



Reports & Attachments User Guide

Reports & Attachments User Guide

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces the new features and improvements for **Reports & Attachments** for release Version 20. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 20 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact **Client Services** Support.

Change "Build CCDA" Paths -- WR 1703061530

DESCRIPTION: This work request removes the Build CCDA paths in the Med Rec discipline of Reports & Attachments for Version 6.

DOCUMENTATION: See [Version 6](#)^[30]

Add New Field to Privacy/Consent Screen for OAS CAHPS -- WR1708181157

DESCRIPTION: This work request adds a checkbox to the Privacy/Consent screen to indicate whether or not a patient is willing to participate in the survey.

DOCUMENTATION: See [Medical Records Discipline - Version 5](#)^[25] and [Version 6](#)^[30].

Chapter 2 Overview

Reports & Attachments is designed to provide the physician and clinical staff an option to quickly access patient reports from multiple disciplines and hospital departments.

Features and benefits of **Reports and Attachments** are:

- Patient information is available interactively and in **real time**
- Communication and security is **compliant** with current HCFA Internet Policy and proposed HIPAA rules
- Easy access to reports & attachments from one screen
- Reports open in Adobe format in the same window and may be viewed or printed.
- Users may **toggle** between reports on an account

NOTE: The **Chartlink Tab** in Image Titles determines which section a scanned image will be available on in the Reports and Attachments application. For information on scanned images being available in Reports and Attachments, see the Table Maintenance - Business Office user guide.

NOTE: When printing a POC Report from an active account, it is defined by a date range spanning from the beginning of the stay through the date and time selected for inclusion in reports and attachments. This allows users to generate reports reflecting the most up-to-date information available. The **Printed** and **Run Date** fields within a POC Report denote the date and time the report is printed, providing a timestamp for reference. When printing a POC Report from an account that has purged, it will also maintain a date range, extending from the start of the stay to the last possible date any changes could have been made before purging to clinical history. For a purged account, the **Printed** and **Run Date/Time** field displays the date and time of purging, as this marks the final moment any alterations could occur. Once an account is purged, it transitions to a static state, and the last version of the report becomes the permanent record saved.

NOTE: Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY, or YYMMDD to be used throughout the Reports and Attachments application. A TruBridge representative will need to be contacted in order for the date format to be changed.

Chapter 3 Updated ChartLink Access

3.1 Overview

This section will explain how to sign on and off the Updated ChartLink application.

3.2 Signing On/Off Updated ChartLink

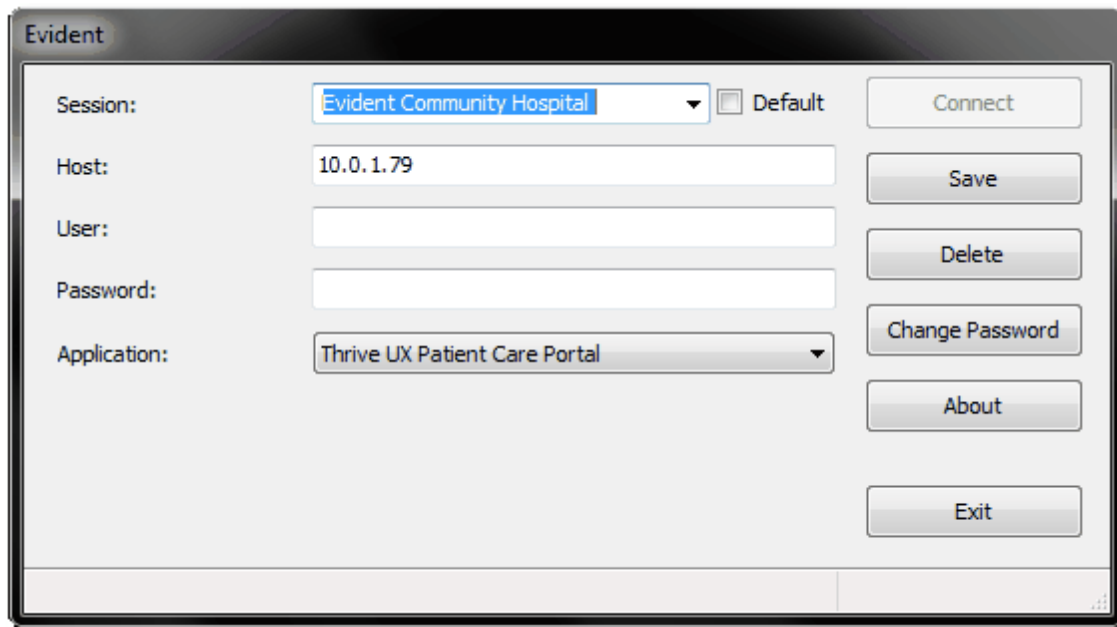
The Updated ChartLink system requires the physician to sign onto the system before accessing the application. The hospital's Information Technology department issues physician numbers, passwords and maintains security settings.

To track physician login and other physician functions within the software, consult the **AR audit trail** system that exists within the Special Functions module.

- Users logging via a desktop icon will utilize the Evident runner for access.
- Facility and Application access settings are configured by the Hospitals Information Technology department.

NOTE: When accessing the CW Runner for the first time, the Application will default to Evident System. Make sure to select the proper application for the role that is logging via the CW Runner, keeping in mind that Updated ChartLink may also be accessed by staff other than physicians. Access to Updated ChartLink is controlled by employee security. Refer to facility Information Technology Department for further information.

Select **Login > Enter login information > Application > TruBridge UX Patient Care Portal**



Evident

Session: Evident Community Hospital ☐ Default Connect

Host: 10.0.1.79 Save

User: Delete

Password: Change Password

Application: Thrive UX Patient Care Portal About

Exit

Runner

NOTE: If a Patient Account is selected in the traditional ChartLink application and access is gained to either the Physician Problem List or Physician Documentation applications, the Updated ChartLink application will open. The user may also access the Updated ChartLink application when accessing the Medication Reconciliation application through Updated CPOE.

Chapter 4 Vital Signs

4.1 Overview

This section will discuss the **Vital Signs** section of Attachments.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Vital Signs**

The screenshot shows a medical software interface with a blue header bar. The header contains the text "THIRIX UX Help" on the left and "LOUIS DONALD P" on the right. Below the header, there is a navigation bar with "CHARTS" and "SMITH ELLA KATHERINE (357351) > REPORTS AND ATTACHMENTS". The main content area is divided into two columns. The left column, titled "DISCIPLINE", lists various medical disciplines with radio buttons next to them: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet, Other, and Growth Charts. The right column, titled "VITAL SIGNS", contains a list of attachments: All Graphic I/Os, Swan Ganz, O2 Saturation Graph, Critical Care Flow Sheet, All Critical Care Flow Sheets, and No attachments found. A left sidebar contains a list of navigation options, with "Reports and Attachments" highlighted.

Vital Signs

4.2 Graphic I & O

The Graphic I & O is a document that includes the patient's vital signs, weight, diet information, and intake and output charted over a 3-day period. The forms print as "Temporary" until three days of information is completed. After three days, the report prints as "Final" and is a part of the patient's permanent chart.

Select Charts > Select Patient Account > Attachments > Vital Signs > Graphic I & O

Vital Signs-Graphic I & O

Data included on the Graphic and I & O form is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Any drug allergies documented through TruBridge
 - Medical Record number

NOTE: In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Vital Signs**

- Each 34-hour period is divided into either two or 4-hour intervals.
- Temperature is reflected in a line graph format
- Pulse, respiration, and blood pressure are reflected in numeric values below the graph.
- Weight, is reflected in pounds or kilograms along with the patient's body-surface area and basic metabolic index.

NOTE: An asterisk (*) denotes multiple values have been charted. The first recorded value displays with subsequent values listed in the Patient Progress Notes.

- **Patient Diet & Percent Consumed**

- Up to three diet entries within a 34 hour period
- Diet description, percentage consumed, and time the entry was charted

- **Breast Feeding**

- Displays for Pediatric and Nursery chart types only.
- Prints breast feeding time, minutes and totals for L, R, L/R breast.

NOTE: If percentage of diet consumed has been charted on a diet through the MedAct, the Breast Feeding section will not print on the report.

- **Intake and Output Record**

- Intake and output volumes reflect totals per shift and a 34-hour total.
- Intake and output values charted by frequency display in the top left-hand corner of the boxes. Volume entries display in the center of the box.
- Intake displays up to 3 categories. Any entries beyond that will be reflected under "Other" and will be detailed on the Patient Progress Notes.
- Output displays up to eight categories. Any entries beyond that will be reflected under "Other" and will be detailed on the Patient Progress Notes.
- Option to use eight or 13-hour I&O total in control table.

The following is a full display of the **Graphic I & O Report**.

Export

Evident Community Hospital

GRAPHIC AND I & O

FROM: 06/27/15 23:00 TO: 06/30/15 22:59 (FINAL)

Medical/Surgical
Page 1 of 1

Printed: 7/02/15 at 07:46

SMITH ELLA KATHERINE AGE: 72 SEX: F
DANIEL E SMITH ROOM: 302-1
ALLERGIES: Eggs Mineral oil M/R#: 970015

Date		06/27/15 - 06/28/15						06/28/15 - 06/29/15						06/29/15 - 06/30/15					
		Saturday - Sunday						Sunday - Monday						Monday - Tuesday					
Hour		23-3	3-7	7-11	11-15	15-19	19-23	23-3	3-7	7-11	11-15	15-19	19-23	23-3	3-7	7-11	11-15	15-19	19-23
F	C																		
105																			
104	40																		
103																			
102	39																		
101																			
100	38																		
99																			
98	37																		
97	Normal																		
96																			

Page: 1/1

Zoom: 104%

PORTRAIT

All reports listed in this section may be **Exported**



to Adobe Acrobat Reader format.

4.3 Swan Ganz

The Swan Ganz report is a document that includes hemodynamics (CVP, PAP, PAWP, CO, MPAP, SV, SVR, PVR, and CI) information.

Select Charts > Select Patient Account > Attachments > Vital Signs > Swan Ganz

DISCIPLINE	VITAL SIGNS
☐ Vital Signs	All Graphic I/Os
☐ Med. Rec.	Swan Ganz
☐ Orders	O2 Saturation Graph
☐ Laboratory	Critical Care Flow Sheet
☐ Medication	All Critical Care Flow Sheets
☐ Radiology	No attachments found
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Vital Signs- Swan Ganz

Data included on the Swan Ganz Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge

NOTE: In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Entered Values**

- Date and time the information was charted
- Name and title of the person who entered the information displays next to the first entry only. Name and title will not display beside each entry made by that person.
- Displays in columns, the following Swan Ganz values that have been entered into the system:
 - o (CVP) Central Venous Pressure
 - o (PAP) Pulmonary Artery Pressure
 - o (PAWP) Pulmonary Artery Wedge Pressure
 - o (CO) Cardiac Output

- **Calculated Values**

- Displays in columns, the following calculated values which are derived from the charted Swan Ganz values:
 - o (MPAP) Mean Pulmonary Artery Pressure
 - o (MAP) Mean Arterial Pressure
 - o (SV) Stroke Volume
 - o (SVR) Systemic Vascular Resistance
 - o (PVR) Pulmonary Vascular Resistance
 - o (CI) Cardiac Index

The following is a full display of the **Swan Ganz Report**.

Evident Community Hospital

SWAN GANZ

From beginning of stay TO: 07/08/14 14:12 Page 1 of 1

Printed: 7/08/14 at 14:12

SMITH ELLA KATHERINE

AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

	CVP	PAP	PAWP	CO	MPAP	MAP	SV	SVR	PVR	CI
06/26/14 10:00 {13 E}	5.0	15 /10	8	6	12	105	109	1333	53	6

PATIENT: SMITH ELLA KATHERINE

NUMBER: 357814

AGE: 58

SEX: F

ROOM: 300-7

PAGE: 1



All reports listed in this section may be **Exported** to Adobe Acrobat Reader format.

4.4 O2 Sat Bar Graph

The O3 Sat Bar Graph is a document that displays the O3LM, FiO3, and O3SAT, which is graphed and includes the method of delivery.

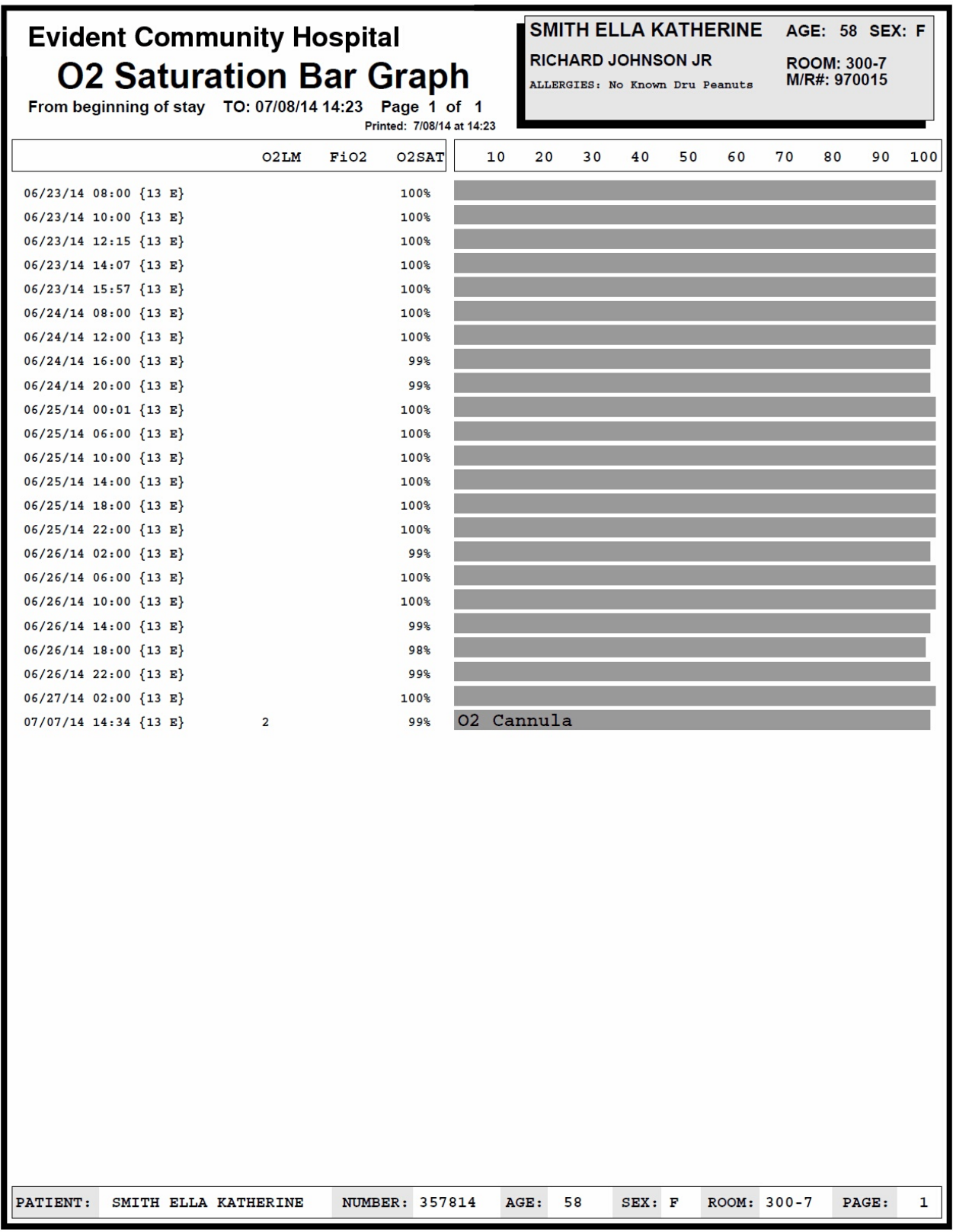
Select **Charts** > **Select Patient Account** > **Attachments** > **Vital Signs** > **O3 Saturation Bar Graph**

Vital Signs - O3 Saturation Graph

Data included in the O3 Sat Bar Graph is outlined below:

- **Demographics box** (located upper right-hand corner)
 - Patient's name
 - Account number
 - Admitting physician
 - Age, sex, and room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
- **O3 Information**
 - O3 L/M, FiO3, and O3 Sat values display numerically
 - O3 Sat values display as a bar graph
 - O3 Sat values display on the bar graph along with the method

The following is a full display of the O3 Sat Bar Graph.





All reports listed in this section may be **Exported** to Adobe Acrobat Reader format.

4.5 Critical Care Flow Sheet

The **Critical Care Flow Sheet** is a document that includes specific patient information charted within the 8-hour time frame. The report provides details of the patient's condition and plan of care and may also be used to track trends in the patient's progress. It is primarily used in the ICU.

Select **Charts** > **Select Patient Account** > **Attachments** > **Vital Signs** > **Critical Care Flow Sheet**

Vital Signs - Critical Care Flow Sheet

Data included on the Critical Care Flow Sheet is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Account number
 - Admitting physician
 - Age, sex, & room number
 - Medical Records number
 - Any drug allergies documented through TruBridge
- **Vital Signs**
 - Pulse and blood pressure display graphically in 15-minute intervals.
 - Temperature and respirations display numerically in 15-minute intervals.

- **Hemodynamics**
 - CVP, PAP, PAWP, and CO/CI values display in 1-hour intervals.
- **Ventilation Mechanics** (Optional)
 - Nursing Administration determines which seven out of twelve options will display.
 - Values display in 1-hour intervals.
- **Intake** (Optional)
 - Nursing Administration determines which four out of twelve options will display.
 - Values display in 1-hour intervals.
 - The "OTHER" box combines all intake values not specified on the flow sheet which may be seen in detail in the Patient Progress Notes.
- **Output** (Optional)
 - Nursing Administration determines which four out of eighteen options will display.
 - Values display in one hour intervals.
 - The "OTHER" box combines all output values not specified on the flow sheet, which may be seen in detail in the Patient Progress Notes.
 - Entries charted by frequency, display in the top left corner of the boxes where volume entries also display.

NOTE: An asterisk (*) adjacent to any value on this flow sheet denotes multiple values have been charted. The first recorded value displays, with subsequent values listed in the Patient Progress Notes.

- **Medications**
 - Medications administered during the selected time frame
 - Date and time of last administration
 - Medication description
 - Location of administration or reason if it is a PRN
 - Dosage
- **Neuro checks**
 - Neuro checks charted through the VS application since last locked shift
 - Date and time information was entered
 - Name and title of person who charted the entry
- **Distinctive Nursing Assessments**
 - Assessments charted in the eight hour period covered, that are flagged as distinctive and should be noted by the nursing staff
 - Date and time of entry
 - In order for this information to be reflected, it must be set up by Nursing Administration.
- **Distinctive Physical Assessments**
 - Assessments charted in the 8-hour period covered that are flagged as distinctive and should be noted by the medical staff
 - Date and time of entry

The following is a full display of the **Critical Care Flow Sheet**:

Evident Community Hospital
Critical Care Flow Sheet
Printed: 7/02/15 at 07:57 Page 1 of 1

SMITH ELLA KATHERINE Number: 357351
DANIEL E SMITH Age: 72
Sex: F
Room: 302-1
M/R#: 970015
ALLERGIES: Eggs Mineral oil

Vital Signs
BP: V-Systolic A-Diastolic
Pulse: •

	07/02/15: 00	01	02	03	04	05	06	07	08
340									
320									
300									
280									
260									
240									
220									
200									
180									
160									
140									
120									
100									
80									
60									
40									
20									

Page: 1 / 1 Zoom: 104% PORTRAIT

All reports listed in this section may be **Exported**



to Adobe Acrobat Reader format.

4.6 All Critical Care Flowsheets

The Critical Care Flow Sheet is a document that includes specific patient information charted within the 8-hour time frame. The report provides details of the patient's condition and plan of care and can also be used to track trends in the patient's progress. It is primarily used in the ICU.

Select **Charts** > **Select Patient Account** > **Attachments** > **Vital Signs** > **All Critical Care Flow Sheet**

Vital Signs - All Critical Care Flow Sheet

Data included on the All Critical Care Flow Sheet is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Account number
 - Admitting physician
 - Age, sex, & room number
 - Medical Records number
 - Any drug allergies documented through TruBridge
- **Vital Signs**
 - Pulse and blood pressure display graphically in 15 minute intervals.
 - Temperature and respirations display numerically in 15 minute intervals.
- **Hemodynamics**
 - CVP, PAP, PAWP, and CO/CI values display in one hour intervals.

- **Ventilation Mechanics (Optional)**

- Nursing Administration determines which seven out of twelve options will display.
- Values display in 1-hour intervals.

- **Intake (Optional)**

- Nursing Administration determines which four out of twelve options will display.
- Values display in 1-hour intervals.
- The "OTHER" box combines all intake values not specified on the flow sheet, which can be seen in detail in the Patient Progress Notes.

- **Output (Optional)**

- Nursing Administration determines which four out of eighteen options will display.
- Values display in one hour intervals.
- The "OTHER" box combines all output values not specified on the flow sheet, which can be seen in detail in the Patient Progress Notes.
- Entries charted by frequency display in the top left corner of the boxes where volume entries also display.

NOTE: An asterisk (*) adjacent to any value on this flow sheet denotes multiple values have been charted. The first recorded value displays, with subsequent values listed in the Patient Progress Notes.

- **Medications**

- Medications administered during the selected time frame
- Date and time of last administration
- Medication description
- Location of administration, or reason if it is a PRN
- Dosage

- **Neuro checks**

- Neuro checks charted through the VS application since last locked shift
- Date and time information was entered
- Name and title of person who charted the entry

- **Distinctive Nursing Assessments**

- Assessments charted in the 8-hour period covered, that are flagged as distinctive and should be noted by the nursing staff
- Date and time of entry
- In order for this information to be reflected, it must be set up by Nursing Administration.

- **Distinctive Physical Assessments**

- Assessments charted in the 8-hour period covered, that are flagged as distinctive and should be noted by the medical staff
- Date and time of entry
- The Critical Care Flowsheet for the last eight hours will appear on the screen. Use the scroll bar or the page selector to access additional information for the last 34 hours.
- To view previous days Critical Care Flowsheets select the date from the lower section of the split screen.

The following is a full display of the **All Critical Care Flow Sheet**.

Evident Community Hospital		SMITH ELLA KATHERINE		Number: 357814						
Critical Care Flow Sheet		RICHARD JOHNSON JR		Age: 58						
Printed: 7/08/14 at 15:16 Page 1 of 1		ALLERGIES: No Known Dru Peanuts		Sex: F						
				Room: 300-7						
				M/R#: 970015						
07/08/14: 08		09	10	11	12	13	14	15	16	
Vital Signs	340									
	320									
	300									
	280									
BP: V=Diastolic A=Diastolic	260									
	240									
	220									
	200									
	180									
	160									
	140									
	120									
	100									
	80									
Pulse: •	60									
	40									
	20									
	0									
	Temp	98.9	98.9	99.2	98.9	98.8				
	Resp	15	17	16	17	18				
	Hemodynamics	CVP			4.0					
		PAP			25 / 13					
		PAWP			11					
		CO/CI		7	3.8					
Ventilation Mechanics	Method									
	O2 L/M									
	FiO2									
	O2 Sat	99 %	97 %	100 %	100 %	99 %				
	Rate									
	Mode									
	PeeP									
Intake	PO				500					
	IV									
	Hespan									
	Lipids									
	Other									
Output	TOTAL				500				500	
	Stool									
	Urine		250			300			550	
	Tube									
	Emesis									
Other										
	TOTAL		250			300			550	



All reports listed in this section may be **Exported** to Adobe Acrobat Reader format.

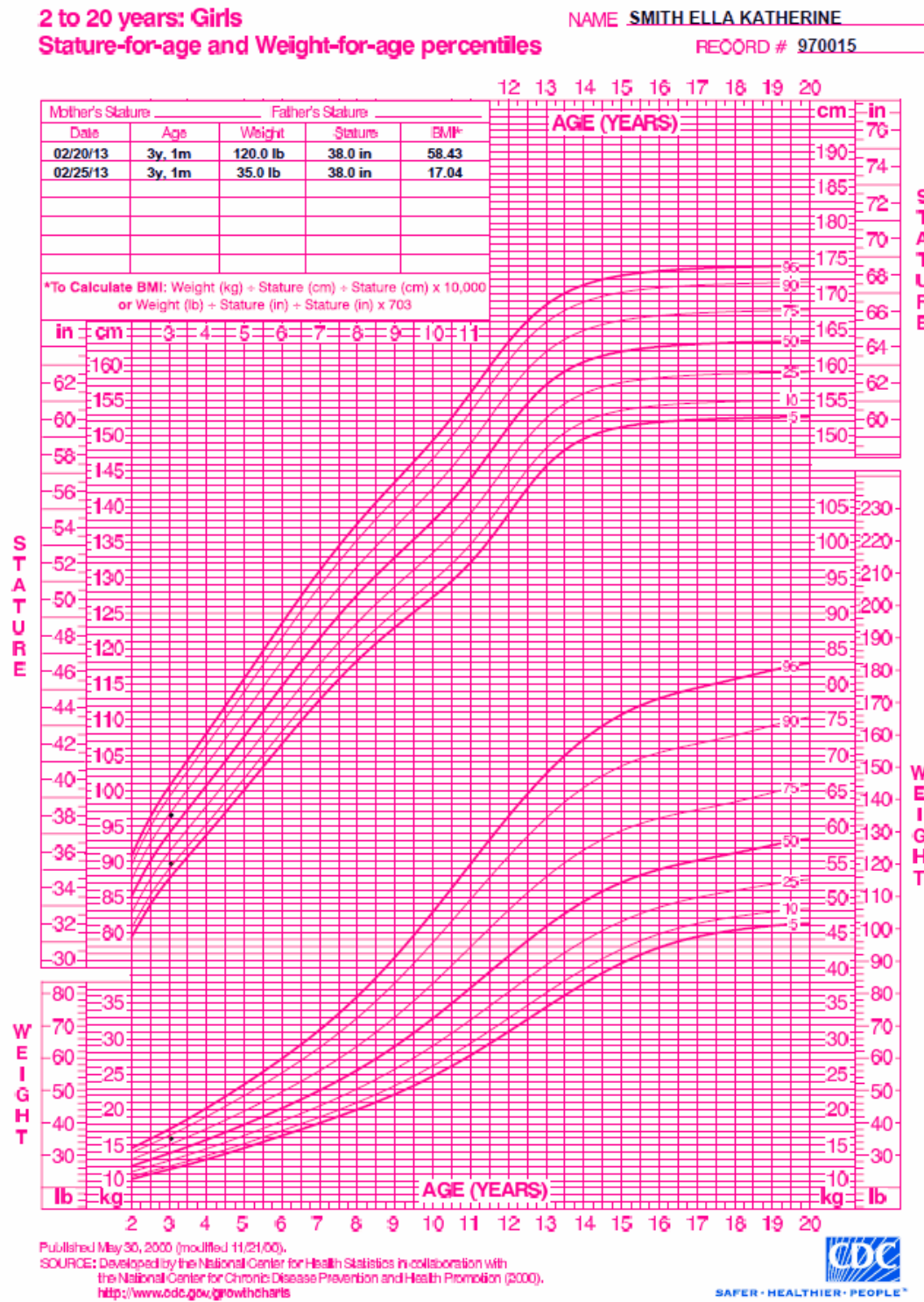
4.7 Growth Charts

Various Growth Charts are available depending upon the patient's age range and gender. Weight and height must be present on the account in order for the growth charts to be accessible. Physicians will have the ability to view historical growth charts: all charts from birth through the current age. Additionally, two different growth charts (5th to 95th Percentile and 3rd to 97th Percentile) are selectable, either for the current age or to include historical weight and height entries.

Data included on the Growth Charts is outlined below:

- **Birth to 36 Months**
 - 5 - 95 Percentile Length and Weight Growth Chart for the sex of the patient
 - 3 - 97 Percentile Length and Weight Growth Chart for the sex of the patient
- **3 Years to 5 Years**
 - Weight for Stature Growth Chart for the sex of the patient
- **3 Years to 30 Years**
 - 5 - 95 Percentile Stature Growth Chart for the sex of the patient
 - 5 - 95 Percentile BMI Growth Chart for the sex of the patient
 - 3 - 97 Percentile Stature Growth Chart for the sex of the patient
 - 3 - 97 Percentile BMI Growth Chart

The following is a full display of a **Growth Chart**.





All reports listed in this section may be **Exported** to Adobe Acrobat Reader format.

4.8 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select **Charts** > **Select Patient Account** > **Attachments** > **Vital Signs** > **Attachments**

Vital Signs - Attachments

Data located in **Attachments**

Deleted Items will display



DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

VITAL SIGNS

All Graphic I/Os

Swan Ganz

O2 Saturation Graph

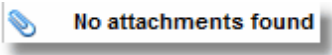
Critical Care Flow Sheet

All Critical Care Flow Sheets

Chartlink Photo

Vital Signs - Attachments

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 5 Medical Records

5.1 Overview

This section will discuss the **Medical Records** section of Attachments.

The **Medical Records** section will display any scanned images for the patient account.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Med Rec**

The screenshot shows a web application interface for patient records. The top navigation bar includes 'CHARTS', 'SMITH ELLA KATHERINE (ACTIVE)', and 'REPORTS AND ATTACHMENTS'. Below this, a patient summary bar displays: SMITH ELLA KATHERINE, MR#: 000297, ACCOUNT#: 345852, DOB: 06/02/1981, Sex: Female, Current Weight: 115 lbs 52.16 kg 52163.10 g, AGE: 36, CrCl: N/A, Height: 65.00 inches, BMI: 19.14 kg/m2, BSA: 1.55 m2, Admit Weight: 110 lbs 0.00 kg 0.00 g, RM: 302-3, Diagnosis: Chest pain, Allergies: CONTRAST MEDIA, IRON RELATED, No Known Food Allergies.

The left sidebar contains a list of menu items: Charts, SMITH ELLA KATHERINE (...), Alerts, Allergies, Charges, Clinical History, Demographics, Documentation, Health Information Resource, Health History, Lab Results, Location Maintenance, MAR, Medication Reconciliation, Order Chronology, Order Entry, PACS Images, Patient Education Docume..., Patient Immunization History, Patient Summary, Plan of Care, Prescription Entry, Problem List, Reports and Attachments (highlighted), and Temporary Registration.

The main content area is divided into two panels. The left panel, titled 'DISCIPLINE', lists various medical disciplines: Vital Signs, Med. Rec. (highlighted with a red box), Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, and Misc. The right panel, titled 'MED. REC.', displays a list of attachments: Consent/Privacy Settings, Chartlink Photo (06/27/2017), CCDA:Patient Summary (06/27/2017), CCDA:Referral/Transition (06/27/2017), and Workshop Form.

Medical Records

5.2 Medical Records Discipline - Version 5

The Med. Rec. area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select **Charts** > **Select Patient Account** > **Attachments** > **Med Rec**

MED. REC.:

Consent/Privacy Settings

Build Patient Summary

Build Referral/Transition of Care Summary

Chartlink Photo

06/27/2017

z_CCDA:Patient Summary

06/27/2017

z_CCDA:Referral/Transition

06/27/2017

Workshop Form

Medical Records

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.

 No attachments found

will display if data is not present in this area to be viewed.

Select Charts > Select Patient Account > Attachments > Med Rec > Consent/Privacy Settings

Patient Consent/Privacy Settings

Consent/Privacy Notice: ☒ Date: 8/17/2017

Med History Consent: Consent given

Exclude From Portal: ☐

Exclude From API: ☐

HIE Shared Data: Share data in emergency only Date: 08/17/2017

Data Sensitivity Level: Normal Date:

Protect Immunization Data: N - not protected, can be shared Date: 08/17/2017

Participate in CAHPS survey: ☐

Patient Consent/Privacy Settings

The **Consent/Privacy Settings** option will open the **Patient Consent/Privacy Settings** screen.

