



# FL EMR TRAINING MANUAL

UPDATED 03.09.2022



## FOREWARD

The information presented in this instruction manual has been developed and compiled to provide the end-user with a thorough understanding of the capabilities and operations of the Electronic Medical Record (EMR) system. It is strongly recommended that this manual be read thoroughly with all cautions noted and observed before using the system in practice.

The Florida Regional EMR Team would like to acknowledge GE Centricity for the resources listed below. These resources were used to develop the training manual specific to the Florida EMR environment.

- Centricity Practice Solution Companion Guide
- Fusion EMR Applications
- Collaboration with Fusion, Florida Department of Corrections (FDC) and Centurion

From the above resources, the Learning Management System (LMS), workflows and visual how-to guides have been developed to assist the end-users in performing their job duties as clinically indicated, per discipline.

Every effort has been made during development and testing, to make operations of the system as reliable and trouble free as possible. Should you experience trouble using the system, or a malfunction occurs, consult the help section of this manual for possible causes and/or corrective measures.

Florida also has a dedicated team of EMR specialist and trainers that are available throughout the state to assist with any questions or concerns related to the EMR system.

If the problem is related to accessing the EMR system, contact the Centurion IT Help Desk at:

Phone: 1-800-305-0468

E-mail: [HelpDesk@TeamCenturion.com](mailto:HelpDesk@TeamCenturion.com)

Tip: Use the **ctrl F** option to quickly find desired workflows within this document.



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Tip: Use the **ctrl F** option to quickly find desired workflows within this document.

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- GENERAL (ADMIN).....
- MEDICAL SERVICES (PROVIDERS) .....
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Tip: Use the **ctrl F** option to quickly find desired workflows within this document.

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## Logging In

**STEP1:** Type in your Login ID.

**STEP2:** Enter password and press tab.

**STEP3:** Select the Location of Care (LOC) from the drop down.

- The Location of Care defines where medical care is given.



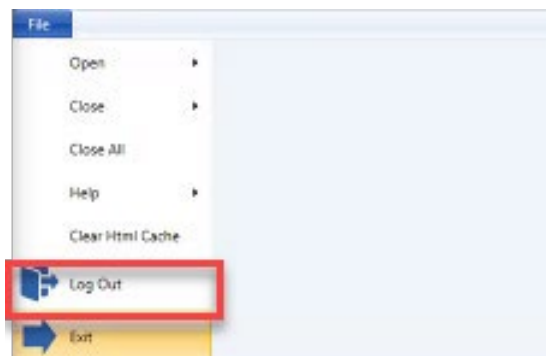
**Note:** This will be the same login used to access Centurion's network and/or computers.

## Logging Out

**STEP4:** The first location is in the **Title Bar** at the top of the EMR.



**STEP5:** The second place is under the **file tab** in the **Title Bar**.



\*\*\* At the end of the shift use the **Exit** button from the **file tab** select exit from Athena sign in page.

## How To – Find Patient and Begin/End a Document

### Find a Patient

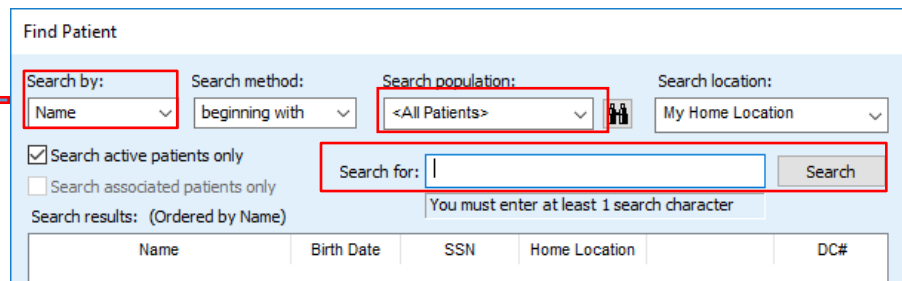


**STEP1:** Select **Find Patient icon** to search for patient. The **Find Patient** window will populate.

to search for patient. The **Find Patient**

**STEP2:** Enter patient's information and select appropriate patient listed under **Search results**.

**Note:** You can search by Name, DC number and other ways to access patient's chart.



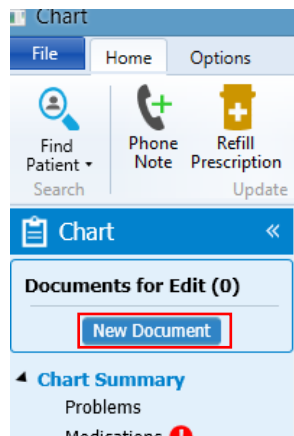
The screenshot shows the 'Find Patient' window with the following fields and options:

- Search by:** Name (dropdown menu)
- Search method:** beginning with (dropdown menu)
- Search population:** <All Patients> (dropdown menu)
- Search location:** My Home Location (dropdown menu)
- Search active patients only
- Search associated patients only
- Search for:** [Text input field]
- Search** button
- Search results:** (Ordered by Name)
- Table headers:** Name, Birth Date, SSN, Home Location, DC#

### Begin a Document

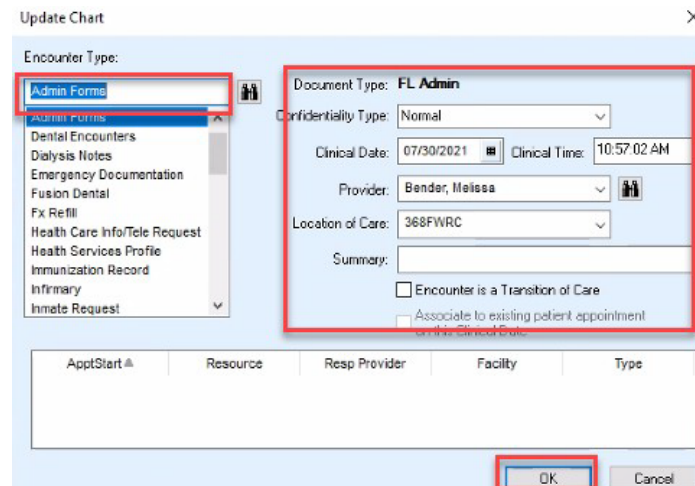
**STEP1:**

**STEP2:** Once within the patient's chart, select **New Document**.



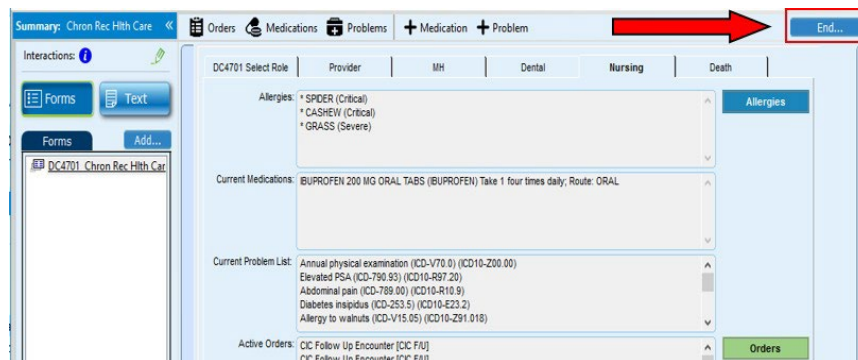
The **Update Chart** window will populate to select the appropriate **Encounter Type**.

**STEP3:** Once the **Encounter Type** is chosen select **OK**.



## Ending a Document

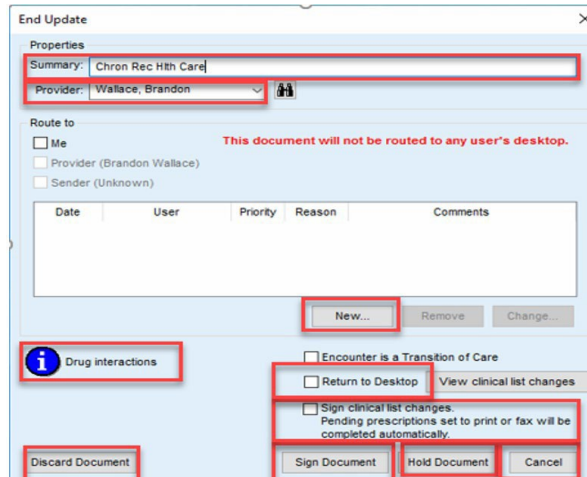
**STEP1:** Select **End** on the top right corner of the **Encounter**.



- **Properties** section:
  - **Summary:** Will display the summary title for the encounter. You will be able to edit this area if necessary.
  - This allows you to change the responsible provider if needed
- **Route to** Section:
  - This allows you to route the document to users' desktops by selecting the **New** button.
  - **Discard** – This will delete the document if created in error.
  - **Sign Document** – This allows the document to permanently become a part of the patient's chart.
  - **Hold Document** – If the document is not yet complete but you would like to move

on to another task you can use this option to come back to the document at a later time to complete.

- When a document is placed on **Hold** and there is no one selected in the **Route to** field the document will automatically be placed on the responsible provider's desktop with an **On Hold** status.
- **Cancel** – This option immediately allows you to return to the document.
- **Drug interactions** – This icon will allow you to review any interactions present. You can view this information by hovering over or selecting icon.
- **Return to Desktop** – Selecting this option will automatically route you back to the user desktop once the document is signed.
- **Sign Clinical list changes** - This option allows you to sign off on any added orders, allergies, medications, problems, directives etc. created within the encounter.



End Update

Properties

Summary: Chron Rec Hth Care

Provider: Wallace, Brandon

Route to


Me This document will not be routed to any user's desktop.

Provider (Brandon Wallace)

Sender (Unknown)

Date	User	Priority	Reason	Comments

New... Remove Change...

 Drug interactions

Encounter is a Transition of Care

Return to Desktop View clinical list changes

Sign clinical list changes.  
Pending prescriptions set to print or fax will be completed automatically.

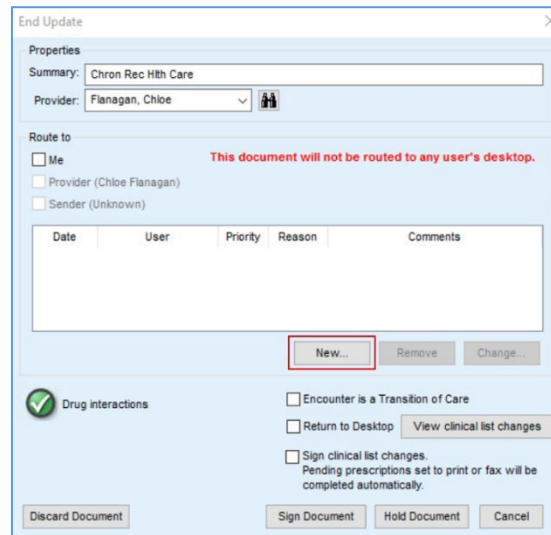
Discard Document Sign Document Hold Document Cancel

## How-To Sign, Route, Discard or Hold a Document

### How-To Route

**STEP1:** Once user selects **End** from within the encounter, the End Update box will appear.

**STEP2:** Select **New** button to add provider to route to.



End Update

Properties

Summary: Chron Rec Hth Care

Provider: Flanagan, Chloe

Route to

Me This document will not be routed to any user's desktop.

Provider (Chloe Flanagan)

Sender (Unknown)

Date	User	Priority	Reason	Comments
------	------	----------	--------	----------

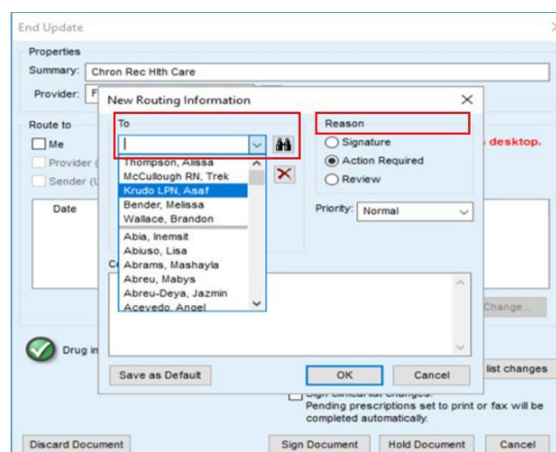
Drug interactions

Encounter is a Transition of Care

Return to Desktop

Sign clinical list changes.  
Pending prescriptions set to print or fax will be completed automatically.

**STEP3:** Use the **drop-down arrow** or the **binoculars icon** to select who the document is being routed to.



End Update

Properties

Summary: Chron Rec Hth Care

Provider: Flanagan, Chloe

Route to

Me This document will not be routed to any user's desktop.

Provider (Chloe Flanagan)

Sender (Unknown)

Date	User	Priority	Reason	Comments
------	------	----------	--------	----------

Drug interactions

Encounter is a Transition of Care

Return to Desktop

Sign clinical list changes.  
Pending prescriptions set to print or fax will be completed automatically.

New Routing Information

To: [ ]

Reason:

Signature

Action Required

Review

Priority: Normal

Thompson, Aissa

McCullough RN, Trek

**Kruko LPN, Asaf**

Bender, Melissa

Wallace, Brandon

Abia, Inemat

Abiuso, Lisa

Abrams, Mashayia

Abreu, Mabys

Abreu-Deya, Jazmin

Acevedo, Angel

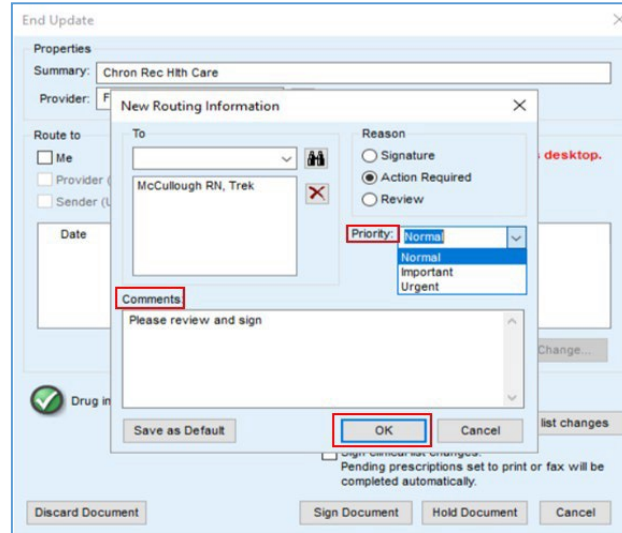
**STEP5:** Select **Priority:**

- Normal, Important or Urgent



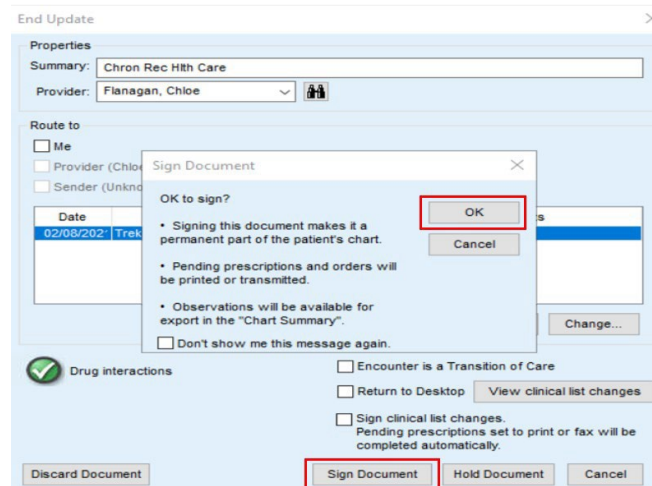
**STEP6:** Enter **Comments** in the comment box

**STEP7:** Select **OK**, to save selections.



### How-To Sign

**STEP1:** Select **Sign Document**. If information is applicable in the sign document box select **OK**

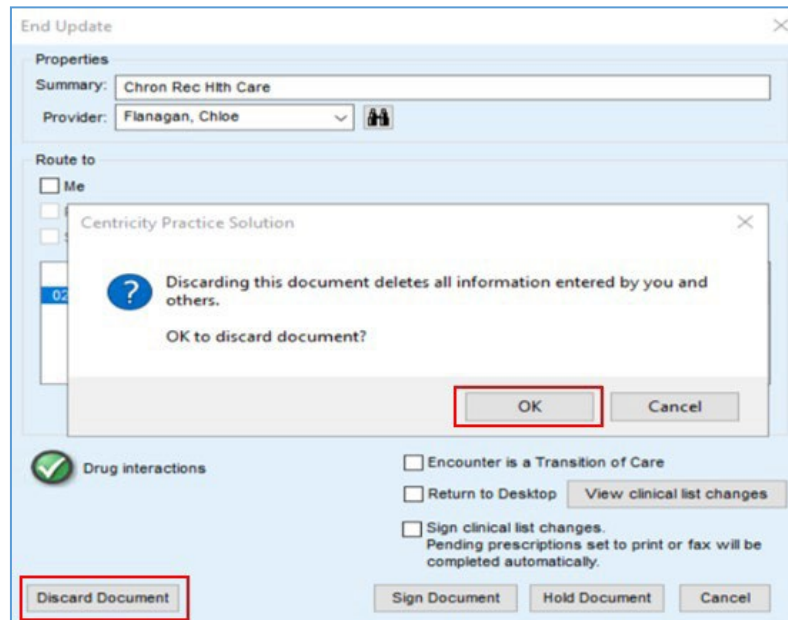


## How-To Discard a Document

**STEP1:** Select **Discard Document**. If information is erroneous select **OK**

## How-To Place Document on Hold

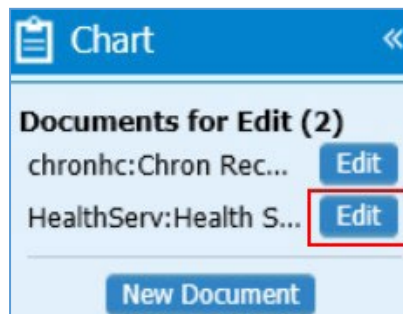
**STEP1:** If unable to complete the encounter at the time it was initiated, select **Hold Document**



- Documents on hold can be located under **Documents for Edit** in the patient's chart
- To return to the document select Edit to resume documentation within the encounter

**STEP2:** To resume a document that is on hold:

- Select the edit button located next to the desired document in the **Documents for Edit** section of the patient's chart





- In the **Documents** section of the provider's chart desktop that initiated the encounter
  - Select the desired document and **double-click** OR select the **Open** icon





## How To – Create and Complete Orders

### How to – Place an Order

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP2:** Select **New Document** to begin a new encounter.

**STEP3:** Choose the corresponding Encounter Type.

**STEP4:** Select your document and complete the form in its entirety.

**STEP5:** Select the **Orders** icon located on the top tool bar. This will cause the Update Orders window to open.

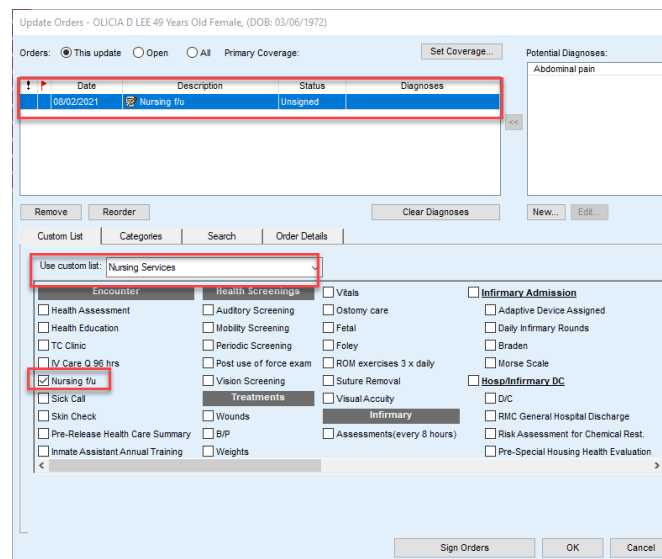
- Note: Some encounters will have a separate orders button within the form.



**STEP6:** Select **Use Custom List** drop-down to search for orders service type. (using Nursing Services for this example)

**STEP7:** Select appropriate order(s).

- Once the order is selected, it will move to the added orders box.



Update Orders - OLICIA D LEE 49 Years Old Female, (DOB: 03/06/1972)

Orders:  This update  Open  All Primary Coverage:  Potential Diagnoses: Abdominal pain

Date	Description	Status	Diagnoses
08/22/2021	Nursing flu	Unsigned	

Remove Reorder

Custom List Categories Search Order Details

Use custom list: Nursing Services

Encounter	Health Screenings	Vitals	Infirmiry Admission
<input type="checkbox"/> Health Assessment	<input type="checkbox"/> Auditory Screening	<input type="checkbox"/> Ostomy care	<input type="checkbox"/> Adaptive Device Assigned
<input type="checkbox"/> Health Education	<input type="checkbox"/> Mobility Screening	<input type="checkbox"/> Fetal	<input type="checkbox"/> Daily Infirmiry Rounds
<input type="checkbox"/> TC Clinic	<input type="checkbox"/> Periodic Screening	<input type="checkbox"/> Foley	<input type="checkbox"/> Braden
<input type="checkbox"/> IV Care Q 96 hrs	<input type="checkbox"/> Post use of force exam	<input type="checkbox"/> ROM exercises 3 x daily	<input type="checkbox"/> Morse Scale
<input checked="" type="checkbox"/> Nursing flu	<input type="checkbox"/> Vision Screening	<input type="checkbox"/> Suture Removal	<input type="checkbox"/> Hosp/Infirmiry DC
<input type="checkbox"/> Sick Call	<input type="checkbox"/> Treatments	<input type="checkbox"/> Visual Accuity	<input type="checkbox"/> D/C
<input type="checkbox"/> Skin Check	<input type="checkbox"/> Wounds	<input type="checkbox"/> Infirmiry	<input type="checkbox"/> RMC General Hospital Discharge
<input type="checkbox"/> Pre-Release Health Care Summary	<input type="checkbox"/> B/P	<input type="checkbox"/> Assessments(every 8 hours)	<input type="checkbox"/> Risk Assessment for Chemical Rest.
<input type="checkbox"/> Inmate Assistant Annual Training	<input type="checkbox"/> Weights		<input type="checkbox"/> Pre-Special Housing Health Evaluation

**STEP8:** Select **Order Details**.

**STEP9:** Complete the Clinical Information section and the Test Information section.

- If applicable, add a potential diagnosis by selecting the specific order and using the arrows between the two boxes to apply the Potential Diagnosis.

Update Orders - OLICIA D LEE 49 Years Old Female, (DOB: 03/06/1972)

Orders:  This update  Open  All Primary Coverage:  Potential Diagnoses: ABDOMINAL PAIN

Date	Description	Status	Diagnoses
08/04/2021	Nursing fu	Unsigned	

Remove Reorder Clear Diagnoses New... Edit...

Custom List Categories Search **Order Details**

Clinical Information  
 Description: Nursing f/u  
 Code: NURFU  
 NDC:  
 Authorized By: Bender, Melissa  
 Modifiers:  
 Instructions: Follow up after treatment for abdominal pain  
 Disposition: In Process

Test Administration  
 Priority:  Normal  Urgent  Stat  
 Start Date: 08/04/2021 End Date:  
 Duration: 0 Days Weeks Months  
 Quantity: 1 Create Transition of Care Document  
 Reason:  
 Test provider:  External  Internal Provider  
 Insurance Notes:  
 Change Coverage... Test Coordination...

Sign Orders **OK** Cancel

**STEP10:** Select **OK**. This will return to encounter.

**STEP11:** Select **END**.

**STEP12:** **Route** document if applicable.

**STEP13:** Select **Sign Document**.

## Complete orders from Patients Chart

**STEP1:** From the Patient's Chart desktop, select **Orders** from the left navigation pane.

**STEP2:** Once within the order view, highlight the corresponding order and select **Complete**.

**STEP3:** Select Orders to Complete window will open.

- Verify correct order(s) is checked.
- Verify your End Date is correct.

**STEP4:** Select **Ok** to complete the selected order(s).

New Document

Chart Summary  
 Problems  
 Medications  
 Allergies  
 Directives  
 Alerts / Flags

Documents  
**Orders**  
 Flowsheet  
 Histories  
 Protocols  
 Graphs  
 Handouts  
 Registration

set Up Links  
 Patient's MAR  
 Fusion Bedboard  
 Krames  
 Lab Manager  
 Fusion Order Manager

Orders

Date	Type	Description	Loc. Of Care
08/02/2021	Test	Nursing fu	368FWRC
08/02/2021	Test	Inmate Request- Medical Records	368FWRC

Select Orders to Complete

Select	Date	Description	Loc. Of Care	Status
<input type="checkbox"/>	08/02/2021	Inmate Request- Medical Records	368FWRC	In Process
<input checked="" type="checkbox"/>	08/02/2021	Nursing fu	368FWRC	In Process

Code:  
 Type:  
 Authorized By:  
 Prime Coverage:  
 Duration:  
 Clinical Notes:  
 Diagnosis:  
 Sent to Provider:  
 Sent to Insurance:  
 Red Flags:

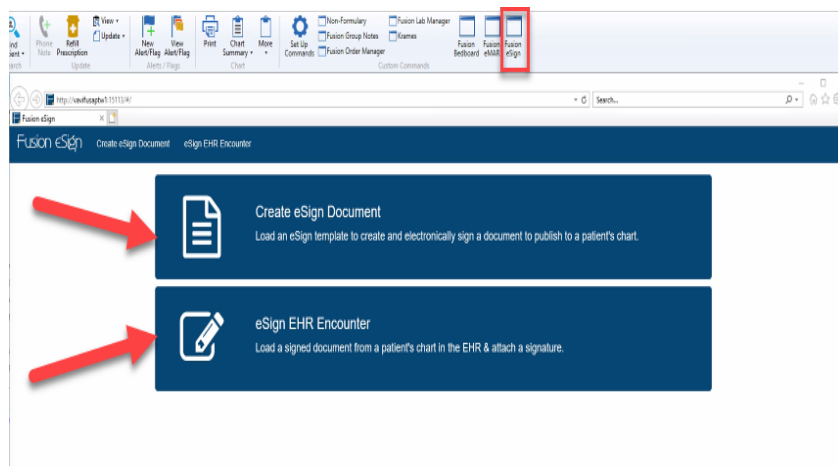
An asterisk (\*) indicates an order that should have been completed when a result document was signed. It wasn't because another user was changing orders for this patient when the document was signed.

Select All Clear All  
 End Date: 08/02/2021

Red flags for selected order

**OK** Cancel

## Fusion eSign Application



- Select the Fusion eSign icon on the top menu bar to open the Fusion eSign application.
- Select “Create eSign Document” if you are completing a document or form that requires signatures. An example of this would be a consent, receipt, or release of responsibility.
- Select “eSign Centricity Encounter if you need to add a real signature to an encounter. An example of this would be a Medical Release Summary.

The screenshot shows the 'Load Patient and Select A Template' screen in the Fusion eSign application. The screen is divided into two panes: 'Load Patient and Select A Template' and 'Preview Document'. The 'Load Patient and Select A Template' pane has fields for 'Search Patient', 'Select Template', and 'Select Header'. The 'Preview Document' pane shows patient information and a consent form. A red box highlights the 'Answer Questions for Template' section below the main form.

**Answer Questions for Template**

Medication

COMMON SIDE EFFECTS INCLUDE, BUT ARE NOT LIMITED TO

OTHER POTENTIAL SIGNIFICANT SIDE EFFECTS INCLUDE, BUT ARE NOT LIMITED TO

Time

12 10 PM

Date: 07/30/2021

Sun	Mon	Tue	Wed	Thu	Fri	Sat
27	28	29	30	01	02	03
04	05	06	07	08	09	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31
01	02	03	04	05	06	07

Continue

## Create eSign Document

- STEP1:** Search and select the patient
- STEP2:** Select the template/DC4 form.
- STEP3:** Select the header that matches the site location.
- STEP4:** Select Continue
- STEP5:** Answer question that are applicable per the template chosen.
- STEP6:** Select Continue.
- STEP7:** See Pg 2 for the next steps in the Create a eSign document

**Load Patient and Select EHR Encounter**

**Search Patient**  
XXTEST, JOAN (250404)

**Document Type Filter:**  
FL Refusal of HC Services

**Select EHR Encounter**  
Refusal of HC Services by Lottie F

**Select Header**  
368-FL WOMENS RECPN CTR

**Continue**

**Authorized Locations**

- 101-APALACHEE WEST UNIT
- 102-APALACHEE EAST UNIT
- 103-JEFFERSON CI
- 104-JACKSON CI
- 105-CALHOUN C.I.
- 106-CENTURY C.I.
- 107-HOLMES C.I.
- 108-WALTON C.I.
- 109-GULF C.I.
- 110-NWIRC MAIN UNIT.
- 111-GADSDEN C.F.
- 112-BAY C.F.
- 113-FRANKLIN C.I.
- 115-OKALOOSA C.I.
- 118-WAKULLA C.I.
- 119-SANTA ROSA C.I.

**Preview Encounter**

Patient: JOAN XXTEST  
DC#: Q50593  
DOB: 09/20/1950  
Sex: Female

Patient Location: 368-FL WOMENS RECPN CTR

FL Women's Reception Center  
3700 NW 111th Place  
Ocala, FL 34482  
Phone: 352.840.8000  
Fax: 352.402.6641

Refusal of HC Services

FLORIDA DEPARTMENT OF CORRECTIONS OFFICE OF HEALTH SERVICES  
REFUSAL OF HEALTH CARE SERVICES

This is to certify that I am refusing the following:  
Medical Services

I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the diagnosis, if known, the nature and purposes of the proposed procedure/treatment/medication, risks and benefits of the proposed procedure/treatment/medication, alternative treatments and their risks and benefits and the consequences and danger to my health and possibly to my life that may result from my refusal of this procedure/treatment/medication.

I have been given time to ask questions about my condition and about my decision to refuse the proposed procedure/treatment/medication that my health care provider has explained to me is medically indicated and necessary. I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment/medication and I am releasing the Department of Corrections, all health care providers, the facility, and facility staff from any and all liability for ill effects that may result from my refusal of treatment.

This form is to be signed in eSign by the Patient, Witnesses, Clinician and Interpreter/Translator if applicable.

## eSign EHR Encounter

- STEP1:** Search and select the patient.
- STEP2:** Select the Document Type Filter drop down and select the encounter.
- STEP3:** Select the EHR Encounter drop down and the appropriate DC4 form.
- STEP4:** Select the header that matches the site location.
- STEP5:** Select Continue.
- STEP6:** See below for the next steps to complete the document.

Patient's Endorsement

Review Document and Accept Legal Text

FL Women's Reception Center  
3700 NW 111th Place  
Ocala, FL 34482  
Phone: 352.840.8000  
Fax: 352.402.6641

Patient: JOAN XXTEST  
DC#: Q50593  
DOB: 09/20/1950  
Sex: Female  
Patient Location: 369-FL-WOMENS RECPN-CTR

FLORIDA DEPARTMENT OF CORRECTIONS OFFICE OF HEALTH SERVICES  
REFUSAL OF HEALTH CARE SERVICES

This is to certify that I am refusing the following:

Medical Services

I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the diagnosis, if known, the nature and purposes of the proposed procedure/treatment/medication, risks and benefits of the proposed procedure/treatment/medication, alternative treatments and their risks and benefits and the consequences and danger to my health and possibly to my life that may result from my refusal of this procedure/treatment/medication.

I have been given time to ask questions about my condition and about my decision to refuse the proposed procedure/treatment/medication that my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment/medication and I am releasing the Department of Corrections, all health care providers, the facility, and facility staff from any and all liability for ill effects that may result from my refusal of treatment.

This form is to be signed in eSign by the Patient, Witnesses, Clinician and Interpreter/Translator if applicable

DC4-711A Refusal of Healthcare Services (Revised 08/01/13)

This form is not to be amended, revised, or altered without approval of the Office of Health Services Administration.

This form is not to be amended, revised, or altered without approval of the Deputy Director of Health Services Administration.

I verify that I have read and agree to the terms printed above.

## Steps for both: Create a eSign Document and EHR Encounter

**STEP1:** Hand the Topaz Signature pad to the patient.

**STEP2:** Allow the patient to review the document.

**STEP3:** They will verify and agree to continue.


Patient's Endorsement

Review Document and Endorsements >

✖ Required Endorsements (0/1)

Topaz Signature Pad Touchscreen / Mouse Topaz Plus

Patient Sign Below Using Touchscreen or Mouse



Clear

Submit Signature to Preview

Return to Previous Step Remove Endorsement from Document Finalize Endorsement and Continue

**STEP4:** Make sure the Topaz Signature Pad is selected.

**STEP5:** Have the patient sign the pad.

**STEP6:** You can clear for them to re-sign or submit the signature for preview.

You also have the option to return to the previous step to make corrections to the document. You can NOT edit an encounter.

medical services

I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the diagnosis, if known, the nature and purposes of the proposed procedure/treatment/medication, risks and benefits of the proposed procedure/treatment/medication, alternative treatments and their risks and benefits and the consequences and danger to my health and possibly to my life that may result from my refusal of this procedure/treatment/medication.

I have been given time to ask questions about my condition and about my decision to refuse the proposed procedure/treatment/medication that my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment/medication and I am releasing the Department of Corrections, all health care providers, the facility, and facility staff from any and all liability for ill effects that may result from my refusal of treatment.

This form is to be signed in eSign by the Patient, Witnesses, Clinician and Interpreter/Translator if applicable

DC4-711A Refusal of Healthcare Services (Revised 05/01/13)

This form is not to be amended, revised, or altered without approval of the Office of Health Services Administration.

This form is not to be amended, revised, or altered without approval of the Deputy Director of Health Services Administration.



JOAN XXTEST 07/30/2021

✔ Required Endorsements (1/1)

Return to Previous Step Remove Endorsement from Document Finalize Endorsement and Continue

**STEP7:** Preview signature on document.

**STEP8:** If signer is satisfied with their signature, select Finalize and Continue.

Fusion eSign

Please hand the device back to the staff member.

Continue

**STEP9:** Retrieve the signature pad and Select continue.

Non-Patient Endorsements

Review Document and Endorsements >

✓ Required Endorsements (0/0)


0 Sgt. P. Brown (signature) ▾

Add Additional Endorsements

Sgt. P. Brown Add Signature

Topaz Signature Pad Touchscreen / Mouse Topaz Plus

Sgt. P. Brown Sign Below Using Touchscreen or Mouse



Clear Submit Signature to Preview

Remove Endorsement from Document Finalize Endorsement and Continue to Final Review


**STEP10:** Select any required signatures and make sure all required endorsements are completed

**STEP11:** To add additional endorsements type out the full name and title of the employee and select Add Signature.


**STEP12:** Clear if you need to re-sign or submit the signature for preview.

**STEP13:** Once all signatures are gathered and are added, select Finalize Endorsement and Continue to Final Review.

DC4-711A Refusal of Healthcare Services (Revised 08/01/13)  
This form is not to be amended, revised, or altered without approval of the Office of Health Services Administration.



JOAN XXTEST 07/30/2021



Sgt. P. Brown 07/30/2021


✓ Required Endorsements (0/0) + 2 Optional Endorsements ▾

Add Additional Endorsements


Sgt. P. Brown Add Signature

Remove Endorsement from Document Finalize Endorsement and Continue to Final Review

This form is not to be amended, revised, or altered without approval of the Deputy Director of Health Services Administration.



JOAN XXTEST 07/30/2021



Sgt. P. Brown 07/30/2021

Return to Previous Step Submit and Add to Patient's Chart

**STEP14:** Review the signed document again and select Finalize Endorsement and Continue to Final Review.

**STEP15:** Select the Submit and Add to Patient's Chart button to complete the document.



**STEP16:** The completed and saved document will open as a PDF file in which a copy can be printed for the patient. It should also be in the Patient's document section of their chart.

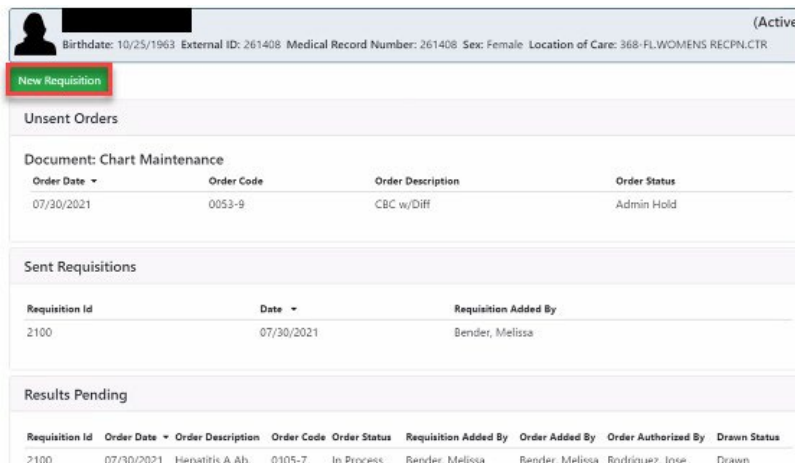


## How to Complete a Lab Requisition

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP2:** Select **Lab Manager** from the **Left Navigation Pane**.

**STEP3:** Select **New Requisition**.



Birthdate: 10/25/1963 External ID: 261408 Medical Record Number: 261408 Sex: Female Location of Care: 368-FLWOMENS RECPN.CTR (Active)

**New Requisition**

Unsent Orders

Document: Chart Maintenance

Order Date	Order Code	Order Description	Order Status
07/30/2021	0053-9	CBC w/Diff	Admin Hold

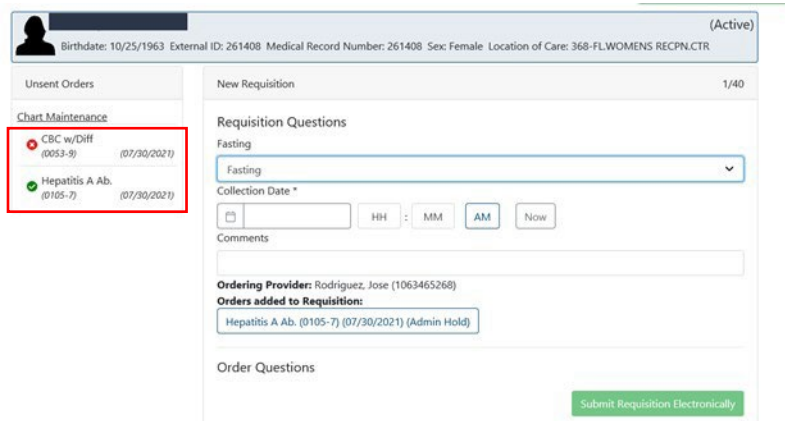
Sent Requisitions

Requisition Id	Date	Requisition Added By
2100	07/30/2021	Bender, Melissa

Results Pending

Requisition Id	Order Date	Order Description	Order Code	Order Status	Requisition Added By	Order Added By	Order Authorized By	Drawn Status
2100	07/30/2021	Hepatitis A Ab.	0105-7	In Process	Bender, Melissa	Bender, Melissa	Rodriguez, Jose	Drawn

**STEP4:** Select each lab to be drawn.



Birthdate: 10/25/1963 External ID: 261408 Medical Record Number: 261408 Sex: Female Location of Care: 368-FLWOMENS RECPN.CTR (Active)

Unsent Orders

Chart Maintenance

- CBC w/Diff (0053-9) (07/30/2021)
- Hepatitis A Ab. (0105-7) (07/30/2021)

New Requisition 1/40

Requisition Questions

Fasting

Fasting

Collection Date \*

HH : MM AM Now

Comments

Ordering Provider: Rodriguez, Jose (1063465268)

Orders added to Requisition:

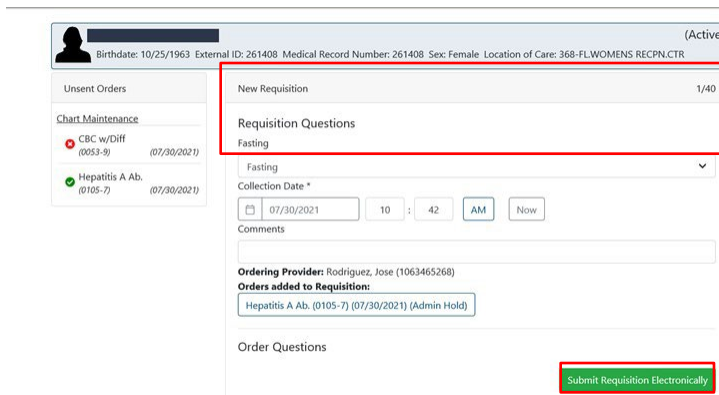
Hepatitis A Ab. (0105-7) (07/30/2021) (Admin Hold)

Order Questions

Submit Requisition Electronically

**STEP5:** Answer all questions applicable to the lab selection.

**STEP6:** Select **Submit Requisition**.



Birthdate: 10/25/1963 External ID: 261408 Medical Record Number: 261408 Sex: Female Location of Care: 368-FLWOMENS RECPN.CTR (Active)

Unsent Orders

Chart Maintenance

- CBC w/Diff (0053-9) (07/30/2021)
- Hepatitis A Ab. (0105-7) (07/30/2021)

New Requisition 1/40

Requisition Questions

Fasting

Fasting

Collection Date \*

07/30/2021 10 : 42 AM Now

Comments

Ordering Provider: Rodriguez, Jose (1063465268)

Orders added to Requisition:

Hepatitis A Ab. (0105-7) (07/30/2021) (Admin Hold)

Order Questions

Submit Requisition Electronically



**STEP7:** Select the **Print Labels** button to print the labels.

**STEP8:** Select the **Print Requisition** button to print the requisition.

Fusion Lab Manager Patient Search Order Search

Print Paper Requisition No DVMO Printers found.

F7301.2100DB BioReference Account: F7301  
 Electronic Requisition Address: 3700 NW 111TH PLACE  
 Order 2100 City, State: OCALA, FL  
 Zip: 34482

---

Patient Name: [REDACTED]  
 Date of Birth: 10/25/1963  
 Gender: F  
 Patient Race: White  
 Patient Ethnicity:  
 Patient ID: 261408  
Provider Information  
 Ordering Physician First: Jose  
 Ordering Physician Last: Rodriguez  
 NPI: 1063465268  
Order Code: Tests Ordered (Total: 1)  
 0105-7 Hepatitis A Ab.  
Clinical Information  
 Collection Date and Time: 07/30/2021 10:42  
AOE  
 Fasting: Fasting  
 Fasting: F  
 Collection Date: 07/30/2021 10:42  
 Comments:  
Diagnosis Codes  
 R01.1

**STEP9:** Place labels on tubes.

**STEP10:** Place tubes and requisition in bag for lab pick-up.

## Order Manager Workflow

**STEP1:** From the **Chart Desktop**, select **Fusion Order Manager** from the left navigation pane.

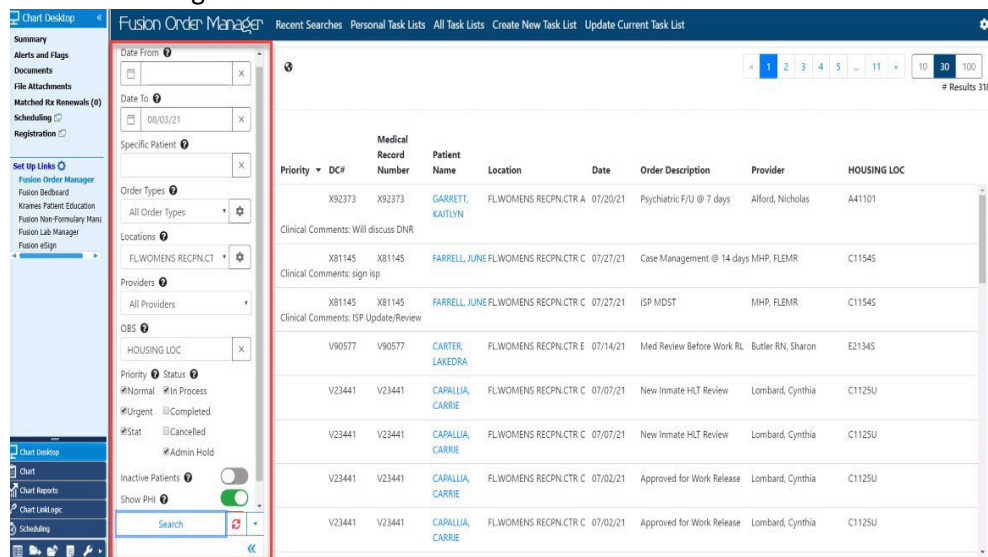
**STEP2:** In the **Order Manager** application, select the desired options for the search criteria

- Date
- Patient
- Order Type
- Location
- Provider “leave as all”
- OBS type in “Housing LOC” to add in the patients’ dorm/bunk location

**STEP3:** Use the toggle buttons to show or hide **PHI** and/or **Comments** (*order comments*).

**STEP4:** Select the **Priority and Status**, applicable to the schedule type being created.

**STEP5:** Select **Search** to generate the orders list.

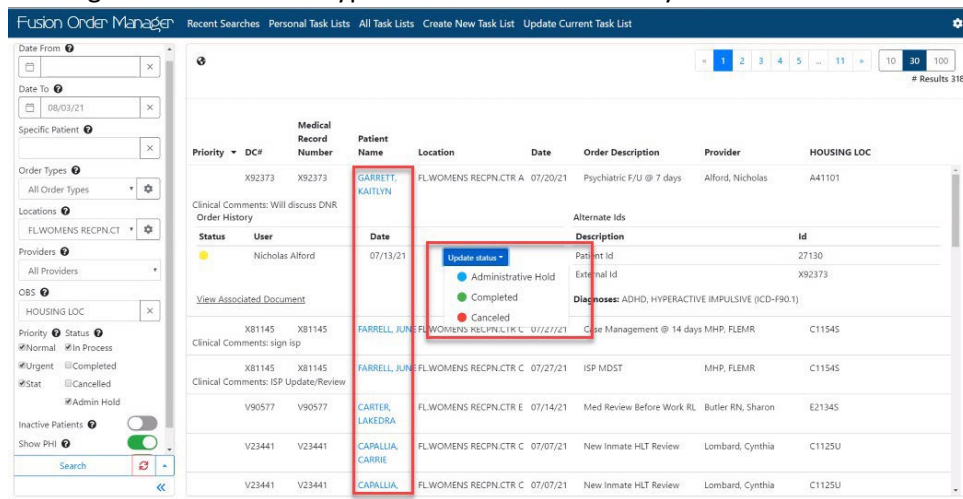


The screenshot shows the Fusion Order Manager interface. On the left, there is a navigation pane with options like Summary, Alerts and Flags, Documents, File Attachments, Matched Rx Renewals, Scheduling, and Registration. The main area displays search criteria: Date From (empty), Date To (08/03/21), Specific Patient (empty), Order Types (All Order Types), Locations (FLWOMENS RECPNCT), Providers (All Providers), and OBS (HOUSING LOC). The search results table is as follows:

Priority	DC#	Medical Record Number	Patient Name	Location	Date	Order Description	Provider	HOUSING LOC
	X92373	X92373	GARRETT, KAITLYN	FLWOMENS RECPNCTR A	07/20/21	Psychiatric F/U @ 7 days	Alford, Nicholas	A41101
Clinical Comments: Will discuss DNR								
	X81145	X81145	FARRELL, JUNE	FLWOMENS RECPNCTR C	07/27/21	Case Management @ 14 days MHP, FLEMIR		C11545
Clinical Comments: sign isp								
	X81145	X81145	FARRELL, JUNE	FLWOMENS RECPNCTR C	07/27/21	ISP MDST	MHP, FLEMIR	C11545
Clinical Comments: ISP Update/Review								
	V90577	V90577	CARTER, LAKEDRA	FLWOMENS RECPNCTR E	07/14/21	Med Review Before Work RL	Butler RN, Sharon	E21345
	V23441	V23441	CAPALLIA, CARRIE	FLWOMENS RECPNCTR C	07/07/21	New Inmate HLT Review	Lombard, Cynthia	C1125U
	V23441	V23441	CAPALLIA, CARRIE	FLWOMENS RECPNCTR C	07/07/21	New Inmate HLT Review	Lombard, Cynthia	C1125U
	V23441	V23441	CAPALLIA, CARRIE	FLWOMENS RECPNCTR C	07/02/21	Approved for Work Release	Lombard, Cynthia	C1125U
	V23441	V23441	CAPALLIA, CARRIE	FLWOMENS RECPNCTR C	07/02/21	Approved for Work Release	Lombard, Cynthia	C1125U

**STEP6:** Selecting the specific **Order** will allow you to **Update Status**.

**STEP7:** Selecting the Patient’s blue hyperlinked name will direct you to their chart.



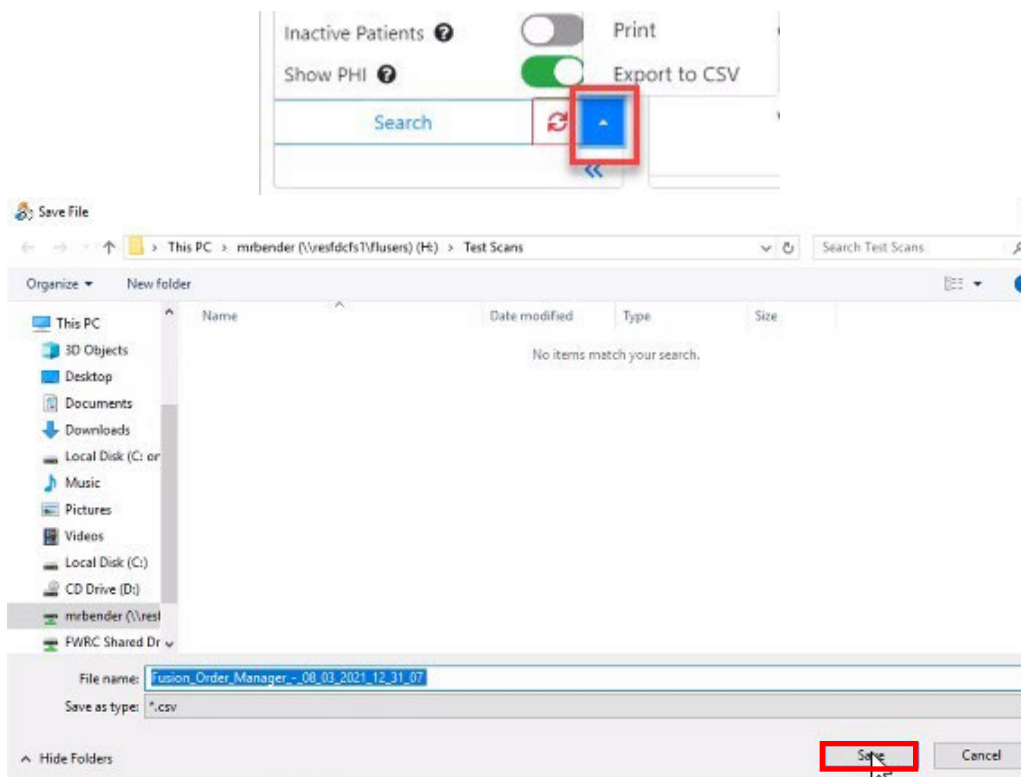
The screenshot shows the Fusion Order Manager interface with a detailed view of an order. The search criteria are the same as in the previous screenshot. The order details for X92373 are shown, including the patient name (GARRETT, KAITLYN), location (FLWOMENS RECPNCTR A), date (07/20/21), and order description (Psychiatric F/U @ 7 days). The provider is Alford, Nicholas, and the housing location is A41101. The status is 'In Process' (yellow dot). The user is Nicholas Alford, and the date is 07/13/21. The 'Update Status' button is highlighted with a red box. The 'Diagnoses' field shows ADHD, HYPERACTIVE IMPULSIVE (ICD-F90.1).

**STEP8:** To print or export the list, select the **blue drop down arrow** at the bottom left and select the desired option.

**STEP9:** Highlight and select **Print** and follow the printing prompts.

**STEP10:** Highlight and select **Export to CSV**.

- From the **File Download** window, select **Save**.
- From the **Save As** window opens. Select the appropriate file location to save your spreadsheet. (i.e.: *H Drive*)



**STEP11:** Enter the file name you would like to save it as, or keep the default name.

**STEP12:** Open the Excel spreadsheet, manipulate the spreadsheet to include or exclude any information desired. Information can now be saved, emailed, printed and provided to designated staff and/or departments.

## Fusion Group Notes Workflow

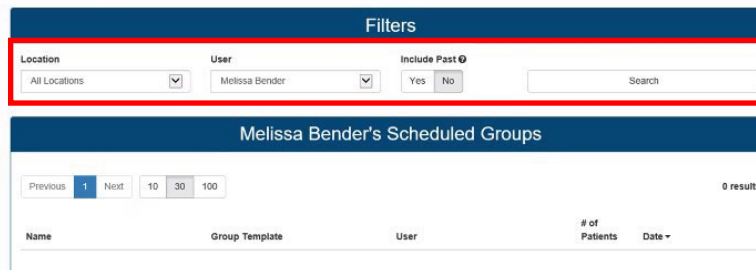
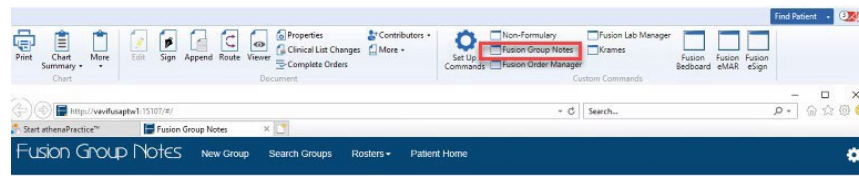
### Navigating to Group Notes

**STEP1:** Select **Fusion Group Notes** from the tool bar.

**STEP2:** The **Group Notes** page will load in a new browser window.

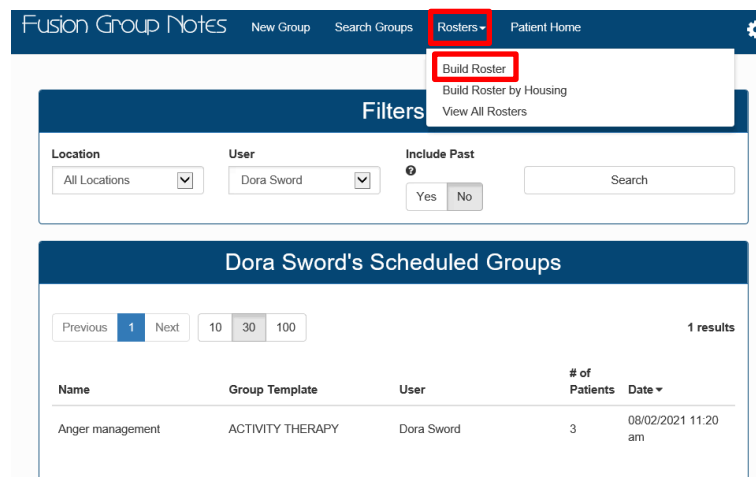
**STEP3:** The links in the menu include: New Group, Search Groups, Rosters, and Patient Home.

- If groups have been previously created, a list of all groups for the selected user will display on the landing screen. To filter the selected user's groups, select the **Location** and choose **Yes or No** to include past groups, and select **Search**.



### Creating/ Building a New Roster

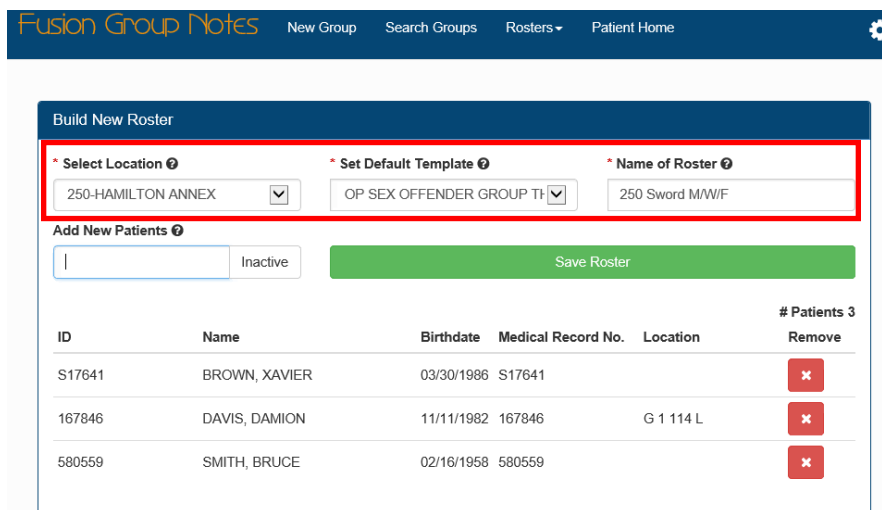
**STEP1:** Select **Rosters**, then **Build Roster**.



