Wolf EMR Course Workbook for Front-End Staff

for British Columbia

Wolf EMR v2016.1.3

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TELUS HEALTH

Information for Life.

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<table>
<tr><td>My name</td><td></td></tr>
<tr><td>Clinic name</td><td></td></tr>
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<tr><td colspan="2">Community Portal
http://telushealthcommunity.force.com/wolfcommunity</td></tr>
</table>

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Introduction

About this workbook

This workbook provides an outline of the functionality and use of Wolf EMR from the perspective of a front-end staff member. Each module is broken into sections based on tasks you perform.

Use this workbook as a reference. It consists of various learning components to help you explore each feature: demonstrations, discussions, hands-on practice, realistic workflow scenario training, and evaluation exercises.

Icons used in this workbook

Content Icon	Meaning	Activity Icon	Meaning
	Tip to make your navigation in the system easier		**Caution** to indicate that you should use caution when performing a task
	Note to indicate that the following content needs extra attention		**Discussion** with your instructor and other learners
	Best Practice to follow to ensure you work as efficiently as possible and achieve desired outcomes		**Activity or scenario** to allow you to practise and apply your learning
	Evaluation to validate your understanding		

For optimal hands-on learning, perform all practice exercises, and complete all scenarios.

An evaluation (short quiz) follows each module. You will be given time to find the information. All questions will be reviewed by the instructor to validate your overall understanding of the material.

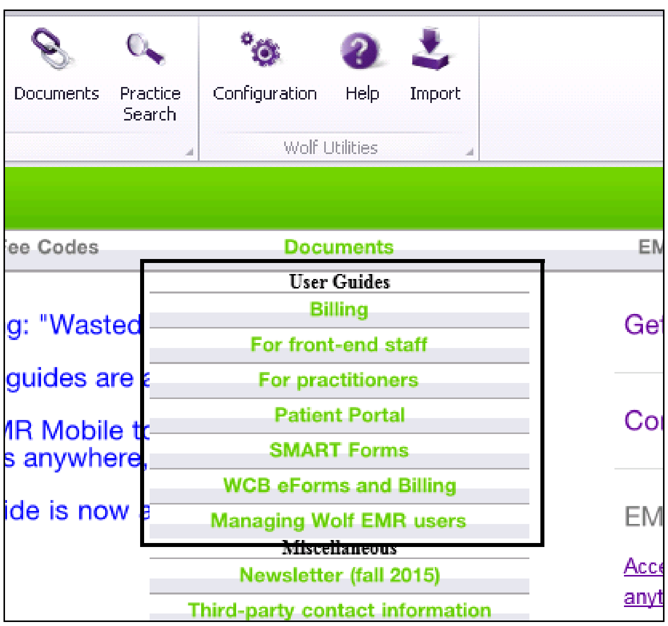
Getting help with Wolf EMR

There is an abundant amount of information that you will be trained on and there are further advanced functions that are not covered in this workbook. Please pay careful attention to your instructor and use this workbook to help you follow along and refer back to. The support does not stop here!

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 for 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.



Accessing the Wolf EMR Community Portal

The Wolf EMR Community Portal provides an extensive amount of learning resources, including articles, user guides, training videos, collaborative forums, and Q and A. To access the Community Portal, on the Wolf EMR Launch page, click **Community Portal**.

Accessing Wolf EMR Support

If you cannot find the answer to your question, have your client number handy, and contact the Wolf EMR support team.

Wolf EMR support team contact information:

- Phone: **1-866-879-9653 (option 1)**
- Email: **WolfEMR.support@telus.com**

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 knowledge to the next level. These courses are offered onsite or via webinar.

To arrange further training, contact the Client Care team:

- Phone: **1-866-879-9653 (option 4)**
- Email: **Accounts.WolfEMR@telus.com**
- 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.

For information about the user conference and materials from past user conferences, keep an eye on the Wolf EMR Launch page.

Managing patients

Introduction to this module

Purpose

In this module you learn how to search for patients, and how to add and modify patient demographic information.

Objectives

Upon completion of this module, you will be able to:

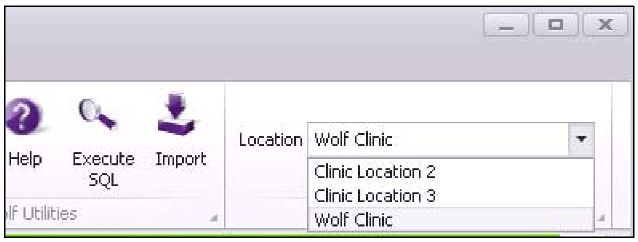
- Search for a patient
- Add a patient
- Modify patient demographic information

Searching for patients

You search for patients to perform many day-to-day tasks, including updating demographics, booking appointments, and viewing patient charts. Although you can search for patients in different areas of the EMR, you most often search for patients from the Appointment Scheduler.

For multi-location clinics:

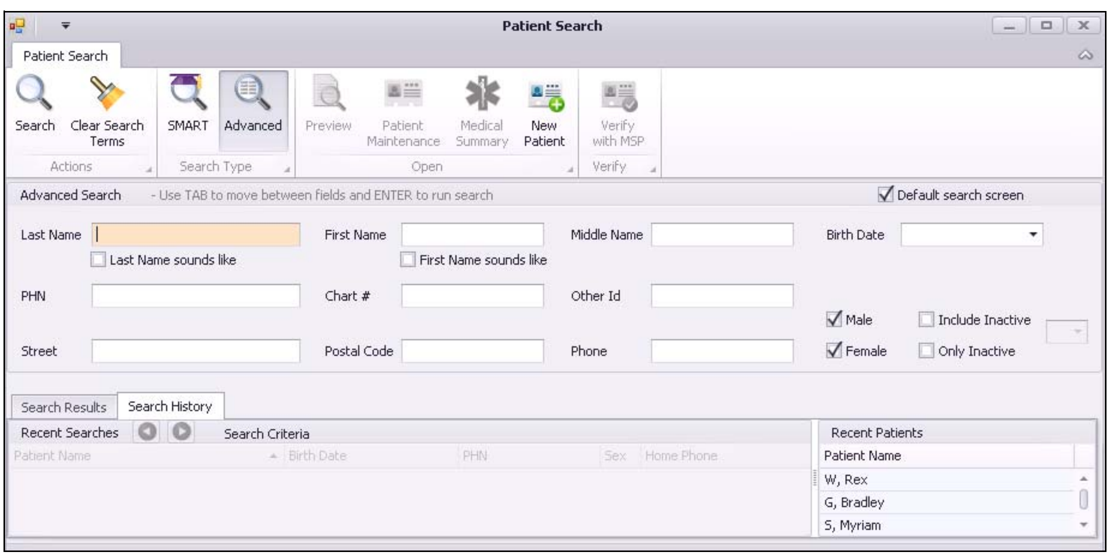
Before you open the Appointment Scheduler, select your location: On the Wolf EMR Launch page, in the **Location** drop-down list, click the location.



To search for patients from the Appointment Scheduler:

1. Open the Appointment Scheduler: On the Wolf EMR Launch page, click **Scheduling** ().

2. On the Appointment Scheduler, in the **Patient Search** area, click **Advanced**. The EMR displays the Patient Search window.



3. In the **Advanced Search** area, enter your search criteria, and then click **Search** ( ) or, on your keyboard, press **Enter**. The EMR displays a list of matching patients in the **Search Results** tab.

4. Perform one of the following actions:

   - To book the patient for an appointment, double-click the patient's name. The EMR displays the patient in the Appointment Scheduler in the **Patient Search** area. You can now book the patient. See "Booking patient appointments" on page 24.

   - To view or modify a patient's demographic information, click the patient, and then click **Patient Maintenance** ( ) or, on your keyboard, press **F9**.

   - To view the patient's chart, select the patient, and then click **Medical Summary** ( ) or, on your keyboard, press **F7**. See "Viewing and entering patient medical history (Medical Summary)" on page 51

   - To record the patient's vitals or visit notes, press **F6**. See "Entering vitals, measurements, and visit notes" on page 63.

   - If you cannot find the patient, you can add the patient: Click **New Patient** ( ). See "Adding patients" on page 9.

Tips for searching for patients

- You can enter part of a patient's last and/or first name.
- If you do not know how to spell a patient's last name, but want to use last name for the search, select the **Last Name sounds like** check box. For example, if you enter "woo", the EMR produces matches for "Wu".
- To include **Inactive** patients (for example, patients who have left the clinic), select the **Include Inactive** check box.
- To find recently searched patients: In the **Search History** tab, in the **Recent Patients** area, select the patient.
- To use a simplified search criteria entry area, click **SMART** ( ).

Practise: Searching for a patient

- Search for a patient using Advanced Search. Select various criteria to narrow your search.
- From your search results, select a patient, and then open Patient Maintenance.
- Search for a patient using SMART Search.
- From your search results, select a patient to book an appointment for.
- View a list of patients whom you have recently searched.

Scenario: Searching for a patient

A patient left the clinic last year, but has just moved back to the city and would like to make an appointment. How can you streamline your search to include only inactive patients?

Adding patients

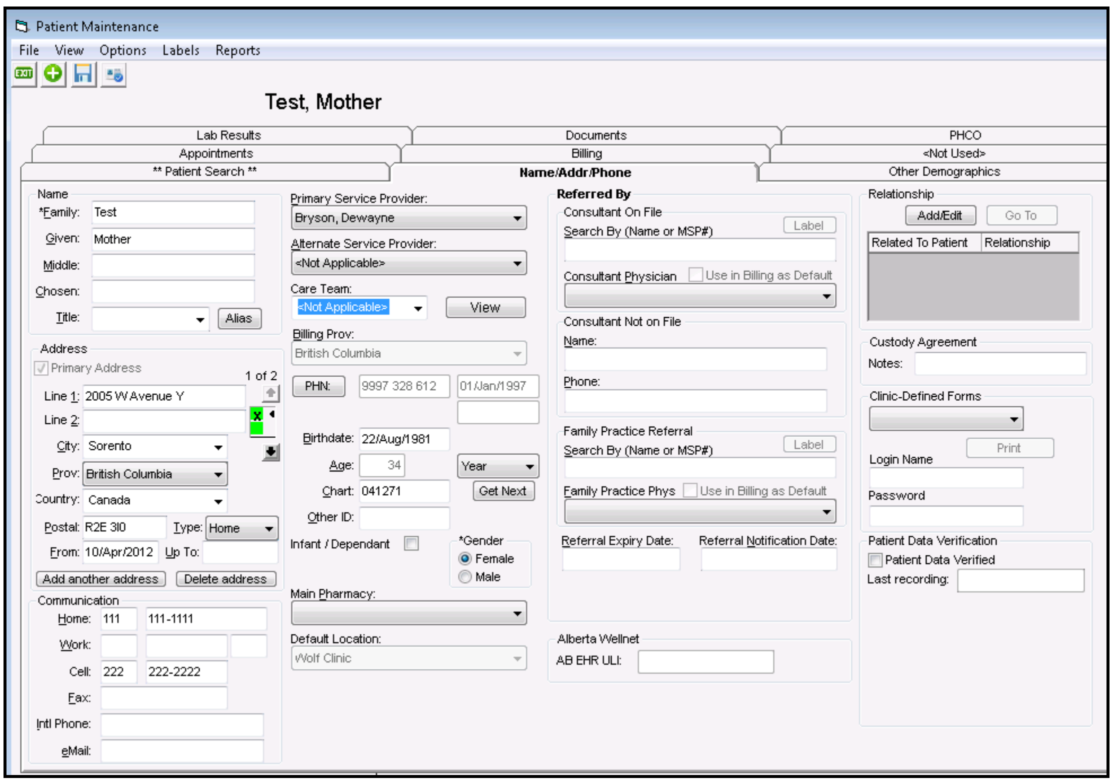
If you search for a patient and the patient is not found, from the Appointment Scheduler, you can add the patient. You must add a patient before you can:

- Schedule the patient for an appointment
- Enter visit notes or other health information for the patient

To add a patient:

1. On the Appointment Scheduler, in the **Patient Search** area, click **Advanced**. The EMR displays the Patient Search window.

2. Click **New Patient** (). The EMR displays the Patient Maintenance window with the **Name/Addr/Phone** tab open.



3. Using the following table, enter the patient's demographic information.

Tips for entering patient demographic information

- The only required fields are **Family** (surname) and **Gender**.
- To jump from field to field, press **Tab**.
- You do not have to capitalize words. The EMR automatically capitalizes words for you.
- To enter multiple addresses for a patient, on the **Address** area, click **Add another address**.
- The EMR warns you if a patient is found with the same name or health card number.

Field	Description
Name	
***Family**	Enter the patient's last name.
Given	Enter the patient's first name.
Middle	Enter the patients middle name or initial.
Chosen	If the patient prefers to be addressed by another name other than their first name, enter the patient's preferred name. **Note:** Wolf EMR displays the chosen name in brackets whereever the patient name is displayed.
Tip: To add a suffix and/or prefix to the patient's name, click the **Other Demographics** tab and then, in the **Display with Patient Name** area, enter information in the **Before** and **After** fields.	
Address	
Line 1	Enter the first line of the patient's address.
Line 2	Enter the second line of the patient's address.
City	In the drop-down list, select the patient's city, or enter the city name.
Prov	In the drop-down list, select the patient's province.
Postal	Enter the patient's postal code. **Tip**: You do not have to use capitals, or enter a space. The EMR automatically formats the postal code for you.
Type	In the drop-down list, select what the address is for.

<table>
<tr><th>Field</th><th>Description</th></tr>
<tr><td colspan="2">Communication</td></tr>
<tr><td>Home</td><td>Enter the patient’s home phone number.</td></tr>
<tr><td>Work</td><td>Enter the patient’s work phone number.</td></tr>
<tr><td>Cell</td><td>Enter the patient’s cell number.</td></tr>
<tr><td>eMail</td><td>If your clinic uses the Patient Portal, enter the patient’s e-mail address. The patient must have a valid e-mail address entered in order to register for the Patient Portal.</td></tr>
<tr><td colspan="2">Second column</td></tr>
<tr><td>Primary Service Provider</td><td>In the drop-down list, select the patient’s primary provider.</td></tr>
<tr><td>Alternate Service Provider</td><td>If the patient sees more than one practitioner, in the drop-down list, select the patient’s secondary provider.</td></tr>
<tr><td>PHN</td><td>To enter the patient’s Personal Health Number, click PHN.
Note:
■ In the PHN field, enter only the numbers. Do not include spaces or hyphens.
■ If the patient is an infant who does not yet have a PHN, enter the mother’s PHN.</td></tr>
<tr><td>Birthdate</td><td>Enter the patient’s birthdate one of the following formats:
■ DD MMM YYYY (for example, 16 Dec 2001)
■ DDMMYY (for example, 161201)
and then, on your keyboard, press Enter.
Note: The EMR automatically calculates the patient’s Age based on the birthdate.</td></tr>
</table>

Field	Description
Infant / Dependant	If the patient is an infant who does not yet have a PHN, select the **Infant / Dependant** check box. **Note:** When an infant is first born, usually the patient is allowed to be submitted under the mother's PHN for a short period of time until the baby gets its own PHN. Selecting this check box ensures that electronically submitted billing is designated with the mother's PHN.
Gender	Select the patient's gender.

<table>
<tr><th>Field</th><th>Description</th></tr>
<tr><td colspan="2">Referred By area</td></tr>
<tr><td colspan="2">
If the patient was referred to your clinic, there are two areas where you can enter a referring practitioner's information. The area you enter information depends on whether the referring practitioner is a General Practitioner or a Consultant (Specialist):
If the patient was referred by a Consultant (Specialist):
1. In the Consultant On File area, in the Search By field, start typing the consultant's last name and then press Enter.
2. In the Consultant Physician drop-down list, select the consultant.
Note: If the consultant is not on file, in the Consultant Not on File area, enter the consultant information.
3. In the Referral Expiry Date field, enter the expiry date for the referral (6 months from the referral date) and then, in the Referral Notification Date field, enter the referral date.
If the patient was referred by a General Practitioner:
1. In the Family Practice Referral area, in the Search By field, start typing the physician's last name and then press Enter.
2. In the Family Practice Physician drop-down list, select the consultant.
3. In the Referral Expiry Date field, enter the expiry date for the referral (6 months from the referral date) and then, in the Referral Notification Date field, enter the referral date.
Tips for entering referring practitioners:

If you want to use the consultant physician or the family practice physician as the default referring physician in billing, ensure that you select the Use in Billing as Default check box.
If the consultant or family practice physician is not in your system, you can add them to the consultant list from the Appointment Scheduler:
a) On the Appointment Scheduler menu, click Configure > New Referral Consultant (Quick Add).

</td></tr>
</table>

> **For multi-location clinics**:
>
> In the **Default Location** drop-down list, select the primary location that the patient receives care from.

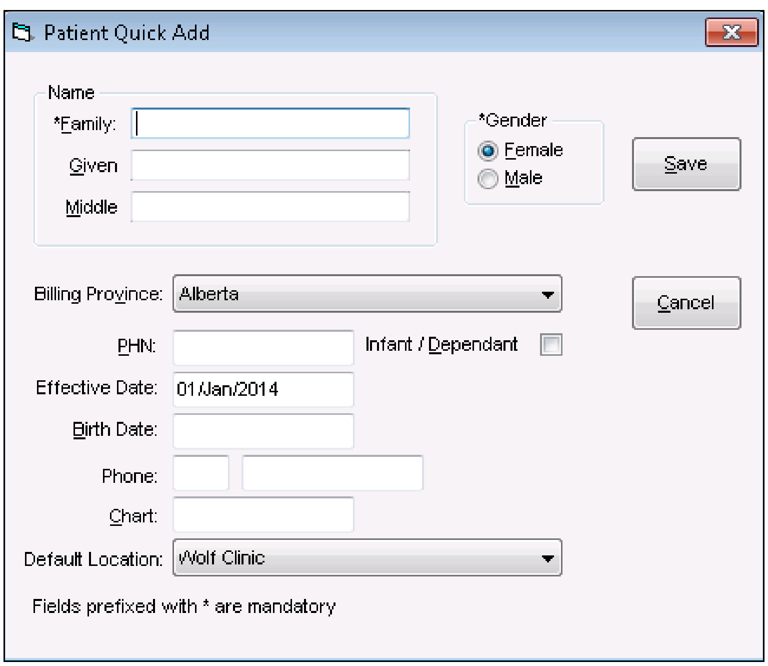
4. To enter the patient's next of kin information, click the **Other Demographics** tab, and then in the **Next of Kin / Contact** area, enter the next of kin's name and contact information.
5. To assign the patient a status other than "Active" (for example, to assign the patient as a "Long Term Care Patient"), click the **Patient Status** tab, and then click **New Status**.
6. Click **Save** ().
7. To verify the patient's PHN with MSP, click **Verify with MSP** ().

Adding patients using Quick Add

If you want to quickly add a patient, and enter only basic information about the patient, you can use Quick Add.

To add a patient using Quick Add:

1. On the Appointment Scheduler menu, click **Patients** > **New Patient (Quick Add)** or, on your keyboard, press **Ctrl** + **Q**. The EMR displays the Patient Quick Add window.



2. Enter the patient's demographic information, and then click **Save**.

Practise: Adding a patient

1. Add a test patient in the Patient Maintenance window. Ensure you do the following:
   - Enter surname as "**Test**"
   - Enter the first name as your first name, followed by "**-Mother**" (for example, "John-Mother")
   - Enter a primary address
   - Enter a home phone number
   - Select the patient's primary practitioner
   - Enter the patient's PHN
   - Enter the patient's birthdate
   - Select the patient's gender
   - Enter the patient's next of kin contact information
   - Save the patient information
   - Verify the patient's PHN with MSP
2. Add another test patient using Quick Add. Ensure you do the following:
   - Enter surname as "**Test**"
   - Enter the first name as your first name, followed by "**-Baby**" (for example, "John-Baby")
   - Select a gender
   - Enter a home phone number

Adding family members

If you want to add a family member of a patient, you can save time by copying some of the patient's information. The EMR populates the Patient Maintenance window with the same last name, address, home phone number, primary service provider, and default location as the patient you copied.

To add a patient's family member:

1. Search for and open the Patient Maintenance window for the patient. See "Searching for patients" on page 6.
2. On the Patient Maintenance menu, click **File** > **Copy Patient**. The EMR displays a Patient Maintenance window for the family member, with the ***Family**, **Address**, **Prov**, **Home** phone number, **Primary Service Provider** fields populated.
3. Enter the remainder of the family member's demographic information, and then click **Save** (). See "Adding patients" on page 9.
4. If you want to link the family member to the patient, enter a relationship. See "Linking patients using relationships" on page 16.

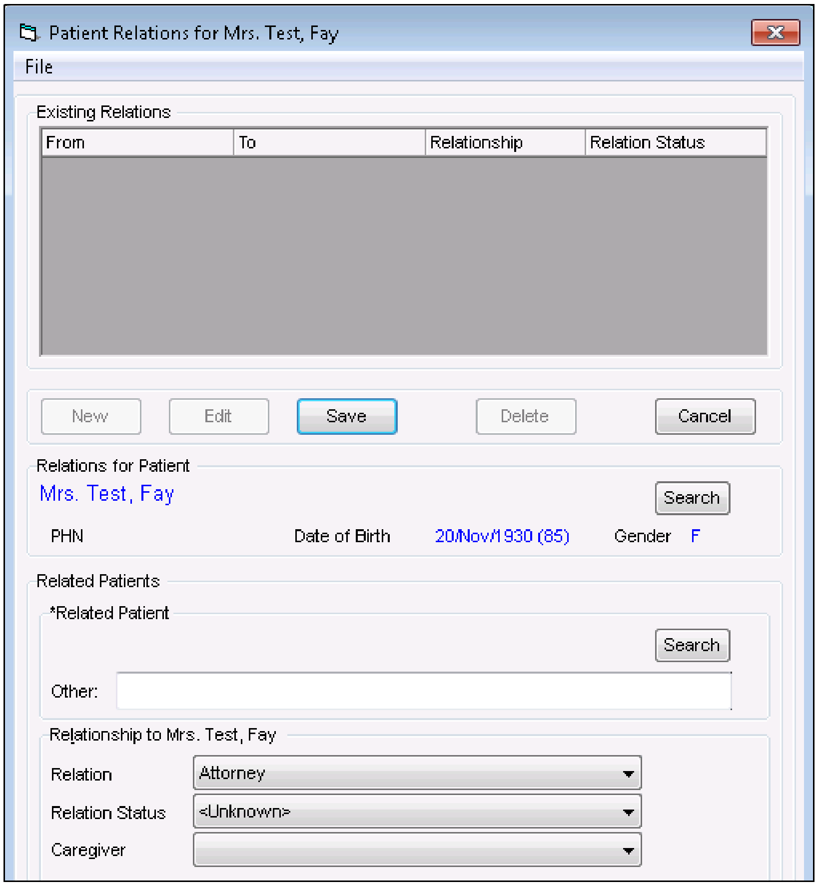
Linking patients using relationships

You can create relationships to:

- Link family members
- Define a patient's primary caregiver
- Note other important patient contacts (for example, a social worker)

To enter a patient's relationships:

1. Open the Patient Maintenance window for the patient. See "Searching for patients" on page 6.
2. In the **Name/Addr/Phone** tab, in the **Relationships** area, click **Add/Edit**. The EMR displays the Patient Relations window.



3. Perform one of the following actions:

   - If this is the first relationship you are adding, in the **Related Patients** area, click **Search**.
   - If the patient already has relations entered, click **New** and then, in the **Related Patients** area, click **Search**.

   The EMR displays the Patient Search window.

4. Search for and double-click the related patient.
5. In the **Relationship to** area, in the **Relation** drop-down list, select the relation type.
6. If the relation is the patient's primary caregiver, in the **Caregiver** drop-down list, click **Primary**.
7. Click **Save**.

Practise: Adding a family member

1. Add a family member by copying the first test patient you added:
   - Enter the first name as your first name, followed by "**-Father**" (for example, "John-Father")
   - Enter the patient's PHN
   - Enter the patient's birthdate
   - Select the patient's gender
   - Save the patient information
2. Using relationships, link all three patients you created up to this point.

Scenario: Adding a patient (specialist clinics)

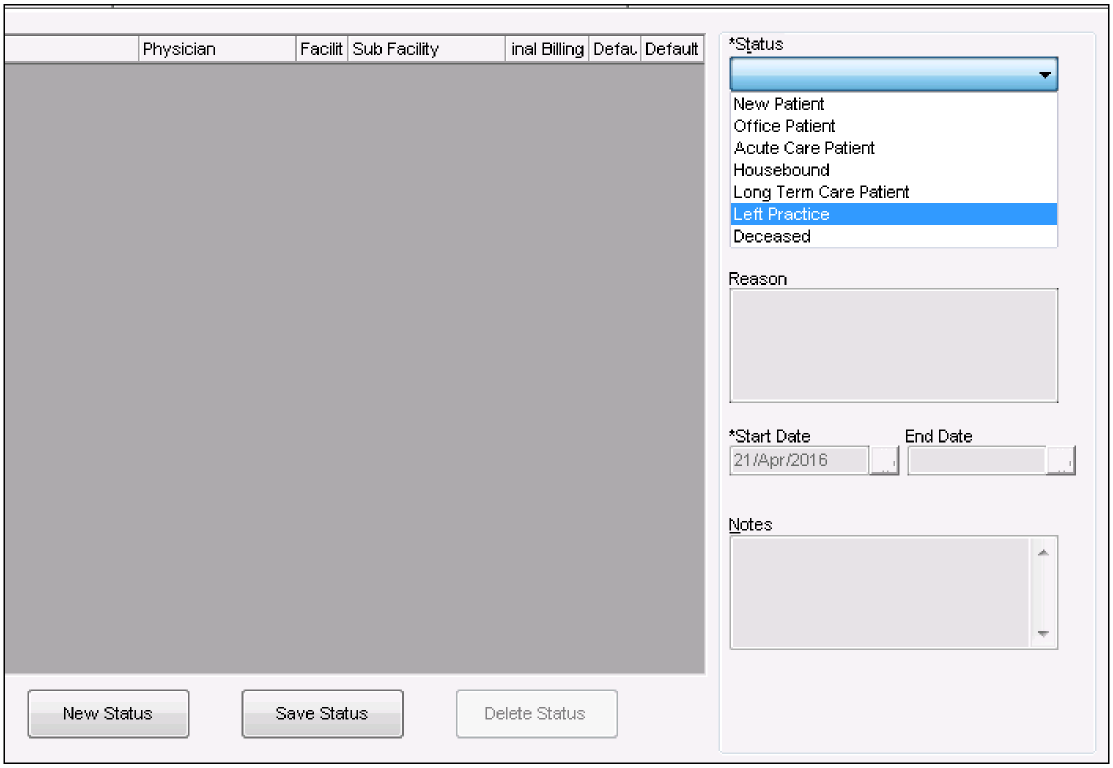
You want to indicate that a new patient was referred by Dr. Bones, but Dr. Bones isn't in the database. How can you identify Dr. Bones as the referring practitioner in the EMR?

Removing patients

When a patient leaves your clinic, you can "remove" the patient by changing their status to inactive. Inactive patients can be searched for and reactivated if needed.

To deactivate a patient:

1. Open the Patient Maintenance window for the patient. See "Searching for patients" on page 6.
2. Click the **Patient Status** tab.
3. Click **New Status**, and then in the **Status** drop-down list, select an inactive-type patient status (for example, Deceased or Left Practice).



4. Click **Save Status**.

Evaluation

Complete the following questions.

1. When you add a patient, what are the required fields?

2. If you are searching for a patient whose last name is hard to spell, can you tell the EMR to search for patients with names the sound like the name you enter (instead of only patients whose names start with what you enter)?

3. What are your options for getting help when you have a question?

4. How do you remove a patient?

End of Module

Managing appointments

Introduction to this module

Purpose

In this module you learn how to perform tasks from the Appointment Scheduler, including how to:

- Search for patients
- Add and modify patient demographic information
- Book and manage appointments

Objectives

Upon completion of this module, you will be able to:

- View and navigate the Appointment Scheduler
- Book a patient appointment
- Manage patient appointments
- Book non-patient appointments
- Block off appointment slots
- Select provider schedules to display by default
- Lock your station from the Appointment Scheduler

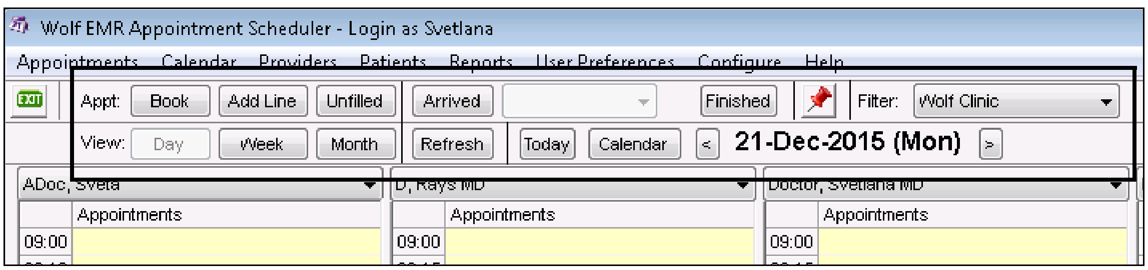
Viewing and navigating the Appointment Scheduler

You can change the view of your Appointment Scheduler to best meet your workflow needs. You can view multiple practitioner schedules simultaneously for a single day, or you can view daily, weekly, and monthly schedules for each practitioner.

You can also quickly navigate to a specific date, or jump forward and backward by day, week or month.

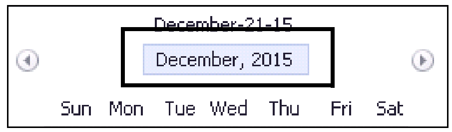
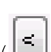
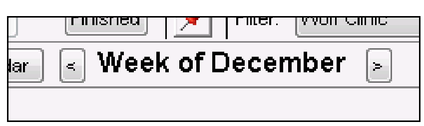
> The schedule defaults to the day view every time it is opened. The day view displays the schedules of your default practitioners. (See “Selecting practitioner schedules to display” on page 35.) You can view only one practitioner at a time when viewing their schedule in a week or month view.

Your schedule view and navigation options are available at the top of the Appointment Scheduler.



Use the following table to change your appointment scheduler view.

View / Action	Steps
Week view	1. Click in the practitioner schedule you want to view. 2. On the **View** menu bar, click **Week**.
Month view	1. Click in the practitioner schedule you want to view. 2. On the **View** menu bar, click **Month**.
Day view (shows all default practitioners' schedules)	On the **View** menu bar, click **Day**.

View / Action	Steps
Navigate to a specific date	On the **View** menu bar, click **Calendar** and then, on the calendar, click the date. **Tips**: ■ To navigate to another month, click <**month**>**,** <**year**> between the two arrows.  The calendar displays the months of the year. Click the month you want. ■ To close the calendar without choosing a date, on your keyboard, press **Esc**.
Navigate forward or back a day	1. Display the schedule in a day view. 2. Beside the displayed date, click the forward arrow () or back arrow (). 
Navigate forward or back a certain number of days	On your keyboard, press **Ctrl** + **U**, and then: ■ 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**.
Navigate forward or back a week	1. Display the schedule in a week view. 2. Beside **Week of <Month>**, click the forward arrow () or back arrow (). 

View / Action	Steps
Navigate forward or back a month	1. Display the schedule in a month view. 2. Beside <**Month**>**,** <**Year**>, click the forward arrow (**)** or back arrow (**)**. 
Navigate back to today	On the **View** menu bar, click **Today**.

Practise: Navigating the Scheduler

Perform the following actions:

- Open a practitioner's schedule in a week view
- View the schedule for all default practitioners for September 21
- Jump forward one day to September 22
- Navigate back to today's date

Scenarios: Navigating the Scheduler

Navigate the schedule for the following situations:

- A patient wants to book an appointment on March 15.
- A doctor requests that the patient return in three months for a follow-up.
- A patient wants an appointment four days from today.

Booking patient appointments

For multi-location clinics:

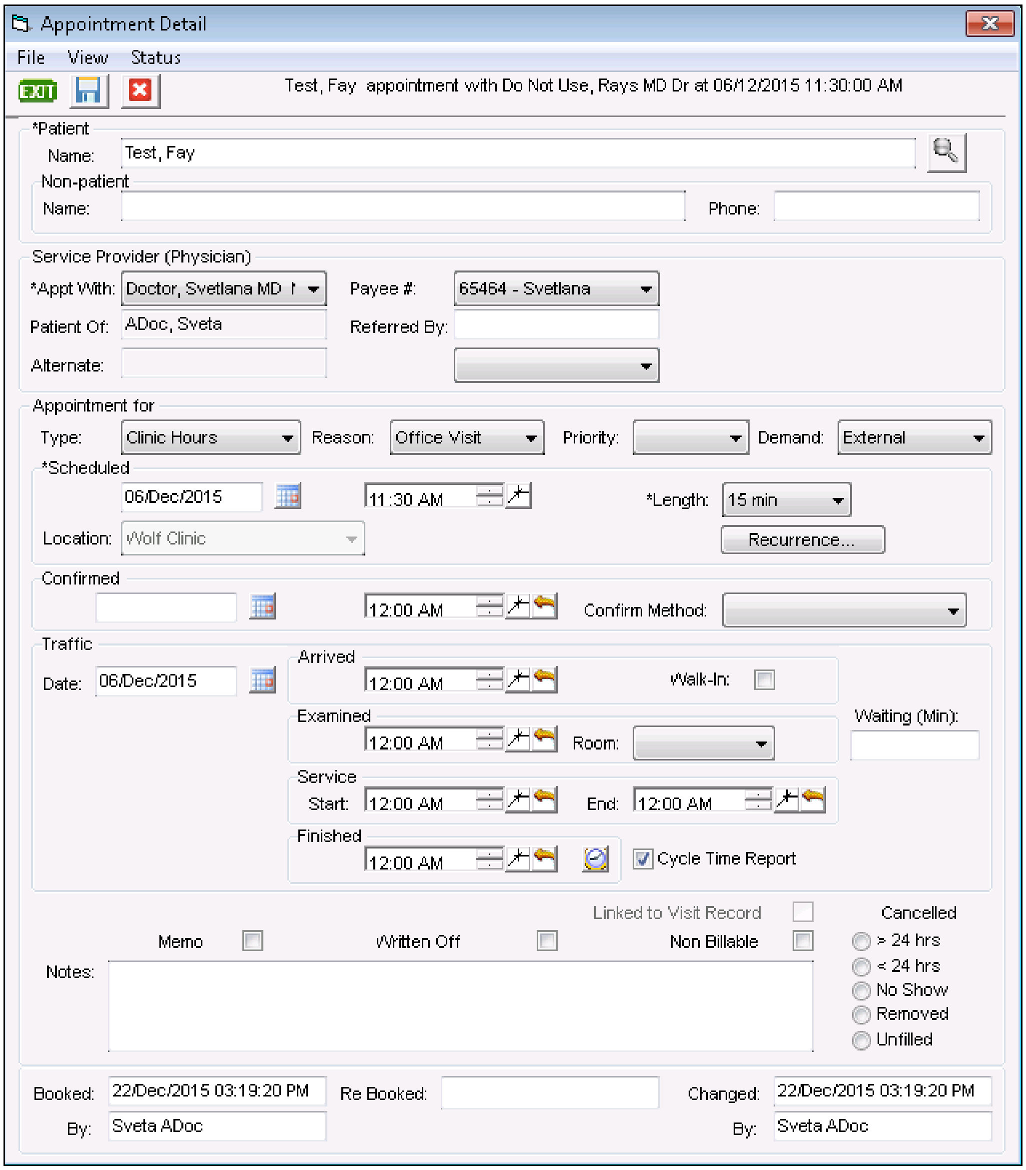
Although you can view appointment schedules for all locations, you can book appointments only for locations that you are assigned to. If you are unable to book at a specific location, ask your Administrator to grant you access.

To book an appointment for a patient:

1. Search for and select the patient. See "Searching for patients" on page 6.

2. If the patient is new and you cannot find the patient, add the patient. See “Adding patients” on page 9.

3. On the patient’s practitioner’s schedule, right-click an empty appointment slot, and then click **Book**. If configured to do so, the EMR displays the Appointment Detail window.



otherwise, the EMR adds the appointment with the default appointment reason and length (you can skip the remainder of the steps).

4. In the Appointment Detail window, use the following table to enter appointment details.

Field	Description
Service Provider area	
Referred By (used by specialists clinics)	If you are booking an appointment for a patient who has seen the practitioner on several occasions, but on each occasion the patient was referred by a different practitioner, you can indicate who the referring practitioner is for this appointment: 1. In the **Referred By** field, enter part or all of the referring practitioners name. 2. In the drop-down list below, select the practitioner. **Note:** The referring practitioner you select for the appointment is populated by default in the associated bill. **Tip**: If the referring practitioner is not in the system, you can quickly add the referring practitioner to your consultants list from the Appointment Scheduler: 1. On the Appointment Scheduler menu, click **Configure** > **New Referral Consultant (Quick Add)**. 2. In the Referral Consultant Quick-Add window, enter the referring practitioner's information, and then click **Save**.
Appointment for area	
Reason	In the drop-down list, select the reason for the appointment.
Length	If the appointment is to be longer than the default length, in the drop-down list, select the appointment length.
Notes	To add additional notes about the appointment, in the **Notes** area, enter your notes. For example, if the patient has more than one appointment reason, you can enter the additional reason(s) in the **Notes** area.
Non Billable	If the appointment is not to be billed, select this check box.

5. Click **Save** ( ).

Tips for booking appointments

- If your EMR is not configured to show the Appointment Detail window, and you want to modify the appointment's details from the Appointment Detail window (for example, to modify both the appointment's length and reason), right-click the appointment, and then click **Edit**.
- If the appointment length is too long, you can quickly reduce the appointment length by one time slot. Right-click the appointment, and then click **Shorten Appointment**.
- To quickly change the reason for an appointment, right-click the appointment, and then click **Change Appointment Reason**.
- To quickly view or add appointment notes, right-click the appointment, and then click **Appointment Notes**.
- You can book multiple patients in one appointment slot:
    1. After you book the first appointment, on the **Appt:** menu bar, click **Add Line** (**Ctrl + I**). The EMR inserts a new line below the current time slot.
    2. Book the next patient as usual in the new space.
- If open time slots are difficult to find, you can perform a search for the next available appointment: On the Appointment Scheduler menu, click **Appointments** > **Time Search**.
- If you want to book an appointment for a patient without entering the patient in the EMR first (for example, to book a meet-and-greet appointment), you can book the appointment as a non-patient appointment. See “Booking non-patient appointments” on page 32.

Practise: Booking patient appointments

- Book a patient for a general office visit
- After the appointment is booked, modify the appointment reason

Scenario: Booking patient appointments

A mother wants to book physicals for her two young children for the same time. Can you enter both siblings for the same appointment start time? If so, how?

Managing appointments

Once an appointment is booked, you can:

- Move the appointment to a new time, day, or schedule
- Cancel the appointment
- Change the appointment's status (to confirmed, arrived, in exam room, and finished)

On the day of the appointment, you can also monitor where the booked patient is (for example, if they are in a waiting room, or if they are in an exam room) using the Clinic Day View window.

Moving an appointment to a new time, day, or practitioner

To move an appointment:

1. On the Appointment Scheduler, right-click the appointment, and then click **Move** (**Ctrl** + **V**). Your cursor changes to a plus sign with arrows on the ends.
2. Navigate to the time, day. and/or schedule where you want to move appointment, and then click an empty time slot. The EMR moves appointment.

Canceling appointments

You cancel appointments to indicate that a patient did not show up for an appointment, to indicate that a patient called to cancel an appointment, or to remove an appointment that was entered in error.

To cancel an appointment:

1. On the Appointment Scheduler, right-click the appointment, click **Cancel**, and then click one of the following options:
   - **Cancel (No Show)**: If, without a warning, the patient does not show up for their appointment.
   - **Cancel (less than 24 hours)**: If the patient cancels with less than 24 hours notice.
   - **Cancel (greater than 24 hours)**: If the patient cancels with more than 24 hours notice.
   - **Remove**: If the appointment was booked in error. (You can only Remove an appointment that is not yet marked as Arrived.)

