

# Ambulatory Chart Abstracting

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## *Participant's Guide*

# Ambulatory Chart Abstracting Syllabus

## Objectives:

Participants will have the knowledge to perform the following after successful completion of the Abstracting course. Using a Clinical Summary form and a Patient History Record, participants will be able to:

- I. Log into Epic.
- II. Perform an accurate patient search.
- III. Create an Abstract Encounter.
- IV. Document allergies.
- V. Enter medications.
- VI. Enter past medical and surgical history.
- VII. Providers only – update a Problem List.
- VIII. Document family history.
- IX. Document social history.
- X. Enter prior immunizations.
- XI. Document external results.
- XII. Enter past vital signs.
- XIII. Complete the Abstract Encounter.

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## What is Abstracting?

It is the process of manually entering historic (already documented) patient information either from a paper chart or office-based electronic medical record into Epic. An Abstract Encounter is the point of entry for this information. It is most beneficial if data is abstracted prior to a doctor's appointment so that the information can be reviewed during the office visit.

Abstracting is not the same as scanning. Scanning involves creating an image of a print document and entering it into the chart. Some providers prefer that labs or outside diagnostic testing results be scanned into Epic. Scanning requires additional equipment, an additional training course and is at the practice manager's discretion.

## What is an Abstract Encounter?

An Abstract Encounter allows historic patient information to be carefully entered into the Epic EHR so pertinent health data is readily available. This information may be entered by physicians, *designated* clinical staff and abstractors. Each office identifies specific information to be abstracted into Epic. Some offices will use Clinical Summary sheets or a specific Abstracting form to identify the specific information to be documented.

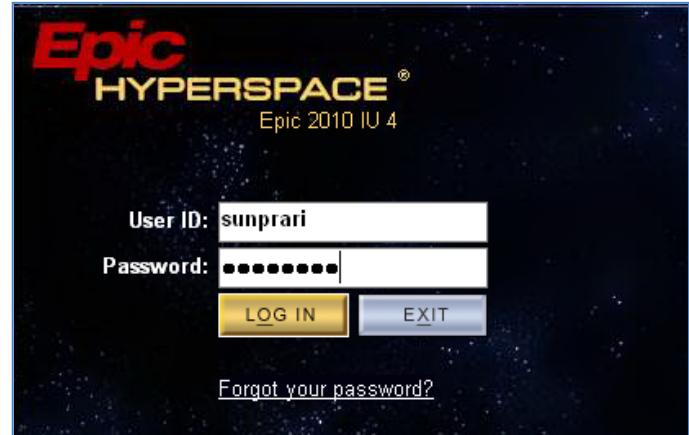
# Getting Started with an Abstract Encounter

## Log in to Epic Hyperspace

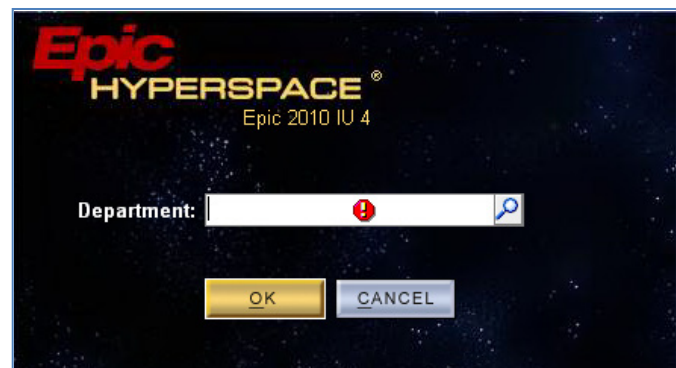
1. Enter your User ID.
2. Enter your Password.
3. Click **LOG IN**.

The Epic Hyperspace Login Department window displays.

4. Ensure that your default log in department displays correctly. If not, change to the correct department. Be sure that you are logging into the Department for which you are abstracting. Do NOT log into your home department, unless appropriate.
5. Click **OK**.



The screenshot shows the Epic Hyperspace login interface. At the top, the text "Epic HYPERSPACE®" is displayed in red and yellow, with "Epic 2010 IU 4" below it. The background is a dark blue space theme with stars. Below the header, there are two input fields: "User ID:" with the text "sunprari" and "Password:" with masked characters. To the right of the password field is a "Forgot your password?" link. At the bottom, there are two buttons: a yellow "LOG IN" button and a grey "EXIT" button.

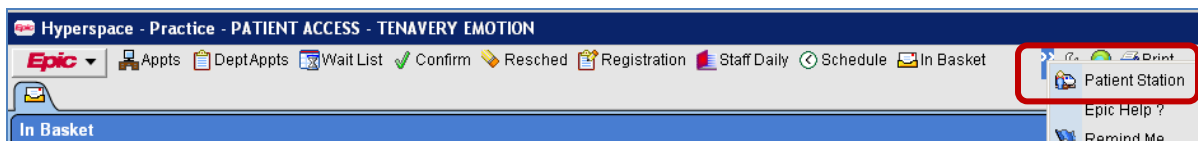


The screenshot shows the Epic Hyperspace department selection window. At the top, the text "Epic HYPERSPACE®" is displayed in red and yellow, with "Epic 2010 IU 4" below it. The background is a dark blue space theme with stars. Below the header, there is a "Department:" label followed by a text input field. The input field contains a red exclamation mark icon and a magnifying glass icon. At the bottom, there are two buttons: a yellow "OK" button and a grey "CANCEL" button.

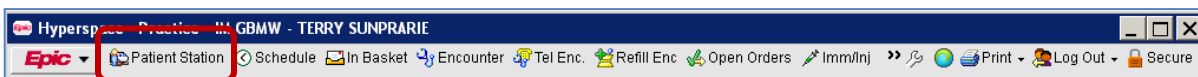
## Initiating an Abstract Encounter

The Abstract Encounter is most often used to enter patient information into the electronic medical record *before* the patient comes to the office for a visit. Details are clarified and reviewed during the visit.

1. Click **Patient Station** from the Epic Speed Bar.

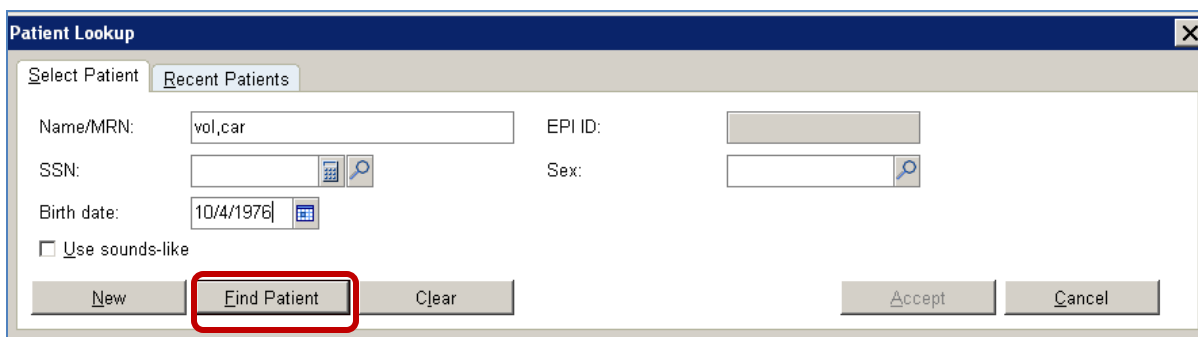


*Abstractor view: Patient Station accessed by clicking chevron on Epic toolbar.*



*Clinical view: Patient Station on Epic toolbar.*

2. Find the patient by using the “3,3” method and birth date.
  - A. To do this, type the first 3 letters of the patient’s last name, comma with *no* space, and the first three letters of the first name. For example, Carolyn Volcanic would be found by entering **vol,car**.
  - B. Enter her birth date.
  - C. Click **Find Patient**.




*Be sure you are using the accepted NorthShore standards for locating patients in Epic. NorthShore Patient Search Methods are outlined on the following page.*

## NorthShore Patient Search Methods

According to NorthShore policy, you must perform each **NorthShore Patient Search Method** in the order they appear below. This is to ensure you do NOT create duplicate patient records.



