



Documentation Tip Sheet

Document Templates

1. Select the  button from the navigation bar.
2. The documentation screen will open. Any documents that have been started but not completed for the patient will display. Select **My** to see your documents or **All** to see documents by other providers.



3. The available documentation types are visible under the **Add New Document** section. Use the Search New Documents box to search and select your favorites.

Note: To select your favorites, click  the next to the documents pertinent to you. This will populate the document section with only what you need.

4. Click on the desired document and the template will open.

Documentation Symbols/Buttons



View a preview of the document



Return to document edit screen



Save the document in draft status



Sign the document



Access additional options



Use Typical



View previous entries for a section



Launch Patient History, Allergies or Home Medications



Insert formatted data or canned text



Opens comment field



Opens further data options for that field




Search for more images




Spellcheck

Sign Documents

1. Click .
2. Select the document on the left to open it in the document viewer.
3. If needed, click **Edit** or **Edit Signers/CC's**.
4. Once you are ready to sign, click Submit. Type in your PIN. Press enter.

Add Copies To

Use "Copies To" to send the report to additional physicians/locations.

Providers who already have a documented relationship with the patient will display. Click  Other... to search for other providers not listed.

Copies To

Robin Carriere (Adm)



SELF

 Other...




If the provider does not exist in the dictionary, it allows you to **Add Recipient**. Enter all required information for the provider, including name, complete address and fax number. Click Save.

Add Addendum to a Signed Document




Once a document is signed it can no longer be edited. If a correction is needed, an addendum can be used to add information to the signed document.

1. Select the  button from the navigation bar.
2. Choose the document to amend.
3. Enter your notes in the addendum section.
4. Click  to save and view your addendum.

Edit a Document


1. Select the  button.
2. Click the document to edit.
3. Complete the required edits.
4. Click  to save in draft status or  to sign the document.

Delete a Document in Draft Status

1. Click the  button.
2. Select the document you would like to delete.
3. Click  and then **Delete Document**
4. A confirmation screen will display. Click  to delete the document.

Add Formatted Data


Use Formatted Data to add pre-built collections of patient information, such as demographics, clinical, and recent laboratory information.

1. From a text box within a document, click  and select **Formatted Data**.
2. Select the data to add and click **Insert**.

Note: Use  the to select favor-

Add Canned Text


Use Canned Text to ...

1. From a text box within a document, click  and select **Canned Text**.
2. Select the text to add and click **Insert**.

Note: Use  the to select favor-

Add Quick Text




Use Quick Text to ...

1. From a text box within a document, click  and select **Quick Text**.
2. Select the text to add and click **Insert**.

Note: Use  the to select favor-

Recall Data

Use Formatted Data to add pre-built collections of patient information, such as demographics, clinical, and recent laboratory information.

1. Click the  button from within the Edit or Preview mode of a document.
2. The Recall screen will display. Use the  drop down to access responses from your own documents, nursing assessments, progress notes or other documents pertaining to the patient's current visit.
3. Check off the data to recall and click  to insert it into to the documentation.



Create Typical

Typicals are used to create sets of personal normal responses using the responses on the document as a building block. You can create typical specific to a patient's age, sex and condition.



Create Typical

1. To create typical for a specific section, first select your own normal responses for the documentation questions.
2. Click the gear icon and select **Create New Typical**.
3. Enter a Name for your typical.
4. Edit and confirm the responses.
5. Click **Save**.


Use Typical

1. Open a new document.
2. Click on the  icon.
3. Select the one you would like to use and click 

Adding Sections

1. Click on the  button and select **Add Content**.
2. Search the available sections and select the section to add.
3. Once you have added all sections click 
4. The new section will display.

Proofread before Signing

- Check numbers to ensure lab values and medication doses are correct (e.g. 15 vs. 50).
- Look for patient gender errors (e.g. he vs. she).
- Check for nonsensical words. Mumbling/poor pronunciation can lead to added words not intended for the report.
- Include punctuation when dictating, as this will cut down editing time.
- Always use the spellcheck  button.