RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Addendum to User Manual

Version 1.1 Patch 41
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Office of Information Technology
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Table of Contents

Preface

The following are Indian Health Service (IHS) components in the Resource and Patient Management (RPMS) Electronic Health Record (EHR).

- Personal Health History
- Adverse Reactions/Allergies
- Chief Complaint
- Exams
- Skin Test
- Delivery Record
- Prescription Drug Query (BEHOPDQ)

1.0 Personal Health History

The Personal Health History component (Figure 1-1) has features so the user can record data regarding **Functional Status**, **Birth Measurements**, **Refusal**, and **Treatment Contract**.

Various options are available for recording personal health data, depending on the selected patient. For example, the **Birth Measurements** option is only available when a patient 6-years old or younger is selected.

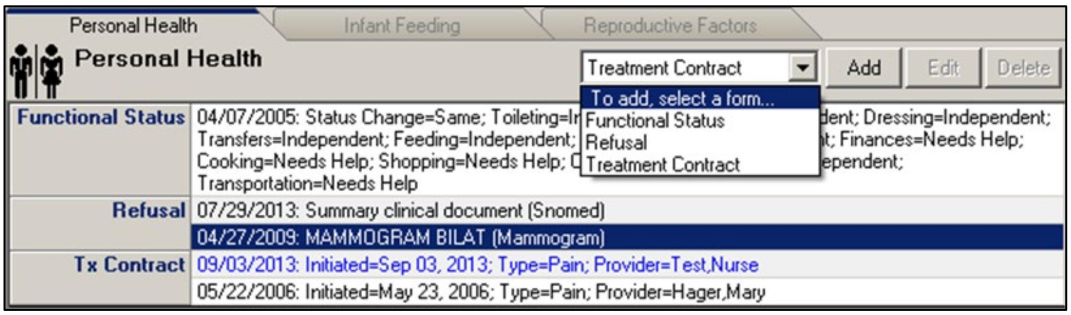


Figure 1-1: Personal Health History component

The choices available on the drop-down list depend on the appropriate **BGOZ** keys that are assigned. Contact the facility's Local Informaticist about the available keys.

This component can be configured so that a particular user or class cannot add or edit reproductive history information.

The Personal Health History component contains the **Display Visit Detail** option on the right-click menu. Selecting this option displays a pop-up showing information about the visit where users can view or print the information.

1.1 Adding Personal Health Records

Users can add several types of personal health records to the Personal Health History component. This includes the following:

- Adding Functional Status, Section 1.2
- Adding Birth Measurements, Section 1.3
- Adding Refusals, Section 1.4
- Adding Treatment Contract Information, Section 1.5
- Using the Lookup Utility Dialog for Provider, Section 1.5.1

Note:	Users must select a patient and an unlocked visit to add personal health record information.

1.2 Adding Functional Status

The **Functional Status** option is where users record the activities of daily living. To add functional status to a record:

1. Select a **patient** and a **visit** in order to add functional status.
2. From the Personal Health History component, select the **Functional Status** option from the drop-down menu in the top-right corner of the component.
3. Once the drop-down item has been selected, click the **Add** button or right-click anywhere inside the component and select **Add**.

   The **Enter Functional Status Record** dialog (Figure 1-2) opens.

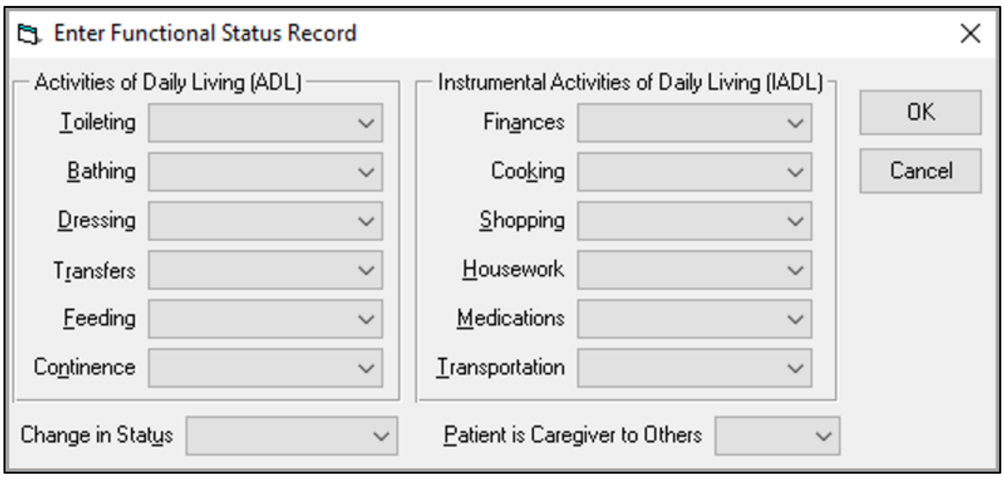


Figure 1-2: Enter Functional Status Record dialog

4. In the **Activities of Daily Living** or **Instrumental Activities of Daily Living** sections, select one of the following for any of the drop-down lists to record a functional status associated with those activities:
   - Independent
   - Needs Help
   - Totally Dependent
5. In **Change of Status**, if users are updating or adding a change in the patient's functional status, select one of the following from the drop-down menu:
   - Same
   - Improvement
   - Decline
6. If **Patient is Caregiver to Others**, select one of the following from the drop-down menu:

- **Yes**
- **No**

7. Click **OK** to add the **Functional Status** record to the Personal Health History component. (Otherwise, click **Cancel**.)

1.3 Adding Birth Measurements

The **Birth Measurements** option is used to record birth measurement information about the current infant on the current visit. This option is only available when a patient 6-years old or younger is selected.

To add birth measurements to a record:

1. Select a **patient** and a **visit** in order to add **Birth Measurements**.
2. From the Personal Health History component, select the **Birth Measurements** option from the drop-down menu in the top-right corner of the component.
3. Once the drop-down item has been selected, click the **Add** button or right-click anywhere inside the component and select **Add**. The **Update Birth Measurements** dialog (Figure 1-3) opens.

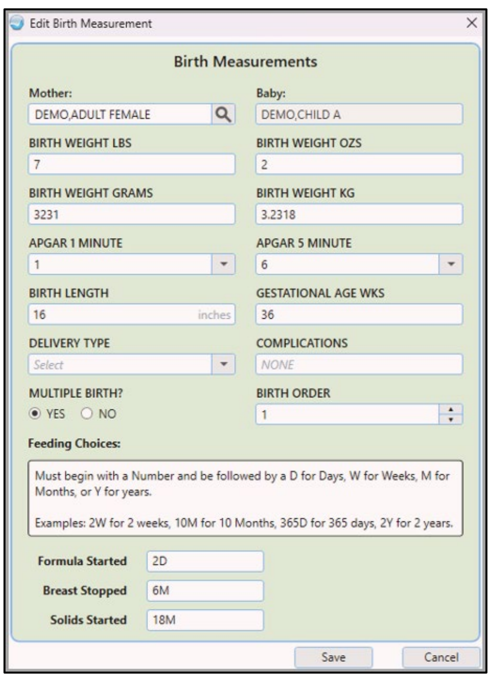


Figure 1-3: Update Birth Measurements dialog

4. In the **Mother** field, click the **Search** button ( ) to open the **Lookup Patient** dialog (Figure 1-4) and follow these steps:

a. In **Search Value**, type a **name**, and then click the **Search** button ( ).

Figure 1-4: Initial Lookup Patient dialog

The updated **Lookup Patient** dialog (Figure 1-5) refreshes with a list of matching names.

b. Click to select a **name**, and then click **OK**. The **Mother** field on the **Update Birth Measurements** dialog (Figure 1-3) populates with the selection.

Figure 1-5: Updated Lookup Patient dialog

> **Note:** Follow the data formatting instructions on the **Update Birth Measurements** dialog.

5. In **Birth Weight**, type the patient's weight at birth.

   The unit of measure for birth weight is automatically updated when an entry is completed for lbs and ozs, or grams or kilograms to other weight measurement fields.

6. In **APGAR 1 minute**, enter a **value** from the drop-down list between **0** and **10**.
7. In **APGAR 5 minute**, enter a **value** from the drop-down list between **0** and **10**.
8. In **Birth Length**, a user can enter a **numeric value** (default is inches). To enter in centimeters, enter a **C** followed by the measurement in centimeters.
   - For inches: Enter a number between **6** and **30**.
   - For centimeters: Enter a number between **16** and **76** (preceeded by **C**).
9. In **Gestational Age WKS**, enter a **numeric value** between **12** and **50**.
10. In **Delivery Type**, select a **value** from the drop-down list. Selecting **Other** will open a mandatory free-text box with a 20-character limit.
11. If **Complications** were present at delivery, enter a free-text answer between **1-240 characters** in length.
12. If **Multiple Birth**, select **Yes**. The **Birth order** field will then be presented and can then be entered manually or using the arrows.
13. In **Birth Order**, type a **numeric value** to indicate the patient's birth order.
14. In the **Feeding Choices** section, type a **value** for the following fields:
    - Formula Started
    - Breast Feeding Stopped
    - Solids Started
15. Click **Save** to add the birth measurements record to the Personal Health History component. (Otherwise, click **Cancel**.)

1.4 Adding Refusals

The **Refusal** option is where users record that the patient refused treatment or assessment on the current visit. A refusal demonstrates that an intention was attempted but the patient declined or stated not to perform the treatment or assessment.

1. Select a **patient** and a **visit** in order to add a **Refusal**.
2. From the Personal Health History component, select the **Refusal** option from the drop-down menu in the top-right corner of the component.
3. Once the drop-down item has been selected, click the **Add** button or right-click anywhere inside the component and select **Add**. The **Enter Service Not Provided/Refusal** dialog (Figure 1-6) opens.

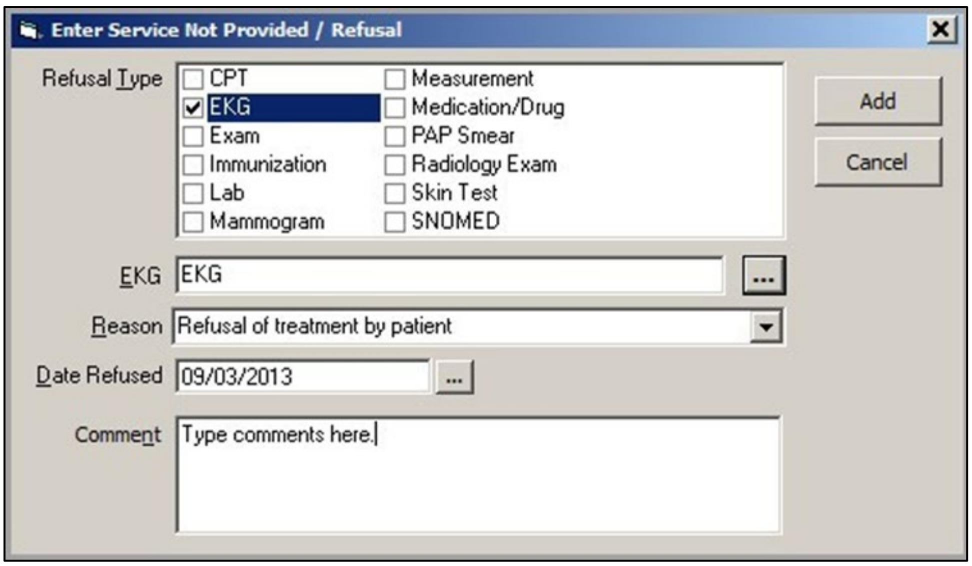


Figure 1-6: Enter Service Not Provided/Refusal dialog

4. In the **Refusal Type** pane, click to select the applicable **refusal type**.

- CPT, Section 1.4.1.1
- EKG, Section 1.4.1.2
- Exam, Section 1.4.1.3
- Immunization, Section 1.4.1.4
- Lab, Section 1.4.1.5
- Mammogram, Section 1.4.1.6
- Measurement, Section 1.4.1.7
- Medication/Drug, Section 1.4.1.8

- PAP Smear, Section 1.4.1.9
- Radiology Exam, Section 1.4.1.10
- Skin Test, Section 1.4.1.11
- SNOMED, Section 1.4.1.12

1.4.1 Refusal Types

Each refusal type is described in the following sections.

1.4.1.1 CPT

1. Select the **CPT** check box on the **Enter Service Not Provided/Refusal** dialog (Figure 1-7). The **Refusal Item** field changes to **CPT**.

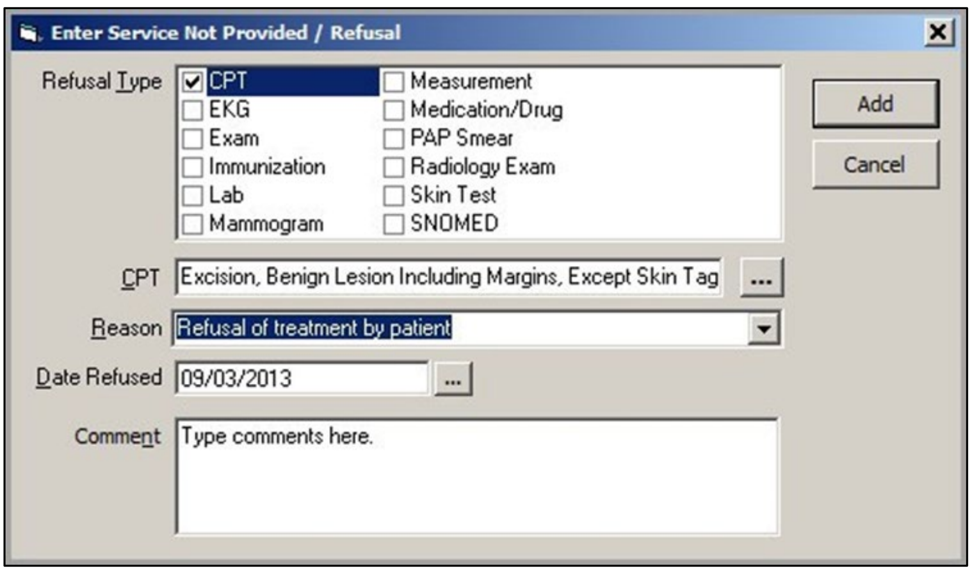


Figure 1-7: Enter Refusal for CPT dialog

2. Click the **Ellipsis** button (...) next to the **CPT** field to display **Procedure Lookup** dialog (Figure 1-8) where users search for and select current procedural terminology.

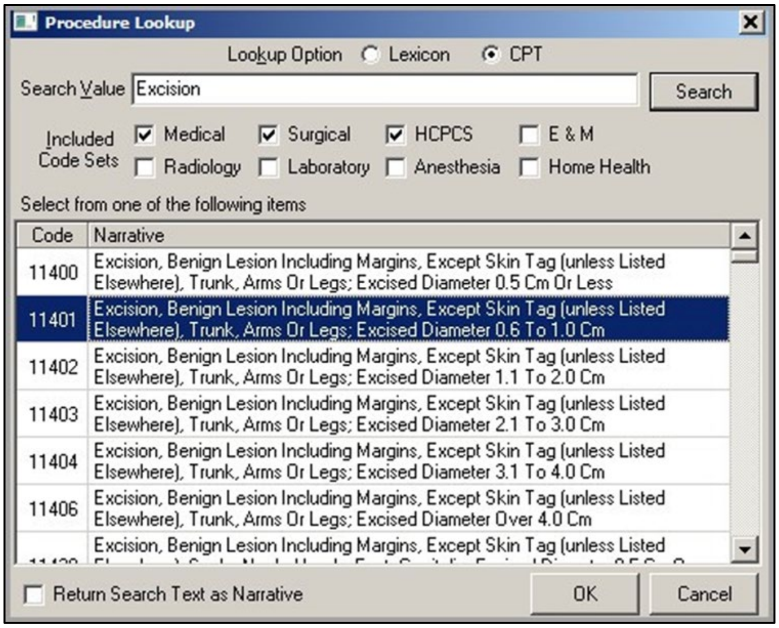


Figure 1-8: Procedure Lookup dialog

3. In the **Procedure Lookup** dialog, in **Lookup Option**, click to select either the **Lexicon** or **CPT** option.

4. In **Search Value**, type a **value** for which to search.

5. In **Included Code Sets**, select on of the following check boxes, as applicable:

   - **Medical**
   - **Surgical**
   - **HCPCS**
   - **E&M**
   - **Radiology**
   - **Laboratory**
   - **Anesthesia**
   - **Home Health**

6. If needed, select the **Return Search Text as Narrative** check box at the bottom of the dialog box.

7. Click the **Search** button (). The search results show a list of procedures that includes the **Code** and **Narrative**.

8. Select a procedure from the list, and then click **OK**. The user's selection populates in the **CPT** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.2 EKG

1. Select the **EKG** check box on the **Enter Service Not Provided/Refusal** dialog (Figure 1-9). The **Refusal Item** field changes to **EKG**.

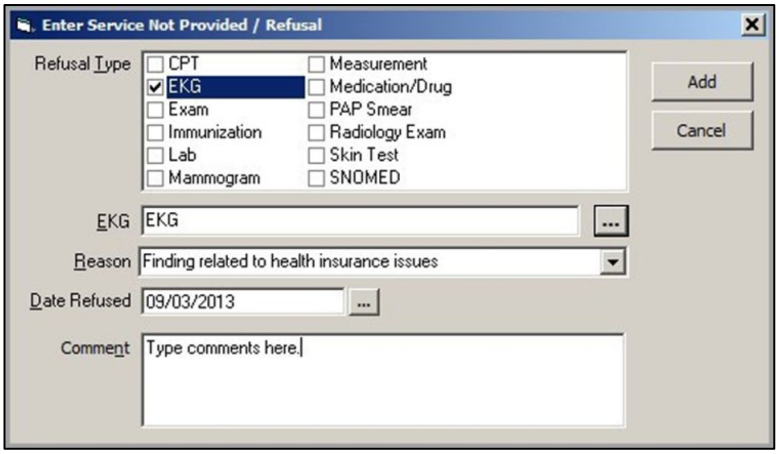
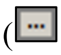


Figure 1-9: Enter Service Not Provided / Refusal dialog

2. Click the **Ellipsis** button () for the **EKG** field to display **Lookup Diagnostic Procedure for EKG** (Figure 1-10), where users select a Diagnostic Procedure for EKG (if any).

Note: EKG is the default pre-populated entry for the **EKG** field.

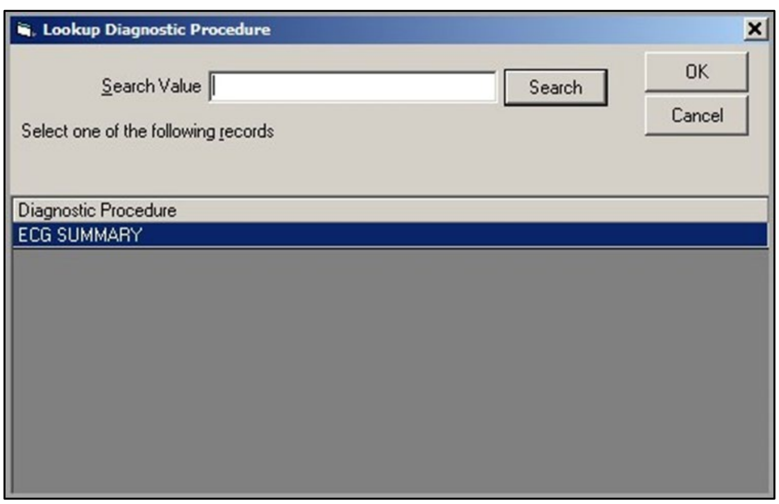


Figure 1-10: Lookup Diagnostic Procedure for EKG dialog

3. In **Search Value**, type a term for which to search, or leave the field blank, and then click **Search**. The Diagnostic Procedure results show a list of procedures.

4. Click to select a **procedure** from the list, and then click **OK**. The selection populates in the **EKG** field of the **Enter Service Not Provided/Refusal** dialog (Figure 1-9).

1.4.1.3 Exam

1. Select the **Exam** check box on the **Enter Service Not Provided/Refusal** dialog (Figure 1-11). The **Refusal Item** field changes to **Exam**.

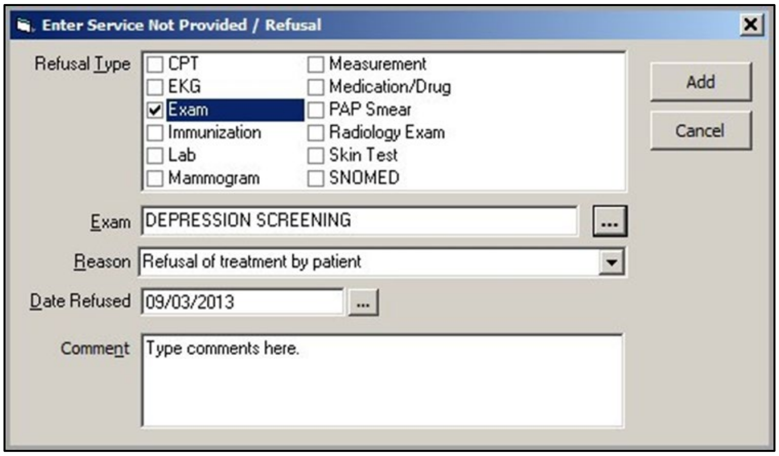


Figure 1-11: Enter Refusal for Exam dialog

2. Click the **Ellipsis** button () for the **Exam** field to display the **Lookup Exam** dialog (Figure 1-12), where the user selects an exam name.

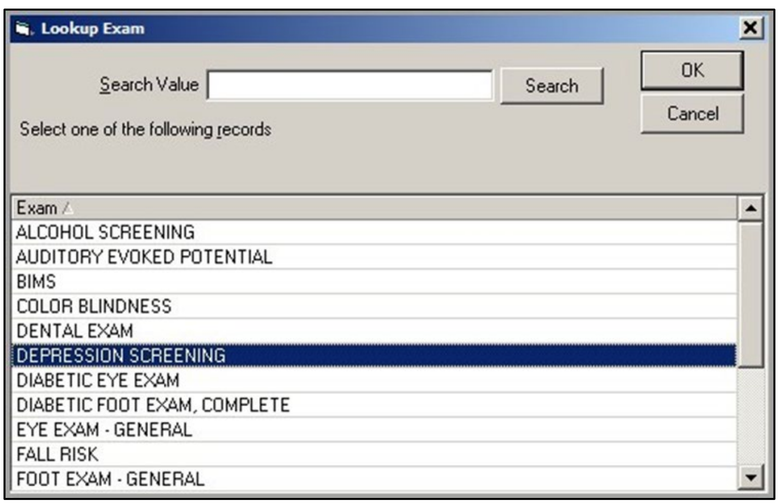


Figure 1-12: Lookup Exam dialog

3. In the **Lookup Exam** dialog, in **Search Value**, type a search term or leave the field blank to return all choices.

4. Click **Search**. The search results show a list of exams.

5. Click to select an **exam** from the list, and then click **OK**. The selection populates in the **Exam** field of the **Enter Service Not Provided/Refusal** dialog (Figure 1-9).

1.4.1.4 Immunization

1. Select the **Immunization** check box on the **Enter Service Not Provided/Refusal** dialog (Figure 1-13). The **Refusal Item** field changes to **Immunization**.

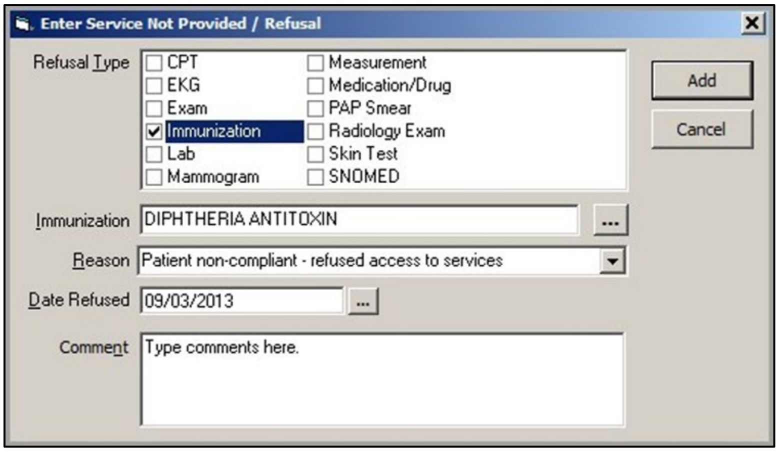


Figure 1-13: Enter Refusal for Immunization dialog

2. Click the **Ellipsis** button (...) for the **Immunization** field to display the **Vaccine Selection** dialog (Figure 1-14) where the user selects a vaccine.

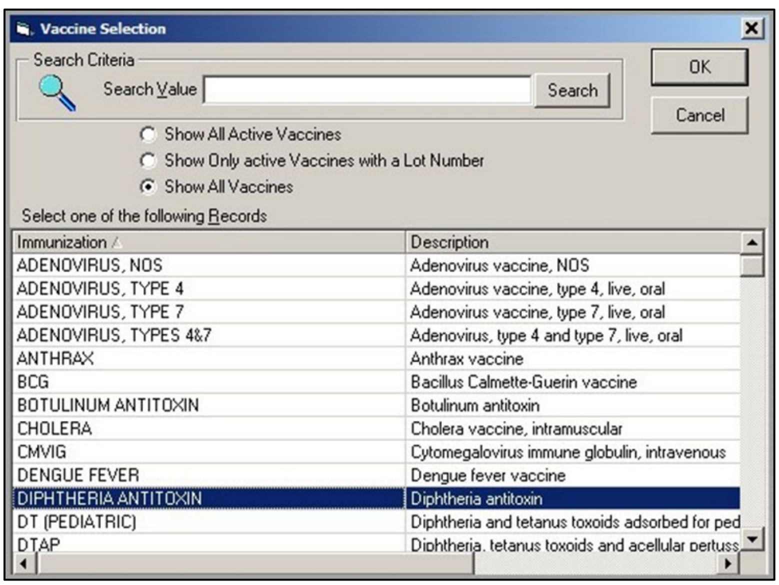


Figure 1-14: Vaccine Selection dialog

3. In the **Vaccine Selection** dialog, in **Search Value**, type a search term or leave the field blank to return all choices.

4. Select one of the following option buttons:

   - **Show All Active Vaccines**

- **Show Only active Vaccines with a Lot Number**
- **Show All Vaccines (default)**

5. Click **Search**. The search results show a list of immunizations and their description.

6. Click to select an **immunization** from the list, and then click **OK**. The selection populates in the **Immunization** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.5 Lab

1. Select the **Lab** check box on the **Enter Service Not Provided/Refusal** dialog. The **Refusal Item** field changes to **Lab** (Figure 1-15).

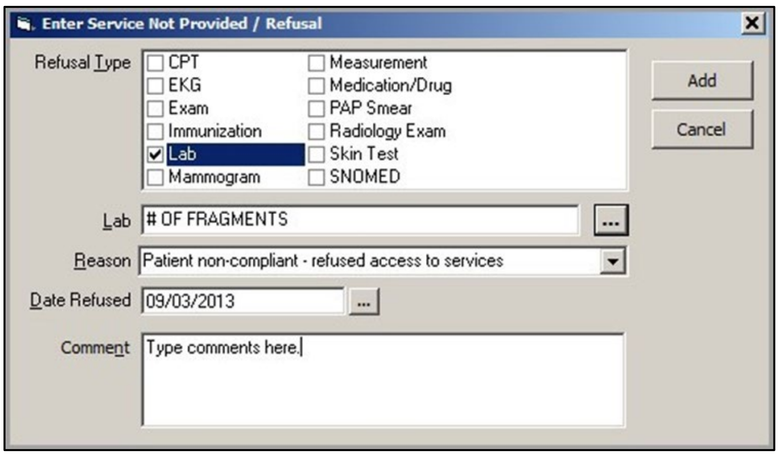


Figure 1-15: Enter Refusal for Lab dialog

2. Click the **Ellipsis** button () for the **Lab** field to display a lookup utility where users select a lab test name.

3. In the **Lookup Lab Test** dialog (Figure 1-16), in **Search Value**, type a search term or leave the field blank to return all choices.

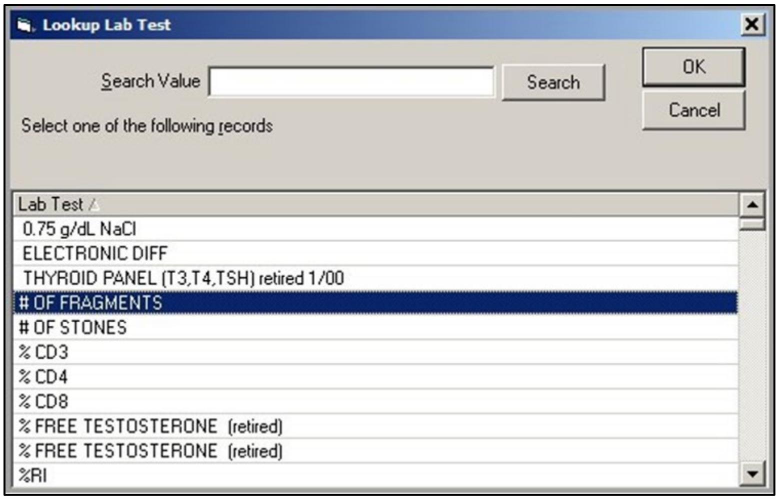


Figure 1-16: Lookup Lab Test dialog

4. Click **Search**. The search results show a list of lab tests.

5. Click to select a **lab test** from the list, and then click **OK**. The selection populates in the **Lab** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.6 Mammogram

1. Select the **Mammogram** check box on the **Enter Service Not Provided/Refusal** dialog. The **Refusal Item** field changes to **Mammogram** (Figure 1-17).