   The EMR displays a dialog box asking you if you want to cancel this appointment.
2. Click **Yes**. If you chose one of the **Cancel** options, the EMR displays the following prompt: "Do you want to create a bill for this cancellation?"
3. Perform one of the following actions:

- If you want to bill the patient for the missed appointment, click **Yes**. See “Creating bills for patients” on page 184.
- If you do not want to bill the patient, click **No**.

Changing an appointment’s status

You must mark the patient as arrived before you can:

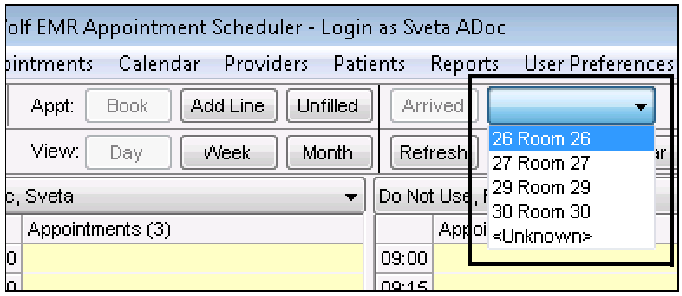
- Indicate which exam room the patient is in
- Create a bill for the appointment

On the Appointment Scheduler, use the following table to change an appointment’s status.

Status	Steps
Confirmed	Right-click the appointment, and then click **Confirm**. The EMR displays a “**C**” on the appointment.
Arrived	Right-click the appointment, and then click **Arrive** (**Ctrl** + **A**). The EMR displays an “**A**” on the appointment, and displays the Verify Patient Details window. **Tips for “arriving” a patient** ■ To modify the patient’s demographic information, on the Verify Patient Details window, click **Open Patient Maintenance**, and then, in the Patient Maintenance window, modify the information as needed. ■ To verify the patient’s PHN with MSP, click **Verify with MSP**. ■ To indicate that you have verified the patient’s demographic information, click **Open Patient Maintenance**, and then select the **Patient Data Verified** check box.

<table>
<tr><th>Status</th><th>Steps</th></tr>
<tr><td>In Exam Room</td><td>Perform one of the following actions:

If your clinic has exam rooms configured, click the appointment and then, in the Appt: bar, in the exam room drop-down list, select the exam room.



The EMR displays the room number on the appointment.
If your clinic does not have exam rooms configured, right-click the appointment, and then click In Exam Room.
</td></tr>
<tr><td>Finished</td><td>Right-click the appointment, and then click Finished (Ctrl + F). The EMR displays an “F” on the appointment.

Note: Practitioners can mark appointments as Finished as well.</td></tr>
</table>

Tip for changing an appointment’s status

If you unintentionally change an appointment’s status (for example, if you unintentionally change an appointment from Confirmed to Arrived), you can change the status back:

1. Right-click the appointment, and then click **Reset Appointment Status.**
2. Right-click the appointment again, and then click the correct status.

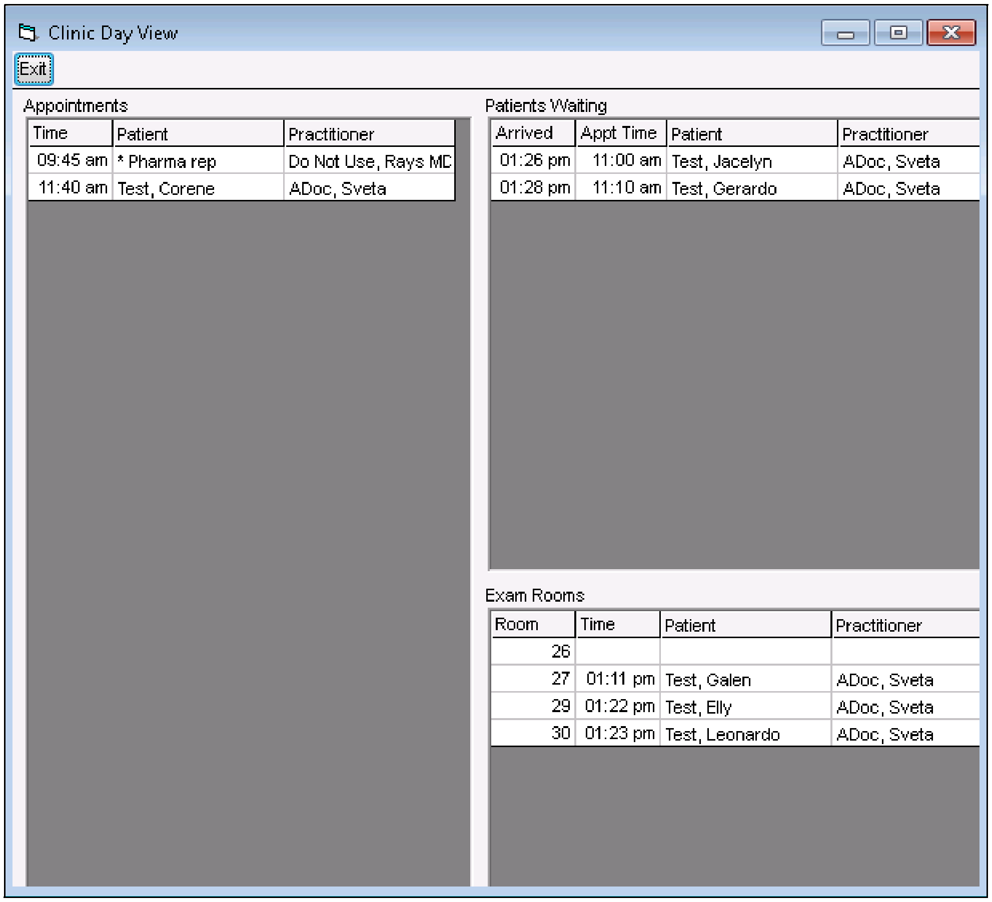
Managing clinic traffic

In one comprehensive window, you can monitor which:

- Patients have appointments for today, but have not yet Arrived
- Patients are waiting for a room
- Exam rooms are occupied, and by whom

To monitor clinic traffic:

With the Appointment Scheduler open, on your keyboard, press **Ctrl + J**. The EMR displays the Clinic Day View window.



The Clinic Day View window contains read-only information. You cannot enter or modify information in this window.

The Clinic Day View window contains three main areas:

- **Appointments**: Displays patients who have appointments for today but have not Arrived.
- **Patients Waiting**: Displays patients who have Arrived for their appointment, but have not been moved to an exam room.
- **Exam Rooms**: Displays patients in Exam rooms. You can see which room a patient is in, when they moved to the room, and which practitioner the patient is booked with.

Scenarios: Managing appointments

Indicate the steps you follow for the following situations:

- A practitioner has a family emergency and asks you to re-book his last appointment of the day with another practitioner.
- A patient calls to tell you that they were in a car accident on their way to their appointment and cannot make it in.
- A patient calls to tell you that they have booked a trip for the week when their next physical is booked. The patient indicates that they will re-book at a later time.
- A patient arrives for their appointment.
- A practitioner asks which room their next patient has been placed in.
- A patient does not show up for their appointment.

Booking non-patient appointments

You can book appointments that are not linked to patients. For example, you can book appointments for:

- Sales representatives
- Staff meetings
- Training and professional development

To book a non-patient appointment:

1. On the Appointment Scheduler, in the **Patient Search** area, in the **Family Name** field, enter a description of the appointment (for example, Pharma Rep).
2. Right-click an empty appointment slot and click **Book**. The EMR opens a a dialog box prompting you to enter a contact phone number.
3. Enter the contact phone number, and then click **OK**. (If you don't want to enter a number, click **Cancel**.)
4. If the EMR displays the Appointment Detail window, perform one of the following actions:

    - If you need to change the appointment details, make your changes, click **Save** ( ) and then click **Exit**.
    - If you do not need to change any of the appointment details, click **Exit**.

The appointment appears in the Scheduler with an asterisk (*****) before the description you entered in the **Family Name** field. For example ***Pharma rep**.

5. Mark the appointment as Non Billable: Right-click the appointment, and then click **Memo (Non-Billable)**.

The asterisk (*****) indicates the appointment is not linked to a patient.

Tips for booking non-patient appointments

- To view the contact's phone number, click the appointment, and then hover your cursor over the appointment.

Practise: Booking appointments that are not linked to patients

- Book a staff meeting.
- Indicate that the staff meeting appointment should not be billed.

Blocking off appointment slots

If you want to block off a practitioner's schedule (for example, for a stat holiday), you can quickly block off an entire day, a selected time range within a day, or a specific appointment slot. When you block off appointment slots, the schedule displays "****DoNotBook**" in those slots.

Use the following table to block off a practitioner's schedule.

To block off a...	Steps
Specific appointment slot	1. On the practitioner's schedule, click the appointment slot. 2. On the Appointment Scheduler menu, click **Providers** > **Block/ Unblock** > **Selected Time Slot for <practitioner name>** or, on your keyboard, press **Ctrl + L**.
A range of appointment slots within a day	1. On the practitioner's schedule, click and drag to select the appointment slots. 2. On the Appointment Scheduler menu, click **Providers** > **Block/ Unblock** > **Selected Time Slot for <practitioner name>** or, on your keyboard, press **Ctrl + L**.

To block off a...	Steps
Specific date	1. On the practitioner's schedule, click the first appointment slot on the date you want to block off. 2. On the Appointment Scheduler menu, click **Providers** > **Block/ Unblock** > **Block Booking for <practitioner name> for <date>** or, on your keyboard, press **Ctrl + K**.

Tips for blocking off appointments:

- You can block off a practitioner's schedule only if you are viewing the schedule in a Day view. You cannot block off a schedule if you are viewing it in a Week or a Month view.
- To unblock appointment slots:
  1. On the practitioner's schedule, click the blocked off appointment slot(s).
  2. On the Appointment scheduler menu, click **Providers** > **Block/Unblock** > **Undo Block for <practitioner name>**.

Practise: Blocking off appointments

On a practitioner's schedule, perform the following actions:

- Block off the entire day for December 25 (or another stat holiday)
- Block off a half day
- Block off one appointment slot
- Unblock the schedule for the half day and single appointment slot you blocked off

Selecting practitioner schedules to display

When you are viewing the appointment schedule in a day view, each practitioner's schedule displays as a column.

On the Appointment Scheduler, you can customize:

- How many practitioner schedules display at once
- What practitioner schedules display by default
- Practitioner groups, enabling you to quickly change the practitioners displayed

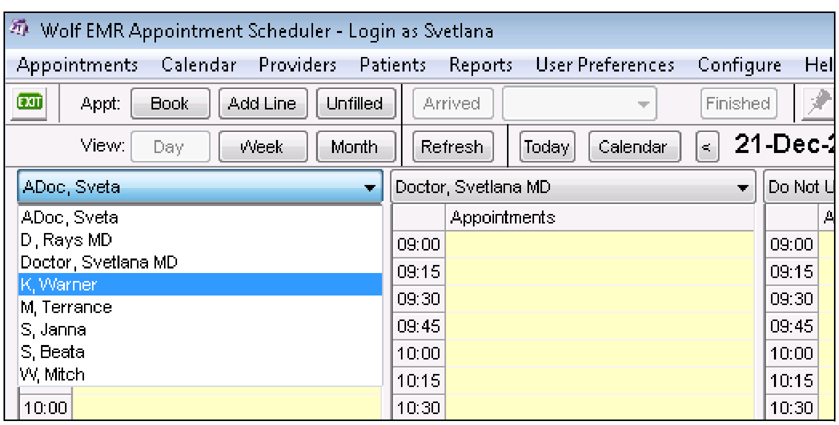
Setting your default practitioner schedule view

To select which practitioner schedules display by default:

1. Set the number of schedules to display: On the Scheduler menu, click **User Preferences > Schedule Display Settings > Set Max Displayed**, and then enter the number of schedules.

Tip: You can display up to eight practitioner schedules at once, however, four tends to facilitate optimal viewing (depending on screen size).

2. At the top of each column, in the practitioner drop-down list, click the practitioner whose schedule you want displayed.

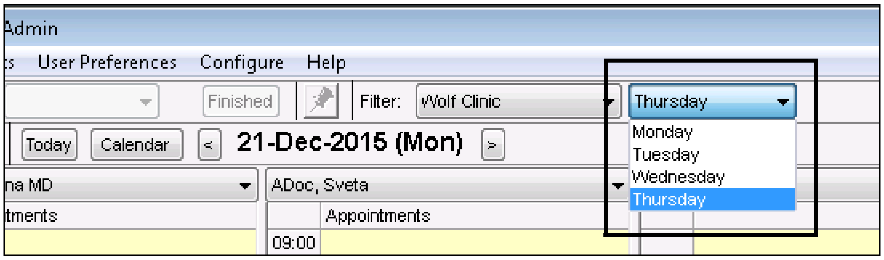


3. When you finish selecting practitioner schedules, save the view: On the Scheduler menu, click **User preferences** > **Schedule Display Settings** > **Save Service Providers Selected**.

If you do not save the view, the practitioners you selected are not saved and your Scheduler reverts to the original Scheduler layout after you book an appointment or close the window.

Creating practitioner groups

If you have different practitioners working each day, in the Appointment Scheduler, you can create practitioner groups. Each time you open the Appointment Scheduler, in the practitioner group drop-down list (located beside the **Filter** field), you can click the group of practitioners you want to display without having to manually set them each time.



> Before you create a practitioner group, select a date when you are sure there are no locums scheduled to work. A locum will replace a practitioner in the group if the locum is scheduled to work on the selected date.

To create a practitioner group:

1. Set the number of schedules to display for the group: On the Scheduler menu, click **User Preferences > Schedule Display Settings** > **Set Max Displayed**, and then enter the number of schedules.
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 the 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. 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”.
8. Click **OK**.

Tips for managing practitioner groups

- To delete practitioner groups:
  In the practitioner group drop-down list, select the group, and then on the Scheduler menu, click **User Preferences > Schedule Display Settings > Remove group**.
- To add members to groups:
  1. In the practitioner group drop-down list, select the group.
  2. Increase the number of schedules (columns) displayed: On the Scheduler menu, click **User Preferences > Schedule Display Settings > Set Max Displayed**.
  3. At the top of each schedule column, in the practitioner drop-down list, click the practitioners you want in the group.
  4. When you finish selecting the practitioners and their order, on the Scheduler menu, click **User Preferences > Schedule Display Settings > Define group**.
- To remove members from groups:
  1. In the practitioner group drop-down list, select the group.
  2. Reduce the number of schedules (columns) displayed: On the Scheduler menu, click **User Preferences > Schedule Display Settings > Set Max Displayed**.
  3. Initialize the screen to clear the practitioners names. On the Scheduler menu, click **User Preferences > Schedule Display Settings > Initialize Screen**.
  4. At the top of each schedule column, in the practitioner drop-down list, click the practitioners you want in the group.
  5. When you finish selecting the practitioners and their order, on the Scheduler menu, click **User Preferences > Schedule Display Settings > Define group**.

Practise: Scheduler set up

Perform the following actions to set up your appointment scheduler:

- Set the number of practitioner schedules to display.
- Select default practitioner schedules to display by default. Select the practitioners so they appear in alphabetical order across the Scheduler.
- Create a practitioner group. Name the group Wednesday and add four practitioners to the group.

Scenario: Scheduler set up

You work in a busy clinic with different practitioners working each day. Five practitioners work each day. How can you set up your Scheduler to display only the practitioners working on a particular day?

Scenario: Modifying practitioner groups

A practitioner changes the days of the week she is working. She is no longer working on Mondays, but her other working days remain the same. She is a member of your “Monday practitioners” group. How do you remove her from your “Monday practitioners” group?

Printing appointment day sheets

You can print a practitioner’s appointment list for the day. The appointment list includes the following information: Length of Appointment, Patient Name, Age, and Chart Number.

To print an appointment list:

1. On the Appointment Scheduler menu, click **Reports > Day Sheet**.
2. In the **Service Provider Selection** drop-down list, select a practitioner’s name, or to print appointments for all providers scheduled for today, select **All on screen**.
3. If you want to print the day sheet in a landscape format, in the **Daysheet Format** drop-down list, select **Landscape #1**.
4. In the **Time Selection** area, select which part of day’s appointments you want to print. You can also enter a specific time period in hours and minutes in the **From** and **Up to** area.
5. Click **Print**.

Creating appointment notes (alerts) for a patient

You can create a note or an alert to pop-up every time a specific patient is:

- Booked and confirmed for an appointment
- Marked as Arrived

For example, a booking alert can read “Patient is often late. Book them 10 minutes earlier than Scheduled appointment time.” An arrival alert can read “Patient is hearing impaired, please make eye contact when speaking to patient.”

To create an appointment note (alert) for a patient:

1. Open the Patient Maintenance window for the patient. See “Searching for patients” on page 6.
2. Click the **Notes** tab.
3. In **Active Notes** area, perform one or both of the following actions:
   - In the **Display at Booking and Confirmation** field, enter a note to display when the patient is booked for an appointment, and confirmed for an appointment.
   - In the **Display at Arrival** field, enter a note to display when the patient is marked as Arrived.
4. Click **Save** ( ).

Locking your station from the Appointment Scheduler

If you have to step away from your workstation, you can quickly lock your workstation from the Appointment Scheduler.

To lock your workstation from the Scheduler:

On the Scheduler menu, click **Appointments > Lock Applications**.

The Wolf EMR login screen is displayed. All of your applications (for example, the WorkDesk and the Scheduler) are still running, they are just locked. When you enter your password, your applications are unlocked and appear as they were when you left them.

> Locking applications is different from choosing **Close All Wolf EMR Applications** from the Wolf EMR Launch page. When you **Close All Wolf EMR Applications**, all of your applications are shut down. You must sign back in and relaunch all of your applications.

Evaluation

Complete the following questions.

1. You can view all practitioner schedules at the same time in week view.
   a) True
   b) False
2. You are booking an appointment for a new patient, so you must first add the patient in the EMR. What should you do before you add the new patient to the system?
3. How do you book an appointment for a pharmaceutical rep lunch-and-learn in the Scheduler?
4. How do you remove an appointment that you made in error?
5. You unintentionally changed an appointment status from Confirmed to Arrived. How do you revert the status to Confirmed?
6. How do you change the Scheduler to see only four practitioner schedules at a time?
7. To quickly block off a single day in a practitioner's schedule, go to the day you want to block off, click any time slot in a provider's schedule, and on your keyboard press
   a) **Ctrl** + **B**
   b) **Ctrl** + **K**

c) **Ctrl** + **D**

d) **Ctrl** + **C**

8. How do you create an alert to display when a specific patient is set as Arrived for an appointment?

9. Your clinic manager wants to know how many patients are currently in the waiting room. How do you find this information?

10. You want to print a practitioner's appointment list, but you want to print only his afternoon appointments. Is this possible?

    a) Yes

    b) No

11. To lock your workstation from the Scheduler, click **Close All Wolf EMR Applications**.

    a) True

    b) False

End of Module

WorkDesk Overview

Introduction to this module

Purpose

This module introduces you to the WorkDesk. The Wolf EMR WorkDesk acts as a communication centre between practitioners and the Front End Staff. Messages, medication refills, referrals, and other tasks are passed between team members.

You use the WorkDesk to monitor, create, and update your clinical tasks, messages, follow up items, and referrals.

You also use the WorkDesk to access and manage patient medical records. You can find, view, and enter patient clinical data on any patient's record.

Objectives

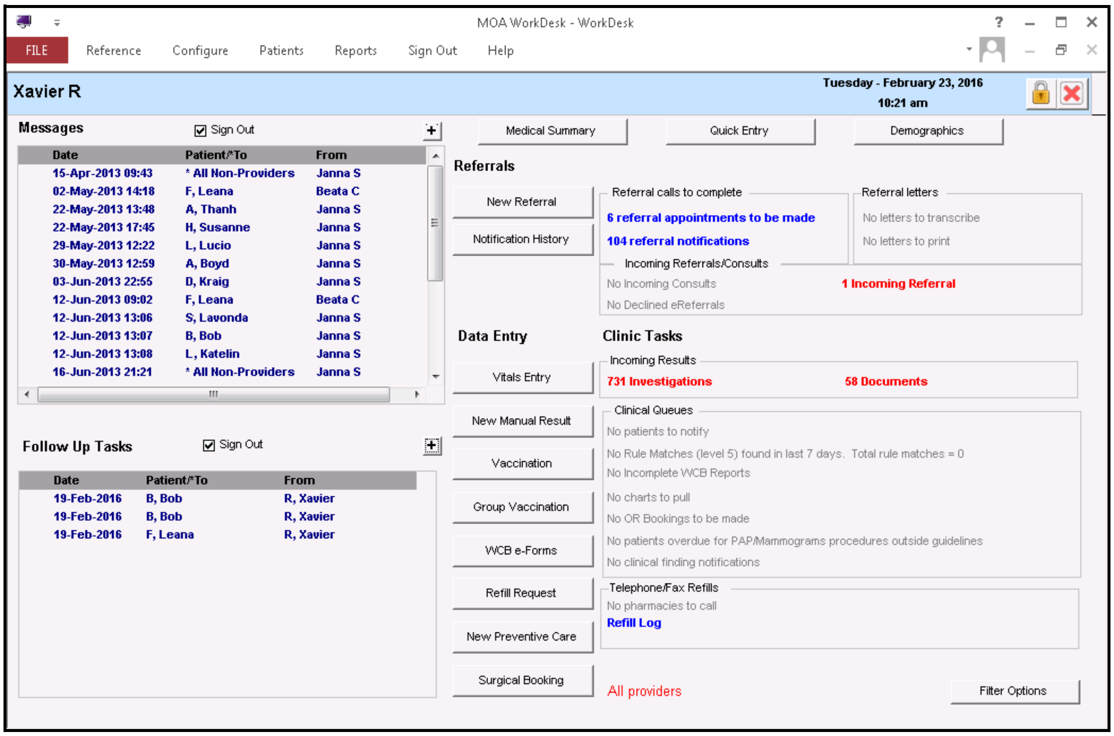
Upon completion of this module, you will be able to:

- Open the WorkDesk
- From the WorkDesk, view your messages, follow up tasks, and other clinical tasks.
- Filter the WorkDesk to display tasks related to only selected practitioners
- From the WorkDesk, open a patient's Medical Summary (medical chart), or Patient Maintenance.
- Open the quick entry window to enter a patient's medical history.
- Recognize what tasks you can perform using the options available in the Data Entry area

Opening the WorkDesk

To open the WorkDesk:

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



Tips for opening the WorkDesk

- When the WorkDesk opens, the EMR displays the WorkDesk icon  in the toolbar at the bottom of your screen.
- When the WorkDesk and the Scheduler are both open, you can click the WorkDesk icon  and the Scheduler icon  to easily move back and forth between the programs.
- When you search for a patient and choose to open the patient's Medical Summary or Vitals Entry window, the EMR opens the WorkDesk.

Viewing your tasks

You use the WorkDesk to track and manage outstanding tasks. On a single window, you can view your:

- Messages
- Follow-up tasks
- Referral tasks
- Other clinical tasks (for example, patients to notify, charts to pull, and pharmacies to call for refills)

The following table summarizes what information you can track in each area of the WorkDesk.

WorkDesk Area	Description
Messages	In the **Messages** area, you can view your active messages and create messages.
Follow Up Tasks	In the **Follow Up Tasks** area, you can view your active follow-up tasks and create follow-up tasks. **Note:** Follow-up tasks are similar to messages; 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, or other matters pertaining to the patient's health.
Referrals	In the **Referrals** area, you can view all outstanding incoming and outgoing referrals. You can also start a referral.

<table>
<tr><th>WorkDesk Area</th><th>Description</th></tr>
<tr><td>Clinic Tasks</td><td>In the Clinic Tasks area, you can view your other outstanding clinical tasks, including:
Incoming Results
■ Incoming investigation (Lab) results
■ Incoming documents
Clinical Queues
■ Patients you need to notify for a follow-up appointment
■ Patient rule matches
■ Incomplete WCB reports
■ Charts you need to pull
■ Patients who are overdue for PAP and Mammogram procedures (based on guidelines)
■ Clinical finding notifications
Telephone/Fax Refills
■ Pharmacies you need to call
■ Prescription refill log</td></tr>
</table>

Filtering the WorkDesk by practitioner(s)

You can filter the WorkDesk by practitioner(s) so that the notifications in the **Clinic Tasks** and **Referrals** areas relate only to the practitioner(s) you select. By default, you see tasks related to all practitioners.

The following notifications are not filtered:

- Patients Overdue for PAP / Mammograms outside guidelines
- Clinical Findings Notifications

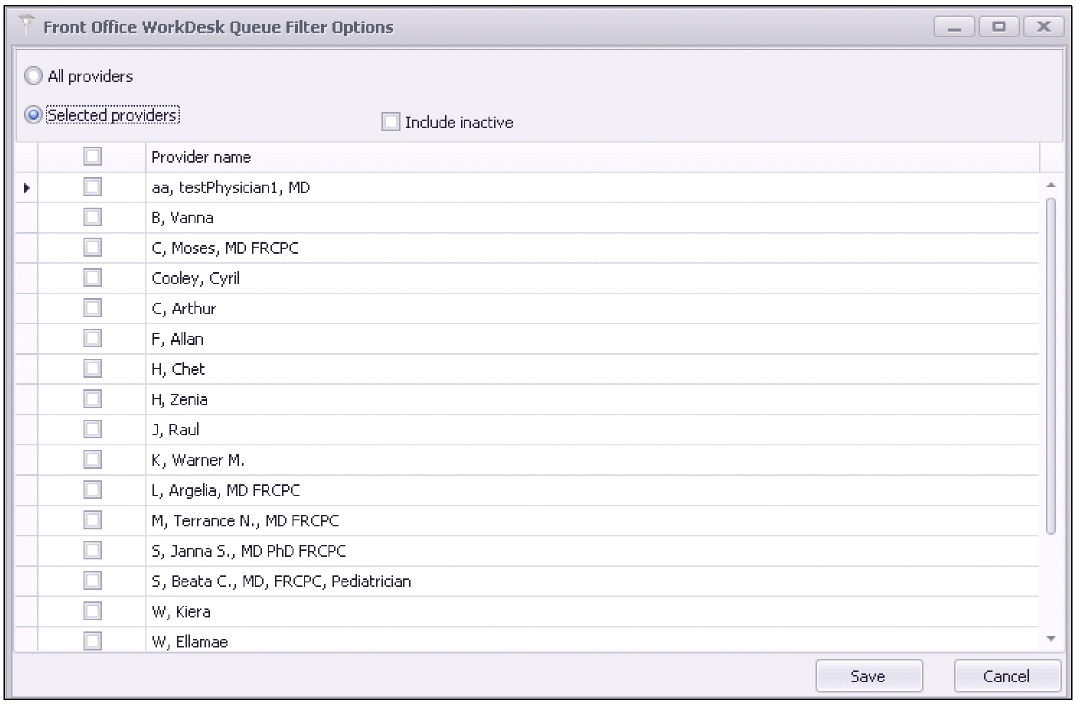
Multi-location clinics

If your clinic has multiple locations set up, you can choose to see notifications relating only to the practitioners in your current location.

By default, you see tasks related to all providers in all of your assigned locations.

To filter the WorkDesk by practitioner:

1. In the lower right corner of your WorkDesk, click **Filter Options**. The EMR displays the Front Office WorkDesk Queue Filter Options window.
2. Perform one of the following actions:
   - If you are in a single location clinic: Select the **Selected Providers** option and then select one or more practitioners.



   - If you are in a multi-location clinic: Select **Providers in my current location** or select **Selected providers** and then select one or more practitioners.
3. **(Optional)** To include inactive practitioners, select the **Include Inactive** check box. The EMR adds all inactive practitioners to the list, shaded in grey.
4. Click **Save**. Red text to the left of the **Filter Options** button shows the filter option in use. For example, if you filtered your WorkDesk to show notifications relating only to specific practitioners, you would see "Filtered by: Selected providers".

Practise: Viewing your tasks

- Open the WorkDesk
- Browse through the options available under **Clinical Tasks**
- Filter your WorkDesk to display tasks related to only one practitioner
- Remove the filter (select **All Providers**)

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 your WorkDesk.

> Your instructor will cover these topics in detail later in the course.

Viewing a patient's Medical Summary (chart)

From the WorkDesk you can open a patient's Medical Summary (medical chart). The Medical Summary contains the patient's:

- Medical history
- Personal history
- Related messages and tasks
- Investigations
- Documents
- Referrals
- Obstetrical history (if applicable)

In the **Current Hx**, **Past Hx**, and **Personal Hx** tabs of the patient's Medical Summary you can add patient data.

To open a patient's Medical Summary from your WorkDesk:

1. At the top 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.

Viewing patient demographic information

To access the Patient Maintenance window from your WorkDesk:

1. At the top of your WorkDesk, click **Demographics**. 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 Patient Maintenance window.

WorkDesk Data Entry options

The following table describes the various **Data Entry** area options.

Data Entry button	Use this button to:
Vitals Entry	Enter patient vitals and other measurements, for example pre-visit measurements, vital signs, and basic chart notes. **Tip**: You can also enter vitals from the Scheduler.
New Manual Result	Enter, view or modify a patient's manual lab results.
Vaccination	■ Record vaccinations administered to the patient. ■ Record that a patient declined a recommended vaccination.
Group Vaccination	Record the administration of a vaccination to a group of patients. The EMR automatically creates multiple vaccination records for each individual patient. You can use this feature to enter vaccination information after a vaccination clinic session has occurred.
WBC e-Forms	Open the WCB Report Manager where you can: ■ View incomplete WCB reports ■ View previously completed WCB reports ■ Start a new WCB report
Refill Request	Create a medication refill request.
New Preventive Care	Record a preventive care procedure result for a PAP smear or a mammogram.

Evaluation

Complete the following questions.

1. How can you navigate back and forth between the WorkDesk and the Scheduler?

___

2. A practitioner tells you that they are expecting lab results to come in for a patient. Which area on your WorkDesk can you check to see if the lab results have come in?

___

3. Your facility hosted a flu shot clinic and you want to record the vaccination for all patients who attended. Which area on your WorkDesk would you use to record a vaccination for a group of patients?

___

End of Module

Viewing and entering patient medical history (Medical Summary)

Introduction to this module

Purpose

In this module you are introduced to the Medical Summary, the SMART patient banner, and the SMART menu. The Medical Summary is essentially a patient's medical chart. The SMART patient banner is located at the top of the Medical Summary and contains a summary of important patient information in one convenient area.

You learn how to view and modify patient information using the SMART patient banner, and how to view patient medical information in the various tabs of the Medical Summary window. You also learn how to add medical history information using Quick Entry.

Objectives

Upon completion of this module, you will be able to:

- Open a patient's Medical Summary
- Identify what information is available in, and what actions you can perform from, the SMART patient banner.
- Identify what information you can view in each tab of the Medical Summary
- Access the SMART menu
- Enter a patient's medical history information using Quick Entry

Opening a patient's Medical Summary

To open a patient's Medical Summary, perform one of the following actions:

- If the patient has an appointment booked today, on the Appointment Scheduler, click the appointment, and then press **F7**.
- If the patient does not have an appointment booked, in the Appointment Scheduler, search for the patient and then, from the search window, open the patient's Medical Summary. See "Searching for patients" on page 6.
- If you are working in the WorkDesk, on the tasks area of the WorkDesk, click **Medical Summary**. See "Viewing a patient's Medical Summary (chart)" on page 48.

> **Tip for opening a patient's Medical Summary**
>
> If you are in a patient's medical summary window and want to view another patient's medical summary, on the top right corner of the window, click  **(Search)**.

Medical Summary window overview

The Medical Summary is essentially the patient's medical chart. From the Medical Summary, you can access all of a patient's medical information, including medical history, visit notes, lab results, and medical reports.

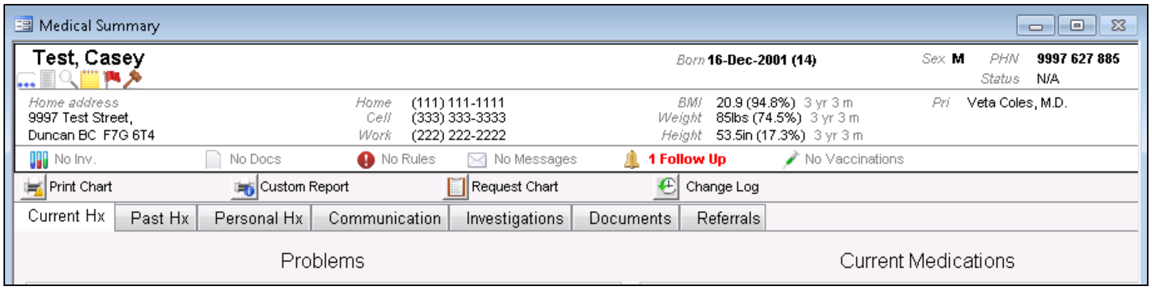
Medical Summary information is grouped into tabs for easy navigation. In tabs containing a large amount of information, you can use filter options to quickly find the information you want.

SMART patient banner overview

The SMART patient banner is located at the top of the Medical Summary. Here, you can view the following information about a patient:

- Basic demographic and contact information
- Date of next appointment
- If the patient has an appointment today, the status of the appointment (for example, Arrived 5 mins, or Exam room 7 min)
- Primary practitioner, referring practitioner, family practitioner, and assigned care team (if applicable)
- Smoking status

- Patient status (for example, if the patient is a long term care patient)
- If the patient is pregnant, and the gestational age
- Most recent vitals



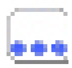
The vitals that display in the SMART patient banner depend on the age of the patient:

- If the patient is 0 to 2 years old, the EMR displays the patient's **HC** (head circumference), **Weight**, and **Height**, and includes percentiles.
- If the patient is 2 to 19 years old, the EMR displays the patient's **BMI**, **Weight**, and **Height**, and includes percentiles.
- If the patient is 20+ years old, the EMR displays the patient's **BMI**, **Weight**, and **BP**.

Tip: You can customize what information displays in the SMART patient banner. On the WorkDesk menu, click **Configure** > **Configure WorkDesk** > **Miscellaneous** tab.

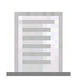
From the SMART patient banner, you can also perform a number of actions by clicking the various icons located below the patient's name or along the bottom of the SMART patient banner (in the notification bar).

The following table describes icons located below the patient's name.

<table>
<tr><th>Icon</th><th>Description</th></tr>
<tr><td></td><td>View patient demographics information

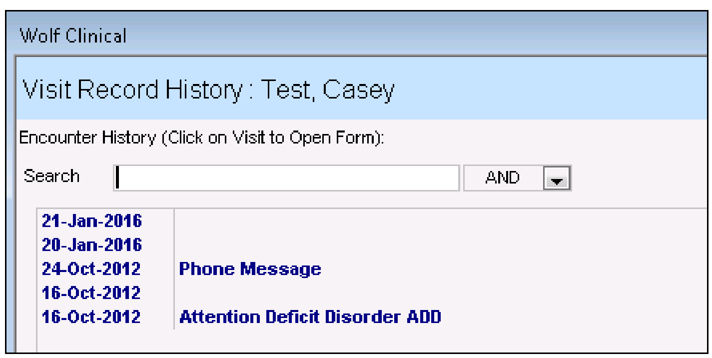
Opens the Patient Maintenance window.</td></tr>
<tr><td></td><td>View Paper Chart

Opens a scanned version of the patient's previous paper chart information or previous medical summary (if available).

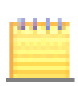
Note: This icon displays only if the patient has a scanned paper chart attached. A document is flagged as a paper chart if the keyword Medical Summary is assigned to the document.</td></tr>
<tr><td></td><td>View Patient Visits

Opens all of the patient's current and previous visit notes in one window.</td></tr>
<tr><td></td><td>Search Patient Visits

Opens the Visit Record History window, which contains a list of previous encounters.

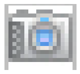
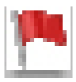
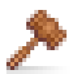
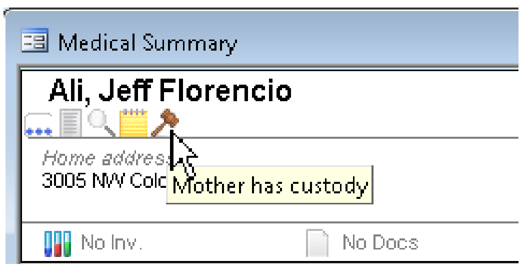


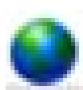
To view detailed visit notes for an encounter, click the encounter. You can also use the Search function to find a specific encounter.

Note: When you enter text in the Search field, the EMR searches text in the visit notes to produce matches.</td></tr>
<tr><td></td><td>Patient Notes

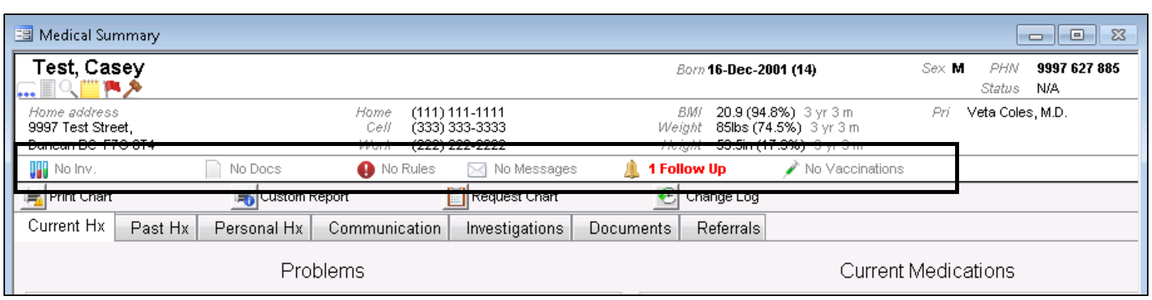
Opens the Notes tab in the Patient Maintenance window.

Note: This icon displays only if in the Patient Maintenance window, on the Notes tab, text is entered in the General Notes area.</td></tr>
</table>

<table>
<tr><th>Icon</th><th>Description</th></tr>
<tr><td></td><td>Patient Photo
Opens patient photo (if available).
Note: This icon displays only if the patient has a photo attached. An image is flagged as a patient photo if the keyword IDPhoto is associated with the image.</td></tr>
<tr><td></td><td>View patient alerts
Opens special alerts for the patient (if available).
Note: This icon displays only if the patient has one or more special alerts.</td></tr>
<tr><td></td><td>Custody information
Hover your cursor over the icon to view the patient’s custody information.


This icon is available only if in the Patient Maintenance window, in the Name/ Addr/Phone tab, in the Custody Agreement area, information is entered in the Note field.</td></tr>
<tr><td></td><td>Patient Portal alert
Indicates that the patient is a Patient Portal user.
Opens Patient Maintenance to the Portal Settings area (if set up).</td></tr>
</table>

The notification bar (located at the bottom of the SMART patient banner) indicates how many investigations, rules, documents, and messages the patient has. 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.



Click any icon in the notification bar to open the related area in the EMR. For example, click the **Investigations** icon to open the Investigation In Basket window for the patient.

The EMR displays the SMART patient banner at the top of most windows relating to a patient, including the patient's:

- Medical Summary
- Vital Entry form
- Messages and tasks
- SOAP Note Examination form, Prenatal forms, and WCB forms
- Medication windows
- Anticoagulation Summary Sheet

Medical Summary tabs

The following table provides an overview of the information available on each of the tabs in the Medical Summary window.

