SCDMH EMR USER MANUAL (revised 07/23/10)

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Introduction

Electronic medical records (EMR) are a fundamental component of health information technology that will transform our healthcare system. EMR technology will eventually feed data to Regional Health Information Networks (RHIOs). RHIOs will, in turn, connect into a National Health Information Network to provide seamless access to critical medical information no matter where it is needed. Information technology is not the end-all-be-all to fix our healthcare system, but it will be a major stepping stone toward streamlining and improving continuity of care. Information technology (IT) has revolutionized most major industries. Yet the most vital industry of all --- healthcare, including behavioral healthcare --- is one of the last to embrace the full benefits of IT.

Healthcare consultants estimate that while the financial services industry spends over 7% of its budget on IT, the healthcare industry spends only 3%. Instituting a standardized, nationwide EMR network will not be easy. Each provider will need to assign resources to implement an EMR, forcing change and adaptation. Change is hard and every stakeholder must be convinced of the benefits. This includes patients who fear their privacy being breached, doctors who believe EMRs threaten their practices and hospitals and clinics that wonder how they are going to pay for such a huge undertaking.

Improving client outcomes is the priority at DMH. We must do what we can with available resources to enhance existing systems with clinical features, moving toward a fully realized EMR. Staff access to computers, though limited in the past, will naturally improve as a consequence of useful clinical modules being developed. An incremental approach based on adding clinical functionality to existing systems, standardizing online forms, imaging medical records where appropriate and providing access to clinical reports will combine to create a reasonably low risk course of action to improve clinical workflow and client care outcomes.

The Office of Network and Information Technology (ONIT) partnered with Santee-Wateree CMHC staff to develop an EMR based on one developed for Santee-Wateree. This new system, with many additional features, has been successfully piloted at Santee Wateree and is now being implemented at other centers. The purpose of this User Manual is to provide detailed feature documentation and to prepare staff to use the system to streamline and enhance the delivery of services to our clients. Please give us your feedback on this manual. We want it to be a valuable reference guide. Help us make it better. Send your feedback to EMR support staff by choosing **Email Help Desk** from the **EMR Home Screen.**

Lastly, it is important to note that adopting an EMR does not change clinical protocols, pathways or standards of care and is not intended to replace a physician’s judgment in treating clients.

Getting Started: How to Log on to the EMR

Start Internet Explorer and either enter the URL (https://emrnet/emr) or click on the EMR link from the DMH Intranet home page and you will be presented with a log on screen. You must identify yourself with your unique CIS/EMR user identification (user id) and password. (Hint: This password is not generally the same as your Novell password which you use to log your PC onto the network.) After successfully entering your CIS/EMR userid and password and clicking **log on** you will be taken to either a **select facility** screen or the **EMR Home** screen.

If your logon is unsuccessful, please check the message above the login prompt. Verify that the **caps lock** is **off** and re-enter your userid and password. If you are still having problems please contact your local systems administrator. (Hint: If the local SA can't solve the problem or is unavailable, then please contact the ONIT Response Line at 803-935-5550 or email **helpdesk** with the details of your problem.)

EMR sessions are associated with specific facilities (Centers or Hospitals). You can only work with one facility at a time. If you are registered at multiple facilities then you will be prompted to select the facility with which you would like to work during this session. Simply click the down arrow and a list of facilities for which you are registered will appear in the drop down. Click a facility and click **go**. (Hint: You can change the facility later inside the application if you wish.) If you are not registered at multiple facilities you will not see the **select facility** screen because this will default (be automatically selected by the application) and you will see the **EMR Home** screen.

The EMR Home Screen: How to Navigate the System

This is home base or the **Home screen** for the EMR and is mainly used to navigate to the various component modules of the system. The Home screen also displays a count of items that need attention and a daily appointment list. It is important to familiarize yourself with the features of this screen because many details are repeated on other screens within the EMR. The horizontal burgundy bar located just under the DMH logo contains **navigation links** to the major EMR components. It is consistent throughout the EMR. (Hint: clicking on the **Home** link at the far left side of the navigation bar always takes you back to this screen from anywhere within the EMR.) The blue bar down the left side of the screen contains some additional links as noted below.

Home Screen: Top (Burgundy) Navigation Bar Links

- **Home:** this page
- **Client**: Look up a specific client's information
- **Staff:** Manage EMR users (available to selected administrative staff)
- **Plan of Care:** View and manage client case load Plans of Care and Progress Summaries
- **Scheduler:** Schedule and manage client appointments
- **Clinical Notes:** Document services rendered to clients

Home Screen: Side (Blue) Navigation Bar Links

- **Email Help Desk:** send a note to the EMR support staff
- **Client Signature:** select a client and a form for the client to sign electronically
- **Change Password:** change your EMR/CIS password (Hint: this will not affect your electronic signature password which is the same as your Novell password).

Home Screen: The overview sections represent

- **Review items - POC items that require the user's review/signature**
- **Rejected items - POC items that were rejected by the reviewer**
- **Clinical Notes Due - Clinical Notes items that are due/past due**
- **POC or PS Due - POC items that are due/past due**

Home Screen: Switch Facility to

This feature at the top right of the Home screen allows you to switch the facility whose records/information you want to work with. This feature allows switching facilities without having to logout and log back in and is exclusively for users who work at multiple facilities.

Home Screen: Switch User to

This feature at the top right of the **Home** screen allows supervisors to view and, within limits, act on the work of their subordinates. The dropdown contains all the users under the current user in the subordinate hierarchy (i.e. includes all of the user’s subordinates, as well as all of their subordinates, etc.). An example would be a supervisor could switch to and view a subordinate’s Plan of Care caseload.

Home Screen: Logout

For security reasons please remember to log out at the end of your session using this logout link in the upper right corner of the screen.

Home Screen: Quick Search

This feature on the right side just under the navigation bar is a short cut which allows looking up a specific client’s information without having to first go to the **Client** link. Once a search criteria is entered and the enter key is pressed, the **Client** screen will display with any matches found.

Search criteria are handled as follows:

- A numeric entry will search on the client id (CID)
- Entries matching nnn-nn-nnnn (where n is a number between 0-9 and yes, you do enter the dashes) are searched based on social security number
- Alphabetic entries are searched based on the client’s last name
- Alphabetic entries separated by a comma are searched based on the client’s last name, first name (e.g. “Doe, Jane” searches for clients named “Jane Doe”).

(Hint: when searching by name you can use a wildcard search to locate all names that begin with what you enter – e.g. typing “Jo” will match Jones, Johns, Johnson, etc.)

Home Screen: Email Help Desk Screen
This screen allows you to send a message directly to the EMR support staff. Please do **not** include any confidential information in your message.

- Select a subject from the drop down choices
- Write your message
- Press the “Send Message” button

EMR support staff will respond to your message as soon as possible. We appreciate feedback and take it seriously. No system is perfect and we fully expect to continuously improve the EMR with your help.

(Hint: This is not the same thing as using GroupWise to email the “helpdesk.” “Helpdesk” is a special user id set up in GroupWise to allow communication directly with the ONIT Response line about such things as network problems or Novell log on problems when the local Systems Administrator is unavailable.)

Home Screen: Diagnosis Discrepancies table
When the system detects a difference between CIS, POC and PMA diagnosis codes for a client on the user’s caseload, a table labeled "**Diagnosis Discrepancies**" will appear on the EMR home page. It will list the number of clients with discrepancies.

To view the clients that have discrepancies click on the "**Show/Hide List**" link following the number of discrepancies. To view the specific discrepancy, click on the "**Show/Hide Details**" link next to the client. A table will appear listing the diagnosis for CIS, POC, and PMA with differences highlighted in blue.

Electronically Signing Forms: Signature Authorization screen

The first time the user attempts to sign a form during an EMR session he/she will be presented with the **Signature Authorization** screen. This is a simple screen that asks for a **Signature ID** and a **Signature Password**. Enter your Novell User id and Novell password. This is the same user id and password that you use to log your PC onto the network after you first turn it on. Make sure your **Caps Lock** key is not on when typing your password.

Your Novell user id and password used for signature authorization may be different from your EMR/CIS user id and password used to sign onto the EMR or CIS. We know this is confusing. This unfortunate situation will be remedied with technology called “single sign-on.” Although this will require additional funding we are hopeful that eventually we’ll be able to implement this to makes things a bit easier for you.

Important Note: This screen will only appear once per login. It comes up the first time you attempt to sign a form. Subsequent signatures will use the same credentials as those entered on the first signing and will not require re-entry of signature id and signature password. Please make sure your computer is secured during any absence. If you will be gone for an extended period either log out of the EMR application (preferred) or lock your workstation (press ctrl-alt-delete and then press the "Lock Workstation" button).

Client Signature – POC:
To obtain a client's signature on a POC go through the **Client Signature** link on the **home page**. (Hint: To obtain a client's signature on a Consent Form go through the Client tab to find the client. Then click on the **Consent** tab, select the consent form and fill it out. When you reach the client signature area it is similar to the following.)

You must locate the client who will be signing a form. Entering a CID or SSN will return only one record when there is a match. Entering a first or last name may return a list of clients from which to choose.

(Hint: when searching by name you can use a wildcard search to locate all names that begin with what you enter – e.g. typing "Jo" will match Jones, Johns, Johnson, etc.
If you do know the entire name it's best to type it in completely because this will lessen search time.)

Select (by clicking on) the desired client in the list resulting from the search. The next screen will present a list of forms that are available for the client to sign with an icon in the last column to indicate if this form has been previously signed by the client. Select/click on the desired form.

On the next screen there will be several fields to fill out as well as a read-only version of the selected form for the client and/or clinician to review. Once the form has been reviewed please select one of the radio buttons at the top of the screen:

- **Accept Plan**
- **Decline Plan**
- **Patient Refused to Sign**

Unless **Patient Refused to Sign** was selected you must now click the **Capture Signature** button. A window will pop-up to display the captured signature. Use the signature pad to let the client sign and press **Ok** on the pop-up window. The captured signature should now appear in the space beneath the **Capture Signature** button.

Once the signature is captured or the **Patient Refused to Sign** button is selected you must enter your signature user id and password – this is your Novell user id and password; the same as when signing any other form (see signature section for details). Press the submit button. The signed form will then be presented for your review.

Change Password Screen:
To change your EMR/CIS password:

- Click **Change Password** on the blue side navigation bar.
- Enter your current password
- Enter your new password twice (this is to minimize the chance of mistyping it)
- Click the submit button

Client: Selecting a client

The Client link takes you to a client search screen that allows you to look up a summary of the client's information, such as medications, allergies, POC, medical notes, schedule, etc.

To locate a client make sure you are on the **Search** link of the **Client** screen. If necessary click the search link to display the search form. Enter information in the search form to identify the client (CID or SSN is easiest as they are discrete identifiers).

- If you are entering the CID or SSN you do not need to fill other fields.
- When searching by name you can use a wildcard search to locate all names that begin with what you enter – e.g. typing "Jo" will match Jones, Johns, Johnson, etc. If you do know the entire name it's best to type it in completely because this will lessen search time.
- You can select to search only the center you are logged in to (see upper right of screen), all centers, or a list of centers by clicking the appropriate radio button. When selecting a list of centers you can select multiple centers by holding down the control key (often labeled "Ctrl") and clicking the centers you want. Each highlighted center will be searched for matches to your entered criteria.
- You may choose to show discharged patients by selecting the appropriate radio button.

If the search criteria were specific enough to return only one match then that client is automatically selected. If the search criteria return multiple possible matches they are presented in a list. Select the client whose information you would like to view by clicking on that entry. To revise your search click on the **Search** link to re-display the search entry form.

Client: Overview link
Once a client is selected their information will load and a new set of links will appear allowing the user to browse the client's information. By default the **Overview** link will be selected. This link provides general information about the client, such as demographic information, diagnosis, allergies, and medications.

If there are any alerts associated with the client then a notification will appear on the Overview link screen. Select the Alerts link for details on any alerts.

If the client has multiple admissions each link will have a list of admissions to select from, with the selection defaulting to the currently active admission. (Hint: Selecting a different admission will change only the "admission related" information.)

Client: Goals link
The Goals link will display the client's goal(s) which were entered on the Individual Plan of Care (POC). To view the plan associated with a goal click the **View Plan**.
If the client is in the user's case load and the plan associated with the goal has not been submitted as complete, there will be an **Edit** link in place of the **View Plan** link allowing the user to directly edit the plan containing the selected goal. Goals that are associated with an expired Plan of Care will be listed as **Inactive.** To add a new goal to the current Plan of Care click on the **Add/Update goals** link above the goals list. If the current Plan of Care has already been submitted as complete (electronically signed) this will open an addendum to add new goals to the plan.

Client: POC link
The POC link will display an overview of the client's Individual Plan of Care (POC). If the client has any closed series POCs they will display in the POC History section. If the client is in the user's case load, then this screen will act very similar to an entry on the Plan of Care case load screen. If the client is not in the user's case load, clicking on the icons will present read-only versions of the forms. Please refer to the Plan of Care section for more details on a POC series and rules as well as the meaning and actions of the various icons and sections.

Client: Med. Notes link
The Med. Notes link will display a list of the client's medical notes. The owner of the form will have the ability to modify them. (Hint: The **owner** of a form is the user who originally created the form.) Medical Notes will be presented with all the forms that need to be completed as well as those that have been completed. Click the radio button on the left to interact with a form. Users who are not owners (creators) of a form will be presented with view-only versions of the completed forms.

Client: CSN link
The CSN link will display a list of the client's clinical service notes. Forms that need to be completed as well as those that are complete will be presented. The owner of a form will have the ability to modify the form. Click the radio button on the left to interact with a form. Users who are not owners of a note will be presented with a view-only version.

Client: Appointments link
The Appointments link will display a list of all appointments for the selected admission. A graph will also be presented to give an overview of appointment(s) status. Add an appointment by clicking the **Add Appointments** link above the graph. View/update appointment details by clicking on that appointment's entry in the list. Updating is available only if the appointment is both in the future and has a status of pending.

Client: Meds link

The Meds link presents more detailed information about the client's medications and allergies than the overview link.

Client: History link
The History link displays (for the selected admission) a graph of the client's GAF scores, diagnosis information, and active medications and allergies, and CAFAS information if available. To view the exact date and score on the GAF chart the user can move the cursor over a data point on the graph and this information will pop up.

Client: Alerts link
The Alerts link will default to displaying all the alerts associated with the client. Add a new alert by clicking on the **Add Alert** link above or below the alerts list. Update an alert by clicking on the **Edit** link in the Action Column of that alert. Delete an alert by clicking on the **Delete** link in the Action Column of that alert.

Selecting **Edit** or **Add** will display a new window. Selecting **Edit** to update an existing alert will pre-fill existing information. Selecting **Add** will bring up a blank alert form. Fill or update the fields as needed and click the **Submit** button.

Deleting an alert will present a confirmation prompt. Verify that you are deleting the correct alert before proceeding. Click the **Delete** button to confirm the deletion.

Client: Consent Forms (see Appendix B for sample forms)

Consent forms are available from the consent forms tab on the client screen:

1. Medicare Auth.
2. Medicaid Auth.
3. Private Ins. Auth.
4. Disclosure Auth.
5. Request to Amend Protected Health Info (PHI)
6. Income Verification
7. Exam/Treatment consent
8. Follow-up contact
9. Request to inspect PHI
10. Neuroleptic consent (English/Spanish)

To start a new copy of a consent form click the circle with the '+'. If there is a current consent form the description next to the '+' turns into a link and can be clicked to view the form. Each time a new consent form is signed that link will show the latest. There is an 'Archive' link at the bottom that shows all forms in chronological order. Use this if access to a previous copy of a form is needed.

Note: The forms do not allow saving for later completion. They need to be completed in one session.

The basic procedure is to fill out the form, and then the client and the witness sign electronically to complete the form.

The following forms deviate from the standard procedure in some way.

- Request to Amend PHI and Request to Inspect PHI

  Once the form is signed and completed, clicking on the link next to the '+' brings up an option to grant/deny the request in addition to a PDF copy of the request. Select the grant/deny link and fill out the form to grant or deny the request.

- Income verification

  This form can have up to 3 times where 'No Proof' is selected.

- Exam/Treatment consent

  Once this form is completed for an admission, clicking on the '+' will ask the user if they want to create a new form or add signatures to the existing form. Clicking on the link next to the '+' (once a signed form exists) shows the original consent and provides links to allow viewing 'additional signature' forms that were added after the original consent.

Client: Import Link

The Import link will allow any documents to be incorporated into the Electronic Medical Record as long as they have been converted to the Portable Document Format (PDF). (Note: These documents must be PDF files and no other file type will be accepted. If you need help in converting other file types to PDF please get in touch with your SA.) These documents are associated with a specific client and are also identified by a date and a document type. This identification process will be useful when searching for this information at some future time.

