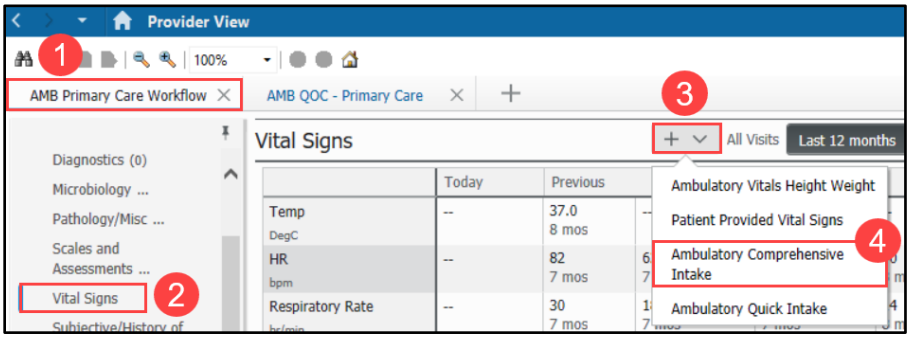
Ambulatory Comprehensive Intake PowerForm for Providers

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

Ambulatory Comprehensive Intake PowerForm

Follow the steps below to document a comprehensive patient intake:

1. Navigate to the AMB Primary Care Workflow within the Provider View.
2. Select the Vital Signs Component.
3. Click the down.
4. Select Ambulatory Comprehensive Intake to open the PowerForm.

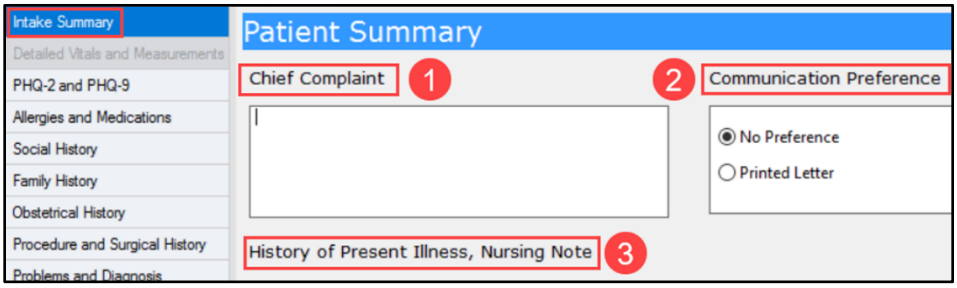


Intake Summary

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

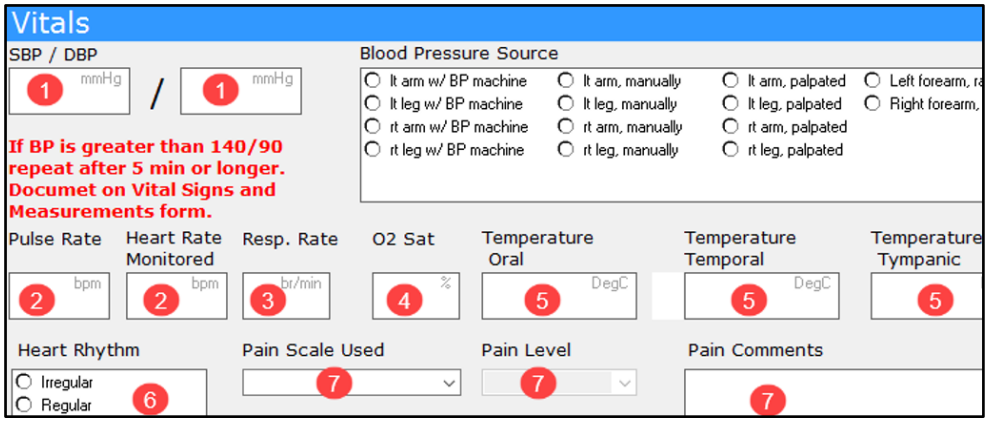
Patient Summary

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.

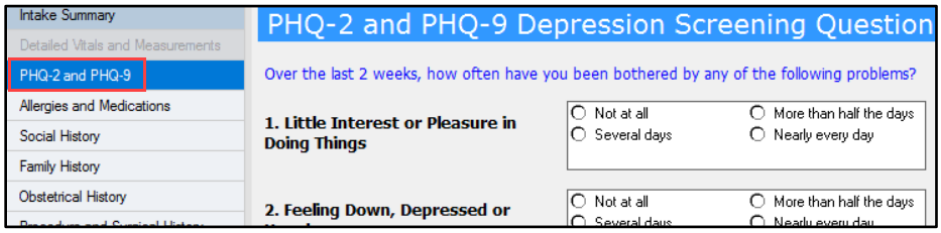


Measurements

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).

