

Add a Nurse Visit Template

Last Modified on 07/28/2021 4:13 pm EDT



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.

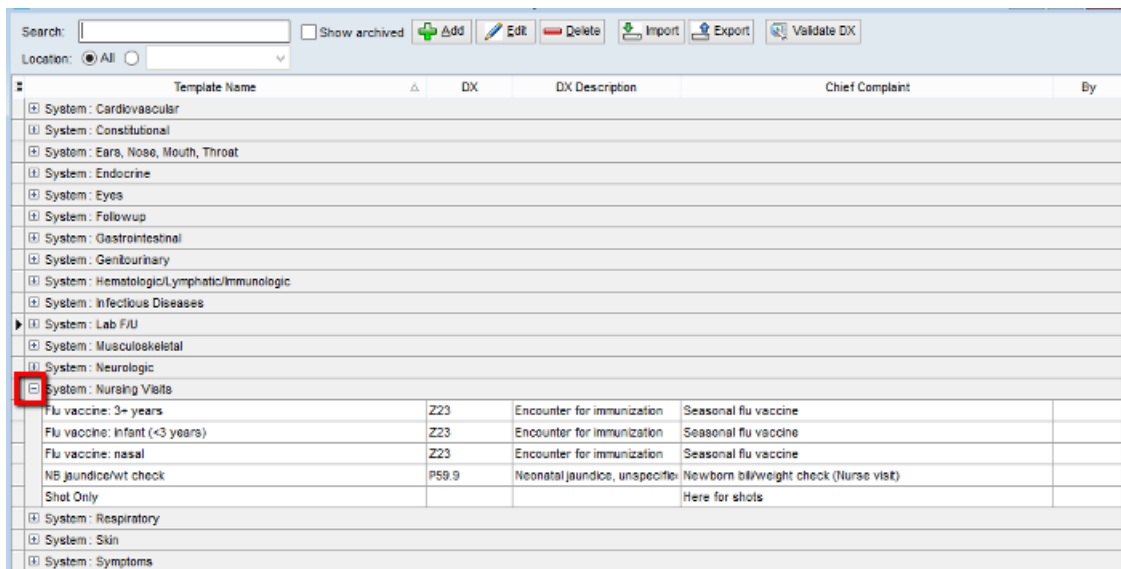
Version 14.19

Path: Clinical tab > Encounter Templates

Overview

This article is meant to provide you with an understanding of the content in a typical nurse visit template. You will be instructed on methods of customization to ensure the templates reflect the workflow of the practice.

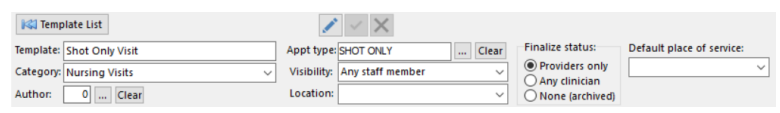
1. Click the **Clinical** tab and select **Encounter Templates**. The Encounter Template Editor displays.
2. Click the **plus** to expand System:Nursing Visits.



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 bili/weight check (Nurse visit)	
Shot Only			Here for shots	
System: Respiratory				
System: Skin				
System: Symptoms				



Tip: It is recommended you expand the System group to ensure you do not duplicate a template.

3. Click the **Add** button.
4. Add the template properties using the table definitions below.



Property	Description
Template	The name given to a template. This should be named for ease of searching.
Category	Method of organizing like templates. All templates edited in this section will be located in the Nurse Visits category.
Author	Assignment of a template to a specific user. Templates assigned an author may only be edited by that user.

Property	Description
Visibility	Ability to restrict who can view and use the template. Nurse templates typically have a visibility of Any Staff Member.
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, but if the nurse staff have permission to finalize their notes the status would be set to Any clinician.
Default place of service	The Default place of service is not a required field. This field can be 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. Enter a complaint into the **CC** field or use the **Phrase Construction** button  to insert phrases.
7. Enter the history of the complaint in the **HPI** field or click the **Phrase Construction** button  to insert phrases.
8. Complete 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 and 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. Add a diagnosis code.
 - a. Click the **Add** button.



Note: Select the **Prim?** checkbox when the diagnosis code involves laterality, severity. 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 ROS** tab. Set the ROS Questions/Symptoms using the table definitions below.

