CareLogic Clinical Record User Guide Part 2

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Using the Document Library Module

The client-scanned Document Library module allows you to search and view service documents that are attached to any client ECR and upload additional documents. This module allows you to search a specific client ECR. The following file formats can be uploaded using the Document Library module: CSV, DOC, DOCX, JPG, PDF, RTF, TIF, TXT, XLS, and XLSX documents.

To access the document library module:

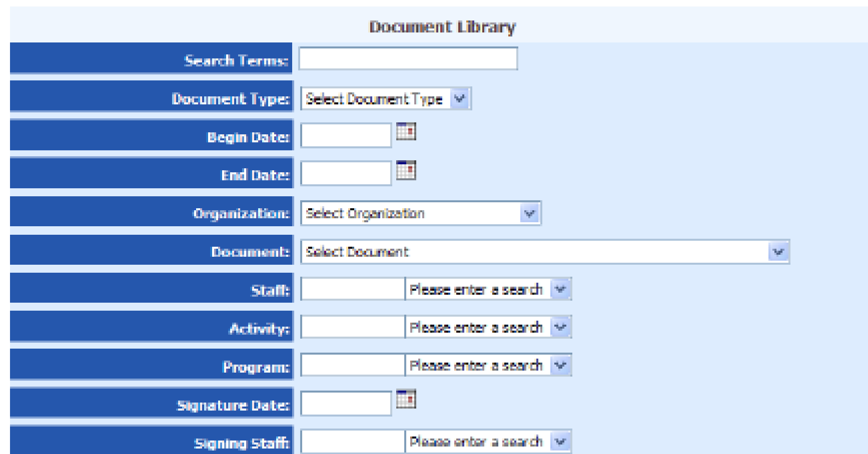
1 Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

Important: Selecting a client ECR limits your search results in the Document Library to the selected client. For organization-wide searches, do not access a specific client's ECR. For these searches, click **Client** in the navigation bar, but do not select a client ECR.

2 Click the Show Menu arrow in the shortcut bar and select **Document Library**.

The **Document Library** page appears.



3 In the **Search Terms** field, enter any identifying keywords associated with the service document you are searching for.

4 In the Document Type field, use the drop-down list to select the file type of the document you are searching for.

5 In the Begin Date field, enter the date the scanned service document becomes active. Your entry must be in the following format: mm/dd/yyyy. You can either manually enter a date or click the Calendar icon to select a date from the popup window.

6 If the scanned service document is to be active for a defined date range only, enter the end date in the End Date field. This is the last date the scanned service document can be used in the system. If the scanned service document is to remain active indefinitely, leave this field blank.

7 By default the document library searches all organizations you have access to with your current login, but if you want to limit the search to one organization, use the drop-down list to select the appropriate organization in the Organization field.

8 In the Document field, use the drop-down list to select a specific service document.

9 By default, the document library search considers all staff members who match the other search criteria. If you want to limit the search to a single staff member, use the Staff field to select the desired staff member. To select an individual staff member, enter the full or partial staff name in the text entry field, press Tab, and then use the drop-down list to select the desired staff member.

10 In the Activity field, use the drop-down list to select the appropriate activity to filter the search results to a specific activity.

11 In the Program field, use the drop-down list to select the appropriate program to filter the search results to a specific program.

12 If you want to search documents based on when they were signed in the system, enter the date you want to search signed documents for in the Signature Date field. Your entry must be in the following format: mm/dd/yyyy. You can either manually enter a date or click the Calendar icon to select a date from the popup window.

13 If you want to search documents based on which staff member signed them, use the Signing Staff field to select the desired staff member. To select an individual staff member, enter the full or partial staff name in the text entry field, press Tab, and then use the drop-down list to select the desired staff member.

14 Click Submit in the status bar.

The **Document Library** page refreshes, displaying the updated search results.

Maintaining Scanned Documents for Clients

The Document Library module allows you to add scanned documents as service document or just as scanned documents attached to the selected client's ECR.

You can only add scanned documents to a specific client ECR, so you must access the **Document Library** through a client ECR rather than organization-wide (see *Using the Document Library Module*).

This page is used to complete the following tasks:

- *Associating Scanned Documents with client ECRs*
- *Adding Scanned Service Documents to client ECRs*
- *Deleting Scanned Documents Associated with Client ECRs*
- *Deleting Scanned Service Documents from Client ECRs*

Associating Scanned Documents with client ECRs

This task includes instructions for associating a scanned document to a client ECR.

To associate scanned documents to client ECRs:

1 Access the **Document Library** page through a client ECR (see *Using the Document Library Module*).

2 Click **Add a Document** in the status bar.

The Scanned Document Information data entry page appears.

Scanned Document Information

Is this a Service Document?	Yes No
Date:	
Document Type:	Select Document Type
Document Name:	
Keywords:	Separate keywords with a comma
Document:	Browse...

3 By default, the response to the **Is this a Service Document?** field is set to **No**.

Note: Selecting **Yes** indicates you want to add a scanned document to the client ECR so that the scanned document will appear with all other service documents of the select service document type in the client ECR (see *Adding Scanned Service Documents to client ECRs*). The document will appear as fully signed, regardless of the signature requirements of the service document type.

4 In the Date field, enter the date at which the scanned document becomes active in the system. Your entry must be in the following format: mm/dd/yyyy. You can either manually enter a date or click the Calendar icon to select a date from the popup window.

5 In the **Document Type** field, use the drop-down list to select what kind of file you are uploading to the client ECR.

6 In the **Document Name** field, enter a name for the document to be saved in the system.

Note: Ensure you name the document clearly so it will be evident to all users in your organization who may access it.

7 In the **Keywords** field, enter any keywords that may be associated with the document you are uploading to the system.

Note: The **Document Library** allows you to search by keywords, so choose keywords applicable only to this document or document type for better search results.

8 In the **Document** field, click the **Browse** button to locate the file you want to upload to the client ECR. Select the desired file in the dialog window that appears and click **Open**. The file path to the desired document appears in the **Document** field.

9 Click **Submit** in the status bar.

The uploaded document is saved to the system and appears in the Document Library search results list page.

Adding Scanned Service Documents to client ECRs

This task includes instructions for adding a scanned document to a client ECR as a service document so that it displays with all other selected service document types in a client ECR.

To add scanned documents to client ECRs as service documents:

1 Access the **Document Library** page through a client ECR (see *Using the Document Library Module*).

2 Click **Add a Document** in the status bar.

The Scanned Document Information data entry page appears.

Scanned Document Information

Field	Value
Is this a Service Document?	Yes / No
Date:	
Organization:	Select Organization
Document:	Select Service Document
Staff:	Please enter a search
Activity:	Please enter a search
Program:	Please enter a search
Signature Date:	
Signing Staff:	Please enter a search
Document:	Browse...

Important: By default, the response to the **Is this a Service Document?** field is set to **No**.

3 Select **Yes** to add a scanned document to the client ECR as a service document.

4 In the Date field, enter the date at which the scanned service document becomes active in the system. Your entry must be in the following format: mm/dd/yyyy. You can either manually enter a date or click the Calendar icon to select a date from the popup window.

5 The **Organization** field is used to select the organization to which the scanned service document applies. This drop-down list includes only the organization you are currently logged into and all child organizations.

6 In the **Document** field, use the drop-down list to select what kind of service document the scanned document should be uploaded as.

7 In the **Staff** field, enter the full or partial name of the staff member you want to associate with the scanned service document, and click the Tab key. The drop-down list is filtered based on your search criteria. Use the drop-down list to select the desired staff member.

8 In the **Activity** field, enter the full or partial name of the activity you want to associate with the scanned service document, and click the Tab key. The drop-down list is filtered based on your search criteria. Use the drop-down list to select the desired activity.

9 In the **Program** field, enter the full or partial name of the program you want to associate with the scanned service document, and click the Tab key. The drop-down list is filtered based on your search criteria. Use the drop-down list to select the desired program.

10 In the **Signature Date** field, enter the date at which the scanned document should be marked as signed in the system.

11 In the **Signing Staff** field, enter the full or partial name of the staff member who signed the scanned service document, and click the Tab key. The drop-down list is filtered based on your search criteria. Use the drop-down list to select the desired staff member.

12 In the **Document** field, click the **Browse** button to locate the file you want to upload to the client ECR as a service document. Select the desired file in the dialog window that appears and click **Open**. The file path to the desired document appears in the **Document** field.

13 Click **Submit** in the status bar.

The uploaded document is saved to the system and appears in the Document Library search results list page and can be accessed as a service document in the client ECR.

Important: Uploading a scanned document as a service document requires a single signature to finish the upload. This sets the service document status as **Fully Signed**, regardless of the signature requirements of the service document type.

Deleting Scanned Documents Associated with Client ECRs

This task includes instructions for deleting a scanned document from a client ECR.

Important: Scanned documents can be accessed through the Document Library search results or by viewing a list of service documents for clients who have had a scanned service document added to their ECRs (see *Deleting Scanned Service Documents from Client ECRs*).

To delete scanned documents from client ECRs:

1 Access the Document Library search results list page through a client ECR (see *Using the Document Library Module*).

Search Results

	Service Date	Document Type	Document Name	Activity	Program	Keywords	Staff	Signing Staff	Signature Date	
Select	7/15/2009	Service Document	MCCA - Test Service Document		Mental Health Counseling (011)		Newton , Ed (2142)	Duncan, Amber (474)	7/15/2009	Delete
Select	7/15/2009	DOC	Outpatient Services						(Not Set)	Delete
Select	7/15/2009	PDF	Progress Notes			progress, note			(Not Set)	Delete
Select	7/1/2009	XLS	OutPatient Consent Form						(Not Set)	Delete

2 Locate the scanned document you want to delete, and click the corresponding **Delete** button.

A delete confirmation dialog window appears.

3 Click **OK** to confirm you want to delete the selected scanned document.

The Document Library search results list page refreshes, deleting the selected scanned document from the system.

Deleting Scanned Service Documents from Client ECRs

This task includes instructions for deleting a scanned service document from a client ECR.

To delete scanned documents from client ECRs:

1 Access a clinical module's service document list through a client ECR

MCCA - MCCA - Test Service Document

	Service Date	Activity	Program	Staff	Signature Date				
Select	5/12/2009			QA Guy, Standard (QSI)	(Not Signed)	Attach		Report	Delete
Select	7/15/2009		Mental Health Counseling (011)	Newton , Ed (2142)	7/15/2009	Attach	Addenda (0)	Report	Delete
Select	7/15/2009			QA Guy, Standard (QSI)	(Not Signed)	Attach		Report	Delete

.

2 Locate the scanned service document you want to delete, and click the corresponding **Delete** button.

A delete confirmation page appears.

Confirm Delete of MCCA - Test Service Document

Reason for Removal:	Please indicate why this document is being removed from the system. Max: 500 characters.
Administrative E-Sign:	

3 Enter the reason for removing the selected scanned service document.

4 In the E-Signature field, enter your electronic signature to complete this page. In order to submit this page and remove the scanned service document from the system, an electronic signature is required.

5 Click Submit in the status bar.

The selected scanned service document is deleted from the system.

Completing the Clinical Institute Withdrawal Assessment of Alcohol Scale - Revised (CIWA-Ar)

The CIWA-Ar module is used in detox programs to assign scores to withdrawal symptoms to better assess client needs.

To complete the CIWA-Ar module:

1 Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

2 Access a service document that contains the CIWA-Ar module.

3 Click the **CIWA-Ar** link in the left pane.

The **Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)** page appears, which contains 10 questions used to determine the CIWA score.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) Entry	
Date/Time Administered:	AM PM
Pulse of heart rate, taken for one minute:	
Blood Pressure:	/
Temperature:	Fahrenheit
Nausea and Vomiting:	Ask "Do you feel sick to your stomach? Have you vomited?" Observation. Select Nausea and Vomiting
Tremor:	Arms extended and fingers spread apart. Observation. Select Tremor
Paroxysmal Sweats:	Observation. Select Paroxysmal Sweats
Anxiety:	Ask "Do you feel nervous?" Observation. Select Anxiety
Agitation:	Observation. Select Agitation
Tactile Disturbances:	Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation. Select Tactile Disturbances
Auditory Disturbances:	Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation. Select Auditory Disturbances
Visual Disturbances:	Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation. Select Visual Disturbances
Headache, Fullness in Head:	Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity. Select Headache, Fullness in Head
Orientation and Clouding of Sensorium:	Ask "What day is this? Where are you? Who am I?". Select Orientation and Clouding of Sensorium
Total CIWA-Ar Score (Maximum possible score 67):	0

4 The **Date/Time Administered** field is used to indicate when the CIWA assessment was administered to the client. Enter the date and time in the text fields, and select either A.M. or P.M.

5 In the **Pulse of heart rate, taken for one minute**, enter the client's pulse after you have timed it for one minute.

6 In the **Blood Pressure** field, enter the client's systolic and diastolic blood pressure numbers.

7 In the **Temperature** field, enter the client's temperature in degrees Fahrenheit.

8 The following ten questions use a rating scale from zero to seven (0-7) indicating no symptoms to very severe symptoms. The questions are also mapped to a value that is used to compute a CIWA score after all questions have been answered. Some of these questions require you to ask the client about withdrawal symptoms, while others require you to make observations and determine the severity of the withdrawal symptoms on your own.

a **Nausea and Vomiting.** Ask the client if he feels sick to his stomach, and observe his reaction to record the level of severity for this symptom.

b **Tremor.** Observe the client to determine the level of severity for this symptom.

c **Paroxysmal Sweats.** Observe the client to determine the level of severity for this symptom.

d **Anxiety.** Ask the client if he feels nervous, and observe his reaction to record the level of severity for this symptom.

e **Agitation.** Observe the client to determine the level of severity for this symptom.

f **Tactile Disturbances.** Ask the client if he is experiencing any itching, pins and needles sensations, burning, or numbness, and observe his reaction to record the level of severity for this symptom.

g **Auditory Disturbances.** Ask the client if he is more aware of sounds around him and how they affect him, and observe his reaction to record the level of severity for this symptom.

h **Visual Disturbances.** Ask the client if he feels sensitivity to light or colors or is experiencing any hallucinations, and observe his reaction to record the level of severity for this symptom.

i **Headache, Fullness in Head.** Ask the client if his head hurts. Do not rate for dizziness or lightheadedness.

j **Orientation and Clouding of Sensorium.** Ask the client what day it is, where he is, and who you are. Use his responses to these questions to determine the level of severity for this symptom.

9 The **Total CIW-Ar Score (Maximum possible score 67)** field displays a read-only total score based on the ratings you assigned for each CIWA-Ar symptom question.

10 Click **Submit** in the status bar.

The CIWA-Ar record is saved for the selected client.

Clinical Orders

The Orders module allows in-patient and residential treatment facilities to track the type of clinical orders that are requested by doctors. Clinical orders can be created through the stand-alone Orders module (as described in this chapter) or through service documents (see page 149 the *System Administration Guide*).

This chapter includes the following topics:

- *Creating Orders Through CareLogic*
- *Creating Medication Orders Through Emdeon's Clinician*
- *Creating Standing Order Protocols*
- *Maintaining Orders*

Creating Orders Through CareLogic

Important: If you are creating an order for a client from within the entire client ECR, the programs available in the **Program** field will include all program(s) the client is currently active in.

If you are creating an order for a client from within a specific episode of care type menu, the programs available in the **Program** field will include only the client's active program(s) in the episode type from which you are currently viewing the client ECR.

This section includes instructions for entering orders into the system. In addition to a wide variety of non-billable orders, the system also contains the following billable orders: Lab, Radiology, Durable Medical Equipment (DME), and EKG. Before orders can be entered into the system, they must be configured by your system administrator (see page 181 the *System Administration Guide*).

Once the billable order types are properly configured, the Claim Engine will process them in the same manner as scheduled activities. After the order activities are converted to claims, they can be batched and sent out for billing. See page 183the *System Administration Guide* for instructions about configuring billable orders.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To access the clinical Orders module:

1 Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

Important: A client's Orders can also be accessed through a Client Episode, but if accessed in that manner, you will only see the Orders attached to the selected episode of care.

2 In the shortcut bar, click **Show Menu** and select **Orders**.

The **Orders** master list page appears, which lists all signed and unsigned orders for the selected client.

Unsigned Orders

	Order Type	Summary	Effective Date	Expiration Date	Status	Signed	Ordered By							
Select	Medication Order	Soma	1/12/2007	(Not Set)		No	Support, Qualifacts (QSI)	Status	Doc		Renew	Group	Report	Delete
Select	Transportation	Transportation	8/4/2009	(Not Set)	Ordered	No	TSTADM, Carol (298)	Status	Doc	Cancellations		Group	Report	Delete
Select	Transportation	Transportation	8/4/2009	(Not Set)	Ordered	No	Anselmo, Phil (2165)	Status	Doc	Cancellations		Group	Report	Delete

Signed Orders

	Order Type	Summary	Effective Date	Expiration Date	Status	Signed	Ordered By						
Select	Medication Order	Clozaril	1/12/2007	(Not Set)		Yes	Support, Qualifacts (QSI)	Status	Doc		Renew	Group	Discontinue
Select	Lab Order	Lab Order Module	1/12/2007	(Not Set)		Yes	Support, Qualifacts (QSI)	Status	Doc		Renew	Group	Discontinue
Select	Radiology Order	Radiology Order Module	1/12/2007	(Not Set)		Yes	Support, Qualifacts (QSI)	Status	Doc		Renew	Group	Discontinue

This page allows you to create the following type of orders:

- *Creating Medication Orders*
- *Creating Seclusion or Restraint Orders*
- *Creating Lab Orders*
- *Creating Automated Lab Orders*
- *Creating Radiology Orders*
- *Creating DME Orders*
- *Creating EKG Orders*
- *Creating Consultation Orders*
- *Creating Transfer Orders*
- *Creating Admit Orders*
- *Creating Discharge Orders*
- *Creating Generic Orders*
- *Creating Activity Level Orders*
- *Creating Dietary Orders*
- *Creating Ratings Scale Orders*
- *Creating Precaution Orders*
- *Creating Transportation Orders*

Creating Medication Orders

Once an order is given for a medication, you must use the instructions in this task to enter the order into the system.

