

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

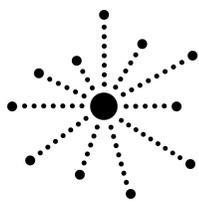
The system will automatically generate and add a Patient Summary and Referral/Transition of Care Summary to the Print Electronic Record list when a visit is created.

Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number**

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**

Patient Summary (HL7 CCD)

Document Effective: 09/05/2013 10:31

Encounter Dates: 08/24/2011 through ONGOING

Contents

- Patient Demographics
- Care Team
- Provider Organization
- Vital Signs
- Allergies
- Procedures
- History of Immunizations
- Problems
- Results
- Medications
- Medications Administered
- Encounters
- Social History
- Patient Decision Aids
- Instructions
- Chief Complaint and Reason For Visit
- Function Status
- Plan of Care

Patient Demographics [\[back to top\]](#)

Name	ELLA KATHERINE SMITH
Address	123 OLD SHELL RD NO 47 MOBILE, AL 36608
Primary Home	2516398100

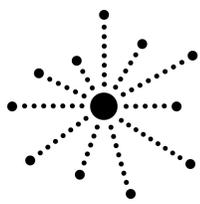
Figure 1.2 Patient Summary (HL7 CCD)

- **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.

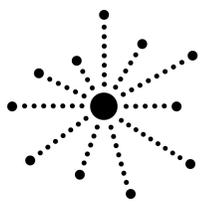


Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Patient Demographics**

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



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 > Care Team**

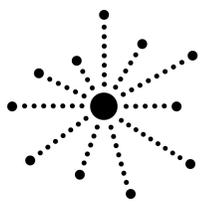
Care Team [back to top]			
Name	Address	Phone	Role
James MD Baxter	1234 Medical Drive Mobile, AL 36608	2515109987 (Work Place)	Attending Physician
Lauryn E Clark	3622 Cottage Hill Rd Mobile, AL 36609	2514783674 (Work Place)	Rounding (Secondary) Physician
Monica D McCall	6600 WALL ST MOBILE, AL 366092702	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 > Provider Organization

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

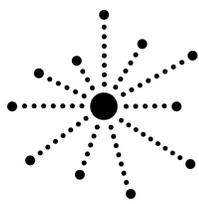
The Vital Signs section of the CCD reflects vital sign values and units documented via Point of Care Flow Charts, Electronic Forms and/or Clinical Information. Body Mass Index (BMI) and Body Surface Area (BSA) values and units are automatically calculated by the system and are displayed in this section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

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

Figure 1.6 Patient Summary (HL7 CCD)



- **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 > Allergies**

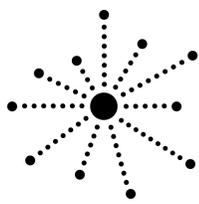
Allergies [back to top]				
Allergy	Code	Allergy Type	Reaction	Status
PEANUTS	0	Food allergy (disorder)	ITCHING	Active
LATEX	0	Allergy to substance (disorder)	RASH; ANAPHYLAXIS	Active
PENICILLIN	0	Drug allergy (disorder)	RASH; ANAPHYLAXIS, DIARRHEA	Active

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 > Procedures**

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 Summary (HL7 CCD)

- **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**

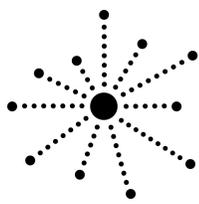
History of Immunizations

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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 > Vital Signs**

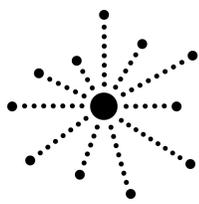
Problems [back to top]				
Problem	Code	Start Date	Resolved Date	Status
CHEST PAIN	29857009	07/29/2013		Active
Anemia	271737000	07/30/2013	07/31/2013	Resolved

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.



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

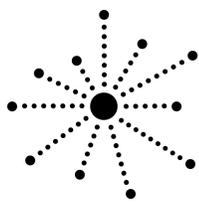
Results [back to top]				
CALCIUM IONIZED - Collect Date/Time: 06/13/2014 10:56				
Test Name	Code	Test Result	Test Units	Test Ref Range
CA IONIZED		1.31	mmol/L	L=1.16 H=1.32
CK + CKMB (ROCHE) - Collect Date/Time: 06/09/2014 04:33				
Test Name	Code	Test Result	Test Units	Test Ref Range
CK		28	U/L	L=20 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 METABOLIC - Collect Date/Time: 06/09/2014 04:33				
Test Name	Code	Test Result	Test Units	Test Ref Range
AGE		113	yrs	
SODIUM		135	mmol/L	L=136 H=145
POTASSIUM		4.4	mmol/L	L=3.5 H=5.1
CHLORIDE		100	mmol/L	L=98 H=107
CO2		24	mmol/L	L=22 H=29
ANION GAP		11	mmol/L	L=8 H=16
GLUCOSE		76	mg/dL	L=65 H=99
BUN		20	mg/dL	L=8 H=23
CREATININE		0.80	mg/dL	L=0.50 H=0.90
BUN/CREAT		25		L=10 H=20
PROTEIN TOTAL		5.9	g/dL	L=6.6 H=8.7
ALBUMIN		3.6	g/dL	L=3.5 H=5.2
GLOBULIN		2.3	mg/dL	L=1.5 H=4.3
A/G RATIO		1.6		
CALCIUM		8.8	mg/dL	L=8.6 H=10.2
BILI TOTAL		0.2	mg/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 > Medications**

Medications [\[back to top\]](#)

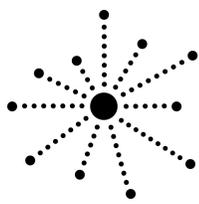
Medication	Code	Dose	Units	Frequency	Route	Modification	Start Date/Time	Stop Date/Time
ASPIRIN 325MG TAB	212033	325	MG	DAILY	PO		09/04/2013 11:39	09/11/2013 12:00
MORPHINE PCA (1MG/ML) 30ML	892477	1	EA	PRN	INTRAVENOUS		09/04/2013 14:04	09/07/2013 14:04
Regular U-100 Insulin Inj; 10ml(Animal)			Unit(s)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

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 > Encounters**

Encounters [\[back to top\]](#)

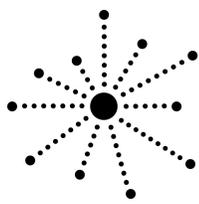
Encounter Diagnosis	Diagnosis Code
AC MYOC INF OF ANTERLAT WAL INI CAR	41001

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 > Social History**

Social History [back to top]

Smoking Status	Code	Start Date	End Date
Current every day smoker	449868002	05/12/1968	

Figure 1.15 Patient Summary (HL7 CCD)

- **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 and End 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.

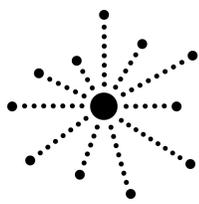
Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Patient Decision Aids**

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 > Instructions**

The screenshot shows a web-based interface for a Patient Summary. At the top left is the title "Instructions" and at the top right is a "[back to top]" link. The main content area is enclosed in a box and contains the following text:

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 your primary care physician.

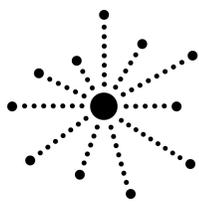
- DIET:
 - Regular diet.
- Activity instructions (state limitations):
 - Do not drive or operate heavy machinery. No heavy lifting.
 - Avoid vigorous activity for 2 weeks.
- Special instructions:
 - Take medications as prescribed., Change dressing daily as instructed..
- Contact your physician if you experience any:
 - Persistent/Increased Pain, Dizziness, Persistent Nausea &/or Vomitting.

