

Level 2 – Level 2 of *Nursing Documentation Using Electronic Health Records* includes chapters 5, 6, 7, and 8. These chapters take the students deeper into EHR features of documentation and enable them to add on to their Nurse Notes using these features. The student is also introduced to documentation in the ambulatory healthcare setting. Exercises are provided for the nurse and nurse practitioner to create an Office Visit Note.

Chapter 8 – Ambulatory Healthcare Exercises

The last chapter of level two provides the student with eight exercises set in ambulatory healthcare. The student practices documenting in the EHR program using features learned in the previous chapter. They create, modify, and prepare addendums to office visit notes and generate reports and excuse notes.

Learning Outcomes

After completing Chapter 8, the students will be able to:

- 8.1 Use Springcharts to create an office visit note.
- 8.2 Use Springcharts to modify an office visit note.
- 8.3 Carryout generating office visit reports.
- 8.4 Use Springcharts to construct an excuse note.
- 8.5 Use Springcharts to make an addendum to the office visit note.

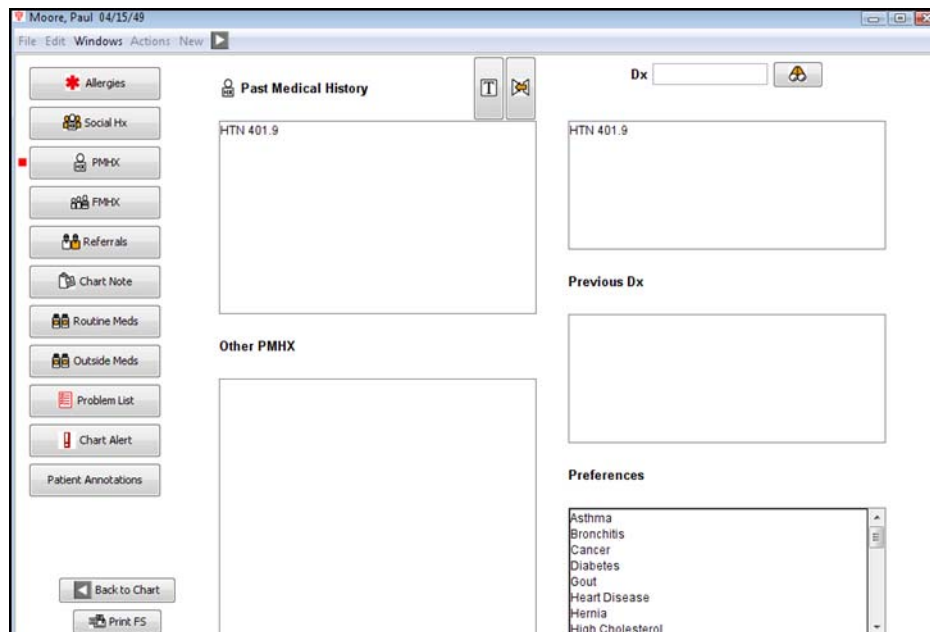
Presentation Outline

Exercise 8.1

Building an Office Visit Note (Part 1—Ambulatory Care Nurse)

1. Open the patient's chart with your name. On the chart menu select *New>New OV*. In the *Office Visit* screen, notice the face sheet information on the left-hand side of the window.

2. Add another past health history item to the face sheet by right-clicking in the *PMHX* section and selecting *Edit*. In the face sheet window, choose another medical condition either from the list of *Preferences* in the lower left or search for a new medical diagnosis in the upper right. Click the [Back to Chart] button in the lower left.



OV 12/05/2010
Edit Actions Database Tools

Pt: Moore, Paul 04/15/49

Patient
Moore, Paul 04/15/49
Age: 61 yrs 7 mns 20 days.
8301 North Main
Sherman, TX 77521
Mother's Last Name: Fischer
Home #: (214) 543-4567
Mobile #: (214) 543-0921
SS#:
Marital Status: Married
Sex: M
Employer: St. John's Hospita
Attending Provider:

Allergies
Allergies: NKA
Other Sensitivities: none

PMHX
HTN 401.9

Note: The OV screen is positioned behind the patient's chart window; you will see the top portion of the window. To bring it to the foreground simply click on the top edge of the OV window.

- A patient is visiting the nurse practitioner because of a flare-up of seasonal allergies and the ambulatory care nurse is performing an initial assessment. Click on the [CC] navigation tab on the right side of the *Office Visit* screen. In the *S Panel* of pop-up text that appears in the right-hand panel select *Allergies/Allergic Reaction, Runny nose, Itchy eyes*. The words are added to the lower middle work area. Click on the [time] and [initial] insert buttons in the lower right section to add the time and your initials to the note.

- Select the [Vitals] navigation tab on the left. All previously created text is now added to the SOAP format. Create and enter vital sign information on your patient. (Documentation of head circumference (HC) is not needed since this is not a pediatric patient.) BMI (body mass index) is grayed out because the program calculates this item from the height and weight.

- Click on the [Done] button in the OV screen. Click the [Save and Skip Billing] button. The note will be finished later and a routing slip created at that time for this office visit. The OV note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.

Patient
 Moore, Paul 04/15/49
 Age: 61 yrs 7 mns 20 days.
 8301 North Main
 Sherman, TX 77521
 Mother's Last Name: Fischer
 Home #: (214) 543-4567
 Mobile #: (214) 543-0921
 SS#: _____
 Marital Status: Married
 Sex: M
 Employer: St. John's Hospital
 Attending Provider: _____

Problem List
 none listed

Routine Meds
 OTC Meds:
 Multiple Vitamin

Outside Meds
 none listed

Default Pharmacy
 Default Pharmacy Not Set

Uncharted Tests
 none listed

Allergies
 Allergies: N/A
 Other Sensitivities: none

PMHx
 HTN 401.9

FMHx
 none listed

Social History
 Nonsmoker

Chart Note
 none listed

Referrals
 Body, Able I M. D.

