

# EHR Version 2.0 User Manual

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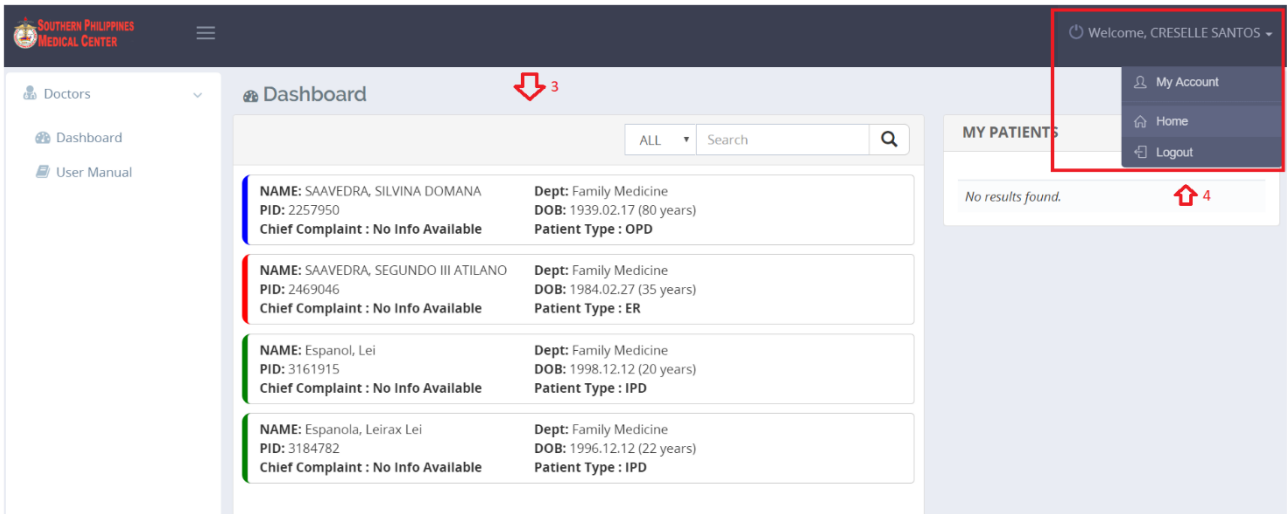
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Login

- 1. Go to EHR at 10.1.80.62/ehrprod, and login as doctor.
- 2. Input username and password, and click the “Login” button.



- 3. After successful login, you will be redirected to the doctor’s dashboard, which is the default page of the system.
- 4. To sign out from the system, click the “Logout” button located at the upper right side of the page.
- 5. To view account information, click “My Account” button located at the upper right side of the page.
- 6. Access to the “User Manual” is also made available below the dashboard.



# Search Patient

1. To Search a Patient, input the Name, HRN, or Case Number.

Dashboard

1

ALL

cabahug, carlito

Q

NAME: CABAHUG, CARLITO SAAVEDRA

PID: 2089602

Chief Complaint : No Info Available

DOB: 1950.07.05 (68 years)

Patient Type : ER

Dashboard

2

ALL

2089602

Q

NAME: CABAHUG, CARLITO SAAVEDRA

PID: 2089602

Chief Complaint : No Info Available

DOB: 1950.07.05 (68 years)

Patient Type : ER

Dashboard

3

ALL

2019300073

Q

NAME: CABAHUG, CARLITO SAAVEDRA

PID: 2089602

Chief Complaint : No Info Available

DOB: 1950.07.05 (68 years)

Patient Type : ER

## Filter by patient type

1. Filter by “ALL” → all encounter type under the doctor’s department will be displayed.  
*(Note: If the doctor has the access permission to view all patients of the hospital, all patient will be displayed.)*  
Color coding for patient type:  
Red – ER  
Gray – Discharge  
Green – IPD  
Blue - OPD
2. Filter by “OPD” → all outpatient under the doctor’s department will display.
3. Filter by “IPD” → all inpatient under the doctor’s department will display.
4. Filter by “ER” → all ER patient under the doctor’s department will display.

Dashboard

1

ALL Search

« 1 2 3 4 5 6 7 8 9 10 »

NAME: REDONDO, SHAINA CARLOS

PID: 3184700

Chief Complaint : No Info Available

DOB: 1990.12.10 (28 years)

Patient Type : OPD

NAME: CAAGBAY, CALVIN CASTARITAS

PID: 1582694

Chief Complaint : No Info Available

DOB: 2007.10.28 (11 years)

Patient Type : OPD

Dashboard

ALL Search

« 1 2 3 4 5 6 7 8 9 10 »

NAME: CABAUG, CARLITO SAAVEDRA

PID: 2089602

Chief Complaint : No Info Available

DOB: 1950.07.05 (68 years)

Patient Type : ER

ER

NAME: Green, Kros OPD

PID: 3184655

Chief Complaint : No Info Available

DOB: 1997.03.26 (22 years)

Patient Type : OPD

Discharge

NAME: Carriedo, Shawn Michael Jr. Barral Jr.

PID: 3184679

Chief Complaint : No Info Available

DOB: 2002.07.28 (16 years)

Patient Type : IPD

IPD

NAME: CABADILLA, CATALINO JR. MARTINEZ

PID: 1304644

Chief Complaint : No Info Available

DOB: 1985.12.03 (33 years)

Patient Type : IPD

NAME: CABAGUIO, CARL CEDRIC CORTEZ

PID: 2988639

Chief Complaint : No Info Available

DOB: 2016.09.26 (2 years)

Patient Type : OPD

OPD

Dashboard

2

OPD

Search

Q

«

1

2

3

4

5

»

NAME: REDONDO, SHAINA CARLOS

PID: 3184700

Chief Complaint : No Info Available

DOB: 1990.12.10 (28 years)

Patient Type : OPD

NAME: GABICA, Gabriel Andrew JOVENAL

PID: 2715412

Chief Complaint : No Info Available

DOB: 2015.04.19 (3 years)

Patient Type : OPD

NAME: Green, Kros OPD

PID: 3184655

Chief Complaint : No Info Available

DOB: 1997.03.26 (22 years)

Patient Type : OPD

NAME: CABAGUIO, CARL CEDRIC CORTEZ

PID: 2988639

Chief Complaint : No Info Available

DOB: 2016.09.26 (2 years)

Patient Type : OPD

NAME: asdasdqwe, asdas asdasd

PID: 3184672

Chief Complaint : No Info Available

DOB: 2014.03.11 (5 years)

Patient Type : OPD

Dashboard

3

IPD

Search

Q

«

1

2

3

4

5

6

7

8

9

10

»

NAME: CAAGBAY, CALVIN CASTARITAS

PID: 1582694

Chief Complaint : No Info Available

DOB: 2007.10.28 (11 years)

Patient Type : IPD

NAME: ma, mas maw

PID: 3184694

Chief Complaint : No Info Available

DOB: -0001.11.30 (2019 years)

Patient Type : IPD

NAME: MACOYCRUZ, ESTERLITO MILO

PID: 3131544

Chief Complaint : No Info Available

DOB: 1954.11.09 (64 years)

Patient Type : IPD

NAME: HADDARINA, HAJAN KIM INSANI

PID: 2519864

Chief Complaint : No Info Available

DOB: 1994.10.05 (24 years)

Patient Type : IPD

NAME: GABRIEL, GABRIELIZA LEAL

PID: 1460796

Chief Complaint : No Info Available

DOB: 1982.11.29 (36 years)

Patient Type : IPD

ER

Search



«

1

2

3

4

5

6

7

8

9

10

»

