

Cerner PowerChart Ambulatory EDUCATION

At the Thomas Judd Care Center, mid-level providers complete the Ambulatory Comprehensive Intake PowerForm as part of the patient visit intake.

Ambul	mbulatory Comprehensive Intake PowerForm								
Follow	the steps below to document a	< > 🔹 🔒 Provider Vie	w						
compre	ehensive patient intake:	A 1 100%		4					
1.	Navigate to the AMB Primary Care	AMB Primary Care Workflow $ imes$	1	AMB QOC - Primary Care	\times +			3	
	Workflow within the Provider	¥		Vital Signs				- All Visits Last 12 months	
	View.	Diagnostics (0)					_		
2.	Select the Vital Signs Component.	Microbiology	`		Today	Previous	_	Ambulatory Vitals Height Weight	
3.	Click the down.	Pathology/Misc	L	Temp		37.0 8 mos		Patient Provided Vital Signs	
4.	Select Ambulatory Comprehensive	Scales and Assessments	L	HR		82 7 mor	6	Ambulatory Comprehensive	
	Intake to open the PowerForm.	Vital Signs 2	L	bpm Respiratory Rate		30	1	Ambulatory Quick Intake 4	
		Subjective/History of	1	hr/min		7 mos	7	mos y mos y m	

Intake Summary

Intake Summary documentation requirements may vary based on the practice. Follow practice guidelines for documentation.

Patient Summary

- 1. Chief Complaint: Enter the patient stated chief complaint.
- 2. Communication Preference: Select or update as needed. This is required to be selected for patient invitations.
- 3. History of Present Illness Nursing Note: HPI is optional and should be used only as directed by the practice.

Vitals

- 1. Blood Pressure.
- 2. Pulse Rate: Document beats per minute when auscultated or palpated. **Document Heart Rate** Monitored when a machine is used to record beats per minute.
- 3. Respiratory Rate.
- 4. O2 Sat.
- 5. Temperature: Document as oral, temporal, or tympanic.
- 6. Heart Rhythm.
- 7. Pain Scale: There is a drop-down list to select a specific scale. After scale selection, a pain level can be documented. Additional comments may be entered in the free textbox.

Intake Summary	Patient Summary	
Detailed Vitals and Measurements	Chief Complaint	2 Communication Preference
PHQ-2 and PHQ-9		
Allergies and Medications	1	
Social History		No Preference
Family History		O Printed Letter
Obstetrical History		
Procedure and Surgical History	History of Present Illness, Nursing Note	
Problems and Diagnosis		

Blood Pressure Source

It arm w/ BP machine

O It leg w/ BP machine

O rt arm w/BP machine

O rt leg w/BP machine

 \sim

02 Sat

4

It arm, manually

O It leg, manually

O rt arm, manually

O rt leg, manually

0

Temperature

Pain Level

Oral

It arm, palpated

O It leg, palpated

O rt arm, palpated

O rt leg, palpated

 $^{\circ}$

Temperature

Pain Comments

Temporal

O

mmHg

Resp. Rate

Pain Scale Used

Vitals SBP / DBP

Pulse Rate

Heart Rhythm

O Irregular

O Regular

If BP is greater than 140/90

repeat after 5 min or longer. Documet on Vital Signs and

Heart Rate

Monitored

Measurements form.

Left forearm,

O Right forearm

Temperature

Tympanic

0



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Measurements

1. Measured and Non Measured Height and Weight fields are available for documentation. Enter the information in the correct field. Measured Height and Weight must be entered yearly. Both Height and Weight need to be measured to calculate a Body Mass Index (BMI).

Measurer	ne	nts		
Weight Measured		Height/Length Measured	BMI Measured	Waist Circumference
kg		cm		cm
Weight Non Measured		Height/Length Non Measured	BMI Non Measured	Pre-Pregnancy Weight
kg		cm		kg

Depression Screening

Select the PHQ-2 and PHQ-9 section to document depression screening and calculate a score. If the PHQ-2 score is greater than 0, the PHQ-9 needs to be completed to calculate a Severity Score. Documentation requirements may vary based on the practice. Follow the practice guidelines for documentation.

