PracticeEHR
Simplifying Healthcare

Practice EHR | User Guide

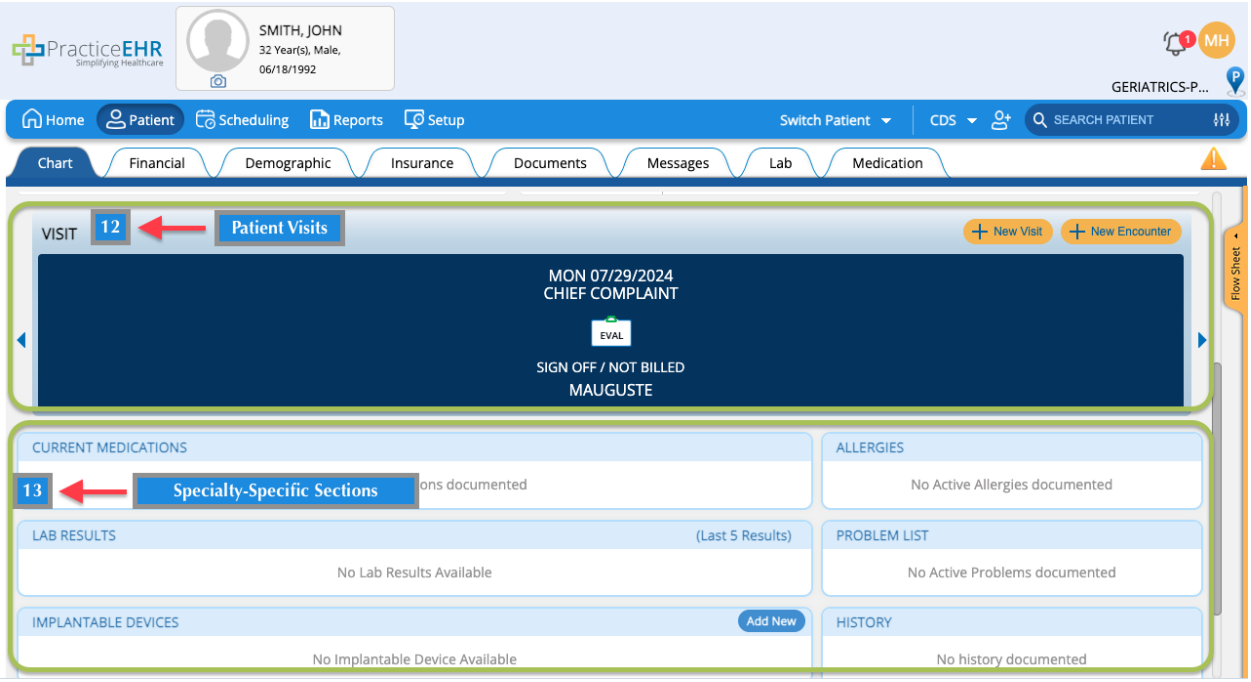
Patient Module | Part 2

Patient Module

The "Patient" module offers extensive information related to a patient's clinical and financial information. A user can add, view, and edit general and visit-specific patient information through the Patient module.

1. Patient Chart

The patient chart allows the user to quickly access crucial patient information like insurance details, next appointment status, preferred pharmacy, vital signs, etc. In short, the patient chart offers a quick overview of a patient's clinical and financial situation, eliminating the need to navigate various tabs within the patient module.



1. *Patient Information*

General patient information, such as their name, age, and birth date, is displayed in the top left corner of the screen beside the Practice EHR logo.

2. *Switch Patient*

Our software retains the last three patient charts within the system, allowing the user to switch through patients without the need to search them. This feature helps save time and enhances the overall user experience.

3. *Clinical Decision Support (CDS)*

Clinical Decision Support (CDS) is a valuable tool for the clinical team to set reminders for individual patients related to the follow-up of their treatment plan. Additionally, the clinical team can suggest CDS interventions. The user can either override with a comment or accept the intervention.

4. *Patient Module Tabs*

This section includes various tabs, which may vary based on the needs or specialty of the practice. Generally, this section consists of the following:

- Chart tab
- Financial tab
- Demographic tab
- Insurance tab
- Documents tab
- Messages tab
- Lab tab, and
- Medication tab

Each tab will be discussed and explained later in this user guide.

5. *Patient Insurance and Appointment Information*

This section displays the primary and secondary insurance information that has been added to the patient's record. Additionally, it shows the Copay amount specified by the respective insurance company.

If appropriate to the specialty of the provider, this section will also show the Medicare cap amount for PT, SOP, or OT services. Moreover, the user can quickly check the patient's next scheduled appointment through this section.

Lastly, if specified by the patient, this section will display the name of the nearest pharmacy to the patient's location.

