New General (NEWGENERAL)

DROP DOWN MENU REMINDER SELF-POPULATING SCRIBE INPUT TAB

NEWGENERAL

Room: @EDROOM@*** @CC@ First Provider Contact Date and Time: @TODAYDATENOREF@ @NOWNOREF@	**REMINDER** to freeze the room number. If a patient is moved to a different room in ED, update the note accordingly. **@CC@ (Chief Complaint)** brings in the triage note the nurse wrote and gives some insight into why they are here.
HISTORY OF PRESENT ILLNESS @NAME@ is a @AGE@ @SEX@ with who presents to the ED by {transportation:54918} for *** Previous History: @PMHPLAIN@ @PSHPLAIN@ @FAMHX@ @EDSOCH@ @HMEDS@ @ALLERGY@	**SCRIBE INPUT** type the story including symptoms, symptom start time, story details, PCP, specialists they have seen, or whatever answers they give to doctor's questions. **DDM** choose between (1) private vehicle, (2) EMS, (3) Police, or (4) other
REVIEW OF SYSTEMS @ROSBYAGE@	**ROS** is a separate tab with buttons you click for specific symptoms and signs the patient reports. A macro must be imported with the doctor's preferences.
PHYSICAL EXAM Triage Vitals: Initial triage vitals were reviewed and interpreted by me in the clinical context. Patient is {triagevitals:71856}. @EDTRIAGEVITALS@ Pulse ox interpretation by physician: ***% {o2satinterp:78312} Initial triage vitals were reviewed and interpreted by me in the clinical context. @PHYSEXAM@	**PE** is a separate tab. The PE is the doctor's hands-on assessment of the patient's body. Doctor will dictate the PE while examining the patient or after leaving the room. A macro must be imported with the doctor's preferences. **DDM** choose between interpretations of abnormal or normal vitals. The default chosen is "normotensive," leave as is if all vitals are normal. **INPUT** the oxygen saturation. **DDM** choose the oxygen therapy, if applicable. "On room air" is default, if on any supplemental therapy, make sure you know how many L and indicate that on the next set of asterisks

NEWGENERAL

DIFFERENTIAL DIAGNOSES, ED ORDERS & ED MEDS DDX: *** Orders: @ORDERSNMENC@ ED Meds: @EDMEDS@	**INPUT** choose between differential diagnosis categorized by chief complaint. Use .ddx **REMINDER** to check if patient is given IV morphine or fentanyl, which requires clicking the “parenteral controlled substances” box in the MDM. **REMINDER** to un-highlight orders and medications before the hospitalist places orders for admissions!
DATA Telemetry: Cardiac Monitor:{CardiacMonitor:50827} Labs: @EDLABS@ EKG: *** @EKG@ The above telemetry rhythm, lab results, and EKG were independently reviewed and interpreted by me, the physician. Radiology: @EDINTERP@ The above radiology results were reviewed by me, the physician.	**DATA** includes lab work, radiology, and EKGs and can be viewed under the tab **WORKUP**, under vitals. **DDM** choose between (1) Normal Sinus Rhythm, (2) Sinus Tachycardia, (3) Sinus Bradycardia, (4) Atrial Fibrillation, and (5) Supraventricular Tachycardia. Then, input the live heart rate (pulse) off the cardiac monitor. Delete this section or insert “n/a” if they are not on the cardiac monitor. **REMINDER** to check the date on the EKG that has automatically populated. If no EKG was ordered for this encounter (check **WORKUP**), and the date is old, delete the old EKG and the EKG title. **REMINDER** to un-highlight labs, EKG, and radiology if they are resulted for admission! Exceptions to “completed” include any cultures (these won’t come back while you are working on the chart). If no data was ordered for the whole visit, delete everything!
PROCEDURES @PROCDOC@	**Procedures** is a separate tab where all specific documentation for procedures is recorded. This is where we also add **Critical Care**. **REMINDER** everything in bold/with ** next to it in procedures is required information and must be filled out for the procedure to be complete.
MEDICAL DECISION MAKING	**MEDICAL DECISION MAKING** is a