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 > Chief Complaint and Reason For Visit**

Chief Complaint and Reason For Visit [back to top]	
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

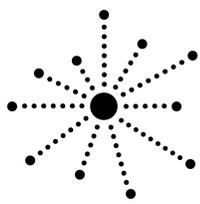
The Function Status section of the CCD reflects the patient's functional and/or cognitive status as entered via the Health History application. "Unknown" will display if no information is entered for the section.

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

Function Status [back to top]				
Description	Code	Date	Type	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 > Plan of Care**

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	

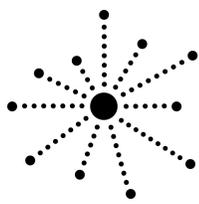
Figure 1.20 Patient Summary (HL7 CCD)

- **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 > Build Patient Summary**

Patient Summary (HL7 CCD)

Document Effective: 07/18/2013 13:07

Encounter Dates: 07/17/2013 through 07/17/2013

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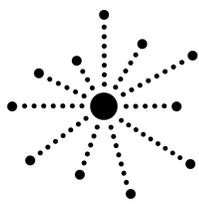
Patient Demographics [\[back to top\]](#)

Name	ELLA KATHERINE SMITH
Address	123 OLD SHELL RD NO 47 MOBILE, AL 36608
Primary Home	2516398100

Edit

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.



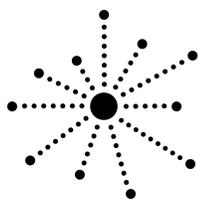
Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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

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.



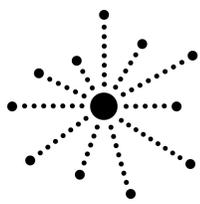
Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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	ALL
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

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

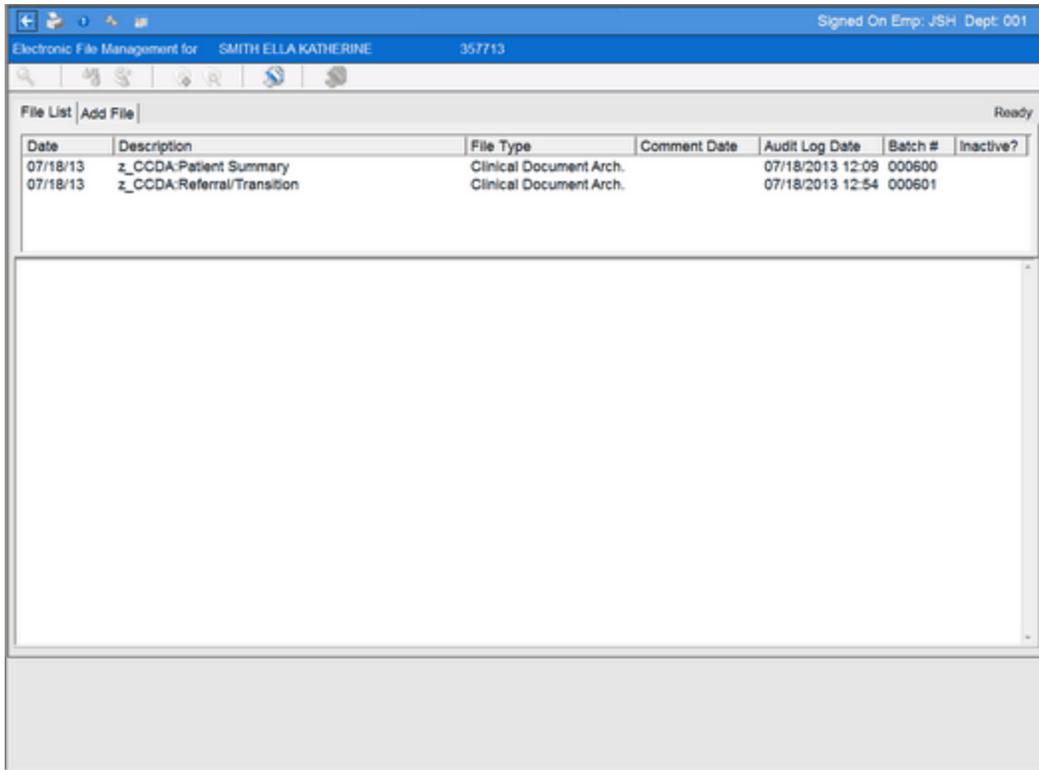


Figure 1.24 Electronic File Management

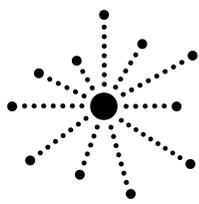
Hospital Discharge Instructions

At this time, individual components of the Hospital Discharge Instructions section may not be excluded. See [Section Edits](#) 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 > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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

SMITH ELLA KATHERINE (357713) MRF: 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 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

Save Document View Document **Edit** Include/Exclude

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.

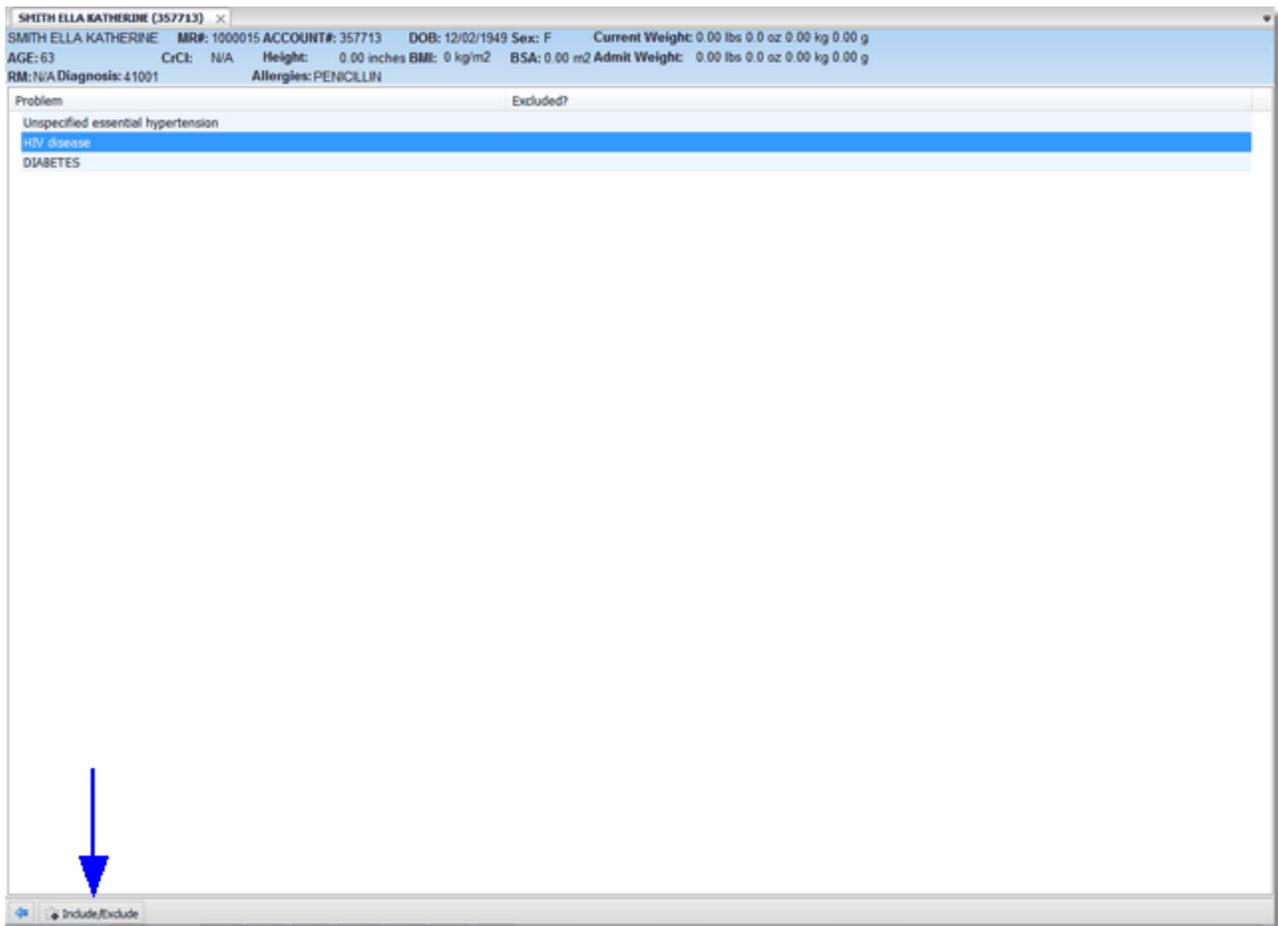
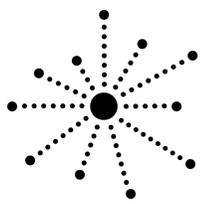
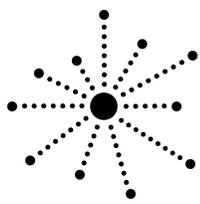


