter templates

Once a consult letter template is created, you can later go back and edit the template as needed. You can:

- Edit a paragraph.
- Add additional paragraphs.
- Delete a paragraph.
- Move a paragraph.
- Delete the entire template.

To edit a consult letter template:

1. Open a Consult Letter form for a test patient. See ["Starting consult letter visit notes" on page 171](#).
2. On the left side of the window, click **Edit/New Template**. The EMR displays the Visit Consult Template Builder window, with your name selected in the MD field.
3. In the template drop-down list, click the template you want to edit.
4. To edit a paragraph:
 - a) In the list of paragraphs for the template, click the paragraph you want to edit. The EMR displays the paragraph contents in the main text area.
 - b) In the text area, modify the text as necessary.
5. To add a new paragraph, complete [Step 7](#). to [Step 9](#). of ["Creating consult letter templates" on page 215](#).
6. To delete a paragraph:
 - a) In the list of paragraphs for the temple, click the paragraph you want to delete.
 - b) Click **Remove Paragraph**. The EMR displays a dialog box with the following prompt: "Remove paragraph from current template?"
 - c) Click **Yes**. The EMR displays a dialog box with the following prompt: "Permanently Delete Paragraph?"
 - d) If the paragraph is not used in other templates, click **Yes**.
7. To move a paragraph within a template:
 - a) In the list of paragraphs for the template, click the paragraph you want to move.
 - b) Complete one of the following actions:
 - To move the paragraph higher on the list, click **Move Up**.
 - To move the paragraph lower on the list, click **Move Down**.
8. To delete an entire template:
 - a) In the template drop-down list, click the template you want to delete.

- b) Click **Delete Template** () . The EMR displays a dialog box with the following prompt:
"Permanently Delete 'template name' from the system?".
 - c) Click **Yes**.
9. Click **Close** () when you are finished editing your templates. The EMR displays a dialogue box with the following prompt: "Save changes?".
10. Click **Yes**.

Managing incomplete visit notes

In the old days of paper charting, you likely created a pile of patient charts to finish or address. Now, with Wolf EMR, your WorkDesk keeps track of your "pile" of incomplete charts. Any time you save a SOAP visit note without locking it, the EMR adds the visit note to your incomplete visit note list. You can then go back and finish your work without missing any incomplete charts.

To view and finish your incomplete visit notes:

1. On your WorkDesk, in the **Tasks** tab, in the **Patient Records** area, click **# Incomplete visit Records** (where # is the number of your incomplete visit notes). The EMR displays the Incomplete Records window.

Incomplete Records

Test, Mother PHN 79827-4114

Born 27-Oct-1970 (43) Sex F Status Long Term C...
 1234 Frist Street, Calgary AB T5R4E3W H (403) 999-8888 Pri Dana Know-Four, MD
 C Fam W Ret

☐ Include All Arrived Appointments

Patient Name	Appt Start	Visit Description
Test, Mother	06-Nov-2013 14:15	
Tapia, Twanna	06-Nov-2013 14:16	
Tarver, Tennie	06-Nov-2013 14:16	
Test, Scott	20-Nov-2013 19:58	<<PTFirst Name>> feels his mood can best
Test, Scott	30-Jan-2014 14:57	
Test, Delta	03-Mar-2014 11:40	
Test, Arm	03-Mar-2014 12:30	Pre Natal Form
Test, Delta	10-Mar-2014 11:00	* Diabetes Mellitus
Test, Scott	11-Mar-2014 10:10	
Test, Mother	11-Mar-2014 10:31	
Test, Father	11-Mar-2014 10:37	The 33 years old year old patient presents
Test, Amy	24-Mar-2014 16:22	
Test, Amy	26-Mar-2014 13:00	Pre Natal Form
Test, Amy	08-Apr-2014 08:43	
Test, Fred	09-Apr-2014 09:49	Right side Arm Pain
Test, Fred	09-Apr-2014 09:49	These are my subjective notes
Test, Hynke	14-Apr-2014 15:16	
Test, Amy	11-Jun-2014 15:07	
Test, Mother	17-Jul-2014 11:58	
Test, Mother	13-Aug-2014 09:00	
Test, Joy	13-Aug-2014 10:10	
Test, Father	03-Sep-2014 14:01	
Test, Mother	12-Sep-2014 19:26	
Test, Amy	08-Oct-2014 11:23	

2. To include incomplete visit notes for all arrived appointments, select the **Include All Arrived Appointments** check box.



Note: The **Incomplete Records** list displays, by default, only records that you have opened and then closed

3. In the list of incomplete visit records, double-click visit record you want to complete. The EMR opens the Consult Letter Examination window for the incomplete visit record.
4. Complete any unfinished areas of the Consult Letter Examination form as described in [“Entering visit notes in the consult letter form” on page 194](#), or [“Entering visit notes using shortcuts and templates” on page 198](#).
5. When you finish the visit note, click **Sign and Lock** (). The EMR displays a dialog box with the following prompt: **“Sign and Lock Record?”**.
6. Click **Yes**. The EMR removes the record from your **Incomplete Records** list.

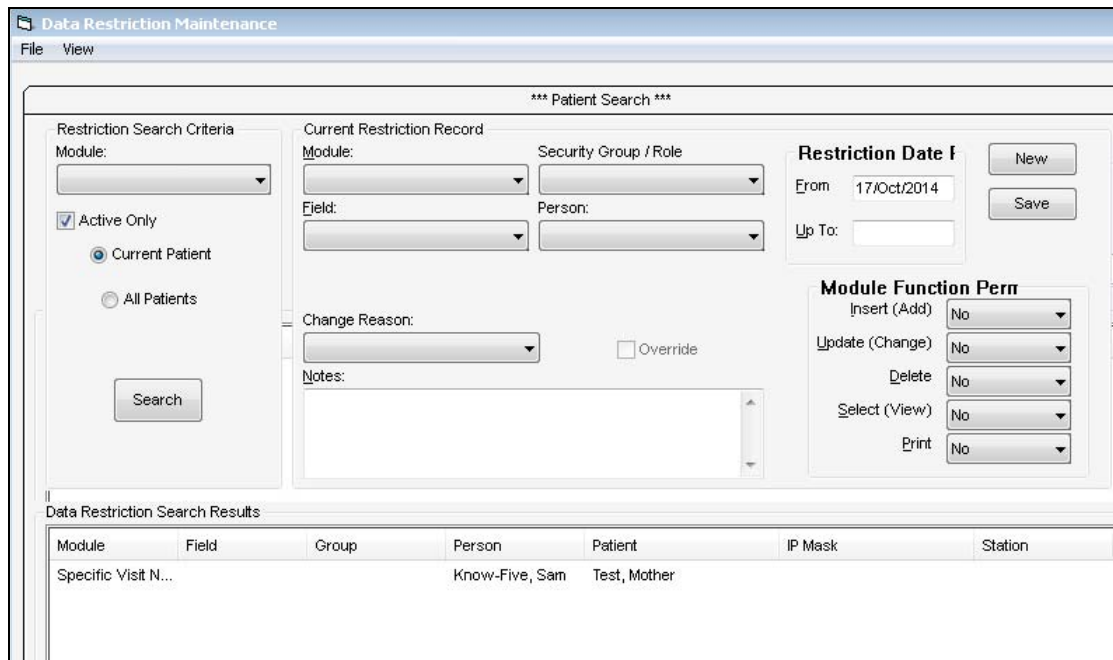
Setting internal privacy restrictions on visit notes

If a patient requests that you to keep their visit notes confidential from all, or some of your clinic staff members, you can restrict selected clinic users from accessing specific patient visit records.

Restricting access to a visit record

To restrict access to a visit record:

1. On any window of the patients chart (for example, the CPP, Medical Summary, or Consult Letter Examination form), on the SMART Patient Banner, click **View Patient Maintenance** (). The EMR displays the Patient Maintenance window.
2. On the Patient Maintenance menu, click **View > Patient Data Restrictions**. The EMR displays the Data Restriction Maintenance window.



Module	Field	Group	Person	Patient	IP Mask	Station
Specific Visit N...			Know-Five, Sam	Test, Mother		

3. In the **Current Restriction Record** area, in the **Module** drop-down list, click **Specific Visit Note**.

4. In the **Security Group/Role**, or **Person** drop-down list, click the group or individual user that you want to restrict access to.



Note: When you select a security group, role, or individual to restrict access to, the EMR displays an **Exception** area with your name selected by default. The person defined in the **Exception** area can access the patient record no matter what restrictions are placed on the record.

Module Function Perm	
Insert (Add)	Yes
Update (Change)	Yes
Delete	Yes
Select (View)	Yes
Print	Yes

5. In **Restriction Date Range** area, leave the date in the **From** field as today's date, and leave the **Up To** field blank.
6. To enable restricted users to perform some actions on the restricted record, in the **Module Function Permissions** area, click **Yes** beside actions you want to enable.
7. In the **Restricted Data Record** drop-down list, click the visit note you want to restrict access to.
8. Click **Save**.
9. To add a restriction to another visit record, or restrict the same record to other users, repeat [Step 3.](#) to [Step 8.](#)
10. When you are finished, click **Close** ().

Removing restrictions on patient records

If you add restrictions to a visit record in error, you or any other user can remove the restrictions at any time. When a visit record restriction is removed, the EMR tracks who removed the restriction in the transaction log.

To remove a restriction on a visit record:

1. Open the Data Restriction Maintenance window for the patient. See [Step 1.](#) to [Step 2.](#) in ["Restricting access to a visit record" on page 223.](#) The EMR lists any current restrictions on the patient's record in the **Data Restriction Search Results** area.

2. If the list of data restrictions for the patient is long, search for the visit note data restriction you want remove:
 - a) In the **Restriction Search Criteria** area, in the **Module** drop-down lists, click **Specific Visit Note**.
 - b) Click **Search**. The EMR filters the **Data Restriction Search Results** area to display only data restrictions related to specific visit records.
3. In the **Data Restriction Search Results** area, click the data restriction you want to remove. The EMR displays the restriction details.
4. In the **Restriction Date** area, enter today's date in the **Up To** field.
5. Click **Save**.

Viewing a restricted patient record

If you have been restricted access to view or perform an action on a specific patient's record, you can Unmask the record for yourself if needed.



Note: You cannot unmask records for other users.

1. Open the patient's Data Restriction Maintenance window, and then search for the restricted record you want to unmask. See [Step 1.](#) to [Step 2.](#) in ["Removing restrictions on patient records" on page 224.](#)
2. In the **Data Restriction Search Results** area, click the data restriction you want to remove. The EMR displays the restriction's details.
3. In the **Restriction Date** area, click **Unmask**. The EMR:
 - Enters tomorrow's date in the **Up To** field
 - Selects your name in the **Person** field
 - Defaults all selections in the **Module Function Permission** area to **Yes**
4. To unmask the patient record for longer than one day, in the **Up To** field enter the date you want access to the record until, or to unmask the record indefinitely, clear the field.
5. To enable yourself permission to perform only specific actions on the record, in the **Module Function Permission** area, select **No** beside actions you do not need access to perform.
6. Click **Save**. The EMR adds a new entry in the **Data Restrictions Search Results** area indicating:
 - That you have unmasked the record.

- The actions you have permission to perform.



Note: You cannot delete this entry. There is a permanent record indicating that you have unmasked the patient's restricted record.

Creating prescriptions and managing medications

In this chapter you learn how to create and manage patient prescriptions. In Wolf EMR, you can create and print patient prescriptions from any window related to a patient's record (via the SMART menu). Once a medication has been prescribed for a patient, you can easily:

- Reprint the prescription
- Modify the prescription
- Refill the prescription
- Discontinue the prescription

Wolf EMR tracks a patient's active (current) and inactive (previous) medications in the Medical Summary, and displays the patient's medications in the Prescription entry window. This enables you to view at-a-glance what medications the patient is taking when you prescribe new medications.

Creating basic prescriptions

Wolf EMR contains an extensive searchable medications list, enabling you to quickly select an appropriate medication to prescribe. You can search for medications by name, category, or targeted system.

For each prescribed medication, you can accept default dose, frequency, and duration prescription details, or modify this information as needed.

Initiating prescriptions

You can start a prescription from almost any window in a patient's record using the **SMART Menu** (right-click menu.)

To initiate a prescription:

1. On any window of a patient's record (SOAP form, Consult Letter form, Medical Summary, patient message/Follow up, or Patient tab) right-click and then in the **SMART Menu**, click **Enter New Medication**. The EMR displays the Add New Medications window, with:

- The medication search area located in the top left area of the window.
- A list of your medication favourites displayed in middle of the window.
- The patient's weight, age, and allergies displayed on the top right of the window.
- The prescription dosage entry area located on the bottom of the window.

Add New Medications

Patient Information: Test, Mother, PHN 79827-4114, Born 27-Oct-1970 (43), Sex F, Status Long Term C..., 1234 Frist Street, Calgary AB T5R4E3W, H (403) 999-8888, P: Dana Know-Four, MD, Fam, Ret.

Weight: 60 kg (132.3 lbs) 6 m ago

Allergies: acetaminophen/caffeine/oc, azithromycin

Search: Includes Generic, Includes OTC, Includes IV, Dose form: <Any>, Starts with, Contains.

Favourites:

Rx Name	Favourite Description	Duration	Notes	Clin
Amoxicillin (Amoxicillin 125 mg/5 mL PWDR) g i PO TID	Amox 125	10		yes
Hydrocortisone cream .5% i topical BID prn	topical			
Acetylsalicylic acid (Apo-ASA TAB) 325 mg i PO OD prn	apo			
Diclofenac topical (Voltaren Emulgel 8% GEL) g i TOP OD	topical			
Non Medication Diabetic needles 100 units				
Amoxicillin (Amox CAP) 250 mg i PO TID	Amox 250			
Non Medication				yes

Dosage: Units/Dose: prn: Units: Route:

Problem: *Duration: *Date Prescribed: 16-Sep-2014

Anticoagulant: Manufacturer: Indications: Potency: Rank: Notes:

Searching for medications to prescribe

When you prescribe a medication, you can search for the medication you want by name, category, or targeted system.

Searching for medications by name

To search for a medication by name:

1. Start a prescription. See ["Initiating prescriptions" on page 227](#).
2. On the Add New Medications window, in the **Search** field, enter part or all of the medication name.
3. Press **Enter**. The EMR displays matching medications in the **Select medication from list** area.
4. To narrow or expand your search results, click one of the following options:

- a) **Contains:** The EMR filters the results to display medication names that contain your search term anywhere in the name.
- b) **Starts with:** The EMR filters the results to display only medication names that start with your search term.



Tip: In the medication search results list, if a medication displays more than once, there are multiple dosage types for that medication. To view the dosage type and size, click and then hover your cursor over the medication name. The EMR displays the dosage type and size as a pop-up message.

5. In the **Select medication from list** area, click the medication you want. The EMR:

- Displays the medication name in the blue **RX** field
- Populates the prescription details area with default values (if available).

The screenshot shows the EMR interface for selecting a medication. At the top, the **RX** field displays the selected medication: **Naproxen (Naprelan 375 ERT) 375 mg i PO OD**. Below this, a search bar contains the text **Napro**. The **Select medication from list** table shows several results for **naproxen**, with **Naprelan 375 ERT** highlighted. To the right, the prescription details panel is populated with the following information:

- Dosage:** 375
- Units/Dose:** 1
- Route:** PO
- Frequency:** OD
- Duration:** No Cut Off
- Date Prescribed:** 07-Jul-2015
- Manufacturer:** Elan Pharma Limited
- Indications:** Pain & inflammation
- Notes:** take with food



Medication search tips

- You can narrow your search results by selecting the form you want the medication to be in. For example, to search for amoxicillin in capsule form, in the **Dose Form** drop-down list, click **CAP**. The search results return all amoxicillin options available in capsule form.
- If you are searching for an over-the-counter medication, in the **Search** area, select the **Include OTC** check box.
- If you are searching for a brand name medication, clear the **Include Generic** check box.



Best practice: If you are not certain how to spell a medication name, in the **Search** field, enter only the first three letters of the medication name. Wolf EMR will not produce accurate search results for misspelled names.

Searching for medications by category

To search for a medication by category:

1. Start a prescription. See [“Initiating prescriptions” on page 227](#).
2. On the Add New Medications window, click the **Drug Category Search** tab. The EMR displays a list of high-level drug categories.

The screenshot shows the 'Drug Category Search' window. At the top, there is a 'Search' field, radio buttons for 'Starts with' and 'Contains' (with 'Contains' selected), a 'Dose form' dropdown menu set to '<Any>', and three checkboxes: 'Include Generic', 'Include OTC', and 'Include IV'. Below these are three tabs: 'Favourites', 'Drug Category Search' (which is active), and 'Search by ATC categories'. The main area displays a list of drug categories under the heading 'Drug Category Search:'. The list includes: alternative medicines, analgesics, anti-infectives, anticoagulants, anticonvulsants, antidepressants, antidiabetic agents, antiemetic/antivertigo agents, antifungals, and antihyperlipidemic agents.

3. In the list of drug categories, click in the category area, and then press the first letter of the category you want to select. For example, press "c" for "central nervous system agents". The EMR displays that area of the alphabetical list.
4. Scroll down the list, and then click the category you want. The EMR displays associated sub-categories to the right.

This screenshot shows the same 'Drug Category Search' window, but with the 'central nervous system agents' category selected and highlighted in the main list. To the right of the main list, a secondary list of sub-categories is displayed, including: analgesics, anticonvulsants, antiemetic/antivertigo agents, antiparkinson agents, general anesthetics, muscle relaxants, miscellaneous central nervous system agents, and anorexiant.

5. Click a sub-category. The EMR displays a list of medications classified within that sub-category in the **Select medication from list** area.

6. In the **Select medication from list** area, click the medication you want. The EMR:

- Displays the medication name in the blue **RX** field
- Populates the Dosage area with default prescription values

Searching for medications by targeted system

To search for a medication by a targeted system for treatment:

1. Start a prescription. See [“Initiating prescriptions” on page 227](#).
2. On the Add New Medications window, click the **Search by ATC Categories** tab. The EMR displays a list of high-level targeted systems.

Search

☐ Starts with ☒ Contains Dose form: <Any>

☐ Include Generic ☐ Include OTC ☐ Include IV

Favourites Drug Category Search Search by ATC categories

Search ATC Category

☒ Alimentary Tract And Metabolism
☒ Antineoplastic And Immunomodulating Agents
☒ Antiparasitic Products, Insecticides & Repellents
☒ Blood And Blood Forming Organs
☒ Cardiovascular System
☒ Dermatologicals
☒ Genito Urinary System And Sex Hormones
☒ Musculo-skeletal System



Note: “ATC” = “Anatomical Therapeutic Chemical”

3. Scroll down the list, and then click the system you are targeting for treatment. The EMR displays a list of associated medications in the **Select medication from list** area.
4. To narrow your search to a specific drug category that targets your selected system:
 - a) Expand a system name. The EMR displays a list of categories below the targeted system.

Search

☐ Starts with ☒ Contains Dose form: <Any>

☐ Include Generic ☐ Include OTC ☐ Include IV

Favourites Drug Category Search Search by ATC categories

Search ATC Category

☒ Genito Urinary System And Sex Hormones
☒ **Musculo-skeletal System**
☒ Anticancer Preparations
☒ Antiinflammatory And Antirheumatic Products
☒ Drugs For Treatment Of Bone Diseases
☒ Muscle Relaxants
☒ Other Drugs For Disorders Of Musculo-skeletal Sys
☒ Topical Products For Joint And Muscular Pain
☒ Nervous System

- b) Click a category name. The EMR displays a list of medications classified under the selected category.
5. To narrow your search further to a specific drug sub-category that targets your selected system:
 - a) Expand a category name. The EMR displays a list of subcategories below the category.
 - b) Click a subcategory name. The EMR displays a list of medications classified under the selected subcategory in the **Select medication from list** area.
6. In the **Select medication from list** area, click the medication you want. The EMR:
 - Displays the medication name in the blue **RX** field
 - Populates the Dosage area with default prescription values

Entering prescription details

After you select a medication, you can enter prescription details for dosage, frequency, and duration. Wolf EMR contains structured fields for you to enter this information.

To enter prescription details for your selected medication:

1. Start a prescription. See ["Initiating prescriptions" on page 227](#).
2. Select a medication. See ["Searching for medications to prescribe" on page 228](#).
3. Using the following table, in the prescription details area (located on the bottom right of the window), enter or modify the prescription details.



Note: Depending on the medication you choose, several of the prescription detail fields may populate with default values. You can edit default values if needed.

Field	Description
Dosage	Below Dosage , click a dosage option (for example, for a 250mg tablet, click 250). If the option you want is not available, enter the dose in the Dosage field.
Units	In the drop-down list, select the dose units. For example, for a 250mg tablet, select mg .
Route	In the drop-down list, select the dose route. For example, for a tablet that the patient is to take orally, select PO (per Orally).
Units/Dose	Below Units/Dose , click the number of units the patient is to take with each administration. If the number you want is not available, enter a number in the Units/Dose field.
Frequency list	In the list of frequency options, click a frequency, or to indicate that the patient is to take the medication as needed, select prn .
Problem	To associate the prescription with a one of the patient's Medical Summary problems, in the drop-down list, click a problem. Note: You can choose only problems that are listed in the patient's problem list. To add a problem to the patient's problem list, select <Add New> .
Duration	In the drop-down list, click a duration. If you are having trouble finding the duration you want, in the Duration field, start to enter the duration (for example, to find "4 days", enter "4"). The EMR takes you to the appropriate area on the list. Note: The Duration option you select determines if and when the medication automatically discontinues. If you expect to refill the medication, click No Cut Off .
Date Prescribed	By default the Date Prescribed is today's date. To set the prescription date to another date, enter the date, or to select the date from a calendar, click  .
Anticoagulant	If this is an anti-coagulation medication that requires regular INR testing, select the Anticoagulant check box. The EMR displays the prescription, and future changes you make to the prescription, on the Anticoagulation Summary Sheet. Note: The Anticoagulant check box displays only if your medication is flagged by the EMR as an anticoagulant.
Notes	Enter any additional prescription notes for the patient (for example, "take immediately following a meal").

4. Click **Prescribe**. The EMR displays the Prescriptions window, with:

- The left side of the window displaying lists of the patient's current Medications, Previous Medications, and Allergies.
- The right side of the window displaying the input area for the current prescription's quantity, repeats, and duration details.

Prescriptions

Test, Mother PHN 9999 999 999

Born: 27-Oct-1970 (44) Sex: F Status: N/A

1234 Test Street, Squamish BC H: (111) 111-1111 Pri: Veta Coles, M.D.

Default Pharmacy: [Dropdown]

Medications

- Clobazam (Frisium TAB) 10 mg i PO qhs
- Lamotrigine (Lamictal TAB) 150 mg i PO BID
- Methylphenidate (Ritalin-SR ERT) 30 mg i PO Q
- Naproxen (Naprelan 375 ERT) 375 mg i PO OD**

Previous Medications: [Empty List]

Allergies: [Empty List]

***Rx: Naproxen (Naprelan 375 ERT) 375 mg i PO OD**

Total Dosage Per Day: 375 mg

*Quantity: [0] Repeats: [0] *Duration: [Long Term] [Single Rx]

Units: [TAB] *Start Date: [08-Jul-2015]

*Next Refill: [Empty] Note: [take with food]

☒ Refill History ☐ Medication History

Next Refill	Last Refill	Quant	Repeats	Pharm Called	Refill Status	Initials
[Empty Table]						

Current Refill (Dbl Click to Delete Prescription Entry):

MedName	Quant	Repeats	Note
[Empty Table]			



Tip: You can go back to the previous window (New Medication window) at any time. At the top of the Prescriptions window, click **Edit Medication Dosing**



5. In the **Quantity** field, complete one of the following options:

- To enter the medication quantity manually, enter the total amount of medication to be dispensed (for example, the number of capsules).
- To have the EMR calculate the quantity for you, enter the duration the patient is to take the medication for.



Note: If you enter information for prescription frequency and duration in the Add New Medication window; then the **Quantity** field is already populated with the calculated number of tablets, applications, etc.

6. In the **Units** list, click the appropriate quantity or duration units (if it is not populated appropriately already).
7. In the **Repeats** field, enter the number of repeats, or to indicate that you do not want any repeats, leave the field blank.
8. In the **Duration** area, complete one of the following actions:
 - a) To indicate that the patient will be on the medication for an extended period of time, select **Long Term**.
 - b) To indicate that the patient to be on the medication only until the prescription runs out, select **Single Rx**.



Tip: Use your **Tab** key to quickly jump from field-to-field in the **Prescriptions** window.

9. If the patient is to start taking the prescription on a day other than today, in the **Start Date** field, enter a new start date, or to select a date on a calendar, click .
10. Review possible drug interactions warnings. See ["Reviewing drug interaction warnings" on page 235](#).
11. If the prescription requires a PharmaCare Special Authorization form, complete the Special Authorization form. See ["Requesting PharmaCare Special Authority for prescriptions" on page 237](#).
12. To prescribe another medication (to print on the same prescription), enter the next medication. See ["Prescribing multiple medications" on page 240](#).
13. To print the prescription, click one of the following options:

- **Quick Print** (

After the prescription prints, the EMR changes the prescription **Status** to **'Printed'**.



Note: If a locum prints a prescription, Wolf EMR adds the text "Locum For 'X' Physician" to the prescription print-out.

Reviewing drug interaction warnings

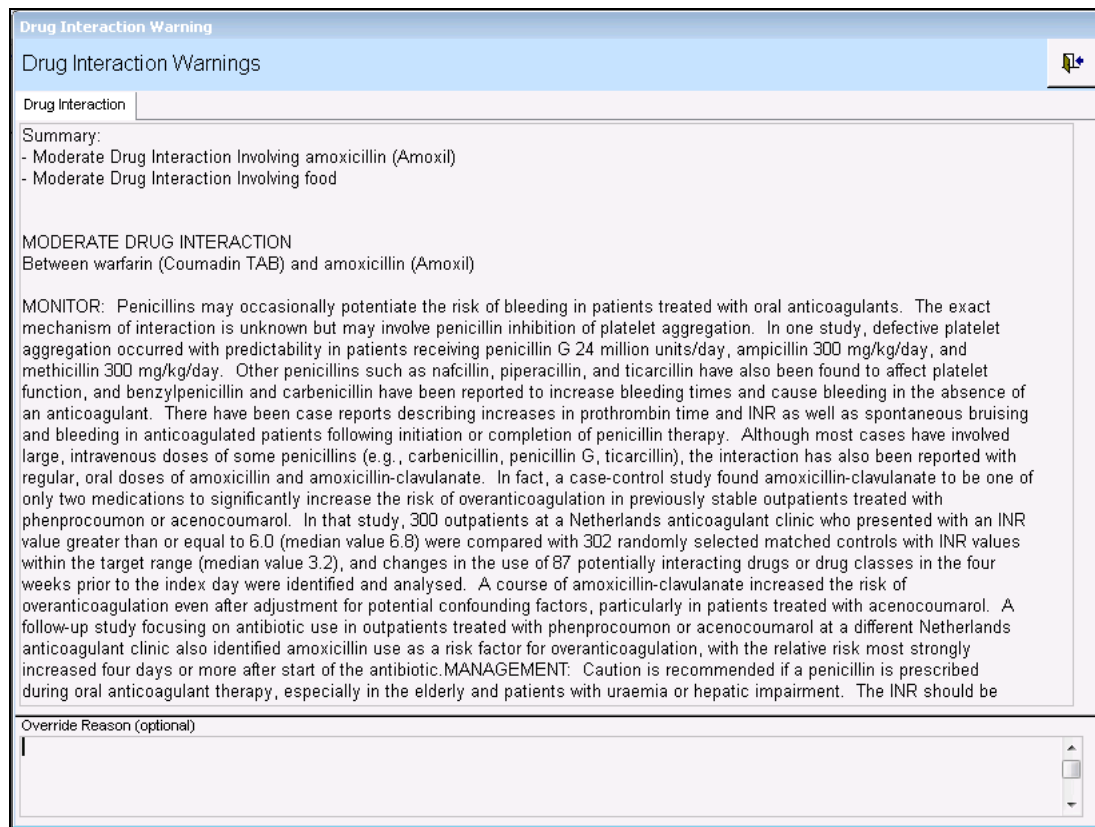
As you prescribe a medication, Wolf EMR checks for possible drug contraindications between the drug you are prescribing and:

- Drugs that the patient is currently taking (listed in the **Current Medications** area on the patient's Medical Summary)
- The patient's allergies (listed in the **Allergies** area on the patient's Medical Summary)
- The patient's current medical conditions (listed in the **Problems** area on the patient's Medical Summary)

To view drug interaction warnings:

1. Search for a medication and enter prescription details for the medication. See [“Searching for medications to prescribe” on page 228](#), and [“Entering prescription details” on page 232](#).

2. On the top of the Add New Medications window, click **Multum** (). The EMR displays possible interactions for the medication.



Drug Interaction Warning

Drug Interaction Warnings

Drug Interaction

Summary:

- Moderate Drug Interaction Involving amoxicillin (Amoxil)
- Moderate Drug Interaction Involving food

MODERATE DRUG INTERACTION
Between warfarin (Coumadin TAB) and amoxicillin (Amoxil)

MONITOR: Penicillins may occasionally potentiate the risk of bleeding in patients treated with oral anticoagulants. The exact mechanism of interaction is unknown but may involve penicillin inhibition of platelet aggregation. In one study, defective platelet aggregation occurred with predictability in patients receiving penicillin G 24 million units/day, ampicillin 300 mg/kg/day, and methicillin 300 mg/kg/day. Other penicillins such as nafcillin, piperacillin, and ticarcillin have also been found to affect platelet function, and benzylpenicillin and carbenicillin have been reported to increase bleeding times and cause bleeding in the absence of an anticoagulant. There have been case reports describing increases in prothrombin time and INR as well as spontaneous bruising and bleeding in anticoagulated patients following initiation or completion of penicillin therapy. Although most cases have involved large, intravenous doses of some penicillins (e.g., carbenicillin, penicillin G, ticarcillin), the interaction has also been reported with regular, oral doses of amoxicillin and amoxicillin-clavulanate. In fact, a case-control study found amoxicillin-clavulanate to be one of only two medications to significantly increase the risk of overanticoagulation in previously stable outpatients treated with phenprocoumon or acenocoumarol. In that study, 300 outpatients at a Netherlands anticoagulant clinic who presented with an INR value greater than or equal to 6.0 (median value 6.8) were compared with 302 randomly selected matched controls with INR values within the target range (median value 3.2), and changes in the use of 87 potentially interacting drugs or drug classes in the four weeks prior to the index day were identified and analysed. A course of amoxicillin-clavulanate increased the risk of overanticoagulation even after adjustment for potential confounding factors, particularly in patients treated with acenocoumarol. A follow-up study focusing on antibiotic use in outpatients treated with phenprocoumon or acenocoumarol at a different Netherlands anticoagulant clinic also identified amoxicillin use as a risk factor for overanticoagulation, with the relative risk most strongly increased four days or more after start of the antibiotic. **MANAGEMENT:** Caution is recommended if a penicillin is prescribed during oral anticoagulant therapy, especially in the elderly and patients with uraemia or hepatic impairment. The INR should be

Override Reason (optional)

3. If, despite an interaction warning, you still want to prescribe the medication, you can optionally record the reason for prescribing. In the **Override Reason** field, enter a reason for override.
4. Close the window. The EMR saves the **Override Reason** in the background and associates the reason to this prescription for future reference.

Requesting PharmaCare Special Authority for prescriptions

In Wolf EMR, you can complete and print the PharmaCare Special Authority Request form as you enter a prescription (from the Prescription window). You can also print the form for a previously entered prescription.

The EMR completes a majority of the form for you, requiring that you only:

- Select the Indication For Special Authority
- Enter specified details for special authority



Note: PharmaCare Special Authority, grants full benefit status to a drug, medical supply or medical device that otherwise would not be covered or only partially covered. Coverage is provided for patients with specific medical circumstances and the actual reimbursement depends on the patient's PharmaCare plan rules, including any annual deductible requirements.



Note: For the patient to receive coverage, they must ensure that Special Authority approval is in place before they purchase the prescription. Coverage is not provided retroactively.

To print a PharmaCare Special Authority:

1. Enter the prescription. See [“Entering prescription details” on page 232](#).
2. Perform one of the following actions:
 - If you are in the process of entering the prescription, on the Prescriptions window, click **Spec Auth** ().
 - If you want to print a Special Authority form for a previously entered prescription, open the

Medication Profile window, click the medication, and then click **Spec Auth** (). See [Step 1](#) to [Step 2](#) in [“Editing prescriptions” on page 251](#).

The EMR displays the BC Reference Based Pricing Special Authority Form window.

3. In the **Indication For Special Authority** area, select a check box.
4. In the **Specific Details** area, enter detailed information regarding the reason for special authority.
5. To print the Special Authority form, complete one of the following actions:

- To print the form on your default printer, click **Quick Print** ().
- To print the form on another printer, click **Print** (). The EMR displays a printer selection window. Click the printer you want, and then click **Print**.

The EMR prints the official provincial form with all fields completed.

	BRITISH COLUMBIA Ministry of Health Services Pharmacare	SPECIAL AUTHORITY REQUEST				
Fax requests in Victoria to 250-952-1965 or, from elsewhere in BC, to 1-800-609-4884 (toll free). OR mail requests to: Pharmacare, Box 9655, Stn Prov Govt, Victoria, BC V8W 9P2 This facsimile is Doctor-Patient privileged and contains confidential information intended only for Pharmacare. Any other distribution, copying or disclosure is strictly prohibited. If you have received this fax in error, please destroy it and notify us by telephone at 604-682-6849 in Vancouver/Lower Mainland, 250-952-2866 in Victoria or 1-800-654-0250 in the rest of BC (Monday to Friday, 8 a.m. to 8 p.m.).						
Use this form to request: • Exemptions to the Reference Drug Program (RDP) • Exemptions to the Low-Cost Alternative Program (LCA) • Restricted Benefits		<i>Forms with information missing will be returned for completion.</i>				
Should approval be granted for this Special Authority request, Pharmacare's authorization is solely for the purpose of providing prescription benefit for the cost of the requested medication. Pharmacare makes no representation about the suitability of the requested medication for the patient's, or any other, medical condition or problem. <i>Please see reverse for category definitions and instructions on completing this form.</i>						
SECTION 1 - PRESCRIBER INFORMATION						
NAME & MAILING ADDRESS Veta C, M.D. 6970 H Street Agassiz, BC V5F 0E2	☐ MAIL CONFIRMATION	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> APPLICATION DATE YYYY MM DD 2015 - 07 - 08 </td> <td style="width: 50%;"> PRESCRIBER'S TELEPHONE # AREA CODE (219) 843-6918 </td> </tr> <tr> <td> PRESCRIBER'S COLLEGE ID # 12345 </td> <td> PRESCRIBER'S FAX # AREA CODE (844) 408-9587 </td> </tr> </table>	APPLICATION DATE YYYY MM DD 2015 - 07 - 08	PRESCRIBER'S TELEPHONE # AREA CODE (219) 843-6918	PRESCRIBER'S COLLEGE ID # 12345	PRESCRIBER'S FAX # AREA CODE (844) 408-9587
APPLICATION DATE YYYY MM DD 2015 - 07 - 08	PRESCRIBER'S TELEPHONE # AREA CODE (219) 843-6918					
PRESCRIBER'S COLLEGE ID # 12345	PRESCRIBER'S FAX # AREA CODE (844) 408-9587					
SECTION 2 - PATIENT INFORMATION						
Personal information on this form is collected for the operations of Pharmacare, Ministry of Health Services. The information will be used so that Pharmacare can decide whether prescription benefit will be provided for the cost of the requested medication. If you have any questions about the collection of this information, call (604) 682-6849 in Vancouver/Lower Mainland, (250) 952-2866 in Victoria or 1-800-654-0250 in the rest of BC, and ask to consult a Pharmacist concerning Special Authorities. Personal information will be used and disclosed in accordance with the privacy protection provisions of the Freedom of Information and Protection of Privacy Act.						
PERSONAL HEALTH NUMBER (PHN) 9999999999	PATIENT (FAMILY) NAME Test					
DATE OF BIRTH (YYYY / MM / DD) 1970-10-27	PATIENT (GIVEN) NAME(S) Mother					
When patient available, please complete: I authorize the prescriber to release information to Pharmacare to obtain Special Authority for prescription benefit, including access to specific health information related to the Special Authority request in the custody of the prescriber, as appropriate.						
PATIENT'S SIGNATURE (OPTIONAL)						
SECTION 3 - MEDICATION DETAIL INFORMATION						
REQUESTED DRUG EXEMPTION (INDICATE BOTH MEDICATION AND DOSAGE REQUESTED)						
☒ NEW REQUEST ☐ RENEWAL						
Interferon beta-1a (Avonex Prefilled Syringe 30 mcg/0.5 mL KIT) 30 mg i IM weekly						
INDICATION(S) FOR SPECIAL AUTHORITY						
☒ Treatment Failure on Reference Drug / Low-Cost Alternative / First-Line Agent (please list medications tried)						
☐ Adverse Reaction to Reference Drug / Low-Cost Alternative / First-Line Agent (please list medications tried and specify adverse reaction)						
☐ Drug / Drug Interaction with Reference Drug or First-Line Agent (please list both drugs that may interact)						
☐ Diagnosis and other patient-specific indicators						
Pharmacare may request additional documentation to support this Special Authority request for certain non-referenced drugs (e.g., zidovudine, interferon, carvedilol, finasteride, etc.).		PRESCRIBER'S SIGNATURE				
PHARMACARE USE ONLY						
☐ DOES NOT MEET GUIDELINES	☐ ADDITIONAL INFORMATION REQUIRED (SEE BELOW)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> EFFECTIVE DATE YYYY / MM / DD </td> <td style="width: 50%;"> DURATION OF THERAPY / TERMINATION DATE YYYY / MM / DD </td> </tr> </table>	EFFECTIVE DATE YYYY / MM / DD	DURATION OF THERAPY / TERMINATION DATE YYYY / MM / DD		
EFFECTIVE DATE YYYY / MM / DD	DURATION OF THERAPY / TERMINATION DATE YYYY / MM / DD					

Prescribing multiple medications

When you prescribe more than one medication for a patient, you can print all the medications on a single prescription printout. Additional medications can be new medications for the patient, or refilled medications.

As you prescribe multiple medications, the EMR tracks the medications in a visible area, enabling you to review your prescribed medications before printing.

To prescribe multiple medications:

1. Enter the first medication for the prescription. See [“Entering prescription details” on page 232](#).
2. On the Prescriptions window, perform one of the following actions:
 - To add a medication that has not been previously prescribed to the patient:
 - a) Click **Add/New** (). Wolf EMR displays an empty Add New Medications window, and saves the previous medication.
 - b) Search for the next medication. See [“Searching for medications to prescribe” on page 228](#).
 - c) Enter prescription details for the medication. See [“Entering prescription details” on page 232](#).
 - To prescribe an active medication that the patient has been previously prescribed, refill the prescription. See [Step 2](#) to [Step 3](#) in [“Refilling prescriptions” on page 254](#).
 - To prescribe an inactive medication that the patient has been previously prescribed, resume the prescription. See [Step 2](#) to [Step 5](#) in [“Resuming an inactive medication” on page 255](#).
3. To add additional medications to the prescription, repeat [Step 2](#) . As each medication is added to the prescription, the EMR displays the medication name in the **Current Refill** area. In the **Medications** area, the word **Refilled** also displays beside the medication’s name.

Multi-Select

Medications

*****Refilled***** Interferon beta-1a (Avonex Pref
 Clonazepam (Frisium TAB) 10 mg i PO qhs
 Lamotrigine (Lamictal TAB) 150 mg i PO BID
 Methylphenidate (Ritalin-SR ERT) 30 mg i PO O
 Naproxen (Naprelan 375 ERT) 375 mg i PO OD

Previous Medications: +

Naproxen (Naprelan 375 ERT) 375 mg i PO OD

Allergies:

*Rx Date: 08-Jul-2015
 *Prescribing MD: Veta Coles, M.D.
☒ May Substitute Generic ☐ No Substitutions ☐ Print Medication

***Rx:** Naproxen (Naprelan 375 ERT) 375 mg i PO OD
 Total Dosage Per Day: 375 mg

*Quantity: 0 Repeats: 0
 Units: TAB
 *Start Date: 08-Jul-2015
 Next Refill:
 Note: take with food

*Duration
☒ Long Term
☐ Short Term

Okayed
 To Come In
 Chart Request
 Denied
 Printed

☒ Refill History ☐ Medication History

Next Refill	Last Refill	Quant	Repeats	Pharm Called	Refill Status	Initials
Current Refill (Dbl Click to Delete Prescription Entry):						
MedName	Quant	Repeats	Note			
Interferon beta-1a (Avonex Prefilled Sy 1 UNIT(S)	0					
Naproxen (Naprelan 375 ERT) 375 mg	30 TAB	0	take with food			



Tip: If you add a medication in error and want to remove it from your prescription, double click the medication on the **Current Refill** list.

4. To print the prescription, click one of the following options:

- **Quick Print** (): To print the prescription to your default printer.
- **Print** (): To select a printer or fax machine to print to.



Note: All medications that display in the **Current Refill** area on the Prescriptions window are included in the printout.

Creating prescriptions for special situations

Although a majority of the prescriptions you create follow the previous workflow, there are several note-worthy scenarios where you enter prescriptions in a different manner. These scenarios include prescribing:

- PRNs (take-as-needed medications)
- Compound medications

- Variable doses
- Medical devices and other non-medication therapies
- Over-the-counter medications
- Intravenous medications

Prescribing PRNs

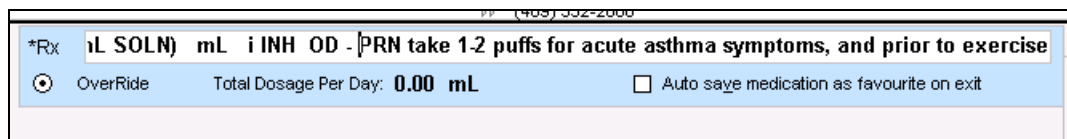
PRN ("take as needed") prescriptions typically do not require a set frequency and/or duration. Instead, PRN prescriptions detail information such as:

- In what situations or cases patient is to take the medication
- What dose should be administered depending on the situation
- The maximum amount of medication the patient can take in a day
- The minimum amount of time required between doses

In the Wolf EMR, you can enter PRN prescription details in a more flexible text field. You do not have to complete the specific dose, frequency, or duration fields.

To prescribe a PRN:

1. Initiate a prescription. See ["Initiating prescriptions" on page 227](#).
2. Select the medication to prescribe. See ["Searching for medications to prescribe" on page 228](#).
3. On the Add New Medications window, click **Override** (located below the blue **Rx** field). The EMR enables you to edit text in the blue **Rx** field.
4. In the **Rx** field, click to the right of the medication name, and enter "PRN", followed by text explaining other important instructions. Examples of instruction types, include:
 - Circumstances in which the patient is to administer the medication.
 - Maximum dose per day.
 - Minimum amount of time between doses.




Note: Do not erase or modify the medication name that is populated by the EMR.

5. Leave the dose, units, and frequency fields blank. You can also enter information to these fields if needed. See [Step 3](#) in ["Entering prescription details" on page 232](#).

6. Complete the remainder of prescription as you would for a basic prescription. See [Step 4 Step 13](#) in “Entering prescription details” on page 232.

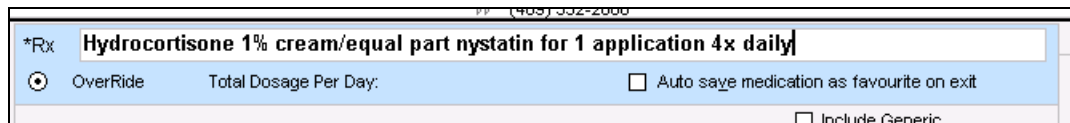
Prescribing compound medications

Compound prescriptions are medications comprised of two or more ingredients that are combined by a pharmacist before dispensing. The multitude of potential compound ingredient combinations are not specifically available in the Wolf EMR’s drug database.

Because you cannot select the whole compound from the medication search list, you instead search for the first ingredient. You can then customize the Rx name to include the remainder of the compound ingredients.

To prescribe a compound:

1. Initiate a prescription. See [“Initiating prescriptions” on page 227](#).
2. Perform a search for the first compound ingredient. See [“Searching for medications to prescribe” on page 228](#).
3. Click **Override** (located below the blue **Rx** field). The EMR enables you to edit text in the blue **Rx** field.
4. In the **Rx** field click to the right of the first ingredient's name, and then enter the remainder of the compound ingredients as you want them to display on the prescription.



*Rx **Hydrocortisone 1% cream/equal part nystatin for 1 application 4x daily**

☒ Override Total Dosage Per Day: ☐ Auto save medication as favourite on exit

☐ Include Generic



Note: The name of the first ingredient that you select from the medication list must remain as is. You cannot edit it.

5. Optionally, in the **Rx** field, enter any application instructions to the right of the compound name.
6. Leave the dose, units, and frequency fields blank. You can also enter information to these fields if needed. See [Step 3](#) in “Entering prescription details” on page 232.
7. Complete the remainder of prescription as you would for a basic prescription. See [Step 4 Step 13](#) in “Entering prescription details” on page 232.



Note: Compounds are not checked for interactions or low/high dosages since these prescriptions are entered in as text only.

Prescribing variable doses

Variable dose prescriptions are prescriptions where dose changes from week-to-week, day-to-day, or within a day. Some examples include:

- Weaning a patient off of a medication by reducing their daily dose each week.
- Instructing a patient to take one capsule in the morning than two capsules in the evening.

These types of medications often have extensive instructions that require greater flexibility for entering.

To prescribe a medication with variable dose instructions:

1. Initiate a prescription. See [“Initiating prescriptions” on page 227](#).
2. Search for a medication. See [“Searching for medications to prescribe” on page 228](#).



Best practice: Select the most basic version of a medication name. If possible, do not select a medication with a pill/capsule/application size specified in it's name.

3. On the Add new Medications window, click **OverRide**. The EMR enables you to edit text in the blue **Rx** field.
4. In the **Rx** field click to the right of the medication name, and then enter the type of variable dose. For example, “Tapering”.

*Rx	Phenobarbital (Phenobarbital TAB) - Tapering - 100mg i PO OD x 10days, then 60mg iPO OD x 1
☒ OverRide	Total Dosage Per Day: mg ☐ Auto save medication as favourite on exit
☐ Include Generic	

5. In the **Rx** field, beside the variable dose type and medication name, enter your detailed dose, frequency, and duration instructions. For example, you can enter “8 tabs x 1 day; 7 tabs x 1 day...”
6. Leave the dose, units, and frequency fields blank. You can also enter information to these fields if needed. See [Step 3](#) in [“Entering prescription details” on page 232](#).
7. Complete the remainder of prescription as you would for a basic prescription. See [Step 4 Step 13](#) in [“Entering prescription details” on page 232](#).

Prescribing medical devices and other non-mediation treatments

You can produce non-medication prescriptions for a number of injections, therapies, or medical devices that require a printed prescription in order for the patient to be eligible for a treatment, or to receive insurance coverage for the treatment.

To prescribe a medical device or another non-medication therapy:

1. Start a prescription. See [“Initiating prescriptions” on page 227](#).

2. On the Add New Medications window, in the **Search** field, enter a descriptive word for a medical device or treatment (for example, "Brace"), and then press **Enter**. The EMR displays a list of matching treatment/device options in the **Select medication from list** area.



Best practice: Enter only one word as your medical device search term, as the EMR is more likely to find a match. For example, enter "brace" instead of "carbon fiber knee brace." You can then select a more specific description from the resulting search list.

3. Click the appropriate device/treatment. The EMR displays the medical device/treatment name in the blue **Rx** field.



Tip: If you cannot find the medical device you want

1. In the **Search** field, enter "Non Medication," and then press enter.
2. In the **Select medication from list** area, click "Non Medication". You can now enter a description beside the words "Non Medication"

4. Click **Override**. The EMR enables you to edit text in the blue **Rx** field.
5. In the **Rx** field, beside the device name (or the text "Non Medication"), enter a detailed device or treatment name and application instructions (for example, carbon knee brace - to be worn during weight-bearing following ACL surgery on the right knee).
6. Leave the dose, units, and frequency fields blank. You can also enter information to these fields if needed. See [Step 3](#) in "Entering prescription details" on page 232.
7. Complete the remainder of prescription as you would for a basic prescription. See [Step 4 Step 13](#) in "Entering prescription details" on page 232.

Prescribing medical devices and other non-medication therapies using SMART Forms (Optional)

If you want a printed prescription for a medical device, therapy, and other non-medication treatment to contain your clinic logo and other customized features, you can use a customized SMART Form as your "prescription pad".

To prescribe a non-medication treatment using a SMART Form:

1. On any window related to the patient, (including a patient's Medical Summary, SOAP form, Consult Letter Examination form, or Patient tab [CPP]), right-click. The EMR displays the SMART Menu.
2. On the **SMART Menu**, click **SMART Forms**. The EMR displays the Send to SMART Form window, with the left side of the window displaying your list of SMART Forms grouped into categories.

3. In the SMART Form category list, expand **Letters**. The EMR displays a list of letter SMART Forms.
4. In the letter SMART Forms list, double click **Physio Chiro Massage Referral** (or the name of your clinic's customized prescription SMART Form). The EMR displays your prescription template in Microsoft Word.
5. In the Word document, enter the device or treatment prescription details.
6. To print the prescription:
 - a) On the Microsoft Word menu, click **File > Print**.
 - b) In the **Printer** drop-down list, click a printer.
 - c) Click **Print** (). The prescription prints, and the EMR saves a copy of the printed prescription in the **Documents** tab on the patient's Medical Summary.



Best practice: Use SMART forms for only NON-MEDICATION prescriptions. Always enter prescriptions for medications in the Add New Medications window. This way, you can easily reference, re-prescribe, and flag prescribed medications for possible interactions.

Prescribing over-the-counter (OTC) and intravenous medications

In Wolf EMR, over-the-counter (OTC) and intravenous medications are categorized differently than other medications, and by default do not display in medication search results. Before you search for an OTC or intravenous medication, you therefore must indicate that medication search results can contain OTC or intravenous medications.

To prescribe an OTC or intravenous medication:

1. Initiate a prescription. See ["Initiating prescriptions" on page 227](#).
2. On the Add New Medication window, in the Search area, select the **Include OTC** check box, or the **Include IV** check box depending on the type of medication you are prescribing.



Tip: If you want **Include OTC** and **Include IV** to be selected by default, users with administrative privilege can change configuration Wolf EMR to have these options selected by default.

3. Search for a medication. See ["Searching for medications to prescribe" on page 228](#). The EMR includes OTC and/or intravenous medications in the list of search results.
4. Enter prescription details and print the prescription. See ["Entering prescription details" on page 232](#).

Reprinting prescriptions

If a patient loses or forgets their prescription, you can re-print the original prescription at any time.

To preprint a prescription:

1. On any window related to the patient's record, right-click and then, in the SMART menu, click **Refill Medications**. The EMR displays the Prescriptions window.
2. On the Prescriptions window, in the **Rx Date** field, enter the date of the original prescription,

or to select the date on a calendar, click . The EMR displays all medications prescribed on the selected date in the **Current Refill** area.



Tip: if you do not know the date the original prescription was created, you can view the start dates of the patient's current medications in the Medication Profile.

To view a patient's Medication Profile:

- On the Prescriptions window, right-click and then, in the SMART menu, click **View Medication List**. The EMR opens the patient's Medication Profile, with a list of the patients current medications and corresponding start times displayed in the **Medications** area.

3. Optionally, modify any of the listed medications' prescription details. See ["Editing prescriptions" on page 251](#).
4. To print the prescription, click one of the following options:

- **Quick Print** (): To print the prescription to your default printer.
- **Print** (): To select a printer or fax machine to print to.

Medication favourites

You can save medications and associated prescription details as medication favourites. When you want to prescribe the medication again, you can simply choose the medication in your favourites list and the EMR populates the prescription details automatically. You can then make modifications to the prescription details as needed before printing the prescription.

Medication favourites enable you to:

- Reduce the amount of time it takes to produce prescriptions with long details (for example, for tapering medications and compound medications).
- Easily find hard-to-spell medications.

- Prescribe common medications in moments.



Note: Medication Favourites can only be created for one medication at a time. You cannot create a favourite that includes multiple medications.

Adding medication favourites

You can add a medication to your favourites list as you are creating a prescription.

To add a medication to your **Medication Favourites** list:

1. Initiate a prescription. See [“Initiating prescriptions” on page 227](#).
2. Search for and select a medication. See [“Searching for medications to prescribe” on page 228](#).
3. On the Add New Medication window, complete one of the following actions:
 - If you are entering a basic prescription, enter or modify information in the dosage, units, frequency, and duration fields. See [Step 3](#) in [“Entering prescription details” on page 232](#).
 - If you are entering a prescription for a compound, variable dose, or non-medication, enter information in the Rx field and other fields on the Add New Medication window as needed. See [“Creating prescriptions for special situations” on page 241](#).



Note: Do not click **Prescribe** at this point.

4. In the middle of the window, click the **Favourites** tab (if not selected already).
5. In the **Description** field, enter a name for the medication favourite.
6. To make the medication favourite available to all providers in your clinic, select the **Clinic-wide** check box.
7. Click **Add Favourite**. Your medication displays in the **Medication Favourites** list.
8. To continue to prescribe this medication to the current patient, complete the prescription. See [Step 4 Step 13](#) in [“Entering prescription details” on page 232](#).



Note: Only prescription details entered in the Add New Medications window save as part of the favourite.

Using medication favourites

To use a medication Favourite:

1. Initiate a prescription. See [“Initiating prescriptions” on page 227](#).
2. On the Add New Medications window, click the **Favourites** tab (if it is not selected already).

3. In the **Search** field, enter all or part of the medication name or favourite description.
4. Press **Enter**. The EMR displays matching medication favourites in your medication favourites list.

Search results for 'Cipro':

Rx Name	Favourite Description	Duration	Notes	Clinic
Ciprofloxacin (Cipro TAB) 500 mg i PO BID		10	Do not take with antacids containing aluminu	

Select medication from list:

Generic Name	Trade Name	Dose Form
Ciprodex		
ciprofloxacin	Cipro	TAB
ciprofloxacin	Cipro	PWDR
ciprofloxacin	Cipro	TAB
ciprofloxacin	Cipro XL	ERT
ciprofloxacin ophthalmic	Ciloxan	SOLN
ciprofloxacin ophthalmic	Ciloxan	OINT
ciprofloxacin-dexamethasone otic	Ciprodex	SUSP
ciprolex		
CiproXL		

Dosage: None Units/Dose: None prn: 0

*Duration: *Date Prescribed: 09-Jul-2015

Notes:

5. Double click the favourite you want. In the Add New Medications window, the EMR populates the medication name and prescription detail fields with the medication favourite default information.
6. Modify the prescription details as needed. See [Step 3](#) in “Entering prescription details” on [page 232](#).
7. Complete the medication as normal. See [Step 4](#) [Step 13](#) in “Entering prescription details” on [page 232](#).