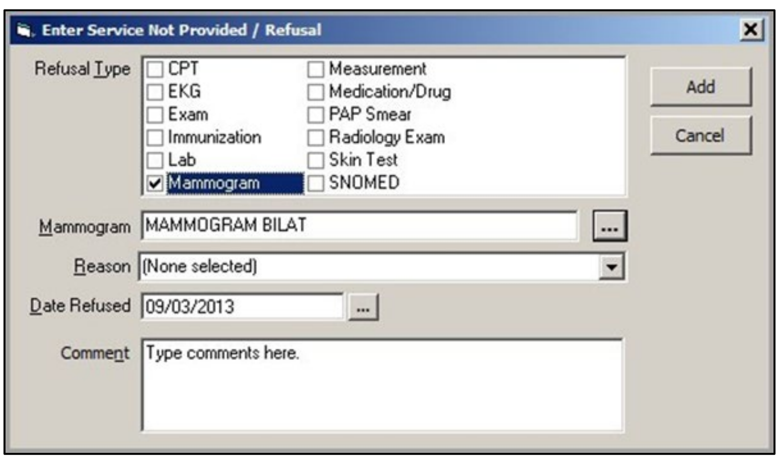


Figure 1-17: Enter Refusal for Mammogram dialog

2. Click the **Ellipsis** button (...) for the **Mammogram** field to display the **Lookup Radiology Exam** dialog (Figure 1-18) where the user selects a radiology exam for mammogram.

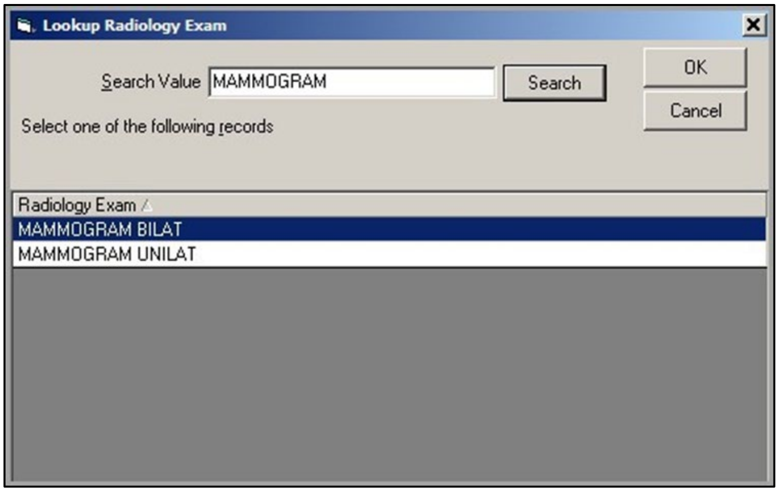


Figure 1-18: Lookup Mammogram dialog

3. In the **Lookup Radiology Exam** dialog, in **Search Value**, type a search term or leave the field blank to return all choices.

4. Click **Search**. The search results show a list of radiology exams.

5. Click to select a **radiology exam** from the list, and then click **OK**. The selection populates in the **Mammogram** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.7 Measurement

1. Select the **Measurement** check box on the **Enter Service Not Provided/Refusal** dialog. The **Refusal Item** field changes to **Measurement** (Figure 1-19).

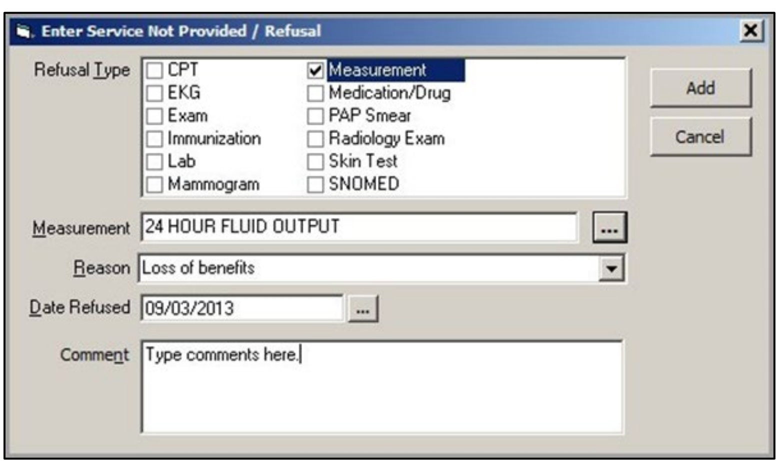


Figure 1-19: Enter Service Not Provided / Refusal for Measurement dialog

2. Click the **Ellipsis** button () for the **Measurement** field to display a lookup utility where the user selects a vital measurement.

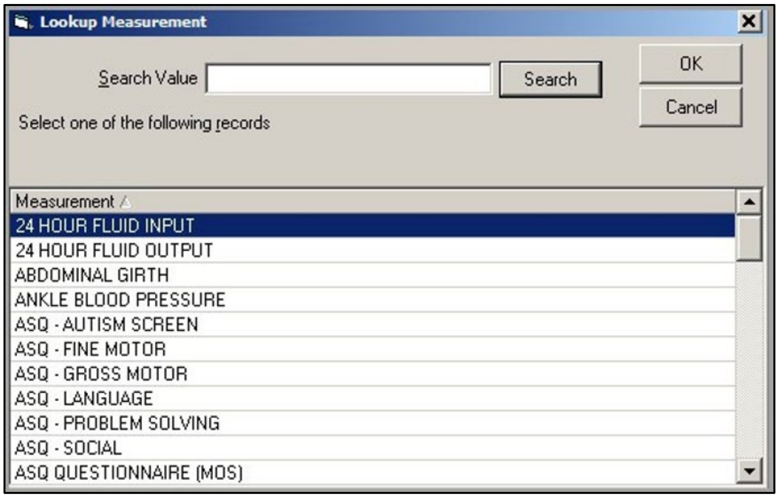


Figure 1-20: Lookup Measurement dialog

3. In the **Lookup Measurement** dialog, in **Search Value**, type a search term or leave the field blank to return all choices.
4. Click **Search**. The search results show a list of measurement options.
5. Click to select a **measurement** from the list, and then click **OK**. The selection populates in the **Measurement** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.8 Medication/Drug

1. Select the **Medication/Drug** check box on the **Enter Service Not Provided/Refusal** dialog. The **Refusal Item** field changes to **Medication/Drug**.

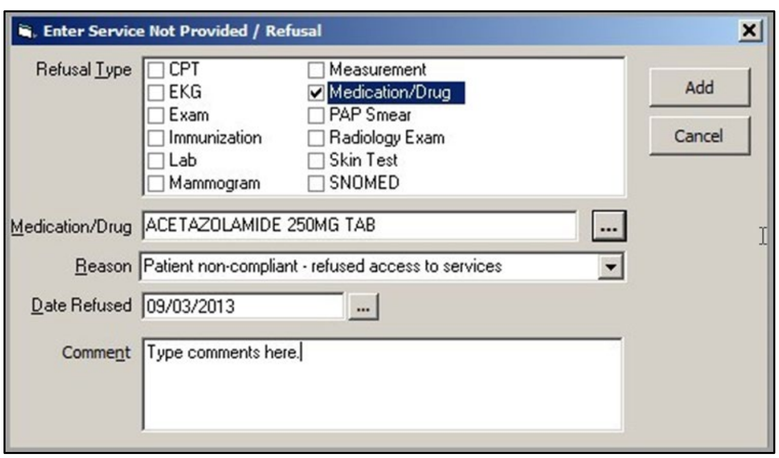


Figure 1-21: Enter Service Not Provided / Refusal for Medication/Drug dialog

2. Click the **Ellipsis** button () for the **Medication/Drug** field to display a lookup utility where users select a drug name.

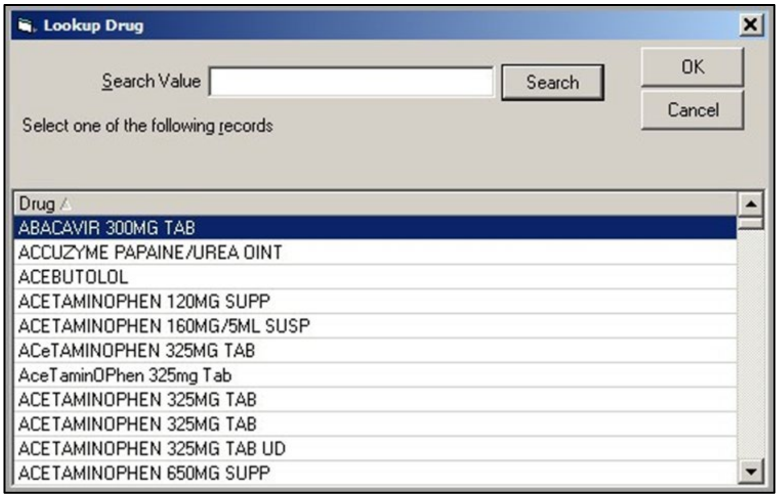


Figure 1-22: Lookup Drug dialog

3. In the **Lookup Drug** dialog, in **Search Value**, type a search term or leave the field blank to return all choices.

4. Click **Search**. The search results show a list of drugs.

5. Click to select a **drug** from the list, and then click **OK**. The selection populates in the **Medication/Drug** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.9 PAP Smear

Select the **PAP Smear** check box on the **Enter Service Not Provided/Refusal** dialog. The **Refusal Item** field changes to **PAP Smear**.

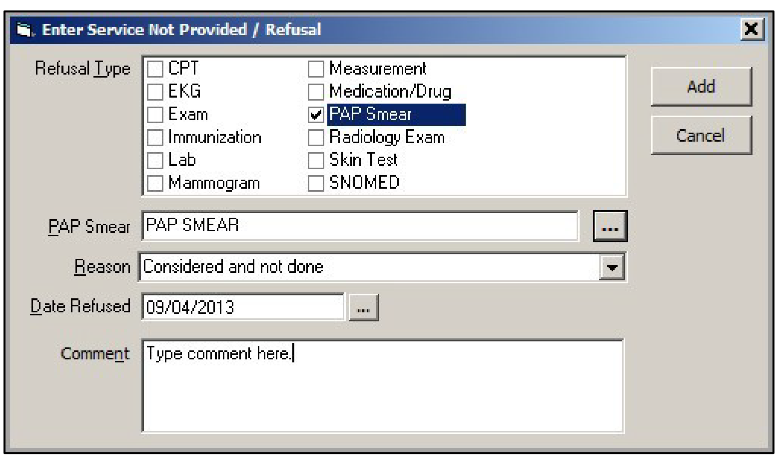


Figure 1-23: Refusal for PAP Smear

There are no other choices other than **PAP Smear** when clicking the **Ellipsis** button (). The **Lookup Lab Test** dialog (Figure 1-24) opens, but defaults to **PAP SMEAR**.

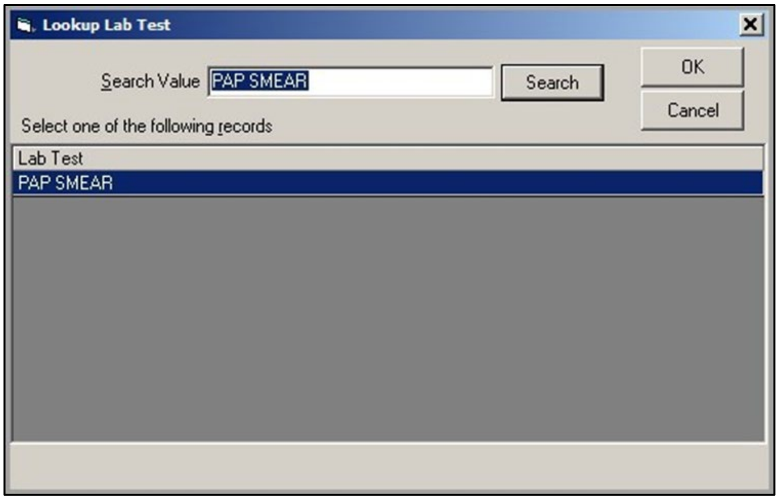


Figure 1-24: Lookup Lab Test dialog

PAP SMEAR auto-populates in the **PAP Smear** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.10 Radiology Exam

1. Select the **Radiology Exam** check box on the **Enter Service Not Provided/Refusal** dialog. The **Refusal Item** field changes to **Radiology Exam**.

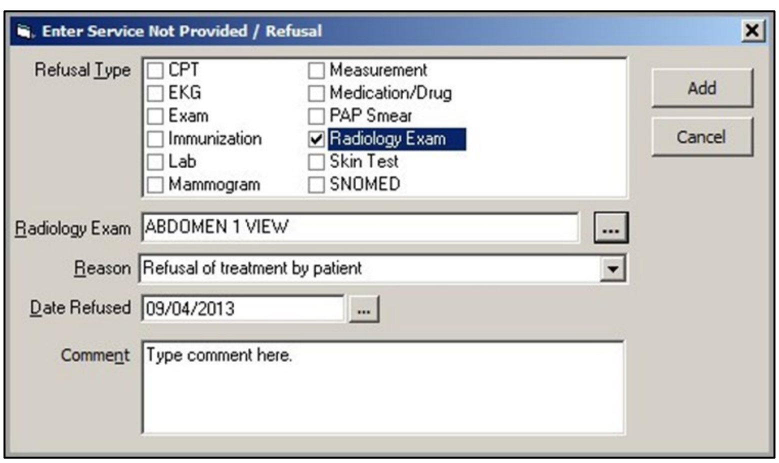


Figure 1-25: Enter Service Not Provided / Refusal for Radiology Exam dialog

2. Click the **Ellipsis** button ()for the **Radiology Exam** field to display the **Lookup Radiology Exam** dialog where users select a radiology exam.

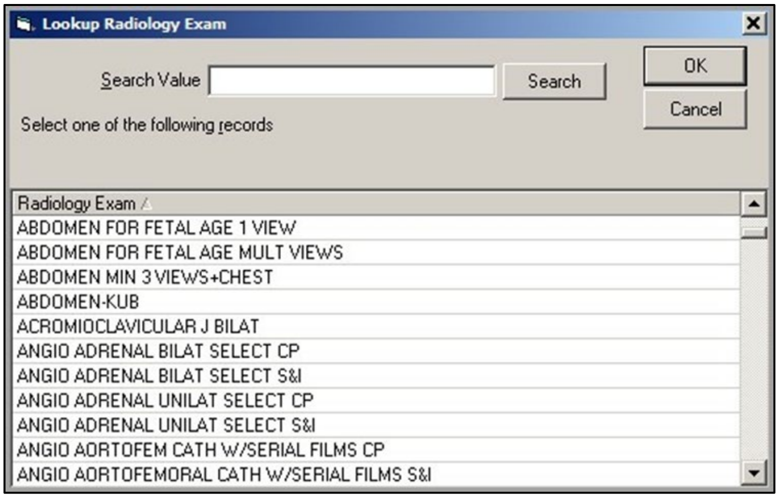


Figure 1-26: Lookup Radiology Exam dialog

3. In the **Lookup Radiology Exam** dialog, in **Search Value**, type a search term or leave the field blank to return all choices.

4. Click **Search**. The search results show a list of radiology exams.

5. Click to select a **radiology exam** from the list, and then click **OK**. The selection populates in the **Radiology Exam** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.11 Skin Test

1. Select the **Skin Test** check box on the **Enter Service Not Provided/Refusal** dialog (Figure 1-27). The **Refusal Item** field changes to **Skin Test**.

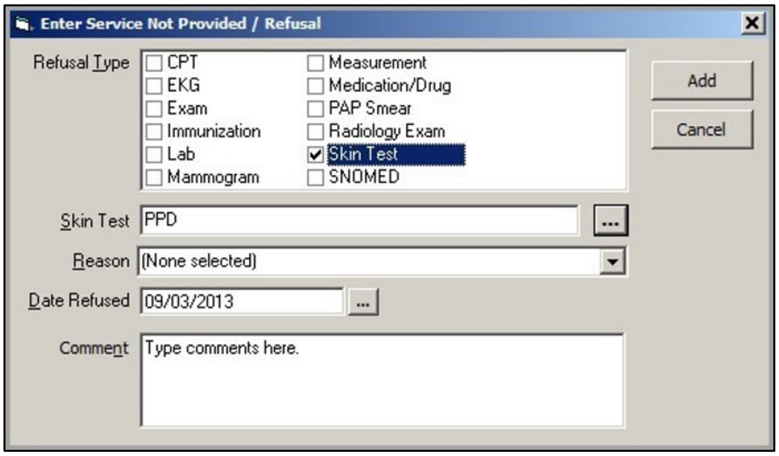


Figure 1-27: Enter Service Not Provided / Refusal for Skin Test dialog

2. Click the **Ellipsis** button () for the **Skin Test** field to display a lookup utility where a skin test is selected.

3. In the **Lookup Skin Test** dialog (Figure 1-28), in **Search Value**, type a search term or leave the field blank to return all choices.

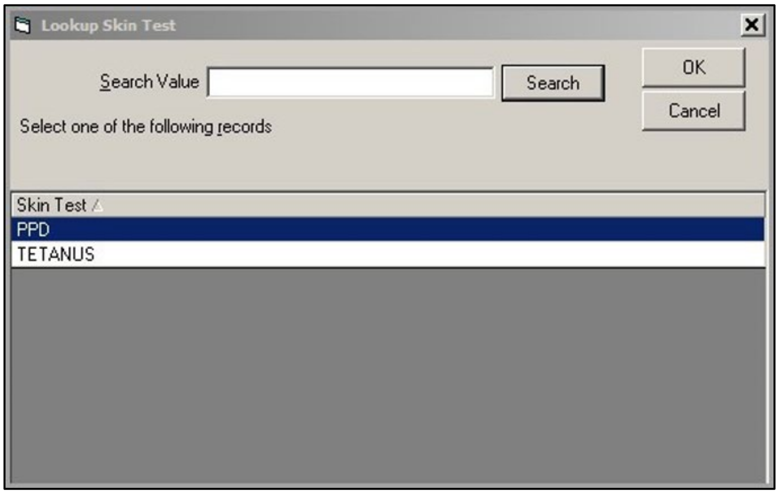


Figure 1-28: Lookup Drug dialog

4. Click **Search**. The search results show a list of skin tests.

5. Click to select a **skin test** from the list, and then click **OK**. The selection populates in the **Skin Test** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.1.12 SNOMED

1. Select the **SNOMED** check box on the **Enter Service Not Provided/Refusal** dialog. The **SNOMED** field changes to **SNOMED**.

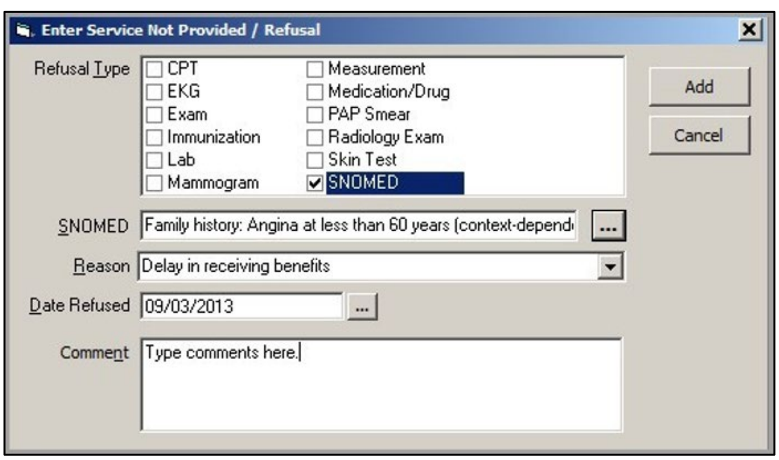


Figure 1-29: Enter Service Not Provided / Refusal for SNOMED Test dialog

2. Click the **Ellipsis** button () for the **SNOMED** field to display the **SNOMED CT Lookup** utility (Figure 1-30) where the user selects a **SNOMED CT** code.

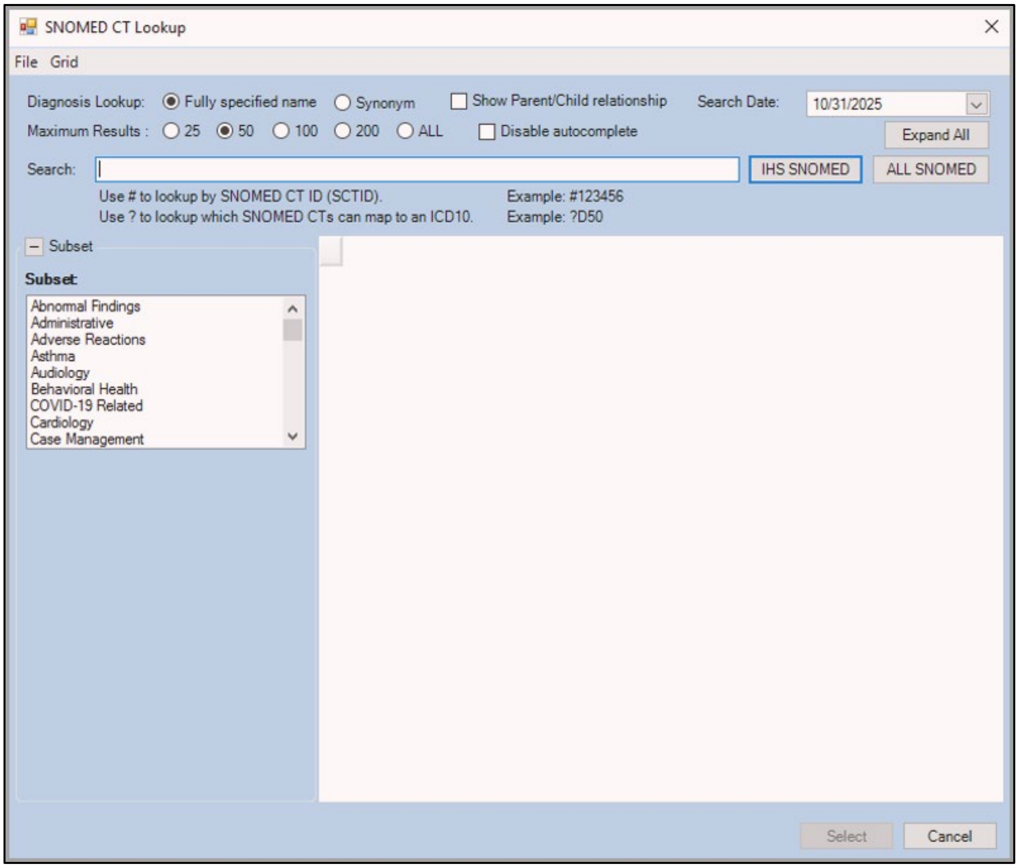


Figure 1-30: SNOMED CT Lookup dialog

3. In the **SNOMED CT Lookup**, select one of the following option buttons:
   - **Fully specified name (default)**
   - **Synonym**
4. Choose **Show Parent/Child relationship** of the SNOMED CT results by selecting that option box.
5. In **Maximum Results**, select one of the following option buttons:
   - **25**
   - **50**
   - **100**
   - **200**
   - **ALL**

   Choose to disable autocomplete if desired.
6. In the **Search** field, type a search term. The user also has the option to search by SNOMED CT ID or by ICD10.

a. Type a **SNOMED CT ID number** preceded by a pound sign (#) to lookup by **SNOMED CT ID (SCTID)**.

b. Type an **ICD-10 code** preceded by a question mark (**?**) to lookup **SNOMED CTs** that can map to that ICD-10 code.

7. In **Subset**, click to select one or more **subsets** to search. Click again to clear a term.

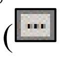
8. Click either the **IHS SNOMED** or the **ALL SNOMED** button to search. The search results show a list of applicable problems and the mapped **ICD** code.

9. Click to select a **problem** from the list, and then click **Select**. The selection populates in the **SNOMED** field of the **Enter Service Not Provided/Refusal** dialog.

1.4.2 Completing the Enter Service Not Provided/Refusal Dialog for All Refusal Types

1. Complete the **Enter Service Not Provided/Refusal** dialog for all refusal types as follows:

   a. In **Reason**, click to select a **refusal reason** from the drop-down menu.

   - The **Date Refused** field defaults to the current date. If needed, change the date by entering it manually or by clicking the **Ellipsis** button () to select from a calendar. The date cannot be a future date.
   - If needed, enter comments about the refusal in the **Comment** field. This field is a free-text field that contains a right-click menu to help in editing the entered text.
   - Click **Add** to add this record to the Personal Health History component. (Otherwise, click **Cancel**.) The record shows in the **Refusal** section.

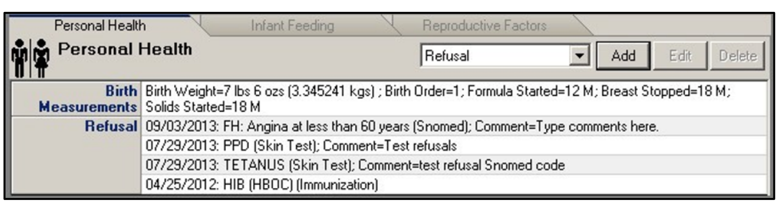


Figure 1-31: Completed Personal Health Refusal dialog

1.5 Adding Treatment Contract Information

The **Treatment Contract** option is where users record that the treatment contract was made with the patient.

1. Select a **patient** and a **visit** in order to add a **Treatment Contract**.

2. From the Personal Health History component, select the **Treatment Contract** option from the drop-down menu in the top-right corner of the component.
3. Once the drop-down item has been selected, click the **Add** button or right-click anywhere inside the component and select **Add** to display the **Add Treatment Contract Record** dialog (Figure 1-32).

Figure 1-32: Add Treatment Contract Record dialog

4. In the **Type** pane, select the type of contract from one of the following:
   - Pain
   - Mental Health

   The **Date Initiated** field defaults to the current date.

   - If needed, change the date by entering it manually or by clicking the **Ellipsis** button (...) to select from a calendar. The date cannot be a future date.
   - If needed, the **Provider** field has a lookup utility where users can search for a name by clicking the **Ellipsis** button (...) to open the **Lookup Provider** dialog. Refer to Section 1.5.1.
5. Click **OK** to add the record to the Personal Health History component. (Otherwise, click **Cancel**.)

1.5.1 Using the Lookup Utility Dialog for Provider

Access the Lookup Utility by clicking the **Ellipsis** button (...) at the end of the **Provider** field. Use this dialog (Figure 1-33) to search for and select a name for the **Provider** field.

Follow these steps to complete the **Lookup Provider** dialog:

Figure 1-33: Initial Lookup Provider dialog

1. Type a few characters in the **Search Value** field (Figure 1-34) and click **Search**. The appropriate names will display in the lower panel of the dialog. If this is not the data the user is looking for, repeat Step 1.

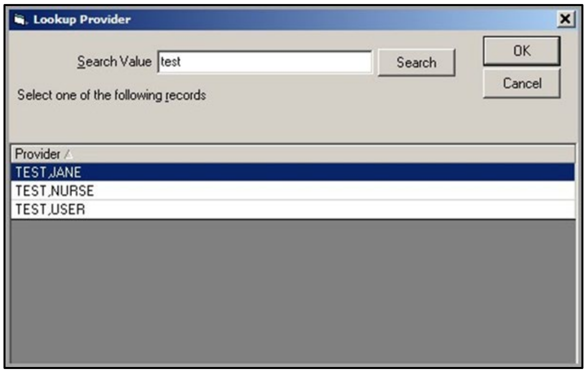


Figure 1-34: Lookup Provider dialog After Search

2. Highlight the appropriate **name** in the lower panel and click **OK**. The selected record will populate the **Provider** field. (Otherwise, click **Cancel**.)

1.6 Editing Personal Health History Records

The **Personal Health** panel may appear like this for a patient:

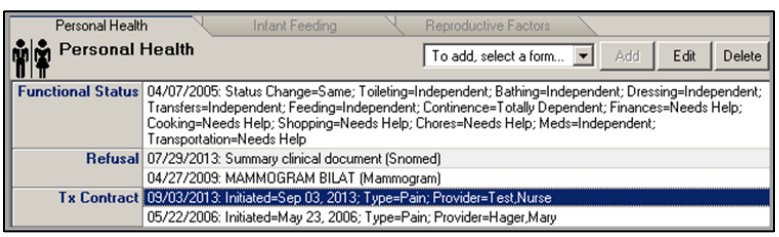


Figure 1-35: Editing Personal Health dialog

There are two ways to edit Personal Health data:

- Edit by double-clicking the existing record in the grid. The appropriate dialog displays.
- Select an existing record and click **Edit** (or select **Edit** on the right-click menu). The appropriate dialog displays.

Note:	A user cannot edit Personal Health data entered by another user.

