

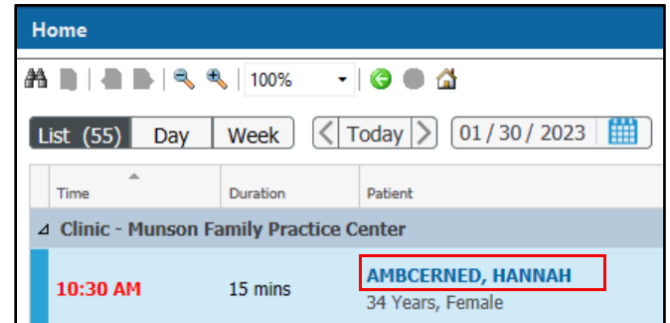
Initial Obstetrics (OB) Visit Documentation for Clinical Staff

Cerner PowerChart Ambulatory EDUCATION

Follow the below workflow steps when seeing a patient for their first Obstetrics (OB) clinic visit.

Ambulatory Organizer

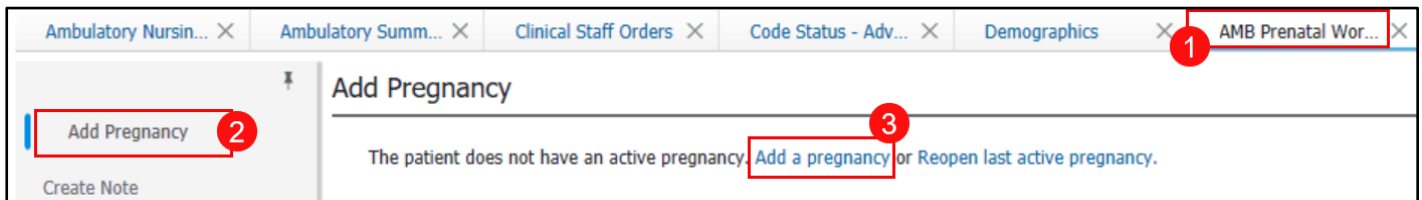
1. Locate the patient on the Ambulatory Organizer and click on the patient's name to open the chart to the correct clinic visit encounter.



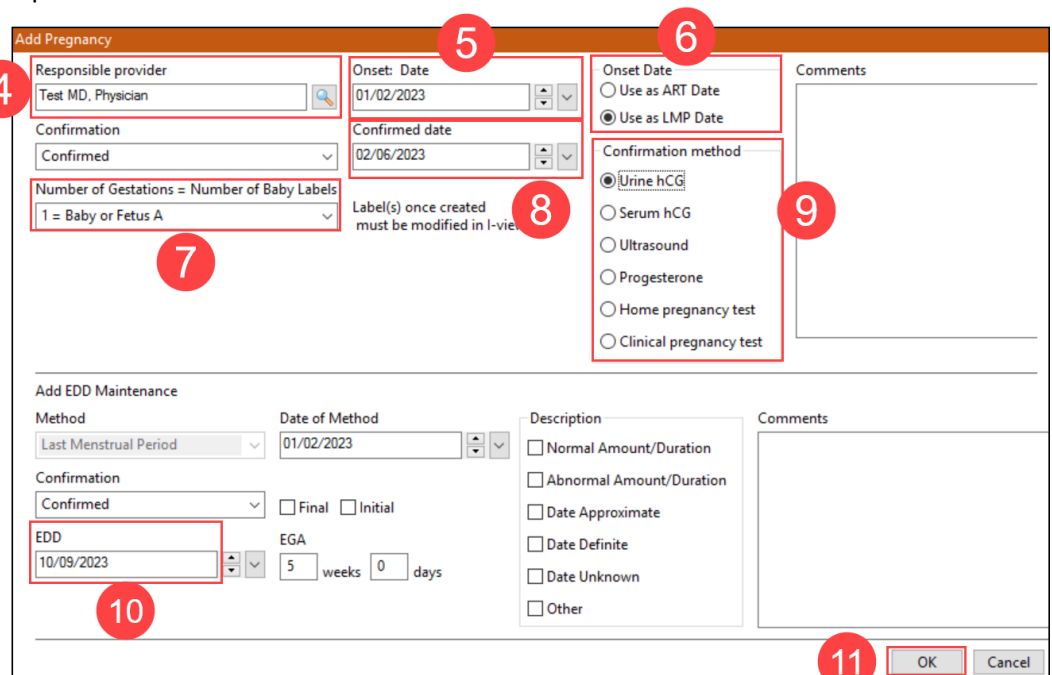
Add a Pregnancy

A Pregnancy must be added first for the Prenatal Workflow documentation to become available. Follow the steps below to add a pregnancy:

1. Navigate to the AMB Prenatal Workflow.
2. Click the Add Pregnancy Component.
3. Click **Add a pregnancy**.



4. Search for the Responsible provider.
5. Enter the Onset Date.
6. Select Use as LMP or ART Date.
7. Indicate the Number of Gestations, if known.
8. Update the Confirmed date, if needed.
9. Select the Confirmation method.
10. The Estimated Date of Delivery (EDD) will display based on information entered.
11. Click OK.



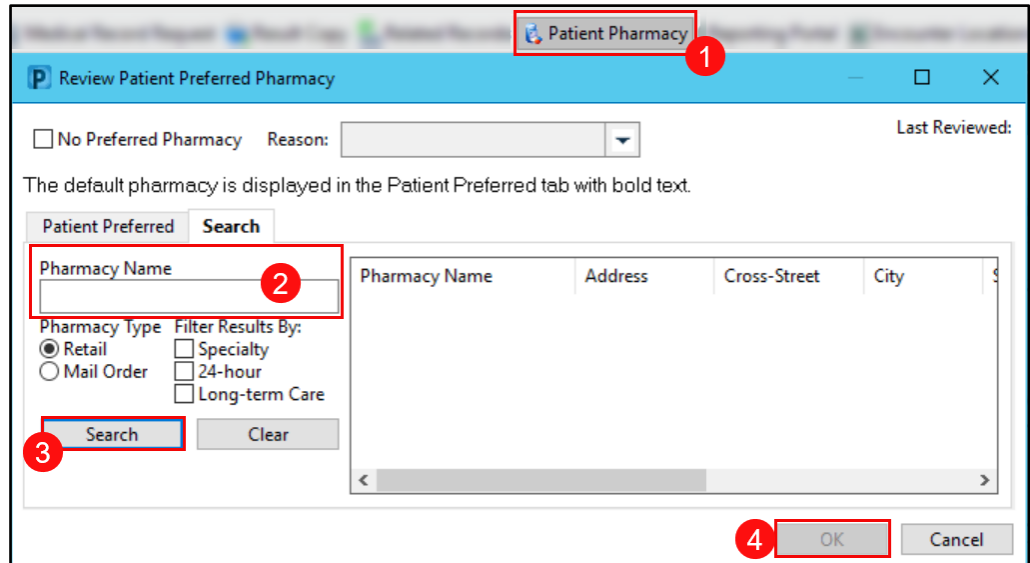
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Patient Pharmacy

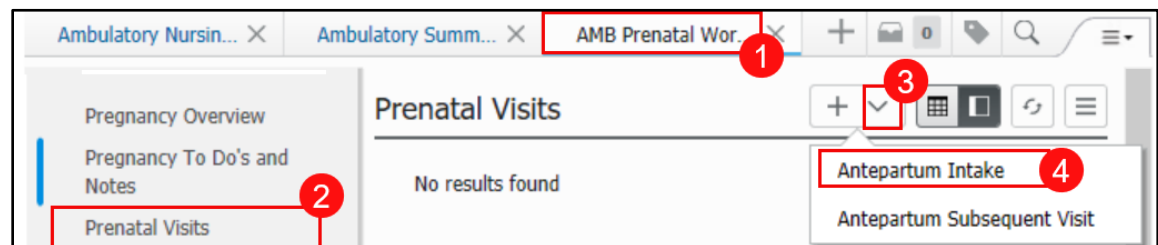
The patient's pharmacy should be reviewed with the patient at the initial patient clinic visit and as needed.

1. Click on **Patient Pharmacy** on the top toolbar.
2. Enter the name of the desired pharmacy.
3. Click **Search**.
4. Highlight the correct pharmacy and click OK.



Antepartum Intake

1. Click on the Ambulatory Prenatal Workflow page.
2. Click on the **Prenatal Visits** Component.
3. Click on the drop-down arrow.
4. Select **Antepartum Intake**.
5. The Antepartum Intake PowerForm opens.
 - a. Fill out all required fields (indicated by red asterisks and yellow fields) and any other needed information per practice guidelines.



