eClinicalWorks

Business Analysis Department

Front Office - II

Kentucky Department for Public Health

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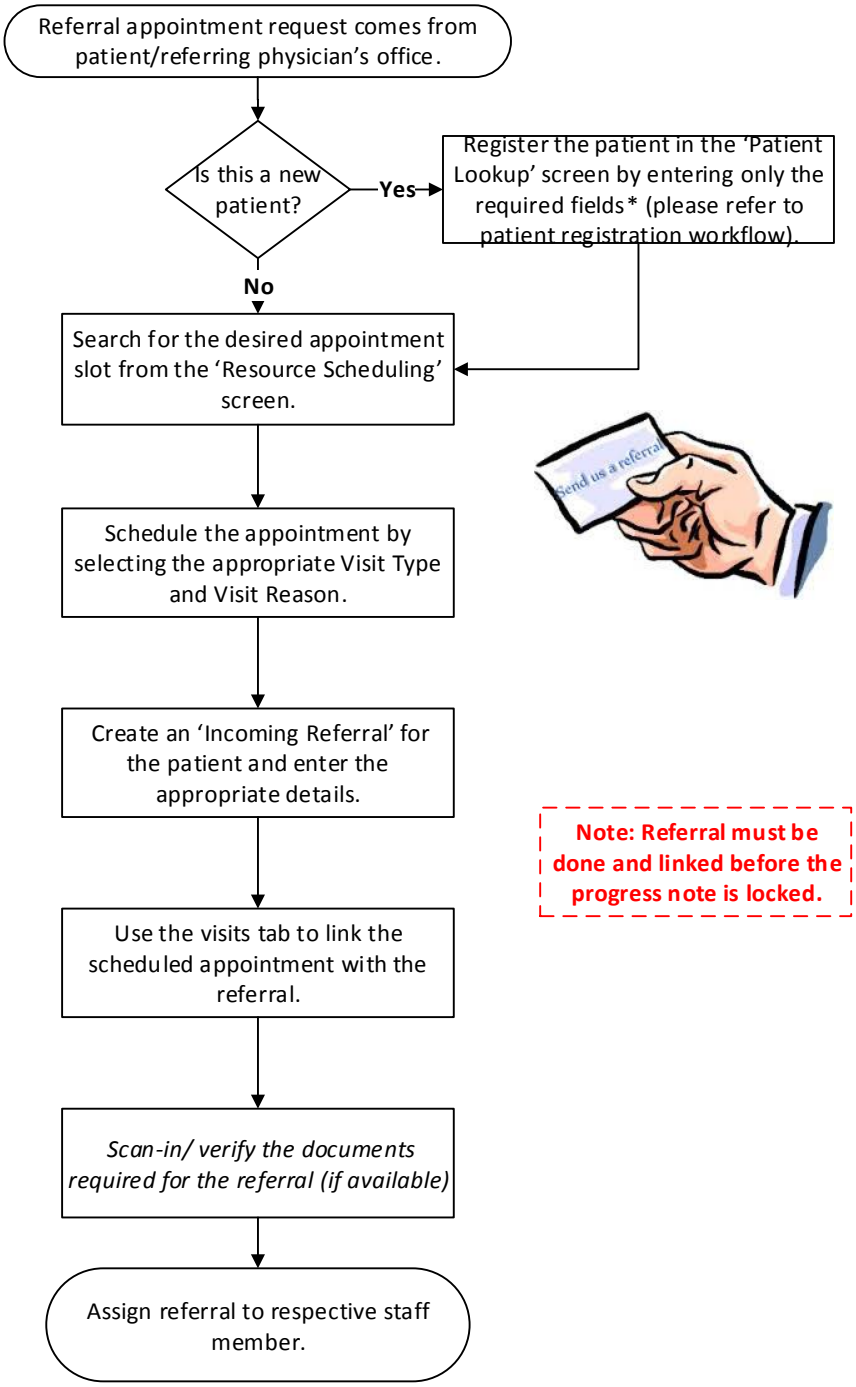
Incoming and Outgoing Referrals

There are 2 types of referrals in eClinicalWorks – Outgoing and Incoming. Primary Care practices will be using only the Outgoing referral since the patient can be seen without an authorization. On the other hand, Specialty offices will be utilizing the Incoming referral feature since some insurances may require the patient's appointment to be the authorized prior to being seen, and the Outgoing Referral.

Incoming Referrals



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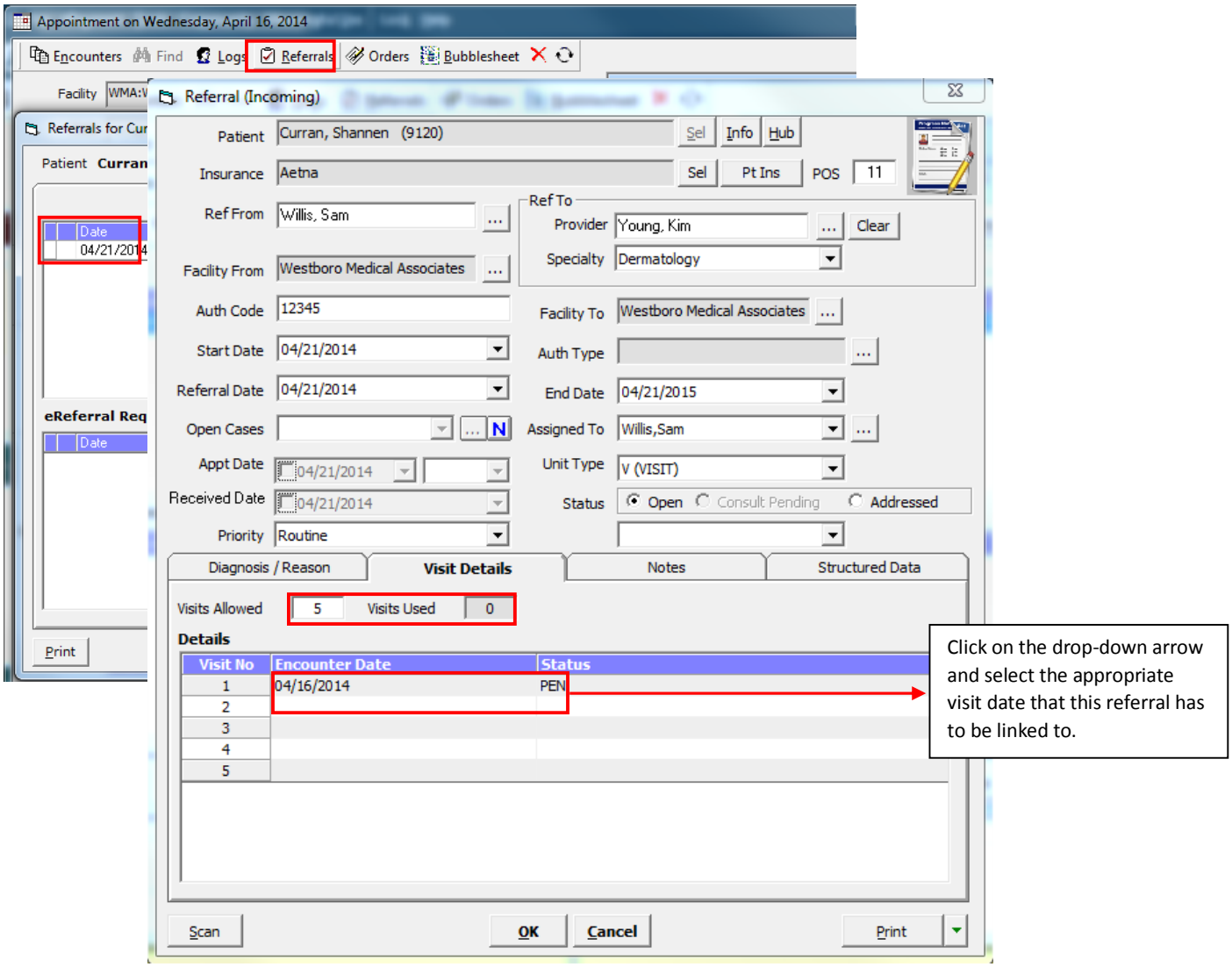
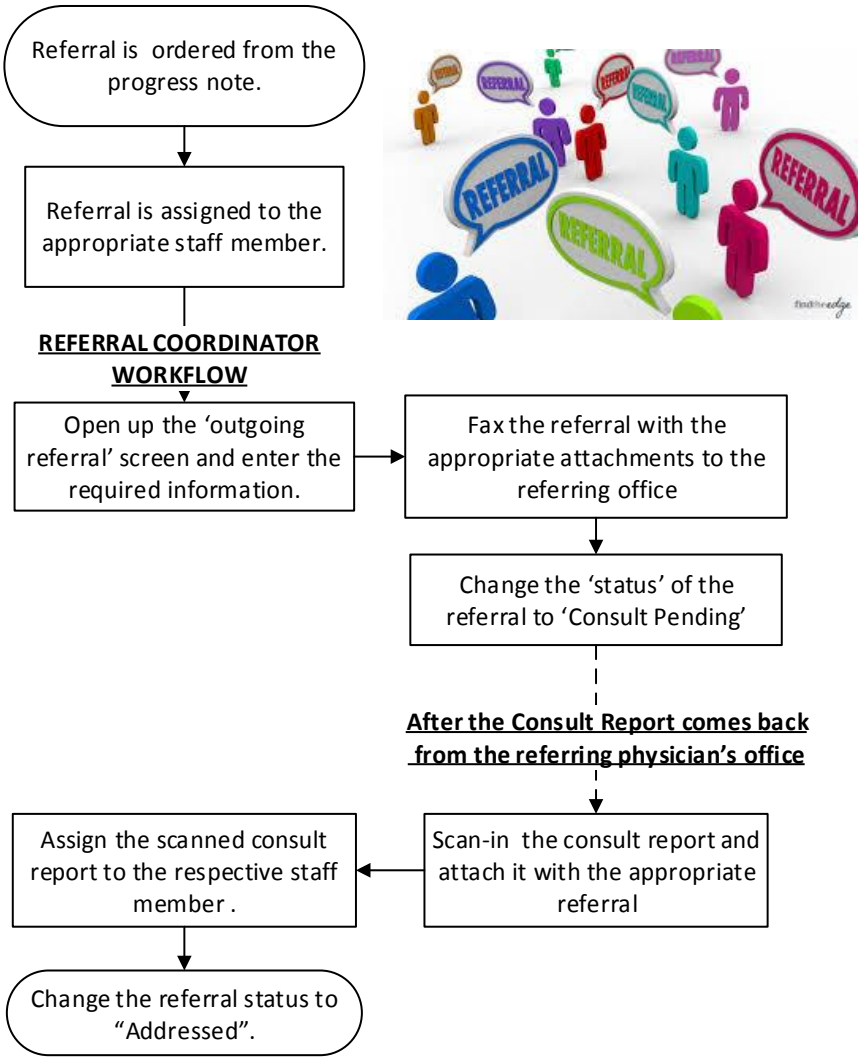
1. An incoming referral can be created for a patient by clicking on the “Referral” button on the ‘Appointment’ screen or by going to the patient’s Hub and clicking on the “Referrals” button.
2. The details of the referral can then be documented on the ‘Incoming Referrals’ screen, as required.
3. Incoming referrals can be linked to the appointment by clicking on the ‘Visit Details’ tab.



Outgoing Referrals



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1. An outgoing referral can be created for a patient by clicking on the "Referral" button on the 'Appointment' screen or by going to the patient's Hub and clicking on the "Referrals" button.
2. In addition, clinicians can initiate an outgoing referral from the Progress Note.

Example of Referral Workflow (Clinician Portion):

Allows the provider to specify the specialist/specialty.

Displays patient and provider information.

Allows provider to specify the reason and diagnosis code.

Referral (Outgoing)

Patient: Curran, Shannen (9120) | Sel | Info | Hub

Insurance: Aetna | Sel | Pt Ins | POS 11

Ref From: Jones, Mary

Ref To — Provider: Barret,Bob | Pref | Clear — Specialty: Neurology

Facility From: Manhattan Surgical Associates

Auth Code: 123445 — Facility To | Clear

Start Date: 04/18/2014 — Auth Type

Referral Date: 04/18/2014 — End Date: 04/18/2015

Open Cases — Assigned To: Dalton, Gail

Appt Date: 04/21/2014 — Unit Type: V (VISIT)

Received Date: 04/21/2014 — Status: Open | Consult Pending | Addressed

Priority: Routine

Diagnosis / Reason | Visit Details | Notes | Structured Data

Reason | Add | Browse | Remove

Sl. No	Description
1	Muscel Spasm

Diagnosis | Previous Dx | Add | Remove

Code	Name
728.87	Muscle weakness (generalized)

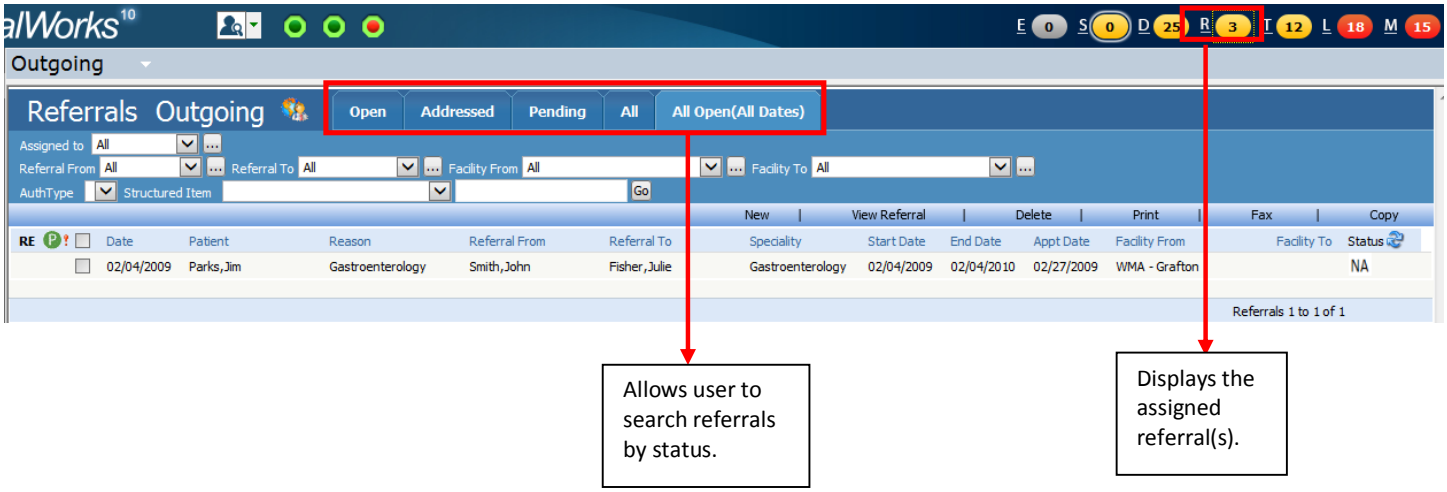
Procedures | Add | Remove

Code	Name

Scan | Attachments (1) | Logs | OK | Cancel | Send Referral

1. Once referral window opens, provider can select his/her name from the 'Referral From' drop down.
2. Provider can specify the specialty or program by clicking on the drop down from the 'Referral To' section.
3. Provider can specify the reason for the referral by using the 'Add' or Browse' button.
4. Provider can also specify the diagnosis code by clicking on the 'Previous Dx' or 'Add' button. In addition, Provider can also specify a procedure by clicking 'Add' under procedures (optional).
5. Attachments such as the Progress Note, lab/DI results, etc. can be attached using the 'Attachments' button.
6. If the provider wants to add notes or special instructions, click on the 'Notes' tab and enter the information.
7. Once completed, provider assigns the referral to the Nurse/Referral Coordinator. Nurse/Referral Coordinator can complete the referral process.