1.	<b>3,3 &amp; DOB</b>	<p>In the <i>Name/MRN</i> field, type the first three letters of the patient's last name, comma, and first three letters of the patient's first name.</p> <p>In the <i>Birth date</i> field, type the patient's date of birth.</p>
2.	<b>Check for typos</b>	Make sure the <b>3,3</b> and <b>birth date</b> are correct and that the 3,3 is in the right order (lastname,firstname).
3.	<b>Last Name (3) and Birth date</b>	<p>Enter only the first three characters of the patient's last name in the <i>Name/MRN</i> field and enter the patient's <b>birth date</b>.</p> <p><i>Note: This is a critical search for PEDS patients who may be in the system under the first name Babygirl, Babyboy, etc.</i></p>
4.	<b>Social Security # Only</b>	If you have a social security number for the patient, enter it in the <i>SSN</i> field.
5.	<b>Different Last Name (3) and Birth date</b>	<p>Ask if the patient could be in the system under a different last name (i.e., a maiden name). If so, search using the first three characters of the different last name in the <i>Name/MRN</i> field and the birth date.</p> <p><i>Note: This is a critical search for PEDS patients who may have been registered under a different last name at birth, and/or women whose marital status has changed.</i></p>
6.	<b>Full Last Name and Use Sounds Like</b>	Enter the patient's <b>FULL last name</b> and check the <b>Use sounds-like</b> box to search for alternate spellings.



1. Select the correct patient. Be cautious when searching for patients with similar names. If there is a patient with the same name and birth date, use a second method of identifying such as an address.

Patient Name	MRN	ID Type	Sex	Birth Date	Address	SSN
TRAINING, ABSTRACT	<2244>	EPI	M	03/30/1970	123 Peach Street, BARRINGTON HIL...	xxx-xx-4026
TRAINING, ABSTRACT	<9601>	EPI	M	03/30/1970	800 Court Lane, Littleton CO 80123	xxx-xx-4788

3 records total, all records loaded.

2. After selecting the correct patient, select +/- 7 Days option to determine if there is an existing open abstract encounter.

After selecting +/- 7 Days all past, current and future encounters for that timeframe appear here.

3. If there isn't an existing Abstract encounter, click **New Encounter**.

4. The New Encounter window displays.
5. The *Date* can be adjusted, if desired.
6. In the *Type* field enter "Abstract".
7. Enter the *Provider* name.
8. The *Department* is where the provider sees the patient.
9. Click **Accept**.

Date: 3/13/2012

Type: Abstract

Provider: SCOECITE, PAT

Department: IM GBMW

Accept Cancel

The Abstract Encounter displays. Activities (far left column) and Abstract Encounter sections will differ based on user role.

**Trainone, David** MRN 206624074 Allergy **Not on File** PCP LERNER, DAVID J. Lang English  
68YO / M, 02/09/1944

3/15/2012 visit with David David J., MD for Abstract

Images Questionnaires Admin Benefits Inquiry References Smart

**Allergies: Not on File**  
Enc No: 4901 PCP: Lerner, David J., MD  
BP: P: T: T Src: Resp: W: H:

**Abstract Encounter**

Meds & Orders  
Enter Results  
History  
Vitals  
Allergies  
Medications  
Progress Notes  
Immunizations  
Enter Results  
Follow-up  
Close Encounter

**Medications & Orders**  
+ Create Medication List Comments  
Search for new order + New Order  
No active orders  
Mark All Taking Mark as Reviewed Never Review  
Click here to select a pharmacy

**Enter/Edit Results**  
Enter/Edit Results

**History**  
History

**Vitals**  
+ New Set of Vitals  
None Taken

### Clinical View

**Trainone, David** MRN 206624074 Allergy **Not on File** PCP LERNER, DAVID J. Language English  
68YO / M, 02/09/1944

3/15/2012 visit with David David J., MD for Abstract

Images Questionnaires Admin Benefits Inquiry References Care Teams

**Allergies: Not on File**  
Enc No: 4901 PCP: Lerner, David J., MD  
BP: P: T: T Src: Resp: W: H:

**Abstract Encounter**

Enter Results  
History  
Vitals  
Medications  
Progress Notes  
Immunizations  
Enter Results  
Follow-up  
Close Encounter

**Enter/Edit Results**  
Enter/Edit Results

**History**  
History

**Vitals**  
+ New Set of Vitals  
None Taken

### Abstractor View

## Entering Allergies

Allergy status must be reviewed at least annually in order to prescribe medications. The Patient Header always displays allergy information.

**Not on File** = no one has addressed allergies.

<b>Trainone, David</b> 68YO / M, 02/09/1944	MRN 206624074	Allergy <b>Not on File</b>
--	------------------	-------------------------------

**No Known Allergies** = the patient does not have any known allergies.

<b>Demo, A</b> 40YO / M, 06/02/1971	MRN 206624637	Allergy <b>No Known Allergies</b>
--	------------------	--------------------------------------

**Allergen Name** = known allergens are listed in red in descending severity.

<b>Train, Jennifer</b> 70YO / F, 02/09/1942	MRN 206624298	Allergy <b>Penicillins, Corticosteroids</b>
--	------------------	--

To note Allergies:

1. Click the **Allergies** activity.
2. If the patient does not have any allergies, select the No Known Allergies box.
3. To note the patient's allergies, type the allergen in the search box and press **ENTER**.



Smith, Faith  
42YO / F, 01/01/1970  
MRN 2059865

3/5/2012 visit with Zinc...

SnapShot  
Chart Review  
Flowsheets  
Results Review  
**Allergies**  
History

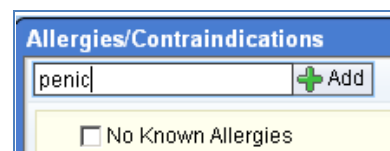
Abstract Encounter  
Meds & Orders  
Enter Results  
History  
Vitals  
Medications



**Allergies/Contraindications**

Add a new agent + Add

☒ No Known Allergies

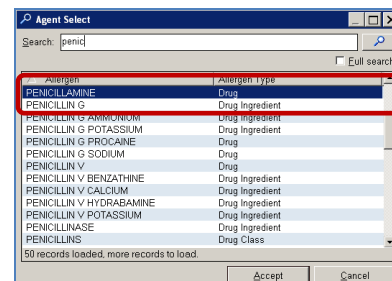


**Allergies/Contraindications**

penic + Add

☐ No Known Allergies

4. Select the correct allergen.  
Selecting the broadest type “Drug Class” is the most comprehensive.
5. Click **Accept**.



If additional information is known, it can be added.

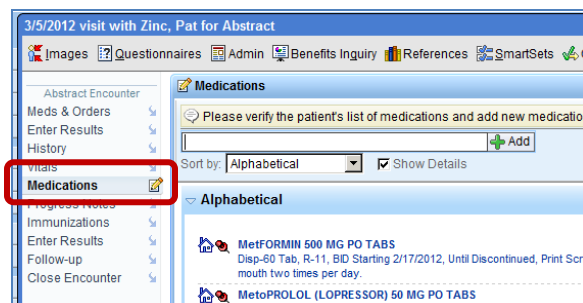
6. **Type:** select the type of reaction.
7. **Reactions:** select the patient’s reactions to the allergen. Additional reactions can be added by clicking the empty row below.
8. **Severity:** indicate the level of severity. Allergies listed with a high severity also have a yellow banner – the yellow banner is not visible on the header though.
9. **Noted:** change to the date the allergy was noted or, if unknown, the date of the last office visit.
10. **Comments:** additional comments can be added if needed.
11. When complete, click **Accept**.

Click the **Visit Navigator** activity to return to the Abstract Encounter.

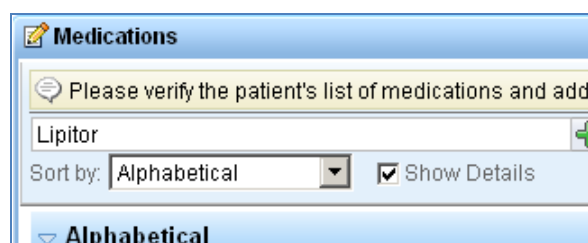
## Entering Historic Medications

Entering the patient's historical medication is a very important part of the abstracting process.