Patient Annotation(s)
 none listed

Chart Evaluation
 Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk
 Not Done Everyone Age 35 yrs to 105 yrs EKG every 104 w
 Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio

Diagnosis Hx
 none listed

Prescription Hx
 none listed

Procedure Hx
 none listed

Insurance
 No Insurance Info

Alert: HTN
 Encounters
 12/05/2010 Office Visit
 12/05/2010 Vitals Check
 Immunizations
 Medications
 Lab
 Imaging
 Medical Tests
 Flow Sheets
 Text Records
 Excuses/Notes
 File Cabinet
 Recycle Bin
 Nursing Documentation
 Correspondence

12/05/2010 Office Visit
Subjective:
 Allergies/Allergic Reaction, Runny nose, Itchy eyes, 3:50 PM jmsmd
Objective:
 Vitals: Temp: 98.4F HR: 90 Resp: 22 BP: 134/72
 O2SAT 94 %
Assessment:
Plan:
 Date Created: 12/05/2010
 Date of Service: 12/05/2010
 Patient Number: 59 Chart ID: 22
 Last Modified: 12/05/2010
Attending Staff:
 Attending Staff Name: John O. Smith, R.N. Role: Nurse

Exercise 8.2

Building an Office Visit Note (Part 2—Primary Care Provider)

Note: Now that the ambulatory care nurse has completed the initial assessment, the office visit is handed over to the nurse practitioner. The nurse practitioner does not start a new *office visit* note (as the ambulatory care nurse did), but edits the existing *office visit* note.

1. Open your chart. Click on the “+” sign beside the *Encounters* heading in the care tree. Select the office visit entry started in Exercise 8.1. Click on the [Edit] button at the bottom of the window.

Patient
 Moore, Paul 04/15/49
 Age: 61 yrs 7 mns 20 days.
 8301 North Main
 Sherman, TX 77521
 Mother's Last Name: Fischer
 Home #: (214) 543-4567
 Mobile #: (214) 543-0921
 SS#: _____
 Marital Status: Married
 Sex: M
 Employer: St. John's Hospital
 Attending Provider: _____

Problem List
 none listed

Routine Meds
 OTC Meds:
 Multiple Vitamin

Outside Meds
 none listed

Default Pharmacy
 Default Pharmacy Not Set

Uncharted Tests
 none listed

Allergies
 Allergies: N/A
 Other Sensitivities: none

PMHx
 HTN 401.9

FMHx
 none listed

Social History
 Nonsmoker

Chart Note
 none listed

Referrals
 Body, Able I M. D.

Patient Annotation(s)
 none listed

Chart Evaluation
 Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk
 Not Done Everyone Age 35 yrs to 105 yrs EKG every 104 w
 Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio

Diagnosis Hx
 none listed

Prescription Hx
 none listed

Procedure Hx
 none listed

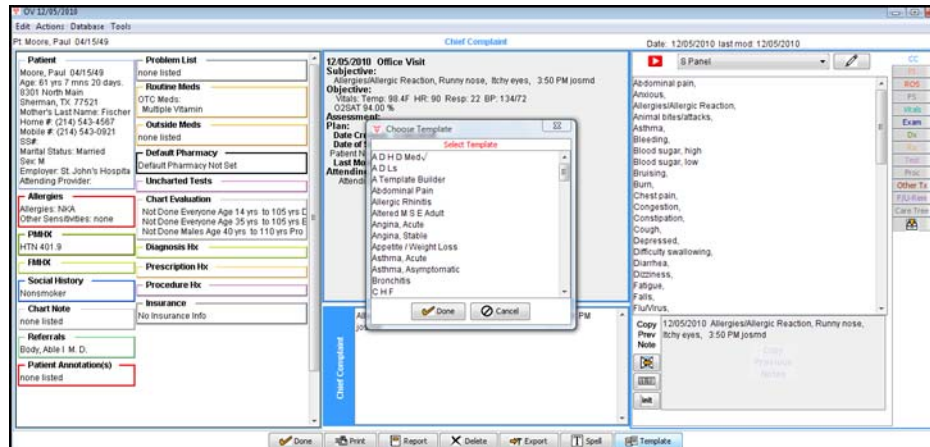
Insurance
 No Insurance Info

Alert: HTN
 Encounters
 12/05/2010 Office Visit
 12/05/2010 Vitals Check
 Immunizations
 Medications
 Lab
 Imaging
 Medical Tests
 Flow Sheets
 Text Records
 Excuses/Notes
 File Cabinet
 Recycle Bin
 Nursing Documentation
 Correspondence