**STEP2:** Complete the three required fields:

- **Select Location-** If only one location is available, it will be automatically selected.
- **Set Default Template-** If the dropdown menu is empty, create a template.

- **Name of Roster**- follow the naming designation of: Site location number, staff name, with identifying markers such as days of the week and time. (ex. 368 Bender MWF 10am)
- **Add a New Patient** by typing either the patient's name or ID.

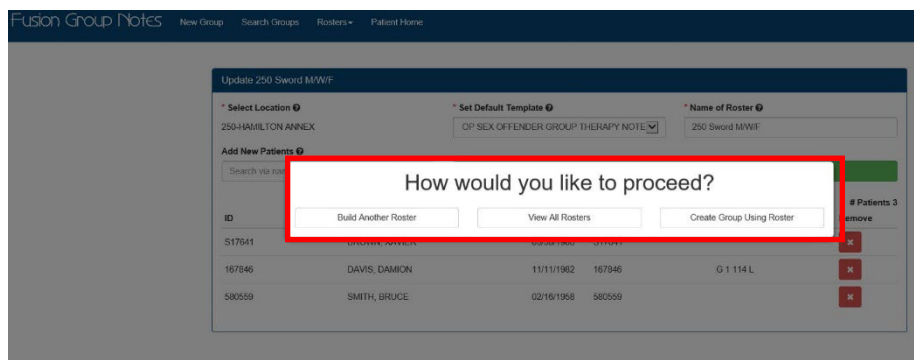


ID	Name	Birthdate	Medical Record No.	Location	# Patients 3	Remove
S17641	BROWN, XAVIER	03/30/1986	S17641			<input type="button" value="x"/>
167846	DAVIS, DAMION	11/11/1982	167846	G 1 114 L		<input type="button" value="x"/>
580559	SMITH, BRUCE	02/16/1958	580559			<input type="button" value="x"/>

**STEP3:** Select **Save Roster**.

**STEP4:** The user will be given the choice on **How would you like to proceed?**

- **Build Another Roster**- allows the user to be sent back to the same page to build another new roster.
- **View All Rosters**- redirects the user to the All Rosters page.
- **Create Group Using Roster**- redirects the user to the Create a Group page with the roster and template already filled in.



## Creating New Group Using “Create Group Using Roster”

**STEP1:** Enter **Group Name** in text box.

**STEP2:** Verify Start and End dates and times are correct, change if needed.

**STEP3:** Select **Save** to save the group documentation to complete later.

**STEP4:** Select **Save and Start** to begin documentation now.



### Create New Group

**Select Roster**

**Select a Group Template**

**Group Name**

**Start Time** 08/02/2021 12 : 14 PM

**End Time** 08/02/2021 01 : 14 PM

Roster (patients not on the roster can be added in group)

Jail ID	Name	Birthdate
S17641	BROWN, XAVIER	03/30/1986
167846	DAVIS, DAMION	11/11/1982
580559	SMITH, BRUCE	02/16/1958

Save
Save and Start

**STEP5:** Complete all documentation in its entirety for both sections and Finalize to add to patients charts.

Fusion Group Notes New Group Search Groups Rosters Patient Home

**Group Name:** Checkers Led by Dora Sword

Group Template: ACTIVITY THERAPY

**Start Time** 08/02/2021 12 : 14 PM **Stop Time** 08/02/2021 01 : 14 PM

**Overall Group Questions**

Activity

Fusion Group Notes New Group Search Groups Rosters Patient Home

**Patient Roster**

All Present All Absent

ID	Name	DOB
S17641	<b>BROWN, XAVIER</b>	03/30/1986
167846	DAVIS, DAMION	11/11/1982
580559	SMITH, BRUCE	02/16/1958

**Add Patients**

Search via name or ID

**Selected Patient Questions**

**BROWN, XAVIER J**  
Sex: M DOB: March 30, 1986 Medical Record No.: S17641

**Attendance**

**DC4-644 Attendance Record Key**

Attended  Refused  Cancelled by Security  Cancelled by Mental Health Staff  Off Unit

SHOS

**Duration (if refused, duration offered) in minutes**

**Level of Participation**

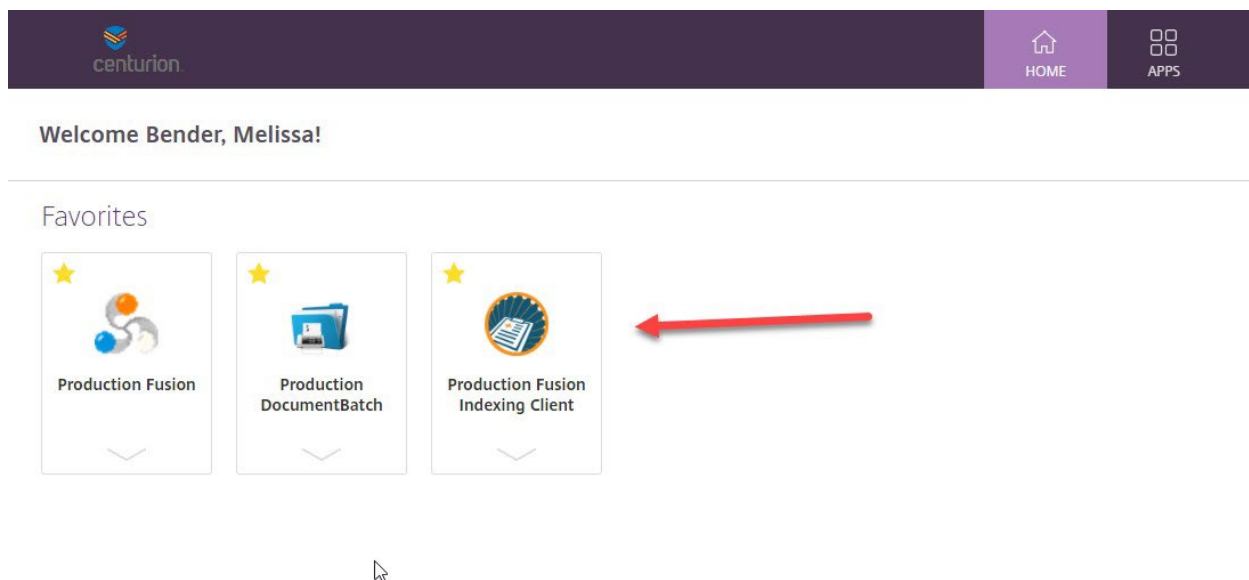
High  Moderate  Minimal  Did Not Participate

**Comments**

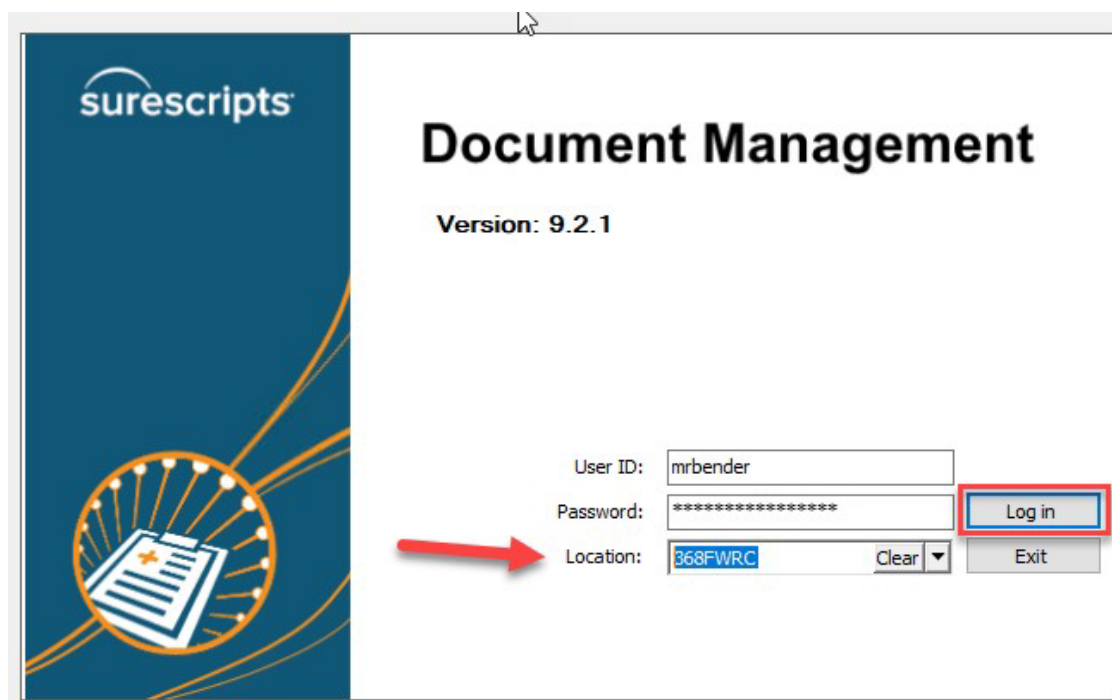
Finalize Entire Group Note and Add to Charts

## Importing Signed Document into EMR

**STEP1:** Select Indexing Client from APP Page.



**STEP2:** Sign into Indexing Client using your log in and password. Confirm correct Location of Care is selected.



**STEP3:** Scan the document using your assigned Scanner.

**STEP4:** Select the designated **Scanner number** from the Path drop down menu.



**STEP5:** Select the document you want to upload from your available files to highlight and hit the single arrow to add Files to import section.

**STEP6:** Import as: **Attachment**

**STEP7:** Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).

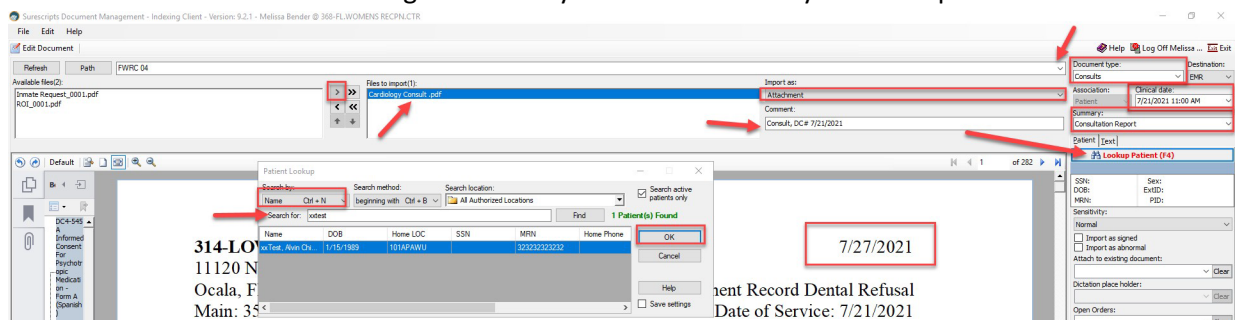
**STEP8:** Select appropriate **Document Type** from the list using the drop down arrow associated with the document you are uploading.

**STEP9:** **Clinical date** and time will auto populate to date and 12:00AM this will need to be changed to exact date and time of document.

**STEP10:** **Summary Text** will auto populate to Document Type this can be changed by highlighting and typing over it.

**STEP11:** Select **Lookup Patient**.

- From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.



**STEP12:** Sensitivity stays as **Normal**.

**STEP13:** Select **Import as Signed** box.

**STEP14:** Leave the **Import as abnormal** **unchecked**.

**STEP15:** Leave **attach to existing document** blank.

**STEP16:** **Open Orders** will stay blank.

**STEP17:** Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.

**STEP18:** Using the drop down arrow next to Physician name **select the name of the staff member who signed the document**.

- Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.

**STEP19:** Carbon copy option will be left blank.

Lookup Patient (F4)

**Alvin Chipmunk xxTest**

SSN:                      Sex: M  
DOB: 1/15/1989        EXID: 74062  
MRN: 3232323...      PID: 67

Sensitivity:

Normal

Import as signed  
 Import as abnormal

Attach to existing document:

Dictation place holder:

Open Orders:

Location of care:


368FWRC      Clear

Physician:

Bender, Melissa - ALL

Carbon copy

Import Document (F9)

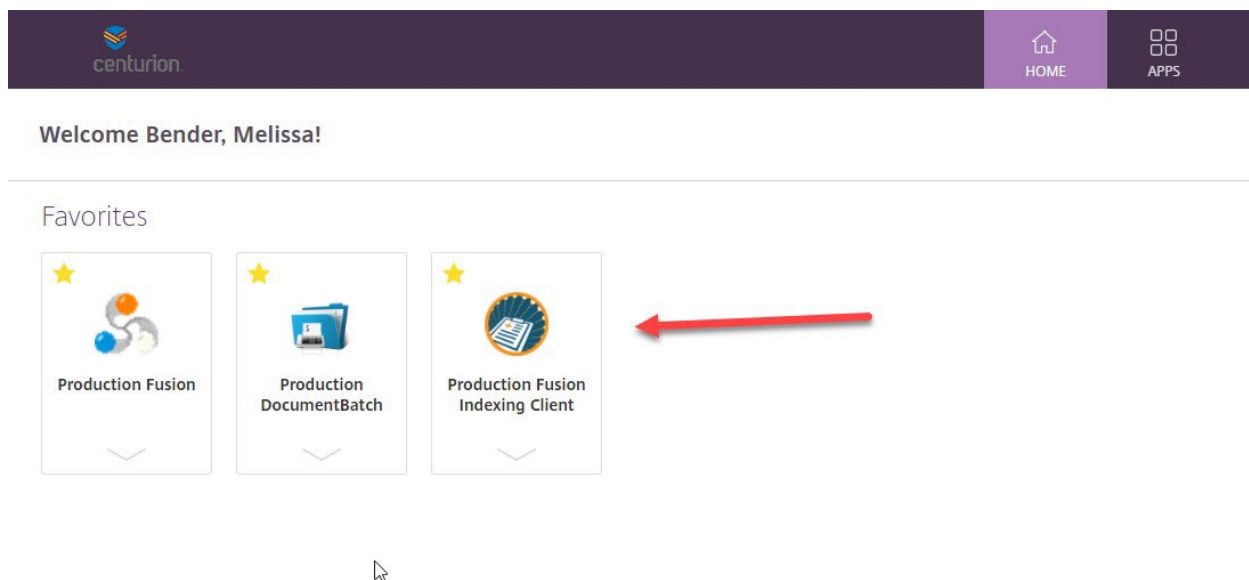


**STEP20: Select Import Document.**

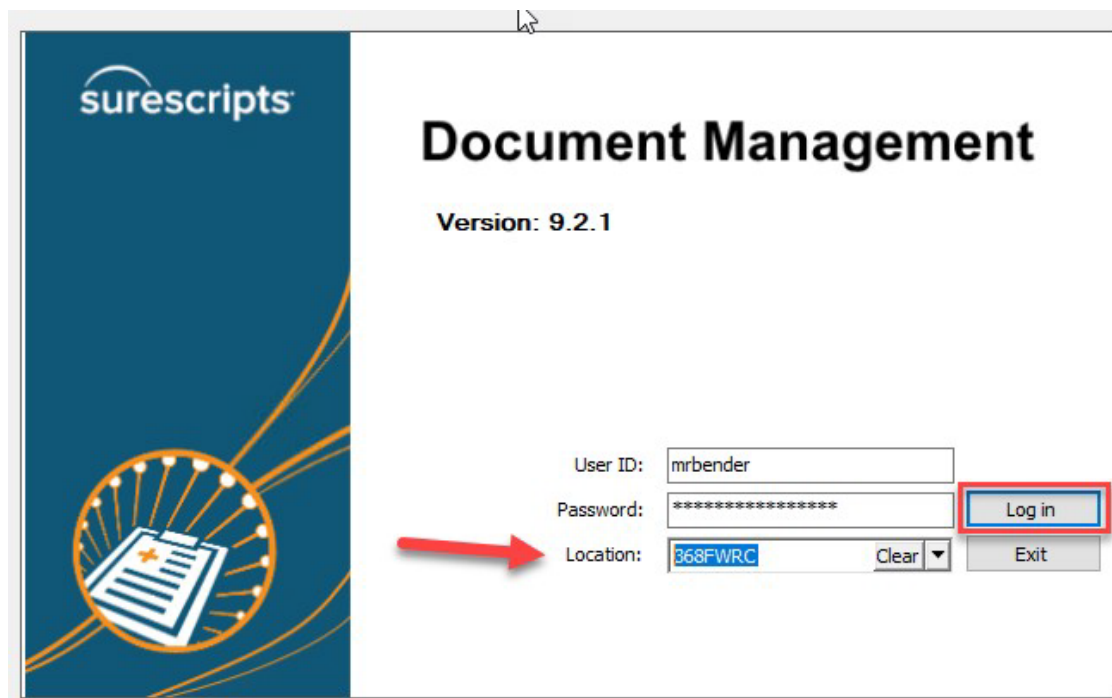
**STEP21: The document will then be imported into patients chart.**

## Importing Unsigned Document into EMR

**STEP1:** Select Indexing Client from APP Page.



**STEP2:** Sign into Indexing Client using your log in and password. Confirm correct Location of Care is selected.



**STEP3:** Scan the document using your assigned Scanner.

**STEP4:** Select the designated **Scanner number** from the Path drop down menu.

**STEP5:** Select the document you want to upload from your available files to highlight and hit the single arrow to add Files to import section.

**STEP6:** Import as: **Attachment**

**STEP7:** Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).

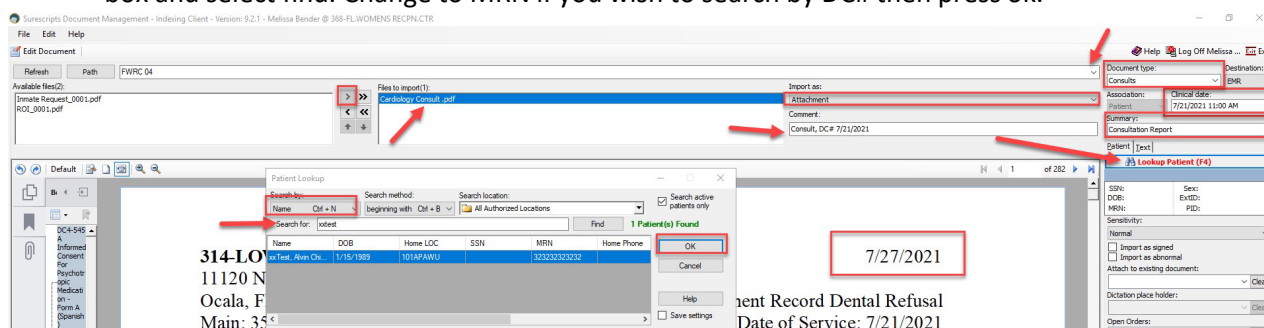
**STEP8:** Select appropriate **Document Type** from the list using the drop down arrow associated with the document you are uploading.

**STEP9:** **Clinical date** and time will auto populate to date and 12:00AM this will need to be changed to exact date and time of document.

**STEP10:** **Summary Text** will auto populate to Document Type this can be changed by highlighting and typing over it.

**STEP11:** Select **Lookup Patient**.

- From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.



**STEP12:** Sensitivity stays as **Normal**.

**STEP13:** Leave the Import as Signed box **unchecked**.

**STEP14:** Leave the Import as abnormal **unchecked**.

**STEP15:** Leave attach to existing document blank.

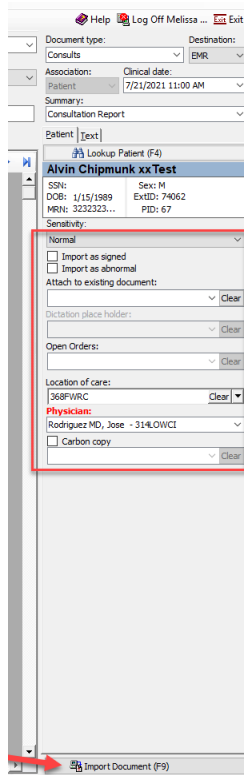
**STEP16:** Open Orders will stay blank.

**STEP17:** **Location of care**, ensure that the correct location is selected, if not use the drop down arrow to update.

**STEP18:** Using the drop down arrow next to Physician name **select the name of the staff member who needs to review and sign the document**.

- Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.

**STEP19:** By Selecting Carbon copy you are wanting the document to be sent to a second person to sign with the first one.



Help Log Off Melissa ... Exit

Document type: Consults Destination: EMR

Association: Clinical date: 7/21/2021 11:00 AM

Patient: Summary: Consultation Report

Patient | Text |

Lookup Patient (F4)

**Alvin Chipmunk xxTest**

SSN: DOB: 1/15/1989 Sex: M ExtID: 74062  
MRN: 3232323... PID: 67

Sensitivity:

Normal

Import as signed  
 Import as abnormal

Attach to existing document:

Dictation place holder:

Open Orders:

Location of care:

368FWRC

**Physician:**  
Rodriguez MD, Jose - 314LOWCI

Carbon copy

Import Document (F9)

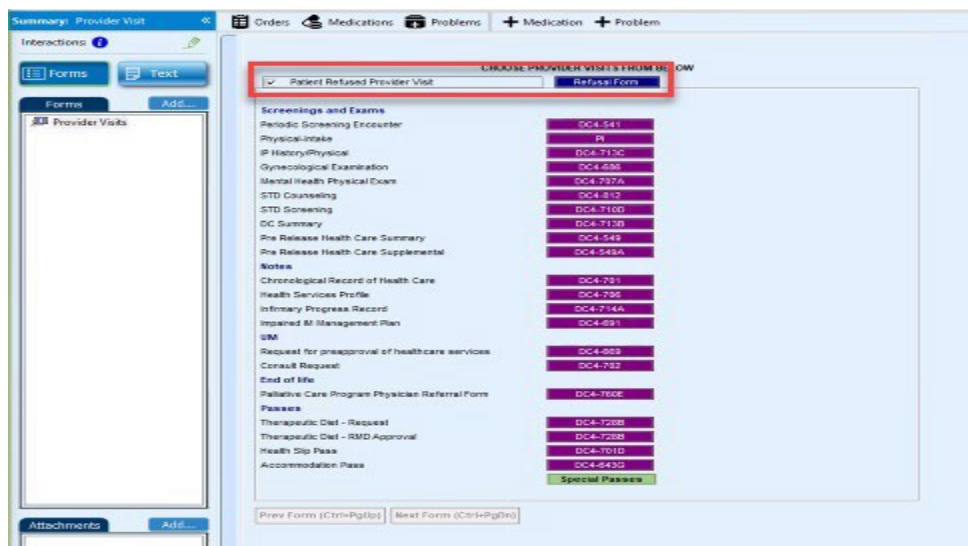
**STEP20:** Select **Import Document**.

**STEP21:** The document will then be imported into patients chart and sent to staff members' desktop to review and sign off on.

## How To – Complete a Refusal

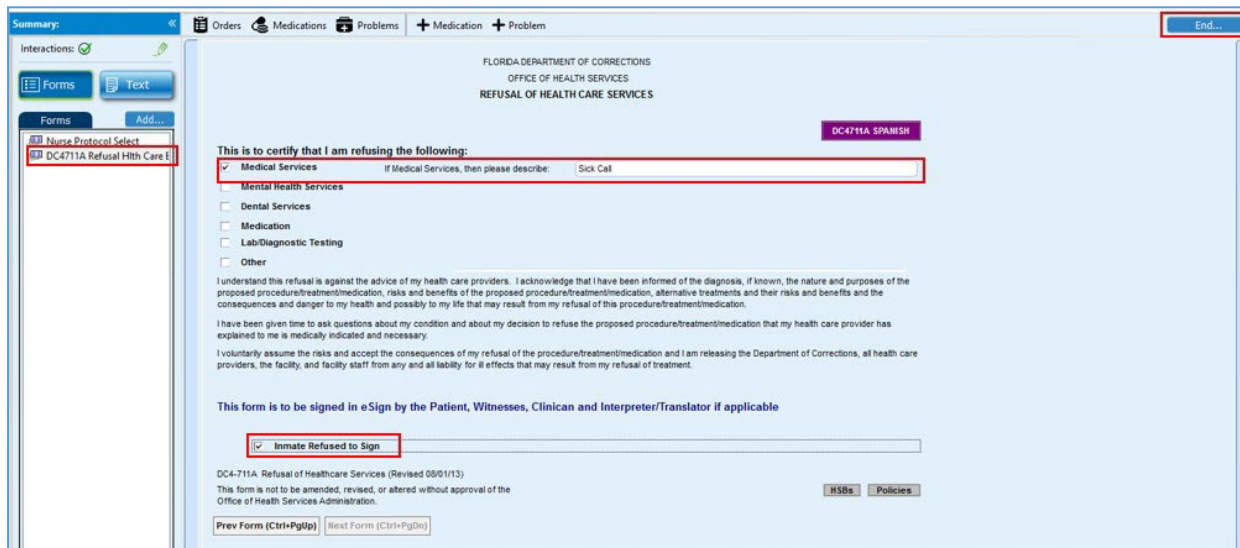
### Completing a Refusal

- STEP1:** Select the **New Document** button to open **Update Chart** window.
- STEP2:** Select the appropriate encounter type needed to satisfy the appointment. (In this example we are using Provider Visits).
- STEP3:** Select ok.
- STEP4:** Select the check box and choose **DC4-711a Refusal of Health Care Services** (the selection will vary with each encounter type)



Service	DC4 Code
Periodic Screening Encounter	DC4-541
Physical Intake	PI
IP History/Physical	DC4-713C
Gynecological Examination	DC4-535
Mental Health Physical Exam	DC4-737A
STD Counseling	DC4-532
STD Screening	DC4-710D
DC Summary	DC4-713D
Pre Release Health Care Summary	DC4-545
Pre Release Health Care Supplemental	DC4-545A
Notes	
Chronological Record of Health Care	DC4-731
Health Services Profile	DC4-735
Interim Progress Record	DC4-744A
Impaired Mgt Management Plan	DC4-691
ISM	
Request for preapproval of healthcare services	DC4-689
Consent Request	DC4-732
End of life	
Palliative Care Program Physician Referral Form	DC4-760C
Passes	
Therapeutic Diet - Request	DC4-728B
Therapeutic Diet - RMD Approval	DC4-728B
Health Svc Pass	DC4-101D
Accommodation Pass	DC4-543D
Special Passes	

- STEP5:** Complete the form as clinically indicated.
- STEP6:** If inmate refused to sign and witness will be Clinical Staff, select the corresponding check box.  
Note: If witness is Non-Clinical Staff documenting leave **Inmate Refused to sign box unchecked.**



**STEP7:** Select **End**.

**STEP8:** From the **End Update** box:

- Verify the **Summary** section is accurate and completed.

**NOTE:** All refusals forms must be routed to a provider for signature.

**STEP9:** Route to clinician and applicable Clinical staff members. Non- Clinical staff signatures will be captured in **Fusion eSign**.

- Select **New** button to add provider or another user to route to.
- Use the drop-down arrow or the binoculars icon to select who the document is being routed to.
- Select the applicable **Reason**:
  - Signature, Action Required or Review
- Select **Priority**:
  - Normal, Important or Urgent
- Enter comments in the **Comment** fields
- Select **OK**, to save selections

**STEP10:** Select **Sign Document** button.

**STEP11:** Go to Fusion eSign to collect patient signature and any other non-clinical staff members' signatures.

- Note: The encounter will need to be completed in order to be accessible within Fusion eSign. **See the Fusion eSign Workflow.**



End Update

Properties

Summary:

Provider:

Route to

Me

Provider (Melissa Bender)

Sender (Unknown)

Date	User	Priority	Reason	Comments
07/30/2021	Jesse Rodriguez MD	Normal	Signature	Please review and sign

**i** Drug Interactions

Encounter is a Transition of Care

Return to Desktop

Sign clinical list changes

Pending prescriptions set to print or fax will be completed automatically.



## Inmate Requests and Informal Grievances Step by Step

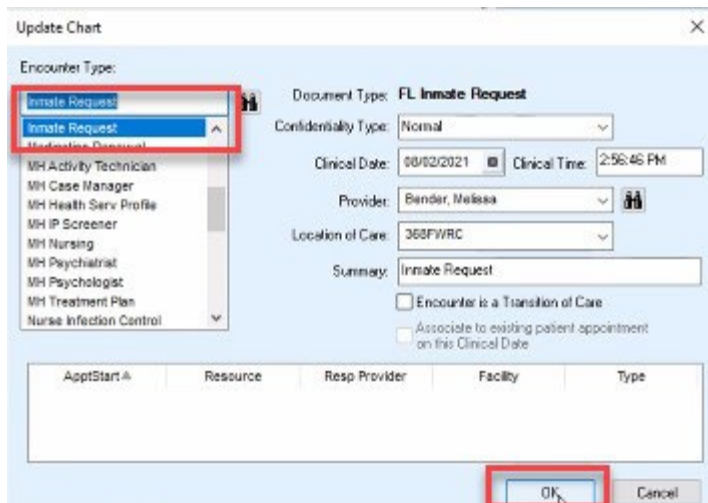
### Inmate requests Received/ Informal Grievances Received

\*Received documentation will be entered into the EMR before answering the request on original form\*

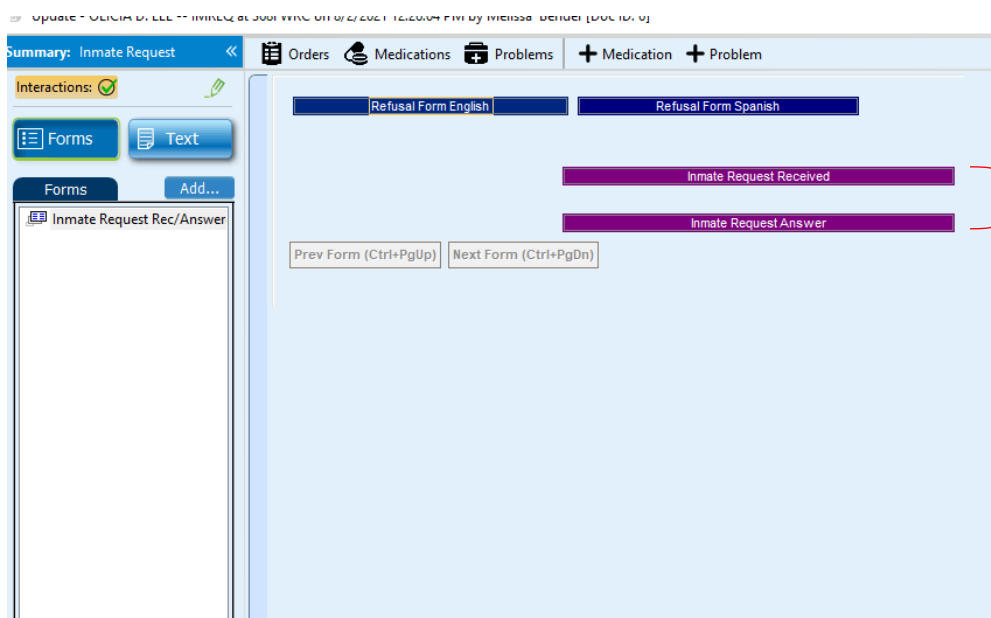
**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP2:** Select **New Document** to begin a new encounter.

**STEP3:** Select **Appropriate Encounter Type**. (For this example we are using the Inmate Request encounter type).



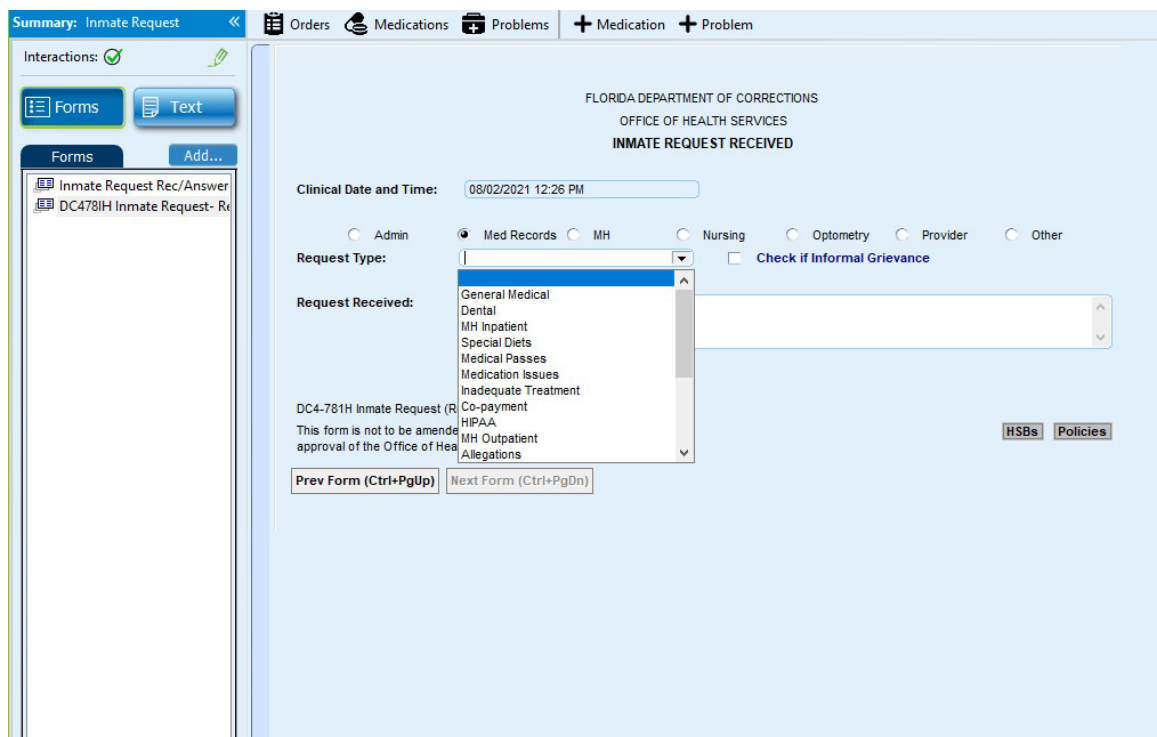
**STEP4:** Select **Inmate Request Received** button from your menu.



**STEP5:** Select the discipline it corresponds to as well as the request type.

- Select the **Informal Grievance** box if applicable.

**STEP6:** Complete form in its entirety, type a brief summary of patients request in text box.



**STEP7:** Scan received request and attach to document.

- See **Importing Document to Unsigned EHR Document Workflow** for attachment instructions.

**STEP8:** Add order for appropriate type of **Inmate Request**.

- Select **Orders** button.
- From Custom List drop down menu select **Inmate Request**.
- Select applicable order.
- Complete **Order Details**.
- Enter brief description of what patient requested in **Instructions** box of the **Order Details**.
- Press ok.

Update Orders - OLUCIA D LEE 49 Years Old Female, (DOB: 03/06/1972)

Orders:  This update  Open  All Primary Coverage:  Potential Diagnoses:

Date	Description	Status	Diagnoses
08/02/2021	Inmate Request- Medical Records	Unsigned	

Remove Reorder

Custom List Categories Search **Order Details**

Use custom list: Inmate Request

**Inmate Request By Department**

- Inmate Request- Admin
- Inmate Request- Dental
- Inmate Request- Medical Records
- Inmate Request- MH IP
- Inmate Request- MH OP
- Inmate Request- Nursing
- Inmate Request- RMC Hospital

**STEP9:** Select **End**.

**STEP10:** Select **Sign Document**.

**STEP11:** Deliver original paper request form to designated person to answer.

### Inmate requests Answer/ Informal Grievances Answer

\*Answers will be recorded on the original request and then recorded in the patients chart as follows.

**STEP1:** Follow steps **1-10** above selecting the **Inmate Request Answer**

**STEP2:** Create orders if applicable.

**STEP3:** When finished Select **End**.

**STEP4:** Select **Sign Document**.

**STEP5:** Complete applicable order for **Inmate Request**.

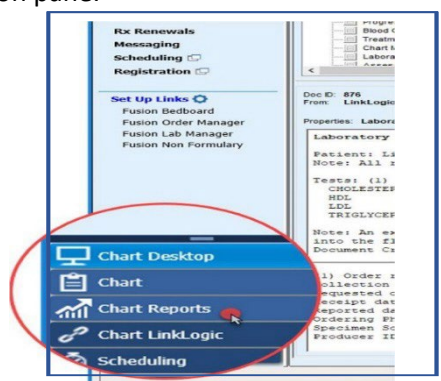
- a. Select **Orders** from left navigation pane.
- b. Locate and select applicable order, select to highlight order.
- c. Select Complete, verify correct order selected and select **OK**.

**STEP6:** Deliver original document back to patient.

## How To - Create, Save and View Inquires

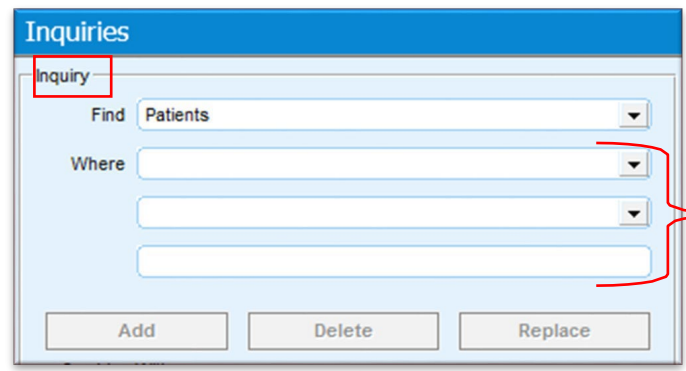
### Creating Inquires

**STEP1:** From your Chart Desktop screen, click the "Chart Reports" module at the bottom left navigation pane.



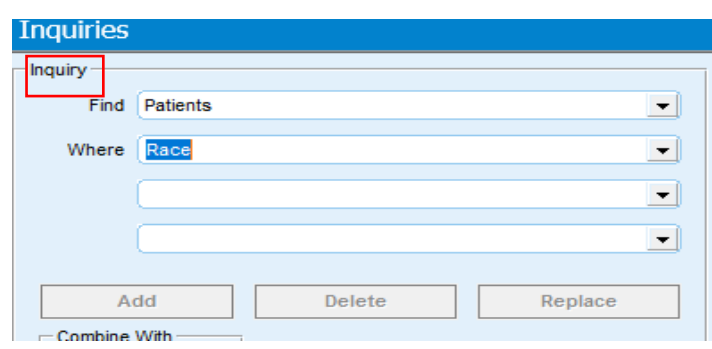
**STEP2:** The Inquiries window will populate. In the Find field, click the drop-down arrow to select what you wish to search for. For this example, we will select "Patients".

**STEP3:** In the Where field, click the drop-down arrow to select the search criteria. For this example,



Note: You can expand your results by using multiple criteria for your search starting with the

we will select "Race". In the next field below, click the drop-down arrow and select the comparison operator. For this example, we will select "is on or after".





In the last field, click the American Indian or Alaskan Native. The drop-down arrow and field will vary based on what you selected in the "Where" field. For instance, sometimes you will be able to type text in

The screenshot shows the 'Inquiries' interface. The 'Find' dropdown is highlighted with a red box and contains the text 'Patients'. Below it, the 'Where' dropdown is set to 'Race', and the relationship dropdown is set to 'is'. There is an empty dropdown field below the relationship field.

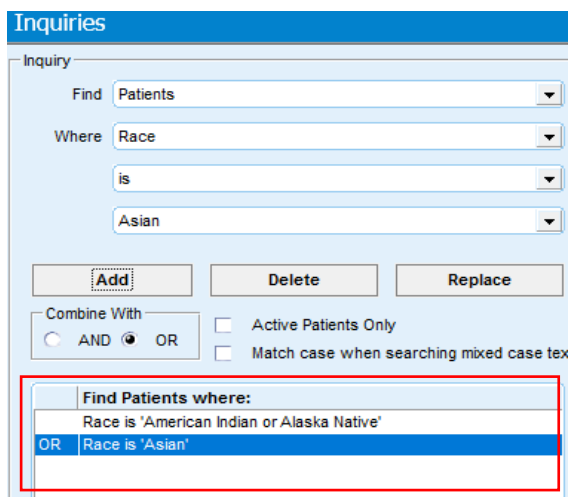
the field or be prompted to select from a list of values to choose from, etc.

This screenshot shows the 'Inquiries' interface with the 'Find' field set to 'Patients', 'Where' set to 'Race', and the relationship set to 'is'. The dropdown menu below the relationship field is open, and 'American Indian or Alaska Native' is highlighted with a red box.

**STEP4:** Click the Add button to add your search criteria, which will appear in the "Find patients where:" section below.

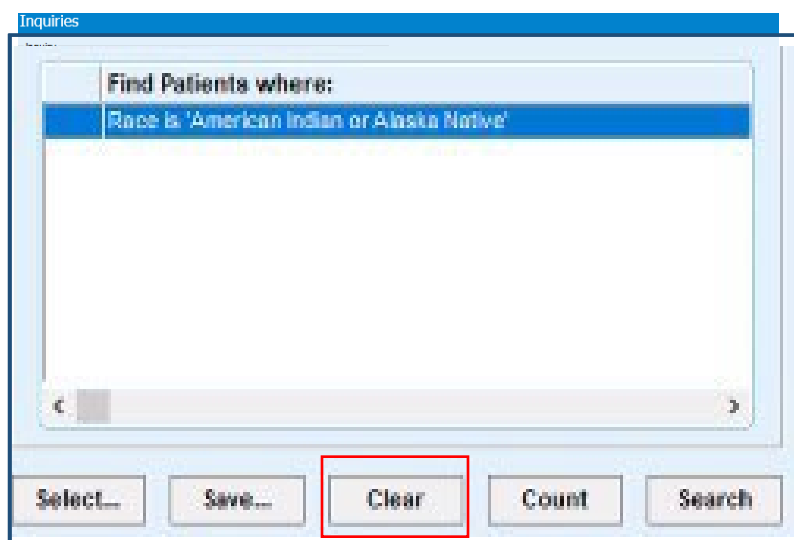
The screenshot shows the 'Inquiries' interface with the 'Add' button highlighted by a red box. Below the 'Add' button are radio buttons for 'Combine With' (AND is selected, OR is unselected) and checkboxes for 'Active Patients Only' and 'Match case when searching mixed case text'. At the bottom, the 'Find Patients where:' section displays the criteria: 'Race is 'American Indian or Alaska Native''.

**STEP5:** To add additional criteria to your inquiry, repeat steps 3-6 (remember, only choose one option from “Find” in a single query). Each time you click the Add button, the criteria will be added to the “Find Documents” section.



**STEP6:** If at any point, you need to modify any of the criteria, first highlight the line you wish to change. To remove the criteria, simply press the Delete button. To change the criteria, ensure you have modified the Where field and/or any of the other two (2) fields below it first, and then click Replace.

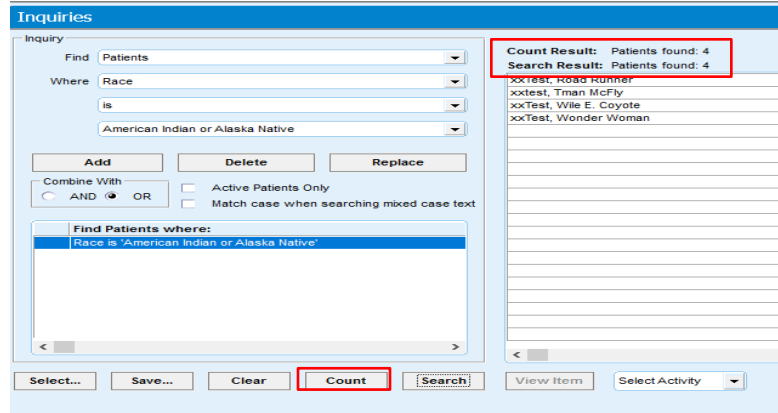
**STEP7:** If you’d prefer to re-start your inquiry from the beginning, click the Clear button to remove all



entered criteria.

**STEP8:** Select **Count** to display only the total number of results or select the **Search** button which will display the results.

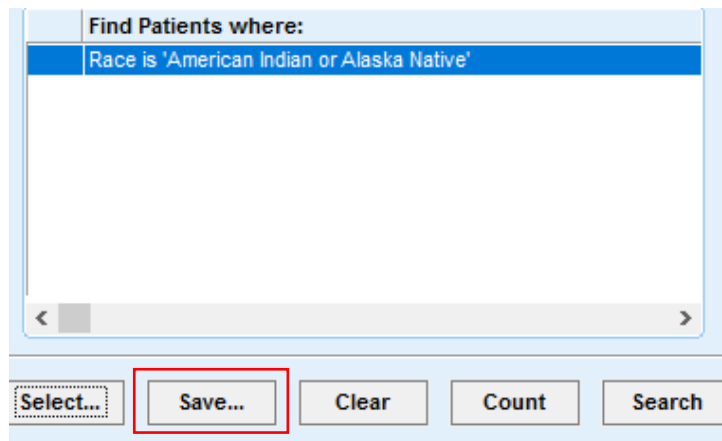
- Note: it is always best to run a count prior to running a search. This lets you know if you need to modify your inquiry.



The screenshot shows the 'Inquiries' window. On the left, the 'Inquiry' section has 'Find' set to 'Patients', 'Where' set to 'Race', and 'is' set to 'American Indian or Alaska Native'. Below this are buttons for 'Add', 'Delete', and 'Replace', and options for 'Combine With' (AND/OR) and checkboxes for 'Active Patients Only' and 'Match case when searching mixed case text'. A list titled 'Find Patients where:' contains one entry: 'Race is 'American Indian or Alaska Native''. At the bottom are buttons for 'Select...', 'Save...', 'Clear', 'Count', and 'Search'. On the right, a results pane shows 'Count Result: Patients found: 4' and 'Search Result: Patients found: 4', with a list of patient names below, including 'xxTest, Road runner', 'xxTest, Tman McFly', 'xxTest, Wile E. Coyote', and 'xxTest, Wonder Woman'. The 'Count' button is highlighted with a red box.

## Saving Inquiries

**STEP1:** If this is an inquiry that you and/or others will access frequently, you can choose to save it by clicking the Save button.



This close-up shows the 'Find Patients where:' section with the entry 'Race is 'American Indian or Alaska Native''. Below it are buttons for 'Select...', 'Save...', 'Clear', 'Count', and 'Search'. The 'Save...' button is highlighted with a red box.

**STEP2:** In the "Save Inquiry" window:

**STEP3:** Use the Name field to name the inquiry. Please note, there is a 20-character limit.

**STEP4:** In the Comment field, you can give more details on the inquiry.

**STEP5:** Select whether you want All Users to use your saved Inquiry, just the Current User Only or access will be Role Based in the "User Access" box.

**STEP6:** Click "ok" to save.

Save Inquiry

Name: Patients race

Comment: American Indian / Alaska Native Patients

User Access

All Users

Current User Only

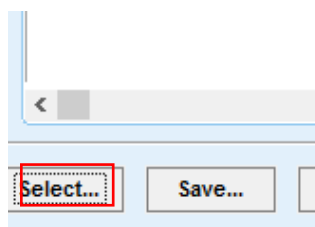
Role Based

OK

Cancel

### Opening an Existing/Saved Inquiry

**STEP1:** Choose the Select button.



**STEP2:** In the “User Access” section, you can filter your results by either “inquiries accessible to all users” or those “accessible to current user only” (you).

Select Inquiry

Name	Type	Comment
Facility 101	Patients	
FL Psych Encounters	Documents	FL Psych Violent Risk Encounters
home_orders	Patients	
Hypertension	Documents	
patient races	Patients	American Indian / Alaska Native
Patients race	Patients	American Indian / Alaska Native Patients
Population	Patients	
race search	Patients	
RMC	Patients	
Save 1	Documents	

User Access

Show inquiries accessible to all users

Show inquiries accessible to current user only  
(Marked with a '+' in the first column)

OK

Cancel

**STEP3:** Printing or Sending an **Alert/Flag** from Inquiry Results Printing Inquiry Results

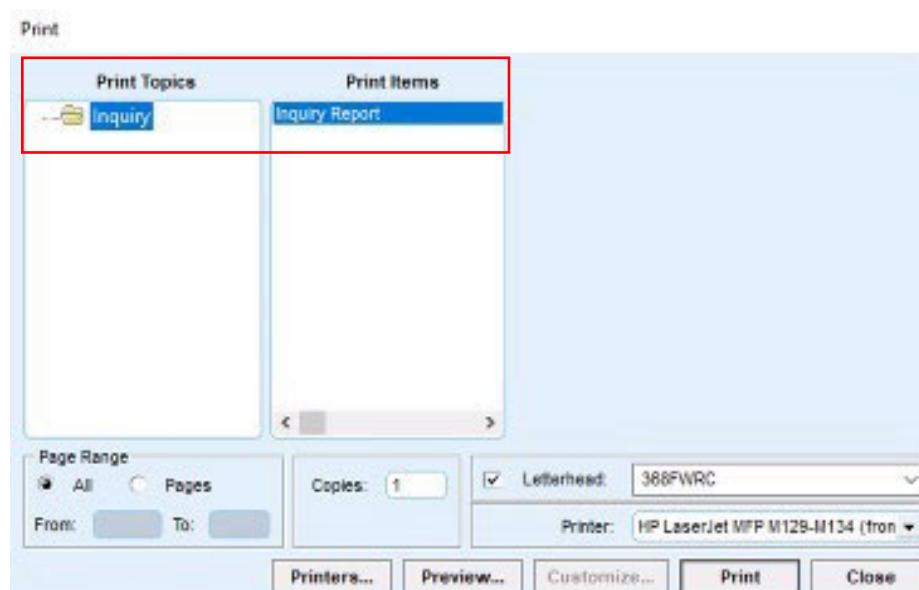
**STEP4:** Once you have the results of your inquiry, click the dropdown next to “**Select Activity**”. The options **Print** or send **Alert/Flag** are available to choose.





**STEP5:** To print your report, select **Print** from the dropdown menu. The screenshot below details the standard printing options that you may already be familiar with from other applications.

- Select number of pages to Print.
- Select number of copies.
- Select appropriate letterhead.
- Choose printer.
- Preview the report.



## Sending an Alert/Flag from Inquiry Results

**STEP1:** To generate an alert/flag based off the results of your inquiry, click the Send Alert/Flag option.

**STEP2:** This function allows you to send a bulk Flag, Care Alert or a Popup Alert to all patients that were returned in your inquiry.

- An example of when this would be useful is when generating a report on patients with diabetes that may be due for their annual diabetic eye exam. From the Send Alert/Flag option, you could then send a Care Alert to each patient's responsible provider reminding them of the due exam with just a few clicks.

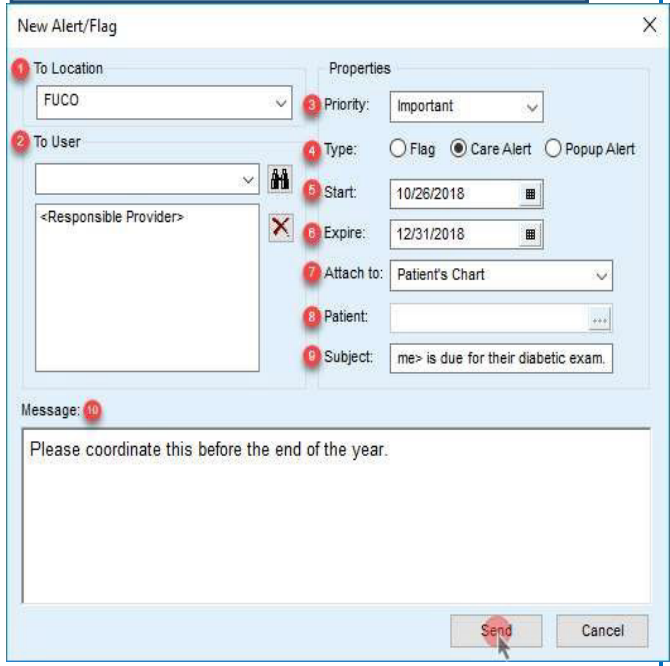


**STEP3:** When you first select Send Alert/Flag from the dropdown, a warning message will popup reminding you that this function will send bulk Alerts/Flags to the patient charts listed in the inquiry and ask if you would like to continue.

**STEP4:** You can disable this message from appearing each time by adding a check next to the “Don’t show me this message again” option and clicking the Yes button

**STEP5:** Fill in the “New Alerts/Flag” window details. Below is a key explaining each option.

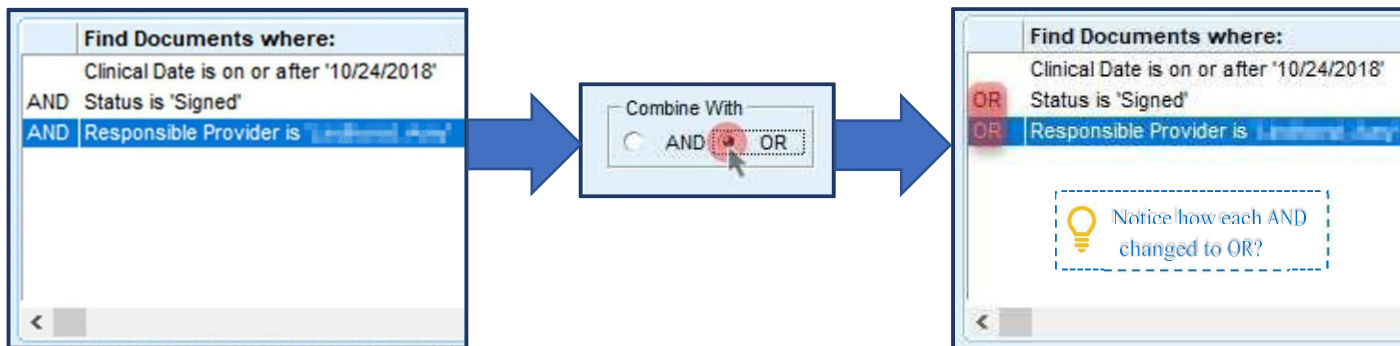
1	To Location	Defines which location to send the note to.
2	To User	Defines which Centricity user should receive the Flag, Care Alert or Popup Alert. The option “<Responsible Provider>” will route automatically to the patients Provider.
3	Priority	Select from Normal, Important or Urgent
4	Type	Choose whether you want to generate a Flag, Care Alert or Popup Alert. If you are unsure of which to choose, jump to the <a href="#">About Flags, Care Alerts and Popup Alerts</a> section on <a href="#">page 10</a> for their definitions.
5	Start Date	The date in which you want the Alert/Flag to appear on the patient’s chart.
6	End Date	The date in which you want the Alert/Flag to be removed from the patient’s chart.
7	Attach To:	The only available option of Patient’s Chart is pre-selected.



### Tips & Examples

#### Tips on Single Search Operator Inquiries

As mentioned at the top of page 3, when using more than one criterion to build your inquiry, you are limited to choosing just one logical operator, either AND or OR. When you toggle between the AND & OR radio buttons, all criteria listed in the “Find Patients where:” section will change.



Find Documents where:	
	Clinical Date is on or after '10/24/2018'
AND	Status is 'Signed'
AND	Responsible Provider is [redacted]
AND	Status is 'In Progress'

This may cause issues if, for instance, you would like to search for patients seen on 10/24/2018 AND by a single provider AND with the status of either ‘Signed’ OR ‘In Progress’. If you added the status of ‘In Progress’ like shown below, you would not find any patients since documents cannot have both the status of ‘Signed’ and in ‘In Progress’.