Tab	Information available
Current Hx: Current History	■ Problems ■ Current medications ■ Encounter records ■ Allergies ■ Vaccinations ■ Blood type

Tab	Information available
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) ■ Family history ■ Other risks
Communication	Uncompleted and completed: ■ Messages ■ Follow ups
Investigations	■ Lab results ■ Manual results ■ Preventive care procedures (for female patients)
Documents	■ Requisition forms and other SMART Forms produced by the clinic ■ Medical reports and other documents attached to the patient record
Referrals	■ Outgoing referrals made for the patient
Obstetrics	■ Pregnancy history information (for female patients if applicable)

Tips for viewing a patient's Medical Summary

- To view detailed information about an item listed in the patient's Medical Summary, double-click the item. For example, to view detailed information about one of a patient's allergies, on the **Current Hx** tab, in the **Allergies** area, double-click the allergy.
- On tabs that contain lists with titled columns, you can re-sort the list by any column. For example, to view a patient's lab results sorted by test, on the **Investigations** tab, in the **Test** column, click the column header.
- On the **Investigations** tab and the **Documents** tab you can quickly find item(s) using the filter options at the top of the tab.

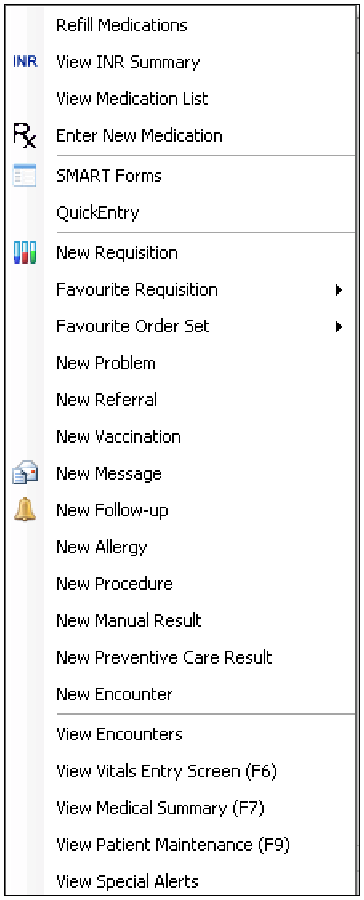
Scenarios: Medical Summary window overview

For the following situations, indicate where in the Medical Summary you can find the needed information.

- You want to view a patient's smoking status.
- A patient asks about the status of their referral to an orthopedic surgeon.
- A patient lost their MRI requisition form and needs to have it reprinted.
- A patient wants to ensure that they are up-to-date on their vaccinations and asks what date they received their last flu vaccination at your clinic.
- You notice that in the patient's SMART patient banner, the patient's Primary Provider is not indicated. You need to assign the patient to the appropriate Primary Provider.

Using the SMART menu

From the Medical Summary, and from most windows related to a patient, you use the SMART menu to access numerous view, data entry, and other action options.



To open the SMART menu:

1. On any window related to a patient's medical record (for example, the Medical Summary or Vital Entry window), right-click, and then click **Show All Menu Items**. The EMR displays the SMART menu.

> The next time you right-click the patient record, the SMART menu will open automatically. You will not have to click **Show All menu Items**.

Tips for using the SMART menu

- SMART menu options are grouped by what they do. Medication and prescription-related options are displayed at the top of the menu, action options are displayed in the middle, while view options are displayed at the bottom.
- You can customize what options display in the SMART menu. If there are SMART menu options you do not use regularly, you can hide these options: On the WorkDesk menu click **Configuration** > **Configure WorkDesk** ( ), and then on the **General** tab, click **Manage Right-Click** menu.

Entering medical history using Quick Entry

If you want to efficiently add basic medical history information to a patient's Medical Summary, use Quick Entry. You can use Quick Entry to enter:

- Social history (including smoking and alcohol use)
- Problems
- Medications
- Allergies
- Procedures and surgeries

You open the Quick Entry Form via the SMART menu.

To enter a patient's medical history using Quick Entry:

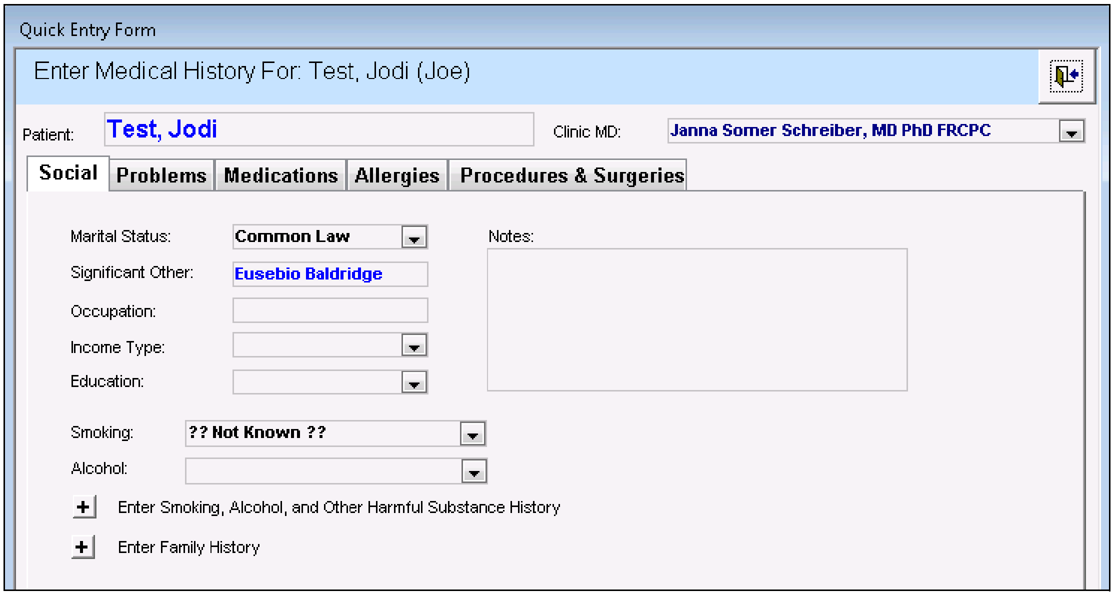
1. On any window related to the patient's medical record (for example, the Medical Summary or Vital Entry window), right-click and then, in the SMART menu, click **Quick Entry**.

If the complete SMART menu does not display, click **Show All Menu Items**.

Tip: If you do not have the patient's medical record open, you can open the Quick Entry window from your Workdesk.

1. At the top of your 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.



Tip for entering medical history using Quick Entry

- If you want to view the patient's Medical Summary as you are entering information in the Quick Entry window, click the patient's name (which is displayed in blue).

Practise: Using the SMART menu and entering medical history using Quick Entry

- Open the Medical Summary for a test patient
- Open the SMART menu and browse through the list of options available. Take note of options that will be important for your daily workflow.
- Using Quick Entry, add "penicillin" to the patient's allergy list
- Using Quick Entry, add "Diabetes type II" to the patient's problem list.

Evaluation

Complete the following questions.

1. How do you open the Medical Summary for a patient who does not have an appointment booked?

2. You are in a patient's Medical Summary and want to see if there are any notes for the patient. Where can you find this information?

3. You are in a patient's Medical Summary and want to search for another patient's medical summary. What is the quickest way to do this?

4. On which tab in the Medical Summary can you add a surgery for a patient?
   a) Current Hx
   b) Past Hx
   c) Personal Hx
   d) Investigations

End of Module

Entering vitals, measurements, and visit notes

Introduction to this module

Purpose

In this module, you learn how to enter a patient's vitals and other measurements. You also learn how to enter basic visit notes. You enter a patient's vitals and visit notes via the Vital Entry window. Any information you enter is automatically transferred to the practitioner's SOAP note (or consult letter). The practitioner can then add to or modify your notes as needed.

Objectives

Upon completion of this module, you will be able to:

- Enter a patient's vitals and measurements
- Enter information in specialized exam templates
- Enter general visit notes in a SOAP form

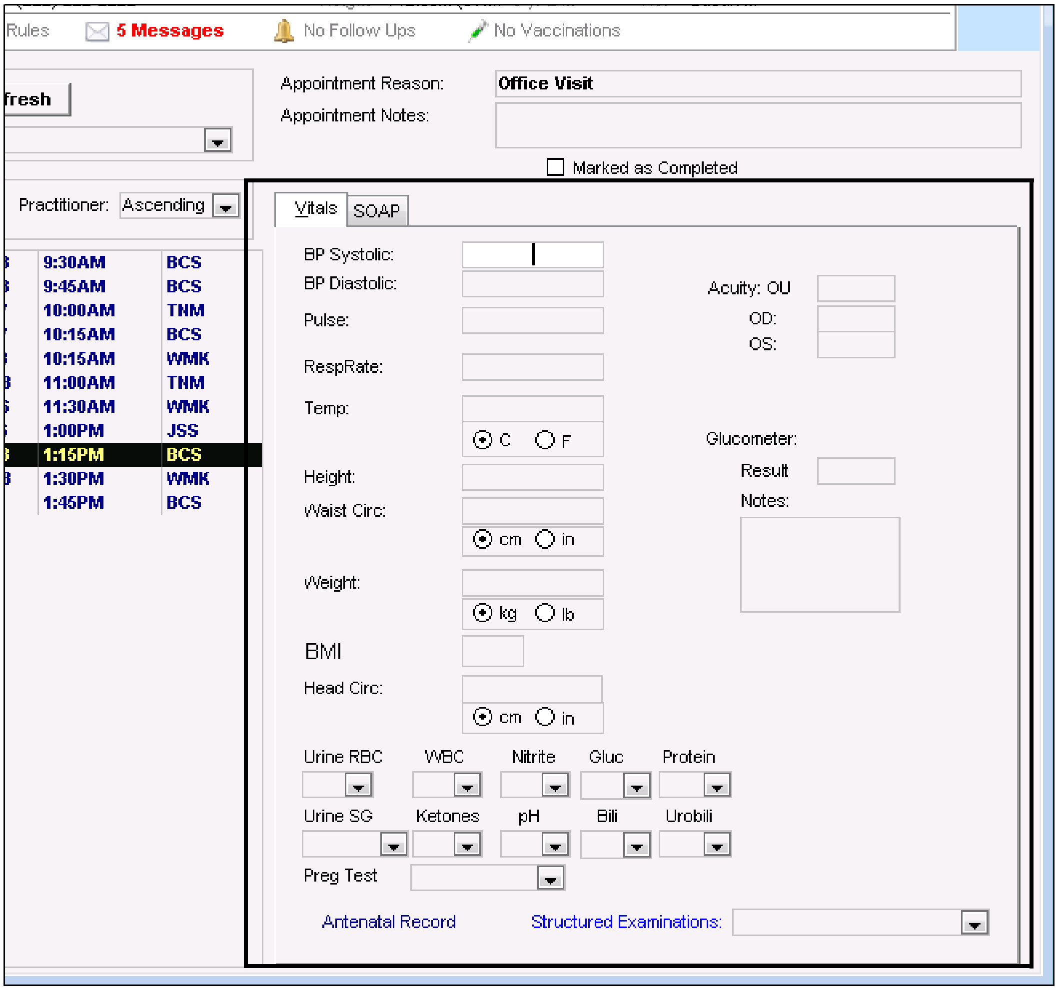
Entering vitals and other measurements

> You can enter a patient's vitals and other visit notes in the Vital Entry window only if the patient has an appointment booked.

To enter a patient's vitals and other measurements:

1. On the Appointment Scheduler, click the patient's appointment and then, on your keyboard, press **F6**.

The EMR displays the Vital Entry (Exam Data) window with the **Vitals** tab open in the right pane.



2. In the **Vitals** tab, enter the patient's vitals and measurements.

Tips for entering and viewing vitals and measurements

- The patient's appointment reason and appointment notes display above the **Vitals** tab.
- To view the patient's Medical Summary (chart), at the top of the window, click anywhere in the SMART patient banner or, on your keyboard, press **F7**.
- You can view specific patient information, and perform actions on the patient using the SMART menu. To open the SMART menu, on the **Vitals** tab, right-click.

Discussion: Opening the Vital Entry window.

What are the advantages of using the **F6** keyboard shortcut to open the Vital Entry window?

Are there workflow situations when it would be more efficient to use the **Vitals** button to open the Vital Entry window?

Practise: Entering patient vitals

Enter the following vital signs for a patient:

- **BP Systolic**: 120
- **BP Diastolic**: 80
- **Temperature**: 38 Celsius
- **Height**: 168 centimeters
- **Weight**: 65 kilograms
- After you enter the patient's weight, press **Tab** or **Enter**. The EMR calculates the BMI value and populates the **BMI** field.

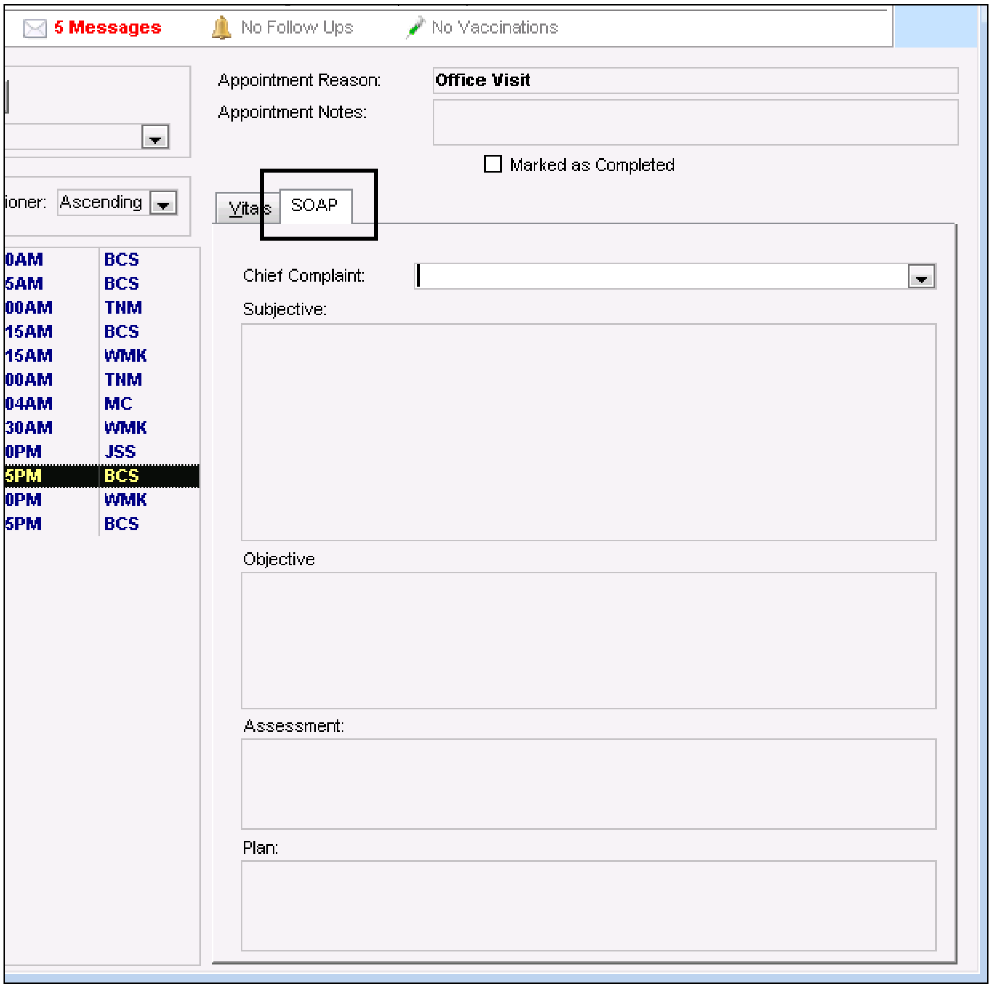
Entering basic visit notes

You use the **SOAP** tab in the Vital Entry window to enter **S**ubjective, **O**bjective, **A**ssessment and **P**lan (SOAP) visit notes.

The information you enter on the SOAP tab appears when the practitioner opens a SOAP note or Consult Letter Examination (specialists) for the same visit. The practitioner can then edit or add to your information as needed.

To enter information in a SOAP note:

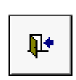
1. Open the Vital Entry window: On the Appointment Scheduler, click the patient's appointment and then, on your keyboard, press **F6**.
2. Click the **SOAP** tab.



3. **(Optional)** In the **Chief Complaint** field, enter the patient's primary reason for seeing the practitioner or, in the drop-down list, click a complaint.
4. Enter information in the **Subjective**, **Objective**, **Assessment** and **Plan** fields.

Best Practice:

At the end of each of your notes, enter your initials. This way, the practitioner can differentiate what notes were entered by you.

5. To save your changes and close the window, click  or, on your keyboard, press **Alt** + **C**.

Practise: Entering information in a SOAP note

Enter the following SOAP notes for a patient:

- **Chief Complaint**: back pain
- **Subjective**: "Patient was seen today complaining of pain in their lower back. Muscle relaxers have not helped."
- **Objective**: new injury

Using structured examination templates

You can enter objective visit notes using visit-specific templates called structured examinations. Structured examinations contain fields specific to a particular problem or type of examination. For example, the **Allergy Shots** structured examination contains fields for Allergen, Strength, Dose, Injection Site, and Reaction.

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:

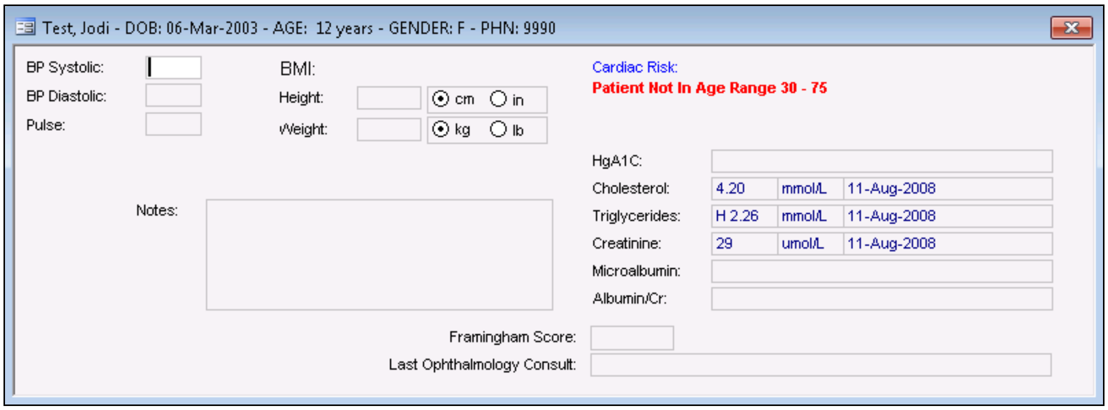
- Track patient trends, disease progress, and compliance for entire groups of patients diagnosed with a specific chronic disease (using Practice Search reports).
- Track a patient's treatment plan, disease progression, and compliance (using disease-specific flowsheets).
- Receive automated reminders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

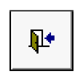
As with SOAP notes, when you enter information in a structured examination, the practitioner sees this information when they open the same structured examination for the visit. The practitioner can edit or add to the information you entered.

CAUTION: Two users should never enter information into the same structured examination for the same patient at the same time.

To enter information using a structured examination:

1. Open the Vital Entry window: On the Appointment Scheduler, click the patient's appointment and then, on your keyboard, press **F6**.
2. At the bottom of the **Vitals** tab, in the **Structured Examinations** drop-down list, select an exam. The EMR opens the structured examination in a new window.



3. Enter data into the various text fields, drop-down lists, and check boxes.
4. When you are finished entering data, click **Close** ().The EMR returns you to the Vital Entry window.
5. To save your changes and close the window, click  or, on your keyboard, press **Alt** + **C**.

Tips for entering and viewing data in structured examinations

- 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, click back to the Vital Entry window and then, on your keyboard, press **F7**.
- If, after you close the structured examination, you want to modify or enter additional information, simply open the structured examination again, and then add or modify information as needed.
- You can enter information into more than one structured examination during a visit.

Practise: Using a structured examination

- In the **Structured Examinations** drop-down list, select an examination type (for example, **Back**).
- Enter the structured examination data.

Evaluation

Complete the following questions.

1. A patient arrives for their physcial and you take their height, weight, and blood pressure. How do you record this information in the patient's chart?

2. When you enter a patient’s vitals, how do you calculate BMI?

3. You are entering visit notes for a patient and they tell you that they have a migraine. Where would you enter this information in the Vital Entry window?

4. You are entering visit notes for a patient with diabetes. If your clinic actively manages and reports on chronic disease management, where do you enter your notes?

End of Module

Pediatric patient visits

Introduction to this module

Purpose

In this module, you learn how to use the various Wolf EMR features related to pediatric patient visits.

Objectives

Upon completion of this module, you will be able to:

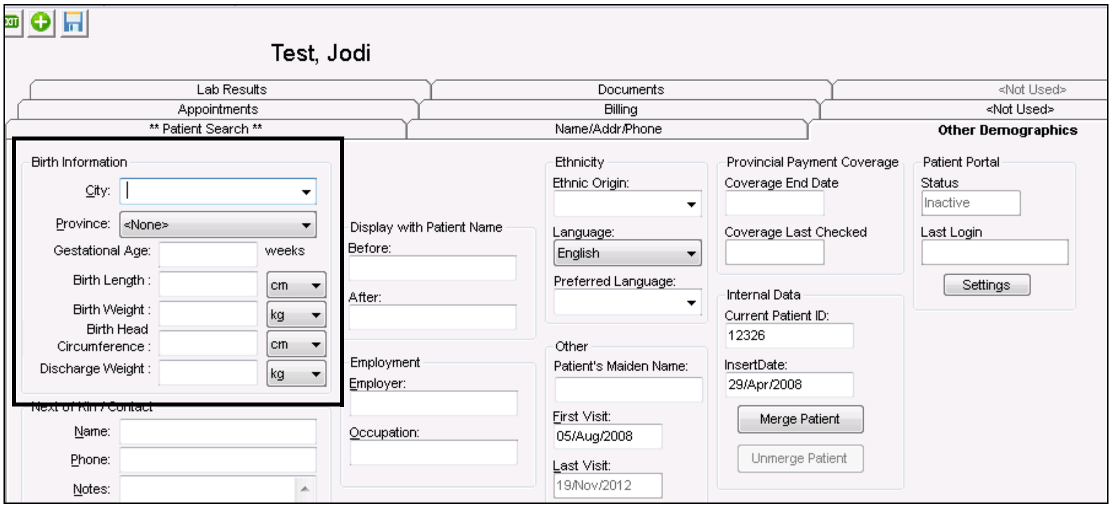
- Enter a patient's birth information
- View pediatric growth charts for a patient
- Enter information into Rourke Baby Records

Entering patient birth information

You enter a patient's birth information in the Patient Maintenance window. Birth information includes the patient's place of birth, gestational age, and birth measurements. The EMR uses the gestational age when displaying adjusted growth charts for the patient.

To enter a patient's birth information:

1. Open the Patient Maintenance window for the patient, and then click the **Other Demographics** tab.
2. In the **Birth Information** area, enter the patient's place of birth, gestational age, and birth measurements.



Best practice

If the patient is a baby or toddler, while you are in the Patient Maintenance window, verify that the patient's Provincial Health Number is up-to-date:

1. On the Patient Maintenance window, click the **Name/Addr/Phone** tab.
2. If the patient has received their own PHN number, clear the **Infant / Dependant** check box (this check box should be selected only if an infant is using their mothers PHN).
3. Beside **PHN**, ensure the patient's health number is entered and correct.
4. At the top of the window, click **Verify with MSP** ( ).

3. Click **Save** ( ), and then click **Close** ( ).

Practise: Entering a patient's birth information

Open the Patient Maintenance window, and then click the **Other Demographics** tab. Enter birth information for the patient.

Viewing pediatric growth charts

Growth charts are 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:

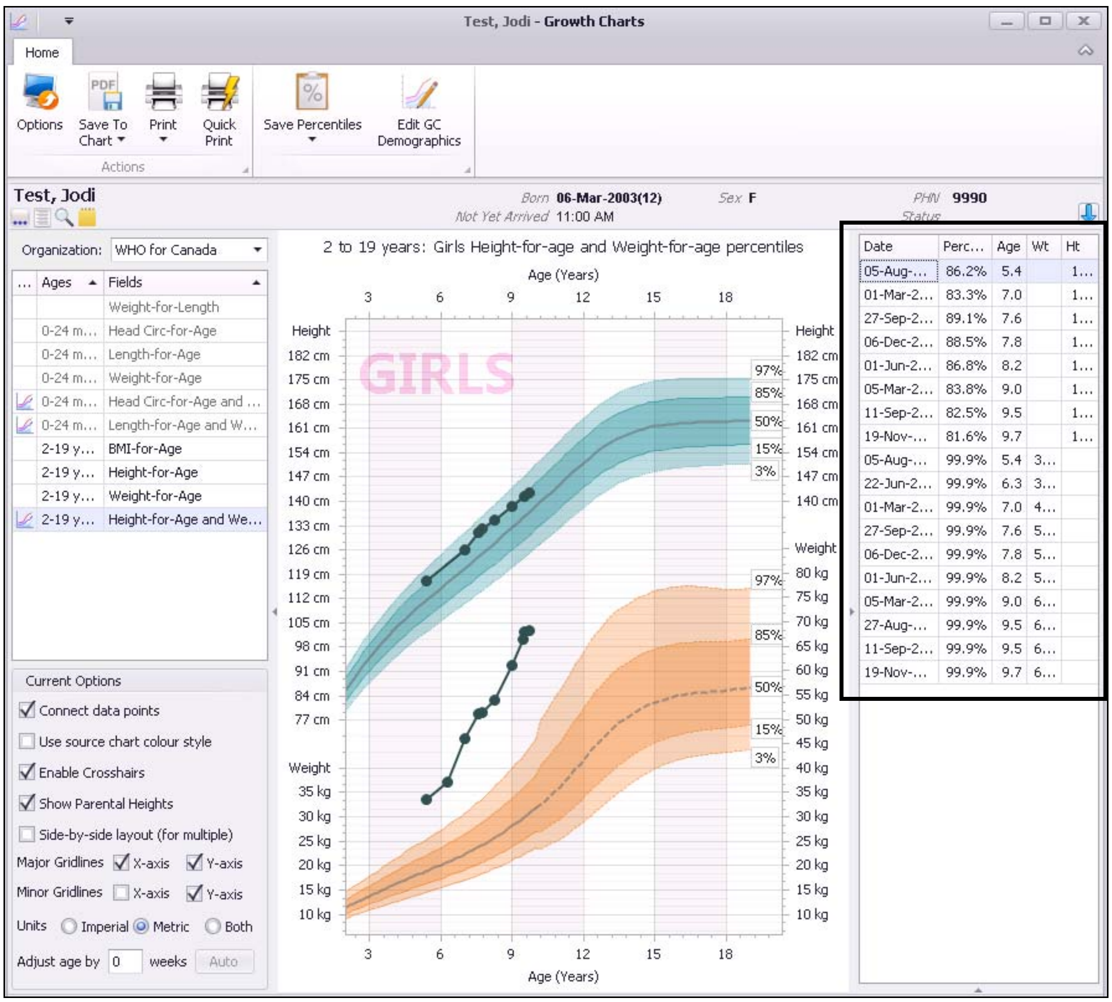
- World Health Organization (WHO) growth charts adapted for Canada
- Centers for Disease Control and Prevention (CDC)
- Canadian Pediatric Endocrine Group (CPEG)

To view a patient's growth charts:

1. On any window related to the patient's record (for example, the Vital Entry window or the Medical Summary window), 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.
   - The data points and percentiles in a table format to the right of the chart.



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 chart.
3. To adjust the chart/percentiles for an early pregnancy, in the **Current Options** area, enter the number of weeks early in the **Adjust age by** field.
4. To modify the way the graph looks, in the **Current Options** area, modify the view options.
5. To view the value and percentile for a data point on the graph, hover your cursor over the data point.
6. To add percentiles to the patient's chart as exam findings, click **Save Percentiles** ( ).

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.

7. 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 (with table)** or **Print**.

Tips for viewing growth charts

- If the patient's gestational age is entered in the **Other Demographics** tab of the Patient Maintenance window, when you click the **Auto** button the EMR automatically populates the **Adjust age by** field.

Note: The **Auto** button is available only if the gestational age you entered is less than 38 weeks.

- To zoom in, hold the **Shift** key and then click the area you want to zoom in to.
- To zoom out, hold the **Alt** key and then click the area you want to zoom out from.
- To hide the percentile table, click the icon to the right of the chart.
- To collapse the patient banner and maximize the growth chart, click the blue up arrow in the top right part of window.
- To attach a growth chart to a referral, you must first save the growth chart as a document in the patient's Medical Summary. You can then attach the growth chart as you do other documents. To save the growth chart as a document, click **Save To Chart** ( ).

Practise: Viewing a patient's growth chart

- View a patient's growth chart from each organization: WHO, CDC, and CPEG
- Adjust the different settings in the **Current Options** area and see how they change how the graph looks.
- Zoom in and zoom out of different areas in the chart.
- Show and hide the data points and percentiles table.
- Sort a column in the data points and percentiles table.
- Collapse the patient banner and maximize the growth chart.

Entering information into Rourke Baby Records

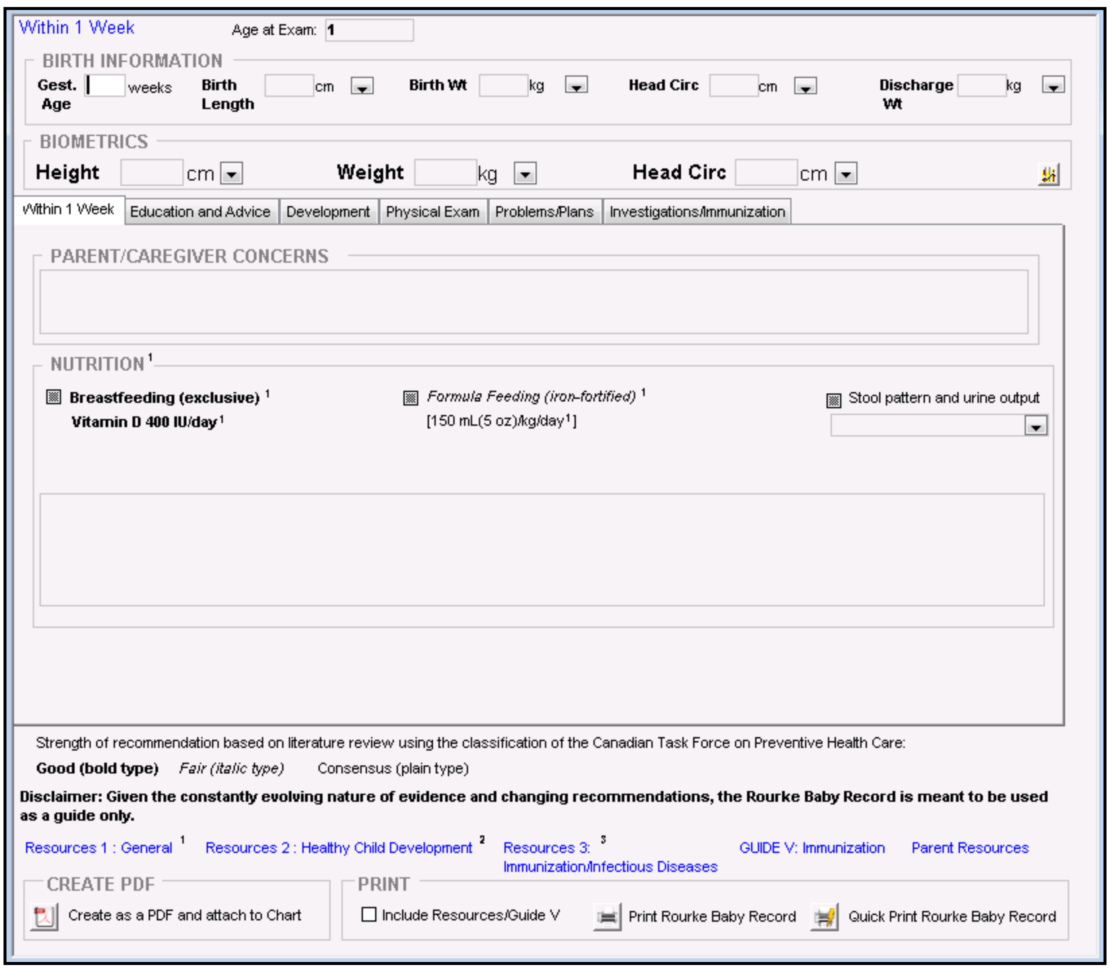
If you enter pediatric patient visit notes into Rourke Baby Records (RBR), you can access the RBR forms in the Structured Examinations list.

Each examination template is broken into sections (tabs) that correspond to the standard RBR format.

> As with other structured examinations, when you enter information in an RBR structured examination, the practitioner sees this information when they open the same structured examination for the visit. The practitioner can edit or add to the information you entered.

To enter information in a Rourke Baby Record form:

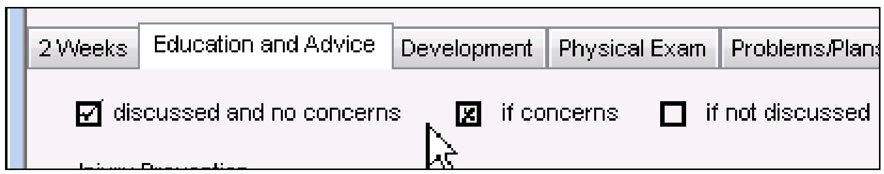
1. Open the Vital Entry window: On the Appointment Scheduler, click the patient's appointment and then, on your keyboard, press **F6**.
2. At the bottom of the **Vitals** tab, in the **Structured Examinations** drop-down list, select an RBR exam. The EMR opens the RBR structured examination in a new window.



3. Enter the data in each of the exam tabs as needed, and then click **Close** ( ). The EMR returns you to the Vital Entry window.

Tips for entering information into RBR exams

- 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.
- Each of the check boxes on the **Education and Advice** and the **Development** tabs supports three different states (**check mark** [discussed and no concerns], **X** [if concerns], or **clear** [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. You can change the state of these check boxes if needed.

Practise: Completing an exam based on the Rourke Baby Records

- In the **Structured Examinations** drop-down list, select and view some of the different Rourke structured examinations.
- Browse through the information on the various tabs.
- Enter the structured examination data for an exam.

Evaluation

Complete the following questions.

1. What organizations can you view growth charts for?

2. You are viewing growth charts for a patient who was born at 36 weeks. How do you view the patient's growth chart adjusted for their premature birth?

3. If you enter a patients birth information in a Rourke Baby Record exams this information automatically populates the **Other Demographics** tab in the Patient Maintenance window.

   a) True

   b) False

End of Module

Obstetric patient visits

Introduction to this module

Purpose

In this module, you learn how to use the various Wolf EMR features related to prenatal visits. For prenatal visits, you enter most of a patient's notes in the prenatal record. Each time the patient returns for a prenatal visit, you add information to the same prenatal record until the pregnancy is finished. From the prenatal record you can also:

- Calculate the patient's estimated date of delivery (EDD) and gestational age based on the last menstrual period (LMP) or ultrasound
- Access the patient's ultrasound images
- Open and print informational prenatal handouts for the patient

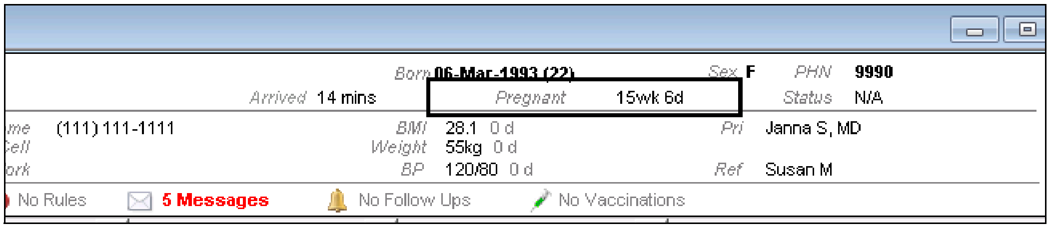
Objectives

Upon completion of this module, you will be able to:

- View a patient's pregnancy status
- Open and enter information in a patient's prenatal record
- Calculate a patient's EDD and gestational age based on LMP
- Calculate a patient's EDD and gestational age based on ultrasound results
- Print or fax a patient's prenatal record
- Record delivery details and lock the prenatal record at the end of the pregnancy

Viewing a patient's pregnancy status

If a patient is pregnant, the SMART patient banner displays "Pregnant" and indicates how far along the patient is in her pregnancy.



The SMART patient banner displays pregnancy information only if a prenatal record has been started for the patient.

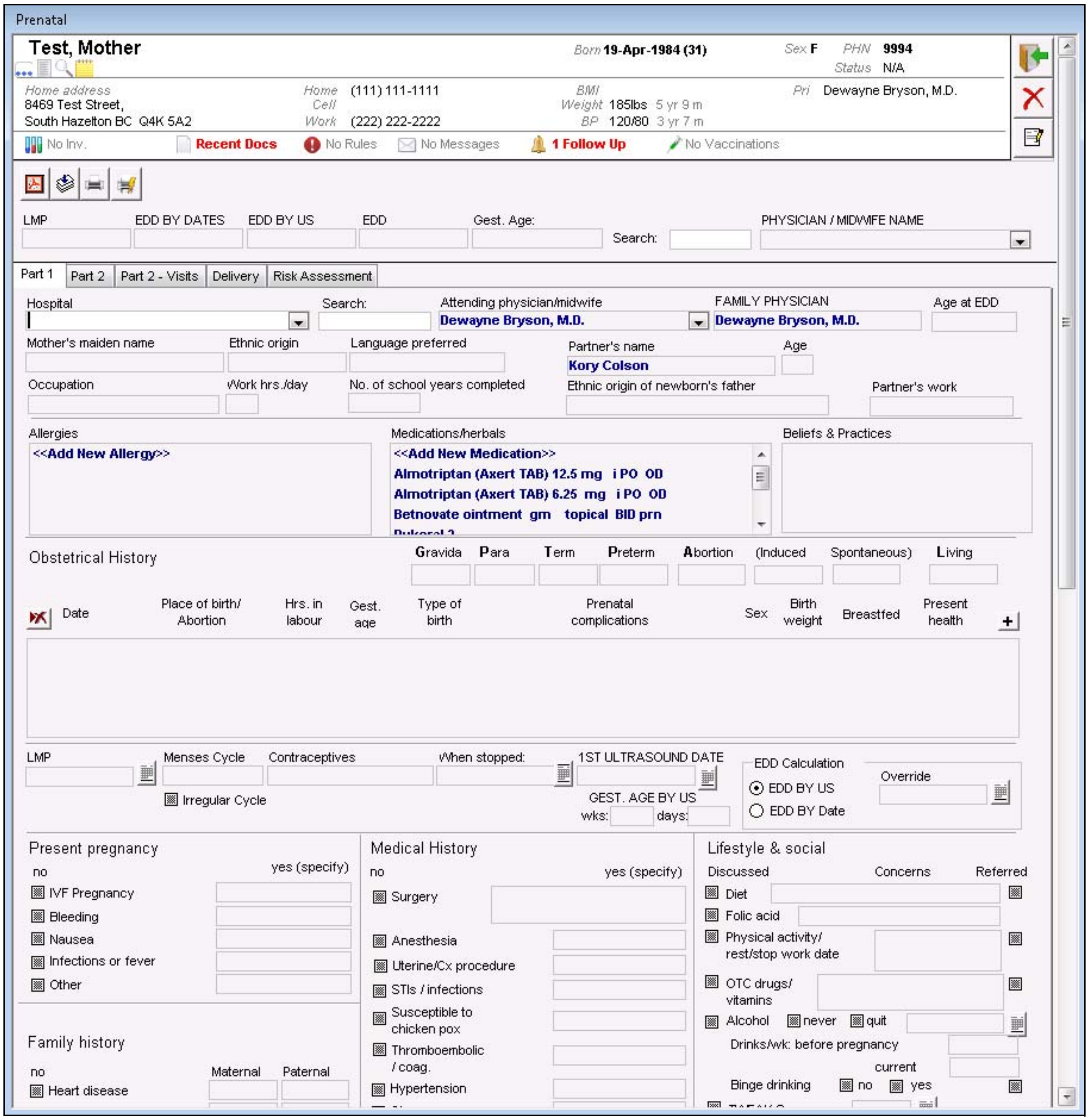
Entering information in the prenatal record

You can enter prenatal medical information and visit notes in the Wolf EMR prenatal record. The prenatal record template is based on the provincial prenatal record. Each time the patient returns for a prenatal visit, you add information to the same prenatal record until the pregnancy is finished. You can then print or fax the entire prenatal record to a hospital, midwife, or consultant. The printed prenatal record looks like the provincial prenatal record.