**NAME:** NONG, NATHAN ER

**PID:** 3184606

**DOB:** -0001.11.30 (2019 years)

**Chief Complaint :** No Info Available

**Patient Type :** ER

**NAME:** CABAUG, Carlo King BACURAYO

**PID:** 2316683

**DOB:** 2011.08.02 (7 years)

**Chief Complaint :** No Info Available

**Patient Type :** ER

**NAME:** CABAUG, CARLITO SAAVEDRA

**PID:** 2089602

**DOB:** 1950.07.05 (68 years)

**Chief Complaint :** No Info Available

**Patient Type :** ER

**NAME:** Yamiiii, Tsuuu Gi

**PID:** 3184664

**DOB:** 2015.03.09 (4 years)

**Chief Complaint :** No Info Available

**Patient Type :** ER

**NAME:** BEBANGO, BERNIE R.

**PID:** 1082254

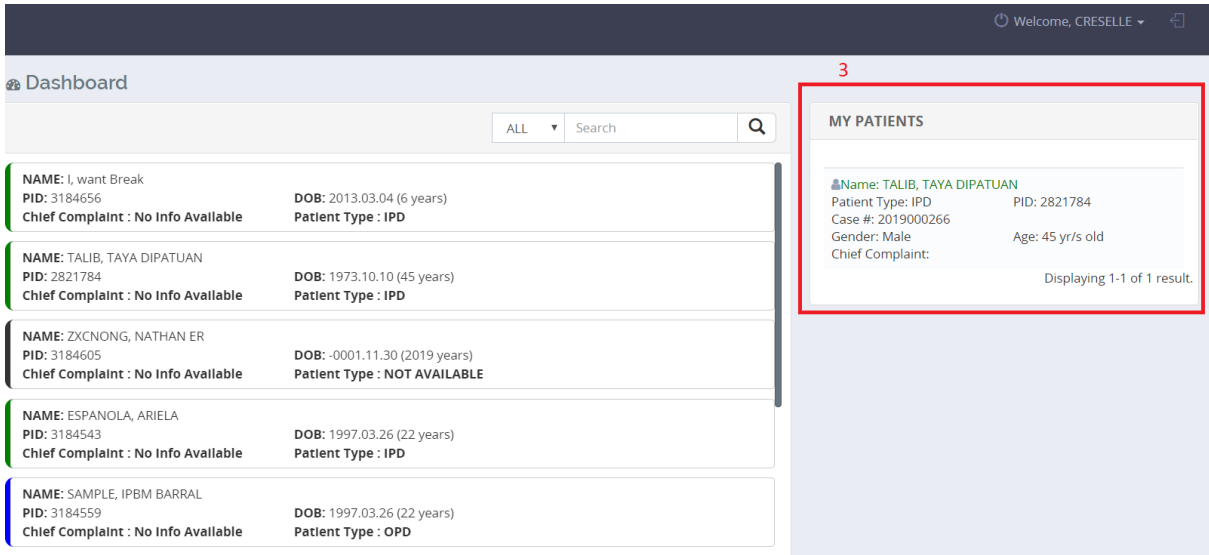
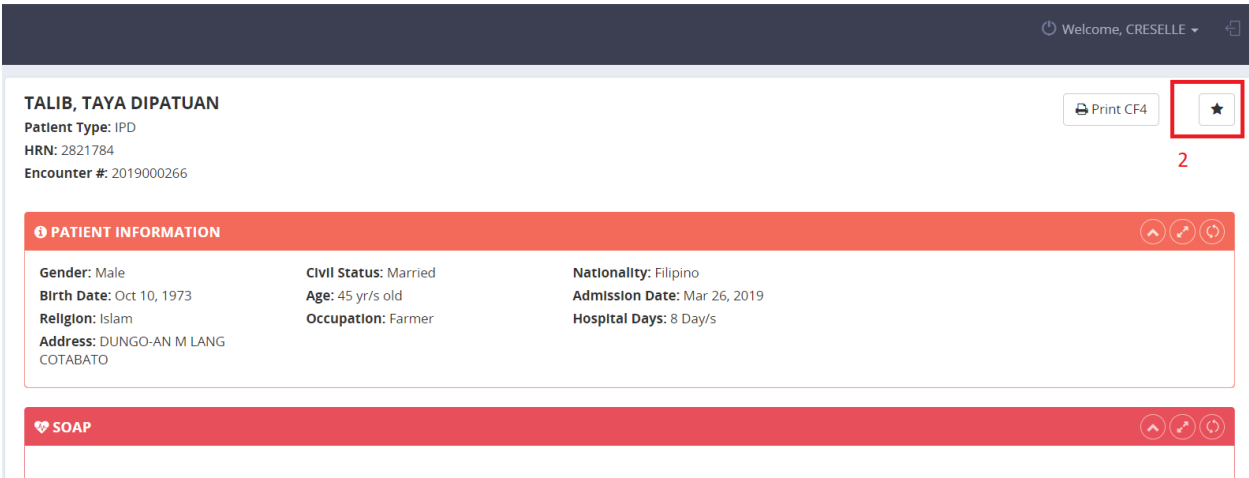
**DOB:** 1984.12.07 (34 years)

**Chief Complaint :** No Info Available

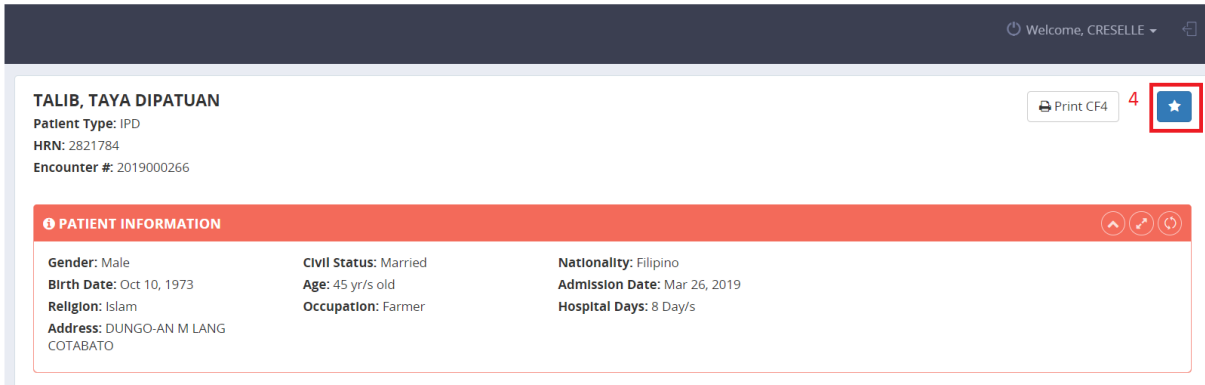
**Patient Type :** ER

Tag/Untag Patient

- 1. Go to the dashboard, and select a patient.
- 2. To “Tag” the patient, click on the star icon at the upper right corner of the page.
- 3. If you go back to the dashboard, you will now see that patient included among the list of patients under the column “My Patients.” This provides a convenient way for the doctor to easily access data pertaining to patients directly under his/her care.

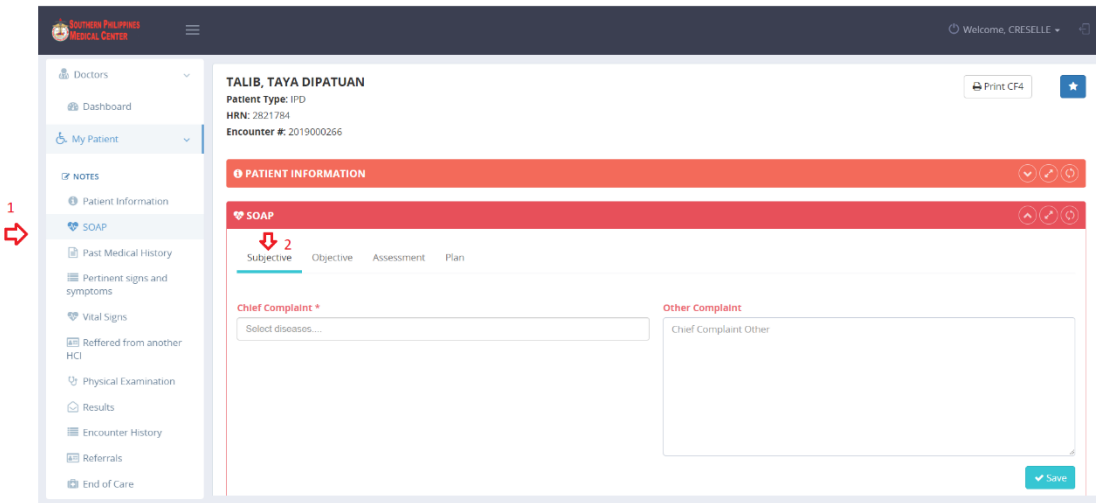


- 4. To “Untag” a patient, first select a patient from “My Patients” then click the star icon (colored blue) in the upper right corner of the page

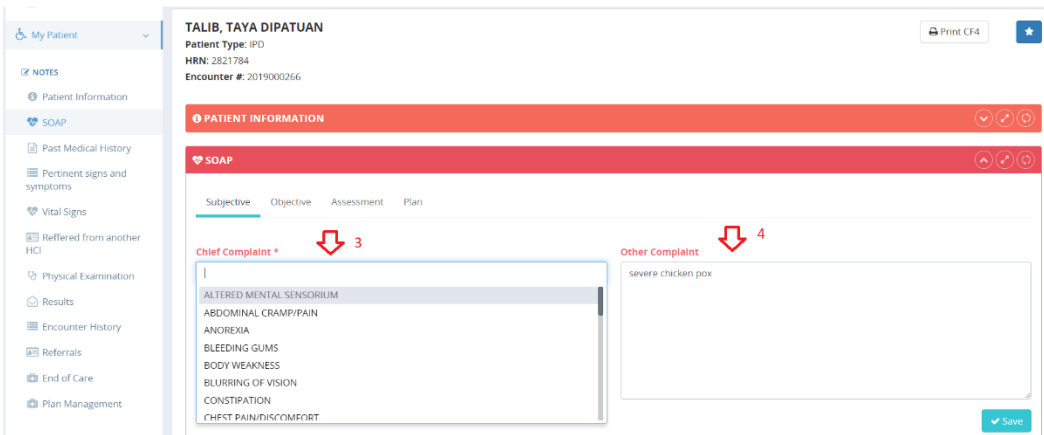


SOAP  
(Subjective)