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.



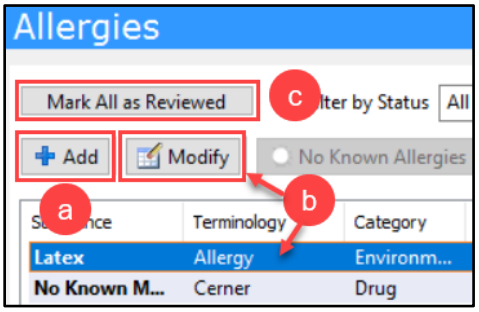
Allergies and Medications

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:

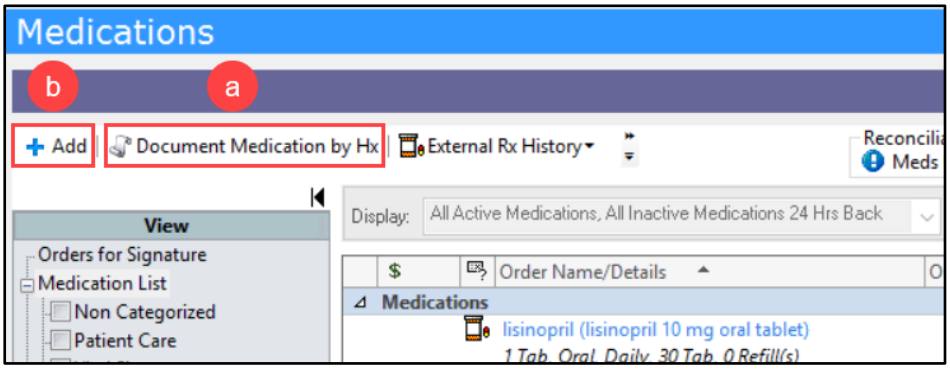
a. Click Add to add an allergy to the list.
b. Select a current allergy on the list, then click Modify to modify an existing allergy.
c. When the allergy review is complete, click the Mark All as Reviewed button.

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.



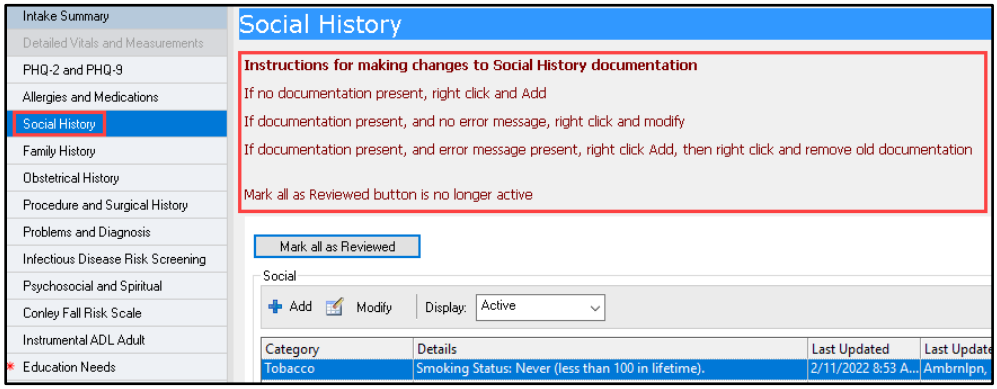
Medications:

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.



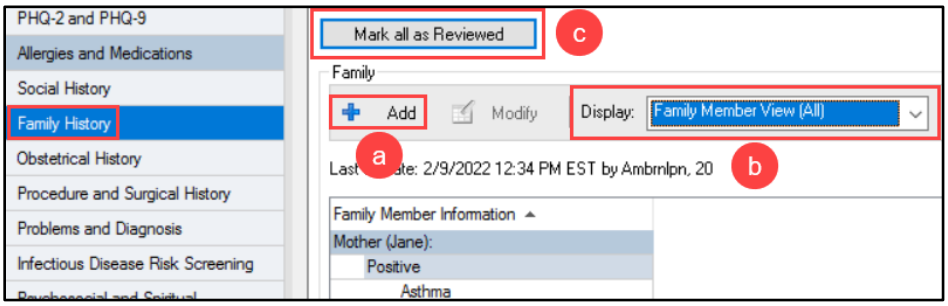
Social History

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.

