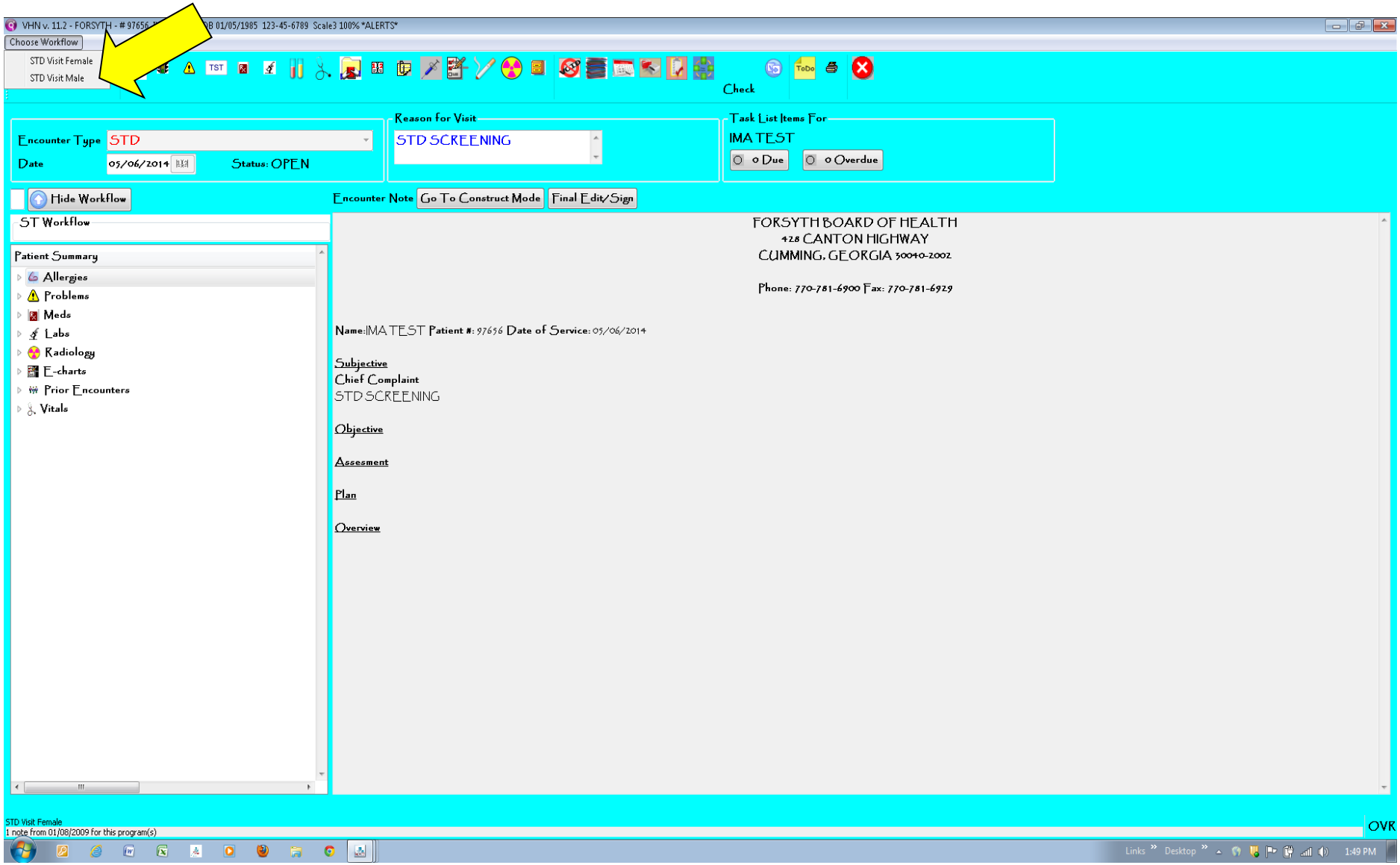
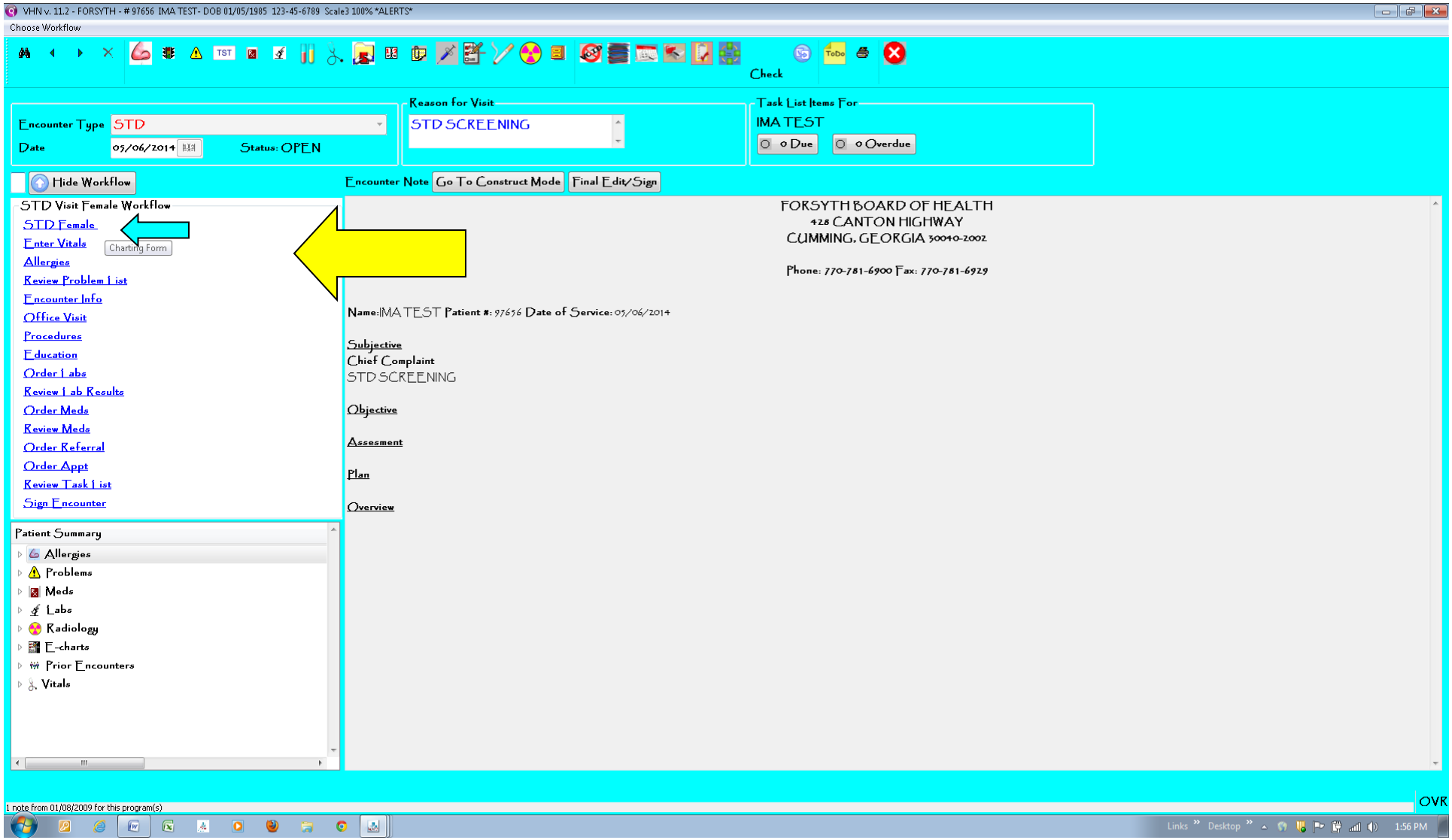
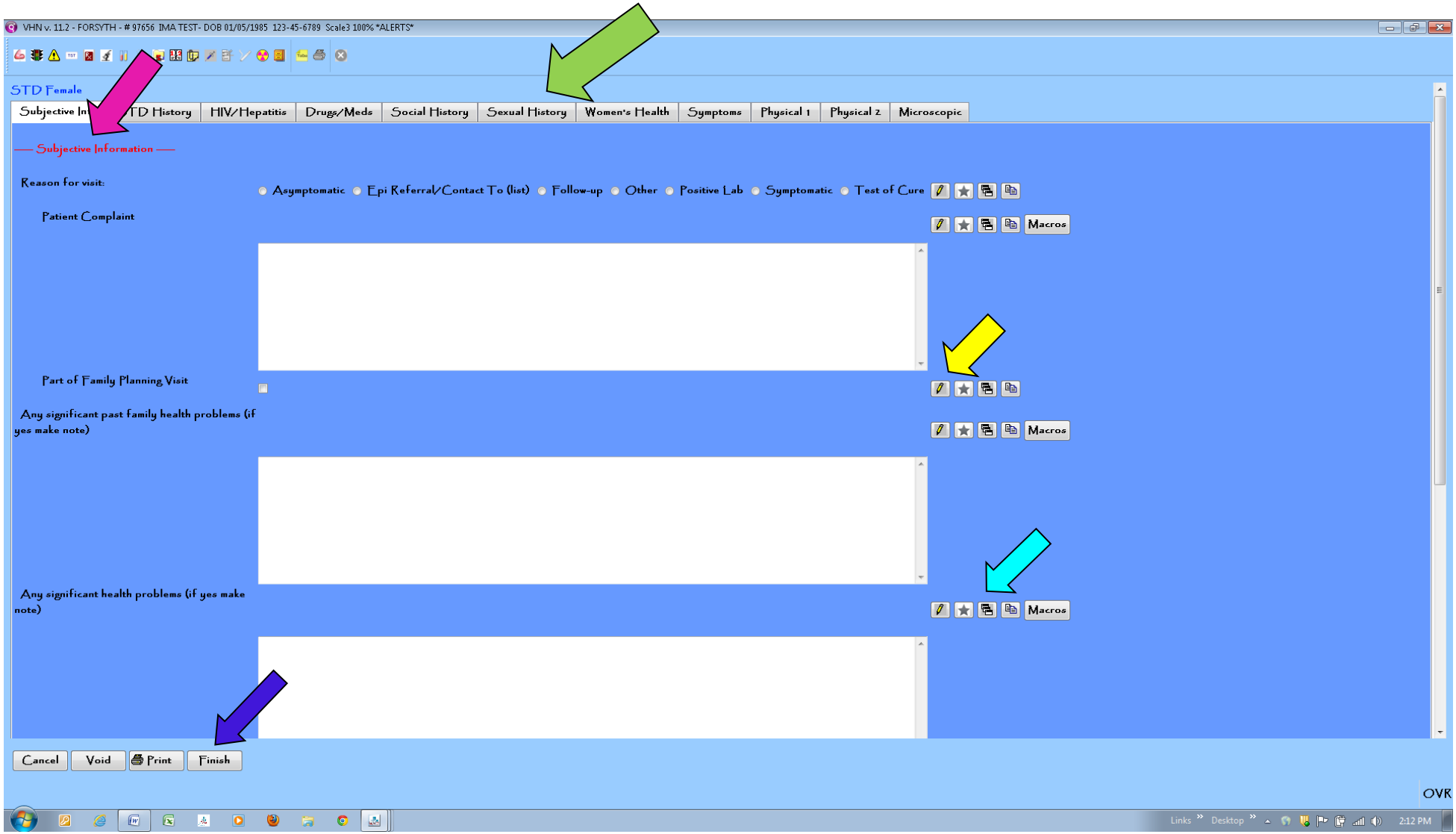


From Encounter Page choose appropriate Encounter Workflow .



Your Encounter workflow should look like this, as you begin to go down the list of items they will check green. You may not need/use every task; they simply serve as reminders or shortcuts. The very first item is the E-Chart (formally known as the gold sheet). The E-chart would be filled out with a new visit/new problem. If the visit is a follow-up visit for treatment/results within a short time frame, then a new e-chart doesn't need to be filled out, only the Encounter (you can reference the e-chart date and other information in your narrative notes, more to come on that later!). If the patient had a lot of changes between the original visit and the follow-up visit the nurse may fill out a new E-chart at their discretion.