Figure 1.26 Patient Summary (HL7 CCD)

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



Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	1	1
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

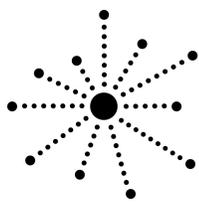
Figure 1.27 Patient Summary (HL7 CCD)

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 > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

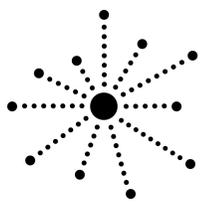
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	0	0
Medications	3	0
Encounters	0	0
Care Team	1	0
Allergies	1	0
Procedures	0	0
Functional Status	0	0
Immunizations	1	0
Medications Administered	3	0
Instructions	0	0
Social History	0	0
Chief Complaint and Reason For Visit	0	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

SMITH ELLA KATHERINE (357713) ×
SMITH ELLA KATHERINE MRN: 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 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

Save Document View Document **Edit** Include/Exclude

Figure 1.28 Patient Summary (HL7 CCD)

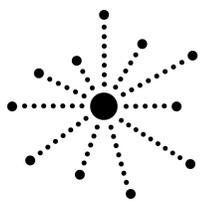
Once **Edit** is selected, the individual medications will display. Highlight the medication to exclude. Multiple medications may be selected by holding down the Ctrl key and selecting the desired medications. When all medications are highlighted, select **Include/Exclude**. Select the  **back arrow** to return to the list of the sections of the CCD.



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	

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.



SMITH ELLA KATHERINE (357713) x

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 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

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
Results	0	0

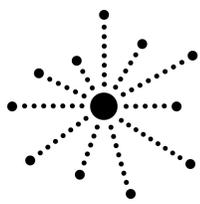
Save Document View Document Edit Include/Exclude

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 > Edit**

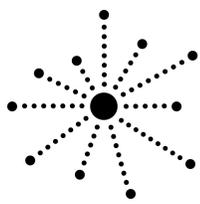
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	4	1
Medications	0	0
Encounters	1	0
Care Team	3	0
Allergies	0	0
Procedures	0	0
Functional Status	0	0
Immunizations	2	0
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

Save Document View Document **Edit** 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.





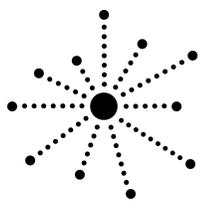
Encounter Diagnosis	Code	Excluded?
AC MYOC INF OF ANTERIAT WAL IN CAR	41001	

SMITH ELLA KATHERINE (357713) x
SMITH ELLA KATHERINE MIR: 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 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:

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.



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

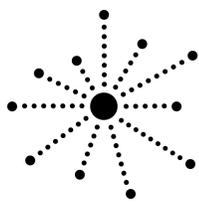
Figure 1.33 Patient Summary (HL7 CCD)

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 > Account Number > Build Patient Summary > Edit**

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

SMITH ELLA KATHERINE (357713) ×
SMITH ELLA KATHERINE MRF: 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 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

Save Document View Document **Edit** Include/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.



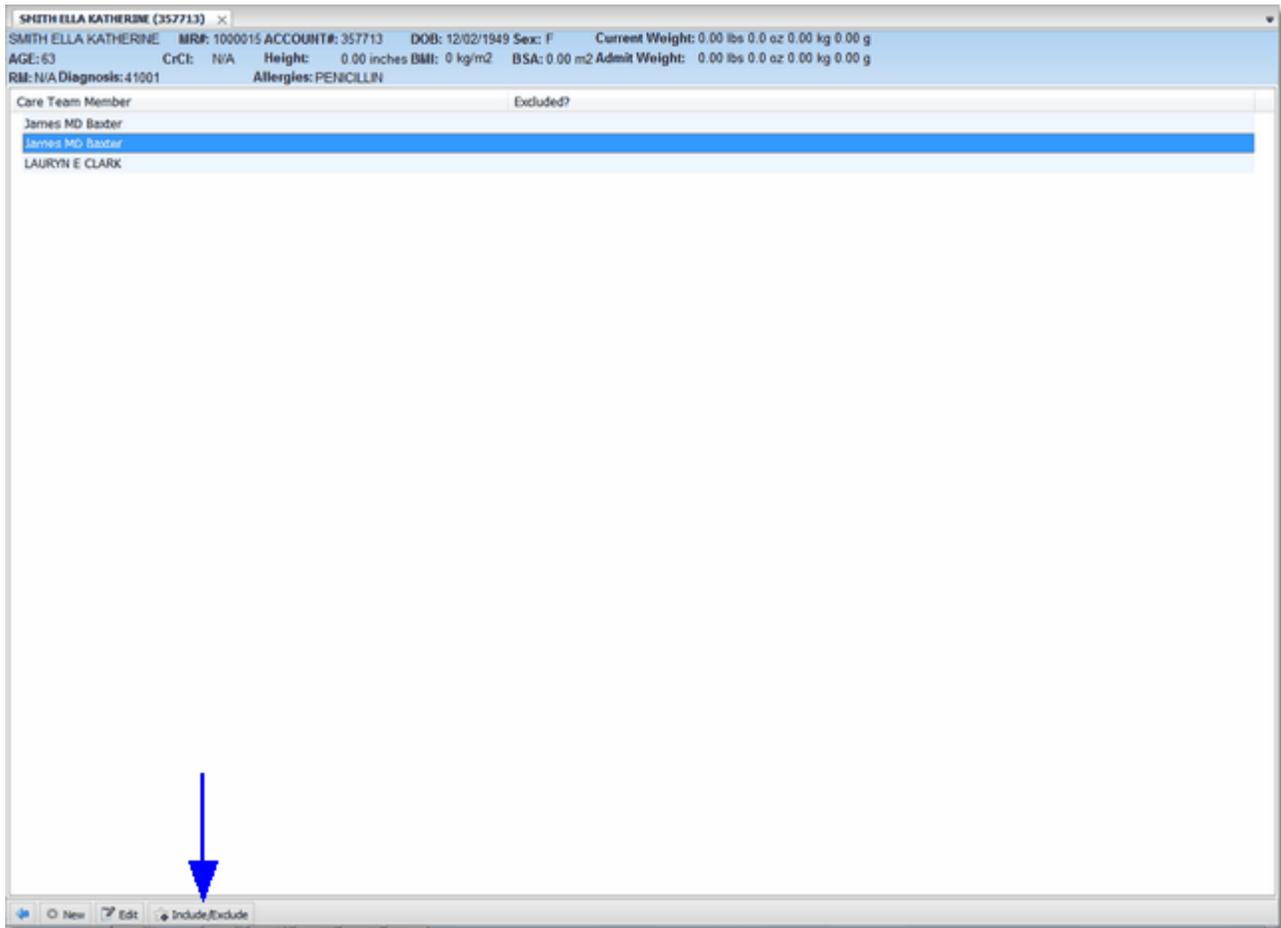
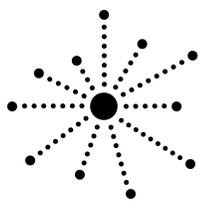
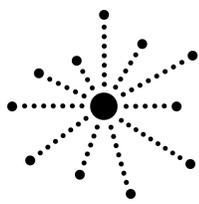


Figure 1.35 Patient Summary (HL7 CCD)

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



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 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: 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	1
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 View Document Edit Include/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.