Make any changes, as applicable. If needed, refer to the following topics for information on how to complete the applicable personal health record:

- Adding Functional Status, Section 1.2

- Adding Birth Measurements, Section 1.3
- Adding Refusals, Section 1.4
- Adding Treatment Contract Information, Section 1.5

1.7 Deleting Personal Health History Records

1. Select a record in the **Personal Health** panel to delete and click **Delete** (or select **Delete** on the right-click menu). The **Remove Record?** information message displays.

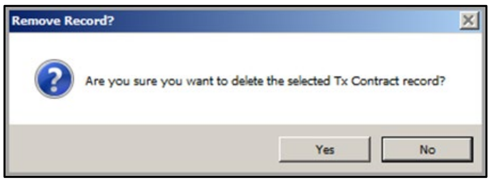


Figure 1-36: Remove Record information message

2. Click **Yes** to remove the selected record. (Otherwise, click **No**.)

Note:	A user cannot delete Personal Health data entered by another user.

2.0 Adverse Reactions/Allergies

The Adverse Reactions panel (Figure 2-1) shows a list of the causative agents associated with the patient's allergies or adverse reactions. It also displays if the adverse reaction record has been verified or unsigned. Any column can be sorted by clicking its heading.

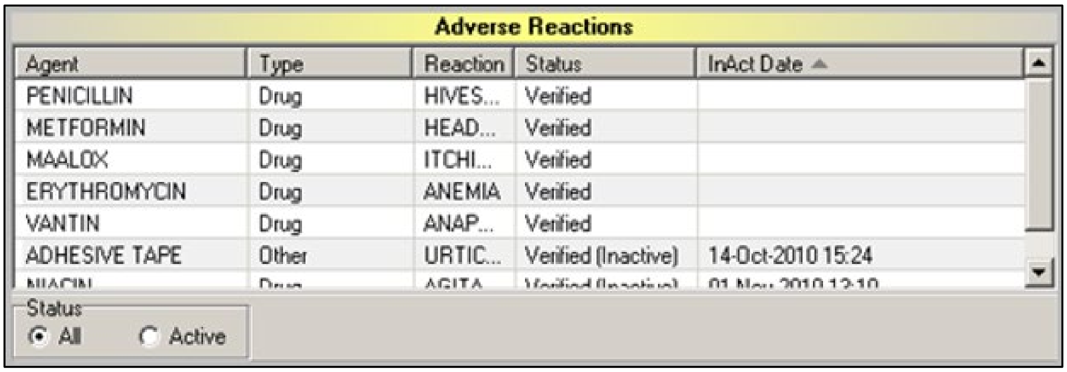


Figure 2-1: Sample Adverse Reactions panel

- Adverse Reactions apply to allergies and to adverse drug reactions. Adverse Reactions/Allergies can be entered via the allergy tracking package.
- Select **Refresh** from the right-click menu to re-display the patient's information so that recent changes will be reflected.

2.1 Data Entry of Adverse Reaction

Sites can be configured (in RPMS) so that a user can enter adverse reactions. The user can select the appropriate option on the right-click menu of the Adverse Reactions panel (Figure 2-2) to enter adverse reactions.

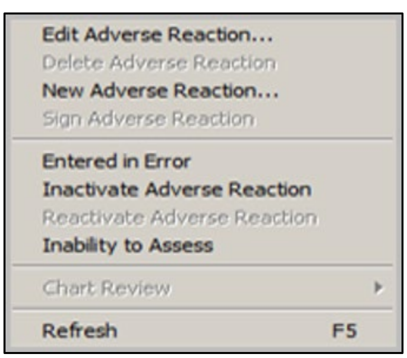


Figure 2-2: Right-click menu showing Adverse Reaction options

- The data is stored and managed through the **RPMS Adverse Reaction Tracking** application.

- The new adverse reaction data will not display on the **Orders** window, however. In this case, it is recommended that sites be configured such that adverse reactions cannot be entered on the **Orders** window (to lessen any confusion).

2.2 Create New Adverse Reaction

Use the **New Adverse Reaction** option on the right-click menu to enter a new adverse reaction for the current patient.

1. Select the **New Adverse Reaction** option and the **Look up Causative Agent** dialog (Figure 2-3) displays.

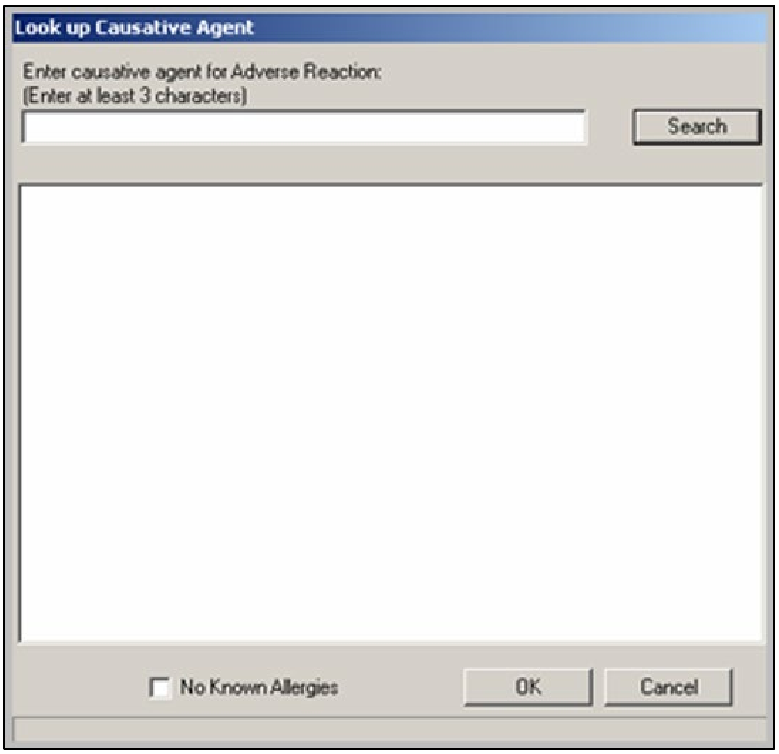


Figure 2-3: Look up Causative Agent dialog

- The **No Known Allergies** option does not appear on this dialog if the current patient has active allergies. If the **No Known Allergies** option does display, and the user wants to record that the patient has no known allergies, select that the option. Upon exiting the application, the user will be asked for an electronic signature.
- To enter a known allergy, enter at least three characters of the causative agent's name in the **Enter Causative Agent for Adverse Reaction** field.

2. Click **Search** and the application displays a list of possible matches in the lower group-box of the **Look up Causative Agent** dialog (Figure 2-4).

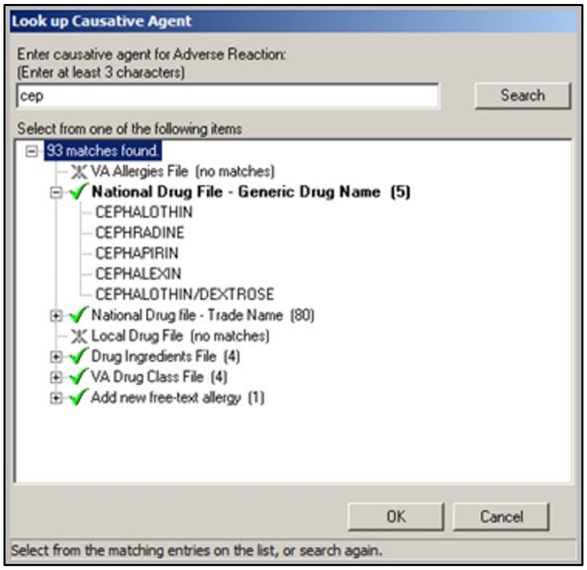


Figure 2-4: Records retrieved in lower group-box

- Users can do one of the two things:
  - Enter a new search by repeating Step 1.

  OR
  - Select from the matching entries in the lower group-box. If no causative agent can be found in the search, users can create a new one. Refer to Section 2.6 for more information.

Note:	For optimized Adverse Reaction checking, users should choose the first entry in the presented list that meets their needs, working from top to bottom. Do not choose a more specific entry than needed.

3. After selecting from the matching entries in the lower group-box, the **Create Adverse Reaction** dialog (Figure 2-5) displays.

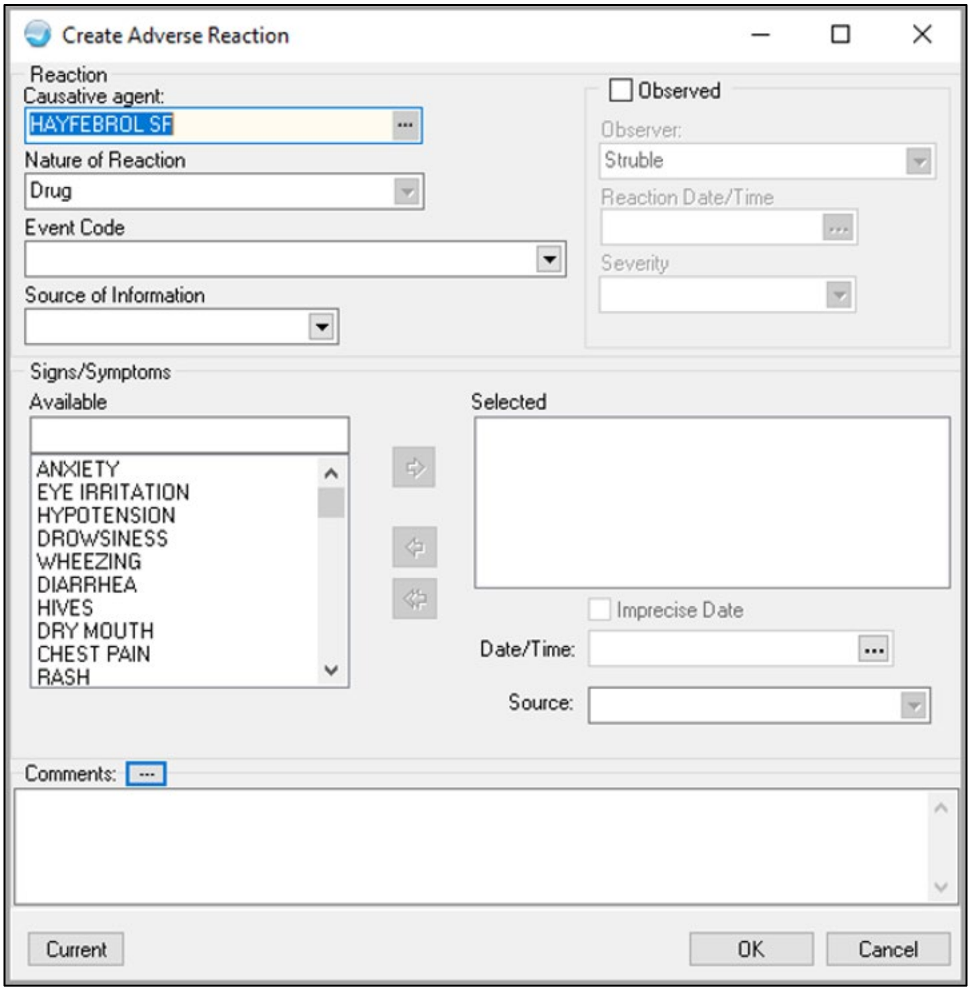


Figure 2-5: Create Adverse Reaction dialog example

4. Select those **options** wanted in the record by selecting from the various group-boxes. If possible, know the current allergies that the patient has.

   a. Click the **Current** button to display the **Current Allergies** pop-up (Figure 2-6).

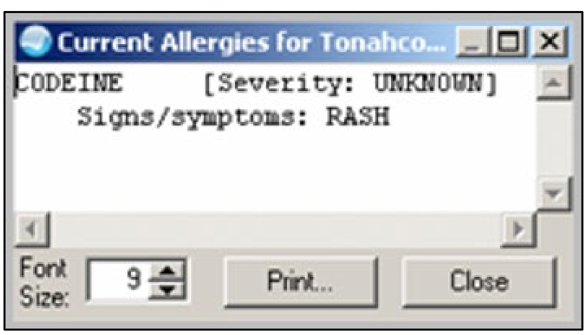


Figure 2-6: Sample Pop-up

- Users can change the font size of the text displayed in this pop-up by adjusting the size in the **Font Size** field (enter manually or use the **Up** and **Down** arrows).

Note:	This does not change the size of the text on the output (when printing).

b. Click **Print** to choose a printer and to output the (entire) contents of this pop-up to the specified printer.

- The detail pop-up has a right-click menu where users can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

c. Click **Close** to dismiss the pop-up.

5. Select the **Observed** check box to activate the fields in the **Observed** group box. Any data in the following fields can be changed:

- **Observer:** This is the name of the person who was the observer when the reaction occurred. Users can change the Observer by selecting from the drop-down list.
- **Reaction Date/Time:** This is the date and time when the reaction was observed. This can be a historical date.
- **Severity:** This is the severity of the reaction, which can be Mild, Moderate, or Severe.

6. The **Causative Agent** field can be changed by clicking the **Ellipsis** button (...) to go to the **Look up Caustic Agent** dialog.

- The **Nature of Reaction** field is not editable.
- The **Event Code** field (Figure 2-7) is a drop-down list of SNOMED terms that define this allergy type.

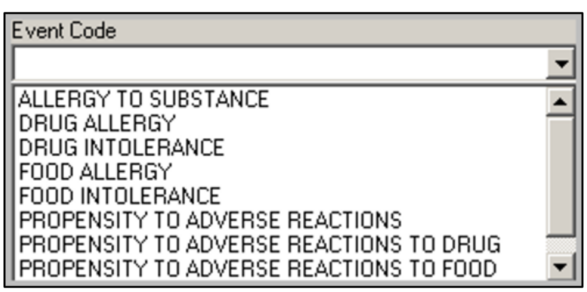


Figure 2-7: Event Code field

Note:	This field is required.

- The **Source of Information** field shows the person who gave the allergy information to the provider.

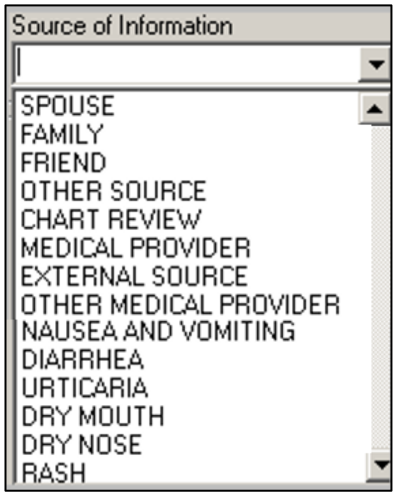


Figure 2-8: Source of Information field

Note: This field is required.

7. The **Signs/Symptoms** group box allows users to select one or more signs/symptoms and move them to the **Selected** field. The top-ten signs/symptoms set up at the site appear first, followed by the rest of the list viewed by scrolling with the **Up** and **Down** arrows. This includes the sign itself and any synonyms.
    - To move a sign/symptom from the **Available** field to the **Selected** field, highlight it and then click the right-pointing arrow ().
    - To move a sign/symptom from the **Selected** field to the **Available** field, highlight it and then click the left-pointing arrow ().
    - To move all of the sign/symptoms from the **Selected** field to the **Available** field, click the left-pointing double arrow () (no selection is necessary).
8. Enter any **comments** about the adverse reaction in the **Comments** field.
    - Each sign/symptom can also have a date/time and a source. These are optional.
    - Enter a comment in the **Comment** box. This is optional.
9. Click **OK** to save the data (otherwise, click **Cancel**).

After clicking **OK**, the new adverse reaction record displays in the Adverse Reaction panel, showing the Agent (Causative Agent) and Reaction (Nature of Reaction). The record also appears in the Patient Postings the next time the patient is selected. The Status will be SIGNED.

2.3 Edit Adverse Reaction

Users can edit any adverse reaction record in the Adverse Reaction panel. To do this, follow these steps:

1. Right-click the **record** to change and select the **Edit Adverse Reaction** option (Figure 2-9).

    - The **Edit Adverse Reaction** dialog displays. This dialog has the same fields as the **Create Adverse Reaction** dialog. Refer to Section 2.6 for more information about the fields.
    - Once an allergy is **SAVED/SIGNED**, only certain fields can be edited. New signs/symptoms may be added. Users will not be able to access all of the fields.

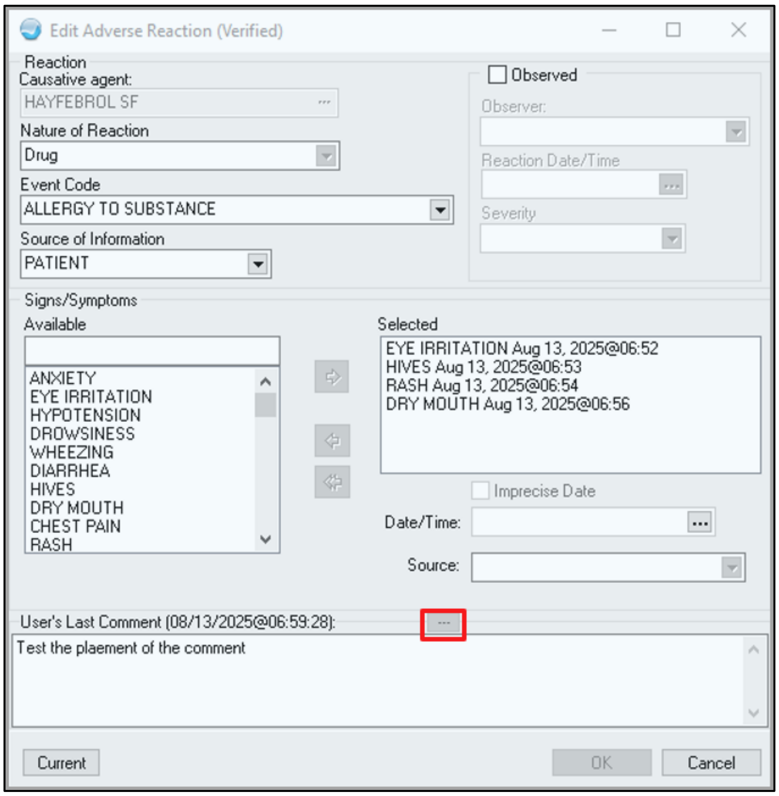


Figure 2-9: Ellipse – Click to view all comments

The comment box (Figure 2-10) will display any comment that the logged-in user has entered in the past. If there are other comments entered for the adverse reaction by other users the **Ellipsis** button (...) will be enabled. Those comments will be presented in chronological order.

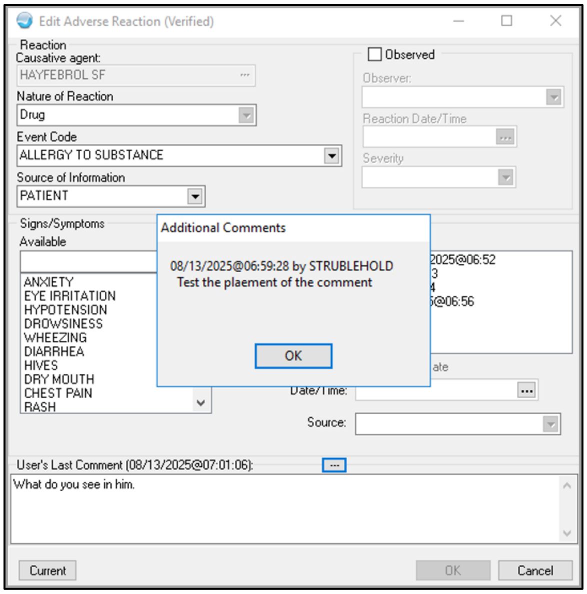


Figure 2-10: Creating a new additional comment

The logged-in user can remove the previous comment entered to add a completely new comment. The system will show in the ellipse (Figure 2-11), the old comment datetime stamped, and the new comment datetime stamped.

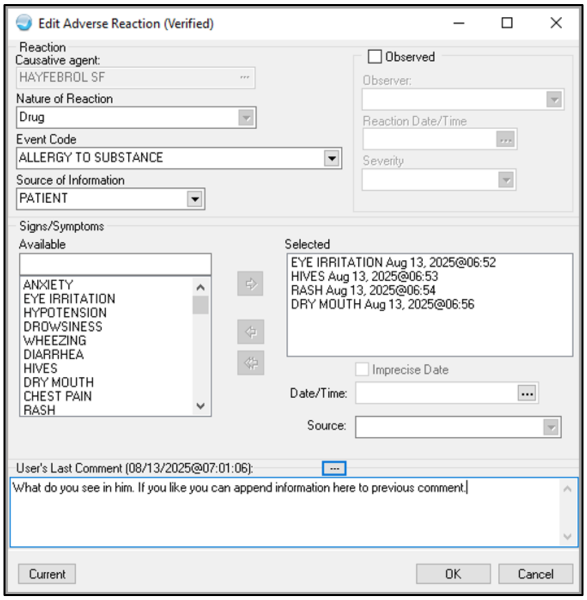


Figure 2-11: Appending an existing comment

The logged-in user can append to the existing comment they entered. The system will show in the ellipse the old comment datetime stamped and the appended comment datetime stamped.

2. Click **OK** to save the data (otherwise, click **Cancel**).

2.4 Delete Adverse Reaction

Once an adverse reaction has been saved, it cannot be deleted through RPMS-EHR. Refer to Section 2.7 to delete an allergy.

Providers can delete their own unsaved adverse reactions. Right-click the (unsigned) allergy and select **Delete Adverse Reaction**. The application displays an information message (Figure 2-12) to confirm that the user wants to delete the record.

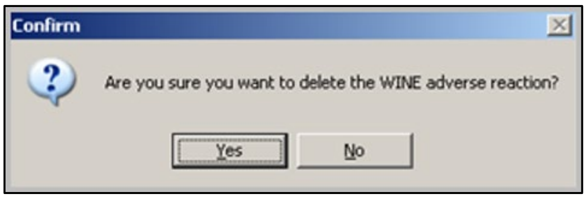


Figure 2-12: Confirmation to delete Adverse Reaction record

Click **Yes** to delete the unsigned adverse reaction and it is removed from the Adverse Reactions component. (Otherwise, click **No** to not remove the record.)

2.5 Sign Adverse Reaction

Allergies are auto-signed, which follows the action in RPMS. If the user has the verifier key, the allergy automatically goes to a verified status. Otherwise, a message is sent to the verifier mail group, and an alert is sent to verify the allergy.

2.6 Create New Causative Agent for Adverse Reaction

Users cannot create a new causative agent for adverse reactions if a search for the agent fails to find any matches. If there is an agent that the user must have added that is not in the **Allergy** file, the following dialog (Figure 2-13) displays:

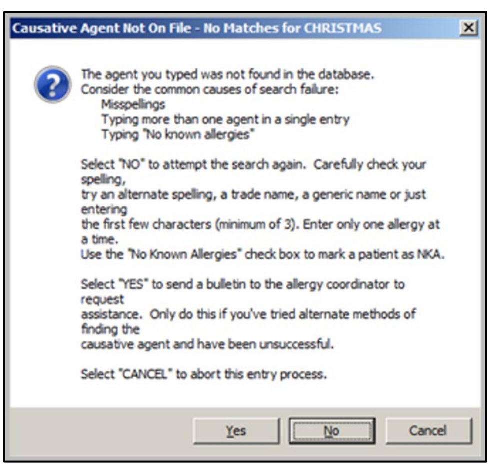


Figure 2-13: Information Message about causative agent

Click **Yes** on the information message to proceed with sending the allergy request. (Otherwise, click **No** to exit the process).

This will NOT add the allergy. The site's Local Informaticist must determine if this allergy should be forwarded nationally and added in a future patch.

2.7 Entered in Error

Adverse reactions that have been saved must be marked as entered in error and cannot be deleted due to auditing requirements.

1. Highlight the chosen **adverse reaction** (Figure 2-14) and then select entered in error from the right-click menu.

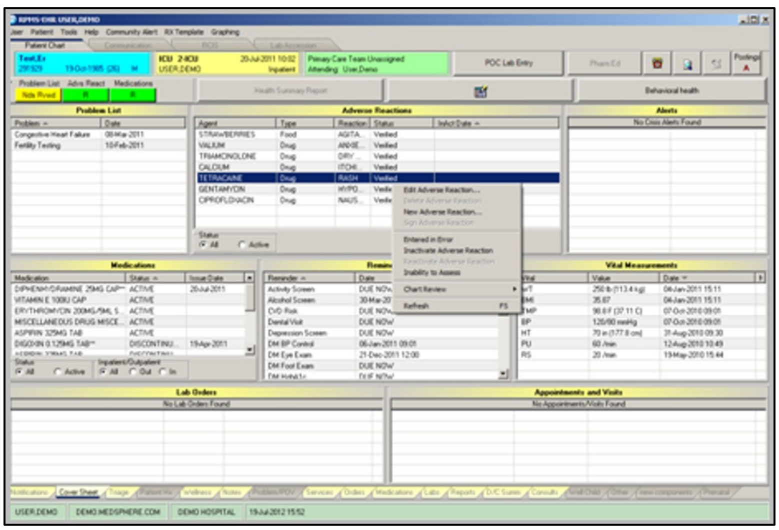


Figure 2-14: Highlight Adverse Reaction window

2. Confirm that the **adverse reaction** is to be marked entered in error (Figure 2-15), as it cannot be undone.

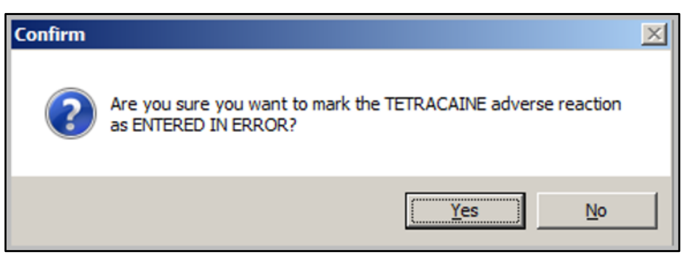


Figure 2-15: Entered in Error confirmation message

3. Enter the **reason** for the error (Figure 2-16).

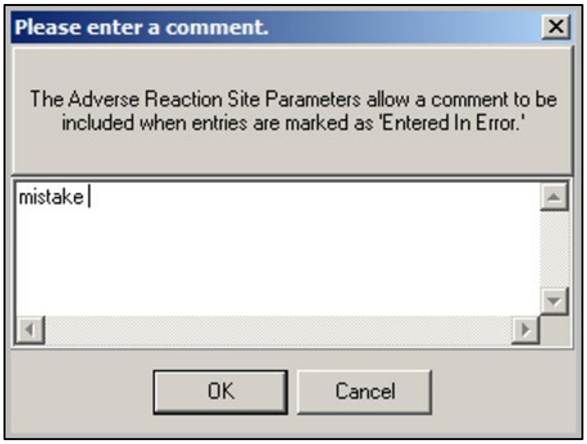


Figure 2-16: Entered in Error comment dialog

2.8 Adverse Reaction Detail

When configured as a pop-up, the Adverse Reaction Detail (Figure 2-17) displays when a table entry is selected by a double-click.

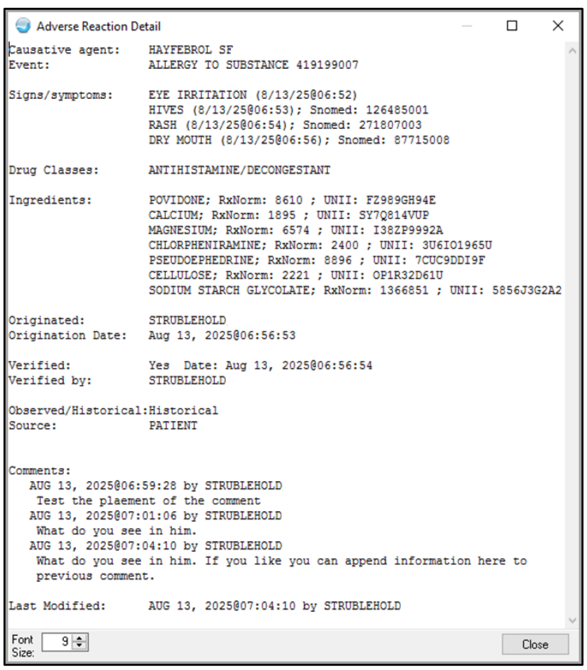


Figure 2-17: Adverse Reaction Detail pop-up example

Note:	If so configured, a print button might also appear on the pop-up.

Users can change the font size of the text displayed in this pop-up by adjusting the size in the **Font Size** field (enter manually or use the **Up** and **Down** arrows).

The detail pop-up has a right-click menu where users can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word). Click **Close** to dismiss the pop-up.

2.9 Inactivate/Reactivate Reaction

Using the right-click menu gives the user the ability to inactivate an adverse reaction if the patient no longer has a reaction instead of marking it as an error.

1. Highlight the **chosen error** and select **Inactivate**.
2. On the **Confirm Inactivity** dialog (Figure 2-18), click **Yes** to confirm inactivating the allergy.