Modifying the order of your medication favourites

If you have numerous favourites for one medication, with each having different dosage directions, finding the medication favourite you want can be cumbersome. For this reason, you can modify the order of your medication favourites list so that favourites with the most commonly prescribed dosage directions display higher on the list.

To modify the position of a medication favourite on your favourites list:

1. Start a prescription for a test patient. See [“Initiating prescriptions”](#) on [page 227](#).
2. On the Add New Medications window, click the **Favourites** tab (if it is not selected already).
3. In your list of medication favourites, click the favourite you want to move.



Tip: If your medication favourites list is extensive, in the **Search** field, enter all or part of the medication name or favourite description, and then press **Enter**. The EMR displays only matching medications in your favourites list.

4. On the right of your medication favourites list, click the **Move Up in Favourites List** () or **Move Down in Favourites List** (). The EMR moves the prescription favourite up or down a level.
5. Continue to click the arrow until the medication favourite is located where you want.
6. On the top of the Add New Medications window, click **Cancel** (). The EMR closes the Add New Medications window, and saves the modifications you made to your medication favourites list.

Modifying medication favourites

After you add a medication favourite, you can later modify the favourite's description or share settings. You cannot modify the medication name or prescription details.

To modify a medication favourite:

1. Start a prescription for a test patient. See [“Initiating prescriptions” on page 227](#).
2. On the Add New Medications window, click the **Favourites** tab (if it is not selected already).
3. In your list of medication favourites, click the favourite you want to modify.



Tip: If your medication favourites list is extensive, in the **Search** field, enter all or part of the medication name or favourite description, and then press **Enter**. The EMR displays only matching medications in your favourites list.

4. To the right of your medication favourites list, click **Edit** (). The EMR displays the **Edit Favourite** window.
5. To edit the description for the medication favourite, in the **Modify the description** field, modify the text displayed.
6. To change the share settings for the medication favourite, click one of the following options:
 - **Personal:** To make the favourite available on your list only.
 - **Clinic Wide:** To make the favourite available to all clinic users.

Modifying prescriptions

Once you enter a prescription for a patient, the prescribed medication remains documented in the patient's Medication Profile.

From the Medication Profile you can modify the prescription details and, optionally reprint the prescription. You can also record that the prescription is being discontinued, and optionally record and adverse reaction to the medication.

Editing prescriptions

If after you print a prescription you realize there is an error on the prescription, from the **Medication Profile** you can edit the prescription details, and then reprint the prescription.

To edit a prescription:

1. On any window related to a patient's medical record, right-click and the, on the SMART menu, click **View Medication List**. The EMR displays the patient's Medication Profile.

Medication Profile

Test, Daughter PHN: 9999 999 999

Sex: F Status: N/A

123 Test Street, Squamish BC

111-111-1111 (H) 222-222-2222 (C) W

Dr: Yeta C, M.D.

Effective (as of) Date: 09-Jul-2015

Medications

Medication Name	Start Date
Clobazam (Frisium TAB) 10 mg i PO qhs	16-Oct-2012
Lamotrigine (Lamictal TAB) 150 mg i PO BID	16-Oct-2012
Methylphenidate (Ritalin-SR ERT) 30 mg i PO OD	16-Oct-2012

Previous Medications

Medication Name	End Date	Start Date

Allergies:

Current Medication

Clobazam (Frisium TAB) 10 mg i PO qhs

Problem: [Dropdown]

Start Date: 16-Oct-2012

End Date: No Cut Off

Note: Medication note

There are no drug interaction overrides recorded for this medication.

Linked Lab Results:

☒ Refill History ☐ Medication History

Next Refill	Last Refill	Quant	Repeats	Ph Call	Refill Status	Initials	Notes
24-Jan-2013	16-Oct-2012	100 T	0	Yes	Printed	VC	

2. In the **Medications** area, click the medication you want to edit. The EMR displays the medication's prescription details on the right side of the window.
3. On the top right of the window, click **Edit Medication Dosing** (). The EMR displays your selected prescription in the Add New Medications window.
4. Modify the prescription details as needed. See [Step 3](#) to [Step 10](#) in “[Entering prescription details](#)” on page 232.
5. Perform one of the following actions:

- To print the prescription on your default printer, click **Quick Print** ().

- To print the prescription on another printer, click **Print** (). The EMR displays a printer selection window. Click the printer you want, and then click **Print**.
- To save the changes in the patient's record, without printing the prescription, click **Save & Close** ().

Discontinuing medications



Best practice: When you instruct a patient to stop taking a medication, always record the discontinuation in the patient's record. This way, the patient's Medication Profile accurately reflects the medications the patient is taking.

Discontinuing medications that a patient is no longer taking also ensures you do not receive medication interaction warnings that are no longer relevant.

When you discontinue a medication, you can record any adverse reactions to the medication at the same time.

To discontinue a medication:

1. Open the patient's Medical Profile. see [Step 1](#) to [Step 1](#) in “Editing prescriptions” on page [251](#).
2. In the **Medications** area, click the medication you want to discontinue. The EMR displays the medication's prescription details on the right side of the window.
3. On the top right of the Medication Profile window, click **D/C Med**. The EMR displays the **Discontinue Medication** window, with the **Date Discontinued** defaulted to today's date.

4. To record that the patient stopped taking the medication on a date earlier than today, in the **Date Discontinued** field, enter the date, or to select a date on a calendar, click . T
5. In the **Reason** drop-down list, select a reason for discontinuing the prescription. If the reason you want is not available, enter your reason in the **Reason** field.

- Click **Discontinue**. The EMR displays the discontinued medication in the **Previous Medications** area on **Medication Profile** window.



Note: Once a medication is discontinued, you can easily reference or resume the medication. Prescriptions are not permanently deleted from a patient's record.

Discontinuing medications due to adverse reactions

If a patient has an adverse reaction to a medication, you can discontinue the medication and record the reaction in the patient's medical record at the same time.

To discontinue a medication due to an adverse reaction:

- Open the Discontinue Medication window and enter the discontinuation date. See [Step 1](#) to [Step 3](#) in "Discontinuing medications" on page 252.
- Click one of the following options:
 - **Allergy**
 - **Adverse Rx**
 - **Anaphylaxis.**

The EMR displays the allergy entry window with the medication and reaction type pre-populated.

The screenshot shows the 'Clinical Records' window for a patient named 'Test, Daughter' (PHN 9999 999 999). The patient's birth date is 28-Aug-1999 (15), sex is F, and status is N/A. The address is 123 Test Street, Squamish BC. The primary care provider is Veta Coles, M.D. The window is titled 'Allergy To:' and has four radio buttons: 'Medication' (selected), 'Category', 'Vaccine Type', and 'Other'. The 'Medication' dropdown is set to 'Clobazam'. Below this, there are several fields: 'Clinical Status' (Active), 'Certainty' (empty), 'Reaction' (Medication reason), 'Symptoms' (empty), and 'Note' (empty). At the bottom, 'Date Noted' is set to 09-Jul-2015.

- In the **Certainty** drop-down list, click the level of certainty (**Confirmed**, or **Suspected**).
- In the **Symptoms** drop-down list, click a symptom. If the symptom you want is not available, then enter the symptom into the **Symptoms** field.

5. To close the allergy entry window, click **Save & Close** (). On the **Medication Profile** window, the EMR displays the discontinued medication in the **Previous Medications** area, and displays the reaction in **Allergies** area.

Refilling prescriptions

After you enter a prescription for a patient once, the process for re-prescribing the prescription is quick and easy. You can refill a single-medication or multiple medications at once. You can also resume an inactive medication.

Using the Refill Request management feature, you can track, respond to, and refill medications in response to requests from pharmacies or patients.

Refilling prescriptions

To refill a prescription:

1. On any window related to a patient's medical record, right-click and then, in the SMART menu, click **Refill Medications**. The EMR displays the Prescriptions window.
2. In the **Medications** area, click the medication you want to refill. The EMR displays the medication's prescription details.
3. In the **Quantity** field, enter the a quantity or duration, and then in the **Units** field, enter the associated quantity or duration units.
4. Enter or modify information in the **Duration** area, and **Refill** field as needed.



Tip: You can edit dosage, and frequency prescription details if needed. At the top of the Prescriptions window, click **Edit Medication Dosing** (). The EMR displays the Add New Medication window.

5. To refill another prescription:
 - a) In the **Medications** list, click the next medication you want to refill. The EMR displays a dialog box with the following prompt: "Save [medication name and prescription details] on prescription?."

- b) Click **Yes**. The EMR displays the word *******Refilled******* in front of the saved medication, and displays the saved medication in the **Current Refill** area (located on the bottom of the Prescriptions window).



Tip: To change quantity, repeat, and/or duration information for multiple medications simultaneously:

1. On the Prescriptions window, select the **Multi-Select** check box.
2. In the **Medications** area, click the medications you want to refill.
3. Modify information in the Quantity field, Repeats field, and Duration area as needed.

Note: Only recommended if no edits are required on the prescription details for each medication.

6. Once you have selected all medications you want to refill, click **Save & Close** (). The EMR displays a dialog box with the following prompt: "Save [last medication name and prescription details] on prescription?".
7. Click **Yes**. The EMR displays a dialog box with the following prompt: "Print Prescription?".
8. To print the refill, click **Yes**.



Note: All medications that display in the **Current Refill** area on the Prescriptions window are included in the refill printout.

Resuming an inactive medication

To resume an inactive medication:

1. Open the patient's Medical Profile window. see [Step 1](#) to [Step 1](#) in "Editing prescriptions" on [page 251](#).
2. In the **Previous Medications** area, click the medication you want to resume.
3. Click **Resume** (). The EMR displays a dialog box with the following message: "Refill <medication name, dose, and frequency> now?"
4. Click **Yes**. EMR opens the Prescriptions window with:
 - The resumed prescription's details displayed
 - The resumed prescription listed in the **Medications** area.
5. Complete the prescription as you would for a refilled prescription. See [Step 3](#) to [Step 8](#) in "Refilling prescriptions" on [page 254](#).

Managing staff-initiated refill requests

If you receive regular requests for prescription refills from pharmacies (and patients), you can effectively manage and respond to refill requests in Wolf EMR.

When a pharmacy calls, your front end staff can initiate a **Refill Request**. This requests displays on your WorkDesk. You can then approve, print, or decline the refill.

To view and manage your **Refill Requests**:

1. On your **WorkDesk**, on the **Tasks** tab, in the **Refill Requests** area, click **# Refills to be Approved** (if # = 1 or more). The EMR displays the Prescription Refill Requests window, with a list of pending refill requests.



Tip: You can quickly view a patient's medical record before responding to a refill request. To open the patient's record, on the refill request list, click a patient. The EMR displays the patient's **Medical Summary**.

2. To reject a refill request:
 - a) To the right of the pending refill request, in the status list, click **Denied**.
 - b) Click **Save & Close** (). The EMR removes the refill request from your list, and notifies your front end staff of rejection.
3. To indicate that the patient is to book an appointment for the refill:
 - a) To the right of the pending refill request, in the status list, click **To Come In**. The EMR adds the patient to your front end staff's **Patient's To Notify list**, and displays a follow-up task window with your name selected in the **To** field.
 - b) On the Follow-ups window, in the **Follow-up Reason** field, add any additional details you want to display in the follow-up.
 - c) Click **Save & Close** (). The EMR adds the follow-up to your follow-up list, and on the patient's medical record, indicates that there is a follow-up item in the **SMART Patient Banner**.

4. To refill a prescription:

- a) On the refill requests list, click the medication name beside the associated patient's name. The EMR displays the prescription in the Prescription Refill window.
- b) Click **Refill**. The EMR displays the prescription in the **Prescriptions** window, with **Quantity**, **Repeats**, and **Duration** entry fields displayed on the right.
- c) Enter and/or edit quantity, and duration details for the refill.



Tip: You can edit dosage, and frequency prescription details if needed. At the top of the Prescriptions window, click **Edit Medication Dosing** (). The EMR displays the Add New Medication window.

- d) Click **Save & Close** (). The EMR displays a dialog box with the following prompt: "Save [last medication name and prescription details] on prescription?."
- e) Click **Yes**. The EMR displays a dialog box with the following prompt: "Print Prescription?"
- f) To print the prescription, click **Yes**.

Electronic requisitions and forms (SMART forms)

In this chapter you learn how to complete electronic versions of requisitions and other forms using Wolf EMR SMART forms. SMART forms are Microsoft Word-based form templates. Wolf EMR contains hundreds of SMART forms of the most commonly used provincial and local forms (including lab and diagnostic imaging requisition forms). You use SMART forms to order labs and other investigations.

SMART forms are centralized in the Wolf EMR database, and are available to all Wolf EMR clients. If the Wolf EMR development team creates a SMART form, the form automatically becomes available on your SMART forms list.

You can define which SMART forms are your favourites, making it easier to access your commonly used forms.

Using SMART forms

You can open and fill out a SMART form from almost any window related to a patient. Once opened, you “fill-out” the form by selecting check-boxes and entering data in text fields. You can then print or fax the form.

To use a SMART form:

1. On any window related to the patient (including the Medical Summary, SOAP form, Consult Letter Examination form, or Patient tab), right-click and then in the SMART menu, click one of the following options:
 - **New Requisition:** To select from SMART forms categorized as requisition forms.
 - **SMART Forms:** To select from all available SMART forms in your system.
 - **Favourite Requisition:** To select from SMART forms categorized as requisition forms and identified as favourites. See [“SMART form favourites” on page 265](#).

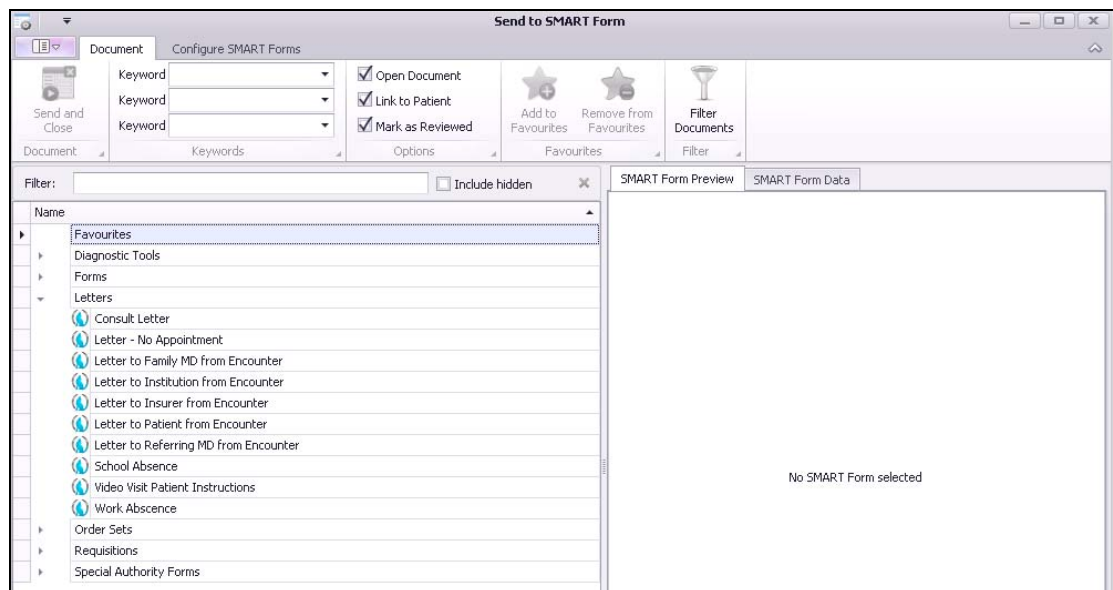
- **Favourite Order Set:** To view order set SMART forms identified as favourites. See “Order Sets” on page 268.



Tip: You can also access SMART forms directly from a visit note:

- On the SOAP form: In the **Assessment** area, click **Order Labs**.
- On the Consult Letter form (Specialists): To the right of the main text area, click **Order Labs**.

The EMR displays the Send to SMART Form Window with a list of available SMART forms displayed in expandable categories.



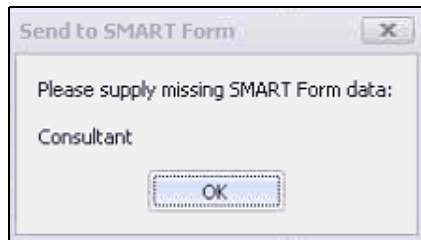
2. In the list of SMART forms, expand the category of forms you want to view (if not expanded already), and then click the form. The EMR displays the selected form on the right side of the window.
3. If you cannot find the form you want:
 - a) In the **Filter** field, enter a search term. (For example, “MRI”.) The EMR filters the SMART form list to display only SMART forms containing your search term.



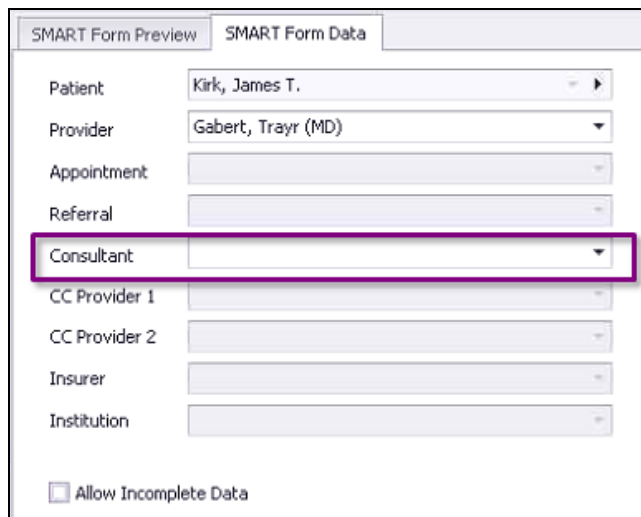
Tips for entering search criteria

- To find a lab requisition, enter the word “**Lab**”
- To find a diagnostic imaging requisitions, enter “**DI**” or “**Imaging**”.
- SMART forms are named by region (for example, “**AB Cg**”), or company/type (for example, “**CDC**”, or “**MIC**”). Try entering these terms to find a form specific to a certain region or company.

- b) In the filtered list of SMART forms, click the form you want. The EMR displays your selected form on the right side of the window.
4. If the SMART form is programmed to pull information from the patient's record, but the information is not available in the current patient's record, the EMR displays a dialog box similar to the following.



and then displays the SMART Form Data tab, where you can enter the missing data.



Enter the missing data in the fields provided, or, to produce the SMART form without the missing data, select the **Allow Incomplete Data** check box.

5. If the SMART form contains an electronic signature, the EMR displays a dialog box with a prompt similar to the following.



To insert your signature, click **Yes**.

6. In the SMART forms list, double-click the form, or click **Send and Close** (). The EMR opens the SMART form in Microsoft Word, with editable check boxes and fields highlighted in grey.

BRITISH COLUMBIA | Ministry of Health | **BCMA** | **LABORATORY REQUISITION**

Yellow highlighted fields must be completed to avoid delays in specimen collection and patient processing. For tests indicated in Blue Text, consult provincial guidelines and protocols (www.BCGuidelines.ca)

Bill to: ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ PATIENT ☐ OTHER: _____

PHN NUMBER: 999999999 ICBC / WorkSafeBC / RCMP NUMBER: _____

SURNAME OF PATIENT: Test FIRST NAME OF PATIENT: Mother

DOB: 01-Aug-1930 SEX: F Pregnant? ☐ YES ☐ NO Fasting? _____ h pc

TELEPHONE NUMBER OF PATIENT: 111-1111x11 CHART NUMBER: _____

ADDRESS OF PATIENT: 123 Test Street CITY / TOWN: Merville PROVINC: BC

DIAGNOSIS: _____ CURRENT MEDICATIONS / DATE AND TIME OF LAST DOSE: _____

HEMATOLOGY

☐ Hematology profile ☐ On warfarin?

☐ Ferritin (query iron deficiency)

HFE – Hemochromatosis (check ☒ ONE box only)

☐ Confirm diagnosis (ferritin first, $\pm$ TS $\pm$ DNA testing)

☐ Sibling/parent is C282Y/C282Y homozygote (DNA testing)

URINE TESTS

☐ Urine culture – list current antibiotics: _____

☐ Macroscopic → microscopic if dipstick positive

☐ Macroscopic → urine culture if pyuria or nitrite present

☐ Macroscopic (dipstick) ☐ Microscopic

☐ Special case (if ordered together)

CHEMISTRY

☐ Glucose – fasting (see reverse for patient instructions)

☐ GTT - gestational diabetes screen (50 g 1 hour & 2 hour test)

☐ GTT - gestational diabetes confirmation (1 hour & 2 hour test)

☐ Hemoglobin A1c

☐ Albumin / creatinine ratio (ACR) - Urine

LIPIDS

☒ one box only. For other lipid investigations, please tests below and provide diagnosis.

☐ Baseline cardiovascular risk assessment (Lipid profile, Total, HDL, non-HDL & LDL Cholesterol, Triglycerides, fasting)

☐ Follow-up of treated hypercholesterolemia & non-HDL cholesterol, fasting not required

☐ Follow-up of treated hypercholesterolemia

MICROBIOLOGY – label all specimens with patient's first & last name, DOB and / or PHN & site

ROUTINE CULTURE

List current antibiotics: _____

☐ Throat ☐ Sputum ☐ Blood ☐ Urine

☐ Superficial ☐ Deep ☐ Wound

HEPATITIS SEROLOGY

☐ Acute viral hepatitis undefined etiology

Hepatitis A (anti-HAV IgM)

Hepatitis B (HBsAg, anti-HBc)

Hepatitis C (anti-HCV)

7. Select any check boxes you want, and enter text in fields highlighted in grey.



Note: You cannot edit text or other items on the form that are not highlighted in grey. For example, you cannot edit a patient's address on the SMART form. You must edit the address in the Patient Maintenance window.

8. To save the form, click **Save** () , or on your keyboard, press <Ctrl><S>. The EMR saves the completed SMART form in the **Documents** tab of the patient's Medical Summary.

9. To print or fax the form:

- On the Microsoft Word menu, click **File > Print**. Microsoft Word displays the print properties window.
- In the printer drop-down list, click the print or fax machine you want.

c) Click **Print** ().

Referencing previously completed SMART forms

After you complete and save a SMART form, the EMR saves the SMART form in the patient's chart. You can reference or reprint the form as needed.

To view a previously completed SMART form for a patient:

1. Open the patient's Medical Summary. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Documents** tab. The EMR displays a complete list of all of a patient's documents and SMART forms.
3. In the **Search** field, enter a word that you know is in the SMART form's name (for example, “lab”). The EMR filters the list to display only documents and SMART forms that contain the search term.

Date	Status	Document Type	Keyword One	Keyword Two	Keyword Three	Content Type	Notes	MD	Review Date
07-Mar-2014	Reviewed	Lab Req-AB Cg (2)							07-Mar-2014
18-Apr-2013	Reviewed	Lab Req-AB Cg						TG	18-Apr-2013

4. In the filtered list of documents, double-click the form you want. The EMR opens the SMART form in Microsoft Word.



Tip: At this point, you can add to or edit information in the SMART form if needed. If you save your changes, the previous version is overwritten in the patient's Documents.

Note: If there is an eSignature on the form, the form is saved in the **Documents** tab as an un-editable PDF. You therefore cannot edit forms that contain eSignatures.

5. To print the SMART form:
 - a) On the Microsoft Windows menu, click **File > Print**. Microsoft Word displays the print properties window.
 - b) In the printer drop-down list, click the print or fax machine you want.

- a) Click **Print** ().

SMART form favourites

Wolf EMR contains hundreds of SMART forms. With so many forms, it can be difficult to find the form you want. To make common SMART forms easy to find, designate these SMART forms as favourites. Favourite SMART forms display at the top of your SMART forms list. You can also open favourite SMART forms using the **Favourite Requisition** option on the SMART menu.

You can add SMART forms to or remove SMART forms from your favourite's list when you open SMART forms for patients (via the Send to SMART form window).



Note: If you remove a Clinic Favourite from your favourites list, the SMART form will still display on the favourites list of other users in the clinic.

To add a SMART form to or remove a SMART form from your favourites list:

1. Open the Send to SMART form window and then, in the left pane, click the form. See [Step 1.](#) to [Step 3.](#) in "Using SMART forms" on page 259.
2. At the top of the window, click one of the following options:

■ **Add to Favourites** ()

■ **Remove from Favourites** ()



Tip: You can also add and remove SMART form favourites without having to open a SMART form for a patient (via the Wolf EMR Maintenance):

1. On the Wolf EMR Launch page, click the **Maintenance** tab.

2. Click **Configure My SMART Forms** (). The EMR displays the Configure My SMART Forms window, with a list of available SMART forms displayed in the left column.

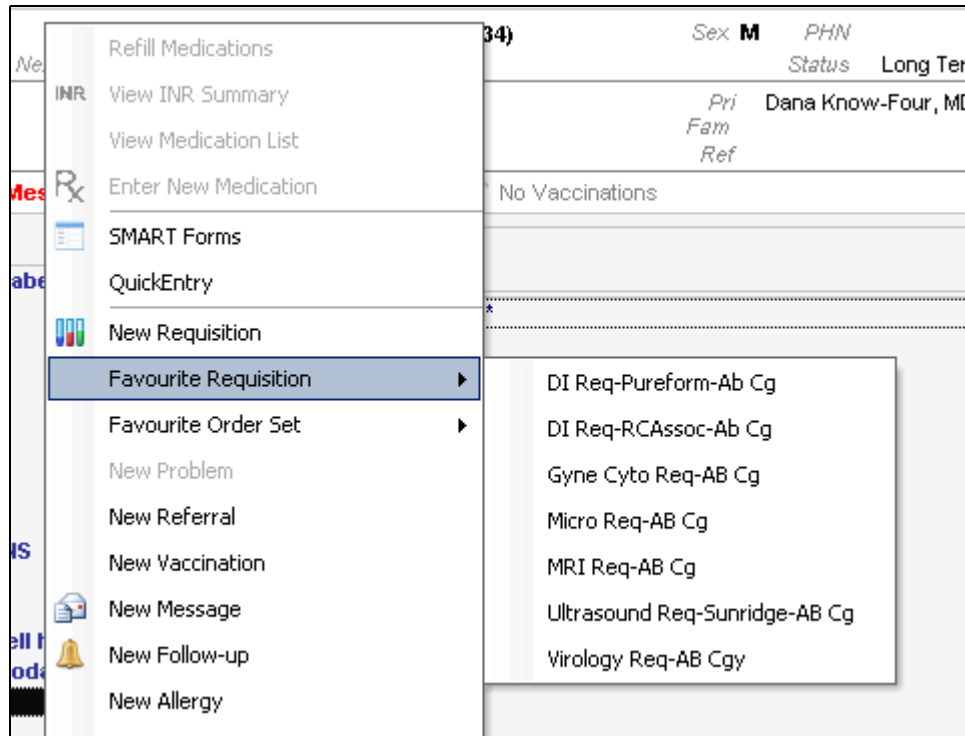
3. Click the form, and then click **Add to Favourites** () or **Remove from**

Favourites ()

Using your favourite SMART forms

To use a favourite SMART form:

1. On any window related to the patient (including a patient's Medical Summary, SOAP form, Consult Letter form, or Patient tab), right-click and then, in the SMART Menu, hover your cursor over **Favourite Requisition**. The EMR displays a list of your Favourite SMART forms.



2. Click the form you want. The EMR opens the form in Microsoft Word.
3. Complete and print the form. See ["Using SMART forms" on page 259](#).



Tip: Your favourite SMART forms also display at the top of your SMART forms list in the Send to SMART Form window.

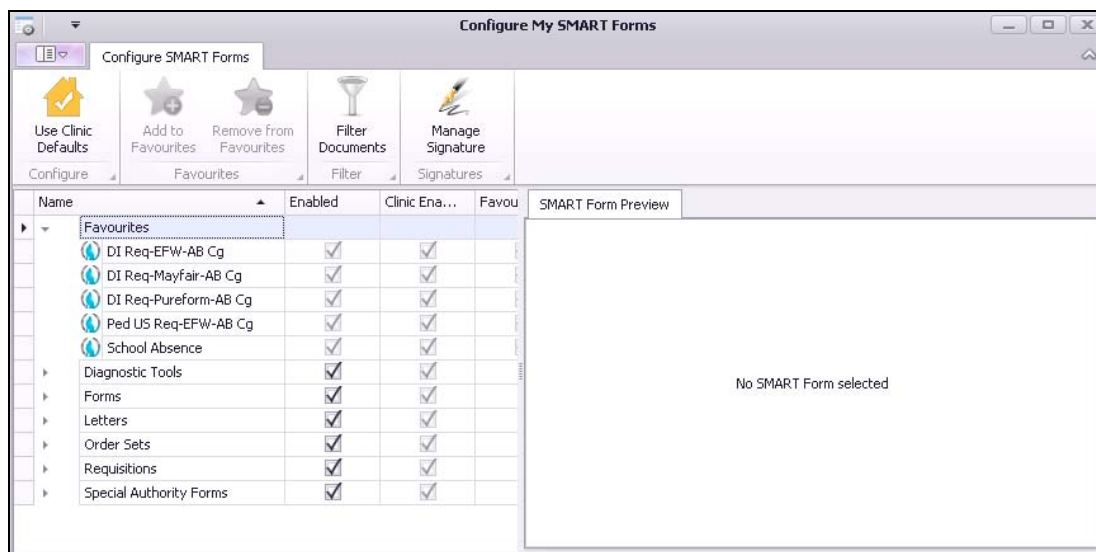
Hiding SMART forms

If there are forms in your clinic's list of SMART forms that you know you will never use (for example, forms from another region), you can hide those forms from your list. In hiding these forms, it becomes easier to find forms that you do use.

To hide a SMART form:

1. On the Wolf EMR Launch page, click the **Maintenance** tab.

2. Click **Configure My SMART Forms** (). The EMR displays the Configure My SMART Forms window, with a list of available SMART forms displayed in the left column.



3. If your list of forms is extensive and you cannot find the form you want:
- Click **Filter Documents** (). The EMR displays a **Filter** field above your SMART form list.
 - In the **Filter** field, enter a search term. (For example, "MRI".) The EMR filters the SMART form list to display only SMART forms containing your search term.
4. In the filtered SMART forms list, click the form you want. The EMR previews the form in the right pane.
5. In the list of SMART forms, beside the SMART form you want to hide, clear the check box in the **Enabled** column.
6. When you are finished hiding SMART forms, click **Close** ().



Tip: If you later decide that you want the SMART form to display on your list of SMART forms, you can enable the SMART form by selecting the **Enabled** check box.

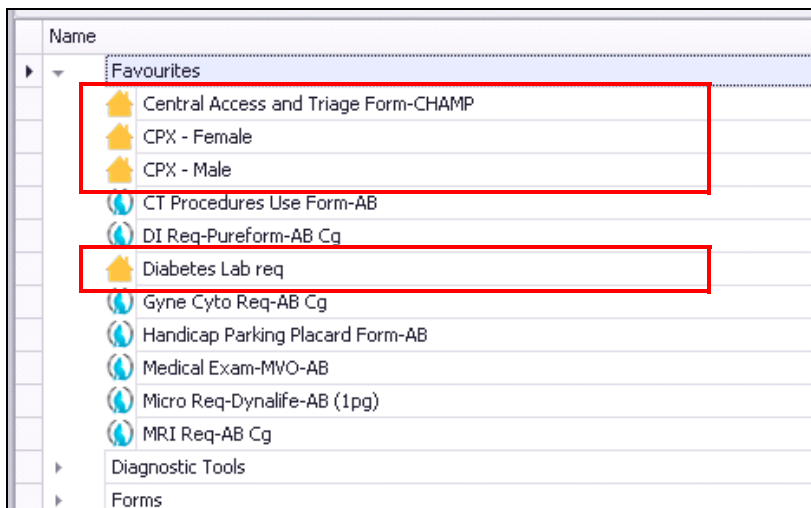
Order Sets

If you fill out certain requisition forms with similar information for specific groups of patients (for example, you select the same core base of lab tests for most diabetic patients), you can create customized copies of these SMART forms with check-boxes and text fields pre-populated.

Also, if you commonly complete a set of requisition forms together, you can customize SMART forms to combine multiple requisition forms, enabling you to open all forms together in one click.

Customized versions of SMART forms are called Order Sets. You can create as many Order Sets as you want for one form.

Order Sets display as “house forms” (with a house icon) in your list of SMART forms.



Note: House forms are forms that have been created or modified by your clinic. These forms are not maintained or updated by TELUS Health.

When you open an Order Set SMART form for a patient, you can edit the pre-populated data as needed before printing and saving the form.

For more information on how to create an order set, see the [Wolf EMR SMART Forms User Guide](#).

Using Order Sets

To use an order set:

1. On any window related to the patient, (including a patient's Medical Summary, SOAP form, Consult Letter Examination form, or Patient tab), right-click and then, in the SMART menu, click one of the following options:
 - **SMART Forms:** To view all available SMART forms in your system.
 - **New Requisition:** To view only SMART forms categorized as requisition forms.

- **Favourite Order Sets:** To view only order set SMART forms defined as favourites.

The EMR displays the Send to SMART Form Window with a list of available SMART forms displayed in the left column.

2. In the list of available SMART forms expand the **Order Set** folder, and then click the form you want. The EMR displays your selected form on the right side of the window.
3. Complete the SMART form. See [“Using SMART forms” on page 259](#).

Printing patient labels

After you complete and print a requisition form, you can print a corresponding patient label for the accompanying lab sample or for the form itself.

To print a patient label:

1. On any window related to the patient (including a patient's Medical Summary, SOAP form, Consult Letter Examination form, or Patient tab), right-click and then, in the SMART menu, click **Print Label**. The EMR displays the Print Label window.

The screenshot shows a 'Print Label' dialog box with the following fields and options:

- Label:** Patient Lab Label (dropdown menu)
- Provider:** Veta C, M.D. (dropdown menu)
- Printer:** Microsoft XPS Document Writer (redirected 8) (dropdown menu)
- Include Inactive Locums:** ☐ (checkbox)
- Copies:** 1 (text field with a document icon)
- Buttons:** Ok, Cancel

2. In the **Label** drop-down list, select the type of label you want to print.
3. In the **Printer** drop-down list, click the label printer you want.
4. In the **Copies** field, enter the number of labels you want to print.
5. Click **OK**.

Sending and managing referrals

In this chapter you learn how to send and manage referrals to external consultants and clinics. When you refer a patient to an external consultant, you initiate a referral in Wolf EMR. When you initiate a referral:

- Wolf EMR tracks where the patient is in the referral process (for example, if the referral letter needs to be completed, or if the patient is waiting for an appointment date/time)
- You create a referral letter from the referral

You have three choices on how you create a referral letter. You can use Basic Referral, you can use the Wolf EMR Referral Letter Composer, or you can use a SMART Form letter template.

Wolf EMR also has an eReferral feature. If your clinic has eReferral set up, you can send and receive referrals electronically to and from other Wolf EMR clinics. When you send an eReferral, the receiving clinic can import sections of the patient's Medical Summary that you choose to share.

Initiating referrals

Before you create a referral letter, you initiate a referral for the patient first. When you initiate a referral, you specify referral details such as the:

- Referral Type
- Consultant, clinic, or facility whom you are referring the patient to
- Urgency of the referral
- Referral reason

The referral details you enter automatically populate your referral letter. The referral details also help you track and manage actions you take towards a referral.

You can initiate a referral from any window related to a patient's medical record (via the SMART menu).

To initiate a referral:

1. On any window related to the patient (including a patient's Medical Summary, SOAP form, consult letter form, or Patient tab), right-click and then, in the SMART menu, click **New Referral**. The EMR displays the New Referral window.

New Referral

Test, Larry PHN: 9990

Log [Icons] Cancel Referral Delete Referral [Icon]

Born: 16-May-1953 (62) Sex: M Status: N/A

342 STest Street, East Vancouver BC K7D 4C1 H: (555) 555-5555 P: Shona M W: (666) 666-6666

Referral Type: **Consultation** Search: [Text] AND [Dropdown] ...info

☐ Search by Consultant Last Name only

*Choose Consultant

From Favourites

By Specialty

By Name

Add New Consultant

Urgent

Routine

☐ Cancel Appt

CC Recipient(s): [Text]

Add to CC

Remove from list

☐ Seen Before ? MD: [Dropdown]

*Referral Reason: [Text]

Current Investigations: [Text]

Booking Notes: [Text]

☐ Consultant Will Notify Patient of Appointment:

Appt Date/Time: [Text]

☐ MSP Referral Sent ☒ Use Medical Hx

Enter Text of Letter: [Text]

☒ LETTER COMPLETED

☐ Letter ☐ Edited

☐ Dictated ☐ Printed

☐ Typed ☐ Sent

Send to SMART Form

Keywords: [Text] ☒ Save and Link File

Keywords: [Text] ☒ Open Document

Keywords: [Text] ☒ Mark As Reviewed

Compose / Print

Quick Print

Print

Linked Documents: [Text]

Reconcile Date: [Text]

Disposition / Outcome: [Text]

If a visit note has been created for the patient today, the EMR also displays a dialogue box with the following prompt: "Use current visit record to build referral letter?"

2. Perform one of the following actions:
 - To include your visit notes in the referral letter, click **Yes**.
 - To start a blank referral, click **No**.
3. In the **Referral Type** list, click the referral type that best describes what the referral is for. The selection defaults to **Consultation**.



Note: Based on the Referral Type you select, the EMR filters the consultant list to display only consultants categorized under the selected type.



Want more Referral Type options?

Users with administrative authority can add, modify, or delete referral types.

To add referral types:

1. On the Wolf EMR Launch page, click **Configuration** ().
2. On the Configuration menu, click **View > Physicians /Service Providers > Referral Types**. The EMR displays the Referral Types Maintenance window.

4. Search for and select a consultant using the **Search** field, or categorized consultants list:

To search for a consultant using the **Search** field:

- a) In the **Search** field, enter the consultant's last name, or to see a list of consultants for a specific specialty, enter the specialty.
- b) To add additional search criteria, press the **Space bar**, and then enter the consultant's first name, specialty, practitioner number, or city (municipality).
- c) If you are searching based on a consultants last name only, below the **Search** field, select the **Search by Last Name only** check box. In the search results, the EMR includes only consultants with matching last names.



Tip: You can set the **Search by Last Name only** check box to be selected by default:

1. On the WorkDesk menu, click **Configure > Configure Workdesk** ().
2. Click the **Referrals** tab.
3. Beside **Search for Consultant Last Name only**, clear the **Apply clinic Setting** check box, and then select the **User Setting** check box.

- d) In the drop-down list to the right of the **Search** field, click one of the following options:

- To search for consultants that contain ALL keywords you enter, click **AND**.

- To search for consultants that contain ANY of the keywords you enter, click **OR**.

- e) In the list of matching consultants, click the consultant you want.

To search for a consultant using the categorized consultants list:

- a) Below **Choose Consultant**, click one of the following:

- **From Favourites:** To view a list of your favourite consultants.
- **By Speciality (Default):** To view a list of consultants of a particular specialty, and then click the specialty you want.
- **By Name:** To view your entire consultants list in alphabetical order.
- **Add New Consultant:** To add a new consultant to your consultants list. See [“Adding and Editing consultants while creating a referral” on page 299](#).



Tip: You can set what option is selected by default in the **Choose Consultant** area:

1. On the WorkDesk menu, click **Configure > Configure Workdesk** ().
2. Click the **Referrals** tab.
3. Beside **Default view of Consultants**, clear the **Apply clinic Setting** check box and then, in the **User Setting** drop-down list, select the option you want.

- b) On the list of consultants, click the consultant you want.



What if I don't know what consultant is available?

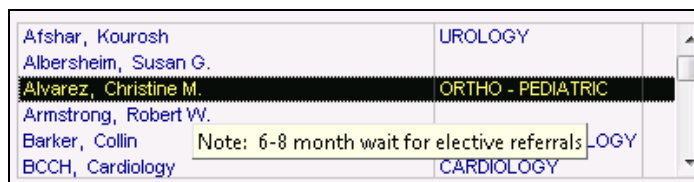
If you do not know the consultant you want (for example, if you do not know which specialists are available), you can instead select a generic specialist. Search for and select **“Next Available Specialist”**.

You or your referral clerk can change the consultant's name in the referral at a later time.



Tip: If there are notes entered for a consultant (for example, if there are notes on booking procedures for a specific consultant), you can view these notes from the list of consultants. To view consultant notes:

- In the list of consultants, click the consultant, and then hover your cursor over the consultant's name. The EMR displays any notes for that consultant as a tool tip.



5. To verify that you selected the correct consultant, on the top right of the window, click **...info**. The EMR displays the Consultant Information window, with details on the consultant you selected.

Consultants

Consultant Information

Dr. Victoria Test

PAEDIATRICS

111-111-1111 MSP: 99999

Fax: 222-222-2222

ABC Paediatrics Clinic

Richmond BC

V6X 1A2 ...edit

Notes:

6. To set the selected consultant as the primary consultant to receive the referral, click **Set as Primary**. The EMR displays the consultant's name in the field below the consultant list.



What if I set the wrong consultant as the Primary Consultant?

If you set the wrong provider as the Primary Consultant, click another provider from the consultants list, and then click **Set as Primary** again. The EMR replaces the Primary Consultant with the new selection.

7. If applicable, enter practitioners to be CC'd on the referral letter:
 - a) Search for a consultant. See [Step 4.](#) to [Step 5.](#)
 - b) Click **Add to CC**. The EMR inserts the selected practitioners name in the **CC Recipient(s)** area.



Tip: To save the primary consultant, ensure you click **Set as Primary** before you add CC'd practitioners.

8. To define the Priority of the referral, click one of the following options:

- **Routine** (default)
- **Urgent**

9. Use the following table to enter information in the rest of the window:

Field/Check box	Information to be entered
Seen Before?	Select this check box if the patient has been previously seen by you, or another provider from your clinic, for the same referral reason. Note: In the MD drop-down list, click the practitioner that the patient saw. Your name displays by default.
Referral Reason	Enter the reason and or diagnosis for the referral. Note: This field is mandatory.
Current Investigations.	Enter any investigations you are awaiting results on (including investigations that you have ordered today).
Booking Notes	Enter notes regarding the appointment booking. Information can include: ■ The type of specialist you want to refer to (for example, "Refer to cardiology") ■ The expected wait times for booking. (for example, "Expected wait time is 4mo "). Note: Information entered here displays in the Notes column in the front end staff's Referral Appointments to be made list.
Consultant Will Notify Patient of Appointment	To indicate that the patient will be notified of the appointment time from the consultant's office, select this check box. The EMR immediately adds an item to your front end staff's Patient's to Notify list. Your staff then know to call the patient to indicate that they can expect a call from the consultant's office. Note: If this check box is selected, the patient does not display on the Appointments to be Made list.

Field/Check box	Information to be entered
MSP Referral Sent	Select this check box if you want to send the referral billing to MSP. (This is a no charge fee referral 3333.) When you save the referral, the EMR automatically creates a bill in Billing with the patient's name, Fee Code, and the Specialist's name to whom the patient is referred. Note: If you do not send the referral billing to MSP now, you can send the referral billing to MSP later, from the Appointments To Be Made window: 1. On your WorkDesk, click <x> referral appointments to be made. The EMR displays the Appointments To Be Made window. 2. In the list of referral appointments to be made, click the referral that you want to send to MSP for billing. The EMR displays the referral details in the right pane. 3. In the right pane, select the Billing Referral Sent check box. The EMR displays the following prompt "Send Referral to MSP?" 4. Click Yes.
Use Medical Hx	This check box is selected by default. When this check box is selected, the EMR includes the patient's medical summary information in the referral letter. If you do not want to include medical summary information in the referral letter, clear this check box.

10. If you do not want to create a referral letter at this point, below **LETTERS TO COMPLETE**, select the **Letter** check box. The EMR adds the patient to your **Letters to Write** list.



11. Click **Save & Close Referral** ().

If you did not select the **MSP Referral Sent** check box, the EMR displays a dialog box with the following prompt "Send Referral to MSP?".

12. Perform one of the following actions:

- If you want to bill MSP for the referral, click **Yes**. The EMR automatically creates a bill in Billing with the patient's name, Fee Code and Specialist's name to whom the patient is referred.
- If you do not want bill MSP for the referral at this time, click **No**. The EMR closes the New Referral window.

Creating and sending referral letters

After you initiate a referral, you can create a referral letter directly from the New Referral window. You can create a referral letter using one of the following methods:

- **Basic Referral:** You enter the text of the letter and then print. You can include medical summary information in the letter, but you cannot customize the content. You cannot attach documents to the letter. (Medical summary information is included in letter, if the **Use Medical Hx** check box is selected.) See [“Creating a basic referral letter” on page 278](#).
- **Referral letter Composer:** Allows you to add information from the patient's medical summary and to attach documents to the referral letter. See [“Creating a referral letter using the Referral Letter Composer” on page 280](#).
- **SMART Form-based Referral letter:** Allows you to include a full medical profile and to customize the referral letter. You can also format the referral letter using Microsoft Word formatting tools. You cannot attach other files or documents to a SMART Form-based consult letter as you can when using the Referral Letter Composer. See [“Creating referral letters using a SMART Form” on page 290](#).

After you create a referral letter you can print the referral or fax the letter to the Specialist.



Note: Referrals received by Specialists have an expiration of six months. If the patient needs to be seen by a specialist after six months, you must send another referral letter.

Creating a basic referral letter

When you create a basic referral letter, you can include medical summary information in the letter, but you cannot customize the content. You cannot attach documents to the letter. (Medical summary information is included in letter, if the **Use Medical Hx** check box is selected.)

To create a basic referral letter:

1. Initiate a referral and complete the New Referral details. See [“Initiating referrals” on page 271](#).



Note: If you want to create a letter based on a previously started referral:

1. Open the patient's Medical Summary. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Referrals** tab.
3. In the patient's list of referrals, double-click the referral you want. The EMR opens the referral in the Existing Referral From <Date> window.

2. In the **Enter Text of Letter** field, enter the content of your letter.



Tip: If the **Enter Text of Letter** field is too small for your letter content:

1. Click **Expand Area** (). The EMR expands the text area and hides the lower fields of the New Referral window.
2. When you finish entering your letter content, click **Minimize Area** (). The EMR minimizes the text area and displays the lower fields of the New Referral window again.

3. To print the referral letter, perform one of the following actions:

- Click **Quick Print** to send the referral letter to your default printer or fax machine.
- Click **Print** () to select a specific printer or fax machine before printing.

4. Indicate the status of the referral letter. In the **LETTER COMPLETED** area, select one or more of the following check boxes:



Note: Most clinics (who do not have stenographers or transcriptionists) use only the **Sent** check box.

The other check boxes, for example **Typed** and **Printed**, are used to go back in forth between the stenographer and the practitioner for review.

- **LETTER COMPLETED:** If you have both written the letter and sent it to the consultant.
- **Letter:** To indicate that a letter needs to be written, but has not been started or finished yet. The EMR adds the patient to your WorkDesk **Letters to Write** list.
- **Typed:** Indicates that the contents of the letter have been typed. If this check box is selected, the EMR adds the letter to your WorkDesk **Letters to Edit** list.
- **Printed:** To indicate that you have printed the letter.
- **Sent:** To indicate that you have sent the letter.



Note: You can indicate the status of the referral later, from the **Referrals** tab in the patient's Medical Summary:

1. Open the patient's referral from the **Referrals** tab in Medical Summary window. (If you are not in the Medical Summary window, see ["Opening a patient's Medical Summary" on page 389.](#))
2. Indicate the status of the referral letter.

5. Click **Save & Close Referral** ()

If you did not select the **MSP Referral Sent** check box, the EMR displays a dialog box with the following prompt “Send Referral to MSP?”.

6. Perform one of the following actions:
- Click **Yes**, to send the referral billing to MSP. The EMR automatically creates a bill in Billing with the patient's name, Fee Code and Specialist's name to whom the patient is referred.
 - Click **No** to not send the referral billing to MSP at this time. The EMR closes the New Referral window.

Creating a referral letter using the Referral Letter Composer

The Referral Letter Composer is a letter creation tool. In the Referral Letter Composer, you enter the basic letter message, select what medical information from the patient's record to include, and select what documents to attach to the referral letter. The EMR then produces a professional letter that includes the information you selected.

To create a referral letter using the referral letter composer:

1. Initiate a referral and complete the New Referral details. See [“Initiating referrals” on page 271](#).



Note: If you want to create a letter based on a previously started referral:

1. Open the patient's Medical Summary. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Referrals** tab.
3. In the patient's list of referrals, double-click the referral you want. The EMR opens the referral in the Existing Referral From <date of referral> window.

2. In the **Enter Text of Letter** field on the New Referral window, enter the content of your letter.

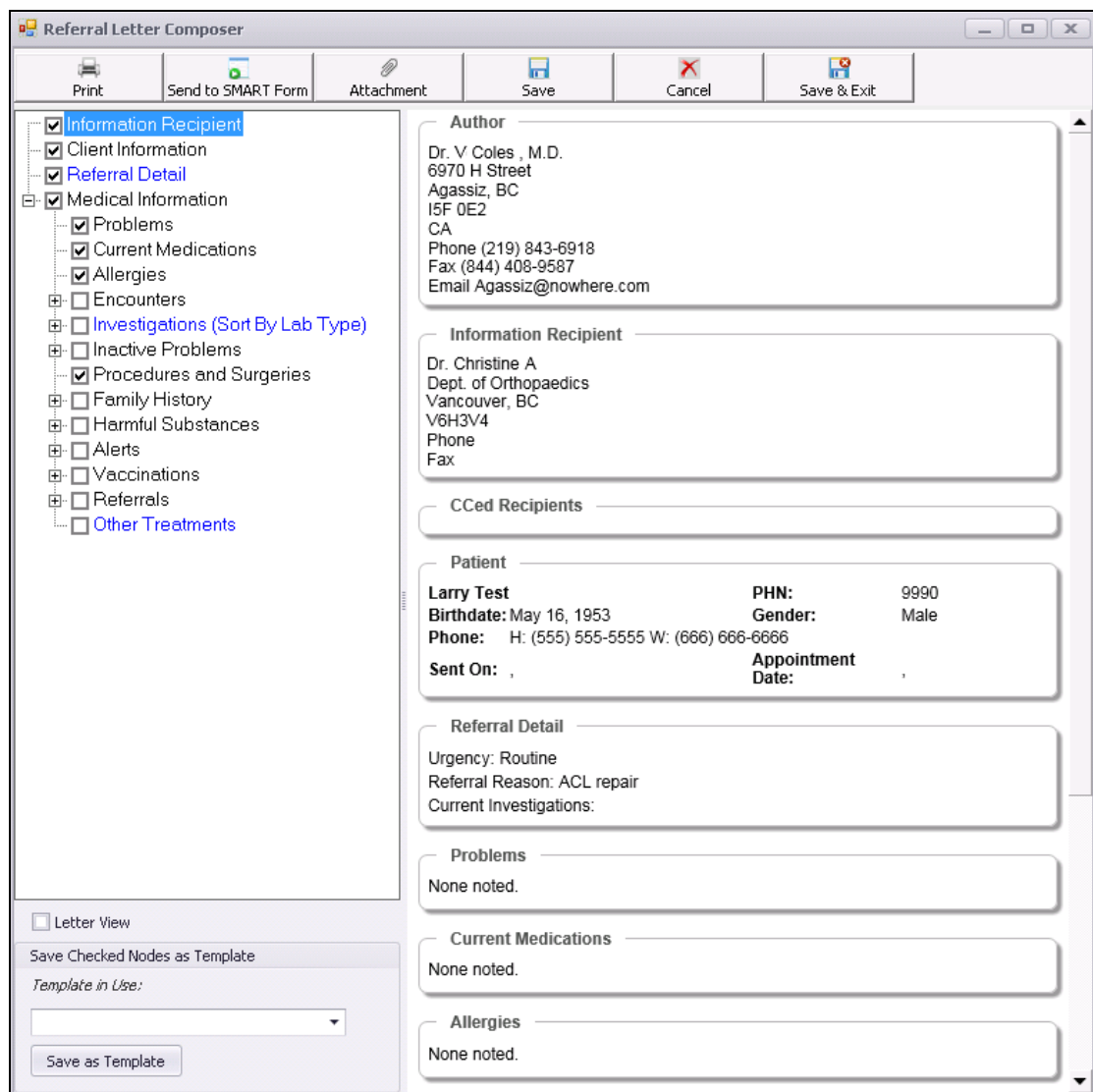


Tip: If the **Enter Text of Letter** field is too small for your letter content:

1. Click **Expand Area** () . The EMR expands the text area and hides the lower fields of the New Referral window.
2. When you finish entering your letter content, click **Minimize Area** () . The EMR minimizes the text area and displays the lower fields of the New Referral window again.

3. Click **Compose** (). If you did not select the **MSP Referral Sent** check box, the EMR displays a dialog box with the following prompt “Send Referral to MSP?”.
4. Perform one of the following actions:
 - Click **Yes**, if you want to send the referral billing to MSP. The EMR automatically creates a bill in Billing with the patient's name, Fee Code and Specialist's name to whom the patient is referred.
 - Click **No** if you do not want to send the referral billing to MSP at this time. The EMR closes the New Referral window.

The EMR displays the Referral Letter Composer window.

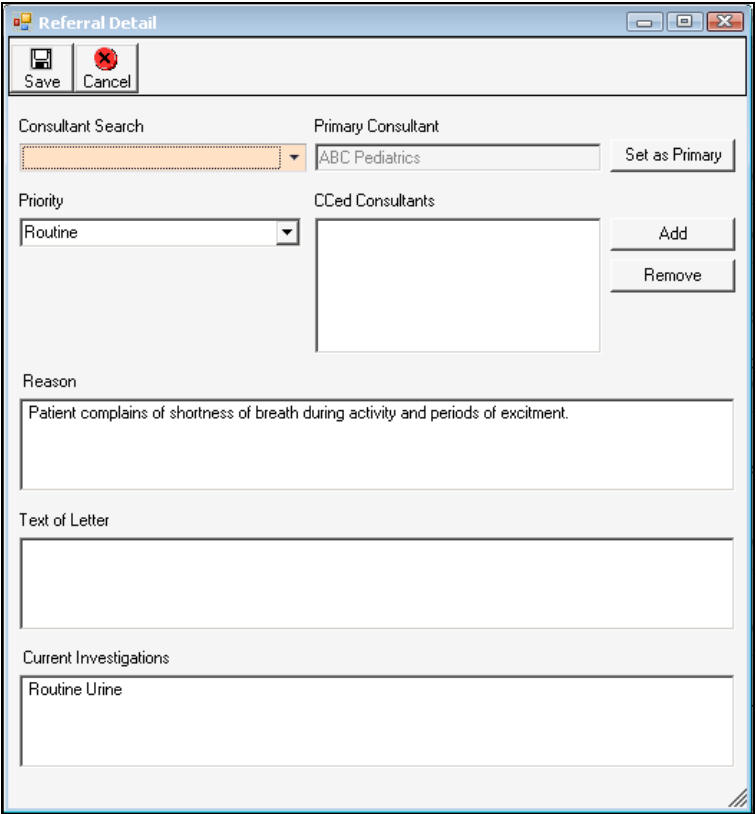


The Referral Letter Composer window is a software interface for creating referral letters. It features a toolbar at the top with buttons for Print, Send to SMART Form, Attachment, Save, Cancel, and Save & Exit. On the left is a tree view of content categories, including Information Recipient, Client Information, Referral Detail, Medical Information (with sub-items like Problems, Current Medications, Allergies, Encounters, Investigations, Inactive Problems, Procedures and Surgeries, Family History, Harmful Substances, Alerts, Vaccinations, Referrals, and Other Treatments), and a Letter View section at the bottom with a 'Save Checked Nodes as Template' option and a 'Template in Use' dropdown. The main area on the right contains several text boxes for patient and referral information:

- Author:** Dr. V. Coles, M.D., 6970 H Street, Agassiz, BC V6H 0E2, CA. Phone (219) 843-6918, Fax (844) 408-9587, Email Agassiz@nowhere.com.
- Information Recipient:** Dr. Christine A, Dept. of Orthopaedics, Vancouver, BC V6H3V4. Phone, Fax.
- CCed Recipients:** (Empty field)
- Patient:**
 - Larry Test** (Name)
 - Birthdate:** May 16, 1953
 - Phone:** H: (555) 555-5555 W: (666) 666-6666
 - PHN:** 9990
 - Gender:** Male
 - Sent On:** (Empty field)
 - Appointment Date:** (Empty field)
- Referral Detail:**
 - Urgency:** Routine
 - Referral Reason:** ACL repair
 - Current Investigations:** (Empty field)
- Problems:** None noted.
- Current Medications:** None noted.
- Allergies:** None noted.