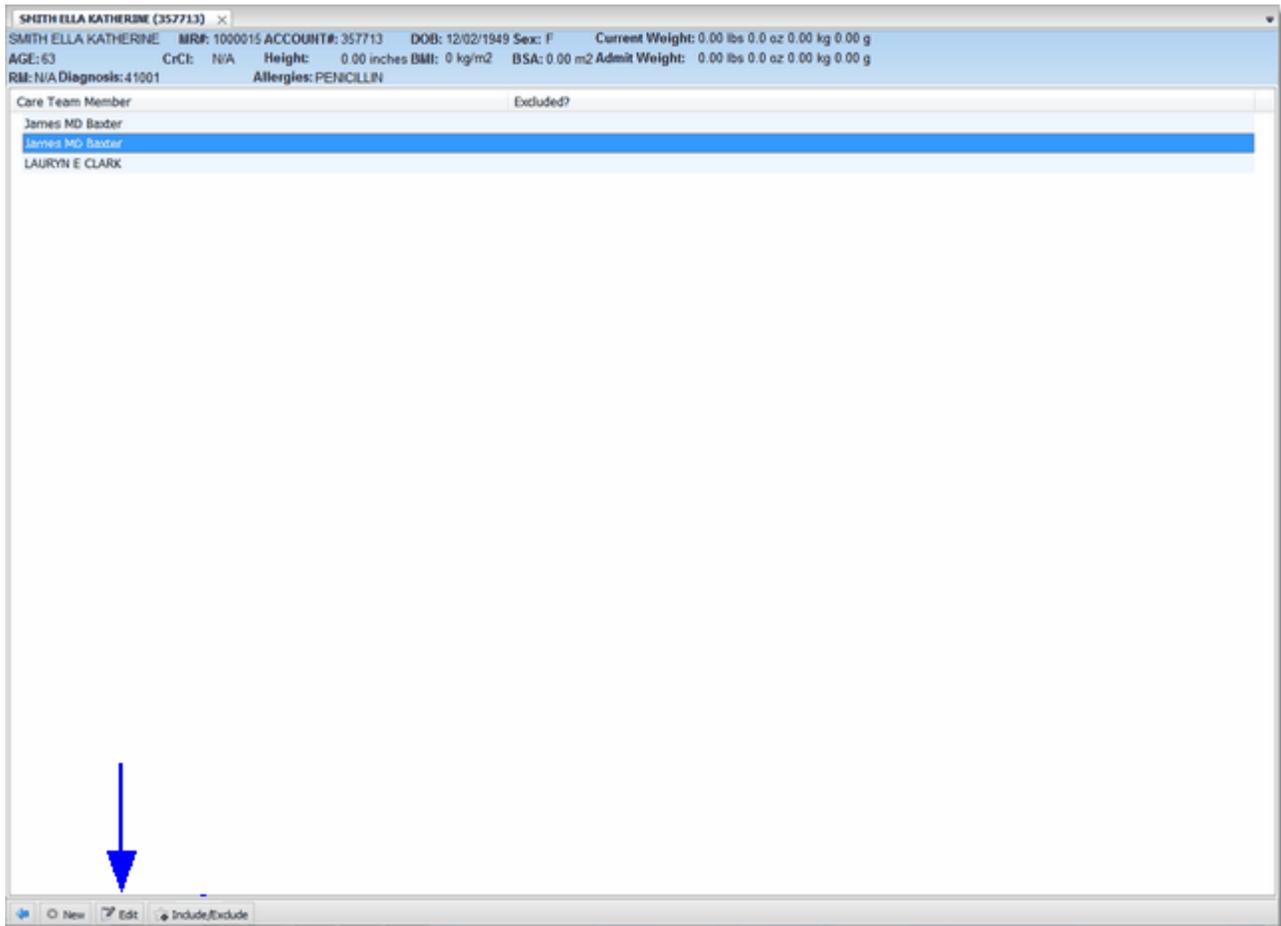
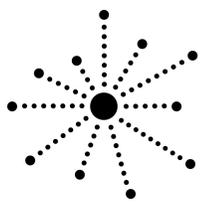
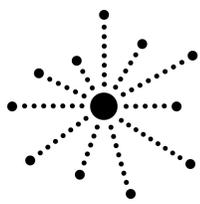


Figure 1.37 Patient Summary (HL7 CCD)

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.



SMITH ELLA KATHERINE (357713) x

SMITH ELLA KATHERINE MRR#: 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 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

Care Team Member

Name:

Type:

Address Line 1:

Address Line 2:

City:

State:

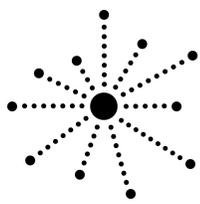
Zip Code:

Telephone:

NPI:

Figure 1.38 Patient Summary (HL7 CCD)

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



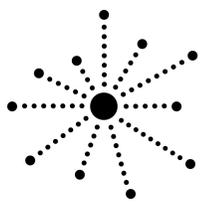
Care Team Member	Excluded?
James MD Baxder	
James MD Baxder	
LAURYN E CLARK	

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.



back



SMITH ELLA KATHERINE (357713) x
SMITH ELLA KATHERINE MRN: 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 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

Care Team Member

Name:

Type:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Telephone:

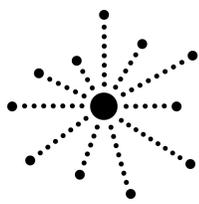
NPI:

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 > Account Number > Build Patient Summary > Edit

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

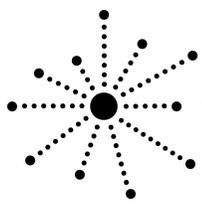
SMITH ELLA KATHERINE (357713) MRF: 1000015 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 63 CrCl: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: N/A Diagnosis: 41001 Allergies: PENICILLIN

Save Document View Document **Edit** Include/Exclude

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.



SMITH ELLA KATHERINE (357713) ×

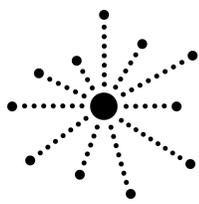
SMITH ELLA KATHERINE MR#: 1000015 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 63 CrCl: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: N/A Diagnosis: 41001 Allergies: PENICILLIN

Allergy	Reactions	Excluded?
PENICILLIN		
PEANUTS	ITCHING	

↓ Include/Exclude

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.



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

SMITH ELLA KATHERINE (357713) ×
SMITH ELLA KATHERINE MRF: 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 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

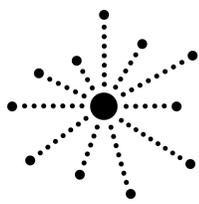
Save Document View Document Edit Include/Exclude

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 > Edit**

SMITH ELLA KATHERINE (357713) x

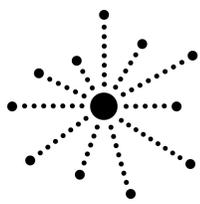
SMITH ELLA KATHERINE MR#: 1000015 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 63 CrCl: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: N/A Diagnosis: Allergies: PENICILLIN

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	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	0

Save Document View Document **Edit** 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.



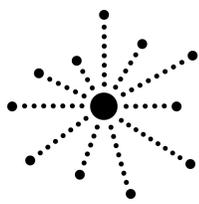
Procedure	Date	Excluded?
HEART ANEURYSM EXCISION	08/14/2013	Exclude
ANGIOPLASTY OF OTH NONCORONARY VESS	08/14/2013	
CT HEAD WWO CONTRAST	08/14/2013	
CHEST PA AND LATERAL	08/12/2013	

SMITH ELLA KATHERINE (357713) x
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 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: PENICILLIN

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.



