

## DocuTAP Training Checklist

*(many checked only after I saw here that it could be done and tried it; wish I'd had this when I first trained on the EMR)*

### Login Screen

- ✓ \_\_\_\_\_ Able to successfully log in
- ✓ \_\_\_\_\_ Answer "Yes" to the location prompt to confirm location

### Home Page

#### Instant Messaging

- ✓ \_\_\_\_\_ Able to send IM to another person
- ✓ \_\_\_\_\_ Able to reply to an IM
- ✓ \_\_\_\_\_ Able to determine if a user is online or not
- ✓ \_\_\_\_\_ Able to move a message from current to received status
- ✓ \_\_\_\_\_ Able to filter messages to quickly locate a desired message

#### Schedule

- ✓ \_\_\_\_\_ Able to select appropriate clinic for schedule
- ✓ \_\_\_\_\_ Able to select appropriate providers and waiting room
- ✓ \_\_\_\_\_ Able to associate with appropriate provider
- ✓ \_\_\_\_\_ Able to use F1 key to ensure that they are current user on system
- ✓ \_\_\_\_\_ Able to move patient from waiting room schedule to their own schedule *(usually, though sometimes it is like trying to grab the soap on the floor of the shower as it takes 2-3 tries to make a drag "stick")*
- ✓ \_\_\_\_\_ 1 color scheme of schedule (e.g. Gray-reg, Red-WR, Blue-in room)
- ✓ \_\_\_\_\_ Can access patient chart from schedule

## Chart Status

- ✓ \_\_\_\_\_ Understands different types of chart statuses
- ✓ \_\_\_\_\_ Can find chart statuses for previous dates by scrolling back
- ✓ \_\_\_\_\_ Can find previous dates' chart statuses by using calendar
- ✓ \_\_\_\_\_ Can access patient chart from the chart status

## Chart Room (main screen only)

- ✓ \_\_\_\_\_ Can switch to tracking board view
- ✓ \_\_\_\_\_ Aware of meaning of yellow and teal colors around room number
- ✓ \_\_\_\_\_ Aware that red ball to left of patient name indicates physician only
- ✓ \_\_\_\_\_ Aware yellow ball indicates physician must discharge and lock chart
- ✓ \_\_\_\_\_ Aware green ball to left of patient name indicates any provider may see patient
- ✓ \_\_\_\_\_ Aware of meaning of RT (room time) and FT (facility time)
- ✓ \_\_\_\_\_ Understands how to determine which patient is next to be seen
- ✓ \_\_\_\_\_ Understands the meaning of yellow and green balls for orders
- ✓ \_\_\_\_\_ Understands how to search for a patient chart by name
- ✓ \_\_\_\_\_ Aware search must be last name space first name (no comma) ***(they really should fix this; as Donald Norman says, when there are accepted standards, you need to follow them. See <http://ed-informatics.org/2010/02/11/computers-in-the-ed-11/> )***

## eRx

- ✓ \_\_\_\_\_ Aware that e-Prescribing not being performed at this time

## Orders

- ✓ \_\_\_\_\_ Aware that the orders screen is for clinical staff use only

## Signoff

- ✓ \_\_\_\_\_ Aware this screen is for physicians only
- ✓ \_\_\_\_\_ Aware that is screen is for signing off on mid-level charts only  
(Physician's own incomplete charts to be signed off using normal locking procedure)
- ✓ \_\_\_\_\_ Understands how to review charts by clicking on icon on right side of screen
- ✓ \_\_\_\_\_ Understands only charts marked as "Review" status should be signed off
- ✓ \_\_\_\_\_ Can perform a "batch" signoff
- ✓ \_\_\_\_\_ Can scan different date range to look for charts needing signed off

## Rx Lookup

- ✓ \_\_\_\_\_ Aware this screen contains limited drug information

## Chart Room (additional screens)

### Summary

- ✓ \_\_\_\_\_ Can obtain overview of patient's medical history from summary screen
- ✓ \_\_\_\_\_ Can compare vitals from previous visits to identify trends
- ✓ \_\_\_\_\_ Can locate and go to a specific visit from the summary screen

### Encounters (main screen)

- ✓ \_\_\_\_\_ Aware that all viewing and entries into patient chart are electronically tracked
- ✓ \_\_\_\_\_ Aware that browsing charts without valid reason is a HIPAA violation
- ✓ \_\_\_\_\_ Understands use of audit tool available from encounters screen
- ✓ \_\_\_\_\_ Able to toggle between patient visits using arrows
- ✓ \_\_\_\_\_ Able to print encounter if patient requests