Users can see their assigned referrals in the 'R' Jelly Bean.



Allows user to search referrals by status.

Displays the assigned referral(s).

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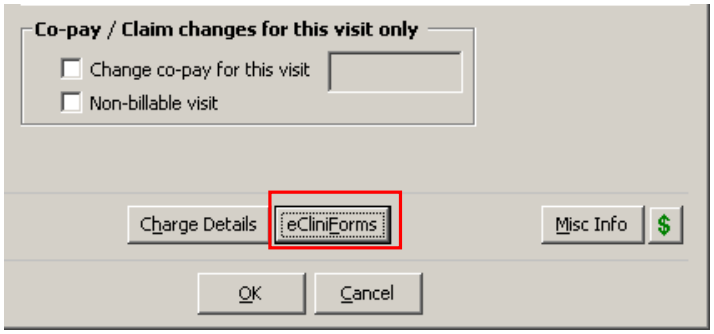
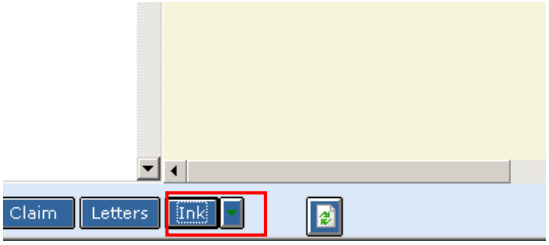
eCliniForm (Overview)

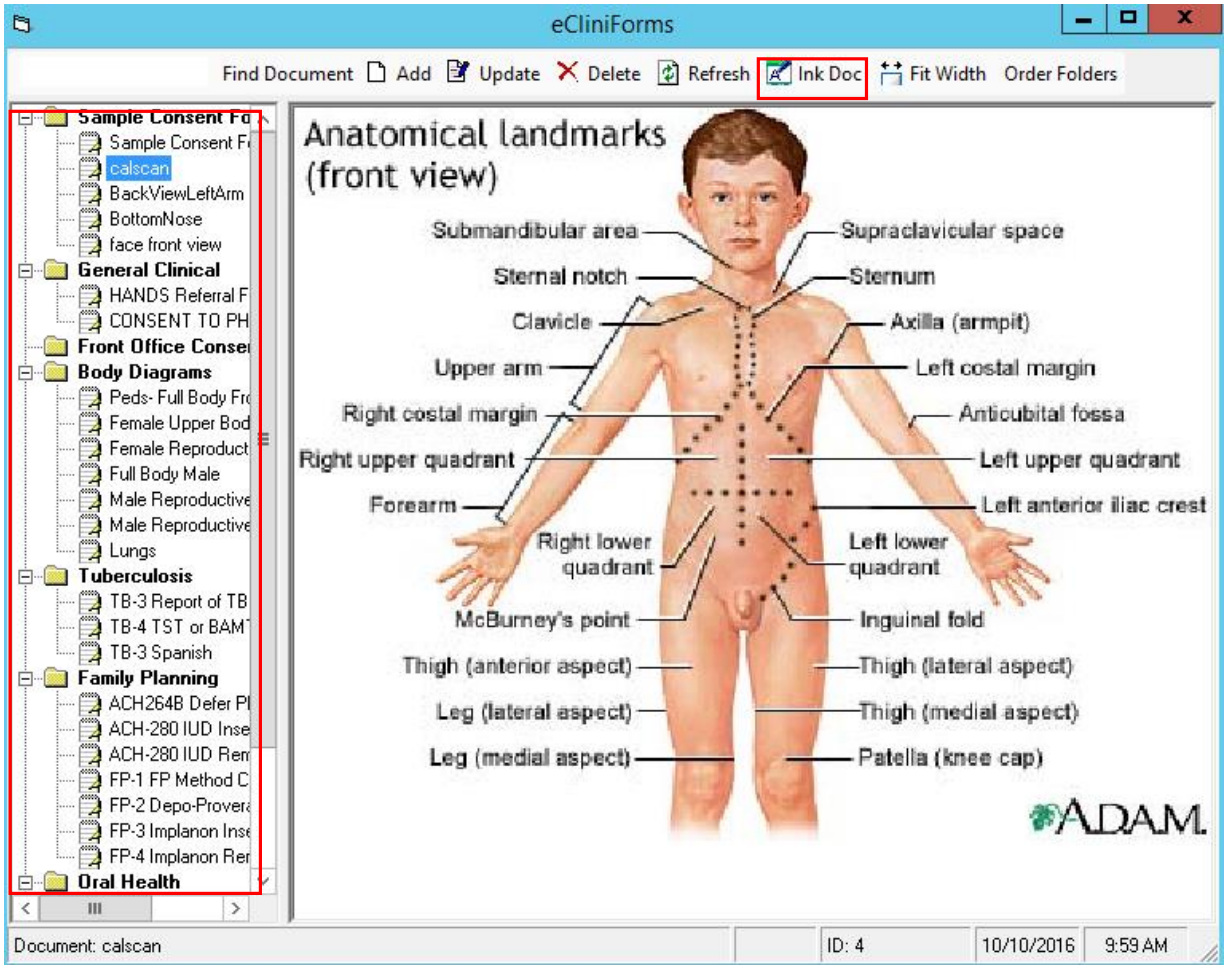
eCliniForms can be utilized with signature pads or iPads (if applicable).

Paper forms that providers/patients need to sign and are not available in the EMR system can be uploaded as 'eCliniForms'. eCliniForms can be accessed through the appointment window and the progress note (INK). eCliniForms can be 'Inked' using the Stylus from the tablet, the Signature Pad or finger using the iPad.

1. To use the eCliniForm from the appointment screen, click 'eCliniform', and from the progress note, click 'Ink' and select the desired eCliniForm from the list and click 'Ink Doc' button.







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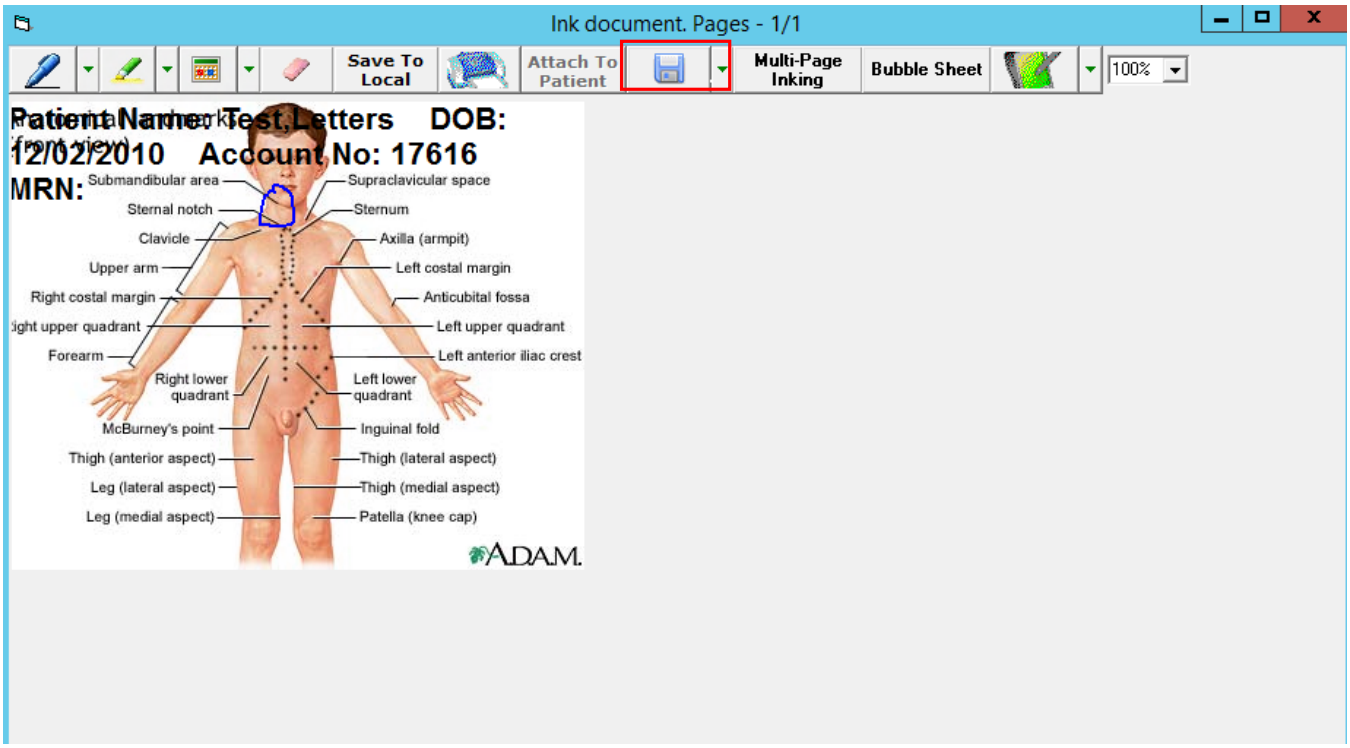
2. Once the document is loaded, provider/staff/patient can ink the document.
3. Once completed, provider/staff can save the document to the patient's chart by clicking on 'Disk' icon

.



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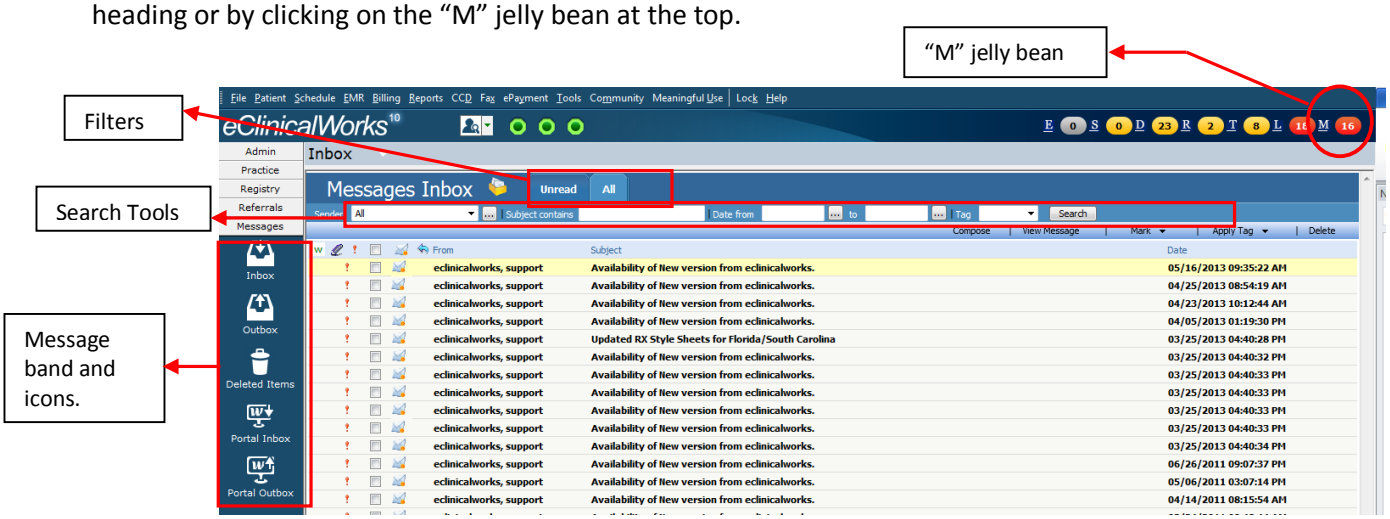
Messaging

The messaging feature in eClinicalWorks allows staff and providers to send and receive messages internally. Messages in eClinicalWorks can be accessed in two ways: from the navigation band under the "Messages" heading or by clicking on the "M" jelly bean at the top.



1. The messages band provides access to incoming messages, lets you send messages and provides a way to delete old messages.
2. The 'M' jelly bean can display different information that is useful to the user:
   a. The number displayed on the 'M' jelly bean corresponds to the number of unread messages in your inbox.
   b. Red 'M' jelly bean means that there is an 'emergent' message.
   c. Yellow 'M' jelly bean means that there is an 'urgent' message
   d. Gray 'M' jelly bean means that there is a 'routine' message.
3. Clicking on the 'M' letter will also give options to access the inbox or outbox.
4. The users can compose a new message by clicking on 'Compose' or 'Create New Message' button.
5. Unlike other jelly bean items attached to a patient (Telephone Encounters, Labs, Actions, etc.), messages are private between the sender and the recipient.

