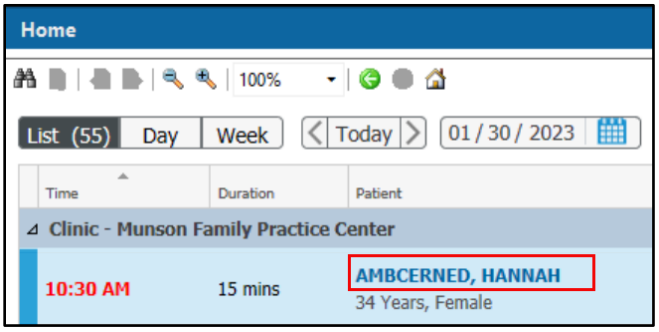
Initial Obstetrics (OB) Visit Documentation for Clinical Staff

Cerner PowerChart Ambulatory **EDUCATION**

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

Ambulatory Organizer

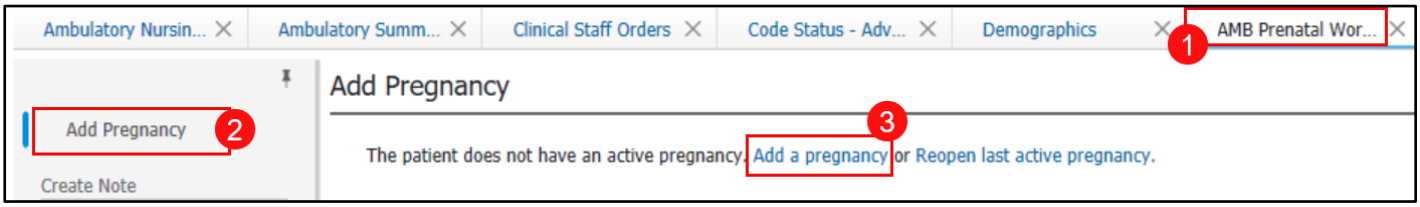
1. Locate the patient on the Ambulatory Organizer and click on the patient's name to open the chart to the correct clinic visit encounter.



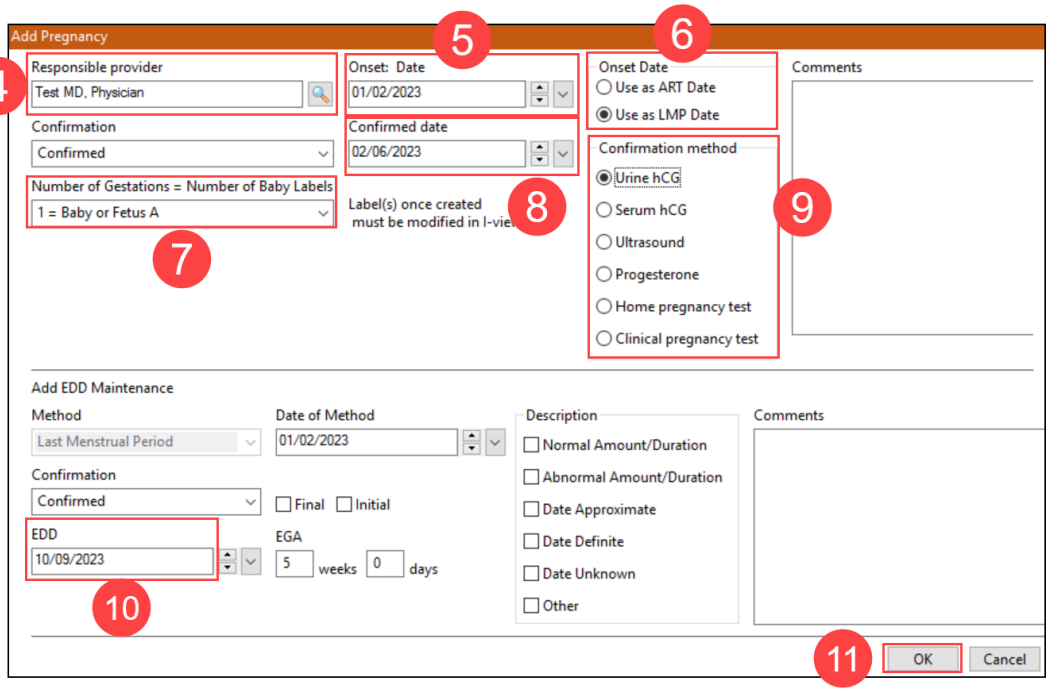
Add a Pregnancy

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**.