Intake Summary PHQ-2 and PHQ-9 Depression Screening Question Detailed Vitals and Measurements Over the last 2 weeks, how often have you been bothered by any of the following problems? PHQ-2 and PHQ-9 Over the last 2 weeks, how often have you been bothered by any of the following problems? Allergies and Medications 1. Little Interest or Pleasure in Doing Things Social History O Not at all O More than half the days Obstetrical History 2. Feeling Down, Depressed or O Not at all O More than half the days								
Detailed Vitals and Measurements PHQ-2 and PHQ-9 Allergies and Medications Social History Family History Obstetrical History Obstetrical History 2. Feeling Down, Depressed or	Intake Summary	PHO-2 and PHO-9 De	pression Scr	eening Ouestion				
PHQ-2 and PHQ-9 Over the last 2 weeks, how often have you been bothered by any of the following problems? Allergies and Medications 1. Little Interest or Pleasure in Doing Things O Not at all O More than half the days Family History Obstetrical History O Not at all O More than half the days 2. Feeling Down, Depressed or O Not at all O More than half the days	Detailed Vitals and Measurements							
Allergies and Medications Social History Family History Obstetrical History 2. Feeling Down, Depressed or	PHQ-2 and PHQ-9	Over the last 2 weeks, how often have you been bothered by any of the following problems?						
Social History I. Ettle Interest of Pleasure in Doing Things O Several days O Nearly every day Bobsetrical History 2. Feeling Down, Depressed or O Not at all O More than half the days	Allergies and Medications	1. Little Tetevent ov Discovers in	O Not at all	O More than half the days				
Family History Obstetrical History 2. Feeling Down, Depressed or O Not at all O More than half the days	Social History	Doing Things	O Several days	O Nearly every day				
Obstetrical History 2. Feeling Down, Depressed or O Not at all O More than half the days	Family History							
z, recind Down, Depressed of	Obstetrical History	2 Feeling Down, Depressed or	O Not at all	O More than half the days				
Decoder and Constant literation of the second secon	Descedure and Constant United	2. reening bown, bepressed of	O Several days	O Neadu everu dau				

Allergies and Medications

Review of allergies and medications are required at every patient visit. The review can be done from the Ambulatory Nursing Workflow or Ambulatory Comprehensive Intake PowerForm.

Allergies:

- a. Click Add to add an allergy to the list.
- b. Select a current allergy on the list, then click Modify to modify an existing allergy.
- c. When the allergy review is complete, click the Mark All as Reviewed button.

Note: If the allergy review is done on the Intake form, the Complete Reconciliation button in the Allergies component on the AMB Primary Care Workflow will need to be clicked for meaningful use credit.



Medications:

- a. Click Document Medication by Hx to begin the medication review. Medication compliance is required when reviewing medications.
- b. Click Add to add a medication order.
- c. When the medication history is completed, the Meds History Reconciliation.





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Social History

Social History is required to be reviewed at every patient visit. This includes documenting at a minimum, tobacco status for meaningful use and safety-home and environment information for rural health clinics. Follow practice guidelines for additional social history documentation.

Intake Summary	Social History	1							
Detailed Vitals and Measurements									
PHQ-2 and PHQ-9	Instructions for makir	Instructions for making changes to Social History documentation							
Allergies and Medications	If no documentation pre	If no documentation present, right click and Add							
Social History	If documentation preser	nt, and no error message, right click and modify							
Family History	If documentation preser	If documentation present, and error message present, right click Add, then right click and remove old documentation							
Obstetrical History									
Procedure and Surgical History	Mark all as Reviewed button is no longer active								
Problems and Diagnosis	Made all as Decisioned								
Infectious Disease Risk Screening	Mark all as Heviewed								
Psychosocial and Spiritual	Social								
Conley Fall Risk Scale	🕂 Add 🛒 Modify	Display: Active ~							
Instrumental ADL Adult	Category	Details	Last Updated	Last Update					
Education Needs	Tobacco	Smoking Status: Never (less than 100 in lifetime).	2/11/2022 8:53 A.	. Ambrnipn,					

Family History

- 1. Family History is required to be reviewed at every patient visit. This history review includes first degree relatives: parents, siblings, and offspring. Positive and negative pertinent information should be documented.
 - a. Click Add to add and/or modify any health history for a family member. Refer to step 2 for more information.
 - b. The display drop-down allows for different viewing options.