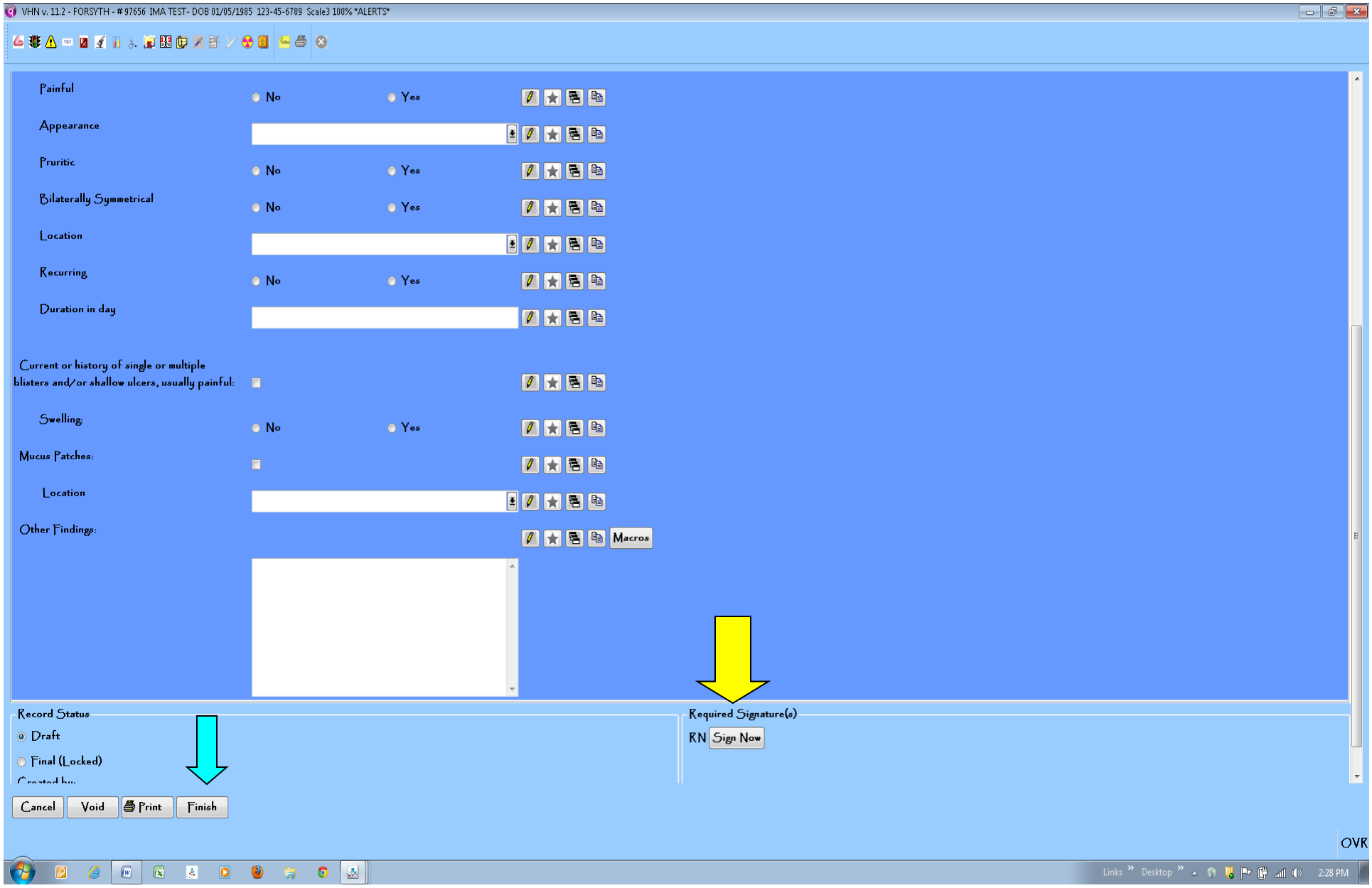


Navigating through the E-chart:

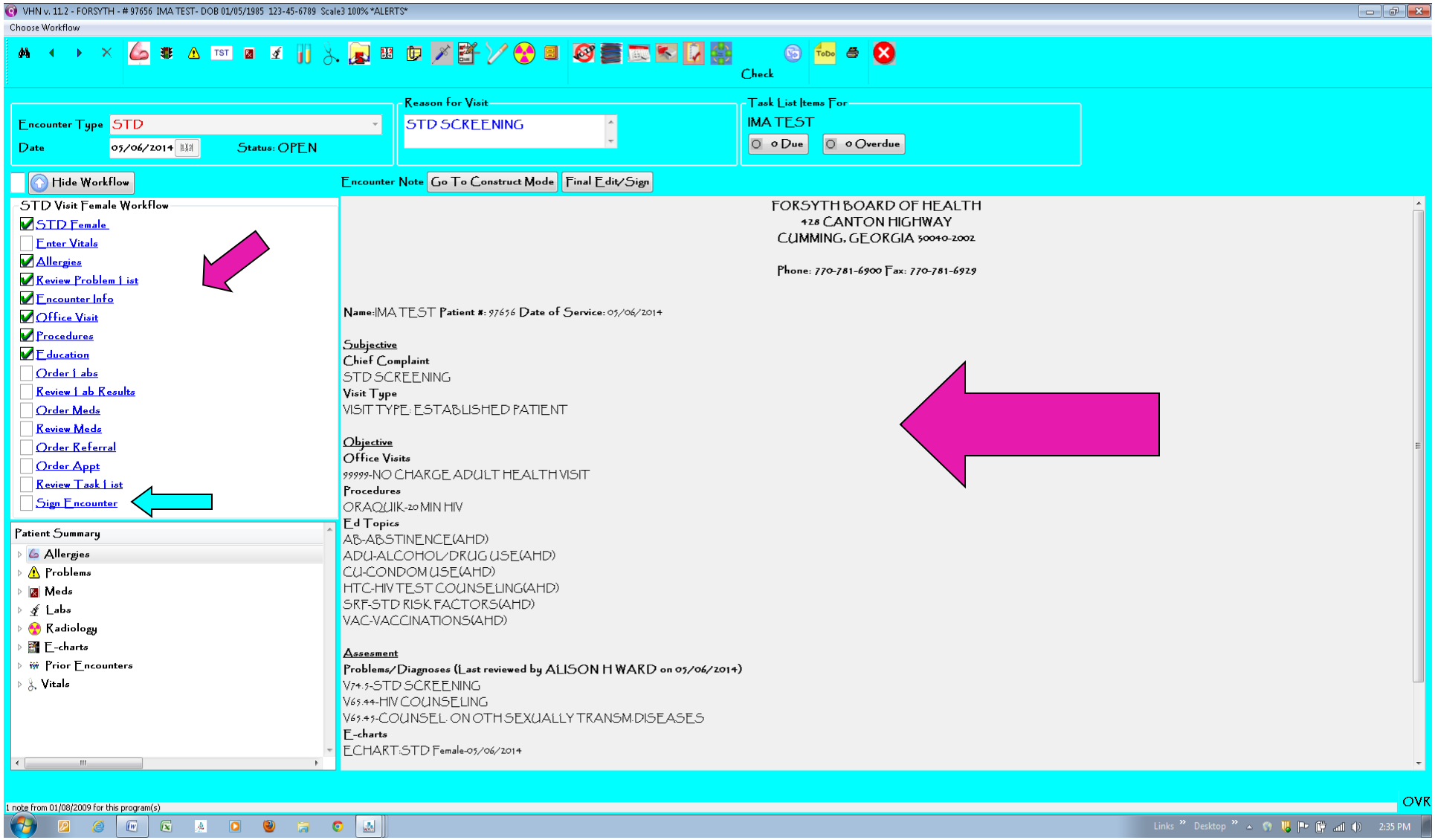
Tabs: Use these to complete and navigate through all sections. Red or Blue Writing: Specific Instructions about the page/item