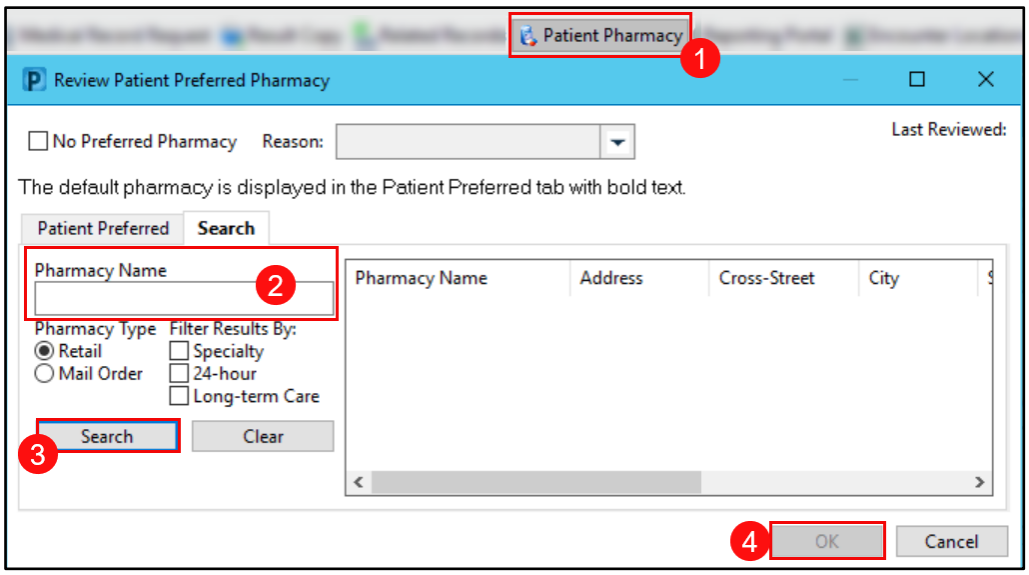
4. Search for the Responsible provider.
5. Enter the Onset Date.
6. Select Use as LMP or ART Date.
7. Indicate the Number of Gestations, if known.
8. Update the Confirmed date, if needed.
9. Select the Confirmation method.
10. The Estimated Date of Delivery (EDD) will display based on information entered.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



Patient Pharmacy

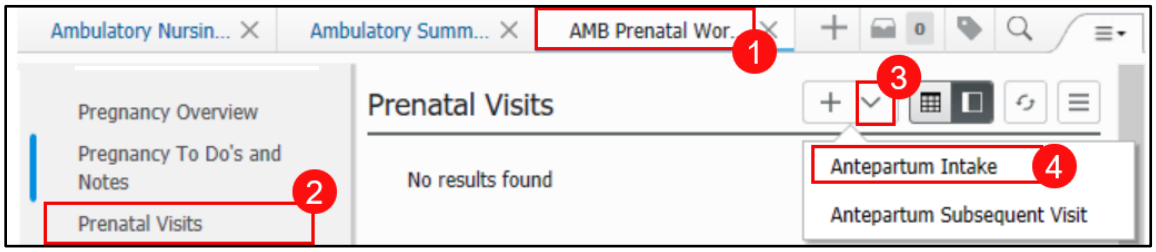
The patient's pharmacy should be reviewed with the patient at the initial patient clinic visit and as needed.

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.