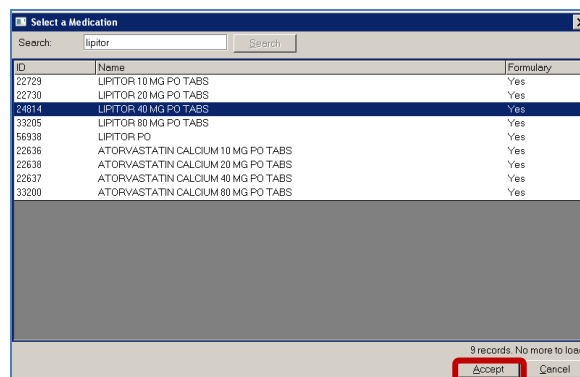
1. Click **Medications** in the Abstract Encounter navigator.



2. Enter the medication name in the search field and press **Enter**.

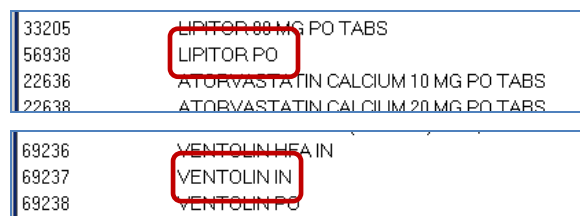


3. Select correct strength if known. Then click **Accept**.



ID	Name	Formulary
22729	LIPITOR 10 MG PO TABS	Yes
22730	LIPITOR 20 MG PO TABS	Yes
24814	LIPITOR 40 MG PO TABS	Yes
33205	LIPITOR 80 MG PO TABS	Yes
56938	LIPITOR PO	Yes
22636	ATORVASTATIN CALCIUM 10 MG PO TABS	Yes
22638	ATORVASTATIN CALCIUM 20 MG PO TABS	Yes
22637	ATORVASTATIN CALCIUM 40 MG PO TABS	Yes
33200	ATORVASTATIN CALCIUM 80 MG PO TABS	Yes

4. If the medication dosage is unknown, select the name and route of the medication only.



33205	LIPITOR 80 MG PO TABS
56938	LIPITOR PO
22636	ATORVASTATIN CALCIUM 10 MG PO TABS
22638	ATORVASTATIN CALCIUM 20 MG PO TABS
69236	VENTOLIN HFA IN
69237	VENTOLIN IN
69238	VENTOLIN PO

The Medication Details screen displays. As a general rule, Abstractors do not adjust any of the information. Clinical staff and providers can adjust information such as dose, route, frequency, start date and so forth, if known.

**New Medications**

**Atorvastatin (LIPITOR) 40 MG PO TABS**  
Take 40 mg by mouth every night at bedtime. Patient takes this medication in the morning,  
Informant: Patient

**Taking?** ☒ ☐ ☐

Accept Cancel

Dose: 40 mg 40 mg

Route: Oral Oral

Frequency: QHS QHS Daily

Starting: 2/14/2007 Ending:

Instructions: Patient takes this medication in the morning

Informant: Patient

Indications: ☐ Cardiovascular Disease ☐ Cerebrovascular Accident ☐ Familial Heterozygous Hyperc...  
☐ Familial Homozygous Hypercho... ☐ Juvenile Rheumatoid Arthritis ☐ Myocardial Infarction  
☐ Nonfamilial Heterozygous Hyp... ☐ Rheumatoid Arthritis ☐ Type II A Hyperlipidemia  
☐ Type II B Hyperlipidemia ☐ Type III Hyperlipidemia ☐ Type IV Hyperlipidemia  
☐ Additional clinical indications

Provider: SNAPPEA, CHRIS

Accept Cancel

5. Click **Accept**.


- The medication appears on the Medications list.

Vitals Medications Progress Notes Immunizations Enter Results

**New Medications**

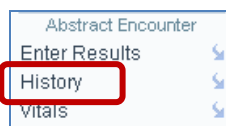
**Atorvastatin (LIPITOR) 40 MG PO TABS**  
Take 1 Tab by mouth every night at bedtime.

**Taking?** ☒ ☐ ☐

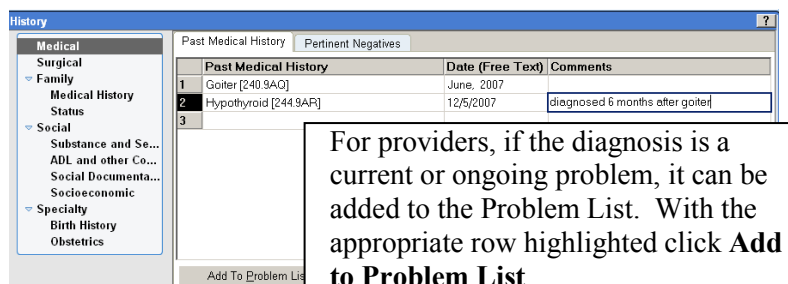
- The  indicates the medication is historical and patient reported.
- Red checkmarks in the *Taking* column automatically display and indicate actively taking medications.

## Entering Patient Medical and Surgical Histories

1. Click **History** from the navigator.



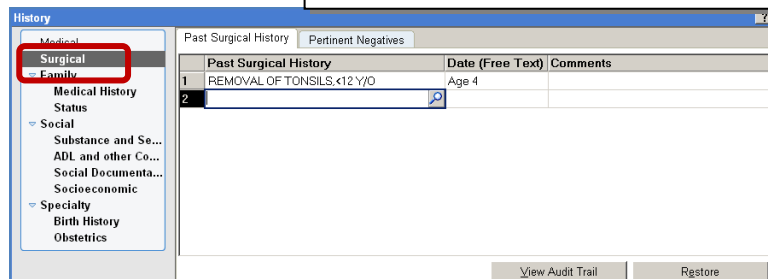
2. Complete the columns. Enter diagnosis or ICD-9 code. Enter date of onset, if known. Comments can be added, if appropriate.



Past Medical History		Date (Free Text)	Comments
1	Goiter [240.9A0]	June, 2007	
2	Hypothyroid [244.9AR]	12/5/2007	diagnosed 6 months after goiter
3			

For providers, if the diagnosis is a current or ongoing problem, it can be added to the Problem List. With the appropriate row highlighted click **Add to Problem List**.

3. Click **Surgical**.
4. Enter the surgical procedure or CPT code. Enter Date if known. Comments can be added if appropriate.



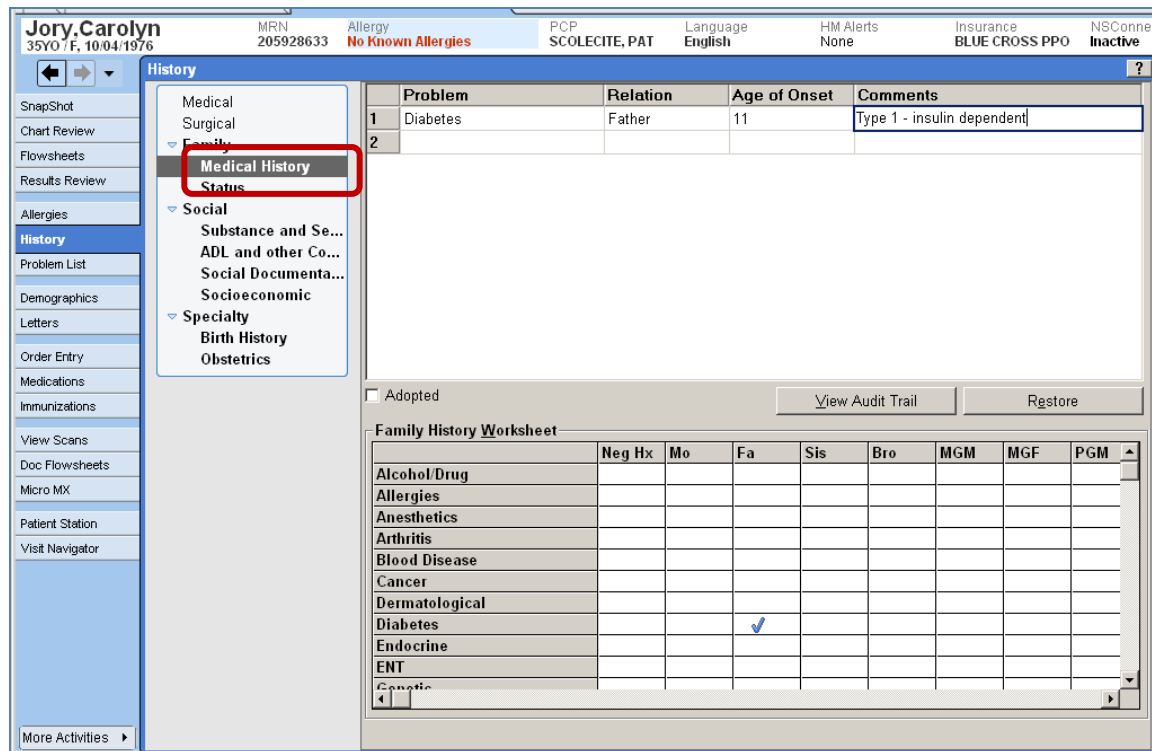
Past Surgical History		Date (Free Text)	Comments
1	REMOVAL OF TONSILS.<12 Y/O	Age 4	
2			

## Family History and Status

There are two sections in Family History: Family Medical History and Family Status.