Important: The medication order documentation presented here is based on the medication orders entered through the standard CareLogic interface. If your system is set up to use e-prescription, please contact QSI Support for documentation around the eRx functionality.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

Important: After the medication order is created, a nurse or other qualified staff member must use the MAR module to enter a record of the drug administration (see *Administering Medications Through MAR*). If your organization tracks patient assistance records for medications, you must use the Patient Assistance module to track this information (see *Tracking Patient Assistance for Medications*).

To create Medication orders:

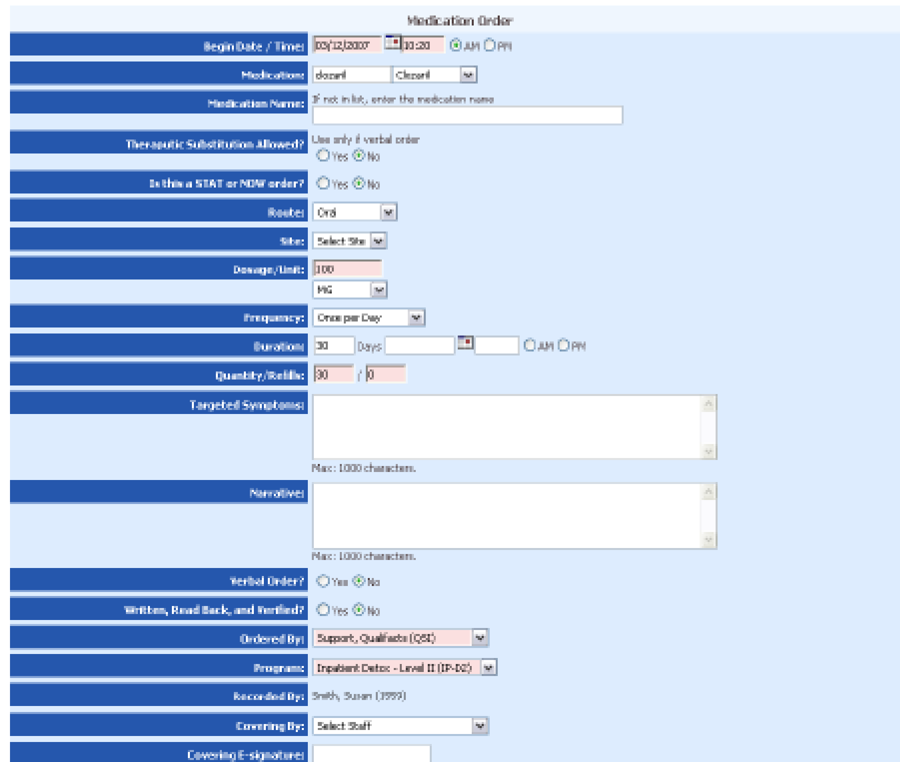
1. Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

3 In the **Select Order Type** field, select the Medication radio button and click the **Create Order** button.

The **Medication Order** page appears. All required fields are highlighted.



4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Medication** field, use the drop-down list to select the medication ordered for the client. The medications available in the drop-down list are populated by the Administration Medication module. If the medication that is ordered is not available in the list, enter the medication name in the **Medication Name** field. This entry can be up to 100 characters.

6 If this is a verbal order, indicate if a therapeutic substitution is allowed for the medication. If this is a written order, ignore the **Therapeutic Substitution Allowed** field.

7 In the **Is This a STAT or NOW Order** field, indicate if this is an emergency order.

8 In the **Route** field, use the drop-down list to select the way in which the medication is to be administered to the client.

9 In the **Site** field, use the drop-down list to select the location where the medication is to be given to the client.

10 In the **Dosage/Unit** field, use the text field to enter the dosage amount of the medication the client is to take and use the drop-down list to select the unit of measurement the client is to take.

11 In the **Frequency** field, use the drop-down list to select the frequency with which the client is to take the medication.

12 In the **Duration** field, indicate the length of time the client will be taking the medication. This field works in conjunction with the **Begin Date/Time** field (Step 4) to specify the length of time the client will take the medication. You can enter the duration in two different ways. If you want the client to take the medication for a finite number of days, enter the number of days in the first text field. If you want to the client to take the medication until a specific date, enter the desired date and time in the fields provided.

13 In the **Quantity/Refills** field, use the first text field to enter the number of pills prescribed for the client and use the second text field to enter the number of refills prescribed.

14 In the **Targeted Symptoms** field, describe the main symptoms the client is experiencing. These are the symptoms the medication is designed to alleviate. This entry can be up to 1,000 characters.

15 In the **Narrative** field, enter any notes or comments about the client taking the medication. This entry can be up to 1,000 characters.

16 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

17 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

18 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is defaulted to the currently logged in user (if the user has 'Order & Sign' privilege) but is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign' in case you need to select another primary doctor for the medication order.

19 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

20 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of ‘Order & Sign’.

21 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

22 Click **Submit** in the status bar.

The medication order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Administering Medications Through MAR

Important: In order to enter medication administration records through MAR, staff members must have the MAR Write privilege level. See page 15 the *Human Resources Guide* for instructions about setting privilege levels.

The Medication Administration Record (MAR) is the module that serves as a legal record for the medications administered to clients at your organization. Once a medication orders is signed, the system automatically creates a MAR record in the ECR, which informs your staff that a medication needs to be administered to the client. For inhouse medication orders, the MAR record is created from the Orders module. For outside medication orders, the MAR record is created from Clinician.

Once a MAR record is created, a nurse or other qualified staff member must administer the medication and then complete the MAR record. Each medication record that is created must be electronically signed by the qualified staff member at the time the medication is administered to the client.

After a medication is administered to a client, it appears in read-only mode through the client’s MAR. All staff members who have access to the client’s ECR will have access to the client’s read-only MAR.

Important: Your system may be configured to capture measurements in metric or US units systemwide. Contact QSI Support for more information about this configuration.

To administer medications through MAR:

1 Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

2 In the shortcut bar, click **Show Menu** and select **MAR**.

The **Medication Administration Record** list page appears. This page is divided into the following three sections.

- **Client Information.** This section lists general information about the client, such as the client’s name and ID number, any known allergies, the admission date, the discharge date, the client’s sex, date of birth, Social Security number, treatment diagnosis, and the treatment program the client is currently enrolled in. If a picture of the client was uploaded into the system (see *Uploading a Client’s Picture*), it is also displayed.
- **MAR Date Range.** By default, the date range is set to the current system date. This means the MAR list displays all active records. If desired, you can enter a past date range to view inactive MAR records for a specific date range. In order to do this, enter the desired date entries in the **Report Begin Date** and **Report End Date** fields and click **Submit** in the status bar.

- **MAR.** This section lists all of the medications that have been administered to the client over the defined date range. All STAT medications are displayed in red text. For each medication, this section lists the date and time it was administered, the name of the medication, the quantity remaining, the staff member who administered the medication, the staff member who prescribed the medication, the client's vital signs at the time the medication was administered, whether the medication was administered to the client by a qualifying staff member or whether a qualifying staff member observed the client taking the medication, the site or location where the medication was injected, whether the medication was missed because the client was not available, whether the medication was given STAT, and any comments associated with the administration of the medication.

Important: Clicking the **Notes** button allows you to view all notes about the selected MAR record or add additional notes to the selected MAR record.

- **Vitals**. This section lists the most recent vitals entered in the **Vitals Flow Sheet** module.

Medication Administration Record

Client	JOHN, GALT (2004)
Allergies	Peanuts
Admission Date	6/16/2008
Discharge Date	Currently Active
Gender	Male
Birth Date	8/13/1973
SSN	123456789
Diagnosis	Anxiety Disorder NOS
Program	

NO IMAGE AVAILABLE

Report Begin Date: 11/11/2008

Report End Date: 11/11/2008

STAT Medication

Date	Time	Medication	Count	Staff	Prescriber	Type	Site	Missed	STAT	Comments
11/11/2008	10:23	Clozaril (CLOZ)	20	QA Guy, Standard (QSI)	Support, Qualifacts (QSI)	Administered		N	N	Notes (1)

Vitals

Date/Time	Staff	Blood Pressure	Heart Rate	Respiratory Rate	Temperature	Height	Weight	BMI	Pain
12/28/2009; 12:53 PM	QA Guy, Standard (QSI)	120/80	120	50	98.8 F	65 in	200 lbs	51.91	8

3 Click **Add MAR Entry** in the status bar.

The **Medication Administration Record** data entry page appears. This page lists all of the medications that have been ordered for the selected client. The following fields are required: Date, Time, and Type. The Comments field is required only for missed and STAT records.

Medication Administration Record

Client	JOHN, GALT (2004)
Allergies	Peanuts
Admission Date	6/16/2008
Discharge Date	Currently Active
Gender	Male
Birth Date	8/13/1973
SSN	123456789
Diagnosis	Anxiety Disorder NOS
Program	

NO IMAGE AVAILABLE

Date/Time	Medication	Count	Prescriber	Type	Site	Missed	STAT	Comments	Signature
11/11/2008 10:35 AM PM	Clozaril (CLOZ) 100 mg Twice a Day	20	QA Guy, Standard (QSI)	Administered	Enter Text			Enter Text	•••••••

4 In the **Date** field, enter the date the qualifying staff member administered or observed the client taking the medication. By default, this field is populated with the current system date. If desired, a past date can be entered in this field.

5 In the **Time** field, enter the time the qualifying staff member administered or observed the client taking the medication. By default, this field is populated with the current system time. If desired, you can enter a different time.

Note: The **Medication** field lists the name of the medication that has been ordered for the client.

6 If the medication is in pill form, the **Count** field is used to enter the quantity remaining. Each time a pill is administered to the client, it must be manually subtracted in this field.

Note: The **Prescriber** field lists the name of the staff member who ordered the medication.

7 In **Type** field, use the drop-down list to indicate whether the medication was administered to the client or whether you observed the client taking the medication.

8 If the medication is not taken orally, use the **Site** field to identify the location where the medication was given. For example, if the medication is to be given as an injection or as a cream, indicate the place on the client's body where the medication was administered.

9 If the client was not available at the time the medication was to be taken, select the **Missed** check box. If this check box is selected, you must enter a note or comment in the **Comments** field. When this option is selected, the system automatically sends an informational alert to the signing staff member so an Incident Report can be completed.

10 If this medication was given as an emergency response, select the **STAT** check box. If you select this check box, you must enter a note in the **Comments** field.

11 If the medication is STAT or the client missed the medication, you *must* enter an explanation or note in the **Comments** field. For all other medication records, this field is optional. This entry can be up to 100 characters.

12 The **Signature** field is used to electronically sign the medication record after it is administered to the client or you observe the client taking it. Each medication record must be signed individually.

13 Click **Submit** in the status bar.

The medication record is saved and listed on the **Medication Administration Record** list page.

Note: If your organization tracks patient assistance records for medications, you must use the Patient Assistance module to track this information (see page 218).

Tracking Patient Assistance for Medications

Patient Assistance programs are funded by pharmaceutical companies to provide low-income clients with medications at no cost. If your organization wants to track which clients are on patient assistance, you must use the Patient Assistance module.

Note: The following task includes instructions for entering patient assistance records for individual clients through the ECR. In addition to this task, patient assistance records can also be entered in batch mode (for multiple clients) through the Client module (see *Adding Patient Assistance Records in Batch Mode*).

To track patient assistance for medications:

1 Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

2 In the shortcut bar, click Show Menu and select **Patient Assistance**.

The **Client Demographics** page appears. This page is divided into the following four sections.

- **Client Demographics.** This section lists general information about the client, such as the client's name, ID number, and date of birth; the admission status and admit organization; the admit episode, admission date, and status; the discharge date, the client's gender, date of birth, age (in years and months), Social Security number, and principal treatment diagnosis. If a picture of the client was uploaded into the system (see *Uploading a Client's Picture*), it is also displayed.
- **Contact Information.** This section lists the client's home address, home phone number, and work phone number.
- **Patient Assistance Date Range.** This section provides search filters which allow you to sort the patient assistance records by **Date Received**, **Date Released**, **Refill Date**, and **Current Expiration Date**. In order to filter the Patient Assistance records, enter the desired date entries in the respective **Begin Date** and **End Date** fields for the search filter type you want to sort by and click **Submit** in the status bar.
- **Patient Assistant List.** This section lists the patient assistance records for the defined date range. For each record, this section lists the medication name, the location where the client receives the medication, the number of medication units remaining, the number of medication units requested, the requested dosage, the date the medication was received, the date the medication was released, the call in refill date, the date the eligibility paperwork was mailed to the pharmaceutical company, the staff member who mailed it, and the expiration date for the patient assistance medication.

Note: If necessary, you can click the **Discontinue** button to discontinue a patient assistance medication.

- **Message Board**. This section displays any messages that have been added to the client message board and have been indicated to display on the **Patient Assistance Whiteboard.**

3 Click **Add Patient Assistance** in the status bar.

The **Client Demographics PA** page changes to data entry mode. This page allows you to enter up to two patient assistance records at a time.

4 In the **Medication** column, use the search-and-select field to select the medication for which the client is receiving patient assistance. In the text field, enter the full or partial name of the medication and press the Tab key to filter the drop-down list. Use the drop-down list to select the desired medication name.

5 In the **Dosage** field, enter the dosage amount for the medication requested.

6 In the **Assistance Location** column, use the drop-down list to select the location where the client receives the medication. This drop-down list, which is populated by your system administrator, can contain such options as Pharmacy or House.

7 The **Remaining Units** column is used to track the number of pills remaining in the medication run (the medication quantity received by the pharmaceutical company).

8 In the **Units Requested** column, enter the total number of pills requested to the pharmaceutical company.

9 In the **Date Med Received** column, enter the date the medication was received.

10 In the **Date Med Released** column, enter the date the medication was released to the client.

11 In the **Call in Refill Date** column, enter the date at which the medication is eligible for a refill.

12 In the **Date Request Sent** column, enter the date the client's eligibility paperwork was mailed to the pharmaceutical company. If more than one set of paperwork was mailed, this column should contain the date the last set of paperwork was mailed.

13 The **Initiating Staff** column displays read-only text that defaults to the current user.

14 In the **Request Sent By** column, use the drop-down list to select the staff member who mailed the eligibility paperwork to the pharmaceutical company.

15 In the **Current Exp Date** column, enter the date the medication is set to expire. This is the date this record will no longer be displayed on the **Client Demographics PA** page by default. This entry must be in the following format: mm/dd/yyyy. You can either manually enter a date or click the Calendar icon to select a date from the pop-up window.

16 Click **Submit** in the status bar.

The patient assistance record is saved and listed on the **Client Demographics PA** page.

Note: You can use the Patient Assistance Whiteboard to view all of the clients receiving patient assistance (see *Using the Patient Assistance Whiteboard*).

Creating Seclusion or Restraint Orders

Once an order is given for a seclusion or restraint order, you must use the instructions in this task to enter the order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Seclusion or Restraint orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, Detox, Dietary Order, Discharge Order, DME Order, EKG Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, SA-ADMIT, Seclusion or Restraint, Transfer Order, Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Seclusion or Restraint radio button and click the **Create Order** button.

The **Seclusion or Restraint Order** page appears. All required fields are highlighted.

Seclusion or Restraint Order

Begin Date / Time: 03/12/2007 01:24 AM PM
Order Type: Mechanical Restraint
Duration of Order: in minutes 60
Reason: Client is a danger to himself.
Max: 2000 characters.
Criteria for Termination:
Max: 2000 characters.
Medical Risk Identified:
Max: 2000 characters.
Phone Order Date: 03/12/2007 01:24 AM PM
Attending M.D. Notified and Consulted? Yes No
Verbal Order? Yes No
Written, Read Back, and Verified? (Only if Verbal Order) Yes No
Ordered By: Support, Qualifacts (QSI)
Program: Inpatient Detox - Level II (IP-02)
Recorded By: Smith, Susan (1559)
Covering By: Select Staff
Covering E-signature:

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Order Type** field, use the drop-down list to select the type of seclusion or restraint order that was ordered. Some example seclusion or restraints are mechanical restraints, physical holds, and seclusion. The order types available in this drop-down list are set up in the Orders Administration module (see page 181 the *System Administration Guide*).

6 In the **Duration of Order** field, enter the number of minutes the order is to be effective. For example, if the client is to be in seclusion for one hour, enter 60 in this field.

7 In the **Reason** field, enter the reason the client is being secluded or restrained. This entry can be up to 2,000 characters.

8 In the **Criteria for Termination** field, enter the criteria that will be used to determine if the order will be terminated. This entry can be up to 2,000 characters.

9 In the **Medical Risk Identified** field, enter any medical risks associated with the order. This entry can be up to 2,000 characters.

10 In the **Phone Order Date** field, enter the date and time the seclusion or restraint order was given by phone. By default, this field is populated with the current system date and time. If desired, you can change the date and time.

11 In the **Attending M.D. Notified** field, indicate if the client's attending (or primary) doctor was notified about the seclusion or restraint order.

12 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

13 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

14 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

15 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

16 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

17 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

18 Click **Submit** in the status bar.

The seclusion or restraint order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Lab Orders

Note: In order to bill for lab orders, they must be properly configured by your system administrator. The Claim Engine will process lab orders in the same manner as scheduled activities. After the lab order activities are converted to claims, they can be batched and sent out for billing. See page 183the *System Administration Guide* for instructions about configuring billable orders.

This section includes instructions for creating lab orders.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Lab orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:
- Activity Order
- Admit Order
- Admit Protocol
- Consultation Order
- Detox
- Dietary Order
- Discharge Order
- DME Order
- EKG Order
- Lab Order
- Medication
- Precaution Order
- Radiology Order
- Ratings Scale Order
- SA-ADMIT
- Seclusion or Restraint
- Transfer Order
- Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Inhouse Lab radio button and click the **Create Order** button.

The **Lab Order Form** appears. All required fields are highlighted. For each Lab order, you must order between one and nine lab tests. The following example Lab Order Form only displays fields for up to four lab test because it has been modified to conserve space in this guide.