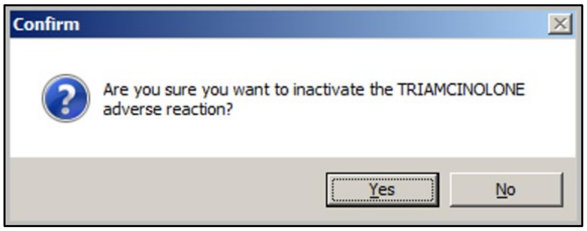


Figure 2-18: Confirm Allergy as Inactive dialog

3. Select the **reason** at the **Reason Prompt** dialog (Figure 2-19).

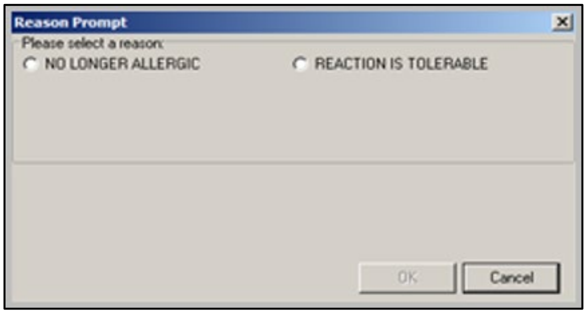


Figure 2-19: Reason Prompt dialog

- View inactive allergies by changing the **Status** option button (Figure 2-20) located at the bottom of the Adverse Reactions component from **Active** to **All**.

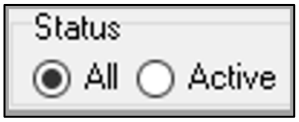


Figure 2-20: Status option button

4. To reactivate an inactive allergy:

   a. Highlight the **allergy** in the list.

b. Right-click and select **Reactivate** from the right-click menu. The **Reactivate** option appears gray on the right-click menu unless the user has selected an inactive allergy.

5. Confirm the reactivation (Figure 2-21).

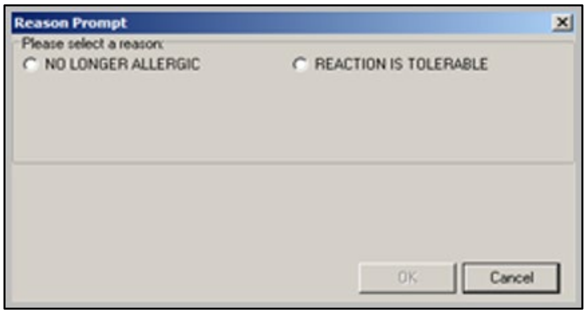


Figure 2-21: Confirming the reactivation dialog

- Reactivated allergies must be verified again, so if the provider does not have the verify key, it reverts back to unverified status.
- Inactivate and reactivate actions do appear on the **Allergy Details** window.

2.10 Verify Adverse Reactions

Sites can be configured in RPMS such that a user can be authorized to verify adverse reaction information. The examples below show how this feature works.

- In the following example (Figure 2-22), the provider has permission to Enter and Verify adverse reactions. Once signed, it also verifies the adverse reaction.

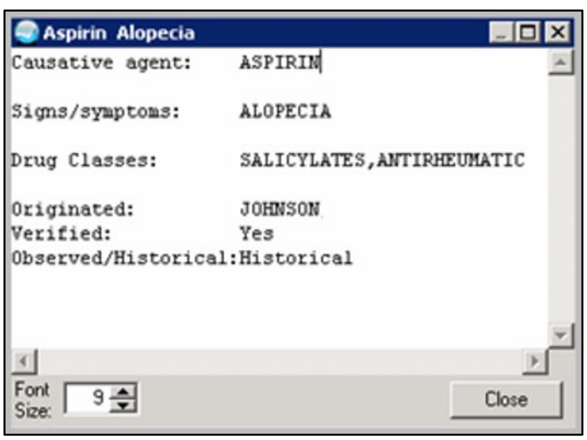


Figure 2-22: Provider with permission to Enter and Verify

- The same provider is prompted to verify allergies entered by other providers because the system recognizes the provider is a verifier, and the patient has unverified allergies.

- Allergies entered by a non-verifier go into the non-verified status on the cover sheet.
- Providers having the verify key receive an alert requesting them to process to verify the allergy. Click the button (Figure 2-23) next to the **Causative Agent** to display the ingredients and drug classes (Figure 2-24) that are part of this allergy.

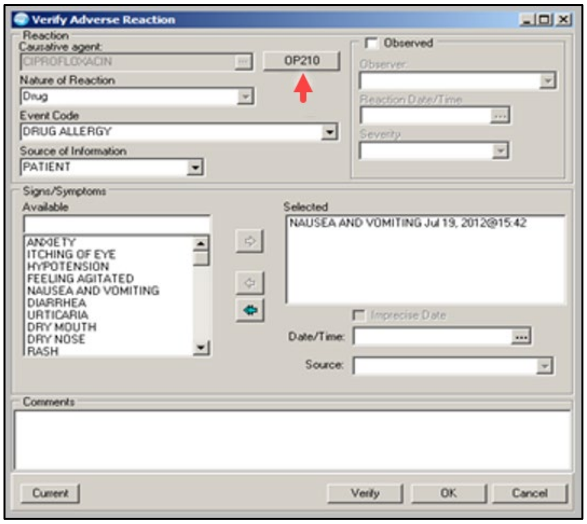


Figure 2-23: Button to display ingredients and drug classes

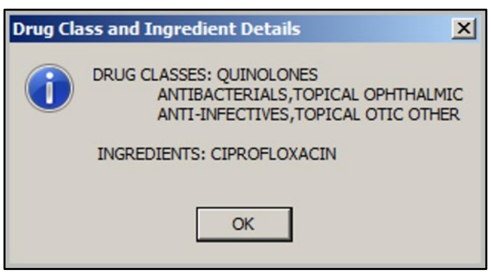


Figure 2-24: Drug Class and Ingredients Details message

- After review and any edits, click the **Verify** button on the **Verify Adverse Reaction** window to bring up a signature box to verify the allergy and remove the alert.

Note:	This verification is a technical verification (correct drug class, ingredients, etc.), not a clinical verification. IE, this is not a chart review investigation or patient interview to verify reaction.

2.11 Unable to Assess

There can be times when the patient is not able to be assessed for allergies. This can be documented on the right-click menu on the cover sheet.

- When unable to assess is chosen, the user must select a reason from the list of options (Figure 2-25).

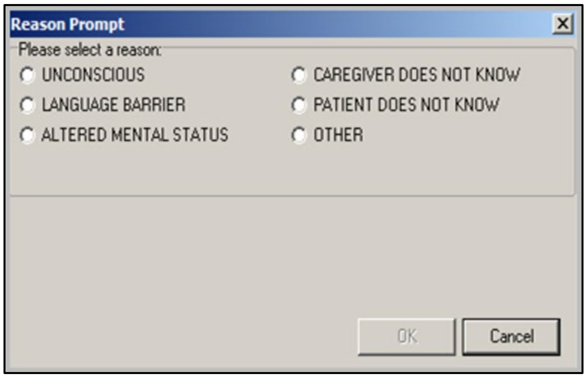


Figure 2-25: Reason Prompt dialog

- If **Other** is selected, a **Comment** free-text field (Figure 2-26) displays to enter a reason.

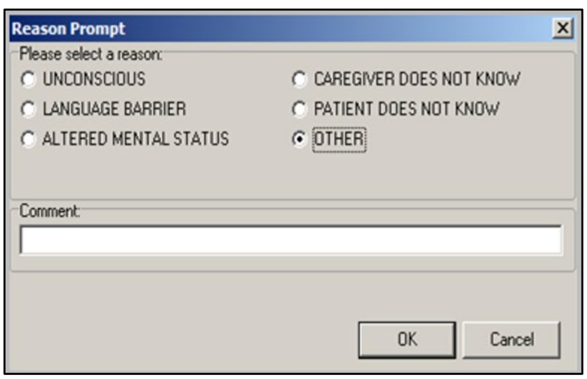
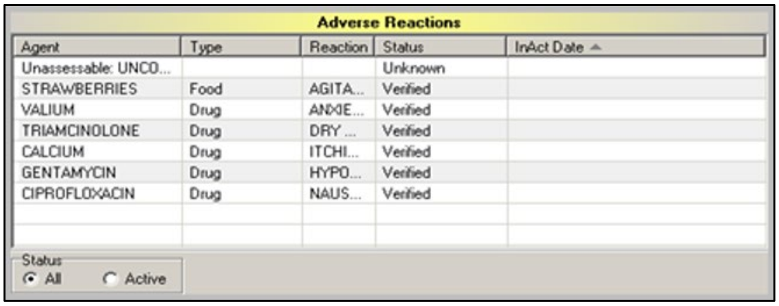


Figure 2-26: Comment free-text field

The inability to access appears in the allergy list so that providers will know it may not be complete.



Adverse Reactions

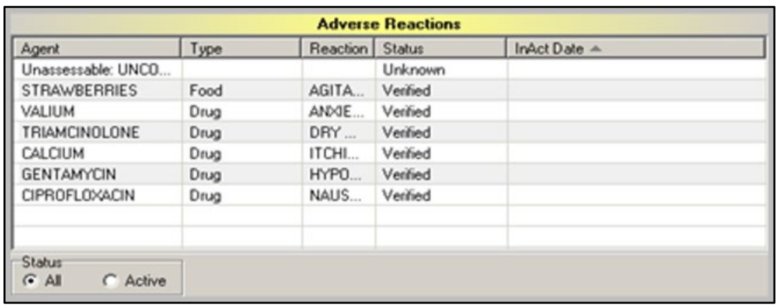
Agent	Type	Reaction	Status	InAct Date
Unassessable: UNCO...			Unknown	
STRAWBERRIES	Food	AGITA...	Verified	
VALIUM	Drug	ANXIE...	Verified	
TRIAMCINOLONE	Drug	DRY ...	Verified	
CALCIUM	Drug	ITCHI...	Verified	
GENTAMYCIN	Drug	HYPO...	Verified	
CIPROFLOXACIN	Drug	NAUS...	Verified	

Status
All Active

Figure 2-27: Unassessable Listing dialog

When the patient can be assessed, the Unassessible listing is automatically removed by two methods:

- The entry of a new allergy.
- Documentation that the allergy list was reviewed.



Adverse Reactions

Agent	Type	Reaction	Status	InAct Date
Unassessable: UNCO...			Unknown	
STRAWBERRIES	Food	AGITA...	Verified	
VALIUM	Drug	ANXIE...	Verified	
TRIAMCINOLONE	Drug	DRY ...	Verified	
CALCIUM	Drug	ITCHI...	Verified	
GENTAMYCIN	Drug	HYPO...	Verified	
CIPROFLOXACIN	Drug	NAUS...	Verified	

Status
All Active

Figure 2-28: Allergy List reviewed

Important: The marking of the patient as Unassessable does not create an event to the Chart Review component.

2.12 Chart Review

The Chart Review component can be accessed by right-clicking inside the Allergy component. Only allergies can be reviewed in the Allergy component.

If the patient has no active allergies, that option can be selected as the review of allergies or the **Reviewed** option can be selected if the patient does have allergies on file. Adding a new allergy automatically updates the chart review with the updated action.

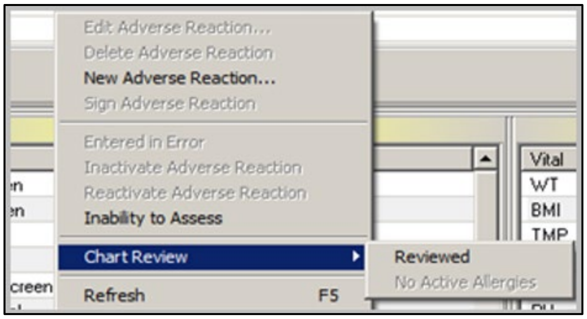


Figure 2-29: Allergy List Reviewed

Selecting **Reviewed** highlights the allergy review on the Chart Review component, and enters the review into the **Signature Action** to be signed. Users cannot do a chart review unless a visit is selected.

3.0 Chief Complaint

The Chief Complaint component is where the user can enter the reason the patient is seeking care for the visit. The component captures the items, such as symptoms, diagnoses, or requests. The component helps healthcare providers focus on the patient's main concern, streamlining the diagnostic process, prioritizing care, and improving communication among medical teams.

The Chief Complaint panel (Figure 3-1) displays the patient's complaint information for the visit selected.

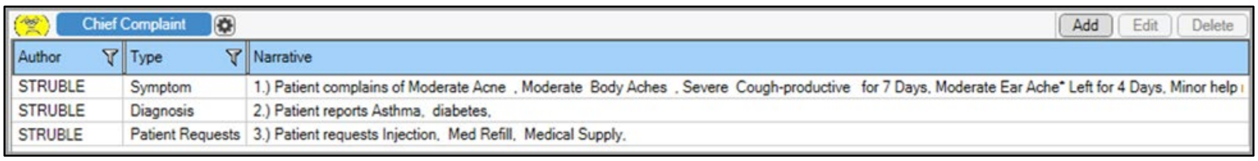


Figure 3-1: Chief Complaint panel

The table contains three columns:

- **Author**–The user that entered the information for the patient's visit.
- **Type**–The type of complaint entered, this can be symptom, diagnosis or request.
- **Narrative**–The description of the entered information.

> **Note:** Rows in the table are created for each complaint type entered into the patient's record for the visit.

3.1 Customizing the Chief Complaint Display

The Chief Complaint component allows users or sites to customize the display of the Chief Complaint table to improve usability.

- The changes will not persist between logins for a user.
- The changes will not affect other users and can be removed later if desired without loss of data.

3.1.1 Sorting and Filtering

Each column can be sorted in multiple ways.

- Left clicking sorts the column ascending.
- Left clicking again reverses that sort to descending.
- Left-clicking a third time returns the column to its original order.

Clicking the **Funnel** icon () at the top of any column displays a check-box list of all items in the column. A check box can be selected so only those data display. The **Funnel** icon () turns color to show that a filter is enabled.

3.1.2 Rearranging Columns

Columns can be rearranged for a particular user. A user may want to move the **Type** column information to the far left. To do this, simply grab the column by left-clicking, and dragging it to the desired location. Again, this does not affect any other users' displays.

3.2 Add Chief Complaint Record

The **Chief Complaint** dialog (Figure 3-2) has four methods for entering a chief complaint:

- Selecting Symptoms
- Selecting Patient Requests
- Selecting Diagnosis
- Free Text Entry

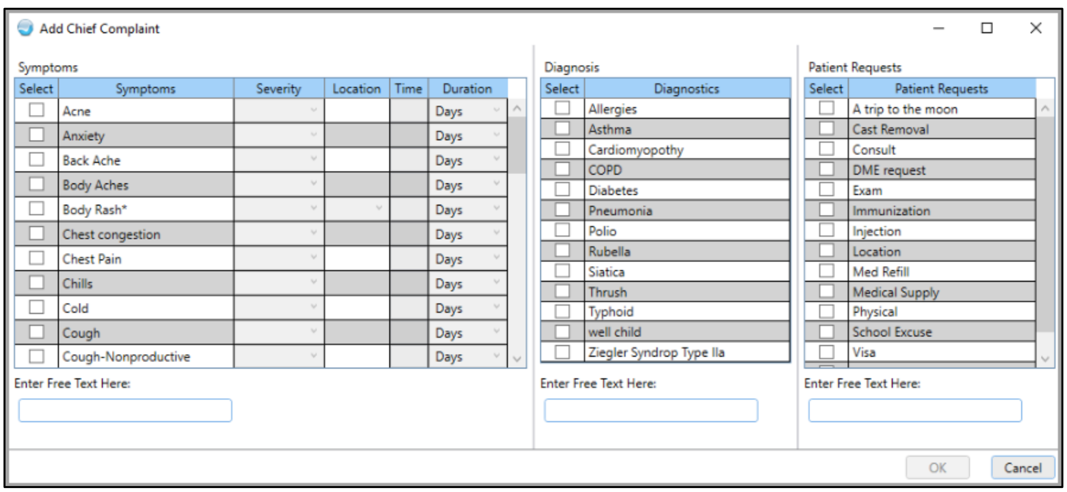


Figure 3-2: Chief Complaint dialog

1. Choose the appropriate complaint by selecting the check box to enter into the patient's record for the visit.

    - Complaints can be chosen from the **Symptoms**, **Diagnoses**, and/or **Requests** tables. Multiple complaints can be entered for the same visit.
    - If a symptom is selected a user can add additional information to the complaint by entering:

- Time
- Duration–Hours, Days, Weeks, Months, or Years
- If the item selected has an asterisk (*) next to it, the location can be entered:
  - Right
  - Left
  - Both

2. **Symptoms**, **Diagnoses**, and/or **Requests** can also be entered as free text (Figure 3-3) if items in the tables do not match the issue for which the patient is presenting.

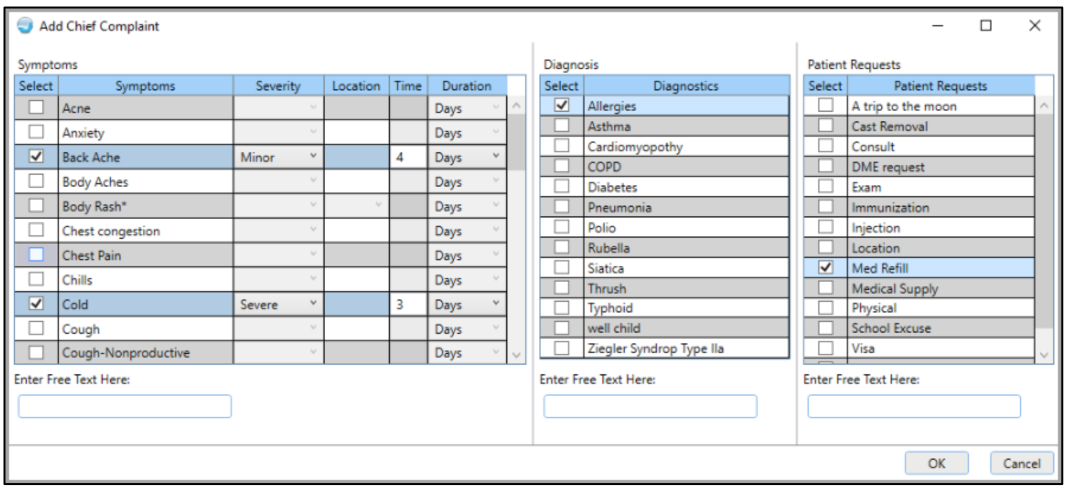


Figure 3-3: Chief Complaint with selections populated

3. Click **OK** when finished.

3.3 Edit Chief Complaint Record

Follow these steps to edit a Chief Complaint record:

1. Select the **Chief Complaint record** to edit.
2. Click the **Edit** button, or utilize the right-click menu option **Edit** to display the **Edit Chief Complaint** dialog (Figure 3-4, Figure 3-5, and Figure 3-6).
   - Users can change any information in this dialog related to the row type selected; other tables will be disabled.

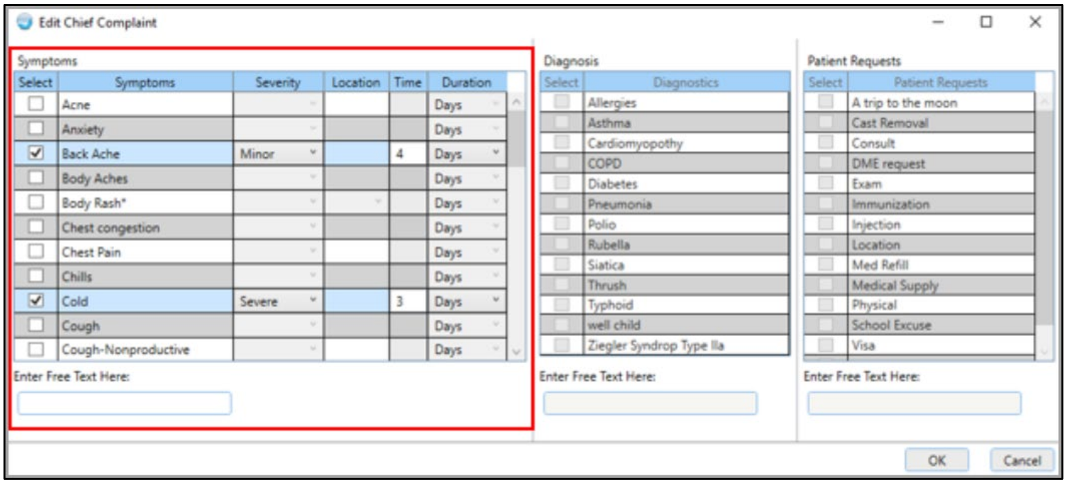


Figure 3-4: Editing of Chief Complaint-type symptom

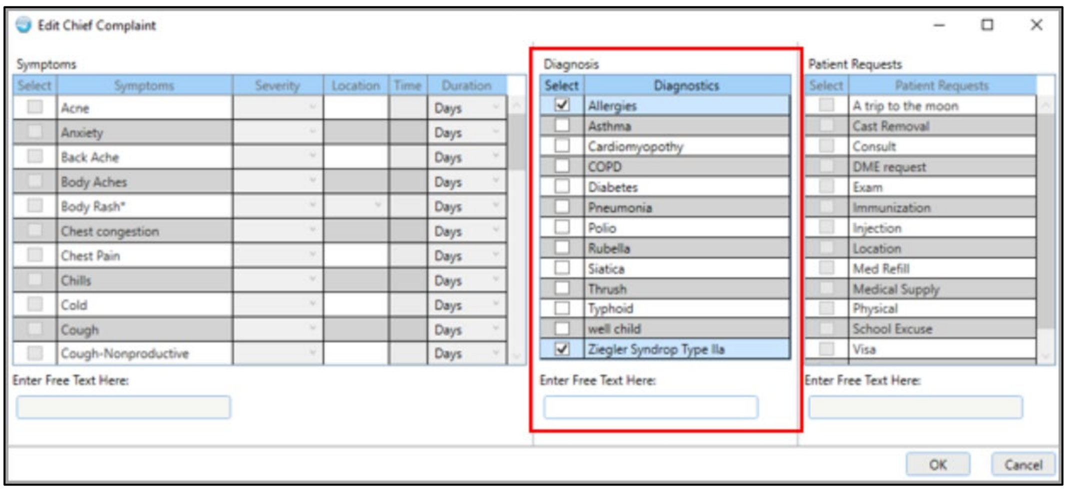


Figure 3-5: Editing of Chief Complaint-type diagnosis

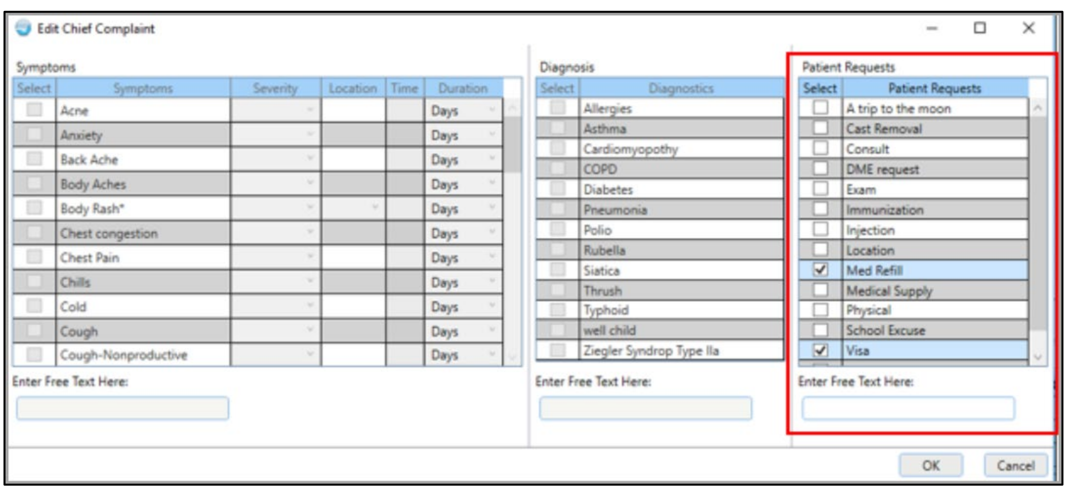


Figure 3-6: Editing Chief Complaint-type request

3. When all information has been updated, click **OK** to return to the Chief Complaint table. (Otherwise, click **Cancel**).

Note:	There are circumstances when the Local Informaticist may remove items in the Chief Complaint picklists. A Chief Complaint record that uses a subsequently deleted picklist item will show as **Free Text** in the **Type** column. In this case, the **Edit Chief Complaint** dialog will open as a free-text editor only, allowing the user to edit or remove the invalid picklist item from the saved entry.

3.4 Delete Chief Complaint Record

Follow these steps to delete a chief complaint record:

1. Select the **Chief Complaint** record to delete.
2. Click **Delete** (or select **Delete Chief Complaint** option on the right-click menu) to display the **Delete Chief Complaint?** information message (Figure 3-7).

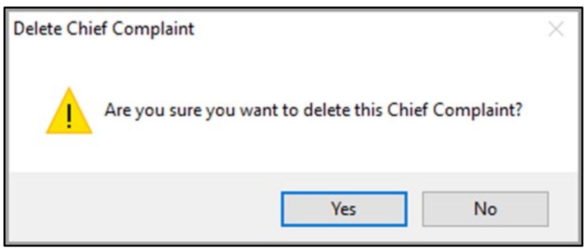


Figure 3-7: Delete Chief Complaint information message

3. Click **Yes** to remove the selected **Chief Complaint** record. (Otherwise, click **No**.)

3.5 Display Visit Detail

Users can view the visit details of a selected record by selecting the **Display Visit Detail** option on the right-click menu to display the **Visit Detail** pop-up.

1. Right-click any row and from the menu (Figure 3-8) option choose **View Visit Detail**.

Figure 3-8: Chief Complaint right-click menu

2. Click **Print** to choose a printer and to output the (entire) contents of the Visit Detail to the specified printer.

   Be aware that the **Print** button may not be there. It appears according to how the application is configured.

Note:	Users can change the font size of the text displayed in the **Visit Detail** dialog by adjusting the size in the **Font Size** field (enter manually or use the **Up** and **Down** arrows). This does not change the size of the text on the output when printing.

   - The Visit Detail has a right-click menu where users can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

3. Click **Close** to dismiss the **Visit Detail** dialog (Figure 3-9).

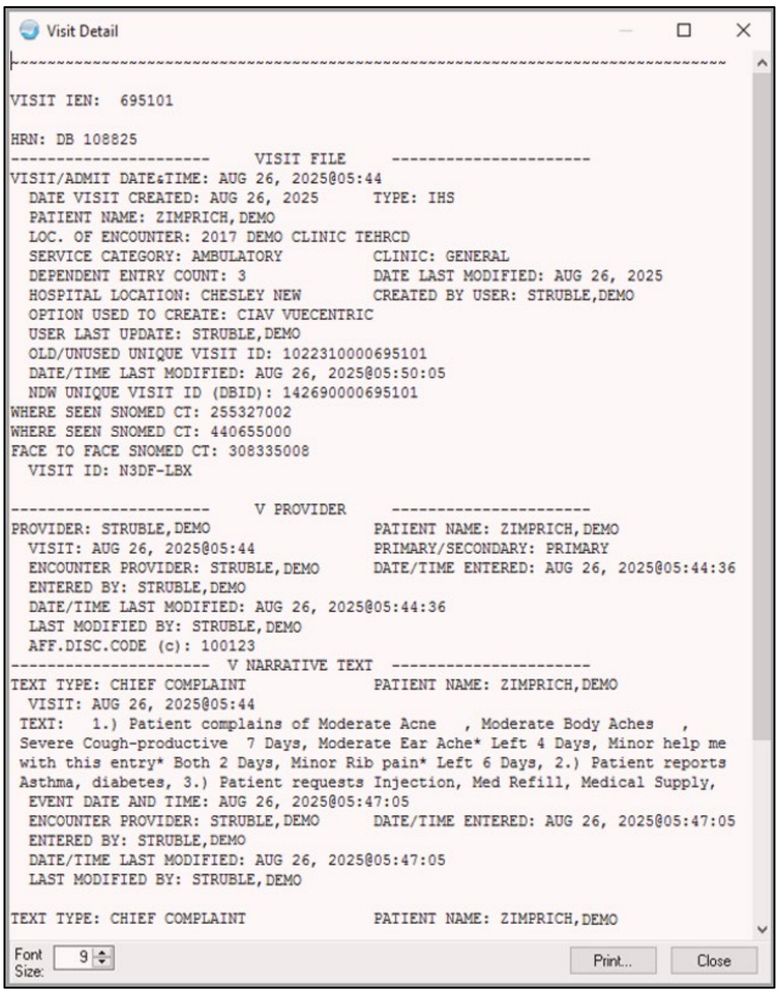


Figure 3-9: View Visit Detail dialog

3.6 Managing Chief Complaint

If the user has the **BGOZ CAC** key, an icon (Figure 3-10) will be visible to the right of the Chief Complaint label within the table. The **Manage Pick Lists** option enables Local Informaticists to manage the picklists (**Symptoms**, **Diagnosis**, and **Requests**) used in the Chief Complaint component.