### Family Medical History

- Under **Family**, click **Medical History**.



**Jory, Carolyn**  
35Y07F, 10/04/1976

MRN 205928633 Allergy No Known Allergies PCP SCOLECITE, PAT Language English HM Alerts None Insurance BLUE CROSS PPO NSConnect Inactive

**History**

- Medical
- Surgical
- Family
  - Medical History**
  - Status
- Social
  - Substance and Se...
  - ADL and other Co...
  - Social Documenta...
  - Socioeconomic
- Specialty
  - Birth History
  - Obstetrics

Problem	Relation	Age of Onset	Comments
1 Diabetes	Father	11	Type 1 - insulin dependent
2			

☐ Adopted View Audit Trail Restore

**Family History Worksheet**

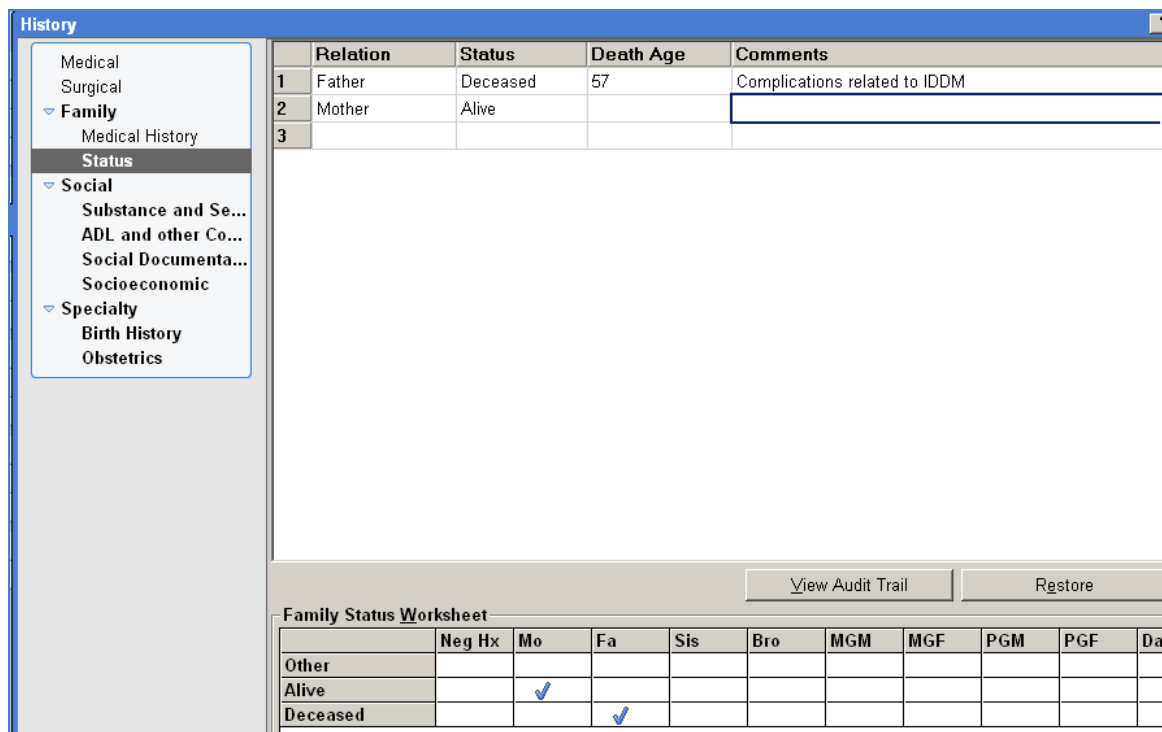
	Neg Hx	Mo	Fa	Sis	Bro	MGM	MGF	PGM
Alcohol/Drug								
Allergies								
Anesthetics								
Arthritis								
Blood Disease								
Cancer								
Dermatological								
Diabetes			✓					
Endocrine								
ENT								
Genetic								

- Use the Family History Worksheet grid to quickly enter data. Click in the cell at the *intersection* of a family member and problem to create a list. More detail can be added in the Age of Onset and Comments columns.



## Family Status

1. **Family Status** is used to document whether family members are alive or deceased.



	Relation	Status	Death Age	Comments
1	Father	Deceased	57	Complications related to IDDM
2	Mother	Alive		
3				

Family Status Worksheet										
	Neg Hx	Mo	Fa	Sis	Bro	MGM	MGF	PGM	PGF	Da
Other										
Alive		✓								
Deceased			✓							

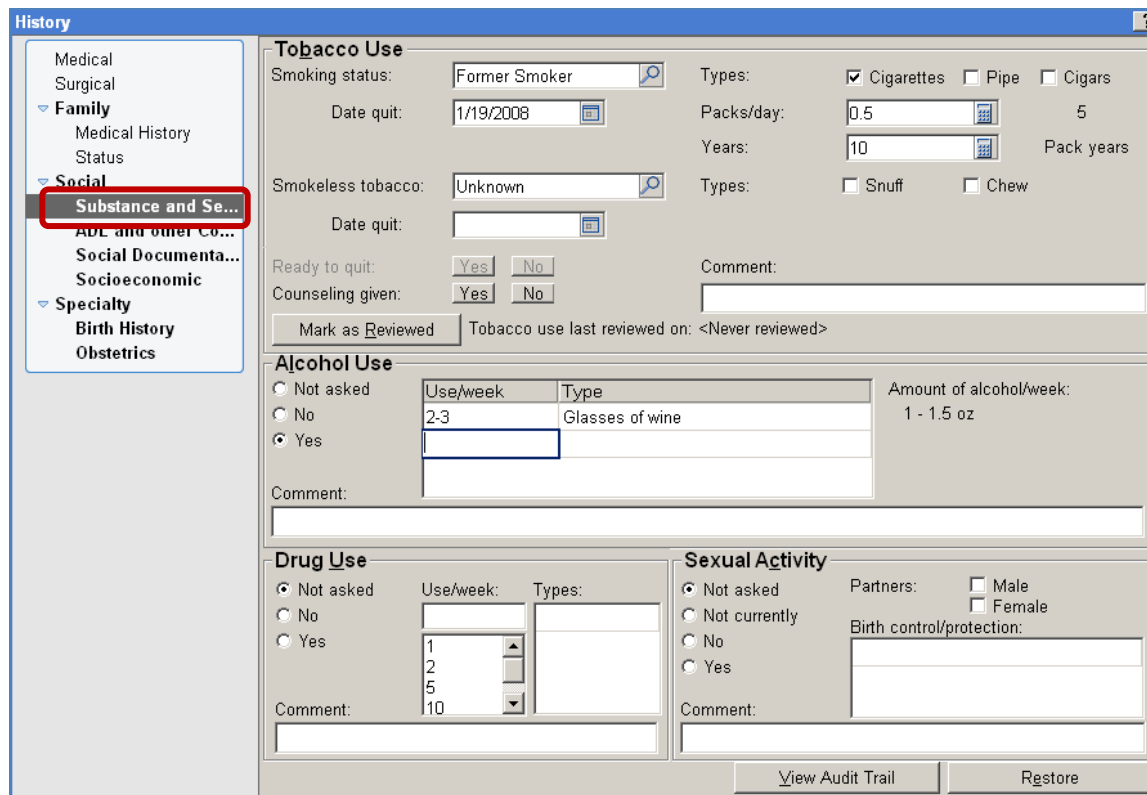
2. Click in the cell at the *intersection* field. Similar to Family Medical History, additional information can be added in the Death Age or Comments column.