The Referral Letter Composer letter displays the following information sections by default:

Information section	Information displayed
Author	Your name, and contact information.
Information Recipient	The primary recipient's name and contact information.
CCed Recipients	Name and contact information for any practitioners that are CCed on the Referral.
Patient	Patient's name and demographic information.

Information section	Information displayed
Referral Detail	The urgency, referral reason, current investigations and referral letter text that you entered in the New Referral window. Note: You can edit information displayed here from the Referral Letter Composer window if necessary. To edit the Referral Detail information: 1. In the left column of the Referral Letter Composer window, right-click Referral Detail (displayed with blue text). 2. Click Properties. The EMR displays the Referral Detail window.  3. Add or edit information as necessary. 4. If you change the Primary Consultant, click Set as Primary. 5. Click Save ().

5. To include additional medical history information, in the left pane:

- a) Select the check box beside each Medical Summary categories you want to include in the referral letter (for example, Problems, Current Medications, Allergies, or Investigations).
- b) If you want to include only specific items from a Medical Summary category, expand the category, and then select the specific items you want.

The screenshot shows a software interface for creating a referral letter. At the top is a toolbar with buttons: Print, Send to SMART Form, Attachment, Save, Cancel, and Save & Exit. The main area is divided into two panes. The left pane contains a tree view of medical summary categories, each with a checkbox. The categories are: Information Recipient (checked), Client Information (checked), Referral Detail (checked), Medical Information (expanded), Problems (checked), Current Medications (checked), Allergies (checked), Encounters (checked), Investigations (Sort By Lab Type) (unchecked), Inactive Problems (checked), Procedures and Surgeries (checked), Family History (checked), Harmful Substances (checked), Alerts (unchecked), Vaccinations (unchecked), Referrals (unchecked), and Other Treatments (unchecked). The 'Encounters' category is expanded, showing a list of dates and descriptions, each with a checkbox. A purple box highlights the 'Encounters' category, and a callout points to it with the text 'Expanded Medical Summary category'. The right pane contains fields for Author, Information Recipient, CCed Recipients, Patient, Father Te, Birthdate, Phone, Sent On, Referral Detail, and Problems. The 'Referral Detail' section includes fields for Urgency, Referral Reason, Text of Referral, Examination, Biometrics, and Attachment(s).



Tip: Clear any pre-selected Medical Summary check boxes for information you want to exclude from the referral letter.

For example, if you select the **Current Medications**, check box, all of the patient's medications are selected in the expanded list below. You can exclude any of the patient's current medications listed below by clearing the check box beside the medication name.



Note: You cannot edit most information in the Referral Letter Composer window directly from the Referral Letter Composer window. Instead you must edit the information from the source.

For example, you must:

- Add or edit allergies in the patient's Medical Summary.
- Edit recipient contact information in the Edit Consultant Information Window.
- Edit patient information in the Patient Maintenance window.



Tip: Items that display in the left pane in blue text are customizable. To customize these items, right-click the blue text.

- **Referral Detail:** You can modify the Primary and CCed consultants, referral priority, referral reason, letter text, and current investigations.
- **Investigations:** You can change the sort order of a patient's listed investigations.
- **Other Treatments:** You can enter details of the patient's non-medication treatments.

6. To attach documents to the referral letter:

- a) At the top of the Referral Letter Composer window, click **Attachment** (). The EMR displays the Attachments window, with a list of files available in the **Documents** area of the patient's Medical Summary.

Drag a column header here to group by that column.								
Attached	File Name	Date	Status	Keyword One	Keyword Two	Keyword ...	Notes	Physician
☐	FatherTest...	24/10/2014	Reviewed	DI Req-Pureform-Ab Cg				Dana Kn...
☐	FatherTest...	24/10/2014	Reviewed	DI Req-AHS-AB				Dana Kn...
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...
☐	FatherTest...	22/10/2014	Reviewed	Consult Letter Composer Full				Dana Kn...
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...
☐	FatherTest...	22/10/2014	Reviewed	Consult letter				Dana Kn...
☐	FatherTest...	06/10/2014	Reviewed	DI Req-Pureform-Ab Cg				Dana Kn...
☐	Father Test...	01/10/2014	Reviewed	e-MS	ReferralLetter			Dana Kn...
☐	FatherTest...	01/10/2014	Reviewed	CPX - Female				Dana Kn...
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Absence				Dana Kn...
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Absence				Dana Kn...
☐	Sunflower_...	24/09/2014					Picture followi...	
☐	FatherTest...	07/03/2014	Reviewed	Lab Req-AB Cg (2pg)				Dana Kn...
☐	FatherTest...	07/03/2014	Reviewed	CPX - Female				Dana Kn...
☐	FatherTest...	07/03/2014	Reviewed	Note - Massage				Dana Kn...
☐	FatherTest...	06/03/2014	Staff Revi...	Consult Letter Composer	WOLF.COMPOSER.CO...		Marked as re...	
☐	Father Test...	06/03/2014	Reviewed	e-MS	ReferralLetter			David Kn...
☐	5. to appt r...	27/08/2013		Cardiology Report			test	
☐	6. link to co...	27/08/2013		Cardiology Report				

- b) In the **Attached** column, select the check box beside the documents you want.
- c) When you finish, click **Close** (). The EMR displays the selected document('s) name(s) in the **Referral Detail** area on the Referral Letter Composer window.



Note: You can attach only files that are available in the **Documents** tab of the patient's Medical Summary.



Note: To attach the prenatal form to a referral letter, you must save the prenatal form as a PDF in the Medical Summary **Documents** tab. You can then attach the prenatal form as you do other documents.

7. To preview the referral letter, on the bottom left of the window, select the **Letter View** check box. The EMR displays the letter in the format it will be printed.

- ☒ Information Recipient
- ☒ Client Information
- ☒ Referral Detail
- ☒ Medical Information
 - ☒ Problems
 - ☒ Current Medications
 - ☒ Allergies
 - ☐ Encounters
 - ☐ Investigations (Sort By Date)
 - ☐ Inactive Problems
 - ☒ Procedures and Surgeries
 - ☐ Family History
 - ☐ Harmful Substances
 - ☐ Alerts
 - ☐ Vaccinations
 - ☐ Referrals
 - ☐ Other Treatments

Johnny A Velcro, MD
 Wolf Alberta Clinic
 4565 W Jardine Place
 Grande Prairie, AB
 A5X 0O5
 Phone:(650) 824-2762 Fax:(735) 844-7487

ACH Cardiology
 ACH, 1820 Richmond Road SW
 Calgary, AB

Phone 955-7858
 Fax 955-7621

CC:

August 07, 2015

Dear Sir / Madam

RE: **Andrea Demetrius Test**
 DoB: ,
 PHN: 9998538348
 Appt:

Address: **4001 E Brighton 10th Street**
Burlington, AB, L3Q 0M9
 Tel: (526) 516728

Urgency: Routine
 Referral Reason: Suspected heart murmur

Below is the related medical information of the patient:

Problems

Problem	Comments	Date
Hypertension Systolic		Aug 4, 2015
*Diabetes Mellitus -Type 1- Insulin Dependent		Aug 4, 2015

Current Medications
None noted.

Allergies
None noted.

Procedures and Surgeries
None noted.

Thank you for seeing this patient in consultation. I look forward to your assessment.

Sincerely

☒ Letter View



Tip: To modify the letter format before it is sent:

1. Click **Send to SMART Form** (). The EMR opens the letter in Microsoft Word.
2. Edit the letter, and then click **Save** (). The EMR saves the edited letter in patient's Medical Summary, in the **Documents** tab.

8. To print, fax, or save (as a PDF) your completed referral letter:

- a) Click **Print** (). The EMR displays the Print Referral window, with the referral attachments indicated with selected check boxes.
- b) Perform one of the following actions:

- To send the referral letter to your default printer, click **Quick Print**.
- To select a specific printer or fax machine before printing or sending, click **Print**.
- To save the referral letter as a PDF file, click the **Collate to PDF** check box, and then click **Quick Print**.



Note: If you are printing or faxing the referral letter, ensure that the **Collate to PDF** check box is cleared.

9. Click **Save & Exit** ().
10. Open the patient's referral from the **Referrals** tab in Medical Summary window. (If you are not in the Medical Summary window, see [“Opening a patient's Medical Summary” on page 389.](#))
11. In the Existing Referral window, indicate the status of the referral letter. In the **LETTER COMPLETED** area, select one or more of the following check boxes:



Note: Clinics who do not have stenographers or transcriptionists use only the **Sent** check box.

The other check boxes, for example **Typed** and **Printed**, are used to track the referral as it is back and forth between the stenographer and the practitioner for review.

- **LETTER COMPLETED:** If you have both written the letter and sent it to the consultant.
- **Letter:** To indicate that you need to write a referral letter, but has not been started or finished yet. The EMR adds the patient to your WorkDesk **Letters to Write** list.
- **Typed:** Indicates that the contents of the letter have been typed. If this check box is selected, the EMR adds the letter to your WorkDesk **Letters to Edit** list.
- **Printed:** To indicate that you have printed the letter.
- **Sent:** To indicate that you have sent the letter.

☒ LETTER COMPLETED		Letter Type:
☒ Letter	☒ Edited	Printed Letter External Fax Internal fax
☒ Dictated	☐ Printed	
☒ Typed	☐ Sent	

12. Click **Save & Close Referral** ().

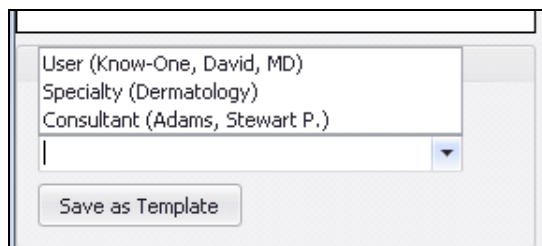
Referral Letter Composer templates

In the Referral Letter Composer, you can customize what Medical Summary categories are pre-selected by default. Default Medical Summary categories can be set for:

- The user who starts the referral letter
- Individual consultants whom you referred to
- Specialties of consultants whom you refer to

To set a Referral Letter Composer template:

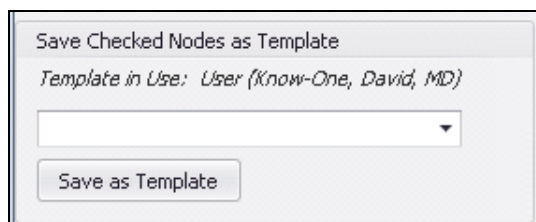
1. Start a referral letter for a patient, and in the Referral Letter Composer window, select the Medical Summary categories you want to include in the letter template. See [“Creating and sending referral letters” on page 278](#).
2. In the **Save Checked Nodes as Template** area, click one of the following options in the drop-down list:
 - **User (<Your name>)**: to indicate that the selected categories are to default for all referral letters you create.
 - **Consultant (<Consultant's name>)**: to indicate that the selected categories are to default only when you refer a patient to the selected consultant.
 - **Specialty (<Specialty name>)**: to indicate that the selected categories are to default only when you refer a patient to a consultant with the selected specialty.



3. Click **Save as Template**.



Tip: After you set default templates for the Referral Letter Composer, you can view what template the EMR defaults to for each referral letter you create. The EMR displays the **Template in Use** in the **Save Checked Nodes as Template** area on the Referral Letter Composer window.



SMART Form-based referral letters

If you want your referral letter to:

- Have a customized format
- Contain your clinic logo
- Include other medical information that you cannot choose in the Referral Letter Composer

you can create the letter using Microsoft Word.

After you initiate a referral, you can populate a Microsoft Word referral letter template (SMART form) with the referral information. You can then edit the letter using Microsoft Word formatting tools.

You can also program your Microsoft Word referral letter template to pull a variety of medical information from the patient's record.

Creating referral letters using a SMART Form

To create a referral letter using a SMART Form:

1. Initiate a referral and complete the New Referral details. See ["Initiating referrals" on page 271](#).



Note: If you want to create a letter based on a previously started referral:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#)
2. Click the **Referrals** tab.
3. In the patient's list of referrals, double-click the referral you want. The EMR opens the referral in the Existing Referral From <Date> window.

2. On the New Referral (or Existing Referral) window, in the **Send to SMART Form** area, click an appropriate keyword in one or more of the **Keyword** drop-down lists.

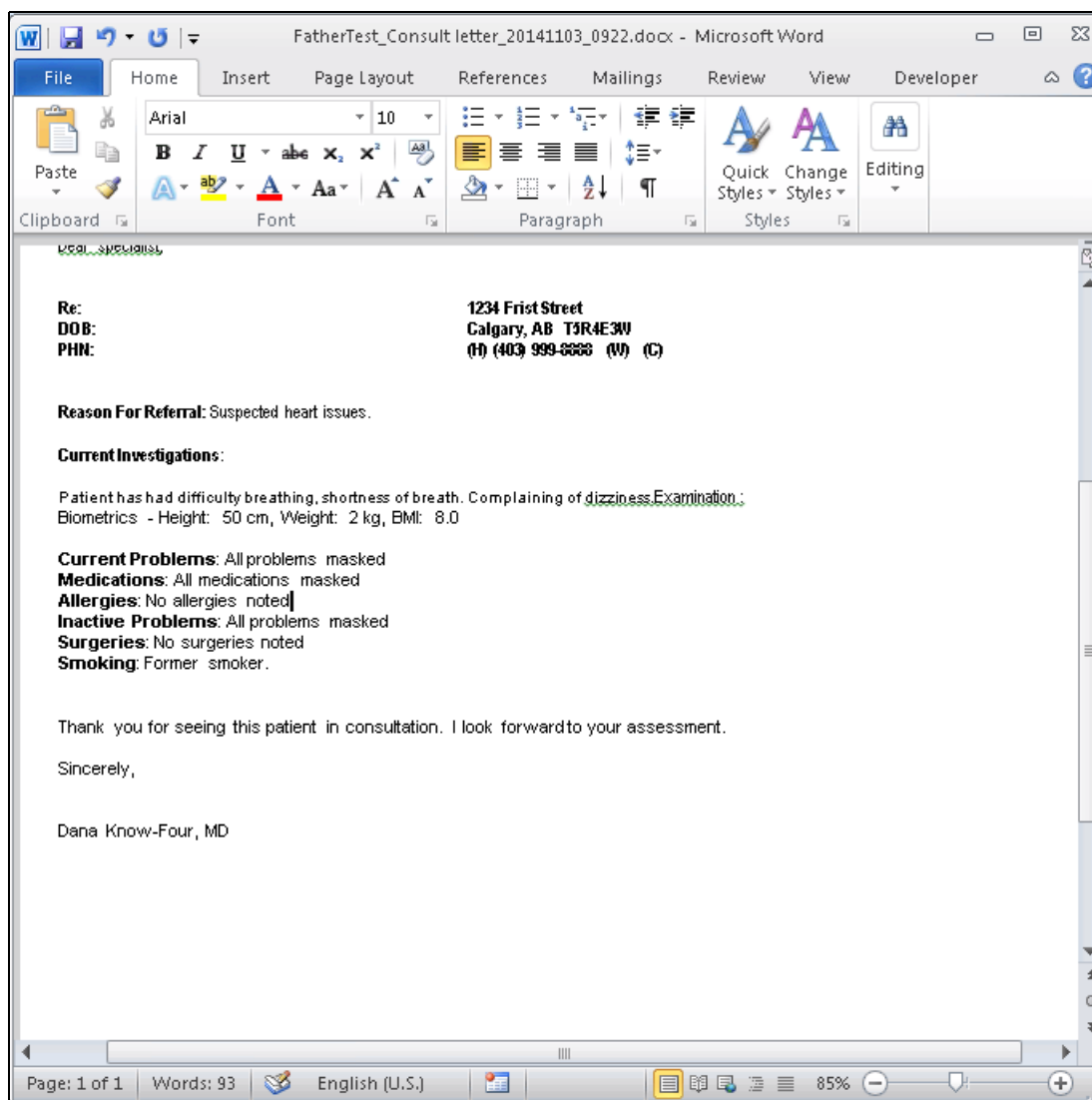


Tip: If you select keywords for your referral letter, you can search for your referral letter in the patient's **Documents** list, using the keywords you select.

3. Perform one of the following actions:

- To start a referral letter using the clinic's default SMART Form template, click **Send to SMART Form** (). The EMR opens Microsoft Word with your referral letter text inserted into a letter template (SMART form).
- To start a referral letter using your own customized referral letter SMART Form:

- a) Right-click anywhere on the New Referral (or Existing Referral) window and then, in the SMART menu, click **SMART Forms**. The EMR displays the Send to SMART Form window.
- b) In the list of SMART Forms, expand the **Letters** category.
- c) Double-click the SMART form you want. The EMR displays a Microsoft Word-based letter document (SMART Form), with the text of your referral letter inserted.



Tip: The Referral Letter SMART Form can automatically pull information such as patient demographics, and various aspects of the patient's medical history. See ["Customizing your Referral Letter SMART Form" on page 292.](#)

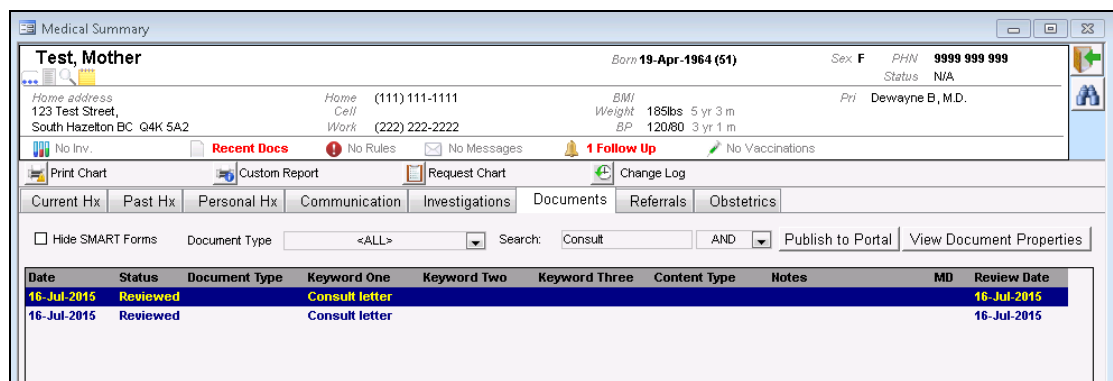
4. Enter your letter text and modify the format of your letter using the various tools available in Microsoft word.

5. To print the referral letter:

- a) In the Microsoft Word menu, click **File > Print**. Microsoft Word displays the print properties window.
- b) In the printer list, click the printer or fax machine you want.

c) Click **Print** ().

6. Click **Save** (), and then click **Close** (). The EMR saves your referral letter in the **Documents** area of the patient's Medical Summary.



Medical Summary

Test, Mother Born **19-Apr-1964 (51)** Sex **F** PHN **9999 999 999**
 Status **N/A**
 Home address **123 Test Street, South Hazelton BC Q4K 5A2** Home Cell **(111) 111-1111** Work **(222) 222-2222** BMI **185lbs** Weight **5 yr 3 m** BP **120/80** 3 yr 1 m
 Pri **Dewayne B, M.D.**

Recent Docs No Rules No Messages **1 Follow Up** No Vaccinations

Print Chart **Custom Report** **Request Chart** **Change Log**

Current Hx **Past Hx** **Personal Hx** **Communication** **Investigations** **Documents** **Referrals** **Obstetrics**

☐ Hide SMART Forms Document Type **<ALL>** Search: **Consult** **AND** **Publish to Portal** **View Document Properties**

Date	Status	Document Type	Keyword One	Keyword Two	Keyword Three	Content Type	Notes	MD	Review Date
16-Jul-2015	Reviewed	Consult letter							16-Jul-2015
16-Jul-2015	Reviewed	Consult letter							16-Jul-2015



Note: You cannot attach other files/Documents to a SMART Form-based consult letter as you can using the Referral Letter Composer. Instead, print or fax additional documents separately.

To print or fax attachments with a SMART Form based consult letter, on the **Documents** tab of the patient's Medical Summary, print or fax each document you want to include.

Customizing your Referral Letter SMART Form

You can create your own customized SMART Form referral letters, both for general referrals, or for specific types of referrals. For example, you want a referral letter for all cardiology referrals, and another for all endocrinology referrals. You can customize a Referral Letter SMART Form to:

- Automatically pull information from the patient's chart, including the patient's Medical Summary.
- Contain headings
- Contain pre-written text

And more...



Note: You can create a customized SMART Form referral letter for your own use or for the entire clinic to use.

For complete instructions on how to customize your referral letter, see the [Wolf EMR SMART Forms User Guide](#).

Managing your referrals

You can monitor your referrals using the Referral List. The Referral List displays patients who:

- Need their referral letters and attachments sent
- Are waiting for an appointment with a consultant
- Have referrals that are not reconciled

You use the Referral List to find a specific patient's outstanding referrals and to modify or update referrals as needed.

You can also track and manage new and pending referrals from your WorkDesk. The **Referrals** area contains several links to referral-related task lists, including:

- **Letters Due Within The Next Week**
- **Letters to Edit**
- **Letters to Write**

You can also view and update a specific patient's referral information and status in the **Referrals** area of their Medical Summary.

Managing your referrals using the Referral List

You can use the Referral List to view and manage both your outstanding referrals, and outstanding referrals for the entire clinic. You can also find a specific patient's referrals and then modify referrals as needed.

To view and manage your outstanding referrals:

1. On the WorkDesk menu, click **Patients > Referral List**. The EMR displays the Detailed List of Referrals for All Patients window, with a list of your patients' referrals.

Detail List of Referrals for All Patients

Test, Baby Daughter Born 15-Jun-2013 (1 yr 4 m) Sex F PHN Status N/A

Caregiver: Mr. Test, Irwan Next Encount... None

Home address: 123 Test Street, Home (111) 111-1111 Cell (222) 222-2222 Work

HC Weight 7kg (0.3%) 5 wk 1 d Pri Dana Know-Four, MD
Height 64cm (0.1%) 5 wk 1 d Fam Ref

No Inv. No Docs No Rules No Messages 1 Follow Up 1 Vaccination

Filters for Referral List

☐ Include Inactive Service Practitioner: Dana Know-Four, MD From Date: 06-Nov-2013 To Date:

Referral Type: << All >> Consultant: Referral Reason: Reconciled: << All >> Disp/Outcome: Priority: << ALL >> Specialty:

Filter by Patient
☒ All Patients
☐ Specific Patient

Click on a column header to sort, double-click on the referral to open

PATIENT	MD	DATE	TYPE	CONSULTANT	SPECIALTY	REFERRAL REASON	CONSULT DATE	WAIT
Test, Baby	DK	29-Oct-2014	Consultation	ABC Pediatrics	Paediatrics	Patient complains of shortness of br		
Test, Delta	DK	28-May-2014	Consultation	Test, David	Allergist	test	30-Jun-2014	1
Test, Fred	DK	28-May-2014	Consultation	Test, David	Allergist	allergy		1
Test, Arm	DK	13-May-2014	Consultation	Test, Anthony	Addiction Medicine	Test referral reason		1
Test, Beta	DK	10-Mar-2014	Consultation	Access Mental Health	Psychiatry	psychiatry	04-May-2014	
Test, Beta	DK	10-Mar-2014	Physiotherapy	ABC test Physio Clinic	Physiotherapy	physio		2
Test, Jay	DK	10-Mar-2014	Consultation	Test, Thomas	Urology	urology		2
Test, Jay	DK	10-Mar-2014	Consultation	Test, Davide	Orthopedics	hip injury		2

The Referral List displays the following information for each referral:

- Patient
 - Patient's MD
 - Date (that referral was created)
 - Type (of referral)
 - Consultant (name)
 - Speciality (of consultant)
 - Referral reason
 - Consult date (if an appointment is booked)
 - Wait (days since referral was initiated)
 - Reconciled (status)
2. To re-sort the referral list by the contents of a column, click the column header.
 3. To view and/or update a specific referral on the list, double-click the referral. The EMR displays the Existing Referral window with all details of the referral displayed.



Tip: You can enter any updates to the referral on the Existing Referral window.

Note: Any updates you make do not reflect in your Referral List until you close and re-open the Detail List of Referrals for All Patients window.

4. If the list of referrals is extensive, you can filter the list using the selections available in the **Filters for Referral List** area. The following table describes the filter options:

Filter	Details
Include Inactive Service	To display referrals initiated by a Provider who is no longer active in your clinic, select this check box.
Practitioner	To view referrals initiated by another practitioner in your clinic, in the drop-down list, click the practitioner's name. Note: Your name is selected in the Practitioner list by default.
Referral Type	To display only referrals with a specific Referral Type, in the drop-down list, click the Referral Type you want. Note: <<All>> is selected by default.
Referral Reason	To display only referrals with a specific referral reason, in this field, enter the reason.
Priority	To display only referrals with a specific priority level, in the drop-down list, click either Urgent , or Routine . Note: <<All>> is selected by default.
From Date	To limit the displayed referrals to a specific date range, in this field, enter the earliest date.
To Date	To limit the displayed referrals to a specific date range, in this field, enter the latest date.
Consultant	To display only referrals to a specific consultant, in the drop-down list, click the consultants name.
Reconciled	■ To display only referrals that are reconciled, in the drop-down list, click Yes. ■ To display only referrals that are not reconciled, in the drop-down list, click No. Note: <<All>> is selected by default.
Disp/Outcome	To display only referrals that have the same outcome, in this field, enter the outcome.
Specialty	To display only referrals that are for a specific specialty, in the drop-down list, click a specialty.
All Patients	To display referrals for all of your patients, in the Filter by Patient area, select All Patients . Note: This option is selected by default.

Filter	Details
Specific Patient	To display referrals only for a specific patient: 1. In the Filter by Patient area, select Specific Patient. The EMR displays the Patient Search window. 2. Search for and select the patient.

5. To view or update a specific referral on the list, double-click the referral. The EMR displays the Existing Referral window with all details of the referral displayed.



Tip: You can enter any updates to the referral on the Existing Referral window.

Note: Any updates you make do not reflect in the Referral List until you close and re-open the Detail List of Referrals for All Patients window.

6. When you are finished viewing and managing your referrals, click **Close Form** ()

Managing a patient's referrals from their Medical Summary

You can view and update a patient's referrals in the **Referrals** tab of their Medical Summary.

To view and manage a patient's outstanding referrals:

1. Open the patient's Medical Summary. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Referrals** tab. The EMR displays a list of the patient's outstanding and completed referrals.

Medical Summary						
Test, Mother			Born 19-Apr-1964 (51)		Sex F PHN 9999 999 999	
Home address 123 Test Street, South Hazelton BC Q4K 5A2			Home Cell (111) 111-1111	BMI 185lbs 5 yr 3 m	PHN Status N/A	
			Work (222) 222-2222	BP 120/80 3 yr 1 m	Pri Dewayne B, M.D.	
No Inv. Recent Docs No Rules No Messages 1 Follow Up No Vaccinations						
Print Chart Custom Report Request Chart Change Log						
Current Hx	Past Hx	Personal Hx	Communication	Investigations	Documents	Referrals
Obstetrics						
Show all referrals						
MD	Date	Type	Consultant	Specialty	Referral Reason	Reconciled O/C
DB	16-Jul-2015	Consultation	, echocardiogram	CARDIOLOGY	Patient complains of shortness of breath	No
DB	15-Mar-2012	Consultation	C, Lisa	PHYSICAL MEDICINE	Consultation problem	No Const
DB	11-Oct-2011	Consultation	LGH, CT	Medical Imaging	Consultation problem	No Const
DB	27-Jul-2011	Consultation	C, Maureen H.	PSYCHIATRY	Consultation problem	No Const
DB	02-Apr-2011	Consultation	P, Paul	GENERAL SURGERY	Consultation problem	No Const
NJ	08-Jul-2010	Consultation	M, Rizwan	PLASTIC SURGERY	Consultation problem	No Const
DB	14-Jan-2009	Consultation	B, Gordon	PSYCHIATRY	Consultation problem	No Const
DB	18-Nov-2007	Consultation	D, Carol	GENERAL SURGERY	Consultation problem	No Const
DB	11-Sep-2007	Consultation	Q, David	CHIROPRACTIC	Consultation problem	No Const
DB	17-Jul-2007	Consultation	K, David	PSYCHIATRY	Consultation problem	No Const
DB	12-Jul-2007	Consultation	M, David	OPHTHALMOLOGY	Consultation problem	No Const

The Referral List displays the following information for each referral:

- Requesting MD

- Date (that referral was created)
 - Type (of referral)
 - Consultant (name)
 - Speciality (of consultant)
 - Referral reason
 - Reconciled (status)
3. To re-sort the order of the patient's referral list, click the header of the column you want to sort the list by.
 4. To view and/or update a specific referral on the list, double-click the referral. The EMR displays the Existing Referral window with all details of the referral displayed.



Tip: You can update the referral in the Existing Referral window.

Note: Any updates you make do not reflect in the Referral tab until you close and re-open the Medical Summary window.

5. If the patient's list of referrals is extensive you can filter the list:
 - a) Above the patients referral list, click **Show all referrals**. The EMR displays the detailed List of Referrals for All Patients window, filtered to display only referrals for the selected patient.
 - b) In the **Filters for Referral List** area, use the various filters available to find the referral(s) you want. See [Step 4.](#) of "[Managing your referrals using the Referral List](#)" on page 293.

Updating referral status'

After you start a referral, ensure that you update the status of the referral letter at each stage of the process, especially if you dictate your letters and have them transcribed. This way your front end staff, or referral clerk knows when it's their turn to take action on, or manage the referral. You can also better manage letters you need to complete.

You can update a referral letter status to indicate that the referral letter is created, printed and/or sent.

If you dictate your letters and a staff member or transcription service transcribes your letters, you can indicate that the referral letter is:

- Dictated
- Typed
- Edited
- Printed

■ Sent

To update the status of a referral letter:

1. Open the patient's referral from the **Tasks** area of your WorkDesk, from your referral list (see [“Managing your referrals using the Referral List” on page 293](#)), or from the patient's Medical Summary (see [“Click **Save & Close** \(\)” on page 299](#).)

To open a patient's referral from the **Tasks** area of your WorkDesk:

- a) On the **Tasks** tab of the WorkDesk, In the **Referrals** area, click **#Letters Due Within the Next Week** (with # indicating the number of referral letters you need to complete). The EMR displays the Letters To Write Window.



Note: Referrals display on the Letters to Write list only if, on the referral window, under **LETTER COMPLETED**, the **Letter** check box is selected. The letter check box indicates that the letter is “ready to write”.

- b) In the **Letters** column, click a patient. The EMR displays basic details about the referral on the right side of the window, including letter status options.

Letters To Write

Practitioner Filter: <<ALL>>

Letters:

- Test, Mother

Test, Mother PHN: 9999 999 999

Born: 19-Apr-1964 (51) Sex: F Status: N/A

123 Test Street, South Hazelton BC Q4K 5A2 H: (111) 111-1111 C: (111) 111-1111 W: (222) 222-2222 Pri: Dewayne Bryson, M.D.

Referral Reason: **Patient is experiencing occasional chest pain and shortness of breath**

Doctor Cardiology **CARDIOLOGY** ...details

Appointment: **Appointment Pending** Notes:

Investigations Pending:

☐ LETTER COMPLETED

☒ Letter ☐ Edited

☐ Dictated ☐ Printed

☐ Typed ☐ Sent

Letter Type: **Printed Letter** **External Fax** **Internal fax**

☒ Use Medical Hx

Letter Text:

Linked Documents:



Tip: If you want to view and modify information in the patient's detailed referral, click **...edit referral**.

2. To indicate that you have completed, printed, and sent a referral letter, on the Referral window, select the **LETTER COMPLETED** check box. The EMR indicates that all aspects of letter creation have been completed, by selecting all of the check boxes below LETTER COMPLETED.
3. To indicate that you have completed only some tasks required to complete a referral, under LETTER COMPLETED, select one or more of the following options:
 - **Letter:** To indicate that you have completed writing the letter.
 - **Printed:** To indicate that you have printed the letter.
 - **Sent:** To indicate that you have sent the letter.
4. If you dictated the letter, under LETTER COMPLETED select one or more of the following options:
 - **Dictated:** To indicate that you have finished dictating the letter.
 - **Typed:** To indicate that the letter has been typed.
 - **Edited:** To indicate that you have edited the letter.
5. Click **Save & Close** ().

Managing the External Consultant list

You can refer patients only to consultants or clinics that are in your clinic's consultant list. If the consultant you want is not in the consultant's list, you can add a new consultant as you create a referral.

If you refer to a particular consultant regularly, you can identify the consultant as a favourite. You can then quickly select the consultant from your favourite consultants list when you initiate a referral.

Adding and Editing consultants while creating a referral

If the consultant you want not available on your consultants list, you can add a consultant when you create a referral.

If you find the consultant you want, but see that any of the consultant's details are incorrect, you can also edit a consultant's details when you create a referral.

Adding a new consultant

To add a consultant to your clinic's consultants list:

1. Start a referral. See [“Initiating referrals” on page 271](#).
2. In the **Choose Consultant** area, click **Add New Consultant**. The EMR displays the ENTER New Consultant window.

The screenshot shows the 'ENTER New Consultant' window. The fields are organized as follows:

- Last Name:** Text input field.
- First Name:** Text input field.
- Title:** Text input field with 'Dr.' as a default value.
- Address:** Text input field.
- Address (2):** Text input field.
- Address (3):** Text input field.
- City:** Text input field with a dropdown arrow.
- Province:** Text input field with 'British Columbia' as a default value and a dropdown arrow.
- Organization:** Text input field.
- Department:** Text input field.
- General Office:** Text input field.
- Pager:** Text input field.
- Cell/Mobile:** Text input field.
- Home:** Text input field.
- Fax:** Text input field.
- Prac #:** Text input field.
- Specialty:** Text input field with a dropdown arrow.
- Email:** Text input field.
- Default Word Template:** Text input field.
- Notes:** Large text area for notes.

3. Use the following table to enter the consultant's information.

Field	Instructions
Last Name	Enter the consultant's last name.
First Name	Enter the consultant's first name.
Title	Enter an appropriate title for the consultant. For example, Dr. , Mr. , Miss . Note: Dr. displays as the default.
General Office	Enter the consultant's office phone number. Note: You can call this number directly using the TELUS Health Mobile App.
Pager	Enter the consultant's pager number Note: You can call this number directly using the TELUS Health Mobile App
Cell/Mobile	Enter the consultant's personal cell phone number. Note: You can call this number directly using the TELUS Health Mobile App

Field	Instructions
Home	Enter the consultant's home phone number. Note: You can call this number directly using the TELUS Health Mobile App
Fax	Enter the consultant's office fax number.
Prac #	Enter the consultant's Practitioner ID number. Note: This number is used to identify the consultant when you bill for the referral.
Specialty	In the Specialty drop-down list, click the consultant's specialty. Note: Avoid adding new specialties to the list, unless the entire clinic agrees to the addition. This ensures consistency when entering and finding consultants.
Address	Enter the consultant's address. If you want to add additional address lines, enter this information into the Address (2) , and Address (3) fields.
City	In the drop-down list, click the consultant's city. If the city you want is not available on the list, enter the city name into the City field.
Province	The EMR populates the Province field by default.
Organization	Enter the consultant's company or clinic name.
Department	Enter the consultant's department, if applicable.
Email	Enter the consultant's email.
Default Word Template	If you have created customized consult letter SMART Forms (for example, for specific specialties), enter the name of the SMART Form you want to default to for this consultant. Note: When you click Send to SMART Form on the New Referral window, the consult letter SMART form you specify here displays.
Notes	Enter any notes regarding the consultant, or the consultant's referral policies. For example, "Call before faxing a referral."

4. When you finish, click **Save & Close** (). The EMR adds the consultant to your clinic's consultants list.

Editing a consultant

To edit a consultant on your consultant's list:

1. Start a referral and select a consultant. See ["Initiating referrals" on page 271](#).

2. After you select a consultant, click **...info**. The EMR displays the Consultant Information window.
3. Click **...edit**. The EMR displays the Edit Consultant Information window.
4. Edit or add information in the fields as necessary.
5. When you finish, click **Save & Close** ()

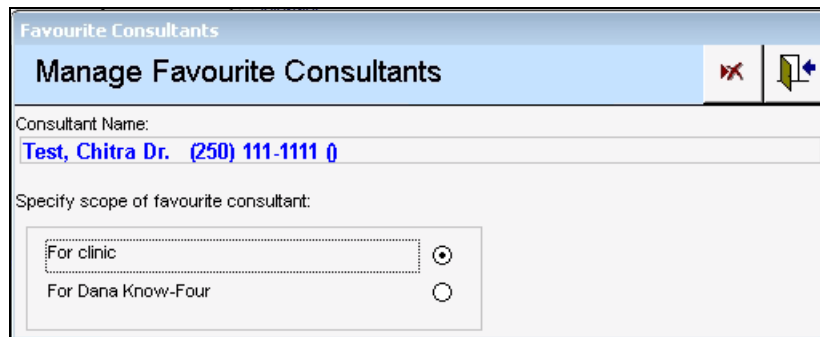
Favourite consultants

After you search for and select a consultant for a referral, you can add that consultant to your favourites list. The next time you create a referral for the same consultant, you can then select the consultant from your favourites list.

Adding consultants to your favourites list

To add a consultant to your favourites list:

1. Initiate a referral, and search for and select a consultant. See [Step 1.](#) to [Step 6.](#) in “Initiating referrals” on page 271.
2. In the **Manage Favourites** area, click **Add currently selected consultant** () . The EMR displays the Manage Favourite Consultants window, with the selected consultant's name and phone numbers displayed at the top.



3. In the **Specify scope of favourite consultant** area, click one of the following options:
 - **For clinic**: The EMR adds the consultant to the Favourite Consultants list of all users in the clinic.
 - **For <your name>**: The EMR adds the consultant to your Favourite Consultants list only.
4. Click **Save & Close** ()

Modifying consultants on your favourites list

When specialists in your area come or go, or when you change your preferred specialists, you can easily edit your Favourites list to reflect the changes. You can remove a consultant, or change the scope of a consultant on your Favourites list from the New Referral window.

To modify your Favourite Consultants list:

1. Initiate a referral. See ["Initiating referrals" on page 271](#).
2. In the **Choose Consultant** area, click **From Favourites**. The EMR displays your Favourite Consultants list.
3. If your list of Favourite Consultants is extensive, and you are having trouble locating the consultant you want to delete or modify:
 - a) In the **Search** field, enter the consultants name or specialty.
 - b) Press **Enter**. The EMR filters your Consultant Favourites list to display only consultants who match your search term.

Search: AND

☐ Search by Consultant Last Name only

*Choose Consultant

From Favourites

By Specialty

By Name

Add New Consultant

B, Maziar	INTERNAL MEDICINE	
B, Richard	ENDOCRINOLOGY	
B, Robert	CARDIOLOGY	E
B, Rodney	PAEDIATRICS	E
B, Thomas	Otolaryngology	
C, George	GENERAL SURGERY	

CC Resident(s):

Manage Favourites

4. In the list of favourites, click the consultant you want to delete or modify.
5. In the **Manage Favourites** area, click **Modify favourite consultant** () . The EMR displays the Manage Favourite Consultant window.
6. To change the scope of the favourite, in the **Specify scope of favourite consultant** area, click one of the following options:
 - **For clinic**: The EMR adds the consultant to the Favourite Consultants list of all users in the clinic.
 - **For <your name>**: The EMR adds the consultant to your Favourite Consultants list only.
7. To delete the favourite, click **Delete consultant from favourites list** ().

eReferrals

You can quickly and securely send electronic versions of referrals using the Wolf EMR eReferral messaging system. When you send an eReferral to a consultant, the consultant can open the referral in the Referral Letter Composer, import attached patient medical information, and then send you a reply through their Wolf EMR.

You can send eReferrals to consultants who:

- Use Wolf EMR
- Are set up to receive eReferrals



Note: If you want to send or receive eReferrals, the eReferral feature must be enabled for your clinic. To request access to the eReferral feature, contact the TELUS Health EMR Customer Care team using one of the following methods:

- E-mail: accounts.wolfemr@telus.com
- Online Case submission: Available on the **Cases** page of the [Wolf EMR Community Portal](#).
- Phone: 1-866-879-9653 (Option 4)

Sending eReferrals

To send an eReferral, you start a referral as normal and use the Referral Letter Composer to create your letter. When you click **Send**, the EMR sends the eReferral letter through the secure eReferral messaging system, with any attachments that you specified.

To create and send an eReferral:

1. Start a referral as normal. See [“Initiating referrals” on page 271](#).



Important: When you select a consultant for an eReferral, ensure that the consultant has an **E** to the right of their name. The **E** indicates that the consultant accepts eReferrals.

*Choose Consultant	General Practice	
CRUZ, WeekdayER		E
DK, WEEKDAY Hospital		E
Kerby, Hospital		E
KG, Weekday Hospital		E
Khullar, CM HOSPITAL		E
Khullar, SK HOSPITAL		E

CC Recipient(s):

Indicates that practitioner accepts eReferrals

2. Create a referral letter using the Referral Letter Composer, and attach any documents to accompany the referral. See [“Creating and sending referral letters” on page 278](#).

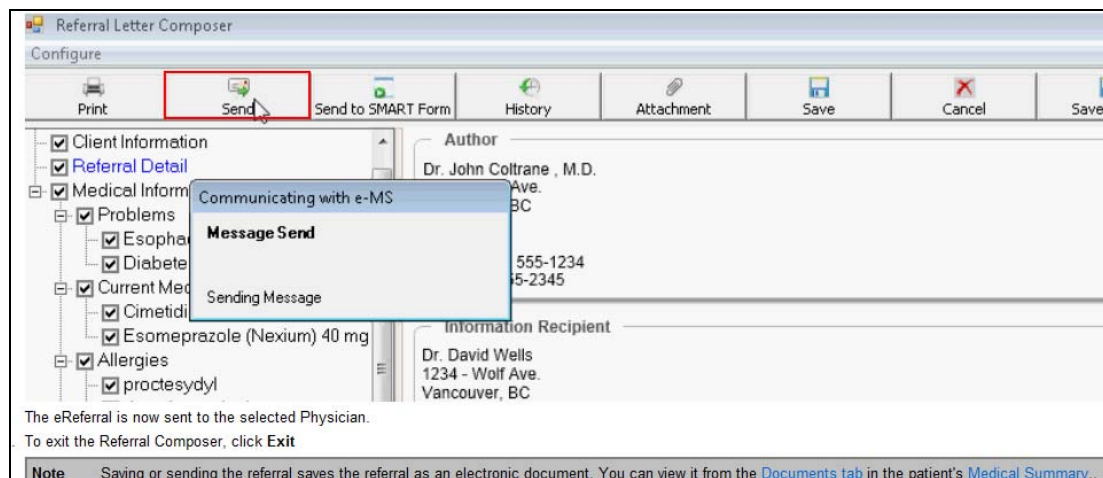


Consult letters created using SMART forms cannot be sent as eReferrals.

3. On Referral Letter Composer window, click **Send**.

The EMR:

- Displays a dialog box with the following notification: “Sending Message”
- Creates a PDF document of the Referral letter and specified attachments, and saves the PDF to the **Documents** tab of the patient's Medical Summary.
- Sends the referral and attached documents to the consultant.



The consultant views the eReferral in the eReferral Letter Composer (not as a PDF document).

4. Click **Save & Exit** ().

Monitoring the status of eReferrals (accepted / declined)

As soon as a consultant's office accepts or declines your referral, you are notified on your WorkDesk. You can view and respond to any accepted or declined eReferrals in the **Referrals** area of your WorkDesk under the headings:

- **Incoming Consults:** Lists all accepted eReferrals, and eReferrals with new messages and attachments from the consultant.
- **Declined eReferrals:** Lists all declined eReferrals.

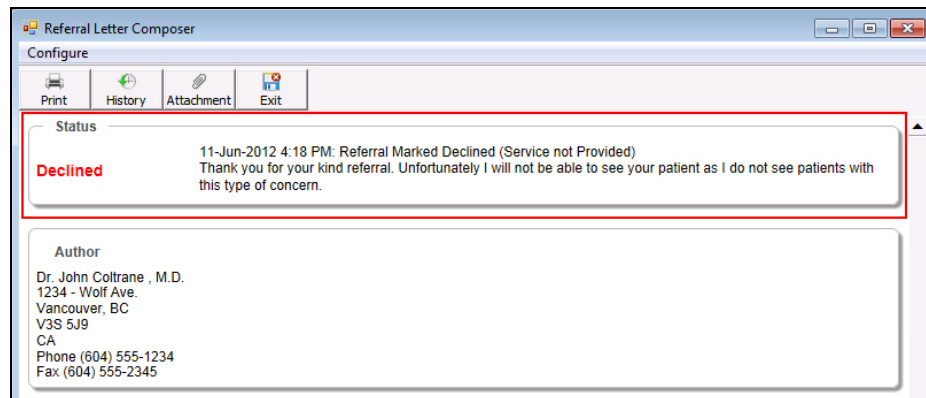
Viewing and responding to declined eReferrals

To view and respond to your declined eReferrals:

1. In the **Tasks** area of your WorkDesk, in the **Referrals** area, click **# Declined eReferrals** (where **#** = the number of declined eReferrals). The EMR displays the Investigation/Document In Basket window with a list of your declined referrals.
2. To view more information about a declined referral, including any messages from the consultant, double-click the referral.
3. To respond to the declined referral, click on of the following options:
 - **Redirect**: To redirect the declined referral to another provider in your clinic.
 - **To Come In**: To assign a **Patient to Notify** task to your front end staff, and create a Follow Up task for you.
 - **Follow Up**: To send a Follow Up task to the clinic member(s) you choose.
 - **Message**: To send a Message to the clinic member(s) you choose.



Note: If you open a declined eReferral in the Referral Letter Composer window, a **Status** banner displays at the top of the window indicating that the referral is declined. The **Status** area also displays any notes included by the consultant's office.



Viewing and responding to accepted eReferrals

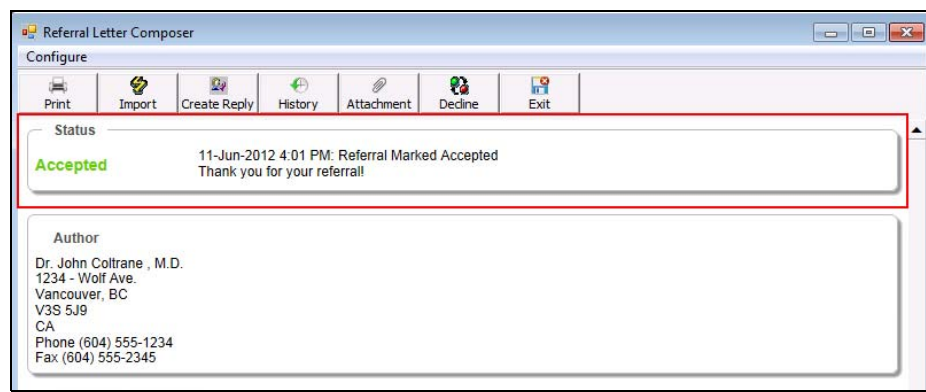
To view and respond to your accepted eReferrals:

1. In the **Tasks** area of your WorkDesk, in the **Referrals** area, click **# Incoming consults** (where **#** = the number of accepted or updated referrals). The EMR displays the Investigation/Document In Basket window with a list of your accepted referrals.
2. To respond to the accepted referral, click one of the following options:
 - **Redirect**: To redirect the referral response to another provider in your clinic.

- **To Come In:** To assign a **Patient to Notify** task to your front end staff, and create a Follow Up task for you.
- **Follow Up:** To send a Follow Up task to the clinic member(s) you choose.
- **Message:** To send a Message to the clinic member(s) you choose.



Note: If you re-open a referral in the Referral Letter Composer window, that was accepted through eReferral, a **Status** banner displays at the top of the window indicating that the referral is accepted. The **Status** also displays any notes included by the consultant's office.



Sending and receiving messages, consult letters, and other documents to and from consultants

You can send messages, consult letters, and other documents back and forth to consultants through the eReferral Letter Composer.

When you receive eReferral messages or documents from consultants, they display on your WorkDesk, in your **Incoming Consuls** list.

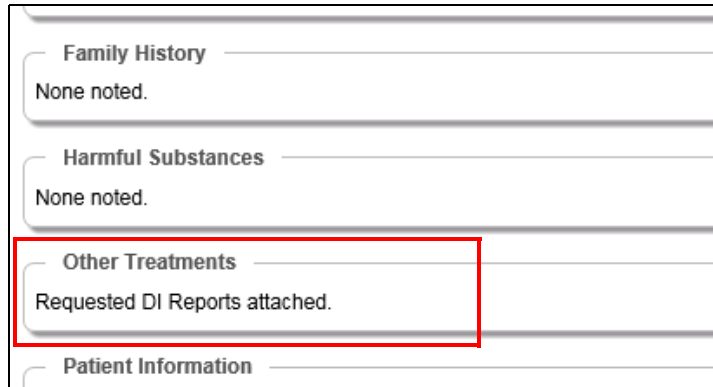
Receiving messages, and other documents

If, after you send an eReferral, you receive messages or documents from the consultant's clinic, you are notified in the **Tasks** area of your WorkDesk under **Incoming Consuls**. From here, you can view and respond to messages. The EMR attaches messages and attachments to the original referral.

To view messages and attachments regarding an eReferral:

1. In the **Tasks** area of your WorkDesk, in the **Referrals** area, click # **Incoming Consuls** (where # = the number of your accepted referrals and referrals with new messages and/or attachments). The EMR opens the Investigation/Documents In-basket.

2. In the list of pending and updated eReferrals, double-click the eReferral. The EMR displays the eReferral in the Referral Letter Composer window, with any messages from the consultant displayed under **Other Treatments**.



The screenshot shows a window with four sections: 'Family History' (None noted), 'Harmful Substances' (None noted), 'Other Treatments' (Requested DI Reports attached), and 'Patient Information'. The 'Other Treatments' section is highlighted with a red rectangular box.

3. To view any new attachments from the consultant (for example, a consult letter), click **Attachment** (). The EMR displays the Attachment window.
4. Respond to the message if needed. See ["Sending messages, and other documents" on page 308](#).
5. When you finish, click **Exit** ().

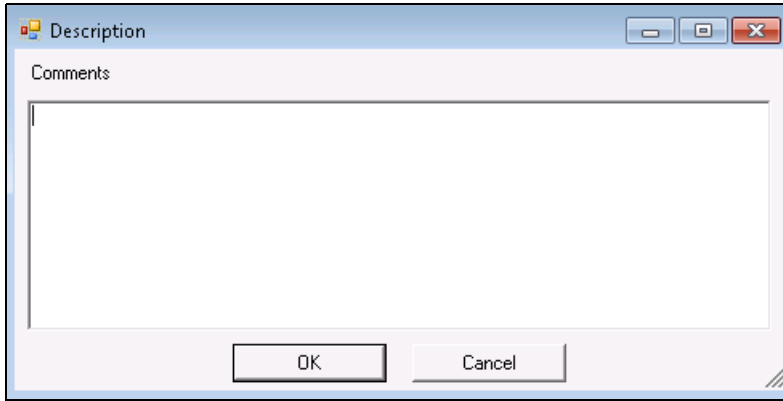
Sending messages, and other documents

Through the Referral Letter Composer, you can send consultants messages and additional documents after you send the original eReferral.

To send messages, and documents to a consultant's clinic:

1. Open the patient's Medical Summary. See ["Medical Summary window overview" on page 392](#).
2. Click the **Documents** tab.
3. In the patient's list of documents, double-click the eReferral. The EMR displays the referral in the Referral Letter Composer window.
4. At the top of the eReferral Letter Composer window, click **Create Reply** (). The EMR opens the Referral Letter Composer in send mode.
5. If you want to send a message to the consultant, enter the message as an Other Treatment:
 - a) In the left pane, select the **Other Treatments** check box.

- b) Right-click the **Other Treatments** tag (in blue), and then click **Properties**. The EMR displays the Description window.

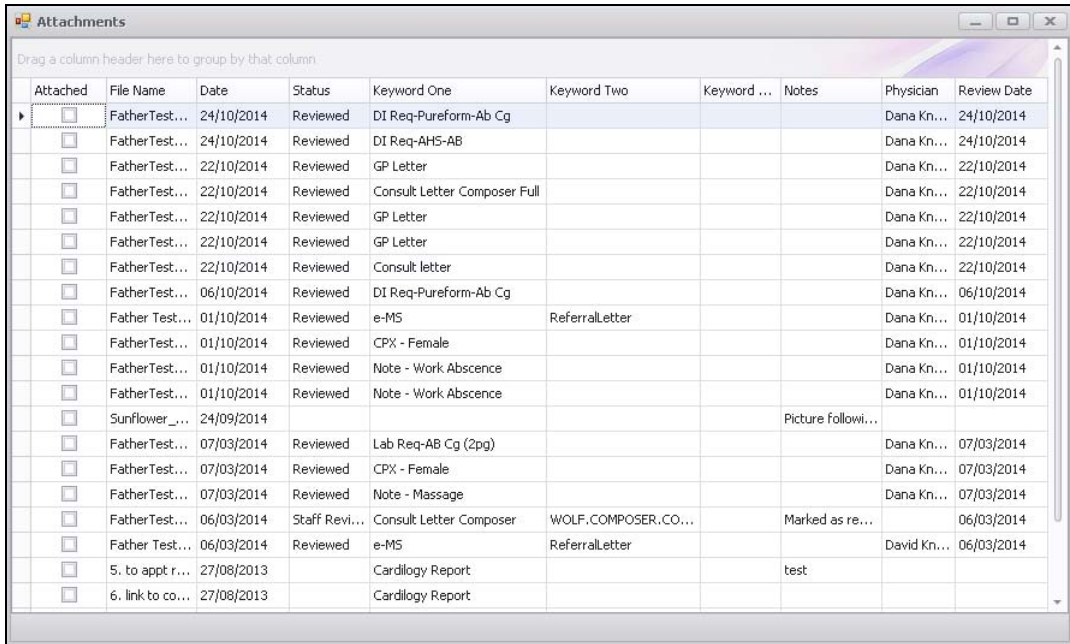


The image shows a window titled "Description" with a "Comments" label above a large text input area. At the bottom are "OK" and "Cancel" buttons.