- **Consent/Privacy Notice:** If checked, the Consent/Privacy notice has been received and signed by the patient. The **Date-Picker** field should indicate when the notice was signed.
- **Med History Consent:** Indicate the patient's Med History Consent by choosing one of the following options from the drop-down:
 - o No Consent
 - o Prescriber
 - o Parental/Guardian consent from any prescriber
 - o Consent given
 - o Parental/Guardian consent from this prescriber only
- **Exclude from Portal:** If checked, will prevent the patient from accessing the CCD in the patient portal.
- **Exclude from API** (Application Program Interface): If this field is selected, it will indicate that the account is being excluded from API. If the check box is unchecked, this will indicate that the account is not excluded from API.

NOTE: This option is also included in the Census Clinical Tab as a single-character field for Y (YES) or N (NO).

- **HIE Shared Data** (Health Information Exchange): When this option is selected, the current date will appear to the side. The drop-down options include:
 - o Share data with HIE
 - o Do not share data with HIE:
 - o Share Data in emergency only

- **Data Sensitivity Level:** When this option is selected, the current date will appear to the side. The drop-down options include:
 - o Normal
 - o Restrictive
 - o Very restrictive
 - **Protect Immunization Data:** When this option is selected, the current date will appear to the side. The drop-down options include:
 - o Y- Protect Data, do not share
 - o N - Not protected, can be shared
 - **Participate in CAHPS Survey:** Indicate whether patients are willing to participate in the OAS (Outpatient and Ambulatory Surgery Center) CAHPS (Consumer Assessment of Healthcare Providers and Systems) Reporting.
 - o Selected indicates YES
 - o Blank indicates NO
1. Double-clicking the **Build Patient Summary** item in the list will generate the CCDA and open the document.
 2. The **Referral/Transition of Care Summary** option will produce the exact same document as the 'Patient Summary,' but the portal will need to be able to tell the difference in the entries. Double-clicking the **Referral/Transition of Care Summary** item in the list will generate the CCDA and open the document. CCDA documents that have been edited and/or printed, emailed or saved to portable media are saved to Electronic File Management. They display in Updated ChartLink in Reports and Attachments under the Medical Records (Med. Rec.) discipline as **z_CCDA:Patient Summary** or **z_CCDA:Referral/Transition** indicating the date the document was created.

Select Charts > Select Patient Account > Attachments > Med Rec > Build Patient Summary

Build Patient Summary

3. Any edited version of the CCDA that is saved will display, listing with an indication of date/time the document was saved. The screen will display the contents section at the top of the document that will allow the user to select a section and scroll to that section of the document.

The action bar on the Document View screen contains the following options:

- **Back arrow:** If selected, this option will direct the user back to the Med. Rec. screen.
- **Edit:** This option will open the document for editing. (see below)
- **Submit to Provider:** If the document has not already been edited and saved, selecting this button will save the document and open a screen that will allow the user to create an e-mail message with the CCDA attached.
- **Print:** This option will save the document and open the "Select a printer" screen. The user may select a network printer from the printer list, Workstation or View
- **Portable Media:** If the document has not already been edited and saved, selecting this button will save the document and display the windows pop-up "Browse for Folder" that will allow the user to select the location on the PC to save the document. Once addressed, a screen for the encryption key entry displays. The user will then type in an encryption key of their choice, Cancel (to go return to the document) or OK to accept and apply. A 'Submitted' message will then display..

4. Selecting **Edit** will display a list screen of all the CCDA document sections with columns indicating the Total Records and Excluded Records count for each section. Sections may be set to **Include/Exclude** entire section. If any section has been set to be excluded, the **Save Document** button may be selected to save the changes. **View Document** will open the CCDA in another window to view.

Select **Charts** > **Select Patient Account** > **Attachments** > **Med Rec** > **Build Patient Summary** > **Edit**

CHARTS > ROGERS JESSICA I (ACTIVE) > REPORTS AND ATTACHMENTS

SMITH ELLA KATHERINE MR#: 970015 ACCOUNT#: 357351 DOB: 02/09/1943 Sex: F Current Weight: 160 lbs 72.57 kg 72574.80 g
 AGE: 72 CrCl: N/A Height: 65.00 inches BMI: 26.63 kg/m2 BSA: 1.82 m2 Admit Weight: 0 lbs 0.00 kg 0.00 g
 RM: 302-1 Diagnosis: Pulmonary injury Allergies: EGGS, MINERAL OIL

Charts

SMITH ELLA KATHERINE (...)

- Alerts
- Lab Results
- Problem List
- Vitals
- Allergies
- Medication Reconciliation
- Order Entry
- Documentation
- Patient Immunization History
- Patient Education Docume...
- PACS Images
- Order Chronology
- Transcriptions
- Prescription Entry
- Clinical History
- Reports and Attachments**
- MAR
- Health History
- Health Information Resource
- Temporary Registration
- Plan of Care
- Charges
- Location Maintenance

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

Section	Total Records	Excluded Records
Care Team	3	0
Provider Organization	1	0
Vitals	4	0
Allergies	2	0
Procedures	0	0
Immunizations	1	0
Problems	5	0
Results	1	0
Active Medications	8	0
Medications Administered During Visit	0	0
Encounters	0	0
Social History	1	0
Patient Decision Aids	0	0
Hospital Discharge Instructions	1	0
Chief Complaint and Reason For Visit	1	0
Functional Status	0	0
Plan of Care	3	0
Future Appointments	0	0
Future Scheduled Test	0	0
Diagnostic Test Pending	0	0
Referral/Transition of Care	0	0

Build Patient Summary

5. Select a section and **Edit** to select individual records within that section to **Include/Exclude**.

Select Charts > Select Patient Account > Attachments > Med Rec > Build Patient Summary > Edit > select section title > Edit

CHARTS » ROGERS JESSICA I (ACTIVE) » REPORTS AND ATTACHMENTS

SMITH ELLA KATHERINE MR#: 970015 ACCOUNT#: 357351 DOB: 02/09/1943 Sex: F Current Weight: 160 lbs 72.57 kg 72574.80 g
 AGE: 72 CrCl: N/A Height: 65.00 inches BMI: 26.63 kg/m2 BSA: 1.82 m2 Admit Weight: 0 lbs 0.00 kg 0.00 g
 RM: 302-1 Diagnosis: Pulmonary injury Allergies: EGGS, MINERAL OIL

Charts

SMITH ELLA KATHERINE (...)

- Alerts
- Lab Results
- Problem List
- Vitals
- Allergies
- Medication Reconciliation
- Order Entry
- Documentation
- Patient Immunization History
- Patient Education Docume...
- PACS Images
- Order Chronology
- Transcriptions
- Prescription Entry
- Clinical History
- Reports and Attachments
- MAR
- Health History
- Health Information Resource
- Temporary Registration
- Plan of Care
- Charges
- Location Maintenance

Include/Exclude

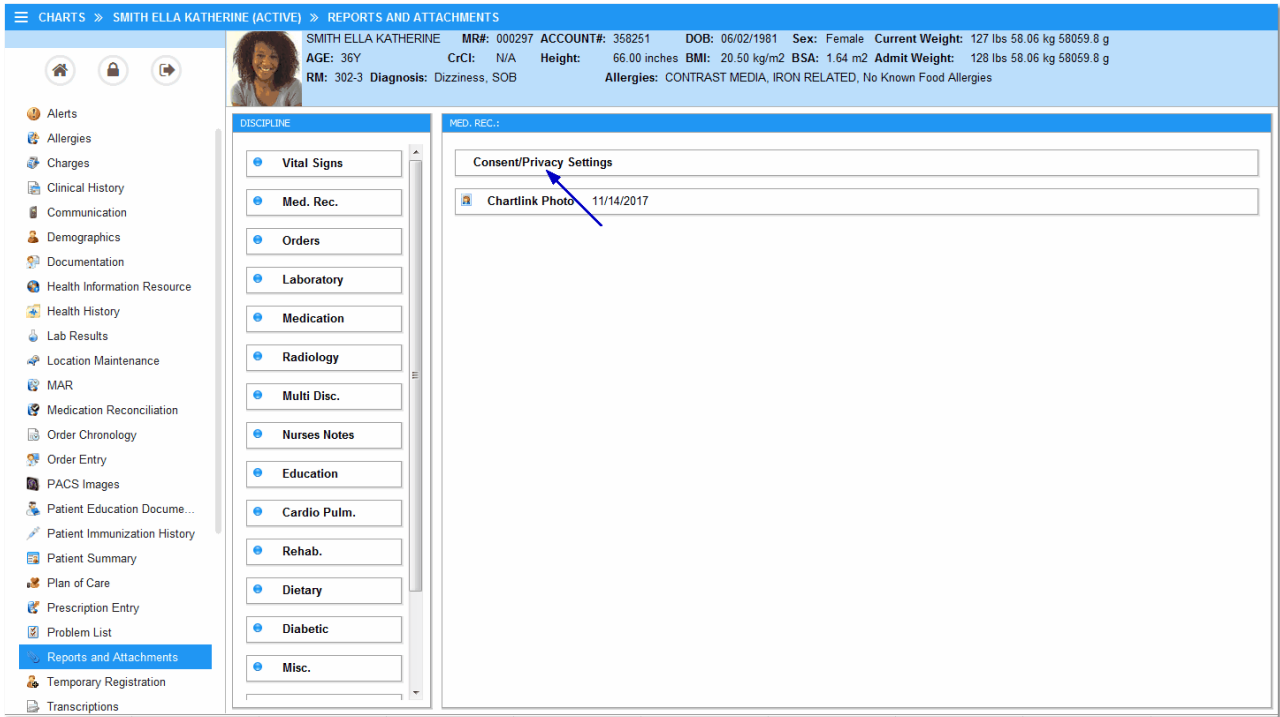
Problem	Excluded?
ASTHMA, UNSPECIFIED	
CHRONIC OBS ASTHMA W/ ACUTE EXACERB	
LOCAL SALMONELLA INF NOS	
Chest pain	
Family history of asthma and other chronic lower respiratory diseases	

Build Patient Summary

5.3 Version 6

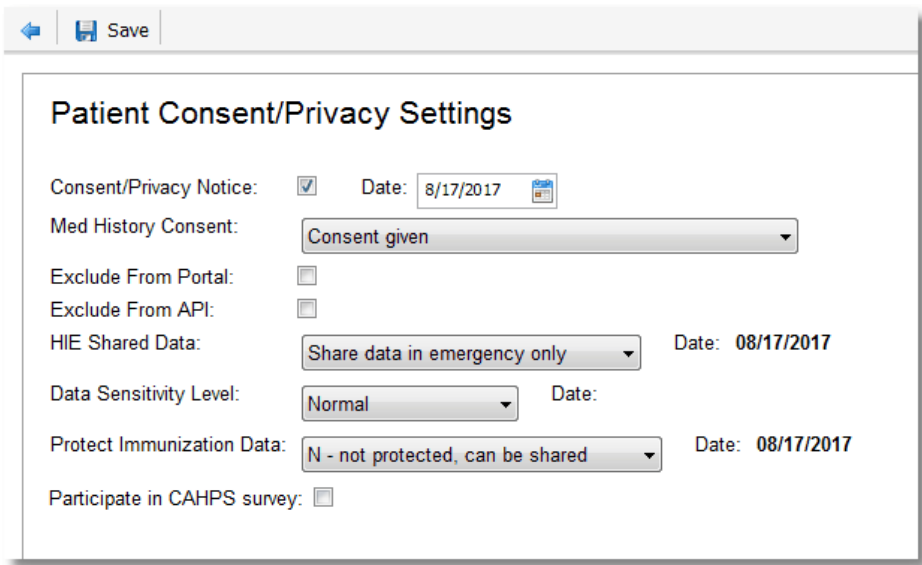
The Medical Record area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Med Rec



Reports & Attachments

Select Charts > Select Patient Account > Attachments > Med Rec > Consent/Privacy Settings



Patient Consent/Privacy Settings

The **Consent/Privacy Settings** option will open the **Patient Consent/Privacy Settings** screen.

- **Consent/Privacy Notice:** If checked, the Consent/Privacy notice has been received and signed by the patient. The **Date-Picker** field should indicate when the notice was signed.
- **Med History Consent:** Indicate the patient's Med History Consent by choosing one of the following options from the drop-down:
 - o No Consent
 - o Prescriber
 - o Parental/Guardian consent from any prescriber
 - o Consent given
 - o Parental/Guardian consent from this prescriber only
- **Exclude from Portal:** If checked, will prevent the patient from accessing the CCD in the patient portal.
- **Exclude from API** (Application Program Interface): If this field is selected, it will indicate that the account is being excluded from API. If the check box is unchecked, this will indicate that the account is not excluded from API.

NOTE: This option is also included in the Census Clinical Tab as a single-character field for Y (YES) or N (NO).

- **HIE Shared Data** (Health Information Exchange): When this option is selected, the current date will appear to the side. The drop-down options include:
 - o Share data with HIE
 - o Do not share data with HIE:
 - o Share Data in emergency only
- **Data Sensitivity Level:** When this option is selected, the current date will appear to the side. The drop-down options include:
 - o Normal
 - o Restrictive
 - o Very restrictive
- **Protect Immunization Data:** When this option is selected, the current date will appear to the side. The drop-down options include:
 - o Y- Protect Data, do not share
 - o N - Not protected, can be shared
- **Participate in CAHPS Survey:** Indicates whether patients are willing to participate in the OAS (Outpatient and Ambulatory Surgery Center) CAHPS (Consumer Assessment of Healthcare Providers and Systems) Reporting.
 - o Selected indicates YES
 - o Blank indicates NO

NOTE: The options for Build Patient Summary and Build Referral/Transition of Care Summary are no longer available from this pathway when Version 6 is turned on in the facility tables.

Chapter 6 Orders

6.1 Overview

This section will discuss the **Orders** section of Attachments.

6.2 Physician's Nursing Order Report

The **Physician's Nursing Order Sheet** is a document that includes the patient's verified nursing orders (CPOE and orders placed via TruBridge).

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Orders**

The screenshot displays the TruBridge software interface. At the top, a blue header bar contains the text "THINK US" and "Help". Below this, a navigation bar shows "CHARTS" and "HOWARD DOUGLAS (357495) » REPORTS AND ATTACHMENTS". The main content area is divided into two columns. The left column, titled "DISCIPLINE", lists various medical disciplines with radio buttons next to them: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet, Other, and Growth Charts. The right column, titled "ORDERS", shows a search bar and a message "No attachments found". A left sidebar contains a list of navigation options, including "Charts", "Alerts", "Lab Results", "Problem List", "Vitals", "Allergies", "Medication Reconciliation", "Prescription Entry", "Patient Immunization History", "Patient Education Document", "PACS Images", "Order Chronology", "Transcriptions", "Clinical History", "Reports and Attachments", "Order Entry", "MAR", "Documentation", "Health History", "Health Information Resource", "Temporary Registration", "Plan of Care", "Charges", "Location Maintenance", "Demographics", and "Visit History".

Orders

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - Admitting physician
 - Age, sex, and room number
 - Any drug allergies documented through TruBridge

NOTE: In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Nursing Order Box**
 - Shaded in gray, each box contains one nursing order of up to 75 characters
- **Nursing Order Comment**
 - Displays any comment that was added, the last time the order was addressed by the nursing staff.
- **Nursing Order Status**
 - Appears directly below the comment
 - The status indicates the last action taken on an order
 - The date and time will indicate the last time the order was addressed
 - Displays initials of the person who charted the nursing order
- **Additional Notes**
 - Unverified nursing orders will NOT be included in this report
 - Nursing orders discontinued within eight hours of the printing of this report, will be included.

The following is a full display of the **Physician's Nursing Order Sheet**.

Evident Community Hospital Physician's Nursing Orders Report Printed: 7/14/14 at 11:07 Page 1 of 1	SMITH ELLA KATHERINE AGE: 58 SEX: F RICHARD JOHNSON JR ROOM: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015
---	---

Side rails up x2	☐	CONT	☐	DISCONTINUE
------------------	--------------------------	------	--------------------------	-------------

PROTIME	☐	CONT	☐	DISCONTINUE
---------	--------------------------	------	--------------------------	-------------

H & H	☐	CONT	☐	DISCONTINUE
-------	--------------------------	------	--------------------------	-------------

CMP	☐	CONT	☐	DISCONTINUE
-----	--------------------------	------	--------------------------	-------------

UA 06/27/14	☐	CONT	☐	DISCONTINUE
-------------	--------------------------	------	--------------------------	-------------

Ambulate x 3 per day	☐	CONT	☐	DISCONTINUE
----------------------	--------------------------	------	--------------------------	-------------

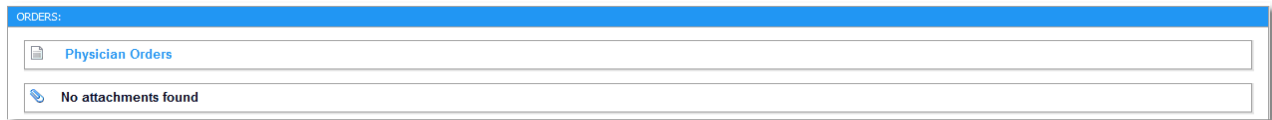
Date: _____ Time: _____ Signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
----------	----------------------	---------	--------	------	----	------	---	-------	-------	-------	---

6.3 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select **Charts** > **Select Patient Account** > **Attachments** > **Orders** > **Attachments**

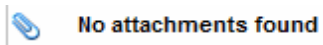


Orders - Attachments

Deleted Items will display



Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



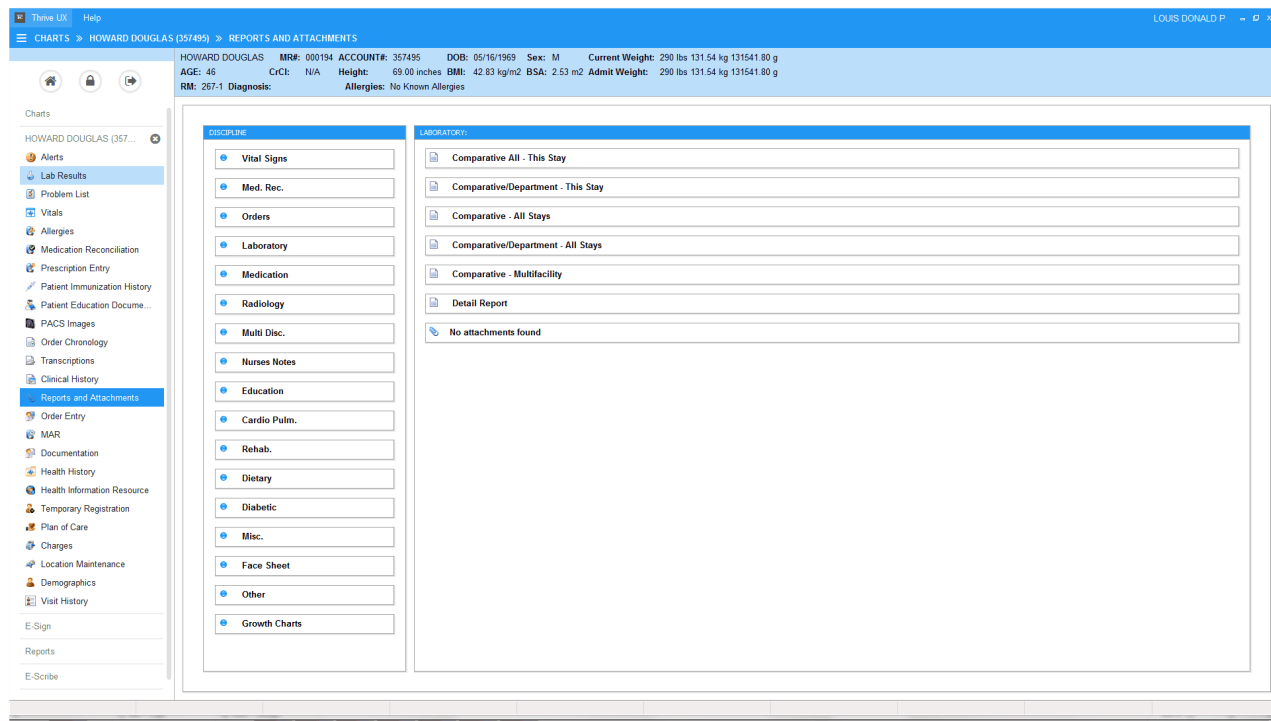
will display if data is not present in this area to be viewed.

Chapter 7 Laboratory

7.1 Overview

This section will discuss the process of reviewing **Laboratory** orders, results and reports.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Laboratory**



Laboratory

7.2 Comparative All - This Stay

The comparative vertical report is an update of all test results for a patient account. The report is a comparative summary presentation of all data with test names along the vertical axis and results listed chronologically along a horizontal axis. Collection dates and times are printed on the horizontal axis. Up to seven events will print per row with subsequent results wrapping below the most current results. Scroll to view all available reports related to this hospital stay.

Select Charts > Select Patient Account > Attachments > Laboratory > Comparative All - This Stay

DISCIPLINE	LABORATORY
☐ Vital Signs	Comparative All - This Stay
☐ Med. Rec.	Comparative/Department - This Stay
☐ Orders	Comparative - All Stays
☐ Laboratory	Comparative/Department - All Stays
☐ Medication	Comparative - Multifacility
☐ Radiology	Detail Report
☐ Multi Disc.	No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Comparative All-This Stay

The following is a full display of the **Laboratory-Comparative Report**.

Reported Date/Time: 07/02/15 8:23 Evident Community Hospital PAGE 1
Medical Director 6600 Wall Street CLIA # 123456789A
John A. Doe, M.D. Mobile, Alabama 36695
LABORATORY -- COMPARATIVE REPORT LACUMV2

NAME.: HOWARD DOUGLAS SEX.....: M ATTENDING: Donald Louis
ACCT#: 357495 AGE.....: 46 Y SECOND...:
ROOM.: 267-1 - PENDING ORDERS DOB.....: 05/16/1969 PRIM CARE.:
ADMIT: 05/01/12 PAT. PHONE: 2515554565
MR#.....: 000194

CHEMISTRY

Collect Dt/tm	101414 1547	101414 1214	101414 0934	REFERENCE	
Report Dt/tm:	101414 1548	101414 1214	101414 0934	RANGE	UNITS
SODIUM		145		136 -	146 mmol/L
POTASSIUM		3.8		3.3 -	5.3 mmol/L
CHLORIDE		90 L		99 -	110 mmol/L
CO2		25		22 -	33 mmol/L
GLUCOSE	PENDING	75	101 H	65 -	100 mg/dl
BUN		4 L		5 -	20 mg/dl
CREATININE		1.9 H		0.6 -	1.5 mg/dl
ANION GAP		30 H		7 -	16
BUN/CREAT		2			

Page: 1 / 2 Zoom: 104% PORTRAIT

The Comparative All – This Stay and all the other laboratory reports listed in this section will display in Adobe Acrobat Reader format.

7.3 Comparative/Department - This Stay

This option will display a columnar version of the patient results by the sub-department of the laboratory for a single account.

Select Charts > Select Patient Account > Attachments > Laboratory > Comparative/Department - This Stay

DISCIPLINE	LABORATORY
☐ Vital Signs	☐ Comparative All - This Stay
☐ Med. Rec.	☐ Comparative/Department - This Stay
☐ Orders	☐ Comparative - All Stays
☐ Laboratory	☐ Comparative/Department - All Stays
☐ Medication	☐ Comparative - Multifacility
☐ Radiology	☐ Detail Report
☐ Multi Disc.	☐ No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Comparative/Department-This Stay

The following is a full display of the **Comparative By Dept – This Stay** report.

Reported Date/Time: 07/02/15 8:25 Evident Community Hospital PAGE 1
Medical Director 6600 Wall Street CLIA # 123456789A
John A. Doe, M.D. Mobile, Alabama 36695
TIME: 8:25 LABORATORY -- COMPARATIVE BY DEPT LACUMV2

NAME.: HOWARD DOUGLAS SEX.....: M ATTENDING: Donald Louis
ACCT#: 357495 AGE.....: 46 Y SECOND...:
ROOM.: 267-1 - PENDING ORDERS DOB.....: 05/16/1969 PRIM CARE.:
PAT. PHONE: 2515554565
ADMIT: 05/01/12 MR#.....: 000194

CHEMISTRY

Collect Dt/tm	101414 1547	101414 1214	101414 0934	REFERENCE	
Report Dt/tm:	101414 1548	101414 1214	101414 0934	RANGE	UNITS
SODIUM		145		136 -	146 mmol/L
POTASSIUM		3.8		3.3 -	5.3 mmol/L
CHLORIDE		90 L		99 -	110 mmol/L
CO2		25		22 -	33 mmol/L
GLUCOSE	PENDING	75	101 H	65 -	100 mg/dl
BUN		4 L		5 -	20 mg/dl
CREATININE		1.9 H		0.6 -	1.5 mg/dl
ANION GAP		30 H		7 -	16
BUN/CREAT		2			

Page: 1 / 1 Zoom: 100% PORTRAIT

The **Comparative By Dept-This Stay** and all the other laboratory reports listed in this section will display in Adobe Acrobat Reader format.

7.4 Comparative - All Stays

This option allows access to comparative results for more than one stay.

Select Charts> Select Patient Account > Attachments > Laboratory > Comparative/Department - All Stay

DISCIPLINE	LABORATORY:
☐ Vital Signs	☐ Comparative All - This Stay
☐ Med. Rec.	☐ Comparative/Department - This Stay
☐ Orders	☐ Comparative - All Stays
☐ Laboratory	☐ Comparative/Department - All Stays
☐ Medication	☐ Comparative - Multifacility
☐ Radiology	☐ Detail Report
☐ Multi Disc.	☐ No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Comparative -All Stays

The following is a full display of the **Comparative - All Stays** report.

Export

Reported Date/Time: 07/02/15 8:26

Medical Director

John A. Doe, M.D.

Evident Community Hospital

6600 Wall Street

Mobile, Alabama 36695

LABORATORY -- COMPARATIVE REPORT

PAGE 1

CLIA # 123456789A

LACUMV2

NAME.: HOWARD DOUGLAS

ACCT#: 357495

ROOM.: 267-1

ADMIT: 05/01/12

SEX.....: M

AGE.....: 46 Y

DOB.....: 05/16/1969

PAT. PHONE: 2515554565

MR#.....: 000194

ATTENDING: Donald Louis

SECOND...:

PRIM CARE.:

- PENDING ORDERS

CHEMISTRY

Collect Dt/tm	101414 1547	101414 1214	101414 0934	REFERENCE	
Report Dt/tm:	101414 1548	101414 1214	101414 0934	RANGE	UNITS
SODIUM		145		136 - 146	mmol/L
POTASSIUM		3.8		3.3 - 5.3	mmol/L
CHLORIDE		90 L		99 - 110	mmol/L
CO2		25		22 - 33	mmol/L
GLUCOSE	PENDING	75	101 H	65 - 100	mg/dl
BUN		4 L		5 - 20	mg/dl
CREATININE		1.9 H		0.6 - 1.5	mg/dl
ANION GAP		30 H		7 - 16	
BUN/CREAT		2			

Page: 1 / 2

Zoom: 104%

PORTRAIT

7.5 Comparative/Departments - All Stays

This option will display a columnar version of the patient results by the sub-department of the laboratory for more than one stay.

Select Charts > Select Patient Account > Attachments > Laboratory > Comparative/Department - All Stay

DISCIPLINE	LABORATORY
☐ Vital Signs	☐ Comparative All - This Stay
☐ Med. Rec.	☐ Comparative/Department - This Stay
☐ Orders	☐ Comparative - All Stays
☐ Laboratory	☐ Comparative/Department - All Stays
☐ Medication	☐ Comparative - Multifacility
☐ Radiology	☐ Detail Report
☐ Multi Disc.	☐ No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Comparative/Department-All Stay

The following is a full display of the **Comparative By Dept – All Stay** report.

Reported Date/Time: 07/02/15 8:28 Evident Community Hospital PAGE 1
Medical Director 6600 Wall Street CLIA # 123456789A
John A. Doe, M.D. Mobile, Alabama 36695
TIME: 8:28 LABORATORY -- COMPARATIVE BY DEPT LACUMV2

NAME.: HOWARD DOUGLAS SEX.....: M ATTENDING: Donald Louis
ACCT#: 357495 AGE.....: 46 Y SECOND...:
ROOM.: 267-1 - PENDING ORDERS DOB.....: 05/16/1969 PRIM CARE.:
PAT. PHONE: 2515554565
ADMIT: 05/01/12 MR#.....: 000194

CHEMISTRY

Collect Dt/tm	101414 1547	101414 1214	101414 0934	REFERENCE	
Report Dt/tm:	101414 1548	101414 1214	101414 0934	RANGE	UNITS
SODIUM		145		136 -	146 mmol/L
POTASSIUM		3.8		3.3 -	5.3 mmol/L
CHLORIDE		90 L		99 -	110 mmol/L
CO2		25		22 -	33 mmol/L
GLUCOSE	PENDING	75	101 H	65 -	100 mg/dl
BUN		4 L		5 -	20 mg/dl
CREATININE		1.9 H		0.6 -	1.5 mg/dl
ANION GAP		30 H		7 -	16
BUN/CREAT		2			

Page: 1 / 1 Zoom: 104% PORTRAIT

The **Comparative By Dept-All Stay** and all the other laboratory reports listed in this section will display in Adobe Acrobat Reader format.

7.6 Comparative - Multifacility

This option allows access to comparative results from all associated **Multifacility** locations.

Select Charts > Select Patient Account > Attachments > Laboratory > Comparative - Multifacility

DISCIPLINE	LABORATORY:
☐ Vital Signs	☐ Comparative All - This Stay
☐ Med. Rec.	☐ Comparative/Department - This Stay
☐ Orders	☐ Comparative - All Stays
☐ Laboratory	☐ Comparative/Department - All Stays
☐ Medication	☐ Comparative - Multifacility
☐ Radiology	☐ Detail Report
☐ Multi Disc.	☐ No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Comparative - Multifacility

The following is a full display of the **Comparative- Multifacility** report.

Export

Reported Date/Time: 07/02/15 8:29
FAC-A: EVIDENT COMMUNITY HOSPITAL
David L. Holbrook, M.D - Med. Dir.

LABORATORY - COMPARATIVE REPORT
6600 Wall Street Mobile, AL 36695

PAGE 1
CLIA#1234567890

NAME.: HOWARD DOUGLAS
ACCT#: 357495
ROOM.: 267-1
ADMIT: 05/01/12

SEX.....: M
AGE.....: 46 Y
DOB.....: 05/16/1969
PAT. PHONE: 2515554565
MR#.....: 000194

ATTENDING: Donald Louis
SECOND...:
PRIM CARE.:

- PENDING ORDERS

CHEMISTRY

Collect Dt/tm	101414 1547	101414 1214	101414 0934	REFERENCE	
Report Dt/tm:	101414 1548	101414 1214	101414 0934	RANGE	UNITS
SODIUM		145		136 - 146	mmol/L
POTASSIUM		3.8		3.3 - 5.3	mmol/L
CHLORIDE		90 L		99 - 110	mmol/L
CO2		25		22 - 33	mmol/L
GLUCOSE	PENDING	75	101 H	65 - 100	mg/dl
BUN		4 L		5 - 20	mg/dl
CREATININE		1.9 H		0.6 - 1.5	mg/dl
ANION GAP		30 H		7 - 16	
BUN/CREAT		2			
CALCIUM		9.00		8.30 - 10.00	mg/dl

Page: 1 / 2

Zoom: 104%

PORTRAIT

7.7 Detail Report

This option allows access to a detail report of all laboratory results for this patient account.