Lab Order Form

Is this an inpatient client? Yes No

If No, Then Diagnosis or ICD-9 Required

Begin Date/Time	End Date/Time	Lab Test	Diagnosis	Repeat Every
04/05/2007 04:31 AM PM	AM PM	Blood	No DSM Diagnosis records found; 292 292.0 - DRUG WITHDRAWAL	day(s)
04/09/2007 08:00 AM PM	AM PM	Urine	No DSM Diagnosis records found; 292 292.2 - PATHOLOGIC DRUG INTOX	7 day(s)
AM PM	AM PM	Select Lab Test	No DSM Diagnosis records found; Enter an ICD-9 Search	day(s)
AM PM	AM PM	Select Lab Test	No DSM Diagnosis records found; Enter an ICD-9 Search	day(s)

Verbal Order? Yes No

Written, Read Back and Verified? (Use Only if Verbal Order) Yes No

Ordered By: Support, Qualifacts (QSI)

Program: Inpatient Detox - Level II (IP-D2)

Recorded By: Smith, Susan (1559)

Covering By: Select Staff

Covering E-signature:

4 The **Is This an Inpatient Client** field is used to identify the type of service the client is receiving when the order was given.

- If the client was given this order while enrolled in an outpatient treatment program, select No in this field. After selecting No in this field, you must select either a DSM or ICD-9 code in the Diagnosis column (Step 8).
- If the client was given this order while enrolled in an inpatient treatment program, select Yes in this field. If you select Yes, you can ignore the Diagnosis column (Step 8).

5 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can enter either a past or future begin date for this lab order.

6 If this is a recurring lab order, use the **End Date/Time** column to enter the date and time the order is to become inactive in the system. Recurring lab orders are valid for 90 days only. This means if you do not enter an end date for a recurring lab order, the system will automatically end date the order 90 days after the begin date.

7 In the **Lab Test** column, use the drop-down list to select the lab tests that must be performed in order to complete the order. Some example lab tests are Admission Protocol, Ammonia, Lipid Panel, and Valproic Acid. For each lab order, the minimum number of lab tests that can be ordered is one and the maximum number of lab tests that can be ordered is eight. The lab test options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

Note: If the order is related to a client enrolled in an inpatient treatment program, ignore the **Diagnosis** column. This column is used for orders related to outpatient services only.

8 In order to bill for orders related to outpatient services, you must select either a DSM or ICD-9 code in the **Diagnosis** column. The system automatically maps the DSM codes to ICD-9 codes so the diagnosis codes are printed on claims. The DSM Diagnosis drop-down list is populated with the DSM codes that have been assigned to the client through the Diagnosis clinical module. The ICD-9 field allows you to search the ICD-9 library and select the desired code.

9 If this is a recurring order, use the **Repeat Every** column to enter the frequency (the number of days) with which it is to be repeated. For example, if you enter 7, the lab test will be performed once a week. This entry can be up to three characters. Once the order is signed by the Ordered By staff (Step 12), a new lab order is automatically created for each frequency and given the appropriate future begin date. The new lab orders are added to the current order group and assigned the begin order status.

10 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

11 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

12 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

13 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

14 The covering staff member is generally the on-call physician or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

15 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

16 Click **Submit** in the status bar.

The lab order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Automated Lab Orders

This section includes instructions for creating automated lab orders, which allows you to receive electronic lab results.

Note: All order privilege levels are set up through the Emdeon enrollment process. If you receive an error message when creating an Automated Lab Order, contact your system administrator to ensure you have the proper privilege level to create orders.

To create Automated Lab orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

3 In the **Create New Order** section, select the Automated Lab Order radio button and click the **Create Order** button.

The **Automated Lab Order** page appears. All required fields have blue dots next to them.

4 In the **Order Type** field, use the drop-down list to select if this is a recurring lab order a standard lab order.

5 In the **Bill Type** field, use the drop-down list to select what funding source is responsible for the lab order costs.

6 The **Patient/Guarantor Information** section lists information that is pulled from the client's Demographics page.

Note: This information should not need to modified.

7 In the Order Information section, use the following steps to complete the Automated Lab Order:

a **Lab.** Use the drop-down list to select the lab to which you want to submit the lab sample for analysis.

b **Operator.** Use the drop-down to select the staff member responsible for the lab order.

c **Ordering Physician.** Use the drop-down list to select the provider who ordered the lab.

d **Collection Date/Time.** Enter the date and time of when the lab sample was collected. This field defaults to the current date and time but can be modified as needed.

e **Client/Facility.** Use the drop-down list to select the facility submitting the lab.

f **Prepaid Amount.** If known, enter the prepaid amount for the lab test.

g **STAT.** If the lab was ordered in an emergency situation, indicate it by selecting the STAT checkbox.

8 Click the **Next** button.

The automated lab order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group. Electronic lab results are displayed in the client ECR.

Creating Radiology Orders

Note: In order to bill for radiology orders, they must be properly configured by your system administrator. The Claim Engine will process radiology orders in the same manner as scheduled activities. After the radiology order activities are converted to claims, they can be batched and sent out for billing. See page 183the *System Administration Guide* for instructions about configuring billable orders.

Once an order is given that must be interrupted by a Radiologist, you must use the instructions in this task to enter the order into the system. Some example Radiology orders are X-ray, Ultrasound, CT, and MRI.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Radiology orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

3 In the **Create New Order** section, select the Radiology radio button and click the **Create Order** button.

The **Radiology Order** page appears. All required fields are highlighted.

Radiology Order Form

Begin Date / Time:	03/28/2007 10:32 AM PM
Order Type:	X-ray
Subtype:	Arm
Position:	Right
Is this an inpatient client?	If no, Then Diagnosis or ICD-9 Required Yes No
Current Diagnosis:	Select Diagnosis
ICD-9 Code:	Select ICD-9 Code
Comments:	Max: 500 characters.
Verbal Order?	Yes No
Written, Read Back and Verified?	Only if Verbal Order Yes No
Ordered By:	Support, Qualifacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1599)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Order Type** field, use the drop-down list to select the type of diagnostic test that was ordered and will be interrupted by the Radiologist. Some example Radiology order types are X-ray, Ultrasound, CT, and MRI. The order types available in this drop-down list are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 The **Subtype** field is used to identify the body part on which the diagnostic test will be performed. For example, if the order type is X-ray, the subtype could be arm. The subtype options in this drop-down list are set up in the Orders Administration module (see page 197 the *System Administration Guide*).

7 The **Position** field is used to identify the exact location where the diagnostic test will be performed. For example, if the order type is X-ray and the subtype is arm, the position could be right. The position options in this drop-down list are set up in the Orders Administration module (see page 197 the *System Administration Guide*).

8 The **Is This an Inpatient Client** field is used to identify the type of service the client is receiving when the order was given.

- If the client was given this order while enrolled in an outpatient treatment program, select No in this field. If you select No in this field, you must select either a diagnosis code or ICD-9 code in Step 9.
- If the client was given this order while enrolled in an inpatient treatment program, select Yes in this field. If you select Yes in this field, you do not have to select a diagnosis code or ICD-9 code in Step 9.

Note: Diagnosis codes and ICD-9 codes are used for orders related to outpatient services only. If this order is related to a client enrolled in an inpatient treatment program, you do not have to select a diagnosis code or ICD-9 code.

9 In order to bill for orders related to outpatient services, you must select either a diagnosis code or an ICD-9 code. The system automatically maps the DSM codes to ICD-9 codes so the diagnosis codes are printed on claims. The **Current Diagnosis** drop-down list is used to select the DSM code associated with the client's current diagnosis. The **ICD-9 Code** field is used to search the ICD-9 library and select the desired code.

10The **Comments** field is used to enter any notes or special instructions about the order. This entry can be up to 500 characters.

11If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

12If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

13The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

14In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

15The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

16The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

17Click **Submit** in the status bar.

The radiology order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating DME Orders

Note: In order to bill for Durable Medical Equipment (DME) orders, they must be properly configured by your system administrator. The Claim Engine will process DME orders in the same manner as scheduled activities. After the DME order activities are converted to claims, they can be batched and sent out for billing. See page 183the *System Administration Guide* for instructions about configuring billable orders.

Once an order is given for DME, you must use the instructions in this task to enter the order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create DME orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, Detox, Dietary Order, Discharge Order, DME Order, EKG Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, SA-ADMIT, Seclusion or Restraint, Transfer Order, Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the DME radio button and click the **Create Order** button.

The **DME Order Form** appears. All required fields are highlighted.

DME Order Form

Field	Value
Begin Date / Time:	03/30/2007 10:54 AM PM
Durable Medical Equipment (DME) Type:	Crutches
Quantity:	1
Is this an inpatient client?	If No, Then Diagnosis or ICD-9 Required Yes No
Current Diagnosis:	No DSM Diagnosis records Found
ICD-9 Code:	Select ICD-9 Code
Verbal Order?	Yes No
Written, Read Back and Verified?	(Only if Verbal Order) Yes No
Ordered By:	Support, Qualifacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Durable Medical Equipment (DME)Type** field, use the drop-down list to select the type of medical equipment that was ordered for the client. Some examples of DME are crutches and wheelchairs. The DME options available in this drop-down list are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 In the **Quantity** field, enter the number of pieces of medical equipment required to fulfill the order.

7 The **Is This an Inpatient Client** field is used to identify the type of service the client is receiving when the order was given.

- If the client was given this order while enrolled in an outpatient treatment program, select No in this field. If you select No in this field, you must select either a diagnosis code or ICD-9 code in Step 8.
- If the client was given this order while enrolled in an inpatient treatment program, select Yes in this field. If you select Yes in this field, you do not have to select a diagnosis code or ICD-9 code in Step 8.

Note: Diagnosis codes and ICD-9 codes are used for orders related to outpatient services only. If this order is related to a client enrolled in an inpatient treatment program, you do not have to select a diagnosis code or ICD-9 code.

8 In order to bill for orders related to outpatient services, you must select either a diagnosis code or an ICD-9 code. The system automatically maps the DSM codes to ICD-9 codes so the diagnosis codes are printed on claims. The **Current Diagnosis** drop-down list is used to select the DSM code associated with the client's current diagnosis. The **ICD-9 Code** field is used to search the ICD-9 library and select the desired code.

9 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

10 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

11 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

12 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

13 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

14 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

15 Click **Submit** in the status bar.

The DME order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating EKG Orders

Note: In order to bill for EKG orders, they must be properly configured by your system administrator. The Claim Engine will process EKG orders in the same manner as scheduled activities. After the EKG order activities are converted to claims, they can be batched and sent out for billing. See page 183the *System Administration Guide* for instructions about configuring billable orders.

Once an order is given for an EKG, you must use the instructions in this task to enter the order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create EKG orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, Detox, Dietary Order, Discharge Order, DME Order, EKG Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, SA-ADMIT, Seclusion or Restraint, Transfer Order, Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the EKG radio button and click the **Create Order** button.

The **EKG Order Form** appears. All required fields are highlighted.

EKG Order Form

Field	Value
Begin Date / Time:	03/30/2007 01:31 ○ AM ⦿ PM
EKG Type:	EKG
Is this an inpatient client?	If No, Then Diagnosis or ICD-9 Required ○ Yes ⦿ No
Current Diagnosis:	No DSM Diagnosis records found
ICD-9 Code:	Select ICD-9 Code
Verbal Order?	○ Yes ⦿ No
Written, Read Back and Verified?	(Use Only If Verbal Order) ○ Yes ⦿ No
Ordered By:	Support, Qualifacts (QSD)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **EKG Type** field, use the drop-down list to select the type of order that was given for the client. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 The **Is This an Inpatient Client** field is used to identify the type of service the client is receiving when the order was given.

- If the client was given this order while enrolled in an outpatient treatment program, select No in this field. If you select No in this field, you must select either a diagnosis code or ICD-9 code in Step 7.
- If the client was given this order while enrolled in an inpatient treatment program, select Yes in this field. If you select Yes in this field, you do not have to select a diagnosis code or ICD-9 code in Step 7.

Note: Diagnosis codes and ICD-9 codes are used for orders related to outpatient services only. If this order is related to a client enrolled in an inpatient treatment program, you do not have to select a diagnosis code or ICD-9 code.

7 In order to bill for orders related to outpatient services, you must select either a diagnosis code or an ICD-9 code. The system automatically maps the DSM codes to ICD-9 codes so the diagnosis codes are printed on claims. The **Current Diagnosis** drop-down list is used to select the DSM code associated with the client's current diagnosis. The **ICD-9 Code** field is used to search the ICD-9 library and select the desired code.

8 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

9 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

10 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

11 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

12 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of ‘Order & Sign’.

13 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

14 Click **Submit** in the status bar.

The EKG order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Consultation Orders

Once an order is given for a client consultation, you must use the instructions in this task to enter the order into the system. Some example consultations are Cardiology, Dental, Dermatology, Endrocrinology, Gastrointestinal, Neurology, Oncology, Pulmonary, and Urology.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Consultation orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:

Activity Order	Discharge Order	Radiology Order
Admit Order	DME Order	Ratings Scale Order
Admit Protocol	EKG Order	SA-ADMIT
Consultation Order	Lab Order	Seclusion or Restraint
Detox	Medication	Transfer Order
Dietary Order	Precaution Order	Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Consultation radio button and click the **Create Order** button.

The **Consultation Order Form** appears. All required fields are highlighted.

Consultation Order Form

Field	Value
Begin Date / Time:	03/30/2007 01:36 ◯ AM ◉ PM
Consultation Type:	Dermatology
Internal Consulting Staff:	jones Jones, Susan (1447)
External Consultants:	
Urgency:	Standard
Reason:	Client has skin discoloration around neck. Max: 1000 characters.
Is this an inpatient client?	If No, Then Diagnosis or ICD-9 Required ◯ Yes ◉ No
Current Diagnosis:	No DSM Diagnosis records found
ICD-9 Code:	Select ICD-9 Code
Verbal Order?	◯ Yes ◉ No
Written, Read Back and Verified?	(Use Only if Verbal Order) ◯ Yes ◉ No
Ordered By:	Support, QualiFacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Consultation Type** field, use the drop-down list to select the type of consultation order that was given for the client. Some example consultations are Cardiology, Dental, Dermatology, Endocrinology, Gastrointestinal, Neurology, Oncology, Pulmonary, and Urology. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 In the **Internal Consulting Staff** field, search and select the internal staff member who will consult with the client to fulfill this order.

7 If an external source is required to fulfill this order, enter the name of the source in the **External Consultants** field.

8 In the **Urgency** field, use the drop-down list to select the urgency of the consultation order. The options available in this drop-down list are set up in the Orders Administration module (see page 198 the *System Administration Guide*).

9 The **Reason** field is used to enter the reason for the consultation. This entry can be up to 1,000 characters.

10 The **Is This an Inpatient Client** field is used to identify the type of service the client is receiving when the order was given.

- If the client was given this order while enrolled in an outpatient treatment program, select No in this field. If you select No in this field, you must select either a diagnosis code or ICD-9 code in Step 11.
- If the client was given this order while enrolled in an inpatient treatment program, select Yes in this field. If you select Yes in this field, you do not have to select a diagnosis code or ICD-9 code in Step 11.

Note: Diagnosis codes and ICD-9 codes are used for orders related to outpatient services only. If this order is related to a client enrolled in an inpatient treatment program, you do not have to select a diagnosis code or ICD-9 code.

11. In order to bill for orders related to outpatient services, you must select either a diagnosis code or an ICD-9 code. The system automatically maps the DSM codes to ICD-9 codes so the diagnosis codes are printed on claims. The **Current Diagnosis** drop-down list is used to select the DSM code associated with the client's current diagnosis. The **ICD-9 Code** field is used to search the ICD-9 library and select the desired code.
12. If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.
13. If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.
14. The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.
15. In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

16. The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.
17. The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.
18. Click **Submit** in the status bar.

The consultation order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Transfer Orders

Once an order is given to transfer a client, you must use the instructions in this task to enter the order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Transfer orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:	Activity Order	Discharge Order	Radiology Order
	Admit Order	DME Order	Ratings Scale Order
	Admit Protocol	EKG Order	SA-ADMIT
	Consultation Order	Lab Order	Seclusion or Restraint
	Detox	Medication	Transfer Order
	Dietary Order	Precaution Order	Transportation

Create Order

Signature

Ordering Physician:	Select Ordering Physician
Signature:	There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Transfer radio button and click the **Create Order** button.

The **Transfer Order** page appears. All required fields are highlighted.

Transfer Order

Begin Date / Time:	03/30/2007 01:44 AM PM
Transfer Type:	Internal
Transfer From:	Inpatient Detox - Level II (IP-D2)
Transfer To Program:	Select internal program or external location to transfer client. Substance Abuse Rehab (SA)
Transfer To External:	Select External Locations
Mode of Transport:	Select Mode of Transport
Transfer Reason:	Client completed current treatment program. Max: 1000 characters.
Verbal Order?	Yes No
Written, Read Back and Verified?	(Use Only if Verbal Order) Yes No
Ordered By:	Support, QualiFacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Transfer Type** field, use the drop-down list to select the type of order that was given for the client. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 The **Transfer From** field is used to select the treatment program the client is being transferred out of. This drop-down list is populated with all the programs the client is currently enrolled in.

Important: A client's Transfer Order can also be created through the Client Episode list, but if accessed in that manner, you will only see the programs attached to the selected client episode available for transferring to and from.

7 If the order requires the client to be enrolled in another treatment program, use the drop-down list in the **Transfer to Program** field to select the desired program.

8 If the order requires the client to be transferred to another treatment facility, use the drop-down list in the **Transfer to External** field to select the desired external source. The options available in this field are set up in the Orders Administration module (see page 201 the *System Administration Guide*).

9 If the order requires the client to be transferred to another treatment facility, use the drop-down list in the **Mode of Transport** field to select the mode of transport that will be used to transfer the client. The options available in this field are set up in the Orders Administration module (see page 201 the *System Administration Guide*).

10 In the **Transfer Reason** field, enter the reason the client is being transferred. This entry can be up to 1,000 characters.

