

# Ambulatory Comprehensive Intake PowerForm for Providers

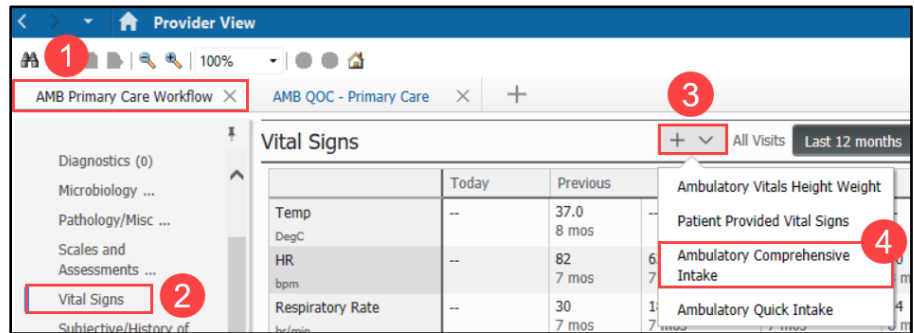
## Cerner PowerChart Ambulatory EDUCATION

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

### 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.

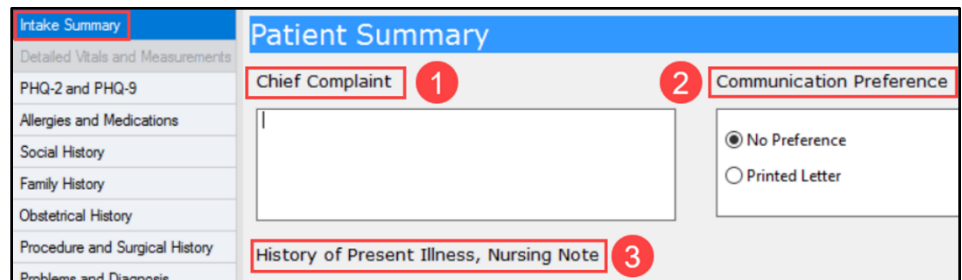


### Intake Summary

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

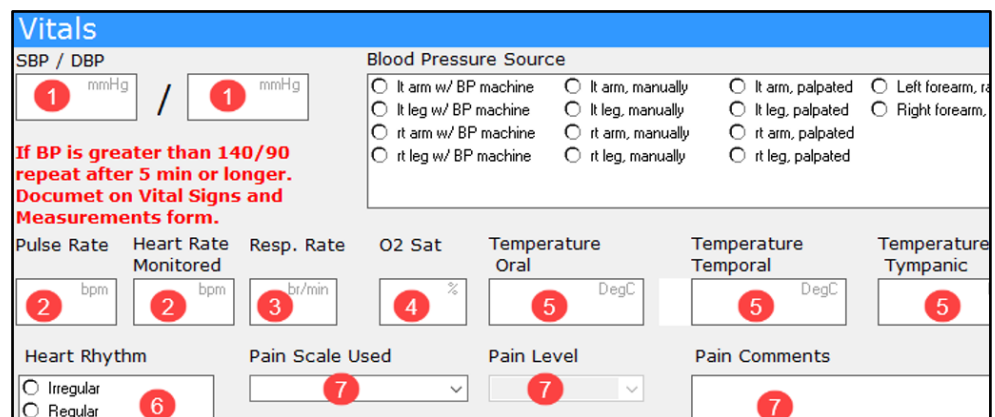
### Patient Summary

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.



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## Cerner PowerChart Ambulatory EDUCATION

### 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:

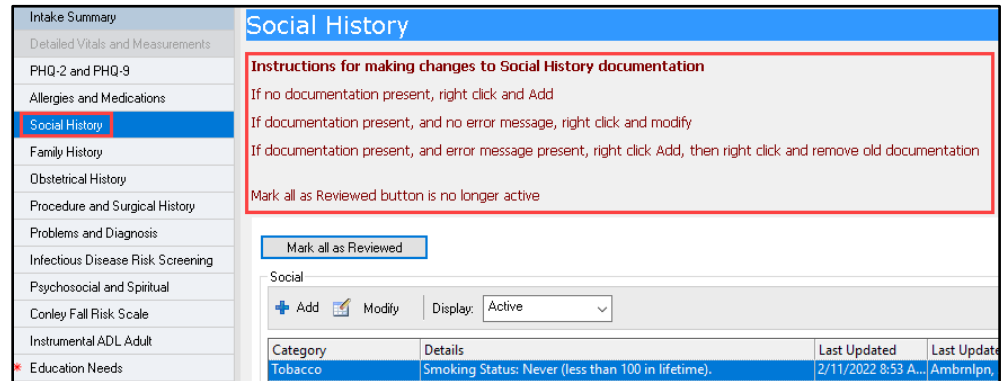
- a. Click Document Medication by Hx to begin the medication review. Medication compliance is required when reviewing medications.
- b. Click Add to add a medication order.
- c. When the medication history is completed, the Meds History Reconciliation.