6. *Body Mass Index (BMI) Information*

The user can view a patient's height, weight, and Body Mass Index (BMI) directly from the patient chart without navigating to the "**Demographics**" tab. Any changes made to the patient's height and weight in the Demographics section will automatically update in the chart tab.

7. *Blood Pressure*

Here, the user can see the systolic and diastolic readings from the last patient visit, eliminating the need to open the previous patient visit, thereby saving time and effort.

8. *Smoking Status*

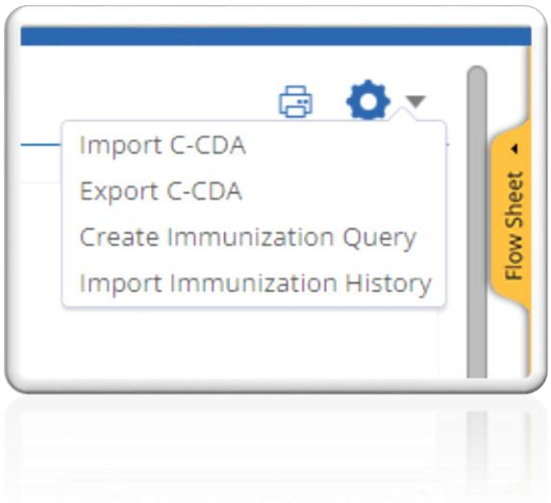
The smoking status of the patient is based on the patient's last visit. In case the provider updates the smoking status of the patient in the ongoing clinical visit, the information will automatically be displayed in the chart after the visit is signed off.

9. *Alerts*

Any clinical or financial alerts created by the administration or clinical team can be viewed by clicking on the alert icon in the top right corner of the screen, just below the patient search option.

10. *Print Chart and Import/Export CDA*

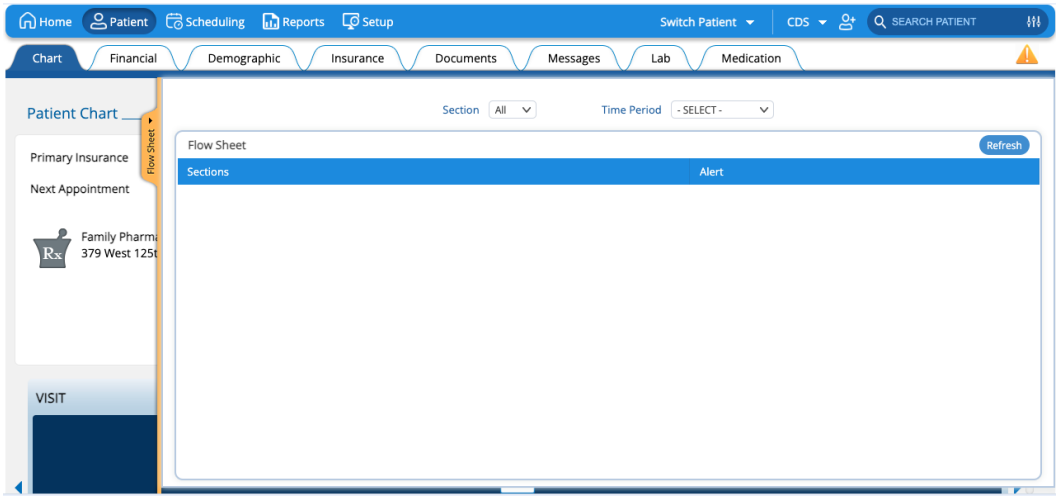
The user can print the patient chart by clicking on the "**Print**" icon.



The user can import or export C-CDA files – short for Consolidated Clinical Data Architecture – to securely transfer a patient's standardized electronic health records.

Additionally, the user can create an immunization query or import a patient's immunization history through this drop-down menu.

11. *Flow Sheet*



The flow sheet contains all signed-off visits in detail. The flow sheet can be extended by clicking on the "**Flow Sheet**" tab present on the right side of the screen.

12. *Patient Visits*

This section will show the six most recent progress notes with the ability to scroll back and forth. A user can have an in-depth view of a particular visit by simply clicking on it.

Using the "**New Visit**" option, a user can easily start a new visit directly from the patient chart.

The user can click "**New Encounter**" to document the clinical care provided outside of the Practice EHR, like charges for OTC supplies, which do not require a chart note or clinical documentation.

13. *Specialty-specific Sections*

The remaining sections below the visit section will vary based on the specialty and needs of the practice. If visible, these sections will include an overview of:

- The surgical, medical, and social history of the patient
- Any allergies reported by the patient
- The patient's current medications
- The patient's last five lab results
- The patient's follow-up and care plan
- The patient's scheduled appointments, etc.