Wolf EMR Course Workbook for Providers

British Columbia

Wolf EMR v2016.1.3

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TELUS | HEALTH

Information for Life.

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

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Community Portal http://telushealthcommunity.force.com/wolfcommunity	

Table of Contents

Introduction

About this workbook

This workbook provides an outline of the functionality and use of Wolf EMR from the perspective of a provider. 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 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.

WorkDesk Overview

Introduction to this module

Purpose

This module introduces you to the WorkDesk. In Wolf EMR, the WorkDesk is where you perform most of your daily tasks. From the WorkDesk you can:

- View your appointment schedule
- Enter patient visit notes
- View and enter clinical data in patient medical records
- Create and manage messages and clinical tasks (for example, tasks related to referrals and patient visits)
- Review your patient investigations (labs) and other received reports and documents

Objectives

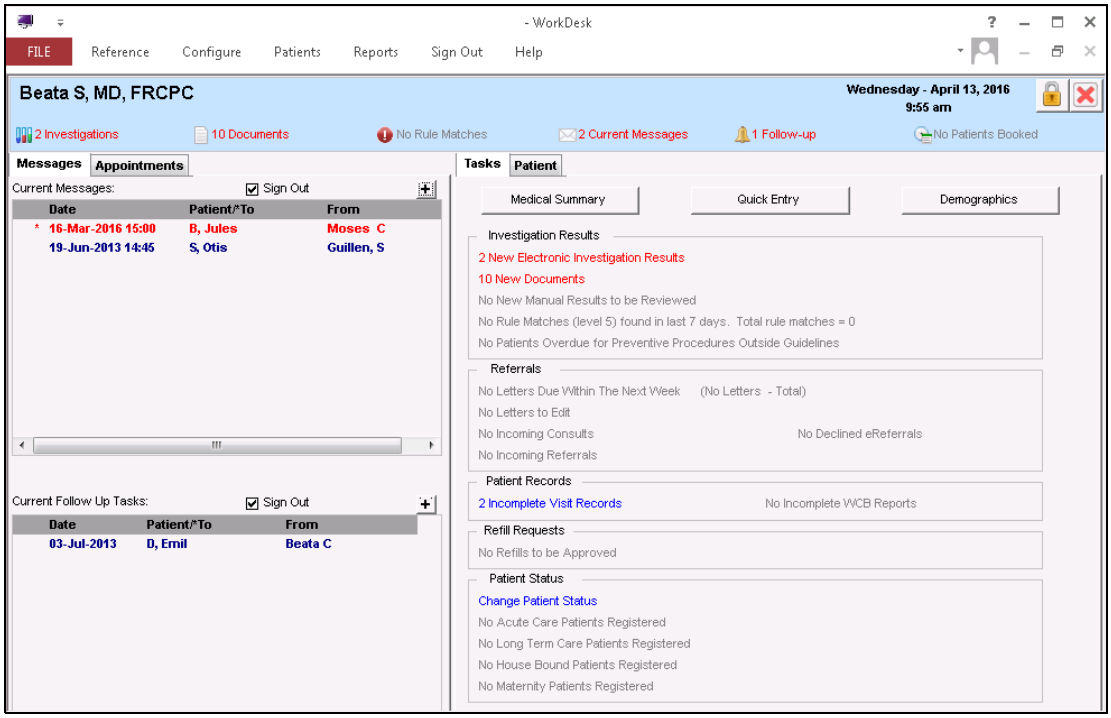
Upon completion of this module, you will be able to:

- Open the WorkDesk
- View your messages, follow up tasks, and other clinical tasks
- View your appointments

Opening the WorkDesk

To open the WorkDesk:

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



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

You can quickly navigate back to the Launch page at any time by clicking the Launch page icon () (located on the toolbar at the bottom of your screen).

Viewing your 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, incomplete visit notes, investigations to review)

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

WorkDesk Area	From this area, you can...
Messages	View your active messages and create messages.
Follow Up Tasks	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: ■ Remind you to call a patient. ■ Serve as a reminder in a patient's record for you to talk to the patient about a test result, treatment option, or other matters pertaining to the patient's health.
Investigation Results	Review: ■ Your investigation (lab) results ■ Your faxed or scanned documents (medical reports) ■ Patients flagged for overdue tests, treatments, and procedures (called "rule matches")
Referrals	View and manage outstanding incoming and outgoing referrals.
Patient Records	View and complete your outstanding tasks related to patient records, including: ■ Incomplete visit notes ■ Incomplete WCB reports
Refill Requests	View and respond to prescription refill requests.
Patient Status	View and manage specific groups of patients, including: ■ Long term care patients ■ Maternity patients

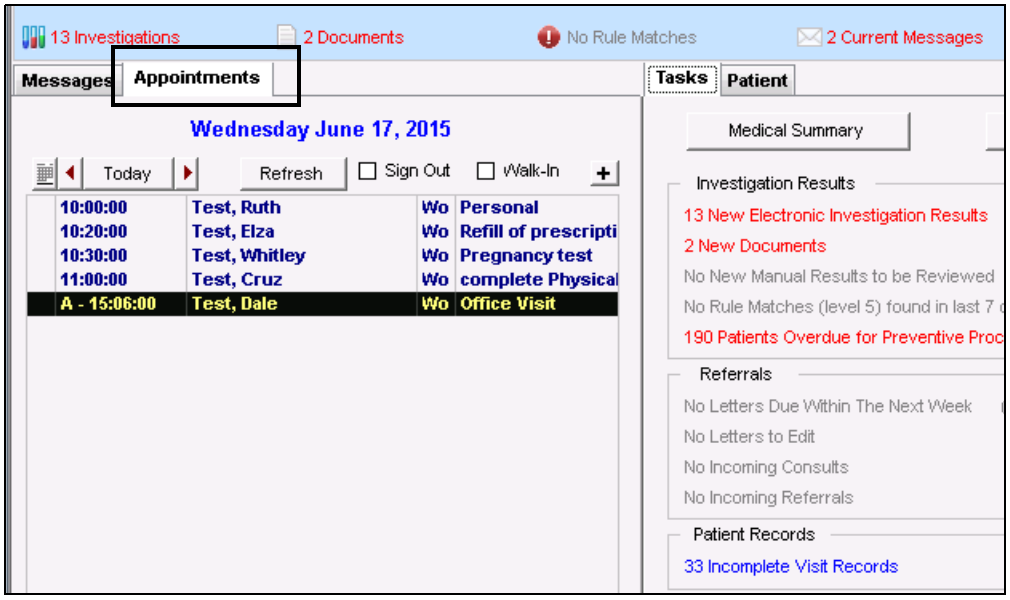
Practise: Viewing your tasks

- Open the WorkDesk
- Browse through the options available on the right side of the window

Viewing your appointments

To view your appointments:

1. Open the WorkDesk. See “Opening the WorkDesk” on page 6.
2. Above the **Messages** area, click the **Appointments** tab. The EMR displays a list of your booked appointments for today.



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

3. To view appointments for another day, use the following table to navigate.

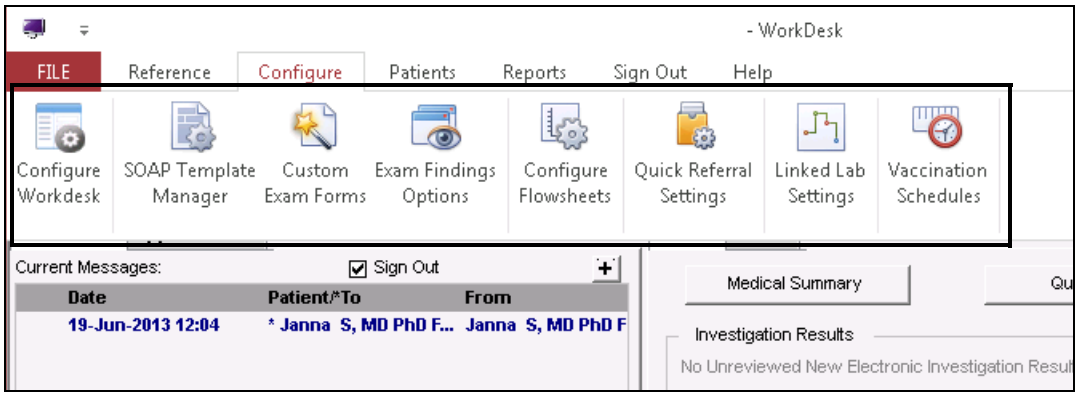
To do this...	Follow these steps...
Jump forward or back one day at a time	Beside the **Today** button, click **Forward** ( ) or **Back** ( ). The EMR jumps a day forward/back with each click.

To do this...	Follow these steps...
Navigate back to today	Click **Today**.
View a specific date	Click  , and then, on the calender, double-click the date.
Refresh the list to reflect any new or cancelled appointments.	Click **Refresh**.

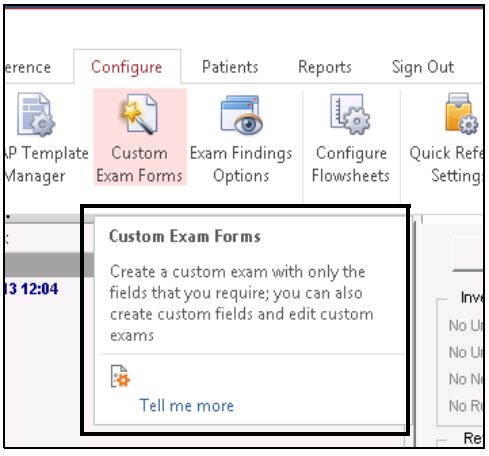
Using WorkDesk menu options

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

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



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



Evaluation

Complete the following questions.

1. How can you easily move back and forth between the WorkDesk and the Launch page?

2. How do your view your appointment list for a specific date?

3. You are expecting lab results to come in for a high-risk patient. Which area on your WorkDesk can you check?

4. It's the end of the day, and you want to finish any patient visit notes you didn't have a chance to complete. Where can you view a list of your unfinished visit notes?

End of Module

Entering visit notes - General Practitioners

Introduction to this module

Purpose

In this module, you learn how to enter basic patient visit notes using the Wolf EMR SOAP form. On the SOAP form you can:

- View and modify visit notes added by your front-end staff.
- Enter your visit notes in a formatted SOAP note.
- View pertinent patient chart information (for example, view a patient's recent lab results).
- Perform actions in the patient's chart (for example, prescribe a medication).

Objectives

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

- Record visit notes in a SOAP form
- Enter a patient's medical history information from the SOAP form
- Record objective visit data using exam templates specific to a particular problem or type of examination
- View patient data and perform actions from the SOAP form
- Manage your incomplete visit notes

Starting SOAP notes

The SOAP form is where you record your visit notes and perform actions in the patient's chart. You can open a SOAP form for any patient on your Appointments list.

To start a SOAP note for a patient:

1. On the WorkDesk, click the **Appointments** tab and then, in your list of appointments, click once on the patient's name. See "Viewing your appointments" on page 8.

Adding patients to your appointments list:

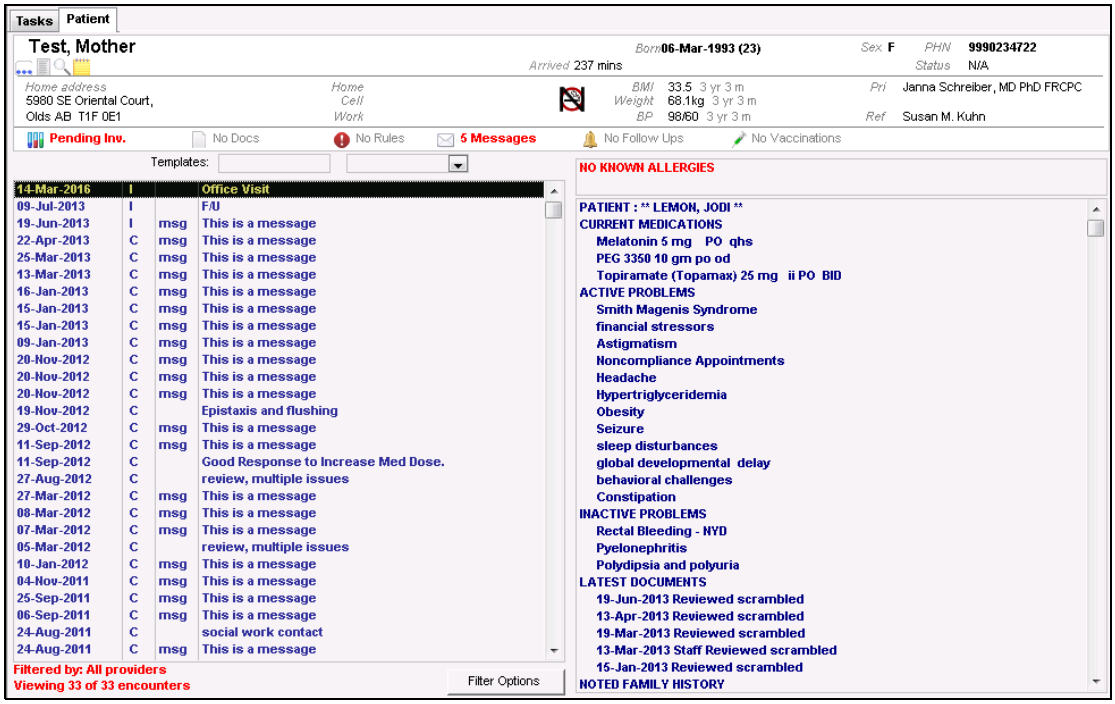
If a patient is not on your appointments list, you must add them to your list before you can start a SOAP note. For example, if a mother is in for a visit and asks that you quickly check her child as well, you must add the child to your appointments list before you can enter a visit note for the child.

To add a patient to your appointments list:

1. At the top of the Appointments list, click  . The EMR displays the Patient Search window.
2. Search for and select the patient.
3. In the Enter New Encounter window, ensure the appointment details are correct (for example, that the **Appointment Start** and **Appointment Length** are correct), and then click  .

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

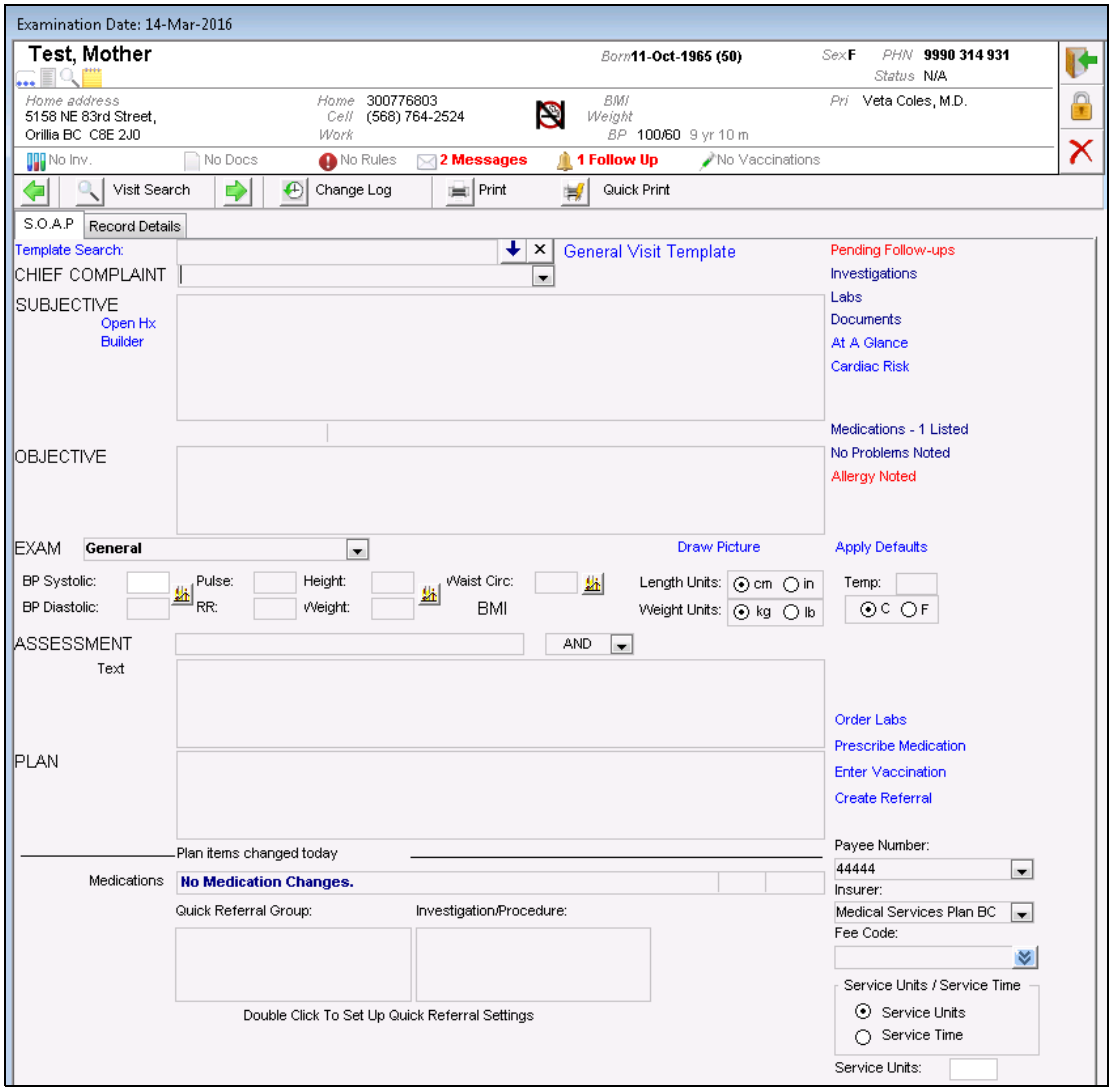
- A list of the patient's previous and current encounters and messages (includes encounter date, status [**C** = complete, **I** = Incomplete], attending physician, and visit type).
- A summary of important and recently added patient chart data.
- The SMART patient banner (located at the top of the window): here you can view a summary of the patient's demographic information, latest vitals and measurements, smoking status, care team information, and notifications.



Tips for viewing patient information from the SMART patient banner

- To view the patient's Medical Summary (medical chart), click anywhere on the SMART patient banner.
- If the patient has any un-reviewed investigations (labs), a number displays beside **Investigations** ( ). To review the investigations, click the icon.
- If the patient has any un-reviewed documents (medical reports), a number displays beside **Documents** ( ). To review the documents, click the icon.
- If there are incomplete messages related to the patient, a number displays beside **Messages** ( ). To view the messages, click the icon.
- If there are incomplete follow-up tasks related to the patient, a number displays beside **Follow Ups** ( ). To view and manage the follow-up tasks, click the icon.
- To view or modify the patient's detailed demographic information, below the patient's name, click .

2. On the list of office visits, double-click the office visit you want to start a SOAP note for. (In most cases this will be the incomplete (**I**) visit listed at the top with today's date.) The EMR displays the SOAP form.



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

Practise: Starting a SOAP note

- In the WorkDesk **Appointments** tab, click a patient's name to open the **Patient** tab.
- Perform the following actions from the SMART patient banner:
  1. Open the patient's Medical Summary (medical chart).
  2. View the patient's demographic information.
- Open a SOAP note for today's visit.

Entering SOAP note data

The SOAP form contains text areas, drop-down lists, and check boxes for easy data entry. You can enter data into as much or as little of the SOAP form as you want.

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

1. Open the SOAP form. See "Starting SOAP notes" on page 12.
2. In the **CHIEF COMPLAINT** field, enter a short description of the primary visit reason or, in the drop-down list, click a visit reason.

Tip: To add visit reasons to the **CHEIF COMPLAINT** drop-down list, double-click the field.

3. In the **SUBJECTIVE** field, enter your subjective finding notes.

Tip: You can check your spelling in any text area on the SOAP form:

- Right-click a text area, and then click **Check Spelling**.

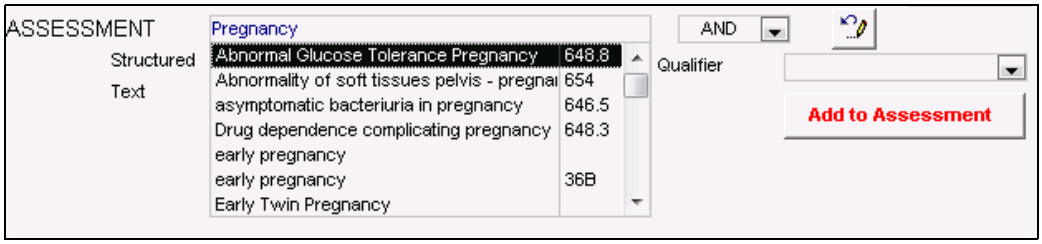
4. In the **OBJECTIVE** field, enter your objective finding notes.
5. In the **EXAM** area, enter the patient's vitals and measurements.

Note: If your front-end staff recorded the patient's vitals and measurements for the visit, these values populate the **EXAM** area.

Tip: To graph a vital or measurement, beside the value you want to graph, click  .

6. In the **ASSESSMENT** area, enter the problem(s) the patient is seeing you for:

a) In the top field, enter all or part of a problem name or ICD9 diagnosis code, and then press **Enter.** The EMR displays a list of matching problems.



b) In the results list, click a problem.

c) (Optional) In the **Qualifier** field, enter the position (for example, right, left, front) or other qualifier information about the problem or, in the drop-down list, click a qualifier.

d) Click **Add to Assessment**. The EMR displays the selected problem in the **Structured** field.

Tips for adding diagnosis' for the visit:

- After you add a diagnosis to the **ASSESSMENT** area, you can chose to add the diagnosis to the patient's Problem List: In the **ASSESSMENT** area, click the diagnosis, and then click **Add To Problem List**.
- If you enter the wrong diagnosis, and have not yet selected **Add to Assessment**, to clear the search field, click **Cancel Search** ( ).
- If you enter the wrong problem, and have selected **Add to Assessment**, to remove the diagnosis, click the diagnosis, and then click **Delete Assessment**.

7. In the **PLAN** area, enter any notes on your plan for treatment, referrals, follow-up, and so on.
8. From the SOAP form, perform any other actions required in response to the visit (for example, create a requisition form, prescribe a medication, or record a patient's medical history information). See:
   - "Using exam templates" on page 17
   - "Performing actions from SOAP notes" on page 21
9. To close the SOAP form, click **Save & Close** ( ). The EMR saves your visit notes, and prompts you to lock the visit note.
10. To "finish" the visit note click **Yes**. To add information to the SOAP note at a later time, click **No**.

A visit note is never truly "locked"; you can go back and edit a locked note if needed.

Practise: Entering basic SOAP notes

- On a test patient's SOAP Form, enter a visit reason into the **CHIEF COMPLAINT** field.
- Enter a few basic notes in the **SUBJECTIVE** area (for example, "pain in lateral aspect of the right ankle resulting in inability to weight bear").
- Enter a few basic notes in the **OBJECTIVE** area (for example, "Swelling, mild bruising, increased pain with pressure on the lateral ligaments of the ankle and upon weight bearing").
- Enter the patient's height and weight into the **Exam** area.
- Graph the patient's weight.
- Enter a few basic notes in the **ASSESSMENT** area (for example, "Restricted inversion ROM").
- Select a diagnosis for the patient visit (for example, "moderate-level inversion sprain").
- Enter a few basic notes in the **PLAN** area (for example, "Advil, RICE, prescription to physiotherapy").

Using exam templates

In the SOAP form, you can enter objective visit notes using visit-specific templates called "exams". Exams contain fields specific to a particular problem or type of examination. For example, the **Diabetes Review** exam includes fields for hypoglycemic episodes, foot testing, peripheral pulses, and Framingham score.

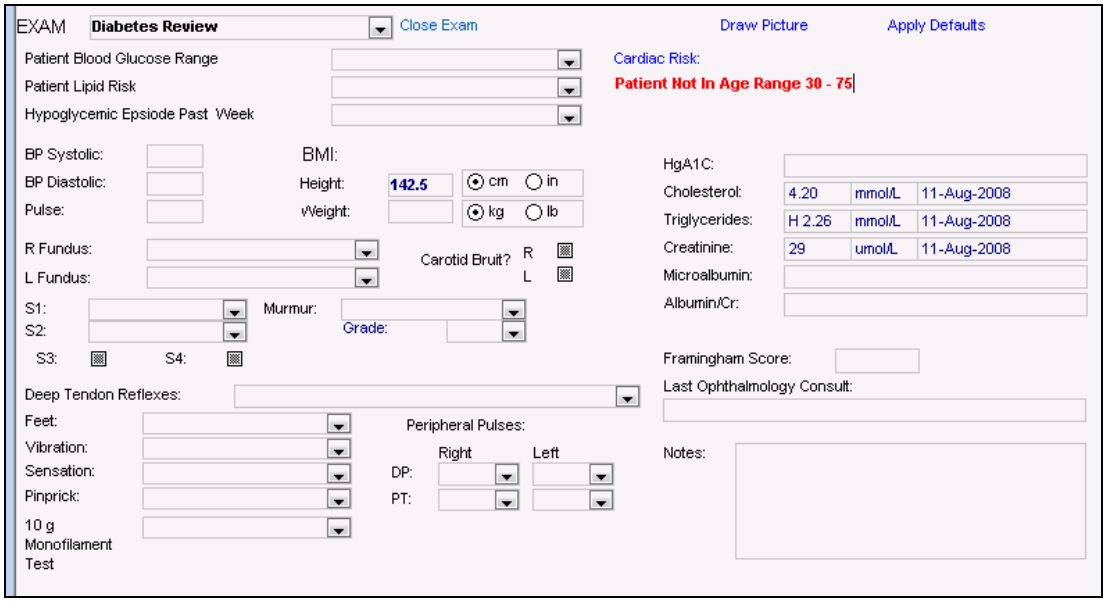
Wolf EMR contains numerous disease-specific Chronic Disease Management (CDM) exams (for example, COPD, Depression, Diabetes Review, and Chronic Kidney Disease). If you enter CDM visit data using the appropriate exams, you can:

- 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).

> **CAUTION**: Two users should never enter information into the same exam for the same patient at the same time.

To use an exam template:

1. On the SOAP form, in the **EXAM** drop-down list, select an exam. The EMR opens the exam in the SOAP form.



2. Enter data into the various text fields, drop-down lists, and check boxes.

> As with SOAP notes, if your nurse or front-end staff enters information in an exam, you see this information when you open the same exam for the visit. You can edit or add to the information as needed.

Tips for entering and viewing exam data

- To view values that were previously entered in an exam field, double-click the field.
- To view a patient's Medical Summary (chart), on your keyboard, press **F7** or click the SMART patient banner.
- When you finish entering exam data, you can minimize the **EXAM** area: click **Close Exam**. The EMR displays the exam data in text format below the **OBJECTIVE** area.
- If, after you close the structured examination, you want to modify or enter additional information, simply open the exam again, and then add or modify information as needed.
- You can enter information into more than one exam during a visit.

Practise: Using exam templates

- Start a new SOAP note for a patient.
- In the **EXAM** drop-down list, select an examination type (for example, **Diabetes Review**).
- Enter exam data, and then click **Close Exam**.

Scenario: Using Structured Exams

You are completing a 6 month check-up for an infant. What exam would likely be most useful for entering the visit data?

Recording patient medical history from the SOAP form

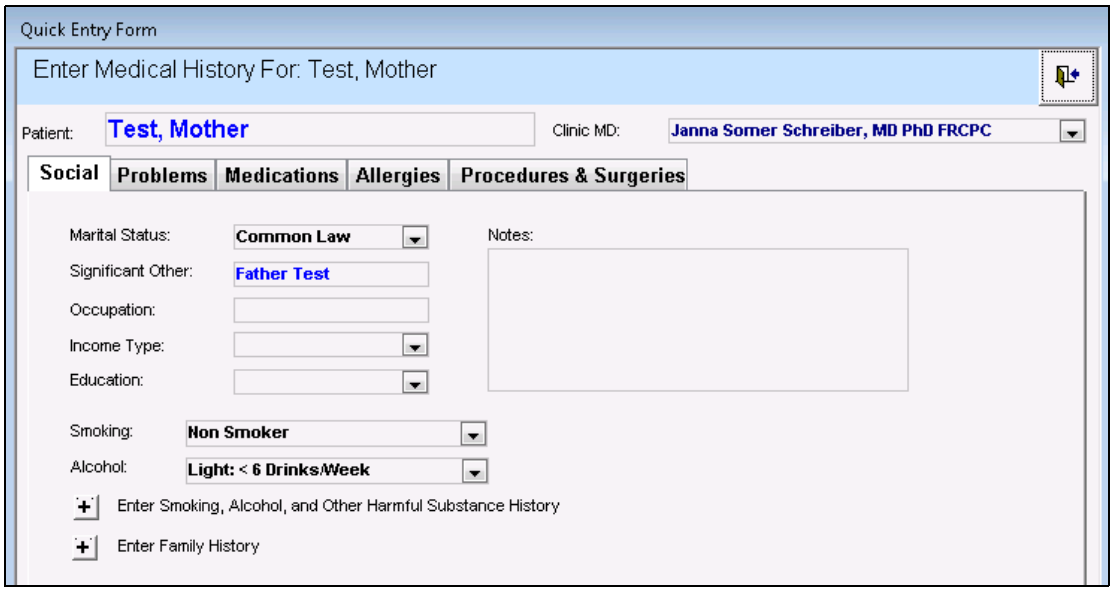
When you are entering visit notes in the SOAP form, you can quickly record a patient's medical history information using Quick Add. Quick Add enables you to record basic information to a patient's Medical Summary regarding:

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

Note: You learn how to add more detailed medical history information to a patient's Medical Summary in later modules.

To record a patient's medical history during a patient visit:

1. On the SOAP form, right-click and then, in the SMART menu, click **Quick Entry**. The EMR displays the Quick Entry Form window.