***NOTE**: This feature is not used for any clinical documentation for a patient. The clinical documentation regarding a patient needs to be done through a telephone encounter.*

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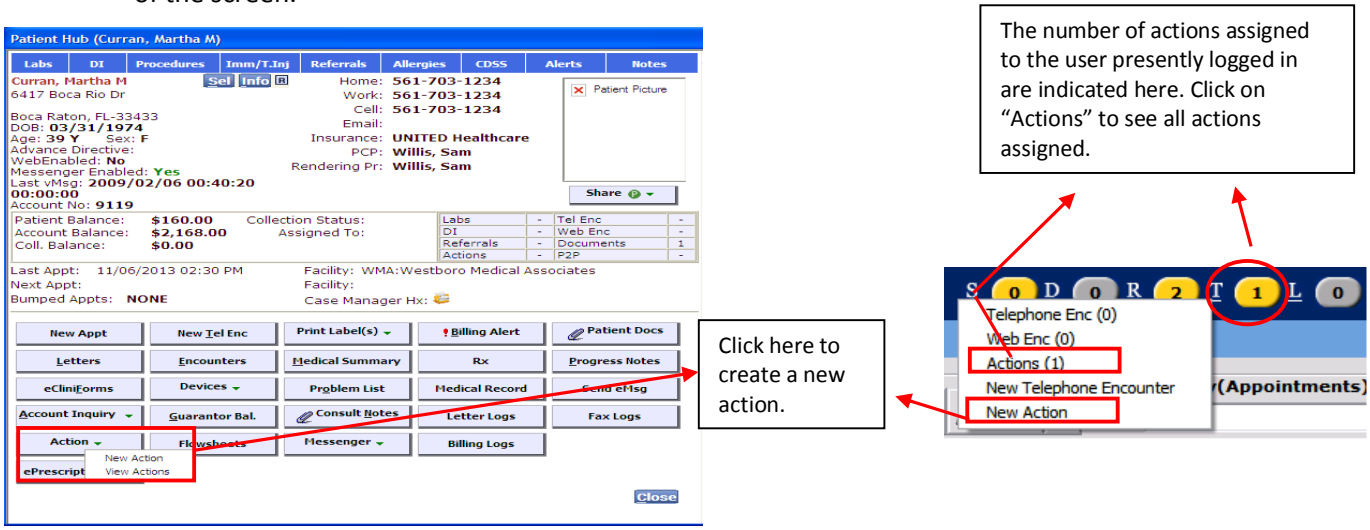
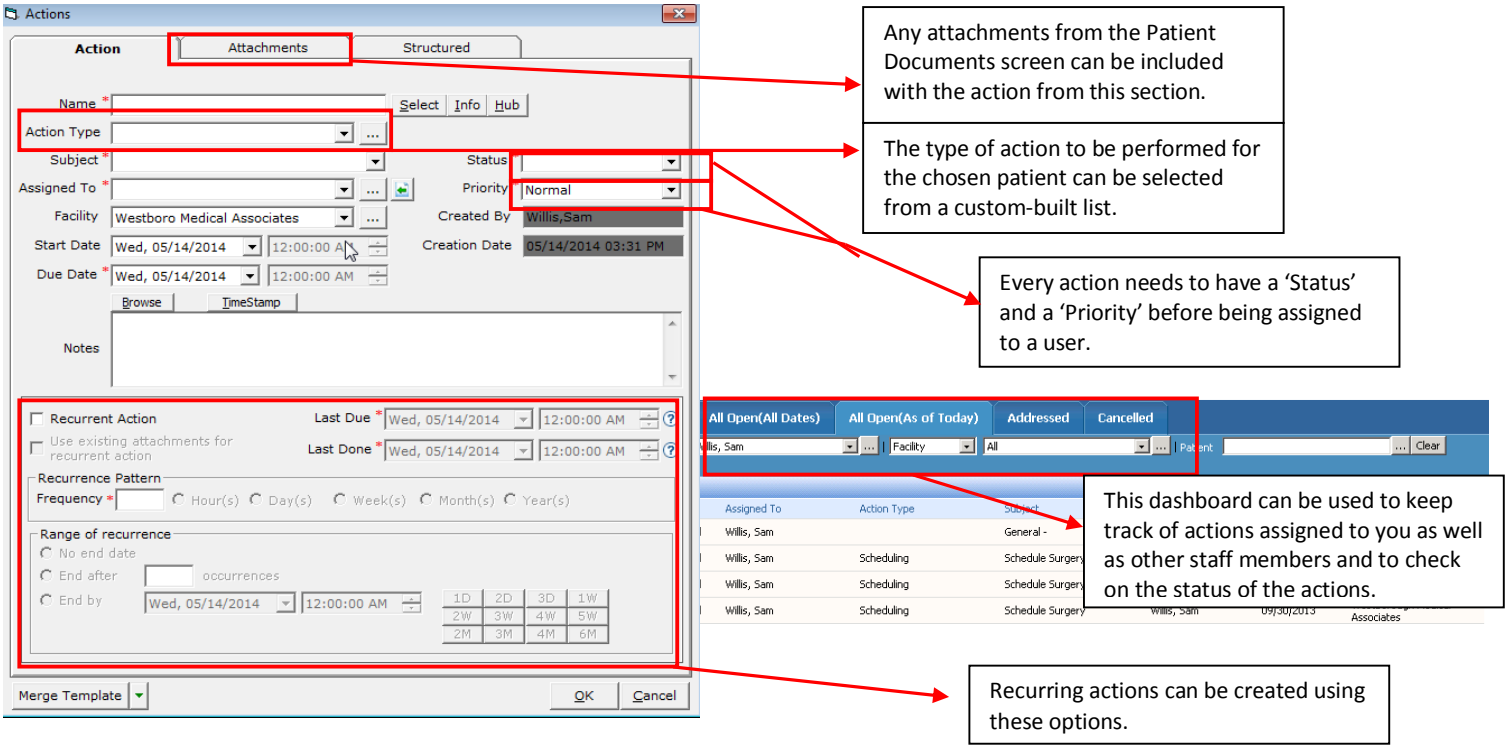
Actions

Creating and Assigning Actions to Staff Members

1. Actions can be created either from the patient Hub or by clicking on the letter 'T' on the top right corner of the screen.



2. Actions can be assigned to a respective staff member with messages, attachments, status codes, priority codes and can also be made to recur over a period of time.



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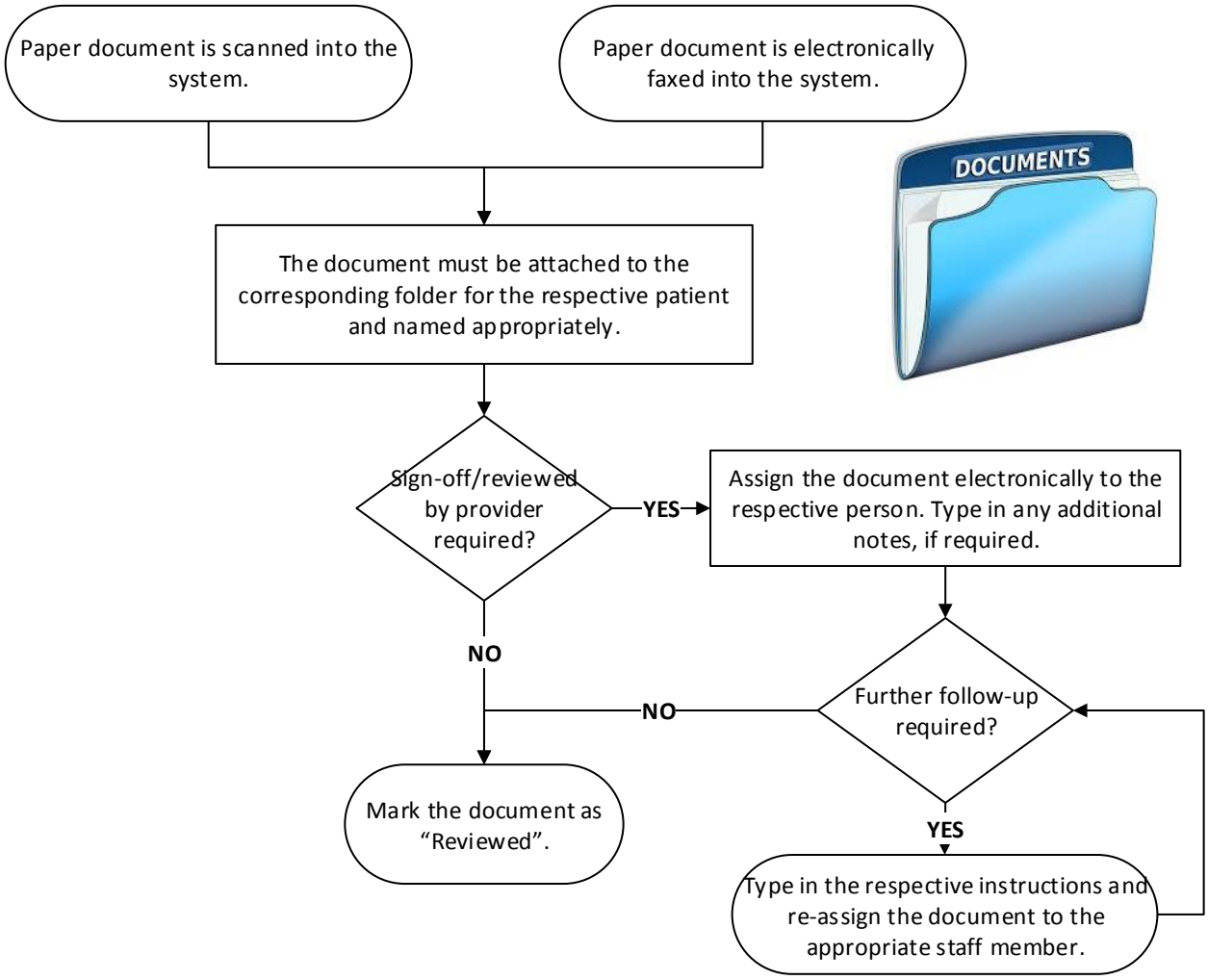
Document Management

The below workflow illustrates the management of documents that are scanned into the system and that are faxed into the system.



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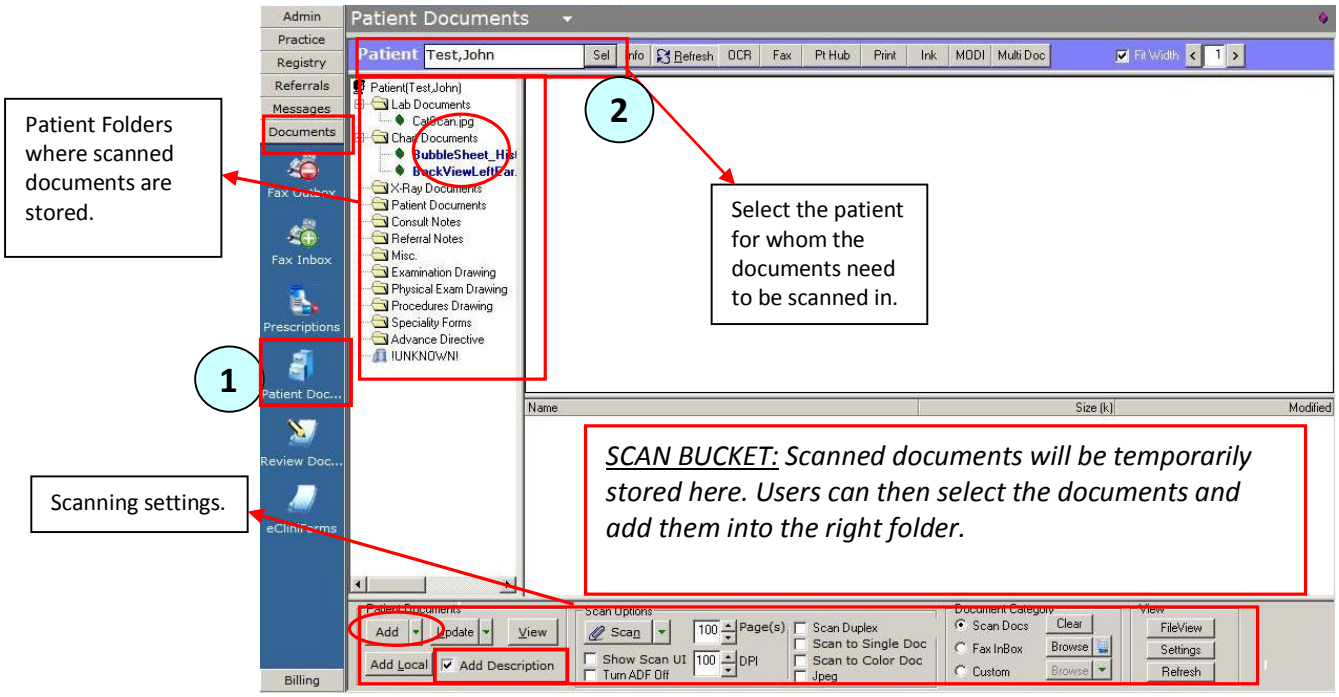
Scanning single - page and multi- page documents and adding them to a patient chart

1. The eClinicalWorks scanning module can be accessed by clicking on the "Patient Documents" icon under the "Documents" band in the left navigation panel or from the Patient Hub.



NOTE: *Prior to scanning in any documents, make sure the "Add Description" check box is checked off always.*

2. Select the appropriate patient by clicking on the "Sel" button on the top of the screen.

3. Feed the document into the scanner. The number of pages can be specified if necessary and then click on the 'Scan' button to scan the document and place it in the 'Scan Bucket' (see screenshot above).

4. The scanned documents can then be moved into the respective patient folder or sub-folder by following a simple 4-step process:
   a) Select the scanned document from the "Scan Bucket" section.
   b) Select the folder or sub-folder where it needs to be added.
   c) Check off add description to be able to rename your document.
   d) Click on the 'Add' button.

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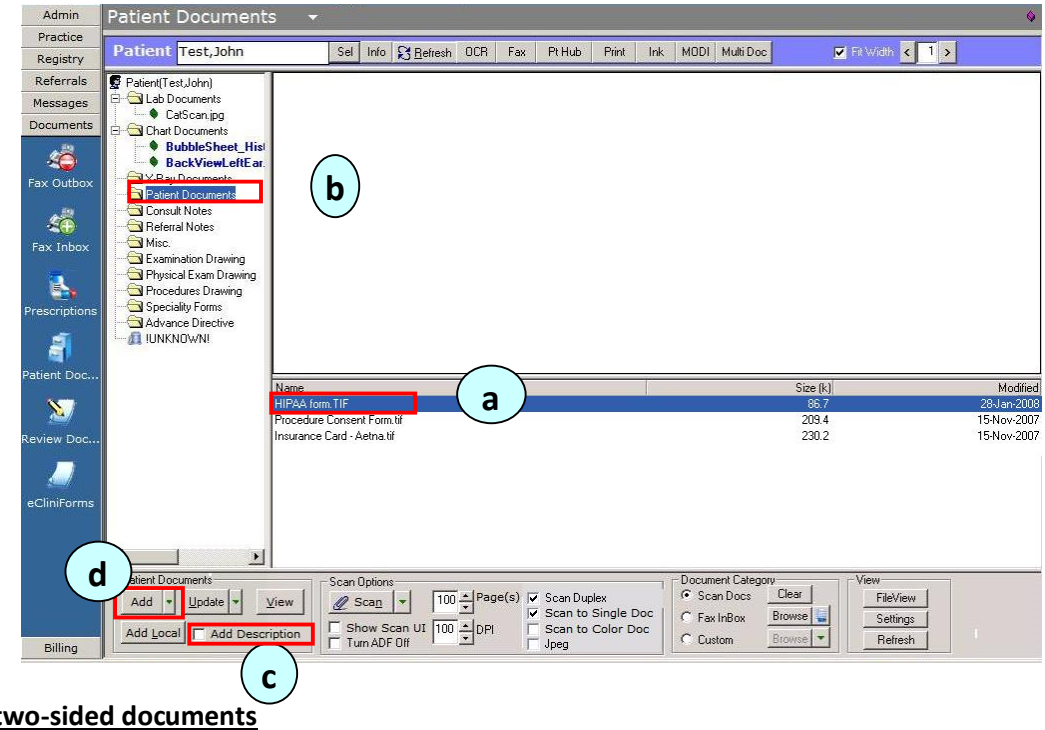
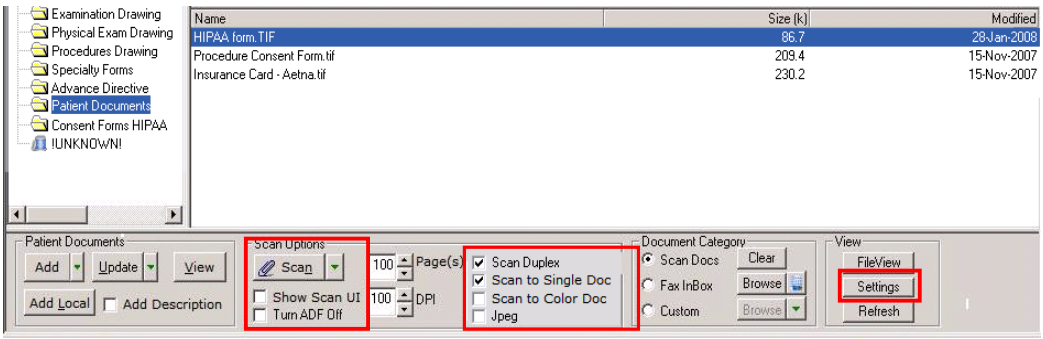


Scanning two-sided documents

5. Two-sided scanning can be done by checking off the **"Scan Duplex"** option prior to clicking on the 'Scan' button. Multi-page scanning can be accomplished by checking off the **"Scan to Single Doc"** option prior to clicking on the 'Scan' button.



