Document Quick Links:

WHAT IS MOIS?	1
ACCESSING MOIS FROM YOUR DESKTOP	2
SIGNING IN THE FIRST TIME Forgot Your Password Set Default Desktop Provider	3
MOIS MODULES	4
GENERAL TIPS SCHEDULER MODULE View Your Schedule Document an Encounter (Progress Notes, etc.) Create a Service Request (Referral) Create a Service Request (Order/Lab Requisition) WORKSPACE MODULE	5567911233477
APPENDIX	8
HOT KEYS	20
PRINT & POST – PROVIDER START UP QUICK REFERENCE	2

The intention of this Start Up Guide is to help you as a physician, nurse practitioner, resident or medical student get your day started quickly and easily, even if this is the first time using the MOIS program. Only the essentials are noted here. As you become more comfortable with the program, you may not need to reference this guide again.

WHAT IS MOIS?

- The Medical Office Information System or more simply "MOIS", is an Electronic Medical Record (EMR) designed for managing data and used as a tool to provide quality patient care.
- Key functionality of MOIS includes documentation of patient medical records, scheduling, billing, evidence-based patient review, auditing, clinical calculators, and other reporting.
- Northern Health carefully selected MOIS as the standard EMR to be used in their clinics.
- Each clinic has their own "instance" of MOIS (i.e. the patient list and information in the Masset instance differs from the patient list and information in the Valemount instance).



ACCESSING MOIS FROM YOUR DESKTOP

- Locate the Citrix icon ^(C) on your desktop taskbar. (*Note: You may need to expand what icons are shown on your taskbar.*)
- Select MOIS from your Citrix program list.



Signing in the First Time

• A logon screen will appear.

MOIS: Logon	x
MOIS	CREATED BY:
2.16.23 - Spring 2014 Julia 140905 Applica Internations for Health Society, 2013. Il rights reserved.	Suite 200 - 1110 6th Avenue • Prince George British Columbia • V2L 3M6 • www.AlHS.ca OFFICE: 250.564.2644 • FAX: 250.564.2655
User Name: jokeil Password:	Change Password
Ok	Cancel

- Your **User Name** will auto-populate with your Windows user name (i.e. Northern Health user name).
- Enter your temporary **Password**, you will be prompted to change your password at this time.

hange Password	
Current User:	JOKEIL
Current Password:	
New Password:	
Confirm Password:	
🔲 User To Choos	e New Password On Next Login
Chan	cancel



- Your **New Password** must fit the following criteria:
 - Minimum 8 characters
 - Contain at least one capital letter
 - Contain at least one number
- Select Change.

Forgot Your Password

- Contact your site manager/site administrator, they can re-set your account and give you a new temporary password.
- You will be prompted to change your password the next time you sign in.

Set Default Desktop Provider

- The Desktop Provider name fills into requisition forms and other areas of the program, it is important to ensure the correct Desktop Provider is displayed when you are logged in.
- If prompted on your initial sign in, **select** your name from the list of providers and choose "**Save as My Default**".
- Note: Medical students should select the provider they are working with.

Name	Practition No.	Payee No.	Payment Type	Active	Service End	System User Name	-
ALICE, DR	00003	00001		Y		-,	
BILL, DR	00002	00001		Y			
INCOCTOR	00000	00001		Y			
COACH 1		00001		Y			
DR. HOWSER				Y			
DUNLOP, KRISTA				Y			
EMERGENCY		00001		Y			
FSJ UPC		00005		Y			
HARVEY THOMMASEN	00005	00005		Y			
AKES DISTRICT CLINIC				Y			
MCCOY, LEONARD	NCC1701	NCC1701		Y			
MOIS, TEST DR.	00006	00001		Y			
PEREIRA, KATHY				Y			
PRIMARY CARE TEAM 1 PG				Y			
TEAM MOIS TEST DR				Y			
TEST RESIDENTS				Y			
WALK IN	00004	00001		Y			
WORTHINGTON, ROBBIN				Y			
BELLE, DR	00005	00001		Ν			
SHABAKA, TAWFIK				N			
TESTER, WORKSPACE				Ν	2014.11.05		
						\sim	

• The Desktop Provider can be changed at any time by left-clicking in the "Desktop Provider" field in the top right of the screen – a window will pop-up and you can select a new provider name from that list.

ecord <u>M</u> odules	Views Action	Utilities Print	Maintenance <u>H</u> elp	Desktop Provider: BILL, DR)
-----------------------	--------------	-----------------	--------------------------	----------------------------	---



MOIS MODULES

MOIS contains the following modules to enable increased patient care and manage work flow:

- Patient Chart
- Workspace
- Scheduler
- Billing
- Administration
- Data Exchange
- Reports

Modules are shown on the bottom left of the MOIS screen.

Note: Some modules may not show on your MOIS account. Access to each module is role-dependent.

MOIS - PRACTICE								
<u>R</u> ecord <u>M</u> odules <u>V</u> iews Ac <u>t</u> io						Desktop Provi	der: BILL, DR	
Patient Chart	Patient S	Summary						
Patient Summary	New Chart	Delete Chart Save	Undo	Refresh	Search	Previous Chart		ar Off
	Chart No.: Name (F/M/L) Birth Date:		Gender:		Current Status: Insurance: ervice Provider:	•	Date: Number:	Dep: 00
Consults	Expand All	Collapse All		In the la	ist 60 dag	ys Since Last	Required in the ne	xt 90 days
	Date	Description			Detail			Hyperlink
Constant Section Scheduler Sche	}	MODULES						
eady. Go To Chart			Task Item	. Me	sq Item: -	User: JOKEIL	Site ID: prac	v02.16.23 b 140905

General Tips

The ellipses indicates there is a list associated with the field. Click the three-dot symbol or click in the space beside and use F4 to prompt the selection list.

F2 - Save

Ctrl-T – Enters today's date

Calendar – Left click on the date field and use F4 to prompt a month-view calendar. **Ctrl-H** – Prompts a patient-specific Health Maintenance Review

See the appendix for a complete list of Hot Keys.



Scheduler Module

The Scheduler Module allows you to:

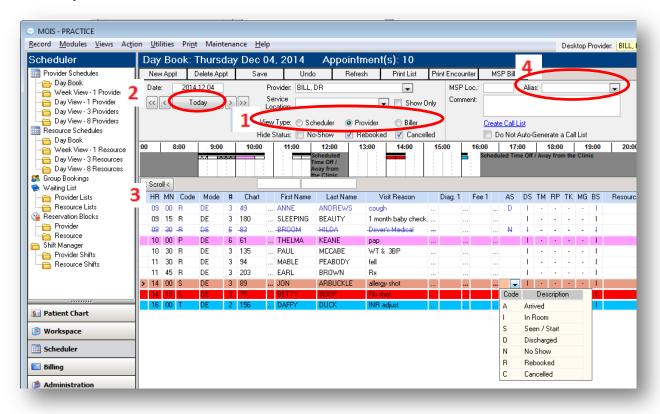
- View your schedule for current, past, and future appointments
- Manage patient appointments
- Track patient appointment status (Arrived, In Room, Seen, Discharged, No Show, Cancelled, or Rebooked)
- Quickly navigate to the patient encounter detail window where you enter your progress note

View Your Schedule

- Click on the Scheduler Module.
- Find your name and select **Open Daybook.**

<u>R</u> ecord <u>M</u> odules <u>V</u> iews Ac <u>t</u>	ion <u>U</u> tilities Pri <u>n</u> t Mai	ntenance <u>H</u> elp			Desktop Provi	der: BILL, DR					
Scheduler	Provider Work L	oad									
Provider Schedules	Work Load Summary	Work Load Summary for Thursday December 04, 2014									
🗕 Week View - 1 Provider	Provider	# of Appoints	# of Group Visits	Total Time (mins)	First Appoint	Last Appoint	\sim				
	ALICE, DR			-	0:00		Open Daybook				
Day View - 8 Providers	BILL, DR	10		175	9:00	16:00	Upen Daybook				

• Your daybook looks like this:



- 1. The view of your daybook can change toggle between view types: Scheduler, Provider, Biller.
 - The "Provider" view is shown above.
 - The columns will show in a different order (and some don't show at all) in different views.