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General Information OB

1. Complete all known fields.
2. Complete the required question: Patient Use of Blood Products.

Antepartum Intake - AMBWAVE

*Performed on: 02/06/2023 0932 EST

Chief Complaint

Communication

No Preference
 Printed Letter

History of Present Illness, Nursing Note

General Information

Preferred Name

Support Person's Name

Support Person Relationship to Patient

Husband Significant other Sister
 Boyfriend Mother Friend
 Father of baby Father Other:

Father of Baby Involved

Yes No

Father of the Baby's Name

Information Given By

Unable to obtain Friend
 Self Parent
 Spouse Sibling
 Daughter Significant other
 Family member Son

Reason Information Not Obtained

Patient Use of Blood Products?

Patient accepts use of blood products
 Patient declines use of blood products

3. If Patient declines use of blood products is selected, an additional Antepartum Risk Factors page will open.
4. Select **Patient declines use of blood products**.
5. Click the return arrow to close the page and return to the main PowerForm.

Antepartum Risk Factors - OB - AMBWAVE

Antepartum Risk Factors, Current Pregnancy

Antepartum Risk Factors default across patient visits. Verify information is correct and current, adjust appropriately.

none Hemoglobinopathies Polyhydramnios

Age 15 or younger Herpes, active Post term pregnancy

Age 16 or 17 Hyperemesis gravidarum Pre-Eclampsia

Age 35 or older Hypertension, gestational Preterm labor

Alcohol use during pregnancy Hx abnormal Pap Previous jaundiced baby

Behavioral health disorder Hx LEEP Previous macrosomic babies

Chronic hypertension, superimposed pre-eclampsia Hx postpartum hemorrhage Previous uterine incision

Deep vein thrombosis Incompetent cervix Pulmonary embolus

Diabetes: Gestational diabetes - diet controlled Infection PUPPS

Diabetes: Gestational diabetes - requiring insulin Intrauterine fetal demise Relative BMI greater than 30

Diabetes (Type I) IV administration of glucose Relative BMI less than 16.5

Diabetes (Type II) Late or No Prenatal Care (Fewer than 4 visits) Rh negative

Drug abuse during pregnancy Magnesium sulfate during pregnancy/labor ROM > 18 hours

Eclampsia Maternal trauma Suspected Macrosomia

Ethnicity: Asian/African-American/Mediterranean Multiple gestation Third trimester bleeding

Grand multiparity Oligohydramnios Tobacco use during pregnancy

Group B Streptococcus Positive Patient declines use of blood products Tocolytic use

GBS status unknown Placenta previa Other:

HELLP syndrome Placental abruption

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Vital Signs and Measurements

Vital Signs and Measurements documentation is required at each visit.

Vitals

1. Document the patient's Blood Pressure and Blood Pressure Source. The Blood Pressure documentation is required to open a pregnancy card for provider documentation.
2. Document Pulse Rate beats per minutes when auscultated or palpated. Document as Heart Rate Monitored when a machine is used to record beats per minute.
3. Document all other fields as needed or per practice guidelines.

Vitals

SBP / DBP mmHg / mmHg

Repeat SBP / DBP mmHg / mmHg

Blood Pressure Source

lt arm w/ BP machine lt arm, manually lt arm, palpated Left forearm, radial cuff
 lt leg w/ BP machine lt leg, manually lt leg, palpated Right forearm, radial cuff
 rt arm w/ BP machine rt arm, manually rt arm, palpated
 rt leg w/ BP machine rt leg, manually rt leg, palpated

Pulse Rate bpm Heart Rate Monitored bpm

Resp. Rate br/min O2 Sat %

Temperature Oral DegC Temperature Temporal DegC Temperature Tympanic DegC

Heart Rhythm Irregular Regular

Pain Scale Used Pain Level Pain Comments

Right click in field above to see Reference Text

Measurements

1. Measured and Non Measured Height and Weight fields are available for documentation.
2. 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).

Measurements

Weight Measured kg

Weight Non Measured kg

Height/Length Measured cm

Height/Length Non Measured cm

BMI Measured

BMI Non Measured

Waist Circumference cm

Pre-Pregnancy Weight kg

Calculated Cumulative Weight Gain kg

Detailed Vitals and Measurements

Select Open to open the Detailed Vitals and Measurements page with field to document Orthostatic Vitals, Respiratory information, such as O2 use, and Weight Changes.

