

Quantum[®]

Quantum[®] EHR for iPad[®]

User Manual

Release 2023



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What's New in this Release

This section describes the updates and enhancements available in Quantum[®] Electronic Health Record (EHR) for iPad[®] in May 2023.

Login Update

The sign in screen for Quantum Electronic Health Record (EHR) for iPad has been updated for increased security. After launching the app, tap *Sign in*. A browser pop-up appears where you can enter your existing login credentials. Tap *Sign In* to continue to Quantum Electronic Health Record (EHR) for iPad.

For more information, refer to "[Log in to Quantum EHR \(for iPad\)](#)" on page 6.

When using Touch ID or Face ID to log in, your last name and first name now display next to the fingerprint or face icon. Additionally, if you use Touch ID or Face ID to log in, you are now required to input your credentials every 7 days.

For more information, refer to "[Using Touch ID and Face ID](#)" on page 7.

About This Manual

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Introduction

This Quantum® Electronic Health Record (EHR) for iPad® User Manual provides information on accessing and using the Quantum EHR (for iPad) app, which is a companion to Quantum EHR.

Documentation Conventions

This manual uses the following conventions:

- Manual titles, special terms, screen and dialog box titles, menu items, button names, and labels that appear on screens and dialog boxes appear in *italic*.

Italic is also used to indicate variables. For example, an email address might be presented as *name@company.com*. When typing the address, you would use the actual user name and company name rather than *name* and *company*.

- Words that are being emphasized appear in bold.
- Text that you type, file names, and URLs appear in `this type style`.
- This manual calls your attention to important information in several ways:

Tip: A tip supplies information that can help you complete a task more quickly or otherwise better understand the capabilities of the product.

Note: A note indicates exceptions to the stated rule or information that emphasizes or supplements important points in the main text. A note can supply information that might apply only in special cases.

Caution! A caution indicates that failure to take or avoid a specified action could result in losing data. When you see a caution, follow the instructions carefully.

Abbreviations and Acronyms

The following is a list of abbreviations and acronyms that are used in this manual.

Abbreviation/Acronym	Description
CCD	Continuity of Care Document
CPT®	Current Procedural Terminology CPT copyright 2022 American Medical Association. All rights reserved.
DAW	Dispense as Written
DFARS	Defense Federal Acquisition Regulation Supplement
Diag	Diagnoses
DOB	Date of Birth
EDD	Estimated Date of Delivery
EPCS	Electronic Prescriptions for Controlled Substances
FARS	Federal Acquisition Regulation Supplement
GB	Gigabyte
HCPCS	Healthcare Common Procedure Code System
HIPAA	Health Insurance Portability and Accountability Act
Hx	History
ICD	International Classification of Diseases
PBM	Pharmacy Benefit Manager
PDF	Portable Document Format
PHI	Protected Health Information
PHQ-9	Patient Health Questionnaire
Rx	Prescription
Sig.	Latin <i>Signa</i>

Abbreviation/Acronym	Description
SNOMED®	Systemized Nomenclature of Medicine
SSN	Social Security Number
URL	Uniform Resource Locator
Vx	Vaccinations

Chapter 1: Getting Started

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About Getting Started

This section provides information that you may find helpful before you begin using Quantum EHR (for iPad), including a general overview, system requirements, basic navigation and system timeout information, instructions for logging in and logging out, and other tips and tricks that may help you complete your tasks more quickly.

About Quantum EHR (for iPad)

The Quantum® Electronic Health Record (EHR) for iPad® app is a companion to Quantum EHR, and is designed to support the physician's workflow. Quantum EHR (for iPad) provides you with access to all of the patient records that are available in your organization, and allows you to perform many of the same clinical tasks that you can perform using the web application. The Quantum EHR (for iPad) home screen, which appears after you log in, is a virtual desktop that provides access to new lab results and tasks, or pending items such as prescription approvals and renewals. Recently viewed patient charts also appear on the home screen. Up to 7 patient charts can be available.

The app appears in landscape view in order to provide you with optimal workspace for viewing patient charts and performing clinical activities. The split-pane display of the patient chart allows you to view the patient's clinical information while you perform other tasks such as writing prescriptions and completing patient encounter notes.

Quantum EHR (for iPad) supports Merit-based Incentive Payment System (MIPS) Advancing Care Information (ACI), Quality Measures, and Meaningful Use (MU) Stage 2 Modified reporting by counting clinical actions from Quantum EHR (for iPad) toward a report's measurements. For more information, see the web application's help.

Important Note About Data Security

No patient data is ever stored on your iPad. A secure connection is used to communicate with the Quantum EHR servers. Quantum EHR and Quantum EHR (for iPad) are designed to be Health Insurance Portability and Accountability Act (HIPAA) compliant.

System Requirements and Settings

In order to access Quanum® Electronic Health Record (EHR) for iPad®, your iPad must meet the hardware and software requirements listed in the following tables.

Hardware Requirements

Your iPad must meet the following hardware requirements.

Item	Requirement
Printer	Printer that supports AirPrint™. The printer must be connected to the same network as your iPad.
Internet connection	Wi-Fi or 5G

Software Requirements

Your iPad must meet the following software requirements.

Item	Requirement
Operating system	iOS 14 or newer. NOTE: iPad Air 1st generation, iPad Mini 2, and iPad Mini 3 do not support iOS 13 or newer.
eReader	The Quanum EHR (for iPad) User Manual that is available from the help will open in the Safari® browser, or you can open it using any PDF reader or the iBook® app.

Settings

Type Size	On your device, under <i>Settings > Display and Brightness > Text Size</i> , you can set your preferred reading type size. If you adjust the size to over 50 percent, the application will not function properly.
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Accessing Quantum EHR (for iPad)

To begin working, tap the Quantum EHR (for iPad) app on the home screen and log in using the user name and password provided to you by customer support.

Notes:

- If you are a member of multiple organizations, the organization you choose when you log in becomes the default care site for performing patient searches, as well as for your new lab results summary. For instructions on switching to a different organization of which you are a member, see "[Switching Between Organizations](#)" on page 9.
- If you also have eLabs (for iPhone) installed, you will not be able to log into the iPhone app until you have logged out of your Quantum EHR (for iPad) session.

Understanding Session Timeout

Your Quantum EHR (for iPad) session may time out for 1 of the following reasons:

- **Server inactivity.** If you are using the app, but have not accessed the Quantum EHR servers with actions such as saving changes or changing patient records over a specified time, you will experience a timeout and the app automatically logs you out. You are prompted to re-enter your password the next time you attempt to access the system.

Note: Specific fields create calls to the server at regular intervals. If you have any of these fields open, you will not experience a server inactivity timeout or lose the data you entered:

- History of Present Illness (HPI) free text
 - Subjective text
 - Objective text
 - Assessment text
 - Plan text
- **Security timeout.** After using the application for an extended period of time, a security timeout occurs. You are prompted to re-enter your password to continue using the app.

Note: Server and security timeout periods are configurable and can be set for your organization in the web app preferences screen.

Log in to Quantum EHR (for iPad)

- 1 On the home screen, tap the *Quantum EHR* icon.
- 2 On the Quantum EHR (for iPad) login screen, tap Sign in.
A browser pop-up appears.
- 3 Type your user name and password.
- 4 Tap *Sign In*.
- 5 If prompted, do one (or both) of the following:
 - Change your password:
 - a Tap and type your new password.
 - b Confirm your password and then tap *Save*.
 - Select and answer your security question(s).
- 6 Do one of the following, based on your organizational affiliation(s):

Note: The organization you choose at login becomes the default context for many of the tasks you can perform.

- **Single organization.** Your login is complete.
- **Multiple organizations.** If you belong to multiple organizations, tap and select the organization under which you want to log in.

Note: If you set a default organization using the web application, you do not have to select an organization each time you log in using the iPad.

The Quantum ePrescribing medication lists are downloaded upon login for the following situations:

- First login
- Any time the Quantum EHR (for iPad) app is updated or reinstalled
- When the medication database is updated
- If your organization medication preferences have changed

Log Out of Quantum EHR (for iPad)

On the Quantum EHR (for iPad) home screen, tap *Log out*.

Using Touch ID and Face ID

Touch ID and Face ID provide a secure and convenient way to access the Quantum Electronic Health Record (EHR) for iPad app. By associating your password with your fingerprint or face, you don't have to enter your password each time you log in to the app.

Note: You are still required to periodically reset your password with this feature, and you will need to reset your Touch or Face ID at that time.

Touch ID is available on the following iPad models:

- iPad (5th generation and later)
- iPad Pro
- iPad Air 2 or later
- iPad mini 3 or later


Face ID is available on the following iPad models:

- iPad Pro 12.9-inch (4th generation)
- iPad Pro 12.9-inch (3rd generation)
- iPad Pro 11-inch (2nd generation)
- iPad Pro 11-inch

Note: If you have an iPad that is shared among users in your office, this feature is not recommended.

After logging in to your device, you can set up this feature. For more information, see "[Setting up Touch or Face ID](#)" below.

Setting up Touch or Face ID

- 1 To enable Touch ID or Face ID, on the Quantum EHR (for iPad) home screen tap , and then tap *Settings*.

Note: You will see either Face ID or Touch ID, depending on the model of your device.

- 2 Tap the switch to enable *Allow Touch/Face ID for Login*.

Note: A warning appears and you will be asked to disable this feature if this is a shared device.

Security (Logged in as <Last name, First name>) appears above the *Allow Touch/Face ID for Login* setting.

- 3 Follow the on-screen prompt and use your finger or look at your device, depending on if you are using Touch or Face ID.
- 4 After confirmation, log out of the app.
You are returned to the sign-in screen.

Note: On the sign-in screen, a fingerprint icon or face icon followed by your name appears to indicate that the feature is enabled.

You are now set up to use Touch or Face ID. The next time you log in to the app, touch the icon and either hold your finger on the home button or look at your device, depending on your device setup.

Note: You must re-enter your username and password every 7 days for security.

Switching Between Organizations

Quantum EHR (for iPad) allows you to be a member of multiple organizations, and to switch between those organizations as needed while remaining logged in. If you are a member of more than 1 organization (for example, if you log in to perform work at multiple care site locations), you can quickly switch from one organizational context to another, in order to perform tasks specific to that organization.

If you belong to more than 1 organization, be aware that you may have different permissions under each, and you may also have access to different product features. Additionally, since each organization maintains a separate patient population, you may not be able to access patients that exist under 1 organization while logged in under a different organization.

Switch Between Organizations

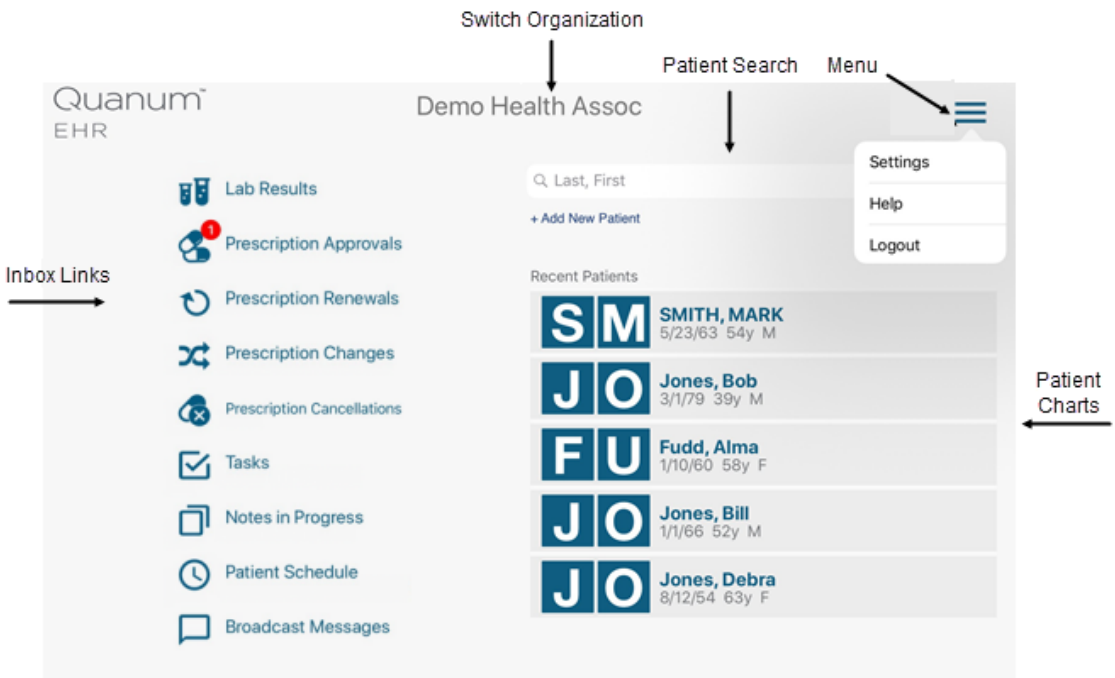
- 1 On the Quantum EHR (for iPad) home screen, tap your organization name.
- 2 Tap the name of the organization to which you want to switch.
You are immediately switched to the selected organization, and assume the permissions and features assigned to you for that organization.

Navigating Quantum EHR (for iPad)

Once you have successfully logged in to Quantum EHR (for iPad), a number of basic navigational features enable you to access the desired information or product functions.

Quantum EHR (for iPad) Home Screen

The image below illustrates the navigational features that are available on the home screen; each of the major navigational features is then described in the table that follows.



Inbox links




Located on the left-hand pane of the Quantum EHR (for iPad) home screen, they allow you to access items that are in your inbox (for you or for your organization), including the following:

- **Lab Results.** Provides access to new lab results for the organization. For more information, see "[Viewing and Managing Lab Results](#)" on page 70.
- **Prescription Approvals.** Provides access to prescriptions needing your approval. For more information, see "[Address a Prescription Approval](#)" on page 91.
- **Prescription Renewals.** Provides access to your pending renewals. For more information on approving prescription renewals, see "[Address a Prescription Renewal](#)" on page 92.
- **Prescription Changes.** Provides access to your pending pharmacy change requests. For more information on addressing pharmacy change requests, see "[Address a Prescription Change Request](#)" on page 93.
- **Prescription Cancellations.** Provides access to prescription cancellations sent to pharmacies and the pharmacies' cancellation responses. For more information, see "[Canceling a New Prescription](#)" on page 98.

Note: Badge counts that display on the inbox and items that display on the *Prescription Approvals*, *Prescription Renewals*, *Prescription Change*, and *Prescription Cancellations* screens vary by your user role:

- If you are a provider, only approvals, renewals, change requests, or cancellations assigned to you display in the list.
 - If you are a clinician, **all** approvals, renewals, change requests, or cancellations display for **all** providers in your organization.
- **Tasks.** Provides access to all open tasks for your organization. For more information, see "[Viewing and Sending Tasks](#)" on page 42.
-

- **Notes in Progress.** Provides access to a list of patient encounter notes that are in progress but not yet finalized. You can filter the list of notes in progress, if needed, by tapping *Filter* and then selecting another user or selecting *Unassigned* or *All Notes*.
Actions that you can take from the *Notes in progress* inbox include:

- **Edit billing details.** Tap  to edit the billing details for an encounter note. For more information, see "[Recording Billing Details for an Encounter](#)" on page 165.
- **Finalize the note.** Tap *Finalize and Sign* at the top right to finalize the note you are viewing. For more information about finalizing notes in progress, see "[Finalize and Sign an Encounter Note](#)" on page 159.
- **Access the patient summary.** Tap  to access and view the patient summary.
- **Print the note and/or billing details.** Tap  to preview or print the note and/or billing details.

For more information about viewing notes in progress, see "[View and Edit an In-Progress Encounter Note](#)" on page 161.

- **Patient Schedule.** Provides access to the list of patients scheduled for the current day. You can also view a list of patients for the next day that patients are scheduled by scrolling to the bottom of the list. You can filter the patient schedule by an individual provider, or all providers in your organization (using the *No Filter* option). Your own schedule displays by default. You can tap a patient name to access the patient's summary.
 - **Broadcast Messages.** Provides a link to brief informational or educational messages such as new product enhancements, system maintenance notifications, or new lab test availability. The number of new messages is displayed in red next to the link.
 - Tap *Broadcast Messages* to view a list of messages, with the most recent message appearing at the top of the list.
-

Navigational Feature

Description

- Tap a message title to view the text.
- Tap *Dismiss* to delete the message, or *Messages* to retain the message and return to the *Broadcast Messages* list.

Note: Dismissing a broadcast message in 1 app will also dismiss it in the other.

Menu

Located at the top right of the Quantum EHR (for iPad) home screen, the menu allows you to access the following features:

- **Settings.** Actions that you can take from the *Settings* tab include:
 - Setting the level of drug interaction warnings and prescribing settings.
 - View the version of the application with the current build number.
 - Allow Touch ID or Face ID for login options. For more information, see "[Using Touch ID and Face ID](#)" on page 7.
- **Log out.** Enables you to log out of the app.
- **Help.** Provides access to the app's online help.

Patient charts

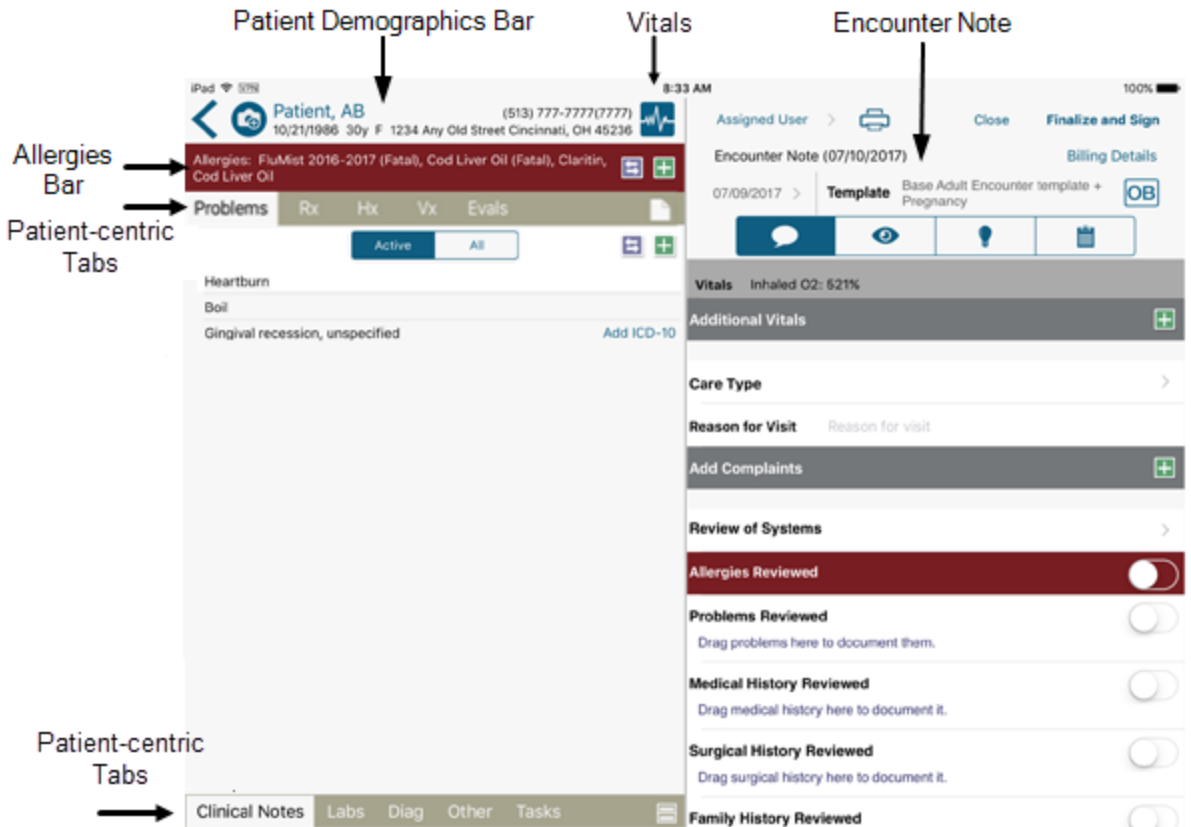
Recently viewed patient charts (up to 7) display on the right side of the Quantum EHR (for iPad) home screen. To open the chart and view the patient summary, tap the chart. For more information, see "[Viewing a Patient Summary](#)" on page 28.

Switch organization

At the top center of the Quantum EHR (for iPad) home screen, you can tap your organization name to see a list of other organizations you can select.

Patient Summary Screen

The image below illustrates the navigational features that are available on the patient summary screen; each of the major navigational features is then described in the table that follows.



Navigational Feature	Description
Patient demographic bar	Displays the patient picture and saved patient demographics. For information about updating patient demographic information, see "Edit Patient Demographics" on page 38 .
Allergy bar	Displays the patient's active allergies and adverse reactions. For information about maintaining the patient's allergy/adverse reaction list, see "Managing Patient Allergies" on page 49 . For information about reconciling the patient's allergies and adverse reactions, see "View and Reconcile a Patient's Allergies and Adverse Reactions" on page 61 .
Vitals	Displays the patient's most recent vitals as well as a link to growth charts. For more information about growth charts, see "View Patient Growth Charts" on page 34 .
Patient-centric tabs	<p>Additional patient-centric tabs are located on the patient summary screen, allowing you to access patient-related information, including the following:</p> <ul style="list-style-type: none"> • Probs. Provides access to a patient's active problems list. • Rx. Provides access to a patient's active medications list (including reported medications, administered medications, and vaccines) and ordered supplies (last 30). • Hx. Provides access to active history information that has been recorded for the patient, including past medical history, surgical history, social history, or family history. • Vx. Provides access to all vaccines (active, inactive, or refused) that have been administered, refused, or reported by the patient. • Evals. Provides access to all risk evaluations that have been completed or are outstanding, except for the COVID-19 screening questionnaire, which is only available when viewing or printing the encounter note in which the questionnaire was completed.

- **Care Rec.** Provides a list of all care recommendations for the patient when a gap in care is identified. These recommendations are based on the patient's clinical information that is currently available in Quantum® Electronic Health Record (EHR).
- **Encounters.** Provides access to all clinical notes (for example, uploaded documents such as consults and referrals, electronically received documents such as discharge summaries, and in-progress or finalized encounter notes in the SOAP format) for the patient.
- **Labs.** Provides access to all of the patient's lab results (even if they still appear on the new lab results list). From the *Labs* tab, you can place a lab order or a lab order task.
- **Diag.** Provides access to all uploaded or electronically received diagnostics results (for example, radiology, pathology, electrocardiac, electroneuro, or microbiology results) for the patient.
- **Other.** Provides access to all uploaded or electronically received documents for the patient which are not categorized as laboratory, radiology, or notes-related documents.
- **PGHD.** Provides access to health-related data that was gathered or recorded by a patient (or their family members or caregivers) and uploaded through the web application.
- **Tasks.** Provides access to all tasks and patient contact reminders with a *New*, *Pending*, or *Completed* status that contain a reference to the patient.

Patient encounter
note

The patient encounter note area can be used to write or view a patient encounter note and record billing details. For more information about documenting a patient visit, see ["Documenting a Patient Encounter" on page 109](#). For information about viewing an existing patient encounter note, see ["View and Edit an In-Progress Encounter Note" on page 161](#). For more information about recording billing details, see ["Record Billing Details for an Encounter" on page 165](#).

Navigational
Feature











Description







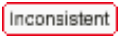



A pregnancy record may be available for a patient if it has been enabled for the patient encounter. For more information, see ["Reviewing the Pregnancy Header and Flowsheets" on page 115](#).









You can print in-progress and finalized encounter notes and/or billing details from the patient summary. See ["Print an Encounter Note" on page 163](#) and ["Print Billing Details" on page 170](#) for more information.

App Icons and Symbols

Located throughout the product, the following icons and symbols are used as indicators or to allow you to access product features and information:

Graphic	Name	Description
	Action	Access options for saving, submitting, or printing a prescription as well as placing lab or radiology orders and tasks, and printing in-progress encounter notes.
	Add a Patient	Add a patient from the Quantum EHR (for iPad) for home screen.
	Add Item	Add items such as allergies, problems, patient history, vitals, encounter notes, lab orders, tasks, or prescriptions.
	Advisory Message	Indicates that a result for a requisition contains a question or that a specific test could not be performed.
	Annotation	Indicates that the lab result has at least 1 annotation. You can tap the icon to see details of the annotation and to add another annotation or mark the result as reviewed. If a lab result is reviewed and has an annotation, only the reviewed icon displays.
	Assessment	Add a diagnosis, risk evaluations, or assessment to the encounter note.
	Billing Details	Indicates that an encounter note contains billing details that are in progress.
	Close Chart	Close a patient chart and return to the Quantum EHR (for iPad) home screen.
	Completed Billing Details	Indicates that an encounter note contains completed billing details.
	Comments	Add, edit, or view comments for the patient.

Graphic	Name	Description
	Copy	Copy items such as diagnoses, plan comments, or assessment comments to other areas within the encounter note.
	Priority out of range	Indicates that a result for a requisition contains data which is priority out of range (high or low) and should be reviewed.
	Default Photo	Indicates the patient has declined having their photo taken.
	EE	Indicates that the pharmacy is enabled for electronic prescriptions.
	EPCS	Indicates that the pharmacy accepts electronic prescriptions for controlled substances.
	Objective	Access the physical exam, active medications reviewed, cognitive/functional status, lab results, and the objective sections of the encounter note.
	Inconsistent	Indicates that medMATCH® reporting has identified that 1 or more of the results for the corresponding requisition is inconsistent. This symbol only appears for results where a physician submitted a test order for a patient and specified the medication(s) prescribed.
	On/Off Switches	Mark items as reviewed or set a series of items on or off.
	Out of Range	Indicates that a result for a requisition contains data which is outside of the normal range.
	Pregnancy Record	Access the pregnancy record if it has been enabled for a patient encounter.
	Planning	Add prescriptions, lab orders, procedures, and radiology orders to the encounter note.
	Print	Access the print options for encounter notes and billing details.




Graphic	Name	Description
	Reconcile clinical information	Reconcile patient allergies and adverse reactions, problems, or medications.
	Remove Item	Remove a selected or added value from the field that it occupies.
	Reviewed/ Available	Indicates that a new result has been reviewed. You can tap the icon to see information about when and by whom the result was reviewed. You can also add an annotation.
	Snippet	Access text shortcuts called snippets which are useful for commonly repeated text phrases.
	Status	Access vitals, complaints, and allergies reviewed sections of the encounter note.
	Take Patient Photo	Indicates that no action has been taken in regards to adding a patient photograph to the patient <i>Summary</i> .
	View Patient	Access the patient's summary while you are viewing a new result's lab details, a pending prescription's details, a task, or a note in progress.
	Vitals	View the patient's last recorded vitals.

Using Text Shortcuts

This section describes text shortcuts that are available throughout the app. For comment boxes or other boxes that accept text, you can use any of the following shortcut methods to enter text:

- Copy and paste text.
- Cut and paste text.
- Save text as a snippet. Snippets are useful for saving and reusing commonly repeated text phrases.
- Replace a word.
- Paste a text snippet.

To use text shortcuts in a comment box, do one of the following:

- Type the text that you want to copy, cut, replace, or save as a text snippet, and then tap and hold the text to activate the text editing options.
- Tap  and then add a new snippet or use a previously saved snippet.
- To delete snippets, tap , tap *Use Snippet*, and then *Edit*. Tap the snippets that you want to delete, and then tap .