•



- 2. Use the "Today" button to look at the schedule for the current date.
 - << moves back 1 week at a time from the date shown
 - < moved back 1 day at a time from the date shown
 - > moves ahead 1 day at a time from the date shown
 - >> moves ahead 1 week at a time from the date shown
- 3. Each column in the daybook has a meaning:
 - HR MN = Hour Minute
 - Code = Visit Code (e.g. "R" usually means it is a Regular visit)
 - Mode = How the visit is carried out (e.g. Direct Encounter with the Patient)
 - # = Length of the visit in blocks (1 = 5 min, 2 = 10 min, etc.)
 - Chart = Chart number of the booked patient
 - First Name, Last Name = Legal name of the booked patient
 - Visit Reason = Why the patient is booked
 - Diag 1 = Diagnostic Code associated with the visit
 - Fee 1 = Fee Code associated with the visit
 - AS = Arrival Status of the patient (See dropdown on above screen shot. E.g. A = Arrived)
 - DS = Document Status (I for Incomplete Progress Note, C for Completed/Saved)
 - TM = Number of templates used in the visit
 - RP = Number of reports made from the visit (e.g. WCB)
 - TK = Number of tasks attached to the visit
 - MG = Number of messages attached to the visit
 - BS = Billing Status (I for Incomplete, B for Billed)
 - Resource = Resources needed for the visit (Site specific)
 - Room = Room number for the visit
 - M = A down arrow will populate if a General Note is added in the Encounter Detail window
 - W = Number of attachments associated with the visit
- 4. Locums choose the name of the provider they are covering for from the dropdown list by "Alias".

Document an Encounter (Progress Notes, etc.)

- **Double click** on a patient name in today's schedule to open their Encounter Window.
- The Encounter Window looks like this:



	ec en 3086			0.563.7845	Work:		Cell:			
	_	2.04 10:00	Slots: E			Diagnoses F	ees	Service	General Note	•
Provider.		К		Arrived:	09:55					
Ser. Loc. Visit Code				In-Room: Seen:	09:59					
	·· _									
Appt Stat	son: pap	•		Discharge:	:					
		<u> </u>								
Progre	ss Note(s)	Measu	urements	Detail / C	Coding	Encounter Summary	Enco	ounter Forms		
Note 1	of 1							Print Note	New Note	Delete Note
Author:	MOIS, TES	T DR.	. . (Complete Crea	ated By:			L		< 1of1 >

- 1. The patient's demographic information is shown on the top of the Encounter Window **always check** to ensure you are working in the correct patient's chart.
- 2. Date and time of the patient's booked visit.
- 3. Navigation tabs to record information from the visit:
 - Progress Note(s) free text area; templates to start notes are also available by clicking in the blank space and pressing F4.
 - Additional notes for the same visit can be added by selecting "New Note" (e.g. a patient is seen by a student and a physician 2 separate notes for the same encounter).
 - There is a creator and author for each progress note the creator has 7 days to edit and the author has 28 days to edit after the note is created.
 - **Measurements** to enter values from the visit (e.g. BP, weight, smoking status); graphing, calculator and templates also available
 - Detail/Coding to enter billing information
 - Encounter Summary shows a read-only view of all items associated with the visit
 - Encounter Forms access forms for chronic disease management visits, WCB, pain management, and others
- 4. Important Toolbar options:

•

- Save F2 is the Save quick key throughout MOIS
 - Chart Views Drop down allows you to easily navigate to a section of the current patient's chart
 E.g. view previous Encounters, Measures, Health Conditions, Medications, etc.
- Action Create an external service request, create tasks/messages within MOIS, print a patient label
- Utilities Access spell check, Health Maintenance Review

Create a Service Request (Referral)

(Note: This section will need to be edited for CDX EMR to EMR Referrals.)

- Click on the **Scheduler** Module.
- **Double click** on a patient name in today's schedule to open their Encounter Window.
- Select Action from the toolbar, a drop down will appear.



<u>R</u> ecord <u>M</u> odules <u>V</u> iews A	\c <u>t</u> io	n <u>U</u> tilit	ties Pri <u>n</u> t Maintenanc	e <u>H</u> elp		Desktop Provider: BILL, DR	
Patient Chart		Enco	ounter			ZACKARY ZEHR 52 YF	ROLD M Chart 243
Patient Summary Demographic Concenters Measures Imaging	•	New F FIRS1	Save Chart Views A FIRST: ZACKARY PHN: BC 788655	YEAR OLD M chart no.: 243 - encounter no.: 1 <u>Action</u> Print Selected Text Utilities Close Create Order for a Consultation Create Order for Lab Requisition	L0001323 Ctrl+R	DoB: 1962.03.15 M Cell: 000.555.3434	
Consults Procedures Interventions Family History Allergy / Intolerances Reaction Risks	ш	> 201	Date: 2014.1 Provider: BILL, D Ser. Loc.: Visit Code: R Visit Reason: KNEE F	Create Order for Image Requisition Create Order for Image Requisition Create Order for Procedure Requisition Create Order for Misc. Reguisition Print Label	Ctrl+L	ses Fees Service () </td <td>General Note</td>	General Note

- Select the type of service request from the list e.g. Create Order for a Consultation.
- An Order Detail window will pop up, fill in the information as appropriate.

MOIS - PRACTICE <u>Record</u> <u>Modules</u> <u>Views</u>	See Content and the set of the se	23
Patient Chart 🛛 🛛	Order Detail	:43
Patient Summay Demographic Finounters Finou	Order Learn Color Order Information FIRST: ZACKARY MIDDLE: WILLIAM LAST: ZEHR DoB: 1962.03.15 SEX: M	TK N

- To navigate to the next screen, select **Print**.
- Here you can choose to include different aspects of the patient chart in the service request.
 - Note: All tabs say (0) until you choose an item from the tab. The number will change to reflect how many items you've added to your letter.



		rge, BL VZM	5.16									
	ounter (0) edure (0)		Document (0))	Messages (0) Intervention (0)		Tasks (0) Image (0)		Othe Consult		Ad	dmission (0)
Measure				· _						(-)		(-)
	Detail	Date	Code		Description		Value	Ah	normal	LOINC Code	Att.	
		2014.11.24		HEIGHT	D occupation		190			3137-7	-	
> 🗸		2014.11.24	458	WEIGHT			95			8350-1	-	
		2014.11.24	39957	ALCOHOL DI	RINKS PER WEEK		8				•	
		2014.11.24	34494	CIGARETTE	SMOKED.CURRENT	(PACK/DAY)	.5			8663-7	•	
		2014.11.24	39959	PHYSICAL A	CTIVITY MINUTES PE	ER WEEK	30				•	
		2014.11.24	34683	OXYGEN SA	TURATION		94			8841-9	·	
		2014.11.24		HEART RAT			85			8893-0	•	
		2014.11.24			6SURE (SYSTOLIC/D	IASTOLIC)	145/85				·	
		2014.11.24		BODY MASS			26.3		Н		·	
		2014.11.24	35158	RESPIRATO	RY RATE		24			9279-1	•	

- To create the report, select Print.
- The service request is sent this is usually via printing and faxing the final copy.
- The service request remains part of the patient chart it can be accessed via the Orders folder.