NEWGENERAL	
@MDM23@ Clinical Tools and Timelines: {edclinicaltools:71863} MIPS: {edmips:71865} Reassessments and Repeat Vitals: @EDCOURSE@ @MULTIPLEVITALS@	separate tab with areas to address acute vs chronic issues, chart review, workup ordered, determinants of health, and risks. **DDM** any code timelines, if applicable, (sepsis, stemi, trauma, stroke) + heart score/NIH flowsheets as needed. “n/a” is selected by default. **DDM** the appropriate MIPS dot phrases about a patient if they are a smoker, hypertensive, etc… The ED course is brought in by the self-populating link seen- add to this part of the chart under the tab **WORKUP**, at the bottom **REMINDER** NEVER make the ED Course section editable.
DISPOSITION: {Disposition:50407} {dispositionjs:54577}	**DISPOSITION** This is where the final decisions get documented. Whether they are getting discharged or admitted, eloped or AMA, this is where we document it. In the first **DDM** choose between (1) Discharge, (2) Admission, (3) Transfer, (4) AMA, (5) Eloped, or (6) Expired. In the second **DDM**, choose the option corresponding to the disposition. **REMINDER** if a patient elopes, don’t choose one of the dispositions from the second DDM. Instead, use .eloped
ATTESTATION Scribe *** By signing my name below, I, ***, attest that this documentation has been prepared under the direction and in the presence of the provider below on @TODAYDATENOREF@ @NOWNOREF@ Physician: @ATTPROVIDER@***, THR Huguley ED	**SCRIBE INPUT** put in your name- you can also make a copy of the note and put your name here permanently! **REMINDER** to freeze the doctor’s name in every chart.

Dax General (DAXGENERAL)

DROP DOWN MENU REMINDER SELF-POPULATING SCRIBE INPUT TAB DAX INPUT

DAXGENERAL

Room: @EDROOM@ @CC@ First Provider Contact Date and Time: @TODAYDATENOREF@ @NOWNOREF@	**REMINDER** to freeze the room number. If a patient is moved to a different room in ED, update the note accordingly. **@CC@ (Chief Complaint)** brings in the triage note the nurse wrote and gives some insight into why they are here.
HISTORY OF PRESENT ILLNESS @NAME@ is a @AGE@ @SEX@ with who presents to the ED by {transportation:54918} for *** @HPISEC@ Previous History: @PMHPLAIN@ @PSHPLAIN@ @FAMHX@ @EDSOCH@ @HMEDS@ @ALLERGY@	**DDM** choose between (1) private vehicle, (2) EMS, (3) Police, or (4) other **SCRIBE INPUT** the story, including symptoms, start time, story details, specialists they have seen, and whatever answers they give to doctor's questions. **DAX INPUT** this is where the doctor's Dax-produced HPI enters the chart. Make sure your physician enters and refreshes the chart so that you can review/make changes to the HPI as necessary.
REVIEW OF SYSTEMS @ROSBYAGE@	**ROS** is a separate tab. This goes hand in hand with the HPI. A macro must be imported with the doctor's preferences.
PHYSICAL EXAM Triage Vitals: Initial triage vitals were reviewed and interpreted by me in the clinical context. Patient is {triagevitals:71856}. @EDTRIAGEVITALS@ Pulse ox interpretation by physician: ***% {o2satinterp:78312} Initial triage vitals were reviewed and interpreted by me in the clinical context. @PHYSEXAM@ @PESEC@	**PE** is a separate tab. Your physician will dictate the PE while examining the patient or after leaving the room. A macro must be imported with the doctor's preferences. **DDM** choose between interpretations of abnormal or normal vitals. The default chosen is "normotensive," leave as is if all vitals are normal. **INPUT** the oxygen saturation. **DDM** choose the oxygen therapy, if applicable. "On room air" is default, if on any supplemental therapy, make sure you know how many L and indicate that on the next set of asterisks

DAXGENERAL	
	DAX INPUT this is where the doctor's Dax-produced physical enters the chart. Make sure to check if your doctor wants this included or deleted.
DIFFERENTIAL DIAGNOSES, ED ORDERS & ED MEDS DDX: *** Orders: @ORDERSNMENC@ ED Meds: @EDMEDS@	**INPUT** choose between differential diagnosis categorized by chief complaint. **REMINDER** to check if patient is given IV morphine or fentanyl, which requires clicking the following in the MDM: ☐ Parenteral controlled substances **REMINDER** to un-highlight orders and medications before the hospitalist places orders for admissions!!!
DATA Telemetry: Cardiac Monitor:{CardiacMonitor:50827} Labs: @EDLABS@ EKG: @EKG@ The above telemetry rhythm, lab results, and EKG were independently reviewed and interpreted by me, the physician. Radiology: @EDINTERP@ The above radiology results were reviewed by me, the physician. @RESULTSEC@	**DATA** includes lab work, radiology, and EKGs and can be viewed under the tab **WORKUP**. **DDM** choose between (1) Normal Sinus Rhythm, (2) Sinus Tachycardia, (3) Sinus Bradycardia, (4) Atrial Fibrillation, and (5) Supraventricular Tachycardia. Then, input the live heart rate (pulse) off the cardiac monitor. Delete this section if they are not on a monitor. **REMINDER** to check the date on the EKG that has automatically populated. If no EKG was ordered for this encounter (check **WORKUP**), and the date is old, delete the old EKG and the EKG title. **DAX INPUT** this is where the doctor's Dax-produced data interpretation enters the chart. If no data was ordered for the whole visit, delete everything!
PROCEDURES @PROCDOC@	You can access this tab by clicking one of the buttons at the top of the note. This is where we also add Critical Care.
MEDICAL DECISION MAKING @MDM23@	**MEDICAL DECISION MAKING** is a separate tab with areas to address acute vc chronic issues, chart review, workup ordered, risks, and social determinants