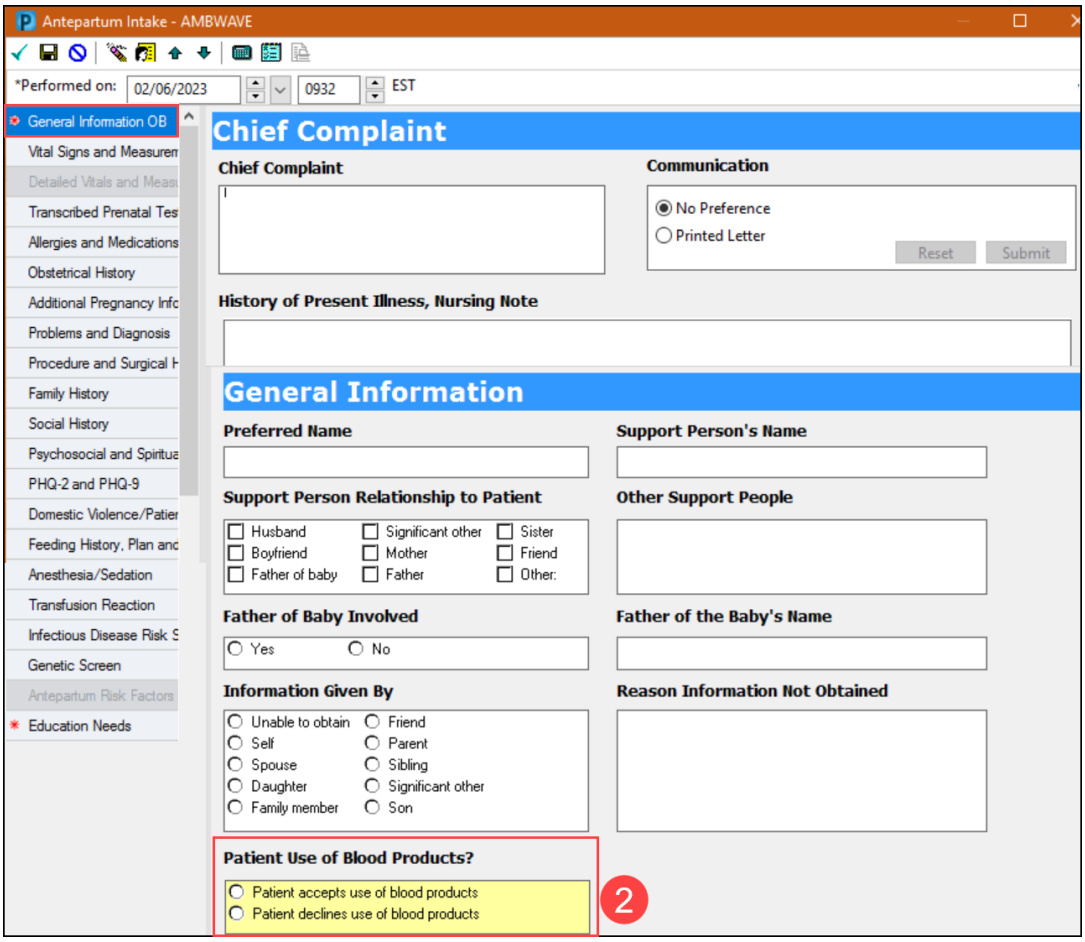
Antepartum Intake

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.

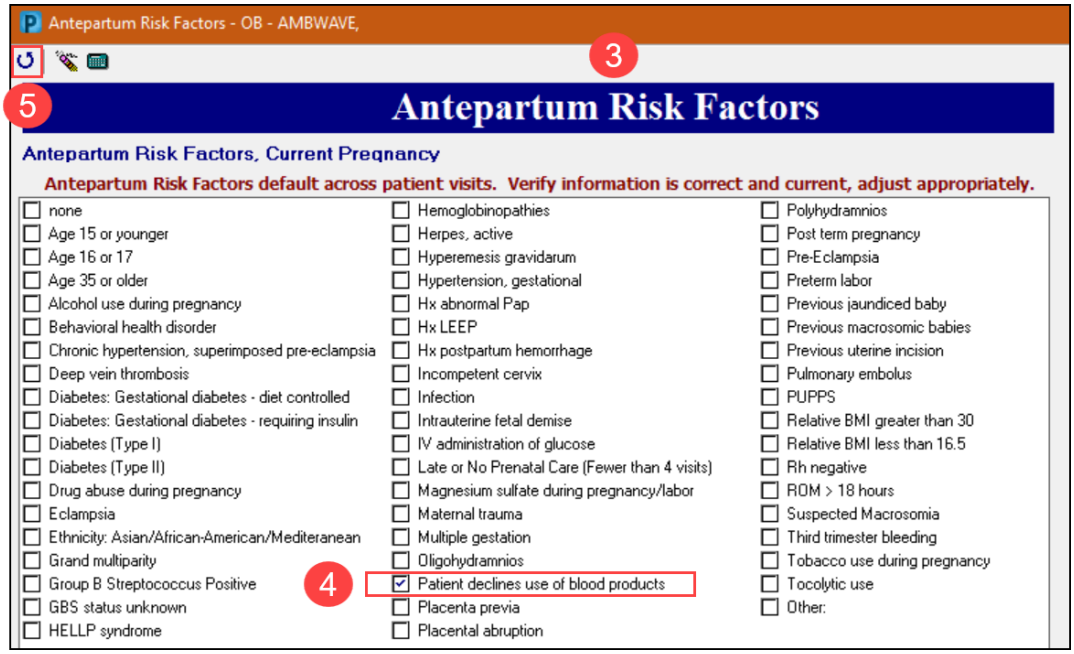


General Information OB

1. Complete all known fields.
2. Complete the required question: Patient 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.

