APPENDIX B: EXERCISES FOR SYNAPSE VERSION 1.0

INTRODUCTION TO SYNAPSE

SYNAPSE is an electronic charting program that simulates documenting information within an electronic medical record. SYNAPSE exercises incorporate many activities that mimic tasks the medical assistant will perform while working in an electronic medical record (EMR). SYNAPSE uses a variety of techniques to build chart notes, including:

- Entering free text in the chart note
- Clicking drop-down lists to populate information in the chart note
- Using standard templates

SYNAPSE allows students to get a feel of how the EMR works without getting into a great deal of extraneous technical content.

INSTRUCTIONS FOR INITIAL SETUP

1. The Sign-In screen is the first screen that will appear when SYNAPSE opens. You will notice a box labeled “Username” with the word “Student1” and a Password box that already has a password installed. These are the initial settings to get you into the program, so just click OK. You should now be in the main menu.

CHANGING YOUR USERNAME AND PASSWORD

1. You will notice an icon labeled “Change Password.” This icon will open a screen to allow you to set up the software using your own name and password. Click the Change Password icon.

2. Enter your first name in the First Name box.

3. Enter your last name in the Last Name box.

4. Enter a username in the Username box. This may be a combination of your first and last name, or a name your instructor will assign you.

5. Next, enter a password. Write down this information so that it is handy in case you forget your username or password. The information is case-sensitive, so pay close attention to whether uppercase or lowercase letters are used.

6. Click the Save icon.

7. Click the Close icon.

8. Click the Quit icon.

9. Reopen the SYNAPSE software.

10. Clear the Username box and enter your username.

11. Clear the Password box and enter your last name.

12. You should now be in the Main Menu.

DESCRIPTION OF THE ICONS USED IN SYNAPSE

SYNAPSE uses a variety of icons that assist the user in navigating through each screen. Next is a description of the various icons found in this program.
Main Menu Screen

The Main Menu screen is the opening screen and contains icons that will allow the user to navigate throughout the software (Figure B-1). Each icon represents a different section within SYNAPSE. Icons found on the Main Menu are described next.

**PATIENTS ICON**

When clicked, the Patients icon takes the user into a screen that lists all of the established patients in alphabetical order. There are only a few established patients within the software prior to beginning the SYNAPSE exercises; however, the patient population will grow with each exercise. Once a new chart is created, it will be stored in the patient database found on this screen.

**NEW PATIENTS ICON**

This icon is used when the user wants to create an electronic chart for a new patient. When the user clicks this icon, a series of tabbed screens appear, requesting the following patient information:

- Name and address
- Birth date
• Social Security number
• Telephone number
• Spouse information
• Responsible party information
• Payer information
• Allergy information
• List of the current medications, including over-the-counter medications

Once the chart has been created, the user will click the Demographics icon in the Patient Information Menu to make changes to this information. This screen should be accessed whenever there is a change in the patient’s demographic information.

LOGS
The Logs icon takes the user to a screen that houses specific logs typically kept in paper form within the medical office. The following table includes a description of each type of log.

<table>
<thead>
<tr>
<th>Name of Log</th>
<th>Description</th>
<th>Tracking Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-House Lab</td>
<td>This log tracks all tests performed in-house or within the medical office.</td>
<td>These logs track results of certain tests performed within the office and aid in tracking lot numbers of various testing reagents, kits, and strips. If the manufacturer sends out a recall notice for a specific lot number of reagents or test kits, the office will know which patients need to be retested.</td>
</tr>
<tr>
<td>Quality Control</td>
<td>This log tracks all of the controls used to check the accuracy of various test kits, strips, and instruments used for testing purposes.</td>
<td>The purpose of running lab controls is to confirm that test kits, strips, and lab equipment are working properly. Quality control logs confirm that the office institutes quality control measures, and may be reviewed when the medical office goes through a site evaluation.</td>
</tr>
<tr>
<td>Universal Narcotics</td>
<td>This log tracks narcotics that are dispensed or administered in the office.</td>
<td>The purpose of this log is to discourage employees tempted to steal narcotics. This log can also be used in reports to find trends within a specific patient population who use the drugs, or practitioners who prescribe the drugs.</td>
</tr>
<tr>
<td>Universal Immunization</td>
<td>This log tracks all immunizations administered in the office.</td>
<td>This log is useful in the event there is a recall on a specific lot number of a vaccine and is also useful for running reports for statistical data.</td>
</tr>
</tbody>
</table>
CHANGE PASSWORD ICON
This icon is used to set up a username and password, or to change an existing password.

PATIENT EDUCATION FORMS ICON
This icon takes the user to a screen that shows a series of educational forms used in the practice. Examples of educational materials include asthma, diabetes, smoking cessation, hypertension, IBS, and many other health-related materials.

QUIT ICON
This icon is used to quit SYNAPSE.

Patient Information Menu Screen
The Patient Information Menu screen is the initial screen within the patient’s personal medical record (Figure B-2). To get to this screen, the user clicks the Patients icon in the Main Menu. Next, the user clicks the name of the patient whose record is being accessed and clicks the Open Patient Record icon. The patient information screen then appears. A series of icons display in this screen, which allows the user to navigate within the patient’s personal medical record. Icons found within this screen are listed next.
PATIENT LIST ICON
This icon is used to navigate from the current patient’s record into the electronic record of another patient.

MAIN MENU ICON
This icon is used to return to the Main Menu, the starting point of SYNAPSE. This icon should be clicked whenever the user needs to document information in the Logs section, retrieve patient education forms, or to quit the program.

DEMOGRAPHICS ICON
This icon is used when the user wants to update the patient’s demographic information. It can also be used to update allergy information, medication information, and the chronic problem list; however, these items can also be updated within progress notes. Because this information is private, more offices are now relying on clinical staff members to perform this task while the patient is behind closed doors.

CHART NOTES ICON
All previous chart notes for each patient are housed within this screen. The chart notes screen is also used to create a new office visit chart note or telephone note.

PRESCRIPTIONS ICON
This icon takes the user to the prescription screen. This screen allows the user to view the patient’s prescription history and to create and discontinue prescriptions. Medication history should also be updated in the Allergies & Meds table found in the Patient Information screen in order for changes to be reflected in the patient’s progress note.

LAB ORDERS ICON
The lab orders screen is used to create a lab requisition when the clinician orders a test. The user can also review the patient’s lab history by clicking the Lab History icon found on this screen, and can update lab results by clicking the Update Lab Results icon.

LEGAL ICON
This screen has a list of topics frequently discussed between the clinician and patient that may have legal implications. Any time one of these topics is addressed, it should be documented within the patient’s chart. Some of the listed items in this screen include privacy statement information, DNR orders, Power of Attorney information, and more. When patients complete and sign these forms, the forms should be scanned into the record for future use.

HEALTH HISTORY ICON
This icon takes the user into a series of tabs that display questions related to the patient’s health. It is here that the user will record information about the patient’s family history, hospitalization history, medical history, and social history. The lab and medication history can also be viewed from this section of the record. Any changes made in the lab and prescription screens will automatically populate into these screens.

IMMUNIZATION LOG ICON
This icon takes the user into the patient’s personal immunization log. Any time a patient has an immunization performed, it should be documented in this log as well as the universal immunization log, which can be accessed by clicking the Logs icon on the Main Menu.
This icon takes the user to a referral letter template that can be used when the patient is referred to an outside physician. Names and addresses of physicians whom the practice routinely refers to are stored within this template to further simplify the referral process.

This icon takes the user to several letter templates that may be used in the medical office. Letter templates include Lab Results Are All Normal, Proof of Appointment, Lab Results (Unable to Reach by Phone), and a Return to Work Excuse. The user just clicks on the appropriate letter and completes the template information. Once the form is completed, it is either printed and given to the patient or sent to the patient, via email when appropriate.

The Medication Log icon navigates the user to the patient’s personal medication log. Any time an injection is administered or an oral medication is dispensed, it is documented within the patient’s electronic medication log.

This icon takes the user to immunization consent forms, special procedure consent forms, and a refusal form that is completed when a patient refuses various treatments or tests. When working in the field, these forms will be scanned back into the patient’s personal medical record.

SYNAPSE is designed to simulate tasks the medical assistant typically performs within the electronic chart. The assignments for SYNAPSE are broken down into modules. Each module represents a portion of a new day in the medical office. Each module will include a variety of activities, including:

- Creating charts for new patients
- Documenting chief complaints and vital signs on existing charts
- Creating lab requisitions and prescriptions
- Documenting within a variety of electronic logs

Data for each new patient is listed within patient data tables. A variety of tasks will be assigned within each module. Modules I through III will end with a list of critical thinking questions that will challenge the user from both a software and clinical viewpoint. Each student should have a blank folder while performing SYNAPSE exercises. Any time the student is asked to print information, it should be printed, labeled, and placed in their SYNAPSE folder. Each module will have a different set of forms to print, so students should separate forms by module number.

Module IV is a competency that is graded by the instructor to evaluate the student’s comprehension of SYNAPSE. An EMR performance evaluation checklist is found at the end of this appendix, following Module IV.

**Module I**

Today’s date: May 14, 2007

Appointments for May 14, 2007:

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Appointment Time</th>
<th>Reason for Appointment</th>
<th>Clinician</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cindy Swaim</td>
<td>9:00 AM</td>
<td>Anxiety</td>
<td>Dr. Heath</td>
<td>Fauna Stout, CMA</td>
</tr>
</tbody>
</table>
Work Assignments

Module I has a total of ten tasks, and it lays the foundation for all other modules because it lists step-by-step instructions for the various tasks. Included throughout the exercises are Help boxes to assist the user what to do if he or she runs into problems while working in particular screens. The following tips may assist the user in finding information quickly when performing future SYNAPSE exercises:

1. Highlight all first-time instructions with a pink marker.
2. Highlight all Help boxes with a yellow marker.
3. Place a large paper clip on the pages that contain first-time instructions or Help boxes.

Task 1-1: Documenting in the Quality Control Log

Every morning, a different person is responsible for opening the lab and turning on the equipment. The person opening the lab also runs controls on various instruments and test kits. Today, it is Fauna Stout’s turn to open the lab and run controls, and you will take on the role of this medical assistant.

1. Log in to SYNAPSE.
2. Begin documentation by clicking the Logs icon on the Main Menu screen.
3. Next, click the drop-down arrow under Quality Control Log. There will be a list of test kits or equipment on which you routinely perform controls. Yesterday, Fauna noticed that several of the patients had lower-than-normal glucose levels. Today she performed a control on the glucose unit to make certain it is functioning correctly. Start the documentation by clicking the word “Glucose.”
4. Click Open Selected Log located at the top center of the screen.
5. Next, click the update button located at the bottom of the screen (Figure B-3). Enter the information listed in Table B-1 within the requested fields.

Figure B-3 Glucose Log with Update button
TABLE B-1  TASK 1-1 INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>05/14/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Name</td>
<td>Glucometer Essential</td>
</tr>
<tr>
<td>Manufacturer’s Name</td>
<td>Jefferson Diagnostics</td>
</tr>
<tr>
<td>Name of Control</td>
<td>High Control</td>
</tr>
<tr>
<td>Lot #</td>
<td>4890</td>
</tr>
<tr>
<td>Exp Date</td>
<td>02/01/2008</td>
</tr>
<tr>
<td>Reference Range or Result</td>
<td>250-300</td>
</tr>
<tr>
<td>Result</td>
<td>250 mg/dL</td>
</tr>
<tr>
<td>Person Performing Control</td>
<td>Fauna Stout, CMA</td>
</tr>
</tbody>
</table>

Help Box: Quality Control Logs

If the log you are working in has no prior entries, you can enter the data in Table B-1 directly; however, if previous entries were made in the log, you need to click the Add Log icon before entering the information.