PHQ-2 and PHQ-9	Mark all as Beviewed				
Allergies and Medications					
Social History	Family				
Family History	Add Modify Display: Family Member View [All]				
Obstetrical History	Last a ste: 2/9/2022 12:34 PM EST by Ambrilion, 20				
Procedure and Surgical History					
Problems and Diagnosis	Family Member Information A				
	Mother (Jane):				
Infectious Disease Risk Screening	Positive				
Psychosocial and Spiritual	Asthma				

- c. Once the Family History review is complete, click Mark all as Reviewed.
- 2. In the Add Family History screen:
 - a. Family members will be listed at the top. Left-click on the relationship name to enter names and demographics. Rightclick on a family member to remove.
 - b. Click the Add Family member drop-down to add a family relationship.

dd Family History 2 ast Update: 2/3/2022 12:34 PM EST by A	umbrnipn, 2	20 🗆 F	ocus Mode	,					b	▼ Add Fami	ily Mi
	Relati	onship	Fathe	er -	Mother	Brother		Sister	Son	Daughter	Т
a		Name	Bob		Jane		+				
	Health	Status		\sim	~		\sim	~	~	~	1
3 QuickList	۹,	C									
3 General Family History		-									
Alcohol abuse		-					Т				1
Diabetes mellitus		-		+			1				1
Heart attack		-									1
Hypertension		-									1
Tuberculosis		-									
		d				e		е	(g	

- c. Click the QuickList magnifying glass to s
- magnifying glass to search for and create a list of histories not found in the General Family History list.d. Selecting negative here will document a negative history for the selected condition for all family relationships listed.
- e. Click in the white or blue column under each family member to document a negative or positive history.
- f. Click on Add Group to add additional groups of histories for review.
- g. Once complete, click OK.



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Obstetrical History

Obstetrical History section is available for documentation pregnancy information.

Intake Summary	Obstetrical History
Detailed Vitals and Measurements	
PHQ-2 and PHQ-9	
Allergies and Medications	Mark All as Reviewed
Social History	🕂 Add 🛒 Modify 🏭 Graphs 👻
Family History	Delivery/Outcome Date/Time Gestation Weeks Pregnancy Outcome Length of Lal
Obstetrical History	No Items to Display
Procedure and Surgical History	<
Problems and Diagnosis	Gravida/Para
Infectious Disease Risk Screening	Gravida Para Fullterm Para Preterm Abortions Living Child Living Comment
Psychosocial and Spiritual	

Procedure and Surgical History

Procedure and Surgical History is required to be documented at a patient's initial visit and at least yearly thereafter.

- a. Click Add to add a procedure/surgery to the history list.
- b. Click the Mark all as Reviewed button when the review is complete.

Intake Summary	Procedure / Sur	gical History	
Detailed Vitals and Measurements		great thocory	
PHQ-2 and PHQ-9	Mark all as Revieward		
Allergies and Medications			
Social History	Procedures		
Family History	Add a Modify	Display: Active	~
Obstetrical History	Procedure A	Procedure Date	Provider
Procedure and Surgical History	Implantation of heart pac		
Problems and Diagnosis	Vasectomy		

Problems and Diagnosis

In the Problems and Diagnosis section, it is required to document patient stated medical problems at every visit. In this window, Problems and Diagnoses can be added, updated, and converted.

- a. Diagnosis is the problem being addressed at current visit.
- b. Problems lists documented chronic conditions that stay with the patient across all encounters.
- c. After selecting a condition in the Problems list, click Convert to add it as a Diagnosis (Problem) being addressed this visit.
- d. Click Mark all as Reviewed when done.





Hepatitis C Description

O active O Non-Treated O Recent exposure O Treated

Ambulatory Comprehensive Intake PowerForm for Providers

Infectious Disease Risk Screening

Yes

Ye.

No

Comment

Infection History

History Genital Herpes, Patient/Partner Genital Herpes Outbreak Last 14 Days

History of Rash/Virus in Last Month History of Recent Positive TB Results

Infectious Disease Risk Factors/Symptoms

Chickenpox Chlamydia

Gonorrhea HIV Exposure

HPV

Syphilis

Chills

Fever

Unusual Fatigue Headache Runny or Stuffy Nose Sore Throat

Intake Summan

PHQ-2 and PHQ-9

Social History

Family History

Psych

Obstetrical History

Problems and Diagn

Conley Fall Risk Scale

Instrumental ADL Adult

Education Needs

Interpreter Services Review of Systems

Allergies and Medications

Procedure and Surgical History

social and Spiritua

Healthcare Decision Maker - Amb

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Hepatitis B Description

Date of Hepatitis B Vaccination

O Yes

Recent Travel History

Recent Travel Detail

O active

O No

O Non-Treated O Recent exposure O Treated

Infectious Disease Risk Screening

Infectious Disease Risk Screening section is available for documentation of Infection History, Infectious Disease Risk Factors/Symptoms, **Tuberculosis Risk** Factors/Symptoms, and several other family member and travel history information.