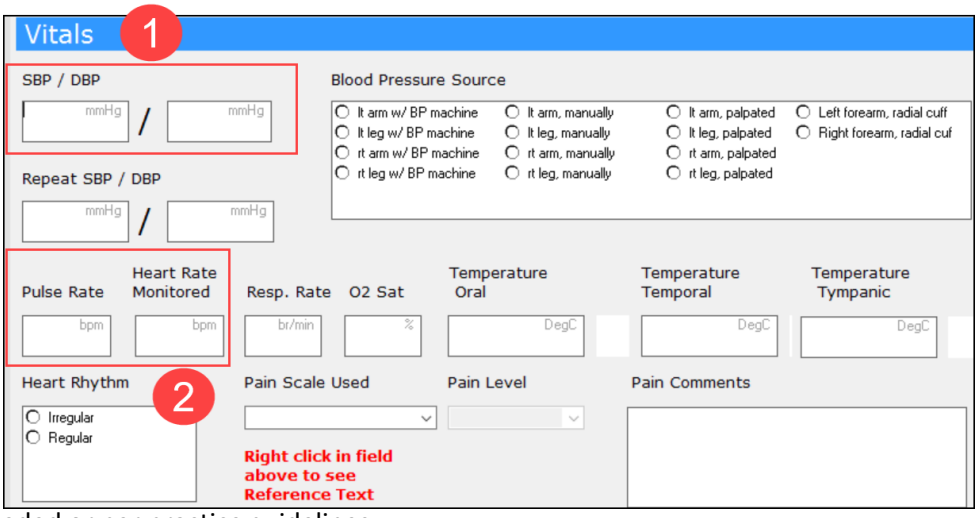


Vital Signs and Measurements

Vital Signs and Measurements documentation is required at each visit.

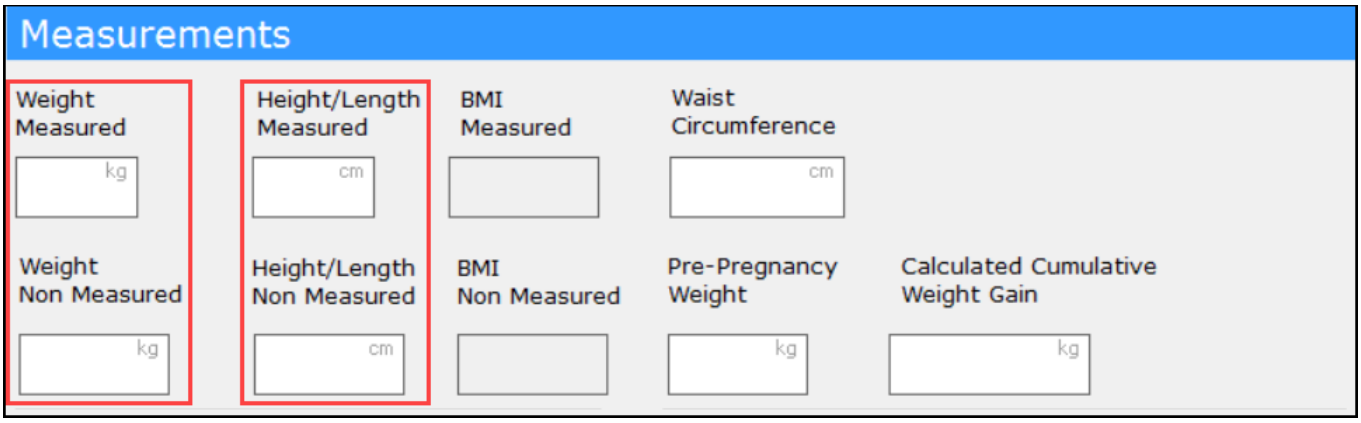
Vitals

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.



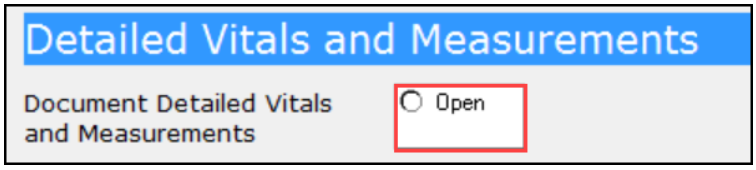
Measurements

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).