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ Can determine Room number patient is occupying from the encounter screen
- ✓ \_\_\_\_\_ Can determine if the patient has been properly brought to their schedule from the encounter screen
- ✓ \_\_\_\_\_ Understands that “microphone” icon is for dictation and isn’t to be used
- ✓ \_\_\_\_\_ Understands that “talking head” is used for free text, but most free-text entries should be made within specific parts of the encounter. This area should be used primarily for free texting in the A/P section.
- ✓ \_\_\_\_\_ Aware that the default security level of all visits is 3 and should not be altered
- ✓ \_\_\_\_\_ Should see the name of the insurer above “summary” and should notify front office if there is no insurer listed so that it can be corrected
- ✓ \_\_\_\_\_ Mid-level providers advised that patients for which no insurer is noted may be patients who must see the physician, and special attention should be given to ensuring that they are aware of who the insurer is before seeing the patient to avoid the possibility that they are following the appropriate payor guidelines.
- ✓ \_\_\_\_\_ Can see potential insurers assigned to patient when the insurance hasn’t been attached to the visit (click on patient’s name, then on Insurance Info in pop up screen)
- ✓ \_\_\_\_\_ Understands proper use of “Mark items as reviewed” checkbox to indicate the areas of the history taken by clinical staff has been reviewed
- ✓ \_\_\_\_\_ Understands that the Social Hx has to be reviewed separately from the rest of hx

### Encounters (Chief Complaint)

- ✓ \_\_\_\_\_ Understands that the items checked in Common Symptoms section (upper part of page) by clinical staff determines which choices appear in the HPI section
- ✓ \_\_\_\_\_ Understands that the provider can edit symptoms chosen by clinical staff prn

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ Understands that the items checked in the Template section (bottom of page) by the provider determines the ROS and PE items are imported

### Encounters (Vitals)

- ✓ \_\_\_\_\_ Vitals typically entered by clinical staff
- ✓ \_\_\_\_\_ Vitals automatically time stamped as done when entered, so if vitals are performed by provider, they should document promptly to ensure accurate time is documented
- ✓ \_\_\_\_\_ New vital set obtained by pressing “New” button right lower corner of screen

### Encounters (Allergy)

- ✓ \_\_\_\_\_ Typically entered by clinical staff and reviewed by provider
- ✓ \_\_\_\_\_ Allergies MUST be entered under category Drugs and perform a search or pick from list
- ✓ \_\_\_\_\_ NEVER free text drug allergies (bypasses the drug-allergy interaction check)
- ✓ \_\_\_\_\_ May have clinical staff enter additional allergies patient makes provider aware of

### Encounters (Med List)

- ✓ \_\_\_\_\_ Typically entered by clinical staff and reviewed by provider
- ✓ \_\_\_\_\_ Meds MUST be entered using the search feature and picked from the search list
- ✓ \_\_\_\_\_ NEVER free text meds (bypasses the drug-drug and drug-allergy interaction checks)
- ✓ \_\_\_\_\_ Typically do not enter specific dosages/directions for meds
- ✓ \_\_\_\_\_ May have clinical staff enter additional meds pt makes provider aware of after triage

### Encounters (PMH)

- ✓ \_\_\_\_\_ Typically entered by clinical staff and reviewed by provider
- ✓ \_\_\_\_\_ Able to add to PMH using Common Diagnosis list
- ✓ \_\_\_\_\_ Able to add to PMH using search feature
- ✓ \_\_\_\_\_ Able to add to PMH Common Diagnosis list (use Lupus as example)

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ Able to add to PMH using free text feature
- ✓ \_\_\_\_\_ May have clinical staff enter additional PMH pt makes provider aware of after triage

### Encounters (Surg Hx)

- ✓ \_\_\_\_\_ Typically entered by clinical staff and reviewed by provider
- ✓ \_\_\_\_\_ Able to add to Surg Hx using Common Surgeries list
- ✓ \_\_\_\_\_ Able to add to Surg Hx using free text feature
- ✓ \_\_\_\_\_ May have clinical staff enter additional Surg Hx pt makes provider aware of after triage
- ✓ \_\_\_\_\_ Same surgery with 2 different dates means same surgery was performed twice

