

# Event Chronology: Add or Edit a Report

Last Modified on 04/17/2024 5:07 pm EDT

Version 21.3

## Overview

Event Chronology is used to produce reports using information within a patient chart or across the entire practice. The information below will show you how to add or edit a report to meet the needs of the practice. To create a new report:

1. From the **Clinical** tab, click **More**, then **Report Criteria**.
2. Click the **plus** button.
3. Enter the **name** of the report and **Notes** describing the report information.
4. Click the **green checkmark** to save the report name.
5. Once the new report is saved, use the table below to add additional information.


To edit an existing report click the report name in the top panel when in the Report Criteria Editor window.

Tab Name	Description
<a href="#">Report Options</a>	The Report Options tab is used to set default information for the criteria of running the report.
<a href="#">Report Sections</a>	The Report Sections tab determines what information from a patient chart will be included when the report is run. Additionally, you have the ability to add information not included by selecting that information in the Available to Add tab. When creating a new report the Report Sections tab will be blank.
<a href="#">Encounter Sections</a>	The Encounter Sections tab selects areas of a note to include or exclude with the report when producing notes. This tab is only used when including Encounter and Well visit notes in the Report Sections selection.
<a href="#">Demographics</a>	The Demographics tab is used to filter the report by information found in the patient's demographic record.
<a href="#">Formatting</a>	The Formatting tab determines how the well and encounter Summary and Finalized notes display and print.

Version 14.19

## Overview

Event Chronology is used to produce reports using information within a patient chart or across the entire practice. The information below will show you how to add or edit a report to meet the needs of the practice. To create a new report:

1. Click **Utilities** on the Smart Toolbar.
2. Select **Manage Clinical Features**.
3. Select **Report Criteria Editor**. The Report Criteria Editor window opens.
4. Click the **green plus** button .
5. Enter the name of the report and Notes describing the report information.
6. Click the **green checkmark** to save the report name.
7. Once the new report is saved, use the table below to add additional information.

To edit an existing report click the report name in the top panel when in the Report Criteria Editor window.

Tab Name	Description
Report Options	The Report Options tab is used to set default information for the criteria of running the report.
Report Sections	The Report Sections tab determines what information from a patient chart will be included when the report is run. Additionally, you have the ability to add information not included by selecting that information in the Available to Add tab. When creating a new report the Report Sections tab will be blank.
Encounter Sections	The Encounter Sections tab selects areas of a note to include or exclude with the report when producing notes. This tab is only used when including Encounter and Well visit notes in the Report Sections selection.
Demographics	The Demographics tab is used to filter the report by information found in the patient's demographic record.
Formatting	The Formatting tab determines how the well and encounter Summary and Finalized notes display and print.