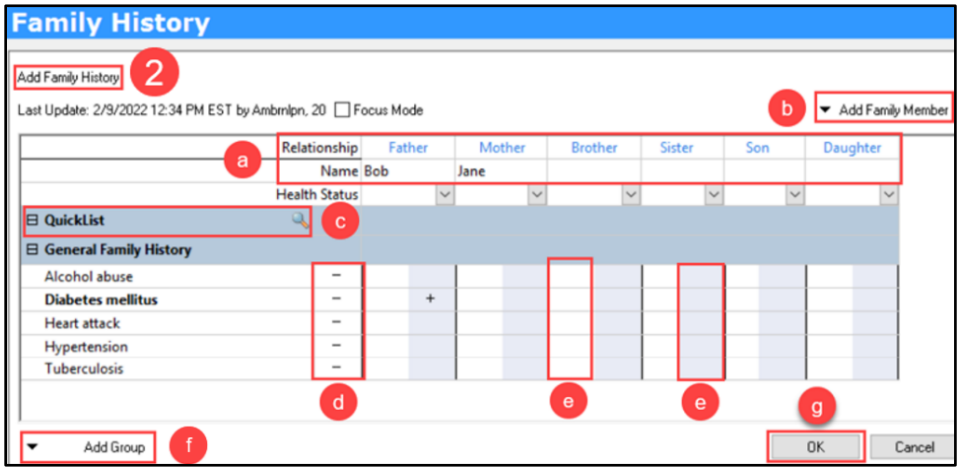


Family History

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.
    c. Once the Family History review is complete, click Mark all as Reviewed.

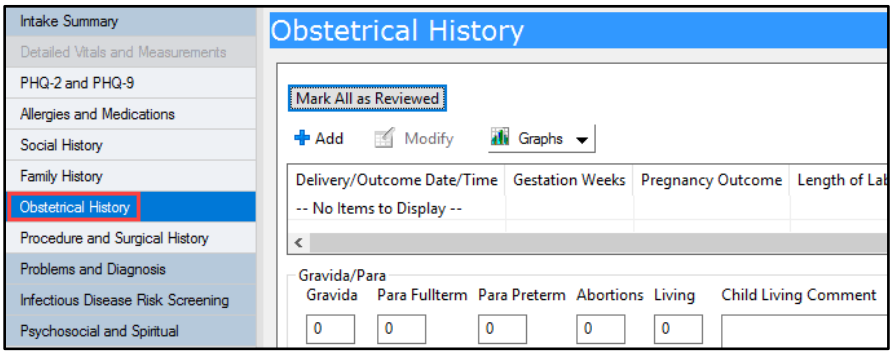


2. In the Add Family History screen:
    a. Family members will be listed at the top. Left-click on the relationship name to enter names and demographics. Right-click on a family member to remove.
    b. Click the Add Family member drop-down to add a family relationship.
    c. Click the QuickList magnifying 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.



Obstetrical History

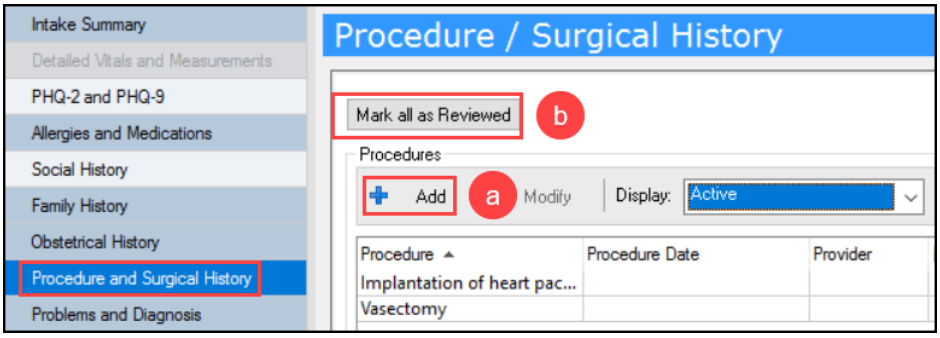
Obstetrical History section is available for documentation pregnancy information.