Pencil: Use this to make notes about specifics. If you write a note, the pencil will turn into a red flag

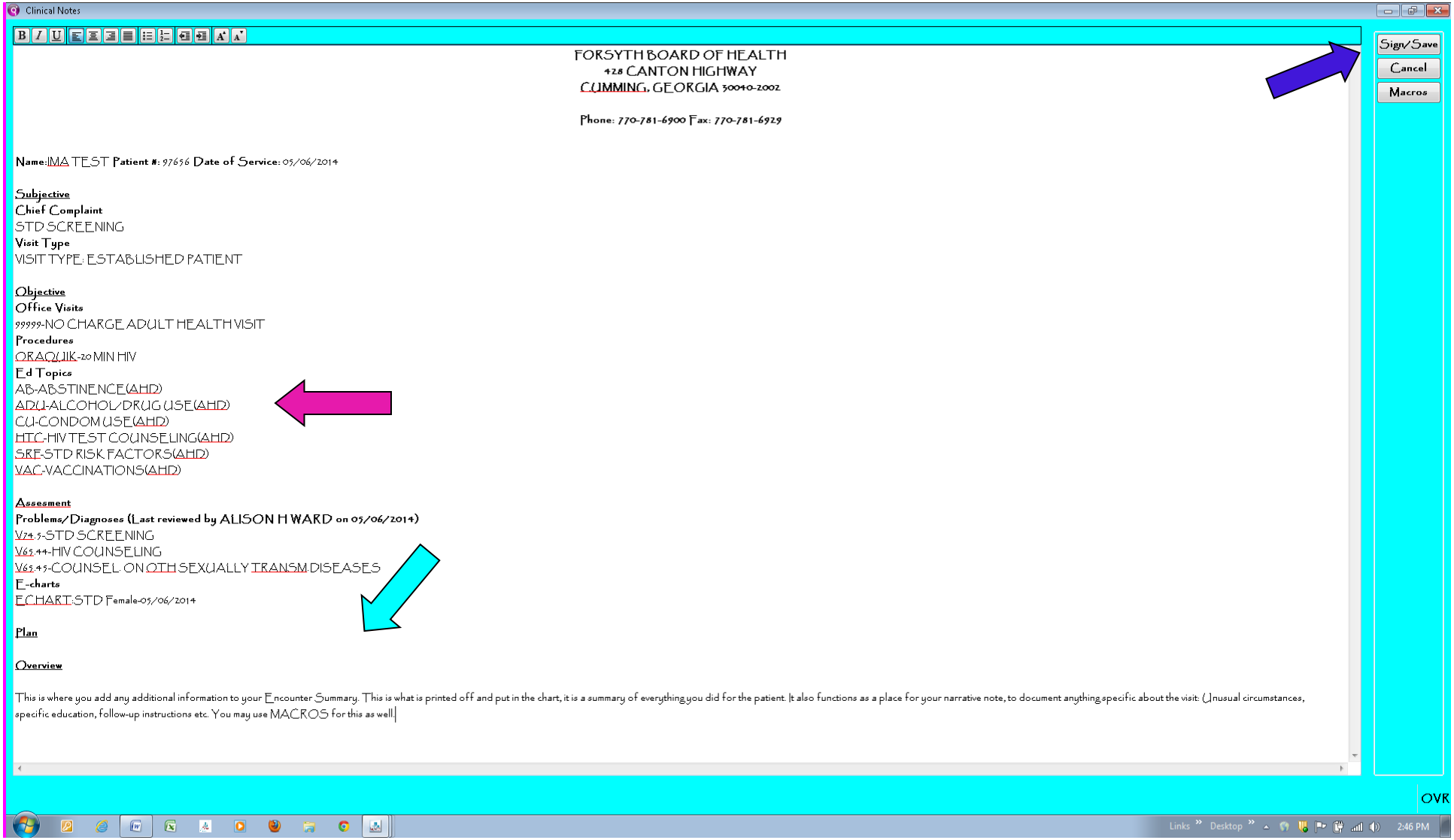
Note card: Click this if you want to