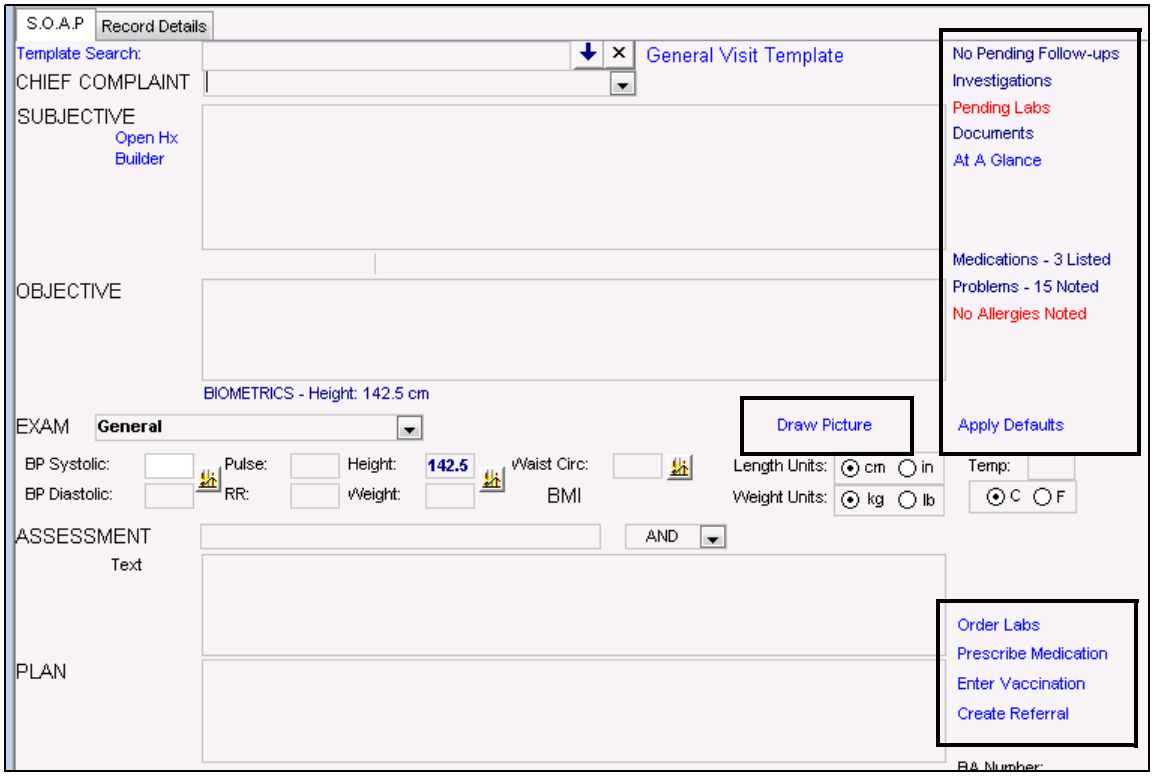
2. In one or more of the tabs, enter information as needed, and then click  .

Tip for entering medical history using Quick Entry

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

Performing actions from SOAP notes

The SOAP form contains a variety of quick-links you can use to view patient information (for example, patient lab results), or to perform common actions (for example, to prescribe a medication). Links are strategically placed, with each link located near the fields it relates to.

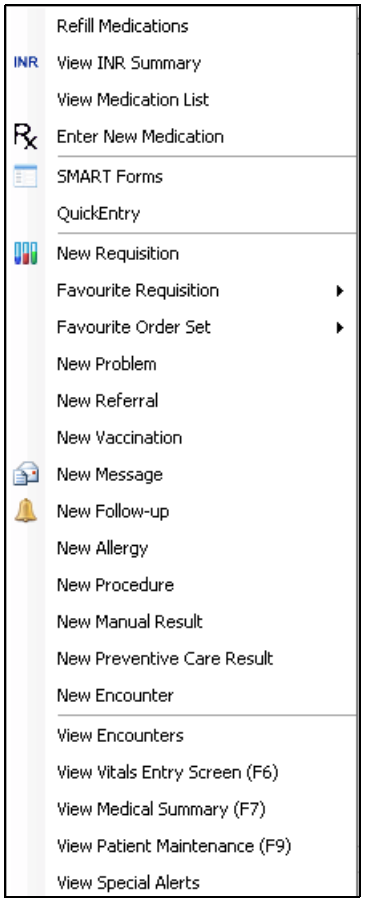


As you enter information in the SOAP form, new links may display in response to the information entered. For example, if you enter and then click a diagnosis in the **ASSESSMENT** area, links display to **Add To Problem List**, **Delete Assessment,** and **Edit Assessment**.

You can perform a number of additional actions from a SOAP note via the SMART menu. For example, you can:

- Send a message or follow-up task regarding the patient
- Perform a Cardiac Risk Assessment
- Record a vaccination

To open the SMART menu, right-click anywhere on the SOAP form.



You can open the SMART menu by right-clicking most windows related to a patient's record, including:

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

As a rule-of-thumb, if a window displays the SMART patient banner, you can open the SMART menu from that window.

Tips for using the SMART menu

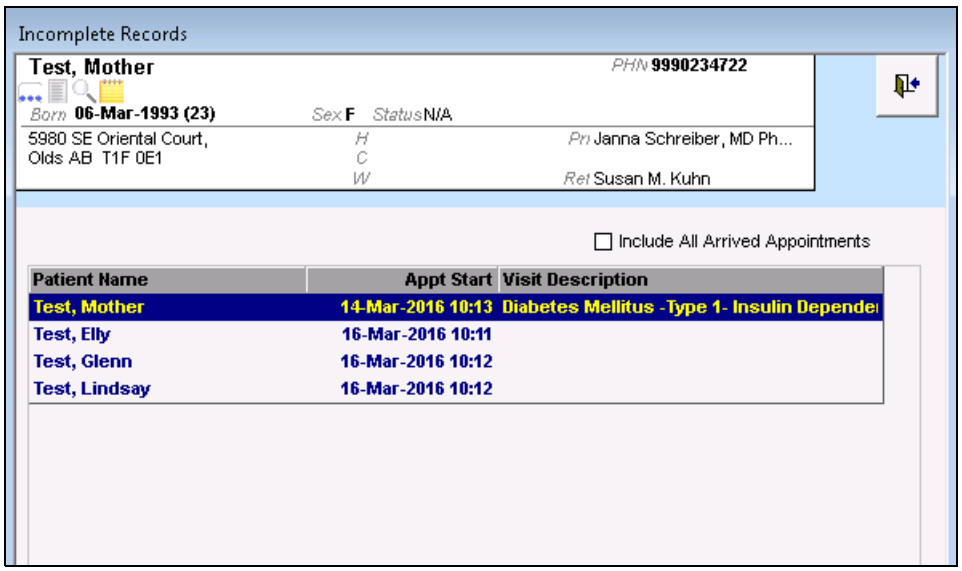
- SMART menu options are grouped by what they do. Medication and prescription-related options are displayed at the top of the menu, action options are displayed in the middle, while view options are displayed at the bottom.
- You can customize what options display in the SMART menu. If there are SMART 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.

Managing your incomplete visit notes

In the old days of paper charting, your desk likely contained a pile of patient charts you had to finish notes for. In Wolf EMR, your "pile" is located on the WorkDesk. Any time you save a SOAP note without locking it, the EMR adds the visit note to your **Incomplete Visit Record** list. From the **Incomplete Visit Record** list, you can go back and finish your notes at your convenience.

To view and finish your incomplete visit notes:

1. On your WorkDesk, in the **Patient Records** area, click **# Incomplete Visit Records**. The EMR displays the Incomplete Records window.



> By default, the **Incomplete Records** list displays only records that you have opened and then closed (without locking). To include incomplete visit notes for all arrived appointments, select the **Include All Arrived Appointments** check box.

2. In the list of incomplete visit records, double-click the visit record you want to complete. The EMR opens the SOAP form for the incomplete visit record.
3. Complete any unfinished areas on the SOAP form, and then save and lock the visit note. See "Entering SOAP note data" on page 15.

Evaluation

Complete the following questions.

1. What is the easiest way to open the patient's Medical Summary (chart) from the SOAP form?

2. In the SOAP form, where do you enter the visit reason?

3. If you select a problem (diagnosis) in the **ASSESSMENT** area of the SOAP form, can you add the problem to the patient's general Problem List?

4. Can you use more than one exam template?

5. You have diagnosed your patient with diabetes. You want to document her full diabetic history. What is the BEST and recommended way to enter her history and diabetic visit notes so that you can effectively manage her condition?

6. During a visit, your patient indicates that they had an appendectomy 2 years ago. What is the quickest way to record this in the patient's chart?

7. You have finished your patient visits for the day and want to ensure that you signed off on all your visit notes. Where can you find a list of your incomplete visit notes?

End of Module

Entering visit notes - Specialists

Introduction to this module

Purpose

In this module, you learn how to enter basic patient visit notes using the Wolf EMR consult letter form. On the consult letter form you can:

- View and modify visit notes added by your front-end staff.
- Enter your visit notes in a consult letter format.
- View pertinent patient chart information (for example, view a patient's recent lab results).
- Perform actions in the patient's chart (for example, prescribe a medication).

Objectives

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

- Record visit notes in a consult letter format
- Enter a patient's medical history information while entering visit notes
- Record objective visit data using exam templates specific to a particular problem or type of examination
- Create and use consult letter templates
- View patient data and perform other actions on a patient's chart while entering visit notes
- Manage your incomplete visit notes

Starting consult letter visit notes

If a patient's visit notes are to be printed/sent as a consult letter, you enter your visit notes in the consult letter form. When you finish your visit notes, you can then print the notes as a consult letter.

Tip: If a majority of your patient visit notes are written in the form of a consult letter, set the Consult Letter form as your default visit note template:

1. On the WorkDesk menu, click **Configure** > **Configure WorkDesk** ( ).
2. In the **General** tab, in the **Default Form** drop-down list, select **Consult Letter**.

To start a consult letter visit note for a patient:

1. On the WorkDesk, click the **Appointments** tab and then, in your list of appointments, click the patient. See "Viewing your appointments" on page 8.

Adding patients to your appointments list:

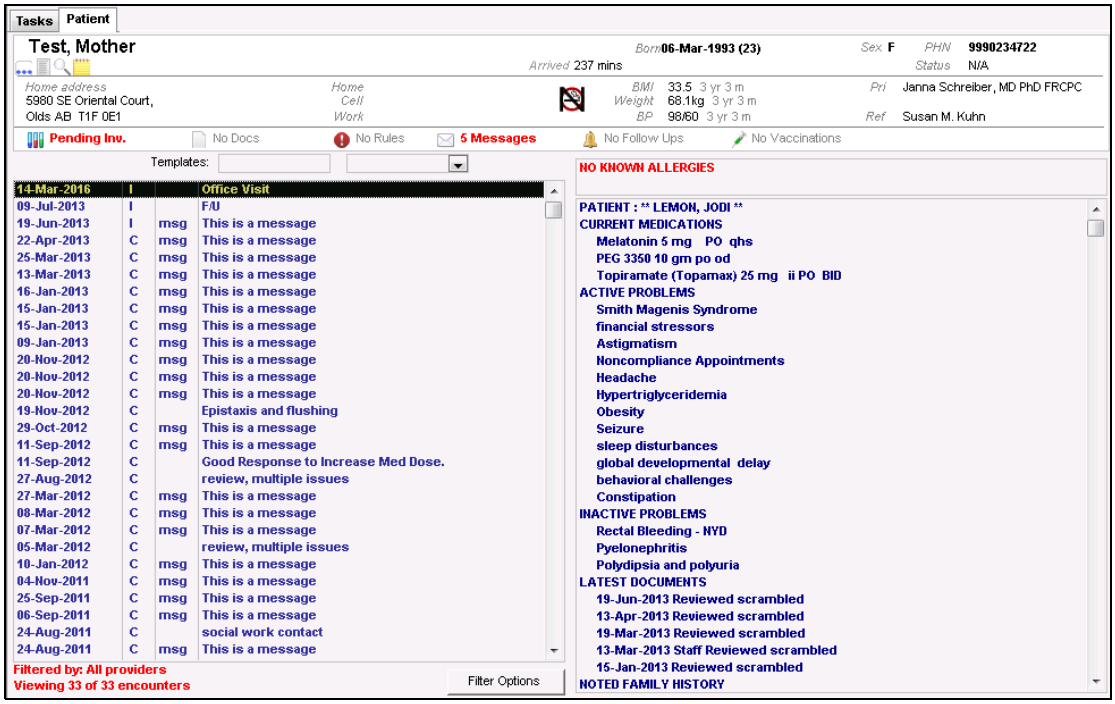
If a patient is not on your appointments list, you must add them to your list before you can start a visit note. For example, if a mother is in for a visit and asks that you quickly check her child as well, you must add the child to your appointments list before you can enter a visit note for the child.

To add a patient to your appointments list:

1. At the top of the Appointments list, click . The EMR displays the Patient Search window.
2. Search for and select the patient.
3. In the Enter New Encounter window, ensure the appointment details are correct (for example, that the **Appointment Start** and **Appointment Length** are correct), and then click .

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

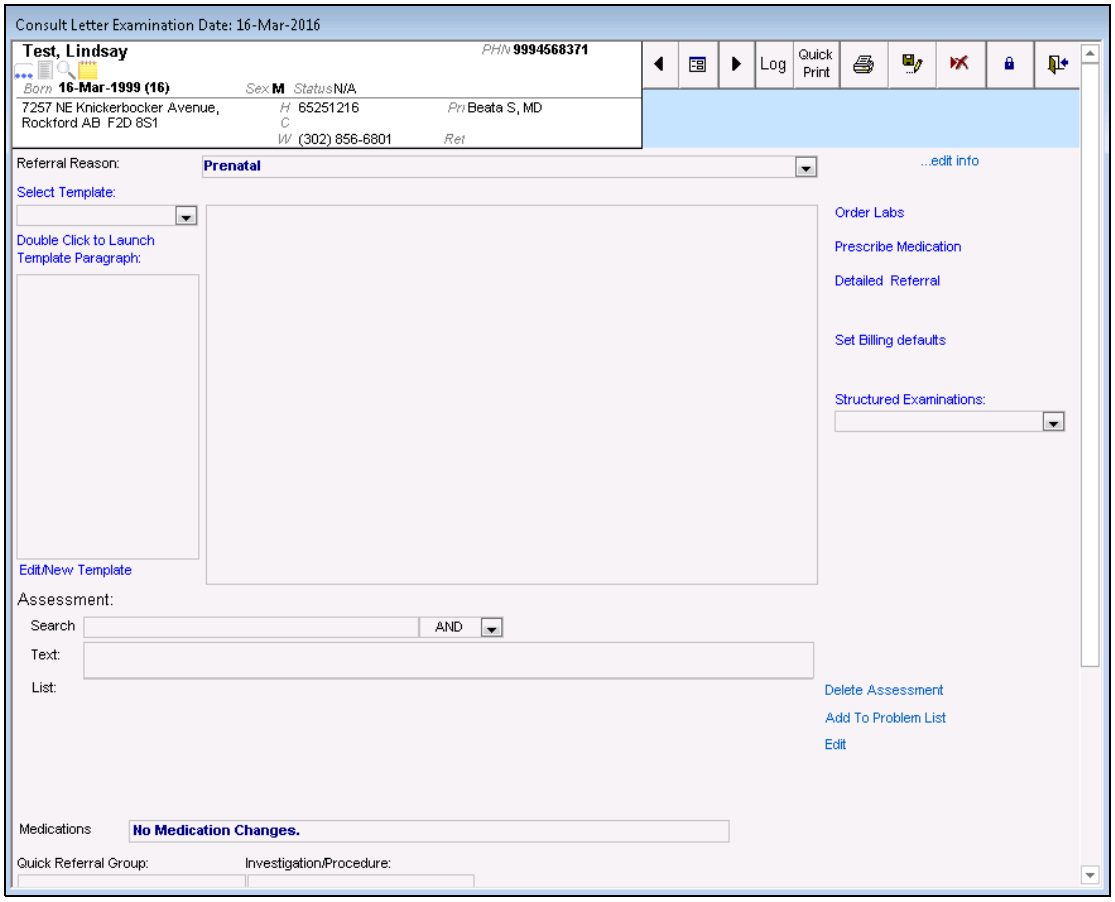
- A list of the patient's previous and current encounters and messages (includes encounter date, status [**C** = complete, **I** = Incomplete], attending physician, and visit type).
- A summary of important and recently added patient chart data.
- The SMART patient banner (located at the top of the window): here you can view a summary of the patient's demographic information, latest vitals and measurements, smoking status, care team information, and notifications.



Tips for viewing patient information from the SMART patient banner

- To view the patient's Medical Summary (medical chart), click anywhere on the SMART patient banner.
- If the patient has any un-reviewed investigations (labs), a number displays beside **Investigations** ( ). To review the investigations, click the icon.
- If the patient has any un-reviewed documents (medical reports), a number displays beside **Documents** ( ). To review the documents, click the icon.
- If there are incomplete messages related to the patient, a number displays beside **Messages** ( ). To view the messages, click the icon.
- If there are incomplete follow-up tasks related to the patient, a number displays beside **Follow Ups** ( ). To view and manage the follow-up tasks, click the icon.
- To view or modify the patient's detailed demographic information, below the patient's name, click .

2. In the list of office visits, click the office visit you want to start a consult letter form for (in most cases this is the incomplete (I) visit listed at the top with today's date), and then in the **Templates** drop-down list, click **Consult Letter**. The EMR displays the consult letter form.



If an MOA, nurse, or other front end staff has entered notes for this visit, this information displays in the consult letter form. You can edit and add to this information as needed.

Practise: Starting a consult letter visit note

- In the WorkDesk **Appointments** tab, click a patient's name to open the **Patient** tab.
- Perform the following actions from the SMART patient banner:
  1. Open the patient's Medical Summary (medical chart).
  2. View the patient's demographic information.
- Open a consult letter form for today's visit.

Entering consult letter note data

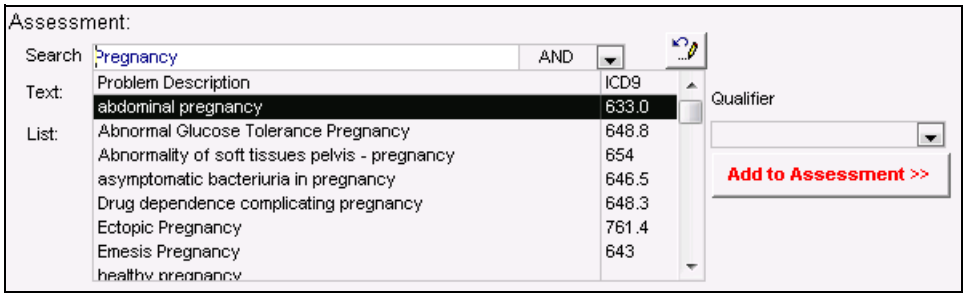
The consult letter form contains structured text areas for easy data entry. A majority of your notes are written in the main text area, with your assessment notes entered in the lower part of the window.

To enter a patient's visit notes in the consult letter form:

1. In the **Referral Reason** field, enter a short description of the primary visit reason or, in the drop-down list, click a primary visit reason.
2. In the main text area, enter your visit notes in the form of a consult letter. (For example, start your notes with a statement such as "Thank you for referring your patient to our clinic regarding...".)

> **Tip**: To check your spelling, in the main text area, right-click, and then click **Check Spelling**.

3. In the **ASSESSMENT** area, enter the problem(s) the patient is seeing you for:
   a) In the top field, enter all or part of a problem name or ICD9 diagnosis code, and then press **Enter.** The EMR displays a list of matching problems.



   b) In the results list, click a problem.
   c) (Optional) In the **Qualifier** field, enter the position (for example, right, left, front) or other qualifier information about the problem, or in the drop-down list, click a qualifier.

d) Click **Add to Assessment**. The EMR displays the selected problem in the **Structured** field.

> **Tip**: When you add a problem to the **ASSESSMENT** area, you can choose to add the problem to the patient's Problem List:
>
> - In the **ASSESSMENT** area, click the problem, and then click **Add To Problem List**.
> - If you enter the wrong diagnosis, and have not yet selected **Add to Assessment**, to clear the search field, click **Cancel Search** ().
> - If you enter the wrong problem, and have selected **Add to Assessment**, to remove the diagnosis, click the diagnosis, and then click **Delete Assessment**.

4. In the **Assessment** area, in the **Text** area, enter any additional assessment notes.
5. From the consult letter form, perform any other actions required in response to the visit (for example, create a requisition form, prescribe a medication, or record a patient's medical history information). See:
   - "Recording a patient's medical history while entering visit notes" on page 43
   - "Performing actions on a patient's chart while entering visit notes" on page 44
6. To print your consult letter, click one of the following options:
   - **Quick Print** (

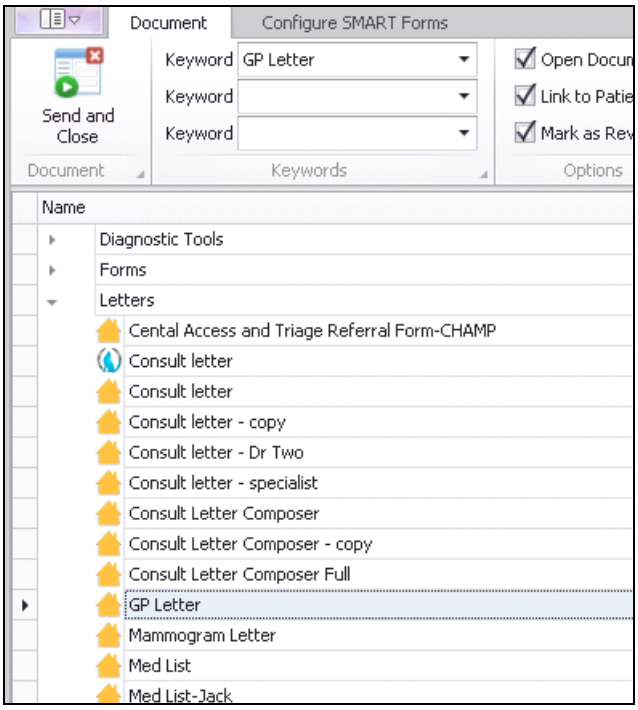
): To print your consult letter to your default printer
   - **Print** (): To print to a selected printer or fax machine or to set preferences before printing/faxing

Printing consult letters using Microsoft Word

If you want more options for formatting your letter, you can pull the data from the consult letter form into a Word Document template (SMART Form). You can then modify the letter before sending it. For example, you can add bullets, add a letterhead, or change the text font.

To open a consult letter in a SMART form (Microsoft Word template):

1. On the consult letter form window, right-click and then, in the SMART Menu, click **SMART Forms**. The EMR displays the Send to SMART Form window.
2. In the left pane, expand the **Letters** category.



3. Double-click the consult letter template you want (unique to each clinic). The EMR opens a letter template in Microsoft Word with your visit notes populated
4. Modify the letter as needed, and then save and print the letter.

7. To save and close your visit notes, click  . The EMR saves your visit notes, and prompts you to lock the visit note.

8. Perform one of the following actions:
   - To “finish” the visit note click **Yes**.
   - To add information to the visit note at a later time, click **No**. The EMR adds the patient to your **Incomplete Visit Record** list.

A visit note is never truly “locked”; you can go back and edit a locked note if needed.

Practise: Entering basic consult letter notes

- Open the consult letter form for a test patient, and then enter a visit reason.
- Enter the body text for the consult letter.
- Enter a diagnosis for the visit.

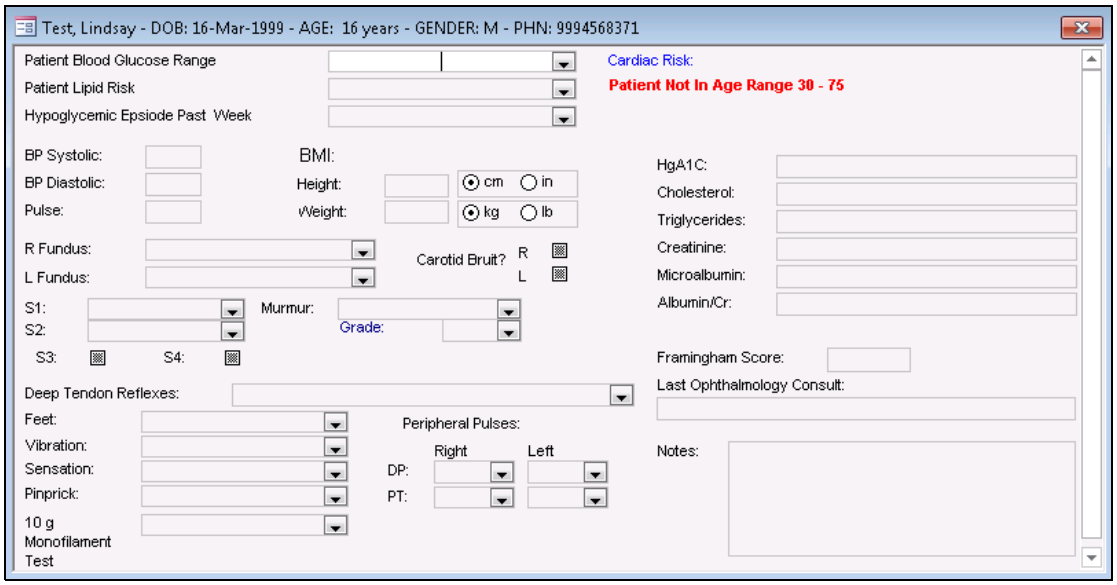
Using structured examination templates

In the consult letter form, you can enter vitals, measurements, and other exam findings using visit-specific templates called "structured examinations". Structured examinations contain fields specific to a particular problem or type of examination. For example, the **Diabetes Review** exam includes fields for hypoglycemic episodes, foot exams, and Framingham score. Information recorded in structured examinations can be searched and reported on.

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

To use a structured examination:

1. On the consult letter form, in the **Structured Examinations** drop-down list, select a structured exam. The EMR opens the structured examination in a new window.



2. Enter data into the various text fields, drop-down lists, and check boxes, and then click **Close** ( ).

- **IMPORTANT:** Information entered in a structured examination is saved in the patient's encounter record, however, structured examinations DO NOT print with your consult letter, unless you print your consult using a SMART Form.
- As with visit notes, if your nurse or front end staff enters information in a structured examination, you see this information when you open the same structured examination for the visit. You can edit or add to the information as needed.

Tips for entering and viewing exam data

- If you only want to enter a patient's vitals, select the **General** exam.
- To graph a vital or measurement, beside the value you want to graph, click  .
- To view values that were previously entered in an exam field, double-click the field.
- To view a patient's Medical Summary (chart), click back to the consult letter form and then, on your keyboard, press **F7** or click the SMART patient banner.
- If, after you close the structured examination, you want to modify or enter additional information, simply open the exam again, and then add or modify information as needed.
- You can enter information into more than one exam during a visit.

Practise: Using exam templates

- Start a consult letter visit note for a patient.
- In the **Structured Exam** drop-down list, select an examination (for example, **Diabetes Review**).
- Enter exam data, and then close the structured exam window.

Scenario: Using Structured Exams

You are completing a 6 month check-up for an infant. What exam would likely be most useful for entering the visit data?

Consult letter templates

If your consult letters follow similar formats for certain types of visits, you can create consult letter templates to save you time. Consult letter templates consist of a series of pre-written paragraphs. You choose which paragraphs you want to include in each letter. Once you insert each paragraph into a consult letter, you can edit the paragraph as needed.

Paragraphs can also:

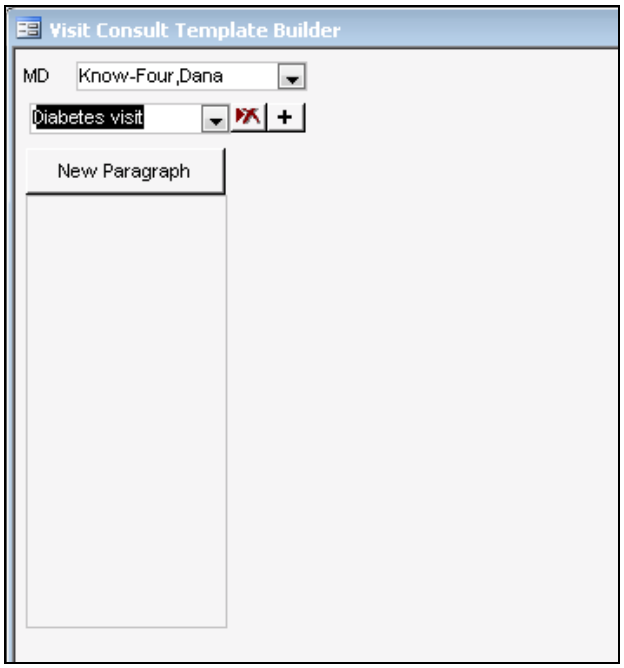
- Automatically pull in data from a patient's chart.
- Contain a series of check box items. In paragraphs with check box items, you select which text items you want to include in the paragraph.

Creating consult letter templates

When you create a consult letter template, you create pre-written paragraphs that can be chosen when the template is used. You can make the entire template in one paragraph; however, if you split your template into numerous paragraphs, the template user can include or exclude paragraphs in the consult letter, as needed.

To create a consult letter template:

1. Open the consult letter form for a test patient. See "Starting consult letter visit notes" on page 28.
2. On the left side of the window, click **Edit/New Template**. The EMR displays the Visit Consult Template Builder window, with your name selected in the **MD** field.



3. If you want to allow other providers to use the template, in the **MD** field, select **<<All MDs>>**.

4. Click  , and then enter a name for the template.

5. To add a paragraph to the template, click **New Paragraph** and then, in the "New paragraph name" window, enter a descriptive name for the paragraph.

6. In the main text area on the Visit Consult Template Builder window, enter text for the paragraph as you want it to appear in the consult letter.