## Social History

Social History encompasses patient information pertaining to tobacco, alcohol, drugs, sexual activity, activities of daily living (ADLs) and socio-economic data. This section is optional for abstraction.

### Substance and Sexuality

1. Click **Substance and Sexuality** under the Social History section. It is divided into 3 sections: Tobacco Use, Alcohol Use, and Drug Use.
2. Enter the available information in the appropriate section.



**History**

- Medical
- Surgical
- Family
  - Medical History
  - Status
- Social**
  - Substance and Sexuality**
  - ADL and other Co...
  - Social Documenta...
  - Socioeconomic
- Specialty
  - Birth History
  - Obstetrics

**Tobacco Use**

Smoking status:  Types: ☒ Cigarettes ☐ Pipe ☐ Cigars

Date quit:  Packs/day:  5

Years:  Pack years

Smokeless tobacco:  Types: ☐ Snuff ☐ Chew

Date quit:

Ready to quit:   Comment:

Counseling given:

Tobacco use last reviewed on: <Never reviewed>

**Alcohol Use**

☐ Not asked ☐ No ☒ Yes

Use/week	Type	Amount of alcohol/week:
2-3	Glasses of wine	1 - 1.5 oz
<input type="text"/>	<input type="text"/>	<input type="text"/>

Comment:

**Drug Use**

☒ Not asked ☐ No ☐ Yes

Use/week:	Types:
1	<input type="text"/>
2	<input type="text"/>
5	<input type="text"/>
10	<input type="text"/>

Comment:

**Sexual Activity**

☒ Not asked ☐ Not currently ☐ No ☐ Yes

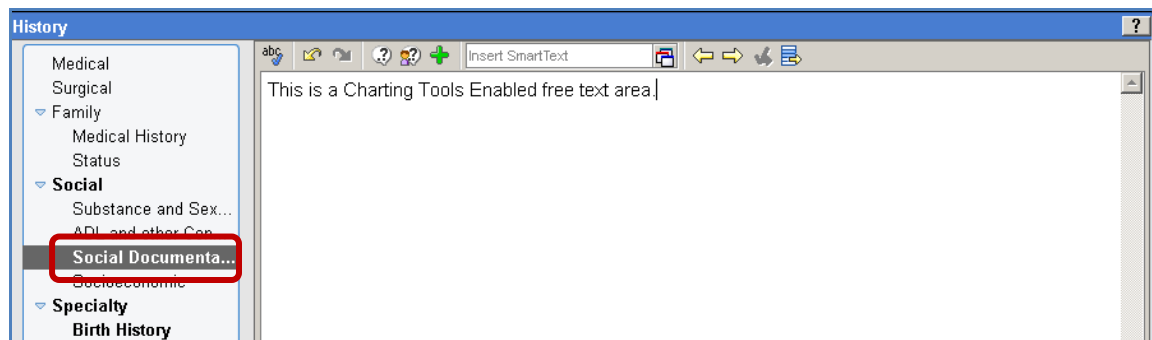
Partners: ☐ Male ☐ Female

Birth control/protection:

Comment:

## Social Documentation

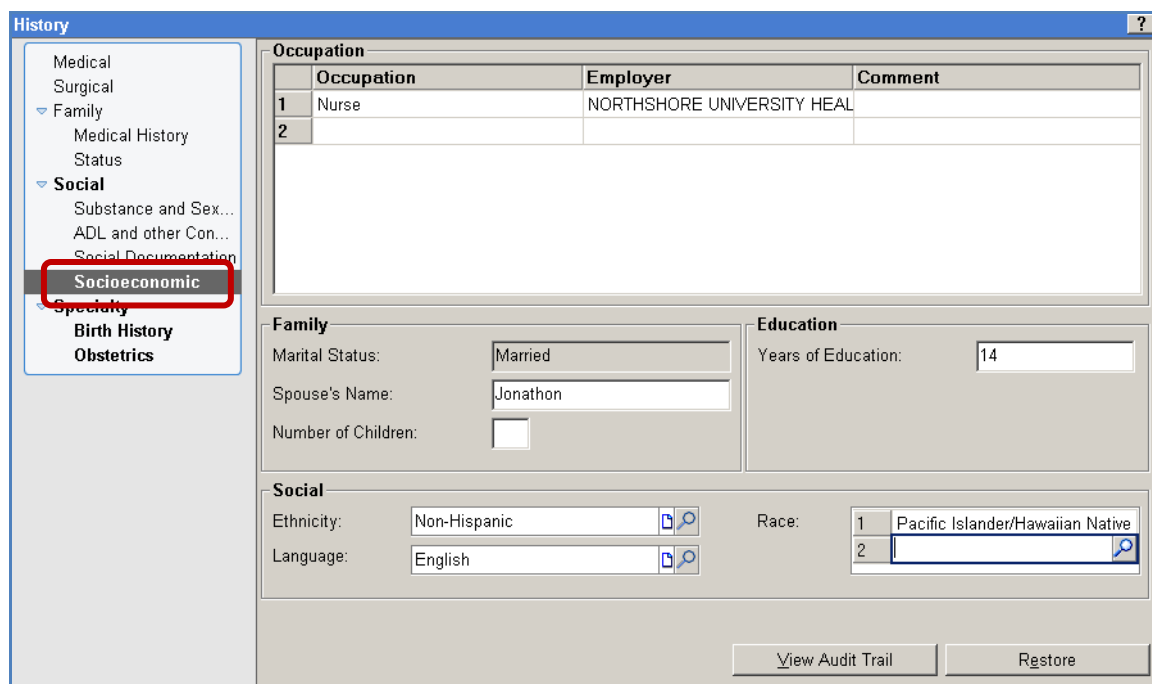
1. Click **Social Documentation**. This free text field can be used for any type of information, such as family or social issues, etc.



The screenshot shows the EPIC History window. On the left sidebar, under the 'Social' category, 'Social Documenta...' is highlighted with a red box. The main window area contains a text field with the placeholder text 'This is a Charting Tools Enabled free text area'.

## Socioeconomic

1. Click **Socioeconomic**. This field is completed during the registration process.
2. Note that more Demographic information is available by clicking the **Demographics** tab in the Activities column.



The screenshot shows the EPIC History window with the 'Socioeconomic' tab selected in the left sidebar. The main window displays demographic information:

Occupation		
Occupation	Employer	Comment
1 Nurse	NORTHSHORE UNIVERSITY HEAL	
2		

Below the table, there are sections for Family, Education, and Social information:

- Family:** Marital Status: Married; Spouse's Name: Jonathon; Number of Children: [empty field]
- Education:** Years of Education: 14
- Social:** Ethnicity: Non-Hispanic; Language: English; Race: 1 Pacific Islander/Hawaiian Native; 2 [empty field]

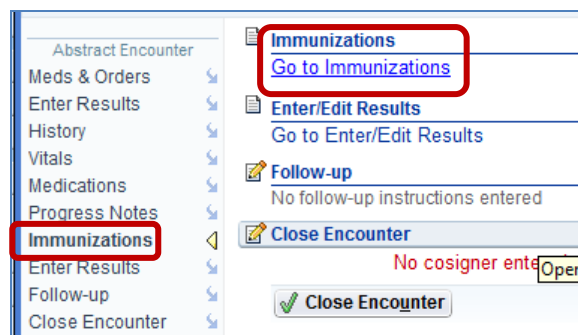
At the bottom right, there are buttons for 'View Audit Trail' and 'Restore'.

**! Clinicians will review and update social history information at the beginning of each patient visit.**

## Immunizations/Injections

Historic immunizations and injections are entered here. Childhood vaccinations, tetanus shots, pneumonia and flu shots, etc., given prior to this visit may be entered to document the Administration History.