Tips:

- Save snippets with a name that will help you identify the text phrase later when you want to reuse it.
- Your snippets are saved even when you delete and reinstall Quantum EHR (for iPad). Also, snippets that you save are available for use on other devices and are tied to your login information.

Using the Auto-Complete Option

You can use the auto-complete feature to reuse content for a particular item in an encounter note such as the *Reason for Visit* or *Add Comments* field for review of systems and physical exam. If you have previously entered text for the *Reason for Visit* or comments for a particular line item in review of systems or physical exam, you can re-use the same text in another encounter note. To do this, type the first few letters of the text and then tap the text in the text box that appears.

Learning About New Features

For each release of Quantum EHR (for iPad), you can review the *What's New?* help topic that describes any significant feature additions or service enhancements that have been added to the product or the user manual topic "[What's New in this Release](#)" on page 6.

Learn About New Features


- 1 On the Quantum EHR (for iPad) home screen, tap *Help*.
- 2 Tap the *What's New?* topic.

The *What's New* topic contains information about new features in the latest release.

Note: If you do not see a feature in the app that is described in the *What's New* topic then you may not have the latest version of the app. Go to the App Store® and download the latest version.


Accessing the User Documentation

In addition to this user manual, Qanum EHR (for iPad) provides the following user documentation:

- **Online Help.** The online help includes several topics that are designed to provide you with quick tips, navigation assistance, and answers to frequently asked questions. To view the available topics, tap  from the Qanum EHR (for iPad) home screen, and then tap *Help*.
- **Qanum EHR (for iPad) QuickStarts.** You can access three Qanum EHR (for iPad) QuickStarts from the *Online Training* area of the Qanum EHR support center (accessed by clicking the *Help* link in the information bar in the web application). The QuickStarts describe how to write prescriptions, document a patient visit, and manage patient clinical information.

Qanum EHR documentation is available directly from the support center (accessed by clicking the *Help* link in the information bar in the web application), or by clicking the help icon that is available on individual pages of the web application.

Access Qanum EHR (for iPad) Help

- 1 On the Qanum EHR (for iPad) home screen, tap  in the top right corner, and then tap *Help*.
- 2 Navigate to additional help topics using the *Related Topics* links at the bottom of each topic or the *Back* button at the top of each topic.
- 3 When you are finished viewing the help, tap outside the help window.

Contacting Customer Support

If you need assistance, please contact customer support using 1 of the following options:

- **By phone:** 1.800.697.9302.
- **By e-mail:** QuantumPremiumSupport@QuestDiagnostics.com

Note: When contacting customer support via email, please include "iPad" in the subject line.

Chapter 2: Patient Management

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About Patient Management

This section describes the patient management functions of Quanam EHR (for iPad). Since much of what you do is directly related to your patients and their care, Quanam EHR (for iPad) makes it easy to access and maintain patient data that is stored in your organization. The following is a list of patient-related tasks that you can perform to ensure the patient data remains accurate and up to date:

- **View the patient list.** You can view a list of today's patients, or the next day's patients, from the Quanam (for iPad) home screen by tapping the *Patient schedule* inbox link. To view the next day's patients, scroll to the bottom of the list. You can filter the patient list by an individual provider, or all providers in your organization (using the *No Filter* option). Your own schedule displays by default. Tap a patient name to access the patient's summary.
- **View patient data.** You can search for existing patients in your organization and then select the patient's chart to view that patient's summary. From the patient summary, you can view the following patient clinical information:
 - Allergies
 - Medications and supplies
 - Problems
 - History information (past medical, surgical, family, social, pregnancy/menstrual history)
 - Lab results
 - Other clinical documents that have been added to the patient's chart
 - Tasks

For information about viewing patient charts, see "[Viewing a Patient Summary](#)" on page 28.

- **Manage patient records.** You can add new patients manually, or edit patient demographics information at any time. For more information, see "[Managing Patient Details](#)" on page 36.
- **Manage patient tasks.** You can create, view, and update tasks. For more information, see "[Viewing and Sending Tasks](#)" on page 42.
- **Manage patient clinical data.** You can add and edit clinical information for the patient in the patient summary, including patient allergies, problems, past medical, surgical, family, and social history. For more information, see "[Managing Patient Clinical Data](#)" on page 48. You can also reconcile the patient's allergies and adverse reactions, problems, and medications from the patient summary. For more information, see "[Reconciling Patient Clinical Information](#)" on page 61.




Viewing a Patient Summary


The patient summary allows you to view the latest patient data that is available in the patient's chart. This section provides instructions for viewing a patient summary and patient photo. Additionally, you will find navigational tips and explanations of the actions you can take from the summary screen. Clinical information that you can view and manage from a patient summary includes allergies, problems, prescriptions and active medications, history, vaccinations, clinical notes, lab results, electronically received diagnostic results, and other clinical documents that may have been added to the patient chart.

Available Actions from the Patient Summary

From the patient's summary, you can perform any of the following:

Note: Depending upon the services to which you have subscribed, you may or may not be able to perform the tasks or see the items described below.

Action	Description
Review and edit patient demographics	Tap the patient's name in the demographic bar to view the patient's contact information. Make changes as needed. For more information about managing patient contact information, see "Edit Patient Demographics" on page 38 .
View or manage a patient photo	Tap  in the demographic bar to take a picture of the patient. Once a photo has been saved for the patient, you can tap the patient photo to view an enlarged version of the photo, retake the photo, or delete it. For more information, see "Add a Patient Photo" on page 38 .
View the last recorded vitals for a patient	Tap  to the right of the patient's demographics information.
View Growth Charts	Tap  and in the top right corner of the vitals screen, tap <i>Growth Charts</i> .
Review, add, or reconcile patient allergies	Review a patient's allergies/adverse reactions, if available, in the allergy bar that displays immediately below the patient's demographic information. Tap the allergy bar, and then tap <i>All</i> to view inactive allergies. For information about maintaining the patient's allergy/adverse reaction list, see "Managing Patient Allergies" on page 49 . For more information about reconciling patient allergies, see "View and Reconcile a Patient's Allergies and Adverse Reactions" on page 61 .



Action	Description
View or manage patient comments	Tap  to the right of the patient summary tabs to view any comments. Make changes as needed. For more information about managing patient comments, see "Managing Comments" on page 60 .
View, manage, or reconcile the patient's problems	Tap the <i>Probs</i> tab to view the patient's active, inactive, and resolved problems. You can also modify an active problem or add a new problem from this tab. For more information, see "Managing Patient Problems" on page 52 . For more information about reconciling patient problems, see "Reconcile a Patient's Problems" on page 62 .
View, manage, and reconcile the patient's medications or write a new prescription	Tap the <i>Rx</i> tab to view and manage medications. See the following: <ul style="list-style-type: none"> • To write a prescription, see "Writing a New Prescription " on page 80. • To reconcile the patient's medications, see "View and Reconcile a Patient's Medications" on page 65. • To view active and inactive patient medications and to manage a patient's active medications list, see "Manage Patient Active Medications" on page 97. • To view vaccinations, see "Viewing and Managing a Patient's Medication History" on page 96. • To add a reported medication, see "Add a Reported Medication" on page 102. • To make changes to a reported medication, see "Manage Patient Active Medications" on page 97.
View and manage patient medical history (including pregnancy and menstrual history as available in the history template), as well as surgical, family, and social histories	Tap the <i>Hx</i> tab to view and manage a patient's history information. For more information, see "Managing a Patient's Medical, Surgical, Family, and Social History" on page 55 .

Action	Description
View patient vaccination records with date administered or refused	Tap the <i>Vx</i> tab to view and manage a patient's vaccination history.
View patient care recommendations	Tap the <i>Care Rec</i> tab to view a patient's active or dismissed care recommendations. For more information, see "View Care Recommendations" on page 59 .
View patient evaluation records	Tap the <i>Evals</i> tab to review evaluations that may have been recently completed or are outstanding.
View finalized and in-progress clinical notes	Tap the <i>Encounters</i> tab to view the patient's clinical notes that are in progress or finalized. For more information about how to access clinical notes, see "View Clinical Notes" on page 107 . You can review the patient's most recent clinical note, if available, in the right-hand pane.
View and annotate patient lab results and write lab orders or lab order tasks	Tap the <i>Labs</i> tab to review the patient's lab results, see "Viewing and Managing Lab Results" on page 70 . To place a lab order on hold for the patient, see "Write a Lab Order or Task" on page 147 . To write a lab order task for the patient, see "Viewing and Sending Tasks" on page 42 .
View patient-generated health data	Tap the <i>PGHD</i> tab to view all patient-generated health data documents and associated text and URLs, if available. For more information, see "View Patient-Generated Health Data (PGHD)" on page 77 .

Action	Description
View other documents	Tap the <i>Other</i> tab to view documents for the patient that have been categorized as "other" (for example, administrative, consents, disability, growth charts, home care records, hospital reports, insurance, patient education, patient photos, pharmacy, transfer summaries, etc). For more information, see "View Other Documents" on page 67 .
View and manage patient tasks	Tap the <i>Tasks</i> tab to view and manage patient tasks and contact reminders. For more information, see "Viewing and Sending Tasks" on page 42 .
Document a patient visit	<p>Tap <i>Start a New Encounter</i> at the top of the right-hand pane to document a patient visit. For more information about patient encounters, see "Documenting a Patient Encounter" on page 109. While documenting a patient encounter, you can do one or more of the following:</p> <ul style="list-style-type: none"> • Write a lab order or task. For more information, see "Write a Lab Order or Task" on page 147. • Place a radiology order or task. For more information, see "Write a Radiology Order or Task" on page 152. • View and update a pregnancy record. For more information, see "Add Pregnancy Information to an Encounter Note" on page 123.

Navigation Tips for the Patient Summary

You can use the following tips to complete tasks more quickly or to rearrange commonly used items:

- **Reposition patient chart tabs or open them in split-view.** You can reposition all of the tabs on the left-hand pane of the patient chart by dragging and dropping them to the desired location. You may want to put the items you commonly use at the top of the pane.
You can also view the patient chart tabs in a split-view so that you can review the contents of 2 tabs at once. To do this, tap  at the bottom right of the patient chart to expand the second row of tabs. To collapse the tabs again, tap .
- **Copy clinical entries to an encounter note.** You can copy several clinical entries from a patient's chart into an open patient encounter note by dragging the item from the patient summary to the note. This includes problems, medications, or history items. The action of dragging items from the chart to the encounter note also marks the items as reviewed. For more information on documenting a patient visit, see "[Documenting a Patient Encounter](#)" on page 109.
- **Initiate an action in an encounter note using a clinical entries from a patient summary.** You can perform the following actions by dragging clinical entries from the patient summary to a specific area of an encounter note:
 - Enter a diagnosis by dragging a problem to the *Diagnosis* area of an encounter note.
 - Write a prescription refill by dragging an active medication to the *Prescriptions* area of an encounter note.
 - Copy the patient's active allergies to the encounter note by marking allergies reviewed.

For more information about documenting a patient visit, see "[Documenting a Patient Encounter](#)" on page 109.


View a Patient Summary

1 On the Quantum EHR (for iPad) home screen, do one of the following:

- Tap the search field, type a patient name (in the format *Last, First*), and then tap *Search*. Continue with step 2.

Note: If only 1 patient matches your search criteria, you are taken directly to the matching patient's chart.


- Tap the name of a recently-viewed patient from the folders area in the right-hand pane. Skip to step 4.

Note: You can also access a patient's summary by tapping  located on a new lab result's details or a pending prescription's details. For more information, see "[Viewing and Managing Lab Results](#)" on page 70 or "[Addressing Prescription Action Items](#)" on page 90.

2 Drag or swipe up and down to scroll through the results.

3 Tap a patient name.

4 Review the clinical information that is available in the patient's chart. For a complete list of available actions that you can take from the patient's summary, see "[Available Actions from the Patient Summary](#)" on page 29.

5 When you are done reviewing the patient's summary, tap  at the top left of the patient chart to return to the Quantum EHR (for iPad) home screen.

View a Patient's Photo

1 While viewing a patient summary, tap the patient's photo.

You can search for a patient from the Quantum EHR (for iPad) home screen, if needed.

2 Tap *Cancel* when finished.

View Patient Growth Charts

1 While viewing a patient summary, tap  to view the patient's most recent vitals.

2 Tap the *Growth Charts* link.

3 Tap the appropriate age range from the list.

Note: Pediatric growth charts are available for patients from birth to 20 years old. Growth charts for patients in this age range are plotted using the available vitals (head circumference, length/height, weight, and BMI) from all encounter notes for a specific patient. If multiple vital sets are available for the same date of service, then the most recent set for that date of service will be used for the growth chart.

- 4 Tap one of the following growth charts from the list:
- For birth to 24 months-Clinical:
 - Length-for-age and Weight-for-age.
 - Head circumference-for-age and Weight-for-length.
 - For ages 2 to 5 years-Clinical:
 - Weight-for-stature.
 - For ages 2 to 5 years-Individual:
 - Weight-for-stature.
 - For ages 2 to 20 years-Clinical:
 - Stature-for-age and Weight-for-age.
 - BMI-for-age.
 - For ages 2 to 20 years-Individual:
 - Weight-for-age.
 - Stature-for-age.
 - BMI-for-age.

Notes:

- To change the growth chart that you are viewing, tap *Growth Chart Options* to return to the selection screen.
- Vitals captured after the patient's maximum age for a specific growth chart will not be plotted. For example, vitals captured after a patient's fifth birthday will not be plotted on 2 to 5 year growth charts.

- 5 To print the growth chart:
- a While viewing the patient growth chart, tap *Print* in the top-right corner.
 - b On the *Printer Options* dialog box, tap *Select Printer*, and tap the appropriate AirPrint Printer.
 - c Choose the number of copies to print and tap *Print*.

Managing Patient Details

Patient details consist of a patient's photo, demographic information, contacts, care team information, patient pharmacies, administrative information, status, and contact preferences.

As part of managing a patient's details, you can:

- Add a new patient at any time from the Quanum EHR (for iPad) home screen.
- Edit patient details from the patient summary screen.
- Update a patient's photo from the patient summary screen.
- Update patient details while writing a prescription (when insufficient demographic information is available for the patient).

Add a New Patient

- 1 Tap *+* *Add New Patient* under the search field of the Quanum EHR (for iPad) home screen.
- 2 Tap *Demography* and do the following:
 - To add the patient's name, birth name, other name, birth date, sex, gender identity, marital status, sexual orientation, mother's maiden name, or social security number, tap *Patient Information*, enter the information as needed, and then tap *Done*.

Note: Patients under 18 years of age must have a guardian or next of kin specified in *Contacts*.

- To add the patient's address(es), phone numbers, email address, and contact preferences, tap *Contact Information*, enter the information as needed, and then tap *Done*.


Note: If your organization is configured for EPCS, the patient's address must include the street, city, state, and zip code.

- To add a patient's ethnicity, race, or languages, tap *Ethnicity/Race/Language*, enter the information as needed, and then tap *Done*.

Note: For the patient's Ethnicity, select the appropriate reason for not reporting the patient's ethnicity, or tap *Select Ethnicity(s)* to specify the patient's ethnicity.


Ethnicity is categorized as *Not Hispanic or Latino* or *Hispanic or Latino*. For Hispanic or Latino, you can choose up to 3 options.

- To add the patient's primary provider, PID, Payer Type (and HIC), consent for eligibility checking, consent for access to PBM history, and consent to share clinical documentation, tap *Administrative Details*, enter the information, and then tap *Done*.
- 3 If you want to set up favorite pharmacies for the patient, do the following:
 - a Tap *Pharmacies*.
 - b Tap *Search*.
 - c Type a value in 1 or more of the boxes, and then tap *Search*.

Note: If you type a *Pharmacy Name* as search criteria, you should also tap  to indicate whether the pharmacy name is an exact match to the characters entered or whether the pharmacy starts with, contains, or sounds like the characters entered.

- d Tap the pharmacies in the search results that you want to add to patient favorites, and then tap *Save*.
 - e If you want to specify a primary (default) pharmacy, tap *Favorites* and then tap a pharmacy.
- 4 If you want to add contacts for the patient, do the following:

Note: If the patient is under 18 years old, the patient must have a *Guardian* or *Next of Kin* contact specified.

- a Tap *Contacts*.
- b Tap .
- c Complete the required contact information, which is marked with a red asterisk (*) and any other information, as needed.


Note: If you want to use the patient's address for the contact, turn the *Copy Patient Address* switch on. The patient's complete address and home phone number will automatically populate in the address and phone boxes. Once copied, you can edit the information, as needed.

- d Tap *Done*.
- 5 Tap *Save*.

Add Patient Demographics While Writing a Prescription or Adding a Reported Medication

- 1 From the insufficient demographics message, tap *Add demographics*.
- 2 Enter demographic information in the available fields.
- 3 Tap *Save*.

Add a Patient Photo

- 1 While viewing a patient summary, tap  (next to the patient's name) and then tap *Add Patient Photo*.

You can search for a patient from the Quantum EHR (for iPad) home screen, if needed.

- 2 Tap the shutter button to take the patient's picture.
- 3 Do one of the following:
 - Tap *Use Photo* to use the picture you just took.
 - Tap *Retake* to take another picture of the patient.
- 4 Do the following to center the patient's photo within the circle:
 - Pinch the photo to zoom in or out.
 - Drag right, left, and up and down to center the photo.
- 5 Tap *Save*.

Edit Patient Demographics

- 1 While viewing a patient summary, tap the patient's name to view the patient's status and demographic information.

You can search for a patient from the Quantum EHR (for iPad) home screen, if needed.

- 2 If you want to edit patient information, contact information, ethnicity, race, language, or administrative details, tap *Demography* and then do the following:
 - To make changes to the patient's status, tap *Status*, tap *Active*, *Inactive*, or *Deceased* and then do one of the following:
 - If you selected *Inactive*, type the date the patient became inactive and then specify the reason why the patient's status has been changed to inactive.
 - If you selected *Deceased*, type the date that you were notified that the patient was deceased and then provide the date of death, information about the death certificate, and name of physician who signed the death certificate, if available.
 - To make changes to the patient's name, birth name, other name, birth date, sex, gender identity, marital status, sexual orientation, mother's maiden name, or social security number, tap *Patient Information*, make changes to the information as needed, and then tap *Done*.
 - To make changes to the patient's address(es), phone numbers, email address, and contact preference, tap *Contact Information*, make changes to the information as needed, and then tap *Done*.

- To make changes to a patient's ethnicity, race, or languages, tap *Ethnicity/Race/Language*, make changes to the information as needed, and then tap *Done*.
- To make changes to the patient's primary provider, PID, Payer Type, HIC, consent for eligibility checking, consent for access to PBM history, and consent to share clinical documentation, tap *Administrative Details*, make changes to the information as needed, and then tap *Done*.
- To add or change an identifier that indicates the patient is part of a specific program or population (for example, chronic care management), tap *Administrative Details*, then tap *Reference/Category*. Enter or change the information as needed, tap *Done*.

Note: The Reference/Category field contents display in place of the address in the patient demographic bar.

- To review the billing-related data that has been added for the patient, tap *Billing*. The information shown on the *Billing* tab is read-only; you cannot modify this information. This information is populated when a lab order is placed for the patient and the results are received by Quantum EHR (for iPad).

3 Tap Save.

Manage a Patient's Photo

1 While viewing a patient summary, tap the patient's photo.

You can search for a patient from the Quantum EHR (for iPad) home screen, if needed.

2 To replace the photo, tap and then do the following:

a Tap the shutter button to take the patient's picture.

b Do one of the following:

- Tap *Use Photo* to use the picture you just took.
- Tap *Retake* to take another picture of the patient.


c Do the following to center the patient's photo within the circle:

- Pinch the photo to zoom in or out.
- Drag right, left, and up and down to center the photo.

d Tap *Save*.

3 To delete the photo, tap and then confirm that you want to delete the photo.


Manage Patient Pharmacies

- 1 While viewing a patient summary, tap the patient's name.
You can search for a patient from the Quantum EHR (for iPad) home screen, if needed.
 - 2 Tap *Pharmacies*.
 - 3 Tap *Favorites*.
 - 4 If the pharmacy the patient wants to use for any prescriptions during this visit appears in the list, tap the pharmacy and then tap *Save*, otherwise, do any of the following:
 - To remove a pharmacy from the patient pharmacies list, tap and swipe the item to the left and then tap *Delete*.
 - To add a new pharmacy to the list:
 - a Tap *Search*.
 - b Type a value in 1 or more of the boxes and then tap *Search*.
- Note:** If you type a *Pharmacy Name* as search criteria, you should also tap  to indicate whether the pharmacy name is an exact match to the characters entered or whether the pharmacy starts with, contains, or sounds like the characters entered.
- c Tap the pharmacies in the search results that you want to add to patient favorites and then tap *Save*.
- 5 Click *Save*.

Manage Contacts

- 1 While viewing a patient summary, tap the patient's name.
You can search for a patient from the Quantum EHR (for iPad) home screen, if needed.
- 2 Tap *Contacts*.
- 3 Do any of the following, as necessary:


Note: If the patient is under 18 years old, the patient must have a *Guardian* or *Next of Kin* contact specified.

 - **Add additional contacts:**
 - a Tap  .
 - b Complete the required contact information, which is marked with a red asterisk (*), and any other information, as needed.

Note: If you want to use the patient's address for the contact, turn the *Copy Patient Address* switch on. The patient's complete address and home phone number will automatically populate in the address and phone boxes. Once copied, you can edit the information, as needed.

- c Tap *Save*.
- **Modify an existing contact:**
 - a Tap a contact.
 - b Type a new value or modify an existing value in each of the boxes, as needed.
 - c Tap *Save*.
- **Remove a contact** Tap and swipe a contact to the left and then tap *Delete*.

Manage Care Team Members

- 1 While viewing a patient summary, tap the patient's name.
You can search for a patient from the Quanam EHR (for iPad) home screen, if needed.
- 2 Tap *Care Team* and review the care team members that have been added for the patient.
- 3 Do any of the following, as necessary:
 - **Add a care team member:**
 - a Tap .
 - b Complete the required care team member information, including either *Last Name/First Name* or *Organization* name, and any other information as needed.
 - c Tap *Save*.
 - **Modify a care team member:**
 - a Click a care team member.
 - b Make any necessary changes.
 - c Tap *Save*.
 - **Remove a care team member.** Tap and swipe a care team member to the left and then tap *Delete*.

Review Billing Details

- 1 While viewing a patient summary, tap the patient's name.
- 2 Tap *Billing* and review the billing-related data that has been added for the patient.
The information shown on the *Billing* tab is read-only; you cannot modify this information. This information is populated when a lab order is placed for the patient and the results are received by Quanam[®] Electronic Health Record (EHR) for iPad[®].

Viewing and Sending Tasks

This section provides information about tasks for yourself or another user in your organization, including instructions for creating tasks, viewing all tasks for your organization or for a specific patient, and updating the status of a task.

There are three task types:

- **General task.** A general task can be a specific request from one user in an organization to another, such as a patient-related task with a lab result attached for reference. You can also assign a due date to a newly created task in order to ensure it is completed in a timely manner.
- **Patient contact reminder task.** A patient contact reminder task allows you to keep track of when your patients need to be contacted with information relating to their lab results, radiology results, follow-up appointments, medications, or any other patient-related information. You can assign a contact reminder task to yourself or another user in your organization. Similar to general tasks, the reminder task references a specific patient and can contain a short message, a subject, and a due date to ensure that it is completed in a timely manner.
- **Order task.** Lab and radiology order tasks can be created from a patient encounter note and assigned to yourself or another user in your organization for completion. Order tasks can be marked completed or canceled, as appropriate, from the tasks *Inbox* or from the *Tasks* tab of the patient summary.


You can view tasks from 2 locations:

- **Tasks Inbox.** A list of all incomplete tasks for your organization is available from the tasks *Inbox*. For more information, see ["View All Tasks for an Organization" on the next page](#).
- **Patient summary.** From the *Tasks* tab of a patient's summary, you can view a list of all tasks with a *New*, *Pending*, or *Completed* status that contain a reference to the patient. You can view all tasks for the patient or sort by new, pending, or past due tasks by tapping the appropriate tab. For more information, see ["View Tasks from the Patient Summary" on page 44](#).


Notes:

- Tasks that have already expired display *Past Due* to the left of the due date.
- While you are viewing a task, you can update the task as necessary. For more information, see ["Update a Task" on page 47](#).

You can create tasks from the following locations:


- **Patient summary.** From the *Tasks* tab of a patient summary, you can add a new task by tapping . For more information, see ["Create a Task" on page 45](#).
- **Create a task while viewing a lab result.** While viewing a lab result in the new lab results list, within the context of an associated patient's summary, or in any other area where a lab result is viewed, you can create a task which automatically references the patient and attaches the lab result.
- **Encounter note.** You can create a lab or radiology order task from a patient encounter note. Lab or radiology order tasks can be used to remind you or another clinician in your office to complete the order using EHR. For more information, see ["Write a Lab Order or Task" on page 147](#) or ["Write a Radiology Order or Task" on page 152](#).

View All Tasks for an Organization

- 1 From the Quantum EHR (for iPad) home screen, tap the *Tasks* inbox.
- 2 Review the list of all incomplete tasks for your organization.
Tasks are sorted by patient name. Tasks that are not assigned to a patient display at the top of the list. To refresh the list of tasks, tap at the top of the list and swipe down.
- 3 To filter the list of tasks, do the following:
 - a Tap .
 - b Select the filter criteria by tapping the appropriate item for *Assigned To* and *Due Date*.
 - c Tap *Set Filter*.
The filter that is applied to the tasks list displays below the organization name.
- 4 Tap the subject of the task you want to view.
The content of the task appears in the right-hand pane.

Note: Tasks that have already expired display *Past Due* to the left of the due date. The date for past due tasks display with red text when viewing the task details.

5 Do any of the following, as needed:


- **View an attached lab report.** If a lab report is attached to a task, you can view it by tapping in the *Attachment* area.
While you are viewing a lab report, you can add another task, if needed, by tapping *Create a Task* and completing the necessary information.
- **Add a note.** To add a note, tap *Add Note*, and then type your notes as needed.
- **View a patient's summary.** To access the patient's summary, tap .
- **Update a task.** Change the task status or to whom the task is assigned. For more information, see "[Update a Task](#)" on page 47.

View Tasks from the Patient Summary

1 Access a patient summary. See "[View a Patient Summary](#)" on page 34.

2 Tap the *Tasks* tab to view **all** tasks and patient contact reminders with a *New*, *Pending*, *Completed*, or *Retracted* status that contain a reference to the patient.

3 Do one of the following:

- Drag or flick up and down to scroll through the list if needed.
- To sort the list by *New*, *Pending*, or *Past Due*, tap the appropriate tab. To view all tasks in the list, tap *All*.
- To sort the list by *Due Date*, *Assigned Date*, or *Created Date*, tap *All*, tap , and then tap the appropriate sort option. You can also order the sorted tasks by tapping *Recent* or *Oldest*.

The following information displays for each task if it is available: task subject, due date, assigned user, and task status (*New*, *Pending*, *Complete* or *Past Due*).

4 Tap the subject of the task you want to view.

Note: For *Past Due* tasks, the date is displayed in red.






5 Do any of the following, as needed:

- **View an attached lab report.** If a lab report is attached to a task, you can view it by tapping in the *Attachment* area.
While you are viewing a lab report, you can add another task, if needed, by tapping *Create a Task* and completing the necessary information.
- **Add a note.** To add a note, tap *Add Note*, and then type your notes as needed.
- **Update a task.** Change the task status or to whom the task is assigned. For more information, see "[Update a Task](#)" on page 47.



