EHR Version 2.0 User Manual

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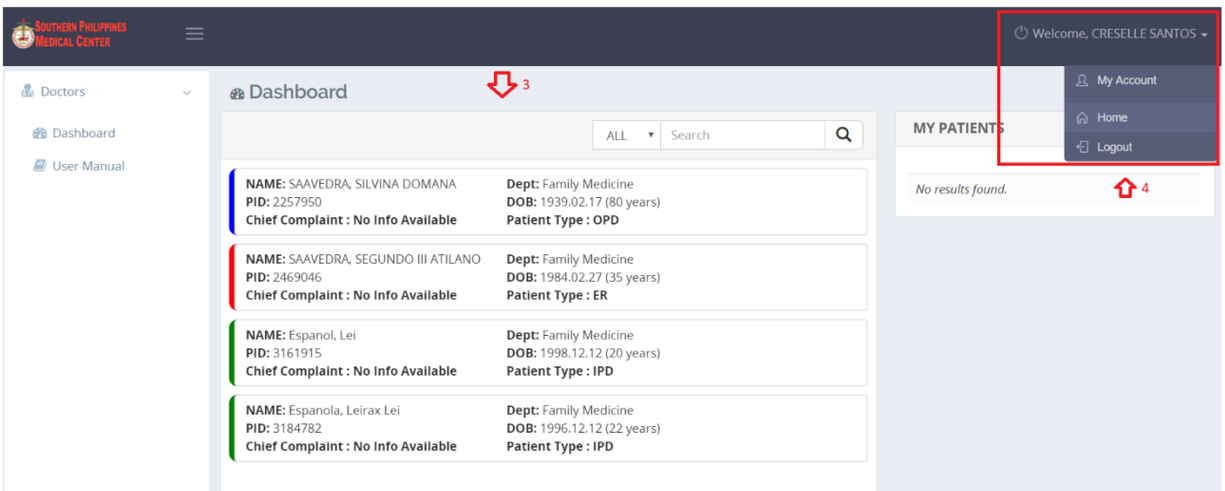
Login

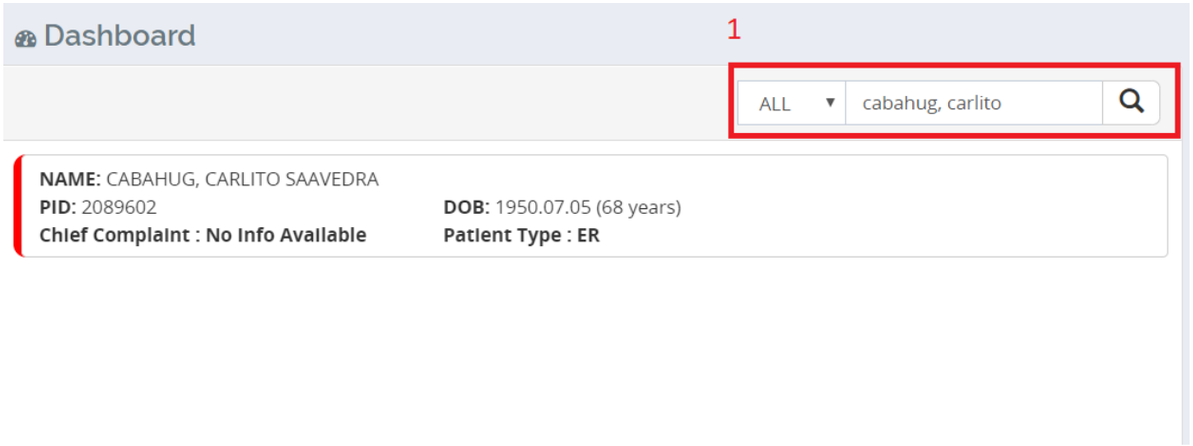
1. Go to EHR at 10.1.80.62/ehrprod, and login as doctor.
2. Input username and password, and click the “Login” button.

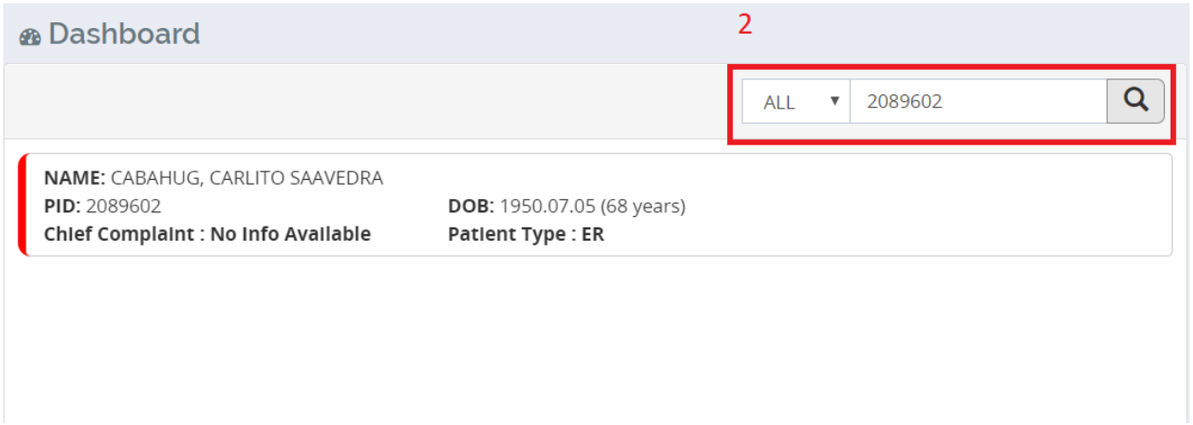
3. After successful login, you will be redirected to the doctor’s dashboard, which is the default page of the system.
4. To sign out from the system, click the “Logout” button located at the upper right side of the page.
5. To view account information, click “My Account” button located at the upper right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