6. Once you have entered the requested information, compare your screen with Figure B-4 to make certain it is correct.

![QC Log Glucose](image)

Figure B-4  In-house glucose testing log for the glucose control

7. Click Save.

8. Next, click the Print All icon. Label your work as Task 1-1 and place it in your SYNAPSE folder.
9. Click Close. When you click Close, you should see the information you entered in the Glucose log. If the information does not match, delete the log by clicking the Update tab. This brings you back to the original screen in which you recorded the log entry. Make the appropriate changes and, once again, click Save. Click Print All, and click Close.

10. Close the Glucose log by clicking the Close tab next to Update.

11. Navigate out of the Open Selected Log screen by clicking Close, which is the little red box with the white X in the upper-right corner of the screen.

12. You should now be back in the Main Menu.

**Task 1-2: Creating a New Chart and Progress Note for the Patient**

The first patient of the day is Cindy Swaim. You greet the patient and take her back to the examination room. First, you will need to create a chart for Ms. Swaim. Information necessary to create the chart and progress note can be found in Table B-2.

**TABLE B-2  CINDY SWAIM’S PATIENT DATA TABLE**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Cindy L. Swaim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s DOB</td>
<td>04/14/1965</td>
</tr>
<tr>
<td>Patient’s Chart Number</td>
<td>268506784</td>
</tr>
<tr>
<td>Patient’s Address</td>
<td>429 Kingston Drive, Louis Center, NY, 01287-1111</td>
</tr>
<tr>
<td>Patient’s Telephone Numbers</td>
<td>Home: 123-842-8421 Work: 123-652-9874</td>
</tr>
<tr>
<td>Patient’s Employer Info</td>
<td>Lakeside Memorial Hospital Fostoria, NY, 01254-6543</td>
</tr>
<tr>
<td>Gender, Marital Status, Blood Type &amp; Smoking Status</td>
<td>Gender: Female Marital Status: Single Blood Type: A+ Smoking Status: Smoker</td>
</tr>
<tr>
<td>Spouse Name, DOB, &amp; Address</td>
<td>N/A</td>
</tr>
<tr>
<td>Responsible Party Info</td>
<td>Patient</td>
</tr>
<tr>
<td>Primary Payer Info</td>
<td>Signal HMO, 135 Carriagehill Lane, Douglasville, NY, 01268506784-00, Policy Holder: Self</td>
</tr>
<tr>
<td>Secondary Payer</td>
<td>None</td>
</tr>
<tr>
<td>Patient Drug Allergies</td>
<td>Tetracycline</td>
</tr>
<tr>
<td>Patient Other Allergy</td>
<td>Dust, Pollen</td>
</tr>
<tr>
<td>Current Mediation List</td>
<td>None</td>
</tr>
<tr>
<td>Preferred Pharmacy</td>
<td>Family Pharmacy Inc., 865 Livingston Ave, Fostoria NY, 01254</td>
</tr>
<tr>
<td>Lab Provider</td>
<td>National Diagnostics</td>
</tr>
<tr>
<td>Privacy Statement</td>
<td>Date the Privacy Statement was signed: 05/14/2007; note to be entered in the Notes box. April Patrick (mother of patient) can receive private information if unable to contact the patient directly. April Patrick’s cell phone number is 123-328-9874.</td>
</tr>
</tbody>
</table>
| Family Health History Info | Father: Age 62, Health: Fair  
Mother: Age 60, Health: Good  
Brother: Age 37, Health: Good  
Sister: Age at Death 6, Cause of Death: Leukemia  
Familial Diseases:  
Cancer: Enter the following note: Paternal grandfather died of liver cancer at age 72.  
Other: Father has emphysema. |
|---------------------------|--------------------------------------------------|
| Hospitalizations, Blood Transfusions, and Serious Injuries | Hospitalizations: 1984, Lakeside Memorial Hospital, emergency appendectomy (no complications)  
Blood Transfusions: The patient has not received any blood transfusions.  
Serious Injuries: None |
| Pregnancies | None |
| Medical History | Place checkmarks in the boxes for chicken pox, diabetes, and high cholesterol.  
Notes: Place the following in the Notes box:  
Chicken pox: 1970 (no complications).  
Diabetes: Diagnosed with borderline diabetes in 2003 (diet controlled)  
High cholesterol: Diagnosed in 2003 (diet controlled) |
| Health Habits | Check Caffeine: Two 12-ounce cups of coffee per day  
Check Tobacco: 1 to 1 1/2 packs of cigarettes per day × 22 years  
Check ETOH:  
Drink Type: Beer  
Drinks Week: Six 12-ounce cans per week  
Check the box for Heavy Lifting  
Occupation: Patient Care Associate |
| Subjective Information | Chief Complaint: Anxiety or stress  
Severity of symptoms is a 4 on a scale from 1 to 10.  
Duration of symptoms is 4 months.  
Associated symptoms: (Positives) Breathing irregularities, decrease in ability to concentrate, history of prior attacks, and increase in appetite or weight. (Negatives) Heart irregularities, and psychotic or delusional behavior  
Aggravating Factors: Crowded areas  
Relieving Factors: Eating and Sleeping |
| Objective Information | Vital Signs:  
Height: 64 inches  
Weight: 162 pounds  
Temperature: 99.8  
Blood Pressure: 150/98  
Pulse: 92  
Respiration: 20  
Pain: 0 |

Subjective Information and Vital Signs Entered By: Fauna Stout, CMA
CREATING A CHART

1. Begin by clicking the New Patients icon on the Main Menu.

2. The first tabbed screen under Patient Information is the Patient Main screen. Using the information provided in Table B-2 fill in the requested fields. When you are finished, click Save. Check your work with Figure B-5.

3. Next, click the Patient Picture tab. This is where you can attach a picture of a patient if you have a scanner or digital image. Check to make certain the patient’s chart number is in the Patient Chart Number box. Under the Patient Picture box is another box labeled Patient Notes. This box serves as a reminder box. You will enter special facts about the patient in this box, such as how the patient wants to be addressed, special events in the patient’s life (such as a wedding or graduation), or notes that remind you to take a certain action during the patient’s next visit. These actions may include having the patient sign a specific form or making certain that the patient returned an X-ray that was borrowed from the office. You should look in this section of the record prior to rooming the patient to see if there are any specific notations directing you to take a specific action. Once the action has been applied, or the event has past, you should remove the note by deleting it and clicking Save. For this visit, enter the following information in the Patient Notes box: “The patient prefers to be addressed by her first name.” Click Save.

4. Click the Responsible Party tab. The patient’s chart number should have automatically populated in this screen, as well as the remainder of screens within the patient information section. Since Cindy is responsible

![Figure B-5 Patient Main screen completed for Cindy Swaim]

**Help Box: Navigating through Fields**

Pressing the Tab key on your keyboard is an excellent way to move from one field to another. When you finish entering information in the field in which you are working, press the Tab key; this will move you to the next available field.
for her own bills, click Self. Note that all of Cindy’s information automatically populates in this screen. Also notice that the numerals listed in the chart number is Cindy’s Social Security number. Offices are currently moving away from using the patient’s Social Security number as an identifier.

5. Click the Primary Payer tab. Click the drop-down menu arrow in the box next to the Name heading. Click Signal HMO. The address information for the insurance company should automatically appear after clicking Signal HMO. Next, enter the subscriber I.D. #, which is 268506784-00. There is no Policy/Group #, so leave that box empty. Under Policy Holder information, click Self. The remainder of the information should automatically populate within the Policy Holder section, except for Cindy’s Social Security number. Enter 268-50-6784. Compare your work with Figure B-6 and click Save.

6. The patient does not have any secondary or tertiary insurance, so you can skip those tabs and go directly to the Allergy & Meds tab. The patient is allergic to Tetracycline. Begin this section by clicking the Click to Add tab within the Patient Drug Allergy List box. Another box will appear. Type Tetracycline in the Enter Patient Drug Allergy field. Next, click the Save button. Once you save your information, it should automatically appear in red in the Patient Drug Allergy List box. The patient is also allergic to dust and pollen, so click the Click to Add tab in the Patient Other Allergy List box. Type Dust in the Enter Patient Other Allergy field. Click Save. Repeat the same instructions for pollen. The patient is not taking any current medications, so click Save. Check your work with Figure B-7.
7. Next click the Preferred Pharmacy tab. Click Update Patient Preferred Pharmacies. The patient selected Family Pharmacy Inc., 865 Livingston Ave, Fostoria NY, 01254 as her preferred pharmacy. Click the Add/Remove button next to this pharmacy. A checkmark should appear in the box of the Add/Remove button. Click Close. The pharmacy you selected should now appear in the Patient Preferred Pharmacies box (see Figure B-8). Click Save.
8. Review each tab and make certain that all of your information saved correctly.

9. Click the Main Menu icon.

10. Click the Patients icon. Cindy Swaim’s name should now be listed within the alphabetical list of patients.

11. Highlight Cindy’s name by clicking the patient selector column, which is the column just to the left of the patient’s name. Click Open Patient Record. The Patient Information screen for Cindy Swaim appears.

12. Click the Legal Icon. You just finished reviewing the privacy statement with the patient. Now click the drop-down menu arrow in the Privacy Statement box. Click Yes. Enter today’s date, May 14, 2007, in the box under the date column. In the Notes box, enter the following information: April Patrick (mother of patient) can receive private information if we are unable to contact the patient directly. Her cell phone number is 123-328-9874. Click Save, and check your work with Figure B-9. Print the screen and label as Task 1-2A.

![Legal Information for Cindy Swaim](image)

Figure B-9   Legal Information screen completed for Cindy Swaim

13. Click Patient Menu and then click the Health History icon.

14. Using Table B-2, enter all of the history information within the Health History sections. Note: Save your information after completing each screen. Make certain that you expound on any disease that was checked within the family history or past medical history tabs by entering information in the Notes sections of those particular screens. Do not enter any information within the lab history screen or the medication history screen. These screens will automatically populate when a prescription is written or a lab requisition is ordered. Refer to Figures B-10, B-11, and B-12 to make certain that information was correctly entered in the corresponding screens.
Figure B-10  Family History screen completed for Cindy Swaim

Figure B-11  Hospitalization screen completed for Cindy Swaim
Figure B-12  Past Medical History screen completed for Cindy Swaim

Figure B-13  Health Habits screen completed for Cindy Swaim
15. Click the Patient Menu icon. Next, click the Chart Notes icon.
   
a. You should see four icons at the top of the screen and two long boxes below the four icons (Figure B-14).

![Chart Notes screen for Cindy Swaim](image)

b. The two boxes below the icons will include a listing of all previous office visits and telephone calls that the patient has had in the past. Your boxes should be blank because the patient has not been seen in the past. When you want to read a previous note of an established patient, just click the date in question and the note from that visit will appear. Each time a patient comes in for a new office visit, you should click the New Office Visit icon. When the patient calls the office for medical results or advice, you should click the Telephone Call icon. Cindy is here for a new office visit, so click New Office Visit.

16. Once you see the New Office Visit Screen, enter the date of Cindy’s visit, which is May 14, 2007. Next, enter the time of Cindy’s visit, 9:00 a.m.

17. Click the Update Progress Note button at the top of the toolbar and then click Save.

18. Next, click the Subjective Tab.

19. Click the drop-down menu in the box under Chief Complaint.

20. Click the words “Anxiety or Stress” from the drop-down list (Figure B-15).
21. Click Update Progress Notes and then click Save.