Scanning color documents and changing scanning resolution

6. Color scanning can be done by checking off "scan to color doc" prior to clicking on the 'Scan' button.

7. Scanning in JPEG can be done by checking off "JPEG" prior to clicking on the scan button.

8. Scanning resolution can be changed by adjusting the DPI value. Default DPI and pages can be defaulted under settings.

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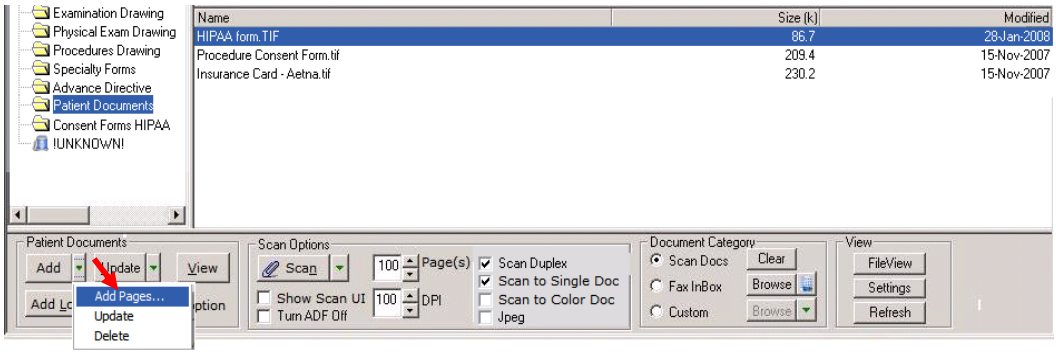
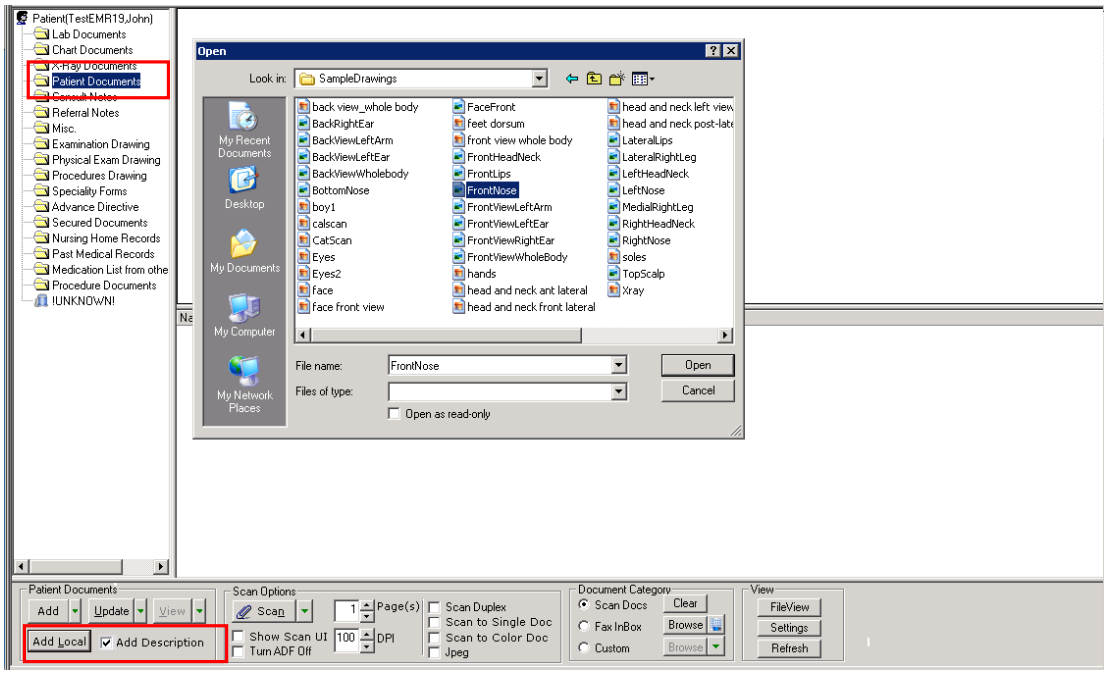
Adding certain pages to a patient chart

9. To add only certain pages from the scanned document to the patient's folders, click the green arrow next to the "Add" button and select "Add Pages". This is typically useful when a faxed document has to be added to the patient's folder without the cover sheet.



Adding a file locally from the computer

10. The **"Add Local"** button located right below the "Add" button can be used to add any 'local' files (i.e., files from your computer) in to one of the patient folders:
    (a) First select the folder where you want to add a 'local' document.
    (b) Then click on the **"Add Local"** button to search for and add the document (*Make sure add description is checked off).*



NOTE: *The recommended naming convention to be followed when adding scanned documents into the respective folders is to "YYYY/MM/DD; County; NameOfDocument". For example, if you are scanning a lab result that was received on the 1st of April, 2011, the scanned document should be named as '2011/04/01; CBC Result'. This recommended naming convention makes it easy to sort the documents in chronological order.*

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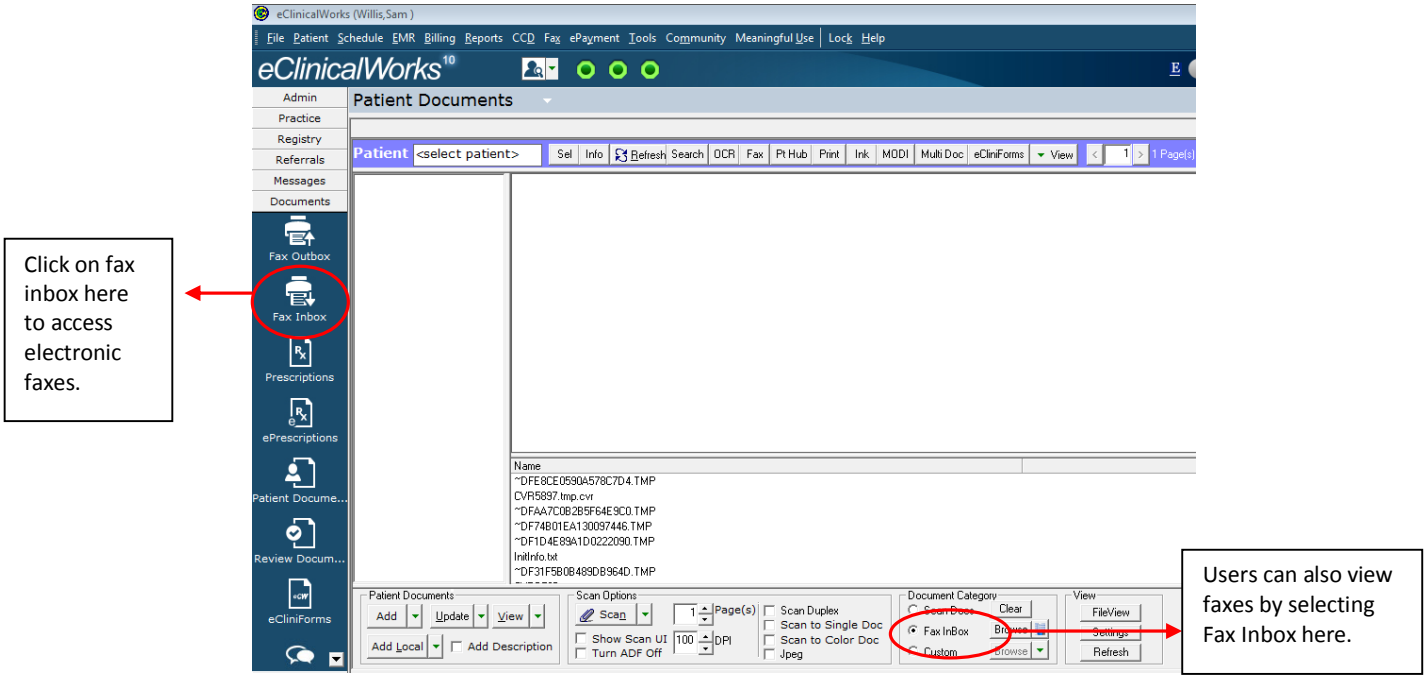
Electronic Faxing & eClinicalWorks

Incoming Faxes

As introduced in the previous section, eClinicalWorks includes a document management feature which allows external entities to fax the document directly into eClinicalWorks. The document then can be attached to the patient's electronic chart.

1. The Fax inbox can be accessed either by clicking on the "Fax Inbox" icon in the "Documents" band, by choosing the "Fax Inbox" option in the 'Patient Documents' screen or by clicking on the letter 'D' of the jelly bean.



2. Attaching received faxes into the respective patient's folder can be done by simply selecting the fax document, selecting the folder where it needs to be added and then clicking on the "Add" button (similar to the process followed for attaching scanned documents).

   Similarly, individual pages from the received fax can be added to a particular folder by using the "Add Pages" option, under the "Add" button (similar to Step 9 above).

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Outgoing Faxes

eClinicalWorks allows users to electronically fax documents from the application. Users can access the fax feature by clicking on the 'Fax' button from various sections of the application (Ex. Progress Notes, Patient Documents, Lab/DI Order, etc.). Once the document(s) is faxed out, users can monitor the status of the outgoing faxes through the 'Fax Outbox' screen.

1. The fax 'outbox' is where all the faxes that were sent out electronically from eClinicalWorks are listed. The fax outbox can be used to monitor the following information:

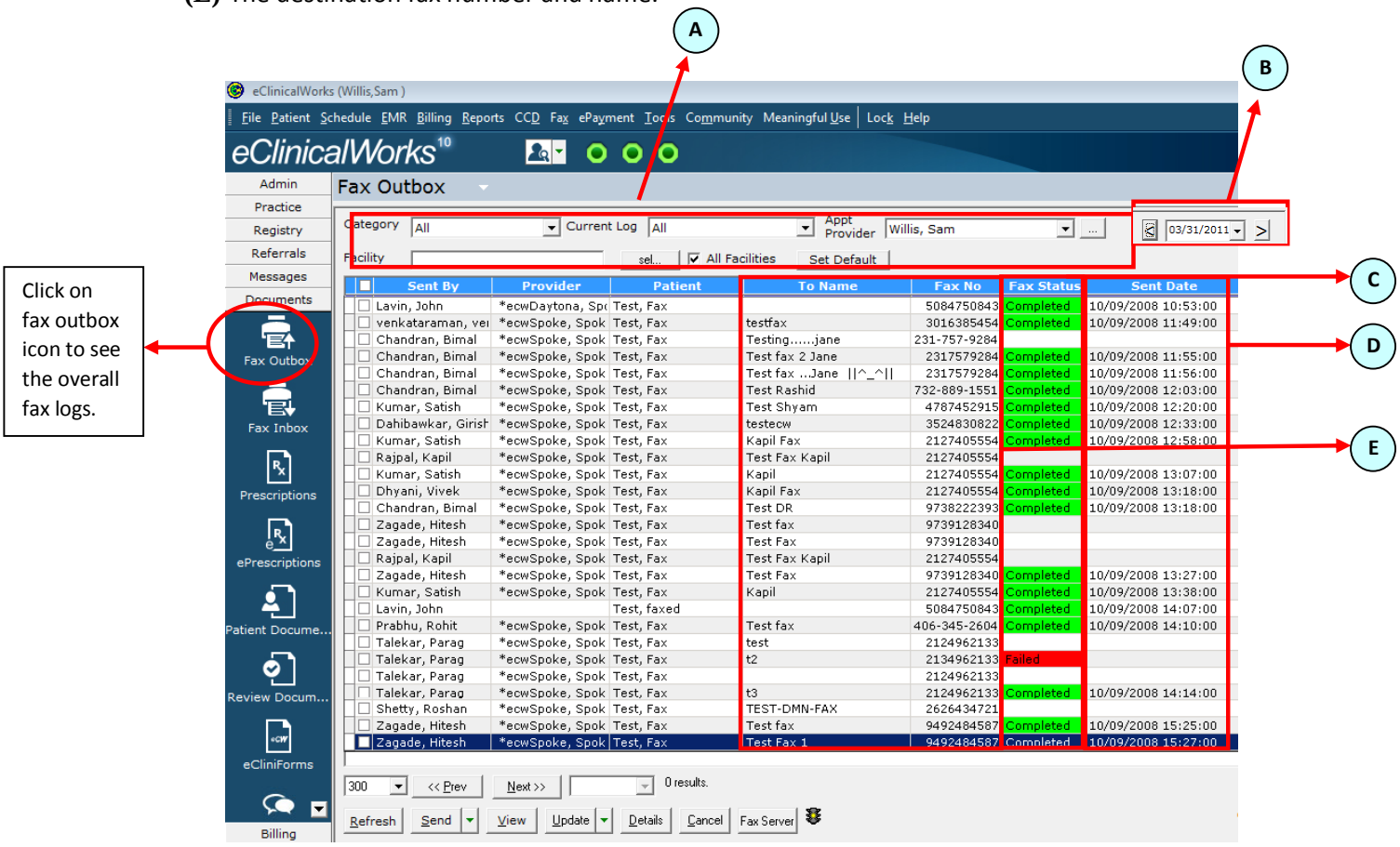
   (A) The number of faxes sent out by a user / provider / facility.

   (B) The number of faxes sent out by date.

   (C) The status of each fax that was sent out (completed/pending/failed).

   (D) The date and time when the fax was sent.

   (E) The destination fax number and name.