### Encounters (Family Hx)

- ✓ \_\_\_\_\_ Typically entered by clinical staff and reviewed by provider
- ✓ \_\_\_\_\_ Able to add to Family Hx using list
- ✓ \_\_\_\_\_ Family Hx usually added to “General” family member, but other options are present
- ✓ \_\_\_\_\_ Able to add to Family Hx using free text feature
- ✓ \_\_\_\_\_ May have clinical staff enter additional Fam Hx pt makes provider aware of after triage

### Encounters (Social Hx)

- ✓ \_\_\_\_\_ Typically entered by clinical staff and reviewed by provider
- ✓ \_\_\_\_\_ Can add/edit info on Social Hx screen
- ✓ \_\_\_\_\_ Should NOT use “Insert into Note” button upper right side of screen
- ✓ \_\_\_\_\_ Must click Reviewed Social History checkbox upper left of screen for each patient

### Encounters (“Procs” short for Procedures)

#### Labs

- ✓ \_\_\_\_\_ Use Procedures area to order labs performed onsite only
- ✓ \_\_\_\_\_ Use Lab section under Plan to order send out labs

## MedDispense

- ✓ \_\_\_\_\_ MedDispense tab is for clinical staff use only—Do not use

## Misc

- ✓ \_\_\_\_\_ Use only the Misc section and the Requires Procedure Note Above section
- ✓ \_\_\_\_\_ Chemical Cautery under Misc Procedures used for Gel-Foam or silver nitrate (use notes)
- ✓ \_\_\_\_\_ Self Pay/Corp Care Labs section is for clinical staff use only
- ✓ \_\_\_\_\_ Items checked in Requires Procedure Note Above section requires procedure note
- ✓ \_\_\_\_\_ Check box to order procedure BEFORE completing procedure note
- ✓ \_\_\_\_\_ Indicate Left, Right, and Bilateral as appropriate

## Supplies

- ✓ \_\_\_\_\_ Use this section to order supplies
- ✓ \_\_\_\_\_ Splints under Requires Procedure Note above must have Cast Splint note completed
- ✓ \_\_\_\_\_ Check box to order supply BEFORE completing Cast Splint note
- ✓ \_\_\_\_\_ Indicate Left, Right, and Bilateral as appropriate

## X-Ray

- ✓ \_\_\_\_\_ Indicate Left, Right, and Bilateral as appropriate
- ✓ \_\_\_\_\_ Recognize the standard study for each body area by the presence of 3 asterisks
- ✓ \_\_\_\_\_ Recognize that for each X-ray ordered, a preliminary reading must be documented
- ✓ \_\_\_\_\_ Recognize that additional X-rays can be ordered by scrolling the page to the right

## “Available Procedures” box/Procedure Notes

- ✓ \_\_\_\_\_ Gray box at the top of the Procs screen is for documenting procedure notes or interpretations of certain tests (e.g. EKG, X-rays, Tympanogram, Audiogram, etc....)
- ✓ \_\_\_\_\_ A number at the end of the procedure is for documenting multiples of the same

procedure – should always use the one without the number for the first procedure of that type (e.g. Cast Splint 2 note should only be used if 2 different splints are applied)

- ✓ \_\_\_\_\_ Abscess Drainage/Incision 2 and Wound repair 2 should only be used if there are different types of abscess drainage or wound repair performed. If multiple abscesses of similar type are drained, or multiple lacerations of the same complexity and location are repaired, only one procedure note is warranted. The comment field on the respective notes should be utilized and in the case of the abscess, ***procedure code 10061 should be used***, and in the case of the wound repair, the lengths of the lacerations should be added together and put on a single procedure note. If lacerations differ with respect to body location or complexity, then multiple procedure notes should be documented

***(don't know how to enter a procedure code for multiple abscesses and couldn't figure it out from looking at the screen.)***

- ✓ \_\_\_\_\_ Abscess Drain/Incision procedure note reviewed in detail
- ✓ \_\_\_\_\_ Audiogram/Tympanogram procedure note reviewed in detail
- ✓ \_\_\_\_\_ Burn treatment procedure note reviewed in detail
- ✓ \_\_\_\_\_ Cast Splint procedure note should be used on all Ortho-Glass and finger splints
- ✓ \_\_\_\_\_ Cast Splint procedure note not used for prefabricated splints (e.g. aircast, cock up splint)
- ✓ \_\_\_\_\_ Dipstick procedure note typically completed by clinical staff
- ✓ \_\_\_\_\_ Ear Irrigation/Wax Removal procedure note reviewed in detail
- ✓ \_\_\_\_\_ EKG Interpretation note reviewed in detail
  - ✓ \_\_\_\_\_ Rate must be documented
  - ✓ \_\_\_\_\_ Rhythm must be documented
  - ✓ \_\_\_\_\_ Axis must be documented
  - ✓ \_\_\_\_\_ R-wave progression must be documented