22. Most physicians will enter the patient’s history of the present illness (HPI) information; however, you will enter it here to see how items populate within the progress note. Start by clicking the Add HPI button. The screen where HPI information is entered appears (Figure B-16).
a. Since location is not a factor, the box is empty.

b. Under Severity of Symptoms, click 4. This signifies the severity of the patient’s symptoms on a scale from 1 to 10.

c. In the row next to severity there is another set of numbers. Click 4 and then click Months. This signifies that the patient has had the symptoms for four months. All of this information should automatically populate within the white HPI box below the chief complaint.

d. Next is the Associated Symptoms box. Associated symptoms are symptoms that may be common with particular chief complaints. You will see a + symbol and – symbol. Click the + symbol first. Click all of the symptoms that are listed as positive in Cindy’s patient data table. Positive symptoms included the following: Breathing irregularities, Decrease in ability to concentrate, History of prior attacks, and Increase in appetite or weight. Now click on the – symbol. Click the symptoms that do not apply, which include the following: Heart irregularities and psychotic or delusional behavior. You didn’t click Decrease in appetite or weight because the patient already stated that she had an increase in appetite or weight.

e. Next is the Aggravating Factors box. Aggravating factors are factors that make the symptoms worse. Cindy stated that crowded areas make her symptoms worse, so click Crowded areas.

f. Next is the Relieving Factors box. Relieving factors are factors that seem to help the symptoms. Cindy stated that eating and sleeping seem to make her symptoms better, so click Eating and click Sleeping. Now that you are through entering the HPI information, click Save. Check your work with Figure B-17.
23. Next, click the Progress Notes icon. You should now be viewing the information within the Subjective Information tab. Click Update Progress Note and then click Save. Now click the Progress Notes tab. The subjective information should have automatically populated within the progress note. Refer to Figure B-18 to make certain that your subjective information is correct.

Figure B-17  Cindy Swaim’s completed HPI table
24. Click the Objective Tab. Enter the patient’s vital signs in the requested fields:

- **Vital Signs:**
  - Height: 64 inches
  - Weight: 162 pounds
  - Temperature: 99.8
  - Blood Pressure: 150/98
  - Pulse: 92
  - Respiration: 20
  - Pain: 0

25. Click the name of the medical assistant you are representing, which is Fauna Stout. This feature illustrates who entered the subjective findings and vital signs. Refer to Figure B-19 to make certain that you entered the information correctly in the Objective screen.
26. Click the Update Progress Note icon at the top of the toolbar and then click Save.

27. Click the Progress Notes tab. Scroll down to view the objective information. You should see the information you entered within the Objective tab now populated within the progress note window. You should also see that the Patient’s Drug Allergy Information and Other Allergy Information automatically populated within the note. You will also see the headings Physical Examination Findings, Assessment, and Plan. These headings illustrate the remainder of information to be added by the clinician. Check your work with Figure B-20.

Figure B-19  Objective screen completed with Cindy Swaim’s vital sign information
Figure B-20  Completed progress notes for Cindy Swaim

28. Review the progress note and look for any errors. When you are satisfied the information is correct, click the Print icon. Print a copy of the progress note and label it Task 1-2B. Do not click the Complete Visit icon until the patient’s visit is completed. Once you click this icon and leave the screen, you cannot enter any further information for this particular visit. The physician still has information to enter, so leave the screen for the physician.
Help Box: Progress Notes

If after viewing the progress note you notice any errors, take the following actions:

If the error occurs in the Subjective information:

1. You should return to the Subjective tab and make the appropriate corrections. Click Update Progress Note and then click Save. Make certain the information saved correctly.

2. If the updated subjective information does not save correctly after applying the above action, try the following:
   a. Click the Cancel icon while in the Subjective tab.
   b. Click Yes, you are sure you want to cancel.
   c. Click the drop-down menu arrow in the Chief Complaint box, even if the correct complaint is already displayed. (This should cause the previous HPI information to disappear.)
   d. Make certain that the correct complaint is displayed.
   e. Click Update Progress Note.
   f. Click Save.
   g. Click Add HPI.
   h. Click the appropriate symptoms.
   i. Click Save.
   j. Click the Subjective tab. The correct information should be displayed in the HPI box.
   k. Click the Progress Notes tab. You should be able to view the amended progress note. The information should now be correct. Note: Remember, you will not click the Complete Visit tab until both you and the physician are completely finished with the patient. Once the note is completed, you will need to click the Complete Visit tab to complete the note; otherwise, the note will not save properly.

If the error occurs in the Objective information:

1. Click the Objective tab.
2. Click Cancel.
3. Enter the corrected information in the appropriate boxes.
4. Click the Update Progress Note icon.
5. Click Save.
6. Click the Progress Notes tab.
7. You should be able to view the amended progress note now. The information should now be correct. Note: Remember, you will not click the Complete Visit tab until both you and the physician are completely finished with the patient. Once the note is completed, you will need to click the Complete Visit icon to complete the note; otherwise, the note will not save properly.
Now that the chart is created and all information is entered, you can alert the physician that the patient is ready to be seen.

When working in the field, the physician will typically exit the patient’s room and instruct the medical assistant to read the Plan section of the progress note. Since this is not possible for these assignments, the plan will be provided in the instructions. The plan for Cindy Swaim states the following:

Plan: In-Office Glucose. Will send the patient’s blood out for a Chem 12. Rx for Alprazolam, 0.5 mg, # 30, Take 1 tablet every day. One month prescription, no refills. Rx for Atenolol tabs, 50 mg, Take 1 tab each day before meals or at bedtime, One month prescription, no refills, Spoke to patient regarding hypertension, hypercholesterolemia, diabetes, and a smoking cessation program. Will give patient educational materials for hypertension, smoking cessation, heart disease, and diabetes. Re: Pt to follow up in one month for a thorough physical.

There are many things that you will need to do to finish with this patient. Time management will be very important. Let’s start our tasks by creating all of the orders for the labs.

**Task 1-3: Ordering Lab Tests**

1. Since you should already be in the Progress Notes screen, click the Labs icon.
2. Click the drop-down menu arrow in the Laboratory box. A list of laboratories will appear. This box depicts which lab conducted the testing. Since the test will be performed in the office, select In-House Testing.
3. Next, click the drop-down menu arrow in the Ordering Provider box. Another drop-down list will appear. Click Dr. Heath.
4. Click the Payer drop-down menu arrow. Select Signal HMO.
5. Click the drop-down menu arrow in the General Lab Tests box. A drop-down list of tests will appear. Scroll and click Fasting Blood Sugar or FBS.
6. Leave the Number and Type of Specimens Sent box empty since we are not sending this test outside the office.
7. In the Today’s Date box, enter the date of Cindy’s appointment, which is 05/14/2007.
8. Next, click the Specimen Prepared By drop-down menu arrow. Click Fauna Stout, since she is the medical assistant taking care of the patient.
9. Click the drop-down menu arrow in the Was patient fasting? box. Click Yes. Check your work with Figure B-21, and make the appropriate corrections before saving the information.
10. Click Save.

11. Click the Preview Box to review the order. If you made an error, perform the steps in the Help Box: Correcting an Error in the Lab Preview Screen.

12. Once information is correct in the Preview box, click the Print icon in the upper-right corner of the lab requisition screen.

13. Label the requisition as Task 1-3A. Place it in your SYNAPSE folder. Close the screen by clicking the X in the upper-right corner.

14. Now click the Lab History icon. Your Fasting Blood Sugar order should be displayed in the Incomplete Labs table.

15. Since the doctor also ordered an outside test, which is the Chem 12, click the Labs icon. Since the patient is having an outside test as well, you should also create the requisition for that test. The patient’s insurance company allows her to go to National Diagnostics, so select that name from the drop-down list.

16. Click Ordering Provider. Select Dr. Heath.

17. Click the Insurance box arrow. Select Signal HMO.

18. Click the General Lab Tests box arrow. Click Chem 12.

19. Type the following information within the Number of and Type of Specimens Sent box: One Red Top Tube.

20. Insert the date of the patient’s appointment in the Today’s Date box.

21. Next, click the Specimen Prepared By drop-down arrow. Select Fauna’s name.
22. Click the drop-down arrow in the Was patient fasting? box. Click Yes. Click Save. Click the Preview Box to view the order.
23. Print a copy of this lab requisition by clicking the Print icon in the upper-right corner of the screen.
24. Label the form Task 1-3B and place it in your SYNAPSE folder. Close the screen by clicking the X in the upper-right corner.
25. Click the Lab History icon. Your order should be displayed in the Incomplete Labs table. Refer to Figure B-22.

**Figure B-22** Lab History table showing the requests for both labs for Cindy Swaim

**Help Box: Correcting an Error in the Lab Preview Screen**

1. If you observe any errors during the lab preview, click out of the preview by clicking the Close box (the white X in the red box in the upper-right corner of the screen).
2. Click the Lab History icon.
3. Click the lab test that has the error.
4. Click the Delete Lab icon.
5. Click the small selector box next to the Click to Delete the Lab heading.
6. Close the screen. The information should no longer be listed in the table.
7. Go to the labs section by clicking the Labs icon, and start the whole lab requisition over.
Now that the lab requisitions are completed, you will need to create the prescriptions.

**Task 1-4: Creating a Prescription**

The first prescription listed is for the patient’s anxiety: Rx for Alprazolam, 0.5 mg, # 30, Take 1 tablet every day. One month prescription, no refills.

1. Click Patient Menu.
2. Click Prescriptions.
3. Click the Pharmacy box drop-down arrow. Select Family Pharmacy Inc. 865 Livingston Ave, Fostoria NY, 01254.
4. Click the Common Drug Formulary drop-down arrow. Select Alpazolam. The instructions that autopopulate on the right side of the screen should match the order above.
5. Next, click the Payer box drop-down arrow. Select Signal HMO.
6. Next, click the drop-down arrow in the Clinician Ordering Medication box. Select Dr. Heath.
7. Next, click the drop-down arrow in the Prescription Created By box. Select Fauna’s name.
8. On the bottom right side of the screen, enter the Start Date as today’s appointment date. Select the End Date as a month from today’s appointment.
9. You will notice two little boxes above the Start Date and End Date boxes. One box is labeled Do Not Substitute and the other box is labeled New Common Drug. The Do Not Substitute box is checked when the doctor does not want the patient to have the generic or less-expensive form of the drug. The New Common Drug box is checked when you create a prescription for a drug that is not listed in the Common Drug Formulary. The doctor did not give instructions that the drug could not be substituted, and the drug is already in the Common Drug Formulary, so uncheck both boxes if they are not already unchecked.
10. Under Refills, select None.
11. Double-check each box to make certain all information is correct.
12. Click Save. The information should automatically populate within the Prescription History table (Figure B-23).
13. Click Preview. The Preview icon will allow you to view the prescription prior to printing it.

14. Click the Print icon in the Prescription Preview box and close the preview box.

15. In the medical office, the prescription would have been given to the physician to sign prior to giving it to the patient. Place the printed prescription in your folder and label it Task 1-4A.

**Help Box: Correcting a Prescription Error after Saving**

If you notice an error when previewing the information in the prescription screen after saving it, do the following:

1. Click the appropriate prescription within the Prescription History table.

2. Click the Delete Rx icon at the top of the toolbar.

3. Click in small empty box next to the Click to Delete the Prescription box.

4. Close the box.

5. Re-create the prescription and save.
The second prescription is for Atenolol, which is used to control the patient’s blood pressure. The physician’s order was for the following: Rx for Atenolol tabs, 50 mg, Take 1 tab each day before meals or at bedtime, One month prescription, no refills. This prescription should be easy to create because most of the necessary information was already entered for the first prescription. The only thing that needs to be changed is the name of the drug. Replace “Alprazolam” with “Atenolol.” Make certain the information on the right matches the physician’s order. The start date should be 05/14/2007 and the end date should be 06/14/2007. Be certain to click None under Refills. Take one final look at the information to make certain it matches the physician’s order before clicking Save. Make certain the information saved in the Prescription History screen. Now click Preview, click out of the preview screen, and print the prescription. In the medical office, this form would be signed by the clinician. Label the prescription Task 1-4B.

Next, you should print the patient education materials.

