

Important Content Update Message

We are currently updating the OP Help Center content for the release of OP 20. OP 20 (official version 20.0.x) is the certified, 2015 Edition, version of the Office Practicum software. This is displayed in your software (**Help tab > About**) and in the Help Center tab labeled Version 20.0. We appreciate your patience as we continue to update all of our content.

Referral Workflow: Create a Tracking Entry

Last Modified on 11/07/2019 12:13 pm EST

Version 14.19

Overview

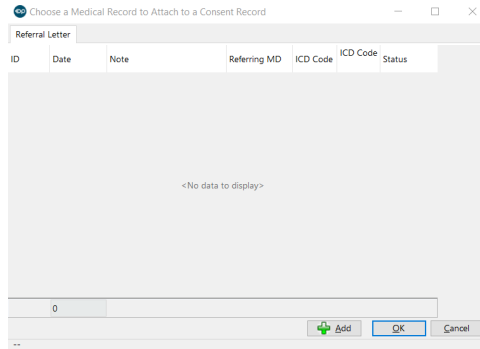
A tracking entry is typically created when a report is sent to the practice from an ER or Urgent Care visit. It can also include a specialist report where a referral was not initiated by the practice. The steps below will walk you through scanning and completing the tracking entry.



Note: The tracking entry workflow may be different than your practice workflow. Always follow your practice policy and procedure.

Scan and Save the Report

1. Navigate to Manage Documents: **Clinical tab or Practice Management tab > Document Mgmt button.**
2. Click the **New Document** button on the Manage Documents window.
3. Click the **Page Scanner** button or **Import Documents** button (if saved).
4. Select the Image in the **Sketch** panel and move to the **Thumbnails** panel.
5. Search for a patient in the Document Details panel by typing the patient name in the **Patient ID** field and select the patient
6. Click the drop-down arrow in **Item Type** and select **Referral Letter**.
7. Click in the **Item category** field and click the **Attach** icon. The **Choose a Medical Record to Attach to a Consent Record** window appears.



8. Click the **Add** button. The **Referral/Care Transition Detail** window appears.
9. Complete the tracking entry by following the steps below:
 - a. Click the **Tracking entry (care transition)** radio button.
 - b. Type or search the Address book for where the report originated in the **Received from** field.



Note: If you selected from the Address book you will receive a Confirm window to add the selected provider to the patient's Coordination of Care network. Click Yes if this will be a continued relationship or No if this will not be ongoing.

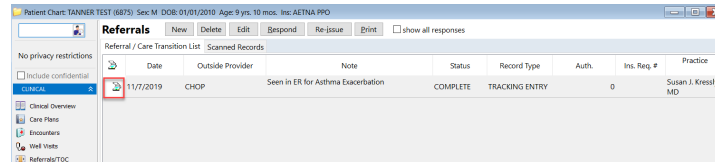
- c. (Optional) Search for and enter a diagnosis code in the DX 1 and DX 2 fields.
 - d. Enter the reason in the **Reason for care transition** field.
 - e. Click the **Save** button.
10. You are returned to the Manage Documents window.
11. Complete the Document Detail confirming the scanned document is addressed to a provider for review. Follow the instruction below.
 - a. **Reviewed?:** Leave the checkbox deselected.
 - b. **Addressed to:** Click the drop-down and select the provider to review the scanned document

Patient Information	
Patient ID	6875
Patient name	TEST, TANNER
Review Details	
Item type	REFERRAL LETTER
Item category	
Reviewed?	<input type="checkbox"/>
Reviewed by	
Review date	
Privacy level	Any staff member
Notes	
Administrative Details	
Creation date	11/07/2019
Created by	Susan Kressly
Created location	Harrahs AC UC2017
Correspondent	
Addressed to	Susan Kressly
Status of original	
Last updated	11/7/2019

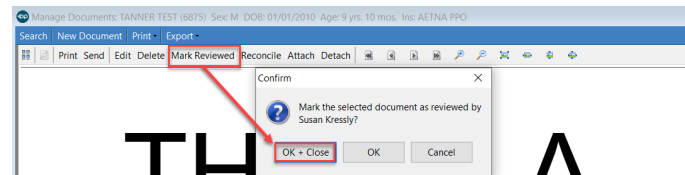
12. Click the **Save** button.