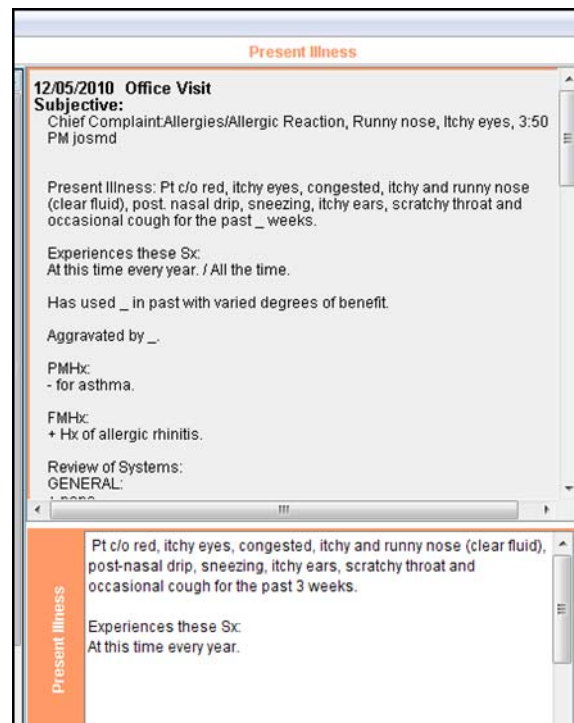
12/05/2010 Office Visit
Subjective:
 Allergies/Allergic Reaction, Runny nose, Itchy eyes, 3:50 PM jmsmd
Objective:
 Vitals: Temp: 98.4F HR: 90 Resp: 22 BP: 134/72
 O2SAT 94 %
Assessment:
Plan:
 Date Created: 12/05/2010
 Date of Service: 12/05/2010
 Patient Number: 59 Chart ID: 22
 Last Modified: 12/05/2010
Attending Staff:
 Attending Staff Name: John O. Smith, R.N. Role: Nurse

Note: In the office visit screen the provider can view the information already documented by the ambulatory care nurse. SpringCharts has office visit templates for some of the most common ailments, enabling provider to quickly select the appropriate template to populate the office visit note. The provider individualizes the note to reflect this patient's condition.

- Click on the [Template] button in the bottom right corner of the *office visit* screen. From the displayed list select: *Allergic Rhinitis*. Notice the entire note has been built very quickly.



- The nurse practitioner completes the note for this patient. Click on the *PI* navigation tab on the right side. The text from the template appears in the lower middle work area. Move the scroll bar to the top of this window and complete the following sentence: *Pt c/o red, itchy eyes, congested, itchy and runny nose (clear fluid), post-nasal drip, sneezing, itchy ears, scratchy throat and occasional cough for the past weeks*. Place your cursor in front of the word weeks, highlight the underscore mark and type: 3. Complete the missing information in the remainder on the *PI* section by either adding or deleting information.



Note: The primary care provider continues through the entire note making changes and additions where necessary for this specific patient.

- A diagnosis must be added. Click on the *Dx* navigation tab on the right side. This patient has had allergies in the past. The diagnosis is in the *Previous Diagnoses* window in the lower right corner. Select *Allergic Rhinitis 477.9* from this list.

Diagnosis

CHEST:
+ none
- Normal excursion, normal fremitus.

LUNGS:
+ none
- Clear to auscultation bilaterally, good breath sounds.

SKIN:
+ none
- No rashes. No abnormal appearing lesions.

Assessment:
Diagnosis:
Allergic Rhinitis 477.9

Plan:
Follow-Up:
RTC as needed based on response to medicine or in one year for reassessment to renew medication.

Date Created: 12/05/2010
Date of Service: 12/05/2010
Patient Number: 59 Chart ID: 22
Last Modified: 12/05/2010
Attending Staff:
Attending Staff Name: John O. Smith, R.N. Role: Nurse

Diagnosis
Allergic Rhinitis 477.9

- Next the nurse practitioner prescribes a medication. Click on the *Rx* navigation tab. Once again, medications for allergies have been prescribed in the past. Select *Allegra* and *Flonase* from the *Previous Prescription* window in the lower right corner.

Prescriptions

12/05/2010 Office Visit
Subjective:
Allergies/Allergic Reaction, Runny nose, Itchy eyes, 3:50 PM josmd

Objective:
Vitals: Temp: 98.4F HR: 90 Resp: 22 BP: 134/72
O2SAT 94.00 %

Assessment:
Plan:
Date Created: 12/05/2010
Date of Service: 12/05/2010
Patient Number: 59 Chart ID: 22
Last Modified: 12/05/2010
Attending Staff:
Attending Staff Name: John O. Smith, R.N. Role: Nurse

Prescriptions
Allegra 180mg i po q am #30 rfxprn
Flonase NS 0.05% ii sprays each nostril q d #16g rfxprn

- The nurse practitioner wants the ambulatory care nurse to administer a subcutaneous allergy injection. Choose the *Proc* navigation tab on the right side. Click on the drop-down arrow beside the *All* category on the upper right side. Select the category: *InjectMed*. From the list displayed below, choose *Kenalog 60 IM*.

- Click on the [Done] button in the *OV* screen. Click the [Save and Skip Billing] button. The *OV* note has been added to the list of encounters in the care tree of the patient's chart. Close the chart.

Exercise 8.3

Building an Office Visit Note (Part 3—Ambulatory Care Nurse)

Note: The nurse practitioner communicates with the ambulatory care nurse regarding administration of the allergy injection.

1. Open your chart. Click on the “+” sign beside the *Encounters* heading in the care tree. Select the *office visit* note you edited in Exercise 8.2. Click on the [Edit] button at the bottom of the window.

The screenshot shows a patient chart for Paul Moore. The left pane contains patient information, problem list, routine meds, outside meds, default pharmacy, uncharted tests, chart evaluation, diagnosis history, prescription history, procedure history, insurance, referrals, and patient annotations. The right pane displays the '12/05/2010 Office Visit' note. The note includes a subject line about an allergic reaction, objective vital signs and physical exam findings, an assessment of allergic reaction, a plan for treatment, and specific prescriptions and procedures.