In order to have access to the Import link the user must have the Import Records role or the Clinical role (see Staff Module: Role Link).

The screen is divided into two sections, import and view.

Client: Import Link – Import New File

This section will only appear if the user has the Import Records role. All three fields on this section are required to import a document. The **Type of Record** field is a drop down to choose the document type. The **Record Date** is the date on the document (not the date it is being imported). The **Record Date** cannot be in the future. The **File to Upload** can be typed in or chosen using the Browse button. If the file name is typed, it must include the full path name of the file (i.e. C:\PDFS\myfile.pdf). The Browse button opens a standard windows file selection window. Once all three fields are completed click the **Save PDF** button.

A verification screen will appear. At the top are two buttons **Import** and **Cancel**. Underneath the buttons are the **Type of Record** and **Date of Record** that were entered on the previous screen. Below is the PDF. The purpose of this screen is to manually verify that the PDF is the correct one and that the type and date are correct. If any of these are not correct, click on the **Cancel** button and it will return you to the previous screen with a message, **Importing PDF Canceled**. If correct click the **Import** button and the PDF will be imported and you will be returned to the previous screen with a message, **PDF import successful.**

Client: Import Link – View Existing Imported Records
This section will appear if the user has either the Import Records role or the Clinical role. The only field required on this screen is the **Type of Record.** Again this field is a drop down, but there is an **ALL** choice in the drop down. The **ALL** choice will not limit the search by type. The other fields are not required, but will limit the search for efficiency. These are the **Beginning Record Date**, **Ending Record Date**, and **Only Search Current Admission**. The date fields can be used separately. If only the beginning date is entered, the search will be from that day forward. If only the ending date is entered, the search will be from that day backward. By default, this search will include information from all admissions. If you only want to search the current admission, click the check box **Only Search Current Admission.** Once you have entered all of your search criteria, click the **Search** button. If your search does not find any imported records, you will be returned to this screen with a message **No Imported PDFS Found.** If your search does find records, you will be presented with a list of records that matched your search. Above the list are four buttons **Select All**, **Unselect All**, **View Selected**, and **Cancel**. These buttons are repeated below the list. The list has three columns. The **Select** column is a check box to select the record as one you would like to view. The **Type of Record** column lists the type. This column is blank unless the type of record is different than the record above it. The final column is the **Date of Record**. The headers for both the **Type of Record** and **Date of Record** columns are links that will sort the results.

The **Select All** button checks the select box by all records. The **Unselect All** button un-checks the box by all records. **View Selected** displays a new screen. The bottom of the screen shows one PDF at a time with three buttons and a counter above the record. The buttons are **Next**, **Prev,** and **Return.** The **Next** and **Prev** buttons will be grayed out if you are at the end of the list. For example, if you are on the first record the **Prev** will be grayed out. If you are on the last record, the **Next** button will be grayed out. If only one record was selected then both buttons will be grayed out. The **Return** button will return you to the first Import records screen. On the right is a counter to let you know where you are in the list of records. Below the buttons are the labels Type of Record, Date of Record and Date/Time of Import.

If the user has the Import Records role, there will be an **Update Record** section with two fields above the record. This section is to change the **Type of Record** and **Record Date** of a previously imported record. If the record is to be changed, both fields are required. Once you click **Update PDF,** the record will be updated and you will be returned to the main Import records screen with a message PDF update successful.

Plan of Care: Working with the POC

Selecting the Plan of Care top navigation link will display the user's case load. If the user does not have a case load then a list of forms that have been submitted for review will display. If the user has a case load as well as records to review, then the case load will display by default with a link above the **Urgency Sections** box to display the review items.

Plan of Care: Urgency Sections
The case load is divided into three sections indicating the urgency of attention needed for each Plan of Care: urgent (attention needed now), warning (attention needed soon) and ok (in compliance). By default only the urgent and warning sections are displayed. To view the Plans of Care that are in compliance please check the **In Compliance** checkbox in the

Section Selection box at the top of the screen and press the **Go** button. The user can use the **Section Selection** box to determine which sections to display. The sections will always be listed from most urgent to least urgent. Urgency is determined for a given series as follows.

- **Urgent** – No plan or one of the mandatory progress summaries is past due
- **Warning** – One of the mandatory progress summaries is due soon
- **OK** – Plan completed and no mandatory progress summaries due soon

Plan of Care: Action Items
This link will list rejected and completed forms. Rejected forms will automatically disappear from the list once they have been modified. Clicking on a rejected item will take you to the same screen as if you clicked on it in the caseload screen. Clicking on an item in the completed list will open the completed form (PDF). Completed forms will remain until they are removed by either checking the box next to them in the list and clicking the remove button or by clicking the remove button at the top of the page that comes up when you click on an entry in the completed list. The purpose of **Action Items** is to make it easier for users to track rejected items and to print completed items.

Plan of Care: Sorting
The case load can be sorted by date, client id, admission number, client name, and admission date. Sort the case load by clicking the appropriate sort header. Clicking the same header again will reverse the direction of the sort. The sort selection and direction are indicated by the arrow next to the header. (Hint: Each section will be sorted separately – e.g. **Attention Needed Now** will be sorted separately from **Attention Needed Soon**, etc.)

Plan of Care: Selecting Client(s)
The case load can be filtered to display only records matching one of the following criteria (or filters).

- **By CID -** To show only the records for a given client enter the client id (CID) in the **List by Client ID** field and press the **Submit** button adjacent to the field.

- **By Last Name -** enter a client's last name and press the submit button next to the field to display all clients with the provided last name. (Hint: when searching by name you can use a wildcard search to locate all names that begin with what you enter – e.g. typing "Jo" will match Jones, Johns, Johnson, etc. If you do know the entire name it's best to type it in completely because this will lessen search time.)

If a filter returns multiple entries, then those entries will be listed in their respective urgency sections beginning with the most urgent. (Hint: To reverse the filter and view the entire caseload again please click on the **Show All** button below the filter boxes.)

Plan of Care: Multiple Pages
Case loads with many entries are divided over multiple pages (screens). To select how many entries are visible per page select an entry from the **Records per page** drop down

list. If multiple pages are necessary to display all the case load entries, then the user can select which page to display by clicking the appropriate entry range link displayed below the **Records per page** drop down list. If all case load entries are displayed on a single page then there will be no entry range link displayed.

Plan of Care: Row/Series
Each entry or row on the Plan of Care screen represents a series. Each series represents a Plan of Care and any associated forms, such as addendums or progress summaries. Each item in a series has a status icon. Refer to the icon legend for their meaning. Clicking on the icon will cause the appropriate action. (Hint: "Plan Not Started" and "Disabled/Not Available" icons do not have an action associated with them.)

Plan of Care: Progress Summaries
Progress summaries 1-4 are listed as separate items (labeled PS1, PS2, PS3, and PS4) and one is due every 90 days. If a progress summary is needed between those 90 day periods, then an **Other PS** should be created. **Other PS** (Other Progress Summaries) and addendums can be added any time there is a completed plan. PS1 requires that a completed plan be present and that the current date be (at most) 30 days prior to the progress summary's due date. PS2-PS4 Progress Summaries require that the previous Progress Summary be completed and that the current date be (at most) 30 days prior to the progress summary's due date. Progress Summaries will change to a state of "warning" (attention needed soon) 30 days prior to their due date.

Other PS should be used to add a progress summary that is not part of the standard four progress summaries series.

Plan of Care: Addendums and Rollover
Addendums are used to add goals or services to a completed plan. Rollover is used when either the current Plan of Care has expired or when the current Plan of Care requires reformulation. A Rollover will create a new series with a new Plan of Care. (Hint: Progress Summary due dates are not related to the Plan of Care, they are based on the admission date; therefore doing a Rollover will not change the due date of the next Progress Summary.)

Plan of Care: Start New or Update
To start or update a Plan of Care click on the icon in the **Plan** column of the case load screen. The EMR attempts to pre-fill the diagnosis from existing data. If there is no diagnosis or if it needs to be altered, please enter a valid diagnosis code and press either the **Enter** or **Tab** keys or click into another field. If the diagnosis code is valid the description will fill in automatically.

Plan of Care: Goals/Objectives/Interventions
The plan must have at least one Goal which has one Objective which in turn has one Intervention.

Adding Goals: Each goal will have at least one objective associated with it. To add a goal click the "+" (add item) icon following the last goal on the plan.

Adding Objectives: Each objective will have at least one intervention associated with it. To add an objective click the "+" (add item) icon following the last objective for the goal to which you want to add an objective.

Adding Interventions: To add an intervention click the "+" (add item) icon following the last intervention for the objective to which you want to add an intervention.

Target Date: Each objective will have a target date. This must either be an actual date in the mm/dd/yyyy format or the word "ongoing" if it is an ongoing objective. Ongoing objectives will carry over their value on roll-over (i.e. when new plan is due or the plan needs to be reformulated). Objectives with dates will have their date fields reset to be blank on roll-over.

Deleting a Goal/Objective/Intervention: To delete a goal/objective/intervention click the "X" (remove item) icon next to the desired item. NOTE: all the sub-items associated with the deleted item will also be deleted. This means any interventions associated with a deleted objective and any objectives associated with a deleted goal will also be deleted.
NOTE: you can not delete the last item in a set. There must be at least one Goal, each goal must have at least one objective, and each objective must have at least one intervention.

Plan of Care: Services
A plan must have at least one service. Select the service, frequency, and type of staff from the drop down list.

- **Add a service:** Click the "+" (add item) icon below the last service
- **Delete a service:** Click the "X" (remove item) icon next to the service you want to delete. (Hint: There must be at least one service remaining. You cannot delete all services.)

The POC and Addendum allow selecting multiple entries for "Type of Staff" for each service. A maximum of 4 items are displayed at a time. If more than 4 are available there will be a scroll bar next to the box that can be used to see the remaining items. There are two ways to select more than one item in the list

- To select consecutive items, hold down the shift key, click on the first entry (type of staff) you want to add, then while still holding down the shift key, click on the last item (type of staff) you want included. All the items in between the first and last will now be highlighted. You can now release the shift key. To undo the multiple selections simply click on an item without holding the shift key; this will make that the only highlighted item.

- To select multiple items (not necessarily consecutive in the list), hold down the control key (usually labeled "ctrl" and found under the shift key). While holding

down the ctrl key select the specific items you want highlighted. Only the items you click will highlight (as opposed to the items in between also being highlighted). Once all the desired items are selected release the ctrl key. To undo the selection click on an item without holding down any keys; this will make it the only selected item.

Plan of Care: Diagnosis Codes (DSM-IV-TR)

The POC accepts up to 6 regular DSM-IV-TR diagnosis codes and up to 6 rule-out diagnosis codes. The program will alert the user if there are more diagnoses in CIS than on the POC and present a button to add them to the POC. Type in the diagnosis and press enter, tab, or click outside the diagnosis field for it to retrieve the diagnosis description.

- If you enter a diagnosis that only has one description and press enter or move the cursor out of the diagnosis code field it will automatically populate the description field.

- If you enter a diagnosis that has multiple descriptions a window will pop up when you either press enter or move the cursor out of the diagnosis code field. It will have a list of links - one for each description. Select the one you want by clicking on it, which will close the pop up window and set the description to the selected one.

- If you want to change the description after selecting one you will have to click in the diagnosis code field and press enter. This will allow the list of descriptions to once again appear for your selection.

- To add more than the standard two diagnosis codes click on the [+] next to the "Additional Diagnosis" header. The program will try to pre-populate the "Additional Diagnosis" fields from CIS. If there is a discrepancy between what's in CIS and what's on the POC the user will be alerted (i.e. it will list the "active diagnosis" from CIS under the applicable diagnosis field).

- To add rule-out diagnoses click on the [+] next to the "Rule-out diagnosis" header.

- To delete a diagnosis click on the [x] next to the field you wish to delete.

- Rule-out diagnoses are free text fields limited to 30 characters.

Plan of Care: Save (finish later), Sign and Save, or Cancel

You may either save a plan for later completion or electronically sign (completing your part of the process) and save it. Saving for later completion does not enforce any rules such as filling in required fields and will not prompt you to sign it or choose a reviewer.

It's merely a convenient way to pause your work on the plan and save it so you can come back to it later. You will be able to pick back up right where you left off. Electronically signing a form completes your part of processing the form and saves it with your electronic signature which includes a date and time stamp.

Save (finish later): To save a plan for later completion click the **Save (finish later)** button. You will not be prompted to fill out any missing required fields. You will be returned to the case load screen. You can continue working on the plan at any time.

Sign and Save: Click the **Sign and Save** button. This will check that all required fields have been filled out and then send you to a screen to select a reviewer if appropriate. After the reviewer is selected (or if no review is required) and if it's the first time then the signature screen is displayed. After signing the plan it cannot be updated unless submission is revoked before the plan is completed. Once the plan is completed (meaning all necessary signatures are present) the plan can no longer be revoked. To add goals or services to the plan use the **Addendum** on the main **Case Load** screen. To reformulate the plan use the **Rollover** function on the main **Case Load** screen.

Cancel: This cancels any changes made to the plan and returns the user to **Case Load** screen.

Once a form has been signed and submitted for review the status icon on the **Case Load** screen for that form will change to indicate it is in a submitted status. It will remain in this status and with this icon until the form has the highest required signature (currently MD for Plan of Care/Addendums, MHP for Progress Summaries). Once all signatures are present then the form's status will change to **complete**.

Until the form is **completed** the submitting user has the ability to revoke the submission to either make corrections or submit the form to a different staff member.

Plan of Care: Unlocking a POC

Once a POC is completed, it is locked but you have the ability to unlock the form. Only forms in the active series can be unlocked. Unlocking a form will require re-signing that form and all subsequent forms. For example, if a plan is unlocked after 2 progress summaries associated with that plan have already been signed then those summaries will be unlocked in the order they were signed once the plan is completed. This is to ensure that changes to the plan (such as adding goals or objectives) are reflected in the summaries and addendums. an unlocked series can be identified by the check mark + "x" icon for all items except one - which has a check mark and pencil icon. The user needs to keep following the checkmark and pencil icon as it moves across the series (i.e. it indicates the current item that needs to be re-signed).

To unlock a POC form:

- Click on the icon associated with the signed form you wish to unlock.

- Click on the "Unlock" button. You will be reminded that you will have to sign all subsequent forms. Click "Ok" or "Cancel" as appropriate.
- Fill out the unlocked form - a reason for unlocking will have to be added.
- Once the unlocked form is completed the next form in line will automatically be unlocked. Continue signing forms until the last one is reached.
- Once the last previously signed form in the series is signed the series will return to its normal state (while re-signing forms all other items are blocked).

Progress Summary: Working with the Progress Summary

Enter a progress summary by clicking on the currently active progress summary's icon for PS1 – PS4 or clicking on the "+" icon in the **Other PS** column of the main case load screen. Fill out the form as appropriate. The following fields are required: GAF, outcome rating, and progress description.

Progress Summary: Save (finish later), Sign and Save, Cancel

Save (finish later): Saves the form without checking required fields and returns the user to the case load screen. This feature allows you to suspend work on a form but save it "as is" so you can finish it later.

Sign and Save: Sign and Save checks required fields, saves the form once all required fields are filled in with appropriate values and either prompts for selection of reviewer or for signature credentials as appropriate. After signing the progress summary it cannot be updated unless the submission is revoked before the progress summary is completed. Once the progress summary is completed (all necessary signatures are present) it can no longer be revoked. Either use **Other PS** to add additional progress summaries, wait for the next summary to be due, or Rollover the series and reformulate the plan (if you filled out PS4).

Cancel: cancels any changes made to form and returns the user to the case load screen.

Progress Summary: Read Only
A read-only view of a Progress Summary is presented when a submitted or completed item is clicked. Pressing the **Done** button on a read-only view of a progress summary will return the user to the previous screen.

Reviewer Selection: Providing for Reviewer Signatures

If a form is submitted for signature and the requirements state that an additional signature is required (e.g. when an MHP signs a Plan of Care, an MD signature is required to finalize the form), the Reviewer Selection screen will be presented, allowing the user to

select the reviewing staff member. To choose a staff member to review a form select the name from the drop down list. The list contains all staff members with the correct level of credentials for the next required signature.

If the reviewer is MD level, a checkbox will also be presented to allow selecting that staff member to be the default selection for the current client for all future forms that require an MD level signature. This checkbox will not be visible for reviewer selections that are not MD level.

The user can add a note to the reviewer by typing in the provided text box.