DAXGENERAL

Clinical Tools and Timelines: {edclinicaltools:71863} MIPS: {edmips:71865} Reassessments and Repeat Vitals: @EDCOURSE@ @MULTIPLEVITALS@ @MDMSEC@	**DDM** any code timelines if applicable (sepsis, stemi, trauma, stroke) + heart score/NIH flowsheet **DDM** the appropriate dot phrases about a patient if they are a smoker, hypertensive, etc… **DAX INPUT** this is where the doctor's Dax-produced MDM enters the chart. **REMINDER** NEVER make the ED Course section editable.
DISPOSITION: {Disposition:50407} {dispositionjs:54577}	**DISPOSITION** This is where the final decisions get documented. Whether they are getting discharged or admitted, eloped or AMA, this is where we document it. In the first **DDM** choose between (1) Discharge, (2) Admission, (3) Transfer, (4) AMA, (5) Eloped, or (6) Expired. In the second **DDM**, choose the option corresponding to the disposition. **REMINDER** if a patient elopes, don't choose one of the dispositions from the second DDM, just document time and state "patient has eloped."
ATTESTATION Scribe *** By signing my name below, I, ***, attest that this documentation has been prepared under the direction and in the presence of the provider below on @TODAYDATENOREF@ @NOWNOREF@ Physician: @ATTPROVIDER@***, THR Huguley ED	**SCRIBE INPUT** put in your name- you can also make a copy of the note and put your name here permanently! **REMINDER** to freeze the doctor's name in every chart.

Garrett (DAXNOTECG)

DROP DOWN MENU REMINDER SELF-POPULATING SCRIBE INPUT TAB DAX INPUT

GARRETT (DAXNOTECG)

HUGULEY EMERGENCY DEPARTMENT Room: @EDROOM(EPT,18882,,,,,,,,,,)@***	**REMINDER** to freeze the room number. If a patient is moved to a different room in ED, update the note accordingly.
@CC@ First Provider Contact Date and Time: @TODAYDATENOREF@ @ @NOWNOREF	**@CC@ (Chief Complaint)** brings in the triage note the nurse wrote and gives some insight into why they are here.
History of Presentation Patient presented to the ED via {transportation:54918}. @HPISEC@ Patient arrived via EMS: pre-hospital vitals: BP ***/***, pulse ***, RR ***, SaO2: ***%, temperature: *** F. glucose: *** pre-hospital medications: *** Physician(s): on file: @PCP@ (PCP) **Previous History** @PMH@ @PSH@ @FAMHX@ @EDSOCH@ Home medications: @HMEDS@ Home medications reviewed as above.	**DROP DOWN MENU** choose between (1) private vehicle, (2) EMS, (3) Police, or (4) other **DAX INPUT** this is where the doctor's Dax-produced HPI enters the chart. Make sure your physician enters and refreshes the chart so that you can review/make changes to the HPI as necessary. **REMINDER** If the patient arrived by ambulance, enter the vital signs obtained by EMS in this section. If the patient did not arrive via EMS, you may delete this section. When EMS vitals are needed, coordinate with Dr. Garrett to obtain them. Please note that EMS vitals differ from triage vitals, which are recorded in the Emergency Department. **SELF-POPULATING** the patient's primary care physician on file, previous history, and home medications will self-populate in this area **REMINDER** If the patient sees any other specialists, you can add them to this list with their speciality in parentheses (ex: Dr. Sharma (Cardiology).)
Review of Systems @ROSBYAGE@:	**ROS** is a separate tab with buttons you click for specific symptoms and signs the patient reports. A macro must be imported with the doctor's preferences