Create a Service Request (Order/Lab Requisition)

- Click on the **Scheduler** Module.
- Double click on a patient name in today's schedule to open their Encounter Window.
- Select **Action** from the toolbar, a drop down will appear.

S ZACKAR	Y ZEHR 5	2 YEAR OLD M chart no.: 243 - encounter no.:	10001458				
Save Chart	t <u>V</u> iews	Action Print Selected Text Utilities Close					
FIRST: ZAC		Create Order for a Consultation	Ctrl+R				м
PHN: BC		Create Order for Lab Requisition			Cell: Fees	000.555.3434 Service	General Note
Date: Provider:	2015.0 BILL, D	Create Order for Image Requisition		ises	rees	Jervice	
Ser. Loc.:		Create Order for Procedure Requisition				·	
Visit Code:	R	Create Order for Misc. Reguisition					
Visit Reason:	SORE :	Print Label	Ctrl+L			·	

- Select the type of service request from the list e.g. Create Order for Lab Requisition.
- An Add Attachment window will pop up.
- **Double-click** the form name to select the desired requisition form from the list.



Attach Form / Letter Attach File		
Select Form / Letter	Maximum Items in Your F	Recent List: 4
E RECENT		-
2 MILLS MEMORIAL HOSPITAL NUCLEAR MEDICINE IMAGING REQUISITION (FORM)	NH	REQ-IMG
TESTING 123(LETTER)		
OUTPATIENT DIETICIAN REFERRAL (FORM)	NH	REFERRAL
> TEST 1 STANDARD OUT-PATIENT LAB REQUISITION (WRINCH) (FORM)	NH	REQ-LAB
□ FORMS		
1 MILLS MEMORIAL HOSPITAL CT	NH	REQ-LAB
2 MILLS MEMORIAL HOSPITAL NUCLEAR MEDICINE IMAGING REQUISITION	NH	REQ-IMG

• The form will pop up, pre-filled with the patient's demographics, the Desktop Provider's name and MSP practitioner number.

<u>Edit View D</u> ocument <u>C</u> omments						
🍛 🍙 🔹 😋 🕤 🖕 💱 🖫 🖕 🛚 🔍 Za	oom In 👻 🔝 🔂	125% 🔹 🥥 💦	😋 📮 🕅 🗞		- 🗞 🤣 😼 -	
SIA	NDARD OUT	-PATIENT LAB	RATORY RE	QUISITIO	N	
to northern health						
the northern way of caring						
Wrinch Memorial Hospital						
2510 Highway 62, Hazelton, B.C.,	V0J 1Y0					
	50-842-4629					
Hour: Monday – Friday 9:00AM –	4:00PM		LAB USE ONLY			
BILLABLE TO:				CIAN & MSP PRA	CTITIONER NUMBER	
MSP WorkSafeBC Patient PERSONAL HEALTH NUMBER	Other:	DOB (YYYY/MM/DD)	BILL, DR			
7886554213	1	962/03/15	00002			
SURNAME OF PATIENT	FIRST NAME	302/00/10	_			
ZEHR	ZACKARY				RACTIONER NUMBER	
ADDRESS	CITY/TOWN		Dr. Mark Jon		RACHONER NOMBER	
123 TREE ST	PRINCE GEO	DRGE	COPY RESULTS		ISP NUMBER	
TELEPHONE # (INCLUDE AREA CODE)			Elisabeth S	Smith		
000.111.2222						
GENDER: M F PREGNANT?	0		рс			
DIAGNOSIS / CURRENT MEDICATIONS, DA	TE AND TIME OF LAST	DOSE	DATE OF COLLE	CTION	TIME OF COLLECTION	
NOTE: PROV	INCIAL GUIDELINE	S / PROTOCOLS SHOUL www.BCGuidelin		FOR TESTS IN	ITALICS	
HEMATOLOGY		URINALYSIS/URINE		н	EPATITIS SEROLOGY	
K Hematology profile		oscopic 🔶 microscopic if di	stick positivo		hepatitis undefined etiology	

- Type directly onto this form, boxes can be selected using a left-click.
- Important:
 - LOCUMS: In order for results to be distributed electronically to the correct EMR, be sure to enter the name of the provider you are covering for in the "Locum For" section.
 - Additional provider names (and in some cases the clinic name) can be added in the "Copy Results To" section.
- Print & Save the form.



Workspace Module

The Workspace Module allows you to:

- View and acknowledge patient results that are downloaded through CIX, CDX, or manually entered
- Manage your task list
- Manage your messages
- Share your workspace and access the workspace of the provider(s) you are covering
- Manage your favourite medications list (user specific)

View Your Workspace

- Click on the **Workspace** Module.
- Click on "My Basket" to see a summary of items that need to be Acknowledged or Reviewed.
- Note: the name associated with the Current Workspace is displayed on the top right.

cord <u>M</u> odules <u>V</u> iews Ac <u>t</u>	ion <u>U</u> tilities Pri <u>n</u> t Maint	tenance <u>H</u> elp		Desktop Provider, BILL, DR
/orkspace	In Basket List			Current Workspace: KEIL, JOY
Workspace Summary	Basket Summary KEIL,	JOA		
Measures	Item	To Acknowledge	To Review	
Consults	Measures	7	7	
Procedures	Imaging	1	2	
- 🛅 Facility Admissions	Consults	1	1	
Progress Note	Documents	3		
🖃 🗍 Task List	Procedures		2	
My Task List		12	12	
A Message Board Inbox Inbox Sent Items Share My Workspace Favourites Adications				

- Select any of the folders under "My Basket" to view the items in the current workspace.
- Details associated with the highlighted results are shown at the bottom of the screen.

ecord <u>M</u> odules <u>V</u> iews Ac	ion	<u>U</u> tilities	Pri <u>n</u> t Maintena	ance <u>H</u> elp				Desktop Provid	er: BILL,	DR		
/orkspace	A	cknowl	ledge - Mez	Sares					Cu	rrent \	Vorkspace:	KEIL, JO
Workspace Summary		Save	Refresh	Change W/S	0 en Chart	Create Task	Create Message F	Reassign Items	Prir	nt	Close Window	
🖃 🛃 My Basket	SI	how: Ack	nowledgements		e Records:	 All Records 	Not Checked	🔘 Checke	d	Checl	ked Since:	-
👝 Imaging		Created	Patier	nt Age	Collected	Tes	t Name	Value	Units	Flag	Status Check	IR M
- 👝 Consults		FOR AC	KNOWLEDGEM	ENT								
- Procedures		15.01.29	ANDREWS, ANN	VE 64	15.01.29	BLOOD PRESSUR	RE (SYSTOLIC/DIAS)	FI 118/76	mm Hg		V	
		15.01.29	BELFRY, BATSO	IN D 74	15.01.26	ECG		normal				
- Cocuments						URIOUT		175	Cms			
- 🛅 Facility Admissions	>	15.01.29	BOOP, BETTY	85	15.01.29	HEIGHT						
Facility Admissions	>			85 54	15.01.29 15.01.29			79	Kg			
Facility Admissions	>	15.01.29			15.01.29	WEIGHT	RE (SYSTOLIC/DIAS)	79	Kg mm Hg			

- To change workspaces, select Change W/S.
- A prompt listing the available workspaces pops up, click on the correct name and choose **Selected User** to switch to their workspace. (Workspaces must be shared in order to show on this list.)
- Results can now be acknowledged from their workspace (your username is associated with the acknowledgement, even if results are checked in another user's workspace).