Workaround: Take advantage of the comparison operators (is, is not, is not blank, etc.) and build your inquiry as seen below. Instead of searching where the status IS ‘Signed’ OR ‘In Progress’, search where the Status IS NOT each of the other statuses except for ‘Signed’ and ‘In Progress’.

Find Documents where:	
	Clinical Date is on or after '10/24/2018'
AND	Responsible Provider is [redacted]
AND	Status is not 'On Hold'
AND	Status is not 'Unsigned'
AND	Status is not 'Moving'
AND	Status is not 'Removing'

### Searching by Dates (Example)



Month Date Range

Week Date Range

Single Day

<b>Find Documents where:</b>	
Clinical Date is on or after '10/01/2018'	
AND	Clinical Date is before '11/01/2018'

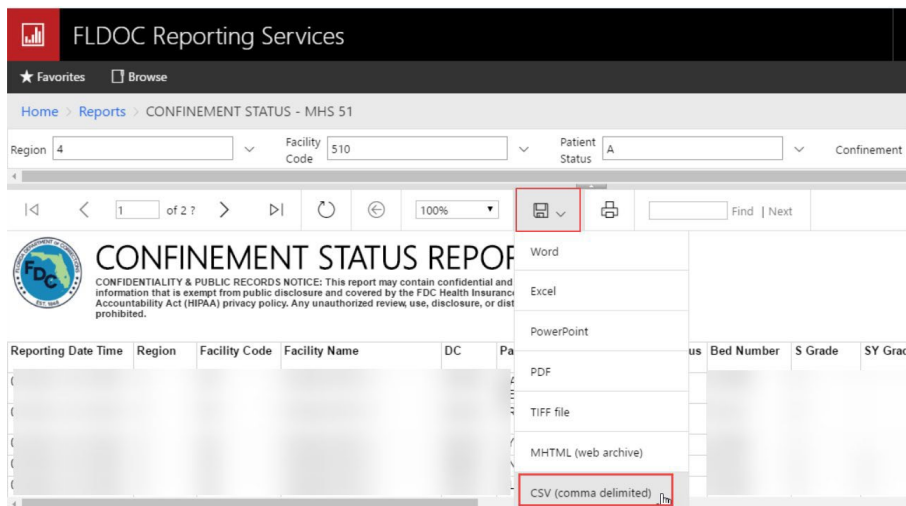
<b>Find Documents where:</b>	
Clinical Date is on or after '10/21/2018'	
AND	Clinical Date is before '10/29/2018'

<b>Find Documents where:</b>	
Clinical Date is on or after '10/24/2018'	
AND	Clinical Date is before '10/25/2018'

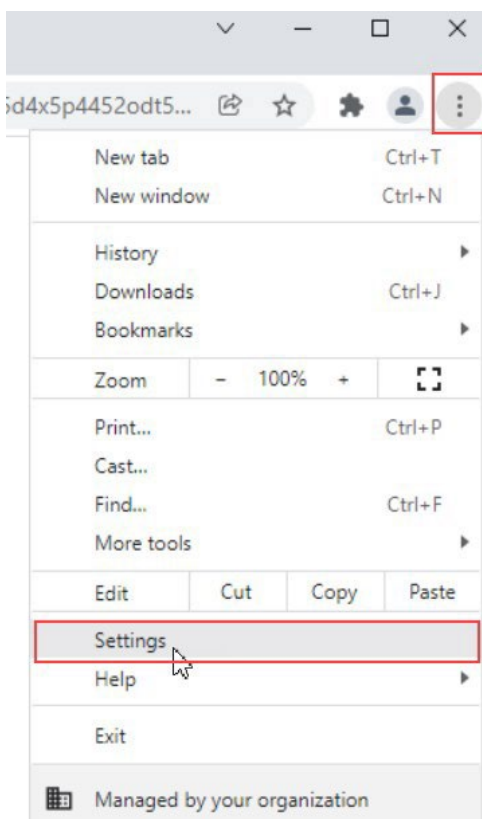
## Exporting SSRS Reports to Excel Format

To save your reports.

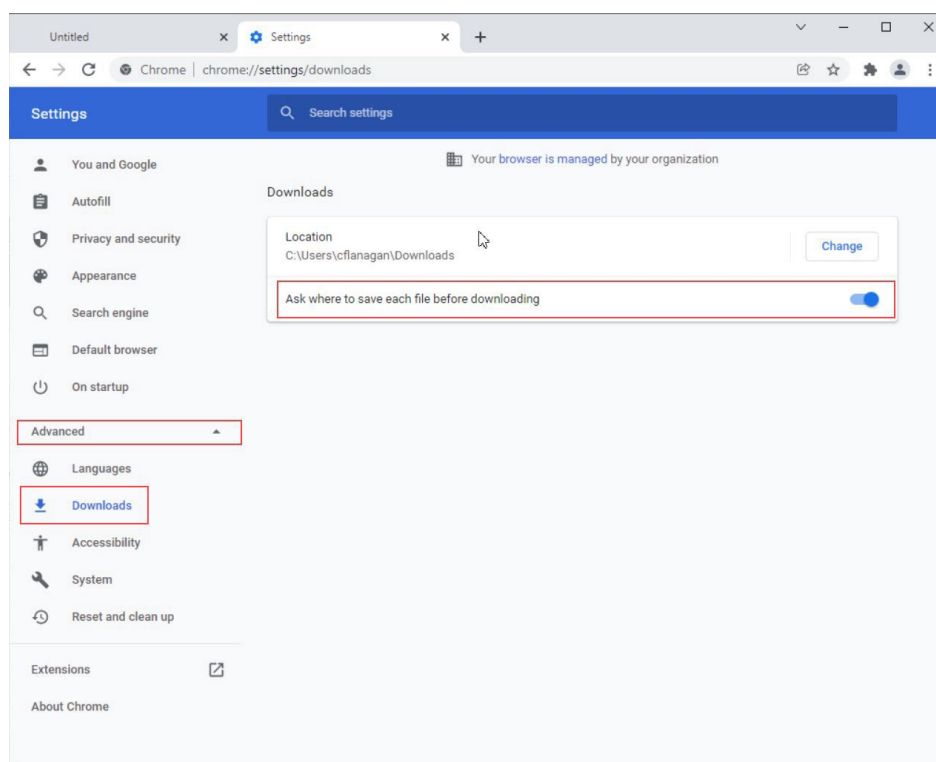
1. Select the floppy disk icon
2. Select CSV (comma delimited)



3. Use the Kabob icon located in the top right corner of the google chrome website and select settings

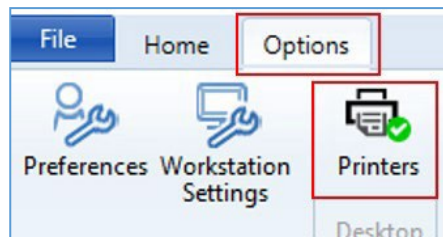


4. From the left navigation pane, select the advanced drop-down and select downloads
5. On the downloads page be sure that the “Ask where to save each file before downloading” toggle is on the right and that the toggle is blue.
  - From there you are able to close out of this window and follow the steps on the “Changing SSRS Reports into an Excel Document”



## How-To Modify Default Printer

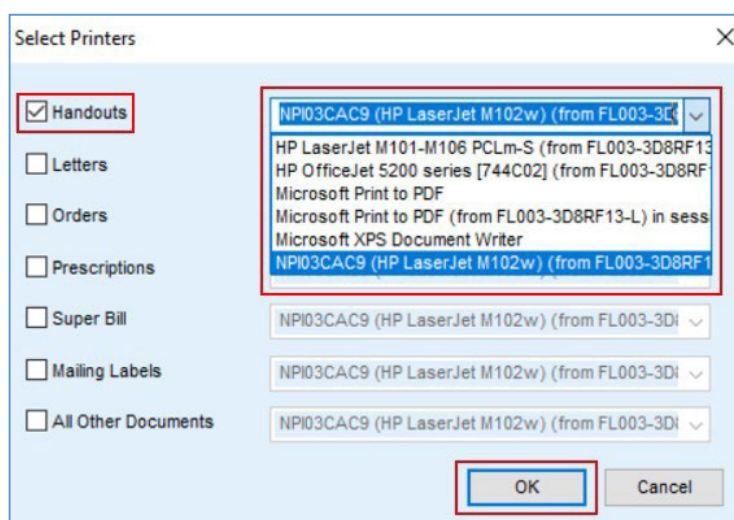
**STEP1:** From the Title Bar, select **Options**, then select **Printers**



**STEP2:** In the **Select Printers** window, the EMR will assume you want to use your computers default printer but will allow users to modify printer settings.

- To modify default settings, select document type and use the drop down arrow to select the desired printer.

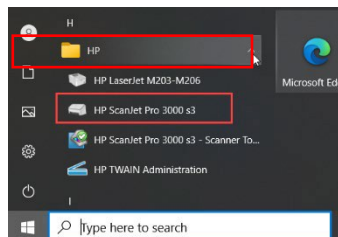
**STEP3:** Select **Ok** to save your changes



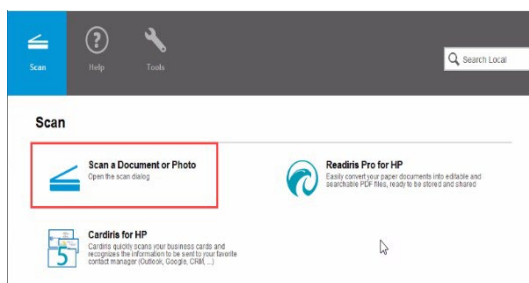
\*\*\*If the desired printer is unavailable, please refer to IT for assistance.

## Initial set up of scanners

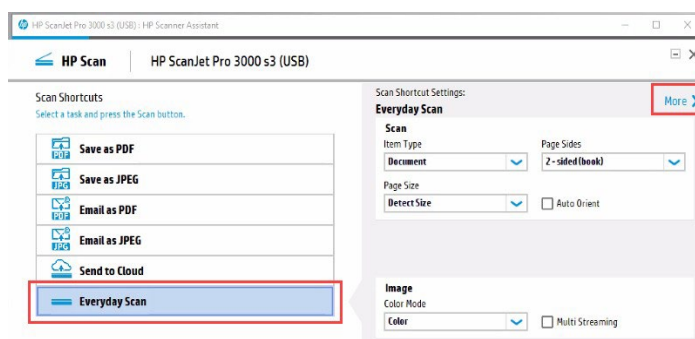
1. Select the start Icon in the bottom left hand corner of your desktop
2. Select the **HP folder**
3. Select **HP ScanJet Pro 3000 s3**



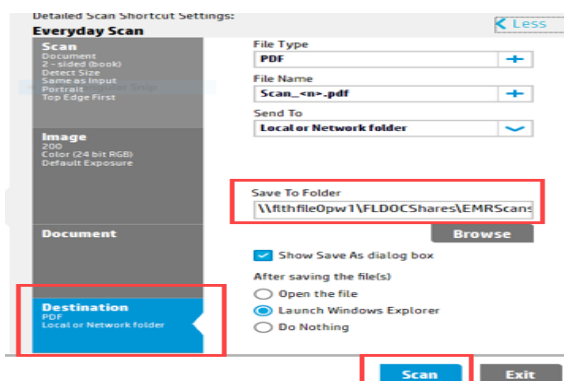
4. Select **Scan a Document or Photo** Icon



5. Select **Everyday Scan**, then select **More**



6. From there, select the **Destination** icon and enter in the appropriate file path
  - Use [\\flthfileOpw1\FLDOCShares\EMRScans\](#) followed by the facility and scanner information see the example below
  - [\\flthfileOpw1\FLDOCShares\EMRScans\419HOM\Scanner 03\](#)
7. Once you have the designated path identified scan your document





## Staff Referrals Workflow

### External Department to Health Services

#### Documenting Received Paper Staff Referral

**STEP1: Non Health Services Staff** member completes the **DC4-529 Staff Referral** on paper and sends to corresponding department.

**STEP2: Find your patient** using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP3:** Select **New Document** to begin encounter.

**STEP4:** Select the appropriate encounter type per discipline. (For this example the **Staff Request/Referral** encounter type is being used).

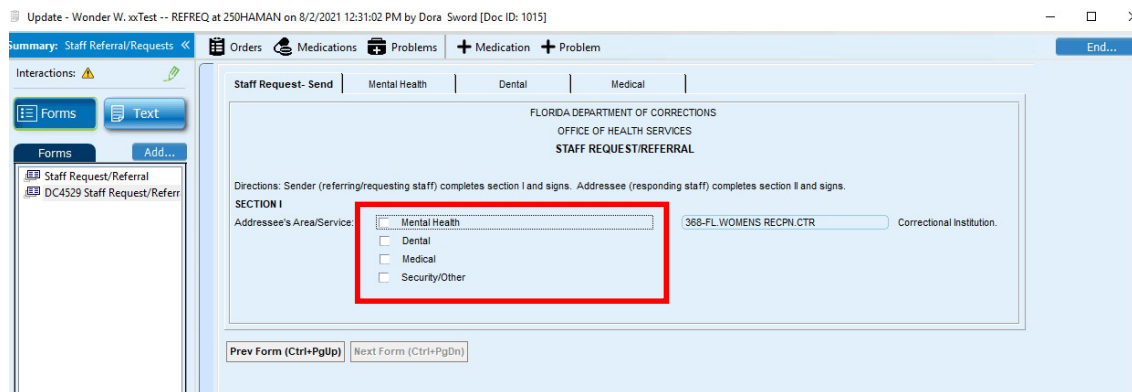
**STEP5:** Select **Staff Request/Referral Send** option.

Update - Wonder W. xxTest -- REFREQ at 250HAMAN on 8/2/2021 12:31:02 PM by Dora Sword [Doc ID: 1015]



The screenshot shows the EHR interface for a 'Staff Referral/Request' form. The form is titled 'Staff Referral/Request' and has a 'Send' button highlighted with a red box. Below the 'Send' button is a 'Received' button. The form also has 'Prev Form (Ctrl+PgUp)' and 'Next Form (Ctrl+PgDn)' buttons. The left sidebar shows a list of forms, with 'Staff Request/Referral' selected.

**STEP6:** Select the **Addressee's Area/Service**.



The screenshot shows the EHR interface for a 'Staff Request-Send' form. The form is titled 'FLORIDA DEPARTMENT OF CORRECTIONS OFFICE OF HEALTH SERVICES STAFF REQUEST/REFERRAL'. The 'Addressee's Area/Service' dropdown menu is highlighted with a red box, and 'Mental Health' is selected. The form also has a '368-FL WOMENS RECPN CTR' dropdown and a 'Correctional Institution.' field. The left sidebar shows a list of forms, with 'DC4529 Staff Request/Referr' selected.

**STEP7:** Select addressee and complete form in its entirety. (For this example Mental Health is being used below).

**STEP8:** Create an **Order** for the specific discipline **Staff Referral/Request**.

- Notate reason for referral in instructions box of the order details.



Update Orders - Wonder Woman xxTest 46 Years Old Female, (DOB: 08/03/1974)

Orders:  This update  Open  All Primary Coverage:

Date	Description	Status	Diagnoses
08/02/2021	MH Referral	Unsigned	

Potential Diagnoses:  
 Borderline personality disorder  
 MH Problem: Aftercare Planning  
 Breast cysts, left  
 Anxiety  
 MH Problem: Anxiety, Pathologica  
 MH Problem: Depression  
**DEPRESSION, CHRONIC, SEV**

Remove Reorder

Custom List Categories Search Order Details

Use custom list: **MH Outpatient**

Categories	Psychiatric Follow Up	Nursing	Other	Follow-up
Psychiatric Meeting	<input type="checkbox"/> Psychiatric F/U @ 7 days	<input type="checkbox"/> Nursing Intervention	<input type="checkbox"/> Interview Staff Request	<input type="checkbox"/> Well Bein
Mental health	<input type="checkbox"/> Psychiatric F/U @ 14 days	<input type="checkbox"/> Individual patient education	<input checked="" type="checkbox"/> MH Referral	<input type="checkbox"/> Well Bein
Comp	<input type="checkbox"/> Psychiatric F/U @ 30 days	<input type="checkbox"/> Individual F/U medication refusal	<input type="checkbox"/> SHOS Mattress, blanket and privacy apparel	<input type="checkbox"/> Confine
ation	<input type="checkbox"/> Psychiatric F/U @ 90 days	<input type="checkbox"/> Individual assessment/side effects	<input type="checkbox"/> HS062 Comments (Shared with Classification)	<input type="checkbox"/> Initial Con
Reception	<input type="checkbox"/> Psychiatric F/U	<input type="checkbox"/> MH Nursing Assessment	<input type="checkbox"/> Participation in CIT intervention	<input type="checkbox"/> Post Use
perm. inst.	<input type="checkbox"/> Psychiatric Crisis Evaluation	<input type="checkbox"/> Nursing F/U to no show	<input type="checkbox"/> MDST	<input type="checkbox"/> 30(28) de
atient intake	<input type="checkbox"/> Psychiatric Isolation Room	<input type="checkbox"/> Nursing inpatient mental eval	<input type="checkbox"/> Premarital evaluation	<input type="checkbox"/> 60(56) de
	<input type="checkbox"/> AMS exam	<input type="checkbox"/> Nursing inpatient physical eval	<input type="checkbox"/> Special evaluation	<input type="checkbox"/> 90(84) de
			<input type="checkbox"/> PREA Interview	<input type="checkbox"/> Post-IMR

Update Orders - Wonder Woman xxTest 46 Years Old Female, (DOB: 08/03/1974)

Orders:  This update  Open  All Primary Coverage:

Date	Description	Status	Diagnoses
08/02/2021	MH Referral	Unsigned	

Potential Diagnoses:  
 Borderline personality disorder  
 MH Problem: Aftercare Planning  
 Breast cysts, left  
 Anxiety  
 MH Problem: Anxiety, Pathologica  
 MH Problem: Depression  
**DEPRESSION, CHRONIC, SEV**

Remove Reorder

Custom List Categories Search Order Details

Clinical Information

Description: MH Referral

Code: MHREF

NDC:

Authorized By:

Modifiers:

Instructions: Refer to MH for: Thoughts of suicide

Disposition:

Test Administration

Priority:  Normal  Urgent  Stat

Start Date:  End Date:

Duration:   Days  Weeks  Months

Quantity:   Create Transition of Care Document

Reason:

Test provider:  External  Internal Provider

Insurance Notes:

**STEP9:** Select **End**.

**STEP10:** Select **Hold**.



**STEP11:** Scan and attach the original **DC4-529** request into the document.

- See **Indexing Client workflow importing into unsigned document** for this process.

**STEP12:** Select **End**.

**STEP13:** Select **Sign Document**.

**STEP14:** Deliver the paper version of the **DC4-529** to the designated staff member to complete.

## Answering Received Paper Staff Referral

**STEP1:** Answering staff member then completes the bottom half of the DC4-529 paper referral form and then enters the response into the patient's electronic record following steps **2-13** as applicable from above selecting **Staff Request/Referral Received**.

**STEP2:** After completing the form, complete corresponding orders.

- Select Orders from left navigation pane of patients chart.
- Locate and select correct Staff referral order.
- Select Complete.
- Press Ok.

**STEP3:** Send the completed **DC4-529 form** back to the staff member who sent it.

## Internal Staff Referrals/Request

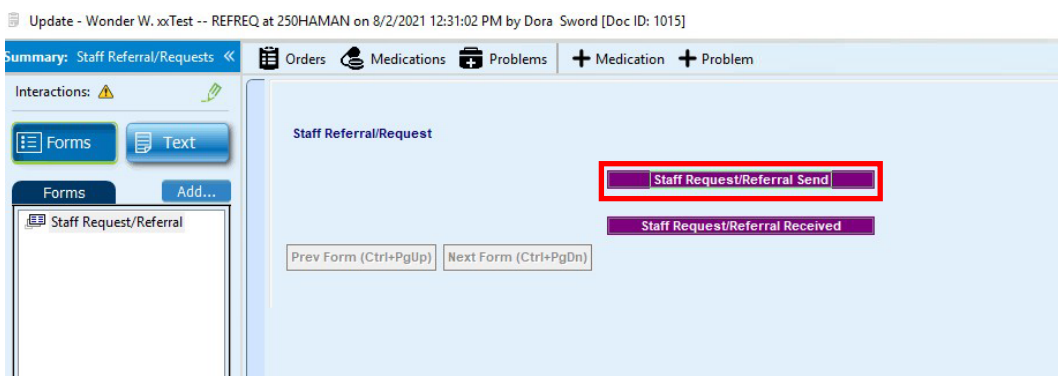
### Sending Referral Electronically

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

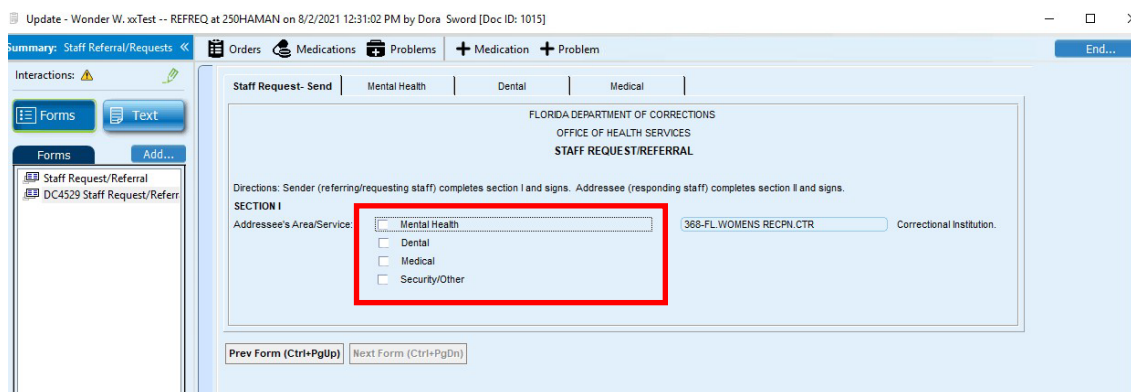
**STEP2:** Select **New Document** to begin encounter.

**STEP3:** Select the appropriate encounter type per discipline. (For this example the **Staff Request/Referral** encounter type is being used).

**STEP4:** Select **Staff Request/Referral Send** option.



**STEP5:** Select the **Addressee's Area/Service**.



**STEP6:** Select addressee and complete form in its entirety. (For this example Mental Health is being used below).

**STEP7:** Create an **Order** for the specific discipline **Staff Referral/Request**.

- The reason for the referral will need to be noted in instructions box of the order details.

## Telephone Call Documentation Workflow

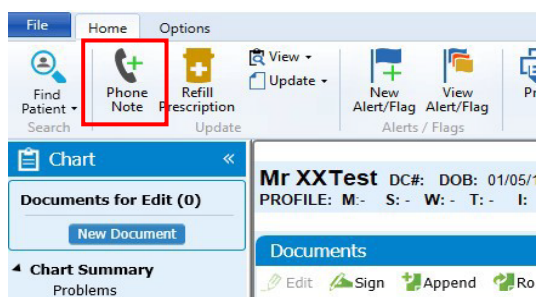
### Begin Documentation

Telephone calls documentation can only be done from the Patients desktop.

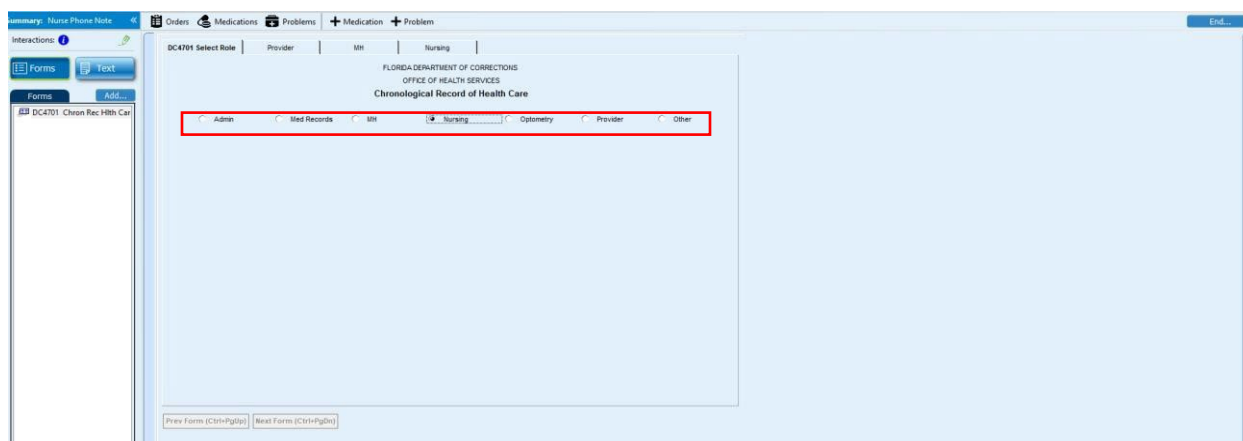
**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list

**STEP2:** Select the **Phone Note** icon.

- The **Chronological Record of Health** encounter form will open.



**STEP3:** Select discipline



**STEP4:** Complete the encounter as clinically indicated

- Modify or add orders, medications, allergies, and problems as indicated per phone call.
- Document in full detail of call in Note section.
- Select **No** in Copay section.

**STEP5:** Select **End** on the top right corner of the encounter.

**STEP6:** From the End Update window:

- Verify the Summary section is accurate and completed.
- Route if applicable, see Routing How-To Guide.



### STEP7: Select Sign Document

End Update

Properties

Summary: Nurse Phone Note

Provider: Thompson, Alissa

Route to

Me **This document will not be routed to any user's desktop.**

Provider (Alissa Thompson)

Sender (Alissa Thompson)

Date	User	Priority	Reason	Comments
------	------	----------	--------	----------

New... Remove Change...

**i** Drug interactions

Encounter is a Transition of Care

Return to Desktop View clinical list changes

Sign clinical list changes.

Pending prescriptions set to print or fax will be completed automatically.

Discard Document Sign Document Hold Document Cancel

**STEP8:** Complete the DC4-781Q Telephone Log. Select **New Document**.

**STEP9:** Select **Admin Forms**.

Find Patient Search Phone Note Refill Prescription Update View New Alert/Flag View Alert/Flag Print Chart Summary More Non-Formulary Fusion Group Note Fusion Order Mana Fusion Lab Manage

Chart

Documents for Edit (0) New Document

Chart Summary Problems Medications Allergies Directives Alerts / Flags Documents Flowsheet Orders Histories Protocols Graphs Handouts

Update Chart

Encounter Type: Admin Forms

Document Type: FL Admin

Confidentiality Type: Normal

Clinical Date: 11/01/2021 Clinical Time: 12:25:47 PM

Provider: Bender, Melissa

Location of Care: 368FWRC

Summary:

Encounter is a Transition of Care

Associate to existing patient appointment on this Clinical Date

ApptStart	Resource	Resp Provider	Facility	Type
-----------	----------	---------------	----------	------

OK Cancel

**STEP10:** Select the DC4-781Q Health Care/Tele Info Request form.

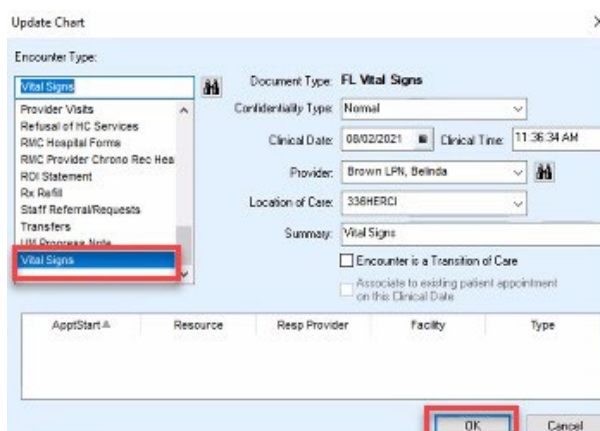
## Chronic Care Clinic Workflow

### Nurse Prep - Chronic Care Workflow

**STEP1: Find Patient.**

**STEP2: Select the New Document button to open the Update Chart window.**

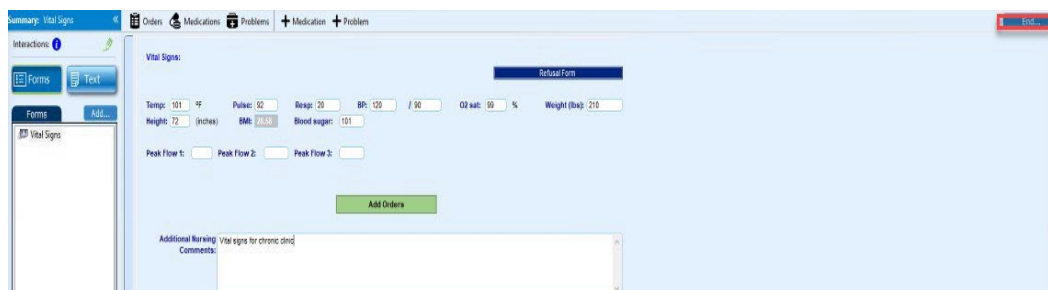
**STEP3: Choose the Encounter Type Vital Signs and then OK.**



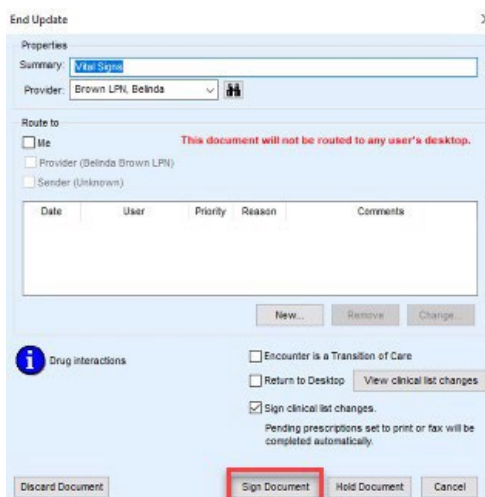
**STEP4: Complete Vital Signs form.**

**STEP5: Notate reason for provider visit as CIC.**

**STEP6: Once complete, END document.**



**STEP7: Select Sign Document.**

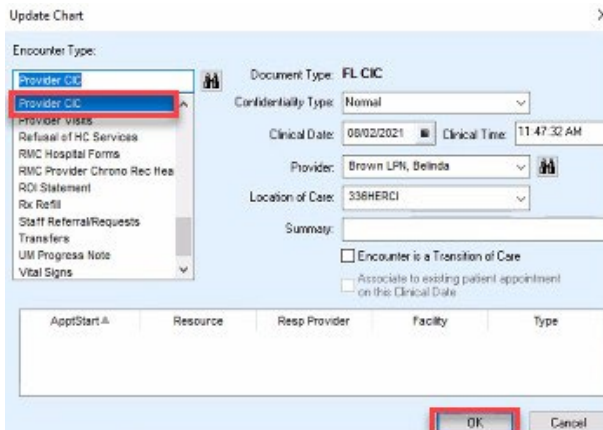




**STEP8:** Notify the clinician that patient is ready.

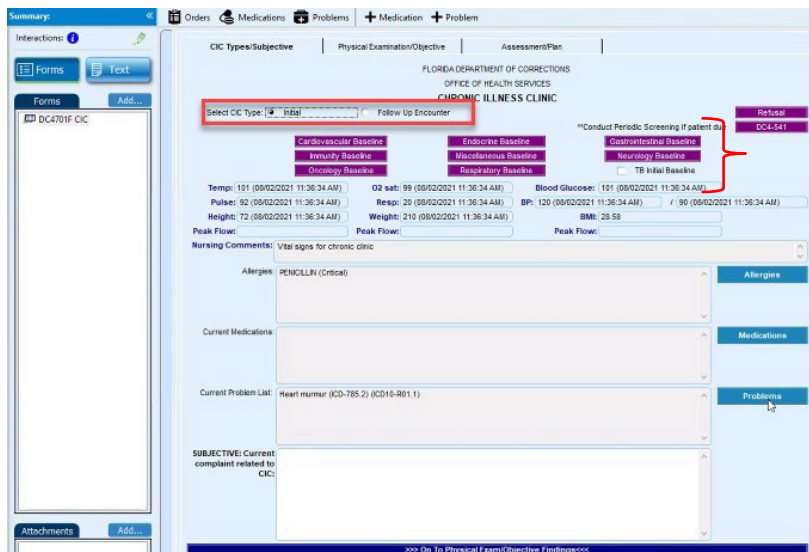
## Provider Chronic Care Clinic Workflow

**STEP1:** Begin a new **Document**, and select the **Provider CIC** encounter type.



**STEP2:** Select **Initial** or **Follow Up Encounter**

- All available clinics will populate based on selection. Select the appropriate clinic form(s).

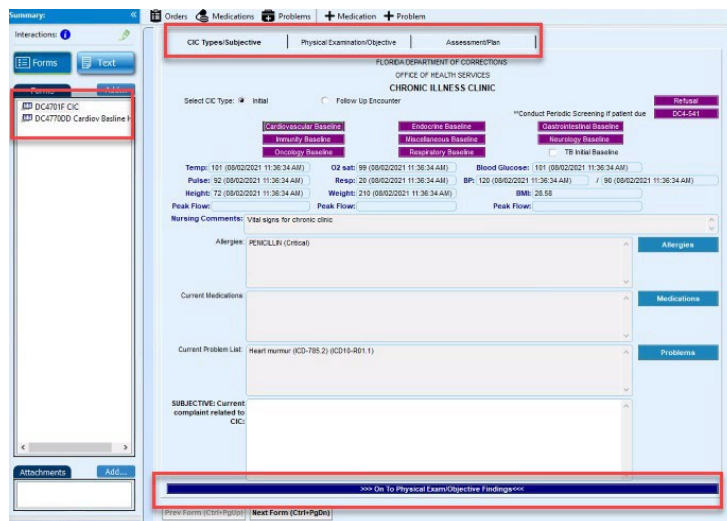


**STEP3:** Forms for the selected clinics will appear on the left hand panel.

**STEP4:** Complete **Chronic Illness Clinic DC4-701F** encounter form in its entirety.

**STEP5:** Select the **Blue Navigation Buttons** at the bottom of the screen and complete each area of the form as clinically indicated.

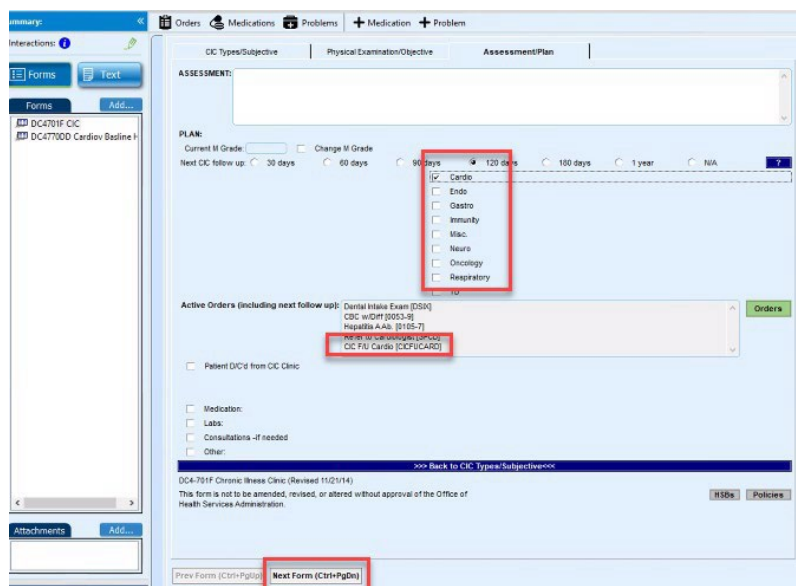




**STEP6:** In the **Assessment and Plan** section, the **Order** for the next appointment can be selected and ordered automatically.

**STEP7:** Select **Orders** front top of the page or the **green** shortcut button within the form to add any other applicable orders needed.

- Be sure to complete all order details for each added order.



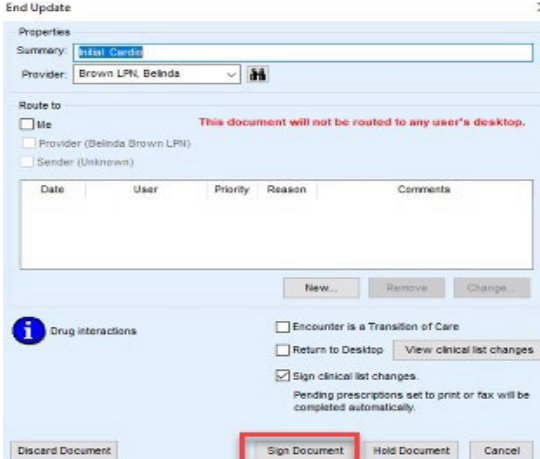
**STEP8:** Select the **Next Form** button to navigate to the next **DC4** form(s) to be completed.

**STEP9:** Complete the form(s) as clinically indicated.

**STEP10:** Select the **END** button to complete the encounter.



**STEP11:** Select Sign Document to complete documentation.



End Update

Properties

Summary: Vital Cards

Provider: Brown LPN, Belinda

Route to

Me **This document will not be routed to any user's desktop.**

Provider (Belinda Brown LPN)

Sender (Unknown)

Date	User	Priority	Reason	Comments
------	------	----------	--------	----------

New... Remove Change...

**i** Drug interactions

Encounter is a Transition of Care

Return to Desktop [View clinical list changes](#)

Sign clinical list changes.

Pending prescriptions set to print or fax will be completed automatically.

Discard Document **Sign Document** Hold Document Cancel

**STEP12:** Navigate to the Orders sections of the Patient's chart and complete the CIC order.

- Select Orders from left navigation pane of patients chart.
- Locate and select order.
- Select Complete.
- Press Ok

## Workflow – Seeing and Documenting on Patients

The screenshot displays the Fusion Order Manager interface. On the left, a navigation pane shows various options, with 'Fusion Order Manager' highlighted. A filter panel is open, showing search criteria for Date From, Date To (08/02/21), Specific Patient, Order Types (Nursing Services), Locations (FLWOMENS RECPN.CT), Providers (All Providers), and Priority (Normal, Urgent, Stat). A search bar at the bottom of the filter panel contains the text 'Search'. The main area shows a table of orders with columns for Priority, DC#, Medical Record Number, Patient Name, Location, Date, Order Description, Provider, and OBS. A red arrow points to the patient name 'GARRETT, KAITLYN' in the second row.

Priority	DC#	Medical Record Number	Patient Name	Location	Date	Order Description	Provider	OBS
	X92373	X92373	<a href="#">GARRETT, KAITLYN</a>	FLWOMENS RECPN.CTR A	07/13/21	Sick Call	Lombard, Cynthia	
Clinical Comments: eval gi								
	V23441	V23441	<a href="#">CAPALLIA, CARRIE</a>	FLWOMENS RECPN.CTR C	07/07/21	New Inmate HLT Review	Lombard, Cynthia	
	V23441	V23441	<a href="#">CAPALLIA, CARRIE</a>	FLWOMENS RECPN.CTR C	07/07/21	New Inmate HLT Review	Lombard, Cynthia	
	U38236	U38236	<a href="#">MARINO, JENNIFER</a>	FLWOMENS RECPN.CTR A	07/20/21	Sick Call	Lukes, Rachelle	
Clinical Comments: Training								
	U06360	U06360	<a href="#">HERNANDEZ, AMERICA</a>	FLWOMENS RECPN.CTR A	07/14/21	Sick Call	Torrey, April	
Clinical Comments: Diarrhea x2 days								
	Q50593	Q50593	<a href="#">XXTEST, JOAN</a>	FLWOMENS RECPN.CTR C	06/17/21	Hemoccult Screening	Brown, Belinda	
Clinical Comments: Give IM Hemoccult cards								
	P80420	P80420	<a href="#">SMITH, GRACE</a>	FLWOMENS RECPN.CTR I	07/20/21	Nursing f/u	Baillargeon, Daniel	
Clinical Comments: follow up abd pain								
	P80420	P80420	<a href="#">SMITH, GRACE</a>	FLWOMENS RECPN.CTR I	07/02/21	UA- Dip	Wallace, Lydia	

STEP1: Select Fusion Order Manager in the left navigational pane of Chart desktop.

STEP2: Using the filters sort your patient queue for the clinic. (Using Nursing Services Order Type for this example)

- Select date range.
- Order Types
- Locations
- Enter OBS term if applicable
- Select Priorities
- Select Statuses
- Select Search to display all open orders.

STEP3: Each order type will display under the description column.

STEP4: Double click on the patient blue hyperlinked name to open patient's chart.

File Home Options

Find Patient Search Phone Note Refill Prescription Update View Update New Alert/Flag View Alert/Flag Alerts / Flags Print Chart Summary More Set Up Commands Non-Formulary Fusion Group Notes Fusion Order Manage

Chart

Documents for Edit (0)

New Document

Chart Summary

Problems Medications Allergies Directives Alerts / Flags

Documents

Flowsheet

Orders

Histories

Protocols

Graphs

Handouts

Registration

Update Chart

Encounter Type:

Nurse Protocol Visit

Nurse Reception

Nurse Visits

Optometry/Ophthalmology

Phone Note

Provider CIC

Provider Visits

Refusal of HC Services

RMC Hospital Forms

RMC Provider Chrono Rec Hea

ROI Statement

Document Type: FL Nurse Protocol Visit

Confidentiality Type: Normal

Clinical Date: 08/02/2021 Clinical Time: 11:12:48 PM

Provider: Bender, Melissa

Location of Care: 368FWRC

Summary:

Encounter is a Transition of Care

Associate to existing patient appointment on this Clinical Date

ApptStart ▲	Resource	Resp Provider	Facility	Type
-------------	----------	---------------	----------	------

OK Cancel

STEP5: Select the new document button from left navigation pane.

STEP6: Choose the Encounter type. (Using Nurse Protocol Visit for this example)

- Select Confidentiality Type.
- Confirm Clinical Date and Clinical Time reflect current. \*Change to correct Date and time to reflect late entries\*
- Confirm Provider name is your name.
- Confirm Location of Care is location care is being given. Change as needed.

STEP7: Select OK to open form landing page.

Summary: Triage

Orders Medications Problems + Medication + Problem

Interactions: 1

Forms Text

Forms Add...

Nurse Protocol Select  
DC4683C Abdom Pain Proto  
Nurse Sick Call Triage Part 1  
Nurse Sick Call Triage Part 2

Copy?  No  Yes  
Reason for encounter:  Sick Call  EMD  Triage

Choose a Nurse Protocol:

DC4-683C	Abdominal Pain	DC4-683MM	Hyperglycemia
DC4-683B	Abnormal Vaginal Bleeding	DC4-683L	Hypertension
DC4-683V	Abrasion/Laceration	DC4-683A	Mental Health Emergency
DC4-683Q	Acne/Folliculitis/Cysts/Abscesses	DC4-683DD	Neurological Changes/Deficits
DC4-683M	Alleged Sexual Battery	DC4-683PP	Non-Traumatic Lower Extremity Swelling
DC4-683FF	Allergic Reaction	DC4-683HH	Non-Traumatic Joint/Extremity Pain
DC4-683R	Athlete's Foot/Fungal Infections	DC4-683F	Penetrating Chest Wound
DC4-683S	Back Pain	DC4-683JJ	Poisoning/Overdose
DC4-683Y	Bite	DC4-684B	Post Fall
DC4-683T	Burn/Sunburn	DC4-683D	Respiratory/Shortness of Breath
DC4-683E	Chest Pain	DC4-683CC	Scabies/Lice
DC4-683U	Cold/URI/Influenza Symptoms	DC4-683N	Seizure
DC4-683GG	Foreign Body Ingestion	DC4-683QQ	Sickle Cell Crisis
DC4-683J	Fracture/Dislocation/Sprain	DC4-683W	Skin
DC4-683K	Head Trauma	DC4-683NN	Smoking Cessation
DC4-683EE	Herpes	DC4-683BB	Urinary Symptoms
DC4-683RR	Hunger Strike	DC4-683KK	Vomiting/Diarrhea
DC4-683LL	Hypoglycemia	DC4-683AA	Additional Comments
DC4-701	Chronological Record of Health Care		
DC4-701C	ER Record		
DC4-760B	Emergency Transfer to Outside Hospital		
DC4-708	Diagram of Injury		
DC4-769	Pre-Special Housing Health Eval		
DC4-711A	Refusal		

HSBs Policies

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn)

STEP8: Answer Copay question.

STEP9: Select reason for encounter.

STEP10: Select appropriate protocol for visit.

STEP11: Select Nurse Protocol Select from left navigation pane to select and add another protocol for visit to encounter.

STEP12: As you select specific answers, other questions, text boxes, or forms will populate to complete.

STEP13: Inside vertical scroll bar moves through the document, Outside vertical scroll bar moves window.

STEP14: You can click on the next form by selecting name of form on the left navigation pane or click **Next Form** at bottom of page.

Summary: Triage

Orders Medications Problems + Medication + Problem

Interactions: 1

Forms Text

Forms Add...

Nurse Protocol Select  
DC4683C Abdom Pain Proto  
Nurse Sick Call Triage Part 1  
Nurse Sick Call Triage Part 2

Current Medications: METOCLOPRAMIDE HCL 10 IRG ORAL TABS (METOCLOPRAMIDE HCL) 1 tab po qday (PRN), Route: ORAL  
STRATITRAX 18 MG ORAL CAPSULE (ATOMOXETINE HCL), Route: ORAL

Chief complaint: Abdominal Pain

PHH: None

History of inguinal hernia?  No  Yes

Any recent abdominal trauma?  No  Yes

Pain location: Left Lower Quadrant

When did the pain start? Yesterday

Chest wax:  Sudden  Gradual

Pain loc:  Constant  Intermittent

Pain level:  1/10  2/10  3/10  4/10  5/10  6/10  7/10  8/10  9/10  10/10  None

Describe pain:  Crampy  Dull/Ache  Sharp  Constant  Radiating

History of abdominal problems/surgery:  No  Yes

Change in stools:  Constipation  Diarrhea  Black tarry stool  Blood in stool

Date of last BM: 05/02/2021 Today Color of stool: Consistency: Odor:

Other Symptoms:  Nausea  Vomiting  Fever  Dysphoresia  Chills  Urinary Sex- see Urinary Symptoms Protocol DC4-683BB  Denies any other symptoms

Passing flatus:  No  Yes

Decreased appetite:  No  Yes

Pain after eating:  No  Yes

Recent change in weight:  Increase  Decrease  N/A

OBJECTIVE:  
Temp: 98 °F Pulse: 99 Resp: 17 BP: 118 / 60 O2 sat: 98 % Weight (lbs): 145

Finger Stick blood sugar:

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn)

Summary: Triage

Orders Medications Problems + Medication + Problem

Interactions:

Forms Add...

Nurse Protocol Select  
DC4683C Abdom Pain Proto  
Nurse Sick Call Triage Part 1  
Nurse Sick Call Triage Part 2

FLORIDA DEPARTMENT OF CORRECTIONS OFFICE OF HEALTH SERVICES  
**ABDOMINAL PAIN PROTOCOL**  
NOTE: ALL PROTOCOLS COMPLETED BY LPNS MUST BE REVIEWED AND COSIGNED BY A RN OR CLINICIAN

**SUBJECTIVE:** Age: 27 Years Old

**Allergies:**  
\* PEANUT BUTTER (Moderate)

**Current Problems:**  
Diarrhea, persistent (ICD-787.91) (ICD10-R19.7)  
Depressed bipolar disorder part remissio (ICD-296.55) (ICD10-F31.75)  
Bipolar 1 disorder (ICD-296.7) (ICD10-F31.9)  
ADHD, hyperactive impulsive (ICD-314.01) (ICD10-F90.1)

**Current Medications:**  
METOCLOPRAMIDE HCL 10 MG ORAL TABS (METOCLOPRAMIDE HCL) 1 tab po daily (PRN); Route: ORAL  
STRATTERA 18 MG ORAL CAPSULE (ATOMOXETINE HCL) ; Route: ORAL

**Chief complaint:** Abdominal Pain

**PMH:** None  
History of inguinal hernia? No  
Any recent abdominal trauma? No  
Pain location: Left Lower Quadrant  
When did the pain start? Yesterday  
Onset was: Sudden Pain is: Constant  
Pain level: 6/10  
Describe pain: Crampy, Sharp  
History of abdominal problems/surgery: No  
Date of last BM: 08/02/2021 Other Symptoms: Denies any other symptoms  
Passing flatus: Yes  
Decreased appetite: Yes  
Pain after eating: No  
Recent change in weight: N/A

**OBJECTIVE:**  
Temp: 98 F Pulse: 99 Resp: 17 BP: 118 / 80 O2 sat: 98 % Weight (lbs): 145  
Skin: Pink  
Pulse: Regular  
Left: Lower Quadrant

Attachments Add...

STEP15: To review the Text version of your documentation  
Select Text button on left navigation pane.

STEP16: To Return to Document select Forms button.

STEP17: Once complete select End top right corner.

Summary: Abdominal Pain Triage

Orders Medications Problems + Medication + Problem

Interactions:

Forms Add...

Nurse Protocol Select  
DC4683C Abdom Pain Proto  
Nurse Sick Call Triage Part 1  
Nurse Sick Call Triage Part 2

Rebound Tenderness?  No  Yes  
Stool guaiac:  Negative  Positive  Not Checked

**FINDINGS REQUIRING IMMEDIATE CLINICIAN NOTIFICATION:**

Temperature greater than 100.4 F  
 Pulse greater than 110 beats per minute  
 Blood Pressure less than 90/60  
 Severe pain (localized or generalized)  
 Weight loss of 10% or more of body weight in 6 months without trying  
 Abdomen firm or rigid  
 Positive Stool Guaiac  
 Black or bloody stools  
 Vomiting  
 Non reducible hernia

**PLAN:**

Clinician notified  
 OTC Medication for specific complaint:  
 Acetaminophen 325mg one or two tablets every 4-6 hours as needed  
 Antacid/Anti-gas Tablets as directed on package  
 Bismacodyl 5 mg as directed  
 Docusate Sodium 100mg as directed  
 Ibsrel Liquid 12 ounce bottle as directed on bottle (Aluminum-Magnesium-Simethicone)  
 100 mg of Magnesia as directed on bottle  
 Simethicone tablets as directed  
 Quaiac card if no BM

End...



End Update

Properties

Summary: Abdominal PainTriage

Provider: Bender, Melissa

Route to

Me

Provider (Melissa Bender)

Sender (Melissa Bender)

Date	User	Priority	Reason	Comments
08/03/2021	Dora Sword	Normal	Signature	Please review and sign.

New Routing Information

To: [Dropdown] [Binoculars]

Sword, Dora

Reason

Signature

Action Required

Review

Priority: Normal

Encounter is a Transition of Care

Return to Desktop

Sign clinical list changes.

Pending prescriptions set to print or fax will be completed automatically.

Sign Document

Hold Document

Cancel

Comments: Please review and sign.

Save as Default

OK

Cancel

STEP18: Summary Text will auto populate with brief description of all forms selected.

STEP19: Route document if applicable.

- Select **New** to open **New Routing Information** window.
- To- Add staff member name using drop down or binoculars.
- Select **Reason**
- Select **Priority**
- Enter Comments
- Select **Ok** to add to End Update window.

STEP20: Check Sign Clinical list Changes box.

STEP21: Select Sign Document and return to patient chart summary.

\*LPNs are required to Route all documentation to RN or Clinician for co-signature.\*

New Document

**Chart Summary**  
 Problems  
 Medications **i**  
 Allergies  
 Directives  
 Alerts / Flags

**Documents**  
**Flowsheet**  
**Orders**  
 Histories  
 Protocols **□**  
 Graphs **□**  
 Handouts **□**  
 Registration **□**

**Set Up Links** **⚙**  
 Patient's MAR

**Orders**  
 Change Send **Complete** View Remove Organize Add

Date	Type	Description
07/20/2021	Test	Psychiatric F/U @ 7 days
07/13/2021	Test	XRAY CHEST 2 VIEW
07/13/2021	Test	CBC w/Diff
07/13/2021	Test	Sick Call

Code: SC  
 Type: Test Order #: 4098-3  
 Authorized By: Cynthia Lombard APRN Signed By: Gregor  
 Prime Coverage: Authorization #:  
 Duration: End Date: Units:

Clinical Notes: eval gi  
 Diagnosis: DIARRHEA, PERSISTENT (ICD-787.91) (ICD10-R19.7)  
 Sent to Provider: 07/13/2021 2:08 PM Service Provider: FDC

STEP22: Select **Orders** from left navigation pane.

STEP23: Locate and click to highlight order for encounter just completed.

STEP24: Select **Complete** to open Select Orders to Complete window.

STEP25: Confirm correct order is checked, **End Date** is correct and select **Ok**.

Select Orders to Complete

Select	Date	Description	Loc. Of Care	Status
<input checked="" type="checkbox"/>	07/13/2021	Sick Call	368FWRC	In Process
<input type="checkbox"/>	07/13/2021	CBC w/Diff	368FWRC	Admin Hold
<input type="checkbox"/>	07/13/2021	XRAY CHEST 2 VIEW	368FWRC	Admin Hold
<input type="checkbox"/>	07/20/2021	Psychiatric F/U @ 7 days	368FWRC	In Process

An asterisk (\*) indicates an order that should have been completed when a result document was signed. It wasn't because another user was changing orders for this patient when the document was signed.

Select All Clear All

End Date: 08/03/2021

Red flags for selected order

OK Cancel





## How to - Order a Medication

**STEP 1:** Find the patient's chart by selecting the **magnifying glass** or by using the **Find Patient** drop down list.

**STEP 2:** Select **New Document** to begin an encounter.

The screenshot shows the Centurion software interface for a patient named Stephen Strange xxTest. The patient's profile information is visible at the top: DOB: 05/15/1975, R/S: Afala, BED: FAC: 320FCRM, RECEPTION: EOS, and PROFILE: M- S- W- T- I- R- - PASSES: None HOLDS: None. The interface is divided into several sections: Problems, Medications, Allergies, Directives, and Alerts / Flags. The 'New Document' button in the left sidebar is highlighted with a red box.

**STEP 3:** Select the **+ Medication** button to open the **New Medication** window.

The screenshot shows the top navigation bar of the Centurion software interface. The '+ Medication' button is highlighted with a red box. The navigation bar also includes 'Orders', 'Medications', 'Problems', and '+ Problem'. The patient's name 'Stephen Strange xxTest' is visible on the left, and 'FLORIDA DEPARTMENT OF CORRECTIONS' is visible at the bottom.

**STEP 4:** Select **Custom List** drop-down arrow to search medication lists.

**STEP 5:** Select the drop-down arrow on the bar below to display the preset medications from the custom list and choose the medication.


The screenshot shows the 'New Medication' window. The patient's information is displayed on the left: Name: Stephen Strange xxTest, Birth: 05/15/1975, Age: 45 Years Old, Sex: Male, Height: , Weight: 185 lb (83.914 kg\*), BSA: Unable to calculate, Insurance: . The 'Find Medication' search results are displayed on the right. The 'Custom List' dropdown is set to 'Analgesics'. The search results are as follows:


Medication	Quantity	Frequency	Route	Form	Strength	Price
ACETAMINOPHEN 160 MG/SML ORAL SOLN	0 x 0	0	ORAL	SOLN	160 MG	\$0.39
ACETAMINOPHEN 325 MG TABS	0 x 0	0	ORAL	TABS	325 MG	\$0.02
ACETAMINOPHEN 500 MG ORAL TABS	0 x 0	0	ORAL	TABS	500 MG	\$0.03
ACETAMINOPHEN 650 MG RECTAL SUPP	0 x 0	0	RECTAL	SUPP	650 MG	\$0.67
ACETAMINOPHEN-CODEINE #3 300-30 MG ORAL TABS	0 x 0	0	ORAL	TABS	300-30 MG	\$0.36
CAFERGOT 1-100 MG ORAL TABLET	0 x 0	0	ORAL	TABLET	1-100 MG	\$15.44
HEADACHE RELIEF 250-250-65 MG ORAL TABLET	0 x 0	0	ORAL	TABLET	250-250-65 MG	\$0.08
IBUPROFEN 100 MG/SML ORAL SUSP	0 x 0	0	ORAL	SUSP	100 MG	\$0.08




**STEP 6:** Enter the following information once the medication is selected: **All fields required.**

- **Instructions** (The beaker icon will indicate if they are understood by the EMR)
  - Medications auto default to DOT.
  - After instructions document **(KOP) (DOH) (EOS) (WR)** if applicable.
- **Comments** (Enter the rationale and reason for DER/Non-Formulary medications indicated in the formulary box with a red circle).
- **Start and Stop Date/Duration- Required**
- **Interactions**

- Yellow yield means a moderate interaction.  requires override or change in medication.