7. To add check box choices to the paragraph:

   a) In the paragraph, click where you want selected check box items to insert.

   b) Enter check box options using the following format: **{Item 1|Item 2|Item 3|...}**. For example, you can enter: "Diet: {Doing all that they think they can do for optimal nutrition | Looking for nutritional advice | Insufficient fruit and vegetables | Excessive simple carbohydrates}"

CAUTION: For check box items, use only letters and numbers. Do not use any special characters such as _?:,.*> or the template will not work properly.

Check box options are limited to a single sentence at most, as you cannot use periods or commas. Use simple statements only.

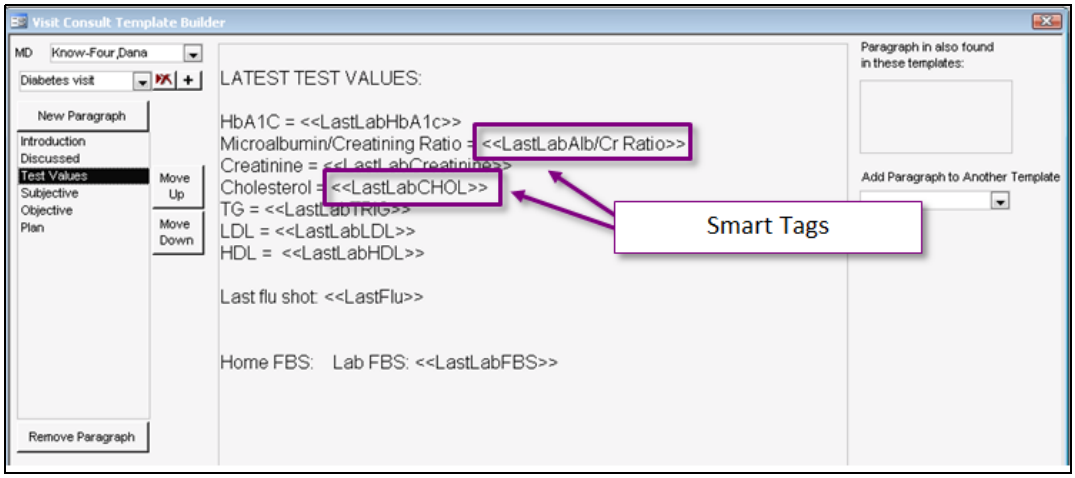
Tip: When the template is used, the first check box is always selected by default. Consider making the first check box blank, or N/A .

8. To have patient data pull into the paragraph automatically (using SMART tags):

   a) Open Wolf EMR online Help and find the SMART tag you want: In the Wolf EMR online Help, search for "SMART tags". The EMR displays the Smart Tags help topic, with a list of available tags you can choose from.

Name	Area it is used	Description
<<age>>	Demographics	Inserts patient's age.
<<APApptID>>	Appointments	Inserts the appointment ID number.
<<APMDID>>	Appointments	Inserts the appointment MD ID number.
<<APApptStart>>	Appointments	Inserts the appointment start time.
<<APApptTypeID>>	Appointments	Inserts the appointment type ID number
<<APPatientID>>	Appointments	Inserts the patient ID making the appointment.
<<APNonPatientName>>	Appointments	Inserts the appointment non-patient name.
<<APApptLength>>	Appointments	Inserts the appointment length

b) On the Visit Consult Template Builder window, in the paragraph, enter the SMART tag name where you want the corresponding patient data to populate.



9. If you want to use the paragraph in another template as well, in the right pane, in the **Add Paragraph to Another Template** drop-down list, select the template.

10. To add additional paragraphs, repeat Step 5 and Step 9 .

Tips for managing consult letter template paragraphs

- To move a paragraph: in the left pane, click the paragraph, and then click **Move Up** or **Move Down**.
- To remove a paragraph: in the left pane, click the paragraph, and then click **Remove Paragraph** ( ).

11. To save and close the template, click .

Practise: Creating consult letter templates

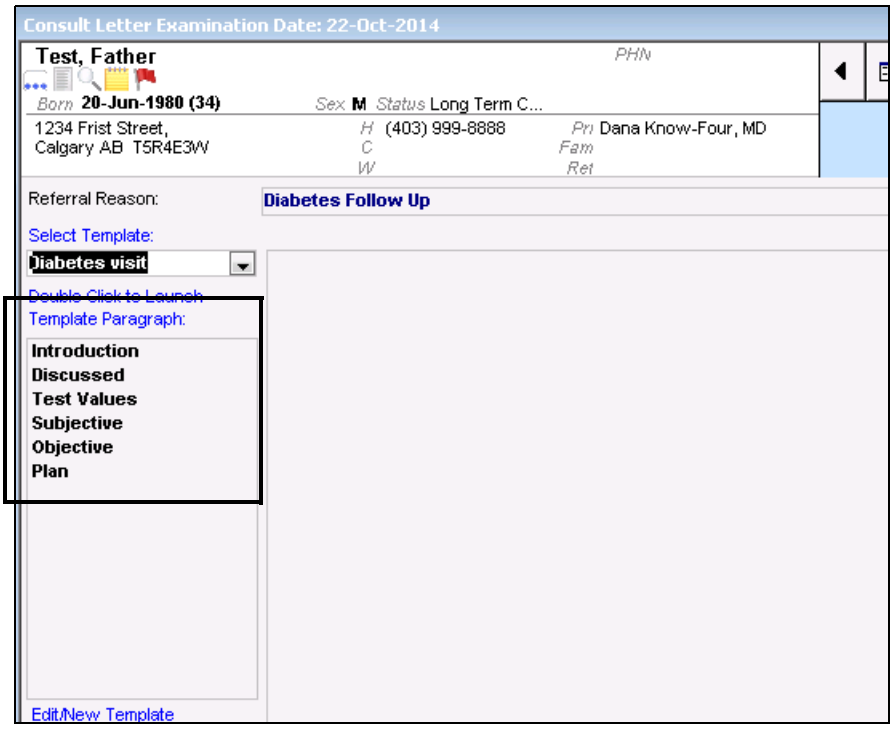
Create a Diabetes Visit consult letter template with paragraphs laid out as follows:

Paragraph name	Paragraph content
Introduction	Thank you for referring **<<patient's first name inserts here>>** to the Wolf Diabetic Centre.
Discussed	DISCUSSED: ☐ Lack of targets for glucose and HbA1C ☐ Smoking cessation ☐ Activity increase ☐ Nutrition
Test Values	LATEST TEST VALUES: HbA1C = **<<Latest lab result inserts here>>** Creatinine = **<<Latest lab result inserts here>>**
Subjective	SUBJECTIVE: Diet: ☐ Doing all that they think they can do for optimal nutrition ☐ Looking for nutritional advice ☐ Insufficient fruit and vegetables ☐ Excessive simple carbohydrates Smoking: ☐ Continues to be a smoker ☐ Working toward smoking cessation ☐ Non Smoker
Plan	Next steps include: ☐ Insulin initiation ☐ Diabetic information handout ☐ Diabetic program referral ☐ Dietitian referral

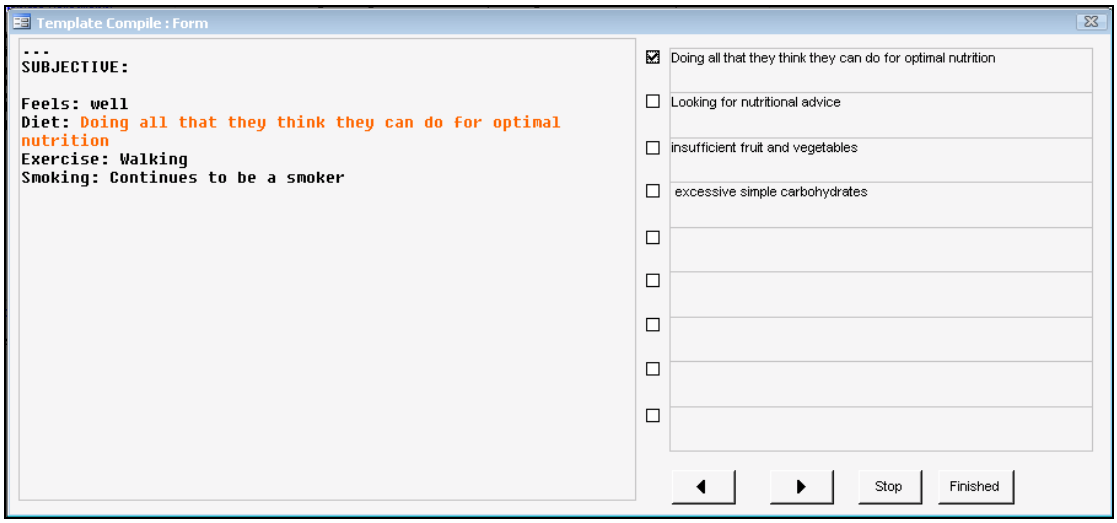
Using consult letter templates

To use a consult letter template:

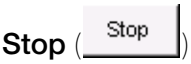
1. On the consult letter form, in the **Select Template** drop-down list, click a template.
2. In the main text area, click where you want a paragraph to insert.
3. In the paragraph list, double-click a paragraph.



The EMR inserts the paragraph's text in the main text area. If the paragraph has check box items associated with it, the EMR opens a window with a list of options to pick from.



Tips for selecting check-box items

- Read the orange text on the left to understand what the check box selection pertains to.
- You can select more than one item.
- To move to the next selection list for the paragraph, click **Next** () or, to go back to a previous selection list, click **Previous** ().
- To exit the selection window, click **Stop** (

). In the main text area, the EMR inserts text for the check boxes you selected.

4. Edit the inserted paragraph text as needed.
5. To insert another paragraph template, repeat Step 2 to Step 4 .

Tips for adding multiple paragraphs

- Each paragraph inserts where your cursor is situated in the main text area. If you want a double space between each paragraph, press **Enter** twice before inserting the next paragraph.
- You can insert paragraphs in any order.

Recording a patient's medical history while entering visit notes

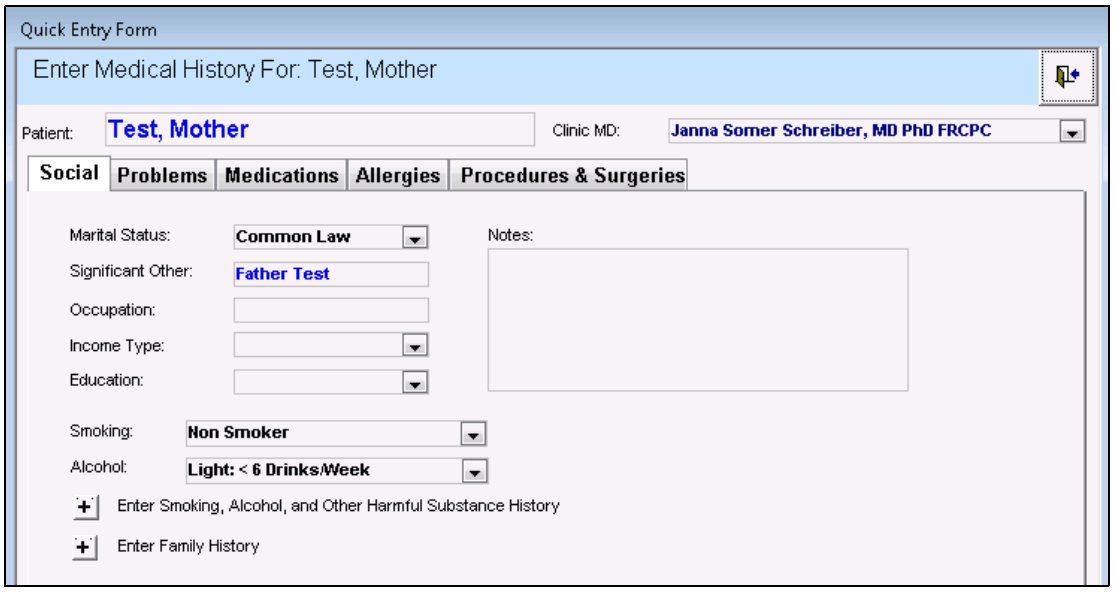
When you are entering visit notes in the consult letter form, you can quickly record a patient's medical history using Quick Add. With Quick Add, you can record basic information to a patient's Medical Summary:

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

> **Note**: In later modules, you will learn how to add more detailed medical history information to a patient's Medical Summary.

To record a patient's medical history during a visit:

1. On the consult letter form, right-click and then, in the SMART menu, click **Quick Entry**. The EMR displays the Quick Entry Form window.

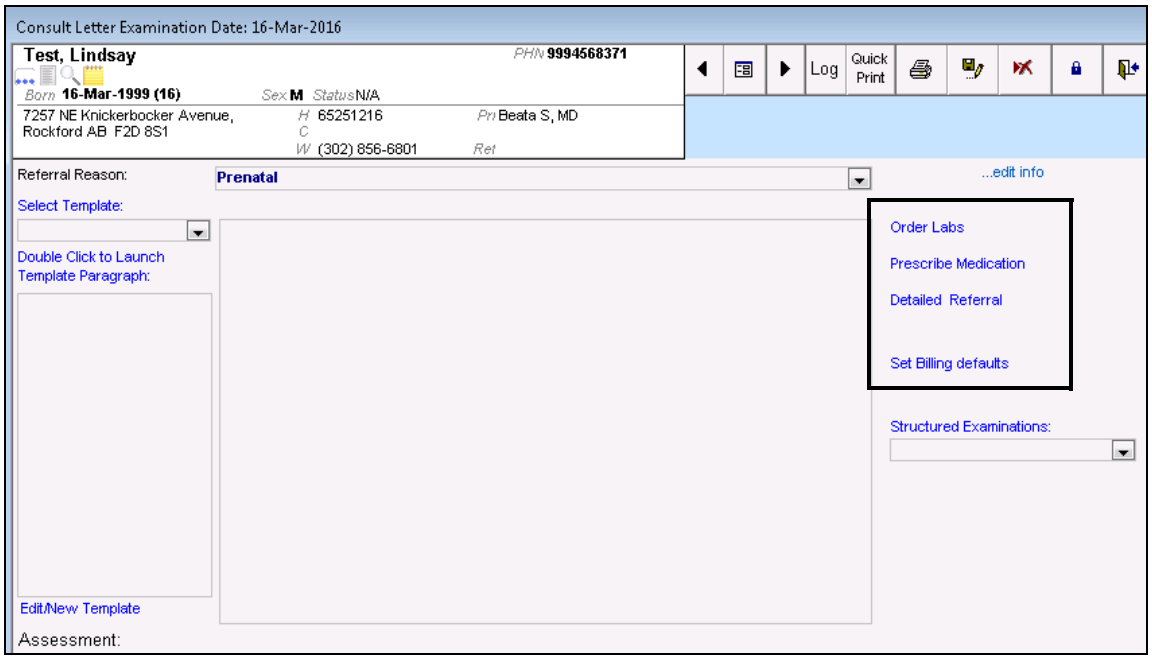


2. In one or more of the tabs, enter information as needed, and then click  .

> **Tip for entering medical history using Quick Entry**
>
> - If you want to view the patient's Medical Summary (medical chart) as you are entering information in the Quick Entry window, click the patient's name (displayed in blue at the top of the window).

Performing actions on a patient's chart while entering visit notes

The consult letter form contains a variety of quick-links you can use to view patient information (for example, patient lab results), or to perform common actions (for example, to prescribe a medication). Links are strategically placed, with each link located near the fields it relates to.

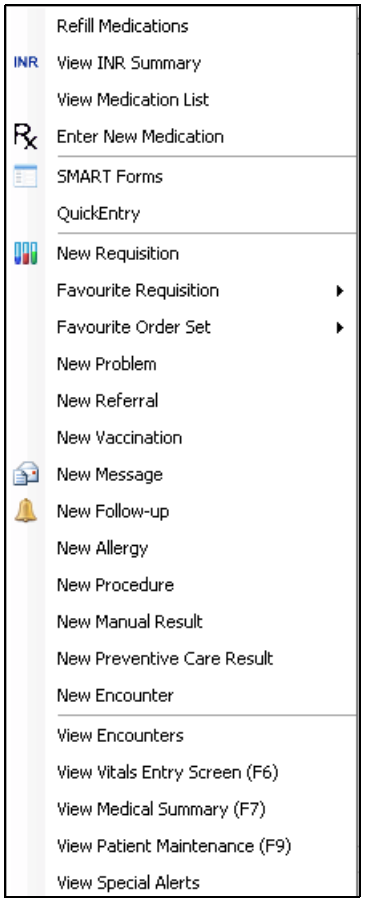


As you enter information in the SOAP form, new links may display in response to the information entered. For example, if you enter and then click a diagnosis in the **ASSESSMENT** area, links display to **Add To Problem List**, **Delete Assessment,** and **Edit Assessment**.

You can perform a number of additional actions from the consult letter form via the SMART menu. For example, you can:

- Send a message or follow-up task regarding the patient to your front end staff (for example, if you want your MOA to send the consult letter to the patient's family physician)
- Perform a Cardiac Risk Assessment
- Record a vaccination

To open the SMART menu, right-click anywhere on the consult letter form.



You can open the SMART menu by right-clicking most windows related to a patient's record, including:

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

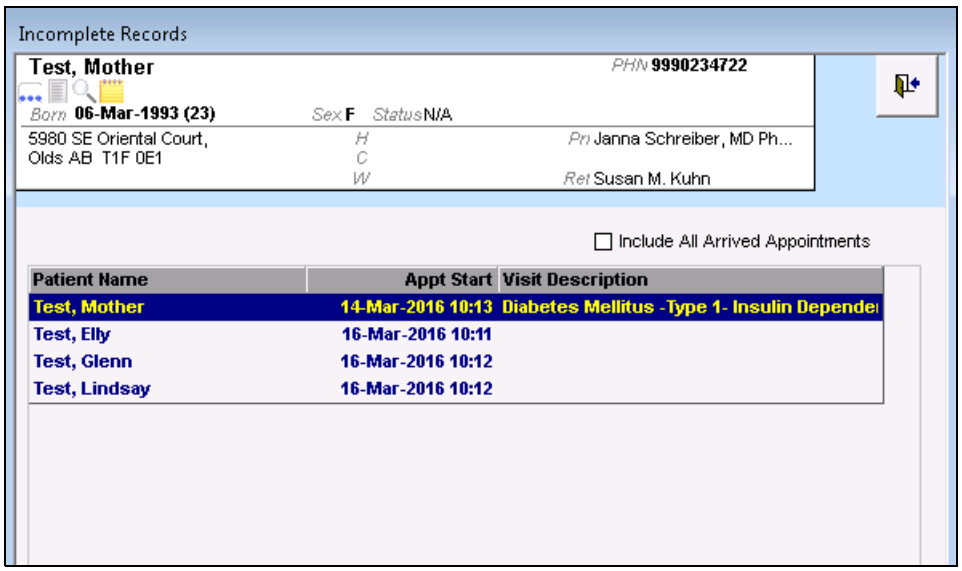
As a rule-of-thumb, if a window displays the SMART patient banner, you can open the SMART menu from that window.

Managing your incomplete visit notes

In the old days of paper charting, your desk likely contained a pile of patient charts you had to finish notes for. In Wolf EMR, your "pile" is located on the WorkDesk. Any time you save a visit note without locking it, the EMR adds the visit note to your **Incomplete Visit Record** list. From the **Incomplete Visit Record** list, you can go back and finish your notes at your convenience.

To view and finish your incomplete visit notes:

1. On your WorkDesk, in the **Patient Records** area, click **# Incomplete Visit Records**. The EMR displays the Incomplete Records window.



> By default, the **Incomplete Records** list displays only records that you have opened and then closed. To include incomplete visit notes for all arrived appointments, select the **Include All Arrived Appointments** check box.

2. In the list of incomplete visit records, double-click the visit record you want to complete. The EMR opens the consult letter form for the incomplete visit record.
3. Complete any unfinished areas on the consult letter form, and then save and lock the visit note. See "Entering consult letter note data" on page 31.

Evaluation

Complete the following questions.

1. What is the easiest way to open the patient's Medical Summary (chart) from the consult letter form?

2. In the consult letter form, where do you enter the visit reason?

3. If you select a problem (diagnosis) in the **ASSESSMENT** area of the consult letter form, can you add the problem to the patient's general Problem List?

4. Can you use more than one exam template?

5. You have diagnosed your patient with diabetes. You want to document her full diabetic history. What is the BEST and recommended way to enter her history and diabetic visit notes so that you can effectively manage her condition?

6. During a visit, your patient indicates that they had an appendectomy 2 years ago. What is the quickest way to record this in the patient's chart?

7. You have finished your patient visits for the day and want to ensure that you signed off on all your visit notes. Where can you find a list of your incomplete visit notes?

8. How do you program a consult letter template to pull a specific piece of patient information automatically? For example, you want a patient's latest HbA1C lab result to pull into the letter.

End of Module

Creating prescriptions and managing medications

Introduction to this module

Purpose

In this module you learn how to create and manage patient prescriptions. In Wolf EMR, you can create and print patient prescriptions from any window related to a patient's record (via the SMART menu). Once a prescription is created and printed, you can easily:

- Re-print the prescription
- Modify the prescription
- Refill the prescription
- Discontinue the prescription

Wolf EMR tracks a patient's active (current) and inactive (previous) medications in the Medical Summary, and displays the patient's medications in the Prescription entry window. This enables you to view at-a-glance what medications the patient is taking when you prescribe new medications.

Objectives

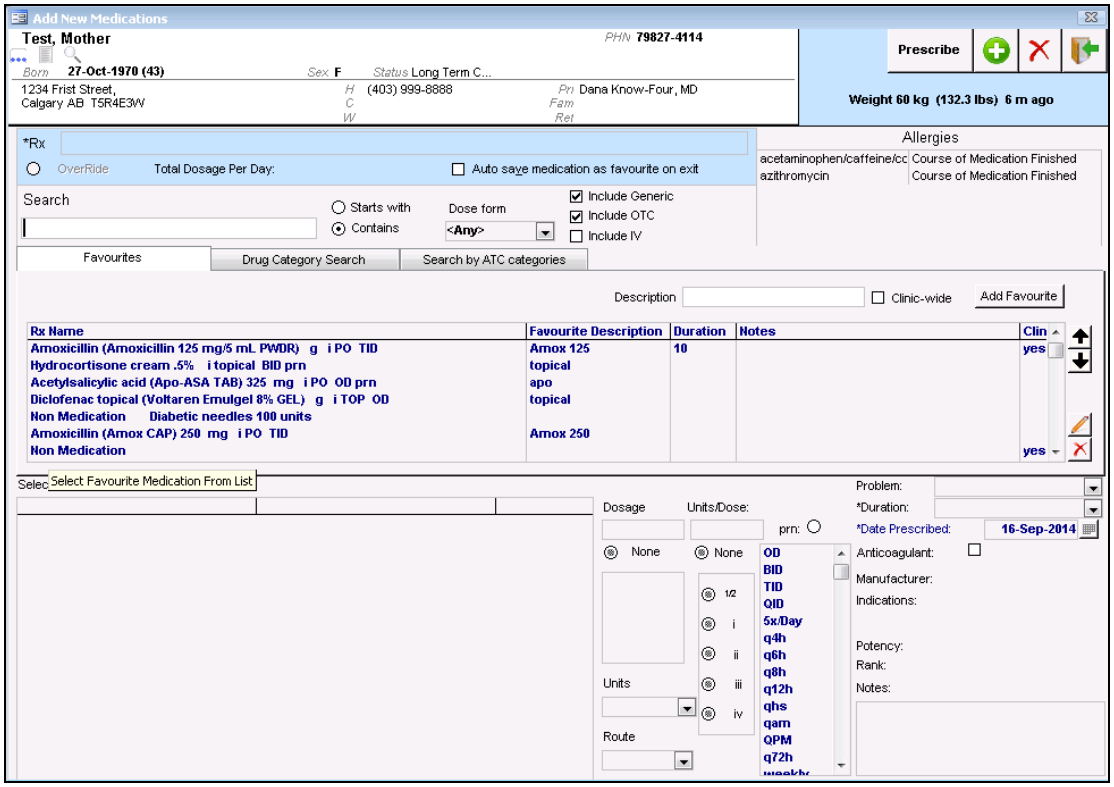
Upon completion of this module, you will be able to:

- Create and print a basic prescription
- Create a prescription for multiple medications
- Modify a prescription
- Reprint a prescription
- Discontinue a medication for a patient
- Refill an active prescription, or resume an inactive prescription
- Record a patient's medications without prescribing the medications

Creating prescriptions

To create a prescription:

1. On any window of a patient's record (including the SOAP form and consult letter form), right-click and then, in the SMART menu, click **Enter New Medication** ( ). The EMR displays the Add New Medications window.



2. Search for a medication to prescribe:

   a) In the **Search** field, enter part or all of the medication name (generic or trade name), and then press **Enter**. The EMR displays a list of matching medications in the **Select medication from list** area.

   b) Click the medication you want.

Medication/treatment search tips

- Wolf EMR does not produce accurate search results for misspelled names. If you are not certain how to spell a medication name, in the **Search** field, enter only the first three letters of the medication name.
- By default, the EMR displays matching medications that start with the term you entered. To include medications that contain your search term anywhere in the name, in the **Search** area, click **Contains**.
- You can narrow your search results by selecting the form you want the medication to be in. For example, to search for amoxicillin in capsule form, in the **Dose Form** drop-down list, click **CAP**. The search results return all amoxicillin options available in capsule form.
- If you are searching for an over-the-counter medication, in the **Search** area, select the **Include OTC** check box.
- If you are searching for a brand name medication, clear the **Include Generic** check box.
- If you are prescribing a compound medication (for example, Hydrocortisone topical (Neo-HC CREA) in 20 mg Glaxal base):
  1. Search for and select the first ingredient of the compound.
  2. In the **Search** area, select **OverRide**. The ***Rx** field becomes editable.
  3. In the ***Rx** field, enter the remainder of the compound name/ingredients, in addition to application instructions.
- If you are prescribing a non-medication treatment (for example, a knee brace):
  1. Search for and select **Non Medication**.
  2. Below the blue ***Rx** field, select **OverRide**. The ***Rx** field becomes editable.
  3. In the ***Rx** field, beside the words **Non Medication**, enter the treatment name and any application instructions.

3. In the prescription details area (located on the bottom right of the Add New Medications window), enter or modify prescription details for:
   - Dosage
   - Frequency
   - Duration

Depending on the medication you choose, the prescription detail fields may populate with default values. You can edit default values as needed.

Tips for entering prescription details

- If you want the EMR to automatically discontinue the medication for the patient when the prescription is completed, in the **Duration** drop-down list, select a duration.
- If the patient will be taking the medication for an extended period of time (continuous), in the **Duration** drop-down list, click **No Cut Off**.

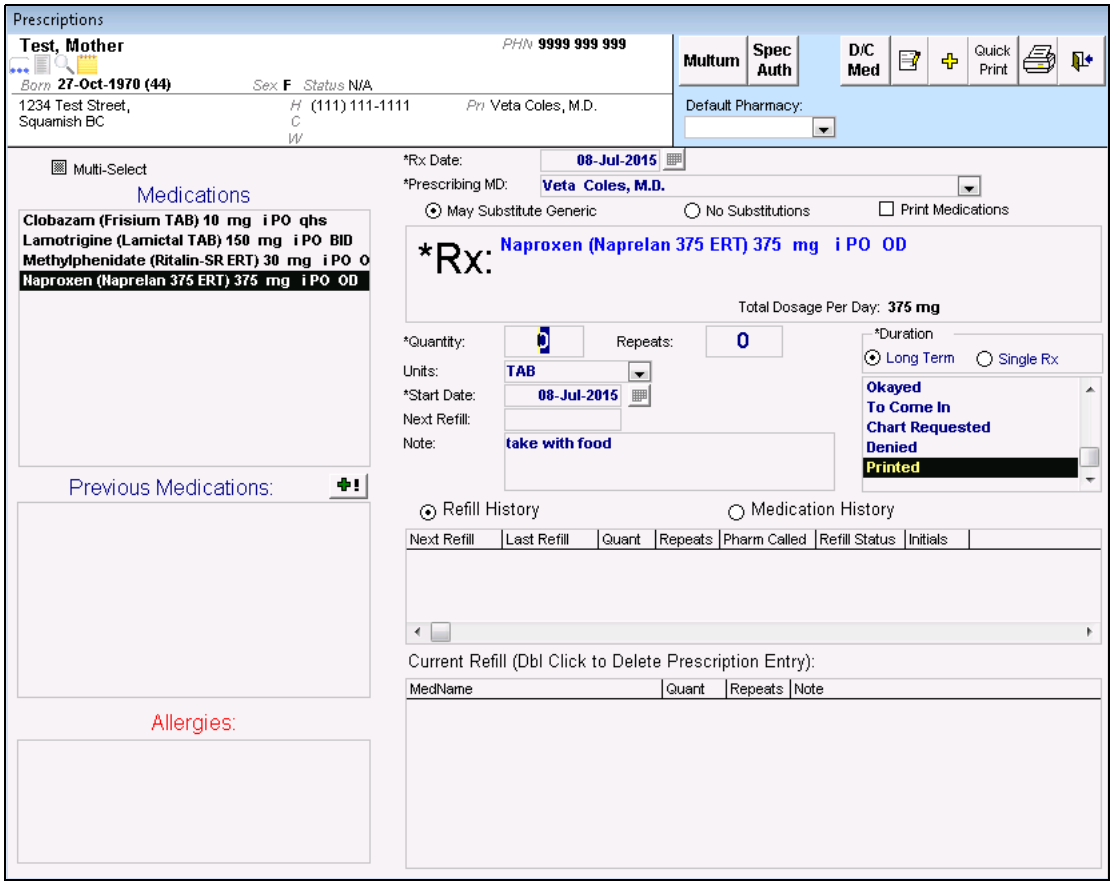
The EMR displays the prescription details at the top of the window, in the blue ***Rx** field.

Tip: To modify the prescription details (for example, to change the prescription details from "1 caps PO" to "1-2 caps PO"):

1. Below the blue ***Rx** field, select **OverRide**, the ***Rx** field becomes editable.
2. In the ***Rx** field, modify the prescription details as needed.