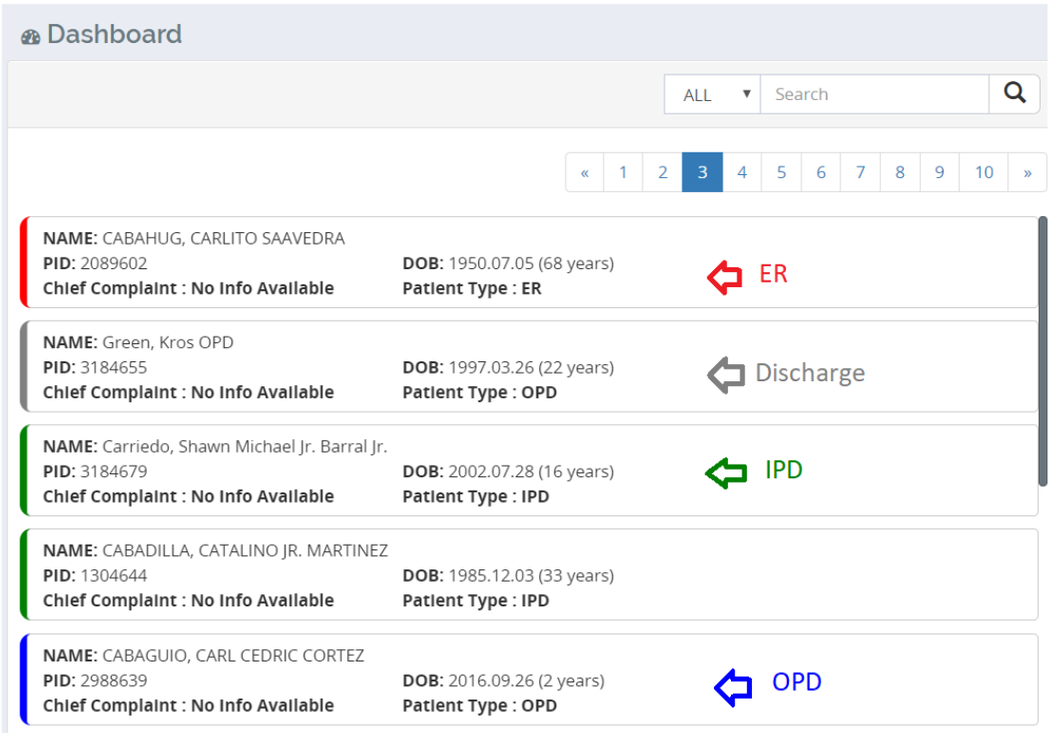


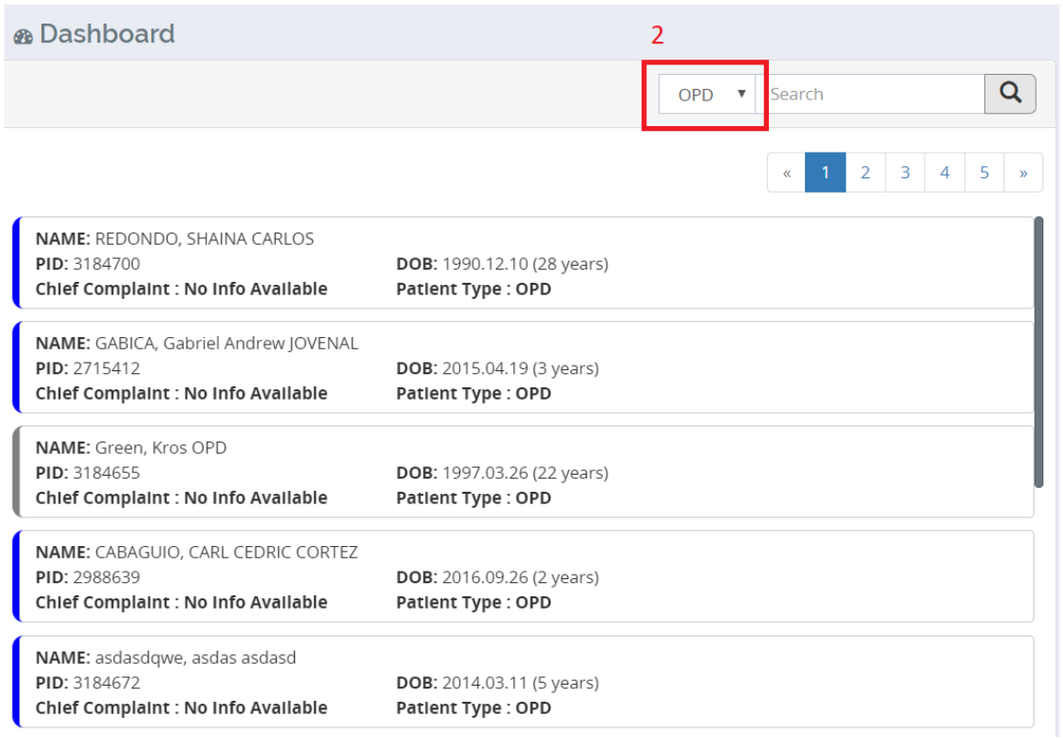


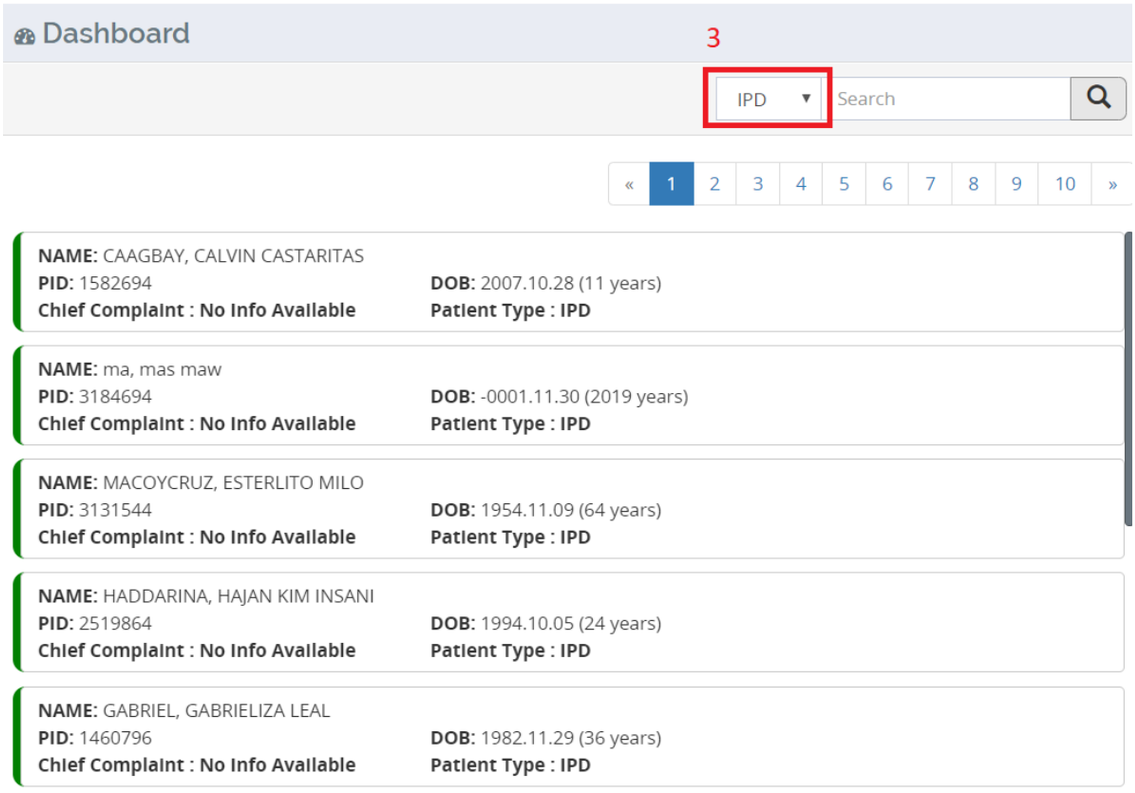
Filter by patient type

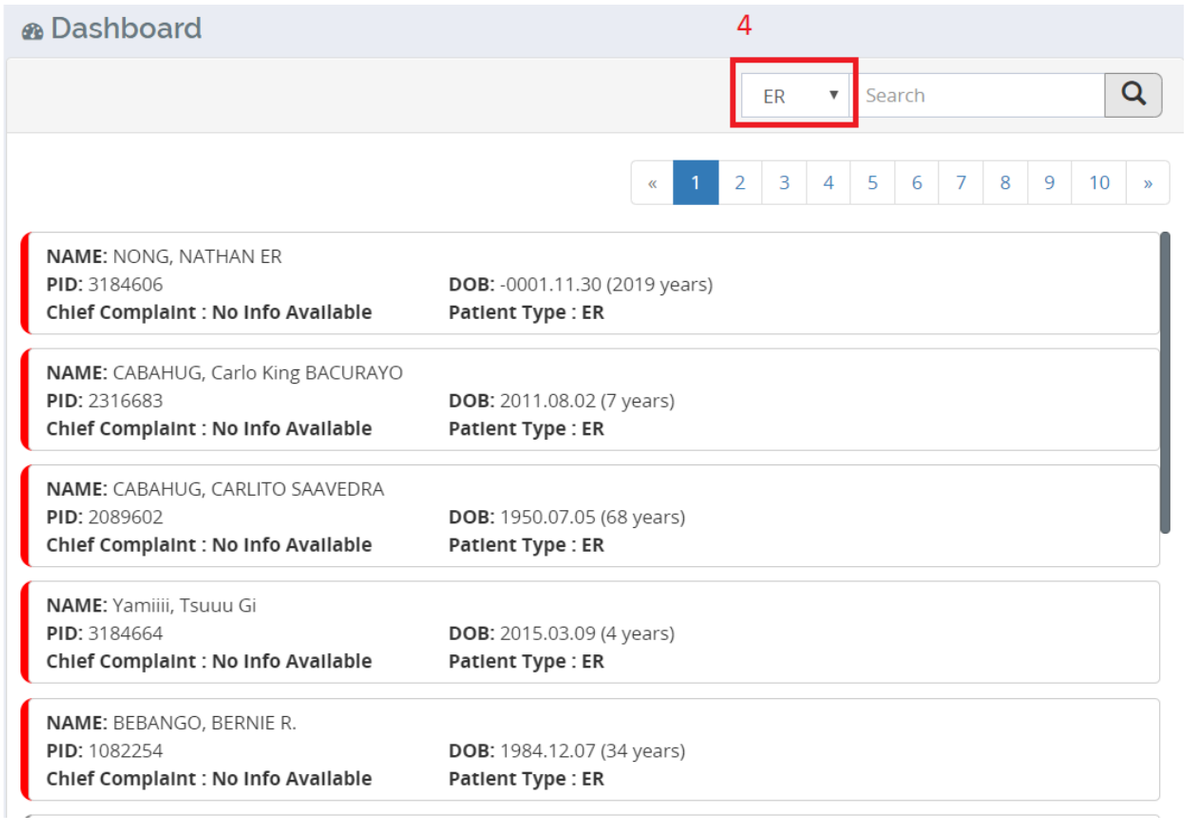
1. Filter by "ALL" ➔ all encounter type under the doctor's department will be displayed.
   (Note: If the doctor has the access permission to view all patients of the hospital, all patient will be displayed.)

   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.



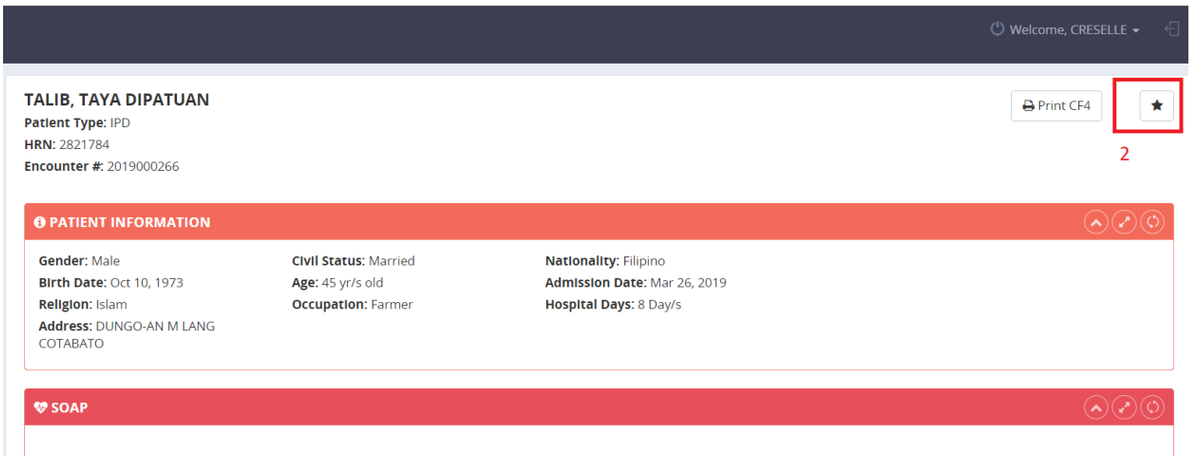

Dashboard
2
OPD
Search
« 1 2 3 4 5 »
NAME: REDONDO, SHAINA CARLOS
PID: 3184700
DOB: 1990.12.10 (28 years)
Chief Complaint : No Info Available
Patient Type : OPD
NAME: GABICA, Gabriel Andrew JOVENAL
PID: 2715412
DOB: 2015.04.19 (3 years)
Chief Complaint : No Info Available
Patient Type : OPD
NAME: Green, Kros OPD
PID: 3184655
DOB: 1997.03.26 (22 years)
Chief Complaint : No Info Available
Patient Type : OPD
NAME: CABAGUIO, CARL CEDRIC CORTEZ
PID: 2988639
DOB: 2016.09.26 (2 years)
Chief Complaint : No Info Available
Patient Type : OPD
NAME: asdasdqwe, asdas asdasd
PID: 3184672
DOB: 2014.03.11 (5 years)
Chief Complaint : No Info Available
Patient Type : OPD

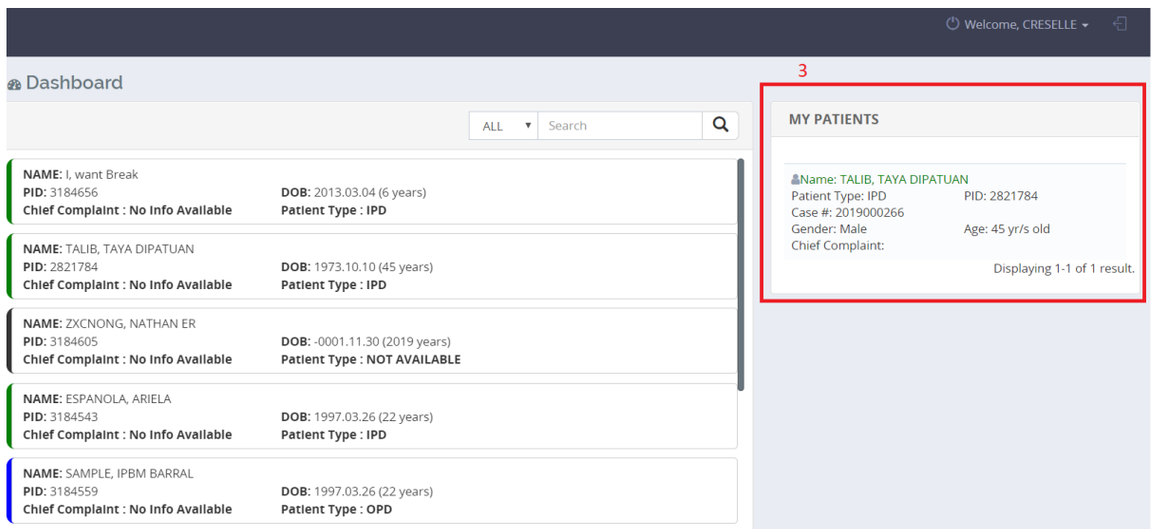

Dashboard
3
IPD
Search
« 1 2 3 4 5 6 7 8 9 10 »
NAME: CAAGBAY, CALVIN CASTARITAS
PID: 1582694
DOB: 2007.10.28 (11 years)
Chief Complaint : No Info Available
Patient Type : IPD
NAME: ma, mas maw
PID: 3184694
DOB: -0001.11.30 (2019 years)
Chief Complaint : No Info Available
Patient Type : IPD
NAME: MACOYCRUZ, ESTERLITO MILO
PID: 3131544
DOB: 1954.11.09 (64 years)
Chief Complaint : No Info Available
Patient Type : IPD
NAME: HADDARINA, HAJAN KIM INSANI
PID: 2519864
DOB: 1994.10.05 (24 years)
Chief Complaint : No Info Available
Patient Type : IPD
NAME: GABRIEL, GABRIELIZA LEAL
PID: 1460796
DOB: 1982.11.29 (36 years)
Chief Complaint : No Info Available
Patient Type : IPD


Dashboard
4
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: CABAHUG, Carlo King BACURAYO
PID: 2316683
DOB: 2011.08.02 (7 years)
Chief Complaint : No Info Available
Patient Type : ER
NAME: CABAHUG, 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

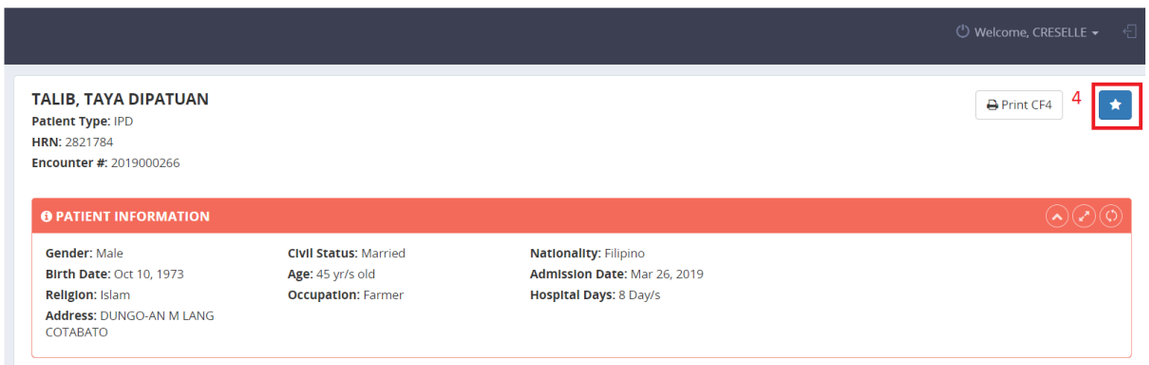
Tag/Untag Patient

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.





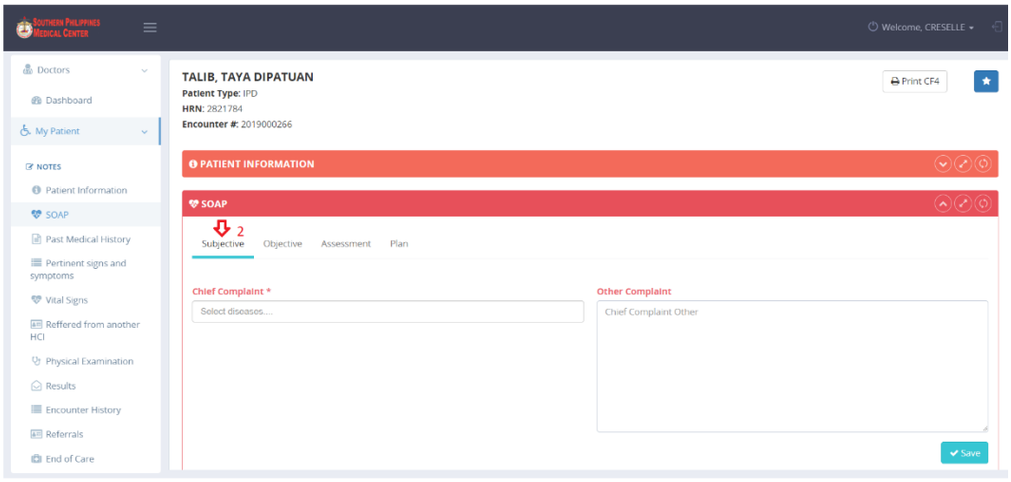
4. To “Untag” a patient, first select a patient from “My Patients” then click the star icon (colored blue) in the upper right corner of the page



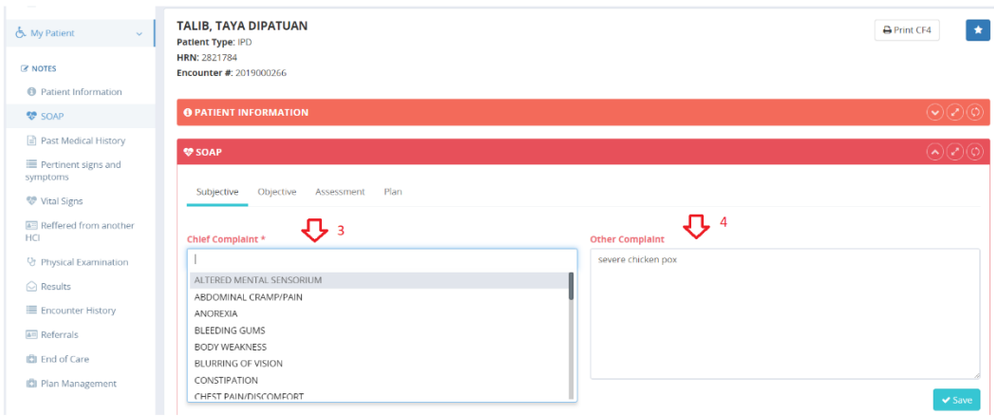
SOAP

(*Subjective*)

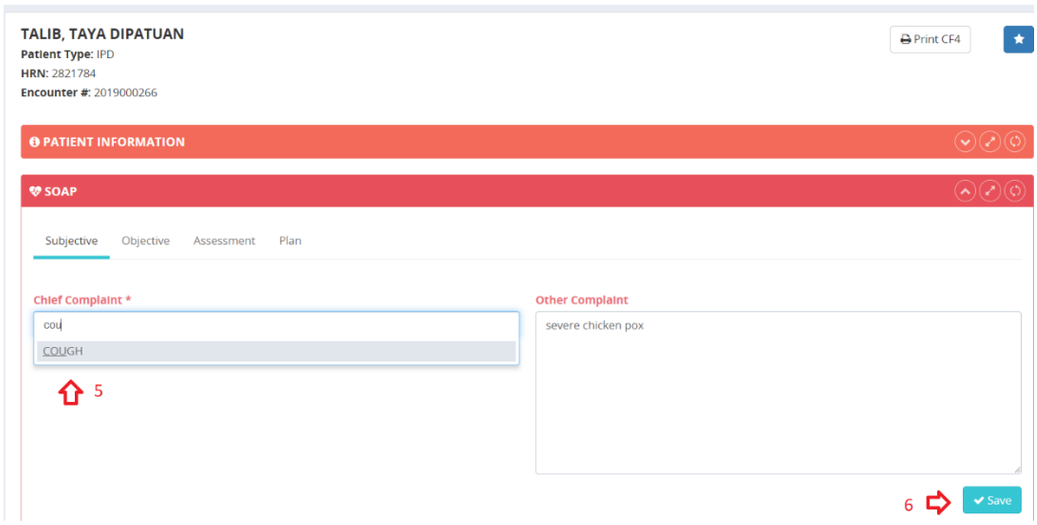
1. To update **SUBJECTIVE** notes, click the SOAP menu item in the left navigation bar (or scroll main window until you see the "SOAP" title bar), then click on the *Subjective* tab.
2. The *Subjective* tab consists of *chief complaint* and *other complaint*.