Figure 3-10: Manage Pick Lists icon

The user is able to update the three picklists (Figure 3-11) with content change requested from providers or remove items from the following picklists:

- Symptoms
- Diagnosis
- Patient Request

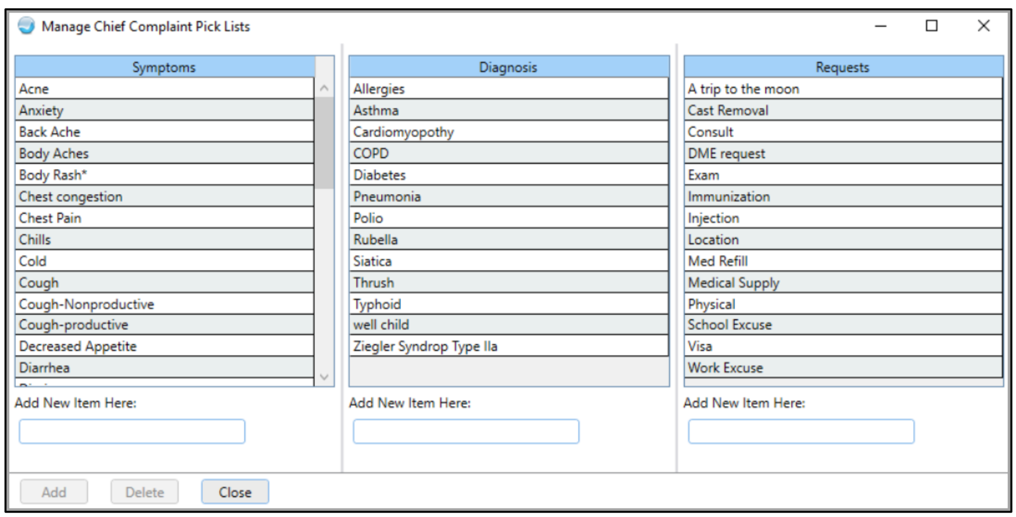


Figure 3-11: Manage Chief Complaint Pick Lists dialog

1. When adding new picklist items to one or more of the three tables, enter the content (**symptom**, **diagnosis**, or **request**) in the free-text area labeled **Add New Item Here**.

   When entering a new pick-list item for Symptoms, certain words can trigger an additional confirmation-question message (Figure 3-12) to determine a location. These words include leg, arm, hand, foot, eye, ear, and so on.

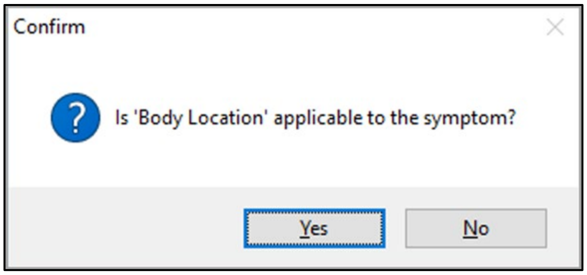


Figure 3-12: Confirm message

2. Click **Yes** or **No**.

   To delete an item from either of the tables, simply highlight the item(s) and click **Delete**.

4.0 Exams

The Exams panel (Figure 4-1) enables users to add, edit, or delete a patient exam.

The location of the exam (not historical) defaults to the provider's location (in the Exams grid). This component can be configured so that a particular user or class cannot add/edit an exam.

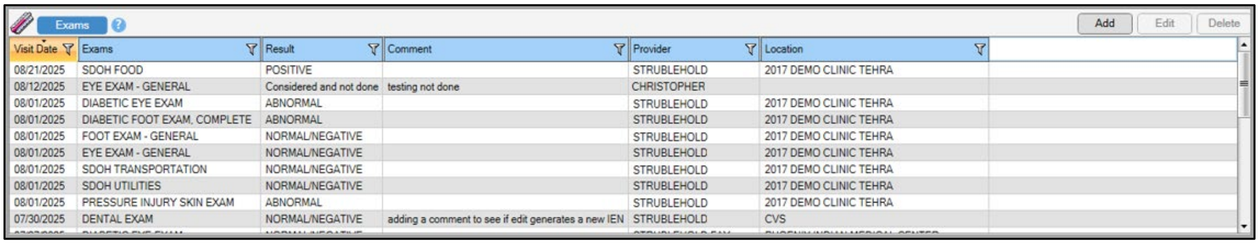


Figure 4-1: Exams panel

4.1 Customizing the Exam Display

The new module allows users or sites to customize the Exam table to improve usability. All changes will persist for a user between logins, but will not affect other users and can be removed later if desired without loss of data.

When the user mouses over the **Question Mark** icon (?) to the right of Exam label, a tooltip (Figure 4-2) explains some of the user preferences that can be done such as show/hide columns and group by.

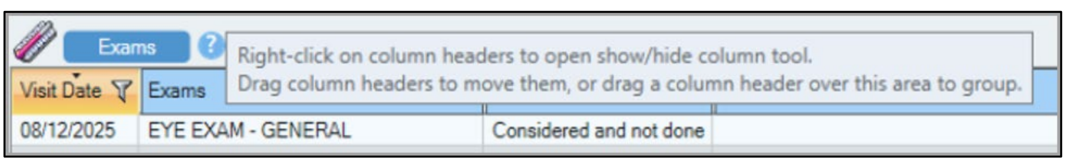


Figure 4-2: Exams tool tip example

4.1.1 Columns

There are five columns initially displayed in the Exam table. Some users may need to see all five, but others may determine that not all columns are needed for their use. Columns can be hidden if desired, but the data is NOT removed, and this will not affect any other users.

To hide a column, right-click any column header. Be aware that left-clicking a column sorts it. Right-click displays the list of all the columns that can be hidden.

Note:	Some columns, such as **Visit Date**, **Exam**, and **Result**, do not appear on this list and cannot be hidden.

All columns that are selected (with check marks) will display (Figure 4-3). If a user does not want to see a particular column, such as location or comment, they can clear that check box and the column will no longer display in their personal view. This setting will persist for future logins for that provider. Any of these check boxes can be cleared.

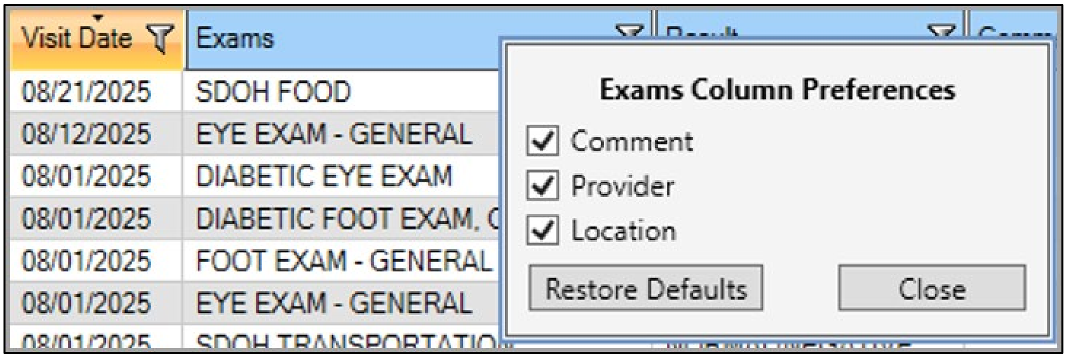


Figure 4-3: Columns selected (check marks) example

Hiding some columns may improve the display for the user, as in Figure 4-3.

Note:	To restore the original five columns, simply click **Restore Defaults**.

4.1.2 Sorting

Each column can be sorted in multiple ways.

- Left-clicking sorts by Visit Date in the Visit Date column.
- Left-clicking again reverses that sort.
- Left-clicking a third time returns the column to its original order.

Clicking the **Funnel** icon () at the top of any column displays a check box list of all items in the column (Figure 4-4). A check box can be selected so only those data display.

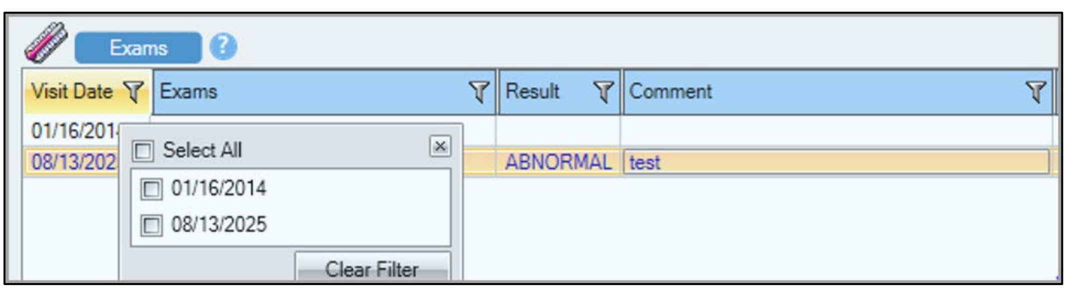


Figure 4-4: Filtering data dialog

The **Funnel** icon turns color () to show that a filter is enabled (Figure 4-5).

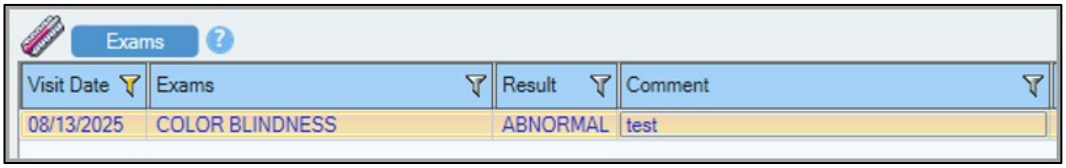


Figure 4-5: Selecting a single date to display

4.1.3 Group By

By left-clicking any column header (Figure 4-6) and dragging the column up into the Exam label area, a message will appear:

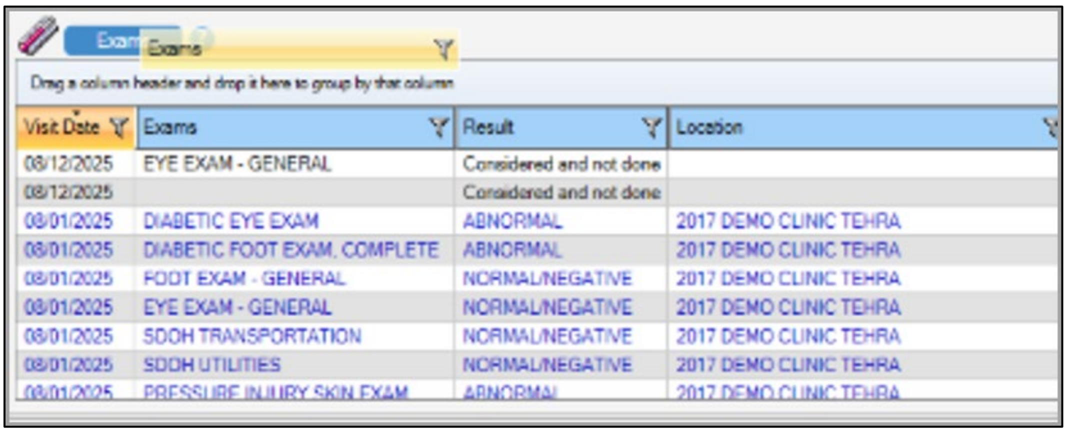


Figure 4-6: Drag a header here and drop it to group by that column

The user releases the left-click and the Exam table is now grouped by that column (Figure 4-7), already expanded with the data rows. This can be done for multiple columns. Clicking the **X** in each item will remove it from the grouping.

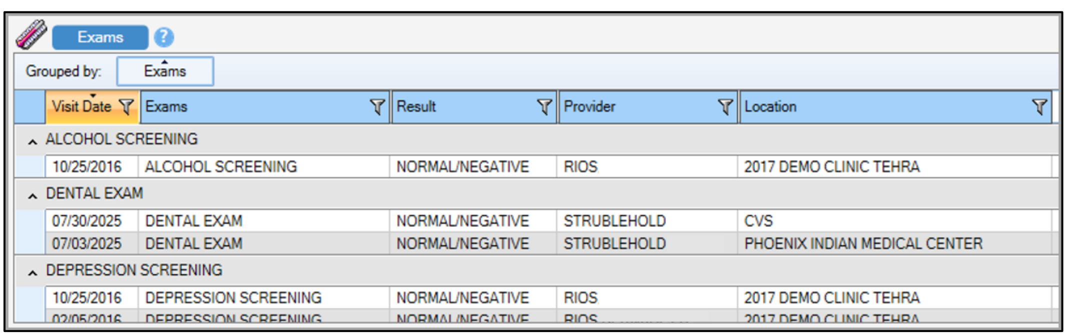


Figure 4-7: Exam Grouped window

4.1.4 Rearranging Columns

Columns can be rearranged for a particular user (Figure 4-8). A user may want to move Result information to the far left and display dates on the right. To do this, simply grab the column by left-clicking, and drag it to the desired location. Again, this does not affect any other users' displays.

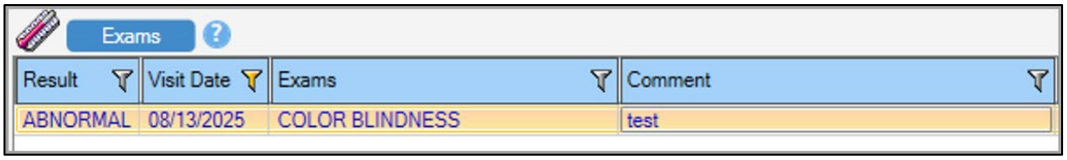


Figure 4-8: Columns rearranged example

4.2 Adding an Exam

The **Add** function creates a current or historical exam or creates a refusal for an exam. Make sure a visit is selected. Follow these steps to add a patient exam:

1. Click **Add** in the Exams component (or select the **Add Patient Exam** option on the right-click menu) to display the **Exam Selection** dialog (Figure 4-9).

> **Note:** Use the scroll bar to view all available exams. Either column can be sorted by clicking its heading.

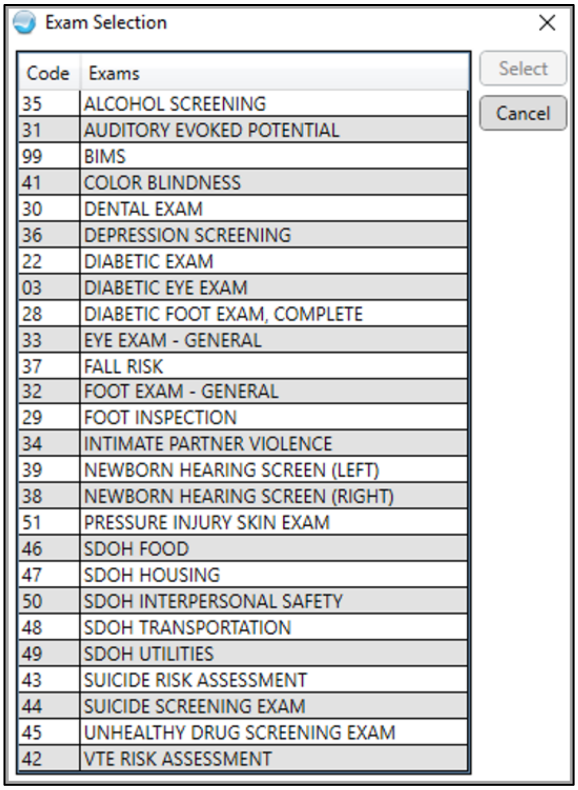


Figure 4-9: Exam Selection dialog

2. Highlight the **exam** to add.
3. Click **Select**. The **Document an Exam** dialog (Figure 4-10) opens. (Otherwise, click **Cancel**.)

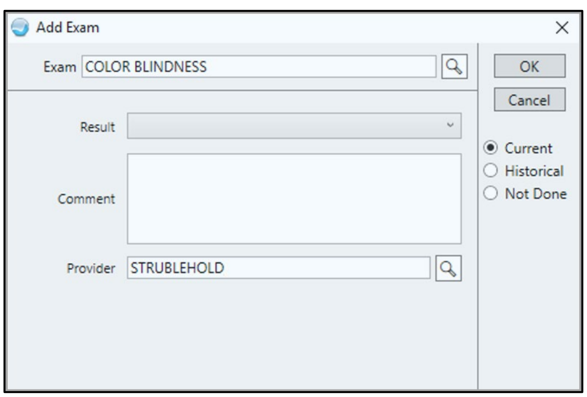


Figure 4-10: Document an Exam dialog

To re-display the **Exam Selection** dialog, click the **Search** button () next to the **Exam** field.

4. Select one of the following options:

- **Current**
- **Historical**
- **Not Done**

4.2.1 Current Exam

1. Select the **Current** option (Figure 4-11) when the exam is for the current visit.

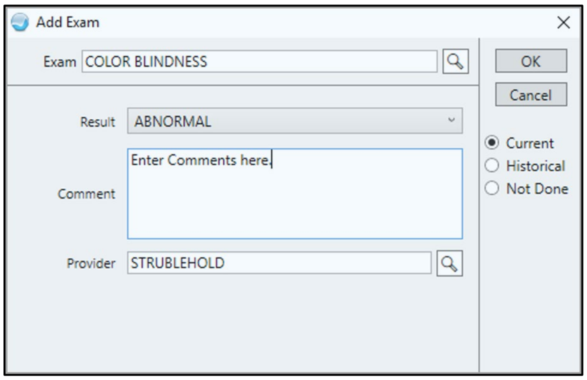


Figure 4-11: Current option on the Document an Exam dialog

2. In **Result**, select the result for the exam from the drop-down list:
   - **Abnormal**
   - **Normal/Negative**
   - **Positive**
   - **Referal Needed**
3. In the **Comment** field, type a comment about the exam (if applicable). This field has a right-click menu to aid in editing the text. Use this field to note abnormal findings, for example.
   - If the provider of the exam is different from what is displayed in the **Provider** field, click the **Search** button ( ) to display the **Lookup** utility. There users can select the proper provider. Refer to Section 4.2.5 for more information.
4. Complete the **Document an Exam** dialog. Refer to Section 4.2.4 for details.

4.2.2 Historical Exam

Users can add a historical exam by having no visit selected and clicking the **Add** button. The **Document an Exam** dialog displays with the **Historical** option selected.

1. If not already selected, select the **Historical** option when the exam is for an historical visit.

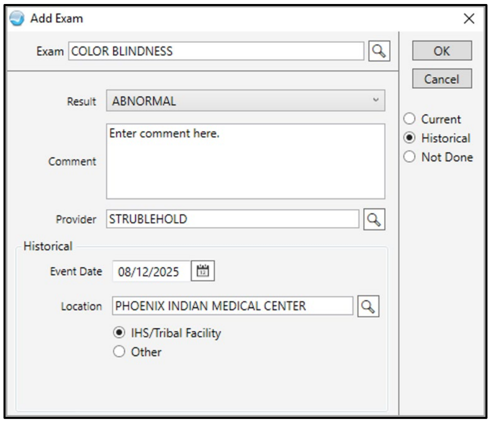


Figure 4-12: Historical Event panel

2. In **Result**, select the result for the exam from the drop-down list:
   - **Abnormal**
   - **Normal/Negative**
   - **Positive**
   - **Referral Needed**
3. In **Comment**, type a comment about the exam (if applicable). This field has a right-click menu to aid in editing the text. Use this field to note abnormal findings, for example.
4. If the provider of the exam is different from what is displayed in the **Provider** field, click the **Search** button () to display the **Lookup** utility, where the proper provider can be selected. Refer to Section 4.2.5 for more information.
5. Complete the **Historical group box**:
   - Enter a date in the **Event Date** field by either manually typing it or by clicking the **Calendar** button () to select from a calendar. It must be a past date.
   - The **Location** field has a right-click menu to aid in editing the information.
   - If the location is an official IHS facility, select the **IHS/Tribal Facility** option.

     A location can be selected from the **Lookup Utility** dialog by clicking the **Search** button (). If a facility name is manually entered, it must be an official IHS facility. If not, when leaving the field, the **Lookup Utility** dialog displays. Refer to Section 4.2.6 for more information.

- If a site has been configured with a default outside location, type **OTHER** in the **Location** field. Then when the **View Visit Detail** pop-up displays, the default outside location displays at the **LOC. OF ENCOUNTER** field.
- If the location is not an official IHS facility, select the **Other** option. Enter the non- official location (for example, Dr. Example Doctor).

6. Complete the **Document an Exam** dialog. Refer to Section 4.2.4 for details.

4.2.3 Exam Not Done

1. Select the **Not Done** option when the exam is not performed.

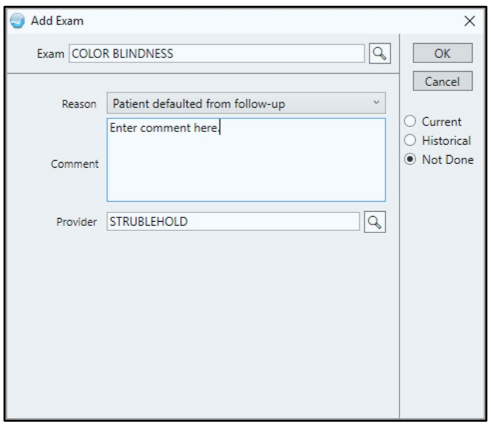


Figure 4-13: Exam Not Done dialog

2. In **Reason**, select the reason for the exam was not performed from the drop-down list.
3. In **Comment**, type a comment regarding the exam not being done (if applicable). This field has a right-click menu to aid in editing the text.
   - If the provider of the exam is different from what is displayed in the **Provider** field, click the **Search** button ( ) to display the **Lookup Utility** where users can select another provider. Refer to Section 4.2.5 for more information.
4. Complete the **Document an Exam** dialog. Refer to Section 4.2.4 for details.

4.2.4 Completing the Document and Exam Dialog

After all fields have been completed, click **OK** to add the exam to the Exams panel. (Otherwise, click **Cancel**.)

- After clicking **OK** on the **Current** or **Historical** dialogs, the record, including any associated SNOMED CT or LOINC, is added to the Exams component.

- After clicking **OK** on the **Not Done** dialog, the record, including any SNOMED CT or LOINC, is added to the Exams component, as well as to the Personal Health History component.

4.2.5 Using the Lookup Utility Dialog for Provider

Access the **Lookup** utility by clicking the **Search** button ( ) at the end of the **Provider** field. Use this dialog to search for and select a name for the **Provider** field.

Follow these steps to complete the **Lookup Utility** dialog (Figure 4-14) for Provider.

1. Type a few characters in the **Search Value** field and click **Search**.

   The appropriate names display in the lower panel of the dialog. If this is not the data the user is searching for, Step 1 should be repeated.

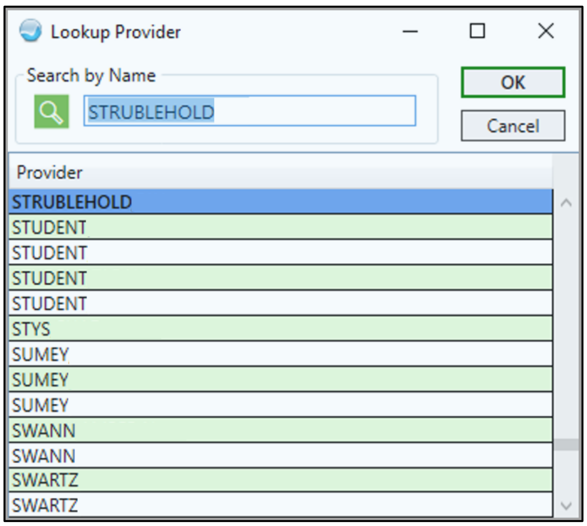


Figure 4-14: Lookup Provider dialog after search

2. Highlight the appropriate **name** in the lower panel and click **OK**. The selected record populates the **Provider** field. (Otherwise, click **Cancel**.)

4.2.6 Using the Lookup Utility Dialog for Location

Access the **Lookup** utility by clicking the **Search** button ( ) at the end of the **Location** field. Use this dialog to search for and select a location for the **Location** field.

Follow these steps to complete the **Lookup Location** dialog (Figure 4-15) for **Location**.

1. Scroll the list to the **location** and select it. Or search for a new location.

2. To search for a **location**, type of few characters in the **Search Value** field and click **Search**.

   The appropriate locations display in the lower part of the dialog. If this is not the location searched for, repeat Step 2.

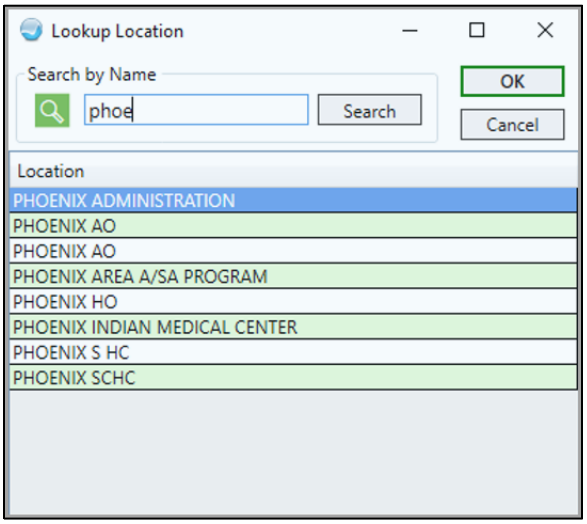


Figure 4-15: Lookup Location dialog after search

3. Highlight the appropriate **location** in the lower panel and click **OK**. The selected record populates the **Location** field. (Otherwise, click **Cancel**.)

4.3 Editing an Exam

An exam can only be edited until the visit attached to it is locked. At that time, the **Edit** option is grayed out and not selectable.

Users can edit a selected exam by clicking the **Edit** button (or by selecting the **Edit Patient Exam** option on the right-click menu).

The **Document an Exam** dialog displays, with the option selected (users cannot change) and the fields populated with data entered during the **Adding an Exam** process.

1. Edit any of the **fields** on the dialog. Refer to Section 4.2 for more information about the fields.

2. After all fields have been edited, click **OK**. (Otherwise, click **Cancel**.)

4.4 Deleting an Exam

Exams can only be deleted while the visit is unlocked. After that date, the **Delete** option is not selectable.

1. Click the **Delete** button (or select the **Delete Patient Exam** option on the right-click menu) to display the Remove Patient Exam? information message (Figure 4-16).

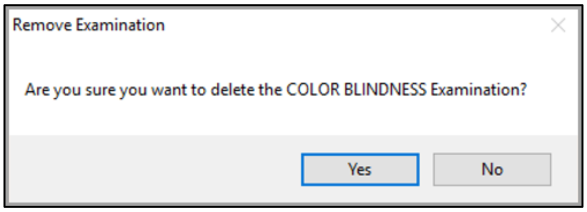


Figure 4-16: Remove patient exam information message

2. Click **Yes** to have the selected exam deleted from the Exam component. (Otherwise, click **No**.)

Clicking **Yes** removes the record from the Exam component. This also removes it from the Personal Health History component. (The reverse is also true.)

5.0 Skin Test

The Skin Test History component (Figure 5-1) contains a history of the patient's skin tests. The **Add**, **Edit**, and **Delete** buttons are only active when the appropriate process can be executed based upon the applicable user permission and/or visit selection.

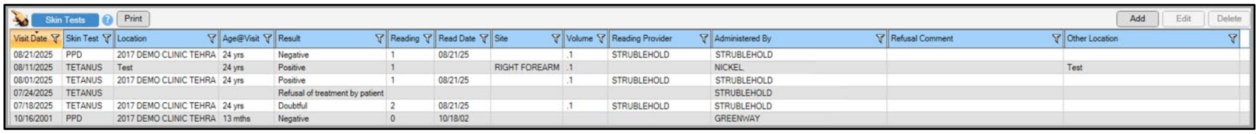


Figure 5-1: Skin Test history panel

The Skin Test History component has the **Display Visit Detail** option on the right-click menu. Select a **record** and then select that option and the **Visit Detail** dialog displays. Refer to Section 5.7 for more information.

After selecting a record, click **Print Record** to display the Official Immunization Record Letter.

5.1 Customizing the Exam Display

The module allows users or sites to customize the Skin Test table to improve usability. All changes will persist for a user but will not affect other users and can be removed later if desired without loss of data.

When the user hovers the mouse pointer over the **Question Mark** icon (), (Figure 5-2) to the right of **Skin Tests** label, a tooltip explains some of the user preferences that can be done such as show/hide columns and group by.

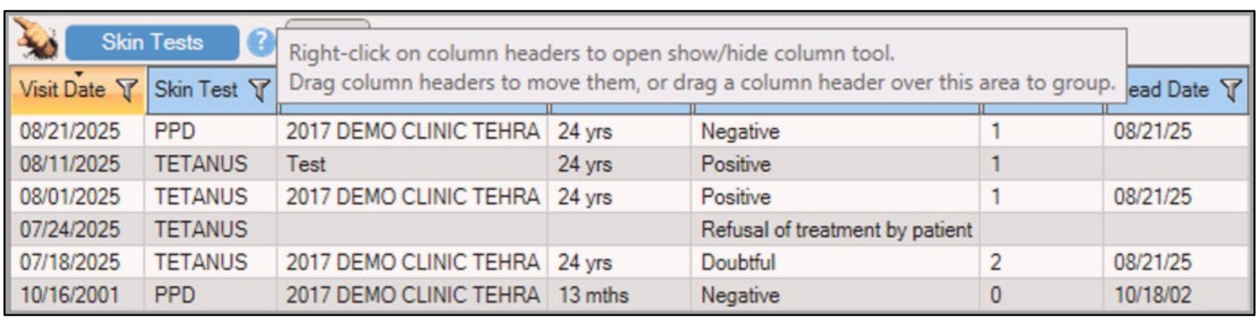


Figure 5-2: Question Mark tool tip

5.1.1 Columns

The component displays 13 columns initially in the Skin Test table. Some users may need to see all 13, but others may determine that not all columns are needed for their use. Columns can be hidden if desired, but the data is NOT removed, and this will not affect the display for any other users.