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Physical Exam @EDTRIAGEVITALS@ Initial triage vitals were reviewed and interpreted by me in the clinical context. O2 interpreted by me to be {normal abnormal:48440} while on room air. @PHYSEXAM@ @PESEC@	**PE** is a separate tab. The PE is the doctor's hands-on assessment of the patient's body. Doctor will dictate the PE while examining the patient or after leaving the room. A macro must be imported with the doctor's preferences. **SELF-POPULATING** triage vitals will self-populate in this area **DDM** this area will allow you to select whether the triage vitals were normal or abnormal while on room air. **DAX INPUT** DAX will add its own physical exam findings if dictated by the physician. This will populate once the physician enters and refreshes the note.
Procedures @PROCDOC@	**Procedures** is a separate tab where all specific documentation for procedures is recorded. This is where we also add **Critical Care**.
Data: Labs/Radiology/EKG Labs @EDLABS@ I. @ATTPROV@, personally reviewed the laboratory values above and incorporated the results into my medical decision making. Radiology @EDINTERP@ I, @ATTPROV@, independently reviewed the above radiology tests and agree with radiologist interpretation. See ED course or MDM for ED MD interpretation. EKG: *** @EKG@ Any EKG ordered during this ED visit was independently reviewed and interpreted by me in clinical context and used in my MDM. - Details were documented in the ED Course	**REMINDER** to check the date on the EKG that has automatically populated. If no EKG was ordered for this encounter (check **WORKUP**), and the date is old, delete the old EKG and enter **no orders for this encounter**
ED Course & Medical Decision Making: @MDM23@ <u>Number and Complexity of Problems</u> Differential Diagnosis: *** {DifferentialsER:67785} Care significantly affected by the following chronic conditions:	**DIFFERENTIAL DIAGNOSIS DDM and REMINDER** Choose between differential diagnosis categorized by chief complaint. Open the dropdown menu, and select the appropriate differential under this list. If the differential needed is not listed, manually type it in using the .ddx dot phrase. If you are unable to find a differential that matches the patient complaint, coordinate with the physician. **CHRONIC CONDITIONS DDM** In this section, list any

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{chronic conditions:48419}

Care of this patient required a high complexity of Medical Decision Making including but not limited to:
{High Complexity MDM:48073}

Amount and/or Complexity of Data Reviewed
Independent historian:
{Independent Historian:48441}

External data reviewed:
{external records:48442}

All workup that was ordered during this ED visit was independently interpreted and details are documented in the ED Course. This includes:
{workup ordered:48443}

Discussions of management or test interpretations with external providers:
{discussion with external provider:48444}

Risk
Consideration of Admission/Observation/Discharge:
{Consideration of Care:48071}

I considered the following discharge prescriptions or medication management in the emergency department:
{Med ED Management:48069}

Social Determinants of Health:
{social Determinants Huguley:54936}

chronic medical conditions that significantly impact the patient's current care (for example, hypertension, COPD, or type 2 diabetes).

MEDICAL DECISION MAKING DDM
In this section, the purpose is evaluating the level of care the patient received in the department.

Standard workups (level 3s, 2s, and 1s): Select **boxes 1, 2, and 4** ("Extensive number of diagnosis or management options are considered above." + "Extensive amount of complex data reviewed including laboratory data imaging, medical records, consultants recommendations." + "When possible, tests results and plan of care were discussed with patient or/and family, related questions answered.").
For high acuity patients (level 1s and 2s): Select **box 5** ("High risk of complications and/or morbidity or mortality are associated with differential diagnostic considerations above.")
If you do a chart review, Select **box 2** ("Significant amount of time spent reviewing old medical records, obtaining case history from another source.")
If the patient is a lower acuity (level 4s and 5s): Select **box 4** (When possible, tests results and plan of care were discussed with patient or/and family, related questions answered.")

INDEPENDENT HISTORIAN DDM An independent historian is someone other than the patient who provides information about the history of the present illness (HPI). The dropdown options include: **Husband, Wife, Son, Daughter, Mother, Father, Brother, Sister, Friend, Caregiver, EMS, and Nursing Home (NH) records**. If the patient is the only person providing their history, select **n/a**

EXTERNAL DATA DDM In this section, document any external data reviewed, also known as chart review. This is dictated by the physician to be added in the ED Course. You will select the corresponding options in the dropdown based on what the doctor dictated. For example, if the physician asks you to include prior lab work and radiology findings in the ED Course, you would document those details there and select **Labs**, **Radiology**, and **See further details documented in ED Course** from the dropdown menu.