Procedure and Surgical History

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

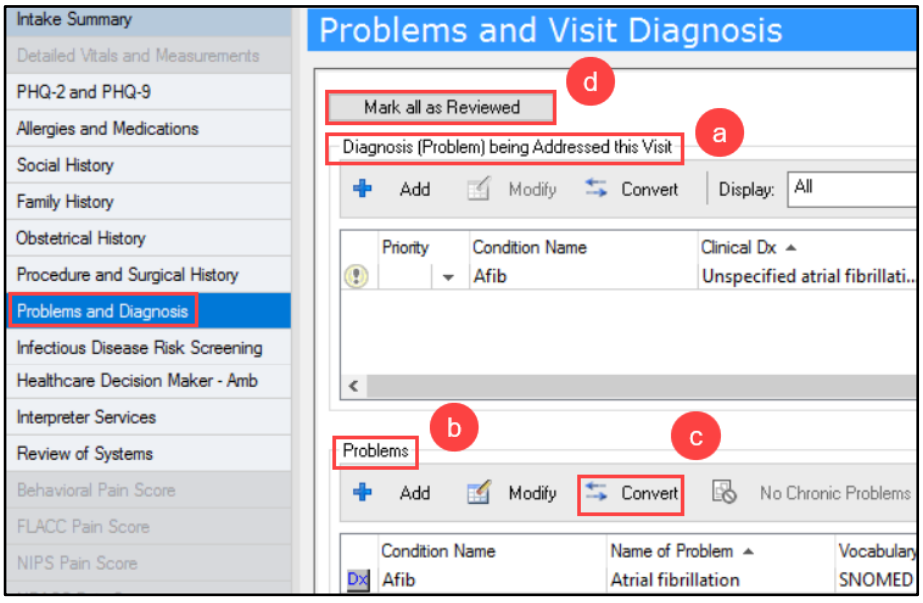
a. Click Add to add a procedure/surgery to the history list.
b. Click the Mark all as Reviewed button when the review is complete.



Problems and Diagnosis

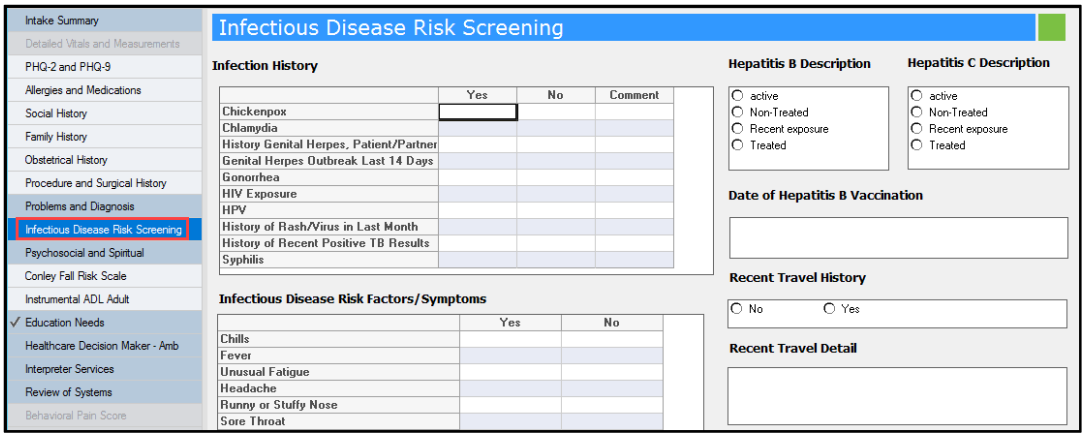
In the Problems and Diagnosis section, it is required to document patient stated medical problems at every visit. In this window, Problems and Diagnoses can be added, updated, and converted.

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.



