

### Introduction

#### Overview

The Patient Summary and Referral/Transition of Care Summary (Continuity of Care Document) documents may be accessed from different locations in the software.

#### **Medical Records**

The system will automatically generate and add a Patient Summary and Referral/Transition of Care Summary to the Print Electronic Record list when a visit is created.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > <u>Account</u> <u>Number</u>

R Print by Account No	umber							2
Print	Submit to HIE	Submit to Provider	r					
Account Nur	nber: 30000243	- Q.						
Patient No	ame: SMITH FLLA KATHERINE							
A day in F						Dentel	-	
Admit L	Aste: 02/07/14 Build	Patient Summary		Build Ret/	Trans Summary Exclude from	n Portal		
Discharge	Date: 02/11/14							
Hect All	Description	D	ept.	Date	File Source	Doc. Cd.	Doc. Description	
	Physician Problem List			10/28/14	Physician Problem List Report			
	Patient Summary	C		10/28/14	CDA			
	Referral fransision of Care	Summary		10/20/14	UDA			
ent list comple	ote.							

Figure 1.1 EMR Print by Account Number

Select the **Exclude from Portal** option to deny a patient or authorized representative viewing of the Patient Summary or Referral/Transition of Care documents within the Patient Portal. The default for this field is blank which allows the Patient Summary or Referral/Transition of Care documents within the Patient Portal. This field may also be selected by the physician from HIR (Health Information Resource).

To view the CCD, select **Build Patient Summary** or **Build Ref/Trans Summary**. The same data elements pull to both documents. The CCD may also be viewed by double-clicking the CCD from the



Print Electronic Record list.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary

atient Sum	nmary (HL7 CCD)	
ocument Effective: 09/0	5/2013 10:31	
ncounter Dates://8/24	V2011 through ONICOINIC	
Contents		
Patient Demographics		
Care Team		
Provider Organization		
Vital Signs		
Allergies		
Procedures		
History of Immunizations		
Problems		
Results		
Medications		
Medications Administere	a	
Encounters		
Social History		
Patient Decision Alds		
Chief Complaint and Dea	man Far Mel	
Criter Complaint and Rea	ISON FOR VISIL	
Plan of Care		
Plan of Gare		
atient Demographi	CS	[back to top
lame	ELLA KATHERINE SMITH	]
Address	123 OLD SHELL RD NO 47 MOBILE, AL 36608	
Primary Home	2516398100	1
Edit		
alt		

Figure 1.2 Patient Summary (HL7 CCD)

- Document Effective: Displays the date and time the CCD was generated
- Encounter Dates: Displays the dates of service
- **Contents:** Gives a list of hyperlinks to the different sections of the CCD. The **back to top** option will take the user to the top of the CCD to select another section.

#### Contents

#### **Patient Demographics**

The Patient Demographics section of the CCD reflects the patient's demographic information entered on the Patient tab on the Registration and ADT screen. "Unknown" will display if no information is entered for a field or section.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Patient Demographics</u>

Patient Demographics	•	
Name	ELLA KATHERINE SMITH	
Address	123 OLD SHELL RD NO 47 MOBILE, AL 36608	
Primary Home	2516398100	
Mobile Contact	2516398400	
Date of Birth	12/02/1949	
Sex	F	
Race	BLACK OR AFRICAN AMERICAN WHITE	
Ethnicity	Not Hispanic or Latino	
Language Spoken	English	

Figure 1.3 Patient Summary (HL7 CCD)

- Name: Pulls from the Patient tab on the Registration and ADT screen
- Address: Pulls from the Patient tab on the Registration and ADT screen
- Primary Home: Pulls from the Patient tab on the Registration and ADT screen
- Mobile Contact: Pulls from the Patient tab on the Registration and ADT screen
- Date of Birth: Pulls from the Patient tab on the Registration and ADT screen
- Sex: Pulls from the Patient tab on the Registration and ADT screen
- **Race:** Pulls from the Patient tab on the Registration and ADT screen. The CCD can display up to five races.
- Ethnicity: Pulls from the Patient tab on the Registration and ADT screen
- Language Spoken: Pulls from the Patient tab on the Registration and ADT screen

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**NOTE**: The Race and Ethnicity codes must be associated with a Meaningful Use value code in the respective business office table in order to pull to the CCD.

#### Care Team

The Care Team section of the CCD reflects the people involved in the patient's care.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Care Team</u>

Care Team			
Name	Address	Phone	Role
James MD Baxter	1234 Medical Drive Mobile, AL 36608	2515109987 (Work Place)	Attending Physician
Lauryn E Clark	3622 Cottage Hill Rd Mobile, AL 36609	2514783674 (Work Place)	Rounding (Secondary) Physician
Monica D McCall	6600 WALL ST MOBILE, AL 366092702	2516398100 (Work Place)	Nurse Assistant

Figure 1.4 Patient Summary (HL7 CCD)

- Name: Pulls the name of the person caring for the patient
- Address: Pulls from the Physician table for physicians. Pulls the provider organization address from the 999999 Physician table for nurses.
- **Phone:** Pulls from the Physician table for physicians. Pulls the provider organization address from the 999999 Physician table for nurses.
- Role: Pulls according to the role responsibility during patient care

#### **Provider Organization**

The Provider Organization section of the CCD reflects the facility's contact information entered in the 999999 Physician table.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Provider Organization</u>

Provider Organization						
Name	CPSI COMMUNITY HEALTH SYSTEM					
Address	6600 WALL ST MOBILE, AL 36695					
Work Place 2516398100						

Figure 1.5 Patient Summary (HL7 CCD)

- Name: Pulls from the 999999 Physician table Physician Group Information
- Address: Pulls from the 999999 Physician table Physician Group Information
- Work Place: Pulls from the 999999 Physician table Physician Group Information

#### **Vital Signs**

The Vital Signs section of the CCD reflects vital sign values and units documented via Point of Care Flow Charts, Electronic Forms and/or Clinical Information. Body Mass Index (BMI) and Body Surface Area (BSA) values and units are automatically calculated by the system and are displayed in this section as well.

If a specific vital sign is not documented, the description does not pull to the display area. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Vital Signs</u>

Vital Signs		[back to top]
Vital Sign	Value	Unit
O2 % BldC Oximetry	97	%
Height	64	in
Weight Measured	125	lbs
Heart Rate	88	bpm
BMI (Body Mass Index)	21.46	kg/m*2
BP Diastolic	80	mmHg
BP Systolic	140	mmHg
BSA (Body Surface Area)	1.6	m^2
Respiratory Rate	19	bpm
Body Temperature	100	degrees



- Vital Sign: if documented during the stay, the following vital signs will populate this section:
  - O2 Sat
  - Height
  - Weight
  - Pulse
  - BMI (Body Mass Index) automatically calculated
  - BP Diastolic
  - BP Systolic
  - BSA (Body Surface Area) automatically calculated
  - Respirations
  - Temperature
- Value: Pulls from POC Flow Charts, Electronic Forms and/or Clinical Information
- Units: Pulls from POC Flow Charts, Electronic Forms and/or Clinical Information

#### Allergies

The Allergies section of the CCD reflects the patient's documented drug, food and environmental allergies. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Allergies</u>

Allergies [back to top							
Allergy	Code	Allergy Type	Reaction	Status			
PEANUTS	0	Food allergy (disorder)	ITCHING	Active			
LATEX	0	Allergy to substance (disorder)	RASH; ANAPHYLAXIS	Active			
PENICILLIN	0	Drug allergy (disorder)	RASH; ANAPHYLAXIS, DIARRHEA	Active			

Figure 1.7 Patient Summary (HL7 CCD)

- Allergy: Displays the description of the allergy
- Code: Will display the RxNorm Code in a future release
- Allergy Type: Displays the allergy type including Allergy to Substance (Environmental), Drug Allergy and/or Food Allergy
- **Reaction:** Displays the reaction to the allergen
- **Status:** Only active allergies will display.

#### **Procedures**

The Procedures section of the CCD reflects the procedure codes from page 2 of the DRG Grouper and Maintenance screen as well as ancillary procedures.



# Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Procedures</u>

Procedures			[back to top]
Procedure	Code	Procedure Type	Date
HEART ANEURYSM EXCISION	3732	ICD-9 CM, Volume 3	08/09/2013
ANGIOPLASTY OF OTH NONCORONARY VESS	3950	ICD-9 CM, Volume 3	08/09/2013
CT HEAD WWO CONTRAST	274535006	SNOMED CT	08/11/2013
CHEST PA AND LATERAL	268449009	SNOMED CT	08/09/2013

Figure 1	.8	Patient	Summarv	(	HL7	CCD)
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- **Procedure:** Pulls from the DRG Grouper and Maintenance screen, page 2, ICD description and/or the Item Master Description, page 1 if the SNOMED Coded is loaded on page 5 of the Item Master
- **Code:** Pulls from the DRG Grouper and Maintenance screen, page 2, ICD and/or the SNOMED Code on page 5 of the Item Master
- **Procedure Type:** Pulls the type of procedure and/or Snomed.
- **Date:** Pulls from the DRG Grouper and Maintenance screen, page 2, Proc-Dt (Procedure Date). Procedures pulling from ancillary orders show the schedule date.

#### **History of Immunizations**

The History of Immunizations section of the CCD reflects the patient's immunizations documented historically and/or administered via Point of Care Pharmacy. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > History of Immunizations

History of Immunizations		[back to top]
Immunization	Code	Date
zoster	121	10/14/2012
Tdap	115	02/15/1963
Td (adult) preservative free	113	07/30/2013

#### Figure 1.9 Patient Summary (HL7 CCD)

- Immunization: Displays the short description of the immunization
- Code: Displays the CVX Code for the immunization
- Date: Displays the date the immunization was administered



#### **Problems**

The Problems section of the CCD reflects problems documented via the Physician Problem List. Problems are included on the summary as follows:

- All problems with an active status are included on the summary by default.
- Problems that are initiated and resolved during the current stay are included on the summary by default.
- Problems that were initiated during a previous stay but resolved during the current stay are not included on the summary by default but may be included on the summary using the Edit option discussed in the next section.

"Unknown" will display if no information is entered for the section.

# Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Vital Signs</u>

Problems				[back to top]
Problem	Code	Start Date	Resolved Date	Status
CHEST PAIN	29857009	07/29/2013		Active
Anemia	271737000	07/30/2013	07/31/2013	Resolved

#### Figure 1.10 Patient Summary (HL7 CCD)

- **Problem:** Displays the description of the problem
- Code: Displays the SNOMED code for the problem
- Start Date: Displays the diagnosis date documented for the problem
- Resolved Date: Displays the resolved date documented for the problem
- Status: Displays the status documented for the problem

#### Results

The Results section of the CCD displays any Laboratory tests and results.

# C · P · S · I Patient Summary - CCD (Continuity of Care Document)

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Results</u>

9								?>
Results								[back to top]
CALCIUM IONIZED - Colle	ect Date/Time: 06/1	3/2014 10:5	6					
Test Name	Code		Test Result	Tes	t Units	Te	est Ref Range	
CA IONIZED			1.31	mm	ol/L	L=	1.16 H=1.32	
CK + CKMB (ROCHE) - Co	llect Date/Time: 06	5/09/2014 04	1:33					
Test Name		Code	Test Result		Test Units		Test Ref Range	
СК			28		U/L		L=20 H=180	
CKMB (ROCHE)			2.2		ng/mL		L=0.0 H=3.8	
REL INDEX/MB%			NO CALC		N/A		L=0.0 H=2.0	
COMPREHENSIVE METAE	30LIC - Collect Dat	e/Time: 06/	/09/2014 04:33					
Test Name		Code	Test Result	Te	est Units	Te	est Ref Range	
AGE			113	yr	s			
SODIUM			135	m	mol/L	L=	136 H=145	
POTASSIUM			4.4	m	mmol/L		3.5 H=5.1	
CHLORIDE			100	m	mol/L	L=	98 H=107	
CO2			24	m	mol/L	L=	22 H=29	
ANION GAP			11	m	mol/L	L=	8 H=16	
GLUCOSE			76	m	g/dL	L=	65 H=99	
BUN			20	m	g/dL	L=	8 H=23	
CREATININE			0.80	m	g/dL	L=	0.50 H=0.90	
BUN/CREAT			25			L=	10 H=20	
PROTEIN TOTAL			5.9	g/e	dL	L=	6.6 H=8.7	
ALBUMIN			3.6	g/e	dL	L=	3.5 H=5.2	
GLOBULIN			2.3	m	g/dL	L=	1.5 H=4.3	
A/G RATIO			1.6					
CALCIUM			8.8	m	g/dL	L=	8.6 H=10.2	
BILI TOTAL			0.2	m	g/dL	L=	0.0 H=1.2	
ALKALINE PHOS			97	U/	L	L=	35 H=105	
AST			52	U/	L	L=	0 H=32	
ALT			46	U/	L	L=	0 H=33	

Figure 1.11 Patient Summary (HL7 CCD)

- Test Name: Displays the description of the result field
- **Code:** Displays the LOINC code for the result field if added to the Reference Range Table for the result
- Test Result: Displays the results for the test performed
- Test Units: Displays the Units defined in the Reference Range Table for the result where applicable
- Test Ref Range: Displays the reference range values for each test

#### Medications

The Medications section of the CCD reflects the patient's active medications on the Pharmacy Profile, home medications entered via Medication Reconciliation that are not associated with an active medication, and medications entered using Prescription Writer. "Unknown" will display if no



information is entered for the section.

# Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Medications</u>

Medications								[back to top]
Medication	Code	Dose	Units	Frequency	Route	Modification	Start Date/Time	Stop Date/Time
ASPIRIN 325MG TAB	212033	325	MG	DAILY	PO		09/04/2013 11:39	09/11/2013 12:00
MORPHINE PCA (1MG/ML) 30ML	892477	1	EA	PRN	INTRAVENOUS		09/04/2013 14:04	09/07/2013 14:04
Regular U-100 Insulin Inj:10ml(Animal)			Unit(s)	PRN	SUBCUTANEOUS		09/04/2013 14:08	

Figure 1.12 Patient Summary (HL7 CCD)

- Medication: Displays the description of the medication
- Code: Displays the NDC number for the medication if available
- Dose: Displays the ordered dose for the medication
- Units: Displays the ordered units for the medication
- Frequency: Displays the ordered frequency for the medication
- Route: Displays the ordered route for the medication
- Modification: Displays modifications to instructions if entered via Prescription Writer
- Start Date/Time: Displays the start date and time for the order
- Stop Date/Time: Displays the stop date and time for the order if entered

#### **Medications Administered**

The Medications Administered section of the CCD reflects the patient's medications administered via Diabetic Record, EMAR and Med-Verify. "Unknown" will display if no information is entered for the section.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Medications Administered</u>

Medications Administered					[back to top]
Medication	Dose	Units	Frequency	Route	Date/Time of Last Dose
ASPIRIN 325MG TAB	325	MG	DAILY	PO	09/04/2013 11:49
PNEUMOVAX VACCINE 0.5ML         0.5         EA         X1         IM         09/04/2013 11:49					

Figure 1.13 Patient Summary (HL7 CCD)

- Medication: Displays the description of the medication administered
- Dose: Displays the last dose documented as given for the medication
- Units: Displays the last units documented for the administration
- Frequency: Displays the ordered frequency for the medication administered
- Route: Displays the ordered route for the medication administered
- Date/Time of Last Dose: Displays the date and time of the last administration for the medication

#### Encounters

The Encounters section of the CCD reflects the patient's principal diagnosis.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Encounters</u>

Encounters	[back to top]
Encounter Diagnosis	Diagnosis Code
AC MYOC INF OF ANTERLAT WAL INI CAR	41001

Figure 1.14 Patient Summary (HL7 CCD)

- Encounters Diagnosis: Pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code description
- **Diagnosis Code:** Pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code

#### **Social History**

The Social History section of the CCD reflects the patient's Smoking Status entered on the Patient tab on the Registration and ADT screen. "Unknown" will display if no information is entered for a field or section.



# Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Social History</u>

Social History			[back to top]
Smoking Status	Code	Start Date	End Date
Current every day smoker	449868002	05/12/1968	



- Smoking Status: Pulls from the Patient tab on the Registration and ADT screen
- Code (Snomed Code): Pulls from the Patient tab on the Registration and ADT screen
- Start Date: Pulls from the Patient tab on the Registration and ADT screen
- End Date: Pulls from the Patient tab on the Registration and ADT screen

**NOTE**: Based on the response entered in the Smoker field on the Patient tab on the Registration and ADT screen; a smoke **Start Date** and/or smoke **End Date** may pull to the CCD. If **Never** or **Unknown** *if ever smoked* is selected, neither Start Date nor End Date will pull to the CCD. If **Current every day** *smoker*, **Current some day smoker**, **Smoker/current status unknown**, **Heavy tobacco smoker** or **Light tobacco smoker** is selected, the Start Date will pull to the CCD. If **Former smoker** is selected, both Start Date will pull to the CCD.

#### **Patient Decision Aids**

The Patient Decision Aids section of the CCD reflects the Patient Education Documents recorded as being given to the patient. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Patient Decision Aids</u>

Patient Decision Aids	[back to top]
Patient Decision Aid	
Chronic Hypertension	
Blood urea nitrogen measurement	

Figure 1.16 Patient Summary (HL7 CCD)

• Patient Decision Aids: Displays the title of the Patient Education Document given to the patient



#### Instructions

The Instructions section of the CCD reflects information pertinent to discharge. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Instructions</u>

Instructions	[back to top]
You were admitted to CPSI COMMUNITY HEALTH SYSTEM on 07/17/2013 with a principle diagnosis of AC MYOC INF OF ANTERLAT WAL INI CAR.	
You had the following procedures done:	
HEART ANEURYSM EXCISION     ANGIOPLASTY OF OTH NONCORONARY VESS	
You had the following tests done:	
DIGOXIN     RPR	
You were discharged from CPSI COMMUNITY HEALTH SYSTEM on 07/22/2013.	
Should you have any questions prior to discharge, please contact a member of your healthcare team. If you have left the hospital and have any questions, please contact yo care physician.	our primary
<ul> <li>DIET:         <ul> <li>Regular diet.</li> </ul> </li> <li>Activity instructions (state limitations):             <ul></ul></li></ul>	

Figure 1.17 Patient Summary (HL7 CCD)

- The first section displays the facility name, admission date and principle diagnosis, which pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code description.
- The second section displays procedures performed which pull from the DRG Grouper and Maintenance screen, page 2, ICD description.
- The third section displays tests performed which includes resulted lab items.
- The fourth section displays the facility name and discharge date.
- The fifth section displays a patient reminder to seek assistance if needed.
- The sixth section displays the patient's discharge instructions as documented via Point of Care.

#### **Chief Complaint and Reason For Visit**

The Chief Complaint and Reason for Visit section of the CCD reflects the chief complaint information entered on the Clinical tab on the Registration and ADT screen.



# Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Chief Complaint and Reason For Visit</u>

Chief Complaint and Reason For Visit		
Chief Complaint	Date of Onset	
Heart disorder	07/17/2013	

Figure 1.18 Patient Summary (HL7 CCD)

- Chief Complaint: Pulls from the Clinical tab on the Registration and ADT screen
- **Date of Onset:** Pulls from the Chief Complaint entry screen on the Clinical tab on the Registration and ADT screen.

#### **Function Status**

The Function Status section of the CCD reflects the patient's functional and/or cognitive status as entered via the Health History application. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Function Status</u>

Function Status [back to 1				
Description	Code	Date	Туре	Status
Dressing disability	228154005	07/28/2013	Functional	Active
Minimal cognitive impairment	110352000	07/29/2013	Cognitive	Removed
Paramnesia	32541007	07/28/2013	Cognitive	Active
Fine motor disability	228159000	07/27/2013	Functional	Inactive

Figure 1.19 Patient Summary (HL7 CCD)

- **Description:** Displays the description of the impairment documented from the Health History Application-Functional/Cognitive Status section
- Code: Displays the SNOMED Code associated with the impairment
- Date: Displays the Onset Date for the impairment documented
- Type: Displays the type of impairment documented, Functional or Cognitive
- Status: Displays the status of the impairment including Active, Inactive, No Impairment and/or Removed



#### Plan of Care

The Plan of Care section of the CCD reflects problems, goals and instructions as entered via the physician's Plan of Care application. "Unknown" will display if no information is entered for the section.

Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Plan of Care</u>

Plan of Care	[back to top]
Care Plan Entries	
Problem: Broken skin [SNOMED: 247442005]	
Goal: Wound care management [SNOMED: 385942004]	
Instructions: Anti-Pressure Mattress, Turn every 2 hours	
Problem: Alteration in comfort: pain [SNOMED: 20361002]	
Goal: Pain relief [SNOMED: 182970005]	
Instructions: Re-position patient	

#### Figure 1.20 Patient Summary (HL7 CCD)

- Problem: Displays the problem description and SNOMED Code
- Goal: Displays the goal description and SNOMED Code documented for the problem
- Instructions: Displays the instructions documented for the goal

#### Edit

#### **Section Edits**

The Patient Summary and Referral/Transition of Care Summary may be edited by selecting the **Edit** option.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > <u>Build Patient Summary</u>

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atient Sum	mary (HL7 CCD)	
ocument Effective: 07/1	V2013 13:07	
ncounter Dates:07/17	2013 through 07/17/2013	
Contents		
Patient Demographics		
Care Team		
Provider Organization		
Vital Signs		
Allergies		
Procedures		
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Problems		
Results		
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Encounters		
Social History		
instructions		
Hospital Discharge Instru	tions	
Chief Complaint and Rea	on For Visit	
Function Status		
Plan of Care		
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lame	ELLA KATHERINE SMITH	
ddress	123 OLD SHELL RD NO 47 MOBILE, AL 36608	
rimary Home	2516398100	

Figure 1.21 Patient Summary (HL7 CCD)

Once the **Edit** option has been selected, a list of all the sections of the CCD will display. The CCD may be edited to exclude an entire section or individual components of a section.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Acc	count
Number > Build Patient Summary > <u>Edit</u>	

SMITH ELLA KATHERINE (357713) ×			v
SMITH ELLA KATHERINE MRI: 1000015 ACCOUN	(T#: 357713 DOB: 12/02/1949 Sex: F Current Weigh	it: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
AGE:63 CrCI: N/A Height:	0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight:	0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM:N/A Diagnosis: Allergies: PEN	CILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	0	0	
Encounters	0	0	
Care Team	3	0	
Allergies	1	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Save Document	A sta Rush sta		

Figure 1.22 Patient Summary (HL7 CCD)

- Section: Section of the CCD
- Total Records: Total number of records included in the section of the CCD
- Excluded Records: Number of records excluded in the section of the CCD
- View Document: Select this option from the action bar to view the attached CCD

To exclude an entire section, highlight the section to be excluded. Once the section is highlighted, select **Include/Exclude** on the action bar. The Excluded Records column will now display ALL for the excluded section. Select **Save Document** to save the changes. "Unknown" will pull to the CCD for the excluded section.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Acc	count
Number > Build Patient Summary > <u>Edit</u>	

SHITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MR#: 10000	015 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Curren	t Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit	Weight: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM: N/A.Diagnosis: 41001	Allergies: PENICILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	1	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	4	AL	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Save Document	P file: Via brokale Brokale		

Figure 1.23 Patient Summary (HL7 CCD)

The process to exclude individual components of a section changes depending on the information contained in the section. Reference the section needing to be edited for the steps.

When the Patient Summary or Referral/Transition of Care Summary is edited, a copy of the document will be saved in Electronic File Management. The document will have a file type of Clinical Document Arch (Clinical Document Architecture). The Patient Summary will be saved with a description of z\_CCDA:Patient Summary, and the Referral/Transition of Care Summary will be saved with a description of z\_CCDA:Referral/Transition. The Electronic File Management audit log will be updated with the date, time and employee name when the document is saved.



Select Hospital Base Menu > Patient Account # > Electronic File Management

🗧 🖕 0	N B			Signed On E	Imp: JSH Dept: 001
Electronic File	Management for SMITH ELLA KATHERINE	357713			
9 3	S ( ) ( ) ( ) ( )				
File List Add	I File				Ready
Date 07/18/13 07/18/13	Description z_CCDA:Patient Summary z_CCDA:Referral/Transition	File Type Clinical Document Arch. Clinical Document Arch.	Comment Date	Audit Log Date 8 07/18/2013 12:09 0 07/18/2013 12:54 0	latch #   Inactive?   00600 00601
					*

Figure 1.24 Electronic File Management

#### **Hospital Discharge Instructions**

At this time, individual components of the Hospital Discharge Instructions section may not be excluded. See <u>Section Edits</u> 15 for excluding the entire section.

#### **Problems**

Follow the steps below to edit the Problems section of the CCD.

To exclude individual problems, highlight the **Problems** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Maste	r Selection > Medical	<b>Records &gt; Print</b>	<b>Electronic Rec</b>	cord > Account
Number > Build Patient Summary >	Edit			

GE:63 CrCI: N/A I M:N/ADiagnosis:41001 Al	feight: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Wei lergies: PENCILLIN	ght: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	1	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
· · · · · · · · · · · · · · · · · · ·	1		

Figure 1.25 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual problems will display. Highlight the problem to exclude. Multiple problems may be selected by holding down the Ctrl key and selecting the desired problems. When all

problems are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



SMITH ELLA KATHERIDE (357713) ×	*
MITH ELLA KATHERINE MR#: 1000015 ACCOUNT#: 357713 DOB: 12/02/1945	Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
GE:63 CrCI: N/A Height: 0.00 inches BMI: 0 kg/m2 M: N/A Diagnosis: 41001 Allergies: DENICULIN	BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
Problem	Excluded?
Unspecified essential hypertension	
HIV disease	
DIABETES	
<b>*</b>	
🗱 🙀 Indude/Exclude	

Figure 1.26 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of problems excluded from the section. Select **Save Document** to save the changes.



#### Patient Summary - CCD (Continuity of Care Document)

community and an entering the second second			
SMITH ELLA KATHERINE (357713) ×			*
SMITH ELLA KATHERINE MR#: 10000	15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current W	eight: 0.00 lbs 0.0 cz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Wei	ight: 0.00 lbs 0.0 cz 0.00 kg 0.00 g	
Ku: N/A Diagnosis: 41001	Allergies: PENCILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems			
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	1	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Life and the fact and the	na de managemente		
an one comment of new comment			

Figure 1.27 Patient Summary (HL7 CCD)

**NOTE**: If a problem has a resolved date less than or equal to the discharge date, the problem will be automatically excluded from displaying on the CCD.

#### **Medications**

Follow the steps below to edit the Medications section of the CCD.

To exclude individual medications, highlight the **Medications** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Maste	r Selection > Medical	<b>Records &gt; Print</b>	<b>Electronic Rec</b>	cord > Account
Number > Build Patient Summary >	Edit			

TH ELLA KATHERINE MRI: 1000015 ACCOUNT	#: 357713 DOB: 12/02/1949 Sex: F Current We	eight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
N/A Diagnosis: 41001 Allergies: P	ENCILLIN	gm: 0.00 los 0.0 d2 0.00 kg 0.00 g	
ection	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	3	0	
incounters	0	0	
Care Team	1	0	
llergies	1	0	
rocedures	0	0	
unctional Status	0	0	
mmunizations	1	0	
Medications Administered	3	0	
hstructions	0	0	
ocial History	0	0	
hief Complaint and Reason For Visit	0	0	
itals	0	0	
lan of Care	0	0	
rovider Organization	1	0	
•			
Case Donated Q. Very Donated 1 2 Eds	49-14		

Figure 1.28 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual medications will display. Highlight the medication to exclude. Multiple medications may be selected by holding down the Ctrl key and selecting the desired

medications. When all medications are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



## Patient Summary - CCD (Continuity of Care Document)

SHITH FILLA KATHERINE (357713)									
SMITH ELLA KATHERINE MR#: 1000015 ACCOU	JNT#: 357713	DOB: 12/02/1949	Sex: F C	urrent Weigh	: 0.00 lbs 0.0 c	az 0.00 kg 0.00 g	1		
AGE:63 CrCI: N/A Height	0.00 inches	BMI: 0 kg/m2	BSA: 0.00 m2 A	Idmit Weight:	0.00 lbs 0.0 d	az 0.00 kg 0.00 g	,		
RM: N/A Diagnosis: 41001 Allergie	R PENICILLIN								
Medication	Dose	Route	Repeat	Excluded?					
ASPIRIN 325MG TAB	325	PO	DAILY						_
MORPHINE PCA (1MG/ML) 30ML	1	INTRAVENOUS	PRN						
Regular U-100 Insulin Inj:10ml(Animal)		SUBCUTANE	PRN						
<b>•</b>									
<b>V</b>									
Include/Exclude									

Figure 1.29 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of medications excluded from the section. Select **Save Document** to save the changes.



#### Patient Summary - CCD (Continuity of Care Document)

SMITH FILLA KATHERINE (357713)			
SMITH ELLA KATHERINE MRI: 1000015 A	CCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current W	feight: 0.00 lbs 0.0 cz 0.00 kg 0.00 g	-
AGE:63 CrCl: N/A H	eight: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit We	Hight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 Alle	rigies: PENCILUN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	3	a 🚽 🚽 🚽 🚽 🚽 🚽	
Encounters	0	0	
Care Team	1	0	
Allergies	1	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	1	0	
Medications Administered	3	0	
Instructions	0	0	
Social History	0	0	
Chief Complaint and Reason For Visit	0	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Save Document 🧠 View Document 🕑 Edit	🔓 Indude,Exclude		

Figure 1.30 Patient Summary (HL7 CCD)

#### **Encounters**

Follow the steps below to edit the Encounters section of the CCD.

To exclude individual components of the Encounters section, highlight the **Encounters** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Edit</u>

SMITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MR#: 1000015	ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current V	Neight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE: 63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit W	eight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 A	llergies:		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	4	1	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	0	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
· · · · · · · · · · · · · · · · · · ·			
Save Document 9, View Document 2 Ed	R 🙀 Include/Exclude		

Figure 1.31 Patient Summary (HL7 CCD)

Once Edit is selected, the individual components of the Encounters section will display. Highlight the

component to exclude. Once the component is highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



SHITH ELLA KATHERINE (357713) ×			•
SMITH ELLA KATHERINE MRI: 10	00015 ACCOUNT	8: 357713 DOB: 12/02/194	9 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 63 CrCI: N/	A Height:	0.00 inches BMI: 0 kg/m2	BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: N/A Diagnosis: 41001	Allergies:		
Encounter Diagnosis		Code	Excluded?
AC MYOC INF OF ANTERLAT WAL IN	VE CAR	41001	
<b>•</b>			
V			
a Include Exclude			

Figure 1.32 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of components excluded from the Encounters section. Select **Save Document** to save the changes.