# Ambulatory Comprehensive Intake PowerForm for Providers

## Cerner PowerChart Ambulatory EDUCATION

### 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.

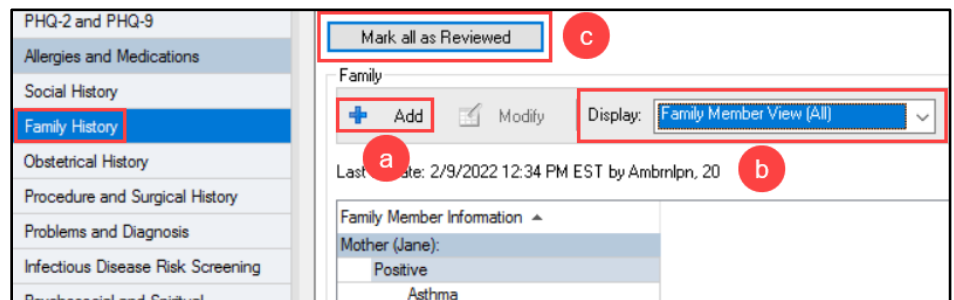


The screenshot shows the Social History section in the Cerner PowerChart interface. On the left is a navigation menu with options like Intake Summary, PHQ-2 and PHQ-9, Allergies and Medications, Social History (highlighted), Family History, etc. The main area is titled 'Social History' and contains instructions for making changes to the documentation. Below the instructions are buttons for 'Add', 'Modify', and 'Display: Active'. A table below shows a 'Tobacco' entry with details 'Smoking Status: Never (less than 100 in lifetime)', last updated '2/11/2022 8:53 A...', and user 'Ambrlmpn'.

### 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.

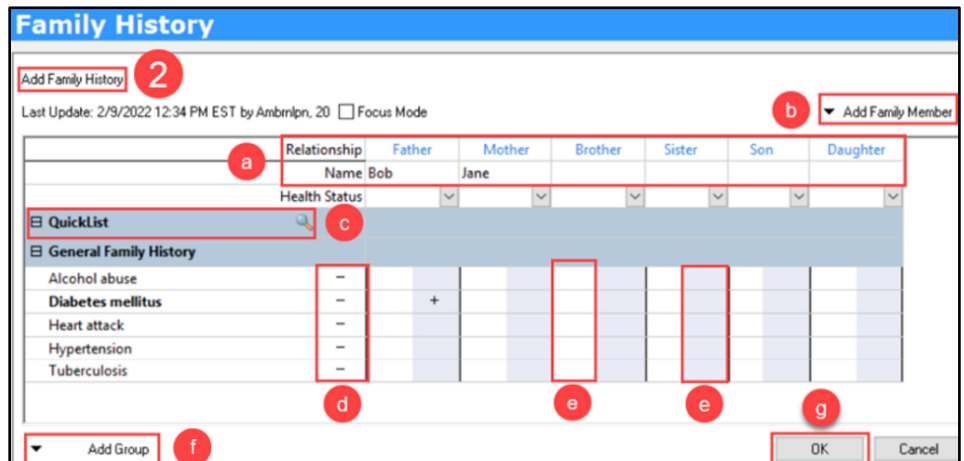
- a. Click Add to add and/or modify any health history for a family member. Refer to step 2 for more information.
- b. The display drop-down allows for different viewing options.
- c. Once the Family History review is complete, click Mark all as Reviewed.



The screenshot shows the Family History review screen. It features a navigation menu on the left with 'Family History' selected. The main area has a 'Mark all as Reviewed' button (labeled 'c'), an 'Add' button (labeled 'a'), and a 'Display: Family Member View (All)' dropdown (labeled 'b'). Below, there is a table for 'Family Member Information' with a row for 'Mother (Jane):' showing a 'Positive' status and 'Asthma' as a condition.

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.