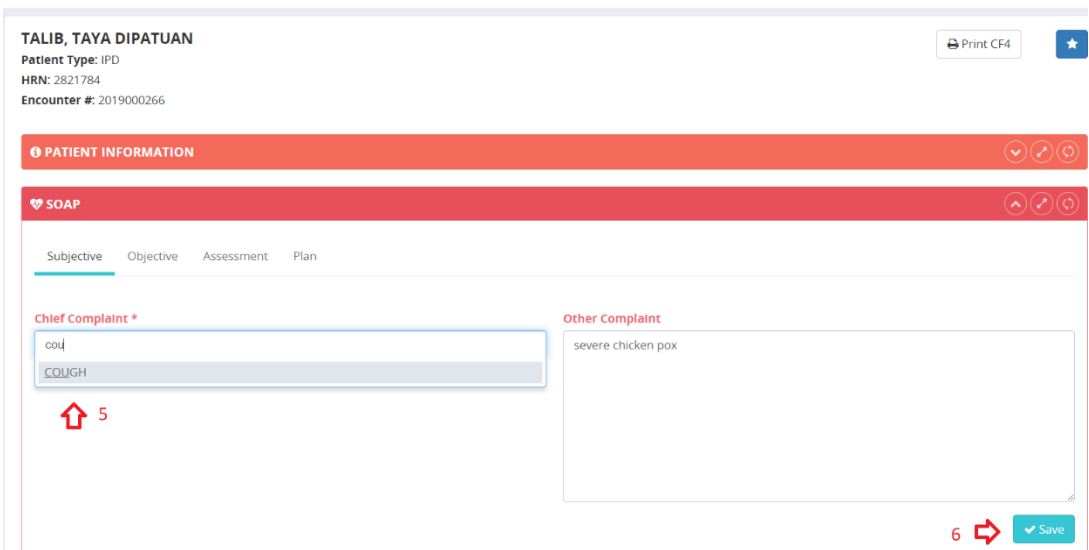
- 1. To update **SUBJECTIVE** notes, click the SOAP menu item in the left navigation bar (or scroll main window until you see the “SOAP” title bar), then click on the *Subjective* tab.
- 2. The *Subjective* tab consists of *chief complaint* and *other complaint*.



- 3. The *chief complaint* is a mandatory field and cannot be left blank. For your convenience, a dropdown list of *chief complaint*, as officially prescribed by PhilHealth, is provided.
- 4. If a disease is not in the dropdown selection, specify it in the “*other complaint*” text box.



- 5. As an extra convenience, you may also type the disease in the *chief complaint* box and the system will automatically display matching deceases from its database.



- 6. Click the **save** button to finalize.



(Objective)

1. To update **OBJECTIVE** notes, click the SOAP menu item in the left navigation bar (or scroll main window until you see the “SOAP” title bar), then click on the *Objective* tab.
2. Input the appropriate text under the *Pertinent Physical Examination* box.
3. Click the **save** button to finalize.

TALIB, TAYA DIPATUAN  
Patient Type: IPD  
HRN: 2821784  
Encounter #: 2019000266

Print CF4

★

PATIENT INFORMATION

SOAP

SubjectiveObjectiveAssessmentPlan

Pertinent Physical Examination

Enter your text here..

3 Save

(Assessment)

1. To update **ASSESSMENT** notes, click the SOAP menu item in the left navigation bar (or scroll main window until you see the “SOAP” title bar), then click on the *Assessment* tab.
2. If patient is IPD, *clinical impression* is only viewable and cannot be edited in the text area, since admitting diagnosis will be coming from admission. If non IPD patient, *clinical impression* is enabled and editable.

SOAP

SubjectiveObjectiveAssessmentPlan

Clinical Impression

Severe fever

ICD Code

+

Date/Time	ICD/RVS Code	Diagnosis	Action

Final Diagnosis \*

Enter your text here..

Other Diagnosis

Enter your text here..

3. Select ICD code in the dropdown (Note: can be multiple ICD).
4. Click the blue “+” sign to officially add the item in the table below.
5. To delete ICD code, click the red button.

SOAP

SubjectiveObjectiveAssessmentPlan

Clinical Impression

Severe Fever

3 A01.2 Paratyphoid fever B

+

4

Date/Time	ICD/RVS Code	Diagnosis	Action
2019-04-04 19:42:38	A01.1	Paratyphoid fever A	5
2019-04-04 19:47:25	A01.2	Paratyphoid fever B	

Final Diagnosis \*

Enter your text here..

Other Diagnosis

Enter your text here..

6. Input *final diagnosis* in the text box area. The *final diagnosis* will be disabled once the encounter is discharged, but if the doctor has access permission to edit final diagnosis and other diagnosis even if

the encounter was already discharged, the text area will be enabled. (Note: *Final diagnosis is required, do not leave it empty*).

7.

Input *other diagnosis* in the text box area. The *other diagnosis* will be disabled once the encounter is discharged, but if the doctor has access permission to edit final diagnosis and other diagnosis even if the encounter was already discharged, the text area will be enabled.
8.

Click *Audit Trail* button to view the trail/history of the user who modified that final diagnosis and other diagnosis.
9.

Click the **save** button to finalize.

ICD Code

+

Date/Time	ICD/IRVS Code	Diagnosis	Action
2019-04-04 19:42:38	A01.1	Paratyphoid fever A	
2019-04-04 19:47:25	A01.2	Paratyphoid fever B	

Displaying 1-2 of 2 results

6

Final Diagnosis \*

Enter your text here..

Audit Trail

8

7

Other Diagnosis

Enter your text here..

9

Save

(Plan)

1.

To update **PLAN** notes, click the SOAP menu item in the left navigation bar (or scroll main window until you see the “SOAP” title bar), then click on the *Plan* tab.
2.

Input *Progress Notes/Clinical Summary* in the appropriate text box.
3.

Click the **save** button to finalize.

TALIB, TAYA DIPATUAN

Patient Type: IPD

HRN: 2821784

Case No: 2019000266

Department: Family Medicine

Print CF4

★

PATIENT INFORMATION

SOAP

Subjective

Objective

Assessment

Plan

1

Progress Notes/Clinical Summary

2

sample

3

Save

## Past Medical History

(History of Present Illness)

1. To update **History of Present Illness** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *History of Present Illness* tab.
2. The default tab is *History of Present Illness*.
3. Input *History of Present Illness*. Do not leave it empty since it is required.
4. Click the **save** button to finalize.

The screenshot shows the Segworks interface for a patient named TALIB, TAYA DIPATUAN. The left sidebar contains a navigation menu with 'Past Medical History' highlighted. The main content area shows the 'PAST MEDICAL HISTORY' section with tabs for 'History of Present Illness', 'Past Medical History', 'Surgical History', 'Family History', 'Social History', 'Gynecological/Obstetric History', and 'Immunization Record'. The 'History of Present Illness' tab is active, showing a text input field for 'History of Present Illness \*'. Below this is a 'PERTINENT SIGNS AND SYMPTOMS ON ADMISSION' section with various checkboxes for symptoms like 'Altered mental sensorium', 'Dizziness', 'Hematemesis', 'Palpitations', etc.

## (Past Medical History)

1. To update **Past Medical History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Past Medical History* tab.
2. The default value for the *Disease* field is “None,” so is the *Specific Description*. Click **save** button to finalize if disease is not applicable.

The screenshot shows the 'PAST MEDICAL HISTORY' form with the 'Past Medical History' tab selected. A red box highlights the 'Disease' and 'Specific Description' fields, both set to 'None'. A red arrow 1 points to the 'Past Medical History' tab. A red arrow 2 points to the 'Disease' field. A 'Save' button is visible below the fields.

3. If disease is applicable, there are list of diseases provided by Philhealth, select one and provide specific description, then click **save** button.

The screenshot shows the 'PAST MEDICAL HISTORY' form with the 'Past Medical History' tab selected. A red box highlights the 'Disease' and 'Specific Description' fields, with 'Cancer' selected in the 'Disease' field and 'Breast Cancer' in the 'Specific Description' field. A red arrow 3 points to the 'Disease' field. A 'Save' button is visible below the fields.

4. After saving, it will be reflected in the table below.
5. To delete selected *disease*, click the red button.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Disease \*

None

Specific Description \*

None

Save

4

Disease	Specific Disease Description	Action
Cancer	Breast Cancer	<div>5</div> <div></div> <div></div>

Displaying 1-1 of 1 result.

(Surgical History)

1. To update **Surgical History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Surgical History* tab. (Note: *Surgical History is not required*)
2. Input the *date of operation*.
3. Input the *Description of surgical operation*.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Date of Operation

2018-03-20

Description of surgical operation

Lumpectomy Surgery

Remarks

Sample remarks

Save

Date of Operation	Description	Remarks	Action
No results found.			