User's Workspace Note PAICE BAILEY, DARCI STEPHENS, TAMARA PEARS, DORI	vailable User Accounts	
STEPHENS, TAMARA	User's Workspace	Note
	PAICE-BAILEY, DARCI	
▶ PEARS, DORI	STEPHENS, TAMARA	
	PEARS, DORI	

A	cknowl	edge - Mea	asures						Current	Work	(space: PE	ARS, I	DOI
	Save	Refresh	Change	W/S	Open Chart	Create Task	Create Message	Reassign Items	: Frim	-	Close Window		
SI	how: Ack	nowledgements	•	Includ	e Records:	O All Records	Not Checked	l 💿 Check	ed	Chec	ked Since:		
	Created	Patie	nt	Age	Collected	Tes	t Name	Value	Units	Flag	Status Check	IR M	
	FOR AC	NOWLEDGEM	ENT										
>	15.01.29	BEAN, JIM		15	15.01.29	UREA NIT DIAFP-	MCNC	10					
	15.01.29	BEAN, JIM		15	15.01.29	RBC # BLD AUTO		5	X10^12/I				
	15.01.29	BEAN, JIM		15	15.01.29	WBC		13					
	15.01.29	BOND, JAMES R	OBERT	75	15.01.25	BLOOD PRESSUR	RE (SYSTOLIC/DIAS	TI 135/86	mm Hg				
	15.01.29	KEANE, DOLLY		10	15.01.29	HEIGHT		145	Cms				

Share Your Workspace

- Click on the **Workspace** Module.
- Click on "Share My Workspace" to open your User Account Workspace Management settings.
- Under "Sharing Workspace With", select **New** to add a new line.
- Use the dropdown under "User Account" to find the name of the person who needs to share your workspace OR whose workspace you need to share (i.e. the person you are covering for).
- Select Apply Changes.
- Note: Workspaces must be shared both ways (i.e. Joe shares with Bill, Bill must also share with Joe).
- **Note:** If a provider did not share their workspace prior to leaving, an administrator can share their workspace with you.



serName: JO UserSettir	KEIL		Full Name: KEIL, JOY				
User Settin			FUILNAME: KEIL, JUT				
	ngs	Workspace Management	Prompt Windows				
nbox Forwardii	ng						
Start	Stop	Forward to User	Acknowledge Mine			Note	
Sharing ₩orks	pace With			New Delete	Worksnace	es Shared V	with KEI
Start	Stop	User Account	Note				
2014.11.24		PEARS. DORI			Start	Stop	Use
2015.01.29			•)		2014.11.24	-	PEA
					2014.10.21		PAIC
					2014.10.21		STE
			Apply Changes	Cancel			
	Sharing Works Start 2014.11.24	Sharing Workspace With Start Stop 2014.11.24	Sharing Workspace With Start Stop User Account 2014.11.24 PEARS. DORI	Sharing Workspace With Start Stop User Account Note 2014.11.24 PEARS. DORI Image: Content of the second of the	Sharing Workspace With Start Stop User Account Note 2014.11.24 PEARS. DORI 2015.01.29 Image: Content of the second of the	Sharing Workspace With Start Stop User Account Note Start 2014.11.24 PEARS. DOBI Image: Comparison of the start 2014.11.24 2015.01.29 Image: Comparison of the start 2014.10.21 2014.10.21 2014.10.21	Sharing Workspace With Start Stop User Account Note Start Stop 2014.11.24 PEARS.DORI Image: Control of the stop 2014.11.24 - 2014.11.24 - 2014.11.24 - 2014.11.24 - 2014.11.24 - 2014.11.24 - 2014.11.24 - 2014.10.21 -

Patient Chart Module

The Patient Chart Module allows you to:

- Navigate the different folders of the patient's chart
- View previous encounters, lab results, medications, diagnoses, patient-specific care plan, consults, etc. and add to these folders as needed.
- For examples of what is found in each section of the patient chart, see the Consistent Data Entry
 document in the appendix a Provider Reference version should be posted in the exam rooms in the
 clinic.

Finding a Patient

- Click on the **Patient Chart** Module.
- In either **Patient Summary** or **Demographic** folder, click on the ellipses by "Chart No" or click in any "Name" space and press F4 a master patient list pops up.
- In the white search boxes, you can search by Last Name, First Name, Middle Name, Date of Birth, Home Phone Number, Chart Number, Insurance Number (PHN), short note or Chart Location to find exact matches.
- You can also type directly in the list (e.g. typing "Mouse,M" and hitting enter takes you to the area of master patient list by Mickey Mouse. It will show all names above and below the search characters.)
- Best practice is to search first by PHN, then DOB, followed by Name.



			[1	1	7		1	1	1
				I						
Last Name	First Name	Middle Name	DoB	Home	Chart No	Alias	Insurance	Ву	Note	Chart Loc.
ADAMS	DILBERT		1970.05.01	250.569.4589	59		9029596344	BC	this is a test	
ADAMS	GILBERT		1945.02.02	250.555.6666	146	BERT	90564561231	BC	SANDSPIT	
ANDBEWS	ANNE		1950.06.23	250-555-5555	49		9046212878	BC	Cathy's mother	

• Alternatively, you can click on **Go To Chart** from any module in MOIS. It prompts the same master patient list, which can be searched as above.

Reports	
	»
Ready.	Go To Chart

Long Term Meds & Prescriptions

There are two folders for recording and managing patient medications – "Long Term Meds" and "Prescriptions".

Most medications should be entered in the Long Term Medications folder. It is a "best possible medication history" that documents regular medications and natural health products that are expected to be taken over a mid to long term. In some cases, it should be used even for, what some would consider a short term medication - e.g. a prescription for antibiotics to be taken with a COPD exacerbation plan.

About Long Term Medications:

- They will print on the clinical summary and referrals.
- The list has the "Reviewed" functionality. (i.e. users check "Review"; this updates the date beside the folder name, indicating when the most recent medication review occurred.)
- Both current and discontinued items are listed.
 - End dates should be added for items that are no longer required; items should not be deleted.
- When entering Long Term Medications for the first time, they must be renewed first before printing.