Select Charts > Select Patient Account > Attachments > Laboratory > Detail Report

DISCIPLINE	LABORATORY
☐ Vital Signs	☐ Comparative All - This Stay
☐ Med. Rec.	☐ Comparative/Department - This Stay
☐ Orders	☐ Comparative - All Stays
☐ Laboratory	☐ Comparative/Department - All Stays
☐ Medication	☐ Comparative - Multifacility
☐ Radiology	☐ Detail Report
☐ Multi Disc.	☐ No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Detail Report

7.8 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Laboratory > Attachments

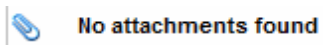
DISCIPLINE	LABORATORY:
☐ Vital Signs	Comparative All - This Stay
☐ Med. Rec.	Comparative/Department - This Stay
☐ Orders	Comparative - All Stays
☐ Laboratory	Comparative/Department - All Stays
☐ Medication	Comparative - Multifacility
☐ Radiology	Detail Report
☐ Multi Disc.	No attachments found
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Laboratory - Attachments

Deleted Items will display



Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 8 Medication

8.1 Overview

This section will discuss the process of reviewing **Medication** reports.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Medication**

The screenshot displays the TruBridge software interface for reviewing a patient's medication report. The top navigation bar shows the path: CHARTS > HOWARD DOUGLAS (557495) > REPORTS AND ATTACHMENTS. The patient's name, HOWARD DOUGLAS, is prominently displayed. Below the name, key demographic and clinical information is provided: MMR: 000194, ACCOUNT#: 357495, DOB: 05/16/1969, Sex: M, Current Weight: 290 lbs 131.54 kg 131541.80 g, AGE: 46, CrCl: N/A, Height: 69.00 inches, BMI: 42.83 kg/m2, BSA: 2.53 m2, Admit Weight: 290 lbs 131.54 kg 131541.80 g, RM: 267-1, and Allergies: No Known Allergies.

The main content area is divided into two columns. The left column, titled 'DISCIPLINE', lists various medical disciplines with a search icon and a dropdown menu. The 'Medication' option is currently selected and highlighted in blue. The right column, titled 'MEDICATION', displays a list of medication-related reports, including MAR Final, MAR Temporary, All MARS, All 5 Day MARS, Scheduled Medications, PCA, Medication Record, Medication Reconciliation Report, and No attachments found. The 'No attachments found' message is accompanied by a magnifying glass icon.

The bottom of the interface features a navigation bar with the word 'Medication' centered, indicating the current view.

Medication

8.2 MAR Final

The MAR-Final is a document that includes the patient's complete medication administration record.

Select **Charts > Select Patient Account > Attachments > Medication**

DISCIPLINE	MEDICATION:
☐ Vital Signs	☐ MAR Final
☐ Med. Rec.	☐ MAR Temporary
☐ Orders	☐ All MARS
☐ Laboratory	☐ All 5-Day MARS
☒ Medication	☐ Scheduled Medications
☐ Radiology	☐ PCA
☐ Multi Disc.	☐ Medication Record
☐ Nurses Notes	☐ Medication Reconciliation Report
☐ Education	☐ No attachments found
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

MAR Final

The previous 34 hours of Medication documentation display is based on one of the following time periods determined by administration: 0700 – 0659, 1500 – 1459 or 3300 – 3359. The medications are grouped by categories (X1, Scheduled/Routine, IV orders, and PRN) and display in the order that they were entered into the system. The previous 34-hours display in eight-hour time periods, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below the initials.

- All continuous IVs that were ordered, scheduled, administered or discontinued during the 34-hour period are covered by the report
- Start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified
- Medication description, flow rate, frequency, and components
- Initials of the person who administered the IV or a "G" (Given) will appear under the appropriate hour of the 8-hour block.

The following is a full display of the **MAR Final** report.

Export

Evident Community Hospital		HOWARD DOUGLAS		AGE: 46 SEX: M	
M.A.R. - FINAL		Donald Louis		DOB: 05/16/1969	
FROM: 07/01/15 07:00 TO: 07/02/15 06:59		ALLERGIES: No Known All		ROOM: 267-1	
Page 1 of 2		DIAGNOSIS:		M/R#: 000194	
Printed: 7/02/15 at 09:07					
Scheduled/Routine Medications		7 - 3		3 - 11	
		7 8 9 10 11 12 13 14		15 16 17 18 19 20 21 22	
				23 0 1 2 3 4 5 6	
Start: 10/13/14		09			
FUROSEMIDE {L		00			
DAILY 40 MILLIGRAMS					
ORALLY					
Start: 10/13/14		09		21	
ACETAMINOPHEN {TYLENOL} 325 MG TABLET		00		00	
325 MG					
BID					
ORALLY					
Start: 11/06/14 Stop: 12/06/14 A		09			
ABILIFY {ARIPRAZOLE} 10 MG TAB		00			
10 MG					
DAILY					
ORALLY					

Page: 1 / 2 Zoom: 104% PORTRAIT

The MAR Final report and the other reports listed in this section will display in Adobe Acrobat Reader format.

Demographics Box

- Patient's name
- Admitting physician
- Age, sex, & room number
- Drug allergies documented through TruBridge
- In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

SMITH ELLA KATHERINE	AGE: 58 SEX: F
RICHARD JOHNSON JR	DOB: 10/31/1955
ALLERGIES: No Known Dru Peanuts	ROOM: 300-7
	M/R#: 970015
DIAGNOSIS:	

One Time Orders

- All X1 medications that were ordered, scheduled, administered or discontinued during the 34-hour period are covered by the report
- Start and stop date, stop code and "Unverified" if the medication has not been verified
- Medication description, dosage, frequency, and instructions
- Scheduled time appears under the appropriate hour of the 8- hour block.
- Initials of the person who administered the medication or "G" (Given) will appear under the appropriate hour of the 8-hour block.

One Time Orders	7 - 3	3 - 11	11 - 7
	7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6
Start: 07/17/14 Stop: 07/17/14 1			
ZOLPIDEM {AMBIEN} 5 MG TAB			
5 MG			
X1			
FOR SLEEP			
PO			

Scheduled/Routine Medications

- All routine medications that were ordered, scheduled, administered or discontinued during the 34-hour period covered by the report
- Start date, stop date if applicable, stop code if applicable and "Unverified" if the medication has not been verified
- Medication description, dosage, frequency, & instructions
- Components and flow rate on piggybacks
- Scheduled time appears under the appropriate hour of the 8-hour block.
- Initials of the person who administered the medication or "G" (Given) will appear under the appropriate hour of the 8-hour block.

Scheduled/Routine Medications														7 - 3								3 - 11								11 - 7							
														7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5	6
Start: 06/24/14														09																							
ATENOLOL {TENORMIN} PO														00																							
50 MG																																					
DAILY																																					
CHECK PULSE BEFORE																																					
ADMINISTRATION, IF <50 HOLD AND CALL MD																																					
Start: 06/24/14														08																							
METFORMIN{GLUCOPHAGE} TAB														00																							
500 MILLIGRAMS																																					
1 TIME DAILY (QD) PO																																					
GIVE WITH MEALS MAX DOSE= 2550 MG/DAY																																					
Start: 06/24/14														09																							
ROSUVASTATIN{CRESTOR} TAB														00																							
20 MG																																					
DAILY																																					
ORALLY																																					

IV Orders

- All continuous IVs that were ordered, scheduled, administered or discontinued during the 34-hour period and covered by the report
- Start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified
- Medication description, flow rate, frequency, and components
- Initials of the person who administered the IV or a "G" (Given) will appear under the appropriate hour of the 8-hour block.

IV Orders		7 - 3	3 - 11	11 - 7
		7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6
Start: 12/04/13 Stop: 12/11/13 A UNVERIFIED				
ROCEPHIN/DW5 IVPB CONTINUOUS				
50 ml/hr				
(a)	1 GM	CEFTRIAZONE {ROCEPHIN} INJ		
(b)	50 ML	D5W {5% DEXTROSE IN WATER}		

8.3 MAR Temporary

The MAR - Temporary is a document that includes the patient's medication administration record for the current 34 hours.

Select Charts > Select Patient Account > Attachments > Medication > MAR Temporary

DISCIPLINE	MEDICATION
☐ Vital Signs	☐ MAR Final
☐ Med. Rec.	☒ MAR Temporary
☐ Orders	☐ All MARS
☐ Laboratory	☐ All 5-Day MARS
☐ Medication	☐ Scheduled Medications
☐ Radiology	☐ PCA
☐ Multi Disc.	☐ Medication Record
☐ Nurses Notes	☐ Medication Reconciliation Report
☐ Education	☐ No attachments found
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

MAR Temporary

The MAR - Temporary is a document that includes the patient's medication administration record for the current 34 hours, based on one of the following time periods determined by nursing administration: 0700 – 0659, 1500 – 1459 or 3300 – 3359. The medications are grouped by categories (X1, Scheduled/Routine, IV orders and PRN) and display in the order that they were entered into the system. The 34 hour displays in eight-hour time periods, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below the initials.

The following is a full display of the **MAR Temporary** report.

Evident Community Hospital		HOWARD DOUGLAS		AGE: 46 SEX: M	
M.A.R. - Temporary		Donald Louis		DOB: 05/16/1969	
FROM: 07/02/15 07:00 TO: 07/03/15 06:59 Page 1 of 2		ALLERGIES: No Known All		ROOM: 267-1	
Printed: 7/02/15 at 09:08		DIAGNOSIS:		M/R#: 000194	
One Time Orders	7 - 3	3 - 11	11 - 7		
	7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6		
Scheduled/Routine Medications	7 - 3	3 - 11	11 - 7		
	7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6		
Start: 10/13/14 09 FUROSEMIDE {L} 00 DAILY 40 MILLIGRAMS ORALLY					
Start: 10/13/14 09 21 ACETAMINOPHEN {TYLENOL} 325 MG TABLET 00 00					

Page: 1 / 2 Zoom: 154% PORTRAIT

Demographics Box

- Patient's name
- Admitting physician
- Age, sex, & room number
- Drug allergies documented through TruBridge
- In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

SMITH ELLA KATHERINE	AGE: 58 SEX: F
RICHARD JOHNSON JR	DOB: 10/31/1955
ALLERGIES: No Known Dru Peanuts	ROOM: 300-7
	M/R#: 970015
DIAGNOSIS:	

One Time Orders

- All X1 medications that were ordered, scheduled, administered or discontinued during the 34-hour period are covered by the report
- Start and stop date, stop code and "Unverified" if the medication has not been verified
- Medication description, dosage, frequency, and instructions
- Scheduled time appears under the appropriate hour of the 8- hour block.
- Initials of the person who administered the medication or "G" (Given) will appear under the appropriate hour of the 8-hour block.

One Time Orders								7 - 3								3 - 11								11 - 7							
								7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6
Start: 07/03/12 Stop: 07/08/12 A																															
HYDROCODONE/APAP{LORTAB}TAB 5/500MG																															
1 EA																															
1X																															
PO																															
MAX OF 8 TABS PER 24 HRS.																															
G																															
08																															
53																															
Start: 07/03/12																															
ASPIRIN TAB 325 MG																															
650 MG																															
1X																															
PO																															
FOR HEADACHE OR TEMP >101																															
G																															
08																															
53																															

Scheduled/Routine Medications

- All routine medications that were ordered, scheduled, administered or discontinued during the 34-hour period covered by the report
- Start date, stop date if applicable, stop code if applicable and "Unverified" if the medication has not been verified
- Medication description, dosage, frequency, & instructions
- Components and flow rate on piggybacks
- Scheduled time appears under the appropriate hour of the 8-hour block.
- Initials of the person who administered the medication or "G" (Given) will appear under the appropriate hour of the 8-hour block.

Scheduled/Routine Medications	7 - 3							3 - 11							11 - 7									
	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5	6
Start: 06/24/14								09																
ATENOLOL {TENORMIN} PO								00																
50 MG																								
DAILY								PO																
CHECK PULSE BEFORE								ADMINISTRATION, IF <50 HOLD AND CALL MD																
Start: 06/24/14								08																
METFORMIN{GLUCOPHAGE} TAB								00																
500 MILLIGRAMS																								
1 TIME DAILY (QD)								PO																
GIVE WITH MEALS MAX DOSE= 2550 MG/DAY																								
Start: 06/24/14								09																
ROSUVASTATIN{CRESTOR} TAB								00																
20 MG																								
DAILY								ORALLY																

IV Orders

- All continuous IVs that were ordered, scheduled, administered or discontinued during the 34-hour period are covered by the report
- Start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified
- Medication description, flow rate, frequency, and components
- Initials of the person who administered the IV or a "G" (Given) will appear under the appropriate hour of the 8-hour block.

IV Orders		7 - 3	3 - 11	11 - 7
		7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6
Start: 07/17/14 Stop: 07/24/14 A				
D5W 500ML/HEPARIN 25,000 UNITS				
100 ml/hr				
COMMENTS: D5W 1 L/HEPARIN 25,000 UN				
E13				
12				
17				
BS				
(a) 1000 ML	D5W	a		
(b) 25000 UNITS	HEPARIN INJ	b		

PRN Medications

- All PRN medications that were ordered, administered or discontinued during the 34 hour period are covered by the report.
- Start date, stop date if applicable, stop code if applicable, and "Unverified" if the medication has not been verified.
- Medication description, dosage, frequency, and instructions.
- Initials of the person who administered the medication or a "G" (Given) will appear under the appropriate hour of the 8-hour block.

PRN Medications		7 - 3	3 - 11	11 - 7
		7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6
Start: 06/24/14 Stop: 07/24/14 A				
XANAX {ALPRAZOLAM} 2 MG TABLET				
2 MG				
PRNQ4H (AS NEEDED) PO				

8.4 All MARs

The All MAR - is an area that includes the patient's medication administration record for 34 hour time periods

The desired date may be selected from the lower section of the split screen for display.

Select **Charts** > **Select Patient Account** > **Attachments** > **Medication** > **All MARs**

All MARs

34 hours of Medication documentation display is based on one of the following time periods determined by administration: 0700 – 0659, 1500 – 1459 or 3300 – 3359. The medications are grouped by categories (X1, Scheduled/Routine, IV orders, and PRN) and display in the order that they were entered into the system. The previous 34-hours display in eight-hour time periods, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below the initials.

- All continuous IVs that were ordered, scheduled, administered or discontinued during the 34-hour period are covered by the report
- Start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified
- Medication description, flow rate, frequency, and components
- Initials of the person who administered the IV or a "G" (Given) will appear under the appropriate hour of the 8-hour block.

The following is a display of the **All MARS** report.

Export

Evident Community Hospital

M.A.R. - Temporary

FROM: 07/02/15 07:00 TO: 07/03/15 06:59 Page 1 of 2
Printed: 7/02/15 at 09:08

HOWARD DOUGLAS

Donald Louis

ALLERGIES: No Known All

DIAGNOSIS:

AGE: 46 SEX: M

DOB: 05/16/1969

ROOM: 267-1

M/R#: 000194

One Time Orders

7 - 3

3 - 11

11 - 7

7 8 9 10 11 12 13 14

15 16 17 18 19 20 21 22

23 0 1 2 3 4 5 6

Scheduled/Routine Medications

7 - 3

3 - 11

11 - 7

7 8 9 10 11 12 13 14

15 16 17 18 19 20 21 22

23 0 1 2 3 4 5 6

Start: 10/13/14

09

FUROSEMIDE {L

00

DAILY 40 MILLIGRAMS ORALLY

Start: 10/13/14

09

ACETAMINOPHEN {TYLENOL} 325 MG TABLET

00

21

00

Page: 1 / 2

Zoom: 154%

PORTRAIT

8.5 All 5 Day MARs

From Updated ChartLink it is possible to display the Temporary and/or Final 5-Day MAR from each day of the selected patient's stay.

Select the desired date from the bottom of the split screen to display the 5-Day MAR for that date.

Select **Charts > Select Patient Account > Attachments > Medication > All 5 Day MARs**

All 5 Day MARs

34 hours of Medication documentation display is based on one of the following time periods determined by administration: 0700 – 0659, 1500 – 1459 or 3300 – 3359. The medications are grouped by categories (X1, Scheduled/Routine, IV orders, and PRN) and display in the order that they were entered into the system. The previous 34-hours display in eight-hour time periods, with the medication administration time(s), the initials of the nurse who administered the medication, and the actual time the medication was administered appearing below the initials.

- All continuous IVs that were ordered, scheduled, administered or discontinued during the 34-hour period are covered by the report
- Start date, stop date if applicable, stop code if applicable, and "Unverified" if the IV has not been verified
- Medication description, flow rate, frequency, and components
- Initials of the person who administered the IV or a "G" (Given) will appear under the appropriate hour of the 8-hour block.

The following is a full display of the **All 5 Day** report.

Export

Evident Community Hospital

5 DAY M.A.R. - Temporary

FROM: 06/30/15 00:00 TO: 07/02/15 24:00 Page 1 of 1
PRINTED: 07/02/15 09:11

HOWARD DOUGLAS

Donald Louis

ALLERGIES: No Known All

DIAGNOSIS:

AGE: 46 SEX: M

DOB: 05/16/1969

ROOM: 267-1

M/R#: 000194

Medication Order	06/30/15	07/01/15	07/02/15		
Scheduled/Routine Medications					
Order#: 00006 Start: 11/06/14 15:13 Stop: 12/06/14 15:13 A ABILIFY {ARIPIPRAZOLE} 10 MG TAB 10 MG DAILY ORALLY					
Order#: 00003 Start: 10/13/14 10:36 ACETAMINOPHEN {TYLENOL} 325 MG TABLET 325 MG BID ORALLY					
Order#: 00001 Start: 10/13/14 10:18 FUROSEMIDE {L 40 MILLIGRAMS DAILY ORALLY					
IV Orders					
Order#: 00007 Start: 11/06/14 15:14					

Page: 1 / 1 Zoom: 104% PORTRAIT

8.6 Scheduled Medications

The Scheduled Medications report is a document that includes all of the current scheduled medications for an 8-hour time period for an individual patient or group of patients. PRNs and large volume IVs do not print on the report.

Select **Charts** > **Select Patient Account** > **Attachments** > **Medication** > **Scheduled Medications**

Scheduled Medications

Data included on the Scheduled Medication Report is outlined below:

- **Patient Information**
 - Patient's name
 - Room number
 - Age
 - Sex
 - Attending Physician
 - Any drug allergies documented through TruBridge
- **Medication Information**
 - Medication description, dosage, frequency, instructions
 - "Unverified" if the medication has not been verified
 - Flow rate and components on IV Piggybacks
- **Omission Information**
 - Date, time, and reason medication was omitted

- Check time which indicates that a medication was not administered within thirty minutes before or 30 minutes after the scheduled time
- **Administration Schedule**
 - An eight-hour time frame prints beside the Omission Information section.
 - Indicates the scheduled time for each medication
 - A "G" (Given) displays below the appropriate time, indicating when the medication was given.

The following is a full display of the **Scheduled Medications** report.

Evident Community Hospital					
Scheduled Medication Report					
Printed: 07/02/15 @ 09:12		FROM: 07/02/15 01:00 TO: 07/02/15 09:00		PAGE: 1 of 1	
HOWARD DOUGLAS 357495 RM: 267-1 AGE: 46 DOB: 05/16/69 SEX: M Attending Dr.: Donald Louis					
ALLERGIES: No Known All			Omission Information		0 0 0 0 0 0 0 0
DIAGNOSIS:					
FUROSEMIDE {L} 40 MILLIGRAMS DAILY ORALLY CHECK 09:00 09					
ACETAMINOPHEN {TYLENOL} 325 MG TABLET 325 MG BID ORALLY CHECK 21:00 09					
ABILIFY {ARIPRAZOLE} 10 MG TAB 10 MG DAILY ORALLY CHECK 09:00 09					
Page: 1 / 1 Zoom: 154% PORTRAIT					

8.7 PCA

The following section will describe the PCA order entry and the PCA Infusion form.

PCA Infusion Form

The PCA Infusion Form is a comparative document that includes the patient's PCA administration chart and assessment from the beginning of stay.

Select **Charts** > **Select Patient Account** > **Attachments** > **Medication** > **PCA**

PCA

Data included on the PCA Infusion Form is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Records number
 - Any drug allergies documented through TruBridge
- **Medication**
 - The PCA medication description will be highlighted in a gray box.
- **Protocol**
 - Date and time protocol was entered

- Continuous infusion rate (Optional)
- Name & title of person who entered the protocol
- Lock-out time
- Bolus / loading dose
- Four-hour limit
- Patient administration dose
- Initial syringe volume

The following is a full display of the **PCA** form.

Evident Community Hospital
PCA INFUSION FORM
 Printed: 7/02/15 at 09:21

Page 1 of 1

HOWARD DOUGLAS
Donald Louis
 ALLERGIES: No Known All

MEPERIDINE PCA

Recorded by...	ROUTE	BOLUS/LOADING DOSE	PATIENT ADMINISTERED DOSE	CONTINUOUS INFUSION RATE	LOCK OUT TIME	4 HOUR LIMIT	AMOUNT PURGED FROM TUBING
11/07/14 10:01 { CPOE- DPL }	INTRAVENOUS	ML	1 ML	2 ML/HR	10	20 ML	2.5 ML

EFFECTIVE/INEFFECTIVE/NOTES

11/07/14 10:01 { CPOE- DPL } BOLUS DOSE

RESP **B.P.** **PULSE** **DEMD** **INJ**

2

Page: 1 / 1 Zoom: 100% LANDSCAPE

8.8 Medication Record

The Medication Record Report is a document that includes all ordered medications for an individual patient.

Select **Charts > Select Patient Account > Attachments > Medication > Medication Record**

DISCIPLINE	MEDICATION
☐ Vital Signs	☐ MAR Final
☐ Med. Rec.	☐ MAR Temporary
☐ Orders	☐ All MARS
☐ Laboratory	☐ All 5-Day MARS
☐ Medication	☐ Scheduled Medications
☐ Radiology	☐ PCA
☐ Multi Disc.	☒ Medication Record
☐ Nurses Notes	☐ Medication Reconciliation Report
☐ Education	☐ No attachments found
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Medication Record Report

Data included on the Patient Drug Information sheet is outlined below:

- **Patient Information**
 - Patient's name
 - Room number
 - Age
 - Sex
 - Attending Physician
 - Drug allergies documented through TruBridge
- **Medication Information**
 - Medication description, dosage, frequency, route, and instructions
 - Start/Stop information
 - Flow rate and components on IV Piggybacks
- **Omission Information**
 - Date, time, and reason medication was omitted

- **Administration Record**

- Date/Time
- Nurse
- Dose/Unit
- Site
- Comments/Reason

The following is a full display of the **Medication Record Report**

Evident Community Hospital Medication Record Page 1 of 1 From beginning of stay Printed: 7/02/15 at 09:23		HOWARD DOUGLAS ATT PHY: Donald Louie CON PHY: ALLERGIES: No Known All DIAGNOSIS:		Number: 357495 Age: 46 Sex: M DOB: 05/16/1969 Room: 267-1 M/R#: 000194
FUROSEMIDE {L	40 MILLIGRAMS	DAILY	ORAL	Start: 10/13/14 10:18
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG	PRN	ORAL	Start: 10/13/14 10:28 Stop: 10/13/14 10:37
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG	BID	ORAL	Start: 10/13/14 10:36
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG	PRN	ORAL	Start: 11/06/14 15:04
ABILIFY {ARIPIPRAZOLE} 10 MG TAB	10 MG	DAILY	ORAL	Start: 11/06/14 15:13 Stop: 12/06/14 15:13
MEPERIDINE PCA	1 EA	PRN		Start: 11/06/14 15:15 Stop: 11/09/14 15:15
LANTUS INSULIN U-100/ML	PER PROTOCOL	PRN		Start: 11/06/14 15:17
ROCEPHIN/DW5 IVPB Give if sign of infection is present upon admit. 1 GM	75 ml/hr CEPOTRIAXONE {ROC	CONTINUOUS		Start: 11/06/14 15:09 Stop: 11/13/14 15:09 D5W {5% DEXTRO
NS W/KCL 20 MEQ 1L NS W/KCL 20MEQ 1 L 1000 ML	125 ml/hr NS			Start: 11/06/14 15:14 20 MEQ KCL IV

8.9 Medication Reconciliation Report

This report can be used to track a patient's medications from admit to discharge or transfer to another care giver or facility.

Select Charts > Select Patient Account > Attachments > Medication > Medication Reconciliation Report

Medication Reconciliation Report

The Medication Reconciliation report will display all medications. The "Home Medications" taken during the Point of Care Initial Interview will be at the beginning of the report followed by a page break. The following pages will present the patients hospital medications. A Continue/Discontinue option for both home and hospital medications will be included beside medication descriptions. The physician will have a section on the report for additional medications.

NOTE: This is a displayed report. It is not interactive.

Data included on the MEDICATION RECONCILIATION REPORT is outlined below:

- **Patient Information**
 - Patient's name
 - Account Number
 - Age
 - Sex
 - Room Number
 - Medical Record Number
 - Attending Physician

- Consulting Physician
- Diagnosis
- Height, Weight, BAS
- Any drug allergies documented through TruBridge

- **Medication Information**
 - Medication description, dosage, frequency, route, and instructions
 - Start/Stop information, including the stop codes
 - Flow rate and components on IV Piggybacks
 - PCA Medications and protocol
 - Diabetic Record Medication and sliding scale
 - The option to continue or discontinue the medication

NOTE: “Med continued on the next page” will print at the bottom of the page if information continues to the next page. “Med is continued from previous page” will print at the top of the subsequent page.

The following is an example of the **Medication Reconciliation Report**.

Evident Community Hospital		HOWARD DOUGLAS		Number: 357495													
Medication Reconciliation Report		Page 1 of 3		Age: 46													
From beginning of stay		ATT PHY: Donald Louis		Sex: M													
Printed: 7/02/15 at 09:24		CON PHY:		Room: 267-1													
		ALLERGIES: No Known All		M/R#: 000194													
		DIAGNOSIS:															
		HT: 69 In WT: 290 lbs 0 oz 131.54 kg 131541.8 gm BSA: 2.53 m ²															
Home Medications: (Based upon information gathered during Nursing Assessment)																	
Medication: Lasix 40MG Oral Tablet <table style="width: 100%;"><tr><td style="width: 33%;">Dose: 40 MILLIGRAMS</td><td style="width: 33%;">Freq: Every 8 Hours</td><td style="width: 33%;">Route: ORAL</td></tr><tr><td>Last Dose:</td><td>Source:</td><td>Indication:</td></tr><tr><td colspan="2">Compliant: Need Educ: Physician:</td><td>Confirmed: LOUIS DONALD P 10/13/14 10:36</td></tr><tr><td colspan="2"></td><td style="text-align: right;">☐ CONT ☐ DISCONTINUE</td></tr></table>						Dose: 40 MILLIGRAMS	Freq: Every 8 Hours	Route: ORAL	Last Dose:	Source:	Indication:	Compliant: Need Educ: Physician:		Confirmed: LOUIS DONALD P 10/13/14 10:36			☐ CONT ☐ DISCONTINUE
Dose: 40 MILLIGRAMS	Freq: Every 8 Hours	Route: ORAL															
Last Dose:	Source:	Indication:															
Compliant: Need Educ: Physician:		Confirmed: LOUIS DONALD P 10/13/14 10:36															
		☐ CONT ☐ DISCONTINUE															
Medication: Tylenol 325MG Oral Tablet <table style="width: 100%;"><tr><td style="width: 33%;">Dose: 325 MILLIGRAMS</td><td style="width: 33%;">Freq: Daily</td><td style="width: 33%;">Route: ORAL</td></tr><tr><td>Last Dose:</td><td>Source:</td><td>Indication:</td></tr><tr><td colspan="2">Compliant: Need Educ: Physician:</td><td>Confirmed: LOUIS DONALD P 10/13/14 10:35</td></tr><tr><td colspan="2"></td><td style="text-align: right;">☐ CONT ☐ DISCONTINUE</td></tr></table>						Dose: 325 MILLIGRAMS	Freq: Daily	Route: ORAL	Last Dose:	Source:	Indication:	Compliant: Need Educ: Physician:		Confirmed: LOUIS DONALD P 10/13/14 10:35			☐ CONT ☐ DISCONTINUE
Dose: 325 MILLIGRAMS	Freq: Daily	Route: ORAL															
Last Dose:	Source:	Indication:															
Compliant: Need Educ: Physician:		Confirmed: LOUIS DONALD P 10/13/14 10:35															
		☐ CONT ☐ DISCONTINUE															
Date: Time: Signature:																	

8.10 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Medication > Attachments

Medications - Attachments

Deleted Items will display



Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



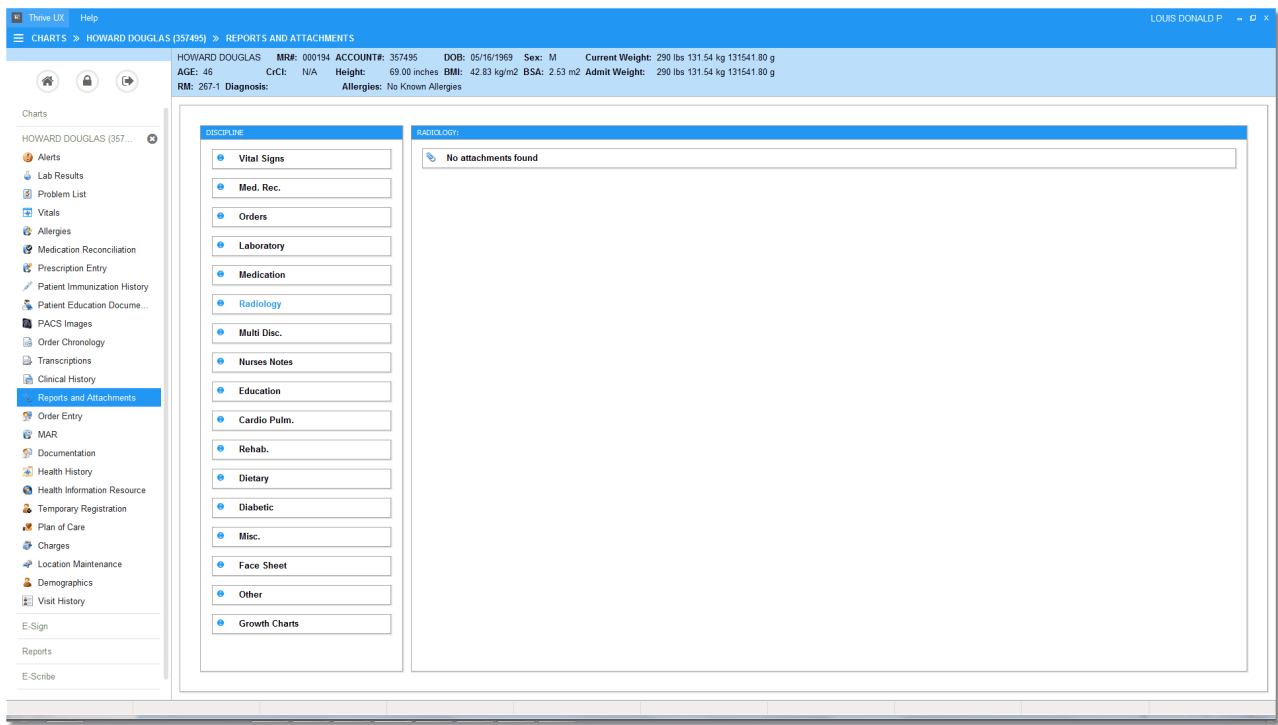
will display if data is not present in this area to be viewed.