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.



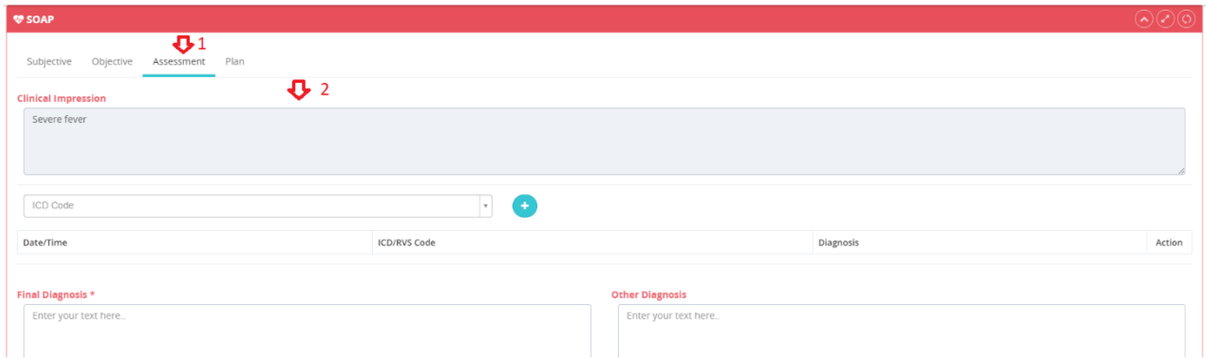
6. Click the **save** button to finalize.

(*Objective*)

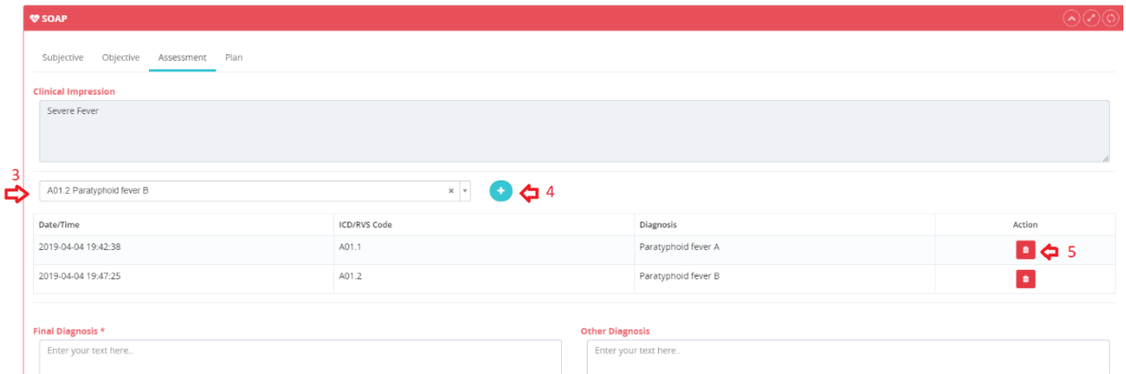
1. To update **OBJECTIVE** notes, click the SOAP menu item in the left navigation bar (or scroll main window until you see the "SOAP" title bar), then click on the *Objective* tab.
2. Input the appropriate text under the *Pertinent Physical Examination* box.
3. Click the **save** button to finalize.

(*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.



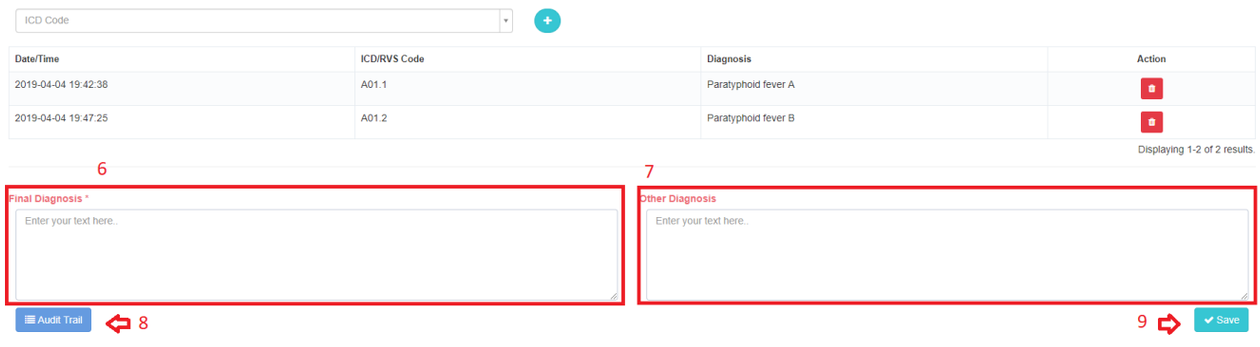
3. Select ICD code in the dropdown (Note: can be multiple ICD).
4. Click the blue "+" sign to officially add the item in the table below.
5. To delete ICD code, click the red button.



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.



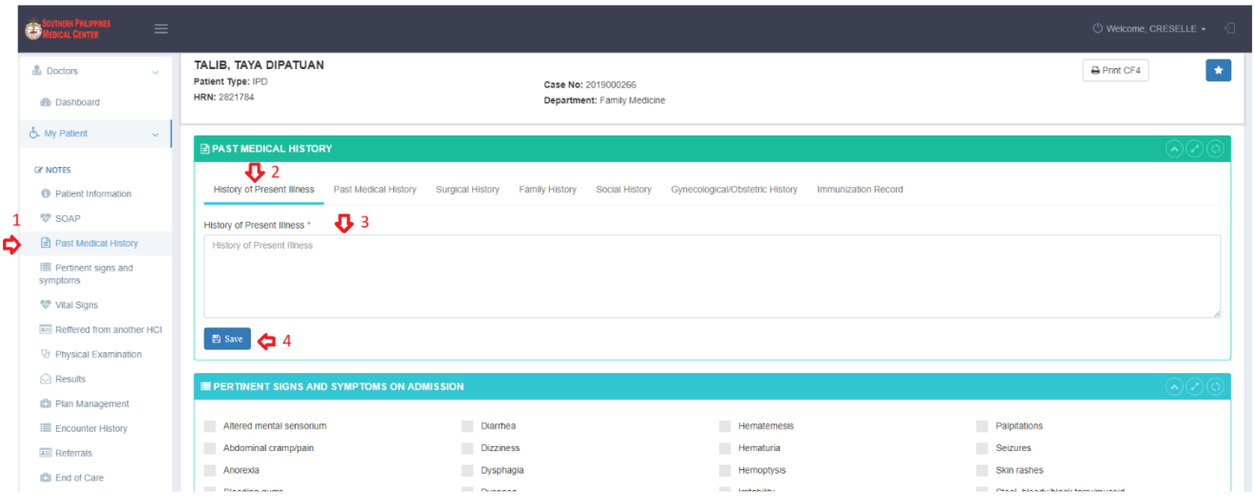
(*Plan*)

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.

Past Medical History

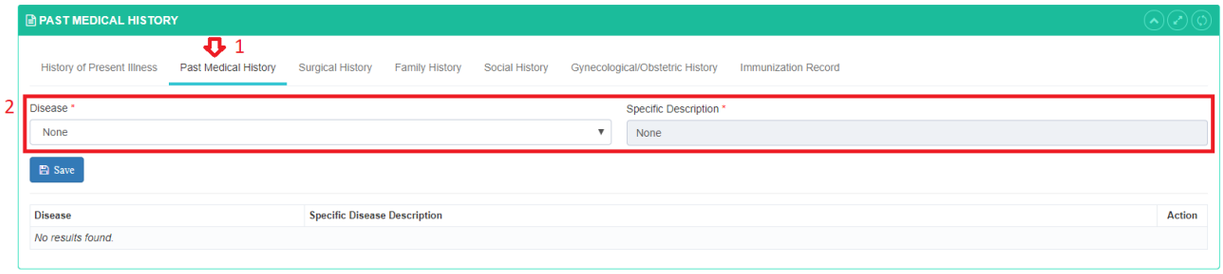
(*History of Present Illness*)

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.

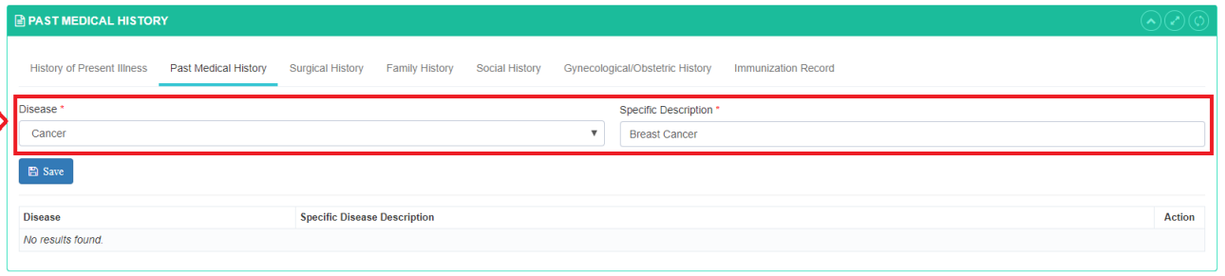


(*Past Medical History*)

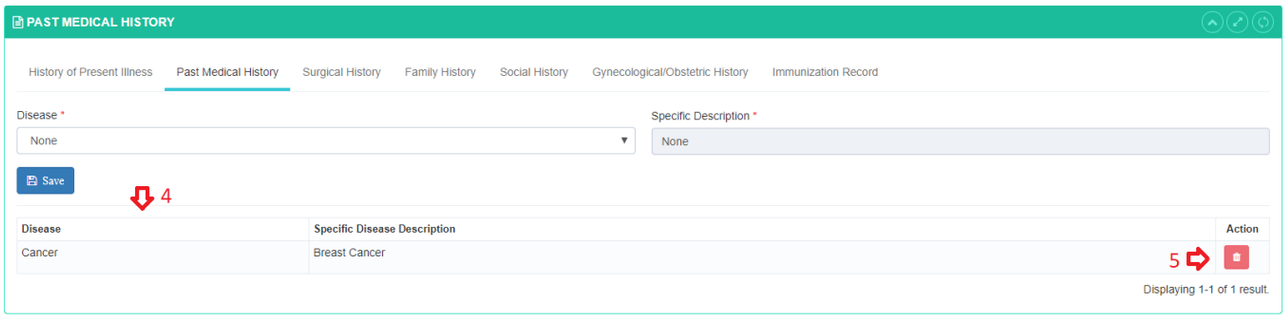
1. To update **Past Medical History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Past Medical History* tab.
2. The default value for the *Disease* field is "None," so is the *Specific Description*. Click **save** button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



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

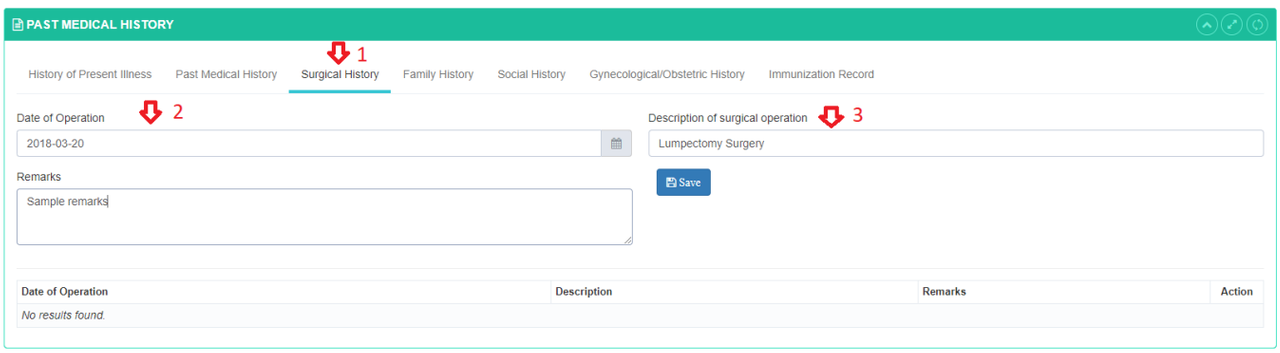


4. After saving, it will be reflected in the table below.
5. To delete selected *disease*, click the red button.

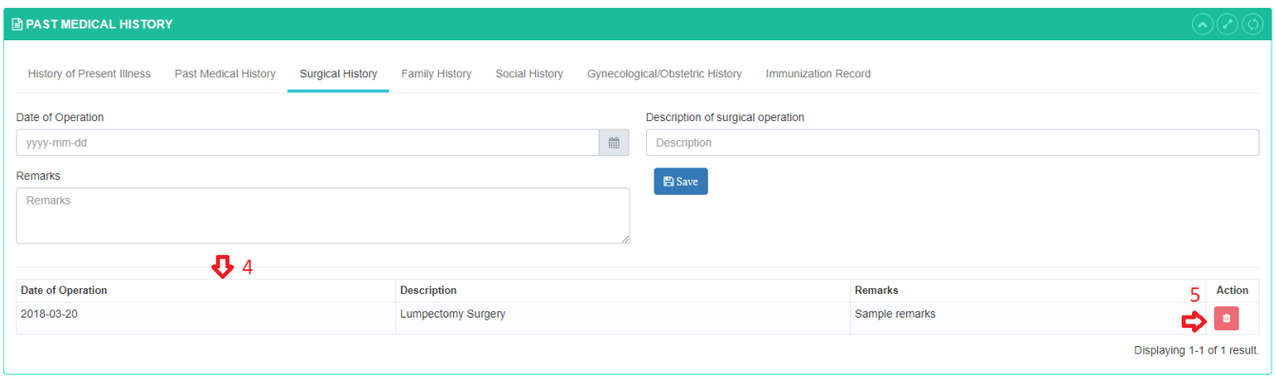


(*Surgical History*)

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*.

