MEDICAL DOCUMENTATION BASIC WORKFLOW

+ USING THE PSYCH MEDICAL NOTE TEMPLATE

Updated: 11/05/25 (V3)

CalMHSA

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NEED MORE HELP? Live Chat (with a real human) or get 1:1 Support @ **https://2023.calmhsa.org/**

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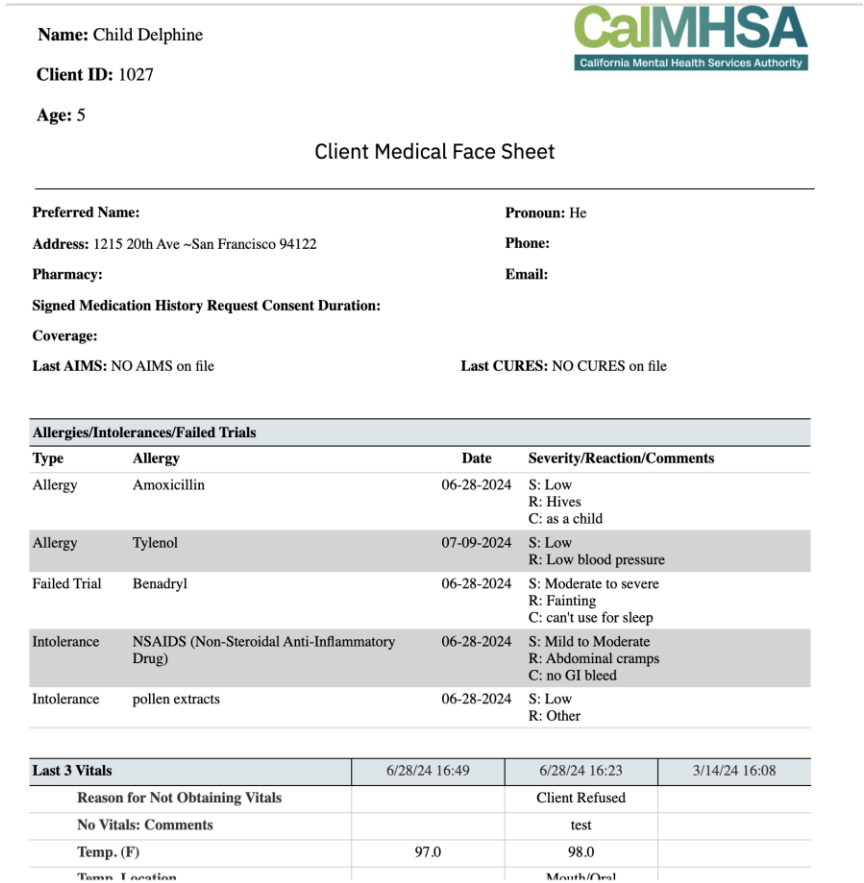
MEDICAL FACESHEETS

- Client Medical Facesheet:
  High level overview of a patient's medical information
- There is also an inpatient-focused facesheet: CalMHSA 113 – Inpatient/CSU Client Face Sheet Report (My Office)



Name: Child Delphine

Client ID: 1027

Age: 5

CalMHSA
California Mental Health Services Authority

Client Medical Face Sheet

Preferred Name: **Pronoun:** He

Address: 1215 20th Ave ~San Francisco 94122 **Phone:**

Pharmacy: **Email:**

Signed Medication History Request Consent Duration:

Coverage:

Last AIMS: NO AIMS on file **Last CURES:** NO CURES on file

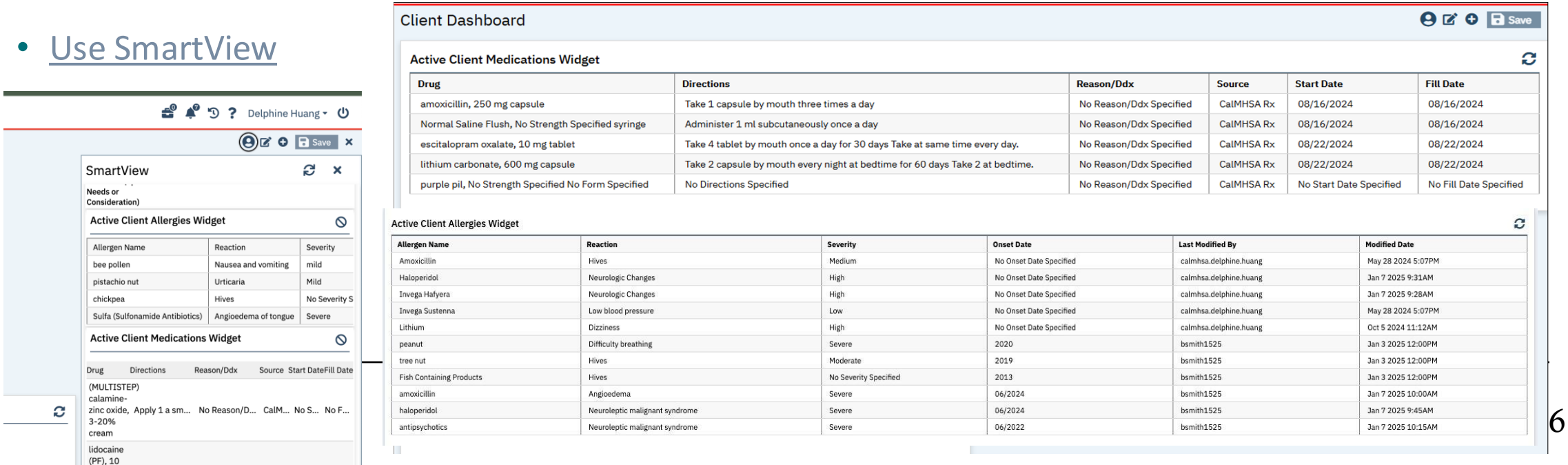
Allergies/Intolerances/Failed Trials

Type	Allergy	Date	Severity/Reaction/Comments
Allergy	Amoxicillin	06-28-2024	S: Low R: Hives C: as a child
Allergy	Tylenol	07-09-2024	S: Low R: Low blood pressure
Failed Trial	Benadryl	06-28-2024	S: Moderate to severe R: Fainting C: can't use for sleep
Intolerance	NSAIDS (Non-Steroidal Anti-Inflammatory Drug)	06-28-2024	S: Mild to Moderate R: Abdominal cramps C: no GI bleed
Intolerance	pollen extracts	06-28-2024	S: Low R: Other