Detailed Vitals and Measurements

Document Detailed Vitals and Measurements Open

Allergies and Medications

Allergies and Medications are required to be reviewed at each patient clinic visit and may be done from the Workflow page or within the Intake PowerForm. Complete the following steps to Review and/or update Allergy and Medications. For more detailed information please see either Clinical Reconciliation or Medication History Documentation on the [Clinical EHR Education website](#).

1. Click on the +Add button to add patient allergy.
2. If the patient has no known allergies, click the No Know Allergies button.
3. If the patient has an environmental or food allergy, but no medication allergies, click on No Know Medication Allergies.
4. If not done on the Workflow page, click Document Medication by Hx to complete the review of medications and Add any medications not listed.
 - a. Follow the process on Medication History Documentation on the [Clinical EHR Education website](#).

The screenshot displays the Cerner PowerChart interface for a patient's Allergies and Medications. The interface is divided into two main sections: Allergies and Medications.

Allergies Section:

- Buttons: + Add (1), Modify, No Known Allergies (2), No Known Medication Allergies (3), Reverse Allergy Check.
- Filter by Status: All.
- Table columns: Substance, Terminology, Category, Reactions, Seve..., Type, C., Est. Onset, Reaction S..., Updated By, Source, Revi..

Medications Section:

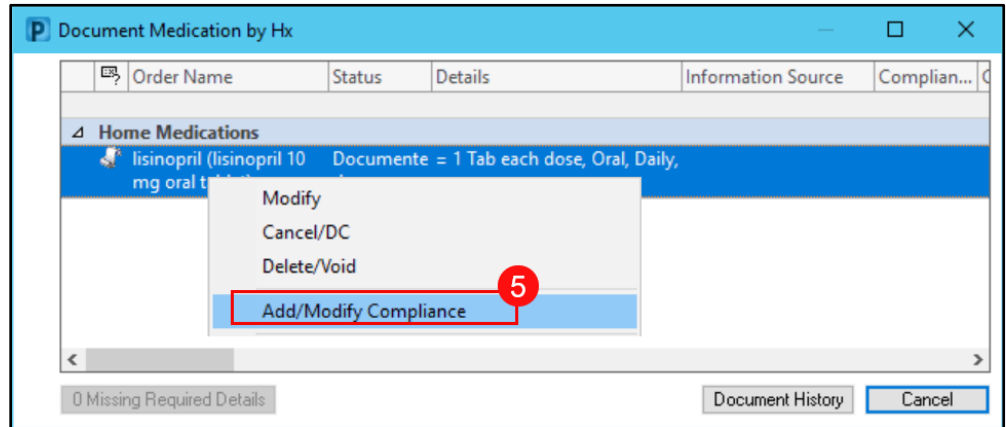
- Buttons: + Add (4), Document Medication by Hx, External Rx History, Rx Plans (0): Error.
- Reconciliation Status: Meds History, Admission, Discharge.
- Display: All Active Medications, All Inactive Medications 24 Hrs Back.
- Table columns: Order Name/Details, Order Com..., Ordering Physician, Status.
- Medications listed:

Order Name/Details	Ordering Physician	Status
digoxin 0.125 mg, Oral, 1700 Daily	Test MD, Physician	Ord
warfarin (Coumadin) 2.5 mg, Oral, 1700 Daily	HD, PPE: Test MD, Physician	Ord
- Details section below the table.
- Footer: Displayed: All Active Orders | All Inactive Orders. Show More Orders... (Dx Table, Orders For Nurse Review, Orders For Signature).

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- Medication Compliance is required when reviewing or adding medications to the patient's Home Medications. Right click on each medication and click Add/Modify Compliance. Select the appropriate compliance status, information source and add comments, if needed.



Obstetrical History

Record all previous pregnancies. Fill out any yellow required fields.

