

Add or Edit a Diagnosis Template

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OP sets **all defaults to share all information**. Any individual decisions by Practice-users to restrict information sharing (access, use, or exchange) are the responsibility of the Practice in the implementation of its 21st Century Cures Act Information Blocking policies and procedures for its Practice and patients.

Version 14.19

Path: Clinical tab > Encounter Templates

About

Below, you'll learn how to manage your Diagnosis Template to ensure that they reflect the workflow of your Practice:

- [Add or Edit a Diagnosis Template](#)
- [Validate DX Codes](#)

Add or Edit a Diagnosis Template

1. Navigate to Encounter Templates by following the path above.
2. Click the **+** to the left of the System Name to expand the System group or click into the Search field and type a template name, and press Enter.
3. Follow the step below to add or edit a template.
 - **Add a template:** Click the **Add** button.
 - **Edit a template:** Select a template, and click the **Edit** button or double-click to open the template. Once the template is displayed, click the **Edit** button.
4. Review, edit or add template properties using the definitions found in the table below.

Property	Description
Template	The name given to a template should be easily identifiable and easy to search. of searching. Diagnosis Template titles are written in all capital letters.
Category	Method of organizing similar Templates.
Author	Assignment of a Template to a specific user. Templates assigned an Author may only be edited by that user.
Appt Type	Selection of a default Appointment Type. This is not a requirement to save the Template.
Visibility	Ability to restrict who can view the selected Template. All Diagnosis Templates should have a visibility level of at least Provider.
Location	Assignment can be made to view Templates by Location. Leave this blank if the Template should be available at all Locations.
Finalize Status	This is who can finalize Notes where the template is applied. Most Templates will be set to Providers only.
Default place of service (Optional)	Used with Templates that are non-office, such as Telehealth, to automatically populate the Place of Service on the Visit Information tab of an Encounter Note.

5. Click the **Encounter Note** tab if not already selected.

6. Review, edit or add the information, in fields of the Encounter Note tab, using the definitions found in the table below.

Field	Description
Counseling <i>(Optional)</i>	Information entered includes counseling that is commonly done during the visit.
Coordination of care <i>(Optional)</i>	Information entered includes activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Typically, the information in this field is entered at the time of the visit.
Assessment <i>(Optional)</i>	The likely diagnosis or additional diagnoses that need to be ruled out can be included in this section of the note.
Plan	This describes what will be done to treat the patient – ordering labs, referrals, procedures performed, medications prescribed, etc. This should address what was discussed or advised with the patient as well as timings for further review or follow-up are generally included.
Instructions	Instructions entered will be visible on the Patient Exit Note. Instructions are typically a summary of the visit written for understanding by the reader.

7. Add a Diagnosis Code.

a. Click the **Add** button.



Note: Select the **Prim?** checkbox when the Diagnosis Code involves laterality, severity, etc. You can add multiple Primary Diagnosis codes that will create a pop-up when the Template is applied to select the most specific code for that visit.

b. Click into the **ICD10 Description** field and click the **Search** button. The ICD10 search window displays.

c. Enter a description or code in the ICD10 Code/Description field and select the Diagnosis Code.

d. *(Optional)* Click the drop-down in the **Problem Status** field and select from the list.



Note: If a Problem Status is not selected in the Encounter Template Editor, it may be selected when charting an Encounter visit.

e. Click into the **SNOMED Description** field, begin typing and click the **Search** button. Select the SNOMED code.

f. Click the **Save** button.

8. Click the **Detailed Exam** tab and review, edit or add the exam points using the table definitions below.

Setting	Description
Pert	Relevant symptom/question to display when the Template is opened.
ABNL	Positive for the finding
NL	Negative for the finding
N/A	Not applicable for the Template; removes from the group list.



Note: To expand an exam group, click the heading. Select the **Show all groups** checkbox to see additional Exam groups.

9. Click the **Orders/Workflow** tab. Select from the below list for detailed instructions on adding to the Orders/Workflow tab.

- [Medications](#)
- [Diag Tests](#)
- [Immunizations](#)

- Resources
- Surveys
- Followup
- Other tasks

10. (Optional) Click the **Procedures** tab. Click [here](#) for detailed information on completing the Procedures tab.
11. Click the **Save** button.

Validate DX Codes

It's recommended to validate your Encounter Template DX Codes annually (close to but after October 1st) to ensure that the DX Codes you have on your templates are valid and specific.

1. Navigate to Encounter Template Editor: **Clinical tab > Encounter Templates**.
2. Click the **Validate DX** button.
3. Review the confirm pop-up and click **OK** when you're ready to continue with running the validation. A validation progress bar is displayed on-screen giving you the opportunity to acknowledge each insufficient code found in your templates.
4. When validation is complete, revisit the identified templates and update the DX Codes to be appropriately coded for specificity.