ROS: Show all groups

Detailed ROS | Freeform ROS

Rpt / Deny	Question / Symptom	Comment
Flu immunization		
Denies	current illness/recent fever	First Click = N/A Second Click = Reports Third Click = Denies
Denies	allergy to eggs or neomycin	
Denies	serious adverse reaction to any prior vaccine	
Denies	use of cortisone, prednisone, other steroids, anti-cancer drugs, or xray treatments in past 3 months	
Denies	transfusion of blood or blood products, or administration of immune (gamma) globulin in the past year	
Reports	prior flu vaccine(s)	

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

 **Note:** Select the **Show all groups** checkbox to see other Review of System 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** button.

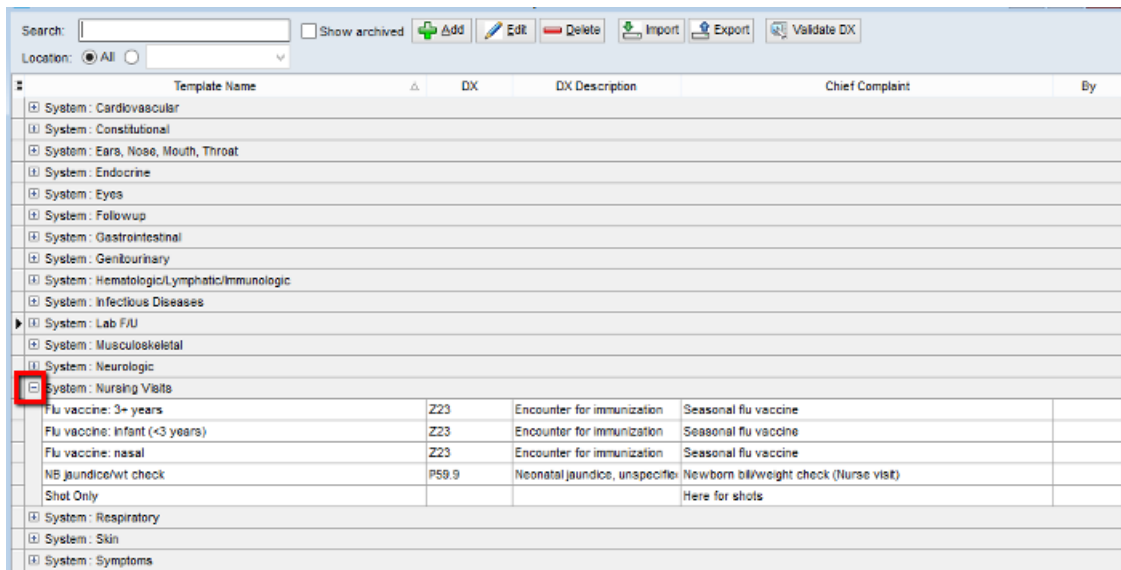
Version 14.10

Utilities > Manage Clinical Features > Encounter Template Editor


Overview

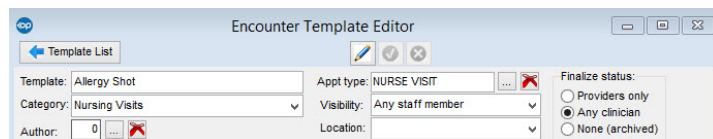
This article is meant to provide you with an understanding of the content in a typical nurse visit template. You will be instructed on methods of customization to ensure the templates reflect the workflow of the practice.

1. Click the **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:Nursing Visits.





i It is not required to expand the group, but it is best practice to make sure you do not duplicate a template.

5. Click the **Create a new template** button  .
6. Add the template properties using the table definitions below.



Property	Description
Template	Name given to a template. Should be named for ease of searching.
Category	Method of organizing like templates. All templates edited in this section will be located in the Nurse Visits category.
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 symptom templates will have a visibility of Any staff member.
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, but if the nurse staff have permission to finalize their notes the status would be set to Clinical Staff Only.

7. Click the **Encounter Note** tab if not already selected.
8. Enter a complaint into the **CC** field or use the **Phrase Construction** button  to insert phrases.
9. Enter the history of the complaint in the **HPI** field or click the **Phrase Construction** button  to insert phrases.
10. Complete 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	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

(optional) Field	Description
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 and 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.

11. 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.

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


12. Click the **Detailed ROS** tab. Set the ROS Questions/Symptoms using the table definitions below.

ROS: <input type="checkbox"/> Show all groups		
Detailed ROS		Freeform ROS
Rpt / Deny	Question / Symptom	Comment
Flu immunization		
Denies	current illness/recent fever	First Click = N/A Second Click = Reports Third Click = Denies
Denies	allergy to eggs or neomycin	
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Note: Select the checkbox **Show all groups** to see other Review of System groups .

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