

EMR PSS Entering Screening Tests: A resource for clinicians

SMH DFCM

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1 ENTERING SCREENING TESTS

1.1 Mantoux

1. Open patient's record
2. Within patients' record window, click on "Data", then "New Report"
3. Date Created = date test was done
4. Select "Diagnostic Tests", then "Mantoux Test"
5. If normal, click "Normal".
6. In the free text area, type in the date when the test was given, the date the test was read, and the area of induration.
7. Click "Save into *patient's name*"

The screenshot shows the 'PS Report' form with several fields and lists. Red circles highlight the following elements:

- Date Created:** Feb 14, 2009
- Date Received:** Jun 18, 2010
- Choose Category:** A list with 'Diagnostic Tests' selected.
- Misc. Diagnostic Test:** A list with 'Mantoux Test' selected.
- Doctors To Notify:** A list of names including Limaye, Navika; Meador, Karine; Mehta, Tushar; Ordean, Alice; PSS, User; Shen, Kay; Skalenda, Joseph; and Solway, Eric.
- Category:** A dropdown menu.
- Author's Name:** A text field.
- Subcategory:** A dropdown menu.
- Normal:** A checkbox.
- Free Text Area:** Contains the text: '5 mm induration on Feb 16, 2009' and '2 step test - Feb 21, 2009 8 mm induration'.
- Buttons:** 'Cancel' and 'Save into SVETSLANA REFUGEE age 23 yr'.

1.2 Pap Smears (F: 18-70)

Until lab interfaces are operational, enter PAPs when reported into PSS chart as described.

This will update the CPP.

1. Open patient's record
2. Within patients' record window, click on "Data", then "New Report"
3. Date Created = date test was done
4. Date Received = date results were received
5. Select "Diagnostic Tests", then "Pap Test Report"
6. If normal, click "Normal". If abnormal, or no transformation zone, indicate result in blank space and put recommendation for follow-up PAP testing
7. Click "Save into *patient's name*"

PSS report

Date Created: Jun 18, 2010 Date Received: Jun 18, 2010

Choose Category:

- Consultant Letter
- Miscellaneous Letters
- Diagnostic Imaging
- Diagnostic Tests**

Misc. Diagnostic Test

- Pap Test Report**
- Mantoux Test
- ECG
- Stress Test (Exercise, Persantine, Dobutamine)
- Holter Monitor
- Loop Recorder
- Ambulatory BP Monitoring

Doctors To Notify

- Kahan, Mel
- Kraftcheck, Erin
- Laraya, Nadine
- Limaye, Navika
- Meador, Karine
- Mehta, Tushar
- Ordean, Alice
- PSS, User

Category: Subcategory:

Author's Name: SJHC cytopathologist ☐ Normal

ASCUS advise rpt in 6 months and test for HPV

Cancel Save into SVETSLANA REFUGEE age 23 yr

1.3 Bone Mineral Density (M+F: >50)

Enter this as a report.

1. Open patient's record
2. Within patients' record window, click on "Data", then "New Report"
3. Date Created = date test was done
4. Date Received = date results were received
5. Select "Diagnostic Imaging", then "Bone Densitometry"
6. If normal, click "Normal". If abnormal (e.g. osteopenia or osteoporosis), indicate result in blank space. Include T scores for lumbar spine (L1-L4), femoral neck, total proximal left femur (e.g. "Lumbar spine T = -1.5"), and if there was a change from previous BMD
7. Click "Save into *patient's name*"

The screenshot shows the 'PS Report' form with the following elements highlighted by red circles:

- Date Created:** Nov 25, 2009
- Date Received:** Jun 18, 2010
- Choose Category:** Diagnostic Imaging (selected), Bone Densitometry (selected)
- Doctors To Notify:** List of doctors including Branigan, Monica, Crispino, Natascha, Edwards, Susan, Hughes, Carol, Jakubovicz, Difat, Jeney, Christa, Kahan, Mel, Kraftcheck, Erin
- Category:** (empty field)
- Author's Name:** (empty field)
- Subcategory:** (empty field)
- Normal:** ☐ Normal
- Text Area:** Osteopenia T score 1.7 -consider bisphosphonate therapy
- Buttons:** Cancel, Save into SHERRY CLARKE age 65 yr

1.4 Colonoscopy (M+F: >50)

Enter this as a report.