About **Prescriptions**:

- Record any short term, one-time, trial/sample medications and natural health products prescribed.
- Includes documentation of every product ordered.
- Items prescribed as a short term or trial will be recorded here.
- Items renewed from long term meds will also be recorded here.
- Medications recorded in this folder can be duplicated but not renewed. (note: duplicated is copied exactly to a new line with the current date)
- Items in Prescriptions will not be sent with referral letters nor listed on the clinical summary.
- Items in the Prescription folder can easily be added to the Long Term Medication list.
- From the **Patient Chart** Module, navigate to the correct patient chart as above.
- Or from the **Encounter Note** window, select **Chart View** from the toolbar.
- Select the Long Term Meds folder.
- Complete the desired action using the **Action** drop-down or the action buttons under the folder name.



ecord <u>M</u> odules <u>V</u> iews	Actio		ri <u>n</u> t Maintena n Medicati		5.02.10)				rovider: BILL, D			Che	rt 2
Patient Summary	-		Delete Record	`	Undo	Refresh	Duplicate	Renew	Attachment	Print R		Review	
Demographic Encounters		FIRST: EARL		MIDDLE:		LAST: Brown		DoB: 1960.0	18.11 Activ	ve ENC#: N	IO ENCO	DUNTE	R .
		Start	End	CDIC		Medica	tion		Dose / Frequer	псу	Indic.	N	1 ()
				02123274	COVERSYL ·								•
- 🛅 Interventions		> 2015.02.10		02162822	METFORMIN			LET 1C	AP ORAL DAILY				-
Allergy / Intolerances	ш	2010.01.01		02344041	WARFARIN S	ODIUM 2.5MG T	ABLET				42731		•
Long Term Meds													

- Select the **Prescriptions** folder.
- Complete the desired action using the **Action** drop-down or the action buttons under the folder name. *Note: the choices in Prescriptions are slightly different than in Long Term Meds.*

MOIS - PRACTICE	_	~~									- 0 %
<u>R</u> ecord <u>M</u> odules <u>V</u> iews	Actio	n <u>U</u> tilities Pri	i <u>n</u> t Mainten	ance <u>H</u> elp				Desktop Prov	ider: BILL, DR		
Patient Chart		Rx - Presc	ription					EAR	L BROWN	54 YR OLD I	A Chart 203
🔙 Patient Summary	^	New Record	Rx Wizard	Rx Favorite	Delete Record	Save	Undo	Refresh	Duplicate	Attachment	Print Rx
		FIRST: EARL		MIDDLE:	l	AST: BROWN		DoB: 1960.08 .	11 Active	ENC#: NO ENO	COUNTER 🛄
Measures											
		Order	CDIC		М	edication		Dose / F	requency	Amount	МÛ
		2015.02.10	00865567	AMOXICILL	IN 250 MG CAPS	ULE		1 CAP ORAL	TID	10 DAY	-
- A Interventions		> 2015.02.10									•
- 🛅 Family History	Ξ										
🗎 🛅 Allergy / Intolerances											
- 🛅 Reaction Risks											
Events											
Social History											

- In either folder, search for medications by:
 - Using the white "search" boxes to show only items that match the text, add an (*) to indicate any letter combination can follow the text. (Otherwise, items with the text anywhere in word will be shown.)
 - Put any character in the "F" field to pull only formulary items.
 - Search by Generic or Brand Name.

CD	CDIC Medications / Drug List				Row Count = 5	
	f AMO*					
1	F Generic Name	Brand Name	ATC Code	ATC Name	Cost	LCA
Ì	* AMOXICILLIN (AMOXICILLIN TRIHYDRATE) 250 MG CAPSU	E AMOXICILLIN CAPSULES 250 MG	J01CA04	AMOXICILLIN	0.11	
	* AMOXICILLIN (AMOXICILLIN) 125 MG/5 ML SUSPENSION	NU-AMOXI SUS 125/5ML	J01CA04	AMOXICILLIN	0.04	
	* AMOXICILLIN (AMOXICILLIN) 250 MG/5 ML SUSPENSION	NU-AMOXI SUS 250MG/5ML	J01CA04	AMOXICILLIN	0.06	
	* AMOXICILLIN 250 MG CAPSULE	NU-AMOXI CAP 250MG	J01CA04	AMOXICILLIN	0.19	

• The searchable list source can be changed between All, CDIC only, or NP only.



Home PgUp		Ok Cancel	PgDwn End
Source: ALL Code List	Save on Close		
ALL			
CDIC			
NP			

- Select the item to be prescribed/added to the Long Term Med list.
- Fill in the **Dose/Frequency** by clicking on the ellipses. A new window will pop up.

Extended: Medication Dose	MIDDLE:	LAST: BROWN	DoB: 1960.08.11	SEX: M
	MIDDLE:	LAST: BHUWN		
CDIC (DIN): 00865567 Brand Name: AMOXICILLIN Generic Name: AMOXICILLIN	250 MG CAPSULE 250 MG CAPSULE		Order Date: 2	015.02.10
Multi-step Dose	Instructions:	Do Not Substitute Note: Do Not Adapt		
Reset Dose	PRN: Repeat:	(when necessary)		
Dose(s) Dose Dose Ur	its Route	e Frequency		
1 CAP	 ORAL 	TID V	New Delete]
Amount 10 DA	(This part only Prescriptions		
	Save	2 / Close Cancel		

- Select Save/Close.
- Select **Print Rx** to print the prescription.
- The patient's allergies will pop-up. (If no allergies are listed, the patient may have allergies that are not entered correctly into their chart.)

Current Patient					
Chart: 203	Patient: EAF	RL BROWN	DoB: 1960.08.11 Sex: M	Insurance: BC 123456789	
Most Recent Me	asures		Allergies / Adverse Reactions		
HEIGHT	165 Cms	2014.08.20	Substance	Reactions	
WEIGHT	79 Kg	2015.01.29	NO KNOWN DRUG ALLERGY		
GFR	No record				

• Select **X** to close the "Pharmacokinetics and Allergies" pop-up.



• Select the items to include.

Current Pa	atient						
Chart: 2	03	Patient: EAI	RL BROWN	DoB: 1960.08.11 S	ex: M Insurance:	BC 123456789	
Prescripti	on List						
Include	Order	CDIC		Medication		Dose / Frequency	Amount
V	2015.02.10	00865567	AMOXICILLIN 250 MG CAPSULE			1 CAP ORAL TID	10 DAY
	2015.02.10	02123274	COVERSYL - 2MG TAB				1 tab daily
V	2015.02.10	02162822	METFORMIN HYDROCHLORIDE	500 MG TABLET		1 CAP ORAL DAILY	1 MONTH
> 🔽	2015.02.10	02344041	WARFARIN SODIUM 2.5MG TAB	LET			1 tab daily

• "Drug Interaction Results" will pop-up, if applicable.