- c) In the **Comments** area, enter your message, and then click **OK**.

6. If you want to send a document to the consultant:

- a) Click **Attachment** (). The EMR displays the Attachments window, with a list of files available in the **Documents** area of the patient's Medical Summary.



The image shows a window titled "Attachments" with a table of documents. The table has columns: Attached, File Name, Date, Status, Keyword One, Keyword Two, Keyword ..., Notes, Physician, and Review Date. The first row is selected.

Attached	File Name	Date	Status	Keyword One	Keyword Two	Keyword ...	Notes	Physician	Review Date
☒	FatherTest...	24/10/2014	Reviewed	DI Req-Pureform-Ab Cg				Dana Kn...	24/10/2014
☐	FatherTest...	24/10/2014	Reviewed	DI Req-AH5-AB				Dana Kn...	24/10/2014
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	Consult Letter Composer Full				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	Consult letter				Dana Kn...	22/10/2014
☐	FatherTest...	06/10/2014	Reviewed	DI Req-Pureform-Ab Cg				Dana Kn...	06/10/2014
☐	Father Test...	01/10/2014	Reviewed	e-M5	ReferralLetter			Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	CPX - Female				Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Absence				Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Absence				Dana Kn...	01/10/2014
☐	Sunflower...	24/09/2014					Picture followi...		
☐	FatherTest...	07/03/2014	Reviewed	Lab Req-AB Cg (2pg)				Dana Kn...	07/03/2014
☐	FatherTest...	07/03/2014	Reviewed	CPX - Female				Dana Kn...	07/03/2014
☐	FatherTest...	07/03/2014	Reviewed	Note - Message				Dana Kn...	07/03/2014
☐	FatherTest...	06/03/2014	Staff Revi...	Consult Letter Composer	WOLF.COMPOSER.CO...		Marked as re...		06/03/2014
☐	Father Test...	06/03/2014	Reviewed	e-M5	ReferralLetter			David Kn...	06/03/2014
☐	5. to appt r...	27/08/2013		Cardiology Report			test		
☐	6. link to co...	27/08/2013		Cardiology Report					

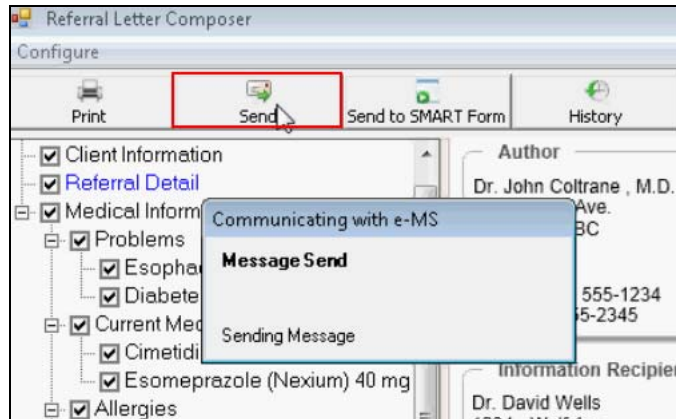


Note: You can attach only files that are available in the **Documents** tab of the patient's Medical Summary.

You can attach letters, growth charts, prenatal records, and WCB forms only if they are saved as documents in the patient's record.

- b) In the **Attached** column, select the check box beside all documents you want to send.

- c) Click **Close** (). The EMR displays the selected document('s) name(s) in the **Referral Detail** area on the Referral Letter Composer window.
7. On the Referral Letter Composer window, click **Send**.



The EMR sends a notification to the consultant.



Note: The consultant receives the notification in their **Incoming Referrals** list.

When the consultant opens the referral, any messages you entered display under **Other Treatments**.

Procedures and Surgeries
Description
Family History
None noted.
Harmful Substances
None noted.
Other Treatments
Please send all related DI Reports.
Patient Information

Quick Referrals

If you configure a customized Quick Referral template for a for consultants or clinics you refer to often, you can refer a patient to that consultant/clinic in only a few clicks. The EMR automatically populates the following information into the referral:

- Referral Type

- Primary consultant
- Referral reason

Starting a Quick Referral



Note: You can use Quick Referral only if you have personally configured your Quick Referral options. Quick Referrals cannot be set for all users at once.

To start a Quick Referral:

1. Open a SOAP Note Examination form (see [“Starting SOAP notes” on page 117](#)), or the Consult Letter Examination form (see [“Starting consult letter visit notes” on page 171](#)) for a patient.
2. In the **Quick Referral** area at the bottom of the window, in the **Referral Group** list, click a group. The EMR displays a list of associated investigations and procedures for the selected Referral Group.
3. In the **Investigation/Procedure** list, click one or more investigation(s) or procedure(s) you want to refer the patient for.

4. Click **Process Orders**. The EMR creates a referral for the patient, and displays the referral in the **Plan items changed today** area.

5. To view and add additional information to the referral, in the **Plan items changed today** area, double-click the referral line. The EMR displays the referral in the Existing Referral from... window with the following information pre-populated:

- Referral Type
- Primary consultant

■ Referral reason

6. Complete the referral, and create a referral letter. See [“Creating and sending referral letters” on page 278](#).

Configuring customized Quick Referrals

To configure a Quick Referral:

1. On the WorkDesk menu, click **Configure > Quick Referral Settings**. The EMR displays the Quick Referral Set-up window.

Wolf Clinical Records

Quick Referral Set-up

Step 1: Select Investigation to be linked

Referral Group: **Message Therapy**
Acupuncture
Physiotherapy
Consultation
Medical Imaging
Podiatry

Investigation:

Step 2: Choose Default Consultant/Investigation

By Specialty
 By Name

Accupuncture
 ACUPUNCTURE
 Addiction Medicine
 alberta childrens hospital
 Allergist
 Amniocentesis
 Anaesthesia
 Anatomical Pathology
 Anesthesia
 Anticoagulation
 Audiology
 Ayurvedic Medicine Practitioner
 Blood Bank
 Breastfeeding
 Cardiology

History:

Step 3: **Link Investigation to Default Choice**

☐ Patient to Book Appt ☐ Print Immediately

2. In the **Referral Group** list, click the group (specialty) you want the Quick Referral to apply to. The EMR displays a list of investigations (or services) associated with the selected group.



Tip: If the group you want is not available, you can add additional groups to the list at this point.

To add a group:

1. Double-click anywhere in Referral Group list area. The EMR displays the Quick Referral Investigation Groups window.
2. In the **Investigation Group** column, enter a group name.

Wolf Clinical Records

Quick Referral Investigation Groups:

Investigation Group:

Massage Therapy	Consultation	▼
Acupuncture	Consultation	▼
Physiotherapy	Consultation	▼
Consultation	Consultation	▼
Medical Imaging	Consultation	▼
Podiatry	Consultation	▼
► Cardiology	Consultation	▼
*	Consultation	▼

3. In the column to the right of the Investigation Group, click one of the following options:

- Consultation
- Investigation
- Booking

4. To save your new group(s) and close the window, click **Close Form** ().

3. In the list of group-associated investigations, click the investigation or specialty you want the Quick Referral to apply to.



Tip: If the investigation you want is not available, you can add additional investigations/specialty options to the selected groups list at this point.

To add an investigation:

1. Double-click anywhere in the field to the right of the **Referral Group** list. The EMR displays the Quick Referral Registry window for the selected group.
2. In the **Investigation/Consultation** column, enter the investigation you want.

Investigation/Consultation:	Investigation Group:
Cardio diagnostic tests	Cardiology
Rapid access cardio consultation	Cardiology
Consultation with specific cardiologist	Cardiology
ECG interpretation	Cardiology
Rehabilitation	Cardiology
*	Cardiology

3. To save your investigation and consultation types and close the window, click



4. In the **Choose Default Consultant/Investigation** drop-down list, click a consultant's name. If the selected consultant has an assigned specialty, then the EMR selects that specialty on the specialty list



Tip: If you cannot find the consultant you want, begin to enter the name of the consultant into the **Choose Default Consultant/Investigation** field, the EMR takes you to the associated alphabetical area on the drop-down list.

5. If a specialty is not automatically selected on the specialty list, click the appropriate specialty for the consultant.
6. To indicate that the patient has to book their own appointment for this type of referral (for example, x-rays), click the **Patient to Book Apt** check box.
7. Click **Link Investigation to Default Choice**. The EMR displays a dialogue box with the following message: "Record Saved".
8. Click **OK**.
9. To save the new Investigations and Consultations and to close the window, click **Close**

Form ()

Specialized visits

In this chapter you learn how to enter visit encounter notes for, and use specialized features for prenatal patients, WCB patients, and pediatric patients.

Prenatal visits

Wolf EMR is equipped with numerous features you can use monitor and record information for prenatal patients. Using these features, you can:

- View the obstetrical history of a patient
- Record notes in the provincial Prenatal Record
- Calculate estimated date of birth (EDB), and gestational age
- Calculate Prenatal Risk Score
- Link documents, such as ultrasound reports, to the Prenatal Record

The following sections describe how to record clinical notes for prenatal visits. The topics include viewing the obstetrical history for a patient, recording notes in the Prenatal Record, linking a document to the Prenatal Record, and accessing a document linked to the Prenatal Record.

Viewing a patient's pregnancy status

If a patient is pregnant, the patient's SMART patient banner displays the word "pregnant" and indicates how far along she is in her pregnancy..

Born 19-Apr-1979 (36)		Sex F	PHN
Pregnant 20wk 1d		Status	
BMI	Weight 185lbs 5 yr 3 m	BP 120/80 3 yr 1 m	Dewayne Bl
0 Messages 1 Follow Up No Vaccinations			



Note: The SMART patient banner displays pregnancy information only if a Prenatal Record has been started for the patient.

Viewing and editing a patient's obstetrical history

You can view and edit a patient's obstetrical history on the **Obstetrics** tab in the patient's Medical Summary. You can view the details of all of a patient's pregnancies, and you can add a new pregnancy from the **Obstetrics** tab.

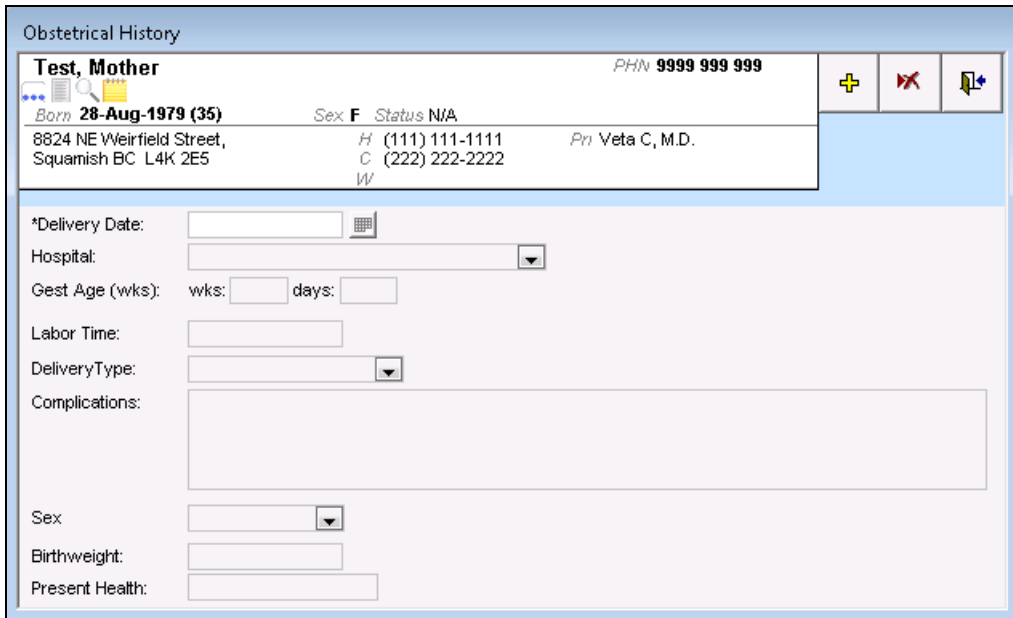


Note: The pregnancy information you add on the **Obstetrics** tab automatically appears on the Prenatal Record. Alternatively, if you add pregnancy information to the Prenatal Record, that information is reflected on the **Obstetrics** tab.

To view and edit a patient's obstetrical history:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#)
2. Click the **Obstetrics** tab.
3. On the **Obstetrics** tab, double-click an entry to view more details about a pregnancy.
4. To add a pregnancy to the list:

- a) Click **Enter New Obstetrical Hx** (). The EMR displays the Obstetrical History window.



The screenshot shows the 'Obstetrical History' window for a patient named 'Test, Mother' with PHN 9999 999 999. The patient's birth date is 28-Aug-1979 (35), sex is F, and status is N/A. The address is 8824 NE Weirfield Street, Squamish BC L4K 2E5. The phone numbers are (111) 111-1111 and (222) 222-2222. The provider is Veta C, M.D. The window contains several input fields: *Delivery Date (with a calendar icon), Hospital (a dropdown menu), Gest Age (wks) with separate fields for weeks and days, Labor Time, Delivery Type (a dropdown menu), Complications (a large text area), Sex (a dropdown menu), Birthweight, and Present Health.

- b) Use the following table to enter information in the Obstetrical History window:

Field	Description
Delivery date	Enter the date of delivery or termination, or to select a date from a calendar, click  .
Hospital	Enter the hospital in which the delivery took place.
Gest Age (wks)	Enter the gestational age of the baby at the time of delivery in wks and days .
Labour Time	Enter the number of hours the mother was in labour for.
Delivery Type	In the drop-down list, click the type of delivery.
Complications	Enter any complications that occurred during the pregnancy or delivery.
Sex	Enter the sex of the baby.
Birthweight	Enter the birth weight of the baby.
Present Health	Enter the present health of the baby/child.

- c) Complete one of the following actions:

- To save and close the obstetrical history entry, click **Close Form** ().

- To save the current entry, and to start a new entry, click **Add New Obstetrical History**

to **Patient Record** (.

Opening the Prenatal Record

You can enter all prenatal visit notes in the Wolf EMR Prenatal Record template. Each time the patient returns for a prenatal visit, you add notes to the same Prenatal Record until the pregnancy is finished. You can then print or fax the entire prenatal record to the hospital or mid wife.

To open the Prenatal Record on the first prenatal visit:

1. On the WorkDesk, click the **Appointments** tab. The EMR displays a list of your appointments for today. See [“Viewing your schedule” on page 16](#).
2. In the **Appointments** list, click the patient whom you want to start a Prenatal Record for. The EMR displays the **Patient** tab (CPP), with a summary of the patient's previous and current office visits.
3. If your MOA or Nurse has already started the Prenatal Record for you, in your list of visit records, double-click the latest visit record labelled **Pre Natal Form**. The EMR displays the Prenatal window.
4. To start a new Prenatal Record:
 - a) On the list of office visits, click the office visit you want to open a Prenatal Record for. (In most cases this will be the incomplete (I) visit listed at the top.)
 - b) In the **Templates** drop-down list, click **Prenatal Form**. the EMR displays the Prenatal window.



Note: The prenatal form includes all information entered for previous visits for this pregnancy.

Prenatal

Test, Mother Born: **28-Aug-1989 (26 yr)** Sex: **F** PHN: **99999** Status: **N/A**

Home address: **8824 Test Street, Squamish BC L4K 2E5** Home Cell: **(111) 111-1111** Work: BMI: **15.4** 3 yr 9 m Weight: **67.5 lbs** 3 yr 9 m BP: Pri: **Veta C, M.D.**

No Inv. No Docs No Rules No Messages No Follow Ups No Vaccinations

Proceed to Part 1
[Proceed to Part 2](#)
[Proceed to Part 2 - Visits](#)
[Proceed to Delivery](#)
[Proceed to Risk Assessment](#)

LMP: EDD BY DATES: EDD BY US: EDD: Gest. Age: Search: PHYSICIAN / MIDWIFE NAME:

Part 1 **Part 2** **Part 2 - Visits** **Delivery** **Risk Assessment**

Hospital: Search: Attending physician/midwife: **Veta C, M.D.** FAMILY PHYSICIAN: **Veta C, M.D.** Age at EDD:

Mother's maiden name: Ethnic origin: Language preferred: Partner's name: **Chester H** Age:

Occupation: Work hrs./day: No. of school years completed: Ethnic origin of newborn's father: Partner's work:

Allergies: **<<Add New Allergy>>** Medications/herbals: **<<Add New Medication>>** Beliefs & Practices:

Clobazam (Frisium TAB) 10 mg i PO qhs
Lamotrigine (Lamictal TAB) 150 mg i PO BID
Methylphenidate (Ritalin-SR ERT) 30 mg i PO OD

Obstetrical History

Gravida	Para	Term	Preterm	Abortion	(Induced)	Spontaneous	Living
							

Date: Place of birth/Abortion: Hrs. in labour: Gest. age: Type of birth: Prenatal complications: Sex: Birth weight: Breastfed: Present health:

LMP: Menses Cycle: Contraceptives: When stopped: 1ST ULTRASOUND DATE: EDD Calculation: **EDD BY US** Override:

☒ Irregular Cycle

GEST. AGE BY US: wks: days:

Present pregnancy: **no** yes (specify): Medical History: **no** yes (specify): Lifestyle & social: **Discussed** Concerns: Referred:

☒ IVP Pregnancy
☒ Bleeding
☒ Nausea
☒ Surgery
☒ Anesthesia
☒ Diet
☒ Folic acid
☒ Physical activity/



Tip: Accessing prenatal handouts

If your clinic has linked patient handouts to the prenatal record (for example, prenatal nutrition information handouts), you can access patient handouts on the **Part 1** tab. On the lower right side of the window, click the blue **Patient Handouts** link.

Calculating an estimated due date and gestational age based on LMP

When you enter the last menstrual period (**LMP**) date and **Menses Cycle** duration in the patient's Prenatal Record, the EMR automatically calculates an estimated due date (EDD). If you select **EDD BY DATE**, the EMR also calculates the gestational age.

To calculate an estimated due date and gestational age by LMP:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record"](#) on page 318.

2. In the **Part 1** tab, under the **Obstetrics History** area, in the **LMP** field, enter the patient's last menstrual period date or select the date from the calendar.
3. In the **Menses Cycle** area, enter the average duration (in days) of the patient's cycle.
4. (Optional) If the patient has an irregular cycle, in the **Menses Cycle** area, select the **Irregular Cycle** check box.
5. In the **EDD Calculation** area, select **EDD BY Date**. The EMR displays the EDD and gestational age at the top of the Prenatal form in the **Pregnancy Summary** area.

Prenatal

Test, Mother Born: 28-Aug-1989 (26 yr) Sex: F PHN: 99999 Status: N/A

Home address: 8824 Test Street, Squamish BC L4K 2E5 Home Cell: (111) 111-1111 Work: BMI: 15.4 3 yr 9 m Weight: 67.5 lbs 3 yr 9 m BP: Pri: Veta C, M.D.

No Inv. No Docs No Rules No Messages No Follow Ups No Vaccinations

Proceed to Part 1
[Proceed to Part 2](#)
[Proceed to Part 2 - Visits](#)
[Proceed to Delivery](#)
[Proceed to Risk Assessment](#)

LMP: 16-Mar-2016 EDD BY DATES: 22-Dec-2016 EDD BY US: 22-Dec-2016 EDD: 18 Weeks 6 D Gest. Age: Search: PHYSICIAN / MIDWIFE NAME: Veta C, M.D.

Part 1 | **Part 2** | **Part 2 - Visits** | **Delivery** | **Risk Assessment**

Hospital: Search: Attending physician/midwife: Veta C, M.D. FAMILY PHYSICIAN: Veta C, M.D. Age at EDD: 27

Mother's maiden name: Ethnic origin: Language preferred: Partner's name: Chester H Age: Partner's work: Chester H

Occupation: Work hrs./day: No. of school years completed: Ethnic origin of newborn's father: Partner's work:

Allergies: <<Add New Allergy>> Medications/herbals: <<Add New Medication>> Clobazam (Frisium TAB) 10 mg i PO qhs Lamotrigine (Lamictal TAB) 150 mg i PO BID Methyphenidate (Ritalin-SR ERT) 30 mg i PO QD Beliefs & Practices:

Obstetrical History

Date	Place of birth/ Abortion	Hrs. in labour	Gest. age	Type of birth	Prenatal complications	Sex	Birth weight	Breastfed	Present health

Pregnancy Summary

LMP: 16-Mar-2016 Menses Cycle: 29 Irregular Cycle: ☐ Contractives: When stopped: 1ST ULTRASOUND DATE: GEST. AGE BY US: wks: days: EDD Calculation: ☐ EDD BY US ☒ EDD BY Date Override:

Present pregnancy: Medical History: Lifestyle & social:

Recording gestational age based on ultrasound and calculating EDD



Tip: Accessing ultrasound images from the prenatal record

- You can link ultrasound images and reports to a patient's Prenatal Record. See ["Linking documents to the Prenatal Record as ultrasound images" on page 336](#)
- You can access linked ultrasound images on the Part 2 tab of the Prenatal Record. See ["Accessing ultrasound images linked to Prenatal Records" on page 338](#).

When you receive the patient's first ultrasound results, enter the **first ultrasound date** and **gestational age by ultrasound** in the patient's Prenatal Record. You can then calculate the estimated due date (EDD) by ultrasound (US), by selecting **EDD BY US** in the **EDD Calculation** area.

To record gestational age based on ultrasound and to calculate the EDD:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record" on page 318](#).
2. In the **Obstetrical History** area, enter information in the following fields:
 - **1st Ultrasound date**: Enter the date of the first ultrasound.
 - **Gest. Age by US**: Enter the Gestational Age by Ultrasound in weeks and days.



Note: You can also enter the first ultrasound date and gestational age on the **Part 2** tab in the **Other Investigations & Comments** area.

3. To calculate an EDD by ultrasound, in the **EDD Calculation** area, select **EDD BY US**. The EMR uses the ultrasound date to calculate the **EDD BY US** date and the **Gestational Age**.



Note: If you want to enter a different estimated due date, use the **Override** feature:

1. Click the calendar icon (to the right of the **Override** field) and select the due date.
2. Double-click the due date to close the calendar. The value you selected gets copied to the **EDD** field (near the top of the window).

Recording Prenatal Record notes on the first visit

A patient's first prenatal visit can include a review of their medical history, a review of their family and medical history, a physical exam, and several discussion topics. The **Part 1** tab of the Prenatal Record contains fields specific to a first visit, so you can easily enter first visit information in one convenient area.

To record Prenatal Record notes on the first visit:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record" on page 318](#).

2. Use the following table to enter, modify, or view the information on the **Part 1** tab of the Prenatal Record.

Field	Description
Pregnancy Summary (top of window)	
LMP	Displays the date of the patient's Last Menstrual Period, entered in the LMP field in the Obstetrical History area.
EDD BY Dates	Displays the estimated due date based on calculations from the LMP date and Menses Cycle duration.
EDD BY US	Displays the estimated due date based on calculations from the 1st Ultrasound date.
EDD	Displays the estimated due date based on the calculations determined by the EDD Calculation information specified.
Gest. Age	The EMR calculates the gestation age based on the EDD date.
Search	Enter the search criteria for the physician/midwife name (the next field), and press Enter .
Physician/midwife name	After entering the search criteria and pressing Enter , in the Physician/midwife name drop-down list, click the name that you want.
General Information	
Note: Some general information fields may be pre-populated with information entered in the Patient Maintenance window.	
Hospital	Enter the name of the hospital where the patient plans to give birth.
Attending physician/ midwife	Displays the attending physician or midwife for the patient. If you want to change this field, enter the name of the attending physician or midwife in the Search field and then select a name from the search results in the drop-down list.
Family Physician	Displays the primary care giver for the patient.
Age at EDD	Displays the age at Estimated Due Date.
Mother's maiden name	Displays the Mother's Maiden Name.
Ethnic origin	Displays the patient's ethnic origins.
Language preferred	Displays the preferred language for the patient.
Occupation	Displays the patient's occupation.

Field	Description
Work hrs./day	Enter the number of hours the patient works per day.
No. of school years competed	Enter the number of school years completed.
Partner's Name	Displays the partner's name.
Age	Displays the age of the partner listed under Partner's Name.
Partner's work	Enter the occupation of the patient's partner.
Ethnic origin of newborn's father	Displays the ethnic origins of the Father.
Allergies	Displays any current allergies. To record an allergy for the patient, click <<Add New Allergy>>. Note: When you add a new allergy or medication through the prenatal record, the EMR automatically updates the patient's Medical Summary with the new information.
Medications/herbals	Displays any current medications.
Beliefs & Practices	Enter any beliefs or practices required by the patient or Father
Obstetrical History (high-level history)	■ Gravida: Enter the number of times the patient has been pregnant. ■ Para: Enter the number of successful pregnancies but the infant is now deceased. ■ Term: Enter the number pregnancies brought to term. ■ Preterm: Enter the number of pre-term pregnancies. ■ Abortion: Enter the number of abortions. ■ Induced: Enter the number of induced abortions. ■ Spontaneous: Enter the number of spontaneous abortions. ■ Living: Enter the number of successful pregnancies and the infant is still alive.

Field	Description
Obstetrical History (detailed list of obstetrical history entries)	- To add an obstetrical history, click  in the Obstetrical History area. - To edit an obstetrical history, double-click an entry in the Obstetrical History section.
LMP	Enter the date of the patient's Last Menstrual Period or select the date from the calendar button.
Menses Cycle	Enter the patient's menstrual cycle in number of days. If no value is entered, then 28 days is the default value.
Irregular Cycle	Select this check box if the patient's menstrual cycle is irregular.
Contraceptives	Enter the contraceptive type used by the patient.
When Stopped	Click to insert a date when the contraceptive type entered was last used.
1st Ultrasound Date	Enter the date of the first ultrasound. Note: If you entered the first ultrasound date on Part 2 of the prenatal record, then that date displays in this field.
Gest. Age by US	Enter the Gestational Age by Ultrasound in weeks and days. Note: If you entered the Gestational Age by Ultrasound on Part 2 of the prenatal record, then that date appears in this field.

Field	Description
EDD Calculation	Select how you want to calculate the EDD. ■ EDD BY US: If selected, the EMR displays the EDD based on based on calculations from the 1st Ultrasound date. ■ EDD BY DATE: If selected, the EMR displays the EDD based on calculations from the LMP date and Menses Cycle duration. Note: You can use the Override feature to enter your own estimate of the due date: 1. Click the calendar icon (to the right of the Override field), and then select the due date. 2. Double-click the due date to close the calendar. The value you selected gets copied to the EDD field (near the top of the window).
Present Pregnancy	Click any check box and enter information relevant to the current pregnancy.
Family History	Enter any information regarding the patient's family history. To specify diseases or conditions in the patient's family history, select the applicable check boxes. Note: A gray check box indicates that the patient has not yet been asked about their family history for this item.
Medical History	Enter any information regarding the patient's medical history. To specify the patient's diseases or conditions, select the applicable check boxes. Note: A gray check box indicates that the patient has not yet been asked about their medical history for this item.
Lifestyle & social	Click or enter the information regarding lifestyle and social status. Topics include Smoking, Drug Use, Alcohol Use, Environmental/Occupational Concerns, Social Issues, and Referrals.
Draw Picture	To include a diagram with the printed record, click Draw Picture .

Field	Description
Physical Examination	Displays information from the Prenatal CPX appointment.
First Trimester Topics Discussed	Select the check boxes in this section to indicate which topics were discussed with the patient.

Recording Prenatal Record notes on subsequent prenatal visits

After the first visit, a patient's subsequent prenatal visits can include recording lab test results, other investigation results, and discussion topics. The **Part 2** tab of the Prenatal Record contains fields specific to second subsequent visits.



Tip: The EMR does not automatically populate electronic lab values, however, the prenatal form identifies if certain lab values are available in the patient's record (displays these lab names in blue text).

You can click labs with blue text to view the lab result, and then choose to have the EMR populate the information into the Prenatal form.

To record Prenatal Record notes on subsequent visits:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record" on page 318](#).

2. Click the **Part 2** tab. The EMR displays the **Part 2** tab of the Prenatal record.

Prenatal

Test, Mother Born: 28-Aug-1989 (26 yr) Sex: F PHN: 99999
 Home address: 8824 Test Street, Squamish BC L4K 2E5 Home Cell: (111) 111-1111 BMI: 15.4 3 yr 9 m Weight: 67.5 lbs 3 yr 9 m BP: Pri: Veta C, M.D.
 No Inv. No Docs No Rules No Messages No Follow Ups No Vaccinations

LMP: 16-Mar-2016 EDD BY DATES: 22-Dec-2016 EDD BY US: 22-Dec-2016 Gest. Age: 18 Weeks 6 d Search: PHYSICIAN / MIDWIFE NAME:
 Proceed to Part 1
 Proceed to Part 2
 Proceed to Part 2 - Visits
 Proceed to Delivery
 Proceed to Risk Assessment

Part 1 Part 2 **Part 2 - Visits** Delivery Risk Assessment

Intended place of birth:
 Alternate place of birth (Hospital):
 Investigations/Results: ABO group: Rh factor: Rubella titre: PP vaccination indicated: STS: HIV test done: Yes No: HBsAg done: Yes No: Results: D M Y: Partner/household contact: NB vaccination indicated: Other tests (e.g. Hep C, Varicella): Prenatal Genetic Screening: Type: Result: Gest. diabetes screen (24-28 wks): D M Y: Result: GBS screen (35-37 wks): Yes No: D M Y: Result: Copy to hospital: Edinburgh Postnatal Depression Scale (28-32 weeks): Score: D M Y: Follow-up: Yes No: Potential or Actual Concerns: Lifestyle: Pregnancy: Labour: Breastfeeding: Postpartum: Newborn: Second & Third Trimester Topics Discussed: Call schedule: Preterm labour: Hospital admission: Doula: Breastfeeding: Risks/benefits of planned or use of blood/blood products: Birth plan: YBAC: Newborn screening: bloodspot/hearing: Infant safe sleep: Pain management: Cesarean: Infant car seats:

3. Use the following table to modify or view the information on the **Part 2** tab of the Prenatal Record.

Field	Description
Intended place of birth	Enter the desired place of birth, or click a value in the drop-down list.
Alternate Place of Birth (Hospital)	Enter the alternate desired place of birth, or click a value in the drop-down list.
Investigations/Results area Displays the various investigations and results for the patient.	
ABO Group	To enter the patient's blood type, in the drop-down list, click one of the following options: O , AB , A or B .
Rh Factor	To enter the Rh of the patient's blood type, in the drop-down list, click + or - .

Field	Description
Antibody titre	■ DMY: Enter the date of the Rh Antibodies test in the format DD-Mmm-YYYY or select a date using the calendar icon. ■ Results: Enter the results of the Rh Antibodies test.
Rhlg given	■ Results: Enter the results of the Rhlg test. ■ DMY: Enter the date of the Rhlg test in the format DD-Mmm-YYYY, or select a date using the calendar icon.
Hemoglobin	Enter the 1st and 3rd Hemoglobin results.
Urine C&S	Enter the details of the Urine Culture and Sensitivity testing.
Rubella titre	■ PP vaccination indicated: Select this check box if the PP vaccination has been taken. ■ Results drop-down list: Click the result of the Rubella test. The result can be Immune or Non-Immune.
STS	Enter the results of the Serologic Test for Syphilis (STS).
HIV test done	To indicate the status of the HIV test, perform one of the following actions: ■ To indicate that the patient has not yet had the HIV test completed, select the No check box. ■ To indicate that the patient has had the HIV test completed, select the Yes check box, and then in the field, enter the results.
HBsAg Done	■ Select the Yes or No check box to indicate if an HBsAg test (for Hepatitis B) has been completed. ■ Results: Select the Positive or Negative check box. ■ DMY: Enter the date of the HBsAg test in the format DD-Mmm-YYYY or select a date using the calendar icon. Select the following check boxes, if applicable: ■ Partner/household contact ■ NB vaccination indicated
Other tests	Enter the results of any other tests such as Hepatitis C or Varicella.
Prenatal Genetic Screening	■ Type: Enter the type of Prenatal Genetic Screening ■ Result: Enter the result.

Field	Description
Gest. diabetes screen (24 - 28 wks)	■ DMY: Enter the date when the patient was last screened for Gestational Diabetes or select a date using the calendar icon. ■ Results: Enter the results for the Gest. diabetes screen.
GBS screen (35-37 wks)	■ Select the Yes or No check box to indicate if the patient has completed a Group B Streptococcus (GBS) screening. ■ DMY: Enter the date when the patient was last screened for GBS or select a date using the calendar icon. ■ Result: Click a result in the drop-down list. The result can be Positive, Negative, or Present in urine. ■ Copy to Hospital: Select this check box if the results should be sent to the hospital.
Edinburgh Postnatal Depression Scale	■ Score: Click the  button (next to the Score field) to open the Edinburgh Postnatal Depression Scale calculator. Click the check boxes to record the patient's answers to the questions, and then click Save (). The EMR displays the patient's score in the Score field. ■ DMY: Enter the date the patient answered the questions, or select a date using the calendar icon. ■ Follow-up: Select the Yes or No check box to indicate if a follow-up is required.
Potential or Actual Concerns area	Enter any potential or actual concerns for various aspects of the patient's life into these fields. Each aspect has its own text box: Lifestyle , Pregnancy , Labour , Breastfeeding , Postpartum , and Newborn .
Second and Third Trimester Topics Discussed area	Select the check boxes of any topics discussed for the second and third trimester.

Field	Description
Other Investigations & Comments	■ 1st US: Enter the 1st Ultrasound date. ■ GA by US: Enter the Gestational Age by Ultrasound in weeks and days ■ If maternal prenatal screen above cut off, amnio: If the prenatal screening results were above the cut off limits, select Yes or No check box to indicate if amniocentesis should be offered to the patient. ■ Comments: Enter any comments.

Calculating a patient's Prenatal Risk Score

To calculate a patient's prenatal risk score, you can use the Prenatal Risk Assessment Calculator on the **Risk Assessment** tab. You calculate the Prenatal Risk Score by selecting check boxes regarding Past Obstetrical History, Problems in Current Pregnancy, Medical History, and Other Risk Factors.

You can use the patient's Prenatal Risk Assessment to assist in counseling, scheduling of prenatal visits, and in management decisions (for example, diagnostic tests and specialist referrals).

To calculate a patient's Prenatal Risk Score:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record"](#) on page 318.

2. Click the **Risk Assessment** tab. The EMR displays the Risk Assessment tab.

Part 1	Part 2	Part 2 - Visits	Delivery	Risk Assessment
Past Obstetrical History ☒ Abortion (12 – 20 weeks) ☐ Cesarean birth (uterine surgery) ☐ Habitual abortion (3+) ☒ Hypertensive disorders of pregnancy ☐ IUGR baby ☐ Macrosomic baby ☐ Major congenital anomalies (e.g. Cardiac, CNS, Down Syndrome) ☐ Neonatal death ☒ Placental abruption ☐ Postpartum hemorrhage ☐ Preterm birth (< 37 weeks) ☐ Rh isoimmunization (affected infant) ☐ Rh isoimmunization (unaffected infant) ☐ Stillbirth Problems In Current Pregnancy ☐ Abnormal maternal serum screening (HCG or AFP > 2.0 MOM) ☒ Alcohol and / or drugs ☐ Anemia (< 100 g per L) ☐ Antepartum bleeding ☒ Blood antibodies (Rh, Anti C, Anti K etc.) ☐ Breasts – no change in size, inverted nipple(s) ☐ Decreased fetal movement ☒ Depression ☐ Diagnosis of large for dates ☐ Diagnosis of small for dates (IUGR) ☒ Gestational diabetes ☐ Hypertensive disorders of pregnancy ☐ Malpresentation ☒ Membranes rupture before 37 weeks ☐ Multiple pregnancy ☐ Polyhydramnios or oligohydramnios ☐ Poor weight gain 26 – 36 weeks (< .5 kg / wk or weight loss) ☐ Pregnancy > 42 weeks ☐ Preterm labour ☐ Proteinuria 1+ or greater ☐ Smoking any time during pregnancy Medical History Diabetes ☐ Controlled by diet only ☐ Insulin dependent ☒ Retinopathy documented Heart Disease ☒ Asymptomatic (no effect on daily living) ☐ Symptomatic (affects daily living) Hypertension ☐ 140 / 90 or greater ☒ Anti-hypertensive drugs ☐ Chronic renal disease Obesity (BMI > 30) ☒ Medical complications eg. diabetes, hypertension, cardiac, pulmonary disease, obstructive sleep apnea ☐ Venous thromboembolism risks ☐ Anesthetic risks Other ☐ Age under 18 at delivery ☐ Age 35 or over at delivery ☐ Alcohol and / or drugs ☐ BMI less than 18.5 (Underweight) ☐ Depression ☐ Height (under 152 cm or 5 ft. 0 in.) ☐ Hx breastfeeding difficulties ☒ Smoking ☐ Other medical / surgical disorders eg. epilepsy, severe asthma, Lupus etc.				

3. Using the check boxes, answer the Prenatal Risk Assessment questions associated with each section. The following table provides an overview of each section.

Section	Description
Past Obstetrical History	Displays questions related to previous pregnancy outcomes.
Problems in Current Pregnancy	Displays questions related to the current pregnancy, for example, Substance Abuse, Depression, Bleeding, Antibodies, or Anemia.

Section	Description
Medical History	Displays questions relating to: ■ Diabetes ■ Heart Disease ■ Hypertension ■ Obesity ■ Other risk factors, for example age, alcohol, BMI, depression, height, history of breast feeding difficulties, smoking, and other medical and surgical disorders.

Recording prenatal visit notes

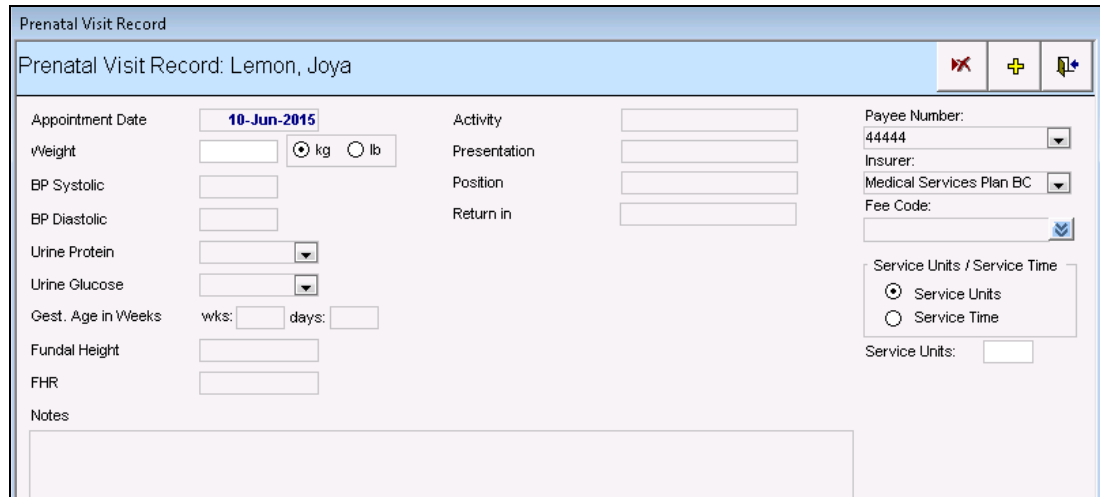
The **Part 2 - Visits** tab of the Prenatal Record lists all current Visit Records for a patient and allows you to enter a new Visit Record or to edit and delete existing ones. Use the **Part 2 - Visits** tab to record prenatal visit notes for each prenatal visit.

To record prenatal visit notes:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record" on page 318](#).
2. Click the **Part 2 - Visits** tab. The EMR displays the **Part 2** tab of the Prenatal record.

Part 1	Part 2	Part 2 - Visits	Delivery	Risk Assessment										
	Date	B.P. Sys. Dia.	Urine Prot. Gluc.	Wt.	Gest. Wks.	Fundus cms.	FHR	FM	Pres.	Pos.	Comments	Next Visit	+	
	10-Jun-2015													

3. To enter a Prenatal visit record for today, on the right side of the **Part 2 - Visits** tab, click **Add** . The EMR displays the Prenatal Visit Record window.



Prenatal Visit Record

Prenatal Visit Record: Lemon, Joya

Appointment Date: 10-Jun-2015

Weight: kg ☒ lb

BP Systolic:

BP Diastolic:

Urine Protein:

Urine Glucose:

Gest. Age in Weeks: wks: days:

Fundal Height:

FHR:

Notes:

Activity:

Presentation:

Position:

Return in:

Payee Number: 44444

Insurer: Medical Services Plan BC

Fee Code:

Service Units / Service Time

☒ Service Units

☐ Service Time

Service Units:



Note: If a patient's vitals were entered in the Vital Entry window by your front end staff, those vital entries are automatically populated in the Prenatal Visit Record window.

4. Enter information in the following fields to complete a Prenatal Visit Record:

- Appointment Date
- Weight (and select **Kg** or **Lbs** to indicate the units of weight)
- Urine Protein
- Urine glucose
- BP Systolic
- BP Diastolic
- Gestational Age in weeks and days
- Fundal Height
- F.H. (Fundus Height)
- FHR
- Activity
- Presentation
- Position
- Return in date
- Payee Number

- Insurer
- Fee Code
- Service Units / Service Time
- Notes

5. To close the Prenatal Visit Record, click **Save & Close** ().

Viewing a Fundus Height Growth chart

Fundal height is a measure of the size of the uterus and is used to assess fetal growth and development during pregnancy. It is measured from the top of the mother's uterus to the top of the mother's pubic bone in centimeters. Fundal height roughly corresponds to gestational age in weeks between 16 to 36 weeks for a vertex fetus. Most practitioners record their patient's fundal height on every prenatal visit. Measuring the fundal height can be an indicator of proper fetal growth and amniotic fluid development.

To view a Fundus Height Growth Chart:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record" on page 318](#).
2. Click the **Part 2 - Visits** tab. The EMR displays the **Part 2** tab of the Prenatal record.
3. On the bottom right corner of the **Part 2 - Visits** tab, click **SYMPHYSIS - FUNDUS HEIGHT GROWTH CHART**.

Linking documents to the Prenatal Record

You can link documents such as patient handouts or ultrasound images, to the Prenatal Record. Once linked, you can easily access these documents by clicking the appropriate link on the Prenatal Record.

When you link a document and choose **Prenatal Form** as the keyword, the document becomes available through the **Patient Handouts** link on the Prenatal Record.



Important:

Documents you link with the keyword **Prenatal Form** are available through the **Patient Handouts** link on the Prenatal Record **for all patients**. Make sure the document does not contain any patient-specific or other confidential information.

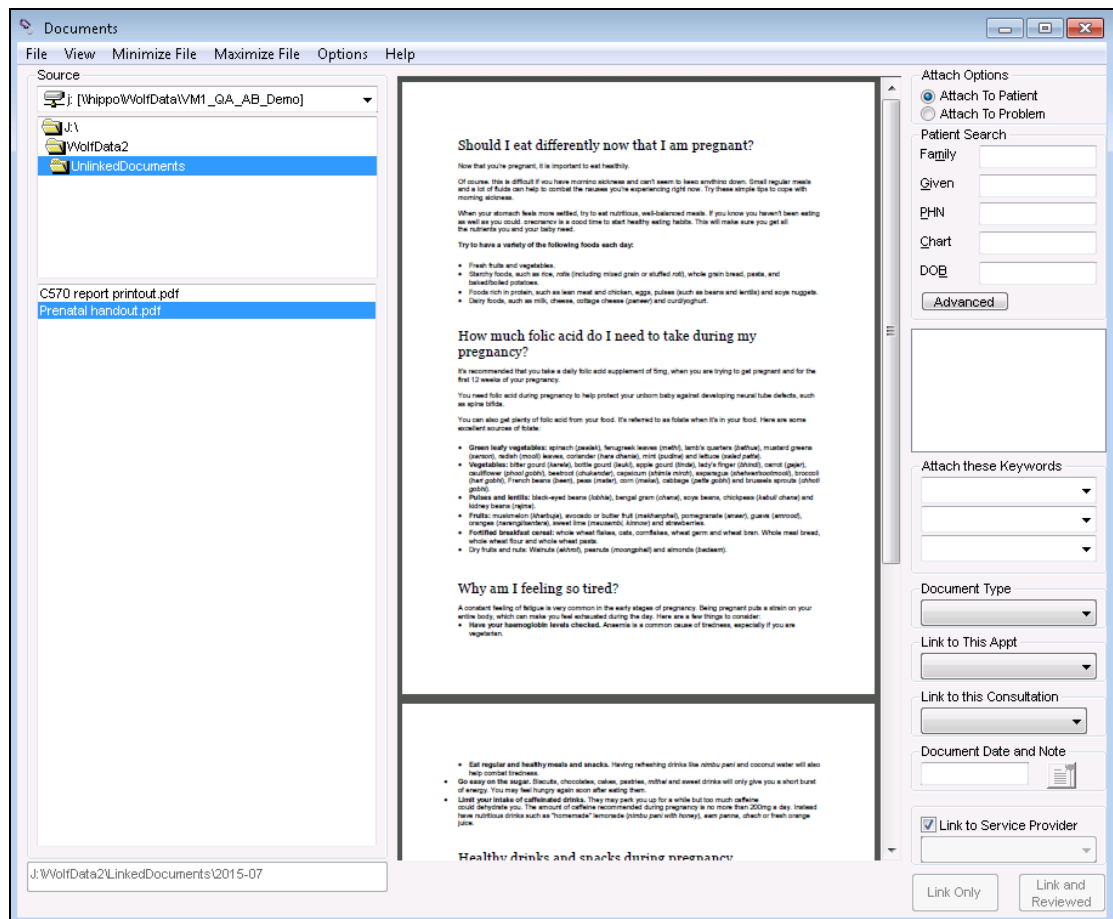
When you link a document to a patient, and choose **Prenatal US** as a keyword, the document becomes available through the **Ultrasound Images** link on the Prenatal Record. You can also view the document from the **Documents** tab on the Medical Summary.

Linking documents to the Prenatal Record as patient handouts

When you link a document and choose **Prenatal Form** as the keyword, the document becomes available through the **Patient Handouts** link on the Prenatal Record.

To link a document to the Prenatal Record as a patient handout:

1. On the Wolf EMR Launch page, click **Documents** . The EMR displays the Documents window.
2. In the **Source** pane, navigate to the location of the folder containing the handout. In most cases the location is: **Wolf Lair/Data/Unlinked documents**, however this can vary depending on your clinic.
3. In the left pane, click a document. The EMR displays a preview of the document.



4. In the **Attach Options** area, select **Attach to Patient**.
5. On the right hand side pane, in the **Patient Search** area, search for and select a test patient.

- In the **Attach these Keywords** drop-down list, click **Prenatal Form**.
You can select up to two other keywords to further describe the document.



Note: If the keyword **Prenatal Form** is not in the current list, then your administrator must enter this document keyword in Configuration.

- In the bottom right corner of the window, click **Link and Reviewed**.



Important:

Documents you link with the keyword **Prenatal Form** are available through the **Patient Handouts** link on the Prenatal Record **for all patients**. Make sure the document does not contain any patient-specific or other confidential information.

Linking documents to the Prenatal Record as ultrasound images

If your front end staff have not done so already, you can link a report/image from the **Documents** area of the patient's Medical Summary to the Prenatal Record. The document is then available through the **Ultrasound Images** link on the Prenatal Record.

To link an ultrasound report or image from a patient's documents to the Prenatal Record:

- Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#).
- Click the **Documents** tab. The EMR displays a list of the patient's documents, including any ultrasound reports/images.
- In the list of documents, click the ultrasound report you want to attach to the Prenatal Record.
- Click **View Document Properties**. The EMR displays the Document Properties window.
- In one of the **Keyword** drop-down lists, click **Prenatal US**.



Note: If the keyword **Prenatal US** is not in the current list, then your administrator can enter this document keyword in Configuration.

- Click **Save and Close** ().

Accessing documents linked to the Prenatal Record

Documents that are linked to the Prenatal Record appear as blue links on the Prenatal Record. Examples of document links include **Patient Handouts** or **Ultrasound Images**. Simply click the document link to access the document.

Accessing patient handouts linked to the Prenatal Record

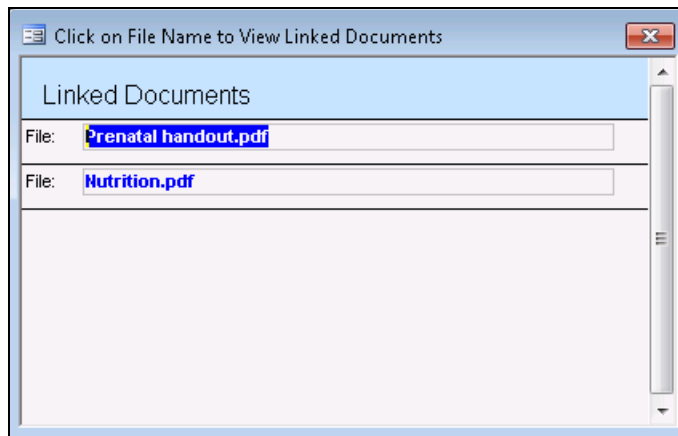
You can access linked patient handouts on the lower right side of the **Part 1** tab of the Prenatal Record; simply click the **Patient Handouts** link.

To Access a patient handout that is linked to the Prenatal Record:

1. Open the Prenatal Record for the patient. See ["Opening the Prenatal Record" on page 318.](#)
2. On the lower right side of the **Part 1** tab, click **Patient Handouts**.

Medical History		Lifestyle & social	
no	yes (specify)	Discussed	Concerns
☐ Surgery		☐ Diet	
☐ Anesthesia		☐ Folic acid	
☐ Uterine/Cx procedure		☐ Physical activity/ rest/stop work date	
☐ STIs / infections		☐ OTC drugs/ vitamins	
☐ Susceptible to chicken pox		☐ Alcohol ☐ never ☐ quit	
☐ Thromboembolic / coag.		Drinks/wk: before pregnancy	
☐ Hypertension		current	
☐ GI		Binge drinking ☐ no ☐ yes	
☐ Urinary		☐ TWEAK Score	
☐ Endocrine/diabetes		☐ Substance use ☐ no ☐ yes	
☐ Neurologic		☐ Heroin ☐ Cocaine ☐ Marijuana	
☐ Hx of mental illness		☐ Methadone ☐ Solvents ☐ Other	
☐ Anxiety ☐ Depression ☐ Bipolar		☐ Prescription ☐ Unknown	
☐ PP depression		☐ Smoking ☐ never ☐ quit	
☐ Other		Cig/day: Before Pregnancy	
		Exposure 2nd hand smoke ☐ no ☐ yes	
		Financial & housing	
		Support systems	
		IPV	
		Public Health Nursing follow-up / assessment	
		Draw Picture	Patient Handouts

If your clinic has more than one prenatal handout, the EMR displays the Linked Documents window.



3. In the list of documents, click the handout you want. The EMR opens the handout in the PDF-XChange Viewer.

4. To print the handout, click **Print** () or, on your keyboard, press **Ctrl + P**.

Accessing ultrasound images linked to Prenatal Records

You can access linked ultrasound images on the **Part 2** tab of the Prenatal Record; simply click the **Ultrasound Images** link.

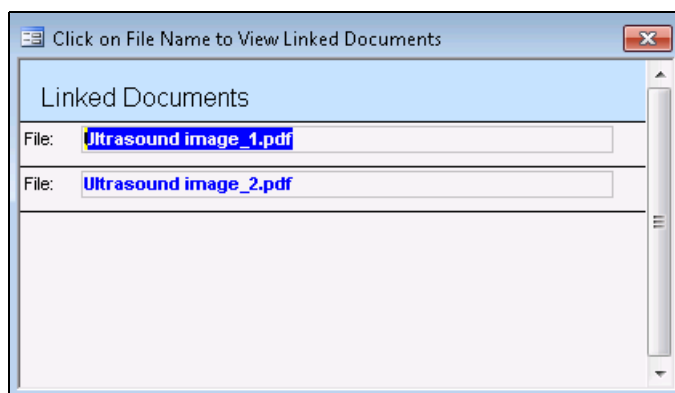
To access an ultrasound image that is linked to the Prenatal Record:

1. Open the patient's prenatal record. See ["Opening the Prenatal Record" on page 318](#).

2. Click the **Part 2** tab and then, in the **Other Investigations & Comments** area, click **Ultrasound Images**.

The screenshot shows a medical record form with several sections. The 'Other Investigations & Comments' section is at the bottom, containing fields for '1st US', 'GA by US', and 'wks: days:'. A red box highlights the 'Ultrasound Images' link. Above this section is a 'Second & Third Trimester Topics Discussed' section with various checkboxes. The top of the form includes sections for 'Hemoglobin', 'Urine C & S', 'Partner/household contact', 'NB vaccination indicated', 'Other tests (e.g. Hep C, Varicella)', 'Result', 'Copy to hospital', 'Edinburgh Postnatal Depression Scale (28-32 weeks)', 'Score', 'D M Y', and 'Follow-up'.

If your clinic has more than one prenatal handout, the EMR displays the Linked Documents window.



3. In the list of documents, click the ultrasounds you want. The EMR opens the ultrasound image in the PDF-XChange Viewer.
4. To print the handout, click **Print** () or, on your keyboard, press **Ctrl + P**.

Printing and faxing the prenatal record

When the prenatal record is to be sent to a hospital or consultant you can print or fax the record from Wolf EMR.

To print or fax a patient's prenatal record:

1. Open the patient's prenatal record. See ["Opening the Prenatal Record" on page 318](#).
2. At the top of the window, click one of the following options:

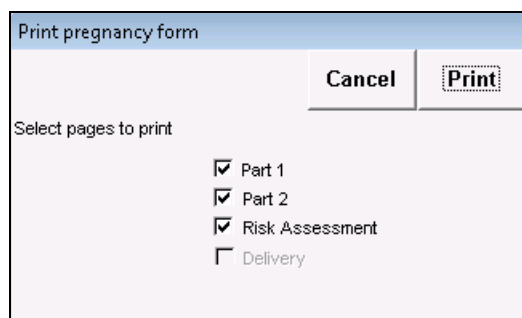
- **Collate and Print Prenatal Record** (

Attaching the prenatal record to a referral

Before you can attach the prenatal record to a referral, you must save the prenatal record as a document in the patient's Medical Summary. You can then attach the prenatal record to the referral as you do other documents.

To attach the prenatal record to a referral:

1. Open the patient's prenatal record. See ["Opening the Prenatal Record" on page 318](#).
2. At the top of the window, click **Attach Prenatal Form to patient's chart** (). The EMR displays the Print pregnancy form window.