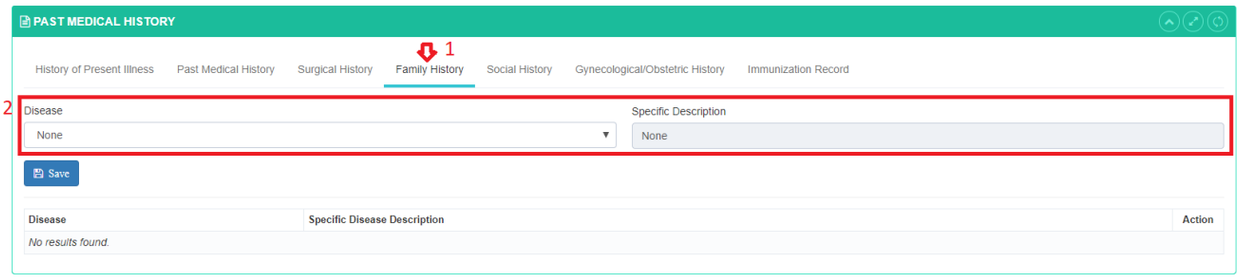


4. After saving, it will be reflected in the table below.
5. To delete *surgical operation*, click the red button.

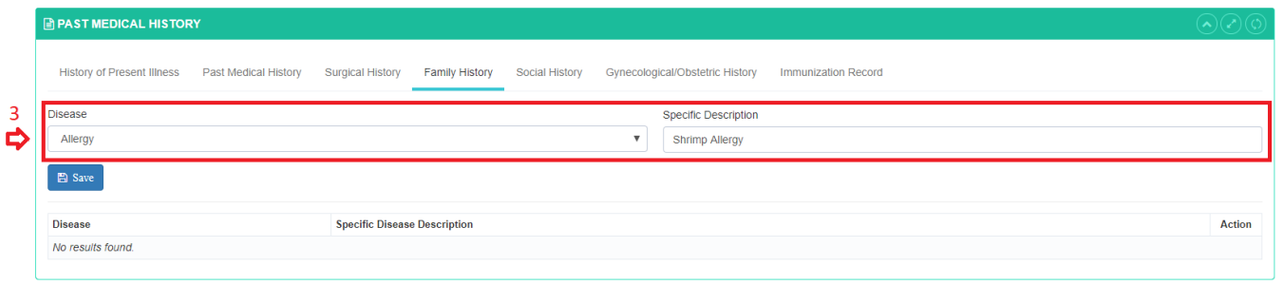


(*Family History*)

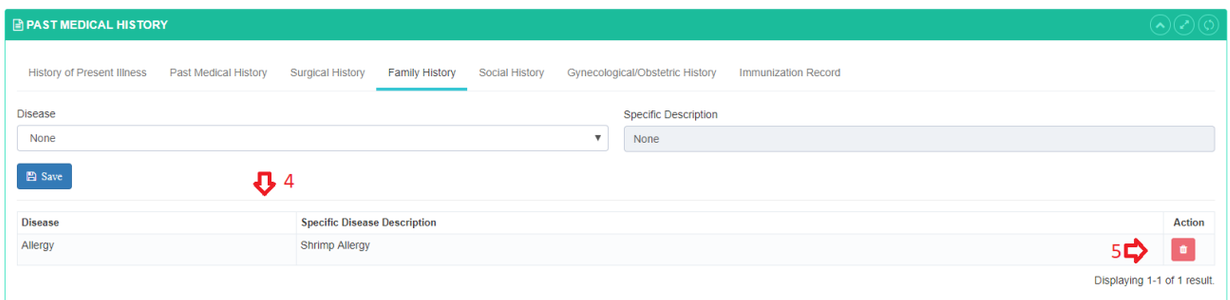
1. To update **Family History** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Family History* tab. *(Note: Family History is not required).*
2. The default value for the *Disease* field is "None," so is the *Specific Description*.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



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

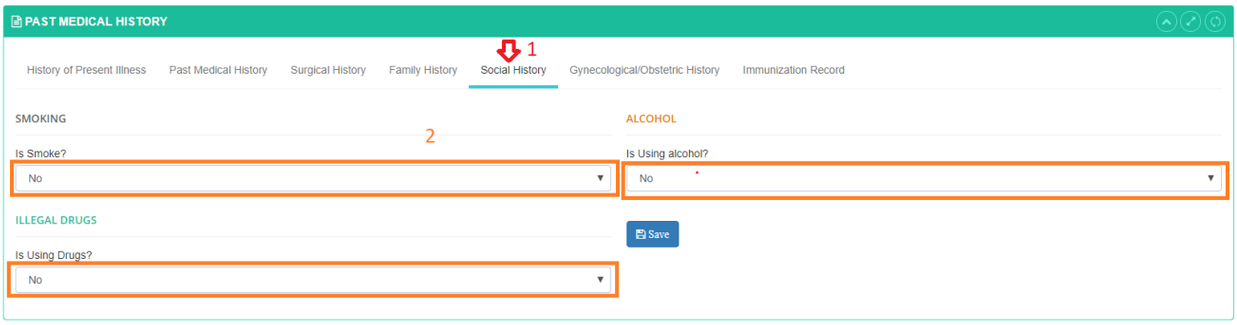


4. Once you click save it will reflect in the table below.
5. To delete selected *disease*, click the red button.

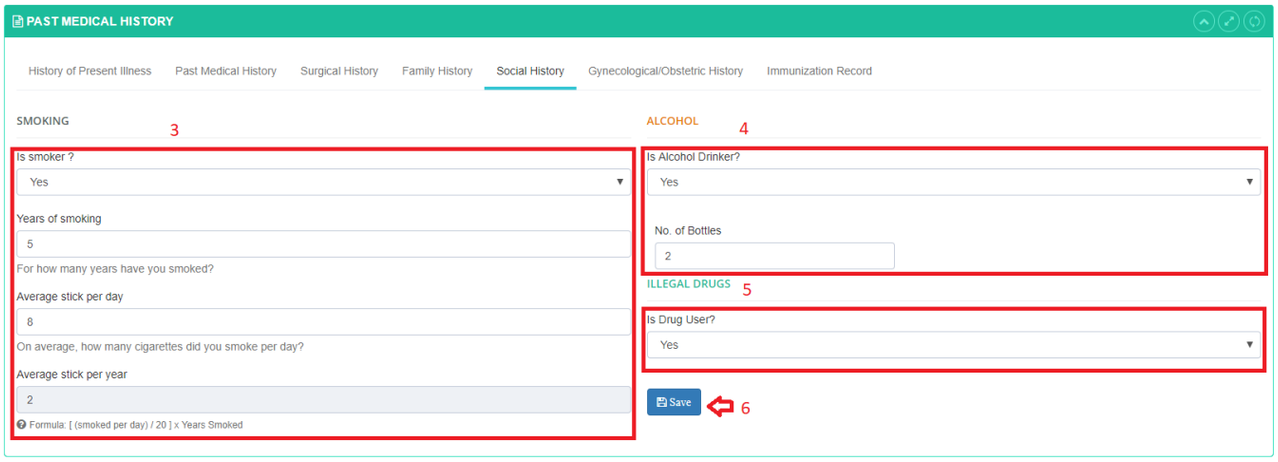


(*Social History*)

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".

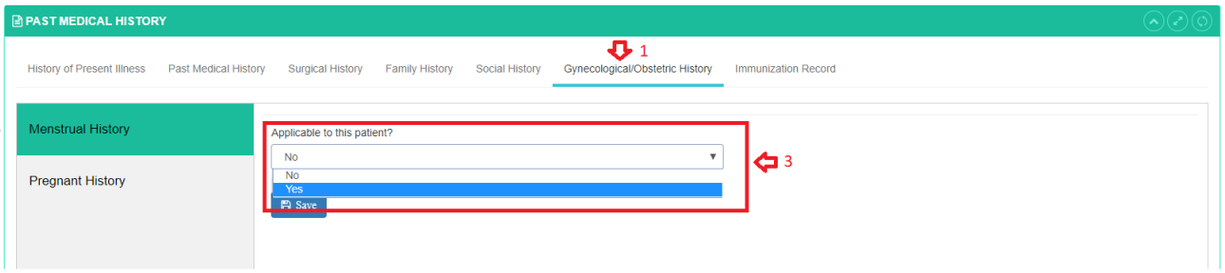


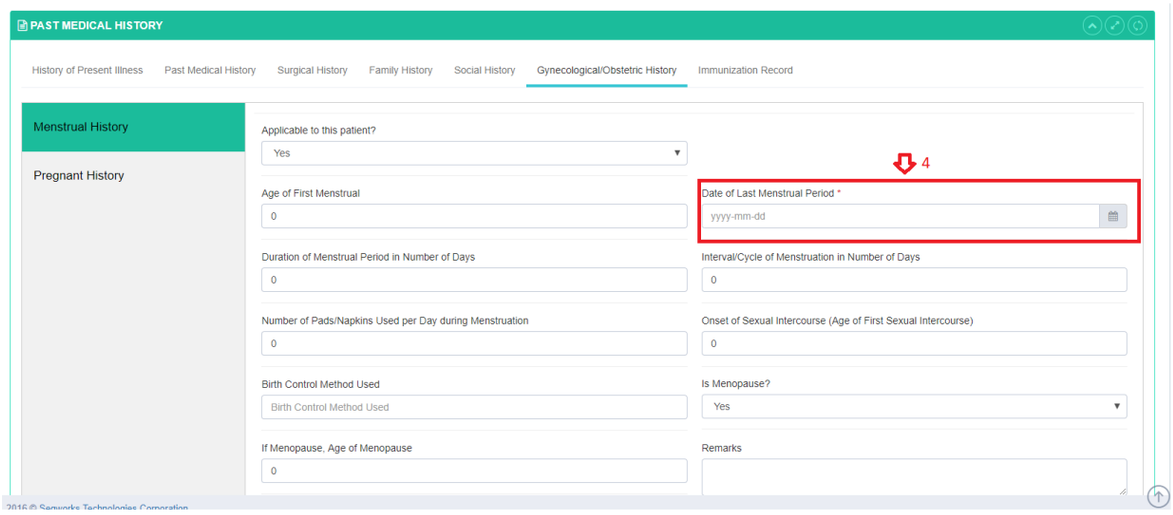
3. Once you select "Yes" for the *Smoking*, the additional details will be displayed. *Average stick per year* is disabled and auto-computed based on the *years of smoking* and *average stick per day*.
4. The *No. of Bottles* per day is required if patient is an alcohol drinker, or have already quit.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



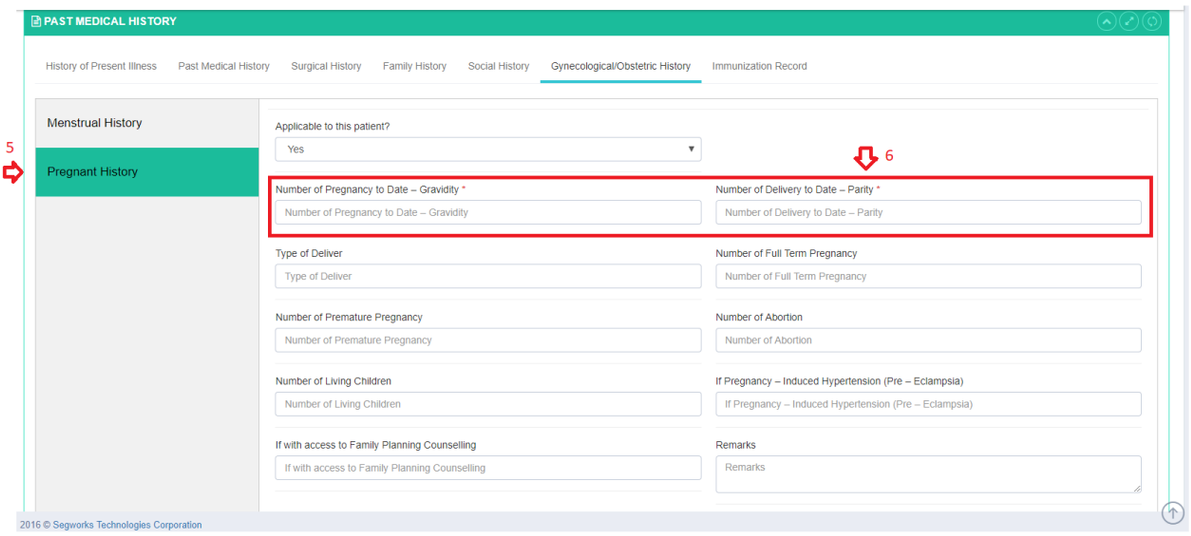
(*Gynecological/Obstetric History*)

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.