4. To view interactions the medication may have with the patient's current medications, allergies, or problems, at the top of the window, click **Multum** (

).
5. At the top of the window, click **Prescribe**. The EMR displays the Prescriptions window.



6. In the **Rx** area, enter or modify prescription details for:
   - Quantity and associated units
   - Repeats
   - Start date
   - general Notes

> **Tip**: If you want to modify the prescription's dose, frequency, or duration, you can go back to the previous window (Add New Mediation window) at any time. At the top of the Prescriptions window, click **Edit Medication Dosing** ( ).

7. To prescribe another medication (to print on the same prescription), enter the next medication. See "Prescribing multiple medications" on page 54.
8. To print the prescription, click one of the following options:
   - **Quick Print** (Quick Print): To print the prescription to your default printer.

- **Print** (): To select a printer or fax machine to print to.

After the prescription prints, the EMR changes the prescription **Status** to '**Printed**'.

Practise: Creating single-medication prescriptions

Create a basic prescription for a common medication.

- From a visit note, start a prescription.
- Search for one of your common medications by name.
- Enter dosage, frequency, and duration details, and then click **Prescribe**.
- Enter quantity, duration, and repeat information, and then select if the patient will be taking the medication for a Short Term or Long Term.
- Print the single-medication prescription.

Prescribing multiple medications

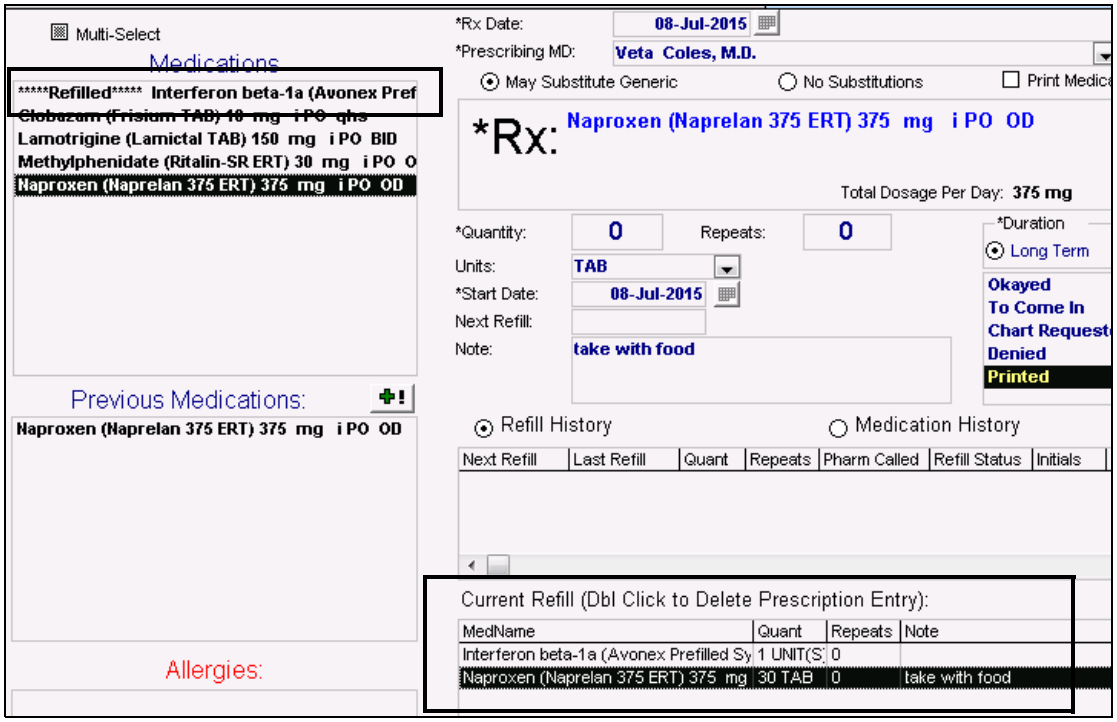
When you prescribe more than one medication for a patient, you can print all the medications on a single prescription printout.

As you prescribe multiple medications, the EMR displays the medications in one area, enabling you to review your prescribed medications before printing.

To prescribe multiple medications for a patient:

1. Prescribe the first medication. See “Creating prescriptions” on page 50.
2. To prescribe additional medications, in the Prescriptions window, perform one of the following actions:
   - To prescribe a medication that has not been previously prescribed to the patient, click **Add/New** (), and then prescribe the medication as normal. See “Creating prescriptions” on page 50.
   - To prescribe a medication that the patient has been previously prescribed, refill or resume the prescription. See “Refilling and resuming prescriptions” on page 59.

   As each medication is added to the prescription, the EMR displays the medication name in the **Current Refill** area. For previously prescribed medications, in the **Medications** area, the word **Refilled** also displays beside the medication’s name.



Tip: If you add a medication in error, in the **Current Refill** list, double-click the medication name to remove it from the final print out.

3. To print the prescription, click one of the following options:

   - **Quick Print** (Quick Print): To print the prescription to your default printer.
   - **Print** ( ): To select a printer or fax machine to print to.

Practise: Prescribing multiple medications

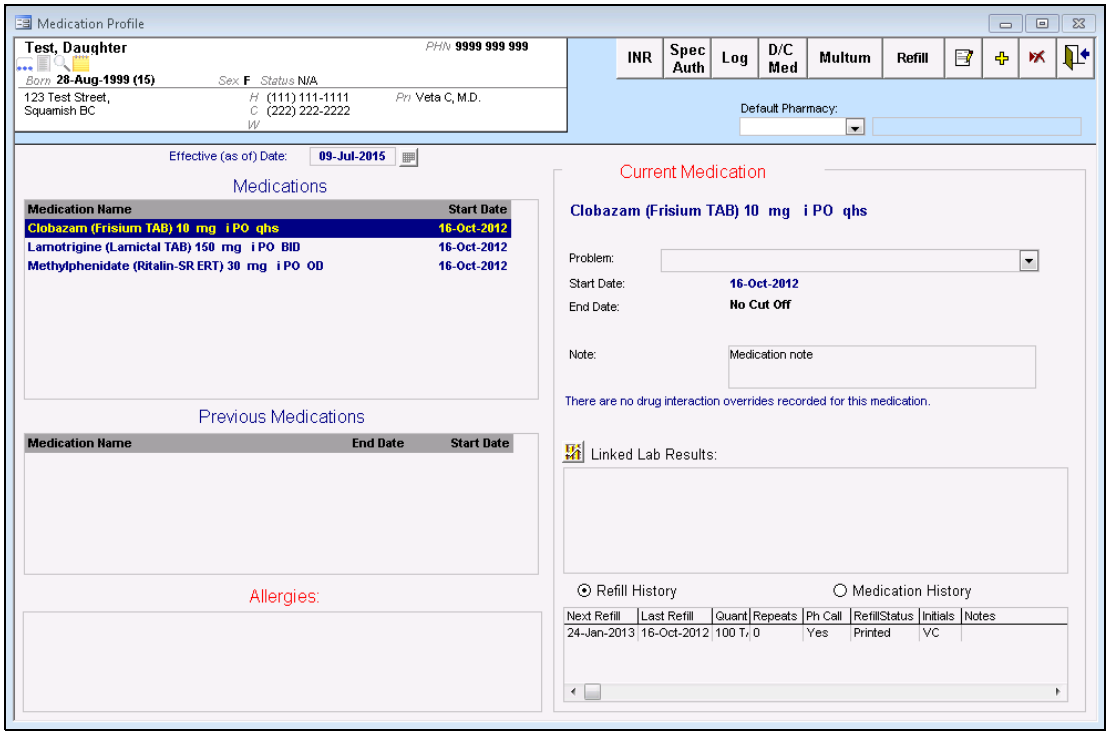
- Create a prescription for Warfarin 1mg once daily for 7 days (continuous).
- Add a prescription for Amoxicillin 250mg, three times daily (TID) for 10 days.
- Review and manage interaction warnings (between Amoxicillin and Warfarin - Moderate drug interaction displays).
- Print a multiple-medication prescription.

Modifying prescriptions

If after you print a prescription you realize there is an error on the prescription, from the **Medication Profile** you can modify the prescription details, and then reprint the prescription.

To modify a prescription:

1. On any window related to the patient's record, right-click and then, in the SMART menu, click **View Medication List**. The EMR displays the patient's medication profile.



2. In the **Medications** area, click the medication you want to modify. The EMR displays the medication's prescription details on the right side of the window.

3. Click **Edit Medication Dosing** ( ). The EMR displays the prescription in the Add New Medications window.

4. Modify the dose, frequency, and duration details as needed, and then click **Prescribe**.

5. In the Prescriptions window, modify the quantity, quantity units, repeats, and start date details as needed.

6. To print the prescription, click one of the following options:

   - **Quick Print** (Quick Print): To print the prescription to your default printer.
   - **Print** ( ): To select a printer or fax machine to print to.

Scenario: Editing prescription details

After you print a prescription for Lipitor, you realize that the dosage you specified is wrong. What is the fastest way to modify the dose, and re-print the prescription?

Reprinting prescriptions

If a patient loses or forgets their prescription, you can re-print the prescription at any time.

To reprint a prescription:

1. On any window related to a patient's record, right-click and then, in the SMART menu, click **Refill Medications**. The EMR displays the Prescriptions window.
2. In the **Rx Date** field, enter the date of the original prescription, or to select the date on a calendar, click  . In the **Current Refill** area, the EMR displays all medications prescribed on the selected date.

Tip: if you do not know the date the original prescription was created, you can view the start dates of the patient's current medications in the Medication Profile.

To view a patient's Medication Profile:

- On the Prescriptions window, right-click and then, in the SMART menu, click **View Medication List**. The EMR opens the patient's Medication Profile, with a list of the patients current medications and corresponding start times displayed in the **Medications** area.

3. Optionally, modify any of the listed medications' prescription details. See "Modifying prescriptions" on page 56.

Tip: If a medication is listed in the **Current Refill** area that you DO NOT want printed on the prescription, double-click the medication. The EMR removes the medication from the **Current Refill** area.

4. To print the prescription, click one of the following options:

- **Quick Print** (

): To print the prescription to your default printer.
- **Print** (): To select a printer or fax machine to print to.

Discontinuing medications

Best practice: When you instruct a patient to stop taking a medication, always record the discontinuation in the patient's record. This way, the patient's Medication Profile accurately reflects the medications the patient is taking.

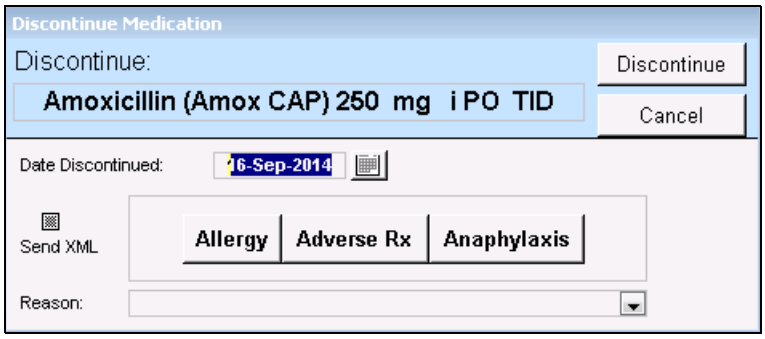
Discontinuing medications that a patient is no longer taking also ensures you do not receive medication interaction warnings that are no longer relevant.

Note: If you are changing a medication's dose details, you do not have to discontinue the medication before prescribing a new dose. Instead, modify the original prescription's details. See "Modifying prescriptions" on page 56.

When you discontinue a medication, you can record any adverse reactions to the medication at the same time.

To discontinue a medication:

1. Open the patient's Medical Profile. See Step 1 in "Modifying prescriptions" on page 56.
2. In the **Medications** area, click the medication and then, at the top of the window, click **D/C Med**. The EMR displays the **Discontinue Medication** window.



3. In the **Reason** drop-down list, select a reason for discontinuing the prescription. If the reason you want is not available, enter your reason in the **Reason** field.
4. Perform one of the following actions:
   - If you are discontinuing the medication due to an adverse reaction, click **Allergy**, **Adverse Rx**, or **Anaphylaxis**, and then, in the allergy entry window, enter the reaction details.
   - If you are discontinuing the medication for another reason, click **Discontinue**.

Scenario: Recording an adverse reaction to a medication

After taking Lipitor for a week, your patient comes back and reports that they are experiencing severe muscle weakness. What is the fastest way to discontinue the medication and record the adverse reaction?

Refilling and resuming prescriptions

After you prescribe a medication to a patient, the process for re-prescribing (refilling) the medication is quick and easy. You can refill a single-medication or multiple medications at once. You can also resume inactive medications.

To refill or resume a prescription:

1. On any window related to a patient's medical record, right-click and then, in the SMART menu, click **Refill Medications**. The EMR opens the Prescriptions window.
2. Perform one of the following actions:
   - If you are refilling an active medication, in the **Medications** area, click the medication you want to refill. The EMR displays the medication's prescription details.
   - If you are resuming an inactive medication, in the **Previous Medications** area, click the medication you want to resume, and then click **Re-activate previous medication** ( ).The EMR adds the medication to the **Medications** area and displays the medication's prescription details.
3. In the **Quantity** field, enter the quantity or duration and then, in the **Units** field, enter the associated quantity or duration units.
4. Modify other prescription details as needed.

Tip: To modify the dosage and frequency prescription details, at the top of the Prescriptions window, click **Edit Medication Dosing** ( ). The EMR displays the Add New Medication window.

5. To refill or resume another prescription, repeat Step 2 to Step 4 .
6. To print the prescription, click one of the following options:
   - **Quick Print** (Quick Print): To print the prescription to your default printer.
   - **Print** ( ): To select a printer or fax machine to print to.

All medications that display in the **Current Refill** area on the Prescriptions window are included in the refill printout.

Scenario: Refilling prescriptions

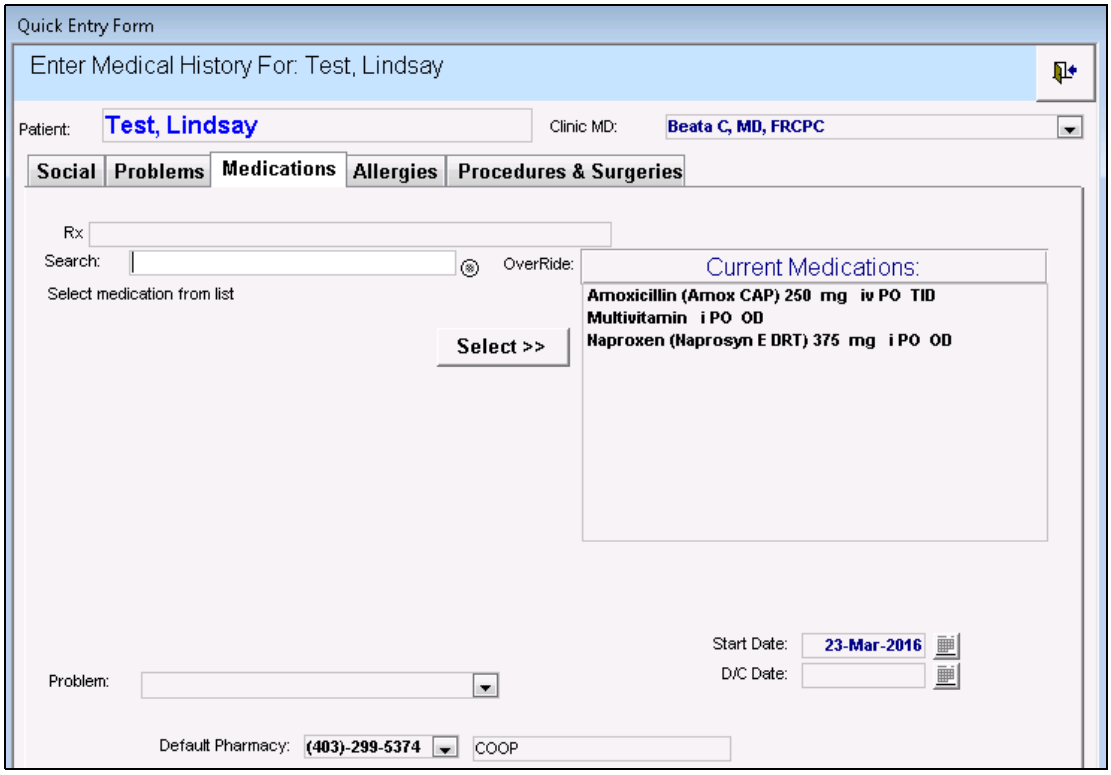
Your patient returns for a medication refill on their Warfarin. How can you quickly refill and print their prescription?

Recording medications

If you want to record that a patient is currently taking or has previously taken a medication, without prescribing the medication, you can add the medication to the patient's medications list using Quick Entry. For example, if a patient received a prescription at the hospital, you can record the medication with fewer prescription details. Quick Entry enables you to record only basic information about the medication, making the entry process faster.

To record a medication using Quick Entry:

1. On any window related to a patient's medical record, right-click and then, in the SMART menu, click **Quick Entry**. The EMR displays the Quick Entry Form.
2. Click the **Medications** tab.



3. In the **Search** field, enter part or all of the medication name, and then press **Enter**. The EMR displays a list of matching medications in the **Select medication from list** area.
4. Click the medication you want. The EMR displays a prescription details entry area.

> Depending on the medication you choose, the prescription detail fields may populate with default values. You can edit default values as needed.

5. Enter or modify the prescription details, and then click **Select >>**.

> **Tip**: If you are recording a medication that the patient has previously taken but is not currently taking, in the **D/C Date** field, enter a discontinue date.

The EMR adds the medication to the patient's medications list.

6. To record additional medications, repeat Step 3 to Step 5 .
7. When you finish, click  .

Evaluation

Complete the following questions.

1. When searching for a medication, you should enter only the first few letters of a medication to save time and minimize the chance of spelling errors.

2. A patient phones the office to report a reaction to a recently prescribed medication. You instruct the patient to stop taking the medication. How should you record the reaction?

3. You want to prescribe Advil Cold and Sinus Plus for a patient with cold. When you search for "Advil", the medication you want does not display in the results. How can you include over-the-counter medications in the search results?

4. You are creating a prescription for 5 medications. How do you check if any of them have potential interactions?

5. A patient who received a prescription two days ago has lost their prescription. How can you re-print the prescription for them?

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

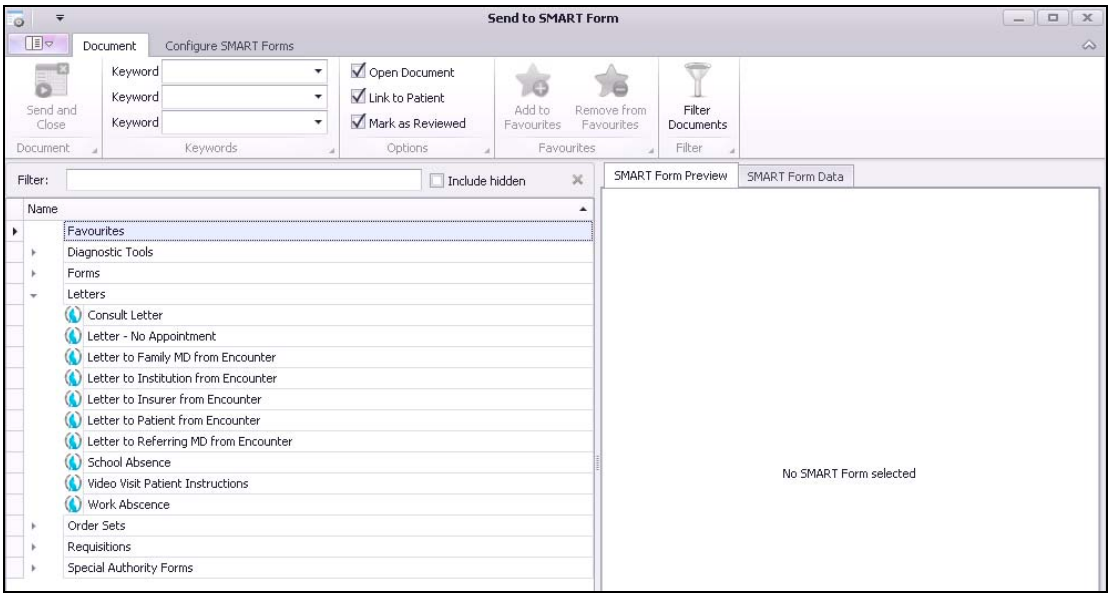
Using SMART forms

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 SOAP form, consult letter form, or Medical Summary 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 list of your favourite requisition SMART forms. See "Managing your favourite SMART forms" on page 68.

   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 a preview of the form.

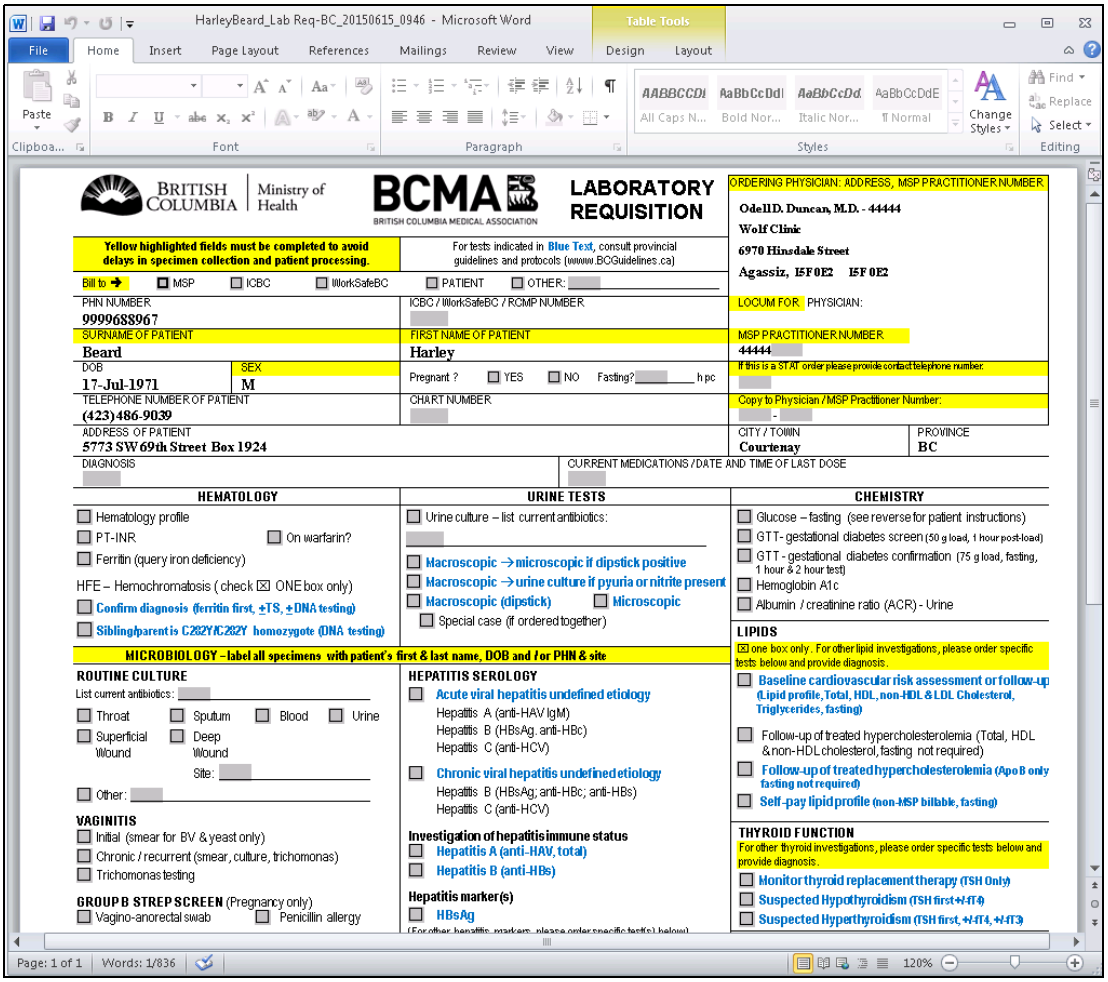
3. If you cannot find the form you want:

   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 a preview of the form.

4. 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.



5. 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.

6. 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.

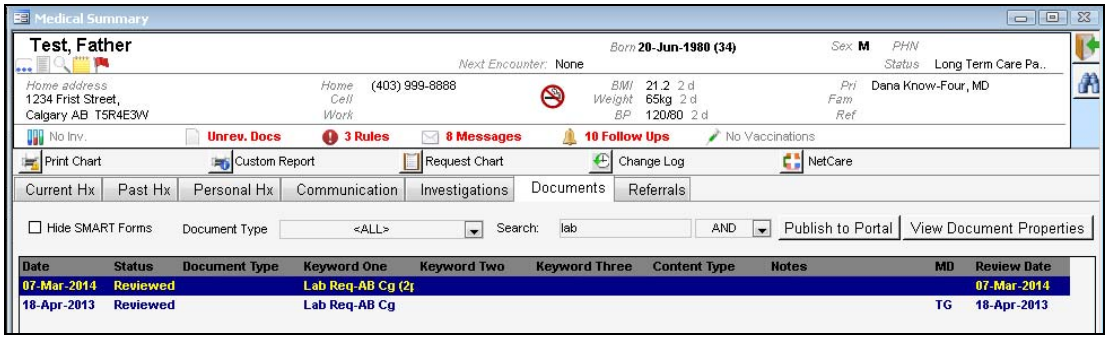
7. To print or fax the form, in the Microsoft Word menu, click **File** > **Print**.

Viewing, modifying, and printing previously completed SMART forms

After you complete and save a SMART form, the EMR saves the SMART form in the patient's Medical Summary. If a patient loses their requisition form, or if a company asks you to re-fax a patient's form, you can reprint or re-fax the form as needed. Also, if you made a mistake on the original SMART form, you can modify the form before you print it.

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.
- From the patient's Medical Summary, 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 64.
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 requisition SMART forms, what is the quickest way to open it?

3. A patient calls the office because they lost their lab requisition form. Where can you find and print a copy of the original form?

End of Module

Creating outgoing referrals

Introduction to this module

Purpose

In this module you learn how to create 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 and send a referral letter
- View and modify a patient's referrals
- Add and modify consultants on your clinic's consultant's list

Initiating referrals

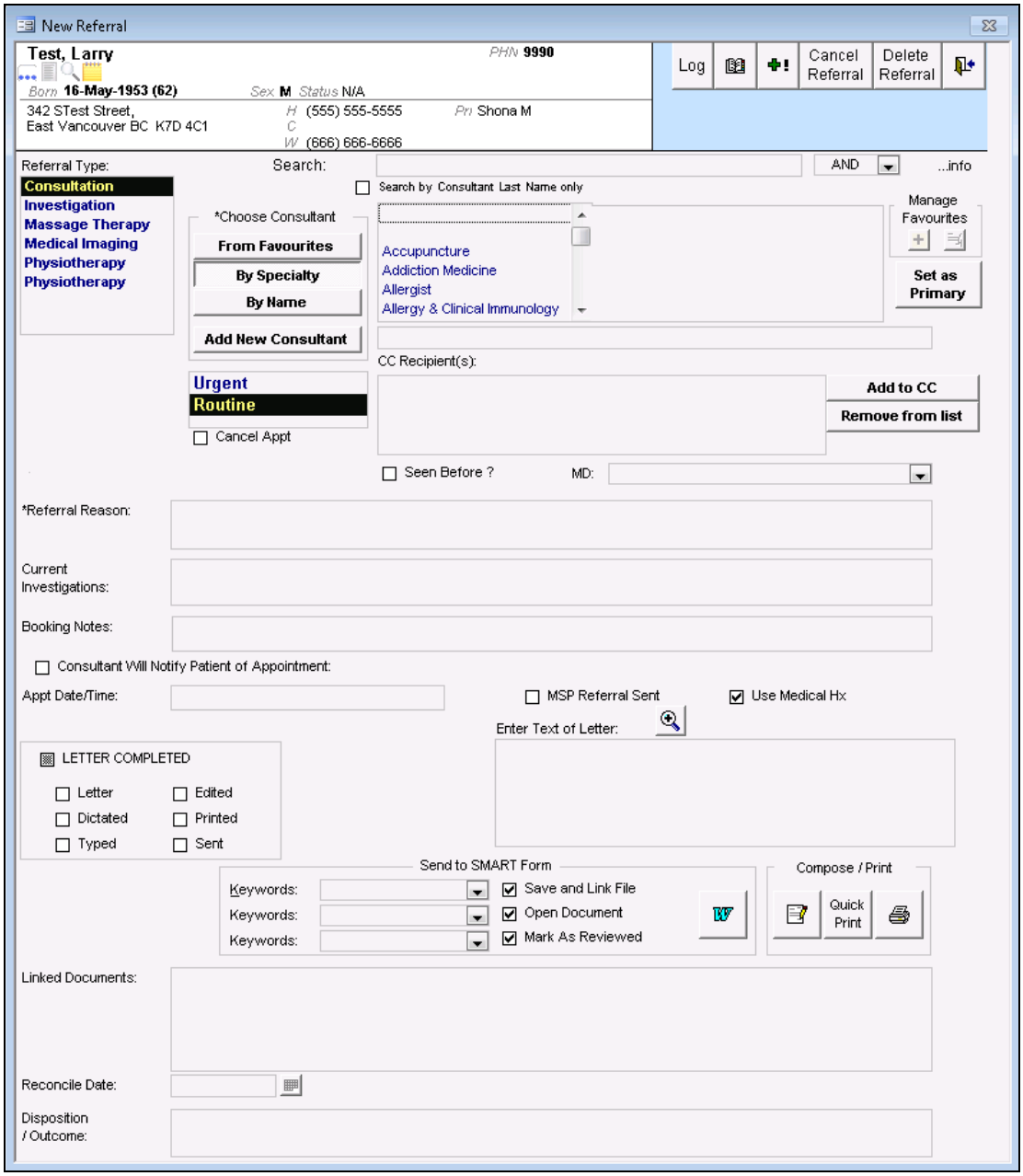
In Wolf EMR, before you create a referral letter, you initiate a referral for the patient. When you initiate a referral, you specify referral details such as the:

- 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. On any window related to the patient (including the SOAP form, or consult letter form), right-click and then, in the SMART menu, click **New Referral**. The EMR displays the New Referral window.