2. The individual patient fax logs can be viewed by clicking on the "Fax Logs" button from the patient's Hub.

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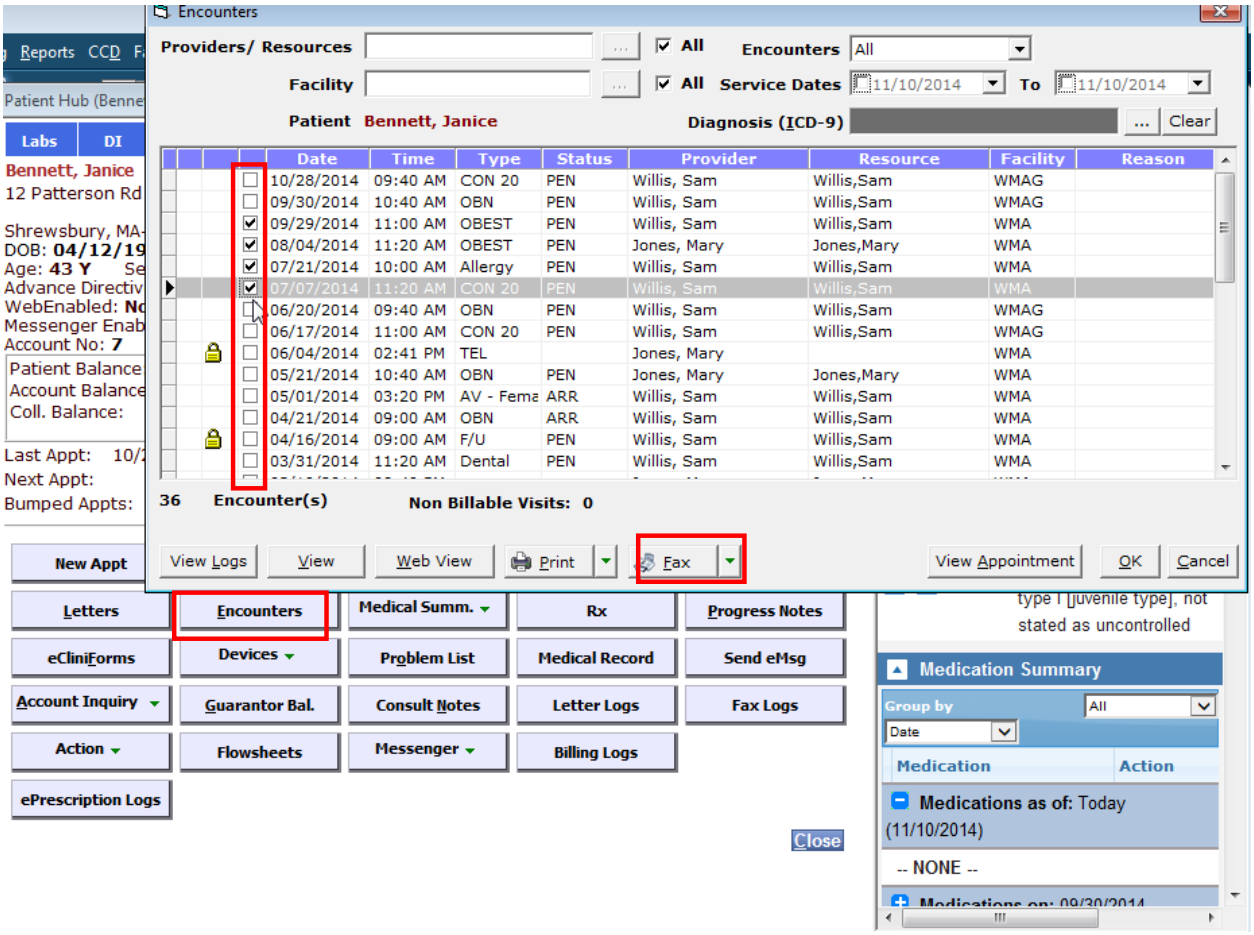
Faxing Multiple Documents from the Patient's Hub

To fax out multiple progress notes for a patient, go to the patient's Hub and then click on the "Encounters" button. Select all of the encounters whose progress notes you want to fax out and then click on the "Fax" button.



On the fax preview screen that opens up, select / enter the respective fax number and then click on the "Send Fax" button.

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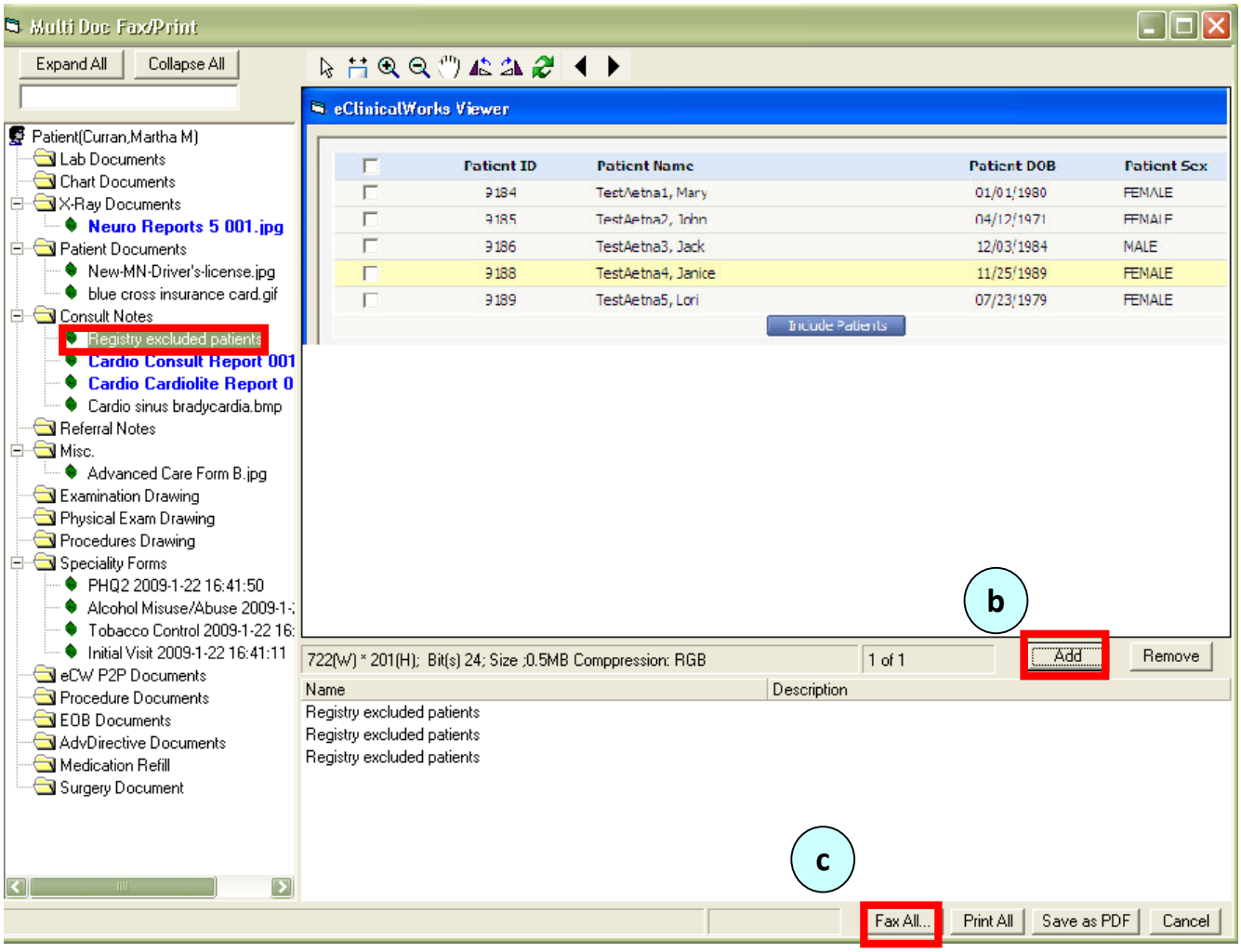
Faxing Multiple Documents from the Patient's Documents Window

To fax out multiple faxed/scanned documents from the patient's documents window:

a) In the patient's Documents window, click on the "Multi Doc" button at the top of the screen.

b) One by one, select the documents that need to be faxed out and then click the "Add" button.

c) When finished selecting all of the documents, click on the "Fax All" button to fax the documents out.



d) Enter/select the destination in the appropriate field (i.e. name of the recipient, destination fax number, etc.)

e) Click "Send Fax".

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Fax Document Preview

To
Name: Willis, Sam
Fax: – 561-555-1515
CC:
Subject: Patient Document
Company:

d

From
Name: Willis,Sam
Provider (Rendering): Sam Willis
Voice #: 561-555-1212
Company: Westborough Medical Associates
Facility: Westborough Medical Associ Browse...

eClinicalWorks Viewer

Patient ID	Patient Name	Patient DOB	Patient Sex
9184	TestAetna1, Mary	01/01/1980	FEMALE
9185	TestAetna2, John	04/12/1971	FEMALE
9186	TestAetna3, Jack	12/03/1984	MALE
9188	TestAetna4, Janice	11/25/1989	FEMALE
9189	TestAetna5, Lori	07/23/1979	FEMALE

Include Patients

Schedule

e

Send Fax Cancel Invert

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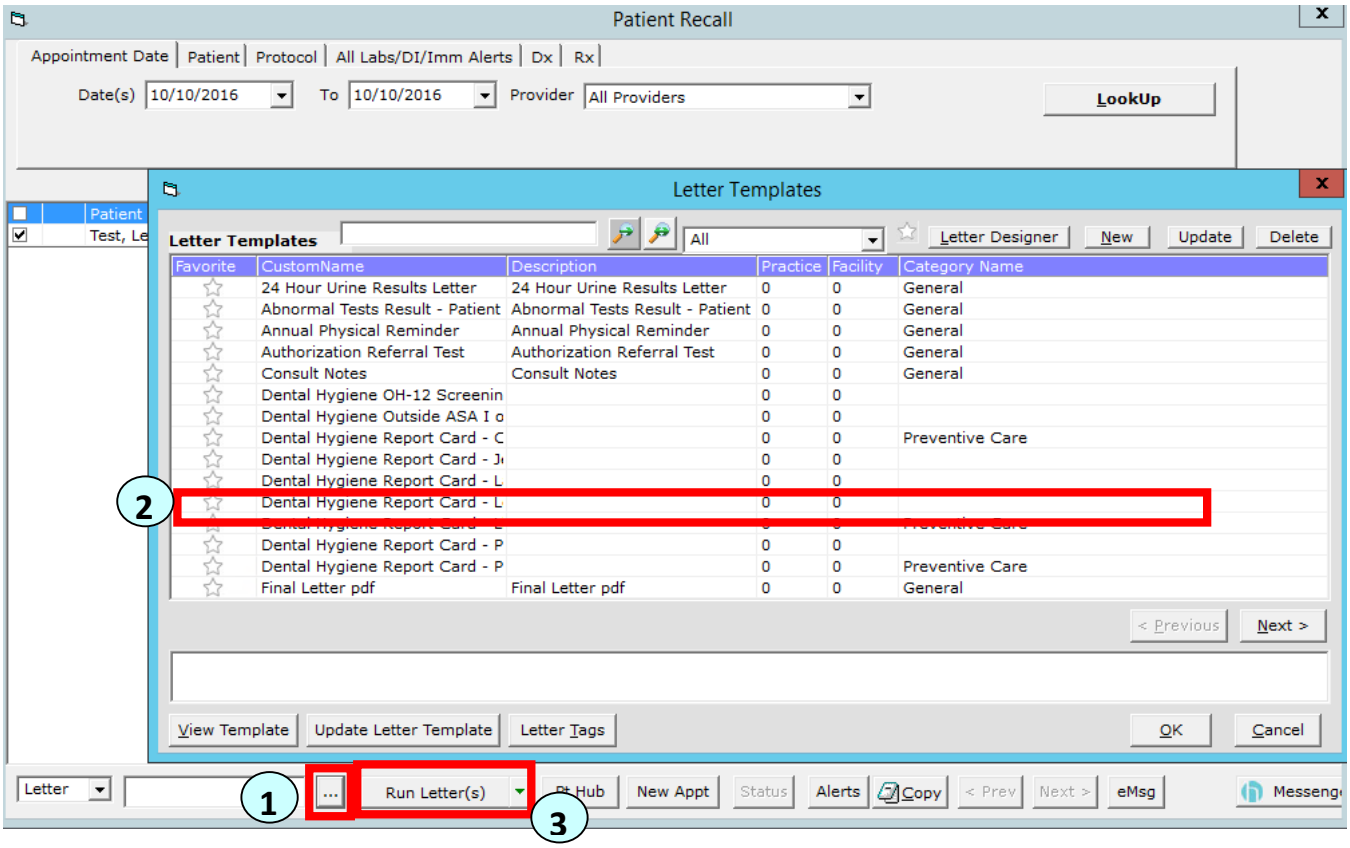
Letters

Generating and Printing Letters for an Individual Patient

Letter templates for commonly generated patient-specific letters can be set up as Microsoft® Word documents in eClinicalWorks. Once these letter templates are set up they can be printed for an individual patient by clicking on the "Letters" button from the patient's Hub or clicking on "Letters" from the patient's progress note and then following three simple steps as outlined below:

1. Click on the "Letter" […] button at the bottom left of the screen
2. Choose the letter template that has to be printed out for the patient.
3. Click on the "Run Letters" button to generate the letter for the patient as a Microsoft® Word document that can be printed out as required.



NOTE: *All letters have been created using tags that work from the progress note.*

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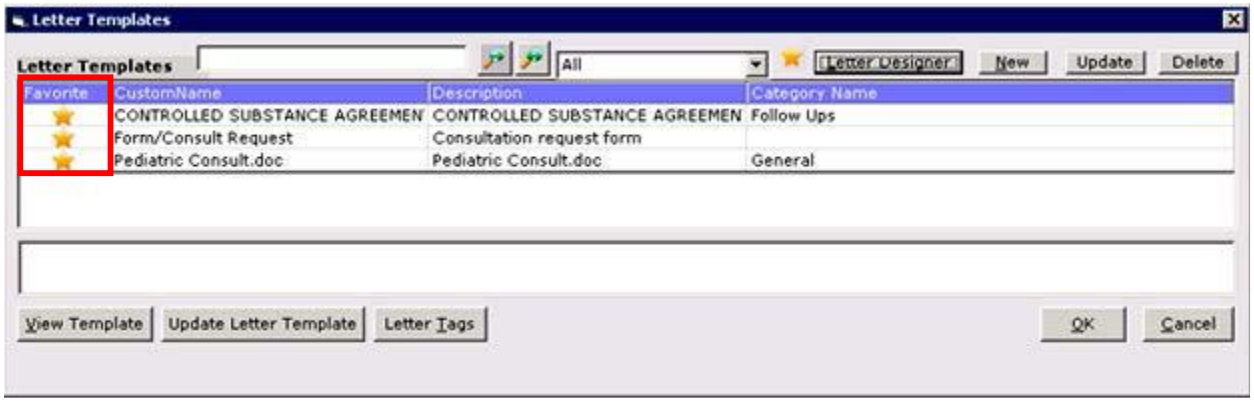
User Favorite Letters

Adding Letters as User Favorites

User can mark preferred letters as favorites.