Detailed Vitals and Measurements

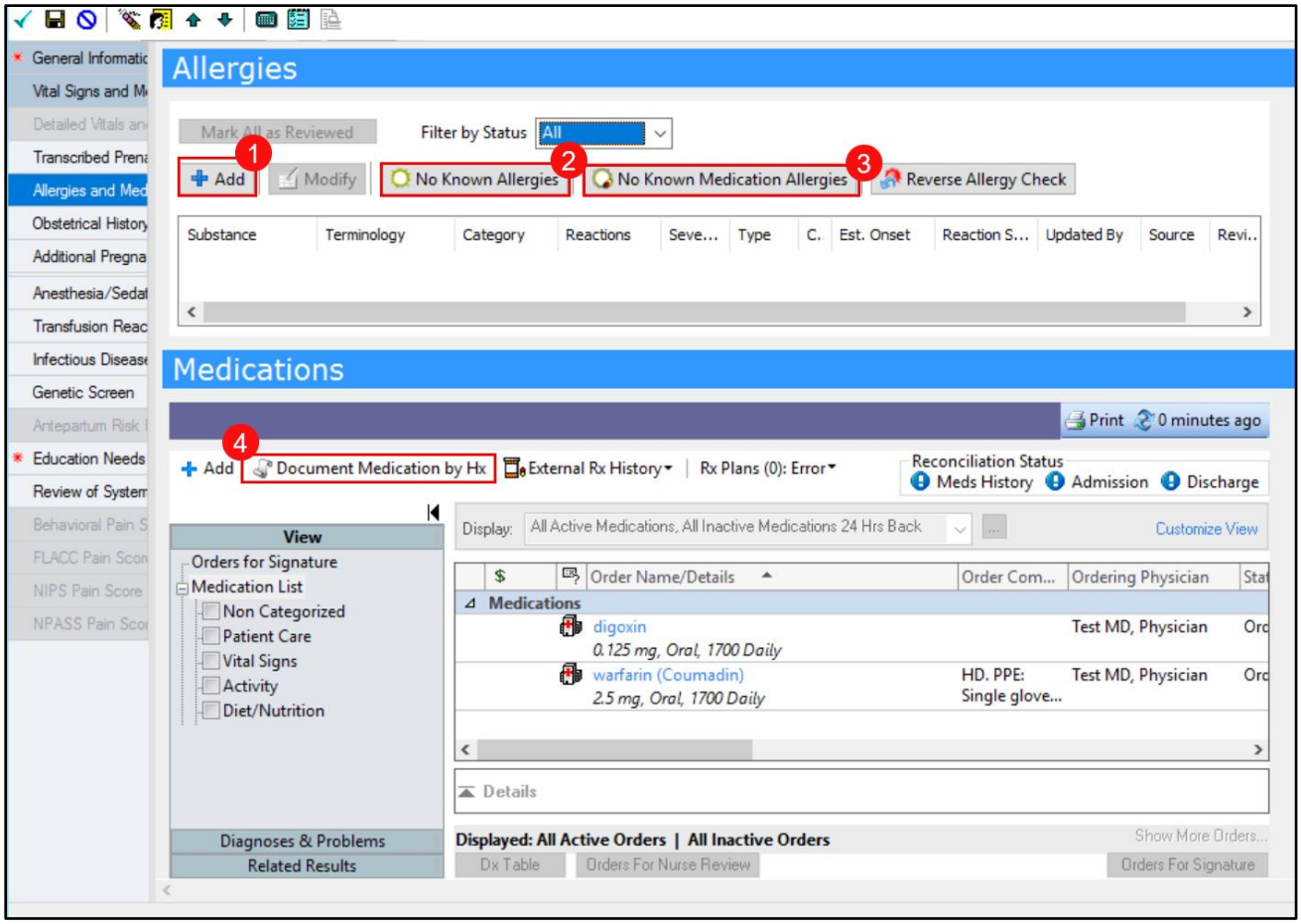
Select Open to open the Detailed Vitals and Measurements page with field to document Orthostatic Vitals, Respiratory information, such as O2 use, and Weight Changes.



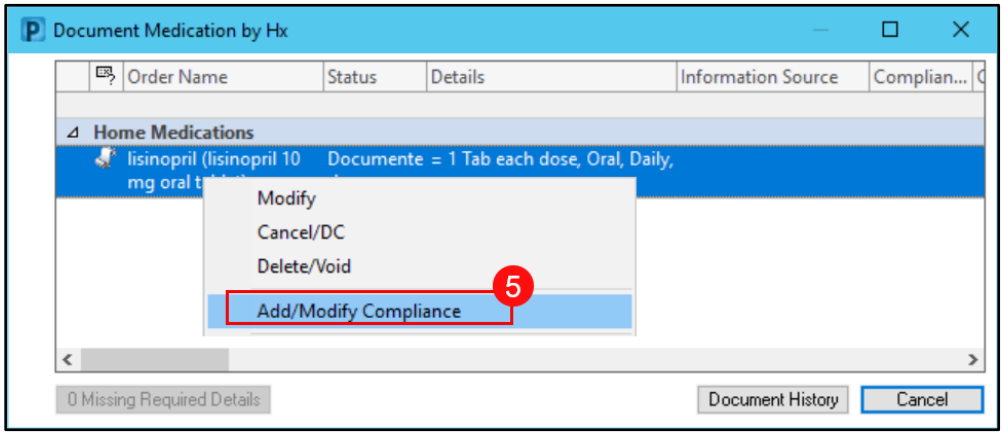
Allergies and Medications

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.