Chapter 9 Radiology

9.1 Overview

This section will discuss the Radiology Transcriptions.

Select Updated ChartLink > Charts > Select Patient Account > Attachments > Radiology



Radiology

Radiology Transcriptions may be viewed from the Transcriptions icon located on the Updated ChartLink navigation panel.

Chapter 10 Multi Disciplinary

10.1 Overview

This section of the Updated ChartLink User Guide will discuss Multi Disciplinary documentation.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Multi Disciplinary**

The screenshot displays the 'Multi-Disciplinary' attachments interface. At the top, a blue header bar contains the text 'THINK LINK' and 'Help'. Below this, a navigation breadcrumb shows 'CHARTS > HOWARD DOUGLAS (357495) > REPORTS AND ATTACHMENTS'. The patient's name 'HOWARD DOUGLAS' is prominently displayed. To the right of the name, a summary of patient data is provided: MRN: 000194, ACCOUNT#: 357495, DOB: 05/16/1969, Sex: M, Current Weight: 290 lbs 131.54 kg 131541.80 g, AGE: 46, CrCl: N/A, Height: 69.00 inches, BMI: 42.83 kg/m2, BSA: 2.53 m2, Admit Weight: 290 lbs 131.54 kg 131541.80 g, RM: 267-1, Diagnosis: Allergies: No Known Allergies. A left-hand sidebar lists various medical categories, with 'Reports and Attachments' highlighted. The main content area is divided into two columns. The left column, titled 'DISCIPLINE', lists various medical disciplines with a blue circular icon next to each: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc. (highlighted), Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet, Other, and Growth Charts. The right column, titled 'MULTI-DISC...', lists various attachment types with a document icon next to each: Discharge Planner, Problem List, Problem Activities, Care Plan, Discharge Summary, Discharge Instructions, Transfer Form, Initial Interview, Initial Physical Assessment, Patient Progress Notes, and No attachments found.

Multi-Discipline

10.2 Discharge Planner

The Discharge Planner is a document that includes financial and environmental concerns, expectations for discharge, potential for activities of daily living, etc. for the patient.

Select Charts > Select Patient Account > Attachments > Multi Disciplinary > Discharge Planner

DISCIPLINE	MULTI DISC.
Vital Signs	Discharge Planner
Med. Rec.	Problem List
Orders	Problem Activities
Laboratory	Care Plan
Medication	Discharge Summary
Radiology	Discharge Instructions
Multi Disc.	Transfer Form
Nurses Notes	Initial Interview
Education	Initial Physical Assessment
Cardio Pulm.	Patient Progress Notes
Rehab.	No attachments found
Dietary	
Diabetic	
Misc.	
Face Sheet	
Other	
Growth Charts	

Discharge Planner

Data included on the Discharge Planner is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - Admitting Physician
 - Age, sex, & room number
 - Medical Record number
 - Drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Discharge Planner**
 - Up to 50 hospital-defined questions that can be answered to document a plan for the patient's discharge
 - The questions appear in bold text with the responses listed below.
 - Once charted, the date, time, name, and title of the person who charted the information will be reflected.

- **Signature Line**
 - A signature line is provided in lower right-hand corner of the report.
- The **Discharge Planner** report and the other reports listed in this section will display in Adobe Acrobat Reader format.

The following is a full display of the **Discharge Planner** report.

Evident Community Hospital

Discharge Planner

Printed: 07/21/14 08:54 Page 1 of 1

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

DISCHARGE PLANNER

Patient's Mental Status: Alert.	07/21/14 08:35 {BARBRA SMITH}
Activities of Daily Living: Good Self Care Potential.	07/21/14 08:35 {BARBRA SMITH}
Present Living Situation: Lives with others.	07/21/14 08:35 {BARBRA SMITH}
Present In Pts Living Environment: Air Conditioning, Heating, Electricity, Telephone, Fire Alarm. Indoor plumbing.	07/21/14 08:35 {BARBRA SMITH} 07/21/14 08:35 {BARBRA SMITH}
Anticipated Needs At Discharge: Prescription meds.	07/21/14 08:35 {BARBRA SMITH}
Patient Goals For Hospitalization: Increase mobility, Manage own care.	07/21/14 08:35 {BARBRA SMITH}
Social Support: Good family support, Supportive friends.	07/21/14 08:35 {BARBRA SMITH}
Anticipated Problems At Discharge: None.	07/21/14 08:35 {BARBRA SMITH}
Emotional Concerns Expressed By Patient: None.	07/21/14 08:35 {BARBRA SMITH}
Intended Destination On Discharge: Home.	07/21/14 08:35 {BARBRA SMITH}
Patient Will Require Assistance With: ADL, Treatments.	07/21/14 08:35 {BARBRA SMITH}
Anticipate Need For Financial Assistance: No.	07/21/14 08:35 {BARBRA SMITH}
Referrals: Discharge coordinator.	07/21/14 08:35 {BARBRA SMITH}
Concerns Expressed by Caregiver: None.	07/21/14 08:35 {BARBRA SMITH}
Patient Care Team Initial Plan: Pt shows good discharge potential, Physical Therapy.	07/21/14 08:35 {BARBRA SMITH}
Case Manager: Patient is progressing on pathway, Good education potential.	07/21/14 08:35 {BARBRA SMITH}
Pharmacy Patient reports compliance on home meds. Patient educated on medication therapy, Family assists w/medication program.	07/21/14 08:35 {BARBRA SMITH} 07/21/14 08:35 {BARBRA SMITH}
Nutritional Needs Assessment: Patient screened for Nutritional Needs. Patient demonstrated good comprehension.	07/21/14 08:35 {BARBRA SMITH} 07/21/14 08:35 {BARBRA SMITH}
Infection Control: No needs identified.	07/21/14 08:35 {BARBRA SMITH}
Physical Therapy: Evaluation Complete, Pt Identified as Fall Risk. Rehabilitation recommended for Discharge.	07/21/14 08:35 {BARBRA SMITH} 07/21/14 08:35 {BARBRA SMITH}
Cardiopulmonary: Weaning process initiated, Resp. treatments needed after discharge.	07/21/14 08:35 {BARBRA SMITH}
Plan Of Care Initiated by Care Team: Pain Management, Respiratory Tx.	07/21/14 08:35 {BARBRA SMITH}

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
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10.3 Problem List

The Problem List is a document that includes the patient's identified problems and goals and the current status of each. It can be used as a reference for the latest activity charted without having to review the Patient Progress Notes.

Select Charts > Select Patient Account > Attachments > Multi Disciplinary > Problem List

Problem List

Data included on the Problem List Report is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Problem List Box**
 - Shaded in gray, each box contains one problem order of up to 75 characters.

- **Problem List Activity**

- Displays last action taken to the problem and any comment that was added
- Next to the action it will display the date, time, and name of person entering the information
- Below the Problem and Action to the problem the goals related to that problem will be listed in order of entry and will be preceded with an asterisk
- Below all goals, report will display last action taken and any comments
- Next to all goals it will display the date, time, and name of person entering the information

- **Problem List Status**

- The status indicates the last action taken on the problem
- Appears directly below the comment
- The date and time will indicate the last time the problem was charted on
- Displays name and title of the person who charted on the problem or goals

- **Additional Notes**

- Problems that have been resolved will display on this report

The following is a full display of the **Problem List** report.

Evident Community Hospital		SMITH ELLA KATHERINE		AGE: 58 SEX: F	
PROBLEM LIST		RICHARD JOHNSON JR		ROOM:	
Printed: 7/21/14 at 10:11 Page 1 of 1		ALLERGIES: No Known Dru Peanuts		M/R#: 970015	
PROBLEM 1 Knowledge Deficit-Medication Therapy					
Addressed 07/21/14 0953 {BARBRA SMIT}					
* Pt/caregiver will acquire and use adequate knowledge regarding medications					
Resolved 07/21/14 0954 {BARBRA SMIT}					
* Pt/caregiver will seek out guidance if necessary					
Addressed 07/21/14 0954 {BARBRA SMIT}					
* Caregiver will provide educational materials for medications					
Addressed 07/21/14 0954 {BARBRA SMIT}					
PROBLEM 2 Safety-Impaired Walking					
PT Ordered					
Intervention 07/08/14 0600 {BARBRA SMIT}					
* Patient will regain maximum ambulatory function					
Verified 07/21/14 0925 {BARBRA SMIT}					
* Patient strengthens muscle tone and joint range of motion					
Verified 07/21/14 0925 {BARBRA SMIT}					
* Patient demonstrates safe use of assistive devices					
Verified 07/21/14 0925 {BARBRA SMIT}					
PATIENT: SMITH ELLA KATHERINE					
NUMBER: 357814		AGE: 58		SEX: F	
ROOM:		PAGE: 1			

10.4 Problem Activities

The Problem Activity report is a document that includes the patient's identified problems and goals as well as any activities charted on each while in Problem Mode within a flowchart. It displays the path of progression toward resolution from the beginning of stay.

Select **Charts** > **Select Patient Account** > **Attachments** > **Multi Disciplinary** > **Problem Activities**

DISCIPLINE	MULTI DISC. 1
☐ Vital Signs	☐ Discharge Planner
☐ Med. Rec.	☐ Problem List
☐ Orders	☒ Problem Activities
☐ Laboratory	☐ Care Plan
☐ Medication	☐ Discharge Summary
☐ Radiology	☐ Discharge Instructions
☐ Multi Disc.	☐ Transfer Form
☐ Nurses Notes	☐ Initial Interview
☐ Education	☐ Initial Physical Assessment
☐ Cardio Pulm.	☐ Patient Progress Notes
☐ Rehab.	☐ No attachments found
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Problem Activities

Data included on the Problem Activity Report is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Problem List Box**
 - Shaded in gray, each box contains one problem order of up to seventy-five characters
- **Problem Activity**
 - Just below the problem box will be list of goals with date, time, and name of person who entered the information

- Following the goals will be the action taken related to the problem contained in a box
 - All goals and goal activity will follow the last action to the problem box in chronological order
 - All entries will be preceded by the date, time, and name of person who entered the information
 - The last action taken will appear in bold with comments listed below
- **Problem List Status**
 - The status indicates the last action taken on the problem
 - Appears directly above the comment
 - The date and time will indicate the last time the problem was charted on
 - Displays name and title of the person who charted on the problem or goals

NOTE: *Problems that have been resolved will display on this report*

The following is a full display of the **Problem Activities** report.

Evident Community Hospital		SMITH ELLA KATHERINE		AGE: 58 SEX: F	
PROBLEM ACTIVITY		RICHARD JOHNSON JR		ROOM: 300-7	
From beginning of stay TO: 07/21/14 10:43 Page 1 of 1		ALLERGIES: No Known Dru Peanuts		M/R#: 970015	
Printed: 7/21/14 at 10:43					
PROB {BARBRA SMITH} PROBLEM 1 Knowledge Deficit-Medication Therapy					
07/21 09:47 GOAL {BARBRA SMITH} Pt/caregiver will acquire and use adequate knowledge regarding medications Pt/caregiver will seek out guidance if necessary Caregiver will provide educational materials for medications					
07/21 09:47 PROB {BARBRA SMITH} Verified					
07/21 09:53 PROB {BARBRA SMITH} Addressed Rank: 1					
07/21 09:54 GOAL {BARBRA SMITH} Caregiver will provide educational materials for medications Addressed					
07/21 09:54 GOAL {BARBRA SMITH} Pt/caregiver will acquire and use adequate knowledge regarding medications Resolved					
07/21 09:54 GOAL {BARBRA SMITH} Pt/caregiver will seek out guidance if necessary Addressed					
PROB {BARBRA SMITH} PROBLEM 2 Safety-Impaired Walking					
07/21 09:25 GOAL {BARBRA SMITH} Patient will regain maximum ambulatory function Patient strengthens muscle tone and joint range of motion Patient demonstrates safe use of assistive devices					
07/01 08:04 PROB {BARBRA SMITH} Addressed Rank: 1					
07/01 08:04 P/A {BARBRA SMITH} INITIAL/SHIFT ASSESSMENT Activity: Ambulated in hallway. Tolerated Activity: Fair. Hygiene: Oral Care.					
07/08 06:00 PROB {BARBRA SMITH} Intervention Rank: 1 PT Ordered					
07/08 06:00 P/A {BARBRA SMITH} INITIAL/SHIFT ASSESSMENT Gait: Moves all extremities well, Gait steady. Weakness: Right leg. Skeletal Assessment: Knee.					
07/21 09:25 PROB {BARBRA SMITH} Verified					
Nurse's signature: _____ (Last Page)					
PATIENT: SMITH ELLA KATHERINE		NUMBER: 357814		AGE: 58 SEX: F ROOM: 300-7 PAGE: 1	

10.5 Care Plan

The Care Plan is a document that includes information regarding the patient's plan of care.

Select **Charts** > **Select Patient Account** > **Attachments** > **Multi Disciplinary** > **Care Plan**

DISCIPLINE	MULTI DISC.
☐ Vital Signs	☐ Discharge Planner
☐ Med. Rec.	☐ Problem List
☐ Orders	☐ Problem Activities
☐ Laboratory	☒ Care Plan
☐ Medication	☐ Discharge Summary
☐ Radiology	☐ Discharge Instructions
☐ Multi Disc.	☐ Transfer Form
☐ Nurses Notes	☐ Initial Interview
☐ Education	☐ Initial Physical Assessment
☐ Cardio Pulm.	☐ Patient Progress Notes
☐ Rehab.	☐ No attachments found
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Care Plan

Data included on the Care Plan is outlined below:

- **Demographics box (located upper right-hand corner)**
 - Patient's name
 - Account number
 - Admitting physician
 - Age, sex, and room number
 - Any drug allergies documented through TruBridge
- **Medical Diagnosis and definition**
- **Nursing Diagnosis**
- **Goals**
- **Interventions**
- **Evaluation column**

The following is a full display of the **Care Plan** report.

Evident Community Hospital

CARE PLAN

Printed: 07/21/14 12:21 Page 1 of 1

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR ROOM: 300-7

ALLERGIES: No Known Dru M/R#: 970015

Peanuts

----- DATE CREATED 07/21/14 FILENAME: P357814

LTC PROBLEM	GOALS	INTERVENTIONS	DISCIPLINE
020407 ACTIVITIES OF DAILY LIVING	Resident will exhibit increased independence	Encourages resident to try ADL's that he/she is currently receiving assistance to complete. Assure resident that staff will assist if needed.	AST
OCCASIONAL	in some ADL's	Praise resident when new ADL is performed independently.	N
ASSISTANCE Direct	by_____.		NA
care staff			
believes resident			
is capable of			
increased			
independence in at			
least some ADL's.			

PATIENT: SMITH ELLA KATHERINE

NUMBER: 357814

AGE: 58

SEX: F

ROOM: 300-7

PAGE: 1

10.6 Discharge Summary

The Discharge Summary is a document that includes the patient's diet, current medications, other instructions, and any other information pertinent to the patient's discharge status. It is part of the patient's permanent chart. The Discharge Instructions are included in the Discharge Summary.

Select Charts > Select Patient Account > Attachments > Multi Disciplinary > Discharge Summary

Discharge Summary

Data included on the Discharge Summary is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number, and page number will appear along the bottom edge of the page.
- **Diet**
 - The patient's diet will display in the top left-hand corner of the report just below the header, preceded by the date, time, name and title of the person who charted the information.
- **Medications**
 - Description of the medications the patient is taking home

- Dosage, frequency, and instructions
- Date and time of last administration
- **Other Instructions**
 - Up to 30 hospital-defined questions that can be answered to detail the instructions given to the patient
 - The questions appear in bold text with the responses listed below.
 - Once charted, the date, time, name, and title of the person who charted the information will be reflected.
 - This section of instructions also prints on the Discharge Instructions report.
- **Other Information**
 - Up to thirty hospital-defined questions can be answered to describe other pertinent patient information
 - The questions appear in bold text with the responses listed below.
 - Once charted, the date, time, name, and title of the person who charted the information will be reflected.
 - This section of information will ONLY print on the Discharge Summary report.
- **Signature Lines**
 - Signature lines are located at the bottom of the report for the patient and the nurse providing the care.

The following is a full display of the **Discharge Summary** report.

Evident Community Hospital Discharge Summary Printed: 07/21/14 14:55 Page 1 of 2		SMITH ELLA KATHERINE AGE: 58 SEX: F RICHARD JOHNSON JR ROOM: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015												
07/21/14 13:36 {BARBRA SMITH}	DIET: REGULAR DIET.													
OTHER INSTRUCTIONS														
07/21/14 13:36 {BARBRA SMITH}	Food and Drug Interactions: Avoid caffeine, Avoid alcohol.													
07/21/14 13:36 {BARBRA SMITH}	Activities: Ambulate during cool hours, Gradually resume normal activities.													
07/21/14 13:36 {BARBRA SMITH}	General Instructions/Notify Physician: Elevated temperature, >101 degrees.													
07/21/14 13:36 {BARBRA SMITH}	Returned/Dispensed to Patient: Discharge instructions.													
07/21/14 13:36 {BARBRA SMITH}	Follow-up Appointment: Date and Time: 07/25/14 08:00 Dr. Williams													
07/21/14 13:36 {BARBRA SMITH}	Require Assistance with: Medications, Ambulation.													
OTHER INFORMATION														
07/21/14 13:36 {BARBRA SMITH}	Discharge to: Home.													
07/21/14 13:36 {BARBRA SMITH}	Mode of Transportation: Ambulatory.													
07/21/14 13:36 {BARBRA SMITH}	Accompanied by: Spouse/SO.													
07/21/14 13:36 {BARBRA SMITH}	Mental Status: Alert and oriented, Calm.													
07/21/14 13:36 {BARBRA SMITH}	Bowel/Bladder Status: No problem.													
07/21/14 13:36 {BARBRA SMITH}	Medication Instruction: Drug information sheet given, Given to: Spouse													
07/21/14 13:36 {BARBRA SMITH}	Pain Management: Understands plan of care.													
07/21/14 13:36 {BARBRA SMITH}	Education Focus Prior to Discharge: Fall prevention, Medications.													
07/21/14 13:36 {BARBRA SMITH}	Service upon Discharge: PT.													
07/21/14 13:36 {BARBRA SMITH}	Equipment upon Discharge: Walker.													
07/21/14 13:36 {BARBRA SMITH}	Continuing Needs Are Met by: Spouse, Patient.													
07/21/14 13:36 {BARBRA SMITH}	Temperature: Temp: 98.9													
07/21/14 13:36 {BARBRA SMITH}	Pain Status: Pain free x 2 hours, Discharged w/pain management.													
Patient's signature: _____ Nurse's signature: _____														
<table style="width: 100%; border-collapse: collapse;"><tr><td style="width: 20%;">PATIENT:</td><td style="width: 30%;">SMITH ELLA KATHERINE</td><td style="width: 20%;">NUMBER:</td><td style="width: 10%;">357814</td><td style="width: 10%;">AGE:</td><td style="width: 10%;">58</td><td style="width: 10%;">SEX:</td><td style="width: 10%;">F</td><td style="width: 10%;">ROOM:</td><td style="width: 10%;">300-7</td><td style="width: 10%;">PAGE:</td><td style="width: 10%;">1</td></tr></table>			PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1			

10.7 Discharge Instructions

The Discharge Instructions is a document that includes the patient's diet, current medications and any other instructions pertinent to the patient's discharge status. The Discharge Instructions are included in the Discharge Summary. This report is given to the patient at discharge.

Select **Charts** > **Select Patient Account** > **Attachments** > **Multi Disciplinary** > **Discharge Instructions**

DISCIPLINE	MULTI DISC.
☐ Vital Signs	☐ Discharge Planner
☐ Med. Rec.	☐ Problem List
☐ Orders	☐ Problem Activities
☐ Laboratory	☐ Care Plan
☐ Medication	☐ Discharge Summary
☐ Radiology	☒ Discharge Instructions
☐ Multi Disc.	☐ Transfer Form
☐ Nurses Notes	☐ Initial Interview
☐ Education	☐ Initial Physical Assessment
☐ Cardio Pulm.	☐ Patient Progress Notes
☐ Rehab.	☐ No attachments found
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Discharge Instructions

Data included on the Discharge Instructions is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Records number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Diet**
 - The patient's diet will display in the top left-hand corner of the report just below the header.

- **Medications**

- Description of the medications the patient is taking home
- Dosage, frequency, instructions
- Date and time of last administration

- **Other Instructions**

- Up to 30 hospital-defined questions that can be answered to detail the instructions given to the patient
- The questions appear in bold text with the responses listed below.
- Once charted, the date, time, name, and title of the person who charted the information will be reflected.
- This section of instructions also prints on the Discharge Summary report.

- **Signature Lines**

- Signature lines are located at the bottom of the report, for the patient and the nurse providing the care.

The following is a full display of the **Discharge Instructions** report.

Evident Community Hospital

Discharge Instructions

Printed: 07/21/14 15:02 Page 1 of 2

SMITH ELLA KATHERINE AGE: 58 SEX:

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

DIET:

REGULAR DIET.

Food and Drug Interactions:

Avoid caffeine, Avoid alcohol.

Activities:

Ambulate during cool hours, Gradually resume normal activities.

General Instructions/Notify Physician:

Elevated temperature, >101 degrees.

Returned/Dispensed to Patient:

Discharge instructions.

Follow-up Appointment:

Date and Time: 07/25/14 08:00

Dr. Williams

Require Assistance with:

Medications, Ambulation.

MEDICATIONS

Zocor 20MG Oral Tablet (Generic = Simvastatin)

Dose: 20 MILLIGRAMS

Continue

Route: ORAL

Frequency: Bed time

Prescription Detail: TAKE 20 MILLIGRAMS ORAL Bed time

Next Dose Due: TAKE AS DIRECTED

Lopressor 50MG Oral Tablet (Generic = Metoprolol)

Dose: 50 MILLIGRAMS

Continue

Route: ORAL

Frequency: Daily

Prescription Detail: TAKE 50 MILLIGRAMS ORAL Daily

Next Dose Due: TAKE AS DIRECTED

Xanax 1MG Oral Tablet (Generic = Alprazolam)

Dose: 1 MILLIGRAMS

Continue

Route: ORAL

Frequency: AS NEEDED EVERY 8HR

Reason for Medication: ANXIETY

Prescription Detail: TAKE 1 MILLIGRAMS ORAL AS NEEDED EVERY 8HR

Next Dose Due: TAKE AS DIRECTED

Glucophage 500MG Oral Tablet (Generic = Metformin)

Dose: 500 MILLIGRAMS

Continue

Route: ORAL

Frequency: Daily

Prescription Detail: TAKE 500 MILLIGRAMS ORAL Daily

Next Dose Due: 07/21/2014 3:00 PM

Zolpidem 5MG Oral Tablet

Dose: 5 Milligrams

New

Route: ORAL

Frequency: ONE TIME

Prescription Detail: TAKE 5 Milligrams ORAL X1

Next Dose Due: 07/21/2014 7:00 PM

Patient's signature: _____

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:		ROOM:	300-7	PAGE:	1
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10.8 Transfer Form

The Patient Transfer Form is a document that includes the patient's demographics, transferring and receiving facilities, medical information, active pharmacy orders, transfer consent, request or refusal, and other information pertinent for the transfer process.

Select Charts > Select Patient Account > Attachments > Multi Disciplinary > Transfer Form

Transfer Form

Data included on the Patient Transfer Form is outlined below:

- **Patient Demographic Information**
 - Patient's name, address, sex, birth date and religion
 - Insurance company, policy number and address
 - Dates of admission, discharge and transfer
 - Facility transferring FROM and TO
 - In addition to the above mentioned information, a single line containing the patient's name, medical record number, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Patient Medical Information** - Displays the most recent:
 - Temperature
 - Pulse
 - Respirations
 - Blood Pressure
 - Allergies
 - Oxygen Saturation

- Oxygen Delivery
- Weight and Height
- Diet

The following is a full display of the **Transfer Form** report.

Evident Community Hospital
Patient Transfer Form

Printed: 7/21/14 at 15:28

Page 1 of 3

Patient Demographic Information

Patient name: SMITH ELLA KATHERINE
 Address: 6600 WALL ST
 MOBILE AL 36695
 Sex: F
 Birthdate: 10/31/1955
 Religion: BAPTIST

Insurance company: BLUE CROSS-I/P
 Policy#: PPL5454518744
 Address: 450 RIVERCHASE PKWY EAST
 BIRMINGHAM AL 35298

Date of admission: 05/16/14

Date of discharge: 07/21/14

Date of transfer: 07/21/14

Facility transferring FROM:

CPSI Community Health System
 6600 Wall Street
 Mobile AL 36695

Facility transferring TO:

Springhill Memorial Hospital
 123 Main Street
 Mobile AL 36695

Patient Medical Information

Temp: 98.9 ORAL 07/21/14 15:28 {BARBRA SMIT} O2 L/M: 2 07/07/14 14:34 {13 E}
 Pulse: 60 RADIAL 07/21/14 15:28 {BARBRA SMIT} FIO2:
 Resp: 18 07/21/14 15:28 {BARBRA SMIT} O2 SAT: 100 07/21/14 15:28 {BARBRA SMIT}
 B/P: 135 /85 LYING 07/21/14 15:28 {BARBRA SMIT} Method: O2 Cannula 07/07/14 14:34 {13 E}
 Weight: 166 lb 07/08/14 10:00 {13 E}
 75.3 kg 75296.3 gm
 Allergies: Peanuts No Known Drug Height: 64 Inches
 Diet: REGULAR DIET

Active Pharmacy Orders

Start date	Description	dose/schedule	Last given
06/24 11:09 E13	ATENOLOL {TENORMIN} PO	50 MG DAILY	
CHECK PULSE BEFORE ADMINISTRATION, IF <50 HOLD AND CALL MD ORAL			
DAI = 0900			
06/24 11:09 E13	METFORMIN{GLUCOPHAGE} TAB	500 MILLIGRAMS 1 TIME DAILY (QD)	
GIVE WITH MEALS MAX DOSE= 2550 MG/DAY ORAL			
1 T = 0800			
06/24 11:09 E13	XANAX {ALPRAZOLAM} 2 MG TABLET	2 MG PRN Q4H (AS NEEDED)	
ORAL			
06/24 11:09 E13	ROSUVASTATIN{CRESTOR} TAB	20 MG DAILY	
ORAL			
DAI = 0900			

Medications continued...
 Signatures on last page...

PATIENT:	SMITH ELLA KATHERINE	M/R#:	970015	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
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Evident Community Hospital

Patient Transfer Form

Printed: 7/21/14 at 15:28

Page 2 of 3

Active Pharmacy Orders				Last given
Start date	Description	dose/schedule		
07/17 10:45 E13	ZOLPIDEM {AMBIEN} 5 MG TAB	5 MG	X1	
	FOR SLEEP		ORAL	
	X1 = One time only			
07/18 09:51 BS	MORPHINE PCA{WATCH}INJ	1 EA	PRN	
			INTRAVENOUS	
07/21 14:38 BS	ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG	PRN	
			ORAL	
07/17 11:17 E13	D5W 500ML/HEPARIN 25,000 UNITS	100 ml/hr		
	D5W 1 L/HEPARIN 25,000 UN			
	=			
	D5W	1000 ML		07/17 12:17
	HEPARIN INJ	25000 UNITS		07/17 12:17
07/17 13:19 E13	ROCEPHIN 1 GM /D5W 50ML	100 ml/hr	Q24H	
	ROCEPHIN 1GM/D5W 50 ML			
	Q24 =			
	CEFTRIAXONE{ROCEPHIN} VL	1 GM		
	D5W {5% DEXTROSE IN WATER}	50 ML		

REASON FOR TRANSFER: Continued need for Rehab.

Special Procedures Scheduled At Transfer Facility: Joint Replacement Surgery.

Method Of Transport: Ambulatory.

Status of Pt: Stable.

Ambulatory Status: With assistance.

Time Of Transfer: 15:00

Hospital/Facility Notified: 14:30

Transfer consent

I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician and/or my attending physician who has recommended that I be transferred to the service of Dr. Williams at Springhill Memorial Hospital. The potential benefits of such transfer, the potential risks associated with such transfer and the probable risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.

Signatures on last page...

PATIENT:	SMITH ELLA KATHERINE	M/R#: 970015	NUMBER: 357814	AGE: 58	SEX: F	ROOM: 300-7	PAGE: 2
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10.9 Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning.

Select the multidisciplinary chart type from the lower split screen to display the desired **Initial Interview**.

Select **Charts > Select Patient Account > Attachments > Multi Disciplinary > Initial Interview**

Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning.

Data included on the Initial Interview is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - The admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Patient Information Box**

- Patient Name
- Birth date and age
- Sex
- Marital Status
- Occupation
- Religion
- Admitting Diagnosis
- Admitting Physician
- Consulting Physician
- Emergency contact information:
 - o Name
 - o Relation
 - o Address
 - o Phone

The following is a full display of the **Initial Interview** report.

Evident Community Hospital		SMITH ELLA KATHERINE		AGE: 58 SEX: F																													
INITIAL INTERVIEW		RICHARD JOHNSON JR		ROOM: 300-7																													
Printed: 07/22/14 09:40		Page 1 of 2		M/R#: 970015																													
Physical Therapy																																	
<table border="1"><thead><tr><th>Patient Name</th><td>SMITH ELLA KATHERINE</td></tr><tr><th>Birth date</th><td>10/31/1955 58</td></tr><tr><th>Sex</th><td>F</td></tr><tr><th>Marital Status</th><td>M</td></tr><tr><th>Occupation</th><td>OFFICE MANAGER</td></tr><tr><th>Religion</th><td>BAPTIST</td></tr><tr><th>Admit. Diag.</th><td></td></tr></thead></table>		Patient Name	SMITH ELLA KATHERINE	Birth date	10/31/1955 58	Sex	F	Marital Status	M	Occupation	OFFICE MANAGER	Religion	BAPTIST	Admit. Diag.		<table border="1"><thead><tr><th>IN AN EMERGENCY</th><td></td></tr><tr><th>Name</th><td>JOHNSON DOROTHY M</td></tr><tr><th>Relation</th><td></td></tr><tr><th>Address</th><td>6601 VAUGHAN CT</td></tr><tr><th>Phone</th><td>251/679-9776</td></tr><tr><th>Admitting Physician</th><td>RICHARD JOHNSON JR</td></tr><tr><th>Second Physician</th><td></td></tr></thead></table>		IN AN EMERGENCY		Name	JOHNSON DOROTHY M	Relation		Address	6601 VAUGHAN CT	Phone	251/679-9776	Admitting Physician	RICHARD JOHNSON JR	Second Physician			
Patient Name	SMITH ELLA KATHERINE																																
Birth date	10/31/1955 58																																
Sex	F																																
Marital Status	M																																
Occupation	OFFICE MANAGER																																
Religion	BAPTIST																																
Admit. Diag.																																	
IN AN EMERGENCY																																	
Name	JOHNSON DOROTHY M																																
Relation																																	
Address	6601 VAUGHAN CT																																
Phone	251/679-9776																																
Admitting Physician	RICHARD JOHNSON JR																																
Second Physician																																	
Physical Therapy Cognitive Eval: General Orientation-Good, Good Teaching Potential.		07/22/14 09:34 {BARBRA SMITH}																															
Pre-Activity Assessment: Regular Exercise, Walks 3x/wk for 30mins.		07/22/14 09:34 {BARBRA SMITH}																															
Household Activities Sweeping, Vacuuming, Dishwashing, Laundry, Cooking.		07/22/14 09:34 {BARBRA SMITH}																															
Occupation _CPSI _.		07/22/14 09:34 {BARBRA SMITH}																															
Home Assessment: Large Yard, 1-level.		07/22/14 09:34 {BARBRA SMITH}																															
Functional Mobility: Needs Asst, Stand/Balance.		07/22/14 09:34 {BARBRA SMITH}																															
Assistive Devices at Home: Walker.		07/22/14 09:34 {BARBRA SMITH}																															
Structural Assessment on Admission-Upper Extremities Sensation Intact.		07/22/14 09:34 {BARBRA SMITH}																															
Structural Assessment on Admission-Lower Extremities Sensation Intact.		07/22/14 09:34 {BARBRA SMITH}																															
Signature: _____																																	
PATIENT: SMITH ELLA KATHERINE		NUMBER: 357814		AGE: 58 SEX: F ROOM: 300-7 PAGE: 1																													

10.10 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Select the multidisciplinary chart type from the lower split screen to display the desired **Initial Physical Assessment**.