- **View all tasks for an organization.** You can view all tasks for all patients in the organization. For more information, see ["View All Tasks for an Organization" on page 43.](#)
- **Create a new task.** To create a new task for a patient, see ["Create a Task" below.](#)

Create a Task

1 To create a task, do one of the following:

- **Create a task from a patient summary.**
 - a Access a patient summary.
 - b Tap the *Tasks* tab.
 - c Tap .
 - d Continue with step 2.
- **Create a task from a lab result.**
 - a View a new lab result or view a lab result from within the context of the associated patient summary. For instructions see ["View and Manage Lab Results from a Patient's Summary" on page 73.](#)
 - b Tap *Full Report* to view the result details.
 - c While viewing the result details, tap *Create a Task*.
- **Create a lab order task.** Create a lab order task from 1 of the following locations:
 - From the patient summary, tap  on the *Labs* tab.
 - From the encounter note for a specific patient encounter, tap  next to *Add Lab Order* in the *Plan* segment () , which is the fourth screen of the note.
 - From the pregnancy record of a patient encounter note, tap  on the *Labs* flowsheet tab.
 - While viewing a lab result for a patient from the labs *Inbox*, tap *Write Lab Order*.

To review complete instructions for adding the task details, see ["Write a Lab Order or Task" on page 147.](#)

- **Create a radiology order task from a patient encounter note.** Do the following:
 - a From the encounter note for a specific patient encounter, tap  next to *Add Radiology Order* in the *Plan* segment () , which is the fourth screen of the note.
 - b Add the task details, as appropriate. For complete instructions, see "[Write a Radiology Order or Task](#)" on page 152.
- 2 To add task details, do the following:
- a Tap *Assigned To* and then scroll and tap the user to whom you want to assign the task.

Notes:

- You can only select 1 recipient per task.
- You can select yourself as a recipient of the task.
- Only active users in your organization show in the list.
- Users assigned the phlebotomist role will not appear in the list.

- b In the *Subject* box, type the title for the task.
- c Tap *Due Date* then scroll and tap a value for the month, date, and year, and then tap *Save*.

Note: The due date can only be the current date or a future date.

- d Type the task message.

- 3 To assign the task, tap *Save*.

Notes:

- If you add a task from a lab result, that result report is automatically attached to the task.
- The task is automatically associated to the patient for whom you are viewing the patient summary, encounter note, or lab result.
- The task type is assigned as follows:
 - Lab and radiology tasks (created from encounter notes) are order tasks.
 - Tasks created while viewing a lab result are general tasks.

Update a Task

1 While viewing a task (either from the tasks *Inbox*, from the *Tasks* tab of a patient summary, or from a lab result), do one or more of the following:

- To change the user to whom the task is assigned, tap ⓘ, scroll and tap the appropriate user from the list, and then tap *Save*.
- To update the task status, tap *Mark Canceled* or *Mark Completed* as appropriate.

Note: The following information applies to tasks for which the status is updated:

- After a task status is updated, the status cannot be reverted to the original value.
- Order tasks can be deleted from an encounter note. If the note was already saved prior to deleting the task, then the task status changes to *Canceled*. For more information about deleting lab order tasks, see "[Document a Procedure](#)" on [page 146](#).
- Tasks that are marked *Erroneous* or *Canceled* are no longer available for viewing in Quantum EHR (for iPad). To view tasks with these statuses, you can access the tasks in Quantum EHR.

- Tap *Add Note* and then type additional notes as needed, and then tap *Save*.

2 Tap outside the task to close it.

Managing Patient Clinical Data

This section provides instructions for managing your organization's patient clinical data.

To maintain the accuracy of your patient data, you can perform the following tasks:

- **Manage patient allergies.** If a patient has any known allergies or adverse reactions, those allergies or adverse reactions can be manually added to the patient's chart from the patient summary screen. Allergies or adverse reactions can either be searched for and added to a patient's allergy/adverse reaction list by category (for example, penicillins), by drug name (for example, amoxicillin), or entered as free text. All active allergy or adverse reactions that are recorded for a patient are viewable from the patient summary screen below the patient's demographics.

For more information about adding and editing patient allergies or adverse reactions, see ["Managing Patient Allergies" on the next page](#). For more information about reconciling patient allergies or adverse reactions, see ["View and Reconcile a Patient's Allergies and Adverse Reactions" on page 61](#).

- **Manage patient problems.** If you need to record any known problems or issues for a patient, you can manually add or modify their *Patient Problems* list. Any problems recorded for a patient can be viewed from the patient summary. For more information about patient problems, see ["Managing Patient Problems" on page 52](#). For more information about reconciling patient problems, see ["Reconcile a Patient's Problems" on page 62](#).
- **Manage patient medical, surgical, family, or social history.** If you need to record a patient's past medical, surgical, family, or social history, you can manage this information from the patient summary. For more information, see ["Managing a Patient's Medical, Surgical, Family, and Social History" on page 55](#).

Managing Patient Allergies

Allergy and adverse reaction information is available on the patient summary screen and can be associated with a patient encounter note if the allergies are marked as reviewed.

When adding new allergies or adverse reactions (to medications or categories in the drug database) to a patient's chart, allergy-to-drug interaction checking is performed across the patient's active medications and stored medications history. When writing prescriptions for a patient, the system also reviews the patient chart for any adverse drug-to-allergy interactions against any active allergies or adverse reactions which have been selected from the drug database (medications or drug categories).

Note: Interaction checking **cannot** be done against allergies or adverse reactions entered as free text.

You can set the severity level of interaction checking in the app settings. Interaction checking is initially set to *Major*, but can be changed if needed. Access *Settings* from the Qanum EHR (for iPad) home screen.


To reconcile a patient's allergies and adverse reactions, see "[View and Reconcile a Patient's Allergies and Adverse Reactions](#)" on page 61.

Notes:


- If a patient has any active allergies or adverse reactions, they appear immediately below the patient's demographic information. All active allergies or adverse reactions are listed regardless of whether they are used by the system for interaction checking.
- Active allergies and adverse reactions are listed on the patient summary in order of severity, with the most severe appearing first in the list.
- To view inactive allergies, tap the allergy bar, and then tap *All*.
- For more information on marking allergies reviewed in a patient encounter note, see "[Associate Existing Clinical Entries to a Patient's Encounter Note](#)" on page 129.

Add a Patient Allergy

- 1 Access a patient summary. See "[View a Patient Summary](#)" on page 34.
- 2 Do one of the following:
 - To indicate that the patient is not aware of any allergies, tap *No Known*.
 - To indicate that the patient's allergy status is unknown, tap *Unknown*.


- To add an allergy, tap , and then complete the allergy details. Search for an allergy by tapping the text box and typing 3 or more letters of an allergy name. If the allergy is not in the system, you can enter a free text allergy.

Notes:

- When coding a reaction, first select the appropriate ICD-10 code. The *SNOMED* code that most closely matches automatically populates below, unless no match is found. If necessary, tap  to remove the match, tap *SNOMED*, type 3 or more characters of a more appropriate SNOMED code or description and select the desired result from the list.
- You must enter device or substance allergies as free text in Quanam EHR (for iPad).
- Interaction checking is not performed for allergies entered as free text.
- Users assigned the Clinician Office Staff role cannot add allergies in Quanam EHR (for iPad).

- To edit an allergy, tap it, make the necessary changes, and then tap *Save*.
- To remove an allergy from the active allergies list, tap it and change the status to *Inactive* or *Erroneous*.

Note: If a patient has multiple active allergies, tap *No Known* to set all active allergies and adverse reactions to inactive.

- To reconcile the patient's allergies and adverse reactions, tap  to the right of the allergy bar. For more information, see "[View and Reconcile a Patient's Allergies and Adverse Reactions](#)" on page 61.

Edit or Remove a Patient Allergy

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Review the existing allergies for the patient at the top of the screen.
- 3 Tap the allergies bar, and then tap the allergy that you want to edit or remove, and then do one of the following.
 - To edit an allergy, make any changes to the existing information on the *Edit Allergy* screen, and then tap *Save*. For more information about adding allergy information, see "[Add a Patient Allergy](#)" on the previous page.
 - To remove an allergy, do the following:
 - a On the *Edit Allergy* screen, tap *Status*.
 - b On the *Allergy Status* screen, tap *Inactive* or *Erroneous*.


c Tap *Save*, or tap *Back* and then tap outside of the allergies screen to close without saving your changes.

If you tap *Save*, the allergy is marked inactive or erroneous, and immediately removed from the patient's active allergies list.

- To view inactive allergies, tap *All*.


Managing Patient Problems


You can view and manage patient problems from the patient's summary. To view inactive and resolved problems, tap *All*. You can tap and drag an active problem to an open encounter note to designate the problem as the current diagnosis. Problems are associated with an ICD and SNOMED code and description; otherwise problems can be entered as free text. For information on using an existing problem as a patient diagnosis in an encounter note, see ["Document Diagnosis Information" on page 141](#).

To reconcile a patient's problems, tap  on the *Probs* tab. For more information, see ["Reconcile a Patient's Problems" on page 62](#).

Note: Only users with roles that have the *Manage Problems* permission can add, edit, reconcile or mark a patient's problems active or inactive.

Add a Patient Problem

- 1 Access a patient summary. See ["Viewing a Patient Summary" on page 28](#).
- 2 Tap the *Probs* tab to view **all** of the patient's active problems.
- 3 If you want to indicate that the patient does not have any problems, tap *No Known*. Otherwise, continue with the next step.
- 4 Tap  to add a problem.

To reconcile the patient's problems, tap . For more information, see ["Reconcile a Patient's Problems" on page 62](#).

- 5 Tap *Description*. On the *Event Description* screen, do one of the following:
 - **Search for and add a problem.** Do the following:
 - a Tap ICD-9, SNOMED, or ICD-10 to indicate the code set that you want to use for the problem.
 - b Tap the search box and type 3 or more characters of the code or description for the problem.
 - c Drag or swipe up and down to scroll through the list of results.
 - d Tap a problem.
If secondary SNOMED or ICD code and description matches exist, the most likely match appears below the primary code or description that you just entered.

Note:

If you selected the ICD-9 code set for this problem, and you also want to associate an ICD-10 code with the problem, tap *Add ICD-10* and select one of the suggested codes or search and select a new ICD-10 code.

- **Add a free text problem.** If the item you want to add cannot be found in the system, type it in as free text. With free text entries, you cannot specify a secondary SNOMED or ICD code.
- 6 At *Onset Date*, tap and enter the approximate date the problem started or tap ⓘ, scroll and tap the date and then tap *Save*.
 - 7 If necessary, tap *Status* to specify a status other than *Active* (default value).
 - 8 At *Resolution/Inactivity Date*, tap and enter the approximate date the problem was resolved or became inactive or tap ⓘ, scroll and tap the date and then tap *Save*.

The *Resolution/Inactivity Date* is only available when you select a status of *Inactive* or *Resolved*.

- 9 Tap *Notes*, type any additional notes for the problem, and then tap *Save*.
- 10 Tap *Other Provider* to type a managing provider, and then tap *Return*.

Notes:

- If you do not specify *Other Provider*, the default provider for the problem is the user currently logged in to the app.
- If an “other” provider is specified for the problem, it displays with the problem in the patient’s summary.

- 11 Tap *Save* to add the problem for the patient.

If a patient has active problems, the *No Known* option continues to display. To set all of the patient's active problems to inactive, tap *No Known*, and then tap *Confirm*.

Edit Patient Problems

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the *Probs* tab, and then tap the problem in the *Active* list that you want to edit.
- 3 To make changes to the problem codes and descriptions, do the following:
 - If no secondary code has been selected for the problem, you can search for and select a matching code or description. With free text entries, you cannot specify a secondary SNOMED or ICD code or description.
 - Delete codes and descriptions and add new ones.
- 4 To change the status, select one of the following:
 - Tap *Inactive* to move the problem to the Inactive list.
 - Tap *Resolved* to move the problem to the Resolved list.
 - Tap *Erroneous* to delete the problem.
- 5 Tap *Save*.

For more information about adding patient problems, see "[Add a Patient Problem](#)" on page 52.

Note: To set all of the patient's active problems to inactive, tap *No Known* and tap *Confirm*.

Managing a Patient's Medical, Surgical, Family, and Social History


You can view and manage a patient's medical, surgical, family, or social history in the patient summary or while documenting a patient visit. This allows you to keep a record of any procedures, conditions, or behaviors which may affect the patient's care. The history categories that display are determined by your context within the system. If you are in the context of a patient encounter note, the history items that display are defined by the encounter template that is applied to the current note. If you are not in the context of an encounter note, then the history items display as follows:

- If you have a designated default history template, that template appears.
- If you do not have a designated default history template, but your organization has set one, then the organization template displays.
- If there are no designated default templates, then a system default template is used.
- If pregnancy and menstrual history information is available for a female patient, it appears on the *All* tab of the *Hx* tab.

Note: If you have an unfinalized encounter note open while you are making changes to the patient history information, keep in mind the following:

- Changing history details to *Inactive* (the history entry is no longer active for the patient) or *Erroneous* (the history entry was entered in error and does not apply to the patient) removes the history item from the encounter note.
- If you make changes to a line item within a history category, the history category is automatically marked as reviewed in the encounter note. For any history categories that do not need updating, you must manually mark the history categories as reviewed.
- You can drag individual history items or the entire *Hx* tab to the encounter note to mark history items as reviewed in the encounter note (this also copies the items to the note). For more information about marking history items reviewed in an encounter note, see ["Associate Existing Clinical Entries to a Patient's Encounter Note" on page 129](#).

Add Past Medical, Surgical, Family, and Social History

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the *Hx* tab to view **all** of the patient's active history items, and then tap .

Note: To filter the history items in the *Hx* tab, tap *Medical*, *Surgical*, *Family*, or *Social*. Pregnancy and menstrual history information, if available, appears on the *All* tab.

The history categories that display are determined by your context within the system. For more information about the items that display, see "[Managing a Patient's Medical, Surgical, Family, and Social History](#)" on the previous page.

- 3 Tap the appropriate category (such as *Medical* or *Surgical*) for which you want to capture patient history information, or tap *All* to scroll through all history categories.
- 4 To indicate any procedures, conditions, or behaviors which may affect the patient's care, do the following:
 - a Tap in the *Yes* or *No* column to indicate a status for an item, or tap a line item in a history category, and then do 1 or more of the following:
 - Tap in the *Yes* or *No* column to indicate a patient's status.
Once you select a line item, it is automatically set to *Yes* but can be changed if needed.
 - The *History Status* is set to *Active* for the line item you select but can be changed to *Inactive* (the history entry is no longer active for the patient) or *Erroneous* (the history entry was entered in error and does not apply to the patient).
 - Additional details can be captured for each history item. The details that can be captured vary by the history category and the line item selected.
 - To add more information for the history group, tap *Add more of this history*, add the appropriate details, and then tap *Done*. You can add a separate status for a history group (*Group Status*) since the status may be different than the line item. Repeat as necessary until you have captured all the relevant details.
 - b When you have finished adding information for a line item, tap *Done*.

Note: All items that are set to *No* for a category are moved to the bottom of the line item list and can be viewed and edited by tapping *Negative responses present*.

- 5 If you identify a procedure, condition, or behavior that is not included in the list, and need to add a new line item, do the following:
 - a Tap *Medical History (Add)*, *Surgical History (Add)*, *Family History (Add)*, or *Social History (Add)* at the top of each list.

b Do one of the following to add a line item:

- **Search and add a line item from the database.** You can search the system database for a line item by typing 3 or more characters of the code or description of the problem and then select it from the list.

Note:

- ICD and SNOMED codes and descriptions are supported for medical, family, and social history items.
- When adding line items to medical history, tap ICD-9, SNOMED, or ICD-10 to indicate the code set that you want to use for the medical history item. ICD-10 is only available for past medical history items.
- CPT® and SNOMED codes and descriptions are supported for surgical history items.

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- **Add a free text history item.** If an item you want to add cannot be found in the database, you can enter the item using free text. Type the item you want to add, and then select it.

Note: Free text items will not be included in reports or alerts, and are not easily shared with others using electronic formats such as a Continuity of Care Document (CCD).

c Continue adding as many new line items as you need. Add additional details to the new line items as needed.

6 When you are done adding patient history information, tap *Save*.

Note: If you have an unfinalized encounter note open while you are making changes to the patient history information, the history category is automatically marked as reviewed in the encounter note. For more information on marking history items reviewed in an encounter note, see ["Associate Existing Clinical Entries to a Patient's Encounter Note" on page 129](#).

Edit Patient History

- 1 Access a patient summary. See ["Viewing a Patient Summary" on page 28](#).
- 2 Tap the *Hx* tab to view **all** of the patient's active history items, and then tap an item in the list.

Notes:

- To filter the history items in the *Hx* tab, tap *Medical*, *Surgical*, *Family*, or *Social*.
- For history items that have been given a custom description, tap ⓘ to view the system description.

- 3 Make the necessary changes to the history item. For more information about adding history information, see ["Add Past Medical, Surgical, Family, and Social History" on page 56](#).
- 4 Tap *Save*.

Note: If you have an unfinalized encounter note open while you are making changes to the patient history information, keep in mind the following:

- Changing history details to *Inactive* or *Erroneous* (the history entry was entered in error and does not apply to the patient) removes the history item from the encounter note.
- If you make changes to a line item within a history category, the history category is automatically marked as reviewed in the encounter note. For any history categories that do not need updating, you must manually mark the history categories as reviewed.
- For more information on marking history items reviewed in an encounter note, see ["Associate Existing Clinical Entries to a Patient's Encounter Note" on page 129](#).

Viewing Care Recommendations

Based on captured Clinical Quality Measures and Clinical Decision Support data that is currently available in Quanum[®] Electronic Health Record (EHR), individual patient care is monitored to ensure that the patient is receiving the appropriate level of routine clinical care as well as proper disease management and preventive care (such as immunizations). When a gap in care is identified for a patient, recommendations display on the *Care Rec* tab on a patient's *Summary* screen. This tab contains a list of active and dismissed recommendations for the patient.

View Care Recommendations

- 1 Access the patient's summary page; for instructions, see "[Viewing a Patient Summary](#)" on [page 28](#).
- 2 Tap the *Care Rec* tab.
- 3 Review the active recommendations for the patient.
- 4 To see dismissed recommendations, tap *Dismissed*.


Notes:

- Care recommendations can be dismissed in the web application for either a specific period of time (default is 2 weeks) or permanently. If a recommendation is dismissed temporarily, it will reappear on the active list at the end of the designated time period. Permanently dismissed recommendations display on the *Dismissed* tab only once.
- To refresh care recommendations, tap at the top of the list and swipe down. The refreshed time displays.


Managing Comments

The *Comments* function allows you to capture details about your patients. Unlike the *Problems* list, comments are free-text. You can enter any details relating to a patient. For example, you can use *Comments* to record specific patient needs such as confinement to a wheelchair or use of a walker.

Add or Edit a Comment

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap .
- 3 Type any comment(s) you want to record in the patient's summary.
- 4 Tap *Save*.



Reconciling Patient Clinical Information

As part of managing the clinical information that is available in a patient chart, you can perform a reconciliation of the patient's problems, allergies and adverse reactions, and medications. Current active and inactive items display for you to review. Additionally, you can add new items as needed, move an active item to the inactive list, and determine if items from an electronically received clinical document should be added to the patient's active list. To reconcile the patient's clinical information, tap  that is available on the *Problems* or *Rx* tab of the patient summary or in the allergy bar.

For more information, see one of the following:

- "Reconcile a Patient's Problems" on the next page
- "View and Reconcile a Patient's Allergies and Adverse Reactions" below
- "View and Reconcile a Patient's Medications" on page 65



View and Reconcile a Patient's Allergies and Adverse Reactions


- 1 Access the patient summary for whom you want to reconcile allergies, and then tap  in the allergy bar at the top left.
- 2 In the *Other Allergies/Adverse Reactions* list, links display for electronically received clinical documents that contain allergies. If links are available, tap 1 (or more) to expand that area and view the allergies and adverse reactions that were included on the electronically received document for the patient.
- 3 Tap  next to an allergy or adverse reaction in the *Other Allergies/Adverse Reactions* list to move it to the patient's active list.

If the medication, substance, or device cannot be identified in the drug database or if an adverse event type cannot be assigned, you are prompted to select the appropriate medication or substance and *Adverse Event Type*, as applicable. After you have done so, tap *Done*.


Electronically received documents may indicate that a patient has allergies to a food, substance or device, no known allergies or adverse reactions, or that a patient is negative for a specific allergy or adverse reaction. These items cannot be added to the *Quantum Active Allergies/Adverse Reactions* list.

Allergies and adverse reactions in the *Other Allergies/Adverse Reactions* list may contain multiple severities or multiple reactions. When multiple severities or multiple reactions occur, you can view them in the *Notes* box on the *Edit Allergies/Adverse Reactions* dialog box.

- 4 Verify that the active allergies and adverse reactions are correct. If no changes need to be made, continue with step 5. Otherwise, do any of the following:
 - **Remove an allergy or adverse reaction from the active list.**
 - a Tap  next to the allergy or adverse reaction that you want to deactivate.
 - b Tap the appropriate status:
 - *Inactive*. The allergy or adverse reaction is no longer applicable to the patient.
 - *Erroneous*. The allergy or adverse reaction was either incorrectly diagnosed or entered in error and no longer applies to the patient.
 - c If necessary, type the appropriate date in the *Inactivated* box.
 - d Tap *Done*.
 - **Modify an allergy or adverse reaction in the active list.**
 - a Tap  next to the appropriate allergy or adverse reaction.
 - b Make any necessary changes, and then tap *Done*.
 - **Add a new allergy or adverse reaction.** Tap *Add an Allergy/Adverse Reaction* and then add the appropriate information and then tap *Done*.


When you add the reaction for the allergy, tap ICD-10 to select the code you want to use for the reaction. The *SNOMED* code that most closely matches automatically populates below, unless no match is found. If necessary, tap  to remove the match, tap *SNOMED*, type 3 or more characters of a more appropriate *SNOMED* code or description and select the desired result from the list.
- 5 Tap *Save* to save your changes and reconcile the patient's allergies and adverse reactions.


Reconcile a Patient's Problems

- 1 Access the patient summary for whom you want to reconcile problems, and then tap the *Probs* tab.
- 2 Tap .
- 3 Review the *Quantum Active Problems* list on the left. Tap the *sort by* option to change how the list is sorted (by onset date or description), if needed.
- 4 In the *Other Problems* list, you can view problems that are not currently active by tapping one of the following items:
 - *Quantum Inactive/Resolved Problems*. Problems that have been marked inactive or resolved.

- *Electronically received clinical documents.* Links display for electronically received clinical documents that contain problems. If links are available, tap 1 or more to expand that area and view the problems that were included on the electronically received document for the patient.

Notes:


- To view additional information about the electronically received document that contained the problems, tap .
- You can change how the list is sorted, if needed, by tapping *sort by* at the top of the list and making another selection.

- 5 Tap  next to each problem name in the *Other Problems* list that you want to move to the patient's *Quantum Active Problems* list.

Electronically received documents may indicate that a patient has no known problems or that a patient is negative for a specific problem. These items can not be added to the active list.

Note: Problems on the *Quantum Inactive/Resolved Problems* list must be manually re-added.

- 6 Verify that the problems in the *Quantum Active Problems* list are correct. If no changes need to be made, continue with step 6. Otherwise, do any of the following:

- **Remove a problem from the *Quantum Active Problems* list.**
 - a Tap  next to the problem in the *Quantum Active Problems* list that you want to deactivate.
 - b Tap the appropriate *Status*:
 - **Inactive.** The problem is no longer an active problem for the patient; however, it has not been resolved and could return.
 - **Resolved.** The problem is resolved and should not return.
 - **Erroneous.** The problem was either incorrectly diagnosed or entered in error and no longer applies to the patient.
 - c If necessary, type the appropriate date in the *Resolution/Inactivity Date* box.
 - d Type a short description indicating why the problem is no longer active in the *Notes* box.
 - e Tap *Done*.
- **Modify a problem in the *Quantum Active Problems* list or review secondary codes.** Tap the problem in the *Quantum Active Problems* list, make the necessary changes, and then tap *Done*.

- **Add a new problem.**

Tap *Add Problem*, add the appropriate information, and tap *Done*. For more information about adding problems, see "[Add a Patient Problem](#)" on page 52.

The problem appears on either the *Quantum Active Problems* or *Quantum Inactive/Resolved Problems* list, depending on whether you specified that the problem was active or inactive.

- **Associate an ICD-10 code with a problem in the *Quantum Active Problems* list.**


- a Tap *Select ICD-10*. This link only displays if the problem is currently coded with ICD-9 or SNOMED.

- b Select one of the suggested codes or search and select a new ICD-10 code.



- c Tap *Save*.

7 Tap *Save* to save your changes and reconcile the patient's problems.

View and Reconcile a Patient's Medications

- 1 Access the patient summary for whom you want to reconcile medications, and then tap the *Rx* tab.
- 2 Tap .
- 3 In the *Other Medications* list, you can view medications for the patient that are not currently active by tapping one of the following items:
 - *Claims History*. Medications that exist in the patient's claims history.
 - *Pharmacy History*. Medications that exist in the patient's pharmacy history.
 - *Quantum Inactive Meds*. Medications that have been previously marked inactive.
 - *Electronically received clinical documents*. Links display for electronically received clinical documents that contain medications. If links are available, tap one (or more) to expand that area and view the medications that were included on the electronically received document for the patient.

Notes:


- To view additional information about the electronically received document that contained the medications, tap .
 - Certain information may not be available or accurate in this report, such as over-the-counter medications, low-cost prescriptions, prescriptions paid for by the patient, errors in insurance claims, or items that the patient requested not be disclosed due to patient privacy. There may be a false positive match if the patient's demographics have information similar to another patient in the Master Patient Index. Therefore, you should verify demographics and medications with the patient.
 - You can view the effective date for controlled substances, when available, for both active and inactive medications.
 - You can change how the list is sorted, if needed, by tapping *sort by* at the top of the list and making another selection.
- 4 Tap  next to each medication name in the *Other Medications* list that you want to move to the patient's *Quantum Active Medications* list.

If the medication cannot be identified in the drug database, the *Edit a Reported Medication* dialog box appears; prompting you to search the drug database for the appropriate medication. After you have entered the appropriate information for the medication, tap *Done*.

Electronically received documents may indicate that a patient has no known medications or that a patient is negative for a specific medication. These items cannot be added to the active list.

5 Verify that the active medications are correct. If no changes need to be made, continue with step 6. Otherwise, do any of the following:

- **Remove a medications from the active list.**

Tap  next to the medication you want to deactivate.

- **Modify a reported medication in the active list.**

a Tap  next to the appropriate reported medication.

b Make any necessary changes, and then tap *Done*.

Note: You cannot edit administered or prescribed medications. Vaccines that have been entered as reported medications are labeled *Administered* and can be edited.

- **Add a reported medication.** Tap *Add a Reported Med* at the top right, and then add the appropriate information. For more information, see "[Add a Reported Medication](#)" on [page 102](#).

The reported medication appears on either the *Quantum Active Medications* or *Quantum Inactive Meds* list, depending on whether you specified that the medication was active or inactive.

6 Tap *Save* to save your changes and reconcile the patient's medications.

Viewing Other Documents

You can view documents that have been uploaded or electronically received for the patient which are not categorized as laboratory, radiology, or notes related documents from the *Other* tab in the patient summary.