4. After saving, it will be reflected in the table below.
5. To delete *surgical operation*, click the red button.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Date of Operation

yyyy-mm-dd

Description of surgical operation

Description

Remarks

Remarks

Save

4

Date of Operation	Description	Remarks	Action
2018-03-20	Lumpectomy Surgery	Sample remarks	<div>5</div> <div></div> <div></div>

Displaying 1-1 of 1 result.

(Family History)

1. To update **Family History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Family History* tab. (Note: *Family History is not required*).
2. The default value for the *Disease* field is “None,” so is the *Specific Description*. Click the **save** button to finalize if disease is not applicable.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Disease

None

Specific Description

None

Save

Disease	Specific Disease Description	Action
No results found.		

3. If *disease* is applicable, there are list of diseases provided by Philhealth. Select one and provide *specific description*, then click save.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Disease

Allergy

Specific Description

Shrimp Allergy

Save

Disease	Specific Disease Description	Action
No results found.		

4. Once you click save it will reflect in the table below.
5. To delete selected *disease*, click the red button.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Disease

None

Specific Description

None

Save

Disease	Specific Disease Description	Action
Allergy	Shrimp Allergy	

Displaying 1-1 of 1 result.

(Social History)

1. To update **Social History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Social History* tab. (Note: *Social history is not required*)
2. Notice that on the highlighted orange box the default value for the Smoking, Alcohol and Illegal Drugs is “No”.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

SMOKING

ALCOHOL

Is Smoke?

Is Using alcohol?

No

No

ILLEGAL DRUGS

Save

Is Using Drugs?

No

3. Once you select “Yes” for the *Smoking*, the additional details will be displayed. *Average stick per year* is disabled and auto-computed based on the *years of smoking* and *average stick per day*.
4. The *No. of Bottles* per day is required if patient is an alcohol drinker, or have already quit.
5. If the patient is a drug user, additional remarks are required.
6. Click save to finalize.

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

SMOKING

ALCOHOL

Is smoker ?

Is Alcohol Drinker?

Yes

Yes

Years of smoking

No. of Bottles

5

2

For how many years have you smoked?

ILLEGAL DRUGS

Average stick per day

Is Drug User?

8

Yes

On average, how many cigarettes did you smoke per day?

Save

Average stick per year

2

Formula: [ (smoked per day) / 20 ] x Years Smoked

(Gynecological/Obstetric History)

- 1. To update **Gynecological/Obstetric History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Gynecological/Obstetric History* tab. (Note: Visible and applicable only for female patients). It consists of 2 categories: *Menstrual History* and *Pregnant History*.
- 2. For *Menstrual History*, the default value is “No”.
- 3. If “Yes”, additional fields will be displayed.

The screenshot shows the 'PAST MEDICAL HISTORY' form with the 'Gynecological/Obstetric History' tab selected. The 'Menstrual History' section is active. A red box highlights the 'Applicable to this patient?' dropdown, which is set to 'Yes'. Another red box highlights the 'Date of Last Menstrual Period' field, which is empty. Arrows 1, 2, 3, and 4 point to the dropdown, the 'Menstrual History' tab, the 'Save' button, and the 'Date of Last Menstrual Period' field respectively.

- 4. Fill up what is applicable but do not leave the *Date of Last Menstrual Period* empty.
- 5. For *Pregnant History*, the default value is “No”.
- 6. If “Yes”, additional fields will be displayed. Fill up what is applicable but do not leave the *Gravidity* and *Parity* empty.

The screenshot shows the 'PAST MEDICAL HISTORY' form with the 'Gynecological/Obstetric History' tab selected. The 'Pregnant History' section is active. A red box highlights the 'Number of Pregnancy to Date - Gravidity' and 'Number of Delivery to Date - Parity' fields, which are empty. Arrows 5 and 6 point to the 'Pregnant History' tab and the highlighted fields respectively.

- 7. Click save to finalize.

(Immunization Record)

- 1. To update **Immunization Record** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Immunization Record* tab. (Note: *Immunization Record is not required*).
- 2. For your convenience, dropdown boxes for *Child Immunization Code*, *Adult Immunization Code*, and *Elderly Immunization Code* are provided, with official predefined list from Philhealth. Select what is applicable.
- 3. Input Immunization in “other immunization” field, if it is not available in the system.
- 4. Put additional remarks if applicable.
- 5. Click the **save** button to finalize

PAST MEDICAL HISTORY

History of Present Illness

Past Medical History

Surgical History

Family History

Social History

Gynecological/Obstetric History

Immunization Record

Child Immunization Code

None

Adult Immunization Code

None

Elderly Immunization Code

None

Other Immunization

Other Immunization

Remarks

Remarks

Save



## Pertinent Signs and Symptoms on Admission

1. Click the **Pertinent Signs and Symptoms** menu item in the left navigation bar (or scroll down main window until you see PERTINENT SIGNS AND SYMPTOMS ON ADMISSION).
2. Tick the box of whatever is applicable for pertinent signs and symptoms of the patient.
3. If specific pain, tick the “Pains” and input the specific pain but if the pain is existing in the display, the system will automatically check the box of the pain upon saving. (See #6 for example)
4. For others, just type the signs or symptoms in free text.
5. Click **save** to finalize.