Once the desired reviewer is selected and optionally a note added, press the **Accept** button to submit the form to the reviewer.

Revoking a POC or Progress Summary submission

To revoke a submission the user clicks on the icon of the submitted form they would like to revoke. The screen for a submitted item will display a read-only version of the submitted form as well as details about who it was submitted to, when it was submitted and the status of the submission.

The user can use this screen to see whose approval the form is waiting on and to review the form.

To revoke the form, press the **Revoke Submission** button. This will revoke the form and display it again in an editable mode, allowing modifications to be made and the form to be saved for later or re-signed and re-submitted.

Caseload Management

The POC has two links related to caseload management: **Temporary Caseload** and **Caseload Management**. The **Caseload Management** link allows users to re-assign all or part of their caseloads. Caseloads can be permanent or temporary. The difference is that a temporary assignment is added to a separate caseload screen and can be revoked by the assigner. A permanent assignment is added to the assignee's regular caseload. Temporary assignments are viewed using the **Temporary Caseload** link.

On the caseload management screen there is a drop-down list that allows you to select the user for whom you want to assign caseloads. By default this list contains the current user and, if they are a supervisor, all of their subordinates (same as switch user list). There is a "Caseload Manager" role that will allow the user to select any other user at the facility and assign their caseloads.

Under the user selection box you will find the caseload assignment boxes - one each for regular caseload and temporary caseload (only the ones that apply will appear). The user selects the members of selected user's caseload on the left and the case load manager(s) they want to assign the selections to on the right (shift-click and ctrl-click are available). The system will then try to distribute the selected caseload as evenly among the caseload managers as possible. For example: user selects 20 entries from their caseload and 4 managers, the system will then assign 5 cases to each selected manager.

If the user is assigning their own caseload they are only able to assign temporarily; if they are assigning for another user they can assign permanently - use the radio buttons beneath the caseload selection box to choose an option.

Under the caseload selection boxes there is a list of cases that have been temporarily assigned to someone else. To undo the temporary assignment, select the appropriate case and click the undo button at the bottom (**select all** convenience button is available).

Reviewing POC Records: Records to Review queue

If the user does not have a case load assigned then the **Plan of Care** link will automatically display the **Records to Review** queue for the user. If the user has a case load assigned and has items to review, the **Records to Review** queue will be accessible via a link at the top of the Plan of Care screen.

The Records to Review screen list a reviewer's queue. It will list the items that the user needs to review and e-sign.

Each line represents one item. Once the reviewer has reviewed the item they can either reject it back to the submitter or approve it by e-sign.

Rejecting an item requires the reviewer to provide a reason for the rejection. Approval requires the reviewer to electronically sign the form and possibly select the next reviewer in line (see Reviewer Selection for details).

Select an item to review by clicking on the link in the queue that corresponds to the item to be reviewed. The user may now review the read-only copy of the item. If changes are needed to the form, it should be rejected to the submitter with a note detailing the changes necessary for approval. Any comments sent with the form by previous submitters will be visible by clicking the **Show Comments** link above the form.

The user has three options: Accept, Reject, Cancel

Accept: Press the **Accept** button to accept the form and sign it. If the form requires additional signatures/approvals, then the approver will be presented with the reviewer selection screen. If the reviewer has not signed any forms under the current session they will be presented with the signature screen as well.

Once the form is approved and if it does not require any further approval it will be removed from the reviewer's queue and put in a completed status. If the form requires additional approval it will remain in the reviewer queue until it is either revoked by the original submitter or completed. Hint: A reviewer can also revoke their submission. For example, if a BA level clinician submitted the plan to an MHP and then the MHP submits to an MD, the MHP can also revoke their submission until the MD signs or rejects – this feature is used in the case of the MHP deciding to reject or needs to re-route.

Reject: Add a rejection reason to text box and press the **Deny** button. A rejection reason is required. This will remove the item from the reviewer's queue and change its status to "rejected". The owner/original submitter will see the form as rejected
A rejected form will have its icon changed to reflect its status. To view the rejection reason and modify the form please click on the icon of the rejected item.

Cancel: Pressing the **Cancel** button will leave the item unchanged in the reviewer's queue for later review/completion.

Rollover
The rollover icon at the end of each case load item/series will close the series and start a new one. This functionality should be used to start a new Plan of Care after the current one expires or to re-formulate a Plan of Care as necessary.

By selecting the "Rollover" icon the user will display a screen allowing them to select which goals to retain for the new Plan of Care. Retained goals will be pre-filled in the new Plan of Care and ready for editing as necessary. It is not required to retain any goals. If no goals are selected an empty goal will be presented in the new Plan of Care

A goal is retained by selecting the checkbox above the goal to be retained. Alternatively the "Select All" button will check all of the goals.

Retained goals and their objectives/interventions can be edited once the rollover is completed.

Once the desired goals are selected for retention then click the **Rollover** button. A new editable Plan of Care form will be presented with the selected goals pre-filled. Any objective whose target date was "ongoing" will have "ongoing" pre-filled on the Rollover plan of Care. All other target dates will be reset to blank and require an entry before signing the plan or addendum.

Staff Module: Administering EMR Users

From the EMR Home page click the **Staff** link on the top (burgundy) navigation Bar. This will bring up the Staff Search screen.

Staff Module: Staff Search screen
Type in the first few letters of the staff's name and click find to search for a specific staff or leave blank to retrieve a list of all staff. You can search by first name or last name depending on which bullet is marked. The **Add New Staff** button will appear if the user has administrative access rights (administrative tasks role).

Staff Module: Query Results screen
The **Query Results** screen lists one or more staff members depending on the search criteria entered on the previous screen. The three small icons beginning at the left of each staff name are links to set up the access level, profile, and role respectively. The columns represent different functional areas where access rights are tracked. The "X" (incomplete) and "√"(complete) within each folder icon indicated whether that particular section of the staff record has been completed. You can hover the mouse pointer over a folder to see a detailed description of each entry.

Staff Module: Access (IT) link
The **Access (IT)** link is the blue icon at the extreme left of each staff row. Follow this link to update staff access levels (Administrative, QA, Group Edit Access levels). You will be able to update who will be supported by this staff member and also limit locations and offices for scheduling appointments.

Staff Module: Profile link
The **Profile** link is the second (green) icon from the left of each staff row. Follow this link to update supervisor selection for auditing and case load monitoring purposes. It is also used to update office and location (which comprises the cost center for billing purposes). This link also allows you to change the role abbreviation that appears before the name on the query results screen. These abbreviations relate to job roles.

Staff Module: Role link
The **Role** link is the third icon from the left of each staff row. Follow this link to update role based security. You can set or restrict access to different parts of the EMR.

Staff Module: Quality Assurance screen
The **Quality Assurance** screen is reached from the Query Results screen by clicking on the QA folder for a particular staff member. The **QA Complete** is checked to indicate that all QA items have been completed. A check here will result in a check mark displayed within the folder under the QA column on the Query Results screen. The **Credentialed Services** link will appear if staff has Administrative and QA privileges.

Staff Module: Credential Services screen
The **Credential Services** link on the **Quality Assurance** screen takes you to a screen that lists all the available services for the staff based on their credentials. You can add and remove services by selecting one or more services and clicking the **add** or **remove** buttons. Services that are added will appear in the scheduler when assigning services to appointments. To select multiple services please press and hold the Ctrl key while you

select the services. The services are not added or removed until you click the submit button at the bottom of the screen.

Staff Module: Staff Profile screen
The **Profile** link is the second (green) icon from the left of each staff row of the Query Results screen. It takes you to the **Staff Profile** screen where you can update, delete or terminate a staff profile. The staff profile contains first and last name, staff code, login id, supervisor, location, office, cost center, and position. A check box is provided to indicate, when checked, that this staff member has been terminated from DMH. Choosing a **supervisor** from the drop down menu on this screen will allow the supervisor to view this staff member's caseload including schedule, clinical notes and Plan of Cares. The **Details** box can be used to add additional information as necessary. The buttons at the bottom determine the action taken on any changes entered via this screen. Changes are applied when the **Update** button is selected. This staff record is removed from this CMHC if the **Delete** button is selected. (Hint: If the staff member is authorized to provide services at other centers, those profiles will be unaffected by this delete. It is used primarily to remove someone who was added in error.) The **Back** button returns the user to the previous screen and discards all changes entered.

Staff Module: Staff Access Level
The **Staff Access Level** screen is reached from the **Query Results** screen by selecting the blue icon at the extreme left of each staff row. This screen authorizes access to different sections of the EMR.

Administrative Access: checking this box allows the staff member to add new staff, add and modify staff profiles including this screen. When this box is checked the **Add New Staff Button** will appear on the Staff Search screen for this staff member.

Quality Assurance Access: checking this box allows the staff member to add and modify credentials and to modify QA information.

Group Edit Access: checking this box allows the staff member to modify client groups for scheduling.

Select **Staff Supported**, **Selected Locations**, or **Selected Offices** to add entries in those categories. Each link brings up a unique screen to allow entries to be added.

The **Update** button at the bottom applies any changes. The **Back** button takes you back to the previous screen.

Staff Module: Staff Supported
The **Staff Supported** screen allows you to add and modify the list of support staff for this profile. Each staff member can potentially support other staff members. This feature allows a staff member to schedule appointments and view caseloads for the supported staff in this list. Select the staff that will be supported by the staff member being profiled and click **Add**. Conversely you can select staff supported and click **Remove**. The

Submit button will apply the changes. The **Back** button will return to the previous screen.

Staff Module: Staff Roles screen

Role based security is used to grant authorization for selected EMR functions to staff. A staff member can belong to multiple roles simply by checking multiple boxes. Below is a table which details the authorizations granted by each role.

Role Name	**Role Description**	**Authorizations**
Admin	Administrative tasks	Add new staff, create and modify staff profiles, grant access to role management.
Role Manager	User roles	Establish and modify staff roles
Medical Notes	Special medical notes	access C-39
Clinical	Clinical tasks	Goals, Med Notes, POC, CSN, Meds, and History links in the Client Section

Clinical Notes: Entering Clinical Documentation

Selecting the **Clinical Notes** top (burgundy) navigation link allows you to document services rendered to clients. It first takes you to a **Search for Form** screen. You must be assigned to the **Clinical** role (see Staff Module) in order to access this section of the EMR.

Clinical Notes: Search for Forms
The **Search for Forms** screen allows you to search for forms three ways: by date, or ticket number, or both date and ticket number. There are three radio buttons on the left side which let you choose how you want to enter the search criteria. The **Enter Date** input text box and/or **Enter Ticket** text box will appear on the right side of the screen depending on which button is selected. The screen will default to **Date** with the current date preloaded in the **Enter Date** textbox. You can enter a new date in **mm/dd/yyyy** format or simply click the calendar symbol and chose the date from the pop up calendar. After entering your search criteria select the **Search** button. If you chose to enter the date manually and did not use the correct format then an error message will display. The same kind of error will display if you enter something other than a number in the **Enter Ticket** window. Simply click **ok** and re-enter the date or ticket number correctly. To reset the **Date** textbox and/or **Ticket** textbox back to its default click the **Reset** button.

If you are currently on the first screen of the Clinical Notes Section and there are outstanding notes to finish then the **Incomplete** screen will display next. This screen will

show all outstanding notes (see more on **Incomplete** screen below). Clicking on the **Skip Incomplete Section** button at the bottom of the screen will take you to the **List** screen which will display clinical forms according to your search criteria.

Clinical Notes: The List screen

The **List** screen displays clinical notes according to search criteria entered on the **Search for Forms** screen. A **Go to Incomplete Section** at the bottom of the screen will take you to the **Incomplete** screen if there are incomplete notes. You can also get here as a result of entering search criteria in the **Client** search and selecting the **CSNs** or **Med Notes** link for a client. If you got here from **Client** search then the **Go to Incomplete Section** button will not appear. To be able to view Category VIII Start **a C-39 with No Sched. Appt** or **Generic Note Assoc. W/ Medication** the Medical Notes role is required. This is only accessible from the **Client** Screen.

A variety of displays can occur in this section depending on search criteria. If no appointments are scheduled for that day then a "No Records Found" message will display at the top of the screen.

Forms will fall under one of the following categories:

- **Process of Being Reviewed** - displays all forms that you have signed and are awaiting a signature from another staff
- **Waiting for your Review** - displays forms that have been signed by another staff and are awaiting your signature (not limited by search criteria)
- **Appointment Info for Search Selection** - displays appointments that fit search criteria
- **Note Information for Search Selection** - displays pending notes that fit search criteria
- **Unsigned Forms for Search Selection** - displays unsigned forms that fit search criteria
- **Walk In Forms for Search Selection** - displays saved forms for clients that where scheduled as walk-in appointments. This form will go to the unsigned section once a transfer occurs.
- **Signed Forms for Search Selection** - displays signed forms according to search criteria
- **Reviewed by you for Search Selection** - displays forms that have your signature on the second signature block
- **Start a C-39 with No Sched. Appt / Generic Note Assoc. W/ Medication –** there is no appointment scheduled. Allows you to enter a C-39 with medication information.
- **Start a C-39 with No Sched. Appt / Generic Note -** there is no appointment scheduled. Allows you to enter a C39 for client selected.
- **Records** - displays all signed forms by client search criteria
- **Unsigned Records** - displays all unsigned forms by client search criteria.

Clinical Notes: The Incomplete screen

The Incomplete screen shows unfinished clinical documentation (incomplete forms and notes). You get to this screen from the **Search for Forms** screen if there are items that need attention. This screen will also appear when the **Go to Incomplete Section** button is selected from the **List** screen. The **Incomplete** screen will only appear if there are notes over 24 hours old that need to be completed or forms waiting or being reviewed or if there are unsigned forms.

A variety of displays can occur in this section. The categories are explained below:

- **Process of Being Reviewed** - displays all forms that you have signed and are awaiting a signature from another staff
- **Waiting for your Review** - displays forms that have been signed by another staff and are awaiting your signature
- **Appointment Info over 72 Hours** - displays scheduled appointments between 72 hours and 90 days old
- **Appointment Info over 24 hours** - displays scheduled appointments between 24 hours and 72 hours old
- **Note Information over 72 hours** - displays pending notes at least 72 hours old
- **Note Information over 24 hours** - displays pending notes between 24 hours and 72 hours old
- **Unsigned Form -** displays all unsigned forms

Clinical Notes: Columns on List / Incomplete / Client Screens

Type of Appointment - Individual or Group appointment
Client ID, First Name, Last Name - (pertaining to client)
*Service Code and Description - y*ou may pick the service code for appointments on the **List** and **Incomplete** screens that haven't been started. The default is the service code chosen in **Scheduler**. You may only start a C-39 from the **Client** screen. The service code will be shown for appointments that have been started. Otherwise, the program displays the service code, description and name of the form.
Date – (date of appointment) You may select a date on the **Client** screen for forms that have not been started.
Time - Pick an appointment time for appointments that have not been started.

Clinical Notes: Group Forms

Group Forms differ from individual forms in that the client information appears after the appointment information. A dropdown box beside the client information allows you to choose whether the client was present or a cancel/no-show. After a group form has been started it is possible to pull up all the clients associated with the form by clicking **Entire Group**.

Alerts - client alerts in red on appointments that have not been started

Ticket number - ticket number of the service on forms that have been started
Bill Date - date the ticket was billed on forms that have been started
Payment - the payment type for this service ticket
.
Clinical Notes: Processing a Form
The modal dialog menu gives you various options depending on the processing state of the form.

- **Start Form** - start a new form
- **Exit Menu** - exit the modal dialog menu
- **Update Form** – update the form
- **View Form** - view the form in "read only" mode (no update allowed)
- **Review Form** - review form for a second signature
- **Delete Form** – delete form (form has been started but not signed)

Clinical Notes: Clinical Service Note (CSN) Form

Section 1 - This section is read only if the group has already been started or a cancellation no-show.

Staff Selection List - allows you to select the staff you want to add to the appointment. Simply click the staff you would like to add and then click the **Add** button.
Staff List - the list of staff that is assigned to your appointment. You can remove staff by selecting the staff from the list and clicking **Remove**.
Staff Time - allows you to enter the staff time
Primary - allows you to select the primary staff
DMHFACIL - pre-filled
Cost Center - dropdown selected based on location and office you have chosen
Location - dropdown list allows you to choose location
Office - dropdown list allows you to choose office
Place of Service - dropdown list allows you to choose place of service
Svc Code, Batchno, Group number – pre-filled
Doctor on Premise - dropdown list allows you to choose doctor on premise. Only appears when the client has Medicare.
Date, Time Service Provided - pre-filled

Section II
Name, CID, Cancel/NS, Bill Time, Ticket, Audit, Pmttp (Payment type) – pre-filled
GAF – may be pre-filled but dropdown allows you to select a GAF score
Incarc - dropdown list
Problem - dropdown list allows you to choose problem
Emerg - dropdown list allows you to choose emergency type
Treatment Goal/Focus - dropdown list allows you to select one of the POC Goals or input your own
Note – pre-filled with prompts

Clinical Notes: Clinical Service Note (CSN) process
Fill out the information for the CSN and click the appropriate processing button.