1. Open patient's record
2. Within patients' record window, click on "Data", then "New Report"
3. Date Created = date test was done
4. Date Received = date results were received
5. Select, then "Colonoscopy"
6. If normal, click "Normal". If abnormal indicate result in blank space
7. Include recommended follow up interval in blank space. *Also add this follow up interval with test type into Personal Box/specialist/exclusion code – Q142A to facilitate searching
8. Include Author's name (physician that did colonoscopy), last name first
9. select a Subcategory of "Procedure Report"
10. Click "Save into *patient's name*"

The screenshot shows the 'PS Report' form with several fields and lists. Red circles highlight the following elements:

- Date Created:** Jun 18, 2010
- Date Received:** Jun 18, 2010
- Choose Category:** A list with 'Diagnostic Tests' and 'Colonoscopy' highlighted.
- Doctors To Notify:** A list of names including Meador, Karine, Mehta, Tushar, Ordean, Alice, PSS, User, Shen, Kay, Skalenda, Joseph, Solway, Eric, and Sood, Priya.
- Category:** A dropdown menu.
- Author's Name:** Springer
- Subcategory:** Procedure Report
- Normal:** A checkbox that is unchecked.
- Report Text:** 2 small polyps in sigmoid rectum-recommend repeat colonoscopy in 10 years based on FHM
- Buttons:** Cancel and Save into Bobby REFUGEE age 100 yr

1.5 Mammogram (F: 50-70)

Enter this as a report.

1. Open patient's record
2. Within patients' record window, click on "Data", then "New Report"
3. Date = date test was done
4. Select "Diagnostic Imaging", then "Mammogram"
5. If normal, click "Normal". If abnormal indicate result in blank space
6. Include recommended follow up interval in blank space. Also add this interval and test to Personal Box
7. Click "Save into *patient's name*"

The screenshot shows the 'PS Report' form with the following elements highlighted by red circles:

- Date Created:** Jun 7, 2010
- Date Received:** Jun 7, 2010
- Choose Category:** A list box containing 'Consultant Letter', 'Miscellaneous Letters', 'Diagnostic Imaging' (highlighted), and 'Diagnostic Tests'.
- Misc. X-Ray:** A list box containing 'Mammogram' (highlighted), 'Chest X-Ray', 'Abdomen X-Ray', 'Lumbar Spine X-Ray', 'Cervical Spine X-Ray', 'Upper GI Series', and 'ERCP X-Ray'.
- Doctors To Notify:** A list box containing names: Branigan, Monica; Crispino, Natascha; Edwards, Susan; Hughes, Carol; Jakubovicz, Difat; Jeney, Christa; Kahan, Mel; Kraftcheck, Erin.
- Category:** A text field.
- Author's Name:** A text field.
- Subcategory:** A dropdown menu.
- Normal:** A checkbox labeled 'Normal'.
- Save into SVETSLANA REFUGEE age 23 yr:** A button at the bottom right.

1.6 Fecal Occult Blood Testing (M+F >50)

Enter this as a Lab Manual Result.

1. Open patient's record
2. Within patients' record window, click on "Data", then "Lab Manual Result" (shortcut ctrl-y)
3. Date = date test was done
4. Laboratory = SMH (or CML, gamma, etc)
5. Lab test = stool occult blood (can type in "occult", then hit "Tab", select from list)
6. Type in the Result = negative x 3 (if this is the case), or positive
Normal = N (if negative x 3) or Abnormal = Y (if any positive)
7. Click "Save into *patient's name*"

Lab Manual Result

← May 4, 2007 → Details

Laboratory: CML

Lab Test: Stool Occult Blood

☐ Enter as lab text

Result: negative

Low:

High:

Abnormal: (Y/N) N

Units:

Done Save into SHERRY CLARKE age 65 yr

1.7 Fasting Blood Sugar (M+F >40)

Enter this as a Manual Lab Result.