Psychosocial and Spiritual

Psychosocial and Spiritual section is used to document stressors, coping and support, as well as spiritual and religious preferences.

atake Summary	Psychosocial	Screening			
etailed Vitals and Measurements	r sychosocial	Screening			
HQ-2 and PHQ-9	Coping	Stressors			Emotional Support
llergies and Medications		De tuisses		C	
ocial History	O Ineffective	Condition	Family problems	Surgery/Frocedure Unknown cause	
amily History		Diagnosis	Finances	Other:	
bstetrical History		Divorce	Hospitalization		
rocedure and Surgical History					
roblems and Diagnosis					
fectious Disease Risk Screening	Spiritual				
sychosocial and Spiritual	Do You Receive				
onley Fall Risk Scale	Comfort From	Religious Preference	0		Comments
strumental ADL Adult	Spiritual Practices	Transional Preference	-		
ducation Needs	O Yes	O Amish	O Hindu	O Non-Denominational	
	O No	O Assemblies of God	O Jehovah's witness	O Driental Urthodoxy	
ealthcare Decision Maker - Amb		O Baptist	O Jewish	O Pentecostal	
terpreter Services		O Buddhist	C Latter-Day Saints	O Presbyterian	
eview of Systems		O Latholic	O Lutheran	Protestant Scientals and	
		O Unristian	Methodist Muslim	 Scientology Seventh Day Adventist 	
ehavioral Pain Score		C Creek Otherden		O Sevenin Day Adventist	

Conley Fall Risk Scale

Conley Fall Risk Scale section is available to score patient risk for falls.

Intake Summary	Conley Fall Risk Sca	ale	
Detailed Vitals and Measurements			
PHQ-2 and PHQ-9	History		1
Allergies and Medications	Months, Including Since		scores 2
Social History	Admission		
Family History	Observations		
Obstetrical History	Impaired Judgment/Lack	O Yes O No	Yes response
Procedure and Surgical History	of Safety Awareness		scores 3
Problems and Diagnosis		0	1
Infectious Disease Risk Screening	Agitation	O Yes O No	scores 2
Psychosocial and Spiritual			
Conley Fall Risk Scale	Impaired Gait, Shuffle,	O Yes O No	Yes response
Instrumental ADL Adult	Wide Base, Unsteady Walk		scores 1
Education Needs			
Healthcare Decision Maker - Amb	Direct Questions (Do You)		
Interpreter Services	Ever Experience Dizziness	O Yes O No	Yes response scores 1
Review of Systems			
Behavioral Pain Score	Ever Wet er Seil Yourself	O Yes O No	Yes response
FLACC Pain Score	on Way to Bathroom		scores 1
NIPS Pain Score			-
NPASS Pain Score	Fall Risk Score		
		Patient is at risk for falls if Conley	



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Instrumental ADL Adult

Instrumental Activities of Daily Living section is available to document levels of independence.

Intake Summary	Instrumenta	Activities o	f Dailv Livin	a
Detailed Vitals and Measurements				_
PHO-2 and PHO-9		Complete independence	Modified independence	Supe
The zand the s	Meal Prep			
Allergies and Medications	Writing			
Sacial History	Keyboarding			
Social History	Phone Use			
Family History	Money Management			
Obstatrical History	Grocery Shopping			
Obstetrical History	Clothing Care			
Procedure and Surgical History	Light Cleaning			
Problems and Diagonasia	Heavy Cleaning			
Problems and Diagnosis	Community Transportation			
Infectious Disease Risk Screening	Community Mobility, Safety			
Payebosocial and Cointual	Care of Others			
Psychosocial and opinicual	Medication Management			
Conley Fall Risk Scale	Other IADL			
Instrumental ADL Adult				

Education Needs

Educational Needs section is required for documentation, indicated by a red asterisk, and may include education needs and learning style preference for the patient and/or family.

- a. Barriers to Learning is required to be documented at every visit.
- b. Patient/Family Learning Style Preferences is where the patient and family preferred learning styles can be documented. Multiple learning styles can be selected by clicking inside the boxes. These preferences will be saved across visits.
- c. Patient/Family Education Needs Comments is a free text box for any additional comments.