2. Click on the *Proc* navigation tab on the right side. Click on *Kenalog* injection in the lower center work area.

The screenshot shows the 'Edit Procedure' window. The procedure name is 'Kenalog 60 IM', the CPT code is 'J3301', and the category is 'InjectMed'. The right pane shows the procedure text, which describes the patient's identification, questions asked, and the procedure performed. The text includes: 'Patient was identified using two sources of id...', 'The patient asked the following questions and...', 'Site:', 'Lot number:', 'NDC number:', 'Pt tolerated procedure well.', and 'Tolerated well without evidence of untoward r...'. At the bottom, there are buttons for 'Save', 'Cancel', and 'Delete'.

- In the *Edit Procedure* window document the injection that you just administered. Choose the pop-up text: *Lot number* and type in the lot number (4331). On the next line select the pop-up text: *NDC number* and type the National Drug Code (0003-0293-05). On the next line choose the pop-up text: *Site* and type: *Left arm*. On a new line document the patient's response to the injection; select the pop-up text: *Tolerated well without evidence of untoward reaction*. Click on the [D & T] button and the [Initials] button. Click the [Save] button.

- Click on the [Done] button in the OV screen. Click the [Save and Skip Billing] button. It is the nurse practitioner's responsibility to complete the routing slip and bill for the encounter. The OV note has been added to the list of encounters in the care tree of your patient's chart. Close the chart.

Exercise 8.4

Creating an Examination Report

1. Open your patient's chart. Highlight the recent *office visit* note. Click on the [Report] button at the bottom of the patient's chart screen. The program automatically opens the OV window and displays the examination report on the screen.

Moore, Paul 04/15/49

File Edit Windows Actions New

Patient
Moore, Paul 04/15/49
Age: 61 yrs 7 mns 20 days
8301 North Main
Sherman, TX 77521
Mother's Last Name: Fischer
Home #: (214) 543-4567
Mobile #: (214) 543-0921
SSN:
Marital Status: Married
Sex: M
Employer: St John's Hospital
Attending Provider:

Problem List
none listed

Routine Meds
OTC Meds:
Multiple Vitamin

Outside Meds
none listed

Default Pharmacy
Default Pharmacy Not Set

Uncharted Tests

Chart Evaluation
Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk
Not Done Everyone Age 35 yrs to 105 yrs EKG every 104 w
Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio

Diagnosis Hx

Prescription Hx
12/05/2010 Allegra 180mg i po q am #30 rf xpm
12/05/2010 Flonase NS 0.05% ii sprays each nostril q d #1

Procedure Hx
12/05/2010 Kenalog 60 IM

Insurance
No Insurance Info

PMHx
HTN 401.9

FMHx

Social History
Nonsmoker

Chart Note
none listed

Referrals
Body, Able I M. D.

Patient Annotation(s)
none listed

Alert: HTN
Encounters
12/05/2010 Office Visit
12/05/2010 Vitals Check
Immunizations
Medications
Lab
Imaging
Medical Tests
Flow Sheets
Text Records
Excuses/Notes
File Cabinet
Recycle Bin
Nursing Documentation
Correspondence

12/05/2010 Office Visit
Subjective:
Allergies/Allergic Reaction, Runny nose, itchy eyes, 3:50 PM jmsmd
Objective:
Vitals: Temp: 98.4F HR: 90 Resp: 22 BP: 134/72
O2SAT 94.00 %
Assessment:
Plan:
Prescriptions:
Allegra 180mg i po q am #30 rf xpm
Flonase NS 0.05% ii sprays each nostril q d #16g rf xp
Procedures:
Kenalog 60 IM
Date Created: 12/05/2010
Date of Service: 12/05/2010
Patient Number: 59 ChartID: 22
Last Modified: 12/05/2010
Attending Staff:

Edit Print Report X

2. Print the report by clicking on the [Print] button in the report window. SpringCharts automatically places the letterhead, patient's name and address, the greeting, and introduction in the report letter. If you are sending an electronic document to your instructor, choose the pdf printer and email the document.

Report for 12/05/2010 Office Visit

This report is intended to review the results of your recent physical examination. Your test result is printed next to the name of the test and the normal range is printed to the right of your result. Identified problems and recommendations are at the end of the report.

Examination:
Vitals: Temp: 98.4F Pulse: 90 Resp: 22 BP: 134/72 HC: -1.0in
O2SAT 94.00 %

Report-Probs

Weight above ideal.
BP above 140/90.
Poor Hearing.
Elevated Cholesterol.
Anemia.
Elevated Liver Enzymes.
Elevated Glucose.
Elevated hemoglobin A1c. Less than 7.

Done Cancel Print Email

3. Close the report window. Submit the printed report to your instructor.

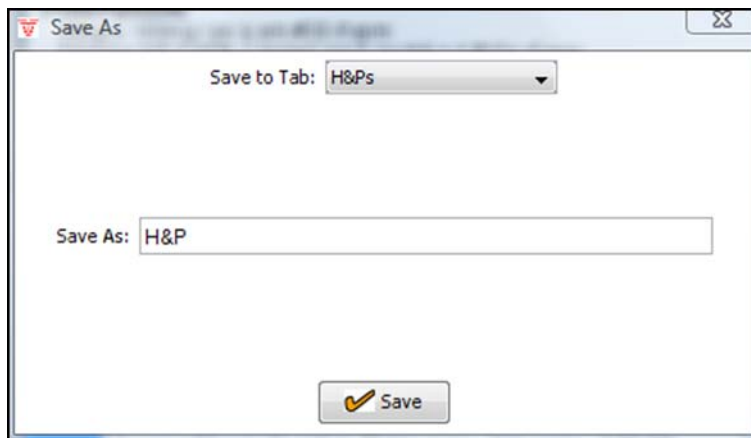
Exercise 8.5

Creating an H&P Report

1. In the OV window, click on the Tools menu and select *H&P*. The H&P contains relevant information from the current physical exam as well as documentation from the patient's face sheet.