Print pregnancy form

Cancel Print

Select pages to print

- ☒ Part 1
- ☒ Part 2
- ☒ Risk Assessment
- ☐ Delivery

3. Select the prenatal tabs you want to include in the attachment, and then click **Print**. The EMR saves the prenatal record in the patient's Medical Summary, in the **Documents** tab.

4. Attach the prenatal record to the referral as you do other documents. See [“Creating a referral letter using the Referral Letter Composer” on page 280](#) or [“Sending eReferrals” on page 304](#).

Entering delivery details and closing the prenatal record



Important: When the patient's pregnancy is complete, always note the delivery details and lock the prenatal record. The EMR then recognizes the patient as no longer pregnant. Also, if the patient has future pregnancies, the EMR will know to start a new prenatal record.

To note delivery details and close the prenatal record:

1. Open the patient's prenatal record. See [“Opening the Prenatal Record” on page 318](#).
2. Click the **Delivery** tab.

The screenshot shows the 'Delivery' tab in the EMR interface. The form contains the following fields:

- DELIVERY DATE:** A date input field.
- WEEKS AT DELIVERY:** Two input fields labeled 'wks:' and 'days:'.
- HRS. IN ACTIVE LABOUR:** A numeric input field.
- DELIVERY TYPE:** A drop-down menu.
- COMPLICATIONS:** A large text area for notes.
- SEX:** A drop-down menu.
- BIRTHWEIGHT:** A numeric input field.
- PRESENT HEALTH:** A text input field.

3. Use the following table to enter the delivery details:

Filed	Description
Delivery Date	Enter the delivery date or the date the pregnancy was terminated.
Weeks at Delivery	Enter the number of weeks and days for the gestational age of the newborn.
Hrs. in Active Labour	Enter the number of hours the patient was in labour.
Delivery Type	In the drop-down list, click the delivery type. Examples of delivery type options include Natural , Breech and C-section .
Complications	Enter any complications from the delivery.
Sex	In the drop-down list, click the sex of the newborn.
Birth Weight	Enter the weight of the newborn at birth.

Filed	Description
Present Health	Enter the present health of the patient.

4. To save and close the prenatal record, click ().

After you enter the delivery date, and close the Prenatal Record, the EMR locks the Prenatal Record.

Recording clinical notes for WCB visits

In this section, you learn how to use the various Wolf EMR features related to WCB visits. For WCB visits, you enter visit notes into the appropriate WCB forms. You can then submit the forms electronically to WCB through the Wolf EMR eBill program. Wolf EMR contains the following provincial WCB forms:

- Form 8: First Report
- Form 11: Progress Report
- You access and manage WCB forms from the WCB Report Manager.

WCB forms



- If your clinic is not on the data centre, use the WCB forms on the WorkSafeBC site <http://www.worksafebc.com/forms/>.
- Most forms are PDFs designed to be printed out and completed. Others can be completed and submitted online, and some are available as an online application. You can also order printed forms at [WorkSafeBC Store](#).
- For support and WCB-related questions, contact WorkSafeBC:
 - Phone: 604-276-3135, or toll-free: 1-888-855-2477
 - Email: ehelp@worksafebc.com

WCB report types and tabs

The WCB report types include **Form 8: First Report** and **Form 11: Progress Report**. Both report types contain the following tabs:

- Interview
- Clinical Information
- Return to Work Planning

- Billing Status

Printing forms

You can print a practitioner's copy for all of the WCB e-forms. You would use this option for a print chart request, a referral, or medical-legal reasons.

Opening the WCB Report Manager

The WCB Report Manager is where you access and manage WCB forms. From the WCB Report Manager, you can:

- Start a new WCB Report for a patient
- View, edit, and complete a patient's incomplete WCB Reports
- View a patient's historical WCB Reports

The method you use to open the WCB Report Manager depends on whether the patient is booked for an appointment or not.

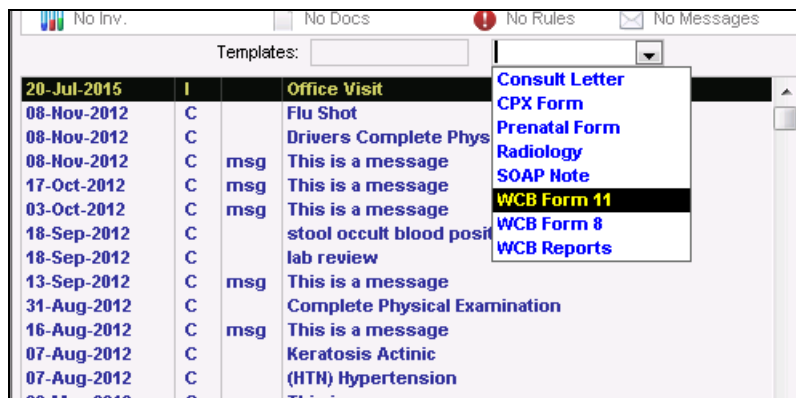
Opening the WCB Report Manager for a patient with a booked appointment

If a patient has a booked appointment, you can open the WCB Report Manager from your WorkDesk Appointments list. If a patient does not have an appointment booked, you can open the WCB Report Manager via the SMART menu.

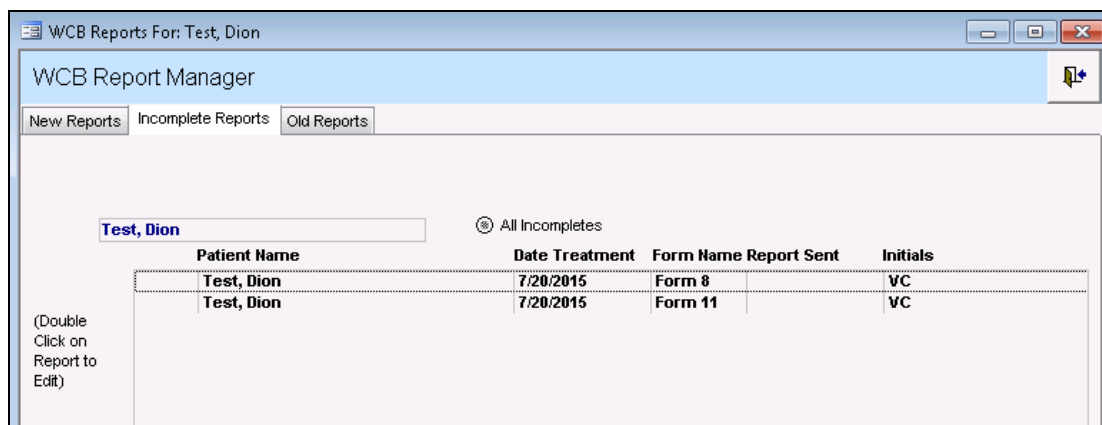
To open the WCB Report Manager for a patient:

1. On the WorkDesk, click the **Appointments** tab. The EMR displays a list of your appointments for today. See ["Viewing your schedule" on page 16](#).
2. In the **Appointments** list, click the patient's name. The EMR displays the **Patient** tab (CPP) with a list of the patient's previous and current office visits.
3. On the list of office visits, click the office visit you want to start or continue a WCB report for. (In most cases this will be the incomplete (I) visit listed at the top.)
4. In the drop-down list above the list of office visits, click one of the following options:
 - **WCB Form 11**: To start a Progress Report (form 11)
 - **WCB Form 8**: To start a First Report (form 8)

- **WCB Reports:** To finish a previously started WCB report.



The EMR displays the WCB Report Manager window.



Opening WCB Report Manager for patients without booked appointments

If a patient does not have an appointment booked, you can open the WCB Report Manager via the SMART menu.

To open the WCB Report Manager for a patient who does not have an appointment booked:

1. On any window related to the patient, (including the Medical Summary, SOAP form, Consult Letter Examination form, or CPP), right-click. The EMR displays the SMART menu.
2. On the SMART menu, click **View WCB Reports**. The EMR displays the WCB Report Manager window.

Starting and completing WCB First Reports

Complete a WCB First Report for the first visit associated with a claim involving a comprehensive consultation, a time loss claim, or a modified duty claim.

To start and complete a WCB First Report:

1. Open the WCB Report Manager for the patient. See [“Opening the WCB Report Manager” on page 343](#).
2. Click the **New Reports** tab. The EMR displays the **New Reports** tab with:
 - A list of WCB Reports to choose from.
 - A list of the patient's recent appointments. (You can associate a WCB Report with a specific appointment).
3. In the **Select Report** area, select **Form 8: First Report**

WCB Reports For: Test, Dion

WCB Report Manager

New Reports | Incomplete Reports | Old Reports

Current Patient: **Test, Dion**

Select Report:

☒ Form 8: First Report
☐ Form 11: Progress Report

Select Appointment:

Appt Date	Reason	Provider
20-Jul-2015	Office Visit	Veta C, M.D.
20-Jul-2015	WCB	Veta C, M.D.
04-Nov-2010	Flu shot FREE	Ethan M,
	Service not in Clinic	

New Report 8

4. In the **Select Appointment** area, perform one of the following actions:
 - If the patient was seen in clinic, click the associated appointment.
 - If the patient was not seen at your clinic (for example, if the patient was visited in the hospital), scroll to the bottom of the appointment list and select **Service Not in Clinic**, and then in the **Select Physician** drop-down list, select a physician.

5. Click **New Report 8**. The EMR displays the WCB First Report form with the **Interview** tab open.

WCB Electronic Forms

Test, Dion PHN: 9999 999 999

WCB Rpt Manager Re-Submit Quick Print

Born: 22-May-1976 (39) Sex: M Status: N/A

123 Test Court, West Vancouver BC L7B 5E8 H (111) 111-1111 C (222) 222-2222 Pri: Veta Coles, M.D.

Interview Clinical Information Return to Work Planning Billing Status

☒ Physicians First Report ☐ Worker's condition of treatment has changed: please describe in Clinical Information Area

WCB Claim Number: [] * Date of Service: 20-Jul-2015

* Date of Injury: []

Employer's Information:

* Employer Name: []

* Address: []

* City: []

* Postal Code: []

* Telephone: []

Inactive

Employee Information:

* Name: Test Dion

* Gender: M * Date of Birth: 22-May-1976

* PHN: 9999999999

* Address: 123 Test Court

* City: West Vancouver

* Province: BC

* Postal Code: L7B 5E8

* Home Telephone: 111 111-1111

* Are you the worker's regular physician? ☐ * How long has the worker been your patient?

☒ 0-6 Months ☒ 7-12 Months ☒ >12 Months

* Who rendered first treatment?: []

E-Form Fee: 19937 Service Location: [] Service Time Start: []

Visit Fee: 100 Service Time End: [] Call Time: []

6. If you selected (in the **Select Appointment** area) an appointment that has SOAP information, the EMR displays a prompt asking if you want to use the exam data to create a new WCB encounter record. Click **Yes**. The window now has a **Copy from existing exam** tab which displays the SOAP information.

- The window now has a **Visit Record Data** tab which displays the SOAP information.

WCB Electronic Forms

Test, Dion PHN 9999 999 999

WCB Rpt Manager Re-Submit Quick Print

Born 22-May-1976 (39) Sex M Status N/A

123 Test Court, West Vancouver BC L7B 5E8 H (111) 111-1111 C (222) 222-2222 Pri Veta Coles, M.D.

WV

Interview Clinical Information Return to Work Planning Billing Status **Copy from existing exam**

Subjective:
Patient complains of fatigue, nausea

System Review:
NECK:
Patient complains of stiffness, pain

Plan items changed today -----

Medications:
No Medication Changes.



Tip: The information on the **Copy from existing exam** tab does not get sent to Billing.

To get this information into the WCB form(s):

- Select text on the **Copy from existing exam** tab, press **Control + C**, then move to the appropriate tab of the WCB form, and paste the text (**Control + V**) into the appropriate field.



Note: The original SOAP encounter is not deleted automatically. You have the option to keep it or delete it.

7. Enter information on the **Interview** tab. Use the following table as a reference.

Field	Description
Report Type check boxes	■ Physicians First Report: Select this check box if you are creating a new WCB First Report (form 8). This form should be completed for first visits involving a comprehensive consultation, a time loss claim, or a modified duty claim. ■ Worker's condition of treatment has changed: please describe in Clinical Information Area: Select this check box if you are creating a WCB Progress Report (Form 11). This report should be submitted if the worker's condition or treatment has changed since last report or if the worker is ready for Return to Work. A report is not necessary or desired if the worker's condition is stable and there will be a planned follow up at an appropriate future date. A report is also not necessary if the worker is enrolled in a WorkSafeBC sponsored rehabilitation program. Payment of benefits to a worker is not contingent on follow-up every two weeks if the above conditions are met.
WCB Claim Number	Enter the WCB Claim Number if known. This claim number is provided by WCB after a First Report has been processed. Note: The WCB Claim number is mandatory when creating a Progress Report.
Date of Injury	Enter the date when the WorkSafeBC related injury occurred. In the case of occupational diseases, enter the date when medical attention was first sought. You can type the date into the text box or click the Calendar button and double-click the date.
Date of Service	The date of service is the date when the service described on this report was performed. It is automatically entered here depending on the appointment the WCB Report was linked to when first creating the report.

Field	Description
Employer's Information	To select a previously entered global employer (an employer entered for any patient in the EMR): - Click the binoculars icon () . The EMR displays a list of previously entered employers. - Click an employer in the list. To enter a new employer: - Click the binoculars icon () , and then click <<Add New>>. - Enter the following Employer Information: ■ Employer Name: Enter the employers name or company name. This name is then available from the employer drop-down list for future use. ■ Address: Enter the address of the employer. ■ City: Click the drop-down arrow to select a city or type in the name of a city. ■ Postal Code: Enter the postal code. ■ Telephone: Enter the area code in the first box and the local telephone number in the second box. To set an employer as inactive if the employer is not the current employer: - Click Inactive. The EMR displays the following message "Do you wish to set the current employer as inactive and enter a new employer for this patient?" - Click Yes. The EMR clears the employer information fields. - Enter the new employer information.
Employee information	Employee information pre-populated from the information in Patient Maintenance, although you can also edit it here. The worker's first name, last name, and PHN should match the information on the worker's British Columbia CareCard.
Are you the worker's regular physician?	If you are the patient's regular practitioner, select this check box. WorkSafeBC may contact you for medical history or to discuss claims issues.

Field	Description
How long has the worker been your patient?	If you selected the Are you the worker's regular physician? check box, select one of the radio buttons to indicate how long you have been the patient's Physician (0-6 months, 7-12 months, or > 12 months). This information is useful for claims information.
Who rendered first treatment?	Enter the medical practitioner (name) or facility (emergency department, clinic, hospital, and so on) who provided the first treatment. This does not include first aid at the work site.
E-Form Fee	Click the drop-down arrow and select the E-Form Fee to display in Billing for this WCB report.
Visit Fee	Click the drop-down arrow and select the Visit Fee to display in Billing for this WCB report.
Service Time Start	Enter the service start time using the 24 hour clock (for example, 1600).
Service Time End	Enter the service end time using the 24 hour clock (for example, 1800).
Call Time	Enter the call time using the 24 hour clock (for example, 1500).

8. Click the **Clinical Information** tab and then enter information in the fields. Use the following table as a reference.

Field	Description
*Prior/Other Problems Affecting Injury, Recovery and Disability (160 char max)	Enter details about pre-existing or new non-occupational conditions that may affect injury, recovery or disability. You can enter a maximum of 160 characters. If insufficient space, add remaining information to the Clinical Information box (at the bottom of the window). For example an MVA while receiving care for WorkSafeBC claim.
ICD9 (x) Search	Enter an ICD9 code or keyword and press Enter , and then in the drop-down list, click a code. This is the ICD9 diagnosis code and is entered on the invoice (claim record). The full set of codes is available at health.gov.bc.ca/msp/infoprac/diagcodes/index.html .
*Diagnosis	Enter a text description of the injury diagnosis. Note: The Diagnosis entered here will be displayed in a second encounter entry to display the diagnosis in the patient's list of Encounter Records found on the Medical Summary as well as other locations.

Field	Description
Primary Injury Codes and Diagnosis area	Enter the following information to describe the injury codes and diagnosis: ■ *Position: In the drop-down list, click the position. This is a code for the anatomical position code (side) of the injury from the WorkSafeBC subset of CSA codes (80/80 list). ■ *Body Part: Enter a body part or its code and then press Enter. In the drop-down list, click one of the results displayed. Note: This is a 5-character (numeric) code for the area of injury (body part) from the WorkSafeBC subset of CSA codes (80/80 list). The full set of codes is available at worksafebc.com/health_care_providers/Assets/PDF/body_parts_complete.pdf ■ *Nature: Enter the nature of the injury or its code and then press Enter. In the drop-down list, click one of the results displayed. Note: This is the 5-character (numeric) code for the nature of injury from the WorkSafeBC subset of CSA codes (80/80 list). The full set of codes is available at worksafebc.com/health_care_providers/Assets/PDF/nature_injury_complete.pdf
*From injury or since last report, has the worker been disabled from work?	If the worker has been disabled from work since the injury or the last report, click Yes in the drop-down list. Otherwise, click No .
Date of Injury	Enter the date of injury or click the Calendar button and double-click the date.
As of what date? (if known)	Enter the date the injury was known or click the Calendar button and double-click the date. Note: This field is displayed only if you selected Yes for *From injury or since last report, has the worker been disabled from work?

Field	Description
Clinical Information	This is a text field for the practitioner to describe the worker's current situation in the usual fashion clinical notes are constructed. The following information might be included: ■ What happened ■ Presented injury, disease, complaints, and so on ■ Treatments and medications being used ■ Subjective symptoms ■ Examination finding ■ The name and date of specialist referral, if appropriate.

9. Click the **Return to Work Planning** tab and then enter information in the fields. Use the following table as a reference.



Note: Return-to-work planning is an important reporting component of Form 8 and Form 11. The information the practitioner provides, along with practitioner participation in the return-to work consultation process assists WorkSafeBC in handling each Worker's claim efficiently and appropriately.

Field	Description
*Is the Worker now medically capable of working full duties, full time?	In the drop-down list, click either Yes or No to indicate if the Worker can return to their normal pre-injury duties. If you click No, elaborate in the "restrictions" area below
*What are the current physical and/or psychological restrictions?	Describe the physical and/or psychological restrictions related to the injury that are barriers to the patient returning to work. This information will be used by the WorkSafeBC case managers and medical advisors in working with employers to find suitable alternative/modified work.

Field	Description
*Estimated time before the worker can return to the workplace in Any Capacity	Estimate the length of time before the worker can return to the workplace in any capacity. For example, the earliest possible return to the workplace if suitable duties were available. Select one of the following options: ■ At Work ■ 1-6 Days ■ 7-13 Days ■ 14-20 Days ■ > 20 Days
*If appropriate, is the worker now ready for a rehabilitation program?	In the drop-down list, click No if the worker is not ready for rehabilitation or if a rehabilitation program is not appropriate. If the worker is ready for rehabilitation, click Yes, and then select the type of rehabilitation program in the additional area that the EMR displays (Select Rehabilitation Program).
Select Rehabilitation Program	If the worker is ready for a rehabilitation program, select Work Conditioning or Other. If you select Other, indicate the type of program (for example, occupational rehabilitation program, pain program) in the Clinical Information area on the Clinical Information tab.
*Do you wish to consult with WCB Physician or nurse or advisor?	In the drop-down list, click Yes or No to indicate if you want to consult with a WCB physician, nurse, or advisor.
If possible, please estimate date of Maximal Recovery	Maximal medical recovery (full recovery or best possible recovery) date. This is sometimes also called date of "maximal medical improvement". It refers to the date at which no further improvement in condition is expected. At that time the worker may still have significant impairment/disability or may be fully recovered. It is recognized that the "date" indicated is an estimate only and may change if the clinical course changes. Enter the date of Maximal Recovery or click the Calendar button and double-click the date.
Further Correspondence to Follow?	In the drop-down list, click Yes or No to indicate whether or not additional correspondence can be anticipated.

Field	Description
Attending Physician	Displays the attending physician for the patient.
*Payee Number	Enter the payee number issued by MSP that uniquely identifies the individual or organization who submits the associated invoice to WorkSafeBC and who will be paid by WorkSafeBC.
Created by (Read-only)	Displays who created the report (or the practitioner for whom you created the report).
Date and Time Created (Read-only)	Displays the date and time the report was created.
Last Edited (Read-only)	Displays when the report was last edited.
Last Edited By (Read-only)	Displays who edited the report (or the practitioner for whom you edited the report)

10. **(Optional)** Click the **Billing Status** tab to view the billing status of the WCB Form.

11. When you finish entering information on all of the tabs, click .

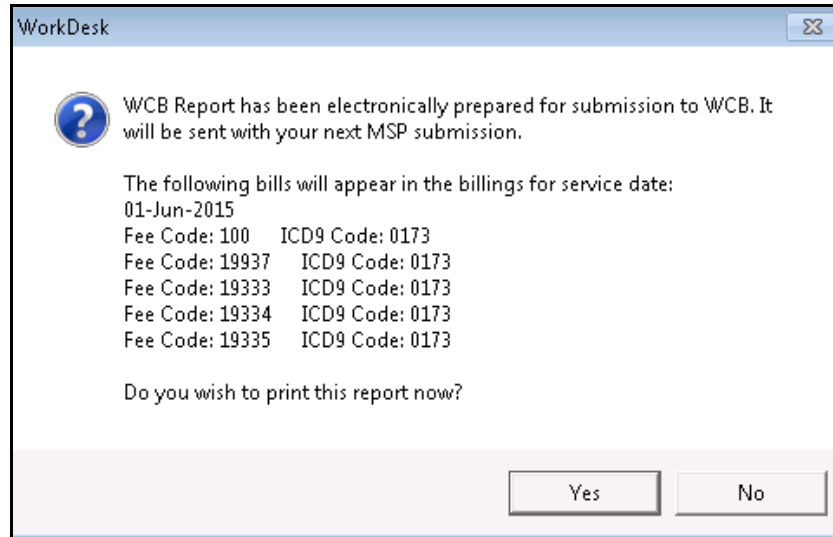


Note: If the **Set Appointment as Finished** check box is displayed, the EMR marks the encounter as finished. If you do not want this to happen, clear this check box (it is selected by default).

The EMR displays a prompt asking you if you want to send the WCB Report to the billing program.

12. Perform one of the following actions:

- If the report information is complete, click **Yes**. The EMR sends the report to the Billing program, and creates and saves 5 bills: 1 office visit, 1 form, and 3 no charge fees. The EMR displays the following prompt:



Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report.

- If the report information is not complete, click **No**. The EMR saves the form for further modification.

The EMR displays the WCB Report twice in the encounter record, to indicate that it is a WCB Report as well as to display the Diagnosis. (This is similar to how the EMR displays a SOAP record several times in the Encounter List to display several impressions or assessments.)

Starting and completing WCB Progress Reports

You can create WCB Progress Reports after you create and submit a new WCB First Report. Create a WCB Progress Report only for completed follow-up visits where relevant changes have occurred since the previous report. You must submit a WCB Progress Report if it has been more than four weeks since the last Form 11 was sent, or a Form 11 is requested by a WorkSafeBC Officer.

When you create a WCB Progress Report, you pull in information from the previous claim and then you update the information as necessary.

To start and complete a WCB Progress Report:

1. Open the WCB Report Manager for the patient. See [“Opening the WCB Report Manager” on page 343](#).
2. Click the **New Reports** tab. The EMR displays the **New Reports** tab.

3. In the Select Report area, select **Form 11: Progress Report**.
4. In the **Select Claim** section, click the claim that you want to update.
5. In the **Select Appointment area**, perform one of the following actions:
 - If the patient was seen in clinic, click the associated appointment.
 - If the patient was not seen at your clinic (for example, if the patient was visited in the hospital), scroll to the bottom of the appointment list and select **Service Not in Clinic**, and then in the **Select Physician** drop-down list, select a physician.
6. Click **New Report 11**. The EMR displays the WCB Progress Report form.
7. If you selected (in the **Select Appointment** area) an appointment that has SOAP information, the EMR displays a prompt asking you if you want to use the exam data to create a new WCB encounter record. Click **Yes**. The window now has a **Copy from existing exam** tab which displays the SOAP information.



Tip: The information on the **Copy form existing exam** tab does not get sent to Billing.

To get this information into the WCB form(s):

- Select text on the **Copy form existing exam** tab, press **Control + C**, then move to the appropriate tab of the WCB form, and paste the text (**Control + V**) into the appropriate field.



Note: The original SOAP encounter does not get automatically deleted. You have the option to keep it or delete it.

8. Click the tabs as required and update the information in the form. See [Step 7](#) to [Step 9](#) in “Starting and completing WCB First Reports” on page 344.



9. When you finish updating information on the tabs, click

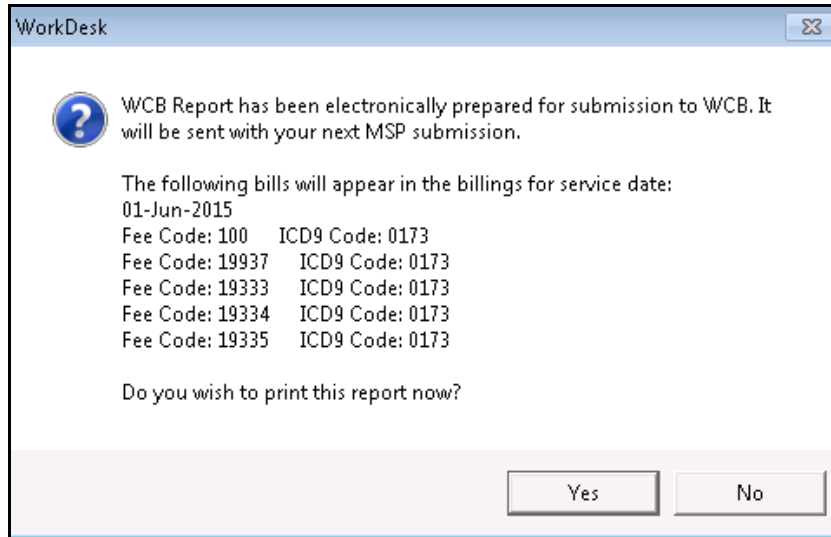


Note: If the **Set Appointment as Finished** check box is displayed, the EMR marks the encounter as finished. If you do not want this to happen, clear this check box (it is selected by default).

The EMR displays a prompt asking you if you want to send the WCB Report to the billing program.

10. Perform one of the following actions:

- If the report information is complete, click **Yes**. The EMR sends the report to the Billing program, and creates and saves 5 bills: 1 office visit, 1 form, and 3 no charge fees. The EMR displays the following prompt:



Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report.

- If the report information is not complete, click **No**. The EMR saves the form for further modification.

Completing regular SOAP visit notes at the same time as WCB reports

If, while a patient is in for a WCB visit, you complete an examination for another problem, you can bill both Alberta Health (for the non-WCB problem), and WCB. For this case, you enter visit notes in both a SOAP Form, and a WCB form. In creating both a SOAP visit note and a WCB note, two separate entries appear in the billing area. You can then easily bill both Alberta Health and WCB.



Tip: Create the WCB Report first. This way the first bill defaults to WCB eSubmission.

If you create the SOAP note first, both bills default to Alberta Health. You or your billing clerk then have to remember to manually change the WCB visit to WCB eSubmission in the billing area.

To create a SOAP visit note at the same time as a WCB visit note:

1. Open and fill out the appropriate WCB form without marking it as complete. See [“Starting and completing WCB First Reports” on page 344](#) or [“Starting and completing WCB Progress Reports” on page 355](#).

2. On the WorkDesk, click the **Appointments** tab. The EMR displays a list of your appointments for today.



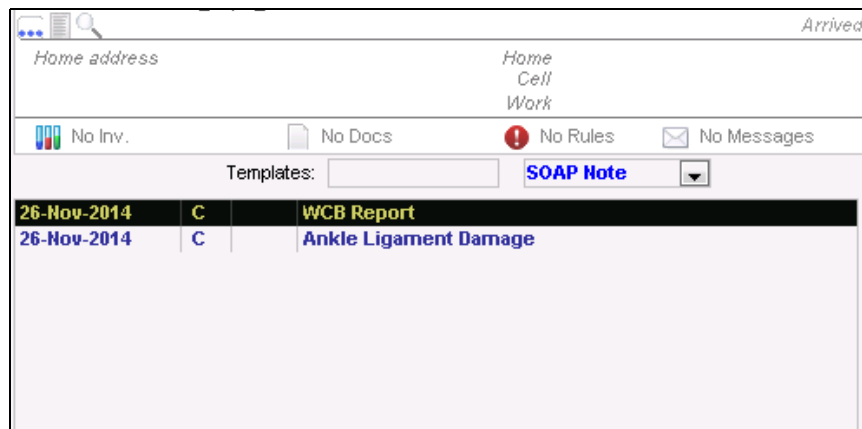
Note: To learn more on how to navigate your Appointments list, to add a patient to your Appointments list, or to view other providers' Appointments lists, see [“Starting SOAP notes for patients without booked appointments” on page 121.](#)

3. In the **Appointments** list, click the patient's name. The EMR displays the patient in the **Patient** tab (CPP), with a summary of the patient's previous and current office visits.
4. On the list of office visits, click the current WCB office visit.
5. In the **Templates** drop-down list, click **SOAP Note**. The EMR displays the SOAP Form.
6. Complete the SOAP Form for the non-WCB problem and examination.
7. In the **Assessment** area on the SOAP form, select an appropriate diagnosis. See [Step 6 on “Entering visit notes in the SOAP form” on page 139.](#)
8. Click **Add to Assessment**. The EMR displays the diagnosis in the **Structured** field of the **Assessment** area.



Note: You must add a Structured Assessment to the SOAP Note to create a second patient encounter. You can then bill for both the WCB visit and the non-WCB examination.

9. Click **Save & Close** () to save and close your SOAP visit note. The EMR displays a dialog box with the following prompt: “Sign and Lock Record?”
10. Click **Yes**. In the **Patient** tab (CPP) of the WorkDesk, the EMR adds a second visit note for the same date as the WCB visit.



Home address		
Home Cell Work		
No Inv.	No Docs	No Rules
No Messages		
Templates:		SOAP Note
26-Nov-2014	C	WCB Report
26-Nov-2014	C	Ankle Ligament Damage

Finishing incomplete WCB Reports for individual patients

Reports that have been created but not Sent to Billing are listed on the **Incomplete Reports** tab of the WCB Report Manager. You can modify or complete an incomplete report and then send it to Billing.

To finish an incomplete WCB Report for an individual patient:

1. Open the WCB Report Manager for the patient. See [“Opening the WCB Report Manager” on page 343](#).
2. Click the **Incomplete Reports** tab. The EMR displays the **Incomplete Reports** tab.

WCB Reports For: Test, Dion

WCB Report Manager

New Reports Incomplete Reports Old Reports

Test, Dion

All Incompletes

Patient Name	Date Treatment	Form Name	Report Sent	Initials
Test, Dion	7/20/2015	Form 8		VC
Test, Dion	7/20/2015	Form 11		VC

(Double Click on Report to Edit)

Close and Save

3. To open a report for editing, double-click the report.
4. Click the tabs as required and update the information in the form. See [Step 7](#) to [Step 9](#) in [“Starting and completing WCB First Reports” on page 344](#).
5. When you finish entering information on the tabs, click **Close and Save** (.

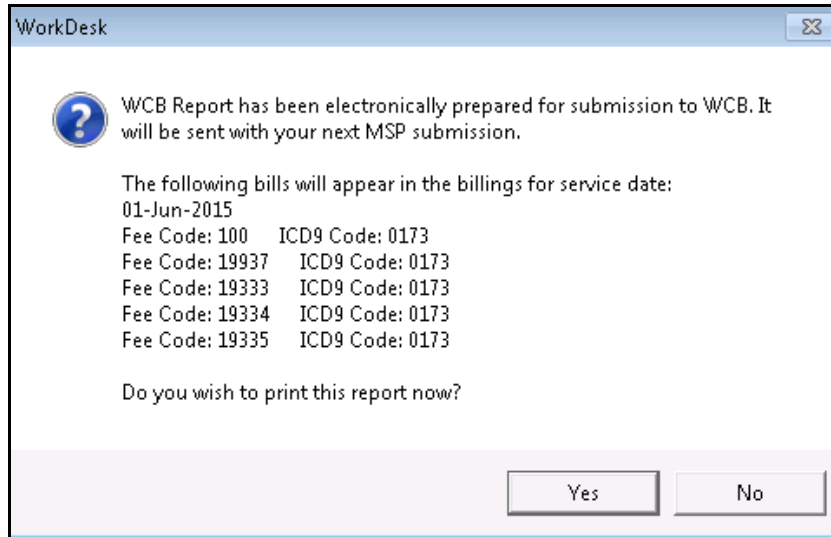


Note: If the **Set Appointment as Finished** check box is displayed, the EMR marks the encounter as finished. If you do not want this to happen, clear this check box (it is selected by default).

The EMR displays a prompt asking you if you want to send the WCB Report to the billing program.

6. Perform one of the following actions:

- If the report information is complete, click **Yes**. The EMR sends the report to the Billing program, and creates and saves 5 bills: 1 office visit, 1 form, and 3 no charge fees. The EMR displays the following prompt:



Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report.

- If the report information is not complete, click **No**. The EMR saves the form for further modification.

Tracking and managing incomplete WCB Reports for all patients

You can track and manage incomplete WCB reports for every patient in your clinic from one convenient location on your WorkDesk.

To track and manage incomplete WCB Reports clinic-wide:

1. In the WorkDesk **Tasks** tab, in the **Patient Records** area, click **# Incomplete WCB Report(s)** (where **#** = the number of your incomplete WCB Reports). The EMR displays the WCB Report Manager window with the **Incomplete Reports** tab open. The **Incomplete Reports** tab lists all of your incomplete WCB reports for all of your patients.



Tip: If you want to see a list of incomplete WCB reports associated with another practitioner, select their name from the **Physician** drop-down list.

2. Double-click a report to open it for editing.
3. Click the tabs as required and update the information in the form. See [Step 7](#) to [Step 9](#) in "Starting and completing WCB First Reports" on page 344.

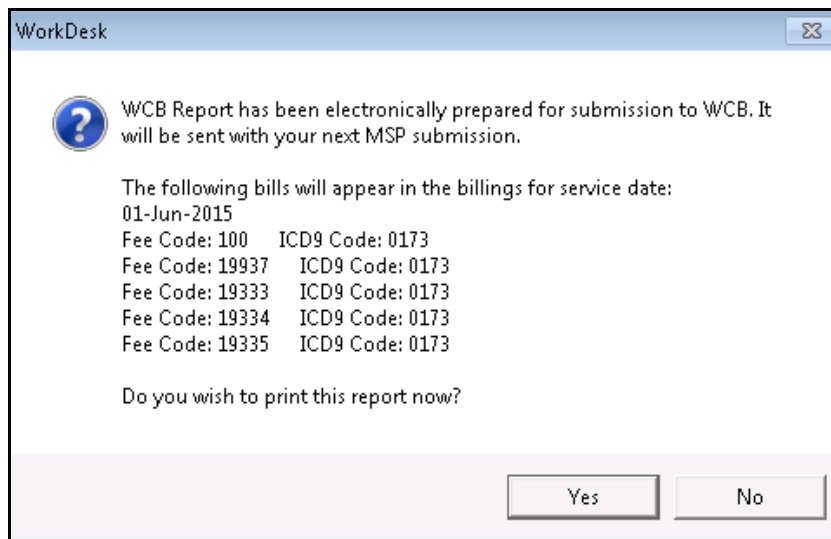
4. When you finish entering information on the tabs, click **Close and Save** ()



Note: If the **Set Appointment as Finished** check box is displayed, the EMR marks the encounter as finished. If you do not want this to happen, clear this check box (it is selected by default).

The EMR displays a prompt asking you if you want to send the WCB Report to the billing program.

5. Perform one of the following actions:
- If the report information is complete, click **Yes**. The EMR sends the report to the Billing program, and creates and saves 5 bills: 1 office visit, 1 form, and 3 no charge fees. The EMR displays the following prompt:



Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report.

- If the report information is not complete, click **No**. The EMR saves the form for further modification.

Viewing previously billed (old) WCB reports

You can view old WCB reports for an individual patient or for all of your patients.

Viewing previously billed (old) WCB reports for individual patients

To view previously billed (old) WCB reports for an individual patient:

1. Open the WCB Report Manager for the patient. See [“Opening the WCB Report Manager” on page 343](#).

2. Click the **Old Reports** tab, and then in the **Previous Reports** area, double-click a report to view the details.

3. Click **Save and Close** () to close the window.

Viewing previously billed (old) WCB reports for all of your patients

To view previously billed (old) WCB reports for all of your patients:

1. In the WorkDesk **Tasks** tab, in the **Patient Records** area, click **# Incomplete WCB Report(s)** (where # = the number of your incomplete WCB Reports). The EMR displays the **Incomplete Reports** tab of the WCB Report Manager window.



Tip: You can still click **# Incomplete WCB Report(s)** even if it displays as **No Incomplete WCB Reports**.

2. Click the **Old Reports** tab, and then in the **Previous Reports** area, double-click a report to view the details.

3. Click **Save and Close** () to close the window.

Recording clinical notes for pediatric patients

The following sections describe how to record clinical notes for pediatric patients.

Entering patient birth information

You can enter a patient's birth information on the **Other Demographics** tab in the Patient Maintenance window. Birth information includes the patient's place of birth, gestational age, and birth measurements.

To enter a patient's birth information:

1. On any window related to the patient (including a patient's Medical Summary, SOAP form, Consult Letter Examination form, or CPP), in the SMART patient banner, click **Patient**

Maintenance (.

2. On the Patient Maintenance window, click the **Other Demographics** tab.

3. Using the following table, enter information in the **Birth Information** area.

The screenshot shows a patient form for 'Test, Jodi'. The 'Birth Information' section is highlighted with a red box. It contains the following fields:

- City: [Dropdown menu]
- Province: [Dropdown menu, currently showing '<None>']
- Gestational Age: [Text input] weeks
- Birth Length: [Text input] [Dropdown menu, currently showing 'cm']
- Birth Weight: [Text input] [Dropdown menu, currently showing 'kg']
- Birth Head Circumference: [Text input] [Dropdown menu, currently showing 'cm']
- Discharge Weight: [Text input] [Dropdown menu, currently showing 'kg']

Other sections visible include:

- Lab Results**: Appointments, ** Patient Search **
- Documents**: Billing, Name/Addr/Phone
- Other Demographics**: Ethnicity, Ethnic Origin, Language, Preferred Language, Provincial Payment Coverage, Coverage End Date, Coverage Last Checked, Patient Portal (Status: Inactive, Last Login), Internal Data (Current Patient ID: 12326, InsertDate: 29/Apr/2008), Merge Patient, Unmerge Patient.
- Employment**: Display with Patient Name (Before, After), Employment, Employer, Occupation.
- Next of Kin / Contact**: Name, Phone, Notes.

Field	Description
City	In the drop-down list, click the Municipality or City where the patient was born.
Province	In the drop-down list, click the Province or State where the patient was born.
Gestational Age	Enter the patient's gestational age at birth (in weeks).
Birth Length	Enter the patient's birth length and then, in the drop-down list, select the units.
Birth Weight	Enter the patient's birth weight and then, in the drop-down list, select the units.
Birth Head Circumference	Enter the head circumference and then, in the drop-down list, select the units.
Discharge Weight	Enter the weight and then, in the drop-down list, select the units.

4. Click **Save** () , and then click **Exit**.

Viewing patient growth charts

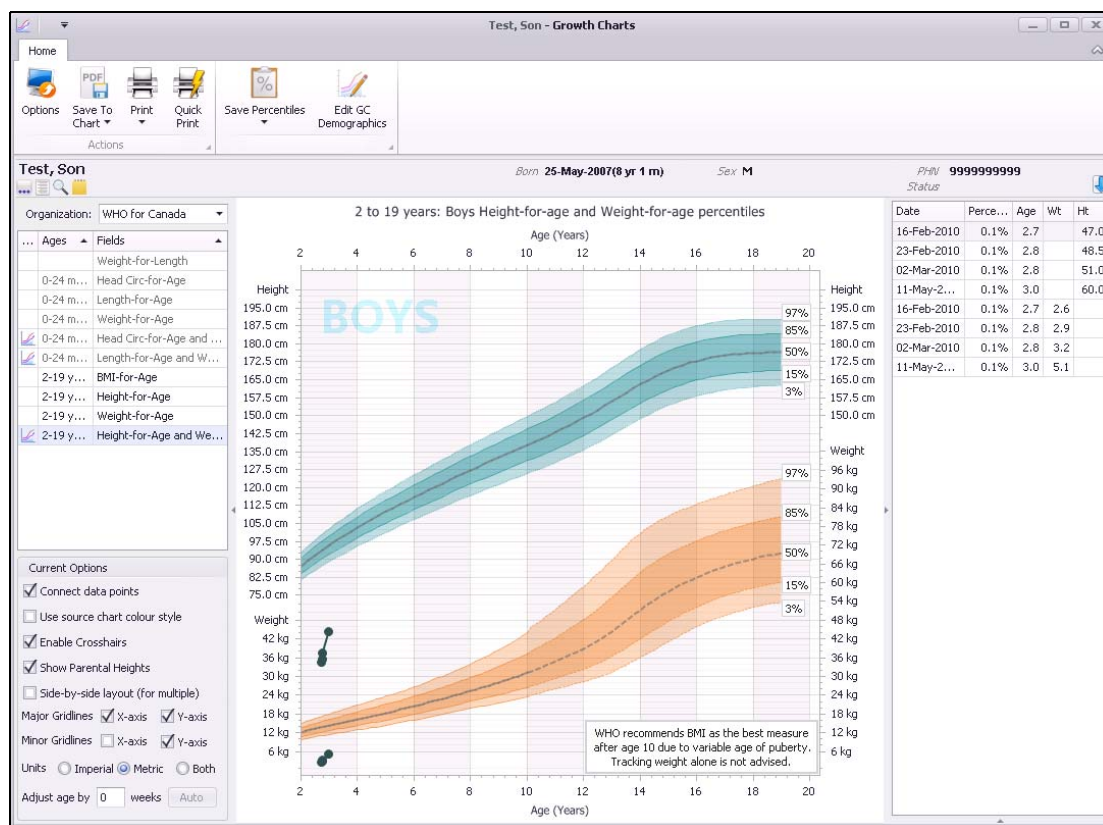
Growth Charts consist of a series of percentile curves that illustrate the distribution of selected body measurements in children. You can display growth charts for patients under the age of twenty years. You can view growth charts from the following organizations:

- World Health Organization (WHO) growth charts adapted for Canada
- Centers for Disease Control and Prevention (CDC)
- Canadian Pediatric Endocrine Group (CPEG)

To view a patient's growth charts:

1. On any window related to the patient (including a patient's Medical Summary, SOAP form, or Consult Letter Examination form), right-click and then, in the SMART Menu, click **View Growth Charts > Child Development Charts**.

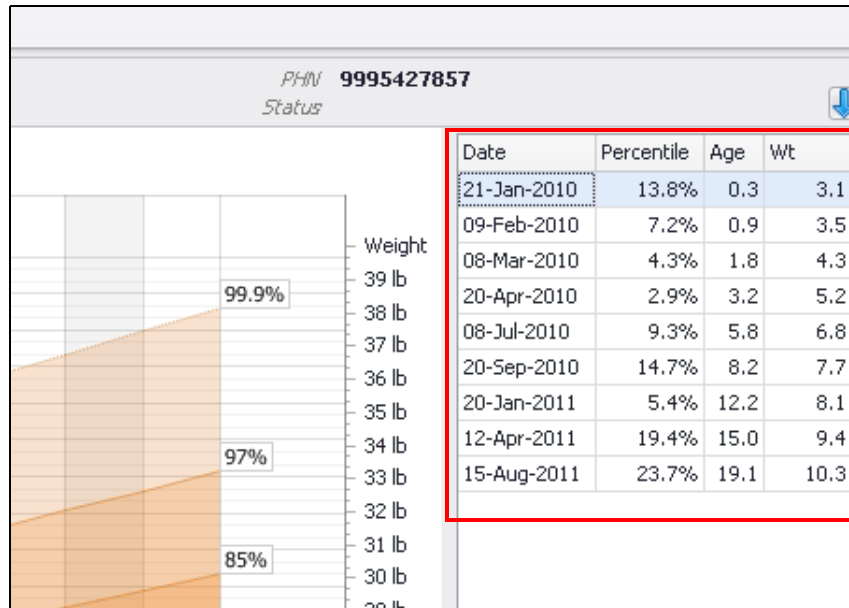
The EMR displays the Growth Charts window. By default, the EMR displays the WHO growth chart adapted for Canada, specific to the patient's gender and age.



Tip: You can set what organization's growth chart displays by default. For example, you can set the CPEG growth charts to display by default:

1. At the top of the window, click **Options** (). The EMR displays the Default Display Options window.
2. In the **User Options** area, clear the **Use Defaults** check box.
3. in the **Your Default Organization** drop-down list, select the organization.
4. Click **Save**.

The EMR displays the data points and percentiles in a table format to the right of the chart(s):



2. To view a different type of chart:
 - a) In the **Organization** drop-down list, click an organization.
 - b) In the list below the **Organization** field, click a specific graph type. The EMR displays the selected chart.
3. To adjust the chart/percentiles for an early pregnancy, in the **Current Options** area, in the **Adjust age by** field, enter the number of weeks early.



Tip: If you entered a patient's gestational age in the Patient Maintenance window, click the **Auto** button. The EMR automatically populates the **Adjust age by** field. See ["Entering patient birth information" on page 362](#).

Note: The **Auto** button is available only if the gestational age you entered is less than 38 weeks.

4. In the **Current Options** area, set the various options to change the way the graph looks.

Field	Description
Connect data points	To connect data points by a line, select this check box. Note: This option is selected by default.
Use source chart colour style	Charts of a particular type (for example, CDC charts) have their own color scheme, which may be different from charts of another type. To display the original color scheme for the chart type, select this check box.

Field	Description
Enable Crosshairs	To have a line extend vertically to the edge of the graph when you hover your mouse over a data point, select this option. Note: The vertical line follows the mouse cursor; a horizontal line is displayed when you get close to the point.
Show Parental Heights	To display of the height of the patient's father, and mother, and the patient's mid-parental height near the vertical axis (on the right side of the graph), select this check box Note: Exact values display in a popup.
Side-by-side layout (for multiple)	To view more than one chart at a time, select this check box. To view more than one chart at a time, on your keyboard, hold the Control key and then click the other charts you want to view.
Major Gridlines: X-axis, Y-axis	To display major gridlines, select these check boxes.
Minor Gridlines: X-axis, Y-axis	To display of the minor gridlines, select these check boxes.
Units: Imperial; Metric; Both	Beside Units , select the units you want to view measurements in. Note: Metric is selected by default.

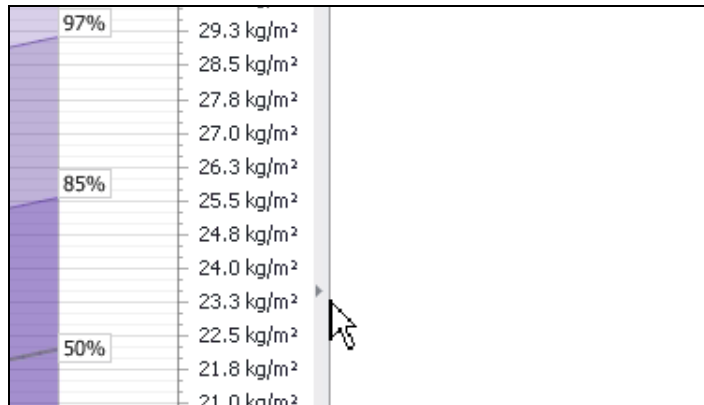


Tip: You can set what options are selected by default in the **Current Options** area:

1. At the top of the window, click **Options** (). The EMR displays the Default Display Options window.
2. In the **User Options** area, clear the **Use Defaults** check box, and then set your User Options defaults.
3. Click **Save**.

5. To zoom in, hold the **Shift** key and then click on the area you want to zoom in to.
6. To zoom out, hold the **Alt** key and then click on the area you want to zoom out from.
7. To re-sort the information in the percentile table, click on one of column headings.

8. To hide the percentile table, click the  icon to the right of the chart.



9. To collapse the patient banner and maximize the growth chart, click the blue up arrow  (located on the top right of the window).
10. To add percentiles as exam findings, click **Save Percentiles** () and then, in the drop-down list, select which organization's percentiles you want to use.



Why save percentiles as exam findings?

- You can graph percentiles together with lab values and other data only if you save the percentiles to the patient's record as exam findings.
- If your clinic uses practice searches and rules that search based on patient percentiles, the patient can be identified only if their percentiles are saved as exam findings.

11. To print the growth chart(s), perform one of the following actions:

- To print the growth chart(s) on your default printer, click **Quick Print** (.
- To print the growth chart(s) with or without the data point table on a selected printer, click **Print** () and then, in the drop down list, select either **Print** or **Print (with table)**.

Attaching growth charts to referrals

You can save a growth chart as a PDF in the **Documents** area of a patient's Medical Summary. You can then add the growth chart as an attachment to a referral.

To attach a growth chart to a referral:

1. Open the growth chart, and use the view options to make the growth chart look the way you want it to look for the referral. See [“Viewing patient growth charts” on page 363](#).
2. Click **Save To Chart** () and then, in the drop-down list, click one of the following options:
 - **Save To Chart:** To save only the growth chart in the **Documents** area of the Medical Summary.
 - **Save To Chart (with table):** To save the growth chart AND a table containing all of the data points on the chart in the **Documents** area of the Medical Summary.
3. Attach the PDF version of the growth chart to the referral. See [“Creating and sending referral letters” on page 278](#).

Completing Rourke Baby Record exams

The Rourke Baby Record (RBR) is the standard examination tool used across Canada for baby and child care. It consists of 12 exams (from within one week to five years of age).

In Wolf EMR, you can access RBR exams on the SOAP form in the **EXAM** area, and on the consult letter form in the **Structured Examinations** drop-down list.



Note: Your administrator must enable the use of RBR examinations for you to use the RBR structured examinations.

You can use the RBR examinations in visit encounters to document each stage of the child's development. Each examination template is broken into sections that correspond to the standard 2014 RBR format.



Tip: The fields in the BIRTH INFORMATION section are synchronized with the related fields on the **Other Demographics** tab in the Patient Maintenance window; if you change these fields in RBR structured examinations, the EMR updates them in the Patient Maintenance, and vice versa. See [“Entering patient birth information” on page 362](#).



Note: If your front end staff entered information into an RBR exam for you, this information is visible when you open the same RBR examination. You can add-to or modify the information as needed.

To record information in a Rourke Baby Record exam:

1. Open a SOAP form (see [“Starting SOAP notes” on page 117](#)), or a Consult Letter form (see [“Starting consult letter visit notes” on page 171](#)) for the patient.
2. Perform one of the following actions:

- If you have the SOAP form open, in the **Exam** drop-down list, click the appropriate Rourke examination.
 - If you have the consult letter form open, in the **Structured Examinations** drop-down list, click the appropriate Rourke examination.
3. Enter the examination data. Each Rourke examination has tabs for **<Age group>**, **Education and Advice**, **Development**, **Physical Exam**, **Problems/Plans**, and **Investigations/Immunization**. Click each tab and enter the associated information.

1 Month Age at Exam: 11 m

BIRTH INFORMATION

Gest. Age weeks Birth Length cm Birth Wt kg Head Circ cm Discharge Wt kg

BIOMETRICS

Length cm Weight kg Head Circ cm

1 Month Education and Advice Development Physical Exam Problems/Plans Investigations/Immunization

PARENT/CAREGIVER CONCERNS

☒ discussed and no concerns ☒ if concerns ☐ if not discussed

NUTRITION¹

☐ Breastfeeding (exclusive)¹ ☐ Formula Feeding (iron-fortified) preparation¹ ☐ Stool pattern and urine output

☒ Vitamin D 400 IU/day¹ [450–750 mL (15–25 oz) /day¹]

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care:
Good (bold type) Fair (italic type) Inconclusive evidence/Consensus (plain type). See literature review table at www.rourkebabyrecord.ca

Disclaimer: Given the constantly evolving nature of evidence and changing recommendations, the Rourke Baby Record is meant to be used as a guide only.

Resources 1 : General¹ Resources 2 : Healthy Child Development² Resources 3 :³ GUIDE V: Immunization Parent Resources

CREATE PDF

☐ Create as a PDF and attach to Chart

PRINT

☐ Include Resources/Guide V



Note: The information you enter in the **Investigations/Immunizations** tab is not reflected in the patient's Vaccination Schedule or on the printed "GUIDE V: Immunization" RBR guide. To view the Vaccination Schedule, click the **View Vaccination Schedule** button. See ["Recognizing when a patient is due for vaccinations"](#) on page 433.



Note: The check boxes on the **Education and Advice** and the **Development** tabs support three different states (selected, crossed-out, and clear).

2 Weeks	Education and Advice	Development	Physical Exam	Problems/Plan
☒ discussed and no concerns ☒ if concerns ☐ if not discussed				

1 Month	Education and Advice	Development	Physical Exam	Problems/Plan
Tasks are set <u>after</u> the time of normal milestone acquisition. <u>Absence of any item suggests consideration for further assessment of develop</u> NB-Correct for age if < 37 weeks gestation				
☒ if attained ☒ if not attained ☐ if not discussed				

Click a check box to change the state.

The state of the check box for certain fields is automatically carried over from previous visits. This helps to ensure you don't discuss the same subject (for example, car seat safety) on each visit. The time period (that is, for how long) that a field's state is carried over depends on the specific field.

4. Optionally, perform one or more of the following actions:

- To save RBR exam to the patient's chart, click **Create as a PDF and attach to Chart**



(). The EMR saves the RBR exam as a PDF in the **Documents** tab of the patient's Medical Summary. The document's **Content Type** is **Rourke Baby Record**.



Tip: You can attach your Rourke Baby Record notes to a referral only if you save them as a PDF in the **Documents** area of the patient's Medical Summary.

- To print or fax the RBR to a selected printer or fax, click **Print Rourke Baby Record**



().

- To print the RBR exam to your default printer, click **Quick Print Rourke Baby Record**



().

Responding to incoming referrals (Specialists)

In this chapter you learn how to view and respond to your incoming referrals. Depending on your clinic's processes you may receive referrals through fax, mail, eReferral, or through a combination of the three mediums. No matter how referrals come in, you are notified to review incoming referrals on your WorkDesk.

How you respond to a referral differs depending on if the referral comes in as fax/mail or as an eReferral.

Viewing incoming referrals

Whether referrals come in through fax, mail, or electronically as eReferrals, you are notified on your WorkDesk via the **Incoming Referrals** link. From here you can review and respond to the referrals.

To view incoming referrals:

1. In the **Tasks** area of your WorkDesk, in the **Referrals** area, click # **Incoming Referrals** (where # = the number of your pending incoming referrals). The EMR opens the Investigation/Documents In-basket window with:
 - Your name selected on the **Practitioner** drop-down list.
 - A list of your un-reviewed incoming referrals.