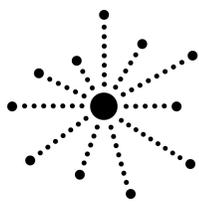
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	0	0
Medications	0	0
Encounters	0	0
Care Team	2	0
Allergies	1	0
Procedures	4	1
Functional Status	0	0
Immunizations	0	0
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	0	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	2	0

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.



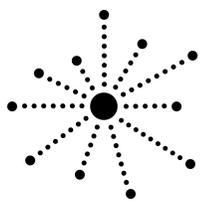
Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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	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

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



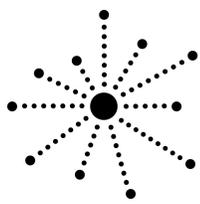
Status	Type	Excluded?
Decreasing disability	Functional	
Minimal cognitive impairment	Cognitive	
Parosmia	Cognitive	
Fine motor disability	Functional	

SMITH ELLA KATHERINE (357713) x
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 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

Include/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.



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
Results	0	0

SMITH ELLA KATHERINE (357713) ×
MIR#: 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 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

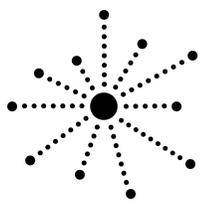
Save Document View Document Edit Include/Exclude

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 > Account Number > Build Patient Summary > Edit**

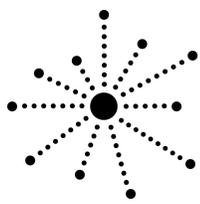
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	3	0
Medications	0	0
Encounters	1	0
Care Team	3	0
Allergies	2	1
Procedures	0	0
Functional Status	0	0
Immunizations	2	0
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

Save Document View Document **Edit** Include/Exclude

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.





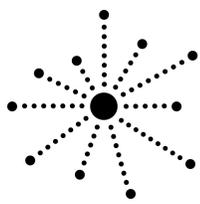
Immunization	Date	Excluded?
Influenza, seasonal, injectable	10/01/2012	
DTP	04/13/2013	

SMITH ELLA KATHERINE (357713) ×
SMITH ELLA KATHERINE MRF: 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 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

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.



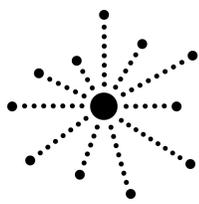
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	3	0
Medications	0	0
Encounters	1	0
Care Team	3	0
Allergies	2	1
Procedures	0	0
Functional Status	0	0
Immunizations	2	1
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

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.



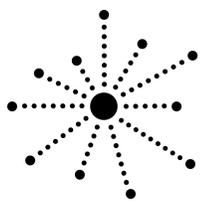
Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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
Results	0	0

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/**

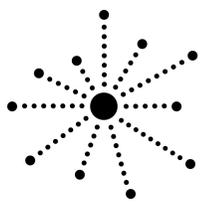
Exclude. Select the  **back arrow** to return to the list of the sections of the CCD.



Medication	Dose	Route	Repeat	Excluded?
ASPIRIN 325MG TAB	325	PO	DAILY	
Regular U-100 Insulin 3q:10ml(Animal)	2	SUBCUTANE...	PRN	
PNEUMOVAX VACCINE 0.5ML	0.5	IM	X1	

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.



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	1
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

SMITH ELLA KATHERINE (357713) x
SMITH ELLA KATHERINE MIR#: 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 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

Save Document View Document Edit Include/Exclude

Figure 1.55 Patient Summary (HL7 CCD)

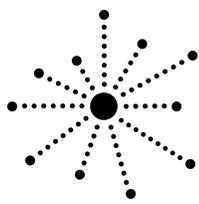
Instructions

At this time, individual components of the Instructions (Patient Decision Aids) section may not be excluded. See [Section Edits](#) 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 > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit

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

SMITH ELLA KATHERINE (357713) MRF: 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 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

Save Document View Document **Edit** Include/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



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

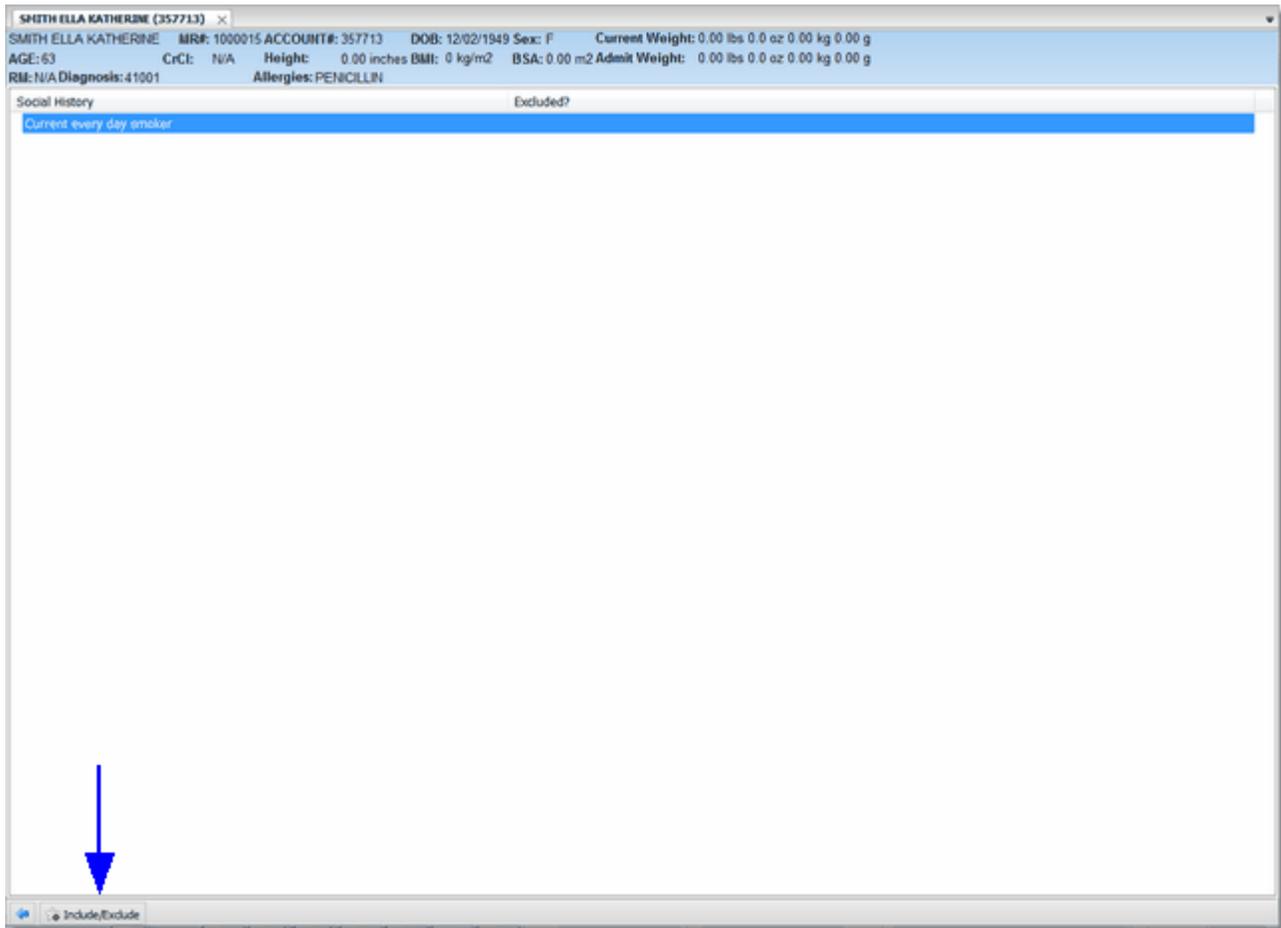
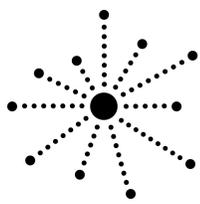
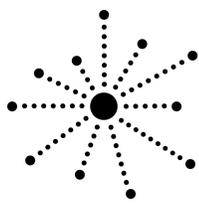


Figure 1.57 Patient Summary (HL7 CCD)

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



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	1
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

Figure 1.58 Patient Summary (HL7 CCD)

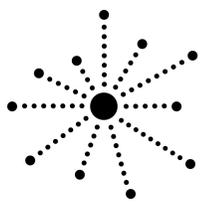
Chief Complaint and Reason For Visit

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 > Edit

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

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.