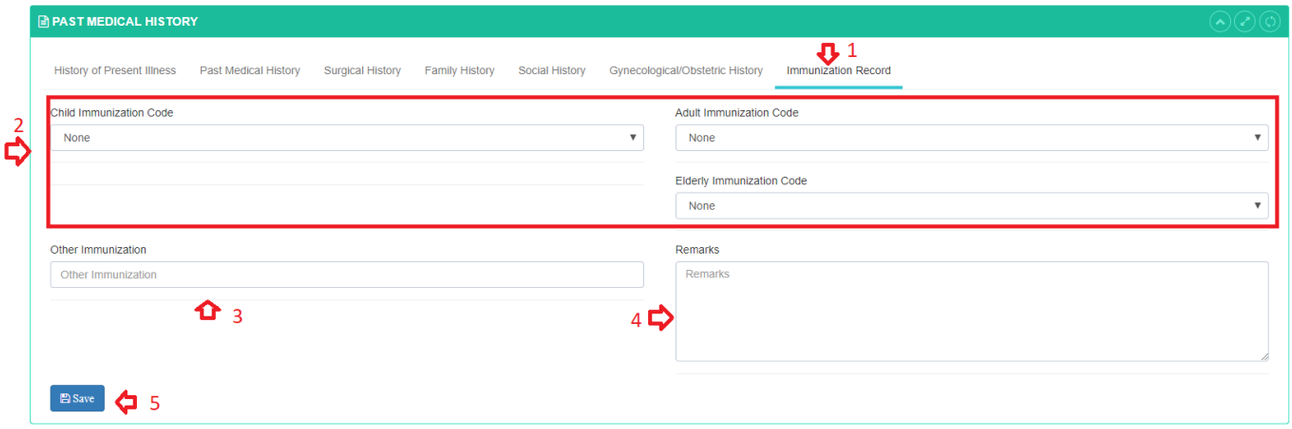
4. Fill up what is applicable but do not leave the *Date of Last Menstrual Period* empty.
5. For *Pregnant History*, the default value is "No".
6. If "Yes", additional fields will be displayed. Fill up what is applicable but do not leave the *Gravidity* and *Parity* empty.



7. Click save to finalize.

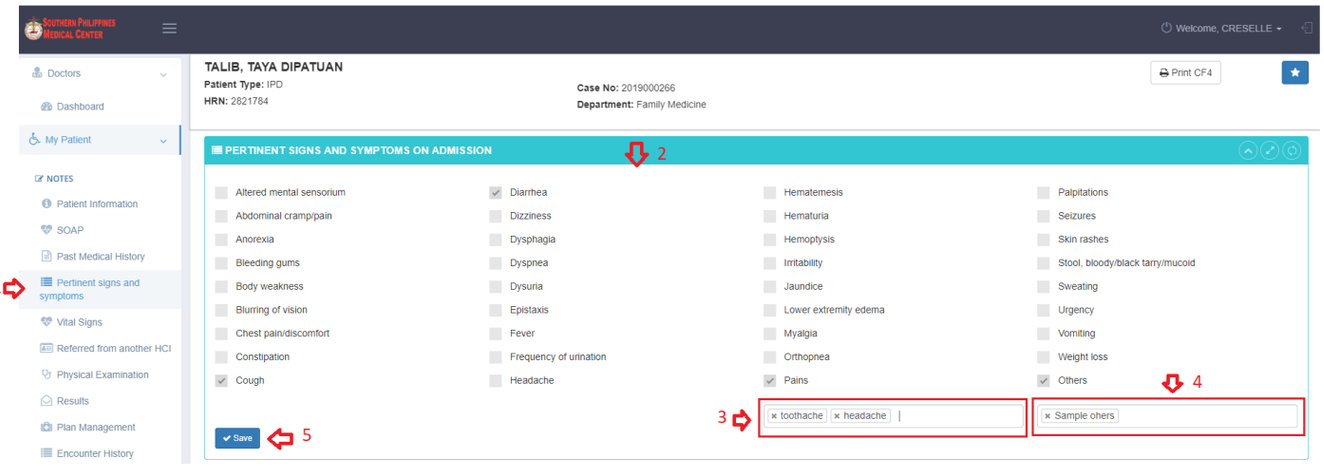
(*Immunization Record*)

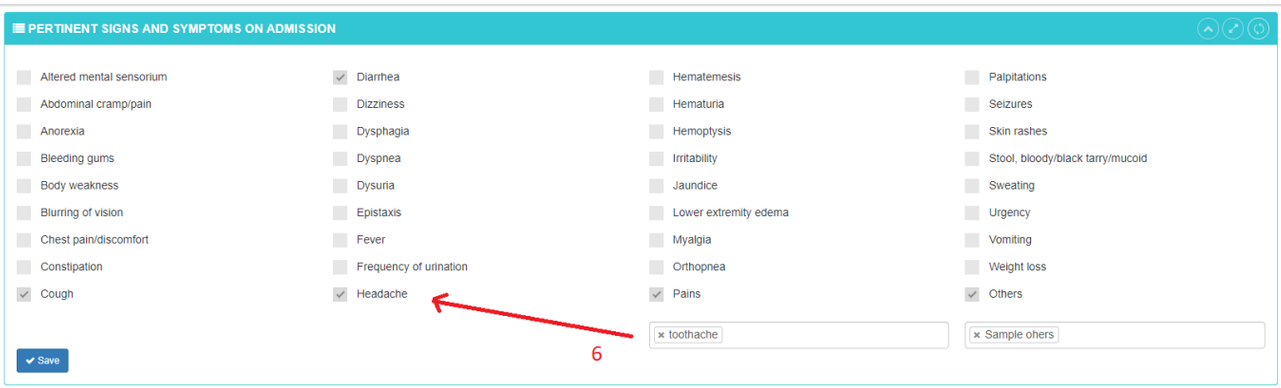
1. To update **Immunization Record** notes, click the **PAST MEDICAL HISTORY** menu item in the left navigation bar (or scroll down main window), then click on the *Immunization Record* tab. *(Note: Immunization Record is not required).*
2. For your convenience, dropdown boxes for *Child Immunization 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



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.

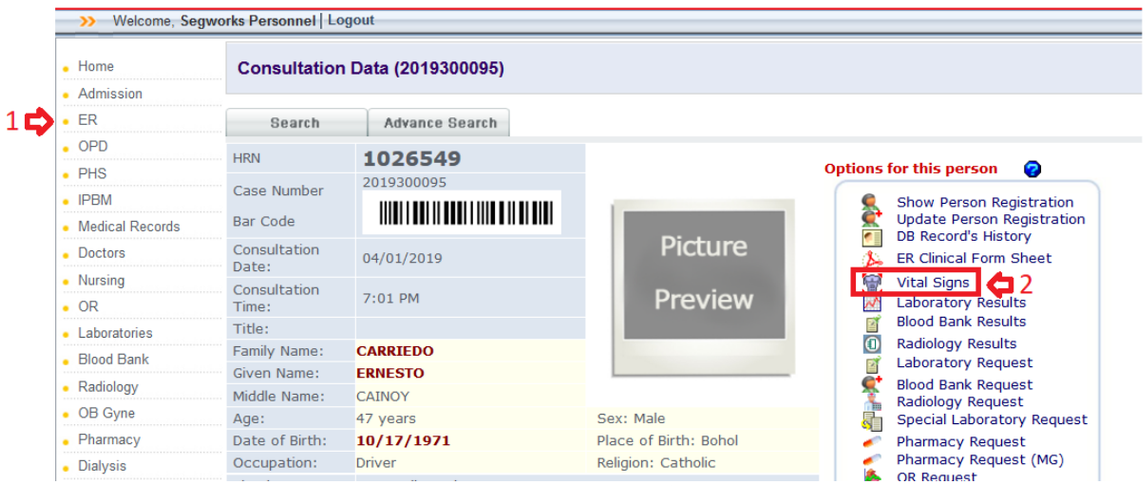




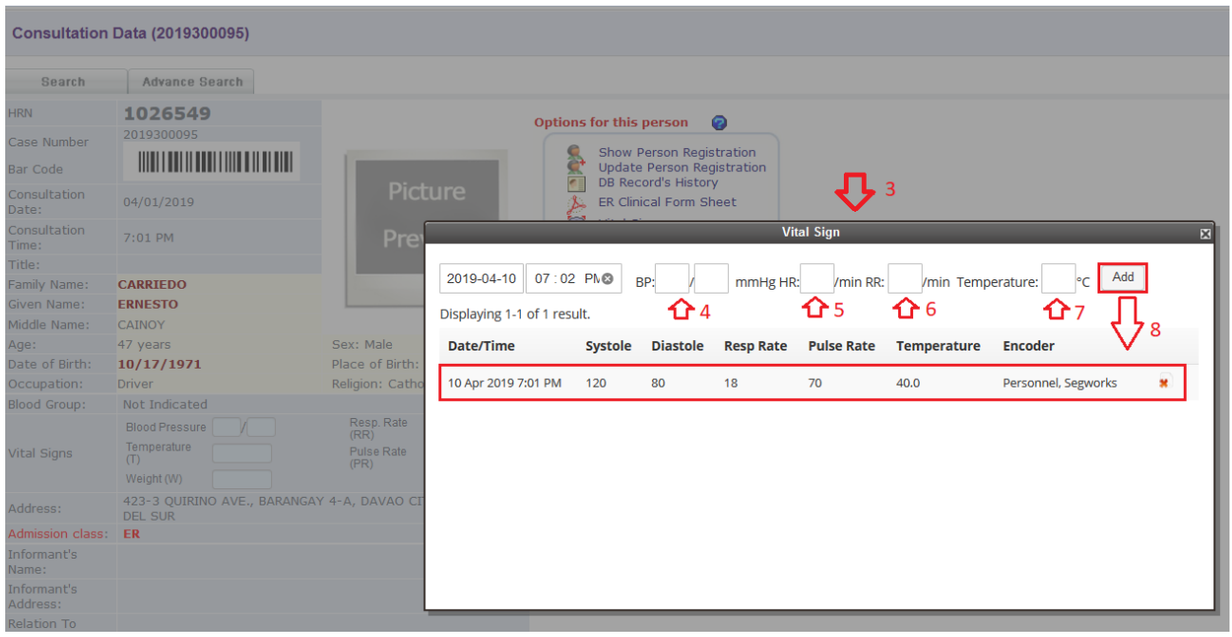
Vital Signs

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

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

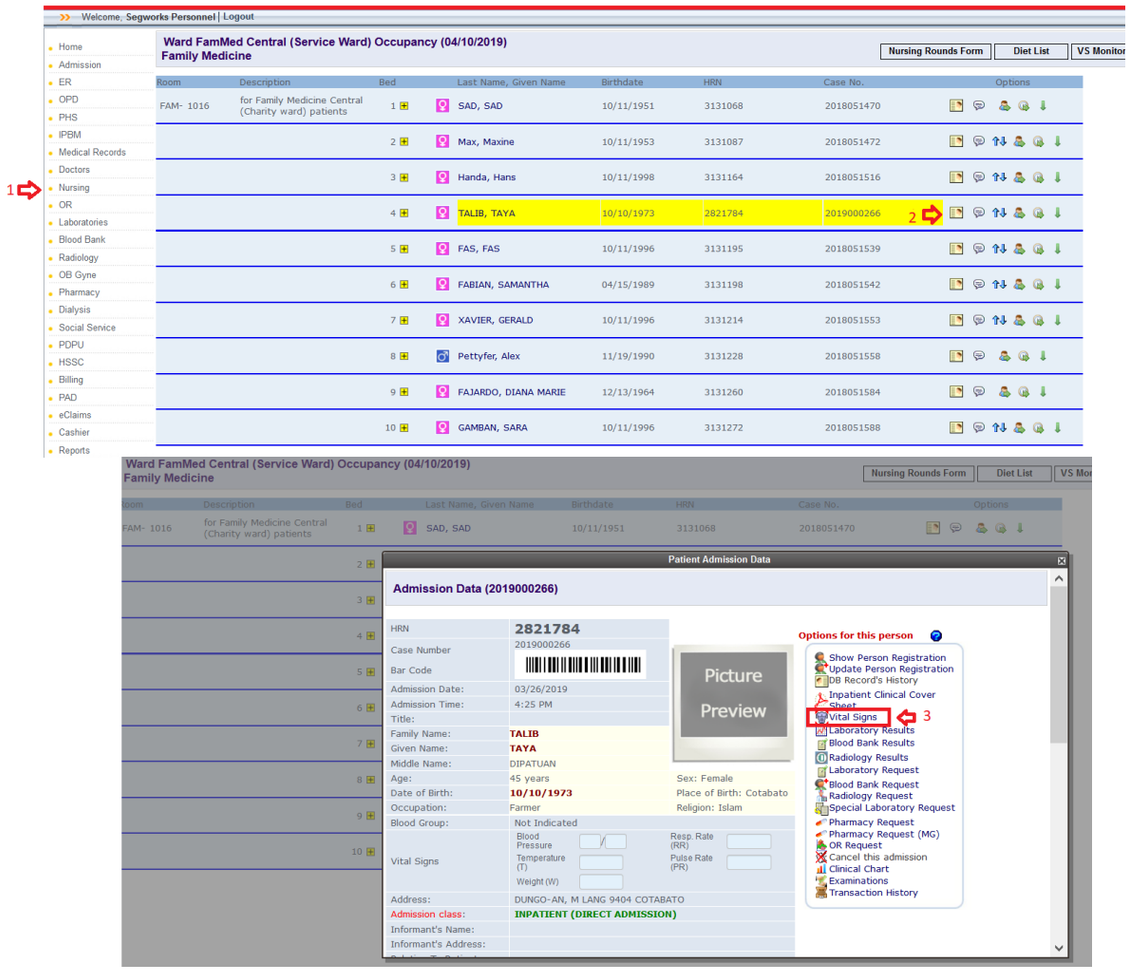


2. Vital signs option is available only to user with a *nurse* job function.
3. A modal for vital signs monitoring will appear upon clicking the vital signs.
4. Input the Blood Pressure (format: systole/diastole)
5. Input Heart Rate
6. Input Respiratory Rate
7. Input Body Temperature
8. Click add to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

