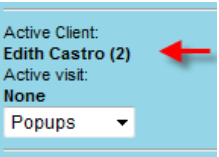
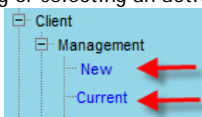
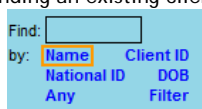
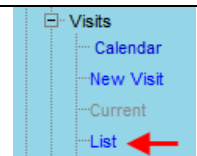
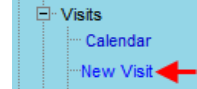
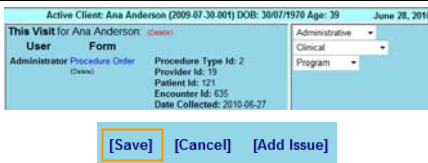
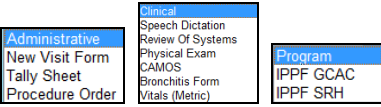
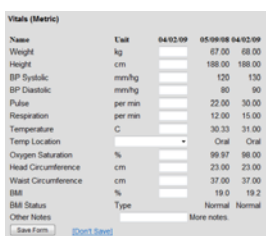
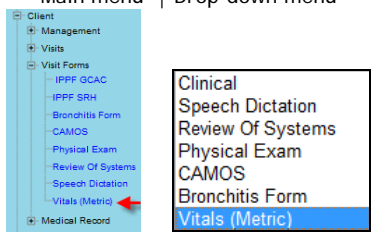

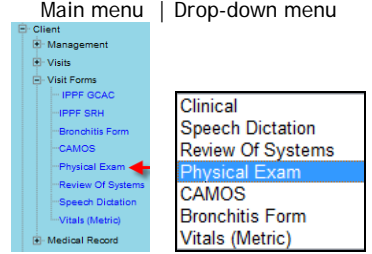


PROCESS DESCRIPTION - VERSION 4.0 (JUNE 2010)

ROLES: CLINIC DATA CLERK / NURSE / DOCTOR		PROCESS 2.5.0: UPDATING CLINIC CHECKS DATA																
#	Step	Observations	Menu options or screen information															
0	<p>Preliminary steps: In order to update a Client Clinic CHECK, you first need to have an Active Client, by creating a new client record or finding an existing one. Clinic Checks are univocally linked to a visit (i.e. a Check must be linked to a specific visit date).</p> <p>Note: Clinic Checks were mentioned in the Forms process guideline (Vitals Form). In this guideline a more complete description of Clinic Checks is presented.</p>	<p>Active client indicator (below Main Menu)</p>  <p>Active client indicator (Top line) Active Client: Edith Castro (2) DOB: 1980-12-30 Age: 28</p>	<p>Creating or selecting an active client</p>  <p>Finding an existing client:</p> 															
1	<p>Verify if client has an open visit You can view a List of existing visits for the active client, by selecting: Client > Visits > List</p> <p>Hint: See Process guide 'Creating a new Visit' for more information on this subject.</p>	<p>Past Visits and Documents (To Billing View)</p> <table><thead><tr><th>Date</th><th>Issue</th><th>Reason/Form</th></tr></thead><tbody><tr><td>2009-04-23</td><td></td><td>test</td></tr><tr><td>2009-02-26</td><td>Y: penicillin</td><td>pap smear and consultation general</td></tr><tr><td>2009-02-25</td><td>Y: penicillin</td><td>paid in advance for service TL</td></tr><tr><td>2009-02-25</td><td>Y: penicillin</td><td>pap smear</td></tr></tbody></table>	Date	Issue	Reason/Form	2009-04-23		test	2009-02-26	Y: penicillin	pap smear and consultation general	2009-02-25	Y: penicillin	paid in advance for service TL	2009-02-25	Y: penicillin	pap smear	
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2009-02-25	Y: penicillin	paid in advance for service TL																
2009-02-25	Y: penicillin	pap smear																
2	<p>Create a new visit In order to create a new visit, select: Client > Visits > New Visit A New Visit Form is displayed</p>	<p>New Visit Form Consultation Brief Description:</p>																
3	<p>Save visit and access Forms Menu Once you save the visit, the bottom part of the screen will split into two columns. The Visit Page (left column) and the Forms Menu (right column). In addition, the Client > Visit Forms menu will become accessible (see next step)</p>																	
4	<p>Enter Vitals Data A relevant check that is usually taken in every visit is the measure of vital signs. By choosing the Vitals category, OpenEMR displays a standard Vitals data entry form.</p> <p>By selecting the Save Form button, the new data is added to a cumulative table of vital signs grouped by visit date, so clinic staff can have a complete view of the evolving vital sign data.</p>		<p>Main menu Drop-down menu</p> 															
5	<p>Enter Physical Exam Data By selecting the Physical Exam category, OpenEMR displays a general Physical Check-up form. Tick boxes, editable diagnosis lists and open text fields are included in this framework to facilitate data entry.</p> <p>The table includes references to 'Within Normal Limits' (WNL), Abnormal (ABN1), System Specific concepts, and enter brief Diagnosis and Comments.</p>		<p>Main menu Drop-down menu</p> 															
6	<p>Enter Other Checks From time to time, the OpenEMR community adds new clinic forms to the system. Some of them may be useful for IPPF clinics, such as a general Review of body systems (comprehensive table to register specific condition found in most body systems), or very specific forms such as CAMOS (Spinocerebellar ataxia, autosomal recessive 5), etc. Use these forms only if they are applicable to your clinic setting.</p>	<p>Review of Systems</p> <p>Constitutional</p> <p>Weight Change: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Fasting: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Fatigue: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Anorexia: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Fever: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Chills: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Night Sweats: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Incontinence: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Irritability: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Heat or Cold: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Intolerance: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Eyes</p> <p>Change in Vision: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Family History of Glaucoma: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Eye Pain: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Itching: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Redness: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Excessive Tearing: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Double Vision: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Blind Spots: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Photophobia: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Ears, Nose, Mouth, Throat</p> <p>Healing Issues: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Discharge: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Pain: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hoarse: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Throat: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Frequent Cough: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Swallow: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Sinus Problems: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Post Nasal Drip: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Sore Throat: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Strep Problems: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Allergies: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Noisiness: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Snoring: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Apnea: <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Main menu Drop-down menu</p> 