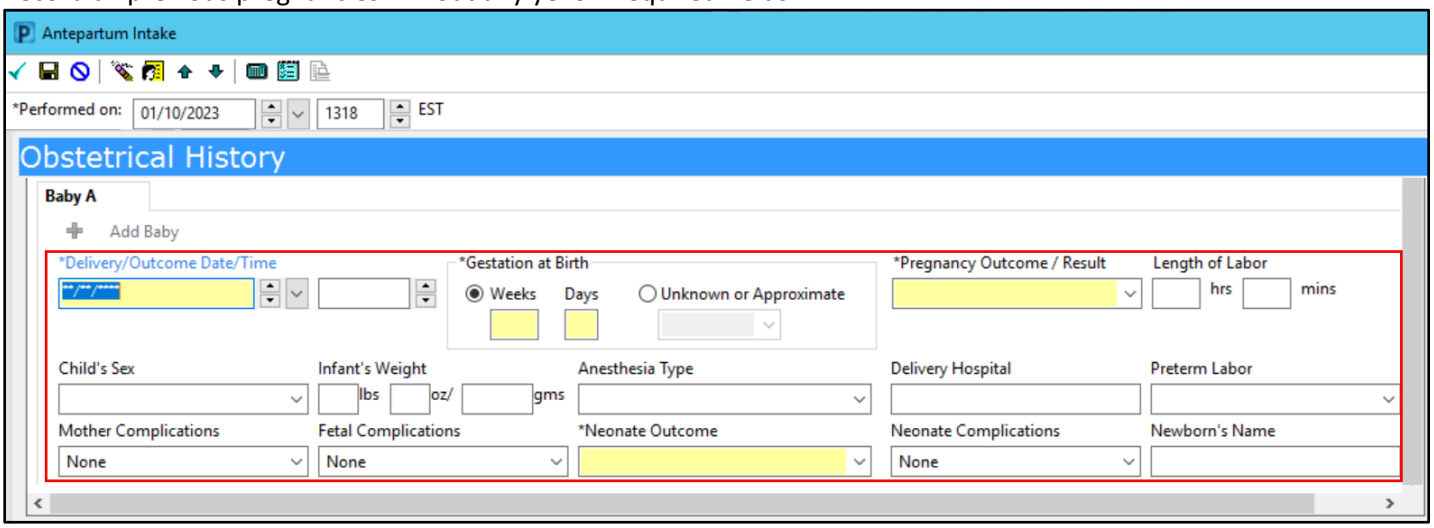


5. Medication Compliance is required when reviewing or adding medications to the patient's Home Medications. Right click on each medication and click Add/Modify Compliance. Select the appropriate compliance status, information source and add comments, if needed.