Last 3 Vitals	6/28/24 16:49	6/28/24 16:23	3/14/24 16:08
Reason for Not Obtaining Vitals		Client Refused	
No Vitals: Comments		test	
Temp. (F)	97.0	98.0	
Temp. Location		Mouth/Oral	

MEDICATION/ALLERGY WIDGETS

- Smartcare has other similar widgets CalMHSA has created our own active medication/prescription and allergy widgets. The SmartView allows a right sideview to appear on any client page without having to leave the page.
- How to Add a Widget to Your Dashboard
- Use SmartView



NOTES

Services (Client) List Page and/or Documents (Client) List Page will show services notes and documents, their authors, and their statuses.

How to View Client Documents

Abbreviated Notes Report- compilation of all notes from all clinicians and primarily where people would write their "plans" for a client.

Most of the information in the client abbreviated notes report will NOT pull into the medical / psych note, primarily just the subjective and A/P sections.

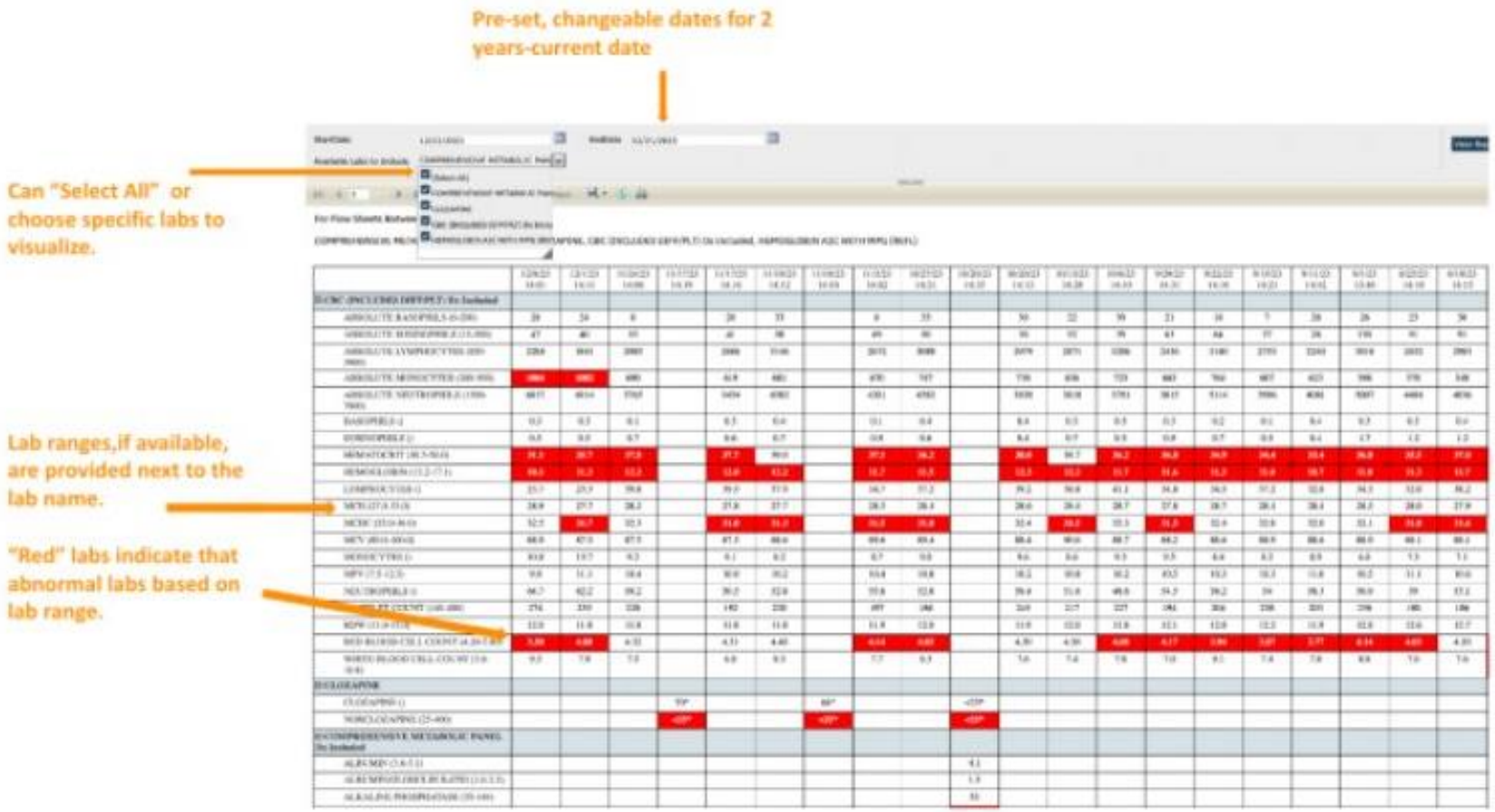
You can search for short terms to help narrow your note search.

If you are looking for full PDFs of Notes within the last 90 days, you can use the Note Service Reviewer.