2. Print the report and submit to your instructor or choose the pdf printer and email the document to your instructor.

- Click the [Done] button and save the H&P under the *H&Ps* category in the care tree.

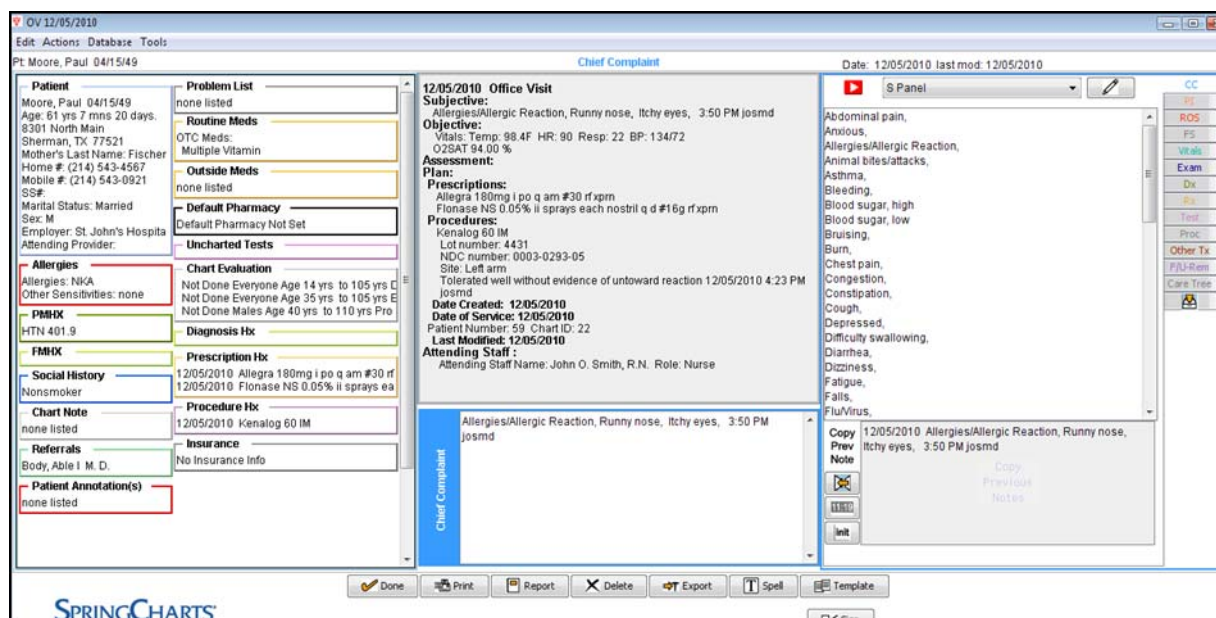


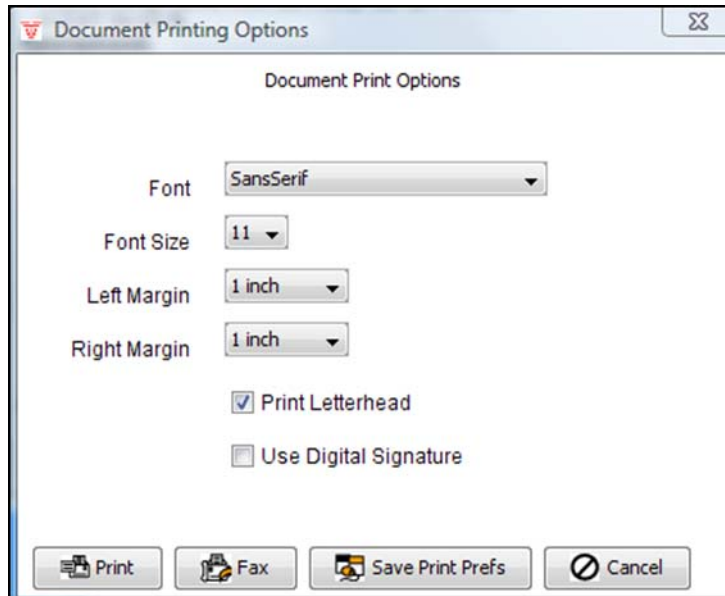
(See Appendix A—Sample Documents; Document 7. *History & Physical Report*)