Review and Medication Reconciliation

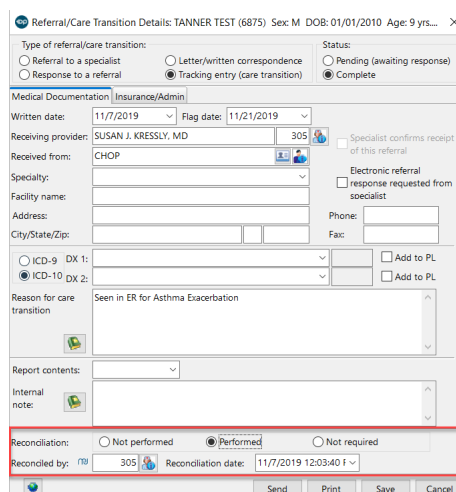
1. Click **Documents** on the Main Navigation Panel.
2. Click to highlight a patient in the Referral Letter type.
3. Click the **Patient Chart** button and select **Referrals/TOC**.
4. Click the scanner icon to the left of the Tracking entry to be reviewed.



5. The scanned document appears in the **Manage Documents** window.
6. Once the scanned document is reviewed, click the **Mark Reviewed** button then the **OK + Close** button. You are returned to the Referral / Care Transition List.



7. Highlight the tracking entry and click the **Edit** button to complete the reconciliation section.
 - a. From the Reconciliation section, select the radio button for **Performed** or **Not Required**.
 - b. The **Reconciled by** will default to the user logged into the OP software if **Performed** was selected. To change the provider or if **Not required** was selected, click the **Provider** button and select the provider from the list.
 - c. The **Reconciliation date** will default to the current date and time if **Performed** was selected. To change the date or if **Not required** was selected, click the drop-down arrow and select the date from the calendar.



The screenshot shows the 'Referral/Care Transition Details' window for patient TANNER TEST (6875). The 'Reconciliation' section at the bottom is highlighted with a red box. It contains the following fields:

- Reconciliation: Not performed **Performed** Not required
- Reconciled by: 305
- Reconciliation date: 11/7/2019 12:03:40

8. Click the **Save** button.



Note: If a new medication was prescribed, a medication allergy or problem was noted on the document, it is the responsibility of the practice to update the patient chart.

Version 14.10

Overview

A tracking entry is typically created when a report is sent to the practice from an ER or Urgent Care visit. It can also include a specialist report where a referral was not initiated by the practice. The steps below will walk you through scanning and completing the tracking entry.



Note: The tracking entry workflow may be different than your practice workflow. Always follow your practice policy and procedure.

Scan and Save the Report

1. Click the **Docs** button on the Smart Toolbar.
2. Click the **New Document** button on the Manage Documents window.
3. Click the **Scanner** button or import the document (if saved).
4. Move the document to the **Preview Panel**.
5. Click the **Patient Search** button in the **Patient ID** field.
6. Select a patient.
7. Click the dropdown arrow in **Item Type** and select **Referral Letter**.
8. Click in the **Item Category field** and click the **Attach** icon. The Choose a Medical Record to Attach to a Consent Record window appears.
9. Click the **Add** button. The **Referral/Care Transition Detail** window appears.
10. Complete the tracking entry by following the steps below:
 - a. Click the **Tracking entry (care transition)** radio button.
 - b. Type or search the Address book for where the report originated in the **Received from** field.



Note: If you selected from the Address book you will receive a Confirm window to add the selected provider to the patient's Coordination of Care network. Click Yes if this will be a continued relationship or No if this will not be ongoing.