Select **Charts** > **Select Patient Account** > **Attachments** > **Multi Disciplinary** > **Initial Physical Assessment**

Initial Physical Assessment

Data included on the Initial Physical Assessment Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Initial Vital Signs**

- Temperature (including site)
- Pulse (including site)
- Respiration
- Blood Pressure (including posture and extremity)
- Weight
- The date, time, name and title of the person who charted the information.

- **Assessment Categories** - Each assessment will be preceded by the appropriate heading below:

- Metabolic/Integument
- Gastrointestinal
- Musculoskeletal
- Pain
- Wound
- Pulmonary
- Genitourinary
- Neurological
- Psychosocial
- Cardiovascular
- Reproductive
- Injury Risk
- Intravenous

The following is a full display of the **Initial Physical Assessment Report**.

Evident Community Hospital

INITIAL PHYSICAL ASSESSMENT Physical Therapy

Printed: 7/22/14 at 10:06

Page 1 of 1

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Initial Vital Signs

Temp:	100.1	ORAL	06/23/14 08:00 {13 E}
Pulse:	66	RADIAL	06/23/14 08:00 {13 E}
Resp:	19		06/23/14 08:00 {13 E}
B/P:	155/85	LYING	06/23/14 08:00 {13 E}
O2 L/M:	2		07/07/14 14:34 {13 E}
FiO2:			
O2 SAT:	100		06/23/14 08:00 {13 E}
Method:	O2	Cannula	07/07/14 14:34 {13 E}
Weight:	166 lbs		06/26/14 10:00 {13 E}
	75.3 kg	75296.3 gm	

Type of Therapy Performed:

07/22/14 09:36 {BARBRA SMIT} ROM Exercise, Gait Training.

Tolerance of Therapy

07/22/14 09:36 {BARBRA SMIT} good.

Gait:

07/22/14 09:36 {BARBRA SMIT} steady.

Coordination:

07/22/14 09:36 {BARBRA SMIT} fair.

Hand Grasps:

07/22/14 09:36 {BARBRA SMIT} right side weakness.

Leg Strength:

07/22/14 09:36 {BARBRA SMIT} right side weakness.

Skin Color:

07/22/14 09:36 {BARBRA SMIT} pink.

Nail Color:

07/22/14 09:36 {BARBRA SMIT} Pink.

Capillary Refill:

07/22/14 09:36 {BARBRA SMIT} less than 3 minutes.

Temperature of Extremity:

07/22/14 09:36 {BARBRA SMIT} warm.

Edema:

07/22/14 09:36 {BARBRA SMIT} none.

Sensations:

07/22/14 09:36 {BARBRA SMIT} c/o numbness.

Pulses:

07/22/14 09:36 {BARBRA SMIT} radial, strong.

Fracture:

07/22/14 09:36 {BARBRA SMIT} right, wrist.

Muscle Spasms:

07/22/14 09:36 {BARBRA SMIT} right, leg.

Arthritis:

07/22/14 09:36 {BARBRA SMIT} right, knee, left, knee, spine.

Signature: _____ Validated by: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
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10.11 Patient Progress Notes

The Patient Progress Notes is a document that includes information from most POC applications charted during a given time frame. The Initial Interview and Initial Physical Assessment are not included in the Patient Progress Notes.

Select the date from the lower split screen to display the desired **Patient Progress Note**.

Select **Charts** > **Select Patient Account** > **Attachments** > **Multi Disciplinary** > **Patient Progress Notes**

Patient Progress Notes

Data included on the Patient Progress Notes is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's Name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Entries**

- Each entry will fall under the appropriate application heading.
- The heading will be highlighted with bold text and preceded by the following:
 - o Time the entry was charted
 - o The name and title of the individual who entered the information
 - o Two to three character code indicating the application in which the entry was charted

- Application codes and descriptions:

- (P/A)-Physical Assessment
- (MED)-Pharmacy
- (MO)-Medical Order
- (F/S)-Floor Stock
- (NSS)-Shift Summary
- (EDU)-Education
- (BSU)-Diabetic Record
- (NAC)-Nursing Activities
- (PCA)-PCA Medications
- (VS)-Vital Signs
- (ORD)-Ancillary Orders
- (PL)-Problem List

- **Signature Line**

- An optional signature line is provided at the bottom of this report for the nurse primarily responsible for the patient's care.

The following is a display of the **Patient Progress Notes**.

Evident Community Hospital		SMITH ELLA KATHERINE AGE: 58 SEX: F	
PATIENT PROGRESS NOTES		RICHARD JOHNSON JR ROOM: 300-7	
FOR: 07/22/14 00:00 TO: 07/22/14 10:20 Page 1 of 1		ALLERGIES: No Known Dru Peanuts M/R#: 970015	
Printed: 7/22/14 at 10:20			
PHYSICAL THERAPY			
07/22/14			
10:17 P/A (BARBRA SMITH)	Physical Therapy Type of Therapy Performed: ROM Exercise, Gait Training. Tolerance of Therapy: endurance to therapy, good. Gait: unsteady. Coordination: fair. Hand Grasps: equal, strong. Leg Strength: right side weakness. Skin Color: pink. Nail Color: Pink. Capillary Refill: less than 3 minutes. Temperature of Extremity: warm. Edema: none. Sensations: c/o numbness. Pulses: radial, strong. Fracture: right, wrist. Muscle Spasms: right, leg. Arthritis: knee, spine.		
Signature: _____ (Last Page)			
PATIENT:	SMITH ELLA KATHERINE	NUMBER: 357814	AGE: 58 SEX: F ROOM: 300-7 PAGE: 1

10.12 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Multi Disc > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

MULTI DISC.

Discharge Planner

Problem List

Problem Activities

Care Plan

Discharge Summary

Discharge Instructions

Transfer Form

Initial Interview

Initial Physical Assessment

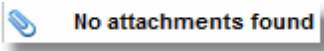
Patient Progress Notes

No attachments found

Multi Disciplinary - Attachments

Deleted items will display  .

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 11 Nurses Notes

11.1 Overview

This section of the Updated ChartLink User Guide will discuss Nurses Notes.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Nurses Notes**

DISCIPLINE	NURSES NOTES
☐ Vital Signs	Initial Interview
☐ Med. Rec.	Initial Physical Assessment
☐ Orders	Patient Progress Notes
☐ Laboratory	24 Hour Summary
☐ Medication	Shift Summary
☐ Radiology	No attachments found
☐ Multi Disc.	
☒ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Nurses Notes

11.2 Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning.

Select **Charts** > **Select Patient Account** > **Attachments** > **Nurses Notes** > **Initial Interview**

Initial Interview

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - The admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Patient Information Box**
 - Patient Name
 - Birth date and age
 - Sex
 - Marital Status
 - Occupation
 - Religion
 - Admitting Diagnosis
 - Admitting Physician
 - Consulting Physician

- Emergency contact information:
 - o Name
 - o Relation
 - o Address
 - o Phone

The following is a full display of the **Initial Interview** report.

Evident Community Hospital**INITIAL INTERVIEW**

Printed: 07/22/14 11:32

Page 1 of 3

SMITH ELLA KATHERINE AGE: 58 SEX: F**RICHARD JOHNSON JR**

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient Name	SMITH ELLA KATHERINE	IN AN EMERGENCY	
Birth date	10/31/1955 58	Name	JOHNSON DOROTHY M
Sex	F	Relation	
Marital Status	M	Address	6601 VAUGHAN CT
Occupation	OFFICE MANAGER	Phone	251/679-9776
Religion	BAPTIST	Admitting Physician	RICHARD JOHNSON JR
Admit. Diag.		Second Physician	

PERTINENT HISTORY**Dietary Consult {Select All that Apply}:**

Nutritional Supplement use/type:. No consult necessary.

06/23/14 12:22 {13 E}

Home Medications:

Glucophage 500MG Oral Tablet

Dose: 500 MILLIGRAMS

Freq: Daily

Route: ORAL

Last Dose:

Compliant: Need Education:

Previous Home Med

Source: Patient

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA

7/21/14 13:44

Lopressor 50MG Oral Tablet

Dose: 50 MILLIGRAMS

Freq: Daily

Route: ORAL

Last Dose:

Compliant: Need Education:

Previous Home Med

Source: Spouse

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA

7/21/14 13:44

Xanax 1MG Oral Tablet

Dose: 1 MILLIGRAMS

Freq: AS NEEDED EVERY 8HR

Route: ORAL

Last Dose: 6/23/14 08:00 AM

Compliant: Y Need Education:

Source: patient

Indication: ANXIETY

Physician: RICHARD JOHNSON JR

Confirmed: SMITH BARBARA

7/21/14 13:44

Zocor 20MG Oral Tablet

Dose: 20 MILLIGRAMS

Freq: Bed time

Route: ORAL

Last Dose:

Compliant: Need Education:

Previous Home Med

Source: Spouse

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA

7/21/14 13:45

DISCHARGE PLANNER**Patient's Mental Status:**

Some or all of the above pertinent history information was originally charted on 02/18/13, Account number 357491 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
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Evident Community Hospital

INITIAL INTERVIEW

Printed: 07/22/14 11:32

Page 2 of 3

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient's Mental Status:

Alert.

07/21/14 08:35 {BARBRA SMITH}

Activities of Daily Living:

Good Self Care Potential.

07/21/14 08:35 {BARBRA SMITH}

Present Living Situation:

Lives with others.

07/21/14 08:35 {BARBRA SMITH}

Present In Pts Living Environment:

Air Conditioning, Heating, Electricity, Telephone, Fire Alarm.

07/21/14 08:35 {BARBRA SMITH}

Indoor plumbing.

07/21/14 08:35 {BARBRA SMITH}

Anticipated Needs At Discharge:

Prescription meds.

07/21/14 08:35 {BARBRA SMITH}

Patient Goals For Hospitalization:

Increase mobility, Manage own care.

07/21/14 08:35 {BARBRA SMITH}

Social Support:

Good family support, Supportive friends.

07/21/14 08:35 {BARBRA SMITH}

Anticipated Problems At Discharge:

None.

07/21/14 08:35 {BARBRA SMITH}

Emotional Concerns Expressed By Patient:

None.

07/21/14 08:35 {BARBRA SMITH}

Intended Destination On Discharge:

Home.

07/21/14 08:35 {BARBRA SMITH}

Patient Will Require Assistance With:

ADL, Treatments.

07/21/14 08:35 {BARBRA SMITH}

Anticipate Need For Financial Assistance:

No.

07/21/14 08:35 {BARBRA SMITH}

Referrals:

Discharge coordinator.

07/21/14 08:35 {BARBRA SMITH}

Concerns Expressed by Caregiver:

None.

07/21/14 08:35 {BARBRA SMITH}

Patient Care Team Initial Plan:

Pt shows good discharge potential, Physical Therapy.

07/21/14 08:35 {BARBRA SMITH}

Case Manager:

Patient is progressing on pathway, Good education potential.

07/21/14 08:35 {BARBRA SMITH}

Pharmacy

Patient reports compliance on home meds.

07/21/14 08:35 {BARBRA SMITH}

Patient educated on medication therapy, Family assists w/medication program.

07/21/14 08:35 {BARBRA SMITH}

Nutritional Needs Assessment:

Patient screened for Nutritional Needs.

07/21/14 08:35 {BARBRA SMITH}

Patient demonstrated good comprehension.

07/21/14 08:35 {BARBRA SMITH}

Infection Control:

No needs identified.

07/21/14 08:35 {BARBRA SMITH}

Physical Therapy:

Evaluation Complete, Pt Identified as Fall Risk.

07/21/14 08:35 {BARBRA SMITH}

Rehabilitation recommended for Discharge.

07/21/14 08:35 {BARBRA SMITH}

Cardiopulmonary:

Weaning process initiated, Resp. treatments needed after discharge.

07/21/14 08:35 {BARBRA SMITH}

Plan Of Care Initiated by Care Team:

Pain Management, Respiratory Tx.

07/21/14 08:35 {BARBRA SMITH}

Some or all of the above pertinent history information was originally charted on 02/18/13, Account number 357491 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

Nurse's signature:_____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	2
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11.3 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Select **Charts** > **Select Patient Account** > **Attachments** > **Nurses Notes** > **Initial Physical Assessment**

DISCIPLINE	NURSES NOTES
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ Patient Progress Notes
☐ Laboratory	☐ 24 Hour Summary
☐ Medication	☐ Shift Summary
☐ Radiology	☐ No attachments found
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Initial Physical Assessment

Data included on the Initial Physical Assessment Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Initial Vital Signs**
 - Temperature (including site)
 - Pulse (including site)
 - Respiration
 - Blood Pressure (including posture and extremity)
 - Weight

- The date, time, name and title of the person who charted the information.

Assessment Categories

Each assessment will be preceded by the appropriate heading below:

• Metabolic/Integument	• Pulmonary	• Cardiovascular
• Gastrointestinal	• Genitourinary	• Reproductive
• Musculoskeletal	• Neurological	• Injury Risk
• Pain	• Psychosocial	• Intravenous
• Wound		

The following is a full display of the **Initial Physical Assessment Report**.

Evident Community Hospital

INITIAL PHYSICAL ASSESSMENT

Printed: 7/22/14 at 11:55

Page 1 of 1

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Initial Vital Signs

Temp:	100.1	ORAL	06/23/14 08:00 {13 E}
Pulse:	66	RADIAL	06/23/14 08:00 {13 E}
Resp:	19		06/23/14 08:00 {13 E}
B/P:	155/85	LYING	06/23/14 08:00 {13 E}
O2 L/M:	2		07/07/14 14:34 {13 E}
FiO2:			
O2 SAT:	100		06/23/14 08:00 {13 E}
Method:	O2 Cannula		07/07/14 14:34 {13 E}
Weight:	166 lbs		06/26/14 10:00 {13 E}
	75.3 kg	75296.3 gm	

INITIAL/SHIFT ASSESSMENT

07/07/14 14:34 {13 E}	Quality of Respirations: Even-regular.
07/07/14 14:34 {13 E}	Breath Sounds: Crackles.
07/07/14 14:34 {13 E}	Cough/Consistency: Productive sputum.
07/07/14 14:34 {13 E}	Respiratory Nursing Interventions: Sputum specimen collected to lab.

Nurse's signature: _____ Validated by: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
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11.4 Patient Progress Notes

The Patient Progress Notes is a document that includes information from most POC applications charted during a given time frame. The Initial Interview and Initial Physical Assessment are not included in the Patient Progress Notes. Documentation from the multi-disciplinary applications prints to the report, also. It is printed at the end of shift and may be signed by the nurse assigned to the patient.

Select the desired date revealed in the lower split screen to display the appropriate Patient Progress Note.

Select **Charts > Select Patient Account > Attachments > Nurses Notes > Patient Progress Notes**

DISCIPLINE	NURSES NOTES
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☒ Patient Progress Notes
☐ Laboratory	☐ 24 Hour Summary
☐ Medication	☐ Shift Summary
☐ Radiology	☐ No attachments found
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Patient Progress Notes

Data included on the Patient Progress Notes is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's Name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Entries**

- Each entry will fall under the appropriate application heading.
- The heading will be highlighted with bold text and preceded by the following:
 - o Time the entry was charted
 - o The name and title of the individual who entered the information
 - o Two to three character code indicating the application in which the entry was charted

Application codes and descriptions:

(P/A)-Physical Assessment	(NSS)-Shift Summary	(PCA)-PCA Medications
(MED)-Pharmacy	(EDU)-Education	(VS)-Vital Signs
(MO)-Medical Order	(BSU)-Diabetic Record	(ORD)-Ancillary Orders
(F/S)-Floor Stock	(NAC)-Nursing Activities	(PL)-Problem List

- **Signature Line**

- An optional signature line is provided at the bottom of this report for the nurse primarily responsible for the patient's care.

The following is a full display of the **Patient Progress Notes**.

Evident Community Hospital		SMITH ELLA KATHERINE AGE: 58 SEX: F RICHARD JOHNSON JR ROOM: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015	
PATIENT PROGRESS NOTES			
FOR: 07/22/14 00:00 TO: 07/22/14 24:00 Page 1 of 2			
		Printed: 7/23/14 at 08:11	
VITAL SIGNS			
07/22/14			
09:00 VS (BARBRA SMITH)	Blood Pressure 135/80 LYING O2 Sat 99 % Respiration 17 Pulse 55 RADIAL Temperature 99.1 ORAL	R ARM	
PHYSICAL ASSESSMENT			
09:00 P/A (BARBRA SMITH)	INITIAL/SHIFT ASSESSMENT Full Reassessment Completed: No changes from previously documented as. Activity: Ambulated in hallway, Assisted by: B Smith, RN Tolerated Activity: Fair. Hygiene: Unassisted, Shower, Oral Care. Nurse's Notes: Notes: Initiated PT this morning with good results. Patient is receptive to all medications and respiratory treatments. Family is at bedside for much of the day.		
PLAN OF CARE {PROBLEM LIST}			
09:36 PL (BARBRA SMITH)	PROBLEM 2 Safety-Impaired Walking Addressed		
10:17 PL (BARBRA SMITH)	PROBLEM 2 Safety-Impaired Walking Addressed		
PHYSICAL THERAPY			
10:17 P/A (BARBRA SMITH)	Physical Therapy Type of Therapy Performed: ROM Exercise, Gait Training. Tolerance of Therapy endurance to therapy, good. Gait: unsteady. Coordination: fair. Hand Grasps: equal, strong. Leg Strength: right side weakness. Skin Color: pink. Nail Color: Pink. Capillary Refill: less than 3 minutes. Temperature of Extremity: warm. Edema: none. Sensations: c/o numbness. Pulses: radial, strong.		
Nurse's signature: _____			
PATIENT: SMITH ELLA KATHERINE NUMBER: 357814 AGE: 58 SEX: F ROOM: 300-7 PAGE: 1			

Evident Community Hospital

SMITH ELLA KATHERINE

AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

PATIENT PROGRESS NOTES

FOR: 07/22/14 00:00 TO: 07/22/14 24:00 Page 2 of 2

Printed: 7/23/14 at 08:11

PHYSICAL THERAPY

Fracture: right, wrist.

Muscle Spasms: right, leg.

Arthritis: knee, spine.

Nurse's signature: (Last Page)

PATIENT: SMITH ELLA KATHERINE

NUMBER: 357814

AGE: 58

SEX: F

ROOM: 300-7

PAGE: 2

- **Included:**

- The **Physician Entered Orders Report** will automatically be included at the end of Patient Progress Notes. The report will include all verified medication, ancillary and nursing orders placed for the patient via physician order entry. This report will also include Verbal and Telephone Orders that are entered via Point of Care Order Entry.

Data included in the Physicians Entered Order Report is outlined below:

- **Patient Information**

- Patient's name
- Account number
- Medical record number
- Date of Birth
- Age
- Sex
- Room number
- Any drug allergies documented through TruBridge

- **Medication Information**

- Date/Time of order placement
- Medication description, dosage, frequency, route, duration, priority and instructions*
- Flow rate and components for IV medications
- Physician's electronic signature with credentials

NOTE: *Renewed medication orders should display the instructions and/or comments from the original order.*

- **Ancillary Order Information**

- Date/Time of order placement
- Ancillary order description, quantity, frequency, duration, days and priority
- Physician's electronic signature with credentials

- **Nursing Order Information**

- Date/Time of order placement
- Description of Nursing Order
- An Action, if taken (Discontinue)
 - Renewed nursing orders will display the instructions and/or comments from the original order
- Physician's electronic signature with credentials

The following is a full display of the **Physician Entered Orders Report**

ChartLink Physician Entered Orders
Acknowledged:071714 0000 - 071714 2400
Run Date/Time: 07/23/14 08:19

SMITH ELLA KATHERINE
Account: 357814
MR#: 970015
Allergies: No Known Drug Allergies, Peanuts

Age: 58
Sex: F
Room: 300-7

ORDER Dt/Tm	SCH Dt/Tm	Medication	Dose/ Freq	Route	Duration	Priority
06/24/14 11:10	06/24/14 11:09	METFORMIN(GLUCOPHAGE) TAB : 500 MG	500 MILLIGRAMS 1 TIME DAILY (QD)	PO		ROUTINE
		GIVE WITH MEALS	MAX DOSE= 2550 MG/DAY		RICHARD C JOHNSON JR MD	
			Signed: 06/24/14 11:10	RICHARD C JOHNSON JR		

ORDER Dt/Tm	SCH Dt/Tm	Medication	Dose/ Freq	Route	Duration	Priority
07/17/14 10:46	07/17/14 10:45	ZOLPIDEM (AMBIEN) 5 MG TAB	5MG	PO	1 DOSES	ROUTINE
FOR SLEEP			X1	RICHARD C JOHNSON JR		
				MD		
			Signed: 07/17/14 10:46	RICHARD C JOHNSON JR		

ORDER Dt/Tm	SCH Dt/Tm	Medication	Dose/ Freq	Rate	Route	Duration	Priority
07/17/14 11:18	07/17/14 11:17	D5W 500ML/HEPARIN 25,000 UNITS		100 ML/HR	INTRAVEN		ROUTINE
	Add: D5W:1000 ML	2B0064 IV SOL	1000ML				
	Add: HEPARIN INJ : 5,000 UNIT/ML		25000UNITS				
(Order Changed)		(Order Changed)					
		D5W 500ML/HEPARIN 25,000 UNITS		100 ml/hr	INTRAVEN		
	Add: D5W:1000 ML	2B0064 IV SOL	1000 ML				
	Add: HEPARIN INJ : 5,000 UNIT/ML		25000 UNITS				
			Changed by: 99/99/99 00:00				
	D5W 1 L/HEPARIN 25,000 UN				RICHARD C JOHNSON JR MD		
			Signed: 07/17/14 11:18 RICHARD C JOHNSON JR				

ORDER Dt/Tm	SCH Dt/Tm	Medication	Dose/ Freq	Rate	Route	Duration	Priority
07/17/14 13:20	07/17/14 13:19	ROCEPHIN 1 GM /D5W 50ML		100 ML/HR	IVPB		ROUTINE
	Add: CEFTRIAXONE(ROCEPHIN) VL : 1 GRAM		Q24H				
	Add: D5W (5% DEXTROSE IN WATER): 50 ML		1GM				
(Order Changed)	-----						(Order Changed)
		ROCEPHIN 1 GM /D5W 50ML		100 ML/HR	IVPB		
			Q24H				
	Add: CEFTRIAXONE(ROCEPHIN) VL : 1 GRAM		1 GM				
	Add: D5W (5% DEXTROSE IN WATER): 50 ML		50 ML				

11.5 24 Hour Summary

The 24-Hour Summary is a document that includes specific patient information charted within the previous 24 hours from the minute it is printed on the system. This worksheet provides both nurses and physicians details of the patient's condition and plan of care. It is one of the primary tools used by nursing to conduct an organized and timely shift change. It is one of the reports preferred by physicians to use as reference while making rounds.

Select **Charts** > **Select Patient Account** > **Attachments** > **Nurses Notes** > **24 Hour Summary**

24 Hour Summary

Data included on the 24 Hour Summary Format A is outlined below:

- **Demographics Box** (upper right-hand corner)
 - Patient's name
 - Account number
 - Admitting and/or consulting physician
 - Age, sex, & room number
 - Medical Record number
 - Drug allergies documented through TruBridge
- **Vital Signs**
 - Pulse and Blood Pressure, displayed either graphically or numerically in one hour intervals
 - Temperature and respirations displayed numerically in one hour intervals

- **Hemodynamics (Optional)**

- CVP, PAP, PAWP and CO/CI values displayed in three hour intervals
- In order for this information to be included, it must be set up by Nursing Administration.

- **O3/Ventilation Information**

- The user determines which seven of twelve options will be included.
- Values display in three hour intervals

NOTE: An asterisk (*) adjacent to any value on this report indicates multiple values have been charted within the specified time frame. The last recorded value is printed. Preceding values are available on-line or in Patient Progress Notes.

- **Intake**

- The user determines which seven of twelve options will be included.
- Values display in three hour intervals
- The "OTHER" box combines all intake values not specified on the report. These details are available on-line or in the Patient Progress Notes
- For Pediatric/Nursery chart types, an option to record breast feeding will appear.

- **Output**

- The user determines which 4 out of 18 options will be included.
- Values display in three hour intervals
- The "OTHER" box combines all output values not specified on the report. These details are available on-line or in the Patient Progress Notes.
- Entries charted by frequency print in the top left corner of each box

- **Weight**

- Admission weight is printed in both pounds and kilograms.
- Yesterday's weight in pounds and kilograms, with date and time charted is printed.
- Today's weight in pounds and kilograms, with date and time charted is printed.

- **Diet**

- Date and time the information was charted
- The diet, along with the date and time it was scheduled to begin.
- Any comments entered
- Percent consumed

- **Current Medications (Optional)**

- Includes all active medications at the time the report is printed
- Medication description, dose, frequency, and autostop date if applicable
- Does not include discontinued medications
- In order for this information to be included, it must be set up by Nursing Administration.

- **Administered Medications (Optional)**

- Lists all medications administered during the previous 24 hours.
- Date and time of last administration
- Medication description
- Location of administration, and the reason for PRN administration
- Dosage
- In order for this information to be reflected, it must be set up by Nursing Administration.

- **Omitted Medications** (Optional)
 - Lists all medications omitted in the previous 24 hours.
 - Medication description
 - Omission date and time or check time
 - Reason for omission
 - Includes discontinued medications
 - In order for this information to be included, it must be set up by Nursing Administration.
- **Neuro Checks** (Optional)
 - Neuro checks charted through the VS application during the previous 24 hour period
 - Date and time information was entered
 - Name and title of person who charted the entry
- **X1 {one-time} and PRN Medications** (Optional)
 - Lists all X1 & PRN administrations in the previous 24 hour period
 - Medication description, quantity, frequency and time of administration
 - Includes a reason for PRN medications
 - Does not include discontinued medications
 - In order for this information to be reflected, it must be set up by Nursing Administration.
- **Blood Glucose Readings** (Optional)
 - Includes all administrations in the previous 24 hour period
 - Date and time entry was charted
 - Blood sugar level
 - Description of medication given (sliding scale insulin only)
 - Unit(s) of medication given and frequency
- **Blood Glucose Readings** (Continued)
 - Any other interventions charted
 - In order for this information to be reflected, it must be set up by Nursing Administration.
- **Immunizations** will print on the final page of the **24 Hour Summary** report for both formats A and B.

NOTE: The 24 Hour Summary report (Format B) has some different options than Format A. Format B also displays and prints in a horizontal format. The option that will display depends on the Chart-type of the selected patient. Please refer to the hospital's Nursing Administration department for more information on the two different formats.

The following is a full display of the 24 Hour Summary report (Format A & B).

Evident Community Hospital

24hr SUMMARY - Medical/Surgical

Printed: 7/23/14 at 09:11 Page 1 of 3

SMITH ELLA KATHERINE

ATT PHY : RICHARD JOHNSON JR
SEC PHY:

ALLERGIES: No Known Dru Peanuts

Number: 357814

Age: 58

Sex: F

Room: 300-7

M/R#: 970015

07/22/14: 10 13 16 19 22 01 04 07 10

Vital Signs

BP: V=Sysolic A=Diastolic

Pulse: ●

280

260

240

220

200

180

160

140

120

100

80

60

40

20

0

Temp

98.9 98.9 99.1 98.8 98.6 99.2 99.1

Resp

17 19 18 17 17 18 16

Hemodynamics

CVP

PAP

PAWP

CO/CI

O2

O2 Sat

* 100 % 100 % * 98 % 100 %

Intake

PO

500

300

Other

TOTAL

500

300

Output

Urine

275

500

Other

TOTAL

275

500

Totals

800

800

775

775

Admission Weight

Admission: 166 lbs 0 oz (75.3 kgs)

Floor Scale

75296.3 gm

Yesterday's Weight

()

Today's Weight

()

Health History

Current Medications

Description

dose/schedule

Description

dose/schedule

ATENOLOL {TENORMIN} PO

50 MG DAILY

Instructions: CHECK PULSE BEFORE ADMINISTRATION, IF <50 HOLD AND CALL MD

Start: 06/24/14 11:09 Stop: 00/00/00 00:00

METFORMIN{GLUCOPHAGE} TAB

500 MILLIGRAM 1 TIME DAILY {QD}

Instructions: GIVE WITH MEALS MAX DOSE= 2550 MG/DAY

Start: 06/24/14 11:09 Stop: 00/00/00 00:00

ROSUVASTATIN{CRESTOR} TAB

20 MG DAILY

Start: 06/24/14 11:09 Stop: 00/00/00 00:00

IV: ROCEPHIN 1 GM /D5W 50ML

Q24H

Comments: ROCEPHIN 1GM/D5W 50 ML

1st Dose: 07/17/14 13:19 Start: 07/17/14 13:19 Stop: 07/24/14 13:19 A

1 GM CEFTRIAXONE(ROCEPHIN) VL

50 ML D5W (5% DEXTROSE IN WATER)

IV: D5W 500ML/HEPARIN 25,000 UNITS

DAILY

Comments: D5W 1 L/HEPARIN 25,000 UN

1st Dose: 07/17/14 11:17 Start: 07/17/14 11:17 Stop: 07/24/14 11:17 A

1000 ML D5W

25000 UNITS HEPARIN INJ

XANAX {ALPRAZOLAM} 2 MG TABLET

2 MG PRNQ4H {AS NEEDED}

Start: 06/24/14 11:09 Stop: 07/24/14 11:09 A

MORPHINE PCA{WATCH}INJ

1 EA PRN

Start: 07/18/14 09:51 Stop: 07/21/14 09:51 A

ACETAMINOPHEN {TYLENOL} 325 MG TABL

325 MG PRN

Start: 07/21/14 14:38 Stop: 00/00/00 00:00

Evident Community Hospital

24hr SUMMARY - Medical/Surgical

Printed: 7/23/14 at 09:11 Page 2 of 3

SMITH ELLA KATHERINE

Number: 357814

Age: 58

Sex: F

Room: 300-7

M/R#: 970015

ATT PHY : RICHARD JOHNSON JR

SEC PHY:

ALLERGIES: No Known Dru Peanuts

Administered Medications

MEDICATIONS	Location/Reason	MEDICATIONS	Location/Reason
07/23 08:44 ROCEPHIN 1 GM /D5W 50ML Dose: 100 UNIT(S)/HR 1 GM CEFTRIAXONE(ROCEPHIN) VL 50 ML D5W (5% DEXTROSE IN WATER)	Connect exist. site	07/23 08:44 ROSUVASTATIN{CRESTOR} TAB Dose: 20 MG	ORALLY
07/23 08:44 XANAX {ALPRAZOLAM} 2 MG TABLET Dose: 2 MG	ANXIETY	07/23 08:44 ATENOLOL {TENORMIN} PO Dose: 50 MG	PO
		07/23 08:44 METFORMIN{GLUCOPHAGE} TAB Dose: 500 MG	PO

X1 & PRN Medications (24hr)

Time/description	Reason	Time/description	Reason
08:44 XANAX {ALPRAZOLAM} 2 MG TABLET Freq: PRN Q4H (AS NEEDED) Dose: 2 MG	ANXIETY		

DIETARY ORDERS

Start Date/Time	Description	Status
06/24/14 0600	REGULAR DIET Breakfast	INCOMPLETE

Evident Community Hospital

24hr SUMMARY - Medical/Surgical

Printed: 7/23/14 at 09:16

Page 1 of 3

SMITH ELLA KATHERINE

Number: 357814

Age: 58 YRS

Sex: F

Room: 300-7

M/R#: 970015

ATT PHY : RICHARD JOHNSON JR

SEC PHY:

ALLERGIES: No Known Dru Peanuts

Administrative Data

Admit Date/tm.: 05/16/14 16:13 LOS: 68

Admitting Diag:

Working Diag 1:

Working Diag 2:

Condition.....: G DNR: Adv Directive: Y Restraints:

Diet.....: REGULAR DIET

Food dislikes.: EGGS

Diabetic.....: N Fluid restricted: N Sodium restricted: N

Smoker.....: 9 - Unknown if ever smoked

Food allergies:

Height.....: 64.00 in 162 cm Pregnant....: N Breast Feeding: N BSA:1.84

1st Weight.....: 166 lbs YD Wgt: Weight: 166 lbs

75.3 kgs

75.3 kgs

75296.3 gm

75296.3 gm

Floor Scale

Bed Scale

06/26 10:00

07/08 10:00

Isolation:

Language: English

Fall Risk:

BMI: 28.49

Violent Pat:

MRSA: Y

VRE: Y

Health History

Current Medications

Description	dose/schedule
ATENOLOL {TENORMIN} PO	50 MG DAILY
Instructions: CHECK PULSE BEFORE ADMINISTRATION, IF <50 HOLD AND CALL MD	
Start: 06/24/14 11:09	Stop: 00/00/00 00:00
METFORMIN{GLUCOPHAGE} TAB	500 MILLIGRAMS 1 TIME DAILY {QD}
Instructions: GIVE WITH MEALS MAX DOSE= 2550 MG/DAY	
Start: 06/24/14 11:09	Stop: 00/00/00 00:00
ROSUVASTATIN{CRESTOR} TAB	20 MG DAILY
Start: 06/24/14 11:09	Stop: 00/00/00 00:00
IV: ROCEPHIN 1 GM /DSW 50ML	Q24H
Comments: ROCEPHIN 1GM/DSW 50 ML	
1st Dose: 07/17/14 13:19	Start: 07/17/14 13:19 Stop: 07/24/14 13:19 A
1 GM	CEFTRIAXONE{ROCEPHIN} VL
50 ML	DSW {5% DEXTROSE IN WATER}
IV: DSW 500ML/HEPARIN 25,000 UNITS	DAILY
Comments: DSW 1 L/HEPARIN 25,000 UN	
1st Dose: 07/17/14 11:17	Start: 07/17/14 11:17 Stop: 07/24/14 11:17 A
1000 ML	DSW
25000 UNITS	HEPARIN INJ
XANAX {ALPRAZOLAM} 2 MG TABLET	2 MG PRNQ4H {AS NEEDED}
Start: 06/24/14 11:09	Stop: 07/24/14 11:09 A
MORPHINE PCA{WATCH}INJ	1 EA PRN
Start: 07/18/14 09:51	Stop: 07/21/14 09:51 A
ACETAMINOPHEN {TYLENOL} 325 MG TABLET	325 MG PRN
Start: 07/21/14 14:38	Stop: 00/00/00 00:00

Description

Omit Date/Time or Check Time

No medication administrations were omitted.