WORKUP DDM In this section, select any category of workup ordered during the encounter (**labs, radiology, EKG, or N/A).**

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EXTERNAL PROVIDERS DDM External providers refers to any consults that were made during the ED encounter. This includes discussion with hospitalists, as well as any specialists (ex. Cardiology, General Surgery, Nephrology, etc.)
If there was a discussion with any of these, select **Yes, see consult details documented below.** If there are no consultants for the encounter, select **n/a**

CONSIDERATION OF CARE DDM
Insert what appropriately applies to the patient. Options include:
-Escalation of care including admission or observation considered, -Patient was admitted , -Patient was placed in observation , -Patient was transferred to another facility , -Patient is medically stable for discharge home with close follow up, -Patient eloped from the ER before assessment/disposition decision was made, and
-Patient left AMA

MEDICATION MANAGEMENT DDM
This section is used to document any medications or interventions that were performed or discussed in the Emergency Department. It also includes any medication management decisions made by the physician.
All patients will receive **see below for any medications/interventions performed in the ED**.
If IV parenteral controlled substances (ex. Morphine, fentanyl, dilaudid) were administered, the patient would receive **used/discussed parenteral controlled substances.**
Any discharged patient will receive **discussed and recommended OTC medication or alternative treatment methods.**
If any new medications were prescribed, they will receive **discussed new medications prescribed, including side effects and medication interactions.**
The options **antibiotics at this time are not recommended** and **antihypertensives at this time are not recommended** will be applied as necessary.

SOCIAL DETERMINANTS DDM Social determinants are non-medical factors that influence a patient's health and access to care. They include social, economic, and environmental conditions that can affect treatment outcomes and overall well-being. To identify these, listen for clues in the patient's history that may suggest that they have barriers to care or lifestyle factors that would affect their health.
Dropdown options are: -Poor access to healthcare, -Lack of insurance, -Poor access to transportation,

GARRETT (DAXNOTECG)	
	-Inadequate housing, -Misuse of alcohol or drugs, -Current daily smoking history, -Problems related to living alone or support group, -Problems ambulating (walking/moving around) at home, -Inadequate health literacy, -Stressful life events, -Lack of routine health care or inadequate health maintenance
Clinical/Quality Tools and Timelines: Merit-Based Incentive Payment System: {MIPSHUGULEYMIPS:51323} Quality Codes Timeline: {SCBHUGULEYCODES:51586} Decision Tools: {Decision tools:67783}	**MIPS DDM** The appropriate MIPS dot phrases about a patient if they are a smoker, hypertensive, etc… If there are no MIPS applicable, select **NOMIPSAPPLICABLE** **QUALITY CODE TIMELINES DDM** Any code timelines, if applicable, (sepsis, stemi, trauma, stroke). If there are no timelines applicable, select **no sepsis, trauma, STEMI or stroke timelines applied** **DECISION TOOLS DDM** Clinical decision tools are standardized scoring systems that help physicians evaluate a patient's risk level, guide medical decisions, and determine appropriate management or disposition. These tools use specific criteria such as symptoms, vital signs, lab results, and medical history to support evidence-based care Examples of decision tools used in the ED include: -heart score (for patients with complaints of chest pain), NIH stroke scale, Ottawa CHF assessment, Ottawa COPD risk scale, NEXUS cervical spine rule, CURB-65 for pneumonia, Wells criteria and PERC rule for PE/DVT, Alvarado score for appendicitis, HINTS exam for vertigo, modified Hestia and sPESI criteria for PE. You must coordinate with Dr. Garrett to confirm which decision tool should be documented for each patient. If none are applicable, select **see MDM**
ED Course/Consults and reassessment @APSEC@ Medications in ED: @EDMEDS@ @MULTIPLEVITALS@ -Please see ED course below for any timed re-assessments. @EDCOURSE@	**DAX INPUT** this is a DAX-produced assessment and plan section. This will populate once the physician enters and refreshes the note. **SELF-POPULATING** Medications administered in the ED, all vitals obtained in the ED, orders placed by the physician, and any consultants involved in the patient's care will be brought in by the self-populating link. The ED course is brought in by the self-populating link seen. To add to this part of the chart, document under the tab **WORKUP**. ED course is located at the bottom of this tab. **REMINDER** NEVER make the ED Course