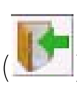
To enter information in the prenatal record:

1. Open the Vital Entry window: On the Appointment Scheduler, click the patient's appointment and then, on your keyboard, press **F6**.
2. At the bottom of the **Vitals** tab, click **Antenatal Record**. The EMR opens the Prenatal window. Each tab on the Prenatal window represents a page of the provincial prenatal record:
   - **Part 1**: Contains fields specific to a first visit, including medical history and obstetrical history.
   - **Part 2**: Contains fields specific to the second and subsequent visits, including lab test results, other investigation results, and discussion topics.
   - **Part 2 - Visits**: Lists all visit records for this pregnancy and allows you to enter a new visit record or to edit and delete existing ones.

The prenatal form includes all information entered for previous visits for this pregnancy.



3. Enter information into the prenatal record as needed.

4. When you finish, click **Save & Close** ().

Tips for entering information

- To record a previous pregnancy, in the **Obstetrical History** area, click +.
- To edit information on a pregnancy listed in the **Obstetrical History** area, double-click the entry.
- A grey check box indicates that the patient has not yet been asked about or screened for an item.
  To indicate a Yes answer for an item, select the check box.
  To indicate that the patient has been asked about the item, but that the answer is “no”, click the check box twice. The check box is no longer gray.
- When you add an allergy, a medication, or an obstetrical history item through the prenatal record, the EMR updates the patient's Medical Summary with the new information, and vice versa.
- If you enter a patient's vitals in the Vital Entry window, those vital entries are automatically populated in the Prenatal Visit Record window.
- 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 bottom right of the window, click the blue **Patient Handouts** link.
- If a lab name is displayed (on the **Part 2** tab) in blue text (as a link), a result for the test is available in the patient’s chart. To view the result, click the blue link.
- To view the Fundus Height Growth Chart, on the bottom right corner of the **Part 2 - Visits** tab, click **SYMPHYSIS - FUNDUS HEIGHT GROWTH CHART**.

Calculating an estimated due date (EDD) by LMP

If you enter the patient’s menstrual information correctly in the prenatal record, the EMR calculates the patient’s estimated due date.

To calculate a patient’s EDD by LMP:

1. Open the patient’s prenatal record.
2. Under the **Obstetrical 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)** In the **Menses Cycle** area, indicate if the patient’s menstrual periods are regular or irregular.

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.

Recording ultrasound results: Calculating gestational age and EDD

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 a patient's ultrasound results and recalculate the EDD:

1. Open the patient's Prenatal Record.
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.

> 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**.

> 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).

> **Linking an ultrasound image to a prenatal record**
>
> When an ultrasound image and/or report comes in, you can attach the file to the prenatal record. To attach the ultrasound image to the prenatal record:
>
> - Link the ultrasound image to the patient as you do other documents, but assign **Prenatal US** as a Keyword or Document Type. See "Managing received documents" on page 125.

Practise: Entering information in the prenatal record

- Open the prenatal record for a patient.
- Enter information in the following areas: **LMP**, **Menses Cycle** area (enter the average duration of the patient's cycle).
- In the **EDD Calculation** area, select **EDD BY Date**. The EMR calculates the EDD date.
- Enter the **First Ultrasound date**.
- Enter the **Gestational age by US**.
- In the **EDD Calculation** area select **EDD BY US**.
- **Family History**: Add a Family History problem.
- **Medical History**: Add an allergy. Go to the patient's Medical Summary and view the allergy you just added.
- **First Trimester Topics Discussed**: Select some topics.
- Browse through the main areas on the **Part 2** tab.
- In the **Investigations/Results** area, record various test results.
- Indicate a Lifestyle concern for the patient.
- Open the **Part 2 - Visits** tab of the Prenatal Record, and then enter a visit note.

Printing or 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.
2. At the top of the window, click one of the following options:

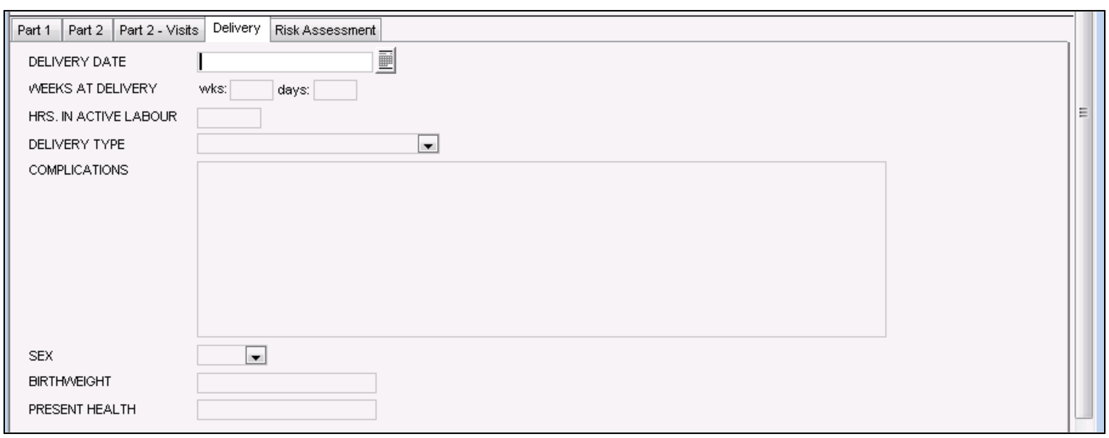
- **Collate and Print Prenatal Record** ( ):To print or fax the entire prenatal record as one document on a selected printer or fax machine. (**Note**: When you choose this option the prenatal record is also saved to the patient's Medical Summary, in the **Documents** tab.)

- **Print to Default Printer** (): To print the prenatal record to your default printer.
- **Print Prenatal Record** (): To print or fax each tab of the prenatal record as a separate document on a selected printer or fax machine.
- **Attach Prenatal Form to patient's chart** (): To save the prenatal record as a PDF document in the patient's Medical Summary, in the **Documents** tab. Use this option if you will be attaching the prenatal form to a referral.

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 start a new prenatal record.

1. Open the patient's prenatal record, and then click the **Delivery** tab.



2. Enter the patient's delivery details, and then click .

   After you enter the delivery date and close the Prenatal record, the EMR locks the Prenatal record.

Evaluation

Complete the following questions.

1. You have just received a patient's first ultrasound results. When the patient was in for her first visit, she was unsure of her last menstrual period date. How can you calculate a more accurate estimate for date of birth?

2. You open the prenatal record for a patient's first prenatal visit and you notice that information from the patient's previous pregnancy (including visit notes) is populated. How do you finishe the old prenatal record and start a new prenatal record?

3. On the prenatal record, in which tab do you enter a patient's visit notes?

End of Module

WCB patient visits

Introduction to this module

Purpose

In this module, 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.

> **Tip: Avoiding refused WCB bills**
>
> Always submit your WCB report and associated bill(s) on the date of service. If a WCB bill is submitted 1-3 days after the service, WCB will reject the bill and you will not be paid.

Objectives

Upon completion of this module, you will be able to:

- Open the WCB Report Manager
- Start a WCB report
- Finish an incomplete WCB report
- Track and manage incomplete WCB forms for all patients

Opening the WCB Report Manager

The WCB Report Manager is where you access and manage WCB forms. From the WCB Report Manager, you can:

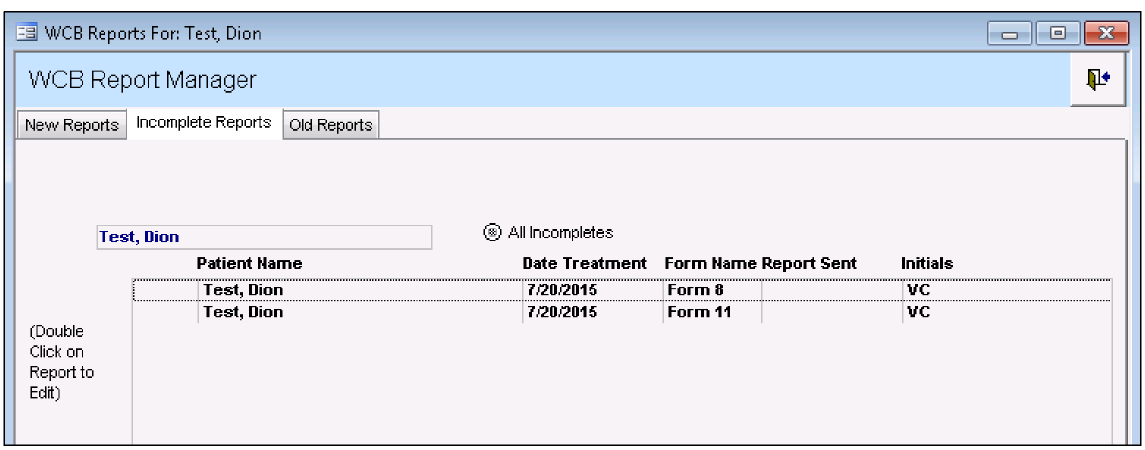
- Start a WCB report for a patient
- View, edit, and complete a patient's WCB reports
- View a patient's historical WCB reports

The method you use to open the WCB Report Manager depends on whether the patient is booked for an appointment.

Use the following table to open the WCB Report Manager for a patient.

Appointment booked?	Steps
Yes	1. Open the patient's Medical Summary: On the Appointment Scheduler, click the patient's appointment and then, on your keyboard, press **F7**. 2. Anywhere in the window, right-click and then, in the SMART menu, click **View WCB Reports**.
No	1. On the WorkDesk, in the **Data Entry** area, click **WCB e-Forms**. The EMR displays the following prompt: "Select WCB E-form for an Individual Patient?" 2. Click **Yes**. The EMR displays the Patient Search window. 3. Search for the patient and then double-click the patient's name.

The EMR displays the patient's WCB Report Manager.



Entering information in WCB forms

You can enter WCB medical information and visit notes in the WCB forms. The WCB forms in Wolf EMR are based on the WorkSafeBC forms. From the WCB Report Manager, you can:

- Start a WCB form for a patient
- Add or modify information on a previously started form

Any information you enter displays when the practitioner opens the form. The practitioner can then enter or modify information as needed.

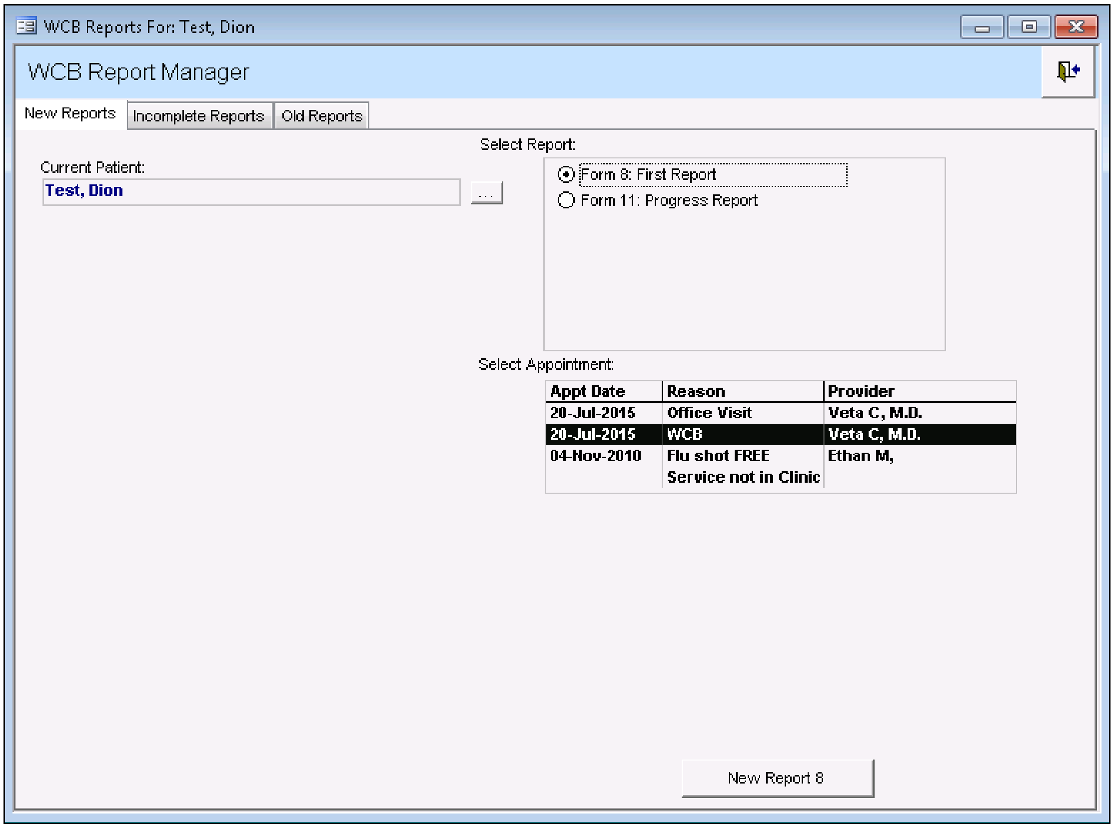
Please be aware of the following

- You must submit a WCB Progress Report if it has been more than four weeks since the last Form 11 was sent, or if a Form 11 is requested by a WorkSafeBC Officer.
- A report is not necessary if the appointment is a follow-up and the worker's condition is stable.
- To be paid for the WCB visit, make sure you submit and bill Form 8 and Form 11 reports within 1-3 days of the service date.
  Best practice: Send your WCB reports within 24 hours just to be sure!
- You will not receive payment for any Form 8 or Form 11 reports that are submitted and billed 7 or more business days following the service date.

Starting a WCB report

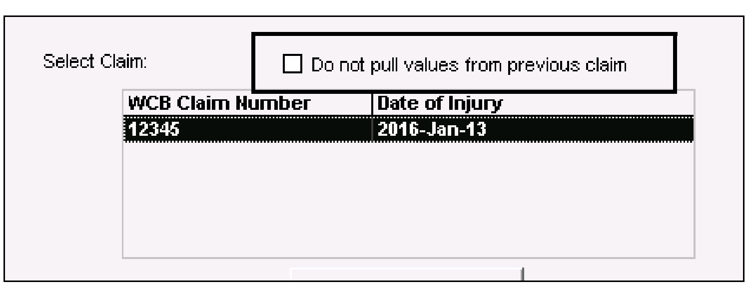
To start a WCB form for a patient:

1. Open the patient’s WCB Report Manager. See “Opening the WCB Report Manager” on page 88.
2. Click the **New Reports** tab.

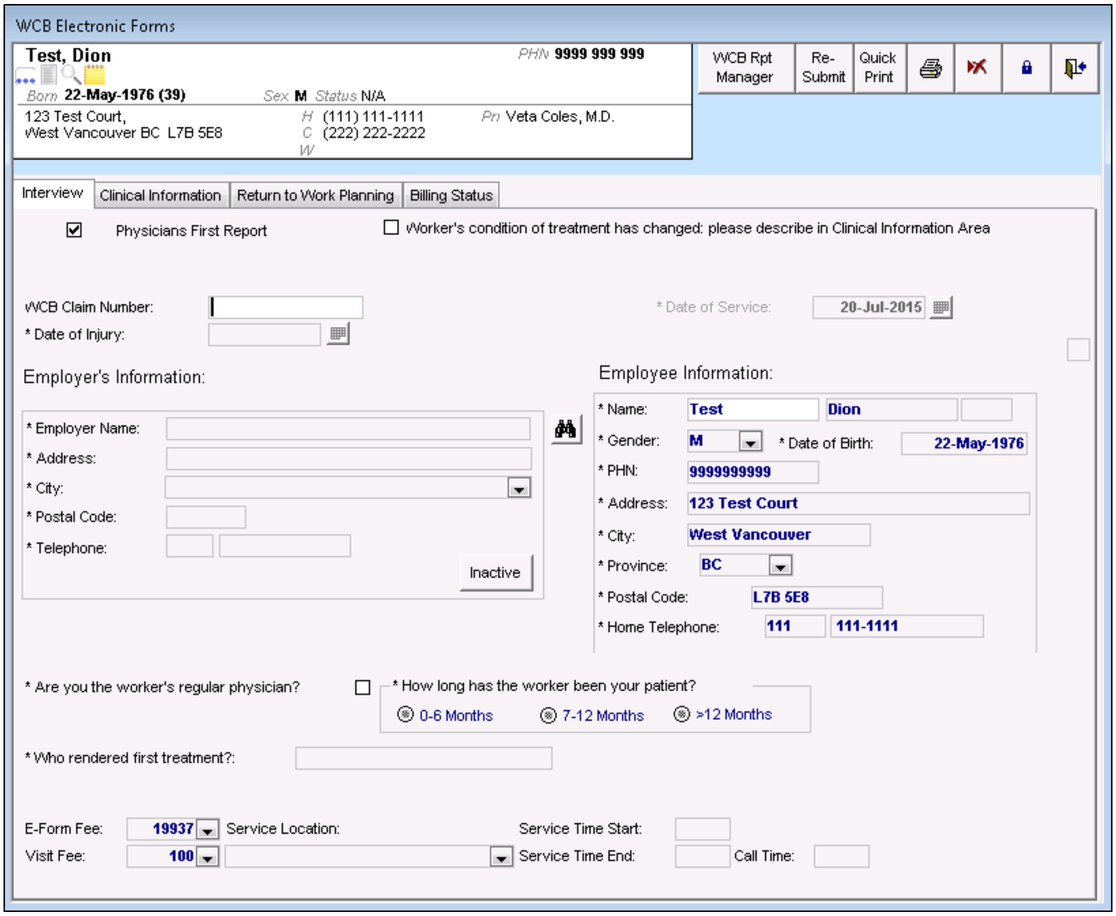


3. In the **Select Report** area, select the WCB form you want to start.
4. In the **Select Appointment** area, perform one of the following actions:
   - If the patient was seen in clinic, click the associated appointment.
   - If the patient was not seen at your clinic (for example, the patient was visited in the hospital), at the bottom of the appointment list, click **Service not in Clinic**, and then in the **Select Physician** drop-down list, select a physician.
5. If you are starting a Progress Report and you want to auto-fill most information in the report based on a previous report for the claim:

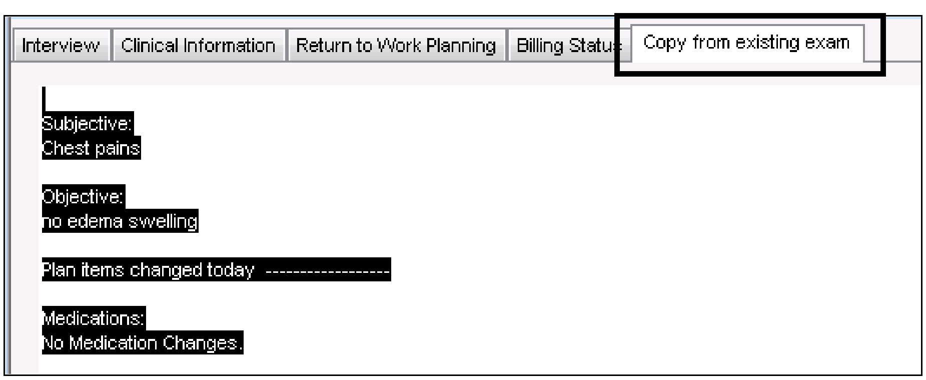
   a) In the **Select Claim** area, select the claim the report is for. The EMR clears the **Do not pull values from previous claim** check box.



6. On the bottom of the window, click **New Report**. The EMR displays the selected WCB form.



7. 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 that displays the SOAP information.



Tip: The information on the **Copy form existing exam** tab does not get sent to WCB.

To make sure this information gets sent to WCB:

1. Highlight text on the **Copy form existing exam** tab.

   Tip: if you want to select all the text in the **Copy form existing exam** tab, on your keyboard, press **Ctrl** + **A**.

2. Copy the highlighted text (press **Ctrl + C**).
3. Navigate to the appropriate tab of the WCB form, click the field, and then paste the text (press **Ctrl + V**).

The original SOAP encounter is not automatically deleted.
You have the option to keep it or delete it.

8. Enter information into each of the form tabs as needed.

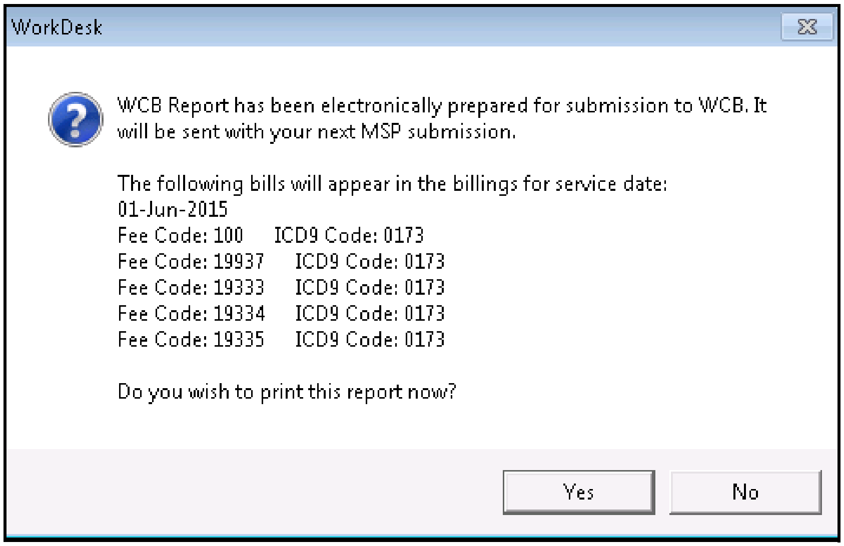
Tips for entering information in WCB forms

- The data entry fields exactly match the WorkSafeBC forms. As with the WorkSafeBC online forms, an asterisk (*) indicates required fields.
- The worker's first name, last name, and PHN must match the information on the worker's British Columbia CareCard.
- To view the billing status of the WCB form, click the **Billing Status** tab.

If you selected to pull information from a previous report (Step 5), most of the form is auto-filled for you. You can modify this information as needed.

9. When you finish entering information on all of the tabs, click . The EMR displays a prompt asking 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 displays a prompt similar to the following:



  Click **Yes** if you want to print the report now. Click **No** if you do not want to print the report. The form is sent to the Billing program and is ready to be billed and submitted.

- 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 patient's encounter record: once to indicate that it is a WCB report, and once 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.)

Practise: Starting a WCB First Report

Find the patient for whom you entered SOAP notes in an earlier exercise.

Start a WCB First Report for that patient. When the EMR displays a prompt asking if you want to use the exam data to create a new WCB encounter record, click **Yes**.

Browse through the information on the following tabs:

- **Interview**
- **Clinical Information**
- **Return to Work Planning**
- **Billing Status**

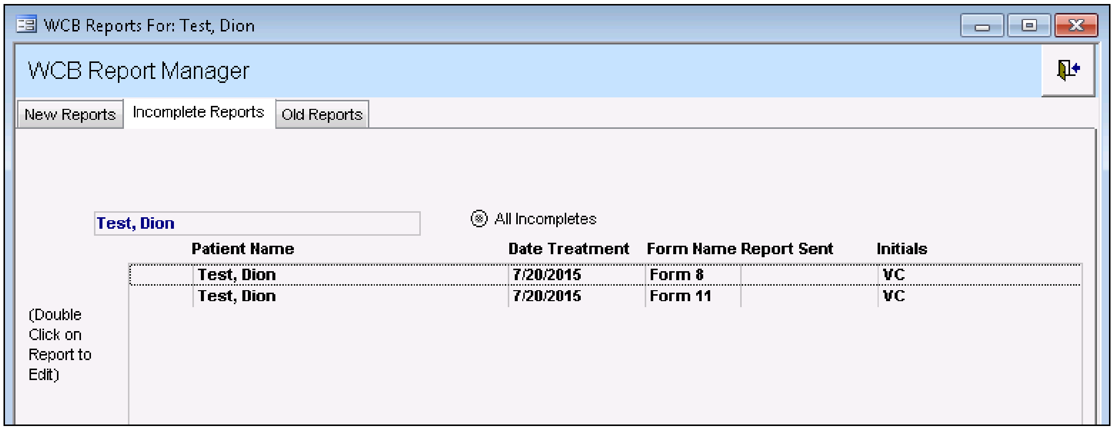
Copy information from the **Copy from existing record** tab and paste it on another tab.

Finishing a previously started WCB form

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 patient's WCB Report Manager. See "Opening the WCB Report Manager" on page 88.
2. Click the **Incomplete Reports** tab.



3. In the list of incomplete reports, double-click the report. The EMR opens the selected report.
4. In the various form tabs, enter and modify information as needed.
5. When you finish entering information, close the form and send the WCB claim to billing. See Step 9 and Step 10 in "Starting a WCB report" on page 89.

Tracking and managing incomplete WCB reports clinic-wide

You can track and manage incomplete WCB reports for all patients in the WCB Report Manager.

To track and manage incomplete WCB Reports clinic-wide:

1. On the WorkDesk, in the **Data Entry** area, click **WCB e-Forms**. The EMR displays the following prompt: "Select WCB E-form for an Individual Patient?"
2. Click **No**. The EMR displays the WCB Report Manager window with the **Incomplete Reports** tab open. The **Incomplete Reports** tab lists all incomplete WCB reports for your clinic.

> To view a list of incomplete WCB reports for a specific practitioner, in the **Physician** drop-down list, select the practitioner's name.

3. To open and modify a report, in the list of incomplete reports, double-click the report. The EMR opens the selected form.
4. In the various form tabs, enter and modify information as needed.
5. When you finish entering information, close the form and send the WCB claim to billing. See Step 9 and Step 10 in "Starting a WCB report" on page 89.

Practise: Tracking and managing incomplete WCB Reports

- View all incomplete WCB reports for every patient in your clinic.
- Filter the results to view only incomplete WBC reports for a specific practitioner.
- Open an incomplete WCB report.

Evaluation

Complete the following questions.

1. You want to create a WCB Progress Report to update a WCB claim. Which tab do you use in the WCB Reports Manager?
   a) New Reports
   b) Incomplete Reports
   c) Old Reports
2. What happens when a patient has a SOAP note for the appointment you create a WCB form for?

   ____

   ____

3. Why would you copy and paste information from the **Copy form existing exam** tab to other fields in the WCB form?

   ____

   ____

4. It's the end of the day and you are about to verify and send all billing claims to WorkSafeBC. You want to ensure that there are no incomplete WCB forms that have not been sent to the billing program. How do you view a list of incomplete WCB forms?

   ____

   ____

End of Module

Electronic requisitions and forms (SMART forms)

Introduction to this module

Purpose

In this module you learn how to complete requisitions and other forms using Wolf EMR SMART forms. SMART forms are Microsoft Word-based form templates that can populate patient information automatically. Wolf EMR contains hundreds of SMART forms for 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 database, and are available to all Wolf clients. If the Wolf development team creates a SMART form for other clinics in your area, the form becomes available on your SMART form list.

You can define which SMART forms are your favourites, making it easier to access your commonly used forms.

Objectives

Upon completion of this module, you will be able to:

- Use a SMART form
- Access and print completed SMART forms
- Define your favorite SMART forms
- Print patient labels

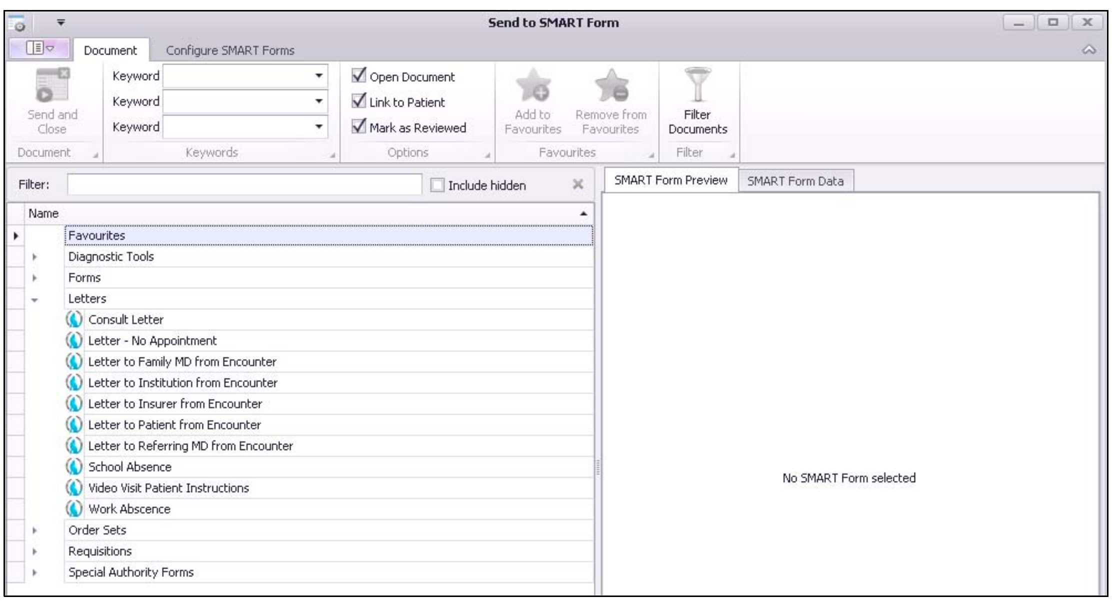
Using SMART forms

You can open and fill out a SMART form from almost any window related to a patient. Once opened, you will notice that the EMR populates most of a patient's information automatically (for example, the patient's name, health number, and address). This decreases the amount of time it takes to fill out the form, and decreases errors. To complete the form, select or clear check boxes, and enter data into text fields. Once you complete a SMART form, you can print or fax it.

To use a SMART form:

1. On any window related to a patient's record (for example, the Medical Summary window or Vital Entry window), 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 SMART forms in your system.
   - **Favourite Requisition**: To select from a drop-down list of SMART forms categorized as requisition forms and identified as favourites. See "Managing your favourite SMART forms" on page 105.

   If you select **New Requisition** or **SMART Forms**, the EMR opens the Send to SMART Form window.



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.

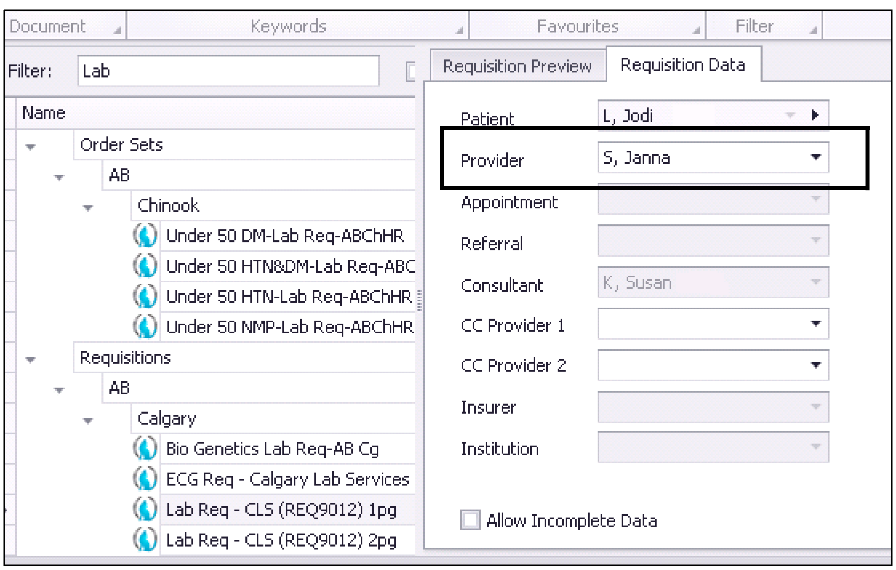
3. If you cannot find the form you want:

    a) In the **Filter** field, enter a search term. (For example, “MRI”.) The EMR filters the list of SMART forms to display only SMART forms containing your search term.

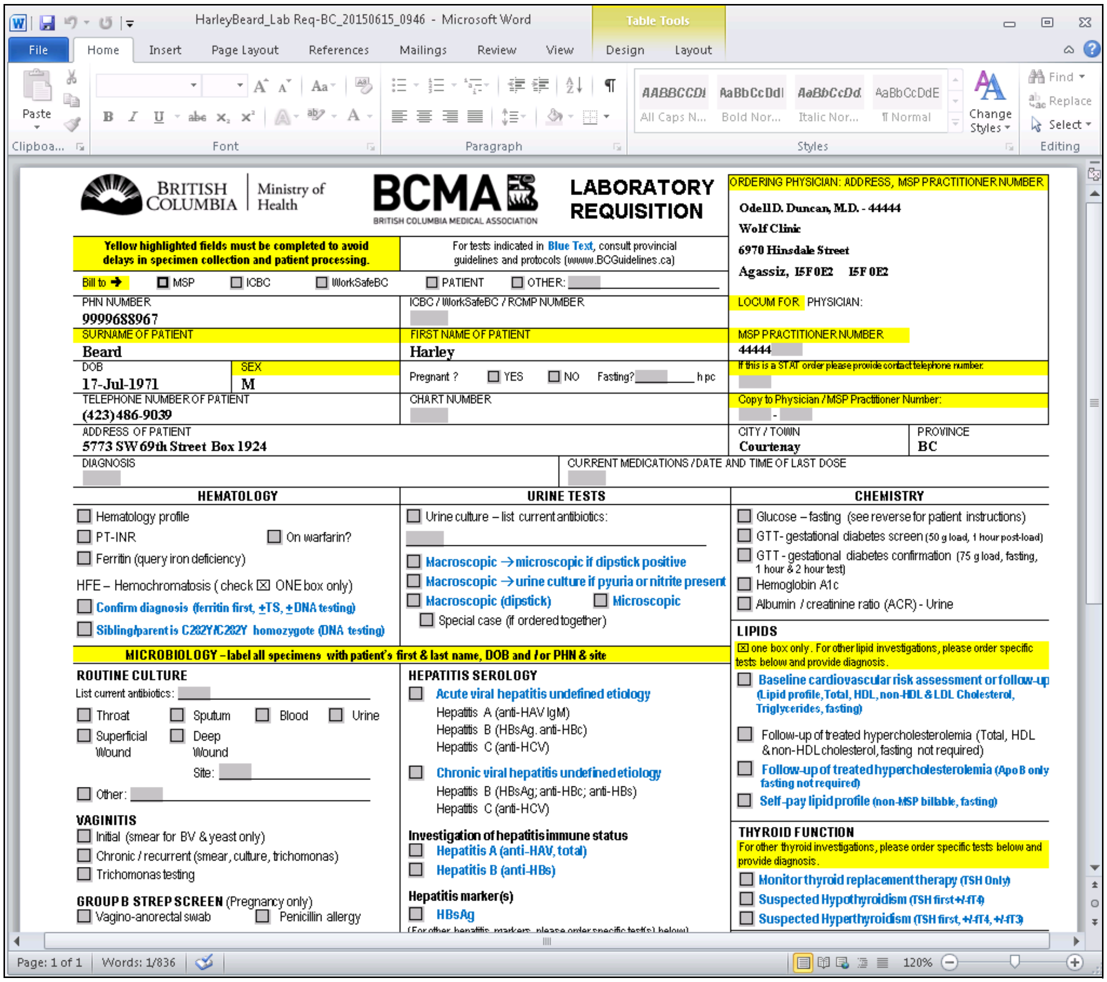
> **Tips for entering search criteria**
>
> - To find a lab requisition, enter the word “**Lab**”
> - To find a diagnostic imaging requisition, enter “**DI**” or “**Imaging**”.
> - SMART forms are named by region (for example, “**AB Cg”**), or company/type (for example, “**CDC**”, or “**MIC**”). Try 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 patient’s appointment is not with their primary practitioner, change the provider information on the SMART form: In the right pane, click the **SMART Form Data** tab or the **Requisition Data** tab and then, in the **Provider** drop-down list, click the provider with whom the patient has an appointment.



5. Click **Send and Close** () or, in the list of SMART forms, double-click the form. The EMR opens the form in Microsoft Word, with editable check boxes and fields highlighted in grey.


HarleyBeard_Lab Req-BC_20150615_0946 - Microsoft Word

BRITISH COLUMBIA | Ministry of Health

BCMA BRITISH COLUMBIA MEDICAL ASSOCIATION

LABORATORY REQUISITION

ORDERING PHYSICIAN: ADDRESS, MSP PRACTITIONER NUMBER

Odell D. Duncan, M.D. - 44444
Wolf Clinic
6970 Hinsdale Street
Agassiz, I5F 0E2 I5F 0E2

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: 9999688967
ICBC / WorkSafeBC / RCMP NUMBER
LOCUM FOR PHYSICIAN:
SURNAME OF PATIENT: Beard
FIRST NAME OF PATIENT: Harley
MSP PRACTITIONER NUMBER: 44444
DOB: 17-Jul-1971
SEX: M
Pregnant ? ☐ YES ☐ NO Fasting? h pc
If this is a STAT order please provide contact telephone number.
TELEPHONE NUMBER OF PATIENT: (423)486-9039
CHART NUMBER
Copy to Physician / MSP Practitioner Number:
ADDRESS OF PATIENT: 5773 SW 69th Street Box 1924
CITY / TOWN: Courtenay
PROVINCE: BC
DIAGNOSIS
CURRENT MEDICATIONS / DATE AND TIME OF LAST DOSE

HEMATOLOGY
☐ Hematology profile
☐ PT-INR ☐ On warfarin?
☐ Ferritin (query iron deficiency)
HFE – Hemochromatosis (check ☒ ONE box only)
☐ Confirm diagnosis (ferritin first, +TS, +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 load, 1 hour post-load)
☐ GTT - gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test)
☐ Hemoglobin A1c
☐ Albumin / creatinine ratio (ACR) - Urine

LIPIDS
☒ one box only. For other lipid investigations, please order specific tests below and provide diagnosis.
☐ Baseline cardiovascular risk assessment or follow-up (Lipid profile, Total, HDL, non-HDL & LDL Cholesterol, Triglycerides, fasting)
☐ Follow-up of treated hypercholesterolemia (Total, HDL & non-HDL cholesterol, fasting not required)
☐ Follow-up of treated hypercholesterolemia (ApoB only fasting not required)
☐ Self-pay lipid profile (non-MSP billable, fasting)

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 Wound ☐ Deep Wound
Site:
☐ Other:

VAGINITIS
☐ Initial (smear for BV & yeast only)
☐ Chronic / recurrent (smear, culture, trichomonas)
☐ Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)
☐ Vagino-anorectal swab ☐ Penicillin allergy

HEPATITIS SEROLOGY
☐ Acute viral hepatitis undefined etiology
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg, anti-HBc)
Hepatitis C (anti-HCV)
☐ Chronic viral hepatitis undefined etiology
Hepatitis B (HBsAg; anti-HBc; anti-HBs)
Hepatitis C (anti-HCV)
Investigation of hepatitis immune status
☐ Hepatitis A (anti-HAV, total)
☐ Hepatitis B (anti-HBs)
Hepatitis marker(s)
☐ HBsAg

THYROID FUNCTION
For other thyroid investigations, please order specific tests below and provide diagnosis.
☐ Monitor thyroid replacement therapy (TSH Only)
☐ Suspected Hypothyroidism (TSH first +/-fT4)
☐ Suspected Hyperthyroidism (TSH first, +/-fT4, +/-fT3)

Page: 1 of 1 | Words: 1/836 | 120%

6. Select any check boxes you want, and enter text into fields highlighted in grey.

> 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.

7. To save the form, click **Save** ( ), or press **Ctrl + S**. The EMR saves the completed SMART form in the **Documents** tab of the patient's Medical Summary.
8. To print or fax the form, in the Microsoft Word menu, click **File** > **Print**.