Author Name	Procedure Code	Service Date	FTF	Program	Status Desc
Caraveo, Sabrina	Psychosocial Rehabilitation Group	11/26/23	60.00	MH Adult Outpatient	In Progress
Progress Note Information	test				
Progress Note Care Plan	plan to have pt talk with his daughter and set up time with group therapy on Tuesdays				
Huang, Delphine	Crisis Intervention/Mobile Crisis	10/09/23	30.00	MH Access	Signed
Progress Note Information	Pt is feeling more agitated and concerned about his well being though no SI. Talked with family including daughter who states that she will stay with pt until morning and call the psychiatrists				
Progress Note Care Plan	sent to psychiatrist and therapist a message to f/u				
Huang, Delphine	Medical Team Conference,Participation by Physician. Pt and/or Family Not Pr	10/09/23	30.00	MH Adult Outpatient	Signed
Narrative	met with team and discussed pt change in behavior and discussed with therapist ,nurse and case manager that he may need more frequency engagements				
Huang, Delphine	Individual Therapy	10/09/23	60.00	MH Adult Outpatient	Signed
Progress Note Information	Discussed with pt how he has been having a lot of anger towards his family.				
Progress Note Care Plan	plan to have pt talk with his daughter and set up time with group therapy on Tuesdays				
Huang, Delphine	Medication Support Existing Client	10/09/23	30.00	MH Adult Outpatient	Signed
Psych Note Chief Complaint	Patient came in today bc he he has issues with controlling his anger at his family and feels out of control				
Psych Note Plan	Plan to start pt on lexapro and risperadone to help with his depression. Follow up with his therapist and call his daughter				

LAB RESULTS

- Cumulative Lab Report- *cumulative report of labs results across time for a client*
- Psych / Medical note will pull in last 2 months of labs, to view historical report of labs, please see the cumulative lab report.
- You can also look at individual lab order results if you click into the lab order itself. It is here that you can mark off if the results have been reviewed.



NOTE TEMPLATE

- Create a new service note using the psych medical note template link
- Transition from old psychiatric note (10)
- Service Tab (11-12)
- Initialization of Previous Note's Textbox (13)
- Show/Hide Functionality: Do not Include in PDF and Delete from Note checkboxes (14)
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  - Diagnoses/Problem List (28)
  - A/P + CURES + Shared Plan Report (29-30)
  - Additional Information (31)
- Billing Diagnosis (32)
- Completing Note, Amend Note, Cosigning, Proxy/Reviewer (33)

TRANSITION FOR THE OLD PSYCHIATRIC NOTE

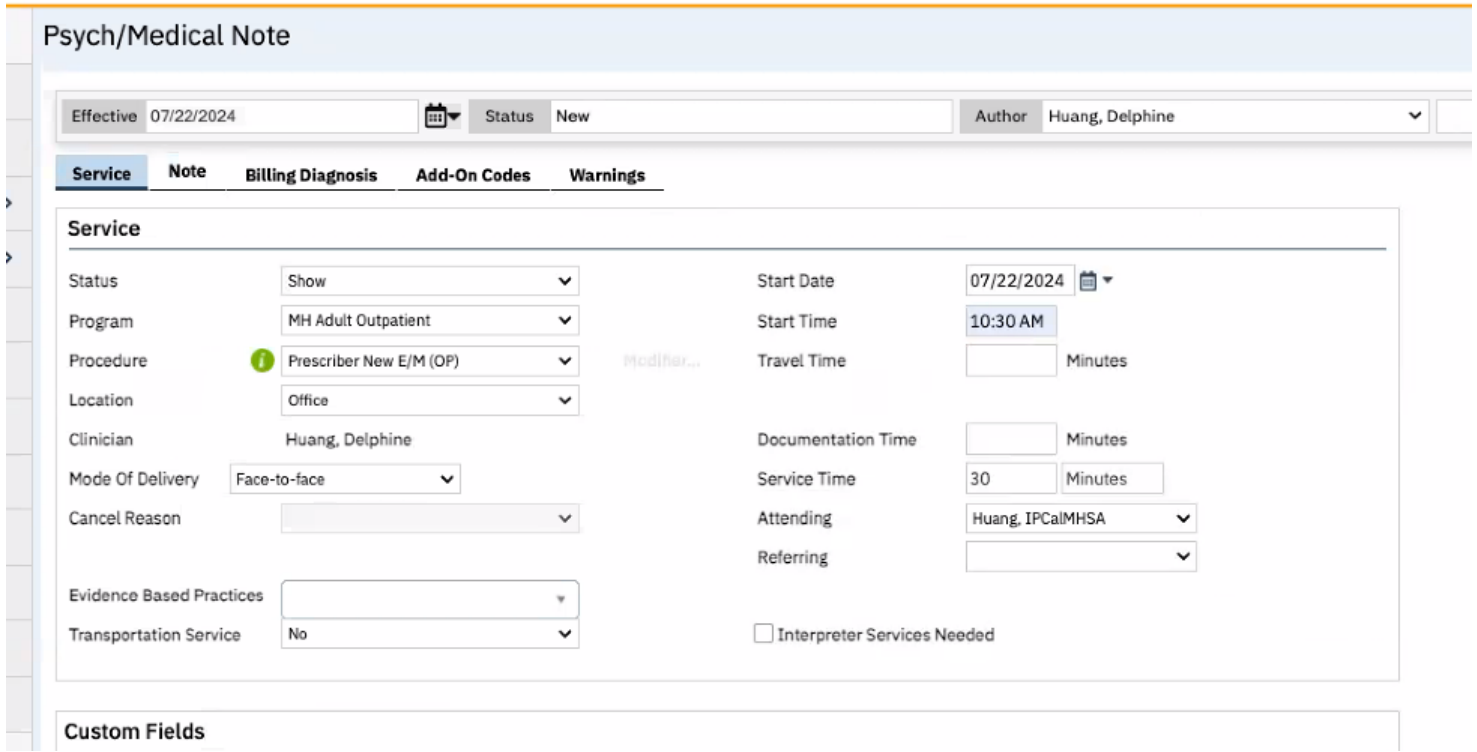
If there are any information in the following sections from the old “Psychiatric Note Template,” there will be a one-time push for each client regardless of procedure code to the new “Psych/Medical Note” template (if assigned to the associated procedure code). It will only initialize the push also if it is the same author, and same CDAG.