- Blue means no potential interactions found. 

- Red means a critical interaction was found.  requires override or change in medication.

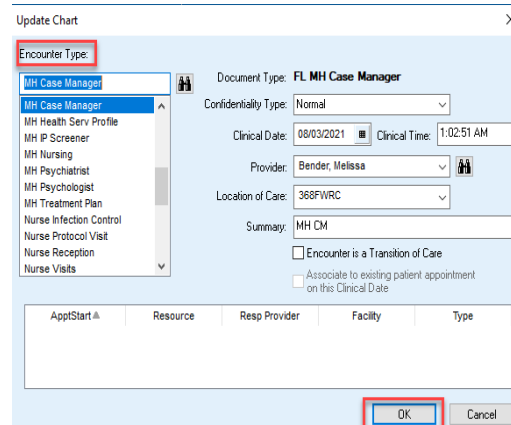
- Green means that the interaction has been overridden. 

- **Quantity- Required**
- **Refills- Required**
- **Authorized By** (The ordering provider).
- **Prescribing Method**
  - Change to **HANDWRITTEN** to transcribe to pharmacy.
  - Leave **Pending Approval** for non-formulary medication approvals, once approved it will be changed to HANDWRITTEN to send to pharmacy.

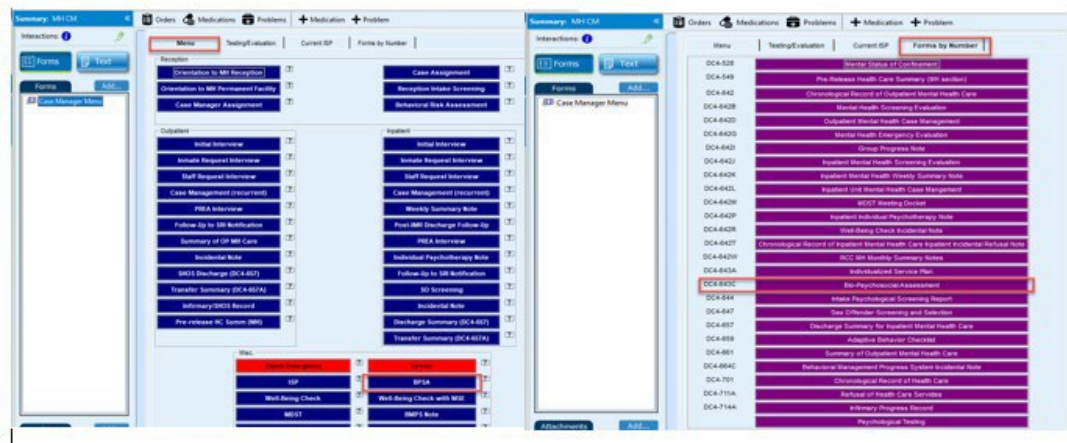
**STEP 7:** Select **OK** to add the Medication into the encounter.

## How to Complete Bio-psychosocial Assessment Workflow

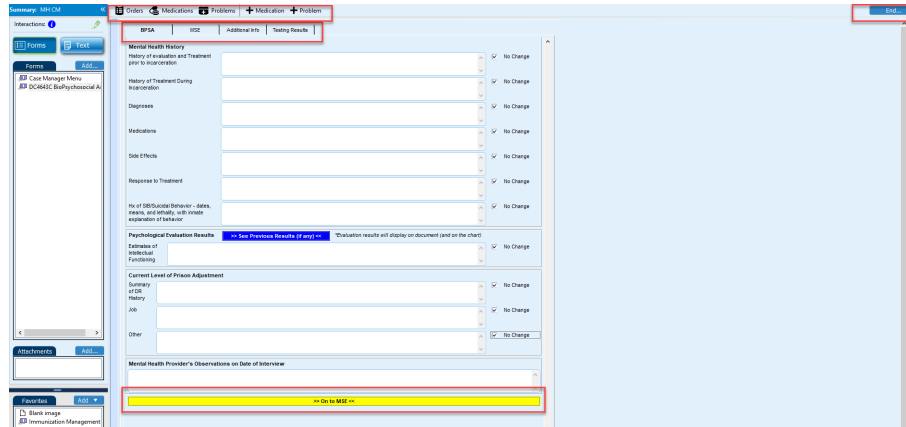
- STEP1:** Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
- STEP2:** Select **New Document** to begin a new encounter.
- STEP3:** Choose the corresponding Encounter Type. (Used MH Case Manager for this example)
- STEP4:** Select **Ok**.



- STEP5:** From Menu select BPSA button or select Forms by Number tab and select DC4-643C Bio-Psychosocial Assessment to open form.

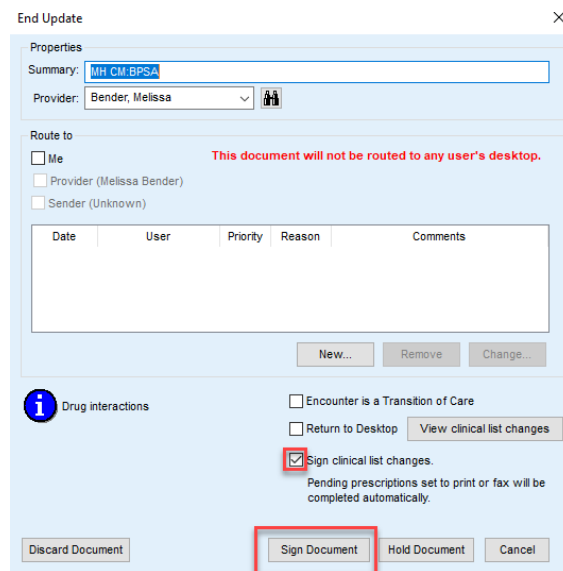


- STEP6:** Complete form in its entirety to include each tab at the top of encounter.
- BPSA
  - MSE
  - Additional Info
- STEP7:** To navigate to each section either select Yellow button on form or select tab options at the top.
- Testing Results tab is view only.
- STEP8:** Add Orders, Medication and Problems as needed using the top tool bar options.
- STEP9:** Once complete select End in top right hand corner of document.



From End Update window

- **Route** document if applicable.
- Ensure the **Sign clinical list changes** box is checked prior to signing document.
- Select **Sign Document**.



End Update

Properties

Summary: MH CM BPSA

Provider: Bender, Melissa

Route to

Me **This document will not be routed to any user's desktop.**

Provider (Melissa Bender)

Sender (Unknown)

Date	User	Priority	Reason	Comments

New... Remove Change...

**i** Drug interactions

Encounter is a Transition of Care

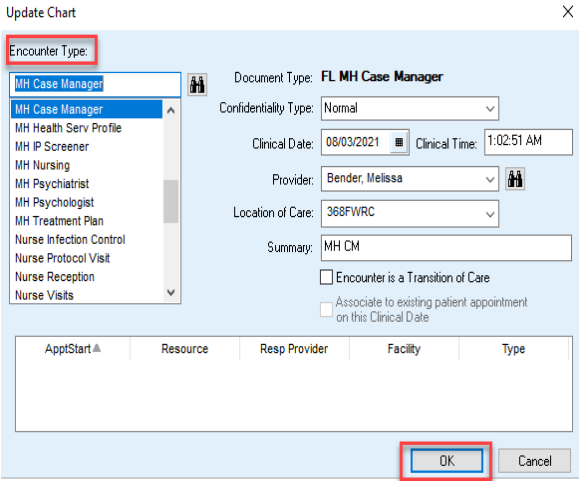
Return to Desktop

**Sign clinical list changes.**  
Pending prescriptions set to print or fax will be completed automatically.

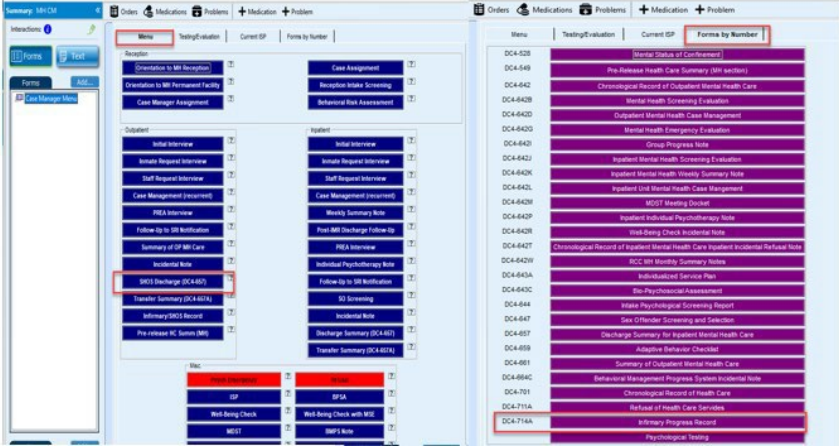
Discard Document **Sign Document** Hold Document Cancel

## How to Document MH Suicide Observation Status (SHOS) Rounds

- STEP1: Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
- STEP2: Click on **New Document** to begin a new encounter.
- STEP3: Choose the corresponding Encounter Type. ( used MH Case Manager for this example)
- STEP4: Select **Ok**.

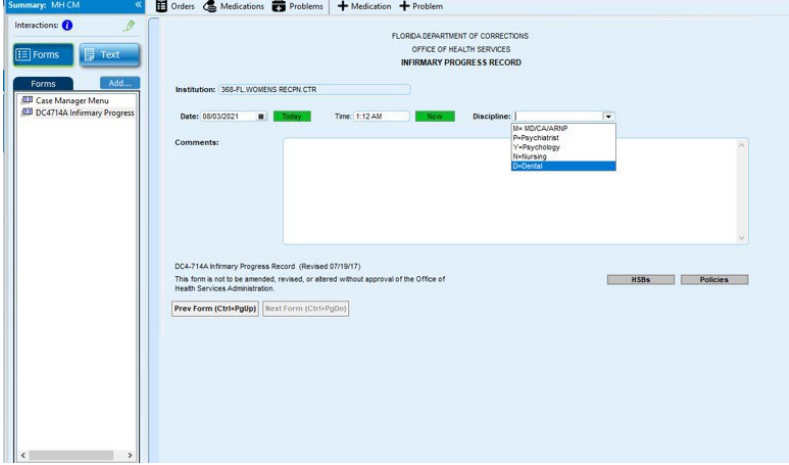


- STEP5: From **Menu** select **Infirmary/SHOS Record** button or select **Forms by Number** tab and select **DC4-714A Infirmary Progress Record** to open form.

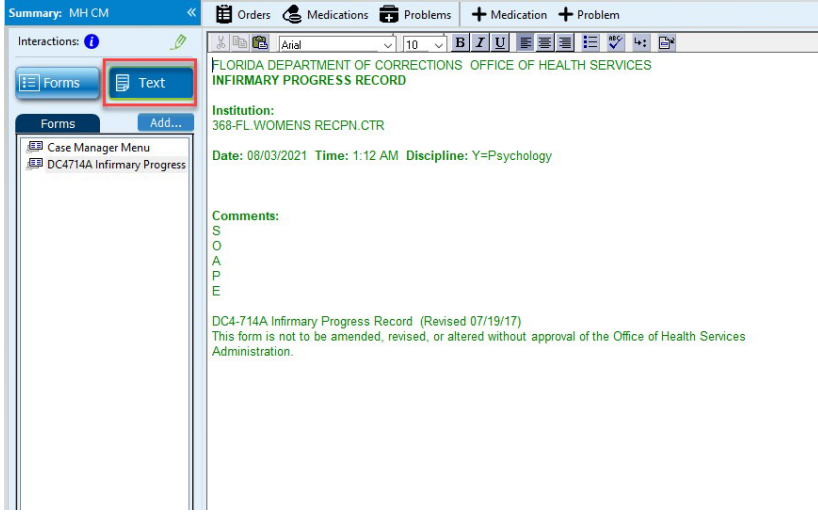


- STEP6: Complete form in its entirety.

- Select **Date** using calendar icon or selecting **Today** to enter today's date.
- Enter time in text box or select **Now** to enter current time.
- Using the drop down arrow select Discipline.
- Enter SOAPE not in **Comments** section.

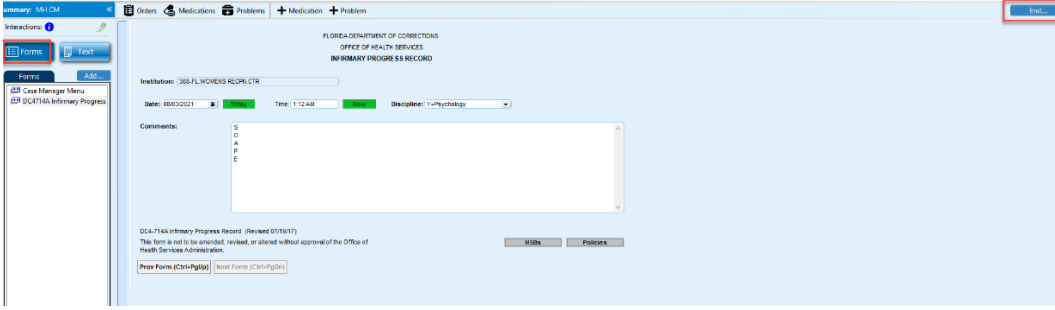


Step 7: To view the text version of your form select Text from the left navigation pane.



STEP7: To return to document select **Forms** from left navigation pane.

STEP8: Once form is complete select **End** button in the top right corner of encounter.



STEP9: From End Update window

- **Route** document if applicable.
- Ensure the **Sign clinical list changes** box is checked prior to signing document.
- Select **Sign Document**.

End Update

Properties

Summary: MH CM:InfirmSHOS Record

Provider: Bender, Melissa

Route to

Me **This document will not be routed to any user's desktop.**

Provider (Melissa Bender)

Sender (Unknown)

Date	User	Priority	Reason	Comments
------	------	----------	--------	----------

New... Remove Change...

**i** Drug interactions

Encounter is a Transition of Care

Return to Desktop [View clinical list changes](#)

Sign clinical list changes.  
Pending prescriptions set to print or fax will be completed automatically.

Discard Document **Sign Document** Hold Document Cancel

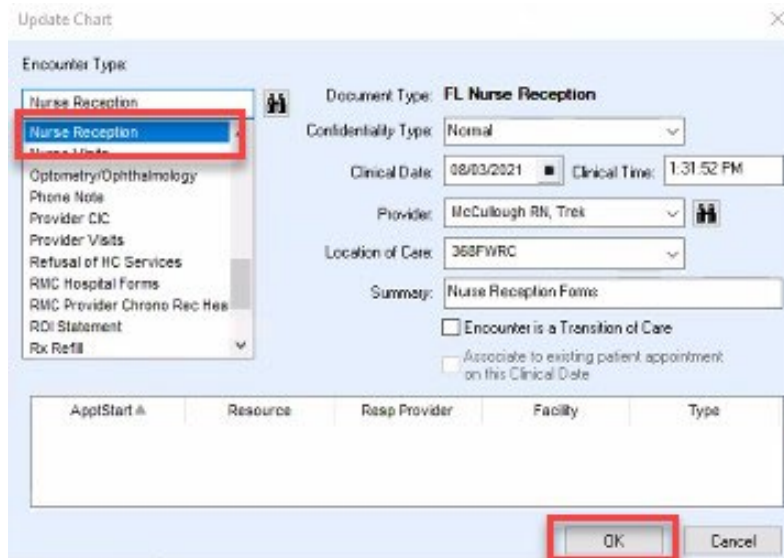
## Nurse Reception Workflow

### Adding Reception Orders

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP2:** Select **New Document**.

**STEP3:** Select the **Nurse Reception** encounter type.



**STEP4:** Select **Add Intake Labs**.

- Choose appropriate lab set for patient demographics
- The authorizing provider of each order must have an NPI#. Select CHO name for standing intake orders.

**STEP5:** Select reception **Orders**.

- Select **Nursing Reception** custom list and check the following orders:
  - Intake Assessment
  - TB Plant
  - Reception Health Education
  - Initial Physical Exam
  - Dental Initial Exam
  - Reception Orientation and Screening
  - Annual Pap Smear (for female camps)
  - Annual Breast Exam (for female camps)
- Complete **Order Details**.



Orders Medications Problems Medication Problem End...

**Referral Form**

**Health Screenings**

- Auditory Screening
- Mobility Screening
- Vision Screening
- STD Screening

**Reception Forms**

DC4-20C TB Symptom Questionnaire	DC4-710 Communicable Disease Record
DC4-701 Chronological Record of Health Care	DC4-710A Immunization Record
DC4-707 Reception Assessment	DC4-770 Inmate Health Education- Green sheet
Vital Signs Vital Signs	

**Passes**

DC4-400 Accommodation(s) Pass	DC4-502 Staff Referral
DC4-700 Health Slip/Pass	Add Intake Labs
	Add Reception Orders

**New Admits: OTHER FORMS:**

DC4-702 Consultation Request	Add Special Pass Orders
DC4-728 Therapeutic Diet Request	
DC4-789 Pre-Special Housing Health Eval	

**New Admits: eSigns to be completed:**

DC4-710C- Auth for Health Evaluation to be completed in eSign  
DC4-463- Consent to MR evaluation to be completed in eSign

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn)

Update Orders - Ole Jake xortest 30 Years Old Male, (DOB: 04/15/1991)

Orders:  This update  Open  All Primary Coverage: Set Coverage... Potential Diagnoses:

Date	Description	Status	Diagnoses
08/03/2021	Initial Physical Exam	Unsigned	
08/03/2021	Reception Health Education	Unsigned	
08/03/2021	Intake Assessment	Unsigned	
08/03/2021	Reception Orientation and Scree	Unsigned	
08/03/2021	Dental Intake Exam	Unsigned	

Remove Reorder Clear Diagnoses New... Edit...

Custom List: Categories Search **Order Details**

Use custom list: Nursing Reception

Intakes	Screenings
<input checked="" type="checkbox"/> Reception	<input type="checkbox"/> Vision Screening
<input checked="" type="checkbox"/> Initial Physical Exam	<input type="checkbox"/> Auditory Screening
<input checked="" type="checkbox"/> Reception Health Education	<input type="checkbox"/> Mobility Screening
<input checked="" type="checkbox"/> Intake Assessment	
<input checked="" type="checkbox"/> Reception Orientation and Screening	
<input checked="" type="checkbox"/> Dental Intake Exam	
Additional Exams	
<input type="checkbox"/> Annual PAP	
<input type="checkbox"/> Annual Breast Exam	

Sign Orders OK Cancel

**STEP6: Select OK.**

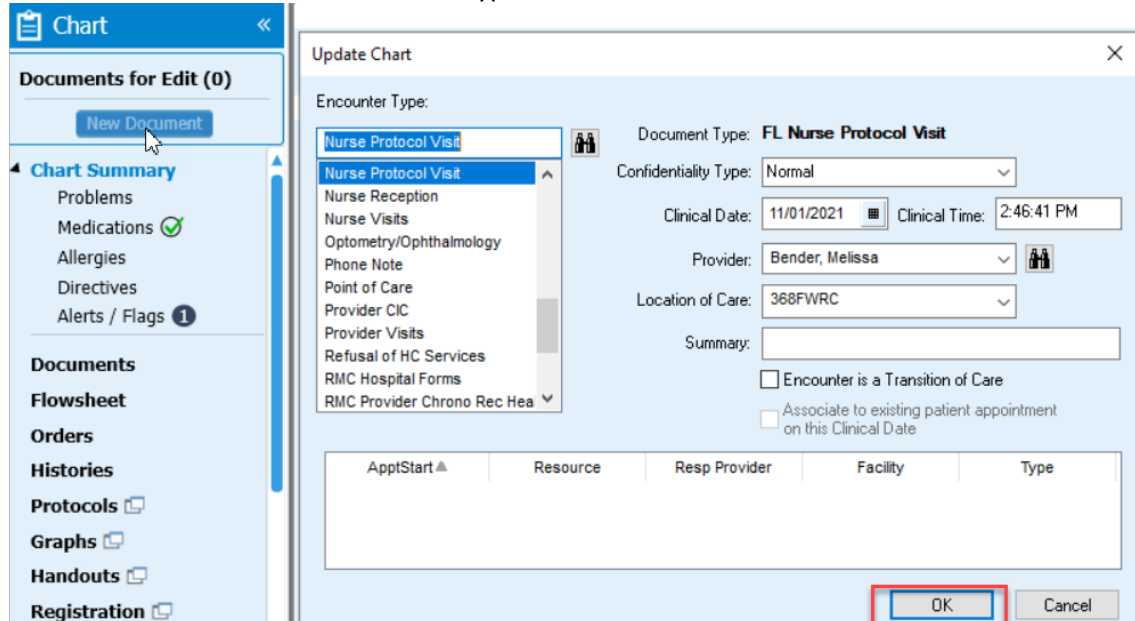
## Nurse Sick Call Workflow

### Triaging Sick Call Request and Scheduling Appointment

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

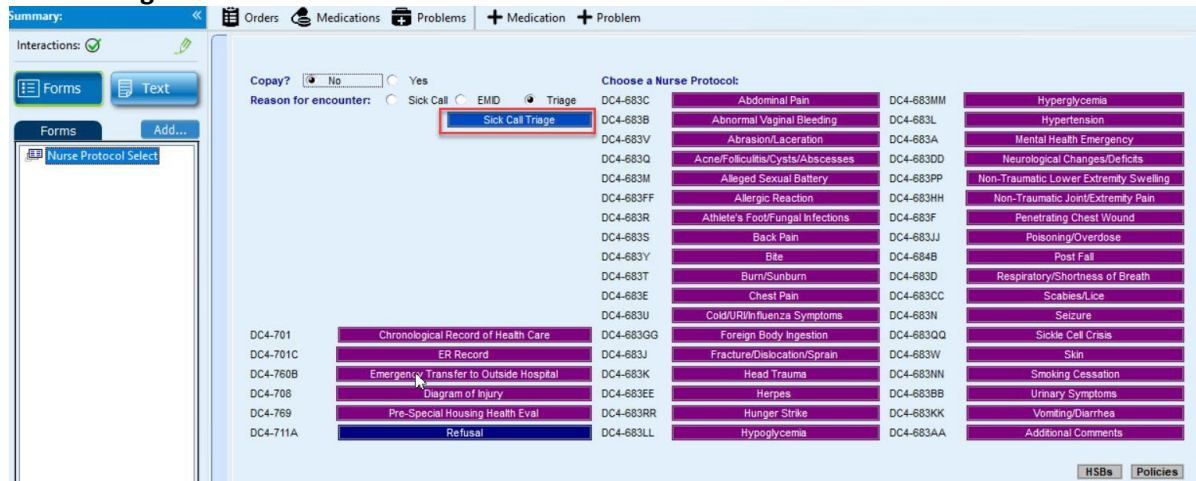
**STEP2:** Click on **New Document**.

**STEP3:** Select **Nurse Protocol Visit** Encounter Type.



**STEP4:** Select Copy, **NO**.

**STEP5:** Select **Triage**.



**STEP6:** Complete form as clinically indicated.

- An order window will populate that an order has been created.
- Select Orders and complete the **Order Details** as indicated by triage level. Change start date to scheduled date.

**STEP7:** Select **End**.

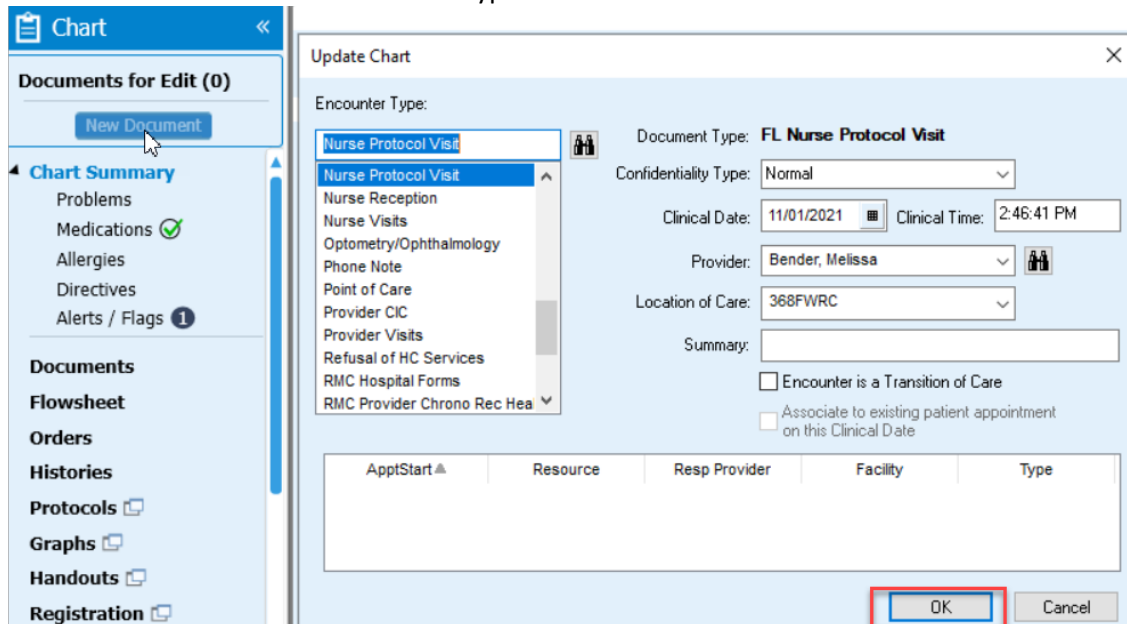
**STEP8:** Sign **Document**.

## Completing sick Call Visit Day of Appointment

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP2:** Click on **New Document** to begin a new encounter.

**STEP3:** Select **Nurse Protocol Visit** Encounter Type.

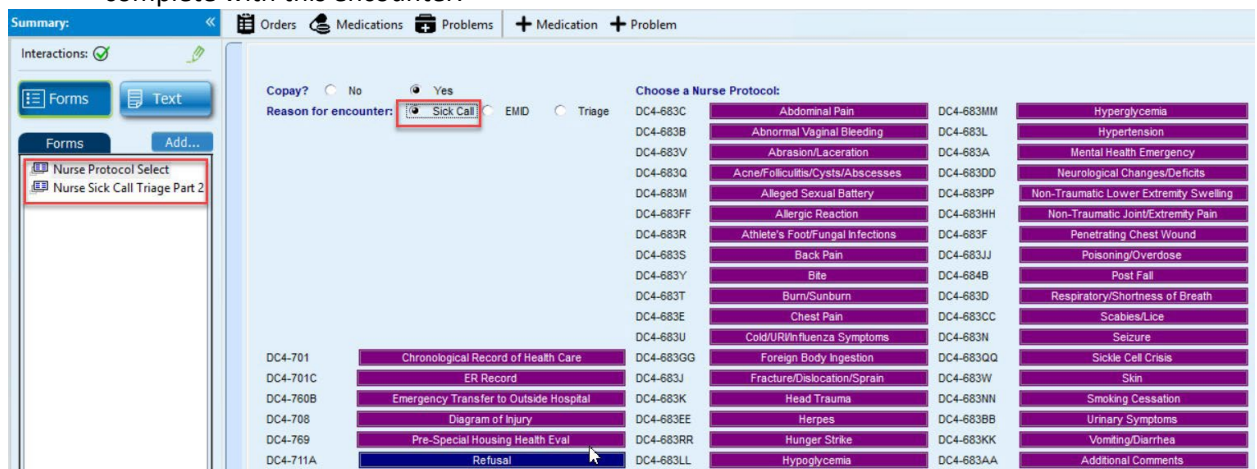


**STEP4:** Select **Copy** option.

**STEP5:** Select **Sick Call** second triage form will auto populate in left navigation pane.

**STEP6:** Select applicable forms associated with sick call request.

- If no appropriate protocol, select **Chronological Record of Health Care** to complete SOAPE note.
- To add more than one protocol to encounter, select the **Nurse Protocol Select** on the left navigation pane to return to protocol options. Select additional protocol to complete with this encounter.



DC4-701	DC4-701C	DC4-760B	DC4-768	DC4-769	DC4-711A
DC4-683C	DC4-683B	DC4-683V	DC4-683Q	DC4-683M	DC4-683FF
DC4-683R	DC4-683S	DC4-683Y	DC4-683T	DC4-683E	DC4-683U
DC4-683G	DC4-683J	DC4-683K	DC4-683EE	DC4-683RR	DC4-683LL
DC4-683M	DC4-683L	DC4-683A	DC4-683DD	DC4-683PP	DC4-683HH
DC4-683F	DC4-683J	DC4-684B	DC4-683D	DC4-683CC	DC4-683N
DC4-683S	DC4-683L	DC4-683D	DC4-683Q	DC4-683W	DC4-683NN
DC4-683Y	DC4-684B	DC4-683D	DC4-683Q	DC4-683W	DC4-683BB
DC4-683T	DC4-683D	DC4-683D	DC4-683Q	DC4-683W	DC4-683KK
DC4-683E	DC4-683CC	DC4-683N	DC4-683Q	DC4-683W	DC4-683AA
DC4-683U	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA
DC4-683G	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA
DC4-683J	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA
DC4-683K	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA
DC4-683EE	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA
DC4-683RR	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA
DC4-683LL	DC4-683N	DC4-683NN	DC4-683Q	DC4-683W	DC4-683AA

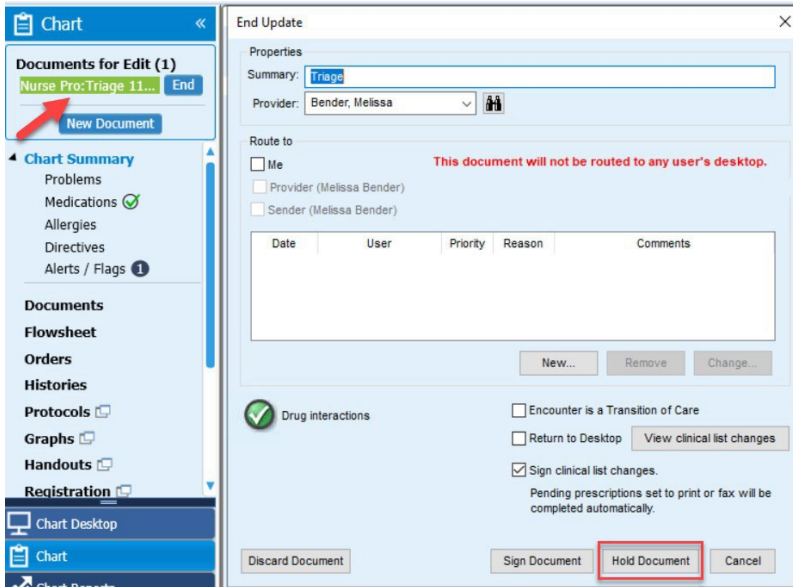
**STEP7:** Complete forms in entirety.

**STEP8:** If need to notify clinician immediately, Nurse will place document on hold.

- Select End and then Hold.

**STEP9:** Notify/speak with clinician, return to the encounter and add clinician orders.

- Select Edit next to the document on hold in the **Document for Edit** section of the patients chart.

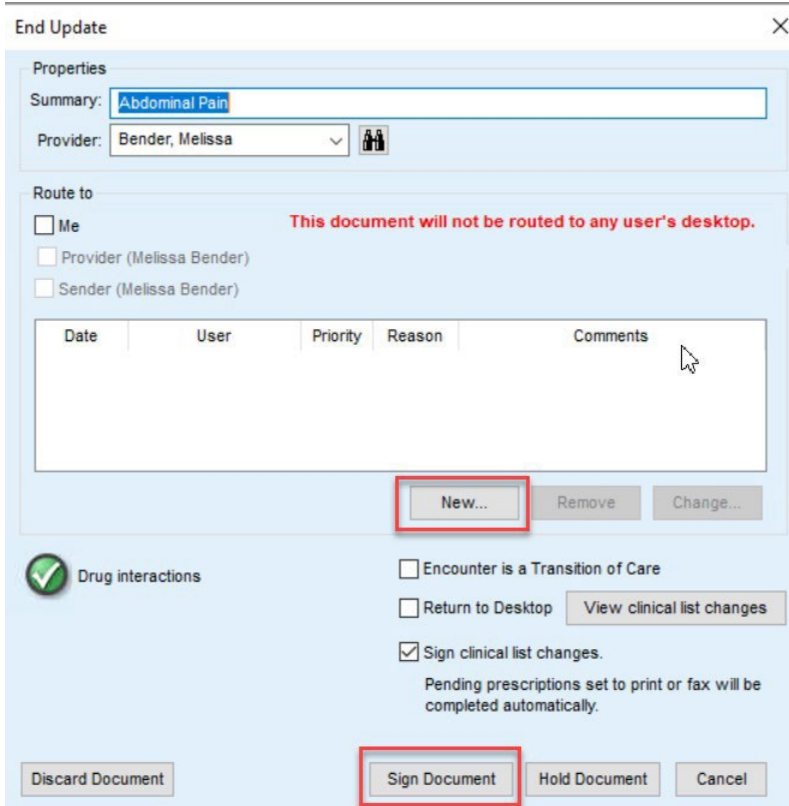


**STEP10:** Enter clinician's orders if applicable.

**STEP11:** Select **End**.

**STEP12:** **Route** to Clinician for signature if necessary.

**STEP13:** Select **Sign Document**.



**STEP14:** Complete Sick Call Order



- Click on the **Orders** link in the left navigation pane.
- Select the **Sick Call** order from the list of orders.
- Click **Complete** in the **Orders** screen toolbar.
- When the **Select Orders to complete** box opens, verify that there is a check mark next to the **Sick Call** order.
- Click **OK** to complete the order and remove it from the patient's orders.

**STEP15:** Document date and time on sick call request form and give paper to medical records to scan into chart.

## Bedboard Workflow

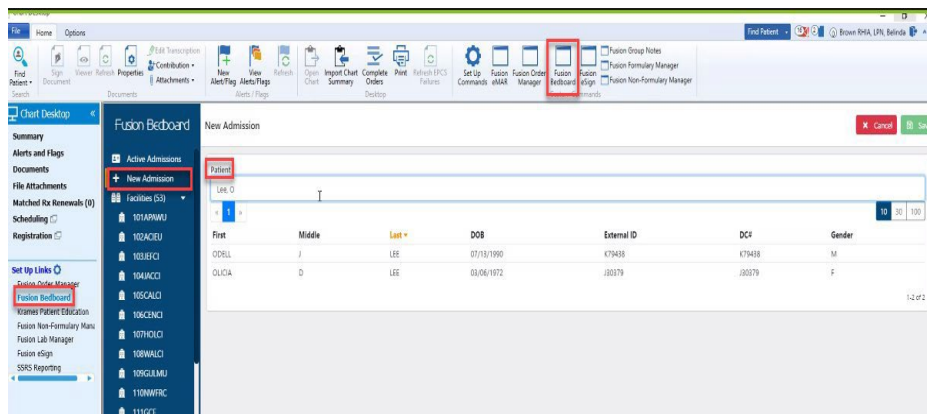
### Bedboard Admission

**STEP1:** Select the icon for Fusion Bedboard either from the **tool bar** or **left navigation pane**.

**STEP2:** Select **+ New Admission** in the left navigation pane.

**STEP3:** Enter the **patient's name** or **DC#** to find the patient.

**STEP4:** Select your patient from the list.



**STEP5:** Select on the blue Use ICD-10 Code link next to Admitting Diagnosis to enable ICD-10 code diagnosis searches

**STEP6:** Enter the admitting diagnosis.

- It will begin searching as soon as you start typing, and the more you enter, the narrower the results will become.

**STEP7:** Document any notes in the **Admission Note** box.

**STEP8:** Select the **Acuity** for the admission using the drop down menu.

**STEP9:** Document any notes required in the **Acuity Note** box.

**STEP10:** If the patient needs to be isolated, check off the corresponding box.

**STEP11:** Verify the **Facility** is correct, or change it accordingly.

**STEP12:** Select the **Infirmiry** where the patient will be placed from the drop down menu.

**STEP13:** Select the **Room** where the patient will be placed from the drop down menu.

**STEP14:** Select the **Bed** where the patient will be placed from the drop down menu.

**STEP15:** Select **+ Add Provider** to add the admitting provider's information.

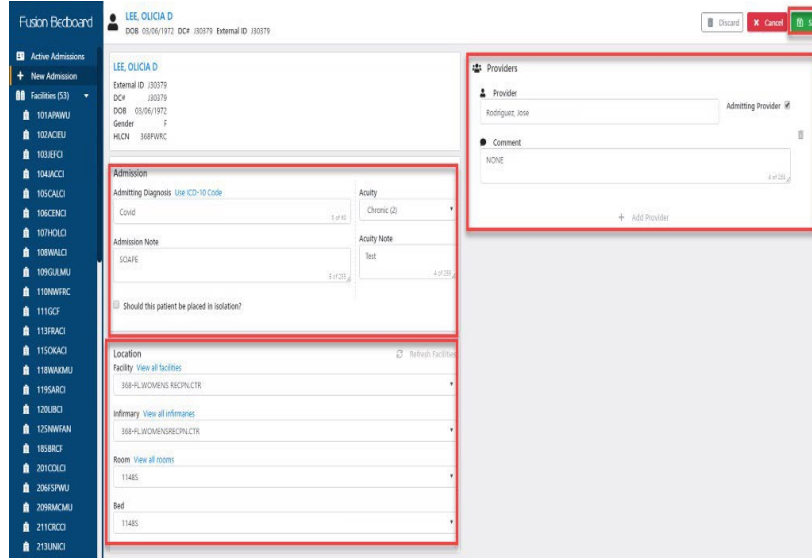
- Type the providers name into the **Provider** box.
- Document in the **Comment** box if applicable.



- An **Admitting Provider** must be selected for all admissions.

**STEP16:** Check off the box labeled **AdmittingProvider**.

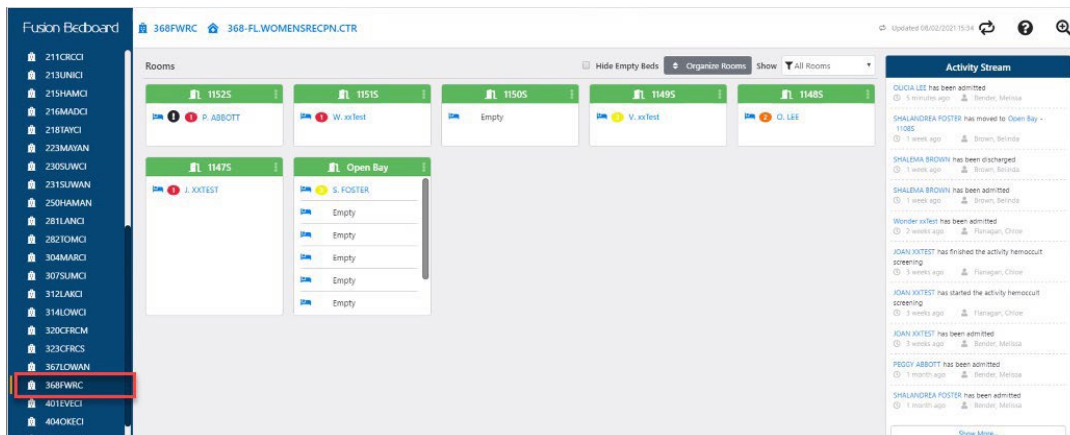
**STEP17:** Select the green **Save** button at the top right of the screen



## Discharging a Patient

**STEP1:** Select infirmaries' facility number from left hand side. It will display the entire infirmary.

- It will show all beds and occupants.



**STEP2:** Select Patient's name to open their **Bedboard Chart**.

**STEP3:** Select the discharge button in the top right hand corner.

Fusion Bedboard

LEE, OLICIA D  
Admitted

Medical Activities Notes Acuties Admissions Movement

Open Orders (1)

Date	Type	Description	Loc of Care	Authorized By	Status
08/02/2021	Test	Inmate Request- Medical Records	368FWRC	Bender, Melissa	In Process

Active Medications (2)

Description	Start Date	Stop Date
HYDROCORTISONE 10 MG ORAL TABS	07/28/2021	08/27/2021
AMODARONE HCL 200 MG ORAL TABS	07/28/2021	08/27/2021

Allergies (0)  
There are no allergies to display.

Problems (0)  
There are no problems to display.

**STEP4:** Enter discharge reason per clinician's order.

**STEP5:** Select save.

Discharge LEE, OLICIA D

Discharge Reason

Test

Follow-Up Orders

Clinicians Orders (NURCLINOR)

Cancel Save

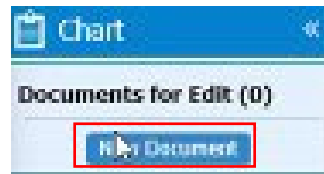


## How to Complete Transfer Summary

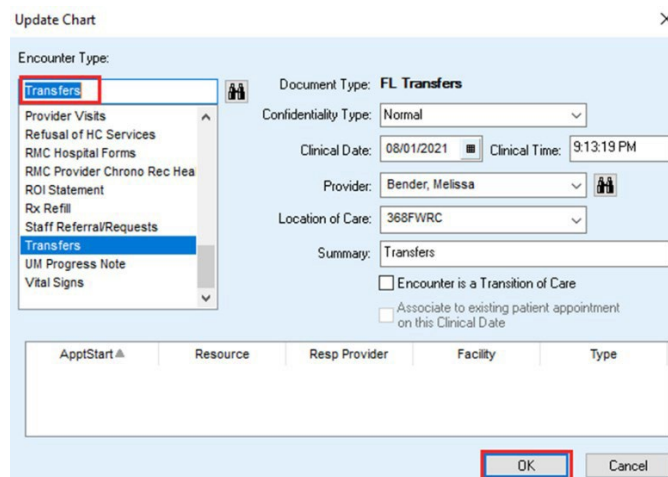
### Transfers – Sending Facility

**STEP1:** Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.

**STEP2:** Click on **New Document** to begin a new encounter.

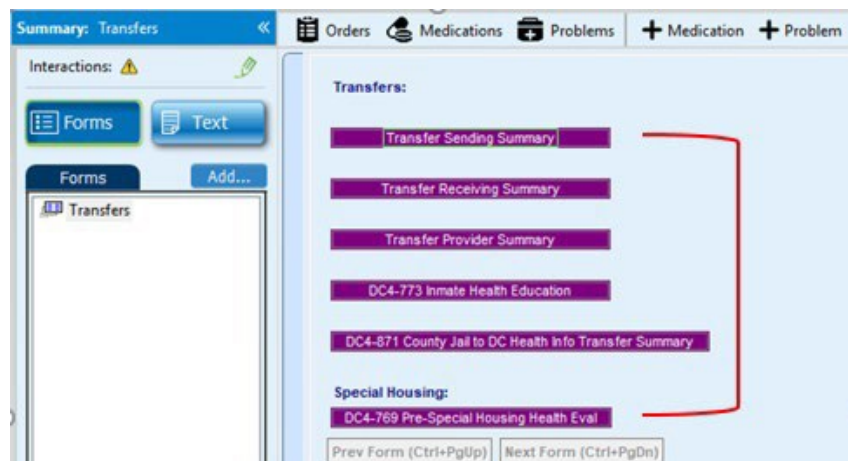


**STEP3:** Select **Transfers** encounter Type.



**STEP4:** Select appropriate form for the step in the process as:

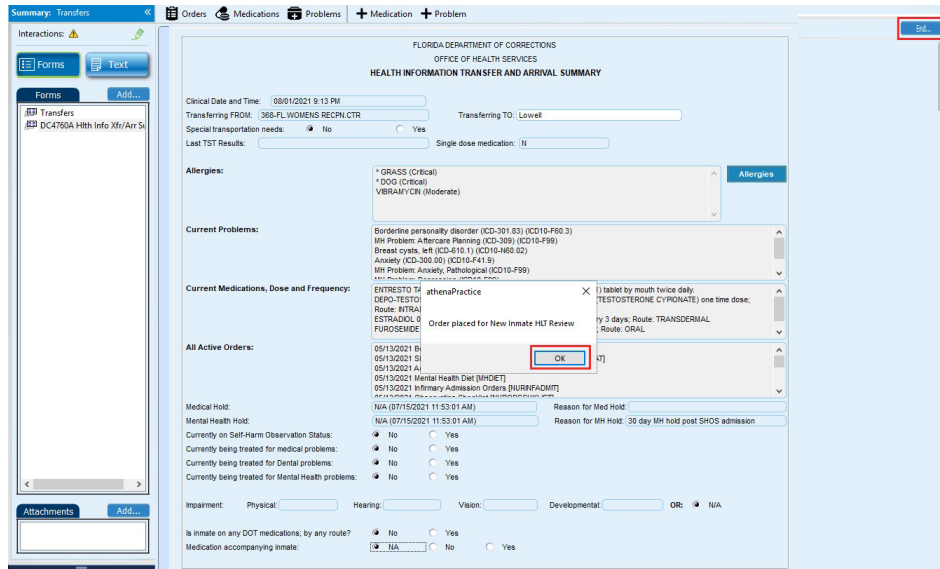
- Transfer Sending Summary
- Transfer Receiving Summary
  - Also select the **DC4-773 Inmate Health Education**.
- Transfer Provider Summary



**STEP5:** Complete form in its entirety.

**STEP6:** An order will auto populate for next process needing to be completed. i.e:

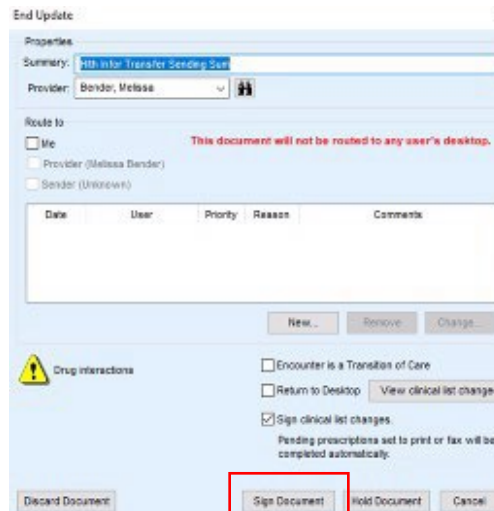
- **New Inmate HLT Review** will auto populate for the permanent facility to complete.
- **Provider Health Review** will auto populate for the provider to complete.



The screenshot shows a web-based form titled "HEALTH INFORMATION TRANSFER AND ARRIVAL SUMMARY" from the Florida Department of Corrections Office of Health Services. The form includes various sections for patient information, allergies, current problems, medications, and medical holds. A red box highlights the "End..." button in the top right corner of the form.

**STEP7:** Select End.

**STEP8:** Select Sign Document.



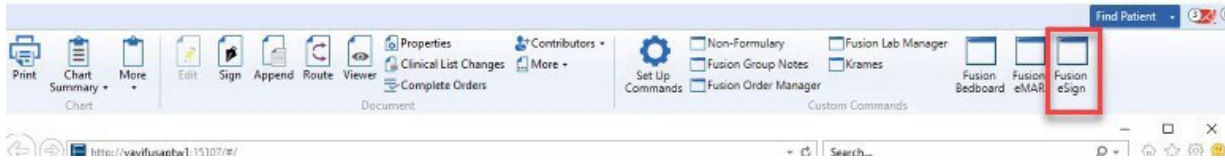
The screenshot shows a dialog box titled "End Update" with a "Properties" section. The "Summary" field contains "HLT info: Transfer Pending Case". The "Provider" is listed as "Bender, Melissa". Under "Route to", the "Me" option is selected, with a red warning message: "This document will not be routed to any user's desktop." Below this is a table with columns: Date, User, Priority, Reason, Comments. At the bottom, there are buttons for "Discard Document", "Sign Document" (highlighted with a red box), "Hold Document", and "Cancel".

**STEP9:** After completing the form, the permanent facility and provider will need to complete corresponding orders.

- Select Orders from left navigation pane of patients chart.
- Locate and select order.
  - **New Inmate HLT Review** for the permanent facility.
  - **Provider Health Review** for the provider.
- Select **Complete**.
- Select **Ok**.

## Fusion eMAR Online Medpass Workflow

**STEP1:** Select Fusion eMAR web application from top tool bar.



**STEP2:** Verify correct institution is selected top right corner, change if necessary.

**STEP3:** Select Medpass on top tool bar.



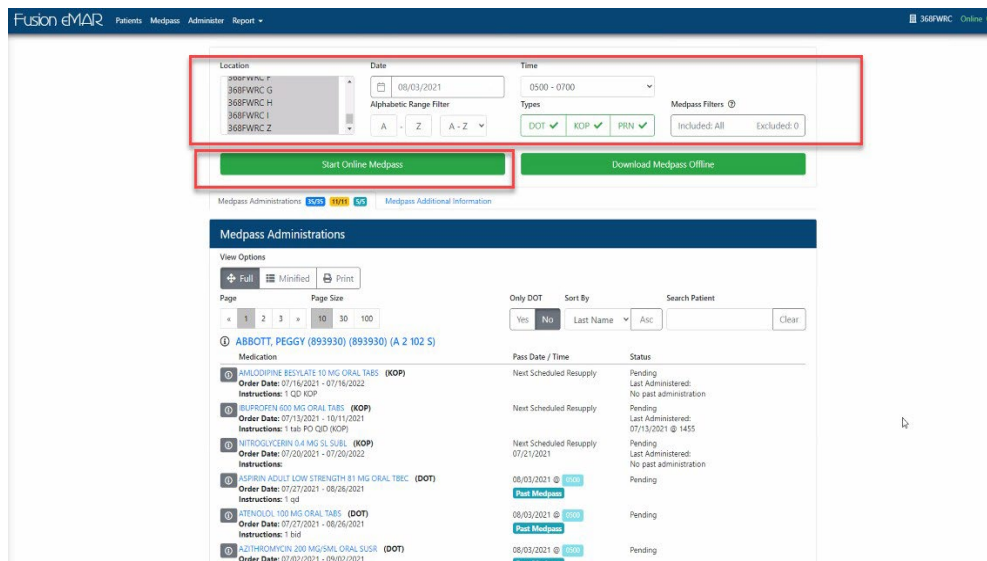
**STEP4:** Select desired Location(s) - Dorms for Medpass.

**STEP5:** To select multiple dorm locations hold CTRL and click on each one to highlight desired location, CTRL A to select ALL, if applicable.

- Select Alphabetic Range filter based on your assigned Medpass.
- Select Date of Medpass.
- Select Types of Medpass - DOT, KOP or PRN.
- Filter Medpass if needed.

**STEP6:** Select Medpass Time from dropdown menu to generate list.

**STEP7:** Once Medpass generates select Start Online Medpass.



The screenshot shows the 'Medpass Administrations' page in Fusion eMAR. At the top, there are filters for Location (368FWRC F, G, H, I, Z), Date (08/03/2021), Time (0500 - 0700), and Types (DOT, KOP, PRN). Below these filters are two buttons: 'Start Online Medpass' (highlighted with a red box) and 'Download Medpass Offline'. The main area displays a table of medication orders with columns for Medication, Pass Date / Time, and Status.

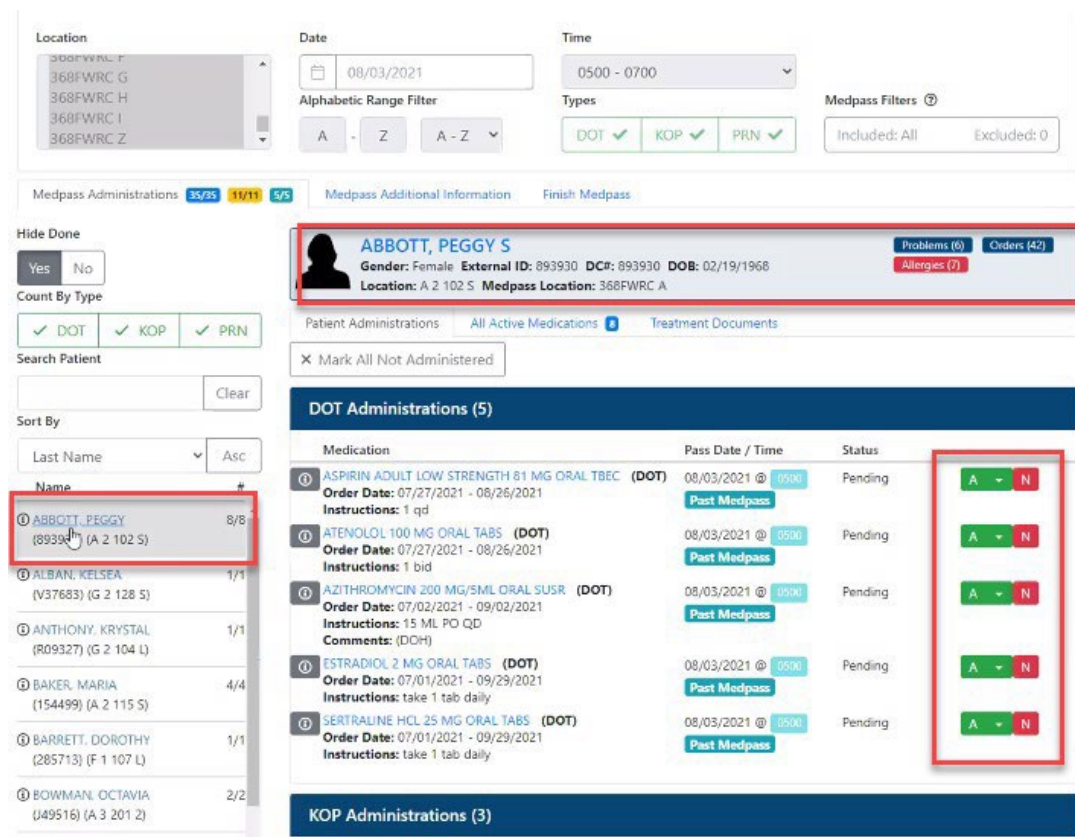
Medication	Pass Date / Time	Status
ABBOTT, PEGGY (893930) (893930) (A 2 102 S)		
MALDOXINE RESULATE 10 MG ORAL TABS (KOP)	Next Scheduled Resupply	Pending
Order Date: 07/16/2021 - 07/16/2022		Last Administered:
Instructions: 1 QD KOP		No past administration
SUPROFEN 400 MG ORAL TABS (KOP)	Next Scheduled Resupply	Pending
Order Date: 07/13/2021 - 10/10/2021		Last Administered:
Instructions: 1 tab PO QID (KOP)		07/13/2021 @ 1455
NITROGLYCERIN 0.4 MG SL SUBL (KOP)	Next Scheduled Resupply	Pending
Order Date: 07/20/2021 - 07/20/2022	07/21/2021	Last Administered:
Instructions:		No past administration
ASPIRIN ADULT LOW STRENGTH 81 MG ORAL TBEC (DOT)	08/03/2021 @ 0900	Pending
Order Date: 07/27/2021 - 08/26/2021		Post Medpass
Instructions: 1 qd		
ATENOLOL 100 MG ORAL TABS (DOT)	08/03/2021 @ 0900	Pending
Order Date: 07/27/2021 - 08/26/2021		Post Medpass
Instructions: 1 bid		
LETHBRONCH 200 MG/ML ORAL SUSP (DOT)	08/03/2021 @ 0900	Pending
Order Date: 07/02/2021 - 09/02/2021		Post Medpass

**STEP8:** Patient's names will populate from list on left side of screen in alphabetic order.

**STEP9:** You can sort the list by Patient Name, Location, Administrations remaining or Administrations total. (\*if there are multiple patient's with the same last name, verify the DC#).