- c. (Optional) Search for and enter a diagnosis code in the DX 1 and DX 2 fields.
 - d. Enter the reason in the **Reason for care transition** field.
 - e. Click the **Save** button.
11. Review the remaining information on the Document Details Panel. Confirm the document is addressed to a provider for review. Click [here](#) for additional information.

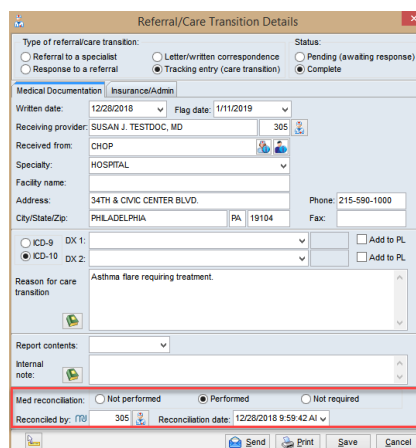
Review and Medication Reconciliation

1. From the Schedule/Practice Workflow window, click the **Documents** tab.
2. Navigate to and expand the heading titled **Referral Letter**.
3. Click to highlight a patient.
4. Click the **Chart** button.
5. Click the **Referrals/Trans** button.
6. Click the scanner icon to the left of the Tracking entry to be reviewed.

SASHA B. TEST (3546) Sex: F DOB: 11/2/2005 Age: 13 yrs. 1 mos.								
Referral / Care Transition List		Scanned Records						
Date	Outside Provider	Note	Status	Record Type	Auth.	Ins. Req. #	Practice Provider	
12/28/2018	CHOP		COMPLETE	TRACKING ENTRY		0	Susan J. Testdoc, MD	
5/14/2018	RADIOLOGY	THIS IS A TEST OF OVERDUE REFERRALS	COMPLETE	REFERRAL		0	Susan J. Testdoc, MD	
11/12/2015	Douglas Nadel	This patient is being referred for further evaluation because of not	COMPLETE	REFERRAL		0	Susan J. Testdoc, MD	
1/30/2015	Michael Gratch	adfdaf	COMPLETE	TRACKING ENTRY		0	Susan J. Testdoc, MD	

7. The scanned document appears in the **Manage Documents** window.
8. Once the scanned document is reviewed, click the **Mark Reviewed** button.
9. Click the **OK + Close** button. You are returned to the Referral / Care Transition List.
10. Highlight the tracking entry and click the **Edit** button to complete the Med reconciliation section.

- a. Select the radio button for **Performed** or **Not Required**.
- b. The **Reconciled by** will default to the user logged into the OP software if **Performed** was selected. To change the provider or if **Not required** was selected, click the **Provider** button and select the provider from the list.
- c. The **Reconciliation date** will default to the current date and time if **Performed** was selected. To change the date or if **Not required** was selected, click the dropdown arrow and select the date from the calendar.



Referral/Care Transition Details

Type of referral/care transition: Referral to a specialist Letter/written correspondence Pending (awaiting response) Response to a referral Tracking entry (care transition) Complete

Medical Documentation | Insurance/Admin

Written date: 12/28/2018 Flag date: 1/11/2019

Receiving provider: SUSAN J. TESTDOC, MD 305

Received from: CHOP

Specialty: HOSPITAL

Facility name:

Address: 34TH & CIVIC CENTER BLVD. Phone: 215-590-1000

City/State/Zip: PHILADELPHIA PA 19104 Fax:

ICD-9 DX 1: Add to PL

ICD-10 DX 2: Add to PL

Reason for care transition: Asthma flare requiring treatment.

Report contents:

Internal note:


Med reconciliation: Not performed Performed Not required

Reconciled by: RTB 305 Reconciliation date: 12/28/2018 9:59:42 AM

Send Print Save Cancel

- d. Click the **Save** button.

Note: If a new medication was prescribed for the patient, you are required to enter the

 medication in the **Medications** tab of the patient chart.