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ ST segments must be documented
- ✓ \_\_\_\_\_ Q waves must be documented
- ✓ \_\_\_\_\_ Interpretation must be documented and signed
- ✓ \_\_\_\_\_ The "This is for Medicare" checkbox is not to be used
- ✓ \_\_\_\_\_ Comments section can be used to document any aspect of EKG for which there isn't an appropriate checkbox
- ✓ \_\_\_\_\_ Epistaxis Control procedure note reviewed in detail
- ✓ \_\_\_\_\_ Excision of lesion procedure note reviewed in detail
- ✓ \_\_\_\_\_ FB Removal procedure note reviewed in detail
- ✓ \_\_\_\_\_ Infusion/IV procedure note is for clinical staff to document IV's
- ✓ \_\_\_\_\_ Joint Injection procedure note is used for drainage of bursa
- ✓ \_\_\_\_\_ Drainage or injection into joint spaces is not standard procedure at MedExpress
- ✓ \_\_\_\_\_ Lesion Removal/Liquid Nitrogen is procedure note to use for cryotherapy
- ✓ \_\_\_\_\_ Med Admin is method to order medications
- ✓ \_\_\_\_\_ Understands all oral meds have same CPT code (J8499)
- ✓ \_\_\_\_\_ Person administering medication is to complete the procedure note
- ✓ \_\_\_\_\_ Provider must order medication, route, and dose
- ✓ \_\_\_\_\_ Nail avulsion procedure note reviewed in detail (used for removal of ingrown nail)
- ✓ \_\_\_\_\_ Nebulizer treatment reviewed in detail (order first, then procedure note)
- ✓ \_\_\_\_\_ Only Albuterol and Atrovent checkboxes should be used under Rx section
- ✓ \_\_\_\_\_ Reduction of Dislocation procedure note reviewed in detail
- ✓ \_\_\_\_\_ Subungual Hematoma procedure note reviewed (cautery is typical tool used)
- ✓ \_\_\_\_\_ Total nail avulsion can be documented using the nail avulsion procedure note
- ✓ \_\_\_\_\_ Trigger point injection procedure code was reviewed

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ Wound dressings procedure note reviewed
- ✓ \_\_\_\_\_ Dressing should be ordered first, then procedure note used to indicate which type
- ✓ \_\_\_\_\_ Wound repair note MUST include documentation of all 3 characteristics
  
- ✓ \_\_\_\_\_ Multiple lacs with same location and complexity should be documented on same repair note and lengths of multiple lacs added to determine total length
- ✓ \_\_\_\_\_ X-ray procedure note is where reading of X-ray is documented
- ✓ \_\_\_\_\_ Either N (normal) or A (abnormal) checkbox should be checked for type of X-ray
- \_\_\_\_\_ Order for X-ray should be selected to “attach” reading to the X-ray study
- \_\_\_\_\_ If multiple X-rays, multiple readings should be performed by attaching each reading to corresponding X-ray study
  
- ✓ \_\_\_\_\_ Trainer should add trainee’s name to list of reviewers
- ✓ \_\_\_\_\_ Reviewer able to attach reviewer’s name to the X-ray readings

### Encounters (HPI)

- ✓ \_\_\_\_\_ Checkbox choices depend on highlighted symptom top half of screen
- ✓ \_\_\_\_\_ Checkbox choices should be used when appropriate
- ✓ \_\_\_\_\_ Free text should only be used to elaborate on checked choices or if no checkbox exists
- ✓ \_\_\_\_\_ Free texted information in HPI is NOT considered in coding calculations
- ✓ \_\_\_\_\_ Onset defaults to “days”, but can be changed when appropriate
- ✓ \_\_\_\_\_ Frequency and Duration can be used to be very specific about timing of symptoms prn
- ✓ \_\_\_\_\_ More general documentation of Timing of symptoms can be done using checkboxes in the Timing section and is generally sufficient for documentation of most complaints
  
- ✓ \_\_\_\_\_ Intensity can be documented using 1-10 scale or checkboxes indicating severity
- ✓ \_\_\_\_\_ Understand what B/W/NC means for the Mod. Fact. Section of the HPI