- **Cancel** - Take you back to originating page
- **Submit** - will give you two or three choices depending on circumstances:
  - **Exit Menu** - takes you back to CSN
  - **Save Form** - allows you to save form without signing
  - **Sign/Save Form** - allows you to sign and save the form

Clinical Notes: CSN walk-in client process
To schedule a walk-in appointment first go through the general process of filling out a Clinical Service Note. After finishing the CSN and pressing submit you will only be given the option to save the CSN. The CSN will be placed in a walk-in appointment slot after it has been saved. When you do obtain the necessary patient information you can transfer the client out of walk in status. You can transfer them out of walk in status by clicking on the **Transfer** button. Search for the new client, select the client and then click **Transfer**.

Clinical Notes: Multiple signatures
Fill out the Clinical Service Note and sign the form. The form will automatically be placed in the queue of the staff member who needs to sign next. Hint: secondary signing staff must be on the staff list. Once the second staffer has signed the CSN then it will be transferred from the **Waiting to be Signed** section to **Signed** section.

The CSN will show up in the **Waiting for your Signature** section. Click the radio button selecting the CSN then the **Review** button. The **Review** button will take you to the signed form. At the top of the page you will see the following three buttons.

- **Cancel** – returns you to the list page
- **Accept** – adds your signature to the form. The form will then be placed in your “reviewed” bin.
- **Deny** - If you choose to deny the form you will be prompted for a denial reason. The form will be returned to the originating staff with your name and the reason for the denial.

Clinical Notes: Initial Clinical Assessment (ICA)

Start a new **ICA** from the **EMR home screen** by first clicking on the ‘**Clinical Notes**’ link on the top navigation bar. You will see a list of scheduled appointments. Click a radio button associated with one of the following individual appointments: **H001**, **H002**, **H003** or **H004.** Select the ‘**Start form**’ button on the dialog window to start a Clinical Service Note (CSN). There will be a command button ‘**Start ICA’** on the left side of the

screen located under CSN title. Information about the current **ICA** status will be available right above the '**Start ICA**' button.

Note: The command button title and information label content will depend on the **ICA** status.

Click the '**Start ICA**' button to open the **ICA** form. The **ICA** form contains about 20 fields. You do not have to insert information into all fields. The mandatory fields have a yellow background and are marked with a red asterisk (*). As with all forms you can use the tab key or the mouse pointer to navigate the fields.

There are a few special features and short cuts that will help you to insert information in some sections of the ICA:

- **'Go directly to MSE Section'** button
  Click this button to start with the MSE section first.

- **Mental Health Medication (Current) section**

  - **Auto complete text box for mediation name:**
    - When you type the first letter of a medication a drop down list with available medications will appear below. Navigate that list and select the medication you want and double click or click the 'Enter' button to place that medication in the medication field. After a medication is entered, the frequency and dosage fields then become mandatory.

  - **Add new medications:**
    - Click '**Add new medication**' or insert a number into the textbox on the right side of the link and new medication rows will appear.

  - **Delete a medication:**
    - Delete a medication name from the textbox and all other fields associated with that medication will be cleared.

  - **Titrate medication:**
    - If it is necessary to use the same medication with a different dosage/frequency you have to insert medication information for the first dosage/frequency, then you can go to the next row and skip the medication name field and simply insert information into dosage/frequency field. The medication name will appear automatically.

- **Allergy section**

  To add fields for a new allergy click the link '**Add new allergy**' or insert a number into the textbox on the right side of the link and new rows with three fields for allergy names will appear.

- **Child and Adolescent section**

  The section is **required** for all patients **18 or under.** The section is **optional** if patient's age is **between 19 and 21**. The user has the choice to add/delete it by clicking the check box on the left side of the section title. The section is **not available** to patients **older then 21**.

You must choose either the '**Yes**' or '**No**' option for '**Complete ICA now**' located at the bottom of the page. If you decide to continue an **ICA** during the next appointment then click '**No**', otherwise click '**Yes**' to complete the **ICA** now. After that you have to click the '**Save and Sign**' button. The dialog window with two buttons '**OK**' and '**Cancel**' will be available.

- If you select the '**Cancel**' button, the form remains open on the screen.
- If you select the '**OK**' button the form will be saved and then signed.

Before signing the form the program checks all the mandatory fields. If some of the mandatory fields are blank (no inserted information) then the alert window will prompt you to insert the information in to that field.

You will then be redirected back to the CSN page. The signed **ICA** will be located underneath the CSN form. You have to scroll down to see the signed **ICA** form. You have to use the PDF document scroll bar to navigate to the signed **ICA** form. If you scroll down to the end of the **ICA** form you will be able to see your signature.

Note: To finish with this service you have to complete and sign the CSN (ticket) form.

Update an ICA

There are two ways to update the **ICA**: either from the '**ICA**' or the '**Clien**t' link on the top navigation bar. The search form is available in either case.

- If you use the **'ICA'** tab you will see your caseload list. You can use a scrollbar or search form to find the patient. If the **ICA** already exists for the patient then the patient's CID, first and last name will be underlined. You have to click on the row to see the current ICA history. The most recent **ICA** will be available for update.

- If you use the '**Client'** tab you must use a search form to find the patient. After you select the patient, the list with a number of tabs will appear underneath the client name. You have to click the '**ICA**' tab (the very last on the right side) to

view the current **ICA** history. The most recent **ICA** will then be available for update.

Delete an incomplete ICA

Note: You cannot delete a completed **ICA**.

If the **ICA** is not completed and there is more than one CSN (appointment) associated with this **ICA** then you have to start to delete it from the most recent record.

- Use the '**ICA'** or '**Clien**t' tabs on the top navigation bar to reach the current **ICA** history.
- If there is more then one record in the **ICA** history list, the most recent record will be located at the top of the list.
- Click the '**Update'** link and then click the '**Delete**' button at the top of the **ICA** form. The dialog window will ask you to confirm or cancel the action. If you select the '**OK**' button then the **ICA** will be deleted.
- If there are more records to delete you have to repeat the previous step.

Clinical Notes: Initial PMA (H012 Initial)

Click on the **Clinical Notes** link on the Top Navigation Bar and a search form will be presented. There are three search options:

- **by date**
- **by ticket number (for signed forms)**
- **by date and ticket number (for signed forms)**

Click the **Search** button to bring up a list with previously scheduled appointments. Appointments will be listed based on the search criteria. Each appointment will be shown with information specific to that appointment including: client ID, first and last name, service code, description, and date/time. Clicking the radio button next to the desired appointment will bring up a dialog box with two options:

- **Start**
- **Exit Menu**

Click the **Start** button to start a new form. There are three buttons at the top and bottom of clinical forms:

- **Save Form**
- **Save and Sign Form**
- **Cancel**

There are also a few links in the middle of the form that will redirect you back to the top. This saves you from having to scroll to reach the command buttons. You can **Save Form** at any time. All the information you have entered into the form will be saved. You can **Cancel** the form at any time and all unsaved information will be lost. **Save and Sign Form** applies your electronic signature and completes the form.

The form name, client name, client ID and ticket number are located on the top of the form. Hint: The ticket number will be blank until you sign the form.

The Initial PMA contains 20 sections, each containing fields where you may input information. The mandatory fields have a yellow background and are marked with a red asterisk (*). You cannot **Save and Sign Form** until all mandatory fields are filled in. All other fields are optional. Use the tab key or the mouse to navigate the sections/fields.

Clinical Notes: Initial PMA (H012 Initial) - Section Descriptions

1. Chief Compliant/Perception of Problem (use client's own words): This field is required. A label with the number of the remaining characters will appear underneath the text area as soon as you start typing into the text area. This feature is common to most free text fields and helps you to manage the number of the characters you insert.

2. History of Present Illness: This field is required.

3. Are You Pregnant? This field is optional. Choose the appropriate response by clicking one of the radio buttons.

4. Target Symptoms for Treatment: These fields are optional. This section contains a list with the symptom's name and the associated check box. The choice "Other" has an associated text box for the appropriate description. You may select as many of the symptoms as necessary or you may skip this section.

5. Substance/Alcohol Use: These fields are required. There are six choices you can select. If **None** is selected then all other choices become disabled. Otherwise, it is possible to select more than one checkbox. Any selections other than **None** will require a description in the text area underneath.

6. Psychiatric History/Hospitalizations: This field is required.

7. Social History: This field is optional.

8. Family History (medical, psychiatric, substance use): This field is optional.

9. Medical History: This field is optional. This section contains a list with the diseases and the associated check boxes. The choice **Other** has an associated text box for the appropriate description. **Elaborate** is a text area for additional comments.

10. Allergies: This field is required. Please select the **NKDA** checkbox if there is no allergy. There are three text boxes for text input. If it is necessary to enter more allergies, please click the **Add More Allergies** link (below the first row of the input boxes). The number in the text box on the right side of the link is the number of allergy rows that will be added.

11. Current Medication: This section is optional and has three types of medication:

- **Mental Health Medication**
- **Physical Healthcare Medication**
- **Other: OTC, Herbals, Vitamins, etc.**

There is a one row of input text boxes shown for each type of medication. If it is necessary to add more medications, please click the link below the last row of each medication type. The number in the text box on the right side of the link is the number of rows that will be added.

Hint: A spell checking routine is available for the psychiatric medications. When you start entering a medication name (generic or trade) then the EMR will suggest the closest match from a standard list published in 2007 by NIMH. If you find that a standard medication is not in the list then please let us know so we can add it to the list.

Mental Health Medication: contains the following fields:

- **Mental Health Medication** - generic or trademarked medication
- **Dosage**
- **Frequency**
- **Amount**
- **Refills**
- **Date D/C** – date when this medication was discontinued
- **Samples**
- **Smp Dsg** – Sample Dosage
- **Smp Amt** – Sample Amount

If a medication name is typed into the **Mental Health Medication** text box (first box in the row), then **Dosage** and **Frequency** must also be entered. This feature is unique to the **Mental Health Medication** section.

Physical Healthcare Medication contains the following optional fields:

- **Physical Healthcare Medication** (generic or trademarked medication)
- **Dosage**
- **Frequency**

- **Purpose**
- **Date D/C** (date when this medication was discontinued)

Other: OTC, Herbals, Vitamins, etc. contains the following optional fields:

- **OTC, Herbals, Vitamins** (generic or trademarked medication)
- **Frequency**
- **Purpose**
- **Date D/C** (date when this medication was discontinued)

The Current medication cannot be deleted or changed. It can be only discontinued. To discontinue a medication it is necessary to indicate the date when it was discontinued **(Date D/C)** or indicate the reason for which it has to be discontinued. The **Reason for Discontinuing Medication** text box becomes visible after the **Date D/C** text box is activated/clicked.

The **Date D/C** field should be entered in **mm/dd/yy** format. Otherwise, the alert window will prompt you to enter a valid date. The **Reason for Discontinuing Medication** field has no format requirements and can contain up to 110 characters

12. Mental Status Examination: This section contains a list with the mental status definitions and the associated check boxes. There are only two fields that are required:

- **Suicidal Ideation**
- **Homicidal Ideation**

If **Yes** is selected for these fields you have to insert a brief description into the associated text box.

13. Diagnosis and Impression of Progress: All fields are required in this section except **Additional Rating** and **Explanation of Diagnosis**. The **GAF** score must be an integer that is no less than 0 and no greater than 100; otherwise the alert window will prompt you to enter a valid score.

Managing Axis I diagnosis on PMA and Follow-Up PMA, the POC and in CIS
Doctors have the ability on the PMA forms to add or change a client's diagnosis in the **Diagnosis and Impression of Progress** section.

If you change the Axis I diagnosis on the PMA then the CIS diagnosis can optionally be updated (synchronized with the PMA) when this PMA is signed and saved. However, the POC diagnosis will not be updated but a notification about any diagnosis discrepancies will be available on the EMR Home Screen for the applicable caseload manager. (This logic is intentional and was set by the EMR Modifications Subcommittee.)

How to add/change diagnosis on existing PMA forms
To change diagnosis code and description click on the text box for the diagnosis code.

Type one, two or three numbers in the code text box and a drop down list with the available codes will appear below the text box. Select the diagnosis code from the drop down.

A drop down list with the available descriptions will then appear. Select the applicable description. If the current diagnosis has only one description then the description text box will be pre-filled without displaying a drop down list.

As you enter the Axis I diagnosis, the system checks it against the existing Active CIS diagnosis. If it is different then a link appears "**Replace PMO Diagnosis with CIS Diagnosis**". If you click this link, the Active CIS diagnosis becomes the Axis I PMA diagnosis.

To add another diagnosis click "**Add other Diagnosis**" and a new line with text boxes will appear.

Below the "**Add other Diagnosis**" link is a text box labeled "**Explanation of Diagnosis**". This text box should contain any additional Axis I explanation necessary. For example, for 293.0 ("Delirium due to...") you would use this text box to indicate the associated General Medical Condition.

If the CIS diagnosis code is not the same as the PMA diagnosis then a warning message will appear when you click "sign and save". A window will pop up "**Current diagnosis is not the same as Active CIS diagnosis. Do you want to overwrite it?**" Clicking YES will change the Active CIS diagnosis to match the new PMA Axis I diagnosis.

When the system detects a difference between CIS, POC and PMA diagnosis codes for a client on the user's caseload, a table labeled "**Diagnosis Discrepancies**" will appear on the EMR home page. It will list the number of clients with discrepancies.

14. Recommendation for Treatment: These fields are optional. This section contains a list of recommendation choices and associated text box for descriptions.

15. MHC SVC/Interventions: At least one check box has to be selected in this section. This section contains a list with the services/interventions. **Further education** has an associated text box for entering a description. There is an **Other** text box for additional information.

16. Medication Ordered: The **Medication Ordered** Section will be pre-filled automatically with information from the **Current Medication** Section (Psychiatric Subsection) when the form is started. It allows users to save time and to avoid the situation where users forget to insert the information in the **Medication Ordered** Section.

A medication in the **Medication Ordered** Section can be discontinued only through the **Current Medication** Section (Mental Health Medication). When a particular psychiatric

medication is discontinued in the **Current Medication** Section, this medication will be removed from the **Medication Ordered** Section automatically.

Ordered Mental Health Medication contains the following fields:

- **Mental Health Medication** (generic or trademarked medication)
- **Dosage**
- **Frequency**
- **Amount**
- **Refills**
- **Samples**
- **Smp Dsg** (sample dosage)
- **Smp Amt** (sample amount)

If the medication name is inserted into the **Mental Health Medication** text box (first text box in the row), then **Dosage** and **Frequency** are also required.

17. Medication Education Provided: These fields are optional. This section contains a list with the medication education choices and the associated check box. The choice **Other** has an associated text box for a description.

18. Justification for Continued Treatment: This field is required (at least one check box has to be selected in this section). This section contains a list with the justification choices.

19. Follow-up: This field is required (at least one text box has to be filled). This section contains four choices for the follow up visit.

20. Extra Notes: This field is optional.

Clinical Notes: Initial PMA (H012 Initial) – Completing the form

If you press the **SAVE FORM** button you will be redirected to the main clinical records page with listed appointments and forms. The form is now located in the **Unsigned Forms** section. Click the radio button to open this form again. The dialog box will appear with these options:

- **Update Form**
- **Exit Menu**
- **Delete Form**

The **Exit Menu** button will close the dialog window.

If you press **Delete Form** then a new dialog window will ask you to confirm or cancel the action. If you select **OK** then the form will be deleted and the record for this client then appears under the **Appointments** section.

Select **Update Form** to continue entering information into the form now. The **Initial PMA** form is opened and you can update any sections/fields.

Select **Save and Sign Form** to apply your electronic signature and complete the form. You will see a dialog window with two buttons: **OK** and **Cancel**. If you select **Cancel**, the form remains opened on the screen. If you select **OK** the form will be saved and then signed. Before signing the form the program checks all the mandatory fields. If some of the mandatory fields are blank then the alert window will prompt you to fill out the field. You have to press **OK** in the alert window and the program will direct your cursor to the field that requires completion. Once all mandatory fields are satisfied then the signing screen appears. You have to use your Novell user id and password for signature authorization and then press the **Submit** button (see the **Electronically Signing Forms** section for additional details)**.**

A screen with the **Clinical Service Note** followed by the signed **Initial PMA** will appear. You can scroll down to see the signed **Initial PMA** form. If you scroll down to the end of the form you will be able to see your signature. (Hint: Use the PDF document scroll bar on the right side of the form to navigate the signed PMA form.) If you would like to print the form then select the printer icon on the PDF tool bar at the top.

