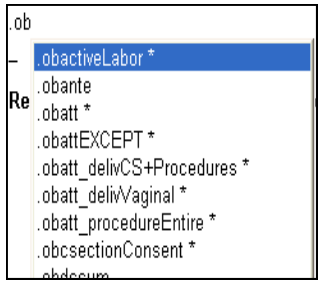
Auto Text / Dotphrases

- Allows quick entry of commonly used phrases or data. Available at system or user level.

To Use:

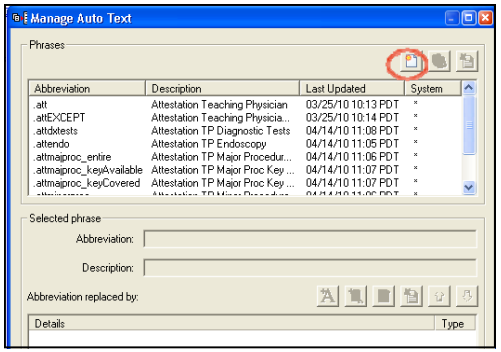
- Begin typing '.' plus the shortcut name of the auto text/ dotphrase (ie. **.**obatt)
- Select the appropriate auto text from the popup box, then *double-click* it. The attestation will be inserted into the note.



To Create Personal Dotphrase:

- Within the Clinical Note 'Add Document' window, click the **Manage Auto Text** button.

- Within the Manage Auto Text window, click **New**.



- Add abbreviation & description beginning with a period. (ie. **.**myautotext)
- Click the 'add text' button & type the desired auto text.

- When finished click Save & Close. You're new dotphrase will be available the same way as the system dotphrases.
- You may also select any text within your note with the mouse, then right click on the selection, and save it as an auto text / dotphrase.

Dotphrase	Description
.allergies	Allergies
.apgars | .apgarsDetailed	Apgar Scores | Apgars w/ components
.birthDate+Time	Birthdate & Time (from Deliv Summ)
.birthWeight+Length	Birthweight & Length (from Deliv
.bpprofile24	BP Profile 24h
.bunCreatLast10	BUN/Creat Last 10
.cbcd | .slideReview	CBC w/Diff | Slide Review
.ccpcp&RefMD	ExternalCC PCP & Referring MD
.chem10 | .chem23	Chem Panels
.coagPanel	Coag Panel
.gentPeak | .gentTrough	Gentamicin Peak or Trough Level
.glucoseLog48hrs	Glucose & Insulin Last 48 hrs
.hospCourse	Hospital Course from DC Record Form
.io	Intake and Output
.ironStudies	iron, ferritin, transferrinSat,retic *
.lfts	Liver Function Tests
.measurements	Wt, Ht, HC, AG, BMI with percentiles
.medicalstudentAddendum | ~Cosign	Med Student Note Addendum or Cosign
.medsActiveOrdersIP	Meds Active Orders Inpatient
.medsHome	Meds Home (Prescriptions + by Hx)
.medsPrescriptions | .medsDocByHx	Meds Prescriptions | Doc'd by Hx
.micro | .microLast7d	Microbiology (last 48 hrs or last 7 d)
.obactiveLabor	Plan for Induction Text Block
.obatt	OB Attending Attestation, E&M
.obattEXCEPT	OB Attending Attestation+, E&M
.obatt_delivCS+Procedures	CS and Other Procedure Attestation
.obatt_delivVaginal	Vaginal Delivery Attestation
.obatt_procedureEntire	OB Operative Procedure Attestation
.obcsectionConsent	CS Consent Text Block
.obdiabetes	Plan for Diabetes Mgmt Text Block
.obega	Estimated Gestation Age (Wks & Days)
.obexam	OB Exam Text Block
.obinduction	Induction of Labor Text Block
.obinductionLaborConsent	Induction of Labor Consent Text Block
.oblaborDeliveryProgressUpdate	L&D Progress Note Update Text Block
.oblaborDelivery_ProgressDETAILED Update	L&D Progress Note Update Detailed Text Block
.obmaternalID	Mom's age, G, P, EGA, admit reason
.oboperativeVaginalDelivery	Operative Vaginal Delivery Text Block
.obpihPanel	PIH Lab Panel
.obpitocinStart	Pitocin Start Text Block
.obpprom	Plan for PPROM Text Block
.obptl	Plan for Preterm Labor Text Block
.obpyelo	Plan for Pyelonephritis Text Block
.obshoulderDystocia	Shoulder Dystocia Text Block
.obspeculumExam	Speculum Exam Text Block
.obtubalLigationConsent	Tubal Ligation Consent Text Block
.obvbacConsent	VBAC Consent Text Block
.obwetPrep	Wet Prep Text Block
.pcp | .referringMD	Provider - Primary Care | Referring MD
.pregnancyTest	Pregnancy Test (ur & bld)
.romTotalTime	ROM duration (from Deliv Summ)
.sigdatetime	Current User + Date + Time
.tfts	Thyroid Function Tests
.type&screen	Type & Screen
.ua | .urineToxScreen	Urinalysis | Ur Drugs of Abuse Screen
.vitals	Vital Signs