Scenario: Using SMART forms

A patient comes in during your walk in clinic hours for a sore throat. The doctor takes a throat swab and instructs you to send the sample to the lab for testing. When you produce the lab requisition form, you see that the patient's primary provider's name is populating the form instead of the provider they saw. How can you change the provider information on the form?

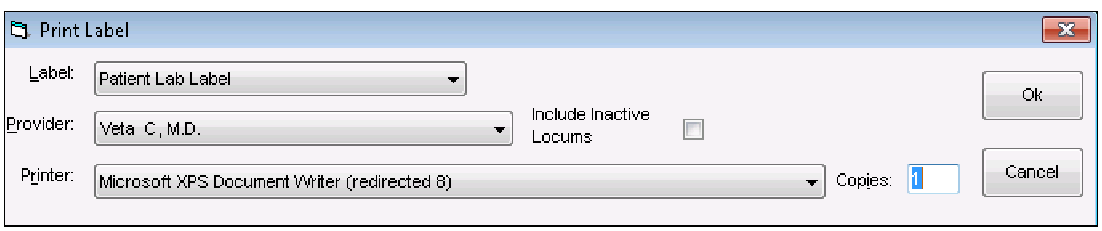
Printing patient labels

After you complete and print a requisition form, you can print a corresponding patient label, either for the accompanying lab sample or for the form itself.

You can print a patient label from almost any window related to the patient (via the SMART menu).

To print a patient label:

1. On any window related to the patient (including a patient's Medical Summary, or the Vital Entry window), right-click and then, in the SMART menu, click **Print Label**. The EMR displays the Print Label window.



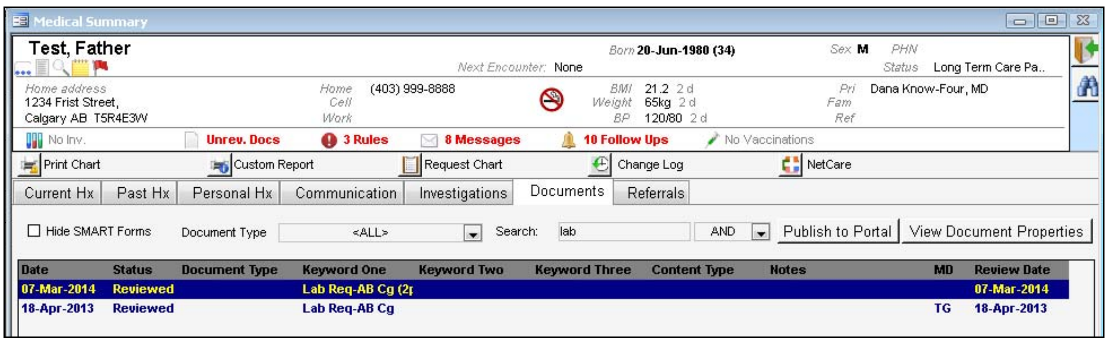
2. In the **Label** drop-down list, select the type of label you want to print.
3. Click **OK**.

Viewing, modifying, and printing previously completed SMART forms

After you complete and save a SMART form, the EMR permanently saves the SMART form in the patient's chart. If a patient loses their requisition form, or if a company asks you to re-fax a patient's form, you can re-print or re-fax the form as needed.

To view and print a previously completed SMART form for a patient:

1. Open the patient's Medical Summary, and then click the **Documents** tab. The EMR displays all of the patient's documents and SMART forms.
2. 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.



3. In the filtered list of documents, double-click the form. The EMR opens the SMART form in Microsoft Word.

> 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 the practitioner has 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.

4. To print or fax the form, on the Microsoft Windows menu, click **File** > **Print**.

Practise: Using SMART forms

- Open a diagnostic imaging requisition form.
- On the SMART form, select a few check boxes, and enter data into a few of the text fields.
- Print and save your form.
- Print a patient lab label.
- Navigate to the **Documents** tab of the patient's Medical Summary, and open the form you just printed.

Managing your favourite SMART forms

Wolf EMR contains hundreds of SMART forms. With so many forms, it can be challenging to find the form you want. To make commonly used 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 requisition 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).

To add 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 100.
2. At the top of the window, click one of the following options:

   - **Add to Favourites** ()
   - **Remove from Favourites** ()

Practise: SMART form favourites

- Define a SMART form you use on a daily basis as a favourite.
- Open your favourite SMART form directly from the SMART menu.

Evaluation

Complete the following questions.

1. When completing a SMART form for a patient, you notice that the patient's old address populates the form. Can you edit the patient's address directly on the form?

____

2. When you want to use one of your favourite SMART forms, what is the quickest way to open it?

____

____

3. If a patient misplaces their lab requisition form, where can you find and print a copy of the original form?

____

____

End of Module

Managing clinic communications and tasks

Introduction to this module

Purpose

In this module 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 one location

Objectives

Upon completion of this module, you will be able to:

- Send a message
- Create a follow-up task
- Manage your messages and follow-up tasks
- Manage your Patients to Notify List

Sending messages

In Wolf EMR, you create messages primarily to:

- Inform users that they have received calls from patients, patient family members, external consultants (specialists), and so on.
- Notify clinic members of upcoming events (such as staff meetings), policy changes, and other non-patient related items.

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

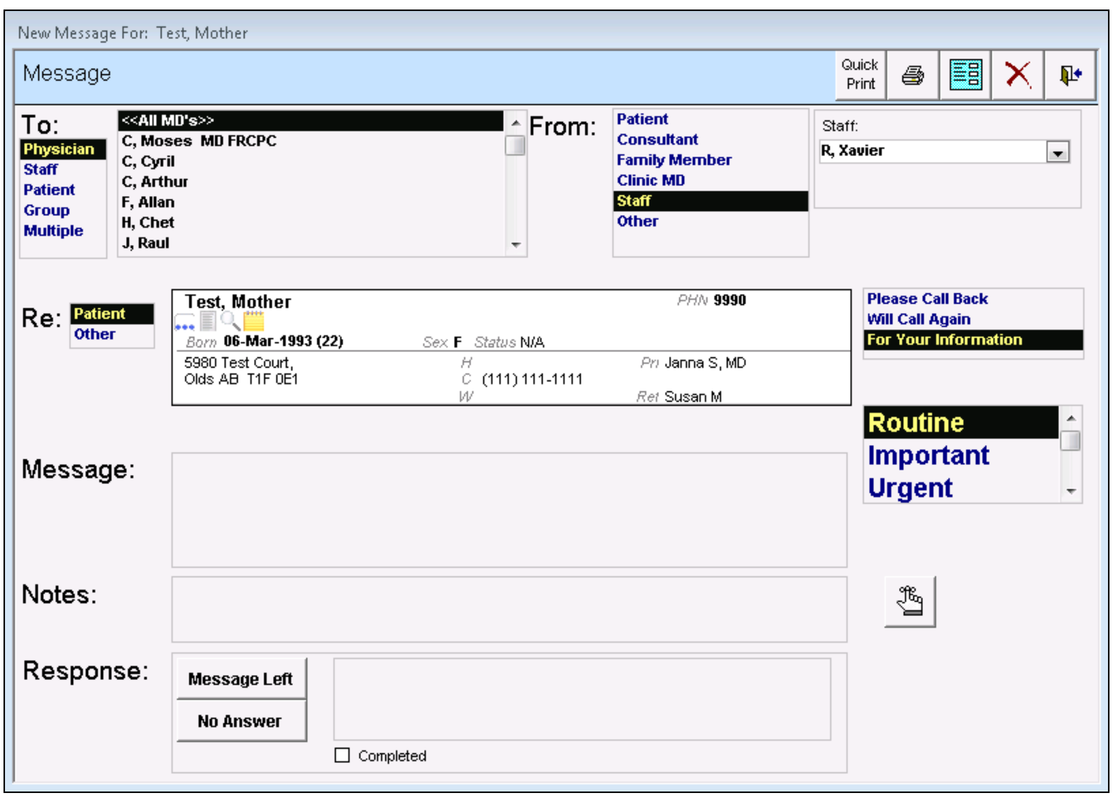
Messages regarding patients are saved in patient records — both in the **Communication** tab of the Medical Summary and in the encounter list. The SMART patient banner also displays a notification if there are any outstanding messages regarding the patient. See "SMART patient banner overview" on page 52.

To create a message:

1. Perform one of the following actions:

   - If you are sending a message regarding a patient, and you have any window of the patient's record open (for example, the Vital Entry window or the Medical Summary), right-click and then, in the SMART menu, click **New Message**.
   - If you do not have the patient's record open, or if you are sending a message that is not regarding a patient message, on the WorkDesk, in the **Current Messages** area, click .

   The EMR displays the New Message window.



> **Best practice**: Always check the message's SMART patient banner to make sure you selected the correct patient. Once a message is sent, it is permanently associated with the selected patient's chart (you cannot delete it or move it to another patient).

2. In the **To** area, click the type of recipient you want to send the message to, and then click the recipient(s).

> **Tips for selecting a recipient type**
>
> - To send a message to a group, click **Group**. All users in that group receive the message; however, as soon as one group member completes the message, the message disappears from the message list of ALL group members.
> - To send the message to multiple users, and to require that each user views and completes the message, in the **To** area, click **Multiple**, and then click the recipients' names.
> - To add a message to a patient's chart without sending the message to a clinic member (for example, you want to add a reminder to discuss something with the patient at their next visit), click **Patient**.

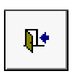
3. To send the message on behalf of someone else (for example, another clinic user, a patient, or an external consultant), in the **From** list, click the type of sender for the message, and then specify a name, facility, and/or contact information.
4. In the **Re** area, click one of the following options:
   - **Please Call Back**
   - **Will Call Again**
   - **For Your Information**
5. Using the following table, select the message's priority level:

Priority	Description
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.

Priority	Description
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. The EMR also displays an Urgent Message pop-up window on the WorkDesk of the recipient. To see the pop-up, the receiver must have the WorkDesk open. 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 (for example, the message is regarding an urgent phone call from another provider or from a pharmacy)

6. In the **Message** field, enter the text of your message.

7. Click .

Scenarios: Creating messages

Create messages for the following situations:

- A specialist calls to speak with Dr. Smith regarding a patient. Dr. Smith is with a patient, so you offer to take a message. Create a message that is From a consultant, and is regarding a patient.
- You want to inform all clinic practitioners and staff members that the clinic's Christmas party will take place on December 10 at 6 PM. All staff members must RSVP by November 30.
  Remember, each recipient must be able to respond to the message individually.

Creating 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 clinic member 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, lifestyle advice, or any other matter pertaining to the patient's health.

> Because follow-up tasks serve such a specific function, they have fewer options than Messages do. For example:
>
> - You cannot send follow-up tasks to several users at once to complete individually. You can send a follow-up task only to a single user or security group. 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 you enter text in the **Follow-up Reason** field).

Follow-up tasks are saved in patient records — in the **Communication** tab of the Medical Summary. The SMART patient banner also displays a notification if there are any outstanding follow-up tasks regarding the patient. See "SMART patient banner overview" on page 52.

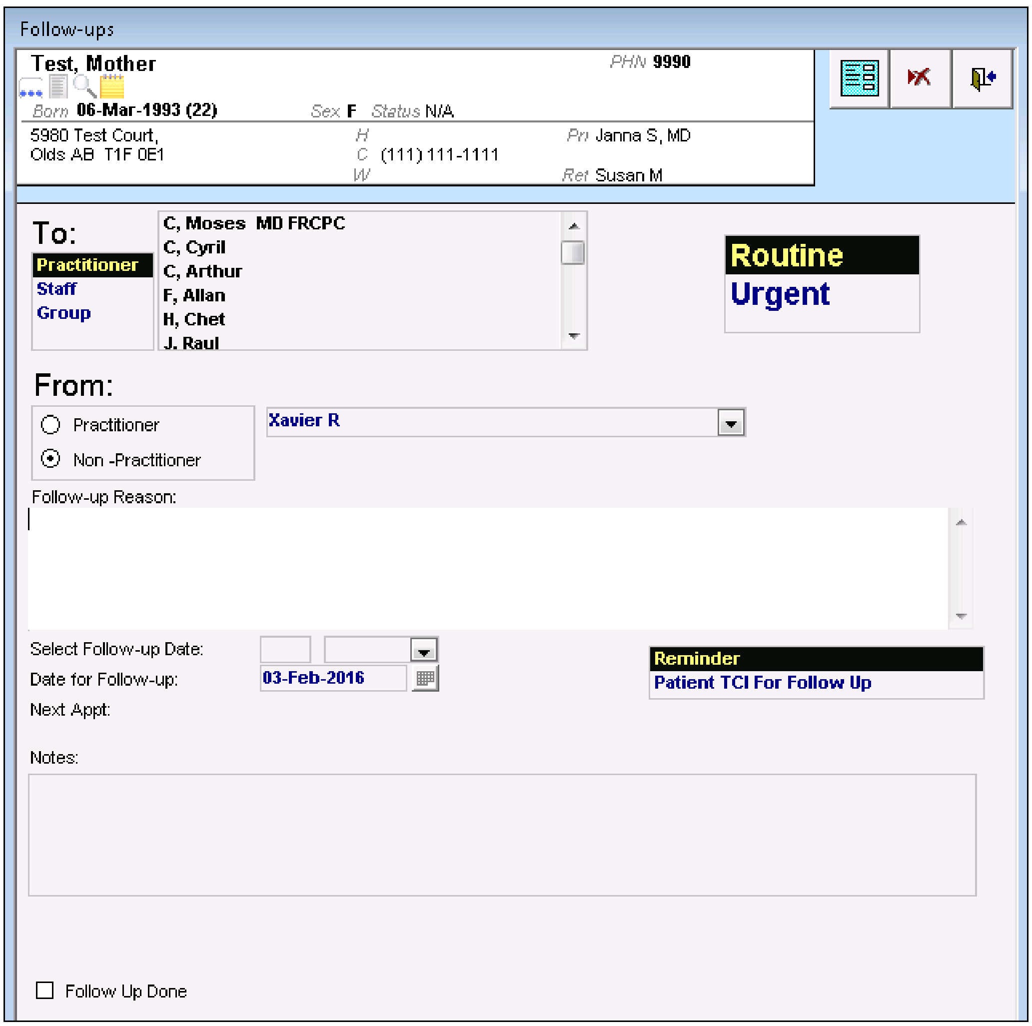
To create a follow-up task regarding a patient:

1. Perform one of the following actions:
   - If you have any window of the patient's record open (for example, the Vital Entry window or the Medical Summary), right-click and then, in the SMART menu, click **New Follow-up**.
   - If you do not have the patient's record open, on the WorkDesk, in the **Current Follow Up Tasks** area, click .

You can also start a follow-up from a message. At the top of the Message window, click **Create New Follow Up Based on Message** ().

Use case: A practitioner sends you a message to contact a patient regarding an abnormal lab result. You call the patient, but you discover that the patient has gone overseas for three months. On the message, you click **Create New Follow Up Based on Message** () to create a follow-up task. You delay the due date of the task to three months from today.

The EMR displays the Follow-ups window.



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

2. In the **To** area, click the type of recipient you want to send the follow-up to, and then click the recipient(s).
3. Using the following table, select the follow-up priority level:

Priority	Description
Routine	The EMR displays the follow-up task in the recipient's Follow Up Tasks list below any urgent follow-up tasks.
Urgent	The EMR displays the follow-up task at the top of the recipient's Follow Up Tasks list in red, with an exclamation mark (**!**) in the first column.

Best practice: Mark follow-up tasks as **Urgent** only if the recipient must address the task right away.

4. To send the follow-up on behalf of someone else, in the **From** area, select one of the following options:
   - **Practitioner**: If the sender is a practitioner
   - **Non-practitioner**: If the sender is an MOA or other front end staff member

   and then, in the drop-down list, select the sender.
5. In the **Follow-up Reason** area, enter the problem and reason for the follow-up.
6. If the due date is a day other than today, in the first **Select Follow-up Date** field, enter the number of days, weeks, months, or years when the follow-up is due. The EMR displays the calculated date, based on the **Select Follow-up Date** fields, in the **Date for Follow-up** field.

Tip: You can also edit the **Date for Follow-up** field. Click **Calendar** ( ) and then click the date you want.

7. In the **Notes** area, enter notes regarding actions you have taken toward completing the follow-up task. For example, "Informed patient during their visit that I will contact them to book an appointment if results are abnormal".
8. Click .

Scenario: Creating a follow-up task

Create a follow-up task for the following situation:

- You receive a message from a physician asking for a patient's charts from their previous GP. You create a follow-up task to remind yourself to call the GP's clinic tomorrow.

Managing messages and follow-up tasks

You manage your messages and follow-up tasks from your WorkDesk. From here, you can view, update, modify, complete, or redirect your messages and follow-up tasks.

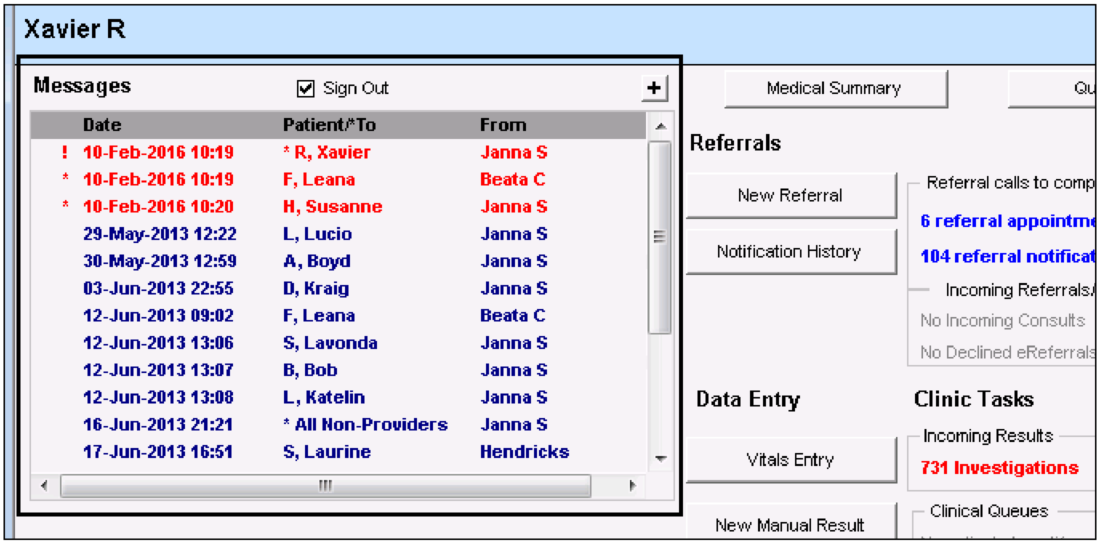
If you complete some action toward a message or follow-up task, but do not fully complete the task, you can document the actions you have taken in the message or follow-up task itself.

Also, if you do not have enough time to address a message or follow-up task, or receive one in error, you can redirect the message or task to another clinic user.

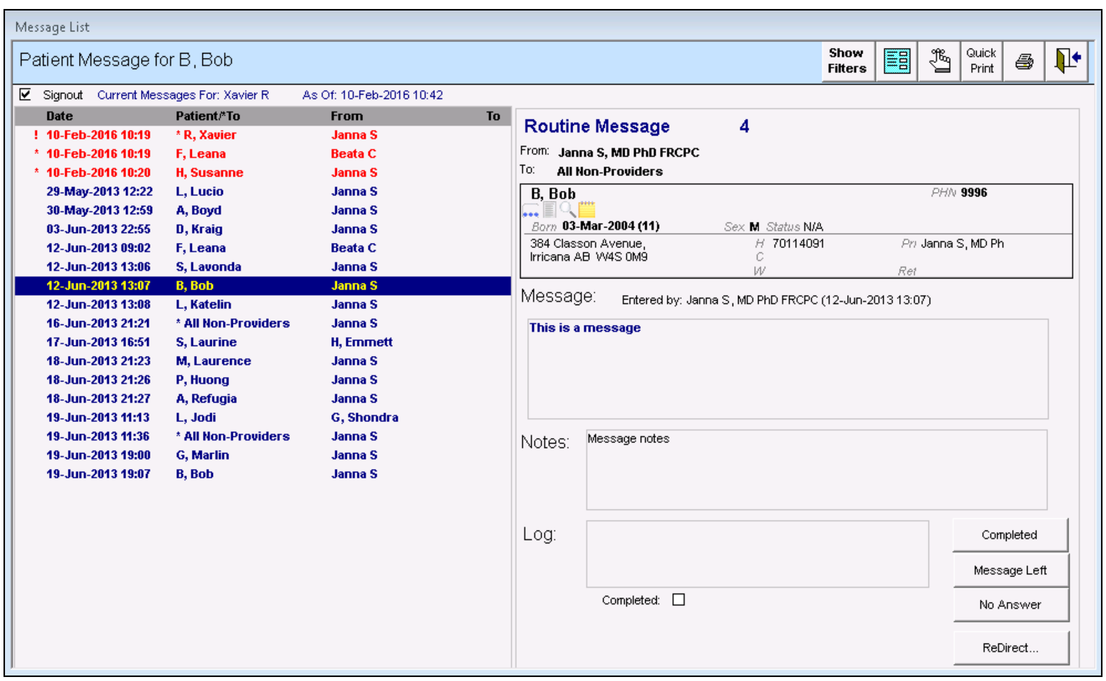
Managing messages

To view and manage your messages:

1. On your WorkDesk, locate the **Messages** area. Your messages are 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 fist column.
    - Bottom: **Routine** messages displayed in blue.



2. 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.



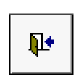
Tip: To reorder your list of current messages by the contents of a column, click the column header. For example, to order the list by sender, click the **From** header.

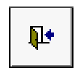
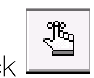
3. To view and address only certain types of messages:

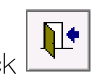
   a) Filter the list of messages to display only the messages you want to address: at the top of the Message List window, click **Show Filters** (Show Filters). The EMR displays filtering options on the left side of the window.

> Once you filter the message list, the list remains filtered until you either:
>
> - Change the filter criteria.
> - Close the Message List window.

4. Using the following table, perform one or more actions to manage a message.

Action	Steps
To record steps you have taken toward the message	In the **Notes** area, enter the steps you have taken.
To record that you called the patient, consultant, family member, and so on, but the they did not answer	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. **Tip**: You can edit the text in the **Log** area as needed.
To modify the message text, or to change the message priority level	Redirect the message to yourself. You can then edit the message and priority: 1. Click **Redirect**. The EMR displays the Redirecting Patient Message window. 2. In the **To** area, select your name, and then modify the message details as needed. 3. Click .

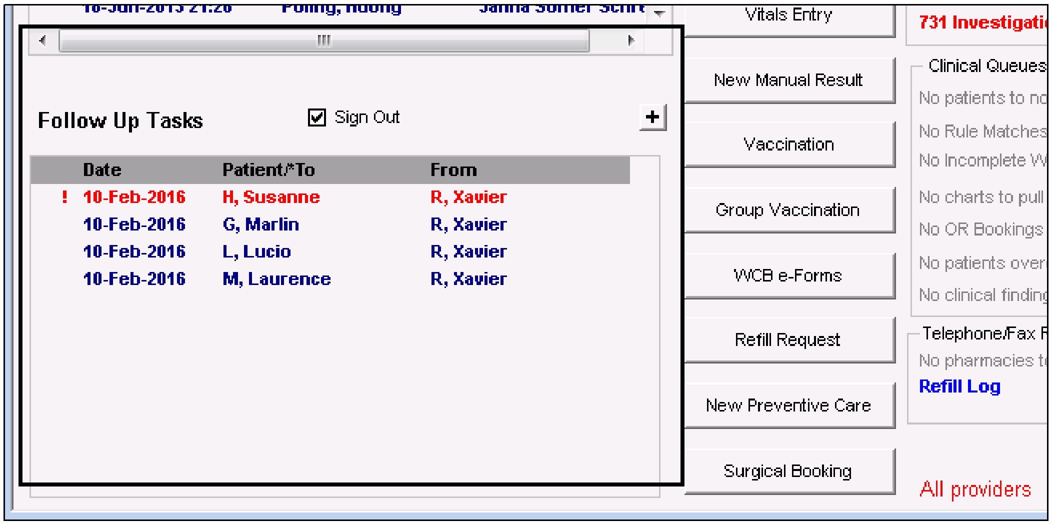
Action	Steps
To pass the message on to another user	1. Click **Redirect**. The EMR displays the Redirecting Patient Message window. 2. In the **To** field, click the user or group you want to redirect the message to. 3. In the **Notes** area, enter any additional notes or instructions to the receiver. 4. Click .
To complete the message (and remove the message from your current messages list)	Click **Completed**.
To create a follow-up task based on the message	At the top of the window, click . The EMR opens the Follow-ups window with the contents of the message displayed in the **Follow-up Reason** field.

5. When you finish managing your messages, on the Message List window, click .

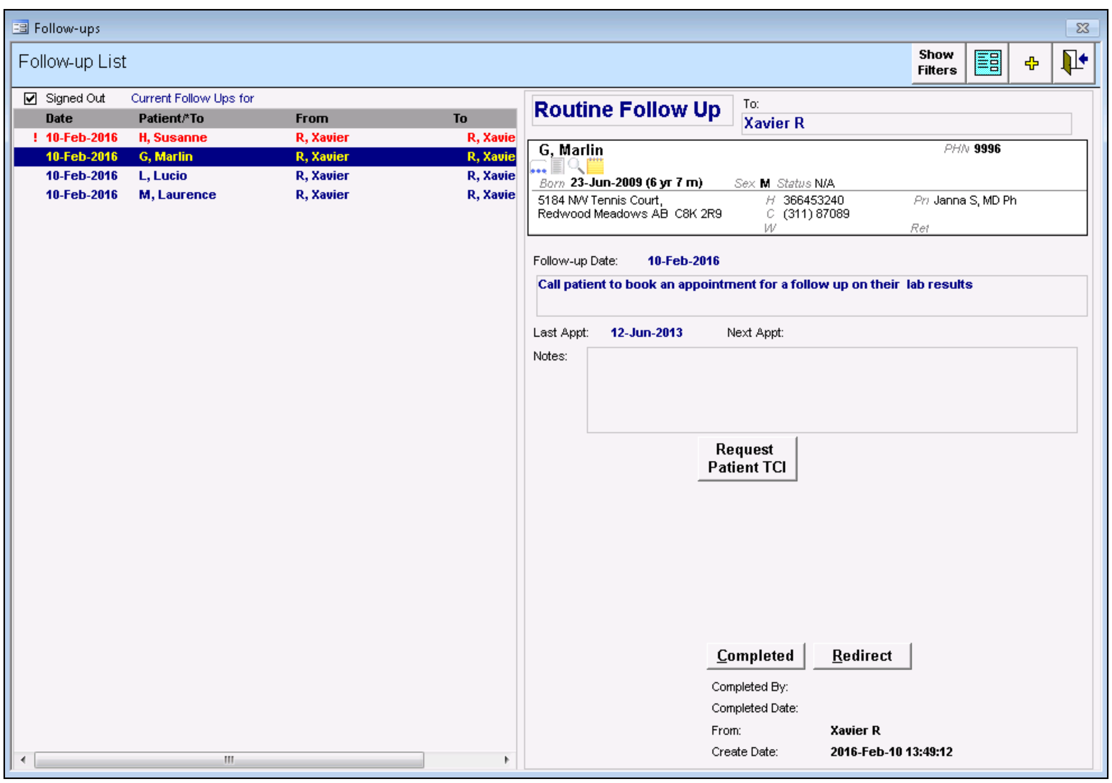
Managing follow-up tasks

To view and manage your follow-up tasks:

1. On your WorkDesk, locate the **Follow Up Tasks** area. Your follow-up tasks are listed chronologically in the following order:
   - Top: **Urgent** messages displayed in red, with an exclamation mark (**!**) in the first column.
   - Bottom: **Routine** messages displayed in blue.



2. In the **Follow Up Tasks** list, double-click a follow-up task. The EMR displays the Follow-up List window, with the selected follow-up task displayed on the right, and your full list of follow-up tasks displayed on the left.



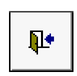
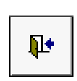
Tip: As with messages, you can reorder your list of current follow-up tasks by the contents of a column: click the column header. For example, to order the list by sender, click the **From** header.

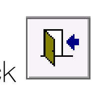
3. To view and manage only certain types of follow-up tasks, filter the list to display only follow-up tasks you want to address. At the top of the Follow-up List window, click **Show Filters** (

). The EMR displays filtering options on the left side of the window.

> Once you filter the follow-up task list, the list remains filtered until you either:
>
> - Change the filter criteria.
> - Close the Follow-up List window.

4. Using the following table, perform one or more actions to manage a follow-up task.

Action	Steps
To record steps you have taken toward the task	In the **Notes** area, enter the steps you have taken.
To modify the follow-up task due date or to change the follow-up task priority level	Redirect the follow-up task to yourself. You can then edit the due date and priority: 1. Click **Redirect**. The EMR displays the Redirect Patient Follow-up window. 2. In the **To** area, select your name, and then modify the follow-up task details as needed. 3. Click .
To modify the text describing the follow up task	In the area below the Follow-up date, edit the text as needed.
To pass the follow-up task on to another user	1. Click **Redirect**. The EMR displays the Redirect Patient Follow-up window. 2. In the **To** field, click the user or group you want to redirect the message to. 3. In the **Notes** area, enter any additional notes or instructions to the receiver. 4. Click .
To complete the follow-up task (and remove the follow-up task from your list)	Click **Completed**.

5. When you finish managing your follow-up tasks, on the Follow-up List window, click .

Scenario: Viewing your messages

You receive a message regarding a patient. Before you respond, you need to check some notes in the patient's record. What is the quickest way to open the patient's record from the message?

Scenario: Viewing your follow-up tasks

While viewing your extensive list of follow-up tasks, you decide to reorder your task list by sender; this way, you can manage all your practitioner-initiated follow-ups first. How do you accomplish this?

Scenario: Redirecting a message

You are on vacation next week, but have several important follow-up tasks that need to be completed by mid-next week. You don’t have enough time to complete them before you leave. How can you forward these tasks to another MOA?

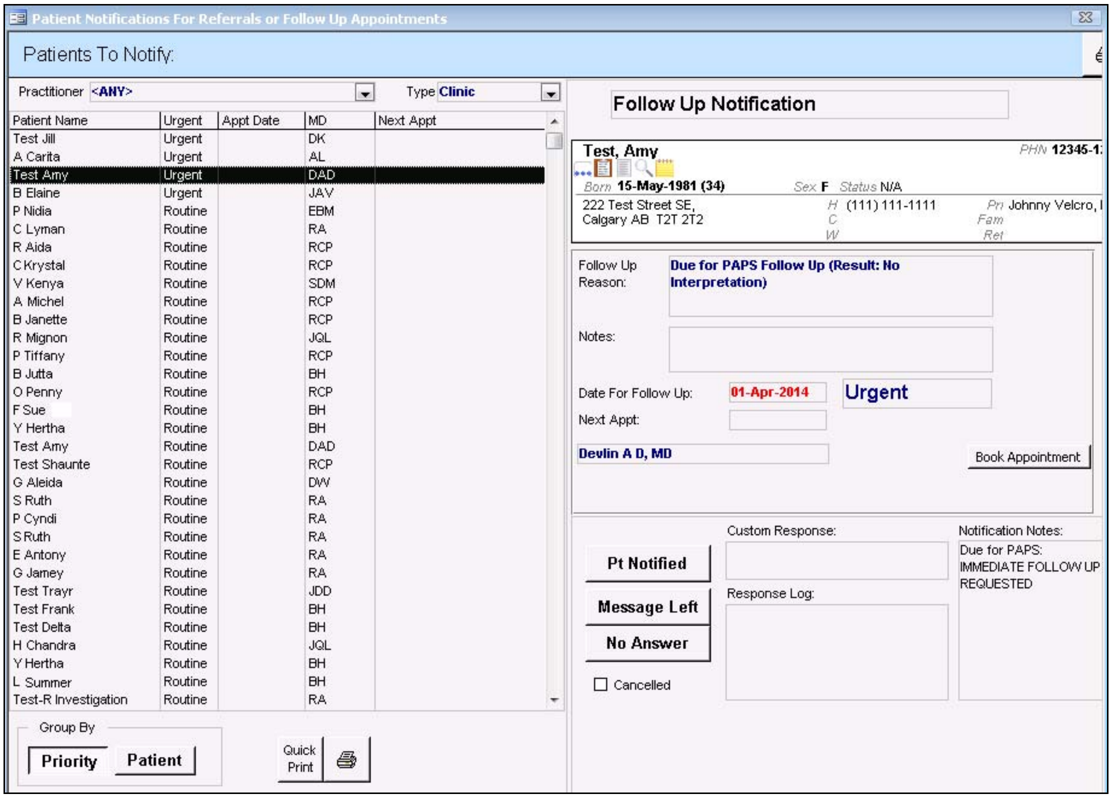
Managing your Patients to Notify list

Your Patients To Notify list contains patients who need to be notified for a follow-up appointment or a referral. Patients display on the Patients To Notify list when:

- A practitioner creates a To Come in (TCI) task regarding the patient (for example, to discuss an abnormal test result)
- A patient receives an appointment date for a referral and needs to be notified

To view and manage your Patients To Notify list:

1. On your WorkDesk, in the **Clinical Queues** area, click **<#> patients to notify** (where # = the number of patients to notify for follow-up appointments). The EMR displays the Patients To Notify window.
2. To view only a particular provider’s patients, in the **Practitioner** drop-down list, click the provider’s name.
3. To view more detailed information about a patient to notify, in the left pane, click an entry for the patient. The EMR displays the Follow Up Notification or Referral Notification to the right.



4. Use the following table to enter information into the **Response Log**:

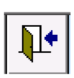
Field	Description
Pt Notified	Click this button to indicate that you notified the patient. The EMR adds the following information to the Response Log: **Patient Notified (<your name>/MM/DDD/YYYY HH:MM)**. **Note:** After you close the Patients To Notify list, the patient is removed from your Patients To Notify list. **Tip**: If you click **Pt Notified** by mistake, click **Pt Notified** again. The patient remains on the list.
Message Left	Click this button to indicate that you called the patient and left a message. The EMR adds the following information to the Response Log: **Message Left (<your name>/MM/DDD/YYYY HH:MM)**. **Note:** The patient remains on the Patients To Notify List.

Field	Description
No Answer	Click this button to indicate that you called the patient, but there was no answer. The EMR adds the following information to the Response Log: **No Answer (<your name>/MM/DDD/YYYY HH:MM)**. **Note:** The patient remains on the Patients To Notify List.
Custom Response	Enter a custom response specific to this entry.
Notification Log	Enter any notification notes. For example, “provided instructions to patient’s wife”.
Cancelled	If the notification was entered by mistake, select this check box. **Note:** After you close the Patients To Notify list, the patient is removed from your Patients To Notify list.

Tip: Printing a patient notification letter

If you cannot get a hold of the patient via phone, you can mail a notification letter to the patient instead. To print a notification letter:

1. In the Patients To Notify window, click the patient’s name.
2. At the bottom of the window, click **Quick Print**.

5. To book an appointment for the selected patient:
   a) In the Follow Up Notification area, click **Book Appointment**. The EMR opens the Appointment Scheduler with the patient’s name selected in the **Patient Search** area.
   b) Book the patient for an appointment. See “Booking patient appointments” on page 24.
6. Click .

Group Discussion: For the following scenarios, what type of message or task do you think is the most appropriate to use? Why?

- A patient has an abnormal CT scan result. Their practitioner wants the patient to come back for a follow up visit.
- A patient is having compliance issues with their Diabetes nutrition plan. You want to remind yourself to book an appointment for the patient and to remind the practitioner to discuss with the patient any setbacks they have and methods for overcoming them.
- You want to remind another MOA to order lab supplies.

Evaluation

Complete the following questions.

1. Can you send a message to yourself?

2. In a patient's record, how do you know, at-a-glance, that there are active follow-up tasks outstanding for the patient?

3. Can you send a follow-up task to multiple people at once, with each recipient having to address the follow-up individually?

End of Module

Managing received documents

Introduction to this module

Purpose

This module covers how to manage incoming electronic faxes and paper documents. You learn how to find and edit electronic faxes, how to scan paper documents, and how link documents to patient records.

Objectives

Upon completion of this module, you will be able to:

- Scan documents
- Find and open your clinic’s incoming electronic faxes
- Edit faxed and scanned PDF documents using Adobe Acrobat
- Link a document to a patient’s record
- View and modify a document in a patient’s record
- Unlink a document from a patient’s record

Scanning documents (using Fujitsu ScanSnap scanners)

When you scan documents using a ScanSnap scanner, the process you follow depends on whether you are scanning single-page documents or multiple-page documents:

- **Single-page documents**: You place an entire pile of single-page documents into the scanner at once. The scanner scans all the documents, and then saves each document as a separate PDF file.
- **Multi-page documents**: You can scan only one multi-page document at a time. The scanner scans both sides of each page, and then saves the pages together as a single PDF file. Blank pages are removed automatically.

Tip: Before you start scanning, divide your documents into two separate piles:

- One pile for the single-page documents
- One pile for the multi-page documents. (Attach each multi-page document with a paperclip to keep them separated.)

Note: A one-page document with information on both sides is considered a multi-page document.

If you do not have a ScanSnap scanner, follow the instructions provided by your IT Hardware provider.

Scanning single-page documents

To scan single-page documents:

1. In the lower-right corner of your desktop, click the blue **Scan Snap** icon ( ), and then click **ONE FILE FOR EACH PAGE** (or the equivalent: the profile name may differ depending how your Scan Snap profiles are set up).
2. Place up to 10 single-page documents in the scanner.

Single pages should not have content on both sides. If a page is double-sided, then scan the page as a multi-page document.

3. On the scanner, press the blue **Scan** button. Your scanned documents are saved to **S:\Scans**.

Scanning multi-page documents

Tip: You do not have to flip over the pages to scan a double-sided document. The scanner automatically scans the back pages of the document.

To scan a multi-page document:

1. In the lower-right corner of your desktop, click the blue **Scan Snap** icon ( ), and then click **ONE FILE FOR ALL PAGES** (or the equivalent: the profile name may differ depending how your Scan Snap profiles are set up).
2. Place the multi-page document in the scanner.
3. On the scanner, press the blue **Scan** button. Your scanned document is saved to **S:\Scans**.

Practise: Scanning documents

- Scan a small pile of sample documents using the **ONE FILE FOR EACH PAGE** profile.
- Scan the same pile of documents using the **ONE FILE FOR ALL PAGES** profile.

Open your clinic's Scans folder to see the files each profile produced.

Finding and opening electronic faxes

Before you import faxes into patient records, review all electronic faxes in your incoming faxes folder.

The location of the incoming faxes folder is unique to your clinic. Your instructor will show you the location of your faxes folder.

The incoming electronic faxes folder typically resides on one computer in the clinic, while other computers contain mapped drives to the faxes folder. If this is the case, to open the electronic faxes folder, click the incoming electronic faxes link (**S:\Scans\Faxes**) on your desktop.

Best Practice: Managing non-patient faxes

- Delete irrelevant electronic faxes.
- Print electronic faxes that are not related to a patient

Record the steps you must follow to open your clinic's faxes folder:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Editing faxes and scans (using external PDF editing applications)

If you want to edit a faxed or scanned document (for example, to remove a fax cover page) using an external PDF editing software application (for example, Adobe Acrobat), you must open, edit and save the document from the Scans or Faxes folder. You can then attach the document to a patient's record in Wolf EMR.

Linking documents to patient records

You link patient-related faxes and scanned documents to patient records. When you link a document to a patient record, the document is accessible in the **Documents** tab of the patient's Medical Summary. You can also choose to notify the patient's provider that a new document is available for the patient.