Investigation/Document In Basket

Test, Father PHN: [redacted]

Born: 20-Jun-1980 (34) Sex: M Status: Long Term C...
1234 Frist Street, Calgary AB T5R4E3W H: (403) 999-8888 Pri: Dana Know-Four, MD
C W Fam Ret

Order New Lab Tests

Reviewed Redirect To Come In Follow-up Message

☐ Electronic Investigation
☐ Documents
☐ Incoming Consults
☒ Incoming Referrals

Note: [text box]
☐ Declined eReferrals

Practitioner:
Dana Know-Four, MD

☐ Signed Out

☒ New ☐ Reviewed
☐ All Documents

Search Keywords: [text box] AND [dropdown]

[View Document Properties](#)

Date	Keyword One	Keyword Two	Keyword Three	Review Note	Patient	Appoi
07-Mar-2014	Referral Letter				Test, Mynke	
27-Aug-2013	Cardiology Report				Test, Father	

2. To review incoming referrals for another practitioner, in the **Practitioner** drop-down list, click the practitioner's name.
3. To filter your list of incoming referrals, select one or more of the options described in the following table.

Filter selection	Results
New (default selection)	Displays only new incoming referrals that are not marked as Reviewed
Reviewed	Displays only reviewed incoming referrals.
All Documents	Displays both reviewed and un-reviewed incoming referrals.
Search Keywords	Displays only incoming referrals containing the word(s) entered into the Search Keywords field.
Date	Displays incoming referrals for a particular date. Enter a date, or to select a date on a calendar, click  .
Patient	Displays incoming referrals for a particular patient only. To search for a patient using the Patient Search window, click  .

4. To view more detailed information for a referral, double-click the referral. The EMR displays the referral in:
 - The PDF x-Change viewer: If the referral came in the form of fax or mail (scan).
 - The Referral Letter Composer window: If the referral is an eReferral.



IMPORTANT: A faxed or scanned referral displays in your **Incoming Referrals** list only if your front end staff selects **Incoming Referral** as the **Document Type** for the document. Otherwise, the referral letter displays in your **New Documents** list.

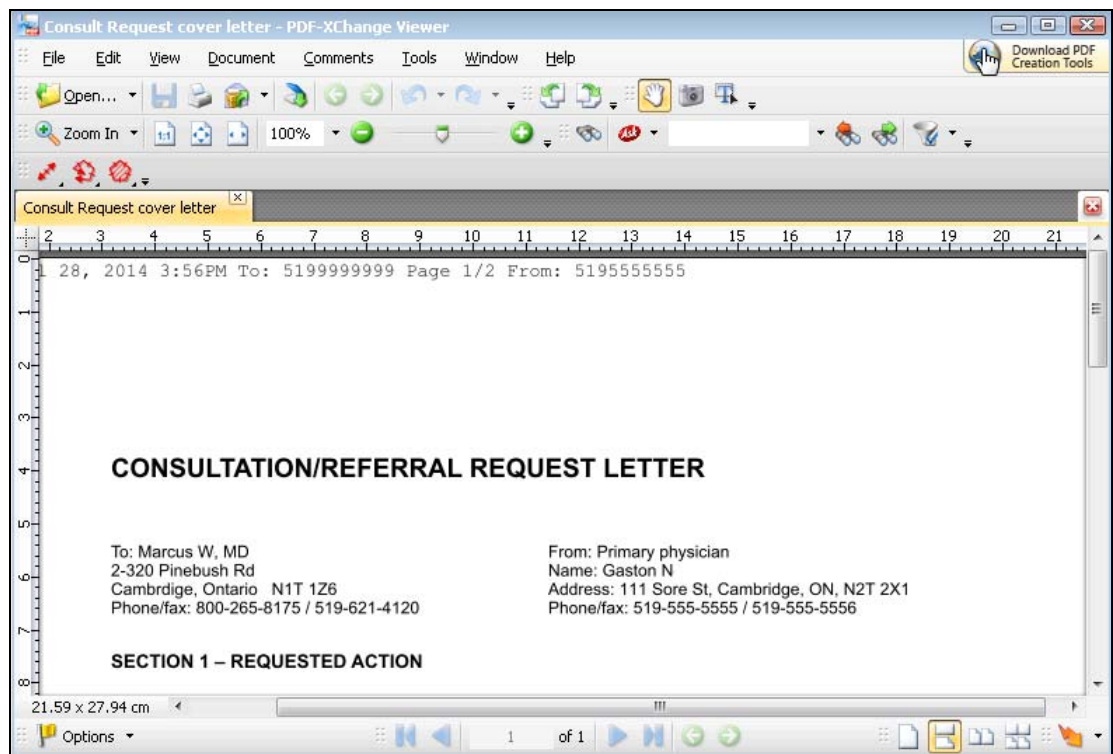
Responding to faxed/mailed referrals

After you view a referral letter from the Investigations/Document In Basket, you can respond by marking the referral as reviewed ("signed-off"), or by initiating an action on the referral (for example, you can send a message to your front end staff to ask the referring clinic for additional health information on the patient). You can initiate one of the following actions:

- Send a **Message**. (RECOMMENDED)
- **Redirect** to another provider.
- Send a request for the patient **To Come In**.
- Send a **Follow Up** task.

To respond to a faxed or mailed referral:

1. Open and view a referral letter. See ["Viewing incoming referrals" on page 371](#). The EMR displays the faxed/scanned referral letter and any associated attachments in PDF x-Change viewer.



2. To close the referral letter, click **Close** ()
3. To respond to the referral, in the Investigation/Documents In-basket window, click the referral you want to respond to.

4. On the top right corner of the Investigation/Document In Basket window, click one of the following options.



Best practice: To notify your front end staff that a referral is accepted, rejected, or needs more information, always choose to send a **Message**. In messages, your front end staff can easily document calls made and actions taken to complete the referral.

Option	Example scenario	Results
Reviewed	Caution: Use this option only if your front end staff have already been passed the referral. You have already spoken with your referral clerk and told her to accept or decline the referral. You then click Reviewed on the referral to clear the referral from your list without sending a message or follow-up task to your referral clerk.	■ The referral no longer displays in your Incoming Referrals list. ■ The referral letter posts to the Documents tab of the patient's Medical Summary without a message, task, or notification created.
Redirect	You do not have availability for the patient, however, another practitioner in your clinic has room to take the patient. You redirect the referral to the available practitioner.	■ The referral moves to another practitioner's Incoming Referrals list and is removed from your Incoming Referrals list.

Option	Example scenario	Results
To Come In	You want to accept the referral and want to: ■ Notify your staff to call the referring clinic to provide a booking time. ■ Remind yourself why you accepted the referral when you see the patient for their visit.	Both you <u>AND</u> your front end staff receive notifications to follow up with the patient or referring clinic: Front end Staff: The patient displays on their Patient's To Notify list. (Prompting them to call the patient or referring clinic to provide the appointment date.) Patient chart (practitioner): A follow-up task displays on the patient's chart for you. (Reminding you why you accepted or rejected the referral.) ■ The referral letter posts to the Documents tab of the patient's Medical Summary. ■ On the SMART Banner of the patient's medical record there is an indication that the patient has an outstanding follow-up item. ■ The referral no longer displays in your Incoming Referrals list.
Follow up	You want accept, reject, or request more information for a referral. You send a Follow up task to your front end staff to contact the patient or referring clinic.	■ A Follow up task displays on your front end staff's WorkDesk. ■ The referral letter posts to the Documents tab of the patient's Medical Summary. ■ The referral no longer displays in your Incoming Referrals list.

Option	Example scenario	Results
Message (Recommended)	You want accept, reject, or request more information for a referral. You send a message to your front end staff to contact the patient or referring clinic. Note: Messages are the best way to pass the referrals onto your front end staff.	- A message displays on the user's message list. - The referral letter posts to the Documents tab of the patient's Medical Summary. - The referral no longer displays in your Incoming Referrals list.



Note: For more information on messages and tasks, see: ["Clinic communications and tasks" on page 79](#).

5. After you finish viewing and responding to your incoming referrals, click **Save & Close**



Tip: If you mark an Incoming Referral as reviewed by mistake, you can "bring it back" if need be:

1. In the filter list area of the Investigation/Document In Basket window, clear the **New** check box.
2. Select the **Date** check-box, and then enter the date that the investigation came in on. The EMR displays all reviewed and un-reviewed incoming referrals for the selected date.

To send a message, or a follow-up task regarding the reviewed referral:

1. On the displayed investigation in the Investigation/Document In Basket window, right-click. The EMR displays the **SMART Menu**.
2. Click **New Message**, or **New Follow-up**.

eReferrals

Using the TELUS Health eReferral feature, other clinics can send you referrals directly from their EMR. Incoming eReferrals appear in your **Incoming Referrals** list along with your faxed and mailed referrals.

With eReferrals, you can:

- Import a patient's medical information into your EMR
- View and import referral attachments into your EMR
- Accept, or reject a referral at the click of a button, with the referring clinic being notified immediately. Your front end staff does not have to call or send a letter to the referring clinic.
- Send messages and documents to, and respond to messages from, the referring clinic.



Note: If you want to send or receive eReferrals, you must be enabled to do so. To request access to the eReferral features, contact the TELUS Health EMR Customer Care team using one of the following methods:

- E-mail: accounts.wolfemr@telus.com
- Online Case submission: Available on the **Cases** page of the [Wolf EMR Community Portal](#).
- Phone: 1-866-879-9653 (Option 4)

Opening and viewing eReferrals

To open and view an Referral:

1. Open and view the referral as you do for regular referrals. See ["Viewing incoming referrals" on page 371](#). The EMR displays the eReferral and any associated attachments and medical information in the eReferral Letter Composer window.

Referral Letter Composer

Configure

Print Import Create Reply History Attachment Accept Decline Exit

Author

Dr. John C. , M.D.
1234 - Wolf Ave.
Vancouver, BC
V3S 5J9
CA
Phone (604) 555-1234
Fax (604) 555-2345

Information Recipient

Dr. David W
1234 - Wolf Ave.
Vancouver, BC
V3S 5J9
Phone (604) 555-1234
Email dwells@wolf.com

CCed Recipients

Patient

Edna Danielson	PHN:	9994106640
Birthdate: September 8, 1928	Gender:	Female
Phone:	Appointment Date:	
Sent On: June 11, 2012		

Referral Detail

Urgency: Routine
Referral Reason: sdfasfsaf

2. To view attachments that came with the referral, click **Attachment** (). The EMR displays the Attachment window.

3. Perform one of the following actions:

- To close the eReferral without responding, click **Exit** ().
- To accept the eReferral, see [“Accepting eReferrals” on page 379](#).
- To decline the eReferral, see [“Declining eReferrals” on page 380](#).
- To request more information, see [“Requesting more information from the referring practitioner” on page 382](#).
- To send a message back to the clinic (without accepting or declining the eReferral), see [“Sending messages and documents” on page 384](#).

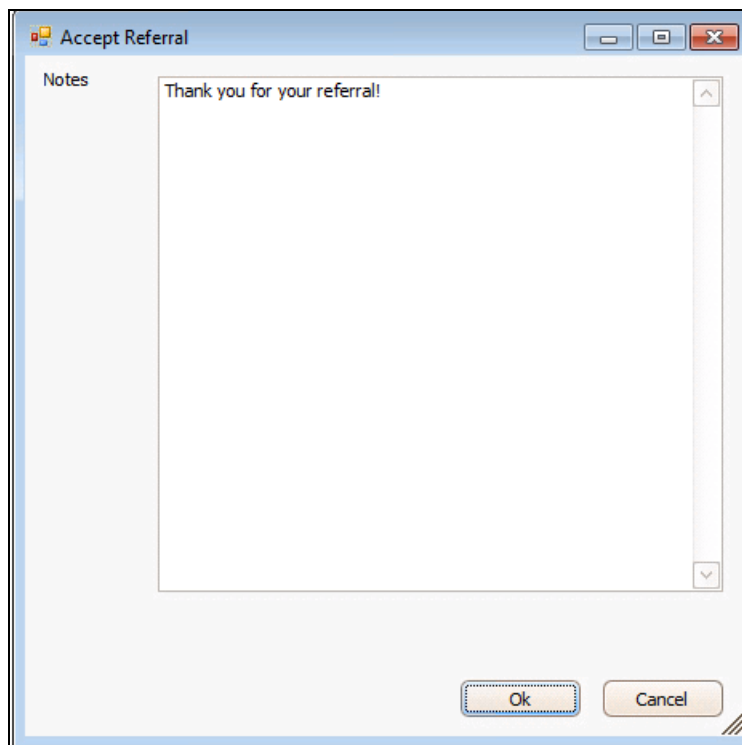
Responding to eReferrals

You can accept or decline an eReferral and the referring clinic is notified immediately. You do not have to call or send a letter to the referring clinic to let them know about the status of the referral. Through your EMR you can also send a message to the referring clinic, for example, to request more information about the patient, or you can redirect a referral to another practitioner in your clinic.

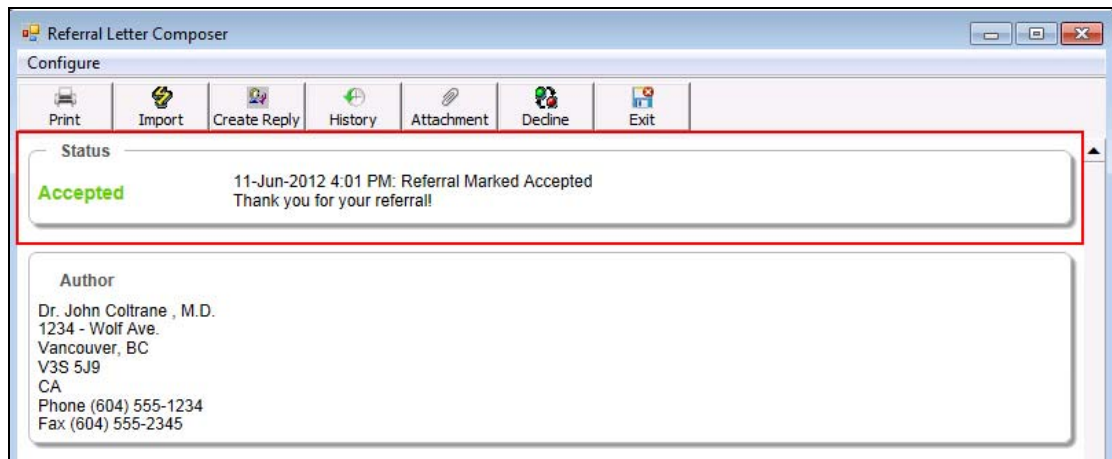
Accepting eReferrals

To accept an eReferral:

1. Open and view the referral. See ["Opening and viewing eReferrals" on page 377](#).
2. On the top of the Referral Letter Composer window, click **Accept** (). The EMR displays the Accept Referral window.
3. In the **Notes** area, enter a message to the referring practitioner if desired.



- Click **OK**. The EMR displays an **Accepted** status header both on your view and on the referring practitioner's view in the Referral Letter Composer.



- Click **Create Reply** (). The EMR opens the eReferral Letter Composer in Send mode.
- Click **Send** (). The EMR sends your response to the referring practitioner's **Incoming Consults** list. The EMR displays an **Accepted** status header on the referring practitioner's view of the Referral Letter Composer.



Important: You must create a reply when you accept an eReferral, in addition to clicking **Accept**. This way, the referring clinic receives a notification. If you do not

click **Create Reply** () and enter a message, the referring clinic does not receive a notification regarding the accepted eReferral.

Declining eReferrals

To decline an eReferral:

- Open and view the referral. See ["Opening and viewing eReferrals" on page 377](#).
- On the top of the Referral Letter Composer window, click **Decline** (). The EMR displays the Decline Referral window.
- In the **Reason** drop-down list, click your reason for declining the referral, or if the reason you want is not available in the **Reason** drop-down list, enter the reason.

4. In the **Notes** area, enter a message to the referring practitioner if desired.

5. Click **OK**. The EMR:
- Displays a **Declined** status header in your Referral Letter Composer window.
 - Sends your response to the referring practitioner's **Declined eReferrals** list.
 - Displays a **Declined** status header on the referring practitioner's view of the Referral Letter Composer.

Requesting more information from the referring practitioner

You can send messages to the referring practitioner if needed. For example, if a referring practitioner has not attached enough information for you to accept the referral, you can request more information from the referring practitioner:

To request more information from the referring practitioner:

1. Open and view the referral in the Referral letter Composer window. See [“Opening and viewing eReferrals” on page 377](#).
2. On the top of the Referral Letter Composer window, click **Accept** (). The EMR displays the Accept Referral window.
3. In the **Notes** area, enter a message to the referring practitioner, detailing what information you require.
4. Click **OK**. The EMR:
 - Displays an **Accepted** status header both on your view and on the referring practitioner's view of the Referral Letter Composer, with your message requesting more information displayed.
 - Sends a notification to the referring practitioner. This notification displays in the referring practitioner's **Incoming Consults** list.

Importing patient medical information from eReferrals

If the referring clinic attaches clinical information such as the patient's problem list, family history, current medications, and allergies to an eReferral, you can import this clinical information directly into the patient's Medical Summary in your EMR. Also, if the referring clinic attaches documents such as diagnostic imaging reports, WCB reports, or prenatal records, you can import these documents into the Documents tab of the patient's Medical Summary.

To import a patient's medical information from an eReferral:

1. Open the eReferral:
 - If you are viewing and responding to the eReferral for the first time, see [“Opening and viewing eReferrals” on page 377](#).
 - If you are importing the patient's medical information at a later time (for example, during the patient's first visit):
 - a) Navigate to the **Documents** tab of the patient's Medical Summary.

- b) In the patient's list of documents, double-click the eReferral. The EMR displays the referral in the Referral Letter Composer window.

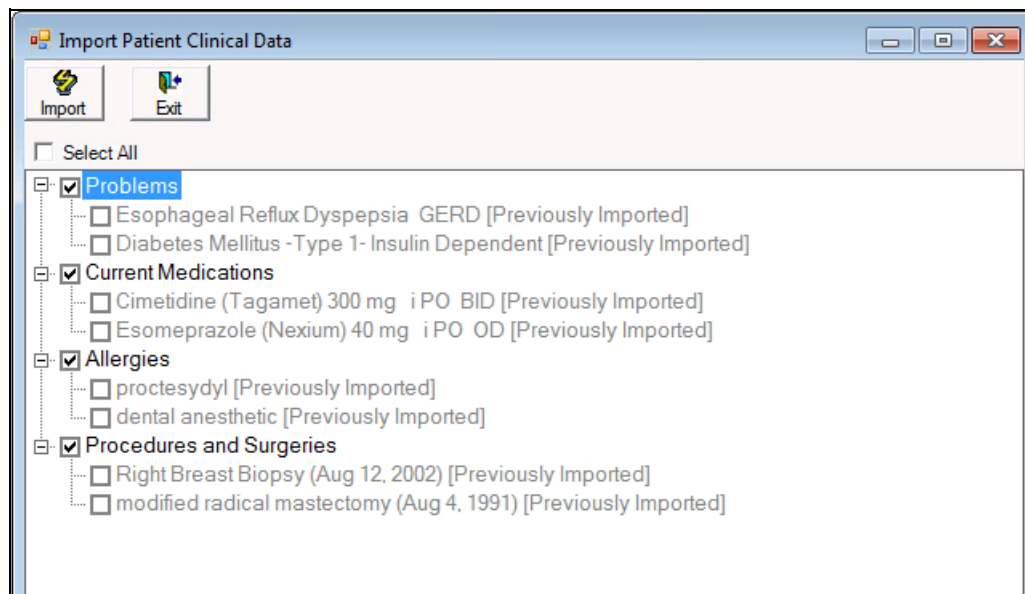


Tip: If you have the Consult Letter Examination form open for the patient, you can quickly open the patient's eReferral:

On the right side of the window, click **Respond to eReferral**.

Note: You can open the patient's eReferral from the Consult Letter Examination for only if your front end staff linked the eReferral to the patient's appointment.

2. On the top of the Referral Letter Composer window, click **Import** (). The EMR displays the Import Patient Clinical Data window, with a list of clinical information that the referring clinic attached to the referral..



3. Select the check box beside items you want to import into the patient's Medical Summary.

4. Click **Import** (). The EMR:

- Displays a dialogue box with the following message: "# records saved to the database successfully" (where "#" = the number of imported items).
- Imports the selected clinical data into the appropriate areas of the patient's Medical Summary.



Note: The EMR does not import any Encounters attached in the eReferral into the patient's Medical Summary.

Sending messages and documents back and forth to referring practitioners

You can send messages, consult letters, and other documents back and forth to referring clinics through the eReferral Letter Composer.

Sending messages and documents

To send messages, consult letters, and documents to the referring clinic:

1. Complete one of the following actions:
 - If you have the Consult Letter Examination form open (for example, if you are currently entering visit notes for the patient), on the right side of the window, click **Respond to eReferral**.

Consult Letter Examination Date: 08-Jun-2012

Bronte, Emily PHN: 1239 898 239

Born: 15-Mar-1978 (34) Sex: F Status: N/A

556 Poplar Street, Oliver BC V0G 0S3 H C Pri

Referral Reason: [Dropdown]

Select Template: [Dropdown] [Double Click to Launch Template Paragraph.](#)

Consult

Order Labs

Prescribe Medication

Detailed Referral

Respond to eReferral

Set Billing defaults

Apply Defaults

Structured Examinations: Abdominal



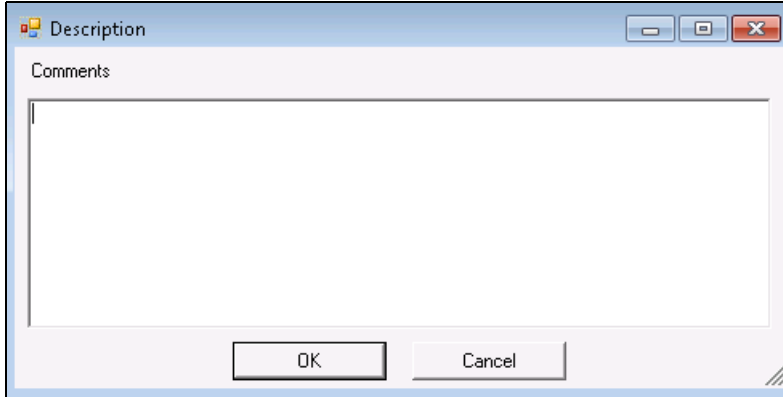
Note: You can open the patient's eReferral from the Consult Letter Examination for only if your front end staff linked the eReferral to the patient's appointment.

- If you don't have the Consult Letter Examination form open:
 - a) Open the patient's Medical Summary. See ["Medical Summary window overview" on page 392](#).
 - b) Click the **Documents** tab.
 - c) In the patient's list of documents, double-click the eReferral.

The EMR displays the referral in the Referral Letter Composer window.

2. At the top of the eReferral Letter Composer window, click **Create Reply** (). The EMR opens the eReferral Letter Composer in send mode.
3. If you want to send a message to the referring clinic, enter the message as an Other Treatment:

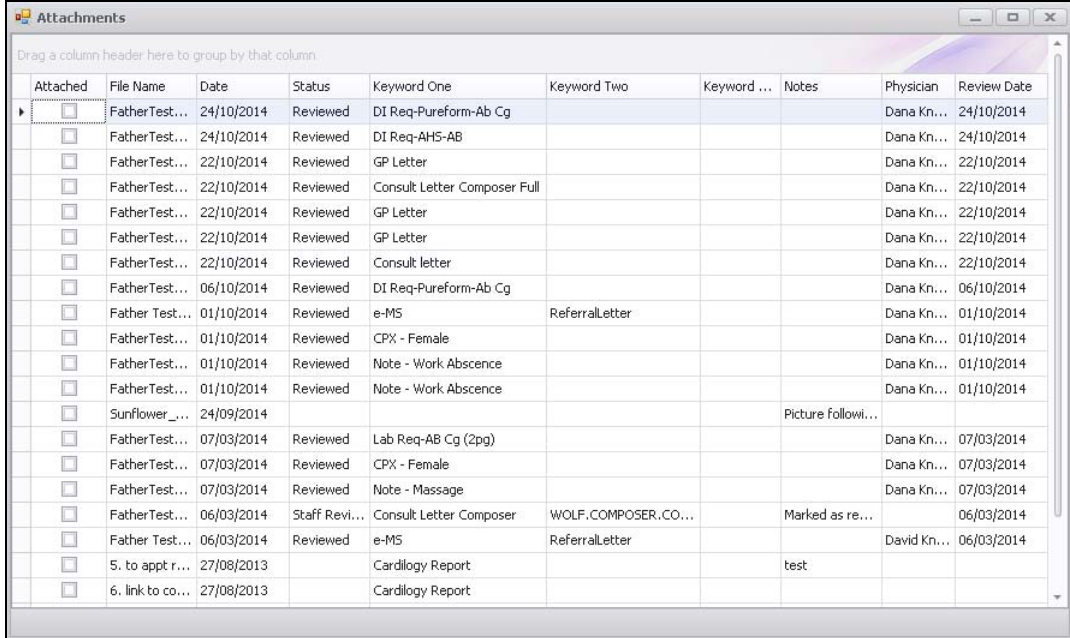
- a) In the left pane, select the **Other Treatments** check box.
- b) Right-click the **Other Treatments** tag (in blue), and then click **Properties**. The EMR displays the Description window.



The image shows a window titled "Description" with a "Comments" label above a large text input area. At the bottom are "OK" and "Cancel" buttons.

- c) In the **Comments** area, enter your message, and then click **OK**.
4. If you want to send a document to the referring clinic:

- a) Click **Attachment** (). The EMR displays the Attachments window, with a list of files available in the **Documents** area of the patient's Medical Summary.



The image shows a window titled "Attachments" with a table of file attachments. The table has columns: Attached, File Name, Date, Status, Keyword One, Keyword Two, Keyword ..., Notes, Physician, and Review Date. The first row is highlighted.

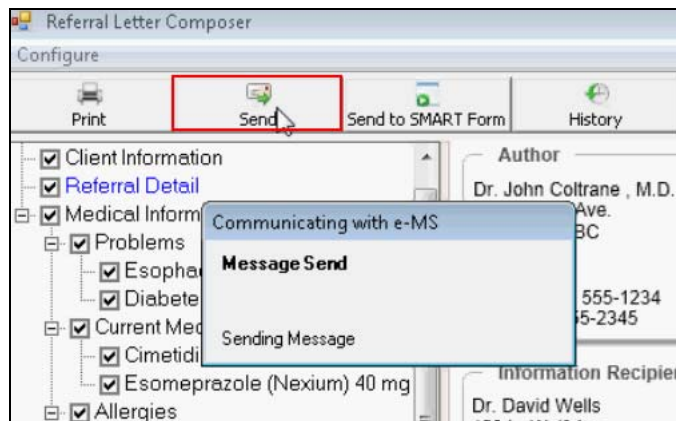
Attached	File Name	Date	Status	Keyword One	Keyword Two	Keyword ...	Notes	Physician	Review Date
☒	FatherTest...	24/10/2014	Reviewed	DI Req-Pureform-Ab Cg				Dana Kn...	24/10/2014
☐	FatherTest...	24/10/2014	Reviewed	DI Req-AHS-AB				Dana Kn...	24/10/2014
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	Consult Letter Composer Full				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	GP Letter				Dana Kn...	22/10/2014
☐	FatherTest...	22/10/2014	Reviewed	Consult letter				Dana Kn...	22/10/2014
☐	FatherTest...	06/10/2014	Reviewed	DI Req-Pureform-Ab Cg				Dana Kn...	06/10/2014
☐	Father Test...	01/10/2014	Reviewed	e-MS	ReferralLetter			Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	CPX - Female				Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Absence				Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Absence				Dana Kn...	01/10/2014
☐	Sunflower_...	24/09/2014					Picture followi...		
☐	FatherTest...	07/03/2014	Reviewed	Lab Req-AB Cg (2pg)				Dana Kn...	07/03/2014
☐	FatherTest...	07/03/2014	Reviewed	CPX - Female				Dana Kn...	07/03/2014
☐	FatherTest...	07/03/2014	Reviewed	Note - Massage				Dana Kn...	07/03/2014
☐	FatherTest...	06/03/2014	Staff Revi...	Consult Letter Composer	WOLF.COMPOSER.CO...		Marked as re...		06/03/2014
☐	Father Test...	06/03/2014	Reviewed	e-MS	ReferralLetter			David Kn...	06/03/2014
☐	5. to apt r...	27/08/2013		Cardiology Report			test		
☐	6. link to co...	27/08/2013		Cardiology Report					



Note: You can attach only files that are available in the **Documents** tab of the patient's Medical Summary.

You can attach consult letters, prenatal records, and WCB forms only if they are saved as documents in the patient's record.

- b) In the **Attached** column, select the check box beside all documents you want to send.
 - c) Click **Close** (). The EMR displays the selected document('s) name(s) in the **Referral Detail** area on the Referral Letter Composer window.
5. On the Referral Letter Composer window, click **Send**.



The EMR sends a notification to the referring practitioner.



Note: The referring practitioner receives the notification in their **Incoming Consults** list.

When the referring practitioner opens the referral, any messages you entered display under **Other Treatments**.

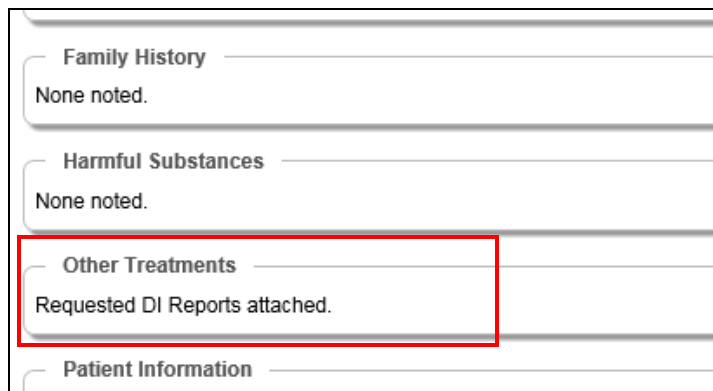
Procedures and Surgeries
Description
Family History
None noted.
Harmful Substances
None noted.
Other Treatments
Please send all related DI Reports.
Patient Information

Receiving messages, and other documents

If, after you receive an eReferral, you receive other related messages or documents from the referring clinic, you are notified in the **Tasks** area of your WorkDesk under **Incoming Referrals**. From here, you can view and respond to messages. The EMR also attaches the messages and attachments to the original referral.

To view messages and attachments regarding an eReferral:

1. In the **Tasks** area of your WorkDesk, in the **Referrals** area, click # **Incoming Referrals** (where # = the number of your pending incoming referrals and referrals with new messages and/or attachments). The EMR opens the Investigation/Documents In-basket.
2. In the list of pending and updated eReferrals, double-click the eReferral. The EMR displays the eReferral in the eReferral Letter Composer window, with any messages from the referring practitioner displayed under **Other Treatments**.



The screenshot shows a form with four sections: Family History, Harmful Substances, Other Treatments, and Patient Information. Each section has a title bar and a text area below it. The 'Other Treatments' section is highlighted with a red rectangular box. The text in the 'Other Treatments' section is 'Requested DI Reports attached.'

3. To view any new attachments, click **Attachment** (). The EMR displays the Attachment window.
4. Respond to the message if needed. See ["Sending messages and documents" on page 384](#).
5. When you finish, click **Exit** ().

Viewing and recording patient medical history (Medical Summary)

This chapter introduces you to the Medical Summary. The Medical Summary is essentially a patient's medical chart and contains a patient's entire medical history. The SMART patient banner is located at the top of the Medical Summary (as with other windows that contain patient information) and contains a summary of important patient information that you can view, at-a-glance, in one convenient area.

In this chapter, you learn how to enter, view, and modify patient medical information from the Medical Summary, the SMART patient banner, and the SMART menu.

Opening a patient's Medical Summary

You can open a patient's Medical Summary from any window related to the patient (any window displaying the SMART patient banner), including:

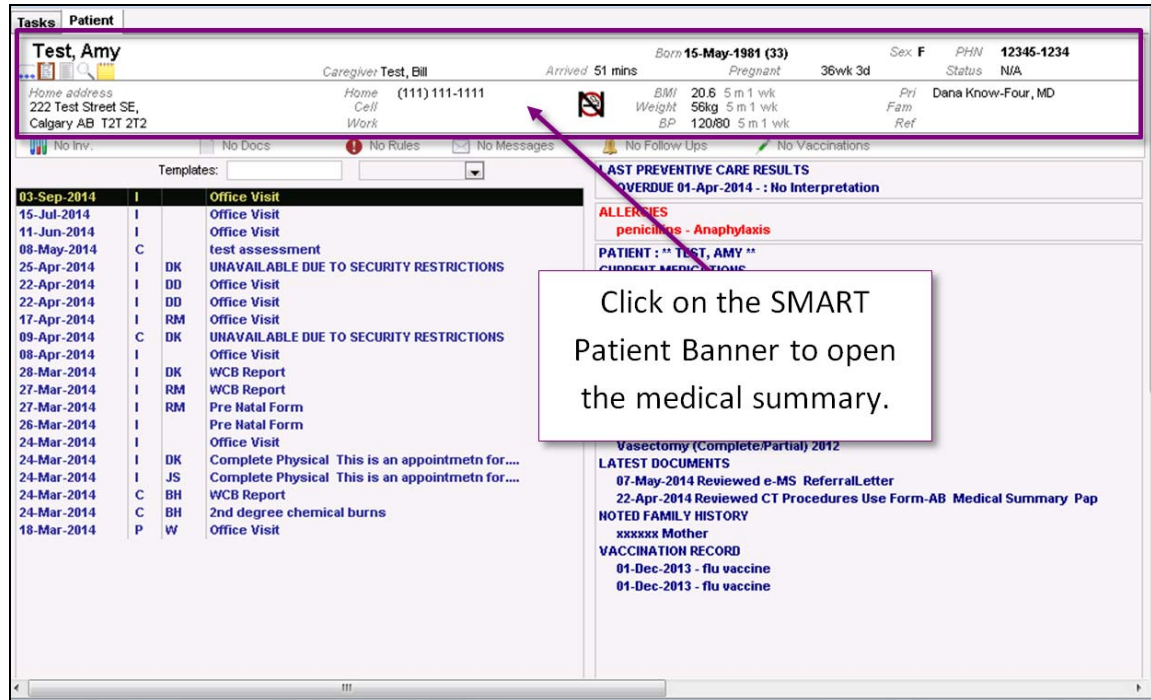
- The SOAP form
- The consult letter form
- The **Patient** tab (CPP)
- Patient related follow-up tasks, and messages
- Referrals

You can also open a patient's Medical Summary directly from your appointment schedule, or you can search for a patient to view from your WorkDesk.

Opening the Medical Summary from the SMART patient banner

To open the Medical Summary from the SMART patient banner:

On any window related to the patient (including the SOAP form, the consult letter form, the **Patient** tab (CPP), and patient-related messages and tasks), click anywhere in the SMART Patient Banner.



The EMR opens the Medical Summary window

Opening the Medical Summary for patients on your appointment schedule

To open the medical summary for a patient on your appointment schedule:

1. On the WorkDesk, click the **Appointments** tab. The EMR displays a list of your appointments for today.



Note: To learn more on how to navigate your appointments list, to add a patient to your appointments list, or to view other providers' appointments lists, see ["Viewing your schedule" on page 16](#).

2. In your **Appointments** list, double-click the patients name. The EMR opens the Medical Summary window with the patient's chart information.

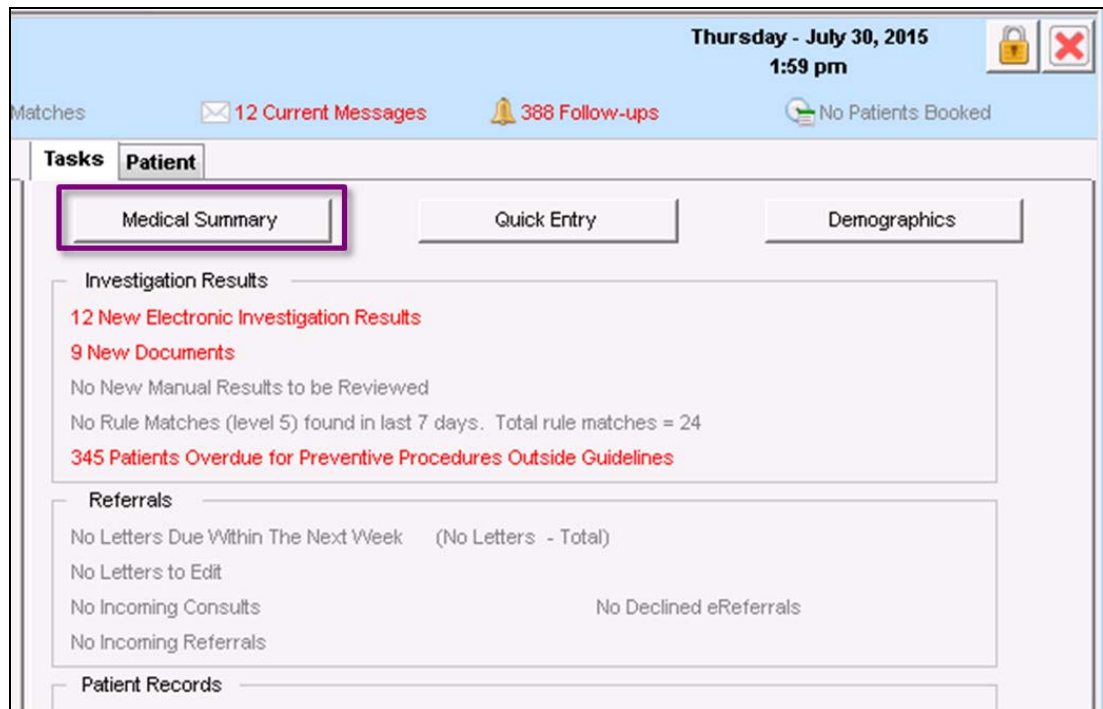


Tip: To open a patient's Medical Summary using a keyboard shortcut, click the patient's appointment and then, on your keyboard, press **F7**.

Opening the medical summary for patients who do not have an appointment booked

To open the medical summary for a patient who does not have an appointment booked:

1. At the top of the **Tasks** area of the WorkDesk, click **Medical Summary**.



The EMR displays the Patient Search window.

2. Search for the patient and then, in the search results list, double-click the patient's name.
The EMR opens the Medical Summary window with the patient's chart information.

Medical Summary window overview

The following sections provide an overview of the tabs and navigation buttons on the Medical Summary window.

Medical Summary

Test, Mother Born: 19-Apr-1964 (51) Sex: F PHN: 9994 200 232 Status: N/A

Home address: 123 Test Street, South Hazelton BC Q4K 5A2 Home Cell: (111) 111-1111 Work: (222) 222-2222

BMI: 185lbs 5 yr 3 m Weight: 120/80 3 yr 1 m BP: 120/80 3 yr 1 m

Pri: Dewayne B, M.D.

No Inv. No Docs No Rules No Messages 1 Follow Up No Vaccinations

Print Chart Custom Report Request Chart Change Log

Current Hx Past Hx Personal Hx Communication Investigations Documents Referrals Obstetrics

Problems

<<Add New Problem>>

Depression

Encounters

Date	Category	Description
07-Nov-2012	C	Hepatitis B Immune Titers low
07-Nov-2012	C	Depression
05-Oct-2012	C	msg This is a message
14-Sep-2012	C	msg This is a message
05-Sep-2012	C	msg This is a message
16-Aug-2012	C	msg This is a message
23-Jul-2012	C	msg This is a message
18-Jul-2012	C	msg This is a message
10-Jul-2012	C	msg This is a message
10-Jul-2012	C	msg This is a message
10-Jul-2012	C	Depression
10-Jul-2012	C	Back Pain
16-Jun-2012	C	msg This is a message

Current Medications

<<Add New Medication>>

Almotriptan (Axert TAB) 12.5 mg i PO OD
 Almotriptan (Axert TAB) 6.25 mg i PO OD
 Betnovate ointment gm topical BID prn
 Dukoral 2
 Duloxetine (Cymbalta DRC) 90 mg i PO OD
 Liothyronine (Cytomel TAB) 25 mcg i PO OD
 Modafinil (Alertec TAB) 100 mg ii PO OD

Allergies

<<Add New Allergy>>

Vaccinations

<<Add Vaccination>>

<<Vaccination Schedule>>

Td 03-Oct-2006

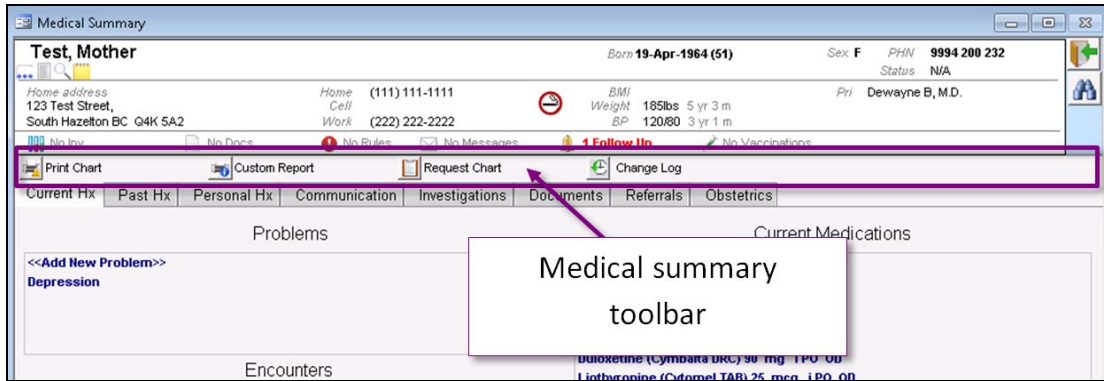
☐ Primary Immunizations Completed

Blood Type:

Medical summary toolbar

The medical summary toolbar is located below the Notification bar in the SMART Patient Banner.

You can click any icon in the Medical Summary toolbar bar to open the related area in the EMR and perform a specific action. For example, you can click the **Print Chart** icon to open the Wolf Clinical Records window, where you can choose clinical documents to print.



The following table describes the icons on the Medical Summary toolbar.

Icon	Description
	Print Chart Opens the Wolf Clinical Records window, where you can choose to print various parts of the medical record.
	Custom Report Opens a Custom Report Form, where you can print Visits, Prescriptions, and Referrals and title the report.
	Request Chart Opens a Chart Request window, with your name populated in the MD Requesting Chart field . The chart request appears as an item in the Clinical Queues area on your front end staff's WorkDesk as a chart to pull.
	Change Log Opens the Change Log window, where you can review all change activity that occurred in this patient's medical summary

Medical Summary window tabs

The following table provides an overview of the information available on each of the tabs in the Medical Summary window.

Tab	Information available on the tab
Current Hx: Current History	■ Problems ■ Current medications ■ Encounter records ■ Allergies ■ Vaccinations ■ Blood type
Past Hx: Past History	■ Inactive problems ■ Previous medications ■ Procedures and surgeries ■ Refuted and terminated allergies
Personal Hx: Personal History	■ Social history ■ Harmful substances (For example, smoking history and alcohol history) ■ Other risks ■ Family history
Communication	Current and previous: ■ Messages ■ Follow ups
Investigations	■ Electronic lab results ■ Some electronic medical reports ■ Manually entered lab results ■ Preventive care procedures (for female patients only: Pap smears, and mammograms)
Documents	■ Medical reports, consult letters and other documents linked to the patient ■ Requisition forms and other SMART Forms created for the patient
Referrals	■ Referral records made for the patient
Obstetrics	■ Pregnancy history information (for female patients if applicable)

Medical Summary window navigation buttons

The navigation buttons are located on the top right of the Medical Summary window.



- Click **Close** () to close the Medical Summary window.
- Click  to search for another patient's Medical Summary.

Problems

The following sections describe how to record, view, and edit problems on a patient's current or inactive problems list.

Recording problems

You can record a diagnosed problem to a patient's problems list or inactive problems list, by searching for and selecting a problem from the Wolf EMR's database of problems. If your clinic is using the new problem list that includes the Canadian Institute for Health Information (CIHI) list (available to only some clinics at this time), you can quickly choose a problem from a list of favourites.

Examples of patient problems include hypertension, diabetes type II, and asthma.



Tip: When you record a problem, the only required information is the problem name, however, it is good practice to enter the year of onset for tracking purposes.

To record a problem in a patient's Problems list or Inactive Problems list:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#). The EMR displays the Medical Summary window with the **Current Hx** tab open.
2. Perform one of the following actions:

- If you are entering a current problem, in the **Problems** area, double-click **<<Add New Problem>>**. The EMR displays the Problems List window.
- If you are entering a previous (inactive) problem, click the **Past Hx** tab and then, in the **Previous Medications** area, click **<<Add New Problem>>**. The EMR displays the Problems List window with **Inactive** displayed in the **Activity** field.



Tip: You can also record a problem for a patient from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **New Problem**.

3. In the **Select Diagnosis** field, enter part or all of the name, or the diagnostic code for the problem, and then on your keyboard, press **Enter**. The EMR displays a list of matching problems.



Note: If the problem is not in the registered list, then the EMR displays a dialog box with the following message: “The value “<word entered>” cannot be found in the Problems list. Please make another selection, or see your Administrator to create this value.”

CAUTION: Do not request a user with administrator authority to add a new problem to the problem list, until:

- you are sure that the problem is not already in the registered list.
- everyone in the clinic agrees that the added problem name is appropriate and necessary.

Otherwise, you risk creating duplicate entries for the same problem. Duplicates of listed problems can hinder your ability to track and manage patients with specific problems.

Note: If your clinic is using the new problem list that includes the Canadian Institute for Health Information (CIHI) list, you cannot edit the problem list.

Note: The new Problem list includes a CIHI quick pick list that acts as your clinic’s default list of Favourites. CIHI problems are those that have been identified by the CIHI as the most commonly used by general practitioners.

4. In the list of results, click the problem, and then click **Update**. The **Select Diagnosis** field changes to the **Active Problem** field and displays the problem you selected in red text.

Active Problem:	Sinus Congestion		
ICD9:	478.19	...view Problem Registry	Qualifier:
SNoMed:			
Date of Current Diagnosis:	22-Aug-2014		Location:

5. Enter information in the remaining fields, using the following table as a reference:

Field	Description
Date of Current Diagnosis	Enter the date of diagnosis. Note: Field defaults to today

Field	Description
Qualifier	In the drop-down list, click the position (for example, right, left, front) or other qualifier information about the problem. If the option you want is not available, enter the qualifier. Note: Users with administrative authority in Wolf EMR can add options to the drop-down list.
Location	In the drop-down list, click the body part where the problem is located. If the option you want is not available, enter a location. Note: Users with administrative authority in Wolf EMR can add options to the drop-down list.
Consultant	If an external consultant is managing this problem: 1. In the field, enter the consultants last name, first name, or specialty, and then press ENTER. The EMR displays a list of matching consultants. 2. Click the consultant you want. Note: If the consultant you want is not available on the list, you can add a consultant to the list. See “Managing the External Consultant list” on page 299.
Indicators	Enter information about the stability, status, and significance of the problem: ■ Stability: Click either Stable or Unstable. ■ Activity: Click either Active (for a current problem) or Inactive (for a previous problem) ■ Temporary?: Click either Temporary or Lifelong. Note: If you click Temporary, the EMR displays a Duration area. In the drop-down list, click the duration. The EMR calculates a date based on today's date and displays the date in the Duration field. ■ Certainty Enter the certainty that the current diagnosis is correct. For example, NYD (Not Yet Determined). ■ Chronicity: Enter the chronicity of the diagnosis. For example, Acute or Chronic.
Notes	Enter any notes or explanations about the problem.

Field	Description
Problem History	Enter or view information in the following fields: ■ Initial Dx: When you first enter a New Problem, it automatically appears as the Initial Dx. The EMR displays the Onset date to the right. You can also enter the date manually. In the Onset field, enter the year when the problem started. ■ Prior Dx: When you change the current Diagnosis, the EMR automatically enters the Prior Diagnosis and records the Prior Diagnosis. The EMR displays the Onset date to the right. You can also enter the date manually. Although you must enter the entire date, the EMR only displays the year. ■ Current Dx: The EMR automatically enters the Current Diagnosis when you first enter the Diagnosis or when you change the diagnosis. The EMR displays the Onset date to the right. You can also enter the date manually. The EMR only displays the year, although the Date of Current Diagnosis field displays the complete date.

6. Perform one of the following actions:

- To add another problem, click **Add** () , and then repeat steps [Step 3](#) to [Step 6](#) .
- To save the problem(s) and close the Problems List window, click **Save & Close** () .

Using problem favourites



Note: Only clinics using the new problem list that includes the Canadian Institute for Health Information (CIHI) list can use problem favourites.

When you search for a problem to add to a patient's problem list, favourite problems display at the top of your search results list. You can also choose a favourite problem directly from your favourites list.

The CIHI problem list acts as your clinic's default list of Favourites. CIHI problems are those that have been identified by the **Canadian Institute for Health Information (CIHI)** as the most commonly used by General Practitioners.

Problem favourites can be customized for the clinic (accessible by all users), or individual users. You can add or remove problems only on your user-specific favourites list.



Note: Users with administrative privileges in Wolf EMR can add clinic-wide favourites.

Recording problems using favourites

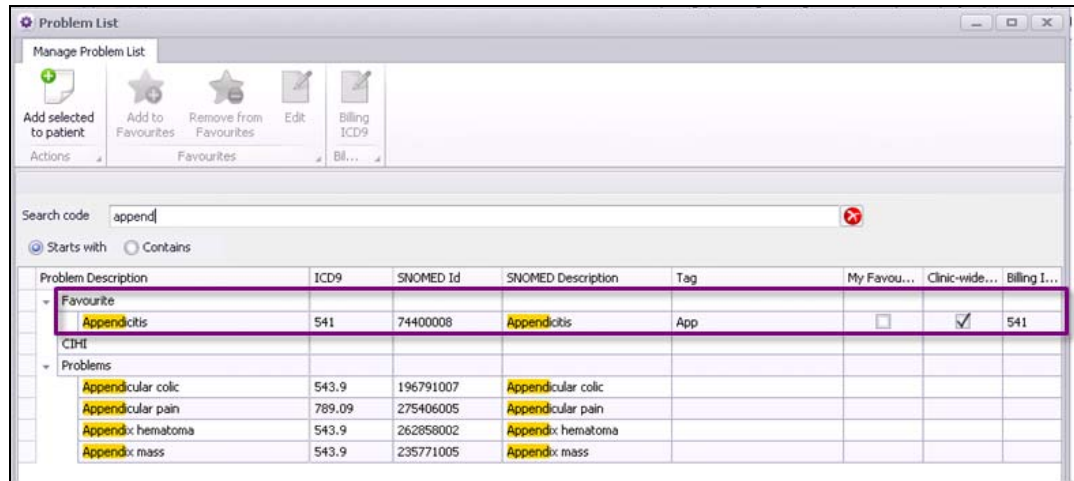
To record a problem from your problem favourites list:

1. Open the Problem List window. See [Step 1](#) to [Step 2](#) in “Recording problems” on page 395.
2. In the **Select Diagnosis** field, enter part or all of the problem name or diagnostic code, and then press **Enter**. The EMR displays a list of matching problems, with matching favourites displayed at the top of the list. Favourite problems are indicated by an asterisk (*) in the **Favourites** column.

Problem Description	SNOMED	Favourite	Tag
Acute appendicitis	85189004	*	Test
Appendicitis	74400004	*	App
Abnormality of left atrial appendage	25335500		
Abnormality of right atrial appendage	25334400		
Abscess of appendix	62224000		
Acute appendicitis with appendix abscess	76643900		

3. In the list of matching problems, click the problem favourite you want, and then click **Update**. The EMR displays the selected problem favourite in the **Active Problem** field.
4. If the problem you want does not display:
 - a) In the **Select Diagnosis** area, click **Advanced**. The EMR displays the Manage Problem List window.
 - b) In the **Search Code** field, enter part or all of the name, or the diagnostic code for the problem.
 - c) Under the **Search Code** field, select **Contains**.
 - d) Press **Enter**. The EMR displays matching problems that contain (anywhere in the problem name, ICD-9 code, or tag) the Search Code entry. Matching problems display in the following order:
 - Problem Favourites (displayed at the top of the list)
 - CIHI problems

■ General problems



e) In the list of matching favourites, click the problem you want, and then click **Add**

Selected to Patient (). The EMR displays the selected problem favourite in the **Active Problem** field on the Problem List window.

5. Finish adding the selected problem to the patient's problem list. See [Step 5](#) to [Step 6](#) in ["Recording problems" on page 395](#).

Adding problems to your favourites list



Note: This procedure applies to clinics using the new problem list that includes the Canadian Institute for Health Information (CIHI) list.



Note: Only users with administrative authority can add clinic-wide problem Favourites. Clinic-wide problem favourites can be viewed by all clinic users.

To add a problem to your favourites list:

1. Open the Problem List window. See [Step 1](#) to [Step 2](#) of ["Recording problems" on page 395](#).

2. In the **Select Diagnosis** area, click **Advanced**.

The 'Select Diagnosis' form includes fields for Diagnosis, SNoMed, Date of Current Diagnosis, Consultant, Qualifier, Location, and a link to '...view Problem Registry'. The 'Advanced' button is highlighted with a red rectangle.

The EMR opens the Manage Problem List window, with:

- Your user-specific and clinic-wide problem favourites displayed at the top of the problem list, under **Favourites**.
- **CIHI** problems displayed below your Favourites list.

The 'Manage Problem List' window displays a table of medical problems. The table is organized into two main sections: 'Favourite' and 'CIHI'. Each section lists the problem description, ICD9 code, SNOMED Id, SNOMED Description, Tag, and checkboxes for 'My Favou...', 'Clinic-wid...', and 'Billing ...'.

Problem Description	ICD9	SNOMED Id	SNOMED Description	Tag	My Favou...	Clinic-wid...	Billing ...
Favourite							
Abrasion AND/OR friction burn of test...		76531002	Abrasion AND/OR friction ...	te	☒	☐	
Androgen poisoning	962.1	291838005	Androgen poisoning		☒	☐	962.1
Andropause	608.89	41982003	Andropause		☒	☐	
Androphobia	300.29	102929005	Androphobia	test	☒	☐	001
CIHI							
Atrial fibrillation and flutter	427.31	195080001	Atrial fibrillation and flutter		☐	☒	427.3
Acute appendicitis	540.9	85189001	Acute appendicitis	test	☐	☒	540.9
Acute bronchitis	466	10509002	Acute bronchitis		☐	☒	466
Acute hepatitis A	70.1	37871000	Acute hepatitis		☐	☒	070.1
Acute hepatitis B	70.3	76795007	Acute type B viral hepatitis		☐	☒	070.3
Acute hepatitis C	70.51	235866006	Acute hepatitis C		☐	☒	573.3
Acute myocardial infarction (AMI)	410.9	57054005	Acute myocardial infarction		☐	☒	
Acute otitis media	382.9	3110003	Acute otitis media		☐	☒	382.9
Alzheimer's disease	331	26929004	Alzheimer's disease		☐	☒	331
Anemia	285.9	271737000	Anemia		☐	☒	285.9
Angina	413.9	194828000	Angina		☐	☒	
Asthma	493.9	195967001	Asthma		☐	☒	493.9
Asymptomatic HIV status	V08	91947003	Asymptomatic human imm...		☐	☒	



Note: The CIHI problem list act as your clinic's default list of Favourites. CIHI problems are those that have been identified by the Canadian Institute for Health Information (CIHI) as the most commonly used by General Practitioners.