Psychiatric Note Template (OLD)	**Psych/Medical Note Template (NEW)**
Today’s Chief Complaint	**Subjective/CC/HPI/Visit Notes**
History of Present Illness	**Client History & Pertinent Information**
Mental Status Exam Additional Comments, Descriptions. *(This excludes the individual sections of the MSE’s radio buttons and/or their associated comments section)*	**MSE/PE**
Plan	**Assessment and Plan**

SERVICES TAB

What will show up on the final PDF

- Status*
- Program*
- Procedure*
- Location*
- Mode of Delivery
- StartDate*
- Start Time*
- Travel Time (if needed)
- Documentation Time
- Service Time*
- Attending (if needed)*



PROCEDURE CODES

Psych Medical Note Template Associated to Procedure Codes- which notes will have the new template and any changes to the "Display As" name.

Which procedure code to use in which scenario is county dependent. Please talk to your admins if you have questions.

CalMHSA Procedure Code ID	CPT	Planned Changes to the Procedure Code Label and add new Template	Current procedure code label	Suggested Facility Type/Role or License/Use Case
80	90792	Prescriber Assessment E/M (OP)	Assessment MD	Outpt: Prescriber, Initial Assessment
74	99201-99205	Prescriber New E/M (OP)	Medication Support New Client	Outpt: Prescriber
73	99212-99215	Prescriber Progress E/M (OP)	Medication Support Existing Client	Outpt: Prescriber
107	99441-99443	Prescriber Telephone E/M (OP)	Medication Support Telephone	Outpt/IP/PHF/CSU/Res: Prescriber
72	99242-99245	Prescriber Consult (OP)	Consult for New and Established Patients	Outpt: Prescriber
49	99451	Physician-to-Physician Consult	Physician Consultation	Outpt/IP/PHF/CSU/Res: only MD/DO to MD/DO Consultation

INITIALIZATION OF PREVIOUS NOTE'S TEXTBOX

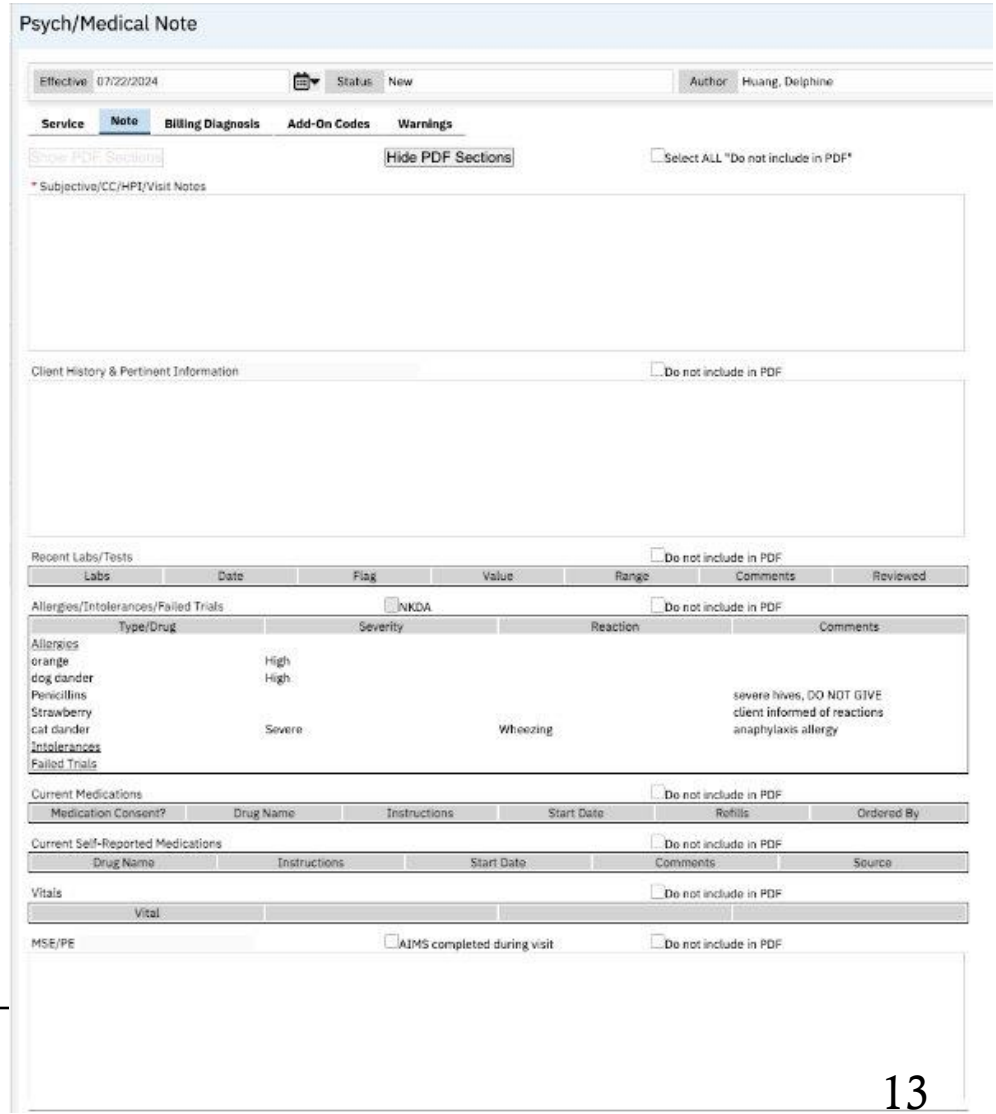
Textbox Data will only initialize If:

- Same Client
- Same Author

Within different programs and different procedures (that also meet the same client, same author criteria) and use the psych medical note template, will initialize from last signed.