GARRETT (DAXNOTECG)	
@ORDERSNMENC@ @CONSULTPROV@	section editable.
DISPOSITION: {dispo ED huguley:72652} {CGERDISPO:50546}	**DISPOSITION** This is where the final decisions get documented. Whether they are getting discharged or admitted, eloped or AMA, this is where we document it. In the first **DDM** choose between (1) Admission, (2) Discharge, (3) Psychiatric admission/transfer, (4) Transfer, (5) Eloped, (6) AMA, (7) Expired. In the second **DDM**, choose the option corresponding to the disposition.
ATTESTATION Scribe @me@ I am scribing for, and in the presence of, Dr. Christopher Garrett MD on @TD@, @NOW@. THIS NOTE IS INCOMPLETE AND NOT MEANT FOR OFFICIAL DOCUMENTATION UNTIL SIGNED BY ATTENDING. (let MD remove after review)*** Patient and/or their authorized representative and all individual present during the visit have each given their verbal or written consent to use voice capturing technologies as required by law. I certify the above information is true and correct and that I personally was present for procedures documented above. Attending: Christopher Garrett MD FACEP THR Huguley ED	**SCRIBE SELF-POPULATING** Your name will automatically populate into this area, make sure to unhighlight it. You can also make a copy of the note and put your name here permanently. **DATE AND TIME SELF-POPULATING** The date and time of the encounter will be self populated in this area. You will need to highlight both of these. **REMINDER** This area with asterisks is a reminder that the note is not complete/official until it has been reviewed and signed by the physician Dr. Garrett. Because of this, the scribe should never delete or modify this area. It acts as a safeguard to ensure that no note is finalized or submitted before physician approval. Once Dr. Garrett completes his review, **he will remove this section himself**.

Ryon (DAXRYON)

DROP DOWN MENU REMINDER SELF-POPULATING SCRIBE INPUT TAB DAX INPUT

RYON (DAXRYON)

Room: @EDROOM(EPT,18882,,,,,,,,,)@*** @CC@	**REMINDER** to freeze the room number. If a patient is moved to a different room in ED, update the note accordingly. **@CC@ (Chief Complaint)** brings in the triage note the nurse wrote and gives some insight into why they are here.
History of Presentation @NAME@ is a @AGE@ @SEX@. @HPISEC@ [ ] Patient's Physician(s) PCP = @PCP@ Previous History Past Medical History @PMHSIMPLE@ Surgical History Relevant to Today's Visit None Social History @SOCX@ @DRUGHX@ Medication History Home Meds @HMEDS@ Allergies @ALLERGY@	**BOX** for Dr. Ryon, he uses it when signing to remind him if he's read his HPI **DAX INPUT** this is where the doctor's Dax-produced HPI enters the chart. Make sure your physician enters and refreshes the chart so that you can review/make changes to the HPI as necessary. **SELF-POPULATING** the patient's primary care physician on file, previous medical/surgical/social history, home medications, and allergies will automatically populate into these areas. **REMINDER** If the patient sees any other specialists, you can add them to this list with their speciality in parentheses (ex: Dr. Sharma (Cardiology).)
Review of Systems @ROSBYAGE@:	**ROS** is a separate tab with buttons you click for specific symptoms and signs the patient reports. A macro must be imported with the doctor's preferences
Physical Exam	

RYON (DAXRYON)

@EDTRIAGEVITALS@ Initial triage vitals were reviewed and interpreted by me in the clinical context. @PHYSEXAM@: [ ]	**SELF-POPULATING** triage vitals will self-populate in this area **PE** is a separate tab. The PE is the doctor's hands-on assessment of the patient's body. Doctor will dictate the PE while examining the patient or after leaving the room. A macro must be imported with the doctor's preferences.
Differential Diagnosis {DDx:64185:a::1}	**DDM** Choose between differential diagnosis categorized by chief complaint. Open the dropdown menu, and select the appropriate differential under this list. If you are unable to find a differential that matches the patient complaint, coordinate with the physician.
Orders Placed in the ED @ORDERSNMENC@	**SELF-POPULATING** All orders placed by the physician during the ED visit will automatically populate here
ED Data and Results All data ordered during this ED visit (i.e. lab results, radiology interpretations, and EKG results) were independently reviewed and interpreted by me in clinical context and used in my MDM. - Specific details were documented in the ED Course. Labs @EDLABS@ Radiology @EDINTERP@ Cardiology My Cardiac Monitor Interpretation: {CardiacMonitor:50827} -Patient was kept on a continuous cardiac monitor to evaluate for any underlying dysrhythmias. EKG @EKG@	**DATA** includes lab work, radiology, and EKGs and can be viewed under the tab **WORKUP**, under vitals. **SELF-POPULATING** All lab, radiology and EKG results with automatically populate into here **REMINDER** to check the date on the EKG that has automatically populated. If no EKG was ordered for this encounter (check **WORKUP**), and the date is old, delete the old EKG and the EKG title. **REMINDER** to un-highlight labs, EKG, and radiology if they are resulted for admission! Exceptions to "completed" include any cultures (these won't come back while you are working on the chart). If no data was ordered for the whole visit, delete everything! **DDM** choose between (1) Normal Sinus Rhythm, (2) Sinus Tachycardia, (3) Sinus Bradycardia, (4) Atrial Fibrillation, and (5) Supraventricular Tachycardia. Then, input the live heart rate (pulse) off the cardiac monitor. Delete this section or insert "n/a" if they are