View Other Documents

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the *Other* tab.
- 3 Drag or swipe up and down to scroll through the list.
- 4 Tap a document in the list to view its content.
If a document was electronically received, it displays as a PDF. If a document was uploaded, it is opened in an applicable viewer (if available).
- 5 To close the document, tap outside of the document.

Chapter 3: Patient Results

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About Patient Results

This section describes the patient results functions of Quantum EHR (for iPad) which allows you to do the following:

- **View and manage lab results.** All new test results that are received by Quantum EHR (for iPad) are consolidated into 1 location, so that you can quickly review the latest lab results for all of your patients. All lab test results that are received for an individual patient are permanently stored, and are accessible from the patient's summary. For information on viewing lab results, see ["Viewing and Managing Lab Results" on the next page](#).
- **Manage results by marking them reviewed or adding annotations.** A lab result can be marked and saved as *Reviewed*. Once a result has been marked as reviewed, the *Reviewed By* message appears in the result details and includes the name of the user who marked it reviewed, as well as the date and time it was reviewed. Annotations can be added to lab results and are available when the lab is viewed and included with printed results. For information on lab result annotations, see ["View and Manage Lab Results from a Patient's Summary" on page 73](#).
- **View all diagnostic results for a particular patient.** All diagnostic results that are received for an individual patient are permanently stored, and are accessible from the patient's summary. For more information on viewing diagnostic results for a particular patient, see ["View Diagnostic Results" on page 76](#).
- **View flowsheet and graph lab data.** You can use a flowsheet to view trends across a patient's lab results. For information on using flowsheets and graphs, see ["Viewing a Flowsheet" on page 75](#).


Viewing and Managing Lab Results

This section provides instructions for accessing all new lab results that are received by Quantum EHR (for iPad), or accessing lab results that are received for a specific patient. Depending on your organization's settings, new lab results may be removed from the *Labs* inbox after they are viewed or printed, or they may need to be manually cleared. All lab results (regardless of whether or not they are “new”) are saved to the associated patient's chart. Even though a result may no longer appear on the new lab results list, it is always available by accessing that patient's summary. (For information on accessing a patient summary, see "[Viewing a Patient Summary](#)" on page 28.)



If your organization has enabled *Interactive Insights*, you can specify whether the results include interactive or static content by choosing a default lab result format from the *General Preferences* page (while in the web application) or while viewing a full report for a patient in the app. The ability to add comments to interactive results is currently not available in Quantum EHR (for iPad). To add comments, access the interactive content version of the lab result in the web application.

In addition to viewing a new lab result, you can also mark it as reviewed or add an annotation. A lab result can only be marked as reviewed once. After a user has marked and saved a lab result as reviewed, a *Reviewed By* message appears in the result details that includes the name of the user who marked the result as reviewed, as well as the date and time it was reviewed. Annotations can be viewed or added anywhere the lab result is available. Any user who can view a lab result can add an annotation to that result.

View and Manage Lab Results from the Inbox


- 1 Tap *Lab Results* on the Quantum EHR (for iPad) home screen.
- 2 To filter lab results, do any of the following
 - Tap *Not Reviewed* to filter the inbox results to only those results that have not yet been reviewed.
 - Tap  , tap an ordering provider name in the list, and then *Save* to filter the list to results associated with the indicated provider.
- 3 Drag or swipe up and down to scroll through the new results for the organization.

Notes:


- Results that are out of range are designated with .
- Results with a priority out of range value are designated with .


- 4 To view details for a lab result, tap a lab result in the list.
- 5 Do any of the following as needed:
 - **View data on an interactive result.** If you are viewing interactive results, you can do any of the following:
 - Switch between a patient or physician-focused view by tapping the appropriate tab.
 - Change how you are viewing the result data by selecting the appropriate tab: *Current* (simple display), *Range* (graphical range bars), *Over time* (graphs that display historical and current result values), or *Population* (enhanced micronutrient reports only; displays the patient's result plotted on a population distribution curve).
 - Review clinical insights related to the results you are viewing such as FAQs, publications, or images.
 - **View the lab result PDF.** To view a PDF file of the complete lab report (report of record), tap *Full Report*.






Tip: Pinch your fingers together or apart to zoom in and out on the report.


- **Write a lab order or task.** To initiate a lab order or task for the patient, do one of the following:
 - From the *Labs* inbox, tap *Write Lab Order* at the top left of the lab details.
 - From the *Labs* tab of the patient summary, tap .

For complete instructions for placing a lab order or task, see "Write a Lab Order or Task" on page 147.

- **Mark results reviewed.** Do any of the following:
 - To mark a single lab result as reviewed, tap  in the heading of the lab result. Turn on *Lab is Reviewed*, and then tap *Save*.

Note: A reviewed lab result is indicated by , and can only be marked once.



- To mark multiple lab results as reviewed, tap . Tap in front of each lab result you want to mark as reviewed () and then tap *Mark Selected Labs Reviewed*.
- To mark all results as reviewed, tap , tap *Select All Labs*, and then tap *Mark Selected Labs Reviewed*.
- **Annotate a result.** From the results list, tap  or  in the heading of the lab result that you want to annotate, type the annotation, and then tap *Save*. Annotations are available on the last page of a lab result full report.

Note: To navigate to a patient's summary from the *Labs* inbox, tap  at the top of the lab details.

View and Manage Lab Results from a Patient's Summary



- 1 Access a patient's summary and then tap the *Labs* tab.
- 2 To filter the results to only those that have not yet been reviewed, tap *Not Reviewed*.
- 3 Drag or swipe up and down to scroll through the new results for the patient.


Notes:






- Results that are out of range are designated with .
- Results with a priority out of range value are designated with .

- 4 To view details for a lab result, tap a lab result in the list.
- 5 Do any of the following as needed:
 - **View data on an interactive result.** If you are viewing interactive results, you can do any of the following:
 - Switch between a patient or physician-focused view by tapping the appropriate tab.
 - Change how you are viewing the result data by selecting the appropriate tab: *Current* (simple display), *Range* (graphical range bars), *Over time* (graphs that display historical and current result values), or *Population* (enhanced micronutrient reports only; displays the patient's result plotted on a population distribution curve).
 - Review clinical insights related to the results you are viewing such as FAQs, publications, or images.
 - **View the lab result PDF.** To view a PDF file of the complete lab report (report of record), tap *Full Report*.

Tip: Pinch your fingers together or apart to zoom in and out on the report.

- **Write a lab order or task.** To initiate a lab order or task for the patient, do one of the following:
 - From the *Labs* inbox, tap *Write Lab Order* at the top left of the lab details.
 - From the *Labs* tab of the patient summary, tap .For complete instructions for placing a lab order or task, see ["Write a Lab Order or Task" on page 147](#).
- **Mark results reviewed.** Do any of the following:
 - To mark a single lab result as reviewed, tap  in the heading of the lab result. Turn on *Lab is Reviewed*, and then tap *Save*.


Note: A reviewed lab result is indicated by , and can only be marked once.

- To mark multiple lab results as reviewed, tap . Tap in front of each lab result you want to mark as reviewed () and then tap *Mark Selected Labs Reviewed*.
- To mark all results as reviewed, tap , tap *Select All Labs*, and then tap *Mark Selected Labs Reviewed*.
- **Annotate a result.** From the results list, tap  or  in the heading of the lab result that you want to annotate, type the annotation, and then tap *Save*. Annotations are available on the last page of a lab result full report.

Viewing a Flowsheet

The flowsheet function allows you to track lab test results for a patient across a specified period of time. You can select an analyte to view a graph of that analyte's data over time.

View a Flowsheet

- 1 Access a lab result. See "[Viewing and Managing Lab Results](#)" on page 70.
- 2 Tap a lab result in the list.
- 3 From the lab details, tap  next to the analyte you want to view.

The lab flowsheet screen displays showing a graph of the selected analyte's data, if available, as well as a list of all historical data for the analyte from the associated performing lab.

Tip: Tap an analyte in the list to highlight that analyte value in the graph. Abnormals are shown in red.

Note: Graphs display only numeric values. If test results include non-numeric values for the analyte, they are included in the list below the graph so that you can view all of the historical data for that analyte, regardless of whether or not it can be graphed.

Viewing Diagnostic Results

All diagnostic results that are uploaded or electronically received for a patient are accessible from the patient's summary (on the *Diag* tab). Diagnostic results include the following types of results:

Result Types			
Audiology	Diagnostic Results	Laboratory	Serology
Blood Bank	EKG	Microbiology	Surgical Pathology
Blood Gases	Electrocardiac	Mycobacteriology	Toxicology
Cardiodiagnostics	Electroneuro	Outside lab	Virology
Chemistry	Hematology	PFT	
Cytopathology	Immunology	Pulmonary Function	

View Diagnostic Results

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the *Diag* tab to view **all** uploaded or electronically received diagnostics results (for example, radiology, pathology, electrocardiac, electroneuro, microbiology, or PFT) for the patient.
- 3 Do one of the following:
 - Drag or swipe up and down to scroll through the list.
 - To sort the list by a specific diagnostics type, tap *Radiology*, or *Other Diag*. To view all results in the list, tap *All*.
- 4 Tap a result in the list to view its content.

If a diagnostic result was electronically received, it displays as a PDF. If a diagnostic result was uploaded, it is opened in an applicable viewer (if available). If an image is associated with a result, (*attached images*) appears next to the result.
- 5 To close the result, tap outside of the result.

Managing Patient-Generated Health Data

Patient-Generated Health Data (PGHD) includes any health-related data that is gathered or recorded by a patient (or their family members or caregivers), such as blood pressure readings using in-home medical devices. Providers, Clinicians, and Clinical Office Staff can add PGHD to the patient's summary in the web app by using the document upload feature or by saving an attachment received in a Direct message. For more information on uploading or saving PGHD documents to the patient's summary, see the online help in the web application.

You can view the actual PGHD documents on the *PGHD* tab of the patient summary of Quantum EHR (for iPad). You can also add and edit notes and URL links in Quantum EHR (for iPad).

View Patient-Generated Health Data (PGHD)

- 1 Access the patient's summary page; for instructions, see "[Viewing a Patient Summary](#)" on [page 28](#).
- 2 Tap the *PGHD* tab in the patient's summary.
- 3 To view PGHD information, do one of the following:
 - Tap the name of the document or file you want to preview.
 - Tap ⓘ to view narrative text and/or a URL related to the document.

Notes:

- Narrative text and URL are not required, so they may or may not appear.
- The URL is not a link; you can copy the URL into a browser to view it.
- The date reflects the date the document was uploaded.

Add Patient-Generated Health Data (PGHD)

- 1 Access the patient's summary page; for instructions, see "[Viewing a Patient Summary](#)" on [page 28](#).
- 2 Tap the *PGHD* tab in the patient's summary.
- 3 Tap + to add a new PGHD item.
- 4 On the *Add PGHD* window, enter a name in the *File Name* field.
- 5 Select one of the following document types:
 - *Patient Generated Health Data*
 - *Advanced Directives*

- *Birth Plan*
 - *Blood Glucose*
 - *Blood Pressure*
 - *Fitness Metrics*
 - *Other*
- 6 Add a URL in the *URL* field, as necessary.
 - 7 Tap ⓘ to select a *Service Date* on the *Service Date* window and tap *Save*.
 - 8 On the *Add PGHD* window, tap *Add* under *Narrative/Notes*.
 - 9 On the *Narrative Text* window, enter text as necessary and tap *Save*.
 - 10 Tap *Save* on the *Add PGHD* window. The item you created appears on the *PGHD* tab.

Edit Narrative and URL Information

- 1 Access the patient's summary page; for instructions, see "[Viewing a Patient Summary](#)" on [page 28](#).
- 2 Tap the *PGHD* tab in the patient's summary.
- 3 Tap ⓘ to edit the *URL* and *Narrative/Notes* fields.
- 4 In the *PGHD* window, enter your changes.
- 5 Tap *Save* to return to the *PGHD* tab.

Chapter 4: ePrescribing and Medication Management

In This Chapter:

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About ePrescribing and Medication Management

This section describes Quantum ePrescribing, which allows you to write a new prescription for a patient in several short tasks. Once these tasks have been completed, the prescription can then be electronically sent or faxed to the pharmacy, or printed so the patient can hand-deliver the prescription to the pharmacy. Additionally, this section describes how you can view and manage a patient's active medication list, view a patient's medication history, or capture information about a reported or administered medication.






Writing a New Prescription

You can write a new prescription from a patient summary, from the *Rx* tab, or from an encounter note. You can select prescription Sig. information from the system or you can manually enter the Sig. when you write the prescription. (For more information about these options, see [“Setting Free Text Sig. Entry”](#) below.) Additionally, some medications may have offers, or coupons, available. As part of the prescription writing process, and depending on the type of offer, you can send it to the pharmacy and/or print a copy for the patient.

As you write a prescription, several indicators can appear that indicate whether or not a particular medication or supply is on the patient's formulary list. This can help you determine the best medication or supply choice based on the patient's insurance coverage, formulary indicator, and copay options. Formulary indicators appear next to medications and supplies so that you are informed as to the formulary status of the medications and supplies that you prescribe.

Note: Formulary information appears only for patients who are members of an associated PBM. If no PBM information is available, a message in the corresponding section indicates that the information is not available. In this case, the only formulary indicator that appears is the “unknown” indicator (described in the table below).

The following formulary indicators may appear for medications and supplies:

Indicator	Description
	On-Formulary/Preferred (Preferred Tier Number). The selected medication or supply is on formulary, and is preferred. The tier number of the preferred medication or supply appears next to the on formulary symbol. This can range from 1 to 99 and is based on the patient's health plan. The most preferred medication or supply has the highest tier number.
	On-Formulary/Non-Preferred. The selected medication or supply is on formulary, but is not preferred.
	Non-Formulary. The selected medication or supply is not on formulary.
	Non-Reimbursable. The selected medication or supply is not on formulary, and is not reimbursable. The medication or supply is not covered by the patient's health plan and no copay data will be shown for the medication or supply.
	Unknown. The selected medication's or supply's formulary status cannot be determined.

Drug to drug interaction checking is performed for new prescriptions against your patient's active medications. Initially, the severity level for checking interactions is set to *Major*. You can change the severity level, if you want, from the settings that are available from the Quantum EHR (for iPad) home screen. For information about making changes to the severity level, see ["Set Severity Level for Interaction Checking" on page 83](#). For complete instructions about writing a new prescription, see ["Write a New Prescription" on page 83](#).

Notes:

- Users assigned the provider role can write, submit, and approve prescriptions. Users assigned the clinician role can write, submit, and approve prescriptions on behalf of an ordering physician.
- Prescriptions written by nurse practitioners and physician assistants can include supervising information on the printed, faxed, or electronically sent prescription.

If you need to capture information about a patient's medication, you can perform one of the following tasks:

- To view and manage a patient's active medication list, ["View and Reconcile a Patient's Medications" on page 65](#) or ["Manage Patient Active Medications" on page 97](#).
- To report a medication that your patient is taking that was not prescribed or administered in the office (such as a vaccine), see ["Add a Reported Medication" on page 102](#).

Setting Free Text Sig. Entry

If you want to write a free text Sig. for your prescriptions or reported medications, you can utilize the *Free Text Sig.* option. When the free text Sig. preference is enabled, a *Free Text Sig* option is available on all prescriptions, which turns off the options to select the frequency, dosage amount, and route and replaces the options with a text box. You can continue to use the *Free Text Sig.* option as needed on a prescription-by-prescription basis. If you want to hide the *Free Text Sig.* option, you can do so from *Settings*.




Set Free Text Sig. Entry

- 1 Tap *Settings* on the Quanam EHR (for iPad) home screen.
- 2 Tap the *Prescribing* option *Show Free Text Sig. Entry* on or off as needed.
When the *Show Free Text Sig. Entry* preference is enabled, the *Free Text Sig.* option is available for prescriptions.

Set Severity Level for Interaction Checking

- 1 Click *Settings* from the Quanam EHR (for iPad) home screen.
- 2 Review the current setting for drug to drug interaction checking and make changes if needed.
The severity level is initially set to *Major*. Selecting a different severity level may return a large number of interaction results.

Write a New Prescription

- 1 Initiate a prescription from one of the following locations:
 - From the *Rx* tab in the patient summary, tap .
 - From the fourth screen of a patient encounter () , tap  to the right of *Prescriptions*.
- 2 Tap *Prescribe*. Set the Free Text Sig. entry preference if prompted. Continue with step 3.

Notes:

- If you are writing a new prescription, you may receive a message indicating there is insufficient demographic information for the patient. If you do not enter complete demographics, you can only save the prescription as “pending.” Tap *Add Demographics* to enter demographics. Tap *Save* to continue writing the prescription or tap *Cancel*.
- For patients under 18, height and weight are required on the *Script* tab. When available, the most recent height and weight values (for patients of all ages), from *Recent Vitals* or encounter notes, will be used to populate the fields.
- If you enter values and dates in the height/weight fields on the *Script* tab, that information is not saved to *Recent Vitals* or encounter notes.

To add information for a reported medication, tap *Report*. See ["Add a Reported Medication" on page 102](#) for more information.



- 3 Tap *Choose med/supply*, tap the correct tab on the *Favorites* screen, and then do one of the following:
 - **Select a favorite medication or supply.** Tap a medication or supply name, or tap Sig. information.
 - **Search for a medication or supply.** Type 3 or more letters of the medication or supply name in the search box. Brand-name drugs begin with capital letters, while generics appear in lowercase.

Notes:


- To electronically prescribe controlled substances, you must be approved as an Electronic Prescribing of Controlled Substances (EPCS) prescriber.
- Some states may treat specific noncontrolled substances (for example, pseudoephedrine, tramadol, etc) as controlled substances, and they will be blocked from electronic submission.

- 4 Complete the prescription Sig. information by doing one of the following:
 - To write a free text Sig., enable *Free Text Sig.*, and then type your instructions. Complete the prescription as needed.
For more information about setting Free Text Sig. entry, see ["Setting Free Text Sig. Entry" on the previous page](#).
 - To select Sig. options, continue with the next step.
- 5 Complete the remaining items for the prescription.

Tips:

- To view formulary information (if available), including *Formulary Alternatives*, tap  next to the dose form. To prescribe a formulary alternative instead of the selected medication, tap an alternative in the list, and then select the dose form.
- To view additional information about the patient's copay and insurance coverage (if available), tap *Copay* or *Coverage information available*.
- If a medication has an associated offer (patient health information, eCopay, patient discount card, or coupon), "*Offer Available*" appears once you select a *Strength and Dose Form*.
- Turn *D.A.W.* on to be dispensed as written (for example, no generics).
- To add a diagnosis to the prescription, tap  next to *Diagnosis*. You can then search for a diagnosis code or select one from the patient's problems or past medical history. Additionally, if you select a problem or history item that is coded in ICD-9, you can map it to an ICD-10 code.
- All prescriptions (controlled and noncontrolled substances) must include *Dose Amount, Frequency, Quantity, and Unit of Measure*, unless you are using *Free Text Sig. Entry* to include directions. If a medication contains package details, you can select the package type in the *Package* field; the *Quantity* and the *Unit of Measure* fields are updated as defined in the package details. If you change the *Package Quantity* field from the default of 1 to a larger number, the *Quantity* amount is automatically multiplied.
- For Schedule II drugs, the maximum supply is 90 days.
- *Refills* is disabled for Schedule II drugs. Additionally for Schedule III-IV drugs, a maximum of 5 refills can be specified.
- To type additional instructions for the pharmacist, use *Notes to Pharmacist*. The following information must be included in this field when prescribing controlled substances for the scenarios described below:
 - Prescriptions for GHB (gammahydroxybutyric acid) require a reason (medical need). Type the text as follows – *GHB: <reason>*.
 - Prescriptions for a Schedule III, IV, or V narcotic drug approved by the FDA, specifically for "opioid detoxification treatment" or "maintenance treatment," must include a NADEAN (Narcotics Addiction DEA Number). The NADEAN automatically populates if the provider has specified a NADEAN on the *General Preferences* page of the web application. These prescriptions must be printed and signed when using a mobile device, or saved and approved via the web (if using EPCS).

- When prescribing medications containing buprenorphine for pain management purposes, the provider is not required to include a NADEAN if they have selected the user preference, *I prescribe medications containing buprenorphine only for pain management purposes*, in the web application.
- Prescriptions sent electronically to “cover” a verbal order in emergency situations must include *Emergency Cover Prescription - Do Not Fill*.
- Schedule II prescriptions in Nevada must include the last exam date.
- If a GHB reason needs to be sent to the pharmacy because it was not on the refill renewal request, you should deny the request and create a new prescription. On the new prescription, you should type *GHB: <reason>* in the pharmacy notes.
- To type notes for internal use only (not to be sent to the pharmacy), use *Office Notes*.
- To save a medication or supply and its associated details to the favorites list, turn on *Save as favorite*. The medication or supply appears in the favorite medications or supplies list after the prescription is sent or saved. At a minimum, you must enter a quantity amount and dose form to save the medication as a favorite, and a quantity amount and frequency to save the supply as a favorite.


6 After all required information has been entered for the prescription, tap , and then do the following:

Note: If you are a clinician writing a prescription on behalf of the physician, you must select an ordering provider.

- Verify or select the pharmacy.** Review the default pharmacy name, and if necessary, tap the default pharmacy name or tap *Choose Pharmacy* to select a different pharmacy. If you want to change the pharmacy, you can select a pharmacy from the *Last Used* or *Patient Favorites* list, or search for a new pharmacy. To search for a pharmacy, tap *Search* and then type search criteria in the search box.
- Verify or select the ordering provider.** The current ordering provider for this patient displays. You can change the provider if needed. If you are a clinician writing a prescription on behalf of the physician, you must select an ordering provider. If the ordering provider selected for a prescription has more than one DEA number captured in the system, you can now select the appropriate DEA number in order to comply with the EPCS regulations, if needed.

Notes:

- If a patient is eligible to receive medications or supplies using mail order, the mail order pharmacies display at the top of the *Favorite Pharmacies* list, under *Mail Order Pharmacies*. Schedule II - V medications cannot be submitted for mail order delivery.
- If you are writing an electronic prescription for a controlled substance, you can identify pharmacies that will accept the prescription by looking for the **EPCS** symbol next to the pharmacy name. You can only save the prescription as pending using the *Save to Rx Approvals* option, and then use Quanum EHR to approve the prescription.
- Some states may treat specific noncontrolled substances (for example, pseudoephedrine, tramadol, etc) as controlled substances, and they will be blocked from electronic submission.
- If you set a *Favorite Pharmacy State* (in Quanum EHR), and search by pharmacy name, results are limited to this state. Otherwise, the results are limited to your organization's state.

- c Effective Date.** For controlled substances, an effective date displays with the current date. You can change the date to a future date if needed. To set an effective date in the future, tap , scroll, and tap the appropriate date from the list, and then tap *Save*. You can also delete the date if needed.

Note: Effective dates cannot be set in the past.

- d** Do any of the following, if available:

- To print a copy of the prescription being submitted to the pharmacy, turn on *Print Copy*.
Your device must support printing in order to access the print options.
- If an offer is available for the medication you are prescribing, and you do **not** want to send it electronically or by fax to the pharmacy, turn off *Send Offer to Pharmacy*.
- If an offer is available for the medication you are prescribing, and you do **not** want to print a copy of the offer and hand it to the patient, turn off *Print Offers on Approval*.

- e** Do one of the following:


- To save the medication or supply to the patient's chart and to submit the prescription electronically or by fax, tap *Send to Pharmacy*.

If you turned on *Print Copy*, the *Print Script* screen appears showing the script (marked "Copy"). Choose the *Printer Options* and then tap *Print*.

- To save the medication or supply to the patient's chart and print the prescription, tap *Add to Chart and Print*. Choose the *Printer Options* and then tap *Print*.
- To save the prescription as pending, tap *Save to Rx Approvals*.

Note: If a message appears indicating there is insufficient demographic information for the patient, you can save the prescription to the *Prescription Approvals* list or tap the link in the message to update the patient's demographic information. See "[Addressing Prescription Action Items](#)" on page 90.

7 To address interactions, do the following:

- a On the interactions screen, tap  next to the medication to view the complete interaction information.
- b Tap *Override Alerts* to prescribe the medication anyway, or tap *Cancel Send* to not prescribe the medication.


You can set the severity level of interaction checking in the *Settings* from the Quantum EHR (for iPad) home screen. Review the current setting for drug-to-drug interaction checking and make changes if needed.

Refilling a Medication or Supply

Refilling a medication or supply is as easy as locating the medication or supply in the patient's active medication list and then initiating the refill. Once the medication or supply has been added to the prescription, you can modify the Sig. as needed.

Note: Schedule II (CII) prescriptions cannot be refilled.

Refill or Deactivate a Medication or Supply

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the *Rx* tab, and then tap *Medications* or *Supplies* to view either the patient's active medications or the last 30 supplies.
- 3 Tap the medication or supply you want to refill or deactivate, and then do one of the following:
 - **Refill the medication.** Tap *Refill this medication*, make any changes needed and then tap . Review the location, ordering provider, and pharmacy information and make changes as needed. Select one of the delivery options. Medications entered using free text cannot be refilled.
 - Schedule II (CII) prescriptions cannot be refilled.
 - Prescriptions using a unit of measure that is no longer valid cannot be refilled until you choose a valid unit of measure.
 - **Remove the medication from the patient's active medication list.** While viewing the medication or supply details, turn off *Active Medication* and then tap *Save*.


Addressing Prescription Action Items

You can access electronic prescription items that require your attention on the Quantum EHR (for iPad) home screen. Actions that you can take include approving or denying pending prescription items (set to pending when written), approving renewal requests (received from a pharmacy), approving, modifying, or denying pharmacy change requests (received from the pharmacy) and approving, modifying or denying pharmacy change requests that do not contain medication changes.

Note: Items that display on the *Prescription Approvals*, *Prescription Renewals*, and *Prescription Changes* screens vary by your user role:

- If you are a provider, only renewals, approvals, and change requests assigned to you display in the list.
- If you are a clinician, **all** pending renewals, approvals, and change requests display for **all** providers in your organization.

Address a Prescription Approval

- 1 From the Quantum EHR (for iPad) home screen, tap the *Prescription Approvals* inbox link. If you are a clinician, the approvals or renewals list displays **all** pending prescriptions for patients in the organization. You can filter the list if needed. To view prescriptions for a specific provider, tap *Filter*, tap the appropriate provider from the list, and then tap *Save*.
- 2 Tap a pending prescription to view details.
- 3 Tap  and then tap one of the following:

Note: If you do not want to include offers (when available) with the prescription, turn off *Send Offer to Pharmacy* and/or *Print Offers on Approval*.

- **Approve.** The prescription is submitted electronically, or printed when it contains a Schedule II drug, or a Schedule III-V drug in a state that requires wet signatures for these classifications of drugs.
- **Approve & Print.** The prescription is submitted and a copy of the script (and any offers, when available) is printed.

Note: If the prescription you are printing contains a Schedule II drug, or a Schedule III-V drug in a state that requires wet signatures for these classifications of drugs, 2 copies of the prescription automatically print when you tap *Approve & Print* this script (one of the copies is marked “Copy”).


- **Deny.** The prescription is denied (and therefore, not submitted).
- **Modify.** The prescription appears with the medication or supply details. Make any necessary changes to the prescription and then tap *Send*.

Notes:

- If the prescription you are modifying is for a controlled substance, the effective date displays. If the date is in the past, the effective date will automatically be updated to the current date. If the effective date is in the future, that date is retained. Null dates remain null.
- If the prescription you are approving contains a unit of measure that is no longer valid, tap *Unit of Measure* and tap an appropriate unit of measure.