OB Quick Tips

LINKS

Phase 3 MDdoc

For OB MDs & AHPs

Updated July 2011

V3.3

OB Documentation Process:

Admission:

1. Complete the **OB MD Inpatient Worksheet** in Adhoc Charting. (recommended, but not required)

- Data will be used to populate your notes
- Data will pull forward to your Discharge Record Form
- Data will pull forward across encounters for 3 months
- Certain fields/sections are shared with Nursing
- Sign form with green check mark when complete

2. Create **OB L&D H&P** Clinical Note or continue to dictate.
   ****See 'New Document' —->*****

Labor:

3. Create **OB L&D Progress Note** Clinical Note.
   - Recommend one Progress Note per labor course
   - Create and sign/submit the initial note.
   - Find/Open the signed/submitted note within the Clinical Documents tab of the patient's chart.

   - Right click or use Modify Icon
   - Scroll to bottom of the note and insert labor updates, using .oblaborDeliveryProgressUpdate
   - Continue this process through course of labor

PostPartum:

4. If Cesarean birth, Create **OB Operative Record—Immediate Post Op** Clinical Note.
   - This is in place of the old 'red border' form.
   - Detailed Operative note should still be dictated

5. Create **OB Delivery Note** Clinical Note.
   - Data will pull forward from Nursing's Delivery Summary Careform
   - If nursing charts an operative vaginal delivery birth and/or shoulder dystocia the appropriate documentation/template will prepopulate the note

6. Create **OB Postpartum Progress** Note daily during hospital stay

Discharge:

7. Create **OB Discharge Record Form** (as done today) in Adhoc Charting
   - Admission and Current Preg Complications will pull forward from OB MD Inpatient Worksheet.
   - Additional Dx since admission is for diagnosis that arose during labor and delivery
   - Brief Hospital Couse will be printed as part of patient handout
   - Detailed Hospital Course will pull to OB Discharge Clinical Note

Discharge (cont…):

8. For complicated patients Create **OB Discharge Summary** Clinical note or continue to dictate.
   - If creating the OB Discharge Summary online data will pull forward from OB Discharge Record Form

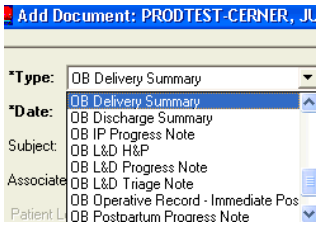
Other OB Document Types

- **OB Triage Note** - if unclear whether patient will be admitted
- **OB IP Progress Note** - maybe used in place of other Progress notes or for events. This is a 'blank' template.
- **OB Antepartum Progress Note** - for patients in hospital who have not yet delivered

Clinical Note "How To's":

New Document:

- Open chart to correct encounter. Select **Clin Docs** tab & Click **Add New** button.
- Select **Doc Type**. Customized template will preload when note type is selected. Items in blue text are pulled directly from the system.



- Adjust **Date** as needed.
- Use **F3** key to navigate through the free text sections of the note.

Submit, Sign or Save Documents:

Save - saves document, but does not "publish" (other users can not see until note has been submitted or signed).

Submit - publishes doc and sends it to any providers you have associated to the document.

Sign - finalizes/authenticated. Only Attendings will have the sign document. Finalized documents can only be updated via an addendum.

Modifying Documents:

- From the **Clinical Documents** tab or **Inbox**, open a doc, then click **Modify** button or right click on the note & select modify

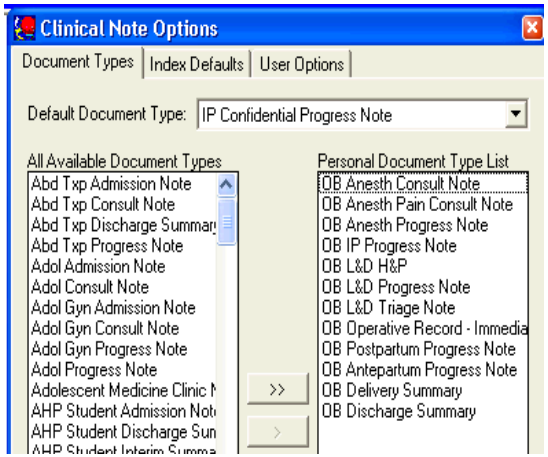
If modifying unauthenticated doc, user may change entire note. If document has been authenticated, modification must be done via an addendum.

User Preferences:

*It is highly recommended users set personal preferences to improve navigation **Clin Docs** tab.*

- From tool bar while in a patient's chart, select **Documents > Options**

- **Default Document Type:** Select most commonly used note type to auto default when adding a new note.
- Create a personal document list. We recommend adding all doc types you will be using to avoid having to search in complete list. .



MDdoc Pearls:

- Document on the correct encounter.
- Docs become public after SUBMIT or SIGN.
- For cosignature, associate a provider.
- Avoid Copy & Paste

MD documentation Guidelines:

1) **Document what you do.**
2) **Do what you document.**
3) **Read before you SIGN.**