RYON (DAXRYON)	
	not on the cardiac monitor.
Procedures {?Procedure?:64222}	**Procedures** is a separate tab where all specific documentation for procedures is recorded. This is where we also add **Critical Care**. **DDM** you will notice that there is not a procedure tab in this note. If there was a procedure to document during this encounter, you will select **PROCDOC** under this dropdown. If there were no procedures to document, you will select **n/a.**
Clinical Tools and Timelines {Clinical Tools:64320}	**DDM** any code timelines, if applicable, (sepsis, stemi, trauma, stroke) + heart score/NIH flowsheets as needed. “n/a” is selected by default.
ED Course & Management Medications received in ED @EDMEDS@ Re-assessments/Consults/ED Course @EDCOURSE@	**SELF-POPULATING** any medications ordered in the ED will be automatically populated into this area The ED course is brought in by the self-populating link seen- add to this part of the chart under the tab **WORKUP**, at the bottom **REMINDER** NEVER make the ED Course section editable.
Problems List and Co-morbidities @AHDIAGPROB@	**SELF-POPULATING** This section documents the patient’s active medical problems and any chronic conditions that may affect their current care or treatment plan. This will automatically populate into this area
Medical Decision Making MDM Narrative: Details are in the ED Course. Details of @MDM23@ Social Determinants of Health that are affecting medical care: {Social Determinants of Health:48065}	**MEDICAL DECISION MAKING** is a separate tab with areas to address acute vs chronic issues, chart review, workup ordered, determinants of health, and risks **SOCIAL DETERMINANTS DDM** Social determinants are non-medical factors that influence a patient’s health and access to care. They include social, economic, and environmental conditions that can affect

RYON (DAXRYON)	
	treatment outcomes and overall well-being. To identify these, listen for clues in the patient's history that may suggest that they have barriers to care or lifestyle factors that would affect their health. **Dropdown options include:** - none - poor access to regular/routine healthcare - poor access to outpatient specialty evaluation - financial constraints limiting access to appropriate medical evaluation or medication use - poor access to transportation - Inadequate housing - misuse of alcohol - misuse of drugs - current daily smoking history - problems related to living alone - problems related to primary support group - problems ambulating at home - from out of town with no local medical care
MIPS {MIPS:53354}	**DDM** the appropriate MIPS dot phrases about a patient if they are a smoker, hypertensive, etc…
Disposition {Dispo Tab:53137} By signing my name below, I attest that this documentation has been prepared under the direction and in the presence of Andrew Michael Ryon, MD. Scribe: *** It was disclosed to the patient as soon as reasonably possible that voice capturing technology that is HIPAA compliant was used during the encounter and their consent was given. This was NOT used in any diagnostic capacity and only used to maintain accurate medical records. I have reviewed all generated records and made edits as needed for accuracy.	**DISPOSITION** This is where the final decisions get documented. Whether they are getting discharged or admitted, eloped or AMA, this is where we document it. **SCRIBE INPUT** put in your name- you can also make a copy of the note and put your name here permanently!