**Task 1-5: Printing Educational Handouts**

The doctor stated that the patient should receive patient education materials for diabetes, smoking cessation, hypertension, and heart disease.

1. Click the Main Menu icon.
2. Next, click Patient Education Forms.
4. Click the Diabetes box (Figure B-24).
5. Choose Print from the File drop-down menu to print.
6. From the File drop-down menu, choose Close to return to the Education Letters screen.
7. Next, click Smoking Cessation tab.
8. Print the form and close the window, returning to the Education Letters screen.
9. Do the same for hypertension and heart disease.

10. Close the windows after printing.

11. After printing all of the handouts, label each handout as Task 1-5. Assign letters A through D for each individual handout. Place the educational handouts in your SYNAPSE folder.

   Now you are ready to draw the patient’s blood for outside testing and perform a finger stick for the in-house glucose testing. You finished the blood draw and blood glucose testing and are ready to log the information. The lab requisition forms have already been completed. Now you will need to record the glucose test in the In-House Test Log.

Task 1-6: Documenting an In-House Procedure within the In-House Test Log

1. Go to the Main Menu.
2. Click Logs.
3. Next, click the drop-down arrow in the In-House Log.
4. Select Glucose.
5. Click Open Selected Log.
6. Click Update.
7. Enter today’s appointment date.
8. Choose the patient’s name from the drop-down list in the Patient Name box.
9. Choose Dr. Heath’s name from the drop-down list in the Ordering Provider box.
10. Enter the Manufacturer’s Name, which is Jefferson Diagnostics.
11. Enter the Expiration Date from the test strips, which is 2/1/2008.
12. Enter the Lot Number, which is 4867.
13. Enter the results. Today’s results are 204 mg/dl.
14. Click the drop-down arrow beside the Name of Person Performing the Test box. Click Fauna Stout’s name.
15. Click Save. Refer to Figure B-25 to make certain that you entered the information correctly.

![In House Log Glucose](image)

Figure B-25   In-house log for Cindy Swaim’s glucose
16. Print the glucose log by clicking the Print All icon. Label printout Task 1-6 and place it in your SYNAPSE folder.
17. Click Close.
18. The information should now appear on the In-House Glucose Test Log.
19. Click Close.
20. Close the Open Selected Log box by clicking the X in the upper-right corner of the window.
21. You should now be back in the Main Menu.

Help Box: In-House Logs

If the log you are working in has no prior entries, you can enter the information using the steps above; however, if other previous entries were made in the log prior to opening, you will need to click the Add Log icon before entering the information.

Task 1-7: Entering a Test Result in the Lab History Section

1. Select the Patients icon from the Main Menu.
2. Select Cindy Swaim’s name.
3. Click Open Patient Record.
4. You should now be viewing Cindy’s Patient Information Menu. Click the Lab Orders icon.
5. Click the Lab History icon.
6. Click the Fasting Blood Sugar test from the incomplete lab table.
7. Click the Update Lab Results icon (Figure B-26).

Figure B-26  Lab History screen for Cindy Swaim
8. Type the lab result: 204 mg/dl.

9. Choose Fauna’s name from the drop-down list in the Name of Person Who Recorded Results box.

10. Enter 5/14/2007 as the date the results were received. Check to make certain you entered the information correctly by comparing your information with Figure B-27.

11. Click Save.

12. Click Lab History.

13. The glucose results should have moved from the Incomplete Labs section to the Completed Labs section. (Figure B-28).
Print the lab history tables by clicking the Print icon. Label the Incomplete Lab table as Task 1-7A and the Complete Lab table as Task 1-7B. Place both tables in your SYNAPSE folder.

Help Box: Printing Tables in the Lab History Screen

The Lab History Tables will not print unless there is data within the tables.

15. Click the Patient Menu icon.

Inform the physician of the patient’s result and determine if he needs you to do anything else for the patient. The physician tells you he wants to go in and discuss the results with the patient, and that he will let you know when he is finished.

The physician re-enters the patient’s examination room and discusses the findings. He notifies you that he is finished and informs you that you can complete the visit. You have already gathered all of the patient’s prescriptions and educational handouts. You enter the patient’s room and distribute and explain each prescription and educational handout. You ask the patient if she has any further questions. She asks you for a proof of appointment letter for her employer.

Task 1-8: Proof of Appointment Letter

1. Go to Cindy Swaim’s Patient Information Menu, if you are not already there.
2. Click Patient Templates.
3. Click the Proof of Appointment button.
4. Insert the date of the appointment in the Date box.

5. Since Cindy’s appointment was for 9:00, select 9:00 AM from the drop-down menu beside the appointment.

6. Click the Clinician drop-down list and select Dr. Heath. Refer to Figure B-29 ensure you properly completed the template.

7. Print the letter and label it Task 1-8 and place it in your SYNAPSE folder.

8. Click Close.

9. Close the template letters by clicking the X in the upper-right corner of the window. You should now be in the Patient Information Menu for Cindy Swaim screen.

**Task 1-9: Completing the Progress Note and Closing Out of the Patient’s Record**

Since the patient is gone and you are done working in the patient’s personal EMR, you can now close the chart note.

1. Click the Chart Notes icon.

2. Click New Office Visit.

3. Click Save.

4. Click Update Progress Notes to make certain that all of the latest information was entered in the chart.

5. Click on the Complete Visit icon. *Note: When you leave this page, you will be unable to enter any additional data within the chart note.*

6. Click Patient Menu.

7. Click the Chart Notes icon.

8. Check to make certain that the date of your progress note saved to the Previous Office Visits box.

9. Click the visit and view the note.

10. Click Chart Notes.
11. Click Patient Menu.

12. Click the Main Menu.

**Task 1-10: Phone Call from Blanche White**

You will receive many phone calls, even while you are working in a clinical capacity. It is important that you document all encounters with the patient, including telephone calls.

Blanche White calls the office to request a refill for her Fosamax. She had several pills left from her previous prescription at the time of her last visit, so she didn’t get the prescription filled. She lost the prescription and is now out of the drug. The pharmacy that Blanche uses is DanMart on Polaris Drive.

1. On the Main Menu, click Patients.
2. Select Blanche White.
3. Click Open Patient Record.
4. Now you should be in the Patient Information Menu screen.
5. Click Chart Notes.
6. Click the Telephone Call icon.
7. Notice there are four tabs in the center of this screen (Figure B-30). The first tab is used when the patient is calling to request a prescription refill. When you click this tab, the Prescription History table will appear, which illustrates all of the medications the patient is currently taking. The second tab is labeled Follow-Up on Lab Test Results. You select this tab when the patient is requesting information regarding a lab test. This screen contains the patient’s lab history for easy referencing. The third tab is labeled Symptoms. This tab is used when the patient has questions regarding symptoms he or she is currently experiencing, or when the patient has questions regarding his or her condition. The fourth tab is labeled Other Calls. This tab is used when the patient is calling about something other than the three previous tabs. Since the patient is calling regarding a prescription refill, keep the Prescription Refill tab current.
8. Enter 05/14/2007 in the Date box.
9. Enter 9:45 AM in the Time box.
10. Enter Blanche White in the Name of Caller box.
11. Click the drop-down list arrow in the Nature of Call box, and select Prescription Refill.
12. The patient’s birthday should have automatically populated in the DOB box.
13. In the Relationship to Patient box, enter Self.
14. The patient’s home phone number should have automatically populated in the Patient’s Phone Number box.
15. The caller’s phone number is the same number as above, so type SAA in this box.
16. The patient’s prescriptions will appear on the screen. Click Fosamax, since that is the prescription the patient is requesting.
17. Another box will appear. Place a checkmark in the box beside the Click to Indicate Telephone Inquiry box. Click out of the box by clicking the X on the upper-right corner of this window.
18. There is only one pharmacy, so you don’t have to click in anything in that box.
19. Select the action you took from the drop-down list: Sent an Electronic Task to the Physician.
20. Select the person who handled the call (Fauna) from the drop-down list.
21. Double-check to make certain that you have all the information correct by comparing your screen with Figure B-31.

22. Click Update Telephone Call.

23. Click Save.

24. Click Complete Telephone Call. Once you click this icon and leave the screen, you will not be able to make any more adjustments, so make certain the information is correct before leaving the screen.

25. Click Patient Menu.

26. Click Chart Notes.

27. Click 5/14/2007 under Previous Telephone Calls.

28. Click the Print icon. Label your assignment as Task 1-10 and place in your SYNAPSE folder.

29. Click the Main Menu. The activities for Module I are now concluded.

**Critical Thinking Questions for Module I**

1. Cindy Swaim stated that she was a borderline diabetic and had high cholesterol during the health history portion of the interview. Her chief complaint was in regard to anxiety. Why shouldn’t the medical assistant enter this information within the Current Problems screen? What information should be entered in the Current Problems screen? Whose responsibility would it be to enter such information?
2. Why is Cindy such a likely candidate for a heart attack?

3. What was the purpose of running a control on the glucometer? Why do you think that Fauna chose the High control?

4. Who may the office leave private information with when Cindy is not available?

5. What part of the chart should you check to find out how Cindy wants to be addressed for future visits? What other type of information may be entered in this section?

6. Cindy’s complaint for today’s visit was anxiety; however, after reading the history information and following her examination, Dr. Heath ordered patient education forms for diabetes, smoking cessation, hyptension, and heart disease. Explain the probable reason that each form was ordered. Dr. Heath did not order a patient education form for anxiety. This may be because there wasn’t one stocked within the EMR. If Dr. Heath did order a patient education pamphlet that was not stocked in the EMR, what would be the next course of action?

**MODULE II**

Today’s date: May 15, 2007


<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Appointment Time</th>
<th>New Patient or Established Patient</th>
<th>Reason for Appointment</th>
<th>Clinician</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morgan Penrose</td>
<td>9:00 AM</td>
<td>NP</td>
<td>UTI</td>
<td>Dr. Schwartz</td>
<td>Roger Wong, RMA</td>
</tr>
</tbody>
</table>

**Work Assignments**

You will be working as Roger Wong, RMA, for the next several tasks.

**Task 2-1: Documenting in the Quality Control Log**

After using the last rapid strep test in the rapid strep kit, Roger needs to open a new strep kit. He will need to run a control prior to using the new kit. Log information is found in Table B-3.

**TABLE B-3  TASK 2-1 INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>05/15/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Name</td>
<td>Two-Step Rapid Strep Test</td>
</tr>
<tr>
<td>Manufacturer’s Name</td>
<td>Jefferson Diagnostics</td>
</tr>
<tr>
<td>Name of Control</td>
<td>+ Control</td>
</tr>
<tr>
<td>Lot #</td>
<td>6598</td>
</tr>
<tr>
<td>Exp Date</td>
<td>06/12/2008</td>
</tr>
<tr>
<td>Reference Range or Result</td>
<td>Positive</td>
</tr>
<tr>
<td>Result</td>
<td>Positive</td>
</tr>
<tr>
<td>Person Performing Control</td>
<td>Roger Wong, RMA</td>
</tr>
</tbody>
</table>

1. Go to the Main Menu and select Logs.
2. Go to the Quality Control Logs and click Rapid Strep Test. Open the selected log and click Update.
3. Enter the information from Table B-3. **Do not forget to save the information.**
4. Print the log and label it Task 2-1.

5. Place the log in your SYNAPSE folder.

6. Close the log window. You should now see the information in the rapid strep log table. Close out of the log by clicking the Close box.

7. Close the Open Selected Log box by clicking the X in the upper-right corner of the window. You should now be back at the Main Menu screen.

**Task 2-2: Creating a New Chart**

Mrs. Morgan Penrose just arrived. You obtained her vitals and performed a medical history. You also obtained her chief complaint and reviewed the privacy statement with her. All responses to Mrs. Penrose’s questions can be found in Table B-4.