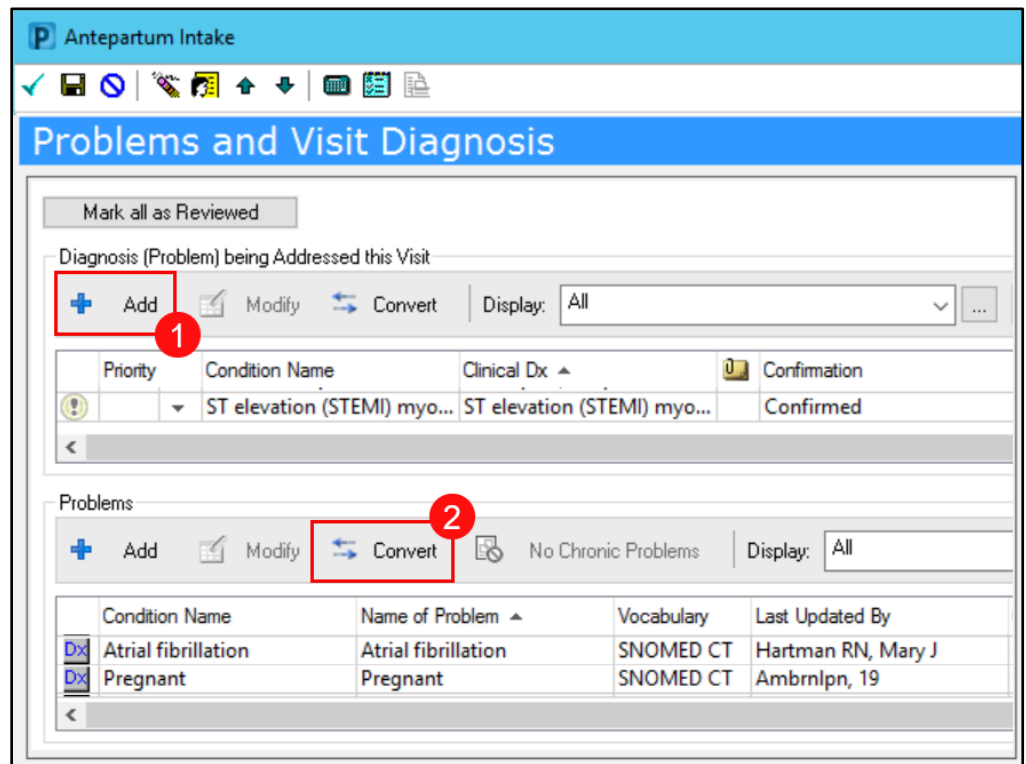
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Problems and Diagnosis

Review and update Diagnosis (Problem) being Addressed this Visit if needed. Do not alter any Problems, as these are chronic problems and are managed by the provider. For more detailed information please see the Problem List Component Guide on the Clinical EHR Education website [Ambulatory Clinical EHR Education | Munson Healthcare](#).

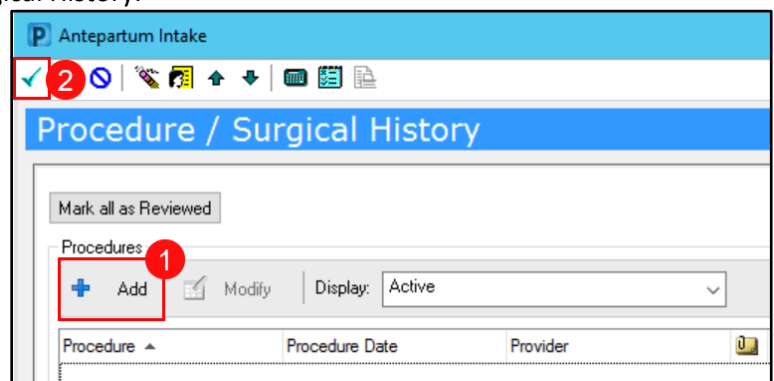
1. Click +Add to add a Diagnosis (Problem) being Addressed this Visit.
2. Click Convert to add a chronic problem to the Diagnosis (Problem) being Addressed this Visit list.



Procedure and Surgical History

Procedure and Surgical History is required to be documented at a patient’s initial visit and at least annually thereafter. Follow practice guidelines regarding additional documentation requirements. For more detailed information please see the Procedure History Component Overview on the Clinical EHR Education website [Ambulatory Clinical EHR Education | Munson Healthcare](#).

1. Click on the +Add button to add Procedure/Surgical History.
2. Click Mark all as Reviewed to document the review of existing Procedure/Surgical History.