To add letters as user favorite:

1. Open Letters window from Patient Recall window.
2. Click the Star icon located to the left of the letter name.

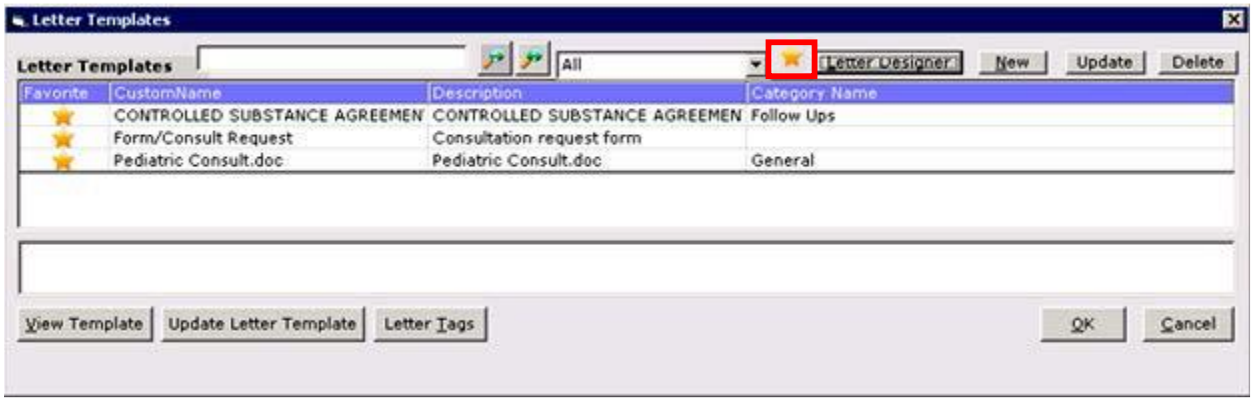


NOTE: *The template is marked as the logged-in user favorite.*

Displaying the User Favorite Letters

To display the user's favorite letters:

1. Open the Letter window from Patient Recall window.
2. Click the Star icon located above the list of letters:



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Removing Letters from User Favorites

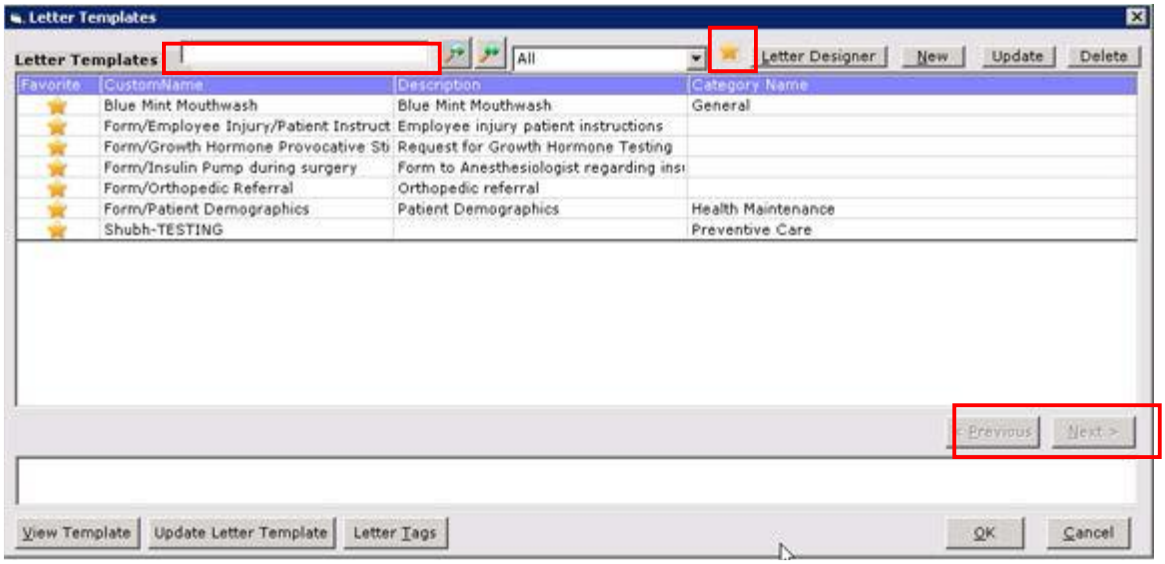
To remove letters from user favorite:

1. Open the Letters window from Patient Recall window.
2. Click the Star icon located above the list of letters. The list of the user's favorite letters displays.
3. Click the Star icon located to the left of the letter name to be removed from favorites. The letter is removed from the list of favorites.

Search Letters

The following enhancements have been made to the Letters:

- Previous and Next buttons have been added to the Letters window. Click these buttons to navigate to previous and next pages, respectively.
- By default, favorite letters display in the Letters window. To view all letters, click the yellow star icon.
- The Search field can be used to search among all letters and not just the favorite letters that display by default in the Letters window:



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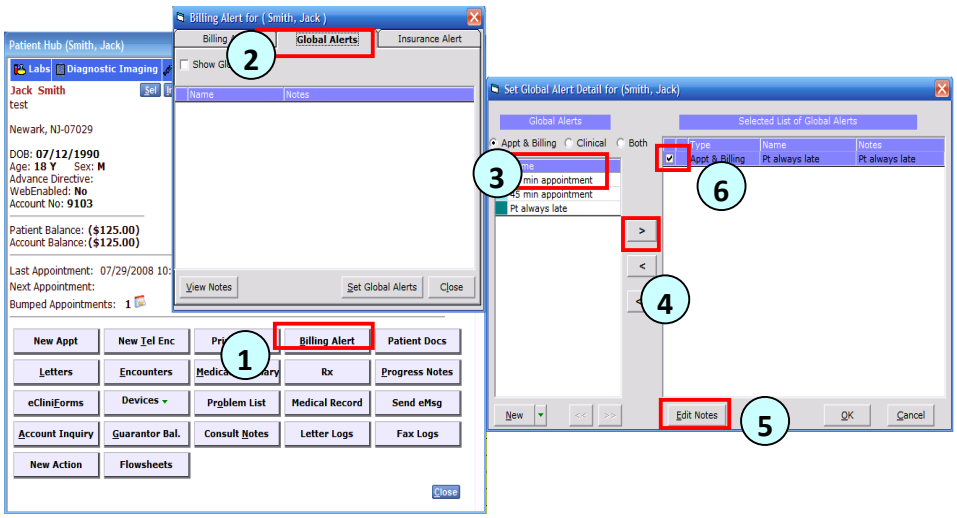
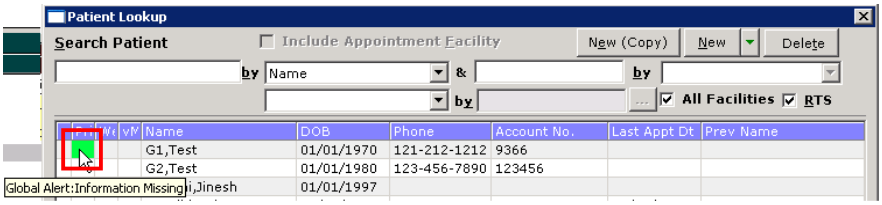
Patient Specific Alerts/Recalls

Global Alerts

Global Alerts can be set from the patient Hub, by clicking on the "Billing Alert" button. These alerts pop-up whenever the patient is selected from the Lookup screen or when an appointment is modified for that patient. The following steps have to be followed to set these alerts for a particular patient.



1. Click on the "Billing Alert" button in the respective patient's Hub.
2. Click on the "Global Alerts" tab and then click on the "Set Global Alerts" button.
3. Choose the type of alert that needs to be set.
4. Select the alert that needs to be set, from the list and click on the ">" button. This applies the selected alert and its respective color code to the patient.
5. Click on 'Edit notes' to add additional details in the notes section of each corresponding alert.
6. For this alert to pop-up, check the check-box on the left-hand side corresponding to the alert set. Finally, click on the "Ok" button when you are done and close out of the patient Hub.
7. Once the global alert is set, it will show up in two places:
   (a) The corresponding color code that will show up next to the patient's name in the 'Lookup' screen. If you move your mouse pointer over the color code, you can see the description of that alert.



   (b) The alert will pop-up whenever you try to schedule an appointment for the patient.

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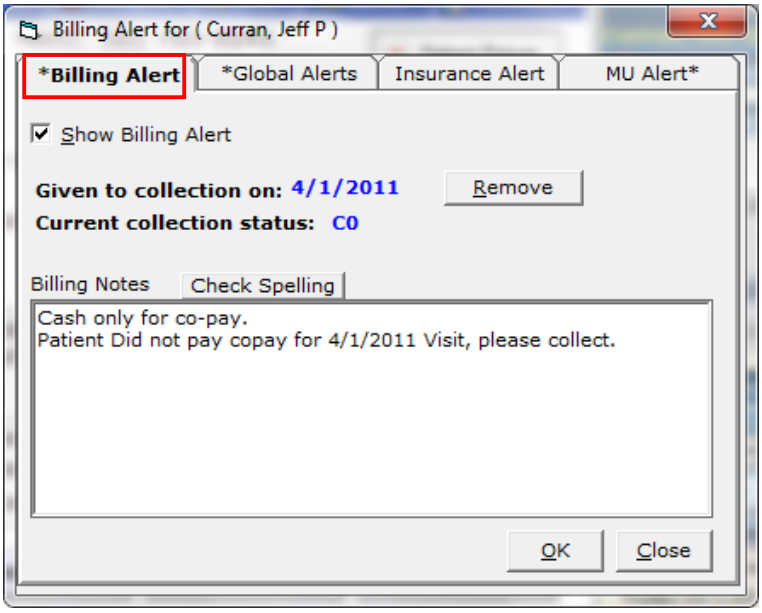
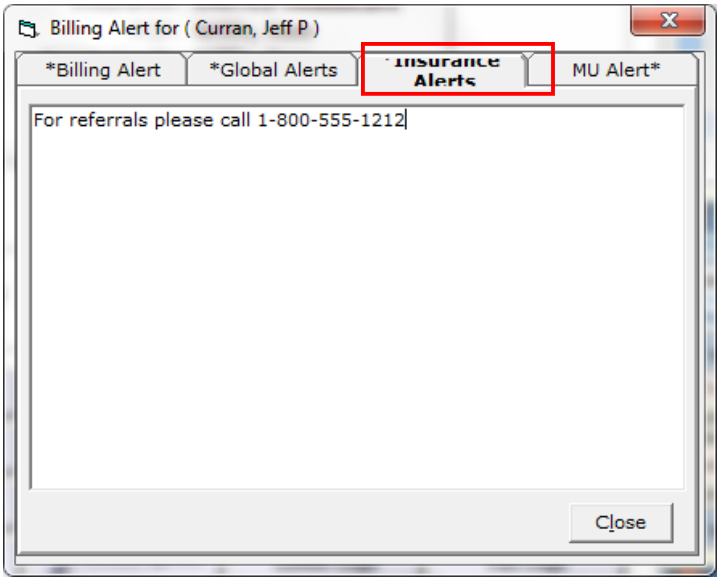
Billing Alert

Billing Alert allows the Biller to add a Billing Note to the patient's account. The note is accessible by the Front Office staff the same way as they would access the Global Alert.



Insurance Alert

Insurance Alert allows the Billing Department to broadcast a message for that particular insurance. It is accessed the same way as the Global and Billing Alert.



*** indicates that there is (an) alert setup.**

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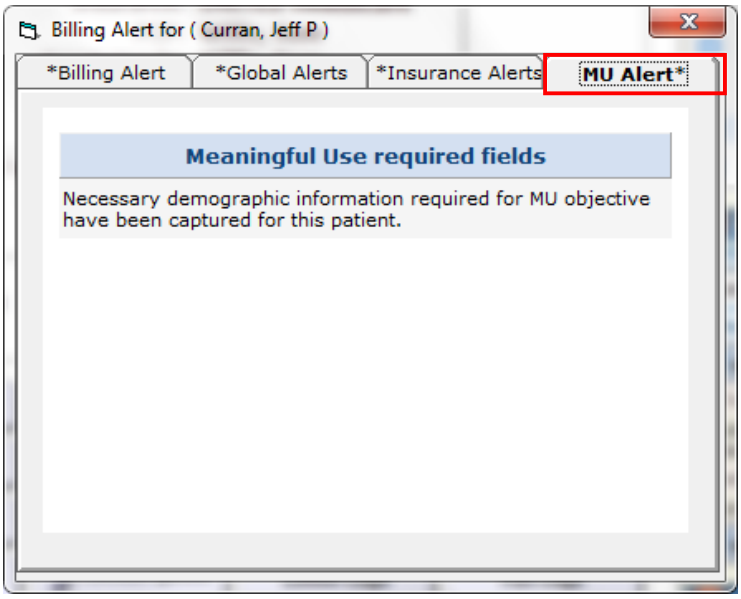
MU (Meaningful Use) Alert

Meaningful Use Alert will pop up if the MU required information is not captured in the patient's demographics.

This includes Race, Ethnicity, Preferred Language, and E-Mail (For Patient Portal).



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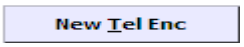
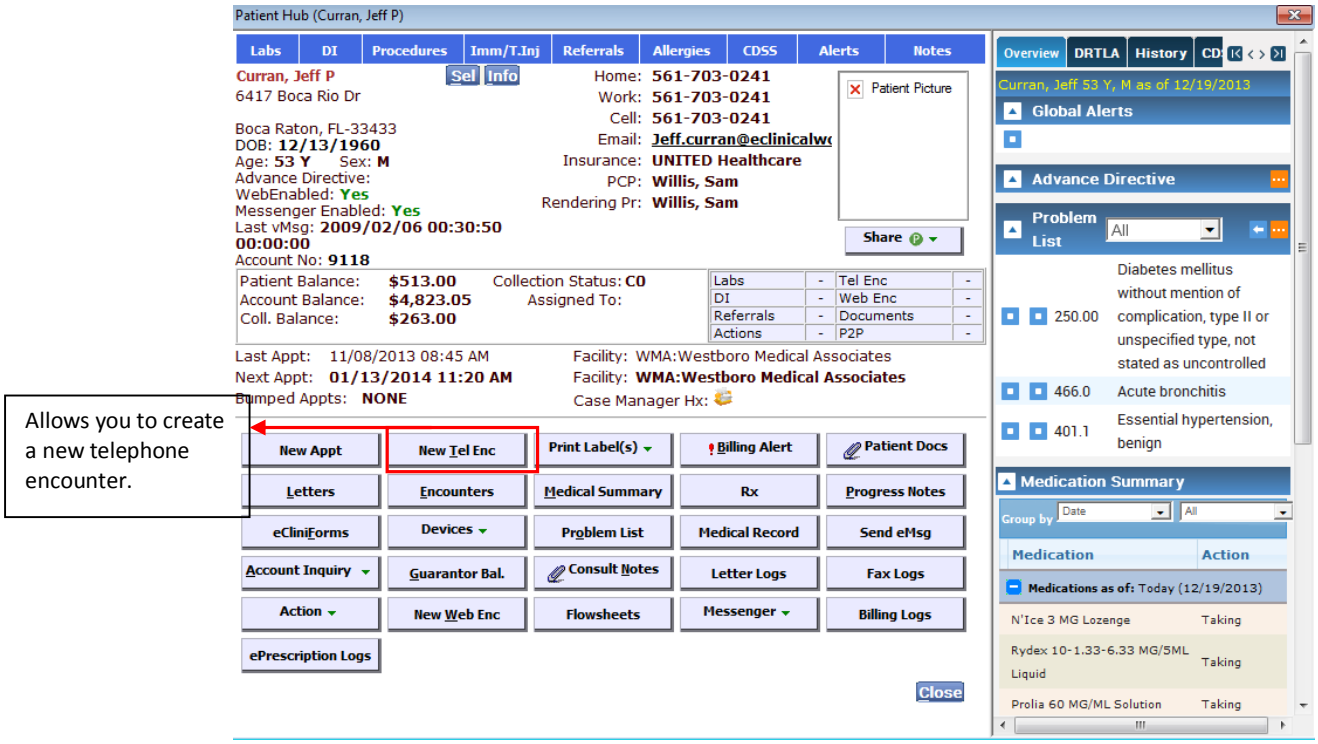
Telephone Encounters

Overview of Creating Telephone Encounters

Providers and staff can document telephone conversations he/she had with the patient using the telephone encounter feature. Once documented, the telephone encounter can be assigned to different staff members in the clinic for further action if needed. (Telephone Encounter Examples: medication refill request, message for the provider, lab result request, etc.).