**TABLE B-4  MORGAN PENROSE’S PATIENT DATA TABLE**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Morgan A. Penrose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s DOB</td>
<td>05/16/1960</td>
</tr>
<tr>
<td>Patient’s Chart Number</td>
<td>257986523</td>
</tr>
<tr>
<td>Patient’s Address</td>
<td>876 Honeycut Lane, Douglasville, NY 01234-1212</td>
</tr>
<tr>
<td>Patient’s Telephone Numbers</td>
<td>Home: 123-457-9865</td>
</tr>
<tr>
<td></td>
<td>Work: None</td>
</tr>
<tr>
<td>Patient’s Employer Info</td>
<td>None</td>
</tr>
<tr>
<td>Gender, Marital Status, Blood Type &amp; Smoking Status</td>
<td>Gender: Female</td>
</tr>
<tr>
<td></td>
<td>Marital Status: Married</td>
</tr>
<tr>
<td></td>
<td>Blood Type: O–</td>
</tr>
<tr>
<td></td>
<td>Smoking Status: Non-smoker</td>
</tr>
<tr>
<td>Patient Picture Screen: Patient Notes</td>
<td>Patient prefers to be addressed by her first name. Patient is getting ready to start nursing school (05/14/2007).</td>
</tr>
<tr>
<td>Spouse Name, DOB, &amp; Address</td>
<td>Chad W. Penrose, DOB: 02/13/1955, Address: Same as patient</td>
</tr>
<tr>
<td>Responsible Party Info</td>
<td>Responsible Party: Spouse</td>
</tr>
<tr>
<td></td>
<td>SS # or ID #: 365-84-9865</td>
</tr>
<tr>
<td></td>
<td>Address and Home: 876 Honeycut Lane, Douglasville, NY 01234-1212</td>
</tr>
<tr>
<td></td>
<td>Home Phone: 123-457-9865</td>
</tr>
<tr>
<td></td>
<td>Work Phone: 123-698-8888</td>
</tr>
<tr>
<td></td>
<td>Employer: Douglasville Textiles, 3658 City Park, N. Douglasville, NY 01236-1245</td>
</tr>
<tr>
<td>Primary Payer Info</td>
<td>Name: Flexihealth</td>
</tr>
<tr>
<td></td>
<td>ID # 365849865-00</td>
</tr>
<tr>
<td></td>
<td>Policy/Group # 4ABDT</td>
</tr>
<tr>
<td></td>
<td>DOB: 02/13/1955</td>
</tr>
<tr>
<td></td>
<td>Gender: Male</td>
</tr>
<tr>
<td></td>
<td>SS # or ID #: 365-84-9865</td>
</tr>
<tr>
<td>Secondary Payer</td>
<td>None</td>
</tr>
<tr>
<td><strong>Patient Drug Allergies</strong></td>
<td>Codeine</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Patient Other Allergy</strong></td>
<td>Strawberries</td>
</tr>
<tr>
<td><strong>Current Mediation List</strong></td>
<td>Singulair, 10 mg/day, Albuterol Inhaler, and Clonazepam, 1 mg/day</td>
</tr>
<tr>
<td><strong>Preferred Pharmacy</strong></td>
<td>DanMart Pharmacy, 567 S. High Street, Douglasville, NY, 01234</td>
</tr>
<tr>
<td><strong>Lab Provider</strong></td>
<td>American Labs</td>
</tr>
<tr>
<td><strong>Privacy Statement</strong></td>
<td>Reviewed and signed May 15, 2007 Enter the following information in the Notes box: No one except the patient can receive private information. Do not leave any information on patient's answering machine.</td>
</tr>
</tbody>
</table>
| **Family Health History Info** | Father: Age 69, Health: Good  
Mother: Age 68, Health: Fair  
Brother: Age 45, Health: Fair  
Brother: Age 41, Health: Good  
Sister: Age 39, Health: Good  
Heart disease: Mother has CAD. Had stent surgery in March 2001.  
High blood pressure: Mother, controlled with medication.  
Asthma: Brother has asthma. Controlled with steroids and breathing tx.  
| **Hospitalizations, Blood Transfusions, and Serious Injuries** | Hospitals:  
1982, Lakeside Memorial Hospital, birth of oldest daughter  
1986, Lakeside Memorial Hospital, birth of youngest daughter  
1987, Lakeside Memorial Hospital, birth of son  
Blood Transfusions: No blood transfusions  
Serious Injuries: None |
| **Pregnancies** | 1982, female, C-section (baby’s heart rated dropped)  
1986, female, C-section (no complications)  
1987, son, C-section (no complications) |
| **Medical History** | Click the following diseases: asthma, chicken pox, and other. In the Note’s box, list the following:  
Asthma: Diagnosed in 1966. Treated with Singulair 10 mg/day and Albuterol Inhaler. Averages 1 attack every 1–2 months.  
Chicken pox: 1965 (no complications)  
Other: Seizure disorder, diagnosed in 1975. Clonazepam, 1 mg capsule/day. (Seizure-free for past 2 years) |
| **Health Habits** | Caffeine, 1 8-ounce cup of coffee/day. Does not smoke or drink alcohol. Occupation: Going to nursing school |
### Subjective Information

<table>
<thead>
<tr>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary tract symptoms:</td>
</tr>
<tr>
<td>Severity of Symptoms: 7</td>
</tr>
<tr>
<td>Duration: 3 days</td>
</tr>
<tr>
<td>Associated Symptoms: + Abdominal pressure or pain, back pain, fever, nausea/vomiting, and urinary frequency. - Hx of UTI, mucus in urine, or vaginal symptoms</td>
</tr>
<tr>
<td>Aggravating Symptoms: Not urinating</td>
</tr>
<tr>
<td>Relieving Factors: OTC pain reliever</td>
</tr>
</tbody>
</table>

### Objective Information

<table>
<thead>
<tr>
<th>Vital Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height: 67 inches</td>
</tr>
<tr>
<td>Weight: 135 pounds</td>
</tr>
<tr>
<td>Temperature: 101.4</td>
</tr>
<tr>
<td>Blood Pressure: 142/86</td>
</tr>
<tr>
<td>Pulse: 90</td>
</tr>
<tr>
<td>Respiration: 18</td>
</tr>
<tr>
<td>Pain: 7</td>
</tr>
</tbody>
</table>

Subjective Information and Vital Signs Entered By: Roger Wong, RMA

---

**CREATING A CHART**

1. In the Main Menu, click New Patients.
2. Complete all of the information within each tab of the Patient Information screen and save. Use Table B-4 to complete each tab.
3. Save each screen as you complete each tab.
4. Go back through each tab and make certain your information is correct and saved.
5. Click Main Menu.
6. Click the Patients tab.
7. Highlight Morgan Penrose and click Open Patient Record.
8. You should now be in the Patient Information Menu for Morgan Penrose.
9. Click the Legal icon.
10. Click the drop-down arrow in the box next to Privacy Statement. Click Yes and enter the Date of today’s visit in the date box. Enter the corresponding information in the Notes box from Table B-4. Save your information.
11. Return to the Patient Menu and click the Health History icon.
12. Enter the corresponding information from Table B-4 within each tab. Remember to save your information within each screen.
13. Click the Patient Menu, then Chart Notes.
14. Click New Office Visit. Enter the date and time of the patient’s visit.
15. Click Update Progress Note and then Save.
16. You are now ready to enter the patient’s subjective information. Start by clicking the Subjective tab.
17. Click the drop-down arrow in the Chief Complaint box.
19. Click Update Progress Note and then click Save.
20. Click Add HPI. Using the HPI information from Table B-4, enter the appropriate information. Click Save after entering the HPI data.
21. Click Progress Note. You should now be on the Subjective tab.
22. Click the Objective tab.
23. Using the patient data table, enter the appropriate information.
24. List Roger Wong as the medical assistant who entered the subjective information and vital signs.
25. Click Update Progress Note, then click Save.
26. Click the Progress Notes tab. Make certain all of your information populated correctly within the progress note.
27. Print the progress note and label it Task 2-2. Place it in your SYNAPSE folder. Leave the screen for the physician. Note: If you made an error in the progress note and do not recall how to correct it, refer to Help Box: Progress Notes.

The doctor goes in to examine Mrs. Penrose. When he comes out of the patient’s room, he instructs you to read the Plans section of the progress note. The plans state the following:

Plans: Complete UA and C&S. Rx for Septra DS Tab # 20, Take 1 tablet every 12 hours for 10 days, No refills. Rx for Singulair Tab, 10 mg, # 30. Take 1 tablet each day, 3 refills, Rx for Clonazepam Tablets, 1 mg, # 30. Take 1 tablet each day, 3 refills. Patient is getting ready to go to nursing school and needs the Hepatitis B series. Will give patient her first Hepatitis B shot today. Patient to return in 4 weeks for second Hepatitis B shot and a complete physical.

There are many tasks to perform, so time management is very important. Since the physician ordered a Complete UA and C&S, you will want to give the patient instructions for performing a clean-catch urine sample and hand the patient a labeled specimen container with cleansing towelettes. Inform the patient what to do with the sample once she collects it. While the patient is collecting the sample, you will create the electronic lab requisitions and prescriptions. Start by creating the lab requisition forms.

**Task 2-3: Creating a Lab Requisition**

1. You should still be in the Progress Note screen for the current visit.
2. Click the Labs icon.
3. Click the drop-down menu arrow in the Laboratory box and select American Labs. This is the lab that is listed as a provider for the patient’s insurance company.
4. Click the Ordering Provider drop-down arrow. Click Dr. Schwartz, since he is the provider who saw Mrs. Penrose today.
5. Click the appropriate payer company.
6. Click the General Lab Tests arrow.
7. Scroll through the list and click UA Complete.
8. In the Number of and Type of Specimens Sent, type One Clean Catch Urine Sample (125 ml).
9. In the Today’s Date box, enter the date of today’s appointment.
10. In the Specimen Prepared By box, select Roger Wong.
11. Choose No in the Was patient fasting? drop-down list.
12. Click Save.
13. Preview the lab order. Make certain it is correct.
14. Click the Print icon. Label this Task 2-3A and place it in your SYNAPSE folder. Close the preview screen.

You now need to create a lab requisition form for the UA Culture & Sensitivity. The information for the last test should still be on the screen, so you will only need to change the name in the General Lab Test box to UA C&S, and change the Number of and Type of Specimens Sent to 1 UA Culture Swab in Liquid Media. Make certain all information is correct before saving. Click Preview. Click the Print icon. Label the requisition form as Task 2-3B and place it in your SYNAPSE folder. Close out of the print preview. Click Lab History and make certain that both tests populated within the Incomplete Labs table. Return to the Patient Menu.

Next, you will create the prescriptions.

**Task 2-4: Creating Prescriptions**

1. Start in the Patient Menu screen for Morgan Penrose.
2. Click Prescriptions.
3. Create prescriptions for all the prescriptions listed under the Plans section of the progress note. The patient’s preferred pharmacy and payer information should automatically be loaded in the prescription screen. List the dosage for Septra as DS, which stands for double strength. Make certain you put today’s date in the Start Date box and the end date for 30 days later on all the prescriptions. There shouldn’t be any checks in the Start Date box or New Common Drug box.
4. Next click Save, Preview, and Print for each prescription. Label prescriptions as Task 2-4A through 2-4C and place in your SYNAPSE folder. **Note: If you made an error on one of the prescriptions and do not remember how to delete it, refer back to Help Box: Correcting a Prescription Error after Saving.**

Since the doctor also ordered a hepatitis B shot, you should print the vaccination information sheets form and consent form for that immunization.

**Task 2-5: Printing Educational VIS Forms**

1. Go to the Main Menu.
2. Click Patient Education Forms, and click Vaccination Information Sheets.
3. Click the Hepatitis B Form, and print it. Label it as Task 2-5 and place it in your SYNAPSE folder. Go to the File Menu and select Close.
4. Select Main Menu, then select Patients.
5. Select Morgan Penrose, and click Open Patient Record. You should now be in the Patient Information Menu for Morgan Penrose.