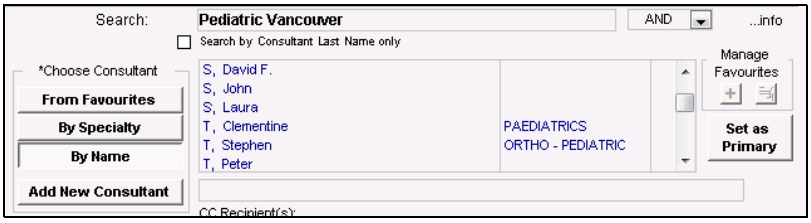


If a visit note has been created for the patient today, the EMR also displays a dialogue box with the following prompt: "Use current visit record to build referral letter?"

- To include your visit notes in the referral letter, click **Yes**.
- To start a blank referral letter, click **No**.

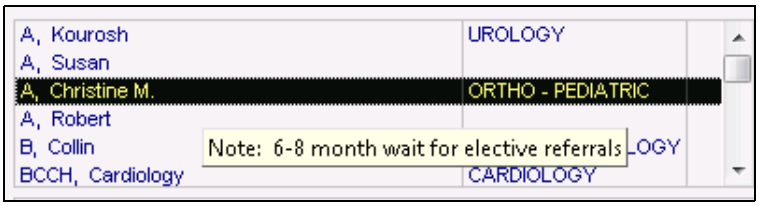
2. In the **Referral Type** list, click the type that best describes what the referral is for. The EMR filters the consultant list to display only consultants categorized under the selected type.

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 (or your front end staff) 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 82.

- 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
***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).
Booking Notes	If a front end staff member reviews and sends your referral letters, enter any referral instructions. For example, enter the type of specialist you want to refer to (for example, "Refer to cardiology"), or the documents you want attached to the referral. **Note:** This information does not display in the referral letter.

Field/Check box	Description
Enter Text of Letter	Enter the referral letter body 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** ().
MSP Referral Sent	Select this check box if you want to bill MSP for the referral. (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, your front end staff can send the referral billing to MSP later.

8. Perform one of the following actions:
   - If a front end staff member reviews and sends your referral letters for you, you are finished. Send a message to the staff member indicating that the referral is ready. See "Sending messages" on page 87.
   - If you are not creating a referral letter now, but will create one later, under LETTER COMPLETE, select the **Letter** check box. The EMR adds the patient to your **Letters to Write** list.
   - 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 77.
   - 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 81.
9. When you finish the referral, click  .

Practise: Initiating a referral

Your patient is experiencing severe abdominal pain, for which you cannot find a cause. You decide 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 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 Profile (current problems, medications, allergies, inactive problems, surgeries, smoking history)

Creating referral letters using the Referral Letter Composer

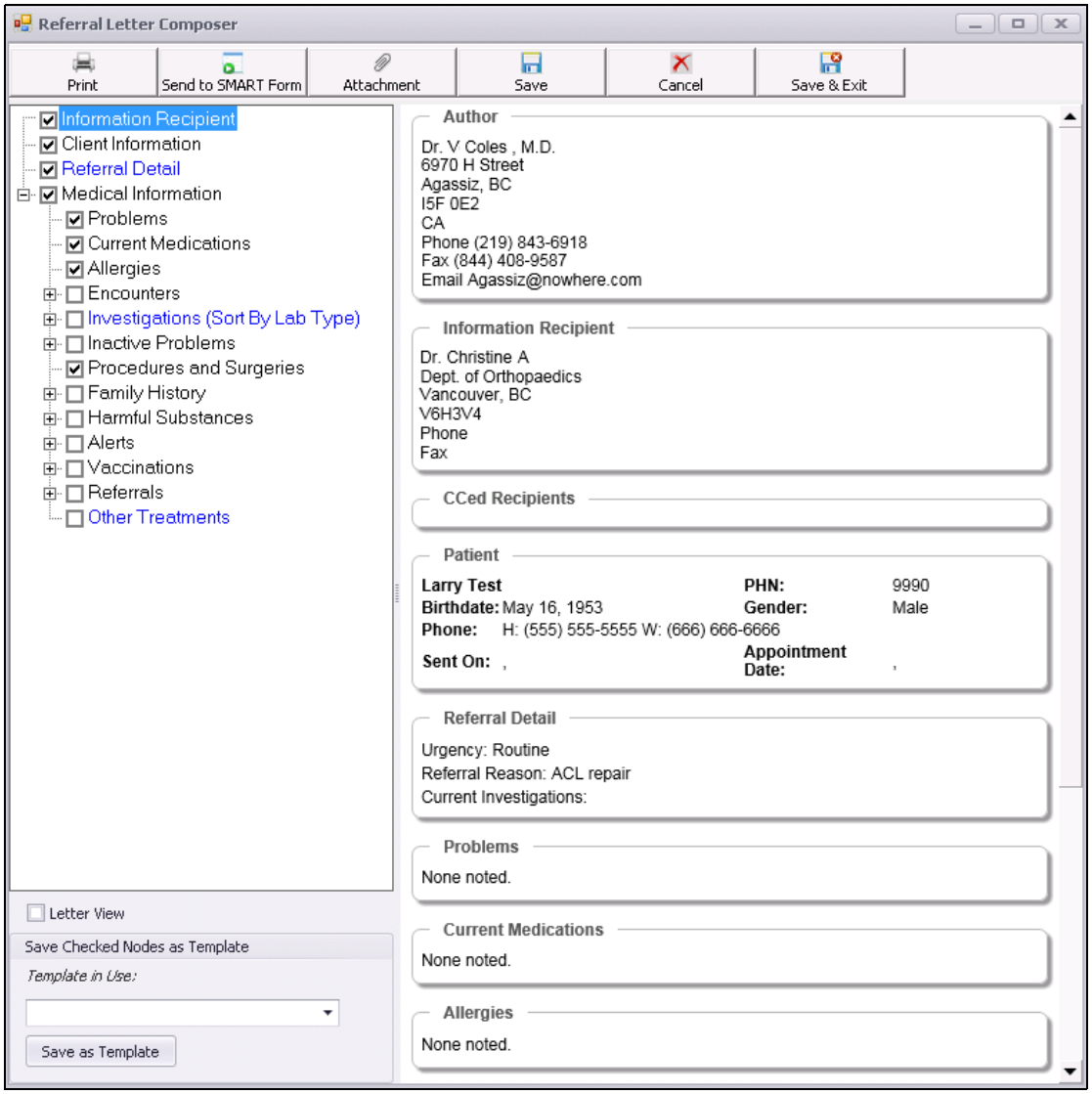
To create a referral letter using the Referral Letter Composer:

1. Initiate a referral and complete the New Referral details. See "Initiating referrals" on page 72.

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. Select what medical history information to include in the letter:

   a) In the left pane, 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 to include, but are selected by default.

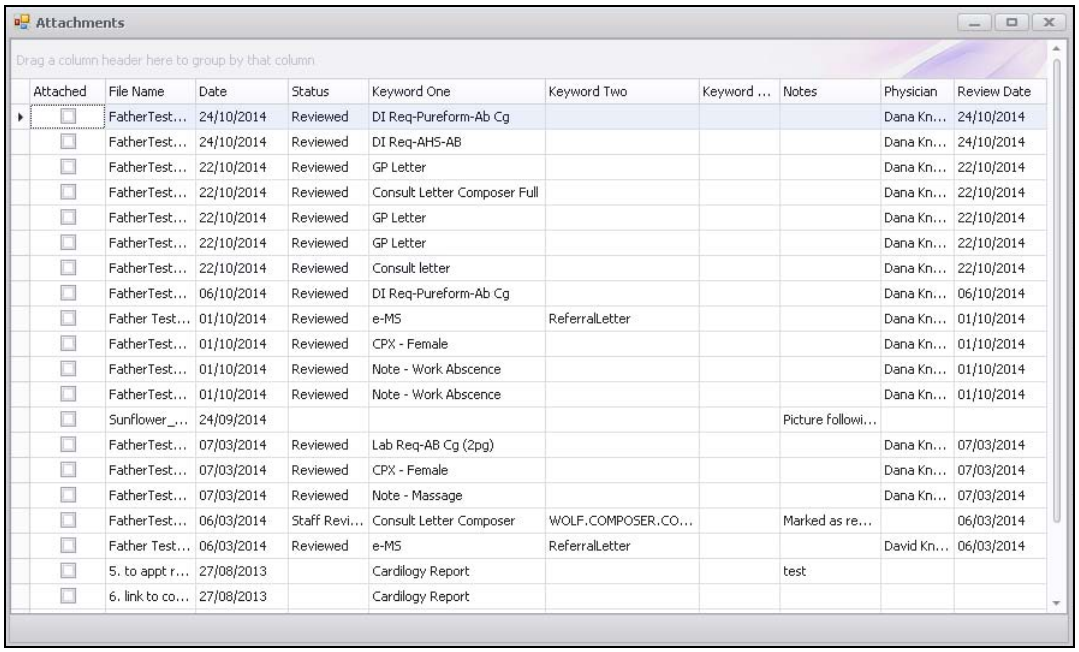
   c) To include only specific items from a Medical Summary category, expand the category, and then select the items you want.

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.



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.

   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.

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
- 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.

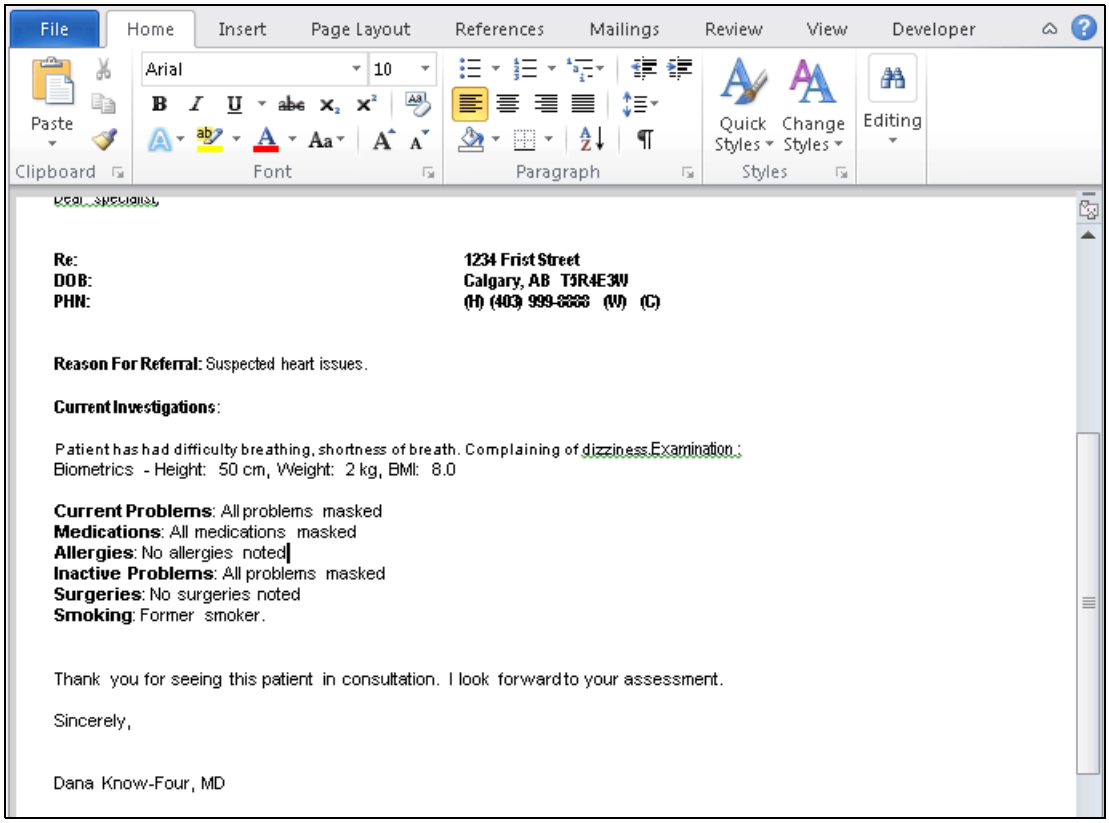
Creating referral letters using a Microsoft Word template (SMART form)

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 72.

> 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.

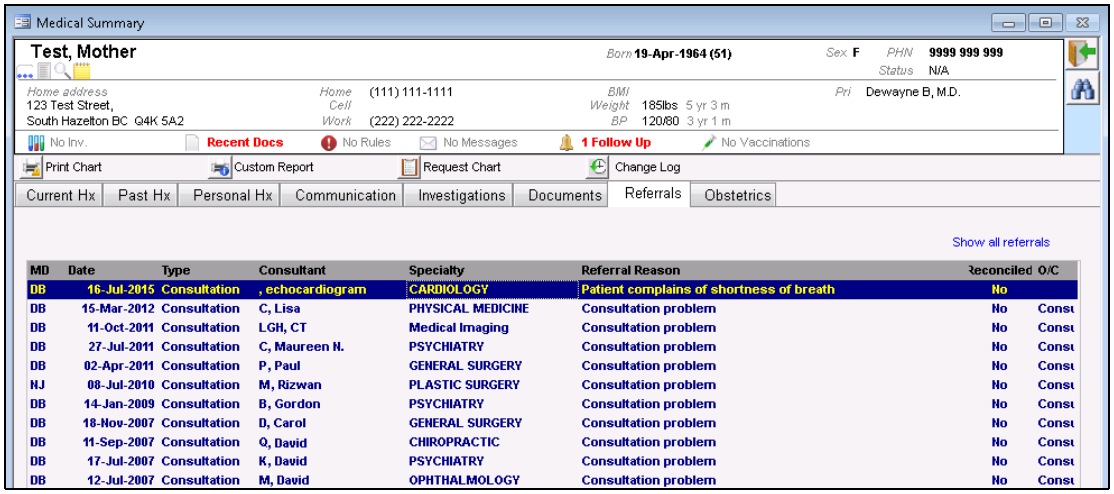
6. To indicate that the letter is completed, in the referral window, select the **LETTER COMPLETED** check box. The EMR adds the patient to the **Referral Appointments to Be Made** list.

Viewing and managing a patient's referrals

You can view and managing a patient's referrals in the **Referrals** tab of their Medical Summary.

To view and manage a patient's referrals:

1. Open the patient's Medical Summary, and then click the **Referrals** tab. The EMR displays a list of the patient's outstanding and completed referrals.



2. To view or update a specific referral on the list, double-click the referral.

Managing consultants

You can refer patients only to consultants or clinics that are in your clinic's consultant list. If the consultant you want is not in the consultant's list, you can add a 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.

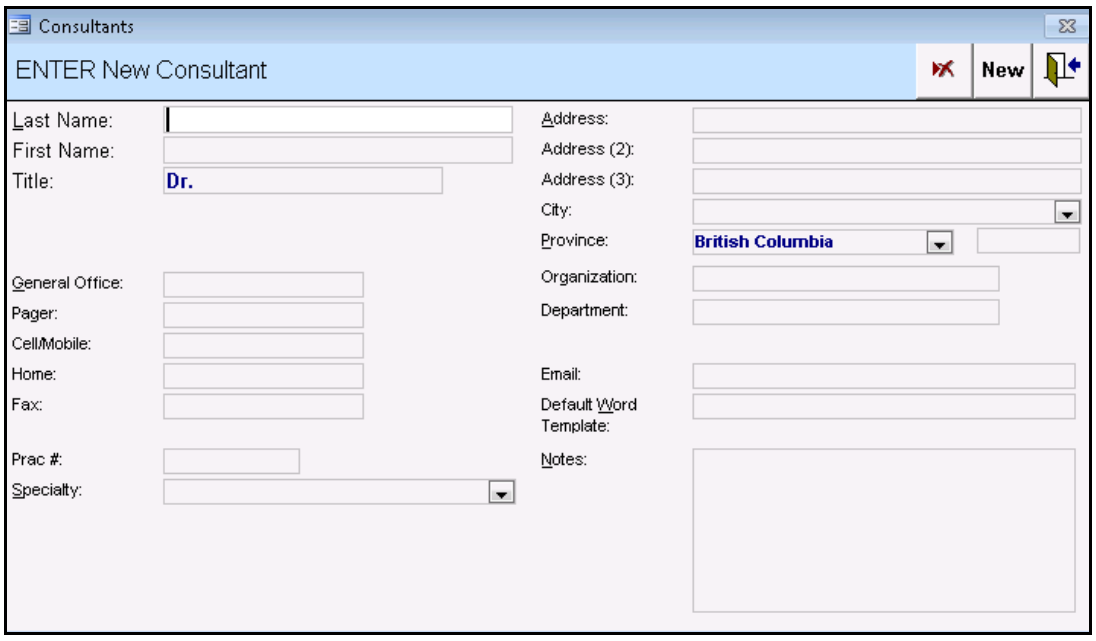
If you refer to a particular consultant regularly, you can identify the consultant as a favourite.

Adding and modifying consultants

To add or modify a consultant:

1. Start a referral. See "Initiating referrals" on page 72.

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 72.
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. A patient asks you about the status of a referral you sent a few months back. How can you view the referral?

4. You are asked by a colleague if you can share some of your favourite consultants with her. Can you change one of your personal favourite consultants to a clinic-wide favourite? If so, how?

End of Module

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
- Create a to-come-in task
- Manage your messages and follow-up tasks
- View and manage a patient's messages and follow-up tasks as you are entering visit notes

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.
- Respond to incoming referrals (specialists)

- Notify clinic members of upcoming events (such as staff meetings), policy changes, and other non-patient related items.

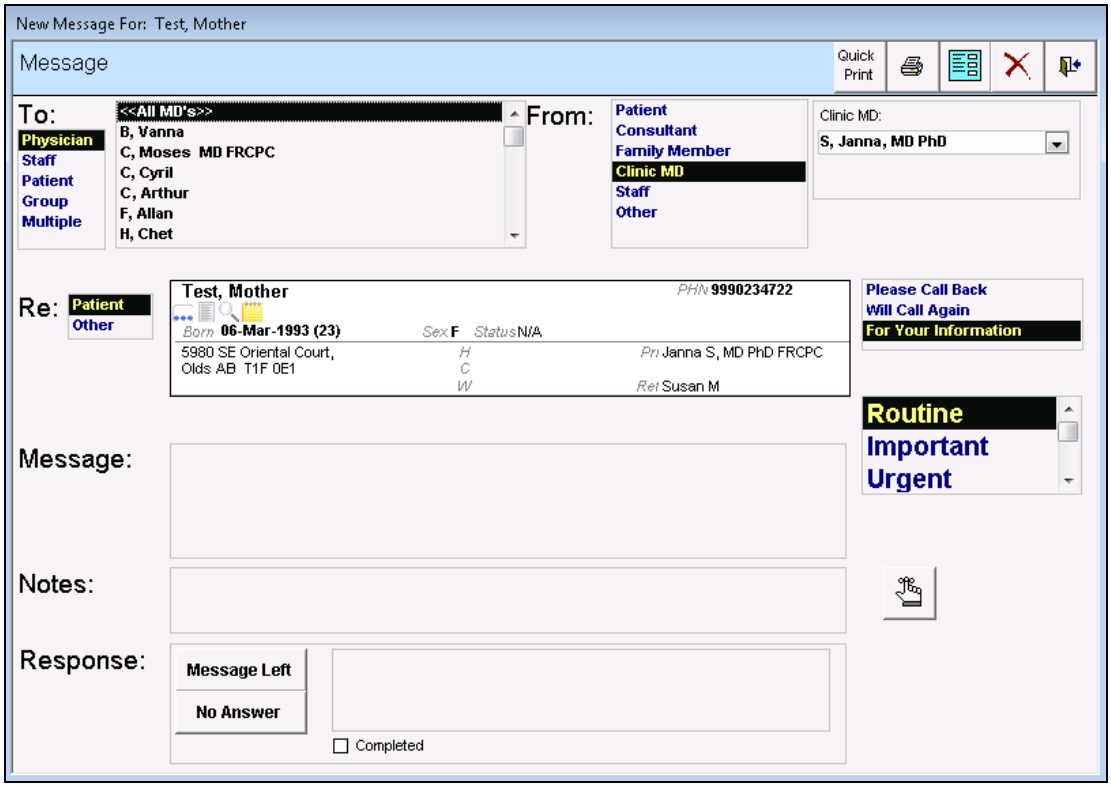
You can create a message from your WorkDesk or from a patient's record. You can create a message regarding a specific patient, or you can create a non-patient message.

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 "Managing a patient's outstanding messages" on page 102.

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 SOAP form), 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, on the WorkDesk, in the **Current Messages** area, click  .

   The EMR displays the New Message window.



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

- You want to remind yourself to call a consultant regarding questions on a report they sent. Create a message to yourself 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; however, you create follow-up tasks primarily to:

- Instruct a clinic member to call a patient or schedule a return appointment (recall).
- Remind yourself to do something during a patient's next visit. For example, to talk to the patient about a particular test result, treatment option, or lifestyle advice.

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 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).

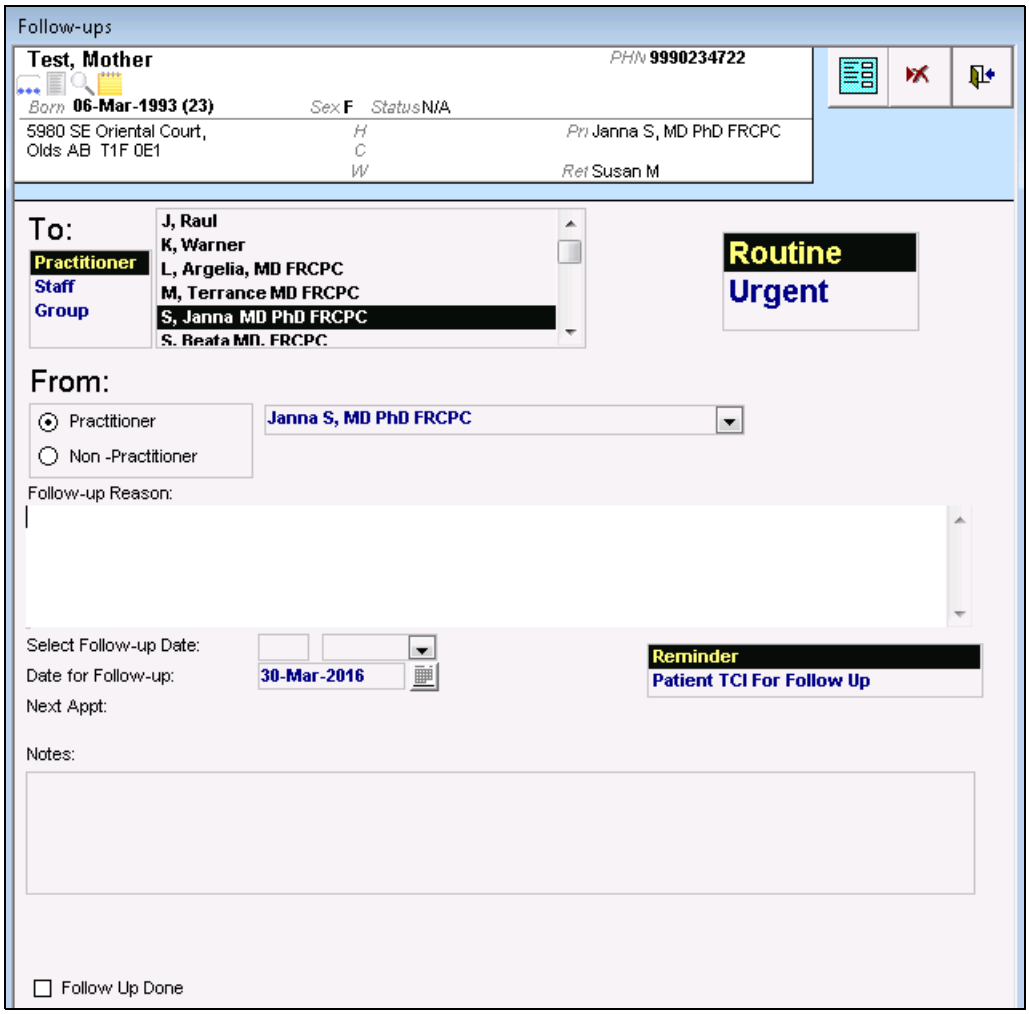
Follow-up tasks are saved in patient records — in the **Communication** tab of the Medical Summary. The SMART patient banner also displays a notification if there are any outstanding follow-up tasks regarding the patient. See "Managing follow-up tasks" on page 98.

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 SOAP form), 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 task regarding a lab result or medical report. From the Investigations/Documents In Basket, click **Follow-up.** See ...

The EMR displays the Follow-ups window.



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

Priority	Description
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. In the **Follow-up Reason** area, enter the problem and reason for the follow-up.
5. 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.

6. 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".
7. Click  .

Scenario: Creating a follow-up task

Create a follow-up task for the following situation:

- During a visit your patient indicates that they will be attending a flu shot clinic next week. You remind yourself to confirm that the patient received their flu shot at their next visit.

Creating to-come-in (TCI) tasks

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

When you create a TCI task, two actions occur:

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

To create a TCI task:

1. Create a follow-up task, and address the task to yourself. See Step 1 to Step 6 in “Creating follow-up tasks” on page 90.

You can also start a To Come In task regarding a lab result or medical report. From the Investigations/Documents In Basket, click **To Come In.** See ...

Always select your name in the **To** area of the follow-up task. If you address the follow-up task to a front end staff member, the task is duplicated for them as they already receive a notification in the **Patients to Notify** list.

2. On the Follow-ups window, in the follow up type list, click **Patient TCI for Follow Up.**
3. Click **Save & Close** (). The Follow-up displays:
   - On the MOA's/Front end staff's WorkDesk in the **Patients to Notify** list, as a notification to contact the patient to book the appointment.
   - In your **Current Follow-up Tasks** list.
   - On the notifications bar of the patient's Medical Summary, as a reminder to address the Follow-up item with the patient during their appointment.

Group Discussion: For the following scenarios what type of message or task would be most appropriate? Why?

- Patient has an abnormal CT scan result. You want the patient to come back for a follow up visit.
- You want your front end staff to contact a specialist's office to check on the status of your patient's referral.
- The patient is having compliance issues with their Diabetes nutrition plan. You want to remind yourself to discuss during the patient's next visit.
- You want to remind your MOA to order more lab supplies.

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.

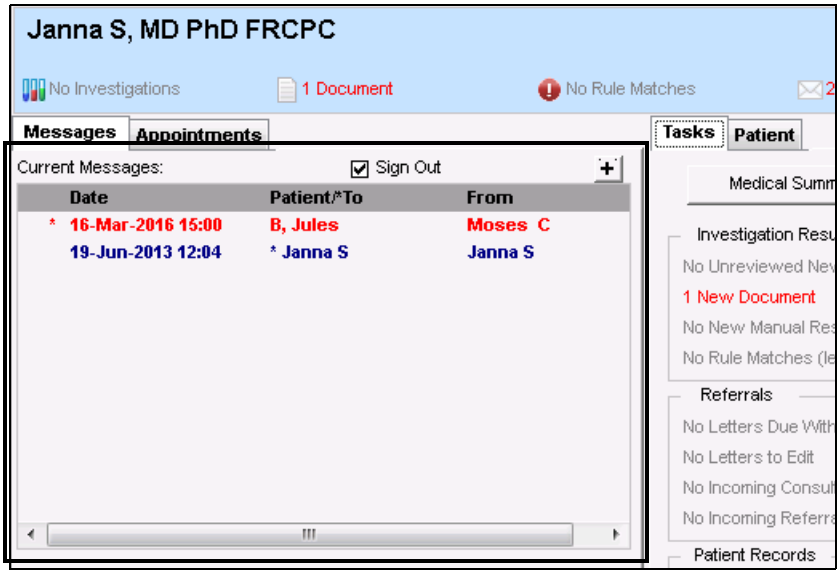
If you complete some action toward a message or follow-up task, but do not fully complete the task, you can document the actions you have taken in the message or follow-up task itself.

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.

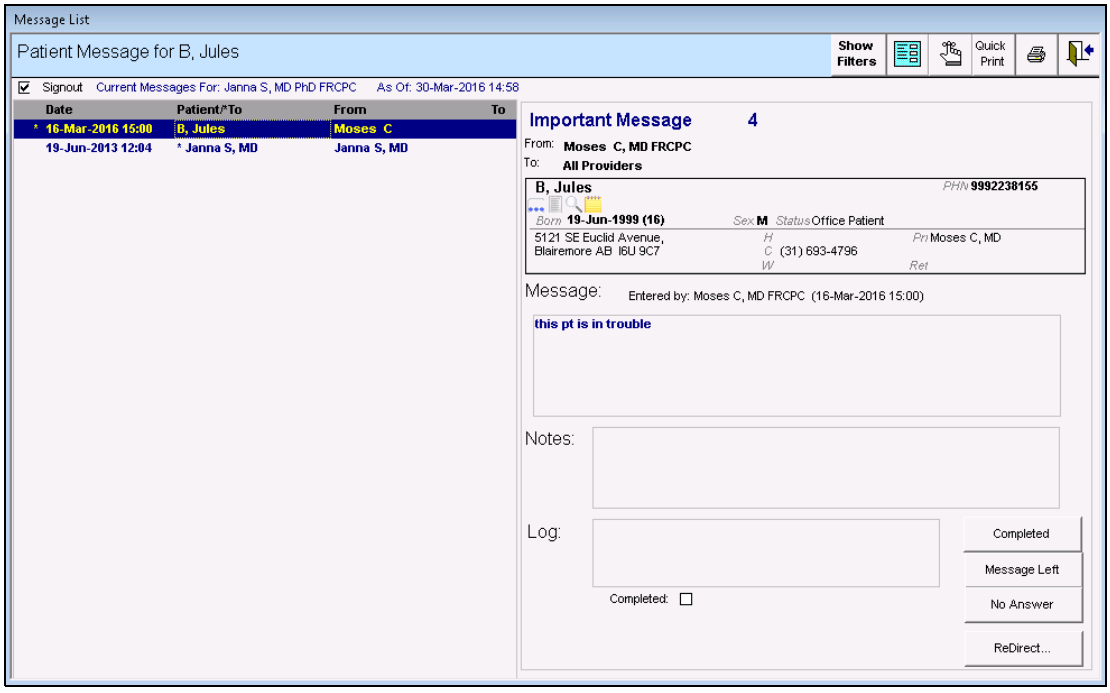
Managing messages

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 first 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** (

). 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  .