- To hide a column right-click any column header. Be aware that left-clicking a column sorts it. Right-click displays the list of all the columns that can be hidden.

Note: Some columns, such as Visit Date and Skin Test, do not appear on this list and cannot be hidden.

- All columns that are selected (with check marks) will display (Figure 5-3). If a user does not want to see a particular column, such as Location or Refusal Comment, clear that check box and the column no longer displays in the user's personal EHR view. This setting will persist for future logins for that provider. Any of these check boxes can be cleared.

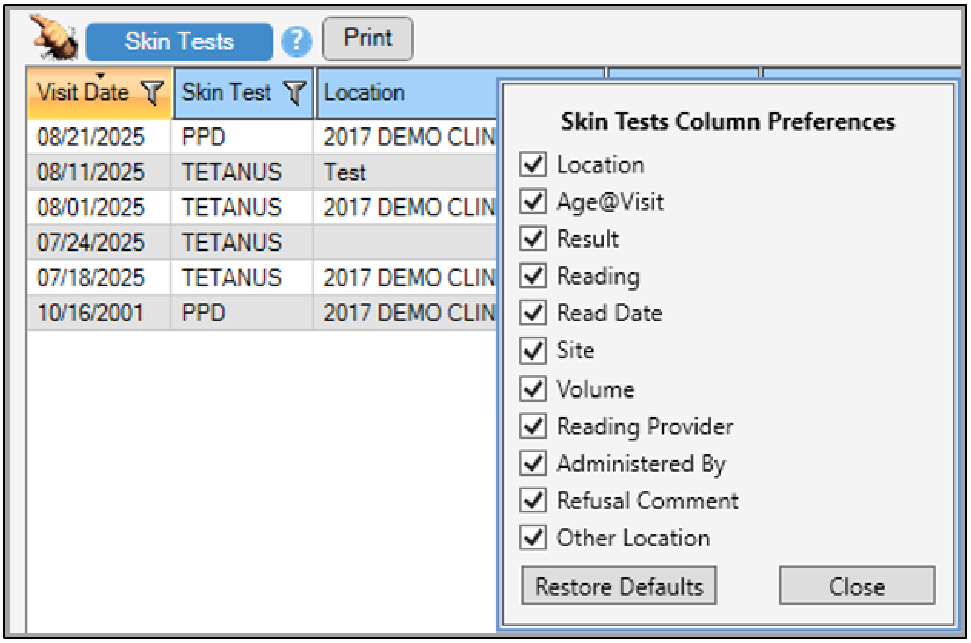


Figure 5-3: Columns selected (check marks) example

Note: To restore the original columns, click **Restore Defaults**.

- Hiding some columns may improve the display for the user, as in Figure 5-3.

5.1.2 Sorting and Filtering

Each column can be sorted in multiple ways.

- Left clicking sorts the column ascending.
- Left clicking again reverses that sort to descending.
- Left-clicking a third time returns the column to its original order.

Clicking the **Funnel** icon ( ) at the top of any column displays a check-box list of all items in the column (Figure 5-4). A check box can be selected so only those data display.

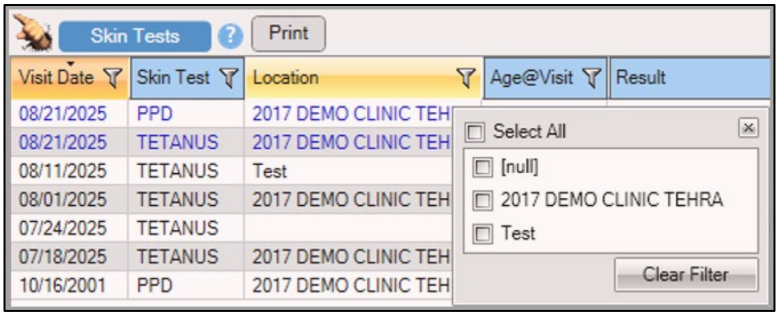


Figure 5-4: Filtering data

The **Funnel** icon turns color ( ) to show that a filter is enabled (Figure 5-5).

Figure 5-5: Selecting a single date to display

The user may clear the filter on any column by clicking the **Funnel** icon ( ) and clicking the **Clear Filter** button.

5.1.3 Group By

By left-clicking any column header (Figure 5-6) and dragging the column up into the Exam label area, a message displays:

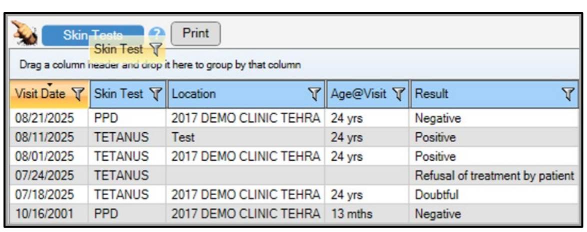


Figure 5-6: Drag a header here and drop it to group by that column

The user releases the left-click and the Skin Test table is now grouped by that column (Figure 5-7), already expanded with the data rows. This can be done for multiple columns. Clicking the **X** in each item will remove it from the grouping.

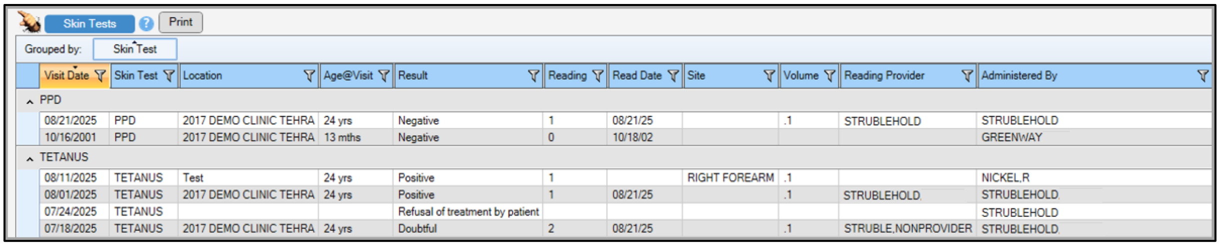


Figure 5-7: Skin Test Grouped window

5.1.4 Rearranging Columns

Columns can be rearranged for a particular user (Figure 5-8). A user may want to move Skin Test information to the far left and display dates on the right. To do this, simply grab the column by left-clicking, and drag into the desired location. Again, this does not affect the display for any other users.

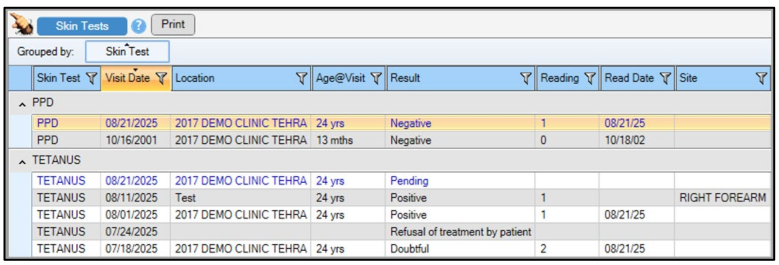


Figure 5-8: Columns rearranged example

5.2 Adding a Skin Test

In order to add a Skin Test record, users must be assigned either the **PROVIDER** key or the **BIZ EDIT PATIENTS** key and cannot hold the **BGO VIEW ONLY** key.

Make sure that a visit is selected. Follow these steps to add a skin test for the current patient:

1. Click the **Add** button in the Skin Test History panel or select **Add Skin Test** on the right-click menu to display the **Lookup Skin Test** dialog (Figure 5-9).

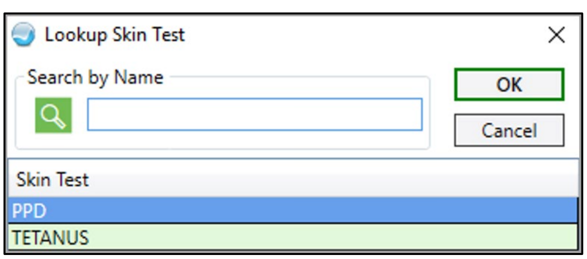


Figure 5-9: Lookup Skin Test dialog

2. In **Search Value**, type the first few characters of the skin test the user is looking for and then click **Search**.

3. Click to select a **skin test** from the **Skin Test** list, and then click **OK**. The **Add Skin Test** dialog (Figure 5-10) opens.

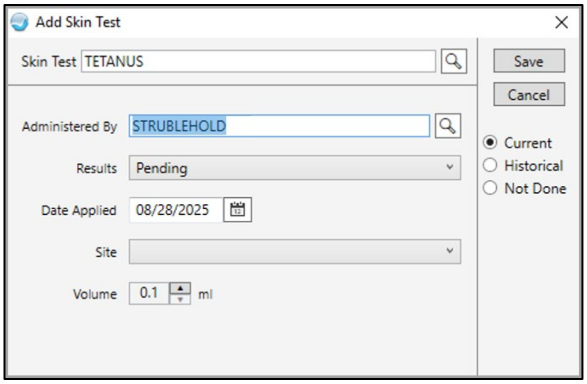


Figure 5-10: Add Skin Test dialog

- The **Skin Test** field can be changed, if needed, by clicking the **Search** button ( ) to open the **Lookup Skin Test** dialog.
- The **Administer By** field default is the current user. Users can change this field by clicking the **Search** button ( ) to display the **Lookup Provider** dialog to select a name. Refer to Section 5.9 for more information.
- Enter **Results** using the drop-down options.

Note:	The default result is Pending when making a Current skin test entry. (The default for a Historical skin test entry is blank) If users do not enter a result value, the result of Pending is initially recorded until the final results are entered. Results can be recorded up to 48 to 72 hours following the initial entry of the skin test, regardless of the visit lock status.

- The **Date Applied** field defaults to the current date. Users can change this date by clicking the **Calendar** button ( ) and selecting another date from the calendar.

4. In the **Site** drop-down menu, select the site of the skin test placement, as applicable.

5. In **Volume**, type the volume of the injection, in ml.

> **Note:** The **Reading**, **Date Read**, and **Reading Provider** fields only appear when a result other than Pending is selected in the **Results** field.

6. In **Reading**, type a number (in mm), or use the **Up** and **Down** arrows to select one.
    - The **Date Read** field defaults to the current date. Users can change this date by clicking the **Calendar** button ( ) and selecting another date from the calendar.
    - The **Reading Provider** field defaults to the logged in user. Click the **Search** button ( ) to open the **Lookup Provider** dialog to search for and select a provider. Refer to Section 5.9 for more information.
7. When the **Add Skin Test** dialog is complete, click **Save**. (Otherwise, click **Cancel**.)

5.3 Adding a Historical Skin Test

When a historical skin test is added, it results in the creation of a historic visit that cannot be billed or exported.

Historical skin tests are added on the **Add Skin Test** dialog by selecting the **Historical** option to display the **Add Historical Skin Test** dialog (Figure 5-11).

A historical skin test record can also be added by not selecting a visit, and then clicking **Add** to display the **Add Historical Skin Test** dialog (with the **Historical** option selected).

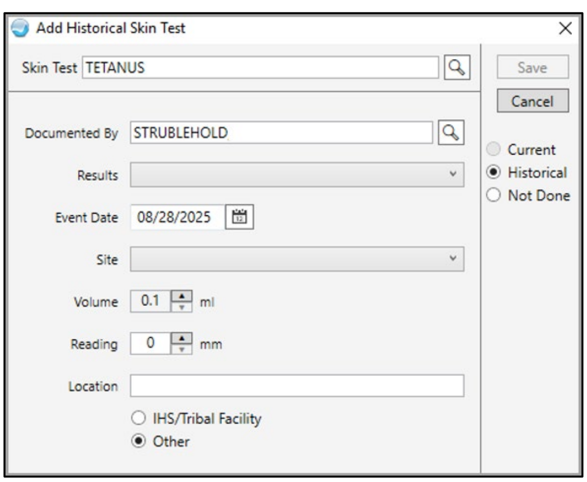


Figure 5-11: Add Historical Skin Test dialog

If needed, users can change any of the fields. Refer to Section 5.2 for more information about these fields.

The following steps apply to the **Add Historical Skin Test** dialog:

- The default for the Event Date is the current date; this is the date the skin test was applied historically. Users can change this date by clicking the **Calendar** button ( ) and selecting another date from the calendar. This cannot be a future date.
- For locations that are official IHS facilities, select the **IHS/Tribal Facility** button. Users can select the location using the **Lookup Location** dialog by clicking the **Search** button ( ). If users select **Other**, a facility name can by typed in free text.
  - If the user's site has been configured with a default outside location, type **Other** in the **Location** field. When users display the **View Visit Detail** dialog, the default outside location displays at the **LOC. OF ENCOUNTER** field.
  - If the location is not an official IHS facility, select the **Other** button. Enter the non-official location (for example, Dr. John Doe). This field has a right-click menu to aid in editing the text.
- When the **Add Skin Test** dialog is complete, click **Save**. (Otherwise, click **Cancel**.)

5.4 Editing a Skin Test

To edit a Skin Test record, users must be assigned either the **PROVIDER** key or the **BIZ EDIT PATIENTS** key and cannot hold the **BGO VIEW ONLY** key.

Highlight a skin test to be changed and click **Edit** (or select **Edit Skin Test** on the right-click menu) to display the **Edit Skin Test** dialog, with information about the selected skin test.

Note: The user will not be allowed to Edit a skin test (the Edit button will remain gray) in circumstances such as when the visit is locked and the edit attempt is more than 72 hours after entry.

The fields on the initial **Edit Skin Test** dialog are the same as those on the **Add Skin Test** dialog. Refer to Section 5.2 for more information about these fields.

If the user does enter **Results** (other than **Refused**), the **Edit Skin Test** dialog (Figure 5-12) changes.

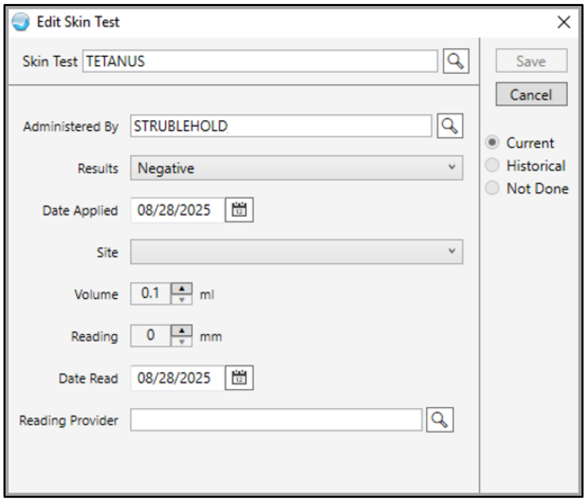


Figure 5-12: Sample Edit Skin Test dialog

The **Reading** field allows only numeric data. Users enter the data by clicking the **Up** and **Down** arrows to increase or decrease the increments by one. This field does not display when **Results** = **No Take**.

Follow these steps to change the results field:

1. Click the **Calendar** button ( ) for the **Date Read** field to select a date, if needed. This cannot be a future date (users cannot select a future date on the calendar for this field).

   Users can select a name for the **Reading Provider** field by clicking the **Search** button ( ) and using the **Lookup Provider** dialog to select a name. This utility works like the **Lookup Utility Dialog** for **Administered By**.

2. Click **Save** to save the data and to change the record on the Skin Test component. (Otherwise, click **Cancel**.)

5.5 Skin Tests Not Done (Refused)

To document the patient refusal for a skin test, follow these steps:

1. Select the **Not Done** option on the **Add Skin Test** dialog. The **Add Skin Test Not Provided/Refused** dialog (Figure 5-13) displays.

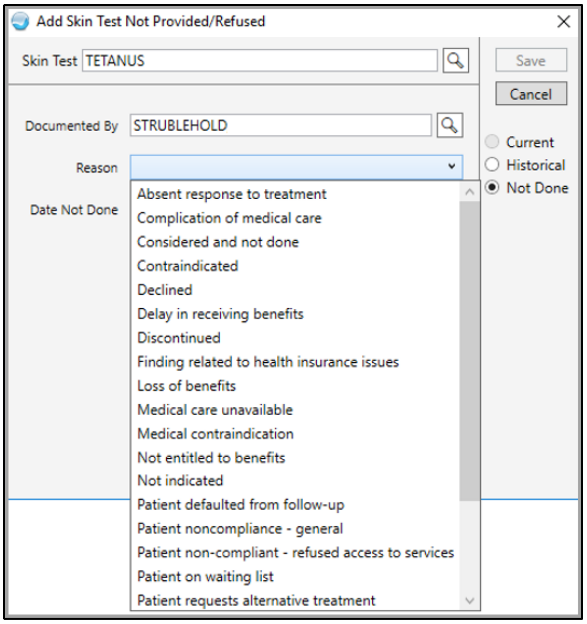


Figure 5-13: Add Skin Test Not Provided / Refused dialog

If needed, change the **Skin Test** and **Documented By** fields. Refer to Section 5.2 for more information about these fields.

2. In **Reason**, select the applicable refusal reason from the drop-down menu.

   The **Date Not Done** defaults to the current date. Users can change this date by clicking the **Calendar** button () and selecting another date. This cannot be a future date (a future date cannot be selected on the calendar for this field).

3. Click **Save**. This adds a skin test record to the Skin Test History component, as well as a refusal **SNOMED CT** code record to the Personal Health History component.

> **Note:** If the user deletes the refused skin test record on the Skin Test History panel, that action also removes it from the Personal Health panel. (The reverse is also true.)

5.6 Deleting a Skin Test

In order to delete a Skin Test record, users must be assigned either the **PROVIDER** key or the **BIZ EDIT PATIENTS** key and cannot hold the **BGO VIEW ONLY** key.

> **Note:** A skin test from a locked visit cannot be deleted, and the Delete button will remain gray.

Follow these steps to delete a skin test for the current patient:

1. Highlight a skin test to delete and click **Delete** (or select **Delete Skin Test** on the right-click menu) to display the **Remove Skin Test?** information message (Figure 5-14).

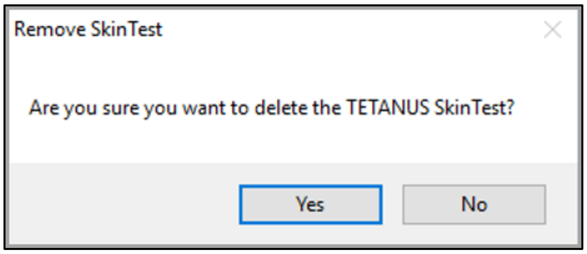


Figure 5-14: Remove Skin Test information message

2. Click **Yes** to remove the selected record. (Otherwise, click **No**.)

Note:	If a refused skin test record on the Skin Test History component is deleted, that action also removes it from the Personal Health panel. (The reverse is also true.)

5.7 Displaying Visit Detail

The Skin Test History component has a **Display Visit Detail** option on the right-click menu.

1. Select a skin test record, right-click, and then select that option. The **Visit Detail** dialog (Figure 5-15) displays.

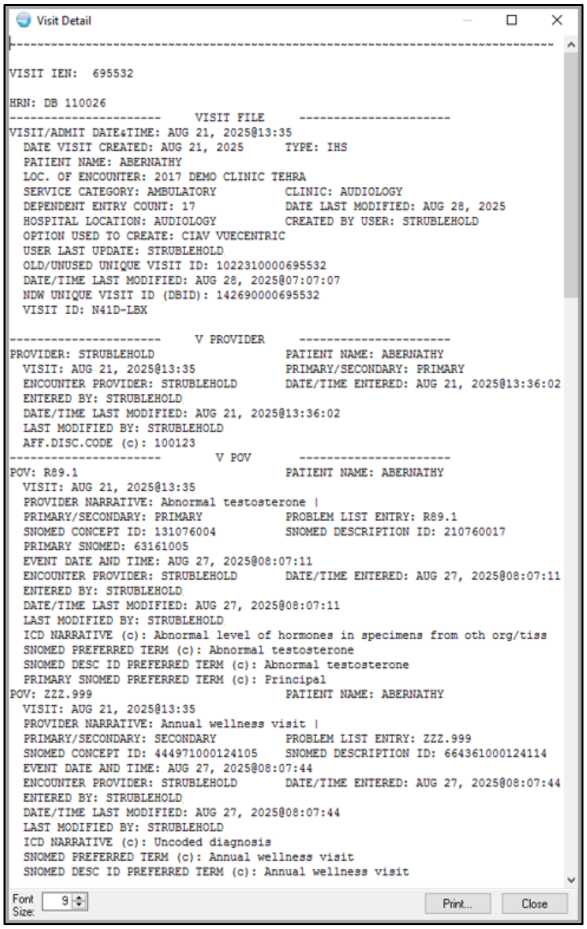


Figure 5-15: Visit Detail dialog example

- If needed, change the font size of the text displayed in this dialog by adjusting the size in the **Font Size** field (enter manually or use the **Up** and **Down** arrows).

Note:	This does not change the size of the text on the output (when printing).

2. Click **Print** to choose a printer and to output the entire contents of the Visit Detail to a specified printer.

   The dialog also has a right-click menu where users can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

3. Click **Close** to dismiss the **Visit Detail** dialog.

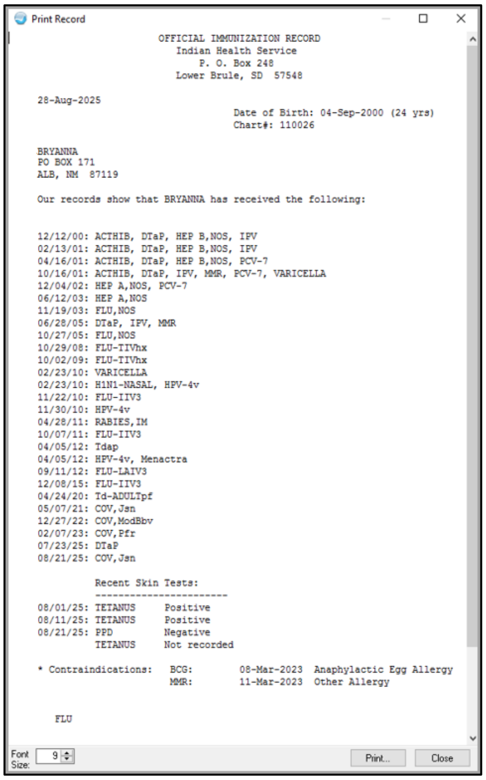
5.8 Using the Print Record Button

To use the **Print Record** button:

1. Click to select a **skin test** record on the Skin Test History panel and then click the **Print** button (Print).

> **Note:** This function requires that a letter template is selected.

The **Print Record** dialog showing the Official Immunization Record (Figure 5-16) displays



OFFICIAL IMMUNIZATION RECORD
Indian Health Service
P. O. Box 248
Lower Brule, SD 57548

28-Aug-2025

Date of Birth: 04-Sep-2000 (24 yrs)
Chart#: 110026

BRYANNA
PO BOX 171
ALB, NM 87119

Our records show that BRYANNA has received the following:

12/12/00: ACTHIB, DTaP, HEP B,NOS, IPV
02/13/01: ACTHIB, DTaP, HEP B,NOS, IPV
04/16/01: ACTHIB, DTaP, HEP B,NOS, PCV-7
10/16/01: ACTHIB, DTaP, IPV, MMR, PCV-7, VARICELLA
12/04/02: HEP A,NOS, PCV-7
06/12/03: HEP A,NOS
11/19/03: FLU,NOS
06/28/05: DTaP, IPV, MMR
10/27/05: FLU,NOS
10/29/08: FLU-TIVhx
10/02/09: FLU-TIVhx
02/23/10: VARICELLA
02/23/10: H1N1-NASAL, HPV-4v
11/22/10: FLU-IIV3
11/30/10: HPV-4v
04/28/11: RABIES,IM
10/07/11: FLU-IIV3
04/05/12: Tdap
04/05/12: HPV-4v, Menactra
09/11/12: FLU-LAIV3
12/08/15: FLU-IIV3
04/24/20: Td-ADULTpf
05/07/21: COV,Jsn
12/27/22: COV,ModBbv
02/07/23: COV,Pfr
07/23/25: DTaP
08/21/25: COV,Jsn

Recent Skin Tests:

08/01/25: TETANUS Positive
08/11/25: TETANUS Positive
08/21/25: PPD Negative
TETANUS Not recorded

* Contraindications: BCG: 08-Mar-2023 Anaphylactic Egg Allergy
MMR: 11-Mar-2023 Other Allergy

FLU

Figure 5-16: Official Immunization Record letter

- If needed, the font size of the text displayed can be changed in this dialog by adjusting the size in the **Font Size** field (enter manually or use the **Up** and **Down** arrows).

> **Note:** This does not change the size of the text on the output when printing.

2. Click **Print** to choose a printer and to output the (entire) contents of the record to a specified printer.

> **Note:** The dialog has a right-click menu where users can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

3. Click **Close** to dismiss the **Print Record** dialog.

5.9 Using the Lookup Provider Dialog

Use the **Lookup Provider** dialog (Figure 5-17) to search for a provider by clicking the **Search** button ( ) near the **Administered By** or **Reading Provider** field on the Add **Skin Test** or **Edit Skin Test** dialog. The **Lookup Provider** dialog opens.

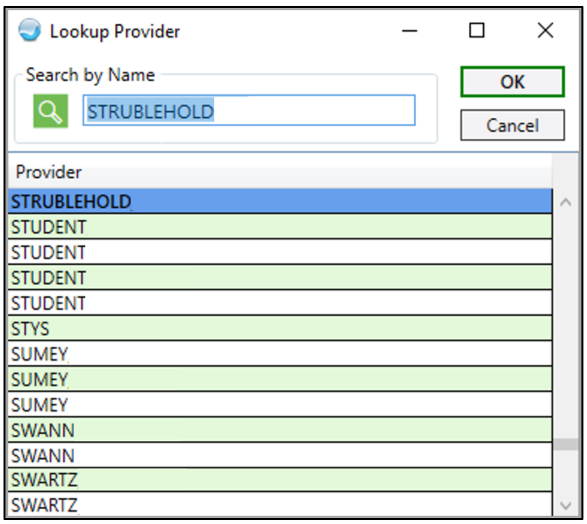


Figure 5-17: Lookup Provider dialog

A list of providers displays in the lower part of the dialog. Users can search for a provider's name by typing a few characters of the provider's last name in the **Search Value** field and then clicking **Search**.

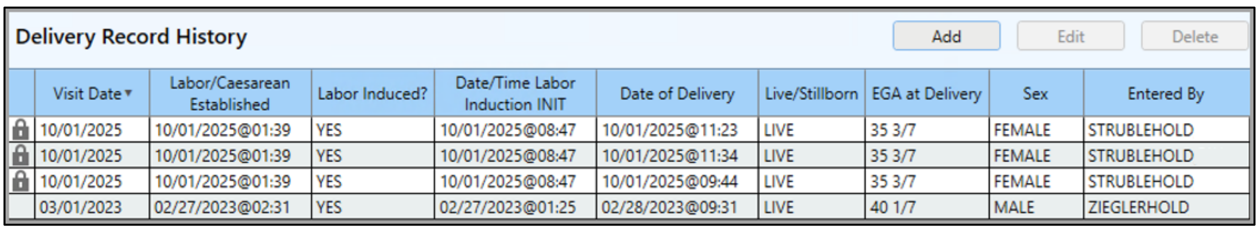
Click to select the **desired name**, and then click **OK**.

6.0 Delivery Record

The Delivery Record component allows the user to document the details of a delivery and the newborn information in one convenient location. This includes information for the mother and the option to record information for the newborn as well.

The component captures items such as the date and time labor was established, labor **SNOMED** code, details of labor induction (if applicable), date and time of delivery, live/stillborn status, estimated gestational age (EGA) at delivery, sex, and multiple births. Users can also associate a newborn once registered, and record measurements including weight, length, APGAR scores, gestational age, delivery type, complications, multiple birth, and birth order. The component records these values in the corresponding **V Delivery** file and in the newborn's **Birth Measurement** file.

The **Delivery Record History** panel (Figure 6-1) displays a table of the patient's Delivery Record History.