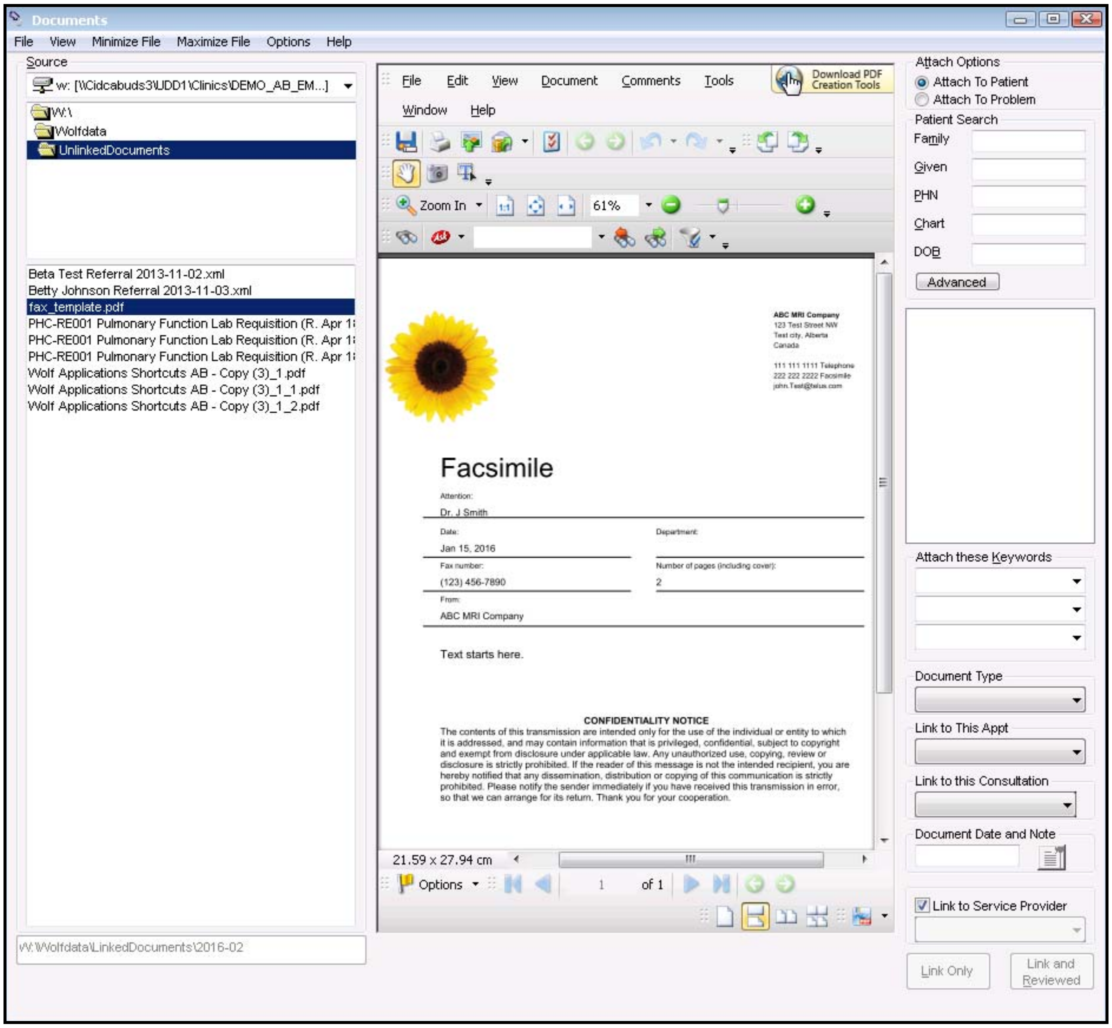
To link a document to a patient record:

1. On the Wolf EMR Launch page, click **Documents** ( ). The EMR displays the Documents window, with a list of unlinked documents displayed in the left pane.

In the **Source** area, ensure the correct location of your unlinked documents is selected:

W:\WolfData\Unlinked Documents

2. Refresh the list of unlinked documents: In the Documents menu click **Options** > **Refresh** or, on your keyboard, press **F5**.
3. In the left pane, click a document. The EMR displays a preview of the document.



> **Tip: Editing documents from the Documents window**
>
> If you do not have an external PDF editing application, and a document is up-side-down, in the Document's window, you can rotate the document before you link it to a patient's record:
>
> 1. In the left pane, select the document you want to edit. The EMR displays the selected document.
> 2. Above the document preview, click **Document** > **Rotate Pages**.
>
> **Note:** From the Documents window, you cannot use other document editing options unless you have purchased the PDF editing software from TELUS Health.

4. In the right pane, in the **Attach Options** area, select **Attach to Patient**.

5. In the **Patient Search** area, click **Advanced**, and then search for and double-click the patient.
6. If the patient search produces no results (because the patient has not yet been added to your system):

   a) At the top of the Patient Search window, click **New Patient** ( ). See “Adding patients” on page 9.

   b) Repeat Step 5 .
7. In the **Attach these keywords** drop-down lists, select one or more keyword to identify the document.

> **Tips for selecting keywords**
>
> - Document keywords help you identify and filter documents in the patient’s record. See “Viewing and modifying documents in patient records” on page 132.
> - You can enter a new keyword, if needed; however, it is best practice to select an option from the drop-down list. This way, documents are assigned consistent descriptions and are easier to identify and search for in the patient's record.
>
>   **Note:** Only users with administrator access can add keywords to the drop-down list. If there is a keyword that should be added, talk to your administrator.
> - If the document is an Ultrasound image or report for a prenatal patient, select the **Prenatal US** keyword. The document becomes available through the **Ultrasound Images** link on the patient’s Prenatal Record.

8. In the **Document Type** drop-down list, select the document type. Document Types help you identify and filter documents in the patient’s record. See “Viewing and modifying documents in patient records” on page 132.
9. To link the document to one of the patient's upcoming visits, in the **Link to This Appt** drop-down list, select the visit.
10. If the document is related to a referral (for example, a consult letter, or appointment confirmation), in the **Link to this Consultation** drop-down list, select the referral.

> If you link a document to a referral, the referral status changes from **Pending** to **Completed**, and reconciles the referral.

11. In the **Document Date and Note** area, enter the date the document was <u>created</u>. Use the format: **ddmmyy** or **dd/mmm/yyyy**.

12. To add notes about the document, click **Note** ( ).

13. If the document is to be reviewed by a provider who is not the patient's primary service provider, clear the **Link to Service Provider** check box and then, in the drop-down list, select the service provider.

14. Click one of the following options:

    - **Link Only**: to add the document to the patient's record and to notify the practitioner to review the document.
    - **Link and Reviewed**: to add the document to the patient's record without notifying the practitioner (typically used for scans that the practitioner has already viewed).

Practise: Linking documents

Open the Documents program, and then perform the following actions:

- In the left pane, select a test document
- Search for a test patient
- Review the different options available under the **Attach these Keywords** drop-down list.
- Review the different options available under the **Document Type** drop-down list.
- Click **Link Only**

Scenario: Linking documents

You are linking a document that contains ECG results for a patient. You want to make sure the document can be easily identified in the Documents tab of the patient's Medical Summary. How can you do this?

Viewing and modifying documents in patient records

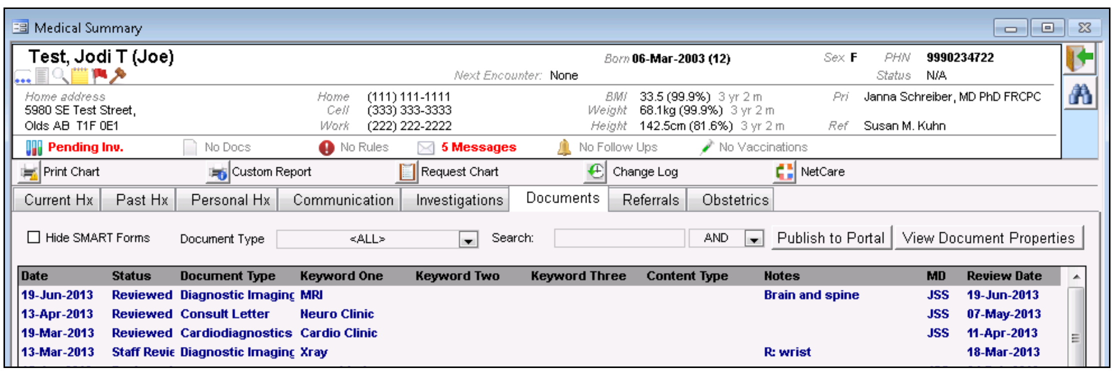
You can view documents linked to a patient in the patient's Medical Summary, in the **Documents** tab. If you need to modify a document, from the **Documents** tab, you can:

- Link the document to a referral or to an appointment
- Modify the creation date, keywords, notes, and document type

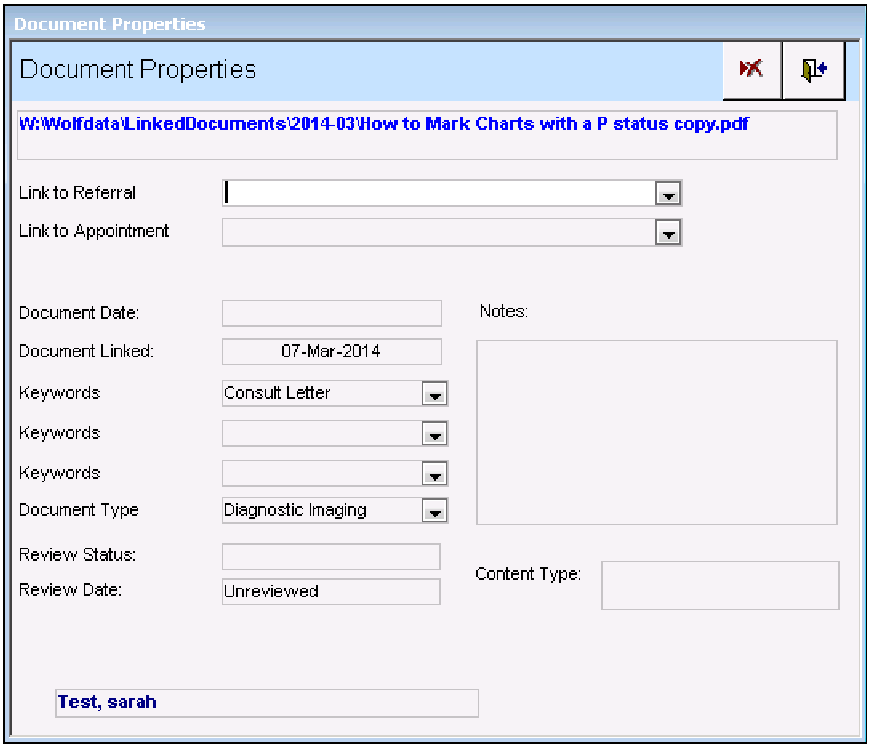
If you add a document to a patient's Medical Summary in error, you can unlink that document (and then link it to another patient), or you can delete the document. If you delete a document linked to the patient's record, you can always retrieve it from the **DeletedDocuments** folder.

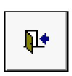
To modify a linked document's properties:

1. Open the patient's Medical Summary, and then click the **Documents** tab. The Document's tab displays a list of all a patient's linked documents.



2. To filter the list of documents, perform one or more of the following actions:
   - In the **Document Type** drop-down list, select the type of documents you want to view. For example, Diagnostic Imaging.
   - In the **Keyword** field, enter one or more keywords that matching documents should contain.
3. To view a document, double-click the document.
4. To modify a document's properties, click the document, and then click **View Document Properties**. The EMR displays the Document Properties window.



5. In the Document Properties window, enter or modify information as needed, and then click .

Unlinking documents from patient records

To remove a document from a patient's record, you must **unlink** the document from the patient. When you unlink a document, you have the choice to either:

- **Unlink the document** and move the document to the **UnlinkedDocuments** folder, OR
- **Unlink the document** and move the document to the **DeletedDocuments** folder.

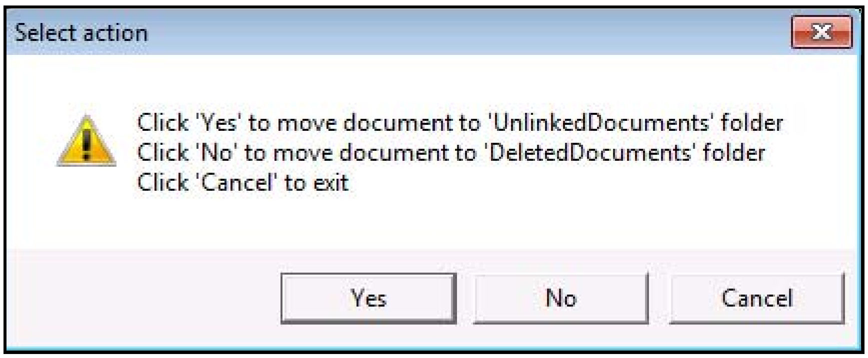
Discussion: Unlinking a document from a patient's record

Discuss the two options available when unlinking a document.

- In which situations would you **Unlink the document** and move the document to the **UnlinkedDocuments** folder?
- In which situations would you **Unlink the document** and move the document to the **DeletedDocuments** folder?

To unlink a document from a patient's record:

1. Open the patient's Medical Summary, and then click the **Documents** tab.
2. Click a document, and then click **View Document Properties**.
3. In the Document Properties window, click **Cancel Link** ().The EMR displays the Select Action window with the following prompt:



4. Perform one of the following actions:
   - Click **Yes** to unlink the document and to move the document to the **UnlinkedDocuments** folder.
   - Click **No** to unlink the document and to move the document to the **DeletedDocuments** folder. (You can retrieve the document from the **DeletedDocuments** folder if necessary.)

Scenario: Viewing and modifying documents from a patient's record

You realize that you linked a document to June Smith's record when you wanted to link it to Jane Smith's record. How do you remove the document from June Smith's record and then link it to Jane Smith's record?

Evaluation

Complete the following questions.

1. You receive an electronic fax that contains information for more than one patient. What are your next steps?

2. You want to scan a one-page document that has information on both sides. Which scanning profile must you select?
   a) ONE FILE FOR EACH PAGE
   b) ONE FILE FOR ALL PAGES
3. After you link a document to a patient record, where can you view that document?

4. You are linking a document to a patient's record, but the patient's practitioner hasn't reviewed the document. How do you link the document to the patient's record and notify the practitioner to review the document?

End of Module

Managing labs and other electronic investigations

Introduction to this module

Purpose

In this module you learn how to import electronically received labs and other investigations into Wolf EMR. You use the Import utility to import new electronic investigations and to match unrecognized patients to investigations.

As a front end staff member you cannot mark imported labs as reviewed. If a provider is unavailable to review their investigations, you can only redirect electronic investigations to other providers in the clinic for review.

Objectives

Upon completion of this module, you will be able to:

- Import electronic investigations
- View and navigate the Import History window
- Manage new patients who are added with investigations
- Redirect investigations to other providers in the clinic (when needed)

Importing electronic investigations

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

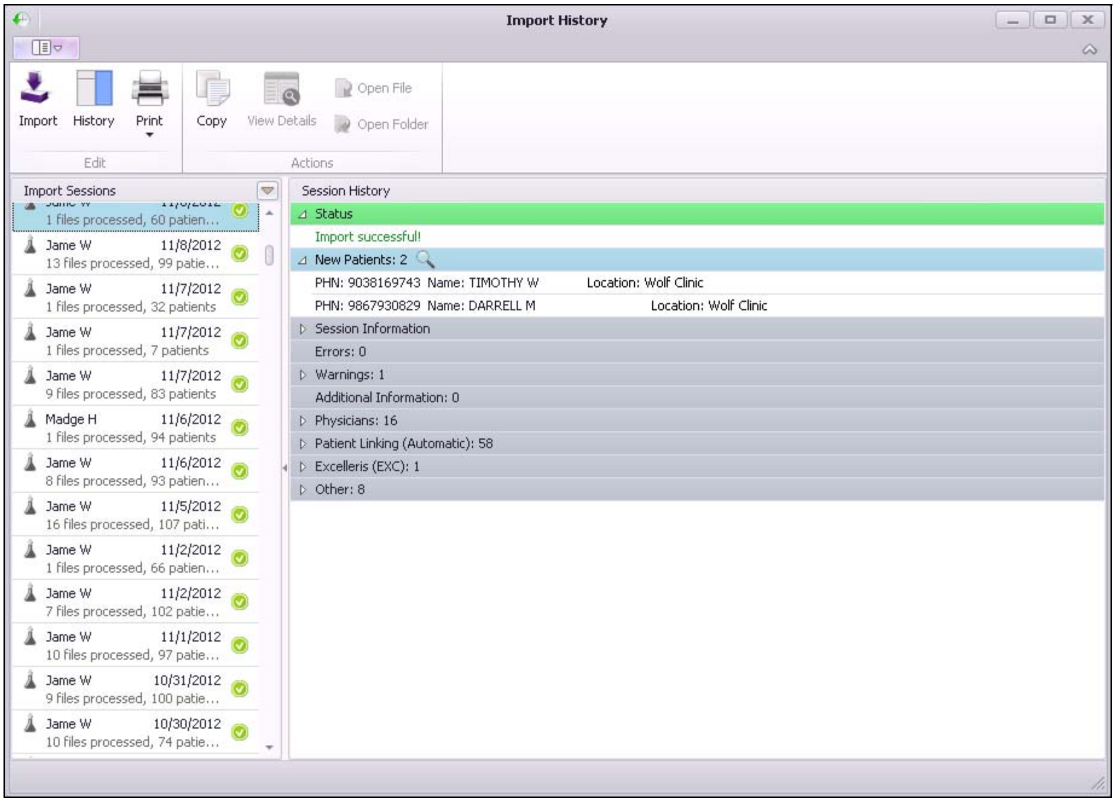
To receive the most up-to-date results, import 3 times daily. Wolf EMR imports all electronic investigations released since the last import.

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 investigations at similar times each day. This way you can ensure that lab downloads occur at regular intervals.

To import new investigations and reports:

1. On the Wolf EMR Launch page, click **Import**( ). The EMR imports investigations and reports from all labs and clinic you are set up to receive electronic imports from, and displays the imported investigations in the Import History window.



The Import History window contains the following information:

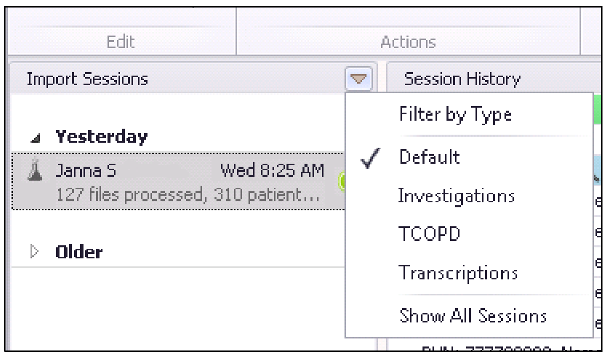
- **Import Sessions**: A list of users who have imported investigations, and on what dates and times those imports occurred.
- **Session History**: A status summary of your imports. Indicates if the current import is successful. Also lists new patients added with the most recent investigation import.

Multi-location clinics

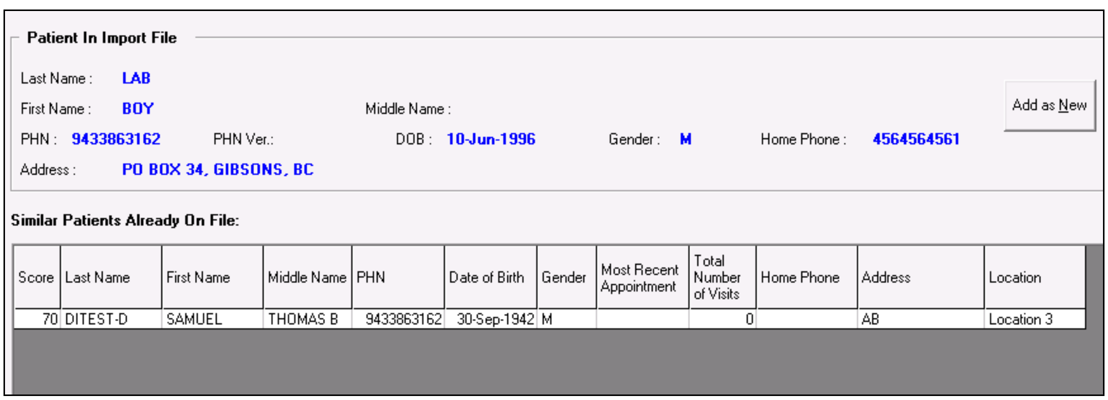
If your clinic has multiple locations, by default you see investigation import information only for locations that you are assigned to.

To view import information for all clinic locations:

- On the **Import Session** header, click the down arrow icon ( ) and then, in the list of filter options, click **Show All Sessions**.



2. If the import contains an investigation belonging to a patient who cannot be identified in your system, the EMR opens the Patient Match Selection Form window.



Perform one of the following actions:

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

> All imported investigations must be linked to patient records. If a lab comes in for a patient who is not part of a provider's panel, you must still add the patient to your EMR. You can then deactivate the patient if needed. See "Managing patients added during investigation imports" on page 141.

> **Multi-location clinics**
>
> 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 patients added during investigation imports" on page 141.

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

3. In the **Session History** area, review the status of your import to ensure the import was successful.

4. When you finish, click **Close** ( ).

> **Tip**: To view the Import History window without importing investigations, on the Wolf EMR Launch page, click the **Maintenance** tab, and then click **Import History** ( ).

Managing patients added during investigation imports

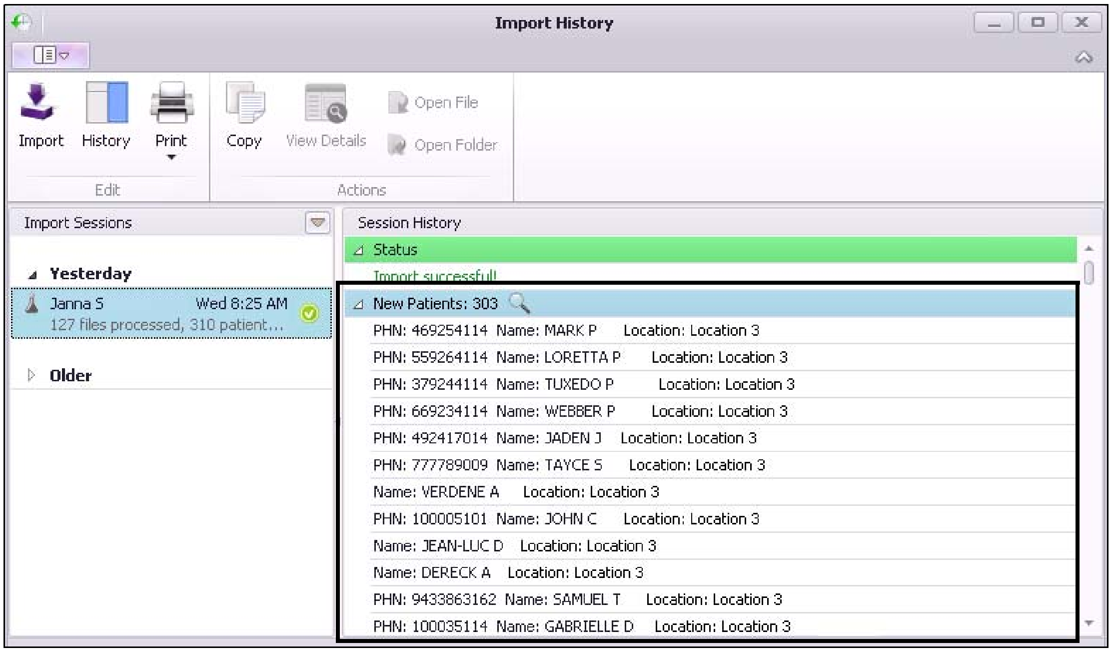
If new patients are added to your EMR during an investigation import (for example, if you receive labs for patients seen by a provider in a hospital), from the Import History window, you can:

- Modify patient demographic information
- Assign the patients to a primary MD
- Assign the patients to another location (if you have a multi-location clinic)
- Change the patients' status
- Deactivate the patients

To manage patients added during an investigation import:

1. Open the Import History window, see "Importing electronic investigations" on page 138.

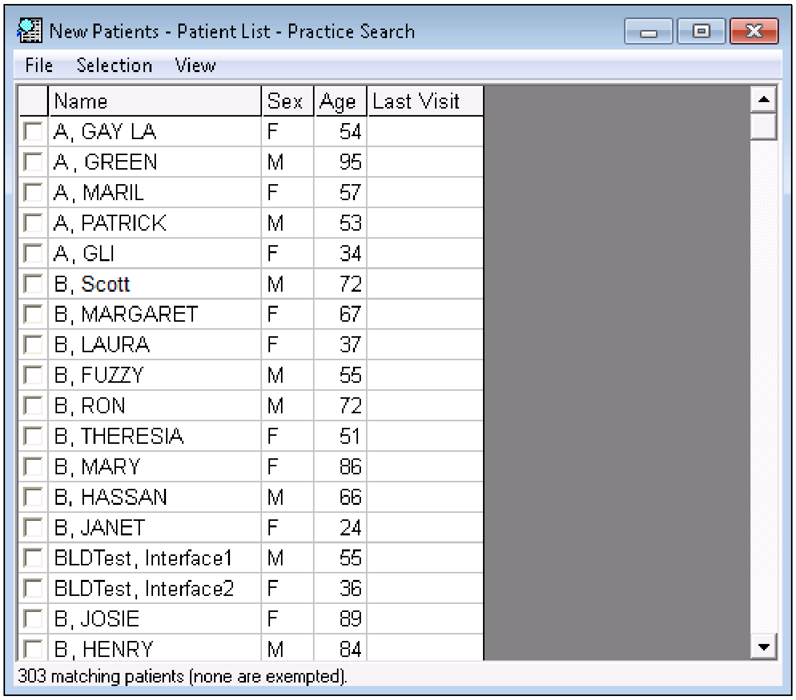
2. In the **Import Session** area, click the import you want to view and manage new patients for. The EMR displays information for the selected import in the **Session History** area, including a list of patients added to your system with the import.



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 added patients as a group:

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



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 selected patients.

Action	Description
Assign Primary MD	To assign the patients a primary provider.
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, patients are assigned to the location that their investigations were ordered from.
Update Patient Status	To update the patients' status (for example, to long term care (LTC) patients). **Note:** If the status you want is not on the list, a user with administrator authority can add statuses as needed.
Deactivate Selected	To deactivate the selected patients.

Scenario: Importing investigations

One of your practitioners completed a hospital shift a few nights ago. As a result, a large number of investigations for unidentified patients came in with today's investigation import. Because these patients are not patients of the clinic, how can you deactivate the patients so that they do not appear as part of the provider's patient panel?

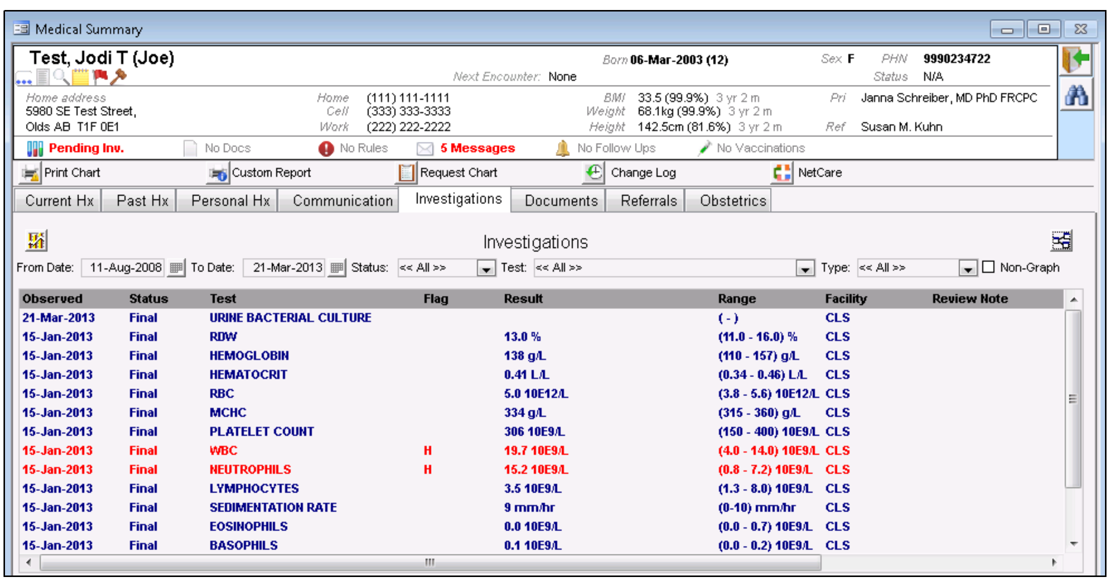
Redirecting electronic investigations

If a provider receives another provider's investigation(s) in error, or if a provider is not available to review their investigations, you can redirect a provider's investigations to another provider in your clinic.

You can redirect an electronic investigation only if it has not yet been reviewed. If you do not see the **Redirect** button, it means the investigation has been reviewed or was entered manually.

To redirect an electronic investigation to another provider:

1. Open the patient's Medical Summary, and then click the **Investigations** tab. The **Investigations** tab lists all of the patient's investigations (both reviewed and un-reviewed).



> **Tip**: You can also quickly access a list of un-reviewed investigations (for all patients) from your WorkDesk:
>
> - On your WorkDesk, in the **Incoming Results** area, click **Investigations**. The EMR opens the Investigation/Document In Basket window with a list of un-reviewed investigations displayed. You can filter the list, for example, by Practitioner or by Patient.

2. Double-click the investigation you want to redirect.
3. Click **Redirect**. The EMR displays the Select Service Provider window.
4. Select the practitioner you want to redirect the investigation to, and then click **OK**.

> **Scenarios: Redirecting electronic investigations**
>
> - Dr. Spark informs you that he received an investigation report for a patient, Jane Cleaver, but Jane Cleaver is not his patient. Jane Cleaver is a patient of Dr. Kane. How do you remove the investigation report from Dr. Spark's In Basket and move it to Dr. Kane's In Basket?
> - Dr. Smith calls in sick for today and asks that the provider on duty reviews her labs for her. How to you move Dr. Smiths un-reviewed investigations to the in basket of the provider on duty?

Evaluation

Complete the following questions.

1. Where do you access the Import utility in Wolf EMR?

2. You were on vacation last week, and you want to see when the last lab import occurred. How do you access this information?

3. You are in the Patient Match Selection Form window and are trying to match a patient to an investigation. However, none of the listed patients match the investigation. What is your next step?

4. You are trying to redirect an electronic investigation, but you do not see the **Redirect** button? What would be an explanation for this?

End of Module

Sending and managing outgoing referrals

Introduction to this module

Purpose

In this module 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

There are several ways to create a referral letter in Wolf EMR, you can use the Referral Letter Composer or you can use a Microsoft Word template (SMART form).

Objectives

Upon completion of this module, you will be able to:

- Initiate a referral
- Create a referral letter
- Send a referral letter
- Track and manage referrals after they are sent
- Add and modify consultants on your clinic's consultant's list

Initiating referrals

In Wolf EMR, before you create a referral letter, you initiate a referral for the patient. When you initiate a referral, you specify referral details such as the:

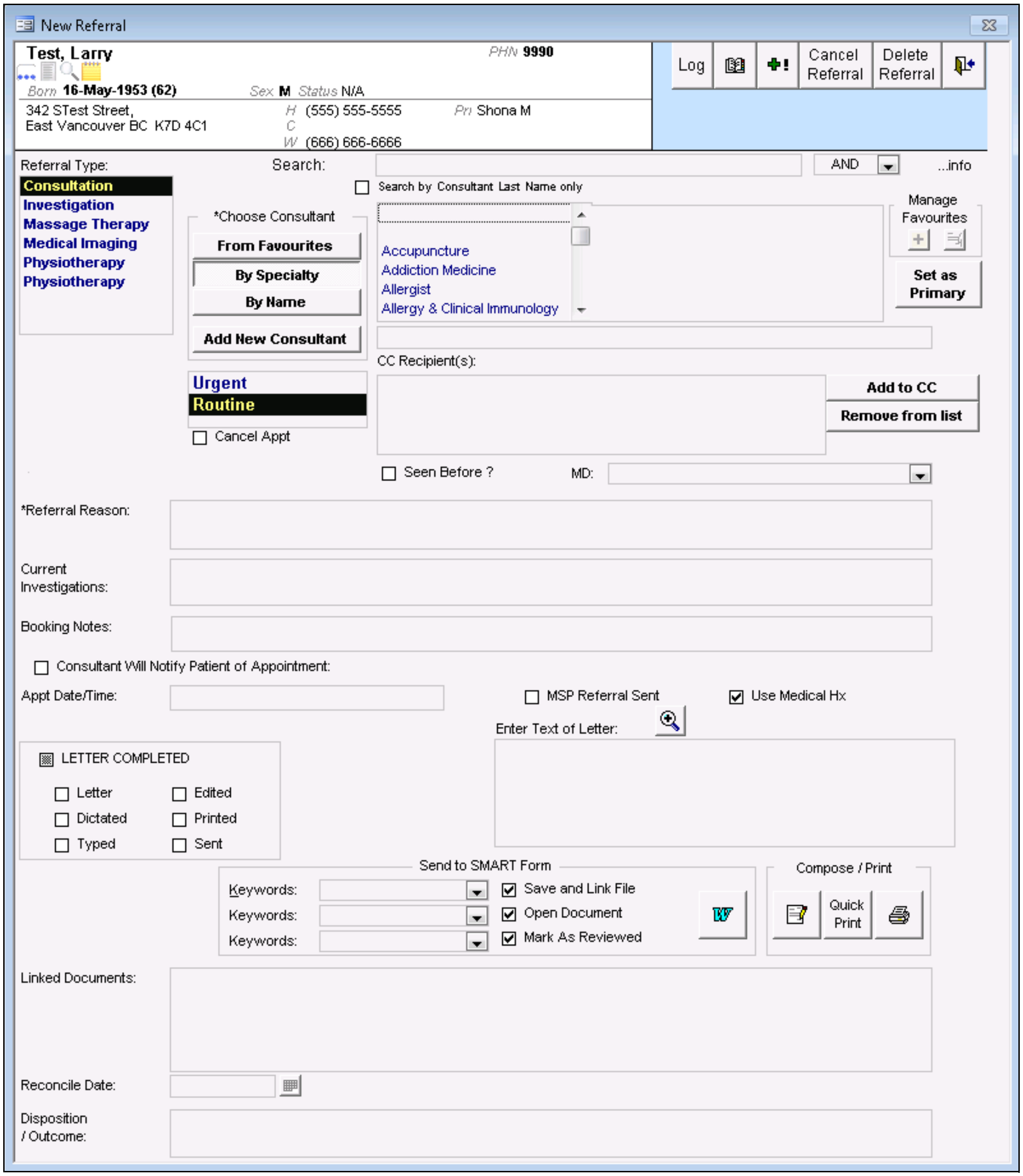
- Referral Type
- Consultant, clinic, or facility where you are referring the patient
- Urgency of the referral
- Referral reason

The referral details automatically populate the referral letter. The referral details also help you track and manage a referral.

To initiate a referral:

1. Perform one of the following actions:
   - If the patient's medical record is open (for example, the Vital Entry window or the Medical Summary window), right-click and then, in the SMART menu, click **New Referral**.
   - If you don't have the patient's medical record open, on your WorkDesk, in the **Referrals** area, click **New Referral**, and then search for and select the patient.

   The EMR displays the New Referral window.

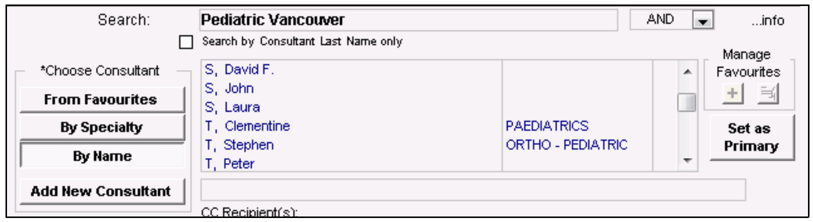


If a visit note has been created for the patient today, the EMR also displays a dialogue box with the following prompt: "Use current visit record to build referral letter?"

- To include, in the referral letter, visit notes entered for today's visit, click **Yes**.
- To start a blank referral letter, click **No**.

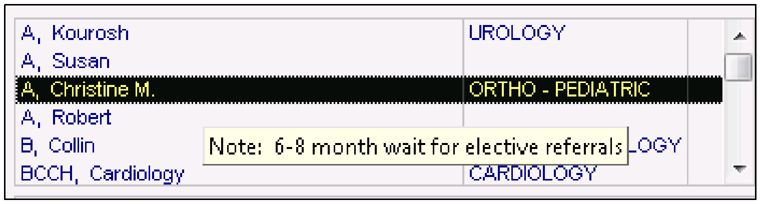
2. In the **Referral Type** list, click the type that best describes what the referral is for. The EMR filters the consultant list to display only consultants categorized under the selected type.

3. Using the following table, search for and select a consultant to refer to.

Search method	Steps
Search field	1. In the **Search** field, enter one or more criteria to search by (for example, **Pediatrics Kelowna**).  **Note:** Separate each search term with a space. 2. In the drop-down list to the right of the **Search** field, click either: ■ **AND**: To search for consultants with ALL of the criteria entered. ■ **OR**: To search for consultants with ANY of the criteria entered. 3. In the list of matching consultants, click the consultant you want. **Tip**: If you are searching by the consultant's last name, select the **Search by Consultant Last Name only** check box.
Favourite consultant search	To search your favourite consultants: 1. In the **Choose Consultant** area, click **From Favourites**. The EMR displays a list of your favourite consultants. 2. Click the consultant you want. **Tip**: You can enter criteria in the **Search** field to narrow the list. For example, enter **cardiology** to view only favourite cardiologists.
Specialty category search	To search for consultants by specialty: 1. In the **Choose Consultant** area, click **By Speciality**. The EMR displays a list of specialties. 2. Click the specialty you want. The EMR displays a list of consultants for the selected specialty. 3. Click the consultant you want. **Tip**: You can enter criteria in the **Search** field to narrow the search. For example, enter **Vancouver** to view only consultants from that city.

Tips for searching for consultants:

- If you do not know the consultant you want (for example, you do not know which specialists are available), search for and select "**Next Available Specialist**". You can specify a consultant at a later time.
- To view consultant notes (for example, on booking procedures or wait times): Click the consultant, and then hover your cursor over the consultant's name.



Note: Consultant notes are added by your clinic. For more information on how to add or modify a consultant's notes, see "Adding and modifying consultants" on page 165.

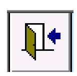
- To verify that you selected the correct consultant, in the top right corner of the window, click **...info**. The EMR displays details on the consultant you selected.

4. To set the selected consultant as the primary practitioner to receive the referral, click **Set as Primary**.
5. If applicable, enter practitioners to be CC'd on the referral letter: Search for and select a consultant, and then click **Add to CC**.
6. To define the Priority of the referral, click either **Routine** or **Urgent.**
7. Use the following table to enter information in the rest of the window.

Field/Check box	Description
Seen Before?	Select this check box if the patient was seen by the selected consultant, for the same referral reason.
MD	In the **MD** drop-down list, select the referring provider's name.
***Referral Reason** (Mandatory)	Enter the reason and/or diagnosis for the referral.
Current Investigations	Enter any investigations you are awaiting results on (including investigations that you have ordered today).

Field/Check box	Description
Booking Notes	Enter notes regarding the appointment booking. For example: ■ "Refer to cardiology" ■ "Expected wait time is 4mo" **Note:** Information entered here displays in the **Notes** column in your **Referral Appointments to be made** list. This information does not display in the referral letter.
Consultant Will Notify Patient of Appointment	If the consultant's clinic will notify the patient of the appointment time, select this check box. The EMR immediately adds an item to your **Patients to Notify** list. You then know to call the patient to indicate that they can expect a call from the consultant's office. **Tip**: If this check box is selected, by default, the patient does not display in the **Appointments to be Made** list. To have these patients to display in the **Appointments to be Made** list: 1. On the WorkDesk menu, click **Configuration** > **Configure Workdesk** (). 2. On the WorkDesk User preferences window, click the **Miscellaneous** tab. 3. Beside **Send 'Referral Notification' task to staff when 'Consultant to Notify' option is checked**, clear the **Apply Clinic Setting** check box, and then select the **User Setting** check box.
Enter Text of Letter	Enter the referral letter content. **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. 2. When you finish entering your letter content, click **Minimize Area** ().