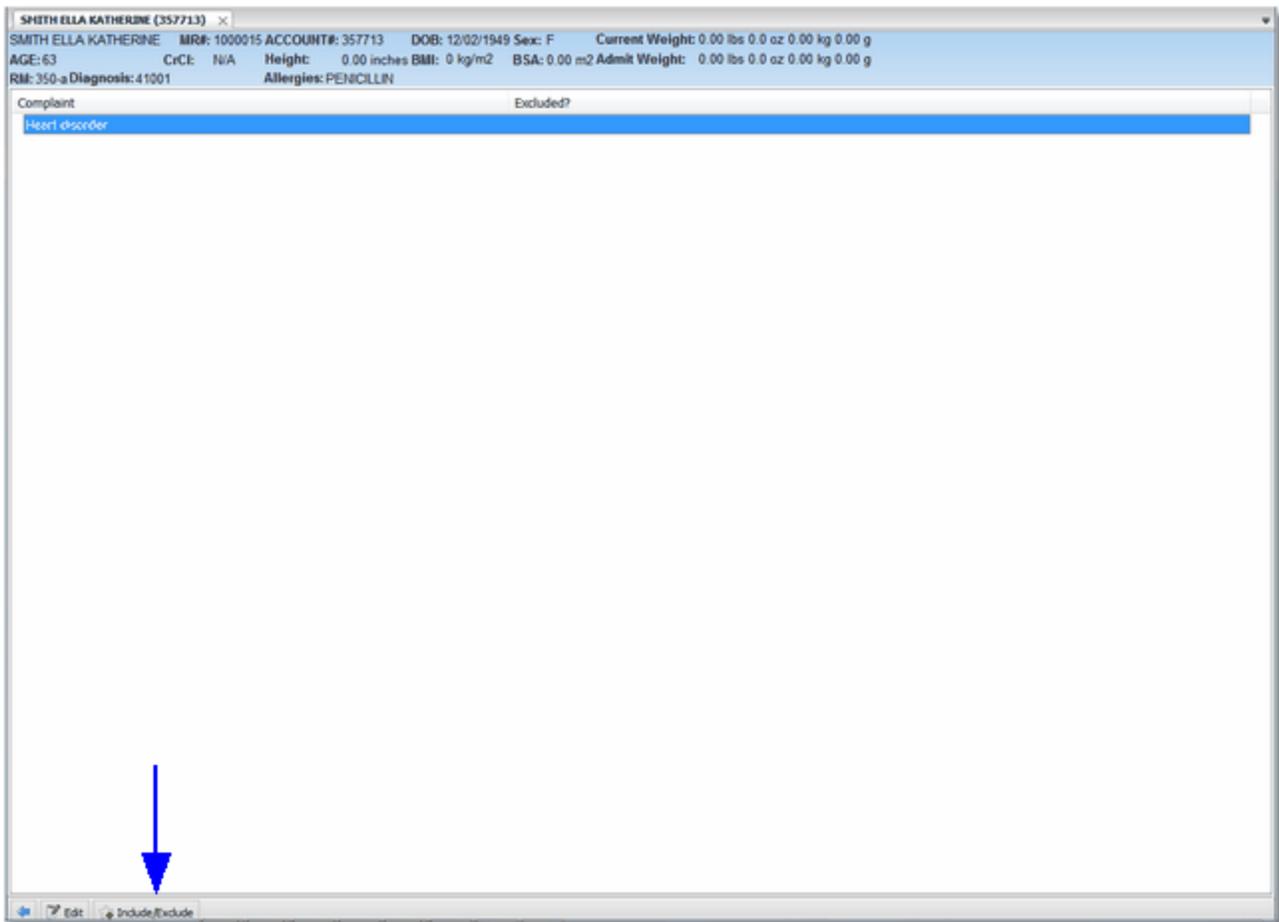
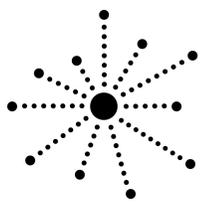
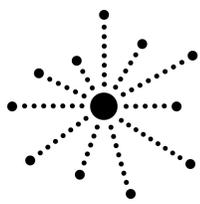


Figure 1.60 Patient Summary (HL7 CCD)

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.



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

SMITH ELLA KATHERINE (357713) x
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 CxCI: 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

Save Document View Document Edit Include/Exclude

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.

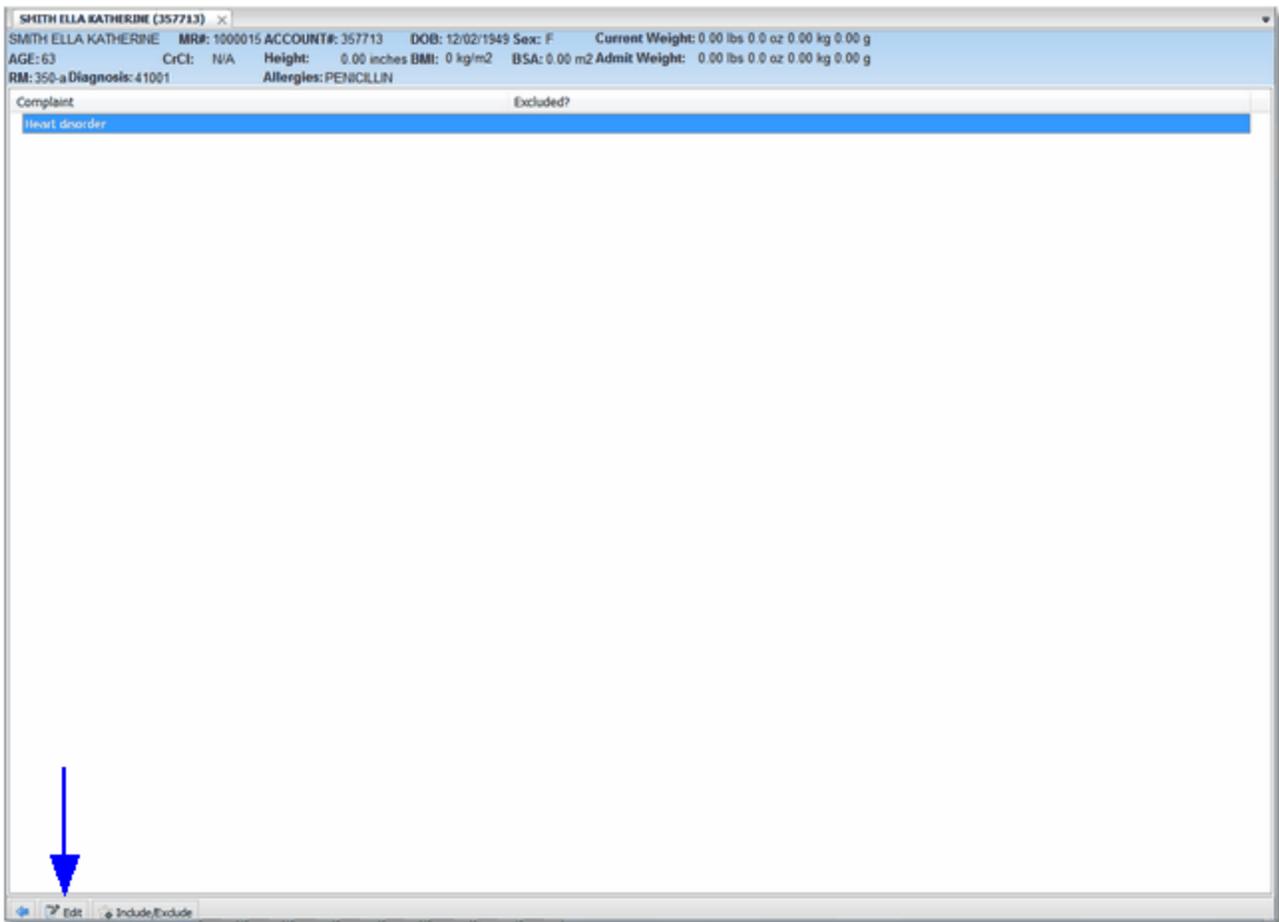
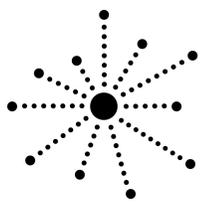
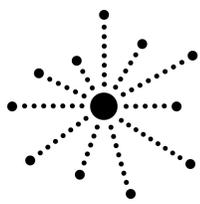