The next step in the process is to fill out the Clinical Service Note associated with this Initial PMA. Please return to the top of the screen and fill out the CSN form (see Clinical Service Notes section).

Clinical Notes: Follow up PMA (H012)

Click on the **Clinical Notes** link on the Top Navigation Bar and a search form will be presented. There are three search options:

- **by date**
- **by ticket number (for signed forms)**
- **by date and ticket number (for signed forms)**

Click the **Search** button to bring up a list with previously scheduled appointments. Appointments will be listed based on the search criteria. Each appointment will be shown with information specific to that appointment including: client ID, first and last name, service code, description, and date/time. Clicking the radio button next to the desired appointment will bring up a dialog box with two options:

- **Start**
- **Exit Menu**

Click the **Start** button to start a new form. There are three buttons at the top and bottom of clinical forms:

- **Save Form**
- **Save and Sign Form**
- **Cancel**

There are also a few links in the middle of the form that will redirect you back to the top. This saves you from having to scroll to reach the command buttons. You can **Save Form** at any time. All the information you have entered into the form will be saved. You can **Cancel** the form at any time and all unsaved information will be lost. **Save and Sign Form** applies your electronic signature and completes the form.

The form name, client name, client ID and ticket number are located on the top of the form. Hint: The ticket number will be blank until you sign the form.

The Follow Up PMA contains 19 sections, each containing fields where you may input information. The mandatory fields have a yellow background and are marked with a red asterisk (*). You cannot **Save and Sign Form** until all mandatory fields are filled in. All other fields are optional. Use the tab key or the mouse to navigate the sections/fields. Some information is brought forward (rolls over) from the most recent PMA. This will save considerable typing if the data has not changed. This “rolled over” information can, of course, be updated as necessary.

Clinical Notes: Follow up PMA form – Sections and Fields

1. Current Medication: (same as Initial PMA, please see Initial PMA section)

2. Interval History:

The medical management program check box is discussed in the next section of the EMR titled “Clinical Notes: Medical Management Program (MMP).

Labs: This field is required.
There are two fields for **Labs**. Either select **None** if there are no labs or enter a brief description in the text box.
Pregnant: This field is optional. This information rolls over from the most resent PMA and can be updated as necessary.

3. Reason for Visit: This field is required. This section contains five reason types and their associated check boxes.

4. Target Symptoms for Treatment: These fields are optional. This section contains a list with the symptom names and associated check boxes. The choice **Other** has an associated text box for entering a description. This information rolls over from the most recent PMA.

5. Symptoms Description: This field is optional. The label with the number of remaining characters will appear underneath the text area as soon as you start typing. This feature helps you to manage the number of characters you insert and is common to most free text fields.

6. Medication Use: These fields are optional. If you select **No** for **Taking regularly** then you have to select one of five options: **Refusing, Skipping dose, Overtaking, Run out, or Other.**

7. SE reported to Medications: This field is required. If you select **Yes** then you have to enter a description in the text box below.

8. MD or ER visit since last MHC visit: This field is required. If you select **Yes** then you have to insert a description in the text box below.

9. Substance/Alcohol Use: This field is required. This information rolls over from the most resent PMA. There are six possible choices including **None**. If **None** is selected then all other choices become disabled. Otherwise, you must include a description in the text box below.

10. Allergies: This field is required. This information rolls over from the most resent PMA. If you have to enter more allergies, please click on the **Add More Allergies** link (below the first row of input boxes). The number in the text box on the right side of the link is the number of allergy rows that will be added when you click.

11. Mental Status Examination: This section contains a list with the mental status definitions and associated check boxes. There are only two fields that are required:

- **Suicidal Ideation**
- **Homicidal Ideation**

If **Yes** is selected for these fields you have to insert a brief description in the associated text box.

12. Diagnosis and Impression of Progress: All fields are required in this section with the exception of **Additional Rating** and **Explanation of Diagnosis**. The axis information rolls over from the most resent PMA. The **GAF** score must be an integer between 0 and 100. Otherwise the alert window will prompt you to enter a valid score.
Note: please see text related to managing diagnosis under Initial PMA item 13.

13. Recommendation for Treatment: These fields are optional. This section contains a list with recommended choices. Five options have an associated text box for a description.

14. MHC SVC/Interventions: This field is required. At least one check box has to be selected in this section. The section contains a list with the services/interventions choices. **Further Education** has an associated text box for a description. The **Other** text box is for additional information.

15. Medication Ordered: (same as Initial PMA, see Initial PMA section)

16. Medication Education Provided: These fields are optional. This section contains a list with the education choices. The choice **Other** has an associated text box for a description.

17. Justification for Continued Treatment: This field is required. At least one check box has to be selected.

18. Follow-up: This field is required. This section contains four choices for the follow up visit and at least one text box has to be filled.

19. Extra Notes: This field is optional.

Clinical Notes: Follow up PMA (H012) – Completing the form

If you press the **SAVE FORM** button you will be redirected to the main clinical records page with listed appointments and forms. The form is now located in the **Unsigned Forms** section. Click the radio button to open this form again. The dialog box will appear with these options:

- **Update Form**
- **Exit Menu**
- **Delete Form**

The **Exit Menu** button will close the dialog window.

If you press **Delete Form** then a new dialog window will ask you to confirm or cancel the action. If you select **OK** then the form will be deleted and the record for this client then appears under the **Appointments** section.

Select **Update Form** to continue entering information into the form now. The Follow Up PMA form is opened and you can update any sections/fields.

Select **Save and Sign Form** to apply your electronic signature and complete the form. You will see a dialog window with two buttons: **OK** and **Cancel**. If you select **Cancel**, the form remains opened on the screen. If you select **OK** the form will be saved and then signed. Before signing the form the program checks all the mandatory fields. If some of the mandatory fields are blank then the alert window will prompt you to fill out the field. You have to press **OK** in the alert window and the program will direct your cursor to the field that requires completion. Once all mandatory fields are satisfied then the signing screen appears. You have to use your Novell user id and password for signature authorization and then press the **Submit** button (see the **Electronically Signing Forms** section for additional details**).**

A screen with the **Clinical Service Note** followed by the signed **Follow UP PMA** will appear. You can scroll down to see the signed **Follow Up PMA** form. If you scroll down to the end of the form you will be able to see your signature. (Hint: Use the PDF

document scroll bar on the right side of the form to navigate within the form.) If you would like to print the form then select the printer icon on the PDF tool bar at the top.

The next step in the process is to fill out the Clinical Service Note associated with this PMA. Please return to the top of the screen now and fill out the CSN form. When the form is ready to be signed, please press the **SUBMIT** button on top of the form.

Clinical Notes: Medical Management Program (MMP)

The Medical Management Program is a special way of documenting clients who require medical management only. Establishing a client in MMP means that the POC will be discontinued (their current POC series is closed). Users should make sure they have finished what they need to do in the POC before placing a client in MMP. This feature of the EMR saves time by reducing the amount of clinical documentation required for these special cases.

To start MMP for the current client, first begin a Follow up PMA (H012) then:

Click the "**Medical Management Program**" check box located right under the "Interval History" title on the Follow up PMA.

Click the "**OK**" button on the dialog window to continue with MMP.

The following fields will appear on the form:

- Client Goal (text box, read only). This goal rolls over from the most recent POC (first client goal).
- Intervening Service since last PMA (check boxes, six options)
- Vital Signs section (height, weight, waist, blood pressure and BMI which calculates automatically after height and weight are entered). This data rolls over from the most recent Nursing form (H021 - Medication Monitoring Form).
- Remain/Discontinue MMP (radio button)
- Patient verbally agrees to continue this level of care (check box)
- Patient agrees to continue current goal/Patient requests new goal (radio button)
- New Goal (text box). This field is mandatory.

To continue MMP for the current client:

Start the follow up PMA for the patient. The most recent MMP information (client goal and vital signs) will be available. Insert all necessary information into the MMP fields and save it.

To Save MMP for the current client:

Click either the “**Save**” or “**Save and Sign Form**” button to add the client to MMP. Reminder: If you choose MMP for the client then the POC will be discontinued.

To Discontinue MMP for the current client:

It is possible to discontinue the MMP at any time by selecting the “Discontinue MMP” radio button near the bottom of the form. A discontinuation reason is required.

If you choose to discontinue the MMP for the client then the next Progress Summary due date will still be based on the admission anniversary, but consider the MMP discontinue date to calculate which PS due date to use.

Example:
Admission Date: 02/23/2001
MMP discontinue date: 06/11/08

Therefore the admission anniversary is 02/23/08, resulting in the following PS due dates (admission anniversary +90, +180, +270 and +360):
05/23/08, 08/21/08, 11/19/08, and 02/17/09

The next PS will be due 08/21/08 since it is the first PS due date after the MMP discontinue date.

Note: When the MMP for the client is discontinued a new series is opened in the POC and a Plan will be due. The due date of the next progress summary will then be calculated based on the admission anniversary and MMP discontinue dates (see above).

If MMP is abandoned (i.e. the user deletes the form on which they put the client into MMP) then the POC will be rolled back and the previously active series will be open again.

Clinical Notes: Medication Monitoring Form (H021)

Click on the **Clinical Notes** link on the Top Navigation Bar and a search form will be presented. There are three search options:

- **by date**
- **by ticket number (for signed forms)**

- **by date and ticket number (for signed forms)**

Click the **Search** button to bring up a list with previously scheduled appointments. Appointments will be listed based on the search criteria. Each appointment will be shown with information specific to that appointment including: client ID, first and last name, service code, description, and date/time. Clicking the radio button next to the desired appointment with service code **H021-M Nursing Services** will bring up a dialog box with two options:

- **Start**
- **Exit Menu**

Click the **Start** button to start a new form. There are three buttons at the top and bottom of clinical forms:

- **Save Form**
- **Save and Sign Form**
- **Cancel**

There are also a few links in the middle of the form that will redirect you back to the top. This saves you from having to scroll to reach the command buttons. You can **Save Form** at any time. All the information you have entered into the form will be saved. You can **Cancel** the form at any time and all unsaved information will be lost. **Save and Sign Form** applies your electronic signature and completes the form.

The form name, client name, client ID and ticket number are located on the top of the form. Hint: The ticket number will be blank until you sign the form.

The Medical Monitoring form contains 14 sections, each containing one or more fields where you may input information. The mandatory fields have a yellow background and are marked with a red asterisk (*). You cannot **Save and Sign Form** until all mandatory fields are filled in. All other fields are optional. Use the tab key or the mouse to navigate the sections/fields. Some information is brought forward (rolls over) from the most recent appointment. This will save considerable typing if the data has not changed. This “rolled over” information can, of course, be updated as necessary.

Clinical Notes: Medication Monitoring form (H021) - sections and field descriptions

1. Additional patient information and Medication Compliant: These fields are required. The first row includes following fields:

- **Child/Adults**
- **Age** (read only)
- **School/Job Employment**

These fields present the information that was previously saved for this client.

The second row includes the following fields:

- **Medication Compliant** (with options: Yes, No, N/A)
- **Reason** (with options: Refusing; Skipping doses, Overtaking, Run out)

If the **N/A** option is selected, then all **Reason** options are disabled and the **N/A** check box under the **Medication Education** section (below **Current medication**) is selected.

The third row includes the following fields:

- **Medication Effectiveness** (with options: Working, Improving, Not Working, Partially Working)

- **Neuroleptic Consent** (with options: Yes, No, N/A)

2. Current Medication: (same as Initial PMA, please see Initial PMA section)

If the **Current Mental Health Medication** is changed during the Medication Monitoring appointment, the C39_2 form has to be submitted to the doctor. Otherwise the changes will not be effective.

3. Medication Education: This field is required. This section contains a list with the medication education choices and associated check box.

4. Allergies: This field is required and this information rolls over from the most resent appointment. If you have to enter more allergies, please click on **Add More Allergies** below the first row of input boxes. The number in the text box on the right side of the link is the number of additional allergy rows that will be added when you click.

5. Physicians, Pharmacy, Hospitalization and Labs: These fields are required.

6. Measurements: This section contains the following fields:

- **Ht** (height) (not required if "N/A" entered into BMI field)
- **Wt** (weight) (not required if "N/A" entered into BMI field)
- **Waist**
- **Pulse**
- **BP standing**
- **BP sitting**
- **Temp**
- **BMI** (entering "N/A" here will allow for blank Ht and Wt when those are unknown)
- **AIMS Date**
- **N/A** (related to AIMS date)
- **FSBS Date**
- **Results** (FSBS)
- **UDS Date**
- **Results** (UDS)
- **EKG Date**
- **Results** (EKG)

There are five required fields in this section: **Ht, Wt, Pulse, BP sitting, AIMS Date** (or **N/A**). The **BMI** (Body mass index) calculates automatically as soon as the information is entered into the **Ht** and **Wt** fields.

7. Other Medical Conditions: This field is optional.

8. Pregnant, Normal Menses, Date of Last Menses: These fields are required. The **Date of Last Menses** field must be entered in **mm/dd/yy** format. Otherwise the alert window will prompt you to enter a valid date.

9. Current Symptoms: This field is required. This section contains a list with the symptom names and check boxes. If **Sleep Disturbance** is selected, then a **Sleep Disturbance Description** has to be selected as well (select one using the radio buttons).

10. Substance/Alcohol Use: This field is required. There are six choices from which to choose. If **None** is selected then all other choices become disabled. Otherwise it is possible to select more then one checkbox. **Illicit drugs** and **Other** have associated text boxes for descriptions. There is text area **Other Health Eroding Behavior/Comments** for optional additional comments.

11. Side Effect Profile: This field is required (at least one must be selected) and contains a list of side effect profile choices and associated check boxes. The **Other/Comments** text area is for adding comments.

12. Outcome Measures: This field is required. The **GAF** score must be an integer between 0 and 100. Otherwise the alert window will prompt you to enter a valid score.

13. Return Appointment Date and Time, Next PMA Date and Time, CSN#: Date fields must be entered in the **mm/dd/yy** format. Otherwise an alert window will prompt you to enter a valid date.

14. Additional Comments / Notes: This field is optional.

Clinical Notes: Medication Monitoring form (H021) – completing the form

Click **SAVE and SIGN FORM** to complete the form. You will see a dialog window with two buttons: **OK** and **Cancel**. If you select **Cancel,** the form remains opened on the screen. If you select **OK,** the form will be saved and then signed but before signing the program checks all mandatory fields. If some mandatory fields are blank (no inserted information) then the alert window will prompt you to insert information into to that field. You have to press **OK** in the alert window and the program will place the cursor in the field that you need to enter. Click **OK** to continue.

The screen with the Clinical Service Note and the signed Med Monitoring form will appear. The signed Med Monitoring form is presented in PDF form and is located below the CSN form. Please scroll down to see the signed form. You use the PDF document scroll bar to navigate the signed Med Monitoring form (this is located at the right edge of the form). If you scroll down to the end of the form you will be able to see your signature. If you need to print the form then click the printer icon on the PDF tool bar.

Return to the top of the screen and fill out the CSN form (see Clinical Service Note section for details). When the form is ready to be signed, please click the **SUBMIT** button at the top of the form, then click **SIGN/SAVE FORM** button in the dialog window. The signed form will then be presented for your inspection.

Clinical Notes: Telepsychiatry ED Module

The Telepsychiatry Emergency Department (ED) Module is designed to automate the clinical documentation of psychiatric consultations conducted via teleconferencing equipment between SCDMH psychiatrists and walk-in ED clients in hospitals around the state. This project was funded in large part by a Duke Endowment grant. The process involves the use of an automated fax server located in Columbia which receives requests from hospitals across the state and relays consultation results back to local fax machines in the EDs. This module is available only to SCDMH staff psychiatrists who are assigned to the ED Telepsychiatry project.

ED Module: To review received faxes for consultation requests

Login to the EMR and select '**30-Duke Endowment Grant**' facility from the drop down list. You will be taken to the home page for ED Telepsychiatry. Here the **Work Queue** with received faxes will be shown. Each incoming fax will be shown with the date and originating hospital name. Faxes typically have a cover sheet with general information about the request and additional pages with any reference information relevant to the client. Three actions are available for each fax:

- **Show/Hide** - to view or hide this fax
- **Start** - to start a Telepsychiatry consult
- **Delete** - to delete this fax from the work queue

ED Module: To Start an Ed Telepsychiatry Consultation

Click the '**Start**" link associated with the consult you would like to start. The '**Search for Client**' form will be available on the next screen. Enter information in the search form to identify the client (CID or SSN is easiest as they are discrete identifiers).