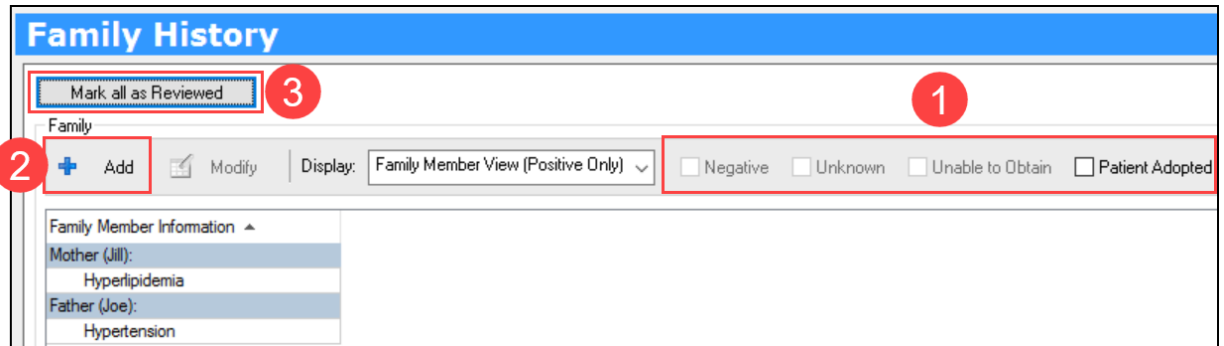
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Cerner PowerChart Ambulatory **EDUCATION**

Family History

Family History review is required at every patient visit. Family history includes first degree relatives; parents, siblings, and offspring.

1. If there is no positive Family History, Select one of the following: Negative, Unknown, Unable to obtain, or Patient adopted.
2. Click Add to add additional family history.
3. Click Mark all as Reviewed to indicate that the existing documented Family History is correct.

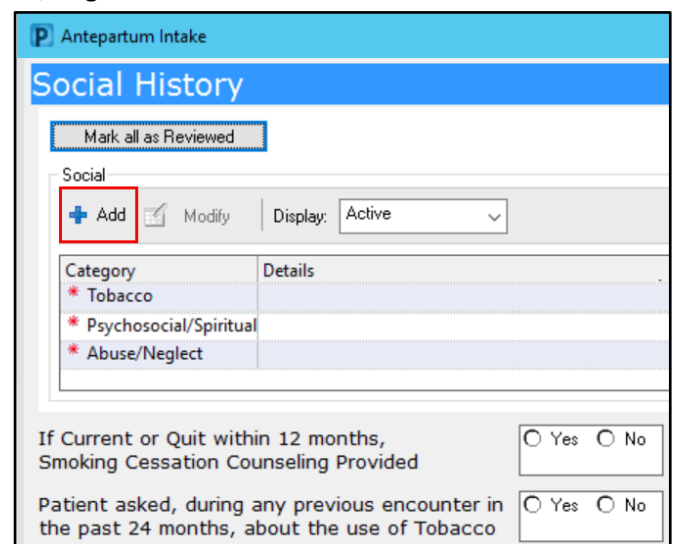


- For more information on how to add family history please see Family History Component Overview on the Clinical EHR Education website [Ambulatory Clinical EHR Education | Munson Healthcare](#).

Social History

Social History is required to be reviewed at every patient visit. This includes documenting, at a minimum, tobacco status for meaningful use, Psychosocial/Spiritual, and Abuse/Neglect.

- For more detailed instructions please see Social History and Documentation Review on the Clinical EHR Education website [Ambulatory Clinical EHR Education | Munson Healthcare](#).
1. Click Add to add new information, or Modify to update existing information.
 2. Review or Add the required Category(s), indicated by a red asterisk, and any others that apply or are required by practice guidelines.