Exercise 8.6

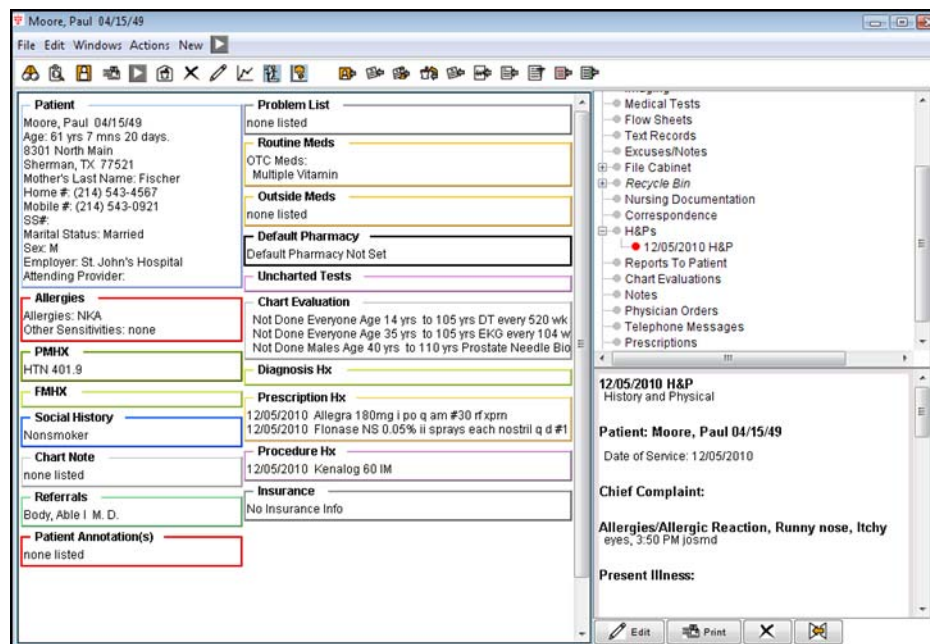
Creating an OV Note Report

- With your *office visit* window still open, click on the [Print] button and print the entire *office visit* note. (To submit your coursework electronically please see section Submitting Assignments Electronically on page xxvii in the front matter of the text.) The OV note is not pre-addressed to any entity and may be sent to a referring primary care provider or other consultant.





2. Submit the printed OV note to your instructor. *Office visit* notes can be added to the body of a letter and printed, faxed, or e-mailed to the patient or others.
3. Close the OV window.
4. In the patient's chart, the *Report to Patient* and the *Office Visit* saved as *Encounters* in the care tree and the *H&P* saved under the *H&P* category in the care tree. Click on the "+" sign beside the *H&P* category and highlight the recently created H&P report. The report is seen in the lower right quadrant where it can be edited and printed.



5. Close the patient's chart.

(See Appendix A—Sample Documents; Document 8. *Office Visit Report*.)

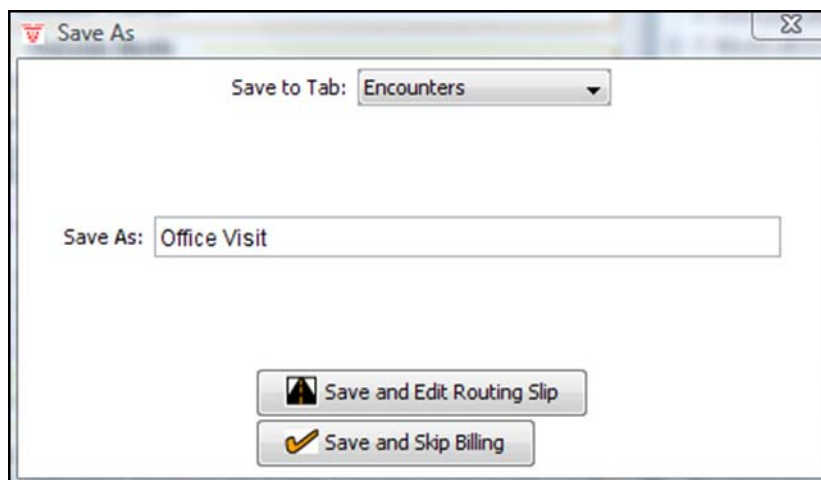
Exercise 8.7

Creating an *Excuse Note*

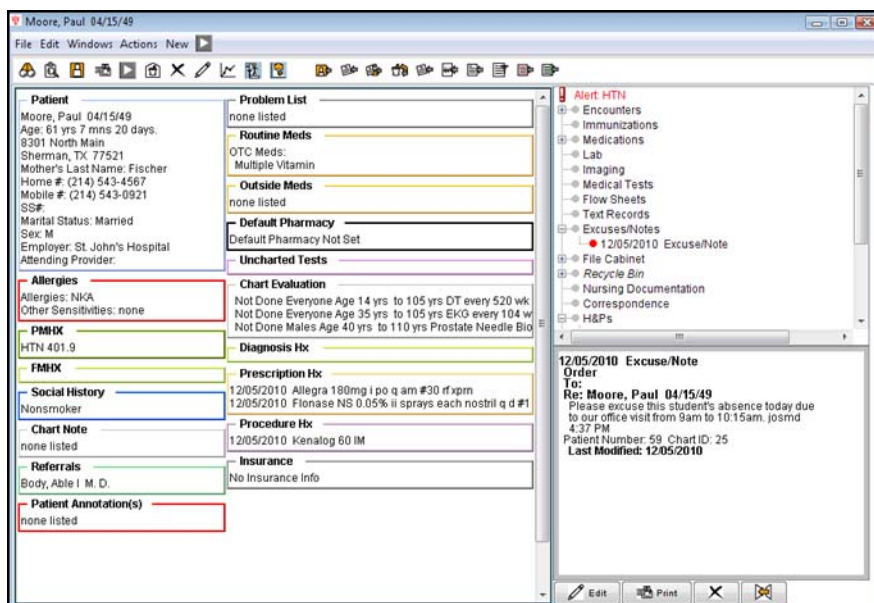
1. Open your patient's chart. Open the recent office visit note by clicking on the '+' next to Encounters. Click on the office visit and click Edit below. Click on the *Tools* menu inside the office visit screen and select *New Excuse/Note/Order* then *New Excuse/Note*. In the *To* area type "To whom it may concern". In the *Note* window select pop-up text to compose an excuse for the student's absence from college for the time that the student was at the doctor's office. Complete the missing information. Add your initials to the note by selecting the [Sign] button.