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ Additional checkboxes can be added for any symptom
- ✓ \_\_\_\_\_ Added checkboxes MUST fall under appropriate heading to maintain coding integrity
- ✓ \_\_\_\_\_ NEVER use the “red X” to delete a symptom (it will delete ALL choices if used)

## Encounters (ROS)

- ✓ \_\_\_\_\_ Both standard and original views for ROS viewed and preference selected
- ✓ \_\_\_\_\_ All non-documented systems reviewed checkbox NOT for routine use
- ✓ \_\_\_\_\_ Import template function reviewed and proper use of explained
- ✓ \_\_\_\_\_ Edit function for ROS for specific templates reviewed (add/remove checks)
- ✓ \_\_\_\_\_ Avoid use of “red X” when editing ROS templates

***I was told we were not allowed to edit ROS templates.***

- ✓ \_\_\_\_\_ Pertinent ROS (PY and PN) obtained from symptoms noted in HPI
- ✓ \_\_\_\_\_ Can document more specific information about specific symptoms in ROS

## Encounters (Exam)

- ✓ \_\_\_\_\_ Use import template function as baseline and alter to fit exam performed (shortcut)
- ✓ \_\_\_\_\_ Use of “remove all” button to erase entire exam documented and start over
- ✓ \_\_\_\_\_ Use of last exam button for baseline exam of little utility (maybe WC or F/U visit?)
- ✓ \_\_\_\_\_ How to draw pictures within the exam screen (may have up to 6 pics per visit)
- ✓ \_\_\_\_\_ Free texting of exam findings should be done in appropriate area of the Physical Exam
- ✓ \_\_\_\_\_ Templates for Exam are not customizable (only part of program that isn't)

## Encounters (Assessment)

- ✓ \_\_\_\_\_ ALL visits MUST have at least one diagnosis
- ✓ \_\_\_\_\_ E-code diagnoses describe how injury occurred, but not what injury is present and

cannot be used as sole diagnosis (e.g. fall, MVC, etc....)

- ✓ \_\_\_\_\_ Symptom should be used as a diagnosis if a more specific diagnosis can't be determined (e.g. Cough, facial pain, abdominal pain, etc....)
- ✓ \_\_\_\_\_ Visits for work-related injury MUST have an injury diagnosis (e.g. wrist sprain or contusion instead of wrist pain)
- ✓ \_\_\_\_\_ Visits related to an auto accident should include an injury diagnosis and MVA as diagnoses (if there is no injury and patient has no complaint/symptoms, use the Eval after other accident (incl MVA) diagnosis for the visit)
- ✓ \_\_\_\_\_ Search for uncommon diagnosis and attach to patient's chart
- ✓ \_\_\_\_\_ Add a diagnosis to common list of diagnoses
- ✓ \_\_\_\_\_ All added diagnoses should be renamed so that it doesn't appear in all caps
- ✓ \_\_\_\_\_ Diagnosis modifiers not generally used (may be used for follow up visits)
- ✓ \_\_\_\_\_ Can create a "differential diagnosis" list using the common diagnoses

## Encounters (Plan)

- ✓ \_\_\_\_\_ Must have a diagnosis assigned to visit for Plan options to appear
- ✓ \_\_\_\_\_ Generic Follow-up section and Free Text area available

## Order Sets

- ✓ \_\_\_\_\_ Combines all elements of the treatment plan into one "click"
- ✓ \_\_\_\_\_ Properly configured Order Sets are most efficient way to discharge once configured
- ✓ \_\_\_\_\_ Copy Order Sets from other physician that can be edited
- ✓ \_\_\_\_\_ Build an Order Set from scratch
- ✓ \_\_\_\_\_ Assist in building Order Sets for Top 10-20 diagnoses
- ✓ \_\_\_\_\_ Order sets should contain items that use 80+% of the time for a given diagnosis
- ✓ \_\_\_\_\_ Can create multiple Order Sets for same diagnosis (e.g. Bronchitis and Bronchitis with

wheezing) if appropriate

## Advice

- ✓ \_\_\_\_\_ Create to allow commonly used instructions to be available with one click
- ✓ \_\_\_\_\_ How to use current advice statements
- ✓ \_\_\_\_\_ Can edit current advice statements
- ✓ \_\_\_\_\_ Can create new advice statements
- ✓ \_\_\_\_\_ Can create new advice headings