11 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

12 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

13 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

14 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

15 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

16 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

17 Click **Submit** in the status bar.

The transfer order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Admit Orders

Once an order is given to admit a client, you must use the instructions in this task to enter the order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Admit orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, Detox, Dietary Order, Discharge Order, DME Order, EKG Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, SA-ADMIT, Seclusion or Restraint, Transfer Order, Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Admit radio button and click the **Create Order** button.

The **Admit Order Form** appears. All required fields are highlighted.

Admit Order Form	
Client:	ADMITTO, DIOXIDE (2702) 01/01/2000
Begin Date / Time:	08/14/2009 12:56 AM PM
Admit to Organization:	Select Admit to Organization
Unit:	Select Unit
Current Diagnosis:	Select Diagnosis
Attending Physician:	If client has inpatient status, select an attending physician from the list below Select Physician Name
Admission Source:	Select Admission Source D
Admission Type:	Select Admission Type D
Admitting Diagnosis:	Enter a DSM Search
ICD-9 Code:	Select a DSM Code to Populate
Reason for Visit:	Enter a DSM Search
ICD-9 Code:	Select a DSM Code to Populate
Verbal Order?	Yes No
Written, Read Back and Verified?	(Use Only if Verbal Order) Yes No
Ordered By:	Select Ordered By
Programs:	Please enter a search Add | Remove
Recorded by:	Standard A. QA Guy (Medical Doctor)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Admit to Organization** field, use the drop-down list to select the organization to which the client is being admitted. This drop-down list includes only the organization you are currently logged into and all child organizations.

6 In the **Unit** field, use the drop-down list to select the unit the client will be admitted to. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

7 If a treatment diagnosis has been completed for the client, use the drop-down list in the **Current Diagnosis** field to the select the client's current diagnosis. If a treatment diagnosis has not been completed for the client, ignore this field.

8 If the client has an inpatient status, use the drop-down list to select the client's attending physician in the **Attending Physician** field.

Note: This field is configurable and may not appear on the page based on your organizational settings. This field is required if the service is to be billed as an institutional claim.

9 In the **Admission Source** field, use the drop-down list to select source of the client's admission to your facility.

Note: This field is configurable and may not appear on the page based on your organizational settings. This field is required if the service is to be billed as an institutional claim.

10 In the **Admission Type** field, use the drop-down list to select type of admission for the selected client.

Note: This field is configurable and may not appear on the page based on your organizational settings. This field is required if the service is to be billed as an institutional claim.

11 In the **Admitting Diagnosis** field, enter the full or partial name of the diagnosis, press Tab to filter the drop-down list, and then use the drop-down list to select the desired diagnosis.

12 The **ICD-9 Code** field drop-down list is filtered based on the DSM code selected in the **Admitting Diagnosis** field. If there are multiple ICD-9 codes associated with the admitting diagnosis, use the drop-down list to select the desired ICD-9 code for this diagnosis

13 In the **Reason for Visit** field, enter the full or partial name of the reason for the client visit, press Tab to filter the drop-down list, and then use the drop-down list to select the desired reason.

14 The **ICD-9 Code** field drop-down list is filtered based on the DSM code selected in the **Reason for Visit** field. If there are multiple ICD-9 codes associated with the reason for the client visit, use the drop-down list to select the desired ICD-9 code for this reason

15 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

16 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

17 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

18 Search for the treatment programs the client is being admitted to. Enter the partial or full name of the treatment program, and press Tab to filter the drop-down list selections in the **Programs** field.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: Clients may be admitted to multiple programs, as long as the programs are part of the same episode of care type.

19 Select the correct program from the search results, and click **Add**.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

20 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

21 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

22 Click **Submit** in the status bar.

The admit order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Discharge Orders

Note: When discharging clients from outpatient treatment programs, it is recommended that your organization use the Program History module (see *Referring/Discharging Clients from Program History*) rather than the discharge order.

Although it is available for outpatient services, the discharge order is designed for discharging clients from inpatient services. The discharge order enables your organization to capture all the necessary information for the UB-04 and 837I.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Discharge orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:
Activity Order
Admit Order
Admit Protocol
Consultation Order
Detox
Dietary Order
Discharge Order
DME Order
EKG Order
Lab Order
Medication
Precaution Order
Radiology Order
Ratings Scale Order
SA-ADMIT
Seclusion or Restraint
Transfer Order
Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Discharge radio button and click the **Create Order** button.

The **Discharge Order** wizard appears, with the **Discharge Order Form** displayed. All required fields are highlighted.

Note: The client's name appears in read-only text in the **Client** field.

4 In **Begin Date/Time** field, enter the discharge date and time for the client.

5 In the **Programs to Discharge From** field, select all of the treatment programs the client is being discharged from. Use the drop-down list to select the name of the treatment program the client is being discharged from. This field only allows you to search for a program the client is currently enrolled in. To select a program, enter the full or partial name in the text field, press Tab, use the drop-down list to select the desired program, and then click the Add button.

Important: A client's Discharge Order can also be created through the Client Episode list, but if accessed in that manner, you will only see the programs attached to the selected client episode available for discharge.

6 In the **Discharge Status** field, use the drop-down list to select the client's discharge status, as it will be listed on the UB-04 or 837I. This field is required if the client is not enrolled in another program. If the client is currently enrolled in another program, this field is optional.

7 The **Principal Procedure** is the procedure that was performed to address the client's primary compliant, as distinguished from the one performed for diagnostic or exploratory purposes. This procedure is included on the UB-04 or 837I. To select an option, enter the full or partial ICD-9 code in the text field, press Tab, and then use the drop-down list to select an option.

8 If you selected a principal procedure in the previous field, you must enter a date in the **Principal Procedure Date** field.

9 In the **Type of Bill** field, use the drop-down list to select the type of bill that will be listed on the UB-04 or 837I. This field is required if the client is not enrolled in another program. If the client is currently enrolled in another program, this field is optional. The options available in this field are set up by your system administrator through the Type of Bill module (see page 140 the *System Administration Guide*).

10. In the **Discharge Reason** field, use the drop-down list to select the reason the client is being discharged from the treatment program. All of the discharge reasons that appear in this drop-down list are set up by your system administrator.

11. The **With Medication** field is used to record the medication status of the client at the time of discharge.

- If the client is taking a medication at the time of discharge, select the **Current Medications** check box. If you know the amount of medication the client has at discharge, select the **Weeks Supply** check box and enter the number of weeks the medication will last.
- If the client was given a prescription at the time of discharge, select the **Prescription** check box. If you know the length of time the medication will last, select the **Weeks Supply** check box and enter the number of weeks the medication will last.

Note: The read-only **Medications** field displays the medications the client is currently taking.

12. If the client was discharged to the care of someone, enter the name of the person in the **Name of Person Discharged To** field and enter the relationship to the client in the **Relationship** field.

13. The **Additional Information** field is used to enter additional information about the discharge. This entry can be up to 1,000 characters.

14. If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

15. If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

16. The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

17. In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

18. The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

19. The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

20. Click **Submit** in the status bar.

The discharge order is created and the **Condition Codes** page appears. The condition codes selected on this page represent the conditions or events relating to the bill that may affect payer processing. All of the codes selected on this page will be included on the UB-04 or 837I.

21In the text entry field, enter the full or partial condition code or description, press Tab, and then use the drop-down list to select the desired condition code.

Note: Repeat this step to select additional condition codes. You can select up to 11 condition codes. Once you click Submit to save the condition codes, a Delete button appears for each code selected. If necessary, you can click the Delete button to remove a condition code.

22Click **Submit** in the status bar.

The condition code values are saved and the **Occurrence Codes** page appears. The occurrence codes selected on this page represent any significant events relating to the bill that may affect payer processing. All of the codes selected on this page will be included on the UB-04 or 837I.

23In the **Occurrence Code** column, enter the full or partial occurrence code or description in the text field, press Tab, and then use the drop-down list to select the desired occurrence code.

24In the **Date** column, enter the date the selected code occurred. This entry must be in the following format: mm/dd/yyyy.

Note: Repeat these steps to select additional occurrence codes. You can select up to eight occurrence codes. Once you click Submit to save the occurrence codes, a Delete button appears for each code selected. If necessary, you can click the Delete button to remove an occurrence code.

25Click **Submit** in the status bar.

The occurrence code values are saved and the **Occurrence Span** page appears. Occurrence spans consist of a code/description and a date range that are used to identify an event which relates to the payment of the claim. All of the codes selected on this page will be included on the UB-04 or 837I.

26In the **Occurrence Span** column, enter the full or partial occurrence span code or description in the text field, press Tab, and then use the drop-down list to select the desired occurrence span.

27In the **From Date** column, enter the beginning date for the occurrence span. This entry must be in the following format: mm/dd/yyyy.

28In the **End Date** column, enter the beginning date for the occurrence span. This entry must be in the following format: mm/dd/yyyy.

Note: Repeat these steps to select additional occurrence spans. You can select up to four occurrence spans. Once you click Submit to save the occurrence spans, a Delete button appears for each record selected. If necessary, you can click the Delete button to remove an occurrence span.

29Click **Submit** in the status bar.

The occurrence span values are saved and the **Value Codes** page appears. Value codes are used to designate values and dollar amounts to identify the data elements necessary to process the claim. All of the value codes selected on this page will be included on the UB-04 or 837I.

30In the **Value Codes** column, enter the full or partial value code or description in the text field, press Tab, and then use the drop-down list to select the desired value code.

31In the **Amount** column, enter the dollar amount for the value code.

Note: Repeat these steps to enter additional value codes. You can select up to 12 value codes. Once you click Submit to save the value code, a Delete button appears for each record selected. If necessary, you can click the Delete button to remove a value code.

32Click **Submit** in the status bar.

The discharge order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Generic Orders

This task includes instructions for entering a generic order into the system. Some example generic order types are Diagnostic, Non-Medical, Strip Search, and Structured Living Protocol.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Generic orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:

Activity Order	Discharge Order	Radiology Order
Admit Order	DME Order	Ratings Scale Order
Admit Protocol	EKG Order	SA-ADMIT
Consultation Order	Lab Order	Seclusion or Restraint
Detox	Medication	Transfer Order
Dietary Order	Precaution Order	Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Generic radio button and click the **Create Order** button.

The **Generic Order Form** appears. All required fields are highlighted.

Generic Order Form

Begin Date / Time:	03/30/2007 02:17 AM PM
Order Type:	Structured Living Protocol
Comment:	Max: 500 characters.
Verbal Order?	Yes No
Written, Read Back and Verified?	(Use Only if Verbal Order) Yes No
Ordered By:	Support, Qualifacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Order Type** field, use the drop-down list to select the type of order that was given for the client. Some example generic orders are Diagnostic, Non-Medical, Strip Search, and Structured Living Protocol. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 The **Comments** field is used to enter any notes or special instructions about the order. This entry can be up to 500 characters.

7 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

8 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

9 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

10 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

11 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

12 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

13 Click **Submit** in the status bar.

The generic order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Activity Level Orders

This task includes instructions for entering an activity level order into the system. Once the activity level order reaches its final status and is signed, a red R appears in the title bar beside the client's name the next time the ECR record is accessed. This is visual indicator that alerts the staff to an activity restriction.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Activity Level orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

3 In the **Create New Order** section, select the Activity radio button and click the **Create Order** button.

The **Activity Level Order Form** appears. All required fields are highlighted.

Activity Level Order Form

Begin Date / Time:	03/30/2007 02:23 AM PM
Activity Level:	Select Activity Level
Mobility Level:	Select Mobility Level
Comments:	Max: 500 characters.
Verbal Order?	Yes No
Written, Read Back and Verified?	(Use Only if Verbal Order) Yes No
Ordered By:	Support, Qualifacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Activity Level** field, use the drop-down list to select the client's activity level. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 In the **Mobility Level** field, use the drop-down list to select the client's mobility level. The options available in this field are set up in the Orders Administration module (see page 202 the *System Administration Guide*).

7 The **Comments** field is used to enter any notes or special instructions about the order. This entry can be up to 500 characters.

8 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

9 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

10 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

11 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

12 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of ‘Order & Sign’.

13 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

14 Click **Submit** in the status bar.

The activity level order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

From this point on, each time this client’s ECR record is accessed, a red R link appears beside the client’s name in the title bar. This provides a visual clue that the client has an activity restriction. When you click the R link, the Orders module appears and you can review the restriction associated with the activity order.

Creating Dietary Orders

This task includes instructions for entering a dietary order into the system. Some example dietary orders are diabetic, kosher, and low sodium.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Dietary orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, Detox, Dietary Order, Discharge Order, DME Order, EKG Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, SA-ADMIT, Seclusion or Restraint, Transfer Order, Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Dietary radio button and click the **Create Order** button.

The **Dietary Order Form** appears. All required fields are highlighted.

Dietary Order Form

Begin Date / Time: 03/30/2007 03:05 AM PM
Dietary Type: Diabetic Kosher Low Sodium
Other:
Caloric Intake:
Dietary Instructions:
Max: 500 characters.
Food Allergies? Yes No
Current Food Allergies:
Verbal Order: Yes No
Written, Read Back and Verified? (Use Only If Verbal Order) Yes No
Ordered By: Support, Qualifacts (QSI)
Program: Inpatient Detox - Level II (IP-D2)
Recorded By: Smith, Susan (1550)
Covering By: Select Staff
Covering E-signature:

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Dietary Level** field, select the check boxes to indicate the type of dietary order that is being created for the client. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 If the desired dietary type is not available in the previous field, enter the dietary type in the **Other** field.

7 If this dietary order restricts the client to a maximum caloric intake level, enter the amount in the **Caloric Intake** field.

8 The **Dietary Instructions** field is used to enter any notes or special instructions about the client's dietary needs. This entry can be up to 500 characters.

9 In the **Food Allergies** field, indicate if the client has any known food allergies.

Note: The **Current Food Allergies** field lists all of the client's food allergies that are entered into the system through the Allergies module (see *Allergies Module*).

10 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

11 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

12 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

13 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

14 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

15 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

16 Click **Submit** in the status bar.

The dietary order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Ratings Scale Orders

This task includes instructions for entering a ratings scale order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Ratings Scale orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:
- Activity Order
- Admit Order
- Admit Protocol
- Consultation Order
- Detox
- Dietary Order
- Discharge Order
- DME Order
- EKG Order
- Lab Order
- Medication
- Precaution Order
- Radiology Order
- Ratings Scale Order
- SA-ADMIT
- Seclusion or Restraint
- Transfer Order
- Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Ratings Scale radio button and click the **Create Order** button.

The **Ratings Scale Order Form** appears. All required fields are highlighted.

Ratings Scale Order Form

Begin Date / Time:	03/30/2007 03:26 AM PM
Order Type:	Select Order Type
Verbal Order?	Yes No
Written, Read Back and Verified?	(Use Only if Verbal Order) Yes No
Ordered By:	Support, Qualifacts (QSI)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1559)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Order Type** field, use the drop-down list to select the type of ratings scale order that is being created for the client. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

7 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

8 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

9 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

10 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

11 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

12 Click **Submit** in the status bar.

The ratings scale order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Precaution Orders

This task includes instructions for entering a precaution order into the system. Some example precaution orders are Arm's Length, Close Watch, Eye View, and Frequent Monitoring.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Precaution orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, Detox, Dietary Order, Discharge Order, DME Order, EKG Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, SA-ADMIT, Seclusion or Restraint, Transfer Order, Transportation

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Precaution radio button and click the **Create Order** button.

The **Precaution Order Form** appears. All required fields are highlighted.

Precaution Order Form

Field	Value
Begin Date / Time:	03/30/2007 02:30 AM / PM
Precaution Type:	Frequent Monitoring
Justification for use of Precautions:	Assault/Aggression Risk
Other Justification:	Client is exhibiting erratic and unpredictable behavior Max: 1000 characters.
Verbal Order?	Yes / No
Written, Read Back and Verified?	(Use Only if Verbal Order) Yes / No
Ordered By:	Support, Qualifacts (Q50)
Program:	Inpatient Detox - Level II (IP-D2)
Recorded By:	Smith, Susan (1550)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **Precaution Type** field, use the drop-down list to select the type of precaution order that is being created for the client. Some example precaution types are Arm's Length, Close Watch, Eye View, and Frequent Monitoring. The options available in this field are set up in the Orders Administration module (see page 186 the *System Administration Guide*).

6 In the **Justification for Use of Precautions** field, use the drop-down list to select the reason given for ordering this precaution order. Some example justifications are Erratic/Unpredictable Behavior, Firesetting, Run Risk, Self-Injurious Behavior, Substance Abuse, and Suicidal Ideation. The options available in this field are set up in the Orders Administration module (see page 199 the *System Administration Guide*).

7 If additional justification options were used for ordering this precaution order, enter the reasons in the **Other Justification** field. This entry can be up to 1,000 characters.

8 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

9 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

10 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

11 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

12 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

13 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

14 Click **Submit** in the status bar.

The precaution order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

Creating Transportation Orders

This task includes instructions for entering a transportation order into the system.

Note: All order privilege levels are set up through the Administration Orders module (see page 214 the *System Administration Guide*). The orders privilege levels determine which staff members are able to order and sign orders, enter orders into the system, and access orders in read-only mode.

To create Transportation orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:			
	Activity Order	Discharge Order	Radiology Order
	Admit Order	DME Order	Ratings Scale Order
	Admit Protocol	EKG Order	SA-ADMIT
	Consultation Order	Lab Order	Seclusion or Restraint
	Detox	Medication	Transfer Order
	Dietary Order	Precaution Order	Transportation
	Create Order		

Signature

Ordering Physician:	Select Ordering Physician
Signature:	There are no unsigned orders in the group.

3 In the **Create New Order** section, select the Transportation radio button and click the **Create Order** button.

The **Transportation Order Form** appears. All required fields are highlighted.

Transportation Order Form

Begin Date / Time:	08/04/2009 07:49 AM PM
End Date:	
Appointment Days:	Check all that apply. Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
Reason public transportation cannot be used:	Select Reason public transportation cannot be used
Type of Transportation:	Select Type of Transportation
Does client need a child car seat:	Yes No
Does client need a infant car seat:	Yes No
Add a Trip?	