1. Print the excuse note and submit to your instructor or choose the pdf printer and email the document to your instructor. Click on the [Done] button.

- Click on the [Sign] button in the lower right section of the OV screen. Select *Permanent Sign and Lock*. Click the [Done] button and skip billing.



- Click on the "+" sign to the left of the *Excuses Notes* category in the care tree and see the saved note. The note is displayed in the lower right window.



- Click on the “+” sign to the left of *Encounters*. A black “lock” icon is present to the left of the recent *office visit* note. No user is able to modify a locked *office visit* note.

Moore, Paul 04/15/49

File Edit Windows Actions New

Patient
Moore, Paul 04/15/49
Age: 61 yrs 7 mns 20 days.
8301 North Main
Sherman, TX 77521
Mother's Last Name: Fischer
Home #: (214) 543-4567
Mobile #: (214) 543-0921
SS#:
Marital Status: Married
Sex: M
Employer: St. John's Hospital
Attending Provider:

Problem List
none listed

Routine Meds
OTC Meds:
Multiple Vitamin

Outside Meds
none listed

Default Pharmacy
Default Pharmacy Not Set

Uncharted Tests

Chart Evaluation
Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk
Not Done Everyone Age 35 yrs to 105 yrs EkG every 104 w
Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio

Diagnosis Hx

Prescription Hx
12/05/2010 Allegra 180mg i po q am #30 rfxpm
12/05/2010 Flonase NS 0.05% ii sprays each nostril q d #1

Procedure Hx
12/05/2010 Kenalog 60 IM

Insurance
No Insurance Info

Allergies
Allergies: NKA
Other Sensitivities: none

PMHx
HTN 401.9

Social History
Nonsmoker

Chart Note
none listed

Referrals
Body, Able I. M. D.

Patient Annotation(s)
none listed

Alert: HTN

Encounters
12/05/2010 Office Visit
12/05/2010 Report to Patient
12/05/2010 Vitals Check

Immunizations

Medications

Lab

Imaging

Medical Tests

Flow Sheets

Text Records

Excuses/Notes
12/05/2010 Excuse/Note

File Cabinet

Recycle Bin

12/05/2010 Excuse/Note Order
To: Moore, Paul 04/15/49
Please excuse this student's absence today due to our office visit from 9am to 10:15am. josmd
4:37 PM
Patient Number: 59 Chart ID: 25
Last Modified: 12/05/2010

Edit Print X

Exercise 8.8

Preparing an Addendum

- Open your patient's chart. Open the recent office visit note that you signed and locked by clicking on the [Edit] button at the bottom of the screen.

Moore, Paul 04/15/49

File Edit Windows Actions New

Patient
Moore, Paul 04/15/49
Age: 61 yrs 7 mns 20 days.
8301 North Main
Sherman, TX 77521
Mother's Last Name: Fischer
Home #: (214) 543-4567
Mobile #: (214) 543-0921
SS#:
Marital Status: Married
Sex: M
Employer: St. John's Hospital
Attending Provider:

Problem List
none listed

Routine Meds
OTC Meds:
Multiple Vitamin

Outside Meds
none listed

Default Pharmacy

Uncharted Tests

Chart Evaluation
Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk
Not Done Everyone Age 35 yrs to 105 yrs EkG every 104 w
Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio

Diagnosis Hx

Prescription Hx
12/05/2010 Allegra 180mg i po q am #30 rfxpm
12/05/2010 Flonase NS 0.05% ii sprays each nostril q d #1

Procedure Hx
12/05/2010 Kenalog 60 IM

Insurance
No Insurance Info

Allergies
Allergies: NKA
Other Sensitivities: none

PMHx
HTN 401.9

Social History
Nonsmoker

Chart Note
none listed

Referrals
Body, Able I. M. D.

Patient Annotation(s)
none listed

Alert: HTN

Encounters
12/05/2010 Office Visit
12/05/2010 Report to Patient
12/05/2010 Vitals Check