Field/Check box	Description
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).

8. Perform one of the following actions:
   - To create and send a referral letter that contains select patient information or attached documents, click **Compose** (). See “Creating referral letters using the Referral Letter Composer” on page 154.
   - To create a basic referral letter that contains the patient’s entire medical profile, but no attachments (for example, if you are sending the patient to the hospital, and the letter is for the emergency team), click . See “Creating referral letters using a Microsoft Word template (SMART form)” on page 158.
9. When you finish the referral, click .

Practise: Initiating a referral

A provider’s patient is experiencing severe abdominal pain for which they cannot find a cause. The provider wants to refer the patient to a gastroenterologist.

Initiate an urgent referral to a gastroenterology specialist.

Creating referral letters

After you initiate a referral, you can create a referral letter using the Referral Letter Composer or using a basic Microsoft Word letter template (SMART form). The method you use depends on what information you want to include in the referral letter.

Method	When to use...
Referral Letter Composer	Use if you want the referral letter to have: ■ Attached documents (for example, medical reports) ■ Only selected information from the patient's Medical Summary
Microsoft Word template	Use if you want the referral letter to have: ■ No attached documents ■ The patient's entire medical history

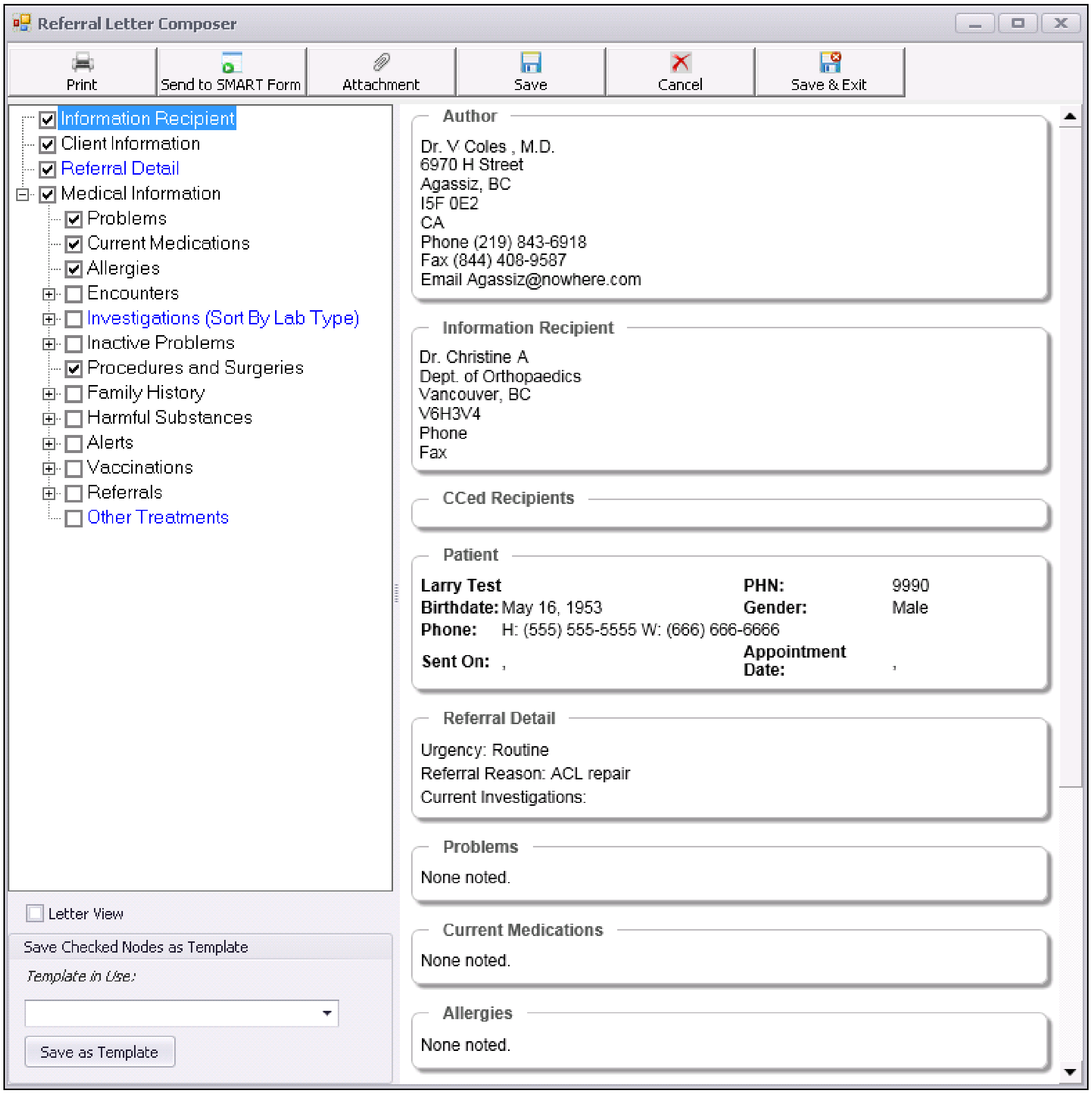
Creating referral letters using the Referral Letter Composer

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 148.

> To create a letter based on a previously started referral:
>
> 1. Open the patient's Medical Summary, and then click the **Referrals** tab.
> 2. 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. Click **Compose** ( ). The EMR displays the Referral Letter Composer window.



3. To select what medical history information to include in the letter, in the left pane:

   a) Select the check box beside the Medical Summary categories you want to include (for example, Current Medications).

   b) Clear the check box beside the Medical Summary categories you do not want, but are selected by default.

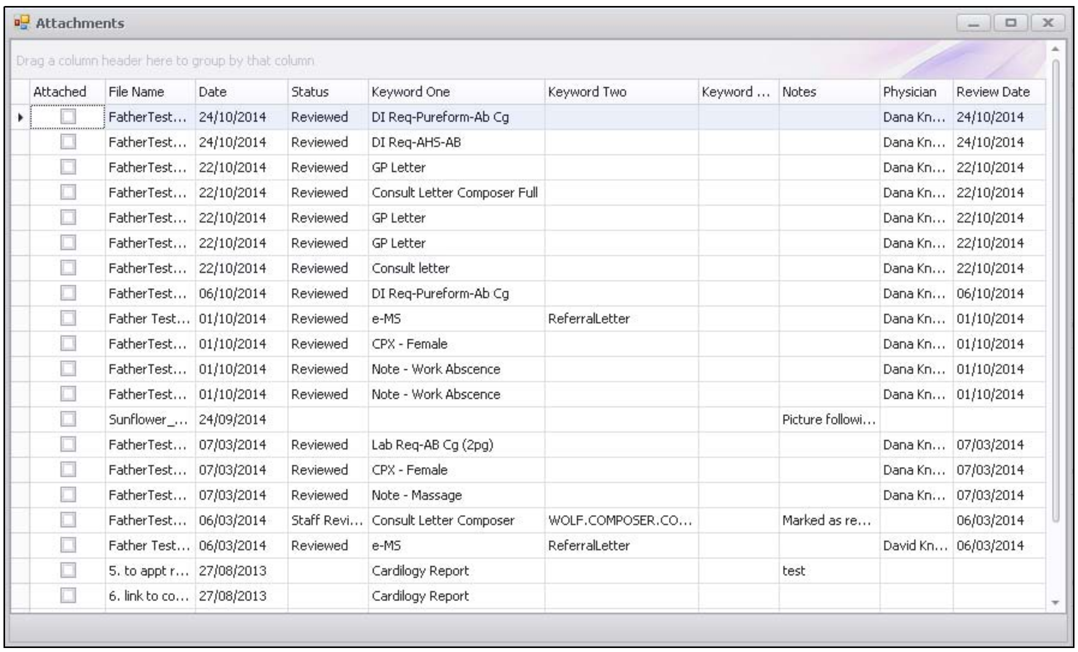
   c) To include only specific items from a Medical Summary category, expand the category, and then select the items you want.

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 investigations.
- **Other Treatments**: You can enter details of the patient's non-medication treatments.

4. To attach documents to the referral letter:

   a) At the top of the window, click **Attachment** ( ). The EMR displays a list of the patient's linked documents.



Attachments

Drag a column header here to group by that column

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 Abscence				Dana Kn...	01/10/2014
☐	FatherTest...	01/10/2014	Reviewed	Note - Work Abscence				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 appt r...	27/08/2013		Cardilogy Report			test		
☐	6. link to co...	27/08/2013		Cardilogy Report					

You can attach only files that are available in the **Documents** tab of the patient's Medical Summary.

   b) Select the documents you want to include with the referral letter.

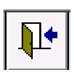
   c) Click **Close** ( ).

5. To print, fax, or save the referral letter as a PDF, click **Print** () and then, in the Print Referral window, perform one of the following actions:

> **Tip**: To view what the letter will look like when it prints, select the **Letter View** check box.

- To send the referral letter to your default printer or fax machine, click **Quick Print**.
- To print to a specific printer or fax machine, click **Print**.
- To save the referral letter as a PDF file, select the **Collate to PDF** check box, and then click **Quick Print**.

> If you are printing or faxing the referral letter, ensure that the **Collate to PDF** check box is cleared.

6. To close the Referral Letter Composer, click .
7. To indicate that the letter is completed, in the referral window, select the **LETTER COMPLETED** check box. The EMR adds the patient to the **Referral Appointments to Be Made** list.
8. Click .

> **Practise: Creating and printing a referral letter**
>
> You have initiated a referral to a gastroenterologist and now you want to compose and send the referral letter.
>
> Create a referral letter using the Referral Letter Composer. Include in the letter:
>
> - The patient's problem list
> - All of the patient's current medications
> - The patient's past surgeries and procedures
> - Two of the patient's investigations
> - An attachment such as a CT scan
>
> Print the letter, and mark the status as completed, printed, and sent in the New Referral window.

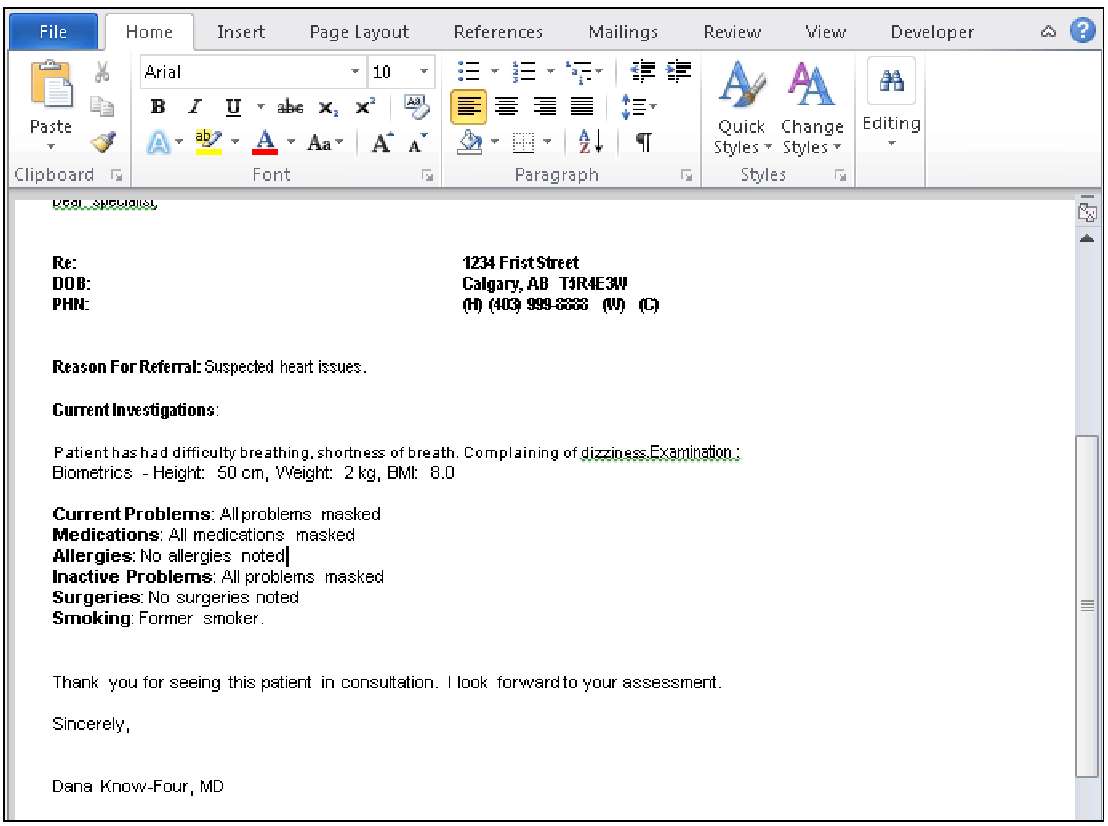
Creating referral letters using a Microsoft Word template (SMART form)

To create a referral letter using a Microsoft Word template (SMART form):

1. Initiate a referral and complete the New Referral details. See “Initiating referrals” on page 148.

> To create a letter based on a previously started referral:
>
> 1. Open the patient’s Medical Summary, and then click the **Referrals** tab.
> 2. 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. Click . The EMR opens Microsoft Word with your referral letter text inserted in a letter template.



3. Enter or modify letter text, or modify the format of your letter using the various tools available in Microsoft word.
4. To print or fax the referral letter, click **File** > **Print**.
5. Click **Save** ( ), and then close the window. The EMR saves the letter in the **Documents** area of the patient’s Medical Summary.

6. To indicate that the letter is completed, in the referral window, select the **LETTER COMPLETED** check box. The EMR adds the patient to the **Referral Appointments to Be Made** list.

Tracking and managing referrals

You can track and manage new and pending referrals from your WorkDesk. The **Referrals** area contains several links to patient lists, including lists of patients who have:

- Referral appointments to be made
- Referral notifications (Patients To Notify list)

You can also monitor and manage all of your clinic's un-reconciled referrals from the Referral List.

Tracking and updating referrals awaiting appointments

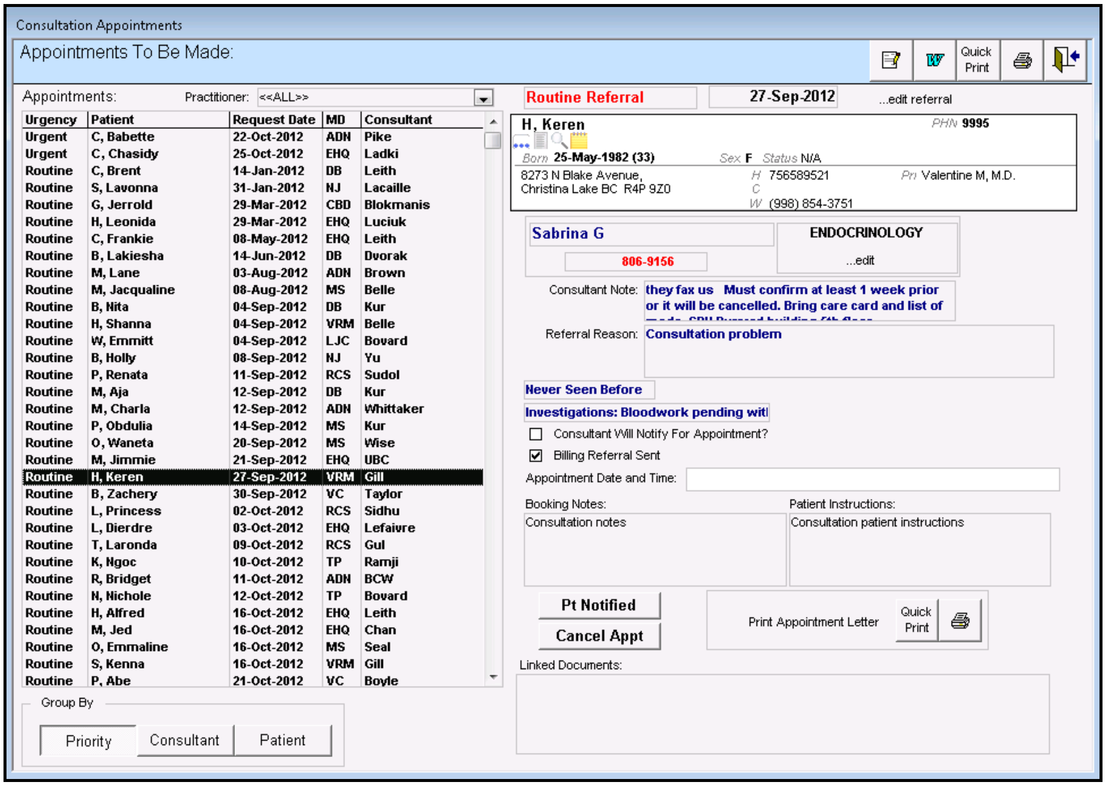
Using the **Appointments To Be Made** list, you can track patients who are waiting for consult appointments.

When you are notified that a patient has been booked for an appointment with the consultant, from the **Appointments To Be Made** list, you can update the referral with the appointment date and time. The EMR removes the patient from your **Appointments To Be Made** list and adds the patient to your **Patients To Notify** list.

To view and update referrals awaiting appointments:

1. On your WorkDesk, in the **Referrals** area, click **<#> referral appointments to be made**. The EMR displays the Appointments To Be Made window.

2. In the left pane, click the patient. The EMR displays the patient's referral details.

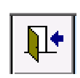


3. In the **Appointment Date and Time** field, enter the appointment date and time in the following format: **DD-Mmm-YYYY HH:MM AM/PM**.

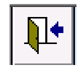
4. If you have notified the patient of their appointment, click **Pt Notified**. The EMR adds the following information to the Response Log: **Patient Notified (<your name>/MM/DDD/YYYY HH:MM)**.

5. If the referral is considered complete, reconcile the referral:

   a) At the top of the referral detail area, click **...edit referral**. The EMR displays the Existing Referral window.

   b) In the **Reconcile Date** field, enter a date, and then click .

> If you are expecting a report or letter back from the consultant, you do not have to manually reconcile a referral. When the consult report or letter is linked to the patient's referral, the EMR reconciles the referral automatically. See Step 10 in "Linking documents to patient records" on page 128.

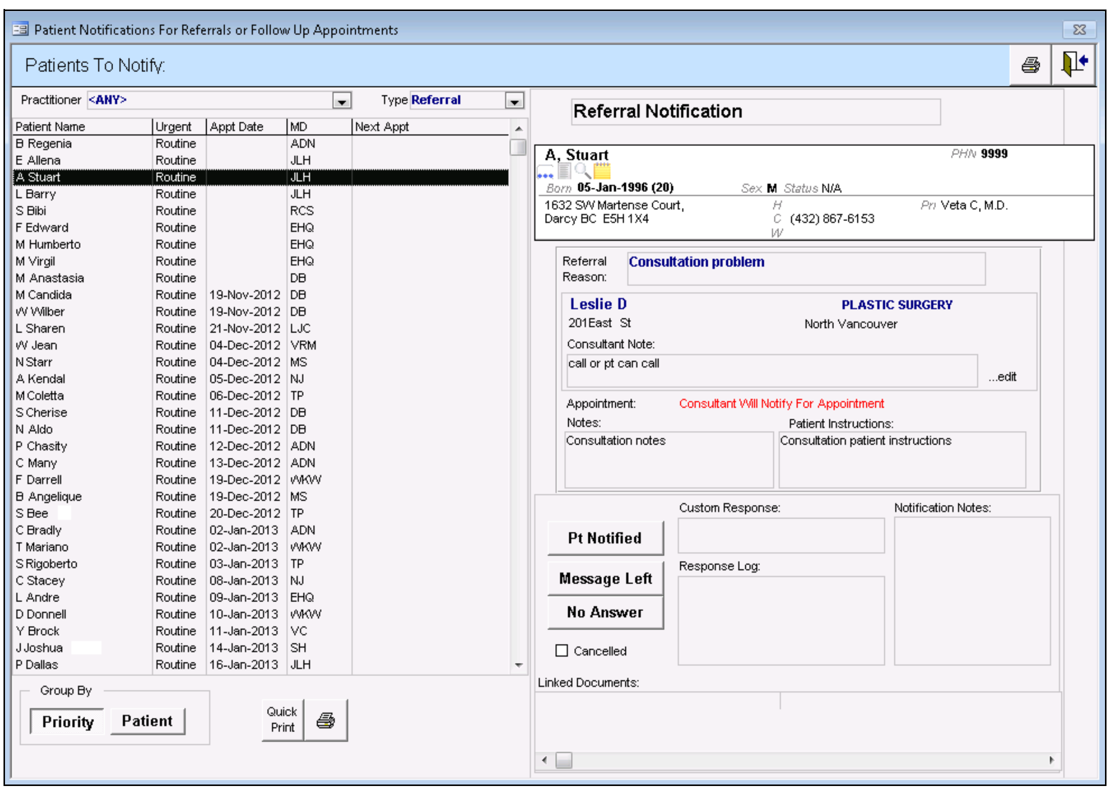
6. To close the Appointments to be Made window, click . The EMR removes the patient from the **Appointments To Be Made** list. If the patient has not been marked as notified, the EMR adds the patient to the **Patients To Notify** list.

Managing patients who need to be notified of appointments

The **Patients to Notify** list contains all patients who have an Appointment Date and Time entered in the referral but have not yet been notified. When you contact the patient, from the **Patients to Notify** list, you can record that the patient has been notified.

To manage patients who need to be notified of booked appointments:

1. On your Workdesk, in the **Referrals** area, click **<#> referral notifications**. The EMR displays the Patients To Notify window, filtered to display only referral notifications.
2. Click a patient in the list. The EMR displays the patient's referral details.



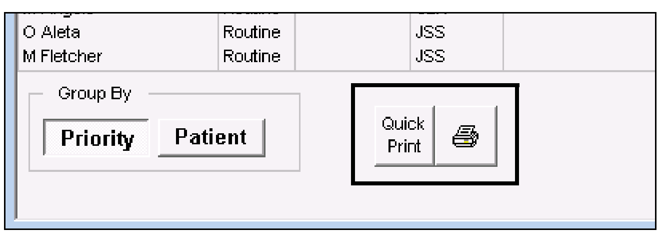
3. Use the following table to enter information into the **Response Log**:

Field	Description
Pt Notified	Click to indicate that you notified the patient. The EMR adds the following information to the Response Log: **Patient Notified (<your name>/MM/DDD/YYYY HH:MM)**. **Note:** After you close the Patients To Notify list, the EMR removes the patient from your Patients To Notify list.
Message Left	Click to indicate that you called the patient and left a message. The EMR adds the following information to the Response Log: **Message Left (<your name>/MM/DDD/YYYY HH:MM)**.
No Answer	Click to indicate that you called the patient, but there was no answer. The EMR adds the following information to the Response Log: **No Answer (<your name>/MM/DDD/YYYY HH:MM)**.
Custom Response	Enter a custom response specific to this entry
Notification Log	Enter any notification notes.
Cancelled	If the notification was entered by mistake, select this check box. When you close the Patients To Notify window, the EMR removes the patient from your Patients To Notify list.

Tip: Printing a referral notification letter

If you have made numerous calls to a patient, and still cannot reach the patient, from the Patients to Notify window, you can print a referral notification letter:

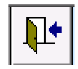
- In the Patients to Notify list, click the patient and then, at the bottom of the list, click a print option.



4. If the referral is considered complete, reconcile the referral:

   a) In the Patients to Notify window, click the patient's SMART patient banner. The EMR opens the patient's Medical Summary.

   b) Click the **Referrals** tab and then, in the list of referrals, double-click the referral. The EMR displays the Existing Referral window.

c) In the **Reconcile Date** field, enter a date, and then click .

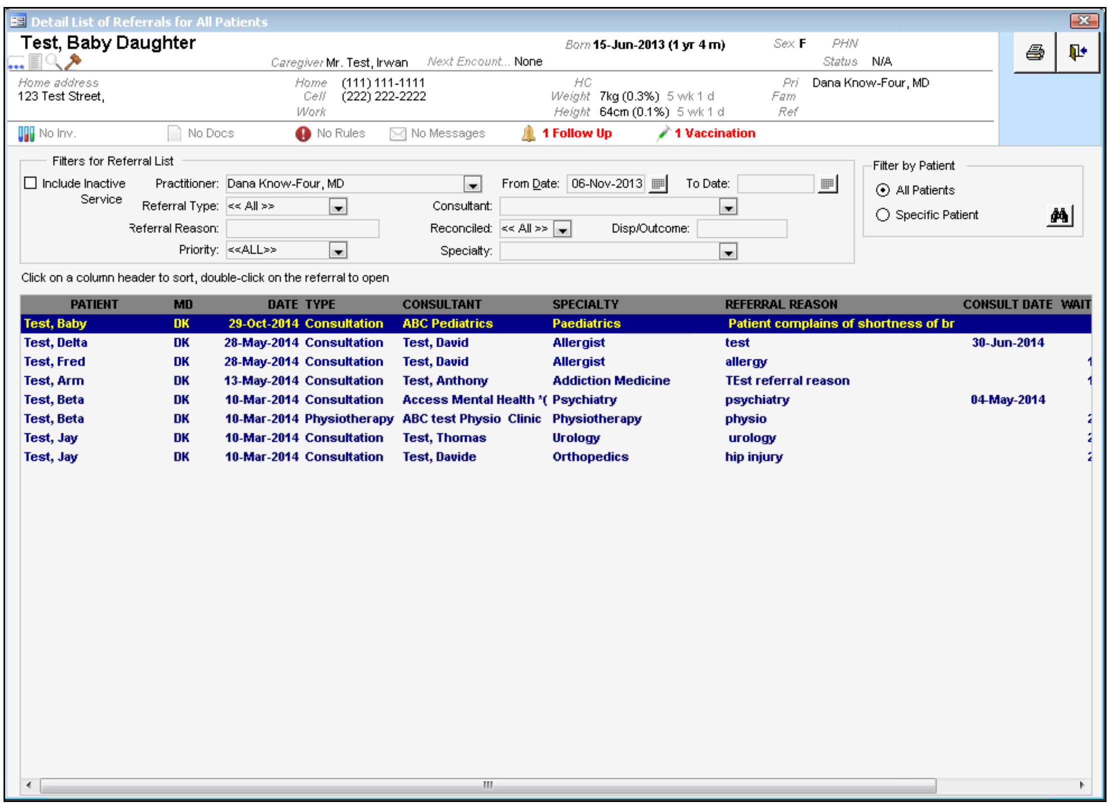
> If you are expecting a report or letter back from the consultant, you do not have to manually reconcile a referral. When the consult report or letter is linked to the patient's referral, the EMR reconciles the referral automatically. See Step 10 in "Linking documents to patient records" on page 128.

Managing referrals using the Referral List

You can use the Referral List to view and manage outstanding referrals for the entire clinic. You can also find a specific patient's outstanding referrals and then modify the referral's information or status.

To view and manage outstanding referrals using the Referral List:

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 outstanding referrals for all patients.



Tips for viewing the Referral List

- To view a specific patient's list of outstanding referrals, In the **Filter by Patients** area, select **Specific Patient**, and then find and select the patient in the Patient Search window.
- If the list of referrals is extensive, you can filter the list using the options available in the **Filters for Referral List** area.
- To re-sort the order of the referral list, click the header of the column you want to sort the list by.

2. 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.
3. To reconcile a referral, in the Existing Referral window, in the **Reconcile Date** field, enter a date.

If you are expecting a report or letter back from the consultant, you do not have to manually reconcile a referral. When the consult report or letter is linked to the patient's referral, the EMR reconciles the referral automatically. See Step 10 in "Linking documents to patient records" on page 128.

Scenario: Viewing the Referral List

A particular specialist seems to be lagging in their response time for booking appointments. You want to view all referrals you have sent to this specialist to see if this is indeed the case. How can you view a list of all un-reconciled referrals for that specialist?

Managing consultants

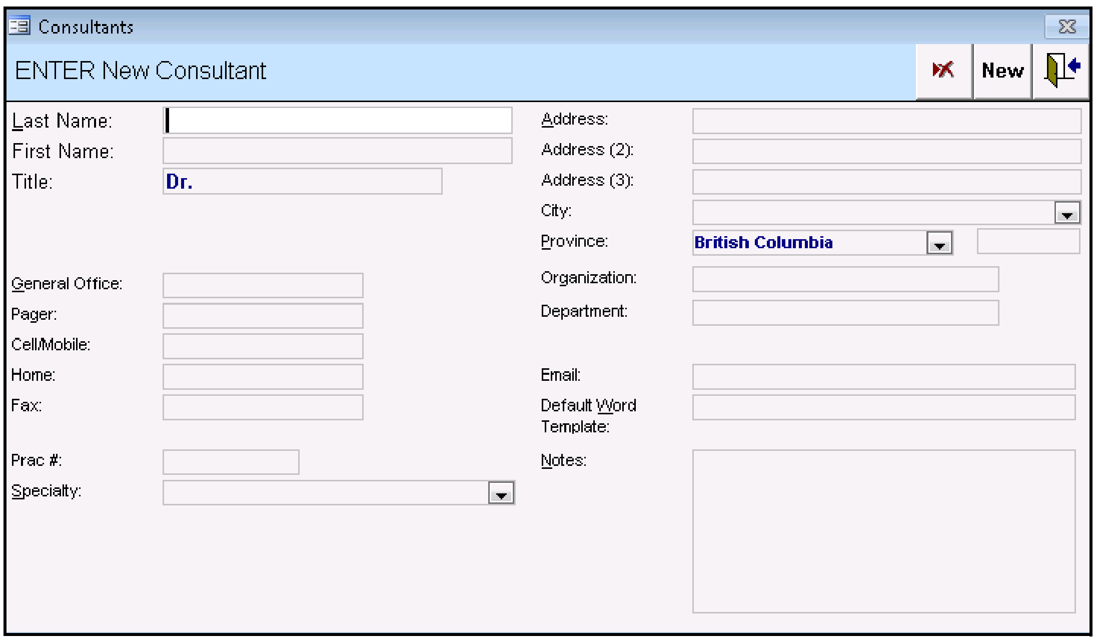
You can refer patients only to consultants or clinics who are in your clinic's consultant list. If the consultant you want is not in the consultant's list, you can add a consultant as you create a referral. If you find the consultant you want, but see that any of the consultant's details are incorrect, you can edit the consultant's details from a referral.

If you refer to a particular consultant regularly, you can identify the consultant as a favourite.

Adding and modifying consultants

To add or modify a consultant:

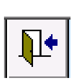
1. Start a referral. See "Initiating referrals" on page 148.
2. Perform one of the following actions:
   - To modify a consultant:
     a) In the consultant search area, search for and click the consultant.
     b) Click **...info**. The EMR displays the Consultant Information window.
     c) Click ...**edit**. The EMR displays the Edit Consultant Information window.
   - To add a consultant, under **Choose Consultant**, click **Add New Consultant**. The EMR displays the ENTER New Consultant window.



3. Enter or modify the consultant's information.

Tips for entering consultant information:

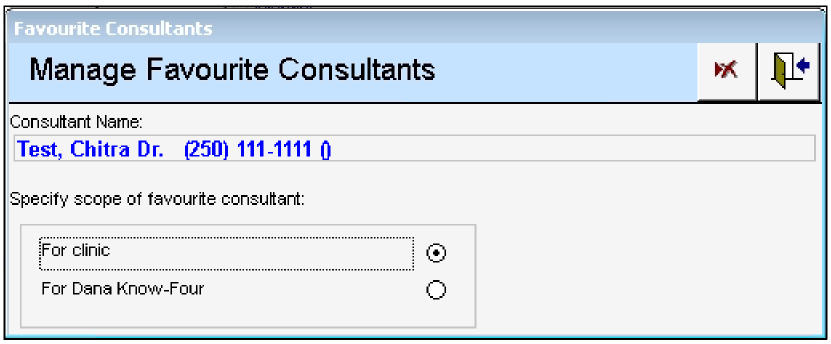
- Always enter a **Title** (for example, Dr., Mr., Mrs.).
- To document special referral instructions for the consultant (for example, on booking procedures or wait times), in the **Notes** area, enter the instructions.

4. Click . The EMR updates your clinic's consultants list.

Adding consultants to your favourites

To add a consultant to your favourites list:

1. Initiate a referral, and then search for and select a consultant. See "Initiating referrals" on page 148.
2. In the **Manage Favourites** area, click **Add currently selected consultant to favourite list** ( ). 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**: To add the consultant to the Favourite Consultants list of all users in the clinic.
   - **For <your name>**: To add the consultant to your Favourite Consultants list only.

Practise: Adding consultants to your favourites list

- Initiate a referral to a consultant you regularly refer to.
- Add the selected consultant to your favourites list.

Evaluation

Complete the following questions.

1. When initiating a referral to a pediatrician, how can you search for a list of Kelowna-based pediatricians?

2. If you are creating a referral letter using the Referral Letter Composer, can you add specific lab results to the printed letter? How?

3. How do you view a list of the referrals that have been un-reconciled for more than four months?

End of Module

Managing incoming referrals (Specialists)

Introduction to this module

Purpose

In this module you learn how to track, manage, and respond to incoming referrals in Wolf EMR. No matter how referrals are received, you can track incoming referrals using:

- The Incoming Referrals list
- Messages
- Patient lists

Using SMART forms, you can send notifications to referring clinics. Using messages, you can track calls made in response to referrals.

Objectives

Upon completion of this module, you will be able to:

- Link an incoming referral to a patient and notify the provider to review the referral
- Track referred patients using patient lists
- Send SMART form notification letters to referring clinics
- Record notifications and phone calls made to patients and referring clinics using messages
- Manage declined referrals

Linking incoming referrals to patients

When you receive a referral letter, your first step is to link the document to a patient record and assign **Incoming Referral** as the **Document Type**. If the patient is not yet added to your system, you can add the patient as you are linking the document.

After you define a referral document as an **Incoming Referral**, the referral displays in the provider's **Incoming Referrals** list.

> If you do not define the document as an **Incoming Referral**, the referral letter displays in the practitioner's **New Documents** list instead.

To link an incoming referral to a patient:

1. On the Wolf EMR Launch page, click **Documents** ( ). The EMR displays the Documents window.
2. Link the referral letter to a patient as you do other documents. See "Linking documents to patient records" on page 128. The following exception applies to referral letters:
   - In the **Document Type** drop-down list, select **Incoming Referral**.
3. If the patient is not yet in your system, you can add the patient from the Documents window:

   a) In the **Patient Search** area, click **Advanced**, and then click **New Patient** ( ) or, on your keyboard, press **F9**.

   b) In the Patient Maintenance window, enter the patient's information. See "Adding patients" on page 9.

> **Tips for adding referred patients**:
>
> - In the Patient Maintenance window, ensure you record the patient's referring provider, and the referral expiry date.
> - If the referring provider you want is not on the consultants list, you can add the referring provider to the consultants list from the Appointment Scheduler:
>   1. On the Appointment Scheduler menu, click **Configure** > **New Referral Consultant (Quick Add)**.
>   2. Enter the referring provider's information, and then click **Save**.

   c) In the Documents window, search for and select the added patient.

4. When you finish entering information in the Documents window, click **Link Only**. The EMR adds the referral to the **Incoming Referrals** list, and the provider can now review and respond to the referral.

> **Practise: Linking referrals to patients**
>
> - Scan a test document and then link the document to a test patient as an incoming referral.

Viewing and responding to accepted, declined, and “need more information” referrals

When you link a referral letter to a patient’s record, the provider is notified on their WorkDesk via the **Incoming Referrals** list. The provider can then view and respond to the referral. When the provider responds to the referral, you receive a message indicating if the referral is accepted, declined, or requires more information. From the message, you can perform a number of actions.

To view and respond to your referral-related messages:

1. On your WorkDesk, in the **Messages** area, double-click the message. The EMR displays the message details. See “Managing messages” on page 114.
2. From the message, you can perform one or more of the following actions:
   - Modify the patient’s demographic information (for example, if the provider declined the referral, you can change the patient’s Status to Inactive): On the message, in the SMART patient banner, click **View patient demographic information** ( ). See “Managing declined referrals” on page 180.
   - Add the patient to a patient list (appointment waiting list). See “Tracking referred patients using patient lists” on page 172.
   - Record any calls made or notifications sent to the referring clinic or patient. See “Recording what notifications have been sent to referring clinics” on page 179.

Tracking referred patients using patient lists

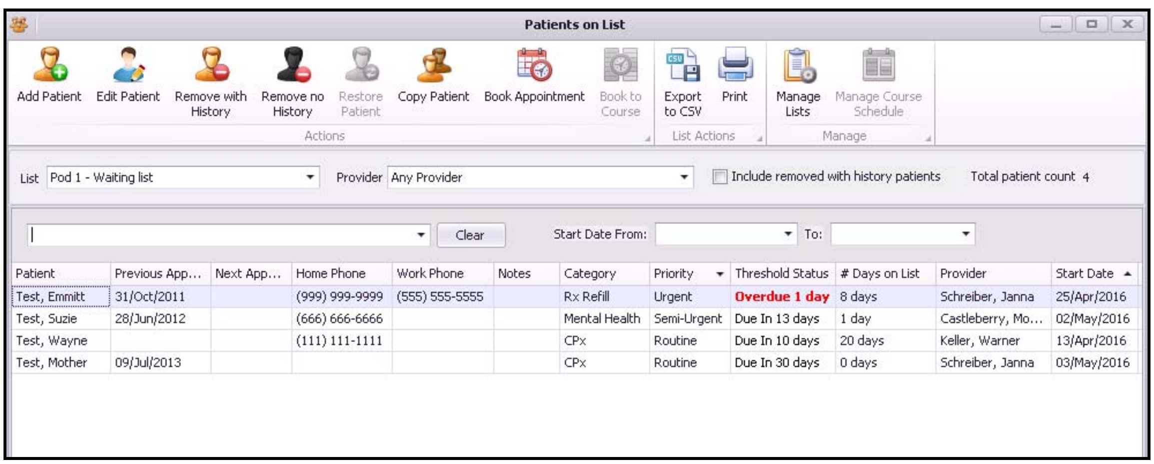
Wolf EMR patient lists are running lists of patients, where you manually add, remove, and restore patients as needed. You can use patient lists to track patients waiting for appointment bookings, and to track patients at different stages in the referral process.

For listed patients, you can:

- Enter notes
- Assign a category and priority
- Book an appointment
- View the appointment status of an appointment booked from the list
- View if the patient is overdue or near-due for an appointment booking

When you book a patient who is on a list for an appointment, you can choose to remove the patient from the patient list automatically.

Your clinic can create as many patient lists as you want, and tailor the lists to suit your workflow. For example, you can have an appointment waiting list for Priority 2 patients, an appointment waiting list for Priority 3 patients, a cancellations list, a list tracking patients who have been called (with no answer), and so on.