	tient							
Chart: 20	1 3 F	Patient: EARL B	ROWN	DoB: 1960.08.11	Sex: M	Insurance:	BC 123456789	
		Show:	 All Interactions 	Drug Interactions	Reaction Risk	s		
Interaction	2							
here are 2	results.							^
Drugs:	02344041	warfarin						1
	00865567	amoxicillin						
Reaction: 1 of 2	Moderate Dr	ug Interaction						
	only two medica acenocoumarol.	tions to significan In that study, 30	tly increase the risk of	icillin-clavulanate. In fact, a case overanticoagulation in previously herlands anticoagulant clinic who	stable outpatients	treated with phenp	procoumon or	
	changes in the of amoxicillin-cla	use of 87 potentia vulanate increase	d with 302 randomly se lly interacting drugs or d the risk of overantic	elected matched controls with INI drug classes in the four weeks p oagulation even after adjustment	R values within the rior to the index day for potential confo	target range (med were identified ar unding factors, pa	ian value 3.2), and nd analysed. A course rticularly in patients	
Drugs:	changes in the of amoxicillin-cla	use of 87 potentia vulanate increase	d with 302 randomly se lly interacting drugs or d the risk of overantic	elected matched controls with INI drug classes in the four weeks p oagulation even after adjustment	R values within the rior to the index day for potential confo	target range (med were identified ar unding factors, pa	ian value 3.2), and nd analysed. A course rticularly in patients	
-	changes in the i	use of 87 potentia vulanate increase	d with 302 randomly se lly interacting drugs or d the risk of overantic	elected matched controls with INI drug classes in the four weeks p oagulation even after adjustment	R values within the rior to the index day for potential confo	target range (med were identified ar unding factors, pa	ian value 3.2), and nd analysed. A course rticularly in patients	
Drugs: Reaction: 2 of 2	changes in the of amoxicillin-cla 02162822 02123274 Moderate Dr	use of 87 potentia vulanate increase metFORMIN perindopril ug Interaction	d with 302 randomly se ly interacting drugs or d the risk of overantic	elected matched controls with INI drug classes in the four weeks p ogulation even after adjustment ogulation even after adjustment	R values within the rior to the index day for potential confo	target range (med were identified ar unding factors, pa	ian value 3.2), and nd analysed. A course ticularly in patients	
Reaction:	changes in the t of amoxicillin-cla 02162822 02123274 Moderate Dr MONITOR: Lim mechanism is ur MANAGEMENT particularly in pa should be appris	use of 87 potentia vulanete increase metFORMIN perindopril ug Interaction ited data suggest iknown. Symptor : Close monitorin tients with advan ed of the signs a tions), how to tre	d with 302 randomly st ly interacting drugs or d the risk of overantic that ACE inhibitors me natic and sometimes s g for the development ced age and/or renal i	elected matched controls with INI drug classes in the four weeks p oagulation even after adjustment	R values within the index day of the	target range (med were identified ar unding factors, pa abetic drugs, inclu are coadministered an interaction is su	ian value 3 2), and nd analysed. A course tricularly in patients tricularly in patients ding metformin. The d with metformin, spected. Patients or, weakness,	

- Select Print Anyway to print the prescription or Cancel Print to change your selection.
- Or if no interactions, simply select **Print (F2)** to print the prescription.

MAR (Medication Administration Record)

Information regarding this folder will be added when it is available.

Health Maintenance Review (Ctrl-H)

The Health Maintenance Review, commonly referred to as the "Ctrl-H", is patient, age, sex, and conditionspecific summary, as of the details in their chart at that moment. Common measures and interventions are shown along with their most recent date/value, the normal range (if applicable), and the patientspecific goals for each measure (if applicable and added to their Care Plan).



The Ctrl-H looks like this:

Patient: EARL BROWN Alias: SMITH	DoB: Gender:	1960.08.11 M	Insurance: B Chart: 2	C 123456789 03	Elow Sheet	<u>P</u> rint
ge = 54 SEX = MAL	.E					
GENERAL AND AGE/SEX		SCREENING				
SCREENING CHOLESTEROL Not SCREENING CHOL/HDL RATIO						
SCREENING FASTING GLUCOSE						
OCCULT BLD STL IMM-MCNC		- 2014.08.29 -	50	[N/A]		=
COLONOSCOPY Was Done 201	4.05.06					_
PHYSICAL ACTIVITY MINUTES	PER WEEK -	- 2014.09.10 -	30	[150 to 1500)]	
ALCOHOLIC DRINKS PER DRIN	KING DAY -	- 2014.08.20 -	1	[0 to 2]		
ALCOHOLIC DRINKS PER DRIN CIGARETTES SMOKED.CURRENT WAIST CIRCUMFERENCE BODY MASS INDEX	(PACK/DAY -	- 2014.08.28 -	110	[0 to 0]		
BODY MASS INDEX	-	- 2014.09.10 -	27.5 H	18.5 to 25] GOAL: < 20	
VACCINATION - TETANUS/DIP	'HTHERIA -	- 2010.08.20				
BLOOD PRESSURE (SYSTOLIC/	DIASTOLIC) -	- 2015.01.29 -	128/80	[N/A] GOAL:	: < 150/90	
EX-SMOKER For 3 Year(s) HIV 1+0+2 AB SERPL QL						
HIV 1+0+2 AB SERPL QL	-	- 2014.12.30 -	NONREACTI	VE [N/A]		
INCENTIVE CLAIM HIST	ORY					
14050 250 INCENTIVE FOR F		- NOT COMPLETED)			
14033 R250 ANNUAL COMPLEX	CARE MANA -	 NOT COMPLETED)			
ANTICOAGULANT THERAP INR PPP		- 2015.01.30 -				

- From anywhere in the Patient Chart Module
- Hold the **Ctrl key** and type **H**, the Health Maintenance Review for the open patient chart will pop-up.
- The Health Maintenance Review can also be accessed from most folders by going to **Utilities** and selecting Health Maintenance Review from the drop-down.

tch User kt		Befre
ĸt		Refre:
		Tienes
ance Review	Ctrl+H	T: BRO
ew		
s to Clipboard		in By
	w	w s to Clipboard

APPENDIX

Hot Keys

Hot Keys are shortcut keys either to navigate to areas of the chart or to quickly complete a task. The full list is given below. Please note that some hot keys might change depending on what module is active.

The most up-to-date copies will state August 2014 on the bottom left.