3. In the **Search Code** field, enter part or all of the problem name or ICD-9 diagnosis code.
4. Below the **Search Code** field, select one of the following options:

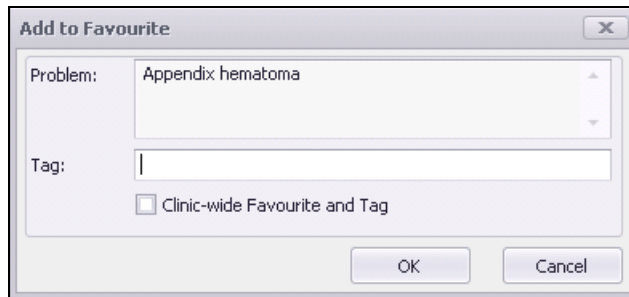
- **Starts with:** To display matching problems that start with the term you entered in the Search Code field.
 - **Contains:** To display matching problems that contain, (anywhere in the problem name, ICD-9 code, or tag) the term you entered in the **Search Code** field.
5. Press **Enter**. The EMR filters your problem list to display matching favourites, CIHI items, and general problems.



Note: Wolf EMR contains a database of over 40,000 problems that you can search from. Because the database is so large, you must perform a search to choose a problem from the general problem list.

The list of problems displayed when you first open the Manage Problem List window, includes only your personal and clinic-wide Favourite problems, and the CIHI list of problems.

6. In the list of problems, click the problem you want to make into a favourite.
7. Click **Add to Favourites** (). The EMR displays the Add to Favourite window.



8. Click **OK**. The EMR adds the problem to your favourites list.

Using problem tags



Note: Only clinics using the new problem list that includes the Canadian Institute for Health Information (CIHI) list can use problem tags.

When you add a problem to a patient's problem list, you can search for a problem using alternative search terms, called tags. For example, you may prefer to enter "DM1" to search for the problem "Type 1 Diabetes".

Because each user may use different abbreviations to search for a problem, multiple tags can be assigned to a problem. Tags can be clinic-wide (can be used by all users), or user-specific.

Adding problems using tags



Note: This procedure applies to clinics using the new problem list that includes the Canadian Institute for Health Information (CIHI) list.

To add a problem to a patient's problem list using a tags:

1. Open the Problem List window. See [Step 1](#) to [Step 2](#) of “Recording problems” on page 395.
2. In the **Select Diagnosis** field on the Problem List window, enter a tag that is assigned to the problem you want. The EMR displays a list of matching problems.

Problem Description	SNoMed	Favourite	Tag
Type 1 diabetes	4663500: *		DM1



Note: The far right column in the problem search results list displays all tags assigned to each problem.

3. Finish adding the selected problem to the patient's problem list. See [Step 4](#) to [Step 6](#) in “Recording problems” on page 395.

Assigning tags to problems



Note: This procedure applies to clinics using the new problem list that includes the Canadian Institute for Health Information (CIHI) list.

If there are no tags assigned to a problem, or if you want to use a tag that is different than the tags currently assigned to a problem, you can assign your own tag(s).

Tags you assign to a problem are user-specific. No other users can view or use your tags.



Note: Only users with administrative authority can assign clinic-wide Tags to problems (tags that can be used by all clinic users).

To assign a tag to a problem:

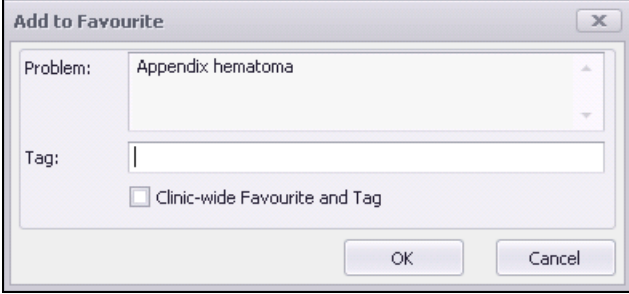
1. Open the Manage Problem List window, and search for the problem you want to assign tags to. See [Step 1](#) to [Step 6](#) of “Adding problems to your favourites list” on page 401.
2. Perform one of the following actions:

- If the problem you want to assign a tag to **is not** on your favourites list or CIHI list:



Note: A problem must first be on the favourites list or CIHI list before you can assign a tag to it.

- In the list of problems, click the problem you want to add assign a tag to.
- Click **Add to Favourites** (). The EMR displays the Add to Favourite window.



- In the **Tag** field, enter the tag you want.



Tip: If you want to add multiple tags, separate each tag name with a comma. (For example, if you want the tags “DM2” and “Diab2” to both work for Type 2 diabetes, enter “DM2,Diab2”.)

You are limited to 50 characters for all tags combined.

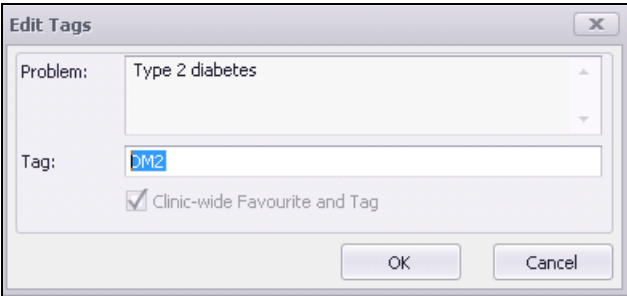
- Click **OK**. The EMR displays the assigned tags in the **Tag** column of the problem list.

- If the problem you want to assign a tag to **is** on your Favourites list:

- In the filtered list of problems, click the problem you want to assign a Tag to.

- Click **Edit** ().

- The EMR displays the Edit Tags window.



d) In the **Tag** field, enter the tag you want.



Tip: If there is a Tag entered already, or if you want to add multiple tags, separate each tag name with a comma. (For example, if you want the tags “DM2” and “Diab2” to both work for Type 2 diabetes, enter “DM2,Diab2”.)

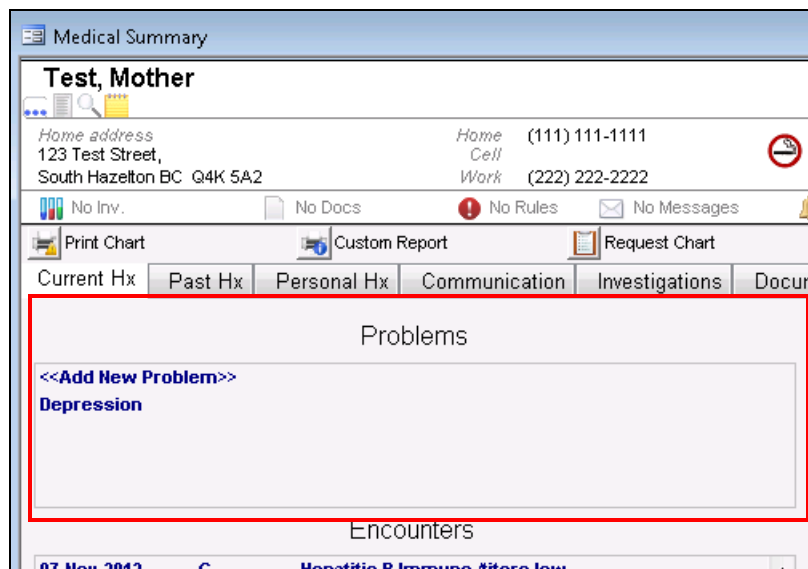
You are limited to 50 characters for all tags combined.

e) Click **OK**. The EMR displays the assigned tags in the **Tag** column of the problem list.

Viewing and editing problems

To view and edit a patient's medical problems:

1. Open the Medical Summary window. See [“Opening a patient's Medical Summary” on page 389](#). The EMR displays the Medical Summary window with the **Current Hx** tab open. The **Problems** area lists the patient's current problems.



2. If you want to view the patient's inactive problems, click the **Past Hx** tab. The **Inactive Problems** area lists the patient's inactive problems.
3. To view or edit detailed information about a specific problem, in the **Problems** or **Inactive Problems** area, double-click the problem. The EMR opens the Problems List window where you can view:
 - Details about the selected problem
 - Lab results, pending labs, medications, and procedures that are linked to the problem
 - A complete list of the patient's problems
 - A complete list of the patient's inactive problems

Problems List

Test, Mother PHN: 9994 200 232

Log Change Diagnosis + - Save

Born: 19-Apr-1964 (51) Sex: F Status: N/A

123 Test Street, South Hazelton BC Q4K 5A2 H (111) 111-1111 P: Dewayne Bryson, M.D.
C (222) 222-2222 W (222) 222-2222

Problems

(HTN) Hypertension

Depression

Current Diagnosis: **Depression**

ICD9: 311 Qualifier: ...view Problem Registry

SNoMed: D9-5201A

Date of Current Diagnosis: 02-Nov-2006 Location:

Consultant: Kirkpatrick, David <PSYCHIATRY> AND

Indicators

*Stability: Stable Certainty:

*Activity: Active Chronicity:

*Temporary?: Lifelong Notes:

Problem History Onset:

Initial Dx: Depression

Prior Dx:

Current Dx: Depression 2006

Linked Lab Results

Linked Pending Lab

Medications For This Problem

<<Add New Medication>>

Procedures For This Problem

<<Add New Surgery>>

Date Checked: 22-Jul-2015

☐ All Meds ☒ Meds For Selected Problem

4. To view a graph of a lab result linked to the problem, in the **Linked Lab Results** area, click

a lab result, and then click **Chart Graph** (.

5. To edit the diagnosis description, click **Change Diagnosis**. The **Current Diagnosis** field clears and changes to the **Select Diagnosis** field.
6. Edit fields as necessary. See [Step 3](#) to [Step 6](#) in "Recording problems" on page 395.

7. When you are finished, **Save & Close** (.

Medications

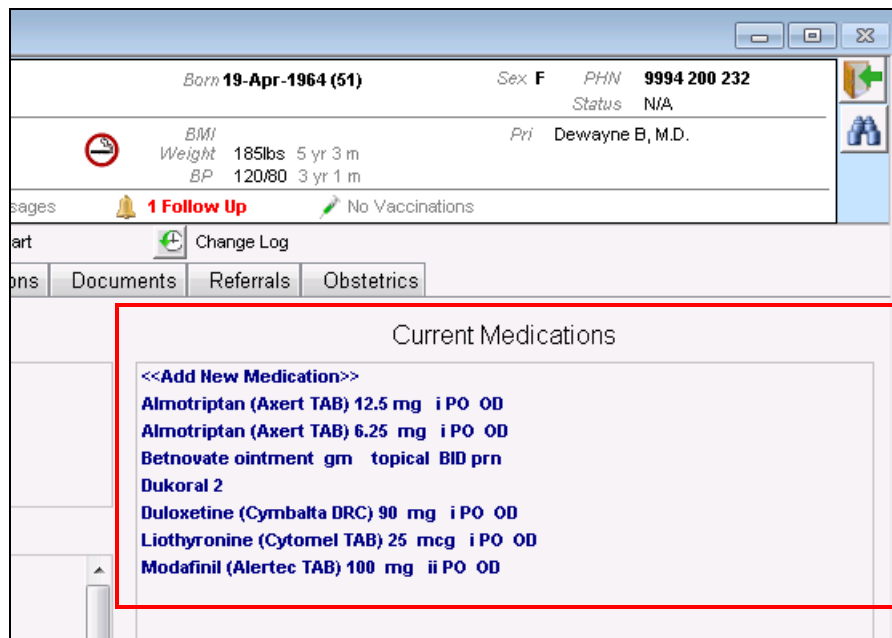
On a patient's Medical Summary, you can view at-a-glance what medications a patient is currently taking, and what medications a patient has taken in the past. You can also create a prescription, or record that a patient is currently taking or has currently taken a medication.

This section covers how to view a patient's medications and treatments. For information on how to create prescriptions, and enter medications, see ["Creating prescriptions and managing medications" on page 227](#).

Viewing patient medications

To view a patient's medications:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#). The EMR displays the Medical Summary window with the **Current Hx** tab open.
2. Perform one of the following actions:
 - To view a patient's current medications, leave the **Current Hx** tab open. The **Current Medications** area lists the patient's current medications.



The screenshot shows a patient's Medical Summary window. At the top, patient information is displayed: Born 19-Apr-1964 (51), Sex F, PHN 9994 200 232, Status N/A, and Primary Care Physician Dewayne B, M.D. Below this, vital signs and other data are shown: BMI, Weight 185lbs 5 yr 3 m, BP 120/80 3 yr 1 m, and a '1 Follow Up' alert. The 'Current Medications' section is highlighted with a red box and contains the following list:

- <<Add New Medication>>
- Almotriptan (Axert TAB) 12.5 mg i PO OD
- Almotriptan (Axert TAB) 6.25 mg i PO OD
- Betnovate ointment gm topical BID prn
- Dukoral 2
- Duloxetine (Cymbalta DRC) 90 mg i PO OD
- Liothyronine (Cytomel TAB) 25 mcg i PO OD
- Modafinil (Alertec TAB) 100 mg ii PO OD

- To view a patient's previous medications, click the **Previous Hx** tab. The **Previous Medications** area lists the patient's previous (inactive) medications.

Born **19-Apr-1964 (51)** Sex **F** PHN **9994 200 232**
 Status **N/A**
 BMI **185lbs 5 yr 3 m** Pri **Dewayne Bryson, M.D.**
 Weight **120/80 3 yr 1 m**
 BP **120/80 3 yr 1 m**
 1 Follow Up No Vaccinations
 Change Log
 Documents Referrals Obstetrics
 Previous Medications
 <<Add New Medication>>
 Acetazolamide (Diamox) 250 mg i PO
 Alprazolam (Xanax) 0.25 mg PO TID
 Alprazolam (Xanax) 0.5 mg i PO TID
 Alprazolam (Xanax) 0.5 mg i PO TID
 Alprazolam (Xanax) 0.5 mg i PO TID prn
 Bupropion (Wellbutrin SR) 150 mg i PO OD
 Bupropion (Wellbutrin SR) 150 mg i PO OD
 Bupropion (Wellbutrin SR) 150 XL 1 po q day
 Bupropion (Wellbutrin SR) 250 mg i PO BID
 Bupropion (Wellbutrin SR) 250 mg i PO OD
 Bupropion XL (Wellbutrin XL) 300 mg i PO OD
 Bupropion xl 300 mg i PO OD
 Buspirone (Buspar) 5 mg i PO BID
 Cephalexin (Keflex) 250 mg PO q6h
 Ciprofloxacin (Cipro) 250 mg i PO BID
 Refuted and Terminated Allergies

- To view more detailed information about a particular medication, in the **Current Medications** area or the **Previous Medications** area, double-click the medication. The EMR opens the patient's **Medication Profile** window with the following information displayed:

- Prescription details for the selected medication
- Lab results linked to the selected medication
- Refill history for the selected medication
- A complete list of the patient's current medications, previous medications, and allergies.

Medication Profile

Test, Daughter PHN: 9999 999 999

Born: 28-Aug-1999 (15) Sex: F Status: N/A

123 Test Street, Squamish BC H: (111) 111-1111 C: (222) 222-2222 Pri: Veta C, M.D.

Effective (as of) Date: 09-Jul-2015

Medications

Medication Name	Start Date
Clobazam (Frisium TAB) 10 mg i PO qhs	16-Oct-2012
Lamotrigine (Lamictal TAB) 150 mg i PO BID	16-Oct-2012
Methylphenidate (Ritalin-SR ERT) 30 mg i PO OD	16-Oct-2012

Current Medication

Clobazam (Frisium TAB) 10 mg i PO qhs

Problem: [Dropdown]

Start Date: 16-Oct-2012

End Date: No Cut Off

Note: Medication note

There are no drug interaction overrides recorded for this medication.

Linked Lab Results:

☒ Refill History ☐ Medication History

Next Refill	Last Refill	Quant	Repeats	Ph Call	Refill Status	Initials	Notes
24-Jan-2013	16-Oct-2012	100	T, 0	Yes	Printed	VC	

Previous Medications

Medication Name	End Date	Start Date

Allergies:

4. To view details for another medication, in the **Medications** area or the **Previous Medications** area, click the medication. The EMR displays the medication details to the right.



Note: From the Medication Profile window, you can modify, refill, re-print, or discontinue prescriptions if necessary. See [“Modifying prescriptions” on page 250](#).

Viewing and editing encounter notes

In the **Encounters** area, you can view a complete list of the patient's encounter notes and messages. You can also view and edit individual encounter notes if needed.

To view a patient's encounter notes:

1. Open the Medical Summary window. See [“Opening a patient's Medical Summary” on page 389](#). The EMR displays the Medical Summary window with the **Current Hx** tab open. The

Encounters area displays a list of the patient's encounter notes and messages arranged by date.

Date	Status	Description
14-Mar-2016	I	Office Visit
09-Jul-2013	I	F/U
19-Jun-2013	I	msg This is a message
22-Apr-2013	C	msg This is a message
25-Mar-2013	C	msg This is a message
13-Mar-2013	C	msg This is a message
16-Jan-2013	C	msg This is a message
15-Jan-2013	C	msg This is a message
15-Jan-2013	C	msg This is a message
09-Jan-2013	C	msg This is a message
20-Nov-2012	C	msg This is a message

Filtered by: Selected providers
Viewing 33 of 33 encounters

Filter Options

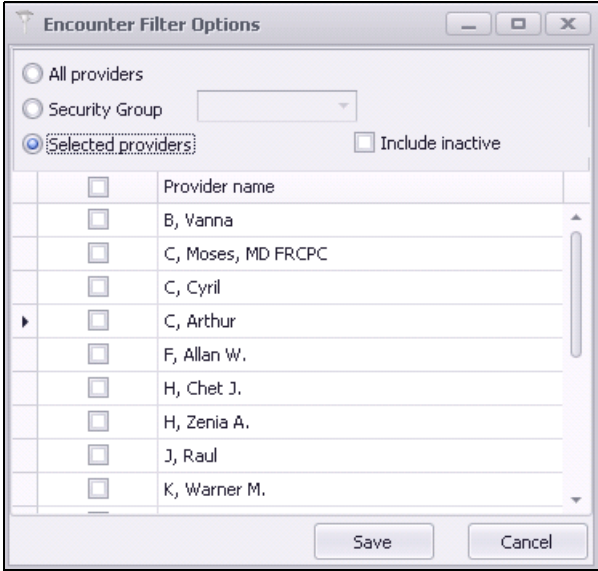


Note:

- A **C** beside the date indicates the encounter is complete.
- An **I** beside the date indicates the encounter is incomplete.

If an encounter is incomplete, you cannot view the encounter notes for that visit from the Medical Summary.

2. To filter the patient's encounter list to display encounters with only specific providers, or encounters with only providers belonging to a specific security group:
 - a) Below the patient's encounter list, click **Filter Options**. The EMR displays the Encounter Filter Options window.



The dialog box titled "Encounter Filter Options" contains three radio buttons: "All providers", "Security Group" (with a dropdown menu), and "Selected providers" (which is selected). To the right of the "Selected providers" option is a checkbox labeled "Include inactive". Below these options is a list of providers with checkboxes next to their names:

☐	Provider name
☐	B, Vanna
☐	C, Moses, MD FRCPC
☐	C, Cyril
☒	C, Arthur
☐	F, Allan W.
☐	H, Chet J.
☐	H, Zenia A.
☐	J, Raul
☐	K, Warner M.

At the bottom of the dialog are "Save" and "Cancel" buttons.

- b) Perform one of the following actions:
- To view visits for a specific security group, click **Security Group** and then, in the drop-down list, select the security group you want.
 - To view visits for specific providers, click **Selected providers** and then, in the list of providers, select the check box beside the provider(s) you want.
- c) Click **Save**. The EMR filters the list and displays the filter criteria at the bottom of the encounter list. The EMR saves your filter selection and applies it to other patients you view going forward.

25-Sep-2011	C	msg	This is a message
06-Sep-2011	C	msg	This is a message
24-Aug-2011	C		social work contact
24-Aug-2011	C	msg	This is a message

Filtered by: Selected providers
Viewing 33 of 33 encounters

Filter Options



Note: If you want to filter encounters, the Encounter filtering feature must be enabled for your clinic. For more information, contact the Wolf EMR Support Team. See [“Contacting Wolf EMR Support” on page 3.](#)

3. To view visit notes entered for a particular encounter, in the **Encounters** area, double-click a completed (C) encounter. The EMR displays the encounter's visit notes in a read-only window.

4. To view to the next encounter's visit notes, click **Go to Next Visit Record** (), or to view to the previous encounter's visit notes, click **Go to Previous Visit Record** ().
5. To edit a completed encounter's visit notes:

- On the top of the read-only window, click **Edit Visit Record** (). The EMR displays the visit notes in the SOAP form, or if the note was written as a consult letter, the EMR displays the visit notes in the consult letter form.
- Edit information in the SOAP form, or consult letter form as needed. See ["Entering visit notes in the SOAP form" on page 139](#), or ["Entering visit notes in the consult letter form" on page 194](#).

6. To view a searchable history of all a patient's encounter visit notes and messages. On the top of the read-only window of an encounter visit note, click **View Encounter History** (). The EMR displays the Visit Record History window.

Wolf Clinical

Visit Record History :

Encounter History (Click on Visit to Open Form):

Search AND

07-Nov-2012	Depression
07-Nov-2012	Hepatitis B Immune Titers low
05-Oct-2012	Phone Message
14-Sep-2012	Phone Message
05-Sep-2012	Phone Message
16-Aug-2012	Phone Message
23-Jul-2012	Phone Message
18-Jul-2012	Phone Message
10-Jul-2012	Phone Message
10-Jul-2012	Phone Message
10-Jul-2012	Back Pain
10-Jul-2012	Depression
26-Jun-2012	Phone Message
25-Jun-2012	Phone Message
22-Jun-2012	Phone Message
31-May-2012	nose bleeds
25-May-2012	Axis II - deferred
25-May-2012	lumbago
23-May-2012	Phone Message
23-May-2012	Phone Message
17-May-2012	Phone Message
17-May-2012	Phone Message
17-May-2012	Phone Message

depression

Allergies and intolerances

On a patient's Medical Summary, you can view and record the patient's allergies and intolerances. You can also view a patient's allergies and intolerances in the same window you use to enter prescriptions and medication information.

Recording allergies and intolerances

To record an allergy or intolerance:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#). The EMR displays the Medical Summary window with the **Current Hx** tab open.

2. In the **Allergies** area, double-click <<Add New Allergy>>.

The screenshot shows a web-based medical summary interface. At the top, there are three tabs: 'Documents', 'Referrals', and 'Obstetrics'. Below these is a section titled 'Current Medications' which contains a list of medications: <<Add New Medication>>, Almotriptan (Axert TAB) 12.5 mg i PO OD, Almotriptan (Axert TAB) 6.25 mg i PO OD, Betnovate ointment gm topical BID prn, Dukoral 2, Duloxetine (Cymbalta DRC) 90 mg i PO OD, Liothyronine (Cytomel TAB) 25 mcg i PO OD, and Modafinil (Alertec TAB) 100 mg ii PO OD. Below the medications section is the 'Allergies' section, which is highlighted with a red rectangular box. Inside the 'Allergies' section, the text '<<Add New Allergy>>' is displayed in red.

The EMR displays the Clinical Records window.

Clinical Records			
Test, Mother		PHN 9994 200 232	
...	Born 19-Apr-1964 (51)		
123 Test Street, South Hazelton BC Q4K 5A2		Sex F Status N/A	
		H (111) 111-1111 C W (222) 222-2222	
		Prn Dewayne Bryson, M.D.	

+

✕

Allergy To:

☒ Medication
 ☐ Category
 ☐ Vaccine Type
 ☐ Other

▼

Clinical Status:

Active

▼

Certainty:

▼

Reaction:

▼

Symptoms:

▼

Note:

Date Noted:

27-Jul-2015



Tip: You can also record an allergy or intolerance for a patient from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

1. On the window, right-click, the EMR displays the SMART menu.
2. On the SMART menu, click **New Allergy**.

3. Enter information in the Clinical Records window, using the following table as a reference.



Tip: When you add an allergy or intolerance, the only required fields are:

- Allergy To
- Clinical Status

Field	Description
Allergy To	In the Allergy To area: 1. Select an option to indicate if the allergy is to a Medication (for example, codeine), a drug Category (for example, sulfa drugs, penicillins), a Vaccine Type (for example, flu), or Other non-medication substances (e.g. latex) . 2. In the drop-down list, click the specific allergen. Note: To filter the list, begin to enter the allergen name. 3. If you cannot find an appropriate option in the drop-down list, or if you selected Other, enter the allergy in the text field.
Clinical Status	In the drop-down list, select one of the following status options: Active , Resolved , Refuted or Terminated and Reclassified .
Certainty	In the drop-down list, select if the allergy is Confirmed or Suspected .
Reaction	In the drop-down list, select an option to indicate the type of reaction the patient experiences.
Symptoms	In the drop-down list, select the patient's primary symptom. If you cannot find the symptom in the drop-down list, or if you want to add additional symptoms, enter the symptom(s) in the text field. Note: Be careful when adding symptoms as they are added clinic-wide and spelling mistakes cannot be corrected.
Notes	Enter any additional notes, as required.
Date Noted	The EMR populates the field with today's date. You can change this field if required, by entering the date in the format of DD-Mmm-YYYY. TIP: If you do not know the exact day, you can enter the date in the format of Mmm-YYYY, for example, "Dec 2013". The EMR uses the first day of the month to complete the date, for example, "Dec 01 2013". You can also select a date using the calendar icon.

4. Perform one of the following actions:

- To add another allergy, click **Add** () and repeat step [Step 3](#)

- To save the allergy and close the Clinical Records window, click **Save & Close** (.

Viewing and editing allergies and intolerances

To view a patient's allergies and intolerances:

1. Open the Medical Summary window. See [“Opening a patient's Medical Summary” on page 389](#). The EMR displays the Medical Summary window with the **Current Hx** tab open. The **Allergies** area displays a list of the patient's allergies.

The screenshot shows a software interface with three tabs at the top: 'Documents', 'Referrals', and 'Obstetrics'. The 'Obstetrics' tab is selected. Below the tabs is a section titled 'Current Medications'. This section contains a list of medications: Almotriptan (Axert TAB) 12.5 mg i PO OD, Almotriptan (Axert TAB) 6.25 mg i PO OD, Betnovate ointment gm topical BID prn, Dukoral 2, Duloxetine (Cymbalta DRC) 90 mg i PO OD, Liothyronine (Cytomel TAB) 25 mcg i PO OD, and Modafinil (Alertec TAB) 100 mg ii PO OD. Below the medications section is a section titled 'Allergies'. This section contains a list of allergies: codeine (Codeine Contin 150 m Adverse Reaction), penicillins, and Anaphylaxis. The 'Allergies' section is highlighted with a red border.

2. In the **Allergies** area, double-click an allergy or intolerance. The EMR opens the Allergy List window. You can view a list of the patient's allergies in the left pane, and details for the selected allergy or intolerance on the right.

Allergy List

Test, Mother PHN 9994 200 232

Log
+
✖
↩

Born **19-Apr-1964 (51)** Sex **F** Status **N/A**
 123 Test Street, South Hazelton BC Q4K 5A2 H (111) 111-1111 C (222) 222-2222
 Pri Dewayne Bryson, M.D.

Active Allergies

codeine (Codeine Con	Adverse Reaction
penicillins	Anaphylaxis

Anaphylaxis

penicillins

Clinical Status: **Active**
 Certainty: **Confirmed**
 Reaction: **Anaphylaxis**
 Symptoms:
 Note:
 Date Noted: **11-Jun-2015**

Refuted and Terminated Allergies

3. In the Allergy List window, in the **Active Allergies** area, click an allergy to view details about the status, certainty, reaction, symptoms.
4. Edit the fields as required. See ["Recording allergies and intolerances"](#) on page 414.
5. To refute an allergy or intolerance, or to report that the allergy or intolerance is resolved:
 - a) In the **Active Allergies** list, click the allergy.
 - b) In the **Clinic Status** drop-down list, click one of the following options: **Refuted**, **Resolved**, or **Terminated and Reclassified**. The EMR moves the allergy or intolerance to the **Refuted and Terminated Allergies** list.
6. To permanently delete an allergy from a patient's record (for example, if you entered an allergy or intolerance in the wrong patient's record):
 - a) In the **Active Allergies** list, click the allergy, and then click **Delete Allergy from Patient's Record** (). The EMR displays a dialog box with the following prompt: "Permanently Delete: <allergy> Allergy Record From Patient's Record?"
 - b) Click **Yes**.

Vaccinations

When you record a patient's vaccinations, you can note:

- Who administered the vaccination.
- If the vaccination was administered at another facility and at which facility it was administered at.
- If a patient refused or declined a recommended vaccination.

If you enter patient vaccination information appropriately, you can make use of the reminder and reporting tools available for vaccinations. Using the Wolf EMR vaccination recommendation tool, you can track what vaccinations your patients are due for. Using the Immunization report, you can produce reports of vaccinations administered over a defined period of time.

Recording vaccinations

You can record vaccinations that were administered at your clinic, and vaccinations that were administered at other facilities. You can also record that a patient refused a vaccination.

To record a vaccination administered to a patient:

1. Perform one of the following actions:

- If you have the patient's Medical Summary open, on the **Current Hx** tab, in the **Vaccinations** area, click **<<Add Vaccination>>**.
- If you have another window of the patient's medical record open (for example, a SOAP note), right-click and then, in the SMART menu, click **New Vaccination**.

The EMR displays the **Vaccinations** entry window.

Vaccinations

Test, Mother PHN 99999-9999

Born **15-May-1981 (34)** Sex **F** Status **N/A**
 123 Test Way, H (111) 111-1111 Pri Janna Schreiber, MD Ph...
 Ardrie AB T2T 5P5 C
 W Ret

☐ Primary Immunizations have been Completed for Patient

Fields prefixed with * are mandatory

*Vaccination Date:
 Date: **03-Mar-2016**
 Approx:

*Location : **Wolf Clinic**
 Administration Facility: **Clinic**
 *Administered By : **Physician/Nurse Prac**
Schreiber, Janna, MD PhD FRCP

*Vaccine:
 Edit ... Series #:
 *Lot #: Expiry: Edit Lot...
 Route:
 Dosage mL
 *Vaccination Injection Site:
 *Reaction: **None**
[AEFI Report \(Public Health Canada\)](#)

Notes:

There are no drug interaction overrides recorded for this vaccination.

☐ Refused Date Refused:
 Refusal Reason:

2. In the **Vaccination Date** area, perform one of the following actions:

- If you know the date the vaccination was administered, in the **Date** field, enter a date, or to select a date on a calendar, click .
- If you are recording a previous vaccination and are unsure of the administration date, in the **Approx** field, enter an approximate date. EMR translates the approximate date into a full date and displays the date in the **Date** field.

**Entering an Approx date**

You can enter the approximate date as:

- Month only: The EMR records the date as the first day of this month in the current year.
- Year only: The EMR records the date as January 1 of the selected year.
- Month and Year: The EMR records the date as the first day of the entered month in the entered year.

You can enter the month in full or as an abbreviation. The year must be a four-digit year.

3. If your clinic has multiple locations, in the ***Location** drop-down list, select the location the vaccination was administered at.
4. In the **Administration Facility** field, complete one of the following actions:
 - If the vaccination was administered in your clinic, in the drop-down list, select **Clinic**.
 - If the vaccination was administered at a facility outside of your clinic, in the drop-down list click the facility. If the facility you want is not available in the list, enter the facility in the field.



Best practice: If you enter a new **Administration Facility**, you can choose to add the facility to the list. Add facilities to the list only if you or other users will be selecting the location often.

To modify or delete Administration Facility drop-down list options (for example, to “clean-up” duplicate or miss-spelled list items):

1. Double-click the **Administration Facility** field tag. The EMR displays the Administration Facility Field List window.

2. Perform one of the following actions:

- To add a facility name, in the bottom row, enter the name.
- To edit a facility name, click the line, and then modify the text as needed.
- To delete a location, click the location line, and then on your keyboard, press **Delete**.

5. When you finish, click .

5. In the **Administered By** area, perform one of the following actions:

- If the individual who administered the vaccination was a practitioner in your clinic, in the drop-down list, select **Physician/Nurse Prac**, and then in the lower drop-down list, click the practitioner.
- If the individual who administered the vaccination was a front end staff member, in the drop-down list, select **Staff**, and then in the lower drop-down list, click the staff member.
- If the individual who administered the vaccination was from a facility outside of your clinic, in the drop-down list, select **Public Health**, and then in the field enter the name of the practitioner, pharmacy, or clinic.

6. In the **Vaccine** field, enter all or part of the vaccination name (for example, flu or dpt), and then on your keyboard, press **Enter**. The EMR displays a list of matching vaccinations.

7. In the list of vaccinations, click the vaccination you want. The EMR displays the full vaccination name in the **Vaccine** field.
8. In the **Series** field, enter the series number of the vaccine, if applicable.
9. In the **Lot #** field, perform one of the following actions:
 - To select a lot number that has previously been entered on the computer you are currently using, in the drop-down list, click the vaccine's lot number. The EMR displays the **Expiry** date for the selected lot.
 - To enter a new lot number that has not been entered previously for another patient, in the **Lot #** field, enter the lot number, and then in the **Expiry** field, enter the lot's expiry date.



Tip: If you want to edit the **Expiry** date, click **Edit Lot**, change the date, and then close the window.



Note: A particular lot number is not available in the drop-down list if it has expired or if the lot has been marked as "Finished"

10. In the **Route** drop-down list, select the vaccination route.



Note: If the route you want is not on the list, you cannot enter the value. Users with administrative authority can add options to the **Route** list if needed via Configuration:

1. On the Wolf EMR Launch page, click **Configuration** ().
2. On the Configuration menu, click **View > Patient Data Codes > Vaccination Types > Route Maintenance**.

11. In the **Dosage** field, enter the vaccination dose.
12. In the **Vaccination Injection Site** drop-down list, select the site where the vaccination was administered. If the injection site you want is not available, then manually enter the value.



Best practice: If you enter a new injection site, you are prompted to add the injection site to the drop-down list. Add injection sites to the list only if:

- You or other users will be selecting the option often
- You can confirm that the option is not already available on the list (perhaps as a different name?)
- You can confirm that you have spelled the injection site correctly

To modify or delete **Vaccination Injection Site** drop-down list options (for example, to “clean-up” duplicate or miss-spelled list items):

1. Double-click the **Vaccination Injection Site** field tag. The EMR displays the Vaccination Injection Site Field List window.

2. Perform one of the following actions:

- To add an injection site, in the bottom row, enter the site.
- To edit a injection site name, click the injection site line, and then modify the text as needed.
- To delete a site, click the injection site line, and then on your keyboard, press **Delete**.

4. Click .

13. To review possible contraindication for the vaccination, at the top of the window, click the

Multum (.

). For more information on viewing drug interaction warnings, see [“Reviewing drug interaction warnings” on page 235](#).

14. To record a reaction to the vaccination:

- a) In the **Reaction** drop-down list, click the type of reaction the patient had, or if the reaction type you want is not on the list, in the **Reaction** field, enter the reaction.

When you save the vaccination entry, the EMR displays the allergy entry window with the vaccination and reaction type populated.

- b) If the patient has an adverse reaction that should be reported to the Public Health Agency of Canada, click the **AEFI Report (Public Health Canada)** link. The EMR opens the Report of Adverse Events Following Immunization (AEFI) SMART form for the patient.



The screenshot shows the 'REPORT OF ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)' form. At the top, it features the Canadian flag and the logos for 'Public Health Agency of Canada' and 'Agence de la santé publique du Canada'. Below the title, there are instructions: 'INSTRUCTIONS: For more complete instructions and definitions, refer to the user guide at: www.phac-aspc.gc.ca/im/aeafi'. The main body of the form contains a definition of AEFI: 'Report events which have a temporal association with a vaccine and which cannot be clearly attributed to other. A causal relationship does not need to be proven, and submitting a report does not imply causality.' It then lists criteria for reporting: 'Of particular interest are those AEFIs which: a) Meet one or more of the seriousness criteria b) Are unexpected regardless of seriousness'. A note section follows, stating: 'Note: • the numbers below correspond to the numbered sections of the form. • All dates should be captured in the following format: YYYY / MM / DD. • When reporting an AEFI, check one of the boxes on the top right hand corner of the first page of the indicate whether it is an INITIAL or FOLLOW UP report. For all follow up reports, please specify the'. The form is partially cut off at the bottom.

Complete, save, and optionally print or fax the form.

15. In the **Notes** area, enter any notes regarding the patient's vaccination.
16. To view details on any interaction warning override(s), click **Drug Interaction Overrides**. The EMR displays the Drug Interaction Override History window.
17. If all of the patient's primary immunizations are completed, at the top of the window, select the **Primary Immunizations have been Completed for this Patient** check box. The EMR indicates the completion of Primary Immunizations on the **Current History** tab in the Medical Summary window.
18. Perform one of the following actions:

- To record another vaccination click **Add** () and repeat steps [Step 2](#) to [Step 18](#).

- If you are finished recording vaccinations, click  to save the vaccination entry and to close the Vaccinations window.

Recording refused vaccinations

If a patient refuses a vaccination, you can record and reference the refusal. This way, you know:

- Not to offer the vaccination again, or
- To provide the patient with more information



Note: If you record refused vaccinations, you can produce practice search reports detailing patients who refused certain vaccinations. In Practice Search, use the search parameter: **Refused Vaccinations**.

To record a refusal to a vaccination:

1. Start to record the refused vaccination as you would for an administered vaccination. See [Step 1](#) to [Step 7](#) of “Recording vaccinations that you administer” on page 512.
2. In the Vaccinations window, select the **Refused** check box.
3. If the patient refused the vaccination on a date other than today, in the **Date Refused** field, enter the date, or to select a date on a calendar, click .
4. Click **Close Form** (.

Recording group vaccinations

If you administer the same vaccination to a group of people (for example, if you administer a vaccine to a family, or if you host a flu shot clinic), you can record the vaccination for all patients at once.



Note: You can record group vaccinations only for patients who have appointments booked on the date the vaccinations took place.

To record a vaccination for a group of patients:

1. On the WorkDesk menu, click **Patients > Group Vaccination** (). The EMR displays the Group Vaccination window.

Wolf Clinical Records

Group Vaccination

Fields prefixed with * are mandatory

1. Select a Vaccination 2. Select Patients 3. Create Vaccination Records

*Vaccine: *Appointment Date: Practitioner Filter:

Brand Name: Appointment Reason:

Series #: Vaccination Records Created for Following Patients

*Lot #: Expiry: Edit Lot...

Route: Dosage: mL

*Vaccination Injection Site:

*Location:

Administration Facility:

*Administered By:

2. Using the following table, under **1. Select a Vaccination**, enter the vaccination information.

Field	Description
Vaccine	Enter all or part of the vaccination name (for example, flu or dpt), and then on your keyboard, press Enter . The EMR displays a list of matching vaccinations. Click the vaccination you want. The EMR displays the full vaccination name in the Vaccine field.
Series #	Enter the series number of the vaccine, if applicable.
Lot #	Perform one of the following actions: ■ To select a lot number that has previously been entered on the computer you are currently using, in the drop-down list, click the vaccine's lot number. The EMR displays the Expiry date for the selected lot. ■ To enter a new lot number that has not been entered previously for another patient, in the Lot # field, enter the lot number.

Field	Description
Expiry	Enter the lot's expiry date.
Route	In drop-down list, select the vaccination route.
Dosage	Enter the vaccination dose.
Vaccination injection Site	In the drop-down list, select the site where the vaccination was administered. If the injection site you want is not available, then manually enter the value.
Location	If your clinic has multiple locations, in the drop-down list, select the location the vaccination was administered at.
Administration Facility	perform one of the following actions: ■ If the vaccination was administered in your clinic, in the drop-down list, select Clinic. ■ If the vaccination was administered at a facility outside of your clinic, in the drop-down list click the facility. If the facility you want is not available in the list, enter the facility in the field.
Administered By	Perform one of the following actions: ■ If the individual who administered the vaccination was a provider in your clinic, in the drop-down list, select Physician/Nurse Prac, and then in the lower drop-down list, click the provider. ■ If the individual who administered the vaccination was a front end staff member, in the drop-down list, select Staff, and then in the lower drop-down list, click the staff member. ■ If the individual who administered the vaccination was from a facility outside of your clinic, in the drop-down list, select Public Health, and then in the field enter the name of the provider, pharmacy, or clinic.

3. Under **2. Select Patient**, perform the following steps:
 - a) In the ***Appointment Date** field, select the date the vaccinations took place.
 - b) In the **Practitioner Filter** drop-down list, select the provider whose patient's were vaccinated, or if patient's from multiple providers were vaccinated, select **<ANY>**.
 - c) If the patients whom were vaccinated had a common appointment reason (for example, "injection", or "vaccination"), in the **Appointment Reason** drop-down list, select the reason, otherwise, leave **<ANY>** selected.

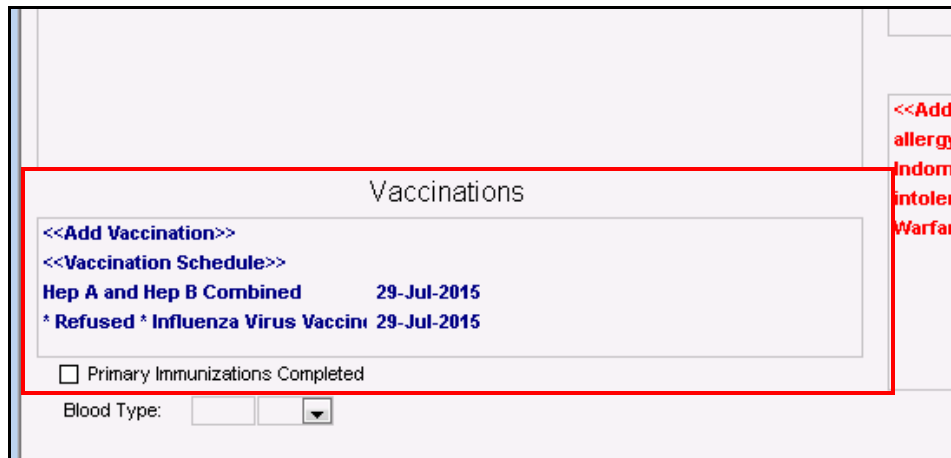
The EMR displays a list of patients whom meet the criteria outlined in this step.

4. In the list of patients, click a patient whom you want to record the vaccination for, and then click . The EMR adds the patient to the **Vaccination Records Created for Following Patients** area.
5. Repeat [Step 4](#) for all patients you want to record the vaccination for.
6. When you finish, click **Close Form** (). The EMR records the vaccination in the Medical Summary of all selected patients.

Viewing and modifying vaccinations

To view or edit a patient's vaccinations:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#). On the **Current Hx** tab, the **Vaccinations** area displays:
 - The patient's administered vaccinations.
 - The patient's refused vaccinations.
 - The **Primary Immunizes Completed** check box.




Note: To quickly indicate that a patient (no matter what age) has received all required Primary Immunizations, select the **Primary Immunizations Completed** check box.

2. To view more detailed information about a vaccination, in the **Vaccinations** area, double-click the vaccination. The EMR displays the Vaccinations window.
3. In the Vaccinations window modify information as needed. For information on how to input vaccination details, see ["Recording vaccinations" on page 420](#).

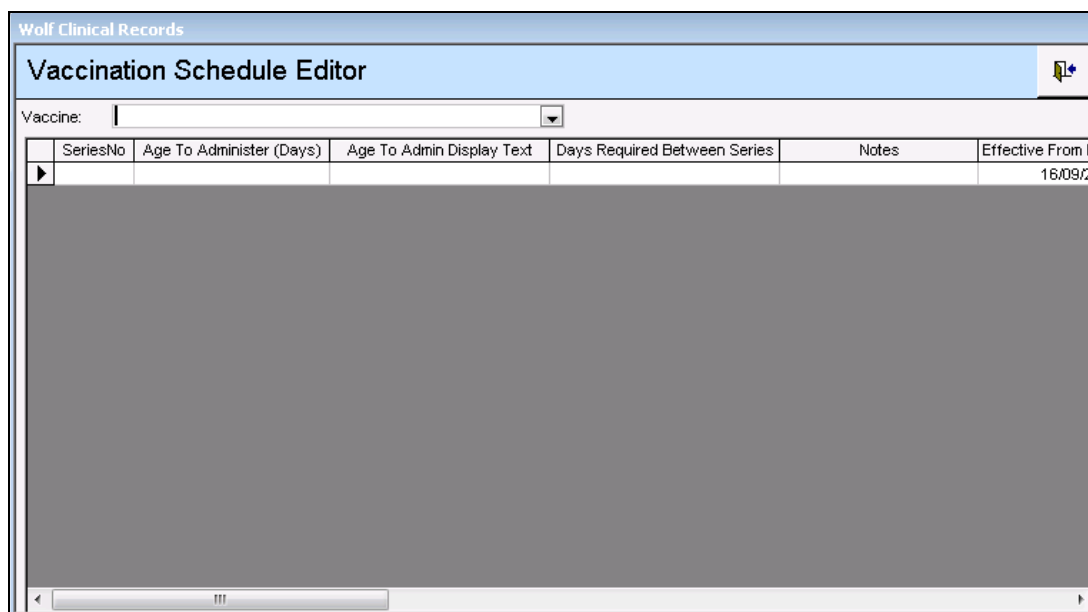
Creating vaccination recommendations

Because there are numerous vaccinations that patients are recommended to take throughout their lifetime, it can be hard to track if a patient is due for, or missing a vaccination.

In Wolf EMR, you can create automatic notifications that displays for patients who are due for vaccinations. Using vaccination schedules you can create automatic vaccination notifications for patients who meet criteria for specific vaccinations.

To create a vaccination schedule:

1. On the WorkDesk menu, click **Configure > Vaccination Schedules** (). The EMR displays the Vaccination Schedule Editor window.



SeriesNo	Age To Administer (Days)	Age To Admin Display Text	Days Required Between Series	Notes	Effective From
					16/09/12

2. In the **Vaccine** drop-down list, select a vaccine. The EMR displays the vaccine name in the **Vaccine** field.



Tip: If you are having trouble finding the vaccination you want, in the **Vaccine** field, begin to enter the vaccine name. The EMR takes you to the appropriate place in the list.

Series	Vaccine
Polio	IPV
Polio (oral)	
quadracel	
Rabies	IMOVAX
Rhogam	
Rotavirus	Rotarix
Rotavirus	RotaTeq
Rubella	Rubella
Td Polio	
Td, Pertussis	Adacel
Td, Polio	
Tetanus, Diphtheria, Pertussis, Polio	Adacel -Polio
Tetanus/Diphtheria	Td adsorbed
Tetanus/Diphtheria/Polio	
Typhoid	Typhim Vi
Typhoid - oral	Vivotif



Note: There should never be more than one instance of the same vaccine the drop-down list. If you see multiple instances, inform a staff member with administrative privileges. Users with Administrative privileges can remove the redundant option.

3. Using the following table, enter the schedule for the vaccine.

Column	Description
Age to Administer (Days)	Enter the recommended age, in days.
Age to Administer Display Text	Enter the recommended age in the format you want the age to display on the Vaccination Schedule (for example, 12 months.)
Days Required Between Series	If the vaccination is a series, enter the number of days required between each vaccination in a series. For example, if two months is required between each vaccination in the series, enter "60" to indicate "60 days."
Notes	Enter any notes you want regarding the recommended vaccination.
Effective From DOB	If the vaccine is new for infants/children, enter a starting date. The EMR displays the vaccination recommendation only on the Vaccination Schedule of patients who's date of birth is AFTER the date specified.

Column	Description
Display	To activate the vaccination schedule, select this check box.



Tip: Use the horizontal scroll bar at the bottom of the Vaccine Schedule Editor window to view the last few columns.

4. When you are finished, click **Close Form** (.

Stopping vaccination recommendations

If a vaccination is taken off the market, or if clinical guidelines for a vaccination changes, you can halt automated recommendations for that vaccination.

To stop a vaccination recommendation:

1. On your **WorkDesk**, click **Configure > Vaccination Schedules** (). The EMR displays the Vaccination Schedule Editor window.
2. On the **Vaccine** drop-down list, select the vaccination you want to stop recommendations for. The EMR displays the recommendations associated with the selected vaccine in the table below.
3. In the **Effective To DOB** column, enter an end date (Typically today's date or an earlier date). The EMR removes the recommendation for any patient born after the date specified.

Recognizing when a patient is due for vaccinations

To recognize when a patient is due for a vaccination:

1. On any window of the patient's record (including the Medical Summary, or a SOAP note), in the SMART patient banner, click  **# Vaccinations** (where **#** = the number of vaccinations the patient is due for). The EMR displays the patient's **Vaccination Schedule**, with:
 - Upcoming vaccinations highlighted in blue
 - Outstanding vaccinations highlighted in orange.

Vaccination Schedule

Test, Baby Daughter PHN

Born **15-Jun-2014 (13 wk 2 d)** Sex **F** Status **N/A**

123 Test Street, H C W Pri Dana Know-Four, MD Fam Ret

Quick Print [Icon] [Icon]

View schedules for:

Vaccination: <<ALL>>

☒ All ☒ Pending ☒ Complete ☒ Refused

From Date: Last 5 years To Date: Next 3 years

16-Sep-2009 16-Sep-2017

Double click highlighted row below to edit vaccination record

Immunization	Schedule	Admin Age	Admin Date
Meningococcal C Conjugate #0	2 mo	Overdue	Due 14-Aug-2014
Pneumococcal 23-Polyvalent #0	2 mo	Overdue	Due 14-Aug-2014
Meningococcal C Conjugate #0	4 mo	Pending	Due 13-Oct-2014
Pneumococcal 23-Polyvalent #0	4 mo	Pending	Due 13-Oct-2014
Meningococcal C Conjugate #0	12 mo	Pending	Due 10-Jun-2015
Pneumococcal 23-Polyvalent #0	12 mo	Pending	Due 10-Jun-2015
MMR #0	12 months	Pending	Due 15-Jun-2015

Color Legend: Refused Overdue Administered Late Pending or Completed



Note: As soon as you record an administered vaccine for a patient, the associated vaccination recommendation no longer displays as "outstanding" on the patient's **Vaccination Schedule**.

Producing immunization reports

In Wolf EMR you can produce a report of immunizations performed in your clinic over a defined period of time. The report can detail administrations of a specific vaccine, and/or vaccinations administered by a specific person.

Report of Immunization By Physician: From 03-Mar-2011 and 04-Mar-2016

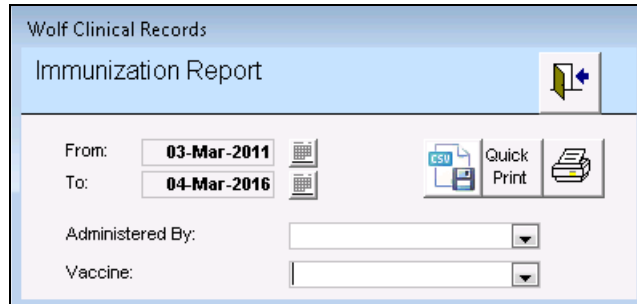
Clinic: Wolf Clinic Phone Office: (632) 791-2356
2805 SE Knight Court Fax: (963) 229-3243
Morley AB EMail: Morley@nowhere.com

Staff: Shondra G

Patient Information				Immunization Administered			
Patient / PHN	Birthdate / Gender	Address, City, Province	Parent / Phone	Date / Location	Agent / Immunogen	Lot # / Manufacturer	Injection Site / Route / Dose (mL)
Famar, T		7863 SW Ryerson Street		21-Mar-2011	hepatitis a&b	AHABB187AC	im rt deltoid
9991123229	M	Spruce View, AB	43545501			glaxosmithkline	4
Collette, C	15-Oct-2004	2001 SE Cameron Court		22-Mar-2011		AHABB200CA	im rt deltoid
9991928831	M	Arviat, AB	271903707		Twinrix JR		2
Hammer, C	29-Jan-2008	7588 N Grove Place		22-Mar-2011		AHABB200CA	im rt deltoid
9991892482	F	Armstrong, AB	(254) 626-8395		Twinrix JR		2
Irons, L	14-Jun-2007	4728 E Essex Street		03-May-2011	hepatitis a&b	AHABB196AC	im rt deltoid
9999821731	F	, AB	(233) 560-3090			glaxosmithkline	1

To produce an immunization report:

1. On the WorkDesk menu, click **Reports > Immunization Records** (). The EMR displays the Immunization Report window.



2. Using the following table, enter criteria for what immunizations should display in the report.

Field	Description
From	Enter the start date from which administered immunizations are to be included, or to select a date from a calendar, click  .
To	Enter the end date to which administered immunizations are to be included, or to select a date from a calendar, click  .
Administered By (Optional)	To include only vaccinations administered by a specific person, in the drop-down list select the person.
Vaccine (Optional)	To produce a report for only a specific vaccine, in the Vaccine drop-down list, select the vaccine.

3. Click one of the following options:

- **Create CSV Extract File** (): To save the report as a CSV file that can be opened in various spreadsheet and statistical analysis applications (for example, Microsoft Excel).
- **Print to Default Printer** (): To print the prenatal record to your default printer.
- **Print** (): To print or fax the report on a selected printer or fax machine.

Recording and viewing blood type

You can record and view a patient's blood type in the **Current Hx** tab of the medical summary.

To view or add a patient's blood type:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#). On the **Current Hx** tab, you can view the patient's blood type in the lower left corner.

Vaccinations

<<Add Vaccination>>

<<Vaccination Schedule>>

Hep A and Hep B Combined 29-Jul-2015

* Refused * Influenza Virus Vaccine 29-Jul-2015

☒ Primary Immunizations Completed

Blood Type: O -

2. To record a patient's blood type, in the **Blood Type** field, enter the letter(s) (**O**, **A**, **B**, or **AB**), and then in the drop-down list, select **+** (positive) or **-** (negative).

Procedures and surgeries

The following sections describe how to record, view, and edit a patient's procedures and surgeries.

Recording procedures and surgeries

To record a procedure or surgery:

1. Open the patient's Medical Summary. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Past Hx** tab.
3. In the **Procedures and Surgeries** area, double-click **<<Add New Procedure>>**.



Note: You can also record a surgery or procedure for a patient from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **New Procedure**.

The EMR displays the Record New Procedure (Surgery) window.

Record New Procedure (Surgery)

Test, Ray Hansel *PHN*

Log Change Procedure + ✕ 📌

Born **22-Sep-1946 (68)** Sex **M** Status **N/A**
 123 Test Way, H (111) 111-1111 Pn
 C
 W (222) 222-2222

*Procedure: OR

Date: 

Surgeon: AND

Problem:

Notes:

Follow-up:

4. Enter information in the Record New Procedure (Surgery) window, using the following table as a reference:

Field	Description
Procedure	Enter the name of the procedure or surgery and then on your keyboard, press Enter. The EMR displays a results list under the Procedure field. In the results list, click the procedure or surgery that you want to add, (for example Aortocor Bypass 1 Coronary Art or Appendectomy) and then click Update. The Procedure field displays the procedure or surgery you selected.
Date	Enter the date of the procedure (in any format), or to select a date from a calendar, click . Note: If you do not know the exact date, you can enter a partial date (for example, month/year, or just year).