Telephone encounters can be created in several different ways. The easiest recommended way is to create it by clicking on the "New Tel Enc" button 

in the patient 'hub'.



Allows you to create a new telephone encounter.

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Telephone Encounter *

1 Answered by: Willis, Sam | Date: 12/19/2013 | Time: 11:59 AM | High Priority 8

2 Patient: Sel | Info | Hub
Curran, Jeff P
DOB:12/13/1960 Age:53Y Sex:M
Tel:561-703-0241
Acct No:9118, WebEnabled: Yes
Elgb Status:

Provider: Willis, Sam
Pharmacy: Publix (P)
63 Lyman St
Boca Raton, FL 33433
Tel:561-213-3421 Fax:561-432-5555

Status 9: Open | Addressed | Addressed and Docs Reviewed

3 Caller: Jeff
Facility: Westboro Medical Associates

4 Reason: Needs call back from MD
AssignedTo 7: Willis, Sam

Perform Eligibility Check

Message | Rx | Labs/DI | Notes | Addendum | Log History | Virtual Visit

5 Message: Complaints | Browse | Check Spelling
Jeff call to discuss his symptoms with Dr. Willis. Please call patient back.

Action Taken 6: Messenger | Reply to patient | Time Stamp | Action Taken | Check Spelling
Willis,Sam 12/19/2013 12:01:45 PM > Call and spoke to Jeff.

Print Script | Send Rx | Print Report | Progress Notes | Document

OK | Cancel

1. The "answered by" field will be populated with the name of the person who creates the telephone encounter. The date and time are also automatically documented.
2. If the telephone encounter is created from the patient's hub, the patient's name and demographic details (including the provider name) will be populated automatically.
3. The name of the caller can be documented under the 'Caller' section. (Example; Mom, Wife, etc.).
4. The reason for the call can be chosen from the respective drop-down or also typed in.
5. The actual message can be typed in the "message" section.
6. The follow-up action taken for the issue can be documented in the respective section.
7. The telephone encounter thus created can be assigned to a provider or staff member appropriately.
8. For issue which requires immediate attention, staff can check off the 'High Priority' check box. This will trigger the Jellybean to turn 'Red'.
9. Once the issue is addressed or taken care of, the telephone encounter can be 'closed' by selecting the "Addressed" option.

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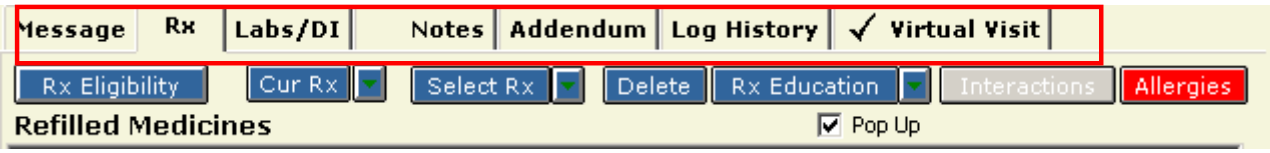
Different Tabs in the Telephone Encounter (Overview)

In addition to the message tab, the telephone encounter also comes with additional tabs where each tab's functionality is explained below:



'Rx' tab – Provides access to the patient's current medications, Rx history and allows providers to refill the selected medications.

'Labs/DI' tab – Provides access to the patient's Labs/DIs and the results.

'Notes' tab – Allows provider/staff to document additional notes.

'Addendum' tab – Allows provider/staff to add an addendum to the addressed (locked) telephone encounter.

'Log History' tab – Provides access to the history of the telephone encounter.

'Virtual Visit' tab – Provides access to the virtual progress note.

NOTE: *The telephone encounter is strongly recommended to document any phone messages which need to be a part of the patient's medical records, including, front office, clinical or billing related phone calls.*

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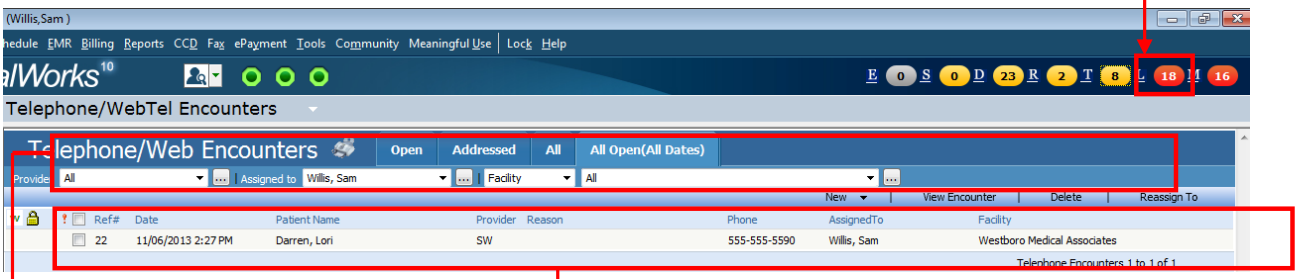
Looking Up the Assigned Telephone Encounters

The assigned telephone encounter will show up in the 'T' jelly bean (the number reflects the amount of telephone encounters that have been assigned to the user). The active (open) telephone encounters are found under the 'Open', 'All' and 'All Open (All Dates)' tab.

Allows you to see how many telephone encounters have been assigned to you.



Filters: Allows you to view desired telephone encounters.

Telephone encounter

If you are assigned a 'High Priority' telephone encounter, the 'T' jelly bean will turn red.

Once the telephone encounter is addressed, it is moved to the 'Addressed' tab.

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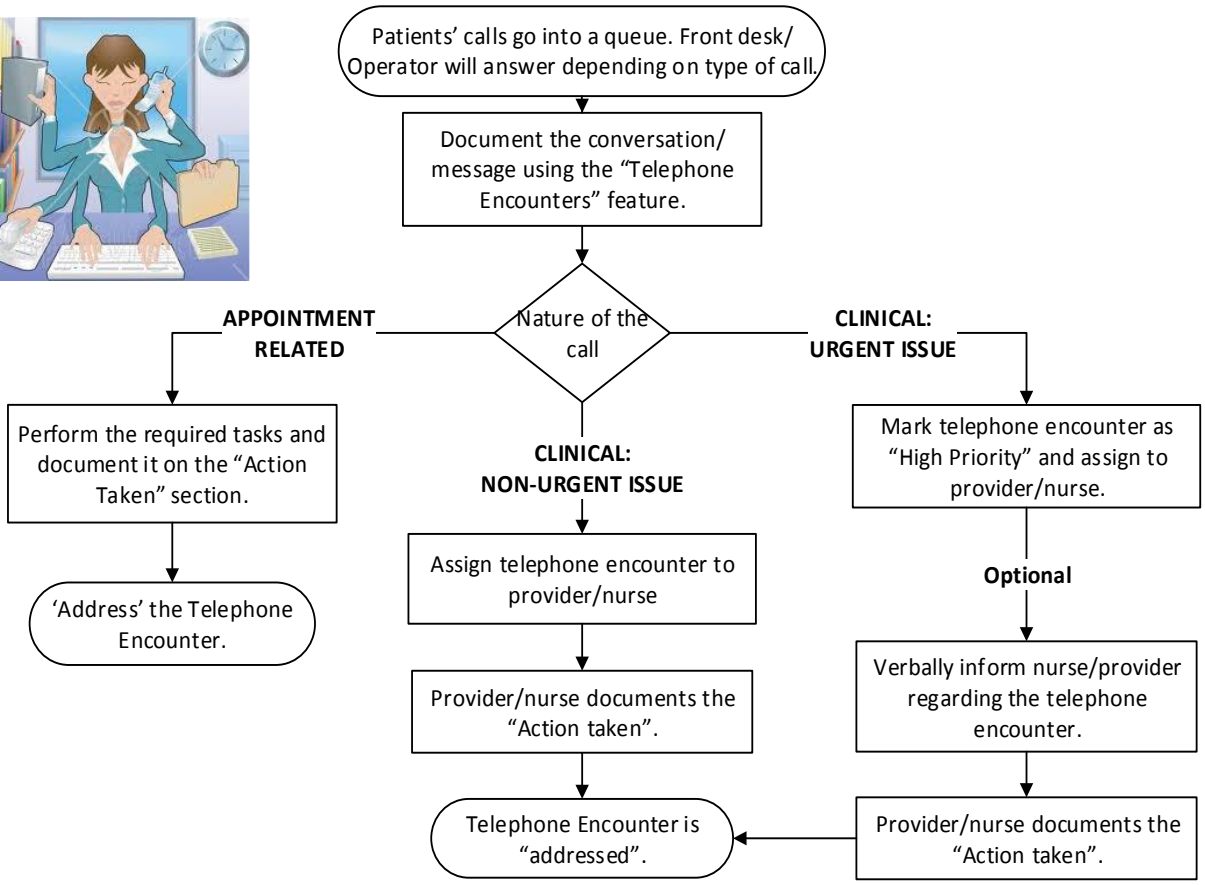
The recommended workflow to handle patient phone calls, relating to clinical and non-clinical calls is below:



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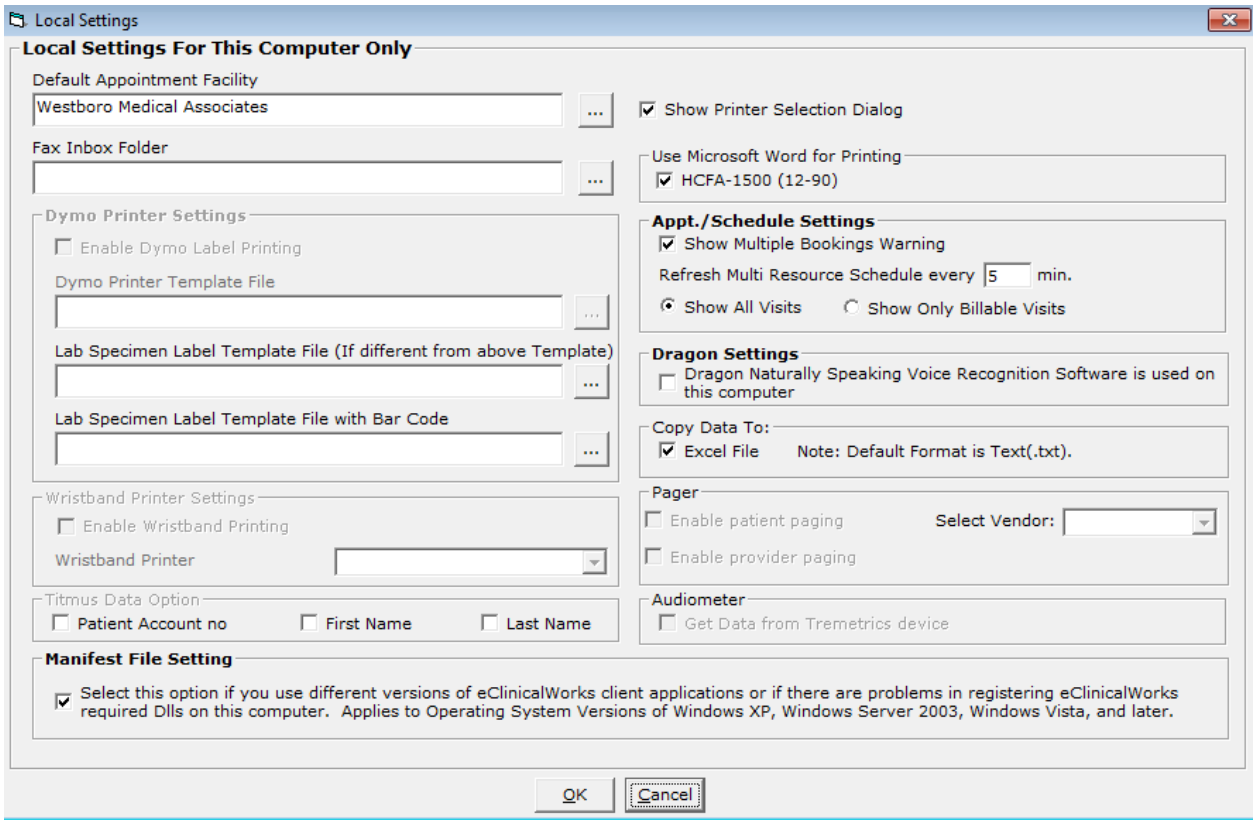
Profile Configuration

Local Settings

1. Local Settings allows users to customize the settings for each machine. The settings allow you to configure the default appointment facility, map the fax inbox folder to the eClinicalWorks application, show deleted appointments on the resource schedule, and export all data to excel.
2. To configure 'Local Settings', go to File>Settings>Local Settings.
3. The important setting for EMR implementation is 'Show Printer Selection Dialog', and 'Copy Data To Excel File'.