1. Click **Immunizations** from the navigator.
2. Click **Go to Immunizations** hyperlink.



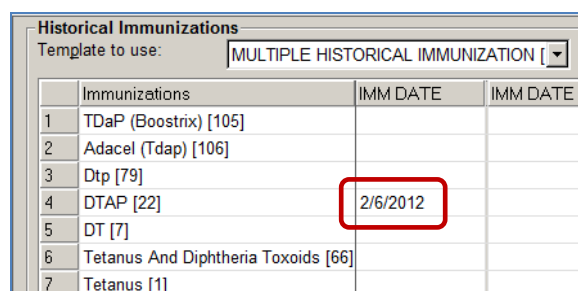
The screenshot shows the Epic Ambulatory Medical Record interface. On the left sidebar, the 'Immunizations' link is highlighted with a red box. On the right pane, the 'Immunizations' section is expanded, and the 'Go to Immunizations' link is highlighted with a red box. Other visible links include 'Enter/Edit Results', 'Follow-up', and 'Close Encounter'.

3. Click **Historical Admins.**



The screenshot shows the 'Immunizations - All Types' toolbar. The 'Historical Admins' button is highlighted with a red box. Other buttons visible include 'All Admin Types', 'Incomplete Admins', 'New Admin', 'Immunization Report', 'E-Sign', 'Refresh', and 'Storage Unit'.

4. Enter immunization dates in the correct immunization row.
5. Click **Accept**.



The screenshot shows the 'Historical Immunizations' table. The table has columns for 'Immunizations', 'IMM DATE', and 'IMM DATE'. The 'DTAP' row (row 4) has the date '2/6/2012' entered in the 'IMM DATE' column, which is highlighted with a red box. The table also includes a 'Template to use' dropdown set to 'MULTIPLE HISTORICAL IMMUNIZATION'.

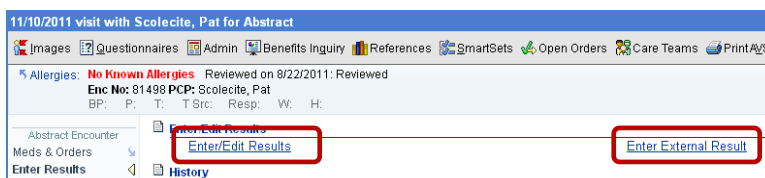
	Immunizations	IMM DATE	IMM DATE
1	TDaP (Boostrix) [105]		
2	Adacel (Tdap) [106]		
3	Dtp [79]		
4	DTAP [22]	2/6/2012	
5	DT [7]		
6	Tetanus And Diphtheria Toxoids [66]		
7	Tetanus [1]		

## Entering External Results

Past non-NorthShore test results can be abstracted into Epic. Some test results may include Laboratory, Radiology, Nuclear Medicine, EKG interpretations, and Mammograms.

Test results from outside agencies can be entered using the External Results function.

1. Click **Enter Results** in the navigator.
2. Click **Enter External Result** hyperlink.
3. A window appears. To enter a common Lab Test, click the '+' sign next to Lab Tests to expand the list.
4. Check the box beside the corresponding lab. You may select more than one lab. If a test is not listed, use the search tool in the Additional test field to locate the test.
5. Enter the name of the provider who ordered the test, if known.
6. Click **Accept**.



11/10/2011 visit with Scolecite, Pat for Abstract

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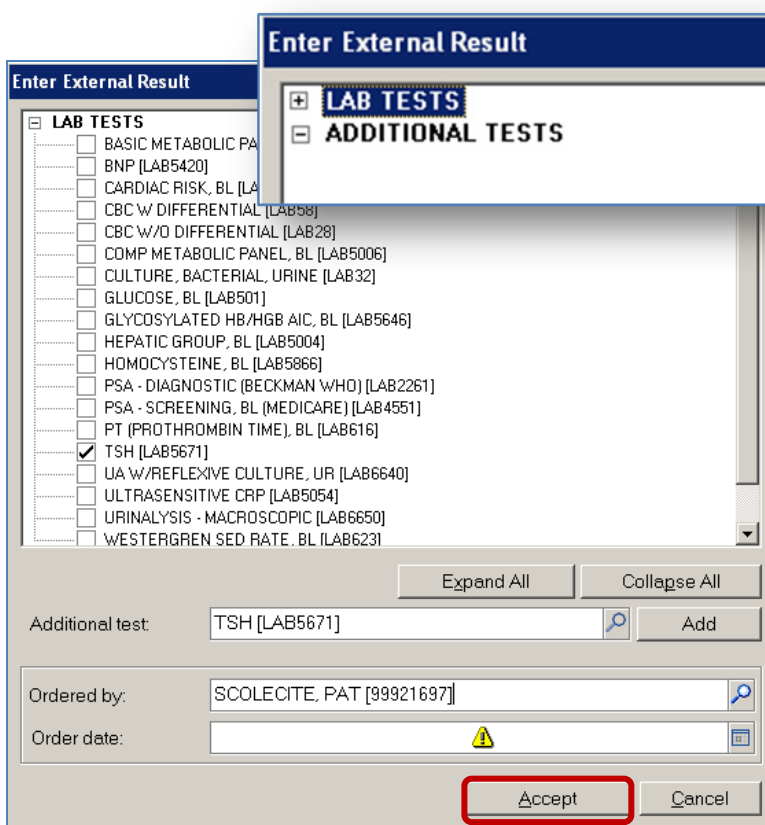
Allergies: No Known Allergies Reviewed on 8/22/2011: Reviewed

Enc No: 81498 PCP: Scolecite, Pat

BP: P: T: T Src: Resp: W: H:

Abstract Encounter Meds & Orders Enter Results History

Enter/Edit Results Enter External Result



Enter External Result

LAB TESTS

LAB TESTS

ADDITIONAL TESTS

BASIC METABOLIC PA

BNP [LAB5420]

CARDIAC RISK, BL [LA

CBC W/ DIFFERENTIAL [LAB58]

CBC W/O DIFFERENTIAL [LAB28]

COMP METABOLIC PANEL, BL [LAB5006]

CULTURE, BACTERIAL, URINE [LAB32]

GLUCOSE, BL [LAB501]

GLYCOSYLATED HB/HGB A1C, BL [LAB5646]

HEPATIC GROUP, BL [LAB5004]

HOMOCYSTEINE, BL [LAB5866]

PSA - DIAGNOSTIC (BECKMAN WHO) [LAB2261]

PSA - SCREENING, BL (MEDICARE) [LAB4551]

PT (PROTHROMBIN TIME), BL [LAB616]

☒ TSH [LAB5671]

UA W/REFLEXIVE CULTURE, UR [LAB6640]

ULTRASENSITIVE CRP [LAB5054]

URINALYSIS - MACROSCOPIC [LAB6650]

WESTERGREN SED RATE, BL [LAB6231]