If this is not intended, then user will need to manually remove data.

If you go to a different screen that data will hold if you don't close out the note, BUT we highly recommend that you also "Save" often.



SHOW AND HIDE PDF SECTIONS FUNCTIONALITY

The reason why we included this functionality is :

1) To appease lumpers and spliters writers and give agency to end users about what type of note they want to use.

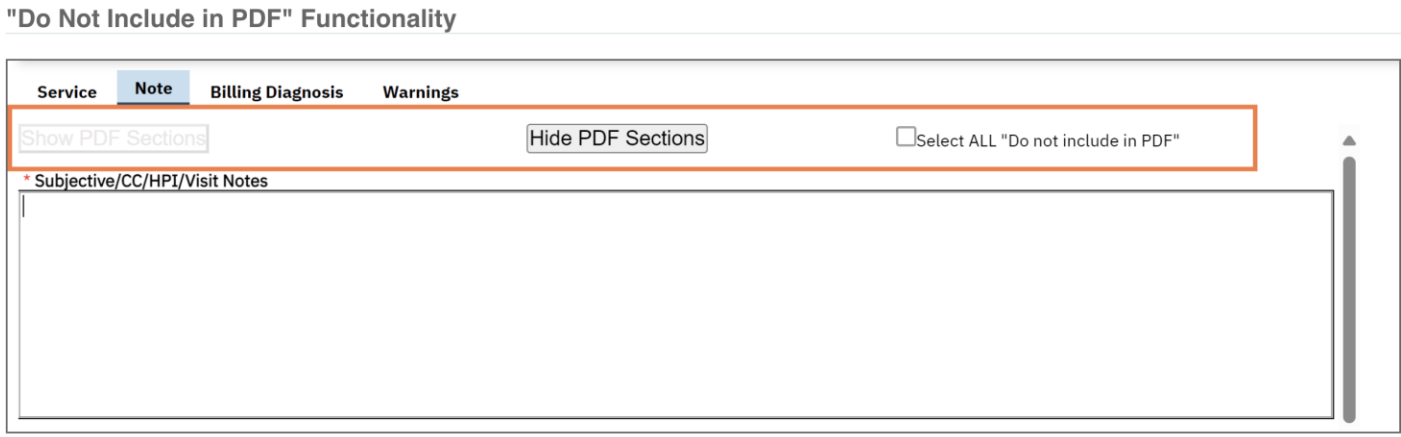
2) Can choose because having a comprehensive note with multiple sections or less sections depending on the user and type of visit.

3) Can preview ahead of time the pdf by toggling between Show and Hide PDF Sections

4) Remove checkbox for "Do not include in PDF"/Delete from Note" if you want have new information that was added to the section.

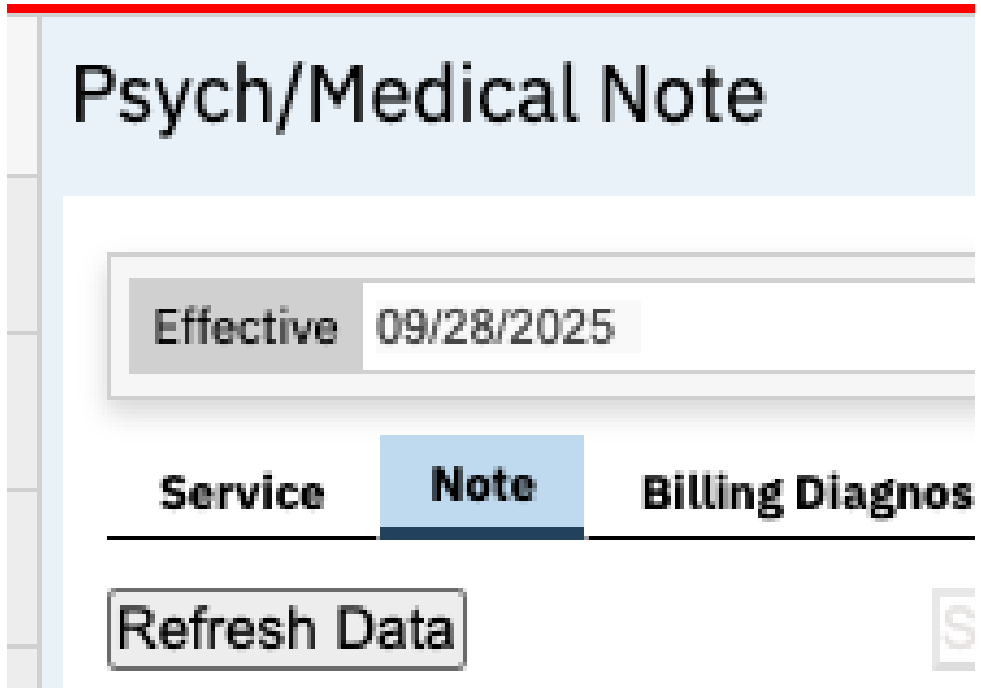
5) If there is no checkbox for "Do not include in PDF/ Delete from Note" then, the data in that textbox will initialize to subsequent note.

6) If there is a mark in the checkbox, then the data will NOT initialize to the subsequent note, only the last signed section will show up next time.