#### Patient Summary - CCD (Continuity of Care Document)

SMITH FU & KATHERINE (352213)			
SAITH ELLA KATHERINE BRA 1000016	ACCOUNT& 357713 DOB: 12/02/19/9 Saw: E Current	Walaht: 0.00 lbs: 0.0 oz 0.00 ka 0.00 a	-
AGE: 63 CICL N/A	Heleht 0.00 inches BMI: 0 kn/m2 BSA: 0.00 w2 Admit V	felekt: 0.00 lbs 0.0 cz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 Al	lergies:	engline in an anna an	
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	4	1	- I
Medications	0	0	
Encounters	1		
Care Team	3	0	
Allergies	0	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	. 1
Instructions	0	0	
Social History	1	0	. 1
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	. 1
Plan of Care	0	0	
Provider Organization	1	0	. 1
Results	0	0	
Save Document 🤐 View Document 🧭 Edi	t o Indude/Exclude		

Figure 1.33 Patient Summary (HL7 CCD)

#### **Care Team**

There are three editing options available for the Care Team section of the CCD:

- 1. Individual care team members may be excluded from the CCD.
- 2. Care team members information may be modified on the CCD.
- 3. Care team members may be added to the CCD.

To exclude individual care team member, highlight the **Care Team** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Acc	count
Number > Build Patient Summary > <u>Edit</u>	

SMITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MRI: 1000015 ACCOUNT	#: 357713 DOB: 12/02/1949 Sex: F Current	Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A Height:	0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit W	feight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 Allergies: F	ENCLUN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	ů l	
Allergies	2	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
· · · · · · · · · · · · · · · · · · ·			
Save Document Q. View Document 2 Edit 2 Ind	.de/Exclude		

Figure 1.34 Patient Summary (HL7 CCD)

Once Edit is selected, the individual care team members will display. Highlight the care team member

to exclude. Once the care team member is highlighted, select **Include/Exclude.** Select the **back arrow** to save the information and return to the list of the sections of the CCD.





## Patient Summary - CCD (Continuity of Care Document)

SMITH ELLA KATHERINE (357713) ×			*
SMITH ELLA KATHERINE MR#: 1000015 ACC	OUNT#: 357713 DOB: 12/02/1949 Sex: F Current Weight	0.00 lbs 0.0 az 0.00 kg 0.00 g	
AGE:63 CrCI: N/A Heig	ht: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight:	0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 Allergi	AS: PENCILLIN		
Care Team Member	Excluded?		
James MD Baxter			
James MD Baxter			
LAURYN E CLARK			
<b>T</b>			
💠 O New 🗹 Edit 🎲 Include/Exclude			
A 10. A 10.8 - 10			

Figure 1.35 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of care team members excluded from the section. Select **Save Document** to save the changes.



## Patient Summary - CCD (Continuity of Care Document)

SHITH FLLA KATHERINE (357713)			
SMITH FLLA KATHERINE MRI: 100001	ACCOUNTE: 357713 DOB: 12/02/19/9 Sext F Current W	eieht: 0.00 lbs. 0.0 oz. 0.00 ka 0.00 a	-
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit We	ight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001	Illergies: PENICILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Core Team	3		
Allergies	2	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
L			
<b>—</b>			
V			
Save Document 🧠 View Document 🎯 B	át 🙀 Indude/Exclude		

Figure 1.36 Patient Summary (HL7 CCD)

To edit a care team member's information, highlight the care team member. Once the care team member is highlighted, select **Edit** on the action bar.



CHITTH DUA PATHERINE (SCTTUS)		
SPUTH ELLA KATHERINE (357713) X	000 1000 00 10 10 10 10 10 10 10 10 10 1	• • • • • • • • • • • • • • • • • • •
SMITHELLA KATHERINE MRK 100	Helebrary 0.00 instan 000: 12/02/1945	Sec. P. Carrier Works 0.0 is 0.0 at 0.0 is 0.0 g
RM: N/A Diagnosis: 41001	Allergies: PENCILLIN	Bake over me warmer wergine in over easier of a consign over g
Care Team Member		Excluded?
Tarmas MD Raytor		
Laward M/s Baster		
LAURYN E CLARK		
· · · · ·		
O New Z Edit include/Exclusion	de	

Figure 1.37 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual care team member's information will display. The care team member's name and type cannot be changed. When all the necessary corrections have been made

select the **back arrow** to save the information and return to the list of care team members.



Concerns on the state	
SHITH ELLA KAT	198208 (357713) ×
SMITH ELLA KAT	Internet Miller todouts ACCOUNTIE: 55/7/3 DOB:12/02/1543 Sex: F Current Wreight Current Wreigh
RM: N/A Diagnosi	CrC: trive mergers. 0.00 mones base or symp. Base 0.00 mp Humm wrengine. 0.00 ms 40 to 2 0.00 kg 0.00 g
Care Team Merr	mbar
Name:	James MD Baxter
Type:	Primary Surgery Doctor -
Address Line 1:	1234 Medical Drive
Address Line 2:	
City:	Mobile
State:	AL .
Zip Code:	36608
Telephone:	2515109987
NPI:	AL4376

Figure 1.38 Patient Summary (HL7 CCD)

To add a care team member, select **New** on the action bar.

4



## Patient Summary - CCD (Continuity of Care Document)

SMITH ELLA KATHERINE (357713) ×	*
SMITH ELLA KATHERINE MR#: 1000015 ACCOUNT#: 357713 DOB: 12/02/1945	9 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RBENA Diagnosis: 41001 Allergies: PENCILLIN	B24: 0.00 m2 wamin weedlan: 0.00 ratio 0.0 of 0.00 kg 0.00 g
Care Team Member	Excluded?
James MD Baxter	
James MD Baxter	
LAURYN E CLARK	
L	
V	
Ŧ	
🕼 O New 🛛 Edit 💪 Include/Exclude	

Figure 1.39 Patient Summary (HL7 CCD)

Once **New** is selected, the care team member's information may be entered. Select the **arrow** to save the information and return to the list of care team members.





SHITH ELLA KAT	HERINE (357713) ×					
SMITH ELLA KAT	HERINE MR#: 1000015 ACCO	JNT#: 357713 DOB: 12/02	2/1949 Sex: F Current	Weight: 0.00 lbs 0.0 az 0.00 k	g 0.00 g	
AGE: 63	CrCI: N/A Height	0.00 inches BMI: 0 kg/	m2 BSA: 0.00 m2 Admit W	feight: 0.00 lbs 0.0 az 0.00 k	g 0.00 g	
RM: N/A Diagnos	is: 41001 Allergie	K PENCILLIN				
Care Team Mer	nber					
Name:						
Type:	Primary Care Physician	-				
Address Line 1:						
Address Line 2:						
City:						
State:						
Zip Code:						
Telephone:						
NO.						
NPT:						
4						
-	4 ° 54 ° 54					
	Figure 1.40 Patient Summary (HL7 CCD)					

#### Allergies

Follow the steps below to edit the Allergies section of the CCD.

To exclude individual allergies, highlight the **Allergies** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Acc	count
Number > Build Patient Summary > <u>Edit</u>	

Section         Total Records         Bududing Records           Hospital Buduruging Judiructions         1         0           Medicational         0         0           Medicational         0         0           Econotaris         1         0           Care Team         3         0           Procedures         0         0           Functional Status         0         0           Procedures         0         0           Functional Status         0         0           Medication Administered         0         0           Statustions         0         0           Statustions         0         0         0           Value of Oreparate and Reson For Value         1         0         0           Provider Organization         0         0         0         0           Provider Organization         1         0 </th <th>SHITH ELLA KATHERINE (357733) × SMITH ELLA KATHERINE MR#: 1000 AGE: 63 CrCI: N/A RM: N/A Diagnosis: 41001</th> <th>15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Wei Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weig Altergies: PENICILUN</th> <th>ght: 0.00 lbs 0.0 oz 0.00 kg 0.00 g ht: 0.00 lbs 0.0 oz 0.00 kg 0.00 g</th> <th></th>	SHITH ELLA KATHERINE (357733) × SMITH ELLA KATHERINE MR#: 1000 AGE: 63 CrCI: N/A RM: N/A Diagnosis: 41001	15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Wei Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weig Altergies: PENICILUN	ght: 0.00 lbs 0.0 oz 0.00 kg 0.00 g ht: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
isepatial backbrige instructions         1         0           Medications         0         0           Convolutions         1         0           Convolutions         0         0           Convolutions         0         0           Convolutions         0         0           Autoritations         0         0           Productions         0         0           Medications         0         0           Productions         0         0           Medications         0         0           Medications         0         0           Medications         0         0           Medications         0         0           Social History         1         0           Other Compliant and Reson For Visit         1         0           Valia         0         0         0           Provider Organization         1         0         0           Results         0         0         0	Section	Total Records	Excluded Records	
Productions         3         0           Redications         0         0           Cara Team         3         0           Arageat         0         0           Productives         0         0           Social History         1         0           Order Graphization         0         0           Productives         0         0           Productives         0         0	Hospital Discharge Instructions	1	0	
Medications 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Problems	3	0	
Encounters         1         0           Care Team         0         0           Annotations         0         0           Procedures         0         0           Annotations         0         0           Social History         1         0           Charl Care         0         0           Provide Organization         0         0           Res of Care         0         0           Provide Organization         0         0	Medications	0	0	
Care tran         3         0           Margan         0         0           Procoderes         0         0           Functional Status         0         0           Medications         0         0           Medications         0         0           Medications         0         0           Social History         1         0           Social History         1         0           Charle Care glast and Reason For Vist         0         0           Provider Organization         1         0           Reaching         0         0	Encounters	1	0	
Alongon     2     0       Procedures     0     0       Provider Organization     1     0       Procedures     0     0	Care Team	3	0	
Procedures       0         Punctional Status       0         Immunizations       0         Medicators Administered       0         Social Idstaty       1         Social Idstaty       0         Virals       0         Provider Organization       0         Provider Organization       0         Provider Organization       0         Provider Organization       0         Results       0	Allergies		0	
Functional Status       0         Immunications       2         Medications Administered       0         Instructions       1         Occal History       1         Chief Compliant and Reason For Visit       0         Pand Care       0         Provider Organization       1         Provider Organization       0         Results       0	Procedures	0	0	
Insuitations          Insuitations       0         Instructions       0         Social Idstry       1         Chief Compliant and Reason For Visit       0         Provider Organization       0         Provider Organization       0         Results       0	Functional Status	0	0	
Medicadors Administered 0 0 0 Instructions 0 0 Social History 1 0 Chief Compliant and Reason For Visit 1 0 Chief Compliant and Reason For Visit 0 Provider Organization 1 0 Results 0 0 Chief Compliant and Reason For Visit 1 Provider Organization 0 Chief Compliant and Reason For Visit 1 Chief Compliant and Reason For	Immunizations	2	0	
Instructions       0       0       0         Social History       1       0       0         Vitals       0       0       0         Provider Organization       1       0       0         Results       0       0       0	Medications Administered	0	0	
Social History         1         0           Chief Compleint and Reason For Visit         0         0           Plan of Care         0         0           Provider Organization         1         0           Results         0         0	Instructions	0	0	
Chef Complete and Reason For Visit 1 0 0 Viais 0 0 Provider Organization 1 0 Results 0 0	Social History	1	0	
Vitais 0 0 0 0 Provider Organization 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Chief Complaint and Reason For Visit	1	0	
Plan of Care 0 0 0 Provider Organization 1 0 Results 0 0	Vitals	0	0	
Provider Organization 1 0 Results 0 0	Plan of Care	0	0	
	Provider Organization	1	0	
	Results	0	0	