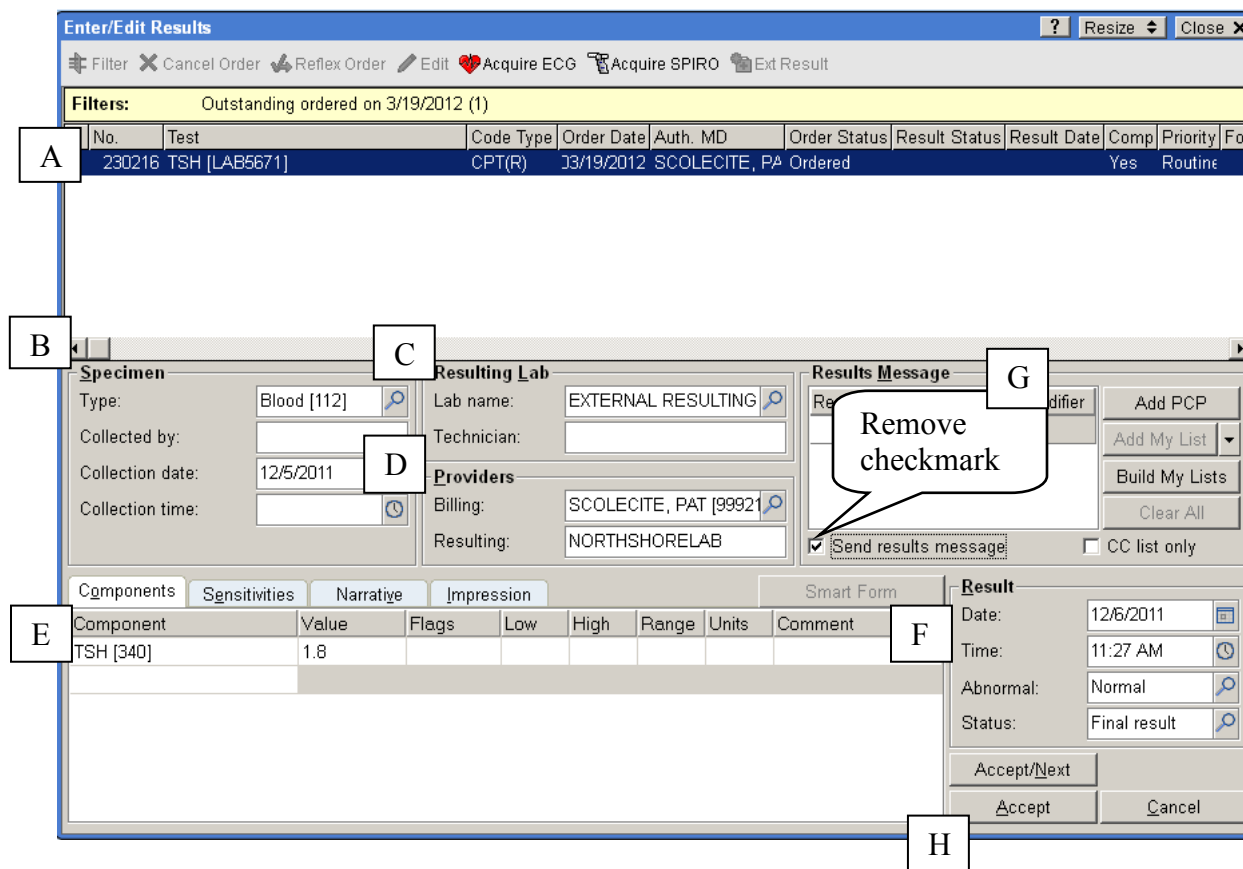
Expand All Collapse All

Additional test: TSH [LAB5671] Add

Ordered by: SCOECITE, PAT [99921697]

Order date: [Warning Icon]

Accept Cancel

7. The **Enter/Edit Results** window displays.


The screenshot shows the 'Enter/Edit Results' window. Callout A points to the test list table. Callout B points to the Specimen section. Callout C points to the Resulting Lab section. Callout D points to the Providers section. Callout E points to the Component tab. Callout F points to the Result section. Callout G points to the 'Send results message' checkbox with a speech bubble saying 'Remove checkmark'. Callout H points to the 'Accept' button.

No.	Test	Code Type	Order Date	Auth. MD	Order Status	Result Status	Result Date	Comp	Priority	Foll
230216	TSH [LAB5671]	CPT(R)	3/3/2012	SCOLECITE, PA	Ordered			Yes	Routine	

**Filters:** Outstanding ordered on 3/19/2012 (1)

**Specimen**  
 Type: Blood [112]  
 Collected by:   
 Collection date: 12/5/2011  
 Collection time:

**Resulting Lab**  
 Lab name: EXTERNAL RESULTING  
 Technician:   
 Billing: SCOLECITE, PAT [99921]  
 Resulting: NORTSHORELAB

**Providers**  
 Billing: SCOLECITE, PAT [99921]  
 Resulting: NORTSHORELAB

**Results Message**  
☒ Send results message  
☐ CC list only

**Components** | Sensitivities | Narrative | Impression | Smart Form

Component	Value	Flags	Low	High	Range	Units	Comment
TSH [340]	1.8						

**Result**  
 Date: 12/6/2011  
 Time: 11:27 AM  
 Abnormal: Normal  
 Status: Final result  
 Accept/Next  
 Accept Cancel

- Select or verify that the correct test is highlighted.
- Specimen section: Enter the Type of specimen and the Collection date.
- Resulting Lab section: Change the Lab name to External Resulting Agency to indicate it was completed outside of NorthShore.
- Providers section: Billing is the name of the provider who ordered the test. It can be left blank if the provider is not listed in the system. Resulting will automatically default with NORTSHORE LAB; you do not need to delete this.
- Component tab: Enter the value of the test.  
Clinicians may enter additional information in the Narrative or Impression tabs.
- Result section: Enter the Date the test was resulted. Enter Time if known. Specify if the test was Abnormal or Normal. Change the **Status** to **Final result**.
- Once the result is marked "Final result" the system places a checkmark in the box next to "Send results message." Remove this checkmark, since these are historic results that the physician has already reviewed.
- Click **Accept**.

## Vital Signs

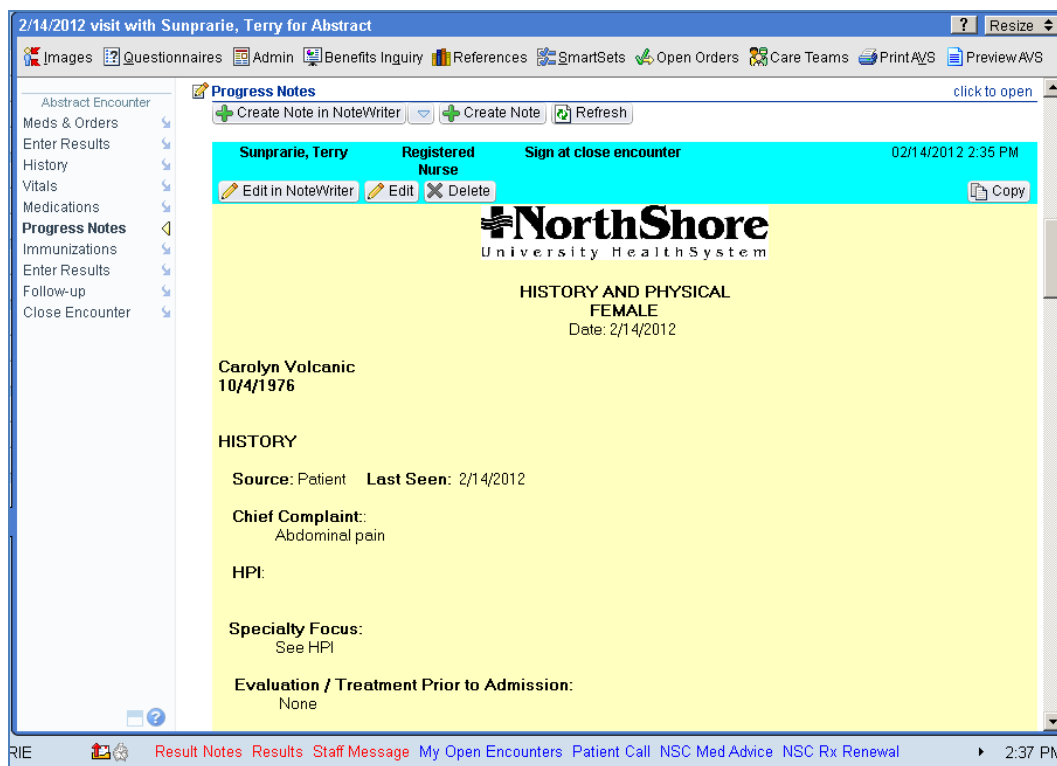
To enter past vital signs, click **Vitals** in the navigator or click **New Set of Vitals** within the Encounter.

1. In the *Taken on* field, change the date to match the date the vital signs were taken.
2. Enter values in the corresponding fields.

