4a. Patient's Profile User Interface - Requirements Specification

This UI shows the collated information of the patient with links to other pt related UIs.

This includes separate sections/boxes for;

- Pt Admin Data
- Pt Allergies & Alerts
- Pt comorbidities & past admission diagnosis

Pt's events in the chronology

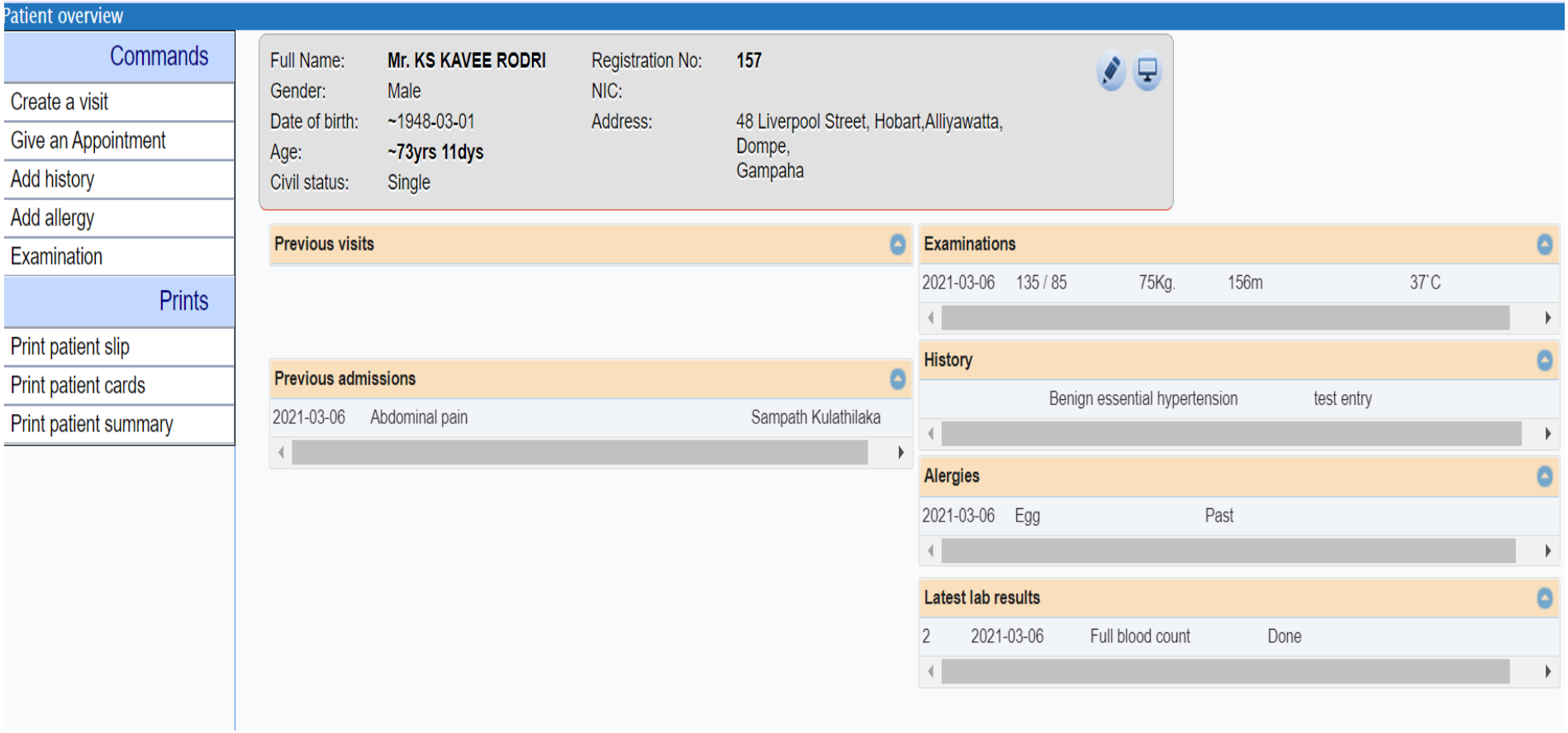
- Inpatient admissions
- Outpatient visits,
- ED visits
- Ad hoc notes
- Scanned documents (from external and internal care providers)
- Pictures & Photos (from external and internal care providers)

