Event Chronology: Overview Report Criteria

Last Modified on 11/14/2019 9:28 am EST

Version 14.19

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

The Report Criteria in Medical Records is used to produce reports using information within a patient chart or across the entire practice. A report created can be specific to a provider, a diagnosis code, gender, age, or insurance. Below is a summary of the Report Criteria window's organization.

Sections of a Report

Report Section	Definition
Report Group	These are the reports available to select when choosing the Medical Records button on the Clinical tab. An optional notes field is used as a description of the report. The Owner field is the user who created the report.
Report Options: Date Range	This is the the Default Date range when choosing the report. The date range can be defined as an All date range, specific number of months, or a start and end date for the report.
Report Options: Provider(s)	This field is used to select an individual provider or group of providers for whom the report is run. If no selection is made, then all providers will be included.
Report Options: Global options	This checkbox option allows records with limited visibility to be available in the report. In addition the checkbox option allows personal information (PHI) to be excluded from the report view.
Report Options: Diagnostic code(s)	This is used to create the report using specific diagnosis codes. You have the ability of using the wildcard search **%** to select a group of diagnosis codes. The report looks at diagnosis code(s) associated to

Report Section	Definition notes.
Prescription contains	This field is used to produce a list of patients with a specific prescription written. The "contains" option allows for a group of medications to be reported. You have the ability for searching for multiple prescription groups by separating each by a comma.
Report Sections: Currently Included	This field determines the list of items included when the report is run.
Report Sections: Available to Add	The list of items not included in the report output and available for selection.
Encounter Sections	If a visit note is included in the report, the output the encounter sections tab sets parameters to define the information to include.
Encounter Section Names	This is an area that is typically not touched by a practice. The information contained in this tab relates to the output text on the notes. The section heading labeled Patient Heading will be the text appearing on the Patient Exit note.
Demographics	The information located in this tab filters the report output by the following: sex, age range, city, state, zip code, or payer.
Formatting	This is an area that is typically not touched by a practice. The information in the Formatting tab changes how the well and encounter notes display in the Summary and Finalized notes. The Heading format changes the font theme of the Heading. The Body text font changes the size of the text as it appears on the notes.

Version 14.10

Overview

Event Chronology is used to produce reports using information within a patient chart or across the entire practice. A report created using Event Chronology can be specific to a provider, a diagnosis code, gender, age, or insurance. Below is a summary of the Report Criteria window's organization. To access the Report Criteria window:

1. Click **Utilities** on the Smart Toolbar.
2. Select **Manage Clinical Features**.
3. Select **Report Criteria Editor.** The Report Criteria Editor Window will appear.

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