see what the answered last time Finish: Use this to save the E-chart for later (can return to update)



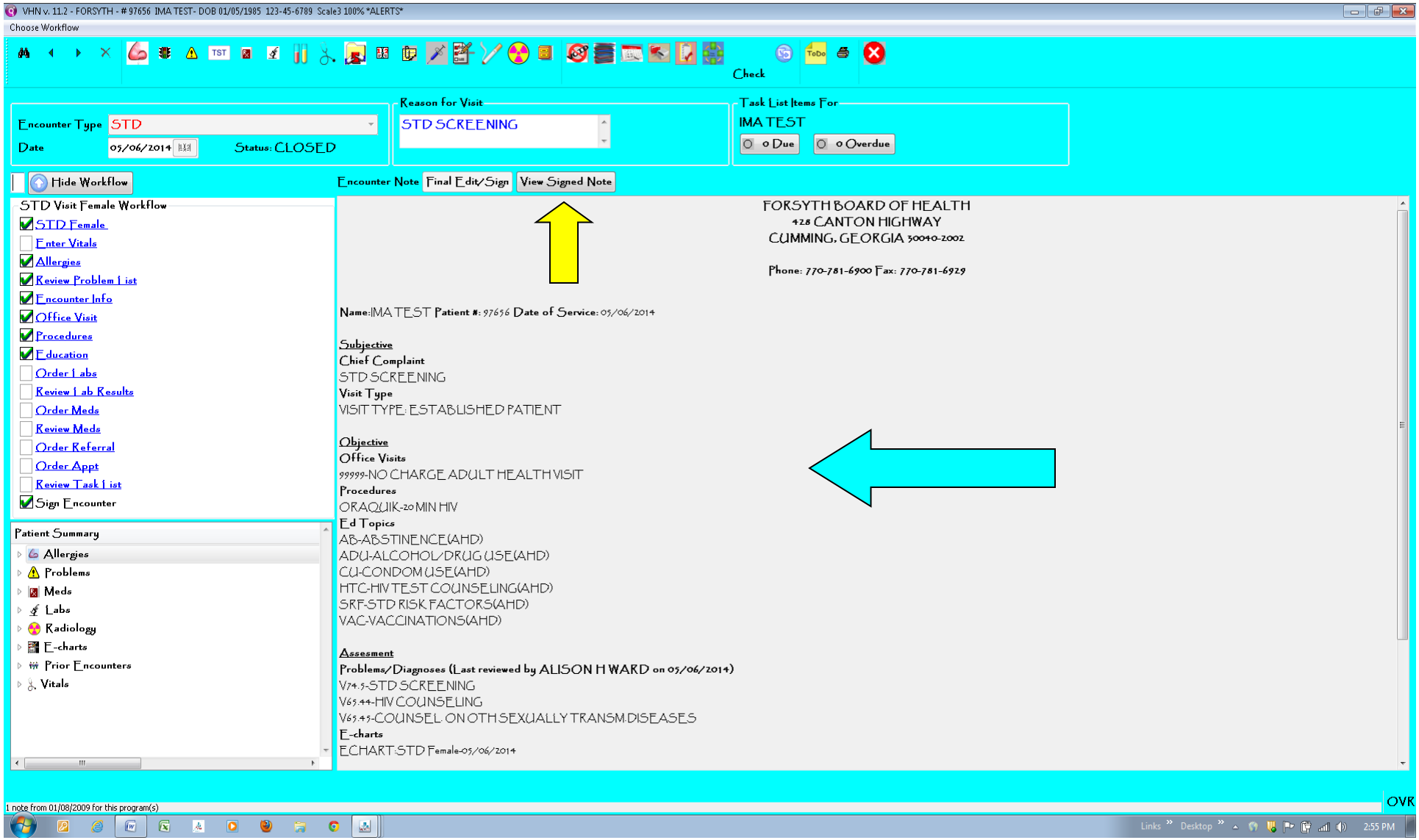
Once you have completed all sections or reviewed responses if someone else worked up the patient, then you will Sign Now to save and lock the e-chart. *hint: you have to scroll to the bottom of the page to find this. Once you Sign Now, then hit Finish to return to the Encounter Page.