Figure 1.41 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual allergies will display. Highlight the allergy to exclude. Multiple allergies may be selected by holding down the Ctrl key and selecting the desired allergies. When all

allergies are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.


SHITH ELLA KATHERINE (357713) $\times$			
SMITH ELLA KATHERINE MR#: 100	0015 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F	Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
IGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2. Allegging: DENICH LIN	Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
Allerer	Reading Perioden	Debuted	
PENOTE LIN	NECCOTS	Excudeur	
PEANUTS	ITCHING		
<b>•</b>			
-			

Figure 1.42 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of allergies excluded from the section. Select **Save Document** to save the changes.



## Patient Summary - CCD (Continuity of Care Document)

SHITH ELLA KATHERINE (357713)			¥ )
SMITH ELLA KATHERINE MRI: 10000	15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current W	feight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit We	laht: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001	Allergies: PENCILIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies			
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Save Document 🔍 View Document 🍞	Edit 🌾 Include/Exclude		
a ren potenent (E			

Figure 1.43 Patient Summary (HL7 CCD)

#### Procedures

Follow the steps below to edit the Procedures section of the CCD.

To exclude individual procedures, highlight the **Procedures** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Edit</u>

SMITH ELLA KATHERINE (357713) ×			÷
SMITH ELLA KATHERINE MR#: 100001	5 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F	Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 r	m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM:N/ADiagnosis: Aller	gies: PENICILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	0	0	
Encounters	0	0	
Care Team	2	0	
Allergies	1	0	
Procedures	4		
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	0	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	2	0	
📙 Save Document 🔍 View Document 🛛 📝 E	idit 🎲 Include/Exclude		

Figure 1.44 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual procedures will display. Highlight the procedures to exclude. Multiple procedures may be selected by holding down the Ctrl key and selecting the desired

procedures. When all procedures are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



SMITH ELLA KATHERINE (357713) X			-
SMITH ELLA KATHERINE MR#: 1000015 ACCOUN	T#: 357713 DOB: 12/02/194	9 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCl: N/A Height:	0.00 inches BMI: 0 kg/m2	BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: Allergies: PENIC	CILLIN		
Procedure	Date	Excluded?	
HEART ANEURYSM EXCISION	08/14/2013	Exclude	
ANGIOPLASTY OF OTH NONCORONARY VESS	08/14/2013		
CT HEAD WWO CONTRAST	08/14/2013		
CHEST PA AND LATERAL	08/12/2013		
1			
<b>V</b>			
a Include/Exclude			

Figure 1.45 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of procedures excluded from the section. Select **Save Document** to save the changes.



SMITH ELLA KATHERINE (357713) ×		
SMITH ELLA KATHERINE MR#: 1000015	ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F	Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m	n2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: N/A Diagnosis: Allergi	es: PENICILLIN	
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	0	0
Medications	0	0
Encounters	0	0
Care Team	2	0
Allergies	1	0
Procedures	4	1 🧹
Functional Status	0	0
Immunizations	0	0
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	0	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	2	0
🚽 Save Document 🔍 View Document 📝 Ed	it 🅱 Include/Exclude	

Figure 1.46 Patient Summary (HL7 CCD)

#### **Functional Status**

Follow the steps below to edit the Functional Status section of the CCD.

To exclude an individual status, highlight the **Functional Status** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Maste	r Selection > Medical	<b>Records &gt; Print</b>	<b>Electronic Rec</b>	ord > Account
Number > Build Patient Summary >	Edit			

MITH ELLA KATHERINE MIRIF 10000 GE:63 CrCI: N/A M:N/A Diagnosis:41001	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weigi Allergies: PENCILLIN	gmc 0.00 lbs 0.0 az 0.00 kg 0.00 g ht: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	0	0	
Encounters	0	0	
Care Team	2	0	
Allergies	0	0	
Procedures	0	0	
Functional Status	4	Ó	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	0	0	
Chief Complaint and Reason For Visit	0	0	
Vitals	9	0	
Plan of Care	0	0	
Provider Organization	1	0	
No. No.			

Figure 1.47 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual impairments will display. Highlight the impairment to exclude. Multiple impairments may be selected by holding down the Ctrl key and selecting the desired entries.

When	all	impairments	are	highlighted,	select	Include/Exclude.	Select	the
return	to tl	he list of the s	ectio	ons of the CC	D.			

back arrow to

4



## Patient Summary - CCD (Continuity of Care Document)

CUITTU DI LA PATHERINE PICTENT						
SHITH ELLA KATHERURE (35/713) ×	ACCOUNTS 307743 DOD 400	0011040 Earls E	Course at Minish	0.00 lbs 0.0 are 0.00 l	ha 0.00 a	
ACE-CO. LINA	Heleber 0.00 instar DBR 0.b	1943 SUX: F	Ldmit Weight	0.00 lbs 0.0 02 0.00 1	kg 0.00 g	
DM-10/4 Diagnosis: 41001	Hornies DENCELIN	grinz Down 0.00 mz P	wanne vreigne.	0.00 105 0.0 02 0.001	Ng 0.00 g	
de la composition e 1001	ingener creacure		0.00			
Status		туре	Excluded?			
Dressing disability		Functional				
Minimal cognitive impairment		Cognitive				
Paramnesia		Cognitive				
Fine motor disability		Functional				
<b>_</b>						
T						
🗢 🕞 Indude/Exclude						

Figure 1.48 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of impairments excluded from the section. Select **Save Document** to save the changes.



CHITTLETILA RATURDINE (SCTTLS)			-
SMITH FLLA KATHERINE (357715) X	15 ACCOUNTE-357713 DOB: 12/02/1949 Sex- E Current V	Meight: 0.00 lbs: 0.0 oz: 0.00 kg 0.00 g	
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit W	eight: 0.00 lbs 0.0 cz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001	Allergies: PENCILUN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	0	0	
Encounters	0	0	
Care Team	2	0	
Allergies	0	0	
Procedures	0	0	
Functional Status	4	1	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	0	0	
Chief Complaint and Reason For Visit	0	0	
Vitals	9	0	
Plan of Care	0	0	
Provider Organization	1	0	
Nesuns	Ŷ	ų.	
<b>•</b>			
V			
🖌 Save Document 🔍 View Document 🍞	Edit 🚱 Include,Exclude		
A 10 A 10	e the the the the the		and the second s

Figure 1.49 Patient Summary (HL7 CCD)

#### Immunizations

Follow the steps below to edit the Immunizations section of the CCD.

To exclude individual immunizations, highlight the **Immunizations** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Acc	count
Number > Build Patient Summary > <u>Edit</u>	

SMITH ELLA KATHERINE (357713) ×	5 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current We	ight: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
NGE: 63 CrCI: N/A RM: N/A Diagnosis: 41001	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weig Allergies: PENCILLIN	hht: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	2	1	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Saus Dog mant			

Figure 1.50 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual immunizations will display. Highlight the immunization to exclude. Multiple immunizations may be selected by holding down the Ctrl key and selecting the desired

immunizations. When all immunizations are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



CHITTLE ILA VATURDINE (SCTTIS)			- 1
CHITH ELLA MATHEORIE (197713) A	12 DOB: 12/22/10/0 Earry E	Current Melaht 0.00 lbs 0.0 oz 0.00 ka 0.00 o	-
ACE-C1 MA Height 0.00	inches Bills 0 kaim2 BEA-0	00	
RM-N/A Diagnosis: 41001 Allernies: PENICI I	BU BU	ou ma statistic trangine to be as a to be sign on g	
In the second seco	Data .	Evel-de B	
2mmuni280on	Date	Excluded?	
Influenza, seasonal, injectable	10/01/2012		
DTP	06/13/2013		
L 1			
1 7			
🔅 🔓 Include/Exclude			

Figure 1.51 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of immunizations excluded from the section. Select **Save Document** to save the changes.