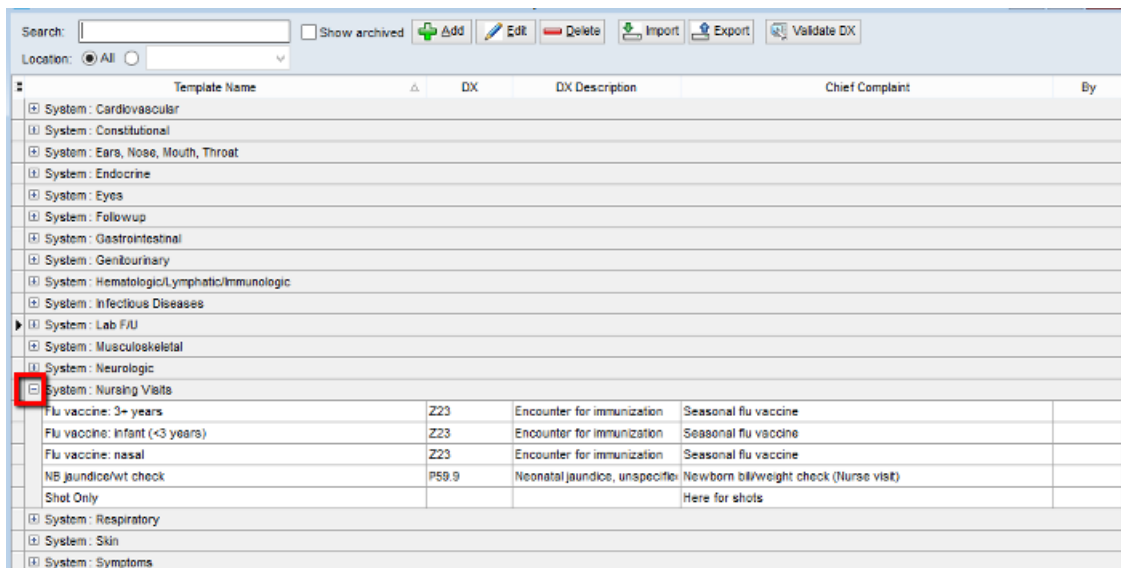
Version 14.10

Utilities > Manage Clinical Features > Encounter Template Editor


Overview

This article will help to provide you with an understanding of the content for a typical diagnosis template. You will be instructed on methods of customization to ensure the diagnosis templates reflect the workflow of the practice.

1. Click **Utilities** in the main menu.
2. Select **Manage Clinical Features**.
3. Select **Encounter Template Editor**. The template list displays.
4. Click the **plus** to expand System group.



Template Name	DX	DX Description	Chief Complaint	By
System: Cardiovascular				
System: Constitutional				
System: Ears, Nose, Mouth, Throat				
System: Endocrine				
System: Eyes				
System: Followup				
System: Gastrointestinal				
System: Genitourinary				
System: Hematologic/Lymphatic/Immunologic				
System: Infectious Diseases				
System: Lab F/U				
System: Musculoskeletal				
System: Neurologic				
System: Nursing Visits				
Flu vaccine: 3+ years	Z23	Encounter for immunization	Seasonal flu vaccine	
Flu vaccine: Infant (<3 years)	Z23	Encounter for immunization	Seasonal flu vaccine	
Flu vaccine: nasal	Z23	Encounter for immunization	Seasonal flu vaccine	
NB jaundice/wt check	P59.9	Neonatal jaundice, unspecified	Newborn bill/weight check (Nurse visit)	
Shot Only			Here for shots	
System: Respiratory				
System: Skin				
System: Symptoms				

5. Double-click to open a template and click the **Edit** button .
6. Review the template properties.

Template List

Template:
 Appt type: ...
 Finalize status: Providers only Any clinician None (archived)

Category:
 Visibility:
 Default place of service:

Author: ...
 Location:


Property	Description
Template	Name given to a template. Should be named for ease of searching. Diagnosis template titles are written in all capital letters.
Category	Method of organizing like templates.
Author	Assignment of a template to a specific user. Templates assigned an author may only be edited by that user.
Appt Type	Selection of a default appointment type. Not a requirement to save the template.
Visibility	Ability to restrict who can view the selected template. All Diagnosis templates should have a visibility of at least Provider.
Location	Assignment can be made to view templates by location.
Finalize Status	Selection set to who may finalize. Most templates will be set to Providers only.

7. Click the **Encounter Note** tab if not already selected.
8. Review and edit the fields of the Encounter Note tab.

Field	Description
Counseling (optional)	Information entered includes counseling that is commonly done during the visit.
Coordination of care (optional)	Information entered includes activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Typically the information in this field is entered at time of visit.
Assessment (optional)	The likely diagnosis should be included in this section of the note. If a conclusive diagnosis has not been made yet, some possible diagnoses can be charted. It may include additional diagnoses that need to be ruled out.
Plan	This describes what will be done to treat the patient – ordering labs, referrals, procedures performed, medications prescribed, etc. This should address what was discussed or advised with the patient as well as timings for further review or follow-up are generally included.
Instructions	Instructions entered will be visible on the Patient Portal when the template is selected. Instructions are typically a summary of the visit written for understanding by the reader.

9. (Optional) Add a diagnosis code.

a. Click the **Add** button .

 **Note:** Click the **Prim?** checkbox when the diagnosis code involves laterality, severity, etc., you can add multiple Primary Diagnosis codes that will create a pop-up when the template is applied to select the most specific code for that visit.


- b. Click into the ICD10 Description field and click the **Search** button. The ICD10 search window displays.
- c. Enter a description or code in the ICD10 Code/Description field and select the diagnosis code.
- d. Click into the SNOMED Description field, begin typing and click the **Search** button. Select the SNOMED code.
- e. Click the **Save** button.

10. Click the **Detailed Exam** tab and review or change the exam points using the table definitions below.

Setting	Description
Pert	Relevant symptom/question to display when template is opened.
ABNL	Positive for the finding
NL	Negative for the finding
N/A	Not applicable for the template. Removes from the group list.



Note: To expand an exam group, click the heading. Select the checkbox **Show all groups** to see additional Exam groups.

11. Click the **Orders/Workflow** Tab. Click [here](#) for detailed information on each tab in Orders/Workflow.
12. Click the **Procedures** tab. Click [here](#) for detailed information on completing the Procedures tab.
13. Click the **Save Changes to template** button  .