Intake Summary	Education Needs/Learning Style
Detailed Vitals and Measurements	
PHQ-2 and PHQ-9	
Allergies and Medications	Barriers to Learning
Social History	None evident Difficulty concentrating Literacy
Family History	Acuity of illness Emotional state Memory problems Cognitive deficits Financial concerns Vision impairment
Obstetrical History	Cultural barrier Hearing deficit Other:
Procedure and Surgical History	Desire/Motivation Language barrier
Problems and Diagnosis	
Infectious Disease Risk Screening	Patient/Family Learning Style Preferences
Psychosocial and Spiritual	None Demonstration Printed materials Verbal explanati
Conley Fall Risk Scale	Family
Instrumental ADL Adult	
Education Needs	
Healthcare Decision Maker - Amb	
Interpreter Services	Patient/Family Education Needs Comments
Review of Systems	Segoe UI V 9 V 🧐 🔏 🖻 🗒 🗸
Behavioral Pain Score	

Healthcare Decision Maker - Amb

Healthcare Decision Maker section is used to capture information regarding healthcare decision making, Guardian, and Advance Directive/DPOAH for the patient.

Intake Summary	Healthcare Decision Maker					
Detailed Vitals and Measurements	Invaluate Decision March					
PHQ-2 and PHQ-9	The purpose of this form is to capture information regarding healthcare decision					
Allergies and Medications	Is adult patient or pediatric patient representative Bight click in box below to view					
Social History	currently able to answer these questions Definitions of Legal Terminology					
Family History						
Obstetrical History						
Procedure and Surgical History	Guardian					
Problems and Diagnosis	If this patient has a SHARDIAN and a copy is in the patients' shart, it will be listed below.					
Infectious Disease Risk Screening	In this patient has a GOARDIAN and a copy is in the patients chart, it will be listed below					
Psychosocial and Spiritual	Please select two in field below as this patient does not have a Letter of Guardianship in their medical record					
Conley Fall Risk Scale						
Instrumental ADL Adult	This patient has a Guardian					
Education Needs	O Yes O No					
Healthcare Decision Maker - Amb						
Interpreter Services	It is not necessary to continue documenting this form if the patient has a Court Appointed Guardian					
Review of Systems	Advance Directive / DPOAH					
Behavioral Pain Score						
FLACC Pain Score	If this patient has an AD/DPOAH and a copy is in the patients' chart, it will be listed below					
NIPS Pain Score	This patient does not have an Advance Directive/DPOAH medical record					
NPASS Pain Score						
	Does the patient have an Advance Directive or DPOAH C Yes C Unknown (C No Jf yes, please ask the patient to bring in a copy of document so it can be added to their medical record.					



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Interpreter Services

Interpreter Services section is available for documentation of Interpretation Type, Agency, and Modality.

Intake Summary	Interpreter Services	
Detailed Vitals and Measurements		
PHQ-2 and PHQ-9	Interpretation Type	Interpretation Reason Patien
Allergies and Medications		
Social History	O Telephonic O Video	
Family History	O Patient declined	
Obstetrical History		
Procedure and Surgical History		
Problems and Diagnosis	Interpreter Name and ID Number	Interpreter Agency Name
Infectious Disease Risk Screening		O Interpreter Connection O Other:
Psychosocial and Spiritual		O Staff/In-house
Conley Fall Risk Scale		
Instrumental ADL Adult	Modality	
Education Needs		
Healthcare Decision Maker - Amb	O Video remote interpretati	
Interpreter Services	O Telephonic interpretation	
D		

Review of Systems

Review of Systems section is available for documentation for clinical staff that perform this review.

Intake Summary	Review of Sv	stem	าร	
Detailed Vitals and Measurements				
PHQ-2 and PHQ-9	General:			
Allergies and Medications		٢	/es	No
Social History	Weight Change >10lbs			
oodar middory	Difficulty Sleeping			
Family History	Blood Transfusion			
Obstetrical History	Fever			
obstelling	Fatigue			
Procedure and Surgical History	Night sweats			
Problems and Diagnosis	Cold intolerance			
- Company Pick Company	Diaphoresis			
Infectious Disease Risk Screening				
Psychosocial and Spiritual	Head and Neck:			
Conley Fall Risk Scale			Yes	No
Instrumental ADI Adult	Visual changes (not glas	sses]		
Instrumental ADE Adak	Dizziness			
Education Needs	Double vision			
Healthcare Decision Maker - Amb	Sinus problems			
Healthcare Decision march - And	Frequent persistent nose	ebleeds		
Interpreter Services	Ear pain			
Review of Systems	Trouble hearing			
Neview of Systems	Ringing in Ears			

Signing the Form

When documentation is done, click the green check on the top of the PowerForm to sign and complete the Ambulatory Comprehensive Intake.

P Ambulatory Comprehensive Intake								
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