Vitals			
<b>Taken on:</b> 2/14/2012 1429			
BP:	100/70	SpO2:	
Pulse:	74	Weight:	
Resp:	24	Height:	
Temp:	100 F (37.8 C)		
Source:	Oral		
<b>Pain Information</b>		Score: <input type="text"/>	
		Location: <input type="text"/>	
		Educated?: <input type="text"/>	
		Comment: <input type="text"/>	
<b>OB/Gyn Status</b>			
LMP:			
Having periods?		<input type="radio"/> Yes <input type="radio"/> No	
Breastfeeding?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
<input type="button" value="Mark as Reviewed"/>		<input type="button" value="Never Reviewed"/>	
<b>Tobacco Use</b>			
<b>Former Smoker (Quit: 1/14/1999)</b>		Cigarettes	
Packs/day: 0.8	Years: 7	Pack Years: 5.6	
<b>Smokeless: Unknown</b>		Ready to quit: <input type="button" value="Yes"/> <input type="button" value="No"/>	
		Counseling given: <input type="button" value="Yes"/> <input type="button" value="No"/>	
<input type="button" value="Mark as Reviewed"/>		<b>Last reviewed: 2/14/2012</b>	
		<input type="button" value="Edit Tobacco Use"/>	

## Progress Notes

Progress Notes are another optional field. There may be an H&P that you would like entered as baseline information, for example. You may elect to summarize the patient's history from the paper chart available in the office. Each physician may choose what information, if any, to put in this field. It is Charting Tool-enabled.



2/14/2012 visit with Sunprarie, Terry for Abstract

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**Progress Notes** [click to open](#)

Create Note in NoteWriter Create Note Refresh

Sunprarie, Terry Registered Nurse Sign at close encounter 02/14/2012 2:35 PM

Edit in NoteWriter Edit Delete Copy

**NorthShore**  
University Health System

**HISTORY AND PHYSICAL**  
FEMALE  
Date: 2/14/2012

**Carolyn Volcanic**  
10/4/1976

**HISTORY**

Source: Patient Last Seen: 2/14/2012

**Chief Complaint:**  
Abdominal pain

**HPI:**

**Specialty Focus:**  
See HPI

**Evaluation / Treatment Prior to Admission:**  
None

RIE Result Notes Results Staff Message My Open Encounters Patient Call NSC Med Advice NSC Rx Renewal 2:37 PM



## Provider Only: Entering Problems on the Problem List

Click **Problem List** to enter the patient's current or ongoing medical problems into the Abstract Encounter. The physician or his/her designee will have reviewed the patient's paper record and determined what problems need to be entered into the EHR.

**! The Problem List should only be documented by the provider.**

1. Open the **Problem List** section from the Activities column.

2. In the **Search for new item** field, enter the medical problem or ICD-9 code and click **Add**.

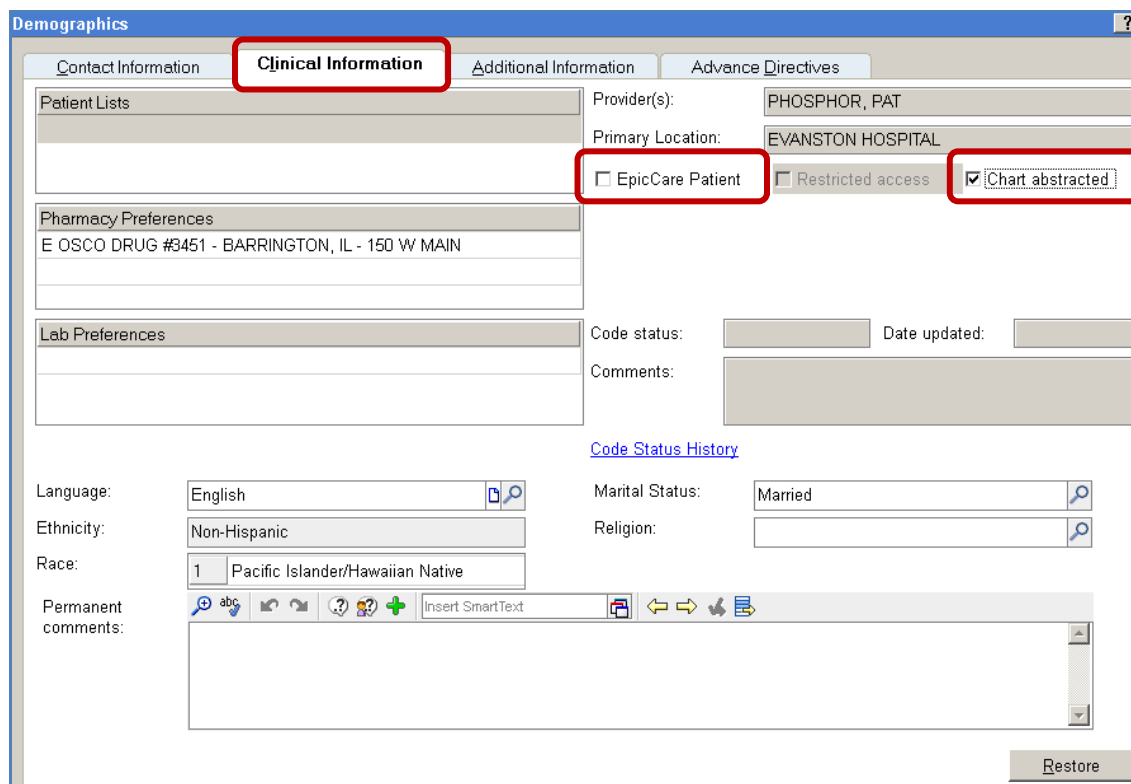
- Note the **Code Search** button is available if you are uncertain of the ICD-9 code.

ID	Name	Code
337.1	HYPERTHYROID(aka Peripheral autonomic neuropathy in disorders classified elsewhere)	337.1
242.90D	Hyperthyroidism	242.90
648.10C	Hyperthyroidism complicating pregnancy	648.10
242.40A	Hyperthyroidism due to ectopic thyroid nodule	242.40
242.80D	Hyperthyroidism due to hydatidiform mole	242.80
242.81C	Hyperthyroidism due to hydatidiform mole with thyrotoxic crisis	242.81
242.81D	Hyperthyroidism due to hydatidiform mole with thyrotoxic storm	242.81
242.80C	Hyperthyroidism due to molar thyrotoxin	242.80
242.80E	Hyperthyroidism due to struma ovarii	242.80
648.13J	Hyperthyroidism in pregnancy, antepartum	648.13
242.80L	Hyperthyroidism secondary to amiodarone	242.80
242.80K	Hyperthyroidism secondary to potassium iodide	242.80
242.80J	Hyperthyroidism secondary to radio contrast dyes	242.80
242.80M	Hyperthyroidism with Hashimoto disease	242.80
242.91U	Hyperthyroidism with storm	242.91
242.90AH	Hyperthyroidism without goiter	242.90
242.90AJ	Hyperthyroidism without goitre	242.90
648.13G	Hyperthyroidism, maternal, antepartum	648.13
242.90AG	Hyperthyroidism, subclinical	242.90
245.2AX	Hyperthyroiditis	245.2

3. Select the appropriate diagnosis from the list and click **Accept**.
4. Complete the fields. Today's date defaults. In the Overview box, add comments, if needed.
5. Click the **File to History** button at the bottom left to automatically file the diagnosis and date in the patient's Past Medical History. Note that the comments do not transfer.
6. Click **Accept**.

## Closing Abstract Encounters

1. Review the paper chart, the Clinical Summary, and other available data to determine the completeness of the information in the Abstract encounter.
2. Go to the **Demographics** tab in the Activities column.
3. Click the **Clinical Information** tab.
4. Check the **EpicCare Patient** box.
5. Check the **Chart abstracted** box.



The screenshot shows the 'Demographics' window with the 'Clinical Information' tab selected. The 'EpicCare Patient' checkbox is checked, and the 'Chart abstracted' checkbox is also checked. The 'Provider(s)' field is 'PHOSPHOR, PAT' and the 'Primary Location' is 'EVANSTON HOSPITAL'. The 'Language' is 'English', 'Ethnicity' is 'Non-Hispanic', and 'Race' is '1 Pacific Islander/Hawaiian Native'. The 'Marital Status' is 'Married'. The 'Code status' is 'Code status: ' and 'Date updated: '. The 'Comments' field is empty. The 'Permanent comments' field is empty. The 'Restore' button is at the bottom right.

6. Return to Visit Navigator and click **Close Encounter**.

Link to Online Module:

<https://northshore.csod.com/catalog/SearchAdvanced.aspx>