- If you are entering the CID or SSN you do not need to fill other fields.
- When searching by name you can use a wildcard search to locate all names that begin with what you enter (similar to any other search form in the EMR). If you do know the entire name it's best to type it in completely because this will lessen search time.
- A match or a list of multiple possible matches will be presented. Select the client by clicking that entry.

- If no matching client was found, click the "**Add as new client**" button that will appear below the 'Search for Client" form. The fields **Last Name, First Name and Sex** are required to add a new client.

The **Notify ED** form comes up on the next screen to allow you to notify the hospital that the consult is to be started for this client. This will alert the hospital ED staff to prepare for the consult. **Please verify that the hospital name and fax number are correct.** You have the option at this point to change the fax number before sending the notification.

Click the '**Submit**" button to send the notification.

After the notification is sent then click the 'CONTINUE TO CONSULTS PAGE" link (located above the notification form) to go to the **Consult** page.

You can start the consult as an Initial (from '**Start an Initial Consult**' section) or as a Follow-up (from '**Start a Follow Up Consult**' section). All previously completed consult forms for the current client will be listed in the '**Start a Follow Up Consult**' section.

Each type of consult will be shown with information specific to that consult including: client ID, first and last name, consult date and time. Clicking the radio button next to the desired consult will bring up a dialog box with two options:

- **Start Form**
- **Exit Menu**

ED Module: Initial and Follow Up ED Consult forms

The form name, consult date, client ID, hospital name and other client identifying information are located on the top of the form. The mandatory fields have a yellow background and are marked with a red asterisk (*). All other fields are optional.

After the ED consult form is completed, saved and signed, then the **Clinical Service Notes** will be presented for you to complete. (The signed ED form will be located at the end of CSN form.) Fill out the information for the CSN and click the appropriate processing button. In order to sign the CSN it is necessary to specify the service code by clicking on the '**Svc Code**' drop down list. Please refer to **"**Clinical Notes: Clinical Service Note (CSN) Form" section for information about filling out the CSN.

ED Module: To Fax Completed Consult to Hospital

After the CSN is signed the "**Send Fax of Consult to Hospital'** button will be available on the screen above the signed CSN form. Click this button to go to the notification screen. **Please make sure that the hospital name and fax number are correct.** If the CSN form cannot be completed right away:

- Click the '**Save form**' button and you will be taken back to the '**Consult**' page.

- Find the signed consult form (Initial or Follow-up) you just completed and click the radio button associated with this form and click '**View PDF**' button on the dialog window.
- The "**Send Fax of Consult to Hospital'** button will be available on the screen above the signed consult form.
- Click this button to go to the notification screen.
- Click the '**Submit**' button to fax consult form and notification to the Hospital.
- Click '**CONTINUE TO CONSULTS PAGE**' link to return to the Consult page.

Appendix A – Sample Clinical Forms

- Addendum to Plan of Care (pdf. final form)
- Addendum to Plan of Care (web form - screen shot)
- Clinical Service Note
- Clinical Service Note (H010)
- Follow Up PMA Form (H012)
- Initial PMA Form (H012)
- Medication Monitoring Form (H021)
- Plan of Care (pdf final form)
- Plan of Care (web form - screen shot)
- Progress Summary (pdf final form)
- Progress Summary (web form - screen shot)

ADDENDUM TO PLAN OF CARE

Dated: 09/04/2007
ADMISSION DATE: 01/01/2007

CLIENT NAME:	CLIENT ID #:	MEDICAID #: (If applicable)
PAT PATIENT2	9449577	

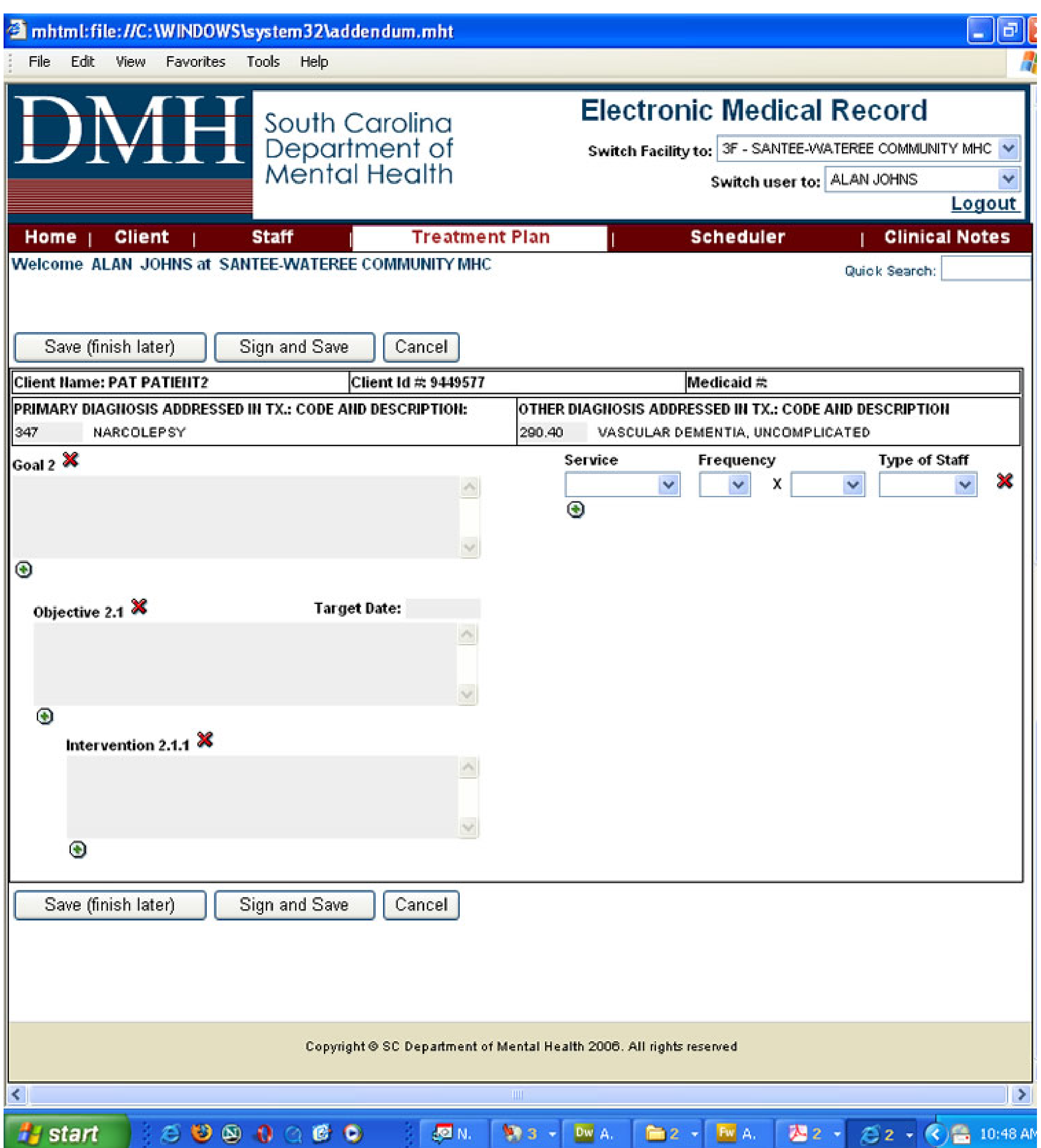
PRIMARY DIAGNOSIS ADDRESSED IN THE TX.: CODE AND DESCRIPTION (changes need to be dated and initialed)	OTHER DIAGNOSIS ADDRESSED IN TX.: CODE AND DESCRIPTION (changes need to be dated and initialed)
347-NARCOLEPSY	290.40-VASCULAR DEMENTIA, UNCOMPLICATED

PROMPTS:
Number Goals and Objectives (1., 1.1, 1.2, 2., 2.1, 2.2 as appropriate)
Goals should be in the words of the client, family, and/or stakeholder - list things they would like to achieve, change, or need help with.
Objectives should be reflective of the client's expectiatons, development, culture/ethnicity, tx. team's expectations, understandable to the client & their family as appropriate to the DX; and behavioral, measurable, achievable.
Interventions at least one for each objective that tells how and what is done to achieve the objective.

(MD MUST INITIAL AND DATE ANY ADDED SERVICES OR CHANGES IN FREQUENCY AFTER MD SIGNATURE/AUTHORIZATION BELOW)

	TARGET DATE	SERVICES	FREQUENCY	TYPE OF STAFF
Goal # 2 addendum goal		MISC	27xYear	NON-MHP
Objective # 2.1 addendum objective	01/01/08			
Intervention # 2.1.1 addendum intervention				

COPY	CLIENT SIGNATURE AND DATE (indicates input and copy offered)	CLINICIAN SIGNATURE, TITLE AND DATE:	PHYSICIAN SIGNATURE, TITLE, AND DATE: (confirms medical necessity and appropriateness)
☐ Accepted ☐ Declined			


mhtml:file://C:\WINDOWS\system32\addendum.mht
File Edit View Favorites Tools Help
DMH
South Carolina Department of Mental Health
Electronic Medical Record
Switch Facility to: 3F - SANTEE-WATEREE COMMUNITY MHC
Switch user to: ALAN JOHNS
Logout
Home | Client | Staff | Treatment Plan | Scheduler | Clinical Notes
Welcome ALAN JOHNS at SANTEE-WATEREE COMMUNITY MHC
Quick Search:
Save (finish later) Sign and Save Cancel
Client Name: PAT PATIENT2
Client Id #: 9449577
Medicaid #:
PRIMARY DIAGNOSIS ADDRESSED IN TX.: CODE AND DESCRIPTION:
347 NARCOLEPSY
OTHER DIAGNOSIS ADDRESSED IN TX.: CODE AND DESCRIPTION
290.40 VASCULAR DEMENTIA, UNCOMPLICATED
Goal 2
Service
Frequency
Type of Staff
Objective 2.1
Target Date:
Intervention 2.1.1
Save (finish later) Sign and Save Cancel
Copyright © SC Department of Mental Health 2006. All rights reserved
start
10:48 AM

CLINICAL SERVICE NOTE

STAFF LIST

TIME: 15 **For Staff:** 6123 DOCTOR USER5
TIME: 10 **For Staff:** 6001 DEMO CLINICIAN
TIME: 10 **For Staff:** 3 STAFF TESTING1

Facility	3H ANDERSON-OCONEE-PICKENS MHC	**Cost Center**	3HS25 ANDERSON MHC-OUTPATIENT ADULTS
Location	060 ANDERSON MENTAL HEALTH	**Office**	115 PHYSICIANS-ADULT
Place Of Service:	11 OFFICE	**Svc Code:**	H012 PSYCHIATRIC/MEDICAL ASSESSMENT
Modifier:	**Batchno:** 240072220	**Group number:**	
Doc Prem:		**Date:**	08/28/2007
Staff ID:	6123	**Time Service Provided:**	08:00

Name:	PATIENT PMA	**Cid:**	10138984	**Bill Time:**	25		
Cancel/NS:		**Ticket:**	216	**Audit:**	207	**Pmttp:**	07
GAF:	75	**Incarc:**	N				

Problem: 1 SUBSTANCE
Emerg: 0 NORMAL HOURS, NO EMERGENCY
Treatment Goal / Focus:

Note

See Corresponding PMA FORM

CLINICAL SERVICE NOTE

STAFF LIST

TIME: 15 **For Staff:** 1076 NATALIA AGAFONOVA
TIME: 15 **For Staff:** 155 SHERRY GRAINGER
TIME: 15 **For Staff:** 2401 ALAN JOHNS

Facility	3F SANTEE-WATEREE COMMUNITY MHC	**Cost Center**	3FC25 SANTEE-WATEREE MHC-SUMTER CLINIC STI
Location	C SUMTER CLINIC	**Office**	25 ADULT-SHORT TERM INTERVENTION
Place Of Service:	11 OFFICE	**Svc Code:**	H010 INJECTABLE MEDICATION ADMINISTRATION
		Svc Code2:	H016 INJECTION ADMINISTRATION
Modifier:	**Batchno:** 191079364	**Group number:**	
Doc Prem:		**Date:**	07/10/2007
Staff ID:	1076	**Time Service Provided:**	08:15

Name:	PAT PATIENT1	**Cid:**	2032640	**Bill Time:**	15		
Cancel/NS:		**Ticket:**	30501643	**Audit:**	1337740	**Pmttp:**	02
		Ticket2:	30501644	**Audit2:**	1337741	**Pmttp2:**	02
GAF:	90	**Incarc:**	N				

Medication	**NDC**
HALDOL DEC (51-100MG)	00703 - 7023 - 01

Problem: 0 PSYCHIATRIC
Emerg: 0 NORMAL HOURS, NO EMERGENCY
Treatment Goal / Focus:

Note

Side Effects / Adverse Reaction

Route

Injection Site

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

NAME: PATIENT PMA **ID: 10138984** **Ticket No: 217**

Current Medication

Mental Health Medication	Dosage	Frequency	Amount	Refills	Date D/C	Samples	Smp Dsg	Smp Amt
ABILIFY	10MG	1 QAM						
BUPROPION	20MG	2 QNS						
CELEXA	30MG	1 or 2 QD						
DEPAKOTE	250MG	2 QHS						

Physical Healthcare Medication	Dosage	Frequency	Purpose	Date D/C
Premarin				
Lotril				

Other: OTC, Herbals, Vitamins, etc.	Dosage	Frequency	Purpose	Date D/C
Vitamin C				

Interval History

Labs: None

Pregnant: ✔ N/A

Reason for Visit:

✔ Medication check | Change in Symptoms | F/U after DC from Hospital | F/U after change in Medications | Other

Target Symptoms for Treatment

✔ AV hallucinations	Depression	✔ Legal problems	✔ Sleep/appetite disturbance
Agoraphobia	Flashbacks	Mania/hypomania	Thought disorganization
✔ Anxiety	Hyperactive/inattentive	✔ Oppositional	✔ Trauma
Court ordered	✔ Hyperverbal	Obsessive/compulsive	✔ Other
✔ Delusions/paranoia	Irritability	✔ SI/HI/Ideation/attempts	other symptoms

Symptoms Description:

Finally has a job. Some depression.

Medications Use

Taking regularly: ✔ Yes

SE Reported to Medications

SE Reported to Medications ....

MD or ER visit since last MHC visit

MD or ER visit since last MHC visit ....

Substance/Alcohol Use

None | ✔ Tobacco | Caffeine | ✔ Alcohol | Street Drugs | Other | (if checked, describe)

Pack a day

Allergies

honey | orange | aspirin

Mental Status Examination

Sensorium	Alert: ✔ Oriented: ✔		Other: (describe)
Appearance	Normal For Patient: ✔		(if not,describe)
Behavior	Cooperative: ✔		(describe)
Psychomotor Abnormalities	None: ✔		Other: (describe)
Speech	Normal For Patient: ✔		(if not,describe)
Cognition	Attention: Intact: ✔		(if not,describe)
	Concentration: Intact: ✔		(if not,describe)
	Memory: Intact: ✔		(if not,describe)
Judgment	Good: ✔	Fair:	Poor: (describe)
Insight	Good: ✔	Fair:	Poor: (describe)
Emotion	Mood: Euthymic: ✔		(if not,describe)
	Affect: Appropriate: ✔		(if not,describe)
Thought Content	Hallucinations: No: ✔		Yes: (describe)
	Delusions: No: ✔		Yes: (describe)
Thought Process	Logical/Goal directed: ✔		Distractible: LOA: FOI:
Suicidal Ideation	No: ✔		Yes: (describe)
Homicidal Ideation	No: ✔		Yes: (describe)
Abnormal Movement	None: ✔		Face: Lips/Tongue: Trunk:

Diagnosis and Impression of Progress

Axis I: 296.34 Major depression, recurrent, severe with psychotic features.