	H U		SIOW	MOIS Hot Keys		M	MOIS
Commonly Used Hot Keys	Hot Keys	Navigation Keys	/s		Screen S	Screen Specific Keys	
Save	F2	Patient Summary	ALTH	Patient Chart		Billing - Unsent	
Prompt	F4	Demographics	ALT 1	Swipe ID Card	F12	Prompt Sent to MSP	ALT F1
Clear This Screen/Refresh	5	Encounters	ALT 2	Audit Report	CTRL SHIFT R	Prompt Unsent by Patient Name	ALT F2
skip to Next Section	F6	Measures	ALT 3	Prescriptions		Prompt Unsent by Provider	CTRL F4
Search Backwards	F7	Imaging	ALT 4	Duplicate Rx or LTM	CTRL D	Prompt Unsent by Service Date	CTRL F5
Search Forwards	5	Consults	ALT 5	Print Prescription	CTRL P	Fee Code Option 1	F11
Find	19	Procedures	ALT 6	Add to Long Term Medications	CTRL U	Fee Code Option 2	F12
Toolbar	F10	Family History	ALT 7	Select from Favorite Medication	SHIFT F4	Duplicate Claim - DOS	ALT F3
Suberning		Allergies/Intolerances (Reaction Risks)	ALIA	Long Lenni Medicadons		publicate claim on Provider	CIRLES
Superfind Next	SHIFT F8	Prescriptions	ALTS	Patient Chart - Measures		Set as Pay Patient (PP) Claim	CTRL P
Account Summary ¹	ALTE	Social History/Risk	ALTO	Graph		Duplicate Claim - NOS	8
Close Active Window	ALT F4	Documents	ALT K	Filter		Change Claim Provider	CTRL D
Open Chart	ALT F9	Health Issues (Conditions)	ALT P	Patient Chart - Orders			
Change Desktop Provider	ALT D	Orders	ALT F	Create Referral Report	CTRL R	Billing - Sent	
Free Text/Zoom (Voice Dictation)	ALT Z	Daybook	ALT 8	Encounters		Prompt Sent by Recon Code	ALT F2
Bill MSP ²	CTRL B	Unsent to MSP	ALT 9	Encounter Detail Window	CTRL Z	Prompt Sent for Chart	ALT F1
Copy	CTRLC	Sent to MSP	ALT O	Text Zoom Window	ALTZ	Resubmit Claim	F2
Private Invoice	ALTI	Tab 1 ⁷	CTRL 1	Flow Sheet (Encounter Form)	ALTE	Debit Claim	CTRL F2
Health Maintenance Review ³	CTRLH			Create Order for a Consultation	CTRL R	Duplicate Claim	J
Create Task ⁴	CTRL K	Printing		Close Encounter Detail Window	CTRL W / Esc	Toggle - Approve/Adjust	CTRL A
Print Labels	CTRLL	Patient Chart				Toggle - Write Off	CTRL W
Create Messages ⁵	CTRL M	Print Demographics	CTRL D	Workspace		Toggle - Mark for Delete	SHIFT F2
New Line	CTRLN	Encounter Care Form	CTRLO	Mark for Review	CTRL R	Detail Expl. Code	CTRLE
	OT N L	Billing Invoicer		Daubook		A rest of the second se	
out Highlighted Text	CTRLX	Print Statement	CTRL A	Daybook Bar - Multi	ALT F2	Billing - Invoice	
Family Summary ⁶	CTRL F	Print Receipt	CTRL R	Daybook Bar - Single	ALT F3	Prompt by Recon Code	ALT F1
Undo	CTRL Z			Copy/Move Daybook Items	CTRL O	Prompt by Payor Code	ALT F2
skip to Next Field	TAB	Letter Writer		Bill MSP ALL (All Encounters)	CTRLI	Prompt by Invoice #	ALT F3
Skip to Previous Field	SHIFT TAB		CTRL P	Find Prescription		Pay Balance	CTRL P
Check off a Box	Space Bar	Print To (Word Processor)	CTRL SHIFT P	Copy Encounter Data		W/O Balance	CTRL W
spen crista		Italice		Default Eee Code C		Data Evchange- Manual En	the Eoldore
Print a Note/Print Select Text	CTRL SHIFT N	Delete	Del	Default Fee Code 3	F12	Link to Order CTRLO	CTRLO
Open Drop-Down List	ALT	Bold	CTRL B	Mark Appointment as Arrived	Þ	Save and Duplicate	3
	CHIET ED	Underline	CTRLU				

 Create Task: Opens the 'Create New Task' window. This option is available from the Patient Chart module.
 Create Messages: Opens the 'Create New Message' window. This option is available from most MOIS screens.
 Available in the Patient Chart module - Demographics folder only.
 When a MOIS screen has multiple horizontal tabs, use CTRL + the number of the tab to navigate to that tab wit Revised August 2014 number of the tab to navigate to that tab without using the mouse (i.e. Patient Detail in Demographics is the second tab for hotkey CTRL 2).



Consistent Data Entry

The **Consistent Data Entry Guidelines** for data entry help to ensure that information is entered into the correct location in the electronic system so that those using the system can quickly and easily find the correct information when it is needed. Being able to rely on an electronic medical record for accurate data means better, safer patient care – a goal that is always at the forefront of our work. Copies of this document should be posted in the clinic you are working in for easy reference. These guidelines include the most up-to-date placement for CDX documents, as well as CIX and Excelleris results that are downloaded directly into the patient chart. These interfaces rely on accurate patient data to ensure information is matched to the correct patient chart.

The most up-to-date copies will state Version2 on the bottom left.