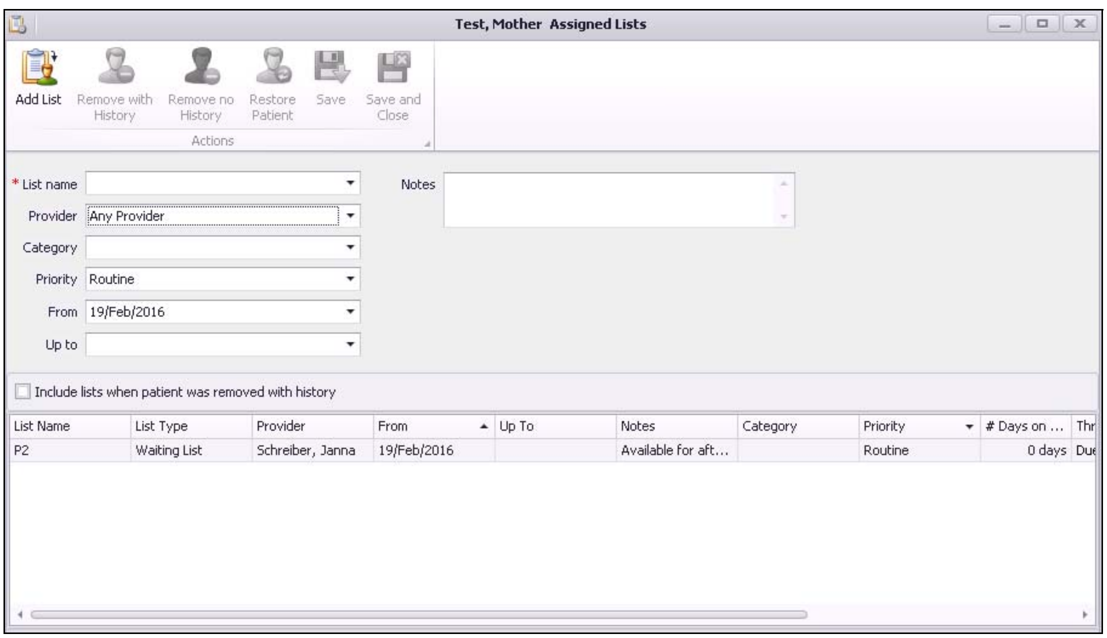


Adding patients to patient lists

You can add a patient to a patient list either from the Appointments Scheduler or from the Patient Maintenance window. Most often, you add a patient to a waiting list after you receive a provider's response message to the referral. For example, the provider sends a message indicating that the referral is accepted and that the patient is a Priority 2. You can then add the patient to your Priority 2 waiting list from the message itself (via the Patient Maintenance window).

To add a patient to a patient list:

1. Perform one of the following actions:
   - If you are adding a patient to the waiting list in response to a message, from the message open the patient's Patient Maintenance window: On the message, in the SMART patient banner, click **View patient demographics information** () or, on your keyboard, press **F9**.
   - If you do not have a patient message open, on the Appointment Scheduler, in the **Patient Search** area, search for and select a patient.
2. On your keyboard, press **Ctrl**+ **G**. The EMR displays the Assigned Lists window for the patient.



> If the patient is currently on one or more patient lists, the list information is displayed at the bottom of the Assigned Lists window.

3. In the Assigned Lists window, select the **List Name**, **Provider**, and **Category** (if applicable), and enter any **Notes**.

4. Click **Save and Close** ().

Viewing patient lists

You can view your clinic's patient lists from the Appointment Scheduler. You can sort a list by any column. You can also narrow the list using a number of filter options.

To display the Patients on List window:

1. On the Appointment Scheduler menu, click **Patients > Patient Lists** or, on your keyboard, press **Ctrl** + **W**. The EMR displays the Patients on List window with the general Waiting List displayed.

- By default, listed patients are sorted first by priority (with Urgent patients displaying at the top), and then by the date patients were added to the list (patients who have been on the list longer are displayed higher on the list).
- The **Threshold Status** column indicates if patients are Near Due or Overdue for appointments.

2. If your clinic has more than one patient list, in the **List** drop-down list, select the patient list you want to view.
3. To display only patients assigned to a specific provider, in the **Providers** drop-down list, click the provider's name.
4. To view detailed information about a patient, click the patient's name, and then perform one of the following actions:
   - To view the patient's demographic information, press **F9.** The EMR displays the Patient Maintenance window for the patient.
   - To view the patient's Medical Summary, press **F7**.
   - To view or enter the patient's vitals for today, press **F6**.

Tips for viewing and using patient lists

- To sort the list by the contents of a column, click the column header.
- To filter the list using a search term, in the field to the left of the **Clear** button, enter a word or phrase. The EMR filters the list to display only patients who contain that word or phrase.
- To filter the list by the contents of a column, hover your curser over the column header, click the icon, and then click the item you want to filter the list by.
- To filter the list to display only patients who were added to the list during a specific time frame, in the Start Date **From** field and the **To** fields, enter the date limit.
- To move a column, click a column header and then drag the column to its new location.

  Note: As soon as you close the Appointment Scheduler or the Patients on List window, the columns revert back to their default positions.
- To modify a patient's list details, click the patients name, and then click **Edit Patient** ( ) or, on your keyboard, press **Ctrl** + **G**.
- To copy the patient to another list, click the patient's name, and then click **Copy Patient** ( ).
- To remove a patient from the list, click the patient's name, and then click one of the following options:
  - **Remove no History** ( ): To permanently remove the patient from the patient list.
  - **Remove with History** ( ): To remove the patient from the list, but allow users to view the patient when the **Include removed with history patients** check box is selected. You can restore this patient to the list if needed.

Booking appointments from patient lists

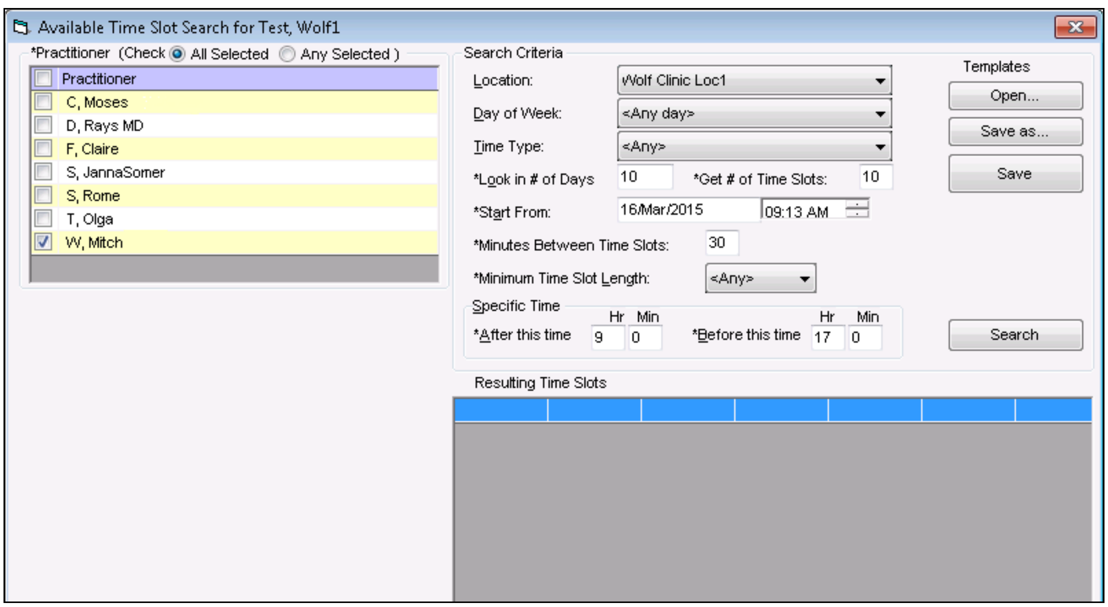
When an appointment slot becomes available, you can search your patient list(s) for a patient to fill the appointment. You can then book an appointment from the Appointment Scheduler (see “Booking patient appointments” on page 24), or from the patient list itself.

> If you book an appointment from the Appointment Scheduler, the EMR prompts you to remove the patient from the patient list automatically.

To book an appointment from the patient list:

1. Open the patient list, and find the patient you want to book. See “Viewing patient lists” on page 174.

2. Click the patient, and then click **Book Appointment** ( ) or, on your keyboard, press **Ctrl** + **T**. The EMR displays the Available Time Slot Search window.



3. In the Available Time Slot Search window:

   a) Select the practitioner(s) you want to book the patient with.

   b) Enter your search criteria, and then click **Search**.

   c) In the **Resulting Time Slots** area, click the appointment slot you want and then click **Book**.

Practise: Tracking referred patients using patient lists

- From the Appointment Scheduler, search for, and add three test patients to your general Waiting List.
- Open the Waiting List.
- Re-sort the list by patient name.
- Modify information displayed in the **Notes** column for one of the listed patients.
- Remove a patient from the list with History.

Scenario: Adding patients to patient lists

You are adding a patient to your Priority 2 list for a surgery. How do you indicate in the list what surgery the patient is waiting for?

Scenario: Viewing patient lists

You have an appointment opening and want to book a patient who has been waiting the longest for an opening. How do you determine what patients have been waiting the longest?

Sending and recording notifications to referring clinics and patients

Depending on your clinic's workflow for managing incoming referrals, you may notify the referring clinic when:

- You receive the referral
- You require additional patient information before the referral can be accepted
- The referral is accepted or declined
- An appointment is booked

If you send notifications via fax, you can fax a letter using a SMART form.

You can track that you have sent notifications and updates to a clinic by updating the original message or follow-up task sent by the provider in response to the referral. In a patient message, you can document that the clinic was called and what was said.

Sending notifications to referring clinics

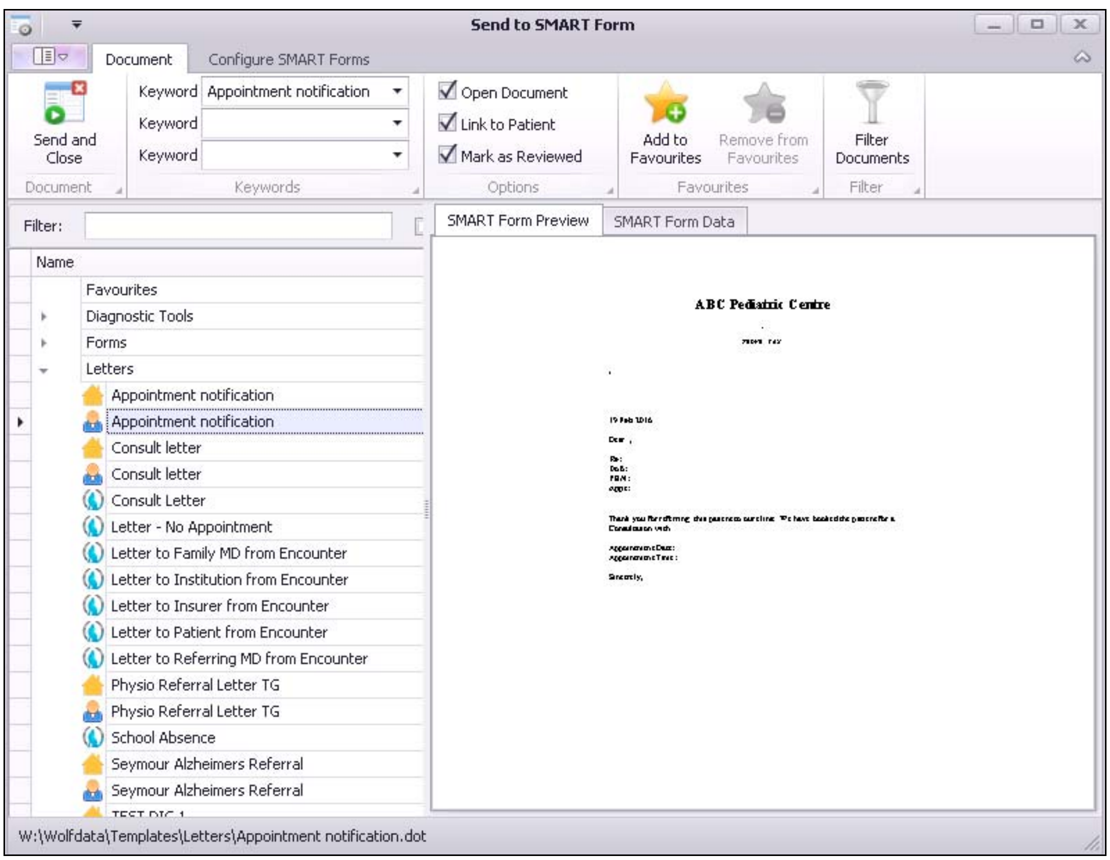
You can use SMART form letter templates to send referral notification letters to referring clinics. When a SMART form letter is sent, it is saved in the patient's Medical Summary, in the **Documents** tab. This way, you can track what letters were sent and when. You can also re-send a letter if needed.

To send a notification using a SMART form letter template:

1. On any window related to a patient's record (for example, the Medical Summary window or Vital Entry window), right-click and then, in the SMART menu, click **SMART Forms**. The EMR opens the Send to SMART Form window.

> **Tip**: You can start a SMART form letter right from a patient message via the SMART menu (right-click menu). For example, if a provider sends you a message indicating that the referral is rejected, you can create a rejection letter right from the message.

2. In the list of SMART forms, expand the **Letter** category, and then click the letter template you want to use. The EMR displays the selected letter template on the right side of the window.



3. Click **Send and Close** ( ) or, in the list of SMART forms, double-click the form. The EMR opens the letter in Microsoft Word, with some of the patient and provider's information populated.
4. Enter or modify information in the letter as needed.
5. To save the letter, click **Save** ( ), or press **Ctrl** + **S**. The EMR saves the completed SMART form in the **Documents** tab of the patient's Medical Summary.
6. To print or fax the letter, in the Microsoft Word menu, click **File** > **Print**.

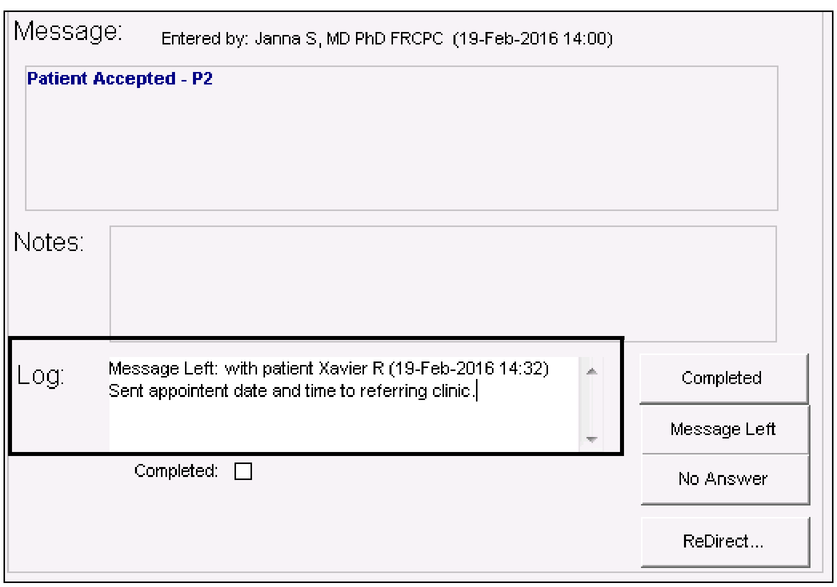
Recording that letters have been faxed

When you fax a notification letter, you can record that the letter was successfully faxed in the SMART form Document properties:

1. Open the patient's Medical Summary, and then click the **Documents** tab.
2. In the Documents list, click the SMART form letter, and then click **View Document Properties**.
3. In the Document Properties window, in the **Notes** area, enter "Letter faxed" with the date and time.

Recording what notifications have been sent to referring clinics

When a provider responds to an incoming referral, you receive a message. In the message's **Log** and **Notes** areas, you can record any phone calls you made or messages you left with the patient and/or referring clinic. You can also create numerous follow up tasks from the message. See "Managing messages" on page 114.



When you have completed your tasks for the accepted or rejected referral, you can then Complete the message. The message and all actions you documented in the message are saved in the patient's record.

Practise: Sending notifications to referring clinics

- Open and fill out a SMART form letter indicating that your clinic requires more information before the referral can be accepted.
- Save the letter to the patient's Medical Summary Documents.

Scenario: Recording calls to clinics

A provider sends you a message indicating that a referral is accepted and that the patient is to be booked right away. You call the patient to give them their appointment information, but you receive an answering machine. How do you record in the patient's record that you called and left a message?

Managing declined referrals

When you decline a referral, you first notify the referring clinic and/or patient (see "Sending and recording notifications to referring clinics and patients" on page 177). You can then change the patient's status to inactive. It is important that you deactivate the patient so that they do not appear as part of the provider's panel.

To change a patient's status to inactive:

1. Open the patient's Patient Maintenance window, and then click the **Patient Status** tab.
2. Click **New Status**.
3. In the **Status** drop-down list, select an inactive-type status.

> The **Status** options are customized by your clinic. For example, you may have an inactive status called "Refused" or "Declined".

4. (Optionally) Enter a **Reason** and any **Notes** regarding the status change.
5. Click **Save Status**.

Evaluation

Complete the following questions.

1. You receive a faxed referral. How do you notify the provider to review the incoming referral?

2. Can you send a referral to a provider for review without adding the patient to your EMR?

3. You receive a message from a provider indicating that a referral is to be rejected. How do you remove the patient from your clinic's roster?

4. When you book an appointment for a patient who is on the Waiting List, does the EMR remove the patient from the Waiting List automatically?

End of Module

Billing patients for services

Introduction to this module

Purpose

This module introduces you to patient billing for uninsured services. You learn how to create a bill, how to record a payment (or a partial payment) to a bill, and how to reverse a payment.

> This module covers only basic information about billing patients directly. For detailed information on billing in Wolf EMR (including provincial billing), be sure to participate in the billing training, or see the **Wolf EMR Billing User Guide**.

Objectives

Upon completion of this module, you will be able to:

- Create a patient bill
- Print an invoice or receipt
- Record a payment toward a patient's bill
- Reverse a payment to a patient's bill
- Write-off a patient's bill

Creating bills for patients

In Wolf EMR you can create bills, print invoices, and print receipts for services billed directly to patients.

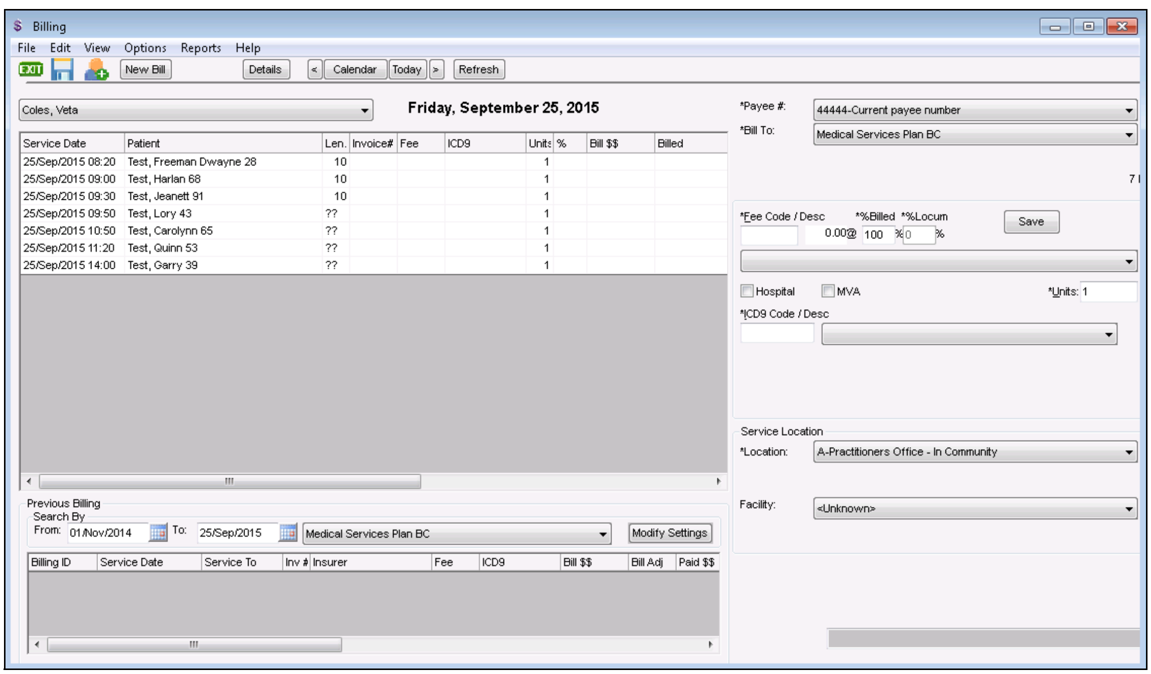
To create a bill for a patient:

1. On the Wolf EMR Launch page, click **Billing** ( ). The EMR displays the Billing window.
2. If you are creating a bill for a day other than today, click **Calendar**, and then click the Service Date.
3. In the provider drop-down list (located in the top left corner), click a provider.

   The main area of the window displays today's billing list for the selected provider.

> The billing list includes all patients with booked appointments with the selected provider for the selected date.

4. In the billing list, click the patient you want to bill. The right pane displays the bill entry area. Here you can enter or modify a bill.



5. If the patient is not on the billing list:

   a) Click **New Bill**. The EMR displays the Patient Search window.

   b) Search for the patient and then double-click the patient's name.

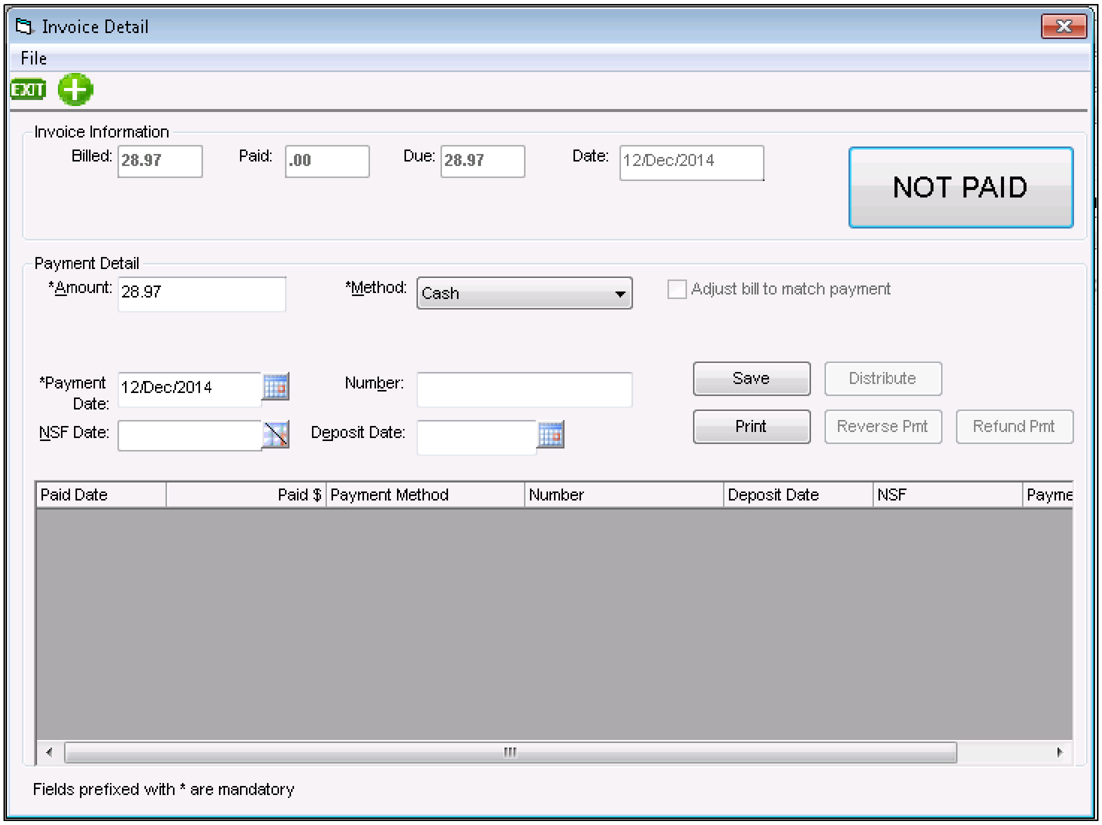
In the bill entry area (right pane), the EMR displays the patient's name in the **New Bill Patient** field.

6. Use the following table to enter information in the bill entry area.

Field	Description
Bill To	In the **Bill To** drop-down list, select **Patient**.
Fee Code/Desc	1. In the **Fee Code/Desc** field, enter the fee code or service description, and then press **Enter**. 2. In the drop-down list below, click the appropriate fee code. **Note:** Before you can bill for a service, the service must be entered in Wolf EMR as a fee code. You typically create custom fee codes for services and products you charge to patients.
Units	Enter the number of services performed or products provided. For example, if the service fee is for vitamins, and the patient is purchasing 3 containers of vitamins, in the **Units** field, enter **3**. The EMR multiplies the Rate by the number of **Units** and displays the total billed amount in the **Bill $$** column in the billing list.
Rate (field to the right of **Fee Code/Desc**)	If you want to charge a different rate than the default, in the **Rate** field, modify the amount.

7. Click **Save**. The EMR displays the following prompt: "Are all services entered for this bill?"
8. Perform one of the following actions:
   - If all services are entered for this bill, click **Yes**.
   - To add more services to the bill, click **No**. The EMR inserts another line into the original bill. Repeat Step 6 and Step 7 .

The EMR opens the Invoice Detail window.



9. Using the following table, in the Invoice Detail window, enter payment information.

Field	Description
***Amount**	Ensure the payment amount is correct. If you are entering a partial payment, enter the actual paid amount.
Method	In the drop-down list, select the method of payment. **Note:** Options in the drop-down list can be customized by your clinic. Users with administrative authority can add additional options (for example, Visa).
Payment Date	If payment was received on a day other than today, enter the date of payment, or to select a date from a calendar, click  .
Number	If the payment is by cheque, enter the cheque number.

Field	Description
NOT PAID	If the patient has not paid the bill, click **NOT PAID**. You can take a payment at a later time and record it in the EMR. See "Recording payments to patient bills" on page 188. The EMR displays a prompt asking if you want to print the invoice.

10. Click **Save**. The EMR displays the payment in the lower pane of the Invoice Detail window.
11. To print a receipt, click **Print**.
12. Click **Exit**.

Invoice Tips:

- Another way to print an invoice is to click the bill in the Billing list, and then on the Billing menu click **File > Print Invoice**.
- If you bill a patient in error, you can delete the bill as long as no payments have been recorded to the invoice:
  1. On the Billing window, In the billing list, click the patient's bill.
  2. In the Billing menu, click **File** > **Delete Bill**.

Practise: Creating a bill for patient

- Create a bill for a patient.
- Use your clinic's fee code for a missed appointment.
- Indicate that the bill is not paid.

Recording payments to patient bills

If you do not receive complete payment at the time you bill a patient (for example, if you bill a patient for missing an appointment and send the bill by mail), you can record a partial or complete payment when you receive payment.

Record a payment as soon as you receive it. The EMR cannot report which bills were paid or not paid unless you record them in the system.

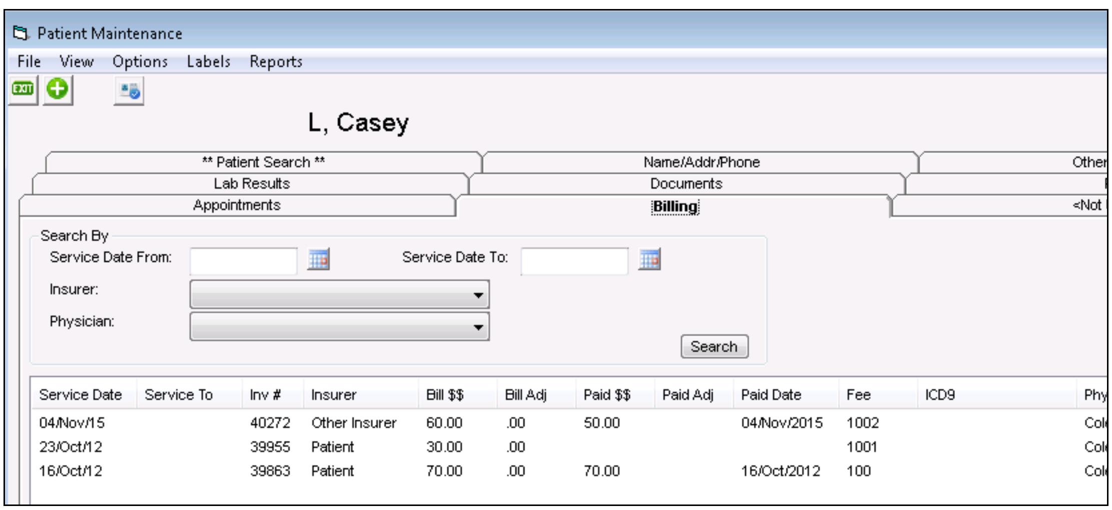
To record a payment to a patient's bill:

1. Open the Patient Maintenance window for the patient.

Tip: How you open the Patient Maintenance window depends on where you are in Wolf EMR at the time of payment. You can open the Patient Maintenance window from:

- **Appointment Scheduler**: See "Searching for patients" on page 6.
- **WorkDesk**: On your WorkDesk, click **Demographics**.
- **Billing** window: On the Billing menu, click **View > Patient Maintenance**.

2. Click the **Billing** tab. The **Billing** tab displays a list of bills created for the patient.



3. Click the bill you want to record a payment for and then, click **View > Invoice Payment** or, on your keyboard, press **Ctrl** + **P**. The EMR opens the Invoice Detail window.
4. In the Invoice Detail window, enter payment information. See Step 9 in "Creating bills for patients" on page 184.
5. Click **Save**. The EMR displays the payment in the lower pane of the Invoice Detail window.
6. To print a receipt, click **Print**.
7. Click **Exit**.

Practise: Adding a payment to a patient's invoice

- Find the bill you created for the missed appointment.
- Make a partial payment and save the invoice.
- Open the invoice again and indicate that the patient has paid in full.

Scenario: Adding a payment to a patient's invoice

A patient is picking up a letter from their practitioner today, so you have already created the bill for this service. However, when the patient arrives they can only pay $20 toward their $50 bill. How do you record the $20 payment that the patient made today?

Scenario: Creating a bill for a patient and adding a payment to a patient's invoice

Donna's visit today was for a Driver's Medical, for which your clinic charges $150. How do you create the invoice and record her payment?

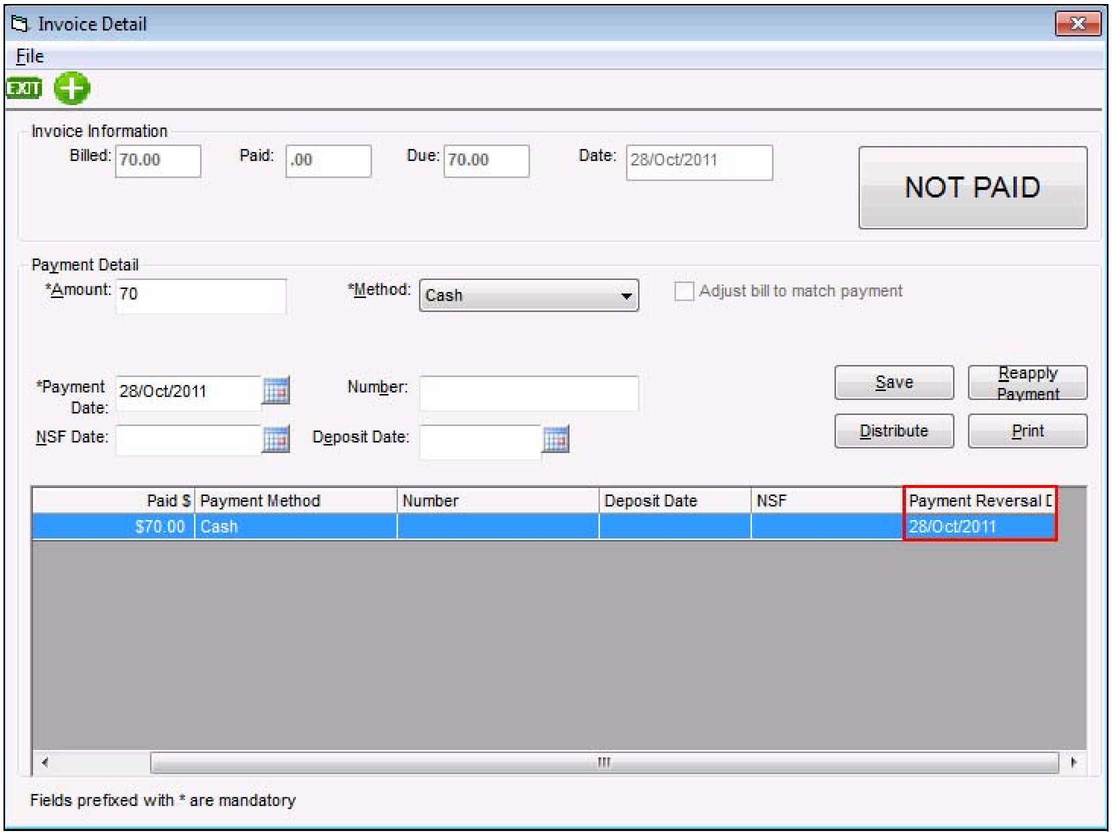
Reversing payments

If you record a payment for a bill in error, or enter the wrong payment information, you can reverse the payment. You reverse a payment from the patient's Invoice Detail window, which you can access from the Billing program, or from the **Billing** tab on the Patient Maintenance window.

To reverse a payment to a patient's bill:

1. Open the Patient Maintenance window for the patient, and then click the **Billing** tab. See Step 1 to Step 2 in "Recording payments to patient bills" on page 188.
2. Click the invoice you want to reverse a payment for and then, on the Patient Maintenance menu, click **View > Invoice Payment** or, on your keyboard, press **Ctrl** + **P**. The EMR opens the Invoice Detail window.
3. In the lower pane of the Invoice Detail window, click the payment you want to reverse.

4. Click **Reverse Pmt**. The EMR treats the payment as unpaid. If you scroll to the right of the payment row, you can see the Payment Reversal Date.



5. Click **Exit**.

Practise: reversing a payment

- Find the invoice that you added a payment to.
- Reverse the payment.

Scenario: Reversing a payment

You enter a payment for a patient bill and realize that you entered Cash instead of Cheque. How can you modify the payment method?

Writing-off bills

You write-off a patient bill if:

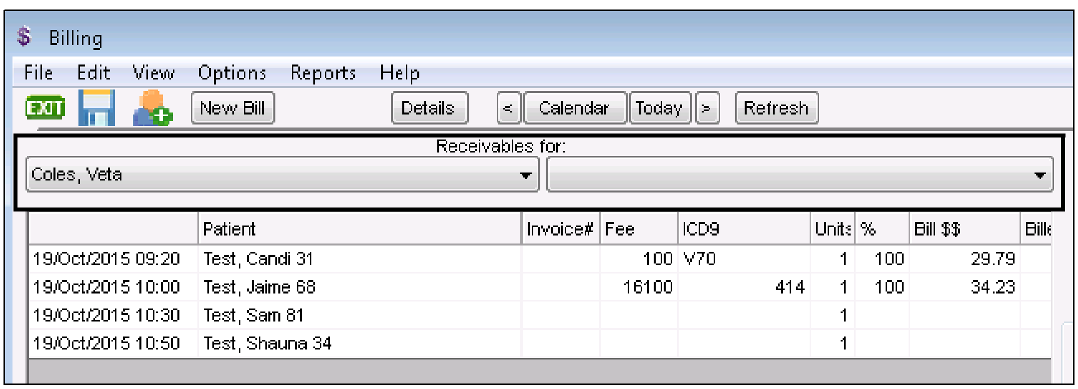
- You know you will not receive payment for the bill.
- You receive only a partial payment for a bill, but you want to mark the bill as complete (that is, you want to accept the bill as fully paid).
- You created the bill in error. For example, you created the bill for the wrong patient.

When you write-off a partially paid bill, the EMR notes the unpaid portion as written-off.

To write-off a patient bill:

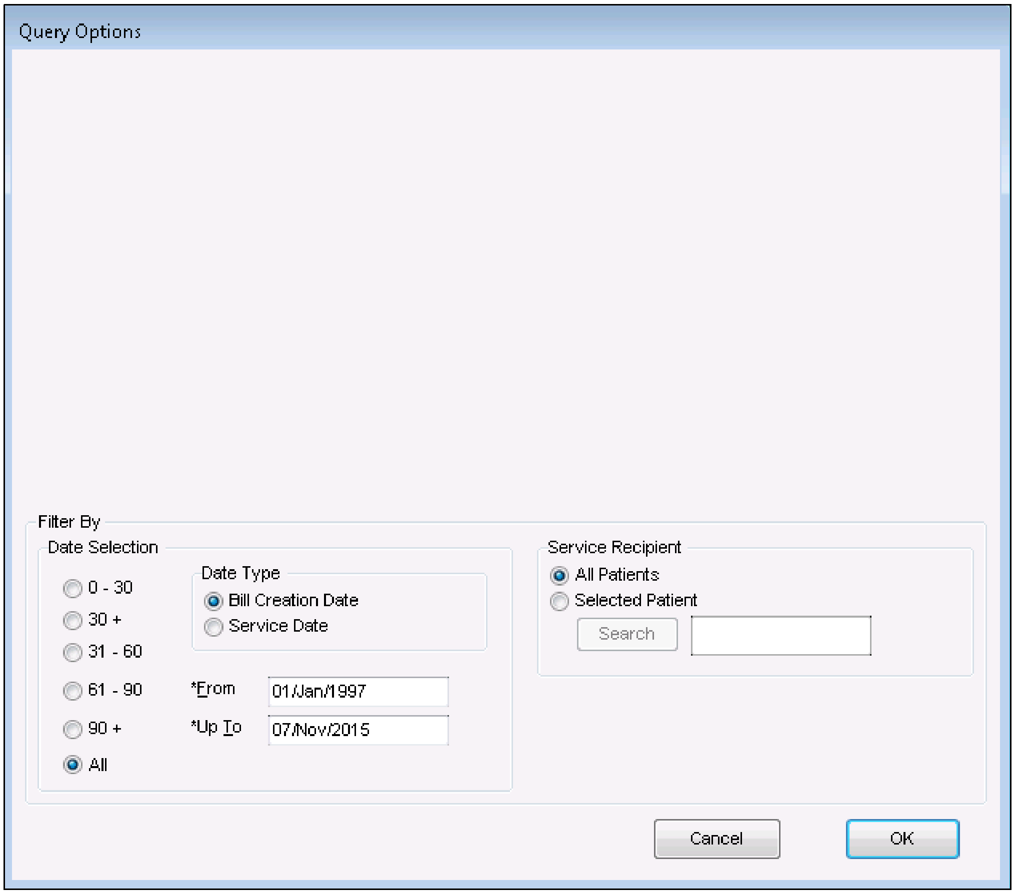
1. If a payment has been applied to the bill, and the payment is to be written-off as well, reverse the payment before you write-off the bill. See “Reversing payments” on page 189.
2. Open the Billing program: On the Wolf EMR Launch page, click **Billing** ().
3. Search for outstanding patient bills:

   a) On the billing menu, click **View** > **Receivables (or 100% Paid)**. At the top of the billing list, the EMR displays two **Receivables for** drop-down lists.



   b) In the left drop-down list, select the practitioner you want to view bills for, or to view bills for all practitioners, click **<All Service Providers>**.

c) In the right drop-down list, select **Patient**. The EMR displays the Query Options window.



d) In the **Date Selection** area, click **All**.

e) Click **OK**. The EMR displays all unpaid and partially paid patient bills in the billing list area of the Billing window.

f)

4. In the list of outstanding patient bills, click the bill you want to write-off and then, on the Billing menu, click **File > Write Off** > **This Invoice**.

5. In the WriteOff Reason window, select one of the following options:

- **Uncollectible**: If you know you will not receive payment for the outstanding bill amount.
- **Mistake**: If there was an error on the bill or if the bill was created in error.

The EMR writes off the bill, and displays the word **WriteOff** in the **Remitted** column of the billing list.

Scenario: Correcting bills

Joe is in for a drivers medical with Dr. Baker. As Joe waits for his medical, you have him pay for the visit and you record a payment for the invoice. Dr. Baker falls behind on her patient visits and Joe ends up waiting for 2 hours. Joe asks for his money back and leaves. How do you reconcile the bill in the EMR?

Evaluation

Complete the following questions.

1. You need to bill a patient, but you do not see the patient in the billing list. What are your next steps?

2. You can record a partial payment on an invoice that you previously created.

    a) True

    b) False

3. You recorded a payment of $50 towards a patient's invoice in error. How can you correct this?

End of Module

Questions?

WolfEMR.Support@telus.com

1-866-879-9653 (Option 1)

Wolf EMR Community Portal at:
https://telushealthcommunity.force.com/wolfcommunity

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