Axis II: No diagnosis

Axis III: Hypertension

Axis IV: Disabled

GAF: 80 | Additional Rating: (desribe)

Recommendation for Treatment

Labs:

Therapeutic drug level:(describe)	HGA1C	Lipid panel
BUN/Creatinine	FBS	
✔ UDS for drugs of abuse	✔ Other diagnostic:(describe)	other diagnostic
Thyroid function	Other diagnostic:(describe)	
CBC / Diff	Other diagnostic:(describe)	
Other labs ordered:(describe)		

MHC svc/Interventions:

Blood sugar	Drug screen	AIMS	Further education (describe)	
Individual therapy	Group therapy	Medication monitoring	Case management	✔ PMA

Other:

Medication Ordered

Medications: Same as above: ✔

Mental Health Medication	Dosage	Frequency	Amount	Refills	Samples	Smp Dsg	Smp Amt
ABILIFY	10MG	1 QAM					
BUPROPION	20MG	2 QNS					
CELEXA	30MG	1 or 2 QD					
DEPAKOTE	250MG	2 QHS					
ELAVIL	15MG	1 BID					

Medication Education Provided: ✔ **Client** ✔ **Family**

✔ Medication, dose, time to take	Lab monitoring required/reason	✔ Financial availability
✔ Purpose/Expected benefits/Risk	Expected length of tx.	Alternative to medication/Risk of no treatment
✔ Common side effects	Effects on pregnancy/nursing	Other (describe)

Justification for Continued Treatment

Requires monitoring of response to medication	Symptoms unstable	✔ Improve level of functioning
Requires monitoring for medication side effects	Prevent decompensation	Prevent hospitalization

Follow-up: Days: Weeks: 8 Months: Other:

Extra Notes

None

INITIAL/EXTENDED PHYSICIAN'S MEDICATION ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

NAME: PATIENT PMA **ID: 10138984** **Ticket No: 216**

Chief Compliant/Perception of Problem (use client's own words)

Chief Compliant/Perception of Problem ....

History of Present Illness

History of Present Illness ....

Pregnant: ✔ N/A

Target Symptoms for Treatment

✔ AV hallucinations	Depression	✔ Legal problems	✔ Sleep/appetite disturbance
Agoraphobia	Flashbacks	Mania/hypomania	Thought disorganization
✔ Anxiety	Hyperactive/inattentive	✔ Oppositional	✔ Trauma
Court ordered	✔ Hyperverbal	Obsessive/compulsive	✔ Other
✔ Delusions/paranoia	Irritability	✔ SI/HI/Ideation/attempts	other symptoms

Substance/Alcohol Use

None ✔ Tobacco Caffeine Alcohol Street Drugs Other (if checked, describe)

Pack a day

Psychiatric History/Hospitalizations

Psychiatric History/Hospitalizations ....

Social History

Social History...... ....

Family History (medical, psychiatric, substance use)

Family History ....

Medical History

N/R	Epilepsy	HIV/AIDS	Migraine headaches	Other
✔ Cancer	Heart disease	Hyperlipidemia	Strokes	
Diabetes	✔ High blood pressure	Kidney disease	✔ Thyroid disease	

Allergies

honey | orange | aspirin

Current Medication

Mental Health Medication	Dosage	Frequency	Amount	Refills	Date D/C	Samples	Smp Dsg	Smp Amt
ABILIFY	100MG	QAM						
BUPROPION	200MG	QNS						
CELEXA	300MG	1 or 2 QD						

Physical Healthcare Medication	Dosage	Frequency	Purpose	Date D/C
Premarin				
Lotril				

Other: OTC, Herbals, Vitamins, etc.	Dosage	Frequency	Purpose	Date D/C
Vitamin C				

Mental Status Examination

Sensorium	Alert: Oriented: ✔		Other: (describe)
Appearance	Normal For Patient: ✔		(if not,describe)
Behavior	Cooperative: ✔		(describe)
Psychomotor Abnormalities	None: ✔		Other: (describe)
Speech	Normal For Patient: ✔		(if not,describe)
Cognition	Attention: Intact: ✔		(if not,describe)
	Concentration: Intact: ✔		(if not,describe)
	Memory: Intact: ✔		(if not,describe)
Judgment	Good: ✔	Fair:	Poor: (describe)
Insight	Good: ✔	Fair:	Poor: (describe)
Emotion	Mood: Euthymic: ✔		(if not,describe)
	Affect: Appropriate: ✔		(if not,describe)
Thought Content	Hallucinations: No: ✔		Yes: (describe)
	Delusions: No: ✔		Yes: (describe)
Thought Process	Logical/Goal directed: ✔		Distractible: LOA: FOI:
Suicidal Ideation	No: ✔		Yes: (describe)
Homicidal Ideation	No: ✔		Yes: (describe)
Abnormal Movement	None: ✔		Face: Lips/Tongue: Trunk:

Diagnosis and Impression of Progress

Axis I: 296.34 Major depression, recurrent, severe with psychotic features.

Axis II: No diagnosis

Axis III: Hypertension

Axis IV: Disabled

GAF: 75 | Additional Rating: (desribe)

Recommendation for Treatment

Labs:
- Therapeutic drug level:(describe)
- ✔ HGA1C
- ✔ Lipid panel
- ✔ BUN/Creatinine
- ✔ FBS
- ✔ UDS for drugs of abuse
- Other diagnostic:(describe)
- ✔ Thyroid function
- Other diagnostic:(describe)
- ✔ CBC / Diff
- Other diagnostic:(describe)
- Other labs ordered:(describe)

MHC svc/Interventions:

- Blood sugar
- Drug screen
- AIMS
- Further education (describe)
- Individual therapy
- Group therapy
- Medication monitoring
- Case management
- ✔ PMA

Other:

Medication Ordered

Medications: Same as above: ✔

Mental Health Medication	Dosage	Frequency	Amount	Refills	Samples	Smp Dsg	Smp Amt
ABILIFY	10MG	1 QAM					
BUPROPION	20MG	2 QNS					
CELEXA	30MG	1 or 2 QD					
DEPAKOTE	250MG	2 QHS					

Medication Education Provided: ✔ **Client** ✔ **Family**

- ✔ Medication, dose, time to take
- Lab monitoring required/reason
- ✔ Financial availability
- ✔ Purpose/Expected benefits/Risk
- Expected length of tx.
- Alternative to medication/Risk of no treatment
- ✔ Common side effects
- Effects on pregnancy/nursing
- Other (describe)

Justification for Continued Treatment

- Requires monitoring of response to medication
- ✔ Symptoms unstable
- ✔ Improve level of functioning
- Requires monitoring for medication side effects
- Prevent decompensation
- Prevent hospitalization

Follow-up: Days: Weeks: 8 Months: Other:

Extra Notes

Extra Notes ....

MEDICATION MONITORING FORM

NAME: PATIENT PMA **ID: 10138984** **Ticket No: 219**

Adult: ✔ **Age:** 34 **School/Job Employment: SCDMH**

Medication Compliant: ✔ No **Reason:** ✔ Run out

Medication Effectiveness: ✔ Working **Neuroleptic Consent:** ✔ No

Current Medication

Mental Health Medication	Dosage	Frequency	Purpose
ABILIFY	10MG	1 QAM	
BUPROPION	20MG	2 QNS	
CELEXA	30MG	1 or 2 QD	
DEPAKOTE	250MG	2 QHS	

Physical Healthcare Medication	Dosage	Frequency	Purpose
Premarin			

Other: OTC, Herbals, Vitamins, etc.	Dosage	Frequency	Purpose
Vitamin C			

(*) Med. Education:

✔ N/A Name Time to Take Dosage Purpose Benefits Side Effects Pillminder Barriers to Care

Allergies

honey | orange | aspirin

Primary Physician: Dr.Demo | **Pharmacy:** CVS

Last Medical Hospitalization: last year | **Last Psychiatric Hospitalization:** 2005

Labs:

Measurements

Ht: 5FT2 **Wt:** 150Lbs **Waist:** **Pulse:** 60 **BP standing:** **BP sitting:** 100/60 **Temp:** **BMI:** 27

AIMS Date: ✔ N/A **FSBS Date:** **Result:** **UDS Date:** **Result:**

EKG Date: **Result:**

Other Medical Conditions

None

Pregnant: ✔ N/A | **Normal Menses:** ✔ N/A | Date of Last Menses: ✔ N/A

Current Symptoms

✔ Denies all symptoms	Delusions/paranoia	Irritability	Thought disorganization
AV hallucinations	Depression	Legal problems	Trauma
Agoraphobia	Flashbacks	Mania/hypomania symptoms	
Anxiety	Flight of ideas	Oppositional	Sleep Disturbance
Appetite over	Hyperactive/inattentive	Obsessive/compulsive	#Hours:
Appetite under	Hyperverbal	SI/HI/attempts	

Substance/Alcohol Use

None ✔ Tobacco Caffeine Alcohol Illicit drugs (decribe) Other (decribe)

Other Health Eroding Behavior/Comments:

Side Effect Profile

Neurological (EPS)	Endocrine	Gastrointestinal
Akathesia	Fatigue	Nausea
Parkinsonism	Increased Thirst	Stomach Cramps
Dystonia	Constant Hunger	Diarrhea
Tremors	Frequent Urination	Constipation
Abnormal Movements	Visual Problems	✔ Dry Mouth
Drooling	Gynecomastia	
Metabolic	Sexual Dysfunction	
✔ Weight Gain	**Other/Comments:**	
Weight Loss	Comments.........................	
Elevated Cholesterol		
Elevated Triglycerides		

Outcome Measures

GAF: 80

Return Appt.Date: 10/01/07 **Time:** 10:00 am | **Next PMA Date:** 11/01/07 **Time:** 10:00 am | **CSN#:**

Additional Comments / Notes

Additional Comments / Notes ....

PLAN OF CARE

Dated: 09/04/2007
ADMISSION DATE: 01/01/2007

CLIENT NAME:	CLIENT ID #:	MEDICAID #: (If applicable)
PAT PATIENT2	9449577	

PRIMARY DIAGNOSIS ADDRESSED IN THE TX.: CODE AND DESCRIPTION (changes need to be dated and initialed)	OTHER DIAGNOSIS ADDRESSED IN TX.: CODE AND DESCRIPTION (changes need to be dated and initialed)
347-NARCOLEPSY	290.40-VASCULAR DEMENTIA, UNCOMPLICATED

PROMPTS:
Number Goals and Objectives (1., 1.1, 1.2, 2., 2.1, 2.2 as appropriate)
Goals should be in the words of the client, family, and/or stakeholder - list things they would like to achieve, change, or need help with.
Objectives should be reflective of the client's expectiatons, development, culture/ethnicity, tx. team's expectations, understandable to the client & their family as appropriate to the DX; and behavioral, measurable, achievable.
Interventions at least one for each objective that tells how and what is done to achieve the objective.

(MD MUST INITIAL AND DATE ANY ADDED SERVICES OR CHANGES IN FREQUENCY AFTER MD SIGNATURE/AUTHORIZATION BELOW)

	TARGET DATE	SERVICES	FREQUENCY	TYPE OF STAFF
Goal # 1 goal 2		WRAPS-CSS	25xWeek	BA
Objective # 1.1 objective 2.1	01/01/08			
Intervention # 1.1.1 intervetion 2.1.1				

COPY	CLIENT SIGNATURE AND DATE (indicates input and copy offered)	CLINICIAN SIGNATURE, TITLE AND DATE:	PHYSICIAN SIGNATURE, TITLE, AND DATE: (confirms medical necessity and appropriateness)
☐ Accepted ☐ Declined			

PLAN OF CARE

CLIENT NAME: PAT PATIENT2	**CLIENT ID** 9449577
Strengths: (programs, institutions, people in client's life that offer support/ motivation) strengths	**Needs:** (treatment or global needs, include legal involvements/requirements, e.g., court ordered to tx.) needs
Abilities (assets/skills of the client that can be used in treatment) abilities	**Preferences:** (appt. times, therapist, types of treatment, language of preference) preferences
Other Service Providers/Referrals: (include co-occuring disabilities/needs beyond the scope of the MHC) [x] **VR** [x] **DDSN** [x] **DSS** [x] **A&D** [x] **DHEC** [x] **MD** [x] **OTHER (list)** list of other	**Referral Source** **Contact Name:** contact name **Telephone:** 1-800-555-5555 **Other:** referral info

Program:

program

Discharge/Transition Criteria (initiated with the client on intake)

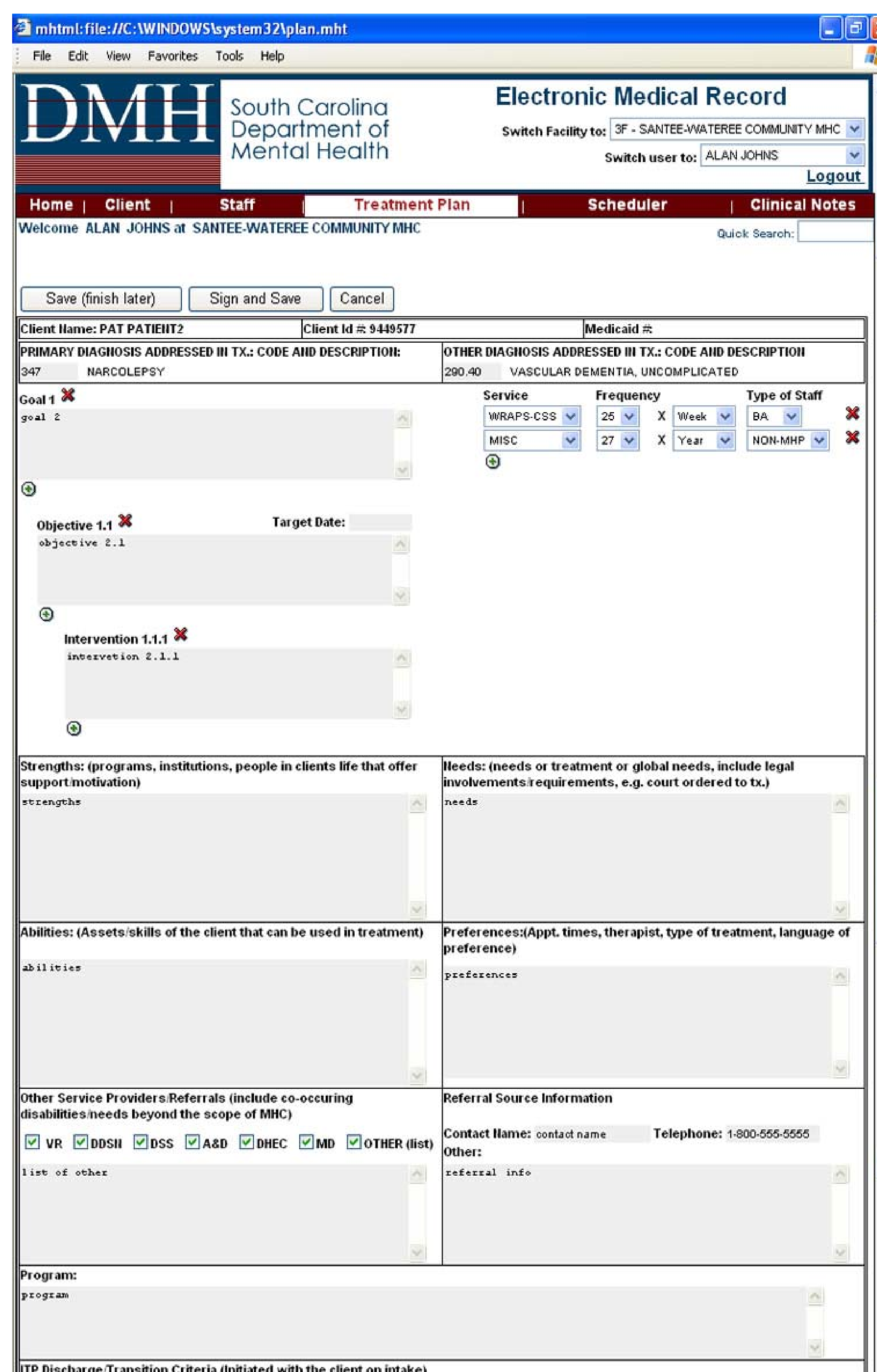
discharge

Center Use:

center use

Other:

other



mhtml:file://C:\WINDOWS\system32\plan.mht

File Edit View Favorites Tools Help

DMH South Carolina Department of Mental Health

Electronic Medical Record

Switch Facility to: 3F - SANTEE-WATEREE COMMUNITY MHC

Switch user to: ALAN JOHNS

Logout

Home | Client | Staff | Treatment Plan | Scheduler | Clinical Notes

Welcome ALAN JOHNS at SANTEE-WATEREE COMMUNITY MHC

Quick Search:

Save (finish later) | Sign and Save | Cancel

Client Name: PAT PATIENT2	Client Id #: 9449577	Medicaid #:

PRIMARY DIAGNOSIS ADDRESSED IN TX.: CODE AND DESCRIPTION:	OTHER DIAGNOSIS ADDRESSED IN TX.: CODE AND DESCRIPTION
347 NARCOLEPSY	290.40 VASCULAR DEMENTIA, UNCOMPLICATED

Goal 1

goal 2

Service	Frequency			Type of Staff
WRAPS-CSS	25	X	Week	BA
MISC	27	X	Year	NON-MHP

Objective 1.1 Target Date:

objective 2.1

Intervention 1.1.1

intervetion 2.1.1

Strengths: (programs, institutions, people in clients life that offer support/motivation)

strengths

Needs: (needs or treatment or global needs, include legal involvements/requirements, e.g. court ordered to tx.)

needs

Abilities: (Assets/skills of the client that can be used in treatment)

abilities

Preferences:(Appt. times, therapist, type of treatment, language of preference)

preferences

Other Service Providers/Referrals (include co-occuring disabilities/needs beyond the scope of MHC)

☑ VR ☑ DDSN ☑ DSS ☑ A&D ☑ DHEC ☑ MD ☑ OTHER (list)

list of other

Referral Source Information

Contact Name: contact name Telephone: 1-800-555-5555

Other:

referral info

Program:

program

ITP Discharge/Transition Criteria (Initiated with the client on intake)

discharge

04/01/07 **to** 06/30/07

PROGRESS SUMMARY

(Due at transfer, discharge, and no less often than every 90 days)

Name: PAT PATIENT2	**ID #:** 9449577

Current GAF: 100	**Current CAFAS (optional):**	**Other Rating:**	**Outcome Rating Scale:** 1- None 2- Limited 3- Some 4- Significant 5- Accomplished

Check All Services Received:

[X] PMA	[ ] PMA-APRN	[ ] Med Adm	[ ] NS	[X] CI	[ ] CI-MHS	[ ] ASSMT	[ ] SPD	[X] IND. Tx.
[ ] Fm. Tx.	[X] Gp. Tx.	[ ] TCM	[X] CCS	[ ] PRS	[X] STAD	[ ] PSS	[X] ACT-1	[ ] ACT-2
[ ] MHS-NOS	[ ] BHP-ES	[X] WRAPS-BI	[ ] WRAPS-CG	[ ] WRAPS-CCS	[ ] WRAPS-TDC	[X] BH-DT		

Summary: 1.Progress on each goal & tx. Objective (outcome rating). 2. Clinical justification of the need for continuing treatment by learly statnig how the continuation of services is necessary to treat the disorder or prevent decompensation (the benefit or impact fo the services) and/or criteria for discharge to another program or from Center. 3. Plan/recommendation for future treatment, include client and family feedback; integration of client into the communtiy and changes in treatment planning. For transfer or discharge, list medications/efficacy.