MANUAL REFRESH

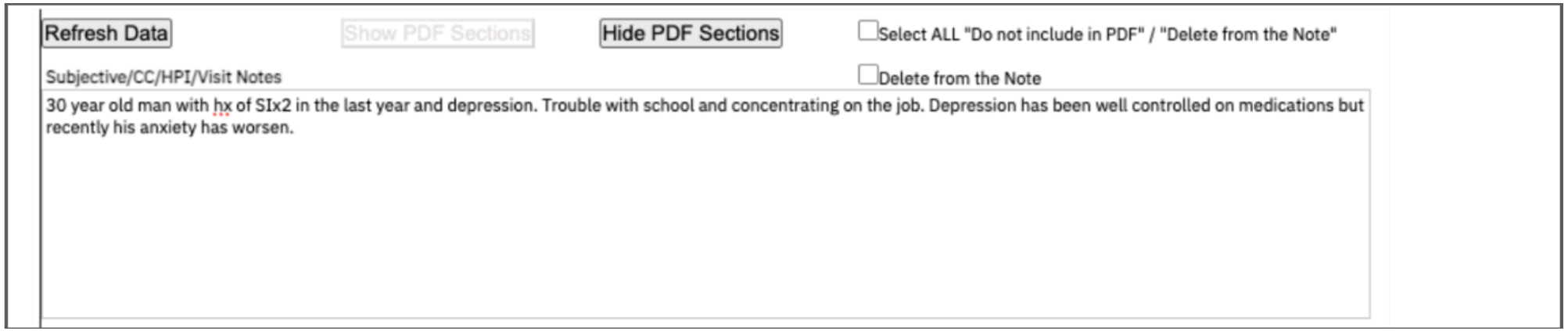
If you leave the note's screen, the system will refresh automatically. However, if you added data from a different source and this information is pushing to tables (eg Diagnosis/Problem List, Orders, Allergies) and you do not see the information automatically show up, you may need to manually refresh to push the new data in.



LEVERAGING KEY PHRASES

- Keyphrases can be used to take preset text and autoload into their note
- It allows customization of the template
  - Creating Assessment as Key Phrases
  - Functional Keyphrases are available for use to pull in specific data *(digital instructions pending for end users)*
  - Counties should make and organize county level/agency level key phrases to support their end users and standardize as they see necessary.
  - End users should learn how to create key phrases to expedite their documentation.
  - Instructions
    - *Keyphrases Set up for Admin*
    - *Users with Edit Agency Key phrases*
    - *How to Add, Edit, and Use Key Phrases: w/ Permission Only*
    - *How to document verbal medication consent in notes*

SUBJECTIVE SECTION



This section can be used to capture the subjective part of a patient visit.
It can also be used to record visit notes, and if you choose to not document using any other sections.
The “Delete From Note" functionality is available.

CLIENT HISTORY

This section can be used to capture the patient's history such as their previous psychiatric, medical, medication, or program history. It can also be used to capture any social, substance use, family history, pertinent tests. The "Do Not Include in PDF" functionality can be utilized.

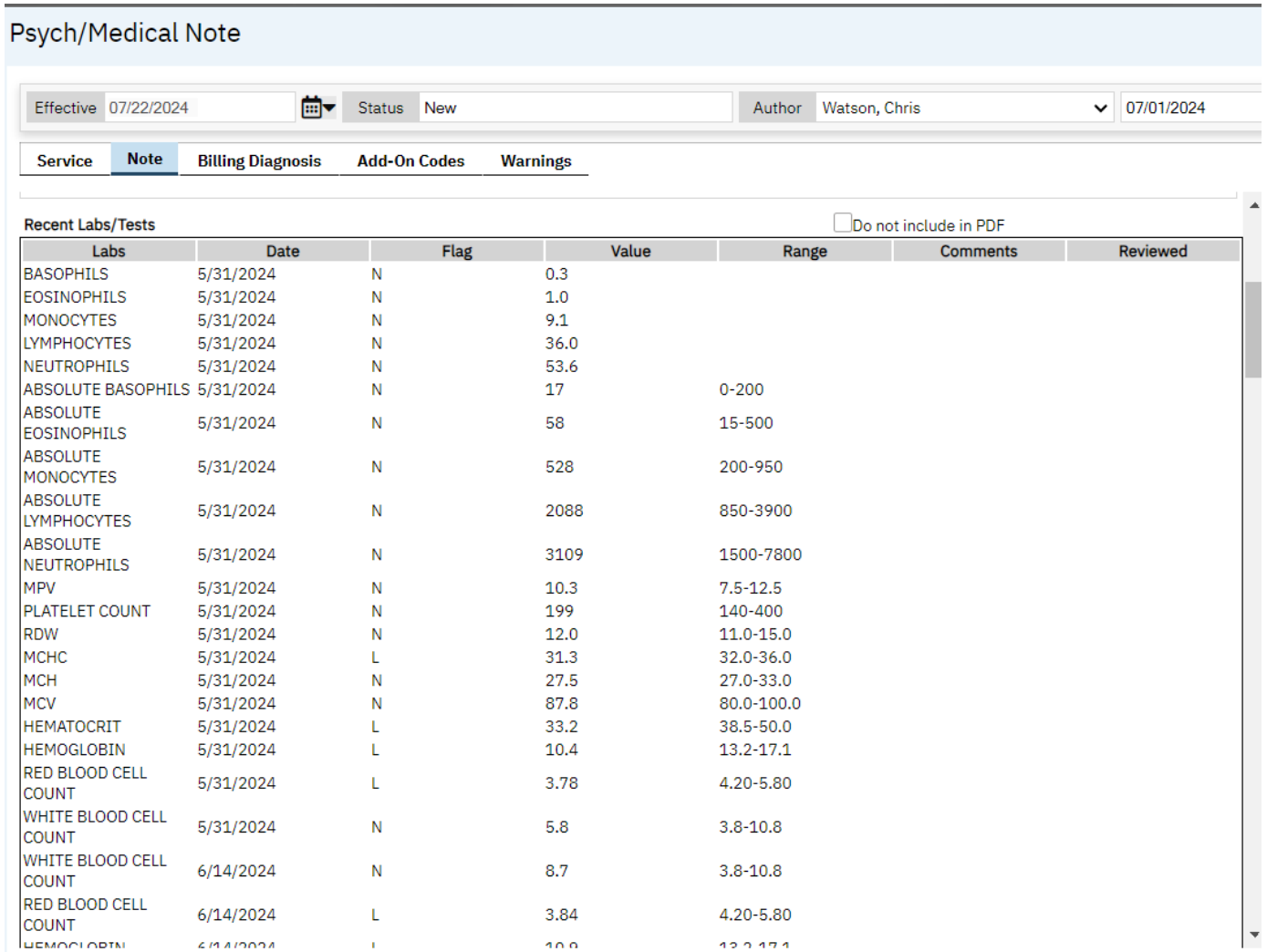
We highly recommend creating Key Phrase Templates (slide 12) to assist with what client history you want your staff to collect. It is different for every user, clinic, and county.