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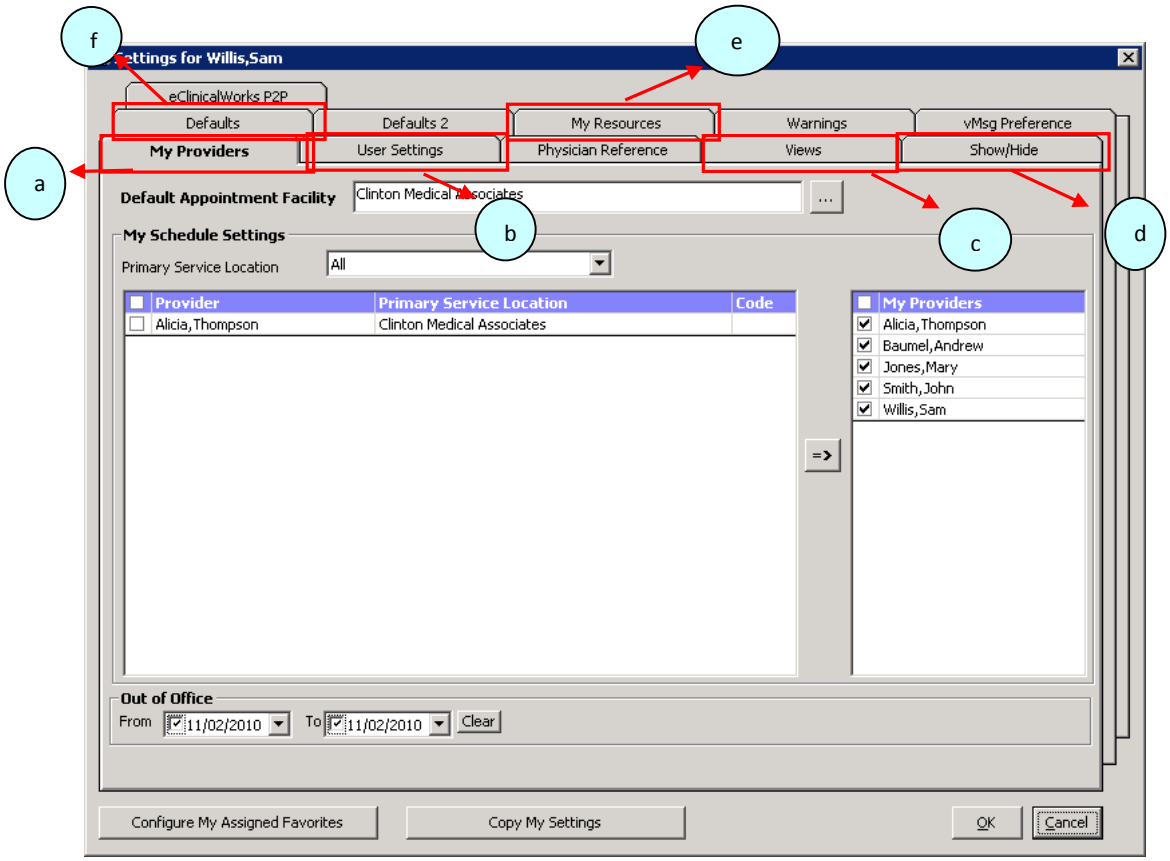
My Settings

1. My Settings allows users to customize system options for his/her profile.
2. To configure user settings, go to File> Settings> My Settings. The five important tabs under which the respective settings need to be configured are 'My Providers', 'User settings', 'Views', 'Show/ Hide' and 'My Resources', and 'Defaults' tabs.
3. Using the options under different tabs, the user will be able to:
    a. '***My Providers***' tab - Select the providers that the user works for/with, and his/her default location.
    b. '***User Settings***' tab – Enable/Disable system settings such as medication interaction, fax refresh rate, select desired home screen, etc.
    c. '***Views***' tab – Select desired view for the selected screen (modern view or classic view).
    d. '***Show/Hide***' tab – Show/Hide the selected options in each specified screen.
    e. '***My Resources***' tab – Select the resources that the user works for/with.
    f. '***Defaults***' tab – Select default options.



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Below are the recommended settings for each tab:

Settings for Crawford,Sheila

Defaults 2 | My Resources | Warnings | eClinicalWorks P2P

My Providers | **User Settings** | Physician Reference | Views | Show/Hide | Defaults

Pop up Drug Interaction Window when Interaction is	○ Severe ◉ Moderate ○ Mild ○ None
Provider/Resource Selection in Office Visits and Encounters Lookup	◉ Pick List ○ Drop-down
Enable Centralized Resource Scheduling (Facility Based)	○ Yes ◉ No
Apply My Facility to Filter Encounters	○ Yes ◉ No
ICD Association for the Procedure Codes Entered in EMR Billing	○ None ◉ One ○ All
Copy Treatment Notes for an Assessment in Carets	○ Yes ◉ No
Automatically get the Diagnosis in the Outgoing Referral	◉ Yes ○ No ☑ Use Practice Defaults
View eCliniForms Toolbar in Progress Notes	☐
Enable UpToDate in Progress Notes Right Panel	☐
Interval in Minutes to Refresh Fax Inbox	0 — 0 means disable automatic refresh
Latest Fax in Fax Inbox Arrives at	○ Top ◉ Bottom
Enable Signature Pad in Fax Preview Window	○ Yes ◉ No
Enable ServerXMLHTTP Object	○ Yes ◉ No
Popup instruction window when ordering Labs/Xrays/Procedures	◉ Yes ○ No
Load PickList by Facility	○ Yes ◉ No
Display style for Structured data elements in Progress Notes	New Line
My home screen	Resource Schedule
Default Right Panel	Templates
Automatically add previously associated assessment when Rx is continued or refilled from Right panel (Medication Summary Screen)	◉ Yes ○ No

Configure My Assigned Favorites | Copy My Settings | OK | Cancel

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Settings for Crawford,Sheila

Defaults 2 | My Resources | Warnings | eClinicalWorks P2P

My Providers | User Settings | Physician Reference | Views | Show/Hide | Defaults

Left Panel Icons	Modern View	Classic View			
Claims Lookup	Pmts/Refunds	Pmts/Adjust	Adjustments	Withheld	Transfer Days
Alerts	CDSS	Classic Alerts	Both		
Manage Rx	Modern View	Classic View			
Favorite Rx	Modern View	Classic View			
Rx Edit	Modern View	Classic View			
Patient Labs, DI and Procedure Hx	Modern View	Classic View			
Cumulative Lab Report	Modern View	Classic View			
Formulary Rx Screen	Modern View	Classic View			
Immunization and Flu Schedule	Modern View	Classic View			
Lab/DI/Procedure Order Screen	Modern View	Classic View			
Device DI Screen	Modern View	Classic View			

Progress Notes popup Screens
(Increase in Size by percentage)
0% 70%

Apply Medication Summary Modern View in
- Current Medications (Progress Notes)
- Current Medications (ManageRx - Modern View)
- Progress Notes Right Panel
- Rx History (Patient Hub)
- Telephone Encounter

Quick-Launch Buttons

P N E S D R T L M A C

P 17 N 10 E 22 S 23 D 45 R 36 T 96 L 13 M 51

Configure My Assigned Favorites | Copy My Settings | OK | Cancel

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Settings for Crawford,Sheila

Defaults 2 | My Resources | Warnings | eClinicalWorks P2P

My Providers | User Settings | Physician Reference | Views | **Show/Hide** | Defaults

Outlook Tree View	○ Show	◉ Hide
Handwritten Signature (Applies to Progress Notes printing, faxing, and locking)	◉ Show	○ Hide
Dispense, Duration, and Refill Info in Select Rx Screen for Standard Drugs	◉ Show	○ Hide
Progress Notes Top Panel	◉ Show	○ Hide
Progress Notes Right Panel	◉ Show	○ Hide
Patient Hub Chart Panel (Right Panel)	◉ Show	○ Hide
Providers Initials in Progress Notes - Visits Drop-down	◉ Show	○ Hide
Discontinued Drugs	○ Show	◉ Hide
Display Insurance Group at Line Item Level Payment Posting	◉ Show	○ Hide
Invalid CPT Codes	○ Show	◉ Hide
Dosage Information for Custom Drugs Linked to Drug Libraries	◉ Show	○ Hide
Single Button for Prescription Based on Patient's Default Pharmacy	◉ Show	○ Hide
Examination Categories (Tree)	◉ Show	○ Hide
CPT Copyright pop up when logging into the application	○ Show	◉ Hide
Custom dosages in Rx Edit Screen	◉ Show	○ Hide
Reconcile menu from Quick Launch Notification (L jelly bean)	○ Show	◉ Hide

Tabs to display in Progress Note Chart Panel*

☑ Overview | ☑ History | ☐ CDSS | ☐ Alerts | ☑ ★OS | ☐ Labs|DI | ☑ ★Templates

* Please note that a minimum of 2 tabs are required to be displayed in the right panel

Configure My Assigned Favorites | Copy My Settings | OK | Cancel

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Settings for Crawford,Sheila

Defaults 2 | My Resources | Warnings | eClinicalWorks P2P

My Providers | User Settings | Physician Reference | Views | Show/Hide | Defaults

Default Superbill	General
Default Lab Requisition Form	General
Default Imaging Requisition Form	General
Default UOM in Growth Charts	Standard
Default Style in Progress Notes	Bulleted
Default Signature Pad	Topaz
Default Timeout for Server Communication	0 **seconds (0 = default timeout)**
Default Progress Note Templates	(•) Generic ( ) Patient Specific
Default Number of Visits for Outgoing Referrals	0
Default Payment Method in Co-pay Screen	( ) Check (•) Credit Card ( ) Cash
Default New Patients Primary Service Location	
Default Option for View All Reports	By Visit
Default Screen for Lab/DI Review	(•) Reports ( ) View all reports (Unreviewed) **Sort By** Order Date

Default Lookup Options

	Lookup Option	Sort By Option	Output Format
Cumulative eReport:	Order Date	Order Date	Regular XSL
View All Reports - By Patient:	Order Date	Order Date	

Configure My Assigned Favorites | Copy My Settings | OK | Cancel

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Settings for Crawford,Sheila

My Providers | User Settings | Physician Reference | Views | Show/Hide | Defaults

Defaults 2 | My Resources | Warnings | eClinicalWorks P2P

Print Medical Record	(•) Modern	( ) Classic	
Choose Ink (* Requires .Net Framework 2.0 or Greater)	( ) Modern	( ) Classic	(•) Version 4
Default tab for acuties under vision examination	( ) Unaided Acuities	( ) Aided Acuities	
Default tab for Notes under Treatment Screen in Progress Notes	(•) Notes	( ) Clinical Notes	
Default Facility for ordering labs from virtual visits	[ ] Primary Service Location		
Expand Collapse of Treatment Notes	( ) Expand on Edit	( ) Expand Always	(•) Regular View
Expand Collapse of HPI Notes	( ) Expand on Edit	( ) Expand Always	(•) Regular View
Expand Collapse of Assessment Notes	( ) Expand on Edit	( ) Expand Always	(•) Regular View
Default View for Immunizations	(•) Imm/T.Inj Hx	( ) Imm Schedule	( ) Flu Schedule
Default for Drug Dosages Look up	(•) Standard	( ) My Favorites	( ) Both
Auto hide Top Panel and Right Panel in	[ ] Progress Notes	[x] Scribe	[x] Care Plan [x] OB Visit
'Done' for Print, Fax and Transmit (* Requires Practice Defaults setting to be enabled)	( ) Modern (Send)	(•) Classic	

Configure My Assigned Favorites | Copy My Settings | OK | Cancel

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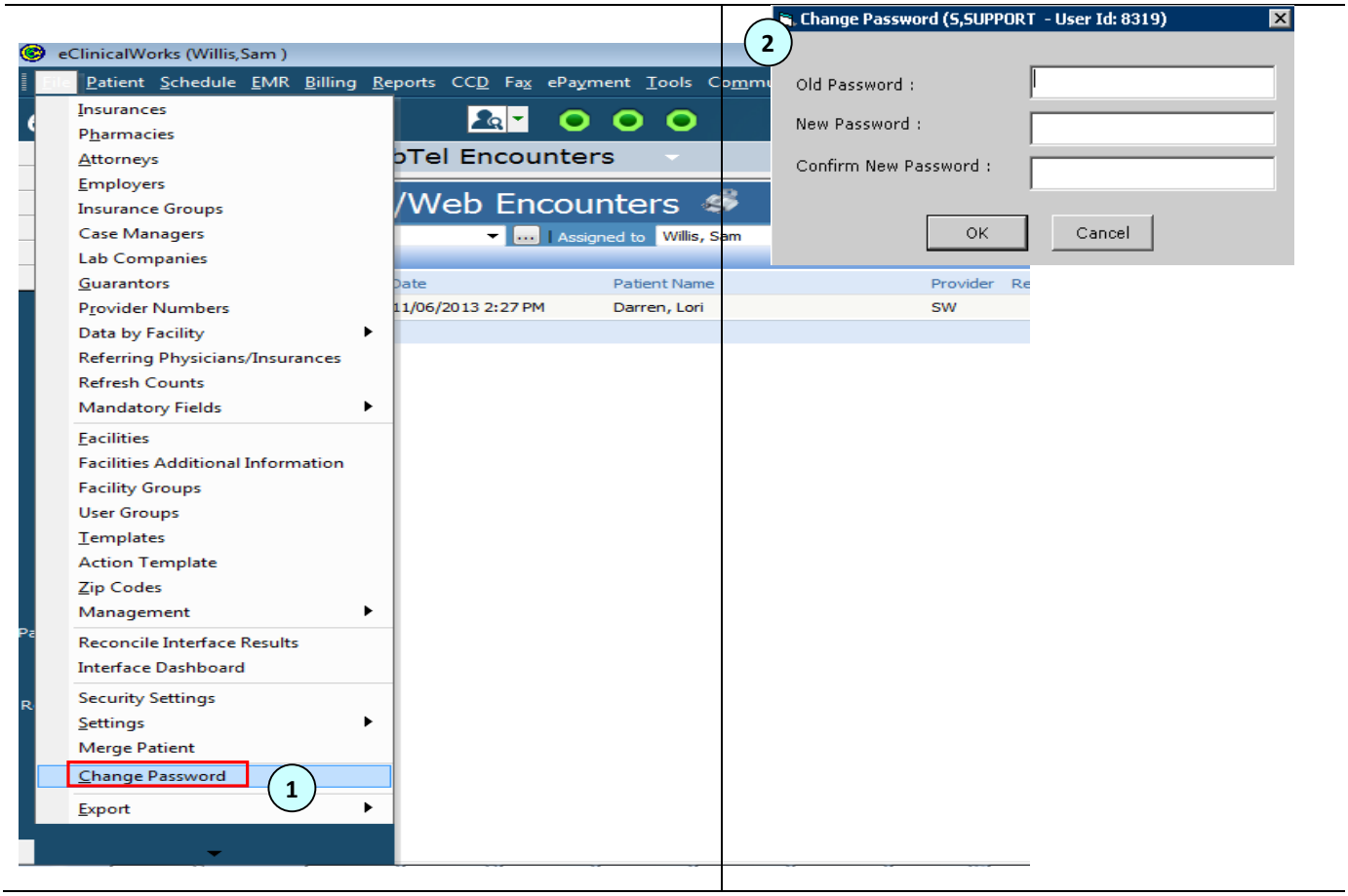
Change Password

1. To change your eClinicalWorks login password, go to File and select “Change Password.”
2. Enter old password, enter the new password (twice) and click “OK”.
3. Password guidelines recommended by COT are as follows:
    a. Alphanumeric.
    b. Minimum of 6 characters.
    c. Changed after 180 days.



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Appendix A: Notices

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