Figure 1.62 Patient Summary (HL7 CCD)

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.



SMITH ELLA KATHERINE (357713) x

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 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

Care Team Member

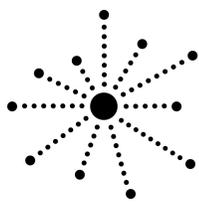
Chief Complaint:

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.



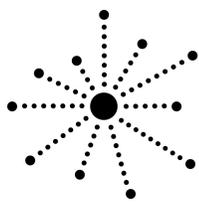
Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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

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



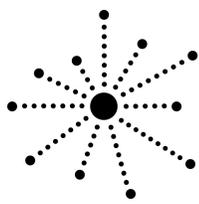
Vital Sign Group	Total Records	Excluded Records
O2 Oximetry	1	0
Height	1	0
Weight	1	0
Heart Rate	1	0
Body Mass Index	1	0
Blood Pressure	2	0
Body Surface Area	1	0
Respiratory Rate	1	0
Temperature	1	0

Buttons: Edit, Include/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.



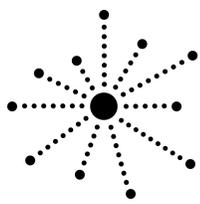
Vital Sign	Value	Excluded?
BP Diastolic	92	
BP Systolic	140	

SMITH ELLA KATHERINE (357713) x
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 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

Include/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.



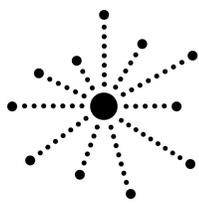
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	0	0
Medications	0	0
Encounters	0	0
Care Team	2	0
Allergies	0	0
Procedures	0	0
Functional Status	0	0
Immunizations	0	0
Medications Administered	0	0
Instructions	0	0
Social History	0	0
Chief Complaint and Reason For Visit	0	0
Vitals	9	1
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

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.

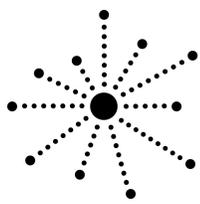


Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

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	0
Provider Organization	1	0
Results	0	0

Figure 1.68 Patient Summary (HL7 CCD)

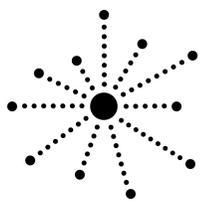
Once **Edit** is selected, the individual problems will display. Highlight the problem to exclude. Multiple problems may be selected by holding down the Ctrl key and selecting the desired problems. When all problems are highlighted, select **Include/Exclude**. Select the  **back arrow** to return to the list of the sections of the CCD.



Plan of Care Problems	Code	Total Records	Excluded Records
Broken skin	247442005	1	0
Alteration in comfort: pain	20361002	1	0

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.



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 Tool on Earth

Save Document View Document Edit Include/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.

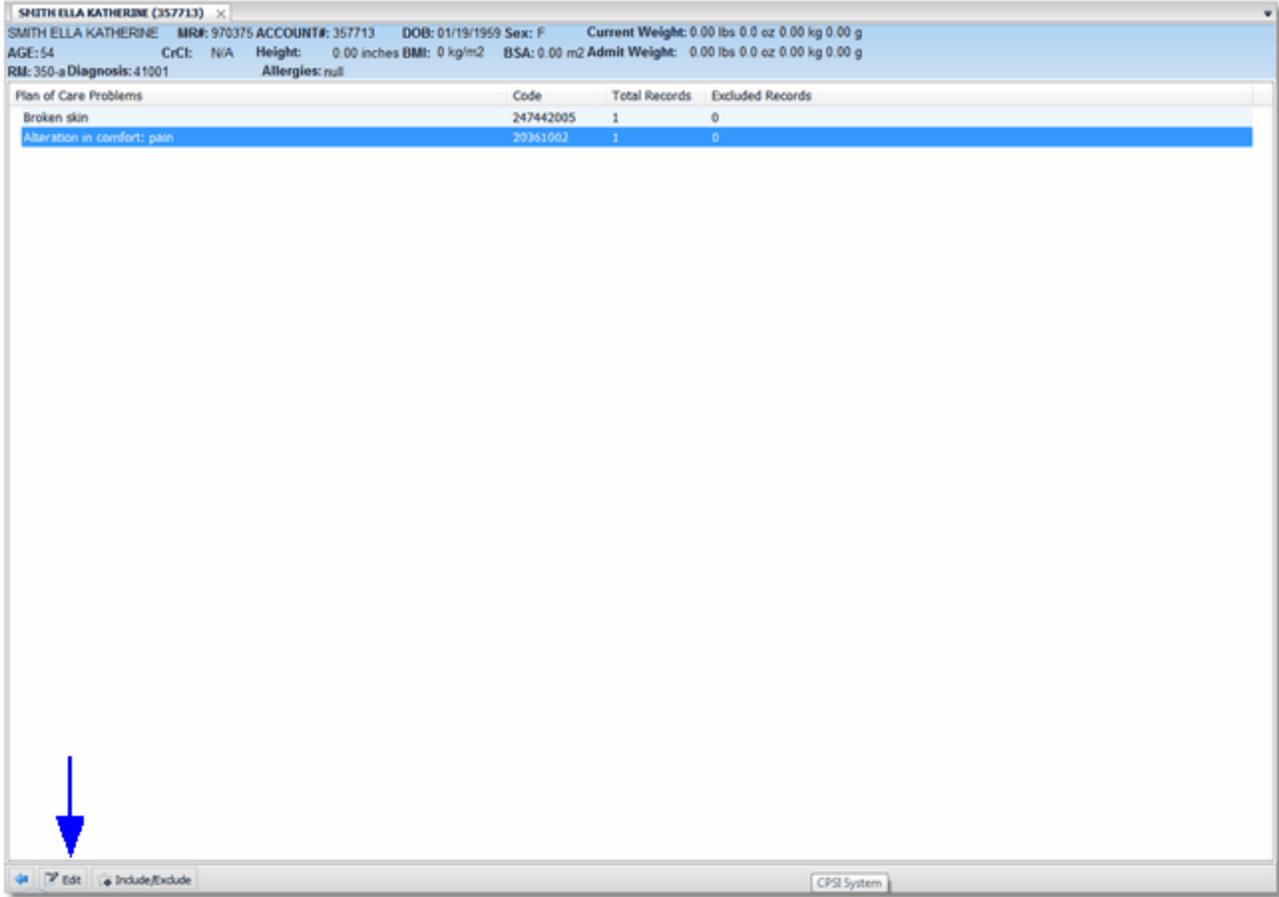
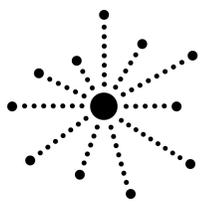


Figure 1.71 Patient Summary (HL7 CCD)

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.