## Labs

- ✓ \_\_\_\_\_ Used for send out labs (in-house labs ordered under Procs screen)
- ✓ \_\_\_\_\_ Most common “Urgent Care” labs listed
- ✓ \_\_\_\_\_ If lab is truly needed that isn’t listed, notify clinical staff of the lab you wish to order verbally and free text it into the A/P area
- ✓ \_\_\_\_\_ Consider referral to PCP/specialist if extensive lab evaluation is needed

## Misc Procedures

- ✓ \_\_\_\_\_ For ordering Doppler studies and Cardiac testing
- ✓ \_\_\_\_\_ Advanced cardiac testing should be accompanied by a Cardiology referral

## Referral Options

- ✓ \_\_\_\_\_ Choose the specialty from the drop down box
- ✓ \_\_\_\_\_ Email Dr. Stuchell if additional choices are needed
- ✓ \_\_\_\_\_ Should be accompanied by Referral Form (found under Letters section)

## Rx

- ✓ \_\_\_\_\_ Can add medication to Common Rx list
- ✓ \_\_\_\_\_ Can search for uncommon medication and prescribe for patient without adding to list

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ Can pick common sig from “My sigs” list (must click, even if only one sig listed)
- ✓ \_\_\_\_\_ Can cancel an Rx if entered in error
- ✓ \_\_\_\_\_ Can add a new sig and save it to “My sigs” for future use
- ✓ \_\_\_\_\_ Can add a new sig as a taper
- ✓ \_\_\_\_\_ Prednisone tapers created
- ✓ \_\_\_\_\_ Can print Rx’s (all or just selected ones)

***Actually, whenever I try to print just one prescription, they all print. I’ve been just checking one “P” box because when I do this all the prescriptions print.***

- ✓ \_\_\_\_\_ Can print DEA # on Rx’s

### X-Ray

- ✓ \_\_\_\_\_ Used to order advanced imaging (CT, MRI, U/S)
- ✓ \_\_\_\_\_ X-rays ordered under Procs screen
- ✓ \_\_\_\_\_ Should be accompanied by Referral Form (found under Letters section)

### Discharge Instructions

- ✓ \_\_\_\_\_ Can add discharge instructions to patient’s plan
- ✓ \_\_\_\_\_ Can print discharge instructions for patient
- ✓ \_\_\_\_\_ Can save copy of discharge instructions to patient’s chart
- ✓ \_\_\_\_\_ Can alter discharge instructions for the current patient only
- ✓ \_\_\_\_\_ Can search for discharge instructions (sometimes not where you think)

### Encounters (Coding)

- ✓ \_\_\_\_\_ MDM Risk must be manually assigned if no prescription is written for the visit
- ✓ \_\_\_\_\_ MDM Risk defaults to Moderate if a prescription is written
- ✓ \_\_\_\_\_ MDM Risk and Dx/Mgt options can be manually overridden IF appropriate
- ✓ \_\_\_\_\_ Job Aid for determining proper MDM Risk and Dx/Mgt options available

Name Keith Conover, M.D., FACEP

- ✓ \_\_\_\_\_ MDM Data, History, and Exam tracked by system based on documentation and should NOT be overridden
- ✓ \_\_\_\_\_ A visit type MUST be selected for each visit (use Other No Charge Visit for Occ Med)
- ✓ \_\_\_\_\_ Suggested E/M code cannot be overridden for New/Est office visits
  
- ✓ \_\_\_\_\_ Green and Red balls indicate which areas of the visit qualify or don't qualify for each Level of Service shown
- ✓ \_\_\_\_\_ Mid-level providers must set the Supervising Physician at the top right of screen
- ✓ \_\_\_\_\_ Understands how to lock chart
- ✓ \_\_\_\_\_ PIN number is set for provider
- ✓ \_\_\_\_\_ Provider understands how and when to unlock chart
- ✓ \_\_\_\_\_ Provider understands how and when to attach an addendum to a visit

## Health Maintenance

- ✓ \_\_\_\_\_ Not currently used by MedExpress

## Lab Hx

- ✓ \_\_\_\_\_ Not currently used by MedExpress

## Images

- ✓ \_\_\_\_\_ Place to access all images scanned into patient's chart
- ✓ \_\_\_\_\_ Images separated into different categories

## Letters

- ✓ \_\_\_\_\_ Place to find various forms
- ✓ \_\_\_\_\_ AMA form, Referral form, Work/School Excuse, and WC forms found here

## Forms

Name Keith Conover, M.D., FACEP

✓ \_\_\_\_\_ Used by clinical staff only