Needed Functions

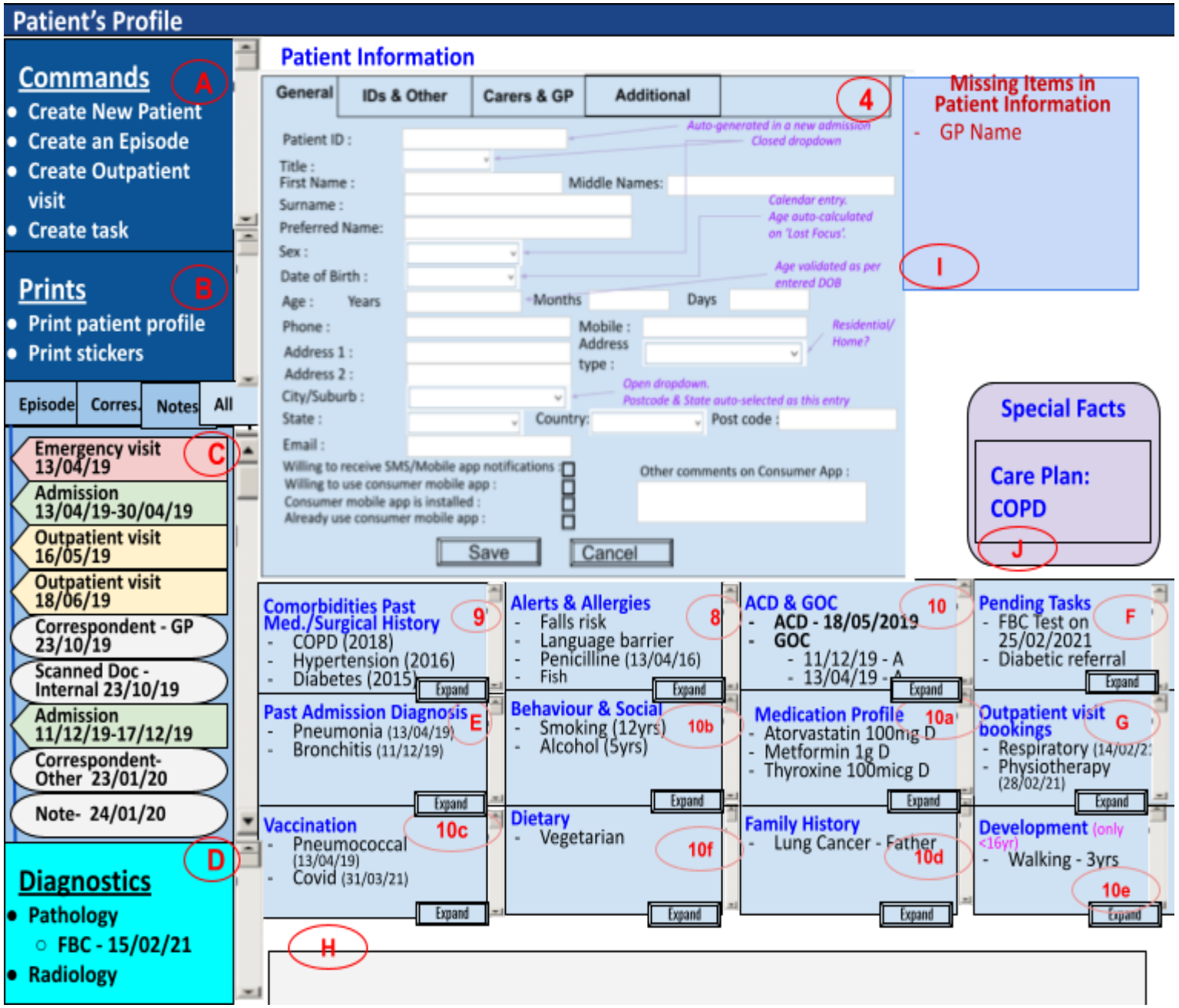
- Overview of patient basic information/profile
- Connections to other pt related data (generally related to the pt but not to the episode/admission)

UIs

Current: 'Patient Overview"



Suggested UI



A. Commands: Commands related to the patient generally (not to a specific episode/admission)

B. Prints related to the patient profile

C. List of episodes, records in the chronology.

Includes- 'Admission', 'Outpatient visit', 'Correspondent - GP', 'Correspondent - Other', Note, Scanned Doc- Internal, Scanned Doc- External, Pictures.

