Report Criteria

Last Modified on 09/22/2021 1:26 pm EDT

Version 14.19

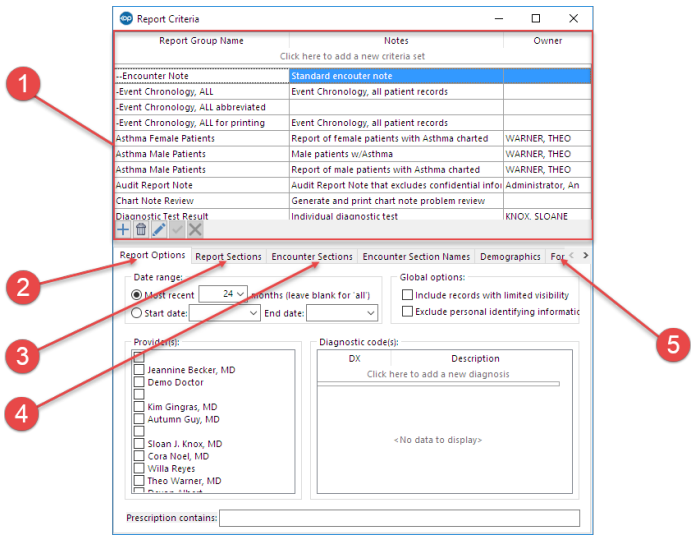
*This window map article points out some of the important aspects of the window you're working with in OP but is not intended to be instructional. To learn about topics related to using this window, see the **Related Articles** section at the bottom of this page.*

About Report Criteria

Path: Clinical tab > More button (Customize group) > Report Criteria

The Report Criteria window generates reports based on saved sets of criteria, such as date range of the visit/event, visibility level of reports, providers with involvement in the note, specific diagnosis codes, and base number for range/OM Summary of diagnoses (or variations on single diagnoses). You can also choose sections of the patient's encounter note, such as the Medication List, Chart Notes, History, previous encounters, prescriptions and diagnostic tests, that you would like to have included in the report.

Using the reporting capabilities in the Event Chronology, you can pre-define the criteria constituting a standard medical record release, specify the report's formatting, as well as content, and generate this report with a single click at the request of patients or specialists.



Report Criteria Map

Number	Section	Description
1	Criteria Sets	The grid contains a list of existing criteria sets.
		The Report Options tab contains the following report configurations: • **Date Range (of records)**: Choose to view records from a selected number of months, or enter a start date and end date. First, click the radio button to the left of your selection, then enter the specific numbers/dates by clicking on the down arrow buttons and selecting from the drop-down menu(s). • **Global Options**: Here you can choose whether to include records with limited visibility

2	Report Options tab	(Author or Provider level; formerly Exempt from Reporting), and/or whether to exclude personal identifying information. To make your selection, click inside the appropriate checkbox(es). • **Provider(s)**: Select provider(s) who had involvement in the record(s) by checking the appropriate box(es). • **Diagnostic Code(s)**: Enter a specific ICD code or a range of codes that will have to appear in the patient record to be displayed. Click inside the white field under the DX column, then click the ellipses button to open the ICD lookup window.
3	Reports Sections tab	The Reports Sections tab selects the sections of the patient record (such as Immunizations, Vital Signs, Messages) that constitute the report. Click on the sub-tab labeled Available to Add to view a list of sections that have not yet been added to your report criteria. To make your selections, select the checkbox to the far left under the Add column. To view sections that have been added, click on the Currently Included sub-tab.
4	Encounter Sections tab	Under the Encounter Sections tab, you can choose the sections of the Patient Encounter Note (such as the Medication List, Chart Notes, History, Encounters, Prescriptions and Diagnostic Tests) that you would like to include or exclude in the report. To make your selections, select or clear the appropriate checkbox(es).
5	Formatting tab	The Formatting tab selects the formatting for the printed report. It specifies the font, text size, and heading style.

Version 14.10

About Report Criteria

> **Path: Utilities Menu > Manage Clinical Features > Report Criteria Editor (Keyboard Shortcut keys: [Alt][U][F][R])**

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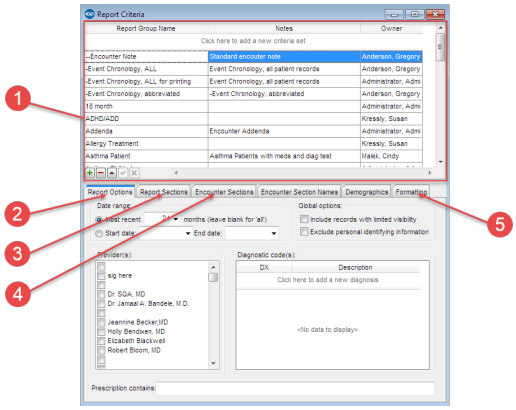

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