**SOUTHERN PHILIPPINES MEDICAL CENTER**

Welcome, CRESELLE

**TALIB, TAYA DIPATUAN**

Patient Type: IPD Case No: 2019000266

HRN: 2821784 Department: Family Medicine

Print CF4

**PERTINENT SIGNS AND SYMPTOMS ON ADMISSION**

1 →

2

3 →

4

5

6

Altered mental sensorium

Abdominal cramp/pain

Anorexia

Bleeding gums

Body weakness

Blurring of vision

Chest pain/discomfort

Constipation

Cough

Diarhea

Dizziness

Dysphagia

Dyspnea

Dysuria

Epistaxis

Fever

Frequency of urination

Headache

Hematemesis

Hematuria

Hemoptysis

Irritability

Jaundice

Lower extremity edema

Myalgia

Orthopnea

Pains

Palpitations

Seizures

Skin rashes

Stool, bloody/black tarry/mucoid

Sweating

Urgency

Vomiting

Weight loss

Others

toothache

headache

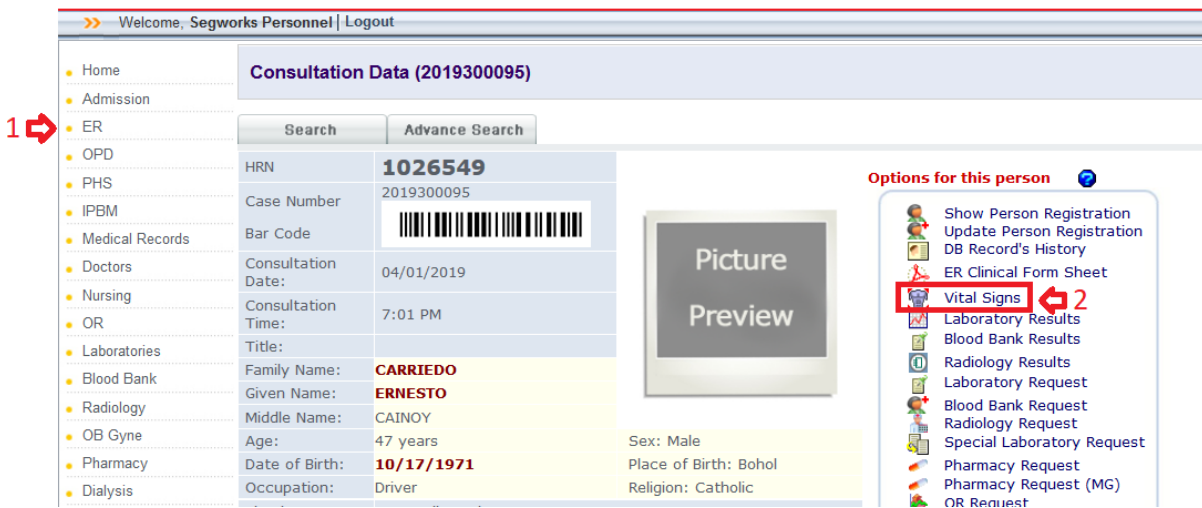
Sample others

Save

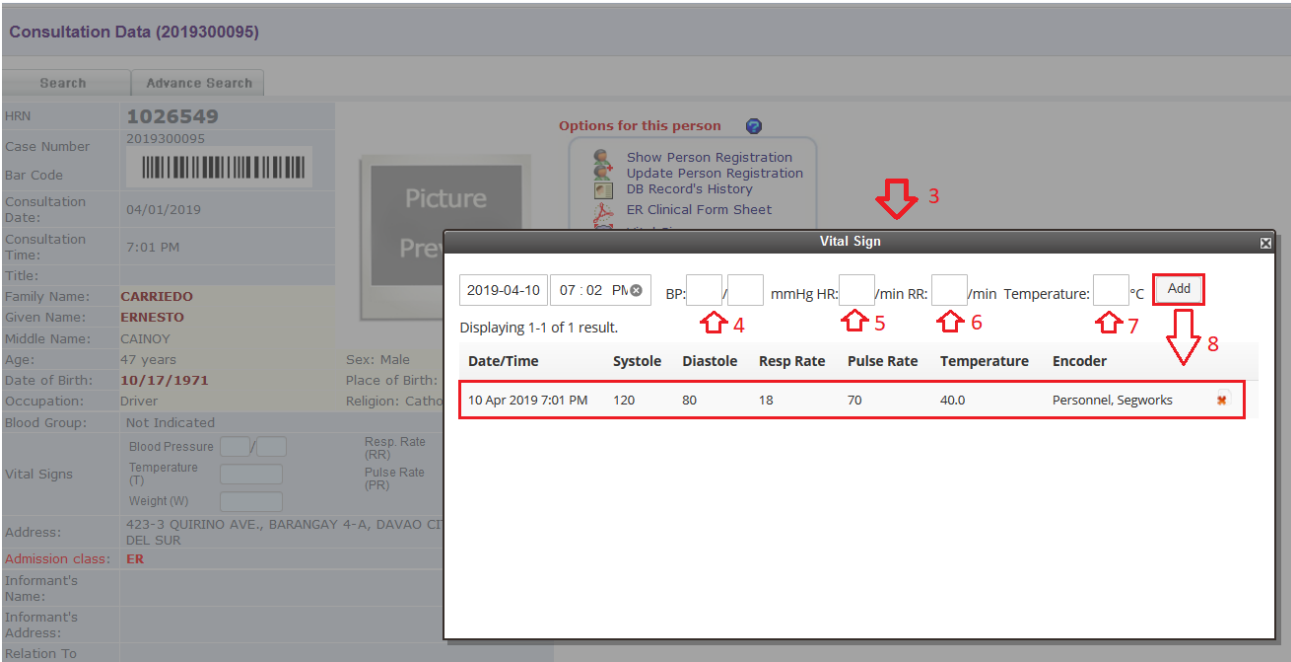
## Vital Signs

(Add Vital Signs in ER, Admission, and OPD Module)

- Go to ER module, search a patient and proceed to consultation data. (Also applicable for Admission and OPD module)



- Vital signs option is available only to user with a *nurse* job function.
- A modal for vital signs monitoring will appear upon clicking the vital signs.
- Input the Blood Pressure (format: systole/diastole)
- Input Heart Rate
- Input Respiratory Rate
- Input Body Temperature
- Click add to save vital signs monitoring.



(Vital Signs monitoring in Nursing)

- 1. Go to Nursing module, select or search patient.
- 2. Click admission data
- 3. Click Vital Signs

Home

Admission

ER

OPD

PHS

IPGM

Medical Records

Doctors

Nursing

OR

Laboratories

Blood Bank

Radiology

Pharmacy

Dialysis

Social Service

PDPU

HSSC

Billing

PAD

eClaims

Cashier

Reports

Ward FamMed Central (Service Ward) Occupancy (04/10/2019)

Family Medicine

Nursing Rounds Form

Diet List

VS Monitor

Room	Description	Bed	Last Name, Given Name	Birthdate	HRN	Case No.	Options
FAM- 1016	for Family Medicine Central (Charity ward) patients	1	SAD, SAD	10/11/1951	3131068	2018051470	
		2	Max, Maxine	10/11/1953	3131087	2018051472	
		3	Handa, Hans	10/11/1998	3131164	2018051516	
		4	TALIB, TAYA	10/10/1973	2821784	2019000266	
		5	FAS, FAS	10/11/1996	3131195	2018051539	
		6	FABIAN, SAMANTHA	04/15/1989	3131198	2018051542	
		7	XAVIER, GERALD	10/11/1996	3131214	2018051553	
		8	Pettyfer, Alex	11/19/1990	3131228	2018051558	
		9	FAJARDO, DIANA MARIE	12/13/1964	3131260	2018051584	
		10	GAMBAN, SARA	10/11/1996	3131272	2018051588	

Ward FamMed Central (Service Ward) Occupancy (04/10/2019)

Family Medicine

Nursing Rounds Form

Diet List

VS Monitor

Admission Data (2019000266)

HRN: 2821784

Case Number: 2019000266

Bar Code: [Barcode]

Admission Date: 03/26/2019

Admission Time: 4:25 PM

Title:

Family Name: TALIB

Given Name: TAYA

Middle Name: DIPATUAN

Age: 45 years

Date of Birth: 10/10/1973

Occupation: Farmer

Blood Group: Not Indicated

Sex: Female

Place of Birth: Cotabato

Religion: Islam

Picture Preview

Vital Signs

Address: DUNGO-AN, M LANG 9404 COTABATO

Admission class: INPATIENT (DIRECT ADMISSION)

Informant's Name:

Informant's Address:

Options for this person

Show Person Registration

Update Person Registration

DB Record's History

Inpatient Clinical Cover Sheet

Vital Signs

Laboratory Results

Blood Bank Results

Radiology Results

Laboratory Request

Blood Bank Request

Radiology Request

Special Laboratory Request

Pharmacy Request

Pharmacy Request (MG)

OR Request

Cancel this admission

Clinical Chart

Examinations

Transaction History

- 4. A modal for vital signs monitoring will appear upon clicking the vital signs.
- 5. Input the Blood Pressure (format: systole/diastole)
- 6. Input Heart Rate
- 7. Input Respiratory Rate
- 8. Input Body Temperature
- 9. Click Add to save vital signs monitoring.

Ward FamMed Central (Service Ward) Occupancy (04/10/2019)

Family Medicine

Nursing Rounds Form

Diet List

VS Monitor

Room	Description	Bed	Last Name, Given Name	Birthdate	HRN	Case No.	Options
FAM- 1016	for Family Medicine Central (Charity ward) patients	1	SAD, SAD	10/11/1951	3131068	2018051470	
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					

Patient Admission Data

Admission Data (2019000266)

Vital Sign

2019-04-10 09:09 PM

BP: [Systole]/[Diastole] mmHg

HR: [Rate] /min

RR: [Rate] /min

Temperature: [Value] °C

Add

Displaying 1-1 of 1 result.

Date/Time	Systole	Diastole	Resp Rate	Pulse Rate	Temperature	Encoder
10 Apr 2019 9:08 PM	118	78	15	70	37.0	Personnel, Segworks

- St. John's Philippines

MEDICAL CENTER

Doctors

Dashboard

My Patient

NOTES

Patient Information

SOAP

Past Medical History

Pertinent signs and symptoms

Vital Signs

Referred from another HCI

Physical Examination

Results

Plan Management

Encounter History

Referrals

End of Care

TALIB, TAYA DIPATUAN

Patient Type: IPD

Case No: 2019000266

HRN: 2821784

Department: Family Medicine

Print CF4

Star

VITAL SIGNS

Date/Time	Systole	Diastole	Pulse Rate	Resp Rate	Temperature	Modified By
Apr 11 2019 01:10 pm	120	70	60	16	39	Personnel, Segworks
Apr 10 2019 09:08 pm	118	78	70	15	37	Personnel, Segworks

2

Displaying 1-2 of 2 results.

REFERRED FROM ANOTHER HEALTH CARE INSTITUTION

No

Yes

If yes, specify reason

Name of originating HCI

Save

- Southern Palmyra Medical Center**

Welcome, CRESELLE

Doctors | Dashboard | My Patient

TALIB, TAYA DIPATUAN  
Patient Type: IPD  
HRN: 2821784

Case No: 2019000266  
Department: Family Medicine

Print CF4

NOTES

  - Patient Information
  - SOAP
  - Past Medical History
  - Pertinent signs and symptoms
  - Vital Signs
  - Referred from another HCI
  - Physical Examination
  - Results
  - Plan Management
  - Encounter History
  - Referrals
  - End of Care