X1 & PRN Medications (24hr)

quantity/freq/time

XANAX {ALPRAZOLAM} 2 MG TABLET 2 MG PRNQ4H {AS NEEDED} 08:44

Reason: ANXIETY

Graphic and I & O Data

Hour	12	16	20	24	4	8	12	INTAKE	3-11	11-7	7-3	24hrs.
C F								P.O. ORAL	300			300
105												
T 40 104												
E												
M 103												
P 39 102												
E												
R 101												
A 18 100								SHIFT TOTAL	300			300
T												
U 99												
R 17 Nrm								OUTPUT	3-11	11-7	7-3	24hrs.
E 98								VOIDED URINE	500			500
27												
36												
Pulse	60	58	59	55								
Resp	19	17	18	16								
BP-Cyst	146	141	155	149								
-Diast	82	79	80	79				SHIFT TOTAL	500			500
O2 L/M								O2 Method Legend				
FIO2								O2 Cannula	- NC	Partial Rebreathing	- PRN	
O2 Sat	100	100	98	100				Simple Mask	- SM	Ventilator	- VNT	
O2 Meth								Venti Mask	- VM	T Piece	- T	
								Non Rebreathing Mask-	NRN	Other	- O	
								Room Air 21%	- RA			

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Evident Community Hospital

24hr SUMMARY - Medical/Surgical

Printed: 7/23/14 at 09:16

Page 2 of 3

SMITH ELLA KATHERINE

Number: 357814

ATT PHY: RICHARD JOHNSON JR

Age: 58 YRS

SEC PHY:

Sex: F

ALLERGIES: No Known Dru Peanuts

Room: 300-7

M/R#: 970015

ANCILLARY DEPARTMENT Orders (24hr Activity)				Comments
Service date/time	Procedure	Autostop	Status	
LABORATORY				
06/27/14 1614	URINALYSIS		NOT COLLECTED	
DIETARY				
07/07/14 0952	REGULAR DIET Breakfast		06/24/14 0600	
SELECTED RESULTS				
06/23/14 1502 POTASSIUM 7.0 HC				
NOTE "SELECTED" RESULTS DO NOT REFLECT INTERPRETIVE DATA NOR, NECESSARILY, ALL RESULTS FOR THIS PATIENT. SEE ADDITIONAL REPORTS FOR THIS INFORMATION				
Nursing Orders				
Diet: REGULAR DIET				
Dinner	Recorded	06/26/14 1800 (13 E)	100% CONSUMED	
PROTIME	Verified	06/23/14 1355 (13 E)		
H & H	Verified	06/23/14 1355 (13 E)		
Collect Urine Drug Screen	Verified	06/23/14 1419 (13 E)		
Stool	Verified	06/23/14 1453 (13 E)		
CMP	Verified	06/23/14 1501 (13 E)		
UA 06/27/14	Verified	06/27/14 1614 (13 E)		
Problem List				
PROBLEM	1 Knowledge Deficit-Medication Therapy			
	Addressed 07/21/14 0953 (BARBRA SMIT)			
PROBLEM	2 Safety-Impaired Walking			
	Addressed 07/22/14 1017 (BARBRA SMIT)			
Comments				

11.6 Shift Summary

The Shift Summary Report is a document that includes all shift information charted the previous 34 hours via Point of Care.

Select Charts > Select Patient Account > Attachments > Nurses Notes > Shift Summary

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

NURSES NOTES:

Initial Interview

Initial Physical Assessment

Patient Progress Notes

24 Hour Summary

Shift Summary

No attachments found

Shift Summary

Data included on the Shift Summary Report is outlined below:

- **Demographics Box (located top center of screen)**
 - Patient's name
 - Account Number
 - Medical Record Number
 - Diagnosis
 - Attending Physician
 - Second Physician
 - Room Number
 - Age
 - Sex
 - Working Diagnosis 1
 - Working Diagnosis 3
 - Length of Stay
 - Height
 - Weight
 - Food Allergies
 - Condition

- Isolation
 - Diet
 - Special Diet Instructions
 - Advanced Directive
 - Violent Patient
 - MRSA
 - VRE
 - Fall Risk
 - Language
 - Ethnicity
 - Smokes
 - Allergies
 - Immunizations
- **Entries**
 - All shift summary information charted the previous 34 hours through Point of Care.

The following is a full display of the **Shift Summary** report.

Shift Summary 7/30/14

Printed: at 11:27 Page 1 of 1

SMITH ELLA KATHERINE Account Number: 357814 MR Number: 970015 Diagnosis: Attending Phy: JOHNSON 2nd Phy: Room: 300-7 Age: 58 Sex: F Working 1: Working 2: LOS: 75 Height: 64.00 Weight: 166 lb oz 75.3 kg 75296.3 gm Food Allergies: Cond: G Isolation: Diet: REGULAR DIET Special Diet Instructions: Adv Dir: Y Violent: MRSA: Y VRE: Y Fall Risk: Language: English Ethnicity: Smokes?: 9 - Unknown if ever smoked Allergies: Peanuts, No Known Drug Allergies Immunizations: pneumococcal polysaccharide PPV23

07/30/14 10:01 {BARBRA SMIT}

Lab results:
MD Notified,
Last pain medication given at:
In Progress,

11.7 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Nurses Notes > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

NURSES NOTES:

Initial Interview

Initial Physical Assessment

Patient Progress Notes

24 Hour Summary

Shift Summary

No attachments found

Nurses Notes - Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 12 Education

12.1 Overview

This section of the Updated ChartLink User Guide will discuss the Education Report.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Education**

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

EDUCATION

Education Report

No attachments found

Education

12.2 Education Report

The Education report is a document that includes multi-disciplinary information on how and when the patient was educated regarding diagnosis, medication administration, etc.

Select Charts > Select Patient Account > Attachments > Education

Education Report

Data included on the Education Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, and room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Education Categories**
 - Each category will be highlighted with bold text within a shaded gray box.
 - There are 34 categories that are all user-defined and can be set up for multi-discipline use.
 - Within the category up to thirty hospital-defined questions with up to twelve answers for each can be set up.
 - The questions appear in bold text with the responses listed below.

-
- Under each category entries made will display in chronological order preceded by the date, the time entry made, and name and title of individual that entered the information.
 - Education questions can be integrated with the Physical Assessment and Initial Interview portions of the chart and will display on the Education report.
- **Entries**
 - Each entry will fall under the appropriate category.
 - The Education Report and the other reports listed in this section will display in Adobe Acrobat Reader format.

Evident Community Hospital EDUCATION		SMITH ELLA KATHERINE AGE: 58 SEX: F RICHARD JOHNSON JR ROOM: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015	
From beginning of stay TO: 07/31/14 12:03 Page 1 of 1 Printed: 7/31/14 at 12:03			
DISCHARGE SUMMARY/INSTRUCTIONS			
Food and Drug Interactions: 07/21/14 13:36 (BARBRA SMIT) Avoid caffeine, Avoid alcohol.			
Medication Instruction: 07/21/14 13:36 (BARBRA SMIT) Drug information sheet given, Given to: Spouse			
Pain Management: 07/21/14 13:36 (BARBRA SMIT) Understands plan of care.			
Education Focus Prior to Discharge: 07/21/14 13:36 (BARBRA SMIT) Fall prevention, Medications.			
Nurse's signature: _____		Validated by: _____	
PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814
AGE:	58	SEX:	F
ROOM:	300-7	PAGE:	1

12.3 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Education > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

EDUCATION

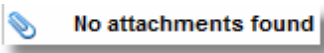
Education Report

No attachments found

Education- Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 13 Cardiopulmonary

13.1 Overview

This section of the Updated ChartLink User Guide will discuss the reports associated with the Cardiopulmonary department.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Cardiopulmonary**

DISCIPLINE	CARDIO PULM.
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ O2 Saturation Graph
☐ Laboratory	☐ Comparative
☐ Medication	☐ Comparative - All Stays
☐ Radiology	☐ Comparative - Multifacility
☐ Multi Disc.	☐ Detail Results
☐ Nurses Notes	☒ EKG 08/23/13
☐ Education	
☒ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary

13.2 Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics and pertinent history.

Select Charts > Select Patient Account > Attachments > Cardiopulmonary > Initial Interview

The screenshot displays the TruBridge software interface. On the left, a vertical sidebar titled 'DISCIPLINE' lists various medical disciplines with radio buttons. 'Cardio Pulm.' is selected and highlighted in blue. The main area on the right is titled 'CARDIO PULM.' and contains a list of attachments. The 'Initial Interview' attachment is selected and highlighted in blue. Below it, other attachments like 'Initial Physical Assessment', 'O2 Saturation Graph', 'Comparative', 'Comparative - All Stays', 'Comparative - Multifacility', 'Detail Results', and 'EKG 08/23/13' are listed. The 'Initial Interview' form is open, showing a large empty text area for documentation.

Cardiopulmonary - Initial Interview

Data included on the Initial Interview is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - The admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

Patient Information Box

Patient's name	Name (person to contact in an emergency)	
Birth date and age	Relation (of above person)	Sex
Address	Marital status	Phone
Occupation	Attending physician	Religion
Consulting physician	Admitting diagnosis	

The Initial Interview report and the other reports listed in this section will display in Adobe Acrobat Reader format.

The following is a full display of the **Initial Interview** report

Evident Community Hospital**INITIAL INTERVIEW**

Printed: 08/04/14 08:02

Page 1 of 3

SMITH ELLA KATHERINE AGE: 58 SEX: F**RICHARD JOHNSON JR**

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient Name	SMITH ELLA KATHERINE	IN AN EMERGENCY	
Birth date	10/31/1955 58	Name	JOHNSON DOROTHY M
Sex	F	Relation	
Marital Status	M	Address	6601 VAUGHAN CT
Occupation	OFFICE MANAGER	Phone	251/679-9776
Religion	BAPTIST	Admitting Physician	RICHARD JOHNSON JR
Admit. Diag.		Second Physician	

PERTINENT HISTORY**Medical History/Neurological:**

No known neurological problems.

07/23/14 08:00 {BARBRA SMITH}

Dietary Consult {Select All that Apply}:

Nutritional Supplement use/type:. No consult necessary.

06/23/14 12:22 {13 E}

Home Medications:

Glucophage 500MG Oral Tablet

Dose: 500 MILLIGRAMS Freq: Daily Route: ORAL

Last Dose: Compliant: Need Education:

Previous Home Med

Source: Patient

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA 7/21/14 13:44

Lopressor 50MG Oral Tablet

Dose: 50 MILLIGRAMS Freq: Daily Route: ORAL

Last Dose: Compliant: Need Education:

Previous Home Med

Source: Spouse

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA 7/21/14 13:44

Xanax 1MG Oral Tablet

Dose: 1 MILLIGRAMS Freq: AS NEEDED EVERY 8HR Route: ORAL

Last Dose: 6/23/14 08:00 AM Compliant: Y Need Education:

Source: patient

Indication: ANXIETY

Physician: RICHARD JOHNSON JR

Confirmed: SMITH BARBARA 7/21/14 13:44

Zocor 20MG Oral Tablet

Dose: 20 MILLIGRAMS Freq: Bed time Route: ORAL

Last Dose: Compliant: Need Education:

Previous Home Med

Source: Spouse

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA 7/21/14 13:45

DISCHARGE PLANNER**Patient's Mental Status:**

Some or all of the above pertinent history information was originally charted on 02/18/13, Account number 357491 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
----------	----------------------	---------	--------	------	----	------	---	-------	-------	-------	---

Evident Community Hospital

INITIAL INTERVIEW

Printed: 08/04/14 08:02

Page 2 of 3

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient's Mental Status:

Alert.

07/21/14 08:35 {BARBRA SMITH}

Activities of Daily Living:

Good Self Care Potential.

07/21/14 08:35 {BARBRA SMITH}

Present Living Situation:

Lives with others.

07/21/14 08:35 {BARBRA SMITH}

Present In Pts Living Environment:

Air Conditioning, Heating, Electricity, Telephone, Fire Alarm.

07/21/14 08:35 {BARBRA SMITH}

Indoor plumbing.

07/21/14 08:35 {BARBRA SMITH}

Anticipated Needs At Discharge:

Prescription meds.

07/21/14 08:35 {BARBRA SMITH}

Patient Goals For Hospitalization:

Increase mobility, Manage own care.

07/21/14 08:35 {BARBRA SMITH}

Social Support:

Good family support, Supportive friends.

07/21/14 08:35 {BARBRA SMITH}

Anticipated Problems At Discharge:

None.

07/21/14 08:35 {BARBRA SMITH}

Emotional Concerns Expressed By Patient:

None.

07/21/14 08:35 {BARBRA SMITH}

Intended Destination On Discharge:

Home.

07/21/14 08:35 {BARBRA SMITH}

Patient Will Require Assistance With:

ADL, Treatments.

07/21/14 08:35 {BARBRA SMITH}

Anticipate Need For Financial Assistance:

No.

07/21/14 08:35 {BARBRA SMITH}

Referrals:

Discharge coordinator.

07/21/14 08:35 {BARBRA SMITH}

Concerns Expressed by Caregiver:

None.

07/21/14 08:35 {BARBRA SMITH}

Patient Care Team Initial Plan:

Pt shows good discharge potential, Physical Therapy.

07/21/14 08:35 {BARBRA SMITH}

Case Manager:

Patient is progressing on pathway, Good education potential.

07/21/14 08:35 {BARBRA SMITH}

Pharmacy

Patient reports compliance on home meds.

07/21/14 08:35 {BARBRA SMITH}

Patient educated on medication therapy, Family assists w/medication program.

07/21/14 08:35 {BARBRA SMITH}

Nutritional Needs Assessment:

Patient screened for Nutritional Needs.

07/21/14 08:35 {BARBRA SMITH}

Patient demonstrated good comprehension.

07/21/14 08:35 {BARBRA SMITH}

Infection Control:

No needs identified.

07/21/14 08:35 {BARBRA SMITH}

Physical Therapy:

Evaluation Complete, Pt Identified as Fall Risk.

07/21/14 08:35 {BARBRA SMITH}

Rehabilitation recommended for Discharge.

07/21/14 08:35 {BARBRA SMITH}

Cardiopulmonary:

Weaning process initiated, Resp. treatments needed after discharge.

07/21/14 08:35 {BARBRA SMITH}

Plan Of Care Initiated by Care Team:

Pain Management, Respiratory Tx's.

07/21/14 08:35 {BARBRA SMITH}

Some or all of the above pertinent history information was originally charted on 02/18/13, Account number 357491 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	2
----------	----------------------	---------	--------	------	----	------	---	-------	-------	-------	---

13.3 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Select **Charts** > **Select Patient Account** > **Attachments** > **Cardiopulmonary** > **Initial Physical Assessment**

DISCIPLINE	CARDIO PULM.
☒ Vital Signs	☐ Initial Interview
☒ Med. Rec.	☒ Initial Physical Assessment
☒ Orders	☐ O2 Saturation Graph
☒ Laboratory	☐ Comparative
☒ Medication	☐ Comparative - All Stays
☒ Radiology	☐ Comparative - Multifacility
☒ Multi Disc.	☐ Detail Results
☒ Nurses Notes	☐ EKG 08/23/13
☒ Education	
☒ Cardio Pulm.	
☒ Rehab.	
☒ Dietary	
☒ Diabetic	
☒ Misc.	
☒ Face Sheet	
☒ Other	
☒ Growth Charts	

Cardiopulmonary - Initial Physical Assessment

Data included on the Initial Physical Assessment Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge

In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Initial Vital Signs**
 - Temperature (including site)
 - Pulse (including site)
 - Respiration
 - Blood Pressure (including posture and extremity)
 - Weight
 - The date, time, name and title of the person who charted the information.

The following is a full display of the **Initial Physical Assessment** report.

Evident Community Hospital INITIAL PHYSICAL ASSESSMENT		SMITH ELLA KATHERINE AGE: 58 SEX: F RICHARD JOHNSON JR ROOM: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015	
Printed: 8/04/14 at 08:22 Page 1 of 1			

Initial Vital Signs

Temp:	100.1 ORAL	06/23/14 08:00 {13 E}
Pulse:	66 RADIAL	06/23/14 08:00 {13 E}
Resp:	19	06/23/14 08:00 {13 E}
B/P:	155/85 LYING	06/23/14 08:00 {13 E}
O2 L/M:	2	07/07/14 14:34 {13 E}
FiO2:		
O2 SAT:	100	06/23/14 08:00 {13 E}
Method:	O2 Cannula	07/07/14 14:34 {13 E}
Weight:	166 lbs	06/26/14 10:00 {13 E}
	75.3 kg 75296.3 gm	

INITIAL/SHIFT ASSESSMENT

07/07/14 14:34 {13 E} 07/07/14 14:34 {13 E} 07/07/14 14:34 {13 E} 07/07/14 14:34 {13 E}	Quality of Respirations: Even-regular. Breath Sounds: Crackles. Cough/Consistency: Productive sputum. Respiratory Nursing Interventions: Sputum specimen collected to lab.
--	---

Nurse's signature: _____ Validated by: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
-----------------	----------------------	----------------	--------	-------------	----	-------------	---	--------------	-------	--------------	---

13.4 O2 Saturation Graph

The O3 Sat Bar Graph is a document that displays the O3LM, FiO3, and O3SAT, which is graphed and includes the method.

Select Charts > Select Patient Account > Attachments > Cardiopulmonary > O3 Saturation Graph

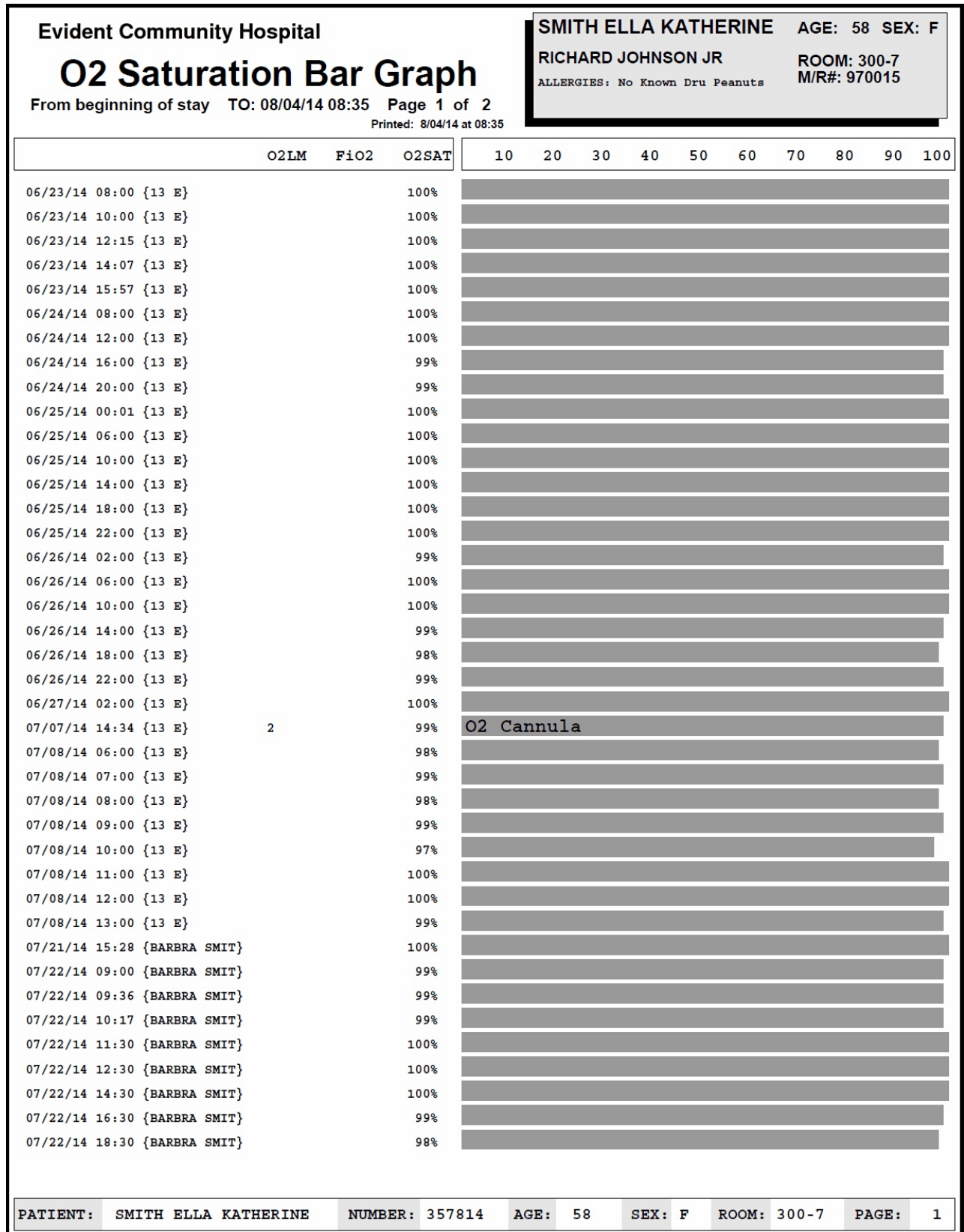
DISCIPLINE	CARDIO PULM.
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ O2 Saturation Graph
☐ Laboratory	☐ Comparative
☐ Medication	☐ Comparative - All Stays
☐ Radiology	☐ Comparative - Multifacility
☐ Multi Disc.	☐ Detail Results
☐ Nurses Notes	☒ EKG 08/23/13
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary - O3Saturaton Graph

Data included in the O3 Sat Bar Graph is outlined below:

- **Demographics box** (located upper right-hand corner)
 - Patient's name
 - Account number
 - Admitting physician
 - Age, sex, and room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
- **O3 Information**
 - O3 L/M, FiO3, and O3 Sat values display numerically
 - O3 Sat values display as a bar graph
 - O3 Sat values display on the bar graph along with the method

The following is a full display of the **O3 Saturation Bar Graph** report.



13.5 Comparative

The comparative vertical report is an update of all test results for a patient account.

Select Charts > Select Patient Account > Attachments > Cardiopulmonary > Comparative Report

DISCIPLINE	CARDIO PULM.
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ O2 Saturation Graph
☐ Laboratory	☐ Comparative
☐ Medication	☐ Comparative - All Stays
☐ Radiology	☐ Comparative - Multifacility
☐ Multi Disc.	☐ Detail Results
☐ Nurses Notes	☐ EKG 08/23/13
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary - Comparative

The report is a comparative summary presentation of all data with test names along the vertical axis and results listed chronologically along a horizontal axis. Collection dates and times are printed on the horizontal axis. Up to seven events will print per row with subsequent results wrapping below the most current results. Since this report is a complete record of all patient results, each report should replace the report previously charted. Preliminary reports with results that do not appear on the comparative report should remain on the chart until they print on the comparative.

The following is a full display of the **Comparative** report.

Reported Date/Time: 07/02/15 10:06 Evident Community Hospital PAGE 1
RESP. CARE -- COMPARATIVE REPORT LACUMV2

NAME.: SEX.....: ATTENDING:
ACCT#: AGE.....: SECOND...:
ROOM.: DOB.....: PRIM CARE.:
PAT. PHONE:
MR#.....:
ADMIT:
No orders with results found

Page: 1 / 1 Zoom: 104% PORTRAIT

13.6 Comparative-All Stays

The Comparative All Stays report is a cumulative report of all test results for a patient .

Select **Charts** > **Select Patient Account** > **Attachments** > **Cardiopulmonary** > **Comparative - All Stays Report**

DISCIPLINE	CARDIO PULM.
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ O2 Saturation Graph
☐ Laboratory	☐ Comparative
☐ Medication	☒ Comparative - All Stays
☐ Radiology	☐ Comparative - Multifacility
☐ Multi Disc.	☐ Detail Results
☐ Nurses Notes	☐ EKG 08/23/13
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary Comparative All Stays

The report is a comparative summary presentation of all data with test names along the vertical axis and results listed chronologically along a horizontal axis. Collection dates and times are printed on the horizontal axis. Up to seven events will print per row with subsequent results wrapping below the most current results. Since this report is a complete record of all patient results, each report should replace the report previously charted. Preliminary reports with results that do not appear on the comparative report should remain on the chart until they print on the comparative.

The following is a full display of the **Comparative** report.

Reported Date/Time: 08/04/14 13:59 Evident Community Hospital PAGE 1
RESP. CARE -- COMPARATIVE REPORT LACUMV2

NAME.: SMITH ELLA KATHERINE SEX.....: F ATTENDING: RICHARD JOHNSON JR
ACCT#: 357814 AGE.....: 58 Y SECOND...:
ROOM.: 300-7 - NO PENDING ORDERS DOB.....: 10/31/1955 PRIM CARE.:DALTON MICHAEL
ADMIT: 05/16/14 PAT. PHONE: 2516398100
MR#.....: 970015

RESPIRATORY CARE

Collect Dt/tm	080414 0933	REFERENCE	
Report Dt/tm:	080414 0934	RANGE	UNITS
O2 METHOD	ROOM AIR		
O2 L/MIN	2		
PUNCTURE SITE	RT RADIAL		
pH	7.45	7.35 -	7.45
pCO2	40	35 -	45 mm/Hg
pO2	95	80 -	100 mm/Hg
HCO3	24	22 -	26 mmol/l
BASE EXCESS	3.0	-2.0 -	4.0 mmol/l
TCO2	25.0	22.0 -	29.0 mmHg
O2 SAT	100	97 -	100 %

REPORTED DATE/TIME: 08/04/14 13:59 **SMITH ELLA KATHERINE** 799 Page: 1 LAST

LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E-Error

13.7 Comparative-Multifacility

The Comparative All Stays Multifacility report is a cumulative report of all test results for a patient across all site associated facilities.

Select **Charts** > Select **Patient Account** > **Attachments** > **Cardiopulmonary** > **Comparative - Multifacility**

DISCIPLINE	CARDIO PULM.
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ O2 Saturation Graph
☐ Laboratory	☐ Comparative
☐ Medication	☐ Comparative - All Stays
☐ Radiology	☒ Comparative - Multifacility
☐ Multi Disc.	☐ Detail Results
☐ Nurses Notes	☐ EKG 08/23/13
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary Comparative Multifacility

The report is a comparative summary presentation of all data with test names along the vertical axis and results listed chronologically along a horizontal axis. Collection dates and times are printed on the horizontal axis. Up to seven events will print per row with subsequent results wrapping below the most current results. Since this report is a complete record of all patient results, each report should replace the report previously charted. Preliminary reports with results that do not appear on the comparative report should remain on the chart until they print on the comparative.

The following is a full display of the **Comparative - Multifacility** report.

Reported Date/Time: 08/04/14 14:56	RESP. CARE - COMPARATIVE REPORT	PAGE 1
FAC-A: Evident Community Hospital	6600 Wall Street Mobile, AL 36695	
David L. Holbrook, M.D - Med. Dir.		CLIA#1234567890
NAME.: SMITH ELLA KATHERINE	SEX.....: F	ATTENDING: RICHARD JOHNSON JR
ACCT#: 357814	AGE.....: 58 Y	SECOND....:
ROOM.: 300-7	- NO PENDING ORDERS	DOB.....: 10/31/1955
	PAT. PHONE: 2516398100	PRIM CARE.:DALTON MICHAEL
ADMIT: 05/16/14	MR#.....: 970015	

RESPIRATORY CARE

Collect Dt/tm	080414 0933	REFERENCE	
Report Dt/tm:	080414 0934	RANGE	UNITS
O2 METHOD	ROOM AIR		
O2 L/MIN	2		
PUNCTURE SITE	RT RADIAL		
pH	7.45	7.35 -	7.45
pCO2	40	35 -	45 mm/HG
pO2	95	80 -	100 mm/HG
HCO3	24	22 -	26 mmol/l
BASE EXCESS	3.0	-2.0 -	4.0 mmol/l
TCO2	25.0	22.0 -	29.0 mmHg
O2 SAT	100	97 -	100 %

REPORTED DATE/TIME: 08/04/14 14:56	SMITH ELLA KATHERINE	799 Page: 1	LAST
LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E-Error			

13.8 Detail Results

The Detail report can be used as an alternative comparative report; however it only provides a results chart copy for inpatients.