SMITH ELLA KATHERNE     RMR: 1000 15 ACCOUNT#: 357713     DOB: 12/02/1549 Sex: F     Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g       AGE:63     CrCl:     N/A     Height:     0.00 inches BMI:     0 kg/m2     BSA: 0.00 m2 Admit Weight:     0.00 lbs 0.0 oz 0.00 kg 0.00 g       RMI: 10/A Diagnosis: 41001     Allergies: PENICILLIN     Total Records     Excluded Records       Section     1     0       Hospital Discharge Instructions     1     0       Problems     3     0       Medications     0     0       Encounters     1     0       Care Team     3     0       Allergies     2     1	
Section         Total Records         Excluded Records           Hospital Discharge Instructions         1         0           Problems         3         0           Medications         0         0           Encounters         1         0           Care Team         3         0           Allergies         2         1	
Hospital Discharge Instructions         1         0           Problems         3         0           Medications         0         0           Encounters         1         0           Care Team         3         0           Allergies         2         1	
Problems         3         0           Medications         0         0           Encounters         1         0           Care Team         3         0           Allergies         2         1	
Medications         0         0           Encounters         1         0           Care Team         3         0           Allergies         2         1	
Encounters         1         0           Care Team         3         0           Allergies         2         1	
Care Team         3         0           Allergies         2         1	
Allergies 2 1	
Procedures 0 0	
Functional Status 0 0	
Immunautors 2	
Medications Administered 0 0	
Instructions 0 0	
Sodal History 1 0	
Chief Complaint and Reason For Visit 1 0	
Vitals 0 0	
Plan of Care 0 0	
Provider Organization 1 0	
Save Document 🔍 Vew Document 🖓 Edit 🖓 Indude/Exclude	

Figure 1.52 Patient Summary (HL7 CCD)

#### **Medications Administered**

Follow the steps below to edit the Medications Administered section of the CCD.

To exclude individual medication administrations, highlight the **Medications Administered** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu >	Master Selection >	<b>Medical Records</b> 2	> Print Electro	nic Record >	Account
Number > Build Patient Sumi	nary > <u>Edit</u>				

SHITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MRI: 1000015	ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current W	eight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE: 63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Wei	ight: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001	illergies: PENCILUN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	3	1	
Encounters	0	0	
Care Team	1	0	
Allergies	1	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	1	0	
Medications Administered	3	0	
Instructions	0	0	
Social History	0	0	
Chief Complaint and Reason For Visit	0	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
1			
We save Document   1 w, two Document   1 w tot   1 & include,Exclude			

Figure 1.53 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual medication administrations will display. Highlight the medication administration to exclude. Multiple medication administrations may be selected by holding down the Ctrl key and selecting the desired items. When all administrations are highlighted, select **Include**/

Exclude. Select the

back arrow to return to the list of the sections of the CCD.



# Patient Summary - CCD (Continuity of Care Document)

SHITH ELLA KATHERINE (357713) ×								*
SMITH ELLA KATHERINE MR#: 100001	15 ACCOUNT#: 357713	DOB: 12/02/194	9 Sex: F	Current Weight:	0.00 lbs 0.0 az	0.00 kg 0.00 g		
AGE:63 CrCl: N/A	Height: 0.00 inch	is BMI: 0 kg/m2	BSA: 0.00	m2 Admit Weight:	0.00 lbs 0.0 oz	0.00 kg 0.00 g		
RM: N/A Diagnosis: 41001	Allergies: PENCILLIN							
Medication	Dose	Route	Repeat	Excluded?				
ASPIRIN 325MG TAB	325	PØ	DAILY					
Regular U-100 Insulin Inj:10ml(Animal)	2	SUBCUTANE	PRN					
PNEUMOVAX VACCINE 0.5ML	0.5	IM	X1					
4 (a Include/Exclude								

Figure 1.54 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of medication administrations excluded from the section. Select **Save Document** to save the changes.



CMITHERIA KATHERINE (157711)		
SMITH ELLA KATHERINE MRIE 10000	15 ACCOUNT#: 357713 DOR: 12/02/1949 Sex: F Current V	/eight: 0.00 lbs 0.0 az 0.00 kg 0.00 g
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit We	hight: 0.00 lbs 0.0 az 0.00 kg 0.00 g
RM: N/A Diagnosis: 41001	Allergies: PENCILLIN	
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	0	0
Medications	3	1
Encounters	0	0
Care Team	1	0
Allergies	1	0
Procedures	0	0
Functional Status	0	0
Immunizations	1	0
Medications Administered	3	a se a companya de la
Instructions	0	0
Social History	0	0
Chief Complaint and Reason For Visit	0	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0
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Figure 1.55 Patient Summary (HL7 CCD)

#### Instructions

At this time, individual components of the Instructions (Patient Decision Aids) section may not be excluded. See <u>Section Edits</u> 15 for excluding the entire section.

#### **Social History**

Follow the steps below to edit the Social History section of the CCD.

To exclude individual components of the Social History section, highlight the **Social History** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu	> Master Selection > Medic	al Records > Print	<b>Electronic Record</b>	> Account
Number > Build Patient Sum	mary > <u>Edit</u>			

SHITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MR#: 1000015 A	CCOUNT#: 357713 DOB: 12/02/1949 Sex: F Curren	it Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A H	leight: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit	Weight: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 All	ergies: PENCILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	3	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	2	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
V			
Save Document Q. View Document 📝 Edit	🖗 Indude/Exclude		

Figure 1.56 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual components of the Social History section will display. Highlight the component to exclude. Once the component is highlighted, select **Include/Exclude.** Select the

4

back arrow to return to the list of the sections of the CCD.



SHITH ELLA KATHERINE (357713) ×		*)
SMITH ELLA KATHERINE MRI: 100	0015 ACCOUNT#: 357713 DOB: 12/02/1949 f	iex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 f	SA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 az 0.00 kg 0.00 g
RM: N/A Diagnosis: 41001	Allergies: PENICILLIN	
Social History	1	xduded?
Current every day emoker		
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(a) Ca Include Buckele		
- 10 sometenese	14 44 44 14 M	

Figure 1.57 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of components excluded from the Social History section. Select **Save Document** to save the changes.



CHITM FILE RATHERING (DETTEN)			
SMITH ELLA KATHERINE (JS7713) X	ACCOUNT& 357713 DOB: 12/02/19/9 Save E Curren	Mejohr 0.00 Rs 0.0 oz 0.00 ko 0.00 o	*
ACE-62 C+C1: N/A	Height 0.00 inches Bills 0 knim2 BSA: 0.00 m2 Admit	Weight 0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM:N/A Diagnosis: 41001 Al	lergies: PENCILLIN	and the second of the second s	
Section	Total Becords	Evolutian Barrooks	
Magazital Discharge Instructions	1	A A	
Evolution of the second	3	0	
Madications	0	0	
Encounters	1	0	
Care Team	1	0	
Allergies	2	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1		
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
- <u>-</u>			
Save Document 🧠 View Document 📝 Edit	t 🙀 Indude/Exclude		

Figure 1.58 Patient Summary (HL7 CCD)

#### **Chief Complaint and Reason For Visit**

Follow the steps below to edit the Chief Complaint and Reason For Visit section of the CCD.

There are two editing options available for the Chief Complaint and Reason for Visit section of the CCD:

- 1. The Chief Complaint and Reason for Visit may be excluded from the CCD.
- 2. The Chief Complaint and Reason for Visit information may be modified on the CCD.

To exclude the Chief Complaint, highlight the **Chief Complaint and Reason For Visit** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Edit</u>

SHITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MR#: 10000	15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Wr	right: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE: 63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Wei-	ght: 0.00 lbs 0.0 az 0.00 kg 0.00 g	
RM: 350-a Diagnosis: 41001	Allergies: PENCILLIN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	4	0	
Medications	0	0	
Encounters	1	0	
Care Team	3	0	
Allergies	2	0	
Procedures	2	0	
Functional Status	0	0	
Immunizations	4	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Save Document 🧠 View Document 💌	Edt		

Figure 1.59 Patient Summary (HL7 CCD)

Once Edit is selected, the Chief Complaint will display. Highlight the Chief Complaint. Once the Chief

Complaint is highlighted, select **Include/Exclude.** Select the **back arrow** to save the information and return to the list of the sections of the CCD.



SHITH FILLA KATHERINE (757713)		-
SMITH FLIA KATHERINE MRI 10000	15 ACCOUNT#: 357713 DOR: 12/02/19/	Sav- F Current Weight: 0.00 lbs 0.0 oz 0.00 ko 0.00 o
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2	BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 az 0.00 kg 0.00 g
RM: 350-a Diagnosis: 41001	Allergies: PENCILLIN	
Complaint		Excluded?
Heart disorder		
<b>•</b>		
V V		
🗰 📝 Edit 👔 Include/Exclude		
	the set of the	

Figure 1.60 Patient Summary (HL7 CCD)

The Excluded Records column will now display the Chief Complaint and Reason for Visit were excluded from the section. Select **Save Document** to save the changes.



SHITH FILA KATHERINE (357713)		
SMITH ELLA KATHERINE MRI: 100001	5 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current We	light: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weig	ght: 0.00 lbs 0.0 az 0.00 kg 0.00 g
RM: 350-a Diagnosis: 41001	Allergies: PENICILLIN	
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	4	0
Medications	0	0
Encounters	1	0
Care Team	3	0
Allergies	2	0
Procedures	2	0
Functional Status	0	0
ammuni2800ns	4	0
meacadons Administered	0	0
Corial Listory	1	0
Chail Complete and Reason For Mart	1	
Veale	0	
Plan of Care	0	0
Provider Organization	1	0
Results	0	0
Save Descret Q. View Descret 1971	Edit (dit turbula Burbula	
and the second s	and the second sec	

Figure 1.61 Patient Summary (HL7 CCD)

To edit the Chief Complaint, highlight the Chief Complaint. Once the Chief Complaint is highlighted, select **Edit** on the action bar.



SHITH ELLA KATHERINE (357713) ×		
SMITH ELLA KATHERINE MR#: 10000	15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Weight:	0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: /	0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: 350-a Diagnosis: 41001	Allergies: PENICILLIN	
Complaint	Excluded?	
Heart disorder		
L 🗕		
▼		
a la million and a		
The second secon	114 14 14 114 14 14 1	

Figure 1.62 Patient Summary (HL7 CCD)

Once Edit is selected, the Chief Complaint will display. When all the necessary corrections have been

made, select the **back arrow** to save the information and return to the list displaying the Chief Complaint.



ATTACASE AND	
THE ELAN WATHERING INFORMATION INFORMATIONI I	
CrC: V/A Preight 0 00 inches Ball: 0 kg/mz BSAC 0.00 m2 Admin Weight 0 100 los 0.0 02 0.00 kg 0.00 g	
300-a transference a 1001 Antergane PEreculary	_
er companie. Bear descere	
	_

Figure 1.63 Patient Summary (HL7 CCD)

#### Vitals

Follow the steps below to edit the Vitals section of the CCD.