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DROP DOWN MENU REMINDER SELF-POPULATING SCRIBE INPUT TAB

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@CC@ First Provider Contact Date and Time: @TODAYDATENOREF@ @NOWNOREF@	**@CC@ (Chief Complaint)** brings in the triage note the nurse wrote and gives some insight into why they are here.
HISTORY OF PRESENT ILLNESS (TRANSCRIBED HPI) @AGE@ @SEX@ (DAX AI HPI) @HPISEC@ Previous History: @PMHPLAIN@ @PSHPLAIN@ @FAMHX@ @EDSOCH@ @HMEDS@ @ALLERGY@	**DAX INPUT** if Dr. Dymott is using DAX, this is where the HPI will populate If DAX is not used in the chart, Dr. Dymott asks that the scribe only create bullet points summarizing the patient's complaints. She will then go into the chart and write her own HPI
REVIEW OF SYSTEMS See HPI	**ROS** does not need to be completed for this note. The tab will not appear in the note
PHYSICAL EXAM @EDTRIAGEVITALS@ EXAM: {JADPHYSICALS:84608} @PESEC@	**DDM** PE is the doctor's hands-on assessment of the patient's body. Doctor will dictate the PE while examining the patient or after leaving the room. You will notice that this note does not have a separate physical exam tab. Instead, there is a dropdown, which will import a written out normal physical exam into the note. Dr. Dymott will then dictate her exam findings for you to write into this area. **Dropdown options include:** - JADADULTEXAM: this will be used for an adult in-depth physical exam - JADCHILDEXAM: this will be used for a child/pediatric in-depth physical exam - JADINFANTEXAM: this will be used

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	for an infant's in-depth physical exam - JADADULTCOVIDEXAM: this will be used for a basic adult physical exam - JADCHILDCOVIDEXAM: this will be used for a basic child/pediatric physical exam - JADCOVIDEXAM: this will be used for a no-touch exam - JADCODEEXAM: this will be used for trauma patients - JADCODEEXAM:
DIFFERENTIAL DIAGNOSES, ED ORDERS & ED MEDS ED Meds: *** @EDMEDS@	**REMINDER** to check if patient is given IV morphine or fentanyl, which requires clicking the "parenteral controlled substances" box in the MDM. **REMINDER** to un-highlight orders and medications before the hospitalist places orders for admissions!
DATA **Labs:** **@EDLABS@** **Radiology:** **@EDINTERP@** **EKG:** **@EKG@** **Data collected during this ED encounter (i.e. lab results, radiology interpretations, and EKG results) were independently reviewed and interpreted by me.**	**DATA** includes lab work, radiology, and EKGs and can be viewed under the tab **WORKUP**, under vitals. **REMINDER** to check the date on the EKG that has automatically populated. If no EKG was ordered for this encounter (check **WORKUP**), and the date is old, delete the old EKG and the EKG title. **REMINDER** to un-highlight labs, EKG, and radiology if they are resulted for admission! Exceptions to "completed" include any cultures (these won't come back while you are working on the chart). If no data was ordered for the whole visit, delete everything!
PROCEDURES @PROCDOC@	**Procedures** is a separate tab where all specific documentation for procedures is recorded. This is where we also add **Critical Care**. **REMINDER** everything in bold/with ** next to it in procedures is required information and must be filled out for the procedure to be complete.

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MEDICAL DECISION MAKING @MDM23@ Clinical Tools and Timelines: {edclinicaltools:71863} MIPS: {edmips:71865} Reassessments and Repeat Vitals: @EDCOURSE@ @MULTIPLEVITALS@	**MEDICAL DECISION MAKING** is a separate tab with areas to address acute vs chronic issues, chart review, workup ordered, determinants of health, and risks. **DDM** any code timelines, if applicable, (sepsis, stemi, trauma, stroke) + heart score/NIH flowsheets as needed. “n/a” is selected by default. **DDM** the appropriate MIPS dot phrases about a patient if they are a smoker, hypertensive, etc… The ED course is brought in by the self-populating link seen- add to this part of the chart under the tab **WORKUP**, at the bottom **REMINDER** NEVER make the ED Course section editable.
DISPOSITION: **DIAGNOSIS:** **@DIAGICD10@** **ED Disposition: @DBLINK(EPT,34510,,1)@** **{dispositionjs:54577}**	**DISPOSITION** This is where the final decisions get documented. Whether they are getting discharged or admitted, eloped or AMA, this is where we document it. In the **DDM** choose between: 1. NORMDC for adult discharge 2. NORMDCPEDS for pediatric (<1 y/o) discharge 3. NORMADMIT for admission 4. NORMTRANSFER for medical transfer 5. PSYCHCLEARDISPO for psychiatric transfer 6. DEADPTCG1 for expired patient 7. AMACG1 for patient leaving AMA **REMINDER** if a patient elopes, don’t choose one of the dispositions from the DDM. Instead, use .eloped
ATTESTATION Scribe *** By signing my name below, I, ***, attest that this documentation has been prepared under the direction and in the presence of Jean Ann Dymott, MD *** on @TODAYDATENOREF@ @NOWNOREF@	**SCRIBE INPUT** put in your name- you can also make a copy of the note and put your name here permanently! **REMINDER** to freeze the doctor’s name in every chart.