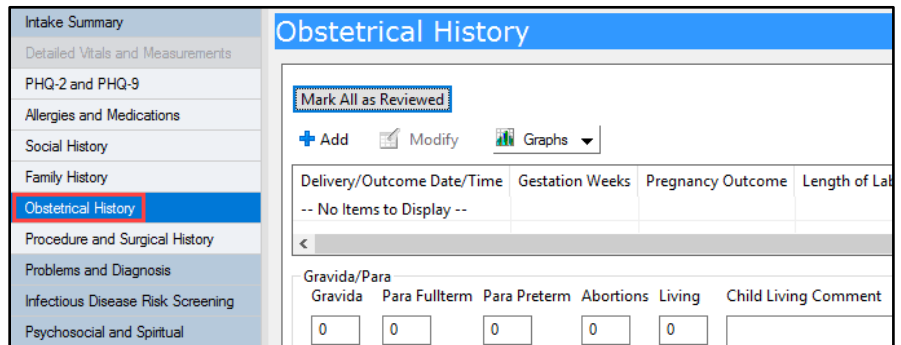
The screenshot shows the 'Add Family History' screen. At the top, there is an 'Add Family History' button (labeled '2') and a 'Last Update: 2/9/2022 12:34 PM EST by Ambrlmpn, 20' timestamp. Below is a table with columns for 'Relationship' (Father, Mother, Brother, Sister, Son, Daughter) and 'Name' (Bob, Jane). A 'QuickList' search bar (labeled 'c') is visible. Below the table is a 'General Family History' section with a grid for conditions like Alcohol abuse, Diabetes mellitus, Heart attack, Hypertension, and Tuberculosis. The grid has columns for each relationship and a '+' sign in the Diabetes mellitus column for the Father relationship (labeled 'd'). At the bottom, there is an 'Add Group' button (labeled 'f'), an 'OK' button (labeled 'g'), and a 'Cancel' button.

# Ambulatory Comprehensive Intake PowerForm for Providers

## Cerner PowerChart Ambulatory EDUCATION

### Obstetrical History

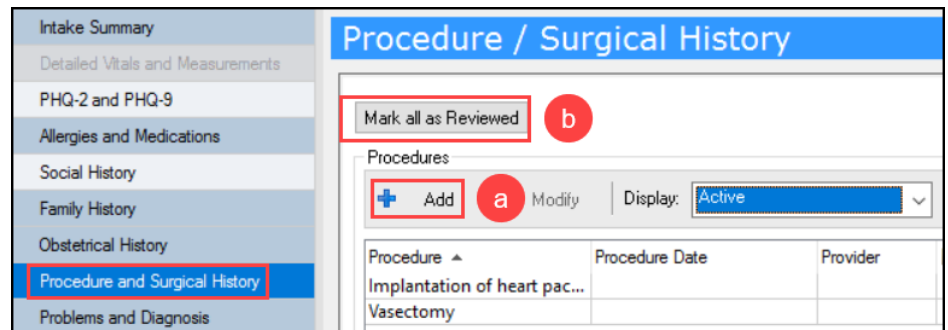
Obstetrical History section is available for documentation pregnancy information.



### Procedure and Surgical History

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

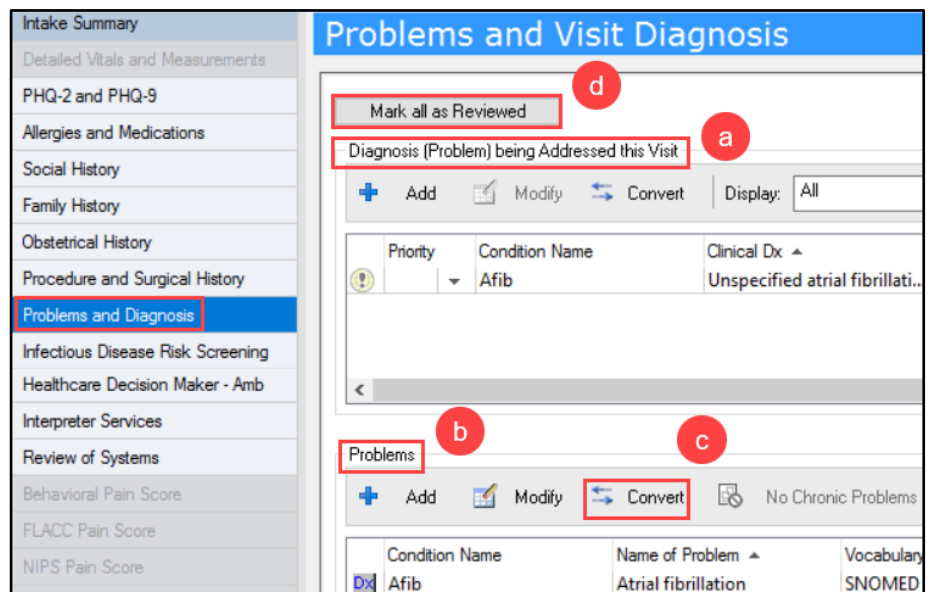
- Click Add to add a procedure/surgery to the history list.
- Click the Mark all as Reviewed button when the review is complete.