LAB RESULTS

This section pushes two months of lab data into the note.

It includes the lab name, result date, if any abnormality (H = high, L= low, N=Normal), the lab value, the range, lab comments, and if it has been reviewed by staff.

The “Do Not Include in PDF” functionality can be utilized.



Psych/Medical Note

Effective 07/22/2024 Status New Author Watson, Chris 07/01/2024

Service | Note | Billing Diagnosis | Add-On Codes | Warnings

Recent Labs/Tests — Do not include in PDF

Labs	Date	Flag	Value	Range	Comments	Reviewed
BASOPHILS	5/31/2024	N	0.3			
EOSINOPHILS	5/31/2024	N	1.0			
MONOCYTES	5/31/2024	N	9.1			
LYMPHOCYTES	5/31/2024	N	36.0			
NEUTROPHILS	5/31/2024	N	53.6			
ABSOLUTE BASOPHILS	5/31/2024	N	17	0-200		
ABSOLUTE EOSINOPHILS	5/31/2024	N	58	15-500		
ABSOLUTE MONOCYTES	5/31/2024	N	528	200-950		
ABSOLUTE LYMPHOCYTES	5/31/2024	N	2088	850-3900		
ABSOLUTE NEUTROPHILS	5/31/2024	N	3109	1500-7800		
MPV	5/31/2024	N	10.3	7.5-12.5		
PLATELET COUNT	5/31/2024	N	199	140-400		
RDW	5/31/2024	N	12.0	11.0-15.0		
MCHC	5/31/2024	L	31.3	32.0-36.0		
MCH	5/31/2024	N	27.5	27.0-33.0		
MCV	5/31/2024	N	87.8	80.0-100.0		
HEMATOCRIT	5/31/2024	L	33.2	38.5-50.0		
HEMOGLOBIN	5/31/2024	L	10.4	13.2-17.1		
RED BLOOD CELL COUNT	5/31/2024	L	3.78	4.20-5.80		
WHITE BLOOD CELL COUNT	5/31/2024	N	5.8	3.8-10.8		
WHITE BLOOD CELL COUNT	6/14/2024	N	8.7	3.8-10.8		
RED BLOOD CELL COUNT	6/14/2024	L	3.84	4.20-5.80		

ALLERGIES

Allergies/Intolerances/Failed Trials ☐ DrFirst NKDA ☐ SmartCare NKDA ☐ Do not include in PDF

Type/Drug	Severity	Reaction	Comments
Allergies			
bee pollen	mild	Nausea and vomiting	
chickpea		Hives	
pistachio nut	Mild	Urticaria	
Sulfa (Sulfonamide Antibiotics)	Severe	Angioedema of tongue	
Intolerances			
Failed Trials			

Authors can input or edit from the Allergies, Intolerance and Failed Trials from Medication Rx and/or the Allergies (Client) screen. It will list the type of allergy (Allergy, Intolerance, Failed Trial), severity, reactions and comments.

Allergies from CalMHSA Rx also push into this note. It will list severity and reactions.

The Do Not Include in PDF" functionality can be utilized.

MEDICATIONS/PRESCRIPTIONS

Current Medications ☐ Do not include in PDF

Consent?	Drug Name	Instructions	Start Date (Fill Date)	Refills	Ordered By	Source
☐	Invega Hafyera 1,092 mg/3.5 mL intram...	Inject 1092 mg intramuscularly once a ...	5/2/2025 (5/30/2...	2.00	Smith, Bonnie	CalMHSA Rx
☐	aspirin 81 mg tablet	Take 1 tablet by mouth once a day for 3...	5/3/2025 (5/13/2...	2.00	Smith, Bonnie	CalMHSA Rx
☐	Acetaminophen	80mg, TbDi, oral 1 each Twice A Day	5/27/2025	0.00	Huang, Delphine	Client Orders
☐	Bupropion HCl	150mg, SR12, oral 1 each Twice A Day	9/28/2025	0.00	Huang, Delphine	Client Orders

This section will pull prescriptions/medications from Client Orders/Medication Rx or CalMHSA Rx modules. It will only display medications that are active, and the end date has not expired within 1 year. It will include the number of refills and who prescribed the medications.

The “Do Not Include in PDF” functionality can be utilized.