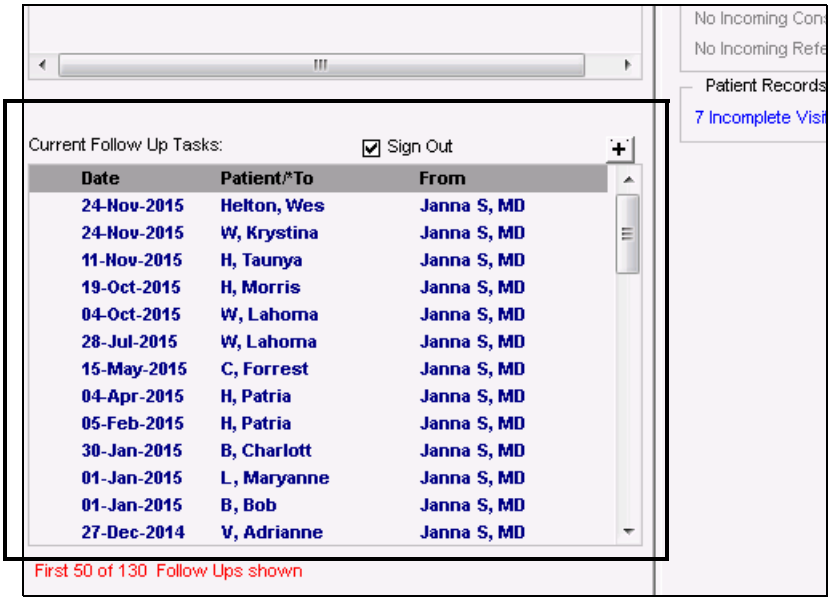
Action	Steps
To pass the message on to another user	1. Click **Redirect**. The EMR displays the Redirecting Patient Message window. 2. In the **To** field, click the user or group you want to redirect the message to. 3. In the **Notes** area, enter any additional notes or instructions to the receiver. 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  .

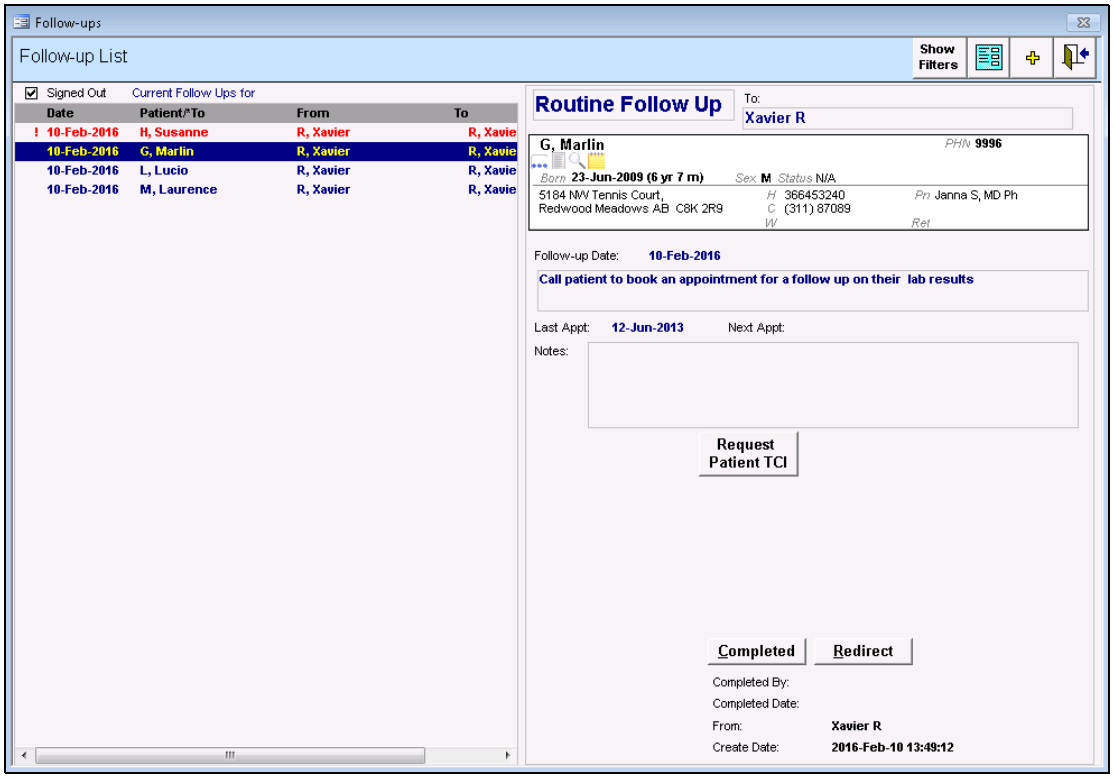
Managing follow-up tasks

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** (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  .

Action	Steps
To complete the follow-up task (and remove the follow-up task from your list)	1. If the follow-up task originated from a TCI task, select the **Patient Notified** check box (if not selected already) 2. Click **Completed**. **Note:** A patient remains on the Front end staff's **Patients to Notify** list, until the **Patient Notified** check box is selected. If you have followed up with a patient on a follow-up item, then there is no need for the patient to remain on the **Patients to Notify** list. For this reason, always select the check box after you have completed the task.

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. How do you accomplish this?

Scenario: Redirecting a message

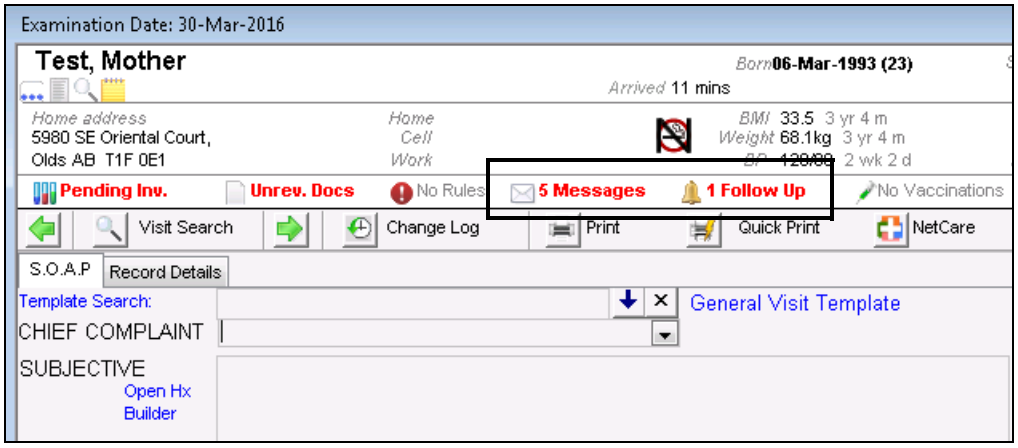
You are on vacation next week, but have several important follow-up tasks that need to be completed by mid-next week. You don't have enough time to complete them before you leave. How can you forward these tasks to another provider?

Scenario: Completing a TCI follow-up task

As you complete a TCI follow-up task, you notice that the **Patient Notified** check box is not selected. Should you select it before completing the follow-up task? If you do not select the **Patient Notified** check box, what are the consequences?

Viewing and managing a patient's messages and follow-up tasks

When you enter visit notes or view a patient's chart, you can view at-a-glance if the patient has any outstanding active messages or follow-up tasks. You can also update and complete the patient's messages and follow-up tasks.



Managing a patient's outstanding messages

To view and manage a patient's outstanding messages:

1. On any window related to the patient's record (including the SOAP form, and Medical Summary), in the SMART patient banner, click **# messages** ( ). The EMR opens the Messages window for the patient.
2. To view a message, in the **Current Messages** list, click the message. The EMR displays the message details on the right side of the window.
3. Update or complete each message as needed. See Step 4 in "Managing messages" on page 95.

Managing a patient's outstanding follow-up tasks

1. On any window related to the patient's record (including the SOAP form, and Medical Summary), in the SMART patient banner, click **# Follow Ups** ( ). The EMR opens the Follow-ups window for the patient.
2. To view a follow-up task, in the **Follow-ups** list, click the follow-up task. The EMR displays the follow-up details on the right side of the window.
3. Update or complete each follow-up task as needed. See Step 4 in "Managing follow-up tasks" on page 98.

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?

4. What is the difference between a Reminder Follow up and a To Come in Follow up?

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 Medical Summary is essentially a patient's medical chart. From the Medical Summary you can view a patient's medical information in a series of organized tabs. You can also add medical history information that is more detailed than the information you enter using Quick Entry.

Objectives

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

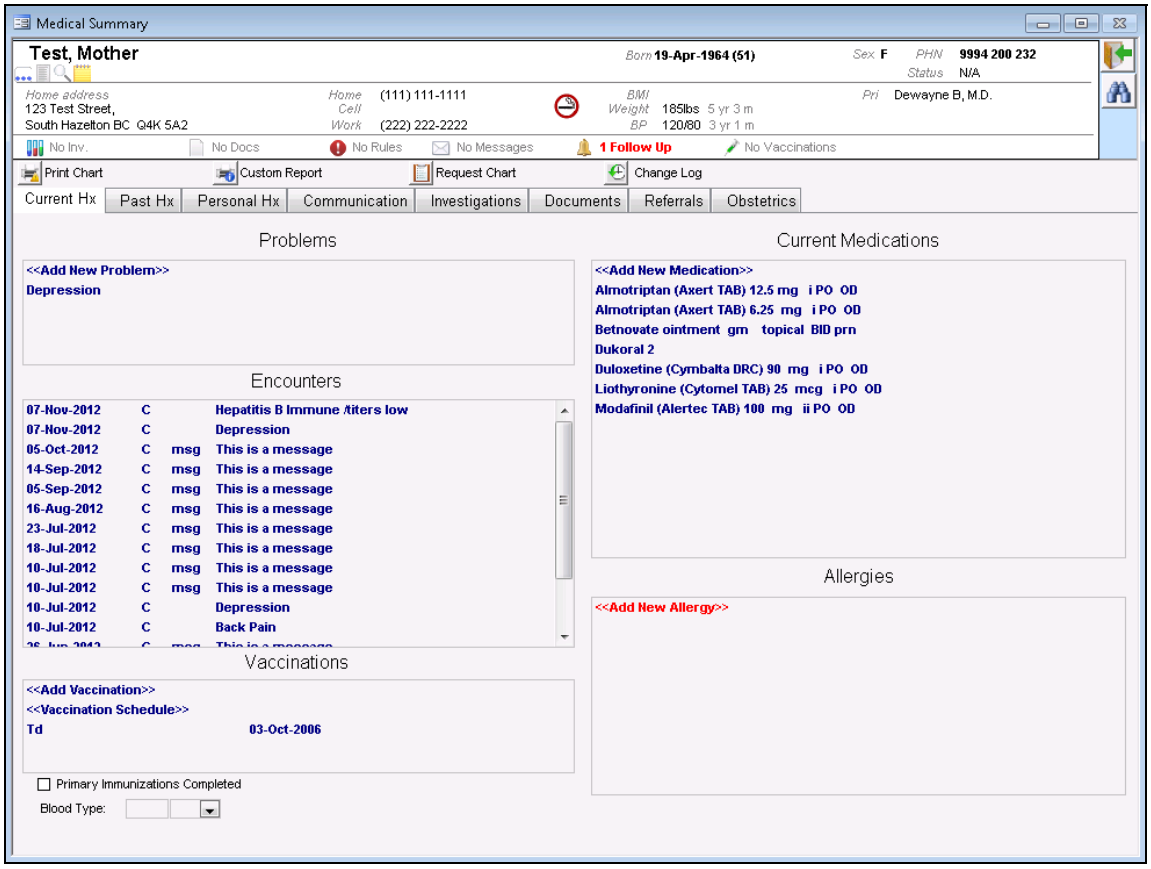
- Open a patient's Medical Summary
- Identify what information you can view in each tab of the Medical Summary
- Enter a patient's detailed medical history information

Opening a patient's Medical Summary

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

- If you have any window related to the patient open (for example, the Patient tab (CPP), the SOAP form, the consult letter form, the Investigation/Document In Basket, or a message or follow-up task), click the SMART patient banner.
- If you do not have a window related to the patient open:
  1. On the WorkDesk, in the **Tasks** area, click **Medical Summary**.
  2. Search for and select the patient.

The EMR opens the patient's Medical Summary.



Tip for opening a patient's Medical Summary

If you are viewing a patient's Medical Summary and want to view another patient's Medical Summary, on the top right corner of the window, click  .

Medical Summary window overview

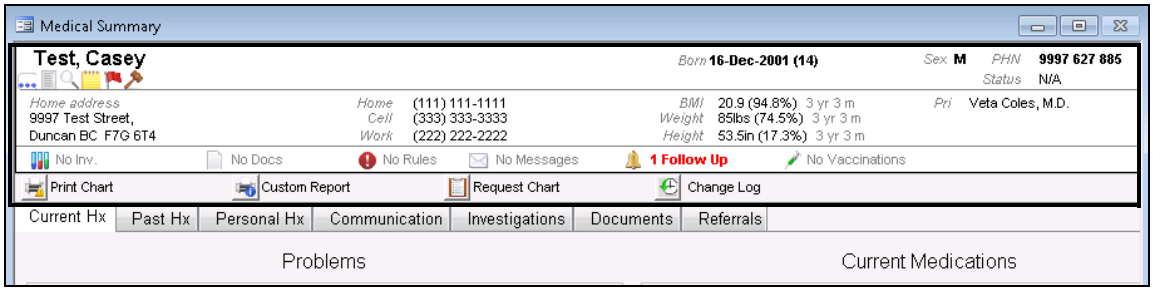
The Medical Summary is essentially the patient's medical chart. From the Medical Summary, you can access all of a patient's medical information, including medical history, visit notes, lab results, and medical reports.

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:

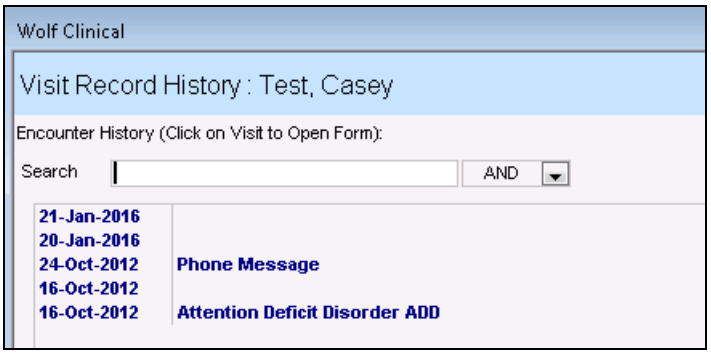
- If the patient is 0 to 2 years old, the EMR displays the patient's **HC** (head circumference), **Weight**, and **Height**, and includes percentiles.
- If the patient is 2 to 19 years old, the EMR displays the patient's **BMI**, **Weight**, and **Height**, and includes percentiles.
- If the patient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

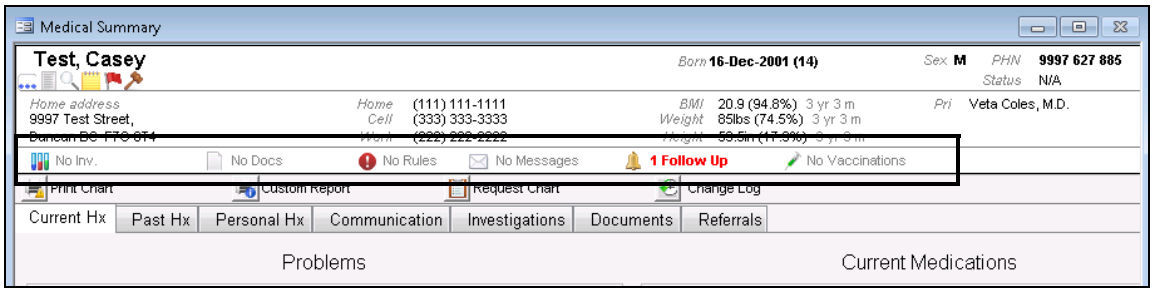
The following table describes icons located below the patient's name.

Icon	Description
	**View patient demographics information** Opens the Patient Maintenance window.
	**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.
	**View Patient Visits** Opens all of the patient's current and previous visit notes in one window.

Icon	Description
	**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.
	**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.
	**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.
	**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.
	**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.

Icon	Description
	**Patient Portal alert** Indicates that the patient is a Patient Portal user. Opens Patient Maintenance to the Portal Settings area (if set up).

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.



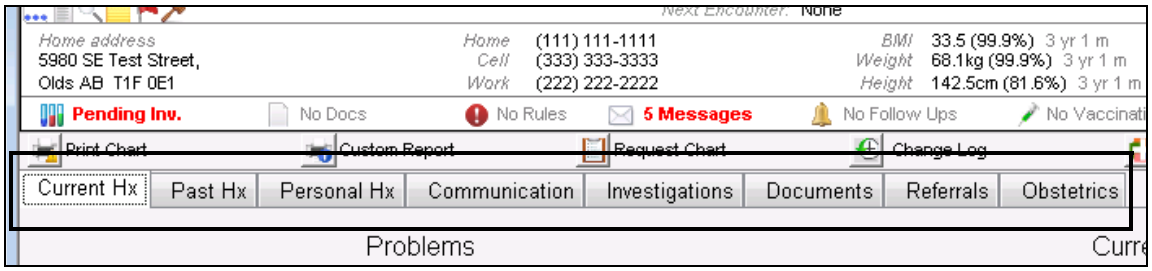
Click any icon in the notification bar to open the related area in the EMR. For example, click the **Investigations** icon to open the Investigation In Basket window for the patient.

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

- Visit notes (SOAP form, consult letter form)
- Vital Entry form
- Messages and tasks
- Prenatal forms, and WCB forms
- Medication windows
- Referrals
- Anticoagulation Summary Sheet

Viewing and entering Medical Summary information

The following table provides an overview of the information you can view and enter in each of the Medical Summary tabs. You can enter patient medical history information in the **Current Hx**, **Past Hx**, **Personal Hx**, and **Obstetrics** tabs.



Tab	Information available
Current Hx: Current History	■ Problems ■ Current medications ■ Encounter records ■ Allergies ■ Vaccinations ■ Blood type
Past Hx: Past History	■ Inactive problems ■ Previous medications ■ Procedures and surgeries ■ Refuted and terminated allergies
Personal Hx: Personal History	■ Social history ■ Harmful substances (for example, smoking history and alcohol history) ■ Family history ■ Other risks
Communication	Uncompleted and completed: ■ Messages ■ Follow ups
Investigations	■ Lab results ■ Manual results ■ Preventive care procedures (for female patients)

Tab	Information available
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 and entering Medical Summary information

- 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.
- To add a medical history entry to the Medical Summary, at the top of the corresponding area, click **<<Add New...>>**. For example, to enter a problem, in the **Current Hx** tab, at the top of the **Problem** area, click **<<Add New Problem>>**.
- If you are not viewing a patient's Medical Summary, but are in another window related to the patient (for example, the SOAP form), you can enter a Medical Summary entry: right-click and then, in the SMART menu, click **New <entry type>** (for example, **New Allergy**).
- Be consistent with your data entry (for example, to enter problems, always search for and select an option with the correct ICD 9 code). This way, you can produce reports on and create automated reminders for patients with specific diagnosis'.
- On tabs that contain lists with titled columns, you can 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.

Practise: Recording a problem

Add arthritis to a patient's Problems list. Indicate that the problem affects the right hip and that the year of onset was 2010.

Practise: Recording a vaccination

You see a patient for their annual physical, and they tell you they got a flu shot last week at a pharmacy. Record this vaccination and note that it was administered at another facility by an unknown individual.

Practise: Recording an allergy

Record that a patient is allergic to dogs. The patient experiences asthma-like symptoms.

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.

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
5. If you are entering a patient's visit notes in the SOAP form, what is the quickest way to record that you have administered a vaccination to the patient?

End of Module

Managing electronic investigation results

Introduction to this module

Purpose

In this module you learn how to view and manage lab and other investigation results that your clinic receives electronically.

Objectives

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

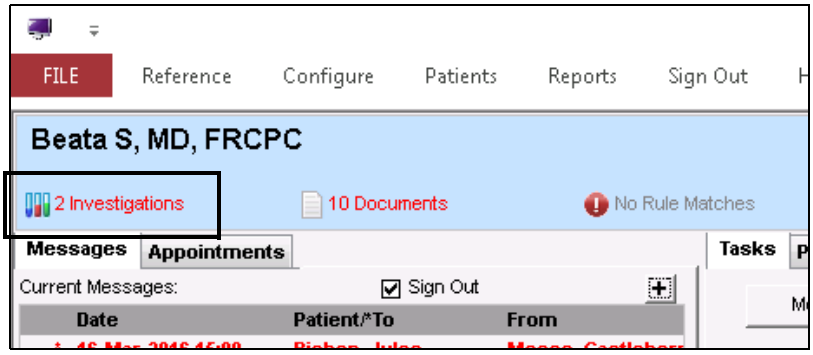
- Review and respond to your investigation results
- View and manage INR results using the Anticoagulation Summary Sheet
- Redirect investigations to other providers in the clinic
- View and print a patient's investigation results during a visit

Reviewing and responding to electronic investigation results

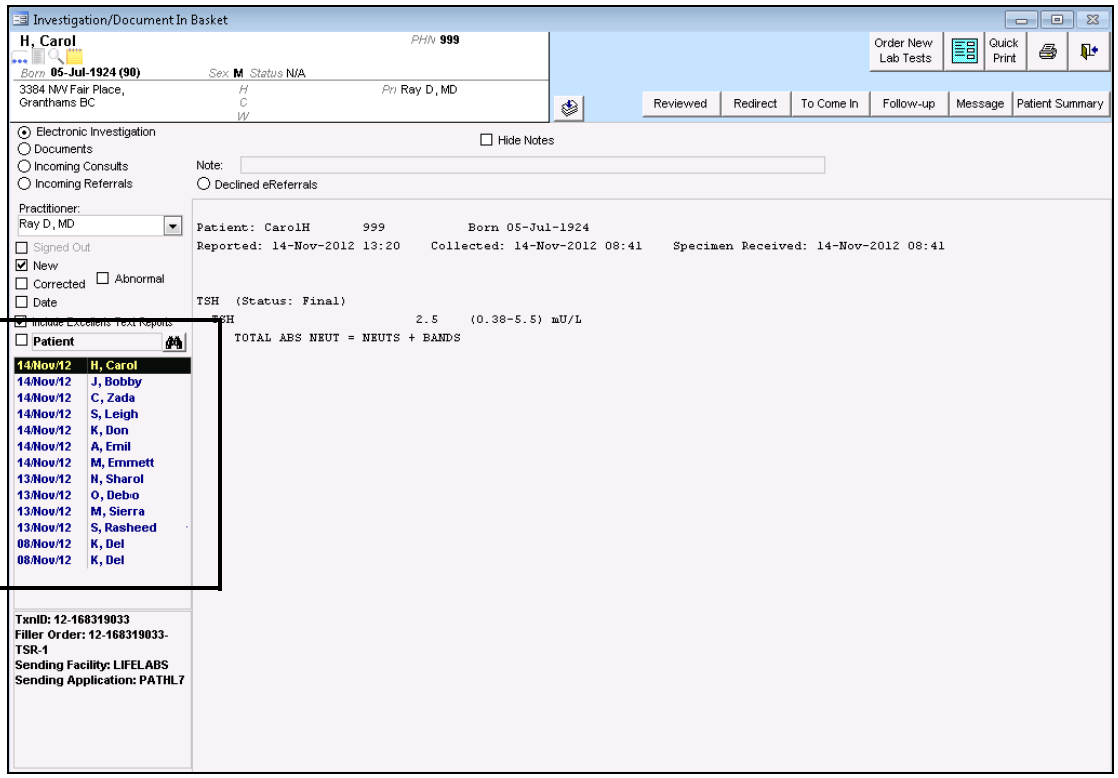
If your clinic receives lab and other investigation results electronically, your front end staff manually imports results several times daily. When investigations for your patients are imported, you are notified on your WorkDesk. From your WorkDesk, you can then view and respond to your electronic investigation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

To view and respond to electronic investigation results:

1. On the WorkDesk, on the blue notification banner at the top of the window, click **<#> Investigations**.



The EMR displays the Investigation/Document In Basket window with your un-reviewed investigations listed in the left column.



Tip: If you want to view and manage only your abnormal results at this time, select the **Abnormal** check box.

2. In your list of electronic investigations, click a patient. The EMR displays the investigation on the right side of the window.

Tips for viewing investigations

- To view the patient's medical record, at the top of the window, click the SMART patient banner or, on your keyboard, press **F7**.
- To simplify your view of an electronic investigation, at the top of the window, select the **Hide Notes** check box.
- If the result contains a blue link , click the link. The EMR opens the link in your default browser.
- To view a running list of a patient's previous results for a particular test, on the investigation, click a numeric result, and then click **Patient Summary**.
- To graph a numeric result, double-click the result.

3. To append (add notes to) the investigation, above the investigation, in the **Note** field, enter your notes.
4. Using the following table, respond to the investigation.

When you choose any response option, the investigation:

- No longer displays as "new" in your Investigation/Document In Basket.
- Is moved to the **Investigations** tab of the patient's Medical Summary.

Option	Use when...	Results
Reviewed	Result is normal. OR You are CC'd on a result pertaining to a patient who belongs to a provider from another clinic.	The investigation no longer displays as "new" in your Investigation/Document In Basket, and no other actions are taken. This is similar to filing away the investigation after you review it.
Redirect	Result pertains to a patient belonging to another provider in your clinic.	The investigation moves to another practitioner's Investigation/Document In Basket and is removed from yours. **Note:** You can redirect labs only to providers who are set up to receive labs in Wolf EMR.

Option	Use when...	Results
To Come In	A patient has an abnormal result. You want to notify your staff to call-back the patient, and simultaneously create a reminder to yourself to discuss the result during the patient's next visit.	Both you AND your front end staff receive notifications to follow up with the patient: 1. **Front end Staff**: The patient displays on their **Patients To Notify** list (prompting them to call the patient to come back for a follow up visit). 2. **Provider**: Patient displays on your follow-up list (prompting you to discuss the patient's test results when they come back for their follow-up visit). **Note:** Ensure you address the task to yourself.
Follow up	A patient has an abnormal result; however, you know that the patient already has an appointment booked. You want to remind yourself to discuss the result, but do not need to notify your front end staff to call-back the patient. Or A patient's results are normal. You send a follow-up task to your front end staff to inform them that no issues were found.	A follow-up task displays on your or another user's follow-up list, depending on whom you assign the Follow-up to.
Message	You want to talk to a colleague about an investigation result before you act on it.	A message displays on either your or another user's message list, depending on whom you send the message to.

5. When you finish viewing and responding to your electronic investigation results, click  .

Practise: Viewing and responding to electronic investigations

- Open your list of un-reviewed electronic investigations.
- Graph an electronic investigation result.
- Display a list of a patient's previous results for a particular investigation.
- Create a To Come In request for the patient.

Viewing INR results and managing patient instructions

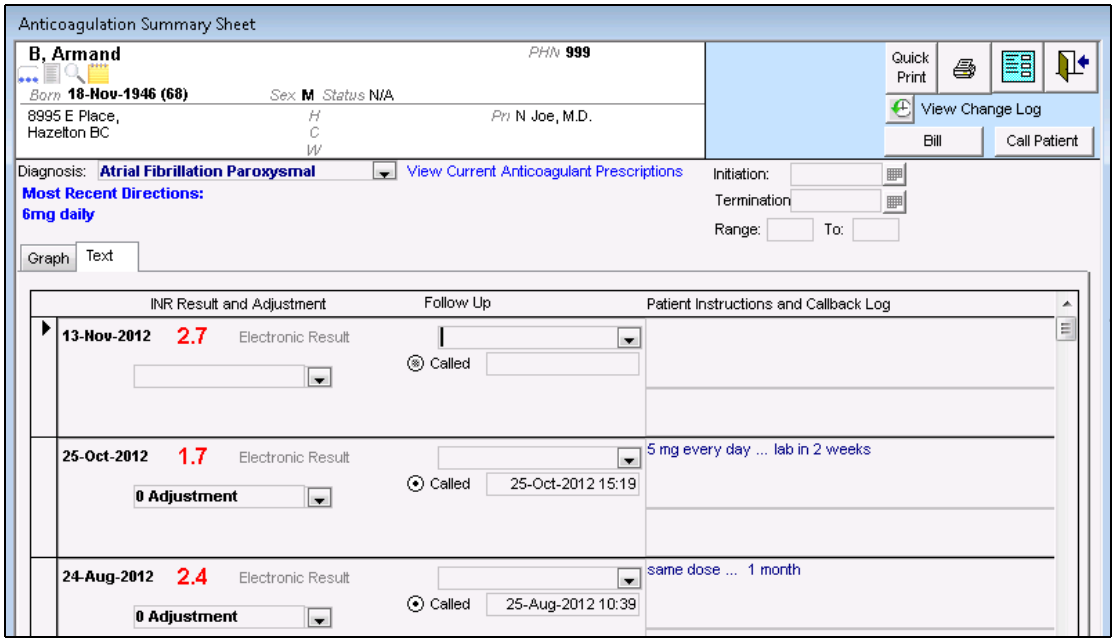
If you receive an INR result, using the Anticoagulation Summary Sheet you can view and manage the patient's:

- INR history
- Anticoagulation medication instructions
- Follow-up appointment and testing instructions

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

To view a patient's INR results and manage anticoagulation treatments:

1. Open your Investigation/Document In Basket, and view investigations for a patient with an INR result. See "Reviewing and responding to electronic investigation results" on page 115.
2. Double-click the numeric INR result. The EMR displays the patient's Anticoagulation Summary Sheet window. The **Text** tab displays:
   - Current and historic INR results
   - Anticoagulation medication dose and frequency at the time of each INR result
   - INR follow-up instructions for each INR result
   - Anticoagulation medication adjustment instructions for each INR result



Tips for viewing the Anticoagulation Summary sheet

- You can open a patient's Anticoagulation Summary Sheet from any window that pertains to the patient: On the window, right-click and then, in the SMART menu, click **View INR Summary**.
- A patient's most recent INR and corresponding anticoagulation medication dosage display at the top of the table in blue.
- If a patient has not received an INR result, the table is blank.
- To view the patient's latest anticoagulation medication prescription, click **View Current Anticoagulant Prescriptions**.
- To view a graph of the patient's INR results, click the **Graph** tab.