Obstetrical History

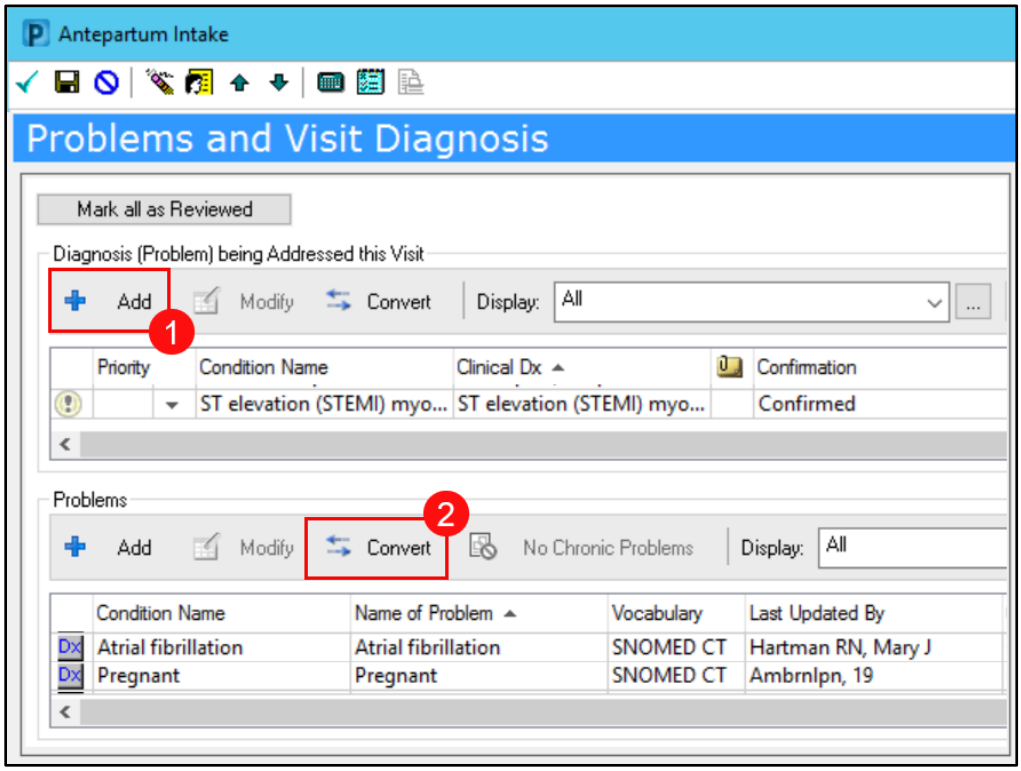
Record all previous pregnancies. Fill out any yellow required fields.



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](#).

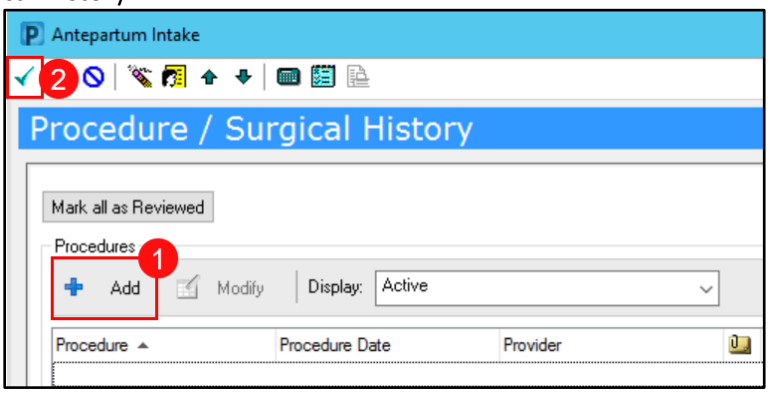
1. Click +Add to add a Diagnosis (Problem) being Addressed this Visit.
2. Click Convert to add a chronic problem to the Diagnosis (Problem) being Addressed this Visit list.



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](#).

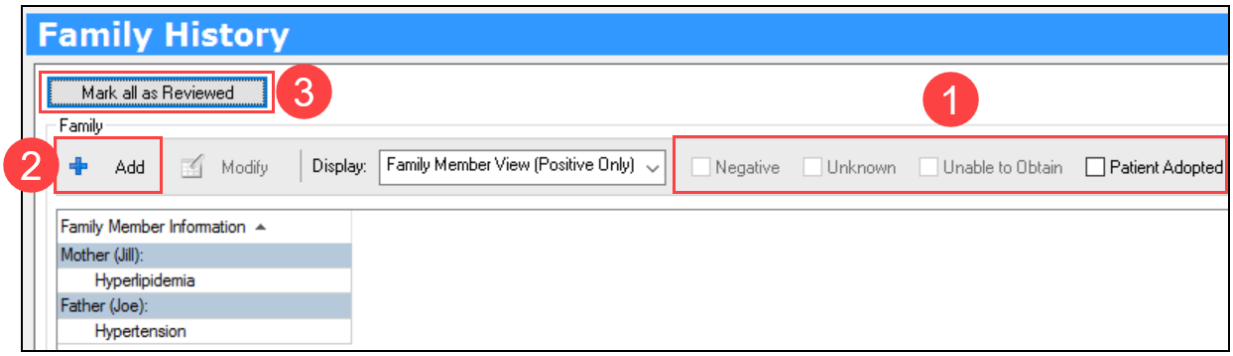
1. Click on the +Add button to add Procedure/Surgical History.
2. Click Mark all as Reviewed to document the review of existing Procedure/Surgical History.



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](#).