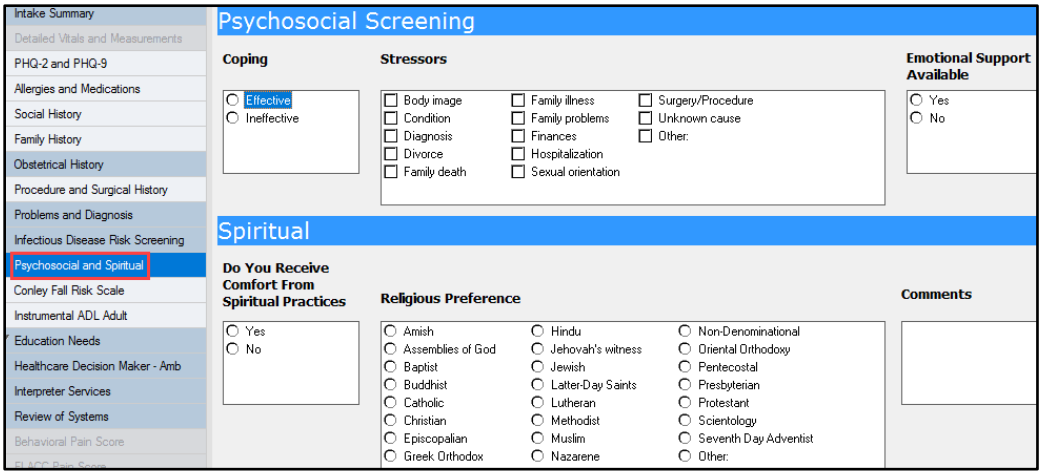
Infectious Disease Risk Screening

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.



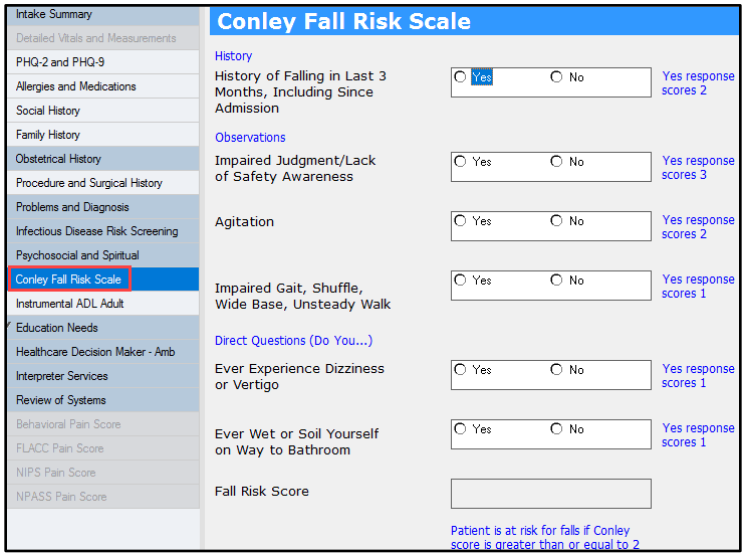
Psychosocial and Spiritual

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



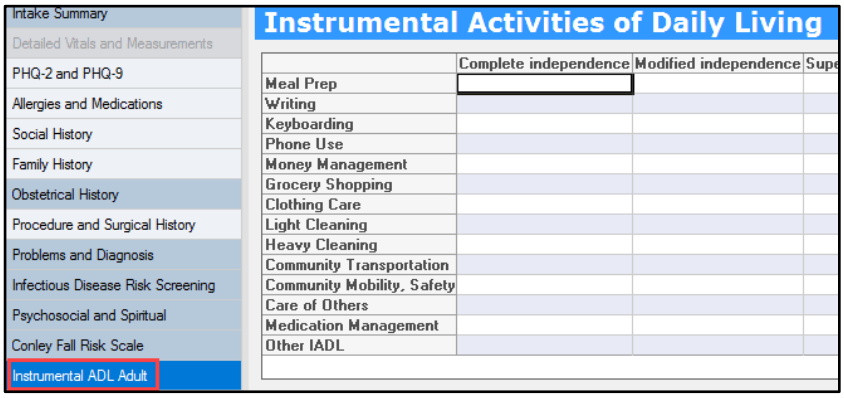
Conley Fall Risk Scale

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



Instrumental ADL Adult

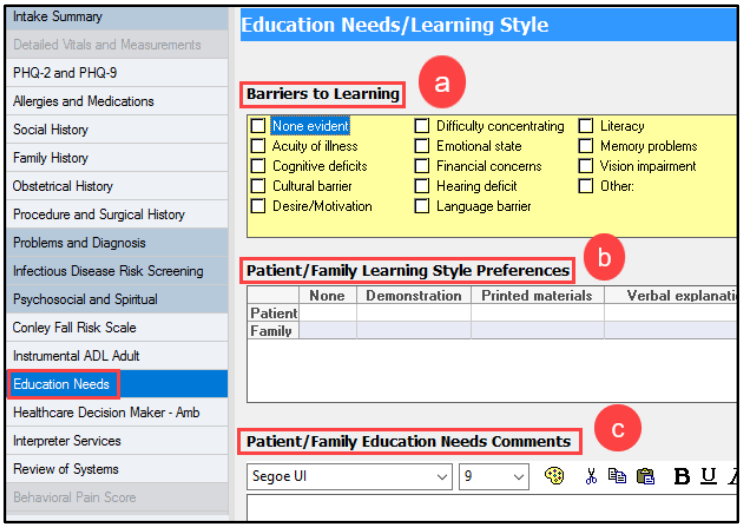
Instrumental Activities of Daily Living section is available to document levels of independence.