Prescriptions that are approved are immediately removed from the *Prescription Approvals* inbox.

Address a Prescription Renewal

- 1 From the Quantum EHR (for iPad) home screen, tap the *Prescription Approvals* inbox link. If you are a clinician, the approvals or renewals list displays **all** pending prescriptions for patients in the organization. You can filter the list if needed. To view prescriptions for a specific provider, tap *Filter*, tap the appropriate provider from the list, and then tap *Save*.
- 2 Tap a pending renewal to view details.
- 3 Tap  and then tap one of the following:

Note: If you do not want to include offers (when available) with the prescription, turn off *Send Offer to Pharmacy* and/or *Print Offers on Approval*.

- **Approve.** Submits the renewal.
- **Deny.** Denies the renewal request. Tap a denial reason from the list, or type a denial reason in the *Other* box (at the bottom of the list), and then tap *Save*.
- **Replace.** Allows you to modify the prescription information in the renewal request. Tap *Replace* and update the pending prescription details, and then tap *Send to Pharmacy*, *Add to Chart and Print* or *Save to Rx Approvals*.

Notes:

- If you have a renewal request for GHB (gammahydroxybutyric acid), the reason (medical need) needs to be sent to the pharmacy. You should deny the request and create a new prescription, and in the new prescription add the GHB: <reason> in the *Notes to Pharmacist* box.
- If you have a renewal request for a narcotic drug approved by the FDA, specifically for “opioid detoxification treatment” or “maintenance treatment”, you should deny the request and create a new prescription. The new prescription is automatically populated with the selected provider’s NADEAN in the NADEAN area.
- If you have a renewal request for a medication using a unit of measure that is no longer valid, you should modify the request using the *Replace* option, and select a valid unit of measure.
- For renewal requests that you must use the *Replace* option, offers and coupons will not be available.
- If you have a renewal request for a prescription that was not dispensed as written, the details for the medication or supply dispensed will appear.
- On a renewal request, you can add or edit a patient's height/length and weight from a link on *Rx Renewals*.

- If you are creating a replace Rx from a renewal response for a controlled substance, the effective date displays. If the effective date is in the past, it will automatically be updated to the current date. If the effective date is in the future, that date is retained. Null dates remain null.


Prescriptions that are approved, denied, or replaced are immediately removed from the *Prescription Renewals* inbox.

Address a Prescription Change Request

1 From the Quantum EHR (for iPad) home screen, tap *Prescription Changes*.

If you are a clinician, the list displays **all** pending change requests for patients in the organization. You can filter the list if needed. To view change requests for a specific provider, tap *Filter*, tap the appropriate provider from the list, and then tap *Save*.

2 Tap a pending prescription to view details.

3 Tap  and then tap one of the following (as applicable):

Note: If a pharmacy makes a change request for a controlled substance, you will not be able to address the change request. You can use the Quantum[®] Electronic Health Record (EHR) web application to cancel the prescription, start a new one (with any needed changes), and submit it to the pharmacy.

- **Keep Prescribed.** Use this option if you want to keep the medication originally prescribed. Tap a reason from the list or type the reason for why you are keeping the originally prescribed medication in the *Other* box (at the bottom of the list), and then tap *Submit*.
- **Accept Change.** Use this option if you want to accept the pharmacy's request to change the originally prescribed medication.

Note: If an interaction exists for the medication, you will receive an interaction alert. Address the interaction by tapping *Override* (to prescribe the medication) or *Cancel*.

- **Modify Change.** Use this option if you want to modify a change request from a pharmacy. Tap or enter modifications to the prescription and then tap *Submit*.


Notes:

- If a pharmacy submits a request for prescriber authorization information, *Prescriber Authorization* appears in the *Change Type* section. See "[Address a Prescriber Authorization Request](#)" on page 95.

- To add or edit a patient's height/length and weight received on a change request, you must tap *Modify Change*.
 - If a change request is sent by a pharmacy and they have not selected a medication, *No alternate medication suggested* appears in the *Change Requested* section. Pharmacies can use this option to communicate the following change types: Generic Substitution, Therapeutic Interchange, Script Clarification, Out of Stock, and Drug Use Evaluation. You can tap *Keep Prescribed (Deny)*, *Accept Change*, or *Modify Change*.
 - You cannot modify a change request for a generic substitution; you may only accept the change (prescribe generic) or keep the original (prescribe medication as written).
 - If an interaction exists for the medication, you will receive an interaction alert. Address the interaction by tapping *Override* (to prescribe the medication) or *Cancel*.
 - For *Drug Use Evaluation* change requests, if available, you can tap the *Additional Drug Details* link to see all reasons for the change request. Tap the ⓘ icon for pharmacy notes entered for each reason.
- **Add (Prior Authorization Number).** Use this option if you want to add a prior authorization number for the prescribed medication. Type the prior authorization number and tap *Submit*.
 - **Do Not Add (Prior Authorization Number).** Use this option if you do not want to add a prior authorization number.


Once a change request is addressed, it is immediately removed from the *Prescription Changes* inbox; change requests that are not addressed are automatically removed by the system after 14 days.

Address a Prescriber Authorization Request

- 1 From the Quantum EHR (for iPad) home screen, tap *Prescription Changes*.
If you are a clinician, the list displays **all** pending change requests for patients in the organization. You can filter the list if needed. To view change requests for a specific provider, tap *Filter*, tap the appropriate provider from the list, and then tap *Save*.
- 2 Tap a pending prescription to view the change details.
- 3 If the change type is Prescriber Authorization, tap  to see a list of requested prescriber statuses.

Note: The pharmacy may request up to 10 responses in one change request.

- 4 For each of the requested items, select a response (active, inactive, enrolled/re-enrolled) and enter the requested information (license number or date).

Note: You must enter dates in the mm/dd/yyyy format, or you can tap  to select a date from the calendar.

When you have completed all fields with valid responses, the *Submit* link is enabled.

Note: The system validates responses as you enter them and displays error message directly below an invalid response.

- 5 Tap *Submit* to submit all responses or *Deny All* to deny the request. If you select *Deny All*, you must enter a reason.

Viewing and Managing a Patient's Medication History

The *Rx* tab of the patient summary contains active and inactive patient medication lists. There are several ways that patient medication lists are maintained. Each time you write a prescription for a patient, add a reported medication, or record an administered medication, a record of each medication or supply is automatically saved to the patient's medications list. For information about adding reported medications to a patient's chart, see ["Adding a Reported Medication" on page 102](#). Additionally, as part of managing a patient's medication list, you can indicate that a patient has no known medications or that you have not yet reviewed the patient's active medications.

The *Active Meds* list provides a list of all the patient's medications that are marked active. To view inactive medications, tap *All Meds*. Medications remain in the patient's active medications list until 1 of the following occurs:

- The duration specified for the medication is reached (if prescribed using ePrescribing). When this occurs, the medication is automatically deactivated.
- The medication is manually deactivated. You can maintain the accuracy of a patient's active medications list by manually updating its content as needed.

You can also review a patient's claims or pharmacy history (medications that were not initiated from Quanam EHR or Quanam EHR [for iPad]) and a patient's vaccination history from the *Rx* tab.

Manage Patient Active Medications

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the Rx tab.
- 3 Do one or more of the following:
 - **Indicate that a patient has no known medications or that the medications have not yet been reviewed.** Tap *No Known* if the patient has no known medications. Tap *Not Reviewed* if you have not yet reviewed the patient's active medications.
 - **Deactivate a medication.** To deactivate a medication, tap the medication from the *Active Meds* list, turn the *Active Medication* switch off, and then tap *Save*.
The medication is immediately marked inactive and now appears on the *All Meds* inactive list.

Notes:

- Deactivating a medication inactivates all active medications with the same name and dose form.
 - If you deactivate a medication that is identified as a vaccine, it still appears on the Vx tab.
- **Deactivate all medications.** To deactivate all medications from the *Active Meds* list, tap *No Known Medications* and then tap *Confirm* to move all active medications to the *All Meds* inactive list.
 - **Add a reported medication.** For more information, see "[Adding a Reported Medication](#)" on page 102.
 - **Edit a reported medication.** Locate the reported medication on the Rx, tab that you want to edit. *Reported* displays next to the date for reported medications (instead of *Prescribed*). Tap the medication, and then tap *Edit* to make your changes.
 - **Cancel an electronically submitted new medication.** For more information, see "[Canceling a New Prescription](#)" on the next page.
 - **Reconcile the patient's medications.** For more information, see "[View and Reconcile a Patient's Medications](#)" on page 65.
- 4 Repeat the previous step until the active medications list accurately reflects the patient's current medications.

Canceling a New Prescription

You can cancel a prescription that you have electronically sent to the pharmacy for up to 7 days after submitting it. This option only applies to new medical prescriptions and only Providers and Clinicians have access to the option.

When you cancel the prescription, you must provide a reason for canceling, which is included in the request that is sent to the pharmacy.

After you cancel the prescription, the medication status is changed to inactive. The medication then appears under *All Meds/Inactive* on the *Rx* tab, and the patient's encounter note is updated to show the canceled medication in the inactive medications. On the *Reconciliation* page, the prescription is moved from *Quantum Active Medications* to *Quantum Inactive Meds*. The medication can be seen in the *Prescription Cancellations* inbox on the main page, waiting for a response from the pharmacy.

For more information on sending a cancellation request, view ["Cancel a New Prescription" below](#).

When responses from the pharmacy are received, the cancel requests are marked either approved or denied. These completed cancel requests remain in the inbox for 14 days.

For more information on receiving a cancellation response from the pharmacy, view ["Address a Prescription Cancellation" on the next page](#).

Cancel a New Prescription

- 1 From the *Rx* tab, tap a new, electronically-sent medication prescription.
- 2 On the *Medication Detail* tab, tap *Cancel this Medication*.

Note: The cancel option is available for only 7 days after the prescription was submitted.

- 3 On the *Cancel Reason* tab, select a reason for canceling the prescription.

Note: If you choose *Other*, you must type a description, and tap *Done*.

- 4 Tap *Save*.

Address a Prescription Cancellation

- 1 From the Quantum EHR (for iPad) home screen, tap *Prescription Cancellations*.

Note: If the cancellation request has received a response, the status appears in the inbox list on the left-hand side.

- 2 Tap a prescription cancellation to view its details. The details include the cancel reason and pharmacy response, with date and time stamp, if received. If a cancel request is still waiting for a response, the pharmacy response field is populated with *Electronic Cancel Sent*.

Note: Cancellation requests are removed from the inbox 14 days after the response is received.

View Claims or Pharmacy History

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the *Rx* tab.
- 3 Tap the *Claims/Pharmacy Medication History* link.
- 4 On the *Claims/Pharmacy* history screen, tap *Claims* or *Pharmacy* to view the medication or supply history.

Note: Certain information may not be available or accurate in this report, such as over-the-counter medications, low-cost prescriptions, prescriptions paid for by the patient, errors in insurance claims, or items that the patient requested not be disclosed due to patient privacy. There may be a false positive match if the patient's demographics have information similar to another patient in the Master Patient Index. Therefore, you should verify demographics and medications with the patient.

- 5 To close the *Claims/Pharmacy* history screen, tap outside of the screen.




View Patient Vaccinations

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 Tap the Vx tab to view all vaccines (active, inactive, or refused) that have been administered, refused, or reported by the patient.

Adding a Reported Medication

You can track medications that your patient is taking that were not prescribed through Quantum EHR by obtaining the details about these medications directly from your patient and then adding that information into the system. This adds the reported medication to the patient's medication list.


Add a Reported Medication

- 1 Add a reported medication from one of the following locations:
 - From the *Rx* tab of a patient summary, tap .
 - From the fourth screen of a patient encounter () , tap  to the right of *Prescriptions*.
- 2 Tap *Report* to add information for a reported medication. Set the *Free Text Sig.* entry option if prompted.
- 3 Tap *Choose med/supply*, and then do one of the following:
 - Tap a medication name or Sig. information for the medication in the list of favorites.
 - Tap the search box and type 3 or more letters of the medication name, and then tap the name below the search field.
 - Type a free text medication name if you cannot find it in the system.

Note: Interaction checking and coverage and copay information is not available for free text medications.

- 4 On the *Script* screen, tap and then type or select a value for each of the following fields as needed:

Note: If you want to type a free text Sig. as opposed to using the options listed below, turn on *Free Text Sig.* and then enter the information. For more information about using the free text Sig. option, see "[Set Free Text Sig. Entry](#)" on page 83.

- Review the recommended route code, which indicates how the medication was administered. Make changes as needed.
- To indicate the dose amount, tap and type the dose amount or tap  to enter the information.
- Select the frequency with which the medication was administered. Turn on *PRN* to specify that the medication or supply was administered/used as needed.
- If you are documenting a vaccine, turn on *Vaccine* and add an administered date.

- To indicate when the medication was administered to the patient, tap and type a start date or tap ⓘ to scroll and tap a value for the date. *Start Date* changes to *Administered* if you are documenting a vaccine.
 - To indicate the total number days over which the medication was taken, type the number of days in *Days Supply*.
 - If you want to allow refills, select the maximum number of refills to allow. The default is 0.
- 5** After all required information has been entered, tap *Save* to add the medication to the active medications list.

Chapter 5: Clinical Notes

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About Clinical Notes

Clinically relevant documents that arrive (either electronically or by uploading) into a patient's chart, and encounter notes created in Quantum EHR, are placed in the *Encounters* tab of the patient summary. View in-progress notes by tapping the *In-Progress* tab or by tapping the *Notes in progress* inbox link from the Quantum (for iPad) home screen. For more information about viewing in-progress or finalized encounter notes, see ["View Clinical Notes" on page 107](#) or ["View and Edit an In-Progress Encounter Note" on page 161](#). For information on documenting a patient visit, see ["Documenting a Patient Encounter" on page 109](#).



Physician Specialty Information in Encounter Notes

Additional support is provided for obstetrics and gynecological care in encounter notes. If you want to capture and review pregnancy information for a patient, you can turn on the pregnancy record. The information that can be captured in the pregnancy record is similar to data captured on the forms most obstetricians use for pregnancy visits. The following features are available:

- **Pregnancy header.** A pregnancy header containing key data such as estimated delivery date (EDD) and previous pregnancy history is available at the top portion of the pregnancy record. For a complete listing of the information that you can capture and view in the pregnancy header, see ["Reviewing the Pregnancy Header and Flowsheets"](#) step 3. For information about adding pregnancy data to the record, see ["Add Pregnancy Information to an Encounter Note"](#) on page 123.
- **Flowsheets.** The pregnancy flowsheets are populated with information that has been entered into the encounter notes (in-progress and finalized) for a patient over the previous 12 months, based upon the date of service available in the pregnancy record. Flowsheets are available on the *Pregnancy*, *Labs*, and *Education* tabs. For more information about viewing data on the pregnancy flowsheets, see ["Reviewing the Pregnancy Header and Flowsheets"](#) on page 115. For information about adding pregnancy data to the flowsheets, see ["Add Pregnancy Information to an Encounter Note"](#) on page 123.

Note: The pregnancy record, including features for entering the data, displays **only** for providers and clinicians when the pregnancy record option is turned on. For more information about enabling or disabling the pregnancy record, see ["Enabling or Disabling the Pregnancy Record"](#) on page 114.

View Clinical Notes

- 1 Do 1 of the following to view in-progress encounter notes:
 - **View in-progress notes from a patient summary.** Do the following:
 - a Tap the *Encounters* tab of a patient summary.
 - b Tap *In-Progress*.
 - c Tap a note in the list to view its contents. To make changes to the note, see [“View and Edit an In-Progress Encounter Note”](#) beginning with step 2.
 - **View in-progress notes from the Quantum EHR (for iPad) home screen.** Do the following:
 - a Tap the *Notes in progress* Inbox link from the Quantum EHR (for iPad) home screen. All notes in progress (up to 300) associated to the currently logged in user appear.
 - b To filter the notes, if needed, tap  and then select another user or select *Unassigned* or *All Notes*.
 - c Tap a note in the list to view its contents in the right-hand pane.
 - d Do one of the following as needed:
 - To access the patient summary and open the note for editing, tap . For more information, see [“View and Edit an In-Progress Encounter Note”](#), beginning with step 2.
 - To finalize the note, tap *Finalize*.
- 2 To view **all** clinical notes for a patient, do the following:
 - a Tap the *Encounters* tab of the patient summary.
 - b Drag or swipe up and down to scroll through the list.
 - c To view only in-progress notes, tap *In-Progress*. To view all of the notes in the list, tap *All*.

For more information about editing an in-progress encounter note, see [“View and Edit an In-Progress Encounter Note”](#) on page 161.
 - d Tap a note in the list to view its content.

Notes:

- If a clinical note was electronically received or entered in to the system manually, it displays as a PDF. If a clinical note was uploaded, it is opened in an applicable viewer (if available).

- Finalized encounter notes display on the left-hand pane of the patient summary if you are currently viewing an in-progress or finalized encounter note on the right-hand pane of the patient summary. You can view and copy information from the finalized note into an open encounter note, or add an addendum. For more information, see ["View and Edit an In-Progress Encounter Note"](#) on page 161 or ["Add an Addendum"](#) on page 160.

e To close the clinical note, tap *Close*.

Documenting a Patient Encounter


You can document a patient encounter from within the context of a patient chart by starting a new note or copying an existing note. The dual-pane view of the patient chart—with the clinical entries on the left-hand pane and the encounter note on the right-hand pane—allows you to easily review the patient’s clinical information and associate those items, if needed, with an open encounter note.

Note: Only users with roles that have the *Manage Encounter Notes* permission can start, copy, edit or finalize an encounter note.

The following list highlights some of the key features of patient encounter notes:

- Copying an existing encounter note can be used to minimize the amount of time it takes to complete an encounter note. You can copy any of the following information from an existing encounter note into a new encounter note:
 - Visit Type
 - Responsible Provider
 - Location
 - Reason for Visit
 - CC & HPI
 - History (Past Medical History, Pregnancy History, Menstrual History, Surgical History, Social History, and Family History)
 - Review of Systems
 - Subjective Text
 - Physical Exam
 - Cognitive/Functional Status
 - Objective Text
 - Diagnosis
 - Assessment Text
 - Procedure
 - Plan of Care (Plan Text, Assessment and Interventions, Goals and Goal Instructions, Patient Clinical Instructions, Future Scheduled Appointments, and/or Patient Health Concerns and Instructions)
 - Referrals
 - Discharge Status

Note: Copy functionality is only available in organizations which have enabled the *Allow users to copy existing encounter notes* organization preference. For more information, see "Set Encounter Note Preferences for an Organization" in the Quantum EHR web help.

- Encounter note templates can be used to minimize the amount of time needed to complete an encounter note.
- Tabbed navigation is available for accessing 4 different encounter note segments.
- Two options are available for marking clinical entries reviewed (including problems, medications, or history items):
 - **Use switches to mark clinical items reviewed.** If you use the  switch to mark clinical items reviewed, the related clinical entries from the patient chart are copied to the encounter note.
 - **Drag and drop clinical information from the patient's chart to the encounter note.** This feature allows you to drag tabs or individual clinical entries such as problems, medications, allergies, or history items to the encounter note in order to associate them with the patient encounter and mark the clinical entries reviewed.
See "[Associate Existing Clinical Entries to a Patient's Encounter Note](#)" on page 129 for more information.
- Comment boxes are available on each page (segment) of the encounter note to capture your notes. There are several options for capturing encounter note information in the comments:
 - **Typing comments.** Simply tap the comments area and type your notes.
 - **Using Text Shortcuts.** See "[Using Text Shortcuts](#)" on page 21.
 - **Copying diagnoses to the Assessment (💡) tab comments or to the Plan Text on the Plan (📋) tab.** See "[Document Diagnosis Information](#)" on page 141.
 - **Copying Assessment (💡) tab comments to the Plan Text on the Plan (📋) tab or vice versa.** See "[Copy Assessment Comments to the Plan of Care](#)" on page 145 or "[Document Plan of Care](#)" on page 156.
- While you are documenting an encounter note, the system periodically saves your changes.

Notes:

- When 2 or more users are attempting to simultaneously edit and save changes to the same open encounter note, the first user can successfully save changes. Subsequent users who attempt to save changes to the same encounter note since it was saved by the first user are prompted with 2 choices: *Overwrite*, which overwrites the first user's changes with the subsequent user's changes and allows continued editing of the note, or *Discard*, which returns the subsequent user to the encounter note to re-enter their changes while retaining the first user's changes.
- If you have marked problems, allergies, medications, or histories reviewed, the encounter note syncs up with the information that is in the patient's chart. Changes made to these items outside the encounter note may cause the chart and the note to be out of sync. If this happens, a message displays next to the item that it is out of sync. You can refresh the note by tapping the switch off and then on again for the particular item.

The following actions are available from a patient encounter:

To	See
Start a new encounter note and choose the encounter note template.	"Start an Encounter Note" on page 119
Set or change any of the following: <ul style="list-style-type: none">• Encounter note name• Date of service• Encounter type• Responsible provider• Urgent/Emergent situation indicator• Patient declines summary indicator	
Copy an existing encounter note and choose the encounter note template.	"Start an Encounter Note by Copying an Existing Encounter Note" on page 120
Set or change any of the following: <ul style="list-style-type: none">• Encounter note name• Date of service• Encounter type• Responsible provider	

To	See
<ul style="list-style-type: none"> • Transitional visit indicator • Urgent/Emergent situation indicator • Patient declines summary indicator 	
Turn on/off the pregnancy record	"Enable or Disable the Pregnancy Record" on page 114
Document pregnancy information	"Add Pregnancy Information to an Encounter Note" on page 123
Associate items from the patient's chart to the encounter note	"Associate Existing Clinical Entries to a Patient's Encounter Note" on page 129
Mark the patient's allergies, problems, and history items reviewed	"Mark Items Reviewed" on page 130
Mark encounter notes erroneous	"Mark Encounter Notes Erroneous" on page 161
Document subjective information	<ul style="list-style-type: none"> • "Document Patient Vitals" on page 131 • "Document Care Type" on page 132 • "Specify Summary of Care Status" on page 132 • "Document the Reason for a Visit" on page 134 • "Document a Chief Complaint and History of Present Illness" on page 134 • "Document Review of Systems Information" on page 135 • "Document Allergies" on page 138
Document objective information	<ul style="list-style-type: none"> • "Document the Physical Exam Information" on page 139 • "Document Medications" on page 140 • "Document Cognitive and Functional Status" on page 140 • "Document Lab Results" on page 152

To	See
Document assessment information	<ul style="list-style-type: none"> • "Document Diagnosis Information" on page 141 • "Document Risk Evaluation" on page 143
Document plan information	<ul style="list-style-type: none"> • "Write Prescriptions" on page 145 • "Document a Procedure" on page 146 • "Document Plan of Care" on page 156 • "Copy Assessment Comments to the Plan of Care" on page 145
Write orders or tasks	<ul style="list-style-type: none"> • "Write Prescriptions" on page 145 • "Write a Lab Order or Task" on page 147 • "Configure Favorite Diagnoses and Tests for Lab Orders" on page 151 • "Write a Radiology Order or Task" on page 152
Add billing details	"Recording Billing Details for an Encounter" on page 165
Assign and finalize the note	<ul style="list-style-type: none"> • "Associate a User to an Encounter Note" on page 159 • "Finalize and Sign an Encounter Note" on page 159
Add to a finalized note	"Add an Addendum" on page 160
Work with in-progress notes	"View and Edit an In-Progress Encounter Note" on page 161
Search for text in a note	"Search for Text in an Encounter Note" on page 163
Print a note	"Print an Encounter Note" on page 163
Print billing details	"Print Billing Details" on page 170

Enabling or Disabling the Pregnancy Record

The pregnancy record, which includes a header, flowsheets, and features for entering the data, can only be enabled by providers and clinicians whose organization subscribes to the *OB/GYN* premium service.

Enable or Disable the Pregnancy Record

1 Do one of the following:

- Access the most recent in-progress encounter note for the patient; for instructions, see "[View Clinical Notes](#)" on page 107.
- Start a new encounter note for the patient; for instructions, see "[Start an Encounter Note](#)" on page 119.

2 Enable or disable the pregnancy record in one of the following ways:

- For an in-progress encounter note, tap the template name at the top of the encounter note and then turn the *Pregnancy Record* on or off as needed.
- For new encounter notes, turn the *Pregnancy Record* on or off while selecting the encounter template.

Notes:

- When the pregnancy record is enabled, the pregnancy header and flowsheet features are available in the current encounter note. Any header and flowsheet data in the most recent encounter note is automatically included in the pregnancy header and flowsheets of new encounter notes while the pregnancy record is enabled.
- When the pregnancy record is disabled, the pregnancy header and flowsheet features are no longer available in the current note. Any header data in the most recent encounter note is no longer automatically included in the pregnancy header of new encounter notes. The header and flowsheet data is still viewable from any encounter note created for the patient while the features were enabled.

For more information about viewing pregnancy record information, see "[Reviewing the Pregnancy Header and Flowsheets](#)" on the next page. For more information about adding pregnancy record information into an encounter note, see "[Add Pregnancy Information to an Encounter Note](#)" on page 123.


Reviewing the Pregnancy Header and Flowsheets

The pregnancy record is divided into 2 sections—the pregnancy header information that displays at the top of the record, and the flowsheet information that displays on the *Pregnancy, Labs, and Education* tabs that are available on the bottom half of the pregnancy record. For details about what is available in each of the sections of the pregnancy record, see “[Review the Pregnancy Header and Flowsheets](#)” below.

Review the Pregnancy Header and Flowsheets

1 Access an encounter note; for instructions, see “[View Clinical Notes](#)” on page 107.

Note: The pregnancy record (header and flowsheets), as well as features for entering the data, display **only** for providers and clinicians when the pregnancy record is turned on. For more information about enabling or disabling pregnancy-related features for a particular patient, see “[Enabling or Disabling the Pregnancy Record](#)” on the previous page. For information about adding pregnancy information to a patient encounter, see “[Add Pregnancy Information to an Encounter Note](#)” on page 123.

2 Tap  at the top right of the encounter note to view the pregnancy record.

3 Review the pregnancy header which includes the following information in different panels:

- **Allergies.** Displays the patient’s allergies, if available, at the top of the pregnancy record. Allergies can be captured in a patient’s summary. For information about adding patient allergies, see “[Add a Patient Allergy](#)” on page 49.
- **Pregnancy Problems/High Risk.** Displays the conditions for which the pregnancy may be considered high risk.
- **Active Medications.** Displays the patient’s active medications, including the medication details.
- **Past Pregnancy Information.** Displays information about the patient’s past pregnancy history.
- **EDD Confirmation.** Displays information about the patient’s initial EDD calculation and the method used for calculation, including:
 - Last Menstrual Period (*LMP*)
 - Initial Exam
 - Ultrasound
 - Indication of method used to calculate initial EDD

- **18-20 Week EDD Update.** Displays information about the patient's final EDD calculation and the method used for calculation, including:
 - Quickening
 - Fundal Ht. @ Umbil.
 - Ultrasound
 - Indication of method used to calculate final EDD
- Other pregnancy information, such as:
 - Gestational age calculation method
 - Estimated date of conception
 - *D (Rh) Type* value
 - *Antibody Screen* value

Note: *Antibody Screen* does not appear if the *D (RH) Type* value is *Positive*.