**STEP10:** Select patients name to open patients Medpass details.

- From here you will click on the A to administer.
- Select the drop down arrow next to the A to Administer with Comment.
- Select the N to Not Administer for patient selected, select the reason the med was not administered and add comment if applicable.
- Add treatment documents as needed for each patient.
- If applicable, select Treatment Documents tab to add required information.



The screenshot displays the Online Medpass interface. At the top, there are filters for Location (368FWRC G, H, I, Z), Date (08/03/2021), Time (0500 - 0700), and Medpass Filters (Types: DOT, KOP, PRN). Below these are tabs for Medpass Administrations (35/35), Medpass Additional Information, and Finish Medpass. A patient selection list on the left shows 'ABBOTT, PEGGY' selected. The main area shows patient details for 'ABBOTT, PEGGY' (DOB: 02/19/1968) and a list of DOT Administrations (5) with columns for Medication, Pass Date / Time, Status, and Action (A/N). The 'ASPIRIN ADULT LOW STRENGTH 81 MG ORAL TBEC (DOT)' row is highlighted, and its action buttons are circled in red.

**STEP11:** Select the next patients name on list and repeat steps above until all names from list have been completed.

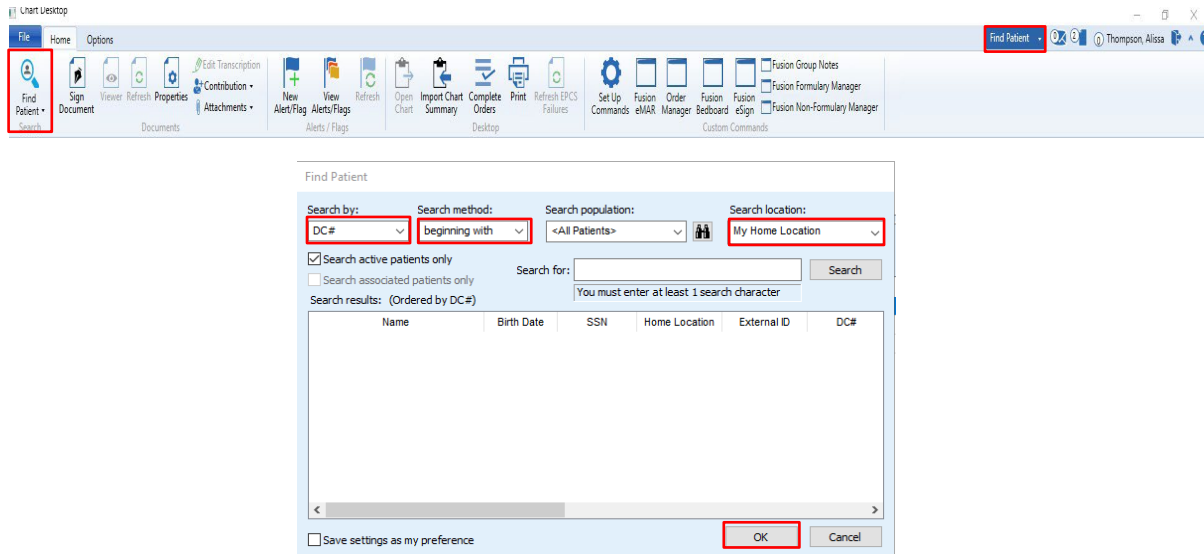
**STEP12:** Select Finish Medpass tab to confirm all administration in Medpass have been completed.

\*\*\*If you exit Online Medpass once you start you will need to repopulate the medpass list using the same selections as completed previously to repopulate list.

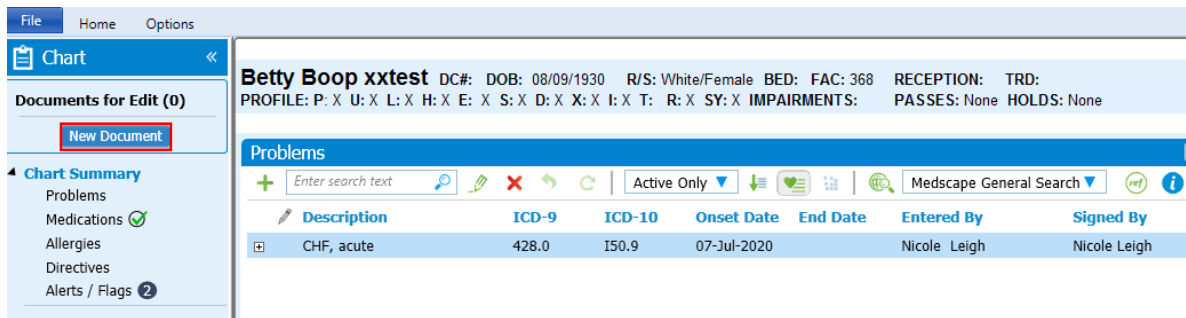
## Nurse Infirmiry Admission Workflow

### Find Patient

**STEP 1:** Using the **Magnifying Glass, Find Patient Drop Down** or **CTRL F**, locate your patient.



**STEP 2:** Select search criteria then, **OK**



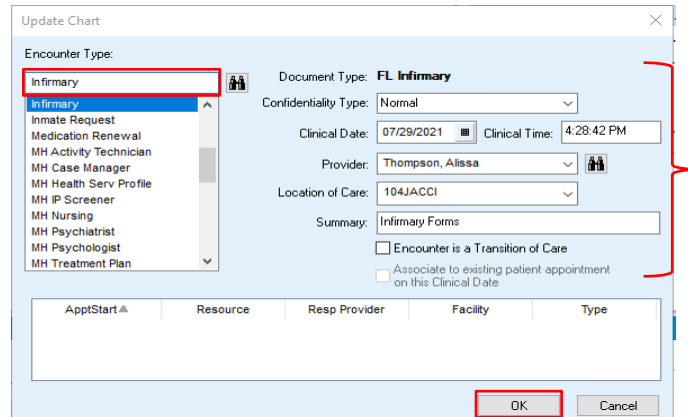
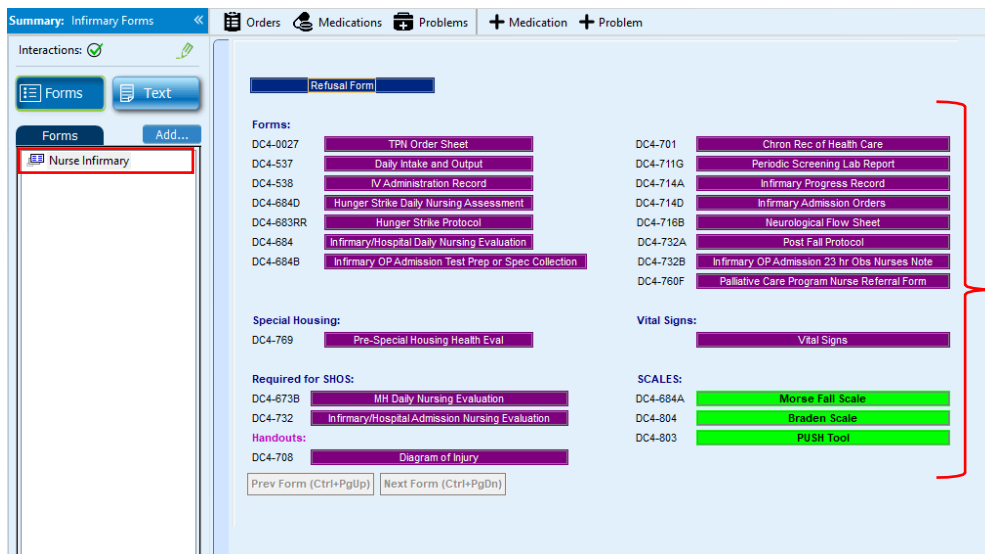
### Choose Encounter Form

**STEP 2:** Select **New Document** from left navigation pane

- Update Chart box will open

## Choose Encounter Type

**Step 3:** Select **Infirmary** from drop down list, then **OK**






## Choose Infirmary Admission Forms

**Step 4:** Select all **Infirmary** encounter forms

- There are 13 forms associated with the **Infirmary** Encounter
- These forms will appear in the forms window in the left navigation pane

Summary: Infirmary Forms < Orders Medications Problems + Medication + Problem

Interactions:  

Forms Text

Forms Add...

- Nurse Infirmary
- DC4714D Infirm Admit Orde
- DC4732 Infirm.Hosp Admn I

Refusal Form

Forms:

DC4-0027	TPN Order Sheet	DC4-701	Chron Rec of Health Care
DC4-537	Daily Intake and Output	DC4-711G	Periodic Screening Lab Report
DC4-538	IV Administration Record	DC4-714A	Infirmary Progress Record
DC4-684D	Hunger Strike Daily Nursing Assessment	DC4-714D	Infirmary Admission Orders
DC4-683RR	Hunger Strike Protocol	DC4-716B	Neurological Flow Sheet
DC4-684	Infirmary/Hospital Daily Nursing Evaluation	DC4-732A	Post Fall Protocol
DC4-684B	Infirmary OP Admission Test Prep or Spec Collection	DC4-732B	Infirmary OP Admission 23 hr Obs Nurses Note
		DC4-760F	Palliative Care Program Nurse Referral Form

Special Housing:

DC4-769 Pre-Special Housing Health Eval

Required for SHOS:

DC4-673B MH Daily Nursing Evaluation

DC4-732 Infirmary/Hospital Admission Nursing Evaluation

Handouts:

DC4-708 Diagram of Injury

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn)

Vital Signs:

Vital Signs

SCALES:

DC4-684A Morse Fall Scale

DC4-804 Braden Scale



DC4-803 PUSH Tool

## Infirmary Admission Orders

### Step 4: Complete the Infirmary Admission Orders Form

- Complete form as clinically indicated

Summary: Inf Admit OrdersInfirm... < Orders Medications Problems + Medication + Problem

Interactions:  

Forms Text

Forms Add...

- Nurse Infirmary
- DC4714D Infirm Admit Orde
- DC4732 Infirm.Hosp Admn I

INFIRMARY ADMISSION ORDERS SHEET  
(Must be completed on ALL Infirmary admissions)

Type of Admission:  Acute Illness  Chronic-Long Term Care

Clinical Date and Time: 07/16/2021 11:22 AM Time Orders Written:  Now

Attending Clinician:

Current Problems: Hepatitis C (ICD-070.70) (ICD10-B19.20)

Admitting Diagnosis:

Condition:

Code Status:

Code Status:

Allergies:

Activity:

Vital Signs:  Every 4 hours  Every shift  Once every 24 hours

Accu-Check

## Adding Orders

**Step 4:** Select either the green **Add Nursing Care Orders** or the green **Orders** button to submit any orders received relating to infirmary admission as directed by the provider.

Change IV catheter, dressing, tubing including IV piggyback tubing and stopcock at least every 96 hours  
 Low bed  
 Seizure precautions  
 Other:

**Add Nursing Care Orders**

Notify Clinician if:

BP is less than 90/60 or greater than 170/110  
 Pulse is greater than 110 or less than 60  
 Urine output is less than 25cc over 4 hours  
 Patient has sudden altered mental status  
 Temp is 101 or higher OR has a 3o increase in one shift  
 Respiratory rate is greater than 24  
 O2 sat is less than 93%  
 Patient receives minimal to no pain relief within 1 hour of pain medication  
 Other

**Orders**

a DC4-714D Infirmiry Admission Order Sheet (Revised 08/11/17)

Update Orders - Mr XXTest 50 Years Old Male, (DOB: 01/05/1971)

Orders:  This update  Open  All Primary Coverage:  Potential Diagnoses: Hepatitis C

Date	Description	Status	Diagnoses

Remove Reorder Clear Diagnoses New... Edit

Custom List Categories Search Order Details

Use custom list: **Nursing Services**

Encounter	Health Screenings	Vitals	Infirmiry Admission
<input type="checkbox"/> Health Assessment	<input type="checkbox"/> Auditory Screening	<input type="checkbox"/> Ostomy care	<input type="checkbox"/> Adaptive Device Assigned
<input type="checkbox"/> Health Education	<input type="checkbox"/> Mobility Screening	<input type="checkbox"/> Fetal	<input type="checkbox"/> Daily Infirmiry Rounds
<input type="checkbox"/> TC Clinic	<input type="checkbox"/> Periodic Screening	<input type="checkbox"/> Foley	<input type="checkbox"/> Braden
<input type="checkbox"/> IV Care Q 96 hrs	<input type="checkbox"/> Post use of force exam	<input type="checkbox"/> ROM exercises 3 x daily	<input type="checkbox"/> Morse Scale
<input type="checkbox"/> Nursing flu	<input type="checkbox"/> Vision Screening	<input type="checkbox"/> Suture Removal	<input type="checkbox"/> Hosp Infirmiry DC
<input type="checkbox"/> Sick Call	<input type="checkbox"/> Wounds	<input type="checkbox"/> Visual/Accuhy	<input type="checkbox"/> DIC
<input type="checkbox"/> Skin Check	<input type="checkbox"/> BP	<input type="checkbox"/> Infirmiry	<input type="checkbox"/> RMC General Hospital Discharge
<input type="checkbox"/> Pre-Release Health Care Summary	<input type="checkbox"/> Weights	<input type="checkbox"/> Assessments(every 8 hours)	<input type="checkbox"/> Risk Assessment for Chemical Rest.
<input type="checkbox"/> Inmate Assistant Annual Training			<input type="checkbox"/> Pre-Special Housing Health Evaluation

Sign Orders OK Cancel

**Step 5: Use Custom List(s) to add all orders as directed**

- Select all orders related to patient as per provider
  - Including actual infirmiry admission order
- Select any orders for diet changes or special needs as prescribed (under **Special Passes/Allowed Items** custom list)
- All selected orders will appear in the top portion of window.



## Order Details

- Complete all necessary steps below for each individual order, before moving to the next, to insure all are complete

Update Orders - Mr XXTest 50 Years Old Male, (DOB: 01/05/1971)

Orders:  This update  Open  All Primary Coverage:  Potential Diagnoses:

!	Date	Description	Status	Diagnoses
	07/16/2021	Adaptive Device Assigned	Unsigned	HEPATITIS C (ICD-070.70) (ICD10-B16)
	07/16/2021	Daily Infirmiry Rounds	Unsigned	<<
	07/16/2021	Braden	Unsigned	
	07/16/2021	Morse Scale	Unsigned	

Remove Reorder Clear Diagnoses New... Edit...

Custom List Categories Search Order Details

Clinical Information

Description: Adaptive Device Assigned

Code: SP-ADAPT

NDC:

Authorized By: Wu MD, Johnny

Modifiers:

Instructions:

Disposition: In Process

Test Administration

Priority:  Normal  Urgent  Stat

Start Date: 07/16/2021  End Date:

Duration: 0  Days  Weeks  Months

Quantity: 1  Create Transition of Care Document

Reason:

Test provider:  External  Internal Provider

FDC

Insurance Notes:

### Step 6: Add a Potential Diagnosis

- Each order must be associated with a diagnosis
- Highlight Order, then highlight the appropriate diagnosis
- Use the << button to attach
- If the problem is not listed, use the **New** button to add a potential diagnosis
  - see the *How To Add Problems* guide for assistance
- The Order Details tab at the bottom will automatically populate once diagnosis is added.

### Step 7: Clinical Information

- Select **Authorized By**: This will be the Authorized provider ordering the Infirmiry Admission
- Enter in any **Instructions** regarding admission
- Disposition**: DO NOT CHANGE

### Step 8: Test Administration

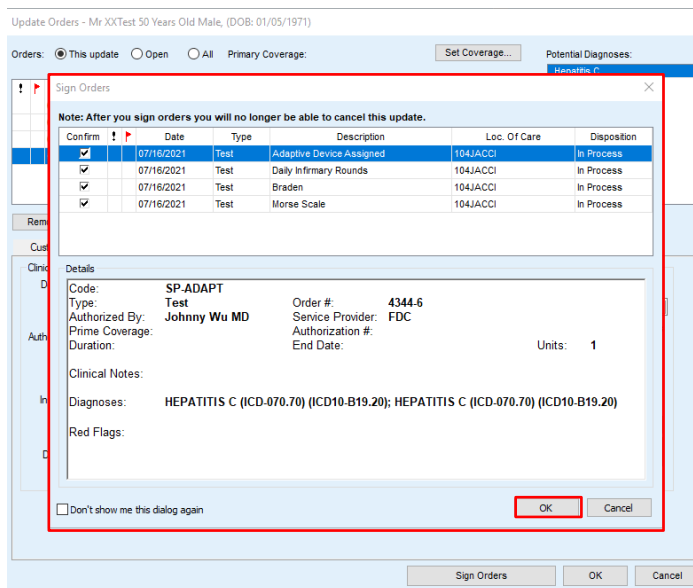
- Priority**
- Start Date** should be the actual date of the admission
- Duration**- If known (End Date will autofill)
  - If duration is unknown, **End Date** should be left blank
- Provider should always be **FDC** *unless* the order is for Labs (Bioreference) or Radiology (MobileX)
- If there are multiple orders, select the **Next Order** button to move to the next.

## Sign Orders



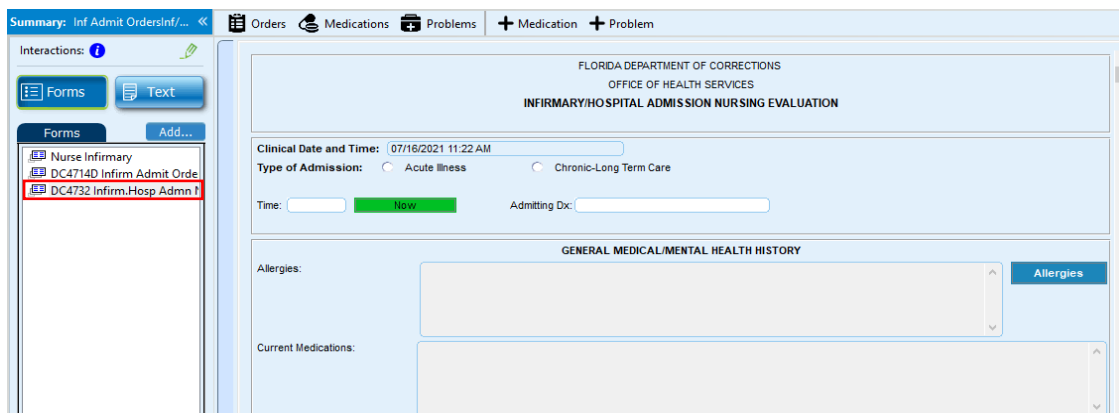
### Step 8: Sign Orders

- Once all steps are complete, **Sign Orders**.
  - A new window will open to give you one last review of the signed orders.



- Review and confirm all information for each order is correct, then select **OK**
  - You will be automatically directed to previous window to complete encounter and any additional forms.

## Infirmiry Admission Nursing Evaluation



Summary: Inf Admit Orders/Inf/... << Orders Medications Problems + Medication + Problem

Interactions:

Forms

- Nurse Infirmiry
- DC4714D Infirm Admit Orde.
- DC4732 Infirm.Hosp Admn I

FLORIDA DEPARTMENT OF CORRECTIONS  
 OFFICE OF HEALTH SERVICES  
 INFIRMIRY/HOSPITAL ADMISSION NURSING EVALUATION

Clinical Date and Time: 07/16/2021 11:22 AM

Type of Admission:  Acute Illness  Chronic-Long Term Care

Time:   Admitting Dc:

GENERAL MEDICAL/MENTAL HEALTH HISTORY

Allergies:

Current Medications:

### Step 8: Complete the Infirmiry Admission Nursing Evaluation

- Complete all necessary fields as clinically indicated within the Infirmiry/Hospital Admission Nursing Evaluation form

- Be sure to scroll to bottom for additional documentation.
- You will have multiple purple buttons throughout selected forms. These are additional forms to be completed as needed within the patient visit.
  - DC4-687 Advanced Directive Information Sheet
  - DC4-804 Braden Scale
  - DC4-708 Body Diagram
    - Print here, complete and give to medical records to scan into chart.
  - DC4684A Morse Fall Scale
    - Complete on all Acute and Chronic Admissions

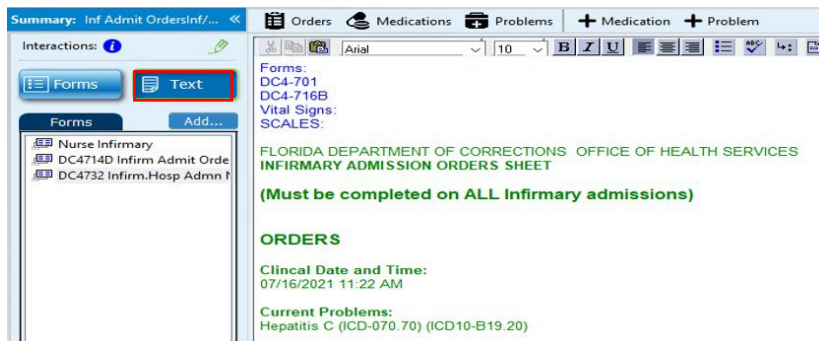
### Step 8: Complete remaining Infirmiry Admission Forms

- There are 13 forms associated with the **Infirmiry** Encounter

## Complete Document

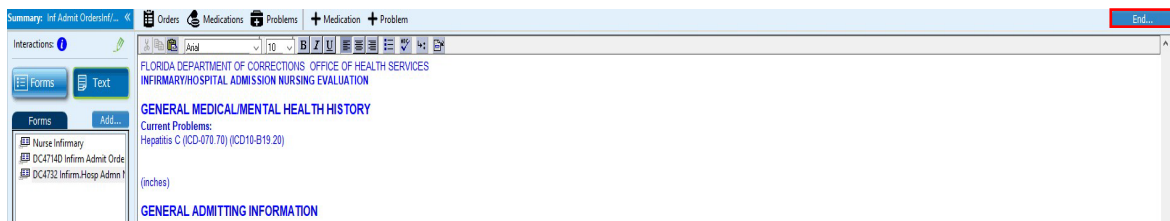
### Step 12: View Completed Document

- Select the Text button to review the note created by all the forms.
- To go back to forms view, select the forms button

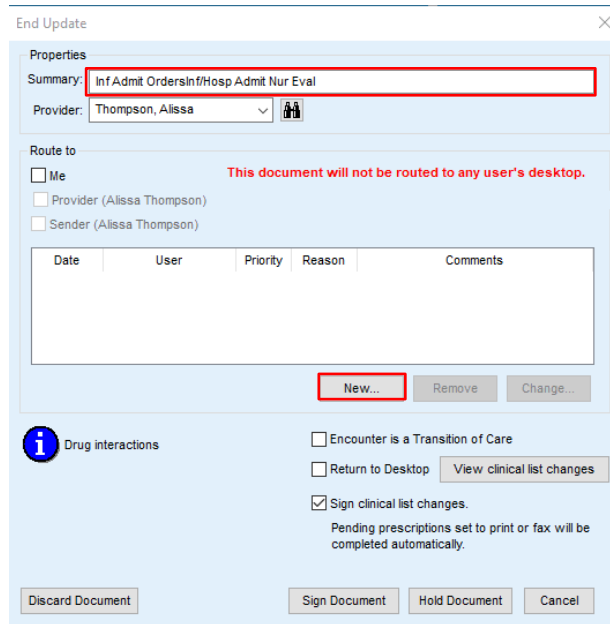


## End Document

### Step 13: Select the End box in the upper right corner.

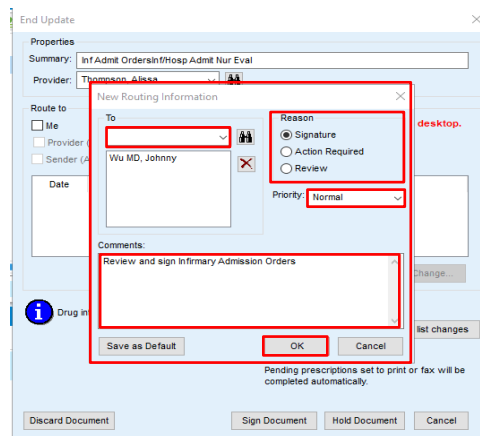


- Verify Summary line is accurate and completed.



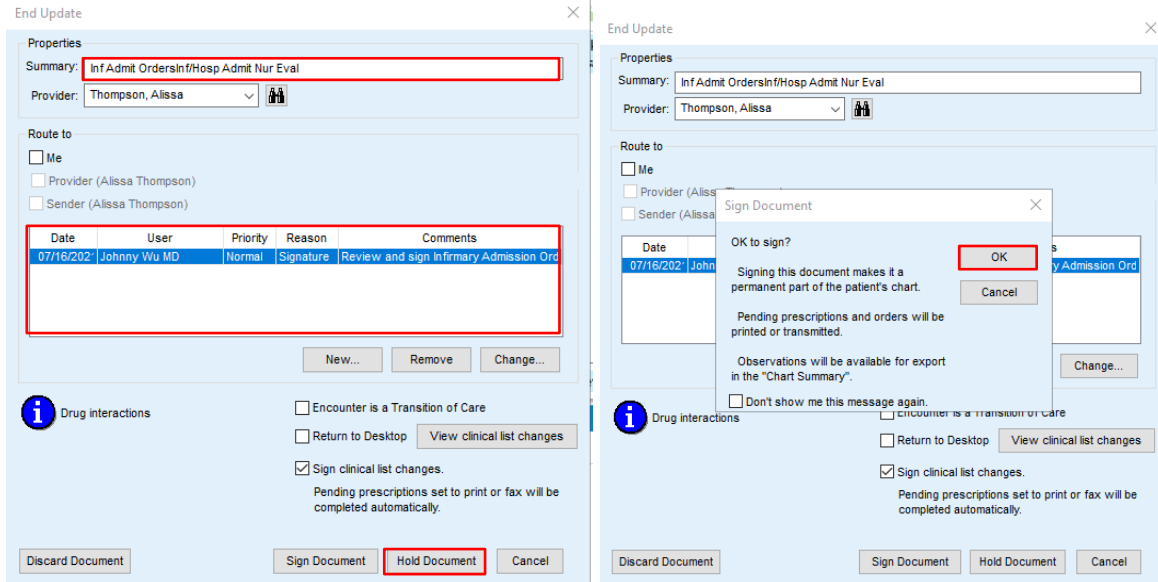
#### Step 14: Routing the Document

- Click **New** to route the document to the Authorizing Provider for Co-signature.
  - This is required for the authorizing provider to sign off on all infirmiry admission orders.



- **To** Choose Authorized Provider
- **Reason:** Signature
- **Priority**
- **Comments:** *Always* add why you are routing
- Select **OK** Once these steps are complete for Routing (Select **OK**)

#### Step 15: End Document



End Update

Properties

Summary: Inf Admit OrdersInf/Hosp Admit Nur Eval

Provider: Thompson, Alissa

Route to

Me

Provider (Alissa Thompson)

Sender (Alissa Thompson)

Date	User	Priority	Reason	Comments
07/16/2022	Johnny Wu MD	Normal	Signature	Review and sign Infirmiry Admission Ord

New... Remove Change...

**i** Drug interactions

Encounter is a Transition of Care

Return to Desktop View clinical list changes

Sign clinical list changes.

Pending prescriptions set to print or fax will be completed automatically.

Discard Document Sign Document Hold Document Cancel

End Update

Properties

Summary: Inf Admit OrdersInf/Hosp Admit Nur Eval

Provider: Thompson, Alissa

Route to

Me

Provider (Alissa Thompson)

Sender (Alissa Thompson)

**i** Drug interactions

Encounter is a Transition of Care

Return to Desktop View clinical list changes

Sign clinical list changes.

Pending prescriptions set to print or fax will be completed automatically.

Discard Document Sign Document Hold Document Cancel

Sign Document

OK to sign?

Signing this document makes it a permanent part of the patient's chart.

OK Cancel

Pending prescriptions and orders will be printed or transmitted.

Observations will be available for export in the "Chart Summary".

Don't show me this message again.

Change...

- Review Encounter Summary information
- Review Routing Information
- Select **Sign Document**
- Then, **OK** to add encounter as permanent part of chart.

## Post Infirmiry Admission Workflow

### Step 16: Order Manager

- Go to **Order Manager** to complete the orders placed in the infirmiry encounter.
  - See *Managing Orders Workflow for help*

### Step 17: Lab Manager

- Go to **Lab Manager** if labs were ordered to complete requisition form as necessary.
  - See *Lab Manager Workflow for help*

### Step 18: BedBoard

- Go into the **Bedboard** and complete required documentation relating to infirmiry admission.
  - See *Bedboard Workflow for help*



## Post Infirmery Admission Workflow

### **Step 16:** Order Manager

- Go to **Order Manager** to complete the orders placed in the infirmery encounter.
  - *See Managing Orders Workflow for help*

### **Step 17:** Lab Manager

- Go to **Lab Manager** if labs were ordered to complete requisition form as necessary.
  - *See Lab Manager Workflow for help*

### **Step 18:** BedBoard

- Go into the **Bedboard** and complete required documentation relating to infirmery admission.
  - *See Bedboard Workflow for help*



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## Fusion Group Notes Workflow

### Building a Roster

1. Select **Rosters**, then **Build Roster**.
2. The three required fields are:
  - Select Location- If only one location is available, it will be automatically selected.
  - Set Default Template- If the dropdown menu is empty, create a template.
  - Name of Roster- Enter Roster name as Site ID Staff Last Name- Something to help you Identify Roster Example: 368 Bender MWF 10am
3. **Add a New Patient** by typing either the patient's name or DC#.
4. Select the correct patient from populated list to add. If desired, add additional patients.
5. Select **Save Roster**.
6. The user will be asked **How would you like to proceed?**
  - **Build Another Roster**- allows the user to be sent back to the same page to build another roster.
  - **View All Rosters**- redirects the user to the **All Rosters** page.
  - **Create Group Using Roster**- redirects the user to the **Create a Group** page using the roster just created.

### Creating New Group Documentation

1. Select **Fusion Group Notes** from the title bar.
2. The **Fusion Group Notes** page will load in a new browser window.
3. Select **New Group** from the top tool bar.
4. Select previously created roster from the **Select Roster** drop down.
5. Select a **Group Template** from the drop down.
6. Enter **Group Name** in text box.
7. Verify Start and End dates and times are correct, change if needed.
8. Select **Save** to save the group documentation to complete later.
9. Select **Save and Start** to begin documentation now.
10. Complete all documentation in its entirety and Finalize to add to patients charts.



## Managing Orders- Scheduling Workflow

1. The **Order Manager** can be accessed from the user's **Chart Desktop**.
2. On the left side of the screen, click on the link titled **Fusion Order Manager**.
3. This will open the **Fusion Order Manager** within the EMR window.
4. Once **Order Manager** is opened, the user can select multiple options in order to search the specific list of orders to create the desired scheduled call-out.
5. Choose **Date Range**
6. Choose **Order Type** (Type of appointment: CIC, Labs, Nursing, etc.)
7. Select the **gear icon**, choose **Select Custom List**
8. Choose appropriate order types, click **search**
9. Choose **Facility Location**
10. Leave **Provider as "ALL"**
11. Search **Specific OBS** (Observation Terms). Here is where you can enter **HOUSING LOC** to add in the patients' dorm/bunk location.
12. Select the toggle buttons to choose to **Show PHI** or **Show Comments** (order comments).
13. Choose **Priority and Status**, depending on the type of schedule you are creating.
14. Select **Search** to generate your orders list.
15. Once the list appears on the screen, you still have the option of including the **PHI** and/or **Order Comments**.
16. Once your list is completed, it can be exported to an Excel spreadsheet. This allows the user to manipulate the list for their specific use.
17. To do this, select the **down arrow icon** at the bottom left.
18. Then highlight and click on **Export to CSV**.
19. The **File Download** window will open, select **Save**.
20. A **Save As** window opens. Select the appropriate file location to save your spreadsheet. (i.e.: *H Drive*)
21. Enter the file name you would like to save it as, or keep the default name.
22. From here, you can manipulate the spreadsheet to include or exclude any information desired. It can now be saved, emailed, printed and provided to designated staff and/or departments.



## Indexing Client Work Flow

### Importing Unsigned Document into EMR

1. Select Indexing Client from APP Page.
2. Sign into Indexing Client using your log in and password.
3. Scan the document using your assigned Scanner.
4. Select the designated **Scanner number** from the Path drop down menu.
5. Select the document you want to upload from your available files to highlight and hit the single arrow to add Files to import section.
6. Import as: **Attachment**
7. Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).
8. Select appropriate **Document Type** from the list using the drop down arrow associated with the document you are uploading.
9. **Clinical date** and time will auto populate to date and 12:00AM this will need to be changed to exact date and time of document.
10. **Summary Text** will auto populate to Document Type this can be changed by highlighting and typing over it.
11. Select **Lookup Patient**.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.
12. Sensitivity stays as **Normal**.
13. Leave the Import as Signed box **unchecked**.
14. Leave the Import as abnormal **unchecked**.
15. Leave attach to existing document blank.
16. Open Orders will stay blank.
17. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
18. Using the drop down arrow next to Physician name **select the name of the staff member who needs to review and sign the document**.
  - Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.
19. By Selecting Carbon copy you are wanting the document to be sent to a second person as well as who you selected in previous step.
20. Select **Import Document**.
21. The document will then be imported into patients chart and sent to staff members' desktop to review and sign off on.



## Importing signed document as its own document

1. Select Indexing Client from APP Page.
2. Sign into Indexing Client using your log in and password.
3. Scan the document using your assigned Scanner.
4. Select the designated **Scanner number** from the Path drop down menu.
5. Select the document you want to upload from your available files to highlight and hit the single arrow to add Files to import section.
6. Import as: **Attachment**
7. Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).
8. Select appropriate **Document Type** from the list using the drop down arrow associated with the document you are uploading.
9. **Clinical date** and time will auto populate to date and 12:00AM this will need to be changed to exact date and time of document.
10. **Summary Text** will auto populate to Document Type this can be changed by highlighting and typing over it.
11. Select **Lookup Patient**.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.
12. Sensitivity stays as **Normal**.
13. **Select** Import as Signed box.
14. Leave the Import as abnormal **unchecked**.
15. Leave attach to existing document blank.
16. Open Orders will stay blank.
17. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
18. Using the drop down arrow next to Physician name **select the name of the staff member who signed the document**.
  - Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.
19. Carbon copy option will be left blank.
20. Select **Import Document**.
21. The document will then be imported into the patients chart.

## Importing a document to an unsigned document

1. From the EHR, Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Encounter type**.
4. Select **document** attachment will be imported to.
5. Select **End**.
6. Select **Hold**, to place document on hold without signing it.
7. Minimize Centricity EMR Open your Citrix app page.



8. Select **Indexing Client** from the APP Page.
9. Sign into Indexing Client using your log in and password.
10. Scan the document using your assigned Scanner.
11. Select the designated **Scanner number** from the Path drop down menu.
12. Select the document you want to upload from your available files to highlight and hit the single arrow to add Files to import section.
13. Import as: **Attachment**
14. Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).
15. Select appropriate **Document Type** from the list using the drop down arrow associated with the document you are uploading.
16. **Clinical date** and time will auto populate to date and 12:00AM this will need to be changed to exact date and time of document.
17. **Summary Text** will auto populate to Document Type this can be changed by highlighting and typing over it.
18. Select **Lookup Patient**.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.
19. Sensitivity stays as **Normal**.
20. Select **Import as Signed box**.
21. Leave the Import as abnormal unchecked.
22. Under **existing document**, use the drop down menu to select the name of the encounter you placed on hold in EMR.
23. Open Orders will stay blank.
24. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
25. Next to **Physician name** using the drop down arrow select your name here.
  - You may also type your name in the box to populate.
26. Leave Carbon copy unchecked.
27. Select **Import Document**.
28. Log out of indexing client when finished.
29. Open EMR application again sign back in if needed.
30. Return to your patients chart.
31. Under **document for edit** section next select edit next to the document you have on hold to open it.
32. On the left navigation pane under **Attachments** you will see the uploaded document.
33. Complete document in its entirety.
34. Select **End** at the top right of encounter.
35. Select **Sign Document**.



## Completing an eSign EHR Encounter

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select the appropriate encounter type option needed to satisfy the appointment.
4. From the corresponding landing page, select applicable form.
5. Complete form in its entirety.
6. Select **End**.
7. **Route** document if applicable.
8. Select **Sign Document**.
9. To add patients signature to document.
10. Select the **Fusion eSign** web application located in the custom commands section of the tool bar.
11. Select **eSign EHR Encounter** option.
12. Enter the patient's name or DC number in the **Search Patient** section select appropriate patient.
13. Under the **Select EHR Encounter** option, use the drop down arrow to locate, and select the encounter needed for patient signature.
  - Note: Encounters will be organized by most recent to oldest.
14. Review and verify the encounter in the Preview Document window then select **Continue**.
15. User will then be prompted to hand the device to the patient. At this time you will turn the screen towards the patient and select **Continue**.
  - Ensure the topaz signature pad is in reach of the patient and advise the patient to follow the prompts on the screen.
16. Once the patient has reviewed the form, advise them to select **I verify that I have read and agree to the terms printed above** to proceed.
17. Advise the patient to sign the document and select **Submit Signature to Preview to proceed**.
18. Once the patient has reviewed the document with their accompanying signature, advise them to select **Finalize Endorsement** and **Continue**.
  - When prompted, staff member will turn the screen back to its original position and select **Continue**.
19. Select **Finalize Endorsement and Continue to Final Review**.
20. Select **Submit and Add to Patient's Chart**.
  - Note: A new window will populate with the completed document.
21. Exit the Fusion eSign web application to return to the EHR.



## How to complete a request for medical records (outside entities)

### Documenting Receipt of Request

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Verify valid Release of Information is in patients chart.
  - Select **Documents** in left navigation pane.
  - Select the + next to ALL folder in the Document View box.
  - Select **FL Admin**, Locate ROI documents.
  - Open attachment to review ROI, confirm validity.
    - If no valid ROI on file, order for appointment is required to have patient sign ROI DC4-711B before releasing information.
3. Select **New Document** to open Update Chart Window.
4. Select **Admin Forms** encounter type.
5. Select **Chronological Record of Health Care DC4-701**.
6. Select appropriate role: **Medical Records**.
7. Complete note specifying details of record request received from outside source.
8. Select **End**.
9. Select **Hold** to place document on hold.
10. Scan received request and attach to document.
  - See **Indexing Client workflow importing to unsigned document** for this process.
11. Select **End**.
12. Select **Sign Document**.
13. Complete Invoice for copies requested send to requester.

### Documenting completion of request

Once payment for copies has been received.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Print requested records from patients chart.
  - Select **Documents** in the left navigation pane of patient chart.
  - Select appropriate/requested documents to print.
  - Hold CTRL key to select multiple documents to print at once.
  - Select **Print** icon or hit ctrl P.
  - Confirm selected documents is highlighted in **Print Items** section of print box.
  - Ensure the **Print attached** images box is checked to print all attachments selected.
  - Verify Printer selected is correct select **Print**.
3. Select **New Document**.
4. Select **Admin** encounter type.
5. Select **Release of Information Notice DC4-744**.
6. Complete form in its entirety.
7. Select **End** at the top right of form.
8. Select **Sign Document**.



9. Follow step 2 above to print DC4-744 Release of Information Notice.
10. Mail copies to requester.
11. Document Records printed and request complete.
12. Select **New Document**.
13. Select **Admin forms** encounter type.
14. Select **Chronological Record of Health care**. Complete note, documenting what copies were printed.
15. Select DC4-542A Inmate Payment Agreement for Copy of Protected Health Information, complete form.
16. Select DC4781Q Telephone Complaints - Request for PHI Log complete form.
17. Select **End** at the top right of form.
18. Select **Sign Document**.

### Documenting telephone requests/release of information

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **Documents** in the left navigation pane of patient chart.
3. Verify valid Release of Information is in patients chart.
  - Select **Documents** in left navigation pane.
  - Select the + next to ALL folder in the Document View box.
  - Select **FL Admin**, locate documents with the description DC4711B, DC# and Date.
  - Open attachment to review ROI, confirm validity.
    - If no valid ROI on file, order for appointment is required to have patient sign ROI DC4-711B before releasing information.
4. Select **New Document**.
5. Select **Admin** encounter type.
6. Select DC4-542A Inmate Payment Agreement for Copy of Protected Health Information, complete form.
7. Select DC4781Q Telephone Complaints - Request for PHI Log complete form.
8. Select **End**.
9. Select **Sign Document**.





## How to Complete a Request for Medical Records from Patients

### Receiving Inmate Request

\*Received documentation will need to be entered into the EMR before answering the request on paper form.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Admin forms** encounter type.
4. Select **Inmate Request Received** button.
5. Complete form in its entirety, entering what the patient wrote verbatim in the text box.
6. Select **End**.
7. Select **Hold** to place document on hold.
8. Scan request and attach to document.
  - See **Indexing Client workflow attach to unsigned document** for this process.
9. Add order for **Inmate Request**.
10. Select **Orders** button.
11. From Custom List drop down menu select **Inmate Request**.
12. Select applicable order.
13. Complete Order details.
  - Enter the requested information in the instruction box.
  - Leave start date today's date.
14. Select **End**.
15. Select **Sign Document**.

### Answering Inmate Request

\*Answers will be recorded on the paper first and then recorded in the patients chart as follows.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Admin forms** encounter type.
4. Select **Inmate Request Answer** button.
5. Complete form in its entirety.
6. Select **End**.
7. Select **Hold** to place document on hold.
8. Scan request and attach to document.
  - See **Indexing Client workflow attach to unsigned document** for this process.



9. Create order for **other referral-Medical Records** if applicable.
  - Specify what appointment is for in the instruction box of Order details.
  - Change start date to when patient will be seen.
10. Select **End**.
11. Select **Sign Document**.
12. Complete applicable order for inmate request.
  - Select Orders from left navigation pane.
  - Locate and select **inmate request-medical records** order.
  - Select Complete, verify correct order selected and Select ok.
13. Deliver original completed request back to patient.

### Completing the Request for copies

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. To locate and view request.
  - Select **Documents** in left navigation pane.
  - Select the + next to **ALL** in the Document View box.
  - Select **FL Admin**.
  - Select document with Summary text Inmate Request Answer.
  - View document gather information needed for the DC4-542A Inmate Payment Agreement for Copy of Protected Health Information.
3. Select **Fusion eSIGN** application from top tool bar.
4. Select first option **Create eSign Document**.
  - Search Patient either by name or DC# and select
  - Select template DC4-542A Inmate Payment Agreement for Copy of Protected Health Information.
  - Select the Header using the drop down box to insert your site information.
  - Answer the questions and select continue.
  - Then hand the patient the topaz signature pad and computer screen.
  - When ready instruct patient through prompts to sign document.
  - Finalize document.
  - Exit out of Fusion eSign.
5. Select **Documents** from patients left navigation pane.
6. Print 2 copies of the DC4-542A Inmate Payment Agreement for Copy of Protected Health Information., give one copy to patient and fax the other copy to inmate banking.
7. Complete Order for appointment.
8. Select orders in the left navigation pane in patient chart,
  - a. Select order for **other referral-Medical Records**.
  - b. Select **complete**.

### Request to pick up copies with proof of payment

1. Patient shows proof of payment for copies requested.



2. Find your patient using the **Magnifying Glass**.
3. Locate and Print requested records from patients chart.
  - Select **Documents** in the left navigation pane of patient chart.
  - Select appropriate/requested documents to print.
  - Hold CTRL key to select multiple documents.
  - Select **Print** icon or hit ctrl P.
  - Confirm selected documents is highlighted in **Print Items** section of print box.
  - Ensure the **Print attached images box** is checked to print all attachments selected.
  - Verify Printer selected is correct select **Print**.
4. Select **New Document**.
5. Select **Admin forms** encounter type.
6. Select **Chronological Record of Health care**. Complete note, documenting what copies were printed.
7. Select DC4-542A Inmate Payment Agreement for Copy of Protected Health Information, complete form.
8. Select DC4781Q Telephone Complaints - Request for PHI Log complete form.
9. Select **End** at the top right of form.
10. Select **Sign Document**.
11. **Complete Order for other referral-Medical Records**.
  - Select orders in the left navigation pane in patient chart.
  - Select order for medical records-other referral.
  - Select **complete**.

## Request to Sign ROI

1. Patient will complete DC4-711b on paper.
2. Scan completed DC4-711b to patients chart.
  - See **Indexing Client workflow attaching signed document** for this process.
  - Ensure the Summary text of this document is ROI-Name of person/entity needing information.
    - Example ROI-Jennifer Jones; ROI-SSA,
  - The Comment box will also identify this same information.
3. Complete Order for **other referral-Medical Records**.
4. From patients chart.
  - Select **Orders** in the left navigation pane in patient chart.
  - Select order for **medical records-other referral**.
  - Select **complete**.



## Release of Information (ROI) Workflow

### Completing ROI

1. Patient will complete DC4-711b Consent and Authorization for Use and Disclosure Inspection and Release of Confidential Information on paper.
2. Scan completed DC4-711b Consent and Authorization for Use and Disclosure Inspection and Release of Confidential Information to patients chart.
3. Scan the document using your assigned Scanner.
4. Open Indexing client App from the Citrix Home Page.
5. Select the designated **Scanner number** from the Path drop down menu.
6. Select the document you want to upload from your available files to highlight and hit the single arrow > to add Files to import section.
7. Import as: **Attachment**
8. Enter description in Comment box using designated format as ROI- Name of Person or Entity ROI is being signed for.
  - Ex: ROI-Melissa Bender
  - Ex: ROI-Social Security Administration
9. Select ROI **Document Type**.
10. **Clinical date** and time will auto populate to current date and 12:00AM this will need to be changed to exact date and time document was completed.
11. **Summary Text** will auto populate to document type. Copy the same information entered in comment box to this box. ROI-Name of person or entity.
  - Ex: ROI-Melissa Bender
  - Ex: ROI-Social Security Administration
12. Select **Lookup Patient** and attach your patient.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.
13. Sensitivity stays as **Normal**.
14. Select the **Import as Signed** box.
15. Leave the Import as abnormal **unchecked**.
16. Leave attach to existing document blank.
17. Open Orders will stay blank.
18. Location of care should be site location.
19. In the Physician box put the name of the Centurion Staff member who witnessed the ROI.
  - **Note: If you are scanning in older active ROIs from the paper chart you will need to put your name here if the employee no longer works for Centurion.**
20. Carbon Copy box stays blank.
21. Select **Import Document**.
  - The document will then be imported into patients chart under the FL ROI folder.



## Locating ROI

1. Open patients chart.
2. Select **Documents**.
3. Select the **ALL Document View** folder.
4. Select **FL ROI** to view scanned ROIs.
5. Read the Summary text or Comment in body of selected document for specifications of ROI.
6. Once located select **Attach** to open the attachment and see what can be released.



## How To – Complete a Refusal

### Completing Refusal with Patient Signature

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select the appropriate encounter type option needed to satisfy the appointment.
4. From the corresponding landing page, select the DC4-711A Refusal form.
  - Note: The view will vary based on the encounter type landing page selected (e.g MH Case Manager, Nurse Protocol, Provider Visit, etc).
5. Once the Refusal form is selected and loaded in left navigation pane, complete the form as clinically indicated.
6. Select **End**.
7. Route document to Provider and clinical staff member witness.
  - If the witness is a non-clinical staff member (e.g. Security), the witness signature will be completed in Fusion eSign.
8. Select **Sign Document**.
9. Have patient sign refusal.
10. Select the **Fusion eSign** web application located in the custom commands section of the tool bar.
11. Once the web page opens, select **eSign EHR Encounter** option.
12. On the left hand side of the web page, type in the patient's name in the **Search Patient section**.
  - Use the patient's name or DC number to search
13. Under the **Select EHR Encounter** option, use the drop down arrow to locate, and select the **refusal encounter** just complete in EHR.
  - Note: Encounters will be organized by most recent to oldest
14. Once the encounter and corresponding information has been previewed, select **Continue**.
15. User will then be prompted to hand the device to the patient. At this time you will turn the screen towards the patient and select **Continue**.
  - Ensure the topaz signature pad is in reach of the patient and advise the patient to follow the prompts on the screen.
16. Once the patient has reviewed the form, advise them to select I verify that I have read and agree to the terms printed above to proceed.
17. Select **Patient** (signature) – Required is selected from the drop-down window under Required Endorsements question, advise the patient to sign the document and select **Submit Signature to Preview to proceed**.

18. Once the patient has reviewed the document with their accompanying signature, advise them to select **Finalize Endorsement** and **Continue**.

- When prompted, staff member will turn the screen back to its original position and select Continue
- From this screen, user is able to add non-clinical staff member witness signature if applicable by typing in the individual's name in the **Add Additional Endorsements** box.
- Have staff sign and select the **Add Signature** button followed by Submit Signature to Preview.
- Note: The document will display again for review with the patient's endorsement and the additional endorsement.

19. Select **Finalize Endorsement and Continue to Final Review**.

20. Select the **Submit and Add to Patient's Chart** button located at the bottom of the document displayed.

- Note: A new window will populate with the completed document.

21. Close out of the Fusion eSign web application and return to the patient's chart.

### Completing Refusal when Patients Refuses to Sign

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select the appropriate encounter type option needed to satisfy the appointment.
4. From the corresponding landing page, select the DC4-711A Refusal form.
  - Note: The view will vary based on the encounter type landing page selected (e.g MH Case Manager, Nurse Protocol, Provider Visit, etc).
5. Complete the form as clinically indicated.
6. Select **Patient Refused to Sign** check box at bottom of the page.
7. Select **End**.
8. Route document to Provider and clinical staff member witness.
  - If the witness is a non-clinical staff member (e.g. Security), the witness signature will be completed in Fusion eSign.
9. Select **Sign Document**.
10. If clinical staff member is witness no further action required.

11. If Non clinical staff member is a witness continue with steps below.
12. Select the **Fusion eSign** web application located in the custom commands section of the tool bar.
13. Once the web page opens, select **eSign EHR Encounter** option.
14. On the left hand side of the web page, type in the patient's name in the **Search Patient section**.
  - Use the patient's name or DC number to search
15. Under the **Select EHR Encounter** option, use the drop down arrow to locate, and select the **refusal encounter** just complete in EHR.
  - Note: Encounters will be organized by most recent to oldest
16. Once the encounter and corresponding information has been previewed, select **Continue**.
17. User will then be prompted to hand the device to the patient. At this time you will select **Continue**.
18. Select I verify that I have read and agree to the terms printed above to proceed.
19. In the patient signature box mark a line through it and **Submit Signature to Preview to proceed**.
20. Review the document on behalf of the patient and select **Finalize Endorsement and Continue**.
  - When prompted, staff member will select Continue.
  - From this screen, user is able to add non-clinical staff member witness signature by typing in the individual's name in the **Add Additional Endorsements** box.
  - Have staff sign and select the **Add Signature** button followed by Submit Signature to Preview.
  - Note: The document will display again for review with the patient's endorsement and the additional endorsement.
21. Select **Finalize Endorsement and Continue to Final Review**.
22. Select the **Submit and Add to Patient's Chart** button located at the bottom of the document displayed.
  - Note: A new window will populate with the completed document.
23. Close out of the Fusion eSign web application and return to the patient's chart.





## Documenting Refusal without Wi-Fi Connectivity

### Complete Refusal on Paper then scan into EHR

1. Complete Refusal on Paper capturing both patient's signature and witness signature.
  - Provider Signature will be captured electronically.
2. Find patient using the **Magnifying Glass** icon.
3. Click on **New Document** to begin a new encounter.
4. Change **Clinical Date** and **Time** to match the paper document and select **Ok**.
5. Select the appropriate encounter type related to Refusal.
  - This will vary as the refusal is located in each encounter.
6. From the corresponding landing page, select the **DC4-711A Refusal** form.
7. Complete form exactly as you did on paper.
8. Select **End**.
9. Select **Hold** to place document on hold.
10. Scan completed refusal using designated scanner.
11. Open Centricity App page.
12. Select **Production Fusion Indexing Client** from the APP Page.
13. Sign into Indexing Client using your log in and password.
14. Select the designated **Scanner number** used to scan refusal form from the Path drop down menu.
15. Select the document you want to upload from your available files and hit the single arrow to **add Files to import section**.
16. Import as: **Attachment**
17. Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).
  - Example- DC4711A 123456 11/29/21
18. Select appropriate **Document Type** MH Refusals.
19. **Clinical date** and **Time** will auto populate to current date and 12:00AM this will need to be changed to exact date and time of document.
  - **Highlight over it and type correct date and time.**
20. **Summary Text** will auto populate to **Document Type** this can be changed by highlighting and typing over it if necessary.
21. Select **Lookup Patient**.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to **MRN** if you wish to search by DC# then press ok.
22. Sensitivity stays as **Normal**.
23. Select **Import as Signed box**.
24. Leave the Import as abnormal unchecked.
25. Under **Attach to existing document**, use the drop down menu to select the encounter you placed on hold in EHR.
  - This will display the document below the refusal you are wanting to import for review.



26. Open Orders will stay blank.
27. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
28. Next to **Physician:** using the drop down arrow select your name here.
  - You may also type your name in the box to populate.
29. Leave Carbon copy unchecked.
30. Select **Import Document**.
31. Log out of indexing client and toggle back to the EHR.
32. From inside patients chart select **Edit** under **Documents for Edit** section on left navigation pane to open document.
33. Confirm under attachments that your refusal is attached.
34. Select End.
35. Route document to Provider.
  - Select New.
  - Enter Providers name in the **To Box** using drop down arrow or binoculars to search.
  - Select Signature.
  - Select Priority.
  - Enter exactly what you need provider to do with document in comments box.
  - Select Ok.
36. This will then display in the Routing box.
37. Select **Sign Document**.



## Staff Referrals Workflow

### DOC Staff to Health Services Staff

1. Non Health Services Staff member completes the DC4-529 Staff Referral on paper and sends to corresponding department.
2. Receiving departments designated staff member will enter the information from the paper document verbatim in the patient's electronic record and scan the paper document into encounter.
3. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
4. Click on **New Document** to begin a new encounter.
5. Select **Staff Referral/Requests** encounter type.
6. Select **Staff Request/Referral Send** option. The form will load.
7. Select the **Addressee's Area/Service** the referral is addressed to.
8. Complete the form verbatim from paper form.
9. Create an Order for the **Staff Referral/Request**.
  - **Notate Addressee and reason for the referral** in **instructions box** of the **order details**.
10. Select **End**.
11. Select **Hold** to place document on hold.
12. Scan request and attach to document.
  - See **Indexing Client workflow** for this process.
13. Select **End**.
14. Select **Sign Document**.
15. Deliver the DC4-529 to the designated staff member to complete.

Receiving designated staff member then completes the bottom half of the DC4-529 referral form and then enters the response into the patient's electronic record.

16. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
17. Click on **New Document**.
18. Select **Staff Referral/Requests** encounter type.
19. Select **Staff Request/Referral Received** option. The form will load.
20. Select the **Staff Referral/Request** order from the drop down menu.
21. Complete the form in its entirety.
22. Add orders if applicable.
23. Select **End**.
24. Select **Hold** to place document on hold.
25. Scan request and attach to document.
  - See **Indexing Client workflow** for this process.
26. Select **End**.
27. Select **Sign Document**.
28. Complete the order for the **Staff Referral/Request**.
29. Send the completed DC5-529 back to the staff member who sent it.



**NOTE: If the same staff member is, doing both of these steps scanning of paper document is only required in answer.**

### Sending Referral Internally

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document**.
3. Select **Staff Referral/Requests** encounter type.
4. Select **Staff Request/Referral Send** option. The form will load.
5. Select the **Addressee's Area/Service** you are sending the referral to.
6. Complete the form in its entirety.
7. Create an Order for the **Staff Referral/Request**.
  - **Notate Addressee and reason for the referral in instructions box of the order details.**
8. Select **End**.
9. **Route** document to the designated discipline staff member.
10. Select **Sign Document**.