Select Charts > Select Patient Account > Attachments > Cardiopulmonary > Detail Results

DISCIPLINE	CARDIO PULM.
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ O2 Saturation Graph
☐ Laboratory	☐ Comparative
☐ Medication	☐ Comparative - All Stays
☐ Radiology	☐ Comparative - Multifacility
☐ Multi Disc.	☒ Detail Results
☐ Nurses Notes	☐ EKG 08/23/13
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary Detail Results

This report is added to the previously printed comparative Detail reports on the patient's chart. Inpatients whose results are completed after being discharged in the system do not print on this report; they print on the M/R File report.

The following is a full display of the **Detailed Report**.

RUN DATE 08/04/14 Evident Community Hospital PAGE 1
 RUN TIME 15:11 CardiopulmoCUMULATIVE REPORT--DETAIL RGRROOM

----	PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
	SMITH ELLA KATHERINE	F	58	103155	051614	970015	357814	300-7	I/P
	ORD: RICHARD JOH	ATT:			SEC:		PRI: DALTON MICH		
	PAT PHONE: (251)639-8100								

---	PROCEDURE---	ARTERIAL BLOOD GAS				ORDER # 39924
--	ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---	
	8/04/14 0911	8/04/14 0933	8/04/14 0933	8/04/14 0933	8/04/14 0934	
	BS	RCJ	RCJ	BS	BS	

ARTERIAL BLOOD GAS	ROOM AIR			
O2 METHOD				
O2 L/MIN	2			
PUNCTURE SITE	RT RADIAL			
pH	7.45		(L=7.35	H=7.45)
pCO2	40	mm/HG	(L=35	H=45)
pO2	95	mm/HG	(L=80	H=100)
HCO3	24	mmol/l	(L=22	H=26)
TCO2	25.0	mmHg	(L=22.0	H=29.0)
BASE EXCESS	3.0	mmol/l	(L=-2.0	H=4.0)
O2 SAT	100	%	(L=97	H=100)

---	PROCEDURE---	PULSE OXIMETER			ORDER # 39922
--	ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
	7/07/14 1547	7/07/14 1547	7/07/14 1548	7/07/14 1548	7/07/14 1548
	RCJ	RCJ	RCJ	E13	E13

---	PROCEDURE---	PULSE OXIMETER			ORDER # 39939
--	ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
	8/04/14 0911	8/04/14 0915	8/04/14 0915	8/04/14 0915	8/04/14 0915
	BS	RCJ	RCJ	BS	BS

---	PROCEDURE---	EKG			ORDER # 39949
--	ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
	8/04/14 0911	8/04/14 0916	8/04/14 0916	8/04/14 0916	8/04/14 0916
	BS	RCJ	RCJ	BS	BS

----	PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
	SMITH ELLA KATHERINE	F	58	103155	051614	970015	357814	300-7	I/P

13.9 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Cardiopulmonary > Attachments

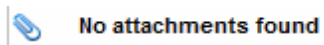
DISCIPLINE	CARDIO PULM.
☐ Vital Signs	Initial Interview
☐ Med. Rec.	Initial Physical Assessment
☐ Orders	O2 Saturation Graph
☐ Laboratory	Comparative
☐ Medication	Comparative - All Stays
☐ Radiology	Comparative - Multifacility
☐ Multi Disc.	Detail Results
☐ Nurses Notes	EKG 08/23/13
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Cardiopulmonary- Attachments

Deleted Items will display



Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 14 Rehabilitation

14.1 Overview

This section of the Updated ChartLink User Guide will discuss the reports located in Rehabilitation.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Rehabilitation**

DISCIPLINE	REHAB.
- Vital Signs - Med. Rec. - Orders - Laboratory - Medication - Radiology - Multi Disc. - Nurses Notes - Education - Cardio Pulm. Rehab. - Dietary - Diabetic - Misc. - Face Sheet - Other - Growth Charts	- Initial Interview - Initial Physical Assessment - No attachments found

Rehabilitation

14.2 Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning.

Select Charts > Select Patient Account > Attachments > Rehabilitation > Initial Interview

The screenshot displays a software interface for the 'Rehabilitation Initial Interview'. On the left, a vertical sidebar titled 'DISCIPLINE' contains a list of categories: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab. (highlighted in blue), Dietary, Diabetic, Misc., Face Sheet, Other, and Growth Charts. The main content area on the right is titled 'REHAB.' and contains a list of attachments: 'Initial Interview', 'Initial Physical Assessment', and 'No attachments found' (indicated by a magnifying glass icon).

Rehabilitation Initial Interview

Data included on the Initial Interview is outlined below:

- **Demographics Box (located upper right-hand corner)**
 - Patient's name
 - The admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

Patient Information Box

Patient's name	Name (person to contact in an emergency)	
Birth date and age	Relation (of above person)	Sex
Address	Marital status	Phone
Occupation	Attending physician	Religion
Consulting physician	Admitting diagnosis	

The **Initial Interview** report and the other reports listed in this section will display in Adobe Acrobat Reader format.

The following is a full display of the **Initial Interview** report.

Evident Community Hospital**INITIAL INTERVIEW**

Printed: 08/06/14 08:05

Page 1 of 3

SMITH ELLA KATHERINE AGE: 58 SEX: F**RICHARD JOHNSON JR**

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient Name	SMITH ELLA KATHERINE
Birth date	10/31/1955 58
Sex	F
Marital Status	M
Occupation	OFFICE MANAGER
Religion	BAPTIST
Admit. Diag.	

IN AN EMERGENCY	
Name	JOHNSON DOROTHY M
Relation	
Address	6601 VAUGHAN CT
Phone	251/679-9776
Admitting Physician	RICHARD JOHNSON JR
Second Physician	

PERTINENT HISTORY**Medical History/Neurological:**

No known neurological problems.

07/23/14 08:00 {BARBRA SMITH}

Dietary Consult {Select All that Apply}:

Nutritional Supplement use/type:. No consult necessary.

06/23/14 12:22 {13 E}

Home Medications:

Glucophage 500MG Oral Tablet

Dose: 500 MILLIGRAMS

Freq: Daily

Route: ORAL

Last Dose:

Compliant:

Need Education:

Previous Home Med

Source: Patient

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA

7/21/14 13:44

Lopressor 50MG Oral Tablet

Dose: 50 MILLIGRAMS

Freq: Daily

Route: ORAL

Last Dose:

Compliant:

Need Education:

Previous Home Med

Source: Spouse

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA

7/21/14 13:44

Xanax 1MG Oral Tablet

Dose: 1 MILLIGRAMS

Freq: AS NEEDED EVERY 8HR

Route: ORAL

Last Dose: 6/23/14 08:00 AM

Compliant: Y

Need Education:

Source: patient

Indication: ANXIETY

Physician: RICHARD JOHNSON JR

Confirmed: SMITH BARBARA

7/21/14 13:44

Zocor 20MG Oral Tablet

Dose: 20 MILLIGRAMS

Freq: Bed time

Route: ORAL

Last Dose:

Compliant:

Need Education:

Previous Home Med

Source: Spouse

Indication:

Physician: BAXTER JAMES

Confirmed: SMITH BARBARA

7/21/14 13:45

DISCHARGE PLANNER**Patient's Mental Status:**

Some or all of the above pertinent history information was originally charted on 02/18/13, Account number 357491 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
-----------------	----------------------	----------------	--------	-------------	----	-------------	---	--------------	-------	--------------	---

Evident Community Hospital

INITIAL INTERVIEW

Printed: 08/06/14 08:05

Page 2 of 3

SMITH ELLA KATHERINE AGE: 58 SEX: F

RICHARD JOHNSON JR

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient's Mental Status:

Alert.

07/21/14 08:35 {BARBRA SMITH}

Activities of Daily Living:

Good Self Care Potential.

07/21/14 08:35 {BARBRA SMITH}

Present Living Situation:

Lives with others.

07/21/14 08:35 {BARBRA SMITH}

Present In Pts Living Environment:

Air Conditioning, Heating, Electricity, Telephone, Fire Alarm.

07/21/14 08:35 {BARBRA SMITH}

Indoor plumbing.

07/21/14 08:35 {BARBRA SMITH}

Anticipated Needs At Discharge:

Prescription meds.

07/21/14 08:35 {BARBRA SMITH}

Patient Goals For Hospitalization:

Increase mobility, Manage own care.

07/21/14 08:35 {BARBRA SMITH}

Social Support:

Good family support, Supportive friends.

07/21/14 08:35 {BARBRA SMITH}

Anticipated Problems At Discharge:

None.

07/21/14 08:35 {BARBRA SMITH}

Emotional Concerns Expressed By Patient:

None.

07/21/14 08:35 {BARBRA SMITH}

Intended Destination On Discharge:

Home.

07/21/14 08:35 {BARBRA SMITH}

Patient Will Require Assistance With:

ADL, Treatments.

07/21/14 08:35 {BARBRA SMITH}

Anticipate Need For Financial Assistance:

No.

07/21/14 08:35 {BARBRA SMITH}

Referrals:

Discharge coordinator.

07/21/14 08:35 {BARBRA SMITH}

Concerns Expressed by Caregiver:

None.

07/21/14 08:35 {BARBRA SMITH}

Patient Care Team Initial Plan:

Pt shows good discharge potential, Physical Therapy.

07/21/14 08:35 {BARBRA SMITH}

Case Manager:

Patient is progressing on pathway, Good education potential.

07/21/14 08:35 {BARBRA SMITH}

Pharmacy

Patient reports compliance on home meds.

07/21/14 08:35 {BARBRA SMITH}

Patient educated on medication therapy, Family assists w/medication program.

07/21/14 08:35 {BARBRA SMITH}

Nutritional Needs Assessment:

Patient screened for Nutritional Needs.

07/21/14 08:35 {BARBRA SMITH}

Patient demonstrated good comprehension.

07/21/14 08:35 {BARBRA SMITH}

Infection Control:

No needs identified.

07/21/14 08:35 {BARBRA SMITH}

Physical Therapy:

Evaluation Complete, Pt Identified as Fall Risk.

07/21/14 08:35 {BARBRA SMITH}

Rehabilitation recommended for Discharge.

07/21/14 08:35 {BARBRA SMITH}

Cardiopulmonary:

Weaning process initiated, Resp. treatments needed after discharge.

07/21/14 08:35 {BARBRA SMITH}

Plan Of Care Initiated by Care Team:

Pain Management, Respiratory Tx's.

07/21/14 08:35 {BARBRA SMITH}

Some or all of the above pertinent history information was originally charted on 02/18/13, Account number 357491 , and copied to this account. I have reviewed the above information and find it to be both current and valid.

Nurse's signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	2
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14.3 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Select **Charts** > **Select Patient Account** > **Attachments** > **Rehabilitation** > **Initial Physical Assessment**

DISCIPLINE	REHAB.
☐ Vital Signs	Initial Interview
☐ Med. Rec.	Initial Physical Assessment
☐ Orders	No attachments found
☐ Laboratory	
☐ Medication	
☐ Radiology	
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☒ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Rehabilitation Initial Physical Assessment

Data included on the Initial Physical Assessment Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.
- **Initial Vital Signs**
 - Temperature (including site)
 - Pulse (including site)
 - Respiration
 - Blood Pressure (including posture and extremity)
 - Weight
 - The date, time, name and title of the person who charted the information.

The following is a full display of the **Initial Physical Assessment** report.

Evident Community Hospital		SMITH ELLA KATHERINE AGE: 58 SEX: F	
INITIAL PHYSICAL ASSESSMENT		RICHARD JOHNSON JR ROOM: 300-7	
		ALLERGIES: No Known Dru Peanuts M/R#: 970015	
Printed: 8/06/14 at 08:43		Page 1 of 1	

Initial Vital Signs			
Temp:	100.1	ORAL	06/23/14 08:00 {13 E}
Pulse:	66	RADIAL	06/23/14 08:00 {13 E}
Resp:	19		06/23/14 08:00 {13 E}
B/P:	155/85	LYING	06/23/14 08:00 {13 E}
O2 L/M:	2		07/07/14 14:34 {13 E}
Fio2:			
O2 SAT:	100		06/23/14 08:00 {13 E}
Method:	O2 Cannula		07/07/14 14:34 {13 E}
Weight:	166 lbs		06/26/14 10:00 {13 E}
	75.3 kg	75296.3 gm	

INITIAL/SHIFT ASSESSMENT	
---------------------------------	--

07/07/14 14:34 {13 E}	Quality of Respirations: Even-regular.
07/07/14 14:34 {13 E}	Breath Sounds: Crackles.
07/07/14 14:34 {13 E}	Cough/Consistency: Productive sputum.
07/07/14 14:34 {13 E}	Respiratory Nursing Interventions: Sputum specimen collected to lab.

Nurse's signature: _____	Validated by: _____
--------------------------	---------------------

PATIENT:	SMITH ELLA KATHERINE	NUMBER: 357814	AGE: 58	SEX: F	ROOM: 300-7	PAGE: 1
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14.4 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Rehabilitation > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

REHAB.

Initial Interview

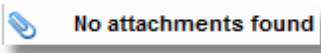
Initial Physical Assessment

No attachments found

Rehabilitation Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 15 Dietary

15.1 Overview

This section will discuss access to Dietary functions from Updated ChartLink.

NOTE: Specific diet items (example: Low Salt Diet, Clear Liquid Diet) can be ordered if the hospital is using specific items in the Dietary item master (versus the use of generic dietary items). The item description will update the diet field in Clinical Information, Medact, Diet reports, and POC reports. Also, entering a new diet order replaces the previous diet order in Clinical Information and the Medact.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Dietary**

DISCIPLINE	DIETARY:
☐ Vital Signs	Initial Interview
☐ Med. Rec.	Initial Physical Assessment
☐ Orders	Nutritional Calculations
☐ Laboratory	No attachments found
☐ Medication	
☐ Radiology	
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Dietary

15.2 Initial Interview

The Initial Interview is a document that includes information regarding the patient's demographics, pertinent history, and discharge planning.

Select Charts > Select Patient Account > Attachments > Dietary > Initial Interview

DISCIPLINE	DIETARY:
☐ Vital Signs	☐ Initial Interview
☐ Med. Rec.	☐ Initial Physical Assessment
☐ Orders	☐ Nutritional Calculations
☐ Laboratory	☐ No attachments found
☐ Medication	
☐ Radiology	
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Dietary Initial Interview

Data included on the Initial Interview is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - The admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge
 - In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

Patient Information Box

Patient's name	Name (person to contact in an emergency)	
Birth date and age	Relation (of above person)	Sex
Address	Marital status	Phone
Occupation	Attending physician	Religion
Consulting physician	Admitting diagnosis	

The **Initial Interview** report and the other reports listed in this section will display in Adobe Acrobat Reader format.

The following is a full display of the **Initial Interview** report.

Evident Community Hospital**INITIAL INTERVIEW**

Printed: 08/07/14 09:28

Page 1 of 2

Nutrition Services**SMITH ELLA KATHERINE** AGE: 58 SEX: F**RICHARD JOHNSON JR**

ROOM: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

Patient Name	SMITH ELLA KATHERINE
Birth date	10/31/1955 58
Sex	F
Marital Status	M
Occupation	OFFICE MANAGER
Religion	BAPTIST
Admit. Diag.	

IN AN EMERGENCY	
Name	JOHNSON DOROTHY M
Relation	
Address	6601 VAUGHAN CT
Phone	251/679-9776
Admitting Physician	RICHARD JOHNSON JR
Second Physician	

Nutritional Risk Assesment:

Diabetes, Poor Dietary Habits.

06/23/14 12:00 {JAMESON C}

Ability to eat as desired:

Eats at desired place, Mobility limitations, Limited food preferences.

06/23/14 12:00 {JAMESON C}

Communicates food preferences,etc.

Oral, Understands diet orders.

06/23/14 12:00 {JAMESON C}

Ability to self-feed

Yes.

06/23/14 12:00 {JAMESON C}

Meds/Txs/Procedures that affect nutritional status

Analgesics, Steroids, Oxygen.

06/23/14 12:00 {JAMESON C}

Signature: _____

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
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15.3 Initial Physical Assessment

The Initial Physical Assessment is a document that includes information regarding the patient's initial vital signs and assessment of body systems.

Select **Charts > Select Patient Account > Attachments > Dietary > Initial Physical Assessment**

Dietary Initial Physical Assessment

Data included on the Initial Physical Assessment Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Age, sex, & room number
 - Medical Record number
 - Any drug allergies documented through TruBridge

In addition to the above mentioned box, a single line containing the patient's name, account number, age, sex, room number and page number will appear along the bottom edge of the page.

- **Initial Vital Signs**
 - Temperature (including site)
 - Pulse (including site)
 - Respiration
 - Blood Pressure (including posture and extremity)
 - Weight
 - The date, time, name and title of the person who charted the information.

The following is a full display of the **Initial Physical Assessment** report.

Evident Community Hospital		SMITH ELLA KATHERINE AGE: 58 SEX: F	
INITIAL PHYSICAL ASSESSMENT		RICHARD JOHNSON JR ROOM: 300-7	
Nutrition Services		ALLERGIES: No Known Dru Peanuts M/R#: 970015	
Printed: 8/07/14 at 09:43		Page 1 of 1	

Initial Vital Signs			
Temp:	100.1	ORAL	06/23/14 08:00 {13 E}
Pulse:	66	RADIAL	06/23/14 08:00 {13 E}
Resp:	19		06/23/14 08:00 {13 E}
B/P:	155/85	LYING	06/23/14 08:00 {13 E}
O2 L/M:	2		07/07/14 14:34 {13 E}
FiO2:			
O2 SAT:	100		06/23/14 08:00 {13 E}
Method:	O2 Cannula		07/07/14 14:34 {13 E}
Weight:	166 lbs		06/26/14 10:00 {13 E}
	75.3 kg	75296.3 gm	

06/23/14 08:00 {13 E}	Meds/Txs/Procedures that affect nutritional status
	Analgesics, Oxygen, Steroids.

Signature: _____	Validated by: _____
------------------	---------------------

PATIENT:	SMITH ELLA KATHERINE	NUMBER:	357814	AGE:	58	SEX:	F	ROOM:	300-7	PAGE:	1
----------	----------------------	---------	--------	------	----	------	---	-------	-------	-------	---

15.4 Nutritional Calculations

Items such as Nutritional Assessments that include the patient's Basal Energy Expenditure (BEE) and Ideal Body Weight (IBW) can be calculated through result entry.

Select Charts > Select Patient Account > Attachments > Dietary > Nutritional Calculations

DISCIPLINE	DIETARY:
☐ Vital Signs	Initial Interview
☐ Med. Rec.	Initial Physical Assessment
☐ Orders	Nutritional Calculations
☐ Laboratory	No attachments found
☐ Medication	
☐ Radiology	
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☐ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Dietary Nutritional Calculations

The following is a full display of the **Nutritional Calculations** report.

CHARTS » SMITH ELLA KATHERINE (DISCHGD) » REPORTS AND ATTACHMENTS

SMITH ELLA KATHERINE MR#: 970015 ACCOUNT#: 357351 DOB: 02/09/1943 Sex: F Current Weight: 160 lbs 72.57 kg 72574.80 g
AGE: 72 CrCl: N/A Height: 65.00 inches BMI: 26.63 kg/m2 BSA: 1.82 m2 Admit Weight: 0 lbs 0.00 kg 0.00 g
RM: 302-1 Diagnosis: Pulmonary injury Allergies: EGGS, MINERAL OIL

Charts

SMITH ELLA KATHERINE (...)

- Alerts
- Lab Results
- Problem List
- Vitals
- Allergies
- Medication Reconciliation
- Order Entry
- Documentation
- Patient Immunization History
- Patient Education Docume...
- PACS Images
- Order Chronology
- Transcriptions
- Prescription Entry
- Clinical History
- Reports and Attachments**
- MAR
- Health History
- Health Information Resource
- Temporary Registration
- Plan of Care
- Charges
- Location Maintenance

Export

RUN DATE 08/08/14 Evident Community Hospital PAGE 1
RUN TIME 14:46 Dietary CUMULATIVE REPORT--DETAIL RGRROOM

---PATIENT NAME---	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
SMITH ELLA KATHERINE	F	66	120241	031614	9/0015	357814	300-/	I/P
ORD: RICHARD JOH	ATT:	SEC:				PRI: DALTON MICH		
FAT PHONE: (251)639-8100								

---PROCEDURE---	DIETARY CONSULT	REC'D--	RESULTED--	ORDER #
8/08/14 1323	8/08/14 1328	8/08/14 1328	8/08/14 1422	20516
RCJ	RCJ	RCJ	RCJ	0000

BASAL ENERGY EXPENDITURE			
WEIGHT	166	lbs	
METRIC WEIGHT	75	kg	
HEIGHT	64	inches	
METRIC HEIGHT	163	cm	
AGE	66	YRS	
BEE	1374	units	

Page: 1 / 1 Zoom: 134% PORTRAIT

Nutritional Calculation

15.5 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Rehabilitation > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

DIETARY:

Initial Interview

Initial Physical Assessment

Nutritional Calculations

No attachments found

Dietary - Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 16 Diabetic

16.1 Overview

This section will discuss access to Diabetic Record information from Updated ChartLink.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Diabetic**

DISCIPLINE	DIABETIC:
☐ Vital Signs	☐ Diabetic Flow Sheet
☐ Med. Rec.	☐ Cumulative Diabetic Report
☐ Orders	☐ Daily Diabetic Report
☐ Laboratory	☐ Weekly Diabetic Report
☐ Medication	☐ No attachments found
☐ Radiology	
☐ Multi Disc.	
☐ Nurses Notes	
☐ Education	
☐ Cardio Pulm.	
☐ Rehab.	
☐ Dietary	
☒ Diabetic	
☐ Misc.	
☐ Face Sheet	
☐ Other	
☐ Growth Charts	

Diabetic Record

16.2 Diabetic Flowsheet

The Diabetic Record Flowsheet will display a cumulative report of all documentation done through the Diabetic Record application.

Select **Charts > select Patient Account > Attachments > Diabetic > Diabetic Flowsheet**

Diabetic Flowsheet

Data included on the Diabetic Flowsheet is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name, Account Number and Medical Record Number
 - Admitting physician
 - Age, sex and room number
 - Any drug allergies documented through TruBridge
- **Diet**
 - The patient's current diet will display in the top right-hand corner of the report, just below the demographics box.
- **Documentation Area**
 - Date and time of each entry charted
 - Name and title of the person who charted each entry
 - Blood sugar level and dose (if administered)
 - Type of Insulin or Hypoglycemic agent administered
 - The site where the medication was given
 - Any additional interventions that were performed

- **Sliding Scale**

- The scale is highlighted in a gray box. It provides the following information:
 - o Date and time the scale was entered, as well as the name and title of the person who entered it
 - o Low and high blood sugar values, as well as the appropriate insulin dosage
 - o Comments, if selected to print. This is an optional feature, please notify the facility Information Technology Department.
- If no sliding scale has been ordered or if one has been discontinued, it will be indicated by the following values and dosage: 0 - 999 0.00

The following is a full display of the **Diabetic Flowsheet** report.

Evident Community Hospital									
DIABETIC FLOW SHEET									
Page 1 of 1 Printed: 8/11/14 at 15:08									
SMITH ELLA KATHERINE Number: 357814 Age: 66 RICHARD JOHNSON JR Sex: F Room: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015									
DIET: REGULAR DIET Glucose Reference Range: 65 - 100 mg/dl									
RECORDED BY...	METHOD	LEVEL	DOSE / UNITS	BOLUS	DESCRIPTION	SITE/OMIT REASON	IX	INTERVENTION/COMMENT	PROTOCOL
07/23/2014 08:44 (HARRIS SMIT)	MAR	500 MG	0	0	METFORMIN (GLUCOPHAGE) TAB	PO	N		
08/08/2014 16:15 (JAMESON C)		OMITTED	0	0	INSULIN ASPART (novolog) INJ 1	DISCONTINUED	N		
08/09/2014 08:00 (JAMESON C)	BLOOD GLUC	145	2 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
12:00 (JAMESON C)	BLOOD GLUC	165	4 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
17:00 (JAMESON C)	BLOOD GLUC	150	2 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
21:00 (JAMESON C)	BLOOD GLUC	160	2 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
08/10/2014 08:00 (JAMESON C)	BLOOD GLUC	170	4 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
12:00 (JAMESON C)	BLOOD GLUC	155	2 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
17:00 (JAMESON C)	BLOOD GLUC	163	4 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
21:00 (JAMESON C)	BLOOD GLUC	135	2 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
08/11/2014 08:39 (JAMESON C)	BLOOD GLUC	142	2 Unit (#)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
1 Dr. Baxter's BG Sliding Scale									
				Low	High	Units	Notify	Comments	
08/08/2014 16:16 (JOHNSON)				0	70	0	0	BG < 50 QJ, BG >50 QJ w/sugar	
Subcutaneous				71	110	1	0		
INSULIN ASPART (novolog) INJ 100U/ML				111	160	2	0		
AC/HS				161	225	4	0		
				226	275	8	0		
				276	360	12	0		
				361	400	16	0		
				401	999	20	Y	0	

16.3 Cumulative Report

The Cumulative Report will display the report from the beginning of the patients stay to the current date.

Select **Charts** > **Select Patient Account** > **Attachments** > **Diabetic** > **Cumulative Report**

Diabetic Cumulative

Data included on the Cumulative Report is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name, Account Number and Medical Record Number
 - Admitting physician
 - Age, sex and room number
 - Any drug allergies documented through TruBridge
- **Diet**
 - The patient's current diet will display in the top right-hand corner of the report, just below the demographics box.
- **Documentation Area**
 - Date and time of each entry charted
 - Name and title of the person who charted each entry
 - Blood sugar level and dose (if administered)
 - Type of Insulin or Hypoglycemic agent administered
 - The site where the medication was given
 - Any additional interventions that were performed

- **Sliding Scale**

- The scale is highlighted in a gray box. It provides the following information:
 - o Date and time the scale was entered, as well as the name and title of the person who entered it
 - o Low and high blood sugar values, as well as the appropriate insulin dosage
 - o Comments, if selected to print. This is an optional feature, please notify the facility Information Technology Department.
- If no sliding scale has been ordered or if one has been discontinued, it will be indicated by the following values and dosage: 0 - 999 0.00

The following is a full display of the **Diabetic Flowsheet** report.

Evident Community Hospital									
DIABETIC FLOW SHEET									
Page 1 of 1 Printed: 8/11/14 at 15:12									
SMITH ELLA KATHERINE Number: 357814 Age: 66 RICHARD JOHNSON JR Sex: F Room: 300-7 ALLERGIES: No Known Dru Peanuts M/R#: 970015									
DIET: REGULAR DIET Glucose Reference Range: 65 - 100 mg/dl									
RECORDED BY...	METHOD	LEVEL	DOSE / UNITS	BOLUS	DESCRIPTION	SITE/OMIT REASON	1X	INTERVENTION/COMMENT	PROTOCOL
07/23/2014 08:44 (BARBRA SMIT)	MAR	500 MG	0	0	METFORMIN(GLUCOPHAGE) TAB	PO	N		
08/08/2014 16:15 (JAMESON C)		OMITTED	0	0	INSULIN ASPART (novolog) INJ 1	DISCONTINUED	N		
08/09/2014 08:00 (JAMESON C)	BLOOD GLUC	145	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
12:00 (JAMESON C)	BLOOD GLUC	165	4 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
17:00 (JAMESON C)	BLOOD GLUC	150	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
21:00 (JAMESON C)	BLOOD GLUC	160	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
08/10/2014 08:00 (JAMESON C)	BLOOD GLUC	170	4 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
12:00 (JAMESON C)	BLOOD GLUC	155	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
17:00 (JAMESON C)	BLOOD GLUC	163	4 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
21:00 (JAMESON C)	BLOOD GLUC	135	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
08/11/2014 08:39 (JAMESON C)	BLOOD GLUC	142	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1
1 Dr. Baxter's BG Sliding Scale									
				Low	High	Units	Notify	Comments	
08/08/2014 16:16 (JOHNSON)				0	70	0	0	BG < 50 UJ, BG >50 UJ w/sugar	
Subcutaneous				71	110	1	0		
INSULIN ASPART (novolog) INJ 100U/ML				111	160	2	0		
AC/HS				161	225	4	0		
				226	275	8	0		
				276	360	12	0		
				361	400	16	0		
				401	999	20	Y	0	

16.4 Daily Diabetic Report

The Daily Report will display 34 hours of data and is used to reveal frequently entered data such that may be seen in an Intensive Care Unit.

Select the date from the lower split screen to view desired report.

Select **Charts > Select Patient Account > Attachments > Diabetic > Daily Diabetic Report**

Daily Diabetic Report

Data included on the **Daily Flow Sheet** is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Account number, age, sex and room number
 - Medical Records number
 - Any drug allergies documented through TruBridge
- **Diet**
 - The patient's current diet will display in the top right-hand corner of the report, just below the demographics box.
- **Graphic Display**
 - 34-Hour graphic representation of all insulin and blood sugar levels.
 - All blood sugar levels plot on the graph; however, only the most recent level/time in each 1-hour increment prints on the report.

- Asterisks indicate more than one level charted within 1-hour increment.
- Interventions print vertically under the time period for which they were performed.
- Lab results plot separately and are indicated in bold.
- Diet percent consumed also graphs. Information pulls from recordings performed in Medact.
- Individual totals for NPH, Regular, IV and Miscellaneous insulin, as well as oral agents given, print in 1-hour increments.

- **Sliding Scale**

- Sliding scales print on a separate page.
- The date, time, name and credentials of the person who entered the scale will print.
- Indicates if the sliding scale is IV or subcutaneous.
- Gray indicates an inactive sliding scale.
- White indicates an active sliding scale.
- Comments: This is an optional feature. Please notify hospital Information Technology Department.

- **Legend:** Located bottom left hand corner of the Diabetic Flow Sheet.

- "*" indicates more than one result during this time period
- "/" indicates a blood glucose > 300
- "o" or plain text indicates Point of Care entry
- • or Bold indicates Lab result

NOTE: In order for lab results to pull to the Diabetic Flow Sheet, the POC control record must be set up to include the items from lab. The item descriptions listed in the POC control record must be set up in the Reference Range Tables.

The following is a full display of the ICU format of the **Diabetic Flow Sheet**.