Delivery Record History | Add | Edit | Delete

	Visit Date	Labor/Caesarean Established	Labor Induced?	Date/Time Labor Induction INIT	Date of Delivery	Live/Stillborn	EGA at Delivery	Sex	Entered By
🔒	10/01/2025	10/01/2025@01:39	YES	10/01/2025@08:47	10/01/2025@11:23	LIVE	35 3/7	FEMALE	STRUBLEHOLD
🔒	10/01/2025	10/01/2025@01:39	YES	10/01/2025@08:47	10/01/2025@11:34	LIVE	35 3/7	FEMALE	STRUBLEHOLD
🔒	10/01/2025	10/01/2025@01:39	YES	10/01/2025@08:47	10/01/2025@09:44	LIVE	35 3/7	FEMALE	STRUBLEHOLD
	03/01/2023	02/27/2023@02:31	YES	02/27/2023@01:25	02/28/2023@09:31	LIVE	40 1/7	MALE	ZIEGLERHOLD

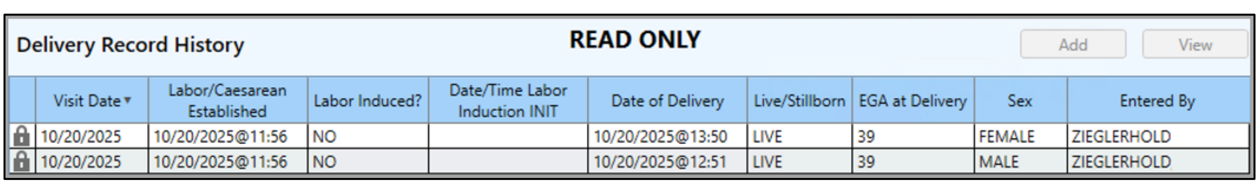
Figure 6-1: Delivery Record History panel

The table contains ten columns:

- **Lock Status**–Indicates if a delivery record is locked (as indicated by the **Lock** icon (🔒) in the row) or unlocked (blank) for editing or deletion. Users cannot edit or delete a delivery record that is locked, and can only view it. Hovering the mouse over the **Lock** icon (🔒) will reveal the reason for the lock.

  The **Lock** icon (🔒) is present under three circumstances:

  – The user has read-only permission with the **BGOZ VIEW ONLY** key as assigned by the Local Informaticist. The **Delivery Record History** table shows READ ONLY (Figure 6-2) at the top. Hovering the mouse over the READ ONLY header reveals the reason.



Delivery Record History | READ ONLY | Add | View

	Visit Date	Labor/Caesarean Established	Labor Induced?	Date/Time Labor Induction INIT	Date of Delivery	Live/Stillborn	EGA at Delivery	Sex	Entered By
🔒	10/20/2025	10/20/2025@11:56	NO		10/20/2025@13:50	LIVE	39	FEMALE	ZIEGLERHOLD
🔒	10/20/2025	10/20/2025@11:56	NO		10/20/2025@12:51	LIVE	39	MALE	ZIEGLERHOLD

Figure 6-2: Delivery Record History Read Only table

  - The delivery record was entered by another user. The record can only be edited or deleted by the original user, or by a user who is assigned the **BGOZ DELIVERY SUPPORT** key by the Local Informaticist.
  - The visit has been locked for modification by Health Information Management.
- **Visit Date**–The date of visit when the information was recorded.
- **Labor/Caesarean Established**–The date and time recorded for the start of labor or a caesarean procedure.
- **Labor Induced?**–Indicates status (Yes or No) if labor was induced.
- **Date/Time of Labor Induction INIT**–The date and time for the initiation of labor induction.
- **Date of Delivery**–The date and time recorded for the newborn delivery.
- **Live/Stillborn**–Indicates status at delivery of LIVE or STILLBORN.
- **EGA at Delivery**–Estimated gestational age at delivery in weeks and days.
- **Sex**–Sex determined at birth.
- **Entered By**–The name of the provider that entered the details at that visit.

6.1 Customizing the Delivery Record History Display

The Delivery Record component allows users to customize the history display grid to improve usability. The changes will persist between different patients within the same EHR session but will not persist between logins for a user. The view customized by one user will not affect other users.

6.1.1 Sorting

Each column can be sorted in multiple ways.

- Left-clicking sorts the column ascending.
- Left-clicking again reverses that sort to descending.
- Left-clicking a third time returns the column to its original order.

6.1.2 Rearranging Columns

Columns can be rearranged for a particular user. A user may want to move the EGA at Delivery column information to the far left. To do this, simply grab the column by left-clicking and drag it to the desired location.

This does not affect the display for any other users. The rearranged view will persist from one patient selection to another within the same EHR session but will reset to the default view when logging back in to EHR.

6.1.3 Component, Buttons, and Right-Click Menu Behaviors

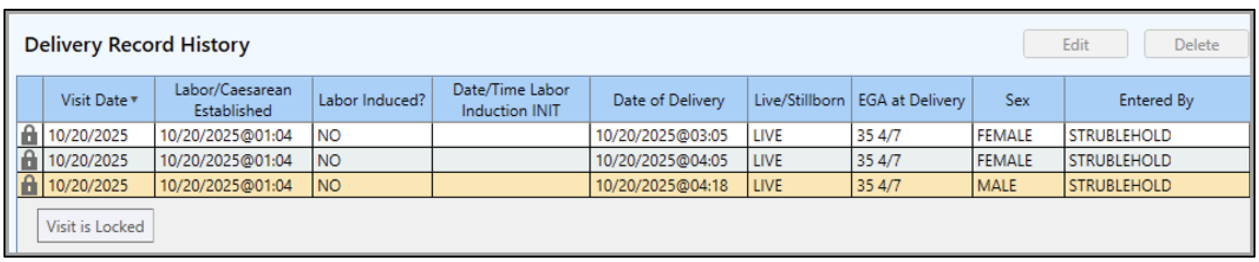
The component availability, buttons, and right-click menu options depend upon the type of patient selected, and the selection of a visit. Buttons that appear on the top of the component are also available in a right-click menu from anywhere within the component window.

- **Delivery Record Component**–Is disabled with the selection of a male patient or a female patient less than 8-years old. The component will display the following message:

  Delivery Record component is disabled. Not medically appropriate.

- **Add**–If no visit is selected, the **Add** button is disabled. The right-click menu **Add** option is also disabled. Once an appropriate patient and a visit are selected, the **Add** button is enabled.

- **View**–If a Delivery Record Entry is locked (as indicated by the **Lock** icon ( ) in the row), clicking in that row will enable a **View** button, but the **Delete** button remains disabled. The right-click menu **View** option is also enabled. Hovering the mouse pointer over the **Lock** icon ( ) shows the reason for the lock (Figure 6-3).



Delivery Record History

Edit Delete

	Visit Date	Labor/Caesarean Established	Labor Induced?	Date/Time Labor Induction INIT	Date of Delivery	Live/Stillborn	EGA at Delivery	Sex	Entered By
	10/20/2025	10/20/2025@01:04	NO		10/20/2025@03:05	LIVE	35 4/7	FEMALE	STRUBLEHOLD
	10/20/2025	10/20/2025@01:04	NO		10/20/2025@04:05	LIVE	35 4/7	FEMALE	STRUBLEHOLD
	10/20/2025	10/20/2025@01:04	NO		10/20/2025@04:18	LIVE	35 4/7	MALE	STRUBLEHOLD

Visit is Locked

Figure 6-3: Help displaying with mouse pointer hovering over locked icon

- **Edit, Delete and Delete Newborn**–If a delivery-record entry is not locked, clicking in that row will enable the **Edit** and **Delete** buttons in the component. Right-clicking a delivery record entry shows a menu with the **Edit** and **Delete** options, as well as the **Delete Newborn** option (Figure 6-4). The **Delete Newborn** option will be active in the right-click menu if a registered patient/newborn is associated with that delivery record.

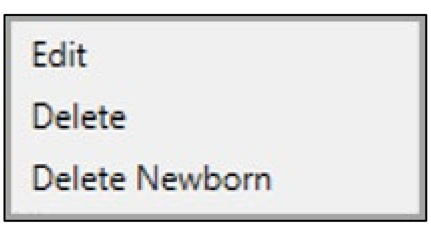


Figure 6-4: Right-click menu showing Edit, Delete, and Delete Newborn options active

- **Edit**–Edits the delivery record and allows editing and adding of the newborn record as well from the **Delivery Record** dialog.
- **Delete**–Deletes all visit related delivery entries including newborn data.
- **Delete Newborn**–Deletes only the newborn data from the delivery entry record.

6.2 Add a Delivery Record

The **Add** function allows the user to enter delivery record information by following these steps.

1. Select an appropriate **patient** and **visit**. The **Add** button will enable once a visit is selected.

Note:	The **Add** button will not appear if a visit is selected that already has a delivery record entry.

2. Click the **Add** button in the Delivery Record component (or select the **Add** option from the right-click menu when clicking anywhere in the component) to display the **Delivery Record** dialog (Figure 6-5).

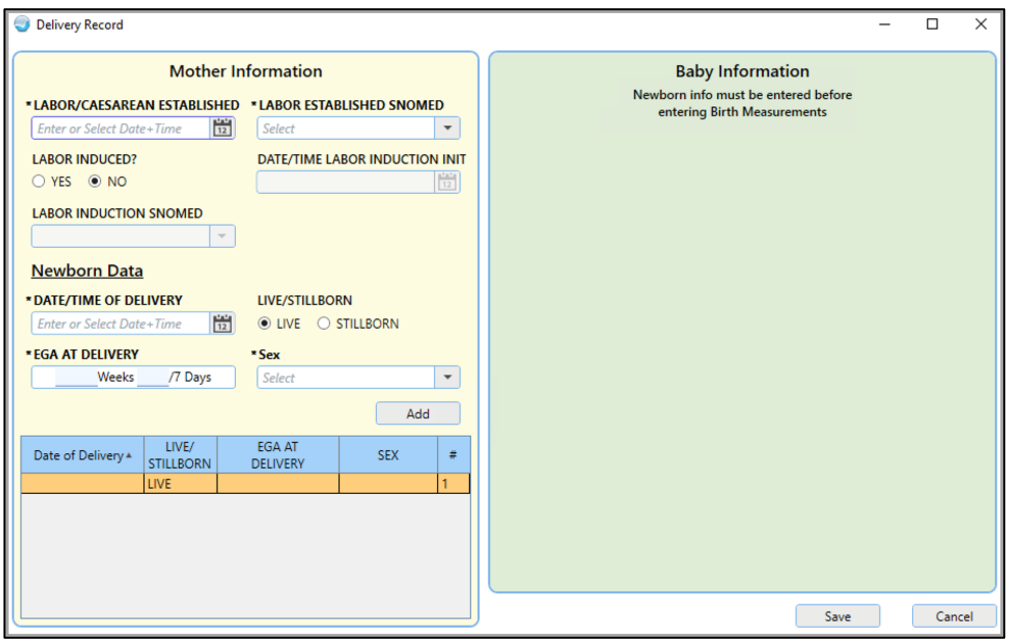


Figure 6-5: Delivery Record dialog

3. Enter the **Mother Information** in that pane:

   a. Enter a date in the **Labor/Caesarean Established** date field manually or by clicking the **Calendar** button ( ) to select from a calendar. It must be a past date.

Note: If there is an error in any of the date fields due to a date issue, or formatting issue, etc., the field will have a red border and a red exclamation mark (**!**) to the right. Hover the mouse over the exclamation mark to display the reason for the conflict in the date field. (See example in Figure 6-6)

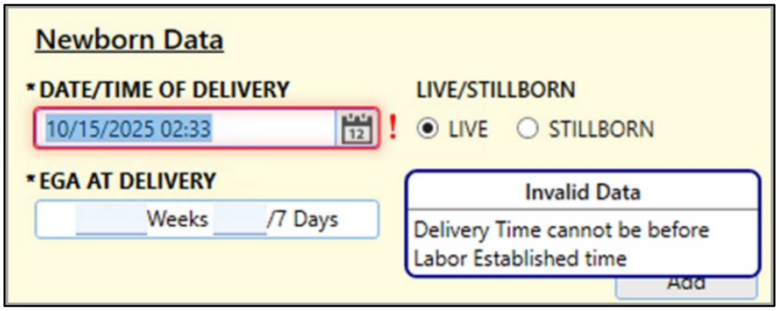


Figure 6-6: Red exclamation mark indicating date field issue example

b. Enter a **Labor Established SNOMED** from the drop-down list.

Note: **Labor/Caesarean Established** and **Labor Established SNOMED** are the minimum required fields to save a record. Once these two fields are entered, the **Save** button will be enabled.

c. Click **Save** or continue entering additional information.

d. In **Labor Induced?**, select the **Yes** or **No** option button. If the **Yes** option is selected:

   i. Enter a **date** in the **Date/Time Labor Induction Init** manually or by clicking the **Calendar** button () to select from a calendar. It must be a past date.

   ii. Enter a **Labor Induction SNOMED** from the drop-down list.

Note: Users are not required to enter newborn information in the **Newborn Data** area of the **Mother Information** pane. To add information, refer to Section 6.2.1.

6.2.1 Newborn Data

Users are not required to enter newborn information in the **Newborn Data** field of the **Mother Information** pane. If information is added, follow these steps.

1. Enter a **date** in the **Date/Time of Delivery** field manually or by clicking the **Calendar** button () to select from a calendar. It must be a past date.

> **Note:** The Date/Time of Delivery cannot be before the date entered in the **Labor/Caesarean Established** field.
>
> Once a **Date/Time of Delivery** is entered, the EGA at **Delivery** and **Sex** fields are mandatory in order to save the record.

2. Enter the **EGA at Delivery** value in weeks and days.
3. Select the **Sex** of the newborn from the drop-down list.

> **Note:** Once the three mandatory fields in **Newborn Data** are entered, the **Baby Information** pane is enabled with the option to associate a registered newborn.

4. In **Live/Stillborn**, select the **Live** or **Stillborn** option button.
5. In the case of multiple births, click the **Add** button. The newborn data is set, the fields are cleared, and another row is added to the table in the dialog. The user must enter the required fields. Once complete, click **Add** to document any additional births.
6. Click **Save** to save the delivery record or proceed to the **Baby Information** pane to associate a registered newborn with the delivery.

6.2.2 Baby Information

1. Enter **Baby Information** in the pane:
   - The **Baby Information** pane is only enabled once **Newborn Data** is entered in the **Mother Information** pane.
   - Data that is entered and saved in the **Baby Information** pane also displays in the Personal Health History component, Birth Measurements form of the newborn's chart in EHR.
   - If multiple births occurred, highlight the corresponding row in the table within the **Mother Information** pane before searching the **Newborn** name. Clicking the **Add** button in the **Mother Information** pane sets the baby information and creates a new newborn record row in the table.
2. Search for a newborn by clicking in the **Find Patient** field or on the **Search** button ().

Note:	The **Search** field will show a watermark of the Date of Delivery entered in **Mother Information**. The list will populate with any registered patients that share the same date of birth as the Date of Delivery. Otherwise, type the patient's last name and the results will populate with a list that narrows as the user types.

3. Click the **patient name** to select. The search window closes and the **Baby Information** pane displays measurement fields for entry.

   a. Enter **Birth Weight**. This can either be entered in the **Pounds** and **Ounces** fields, or in the **Grams** or **Kilograms** fields.

Note:	The system will convert pounds/ounces to grams (or kg) and vice versa.

   b. Enter **Apgar 1 Minute** and **Apgar 5 Minute** drop-down list between **0** and **10**.

   c. Enter **Birth Length**. The default measurement is inches. To enter in centimeters, enter a **C** followed by the measurement in centimeters.

   - For **inches**: Enter a number between **6** and **30**.
   - For **centimeters**: Enter a number between **16** and **76** (proceeded by a **C**).

   d. **Gestational Age Wks** defaults to the value entered in the **Mother Information** pane (unless a value has already been recorded in the newborn's **Birth Measurement** file). Enter a numeric value between **12** and **50**.

Note:	The user should confirm that the **Gestational Age Wks** located in the **Baby Information** pane matches the **EGA at Delivery** field in the **Mother Information** pane. The system will identify any conflicting information in these values and prompt the user (Figure 6-7) if they want to proceed when attempting to save.

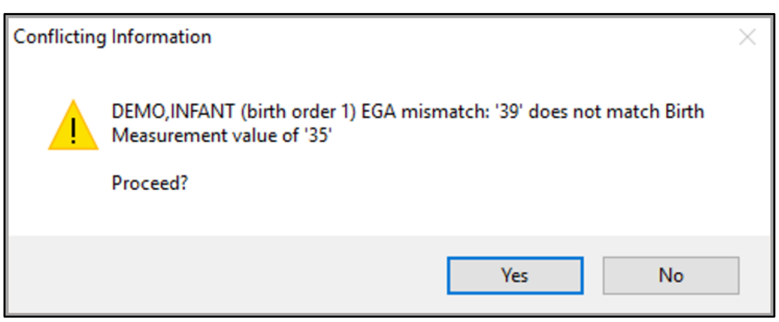


Figure 6-7: Conflicting Information warning message

e. Select the **Delivery Type** using the drop-down menu options. Selecting **Other** will open a mandatory free-text box with a 20-character limit.

f. Enter **Complications** as an optional free-text field with a 20-character limit.

g. If **Multiple Birth**, select **Yes**. The **Birth order** field will then be presented and can then be entered manually or using the arrows.

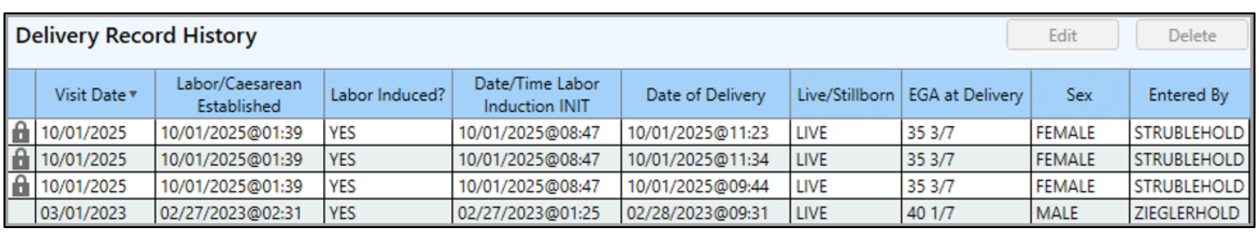
> **Note:** The **Multiple Birth?** option button will be checked **Yes** if multiple births were entered in the **Mother Information** pane.

h. Click **Save** to save the **Delivery Record**. (Otherwise, click cancel.) When saved, the table in the **Delivery Record History** is updated with a row (or rows, in the event of multiple births) reflecting the data entered.

6.3 Edit a Delivery Record

The **Edit** function allows the user to modify delivery record information.

> **Note:** A delivery record cannot be edited if it is locked as indicated by the **Lock** icon () in the record row.
>
> Hovering the mouse over the **Lock** icon () will reveal the reason for the lock. A delivery record will be locked in three circumstances:
>
> The user has Read Only permission.
>
> The delivery record was entered by another user (another user may edit only if they hold the **BGOZ DELIVERY SUPPORT** key assigned by the Local Informaticist.)
>
> The visit has been locked for modification by Health Information Management.



Delivery Record History

Edit Delete

	Visit Date	Labor/Caesarean Established	Labor Induced?	Date/Time Labor Induction INIT	Date of Delivery	Live/Stillborn	EGA at Delivery	Sex	Entered By
	10/01/2025	10/01/2025@01:39	YES	10/01/2025@08:47	10/01/2025@11:23	LIVE	35 3/7	FEMALE	STRUBLEHOLD
	10/01/2025	10/01/2025@01:39	YES	10/01/2025@08:47	10/01/2025@11:34	LIVE	35 3/7	FEMALE	STRUBLEHOLD
	10/01/2025	10/01/2025@01:39	YES	10/01/2025@08:47	10/01/2025@09:44	LIVE	35 3/7	FEMALE	STRUBLEHOLD
	03/01/2023	02/27/2023@02:31	YES	02/27/2023@01:25	02/28/2023@09:31	LIVE	40 1/7	MALE	ZIEGLERHOLD

Figure 6-8: Delivery Record History dialog

To edit a delivery record:

1. Select the appropriate **patient**. A visit selection is not necessary in order to edit a delivery record.
2. Click in the row of the record in the **Delivery Record History** table to edit, and either click the **Edit** button in the top-right corner, or right-click in the row and select **Edit**.

   The **Delivery Record** dialog appears. The user can enter or modify any of the existing fields in the **Mother Information** or **Baby Information** panes as detailed in Add a Delivery Record.
3. Once the necessary changes have been made, click the **Save** button.

The **Delivery Record History** table updates with the information entered.

6.4 Delete a Delivery Record

The Delete function allows the user to delete a delivery record.

> **Note:** A delivery record cannot be deleted if it is locked as indicated by the **Lock** icon (🔒) in the record row.
>
> Hovering the mouse over the **Lock** icon (🔒) will reveal the reason for the lock. A Delivery Record will be locked in three circumstances:
>
> The user has Read Only permission.
>
> The delivery record was entered by another user (another user may edit only if they hold the **BGOZ DELIVERY SUPPORT** key assigned by the Local Informaticist.)
>
> The visit has been locked for modification by Health Information Management.

To delete a delivery record:

1. Select the appropriate **patient**. A visit selection is not necessary in order to delete a delivery record.
2. Click in the row of the record in the **Delivery Record History** table to edit, and either click the **Delete** button in the top-right corner, or right-click in the row and select **Delete**.

   The **Reason for deleting delivery record?** dialog (Figure 6-9) displays.

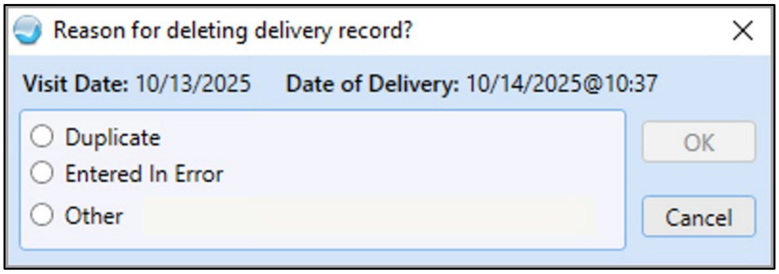


Figure 6-9: Reason for deleting delivery record? dialog

3. Select the option button to justify the reason for deleting the record. Options include:
    - **Duplicate**
    - **Entered in Error**
    - **Other**–If selected, a comment field opens to the right for the user to complete the reason
4. Click **Cancel** to avoid deleting the record, otherwise click **OK**. The dialog will close and the record is deleted from the **Delivery Record History** table.

6.5 Delete a Newborn Associated with a Delivery Record

The newborn and accompanying data associated with a delivery record may be deleted if desired.

> **Note:** A newborn data record cannot be deleted if it is locked as indicated by the **Lock** icon ( ) in the record row.
>
> Hovering the mouse over the **Lock** icon ( ) will reveal the reason for the lock. A Delivery Record will be locked in three circumstances:
>
> The user has Read Only permission.
>
> The delivery record was entered by another user (another user may edit only if they hold the **BGOZ DELIVERY SUPPORT** key assigned by the Local Informaticist.)
>
> The visit has been locked for modification by Health Information Management.

There are two methods to deleting a newborn associated with a delivery record.

6.5.1 Delete Associated Newborn Directly from Delivery Record History Table

1. Select the appropriate **patient**. A visit selection is not necessary in order to delete the newborn associated with a delivery record.

2. Right-click in the row of the delivery record (Figure 6-10) in to reveal the menu with the option to **Delete Newborn**.

> **Note:** In the circumstance of multiple births, each delivery and newborn will be represented as a separate row in the Delivery Record History table.

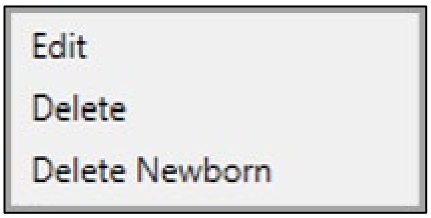


Figure 6-10: Right-Click Menu showing Edit, Delete and Delete Newborn options active

3. Select **Delete Newborn**. A pop-up box (Figure 6-11) prompts confirmation.

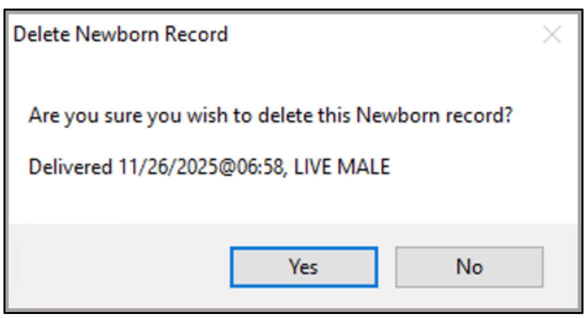


Figure 6-11: Delete Newborn Record dialog

4. Select **Yes** to delete the Newborn record and associated data, otherwise select **No**.

The system removes that newborn and associated data from the delivery record and from the Delivery Record History table.

6.5.2 Delete Newborn Data Within Delivery Record

1. Select the appropriate **patient**. A visit selection is not necessary in order to delete the newborn associated with a delivery record.

2. Click in the row of the record with the newborn data in the **Delivery Record History** table.

> **Note:** In the instance of multiple births, each delivery and newborn will be represented as a separate row in the Delivery Record History table.

3. Either click the **Edit** button in the top-right corner, or right-click in the row and select **Edit**.

   The **Delivery Record** dialog (Figure 6-12) displays.

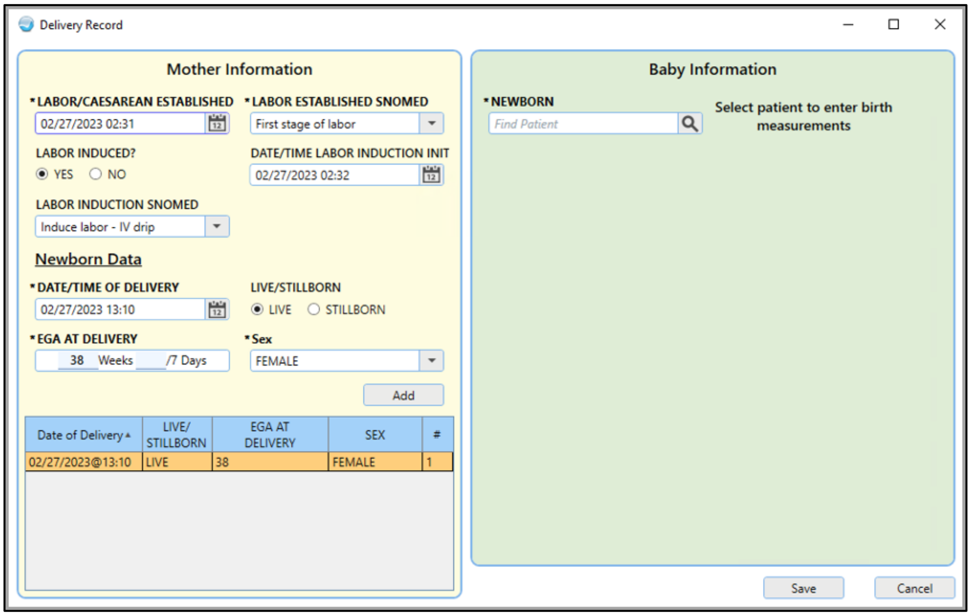


Figure 6-12: Delivery Record dialog with Baby Information

4. Select a **row** in the **Newborn** table located at the bottom of the **Mother Information** pane to highlight the row.

5. Right-click in the row **Newborn Data** and the **Delete** option (Figure 6-13) appears.

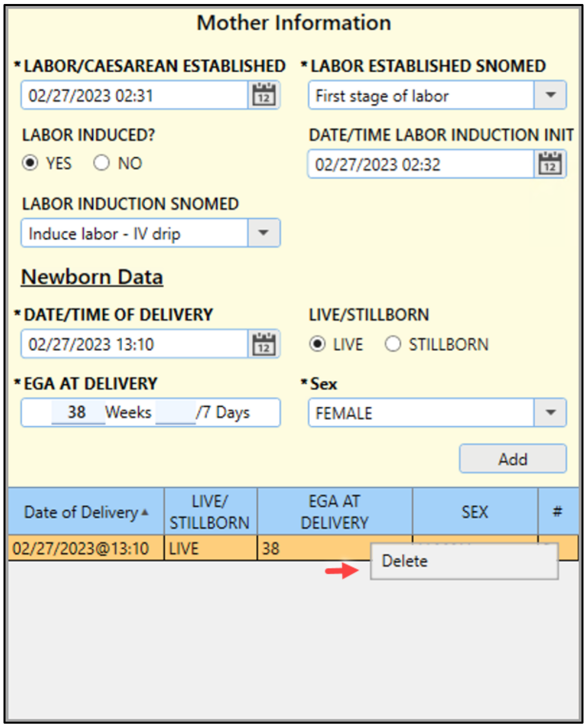


Figure 6-13: Newborn Data delete option

6. Click **Delete** and the system removes the **Newborn Data** record (Figure 6-14) from the table in the **Mother Information** pane.

   The fields in the **Newborn Data** pane are cleared, allowing the user to either re-enter information or click the **Save** button to close the dialog.