REFERRED FROM ANOTHER HEALTH CARE INSTITUTION

No Yes

Further eye surgery

Name of originating HCI \* San Pedro Hospital

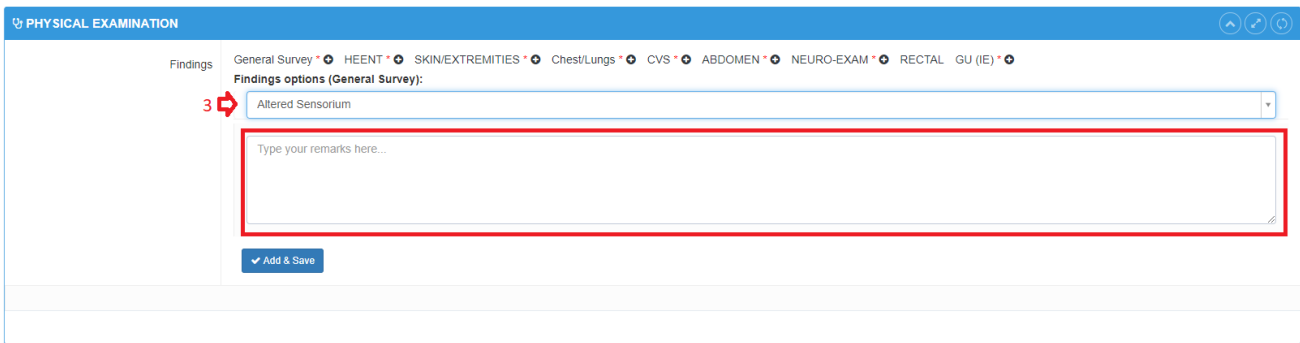
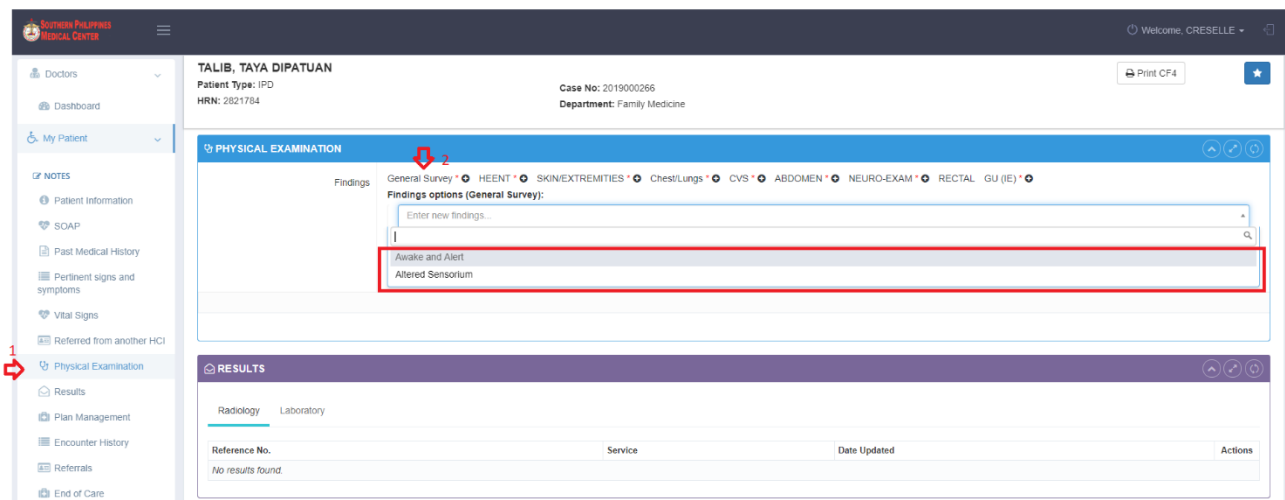
Save

PHYSICAL EXAMINATION

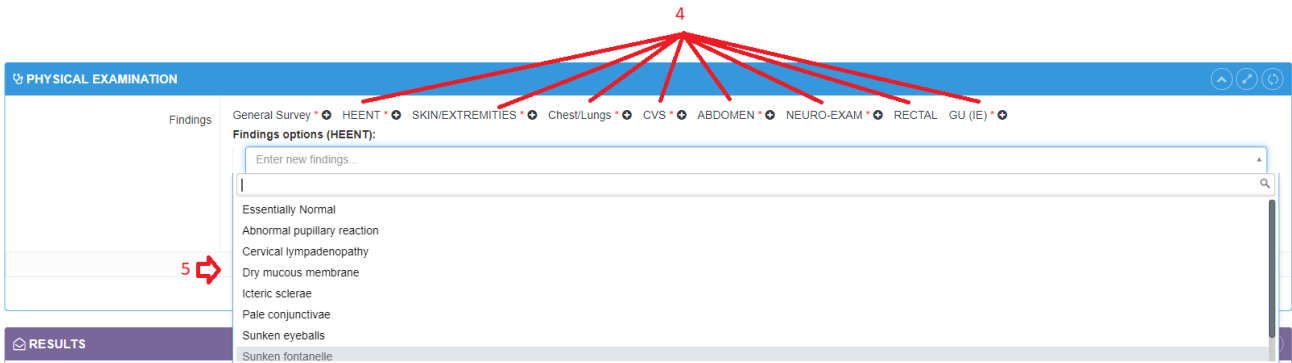
Findings General Survey \* HEENT \* SKIN/EXTREMITIES \* Chest/Lungs \* CVS \* ABDOMEN \* NEURO-EXAM \* RECTAL GU (I/E) \*

# Physical Examination

1. Click the **Physical Examination** menu item in the left navigation bar (or scroll down main window until you see PHYSICAL EXAMINATION).
2. In *General Survey*, there are two options: “Awake and Alert” and “Altered Sensorium”.
3. If “Altered Sensorium”, input a remarks.



4. Except for *RECTAL*, you are required to provide data for *HEENT*, *SKIN/EXTREMITIES*, *CHEST/LUNG*, *CVS*, *ABDOMEN*, *NEURO-EXAM* and *GU (IE)*.
5. All list of findings from the dropdown menus are officially provided by Philhealth, hence select what is applicable.



- 6. If finding/s is not found in the list, select “others” and input a remarks.
- 7. Click *Add & Save*.
- 8. “Others” are presented in italic.
- 9. To delete findings, click the yellow button.
- 10. If “Essentially Normal” it will overwrite all findings.

PHYSICAL EXAMINATION

Findings

General Survey • HEENT • SKIN/EXTREMITIES • Chest/Lungs • CVS • ABDOMEN • NEURO-EXAM • RECTAL • GU (IE) •

Findings options (CVS):

6

Others

Sample for other findings

7

Add & Save

HEENT • SKIN/EXTREMITIES • Chest/Lungs •

Abnormal pupillary reaction • Dry mucous membrane • Pale conjunctivae • Wheezes • Weak pulses • Cold clammy •

PHYSICAL EXAMINATION

Findings

General Survey • HEENT • SKIN/EXTREMITIES • Chest/Lungs • CVS • ABDOMEN • NEURO-EXAM • RECTAL • GU (IE) •

HEENT • SKIN/EXTREMITIES • Chest/Lungs •

Abnormal pupillary reaction • Dry mucous membrane • Pale conjunctivae • Wheezes • Weak pulses • Cold clammy •

CVS •

Others • Sample for other findings •

Essentially normal •

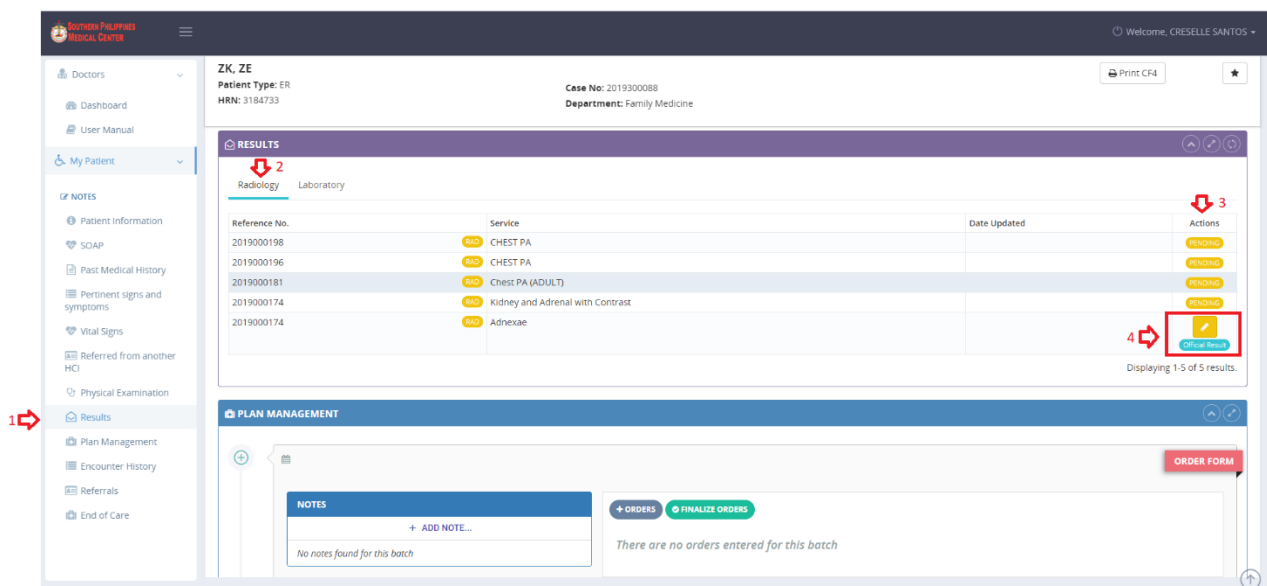
9

10

8

## View Results

1. Click the **Results** menu item in the left navigation bar (or scroll down main window until you see RESULTS title bar).
2. For *Radiology*, the *reference no.*, *service name*, *date updated*, and *actions* are indicated.
3. The status of a radiology service can be seen in the “actions” column. The sequence order of the status is from *pending*, *served*, *initial result* and lastly to *official result*.
4. Clicking the *Initial Result* or *Official Result*, will generate the result in PDF format.