Evident Community Hospital																	SMITH ELLA KATHERINE		Number: 357814								
DIABETIC FLOW SHEET -ICU																	RICHARD JOHNSON JR		Age: 66								
From: 08/10/14 TO: 08/11/14																	ALLERGIES: No Known Dru Peanuts		Sex: F								
																	DIET: REGULAR DIET		Room: 300-7								
																	Glucose Reference Range: 65 - 100 mg/dl		M/R#: 970015								
Time	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	Time		
Gluc		163				135											142									Gluc	
Time		17:00				21:00											08:39									Time	
1000																										1000	
900																										900	
800																										800	
700																										700	
600																										600	
500																										500	
400																										400	
300																										300	
200																										200	
100																										100	
0																										0	
Time																										Time	
100																										100	
75																										75	
50																										50	
25																										25	
0																										0	
Carb																										Carb	
Time																										Time	
+ indicates no blood glucose recorded * indicates more than one result during this time period ^ indicates a blood glucose > 1000 ○ or Plain text indicates Point of Care entry ● or Bold indicates Lab result																											
RECORDED BY...	METHOD	LEVEL	DOSE / UNITS	BOLUS	DESCRIPTION	SITE/OMIT REASON	IX	INTERVENTION/COMMENT	PROTOCOL																		
08/10/2014 17:00 (JAMESON C)	BLOOD GLUC	163	4 Unit (s)	0	INSULIN ASPART (novolog)	INJ 1	RIGHT ARM	N	1																		
21:00 (JAMESON C)	BLOOD GLUC	135	2 Unit (s)	0	INSULIN ASPART (novolog)	INJ 1	LEFT ARM	N	1																		
08/11/2014 08:39 (JAMESON C)	BLOOD GLUC	142	2 Unit (s)	0	INSULIN ASPART (novolog)	INJ 1	RIGHT ARM	N	1																		

Evident Community Hospital

DIABETIC FLOW SHEET -ICU

From: 08/10/14 TO: 08/11/14

Page 2 of 2

Printed: 8/11/14 at 15:54

SMITH ELLA KATHERINE

Number: 357814

Age: 66

RICHARD JOHNSON JR

Sex: F

Room: 300-7

ALLERGIES: No Known Dru Peanuts

M/R#: 970015

DIET: REGULAR DIET

Glucose Reference Range: 65 - 100 mg/dl

1	Dr. Baxter's BG Sliding Scale	Low	High	Units	Notify	Comments
	08/08/2014 16:16 (JOHNSON)	0	70	0	0	BG < 50 QJ, BG >50 QJ w/sugar
	Subcutaneous	71	110	1	0	
	INSULIN ASPART (novolog) INJ 100U/ML	111	160	2	0	
	AC/HS	161	225	4	0	
		226	275	8	0	
		276	360	12	0	
		361	400	16	0	
		401	999	20	Y	0

16.5 Weekly Report

The Weekly Report will display the most recent seven days of entered data for the patient. This report is utilized for capturing less frequently entered data such as seen on a Medical Surgical Unit.

Select Charts > Select Patient Account > Attachments > Diabetic > Weekly Diabetic Report

Diabetic Weekly Report

Data included on the **Weekly Diabetic Flow Sheet** is outlined below:

- **Demographics Box** (located upper right-hand corner)
 - Patient's name
 - Admitting physician
 - Account number, age, sex and room number
 - Medical Records number
 - Any drug allergies documented through TruBridge
- **Diet**
 - The patient's current diet will display in the top right-hand corner of the report, just below the demographics box.
- **Graphic Display**
 - 7-Day graphic representation of all insulin and blood sugar levels.
 - All blood sugar levels plot on the graph, however only the most recent level/time in each 6-hour increment prints on the report.
 - Asterisks indicate more than one level charted within a 6-hour increment.
 - Interventions print vertically under the time period for which they were performed.

- Lab results plot separately and are indicated in bold.
- Diet percent consumed also graphs. Information pulls from recordings performed in Medact.
- Individual totals for NPH, Regular, IV and Miscellaneous insulin, as well as oral agents give print in 6 hour increments.

- **Sliding Scale**

- Sliding scales print on a separate page.
- The date, time, name and credentials of the person who entered the scale will print.
- It will indicate if the sliding scale is IV or subcutaneous.
- Gray indicates an inactive sliding scale.
- White indicates an active sliding scale.
- Comments, This is an optional feature, please notify hospital Information Technology Department.

- **Legend:** Located bottom left hand corner of the Diabetic Flow Sheet.

- "*" indicates more than one result during this time period
- "^" indicates a blood glucose > 300
- "o" or plain text indicates Point of Care entry
- • or Bold indicates Lab result

NOTE: In order for lab results to pull to the Diabetic Flow Sheet, the POC control record must be set up to include the items from lab. The item descriptions listed in the POC control record must be set up in the Reference Range Tables.

The following is a full display of the Weekly format of the **Diabetic Flow Sheet**.

Evident Community Hospital										SMITH ELLA KATHERINE		Number: 357814			
DIABETIC FLOW SHEET -Routine										RICHARD JOHNSON JR		Age: 66			
From: 08/05/14 TO: 08/11/14										Printed: 8/11/14 at 16:10		Sex: F			
										ALLERGIES: No Known Dru Peanuts		Room: 300-7			
												M/R#: 970015			
										DIET: REGULAR DIET					
										Glucose Reference Range: 65 - 100 mg/dl					
Date	5-Aug 2014	Tue	6-Aug 2014	Wed	7-Aug 2014	Thu	8-Aug 2014	Fri	9-Aug 2014	Sat	10-Aug 2014	Sun	11-Aug 2014	Mon	Date
Gluc Time										145 150* 160 08:00 17:00 21:00	170 163* 135 08:00 17:00 21:00	142 08:39			gluc Time
1000															1000
900															900
800															800
700															700
600															600
500															500
400															400
300															300
200															200
100															100
0															0
Time	06 12 18		06 12 18		06 12 18		06 12 18		06 12 18		06 12 18		06 12 18		Time
% Cons	100 75 50 25 0														% Cons
Carb Time															Carb Time
+ indicates no blood glucose recorded * indicates more than one result during this time period ^ indicates a blood glucose > 1000 () or Plain text indicates Point of Care entry ● or Bold indicates Lab result															
RECORDED BY...	METHOD	LEVEL	DOSE / UNITS	BOLUS	DESCRIPTION	SITE/OMIT REASON	IX	INTERVENTION/COMMENT	PROTOCOL						
08/08/2014 16:15 (JAMESON C)			OMITTED	0	INSULIN ASPART (novolog)	INJ 1	DISCONTINUED	N							
08/09/2014 08:00 (JAMESON C)	BLOOD GLUC	145	2 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	RIGHT ARM	N	1						
12:00 (JAMESON C)	BLOOD GLUC	165	4 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	LEFT ARM	N	1						
17:00 (JAMESON C)	BLOOD GLUC	150	2 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	RIGHT ARM	N	1						
21:00 (JAMESON C)	BLOOD GLUC	160	2 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	LEFT ARM	N	1						
08/10/2014 08:00 (JAMESON C)	BLOOD GLUC	170	4 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	RIGHT ARM	N	1						
12:00 (JAMESON C)	BLOOD GLUC	155	2 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	LEFT ARM	N	1						
17:00 (JAMESON C)	BLOOD GLUC	163	4 Unit(s)	0	INSULIN ASPART (novolog)	INJ 1	RIGHT ARM	N	1						

Evident Community Hospital

DIABETIC FLOW SHEET -Routine

From: 08/05/14 TO: 08/11/14

Page 2 of 2

Printed: 8/11/14 at 16:10

SMITH ELLA KATHERINE

Number: 357814

RICHARD JOHNSON JR

Age: 66

Sex: F

Room: 300-7

M/R#: 970015

ALLERGIES: No Known Dru Peanuts

DIET: REGULAR DIET

Glucose Reference Range: 65 - 100 mg/dl

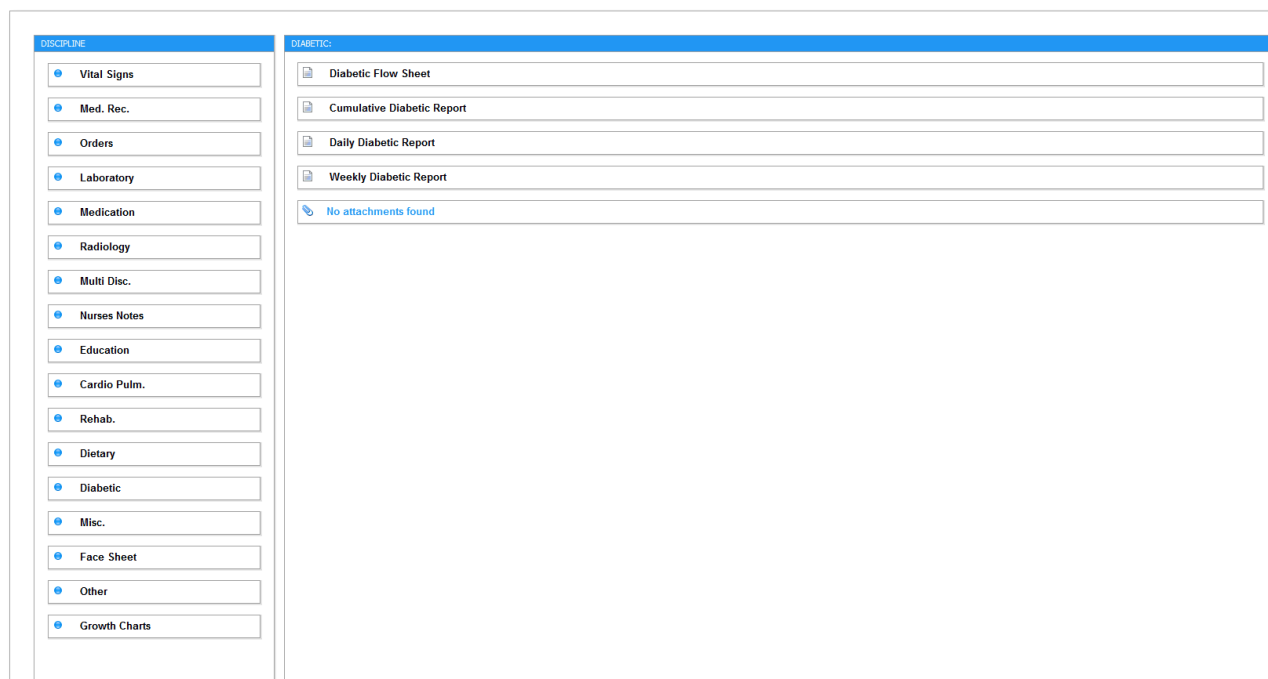
RECORDED BY...	METHOD	LEVEL	DOSE / UNITS	BOLUS	DESCRIPTION	SITE/OMIT REASON	1X	INTERVENTION/COMMENT	PROTOCOL
08/10/2014 21:00 (JAMERSON C)	BLOOD GLUC	135	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	LEFT ARM	N		1
08/11/2014 08:39 (JAMERSON C)	BLOOD GLUC	142	2 Unit(s)	0	INSULIN ASPART (novolog) INJ 1	RIGHT ARM	N		1

1	Dr. Baxter's BG sliding Scale	Low	High	Units	Notify	Comments
08/08/2014 16:16 (JOHNSON)		0	70	0	0	BG < 50 OJ, BG >50 OJ w/sugar
Subcutaneous		71	110	1	0	
INSULIN ASPART (novolog) INJ 100U/ML		111	160	2	0	
AC/HS		161	225	4	0	
		226	275	8	0	
		276	360	12	0	
		361	400	16	0	
		401	999	20	Y	0

16.6 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Diabetic > Attachments



Diabetic - Attachments

Deleted Items will display



Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 17 Miscellaneous

17.1 Overview

This section will discuss access to Miscellaneous functions from Updated ChartLink.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Miscellaneous**

The screenshot displays a web interface for viewing attachments. On the left, a sidebar titled "DISCIPLINE" lists various medical categories, each with a blue circular icon and a text box: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet, Other, and Growth Charts. The "Misc." option is highlighted with a blue border. The main area on the right is titled "MEDIC." and contains a search bar with the text "Census Report" and a magnifying glass icon. Below the search bar, a message states "No attachments found" next to a magnifying glass icon. The interface has a clean, professional design with blue accents.

Miscellaneous

17.2 Census Report

The Physician Census is a document that provides physicians with a concise listing of the patients for whom they are the attending or consulting physician, as well as the patient's most recent vital signs.

Select **Charts** > **Select Patient Account** > **Attachments** > **Miscellaneous** > **Census Report**

The screenshot displays a web application interface for generating a Census Report. On the left, a vertical sidebar titled 'DISCIPLINE' contains a list of medical disciplines, each with a blue circular icon and a text label: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet, Other, and Growth Charts. The main content area on the right is titled 'MISC.' and features a search bar with the text 'Census Report'. Below the search bar, a message states 'No attachments found'.

Census Report

Data included on the Physician Census is outlined below:

- **Physician Name Box** (located upper right-hand corner)
 - Physician's name
 - The name of the nursing unit
 - This information is duplicated along the bottom edge of the report as well.
- **Patient Information:** Each page will display information for one patient and will include the following:
 - Patient room number
 - Patient name, age, sex, and length of stay
 - Admitting diagnosis
 - Demographics: Condition, Advanced Directives, Restraints, Admit Date, Medical Record Number, Violent, MRSA, VRE, Isolation, Fall Risk, Language, and Ethnicity
 - Most recent set of vital signs
 - Temperature (including site)
 - Pulse (including site)
 - Respiration

- Blood pressure (including posture and extremity)
- Oxygen: L/M, FiO3, O3 Sat, and Method
- Most recent weight
- Date and time the vitals were charted
- Name and title of the person who charted the vitals

NOTE: *Patients, for whom a physician is consulting, are highlighted in a gray box. The attending physician's name is indicated at the top of the box.*

The **Census Report** will display in Adobe Acrobat Reader format.

The following is a full display of the Census Report.

Evident Community Hospital

Physician Census

Printed: 08/14/14 14:07 (Thursday) Page 1 of 1

RICHARD JOHNSON JR

NS Medical-Surgical

Room: 300-7

SMITH ELLA KATHERI Age: 66 Sex:F LOS: 90

Diagnosis:

Cond: G DNR: Adv Directive: Y Restraints:

Admit Date: 05/16/14 MR Number: 970015

Violent: MRSA: Y VRE: Y Isolation:

Fall Risk:

Language: English

Ethnicity:

Temp: 99.1 ORAL 07/30/14 08:00 {BARBRA SMIT}

Pulse: 65 RADIAL 07/30/14 08:00 {BARBRA SMIT}

Resp: 17 07/30/14 08:00 {BARBRA SMIT}

B/P: 130/82 LYING 07/30/14 08:00 {BARBRA SMIT}

O2 L/M: 2 07/07/14 14:34 {13 E}

FIO2:

O2 SAT: 100 07/30/14 08:00 {BARBRA SMIT}

Method :O2 Cannula 07/07/14 14:34 {13 E}

Weight: 166 lbs 07/08/14 10:00 {13 E}

75.3 kgs 75296.3 gm

RICHARD JOHNSON JR

NS Medical-Surgical

Evident Community Hospital

Physician Census

Printed: 08/14/14 14:07 (Thursday) Page 1 of 1

RICHARD JOHNSON JR

PHYS APPS CROSSTRAIN

Room: 177-8

PETERSEN ASHLYNN Age: 26 Sex: F LOS: 94

Diagnosis: Abdominal pain

Cond: G DNR: Adv Directive: Y Restraints:

Admit Date: 05/12/14 MR Number: 000275

Violent: MRSA: N VRE: N Isolation:

Fall Risk:

Language: English

Ethnicity:

Temp: 100.1 ORAL 06/10/14 13:08 {13 E}

Pulse: 66 RADIAL 06/10/14 13:08 {13 E}

Resp: 20 06/10/14 13:08 {13 E}

B/P: 145/75 LYING 06/10/14 13:08 {13 E}

O2 L/M:

Fio2:

O2 SAT: 100 06/10/14 13:08 {13 E}

Method :

Weight: 135 lbs 06/09/14 09:55 {EMPLOYEE S}
61.24 kgs 61235 gm

RICHARD JOHNSON JR

PHYS APPS CROSSTRAIN

17.3 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Census > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

MISC.

Census Report

No attachments found

Census - Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 18 Face Sheet

18.1 Overview

This section will discuss the feature of the Face Sheet.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Face Sheet**

The screenshot displays a software interface for managing face sheets. On the left, a vertical sidebar titled "DISCIPLINE" contains a list of medical disciplines, each with a blue circular icon and a text box. The disciplines listed are: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet (highlighted in blue), Other, and Growth Charts. On the right, a larger panel titled "FACE SHEET:" contains a list of face sheets. The list includes three entries: "Face Sheet" with a document icon, "FACESHEET" with a red circular icon, and "FACESHEET 08/23/13" with a calendar icon. The "FACESHEET 08/23/13" entry is highlighted.

Face Sheet

18.2 Face Sheet

The Face Sheet is the patient's record of admission.

Select **Charts**> **Select Patient Account** > **Attachments icon** > **Face Sheet**

The screenshot displays a software interface for a patient's Face Sheet. On the left, under the heading "DISCIPLINE", there is a vertical list of buttons with blue circular icons. The buttons are: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet (highlighted in blue), Other, and Growth Charts. On the right, under the heading "FACE SHEET", there is a list of attachments. The first attachment is "Face Sheet" with a document icon. The second attachment is "FACESHEET" with a red circular icon containing a white 'X'. The third attachment is "FACESHEET 08/23/13" with a document icon.

Face Sheet

The data included on a Face Sheet is facility defined. Some examples of patient data that can be included on the Face Sheet is outlined below:

- Patient Name
- Room Number
- Hospital Number
- Address
- Age
- Birth date
- Sex
- Birthplace
- City
- State
- Zip Code
- Social Security Number
- Religion
- Patient Telephone
- Spouse Information
- ho to Notify in an Emergency

- Patient Employer
- Guarantor Name
- Admitting Physician
- Consulting Physician
- Admitting Service
- Admitting Diagnosis
- Allergies
- Date of Last Admission
- Admission Date
- Time of Admission
- Financial Class
- Medical Records Number

The **Face Sheet** will display in Adobe Acrobat Reader format.

The following is a full display of the **Face Sheet** .

COMMUNITY HEALTH SYSTEM		6600 Wall Street		Mobile		AL 36695	
RECORD OF ADMISSION							
STAY TYPE I/P	SUB TYPE PSYCH	SERVICE OBSERVAT	EXPECT DATE 5/16/14				
PATIENT NAME SMITH ELLA KATHERINE		ROOM NO. 300-7	HOSP. NO. 357814	ADDRESS LINE - 1 6600 WALL ST		ADDRESS LINE - 2	
AGE 66	BIRTHDATE 12/02/1947	SEX F	BIRTHPLACE ALABAMA	CITY MOBILE	STATE AL	ZIP CODE 36695	COUNTY CODE MOB
SSAN 369142648	NATIONALITY AFAMER	CIVIL ST. M	MILITARY N	RELIGION BAPTIST	CHURCH COTTAGE HILL BAPTIST	PATIENT TELEPHONE 251-639-8100	
SPOUSE INFORMATION	NAME OF HUSBAND OR NAME OF WIFE SMITH JERRY		SPOUSE BIRTHPLACE FLORIDA		SPOUSE EMPLOYER NAME		
	SPOUSE ADDRESS 123 CODY RD		SPOUSE EMPLOYER ADDRESS MOBILE AL				
NAME OF FATHER		BIRTHPLACE		NAME OF MOTHER		BIRTHPLACE	
NOTIFY IN CASE OF EMERGENCY	NAME JOHNSON DOROTHY M		RELATIONSHIP	ADDRESS 6601 VAUGHAN CT SATSUMA AL		TELEPHONE 251-679-9776	
PATIENT EMPLOYER NAME R & R CONSTRUCTION INC		EMPLOYER ADDRESS 1725 SPRINGDALE MOBILE		EMPLOYER TELEPHONE 251-634-8170		GUARANTOR OCCUPATION BUSINESS OFFI	
GUARANTOR NAME SMITH ELLA KATHERINE		GUARANTOR TELEPHONE 251-639-8100		HOSPITALIZATION INSURANCE BLUE CROSS-I/P PPL5454518744 /562113			
GUARANTOR ADDRESS - 1 6600 WALL ST		CITY MOBILE					
GUARANTOR ADDRESS - 2		STATE AL		ZIP CODE 36695	DATE	TIME	PLACE
ATTENDING PHYSICIAN JOHNSON		CONSULTING PHYSICIAN	ADMITTING SERVICE OBSERVAT	SMOKER 3	ADMITTING DIAGNOSIS		
ALLERGIES No Kn Peanu		DATE LAST ADM. 5/13/14		PREV. ADM. NO. 357811	ADMISSION DATE 5/16/14	TIME OF ADMISSION 4:13 PM	INITIALS RCJ
FINANCIAL CLASS B	MEDICAL RECORDS NUMBER 970015	ADMISSION CODE 31/ELPR	HOME 1	SHORT TERM HOSPITAL 2	SKILLED NURSING FACILITY 3	INTERMEDIATE CARE FACILITY 4	HOME HEALTH AGENCY 5
CANCER/ CHILD_HOSP 6			LEPT AMA 7		EXP 20	OTHER 70	TIME PM
PRINCIPAL DIAGNOSIS:							
ADVANCE DIRECTIVE = Y							
CODE							
SECONDARY DIAGNOSIS:							
PRINCIPAL OPERATION/DATE:							
SECONDARY OPERATIONS:							
Consultation With _____							
Results: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Not Treated ☐ Diagnosis Only ☐ Died ☐ Released Against Advice							
Cause of Death _____ Autopsy: ☐ Yes ☐ No							
I have examined and approved this complete medical record on _____ 20 _____							
Signed _____ Attending Physician							
ADMISSION - SUMMARY SHEET							

18.3 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Face Sheet > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

FACE SHEET:

Face Sheet

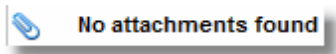
FACESHEET

FACESHEET 08/23/13

Face Sheet - Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 19 Other

19.1 Overview

This section will discuss the Other section under attachments located in Updated ChartLink.

Select **Updated ChartLink > Charts > Select Patient Account > Attachments > Other**

The screenshot shows the 'Other' section of the Updated ChartLink interface. On the left, a sidebar titled 'DISCIPLINE' lists various categories: Vital Signs, Med. Rec., Orders, Laboratory, Medication, Radiology, Multi Disc., Nurses Notes, Education, Cardio Pulm., Rehab., Dietary, Diabetic, Misc., Face Sheet, Other (highlighted), and Growth Charts. The main content area is titled 'OTHER:' and displays a list of attachments. The first attachment is 'ABN 05/26/11' with a document icon. The second attachment is 'ORDER RESULTS' with a circular arrow icon. The third attachment is 'ORDER RESULTS 01/25/11' with a document icon.

Other

19.2 Attachments

The Attachments area will contain any Scanned Images, Electronic Forms or Photo Uploads that have been assigned to this section.

Select Charts > Select Patient Account > Attachments > Other > Attachments

DISCIPLINE

Vital Signs

Med. Rec.

Orders

Laboratory

Medication

Radiology

Multi Disc.

Nurses Notes

Education

Cardio Pulm.

Rehab.

Dietary

Diabetic

Misc.

Face Sheet

Other

Growth Charts

OTHER:

ABN 05/26/11

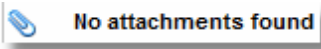
ORDER RESULTS

ORDER RESULTS 01/25/11

Other - Attachments

Deleted Items will display 

Setup to display items may be referenced in the [Image Title](#) User Guide or the [Electronic Forms](#) User Guide.



will display if data is not present in this area to be viewed.

Chapter 20 Growth Charts

20.1 Overview

Growth Charts consist of a series of percentile curves that illustrate the distribution of selected body measurements in children. Growth charts are tools that contribute to forming an overall clinical impression for the child being measured. Growth charts can be added to Virtual Chart tab and printed at any time.

20.2 Growth Charts

Various growth charts, including WHO Growth Charts, are available depending upon the patient's age range and gender. Growth Charts for boys display blue and girls display pink. Weight and height must be present on the account in order for the growth charts to be accessible. Head circumference must be present for WHO Growth Charts. Physicians will have the ability to view historical growth charts: all charts from birth through the current age. Additionally, two different growth charts (5th to 95th Percentile and 3rd to 97th Percentile) are selectable, either for the current age or to include historical weight and height entries.

Select Reports and Attachments > Growth Charts

The screenshot shows a web application interface for selecting growth charts. At the top, a blue header bar contains the text "CHARTS > BETKOWSKI JAMES MARTIN (DISCHGD) > REPORTS AND ATTACHMENTS". Below this, a patient information bar displays: "BETKOWSKI JAMES MARTIN MR#: 000330 ACCOUNT#: 357950 DOB: 06/21/2000 Sex: M Current Weight: 139 lbs 63.05 kg 63049.30 g AGE: 16 CrCl: N/A Height: 70.00 inches BMI: 19.94 kg/m2 BSA: 1.76 m2 Admit Weight: 0 lbs 0.00 kg 0.00 g RM: 101-4 Diagnosis: Allergies:". On the left is a "System Menu" with various icons and links, including "Reports and Attachments" which is highlighted. The main content area is titled "GROWTH CHARTS:" and contains two sections. The "DISCIPLINE" section on the left lists various medical disciplines with radio buttons, and "Growth Charts" is selected and highlighted with a red box. The "GROWTH CHARTS:" section on the right contains two checkboxes: "Include only Well Child Visits" (unchecked) and "Show All Charts for Historical Comparison" (checked), both highlighted with a red box. Below these are several rows of growth chart options, each with a document icon and a title, such as "Stature-for-age and Weight-for-age (2 to 20 years) - Set 1", "Body Mass Index (2 to 20 years) - Set 1", "WHO Length-for-age and Weight-for-age (Birth to 24 months)", "Length-for-age and Weight-for-age (Birth to 36 months) - Set 1", "Length-for-age and Weight-for-age (Birth to 36 months) - Set 2", "WHO Head Circ. and Weight-for-length (Birth to 24 months)", "Head Circ. and Weight-for-length (Birth to 36 months) - Set 1", "Head Circ. and Weight-for-length (Birth to 36 months) - Set 2", and "Weight-for-stature (2 to 5 years) - Set 1".

Growth Charts

Include only Well Child Visits: If selected, the growth chart that is chosen will only display the vital signs entered on a patient that has the **Well Child** check box selected in Vital Signs entry. If this is deselected, all vitals display.

Show All Charts for Historical Comparison: If selected, all available Growth Charts that exist for the patient will be displayed for selection.

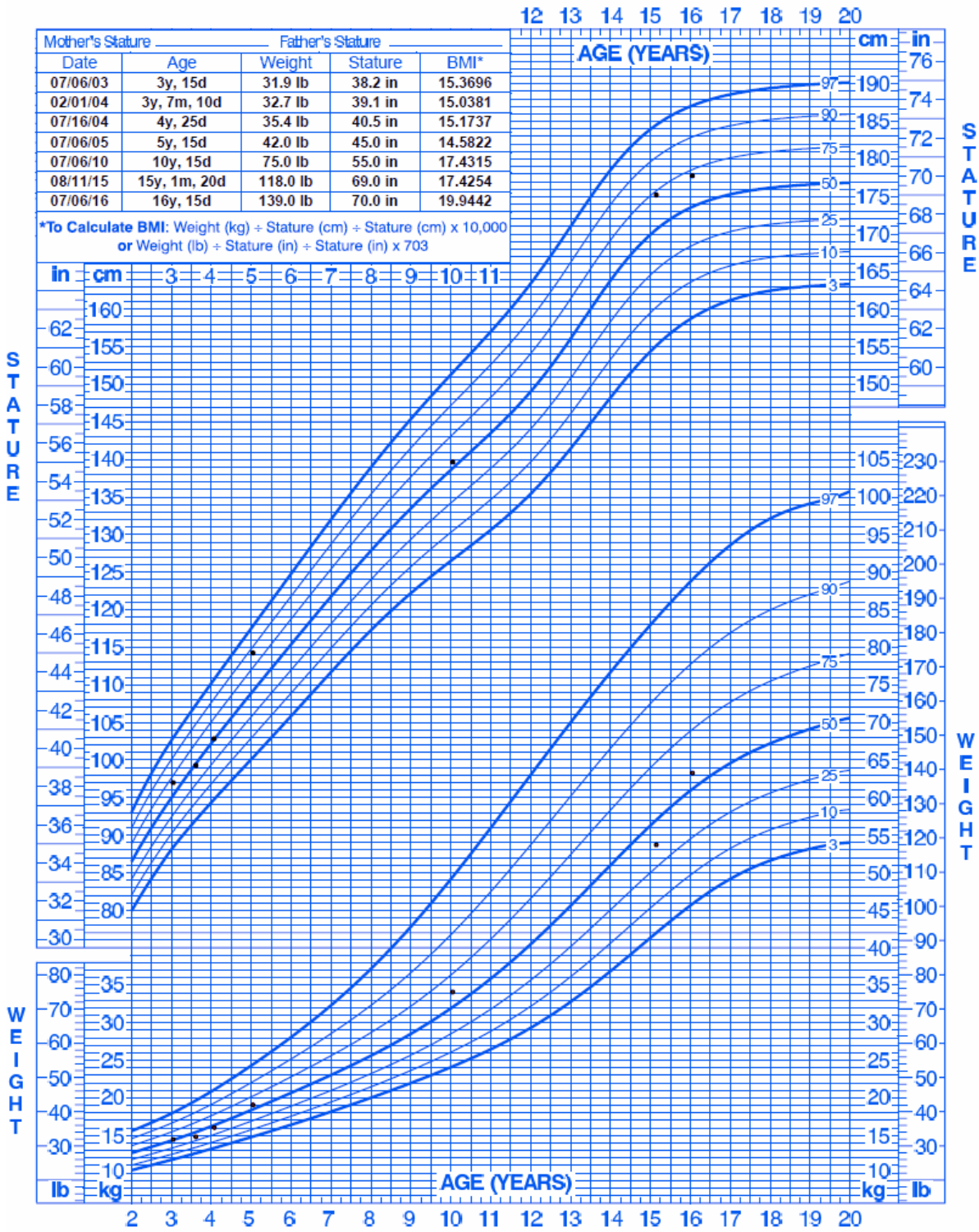
Data included on the available Growth Charts is outlined below:

- **Birth to 36 Months**
 - Length-for-age and Weight-for-age for the sex of the patient - Set 1 (5 - 95 Percentile)
 - Length-for-age and Weight-for-age for the sex of the patient - Set 2 (3- 97 Percentile)
 - Head Circ. and Weight -for-length for the sex of the patient - Set 1 (5 - 95 Percentile)
 - Head Circ. and Weight for length for the sex of the patient - Set 2 (3- 97 Percentile)
- **2 Years to 5 Years**
 - Weight-for-stature for the sex of the patient - Set 1 (5 - 95 Percentile)
 - Weight-for-stature for the sex of the patient - Set 2 (3- 97 Percentile)
- **2 Years to 20 Years**
 - Stature-for-age and Weight-for-age for the sex of the patient - Set 1 (5 - 95 Percentile)
 - Stature-for-age and Weight-for-age for the sex of the patient - Set 2 (3- 97 Percentile)
 - Body Mass Index for the sex of the patient - Set 1 (5 - 95 Percentile)
 - Body Mass Index for the sex of the patient - Set 2 (3- 97 Percentile)
- **WHO Birth to 24 Months**
 - Length-for-age and Weight-for-age for the sex of the patient
 - Head Circ. and Weight-for-length for the sex of the patient
- **No attachments found** displays when there are no vitals signs available for the age ranges within a Growth Chart.

The following page is an example of a growth chart.

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

NAME BETKOWSKI JAMES MARTIN
RECORD # 000330



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with
the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>



The following information will display on the Growth Chart:

- **Name:** Patient Name from the Patient Profile.
- **Record #:** Medical Record Number from the Patient Profile.
- **Date:** The date the vitals were entered from the Date/Time field in the Vitals application.
- **Age:** The patient's age at the time the vitals were entered in y,m,d format.
- **Weight:** The patient's weight in pounds.
- **Stature:** The patient's height in inches.
- **BMI:** The patient's calculated Body Mass Index from the weight and height.
- Male patients will display in blue font. Female patients will display in pink font.

The **Export** option displays on the action bar allowing the growth chart to be printed.

Select the back arrow to return to the Growth Charts.