3. To modify a patient's INR test and anticoagulation medication instructions, on the **Text** tab, in the top entry area of the INR table, use the following table to enter information.

If the patient is to...	Follow these steps...
Come in for a follow-up appointment	■ In the **Follow Up** drop-down list, click a recommended time until the next patient follow up visit or, in the field, enter a time (for example, ***3 days***).

If the patient is to...	Follow these steps...
Maintain their current anticoagulation medication dose	■ In the I**NR Result and Adjustment** column, in the drop-down list, click **No Adjustment**. The EMR displays the text "Continue with Current Dose" in the **Patient Instructions and Callback Log** column.
Start or modify their current anticoagulation medication dose	1. In the **INR Result and Adjustment** column, in the drop-down list, click **Adjust Anticoagulant**. The EMR displays the Enter new Anticoagulant Dosage window. 2. In the **New Dosage** field, enter the anticoagulation medication dosage directions. 3. Click  . The EMR displays the text "MEDICATION ADJUSTMENT: <medication name and dosage instructions>" in the **Patient Instructions and Callback Log** column.
Follow additional instructions (for example, to go for another INR test)	■ In the **Patient Instructions and Callback Log** column, enter the instructions (for example, "take Vitamin K").
Stop taking their anticoagulation medication indefinitely	■ In the **Termination** field at the top of the window, enter a termination date.

4. Perform one of the following actions:
   - If you have called the patient, click **Called**.
   - If a front-end staff is to contact the patient, send the patient's INR, follow-up, and anticoagulation medication instructions to your front-end staff:
     a) At the top of the window, click **Call Patient**. The EMR displays a new message, with the patient's instructions displayed in the **Message** text area.
     b) In the **To** area, click the individual or group you want the message to go to.
     c) Enter or modify the text of the message as needed, and then click  .
5. To bill the province for INR management, on the top right of the Anticoagulation Summary Sheet window, click **Bill**.
6. When you finish entering instructions in the Anticoagulation Summary Sheet, click  .

7. To clear the INR result from your Investigation/Document In Basket, click **Reviewed**.

Practise: Managing INR results

- Open the Anticoagulation Summary Sheet from the Investigation/Document In Basket window.
- Click the **Graph** tab to display the patient's INR graph.
- If not displayed already, show the patient's anticoagulation medications on the INR graph.
- Click the **Text** tab.
- Indicate that the patient is to have no change to their anticoagulation medication dose, and that they are to get an INR test in 3 weeks.
- Send the instructions to your front end staff.

Viewing and printing a patient's investigation results

When a patient comes in for a visit, you can view all of the patient's investigation results in the **Investigations** tab of their Medical Summary.

Also, if a patient has any un-reviewed investigations, you can view and respond to the investigations from any window of the patient's medical record via the SMART patient banner.

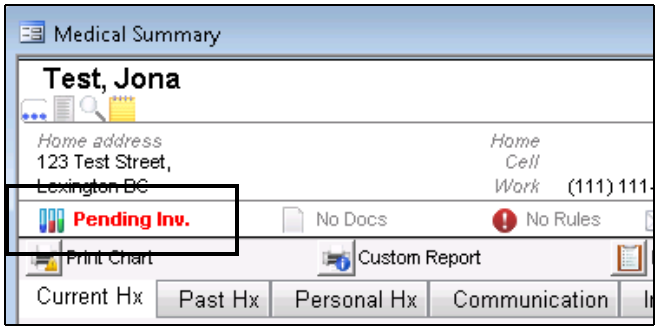
When you view investigations, you can print the results, and give them to the patient as a reference.

Best practice: Before or during a patient visit, ensure the patient does not have any un-reviewed investigations.

Viewing a patient's unreviewed investigations

To view a patient's unreviewed investigations:

1. If the patient's SMART patient banner shows a **Pending Inv.** notification (in red), click the notification.



The EMR opens the Investigation/Document In Basket window with the patient's un-reviewed investigations displayed.

2. View and respond to the investigations. See "Reviewing and responding to electronic investigation results" on page 115.

Viewing a patient's investigations history

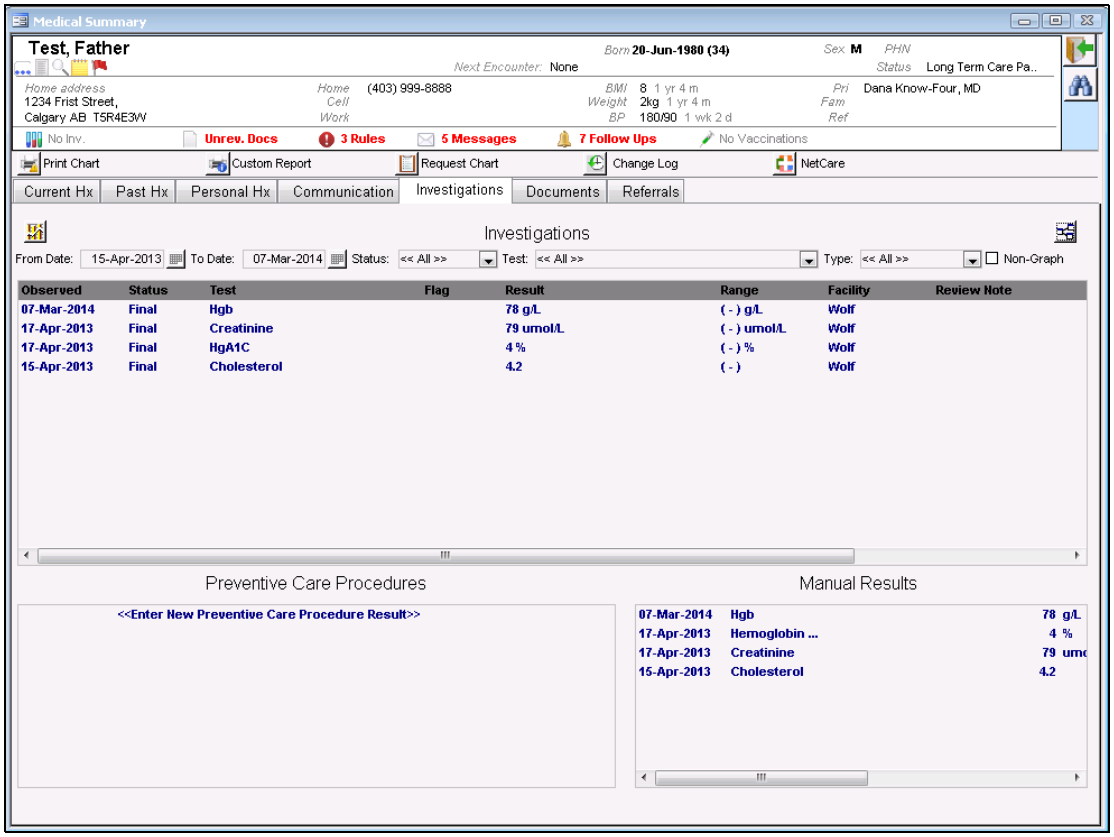
In the **Investigations** tab of a patient's Medical Summary, you can search, view, print, and graph the patient's current and historical investigations.

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

- Specific investigation
- Summary of results for a specific test
- Graph

To view a patient's investigations:

1. Open the patient's Medical Summary, and then click the **Investigations** tab. The EMR displays a list of the patient's investigations.



Tips for viewing a patient's investigations

- To re-order the list based on the contents of a column, click the column's header.
- To filter the list of investigations, above the list, select one or more of the filter options.
- To view an investigation in greater detail, double-click the investigation. The EMR opens the investigation in the Investigation/Document In Basket window.
- To graph an investigation result, click the investigation, and then click **Graph** () (located above the list).

2. To print an investigation result, double-click the result and then, in the Investigation/ Document In Basket window, perform one of the following actions:

   - To print a summary of results for a specific test, click the test result, and then click **Patient Summary** (located in the top right of the window). The EMR displays a summary of all of the patient's current and historic results in Microsoft Word. Click **File** > **Print**.
   - To print the displayed investigation results only, click **Quick Print** (

) or **Print** ().

Practise: Viewing a patient's investigations and documents during their visit

- Open a patient's Medical Summary, and then click the **Investigations** tab.
- Re-order the investigations list by **Test**.
- Filter the list, so that only investigations with a **Type** of **H** are displayed. (This displays investigations with an abnormally high result.)
- Graph an investigation result.

Evaluation

Complete the following questions.

1. If you are viewing a patient's Medical Summary, how do you identity whether the patient has any un-reviewed investigations?

2. When you are reviewing your investigations, you notice that a patient has an abnormal Pap test. You want to both inform your front end staff to call-back the patient AND remind yourself to discuss the result when the patient is back to see you. What action(s) should you select?

   a) Reviewed

   b) Redirect

   c) To Come In

   d) Follow-up

   e) Message

3. After you enter a patient's INR instructions and anticoagulation medication instructions in the Anticoagulation Summary Sheet, how can you inform your staff to call the patient?

4. When you are reviewing your investigations, how do you clear normal results?

End of Module

Managing incoming documents

Introduction to this module

Purpose

In this module you learn how to view and manage medical reports and other documents that come in for you via fax, mail, or direct import.

Objectives

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

- View your unreviewed documents
- Perform actions in response to documents
- Append (add notes to) documents
- Identify if a patient has any un-reviewed documents
- View all of a patient's linked documents
- Print a document

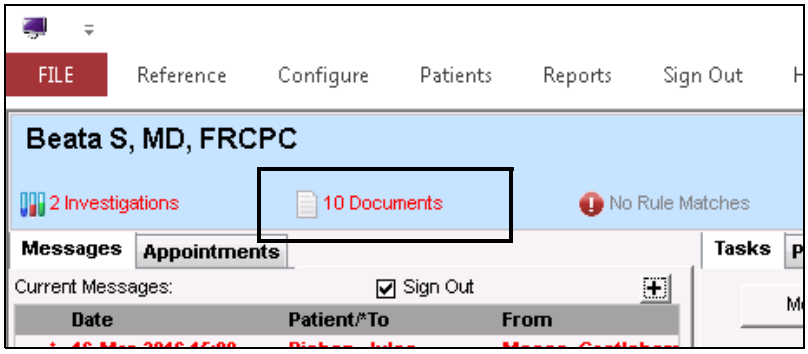
Reviewing and responding to documents

Faxed and mailed documents are manually imported into Wolf EMR and linked to patients by your front end staff.

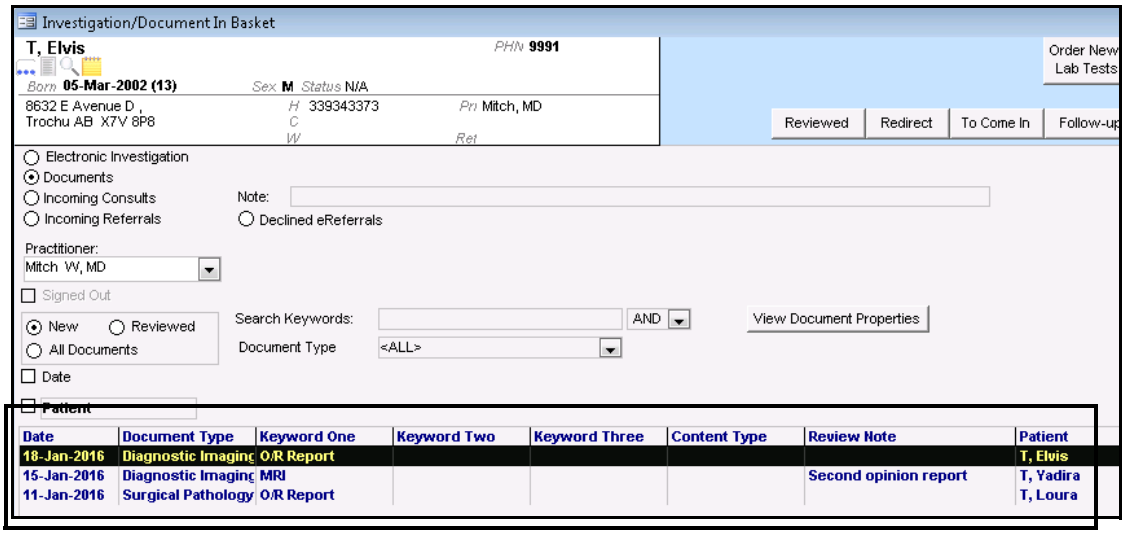
As front-end staff link documents to your patients, you are notified on your WorkDesk. You can then view and respond to each document.

To view your incoming documents:

1. On the WorkDesk, in the blue notification banner, click **<#> Documents**.



   The EMR opens your Investigation/Document In Basket, with a list of your un-reviewed documents displayed.



2. To view a document, double-click the document. If the document is in PDF format (which most scanned/faxed documents are), the EMR displays the document in PDF-XChange Viewer.

If the document is in a format other than a PDF, the EMR opens the appropriate application (if available) to display the document. For example, Word documents open in Microsoft Word.

3. To append (add notes to) a document, click the document and then, in the **Note** field, enter your notes.

Tip: Modifying a document's properties

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

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

As you review your incoming documents, you can modify the document's properties (including Document Type and Keywords), if needed.

To modify the document's properties:

1. Click **View Document Properties**. The EMR displays the Document Properties window.
2. Add or modify information in the document properties as needed, and then click  .

4. Using the following table, respond to the document.

When you choose any response option, the document:

- No longer displays as "new" in your Investigation/Document In Basket.
- Is moved to the **Documents** tab of the patient's Medical Summary.

Option	Use when...	Results
Reviewed	Result is normal and no action needs to be taken. Or The document is for your information only.	The document no longer displays as "new" in your Investigation/Document In Basket, and no other actions are taken.
Redirect	Document pertains to a patient belonging to another practitioner in your clinic.	The document moves to another provider's Investigation/Document In Basket and clears from yours.

Option	Use when...	Results
To Come In	A patient has an abnormal result (for example, an abnormal MRI report). You want to notify your staff to call-back the patient, and simultaneously create a reminder to yourself to discuss the result during the patient's next visit.	Both you AND your front end staff receive notifications to follow up with the patient: 1. **Front end Staff**: The patient displays on their **Patients To Notify** list (prompting them to call the patient to come back for a follow up visit). 2. **Provider**: Patient displays on your follow-up list (prompting you to discuss the patient's test results when they come back for their follow-up visit). **Note:** Make sure you address the task to yourself.
Follow up	A patient has an abnormal result (for example, an abnormal MRI report), however; you know that the patient already has an appointment booked. You want to remind yourself to discuss the result, but do not need to notify your front end staff to call-back the patient. Or A patient's results are normal. You send a follow-up task to your front end staff to inform them that no issues were found.	A follow-up task displays on your or another user's follow-up list, depending on whom you assign the Follow-up to.
Message	You want to talk to a colleague about the result before you act on it.	A message displays on either your or another user's message list, depending on whom you send the message to.

5. When you finish viewing and responding to your electronic investigation results, click  .

Practise: Viewing your new electronic documents

- Open your list of new documents.
- Open a PDF document.
- Add a Keyword to the document.
- Mark the document as reviewed.

Scenario: Modifying documents

You are reviewing your documents and notice that an MRI report is labeled as a CT scan report. How do you change the document's keyword to MRI?

Viewing and printing a patient's documents

When a patient comes in for a visit, you can view all of the patient's documents in the **Documents** tab of their Medical Summary.

Also, if a patient has any un-reviewed documents, you can view and respond to the documents from any window of the patient's medical record via the SMART patient banner.

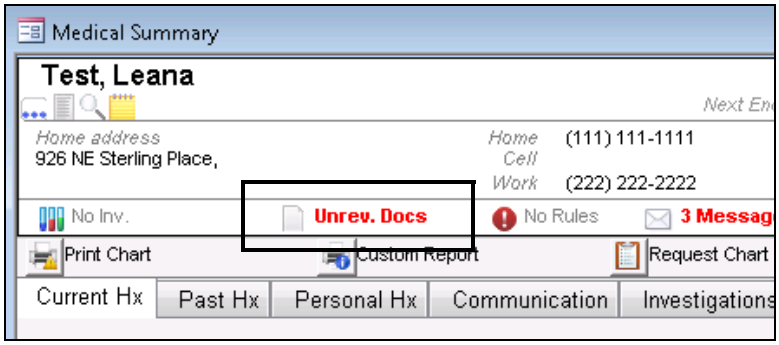
If needed, you can print documents, and give them to the patient as a reference.

Best practice: Before or during a patient visit, ensure the patient does not have any un-reviewed documents.

Viewing a patient's un-reviewed documents

To view a patient's un-reviewed documents:

1. If the patient's SMART patient banner shows an **Unrev. Docs** notification (in red), click the notification.



The EMR opens the Investigation/Document In Basket window with the patient's un-reviewed documents displayed.

2. View and respond to the documents. See "Reviewing and responding to documents" on page 127.

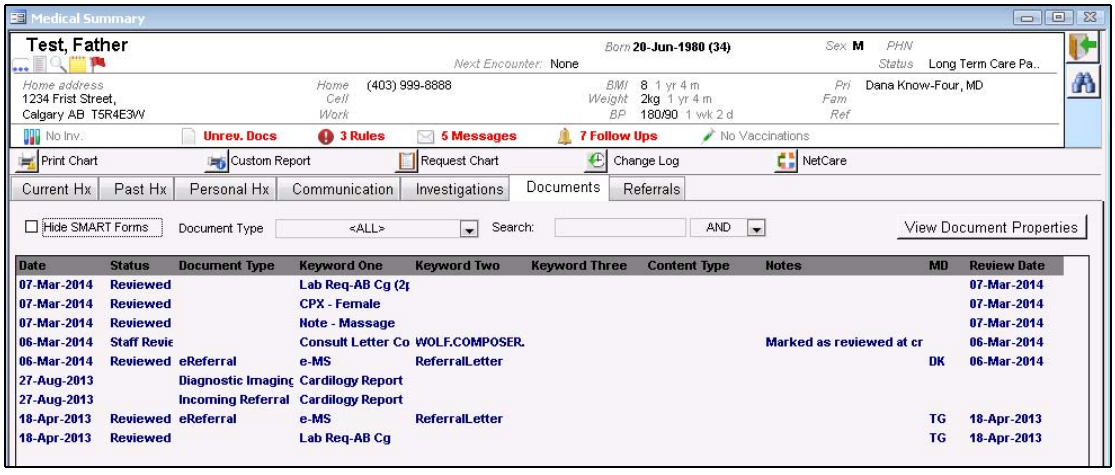
Viewing a patient's linked documents

In the **Documents** tab of a patient's Medical Summary, you can search, view, and print the patient's current and historical documents. Documents include:

- Received scanned and faxed medical reports (for example, diagnostic imaging reports, and consult letters).
- Requisition forms, and other SMART forms created for the patient in Wolf EMR.
- Modified referral letters

To view a patient's documents:

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



Tips for viewing a patient's documents

- To re-order the list based on the contents of a column, click the column's header.
- To filter the list of documents, above the list, select one or more of the filter options.
- To view a document, double-click the document. If the document is in PDF format (which most scanned/faxed documents are), the EMR displays the document in PDF-XChange Viewer; Otherwise, the EMR opens the appropriate application (if available) to display the document. For example, word documents open in Microsoft Word.

2. To print a PDF document, double-click the document and then, in PDF-XChange Viewer, click  .

Evaluation

Complete the following questions.

1. A patient has an abnormal CT scan. You see that the patient already has an appointment booked. If you want to remind yourself to discuss the result when the patient is back to see you, what action should you select?

   a) Reviewed

   b) Redirect

   c) To Come In

   d) Follow-up

   e) Message

2. You are reviewing a hospital report from the Investigations/Document In Basket. You want to note the important points so that they display beside the document name in the patient's Medical Summary. How do you add notes to the document?

   _____

3. A patient asks for a copy of their MRI report. How do you print the document?

   _____

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

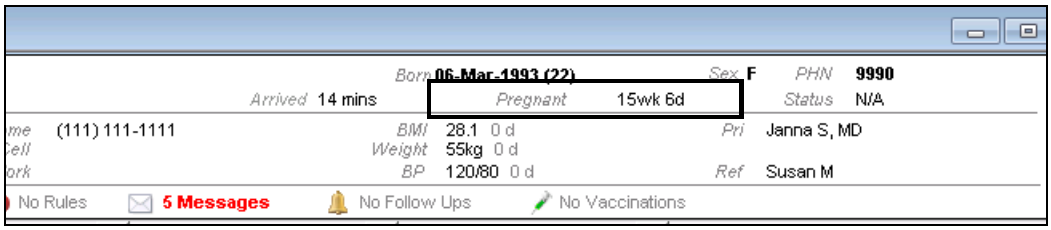
Objectives

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.



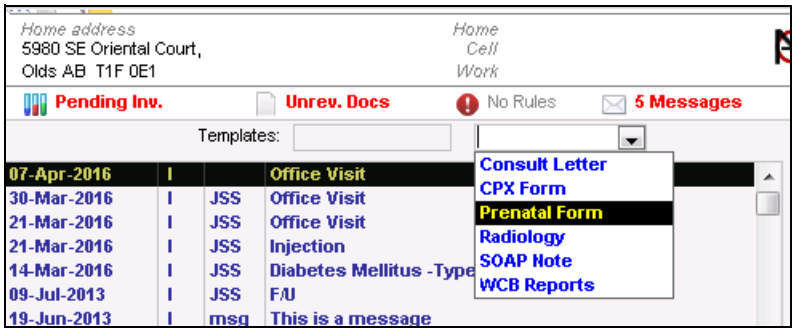
The SMART patient banner displays pregnancy information only if a prenatal record has been started for the patient.

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. On your workdesk, in your **Appointments** list, click the patient. The EMR opens the **Patient** tab (CPP) for the patient.
2. Click today's visit and then, in the **Templates** drop-down list, click **Prenatal Form**.



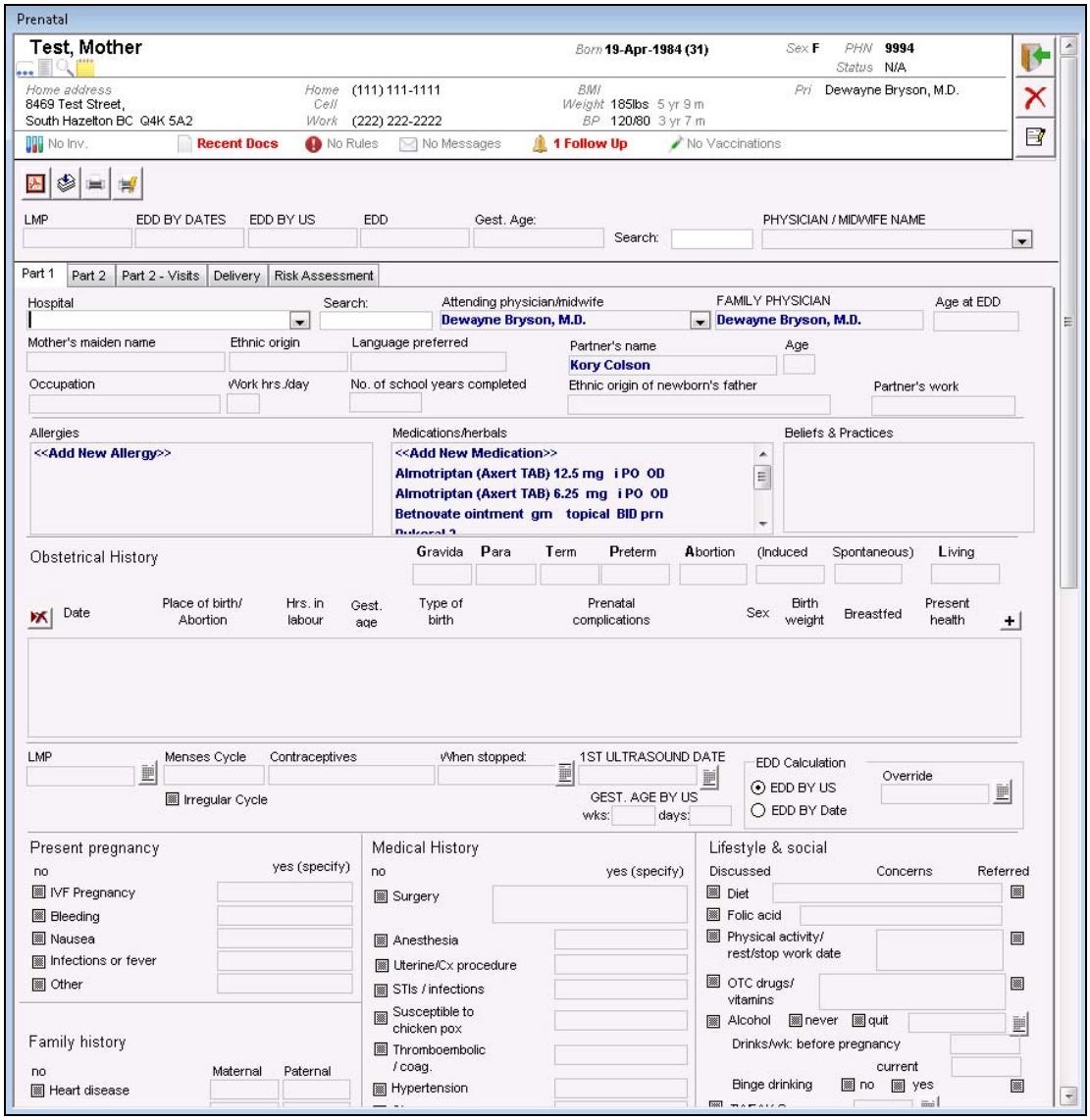
If your MOA or nurse has already started the Prenatal Record for you, in your list of visit records, double-click the latest visit record labelled **Pre Natal Form**.

The EMR 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  .

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 gray 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 your front end staff entered the patient’s vitals, 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).

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:

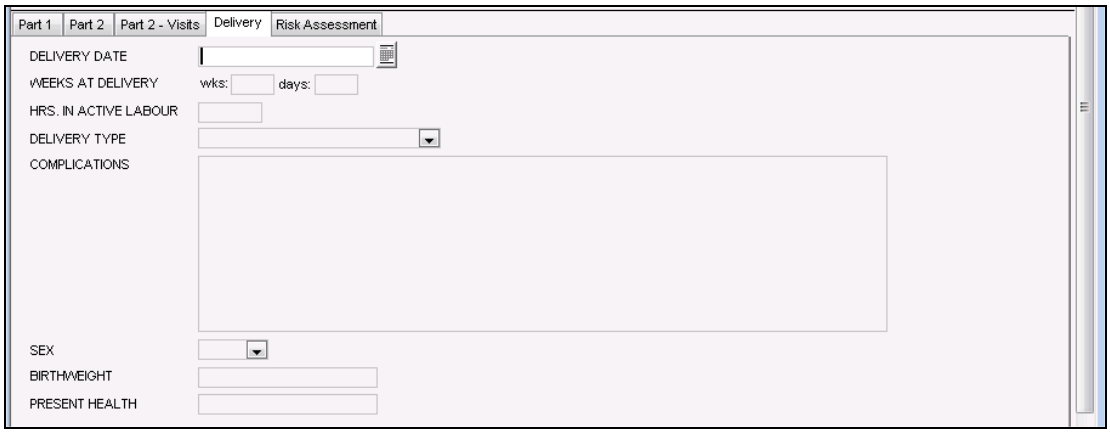
   - **Collate and Print Prenatal Record** ():To print or fax the entire prenatal record as one document on a selected printer or fax machine. (**Note**: When you choose this option the prenatal record is also saved to the patient's Medical Summary, in the **Documents** tab.)