Field	Description
Surgeon (Optional)	To enter the surgeon: 1. In the Surgeon field, start entering the name or specialty of the surgeon performing the procedure, and then on your keyboard, press Enter. The EMR displays a results list under the Surgeon field. 2. In the results list, click the surgeon. Note: You can select only surgeons who are on your clinic's consultants list. To add a surgeon to your consultants list, click . For information on how to input information for the consultant, see "Adding and Editing consultants while creating a referral" on page 299.
Problem	If the purpose of the surgery is to manage a medical problem that is currently listed on the patient's Problem List, select the problem in the drop-down list. Tip: If you do not see the appropriate problem, click <<Add New>> and then, in the Problem List window, add the new problem. See "Recording problems" on page 395.
Notes	Enter any notes about the procedure or surgery.
Follow-up	Enter any notes to reference when following up with the patient.

5. Perform one of the following actions:

- To add another procedure, click **Add** () and repeat steps [Step 4](#)
- If you are finished adding procedures, click  to save the procedure entry and to close the Record New Procedure (Surgery) window.

Using Procedure favourites (available only to select clinics)

If your clinic has been implemented with the new ICD9-based procedure list, when you search for a procedure or surgery to add to a patient's procedure list, favourites display at the top of the results. You can also choose a favourite procedure directly from your favourites list.

Procedure favourites can be clinic-wide (can be used by all users), or user-specific (can be used by you only). You can add or remove procedures in your user-specific favourites list only.



Note: Only users with administrative privileges can add clinic-wide favourites.

Recording procedures and surgeries using favourites

To record a procedure or surgery to a patient's record using procedure favourites:

1. Open the Record New Procedure (Surgery) window. See [Step 1](#) to [Step 3](#) "Recording procedures and surgeries" on page 436.
2. In the **Procedure** field, enter the name of the procedure or surgery and then on your keyboard, press **Enter**. The EMR displays a results list under the **Procedure** field. Matching procedure favourites display at the top of the list and are indicated by an asterisk (*) in the **Favourites** column.

Record New Procedure (Surgery)

Example, Example PHN

Log Change Procedure + X ↵

Born 03-Mar-1969 (45) Sex F Status N/A

12 First, Calgary AB H C W Pn Marilyn Merlot

*Procedure: App OR

Date:	Procedure Desc	ICD9	Favourite	Tag
	Appendectomy	47.09	*	App
Surgeon:	Application of cast	93.53		
	Application of cervical collar	93.52		
	Application of crown	23.41		
Problem:	Application of Crutchfield tongs of skull	93.41		
	Application of dressing, pressure	93.56		
Notes:	Application of external fixation device,	78.14		
	Application of external fixation device,	78.15		
	Application of external fixation device,	78.12		
	Application of external fixation device,	78.19		
	Application of external fixation device,	78.16		
	Application of external fixation device,	78.13		
	Application of external fixation device,	78.11		
	Application of external fixation device,	78.18		
	Application of external fixation device,	78.17		

Favourite indicated by an asterisk (*).

3. In the list of matching procedures, click the procedure you want, and then click **Update**. The **Procedure** field displays the procedure or surgery you selected.
4. If the procedure or surgery you want does not display:

- a) In the Record New Procedure (Surgery) window, click **Advanced**.

Record New Procedure (Surgery)

Example, Example PHN

Log Change Procedure + -

Born **03-Mar-1969 (45)** Sex **F** Status **N/A**

12 First, Calgary AB H C W Pn Marilyn Merlot

*Procedure: [] OR []

Date: []

Surgeon: [] AND []

Problem: []

Notes: [] Follow-up: []

Advanced

The EMR displays the Procedure List window. Procedure Favourites display at the top of the list. General procedures display below the list of favourite procedures.

Procedure List

Manage Procedure List

Add selected to patient Add to Favourites Remove from Favourites Edit

Search code [Enter name, keywords, ICD9 code etc]

☒ Starts with ☐ Contains

Procedure Description	ICD9	SNOMED Id	SNOMED Description	Tag	My Favourite	Clinic-wide Favourite
Favourite						
Ankle disarticulation	84.13	397217001	Ankle disarticulation	AnkID	☐	☒
Appendectomy	47.09	80146002	Appendectomy	App	☒	☐
Excision of lesion of tonsil and ade...	28.92	NULL	NULL	Tonsil	☒	☐
Excision of lymph node	40.29	58347006	Excision of lymph node	lymph	☒	☐
Lumpectomy of breast	85.21	392021009	Lumpectomy of breast	lump	☒	☐
Procedures						
(Laparoscopic) adjustment of size ...	44.98	NULL	NULL			
24 Hour ECG	89.5	252417001	24 Hour ECG			
Abdominal - coronary artery bypass	36.17	NULL	NULL			
Abdominal lymphangiogram	88.04	91119001	Abdominal lymphangiogr...			
Abdominal paracentesis	54.91	89305009	Abdominal paracentesis			
Abdominopelvic amputation	84.19	359720005	Abdominopelvic amputat...			
Abdominoperineal pull-through pro...	48.49	86789002	Abdominoperineal pull-t...			
Abdominoperineal resection of the ...	48.5	NULL	NULL			
Above elbow amputation	84.07	180011006	Above elbow amputation			
Accessory splenectomy	41.93	11973000	Accessory splenectomy			
Accessory-hypoglossal nerve anas...	4.73	57398002	Accessory-hypoglossal ...			
Achillorrhaphy	83.64	12237002	Achillorrhaphy			
Achillotomy	83.11	367446003	Achillotomy			
Acupuncture for anesthesia	99.91	182614009	Acupuncture for anesth...			

- b) In the **Search Code** field, enter part or all of the name, or the diagnostic code for the procedure.

- c) Under the **Search Code** field, select **Contains**.
- d) On your keyboard, press **Enter**. The EMR displays matching procedures that contain (in the procedure name, ICD-9 code, or tag) the Search Code entry.
- e) In the list of matching favourites, click the procedure you want, and then click **Add**

Selected to Patient (). The EMR displays the selected procedure favourite in the **Procedure** field.

5. Finish recording the procedure or surgery. See [Step 4](#) to [Step 5](#) in “Recording procedures and surgeries” on page 436.

Adding procedures to your favourites list



Note: Only users with administrative authority can add clinic-wide procedure favourites (favourites that can be viewed by all clinic users).

To add a procedure to your favourites list:

1. Open the Record New Procedure (Surgery) window. See [Step 1](#) to [Step 3](#) “Recording procedures and surgeries” on page 436.
2. Click **Advanced**. The EMR displays the Procedure List window. Procedure favourites display at the top of the list. General procedures display below the list of favourite procedures.

Procedure List

Manage Procedure List

Add selected to patient
 Add to Favourites
 Remove from Favourites
 Edit

Actions Favourites

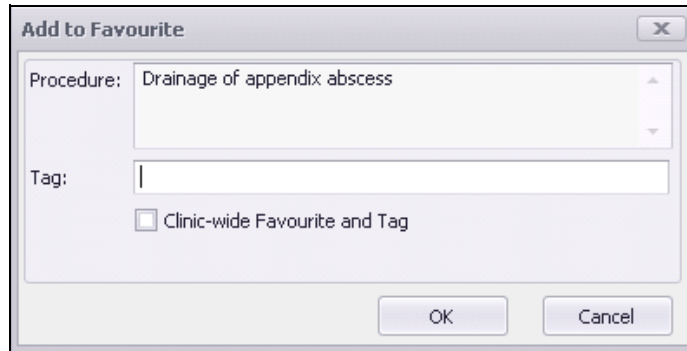
Search code

☒ Starts with ☐ Contains

Procedure Description	ICD9	SNOMED Id	SNOMED Description	Tag	My Favourite	Clinic-wide Favourite
Favourite						
Ankle disarticulation	84.13	397217001	Ankle disarticulation	AnkD	☐	☒
Appendectomy	47.09	80146002	Appendectomy	App	☒	☐
Excision of lesion of tonsil and ade...	28.92	NULL	NULL	Tonsil	☒	☐
Excision of lymph node	40.29	58347006	Excision of lymph node	lymph	☒	☐
Lumpectomy of breast	85.21	392021009	Lumpectomy of breast	lump	☒	☐
Procedures						
(Laparoscopic) adjustment of size ...	44.98	NULL	NULL			
24 Hour ECG	89.5	252417001	24 Hour ECG			
Abdominal - coronary artery bypass	36.17	NULL	NULL			
Abdominal lymphangiogram	88.04	91119001	Abdominal lymphangiogr...			
Abdominal paracentesis	54.91	89305009	Abdominal paracentesis			
Abdominopelvic amputation	84.19	359720005	Abdominopelvic amputat...			
Abdominoperineal pull-through pro...	48.49	86789002	Abdominoperineal pull-t...			
Abdominoperineal resection of the ...	48.5	NULL	NULL			
Above elbow amputation	84.07	180011006	Above elbow amputation			
Accessory splenectomy	41.93	11973000	Accessory splenectomy			
Accessory-hypoglossal nerve anas...	4.73	57398002	Accessory-hypoglossal ...			
Achillorrhaphy	83.64	12237002	Achillorrhaphy			
Achillotomy	83.11	367446003	Achillotomy			
Acupuncture for anesthesia	99.91	182614009	Acupuncture for anesth...			

3. In the **Search Code** field, enter part or all of the procedure or surgery name or ICD-9 code.
4. Below the **Search Code** field, select one of the following options:
 - **Starts with:** To display matching procedures that start with the term you entered in the Search Code field.
 - **Contains:** To display matching procedures that contain (in the procedure name, ICD-9 code, or tag) the Search Code entry.
5. On your keyboard, press **Enter**. The EMR filters your procedure list to display matching favourites, and general procedures.

6. Click the procedure you want, and then click **Add to Favourites** (). The EMR displays the Add to Favourite window.




Note: Only users with administrative authority can add clinic-wide favourites and tags. The EMR displays a **Clinic-wide Favourite and Tag** check box for users with administrative authority.

7. To define a tag for the procedure, in the **Tag** field enter a term. See [“Using Procedure tags \(some clinics only\)” on page 443](#).
8. Click **OK**. The EMR adds the procedure to your favourites list.

Using Procedure tags (some clinics only)

When you record a procedure or surgery for a patient, you can search for the procedure using alternative search terms, called tags. For example, you may prefer to enter “App” to search for “Appendectomy”.

Because each user may use different abbreviations to search for a procedure, multiple tags can be assigned to a procedure. Tags can be clinic-wide (can be used by all users), or user-specific (can be used by you only).

Recording procedures and surgeries using tags

To record a procedure for a patient using a tag:

1. Open the Record New Procedure (Surgery) window. See [Step 1](#) to [Step 3](#) [“Recording procedures and surgeries” on page 436](#).

- In the **Procedure** field, enter a tag that is assigned to the procedure you want. The EMR displays a list of matching procedures.

Record New Procedure (Surgery)

Example, Example PHN

Log Change Procedure + ✖ ↺

Born **03-Mar-1969 (45)** Sex **F** Status **N/A**

12 First, Calgary AB H C W Pri Marilyn Merlot

*Procedure: **App** OR

Date:	Procedure Desc	ICD9	Favourite	Tag
	Appendectomy	47.09	*	App
Surgeon:	Application of cast	93.53		
	Application of cervical collar	93.52		
	Application of crown	23.41		
Problem:	Application of Crutchfield tongs of skull	93.41		
	Application of dressing, pressure	93.58		
Notes:	Application of external fixation device,	78.14		
	Application of external fixation device,	78.15		
	Application of external fixation device,	78.12		
	Application of external fixation device,	78.19		
	Application of external fixation device,	78.16		
	Application of external fixation device,	78.13		
	Application of external fixation device,	78.11		
	Application of external fixation device,	78.18		
	Application of external fixation device,	78.17		



Note: The far right column in the procedure search results list displays all tags assigned to each procedure.

- Finish recording the procedure or surgery. See [Step 4](#) to [Step 5](#) in “Recording procedures and surgeries” on page 436.

Assigning tags to procedures

If there are no tags assigned to a procedure, or if you want to use a tag that is different than the tags currently assigned to a procedure, you can assign your own tag(s).

Tags you assign to a procedure are user-specific. No other users can see or use your tags.



Note: Only users with administrative authority can assign clinic-wide tags to procedures.

To assign a tag to a procedure:

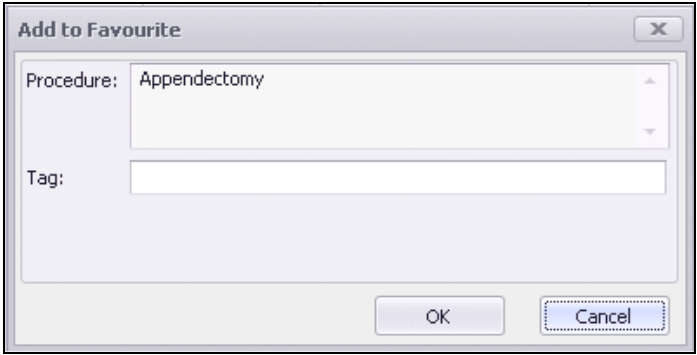
- Open the Record New Procedure (Surgery) window. See [Step 1](#) to [Step 3](#) “Recording procedures and surgeries” on page 436.
- Click **Advanced**. The EMR displays the Procedure List window. Procedure Favourites display at the top of the list. General procedures display below the list of favourite procedures.
- In the **Search Code** field, enter part or all of the procedure or surgery name or ICD-9 code.
- Below the **Search Code** field, select one of the following options:

- **Starts with:** To display matching procedures that start with the term you entered in the Search Code field.
 - **Contains:** To display matching procedures that contain (in the procedure name, ICD-9 code, or tag) the Search Code entry.
5. On your keyboard, press **Enter**. The EMR filters your procedure list to display matching favourites, and general procedures.
 6. If the procedure you want to assign a tag to **is not** on your favourites list:

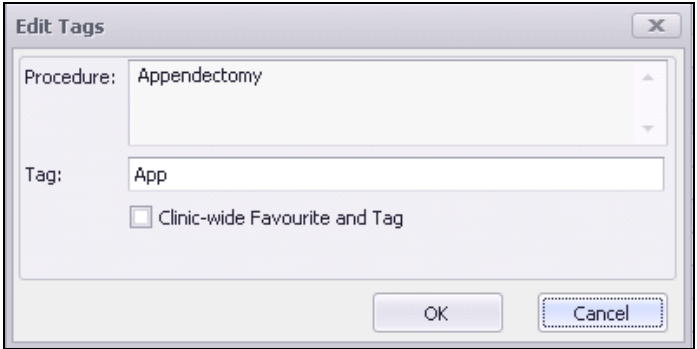


Note: A procedure must first be on the favourites list before you can assign a tag to it.

- a) In the list of procedures, click the procedure you want to assign a tag to.
- b) Click **Add to Favourites** (). The EMR displays the Add to Favourite window.



7. If the procedure you want to assign a tag to **is** on your Favourites list:
 - a) In the filtered list of procedures, click the procedure.
 - b) Click **Edit** (). The EMR displays the Edit Tags window.



8. In the **Tag** field, enter the tag you want.



Tip: If there is a tag entered already, or if you want to add multiple tags, separate each tag name with a comma.

You are limited to 50 characters for all tags combined.

9. Click **OK**. The EMR displays the assigned tags in the **Tag** column of the procedure list.

Viewing and editing procedures and surgeries

To view and edit a patient's procedures and surgeries:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Past Hx** tab. The **Procedures and Surgeries** area lists the patient's procedures and surgeries.

Current Hx	Past Hx	Personal Hx	Communication	Investigations	Docur
Inactive Problems					
<<Add New Problem>>					
Adjustment Disorder					
Myoclonic Jerking					
Procedures and Surgeries					
<<Add New Procedure>>					
Hysterectomy with A & P Repair					
2006-Dec-19					
Breast Biopsies - L					

- To edit, remove, or view detailed information about a specific procedure or surgery, in the **Procedures and Surgeries** area, double-click the procedure or surgery. The EMR displays the Edit Procedural/Surgical History window.

Edit Procedural/Surgical History: Combs, Jenifer

Test, Mother		PHN: 9994 200 232		Log	Change Procedure	+	-	+
Born	19-Apr-1964 (51)	Sex	F	Status	N/A			
123 Test Street, South Hazelton BC Q4K 5A2		H	(111) 111-1111	Pri	Dewayne Bryson, M.D.			
		C						
		W	(222) 222-2222					

*Procedure: **Hysterectomy with A & P Repair**

Date: **12-Dec-2006**

Surgeon: AND

Problem: **<<Add New>>**

Notes:

Follow-up:

- View and edit the fields as required. See [“Recording procedures and surgeries” on page 436](#) for a description of the fields.
- To change the type of procedure or surgery displayed in the **Procedure** field, at the top of the window, click **Change Procedure**. The EMR clears the **Procedure** field. You can now search for and select a procedure or surgery.
- If you want to remove the procedure or surgery from the patient's Procedures and Surgeries list:
 - At the top of the window, click **Delete Surgery From Patient's Medical History**


(). The EMR displays a dialog box with the following prompt: “Delete <procedure or surgery> form Patient's Medical History?”
 - Click **OK**.

Recording and viewing social history

A patient's social history can include the following information:

- Ethnic origin
- Preferred language
- Marital status

- Significant other information
- Occupation
- Income type
- Education
- Next of kin contact information
- Contraception method



Tip: You can set the following Social History values in Patient Maintenance, on the **Other Demographics** tab:

- Ethnic Origin
- Preferred Language
- Language
- Occupation
- Maiden Name
- Next of Kin

When you change the above fields on the **Other Demographics** tab, the changes are reflected in the Social History area of the Medical Summary. Conversely, when you change the above fields in the Social History window, the changes are reflected on the **Other Demographics** tab.

To view and record a patient's social history:

1. Open the Medical Summary window. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Personal Hx** tab. The **Social History** area displays a patient's social history information.

Medical Summary

Test, Mother

Home address: 123 Test Street,
South Hazelton BC Q4K 5A2

Home Cell: (111) 111-1111
Work: (222) 222-2222

No Inv. No Docs No Rules No Messages 1 Follow

Print Chart Custom Report Request Chart

Current Hx Past Hx Personal Hx Communication Investigations Documents

Social History

Marital Status: **Married**

Significant Other: **Kory Test**

Income: **Employed**

Occupation: **Administration**

Education Level: **College**

Family History ...View Family Tree

3. To record and view detailed social history information for the patient, click anywhere in the **Social History** area. The EMR displays the Personal History Records window.

Personal History Records

Social History: Test, Mother

Ethnic Origin: **Asian**

Preferred Language:

Language: **English**

Marital Status: **Married**

Significant Other: **Kory Test**

SO Ethnic Origin:

SO Date of Birth:

SO Occupation:

Occupation: **Administration**

Income Type: **Employed**

Education: **College**

Contraception Method:

Notes:

☐ Student ?

☐ CareGiver ?

☐ Home Care ?

Institution:

Name of Care Recipient:

DateChecked: **29-Jul-2015**

Maiden Name:

Next of Kin: **Ervin Test**

Phone: **333-333-3333**

Note:



Tip: You can also quickly open the Personal History Records window from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **View Social History**.



Tip: Several fields in the Social History window are drop-down combo boxes. To use a drop-down combo box, click a value in the drop-down list or enter text in the field.

If you enter new text, the EMR displays a dialog box asking you if you want to add the new text to the master list. The master list is for all users. If you click **Yes**, the EMR adds the new text to the drop-down list to make future data entry easier for everyone.

Note: To avoid duplicate entries in a drop-down list, consult other clinic members to ensure that they agree with the new entry.

4. Use the following table to record or edit social history information.

Field	Description
Ethnic Origin	Enter the patient's ethnic origin. Click a value in the drop-down list or enter a value in the text field.
Preferred Language	Enter the patient's preferred language. Click a value in the drop-down list or enter a value in the text field.
Language	Enter the patient's language. If the language is not known, select <Unknown> .
Marital Status	In the drop-down list, click the patient's marital status.
Information about patient's significant other	
Significant Other	Enter the name of the patient's significant other.
SO Ethnic Origin	Enter the ethnic origin of the patient's significant other. Click a value in the drop-down list or enter a value in the text field.
SO Date of Birth	Enter the date of birth of the patient's significant other. Enter the date in the format DD-Mmm-YYYY or use the calendar icon to choose a date.
SO Occupation	Enter the occupation of the patient's significant other.
Information about patient's occupation and education	
Occupation	Enter the patient's occupation.
Income Type	In the drop-down list, click the patient's income type.
Education	In the drop-down list, click the patient's education level.
Patient's maiden name and next of kin information	
Maiden Name	Enter the patient's maiden name.
Next of Kin	Enter the name of a close relative of the patient.
Phone	Enter next of kin's telephone number.
Note	Enter any additional information or explanations.
DateChecked	The EMR displays the current date in this field.
Other patient information	
Contraception Method	Enter the patient's method of contraception.
Notes	Enter any additional information or explanations.
Student?	If the patient is a student, select this check box.
CareGiver	If the patient is a caregiver, select this check box.
Home Care?	If the patient is receiving home care, select this check box.

Field	Description
Institution	If the patient is a caregiver, enter the name of the institution where the patient is a caregiver.
Name of Care Recipient	If the patient is a caregiver, enter the name of the client receiving care from the patient.

5. Click  to save your changes and to close the Social History window.

Harmful substances and other risks

In the **Harmful Substances** area of the medical summary, you can view and record information on:

- Smoking history
- Alcohol history
- History of use of other harmful substances
- Other risk factors (for example, risky behaviors)

Recording and viewing smoking history

To view, record, and verify a patient's smoking history:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Personal Hx** tab. The **Harmful Substances** area displays the patient's smoking history.

Born 19-Apr-1964 (51)		Sex F	PHN 9994 200 232
		Status N/A	
BMI	Weight	185lbs 5 yr 3 m	
BP	120/80	3 yr 1 m	
Pages		1 Follow Up No Vaccinations	
Change Log			
Documents Referrals Obstetrics			
Harmful Substances			
Quit < 1 year			
"PackYrs Smoked": 34			
Moderate: 7-24 Drinks/Week			
T-ACE Score: 0			

3. To record or view detailed information about the patient's smoking status, click anywhere in the **Harmful Substances** area. The EMR displays the Personal Risks window.

Personal Risks	
Test, Mother PHN 9994 200 232	
Born 19-Apr-1964 (51) Sex F Status N/A	
123 Test Street, South Hazelton BC Q4K 5A2 H (111) 111-1111 C (222) 222-2222 Pri Dewayne Bryson, M.D.	
Smoking	
Quit < 1 year	
Year Of Onset:	1980
Pack(s)/Day:	1.00
Date Quit:	2014
"PackYrs Smoked":	34
Target Date:	
☐ Click to indicate that you verified status Last checked : 29-Jul-2015	
Alcohol	
Moderate: 7-24 Drinks/Week	
Tolerance:	0
Annoyance:	0
Cut Down:	0
Eye Opener:	0
T-ACE Score:	0
☐ Click to indicate that you verified status Last checked : 29-Jul-2015	
Other Risks	
Patient Screen	



Tip: You can also quickly open the Personal Risks window for a patient from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **View Smoking/Alcohol/Drug History**.

4. In the **Smoking** area, view or edit the fields, using the following table as a reference.

Field	Description
Smoking status	In the drop-down list, click one of the following options based on the patient's smoking history: ■ ?? Not Known ?? (This is the default.) ■ Non-Smoker ■ Quit < 1 year ■ Quit > year ■ Smoker
Year Onset	If the patient has a history of smoking, enter the year that the patient started smoking. You can also use the calendar icon to select a date.
Pack(s)/Day	Enter the average amount of packs a day the patient smokes or used to smoke.
Date Quit	If the patient has quit smoking on a certain date, enter the date. You can also use the calendar icon to select a date.
PackYrs Smoked	If the Year of Onset , Pack(s)/Day and the Date Quit fields are all filled out, then the EMR automatically calculates and populates the PackYrs Smoked field. You can edit the PackYrs Smoked field if required.
Target Date	If the patient is currently smoking but plans to quit on a certain date, enter the patient's target quit date in the format of DD/MM/YY .

Field	Description
Verified Smoking Status check box:	■ If you make any changes to the above fields, the EMR automatically selects the Click to indicate that you verified status check box and adds the current date as the last time you checked with the patient on their Smoking History. ■ You can also manually select this check box which adds today's date as a confirmation that the patient's current smoking status has not changed. ■ You can select this check box each time you go back into the Personal Risks window.

5. Click  to save your changes and to close the Personal Risks window.

Viewing and recording alcohol history

To view, and record a patient's alcohol history:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Personal Hx** tab. The **Harmful Substances** area displays the patient's alcohol history.



Documents Referrals Obstetrics

Harmful Substances

Quit < 1 year

"PackYrs Smoked": 34

Moderate: 7-24 Drinks/Week

T-ACE Score: 0

3. To edit or verify a patient's alcohol status, click anywhere in the **Harmful Substances** area. The EMR opens the Personal Risks window.

Personal Risks

Test, Mother PHN 9994 200 232

Born 19-Apr-1964 (51) Sex F Status N/A

123 Test Street, South Hazelton BC Q4K 5A2 H (111) 111-1111 C Pri Dewayne Bryson, M.D. W (222) 222-2222

Smoking

Quit < 1 year

Year Of Onset: 1980

Pack(s)/Day: 1.00

Date Quit: 2014

"PackYrs Smoked": 34

Target Date:

☐ Click to indicate that you verified status
Last checked : 29-Jul-2015

Alcohol

Moderate: 7-24 Drinks/Week

Tolerance: 0

Annoyance: 0

Cut Down: 0

Eye Opener: 0

T-ACE Score: 0

☐ Click to indicate that you verified status
Last checked : 29-Jul-2015

Other Risks

Patient Screen



Tip: You can also quickly open the Personal Risks window for a patient from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **View Smoking/Alcohol/Drug History**.

4. In the **Alcohol** area, view or edit the fields, using the following table as a reference.

Field	Description
Alcohol status	In the drop-down list, click one of the following options to describe the patient's alcohol consumption: ■ Non Drinker ■ Ex Drinker ■ Light: < 6 Drinks/Week ■ Moderate: 7-24 Drinks/Week ■ Heavy: > 24 Drinks/Week ■ ?? Not Known ?? (This is the default.)
Tolerance	Enter the number of drinks to reach tolerance.

Field	Description
Annoyance	Enter 1 if patient reports ever being annoyed when asked about their drinking.
Cut Down	Enter 1 if patient reports ever having thought about cutting down their drinking.
Eye Opener	Enter 1 if patient reports ever having had a drink in the morning to offset a hangover.
T-ACE Score	After you enter the above four fields, the EMR automatically calculates and displays the T-ACE Score value. You can edit the T-ACE Score value if required.
Verified Alcohol Status check box	■ If you make any changes to the above fields, the EMR automatically selects the Click to indicate that you verified status check box and adds the current date as the last time you checked with the patient on their Alcohol History. ■ You can also manually select this check box which adds today's date as a confirmation that the patient's current alcohol status has not changed. ■ You can select this check box each time you go back into the Personal Risks window.

5. Click  to save your changes and to close the Personal Risks window.

Viewing and recording other risks

To view and record a patient's other risk factors:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#).
2. Click the **Personal Hx** tab.

3. Click anywhere in the **Harmful Substances** area. The EMR opens the Personal Risks window. Risks, other than Alcohol and smoking, previously recorded for the patient are displayed in the **Other Risks** area.



Tip: You can also quickly open the Personal Risks window for a patient from any window related to that patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **View Smoking/Alcohol/Drug History**.

4. To view or edit detailed information for a recorded risk:
- In the list of Other Risks, double-click the risk. The EMR displays the New Patient Risk window.
 - View and edit information as needed. See [Step 5](#) for a description of each entry field.
 - If you want to delete the risk entry, click .
 - When you are finished, click .
5. To record a risk:

- a) In the **Other Risks** area, click **Screen**. The EMR displays a list of risks.

- b) Double-click the risk you want to record information for.



If the risk you want is not available, users with administrative authority in Wolf EMR can add additional harmful substances and other risk factors to the list.

- c) The EMR displays the New Patient Risk window.

- d) Enter information in the New Patient Risk window, using the following table as a reference.

Field	Description
Exposure	Enter the type of exposure the patient has had to the substance or other risk.
Active ?	In the drop-down list, click either Active or InActive .
AgeOnset	Enter the patient's age at the time of first exposure.
Onset Date	Enter the date the risk exposure began. Note: You can enter partial dates. For example, you can enter "Jan 2005"

Field	Description
End Date	If exposure to the substance or risk has stopped, enter the date of last exposure. Note: You can enter partial dates. For example, you can enter “Jan 2005”
Notes	Enter any additional notes about the risk factor.
Date Checked	The EMR records today's date automatically, however, you can enter a different date if needed. Use the date format DD-Mmm-YYYY .

e) Click .

Family history

You can view and record a patient's Family History in the **Personal Hx** tab of the Medical Summary.

Recording family history problems

To record a family history problem for the patient:

1. Open the patient's medical summary. See [“Opening a patient's Medical Summary” on page 389](#).
2. Click the **Personal Hx** tab.
3. In the **Family History** area, double-click **<<Add New Family History>>**.



Tip: You can also record family history information from any window related to a patient (for example, the SOAP form, consult letter form, or **Patient** tab):

- On the window, right-click and then, in the SMART menu, click **New Family Hx**.

The EMR displays the Family History Input window.

Family History

Family History Input Log

1. Select Diagnosis 2. Link to Family Member (optional) 3. Add Details (optional) 4. Save

☒ Screening ☐ Problem List ☒ Show All ☐ Show Biological Family Only

Age Of Onset:

☐ Cause of Death?

Problem Notes:

Date Noted: 30-Jul-2015

ProblemDesc	ICD9
(asthma)	493
(HTN) Hypertension	401
Acute Myocardial Infarction (I	410
Alcoholism	303
Alcoholism Chronic	3050
Alive and Well	
Attention Deficit Disorder ADI	314.0
Barrett's Esophagus	530
Bipolar Disorder	296.4
Bipolar Disorder (Manic Depr	296.4
Bipolar Disorder Depression	296.4
Bipolar Disorder In Remission	
Bipolar Disorder Manic Unspe	
Bipolar Disorder Mixed	296.4
Bipolar Disorder Psychotic Fe	296.43
Breast Cancer	174
Cancer	
Cardiac arrest	427.5
Chemical Dependency	304
Colon Cancer	153.9
Colon NOSPolyp	556
Coronary Artery Stent	414.0
Dementia	290
Depression	311
Depressive Disorder Major	
Diabetes Mellitus - Type 2	250.02
Diabetic Nephropathy	250.6
Drug Abuse	305
Drug Addiction	304.9
Drug Dependence	648.3
Duodenal Ulcer	532

Listed/Potential Family (DbClick to Edit):

<<Add New Family Member>>

Relationship	Maternal	Paternal
Mother		
Father		
Brother		
Sister		
Uncle		
Aunt		
Uncle		
Aunt		
Grandmother		
Grandfather		
Grandmother		
Grandfather		
Son		
Daughter		
Niece		
Niece		
Nephew		
Nephew		

All Listed Family History:

<Enter Assessment>

<<Add New Family Member>>

Mother
Father
Brother
Sister
Uncle
Aunt

4. Enter the family member's problem:

- a) In the **Select Diagnosis** area, select the **Problem list** radio button. The EMR displays a Problem List search field.

Family History

Family History Input

1. Select Diagnosis 2. Link to Family Member (optional)

☐ Screening ☒ Problem List ☒ Show All ☐ Show Bi

<Enter Assessment>

Listed/Potential Family (DbClick to Edit):

<<Add New Family Member>>

Mother
Father
Brother
Sister
Uncle
Aunt

- b) In the search field, enter a problem name.

- c) Click **<Enter Assessment>**. The EMR displays a list of matching problems.
 - d) In the list of matching problems, click the appropriate problem.
5. (Optional) If you want to link the diagnosis or problem to a specific family member, in the **Link to Family Member** area, click a family member type (for example, Mother).

**Tips:**

- If the **Show Biological Family Only** option is selected, the EMR displays only relations with the status **Biological** (in the "Patient Relations for" window in the **Relationships** area in Patient Maintenance).
- To enter a new family member, click **<<Add New Family Member>>**
- To edit a family member's information (for example, Name, Year of Birth, Deceased, Year of Death, Note, or Date Checked), double-click the family member's name.

6. (Optional) In the **Add Details** area, enter the following details:
- **Age of Onset:** Enter the age when the family member was diagnosed.
 - **Cause of Death?:** Select this check box if the selected problem was the cause of death.
 - **Problem Notes:** Enter any further notes or explanations here.
 - **Date Noted:** Enter the date the Family History was modified in the format of: DD/ Mmm/ YYYY. The default value is today's date.



7. To save the entry, . The EMR displays the diagnosis and the family member in the **All Listed Family History** area.
8. To record additional family history problems, repeat [Step 4](#) to [Step 7](#)



9. Click .

Viewing and editing family history details

To view and edit family history details:

1. Open the Medical Summary window. See ["Opening a patient's Medical Summary" on page 389](#).

2. Click the **Personal Hx** tab. The **Family History** area lists the patient's family member's problems.

The screenshot shows a software interface for viewing patient medical history. At the top, there are tabs: Current Hx, Past Hx, Personal Hx (selected), Communication, Investigations, and Do. Below the tabs, the 'Social History' section is displayed, containing fields for Marital Status (Married), Significant Other (Kory Test), Income (Employed), Occupation (Administration), and Education Level (College). Below this, the 'Family History' section is highlighted with a red box. It contains a link '<<Add New Family History>>' and a table with two columns: 'Cause of Death' and 'Mother'. The table lists 'Breast Cancer' and 'Depression' under 'Cause of Death', and 'Mother' and 'Father' under 'Mother'.

Social History	
Marital Status:	Married
Significant Other:	Kory Test
Income:	Employed
Occupation:	Administration
Education Level:	College

Family History	
...View Family Tree	
<<Add New Family History>>	
Breast Cancer	Cause of Death
Depression	Mother
	Father

3. To view or edit detailed information for a family member's problem(s), in the **Family History** area, double-click a family history entry. The EMR opens the Family History Records window, and displays details of the selected family member's significant medical history, including:
- A list of their problems
 - Age of onset
 - Date of birth
 - Date of death
 - Other notes entered for the family member

Family History Records

Mother's Significant Medical History Log  

Name: Date of Birth: 
 Date of Death: 
☐ Deceased

Member Notes:

Problems:

Breast Cancer
 Depression

Age Onset: Date Noted:
 Problem Notes:

Cause of Death

Date Checked:

4. In the **Problems** area, click the problem you want to view or edit details for.
5. Edit the fields as required. See ["Recording family history problems" on page 460](#) for a description of the fields.
6. To delete the problem from the family member's history, click **Delete Record** ().
7. Click **Save & Close** ().

Appointment Scheduler overview

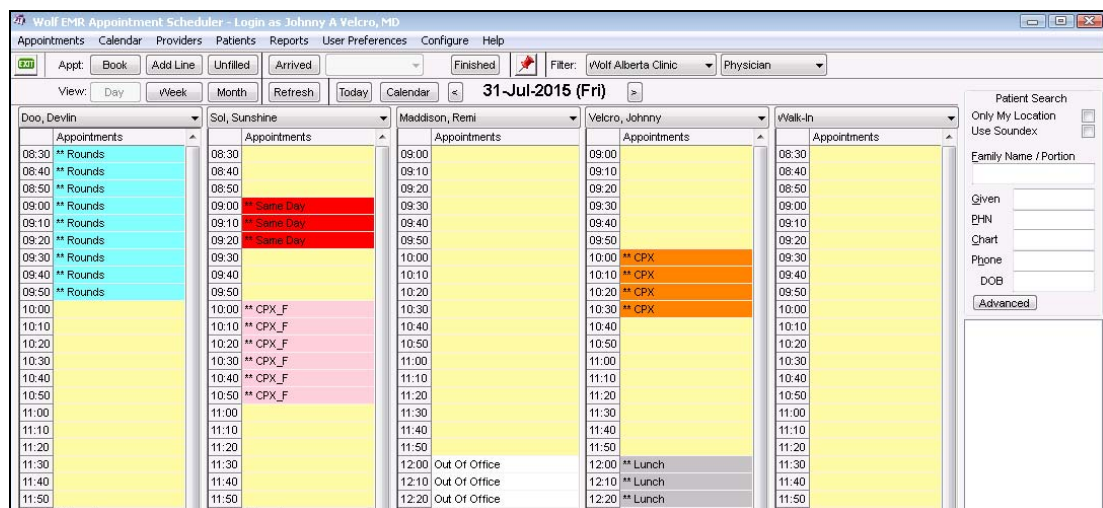
This chapter introduces you to the Appointment Scheduler. You use the Scheduler to view appointments for the entire clinic. Your front end staff use the scheduler to book and manage appointments, and resources.

This module covers how to open and navigate the Scheduler and how to set up practitioner schedules and groups of practitioners for ease of access.

Opening the Scheduler

To open the Scheduler:

1. If your clinic has multiple locations set up, on the Wolf EMR Launch page, in the **Location** drop-down list, click your current clinic location.
2. On the **Wolf Programs** menu bar, click **Scheduling**. The Appointment Scheduler opens on today's date.





Note: If your clinic supports multiple-locations, your current location is automatically selected in the **Filter** drop-down list.



Tips:

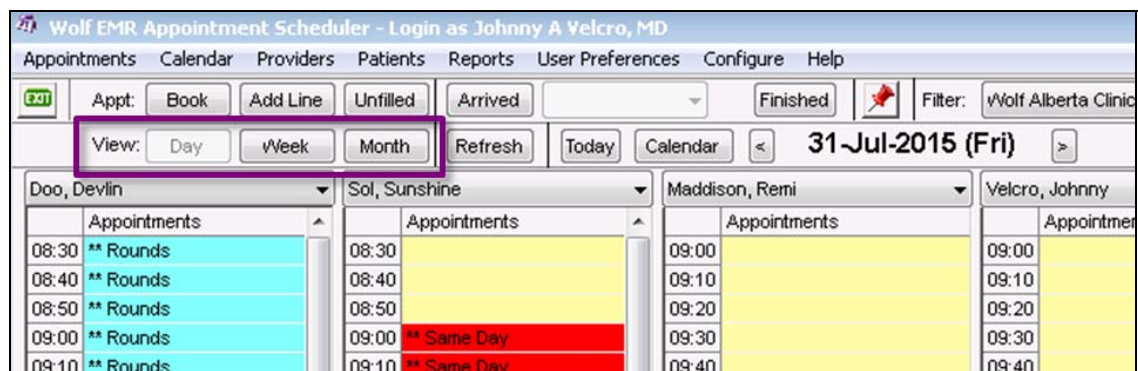
- To display the schedule for another clinic location, click the location from the **Filter** drop-down list.
- To display the schedules for all clinic locations, click **<All Locations>** in the **Filter** drop-down list.

Viewing and navigating the Scheduler

You can view and navigate the Scheduler to best meet your workflow needs. You can view schedules by day, week, or month. You can also quickly navigate the Scheduler to a specific date, or forward and backward through the clinic schedule by day, week or month.

Viewing the schedule by day, week, or month

Using options available in the **View** menu bar, you can view the schedule by day, week, or month.



You can simultaneously view multiple practitioner schedules for a single day or you can view daily, weekly, and monthly schedules for yourself or other practitioners individually.



Note: The schedule defaults to the day view every time it is opened. The day view displays the practitioner's schedules that were selected to be the default. (See ["Selecting default practitioner schedules to display" on page 471.](#)) You can only view one practitioner at a time when viewing their schedule in week or month view.

Viewing your schedule in week view

To view one week of your schedule:

1. Click in your schedule.
2. On the **View** menu bar, click **Week**.

Viewing your schedule in month view

To view one month of your schedule:

1. Click in your schedule.
2. On the **View** menu bar, click **Month**.

Viewing all default practitioners' schedules in day view

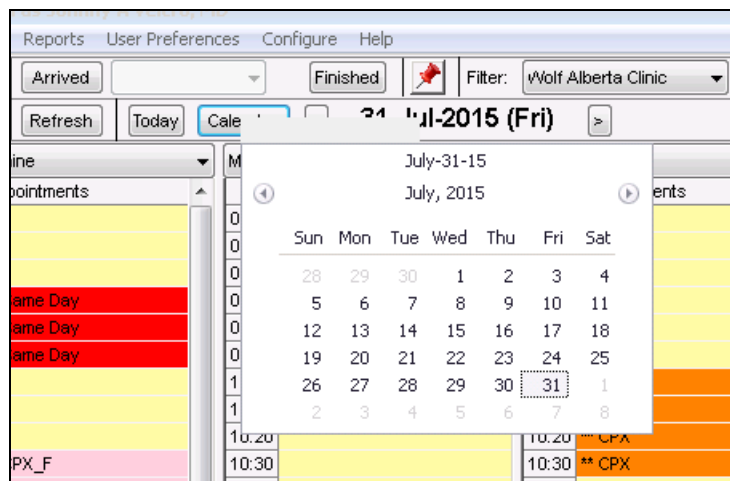
To view one day of all default practitioner schedules:

On the **View** menu bar, click **Day**.

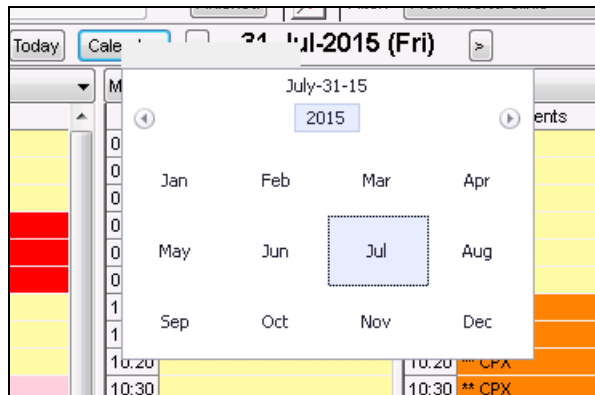
Viewing a specific date in the Scheduler

To navigate to a specific date in the Scheduler:

1. On the **View** menu bar, click **Calendar**. The EMR displays the calendar.



- Click the month date between the two arrows. The calendar displays a window with the months of the year.



- Click the month you want to display. The calendar displays the month you selected. In the calendar, click the date you want to display. The Scheduler displays that date.

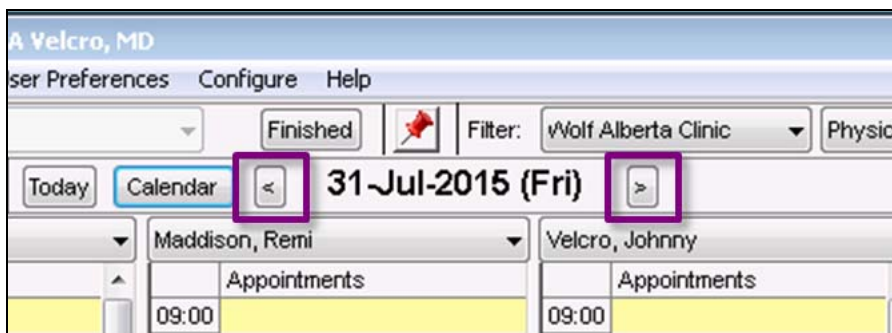


Tip: To close the calendar without choosing a date, on your keyboard, press **Esc**.

Navigating the schedule by day

To move forward or backward in the schedule one day at a time:

Click the forward arrow (>) or back arrow (<) beside the displayed date.



Navigating the schedule by a specific number of days

You can navigate forward and backward in the schedule by a specific number of days. This navigation method is useful if you need to view your availability for a specific number of days in the future.

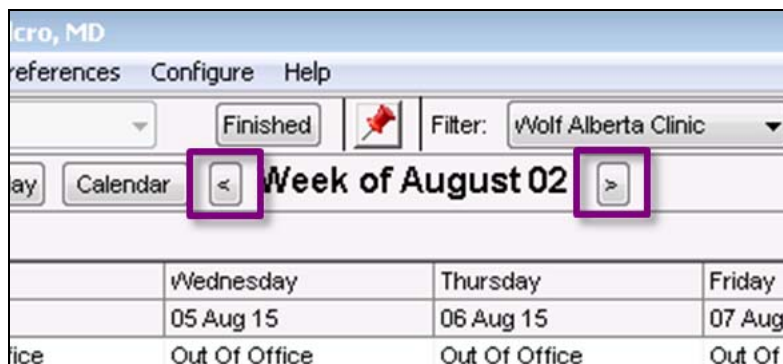
To navigate the schedule by a specific number of days:

1. On your keyboard, press **Control + U**. The EMR displays a dialog box with the following prompt: "Enter the number of days to jump to".
2. Perform one of the following actions:
 - To move forward, enter the number of days you want to move forward.
 - To move backward, enter a minus sign - and then the number of days you want to move backward. For example **-3**.
3. Click **OK**.

Navigating the schedule by weeks

To move forward or backward in the schedule a week at a time:

1. Open your schedule in week view. See ["Viewing your schedule in week view" on page 467](#).
2. Click the forward arrow (>) or back arrow (<) beside **Week of <Date>**.

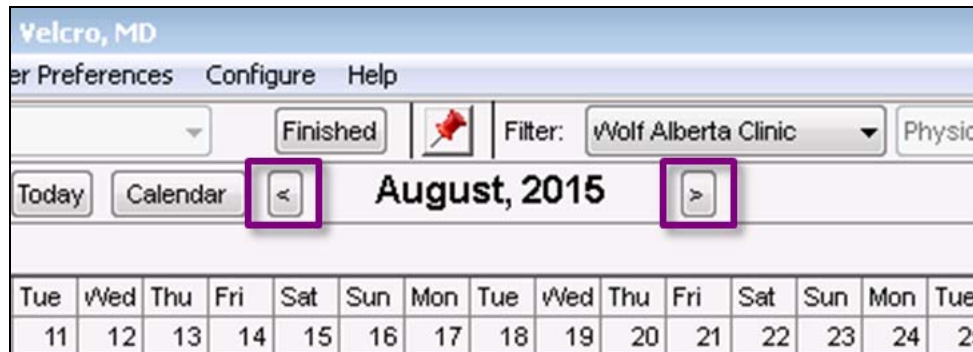


Navigating the schedule by months

To move forward or backward in the schedule a month at a time:

1. Open your schedule in month view. See ["Viewing your schedule in month view" on page 467](#).

- Click the forward arrow (>) or back arrow (<) beside the displayed month.



Navigating back to today's schedule

Sometimes you are in the middle of checking your appointments days, weeks, and months in advance, but then you need to see today's schedule to find out when your next patient is in.

To quickly navigate back to today's schedule:

On the **View** menu bar, click **Today**.

Setting up practitioner schedules

There are several ways to set up your Scheduler view. If you want to view other practitioner schedules in conjunction with yours, you can select the number of practitioner schedules to display, and choose to display only a default set of practitioners working today. You can also create groups of practitioners to display at the same time.

Setting the number of practitioner schedules to display

You can choose the number of practitioners you want to display in the Scheduler for optimal viewing. Each practitioner schedule is displayed as a column in the Scheduler.

- On the Scheduler menu, click **User Preferences > Schedule Display Settings > Set Max Displayed**. The EMR displays a dialog box.
- In the dialog box, enter the number of practitioners (columns in the scheduler) you want to display at once and click **OK**.



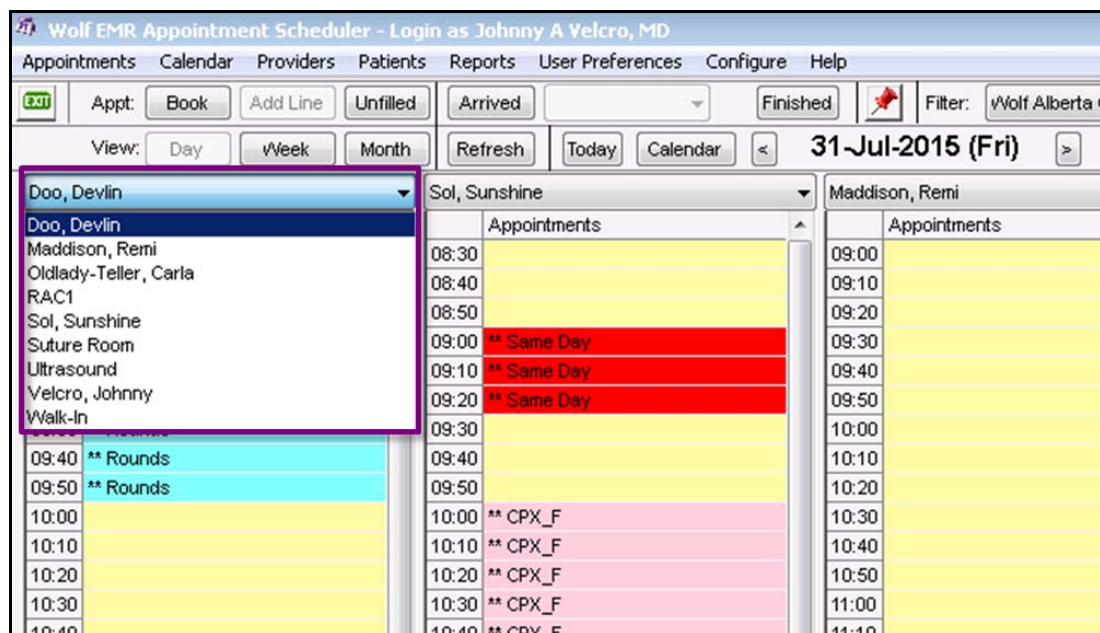
Tip: You can display up to eight practitioner schedules at once, however, four tends to facilitate optimal viewing (depends on screen size).

Selecting default practitioner schedules to display

You can select specific practitioners to display by default. This feature is useful if you want the Scheduler to display only the practitioners who are working today.

To select default practitioner schedules to display:

1. Select the number of practitioner schedules to display. See [“Setting the number of practitioner schedules to display” on page 470.](#)
2. At the top of each schedule column, in the practitioner drop-down list, click the practitioners you want to set as default in the Scheduler. (This also sets the order that the practitioner schedules display across the Scheduler.)



Best practice: Set your own schedule to display in the far left column. When you click day, week, or month view, your schedule will automatically open in these views (instead of another practitioner's schedule)

3. When you finish selecting practitioners for each column, on the Scheduler menu, click **User preferences > Schedule Display Settings > Save Service Providers Selected** to save this view.



Note: If you do not save this view, the practitioners you selected are not saved and your Scheduler reverts to the original Scheduler layout before you changed the columns.

Creating practitioner groups

If you set practitioner groups, you can view a specified group of practitioner schedules in one click. For instance, on any given day only certain practitioners may be in the office. You can create a practitioner group for every day of the week.



Note: Before you begin this process, select a date when you are sure there are no locums scheduled to work. They will replace the practitioner in this group.

To create a practitioner group:

1. Set the appropriate number of columns to display in the scheduler. See [“Setting the number of practitioner schedules to display” on page 470](#).
2. On the Scheduler menu, click **User Preferences > Schedule Display Settings > Add group**. The EMR displays the Add Physician Group dialog box.
3. In the **New Physician Group** field, enter a name for your practitioner group.
4. Click **OK**. The EMR displays a dialog box with the following message: “Screen Initialized - select desired Service Providers for each appointment list - DO NOT select locums, they will automatically replace Office Service Providers”
5. Click **OK**. The EMR displays a dialog box with the following message: “Physician group added”.
6. Click **OK**. A drop-down list appears beside the **Filter** field, displaying the group you just created. All practitioner schedules are removed from the screen and are replaced with blank schedules.
7. At the top of each schedule column, in the practitioner drop-down list, click the practitioners you want to add to the group.



Note: Ensure that your practitioner selections are correct and appear in the order you want. The practitioner selections on your screen will become the practitioner group.

8. On the Scheduler menu, click **User Preferences > Schedule Display Settings > Define group**. The EMR displays a dialog box with the following message: “<group name> defined”.
9. Click **OK**.



Note: Practitioners can be a member of more than one group.

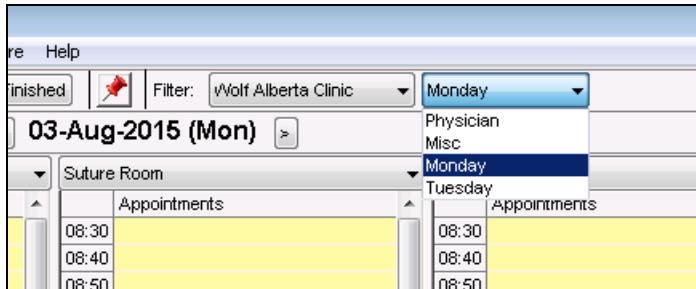
Important:

Groups are user-specific, so they are not visible to other users in the clinic.

Viewing a practitioner group

To view a practitioner group:

In the practitioner group drop-down list beside the **Filter** field, click the group of practitioners you want to display.



The Scheduler displays the practitioner group.

Deleting a practitioner group

If you no longer require a practitioner group, you can delete it.

To delete a practitioner group:

1. In the practitioner group drop-down list beside the **Filter** field, click the practitioner group that you want to delete. The Scheduler displays the practitioner group.
2. On the Scheduler menu, click **User Preferences > Schedule Display Settings > Remove group**. The EMR displays a dialog box with the following message: "Remove Physician Group: <group name>?".
3. Click **Yes**. The EMR displays a dialog box with the following message: "Physician Group removed".
4. Click **OK**.

Modifying a practitioner group

If you work in a busy clinic with schedules that change regularly, you can easily modify practitioner groups to adapt to these changes.

The modifications you want to make to the group determine which method you use:

- To change the members in a group, see ["Changing practitioner group members" on page 474](#).
- To change the name of a practitioner group, see ["Changing the name of a practitioner group" on page 474](#).

Changing practitioner group members

To change practitioner group members:

1. In the practitioner group drop-down list beside the **Filter** field, click the practitioner group you want to change.



Tips:

- To remove members, initialize the screen to clear the practitioners names: On the Scheduler menu, click **User Preferences > Schedule Display Settings > Initialize Screen**.
- To add members, increase the Set Max Displayed number to the number of practitioners who will be in the group: On the Scheduler menu, click **User Preferences > Schedule Display Settings > Set Max Displayed**.

2. In the practitioner drop-down list at the top of each schedule column, click the practitioners you want in the group.
3. When you are finished selecting the practitioners for each column, on the Scheduler menu, click **User Preferences > Schedule Display Settings > Define group**.

Changing the name of a practitioner group

If you want to change the name of a practitioner group, you must first delete the group and then recreate the group with the new name.

To change the name of a practitioner group:

1. Delete the practitioner group that you want to rename. See [“Deleting a practitioner group” on page 473](#).
2. Recreate that group with the new name. See [“Creating practitioner groups” on page 472](#).



Questions?



WolfEMR.Support@telus.com



1-866-879-9653 (Option 1)



<https://telushealthcommunity.force.com/wolfcommunity>