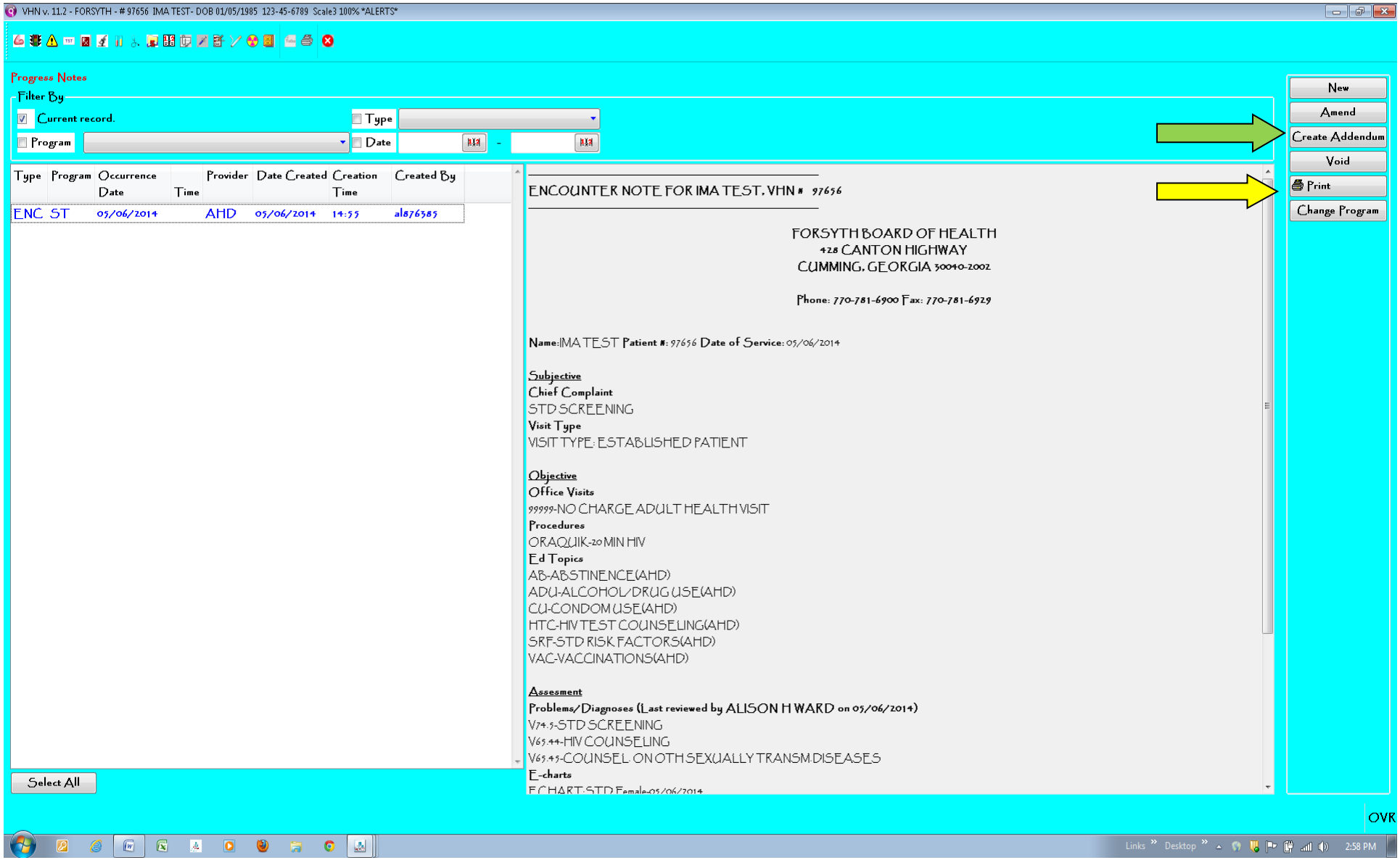
Begin working through the Encounter, the items you complete will pull over into the Encounter Summary. The very last item you will complete is Sign Encounter, this will pop up a new page that you may add a narrative note, before signing and saving.



This is where you may document anything specific about the visit that you want to include on the Encounter Summary. This may include: specifics about any unusual circumstances, referrals, specific education, follow-up instructions, etc. This functions as your Narrative note. Your Education topics are already listed; refer to Definitions on QA key for what is included. You may also elaborate on education in the Narrative Note. Once you are done with your note, you will Sign/Save Once you have Sign/Saved, you will have to create and addendum to add any additional information.



Your Encounter is now complete! To **Print** a copy of your Encounter Summary, including the narrative you added click on View Signed Note.



If you forgot to add an important piece of information, you may add an Addendum to the Encounter Summary here. Otherwise you may **Print!**

The page that is printed from here will be what is put in the chart. The E-chart (the questions/answers form) will **NOT** be printed, but remain in the computer for future reference/audit purposes. You have the ability to print the E-chart if needed, to send with the patient for a referral or records request. This can be done from the main patient page under the “E-charting” symbol.