Immunizations

Medications

Lab

Imaging

Medical Tests

Flow Sheets

Text Records

Excuses/Notes
12/05/2010 Excuse/Note

File Cabinet

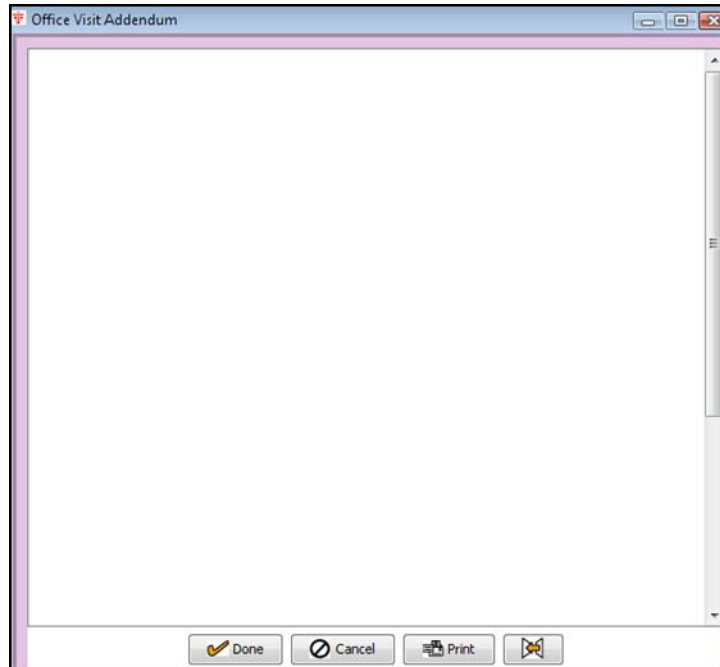
Recycle Bin

12/05/2010 Office Visit
Subjective:
Allergies/Allergic Reaction, Runny nose, Itchy eyes, 3:50 PM josmd
Objective:
Vitals: Temp: 98.4F HR: 90 Resp: 22 BP: 134/72
O2SAT: 94.00 %
Assessment:
Plan:
Prescriptions:
Allegra 180mg i po q am #30 rfxpm
Flonase NS 0.05% ii sprays each nostril q d #16g rfxp
Procedures:
Kenalog 60 IM
Lot number: 4431
NDC number: 0003-0293-05
Site: Left arm
Tolerated well without evidence of untoward reaction 12/05/2010 4:23 PM josmd
Date Created: 12/05/2010

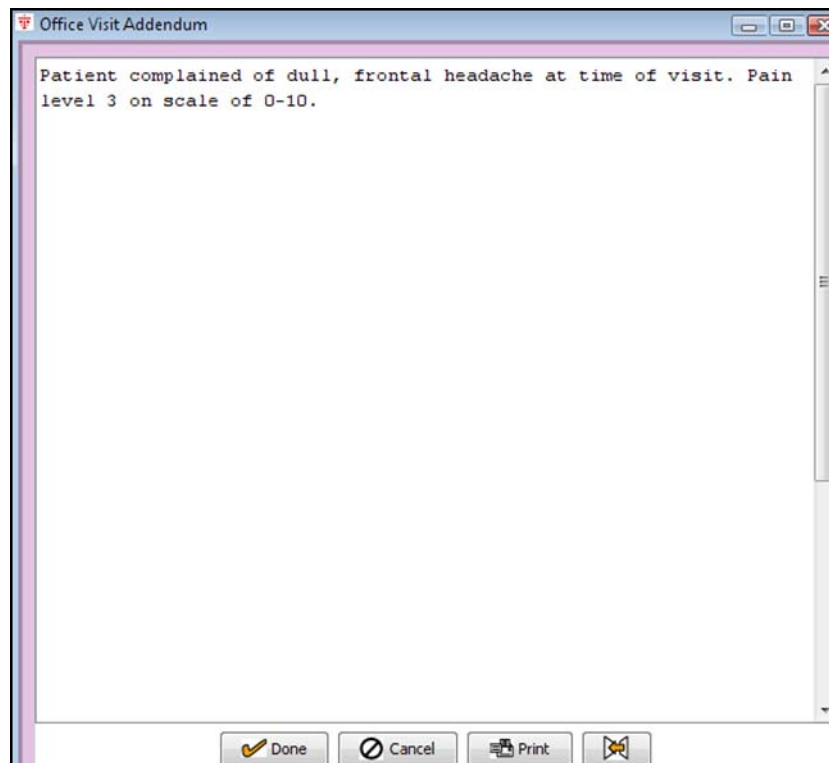
Edit Print Report X

Not Editable
You cannot edit something after it is signed. Do you want to add an addendum?
Yes No

2. A warning note appears stating that you are not able to edit this note. Create an addendum. Click the [Yes] option.



3. In the *Office Visit Addendum* window add the following comment: *Patient complained of dull, frontal headache at time of visit. Pain level 3 on scale of 0–10.*



4. Click on the [Done] button. Close the office visit screen.
5. Scroll to the bottom of the office visit note in the lower right corner of the patient's chart. The addendum appears at the end of the OV note. The addendum is automatically signed and dated.

The screenshot displays a patient's EHR for Paul Moore, born 04/15/49. The interface is divided into several sections:

- Patient Information:** Name, age, address, phone numbers, marital status, sex, employer, and attending provider.
- Allergies:** Allergies: NKA, Other Sensitivities: none.
- PMHx (Past Medical History):** HTN 401.9.
- FMHx (Family Medical History):** None listed.
- Social History:** Nonsmoker.
- Chart Note:** None listed.
- Referrals:** Body, Able I. M. D.
- Patient Annotation(s):** None listed.
- Problem List:** None listed.
- Routine Meds:** Multiple Vitamin.
- Outside Meds:** None listed.
- Default Pharmacy:** Default Pharmacy Not Set.
- Uncharted Tests:** None listed.
- Chart Evaluation:** Not Done Everyone Age 14 yrs to 105 yrs DT every 520 wk, Not Done Everyone Age 35 yrs to 105 yrs EKG every 104 w, Not Done Males Age 40 yrs to 110 yrs Prostate Needle Bio.
- Diagnosis Hx:** None listed.
- Prescription Hx:** 12/05/2010 Allegra 180mg i po q am #30 rfxprn, 12/05/2010 Flonase NS 0.05% ii sprays each nostril q d #1.
- Procedure Hx:** 12/05/2010 Kenalog 60 IM.
- Insurance:** No Insurance Info.

On the right side, there is a list of recent encounters and a detailed office visit note from 12/05/2010. The note includes a chief complaint of dull, frontal headache, a physical exam showing a pain level of 3 on a scale of 0-10, and a diagnosis of tension headache. The note is signed by John O. Smith, R.N. on 12/05/2010 at 4:39 PM. An addendum is also present, stating that the patient complained of the headache at the time of the visit.

6. Using the [Print] button located at the bottom of the window, print the OV note and submit to your instructor. If you are transmitting an electronic document to your instructor, choose the pdf printer and send the document as an e-mail. Close the patient's chart.