**Task 2-6: Creating and Printing an Immunization Consent Form**

1. Click the Authorization/Refusal Forms icon.
2. Click Immunization Consent Form.
3. Since the patient is only having one immunization today, click the drop-down arrow in the box beside 1. Click Hepatitis B. Do not do anything with the extra boxes.
4. Enter the name of the patient in the Typed Name box.
5. Enter the date of the visit in the Today’s Date box. Refer to Figure B-32 to make certain that the form is properly completed.

6. Click Print.

7. In the medical office, both the patient and medical assistant would sign this form prior to scanning it back into the chart. This form must be signed. Label your work as Task 2-6 and place it in your SYNAPSE folder.

Once you have everything printed, take all of the paperwork into the patient’s room. Give the patient all of her prescriptions and explain each one. Next, give the patient the VIS form for the hepatitis B immunization. Ask the patient to read the form thoroughly while you prepare the injection. After returning from preparing the injection, ask the patient if she has any questions. She states that she doesn’t. Ask the patient to sign the consent form. Then, you give the patient the injection. Following the injection, you give the patient her prescriptions and tell her to schedule an appointment for a thorough physical. Dismiss the patient. You now need to enter the injection within the electronic chart.

**Task 2-7: Entering Immunization Information in the Patient’s Immunization Log**

1. Go to the Patient Information Screen for Morgan Penrose.

2. Click Immunization Log.

3. Click the Update tab at the bottom of the screen. (If the patient had a previous vaccine, you will need to click Add Immunization before entering the information.)
4. Enter the information from Table B-5.

**TABLE B-5  TASK 2-7 IMMUNIZATION INFORMATION**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>05/15/2007</td>
</tr>
<tr>
<td>Time</td>
<td>9:30 AM</td>
</tr>
<tr>
<td>Ordering Physician</td>
<td>Dr. Schwartz</td>
</tr>
<tr>
<td>Immunization Name</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Number in Series</td>
<td>#1</td>
</tr>
<tr>
<td>Amt. Given</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>Location</td>
<td>R. Deltoid</td>
</tr>
<tr>
<td>Route</td>
<td>IM</td>
</tr>
<tr>
<td>Person Who Administered Injection</td>
<td>Roger Wong, RMA</td>
</tr>
</tbody>
</table>

5. Compare your screen to Figure B-33, then click Save.

6. Click Print All. Label the form Task 2-7 and place it in your SYNAPSE folder.

7. Click Close. You should now be in the Immunizations for Morgan Penrose log.

8. Close the screen. You should now be back in the Patient Information Menu screen.

**Task 2-8: Closing the Chart Note for Morgan Penrose**

Since the patient is finished and you are done working in the patient’s personal EMR, you can now close the chart note.

1. Click Chart Notes.
2. Click New Office Visit.
3. Click Update Progress Note, and then click Save.
4. Click Complete Visit. After you leave this page, you will be unable to enter any additional data within this chart note.

5. Click Patient Menu.

6. Click the Chart Notes icon. Check to make certain that the date of your progress note saved to the Previous Office Visits box. Open the box and preview it.

7. Click Chart Notes. If the progress note is not listed in the Previous Office Visits box, you did not correctly exit the note. Return to the New Office Visit screen and review the information. If the information is correct, click the Update Progress Note button, click Save, and then click Complete Visit. Check to make certain that the information saved correctly this time. Click the Main Menu icon.

**Task 2-9: Entering Immunizations on the Global Immunization Log**

Now that you entered the information in the patient’s personal information log, you will enter the information into the global immunization log. This log tracks all immunizations given in the office.

1. From the Main Menu, click Logs.
2. In the Global Immunization log drop-down list, choose Hepatitis B.
3. Click Open Selected Log, and then click Update.
4. Record the requested information. The only additional information you will need to complete this log is the Drug Form Injectable, Amt Given: 0.5 ml, Ordering Clinician: D.J. Schwartz MD, Manuf Name: CKD, Lot Number, 13698P, Exp Date: 06/15/2008, Who Administered: Roger Wong.
5. Click Save and then click Print All. Label the document Task 2-9. Click Close.
6. You should now see the Hepatitis B Immunization Log in the table.
7. Click the Close button at the bottom of the screen. Close the Open Selected Log screen. You should now be back at the Main Menu screen.

**Critical Thinking Questions for Module II**

1. Why do you think the physician ordered a culture and sensitivity in addition to the complete UA?
2. The patient arrived with urinary symptoms, so why do you think the physician ordered prescriptions for Clonazepam and Singulair in addition to the Septra DS? The patient also had Albuterol inhaler listed for her current meds. What might be a logical explanation as to why the physician didn’t order a prescription for this medication?
3. What would you do if the patient refused to sign the immunization consent form?
4. Why did you have to record the immunization on two separate logs?

**Module III**

**Today’s date: May 16, 2007**

**Appointments for May 16, 2007**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Appointment Time</th>
<th>Reason for Appointment</th>
<th>Clinician</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Cook</td>
<td>1:00 PM</td>
<td>Sports physical</td>
<td>Megan Speck, NP</td>
<td>Roger Wong, RMA</td>
</tr>
<tr>
<td>Blanche White</td>
<td>1:15 PM</td>
<td>Complete physical</td>
<td>Dr. Schwartz</td>
<td>Roger Wong, RMA</td>
</tr>
</tbody>
</table>
## TABLE B-6  KEVIN COOK’S DATA TABLE

<table>
<thead>
<tr>
<th>Data Category</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Name</td>
<td>Kevin R. Cook</td>
</tr>
<tr>
<td>Patient’s DOB</td>
<td>03/12/1995</td>
</tr>
<tr>
<td>Patient’s Chart Number</td>
<td>219365878</td>
</tr>
<tr>
<td>Patient’s Address</td>
<td>1756 Edgeview Road, Douglasville, NY 01234-1212</td>
</tr>
<tr>
<td>Patient’s Telephone Numbers</td>
<td>Home: 123-786-0098, No work number</td>
</tr>
<tr>
<td>Patient’s Employer Info</td>
<td>None</td>
</tr>
<tr>
<td>Gender, Marital Status, Blood Type &amp; Smoking Status</td>
<td>Gender: Male, Marital Status: Single, Blood Type: Leave blank (not known), Smoking Status: Non-smoker</td>
</tr>
<tr>
<td>Patient Picture Screen: Patient Notes</td>
<td>Patient prefers to be addressed by his middle name, which is Ryan.</td>
</tr>
<tr>
<td>Responsible Party Info</td>
<td>Responsible Party: Other (Father), Name: David M. Cook, SS # or ID #: 356-98-5987, Address and Home: 1756 Edgeview Road, Douglasville, NY 01234-1212, Home Phone: 123-786-0098, Work Phone: 123-876-0987, Employer: Self-employed, Douglasville, NY 01234-1212</td>
</tr>
<tr>
<td>Primary Payer Info</td>
<td>Name: Signal HMO, ID # 356985987-00, Policy Holder Information: Other (father’s information), Policy/Group: None, Gender: Male, DOB: 03/14/1967</td>
</tr>
<tr>
<td>Secondary Payer</td>
<td>None</td>
</tr>
<tr>
<td>Patient Drug Allergies</td>
<td>Aspirin</td>
</tr>
<tr>
<td>Patient Other Allergy</td>
<td>Dog and cat dander</td>
</tr>
<tr>
<td>Current Mediation List</td>
<td>None</td>
</tr>
<tr>
<td>Preferred Pharmacy</td>
<td>Douglasville Pharmacy, 7890 Cobblestone Place, Douglasville, NY</td>
</tr>
<tr>
<td>Lab Provider</td>
<td>Smith, Wright, &amp; Kennedy</td>
</tr>
<tr>
<td>Privacy Statement</td>
<td>Reviewed and signed, May 16, 2007, Enter the following information in the Note’s box: Father stated that private information may be left with him and the patient’s mother.</td>
</tr>
</tbody>
</table>
### Task 3-1: Creating an Electronic Chart and Progress Note

You are acting as Roger Wong in these exercises.

1. Using Table B-6, create an electronic chart and new progress note for Kevin Cook. Refer to Module I if you forget any of the specific components for creating a chart. The only difference in creating a progress note for this patient is that he is coming in for a sports physical instead of with symptoms.

2. Within the Subjective tab, type the words “Sports Physical” in the Chief Complaint box. You will not need to perform an HPI since the patient doesn’t have any symptoms.

3. Click Update Progress Note, then click Save.

4. Next, click the Progress Notes tab. You should see the words “Sports Physical” under the Chief Complaint heading within the Subjective tab.

5. Click the Objective tab and enter the objective information.

6. Click Update Progress Note, then click Save.

7. Click the Progress Notes tab. Your subjective and objective information should populate in the progress note.

8. Click the Print icon and label the assignment Task 3-1.

---

| Family Health History Info | Father: Age 40, Health: Good  
|                           | Mother: Age 39, Health: Good  
|                           | Brother: Age 16, Health: Good  
|                           | Sister: Age 9, Health: Good  
|                           | Heart disease: Maternal grandmother (heart attack at age 62).  
|                           | Other: Epilepsy, brother (onset at age 12, controlled with meds).  
| Hospitalizations, Blood Transfusions, and Serious Injuries | Hospitalizations: None  
|                                                           | Blood Transfusions: None  
|                                                           | Serious Injuries: None  
| Pregnancies | N/A  
| Medical History | Click the following disease: Chicken pox. In the Note’s box, list the following: Chicken pox: 1998 (no complications)  
| Health Habits | Caffeine, 3 12-ounce cans of soda per day. Does not smoke or drink alcohol. Does not work.  
| Subjective Information | Patient here for sport’s physical: Type “Sports Physical” in the Chief Complaint box.  
| Objective Information | Vital Signs:  
|                       | Height: 73 inches  
|                       | Weight: 165 pounds  
|                       | Temperature: 98.4  
|                       | Blood Pressure: 110/64  
|                       | Pulse: 64  
|                       | Respiration: 14  
|                       | Pain: 0  
|                       | Subjective Information and Vital Signs Entered By: Roger Wong, RMA  

---
You instruct Kevin on how to disrobe. Kevin’s dad hands you a sports physical form from Kevin’s school that needs to be completed. You give the form to Megan Speck, the nurse practitioner, before she examines the patient. Normally you would wait until the NP is finished with the patient to complete the record; however, you are finished recording this particular progress note, and you are ready to take a new patient to the room, so you complete and close the record at this time.

Task 3-2: Completing the Progress Note
1. Because you updated and saved the progress note information, you can now click the Complete Visit icon.
   
   Note: Remember that once you leave the screen, you will be unable to make changes.

2. Click the Patient Menu icon, and then click Chart Notes.

3. You should see the date of the visit in the Previous Office Visits box.

4. Click today’s visit date to make certain the note saved properly.

5. Click the Chart Notes icon, and then click the Main Menu icon.

Task 3-3: Entering Information in a Previously Created Chart
While the nurse practitioner is in the room with Kevin Cook, Blanche White enters the reception area. She has an appointment with Dr. Schwartz. Since you are covering both Megan Speck and Dr. Schwartz, you will be taking care of Mrs. White.

1. Start by clicking the Main Menu icon, if you aren’t already there.

2. Open Mrs. White’s EMR by clicking the Patients icon, selecting her name, and then clicking Open Patient Record.

3. Click the Demographics icon. Read the information in the Patient Picture tab to see if Mrs. White has a preference on how she wants to be addressed, or to see if there are any other notes that may need attention before calling back the patient. You notice there is nothing entered in this section. When the patient enters the examination room, you ask her if she has a preference for the way she wants to be addressed. The patient states that she prefers to be addressed by her first name. The patient goes on to tell you that her granddaughter is getting married this weekend, on May 18. This is an important event in the patient’s life, and you will want to ask her about the wedding on her next visit. Because of this, you should enter the information within the Patient Notes box as a reminder.