To exclude individual vital signs, highlight the **Vitals** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Edit</u>

SHITH ELLA KATHERINE (357713) ×			*
SMITH ELLA KATHERINE MR#: 1000015 ACC	OUNT#: 357713 DOB: 12/02/1949 Sex: F Current V	Neight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A Heig	ht: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit We	eight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 Allerg	ies: PENCILUN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	0	0	
Encounters	0	0	
Care Team	2	0	
Allergies	0	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	0	0	
Chief Complaint and Reason For Visit	0	0	
Vitals	9	0	
Plan of Care	0	0	
Provider Organization	1	0	
Results	0	0	
Ber save bodument   Ve, wew Document   @ Edit   1	* Incree/Excree		

Figure 1.64 Patient Summary (HL7 CCD)

Once **Edit** is selected, the vital sign groups will display. Highlight the vital sign group to exclude. Multiple vital sign groups may be selected by holding down the Ctrl key and selecting the desired

entries. When all vital sign groups are highlighted, select **Include/Exclude.** Select the **arrow** to return to the list of the sections of the CCD.

back



## Patient Summary - CCD (Continuity of Care Document)

SHITH FILA KATHERINE (357713)			
SMITH FLLA KATHERINE MRP 1000015 ACCOUNT# 357713	DOB: 12/02/1949 Sev: F Current Weight: 0.00 lbs	0.0 oz 0.00 ka 0.00 a	
AGE:63 CrCI: N/A Height: 0.00 inc	hes BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs	0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001 Allergies: PENICILLIN			
Vital Sign Group	Total Records	Excluded Records	
O2 Oximetry	1	0	
Height	1	0	
Weight	1	0	
Heart Rate	1	0	
Body Mass Index	1	0	
Blood Pressure	2	0	
Body Surface Area	1	0	
Respiratory Rate	1	0	
Temperature	1	0	
T			
💠 🍞 Edt 👒 Indude/Exclude			

Figure 1.65 Patient Summary (HL7 CCD)

Each vital sign group may contain multiple records. To exclude an individual record within a group, select the group then **Edit**. Highlight the vital sign to exclude. Multiple vital signs may be selected by holding down the Ctrl key and selecting the desired entries. When all vital signs are highlighted,

select Include/Exclude. Select the

**back arrow** to return to the list of vital sign groups.



SHITH BLIA KATHERINE (357713) ×           SMITH ELLA KATHERINE MR#: 1000015 ACCOUNT#: 357713         DOB: 12/02/1949 Sex: F         Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g				
AGE:63 CrCl: N/A Height: 0.00 inches I RM: N/A Diagnosis: 41001 Allergies: PENICILLIN	BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lb	s 0.0 oz 0.00 kg 0.00 g		
Vital Sign	Value	Excluded?		
BP Deestole	80			
BP Systolic	140			
•				
4 G Indude/Exclude				

Figure 1.66 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of vital signs excluded from the section. Select **Save Document** to save the changes.



## Patient Summary - CCD (Continuity of Care Document)

SHITH ELLA KATHERINE (357713) ×			*
SMITH ELLA KATHERINE MRM: 10000	15 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Curren	at Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
AGE:63 CrCI: N/A	Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit	Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
RM: N/A Diagnosis: 41001	Allergies: PENCILUN		
Section	Total Records	Excluded Records	
Hospital Discharge Instructions	1	0	
Problems	0	0	
Medications	0	0	
Encounters	0	0	
Care Team	2	0	
Allergies	0	0	
Procedures	0	0	
Functional Status	0	0	
Immunizations	0	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	0	0	
Chief Complaint and Reason For Visit	0		
Vitais	9		
Plan or Care		0	_
Provider Organization	1	0	
🛃 Save Document 🔍 View Document 🏾	Edit 🧊 Include/Exclude		

Figure 1.67 Patient Summary (HL7 CCD)

#### Plan of Care

Follow the steps below to edit the Plan of Care section of the CCD.

To exclude individual problems along with the associated goals and instructions, highlight the **Plan of Care** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Edit</u>

MTH ELLA KATHERINE MR#: 97037 GE:54 CrCI: N/A dl: 350-a Diagnosis: 41001	5 ACCOUNT#: 357713 DOB: 01/19/1959 Sex: F Current Weight Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight:	E 0.00 lbs 0.0 cz 0.00 kg 0.00 g	
al: 350-a Diagnosis: 41001	Height: 0.00 inches BMI; 0 kg/m2 BSA; 0.00 m2 Admit Weight:		
ac 550-a bragmonistia 1001	Allernier ad	0.00 lbs 0.0 dz 0.00 kg 0.00 g	
artica	Total Pacards	Eurland Parande	
Hereitel Bischesse Testeutions	Total Necords	Excluded Records	
Rospital Discharge Instructions	1	0	
Propertie	2		
Encounters	1	0	
Care Team	*	0	
Allernies	0	0	
Procedures	2	0	
Functional Status	0	0	
Immunizations	2	0	
Medications Administered	0	0	
Instructions	0	0	
Social History	1	0	
Chief Complaint and Reason For Visit	1	0	
Vitals	0	0	
Plan of Care	2	0	
Provider Organization	1	0	
Results	0	0	

Figure 1.68 Patient Summary (HL7 CCD)

Once **Edit** is selected, the individual problems will display. Highlight the problem to exclude. Multiple problems may be selected by holding down the Ctrl key and selecting the desired problems. When all

problems are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



SHITH ELLA KATHERINE (357713) × MITH ELLA KATHERINE MR#: 9703 GE:54 CrCI: N/A	75 ACCOUNT#: 357713 DOB: 01/19/19 Height: 0.00 inches BMI: 0 kg/m2	69 Sex: F (	Current Weight: 0. Admit Weight: 0.	100 lbs 0.0 oz 0.00 kg 0.00 g 100 lbs 0.0 oz 0.00 kg 0.00 g
M: 350-a Diagnosis: 41001	Allergies: null			
Plan of Care Problems		Code	Total Records	Excluded Records
Broken skin		247442005	1	0
Averadori in connore, pain		20301002	1	v
Ļ				
Edit 🕞 Indude/Exclude				

Figure 1.69 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of problems excluded from the section. Select **Save Document** to save the changes.



SMITH ELLA KATHERINE (357713) $\times$		•
SMITH ELLA KATHERINE MR#: 97037 AGE:54 CrCI: N/A RM: 350-a Diagnosis: 41001	5 ACCOUNT#: 357713 DOB: 01/19/1959 Sex: F Cur Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Adi Allergies: null	rrent Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g mit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	2	0
Medications	0	0
Encounters	1	0
Care Team	3	0
Allergies	0	0
Procedures	2	0
Functional Status	0	0
Immunizations	2	0
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	2	1
Provider Organization	1	0
Results	0	0
		TNT - The Coolest Screen Capture Yool on Earth
In Save Document 4 View Document	Edit Indude_Exclude	

Figure 1.70 Patient Summary (HL7 CCD)

To edit a goal and the associated instructions, highlight the problem. Once the problem is highlighted, select **Edit** on the action bar.



SMITH ELLA KATHERINE (357713) ×			
SMITH ELLA KATHERINE MR#: 970375 ACCOUNT#: 357713 DOB: 01/19/19	59 Sex: F	Current Weight: 0	1.00 lbs 0.0 cz 0.00 kg 0.00 g
AGE: 54 CrCI: N/A Height: 0.00 inches BMI: 0 kg/m2 Alleration: e.d.	8/SA: 0.00 m2 /	Admit Weight: 0	1.00 lbs 0.0 cz 0.00 kg 0.00 g
Elas of Case Broblems	Code	Total Bacarde	Eveluded Remote
Broken diin	247442005	1	0
Alteration in comfort: pain	20361002	1	
Entern Descend das Described and De			
▼			
💠 🍸 Edit 😘 Include/Exclude			CPSI System

Figure 1.71 Patient Summary (HL7 CCD)

Once **Edit** is selected, the goals and instructions for the selected problem will display. Highlight the goal to exclude. Multiple goals may be selected by holding down the Ctrl key and selecting the desired

goals. When all goals are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.



# Patient Summary - CCD (Continuity of Care Document)

SHITH ELLA KATHERINE (357713) ×         •           MITH ELLA KATHERINE MR#: 970375 ACCOUNT#: 357713         DOB: 01/19/1959 Sex: F         Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g           EE: 54         CrCl: N/A         Height: 0.00 inches BMI: 0 kg/m2         BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g           MISS:0.000ext: 41001         Alterates: rul         SSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g				
Iteration in comfort: pain [2	0361002]			
Goal	Instructions	Excluded?		
Pain relief	Re-position patient			
<b>▼</b>				
- Man Internet				
Car car    C+ tronge/Exclude				

Figure 1.72 Patient Summary (HL7 CCD)

To edit the instructions associated with a goal, highlight the goal then select **Edit** from the action bar.