Day	Pickup Time	Pickup Location	Appt/Depart Time	Arrival Location
No records found				

Verbal Order?	Yes No
Written, Read Back and Verified?	(Use Only If Verbal Order) Yes No
Ordered By:	Anselmo, Phil (2165)
Program:	Select Program
Recorded by:	Standard QA Guy (Medical Doctor)
Covering By:	Select Staff
Covering E-signature:	

4 The **Begin Date/Time** column is used to indicate when the order becomes effective in the system. Once an order is effective, it can be signed. By default, this field is populated with the current date and time. If desired, you can modify the begin date and time of the order.

5 In the **End Date** field, enter the date at which the order is not longer active in the system.

6 In the **Appointment Days** field, indicate which days of the week the client has standing appointments for which he needs transportation provided.

7 If public transportation is available, select a reason why the client cannot use public transportation from the drop-down list in the **Reason public transportation cannot be used** field.

8 In the **Type of Transportation** field, use the drop-down list to select what kind of transportation the client needs.

9 In the **Does client need a child car seat** field, indicate if the client requires a car seat for transportation or not.

10 In the **Does client need an infant car seat** field, indicate if the client requires an infant car seat for transportation or not.

11 In the **Add a Trip?** field, select the checkbox if you want to create a new trip for this client.

Note: If you select this checkbox, you must complete the **Trip Entry** form after submitting the **Transportation Order Form**.

Important: If the client currently has trips scheduled, they appear in a trips list, displaying the trip's day of the week, pickup time, pickup location, appointment/departure time, and the arrival location. Multiple trips will be displayed by pickup time and location ascending.

12 If this order was given verbally, select Yes in the **Verbal Order** field. If this order was written, select No in this field.

13 If this is a verbal order, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written order, ignore the **Written, Read Back, and Verified** field.

14 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

15 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the order was given. After you select an option in this field, the system will automatically discontinue the order when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the order into the system.

16 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this order was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

17 The **Covering E-Signature** field is used by the covering staff member to electronically sign the order. This signature is for informational purposes only; it does *not* complete or lock the order.

18Click **Submit** in the status bar.

If you did not select the checkbox in the **Add a Trip?** field, the transportation order is saved, listed on the **Orders** page, and becomes a part of the current order group. Each time you add a new order from this page it is automatically added to the current order group.

If you did select the **Add a Trip?** checkbox, the Trip Entry form appears, which is divided into four sections.

Trip Entry

Trip Type: Inbound Outbound

19In the **Trip Entry** section, indicate what kind of trip you are scheduling in the **Trip Type** field.

Pick-up Information

Pick-up Time: (Not Assigned)
Departure Time: AM PM
Location:
Available Addresses: Select Available Addresses
Country: United States of America (USA)
Street 1:
Street 2:
APT/Suite:
City: Select City
State/Province: Select State
Postal Code: - Do City/State lookup using Postal Code code
County: Select County
Directions:
Max: 500 characters.
Telephone:

20In the **Pick-up Information** section, enter the following fields to complete the form.

a **Pick-up Time.** The pick-up time is displayed as read only text and cannot be edited.

b **Departure Time.** Enter the time of departure for the client transportation and indicate if it is in the morning of afternoon/evening. This field only appears if you indicate this was an Outbound trip in the **Trip Type** field.

c **Location.** Enter the location where the client is to be picked up for the trip.

d **Available Addresses.** Use the drop-down list to select from the available addresses associated with the client. If you select an address from this list, the address fields below will be populated automatically.

e **Country.** Use the drop-down list to select the country in which the client should be picked up.

Important: If you select the USA, or one of its territories, this page allows you to enter a domestic address. If the client works outside the USA, you must enter an international address. Once you select a country other than the USA, the page is refreshed to display all of the address fields as text entry fields. This means that when you enter an international address, you must manually enter the city, state/province, postal code, and county.

f **Streets.** Enter the street address for the client's pickup location.

g **APT/Suite.** If the address contains an apartment or suite number, enter it in this field.

Note: For addresses located within the USA, or one of its territories, use one of the following methods to enter the city, state/province, and postal code (zip code).

- To use the Postal Code Lookup feature, select the **Do City/State lookup using Postal Code** check box, enter the postal code (and postal code extension, if known), and press Tab. The system performs a postal code lookup and automatically populates the City and State fields. The city that is preceded by an asterisk is the postal service's preferred city for the postal code entered.
- To manually enter the city, state, and postal code, uncheck the **Do City/State lookup using Postal Code** check box, enter the city, use the drop-down list to select the state, and enter the postal code (and postal code extension, if known).

h **County.** Before you can select the county, you must select a state (by either method described in the previous step). The **County** field is automatically filtered to include only the counties that are located within the selected state. Use the drop-down list to select the appropriate county.

i **Directions.** Enter any information, comments, or special directions for the client pick-up location. This field can be up to 500 characters.

j **Telephone.** Enter a telephone number where the client can be reached at the entered location.

Drop-Off Information
Drop-off Time: (Not Assigned)
Appointment Time: AM PM
Location:
Available Addresses: Select Available Addresses
Country: United States of America (USA)
Street 1:
Street 2:
APT/Suite:
City: Select City
State/Province: Select State
Postal Code: - Do City/State lookup using Postal Code code
County: Select County
Directions: Max: 500 characters.
Telephone:
Notes: Max: 4000 characters.
Do you want to establish a round trip? Yes No

21 In the **Drop-Off Information** section, enter the following fields to complete the form.

a **Drop-off Time.** The drop-off time is displayed as read only text and cannot be edited.

b **Location.** Enter the location where the client is to be dropped off for the trip.

c **Available Addresses.** Use the drop-down list to select from the available addresses associated with the client. If you select an address from this list, the address fields below will be populated automatically.

d **Country.** Use the drop-down list to select the country in which the client should be dropped off.

Important: If you select the USA, or one of its territories, this page allows you to enter a domestic address. If the client works outside the USA, you must enter an international address. Once you select a country other than the USA, the page is refreshed to display all of the address fields as text entry fields. This means that when you enter an international address, you must manually enter the city, state/province, postal code, and county.

e **Streets.** Enter the street address for the client's drop-off location.

f **APT/Suite.** If the address contains an apartment or suite number, enter it in this field.

Note: For addresses located within the USA, or one of its territories, use one of the following methods to enter the city, state/province, and postal code (zip code).

- To use the Postal Code Lookup feature, select the **Do City/State lookup using Postal Code** check box, enter the postal code (and postal code extension, if known), and press Tab. The system performs a postal code lookup and automatically populates the City and State fields. The city that is preceded by an asterisk is the postal service's preferred city for the postal code entered.
- To manually enter the city, state, and postal code, uncheck the **Do City/State lookup using Postal Code** check box, enter the city, use the drop-down list to select the state, and enter the postal code (and postal code extension, if known).

g **County.** Before you can select the county, you must select a state (by either method described in the previous step). The **County** field is automatically filtered to include only the counties that are located within the selected state. Use the drop-down list to select the appropriate county.

h **Directions.** Enter any information, comments, or special directions for the client drop-off location.

i **Telephone.** Enter a telephone number where the client can be reached at the entered location.

j **Notes.** Enter any other comments or notes about the client drop-off location. This entry can be up to 4,000 characters.

k **Do you want to establish a round trip?** Indicate if you want to create a return trip for this client transportation order or not.

Note: If you select **Yes** in this field, you must complete the return trip entry form.

Stop #1

Appointment Time: AM PM
Location:
Available Addresses: Select Available Addresses
Country: United States of America (USA)
Street 1:
Street 2:
APT/Suite:
City: Select City
State/Province: Select State
Postal Code: - Do City/State lookup using Postal Code code
County: Select County
Directions:
Max: 500 characters.
Telephone:

Important: The Stops section of the Trip Entry form only appears if your organization has been configured to provide courtesy stops for clients. Contact your system administrator or QSI support for more information about this configuration. Your organization has the ability to add a maximum allowable number of courtesy stops as well, so the number of stops available will vary based on organizational needs.

22In the **Stops** section, enter the following fields to complete the form.

a **Appointment Time.** Enter the client's appointment time at the selected courtesy stop, and indicate if it is AM or PM.

b **Location.** Enter the location for the client's courtesy stop on the trip.

c **Available Addresses.** Use the drop-down list to select from the available addresses associated with the client. If you select an address from this list, the address fields below will be populated automatically.

d **Country.** Use the drop-down list to select the country in which the client should be dropped off.

Important: If you select the USA, or one of its territories, this page allows you to enter a domestic address. If the client works outside the USA, you must enter an international address. Once you select a country other than the USA, the page is refreshed to display all of the address fields as text entry fields. This means that when you enter an international address, you must manually enter the city, state/province, postal code, and county.

e **Streets.** Enter the street address for the client's courtesy stop location.

f **APT/Suite.** If the address contains an apartment or suite number, enter it in this field.

Note: For addresses located within the USA, or one of its territories, use one of the following methods to enter the city, state/province, and postal code (zip code).

- To use the Postal Code Lookup feature, select the **Do City/State lookup using Postal Code** check box, enter the postal code (and postal code extension, if known), and press Tab. The system performs a postal code lookup and automatically populates the City and State fields. The city that is preceded by an asterisk is the postal service's preferred city for the postal code entered.
- To manually enter the city, state, and postal code, uncheck the **Do City/State lookup using Postal Code** check box, enter the city, use the drop-down list to select the state, and enter the postal code (and postal code extension, if known).

g **County.** Before you can select the county, you must select a state (by either method described in the previous step). The **County** field is automatically filtered to include only the counties that are located within the selected state. Use the drop-down list to select the appropriate county.

h **Directions.** Enter any information, comments, or special directions for the client courtesy stop location.

i **Telephone.** Enter a telephone number where the client can be reached at the entered location.

23 Click **Submit** in the status bar.

If you select **No** in the **Do you want to establish a round trip?** field, the trip entry information is saved and listed on the **Transportation Order Form** page.

If you selected **No** in the **Do you want to establish a round trip?** field, a new **Trip Entry** form appears, which reverse the pick-up and drop-off location information. All fields can be edited except for the **Do you want to establish a round trip?** field.

24 If creating a round trip order, review all address details and make any necessary changes.

25 Click **Submit** in the status bar.

The trip entry information is saved and listed on the **Transportation Order Form** page.

Creating Medication Orders Through Emdeon's Clinician

This section explains how to create medication orders through Emdeon's Clinician. Because Emdeon's Clinician is integrated into CareLogic, there is a seamless process for creating and completing these orders.

You should be aware of the following information when using Emdeon's Clinician:

- The Bill To staff in CareLogic is referred to as the Bill Type in Clinician.
- The Client ID in CareLogic is referred as the Patient ID in Clinician.
- The client's Social Security Number in CareLogic will *not* be pulled into Clinician.
- Emdeon does not allow electronic submission of controlled substances. Therefore, all controlled substances entered into Clinician must be printed.
- The text entered in the Comments field on the RxPad page is automatically pulled into the CareLogic MAR module. This allows for triration management.
- In Clinician, formulary drugs contain the letter 'F' in front of the drug name.

Note: In order to create medication orders through Emdeon's Clinician, the Emdeon configuration must be enabled for your organization. This configuration, along with all other organization configurations, is controlled by Qualifacts Systems. If your organization wants to use the Emdeon configuration, contact a Customer Support representative for assistance. If your organization does not want to use Emdeon's Clinician to create medication orders, you must use the standard CareLogic Orders module (see page 385).

Emdeon's Clinician provides the following benefits when using medication orders:

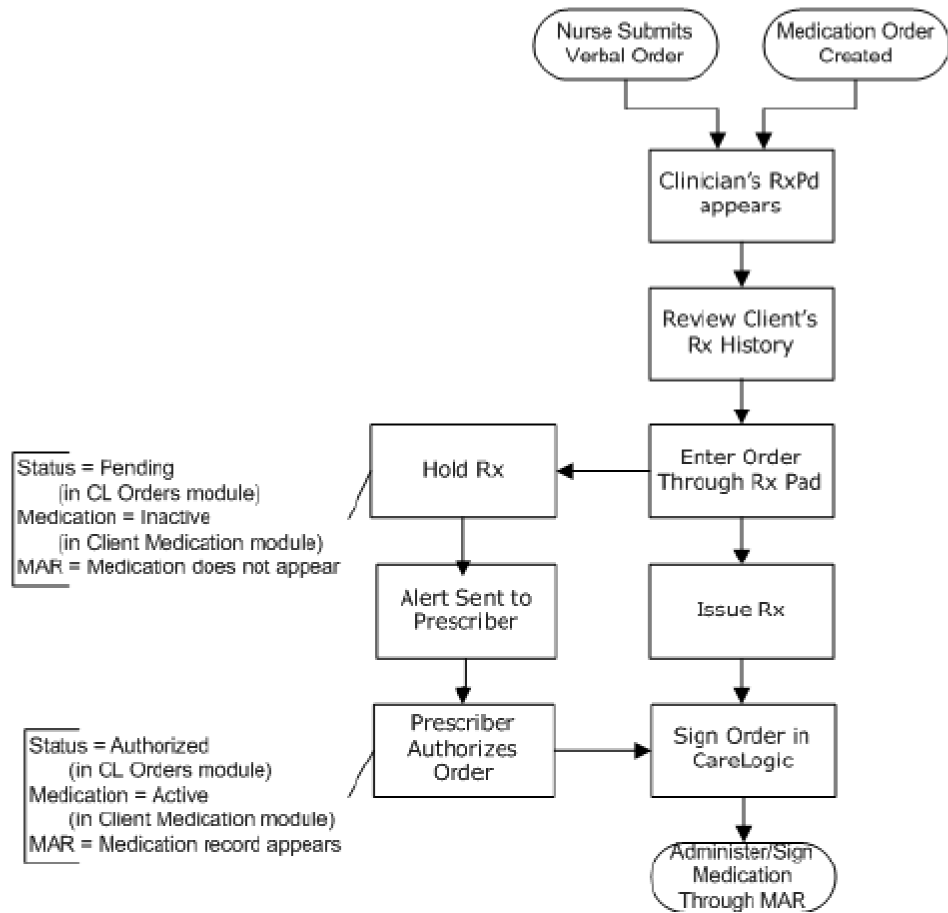
- Access to the First DataBank. First DataBank is the leading provider of context-relevant, integrated drug database products.
- Access to the Rx Hub. For consenting clients, the Rx Hub provides prescription eligibility, benefit, formulary, and medication history information to authorized physicians at the point of service.
- Real-Time Drug Utilization Review capability.

The integration of Emdeon's Clinician into CareLogic provides the following benefits:

- Improved patient safety and quality of care is achieved in the following ways:
  - Eliminates illegibility in prescription writing.
  - Warning and alert systems are provided.
  - Access to a client's prescription history.
- Reduces or eliminates phone calls and call-backs to pharmacies.
- Streamlines refill requests and authorization processes.
- Reduces or eliminates faxing.
- Increases patient compliance, formulary adherence, and reporting ability.
- Results in greater organizational efficiency which leads to more client time with prescribers.

Important: After the medication order is created, a nurse or other qualified staff member must use the MAR module to enter a record of the drug administration. See *Administering Medications Through MAR* for more information. If your organization tracks patient assistance records for medications, you can also use the Patient Assistance module (see *Tracking Patient Assistance for Medications*).

The following diagram shows the process flow for entering medication orders through Emdeon's Clinician.



To create medication orders through Emdeon's Clinician:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type:			
	○ Activity Order	○ Discharge Order	○ Radiology Order
	○ Admit Order	○ DME Order	○ Ratings Scale Order
	○ Admit Protocol	○ EKG Order	○ SA-ADMIT
	○ Consultation Order	○ Lab Order	○ Seclusion or Restraint
	○ Detox	○ Medication	○ Transfer Order
	○ Dietary Order	○ Precaution Order	○ Transportation

Create Order

Signature

Ordering Physician:	Select Ordering Physician
Signature:	There are no unsigned orders in the group.

3 In the **Select Order Type** field, select the Medication radio button and click the **Create Order** button.

Clinician's **Benefit Plans** page opens within CareLogic. This page lists the benefit plans available to the selected client.

4 Select the desired benefit plan or click the **Use None** button.

The **RxPad** page appears for the selected client.

5 Complete all required fields on this page. If you need help completing this page, click the Help link for assistance.

6 After the **RxPad** page is complete, click one of the following buttons.

- **Issue.** If the medication is ready to be administered to the client, click the **Issue** button. After the page is refreshed, a summary of the medication issued appears. At this point, you can print details of the issued medication, print the issued medication label, enter another medication for the client, or view the client's Rx History.
- **Hold.** If the medication must be authorized before being administered to the client, click the **Hold** button. After the page is refreshed, a summary of the medication on hold appears. At this point, you can print details of the medication on hold, enter another medication for the client, or view the client's Rx History.

7 Once the medication record has been issued or authorized, click **Return to CareLogic** in the status bar.

At this point, the following updates have been made in CareLogic.

- The medication record is listed in the Unsigned Orders list. To view the record in read-only mode, click the **Select** button. To sign the medication order, click **Sign Pending** in the status bar (see page 470).
- The medication is listed as active in the client's Medication History module (see *Viewing a Client's Medication History*).
- The medication record appears in the MAR module and is ready to be administered to the client (see *Administering Medications Through MAR*).

Creating Standing Order Protocols

Note: In order to create Standing Orders Protocol (SOPs) for clients, the SOPs must be set up through the Administration module (see page 215 the *Clinical Record Guide*).

SOPs can consist of any number of individual orders. They are beneficial to organizations that use a defined set of orders for similar clients. For example, if your organization's admission process requires a lab order, a consultation order, and an admit order, you can create an Admission SOP that consists of these three order types. This section includes instructions for creating SOPs for clients.

To create standing order protocols:

1 Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

2 In the shortcut bar, click **Show Menu** and select **Orders**.

The **Orders** master list page appears, which lists all signed and unsigned orders for the selected client.

3 Click **Create New Order** in the status bar.

The **Orders** page appears, which is divided into three sections. The **Orders** section lists all of the orders that are in the current group. The **Create New Order** section is used to select the type of order you want to create. This section includes both standard order types as well as SOPs. The **Signature** section is used to identify the ordering physician and sign the orders in the group.