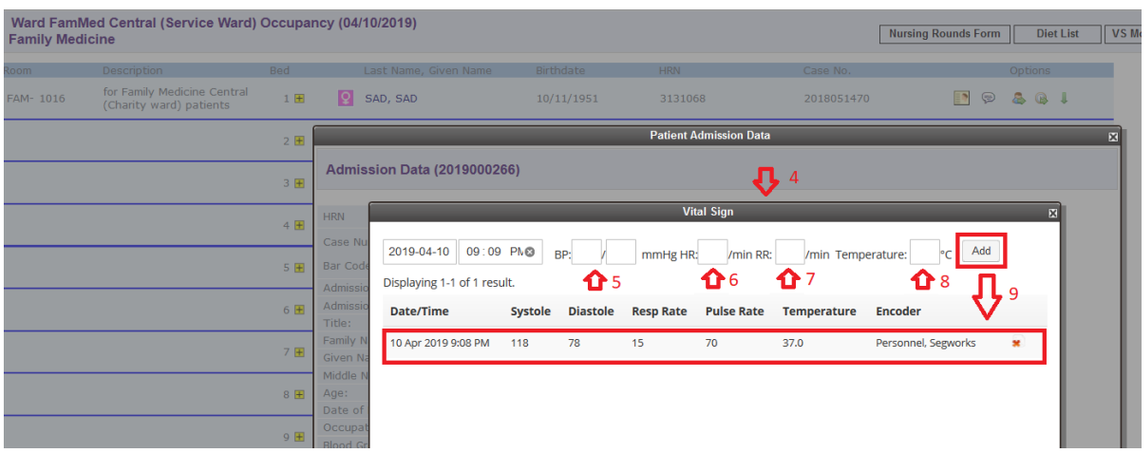


(Vital Signs monitoring in Nursing)

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

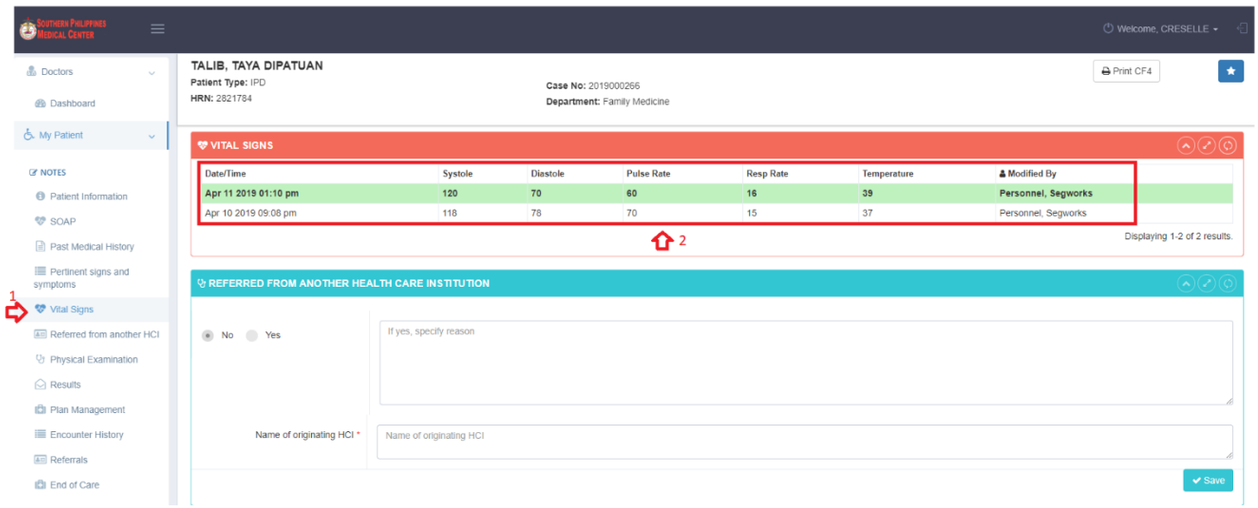


4. A modal for vital signs monitoring will appear upon clicking the vital signs.
5. Input the Blood Pressure (format: systole/diastole)
6. Input Heart Rate
7. Input Respiratory Rate
8. Input Body Temperature
9. Click Add to save vital signs monitoring.



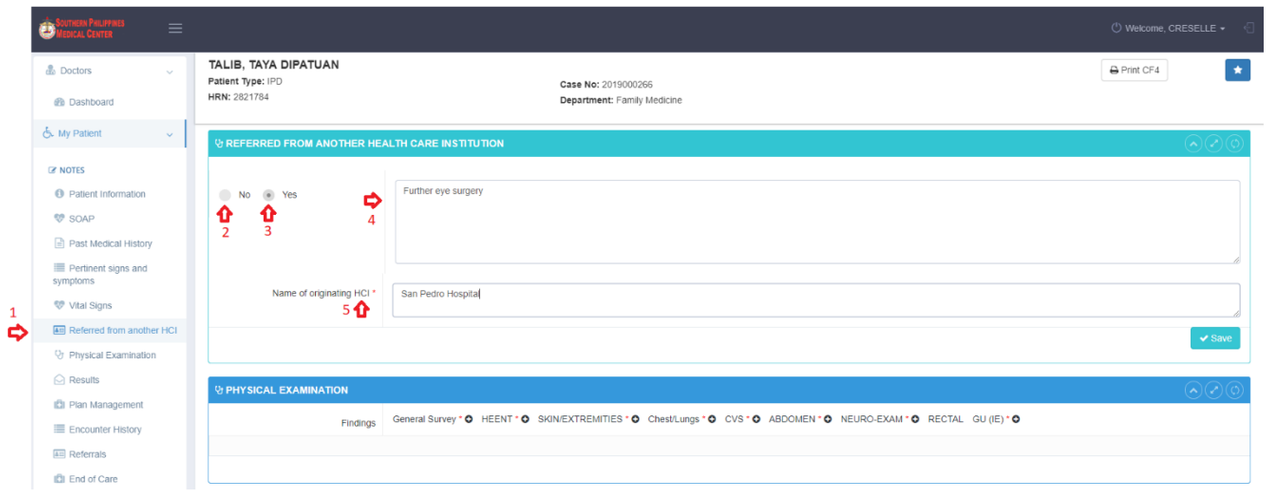
(View Vital Signs)

1. To view **Vital Signs**, click vital signs in the navigation bar or just by scrolling down.
2. Vital signs portlet is only viewable in EHR, the vital signs data is sorted by descending order.



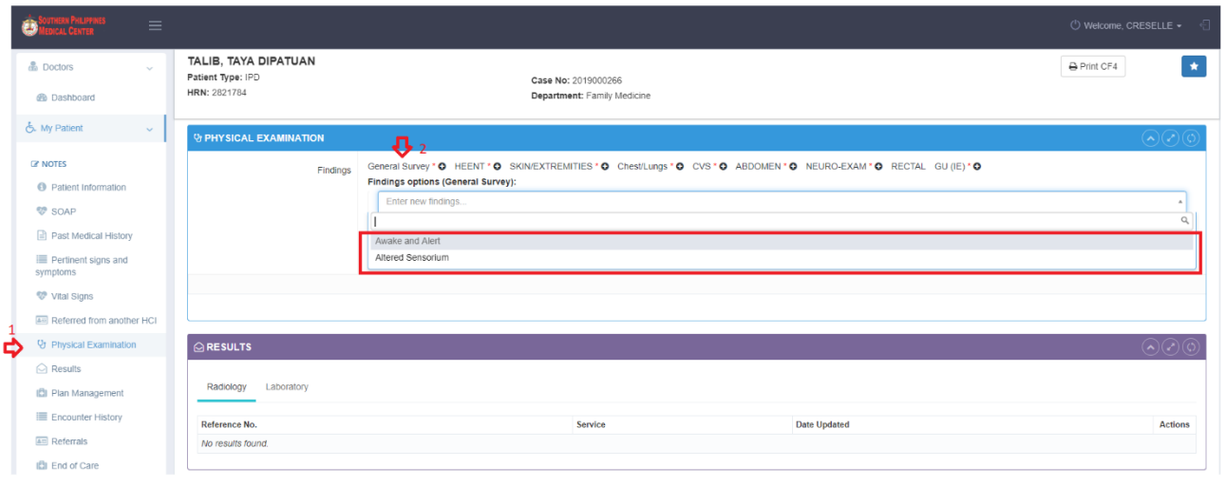
Referred from another HCI

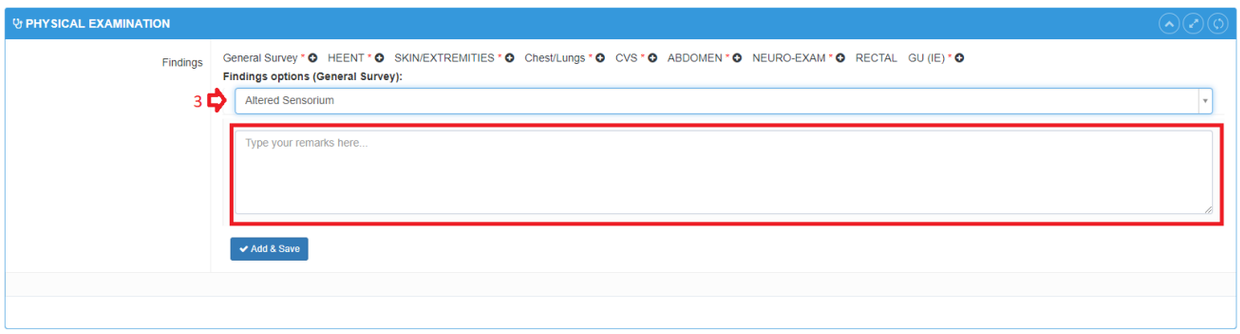
1. Click the **Referred from another HCI** menu item in the left navigation bar (or scroll down main window until you see REFERRED FROM ANOTHER HCI).
2. The default value for referred from another HCI is “No,” and the *remarks* and *name of originating HCI* will be disabled.
3. If “Yes” input remarks and name of originating HCI.



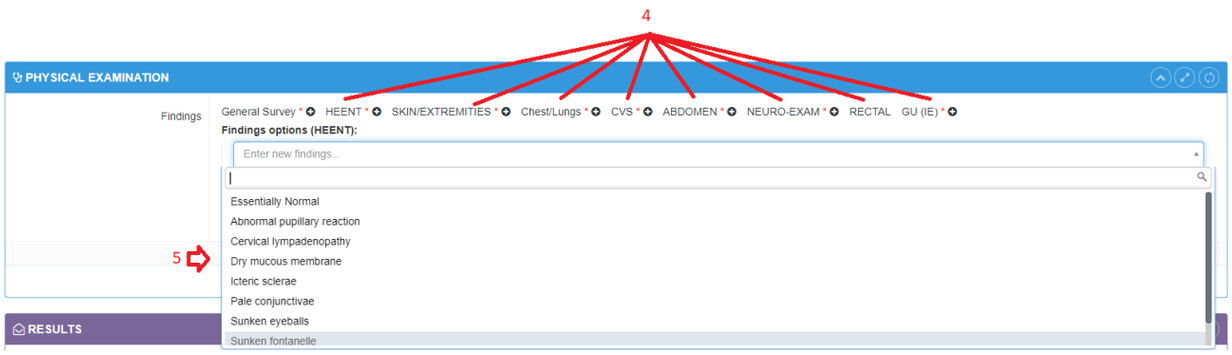
Physical Examination

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.

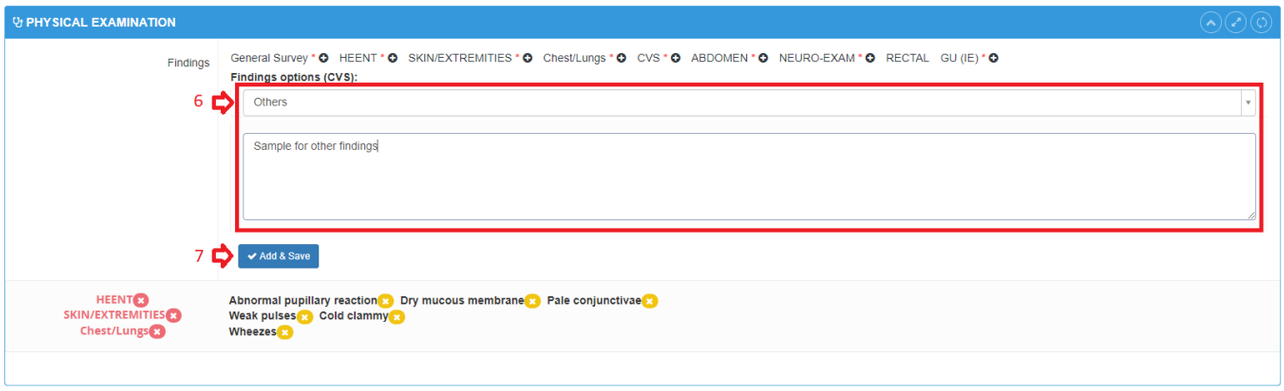




4. Except for *RECTAL*, you are required to provide data for *HEENT*, *SKIN/EXTREMITIES*, *CHEST/LUNG*, *CVS*, *ABDOMEN*, *NEURO-EXAM* and *GU (IE)*.
5. All list of findings from the dropdown menus are officially provided by Philhealth, hence select what is applicable.