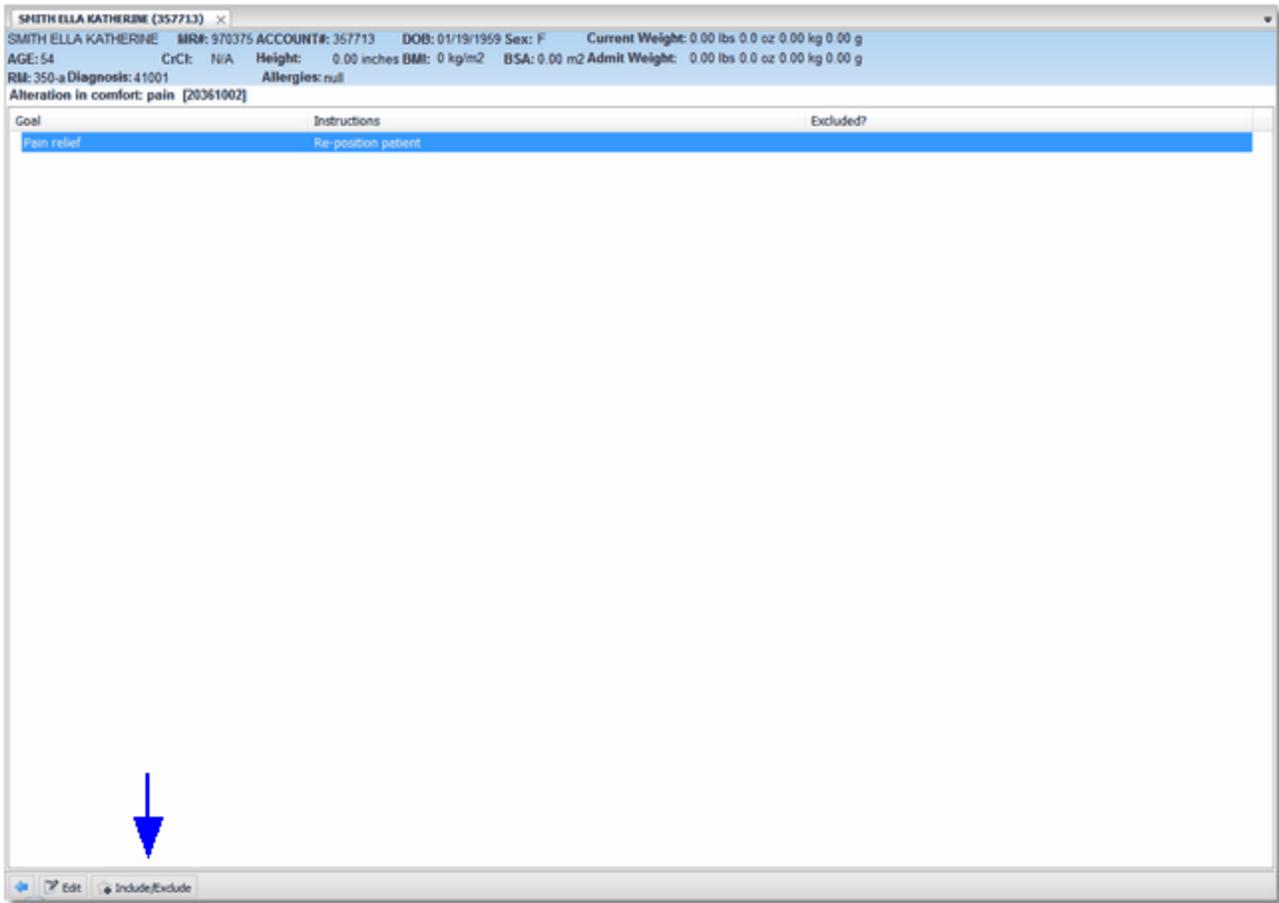
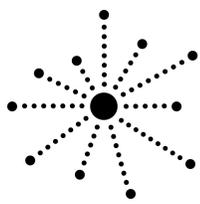
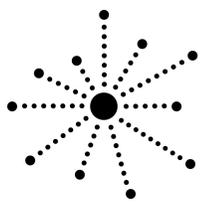


Figure 1.72 Patient Summary (HL7 CCD)

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



SMITH ELLA KATHERINE (357713) x

SMITH 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
AGE: 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
RM: 350-a Diagnosis: d1001 Allergies: null
Alteration in comfort: pain [20361002]

Goal	Instructions	Excluded?
Pain relief	Re-position patient	

↓

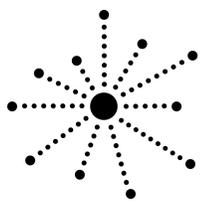
← Edit Include/Exclude

Figure 1.73 Patient Summary (HL7 CCD)

Modify the instruction field as needed. Select the



back arrow to save the information and return to the list of goals.



SMITH ELLA KATHERINE (357713)

SMITH ELLA KATHERINE MRN: 970375 ACCOUNT#: 357713 DOB: 01/19/1959 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 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
RM: 350-a Diagnosis: 41001 Allergies: null

Plan of Care Entry

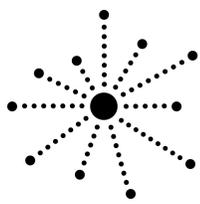
Goal: Pain relief

Instructions: Re-position patient

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 > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

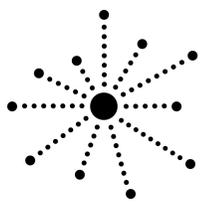
Section	Total Records	Excluded Records
Hospital Discharge Instructions	1	0
Problems	3	0
Medications	0	0
Encounters	1	0
Care Team	3	0
Allergies	2	0
Procedures	0	0
Functional Status	0	0
Immunizations	2	0
Medications Administered	0	0
Instructions	0	0
Social History	1	0
Chief Complaint and Reason For Visit	1	0
Vitals	0	0
Plan of Care	0	0
Provider Organization	1	0
Results	0	0

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.



SMITH ELLA KATHERINE (357713) x

SMITH ELLA KATHERINE MRF: 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 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

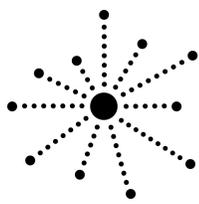
Provider Organization
Facility Name: CPSI COMMUNITY HEALTH SYSTEM
Facility NPI#: 1730115940
Address Line 1: 6600 WALL ST
Address Line 2:
City: MOBILE
State: AL
Zip Code: 36695
Telephone: 2516398100

Figure 1.76 Patient Summary (HL7 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 > Edit**

SMITH ELLA KATHERINE (357713) x

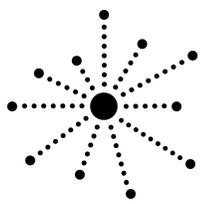
SMITH ELLA KATHERINE MR#: 1000015 ACCOUNT#: 357713 DOB: 12/02/1949 Sex: F Current Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
AGE: 63 CrCl: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 lbs 0.0 oz 0.00 kg 0.00 g
RM: N/A Diagnosis: Allergies: PENICILLIN

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 Include/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.

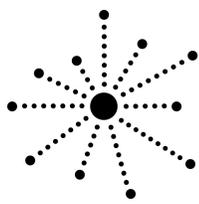


Result Group	Total Records	Excluded Records
DIGOXIN	1	0
CBC	21	0

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/**

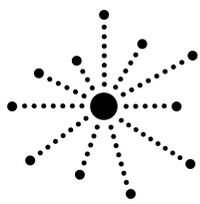
Exclude. Select the  **back arrow** to return to the list of vital sign groups.



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	
MCH	30.0000	09/26/2013	
MCH	30.0000	09/26/2013	
#BASOPHILS	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	

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.



SMITH ELLA KATHERINE (357713) x

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 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: 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 Include/Exclude

Figure 1.80 Patient Summary (HL7 CCD)