JOHN, GALT (2004)
Orders

Order Type	Summary	Effective Date	Expiration Date	Status	Signed
No orders found.					

Create New Order

Select Order Type: Activity Order, Admit Order, Admit Protocol, Consultation Order, DME Order, Dietary Order, Discharge Order, EKG Order, Generic Order, Lab Order, Medication, Precaution Order, Radiology Order, Ratings Scale Order, Seclusion or Restraint, Transfer Order

Create Order

Signature

Ordering Physician: Select Ordering Physician

Signature: There are no unsigned orders in the group.

4 In the **Select Order Type** field, select the radio button of the SOP you want to create and click the **Create Order** button.

The **SOP** wizard opens for the selected SOP. The SOP wizard, which appears in the left pane, contains a link for each individual order within the SOP. Notice that all required orders are listed in bold, red text.

Admit Protocol
JOHN, GALT (2004)

- Admit Order
- CBC
- Dietary Order
- Consultation Order
- Sign & Complete SOP

* Orders in bold, red text are required for the submission of this standing order.

Admit Order Form

Client: JOHN, GALT (2004)
Begin Date / Time: 08/12/2008 11:15 AM PM
Unit: Select Unit
Current Diagnosis: Select Diagnosis
DSM Code: Enter a DSM Search
ICD-9 Code: Enter an ICD-9 Search

5 Complete each order within the SOP. All required orders must be complete in order to submit the SOP.

Important: A client's Standing Order Protocol can also be created through a Client Episode, but if accessed in that manner, you will only see the programs attached to the selected client episode available for creating standard order protocols.

6 Click the **Sign & Complete SOP** link.

The **Signature** page appears. All required fields are highlighted.

7 If this SOP was given verbally, select Yes in the **Verbal Order** field. If this SOP was written, select No in this field.

8 If this is a verbal SOP, indicate if the order was written, read back, and verified to the staff member who ordered it. If this is a written SOP, ignore the **Written, Read Back, and Verified** field.

9 The **Ordered By** field is used to select the client's primary (or attending) doctor. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

10 In the **Program** field, use the drop-down list to select the treatment program the client was enrolled in when the SOP was conducted. After you select an option in this field, the system will automatically discontinue the orders within the SOP when the client is discharged from the program.

Important: The options in the **Program** field are determined by the programs you are admitted to and the episode types to which the client is admitted.

Note: The read-only **Recorded By** field displays the name of the staff member who is entering the SOP into the system.

11 The covering staff member is generally the on-call staff or a resident. In many cases, the covering staff will give an order when the attending (or primary) doctor is not available, either after hours or on the weekends. If this SOP was given by a covering staff member, use the drop-down list in the **Covering By** field to select the appropriate staff member. This field is filtered to include only the active staff members with an Orders privilege level of 'Order & Sign'.

12 The **Covering E-Signature** field is used by the covering staff member to electronically sign the SOP. This signature is for informational purposes only; it does *not* complete or lock the order.

13 Click **Submit** in the status bar.

The SOP record is saved and listed on the **Orders** page.

Maintaining Orders

After an order is created, you must use this section to maintain it. This section contains the following topics:

- *Accessing Order Groups*
- *Updating Orders*
- *Selecting the Next Order Status*
- *Associating Orders with Service Documents*
- *Renewing Orders*

- *Reviewing Client Cancellations (Transportation Only)*
- *Viewing All Inactive Orders*
- *Renewing All Orders in Bulk*
- *Signing Orders*
- *Signing All Pending Orders in Bulk*
- *Discontinuing Orders*
- *Deleting Pending Orders*

Accessing Order Groups

Each time an order is entered into the system it automatically becomes part of the current order group. Once you access an order group, you can add any number of orders to the group. Every order is automatically associated with the currently selected group. A group can consist of a single order or multiple orders.

The system creates order groups as a means for managing the orders. When working within an order group, you can renew and sign all of the orders within the group in bulk.

To access order groups:

1. Access the **Orders** list page (see *Creating Orders Through CareLogic*).
2. Click the **Group** button to access the order's group.

The **Orders Group** page appears. The top section of this page lists all of the orders that are in the current group. In the following example, there are two orders in the current group. Each time you add new orders, they are automatically added to the currently selected group.

Orders Group

	Order Type	Summary	Effective Date	Expiration Date	Status	Signed				
Select	Medication Order	Clozaril	2/19/2007	(Not Set)	Waiting	No	Status	Documents	Renew	Discontinue
Select	Lab Order	Lab Order Module	4/2/2007	(Not Set)	Waiting	No	Status	Documents	Renew	Delete

Create New Order

Select Order Type: Medication Order, Transfer Order, Lab Order, Seclusion or Restraint, Discharge Order, Activity Order, Radiology Order, Admit Order, Dietary Order, DME Order, EKG Order, Ratings Scale Order, Generic Order, Consultation Order, Precaution Order

Create Order

Signature

Ordering Physician: QA Guy, Standard (QSI)

Signature:

Updating Orders

As long as an order has not been signed, it can be updated from either the **Orders** list page or the **Orders Group** page.

To update orders:

1 To update an order from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To update an order from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 Click the **Select** button that corresponds with the order you want to update.

The corresponding order page appears. You can edit any of the fields on this page. See *Creating Medication Orders* for field descriptions for medication orders. See page 395 for field descriptions for seclusion and restraint orders.

3 After making the desired edits, click **Submit** in the status bar.

The updated order is saved.

Selecting the Next Order Status

The Administration Orders module is used to configure the status life cycle for each order type (see page 179 the *System Administration Guide*). Once the status life cycle is defined, you can use this task to select the next order status throughout the life cycle of the order.

Note: Billable orders will not be processed by the Claim Engine until they reach their end order status state.

To select the next order status:

1 To select the next order status from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To select the next order status from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 On the **Orders** list page, click the **Status** button.

On the **Orders Group** page, click the **Status** button.

The **Order Status Form** appears. The top of this page lists the **Status History** for the selected order.

Status History

Status	Status Date	Entered By
Pending	4/3/2007	QA Guy, Standard (QSI)
Waiting	4/3/2007	QA Guy, Standard (QSI)

Order Status Form

Next Order Status:	Complete

3 In the **Next Order Status** field, use the drop-down list to select the next status you want to assign to the selected order. The order status options available in this drop-down list are set up in the Orders Administration module (see page 189 the *System Administration Guide*).

4 Click **Submit** in the status bar.

The new order status is assigned to the order, and the **Status History** section is refreshed to reflect the new order status.

Status History

Status	Status Date	Entered By
Pending	4/3/2007	QA Guy, Standard (QSD)
Waiting	4/3/2007	QA Guy, Standard (QSD)
Complete	4/3/2007	QA Guy, Standard (QSD)

Order Status Form

Next Order Status: Select Next Order Status

Associating Orders with Service Documents

This task includes instructions for associating an order to a service document after the order has already gone into effect. For example, a seclusion and restraint order may require a review of the restraint to ensure the client is being protected.

In order to associate an order with a service document, the order must be properly configured through the Orders Module (see page 181 the *System Administration Guide*).

To associate orders with service documents:

1 To attach an order to a service document from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To attach an order to a service document from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 On the **Orders** list page, click the **Doc** button.

On the **Orders Group** page, click the **Documents** button.

The **Service Documents Associated with** the selected order page appears. The top part of this page lists the service documents that are currently associated with the selected order. The bottom part of this page is used to select the service documents you want to associate with the order.

Service Document(s) Associated with Medication

Service Document	Service Date	Staff	Signature
No records found.			

Add Service Document

Add New Document: Select Add New Document

3 In the **Add New Document** field, use the drop-down list to select the service document you want to associate with the selected order.

4 Click **Submit** in the status bar.

The selected service document opens, which allows you to complete it.

5 After completing the service document, click **Submit** in the status bar.

The service document is listed on the **Service Documents Associated with** page.

Note: If desired, you can repeat Steps 3 through 5 to associate additional service documents with the selected order.

Service Document(s) Associated with Medication

	Service Document	Service Date	Staff	Signature		
Select	Treatment Diagnosis	10/20/2006	QA Guy, Standard (QSI)	(Not Signed)	Report	Delete

Add Service Document

Add New Document: Select Add New Document

Renewing Orders

The renew process is used to create a new order by making a copy of an existing order. You can renew both active and pending orders. Once an order is renewed, the system automatically creates a new pending order. The following rules are used to determine the effective and expiration dates for the original and new order.

- If the original order does not have an expiration date defined, the current system date is automatically set as the expiration date for the original order.
- If the original order has an expiration date defined, the original order remains effective until the expiration date arrives.
- The effective date for the new order is automatically set to the current system date.
- The expiration date for the new order is determined by the date range of the original order. The new order automatically inherits the same number of days for its effective and expiration dates as the original order. For example, if the original order's date range is five days, the new order's effective date is set to the current system date and the expiration date is set to five days from the current system date.

Note: When an order is renewed, the new order is automatically unsigned, regardless of whether the original order was signed or not.

To renew orders:

1 To renew an order from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To renew an order from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 Click the **Renew** button that corresponds with the order you want to renew.

The **Renew Order Confirmation** page appears.

3 Select **Yes** to confirm you want to renew the selected order.

4 Click **Submit** in the status bar.

The effective and expiration dates for the original and new order are set according to the rules listed above.

Reviewing Client Cancellations (Transportation Only)

CareLogic offers you the ability to review client cancellations of transportation orders.

To access client cancellations list:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Location the transportation order you want to view the client cancellations list for, and click the corresponding **Cancellations** button.

The Client Cancellations list page appears.

Client Cancellations

	Begin Date	End Date	Comments	
Select	8/1/2009	8/3/2009	Missed three days	Delete
Select	7/23/2009	7/23/2009	DNS	Delete

This page is used to complete the following tasks:

- *Adding Client Cancellations*
- *Updating Client Cancellations*
- *Deleting Client Cancellations*

Adding Client Cancellations

This task includes instructions for adding client cancellation records to the system.

To add client cancellations:

1 Access the Client Cancellations list page (see *Reviewing Client Cancellations (Transportation Only)*).

2 Click **Add Client Cancellation** in the status bar.

The **Client Cancellation Entry** page appears.

Client Cancellation Entry

Begin Date:

End Date:

Comments:

Max: 4000 characters.

3 In the **Begin Date** field, enter the first date at which the client wants to cancel any existing transportation orders.

4 In the **End Date** field, enter the last date at which the client wants to cancel any existing transportation orders.

5 In the **Comments** section, enter any information or details about the client cancellation. This entry can be up to 4,000 characters.

6 Click **Submit** in the status bar.

The client cancellation is saved and listed on the **Client Cancellations** list page. Any transportation orders for the selected client that fall in the date range saved for this client cancellation will be marked as **CBC - Cancelled By Client** in the system.

Updating Client Cancellations

After client cancellations are entered into the system, you must use the instructions in this task to update them.

To update client cancellations:

1 Access the Client Cancellations list page (see *Reviewing Client Cancellations (Transportation Only)*).

2 Locate the client cancellation record you want to update and click the corresponding **Select** button.

The **Client Cancellation Entry** page appears. You can edit any of the fields on this page. All required fields are highlighted. See *Adding Client Cancellations* for field descriptions.

3 After making the desired edits, click **Submit** in the status bar.

The updated client cancellation record is saved and listed on the **Client Cancellations** list page.

Deleting Client Cancellations

This task is used to delete client cancellations from the system.

To delete client cancellations:

1 Access the Client Cancellations list page (see *Reviewing Client Cancellations (Transportation Only)*).

2 Locate the client cancellation record you want to delete and click the corresponding **Delete** button.

A delete confirmation page appears.

3 Select **Yes** to confirm you want to delete the selected client cancellation record.

4 Click **Submit** in the status bar.

The selected client cancellation record is deleted from the system.

Viewing All Inactive Orders

An order is considered inactive if it has a past effective and expiration date and it has been signed. This task includes instructions for viewing all inactive orders for the selected client.

To view all inactive orders:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Show Inactive** in the status bar.

The **Inactive Orders** page appears, which lists all inactive orders for the selected client.

Inactive Orders

	Order Type	Summary	Effective Date	Expiration Date	Status	Ordered By					
Select	Medication	Medication Order Module	1/1/2007	1/11/2007	Pending	Support, QualFacts (QSI)	Status	Doc	Renew	Group	Expired

3 After reviewing the inactive orders, click **Show Active** in the button bar to return to the Orders master list page.

Renewing All Orders in Bulk

This tasks is used to renew all the active orders in bulk. You can renew orders in bulk from either the **Orders** list page or the **Orders Group** page.

When the orders are renewed from the **Orders** list page, all of the active orders for the selected client are renewed in bulk, which means the corresponding number of pending orders are automatically created.

When an order group is renewed in bulk from the **Orders Group** page, all of the active orders in the order group are renewed and the corresponding number of pending orders are automatically created. When an order group is renewed in bulk, a new order group is created for the new pending orders. This means the original orders and the new orders are in two different order groups.

Note: See *Renewing Orders* for an explanation of how the effective and expiration dates are assigned to the original and new orders.

To renew all orders in bulk:

1 To update an order from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To update an order from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 Click **Bulk Renewal** in the status bar.

The **Active Orders Renewal** page appears.

Note: If you are renewing the orders in bulk from the **Orders** list page, then all of the active orders for the selected client are listed on this page. If you are renewing the orders in bulk from the **Orders Group** page, then all of the active orders for the selected group are listed on this page.

Active Orders Renewal

	Order Type	Summary	Cur. Expiration	Ordered By
☑	Medication	Medication Order Module	(Not Set)	Support, Qualifacts (QSI)
☑	Medication	Medication Order Module	(Not Set)	Support, Qualifacts (QSI)
☐	Medication	Medication Order Module	(Not Set)	Support, Qualifacts (QSI)

3 Select the check boxes of the orders you want to renew.

4 Click **Submit** in the status bar.

The selected orders are renewed and listed as pending orders.

Signing Orders

This task includes instructions for signing the orders associated with the current order group. Once an order is signed, it is locked and cannot be modified. The only change that can be made to an order once it is signed is the order status.

Note: If desired, you can set up a trigger that requires the ordering staff member to electronically sign the order before the final order status can be assigned to the order (see page 194 the *System Administration Guide*). For example, suppose you want to require all billable orders to be signed before a claim is created. In this scenario, you would set up a trigger for each billable order type that requires a signature before the bill status state can be assigned.

To sign orders:

1 Access the **Orders Group** page (see *Accessing Order Groups*).

Orders Group

	Order Type	Summary	Effective Date	Expiration Date	Status	Signed				
Select	Medication Order	Clozaril	2/19/2007	(Not Set)	Completed	No	Status	Documents	Renew	Discontinue
Select	Lab Order	Lab Order Module	4/2/2007	(Not Set)	Completed	No	Status	Documents	Renew	Delete

Create New Order

Select Order Type: Medication Order, Transfer Order, Lab Order, Seclusion or Restraint, Discharge Order, Activity Order, Radiology Order, Admit Order, Dietary Order, DME Order, EKG Order, Ratings Scale Order, Generic Order, Consultation Order, Precaution Order

Create Order

Signature

Ordering Physician: QA Guy, Standard (QSI)

Signature: •••••••

Note: By default, the **Ordering Physician** field is automatically populated with the name of the staff member who gave the order. This is the staff member who must sign the order.

2 The ordering staff member must enter a valid electronic signature in the **Signature** field.

3 Click **Submit** in the status bar.

The orders in the group are signed and the **Orders Group** page is refreshed. The Signed column indicates that the orders have been signed and the Signature field indicates that there are no unsigned orders in the group.

Note: When the signed order record is selected, the Recorded By field lists the name and all credentials of the staff member who made the order and the date and time the order was signed.

Signing All Pending Orders in Bulk

This task includes instructions for signing all pending orders in bulk.

To sign all pending orders in bulk:

1 Access the **Orders** list page (see *Creating Orders Through CareLogic*).

2 Click **Sign Pending** in the status bar.

The **Pending Orders** page lists all pending orders for the selected client.

Pending Orders

	Order Type	Summary
☑	Seclusion & Restraint	Seclusion Order Module
☑	Seclusion & Restraint	Seclusion Order Module

Signature

Signature: •••••••

3 Select the check boxes of the orders you want to sign.

4 Enter an electronic signature in the **Signature** field.

5 Click **Submit** in the status bar.

A confirmation message appears in the status bar and the selected orders are listed in the **Active Orders** section of the **Orders** list page.

Discontinuing Orders

Orders can be discontinued only if an expiration date has been defined and the order has been signed. An order can be discontinued from either the **Orders** list page or the **Orders Group** page. This task includes instructions for discontinuing an order.

To discontinue orders:

1 To discontinue an order from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To discontinue an order from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 Click the **Discontinue** button that corresponds with the order you want to discontinue.

The **Discontinue Order Confirmation** page appears.

3 Select **Yes** to confirm you want to discontinue the selected order.

4 Click **Submit** in the status bar.

The selected order is listed on the **Orders** list page with a status of Discontinued.

Deleting Pending Orders

Once an order has been signed, it is active and cannot be deleted. You can only delete pending orders. Pending orders can be deleted from either the **Orders** list page or the **Orders Group** page.

To delete pending orders:

1 To delete an order from the master orders page, access the **Orders** list page (see *Creating Orders Through CareLogic*).

To delete an order from the order group page, access the **Orders Group** page (see *Accessing Order Groups*).

2 Click the **Delete** button that corresponds with the order you want to delete.

The **Delete Order Confirmation** page appears.

3 Select **Yes** to confirm you want to delete the selected order.

4 Click **Submit** in the status bar.

The selected order is deleted and removed from the system.

Service Documents

CareLogic gives you the flexibility to build your own service documents. By using the Service Documents module (see page 149 the *System Administration Guide*), you can configure the service documents to meet the specific needs of your treatment facility. Service documents can consists of any number of clinical modules (see *Clinical Modules*) and clinical orders (see *Clinical Orders*).