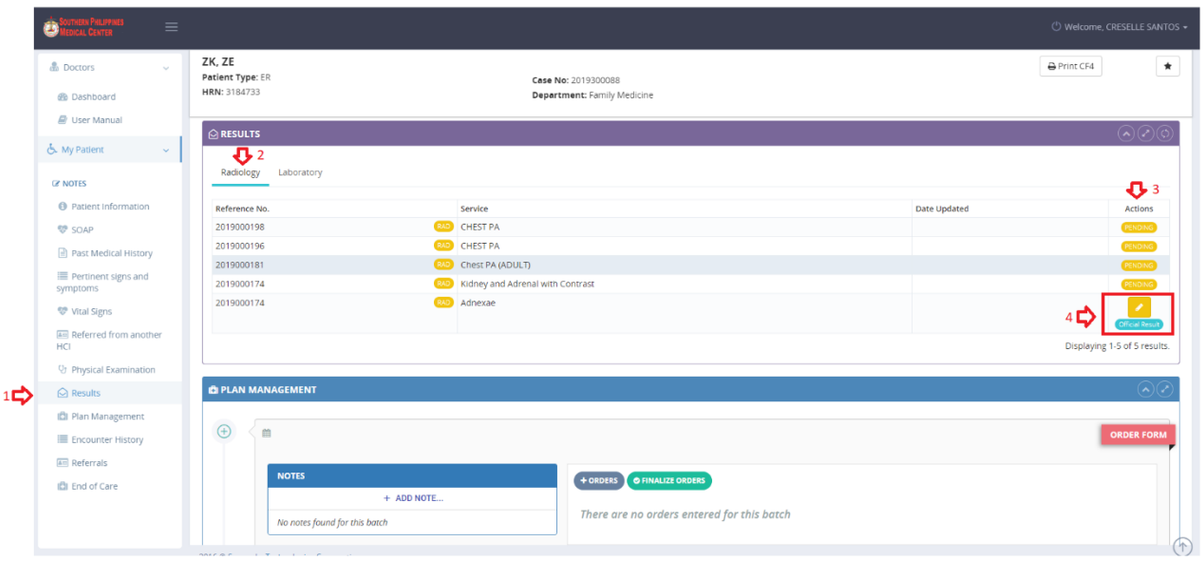


6. If finding/s is not found in the list, select “others” and input a remarks.
7. Click *Add & Save*.
8. “Others” are presented in italic.
9. To delete findings, click the yellow button.
10. If “Essentially Normal” it will overwrite all findings.

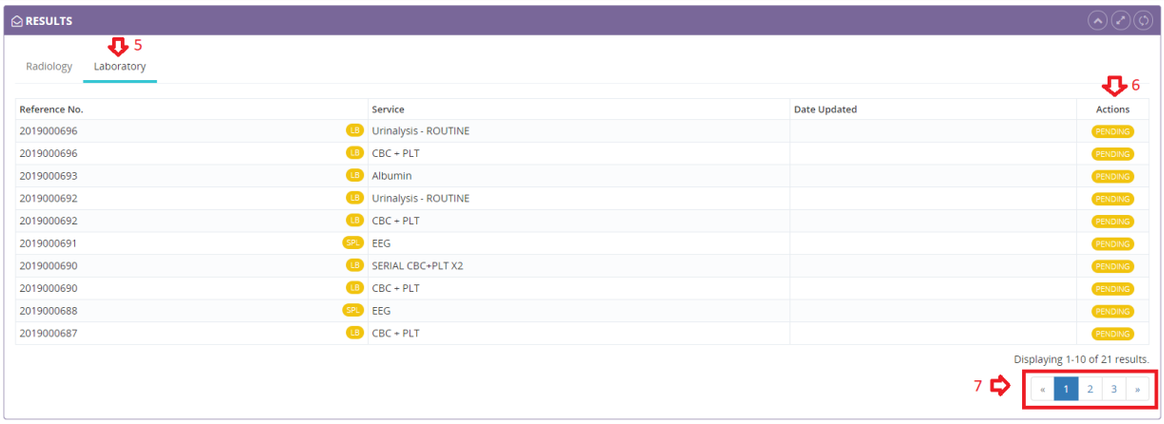


View Results

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.



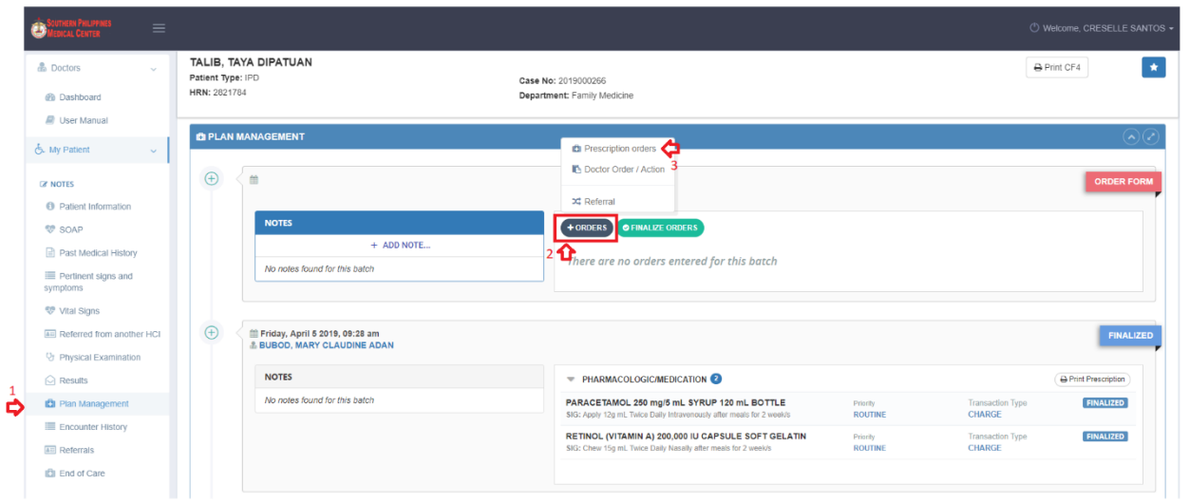
5. For *Laboratory*, the *reference no*., *service name*, *date updated*, and *actions* are indicated.
6. The status of a laboratory service can be seen in "actions" column. The sequence order of the status is from *pending*, *served*, *to with result*. Clicking the *Initial Result* or *Official Result*,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



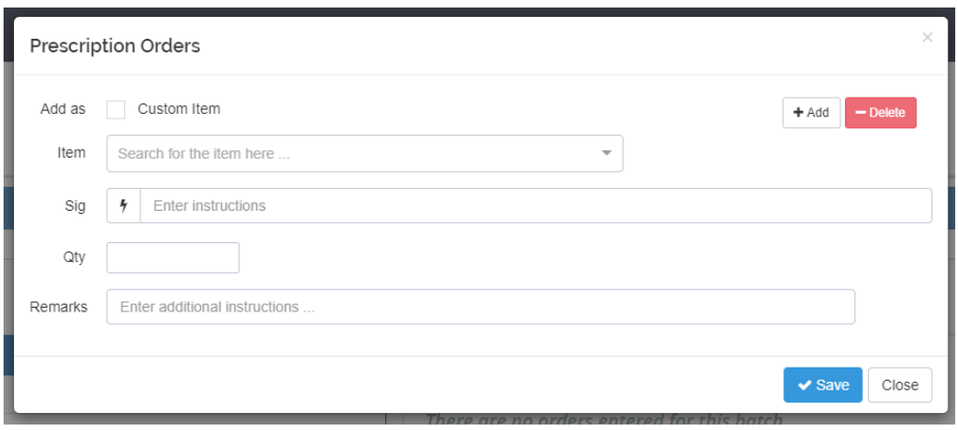
Plan Management

(Prescription)

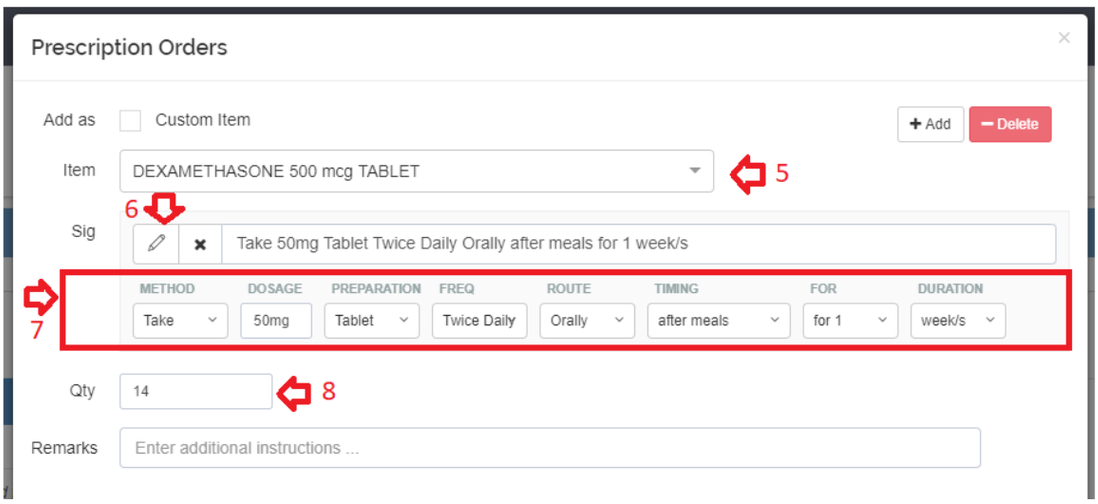
1. Click the **Plan Management** menu item in the left navigation bar (or scroll down main window until you see PLAN MANAGEMENT title bar).
2. Upon clicking *ORDERS* button, *Prescription, Doctor Order/Action and Referral* will be displayed.
3. Select *Prescription orders*, to write prescription for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



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

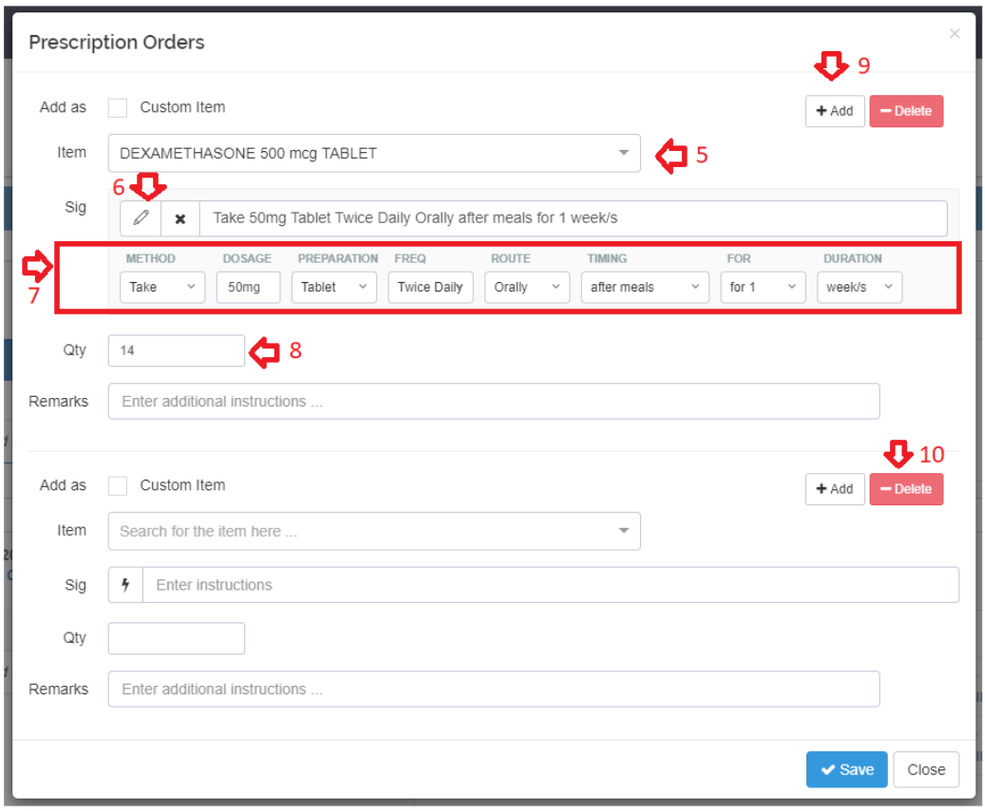


5. Search medicine in the *Item* dropdown. If medicine is not available in the list, the user can input a medicine in a free text format by ticking the *custom item*.
6. Click the *pencil button* to display predefined fields for signetur.
7. Each field has a predefined list of data. Select the appropriate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



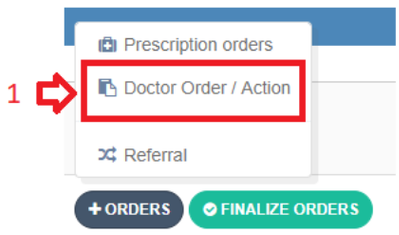
8. Input quantity and remarks(*optional)*.

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



(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.