5. For *Laboratory*, the *reference no.*, *service name*, *date updated*, and *actions* are indicated.
6. The status of a laboratory service can be seen in “actions” column. The sequence order of the status is from *pending*, *served*, *to with result*. Clicking the *Initial Result* or *Official Result*, will generate the result in PDF format.
7. The “Results” is capable of displaying 10 services per page.

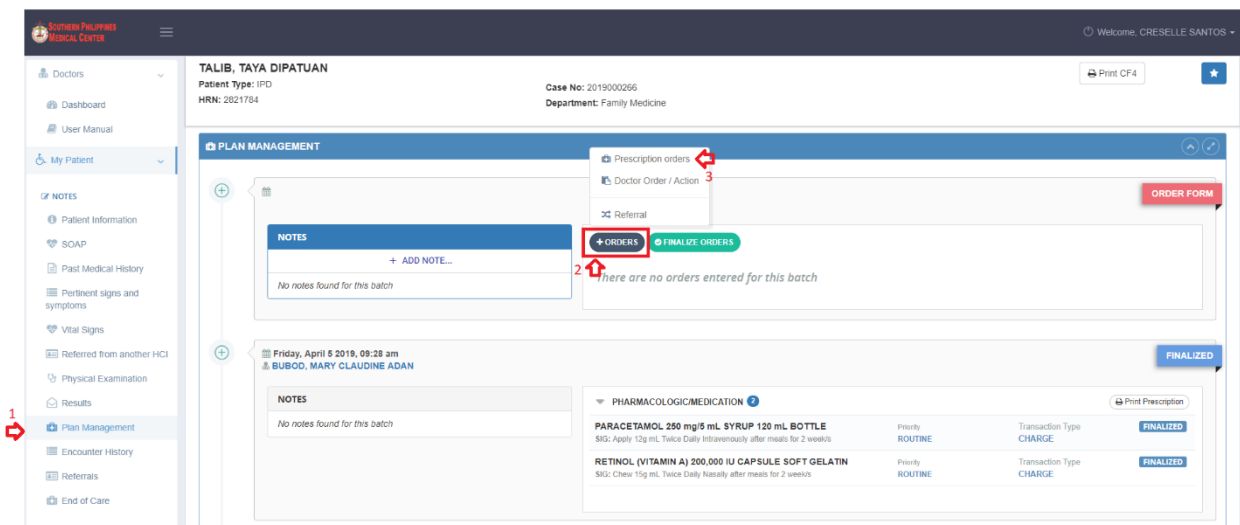




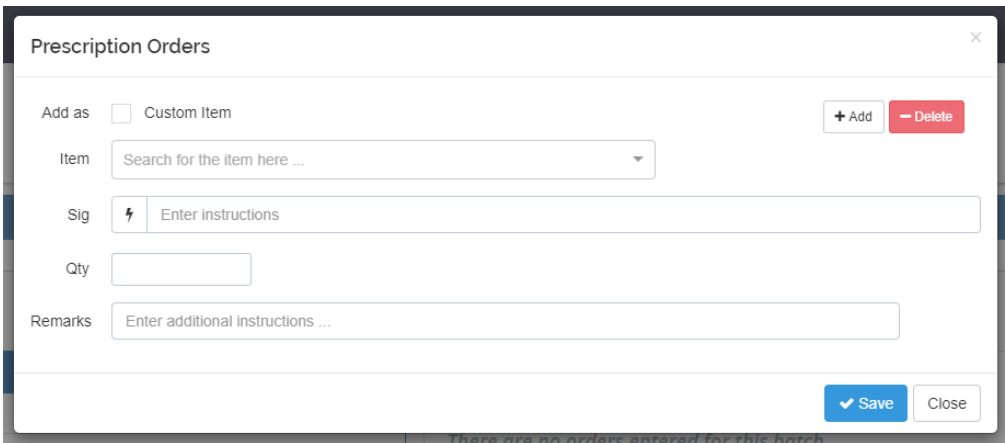
# Plan Management

## (Prescription)

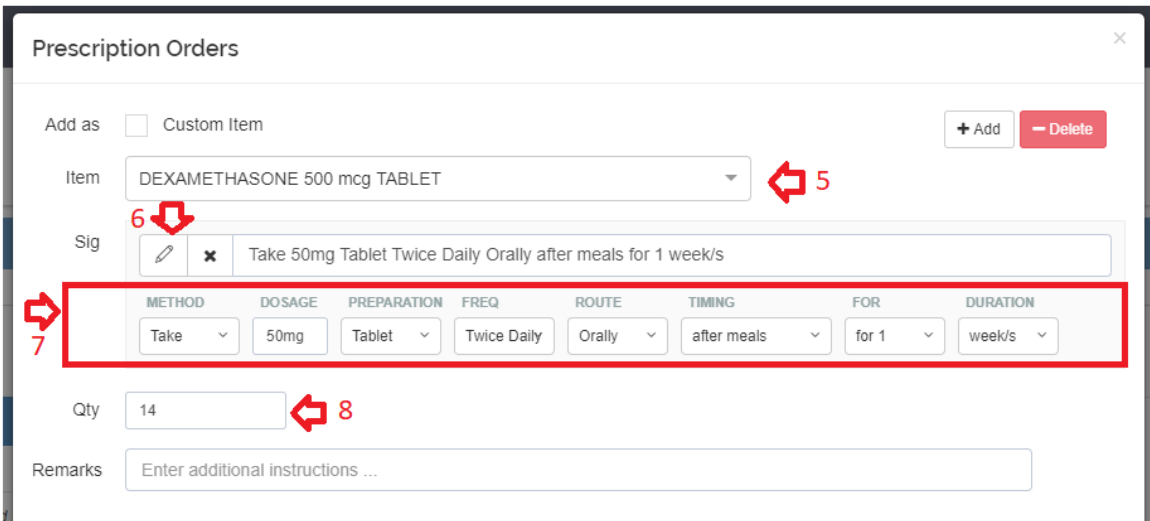
1. Click the **Plan Management** menu item in the left navigation bar (or scroll down main window until you see PLAN MANAGEMENT title bar).
2. Upon clicking *ORDERS* button, *Prescription*, *Doctor Order/Action* and *Referral* will be displayed.
3. Select *Prescription orders*, to write prescription for patients.



4. Upon clicking *Prescription Orders*, a modal will appear.



5. Search medicine in the *Item* dropdown. If medicine is not available in the list, the user can input a medicine in a free text format by ticking the *custom item*.
6. Click the *pencil button* to display predefined fields for signetur.
7. Each field has a predefined list of data. Select the appropriate instruction. The user also has the option to manually type an instruction inside *sig* field.



8. Input quantity and remarks(*optional*).

- 9. Just click the **Add** button, to add more medicine.
- 10. Click **Delete** button to remove medicine from the batch.
- 11. Click save.

Prescription Orders

Add as ☐ Custom Item

+ Add

- Delete

Item

DEXAMETHASONE 500 mcg TABLET

Sig

Take 50mg Tablet Twice Daily Orally after meals for 1 week/s

METHOD

DOSAGE

PREPARATION

FREQ

ROUTE

TIMING

FOR

DURATION

Take

50mg

Tablet

Twice Daily

Orally

after meals

for 1

week/s

Qty

14

Remarks

Enter additional instructions ...

Add as ☐ Custom Item

+ Add

- Delete

Item

Search for the item here ...

Sig

Enter instructions

Qty

Remarks

Enter additional instructions ...

✓ Save

Close

(Doctor Order/Action)

- 1. Select *Doctor Order/Action* to input order or action for patients in a free text format. Upon clicking it a modal will appear.
- 2. Input the order or action in the textbox.
- 3. Click save.

Prescription orders

Doctor Order / Action

Referral

+ ORDERS

FINALIZE ORDERS

Doctor Order / Action

Action

Perform physical examination

✓ Save order

Close

(Referral)

1. Select *Referral* to refer patient to another department. Upon clicking it a modal will appear.
2. Select a referral department.
3. Indicate *Reason for Referral* by selecting a reason from the dropdown list.
4. Click *delete order* to cancel the referral.
5. Click *save referral order* to save.

Referral Order

Referral Type

☒ Interfacility

Refer this patient to

Refer this patient to ...

Reason for Referral

Reason for Referral ...