This chapter describes the basic tasks associated with service documents. The following topics are included in this chapter:

- *Attach Service Documents to Activities*
- *Associate a Service Document With a Program*

- *Create an Order Through a Service Document*
- *Schedule an Activity Through a Service Document*
- *Delete Unsigned Service Documents*
- *Sign Service Documents*
- *Access Completed Service Documents from Within a New Service Document*
- *Service Document Copy Forward*
- *Copy Forward Configurable Form Fields*
- *Add an Addendum to Service Documents*
- *Audit a Service Document*
- *Accept a Signed Service Document*
- *Reject a Signed Service Document*
- *Print Service Documents*
- *Delete Signed Service Documents*
- *Complete Service Document Groups*

Attach Service Documents to Activities

This task is used to attach a service document to an activity. Every activity that is set up in the system must have a corresponding service document crosswalk record (see the page 169 *System Administration Guide*). The process of attaching a service document to an activity is available only if there are no activities currently associated with the service document.

To attach service documents to activities:

1 Access the desired service document list page.

Discharge - Discharge Summary

	Service Date	Activity	Program	Staff	Signature Date				
Select	10/17/2008			QA Guy, Standard (QSD)	10/17/2008	Attach	Report	Delete	Audit

2 Click the **Attach** button.

The **Activities without Documentation** page appears. This page lists all of the activities associated with the selected client that are not attached to a service document. For each activity, this page lists the activity date and time, activity code, staff member associated with the activity, and status of the activity.

Activities without documentation

Activity Date	Activity Time	Activity Code	Activity Staff	Activity Status
1/12/2007	1/12/2007 1:00 PM	Memo to Chart (MEMO)	Support, Qualifacts	Kept

3 Click the **Attach** button to associate the service document with the activity.

The service document is attached to the selected activity. Your Web browser is refreshed to display the service document list page. A confirmation message appears in the button bar, and the **Attach** button is replaced with an **Unattach** button.

Note: Once a service document is attached to an activity, the **Attach** button is replaced with the **Unattach** button. The **Unattach** button is used to remove the service document from the activity it is currently attached to. If desired, you can then attach the service document to another activity by using the **Attach** button.

Associate a Service Document with a Program

Program Selection in a service document allows the service document to be associated with a program if it is completed separately from activity documentation. This is important if the service document should be included in state reporting, and may be useful in other situations.

You can select a program for the service document by editing the session information.

1 Go to ECR → select a service document.

2 Click the **Edit Session Information** link.

Note: The **Edit Session Information** link will only be displayed if the program selection is required and the service document is not attached to an activity.

Session Information

Client:	Badun, Jasper (1102)
Staff:	House, Greg (1427)
Document Date:	1/9/2012
Client Program:	(Not Set)
	Edit Session Information

3 Select a program from the dropdown list.

Note: The dropdown list will only display active programs for the client.

Program: Select Program

Submit Cancel

4 Click the **Submit** button in the **Edit Session Information** window.

The first module in the service document will available to complete.

Note: If the program selection is required, the module containing the session information can still be submitted without selecting a program. The program selection validation is done in the signature module. A signature field will not be displayed if the program selection is required but has not been made.

Create an Order Through a Service Document

When setting up your service documents (see page 149 the *System Administration Guide*), you have the ability to link the Orders module to service documents. When you enable this feature, the Orders module is linked to the service document, which means you can create an order directly from the service document.

Important: When orders are created through service documents, they are simply linked to the service document. It is important to understand that orders are not a part of the service documents. The orders that are created through service documents must be signed separately from the service document.

To create an order through a service document:

1 Access a service document that has been configured with the Orders module enabled.

2 Click the Orders link in the left pane

The Orders module appears. See *Clinical Orders* for detailed instructions about using the Orders module.

Schedule an Activity Through a Service Document

When setting up your service documents, you have the ability to configure them so that activities can be scheduled through the service documents (see page 149 the *System Administration Guide*). This feature allows your staff members to meet with clients on an unscheduled basis, and then schedule the activity after the fact - when they complete the service document. Once an activity is scheduled through a service document, it is automatically marked as Kept, which means it will be processed by the nightly run of the Claim Engine.

Note: Scheduling a service through a service document still must pass all scheduling validation issues (see the Scheduling Guide) and Scheduling Rules (see the System Administration Guide).

Note: Staff participating in pay for performance will need to select a value for the **Method of Delivery** field for the service to be included. If the field is not visible, contact your system administrator

To schedule an activity through a service document:

1 Access a service document that has been configured to schedule an activity.

2 Click the Schedule Service link in the left pane.

The **Schedule a Service** page appears. All required fields are highlighted.

3 Enter the date of the activity in the **Service Date** field. This entry must be either today's date or a past date. It cannot be a future date. This entry must be in the following format: mm/dd/yyyy. You can either manually enter a date or click the Calendar icon to select a date from the pop-up window.

4 In the **Time From** field, enter a start time for the activity, and select either A.M. or P.M.

5 In the **Time To** field, enter an end time for the activity, and select either A.M. or P.M. The value you enter in this field must be later than the value in the Time From field.

6 If the activity you are scheduling has been set up to allow for non-billable minutes entry, you can enter the number of minutes from this session which should not be billed for in the **Non-billable Minutes** field.

Note: The **Non-billable Minutes** field is not used unless you select an activity that has been set up to allow for non-billable minute entry. The entered amount in this field cannot exceed the actual duration of the appointment.

7 By default, the **Staff Name** field is automatically populated with the staff member's name who is scheduling the activity. If desired, you can use the drop-down list to select a different staff member.

Note: The **Client** field is automatically populated with the selected client.

Important: A service can also be scheduled through service documents in a Client Episode, but if accessed in that manner, you will only see the programs attached to the selected client episode available for scheduling services in the **Client Program** field.

8 After selecting a client in the previous step, the **Client Program** field is automatically filtered with the programs that are available to the client. Use the drop-down list in this field to select the desired treatment program for the client.

Note: If the staff selected in step 7 has a primary program designated and the client is active in that program the **Client Program** field defaults to the staff's primary program.

9 In the **Activity** field, use the drop-down list to select the activity you are scheduling. The activities that are available in this field are set up on the **Activity Codes** page (see page 46 the *System Administration Guide*).

10The **Organization** field is used to select the organization that staffs the clinician. This is the organization that will bill for the activity. This drop-down list contains the organization you are currently logged into and all child organizations.

11In the **Contact Location** field, use the drop-down list to select the actual location where the scheduled activity will occur. This is the location where the staff member and the client will meet. Depending on the situation, the contact location could be the staff member's office, the client's home or office, a hospital, etc.

12If you want to display a message with the activity on the Front Desk Schedule, select the **Show on Front Desk** check box and then make an entry in the **Description** field. The maximum length allowed in this field is 100 characters.

13Click **Submit** in the status bar.

The activity is saved and the status of the activity is marked as Kept. During the nightly run of the Claim Engine, the activity will be processed fro billing.

Delete Unsigned Service Documents

Depending on the needs of your organization, each service document can be set up so that staff member's are required to have the 'Delete Unsigned Documents' privilege level in order to delete unsigned service documents (see page 155 the *System Administration Guide* for information about configuring the service document and page 17the *Human Resources Guide* for information about assigning the privilege level). If this feature is set up for the selected service document, and a staff member does not have the appropriate privilege level, then the Delete button will not be available.

If the service document is configured without delete restrictions, then all staff members who have access to the ECR can delete unsigned service documents. Once a service document is signed, it is locked and cannot be deleted. If the service document has been signed, you must use the steps on page 170.

To delete unsigned service documents:

1 Access the desired service document list page.

Discharge - Discharge Summary

	Service Date	Activity	Program	Staff	Signature Date				
Select	10/17/2008			QA Guy, Standard (QSD)	10/17/2008	Attach		Report	Delete

2 Click the **Delete** button that corresponds with an unsigned service document.

The Confirm Delete page appears.

3 Select **Yes** to confirm you want to delete the selected service document.

4 Click **Submit** in the status bar.

Your Web browser is refreshed and returned to the service document list page. A confirmation message appears in the button bar, which indicates the selected service document has been deleted from the system.

Sign Service Documents

All service documents must be electronically signed by at least one staff member. Once a document is signed, it is locked and cannot be modified. The number of staff signatures required on a service document is defined when the service documents are configured (see page 151 the *System Administration Guide*).

Staff signatures can be configured to include the job title. Contact Qualifacts for assistance.

In addition to the staff signature, a service document can also be configured for external signatures (clients or guarantors). In order for a client to sign a service document, the signature pad hardware device must be installed.

Note: When a service document is configured to enable an external signature, the signature field is optional on that service document.

To sign service documents:

1 Access a service document.

2 Click the Signatures link in the left pane.

The **Electronic Signatures** page appears.

Note: If a module within the service document has required fields and validation enabled, bypassing it will produce a validation error when selecting the signature page. All validation errors must be cleared before the signature page will display the signature field.

Electronic Signatures

Validation Issues:	Error: Requirements not met for Modified Mini.
Electronic Signature:	The document can not be signed until the errors above are resolved.

Signature History

Action	Date	Staff
No records found		

Note: The **Signatures** field is available only if the service document has been configured to allow external signatures. If the service document is not configured to allow an external signature, the **Signatures**, **Guarantor**, and **New Guarantor** fields are *not* available.

1 If your service document was set up to Enable Progress Trending, your service document trending questions appear. For each trending question, use the drop-down to select the appropriate rating scale.

Important: If the selected service document has been completed for the same client before, the Progress Trending chart displays the trends associated with each question.

2 Click the **Click to Sign** button below the **Signatures** field.

A **Signature Capture** window opens.

3 Have the client or guarantor manually sign the signature pad.

The external signature appears in the **Signature Capture** window.

4 Click the **OK** button on the **Signature Capture** window.

The external signature is captured and it and the date and time of signing are displayed in the service document.

5 If the client's guarantor was present during the signing, use the drop-down list in the **Guarantor** field to select the guarantor's name. If the guarantor is not listed in the drop-down list, manually enter the guarantors name in the **Enter New Guarantor** field.

6 The **Electronic Signature** field is used by the staff member to sign the service document. Once a valid electronic signature is entered, the service document is locked and cannot be modified.

Note: The service document can be signed even if the document is not complete. refer to for details.

7 If the service document was configured to require multiple staff signatures, the **Next Staff to Sign** field appears. After the first staff member signs the service document, the next staff to sign the document must be selected.

Note: The **Next Staff to Sign** field is available only if the service document has been configured to allow multiple staff signatures.

Note: If the service document you are completing is associated with a service that was assigned to an **Incident/Bill To** supervisor, the **Incident/Bill To** staff member you selected on the Appointment Status page appears as read-only text and will be required to approve and sign the service document before it is billed out.

8 If the **Next Staff to Sign** field has been set up to allow users to select multiple staff members at one time, you must search for the staff by partial or full name and select the desired staff member from the filtered drop-down list. Once selected, click the Add link to add the selected staff member to the Next Staff to Sign list.

Note: This option is used to accelerate the document signature process for service documents that require multiple signatures. For example, if 4 providers must sign off on a treatment plan, rather than assigning the document for review and signatures one provider at a time, this option allows you to send alerts to all 4 providers to have them review and sign it at once.

9 Click **Submit** in the status bar.

The service document is saved and the record is displayed on the list page. Notice that the **Signature Date** column displays the date the service document was signed.

Discharge - Discharge Summary

	Service Date	Activity	Program	Staff	Signature Date				
Select	10/17/2008			QA Guy, Standard (QSI)	10/17/2008	Attach	Addenda (0)	Report	Dele

Note: When a signed service document is opened, the staff signature field lists the staff member's name and all staff credentials, as well as the date and time the service document was signed.

Service Document Review History

All service document links display a list of created service documents when initially selected. Each created service document contains a signature history table, or **Review History**, on the signatures page. The table will be blank if no signatures have been recorded. This allows clinicians and supervisors to review a document's progress through signatures. The **Review History** on client service documents will only display to the creator of the document, any staff selected to sign next, and clinical supervisors. The view capability for supervisors will occur only if the document is signed on or after the date the employee is assigned to their supervision.

Once the document is fully signed the **Review History** is visible only for those with the **Show Service Document Review History** privilege level. Supervisory status will no longer be considered when determining who can view the **Review History**. Refer to *Set Up User Privileges* for details.

Sign an Incomplete Service Document

There are some cases when documents need to be marked Incomplete. An example would be when a client has left the program prior to document completion but with services provided. This procedure allows a service document to be marked Incomplete but still be signed.

Note: This option is not recommended for service documents that are used for State Reporting.

Access the Signature module for a service document to be signed. Refer to *Sign Service Documents* for details.

Follow the normal signature procedures. Add the steps below.

- Indicate on the **Status** row whether the document is Incomplete or Complete.

Note: The following fields are only required if the status is Incomplete.

- Select the incomplete category.
- Enter a reason for the document being incomplete.

Client Signature Module

CareLogic offers a standard module to record more detailed information about any external participants such as family members, probation officers, or others who were present for and may have participated in the client session.

You can also use this module to record external individuals who were invited to the session but failed to attend.

To complete the client signature module:

1 Access the ECR module.

2 Access a service document that contains the Client Signature module.

3 Click the **Client Signature** link in the left pane.

The **Client Signature** page appears.

4 In the **Client Signed Date** field, enter the date on which the client signed off on the document.

5 Enter any client quotes, notes, or comments in the **Client Comments** field.

6 Indicate if the client participated in making decisions about his treatment.

Note: Your service document can be configured to modify the name of this field. Please contact QSI Support for details on configuring your service document to change this field label.

7 Indicate if the client's family participated in making decisions about his treatment.

Note: Your service document can be configured to modify the name of this field. Please contact QSI Support for details on configuring your service document to change this field label.

8 Provide more details about the client and his family's participation in the decision making process in the **Summary of Collaboration** field.

9 Indicate if the client received a copy of the document being completed.

10 Indicate if the client refused a copy of the document.

11 Indicate if the client received a a copy of the Client's Rights Brochure.

12 Click the **Click to Sign** button below the **Client's Signature** field.

A **Signature Capture** window opens.

13 Have the client or guarantor manually sign the signature pad.

The external signature appears in the **Signature Capture** window.

14 Click the **OK** button on the **Signature Capture** window.

The external signature is captured and it and the date and time of signing are displayed in the service document. The Signature History of the document is listed at the bottom of the page.

15 In the Participant table, provide the following information about all external participants in the client's session:

a Enter the external Participant Name.

b Select the participant's Role/Relationship to the client.

c Indicate if the participant was invited to the session.

d Indicate if the participant actually attended the meeting or not.

16 Click **Submit** in the status bar.

The external signature is captured and it and the date and time of signing are displayed in the service document.

Access Completed Service Documents from Within a New Service Document

CareLogic allows you to access previously completed service documents for the currently selected client directly from the new service document you have open. The Document List appears in all open service documents and is located below the Service Document Wizard and displays the last 50 service documents for the selected client. The list displays the date of the document and the staff who completed the documentation.

Note: A configuration exists which allows you to define if you want all completed service documents to appear in the drop-down list or if you want the list to be filtered and to display only the completed service document types as the one you currently have open. Please contact QS I Support for more information about this configuration.

Service Document Copy Forward

The Copy Forward feature enables clinicians to create new service documents for clients while reviewing the client's older service document. This feature allows clinicians to copy forward the previous session information that is pertinent to the current session information.

Important: Service documents can only be copied forward if they are part of the same instance of a service document. For example, you cannot copy forward a treatment diagnosis service document from one instance of that service document to another.

A user may only copy forward a service document on which he (the logged in user) is the first signature on the document.

The Copy Forward feature is available on service documents that are built using both standard CareLogic clinical modules (see *Clinical Modules*) and configurable forms (see page 187 the *System Administration Guide*).

- In order to copy forward service documents built using standard clinical modules, the 'Copy Service Document' option must be selected in the **Modules** list (see page 187 the *System Administration Guide*).

- In order to copy forward service documents built using configurable forms, the fields that are to be copied must be flagged for copy forward on the **Field Codes** page (see page 187 the *System Administration Guide*).

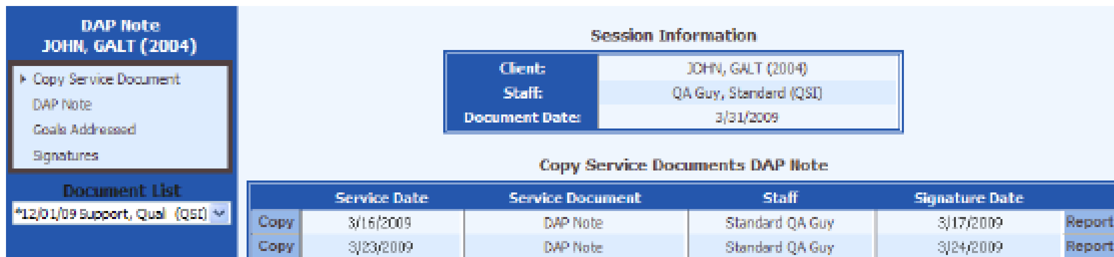
To copy forward service documents:

Note: The copy forward feature is available on service documents that are accessed either through the ECR module or the Schedule.

1 Access a service document that has been setup to allow the copy forward functionality.

By default, the **Copy Service Document** link is selected in the left pane. A list page appears in the right pane for the selected service document, displaying all of the signed service documents that can be copied forward. This page will list up to a maximum of 10 past service documents.

Important: To review the contents of a service document, click the **Report** button. Once you locate the service document you want to copy forward, continue with the next step.



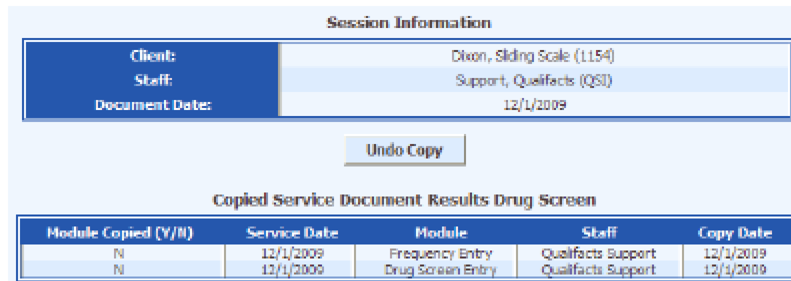
2 Locate the service document you want to copy forward and click the **Copy** button.