4. Enter the following notes in the Patient Notes box: Patient prefers to be addressed by her first name. Patient’s granddaughter is getting married May 18, 2007. (The next time the patient comes in to the office, you may want to ask the patient about the wedding.) Click Save.

You ask Blanche if any demographic information has changed since her last visit. She states that it hasn’t. Next, you ask if any legal information has changed since her last visit, such as privacy information, DNR information, etc. The patient once states it hasn’t. Now you are ready to create a new progress note.

1. Click the Patient Main button at the top of your toolbar. You should now be in the Patient Information Menu for Blanche White.

2. Click the Chart Notes icon, and then New Office Visit.

3. Enter the date and time of the patient’s appointment, and then click Update Progress Note. Click Save.

4. Click the Subjective tab. Enter “Complete Physical” in the Chief Complaint box. Click Update Progress Note, and then click Save.
5. Click the Objective Tab. Enter the following information:
   - Height: 60 inches
   - Weight: 164 pounds
   - Temperature: 97.8
   - Blood Pressure: 134/82
   - Pulse: 88
   - Respiration: 18
   - Pain: 0

   Subjective information and vital signs entered by Roger Wong, RMA

6. Click the Update Progress Note button, then click Save.

7. Click the Progress Notes tab. Make certain that all of your information populated correctly in the progress note.

8. Click the Print icon at the top of the toolbar and label the assignment Task 3-3. Place the assignment in your SYNAPSE folder.

9. Do not click the Complete Visit icon until the clinician has finished entering the information. For now, click the Main Menu icon.

You are now finished entering the information within the patient’s chart, and you instruct the patient how to disrobe. You leave the room and spot Megan, the nurse practitioner. Megan tells you Kevin Cook needs his second MMR shot because the parents cannot find records that prove he had the second immunization. The clinic in which he received the immunization is now closed. Mr. Cook and Kevin opted to have a second MMR instead of having a titer performed. Megan also tells you the patient needs a proof of appointment letter.

**Task 3-4: Retrieving and Printing a VIS Form and a Consent Form**

Since the patient needs an immunization, you will need to retrieve and print both a VIS form and an immunization consent form.

1. Click Patient Education Forms on the Main Menu screen.

2. Click Vaccination Information Sheets, then click MMR.

3. Print this form and label the assignment Task 3-4A.

4. Close the form and return to the Main Menu.

5. Click the Patients icon.

6. In the patient list, select Kevin Cook and click Open Patient Record.

7. Select the Authorization and Refusal Forms tab, and then click the Immunization Consent Form icon.

8. In box 1, choose MMR from the drop-down list.

9. Since the father is with the patient today, enter the father’s name, David Cook, in the Typed Name box at the bottom of the form.

10. Enter the date of the appointment in the Today’s Date box.
11. Print the form. Label the form Task 3-4B. In the medical office, the father would sign the form and the medical assistant would sign the witness box. Place Task 3-4A and Task 3-4B in your SYNAPSE folder.

12. Return to the Patient Information screen.

Now that you have printed the VIS and consent forms, you need to print a proof of appointment letter.

**Task 3-5: Printing a Proof of Appointment Letter**


2. Enter today’s date, the time of the appointment, and the clinician’s name.

3. Click the Print tab. Label the document Task 3-5 and place it in your SYNAPSE folder.

4. Return to the Main Menu.

You take the forms to the exam room, where the patient and his father are waiting. You ask the father to read over the VIS form and to sign the consent form while you go and prepare the immunization. You prepare the MMR immunization and re-enter the patient’s room. You administer the injection in the subcutaneous tissue of the patient’s left arm. The father of the patient asks if they can also have some kind of proof that the patient received his second MMR today. You tell the father that you can print him a copy of the immunization log from his electronic chart as soon as you enter the information.

**Task 3-6 Documenting an Immunization in the EMR and Printing a Copy for the Patient**

1. From the Patient Information Menu for Kevin Cook, click the Immunization Log icon.

2. Click the Update tab at the bottom of the box.

3. Complete the requested information by referring to Table B-7.

**TABLE B-7 TASK 3-6 IMMUNIZATION TABLE**

<table>
<thead>
<tr>
<th>Date</th>
<th>May 16, 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>1:25 PM</td>
</tr>
<tr>
<td>Ordering Clinician</td>
<td>Megan Speck, NP</td>
</tr>
<tr>
<td>Immunization Name</td>
<td>MMR</td>
</tr>
<tr>
<td>Number in Series</td>
<td>2</td>
</tr>
<tr>
<td>Amt Given</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>Location</td>
<td>Left Arm</td>
</tr>
<tr>
<td>Route</td>
<td>Sub Q</td>
</tr>
<tr>
<td>Person Who Administered Injection</td>
<td>Roger Wong, RMA</td>
</tr>
</tbody>
</table>

4. Save the information and print the form.

5. Label it Task 3-6 and place it in your SYNAPSE folder.

6. Click the Close icon. You should now see the immunization log for Kevin Cook. Close the immunization log for Kevin Cook.

You give the patient’s father a copy of the immunization log so that they have verification that Kevin received the immunization. Kevin and his father leave after waiting the appropriate amount of time following the injection.

You now need to enter the immunization information in the global immunization log within the Main Menu.
Task 3-7: Entering Immunization Information in the Global Immunization Log

1. From the Main Menu, click the Logs icon.
2. Click the Global Immunizations Log drop-down arrow, and select MMR.
3. Click Open Selected Log, and then select Update.
4. Enter the information found in the Table B-8.

TABLE B-8 TASK 3-7 GLOBAL IMMUNIZATION LOG TABLE

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>05/16/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Name</td>
<td>Kevin R. Cook</td>
</tr>
<tr>
<td>Drug Form</td>
<td>Injectable</td>
</tr>
<tr>
<td>Amt. Given</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>Ordering Clinician</td>
<td>Megan Speck, NP</td>
</tr>
<tr>
<td>Manufacturer’s Name</td>
<td>New York Pharmaceuticals</td>
</tr>
<tr>
<td>Lot Number</td>
<td>789451B</td>
</tr>
<tr>
<td>Exp Date</td>
<td>08/01/2008</td>
</tr>
<tr>
<td>Person Who Administered Injection</td>
<td>Roger Wong, RMA</td>
</tr>
</tbody>
</table>

5. Click Save and then print the form. Label the form Task 3-7.
6. Close the log and return to the Main Menu.

You just had a call sent back to you from the operator. It is Robert Green. He wants to know if he can have a prescription refill for his Cardizem.

Task 3-8: Documenting a Phone Call

You first need to bring up Robert Green’s electronic chart. Follow the steps below.

1. Click the Patients icon on the Main Menu.
2. Select Robert Green, and then click Open Patient’s Record.
3. Click Chart Note, and then click Telephone Call.
4. Enter 05/16/2007 in the Date box and 1:45 PM in the Time box.
5. Click Save.
6. Enter Robert Green’s name in the Name of Caller box.
7. Enter “Self” in the Relationship to Patient box.
8. Enter abbreviation, SAA, in the Caller’s Phone Number box.
9. In the Nature of the Call box, click Prescription Refill.
10. You should already be in the Prescription Refill tab, so check to see if the patient has any refills for Cardizem. The patient does not have any refills, so you will need to send an electronic task to the physician.
11. Click Cardizem in the Prescription Refill table.
13. In the Action Taken box, click the drop-down arrow and select Sent Electronic Task to Physician.
14. Choose Roger Wong as the Name of Clinician or Medical Assistant that Handled the Call.
15. Double-check all of your information to make certain that the information is correct. Click Update Telephone Call, then Save.
16. Click Complete Telephone Call. Take one last look, because once you exit this screen, you will no longer be able to make any changes.
17. Click Patient Menu. Click Chart Notes.
18. Double-click the 05/16/2007 Previous Telephone Calls Entry to view the saved message. Click Print. Label the document Task 3-8 and file it in your SYNAPSE folder.
19. Return to the Main Menu.

Now that you have finished the call, you go to see if Dr. Schwartz is finished with Blanche. Dr. Schwartz is just exiting the patient’s room when you arrive at the door. The doctor instructs you to read the Plans section of the progress note. The Plans section reads as follows:

Plans: In-Office PT and INR level today. After obtaining results, will adjust the patient’s Wafarin Sodium medication if necessary. Depression much better; will continue to monitor over next couple of months. Patient to return in two weeks for another Pro-Time and INR.

You will need to perform a PT and INR level on the patient using your new CLIA-waived analyzer. Start by creating a lab requisition form for the patient.

**Task 3-9: Creating a Lab Requisition Form**

1. From the Main Menu, click the Patients icon.
2. Select Blanche White from the list of patients, and click Open Patient Record.
3. Click the Lab Orders icon.
4. Click In-House Testing in the Laboratory box, since we are performing this particular testing in the office.
5. Click D. J. Schwartz MD in the Ordering Provider box.
6. Click Medicare as the Payer, since Medicare is the primary payer.
7. Click Prothrombin Time in the General Lab Tests box.
8. Do not type anything in the Number of and Type of Specimens Sent box because we are performing the test in-house.
9. Enter today’s date in the Today’s Date box.
10. In the Specimen Prepared By box, select Roger Wong.
11. Select Yes in the Was patient fasting? box.
12. Click Save.
13. Click Preview, and then click the Print icon on the Preview screen. Label it Task 3-9A and place in your SYNAPSE folder. Close out of the preview.
14. Create a New Lab Requisition for the INR order. The only thing that will need to be changed is the name of the general lab test. Change the name of the general lab test to INR. Click Save.

15. Click Preview, and then click the Print icon. Label it Task 3-9B and place it in your SYNAPSE folder.

16. Next, click the Lab History icon. You should see both tests entered on the Incomplete Labs Log, as well as a previous test that was performed.

17. If you made an error, follow the instructions for deleting a log in Module I.

You enter the patient’s room and perform the PT and INR via capillary stick. The results are as follows: PT 25.8 Seconds and INR 2.6. You will need to document this result in the Update Lab Results box.

**Task 3-10: Entering Lab Results in the Electronic Medical Record**

1. From the Lab Requisition for Blanche White screen, click Lab History.

2. Click the PT results, and then click Update Lab Results.

3. Enter 25.8 seconds in the Lab Test Results box.

4. Select Roger Wong as the Name of Person Who Recorded Results, enter the date of today’s appointment, and click Save.

5. Click the Lab History icon.

6. You should notice that the result was sent from the Incomplete Labs box to the Completed Labs box.

7. Now repeat the same action for the INR results. There is no unit for INR, so you can enter 2.6 as the result.

8. Make certain that the test was sent to the Completed Labs box.

9. Print the screen and label the Incomplete Labs form Task 3-10A. Label the Complete Labs form Task 3-10B. File the forms in your SYNAPSE folder.

After completing the documentation, you immediately notify the physician of the result so that the physician can make any necessary adjustments in the patient's medication. If the physician was waiting on the result before finalizing the progress note, the physician would be responsible for closing the note. However, since you are finished with this project, you will complete the progress note.

**Task 3-11: Finalizing the Progress Note**

1. Click the Current Visit tab for Blanche White.

2. Click Update Progress Note, and then click Save.

3. Click Complete Visit. *(Note: Make certain that everything is correct before leaving this screen, because once you leave you will be unable to make changes.)*

4. Click the Patient Menu icon, then Chart Notes. Click the 05-16-2007 visit in the Previous Office Visits box to preview the note.