- **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 a 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 finish 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

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:

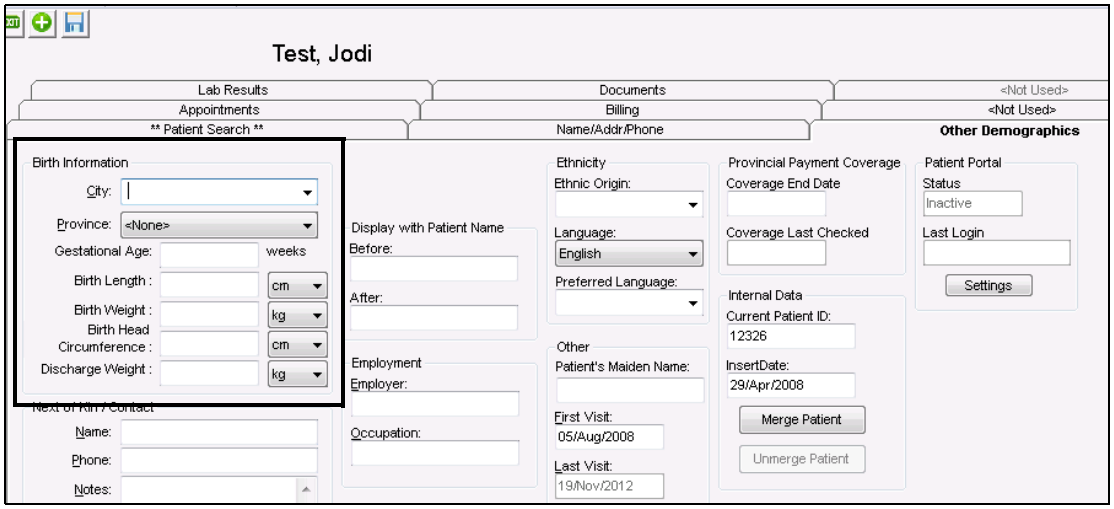
- Enter a patient's birth information
- View pediatric growth charts
- Use the Rourke Baby Records

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: on any window related to the patient, in the SMART patient banner, click  .
2. Click the **Other Demographics** tab.
3. In the **Birth Information** area, enter the patient's place of birth, gestational age, and birth measurements.



4. 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. In Wolf EMR, you can view growth charts from the following organizations:

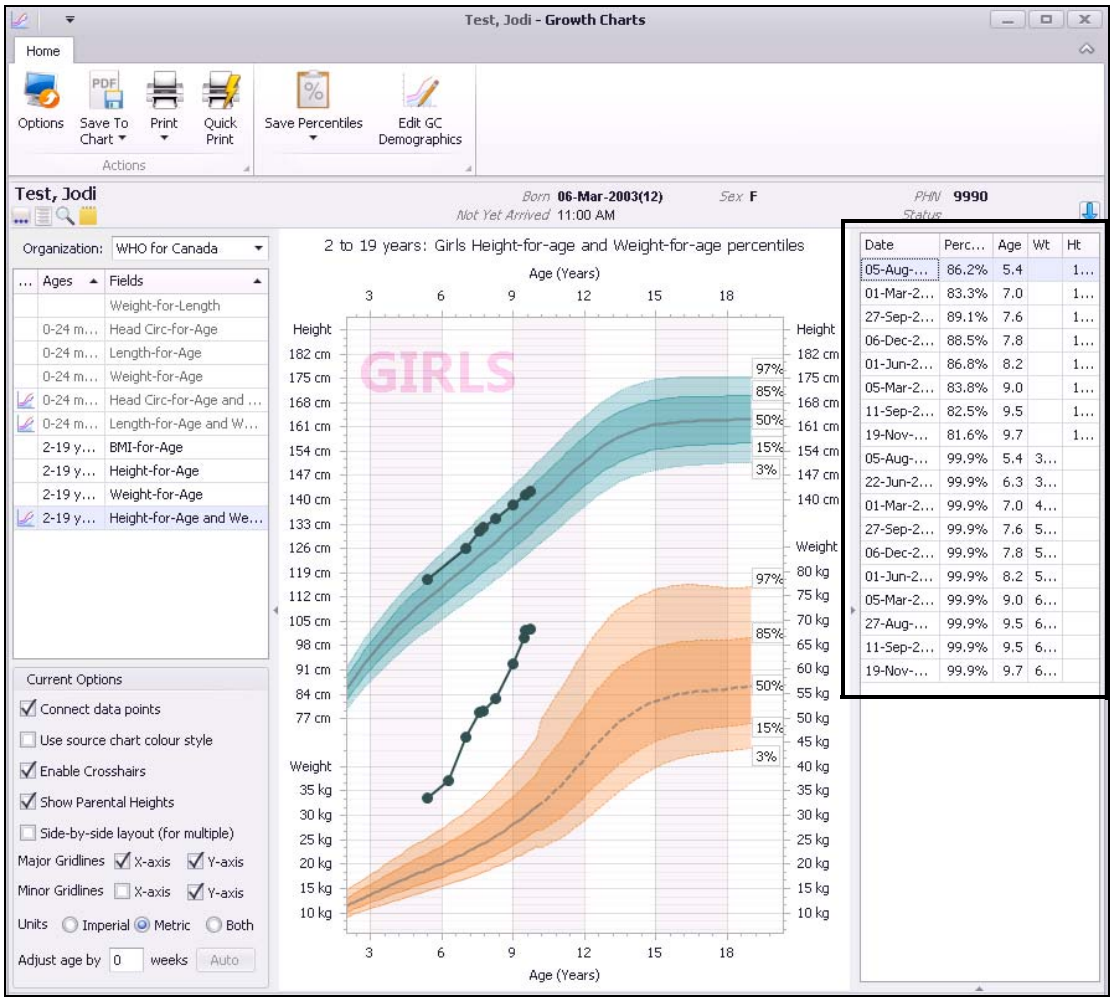
- World Health Organization (WHO) growth charts adapted for Canada
- Centers for Disease Control and Prevention (CDC)
- Canadian Pediatric Endocrine Group (CPEG)

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
- In the **Current Options** area, adjust the settings to see how they change the graph.
- 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), from a patient visit note, you can access the RBR forms in the **Exam** list.

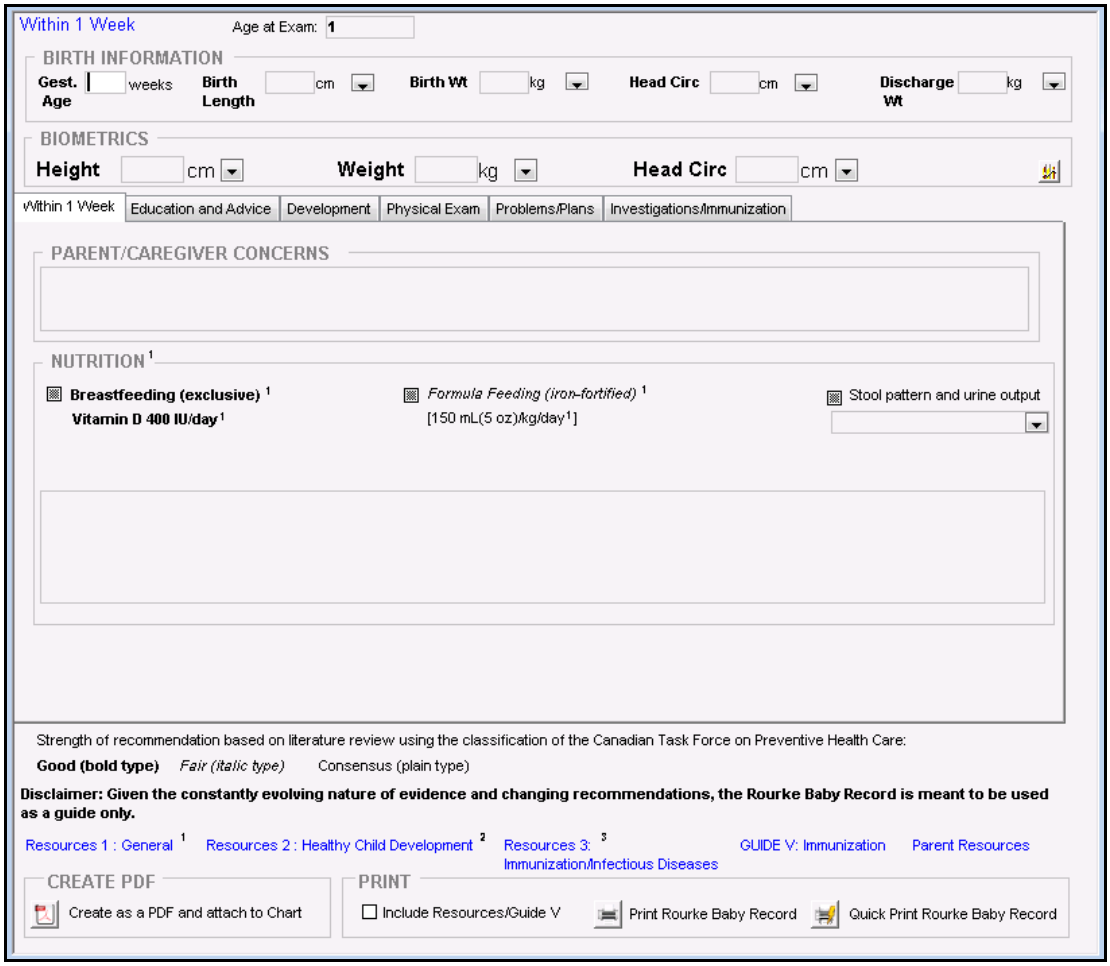
Each exam is broken into sections (tabs) that correspond to the standard RBR format.

As with other exams, if your front-end staff entered information in an RBR exam, you see this information when you open the same exam for the visit. You can edit or add to the information as needed.

To enter information in a Rourke Baby Record form:

1. Perform one of the following actions:
   - If you are entering visit notes in the SOAP form, in the **Exam** drop-down list, select an RBR exam.
   - If you are entering visit notes in the consult letter form (specialists), in the Structured Exam drop-down list, select an RBR exam.

   The EMR displays the RBR exam.



2. Enter data in each of the exam tabs as needed.

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

- From a visit note open a Rourke exam.
- Browse through the information on the various tabs.
- Enter some data in the exam.

Scenario: Completing an exam based on the Rourke Baby Records

A mother arrives with her 6-month old for a check-up. She is concerned that her son seems small for his age. Which structured exam would you use to verify or disprove this?

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

4. What is the primary benefit of recording a patient's birth information?

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 Form
- Finish an incomplete WCB form
- Track and manage your incomplete WCB forms

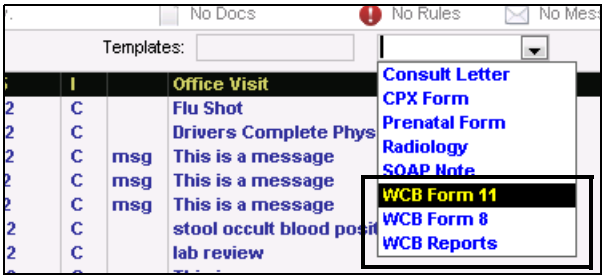
Opening the WCB Report Manager

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

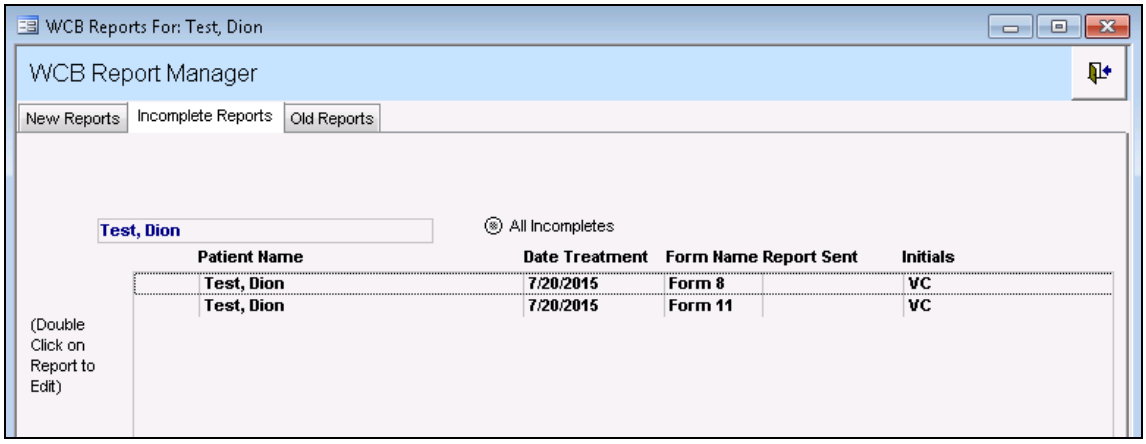
- Start a WCB report for a patient
- View, edit, and complete a patient's WCB reports
- View a patient's historical WCB reports

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. On your workdesk, in your **Appointments** list, click the patient. The EMR opens the **Patient** tab (CPP) for the patient. 2. Click today's visit and then, in the **Templates** drop-down list, click one of the following options: ■ **WCB Form 11**: To start a Progress Report (form 11) ■ **WCB Form 8**: To start a First Report (form 8) ■ **WCB Reports**: To finish a previously started WCB report. 
No	1. Open the patient's Medical Summary: On your WorkDesk, click **Medical Summary**, and then search for and select the patient. 2. On the Medical Summary window, right-click and then, in the SMART menu, click **View WCB Reports**.

The EMR opens the patient's WCB Report Manager.



Entering information in WCB forms

You 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

If a nurse or other front end staff entered information in the WCB form, you can view, add-to, and modify this information.

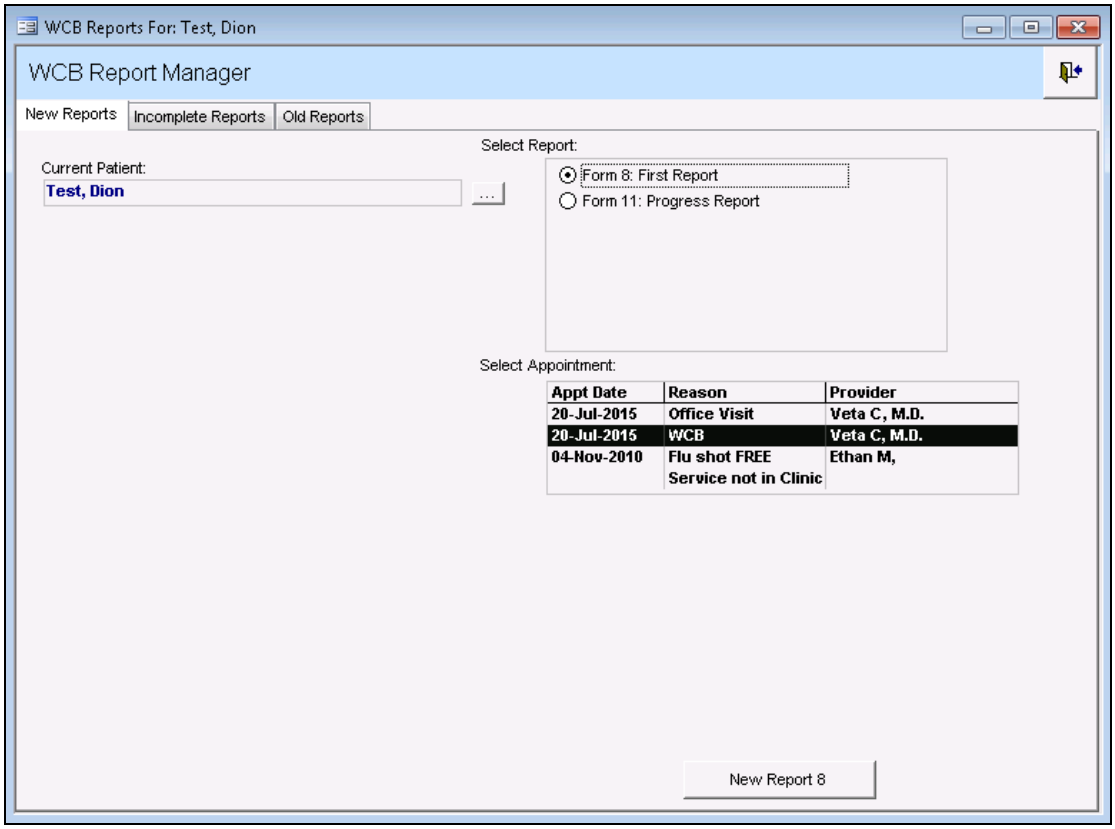
Please be aware of the following

- 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 form

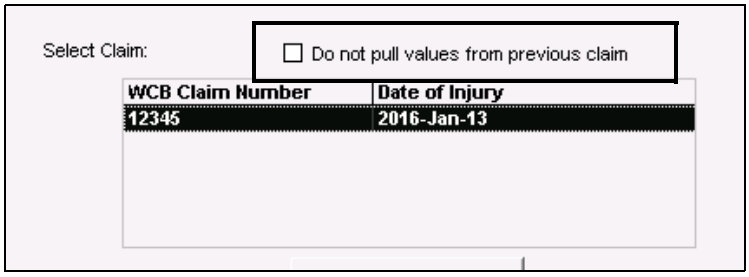
To start a WCB form for a patient:

1. Open the patient's WCB Report Manager. See "Opening the WCB Report Manager" on page 152.
2. Click the **New Reports** tab.

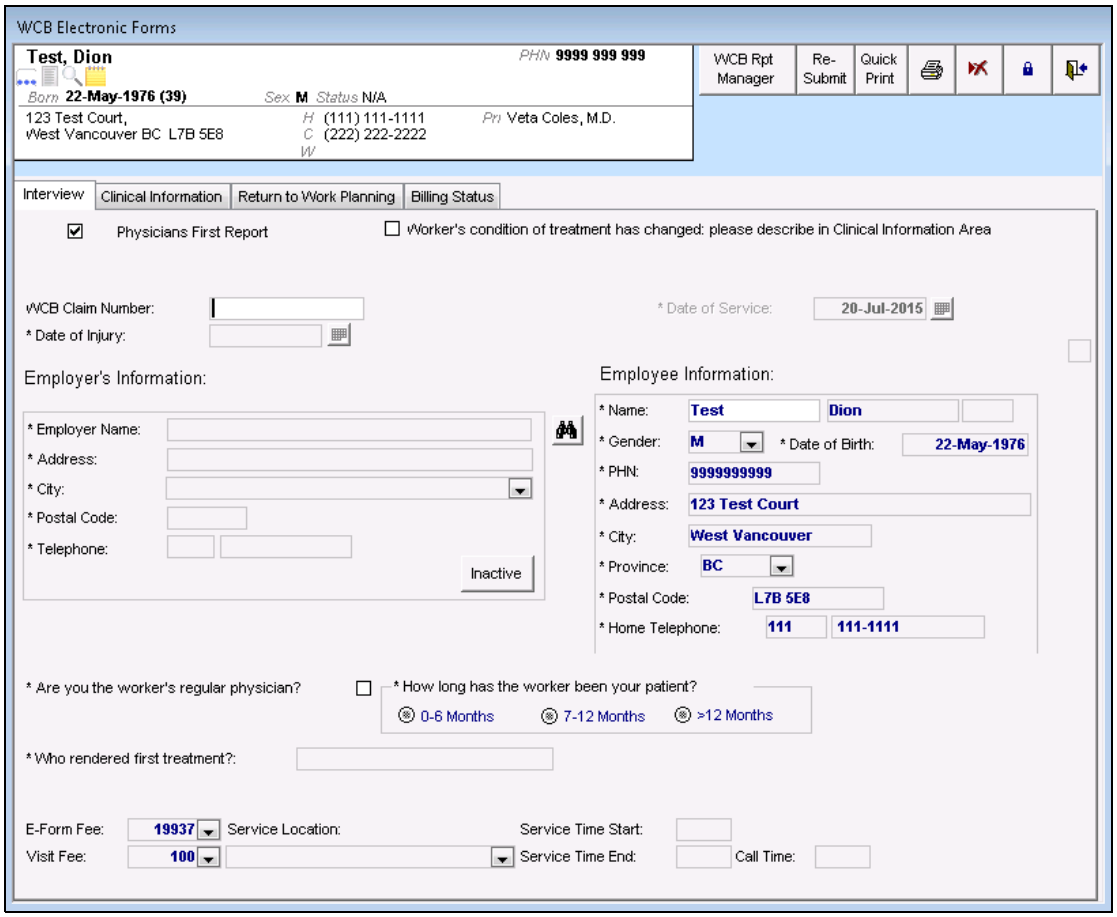


3. In the **Select Report** area, select the WCB form you want to start.
4. In the **Select Appointment** area, perform one of the following actions:
   - If the patient was seen in clinic, click the associated appointment.
   - If the patient was not seen at your clinic (for example, the patient was visited in the hospital), at the bottom of the appointment list, click **Service not in Clinic**.
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.

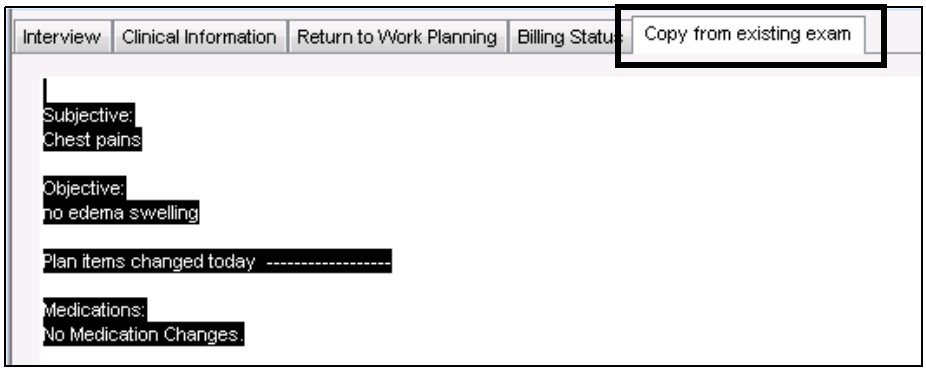


6. On the bottom of the window, click **New Report**. The EMR displays the selected WCB form.



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

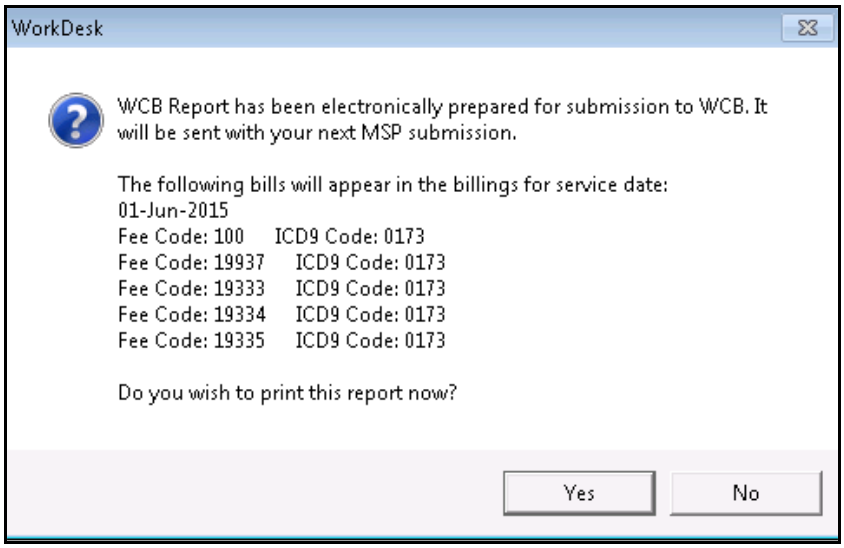
- The data entry fields exactly match the WorkSafeBC forms. As with the WorkSafeBC online forms, an asterisk (*) indicates required fields.
- The worker's first name, last name, and PHN must match the information on the worker's British Columbia CareCard.
- To view the billing status of the WCB form,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

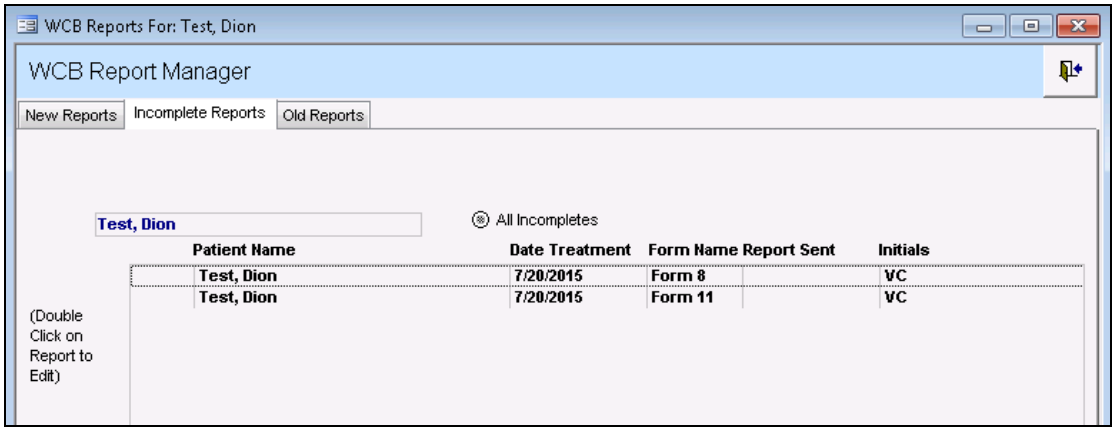
Copy information from the **Copy from existing record** tab and paste it on another tab.

Finishing a patient's previously started WCB form

Reports that have been created but not Sent to Billing are listed on the **Incomplete Reports** tab of the patient's 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 152.
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 form” on page 154.

Tracking and managing your incomplete WCB reports

You can track and manage all of your incomplete WCB reports (for all of your patients) from one location on the WorkDesk.

To track and manage your incomplete WCB Reports:

1. In the WorkDesk **Tasks** area, in the **Patient Records** area, click **# Incomplete WCB Report(s)**. The EMR displays the WCB Report Manager window with the **Incomplete Reports** tab open. The **Incomplete Reports** tab lists all of your incomplete WCB reports.
2. To open and modify a report, in the list of incomplete reports, double-click the report.
3. In the various form tabs, enter and modify information as needed.
4. 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 form” on page 154.

Scenario: Tracking and managing incomplete WCB Reports

Your biller is about to send the clinic’s claims into WCB. To ensure that all WCB bills go through, the biller asks you to finish any outstanding WCB forms. How do you know if you have properly finished all of your WCB forms?

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

Responding to incoming referrals (Specialists)

Introduction to this module

Purpose

In this module you learn how to view and respond to incoming referrals. When a referral comes in for you, you are notified on your WorkDesk. You can choose to accept the referral, decline the referral, or request more information from the referring clinic. When you respond to a referral, your front-end staff are notified. Your front-end staff can then manage the referral, based on your response.

Objectives

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

- View your incoming referrals
- Respond to referrals

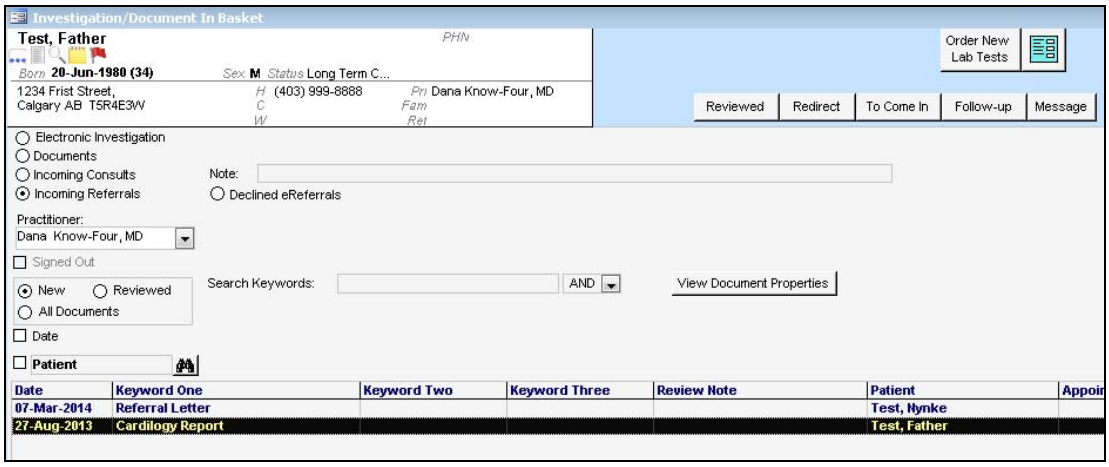
Viewing and responding to incoming referrals

Whether referrals come in through fax or mail, you are notified on your WorkDesk via the **Incoming Referrals** link. From here you can review and respond to the referrals.

IMPORTANT: A faxed or scanned referral displays in your **Incoming Referrals** list only if your front-end staff selects **Incoming Referral** as the **Document Type** for the document. Otherwise, the referral letter displays in your **New Documents** list.

To view incoming referrals:

1. In the **Tasks** area of your WorkDesk, in the **Referrals** area, click **# Incoming Referrals**. The EMR opens your Investigation/Document In-basket with a list of your un-reviewed referrals.



Tip: To review incoming referrals for another practitioner, in the **Practitioner** drop-down list, click the practitioner's name.

2. To view the referral letter and attached documents, double-click the referral. The EMR opens the letter in PDF x-Change viewer.
3. Using the following table and the options in the top right corner of the Investigation/Document In Basket window, respond to the referral.

Best practice: To notify your front-end staff that a referral is accepted, rejected, or needs more information, always choose to send a **Message**. In messages, your front-end staff can easily document calls made and actions taken to complete the referral.

Option	Example scenario	Results
Reviewed	**Caution**: Use this option only if your front-end staff have already been passed the referral. If you have told your referral clerk to accept or decline the referral, click **Reviewed** to clear the referral from your list without sending a message or follow-up task to your referral clerk.	■ The referral no longer displays in your **Incoming Referrals** list. ■ The referral letter posts to the **Documents** tab of the patient's Medical Summary without a message, task, or notification created.
Redirect	You do not have availability for the patient; however, another practitioner in your clinic does. You redirect the referral to the available practitioner.	The referral moves to another practitioner's **Incoming Referrals** list and is removed from your **Incoming Referrals** list.
Message	You want to accept, reject, or request more information for a referral. You send a message to your front-end staff to contact the patient or referring clinic. **Note**: Messages are the best way to pass the referrals to your front-end staff.	■ A message displays on your front-end staff's message list. ■ The referral letter posts to the **Documents** tab of the patient's Medical Summary. ■ The referral no longer displays in your **Incoming Referrals** list.

4. After you finish viewing and responding to your incoming referrals, click  .

Scenario: Responding to a referral

You have viewed a referral letter and want to accept the referral. What steps do you take?

Evaluation

Complete the following questions.

1. You have viewed a referral letter and want to accept the referral. What steps do you take?

2. You have received a referral, but do not have enough room to take on a new patient. A new provider has just joined your clinic, and you know they have room to take the patient. How do you “pass on” the referral to the other provider?

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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