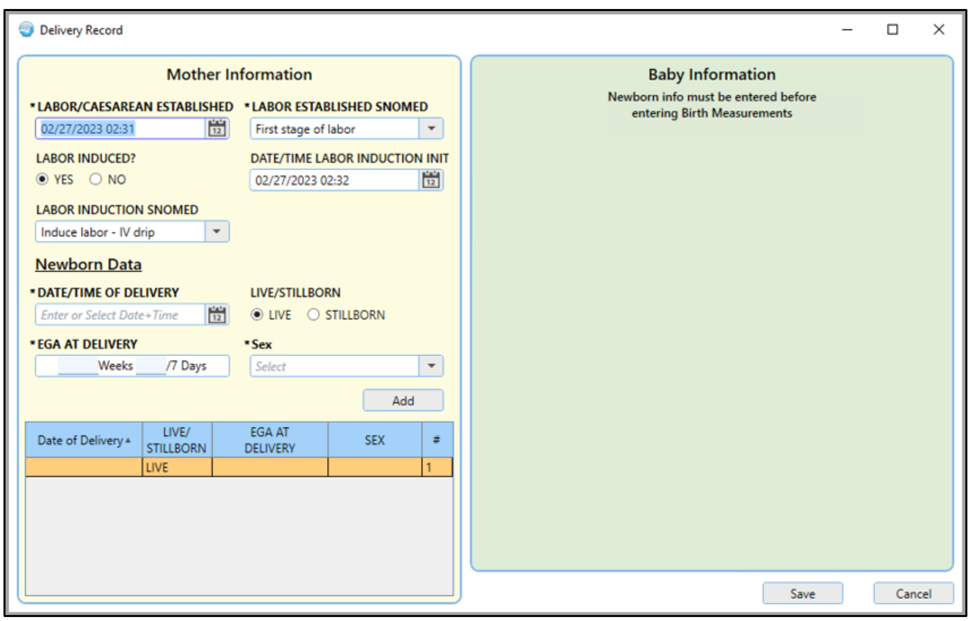


Figure 6-14: Delete removing Newborn Data record information

7. If the user clicks **Save** without re-entering newborn information, the **Delivery Record History** table will be updated with the removal of data values in the fields for **Date of Delivery**, **EGA at Delivery**, and **Sex**.

7.0 Prescription Drug Query (BEHOPDQ)

The Prescription Drug Query (PDQ) component is a tool to allow authorized users to request information from a state prescription drug monitoring program (PDMP) using a PDMP gateway.

State PDMP programs are operated independently by states and follow state rules and regulations related to access considerations and substances reported. As such, end-users should be aware of state program differences.

Information returned from the state PDMP may be viewed, but it will not be stored independently within RPMS or EHR.

When a user requests and reviews PDMP information on a patient, appropriate information will be documented for the purposes of tracking and reporting.

This section will provide clinical informaticists and end users with the information needed to set up and utilize the Prescription Drug Query (PDQ) component of the Resource and Patient Management System (RPMS) Electronic Health Record (EHR).

7.1 System Navigation

The PDQ component has several RPMS site parameters, one menu, and one parameter template used by site managers or clinical informaticists. It also has one EHR component for end users.

7.1.1 Parameters

There are five parameters related to the PDQ component. They are:

- **BEHOPDQ INTERFACE URL**
- **BEHOPDQ INTERFACE PORT**
- **BEHOPDQ INTERFACE USERNAME**
- **BEHOPDQ INTERFACE PASSWORD**
- **BEHOPDQ SSL CONFIGURATION**

The parameters are set at the system level and are best set using the provided menu (refer to Section 7.1.3).

7.1.2 Parameter Template

There is a parameter template to allow a user to set all the needed parameters in one option. The parameter template is named **BEHOPDQ CONFIGURATION**.

7.1.3 RPMS Menus

There is a new PDMP Main Menu (BEHOPDQ MAIN) that is in the RPMS-EHR Configuration Master Menu (BEHOMENU) tree (Figure 7-1). The PDMP menu contains the **PDMP Configuration (BEHOPDQ CONFIGURATION)** and **PDMP Query Report (BEHOPDQ QUERY REPORT)** options.

```
Select RPMS-EHR Configuration Master Menu <TEST ACCOUNT> Option: PDMP  PDMP Main
 Menu

2017 DEMO CLINIC TEHRC        RPMS-EHR Management                    Version 1.1
                                 PDMP Main Menu


   CO     PDMP Configuration
   QR     PDMP Query Report


Select PDMP Main Menu <TEST ACCOUNT> Option:
```

Figure 7-1: PDMP Main Menu within RPMS-EHR Configuration Master Menu tree

7.1.4 EHR Component

The EHR component is named **PDMP Request** Button. It is a button-style component (Figure 7-2) suitable for use in the header area of most EHR template layouts, or any other location desired at the local site. The button label changes depending on factors, such as having a patient selected or having clicked the button. Refer to Section 7.2.2.3 for additional information.

Figure 7-2: Excerpt of EHR template showing PDMP Request Button with label text Request PDMP

7.2 Package Management

The PDMP Request tool is a button style component of the EHR. After the site has gained access to the PDMP Gateway, set up the parameters, and installed the component on the user’s EHR template, authorized users will be able to request PDMP information for a given patient.

7.2.1 Gateway Access

Depending on the selected PDMP gateway vendor, sites or users or both may be required to arrange access directly with the vendor using the vendor's established process. A security certificate for the site may be needed to ensure the tool can communicate with the PDMP gateway. Specific information regarding access will be available during deployment.

7.2.2 Component Set Up

Component set up consists of two parts, parameter configuration in RPMS and the addition of the component to the EHR template or templates of the users who will be using the tool.

7.2.2.1 PDMP Configuration in RPMS

A user with the proper access will need to set the parameters. The patch supplies a menu option to assist in setting the needed parameters.

> **Note:** The parameter settings for any given site may be different from the examples shown here.

To set the PDMP parameters:

1. Log into **RPMS** and navigate to the **RPMS-EHR Configuration Master Menu** option.
2. Select the **PDMP Main Menu** option.
3. Select the **PDMP Configuration** option.

You will be prompted for each parameter in turn.

The **URL/IP** value and, if needed, the username and password will be given to you on deployment.

An example of setting the parameters for a test system (Figure 7-3) is shown below. Some values have been edited and obscured with **X** for security purposes. Set up for a production system will have different values, but the same parameters.

```
Select PDMP Main Menu <TEST ACCOUNT> Option: CO  PDMP Configuration

2017 DEMO CLINIC TEHRC        RPMS-EHR Management                    Version 1.1
                               PDMP Configuration

------- Setting Interface URL/IP  for System: 2017-DEMO-HQ.ABQ.IHS.GOV -------
URL/IP: secure.xxx.xxx  Replace

---- Setting Interface Port Number  for System: 2017-DEMO-HQ.ABQ.IHS.GOV ----
Port Number: 443//
```

```
------ Setting Interface Username  for System: 2017-DEMO-HQ.ABQ.IHS.GOV ------
Username: mtlsxxxprepxxxx  Replace

------ Setting Interface Password  for System: 2017-DEMO-HQ.ABQ.IHS.GOV ------
Password: Q-xxx-#u//

---- Setting SSL Configuration Name  for System: 2017-DEMO-HQ.ABQ.IHS.GOV ----
Name: BEHOPDQ//
Enter RETURN to continue or '^' to exit:

2017 DEMO CLINIC TEHRC        RPMS-EHR Management                   Version 1.1
                              PDMP Configuration


   CO     PDMP Configuration
   QR     PDMP Query Report


Select PDMP Main Menu <TEST ACCOUNT> Option:
```

Figure 7-3: Setting parameters for test system example

7.2.2.2 EHR Component Configuration

Add the component **PDMP Request Button** to your EHR template or templates in the usual manner. The component is a small button designed to be placed in the header area or similar. Once added, there are limited properties (Figure 7-4) for the component.

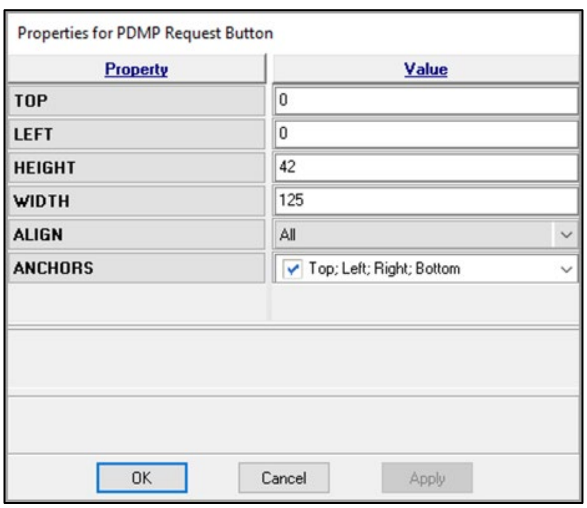


Figure 7-4: Properties window for the PDMP Request Button

7.2.2.3 EHR Component Display

When no patient has been selected in EHR, the component is inactive and displays **No Patient Selected** (Figure 7-5).

Figure 7-5: PDMP Request Button appearance when no patient is selected

When a patient has been selected, the component displays **Request PDMP** (Figure 7-6).

Figure 7-6: PDMP Request Button appearance when patient is selected and system is ready for request

There is tooltip text (Figure 7-7) when you hover the mouse over the component:

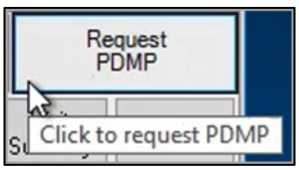


Figure 7-7: Tooltip text when the tool is ready for a request

The button is inactive and displays **Requesting PDMP…** (Figure 7-8) when a request is in progress. There is tooltip text that displays **Waiting for PDMP Response**.

Figure 7-8: PDMP Request Button appearance when request has been initiated

The button pulses blue and displays **View PDMP** when the request has been returned. The hover text displays **Click to open PDMP report** (Figure 7-9).

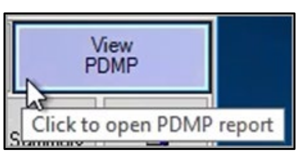


Figure 7-9: PDMP Request Button appearance when a PDMP response has been received

The button pulses blue and displays **Error** when there was a problem with the request. The hover text displays (Figure 7-10).

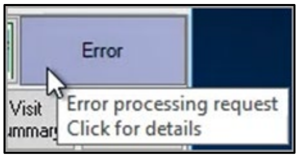


Figure 7-10: PDMP Request Button appearance when error has occurred

Clicking the button in this state displays the specific error to assist in troubleshooting. Some errors will come from the RPMS side (Figure 7-11 and Figure 7-12) if the user is not set up as an authorized user.

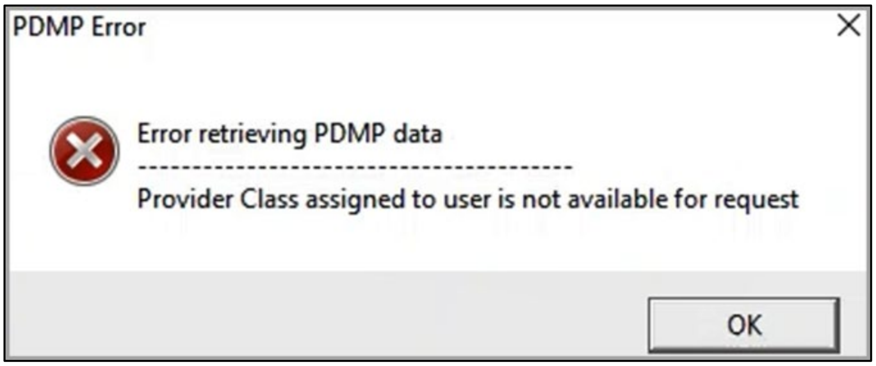


Figure 7-11: PDMP Error window for Provider Class not authorized

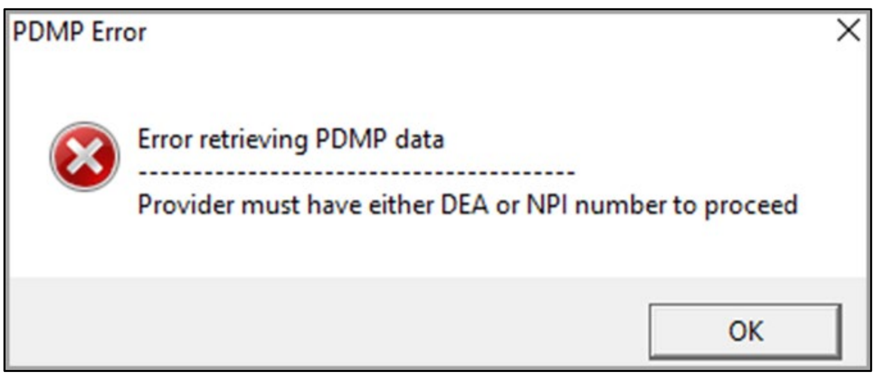


Figure 7-12: PDMP Error window for a provider with no DEA or NPI

Some errors (Figure 7-13) will be passed though from the vendor side and may require corrections outside of RPMS to resolve.

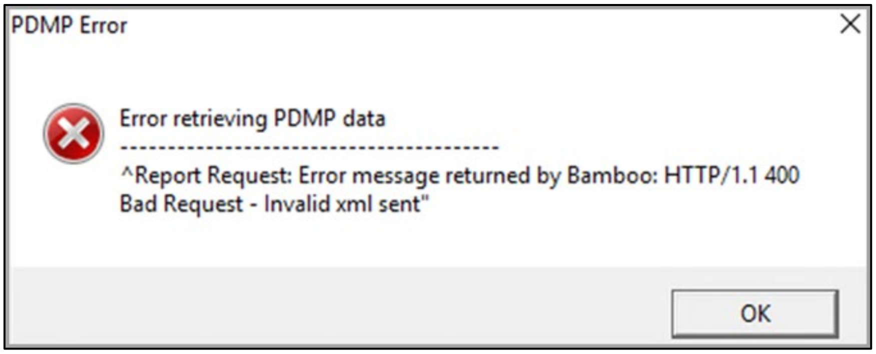


Figure 7-13: PDMP Error window with information from the vendor system

7.2.2.4 Authorized User Set Up

Only authorized users will be able to request and receive the PDMP information. Authorized users include those users registered with a state PDMP, and in general, are prescribers or pharmacists. Delegates of authorized users will not be permitted to request and receive information using this component.

Within RPMS, the request will require the user to have a Provider Class that can be mapped to a gateway vendor role (refer to Section 7.4 for an example list). In addition, the user must have a valid Drug Enforcement Administration (DEA) number or National Provider Identifier (NPI) number or both.

7.3 Package Operation

When a prescriber or pharmacist needs to see information from a state PDMP, they may now request that information from within the EHR if the PDMP Request Tool component was added to their EHR template, and the user is authorized to do so.

Note: Delegates of authorized users will not be permitted to request or receive information using this component.

Prescribers and other users should review the responsibilities around PDMP use as outlined in the Indian Health Manual (IHM) Part 3 Chapter 32. In particular, prescribers should do a self-audit at least quarterly, which can be done both through the state PDMP and in RPMS using the **PDMP Query Report** option (refer to Section 7.3.4).

This section outlines a typical workflow; however, there may be variations in workflow from site to site.

7.3.1 Orientation to the Tool

The tool may be placed anywhere on an EHR template but is designed to sit in the header area. The tool is a button that will display various text depending on if a patient is selected and whether a request has been initiated.

When no patient has been selected in the EHR, the component will be inactive (grayed out) and display **No Patient Selected** (Figure 7-14).

Figure 7-14: PDMP request button with no patient selected

When a patient has been selected, the component displays Request PDMP (Figure 7-15).

Figure 7-15: PDMP request button with patient selected and system ready for request

There is tooltip text (Figure 7-16) when you hover the mouse over the component.

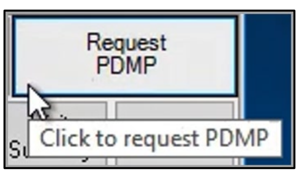


Figure 7-16: Tooltip Text when tool is ready for request

The button is inactive and displays **Requesting PDMP…** when a request is in progress. There is tooltip text (Figure 7-17) that displays **Waiting for PDMP Response**.

Figure 7-17: PDMP request button tooltip text when Request Has Been Initiated

The button pulses blue and displays **View PDMP** when the request has been returned. The tooltip text (Figure 7-18) displays **Click to open PDMP report**.

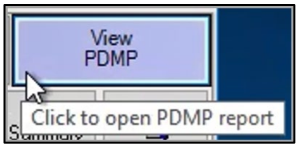


Figure 7-18: PDMP request button when PDMP response has been received

The button pulses blue and displays Error when there was a problem with the request. The tooltip text (Figure 7-19) displays Error processing request Click for details.

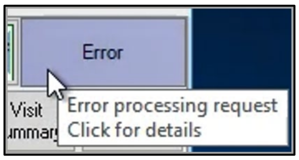


Figure 7-19: PDMP request button when an error has occurred

Clicking the button in this state will display the specific error (Figure 7-20) to assist in troubleshooting. Some errors will come from the RPMS side if the user is not set up as an authorized user.

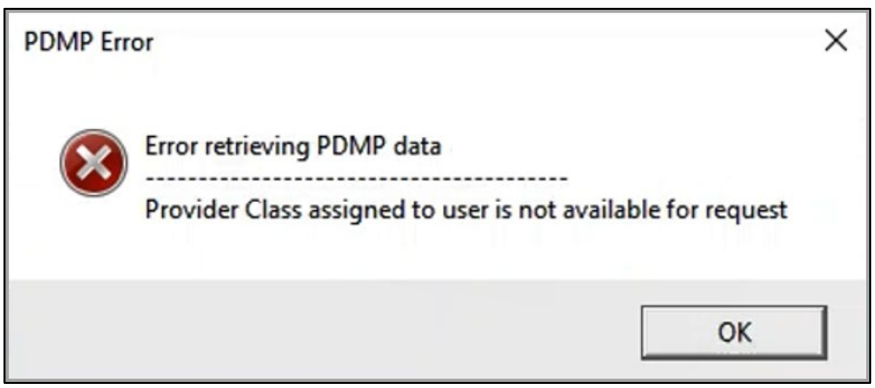


Figure 7-20: PDMP error window for a Provider Class that is not authorized

Some errors will come from the RPMS side (Figure 7-21) if the user is not set up as an authorized user.

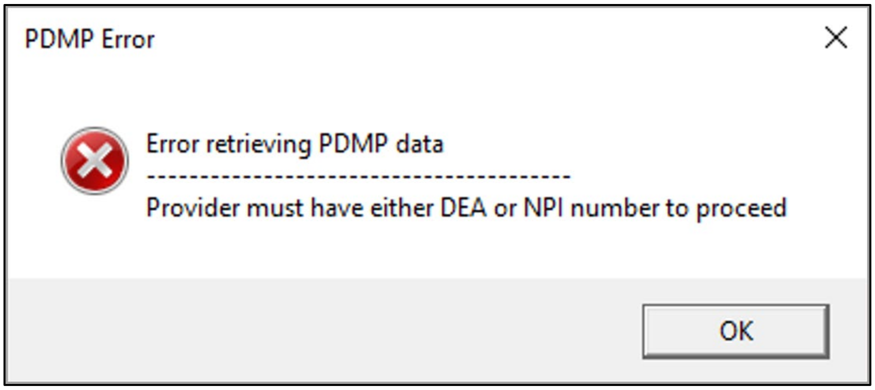


Figure 7-21: PDMP Error window for a provider with no DEA or NPI

Some errors will be passed from the vendor side (Figure 7-22) and may require corrections outside of RPMS to resolve.

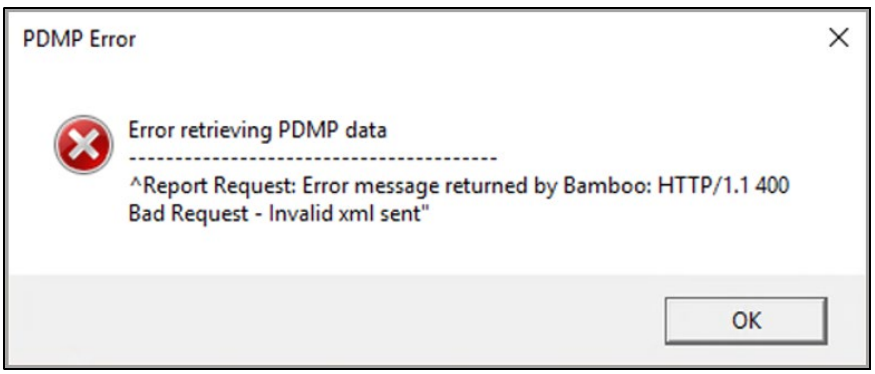


Figure 7-22: PDMP error window with information from the vendor system

7.3.2 Requesting PDMP Information for a Selected Patient

Steps to request information:

1. Log into the **EHR**.
2. Select a **patient** and a **visit**. The patient must have a complete address in RPMS for a successful request.
3. Navigate to the **PDMP Request** component. This is designed to be placed in the header area of an EHR template, but location and size may be customized locally.
4. Click the **Request PDMP** button to send the request. If a visit has not yet been selected, the **Encounter Context for Current Activities** window opens so a visit may be selected or created.
5. When the text changes to **View PDMP**, click the button again to open the PDMP response.

> **Note:** Response content may not be printed, copied, or saved. The report must be opened in order for documentation of PDMP Record Reviewed to be stored in RPMS.

6. Review the **results**. Users may interact with the rest of the patient chart while a PDMP response is open, but the report will close if the patient selected in EHR changes.

7. Close the **results** when finished. Users may not reopen a given PDMP response but may make another request for the same patient if needed.

7.3.3 PDMP Response Content

The content of the response will depend on the vendor being used, the location of the facility requesting from, the state PDMP being queried, and the patient characteristics. Users will usually see a summary section, as well as more detailed information on specific prescriptions, prescribers, and pharmacies being utilized by the patient. Some states may also provide specific risk indicators, graphs, charts, and other content.

7.3.4 Query Auditing

Prescribers should be performing self-audits at least quarterly according to the Indian Health Manual (IHM) Part 3 Chapter 32. These audits should be done with both the state PDMP where available and using the **PDMP Query Report** in RPMS. If a prescriber does not have direct access to this report, they should request a copy from an authorized user as needed.

There is a report in RPMS that will display a summary of requests. The report may be filtered by date range, patient, and requestor. Output will include the date of the request, the patient, the requesting user, and the status (success or failure). There will be subtotals of successful requests and failures, and an overall total number of requests.

Steps to run the report:

1. Log into **RPMS** and navigate to the **BEH–RPMS-EHR Configuration Master Menu** option.

2. Select the **PDMP–PDMP Main Menu** option.

3. Select the **QR–PDMP Query Report** option.

4. Input the desired **start date** at the **Begin with DATE:** prompt.

5. Input the desired **end date** at the **End with DATE:** prompt.

6. Select whether or not to include all **patients**.

7. Select whether or not to include all r**equestors**.
8. Select a **method** to sort the report. Available options include date, patient, requestor, and status.
9. Choose the **output device**.

The report will list the requests from the selected date range, sorted by the selected method. The report will include subtotals for failed and successful requests and the total number of requests for the date range selected. A sample report (Figure 7-23) is shown below.

```
Prescription Drug Query Report                      08/29/2024 14:04  Page: 1
Report Criteria:
  Inclusive Dates: 07/30/2024 to 08/29/2024       Sorted by: Requestor
  Patient: All
  Requestor: All
--------------------------------------------------------------------------------
Date/Time         Patient                       Requesting User        Status
--------------------------------------------------------------------------------
08/20/2024@14:26  DEMO,PATIENT THREE-ONE        DEMO,PROVIDER M        SUCCESS
08/20/2024@15:15  DEMO,PATIENT THREE-ONE        DEMO,PROVIDER M        SUCCESS
08/21/2024@14:17  TESTPATIENT,BETTY             DEMO,PROVIDER M        SUCCESS
08/02/2024@14:27  TESTPATIENT,ALICE             DOCTOR,PAUL            SUCCESS
08/02/2024@14:29  DEMO,PATIENT ACFOUR-EIGHT     DOCTOR,PAUL            SUCCESS
08/19/2024@12:29  TESTPATIENT,ALICE             DOCTOR,PAUL            SUCCESS
08/19/2024@13:04  TESTPATIENT,ALICE             DOCTOR,PAUL            SUCCESS
08/19/2024@13:38  TESTPATIENT,BETTY             DOCTOR,PAUL            SUCCESS
08/19/2024@13:40  TESTPATIENT,BETTY             DOCTOR,PAUL            SUCCESS
08/02/2024@14:31  TESTPATIENT,ALICE             EPCS,PROVIDER N        FAILURE
08/19/2024@13:24  TESTPATIENT,BETTY             EPCS,PROVIDER N        FAILURE
08/19/2024@13:26  TESTPATIENT,BETTY             EPCS,PROVIDER N        FAILURE
08/20/2024@15:17  DEMO,PATIENT ACTHREE-THREE    EPCS,PROVIDER N        FAILURE
08/20/2024@15:17  DEMO,PATIENT ACTHREE-THREE    EPCS,PROVIDER N        FAILURE
08/20/2024@15:20  DEMO,PATIENT ACTHREE-THREE    EPCS,PROVIDER N        FAILURE

--------------------------------
Failed Queries:              6
Successful Queries:          9

Total Queries:              15
End of report.
```

Figure 7-23: Listing the requests from the selected date range

7.4 Gateway Role to Provider Class Mapping

These are examples of the gateway roles and the mapped Provider Class from RPMS (Table 7-1). This list may change with gateway vendor changes or RPMS patches.

The mapping will be automatic based on the assigned Provider Class for the user in RPMS. Provider Class is set using the **Add/Edit Providers** option and should not be confused with User Class or Person Class.

Table 7-1: Gateway Roles and the mapped Provider Class from RPMS examples

Role	Provider Class
Dentist	DENTIST
Naturopathic Physician with prescriptive authority	NATUROPATH PHYSICIAN
Nurse Practitioner	APRN PSYCHIATRIC NURSING SPEC
Nurse Practitioner	NURSE PRACTITIONER
Nurse Practitioner	PEDIATRIC NURSE PRACTITIONER
Optometrist with prescriptive authority	CONTRACT OPTOMETRIST
Optometrist with prescriptive authority	OPTOMETRIST
Pharmacist	CLINICAL PHARMACY SPECIALIST
Pharmacist	PHARMACIST
Pharmacist with prescriptive authority	PHARMACY PRACTITIONERS
Physician	ALLERGIST/IMMUNOLOGIST
Physician	ANESTHESIOLOGIST
Physician	CARDIOLOGIST
Physician	CONTRACT OB/GYN
Physician	CONTRACT PHYSICIAN
Physician	CONTRACT PODIATRIST
Physician	CONTRACT PSYCHIATRIST
Physician	DERMATOLOGIST
Physician	EMERGENCY ROOM PHYSICIAN
Physician	ENDOCRINOLOGIST
Physician	FAMILY PRACTICE
Physician	GASTROENTEROLOGIST
Physician	HEPATOLOGIST
Physician	INTERNAL MEDICINE
Physician	MD
Physician	NEPHROLOGIST
Physician	NEUROLOGIST
Physician	NEUROSURGEON
Physician	OB/GYN
Physician	ONCOLOGIST-HEMATOLOGIST
Physician	OPHTHALMOLOGIST
Physician	ORTHOPEDIST
Physician	OSTEOPATHIC MEDICINE
Physician	OTOLARYNGOL
Physician	PATHOLOGIST

Role	Provider Class
Physician	PEDIATRICIAN
Physician	PLASTIC RECONSTRUCTIVE SURGEON
Physician	PODIATRIST
Physician	PSYCHIATRIST
Physician	PULMONOLOGIST
Physician	RHEUMATOLOGIST
Physician	SPORTS MEDICINE PHYSICIAN
Physician	SURGEON
Physician	TRIBAL PHYSICIAN
Physician	UROLOGIST
Physician assistant with prescriptive authority	PHYSICIAN ASSISTANT
Psychologist with prescriptive authority	CONTRACT PSYCHOLOGIST
Psychologist with prescriptive authority	PSYCHOLOGIST

Glossary

Adverse Reactions/Allergies

The Adverse Reactions panel shows a list of the causative agents associated with the patient’s allergies or adverse reactions. It also displays if the adverse reaction record has been verified or unsigned.

Chief Complaint

The Chief Complaint component is where to enter the description of why the patient is presenting for care for the visit. The component captures these items as symptoms, diagnoses or requests. The component helps healthcare providers focus on the patient’s main concern, streamlining the diagnostic process, prioritizing care, and improving communication among medical teams.

Exams

The Exams panel enables users to add, edit, or delete a patient exam.

Skin Test

The Skin Test History component contains a history of the patient’s skin tests.

Delivery Record

The Delivery Record component allows the user to document the details of a delivery and the newborn information in one convenient location.

PDMP gateway

A system allowing an authorized user to query multiple state PDMP databases at once.

Prescription Drug Monitoring Program

An electronic database that tracks controlled substance prescriptions in a state.

Acronym List

Acronym	Term Meaning
Adverse Reactions/Allergies	Displays a list of the causative agents associated with the patient’s allergies or adverse reactions.
BEHOPDQ	The RPMS namespace for the PDMP Query tool
Chief Complaint	Enables the user to enter the reason the patient is seeking care for the visit.
DEA	Drug Enforcement Administration
Delivery Record	Enables the user to document the details of a delivery and the newborn information in one convenient location.
EHR	Electronic Health Record
Exams	Enables users to add, edit, or delete a patient exam.
ID	Identification
IHM	Indian Health Manual
IHS	Indian Health Service
IP	Internet Protocol
NPI	National Prescriber Identifier
Personal Health History	Enables the user can record data regarding Functional Status, Birth Measurements, Refusal, and Treatment Contract.
PDMP	Prescription Drug Monitoring Program
PDQ	Prescription Drug Query
RPMS	Resource and Patient Management System
Skin Test	Enables users to a history of the patient’s skin tests.
URL	Uniform Resource Locator

Contact Information

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