1. Open patient's record
2. Within patients' record window, click on "Data", then "lab manual result"
3. Date = date test was done
4. Laboratory = CML, SMH, etc
5. Lab test = FBS
6. Result = actual number (i.e. 5.4)
7. Abnormal = N (if ≤ 6.0), abnormal = Y (if ≥ 6.1)

Lab Manual Result

← Jun 7, 2010 → Details

Laboratory: SJHC

Lab Test: FBS

☐ Enter as lab text

Result: 5.4

Low:

High:

Abnormal: (Y/N) N

Units: MMOL/L

Done Save into SVETSLANA REFUGEE age 23 yr

1.8 Cholesterol (variable)

1. Open patient's record
2. Within patients' record window, click on "Data", then "lab manual result"
3. Date = date test was done
4. Laboratory = CML, SMH, etc
5. Lab test = Chol
6. Result = actual number (i.e. 5.4)
7. Abnormal = N for all
8. Repeat above procedure for LDL, HDL, TG and Chol/HDL ratio

1.9 Results Entered are Visible in EMR

1. The latest dates of results are shown on the EMR

PS Dr. Judy Thompson - PSS

File Edit Style Settings Patient View Data ** Checked Out **

REFUGEE, SVETSLANA next visit: Jun 30, 2010 age 23 yr 107 (#J00003857)

HPI
M: Breast CA 45, GDM, HTN 40, CAD 70
F: Alcohol abuse, smoker, CAD, Lung Ca 67 - died 69
Sis: GDM, hypothyroid
MGM: A FIB, TIA, DM2
B: alcohol abuse
MGF: A&W
PGM: A&W
PGF: Alcohol abuse, Cirrhosis
Varicella immune - Mar 3, 2008
Rubella immune Mar 3, 2008
Sx: Appendectomy 2000...
Asthma...
G3P2TA1...
Sx: C/S for fetal distress: (Apr 2010)...

PMH
measles, mumps, rubella virus vac... Jan 1, 2007
Adacel Jan 1, 2010

ALL
Penicillins-> hives
Insect: Wasp-> localized swelling withing minut...
Aeroallergen: Tree Pollen, Grass Pollen, Ragw...

IMM
measles, mumps, rubella virus vac... Jan 1, 2007
Adacel Jan 1, 2010

PRE
diabetic eye exam
Pre conception folate advice (inappropriate)
Obesity Counselling
Preventive Care
Last CGA: Oct 4, 2009
Last Flu Shot: never done
Last FOBT: never done
Last Mammo: Jun 9, 2010
Last Pap: Lab: never done, Other Report: Jun 18, 2010
Last BMD: Jun 9, 2010
Last Colonoscopy: Jun 15, 2009
Last TB: never done

Needs Czech translator for all appointments
Next colonoscopy 2019 excusion: Q142 (2009)
Married to Yuri Moved to Canada as a refugee e...
homemaker
Grade 7
current smoker - 10 cigarettes/day, second-hand smoke exposure ...
6 - 8 alcoholic drinks per week ...
previous recreational drug use: THC ...

Prev JT Msg Next JT Msg

2. The results are also shown in the progress notes.

PS Dr. Judy Thompson - PSS

File Edit Style Settings Patient View Data ** Checked Out **

REFUGEE, SVETSLANA next visit: Jun 30, 2010 age 23 yr 107 (#J00003857)

Appendectomy 2008...
Gall bladder removal 2007

Vericella immune
Rubella immunity 1

No known allergies Jun 15, 2010

Alesse 28 Tablets T po od

Patient has an appointment with cardiologist Dr. Mary Kerthump on August 5 at 10:00 am.

Next colonoscopy 2019 excusion: Q142 (2009)
business phone: 416 555-1234SIN: 111 222 2...

Pre-conception folate advice (inappropriate)
Obesity Counselling
Needs CGA
Preventive Care

Last CGA:
Last Flu Shot: never done
Last FOBT: never done
Last Mamm: Jun 9, 2010
Last Pap: Lab: never done, Other Report: Jun 15, 2010
Last BMD: Jun 9, 2010
Last Colonoscopy: Jun 15, 2009
Last TB: never done

Aug 13, 2008 Pap Test Report ES
Received: Jun 11, 2010
Normal - Negative for Intraepithelial Lesion or Malignancy

Jan 8, 2009 Manual Entry Lab Data OS
HDL 12

Feb 14, 2009 Mantoux Test JT
Received: Jun 18, 2010
5 mm induration on Feb 16, 2009
2 step test - Feb 21, 2009 8 mm induration

Jun 15, 2009 Manual Entry Lab Data OS
Stool Occult Blood negative x 3

Prev JT Msg JT: 3 messages Next JT Msg