Objective Number	Outcome Rating
1.1	1

Progress text Progress text

Clinician's Signature and Title:	**Date:**

mhtml:file://C:\WINDOWS\system32\progress.mht

File Edit View Favorites Tools Help

DMH South Carolina Department of Mental Health

Electronic Medical Record

Switch Facility to: 3F - SANTEE-WATEREE COMMUNITY MHC

Switch user to: ALAN JOHNS

Logout

Home | Client | Staff | Treatment Plan | Scheduler | Clinical Notes

Welcome ALAN JOHNS at SANTEE-WATEREE COMMUNITY MHC

Quick Search:

Save (finish later) | Sign and Save | Cancel

ITP Review Period
06/30/07 to 09/28/07

PROGRESS SUMMARY

(Due at transfer, discharge, and no less often than every 90 days)

Name: PAT PATIENT2

ID#: 9449577

Current GAF: | Current CAFAS optional: | Other Rating:

Outcome Rating Scale:
1-None 2-Limited 3-Some 4-Significant 5-Accomplished

Check All Services Received:

☐ PMA ☐ PMA-APRN ☐ Med Adm ☐ NS ☐ CI ☐ CI-MHS ☐ ASSMT ☐ SPD ☐ IND.Tx.

☐ Fm. Tx. ☐ Gp. Tx. ☐ TCM ☐ CCS ☐ PRS ☐ STAD ☐ PSS ☐ ACT-1 ☐ ACT-2

☐ MHS-NOS ☐ BHP-ES ☐ WRAPS-BI ☑ WRAPS-CG ☐ WRAPS-CCS ☐ WRAPS-TDC ☐ BH-DT

Summary: 1. Progress on each goal & tx. Objective (outcome rating and narrative). 2. Clinical justification of the need for continuing treatment by clearly stating how the continuation of services is necessary to treat the disorder or prevent decompensation (the benefit or impact of services) and/or criteria for discharge to another program or from Center. 3. Plan/recommendation for future treatment, include client and family feedback; integration of client into the community and changes in treatment planning. For transfer or discharge, list medications/efficacy

Objective Number	Outcome Rating
1.1	

Appendix B - Sample Consent Forms

- Authorization to disclose protected health information
- Consent to examinations and treatment
- Consent for follow-up contact
- Income verification / Determination of ability to pay reduction
- Medicaid release form
- Medicare release form
- Neuroleptic (Antipsychotic) Medication Consent Form
- Private Insurance release form
- Request to amend SCDMH protected health information
- Request to inspect and/or copy SCDMH protected health information

I PAT PATIENT3 at Happy Lane , Happy , SC 29222 DOB 05/10/1976, SSN 333-33-3333, Medical record (admission number) 1010351 authorize the release of my SCDMH health information, as specified below, for the following purpose:
testing
I authorize the release of the following information for the time period from
01/01/01 to **01/01/10**

Information from **all** SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices.

AND The information authorized to be released includes:
All information from above

This information should be released to:
Name: Fake Name
Street: 200 Nowhere Lane
City: Imagineville
State: SC
ZIP: 29999
Phone: 555-555-5555
Relationship: N/A

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information.
I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me.
I do not want the following information disclosed:

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

I understand the information disclosed may be subject to re-disclosure by the entity name above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. I understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

Authority if signed by Personal Representative:

Method of Release:

Sample

Consent to Examinations and Treatment

Consent and authority is hereby given to this mental health facility and its professional staff to perform or have performed examinations and/or psychotherapy and/or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me and I understand it.

I have been provided a copy of the SCDMH Notice of Privacy Practices and an opportunity to review it and ask questions.

☑ Yes ☐ No

Client Signature:
PAT PATIENT3
Sample

Date: 05/18/2009

Parent or Legal Guardian:
Fake Name
Fake Name

Date:05/18/2009

SIGNIFICANT OTHER PARTICIPANTS INVOLVED IN THE IDENTIFIED PATIENT'S SERVICES

I agree to participate in therapy focused on the patient signing above. I understand that any information that I give may be included in the patient's record and disclosed as allowed by law. I also understand that if I want to receive therapy or other treatment services, a separate consent to examination and treatment is required.

Name: Participant One
Relationship: none
Participant one
Date:05/18/2009

Name: Participant Two
Relationship: none
Participant Two
Date:05/18/2009

Name: Participant Three
Relationship: none
Date:05/18/2009

Name:
Relationship:
Date:05/18/2009

Name:
Relationship:
Date:05/18/2009

Name:
Relationship:
Date:05/18/2009

Consent for Follow-up Contact

Purpose

We want to measure the benefits to consumers who have received treatment/service offered by this MHC. This information will help improve serivces to others in the future.

We hope you will consent to be contacted after discharge, but you do not have to do so. Your consent will not affect how you are treated at this agency. If you refuse, it will not keep you from receiving routine services.

Procedures

You will be contacted one or two months after discharge and asked some questions about how you are doing. Your spouse or other contact person (names by you below) may be contacted for information about how you are doing. Your aftercare referral may also be contacted to provide follow up information. We will send you a questionnaire in the mail and ask that you return it and we may contact you by telephone.

Confidentiality

Your privacy will be safeguarded. Your participation and all information obtained in this study are protected by state and federal law. Your name will not appear on any data that is published. All information will be used to improve services.

Risk/Discomfort

There is virtually no risk of physical or emotional harm from this survey. No experimental procedures are involved.

Questions or Comments

If you have any questions about this survey, please contact your case manager.

Permission

This study has been explained to me. I understand the purpose of this survey. My signature below shows that I give voluntary consent to participate and have been given a copy of this form.

I give my permission for you to contact the following person for follow up information.

Name: Fake Name Relationship: None

Address: 200 Nowhere Lane, Fakeville, SC, 29999

Phone: 555-555-5555

Consumer Signature:

Sample

COMMUNITY MENTAL HEALTH CENTER

DETERMINATION OF ABLITITY TO PAY REDUCTION

Client	PAT PATIENT3 "	**UCID**	9524889"	**Guarantor of payment if other than client**	"
SS:	333-33-3333	**Date of Birth:**	05/10/1976	**Prepared By:**	ALAN JOHNS

INCOME	CURRENT
Self	100
Spouse/Household	100
Alimony/Child Support	100
Public Assistance (list each type)*	
type on	100
type two	100
other (list each)**	
other type one	100
other type two	100
GROSS INCOME	700

EXTRAORDINARY EXPENSES	CURRENT
Medical	50
Alimony/Child Support	50
other (non-discretionary)***	
other out one	50
other out two	50
GROSS EXPENSES	

GROSS INCOME	LESS GROSS EXPENSE	EQUAL ADJUSTED GROSS INCOME	NUMBER OF DEPENDENTS
700		500	4

* List each type of public assistance, such as food stamps, AFDC, etc.

** For other recent income, other liquid assets of funds available for payment of medical bills including bank assets accumulated from public benefit payments , trust, etc.

*** For recent non-recurring expenses, medial-expenses, etc

SECTION 1:

✔ **PROOF PROVIDED**

I ACKNOWLEDGE THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE AND THAT I WILL UPDATE THE INFORMATION AS IT AFFECTS MY ABILITY TO PAY. YOU MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES IF YOU GIVE FALSE OR INCOMPLETE INFORMATION.

I AUTHORIZE ANY ENTITY HOLDING FINANCIAL RECORDS OR OTHER INFORMATION IN ANY FORM PERTAINING TO THE FINANCIAL INFORMATION GIVEN BY ME ABOVE TO DISCLOSE TO THE CENTER ANY FINANCIAL INFORMATION NECESSARY FOR THE CENTER TO DETERMINE MY ELIGIBILITY, IF ANY, FOR A REDUCTION ON MY BILL.

☐ Self Pay ☐ Medicaid ✔ Medicare ☐ Champus ☐ Private Ins ☐ Medicaid HMO

I have been given a completed copy of this form and understand that I may request a review of my ablity to pay at any time. This information may be updated at any time but must be reviewed at least anually.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT, AFTER ANY BALANCE REDUCTION FOR WHICH I MAY QUALIFY, FOR SERVICES PROVIDED TO ME BY THE CENTER AND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

○ **NO PROOF**

I understand that in order to qualify for a reduction on my bill that I must provide proof of income, which I did not
provide on my initial visit. I will be allowed THREE(3) visits from this date to bring this proof and have my financial information
assessed to see if I qualify to receive a reduction of balances for services rendered from this initial visit to present.
Failure to provide this information within 3 visits will result in possibly qualifying for a reduction on any future balance I may incur.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT, AFTER ANY BALANCE REDUCTION FOR WHICH I MAY QUALIFY, FOR
SERVICES PROVIDED TO ME BY THIS CENTER AND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

○ **UNEMPLOYED/NO INCOME**

I do hereby certify that I am currently unemployed and have no income. Failure to inform the Center of any changes in my financial or employment status may result in loss of any eligibility for a balance reduction based on income, for services rendered to me.

Signature:

Sample

MEDICAID

I authorize release of any medical information necessary to procress **MEDICAID** claims and request payment of benefits to The Department of Mental Health for services provided by them.

Sample

Client Signature

Clinician Signature

Date: 05/18/2009

MEDICARE

I authorize the release of any medical information necessary to process **MEDICARE** claims and request payment of benefits to the Department of Mental Health for any unpaid bills for services provided by them during the period of 05/18/2009 thru 05/18/2010 .

Sample

Client Signature

Clinician Signature

Date: 05/18/2009

South Carolina Department of Mental Health
Neuroleptic (Antipsychotic) Medication Consent Form

Client: BERTHA LLOYD **ID#:** 7900248

I understand that neuroleptic medication (antipsychotics) may be very helpful in treating my medical condition. Clozaril, Risperdal, Zyprexa, Seroquel, Geodon, Abilify and Invega are examples of newer neuroleptics. Haldol, Prolixin, and Navane are examples of older neuroleptics.

These medicines may help me think more clearly, feel less aggressive and hostile, and may decrease other psychiatric symptoms. Some of them may help my mood. If I take these medicines regularly, they may keep many of my symptoms from coming back. The medical staff cannot guarantee how I will respond to any of these medicines.

I have talked with my doctor or nurse practitioner about common side effects seen with these medicines. We have talked about tardive dyskinesia (TD). I have been told that TD describes movements of the mouth, jaw, tongue, hands, feet, or body that may be irreversible. I know it happens most often when you take an older medicine for a long time, and that it can occur spontaneously even when someone has never taken these medicines. The newer neuroleptics can cause it too, but much more rarely than the older medicines. Sometimes it appears after medicine is stopped or decreased. I have been advised by my doctor or nurse practitioner to report any symptoms of TD, or other problem related to taking my medicine, as soon as possible.

My doctor or nurse practitioner and I also talked about the side effects that may be related to the use of these medications. I have been told that they may cause my blood sugar and/or cholesterol levels to go up. I have been told this especially true for the newer ones. I have been told that while taking neuroleptic medication I may have to be monitored for these side effects, including blood testing.

My doctor or nurse practitioner and I have talked about different treatments for my symptoms and we agree that neuroleptic medicines may help my illness. I have been told that without this medication my condition may improve very slowly but is more likely to get worse.

The doctor or nurse practitioner will try to answer questions I have about these medicines. We will work together if we need to change the dose of my medicine, switch from one medicine to another, or stop my treatment. I agree to take these medicines as prescribed by my doctor for the treatment of my medical condition.

Client Signature	Date/Time	Prescribing Health Care Provider	Date/Time
		[signature]	02/24/2010

Substitute Decision Maker	Date/Time	Other Signature, if indicated	Date/Time
[signature]	02/24/2010		

VERBAL CONSENT IN LIEU OF WRITTEN CONSENT

Verbal consent was given by: **John** — **Substitute Decision Maker (relationship)** — **Date:** **02/24/2010**

Physician/Nurse Practitioner obtaining consent: [signature] — **Signature** — **Date:** **02/24/2010**

Witness: [signature] — **Signature** — **Date:** **02/24/2010**

PRIVATE INSURANCE

I authorize release of any medical information necessary to process claims for PAT PATIENT3 and request payments of benefits to The Department of Mental Health for services provided by them

Sample

Client Signature

Clinician Signature

Date: 05/18/2009

REQUEST TO AMEND SCDMH PROTECTED HEALTH INFORMATION

Name: PAT PATIENT3
Date of Birth: 05/10/1976
SS#: 333-33-3333
Address: Happy Lane , Happy , SC 29222
Phone: 555-555-5555

Description of the information to be amended, including dates of documentation if applicable:
words words

SCDMH facility, center, clinic, program or office documenting this information:
N/A

Name(s) of SCDMH staff documenting this information:
N/A

The reason(s) why I believe that the above information is incorrect or incomplete:
words words

I am requesting that the described information be amended to read as follows:
words words words words words words words words words words words words words words words

Sample

REQUEST TO INSPECT AND/OR COPY SCDMH PROTECTED HEALTH INFORMATION

Name: PAT PATIENT3
Date of Birth: 05/10/1976
SS#: 333-33-3333
Address: Happy Lane Happy SC 29222
Phone: 555-555-5555

I am requesting access to my protected health information as contained in the South Carolina Department of Mental Health (SCDMH) Designated Record Set, for inspecting and/or copying as indicated below:

Entire Medical Record for the time period from: 01/01/01 through 01/01/10
Entire Financial Record for the time period from: 01/01/01 through 01/01/10

Other:

I understand that my access to this informaton does not include psychotherapy notes; information needed for some legal proceedings involving SCDMH; research information; information provided under the promise of confidentiality where access is likely to reveal the source or when a SCDMH licensed health care professional determines that my access is reasonably likely to endanger my or other person's life or physical safety.

I understand that SCDMH will usually provide access within 30 days of receipt of my request. If the information is not located on site, SCDMH will notify me in writing and may take up to 60 days to provide access. Within that time period, if there will be additional delays, SCDMH may take a one time 30 day extension by letting me know in writing the reasons for the delay and the date that action will be taken. SCDMH will notify me in writing if it denies me access. I may have the right to have that decision reviewed and SCDMH will comply with the reviewer's decision. Instead of providing access/copies, if I agree, SCDMH may provide me with a written summary of the information requested. I understand that SCDMH may charge for its cost of providing copies or a written summary, an will let me know what those charges are before I am billed for them.