# Patient Summary - CCD (Continuity of Care Document)

TH ELLA KATHERINE MR#: 54 CrCI: 350-a Diagnosis: 41001 pration in comfort: pain [203	70375 ACCOUNT#: 357713 DOB: 01/19/1959 Sex: F Curr N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Adm Allergies: null 5002]	ent Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g It Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g	
al	Instructions	Excluded?	
ain rebof	Re-position patient		
1			

Figure 1.73 Patient Summary (HL7 CCD)

۹

Modify the instruction field as needed. Select the return to the list of goals.

back arrow to save the information and



SNITH FULA	KATHERINE (357713	0 ~				-
SMITH ELLA	KATHERINE MR	97037	ACCOUNTE: 35	7713 DOB: 0	1/19/195	959 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kp 0.00 o
AGE:54	CrCt	N/A	Height: 0.0	0 inches BMI: 0	kg/m2	2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: 350-a Dia	agnosis: 41001		Allergies: null			
Plan of Care	e Entry					
Goal:	Pain relief					
Instructions:	Re-position patier	nt.				
<b>*</b>						
•						
4						

Figure 1.74 Patient Summary (HL7 CCD)

## **Provider Organization**

To edit the section, highlight the **Provider Organization** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu	> Master Selection > M	Medical Records > I	Print Electronic	<b>Record</b> > Accour	ıt
Number > Build Patient Sum	mary > <u>Edit</u>				

SMITH ELLA KATHERINE MIRI: 1000015 ACCOUNTIE: 357713 AGE:63 CrCI: N/A Height: 0.00 inche Rilk N/A Diagnosis: 41001 Allergies: PENICILLIN Section Hospital Discharge Instructions Problems Medications Encounters Care Team Allergies Procedures Procedures Procedures Procedures Procedures Procedures Procedures Procedures Procedures Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider: Organization Results	DOB: 12/02/1949 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0 BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0	00 g 00 g
AGE:53 CrCI: N/A Height: 0.00 inche RNI: N/A Diegnosis:41001 Allergies: PENICILLIN Section Hospital Discharge Instructions Problems Medications Encounters Care Team Allergies Procedures Procedures Procedures Procedures Procedures Social History Chief Complaint and Reason For Visit Vitals Plan of Care Plan of Care Plan of Care Plan of Care	BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 az 0.00 kg 0	00 g
Rttl: N/A Disgnostis: 41001         Altergies: PENICILLIN           Section         Hospital Discharge Instructions           Problems         Medications           Medications         Encourters           Care Team         Altergies           Procedures         Functional Status           Prunctional Status         Immunizations           Medications Administered         Social History           Chief Complaint and Reason For Visit         Visits           Plan of Care         Provider Organization           Results         Social History		
Section Hospital Discharge Instructions Problems Medications Encounters Core Team Allergies Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Procedure Procedure Organization Results		
Hospital Discharge Instructions Problems Medications Encounters Care Team Allergies Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	Total Records	Excluded Records
Problems Medications Encounters Care Team Allergies Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	1	0
Medications Encourters Core Team Allergies Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Proveder Corporatetion Results	3	0
Encounters Care Team Allergies Frocedures Functional Status Jmmunizations Medications Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Corganization Results	0	0
Care Team Allergies Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	1	0
Allergies Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	3	0
Procedures Functional Status Immunizations Medications Administered Instructions Social History Chief Completint and Reason For Visit Vitals Plan of Care Provider Organization Results	2	0
Functional Status Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	0	0
Immunizations Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	0	0
Medications Administered Instructions Social History Chief Complaint and Reason For Visit Vitals Flan of Care Provider Organization Results	2	0
Instructions Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	0	0
Social History Chief Complaint and Reason For Visit Vitals Plan of Care Provider Organization Results	0	0
Chief Compleint and Reason For Visit Vitals Flan of Care Provider Organization Results	1	0
Vitals Plan of Care Provider Organization Results	1	0
Plan of Care Provider Organization Results	0	0
Provider Organization Results	0	0
Results	1	0
Save Document Q. View Document IV Edd		

Figure 1.75 Patient Summary (HL7 CCD)

Once **Edit** is selected, the Provider Organization information will display. Only the address and phone number information may be modified. When all necessary corrections have been made, select the

back arrow to save the information and return to the list of the sections of the CCD.

4



SHITH FLLA KAT	HERINE (357713) ×							
SMITH ELLA KAT	HERINE MR#: 100	0015 ACCOUNT#: 357	713 DOB: 12/02/194	9 Sex: F Current	Weight: 0.00 lbs 0.0 oz	0.00 kg 0.00 g		
AGE:63	CrCI: N/A	Height: 0.00	inches BMI: 0 kg/m2	BSA: 0.00 m2 Admit V	feight: 0.00 lbs 0.0 az	0.00 kg 0.00 g		
RM: N/A Diagnos	MEN/ADiegnosis: 41001 Allergies: PENICILLIN							
Provider Organi	cost costs with the	EALTH EVETERA						
Facility NPI#:	1730115940	EALTH STOLEN						
Address Line 1:	6600 WALL ST							
Address Line 2:								
City:	MODIE							
State	AL							
Zin Code:	20000							
Telephone	30035							
renephone.	2516398100							
\$								
			Figur	e 1.76 Patient	Summary (HL	7 CCD)		

#### Results

Follow the steps below to edit the Results section of the CCD.

To exclude individual results, highlight the **Results** section. Once the section is highlighted, select **Edit** on the action bar.



Select Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > <u>Edit</u>

SMITH ELLA KATHERINE (357713) ×				
SMITH ELLA KATHERINE MR#: 1000015 AC	COUNT#: 357713 DOB: 12/02/1949 Sex: F	Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g		
AGE: 63 CrCI: N/A He	ight: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 n	n2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g		
RM: N/A Diagnosis: Allergies:	PENICILLIN			
Section	Total Records	Excluded Records		
Hospital Discharge Instructions	1	0		
Problems	0	0		
Medications	0	0		
Encounters	0	0		
Care Team	2	0		
Allergies	1	0		
Procedures	0	0		
Functional Status	0	0		
Immunizations	0	0		
Medications Administered	0	0		
Instructions	0	0		
Social History	1	0		
Chief Complaint and Reason For Visit	0	0		
Vitals	0	0		
Plan of Care	0	0		
Provider Organization	1	0		
Results	2	1		
🛃 Save Document 🔍 View Document 📝 Edit	% Indude/Exclude			

Figure 1.77 Patient Summary (HL7 CCD)

Once Edit is selected, the individual results will display. Highlight the test to exclude. Multiple tests may be selected by holding down the Ctrl key and selecting the desired procedures. When all

procedures are highlighted, select **Include/Exclude.** Select the **back arrow** to return to the list of the sections of the CCD.


## Patient Summary - CCD (Continuity of Care Document)

SHITH ELLA KATHERINE (357733) × SMITH ELLA KATHERINE MRIF: 100000015 ACCOUN	T#: 357713 DOB: 12/02/1949 Sex: F Current Weight: 0.0	00 lbs 0 0 cz 0 00 kg 0 00 g	
AGE:63 CrCI: N/A Height: RM:N/A Diagnosis: Allergies:	0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.0	10 lbs 0.0 oz 0.00 kg 0.00 g	
Result Group	Total Records	Excluded Records	
DBGOXIN	1	0	
4 2 Est indude,Endude			

Figure 1.78 Patient Summary (HL7 CCD)

Each result group may contain multiple records. To exclude an individual record within a group, select the group then **Edit**. Highlight the result to exclude. Multiple results may be selected by holding down the Ctrl key and selecting the desired entries. When all results are highlighted, select **Include**/

Exclude. Select the

**back arrow** to return to the list of vital sign groups.



SHITH ELLA KATHERINE (357713) ×	INT#-357713 DOI	B-12/02/19/19 Sav: F Current Weight: 0.00 bs 0.0 or 0.00 ks 0.00 o
GE:63 CrCI: N/A Height ML:N/A Diagnosis: Allergies:	0.00 inches BM	t: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
Result	Value	Date Excluded?
MANUAL DIFF	NOT INDICA	09/26/2013
#NEUTROPHILS	2.5000	09/26/2013
RBC MORPH	NORMAL	09/26/2013
#MONOCYTES	0.3000	09/26/2013
#LYMPHOCYTES	2.8000	09/26/2013
#EOSINOPHILS	0.5000	09/26/2013
%MONOCYTES	6.0000	09/26/2013
%LYMPHOCYTES	55.0000	09/26/2013
%EOSINOPHILS	9.0000	09/26/2013
%BASOPHILS	3.0000	09/26/2013
PLATELET CT	200.0000	09/26/2013
MCV	95.0000	09/26/2013
MCHC	30.0000	09/26/2013
MCH	30.0000	09/26/2013
/EASOPHELS	0.2000	09/26/2013
HEMOGLOBIN	13.5000	09/26/2013
HEMATOCRIT	40.0000	09/26/2013
%NEUTROPHILS	50.0000	09/26/2013
WBC	5.0000	09/26/2013
RBC	4.0000	09/26/2013
RDW	12.5000	09/26/2013
Ţ		
Ga Indude/Exclude		

Figure 1.79 Patient Summary (HL7 CCD)

The Excluded Records column will now display the number of tests results excluded from the section. Select **Save Document** to save the changes.



## C · P · S · I Patient Summary - CCD (Continuity of Care Document)

SMITH ELLA KATHERINE     MR#: 1000015 ACCOUNT#: 357713     DOB: 12/02/1949     Sex: F     Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00       AGE: 63     CrCl:     N/A     Height:     0.00 inches     BMI:     0 kg/m2     BSA: 0.00 m2 Admit Weight:     0.00 lbs 0.0 oz 0.00 kg 0.00       RM: N/A Diagnosis:     Allergies: PENICILLIN     Total Records     Excluded Records       Section     1     0	00 kg 0.00 g 00 kg 0.00 g ords
AGE: 63 CrCI: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 ibs 0.0 oz 0.00 kg 0.00   MM: N/A Diagnosis: Allergies: PENICILLIN Total Records Excluded Records   Section Total Records 0 0   Problems 0 0 0   Medications 0 0 0   Care Team 2 0 0   Allergies 1 0 0   Procedures 0 0 0   Functional Status 0 0 0   Medications kdministered 0 0 0   Immunizations 0 0 0   Medications kdministered 0 0 0	00 kg 0.00 g ords
RM: N/A Diagnosis: Allergies: PENICILLIN   Section Total Records Excluded Records   Hospital Discharge Instructions 1 0   Problems 0 0   Medications 0 0   Encounters 0 0   Care Team 0 0   Allergies 1 0   Procedures 0 0   Functional Status 0 0   Immunizations 0 0   Medications Administered 0 0	ords
SectionTotal RecordsExcluded RecordsHospital Discharge Instructions10Problems00Medications00Incounters00Care Team20Allergies00Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	ords
Hospital Discharge Instructions10Problems00Medications00Encounters00Care Team20Allergies10Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	
Problems00Medications00Encounters00Care Team20Allergies10Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	
Medications00Encounters00Care Team20Allergies10Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	
Encounters00Care Team20Allergies10Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	
Care Team20Allergies10Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	
Allergies10Procedures00Functional Status00Immunizations00Medications Administered00Instructions00	
Procedures 0 0   Functional Status 0 0   Immunizations 0 0   Medications Administered 0 0   Instructions 0 0	
Functional Status     0     0       Immunizations     0     0       Medications Administered     0     0       Instructions     0     0	
Immunizations     0     0       Medications Administered     0     0       Instructions     0     0	
Medications Administered 0 0   Instructions 0 0	
Instructions 0 0	
Social History 1 0	
Chief Complaint and Reason For Visit 0 0	
Vitals 0 0	
Plan of Care 0 0	
Provider Organization 1 0	
Results 2 1	

Figure 1.80 Patient Summary (HL7 CCD)