### Review orders in Order Manager

The Designated Staff Member assigned to review orders in Order Manager will need to review Staff Referral/ Request orders on a regular basis to ensure referrals are completed appropriately.

1. From chart desktop open Fusion Order Manager.
2. Select Date Range.
3. Enter custom order list for Staff Referral/Request.
4. Enter Site Location.
5. Select Search.
6. Export List to sort and review.

### Receiving Referral Internally

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document**.
3. Select **Staff Referral/Requests** encounter type.
4. Select **Staff Request/Referral Received** option. The form will load.
5. Select the **Staff Referral/Request** order from the drop down menu.
6. Complete the form in its entirety.
7. Add orders if applicable.
8. Select **End**.
9. **Route** document back to sending staff member.
10. Select **Sign Document**.
11. Complete the order for the **Staff Referral/Request**.



## How to Complete Transfer Summary

### Transfers – Sending Facility

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Transfers** encounter Type.
4. Select **Transfer Sending Summary**.
5. Complete form in its entirety.
6. An order for **New Inmate HLT Review** will auto populate for the Receiving Facility to complete. Press ok.
7. Select **End**.
8. Select **Sign Document**.

### Transfers – Receiving In-Transit Facilities

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Transfers** encounter Type.
4. Select **Transfer Receiving Summary**.
5. Select corresponding In Transit number.
  - An order for **New Inmate HLT Review** will auto populate for the permanent facility to complete. Press ok.
6. Complete form in its entirety.
7. At the bottom of the form you can select the check box to Review the Sending facility information.
8. Select **End**.
9. Select **Sign Document**.

### Transfers – Receiving Permanent Facility

1. Pull **New Inmate HLT Review Orders** list from Order Manger.
2. Complete the transfer Summary's for all patients on the list.
3. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
4. Click on **New Document** to begin a new encounter.
5. Select **Transfers** encounter Type.
6. Select **Transfer Receiving Summary**.
7. Select Permanent Facility.
  - An order for **Provider Health Review** will auto populate for the provider to complete. Press ok.
8. Complete form in its entirety.
9. At the bottom of the form you can select the check box to Review the Sending facility

10. Select **Transfers** from the left navigation pane to go back to the landing page.
11. Select **DC4-773 Inmate Health Education** form.
12. Complete form in its entirety.
13. Select **End**.
14. **Route** to Provider.
15. Select **Sign Document**.
16. Complete order for **New Inmate HLT Review**.
  - Select Orders from left navigation pane of patients chart.
  - Locate and select order for **New Inmate HLT Review**.
  - Select Complete.
  - Press Ok.

### Transfers- Providers

1. Review **Chart Desktop Summary** to find routed **Transfer Summary**.
2. Double click the document to navigate to the patient's chart.
3. Click on **New Document**.
4. Select **Transfers** encounter Type.
5. Select **Transfer Provider Summary**.
6. Complete form in its entirety.
7. Select **End**.
8. Select **Sign Document**.
9. Complete order for **Health Review-Transfer**.
  - Select Orders from left navigation pane of patients chart.
  - Locate and select order for **Health Review-Transfer**.
  - Select Complete.
  - Press Ok.
10. Navigate back to **Chart Desktop**
11. Select remove on the routed patient's **Transfer Summary**.

**NOTE: Documents are being routed to your desktop for a reminder that transfers need to be completed within 7 days of arrival to permanent institution.**



## How to Complete a Fusion eSign Document

1. Select **Fusion eSign** application icon from the user's **Toolbar**.
2. This will open a new window for **Fusion eSign**.
3. From the **eSign** menu, select **Create eSign Document**.
4. Enter the patient's name or ID# in the **Search Patient** box.
5. Select appropriate patient.
6. Verify patient's information is correct in the **Preview Document** section to the right.
7. Select the appropriate DC4 form number using the **Select Template** dropdown arrow.
  - The form will appear in the **Preview Document** window.
8. Select your site location by using the **Select Header** drop down arrow.
9. Select **Continue**.
10. Answer questions, if applicable, regarding the treatment being rendered. Then select **Continue**.
11. You will be prompted to hand the device to the patient and press continue.
12. A preview of the document will appear, allow the patient to review document and **verify and agree to terms of treatment** at bottom of document.
13. The patient will now sign using the **Topaz Signature Pad** and **Submit Signature to Preview**.
14. A preview of the signed document will appear. The patient will be presented with a choice to **Return to Previous Step, Remove Endorsement from Document** or **Finalize Endorsement and Continue**.
15. After selecting **Finalize Endorsement and Continue**, the patient will be prompted to hand the device back to the staff member.
16. The **Required Endorsements** box will list the remaining required signatures.
17. The **Add Additional Endorsements** is optional for any additional staff per policy. (Any name(s) entered here should be as per FLDOC policy. Full name and Credentials)
18. The required staff member will sign using the **Topaz Signature Pad** and **Submit Signature to Preview**.
19. A preview of the signed document will appear. You will again have one last chance to **Add Additional Endorsements** if needed.
20. Select **Finalize Endorsement and Continue to Final Review**.
21. After finalizing the endorsement, you will be able to review the entire document.
22. Select **Submit and Add to Patient's Chart**.
23. The Completed Document will appear.
24. Exit out of Fusion eSign to return to the EHR.
25. The signed document will be located in the patient's chart documents.



## How to Complete a eSign Document without Wi-Fi Connectivity

### Electronic Consent Must Also be completed when completing a paper consent form.

1. Complete paper consent documenting date and time on paper form.
2. Scan paper consent into patients chart as its own document using Fusion Indexing Client App.
3. Open Production Fusion Indexing Client from APP Page.
4. Sign into Indexing Client using your **log in and password**. Ensure LOC is your site ID.
5. Scan the document using your assigned Scanner.
6. Select the designated **Scanner number** from the Path drop down menu.
7. Select the document you want to upload from your available files select the single arrow to add Files to import section.
8. Import as: **Attachment**
9. Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).
10. Select appropriate **Document Type** from the list using the drop down arrow associated with the document you are uploading.
11. **Clinical date** and time will auto populate to date and 12:00AM this will need to be changed to exact date and time of document.
  - **Highlight over it and type correct date and time.**
12. **Summary Text** will auto populate to **Document Type** this can be changed by highlighting and typing over it if necessary.
13. Select **Lookup Patient**.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to **MRN** if you wish to search by DC# then press **ok**.
14. Sensitivity stays as **Normal**.
15. **Select** Import as Signed box.
16. Leave the Import as abnormal **unchecked**.
17. Leave attach to existing document blank.
18. Open Orders will stay blank.
19. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
20. Using the drop down arrow next to Physician **select the name of the staff member who signed the document**.
  - Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.
21. Carbon copy option will be left blank.
22. Select **Import Document**.
23. The document will then be imported into the patients chart.
24. Log Out of Fusion Indexing Client.
25. Log into Centricity EHR and Complete the consent in Fusion eSign.
26. Select **Fusion eSign** application icon from the user's **Toolbar**.
27. This will open a new window for **Fusion eSign**.
28. From the **eSign** menu, select **Create eSign Document**.





29. Enter the patient's name or ID# in the **Search Patient** box.
  - Select appropriate patient.
30. Verify patient's information is correct in the **Preview Document** section to the right.
31. Select the appropriate DC4 form number using the **Select Template** dropdown arrow.
  - The form will appear in the **Preview Document** window.
32. Select your site location by using the **Select Header** drop down arrow.
33. Select **Continue**.
34. Answer questions, if applicable, regarding the treatment being rendered. Then select **Continue**.
35. You will be prompted to hand the device to the patient and press continue.
36. A preview of the document will appear, Select **verify and agree to terms of treatment** at bottom of document to move forward.
37. Use **Topaz Signature Pad** enter **See Scanned Consent** and select **Submit Signature to Preview**.
38. A preview of the signed document will appear. Select **Finalize Endorsement and Continue**.
39. After selecting **Finalize Endorsement and Continue**, the patient will be prompted to hand the device back to the staff member and Press Continue.
40. The **Required Endorsements** box will list the remaining required signatures to sign document.
41. Using the **Topaz Signature Pad** Sign the document and **Submit Signature to Preview**.
42. A preview of the signed document will appear.
43. Select **Finalize Endorsement and Continue to Final Review**.
44. After finalizing the endorsement, you will be able to review the entire document.
45. Select **Submit and Add to Patient's Chart**.
46. The Completed Document window will display.
47. Exit out of Fusion eSign to return to the EHR.
48. The signed document will be located in the patient's chart documents.



## How To – Create, Complete & Remove Orders

### How to – Place an Order

1. Find patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Choose the corresponding Encounter Type.
4. Select your document and complete the form in its entirety.
5. Select the **Orders** icon located on the top tool bar. This will cause the Update Orders window to open.
  - **Note:** Some encounters will have a separate orders button within the form.
6. Select **Use Custom List** drop-down to search for orders by service type.
  - Select appropriate order.
  - Once the order is selected, it will move to the added orders area located at the top of the Update Orders window.
  - To order the same order multiple times in the same encounter select the **Reorder** button located just below that top box.
7. Select **Order Details for each order.**
  - Complete the Clinical Information section and the Test Information section.
    - Change Authorized By: **Only if taking a verbal order from someone.**
    - Enter any directions in the Instructions box as needed for the order.
    - Select a priority of the order as needed.
    - Change the **Start Date:** to the date the order will need to be completed.
    - Entering an **End Date** should only be done on **hold** and **pass** orders.
    - If applicable to the order, add a potential diagnosis by selecting the specific order, highlighting the diagnosis and using the arrows between the two boxes to apply the Potential Diagnosis. Examples: Labs, Radiology, some immunizations etc.
    - All other parts of this section should be left as it is designed to be.
8. Select **OK**. This will return to encounter/form.
9. Select **END**.
10. **Route** document if verbal order was entered.
11. Select **Sign Document**.

### Completing orders from Patients Chart when the documentation is completed

1. From the Patient's Chart desktop, select **Orders** from the left navigation pane.
2. Once within the order view, highlight the corresponding order and select **Complete**.
3. Once the Complete button is selected, Select Orders to complete screen will open.
  - Verify the end date listed it the date documentation was completed.
  - To change select the Calendar icon and change the date.
4. Select **Ok** to complete the selected order(s).



## How-To Set Default Printer

1. From the Title Bar, select **Options**.
2. Select **Printers**.
3. In the Select Printers window, the EMR will assume you want to use your computers default printer but will allow users to modify printer settings.
  - To modify default settings, select document type and use the drop down arrow to select the desired printer.
4. Select **Ok** to save your changes.
  - Note: If the desired printer is unavailable, please refer to IT for assistance.



## DOCUBATCH

1. Open **Production DocumentBatch** application from Centurion App Page.
2. Select three dots next to Patient Search box to open patient search.
  - Enter patients information select Search.
  - Find and highlight patient hit Select.
3. Select all Document Types needed for packet.
4. Select Specific Date ranges of documentation needed.
5. Enter LOC Filter.
6. Select **Pull Documents**.
  - All selected documents will pull in box below.
7. Select all documents needed for packet.
8. You can check a document and hit Preview Document to see it first.
9. When finished selecting all documents enter File Name in the **Combined Filename** box.
10. Ensure Combine Documents box is checked.
11. **File Save Path** should be the same designated file path as the scanner folder used in indexing client.
12. Once all documents have been selected and ready to save hit **Save Documents**.
13. This will save all documents in one packet to the designated file path.
14. Use Indexing Client to upload the saved documents to the EMR.



## Inmate Requests and Informal Grievances Workflow

**Please use the following steps when the Inmate Request or Informal Grievance is received and answered by two different staff members (end users):**

### Inmate Requests Received or Informal Grievances Received

\*Received documentation will be entered into the EMR before answering the request on the original request form\*

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Appropriate Encounter Type**.
4. Select **Inmate Request Received** button from your menu.
5. Complete form in its entirety, type a brief summary of patients request in text box.
6. Select the **Informal Grievance** box if applicable.
7. Select **End**.
8. Select **Hold** to place document on hold.
9. Scan received request and attach to document.
  - See **Indexing Client workflow importing into unsigned document** for this process.
10. Add order for appropriate type of **Inmate Request**.
  - Select **Orders** button.
  - From Custom List drop down menu select **Inmate Request**.
  - Select applicable order.
  - Complete **Order Details**.
  - Enter brief description of what patient requested in Instructions box.
  - Press ok.
11. Select **End**.
12. Select **Sign Document**.
13. Deliver original paper request form to designated person to answer.

### Inmate requests Answered or Informal Grievances Answered

\*Answers will be recorded on the original request and then recorded in the patients chart as follows.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Appropriate Encounter Type**.
4. Select **Inmate Request Answer** button.
5. Complete form entirely, to include entering a brief summary of your answer into text box.
6. Check **Informal Grievance** box if applicable.
  - Note: Informal Grievances will be documented in SOAPE format.
7. Select **End**.



8. Select **Hold** to place document on hold.
9. Scan completed request and attach to document.
  - See **Indexing Client workflow importing into unsigned document** for this process.
10. Create orders if applicable.
11. When finished Select **End**.
12. Select **Sign Document**.
13. Complete applicable order for inmate request.
  - Select **Orders** from left navigation pane.
  - Locate and select applicable order, select to highlight order.
  - Select Complete, verify correct order selected and select **OK**.
14. Deliver original document back to patient.



## How To - Create, Save and View Inquires

1. From your Chart Desktop screen, select the **Chart Reports** module at the bottom left navigation pane.
2. The Inquiries window will populate. In the **Find** field, click the drop-down arrow to select the appropriate category.
3. In the **Where field**, click the drop-down arrow to select the search criteria.
4. In the next field below, click the drop-down arrow and select the comparison operator.
5. In the last field, type the value required based on your previous selections. The drop-down-arrow and field will vary based on what you selected in the **Where** field.
6. Select the **Add** button to add your search criteria, which will appear in the **Find patients where** section below.
7. To add additional criteria to your inquiry, repeat steps 3-6 (remember, only choose one option from **Find** in a single query). Each time you click the **Add** button, the criteria will be added to the **Find Documents** section.
8. Once you have added all the criteria for your search, you can either click the **Count** button to display only the total number of results that matched criteria, select the **Search** button which will display the results, or you can click both buttons, one after another to see both results.
9. If this is an inquiry that you and/or others will access frequently, you can choose to save it by clicking the **Save** button.
10. In the **Save Inquiry** window:
  - Use the **Name** field to name the inquiry. Please note, there is a 20-character limit.
  - In the **Comment** field, you can give more details on the inquiry.
  - Select whether you want **All Users** to use your saved inquiry, just the **Current User Only** or *access will be Role Based* in the **User Access** box.
  - Select **OK**
11. To Open an Existing /Saved Inquiry. Click the **Select** button.
12. In the **User Access** section, you can filter your results by either **inquiries accessible to all users** or those **accessible to current user only**.
13. To Print Inquiry Results. Click the dropdown next to **Select Activity** and choose **Print**.
14. A screen will appear with your standard printing options.
15. To Send an Alert/Flag based off of the inquiry results, you would follow the same instructions as if printing, but choose the option **Send Alert/Flag** are available to choose.
16. This function allows you to send a bulk **Flag, Care Alert** or a **Popup Alert** to all patients that were returned in your inquiry.

17. When you first select **Send Alert/Flag** from the dropdown, a warning message will popup reminding you that this function will send bulk Alerts/Flags to the patient charts listed in the inquiry and ask if you would like to continue. You can disable this message from appearing each time by adding a check next to the ***Don't show me*** this message again option and clicking the Yes button.
18. Complete the **New Alerts/Flag** window with your details and send.
19. To Export, select **Print Preview**
  - Select the document icon in the left corner of the window
  - Choose your exported location





## How To Sign, Route, Discard or Hold a Document

### How To Route

Once user has completed all encounters/forms and selects **End** from within the encounter, the End Update box will appear.

1. Select **New** button to add provider or another user to route to.
2. Use the drop-down arrow or the binoculars icon to select who the document is being routed to.
3. Select the applicable **Reason**: Signature.
4. Select **Priority**: Normal, Important or Urgent.
5. Enter comments in the **Comment** box.
6. Select **OK**.

### How To Sign

1. From within the End update box, select **Sign Document**.

### How To Discard a Document

1. From within the End update box, select **Discard Document**.
  - To be used if information is erroneous.
2. Select **OK**.

### How To Place Document on Hold

1. If unable to complete the encounter at the time it was initiated, select **Hold Document**.
  - Documents on hold can be located under **Documents for Edit** in the patient's chart.
2. To resume a document that is on hold:
  - Select the **edit** button located next to the desired document in the **Documents for Edit** section of the patient's chart..

**OR**

- In the Documents section of the provider's chart desktop that initiated the encounter.
- Select the desired document and double-click OR select the Open icon.



## Telephone Call Documentation Workflow

Telephone calls documentation can only be done from the Patients desktop.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Select the **Phone Note** icon.
  - The **Chronological Record of Health** encounter form will open.
3. Select discipline
4. Complete the encounter as clinically indicated
  - Modify or add orders, medications, allergies, and problems as indicated per phone call.
  - Document in full detail of call in Note section.
  - Select **No** in Copay section.
5. Select **End** on the top right corner of the encounter.
6. From the End Update window:
  - Verify the Summary section is accurate and completed.
  - Route if applicable, see Routing How-To Guide.
7. Select **Sign Document**
8. Complete the DC4-781Q Telephone Log. Select **New Document**.
9. Select **Admin Forms**.
10. Select the DC4-781Q Health Care/Tele Info Request form.
11. Place a check next to the DC4-781Q and complete form as indicated.
12. Select **End**.
13. Select **Sign Document**.

### Type of Phone Notes

Administrative Note- Used for any type of inquiry or information sharing phone call regarding the patient e.g. family inquiry, next of kin notification, transitional control call, etc.

Provider Contact- When nursing staff contacts medical provider regarding a patient care, this encounter is to be completed by nursing then routed to the corresponding medical provider for signature.

Nurse Telephone Triage- Nursing must use this encounter to triage calls from institutional staff about the patient and order appointment if applicable.

Nurse Death Notification- Upon notification of death, this form is to be completed by nursing and routed to the facility's chief medical officer.



## Mortality Notification Workflow

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Mortality Review Documentation** encounter type.
4. Complete form in its entirety.
  - Please note that when selecting the **Responsible facility** from the drop down you must enter the site that will be completing the mortality review.
5. Select **End**.
6. **Route** to the FDC mortality coordinator and the Contractor's mortality coordinator.
  - **Nancy Replinger, Tammy Macey and Linda Dorman.**
  - **If another site will be completing the mortality review also route to that facilities HSA/Nurse Manager.**
7. **Sign Document.**



## Chronic Illness Care Workflow

### Enrolling patient in clinic

1. Determine patient needs to be in clinic.
2. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
3. Select **New Document**.
4. Select the encounter type **Provider Visits**.
5. Select DC4701 Chronological Record of health care.
6. Complete form in its entirety documenting reason for clinic enroll.
7. Add orders to **Enroll** into clinic as well as the corresponding **Initial clinic** order.
  - Note: Immunity clinic requires you to also add Enroll **340B** and **340B DOH** Visit orders.
  - 340B DOH visit order in the instructions box please notate initial visit.
8. Select **End**.
9. Select **Sign Document**.

### Pre Clinic Encounter

10. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
11. Select **New Document**.
12. Select the encounter type **Vital Signs**.
13. Complete form in its entirety.
14. Select **End**.
15. Select **Sign Document**.
16. Notify Provider that the chart prep is complete and patient is ready.
  - Workflow may vary by site's preference.

### Chronic Clinic Encounter

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document**.
3. Select encounter type **Provider CIC**.
4. Select radio button for either **Initial** or **Follow Up** and select the appropriate Clinic options.
  - **Note: if multiple clinics, select all applicable options.**
  - This will load all required forms in the left navigation pane.
5. Complete all forms as clinically indicated.
6. Enter orders using the **Orders** button on top tool bar.
  - For Immunity Clinics, there will be the ENROLL CIC Immunity, CIC F/U Immunity, ENROLL 340B, and 340B DOH Visit
7. Edit the patient's medication using either the **Medications** button or the **+ Medication** on top tool bar.
8. Edit the patient's diagnoses using either the **Problems** button or the **+ Problem** on top tool bar.
9. Select **End**.
10. Select on **Sign Document**.
11. **Complete** orders for appointment.
  - Select **Orders** from left navigation pane.
  - Find and highlight order you want to complete and select **Complete** from tool bar.



- From the update order box you can check off on multiple orders you want to complete at same time.
- Ensure date is correct and select **Ok**.

### Discontinuing a Chronic Illness Clinic

1. On the Assessment plan tab of the Chronic Clinic document check the discontinue clinic box.
2. Select the clinic you wish to discontinue.
3. Once documentation is complete and signed off you will then need to complete the **ENROLL Clinic** order of the clinic you wish to discontinue.
4. Go to patient Orders.
5. Highlight the **ENROLL** clinic order and then select **Complete**.
6. Verify date is the date the clinic is to be discontinued and select **Ok**.



## Immunity Clinic Workflow

### To Add Patient to Immunity Clinic and Refer to DOH (340b Program)

1. Find your patient using the **Magnifying Glass** icon.
2. Click on **New Document** to begin a new encounter.
3. Select the **Appropriate** encounter type.
4. Select the **document**.
5. Complete document in its entirety.
6. Select the **Orders** button from top tool bar to add orders.
7. From the **Use Custom List** drop down menu select the following orders.
  - Select **CIC** custom List to add Clinic orders.
    - **ENROLL CIC Immunity** order the start date will stay today's date as this is the day they are being placed in the clinic.
    - **CIC Initial Immunity** order change the start date to the future date to complete paperwork.
    - **ENROLL 340B** order the start date will stay today's date as this is the day they are being placed in the clinic
    - **340B DOH Visit** order change the start date to the future date to complete the visit
  - Add any other applicable orders needed be sure to complete the Order Details on each order.
8. When all orders have been added **Select Ok** to go back to document.
9. Select **End** to end document.
10. Select **sign document**.

### Scheduling 340B visit

1. Coordinate with DOH when they will be visiting your site.
2. Using Fusion Order Manager.
3. Pull the 340B DOH Visit orders.
4. Add patients to the scheduled date worked out with DOH.

### 340B Provider (Read-Only)

1. Find your patient using the **Magnifying Glass** icon.
2. Review patient's chart for any information needed.
3. Complete documentation on paper then give to designated staff member to scan completed forms into EMR.

### Medical Records Staff or Designated Staff member documentation of DOH Appointment

1. Scan 340B documentation as not signed using Indexing client.
  - Follow the Indexing Client Workflow for importing unsigned documents.



- Select 340B documentation as document type.
  - Enter date and time of appointment.
  - Entering site providers name in the physician box NOT the DOH provider.
2. Then document the appointment and create the next appointment for DOH.
  3. Find your patient using the **Magnifying Glass** icon.
  4. Select **Encounter Type** depending on role.
  5. Select **Chronological Record of Health Care**.
  6. Document patient seen by 340b provider.
  7. Add Order for follow up appointment with DOH provider.
    - Select **Orders**.
    - Select **CIC** custom list.
    - Select **340B DOH Visit**
    - Complete Order Details.
      - Change start date to next appointment date with DOH.
  8. Select **End**.
  9. Select **Sign Document**.
  10. Complete order for today's DOH appointment.

### Documenting Immunity Clinic in EMR when seen by 340b Provider. To be completed by designated Site Medical Provider as Record Review

1. When you receive the DOH paperwork in your chart desktop you will review and sign off on it.
2. Then you will need to document the immunity clinic paperwork with information the DOH provided from their documentation sent to you.
3. Find your patient using the **Magnifying Glass** icon.
4. Click on **New Document** to begin a new encounter.
5. Select the **Provider CIC** encounter type.
6. Select **Initial** or **Follow up**.
7. Select **Immunity clinic**.
8. Complete both the DC4-701F and the corresponding flow sheet in its entirety.
9. **Add** any new medications and orders DOH provider wrote.
10. **Select next IC Clinic follow up**.
  - a. **DOH follow up apt will be made by DOH support staff.**
11. Select **End**.
12. Select **Sign Document**.
13. Complete Order for Immunity Clinic initial or follow up.

### Providers without 340B Program

1. Find your patient using the **Magnifying Glass** icon.
2. Click on **New Document** to begin a new encounter.
3. Select the **Provider CIC** encounter type.
4. Select the **Initial or Follow up Clinic**.



5. Complete documentation in its entirety.
6. Add Orders as applicable.
7. Add Medications as applicable.
8. Select **End**.
9. Select **Sign Document**.
10. **Complete** Order for today's clinic appointment.





## How to - Complete an Inmate Health Slip Pass

### Assigning/Creating Health Slip Pass

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select appropriate Encounter Type for visit. In this scenario select **Provider Visits**.
4. Select the **Health Slip Pass DC4-701D** located in the Passes section of the provider visits menu.
5. Complete form in its entirety.
6. Select **Orders** at the top of form or green **Add Order** from within the encounter.
7. From the Custom List drop down menu select **Special Passes/allowable items**.
8. Select applicable pass or passes.
9. Complete the Order Details for each pass selected.
  - Select the **start date** and **stop date** for each pass.
  - If **other pass** is selected, document type of pass in the **instruction** field.
  - ADA passes- Please leave stop date **blank** as this pass has no expiration date.
10. Select **OK** to add passes into encounter.
11. Select **End**.
12. Select **Sign Document**.

### Revoking a Pass workflow

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select encounter type, for this example **Provider Visits**.
4. Select **Chronological Record of Health care DC4-701** encounter type.
5. Complete all fields of form documenting rationale for the revocation of the pass.
6. Select **End**.
7. Select **Sign Document**.
8. Select **Orders** in the left navigation pane.
9. Select pass order being revoked.
10. Once highlighted, select **complete**.
11. Verify pass is selected and select **OK** to remove pass from patient's record.
12. Collect expired pass from patient.

### Printing Passes

1. From Inside patients chart select **Orders** from the left Navigation pane.
2. Find and select the Pass you want to print to highlight it.
3. From the top tool bar select **PRINT** icon.
4. From the Print box unselect the **Consolidated Summary of Services** and **Select the Selected Orders Option**.
5. Ensure the **Provider Form** is checked.
6. Confirm printer information displayed is correct or change if needed.
7. Select **Print**.



## Optometry Workflow

### Provider: Optometry Consult Request Process

1. Find patient using the **Magnifying Glass** icon.
2. Click on **New Document** to begin a new encounter.
3. Select **Provider Visits** encounter type.
4. Select the **UM Consultation request** DC4-702 Consultation.
5. Fill out the form as clinically indicated completing all fields in its entirety.
6. Select **New Consult Order**.
7. From **Custom List** select **Refer to Optometrist**.
8. Select **Ok**. This will return to the encounter.
9. Complete form in its entirety.
10. Select **End**.
11. **Route** document to site Consult Coordinator.
12. Select **Sign document**.

### Optometrist

1. Day of appointment: Find patient using the **Magnifying Glass** icon.
2. Select **New Document** to begin a new encounter.
3. Select the **Optometry/Ophthalmology** encounter type.
4. Complete the **DC4-702A Vision Assessment**.
  - Check the Continue to expanded Optometry Exam box.
5. Complete the Expanded Optometry Exam.
6. Next appointment date Order will auto generate.
7. Select **End**.
8. **Rote** document to **site provider** and **consult coordinator**.
9. Select **Sign document**.
10. **Prescriptions** will be written on paper and given to consult coordinator to process.

### Site provider

1. Review and sign off on the consult from chart desktop or patients chart.

### Consult Coordinator

1. Review consult and enter provider follow up to complete new consult if needed for annual follow ups.
2. Find your patient using the **Magnifying Glass** icon.
3. Select **New Document**.
4. Select **Admin Forms**.
5. Select **Chronological Record of Health Care**.
6. Complete as needed for adding an appointment.
7. Select **Orders** from top tool bar.
8. Using the Custom List drop down menu select **Medical Services**.



## Radiology Workflow Process

### Ordering

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Provider Visits** or **Provider CIC encounter type** (depending on type of visit).
4. Select appropriate forms needed for appointment. Complete selected forms.
5. Select **Orders** (either top tool bar or shortcut within form).
6. In the **Custom List tab**, select the **Radiology-MobileX/Diagnostics**, Select each radiology test requesting to be completed.
7. Select **Diagnosis** related to order and attach to order, if provisional for test add by selecting add problem. (This is mandatory)
8. Select the **Order Details** and complete for each test ordered.
9. Complete reason/rationale for test in the **instructions** box. (Mandatory)
10. Select **OK**. This will bring you back to encounter.
11. Select **End**.
12. Select **Sign Document**.

### Day of Radiology Appointment

1. Designated Staff will go to **Order Manager** and pull list of patients scheduled to be seen that day.
  - Print list for Radiology Technician.
2. Once patients have been checked in the staff member will change the status of the orders from **ADMIN HOLD** to **IN PROCESS**.
  - Ensure this process is only done once patient is present for exam.
3. The order will auto complete after results have been sent back and are signed off by provider.
4. If patient refuses staff will complete refusal and remove the order with the Reason as Refused.

\*Once the results are processed MobileX will send results to patients chart and doctors desktop for review and signature.



## How to - Order a Medication

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document** to begin a new encounter.
3. Select the appropriate **Encounter Type**.
4. Complete the form in its entirety as clinically indicated.
5. Select the **+ Medication** icon to open the New Medication window.
6. From **Custom List** drop-down arrow.
  - Select the desired medication.
  - From the next drop-down arrow on the bar select from the display of preset medications.
  - Select the desired medication.
7. Enter the following information once the medication is selected:
  - **Instructions**, write the directions for the medication. If medication is to be for DOT, PRN, EOS or WR or use ( ) after the medication directions i.e. 1 tab PO Q AM (DOT).
  - **Comments**, if the medication is off formulary and requiring a **DER** place the rationale and reason in this area.
    - Placing the word **Profile** in this box will have the medication go to eMAR and tell pharmacy to not fill the medication.
    - Enter **DOH** here when entering all medications being filled by DOH.
  - **Enter Start Date. (Mandatory)**
  - **Duration or Stop Date. (Mandatory)**
  - **Quantity. (Mandatory)**
  - **Refills. (Mandatory)**
  - **Interactions**, if any color other than a green check mark, or the blue circle with white I inside select and update this area as clinically indicated.
  - Select the appropriate problem for each medication. If not listed add **NEW PROBLEM**.
  - **Authorized By** (The ordering provider).
  - **Prescribing Methods**
    - **Handwritten**- sends **Formulary** medications to the pharmacy and eMAR.
    - **Pending Approval**- All **NON-FORMULARY** medications sent to RMD for approval.
8. If adding more medications select **SAVE and CONTINUE** and repeat steps 1-8. If not select **OK** and return to the encounter.
9. Complete the encounter by selecting **END**.
10. Select **Sign Document**.

\*\* Narcotics: All narcotics are entered into the EMR and to be written on an official state prescription, fax to the pharmacy and give paper copy to medical records to scan into patients chart.



## DER Process – Non-Formulary Meds

### Ordering Medication

1. Find the patient's chart by clicking on the **magnifying glass**, or by using the **Find Patient** drop down list.
2. Select **New Document**.
3. Select the appropriate encounter type.
4. Select appropriate document.
5. Select the **+ Medication** button to open the **New Medication** window.
6. Select the **Custom List** labeled **\*Common meds requiring DER**.
7. Using the drop down menu select the non-formulary medication from the list.
8. Enter the following information:
  - Enter instructions for medication.
  - Place rationale and reason for non-formulary medication in the **Comments box**.
  - Select Start and Stop Date.
  - Enter Quantity.
  - Enter Refills.
  - Ensure **Prescribing Method** is pending approval.
9. Select Diagnosis.
10. Check Allergies.
11. Check Drug Interactions and fix if applicable.
12. Select **Save and Continue** to add another medication or **OK** to return to encounter.
13. Complete form in its entirety.
14. Select End.
15. Select **Sign Document**.

### Approving or Denying Non-Formulary Medication

1. From the chart desktop, select **Non-Formulary Manager** located in the **Custom Commands** section of the **Toolbar** at the top of the screen.
2. A browser window will open to the **Non-Formulary Manager**, listing all the non-formulary medications ordered needing review.
3. Review medication requests select Approve or Deny as applicable.
4. Once DER's have been completed, the system will send an alert via the chart desktop to both the patient's chart and the ordering provider.
5. Click on the **X** symbol at the top right of the browser window to return to the **EMR**.



## EOS/Work Release Process Step by Step

Classification will send out the 90 day list weekly to appropriate staff.

Designated staff will then schedule the appointments Sixty (60) to ninety (90) days prior to end-of-sentence and as close to sixty (60) days as practical for inmates without placement needs. For inmates with clinically significant functional impairment and/or disabilities, the assessment shall be completed six months (180 days) prior to release date. Ensure Pre-release HIV has been completed in accordance with HSB 15.03.08 Human Immunodeficiency Virus (HIV) Disease and Continuity of Care ([Per HSB 15.03.04](#)). The steps are:

### To Add Orders:

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select the **Appropriate** encounter type.
4. Select the **Chronological Rec of Health Care** form.
5. Select appropriate role.
6. Document in free text box what orders are being added.
7. Select the **Orders** button from top tool bar to add orders.
  - Select **Medical Services** custom List to add medical appointment order.
  - Select **EOS Physical order**
  - Complete the **Orders Details**.
  - Add **EOS** or **Work Release** in the Instructions box for the type of appointment being scheduled.
8. Add order for **HIV lab** if applicable for EOS.
  - Select **Labs bio reference** from the custom List.
  - Select order **HIV AG/AB 4<sup>th</sup> gen**.
  - Complete **Order Details** for Lab ensuring that the Authorized by section is changed to Provider with a valid NPI on file.
9. Add order for the **Non-Inmate Encounter**.
  - Select **MH Outpatient** custom List.
  - Select **Non-Inmate Encounter**.
10. Complete **Order Details** to include documenting **EOS** or **Work Release** in the instructions box.
11. When all orders have been added **Select Ok** to go back to document.
12. Select **End** to end document.
13. Select **sign document**.

## Medical Provider Process for Completing End of Sentence Review

### Nurse Chart Prep:

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter.
3. Select **Vitals** encounter type, complete form.
4. Select **End**.
5. Select **Sign Document**.

### Provider

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Provider Visits** encounter Type.
4. Select **DC4549** button for **Pre Release Health Care Summary**.
  - Also, select DC4549a to complete if applicable.
5. Select appropriate **Med contact type** from drop down menu, complete form in its entirety.
6. Add **EOS/Work Release** medications if applicable.
  - Select **+ Medications** button from top tool bar.
  - Select appropriate medication from custom list.
  - Enter instructions for medication.
  - In ( ) next to instructions document EOS or WR. EX (EOS)
    - i. \*When you do this a message that instructions are not understood will display, this is ok it will go where it needs to go just continue process as below\*
  - Select start and stop date.
  - Quantity to dispense.
  - Change prescribing method to **HANDWRITTEN**.
  - To add another medication select **Save and Continue**, repeat steps b-g.
  - Press **ok** to add medication into encounter.
7. Select **End**.
8. Select **Sign Document**.
9. To capture patient signature on document.
10. Select **Fusion eSign** application from top tool bar to open in separate window.
11. Select second option **eSign EHR Encounter**.
12. **Search Patient** enter DC# or Patients name.
13. Using the drop down arrow next to **Select EHR Encounter** select the encounter type Pre Release form dated with today's date.
14. Select your site location using the drop down arrow under **Select Header** box.
15. Follow the prompts to capture your patient's signature.
16. Once completed exit out of Fusion eSign back into patients chart.
17. Select **Orders** from left navigation Pane.
18. Select the **EOS/Work Release** order appropriate to type of appointment and select **Complete**.
19. Verify in the Patient's Order screen if there currently is an **Approval/Disapproval for Work Release** order.
  - If there is no order, complete a **DC4-706 Health Service Profile**. Be sure to answer questions regarding work release.
  - Add end dates to the Orders for **Approval/Disapproval for Work Release** dated for 25 years.
20. Select **Orders** from left navigation Pane.
21. Select the **EOS/Work Release** order appropriate to type of appointment and select **Complete**.
22. **\*\*\* APPROVAL/DISSAPPROVAL FOR WORK RELEASE ORDERS REMAIN IN CHART UNTIL CHANGE IN CIRCUMSTANCE\*\*\***

## Mental Health Provider

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Appropriate** encounter Type.
4. Select **DC4549** button for **Pre Release Health Care Summary**.
5. Select appropriate **Med contact type** from drop down menu, complete form.
6. Select **End**.
7. Select **Sign Document**.
8. **Route** to Psych Provider if **EOS/Work Release meds** are needed.
9. Complete order for appropriate **Non-Inmate Encounter** with EOS/Work Release instruction.
10. Verify in the Patient's Order screen if there currently is an **MH Approval/Disapproval for Work Release** order.
  - If there is no order, complete a **DC4-706 Health Service Profile**. Be sure to answer questions regarding work release.
  - Add end dates to the Orders for **MH Approval/Disapproval for Work Release** dated for 25 years.

**\*\*\* APPROVAL/DISSAPPROVAL FOR WORK RELEASE ORDERS REMAIN IN CHART UNTIL CHANGE IN CIRCUMSTANCE\*\*\***

## Psych Provider to Add EOS/Work Release Medications

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Appropriate** encounter Type.
4. Select the **Chronological Rec of Health Care** form.
5. Select appropriate role.
6. Select Record Review.
7. Document in free text box incidental note.
8. Add **EOS/Work Release** medications.
  - Select **+ Medications** button from top tool bar.
  - Select appropriate medication from custom list.
  - Enter instructions for medication and (EOS) OR (WR) after.
    - \*When you do this a message that instructions are not understood will display, this is okit will go where it needs to go just continue process as below\*
  - Select start and stop date.
  - Quantity to dispense.
  - Change prescribing method to **HANDWRITTEN**.
  - Press **ok** to add medication into encounter.
9. Select **End** to end document.
10. Select **sign document**.





## How To – Create an ISP

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select **MH Case Manager** encounter type
4. Select **ISP DC4-643A** from the **Misc.** section of the landing page
5. Complete all fields as clinically indicated
  - Adding a new diagnosis
    - Select the **Add Problems** button located under the active problems list and the **New Problem** window will appear
    - Before typing the diagnosis in the text box next to **Search for:**, select **\*Smart List** from the drop down box next to **Using:**
  - Adding a new MH Problem:
    - Before typing the desired MH Problem number/name in the text box next to **Search for:**, Select **Mental Health Problems** from the drop down box next to **Using:**
    - Be sure to complete the **Problem Details** section as clinically indicated
    - If multiple MH Problems/Diagnosis need to be added, select **Save and Continue**
    - Once all desired MH Problems/Diagnosis have been added, select **OK**
  - Updating existing MH Problem(s)/Diagnoses:
    - Select the **Problems** icon (closest to the left) and the **Update Problems** window will appear
    - To *change* an existing MH Problem/Diagnosis:
      - Highlight the desired MH Problem/Diagnosis and select the **Change** button located at the bottom of the window
      - Update accordingly and select **OK** to return to the **Update Problems** window
    - To *remove* an existing MH Problem/Diagnosis:
      - Highlight the desired MH Problem/Diagnosis and select the **Remove** button located at the bottom of the window
      - Enter the corresponding **End Date**
      - From the drop down window, select the appropriate **Reason for Removal**
      - Select **OK** to return to the **Update Problems** window
    - Select **Ok** to return to the encounter
      - Note: Both the Diagnosis and MH problem(s) will appear in the patient's **Problems/Diagnosis** section of the **Chart Summary**
      - From the **Mental Health Diagnoses** section of the ISP, select only the appropriate Mental Health diagnoses from the drop down window
      - Note: in the **Problem #/Problem Name** section of the ISP, Only the active **MH Problems** from the patient's chart options will appear in the drop down menu

- Input the **Target Date (Next Review Date)** in the corresponding box at the bottom of the encounter

#### 6. Creating Orders:

- Select the **Orders** icon in the top of the top tool bar. The **Update Orders** window will automatically appear
- From the **Custom List** section, select **MH MDST Treatment Meeting** option from the drop down menu
- Select **ISP MDST**, **ISP Patient Signed**, and **MDST** (only select **MDST** if patient is located at a S3facility)
- If other orders need to be added to the ISP, add as clinically indicated from the corresponding custom list(s)
- Once all appropriate orders have been created, select the **Order Details Tab** and complete as clinically indicated
  - For **ISP MDST**:
    - In the **Instructions** section, input the type of ISP that will be due at the next target date (ex. 30 day ISP)
    - Change the **Start Date** to match the date selected from the **Target Date (Next Review Date)** section located at the bottom of the ISP
  - For **ISP Patient Signed**:
    - In the **Instructions** section, input “will sign during MDST” or “will sign during next MH appointment” depending on the facilities preference and in line with corresponding policies and procedures
  - For **MDST** (S3 facilities only):
    - In the **Instructions** section, input the information that will be presented in MDST for that particular patient
    - Note the date input into the **Start Date** section will correspond with when that documentation will be presented in MDST
- Attaching a Diagnosis to an Order:
  - From the **Update Orders** window, highlight the desired order that needs a corresponding diagnosis.
    - If more than one order needs to have a diagnosis added, Hold down the **CTRL** button and select all corresponding orders
  - From the **Potential Diagnoses** section, select the corresponding diagnosis/diagnoses from the list
    - The MH Problems **do not** need to be added to the order, only the Diagnosis/Diagnoses
    - If more than one diagnosis needs to be added an order, hold down the **CTRL** button on the keyboard and select the corresponding diagnoses
- Once all appropriate information regarding the order(s) has been entered, select **OK** to return to the encounter

7. Adding the **MDST Docket** for inpatient locations
  - From the **MH Case Manager** landing page, select the **MDST** button from the **Misc.** section to add the MDST docket to the current encounter.
  - Complete as clinically indicated (refer to MDST Workflow for more details)
  - Note: MDST order **WILL NOT** need to be created if this form is added to the encounter
    - MDST obs term will be added to the clinical list changes upon entering **Duration of meeting (in min):** section
8. Select **End** (see below for next steps in this workflow)

#### If ISP IS presented during MDST meeting

1. Select the **Sign Clinical List Changes** check box from the **End Update** window
  - Note: Since ISPs are typically prepared prior to the MDST meeting, the **Clinical List Changes** need to be signed off on when the document is put on hold. This will allow other end users to sign off on their documentation
2. Select **Hold Document**
  - Note: ISP **will not** be signed until the MDST meeting, at which time, all parties (**including centurion staff**) will sign the document using the **Fusion eSign** application. Refer to **MDST Workflow** for more information.

#### If ISP IS NOT presented during MDST meeting

1. Select the **New** button from the **End Update** window and route to appropriate clinical staff for co-signature
2. From the **New Routing Information** window:
  - Select **Signature** in the **Reason** section
  - In the **Comments** Section, input what type of ISP is being routed for signature (ex. 30 day ISP)
  - Select **OK** to return to the **End Update** window
3. Select **Sign Document**
4. Satisfying orders
  - Select the **Orders** section in the left navigation pane
  - Select the **ISP MDST** order that is scheduled for today's date
  - Select **Complete** in the **Orders** toolbar
  - When the **Select Orders to Complete** window appears, make sure the check mark is next to the appropriate order
    - If multiple orders need to be satisfied, check the box next to the corresponding orders
5. Select **OK** to satisfy the order(s) and it will be removed from the **Orders** list
6. ISP will be signed by the patient as clinically indicated in the corresponding policies and procedures



## How To – Update an ISP

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select **MH Case Manager** encounter type
4. Select **ISP DC4-643A** from the **Misc.** section
5. If the patient is located at an inpatient facility, also select the **MDST Docket** and complete as clinically indicated (refer to MDST Workflow for more details)
6. Update the information as clinically indicated
  - Input the **Target Date (Next Review Date)** in the corresponding box at the bottom of the encounter
  - Creating Orders:
    - Select the **Orders** icon in the top of the top tool bar. The **Update Orders** window will automatically appear
    - From the **Custom List** section, select **MH MDST Treatment Meeting** option from the dropdown menu
    - Select **ISP MDST**, **ISP Patient Signed**, and **MDST** (only select **MDST** if patient is located at aS3 or higher facility)
    - If other orders need to be added to the ISP, add as clinically indicated from the corresponding custom list(s)
    - Once all appropriate orders have been created, select the **Order Details Tab**
      - For **ISP MDST**:
        - In the **Instructions** section, input the type of ISP that will be due at the next target date (ex. 30 day ISP)
        - Change the **Start Date** to match the date selected from the **Target Date(Next Review Date)** section located at the bottom of the ISP
      - For **ISP Patient Signed**:
        - In the **Instructions** section, input “will sign during MDST” or “will sign during next MH appointment” depending on the facilities preference and in line with corresponding policies and procedures
      - For **MDST**:
        - In the **Instructions** section, input the information that will be presented in MDST for that particular patient
        - Note the date input into the **Start Date** section will correspond with when that documentation will be presented in MDST
    - Attaching a Diagnosis to an Order:
      - From the **Update Orders** window, highlight the desired order that needs corresponding diagnosis.
        - If more than one order needs to have a diagnosis added, Hold down the **CTRL** button and select the corresponding orders

- From the **Potential Diagnoses** section, select the corresponding diagnosis/diagnoses from the list below
    - The MH Problems **do not** need to be added to the order, only the Diagnosis/Diagnoses
    - If more than one diagnosis needs to be added an order, hold down the **CTRL** button on the keyboard and select the corresponding diagnoses
- 7. Note: if any of the providers have changed since the last ISP was completed, the designated staff member will need to complete the **DC4-701 Chorological Record of Health Care** prior to updating the ISP. See corresponding workflow for more information
- 8. Note: the current ISP may also be viewed by selecting the **Current ISP** tab from the **MH Case Manager** landing page
- 9. Adding the **MDST Docket** for inpatient locations
  - From the **MH Case Manager** landing page, select the **MDST** button from the **Misc.** section to add the MDST docket to the current encounter.
  - Complete as clinically indicated (refer to MDST Workflow for more details)
  - Note: MDST order **WILL NOT** need to be created if this form is added to the encounter
    - MDST obs term will be added to the clinical list changes upon entering **Duration of meeting (in minutes):** section
- 10. Select **End**

#### If ISP IS presented during MDST meeting

1. Select the **Sign Clinical List Changes** check box from the **End Update** window
  - Note: Since ISPs are typically prepared prior to the MDST meeting, the **Clinical List Changes** need to be signed off on when the document is put on hold. This will allow other end users to sign off on their documentation
2. Select **Hold Document**
  - Note: ISP **will not** be signed until the MDST meeting, at which time, all parties (including centurion staff) will sign the document using the **Fusion eSign** application. Refer to **MDST workflow** for more information.

#### If ISP IS NOT presented during MDST meeting

1. Select the **New** button from the **End Update** window to route to appropriate clinical staff for co-signature
2. From the **New Routing Information** window:
  - In the **Reason** section, select **Signature**
  - In the **Comments** Section, input what type of ISP is being routed for signature (ex. 30 day ISP)
  - Select **OK**
3. Select **Sign Document**
4. Satisfying orders
  - Select the **Orders** section in the left navigation pane
  - Select the **ISP MDST** order that is scheduled for today's date

- Select **Complete** in the **Orders** toolbar
  - When the **Select Orders to Complete** window appears, make sure the check mark is next to the appropriate order
    - If multiple orders need to be satisfied, check the box next to the corresponding orders
5. Select **OK** to satisfy the order(s) and it will be removed from the **Orders** list
  6. ISP will be signed by the patient as clinically indicated in the corresponding policies and procedures



## Inpatient MDST Workflow

### Creating the MDST Docket

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. From the **Documents for Edit** section of the patient's chart:
3. Select **New Document**
4. Select **MH Case Manager** encounter type
5. Select the **MDST** button in the **Misc.** section to populate the MDST docket
  - Note: if being prepared prior to MDST, complete as much of the encounter as clinically indicated
6. Select **End**
7. Select the **Sign Clinical List Changes** check box from the **End Update** window
8. Select **Hold Document**
9. During MDST: The MHP will be in charge of inputting the appropriate information for each of the department sections listed below
  - Psychiatry, Nursing/Medical, Activity Therapist, Classification, Security, Psychologist, and Other (if applicable)

### MDST Meeting

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. From the **Documents for Edit** section of the patient's chart, select the **Edit** button to open the corresponding encounter
  - Present the information to MDST meeting attendees
    - If changes need to be made, modify accordingly
3. Once the information in the corresponding encounter has been reviewed thoroughly by the MDST attendees, select **End**
4. Select **Sign Document** at the bottom on the **End Update** window and proceed to the **Fusion eSign** Application
5. Obtaining required signatures using **Fusion eSign**:
  - Select the **Fusion eSign** web application located in the **custom commands** section of the tool bar
  - Once the web page opens, select **eSign EHR Encounter**
  - On the left hand side of the web page, type the patient's name or DC# in the **Search Patient** section and select the corresponding patient
  - Under the **Select EHR Encounter** option, use the drop down arrow to locate, and select the desired MDST documentation
    - Note: Encounters will be organized by most recent to oldest
    - If desired, use the **FL MH Case Manager** option from the **Document Type Filter** drop down window to specify even further
  - Once the encounter and corresponding information has been previewed, select **Continue**
  - User will then be prompted to hand the device to the patient. At this time you will turn the

screen towards the patient and select **Continue**

- Ensure the topaz signature pad is in reach of the patient and advise the patient to follow the prompts on the screen
  - Once the patient has reviewed the form, advise them to select **I verify that I have read and agree to the terms printed above** to proceed
  - Once **1 Patient (signature) – Required** is selected from the drop-down window under **Required Endorsements**, advise the patient to sign the document and select **Submit Signature to Preview** to proceed
  - Once the patient has reviewed the document with their accompanying signature, advise them to select **Finalize Endorsement and Continue**
  - When prompted, staff member will turn the screen back to its original position and select **Continue**
  - Adding additional signatures:
    - In the Add Additional Endorsements section, type in the name of the staff member and the department that they are representing and select **Add Signature**
      - Ex. “J. Ross, Security”
    - Select the **Submit Signature to Preview** once the individual has signed in space provided
    - The document will display again for review with the patient’s endorsement and additional endorsement(s)
    - To add the remaining MDST Signatures, type in the name of the staff member and their department then select **Add Signature**
  - Repeat steps associated with the **Adding additional signatures** bullet point above until all necessary signatures are obtained
    - The MHP will be the **ONLY** one with an electronic signature.
    - Psychiatry, Psychology, Nursing/Medical, Activity Therapist/ Group Counselor, Aftercare Coordinator (if applicable), Classification, Security, Education signatures will all be obtain via **Fusion eSign**
  - Select **Finalize Endorsement and Continue to Final Review**
  - Select the **Submit and Add to Patient’s Chart** button located at the bottom of the document displayed causing a new window to populate to display the complete document.
  - Close out of the **Fusion eSign** web application and return to the patient’s chart
6. To view the completed MDST documentation
- Select the **Documents** view in the left navigation pane of the patient’s chart
  - The **Paperclip** icon indicates that the eSign document has been added to the corresponding encounter
    - Note: User may be required to refresh the patient’s chart in order to view the changes made in Fusion eSign
7. Satisfying Orders
- Select the **Orders** section in the left navigation pane of the patient’s chart
  - Select the desired MDST order that is scheduled for today’s date
    - (ex. ISP MDST)



- Select **Complete** in the **Orders** toolbar
  - When the **Select Orders to Complete** window appears, make sure the check mark is next to the appropriate order
    - If multiple orders need to be satisfied, check the box next to the corresponding orders
8. Select **OK** to satisfy the order(s) and it will be removed from the **Orders** list



## Outpatient MDST Workflow

During MDST the MHP will present the appropriate documentation using the steps below:

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. From the **Documents for Edit** section of the patient's chart, select the **Edit** button to open the desired MDST encounter
3. Present the information to the MDST meeting attendees
  - If changes need to be made, modify accordingly
4. Once the information in the corresponding encounter has been reviewed thoroughly by the MDST attendees, select **End**
5. Select **Sign Document** at the bottom on the **End Update** window and proceed to the **Fusion eSign** application
6. Obtaining required signatures using **Fusion eSign**:
  - Select the **Fusion eSign** web application located in the **custom commands** section of the tool bar
  - Once the web page opens, select **eSign EHR Encounter**
  - On the left hand side of the web page, type the patient's name or DC# in the **Search Patient** section and select the corresponding patient
  - Under the **Select EHR Encounter** section, use the drop down arrow to locate, and select the desired MDST documentation
    - Note: Encounters will be organized by most recent to oldest
    - If desired, use the **FL MH Case Manager** option from the **Document Type Filter** drop down window to specify even further
  - Once the encounter and corresponding information has been previewed, select **Continue**
  - User will then be prompted to hand the device to the patient. At this time, select **Continue**
    - Note: Since patients are not present during Outpatient MDST meetings, their signature will be obtained during their next MH appointment.
    - Refer to the **Obtaining the patient's signature during MH appointment** section below for further information
  - Select **I verify that I have read and agree to the terms printed above** to proceed
  - Once **1 Patient (signature) – Required** is selected from the drop-down window under **Required Endorsements**, Select **Submit Signature to Preview** to proceed
  - Select **Finalize Endorsement and Continue**
  - Select **Continue**
  - Adding additional signatures:
    - In the Add Additional Endorsements section, type in the name of the staff member and the department that they are representing and select **Add Signature**
      - Ex. "J. Ross, Security"
    - Select the **Submit Signature to Preview** once the individual has signed in space provided
    - The document will display again for review with the additional endorsement(s)
    - To add the remaining MDST Signatures, type in the name of the staff member and their department then select **Add Signature**
  - Repeat steps associated with the **Adding additional signatures** bullet point above until all necessary signatures are obtained
    - The MHP will be the **ONLY** one with an electronic signature.



- Psychiatry, Psychology, Nursing/Medical, Activity Therapist/ Group Counselor, Aftercare Coordinator (if applicable), Classification, Security, Education signatures will all be obtain via **Fusion eSign**
  - Select **Finalize Endorsement and Continue to Final Review**
  - Select the **Submit and Add to Patient's Chart** button located at the bottom of the document displayed causing a new window to populate to display the complete document.
  - Close out of the **Fusion eSign** web application and return to the patient's chart
7. To view the completed MDST documentation
- Select the **Documents** view in the left navigation pane of the patient's chart
  - The **Paperclip** icon indicates that the eSign document has been added to the corresponding encounter
    - Note: User may be required to refresh the patient's chart in order to view the changes made in Fusion eSign
8. Satisfying Orders
- Select the **Orders** section in the left navigation pane of the patient's chart
  - Select the desired MDST order that is scheduled for today's date
    - (ex. ISP MDST)
  - Select **Complete** in the **Orders** toolbar
  - When the **Select Orders to Complete** window appears, make sure the check mark is next to the appropriate order
    - If multiple orders need to be satisfied, check the box next to the corresponding orders
9. Select **OK** to satisfy the order(s) and it will be removed from the **Orders** list

### Obtaining the patient's signature during MH appointment

1. Select the **Fusion eSign** web application located in the **custom commands** section of the tool bar
2. Once the web page opens, select **eSign EHR Encounter**
3. On the left hand side of the web page, type the patient's name or DC# in the **Search Patient** section and select the corresponding patient
4. Under the **Select EHR Encounter** option, use the drop down arrow to locate, and select the desired MDST documentation
  - Note: Encounters will be organized by most recent to oldest
  - If desired, use the **FL MH Case Manager** option from the **Document Type Filter** drop down window to specify even further
5. Once the encounter and corresponding information has been previewed, select **Continue**
6. User will then be prompted to hand the device to the patient. At this time you will turn the screen towards the patient and select **Continue**
7. Ensure the topaz signature pad is in reach of the patient and advise the patient to follow the prompts on the screen
8. Once the patient has reviewed the form, advise them to select **I verify that I have read and agree to the terms printed above** to proceed
9. Once **1 Patient (signature) – Required** is selected from the drop-down window under **Required Endorsements**, advise the patient to sign the document and select **Submit Signature to Preview** to proceed
10. Once the patient has reviewed the document with their accompanying signature, advise them to select **Finalize Endorsement and Continue**
11. When prompted, staff member will turn the screen back to its original position and select **Continue**



12. Select **Finalize Endorsement and Continue to Final Review**
13. Select the **Submit and Add to Patient's Chart** button located at the bottom of the document displayed causing a new window to populate to display the complete document.
14. Close out of the **Fusion eSign** web application and return to the patient's chart
15. At this time, proceed to the **Documents for Edit:** section of the patient's chart and select **New Document**
16. Select **MH Case Manager** (or other clinically appropriate encounter type) and complete the required documentation for the scheduled MH appointment (see corresponding workflow for more information)
  - Note: once the encounter has been signed and you have started to satisfy the appropriate orders relating to the current MH appointment, be sure to include the **ISP Patient Signed** order before selecting **OK** from the **Select Orders to Complete** window
    - This will be located in the **Orders** section of the patient's chart



## How To Refer to Psychologist or Psychiatrist requesting Psych Change

### Mental Health Professional

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select **MH case manager** encounter type
4. Select **Chronological Record of Health Care DC4-701**.
5. Complete all fields as clinically necessary documenting need for request for psych grade change.
6. Select **End**.
7. **Route** encounter to Psychologist or Psychiatrist to review for psych grade change
8. Select **Sign Document**.