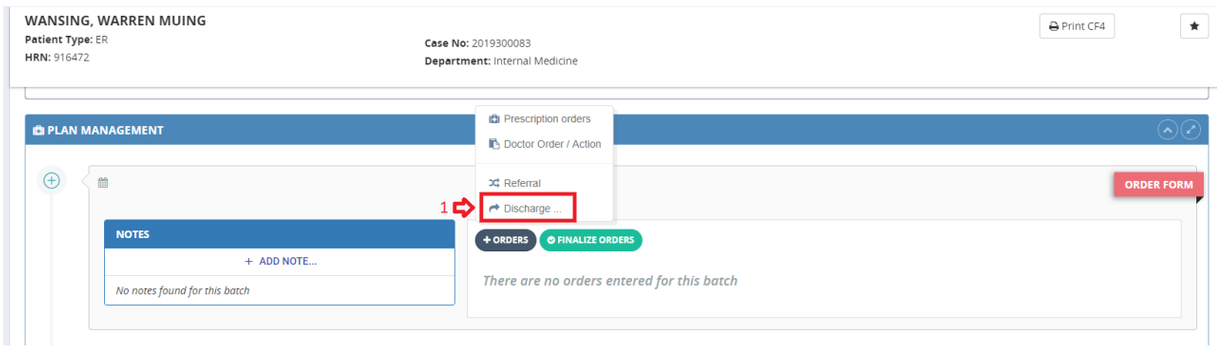


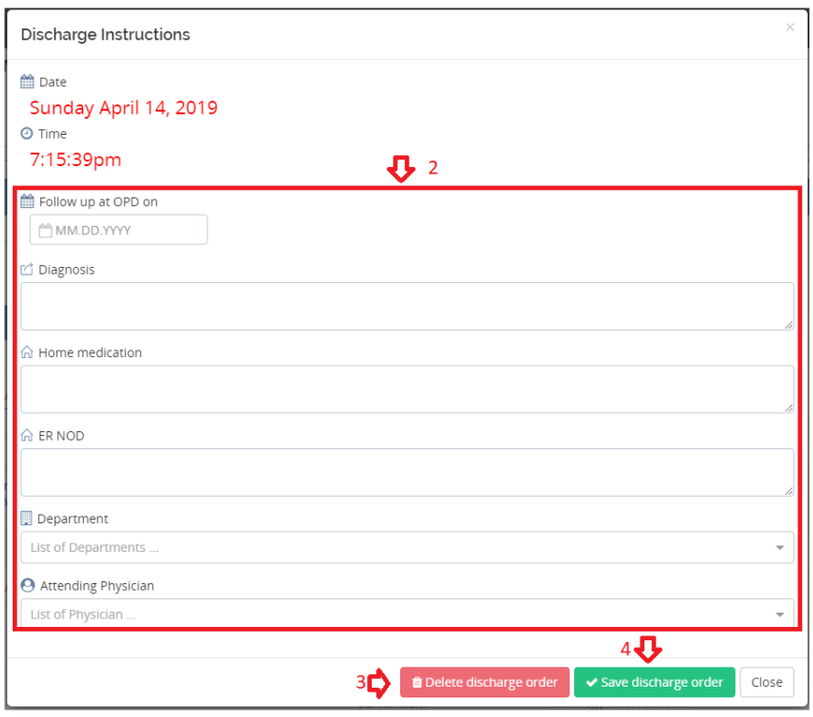
(Referral)

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.

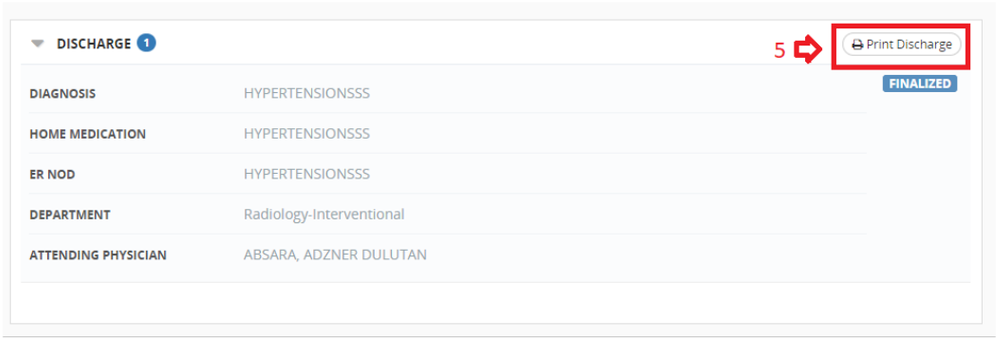
(Discharge order)

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.



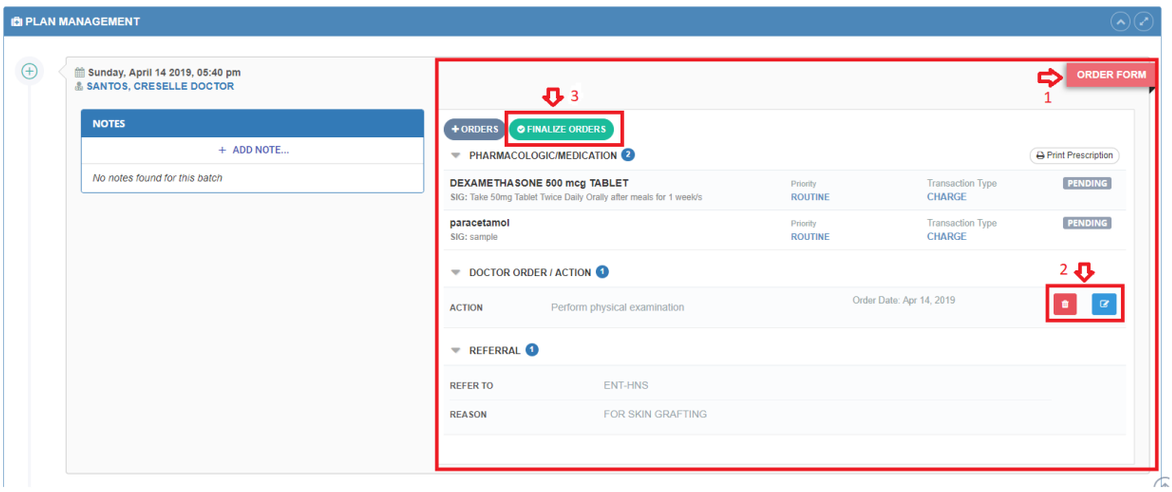


5. Click *Print Discharge* button to generate ER discharge slip.

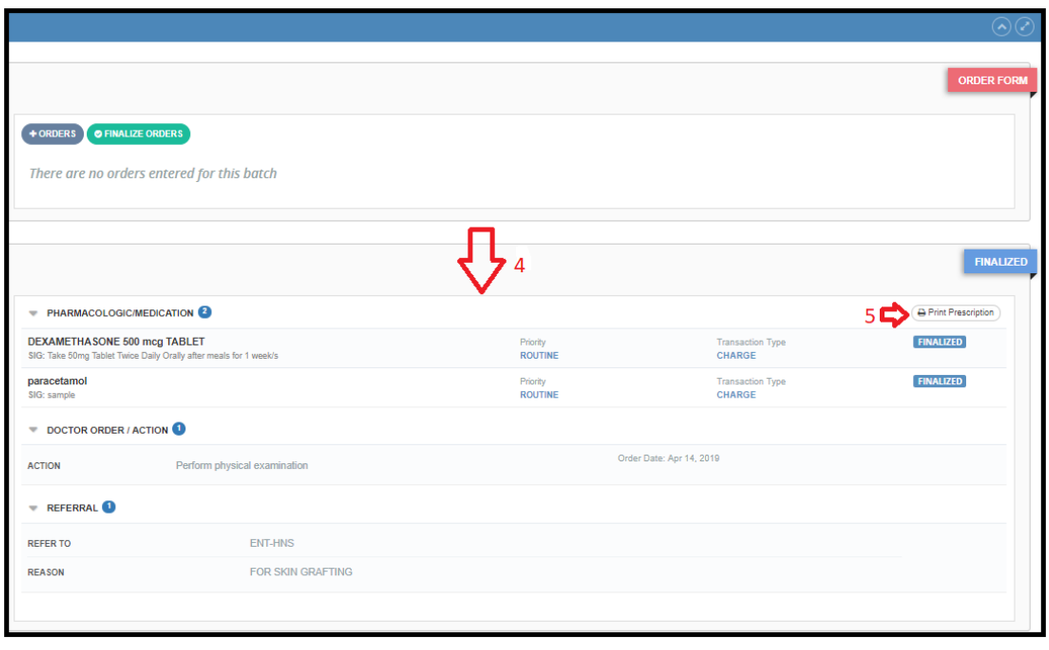


(Finalize Orders)

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.

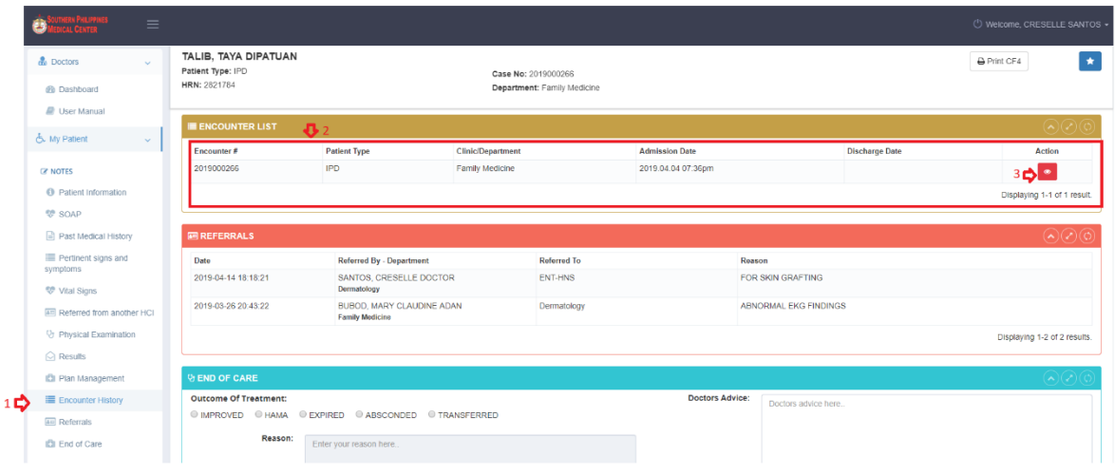


4. Once the orders are finalized, the whole order batch will shift below the order form.
5. Click *Print Prescription* to generate a Rx prescription.



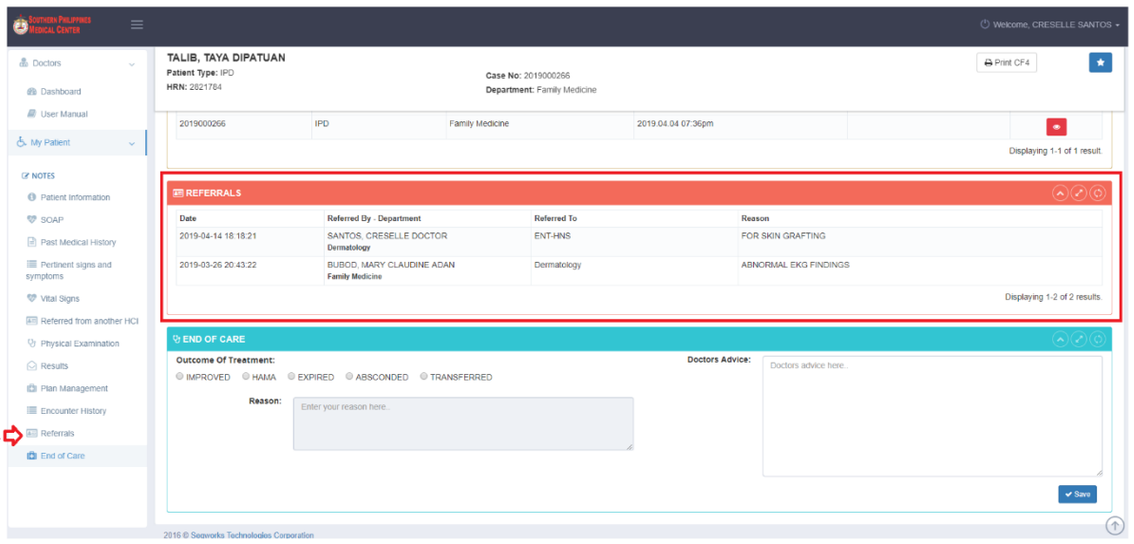
Encounter List

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.



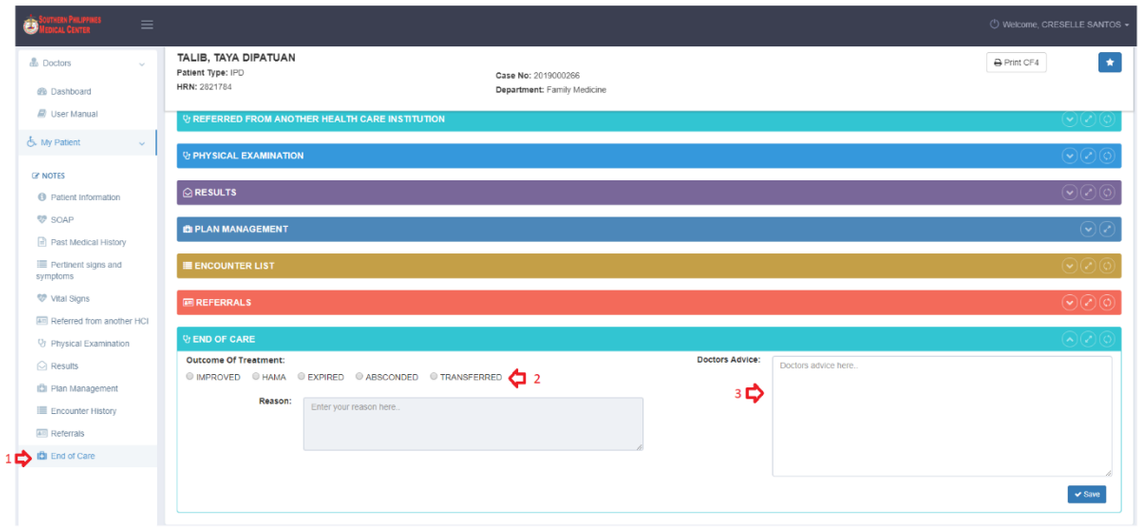
View Referrals

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.



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.