- Date Anti-D Immune Globulin was given (*Anti-D IG Admin Date*)

Note: *Anti-D IG Admin Date* does not appear if the *D (RH) Type* value is *Positive*.

- Human Chorionic Gonadotropin (hCG+)

Notes:



- Pregnancy header data which is entered into the pregnancy record is available to view as soon as you save your changes. In addition, if the *Date of Service* is changed, and the gestational age (*GA*) is available, it is automatically updated based on the new service date. For information about entering pregnancy header data into the pregnancy record, see "[Add Pregnancy Information to an Encounter Note](#)" on page 123.
- While a patient's pregnancy record is turned on, any header data in the most recent encounter note is automatically included in the pregnancy header and in any new encounter note created for the patient. For more information about enabling or disabling the pregnancy record for a particular patient, see "[Enabling or Disabling the Pregnancy Record](#)" on page 114.

- 4 Review the pregnancy record flowsheets which include the following information:


Note: The pregnancy flowsheets contain information that has been entered into the encounter notes (in-progress and finalized) for a patient over the previous 12 months, based upon the date of service. For example, if the date of service is November 10, 2012, the flowsheets display data collected between 11/10/2011-11/10/2012. If the date of service is changed for an in-progress note, the flowsheets are automatically updated based on the new date, so that only data from encounter notes created within 12 months of the new date are included.

- *Pregnancy flowsheet.* Displays the following data:
 - **GA.** Calculated value for gestational age.
 - **FH (cm).** Fundal height value in centimeters.
 - **Present.** Value selected for the presentation, or a value that was entered for *Other*.
 - **FHR (BPM).** Fetal heart rate in beats per minute (up to 8 characters).
 - **FM.** Value selected for fetal movement.
 - **PTL S/S.** Value selected for preterm labor signs and symptoms.
 - Cervix exam data:
 - **Dil.** Dilation value in centimeters.
 - **Eff (%).** Percentage of effacement.
 - **Station.** Value selected for station.
 - **US (cm).** Fetal length in centimeters.

Note: The ultrasound length can include 1 decimal.

- **BP.** Patient's blood pressure that was captured as part of the vitals for the corresponding encounter.
- **Wt.** Patient's weight that was captured as part of the vitals for the corresponding encounter.
- **Urine Albumin.** Value selected for urine albumin, or a value that was entered for *Other*.
- **Urine Glucose.** Value selected for urine glucose, or a value that was entered for *Other*.
- **Pain (0-10).** Value selected for the patient's pain level.
- **Next Appt (wks).** Number of weeks in which the patient's next appointment should occur.
- **Comments.** Displays  if comments are available. Tap  to review the comments and then tap outside the comment box to close it.

Note: For information about entering patient header data (including gestational age) from an encounter note, or for entering pregnancy information directly into the flowsheet, see ["Add Pregnancy Information to an Encounter Note" on page 123](#).

- **Labs** flowsheet. Displays the following data:
 - **Test.** Industry-recommended lab tests for various stages of the pregnancy.
 - **Date Ordered.** Date(s) identifying when lab tests were ordered for the patient.
 - **Gest. Age.** The calculated gestational age for the patient as of the date the test was ordered.
 - **Results/Comments.** Lab-related comments or results entered by a user.
 - **Option to write a lab order.** You can place a lab order or task from the *Labs* flowsheet. Tap , and then create the order or task. For complete instructions, see ["Write a Lab Order or Task" on page 147](#).

Notes:


- If a test was ordered multiple times, the test displays multiple times.
- Lab orders that are entered from the encounter note appear in the *Labs* flowsheet tab as soon as you save the order.

- **Education** flowsheet. Displays the following data (for each trimester):
 - **Subject.** Industry-recommended topics to discuss with the patient during various stages of the pregnancy.
 - **Provided.** Date(s) entered by a user identifying when educational materials were provided to the patient.
 - **Counseled.** Date(s) entered by a user identifying when topics were discussed with the patient.
 - **Comments.** Additional education-related comments entered by a user.

Notes:

- Education flowsheet data can be entered directly into the flowsheet. For information about entering pregnancy-related education data from an encounter note, see ["Add Pregnancy Information to an Encounter Note" on page 123](#).
- If 1 topic was addressed on multiple occasions, only the most recent data entered for the topic appears.

Start an Encounter Note

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on page 28.
- 2 On the *Encounters* tab, tap  > *Start New Note*.
- 3 Choose the appropriate encounter template for this patient visit and, if applicable, turn on *Pregnancy Record* to capture pregnancy information. For more information about capturing pregnancy information during a patient visit, see "[Add Pregnancy Information to an Encounter Note](#)" on page 123.

Encounter templates are usually created with a sub-set of categories and line items that can be used to document a patient's review of systems and physical exam. Templates also define the history line items (medical, surgical, family, or social) that are available in the patient summary. Several template types are available for selection:

- **Default template.** To use your default template, if one is set, tap the highlighted template.
If you do not have a personal default template set, but your organization has designated a default template, it is highlighted and available for selection.
- **System default.** To review **all** categories and line items for review of systems and physical exam, tap *System Default*, if available. Since this option displays all categories and line items, it is recommended that you utilize a default template to streamline your encounter note documentation.
- **Customized template.** To use a customized template that was created for a specific encounter type, tap the appropriate custom template from the list.
- **Master template.** To use a master template, tap the appropriate master template from the list. Master encounter templates are created by system administrators and are available to all users in all organizations. Most master templates (with the exception of the *Well Adult* master templates) display gender-specific information appropriate for the patient's gender. If the patient's gender is undifferentiated, then categories and line items display for both genders.

Note: If you need to change the template later, tap *Template* and then tap the new template.

- 4 If you want to change the name of the encounter note, tap the name, type a new name, and then tap *Done*.

Note: The name of the encounter note defaults to your organization's encounter note naming convention.

- 5 The date of service appears at the top of the new note and defaults to the current date. If you need to change the date, tap the date and then scroll and tap a value for the month, date, and year, and then tap *Save*.

Additional information that you can capture while setting the appropriate date of service includes:

- **Encounter type.** The encounter type is set to *Office visit with provider*. If you need to change the encounter type, tap *Office visit with provider* to make your selection.

Note: Only encounter notes with an encounter type of *Office visit with provider* contribute to Meaningful Use or Advancing Care Information metrics.

- **Responsible provider.** Tap and select the appropriate provider as the *Responsible Provider* for the note. This option only displays if *Office visit with provider* is selected for the encounter type.


Note: When the *Responsible Provider* option is displayed, you must select a provider from the list to continue creating the encounter note.

- **Urgent or emergent situation.** Turn on *Urgent/Emergent Situation* if the patient's medical condition is urgent or emergent, where time is of the essence, and a delay in treatment would jeopardize the patient's health status.
- **Patient declines summary.** Turn on *Patient Declines Summary* if the patient refuses a copy of the current visit's office visit summary.
- **Enable ICD-10.** Turn on *Enable ICD-10*, if it is not already enabled, to use the ICD-10 code set for this encounter note. When *Enable ICD-10* is turned off, the ICD-9 code set will be used for the encounter note.

Note: The items listed above can be changed until the note is finalized.

- 6 Continue documenting the patient's visit in one or more of the segments. For a complete list of actions that are available from a patient encounter, see the table that begins on [page 109](#).

Start an Encounter Note by Copying an Existing Encounter Note

- 1 Access a patient summary. See "[Viewing a Patient Summary](#)" on [page 28](#).
- 2 On the *Clinical Notes* tab, tap  > *Copy Existing Note*.
- 3 Tap an encounter note in the list.

Notes:

- You can quickly search for an encounter note by typing the first 3 letters of any word in an encounter note's name.
- Encounter notes that are italicized indicate that the originating note is in progress. Encounter notes that are not italicized indicate that the originating note is finalized.

- 4 Review the template associated with the encounter note you are copying. If you do not want to use this template for the new note, tap *Choose Template*, and then tap a template name in the list.

Note: The template that is associated with the originating note is automatically assigned to the new note if the template is still available and active. If the template associated with the originating note is no longer available, then the following information is used for initial template designation:

- If you have designated an encounter template as your personal default template, it is automatically selected, but can be changed, if needed.
- If your organization has designated an encounter template as a default template for the organization, then the organization default template is automatically selected if you do not have a personal default template set.
- If no template is set as your personal or organizational default template, and you do not select a customized encounter template from the *Select Template* dialog box, then a system default template is used for the note that includes a predefined set of review of system, physical exam, and history categories and line items appropriate for the patient's sex. If the patient's sex is *Undifferentiated* or *Unknown*, then all categories and line items in the system default template for both sexes will display.

- 5 Review the information available for copying into the new encounter note and do any of the following:

Note: All sections of the encounter note which contain content are automatically selected. Unselected sections indicate that the originating encounter note did not have any content in them.

- To remove a section you do not want to copy into the new encounter note, tap the appropriate section on the left-hand side to clear the check mark.
- To add a section you want to copy into the new encounter note, tap the appropriate section on the left-hand side to select it.
- To add or remove all sections in a grouping, tap *Select All* or *Deselect All*.

- 6 Tap *Copy*.

- 7 If you want to change the name of the encounter note, tap the name, type a new name, and then tap *Done*.

Note: The name of the encounter note defaults to your organization's encounter note naming convention.

- 8 The date of service appears at the top of the new note and defaults to the current date. If you need to change the date, tap the date and then scroll and tap a value for the month, date, and year, and then tap *Save*.

Additional information that you can capture while setting the appropriate date of service includes:

- **Encounter type.** The encounter type is set to *Office visit with provider*. If you need to change the encounter type, tap *Office visit with provider* to make your selection.

Note: Only encounter notes with an encounter type of *Office visit with provider* contribute to Meaningful Use or Advancing Care Information metrics.



- **Responsible provider.** Tap and select the appropriate provider as the *Responsible Provider* for the note. This option only displays if *Office visit with provider* is selected for the encounter type.

Note: When the *Responsible Provider* option is displayed, you must select a provider from the list to continue creating the encounter note.

- **Urgent or emergent situation.** Turn on *Urgent/Emergent Situation* if the patient's medical condition is urgent or emergent, where time is of the essence, and a delay in treatment would jeopardize the patient's health status.
 - **Patient declines summary.** Turn on *Patient Declines Summary* if the patient refuses a copy of the current visit's office visit summary.
 - **Enable ICD-10.** Turn on *Enable ICD-10*, if it is not already enabled, to use the ICD-10 code set for this encounter note. When *Enable ICD-10* is turned off, the ICD-9 code set will be used for the encounter note.
- 9 Continue documenting the patient's visit in 1 or more of the segments.

Add Pregnancy Information to an Encounter Note


1 Do 1 of the following:

- For notes in progress, access an existing encounter note that has the pregnancy record turned on, and then tap  at the top right of the encounter note to view the pregnancy record.
- For new encounter notes, turn the *Pregnancy Record* on while selecting the encounter template, and then tap  at the top right of the encounter note to view the pregnancy record.

Notes:

- The pregnancy record, as well as features for entering the data, display **only** for providers and clinicians when the pregnancy record is turned on. While a patient's pregnancy record is turned on, any header data in the most recent encounter note is automatically included in the pregnancy header and in any new encounter note created for the patient. For more information about enabling or disabling pregnancy-related features for a particular patient, see "[Enabling or Disabling the Pregnancy Record](#)" on page 114.
- Pregnancy header data which is entered into the pregnancy record is available to view as soon as you save your changes. In addition, if the *Date of Service* is changed, and the gestational age (GA) is available, it is automatically updated based on the new service date.



2 To capture high risk information for the patient, do the following:

- a Tap the *Pregnancy Problems/High Risk* panel and then tap the conditions that apply.
- b To add an additional high risk condition, type the condition in the space provided at the bottom of the list and then tap .

Conditions that you type and add are automatically added to list of high risk items for the patient.

- c Tap *Done* when you are done selecting and adding items.

3 To capture past pregnancy information, tap the pregnancy history panel, and then do the following:

- a Tap   as needed to identify past pregnancy information for any of the listed items.
- b Tap *Done* to save your changes.

- 4 To capture initial EDD information, tap the *EDD Confirmation* panel, and then do one or more of the following:
- To specify the initial EDD based upon the patient's last menstrual period, do the following:
 - a Type the *LMP Date* or tap ⓘ, scroll to the date of the patient's last menstrual period, and then tap *Done*.

The initial EDD based upon the LMP is automatically calculated after you enter the LMP date. To make changes to that date, see step *b*; otherwise, continue with step *c*.
 - b To specify the initial EDD (based on the LMP date), tap *LMP EDD*, scroll to the appropriate date or tap the LMP EDD calculation (*Use LMP + 280 Days*), and then tap *Done*.
 - c To indicate that the initial EDD was based upon the LMP, tap *Initial EDD Method*, select *LMP*, and then tap *Done*.
 - d To save your changes on the *EDD Confirmation* screen, tap *Done*.
 - To specify the initial EDD based upon the patient's initial exam, do the following:
 - a Type the *Initial Exam Date* or tap ⓘ, scroll to the date of the patient's first exam, and then tap *Done*.
 - b To capture the number of weeks in the pregnancy, tap *x* for the weeks or days, type the appropriate number, and then tap *Done*.
 - c To specify the initial EDD (based on the initial exam date), tap *Initial Exam EDD*, scroll to the appropriate date, and then tap *Done*.
 - d To indicate that the initial EDD was based upon the initial exam, tap *Initial EDD Method*, select *Initial Exam*, and then tap *Done*.
 - e To save your changes on the *EDD Confirmation* screen, tap *Done*.
 - To specify the initial EDD based upon an initial ultrasound, do the following:
 - a Type the *Ultrasound Date* or tap ⓘ, scroll to the date of the patient's initial ultrasound, and then tap *Done*.
 - b To capture the number of weeks in the pregnancy, tap *x* for the weeks or days, type the appropriate number, and then tap *Done*.
 - c To specify the initial EDD (based on the ultrasound), tap *Ultrasound EDD*, scroll to the appropriate date, and then tap *Done*.
 - d To indicate that the initial EDD was based upon the initial ultrasound, tap *Initial EDD Method*, select *Ultrasound*, and then tap *Done*.
 - e To save your changes on the *EDD Confirmation* screen, tap *Done*.

- To indicate that the initial EDD was calculated in a method other than LMP, initial exam, or ultrasound, do the following:
 - a Tap *Initial EDD Method*, select *Other*, type the appropriate date, and then tap *Done*.
 - b To save your changes on the *EDD Confirmation* screen, tap *Done*.
- 5 To capture final EDD information, tap the *18-20 Week EDD Update* panel, and then do one or more of the following:
 - To specify the final EDD based upon the quickening date, do the following:
 - a Type the *Quickening Date* or tap ⓘ, scroll to the appropriate date of the initial fetal movement, and then tap *Done*.
 - b To specify the final EDD (based on the quickening date), tap *Quickening EDD*, scroll to the appropriate date or click the quickening EDD calculation (*Use quickening + 22 weeks*), and then tap *Done*.
 - c To indicate that the final EDD was based upon the quickening date, tap *Final EDD*, select *Quickening*, and then tap *Done*.
 - d To save your changes on the *EDD Update* screen, tap *Done*.
 - To specify the final EDD based upon the fundal height, do the following:
 - a Type the *Fundal Ht. @ Umbil.* or tap ⓘ, scroll to the appropriate date of the fundal height measurement, and then tap *Done*.
 - b To specify the final EDD (based on the fundal height), tap *Fundal Ht. EDD*, scroll to the appropriate date or click the fundal height EDD calculation (*Use Fundal Ht. + 20 weeks*), and then tap *Done*.
 - c To indicate that the final EDD was based upon the fundal height, tap *Final EDD*, select *Fundal Ht. at Umbil.*, and then tap *Done*.
 - d To save your changes on the *EDD Update* screen, tap *Done*.
 - To specify the final EDD based upon an updated ultrasound, do the following:
 - a Type the *Ultrasound Date* or tap ⓘ, scroll to the appropriate date of the ultrasound, and then tap *Done*.
 - b To add the number of weeks in the pregnancy when the ultrasound was performed, tap x for the weeks or days, type the appropriate number, and then tap *Done*.
 - c To specify the final EDD (based on the ultrasound date), tap *Ultrasound EDD*, scroll to the appropriate date, and then tap *Done*.
 - d To indicate that the final EDD was based upon an ultrasound, tap *Final EDD*, select *Updated Ultrasound*, and then tap *Done*.
 - e To save your changes on the *EDD Update* screen, tap *Done*.
 - To indicate that the final EDD was calculated in a method other than quickening, fundal height measurement, or ultrasound, do the following:

a Tap *Final EDD*, select *Other*, type the appropriate date, and the tap *Done*.

b To save your changes on the *EDD Update* screen, tap *Done*.

6 To capture other pregnancy data, tap the panel below the pregnancy history panel and then do one or more of the following:

- To indicate which method is being used (last menstrual period or estimated date of delivery) to calculate the gestational age, tap *Gest. Age Calc. Method*, tap the method, and then tap *Done*.

Note: The following data is used to calculate the gestational age:

- If *LMP* is selected, the gestational age will be (*Date of Service* - *LMP*), in weeks and days.
- If *EDD* is selected, the gestational age will be (280 days - [*EDD* - *Date of Service*]), in weeks and days. If both final EDD and initial EDD are available, the final EDD is used.

- The estimated date of conception is automatically calculated using the LMP if it is available (LMP + 14 days). You can also manually enter a date, or tap ⓘ, select the appropriate date, and then tap *Done*.
- To add the patient's Rhesus (Rh) factor value, tap *D (Rh) Type*, tap the appropriate value (*Positive*, *Negative*, or *Undetermined*), and then tap *Done*.
- To add the antibody screening value, tap *Antibody Screen*, tap the appropriate value (*Positive*, *Negative*, or *Undetermined*), and then tap *Done*.

Note: *Antibody Screen* does not appear if the *D (RH) Type* value is *Positive*.

- To indicate that the anti-D immune globulin drug was administered, tap *Anti-D IG Admin Date*, type a date, or tap ⓘ, select the appropriate date, and then tap *Done*.


Note: *Anti-D IG Admin Date* does not appear if the *D (RH) Type* value is *Positive*.

- To indicate when the *hCG+* test was performed, type a date, or tap ⓘ, select the appropriate date, and then tap *Done*.

7 To view and enter pregnancy flowsheet data, such as fundal height, fetal movement, or details about a cervix exam, do one or both of the following:

- To view pregnancy data that was captured in one or more previous encounters, tap the *Pregnancy* flowsheet tab.


For more information about viewing the pregnancy flowsheet and details about the information that may be available, see "[Reviewing the Pregnancy Header and Flowsheets](#)" on page 115.

- To view comments, if they are available, tap the *Pregnancy* flowsheet tab and then tap  , review the comments and then tap outside the comment box to close it.
- To add pregnancy information for the current encounter, do the following:
 - a Tap the *Pregnancy* flowsheet tab.
 - b Tap the top row of the flowsheet or tap *Edit* in the far right of the row.
This row displays today's date.
 - c Tap any of the items listed to enter data:
 - **Fundal Height (cm)**. Enter the fundal height value in centimeters.
 - **Presentation**. Highlight *Vertex* or highlight *Other* and enter a value, then tap *Done*.
 - **Fetal Heart Rate (BPM)**. Enter the fetal heart rate in beats per minute (up to 8 characters).
 - **Fetal Movement**. Highlight *Positive* or *Negative* for fetal movement, and then tap *Done*.
 - **Preterm Labor Symptoms**. Highlight *Present* or *Absent* to indicate whether preterm labor signs and symptoms are present, and then tap *Done*.
 - **Dilation**. Enter the cervix dilation value in centimeters.
 - **Effacement (%)**. Enter the percentage of effacement.
 - **Station**. Highlight the appropriate value for station, and then tap *Done*.
 - **Ultrasound length (cm)**. Enter the fetal length in centimeters.
 - **Urine Albumin**. Highlight the appropriate value (*Positive* or *Negative*), or highlight *Other* and enter a value, and then tap *Done*.
 - **Urine Glucose**. Highlight the appropriate value (*Positive* or *Negative*), or highlight *Other* and enter a value, and then tap *Done*.
 - **Pain (0-10)**. Highlight the appropriate value for the patient's pain level, and then tap *Done*.
 - **Next Appt (wks)**. Highlight the appropriate value for the number of weeks in which the patient's next appointment should occur, and then tap *Done*.
 - d Type comments as needed.
 - e When you are done with your changes to the pregnancy information for this patient encounter, tap *Done*.
- 8 To view or order obstetric lab tests, do one or more of the following:
 - To view obstetric lab tests that were ordered for the patient, tap the *Labs* flowsheet tab.
The labs flowsheet displays the following information:
 - **Test**. Industry-recommended lab tests for various stages of the pregnancy.

- **Date Ordered.** Date(s) identifying when lab tests were ordered for the patient.
- **Gest. Age.** The gestational age for the patient as of the date the test was ordered.
- **Results/Comments.** Lab-related comments or results entered by a user.

Notes:



- If a test was ordered multiple times, the test displays multiple times.
- Lab orders that are entered from the encounter note appear in the *Labs* flowsheet tab as soon as you save the order.

- To place a lab order or task from the *Labs* flowsheet, tap  and then complete the necessary information. For complete instructions to place a lab order or task, see ["Write a Lab Order or Task" on page 147.](#)
- 9 To view or update education flowsheet data, do one or more of the following:
- To view information about pregnancy-related patient education materials that are recommended for or provided to the patient, tap the *Education* flowsheet tab, and then tap the appropriate trimester for which you want to view data.

The education flowsheet displays the following data (for each trimester):

- **Subject.** Industry-recommended topics to discuss with the patient during various stages of the pregnancy.
- **Provided.** Date(s) entered by a user identifying when educational materials were provided to the patient.
- **Counseled.** Date(s) entered by a user identifying when topics were discussed with the patient.
- **Comments.** Additional education-related comments entered by a user.

Note: If 1 topic was addressed on multiple occasions, only the most recent data entered for the topic displays.

- To add information about patient education that was provided, tap the *Education* flowsheet tab, tap the appropriate trimester for which you want to add data, and then do the following:
 - a Tap the row, or tap *Edit* in the far right of the row, that has the appropriate subject for which you want to add information.
 - b To indicate when the education materials were given to the patient, manually enter a *Materials Provided* date, or tap , select the appropriate date, and then tap *Done*.
 - c To indicate when the patient was counseled on the subject, manually enter a *Counseled* date, or tap , select the appropriate date, and then tap *Done*.

d Type comments as needed.

e Tap *Done*.


10 When you are done reviewing and adding information to the pregnancy record, click *Done*. Your changes are automatically saved.

11 Continue documenting the patient visit or tap *Close* to close it. When the note is complete, tap *Finalize* to prevent further modifications.

See the following for more information, as needed:

- ["Associate Existing Clinical Entries to a Patient's Encounter Note" below.](#)
- ["Document the Physical Exam Information" on page 139.](#)
- ["Document Diagnosis Information" on page 141.](#)
- ["Document a Procedure" on page 146.](#)
- ["Finalize and Sign an Encounter Note" on page 159.](#)

Associate Existing Clinical Entries to a Patient's Encounter Note

1 Tap .


2 To review and associate allergies, a history item (medical, surgical, family, or social), or problem with the current encounter note, do one of the following:

- Turn the switch on for the item that you want to mark reviewed. When you mark allergies, problems, or a history item reviewed using the switch, **all** active clinical entries for that category in the patient's chart are added to the open encounter note. For additional information, see ["Mark Items Reviewed" on the next page.](#)
- Tap and drag the tab or individual item from the patient summary on the left-hand pane to the encounter note on the right-hand pane.

Note: If you want to remove a problem or history item you have added, tap and swipe the item to the left and then tap *Delete*. Allergies can only be removed by turning the switch off.


Keep the following in mind when associating items to an encounter note:

- Only active clinical entries can be associated with an encounter note. If you associate a clinical entry to an encounter note and that item is later marked inactive or erroneous, the clinical entry is removed from the encounter note.
- When you move a history item, the related history section is marked reviewed (set to on) if it was turned off.
- When you move a medication, the active medications section is marked reviewed (set to on) if it was turned off.

- If you want to specify a problem as the patient’s diagnosis, you can tap and drag the problem to the diagnosis area of the encounter note. See step 2 of “[Document Diagnosis Information](#)” for more information.
- If you make changes to a patient’s history, problem, or medication that is associated with the encounter note, you will need to refresh the encounter note by tapping  for the appropriate clinical area to view the changes.


Note: To remove an associated history item, problem, or medication from the encounter note, tap and swipe the item to the left and then tap *Delete*.

Mark Items Reviewed


- 1 Tap .
- 2 To mark items reviewed, such as allergies, problems, and history items, do one of the following:
 - Turn the switch on for the appropriate item. When you mark allergies, problems, or a history item reviewed using the switch, **all** active clinical entries for that category in the patient’s chart are added to the open encounter note.
 - Tap and drag the tab or individual item from the patient summary on the left-hand pane to the encounter note on the right-hand pane.

Note: If you want to remove a problem or history item you have added, tap and swipe the item to the left and then tap *Delete*. You can only remove allergies by turning the switch off.

Document Patient Vitals

1 Tap .

2 Do the following:


- a Tap  to the right of *Vitals*, and then do one or more of the following (drag or swipe horizontally to scroll to the appropriate vital):
- Type the numeric value for a vital (such as *Length/Height*, *Weight*, *Temperature*, or *Head Circumference* for patients 5 and under).
 - Tap the appropriate unit of measure as needed.

Note: If you select a specific unit of measure (English or metric) for a vital, the system defaults to the same type of unit of measure across all vitals.



For several vitals, you can provide additional information, such as the temperature route, cuff position for blood pressure readings, and location of pulse readings by tapping the appropriate location on the image of the body. For blood pressure, you can also select the patient position from 1 of 3 choices (*Sitting*, *Standing*, *Lying Down*).

The patient's body mass index (BMI) is calculated based upon the saved height and weight values. You can view the BMI value after you save your vital entries. BMI is not calculated for patients who are under 2 years old.

If the patient is under 20 years old and their Sex (as entered on the patient's *Demography* tab) is *Unknown* or *Undifferentiated*, you are required to select a Sex for the most appropriate percentile calculations.

- Type comments for a particular vital, if needed. You do not have to record a vital measurement when adding comments.
 - For height, weight, and blood pressure, you can capture a reason for not documenting measurements, if needed. Tap in the *Not Obtained Reason* box, scroll and select the appropriate reason, or tap *Other Reason* and type the reason. Tap *Save*.
- b When you are finished adding the patient's vitals, tap *Save*.
- c You can add additional vitals, if needed, by tapping  to the right of *Additional Vitals*.

Document Care Type

- 1 Tap .
- 2 Tap *Care Type*.
- 3 Tap *New Patient Visit (Never Seen by Provider)*, *New Patient Visit (Over 3 years Since Visit)*, *Referral*, *Transitional Visit*, or *Discharge Follow-Up* to indicate the type of care the patient received during the visit.
- 4 If you selected *Referral*, tap *Referred by* and enter the doctor's name.
- 5 If you selected *Discharge Follow-Up*, tap *Discharge Date* and either enter the date or tap  to select the correct month, day, and year.
- 6 Tap *Save*.

Specify Summary of Care Status

- 1 Tap .
- 2 Tap *Summary of Care*.

Note: The *Summary of Care* link is only available for encounter notes with a care type of *New Patient Visit (Never Seen by Provider)*, *Referral*, or *Transitional Visit*.