### 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.

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



# Ambulatory Comprehensive Intake PowerForm for Providers

## Cerner PowerChart Ambulatory EDUCATION

### 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.

Infectious Disease Risk Screening																																																			
<table border="1"> <tr> <th colspan="4">Infection History</th> </tr> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Comment</th> </tr> <tr> <td>Chickenpox</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Chlamydia</td> <td></td> <td></td> <td></td> </tr> <tr> <td>History Genital Herpes, Patient/Partner</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Genital Herpes Outbreak Last 14 Days</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Gonorrhea</td> <td></td> <td></td> <td></td> </tr> <tr> <td>HIV Exposure</td> <td></td> <td></td> <td></td> </tr> <tr> <td>HPV</td> <td></td> <td></td> <td></td> </tr> <tr> <td>History of Rash/Virus in Last Month</td> <td></td> <td></td> <td></td> </tr> <tr> <td>History of Recent Positive TB Results</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Syphilis</td> <td></td> <td></td> <td></td> </tr> </table>				Infection History					Yes	No	Comment	Chickenpox				Chlamydia				History Genital Herpes, Patient/Partner				Genital Herpes Outbreak Last 14 Days				Gonorrhea				HIV Exposure				HPV				History of Rash/Virus in Last Month				History of Recent Positive TB Results				Syphilis			
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<b>Hepatitis B Description</b> <input type="radio"/> active <input type="radio"/> Non-Treated <input type="radio"/> Recent exposure <input type="radio"/> Treated		<b>Hepatitis C Description</b> <input type="radio"/> active <input type="radio"/> Non-Treated <input type="radio"/> Recent exposure <input type="radio"/> Treated																																																	
<b>Date of Hepatitis B Vaccination</b> <input type="text"/>																																																			
<b>Recent Travel History</b> <input type="radio"/> No <input type="radio"/> Yes																																																			
<b>Recent Travel Detail</b> <input type="text"/>																																																			

### Psychosocial and Spiritual

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

Psychosocial Screening			
<b>Coping</b> <input type="radio"/> Effective <input type="radio"/> Ineffective		<b>Stressors</b> <input type="checkbox"/> Body image <input type="checkbox"/> Family illness <input type="checkbox"/> Surgery/Procedure <input type="checkbox"/> Condition <input type="checkbox"/> Family problems <input type="checkbox"/> Unknown cause <input type="checkbox"/> Diagnosis <input type="checkbox"/> Finances <input type="checkbox"/> Other: <input type="checkbox"/> Divorce <input type="checkbox"/> Hospitalization <input type="checkbox"/> Family death <input type="checkbox"/> Sexual orientation	
		<b>Emotional Support Available</b> <input type="radio"/> Yes <input type="radio"/> No	
Spiritual			
<b>Do You Receive Comfort From Spiritual Practices</b> <input type="radio"/> Yes <input type="radio"/> No		<b>Religious Preference</b> <input type="radio"/> Amish <input type="radio"/> Hindu <input type="radio"/> Non-Denominational <input type="radio"/> Assemblies of God <input type="radio"/> Jehovah's witness <input type="radio"/> Oriental Orthodoxy <input type="radio"/> Baptist <input type="radio"/> Jewish <input type="radio"/> Pentecostal <input type="radio"/> Buddhist <input type="radio"/> Latter-Day Saints <input type="radio"/> Presbyterian <input type="radio"/> Catholic <input type="radio"/> Lutheran <input type="radio"/> Protestant <input type="radio"/> Christian <input type="radio"/> Methodist <input type="radio"/> Scientology <input type="radio"/> Episcopal/ian <input type="radio"/> Muslim <input type="radio"/> Seventh Day Adventist <input type="radio"/> Greek Orthodox <input type="radio"/> Nazarene <input type="radio"/> Other:	
		<b>Comments</b> <input type="text"/>	