## How To Update Psych Grade from a consult

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Select **New Document** to begin a new encounter
3. Select either **MH Psychologist** or **MH Psychiatrist** encounter type
4. Select the **Chronological Record of Health Care**
5. Select **Change in S grade** as the **Reason for Encounter** option
  - After completing the note section of this form, select the **DC4-706** button that appeared next to the **Change in S grade** option to be directed to the Health Service Profile
6. From the Health Service Profile form, select the **Psychiatric Provider** radio button on from the **Select Role** Tab
  - Complete the Health Service Profile as clinically indicated
7. Select **End**
8. Select **Sign document**

### If the psych grade is being updated from an appointment

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Select on **New Document** to begin a new encounter
3. Select either **MH Psychologist** or **MH Psychiatrist** encounter type
4. Select the clinically appropriate form associated with that appointment type
5. If the document doesn't have a link to the health service profile embedded into the form, follow steps 4-6 listed above.
6. Select **End**
7. Select **Sign document**



## Transfer Patient to CSU/TCU Workflow

### Completing Transfer Summary for Inpatient Mental Health (DC4-657A)

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Case Manager** Encounter type.
4. Select the **Transfer Summary for Inpatient Mental Health DC4-657A** button.
5. Complete form as clinically indicated.
6. Select **End**.
7. Select **Sign Document**.
8. Satisfying orders.
  - Select the **Orders** section in the left navigation pane.
  - Select the corresponding order(s).
  - Select **Complete** in the **Orders** toolbar.
  - When the **Select Orders to Complete** window appears, make sure the check mark is next to the appropriate order.
    - If multiple orders need to be satisfied, check the box next to the corresponding orders.
  - Select **OK** to satisfy the order(s) and it will be removed from the **Orders** list.

### Completing MHIT documentation

Once the MHIT documentation has been completed, printed, and scanned onto your computer, complete the steps below.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Case Manager** Encounter type.
4. Select the **Chronological Record of Health Care DC4-701**.
  - Document in the notes section that the relevant MHIT documentation has been completed.
5. Select **End**.
6. Place Document on **Hold**.
7. Scan MHIT documentation into the designated Scanner.
8. Attach MHIT documentation into encounter using **indexing client**, How to attach to document on hold section.
9. From the patients chart select **Edit** button next to the document on hold under the **Documents for edit** section.
10. Add any applicable orders.
11. Select **End**.
12. **Route** to appropriate clinical staff (facility's MH director/RMHD) for co-signature.
  - Select **New**.
  - **Enter** staff in the **TO** section.
  - Select **Signature** in the **Reason** section.
  - In the **comments** section, input clinically appropriate description
    - Ex. "transfer paperwork for CSU/TCU "
  - Select **OK**.

13. Select **Sign Document**.



## Admitting and Discharging Inpatient (IP) Units

### Admit to CSU, TSU and CHMHTF Attending Clinician

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Psychiatrist/MH Psychologist** Encounter type.
4. Select appropriate document.
  - Psychiatrist select either IP incidental Note or DC4642A psych FU.
  - Psychologist select the IP incidental Note.
5. Complete all fields as clinically indicated (use your resources as reference).
6. Select **Orders**.
7. Custom list **MH Admission and Placements**.
8. Select **Appropriate Status Order and Update Grade**.
  - Complete Order Details for all orders.
  - \*DO NOT COMPLETE STATUS ORDER UNTIL DISCHARGED\***
9. Select **Ok**.
10. Select **End**.
11. **Route** document to nursing.
  - **Select Review and comment see orders.**
12. Select **Sign Document**.
  - \*DO NOT FORGET TO UPDATE PROFILE GRADE THROUGH THE HSP\***

### Discharge from CSU, TSU and CHMHTF Attending Clinician

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Psychiatrist/MH Psychologist** Encounter type.
4. Select appropriate document.
  - Psychiatrist select either IP Incidental Note or DC4642A Psych FU.
  - Psychologist select either the IP incidental Note.
5. Complete all fields as clinically indicated (use your resources as reference).
6. Select **End**.
7. **Route** document to nursing.
  - **Select Review and comment discharge from current status.**
8. Select **Sign Document**.
9. Select **Orders** from patient chart.
10. Locate and highlight the **Status** order.
11. Select **Complete**.
  - **Ensure the completion date is date of discharge.**
12. Select **Ok**.

**All other related orders are to be completed by discharging nurse.**





## Admitting and Discharging Outpatient (OP) SHOS

### Admit OP SHOS Attending Clinician

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Psychiatrist/MH Psychologist** encounter type.
4. Select **Infirmary SHOS/Record**.
5. Complete all fields as clinically indicated (use your resources as reference).
6. Select **Orders**.
7. Custom list **MH Admission and Placements**.
8. Select **SHOS Admission** this will auto populate all required orders for admission.
  - Complete Order Detail for all orders.
  - **Note: DO NOT COMPLETE SHOS STATUS ORDER UNTIL DISCHARGE**
9. Select **Ok**.
10. Select **End**.
11. **Route** document to nursing.
  - **Select Review and comment see SHOS orders.**
12. Select **Sign Document**.

### Discharge OP SHOS Attending Clinician

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Psychiatrist/MH Psychologist** encounter type.
4. Select **Infirmary SHOS/Record**.
5. Complete all fields as clinically indicated (use your resources as reference).
6. Select **End**.
7. **Route** document to nursing staff to handle discharge.
  - **Select Review and comment discharge from SHOS.**
8. Select **Sign Document**.
9. Select **Orders** from patients chart.
10. Locate and highlight the **SHOS Status** order.
11. Select **Complete**.

**\*All other SHOS related orders are to be completed by discharging nurse.**



## Indexing DC4-664 MH SOCTS Attendance Record Work Flow

1. Scan DC4-664 MH SOCTS Attendance Record form using your assigned scanner.
2. Open Indexing Client from APP Page.
3. Sign into Indexing Client using your log in and password and correct Location of Care.
4. Select the designated **Scanner number** from the Path drop down menu.
5. Select the document you want to upload from your available files to highlight and hit the single arrow to add Files to import section.
6. Import as: **Attachment**
7. In Comment box type **DC4-664 MH SOCTS Attendance Record Date started- Date Ended.**
8. Select appropriate **Document Type DC4-664 - MH Activity Log** from the drop down menu.
9. **Clinical date** and time will auto populate to Todays Date and 12:00AM the time will need to be changed to **current time** document is being uploaded into the system.
10. **Summary Text** will auto populate to Document Type highlight over the **DC4-664 - MH Activity Log** and type **DC4-664 MH SOCTS Attendance Record.**
11. Select **Lookup Patient.**
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Change to MRN if you wish to search by DC# then press ok.
12. Sensitivity stays as **Normal.**
13. Select the **import as signed box.**
14. Leave the Import as abnormal **unchecked.**
15. Leave attach to existing document blank.
16. Open Orders will stay blank.
17. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
18. Using the drop down arrow next to Physician: **select the staff member who reviewed and signed the documents name.**
19. Carbon copy option will be left blank.
20. Select **Import Document.**

\*Staff looking for this documentation can select the MH Document View folder and then select the + button next to it and select FL MH Case Manager and all of those documents will be there\*



## MH Outpatient (OP) Incidental Refusal Note Workflow

1. Select the appropriate encounter type option needed to satisfy the appointment (e.g MH Case Manager).
2. From the corresponding landing page, select the appropriate document type (e.g Initial Interview, Case Management (recurrent), PREA interview, etc.).
3. Select the appropriate reason(s) for encounter then check the corresponding **Refused** box.
  - Once that box is refusal box is selected, a pop up will appear with further instructions. Select **OK**.
4. Select the **Inmate refused mental health services (DC4-711A)** located at the top of the form.
5. Select the **Incidental Refusal Note** button once it appears.
6. To complete the incidental note, Select **DC4701 Chron Rec of Hlth Car** from the left navigation pane or select **Next Form** at the bottom of the screen.
7. Select the **MH** radio button.
8. Complete Incidental Refusal Note as clinically indicated.
  - Select applicable **housing status**
  - Select **Other- Incidental Note:** as the reason for encounter
  - Be sure to include **patient's stated for refusal** and **any statements and description of efforts taken to encourage participation**
9. Select **End**.
10. Select **Sign Document**.

### Note:

- The DC4-711A will be completed as its own document. If there is no Wi-Fi available when refusal is being completed, the DC4-711A can be completed within the same encounter.
  - Refer to the **How to Complete a Refusal** document for further instructions.
- **IP refusals** will be completed using the DC4-642T

### If there is no Wi-Fi:

#### Note:

- DC4-711A will need to be completed both on paper and electronically.
- If the refusal is being scanned in by someone other than the person who completed the assessment (e.g MH Clerk, Medical Records), then it will be scanned in as its own document with the same clinical date and time as the assessment so it displays next to the corresponding note. (see further instructions below)

### Importing signed document as its own document

1. Select **Production Fusion Indexing Client** from the APP Page.
2. Sign into Indexing Client using your log in and password.
3. Select the designated **Scanner number** used to scan refusal form from the Path drop down menu.
4. Select the document you want to upload from your available files and hit the single arrow to **add Files to import section**.
5. Import as: **Attachment**
6. Enter description of scanned item in Comment box using designated format (Form#, DC#, Date).
  - a. Example- DC4711A 123456 11/29/21



7. Select appropriate **Document Type** MH Refusals.
8. **Clinical date** and **Time** will auto populate to current date and 12:00AM this will need to be changed to exact date and time of document.
  - a. **Highlight over it and type correct date and time.**
9. **Summary Text** will auto populate to **Document Type** this can be changed by highlighting and typing over it if necessary.
10. Select **Lookup Patient**.
  - a. From the patient lookup box you are going to type in patients name in the search for box and select find. Change to **MRN** if you wish to search by DC# then press ok.
11. Sensitivity stays as **Normal**.
12. Select **Import as Signed** box.
13. Leave the Import as abnormal **unchecked**.
14. Open Orders will stay blank.
15. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
16. Next to **Physician: select the name of the staff member who signed the document**.
  - Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.
17. Leave Carbon copy unchecked.
18. Select **Import Document**.
19. The document will then be imported into the patients chart.



## MH SHOS Rounds Workflow Instructions

### SHOS Daily Rounds

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **MH Case Manager** encounter type.
4. Select **Infirmary/SHOS Record**.
5. Complete all fields as clinically indicated (use your resources as reference)
6. Select **End**.
7. Select **Sign Document**.



## Telepsych Consult Workflow

### Follow to refer a patient to Telepsych for a psychiatric consult- S2 Facilities only

1. Select " Find Patient"
2. Select " New Document"
  - Select " MH Psychiatrist"
  - Consult Request
  - Complete what would be the front side of the consult form
  - Save
  - Route to Dr. Greenfield
  - Click " Orders"
    - Utilization Management
    - Refer to Psychiatrist
  - Click "End"
3. Facility coordinator will request clinic for patient on Telepsych clinic request portal page
4. Dr. Greenfield Electronically signs document
5. Dr. Greenfield routes to Brittany Spain for scheduling
6. Once scheduled by the Statewide Telehealth Coordinator, facility will schedule in the EMR.
7. Facility will send any required documentation to the provider that is not in the EMR utilizing the Chart checklist as a coversheet
8. Chart checklist is found on the Telepsych portal page.
9. Any documents not on the chart checklist must be scanned to the provider.
10. One patient packet per scan. DO NOT scan multiple patients in one file.
11. Provider will
12. Fill out the backside of the consult in paper form. S-grade change, orders (if applicable), or any other form will be completed in the EMR.
13. Scan/ send the backside of the consult to the facility coordinator (most providers do not have access to a EMR scanner at this time.)



## Telepsych Medication Consents Workflow

Follow for psychiatric medication consents for telehealth.

1. Provider will inform Patient Facilitator a medication will be started
2. Patient facilitator will
  - initiate medication consent for the applicable medication
  - have patient sign consent form on the signature pad
  - write “Telehealth” on the signature pad when prompted for a provider signature
  - route to Telepsych provider for signature
3. Provider will electronically sign consent



## Nursing – How to Complete a TB Clinic

1. Find the patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Select **New Document** to begin a new encounter
3. Select the **Nurse Infection Control** encounter
4. Select the button for the **DC4-719 – TB/INH Tx for Latent TB Infection Nursing** form
5. Complete the **DC4-719** as clinically indicated (next appt in 28 days)
6. Select the button at the top of the screen labeled **Orders**
7. When the Update Orders box opens select the **Labs-Bioreference** custom list
8. Select check box next to **Hepatic Function Panel** to place a check mark and order the lab
9. Select **Latent Tuberculosis** in the **Potential Diagnoses:** box
10. Select << button to add the diagnosis to the lab order created
  - Once the diagnosis is added the **Order Details** tab will auto populate
11. Select the **Order Details** tab
12. Type **Monthly LFT for INH/B6 treatment** in the **Instructions** field
13. Enter the ordering provider in the **Authorized By** field by searching with the binocular icon or using the drop down list
14. Change the **Start Date** by entering the date that is two weeks after the date of this encounter
15. Select the **Nursing Services** custom list
16. Place a check mark in the box next to **TC Clinic**
17. Select on the **Order Details** tab
18. Type **Monthly TC Clinic** in the Instructions field
19. Change the **Start Date** to schedule the appointment for 28 days from the date of this encounter
20. Select **OK**
21. Select **End**
22. **Route** to designated provider to sign orders
  - Select “signature” as **Reason** and input “sign orders” in **Comment field**
23. Select **Sign Document**

### Completing Order for appointment

24. Select **Orders** link in the left navigation pane
25. Select the TC Clinic that is completed
26. Select **Complete** in the **Orders** toolbar
27. When the **Select Orders to Complete** window opens, make sure the correct order has a check mark in the box next to it
28. Select **OK** to complete the order and remove it from the **Orders** list





## Hunger Strike Documentation

### Upon Notification of Nine Missed Meals or an Inmate Declared Hunger Strike

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select **Nurse Visits**
4. Select **No** for **Copay**
5. Click on the **Chronological Record of Health Care (DC4-701)**
6. Select the **Nursing** radio button
7. Document notification of hunger strike in incidental note
8. Add any orders given by provider
9. Click **End** button to finish encounter
10. **Route** to provider notified of hunger strike
11. Select **Sign Document**

### Upon Arrival of Inmate for Assessment by Nursing Staff

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select **Nurse Protocol Visit**
4. Select **No** for **Copay**
5. Click on **Hunger Strike** protocol button (**DC4-683RR**)
6. Complete nursing protocol
7. Add any orders given by provider
8. Click **End** button to finish encounter
9. **Route** to provider notified of hunger strike
10. Select **Sign Document**

### Daily Nursing Follow-Up Documentation

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Click on **New Document** to begin a new encounter
3. Select **Nurse Visits**
4. Select **No** for **Copay**
5. Click on **Hunger Strike Daily Nursing Assessment (DC4-684D)**
6. Complete nursing protocol
7. Select **End** button to finish encounter
8. Select **Sign Document**



## Nursing – Infirmiry Admission Workflow

### Infirmiry Admission

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Verify the **Infirmiry Admission** order in the **Orders** section of the patient’s chart
3. Once verified, select **New Document** to begin a new encounter
4. Select **Infirmiry** encounter type
5. Select forms required for the current admission
  - Acute Admission – **DC4-732 & DC4-714D**
  - Chronic Admission – **DC4-732 & DC4-714D**
  - 23 hour Observation – **DC4-732B**
  - Test Preparation and Specimen Collection – **DC4-732A**
6. Complete each form
7. Select **End** button to finish encounter
8. **Route** to the provider that ordered the admission
  - **See the “Routing How to”**
9. Select **Sign Document**
10. Select the **Orders** link in the left navigation pane
11. Select the **Infirmiry Admission** order from the list of orders
12. Select **Complete** in the **Orders** screen toolbar
13. From the **Select Orders to Complete** box, verify that there are check marks next to the **Infirmiry Admission** orders
14. Select **OK** to complete the order

### Bedboard Admission

1. Select the icon for **Fusion Bedboard** in the **Custom Commands** section of the EMR toolbar
  - This will open **Fusion Bedboard Web Application** in a new browser window
2. Select **+ New Admission** in the left navigation pane
3. Enter the patient’s name or DC# to find the patient you want to admit
4. Select your patient from the list
5. Select on the blue **Use ICD-10 Code** link next to **Admitting Diagnosis** to enable ICD-10 code diagnosis searches
6. Enter the admitting diagnosis
  - It will begin searching as soon as you start typing, and the more you enter, the narrower the results will become
7. Select on the correct admitting diagnosis
8. Document any notes in the **Admission Note** box
9. Select the **Acuity** for the admission using the drop down menu
10. Document any notes required in the **Acuity Note** box
11. If the patient needs to be isolated, check off the corresponding box
12. Verify the **Facility** is correct, or change it accordingly
13. Select the **Infirmiry** where the patient will be placed from the drop down menu.
14. Select the **Room** where the patient will be placed from the drop down menu
15. Select the **Bed** where the patient will be placed from the drop down menu

16. Select **+ Add Provider** to add the admitting provider's information.
17. Type the providers name into the **Provider** box
  - The EMR will begin searching after you enter a minimum of three letters
18. Document in the **Comment** box if applicable
19. An **Admitting Provider** must be selected for all admissions. Check off the box labeled **Admitting Provider**
  - If you are documenting multiple providers make sure one of them is noted to be the **i. Admitting Provider**
20. Select the green **Save** button at the top right of the screen
21. Select the **X** button at the top right of the browser window to close the browser and return to the EMR



## Processing Labs Workflow

### Processing BioReference Labs

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **Lab Manager** from the **Left Navigation Pane**.
3. Select **New Requisition**.
4. Select each lab drawn.
5. Answer all questions applicable to the lab selection.
6. Select **Submit Requisition**.
7. Select the **Print Labels** button to print the labels.
8. Select the **Print Requisition** button to print the requisition.
9. Place labels on specimen tubes.
10. Place specimen tubes and requisition in bag for lab pick-up.

### Refused BioReference Labs

Use the following steps if a patient refuses lab appointment.

1. Complete the refusal in the EMR
2. Remove the order for each lab refused noting that labs were refused.
  - Select **Orders**
  - Highlight lab order refused.
  - Select **Remove** from tool bar.
  - Enter Refused in the comments box.
  - Select **Ok**.

### Rescheduling BioReference Labs

Use the following steps if the patient labs are now drawn and therefore requires rescheduling their lab appointment.

1. Shred pre-printed requisitions and labels.
2. Change order date to future rescheduled date and Change Status back to **ADMIN HOLD**.
  - Select **Orders**
  - Highlight lab order needing rescheduled.
  - Select **Change** from the tool bar.
  - From the Change window change Start Date to rescheduled date AND at the bottom right of window, change status back from *In Process* to **ADMIN hold**. (This step is vital in ensuring that the rescheduled lab can be processed correctly at next appointment)

### Processing In House Labs

Use the following steps to process lab services completed and resulted at the facility level (in house labs) such as Urinalysis Dipsticks, PT/INR, and/or Hemocult cards. These labs are not sent to BioReference.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document** from the **Left Navigation Pane**.
3. Select appropriate **Encounter type** related to type of documentation.



- **Point of Care-** to enter UA-dip, hemocult and PT/INR documentation.
  - **Nurse Visits-** Select DC4-711G form to enter PE lab UA- Dip results.
4. Once documentation is complete select **End**.
  5. Route to applicable staff member as needed.
  6. **Sign Document.**
  7. Select **Orders** from left navigation pane.
  8. Search and select lab order to highlight and hit **Complete**.
  9. **Verify** the correct order is selected in the Select Orders to Complete window and press **OK**.

### Processing Refused In House Labs

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document** from the left navigation pane.
3. Select **Refusal of Health Care Services** encounter type.
4. Complete form in its entirety.
5. Select **End**.
6. Enter **Routing** information as applicable.
7. **Sign Document.**
8. Go to fusion eSign to capture patient's signature.
9. From patients chart.
10. Select **Orders** from the left navigation pane.
11. Find and select orders refused select **Remove**.
12. Enter patient Refused in the reason box.
13. Repeat for each lab refused.

### Processing Rescheduled In House Labs

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document** from the left navigation pane.
3. Select **Nurse Visits** encounter type.
4. Select **Chronological Record of Health Care DC4-701** form.
5. Enter incidental note as to why the appointment is being rescheduled.
6. Select **End**.
7. **Sign Document.**
8. Select **Orders** from the left navigation pane.
9. Find and select order to reschedule and select **Change**.
10. Change start date to the new scheduled date.
11. Repeat for each lab needing rescheduled.

### Processing STAT Labs

1. Please prepare these labs using the same process prior to electronic medical records.
2. STAT lab orders will need to be completed in EMR once Drawn.
  - Select **Orders**
  - Highlight order drawn, Select **Complete**.
  - Verify date is correct and press **OK**.
3. When results are received they will be scanned into EMR under Lab Report document type using Indexing Client.



All labs should be ordered and processed using the EMR at all times, in the event the EMR is down or internet connectivity is unavailable please use the following steps below for processing patient labs.

#### When EMR Lab Manager is showing an error for BIOREFERENCE Labs.

1. Please contact the help desk with the error code.
2. Bioreference website can be utilized to create and print requisitions.
  - Ensure that your requisitions have the following criteria.
    - Patients First and Last Name are as displayed in the patients Profile in EMR.
    - DOB is entered and accurate.
    - Bioreference account number, the order number, and the patient's initials are located on the requisitions when printed.
    - All labs must be sent with printed requisition.
3. Once system is back up the orders will have to be manually changed to **In Process** for all labs submitted during lab manager downtime using the Bioreference website.
  - Select **Orders**
  - Highlight order drawn, Select **Complete**.
  - Verify date is correct and press **Ok**.
4. *DO NOT COMPLETE THE ORDERS*. Once resulted they will be sent directly to the EMR.

#### When internet connectivity is completely down or unavailable

1. HSA will notify their RD immediately when pre-printed requisitions will be utilized. The RD will notify state leadership.
2. Use pre-printed paper requisitions. Sites should have a **minimum of 20** of these on hand for this option when needed. Located on the portal under EMR tab.
3. HSA will personally verify and initial all pre-printed requisitions to ensure the below information is included before they are sent to BioReference
  - Patients First and Last Name and DC #
  - DOB is entered and accurate.
  - Ordering provider's name and NPI number
  - Correct labs are selected on the requisition
4. Once system is up and running again.
5. Orders will need to be completed in charts for all labs sent with paper requisitions.
  - Select **Orders**
  - Highlight order drawn, Select **Complete**.
  - Verify date is correct and press **OK**.



## Reception Workflow

### To Add Reception Orders:

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select on **New Document**.
3. Select the **Nurse Reception** encounter type.
4. Select **Add Intake Labs**.
  - Choose appropriate lab set for patient demographics.
  - The authorizing provider of each order must have an NPI#. Select site CHO for standing orders.
5. Select reception **Orders**.
  - Select **Nursing Reception** custom list and check the following orders:
    - Intake Assessment
    - TB Plant
    - Reception Health Education
    - Initial Physical Exam
    - Dental Initial Exam
    - Reception Orientation and Screening
    - Annual Pap Smear (for female camps)
    - Annual Breast Exam (for female camps)
  - Complete **Order Details**.
6. Select **OK**.
7. Select **End**.
8. **Sign** encounter.

### Nursing

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document**.
3. Select encounter type **Nurse Reception**.
4. Select buttons for documents:
  - TB Symptom Questionnaire (DC4-520C)
  - Health Appraisal (DC4-707)
  - STD Screening
  - Communicable Diseases Record (DC4-710)
  - Immunization Record (DC4-710A) to record any immunizations given
  - Inmate Health Education – Green Sheet (DC4-773)
  - Any applicable screening forms (Auditory, Mobility, Vision)
5. Complete all forms selected.
6. Select **End**.
7. Select **Sign Document**.
8. **Select New Document**.



9. Select encounter type **Point of Care**. Complete all applicable choices in this encounter.
10. Select **End**.
11. Select **Sign Document**.
12. Complete Authorization for Health Evaluation (DC4-711C) using **E-Sign** first option.
13. Add inmate signature to nursing forms using **E-Sign** second option.
14. Select **Orders** from **Left Navigation Pane**.
15. Highlight **intake assessment order** and select **Complete**.
16. Check off all completed reception orders in the **Select Orders to complete** box.
17. Select **OK**.

## Lab Tech

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **Lab Manager** from the **Left Navigation Pane**.
3. Select **New Requisition** button.
4. Select on each lab you will be drawing.
5. Answer all questions.
6. Select **Submit Requisition**.
7. Select **Print Labels** button.
8. Select **Print Requisition** button.
9. Place labels on tubes.
10. Place tubes and requisition in bag.
11. Select **New Document**.
12. Select **Point of Care** encounter type.
13. Complete the **UA Dip** documentation.
14. Select **End**.
15. **Sign Document**.

## Nurse (Prep for PI)

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document**.
3. Select **Vital Signs**.
4. Enter vital signs and any additional comments.
5. Select **End**.
6. Select **Sign Document**.

## Provider (Initial Physical Exam)

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select on **New Document**.





3. Select **Provider Visits** encounter type.
4. Select **PI** button.
5. Complete form, checking the box to **Change M Grade**.
6. Complete the form.
7. Add any applicable orders.
8. Select **End**.
9. Select **Sign Document**.
10. Select **New Document**
11. Select **Health Service Profile**.
12. Select **Medical Provider** radio button.
13. Complete form.
14. Select **End**.
15. Select **Sign Documents**.
16. Select **Orders** from **Left Navigation Pane**.
17. Highlight order for **Initial Physical Exam**.
18. Verify order for **Intake Physical Exam** is checked off.
19. Select **OK**.

### Provider (Gyno Exam Female Camps)

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list
2. Select on **New Document**.
3. Select **Provider Visits** encounter type.
4. Select on button labeled **Gynecological Exam (DC4-686)**.
5. Complete form.
6. Select purple button at the bottom labeled **Breast Diagram** to print handout.
7. Complete printed form and give to medical records to scan into chart.
8. Add lab order for today's PAP.
9. Select **End**.
10. Select **Sign Document**.
11. Select **Lab Manager** from the **Left Navigation Pane**.
12. Select **New Requisition**.
13. Select pap order.
14. Select **Submit Requisition**.
15. Select the **Print Labels** button to print the labels.
16. Select the **Print Requisition** button to print the requisition.
17. Place labels on specimen.
18. Place specimen and requisition in bag for lab pick-up.
19. Select **Orders** from **Left Navigation Pane**.
20. Complete **Annual PAP** and **Annual Breast Exam** orders.



## Mental Health Provider

1. Complete **MH Consent Form (DC4-663)** in **E-Sign. First Option.**
2. Complete Orientation to Mental Health Documentation.
3. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
4. Select on **New Document.**
5. Select **MH Case Manager** Encounter type.
6. Select **Orientation to Mental Health Reception (DC4-701).**
7. Check **MH Orientation** box and complete form.
8. Select **Case Manager** Menu to return to the landing page.
9. Select **Reception Intake Screening (DC4-644)** complete form in its entirety.
10. Add orders as applicable.
11. Select **End.**
12. Select **Sign Document.**
13. Select **Orders** from **Left Navigation Pane.**
14. Select on **Reception Orientation and Screening** order.
15. Select **Complete.**
16. Verify the correct order is checked off and select **OK.**

## Dental

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select on **New Document.**
3. Select **Dental Encounters** encounter Type.
4. Select on **Dental Intake Exam (DC4-735).**
5. Complete **DC4-735, DC4-724** and **DC4-700A** forms.
6. Add any applicable orders.
7. Select **End.**
8. Select **Sign Document.**
9. Select **Orders** from **Left Navigation Pane.**
10. Select on **Dental Intake Exam** order.
11. Select **Complete.**
12. Verify the correct order is checked off and select **OK.**



## Nurse Sick Call Workflow

### Triaging Sick Call Request and Scheduling Appointment

1. Find patient using the **Magnifying Glass** icon.
2. Click on **New Document**.
3. Select **Nurse Protocol Visit** Encounter Type.
4. Select Copay, **NO**.
5. Select **Triage**.
6. Complete form as clinically indicated.
  - An order window will populate that an order has been created.
  - Select Orders and complete the **Order Details** as indicated by triage level. Change start date to appropriate date of appointment inmate will be seen.
7. Select **End**.
8. Sign **Document**.

### Completing sick Call Visit Day of Appointment

1. Find patient using the **Magnifying Glass** icon.
2. Click on **New Document** to begin a new encounter.
3. Select **Nurse Protocol Visit** Encounter Type.
4. Select **Copay option**.
5. Select **Sick Call** second triage form will auto populate in left navigation pane.
6. Select applicable forms associated with sick call request.
  - If no appropriate protocol, select **Chronological Record of Health Care** to complete SOAPE note.
  - To add more than one protocol to encounter, select the **Nurse Protocol Select** on the left navigation pane to return to protocol options. Select additional protocol to complete with this encounter.
7. Complete forms in its entirety.
8. Enter orders as clinically indicated.
9. Select **End**.
10. **Route** to Clinician for signature if applicable or RN.
  - LPN to route documents to RN
11. Select **Sign Document**.
12. Complete **Sick Call Order**
  - Click on the **Orders** link in the left navigation pane.
  - Select the **Sick Call** order from the list of orders.
  - Click **Complete** in the **Orders** screen toolbar.
  - When the **Select Orders to complete** box opens, verify that there is a check mark next to the **Sick Call** order.
  - Click **OK** to complete the order and remove it from the patient's orders.
13. Document date and time on sick call request form and provide to designated staff member to scan into chart using indexing client.



## Emergency Transfer to Outside Hospital Workflow

Complete the steps below after speaking to provider and an order has been entered in the EMR to send patient to the ER.

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Select **Emergency Documentation** Encounter Type.
4. Complete forms in entirety.
5. Enter orders as applicable.
6. Select **End**.
7. **Route** to Clinician for signature if applicable.
8. Select **Sign Document**.
9. Print Copy for Ambulance Driver.
10. Select **Documents**.
11. Highlight Document.
12. Select Print Icon from top tool bar.
13. Ensure Selected Document is highlighted and select Print.
14. Print any other documentation needed to send with the patient.
15. Complete order for send to outside hospital.



## Elastography Ordering Workflow

### Identification and Scheduling of Elastography patients

1. RIDCM team identifies a patient who requires elastography.
2. RIDCM team schedules the patient for a Nursing Follow Up with NPO instructions to be placed on NPO after mid-night and orders the elastography appointment in the EMR.
3. RIDCM team is aware of the elastography technician's schedule. The elastography order is located under the Medical Services Custom list and is not associated with a MobileX order.
4. RIDCM distributes an email weekly to all reception centers indicating the elastography schedule for the week and how many scans will be performed at each facility.
5. Patients are placed on the call-out by the facility scheduler the day prior to the elastography appointment. (Nursing F/U) At this appointment, the patient will be educated by nursing staff of their pending elastography appointment and the need to remain NPO after midnight the night before the exam.
6. Facilities will complete the Nursing F/U order in the EMR when this is completed.

### Patients requiring transport to the Reception Center for Elastography exam

1. RIDCM distributes an email weekly to facilities indicating the elastography schedule for the week, who is going and what facility.
2. Sites will complete trip tickets for security transfers to Reception Centers for this test to be completed.

### Day of Elastography Scan Appointment

1. Inmates are brought to medical based on the call-out delivered to security the day prior.
2. Scan is completed and the results are sent to the RIDCM team.

### Completing the Elastography Order

1. The elastography results are received by the RIDCM team.
2. Appropriate re-staging of the patient is completed if clinically appropriate.
3. Elastography results are scanned into the patient's EMR and placed in the imaging folder.
4. RIDCM team routes the results to the facility provider for review and signature.
5. The RIDCM will complete the Elastography order.



## COVID Vaccine Documentation Workflow

### Completing COVID Consent

1. Complete DC4-710B for the Pfizer vaccine as it has FDA approval.
2. For vaccines that are operating under emergency use authorization, complete the COVID consent form CON-059 on paper.
  - Scan and import document using the Indexing Client Application.
  - See **Importing Signed Document into EMR Workflow** for importing instructions.

### Completing COVID Documentation

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **New Document**.
3. Select the **Nurse Infection Control** encounter type.
4. Select the **COVID Test and Vaccine** document.
5. Complete form in its entirety.
6. Return to the Nurse Infection Control landing page by selecting Nurse Infection Control in the left navigation pane.
7. Select the **Yellow Immunization Record**.
8. Select the "**G**" corresponding with Covid-19 to add immunization.
9. Complete all required documentation.
10. Once completed select **Done** and close Immunization Management window using the red **X** in the top right hand corner of the immunization Management window only.
11. Select **End**.
12. Select **Sign Document**.



## Complete Offline Medpass in Fusion eMAR Workflow

1. Open your Chrome browser and navigate to **http://vaabfusiopw1:15109/#/**
2. Verify the correct institution is selected at the top right corner
  - Change location if necessary.
3. Select **Medpass** on top tool bar.
4. Select desired Dorm Location(s) for Medpass.
  - To select multiple dorm locations hold CTRL and click on each one to highlight desired locations
  - CTRL A to select ALL, if applicable.
5. Select **Alphabetic Range** filter based on your assigned Medpass.
6. Select the **Date** of Medpass.
7. Select Types of Medpass (DOT, KOP or PRN).
  - Filter Medpass as appropriate
8. Select Medpass **Time** from dropdown menu to generate list.
9. Once Medpass list generates select **Download Medpass offline** (*this process has to be completed while online*).
10. Once offline open the downloaded Medpass.
  - Select **Administer** from Title-bar to open a drop down menu.
  - From the drop down menu select your appropriate Medpass.
11. Once the downloaded Medpass opens begin administering the offline Medpass.
12. Patient's names will populate from list on left side of screen in alphabetic order.
  - You can sort the list by Patient Name, Location, Administrations remaining or Administrations total.

\*If there are multiple patient's with the same last name, verify the DC#\*
13. Select patients name to open patients Medpass details.
  - From here you will click on the **A** to administer.
  - Select the drop down arrow next to the **A** to **Administer with Comment**.
  - Select the **N** to **Not Administer** for patient selected,
  - Select the **reason** the med was not administered and add comment if applicable.
14. Add treatment documents as needed for each patient.
  - If applicable, select **Treatment Documents** tab to add required information.
15. Select the next patients name on list and repeat steps above until all names from list have been completed.
16. Select **Finish Medpass** tab to confirm all administration in Medpass have been completed.

Once you connect online, all offline Medpasses completed will automatically upload into the eMAR system. Please make sure to leave your browser open until the computer is reconnected and has updated the eMAR online.



## How to complete an Online Medpass in Fusion eMAR

1. Select **Fusion eMAR** web application from top tool bar.
2. Verify correct institution is selected top right corner, change if necessary.
3. Select **Medpass** on top tool bar.
4. Select desired Location(s) - Dorms for Medpass.
  - To select multiple dorm locations hold CTRL and click on each one to highlight desired location, CTRL A to select ALL, if applicable.
5. Select **Alphabetic Range** filter based on your assigned Medpass.
6. Select **Date** of Medpass.
7. Select Types of Medpass - DOT, KOP or PRN.
  - Filter medpass if needed.
8. Select Medpass **Time** from dropdown menu to generate list.
9. Once Medpass generates select **Start Online Medpass**.
10. Patient's names will populate from list on left side of screen in alphabetic order.
  - You can sort the list by Patient Name, Location, Administrations remaining or Administrations total. (\*if there are multiple patient's with the same last name, verify the DC#).
11. Select patients name to open patients Medpass details.
  - From here you will click on the **A** to administer.
  - Select the drop down arrow next to the **A** to **Administer with Comment**.
  - Select the **N** to **Not Administer** for patient selected, select the reason the med was not administered and add comment if applicable.
12. Add treatment documents as needed for each patient.
  - If applicable, select **Treatment Documents** tab to add required information.
13. Select the next patients name on list and repeat steps above until all names from list have been completed.
14. Select **Finish Medpass** tab to confirm all administration in Medpass have been completed.

Note: If you exit Online Medpass once you start you will have to repopulate the medpass list again.





## UM Consult/ Prior Approval Request Workflow

### New Consult Order by Provider DC4-702

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Choose the corresponding Encounter Type **Provider Visits** and select **Ok**.
4. Select the DC4-702.
  - Complete the form(s) entirely.
5. Select the **New Consult Orders** button from the top of the form. This will cause the Update Orders window to appear.
6. From the **Utilization Management** custom list, select appropriate referral order.
  - Once the order is selected, it will move to the added orders area located at the top of the Update Orders window.
  - Complete **Order Details**.
7. Select **OK**. This will enter order into encounter/form.
  - Referral will be noted in the **Specialty Service** grey box.
8. Once complete select **END**.
9. **Route** document to the designated **consult coordinator** at the site.
10. Select **Sign Document**.
11. Go to **Fusion eSign** to collect patient signature on form.

### New Prior Authorization Request by Provider DC4-669

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Click on **New Document** to begin a new encounter.
3. Choose the corresponding Encounter Type **Provider Visits** and select **Ok**.
4. Select the DC4-669.
  - Complete the form(s) entirely.
5. Select the **Prior Approval Order** button from the top of the form. This will cause the Update Orders window to appear.
6. From the **Utilization Management** custom list, select appropriate prior authorization order.
  - Once the order is selected, it will move to the added orders area located at the top of the Update Orders window.
  - Complete **Order Details** to include what is being requested in the instructions box.
7. Select **OK**. This will enter order into encounter/form.
  - Referral will be noted in the **Service Requested** grey box.
8. Once form is complete select **END**.
9. **Route** document to the designated **consult coordinator** at the site.
10. Select **Sign Document**.



## Consult Coordinator

To pull New Orders:

1. Sign into Centricity.
2. From your **Chart Desktop** open **Order Manager**.
3. Search by using the custom list **Utilization Management** as **Order Type**.
4. Select your **Site Location**.
5. Select **Admin Hold** Status ONLY for new orders, then select search to run the list.
6. To **Print** or **Export** the list to excel.
  - Select the drop down arrow next to red reset icon.
  - The print option will print to the designated printer.
  - The Export to CVS option will download to an excel file.

## Process when DC4-702 Consult/DC4-669 Prior Authorization is routed by Provider

1. From **Chart Desktop**, select **Documents**.
2. Select the **consult document** routed from the provider.
3. Select **Append**.
4. Select **Click here to do a Full Update**.
5. Select **UM Progress Note** encounter type.
6. Select **OK**.
7. Complete the form in its entirety.
  - UM Role.
  - Select UM referral order from drop down menu.
  - Answer questions, and complete note.
8. Select **End**.
9. Select **Hold**.
10. Go to the Centurion App page.
11. **When all packet documentation is electronic** Log into **DOCUBATCH**. To create packet for UM. Otherwise skip to step 14.
  - Select the **Patient**.
  - Select the **Three Dot Icon** under Patient Search, the search patient box will populate.
  - Enter information related to patient and select **Search**.
  - From the list highlight patient and click **Select**.
  - Select all applicable **Document Types (these are related to the encounter types from EMR)** needed for packet requirement.
  - Select **Pull Documents**.
  - Select all appropriate documents to include in package by checking the boxes next to each one.
    - To preview the document highlight document and select **Preview Document**.
  - Enter Consult Labeling Guideline into **Combined Filename** text box.
  - Select or enter the designated file path associated with your Scanner.
  - Select **Save Documents**.
12. **EXIT** out of DOCUBATCH.



13. Until all documentation is electronic you will **print and scan** it all together as one packet.
14. **Print** all electronic documentation and combine it with corresponding paper documentation from charts.
15. **Scan** both the printed electronic documentation and the paper chart documentation into indexing client using the designated scanners as **one packet**.
16. Log into **Fusion Indexing Client to attach packet to UM Progress Note**.
  - See **Indexing Client workflow for how to import into unsigned document** for this process.
  - Ensure you are using the *Labeling Guidelines* below to label the packet.
    - Office Visits: Last-First-DC-SpecialtyService-TypeofVisit-Acuity-DateRouted
      - Example: Brown-John-123456-Gastro-Initial-Routine-9102021
    - Prior Approvals: Last-First-DC-ServiceRequested-Acuity-DateRouted
      - Example: Brown-John-123456-CT-Routine-9102021
    - Referrals routed after 4PM EST should be labeled using next business day's date
17. Select **END**.
18. From the End Update window change the **Summary to the correct Labeling Guideline** listed below for the type of consult you are submitting.
  - Office Visits: Last-First-DC-SpecialtyService-TypeofVisit-Acuity-DateRouted
    - Example: Brown-John-123456-Gastro-Initial-Routine-9102021
  - Prior Approvals: Last-First-DC-ServiceRequested-Acuity-DateRouted
    - Example: Brown-John-123456-CT-Routine-9102021
  - Referrals routed after 4PM EST should be labeled using next business day's date
19. **Route** document to the designated **UM Chart Desktop**.
  - **For all Interstate Compact Inmates Route Packets to Meagan Williams and Donna Grahams desktop.**
20. **Sign** document.
21. Change Order Status from **Admin Hold** to **In Process**.
  - Select **Orders** from the left navigation pane.
  - Select appropriate **Referral Order** or **Prior Authorization** order to highlight.
  - Select **Change** from tool bar.
  - From **Change Status** drop down select **In Process**.

### Process when DC4-702 Consult/DC4-669 Prior Authorization is not routed by Provider

1. From **Patients Chart**, select **Documents**.
2. Select the **Consult Document** for submission to UM.
3. Select **Append**.
4. Select **Click here to do a Full Update**.
5. Select **UM Progress Note** encounter type.
6. Select **OK**.
7. Complete the form in its entirety.
  - UM Role.
  - Select UM referral order from drop down menu.
  - Answer questions, and complete note.



8. Select **End**.
9. Select **Hold**.
10. Go to the Centurion App page.
11. **When all packet documentation is electronic** Log into **DOCUBATCH**. To create packet for UM. Otherwise skip to step 14.
  - Select the **Patient**.
  - Select the **Three Dot Icon under** Patient Search, the search patient box will populate.
  - Enter information related to patient and select **Search**.
  - From the list highlight patient and click **Select**.
  - Select all applicable **Document Types (these are related to the encounter types from EMR)** needed for packet requirement.
  - Select **Pull Documents**.
  - Select all appropriate documents to include in package by checking the boxes next to each one.
    - To preview the document highlight document and select **Preview Document**.
  - Enter Consult Labeling Guideline into **Combined Filename** text box.
  - Select or enter the designated file path associated with your Scanner.
  - Select **Save Documents**.
12. **EXIT** out of DOCUBATCH.
13. Until all documentation is electronic you will **print and scan** it all together as one packet.
14. **Print** all electronic documentation and combine it with corresponding paper documentation from charts.
15. **Scan** both the printed electronic documentation and the paper chart documentation into indexing client using the designated scanners as **one packet**.
16. Log into **Fusion Indexing Client to attach packet to UM Progress Note**.
  - See **Indexing Client workflow for how to import into unsigned document** for this process.
  - Ensure you are using the Labeling Guidelines below to label the packet.
    - Office Visits: Last-First-DC-SpecialtyService-TypeofVisit-Acuity-DateRouted
      - Example: Brown-John-123456-Gastro-Initial-Routine-9102021
    - Prior Approvals: Last-First-DC-ServiceRequested-Acuity-DateRouted
      - Example: Brown-John-123456-CT-Routine-9102021
    - Referrals routed after 4PM EST should be labeled using next business day's date
17. Select **END**.
18. From the End Update window change the **Summary to the correct Labeling Guideline** listed below for the type of consult you are submitting.
  - Office Visits: Last-First-DC-SpecialtyService-TypeofVisit-Acuity-DateRouted
    - Example: Brown-John-123456-Gastro-Initial-Routine-9102021
  - Prior Approvals: Last-First-DC-ServiceRequested-Acuity-DateRouted
    - Example: Brown-John-123456-CT-Routine-9102021
  - Referrals routed after 4PM EST should be labeled using next business day's date
19. **Route** document to the designated **UM Chart Desktop**.



- **For all Interstate Compact Inmates Route Packets to Meagan Williams and Donna Grahams desktop.**
20. **Sign** document.
  21. Change Order Status from **Admin Hold** to **In Process**.
    - Select **Orders** from the left navigation pane.
    - Select appropriate **Referral Order** or **Prior Authorization** order to highlight.
    - Select **Change** from tool bar.
    - From **Change Status** drop down select **In Process**.

### Once approval is received Route document to RMC Schedulers

1. Once document is approved and ready to be scheduled you will then route the document with the approval authorization to the designated RMC Scheduling box.
2. From **Chart Desktop** select **Documents**.
3. Select the document to highlight it and Press **Route**.
4. In the To box select the Binoculars to open the search option.
5. Type RMC into the Search bar and press enter.
6. Select **RMC Schedule Medical box**.
7. Press OK.
8. Enter in the Comments box please schedule and hit route.
9. RMC staff will then update the order to reflect the scheduled date of the appointment.

### Once Consult Appointment from RMC is completed and Routed back to you, complete the following.

1. Sign into Centricity.
2. From **Chart Desktop** select **Documents**.
3. Select the **UM Progress note** routed to you from RMC staff with completed consult attached.
4. Double click on document to open patients chart.
5. **Route** to MD for Review and signature from inside patient's chart.
  - **Select Route from toolbar.**
  - **Select New**
  - **Enter Providers Name**
  - **Enter comments**
  - **Select ok**
  - **Then Route.**
6. Then Select **Append** to add note to document.
7. Select **Click here to do a Full Update**.
8. Select **Admin Forms** encounter type and press ok.
9. Select **Chronological Record of Care DC4-701** document.
10. Complete the form in its entirety.
11. **Add** applicable Follow up order with provider.
  - Complete Order Details.
12. Select **End**.
13. **Sign** Document.



## As Utilization Management Staff Member

### Assigning Consult

1. Sign into Centricity.
2. From **Chart Desktop** select **Documents**.
  - a. Change Document View to the designated **UM Desktop**.
3. Select **Document** to highlight.
4. Select **Route** document to the designated staff member to work on.
5. **Remove** Document from UM Chart Desktop.

### Reviewing and Documenting Consult Request UM/DOC UM

1. Sign into Centricity.
2. From **Chart Desktop** select **Documents**.
3. Select the **Consult Document** to review.
4. Enter information in other system and follow that protocol.
5. To document decision highlight document and select **Append**.
6. Select **Click here to do a Full Update**.
7. Select **UM Progress Note** encounter type.
8. Select **OK**.
9. Complete the form in its entirety.
  - UM Role.
  - Select Appropriate **UM Referral Order** or **Prior Authorization** order from drop down menu.
  - Answer questions, and complete note.
10. Select **END**.
11. **Route** document to the next designated staff member.
  - Approvals go to RMC Scheduler **Honor Hines** and Site Consult Coordinator.
  - ATPs and resubmissions should be routed back to Site Consult Coordinator.
12. **Sign** document.

## As the Scheduler at RMC

To document when the appointment is being scheduled.

1. Sign into Centricity.
2. From **Chart Desktop** select **Documents**.
3. Select the **Consult Document**.
4. Select **Append**.
5. Select **Click here to do a Full Update**.
6. Select **UM Progress Note** encounter type.
7. Select **OK**.
8. Complete the form in its entirety.
  - UM Role.



- Select Appropriate **UM Referral Order** or **Prior Authorization** order from drop down menu.
  - Answer questions, and complete note.
9. Select **END**.
  10. **Sign** document.
  11. Change the appropriate referral **Order**.
    - Select **Orders** from left navigation pane.
    - Select appropriate **Referral Order** or **Prior Authorization** order to highlight.
    - Select **Change** from tool bar.
    - Change date of order to date of scheduled appointment.
    - **For Day trip Appointments**
      - Enter Day trip and to where in the Authorization number field. (Ex: Day trip to RMC, Day trip to Lowell)
    - Appointments that require a Transfer to RMC
      - Enter Appointment at RMC in the Authorization number field.
    - In the Administrative comments field Enter who patient is seeing for appointment.
  13. RMC Scheduling team please route document to Site Coordinators so they can prepare accordingly.

### To document and attach documentation after appointment is completed at RMC

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **Documents** from left navigation pane.
3. Search and Select **Original Provider Visit DC4-702 Consult document** corresponding with this visit.
4. Select **Append**.
5. Select **Click here to do a Full Update**.
6. Select **UM Progress** encounter type.
7. Select **OK**.
8. Complete the form in its entirety.
9. Select **End**.
10. Select **Hold**.
11. Scan consultation report and attach to document.
  - See **Indexing Client workflow importing into unsigned document** for this process.
12. Select **END**.
13. **Route** document back to Site Consult Coordinator.
14. **Sign** document.
15. **Complete** corresponding Referral order.
  - Select **Orders** from left navigation pane.
  - Select appropriate **Referral Order** or **Prior Authorization** order to highlight.
  - Select **Complete** from tool bar.



To document and attach documentation after appointment is completed from other outside source other than RMC. (If patient is returned directly to the site after appointment)

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **Documents** from left navigation pane.
3. Search and Select **Original Provider Visit DC4-702 Consult document** corresponding with visit.
4. Select **Append**.
5. Select **Click here to do a Full Update**.
6. Select **UM Progress Note** encounter type.
7. Select **OK**.
8. Complete the form in its entirety.
9. **Add** applicable Follow up order with provider.
  - a. Complete Order Details.
10. Select **End**.
11. Select **Hold**.
12. Scan consultation report and attach to document.
  - a. See **Indexing Client workflow importing into unsigned document** for this process.
13. Select **END**.
14. **Route** document to Site Provider for signature.
15. Select the applicable **Reason**: Signature, Action Required or Review.
16. Select **Priority**: Normal, Important or Urgent.
17. Enter comments in the **Comment** box.
18. Select **OK**, to save selections.
19. **Sign** document.
20. **Complete** corresponding Referral order.
  - a. Select **Orders** from left navigation pane.
  - b. Select appropriate **Referral Order** or **Prior Authorization** order to highlight.
  - c. Select **Complete** from tool bar.

### To Print Packets to send with patients for appointments

\*Print the entire packet as need for the scheduled appointment with the specialist.\*

1. Find your patient using the **Magnifying Glass** icon or the **Find Patient** drop down list.
2. Select **Documents** from left navigation pane.
3. Using the Document View Folder Select Medical folder.
4. Using the little plus next to it will open the different encounter types, select FL Provider Visits.
5. Search and Select Original **Provider Visit DC4-702 Consult document**.
6. Open the appended documents select the **UM Progress note with Packet attached**.
7. Select **Attach**, to open attached packet.
8. Select **Print**.
9. Place the printed packet in the envelope and send with patient on day of appointment.



**SECTION 3..... DENTAL SERVICES**

DENTAL: HEALTH QUESTIONNAIRE FOR DENTAL ASSISTANTS/HYGIENIST.....3  
DENTAL: HEALTH QUESTIONNAIRE FOR DENTIST.....4  
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DENTAL: COMPLETE REFUSALS.....6  
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## How To – Dental Health Questionnaire Prepared by Dental Assistant/Hygienist

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
    - Search by DC#
    - Type in DC# in Search For box
    - Select Search
    - Select patient name in the Search Results box
    - Select OK
  2. Select New Document.
  3. Select Dental Encounters.
  4. Select OK.
  5. Select the DC4 – 734 Dental Health Questionnaire (English or Spanish).
  6. Complete the Health Questionnaire in its entirety, making sure to scroll all the way to the bottom of the document.
    - Select the end button at the top right hand corner of the document.
    - Select “New” button to add provider or another user to route to.
    - Select the provider you wish to route to.
    - Select the reason for your route (Signature, Action Required, or Review) & add a comment (ie: Sign Dental Hlth Quest).
    - Select OK.
    - Select Hold Document.
- Assistant job is complete / switch user to dentist.

### **Dentist portion of Health Questionnaire.**

1. Dentist will login to EMR.
  - The patient document will be on hold on the Dentists Chart Desktop.
  - Double left click on the Pencil to review documentation.
  - Select End.
  - Select Sign Document.
  - A pop up window will appear asking if you want to be the Provider for this document
  - Select Yes.
2. Continue to eSign to have patient sign the Health Questionnaire (Dentist Login).
  - *See Tab 7 or Pages 12 – 13, How To eSign EHR Encounters.*  
**NOTE:** Patient signature will be actual signature, Dentist signature on this document will be electronic only.

## How To – Dental Health Questionnaire

### Prepared by Dentist

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
  - Search by DC#
  - Type DC# in Search For box
  - Select Search
  - Select patient name in the Search Results box
  - Select OK
2. Select New Document.
3. Select Dental Encounters.
4. Select OK.
5. Select the Dental Health Questionnaire.
6. Complete the Health Questionnaire in its entirety, making sure to scroll all the way to the bottom of the document.
7. Select End.
8. Select Sign Document.
9. Continue to eSign to have patient sign the Health Questionnaire (Dentist Login).
  - *See Tab 7 or Pages 12 – 13, How To eSign EHR Encounters.*

**NOTE:** Patient signature will be actual signature, Dentist signature on this document will be electronic only.

## How To - Sign, Route, Discard or Hold a Document

### How-To Route

Once user has completed all encounters/forms and selects End from within the encounter, the End Update box will appear.

1. Select “New” button to add provider or another user to route to.
2. Use the drop-down arrow or the binoculars icon to select who the document is being routed to.
3. Select the applicable Reason: Signature.
4. Select Priority: Normal, Important or Urgent.
5. Enter comments in the Comment box.
6. Select OK, to save selections.
7. Select Hold Document, see How –To Place a Document on Hold, below.

### How-To Sign

1. From within the End update box, select Sign Document – Dentist Only.
  - Assistants will HOLD the document (NEVER Sign Document) and route to Dentist.

### How-To Discard a Document

1. From within the End update box, select Discard Document.
  - To be used if information is erroneous.
2. Select OK.

### How-To Place Document on Hold

1. If unable to complete the encounter at the time it was initiated, select Hold Document.
  - Documents on hold can be located under Documents for Edit in the patient’s chart.
2. To resume a document that is on hold:
  - Select the edit button located next to the desired document in the Documents for Edit section of the patient’s chart.

OR

- In the Documents section of the initiating provider’s chart desktop.
- Select the desired document and double-click OR select the Open icon.