5. Return to the Main Menu.

**Critical Thinking Questions for Module III**

1. What was the purpose for writing down the date of Blanche’s granddaughter’s wedding?

2. Why do you think Kevin’s father decided to have Kevin receive the second MMR instead of having a blood titer to determine Kevin’s level of immunity?
3. In regard to the telephone call for Mr. Green, what information in the prescription history section caused you to send an electronic task to the physician instead of calling in a prescription for the Cardizem?

4. When you documented the labs in Blanche’s electronic file, there was an outstanding blood test that was more than a month old? Which test was more than a month old. What would you do if you observed an outstanding test that was over a month old while working in the field?

5. What medication is Blanche taking that prompts the need to have Pro-Time and INR performed on a regular basis?

**Module IV: Procedure B-1 Create and Maintain the EMR**

Module IV is an EMR competency, and it is designed to test your knowledge in performing tasks within the electronic chart. No step-by-step instructions are included; use the Performance Evaluation Checklist at the end of this section as documentation of your competency in this skill.

Today’s date: May 17, 2007

Appointments for May 17, 2007

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Appointment Time</th>
<th>Reason for Appointment</th>
<th>Clinician</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul M. Myers</td>
<td>2:00 PM</td>
<td>Cold/flu symptoms</td>
<td>Dr. Heath</td>
<td>Fauna Stout, CMA</td>
</tr>
</tbody>
</table>

**Task 4-1: Creating an Electronic Chart and Progress Note**

1. Refer to Table B-7 for patient information. Create an electronic chart and new progress note for Paul Myers.

**TABLE B-7 PAUL MYERS’S DATA TABLE**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Paul M. Myers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s DOB</td>
<td>08/12/1945</td>
</tr>
<tr>
<td>Patient’s Chart Number</td>
<td>985632998</td>
</tr>
<tr>
<td>Patient’s Address</td>
<td>2487 Springdale Court, Douglasville, NY 01234-1212</td>
</tr>
<tr>
<td>Patient’s Telephone Numbers</td>
<td>Home: 123-786-6890 Work: 123-879-9865</td>
</tr>
<tr>
<td>Patient’s Employer Info</td>
<td>Douglasville Steel Douglasville, NY 01234-1215</td>
</tr>
<tr>
<td>Gender, Marital Status, Blood Type &amp; Smoking Status</td>
<td>Gender: Male Marital Status: Married Blood Type: O+ Smoking Status: Smoker</td>
</tr>
<tr>
<td>Patient Notes</td>
<td>Patient is hard of hearing in the left ear.</td>
</tr>
<tr>
<td>Responsible Party Info</td>
<td>Responsible Party: Self SS #: 985-63-2998 Address: SAA Home Phone: SAA Work Phone: SAA Employer: Douglasville Steel, Douglasville, NY 01234-1215</td>
</tr>
</tbody>
</table>
| **Primary Payer Info** | Name: Flexihealth  
ID # 985632998-00  
Policy/Group: 6532001  
Gender: Male  
Policy Holder: Self  
SS#: 985-63-2998 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Secondary Payer</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Patient Drug Allergies</strong></td>
<td>Penicillin</td>
</tr>
<tr>
<td><strong>Patient Other Allergy</strong></td>
<td>None</td>
</tr>
</tbody>
</table>
| **Current Mediation List** | Accupril capsules, 20 mg  
Glyburide tablets, 2.5 mg  
Viagra tablets, 50 mg |
| **Preferred Pharmacy** | DanMart Pharmacy 8700 Polaris Drive, Douglasville, NY 01234 |
| **Lab Provider** | American Labs                                   |
| **Privacy Statement** | Reviewed and Signed, May 17, 2007  
Enter the following information in the Note’s box: Can leave information on the patient’s home answering machine and with wife, Carol. |
| **Family Health History Info** | Father: Age at death: 72, Cause of death: Heart failure  
Mother: Age 84, Health: Poor  
Brother: Age 66, Health: Fair  
Sister: Age 54, Health: Good  
Diabetes: Type II diabetes both father and mother  
Heart disease: CHF, father  
High blood pressure: Mother, father, and brother |
| **Hospitalizations, Blood Transfusions, and Serious Injuries** | Hospitalizations: 1976, Riverside Hospital, hernia repair  
Blood Transfusions: None  
Serious Injuries: None |
| **Pregnancies** | N/A                                              |
| **Medical History** | Click the following diseases: Chicken pox, diabetes, high cholesterol, measles, mumps, other  
In the Note’s box, list the following:  
Chicken pox: UCHD (no complications)  
Diabetes: Type II, diagnosed in 1995, controlled with diet and oral medication  
High cholesterol: Diagnosed in 2001, diet controlled  
Measles: UCHD (no complications)  
Mumps: UCHD (no complications)  
Health Habits
Caffeine, drinks 1 10–12-ounce cup of coffee per day.
Tobacco: Smokes ½–1 pack of low-filter cigarettes per day. Has been a smoker for 32 years.
ETOH:
Drink type: Beer
Drinks per week: 6 pack
Occupation: Steel worker
Heavy lifting

Progress Notes: Date, Time, Clinician, and MA
Date: May 17, 2007
Time: 2:00 PM
Clinician: Dr. Heath
MA: Fauna Stout, CMA

Subjective Information
Chief Complaint: Cold, flu, sore throat
HPI:
Severity: 6
Duration of symptoms: 7 days
+: Ear pain, fever, head or facial pain, nasal drainage, productive cough.
–: Light sensitivity, nausea or vomiting or other GI disturbances, sore throat.
Relieving factors: OTC: Sinus/flu medication

Objective Information
Vital Signs:
Height: 70 inches
Weight: 215 pounds
Temperature: 99.7
Blood Pressure: 146/92
Pulse: 92
Respiration: 20
Pain: 6
Subjective Information and Vital Signs Entered By: Fauna Stout

2. When finished, print the note.
3. Label it Task 4-1 and place it in your SYNAPSE folder.
4. You will not complete the progress note until later.

**Task 4-2: Creating and Printing an Electronic Prescription**

1. Accupril, 20 mg Cap. Quantity: 30, Take 1 capsule each day, 0 refills
2. Atenolol, 50 mg, Tab, Quantity: 30, Take 1 tab each day before meals or at bedtime, 0 refills
3. Glyburide, 2.5 mg Tab, Quantity: 60, Take 1 tab in the morning and one tab in the evening, 0 refills
4. Viagra, 50 mg, Quantity: 10, Take 1–2 tabs 30 minutes before sexual intercourse, 0 refills
5. All prescriptions are considered one-month prescriptions.
6. Print and label the documents Tasks 4-2A through 4-2D and place them in your SYNAPSE folder.
Task 4-3: Creating and Printing Lab Requisition Forms
1. HgbA1c (in-house), patient was fasting.
2. Print and label it Task 4-3A and place it in your SYNAPSE folder.
3. Chem 12: American Labs, Patient was fasting, sent 1 SST tube.
4. Print and label it Task 4-3B and place it in your SYNAPSE folder.

Task 4-4: Entering Lab Results in the Patient’s Electronic Medical Record
2. Print and label the Incomplete Lab table Task 4-4A.
3. Print and label the Complete Lab table Task 4-4B.
4. Place both forms in your SYNAPSE folder.

Task 4-5: Printing Educational Forms and VIS Forms for the Patient
1. Diabetes and hypertension educational forms.
2. Shingles VIS form.
3. Print and label the forms Task 4-5A through 4-5C and place them in your SYNAPSE folder.

Task 4-6: Creating a Consent Form to go with Immunization
1. Print the form, label it Task 4-6, and place it in your SYNAPSE folder.

Task 4-7: Entering an Immunization in the Personal EMR

<table>
<thead>
<tr>
<th>Date</th>
<th>May 17, 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>2:45 PM</td>
</tr>
<tr>
<td>Ordering Physician</td>
<td>Dr. Heath</td>
</tr>
<tr>
<td>Immunization Name</td>
<td>Shingles</td>
</tr>
<tr>
<td>Number in Series</td>
<td>1</td>
</tr>
<tr>
<td>Amt Given</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>Location</td>
<td>Left Arm</td>
</tr>
<tr>
<td>Route</td>
<td>Sub-Q</td>
</tr>
<tr>
<td>Person Who Administered Injection</td>
<td>Fauna Stout, CMA</td>
</tr>
</tbody>
</table>

1. Print and Label the form Task 4-7.
Task 4-8: Entering an Immunization in the Global Immunization Log

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>05/17/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Name</td>
<td>Paul Myers</td>
</tr>
<tr>
<td>Drug Form</td>
<td>Injectable</td>
</tr>
<tr>
<td>Amt Given</td>
<td>0.5 ml</td>
</tr>
<tr>
<td>Ordering Physician</td>
<td>Dr. Heath</td>
</tr>
<tr>
<td>Manuf Name</td>
<td>New York Pharmaceuticals</td>
</tr>
<tr>
<td>Lot Number</td>
<td>2365879 C</td>
</tr>
<tr>
<td>Exp</td>
<td>12/10/2008</td>
</tr>
<tr>
<td>Person Who Administered Injection</td>
<td>Fauna Stout, CMA</td>
</tr>
</tbody>
</table>

1. Print and label it Task 4-8 and place it in your SYNAPSE folder.

Task 4-9: Creating and Printing a Proof of Appointment Letter

1. Label it Task 4-9 and place it in your SYNAPSE folder.

Task 4-10: Properly completing Paul Myer’s Progress Note from 05/17/2007

1. Label it Task 4-10 and place it in your SYNAPSE folder.

Task 4-11: Creating and Printing a Telephone Note

1. Date: May 27, 2007
2. Time: 4:15 PM
3. Patient is calling from home.
5. Sent electronic task to the physician.
7. Print and label it Task 4-11.
PROCEDURE B-1  Create and Maintain the EMR

TASK: Create an electronic medical record and perform various tasks within the EMR.

CONDITIONS: In a simulated medical office situation, students will be provided a computer, SYNAPSE software, and Module IV text information to perform the electronic tasks within the EMR.

STANDARD: The student will accurately create a medical record and perform electronic tasks from the directions provided in Module IV. The student will have a total of 1 hour to complete all tasks listed below. All documentation must be completed accurately. A maximum of three attempts may be used to complete the competency. Any step denoted by an asterisk (*) is a critical step; if omitted or incorrectly performed, the complete task must be repeated.

<table>
<thead>
<tr>
<th>PROCEDURE STEPS</th>
<th>POINTS POSSIBLE</th>
<th>FIRST ATTEMPT</th>
<th>SECOND ATTEMPT</th>
<th>THIRD ATTEMPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Task 4-1</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Task 4-1</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Task 4-2</td>
<td>15</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Task 4-3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Task 4-4</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Task 4-5</td>
<td>15</td>
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<td>7. Task 4-6</td>
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<tr>
<td>8. Task 4-7</td>
<td>15</td>
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<tr>
<td>9. Task 4-8</td>
<td>15</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. Task 4-9</td>
<td>15</td>
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<tr>
<td>11. Task 4-10</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Task 4-11</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE TIME BEGAN______

NOTE TIME ENDED______

Total Points Possible
Points Achieved by Student
Note: If grading on a 0–100 scale, when total possible points do not add up to 100, divide points earned by total points possible and multiply by 100 for equivalent score.

Evaluator’s Signature: ________________________________

Comments:

**ABHES COMPETENCY:** VI.B.1.a.(2)(n) Application of electronic technology; VI.B.1.a.(3)(b) Prepare and maintain medical records; VI.B.1.a.(3)(d) Apply computer concepts for office procedures; VI.B.1.a.(3)(e) Locate resources and information for patients and employers; VI.B.1.a.(5)(b) Document accurately.

**CAAHEP COMPETENCY:** III.C.3.a(1)(c) Organize a patient’s medical record; III.C.3.c(4)(c) Utilize computer software to maintain office systems; III.C.3.c(2)(d) Document appropriately.