4

Delete Order

5

Save referral order

Close

(Discharge order)

1. *Discharge order* is only visible to ER encounter patients. Select *discharge* to generate discharge slip for patient. Upon clicking it a modal will appear.
2. Fill up necessary fields.
3. Click *delete discharge order* button to cancel discharge order.
4. Click *save discharge order* button to save.

WANSING, WARREN MUING

Patient Type: ER

HRN: 916472

Case No: 2019300083

Department: Internal Medicine

Print CF4

★

PLAN MANAGEMENT

Prescription orders

Doctor Order / Action

Referral

Discharge ...

ORDER FORM

NOTES

+ ADD NOTE...

No notes found for this batch

+ ORDERS

FINALIZE ORDERS

There are no orders entered for this batch

Discharge Instructions

Date

Sunday April 14, 2019

Time

7:15:39pm

Follow up at OPD on

MM.DD.YYYY

Diagnosis

Home medication

ER NOD

Department

List of Departments ...

Attending Physician

List of Physician ...

3

Delete discharge order

4

Save discharge order

Close

5. Click *Print Discharge* button to generate ER discharge slip.

DISCHARGE 1

5

Print Discharge

FINALIZED

DIAGNOSIS	HYPERTENSIONSSS
HOME MEDICATION	HYPERTENSIONSSS
ER NOD	HYPERTENSIONSSS
DEPARTMENT	Radiology-Interventional
ATTENDING PHYSICIAN	ABSARA, ADZNER DULUTAN

(Finalize Orders)

- 1. All orders will be reflected here in order form making it as a draft.
- 2. User can go back to *orders* to edit or add some orders. To edit or delete a *doctor order/action* click the **red button for delete** and **blue button for edit**.
- 3. Click *Finalize Orders* to officially save it as finalized.

PLAN MANAGEMENT

Sunday, April 14 2019, 05:40 pm  
SANTOS, CRESELLE DOCTOR

NOTES  
+ ADD NOTE...  
No notes found for this batch

3

1

ORDER FORM

Print Prescription

2

FINALIZE ORDERS

PHARMACOLOGIC/MEDICATION 2

DEXAMETHASONE 500 mcg TABLET  
SIG: Take 50mg Tablet Twice Daily Orally after meals for 1 week/s  
Priority ROUTINE  
Transaction Type CHARGE  
PENDING

paracetamol  
SIG: sample  
Priority ROUTINE  
Transaction Type CHARGE  
PENDING

DOCTOR ORDER / ACTION 1

ACTION Perform physical examination  
Order Date: Apr 14, 2019

REFERRAL 1

REFER TO ENT-HNS

REASON FOR SKIN GRAFTING

- 4. Once the orders are finalized, the whole order batch will shift below the order form.
- 5. Click *Print Prescription* to generate a Rx prescription.

ORDER FORM

ORDERS FINALIZE ORDERS

There are no orders entered for this batch

4

5

Print Prescription

FINALIZED

PHARMACOLOGIC/MEDICATION 2

DEXAMETHASONE 500 mcg TABLET  
SIG: Take 50mg Tablet Twice Daily Orally after meals for 1 week/s  
Priority ROUTINE  
Transaction Type CHARGE  
FINALIZED

paracetamol  
SIG: sample  
Priority ROUTINE  
Transaction Type CHARGE  
FINALIZED

DOCTOR ORDER / ACTION 1

ACTION Perform physical examination  
Order Date: Apr 14, 2019

REFERRAL 1

REFER TO ENT-HNS

REASON FOR SKIN GRAFTING

## Encounter List

1. Click the **Encounter List** menu item in the left navigation bar (or scroll down main window until you see ENCOUNTER LIST title bar).
2. All encounters of the patient will be reflected in the encounter list.
3. To view a specific encounter, click the red button in action. Encounter that is already discharged is viewable only and cannot be updated.

Doctors

Dashboard

User Manual

My Patient

NOTES

SOAP

Past Medical History

Pertinent signs and symptoms

Vital Signs

Referred from another HCl

Physical Examination

Results

Plan Management

Encounter History

Referrals

End of Care

TALIB, TAYA DIPATUAN

Patient Type: IPD

Case No: 2019000266

HRN: 2821784

Department: Family Medicine

ENCOUNTER LIST

Encounter #	Patient Type	Clinic/Department	Admission Date	Discharge Date	Action
2019000266	IPD	Family Medicine	2019.04.04 07:36pm		<div>3</div>

Displaying 1-1 of 1 result

REFERRALS

Date	Referred By - Department	Referred To	Reason
2019-04-14 18:18:21	SANTOS, CRESELLE DOCTOR Dermatology	ENT-HNS	FOR SKIN GRAFTING
2019-03-26 20:43:22	BUBOD, MARY CLAUDE ADAN Family Medicine	Dermatology	ABNORMAL EKG FINDINGS

Displaying 1-2 of 2 results

END OF CARE

Outcome Of Treatment:

IMPROVED

HAMA

EXPIRED

ABSCONDED

TRANSFERRED

Doctors Advice:

Doctors advice here...

Reason:

Enter your reason here...

## View Referrals

1. Click the **REFERRALS** menu item in the left navigation bar (or scroll down main window until you see REFERRALS title bar).
2. The date and reason for referrals are indicated in the table, also the name of the physician who referred the patient and his respected department will be reflected. Once the patient is referred to another department, e.g. Dermatology, all doctors under Dermatology department can view and access the patient.

Doctors

Dashboard

User Manual

My Patient

NOTES

SOAP

Past Medical History

Pertinent signs and symptoms

Vital Signs

Referred from another HCl

Physical Examination

Results

Plan Management

Encounter History

Referrals

End of Care

TALIB, TAYA DIPATUAN

Patient Type: IPD

Case No: 2019000266

HRN: 2821784

Department: Family Medicine

2019000266	IPD	Family Medicine	2019.04.04 07:36pm		<div></div>
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Displaying 1-1 of 1 result

REFERRALS

Date	Referred By - Department	Referred To	Reason
2019-04-14 18:18:21	SANTOS, CRESELLE DOCTOR Dermatology	ENT-HNS	FOR SKIN GRAFTING
2019-03-26 20:43:22	BUBOD, MARY CLAUDE ADAN Family Medicine	Dermatology	ABNORMAL EKG FINDINGS

Displaying 1-2 of 2 results

END OF CARE

Outcome Of Treatment:

IMPROVED

HAMA

EXPIRED

ABSCONDED

TRANSFERRED

Doctors Advice:

Doctors advice here...

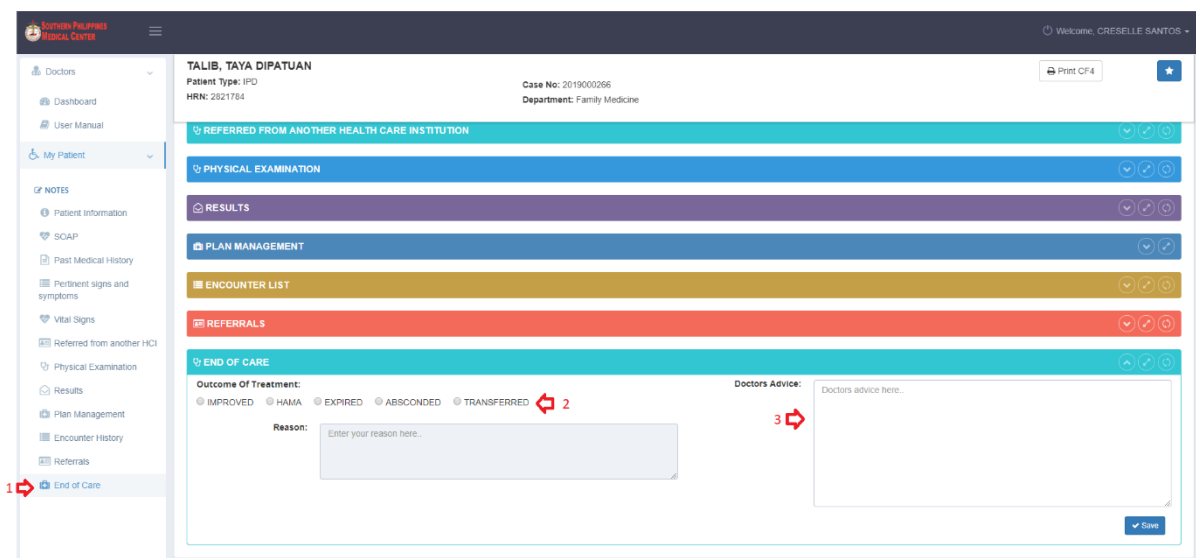
Reason:

Enter your reason here...

Save

## End of Care

1. Click the **End of Care** menu item in the left navigation bar (or scroll down main window until you see END OF CARE title bar).
2. Indicate the outcome of treatment by selecting predefined choices. If *transferred*, the *reason* textbox will be enabled.
3. Input *Doctor's Advice* if applicable (*Optional*).



## Generate CF4

1. CF4 PDF is located at the right side of the header.