With the exception of the document signatures, all of the data in the service document is copied forward into a new instance of the service document.

3 At this point, you can complete the new service document.

Important: After copying forward a service document, you have the ability to Undo the copy forward and remove the newly created record by clicking **Return to List** and selecting the unsigned service document you created with the copy forward functionality.

When you select the unsigned, copied forward service document, the Copy Service Document page of the service document wizard appears. This screen displays the modules that were copied forward and also provides an **Undo** button to remove the record you created with the copy forward.



Copy Forward Configurable Form Fields

The Copy Forward Configurable Form Fields feature enables designated fields to be copied forward across service document types, reducing redundant data entries in the Initial Assessment, Discharge Summary, POMS, and Plan of Care modules.

Important: This is not a general capability. Only those fields and service documents discussed in this section have the capability.

Copy Forward-Presenting Concerns

The **Copy Forward- Presenting Concerns** feature is used to copy the **Presenting Problem** field in **Intake Tracking** to the **Presenting Concerns** field in the **Copy Forward: IA – History and Discharge Summary**, **POMS**, and **Plan of Care** modules. Each module will be populated from the **Presenting Problem** field in **Intake Tracking** or from the most current completed version of itself.

This feature operates through the Point of Entry module. Refer to *Copy Forward Configurable Form Fields* in the PoE guide.

Copy Forward-Priority Group and Summary

The **Copy Forward-Priority Group and Summary** is used to pre-populate the **POMS Record** and the **Tx Plan Info** modules. The priority group information will copy forward to the POMS Record. The summary will copy forward to the Tx Plan Info module.

Add a Copy Forward-Priority Group and Summary Record

1 Go to ECR → service document containing **Copy Forward-Priority Group and Summary**.

2 Select the **Copy Forward-Priority Group and Summary** module.

The **Copy Forward-Priority Group and Summary** module will be displayed.

Copy Forward: Priority Group and Summary

Priority Group/MH Only

Priority Group: Select Priority Group D

Summary of Therapeutic Need / Justification of Diagnosis (MH) / or D&A Psychosocial

Summary: Initial summary information

Max: 4000 characters.

3 Select a **Priority Group**.

4 Edit or enter **Summary** information.

5 Click **Submit**.

6 Complete the rest of the service document.

Copy Forward-Plan of Care

The **Copy Forward-Plan of Care** is used to pre-populate the **Tx Plan Info** modules.

Add a Copy Forward-Plan of Care Record

1 Go to ECR → service document containing **Copy Forward-Plan of Care**.

2 Select the **Copy Forward-Plan of Care** module.

The **Copy Forward-Plan of Care** module will be displayed.

Copy Forward: Plan of Care

Client Strengths/Abilities/Supports:	Initial strengths and abilities information Max: 2000 characters.

3 Edit or enter **Client Strengths/Abilities/Supports** information.

4 Click **Submit**.

5 Complete the rest of the service document.

Copy Forward-POMS Record and Plan of Care

The Copy Forward-POMS Record is used to pre-populate the **POMS Record** and the **Plan of Care** modules. The demographic and school information will copy forward to the **POMS Record**. The school information will copy forward to the **Plan of Care**.

Add a Copy Forward-POMS Record

1 Go to ECR → any service document containing **Copy Forward-POMS Record and Plan of Care**.

2 Click **Add a POMS Record** button.

The **Copy Forward-POMS Record and Plan of Care** entry page will appear.

Copy Forward: POMS Record and Plan of Care

Staff Member Completing:	Select Staff
Living Arrangements:	Select Living Arrangements D
Marital Status:	Select Marital Status D
Race:	Select Race D
Ethnicity:	Select Ethnicity D
Gender:	Male Female
Employment:	Select Employment D
Are you disabled?	Yes No
Are you a Veteran?	Yes No
Education:	Select Education
Education Date Range:	to
Graduation Date:	
Primary Language:	Select Primary Language D
Are you 17 or under?	Yes No

School Information

School Attendance:	Select School Attendance D
School Performance:	Select School Performance D
School Behavior:	Select School Behavior D
Source of School Information:	Select Source of School Information D

3 Complete the form:

- Staff Member Completing: Choose from the dropdown (required).
- Living Arrangements: Choose from the dropdown (required).
- Marital Status: Choose from the dropdown (optional).
- Race: Choose from the dropdown (optional).
- Ethnicity: Choose from the dropdown (optional).
- Gender: Indicate the client's gender (optional).
- Employment: Choose from the dropdown (optional).
- Are you disabled: Indicate whether the client is disabled (optional).
- Are you a Veteran: Indicate whether the client is a veteran (optional).
- Education: Choose from the dropdown (optional).
- Education Date Range: Enter beginning and end dates of education period (optional).
- Graduation Date: Enter the latest date of graduation (optional).
- Primary Language: Choose from the dropdown (optional).
- Are you 17 or under: Indicate whether the client age is 17 or less (required).

The following fields will only be displayed if the previous question is marked **Yes**:

- School Attendance: Choose from the dropdown (optional).
- School Performance: Choose from the dropdown (optional).
- School Behavior: Choose from the dropdown (optional).
- Source of School information: Choose from the dropdown (optional).

4 Click **Submit**.

Add an Addendum to Service Documents

Once a service document is signed, it is locked and cannot be modified. If you need to add or update any of the information in a signed service document, you must add an addendum to it. For each service document, multiple addenda can be added. The Addenda button displays the number of addenda associated with each service document.

Note: When you print a service document (see *Print Service Documents*), the report automatically includes all of the addendum information.

To add an addendum to service documents:

1 Access the desired service document list page.

Discharge - Discharge Summary

	Service Date	Activity	Program	Staff	Signature Date				
Select	10/17/2008			QA Guy, Standard (QSD)	10/17/2008	Attach	Addenda (0)	Report	Delete

2 Click the **Addenda** button.

The **Addenda** list page appears for the selected service document.

3 Click **Add Addendum** in the status bar.

The **Addenda** page changes to data entry mode. Both the Addendum Narrative and Electronic Signature are required.

Addenda

Narrative	Signed By	Signed Date
	No records found	

Addendum

Addendum Narrative: Information available after the meeting that is needed for this note

Text for addendum narrative goes here.

Max: 2000 characters.

Electronic Signature: This addendum must be signed at the time it is created.

•••••••

4 In the **Addendum Narrative** field, enter the information you want to add to this service document. This entry can be up to 2,000 characters.

5 The addendum record must be signed at the time the narrative is written. In the **Electronic Signature** field, enter a valid electronic signature for your user account.

6 Click **Submit** in the status bar.

The addendum record is saved and listed on the **Addenda** list page.

Addenda

Narrative	Signed By	Signed Date
Text for addendum narrative goes here.	QA Guy, Standard (QSI)	10/17/2008 9:29 AM

Note: All addendum information that is added to a service document is automatically included in the printed report (see *Print Service Documents*).

Audit a Service Document

System Administrators have the ability to audit an individual service document to view the entire audit history of which staff members have viewed, created, modified, deleted, and printed that document.

Important: Only users with the Administrator privilege level have access to the Audit button.

To audit a service document:

1 Access the desired service document list page.

Discharge - Discharge Summary

	Service Date	Activity	Program	Staff	Signature Date				
Select	10/17/2008			QA Guy, Standard (QSI)	10/17/2008	Attach	Report	Delete	Audit

2 Click the **Audit** button.

The **Audit Log** page appears, displaying all staff members who accessed the selected service document.

Begin Date: N/A, End Date: N/A, Staff: All, Service Document: All, Client: Albert, Lisa (3049) Organization: All, Actions: None

Audit Log

Primary Key	Date	Time	Client Name	Staff	Action	Page Title/Service Document	Comments
18829	11/16/2010	08:57 AM	Albert, Lisa (3049)	Dude, QA (QSI)	Create	Arrest History	
18829	11/16/2010	08:57 AM	Albert, Lisa (3049)	Dude, QA (QSI)	View	Arrest History	
18829	11/16/2010	08:58 AM	Albert, Lisa (3049)	Dude, QA (QSI)	Modify	Arrest History	
18829	11/16/2010	09:00 AM	Albert, Lisa (3049)	Dude, QA (QSI)	Print	Arrest History	

Important: The Audit Log list page displays the primary key (an internal tracking key), the date and time the audit record occurred, the client whose health information was accessed, the staff member who accessed the client's record, the action the staff member took, the page on which the action occurred, and any comments associated with the action (which includes Black Box and Client Access Log comments).

The Audit Log results page can be exported as a spreadsheet by clicking the **Export to Excel** button in the status bar.

Accept a Signed Service Document

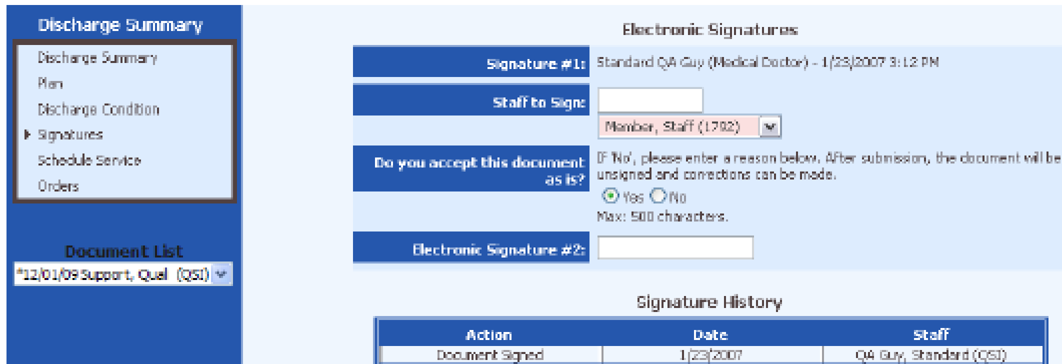
By default, once a service document that requires multiple signatures is signed, it is locked and cannot be modified by anyone, including the supervisor of the staff member who signed it. However, if you want to give supervisors the ability to review and then either accept or reject signed service documents, you must enable this feature when configuring your service documents (see page 151 the *System Administration Guide*).

To accept a signed service document:

1 Access a service document that has been configured to allow signed documents to be either accepted or rejected by the next staff to sign.

2 Click the Signatures link in the left pane.

Note: In the following example, the Discharge Summary service document is displayed. The **Signature #1** field lists the name of the first staff member who signed the document. The **Staff to Sign** field lists the name of the next staff member who is required to sign the document. The Signature History of the document is listed at the bottom of the page.



3 In the **Do You Accept This Document As Is** field, select Yes to indicate the service document has been reviewed and accepted.

4 In the **Electronic Signature #2** field, enter an electronic signature to lock the service document so that it cannot be modified.

5 Click **Submit** in the status bar.

The service document is completed and locked, which means it cannot be modified. A new record is added to the Signature History section.

Reject a Signed Service Document

By default, once a service document that requires multiple signatures is signed, it is locked and cannot be modified by anyone, including the supervisor of the staff member who signed it. However, if you want to give supervisors the ability to review and then either accept or reject signed service documents, you must enable this feature when configuring your service documents (see page 151 the *System Administration Guide*).

Note: When a signed service document is rejected, an alert is automatically sent to the first staff member who signed (see *Alerts*).

To reject a signed service document:

1 Access a service document that has been configured to allow signed documents to be either accepted or rejected by the next staff to sign.

2 Click the Signatures link in the left pane.

Note: In the following example, the Discharge Summary service document is displayed. The **Signature #1** field lists the name of the first staff member who signed the document. The **Staff to Sign** field lists the name of the next staff member who is required to sign the document. The Signature History of the document is listed at the bottom of the page.

3 In the **Do You Accept This Document As Is** field, select No to indicate the service document is not acceptable as is.

A new text box appears.

4 Enter the reason you are rejecting the document in the text field. This field, which can be up to 500 characters, is a required field. The text you enter in this field is attached to the service document for future reference.

5 In the **Electronic Signature #2** field, enter an electronic signature to unlock the service document so that it can be modified by the first staff member to sign.

6 Click **Submit** in the status bar.

The service document is unlocked and can be modified by the staff members who originally had access to it, including the first staff to sign. A new record is added to the Signature History section.

Print Service Documents

This task is used to generate a report, in PDF format, of the selected service document. The report includes all of the information contained in the service document, including all addendum information that has been added (see *Add an Addendum to Service Documents*). Once the report is created, you can use the Adobe Acrobat Reader to view and print it.

To print service documents:

1 Access the desired service document list page.

2 Click the **Report** button.

A new Web browser opens, displaying a report of the selected service document in the PDF format. The top of the report lists the following session information:

- **Client.** The name of the client associated with the service document and the date of birth.
- **Staff.** The staff member associated with the service document.
- **Document Date.** The date the service document was created.

Note: If the service document included the Schedule a Service module or was associated with a scheduled service, the printed service document contains more information such as date and time of service (including the number of non-billable minutes where applicable), the scheduled activity, the program associated with the scheduled activity, and the organization at which the service was provided.

The body of the report is specific to the service document.

Delete Signed Service Documents

Once a service document has been signed, you can use this task to delete it. If the service document has not been signed, you must use the steps on page 169.

To delete signed service documents:

1 Access the desired service document list page.

Discharge - Discharge Summary

	Service Date	Activity	Program	Staff	Signature Date				
Select	10/17/2008			QA Guy, Standard (QSI)	10/17/2008	Attach	Addenda (0)	Report	Dele

2 Click the **Delete** button that corresponds with an signed service document.

The Confirm Delete page appears.

3 In the **Reason for Removal** field, enter the reason the service document is being deleted. This entry can be up to 500 characters.

4 In the **Administrative E-Sign** field, enter an administrative electronic signature.

5 Click **Submit** in the status bar.

Your Web browser is refreshed and returned to the service document list page. A confirmation message appears in the button bar, which indicates the selected service document has been deleted from the system.

Complete Service Document Groups

CareLogic offers you the ability to create service document groups for capturing multiple sets of information in one module. The service document group module creates tabbed containers that house each service document associate with the group and allows each service document to be signed by the appropriate staff.

If you attempt to delete a Service Document Group, a warning appears to alert you that you are deleting all service documents associated with the service document group.

Note: See the System Administration Guide for more information about setting up service document groups and adding instances to them.

To complete service document groups:

1 Access the service document list page for a service document that has been configured as a service document group.

SHIFT - SHIFT NOTES

	Service Date	Activity	Program	Staff	Signature Date			
Select	8/3/2009			QA Guy, Standard (QSI)	(Not Signed)	Attach	Report	Delete
Select	8/3/2009			QA Guy, Standard (QSI)	(Not Signed)	Attach	Report	Delete

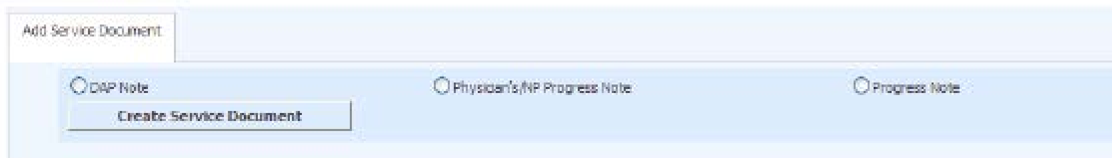
2 Click **Add a Service Document** in the status bar.

The **Add a Service Document** tabbed container page appears.

3 If the service document group has been set up to require a final signature, you must search for the staff member who is responsible for being the final signature on the service document group by partial or full name, and use the drop-down list to select the desired staff member.

4 Click **Submit** in the status bar.

The service documents available in the service document group appear



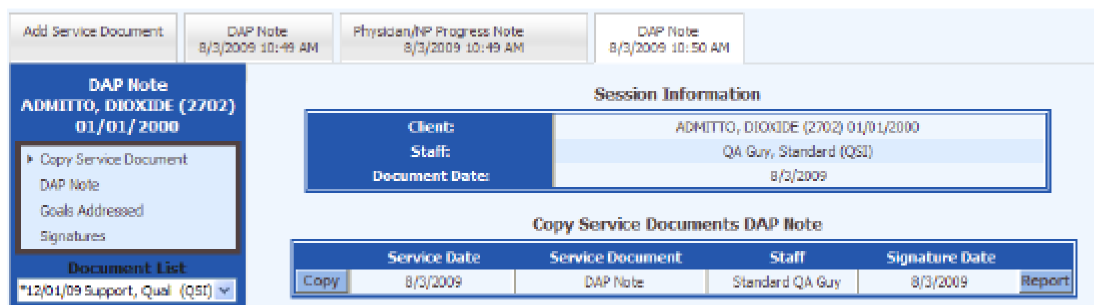
Note: The service documents available to create on this page are determined by how the service document group was set up by your system administrator and which clinical service documents were added to the group.

5 Select the service document you want to create for this service document group.

6 Click **Create Service Document**.

Note: If the group maximum limit for the service document type has been reached the selection will not be available for selection.

The selected service document list page appears, with the tabbed containers of any previously created service documents in the selected group displayed above.



7 Complete the service document as you normally would by clicking the appropriate module in the left pane and completing each form in the service document.

Note: Each service document in the service document group may have different requirements for signatures based on how your system is configured. Please contact your system administrator or QSI support for more details.

Note: Each service document in the group can also be accessed outside the group if a menu link is available.

Delete a Service Document Group

Note: Deleting a service document group will also delete all service documents contained in the group.

To delete a service document group:

1. Access the ECR module.

Note: You can access the ECR module either by performing a client search (see *Searching for Clients*) or by accessing your caseload (see *Maintaining Your Caseload*).

2. Select the desired service document group's menu link.

   The desired service document group's list page appears.

3. Click **Delete** on the desired service document group.

   Note: The **Delete** button can be privileged to only display if the user has the correct privilege level.

   The **Confirm Delete of Service Document Group** page appears.

	Confirm Delete of Service Document Group
Reason for Removal:	Please indicate why this document is being removed from the system. Max: 500 characters.
Administrative E-Sign:	
NOTE:	Deleting this Service Document Group will remove ALL Service Documents attached to this group.

4. In the **Reason for Removal** field, enter the reason the service document group is being deleted.

5. In the **Administrative E-Sign** field, enter your electronic signature.

6. Click **Submit**.