### Conley Fall Risk Scale

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

Conley Fall Risk Scale	
<b>History</b> History of Falling in Last 3 Months, Including Since Admission	<input type="radio"/> Yes <input type="radio"/> No <span style="float: right;">Yes response scores 2</span>
<b>Observations</b> Impaired Judgment/Lack of Safety Awareness	<input type="radio"/> Yes <input type="radio"/> No <span style="float: right;">Yes response scores 3</span>
Agitation	<input type="radio"/> Yes <input type="radio"/> No <span style="float: right;">Yes response scores 2</span>
Impaired Gait, Shuffle, Wide Base, Unsteady Walk	<input type="radio"/> Yes <input type="radio"/> No <span style="float: right;">Yes response scores 1</span>
<b>Direct Questions (Do You...)</b>	
Ever Experience Dizziness or Vertigo	<input type="radio"/> Yes <input type="radio"/> No <span style="float: right;">Yes response scores 1</span>
Ever Wet or Soil Yourself on Way to Bathroom	<input type="radio"/> Yes <input type="radio"/> No <span style="float: right;">Yes response scores 1</span>
Fall Risk Score	<input type="text"/>
Patient is at risk for falls if Conley score is greater than or equal to 2	

# Ambulatory Comprehensive Intake PowerForm for Providers

Cerner PowerChart Ambulatory EDUCATION

## Instrumental ADL Adult

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

Intake Summary		Instrumental Activities of Daily Living			
Detailed Vitals and Measurements			Complete independence	Modified independence	Supervised
PHQ-2 and PHQ-9		Meal Prep			
Allergies and Medications		Writing			
Social History		Keyboarding			
Family History		Phone Use			
Obstetrical History		Money Management			
Procedure and Surgical History		Grocery Shopping			
Problems and Diagnosis		Clothing Care			
Infectious Disease Risk Screening		Light Cleaning			
Psychosocial and Spiritual		Heavy Cleaning			
Conley Fall Risk Scale		Community Transportation			
Instrumental ADL Adult		Community Mobility, Safety			
		Care of Others			
		Medication Management			
		Other IADL			

## 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.

- Barriers to Learning is required to be documented at every visit.
- 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.
- 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		<b>Barriers to Learning</b> <span style="color:red">a</span>				
Social History		<input type="checkbox"/> None evident <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Literacy				
Family History		<input type="checkbox"/> Acuity of illness <input type="checkbox"/> Emotional state <input type="checkbox"/> Memory problems				
Obstetrical History		<input type="checkbox"/> Cognitive deficits <input type="checkbox"/> Financial concerns <input type="checkbox"/> Vision impairment				
Procedure and Surgical History		<input type="checkbox"/> Cultural barrier <input type="checkbox"/> Hearing deficit <input type="checkbox"/> Other:				
Problems and Diagnosis		<input type="checkbox"/> Desire/Motivation <input type="checkbox"/> Language barrier				
Infectious Disease Risk Screening		<b>Patient/Family Learning Style Preferences</b> <span style="color:red">b</span>				
Psychosocial and Spiritual		None	Demonstration	Printed materials	Verbal explanation	
Conley Fall Risk Scale		Patient				
Instrumental ADL Adult		Family				
Education Needs						
Healthcare Decision Maker - Amb		<b>Patient/Family Education Needs Comments</b> <span style="color:red">c</span>				
Interpreter Services		Segoe UI				
Review of Systems						
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		The purpose of this form is to capture information regarding healthcare decision	
PHQ-2 and PHQ-9		Is adult patient or pediatric patient representative currently able to answer these questions	
Allergies and Medications		<input type="radio"/> Yes <input type="radio"/> No	
Social History		Right click in box below to view Definitions of Legal Terminology	
Family History			
Obstetrical History		<b>Guardian</b>	
Procedure and Surgical History		If this patient has a GUARDIAN and a copy is in the patients' chart, it will be listed below	
Problems and Diagnosis		Please select 'No' in field below as this patient does not have a Letter of Guardianship in their medical record	
Infectious Disease Risk Screening		This patient has a Guardian	
Psychosocial and Spiritual		<input type="radio"/> Yes <input type="radio"/> No	
Conley Fall Risk Scale		It is not necessary to continue documenting this form if the patient has a Court Appointed Guardian	
Instrumental ADL Adult		<b>Advance Directive / DPOAH</b>	
Education Needs		If this patient has an AD/DPOAH and a copy is in the patients' chart, it will be listed below	
Healthcare Decision Maker - Amb		This patient does not have an Advance Directive/DPOAH medical record	
Interpreter Services		Does the patient have an Advance Directive or DPOAH	
Review of Systems		<input type="radio"/> Yes <input type="radio"/> Unknown	
Behavioral Pain Score		If yes, please ask the patient to bring in a copy of document so it can be added to their medical record.	
FLACC Pain Score			
NIPS Pain Score			
NPASS Pain Score			

# Ambulatory Comprehensive Intake PowerForm for Providers

## Cerner PowerChart Ambulatory EDUCATION

### 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.