## How To – Complete Refusal

### Completing Refusal with Patient Signature (Dentist Log On)

**NOTE: Only the patient’s actual signature is required, there will be no need for a witness unless the patient refuses to sign the refusal. The Dentists signature will be electronically signed.**

1. Find the patient using the Magnifying Glass icon or the Find Patient drop down list.
2. Select New Document.
3. Select Dental Encounters.
4. Select OK.
5. From the dental encounters list, select the following encounter forms:
  - DC4-724 Dental Treatment Record.
  - DC4-700A Dental Contact Coding
  - DC4-711A Refusal Form, (green refusal option).
  - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
6. All Forms will need to be completed in their entirety.
  - **On the DC4-711A Refusal Form**, select the box for Dental Services.
  - In box to the right, list what dental services are being refused. Be specific, if the patient states why they refused, list it also.  
**Example:** DSOT Extraction #9, “I don’t want to lose my front tooth.”
7. If the patient needs to be placed on another wait list:
  - Select the Order tab and *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*
8. Select End in the upper right hand corner.
9. Select Sign Document – Dentist Only.
10. To obtain the patient’s signature on the Refusal Form, *See Tab 7 or Pages 12 – 13, How To Fusion eSign EHR Encounter as needed.*

## Completing Refusal when Patients Refuses to Sign (Dentist Log On)

1. Find the patient using the Magnifying Glass icon or the Find Patient drop down list.
2. Select New Document.
3. Select Dental Encounters.
4. Select OK.
5. From the dental encounters list, select the following encounter forms:
  - DC4-724 Dental Treatment Record.
  - DC4-700A Dental Contact Coding
  - DC4-711A Refusal Form, (green refusal option).
  - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
6. All Forms will need to be completed in their entirety.
  - On the DC4-711A Refusal Form, select the box for Dental Services.
  - In box to the right, list what dental services are being refused. Be specific, if the patient states why they refused, list it also.
7. If the patient needs to be placed on another wait list:
  - Select the Order tab and *See Tab 5 or Pages 8 - 9, How To Create, Complete, & Verify Orders.*
8. Select End.
9. Select Sign Document – Dentist Only.
10. Obtaining Signatures in Fusion eSign EHR.
  - The Dental Assistant/Dental Hygienist will need to sign as a witness in Fusion eSign under an added signature/endorsement.
  - If the witness is a non-clinical staff member (e.g. Security), the witness signature will be completed in Fusion eSign.
11. To obtain the Dental Assistant or Dental Hygienist witness signature and/or if non clinical staff member is a witness (Security) *See Tab 7 or Pages 12 – 13, How To obtain signatures in Fusion eSign EHR.*

## How To – Create, Complete & Verify Orders

### How to – Create an Order

1. From within the patients New Document, select the Orders icon located in the top tool bar. This will cause the Update Orders window to appear.
  - **Note:** Some encounters will have a separate orders button within the form.
2. From the Use Custom List drop-down select Dental Visit.
3. Select the applicable Order/Wait List.
  - Once the order is selected, it will move to the added orders area located at the top of the Update Orders window.
4. Select Order Details.
5. Complete the *Clinical Information* section and the *Test Administration* sections.
  - In the **Instructions box** fill in any wait list Remarks. Select the **Disposition** drop down and select **Admin Hold**.
  - The **start date** will be the date the patient is placed on their applicable wait list, this date can be changed if backdating is warranted. With exception to DSAX's, never forward date. **NEVER** fill in an End Date.
6. Select Ok.
7. Select END if you are done with all other documentation.
8. Select Sign Document – Dentist Only.

### Complete orders from a Chart

1. From the Patient's Chart desktop, select Orders from the left navigation pane.
2. Once within the order view, highlight the corresponding order and select Complete (green check).
3. Once the Complete button is selected, Select Orders to Complete screen will appear.
  - Verify that you have chosen the correct list by viewing the date the patient was placed on the list and by viewing the order/wait list name to ensure you have selected the correct order.
4. Select Ok to complete the selected order(s).

### Verify Order Completion

1. To verify that the order was completed, select the Organize button at the top of the Orders screen.
2. Once the Organize Orders box appears, select only Complete in the Status box to the top right.
3. Select Ok.
4. The list of completed orders will load for you to verify.



**NOTE: You are only required to obtain the patients actual signature, no witness signature is required for all consents. Dentist signature is electronic, except on the Receipt of Provisions form.**

1. Select Fusion eSign application icon from the user's Toolbar.
  - This will open a new window for Fusion eSign.From the eSign menu, select Create eSign Document.
  - The following forms can be found in this selection:
    - DC4-545 Consent for Ortho Band Removal
    - DC4-724A Receipt of Provisions
    - DC4-759 Consent for & Prior to Endodontic Treatment (english/spanish)
    - DC4-762 Authorization & Consent for Dental Surgery (english/spanish)
    - DC4-763 Consent for Tooth Removal (english/spanish)
2. Enter the patient's DC# in the Search Patient box.
3. Select appropriate patient (in blue box pop up).
4. Verify patient's information is correct in the Preview Document section to the right.
  - Select the Template dropdown arrow to choose applicable DC Form.
    - The form will appear in the Preview Document window.
5. Select your site location by using the Select Header drop down arrow.
  - This information will auto populate with your home location.
  - Keep in mind, if you are covering at another clinic, this information will need to be changed to reflect the location of coverage where the patient is located and being treated.
6. Select Continue.
7. Answer questions, regarding the treatment being rendered.
  - Condition (ie: NRCT #3)
  - I Hereby Authorize (name of Dentist)
  - My Condition, Which Includes (ie: Extraction #3)
8. Select Continue.
9. You will be prompted to hand the device to the patient and Select Continue.
  - A preview of the document will appear, allow the patient to review document and then select *I verify that I have read and agree to terms printed above* at bottom of document.
10. In the Patient's Endorsement box, under Required Endorsements, select the drop down arrow and then select *1 Patient (signature) – Required*.
11. The patient will now sign using the Topaz Signature Pad.
12. If signature is acceptable, select Submit Signature to Preview.
13. A preview of the signed document will appear.
  - Review form, making sure to scroll all the way to the bottom.
14. If form and signature are acceptable, select Finalize Endorsement and Continue, the patient will be prompted to hand the device back to the staff member.
15. Select Continue.

16. The Required Endorsements box will list the remaining required Endorsements.
  - Staff will need to ensure to select each required endorsement and obtain signatures for each, after each signature select Submit Signature to Preview. Add Additional Endorsements is optional for any additional staff per policy. (Any name(s) entered here should be as per FLDOC policy. Full name and Credentials).
  - If no further Endorsements are required (0/0) then you will proceed to #20, below.
17. Once all signatures have been obtained, a preview of the signed document will appear. You will again have one last chance to Add Additional Endorsements if needed.
18. Select Finalize Endorsement and Continue to Final Review.
19. After finalizing the endorsement, you will be able to review the entire document.
20. Select Submit and Add to Patient's Chart.
21. The completed document will appear.
22. Exit out of Fusion eSign to return to the patients chart.
23. To view the signed document:
  - Select Documents on the left tool bar of patients chart.
  - Under Document View window select the file folder for Consents/eSign/ROI.
  - Select the Consent you wish to review.
  - Select Attach, found on the left middle of screen.
  - Once reviewed, close view window.

## How To - Complete an eSign EHR Encounter

**NOTE: You are only required to obtain the patients actual signature, no witness signature is required unless the patient refuses to sign a refusal form. Dentist signature is electronic.**

1. To add patient's signature to document, select the Fusion eSign web application located in the custom commands section of the tool bar.
2. Select eSign EHR Encounter option.
  - Documents found under this option are any encounters selected off of the purple encounter list after selecting New Document. These forms will require a signature to an already created encounter document.  
(ie: Health Questionnaires, Refusals....)
3. Enter the patient's DC# in the Search Patient section then select appropriate patient (blue box pop up).
4. From the Document Type Filter drop down menu, select FL Dental Encounters.
5. From the EHR Encounter drop down menu, select the encounter needed for patient signature.
  - **Note:** Encounters will be organized by most recent to oldest.
6. From the Select Header menu, make sure to choose the location in which the patient is located & treated (this will auto default to your home location). **Make sure to change if you are covering at a clinic other than your normal home location.**
7. Scroll all the way to end of the page to review for accuracy on the completed document.
8. If accurate, select Continue.
9. User will then be prompted to hand the device to the patient. At this time you will turn the screen towards the patient and select Continue to allow the patient to review the completed document.
  - Once the document has been reviewed by patient, select *I verify that I have read and agree to the terms printed above* to proceed.
  - Ensure the topaz signature pad is in reach of the patient and advise the patient to follow the prompts on the screen.
  - Under Required Endorsements (0/1) select the drop down option, *1 Patient (signature) – Required*
10. Advise the patient to sign the document.
11. Select Submit Signature to Preview.
12. Review the document with the patient's accompanying signature then select Finalize Endorsement and Continue.
  - When prompted, staff member will turn the screen back to its original position and select Continue.

13. If no further signatures are required, select Finalize Endorsement and Continue to Final Review.
  - **NOTE:** You can add additional endorsements if needed by typing in the staff member name and title and then selecting Add Signature.
14. Scroll all the way to bottom of the document and select Submit and Add to Patient's Chart.
  - **Note:** A new window will populate with the completed document for further review.
15. Exit the Fusion eSign web application to return to the patients chart.

## How To – Fusion Order Manager for Reception Centers

1. Select Fusion Order Manager which can be accessed from the tool bar located on the left side of the screen.
2. This will open the Fusion Order Manager within the EMR window.
3. Once Order Manager is opened, select Global Task Lists from blue task bar located at top of screen.
4. Select your facility name, your list should then appear.
  16. **NOTE:** If further filtering is required, you will need to do so using the left side tool bar/search parameters. Do not filter from within the list.
    - Once filtering is complete, select search from the bottom of tool bar.
5. Select Search to generate your wait list.
6. Once your list is obtained, it can be exported to an Excel spreadsheet. This allows the user to manipulate the list for their specific use/call outs.
7. To do this, select the down arrow icon at the bottom left of the Fusion Order Manager search parameter tool bar.
8. Select Export to CSV.
9. A Save File window opens. Select your H: drive to save your Excel Wait List spreadsheet.
  - Enter the file name you would like to save it as, or keep the default name.
10. Select Save.
11. You will now need to open the Excel document from the H: drive file in which you saved it.
12. From here, you can manipulate the spreadsheet to include or exclude any information desired, you can also use filters. It can now be saved, printed, or scanned & emailed to provide to designated staff and/or departments.
  - **NOTE:** When submitting call outs, the only information that should be printed on the copy for Security is *Name, DC#, Bunk, Date & Time of Call Out, and Location of Call Out (Dental Clinic)*. You will need to remove ALL HIPPA information prior to call out submission.



## How To – Fusion Order Manager for Regular Clinics

1. Select Fusion Order Manager which can be accessed from the tool bar located on the left side of the screen.
2. This will open the Fusion Order Manager within the EMR window.
3. Once Order Manager is opened, the user can select multiple options to search the specific list of orders (wait lists) to create the desired scheduled call-out.
4. Choose the date range.
  - *Date From* should always be left blank.
  - *Date To* should always be the current date.
5. Under Order Types drop down menu, select All Order Types.
  - Select the Order Type gear icon to the right of the drop down arrow to select which wait list or lists you would like to view.
  - From the Custom List drop down, select Dental Visit.
    - Choose appropriate order types/wait lists, then select Search.
    - Keep in mind that when choosing your order types/wait lists, you will need to include ALL wait list even those that aren't normally used by your clinic. Although the Periodontal or Orthodontics wait list aren't used, you will still be required to select them as staff may have accidentally chosen this list when creating the order.
6. Choose Facility Location.
7. Leave Provider as "ALL".
8. In the OBS (Observation Terms) box type in Housing Loc and select the blue highlighted HOUSING LOC. This will add in the patients' dorm/bunk location.
9. The remainder of the search parameters will stay as is, no need to change.
10. Select Search to generate your orders list.
  - **NOTE:** You can select Create New Task List in the upper tool bar.
  - In the pop up box type in the Task List Name you wish to save and then select Save (**NEVER** select the button, Is This Task List Global, it should always remain off).
  - Saving your Task List will allow you to quickly view saved lists/search parameters, you will not have to apply the search parameters each time.
11. Once your list is completed, it can be exported to an Excel spreadsheet. This allows the user to manipulate the list for their specific use/call outs.
12. To do this, select the down arrow icon at the bottom left of the Fusion Order Manager search parameter tool bar.
13. Select Export to CSV.
14. A Save File window opens. Select your H: drive to save your Excel Wait List spreadsheet.
15. Enter the file name you would like to save it as, or keep the default name.
16. Select Save.
17. You will now need to open the Excel document from the H: drive file in which you saved it.

18. From here, you can manipulate the spreadsheet to include or exclude any information desired, you can also use filters. It can now be saved, printed, or scanned & emailed to provide to designated staff and/or departments.

- **NOTE:** When submitting call outs, the only information that should be printed on the copy for Security is *Name, DC#, Bunk, Date & Time of Call Out, and Location of Call Out (Dental Clinic)*. You will need to remove ALL HIPPA information prior to call out submission.

## How To – Create a Dental Call Out

1. Follow to **How To – Managing Orders** to run and save your Wait Lists onto your H: Drive
2. You will need to open the Excel file just saved into your H: Drive.
3. When the file opens, you will see that some of the information has been cut off or is in hashtag form.
4. You will need to widen the columns to be able to see the information needed.
  - Left click the triangle area in the upper left corner of the spreadsheet to select the entire sheet.
  - With entire spreadsheet selected, you will now need to widen the columns to view all data.
  - Place your cursor on the line between the A & B, at the top of the spreadsheet, your cursor will turn into a cross when you've placed it in the correct spot.
  - Double left click and the columns will open wide enough to view all data.
- Left click on align left button  found in your tool bar in the Paragraph section.
6. You will find that some columns have information that is not needed, such as Priority, Medical Record Number, and Admin Comments. You will need to remove these columns before going further.
  - Select each column you wish to remove by first left clicking on the letter above the column and second by right clicking and selecting delete.
7. You will now need to apply a Filter across row 1.
  - Select row 1 by left clicking on the number 1 to the left of the spreadsheet.
  - With row 1 selected you will need to left click on the Sort & Filter option in the upper right of the spreadsheets Home tool bar.
  - When the drop down appears, select Filter.
8. You will now need to arrange your wait lists by date placed on wait list, from oldest to newest.
  - Select the date column by left clicking on the letter above the word Date.
  - Select the drop down arrow.
  - Select Sort Oldest to Newest.
9. Now you will need to sort out each of your wait lists to be able to view one at a time.
  - In the Order Description Column, select the drop down arrow.
  - Click on the Select All box, this will deselect all lists.
  - You will now be able to select each individual list. To view the next list, you will need to deselect the previous list and then select your next list to view.
10. Now to begin putting your Call Out together.
  - At the bottom of the spreadsheet you will see a plus sign . Select this button to add a blank spreadsheet.



- As you are filtering through your wait lists, you can copy and paste each patient that you wish to place on your call out for the next day.
  - You can toggle back and forth between each of your spreadsheets until you have built your call out.
  - You will need to remove the Date column as it is no longer needed on the call out spreadsheet.
  - Keep in mind, you will need to place headings for Date of call out, Time of call out, DC#, Name, Type of Treatment Needed, Housing Location, and Comments/Remarks.
  - Once you have completed your call out, you will need to print the amount of copies needed for your clinic.
  - Now you will need to remove ALL HIPPA information prior to printing a copy to be provided to Security.
  - If you are required to email your call outs to Security, print a copy and then you will need to scan the copy to your Scan folder and then attach in an email. DO NOT save the call out and then attach it in an email to Security as this could be a potential HIPPA violation as it will also include your wait list spreadsheet.
11. After printing out your clinic call out, you will need to go into each patient's orders/wait list and change their order from Admin Hold to **In Process**.
- Find patient.
  - Select Order from far left tool bar within patient's chart.
  - Select the order/wait list that prompted the call out.
  - Select Change (green pencil) in Orders tool bar above the list of orders.
  - Change the Status from Admin Hold to In Process. This lets our staff know which patients have been scheduled and which are still waiting to be seen.
  - Keep in mind that if you have changed an order to In Process and the patient doesn't report for the call out or is rescheduled, you will need to change the order/wait list back to Admin Hold unless you already have the patient rescheduled on your next call out.

## How To – Answering & Receiving Request/Grievance

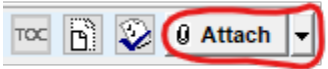
### Receiving a Request/Grievance

1. Date stamp the request/grievance in the Date Received area on the paper DC6-236 Inmate Request Form.
2. Within Production Fusion, Find Patient using the Magnifying Glass icon or the Find Patient drop down list.
3. Select New Document.
4. Select Dental Encounters.
5. Select Ok.
6. From the purple encounters list, select Inmate Request Received.
7. Select the bubble for Other.
8. From the Request Type drop down, select Dental.
  - If grievance received, select the box “Check if Informal Grievance” written in blue.
9. Type in a brief description of what the patient is requesting/grieving in the Request Received big white box.
10. Select End from upper right corner of document.
11. Select Sign Document – Any Dental staff member can sign this type of document.

### Answering/Returning a Request/Grievance

1. Answer the paper request within the Response area.
2. Stamp or print your name in the Official (Print Name) area.
3. Sign your name in the Official (Signature) area.
4. Print the Date in the Date area.
5. Within Production Fusion, Find Patient using the Magnifying Glass icon or the Find Patient drop down list.
6. Select New Document.
7. Select Dental Encounters.
8. Select Ok.
9. From the purple encounters list, select Inmate Request Answered.
10. Select Next Form.
11. Select the bubble for Other.
12. From the Request Type drop down, select Dental.
  - If Informal Grievance, select the box “Check if Informal Grievance” written in blue.
13. Type in a brief description of your answer to the patient in the Request Answer big white box.
14. Fill in the Date Returned to Inmate section.
15. Select Orders tab in upper tool bar to place the patient on a wait list, if applicable. See *Tab 5 or Pages 8 – 9 How To **Create**, **Complete**, & **Verify** Orders.*

16. Select End in upper right corner of document.
17. Select Hold Document.
18. See *Tab 9 or Pages 21 – 25 How To for Indexing Client* to scan and attach the answered request/grievance into the Held Document.
19. Exit out of Indexing Client and return to the EMR, patient's chart.
20. In the upper left corner you will see Documents For Edit, Select the blue Edit button.
  - Review document, you should see the attachment in the white box to the left.
21. Select End in the upper right corner of document.
22. Select Sign Document.
23. Select Document from the left side tool bar of patient's chart to locate the answered request and ensure the request was attached correctly. You should see a paperclip symbol. You can view the attached document by selecting the Attach button on the left of the document view screen.



## How To – Scan & Attach Using Indexing Client

\\flthfile0pw1\fldocshares\EMRScans

### Importing Unsigned Document into EMR

1. Select Indexing Client from APP Page.
2. Sign into Indexing Client using your log in and password.
3. Scan the document you are uploading to the designated path assigned to your scanner.
4. Select the designated path assigned to your scanner from the drop down menu.
5. Select the document you want to upload from your available files and hit the single arrow to add Files to import section.
6. Import as: Attachment
7. Enter description of scanned item in Comment box (Form#, DC#, Date).
8. Select appropriate Document Type from the list using the drop down arrow associated with the document you are uploading.
  - Clinical date and summary will auto populate.
9. Select Lookup Patient.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Does not search by DC#.
  - Select patients name in the results box and press OK.
  - Sensitivity stays as Normal.
10. Leave the Import as Signed box unchecked.
11. Leave the Import as abnormal unchecked.
12. Leave attach to existing document blank.  
Open Orders will stay blank.
13. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
14. Using the drop down arrow next to Physician name select the name of the staff member who needs to review and sign the document.
  - Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.
15. By Selecting Carbon copy you are wanting the document to be sent to a second person as well as who you selected in previous step.
16. Select Import Document.
17. The document will then be imported into patients chart and sent to staff members' desktop to review and sign off on.

### Importing signed document as its own document

1. Select Indexing Client from APP Page.
2. Sign into Indexing Client using your log in and password.
3. Scan the document you are uploading to the designated path assigned to your scanner.
4. Select the designated path assigned to your scanner from the drop down menu.

5. Select the document you want to upload from your available files and hit the single arrow to add Files to import section.
6. Import as: Attachment.
7. Enter description of scanned item in Comment box (Form#, DC#, Date).
8. Select appropriate Document Type from the list using the drop down arrow associated with the document you are uploading.
  - Clinical date and Summary will auto populate.
  - Select Lookup Patient.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Does not search by DC#.
  - Select on patients name in the results box and press OK.
  - Sensitivity stays as Normal.
9. Select Import as Signed box.
10. Leave the Import as abnormal unchecked.
11. Leave attach to existing document blank.
12. Open Orders will stay blank.
13. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
14. Using the drop down arrow next to Physician name select the name of the staff member who signed the document.
  - Note: All staff members' names are listed here, you can start typing in box and it will populate or you can use drop down arrow and select the name.
15. Carbon copy option will be left blank.
16. Select Import Document.
17. The document will then be imported into the patients chart.

### Importing a document to an unsigned document

1. From the EHR, Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. Click on New Document to begin a new encounter.
3. Select Encounter type.
4. Select document attachment will be imported to.
5. Select End.
6. Select Hold, to place document on hold without signing it.
7. Minimize Centricity EMR Open your Citrix app page.
8. Select Indexing Client from the APP Page.
9. Sign into Indexing Client using your log in and password and correct location of care.
10. Scan the document you are uploading to the designated path assigned to your scanner.
11. Select the document you want to upload from your available files and hit the single arrow to add Files to import section.
12. Import as: Attachment.

13. Enter description of scanned item in Comment box (Form#, DC#, Date).
14. Select appropriate Document Type from the list using the drop down arrow associated with the document you are uploading.
  - Clinical date and Summary will auto populate.
15. Select Lookup Patient.
  - From the patient lookup box you are going to type in patients name in the search for box and select find. Does not search by DC#.
  - Select on patients name in the results box and press OK.
  - Sensitivity stays as Normal.
16. Select Import as Signed box.
17. Leave the Import as abnormal unchecked.
18. Under existing document, use the drop down menu to select the name of the encounter you placed on hold in EMR.
19. Open Orders will stay blank.
20. Location of care, ensure that the correct location is selected, if not use the drop down arrow to update.
21. Next to Physician name using the drop down arrow select your name here.
  - You may also type your name in the box to populate.
22. Leave Carbon copy unchecked.
23. Select Import Document.
24. Log out of indexing client when finished.
25. Open EMR application again sign back in if needed.
26. Return to your patients chart.
27. Under document for edit section next select edit next to the document you have on hold to open it.
28. On the left navigation pane under Attachments you will see the uploaded document.
29. Complete document in its entirety.
30. Select End at the top right of encounter.
31. Select Sign Document.

## How To – Contact Coding Sheet Encounter

1. From within the patients New Document, complete all necessary forms (ie: Treatment Notes DC4-724) and then proceed to next form – Contact Coding Form DC4-700A.
2. Under the **Dental Contact Coding tab**, select if there will be a Co-Pay for the visit.
3. Select the Type of Visit by clicking in the corresponding box and then type in the number 1.
  - *If applicable*, select the Blades and/or Needles, Holds, Actions, and/or Passes/Comments by clicking the appropriate box and typing in the amount used/completed.
4. **Under the Procedures tab**, select all applicable treatment completed for each category by selecting the procedure and then typing in the amount performed on each. Make sure to scroll all the way down to the bottom of the form to view each category.
5. **Under the Prosthodontics tab**, select all applicable treatment completed. If not applicable, then proceed to step 6.
6. If the patient is to be placed back on a Wait List, select the **Orders tab** at the top left of the document and *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders*, to create a new order if applicable.
7. If Medications were provided, select the **Medications tab** at the top of document.
  - At bottom left of pop up screen, select New.
  - Under Find Medication, select Dental from the drop down custom list menu.
  - Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
  - Under Prescribing Method select Samples Given from the drop down menu.
  - On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
  - Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
  - If applicable, leave comments.
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.
8. Select Ok.
9. Once all forms have been completed, select End in the upper right corner.
10. Sign document – Dentists only.

## Diet Passes

### Creating a Dental Diet Pass

**NOTE: Diet Passes are entered separate from the treatment documentation. Complete all other documentation first.**

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list
2. Select New Document.
3. Select Dental Encounters.
4. Select Ok.
5. Select the Health Slip Pass DC4-701D from the purple Dental Encounter list.
6. Fill in the Authorized By, white box.
7. Fill in the Date, you can either type it in or select the calendar icon and then click on the date.
8. Select the green Add Order button in the top left corner from within the encounter.
9. From the Custom List drop down menu select Dental Visit.
10. Select *Mechanical Diet*.
  - **NOTE:** Do not add a Potential Diagnoses, as this prints out on the patient's diet pass.

Complete the Order Details tab for the pass selected.

- **Authorized By:** should be the treating Dentist's name.
  - **Instructions** field is to be left blank, this will print on pass as clinical notes.
  - **Disposition** should be In Process.
  - Select the **Start Date and End Date**. (Dental Diet passes are issued for no more than 30 days at a time)
11. Select OK to add pass into encounter.
    - **DO NOT** select Sign Order.
  12. Select End.
    - If diet pass was completed under **Dental Assistant/Hygienist log in**, you will need to Route the document to the Dentist for their signature and then place the document on Hold, *See Tab 3 or Page 5, How To Table of Contents for Sign, Route, Discard, or Hold a Document*.
      - As an Assistant you will then need to place the Document on Hold, **Do Not** Sign the Document as you are not a Provider.
      - By placing the Document on Hold, the Dentist will now be able to log in to review the document and then sign off on it.
      - **If the Diet Pass was completed under the Dentist log in, the Dentist will need to Select Sign Document.**




13. Two Diet Passes will need to be printed, one for Food Service/Security and one for the patient.
14. To print, Select Orders from left navigation pane.
15. Select the “Dental” Diet Order.
16. Select Print icon on top tool bar.
17. Under the Print Topics, select Orders.
18. Under the Test and Referrals section, select Provider Form.
19. Select Preview to confirm the diet pass information.
20. Once confirmed change the number of copies needed to 2 and select Print.
21. You may now close this document.

### Discontinuing a Diet Pass

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. Select New Document.
3. Select Dental Encounters.
4. Select Ok.
5. From the dental encounters list, select the following encounter forms:
  - DC4-724 Dental Treatment Record.
  - DC4-700A Dental Contact Coding Sheet.
  - IF Applicable, DC4-711A Refusal Form, (green refusal option).
  - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
6. Complete DC4-724 Dental Treatment Record form documenting rationale for the discontinuation of the pass.
7. Complete DC4-700A Dental Contact Coding Sheet.
8. Select End.
  - If completed under **Dental Assistant log in**, you will need to Hold & Route the document to the Dentist for their signature. *See Tab 3 or Page 5, How To Table of Contents for Sign, Route, Discard, or Hold a Document.*
    - As an Assistant you will then need to place the Document on Hold, **Do Not Sign** the Document.
    - By placing the Document on Hold, the Dentist will now be able to log in to review the document and then sign off on it.
    - **If the Diet Pass was completed under the Dentist log in, the Dentist will need to select Sign Document.**

9. Select Orders in the left navigation pane.
10. Select pass order being discontinued.
11. Select Complete (green check).
12. In the pop up box, verify the correct order is selected then select Ok to complete the order.
13. Collect paper copy of expired/discontinued pass from patient.

## How To - Outside Dental Consults (DC4 – 702)

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3-4 How To – Dental Health Questionnaire.*
    - If found you can view the form by selecting it and then selecting  or by viewing it in the pane found below the selected form.
  - **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. Select New Document.
4. Select Dental Encounters.
5. Select Ok.
6. Select DC4-702 Consultation Request from the purple encounters list.
  - The DC4-724 and DC4-700A will automatically populate to complete as well, located in the white forms box to the left of the purple encounters list.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.

Complete the DC4-702 Consultation Request Form in its entirety, making sure to scroll all the way to the bottom of the form.

7. To complete the Associated Diagnosis box:
  - Select the blue Add Problem button to the right.
  - Select the New button on the lower left of the pop up box.
  - Type in the problem in the Search For box.
  - Select the problem.

- Fill in the Comments box, if applicable.
  - Select Ok.
  - Within the Associated Diagnosis box select the box next to the problem just added.
8. Select Next Form.
9. Dentist will complete the DC4-724 Dental Treatment Record.
10. Select Next Form.
11. Complete the DC4-700A Dental Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How To - Entering Contact Coding Sheet Encounters.*
12. To add the patient to their next wait list, if need be, select Orders at the top left of the Contact Coding Sheet and then *See Tab 5 or Pages 8 – 9, How To **Create**, Complete, & Verify Orders.*
- Using the Custom List drop down, select Dental Visit.
  - Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
  - The Disposition should autofill to Admin Hold, **if not**, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date (date in which patient placed on wait list).
  - **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
  - Select Ok.
14. Verify ALL forms have been completed.
15. Select END in upper right corner.
16. Select Sign Document – Dentist Only.

#### You will now have to Print the DC4-702 Consult Request Form

1. Within the patient's chart, select Documents from the left side tool bar.
2. Select the document containing the Dental Consultation Request by left clicking on it.
3. Select the Print icon from the top tool bar.
4. Under Print Topics section, select Documents.
5. Under Print Items section, choose Selected Documents.
6. Select Print.
7. You will need to staple any corresponding radiographs to the printed DC4-702 Consultation Request Form and mail to the **Oral Surgery Clinic**, Amy Fissell or **Endo Clinic**, Wendy Hudd.

**IF Applicable, You will now have to remove the patient from their previous Wait List**

To remove patient from former wait list, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*

- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.
- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.

**NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**

- Select OK.

## Dental Intake Exam (DSIX) Workflow (Dentist Log In)

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. Select New Document.
3. Select Dental Encounters.
4. Select Ok.
5. Select & Complete the DC4-735 Intake Exam.
  - The DC4-700A and DC4-724 will automatically populate to complete as well located in the white forms box to the left of the purple encounters list.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
  - Complete the tooth indication chart.
  - Select Yes to add the patient to the Class II wait list, this will pop up an orders box. *See Tab 5 or Pages 8 – 9, how to **Create**, Complete, & Verify Orders.*
    - **Do not** ask if the patient would like to be placed on the Class II Ext wait list, place them on automatically.
  - Note if there are any Prosthesis present.
  - Deposits, Gingival Conditions and Masticating Efficiency should be completed.
  - Regional Head and Neck Exam should be completed, and any remarks noted on the comment line to the right.
  - Select Next Form button at the bottom to move to next form in the list.
  - A pop up window will generate a remark that the patient will be placed on the periodic wait list, select ok to continue.
6. The DC4-724 Dental Treatment Record will auto populate a generic DSIX entry, this entry can be modified if applicable.
7. The DC4-700A Dental Contact Sheet will auto fill in the generic codes for a DSIX appointment. (DSIX, no copay, Procedures: Reception Intake Exam, Oral Hygiene Instructions one-on-one). *See Tab 10 or Pages 26 – 27, How To for Entering Contact Coding Sheet Encounters.*
8. Select End.
9. Select Sign Document – Dentists Only.
10. Once Document is electronically signed by the Dentist the Annual exam order will automatically be added to the patients chart.
11. Select Orders from the left side tool bar within patient’s chart and **Verify** that the patient’s next periodic exam, labeled Dental Periodic Wait List, has been automatically generated. Based on their age (every 2 years if under age 50 and every year if 50 or older). *See Tab 5 or Pages 8 – 9, How To Create, Complete, & **Verify** Orders.* Also **Verify** the Order that the patient was placed on the Class II Extraction wait list.

**You will now have to remove the patient from their previous Dental Intake Exam Wait List**

You will also need to complete the DSIX order to remove the patient from the DSIX wait list. You have two ways to do this.

1. See *Tab 5 or Pages 8 – 9, How To Create, **Complete**, & Verify Orders*. You will need to complete this on each intake exam see for the day.
2. From within Fusion Order Manager Wait List, left click just below the DC#. This will open up the details of the wait list.
  - Select the blue Update Status button.
  - Select Completed. Once ALL exams have been completed for the day, you will do this for each intake exam seen for the day.

## Dental Periodic Exam (DSAX) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. Select New Document.
3. Select Dental Encounters.
4. Select Ok.
5. Select DC4-735 Periodic Exam from the purple encounters list.
  - Once you have selected the form it will pop up for you to complete as well as place it in the white forms box to the left. Make sure to scroll all the way down to ensure the form has been completed in its entirety.
  - DC4-724 and DC4-700A will automatically populate to complete as well located in the white forms box to the left of the purple encounters list.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
6. Select Next Form.
7. Complete the DC4-724 Dental Treatment Record.
8. Select Next Form.
9. Complete the DC4-700A Dental Contact Coding form, See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet.
  - Select the Orders tab from the top tool bar within the new document. You will need to **Verify** that the next Periodic Exam has been created. The system should automatically place the patient back on the Periodic Exam Wait List per their age.  
  
**Reminder:** Periodic Exam should be performed per patient's age (every 2 years if under age 50 and every year if 50 or older)
10. Verify ALL forms have been completed.
11. Select End.
12. Select Sign Document – Dentists Only.

### You will now have to remove the patient from their previous Dental Intake Exam Wait List

To complete today's Dental Periodic Wait List order, *See Tab 5 or Pages 8 – 9, How To Table of Contents for Create, **Complete**, & Verify Orders.*




## Record Review (DSRR) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. You will need to Review the EMR chart just as you would during a paper chart record review.
3. To review the patient's previous progress notes, (example: Outstanding Outside Consults) you will need to select Documents on the far left tool bar of the patients chart.
  - Select the Dental File Folder under Document View.
  - Documents can be found as an attachment to a Treatment Record.
  - Select the Treatment Record you wish to view, if there is an attachment you will see a paper clip to the left of the document. To view attached document select the Attach button on the middle right of the screen. This will bring up the attached Document to review.
  - From Documents you will also need to review the previous few progress notes to check for any outstanding treatment needed. (Example: suture removal, next wait list...)
  - Select the Consents File Folder under Document View to review any Consents.
5. You will also need to pull up your wait lists in Fusion Order Manager and convert to Excel format, *See Tab 8 or Pages 14 – 18, Fusion Order Manager.*
  - Check each chart for the need of being placed on a wait list.
  - If on wait list in chart, make sure the patient is also showing up on the Excel list accurately, **if not**, you will need to Change the order or Create one, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.* Keep in mind to back date the order so the patient will appear on the wait list correctly if need be.
  - Make sure to check the Dental Periodic (DSAX) wait list for the patients next Periodic Exam. If need be, Create the order or change it.
6. Select New Document.
7. Select Dental Encounters.
8. Select Ok.
9. From the dental encounters list, select the following encounter forms:
  - DC4-724 Dental Treatment Record.
  - DC4-700A Dental Contact Coding
  - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
10. Complete the DC4-724 Dental Treatment Record & DC4-700A Contact Coding Sheet form in their entirety.

11. If the patient should be placed on a wait list during this entry, select Orders to Create a new order, *aka*, add to wait list.
  - See *Tab 5 or Pages 8 – 9*, How To Table of Contents for **Create**, Complete, & Verify Orders.
12. Select End
13. Select Sign Document.

## Dental Emergency / Sick Call / Sick Call Follow Up Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3-4 How To – Dental Health Questionnaire.*
    - If found you can view the form by selecting it and then selecting  or by viewing it in the pane found below the selected form.
  - **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. Select New Document.
4. Select the Dental Encounters.
5. Select Ok.
6. From the dental encounters list, select the following encounter forms:
  - DC4-724 Dental Treatment Record.
  - DC4-700A Dental Contact Coding
  - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
7. If **Extraction** is indicated, please *See Tab 6 or Pages 10 – 11, How To* complete Fusion eSign Document.
8. If **Refusal** is indicated, please *See Tab 4 or Pages 6 – 7, How To Complete a Refusal* starting on #5 of the instructions.
9. If a **Diet Pass** or **Outside Consult** is needed, *See Tab 11 or Pages 28 – 30 or Pages 31 – 33, How To* complete Diet Passes / Outside Consults.
  - Diet Passes will be completed on a separate encounter.

10. Complete each form in its entirety.
  - Selecting the Prev Form and Next Form buttons at the bottom of each page to move back and forth between each form or by clicking on the form you wish to view from the white forms box to the left.
11. To **Add Orders** (add to the wait list) if applicable, *See Tab 5 or Pages 8 – 9, How To Table of Contents to **Create**, Complete, & Verify Orders.*
12. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet. **NOTE:** This does not apply to OTC meds, only meds that would have required a script to be written in the past. (ie: Amox. Clind.)
  - At bottom left of pop up screen, select New.
  - Under Find Medication, select Dental from the drop down custom list menu.
  - Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
  - Under Prescribing Method select Samples Given from the drop down menu.
  - On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
  - Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
  - If applicable, leave comments.
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.
13. Select End.
14. Select Sign Document – Dentist Only.

### You will now have to remove the patient from their previous Wait List

To remove/complete patient from former wait list, *See Tab 5 or Pages 8 – 9, How To Create, **Complete**, & Verify Orders.*

- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.
- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.
- **NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**
- Select OK.

## Treatment Plan (DS) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1,2 or Pages 3 - 4 How To – Dental Health Questionnaire.*



- **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. Select New Document.
  4. Select Dental Encounters.
  5. Select Ok
  6. Select the DC4-764 Dental Treatment Plan from the purple encounters list.
    - This will auto generate both the DC4-724 Dental Treatment Record and the DC4-700A Dental Contact Coding Sheet.
    - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
    - Complete each of the forms, scrolling to the bottom of each form to ensure completed.
  7. Complete the PSR section.
    - If a 4 is recorded in any sextant, a pop up window will indicate Periodontal Exam is required.
    - Select Ok.
    - Select Yes or No to conduct Period Chart Now question.

- If you choose Yes to perform the Perio Chart during the current visit, you will then need to select the purple Periodontal Charting button to the right.
  - The Perio Chart form will be placed in the white forms box to the left to be completed during this visit.
8. Complete the Regional Head and Neck Exam, making sure to answer each yes or no question. If all questions are no, select the green All Normal button.
    - If any question has a Yes answer, you will need to fill in the comments section to explain the Yes answer.
  9. Select, On To Tooth Chart, in the white box written in purple located at bottom of page.

### Tooth Chart Workflow

**(DO NOT use the Initial Exam or Switch Status buttons on the upper left of Tooth Chart)**

1. Existing Conditions box: **(you will only record the missing teeth, do not record any other existing conditions)**
  - Under Existing Conditions type Missing in the search bar and then select Search.
  - Select Missing – Crown and Root condition from drop down menu.
  - Select tooth with existing condition by clicking on the tooth affected until all existing conditions have been noted on tooth chart.
2. Treatment Plan Box:
  - Select Search to view all listed conditions or type the condition in the search bar and then select Search.
  - Select condition from drop down menu.
  - Select tooth/surface with existing condition by clicking on the tooth surface affected until all treatment planned conditions have been noted on tooth chart. (treatment planned conditions will appear in red)
    - NOTE: *Multisurface* means 2 separate surfaces on one tooth, example: 2 – O, B.
    - *Restoration – Multisurface* - means multiple surfaces listed together on one tooth, example: 2 – MOD
    - *Restoration - Single* - means one single surface listed at a time, example: 2 – O (DO NOT use this option if a tooth has multi-surfaces as it will list each surface separately under the Pending tab in the bottom left.)
3. Select Next Form until each form has been completed.
  - If Perio Charting was requested during this visit, you will need to ensure you complete this form as well. Again, it will be located in the white forms box to the left and can be accessed by selecting Previous or Next Form button or by clicking on the forms within the white box to the left.
4. Dentist will complete the DC4-724 Dental Treatment Record.
5. Select Next Form.
6. Complete the DC4-700A Dental Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How*

To Enter Contact Coding Sheet.

7. To **Add Orders** (add to the wait list), *See Tab 5 or Pages 8 – 9, How To Table of Contents to Create, Complete, & Verify Orders.*
  - Using the Custom List drop down, select Dental Visit.
  - Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
  - The Disposition should autofill to Admin Hold, **if not**, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date (date in which patient placed on wait list).
  - **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
  - Select Ok.
8. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet. **NOTE:** This does not apply to OTC meds, only meds that would have required a script to be written in the past. (ie: Amox. Clind.)
  - At bottom left of pop up screen, select New.
  - Under Find Medication, select Dental from the drop down custom list menu.
  - Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
  - Under Prescribing Method select Samples Given from the drop down menu.
  - On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
  - Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
  - If applicable, leave comments.
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.
9. Once Orders and ALL forms have been completed, select End in the upper right corner.
10. Select Sign Document – Dentist Only.

### You will now have to remove the patient from their previous Wait List


To remove/complete patient from former wait list, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*

- Select Orders on far left of patients chart.

- Select the correct order/wait list, by date.
- Select Complete found in top Orders ribbon (green check).
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.
- **NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**
- Select OK.



## Preventative (DS) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3-4 How To – Dental Health Questionnaire.*
    - If found you can view the form by selecting it and then selecting  or by viewing it in the pane found below the selected form.
  - **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. Select New Document.
4. Select Dental Encounters.
5. Select Ok.
6. Select Dental Tooth Chart from purple list of encounters.
  - Review the tooth chart.
  - Review the lower left white box to see what type of cleaning has been treatment planned.
7. Select Next form at bottom of page.
8. Complete DC4-724, Treatment Record Notes.
9. Select Next Form.
10. Complete the DC4-700A, Dental Contact Coding Sheet in its entirety, *See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet.*
11. To **Add Orders** (add to the wait list), *See Tab 5 or Pages 8 – 9, How To Table of Contents to Create, Complete, & Verify Orders.*
  - Using the Custom List drop down, select Dental Visit.
  - Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the

- patients wait list.
  - The Disposition should autofill to Admin Hold, if not, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date.
  - **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
  - Select Ok.
12. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet. **NOTE:** This does not apply to OTC meds, only meds that would have required a script to be written in the past. (ie: Amox. Clind.)
- At bottom left of pop up screen, select New.
  - Under Find Medication, select Dental from the drop down custom list menu.
  - Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
  - Under Prescribing Method select Samples Given from the drop down menu.
  - On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
  - Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
  - If applicable, leave comments.
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.
13. Select the Dentist Visit – Fusion (Tooth Chart) from the white Forms box to the left.
- Once Hygiene treatment has been completed, select the green complete button, in bottom left hand box next to the type of treatment rendered for the day.
14. Select End in the top right corner
15. Select Sign Document.


### You will now have to remove the patient from their previous Wait List

To remove/complete patient from former wait list, See *Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*

- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.

- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.
  - **NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**
- Select OK.

## Restorative (DS) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3-4 How To – Dental Health Questionnaire.*
    - If found you can view the form by selecting it and then selecting  or by viewing it in the pane found below the selected form.
  - **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. Select New Document.
4. Select Dental Encounters.
5. Select Ok.
6. Select Dental Tooth Chart from purple list of encounters.
  - Review the tooth chart.
7. Review the lower left white Pending box to see what type of treatment has been planned.
8. Select Next Form at the bottom of the Tooth Chart.
9. Dentist will complete the DC4-724 Treatment Record.
10. Select Next Form at bottom of document.
11. Complete the Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet.*
12. To **Add Orders** (add to the wait list), *See Tab 5 or Pages 8 – 9, How To Table of Contents to Create, Complete, & Verify Orders.*
  - Using the Custom List drop down, select Dental Visit.
  - Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
  - The Disposition should autofill to Admin Hold, if not, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date.

- **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
  - Select Ok.
13. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet. **NOTE:** This does not apply to OTC meds, only meds that would have required a script to be written in the past. (ie: Amox. Clind.)
- At bottom left of pop up screen, select New.
  - Under Find Medication, select Dental from the drop down custom list menu.
  - Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
  - Under Prescribing Method select Samples Given from the drop down menu.
  - On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
  - Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
  - If applicable, leave comments.
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.
14. Select the Dentist Visit – Fusion (Tooth Chart) from the white Forms box to the left.
- Once treatment has been completed, select the green complete button, in bottom left hand Pending box next to the type of treatment rendered for the day. **NOTE:** Click one time and allow time for computer to complete the task, do not keep clicking or you will have chosen to complete several treatments for the day.
15. After ALL documents have been completed, select End in the top right corner.
16. Select Sign Document – Dentist Only

### You will now have to remove the patient from their previous Wait List

To remove/complete patient from former wait list, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*

- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.
- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.
  - i. **NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**
- Select OK.

## Extraction (DS) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3-4 How To – Dental Health Questionnaire.*



- **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics?
    - Any allergies to Latex?
    - Any allergies to Nickel Metals?
    - Any allergies to Iodine?
3. Select New Document.
  4. Select Dental Encounters.
  5. Select Ok.
  6. Select Dental Tooth Chart from purple list of encounters.
    - Review the tooth chart.
    - Review the lower left white Pending box to see what type of treatment has been planned.
  7. **If Extraction** is indicated, *See Tab 6 or Pages 10 – 11, How To for Fusion eSign Document.*
    - Once eSign consent complete, proceed to step #9, below.
  8. **If Refusal** is indicated. *See Tab 4 or Pages 6 – 7, How To Complete a Refusal, starting with step #5.*
  9. Select Next Form at the bottom of the Tooth Chart.
  10. Dentist will complete the DC4-724 Treatment Record.
  11. Select Next Form at bottom of document.
  12. Complete the DC4 – 700A Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet.*
  13. To **Add Orders** (add to the wait list), *See Tab 5 or Pages 8 – 9, How To Table of Contents to Create, Complete, & Verify Orders.*
    - Using the Custom List drop down, select Dental Visit.

- Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
  - The Disposition should autofill to Admin Hold, if not, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date.
  - **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
  - Select Ok.
14. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet. **NOTE:** This does not apply to OTC meds, only meds that would have required a script to be written in the past. (ie: Amox. Clind.)
- At bottom left of pop up screen, select New.
  - Under Find Medication, select Dental from the drop down custom list menu.
  - Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
  - Under Prescribing Method select Samples Given from the drop down menu.
  - On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
  - Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
  - If applicable, leave comments.
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.
15. Select the Dentist Visit – Fusion (Tooth Chart) from the white Forms box to the left.
- Once treatment has been completed, select the green complete button, in bottom left hand Pending box next to the type of treatment rendered for the day. **NOTE:** Click one time and allow time for computer to complete the task, do not keep clicking or you will have chosen to complete several treatments for the day.
16. After ALL documents have been completed, select End in the top right corner.
17. Select Sign Document – Dentist Only.

### You will now have to remove the patient from their previous Wait List

To remove/complete patient from former wait list, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*


- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.
- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.

**NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**

- Select OK.



## Prosthetic (DS) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3 - 4 How To – Dental Health Questionnaire.*
    - If found you can view the form by selecting it and then selecting
  or by viewing it in the pane found below the selected form.
  - **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. Select New Document.
4. Select Dental Encounters.
5. Select Ok.
6. Select Dental Tooth Chart from purple list of encounters.
  - Review the lower left white Pending box to see what type of prosthetic work needs to be done.
7. Select Next form at bottom of page.
8. Dentist will complete DC4-724, Treatment Record.
9. Select Next Form.
10. Complete the DC4-700A Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet.*
11. To **Add Orders** (add to the wait list), *See Tab 5 or Pages 8 – 9, How To Table of Contents to Create, Complete, & Verify Orders.*
  - Using the Custom List drop down, select Dental Visit.
  - Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
  - The Disposition should autofill to Admin Hold, if not, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date.

- **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
- Select Ok.

12. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet. **NOTE:** This does not apply to OTC meds, only meds that would have required a script to be written in the past. (ie: Amox. Clind.)

- At bottom left of pop up screen, select New.
- Under Find Medication, select Dental from the drop down custom list menu.
- Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
- Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
- Under Prescribing Method select Samples Given from the drop down menu.
- On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
- Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
- If applicable, leave comments.
- Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.

13. **IF at the Delivery phase:**

- Select the Dentist Visit – Fusion (Tooth Chart) from the white Forms box to the left.
- Once prosthetic has been delivered, select the green complete button, in bottom left hand Pending box next to the type of treatment rendered for the day.  
**NOTE:** Click one time and allow for computer to complete the task, do not keep clicking or you will have chosen to complete several treatments for the day.

14. To complete the DC4-724A Receipt of Provisions, *See Tab 6 or Pages 10 – 11*, How To for Fusion eSign Document.

15. Select End in the top right corner.

16. Select Sign Document – Dentist Only

### You will now have to remove the patient from their previous Wait List

To remove/complete patient from former wait list, *See Tab 5 or Pages 8 – 9*, How To Create, **Complete**, & Verify Orders.

- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.

- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.
  - **NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**
- Select OK.

### PROSTHETIC APPROVAL REQUESTS (PO#'s)

#### How To – Request a Prosth PO#

1. E-Mail your dental director requesting an approval.
2. In the e-mail include:
  - Patient Name
  - DC#
  - Type of case.
3. Dental Director will review EMR treatment record / tooth chart (all relevant information including Intake / EOS dates are visible there) and reply approving / disapproving and CC: Michael Sanders.
4. Michael Sanders will “Reply All” with the PO#. (PO# will also be available on the portal).
5. Once PO# has been received:
  - a. Go to patient’s chart
  - b. Select Order from left tool bar.
  - c. Select the Prosthetic Wait List.
  - d. Select Green Pencil to Change.
  - e. In the Instructions Box type in the issued PO# and all other applicable wait list remarks.
  - f. Select Ok.
6. PO# should be written in the dental treatment record DC4-724 on date impressions are taken / case is started.  
(if patient transfers, everyone should be aware that PO# will be written there)

## Endodontic (DS) Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3 - 4 How To – Dental Health Questionnaire.*



- **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics?
    - Any allergies to Latex?
    - Any allergies to Nickel Metals?
    - Any allergies to Iodine?
3. Select New Document.
  4. Select Dental Encounters.
  5. Select Ok.
  6. Select Dental Tooth Chart from purple list of encounters.
    - Review the tooth chart.
    - Review the lower left white Pending box to see what type of treatment has been planned.
7. **If Endodontic treatment** is indicated, *See Tab 6 or Pages 10 – 11, How To for Fusion eSign Document.*
- Once eSign consent complete, proceed to step #9, below.
8. **If Refusal is indicated.** *See Tab 4 or Pages 6 – 7, How To Complete a Refusal, starting with step #5.*
  9. Select Next Form at the bottom of the Tooth Chart.
  10. Dentist will complete the DC4-724 Treatment Record.
  11. Select Next Form at bottom of document to continue to DC4-700A Contact Coding Sheet.
  12. Complete the DC4-700A Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet.*
13. To **Add Orders** (add to the wait list), *See Tab 5 or Pages 8 – 9, How To Table of Contents*

to **Create**, Complete, & Verify Orders.

- Using the Custom List drop down, select Dental Visit.
- Select the wait list the patient should be added to.
- Select Order Details tab.
- Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
- The Disposition should autofill to Admin Hold, if not, you will need to select the drop down and change to Admin Hold.
- The Start Date will default to the current date.
- **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
- Select Ok.

14. If Medications were provided, select the **Medications tab** at the top of the Contact Coding Sheet.

- At bottom left of pop up screen, select New.
- Under Find Medication, select Dental from the drop down custom list menu.
- Select the drop down menu found directly beneath and then select the applicable medication from the list of dental medications.
- Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed, (refills should be 0).
- Under Prescribing Method select Samples Given from the drop down menu.
- On the left of the Medications pop up box, select Probs from the options Alrgs(0), Meds(0), and Probs(0) then on the bottom left of the pop up box select New Problem.
- Search for the problem in which caused the need for the medication to be prescribed, once selected, it will appear in the Description box. (ie: Tooth Extraction or Abscess, tooth)
- If applicable, leave comments.
- Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.

15. Select the Dentist Visit – Fusion (Tooth Chart) from the white Forms box to the left.

- Once treatment has been completed, select the green complete button, in bottom left hand Pending box next to the type of treatment rendered for the day. **NOTE:** Click one time and allow time for computer to complete the task, do not keep clicking or you will have chosen to complete several treatments for the day.

16. After ALL documents have been completed, select End in the top right corner.

17. Select Sign Document – Dentist Only.

### You will now have to remove the patient from their previous Wait List

To remove/complete patient from former wait list, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*

- Select Orders on far left of patients chart.
- Select the correct order/wait list, by date.
- Select Complete found in top Orders ribbon (green check)
- A pop up box will appear to verify you are removing from the correct list/completing the correct order.
- **NOTE: Medical Orders could also be listed amongst the Dental Orders, do not Change, Send, Complete, or Remove a Medical Order.**
- Select OK.

## Dental Class II Extraction Workflow

1. Find your patient using the Magnifying Glass icon or the Find Patient drop down list.
2. To View a Patient's Medical Health Questionnaire (aka: Health Appraisal)
  - From within the patient's chart select Documents.
  - Within the Document View box select the plus sign next to the Nursing folder.
  - Select FL Nurse Reception folder.
  - To the right of Document View, you will find the DC4-707 Health Appraisal.
    - If not found, you will need to complete a Dental Health Questionnaire, *See Tab 1, 2 or Pages 3 - 4 How To – Dental Health Questionnaire.*



- **You are required to ask the following 4 Allergy Questions:**
    - Any allergies to Local Anesthetics
    - Any allergies to Latex
    - Any allergies to Nickel Metals
    - Any allergies to Iodine
3. If Extraction is indicated, *See Tab 6 or Pages 10 – 11, How To* for Fusion eSign Document.
    - Once Extraction consent has been obtained, proceed to step #4
    - If a Refusal is indicated, *See Tab 4 or Pages 6 – 7, How To* Complete a Refusal.
  4. Select New Document.
  5. Select Dental Encounters.
  6. Select Ok.
  7. From the dental encounters list, select the following encounter forms:
    - DC4-724 Dental Treatment Record.
    - DC4-700A Dental Contact Coding
    - This will place the forms in the white Forms box to the left of screen.  
**NOTE:** You can toggle back and forth between the forms and encounter screen by selecting the Previous and Next Forms buttons at the bottom of the page or by clicking on the form you wish to view from the white forms box to the left.
  8. Complete each form in its entirety.
    - Selecting the Prev Form and Next Form buttons at the bottom of each page to move to/from forms.
  9. Dentist will complete the DC4-724 Dental Treatment Record.
  10. Select Next Form to continue to the DC4-700A Contact Coding Sheet.

11. Complete the DC4-700A Contact Coding Sheet, *See Tab 10 or Pages 26 – 27, How To Enter Contact Coding Sheet. (No Co-Pay for Class II Extractions)*
12. If more Class II Extractions are indicated, patient will need to be placed *back* on the Class II Extraction Wait List (*proceed to step 13*). If not, Select END and proceed to *Step 15*.
13. **To add patient back to the Class II Extraction Wait List, select Orders** at the top left of the Contact Coding Sheet and then *See Tab 5 or Pages 8 – 11, How To Create, Complete, & Verify Orders.*
  - Using the Custom List drop down, select Dental Visit.
  - Select the wait list the patient should be added to.
  - Select Order Details tab.
  - Under the Instructions box – Type any remarks that will need to appear on the patients wait list.
  - The Disposition should autofill to Admin Hold, if not, you will need to select the drop down and change to Admin Hold.
  - The Start Date will default to the current date.
  - **NOTE:** NEVER place an End Date, this area should always be left blank when adding to wait lists.
  - Select Ok.
14. If Medications were given, select the **Medications tab** while in the Contact Coding Sheet Form.
  - At bottom left of pop up screen, select New
  - Under Find Medication, select Dental from the drop down menu
  - Select the drop down menu found directly underneath and then select the applicable medication from the list of dental medications
  - Always make sure the Route box, Instructions box, Duration box, Quantity box, & Refills box, are completed.
  - Under Prescribing Method select Samples Given in the drop down menu.
  - On the bottom left of the pop up box select New Problem
  - Search for the problem in which caused the need for the medication to be prescribed (ie: tooth extraction), once selected, it will appear in the Description box.
  - If applicable, leave comments
  - Select an end date
  - Select Save and Continue **if** more Problems need to be added, otherwise select Ok once complete.

**You will now have to remove the patient from their previous Wait List**

15. **Remove/Complete** patient from original Class II Extraction Wait List, *See Tab 5 or Pages 8 – 9, How To Create, Complete, & Verify Orders.*



- If patient was placed back on the Class II Wait List, both Wait Lists will appear. Please make sure to select the Class II Wait List with the oldest date to complete.