These include episode date/upload date.

One curser moves above the item tooltip text should appear with the following;

- Admission - Consultant, How many days back, Primary Diagnosis
- Outpatient visit- Seen by whom, Situation
- Correspondent - who sent
- Note - who entered
- Scanned doc - origin
- Pictures/photos - topic, author

There should be different tabs to filter as per the type of entries.

Once a box clicked it should lead to the relevant page.

- 'Admission' leads to- '**Inpatient Interface'** (goto)
- 'Outpatient visit' leads to- '**Outpatient Interface'** (goto)
- 'Correspondents', Note, Scanned Doc, Pictures lead to - '**Progress Notes'** (goto)

D. Diagnostics

Has pathology and radiology results in separate sections, listed latest in the top.

Clicking those diagnostics should lead to relevant '**Pathology view**' or '**Radiology view**' interfaces. These interfaces can appear in 12.

E. **Past Admission Diagnosis of inpatient and outpatient episodes** (

Secondary diagnosis should be popped up as a tooltip text one curser over the relevant diagnosis.

'Exapand' button should lead to viewing more details on admissions and diagnosis. Admission diagnosis should be auto-populated from the discharge summaries/outpatient summaries of the past admissions.

F. **Pending general Tasks** under patient profile (but not related to an episode)

Tasks should be listed with dates. Tooltip text should show the author.

Once clicked it should lead to deals of the task and editing interface. This interface can appear in 12.

G. **Booked Outpatient visits** are listed here in putting the latest in the top.

By clicking 'Edit' this can be edited or through 'create outpatient visit' in the command list of this UI. This interface can appear in 12.

H. Area to view expanded section

I. Missing Items in Patient Information
This box shows missing important (but not mandatory) information (fields) from the Patient Registration UI.
These are picked from the 'Missing_Item' (=Yes) in the fields table.

J. **Special facts** box has various information important inpatient care.
'**Care Group**' is the care pathway/diagnostic related care group that the patient is allocated (during one of the visit) from the **inpatient interface**

4. Patient Information section; 4. Patient Registration - Requirements Specification

8. Alerts and Allergies (the author should be indicated as a tooltip text one curse move above the relevant alert/allergy).

Edit button should lead to the data entry UI which is described in '**8. Alerts/Allergies- Requirements Specification**'. These are entered through this interface. These interfaces can appear in 12.

9. Comorbidities, Past Medical/Surgical History
'Exapand' button should lead to the data entry UI (that appears in 12) which is described in '**9. Comorbidities & Past Medical History-Requirements Specification**'.

10. Advanced Care Directives (ACD) & Goals of Care (GOC) Plans
ACD should be able to upload into this interface by clicking the 'Edit' button.
GOC is entered through admission (**Inpatient interface**). In this interface, GOC will be listed with date and GOC level. The tooltip of these should show the authors of the GOC form. Once clicked full GOC form should be viewed. These can be viewed in 12.

10a. **Medication Profile**
This contains the medication patient is currently on. This shows drug name, dose, and frequency. By clicking 'Edit' button user gets directed into the 'Medication Profile' interface which shows the current medication, dose, and frequency, date started, old ceased medication and comments related to those. Adding, ceasing or modifying the dosage of medication is also possible.

10b. Behaviour and Social Information

There is dedicated interface **Behaviour and Social Information** data entry which should when ‘Expand’ is clicked.

10c. **Vaccination Record**

There is dedicated interface vaccnication data entry which should when ‘Expand’ is clicked.

10d. **FamilyHistory**

There is a dedicated interface for **Family History** data entry which should be shown when ‘Expand’ is clicked.

10e. **Development History**

There is a dedicated interface for **Development History** data entry which should be shown when ‘Expand’ is clicked.
This is available only for patients equal or less than 16 yrs of age.

10f. Dietary History