				Downloaded through CIX, Excelleris, CDX (Clinical Document Exchange)	Downloaded through CIX, Excell
the northern way of caring			what the patient "brings to the table"		
			Patient Resources: Personal resources/		
. northern health	ノー			E.g. Socioeconomic deprivation	
	6		"Transportation to Appointments"	addressed by care	 ATrauma Report
			E.g. "English as a Second Language",	Needs for Care: Needs that can be	 Assault Report
		 AReferral Note 	These usually spin off of Needs.		 APhysician Initial Assessment Note
		 E.g. Referral letters 	patient from getting necessary care.	Exposure"	electronic)
		and other items sent	Barriers to Care: Obstacles preventing a	E.g. "Lung Cancer due to Asbestos	 Previous Charts (scanned from paper or
	pop-up; entries have start and end dates	interventions, labs, procedures, images		currently have	Care Benefits Application)
messages between providers/staff	Private alerts that never show up as a	All service requests for consultations,	Planned Actions: Actions to achieve goals	the person is at risk for, but does not	 Letters of Entitlement (e.g. BC Palliative
providers/staff or patient-related	Alerts	Olders (All-F)	or birokinet Soara	Risks for Conditions: Contains conditions	 Letters from clients
Tasks/Messages: Patient specific tasks for	Alaute	Output (Alt F)	8 annuidar anala		 AGeneral Letter
	 Off-site Walk-In Clinic Reports 		Gook: Qualitative or quantitative natient	previous smoker only)	 Acardiac Arrest Note
Immunization	ATransfer Note		 Contracts (e.g. Long Term Opiate) 	 Smoking status (for current smoker or 	Birth Records
• E.e. for CDM. Complex Care. Pap.	 cmergency bepartment note 			miscarriage, etc	Band Letters
Recalls: Notices for follow-up, coded	Chief Series Annual Construction Protocol	•E.g. Encounter Forms – CHF		dependence, cancer, pregnancy,	SUCH as:
Autor visiti (room out)	 Emergency Visits (attach ED reports) 	•E.g. Insurance Forms – WCB Report	of Treatment)	 E.g. Diabetes, depression, tobacco 	All documents not attached elsewhere,
Order Against (Inclis Only)	nsuchistric care)	Encounter Documentation Forms	 MOST form (Medical Orders for score) 	 start and the dates must be listed 	
 E.g. Risk of Violence or Restraining 	 ADischarge Summary (including 	Enounter Fortunation Forms	 Refusal of all immunizations 	Othe control of per entry/line	docalitetto.
Reminders	discilar Se summaries		preferences for care (including refusals)	All should be coded entries	viewabie liefe, (opdoli to liitei out diese
populo mien ni88erea)	discharge summaries		Preferences: Includes consent		viouship have fontion to filter out there
Patient-specific notifications (snow as	All facility stays, including emergency visits and other facility admission and	Repository of Paper Forms, Dynamic	consolidated view of shared patient data	conditions: All past and present health	All documents including forms and letters
Modifications					
Notifications	Eacility Admissions (Alt-V-Y)	Forms	Care Plan	Health Issues (Alt-P)	Documents (Alt-K)
		yremmus		events	- now in care Plan – Prejerences
		 Not sent with referral letters, not on 	(add an end date as needed)	 Contraindications due to adverse 	Long Term Upiate)
not appear in referrals	medications	will be recorded here	 Current and discontinued are listed 	to Immunizations	DINK/LEVEL OF INTERVENTION & CONTracts (e.g.
As needed, mark as sensitive so they do	E.g. Antipsychotics, Plan B, Rhogam, STI	 Items renewed from long term meds 	 "Reviewed" functionality 	Redcululi Risks, all auverse events reidted	Previously contained:
	 Medications provided at point of care 	product ordered	 Shows on Patient Summary 	events: Adverse events linked to related	
 Sleep information 	 Immunizations (including historical) 	 Includes documentation of every 	reterrals		 Some Vaccinations (MOIS only)
 Family issues 	and cancelled	 Include all dispensed samples 	 Will print on clinical summary & 	Risks	Exercise, Drug & Alcohol)
Diet information	have been given, omitted, withheld,	prescribed	taken over the middle to long term	 Drug, food or Environmental Reaction 	 Counselling (e.g. Tobacco Cessation,
social Determinants of Health	 Documentation of all medications that 	medications and natural nealth products	natural nearth products expected to be	tood (include No known brug Allergy)	 Allergy Desensitization Summary
Socioeconomic details (not diagnoses),	Medication Administration Record	Short term, one-time, trial/sample	Current list of regular medications and	Reaction Risks: Allergy status to drug or	Non-operative interventions
Social History (Alt-U)	MAK (IT available)	Prescriptions (Alt-S)	Long Term Meds (Alt-C)	Allergy/Intolerance (Alt-A)	Interventions (Alt-V-I)
Social History (Alt O)	MAR (if available)	Drecorintions (Alt S)	Long Term Mede (Alt C)	Allermy/Intolerance / Alt Al	Interventions / Alt V/IV
	Aspecialist Reports WCB Consults				
	 Prenatal Notes (from other providers) 				
resection)	 Pharmacy Notes 				
excision biopsy, vasectomy, wedge	 AOutpatient Consult Note 		 Exercise stress test 		or without linking charts)
Significant In-onlice biocedures (e.g.	 Opnthalmology Reports 			Ambulatory Care Reports - now in Consults	 ramily nistory pertinent to care (with
 Configuration office according to a 	 Collogical Collignity Flogless Note 		- cos a cos (normal or appointed)	 now in Facility Admissions 	Indexed within the more instance
Nerve block	Acong Lerm Care Progress Note	• x-lay	 Calified Risk Assessment or "abnormal" 	Visits to Emergency & Walk-In Clinic Reports	 Linked family relationships – for those indexed within the source instance
Manue Block		Y row	Cardiar Dick Assessment	Previously contained:	
ALabour & Delivery Summary	Off-site Multidisciplinary Team Note	• Ultrasound	overnight oximetry		Family History (Alt-7)
Guided Biopsv	Alinnatient Consult/Progress Note	M	 Pulmonary function test snirometry 	 WCB Reports & Encounter Forms 	
^Endoscopy Note	A History & Physical Note	•MIBI	 PHQ-9, CSHA Frailty score 	 On-site shared care provider notes 	
Day Surgery Report	 AFmergency Department Consult 	Mammoeram (Screening & Diagnostic)	 Tobacco/alcohol use. activity level 	calculators, measurements from visit	 Connections (with allied services)
 Angiogram, biopsy, colonoscopy 	 Diabetes Education 	 CT (Computed Tomography) 	 Pap smears 	status (e.g. arrived, no show), forms,	 Next of kin, emergency contacts
procedures	 Audiology Reports 	 Bone Densitometry 	 Height, weight, BMI, BP 	 Progress notes include appointment 	 Chart status (e.g. Active, Inactive)
out of clinic/office); not minor office	 Ambulatory Care Progress Note 	contain image attachments)	measurements (including at point of care)	booked in the MOIS instance	 Legal name and contact information
All medical and surgical procedures (in or	All consultation letters received	All Adiagnostic imaging reports (may	All Alab results and manually entered	All patient interactions/appointments	Patient identification details
Procedures (Alt-6)	Consults (Alt-5)	Imaging (Alt-4)	Measures (Alt-3)	Encounters (Alt-2)	Demographics (Alt-1)

Northern Health MOIS/ICCIS Summary Guidelines for Consistent Data Entry – PROVIDER REFERENCE

19Dec2014 SummaryVersion2

MOIS/ICCIS HOW TO: Physician/Locum - Start Up Guide



Where to go for Help

• From any Module in MOIS, select **Help** from the toolbar. Find the User Manual here.

ecord <u>M</u> odules <u>V</u> iews	Actio	n <u>U</u> tilities Pri <u>n</u>	<u>n</u> t Maintenance			Desktop Provi	ider: BILL, DR		
Patient Chart		Patient Su	mmary 🛛	User <u>M</u> anual					
🔙 Patient Summary	~	New Chart	Delete Chart		Search	Previous Chart	Next Chart	Tear Off	
Demographic		Chart No.:		Summer Strengthere	ent Status:		Date:		
Encounters		Name (F/M/L):		Concession of the American	nsurance:		Number:		Dep: 00
- Califications		Birth Date:			e Provider:			-	
Consults		Expand All Col	llapse All	The second se	60 day	s Since Last	Required in	n the next 90	days
Procedures		Date De	escription		Detail			Н	yperlink

- Online, the site on OurNH is currently being updated. NH-specific documentation will be found here.
 Information regarding this website will be added when it is available.
- For technical issues, contact ITS Service Desk
 - by email: servicedesk@northernhealth.ca
 - by phone: 1-888-558-4357

PRINT & POST – PROVIDER START UP QUICK REFERENCE

The following reference sheet is a quick reminder for the main items mentioned in this manual. Print & Post as needed.



E	PROVIDER START UP						
For:	Physician (new or locum), Nurse	Practitioner, Resident, Medical Student					
Accounts		MOIS Username: jsmith Password: aaaaaaaa for MOIS does not correspond to your NH password (i.e. change your MOIS password and vice versa)					
General Tips	click in the space beside and use F4 to F2 – Save Ctrl-T – Enters today's date Calendar – Left click on the date field and us Ctrl-H – Prompts a patient-specific Health Ma	e F4 to prompt a month-view calendar.					
Scheduler	 Scheduler – View patients booked for the day. Enter a Progress Note – Double-click the patient's name to open the Encounter Window & type a progress note. Create a Service Request (Consult/Referral/Lab or X-ray Requisition) – Open the Encounter Window, select "Action" from the Toolbar, select "Create Order for". View a patient's previous encounters – Open the Encounter Window, select "Chart Views" from the Toolbar, select "Encounters" or other chart area. Create a Prescription – Open the Encounter Window, select "Chart Views" from the Toolbar, select "Prescriptions" or "Long Term Meds". 						
Patient Chart	space and press F4 – always search using Pl MOIS without first searching by each of these Or Select "Go To Chart" on the bottom left corne						
Workspace	messages. Note: The user's "Current Worksp Change Workspaces – Select the Measures from the Toolbar, click on the correct name fro their workspace.	results (labs, consults, etc.); manage tasks and ace" is shown on the right above the toolbar. folder under "My Basket", select "Change W/S" om the pop-up and choose "Selected User" to view space by selecting "Change W/S" from the Toolbar,					