- 3 Tap one of the following options:
 - *Incorporated*. An electronic summary of care has been received, stored in Quantum EHR, and has been reconciled against a patient's medications, allergies, and problems.
 - *Requested; not available*. A summary of care has been requested from the patient's previous/other healthcare provider or looked for via a health information exchange (HIE), but was not available or could not be found.
 - *Available; not received*. A summary of care (in CCDA format) exists, but your organization does **not** have an electronic copy of it at this time.
 - *Received; not incorporated*. An electronic copy of the patient's summary of care (in CCDA format) has been received, but either has not yet been associated with the patient's chart (in Quantum EHR), or reconciled against the patient's medications, allergies, and problems.
 - *Not requested*. No steps have been taken to locate an electronic copy of the patient's summary of care.
- 4 Tap *Save*.


Notes:

- The Summary of Care status can be updated after an encounter note is signed and finalized. See "[Edit Summary of Care Status](#)" below.
- Summary of Care data does not display on the printed note.

Edit Summary of Care Status



- 1 Tap *Clinical Notes* and tap the link for the note you want to update.
- 2 Do one of the following:
 - If the note is *In-Progress*, tap *Summary of Care* and tap the updated option.
 - If the note is *Finalized and Signed*, tap the *Summary of Care* link above the patient summary and tap the updated status.
- 3 Click *Save*.





Document the Reason for a Visit


- 1 Tap .
- 2 Tap *Reason for Visit*, and then type a brief description of the reason for the patient's visit. If you have previously entered text for the *Reason for Visit* and you would like to re-use the same description, you can type the first few letters of the text and then tap the text in the text box that appears.

Note: For instructions to save or use a text snippet or for other text shortcut options, see "Using Text Shortcuts" on page 21.

Document a Chief Complaint and History of Present Illness

- 1 Tap .
- 2 Do the following:
 - a Tap  to the right of *Add Complaints*.
 - b Type 1 or more complaints as needed, and then tap *Save*.

To add more complaints, tap  to the right of *Additional Complaints*. To remove a chief complaint and history of present illness, tap and swipe the item to the left and then tap *Delete*.
 - c If you want to document the history of the present illness for a chief complaint, tap the complaint and then do one or more of the following:
 - Use the *Free Text* template option to add details about the complaint. You can add or paste up to 50,000 characters. However, if you attempt to paste more than 50,000 characters, you will receive an error message.
 - To use an HPI template to enter information for the complaint, tap *Template*, and then tap the appropriate template. Do one or more of the following:
 - Tap a category to expand it and view related symptoms, problems, behaviors, or conditions.
 - Tap *Y* or *N*, as appropriate for items and type comments as needed.
 - Mark items reviewed by tapping the item to display .
 - Tap  to enter additional detail for an item, if needed. Tap  when you are done to collapse the section.


- To add 1 or more categories to the history of present illness form, tap *Add System*, and then select the category or categories that you want to add to the history of present illness.
- To identify a symptom, problem, behavior, or condition that is not included in the list (add a new line item), tap  at the bottom of the list to add an *Other* entry.
- To add additional information for a history of present illness, type text in the *Additional Comments* box.

Additional comments can be added without selecting any of the available options.

Note: If you choose to switch templates after entering data for a chief complaint, the data you entered will be removed.

3 When you are done adding information for the chief complaint, tap *Done*.

Document Review of Systems Information

1 Tap .

2 To capture review of systems information or to defer addressing system options, tap *Review of Systems*, and then do one or more of the following (the review of systems options that display are defined by the encounter template that is applied to the current note):

- To add one or more review of systems categories that are not displayed, tap *Add System*, tap 1 or more systems that you want to add, and then tap *Done* at the top of the list.

Notes:


- Categories that are already included in the existing encounter template do not display for selection.
 - Categories that are only partially included in the current template (only a few line items were initially selected for inclusion in the template) display in the list as *Partial* and are available for selection. If you select a partial category, the remainder of the line items will be added to your encounter note.
 - Categories that you add are not saved to the encounter template.
 - If you add a category to an existing note, make selections for that category, and then later remove it all within the same session, your selections are not saved.
- To indicate that the patient **denies** system options, do one of the following:
 - To indicate that the patient denies all options in **all systems**, turn on *Patient denies all options in all systems*.

- To indicate that the patient denies all options in **a system**, turn on *Patient denies all options in this system* for the appropriate system.
- To indicate that the patient **confirms** system options, do one of the following:
 - To indicate that the patient confirms all options in **all systems**, turn on *Patient confirms all options in all systems*.
 - To indicate that the patient confirms all options in **a system**, turn on *Patient confirms all options in this system* for the appropriate system.

Note: When you indicate that a patient denies or confirms all options (for a system or for all systems), all options are automatically set to *No* or *Yes*. You can still edit individual line items, if needed, and then the *Patient denies (or confirms) all options in this system and the Patient denies (or confirms) all options in all systems* indicators automatically turn off.

- To **defer** system options, do one of the following:
 - **Mark all systems deferred.** Turn on *Defer all systems*.
If you need to change this option later, turn it off or tap *Undo* for a category.
 - **Mark a system deferred.** Tap *Defer* to the right of a system to mark that system's options deferred.
If you need to change this option later, tap *Undo* for the appropriate system and make your selections.
- To specify that a patient has a problem with one or more systems, drag or swipe up and down to scroll to the appropriate system, and then do one or more of the following:
 - Tap in the *Yes* or *No* column for each problem as appropriate. You can optionally type comments for any selected line item by tapping *Add Comment* below the system name and then typing your notes.
If you have previously entered text for this line item and you would like to re-use the same comment, you can type the first few letters of the text and then tap the text in the text box that appears.

Note: For instructions to save or use a text snippet or for other text shortcut options, see ["Using Text Shortcuts" on page 21](#).


- Identify a problem not included in the list (add a new line item) by tapping  at the bottom of the line item list to add a free text *Other* item. Type the name of the new line item and then tap in the *Yes* or *No* column, as appropriate.

- To add additional information for a system, type text (up to 2000 characters) in the *Comments* box or use a text snippet, if available. Additional comments can be added without selecting any of the available options.

Note: For instructions to save or use a text snippet or for other text shortcut options, see ["Using Text Shortcuts" on page 21](#).

- To return to the encounter note, tap *Done* at the top of the right-hand pane.

Document Allergies

- 1 Tap .
- 2 To manage a patient's allergy list while viewing an encounter note, do one of the following:
 - To mark allergies reviewed, turn the switch on.



Note: When you use this option, **all** active allergies in the patient's chart are added to the open encounter note.

- To add a patient allergy or to indicate that the patient's allergies are not known or unknown, follow the "[Add a Patient Allergy](#)" on page 49 instructions starting with step 2.
- To make changes to an existing allergy, follow the "[Edit or Remove a Patient Allergy](#)" on page 50.

Keep the following in mind when adding or editing allergies from an encounter note:

- All active allergies appear in the *Allergies Reviewed* section of the encounter note as long as the switch is turned on.
- Allergies that are added to the patient's chart while the encounter note is open are considered reviewed.
- All reviewed allergies remain in the patient's encounter note if you switch encounter templates.

Document the Physical Exam Information


- 1 Tap .
- 2 To enter information gathered during the patient's physical exam, tap *Physical Exam*, and then do one or more of the following (the physical exam options that display are defined by the encounter template that is applied to the current note):
 - To add 1 or more physical exam categories that are not displayed, tap *Add System*, tap 1 or more systems that you want to add, and then tap  at the top of the list.

Notes:

- Categories that are already included in the existing encounter template do not display for selection.
 - Categories that are only partially included in the current template (only a few line items were initially selected for inclusion in the template) display in the list as *Partial* and are available for selection. If you select a partial category, the remainder of the line items will be added to your encounter note.
 - Categories that you add are not saved to the encounter template.
 - If you add a category to an existing note, make selections for that category, and then later remove it all within the same session, your selections are not saved.
- To indicate that a patient has no problems with system options, do one of the following:
 - **To indicate that the patient has no problems with all systems**, turn on *Patient affirms all options in all systems*.
 - **To indicate that the patient has no problems with a system**, turn on *Patient affirms all options in this system* for the appropriate system.

Note: When you indicate that a patient has no problems with all options (for a system or for all systems), all options are automatically set to Yes. You can still make changes to a system, if needed, by tapping a line item.


- To defer system options, do one of the following:
 - **Mark all systems deferred.** Turn on *Defer all systems*.
If you need to change this option later, turn it off or tap *Undo* for a system.
 - **Mark a system deferred.** Tap *Defer* to the right of a system to mark that system's options deferred.
If you need to change this option later, tap *Undo* for the appropriate system and make your selections.

- To indicate “normal” physical exam options for the patient, drag or swipe up and down to scroll to the appropriate system, and then do one or more of the following:
 - Tap in the *Yes* column for each problem as appropriate. You can optionally type comments by tapping *Add Comment* below the system name and then typing your notes.
 - Identify a problem not included in the list (add a new line item) by tapping  at the bottom of the line item list to add a free text *Other* item. Type the name of the new line item and then tap *Yes* if appropriate.
- To add additional information for a system, type text in the *Comments* box or use a text snippet, if available. Additional comments can be added without selecting any of the available options.

Note: For instructions to save or use a text snippet or for other text shortcut options, see ["Using Text Shortcuts" on page 21](#).


- To return to the encounter note, tap *Done* at the top of the right-hand pane.

Document Medications

- 1 Tap .
- 2 To mark active medications reviewed, do one of the following:
 - Turn the switch on. When you mark medications reviewed using the switch, **all** active medications from the patient's chart are added to the open encounter note.
 - Tap and drag the tab or individual item from the patient summary on the left-hand pane to the encounter note on the right-hand pane.


Note: If you want to remove a medication you have added, tap and swipe the item to the left and then tap *Delete*.


Document Cognitive and Functional Status

- 1 Tap .
- 2 To enter information gathered during the patient's cognitive and functional evaluation, tap *Cognitive/Functional Status*.
- 3 Tap *Cognitive Status* and do the following:
 - a Tap the search box and type 3 or more characters of a SNOMED description or a free text description.
 - b Drag or swipe up and down to scroll through the list of results.
 - c Tap a status.

- 4 If you want to add notes regarding the patient's cognitive status, type the information directly in the *Notes* box or use text snippets.
- 5 Tap *Functional Status* and do the following:
 - a Tap the search box and type 3 or more characters of a SNOMED description or a free text description.
 - b Drag or swipe up and down to scroll through the list of results.
 - c Tap a status.
- 6 If you want to add notes regarding the patient's functional status, type the information directly in the *Notes* box or use text snippets.
- 7 Tap *Done*.

Document Diagnosis Information

- 1 Tap .
 - 2 To add 1 or more diagnoses, do one of the following:
 - Add a problem from the patient summary. The problem is automatically added to the encounter note diagnosis.
For more information about adding a problem, see ["Add a Patient Problem" on page 52](#).
 - Tap and drag a problem from the patient's problem list to the *Diagnosis* area of the encounter note.
- Notes:**


 - If the problem you select for a diagnosis has an inactive or non-billable code for the encounter note's date of service, an indicator displays so that you can update the code if needed.
 - If you select a problem that is coded in ICD-9, and you are coding the note in ICD-10, you will be prompted to associate the ICD-10 code (and the appropriate SNOMED code).
- Tap  to the right of *Diagnosis* and then do one or more of the following:
 - Tap *Description*, and then tap the code set that you want to use for your search.
If secondary SNOMED or ICD code and description matches exist, the most likely match appears below the primary code or description that you just entered.

Note:

You have the option of using an ICD-9 coded diagnosis to help you locate the appropriate ICD-10 coded diagnosis. Type 3 or more characters of the code or description and then tap the code or description in the list.

- Add a free text diagnosis. If the code or description that you enter does not match one of the codes or descriptions that is in the system database, you can type the appropriate diagnosis in the *Description* box (as free text).


Notes:

- A diagnosis that is entered with free text is not saved as a code since it is not selected from the system database.
 - You cannot specify a secondary SNOMED or ICD code for free text entries.
- Turn *Primary DX* on if you want this diagnosis to be considered the primary diagnosis. You can mark more than 1 diagnosis as primary. Setting a primary diagnosis is optional.
 - If you want to add the diagnosis to the patient's problem list, turn on *Add to Patient's Problem List* and then add the appropriate details.
 - Tap *Save* to add the diagnosis to the encounter note and the patient's problem list if that option was selected.
- 3 To copy encounter diagnoses to the comments on the *Assessment* (💡) tab or the *Plan* (📋) tab, tap  to the right of *Diagnosis* and then do one or more of the following:
- Tap *Copy Diagnoses to Assessment*.
 - Tap *Copy Diagnoses to Plan Text*.

Note: For each diagnosis copied into the *Plan or Assessment* comments, a *Status:* line is included so that you can make any additional diagnosis-specific comments, as needed.

- 4 If you want to copy any diagnoses that have already been entered into the encounter note into the *Plan Text* box, click *Copy All Diagnoses*.
- 5 To edit an existing diagnosis, tap the diagnosis, make your changes, and then tap *Save*.
- 6 To remove a diagnosis that you have added, tap and slide the diagnosis to the left and then tap *Delete*.

Document Risk Evaluation

- 1 Tap .
- 2 Tap *Risk Evaluations*.
- 3 If you want to document risk evaluation information, type the information directly in the *Free Text* box or use text snippets.
- 4 If you want to answer *Evaluation Questions*, do the following:
 - Tap *Evaluation Questions*.
 - Tap *Yes* or *No* next to an item to indicate whether or not you evaluated the patient, and then do the following:
 - a Type or select the necessary data.

Note: *Evaluation Questions* are used for reporting on Clinical Quality Measures. For more information, see "[Quality Measures Reporting](#)" in the Quantum EHR web help.

- b Tap the *Comments* field to add any additional information about the evaluation.
 - c Tap *Save*.
- 5 If you want to answer *Questionnaires*, do one or more of the following:
 - To complete the COVID-19 Screening Questions:
 - a Tap *COVID-19 Screening Questions*.
 - b Tap *Yes* or *No* for each of the questions.
 - c Tap *Save*.
 - To complete the Fall Risk Assessment:
 - a Tap *Fall Risk*.
 - b Tap a response for each of the 10 questions.

The score is then automatically calculated and appears in the *Total Score* box. A score of 4 or higher is considered at risk for falling.
 - c Tap *Save*.
 - To complete the Patient Health Questionnaire (PHQ-2):
 - a Tap *Patient Health Questionnaire (PHQ-2)*.

Tip: Tap the *Questionnaire - Overview* link at the top of the questionnaire to learn more about the *Patient Health Questionnaire (PHQ-2)*.
 - b Tap a response for each of the 2 questions.

The score is then automatically calculated and appears in the *Total Score* box. A score of 3 or higher indicates the patient needs to complete the Patient Health Questionnaire (PHQ-9).

c Tap *Save*.

- To complete the Patient Health Questionnaire (PHQ-9):

a Tap *Patient Health Questionnaire (PHQ-9)*.

Tip: Tap the *Questionnaire - Overview* link at the top of the questionnaire to learn more about the Patient Health Questionnaire (PHQ-9).

b Tap a response for each of the 10 questions.

The score is then automatically calculated and appears in the *Total Score* box. Refer to the *PHQ-9 Score Chart* shown below for the results.

Total Score	Depression Severity
1 – 4	Minimal Depression
5 –9	Mild Depression
10 –14	Moderate Depression
15 –19	Moderately Severe Depression
20 –27	Severe Depression

c Tap *Save*.

- To complete the Patient Health Questionnaire (PHQ-9M) for adolescents:

a Tap *Patient Health Questionnaire (PHQ-9M)*.

Tip: Tap the *Questionnaire - Overview* link at the top of the questionnaire to learn more about the *Patient Health Questionnaire (PHQ-9M)*.

b Tap a response for each of the 13 questions.

The score is then automatically calculated and appears in the *Total Score* box. Refer to the *PHQ-9M Score Chart* shown below for the results.

Total Raw Score	Severity of Depressive Disorder or Episode
0 – 4	None

Total Raw Score	Severity of Depressive Disorder or Episode
5 – 9	Mild
10 –14	Moderate
15 –19	Moderately Severe
20 –27	Severe

c Tap *Save*.

6 If you want to answer *Evaluation Questions*, do the following:

- Tap *Evaluation Questions*.
- Tap *Yes* or *No* next to an item to indicate whether or not you evaluated the patient, and then do the following:
 - a Type or select the necessary data.

Note: *Evaluation Questions* are used for reporting on Clinical Quality Measures. For more information, see "[Quality Measures Reporting](#)" in the Qunam EHR web help.

b Tap the *Comments* field to add any additional information about the evaluation.

c Tap *Save*.

Copy Assessment Comments to the Plan of Care

1 Tap .

2 Tap  to the right of *Assessment* and then tap *Copy Assessment to Plan Text*.


Write Prescriptions

Prescriptions written from the patient's chart (from the *Rx* tab) are automatically included in the note if the prescription is written within 48 hours of starting a note. If the note has been finalized during this time, the prescription information appears in an addendum.



1 Tap .

2 To order a medication for the patient, tap  to the right of *Prescriptions* and then follow the instructions for "[Writing a New Prescription](#)" on page 80.


Ordered items display at the bottom of the screen.

- 3 To order prescription refills, tap and drag an active medication from the patient's chart to the *Prescriptions* area of the encounter note and then follow the instructions for "Refilling a Medication or Supply" on page 89.
- 4 To add a lab order or task, tap  to the right of *Add Lab Order* and then follow the instructions to "Write a Lab Order or Task" on the next page.

Document a Procedure

- 1 Tap .
- 2 To enter a procedure during a patient encounter, tap  to the right of *Additional Procedure* and do the following:
 - a Use 1 of the following options to enter a code or description:
 - **Search and add a code by CPT® or HCPCS code or description.** Type 3 or more letters or numbers of the code or description, and then tap the appropriate procedure in the list. If necessary, tap and scroll to view all items in the list.

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 - **Add a free text description.** To add a description that is not found in the database, type the description and then tap *Procedure Order* to return to the order.- b To add modifiers to a procedure, tap  to the right of *Add Modifier* and then type 2 or more characters of the modifier code or description. Select the modifier that you want to associate with the procedure.

You can only add modifiers to items that are stored as CPT/HCPCS codes. You may add up to 4 modifiers per code. Modifier descriptions are added to the *Notes* box.
- c In the *Notes* box, type any additional information relating to the procedure.

If you have added procedure modifiers to the encounter note, the modifier descriptions appear here and can only be edited until the procedure is saved.
- d To indicate that the procedure was not performed in the office, turn off *Performed in Office*.

You can add the time the procedure was performed, if needed.
- e Tap *Save*.

Note: You can add up to 20 procedures per encounter note.





- f To remove a procedure that you have added, tap and swipe the item to the left and then tap *Delete*.
- g To copy the procedure to the patient's medical history, turn the switch on.
- h To copy the procedure to the patient's surgical history, turn the switch on.

Note: Any changes that are made to the procedure after it is already copied to the patient's medical or surgical history are not copied to the history item.

Write a Lab Order or Task

Lab orders written from the patient's chart (from the *Labs* tab) are automatically included in the note if the order is written within 48 hours of starting the note. If the note has been finalized during this time, the order information appears in an addendum.

1 Initiate a lab order or task from 1 of the following locations:

- From the patient summary, tap  on the *Labs* tab,
- From the encounter note for a specific patient encounter, tap  next to *Add Lab Order* in the *Plan* segment ().
- From the pregnancy record of a patient encounter note, tap  on the *Labs* flowsheet tab.
- While viewing a lab result for a patient from the labs *Inbox*, tap *Write Lab Order*.
If an order was not previously placed for the patient, or if the patient's SSN, Patient Identification or Number (PID) has not yet been entered (and the lab requires that information), then you can only submit a lab order task.



2 To change the ordering lab, if necessary, tap the lab name and then scroll to the correct lab, and then tap *Save*.

Note: When you change labs, note the following:

- Changing the lab restarts the order entry process. If you want to switch to a different lab, you should do so before entering information in the order. You can specify only a client for which the system administrator has enabled orders.
- The list of favorite diagnoses and tests grids are lab specific, so you may notice changes in these grids when you change the ordering lab.

3 To change the client, if necessary, tap the client name and then scroll to the correct client, and then tap *Save*.

Note: If you have access to multiple organizations, you have the ability to access and place lab orders from any of the labs and client numbers that you may have association to, irrelevant of the organization from which you have logged in. When changing the ordering lab or client number be careful to consider which organization the resulted test will appear as specific client numbers will only result to their associated organization.

- 4 To view contact information for Quest Diagnostics®, Quantum eLabs or EHR, or for any of the labs for which you can place orders, tap .
- 5 To configure favorite diagnoses and test groups, tap , and then complete 1 or more of the configuration options. For more information about configuring favorite groups that are available while placing orders, see ["Configure Favorite Diagnoses and Tests for Lab Orders" on page 151](#).
- 6 Specify at least 1 diagnosis and 1 order code:
 - Select a diagnosis (that is, the ICD code associated with the patient’s condition), if applicable, by doing 1 of the following:
 - Tap a diagnosis from the favorites to add it to your order.

Diagnoses that appear on the first group of favorites are patient-specific diagnoses (which are added when the patient is registered or an order is placed for the patient), if available. Next, the 15 most recently-used diagnoses from previous orders display, followed by any other favorites that are currently configured. Tap and swipe horizontally to view other favorite diagnoses groups, if they are available. For more information about configuring favorite groups that are available while placing orders, see ["Configure Favorite Diagnoses and Tests for Lab Orders" on page 151](#).
 - Search for a diagnosis by entering the code or text.

If no search results are found after entering the code or text in the search box, or the results do not match the diagnosis that you want to enter, you can type a free text diagnosis (a diagnosis that is not available in the system database). Lab orders that have free text diagnoses can only be saved as lab order tasks. For more information about lab order tasks, see [step 7](#).

You can select up to 10 diagnoses per lab order. To remove a diagnosis that you already added to the order, tap the X to the left of the item. You can add or remove diagnoses as needed before you place the order.
 - Select an order code (that is, the code used by the lab to identify the test or panel) by doing 1 of the following:
 - Tap a test from the list of favorites to add it to your order.


Note: To view a test's details, including its code, description, and a list of any included tests, tap the test name.

Tests that appear on the first group of favorites are the 15 most recently-used tests from previous orders. Tap and swipe horizontally to view other favorite test groups, such as patient-specific tests, if they are available. For more information about configuring favorite groups that are available while placing orders, see "[Configure Favorite Diagnoses and Tests for Lab Orders](#)" on page 151.

- Search for a test by entering the code or text.

If no search results are found after entering the code or text in the search box, or the results do not match the test that you want to enter, you can type a free text test (a test that is not available in the system database). Lab orders that have free text tests can only be saved as lab order tasks. For more information about lab order tasks, see the next step.

You can select up to 15 tests per lab order. To remove a test that you already added to the order, tap the X to the left of the item and then tap *Remove*. You can add or remove tests as needed before you place the order.

7 Tap  and then do one of the following:

- **Select the ordering provider.** Select the appropriate ordering provider for this lab order or task. The *Ordering Provider* displays the logged in user if the logged in user is a provider. The last provider that ordered labs for this patient displays for subsequent orders.
- **Put the order on hold.** To place the order on hold so that it can be completed later, tap *Place Hold Order*.

If Ask At Order Entry Questions (AOEs) and/or Advance Beneficiary Notice (ABN) information is required for this order, tap the appropriate item to add and save the information. If you are adding ABN information, you can review the ABN rules for the order by tapping *ABN Rules*.

The order is placed on the *Hold List* and can be accessed from the web application for completion. When you are ready to complete the order, retrieve it from the hold list, provide the remaining required information, file the order, and print the requisition and any associated labels.

Note: Depending on the patient's insurance carrier, the lab with which the order is put on hold might be different than the lab that you originally selected. If the order does not appear on the hold list for the expected lab, check the hold lists for the other labs that you can access.

- **Place a scheduled order.** To place a scheduled order that can be completed at a later date, tap *Place Scheduled Order*, select the appropriate date, and then tap *Save*. The order is placed on the scheduled orders list and can be accessed from the web application for completion.
- **Add a lab order task.** To create a lab order task for the patient, which includes the diagnoses and tests you selected for the order, tap *Add Lab Order Task*. To complete the task, do the following:

Note: For the following situations, you can only create a lab order task:

- When your lab order contains free text selections for diagnoses or tests.
- When you do not add a diagnosis to the order; a diagnosis is required for a hold order.
- When template tests have been selected.
- When the order is for a patient who has Medicare or ICR insurance.
- If you are placing a lab order with Athena Diagnostics and you have not yet agreed to the financial terms and conditions.

- To assign the task to yourself or another user in your organization, tap *Assigned To* and then scroll through the list of users in your organization until the correct user name is highlighted. Tap *Save* to assign this task to the selected user.
- Add notes in the *Message* area, if needed.
- Tap *Done*.


The diagnoses and tests that you selected are automatically added to the lab order task. The tests appear as the *Lab Description* and the diagnoses appear in the *Messages* area. The due date for the task is set to today's date to help ensure it is completed in a timely manner.

After the task is saved it appears in the web application in the tasks *Inbox* of the *Quick View* page and in the *Patient Tasks* section of the patient's summary identified with *Order* in the *Subject* column. The task status is set to new when it is initially created. In the web application, the task can be marked as completed or canceled. When the note is saved, the plan notes area is also updated to indicate that a lab order task was created for this patient.



If you want to remove a lab task you have added, tap the task and swipe left, then tap *Delete*. If the note has already been saved, the task status is changed to *Canceled*.

Note: You can edit the task until the note is finalized or the task is completed or canceled.

Configure Favorite Diagnoses and Tests for Lab Orders

- 1 To configure the list of favorite diagnoses or tests that are available while placing orders, tap  in the top right-hand corner of the order and then do one or more of the following as needed:
 - To create and manage favorite groups, continue with step 2.
 - To add, edit, or remove favorites within a group, continue with step 3.

Note: You cannot make changes to or delete the *Recently Ordered* or *Patient Specific* groups.


- 2 To create and manage favorite groups, do the following:
 - a Tap the favorite group that is currently displaying in the *Diagnosis Favorites* or *Test Favorites* area.
 - b To add a new group, do the following:
 - i Tap the favorite that is currently displaying in the *Diagnosis Favorites* or *Test Favorites* area.
 - ii On the *Favorite Selection* screen, tap .
 - iii Type the name for the favorite group, and then tap *Done*.
To add diagnoses or tests to this group, see step 3.
 - c To delete or rearrange the order of the groups, tap *Edit* on the *Favorite Selection* screen and do one or more of the following:
 - To remove a group and its associated codes, tap and swipe the group to the left and then tap *Delete*.
 - To rearrange the order of groups that will be available on the order pad, tap  to the right of the group that you want to move and then drag and drop the group to the desired location in the list.

Note: The groups display on the order pad as they are listed in the *Favorite Selection* screen. You cannot move or delete the *Patient Specific* or *Recently Ordered* groups.

- Tap *Done* when you are done deleting or rearranging groups.
- 3 To add, edit, or remove codes within a group, do the following:
 - a Tap the favorite that appears in the *Diagnosis Favorites* or *Test Favorites* area and then tap the group for which you want to manage codes.
 - b Do one or more of the following:


- To add codes, search for the code using the search box and then tap the code from the search results to add it to your favorite group.

Only codes that are in the database can be added to the diagnoses or tests favorites tabs. You can add a free text diagnoses or test to your order, however, free text selections on your order will prevent you from being able to place the order on hold.