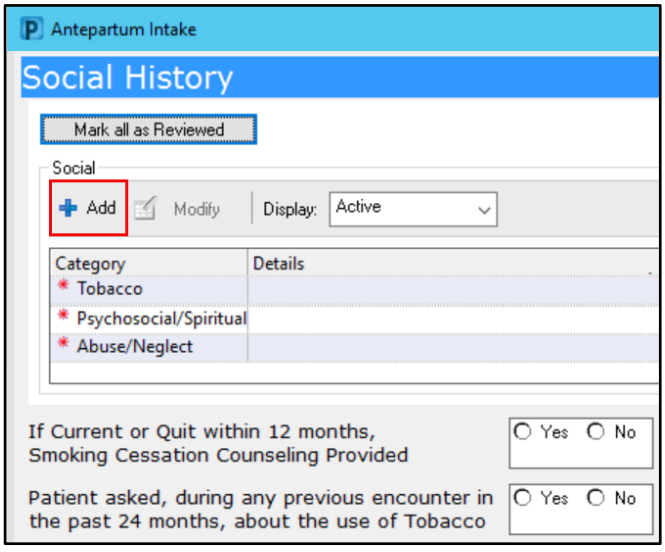
Social History

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](#).

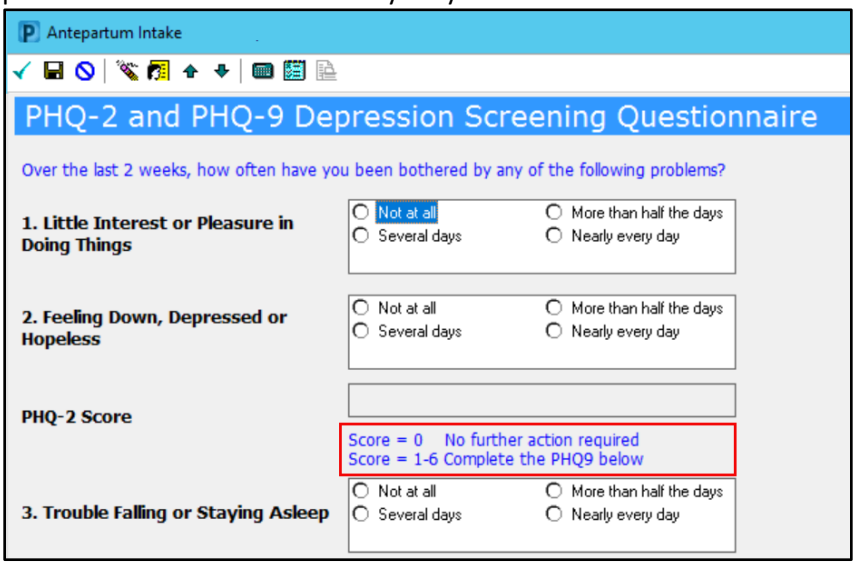
1. Click Add to add new information, or Modify to update existing information.

2. Review or Add the required Category(s), indicated by a red asterisk, and any others that apply or are required by practice guidelines.



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.



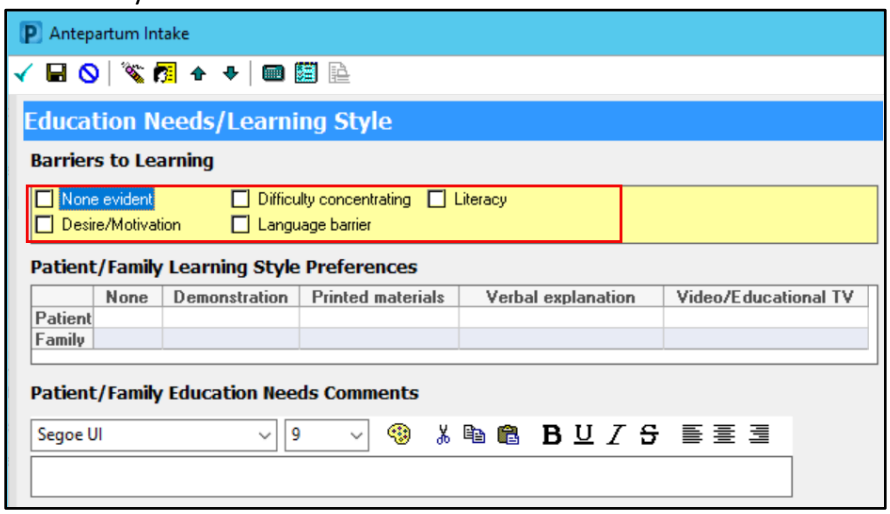
Note: The PHQ-2 Score is calculated once documented. If the Score is 1 or above, the PHQ-9 is required to be completed.

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.



Signing the Form

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