Education Needs

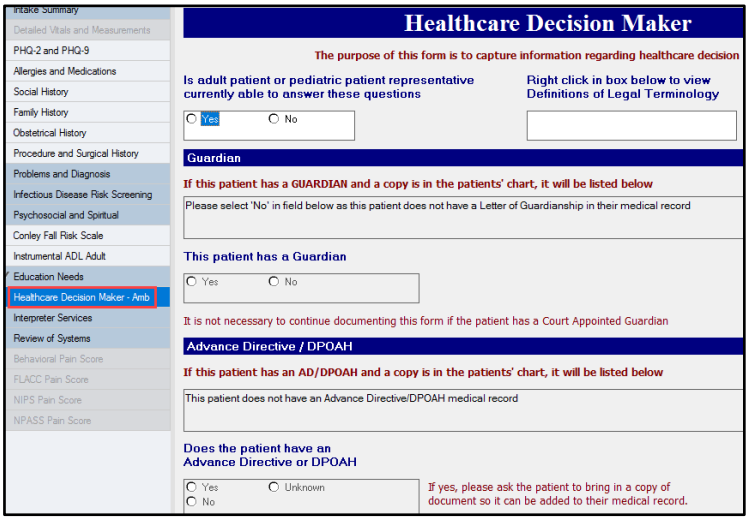
Educational Needs section is required for documentation, indicated by a red asterisk, and may include education needs and learning style preference for the patient and/or family.

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.



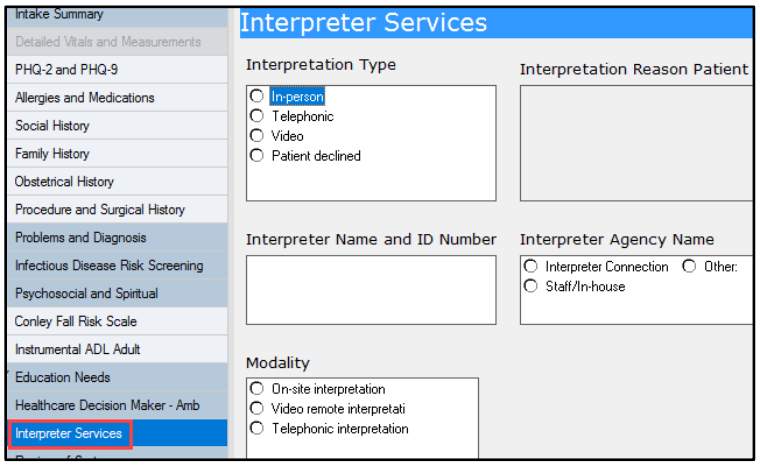
Healthcare Decision Maker - Amb

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



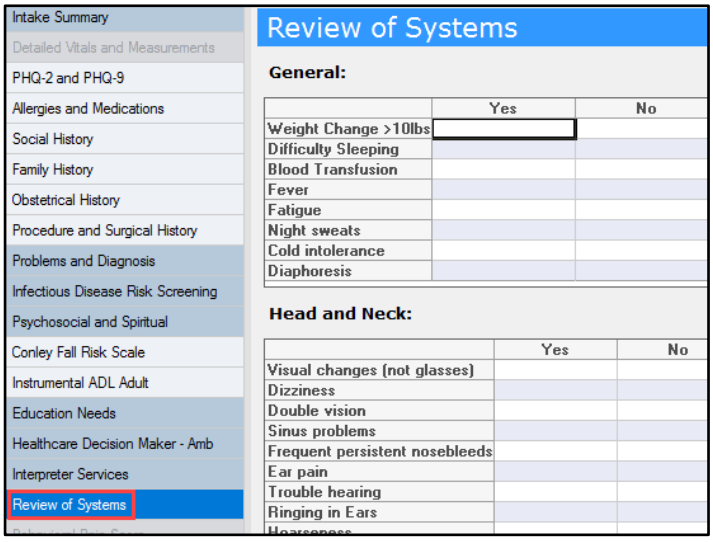
Interpreter Services

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



Review of Systems

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



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.