- To remove codes from the group, tap *Edit*, tap and swipe the item to the left and then tap *Delete*. Tap *Done* when you are done removing codes from the group.
- To rearrange the order of codes in the group, tap *Edit*, and then tap  to the right of the code that you want to move and drag and drop the code to the desired location in the list. Tap *Done* when you are done rearranging codes in the group.

Note: The codes appear on the order pad as they are listed in the favorite group on the *Configure Favorites* screen.

Document Lab Results

- 1 Tap .
- 2 Tap *Lab Results*.
- 3 Tap each lab result that you want to include in the encounter note.



Note: You can add final or corrected lab results which have been electronically received by Quantum eLabs, ePrescribing, or EHR within the last 6 months.

- 4 Tap *Save*.

Note: If an updated version of a lab result in the encounter note is received by Quantum eLabs, ePrescribing, or EHR, the latest (updated or corrected) result is not automatically added. You must manually add the corrected version of the result to the encounter note.

- 5 To edit the list of lab results in the encounter note, tap the lab results section, make your changes, and then tap *Save*.

Write a Radiology Order or Task

- 1 Tap .
- 2 Tap  to the right of *Add Radiology Order*.
- 3 Tap *Procedure* and add a procedure by doing one of the following:

- **Select a favorite radiology procedure.** If favorite radiology procedures have been set up for your user account or for your organization, you can tap the appropriate item from the list of favorite radiology procedures.

The radiology favorites list can be created in Quantum EHR. When you are viewing the radiology favorites from Quantum EHR (for iPad), they are listed by user favorites first followed by organization favorites.

- **Search and add a procedure by code or description.** Do the following:
 - a Tap in the search box and then type 3 or more letters or numbers of the code or description.


Note: You can search for *ICD, CPT® & HCPCS level II, SNOMED* codes/descriptions.

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- b Tap the appropriate procedure in the list. If necessary, tap and scroll to view all items in the list.
- **Add a free text procedure.** To add a procedure or description that is not found in the database, type the description and select the text to return to the order.

Note: Free text entries are not included in reports or alerts, and are not easily shared with others using electronic formats such as CCD.

- 4 Tap  to the right of *Add Diagnosis*, and then do one of the following:

Notes:


- A diagnosis is required for all radiology orders.
 - If you have copied a patient problem to the *Diagnosis* area of the encounter note, the diagnosis is added to the radiology order.
- **Search and add a diagnosis by code or description.**
 - a Tap ICD-9, SNOMED, or ICD-10 to indicate the code set that you want to use for the radiology order.
 - b Type 3 or more letters or numbers of the code or description.

Note: You can search for *ICD* or *SNOMED* codes/descriptions.

- c Tap the appropriate diagnosis in the list. If necessary, tap and scroll to view all items in the list.

- **Add a free text description.** To add a description that is not found in the database, type the description and then tap *Radiology Order* to return to the order.

Note: Free text entries are not included in reports or alerts, and is not easily shared with others using electronic formats such as CCD.

Tip: To clear the diagnosis and search for a new code or description, tap  to the right of the diagnosis that you want to remove and then tap *Delete*.


- 5 If necessary, tap  to the right of *Add Diagnosis* to add additional diagnoses.


Note: You can enter up to 10 diagnoses. Diagnoses appear on screen and in printed radiology orders for the order in which they were entered.

- 6 Tap *Ordering Provider* and then tap the name of the provider who is ordering the procedure if the logged in user is not a provider.

Note: Defaults to the user who is currently logged in (if that user is a provider).


- 7 If you have an authorization code for the procedure from the patient's insurance company, type it in the *Prior Auth. Number* box.
- 8 Type any additional information that is relevant to the procedure in the *Instructions* box.
- 9 If you want to include information about a patient's active allergies on the radiology order, turn on *Include Allergies*.

The patient's active allergy list appears. If you want to remove 1 or more allergies from the list, tap  to the right of the allergy that you want to remove and then tap *Delete*.

- 10 Tap  and then do one of the following:

- **Finalize the radiology order.** To finalize the radiology order, tap *Finalize Order*. The order is saved and considered finalized.

Note: In order to save and finalize an order, you must fill in all required fields. A finalized radiology order can be edited until the encounter note is saved. After the note is saved, you can **only** view it.

If you want to remove a radiology order you have added, tap  to the right of the order that you want to remove and then tap *Delete*.

- **Finalize and fax the radiology order.** To finalize and then fax the radiology order to a radiology location, do the following:
 - a Tap *Fax and Finalize Order*.

- b Tap the radiology location where the order should be faxed.

Note: If radiology locations have not been set up in the web application, you will not be able to fax and finalize your order. For more information on setting up radiology locations, refer to the Quantum EHR online help.

- **Add a radiology order task.** To create a radiology task, tap *Assign Order Task*. To add details to the task, do the following:
 - a To assign the task to yourself or another user in your organization, tap *Assigned To* and then scroll through the list of users in your organization until the correct user name is highlighted. Tap *Save* to assign this task to the selected user.
 - b Add notes in the *Message* area, if needed.
 - c Tap *Done*.

The procedures and diagnoses that you selected are automatically added to the radiology order task. The due date for the task is set to today's date to help ensure it is completed in a timely manner. The task status is set to new when it is initially created.

Once the task is saved it can be accessed from the following locations:


- *Tasks Inbox* accessed from Quantum EHR (for iPad) home screen.
- *Tasks* tab from the patient's summary.

In the web application, the task can be accessed from the following locations:


- *Tasks Inbox* on the *Quick View* page.
- *Tasks Inbox* available from the *Tasks* menu of the *Message Center* tab.
- *Patient Tasks* section of the patient's summary.

For more information about managing tasks, see "[View All Tasks for an Organization](#)" on page 43 or "[View Tasks from the Patient Summary](#)" on page 44.



When the note is saved, the plan notes area is also updated to indicate that a radiology order task was created for this patient.

If you want to remove a radiology task you have added, tap  to the right of the task that you want to remove and then tap *Delete*. If the note has already been saved, the task status is changed to *Canceled*.




Note: You can edit the task until the note is finalized or the task is completed or canceled.

- 11 Tap  to the right of *Additional Radiology Order* to place additional radiology orders as needed.


Document Plan of Care


- 1 Tap .
- 2 To copy diagnoses in the encounter note into the *Plan Text*, tap  to the right of *Plan of Care* and then tap *Copy Diagnoses to Plan Text*.

Note: For each diagnosis copied into *Plan Text*, a *Status:* line is included so that you can make any additional diagnosis-specific comments, as needed.

- 3 Tap in the *Plan Text* box to enter notes regarding the plan of care.
- 4 To copy the information you entered in the *Plan Text* comments to the *Assessment* comments (located on the *Assessment* [] tab of the encounter note), tap  to the right of *Plan of Care* and then tap *Copy Plan Text to Assessment*.
- 5 To add assessment and interventions information, tap  to the right of *Assessment and Interventions* and then do the following:

Note: Interventions are used for reporting on Clinical Quality Measures.


- a Type any notes or information you want to record about your assessment of the patient.
 - b Type any notes or information that you want to record about the intervention that is not associated with a Clinical Quality Measure in the *Interventions* box.
 - c To indicate an intervention for a particular Clinical Quality Measure:
 - i Tap the appropriate Clinical Quality Measure to view the intervention value sets.
 - ii Tap the appropriate intervention value set.
 - iii Tap the appropriate interventions that were performed.
To clear an item that is selected, tap it again to remove the check mark.
 - d Tap *Done*.
 - e Add additional assessments and interventions as needed.
If you want to remove an assessment and the corresponding intervention, tap and swipe left, and then tap *Delete*.
 - f Tap *Save*.
- 6 To add patient health concerns that you want to document separately from problems, tap  to the right of *Add Health Concerns*. Select an *ICD-10* and/or *SNOMED* entry for the *Health Concern*. The best match from the other code set populates.

Note: To clear the health concern entry and search for a new code or description, tap  to the right of the entry that you want to remove.

In the *Instructions* box, type how the patient will manage this health concern.


Note: You can enter text in the *Instructions* box after selecting an *ICD-10* and/or *SNOMED* entry.

To delete saved health concerns and instructions, if needed, tap and swipe left and then tap *Delete*.

- 7 To add a patient goal and instructions, tap  to the right of *Add Goal(s) and Goal Instructions*. Select a *SNOMED* entry for the patient goal. Select whether the goal is a *Provider Goal* (default selection), *Patient Goal*, or *Shared Goal*, and type instructions.

Note: You can enter text in the *Instructions* field after selecting a *SNOMED* entry.

To delete a saved goal and instructions, if needed, tap and swipe left and then tap *Delete*.

- 8 To document plan of care information, add one or more of the following (by typing directly in the box or using text snippets):
- **Patient Clinical Instructions.** Capture any instructions that you provided to the patient during the visit.
 - **Future Scheduled Appointments.** Capture information about when you want to see the patient again.
 - **Education Materials Provided.** Capture information about patient education materials that you provided to the patient to help aid treatment decisions.
- 9 To document that you have referred the patient to another provider, tap  to the right of *Referrals* and then add the appropriate information. You can add a reason and/or information about to whom you are referring. Save your changes.
- If you need to delete the referral later, tap and swipe left, and then tap *Delete*.
- 10 If this is a visit type of *Visit with provider* or *Visit with clinician*, document the location where the patient is to be discharged at the conclusion of the encounter in the *Discharge Status* field. By default, *Home* is selected.

Note: The following *Discharge Status* selections are available:

- **Alternative home.** The patient was discharged and is going to a private residence that is not their home (eg, a family member's home)
- **Expired.** The patient died during this encounter

- **Home.** The patient was discharged and is going to return home
- **Hospice, healthcare facility.** The patient was discharged to another healthcare facility for palliative care
- **Hospice, home.** The patient was discharged to their home for palliative care
- **Left against advice.** The patient self-discharged against medical advice
- **Long-term care.** The patient was discharged into long-term care to be monitored through an ongoing episode-of-care
- **Other.** The discharge disposition has not otherwise been defined
- **Other healthcare facility.** The patient was transferred to another healthcare facility
- **Psychiatric hospital.** The patient was transferred to a psychiatric facility
- **Rehabilitation.** The patient was discharged and is to receive post-acute care rehabilitation services
- **Skilled nursing facility.** The patient was discharged to a skilled nursing facility for additional care

Historic finalized encounter notes do not have a *Discharge Status* selection. If you edit this field, the blank selection will no longer be available.

Note: Information that you capture in the *Plan of Care* area of a patient's encounter note is available on the office visit summary that you can print and hand to the patient at the end of the visit.

Associate a User to an Encounter Note

- 1 Access an existing encounter note to which you want to associate a user.
- 2 Tap *Assigned User* at the top left of the encounter note.
- 3 Scroll and tap the user to associate with the encounter note.

Note: You can only associate active users from your own organization that are assigned the provider, clinician, or clinical office staff roles.

- 4 Tap *Save*.


When you associate a note to a user, the user receives a task to complete which they can access from the *Quick View* page in the *Notes in Progress* section (in the web application).

Note: Encounter notes that are associated with a particular user for review can still be finalized by another user.

- 5 Change or remove the assigned user at any time (until the note is finalized) by doing one of the following:
 - To change the assigned user, tap the user name at the top right of the note, scroll and tap another user from the list, and then tap *Save*.
 - To remove the assigned user, tap the user name at the top right of the note, scroll to the top of the user list and tap (*No one*), and then tap *Save*.

Finalize and Sign an Encounter Note

- 1 Do one of the following:
 - To finalize and sign an encounter note from the patient summary, do the following:
 - a Tap the *Encounters* tab of a patient summary.
 - b Tap *In-Progress*.
 - c Tap a note in the list to view its contents. To make changes to the note, see [“View and Edit an In-Progress Encounter Note”](#), beginning with step 2.
 - To finalize and sign an encounter note from the *Notes in progress* inbox, do the following:
 - a Tap the *Notes in progress* link from the Quantum EHR (for iPad) home screen. All of your notes in progress (up to 300) appear.
 - b To filter the notes, tap *Filter* and then select a filter option (another user, *Unassigned*, or *All Notes*).
 - c Tap a note in the list to view its contents in the right-hand pane.

- d Tap  to access the patient summary and open the in-progress note for editing.
- e To make changes to the note, see step 2 of “[View and Edit an In-Progress Encounter Note](#)”.

Other users can also add notes to the encounter note until it is finalized.

- 2 When the encounter note is complete, tap *Finalize and Sign* at the top of the note. Encounter notes do not need to be finalized as soon as they are added. They can remain “in-progress” and can continue to be edited until they are finalized and signed.


Note: Once an encounter note is finalized and signed, you (or any other user) cannot make further changes to it. If you want to add additional notes later, you can add an addendum (using the *Add Addendum* button that replaces the *Finalize and Sign* button). See “[Add an Addendum](#)” below.

To print the finalized note, see “[Print an Encounter Note](#)” on page 163.

Add an Addendum

- 1 Access a patient summary. See “[Viewing a Patient Summary](#)” on page 28.
- 2 Tap the *Clinical Notes* tab.
- 3 On the *All* tab, locate and tap the finalized and signed note to which you want to add an addendum.


Note: You can view and copy information from the finalized note into an open encounter note, or add an addendum. For more information, see “[View and Edit an In-Progress Encounter Note](#)” below.

- 4 Tap *Add Addendum*.
- 5 If you want to add or change an assigned user, tap , select a name from the list or select (*No one*), and then tap *Save*.
- 6 Type your comments and then do one of the following:
 - Tap *Save*.
 - Tap *Save & Sign* to finalize the addendum and add an electronic signature.

Note: The note is considered in-progress and displays in the *Notes in progress* inbox and the *In-Progress* area of the *Clinical Notes* tab of the patient summary until the addendum is signed. Once the addendum is signed, it appears with the finalized notes. Multiple, unsigned addenda can be added to finalized notes.


The addendum displays at the bottom of the finalized note. To print the finalized note, see ["Print an Encounter Note" on page 163](#).

Mark Encounter Notes Erroneous

- 1 Locate the encounter note that you want to mark as erroneous from the *Encounters* tab of the patient summary or from the *Notes in progress* inbox.
- 2 Do one of the following to view the note:
 - a From the *Notes in progress* inbox, tap the note and then tap .
 - b On the *Encounters* tab, tap the note.
- 3 At the top of the note, tap *Mark Erroneous*.
- 4 Tap *Reason* to enter a reason for marking the note erroneous, if applicable.
- 5 Click *Save*.

Note: The note is no longer visible in EHR for iPad, but you can view it in the web app.


View and Edit an In-Progress Encounter Note

- 1 Do one of the following to view in-progress encounter notes:
 - **View in-progress notes from a patient summary.** Do the following:
 - a Tap the *Clinical Notes* tab of a patient summary.
 - b Tap *In-Progress*.
 - c Tap a note in the list to view its contents. To make changes to the note, continue with step 2.
 - **View in-progress notes from the Qanum EHR (for iPad) home screen.** Do the following:
 - a Tap the *Notes in progress* inbox link from the Qanum EHR (for iPad) home screen. All of your notes in-progress (up to 300) appear.
 - b To filter the notes, tap *Filter* and then select a filter option (another user, *Unassigned*, or *All Notes*).
 - c Tap a note in the list to view its contents in the right-hand pane.
 - d Tap  to access the patient summary and open the in-progress note for editing.
 - e To make changes to the note, continue with step 2.
- 2 Make the necessary changes in any area of the encounter note.

Note: If the encounter note is for an *Office Visit with Provider*, and a provider hasn't been selected, you must select a provider before you can continue making any changes to the note.



- 3 If you want to copy information from a finalized encounter note to the in-progress note, do the following:
 - a While viewing the in-progress note in the right-hand pane, tap the *Clinical Notes* tab of the patient summary and then tap the finalized note from which you want to copy information.

The finalized note opens in the left-hand pane of the patient summary.
 - b Tap and hold the text that you want to copy to activate the text editing options. Highlight the word or words by dragging the grab points to highlight the text.
 - c Tap *Copy*.
 - d In the in-progress encounter note comment box, tap and hold the area where you want to paste the text, and then tap *Paste*.

Note: If you want to save the copied text as a snippet, tap *Use Snippet* from the text editing options, or tap  in the comment box, then tap and paste the text in the snippet box. Type a name for the snippet for later use and then tap *Save*. For more information on using text editing options, see "[Using Text Shortcuts](#)" on page 21.

- 4 When you are done making your changes, you can either tap *Close* or *Finalize and Sign* if the encounter note is complete and you (or any other user) do not need to make further changes to it.
- 5 To print the note, see “[Print an Encounter Note](#)” below.



Search for Text in an Encounter Note

- 1 Locate the encounter note that contains text you want to find, from the *Encounters* tab of the patient summary or from the *Notes in progress* inbox.
- 2 Do one of the following to view the note:
 - a For in-progress notes, tap  and then tap *Preview Note*.
 - b For finalized notes, tap the note.
- 3 While viewing the note, tap .
- 4 Select the app that you want to use for searching text.

Apps that are currently installed on your device that can be used for viewing PDF files are available for selection.
- 5 While viewing the note in your device's PDF viewer, use the search capability of that viewer to search for text within the note.

Print an Encounter Note

Do one of the following to print an encounter note:

- To print an in-progress encounter note while you are viewing it, tap  and then tap 1 of the following:
 - To print or preview the current note that you are viewing, tap *Print Current Note* or *Preview Current Note*.
 - To print billing details along with the current note that you are viewing, tap *Print Current Note with Billing*.
 - To print and record a reason for printing, tap the appropriate *Print Reason*.
- To print a finalized encounter note while you are viewing it, tap  and then tap 1 of the following:
 - To print the current note in focus, tap *Print Current Note*.
 - To print billing details along with the current note that you are viewing, tap *Print Current Note with Billing*.
 - To print and record a reason for printing, tap the appropriate *Print Reason*.

Note: Print reasons such as *Print Office Visit Summary*, *Referral*, and *Transfer/Transition of Care Report* should be used if your organization participates in Advancing Care Information (ACI) or Meaningful Use (MU) reporting.

Your iPad must be connected to a printer that supports AirPrint in order to print encounter notes.

Recording Billing Details for an Encounter

After a patient has received care at your organization and an encounter note for the patient visit has been created, you can record billing details for the patient visit. This information includes any billable diagnoses made, or procedures performed, during the encounter. Billing details can be delivered electronically to a Practice Management System (PMS) associated with your organization, or printed for manual distribution.

Note: Your organization must be associated with a PMS to electronically send billing details.

Record Billing Details for an Encounter


- 1 View an existing encounter note, or add a new encounter note.
- 2 While viewing an encounter note, tap *Billing Details*.

Notes:

- Billing details can only be captured for encounter notes that contain information.
- Eligible diagnoses captured as ICD codes, billable procedures (those identified in the encounter note as *Performed in Office* and captured as CPT@/HCPCS level II codes), and procedure modifiers automatically appear and are selected in the billing details. Administered medications do not automatically populate the billing details and must be added manually.
- Billing details are based upon the ICD coding selection in the encounter note. If you selected ICD-9, ICD-9 codes will be used in the billing detail. Likewise, if you have selected ICD-10, ICD-10 codes will be used in the billing detail.
- You cannot include multiple instances of a diagnosis code in the billing details.
- Inactive and non-billable codes are labeled as such. A warning message appears if these codes are selected.

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- 3 Tap *Servicing Provider* and then tap the provider name under whom the encounter should be billed.
- 4 In the *Diagnoses* column, review the diagnoses. Tap  to search for and add additional diagnoses.

Note: You must select an entry from the coded search results. Free text entries are not supported and cannot be added to billing details.

- 5 As applicable, tap diagnoses to select them and tap selected diagnoses to unselect them.

Selected diagnoses appear on the final bill with a checkmark in the associated check box.

- 6 In the *CPT/HCPCS II* column, tap categories to reveal Evaluation and Management (E&M) codes and procedures. If applicable, tap  to search for and add additional CPT®, HCPCS Level II codes, or E&M codes.

Notes:

- Procedures are divided into several categories based on the type of procedure performed. These categories can be reorganized and renamed to better reflect your organization's practices. For additional information refer to "Configure the Billing Template" in the Quantum EHR Online Help.
- Procedures captured as a CPT/HCPCS II code that do not match the default list of billable procedures are added to the *Miscellaneous Procedures* section.
- When searching for CPT, HCPCS Level II codes, or E&M codes, you must select an entry from the coded search results. Free text entries are not supported and cannot be added to billing details.

- 7 As applicable, tap procedure codes and E&M codes to select them and tap selected procedure codes and E&M codes to unselect them.

Selected CPT and HCPCS codes appear on the final bill with a checkmark in the associated check box.

- 8 To associate a diagnosis with a procedure or E&M code, tap and hold a diagnosis, then drag it to a new position under the billable item in the *CPT/HCPCS II* column.

The first diagnosis under the billable item becomes the *Primary* diagnosis for the item; the word *Primary* appears next to this diagnosis. If there are multiple diagnoses, you can reorder them by tapping and dragging.

Notes:

- If only 1 diagnosis is present, it is automatically associated with all procedures when the billing details are finalized.
- Both the diagnosis and procedure are automatically selected when you drag a diagnosis to an item in the *CPT/HCPCS II* column.
- Procedures and E&M codes which do not have an associated diagnosis are identified by a warning message.

- To edit the primary diagnosis for an item, tap and drag a new diagnosis above the primary diagnosis.
 - To break the association between a diagnosis and another item, tap and swipe the item to the left and then tap *Delete*.
- 9 To add modifiers to a CPT/HCPCS code item, do the following:
- a Tap and swipe a billable item to the left and then tap *Add Modifiers*.
You can only add modifiers to items that are stored as CPT/HCPCS codes.
 - b Type 2 characters to search for a modifier by code or 3 characters to search for a modifier by description.
 - c Tap the modifier code that you want to associate with the item.
The modifier appears below the selected CPT/HCPCS coded option. You may select up to 4 modifiers per CPT/HCPCS code.

Note: To remove a modifier, tap and swipe the item to the left and then tap *Delete*.



- 10 If your organization is not set up to send billing details to external organizations, a *Notes* box is available. Type any notes about the billing details in this box, if it is available.
- 11 To save the billing details, do one of the following:
- To save the billing details for future modification later editing, tap *Save*.
 - To finalize billing details, tap the appropriate button:
 - If your organization is associated with a PMS, tap *Send to PMS* to finalize the billing details and send them to an associated PMS.
 - If no PMS is associated with your organization, then the *Complete* link appears in place of *Send to PMS*. Tap *Complete* to finalize the billing details without sending them to a PMS.

Note: When billing details are sent to a PMS or otherwise finalized, the *Billing Details* link is replaced by the *Completed Billing* link. Finalized billing details cannot be edited. Instead, tapping the *Completed Billing* link opens the details in PDF format.

- 12 To print a copy of the billing details, see "[Print Billing Details](#)" on page 170.

Edit Pending Billing Details

- 1 View an existing encounter note, or add a new encounter note. For more information, please see "[Documenting a Patient Encounter](#)" on page 109.

Note: If an encounter note is marked with  or , then billing details are available for the note.

2 While viewing an encounter note, tap *Edit Billing*.


Notes:

- Diagnoses captured as ICD codes, billable procedures (those identified in the encounter note as *Performed in Office* and captured as CPT®/HCPCS level II codes), and procedure modifiers added to the encounter note after the billing details were recorded are not added to the available billing details.
- Billing only supports 1 ICD code set and if you change the ICD coding selection on your encounter note (from ICD-9 to ICD-10, or vice versa), billing details are not changed. You must delete your billing details and start over to use a different code set.
- You may not include multiple instances of a diagnosis code in the billing details.


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3 Tap *Servicing Provider* and then tap the provider name under whom the encounter should be billed.

4 In the *Diagnoses* column, tap diagnoses to select them and tap selected diagnoses to unselect them. Tap  to search for and add additional diagnoses.

Selected diagnoses appear on the final bill with a checkmark in the associated check box.

5 In the *CPT/HCPCS II* column, tap procedure codes and E&M codes to select them and tap selected procedure codes and E&M codes to unselect them. Tap  to search for and add additional CPT®, HCPCS Level II codes, or E&M codes.

Selected CPT and HCPCS codes appear on the final bill with a checkmark in the associated check box.

6 To associate a diagnosis with a procedure or E&M code, tap and hold a diagnosis, then drag it to a new position under the billable item in the *CPT/HCPCS II* column.

The first diagnosis under the billable item becomes the *Primary* diagnosis for the item; the word *Primary* appears next to this diagnosis. If there are multiple diagnoses, you can reorder them by tapping and dragging.

Notes:

- If only 1 diagnosis is present, it is automatically associated with all procedures when the billing details are finalized.
- Both the diagnosis and procedure are automatically selected when you drag a diagnosis to an item in the *CPT/HCPCS II* column.
- Procedures and E&M codes which do not have an associated diagnosis are identified by a warning message.

- To edit the primary diagnosis for an item, tap and drag a new diagnosis above the primary diagnosis.
- To break the association between a diagnosis and another item, tap and swipe the item to the left and then tap *Delete*.

7 To add modifiers to a CPT/HCPCS code item, do the following:

a Tap and swipe a billable item to the left and then tap *Add Modifiers*.

You can only add modifiers to items that are stored as CPT/HCPCS codes.

b Type 2 characters to search for a modifier by code or 3 characters to search for a modifier by description.

c Tap the modifier code that you want to associate with the item.

The modifier appears below the selected CPT/HCPCS coded option. You may select up to 4 modifiers per CPT/HCPCS code.

Note: To remove a modifier, tap and swipe the item to the left and then tap *Delete*.

8 If your organization is not set up to send billing details to external organizations, a *Notes* box is available. Type any notes about the billing details in this box, if it is available.

9 To save the billing details, Do one of the following:

- To save the billing details for future modification later editing, tap *Save*.
- To finalize billing details, tap the appropriate button:
 - If your organization is associated with a PMS, tap *Send to PMS* to finalize the billing details and send them to an associated PMS.
 - If no PMS is associated with your organization, then the *Complete* link appears in place of *Send to PMS*. Tap *Complete* to finalize the billing details without sending them to a PMS.


10 To print a copy of the billing details, see "[Print Billing Details](#)" on the next page.

Notes:

- When billing details are sent to a PMS or otherwise finalized, the *Edit Billing* link is replaced by the *Completed Billing* link. Finalized billing details cannot be edited. Instead, tapping the *Completed Billing* link opens the details in PDF format.
- Only 1 user can modify billing details for a encounter note at a time. If another user saves modifications to billing details that you are modifying, you will be unable to save your changes. When you attempt to save or finalize the billing details, you will be notified that another user's changes have preempted your own.


Delete Billing Details

- 1 View billing details. For more information, please see "[Edit Pending Billing Details](#)" on [page 167](#).

Note: If an encounter note is marked with  or  , then billing details are available for the note.

- 2 While viewing billing details, tap *Delete*.
- 3 When prompted, tap *Delete* to confirm that you want to delete the billing details.

Print Billing Details

- 1 View an in progress or finalized encounter note.
- 2 Tap  and then tap one of the following:
 - To print billing details for the note that you are viewing, tap *Print Current Billing*.
 - To print billing details, along with the current note that you are viewing, tap *Print Current Note with Billing*.

Your iPad must be connected to a printer that supports AirPrint in order to print billing details and encounter notes.

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What product are you using? (Please provide version number)

What topics do you refer to most often?

How often do you refer to the documentation or help?

Often Occasionally Never

How is the level of detail in the documentation or help?

Too little Just right Too much

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