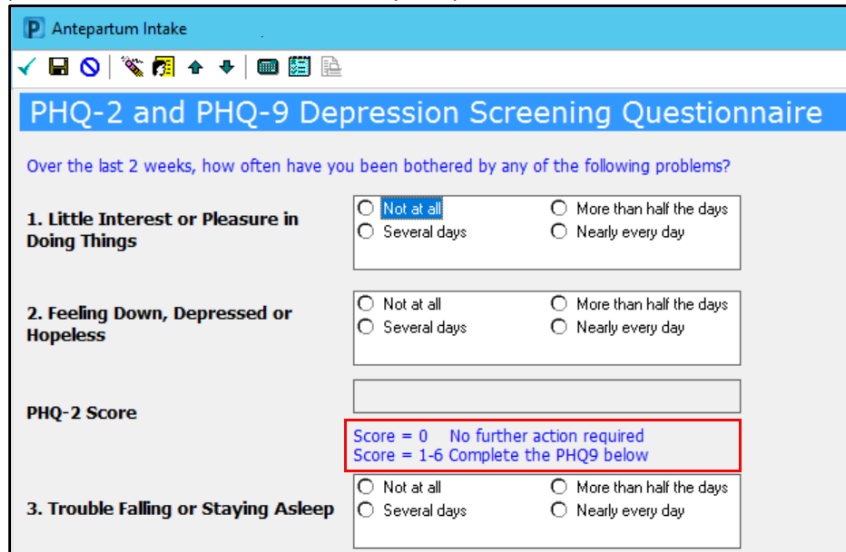


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Depression Screening

Document depression screening by selecting the PHQ2 and PHQ9 page. This is required to be documented at a patient's initial visit and at least yearly thereafter.



PHQ-2 and PHQ-9 Depression Screening Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little Interest or Pleasure in Doing Things

Not at all More than half the days
 Several days Nearly every day

2. Feeling Down, Depressed or Hopeless

Not at all More than half the days
 Several days Nearly every day

PHQ-2 Score

Score = 0 No further action required
 Score = 1-6 Complete the PHQ9 below

3. Trouble Falling or Staying Asleep

Not at all More than half the days
 Several days Nearly every day

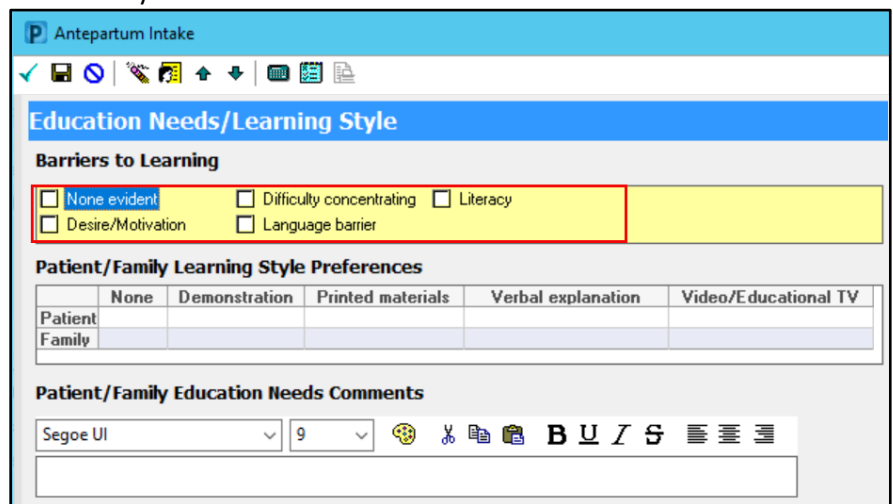
Note: The PHQ-2 Score is calculated once documented. If the Score is 1 or above, the PHQ-9 is required to be completed.

Education Needs/Learning Style

Barriers to Learning is required to be documented at every visit.

Patient/Family Learning Style Preferences is to be documented once and updated as needed. Multiple learning styles can be selected by clicking in the boxes. The documented Preferences will be saved across visits.

Patient/Family Education Needs Comments is a free text box for any additional comments.



Education Needs/Learning Style

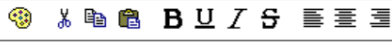
Barriers to Learning

None evident Difficulty concentrating Literacy
 Desire/Motivation Language barrier

Patient/Family Learning Style Preferences

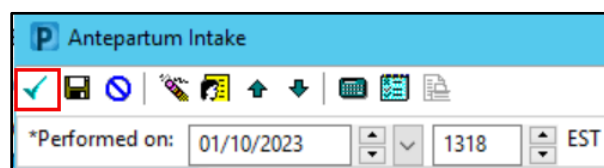
	None	Demonstration	Printed materials	Verbal explanation	Video/Educational TV
Patient					
Family					

Patient/Family Education Needs Comments








Segoe UI 9 

Signing the Form

When documentation is complete, click the green check on the PowerForm toolbar to sign the Antepartum Intake PowerForm.



Antepartum Intake

*Performed on: 01/10/2023 1318 EST