HOME MEDICATIONS

Current Self-Reported Medications ☐ Do not include in PDF

Drug Name	Instructions	Start Date (Last Writte...	Comments	Info Provided By
calamine 3 %-zinc oxide 20 % topical cream	Apply 1 a small amount to skin twice a day as ...			
risperidone 1 mg/mL oral solution				
lidocaine (PF) 10 mg/mL (1 %) injection solution				
lidocaine (PF) 3.5 % eye gel	Apply 2 drop into affected eye once a day for 1...			
risperidone 1 mg/mL oral syringe (FOR ORAL U...	Take 120 mg by mouth twice a day for 10 days...	1/1/2018 (4/20/2025)		Patient
albuterol sulfate HFA 90 mcg/actuation aeroso...	Inhale 2 vial using inhaler once a day as neede...	8/3/2016 (4/24/2025)		PBM/Pharmacy
prednisone 1 mg tablet	Take 5 tablet by mouth for 10 days			

This section will push non-prescribed/home medication from Medication Rx module's "Add Medication" section and CalMHSA Rx module. It will only display medications that are active and the end date has not expired. It will include "Comments" and "Source". The initiated date is displayed here.

The "Do Not Include in PDF" functionality can be utilized

ORDERS

Current Orders - Non-Medications ☐ Do not include in PDF

Type	Description	Date	Ordered By
Additional	5150 - Legal	5/20/2024	Caraveo, Sabrina
Additional	Rx Order	4/14/2025	Huang, Delphine
Additional	5150 - Legal	6/6/2025	Huang, Delphine
Additional	5150 - Legal	8/18/2025	Ngo, Lam
Additional	5150 - Legal	8/5/2025	Ngo, Lam
Labs	pregnancy test (Lab Corp - 83456)	8/19/2025	Caraveo, Sabrina

This section will push non-medication active Client Orders (eg lab, nursing, legal, additional order types) from Client Order screen.

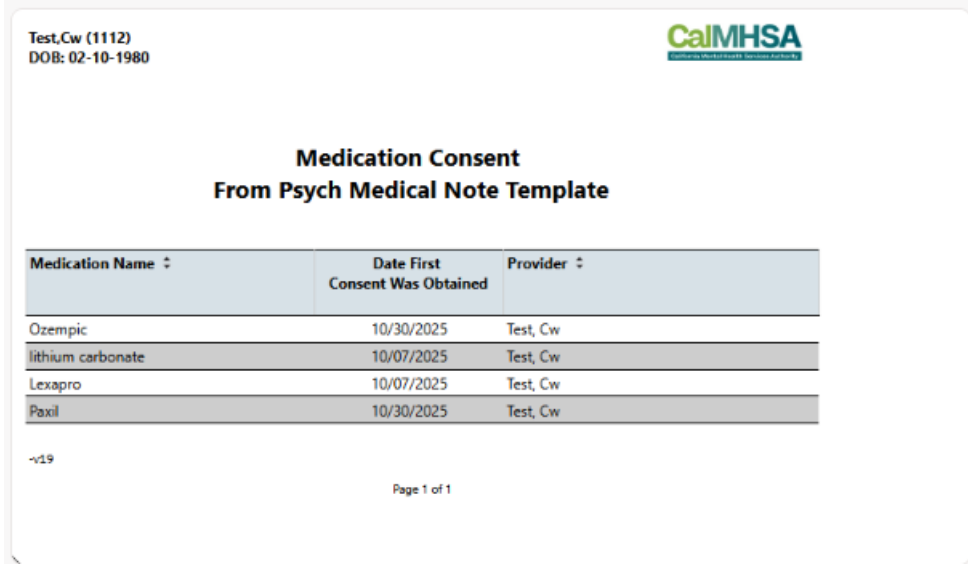
The “Do Not Include in PDF” functionality can be utilized

MEDICATION CONSENTS

Current Medications

Consent?	Prev	Drug Name	Instructions	Start Date (Fill Date)	Refills	Ordered By	Source
☐	Y	Prozac 10 mg capsule	Take 1 capsule by mouth once a day fo...	11/3/2025	0.00	Smith, Bonnie	CalMHSA Rx
☑	Y	carvedilol 3.125 mg tablet	Take 2 tablet by mouth every morning f...	11/4/2025	0.00	Smith, Bonnie	CalMHSA Rx
☑	N	Albuterol Sulfate 0.63mg/3 mL, nebu, i...	1 Puff Inhalation Every 4 Hours	11/4/2025	0.00	Watson, Chris MD ...	Medication Rx
☐	N	Lithium Carbonate 300mg, cap, Oral	1 each Oral Once A Day	11/5/2025	0.00	Watson, Chris MD ...	Medication Rx

- If verbal or written consent is captured for certain medications, you can check off that you captured this under the medication consent column.
    - How to Document Medication Consents within the Psych Medical Note Template or Any Textbox
- If you want to see a compiled medication list from all providers, please use CalMHSA 116 – Medication Consent From Psych Medical Note Template.



Test,Cw (1112)
DOB: 02-10-1980

CalMHSA

Medication Consent
From Psych Medical Note Template

Medication Name	Date First Consent Was Obtained	Provider
Ozempic	10/30/2025	Test, Cw
lithium carbonate	10/07/2025	Test, Cw
Lexapro	10/07/2025	Test, Cw
Paxil	10/30/2025	Test, Cw

-v19

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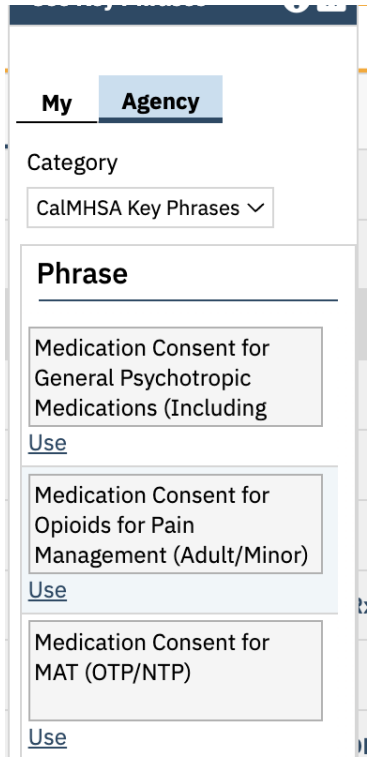
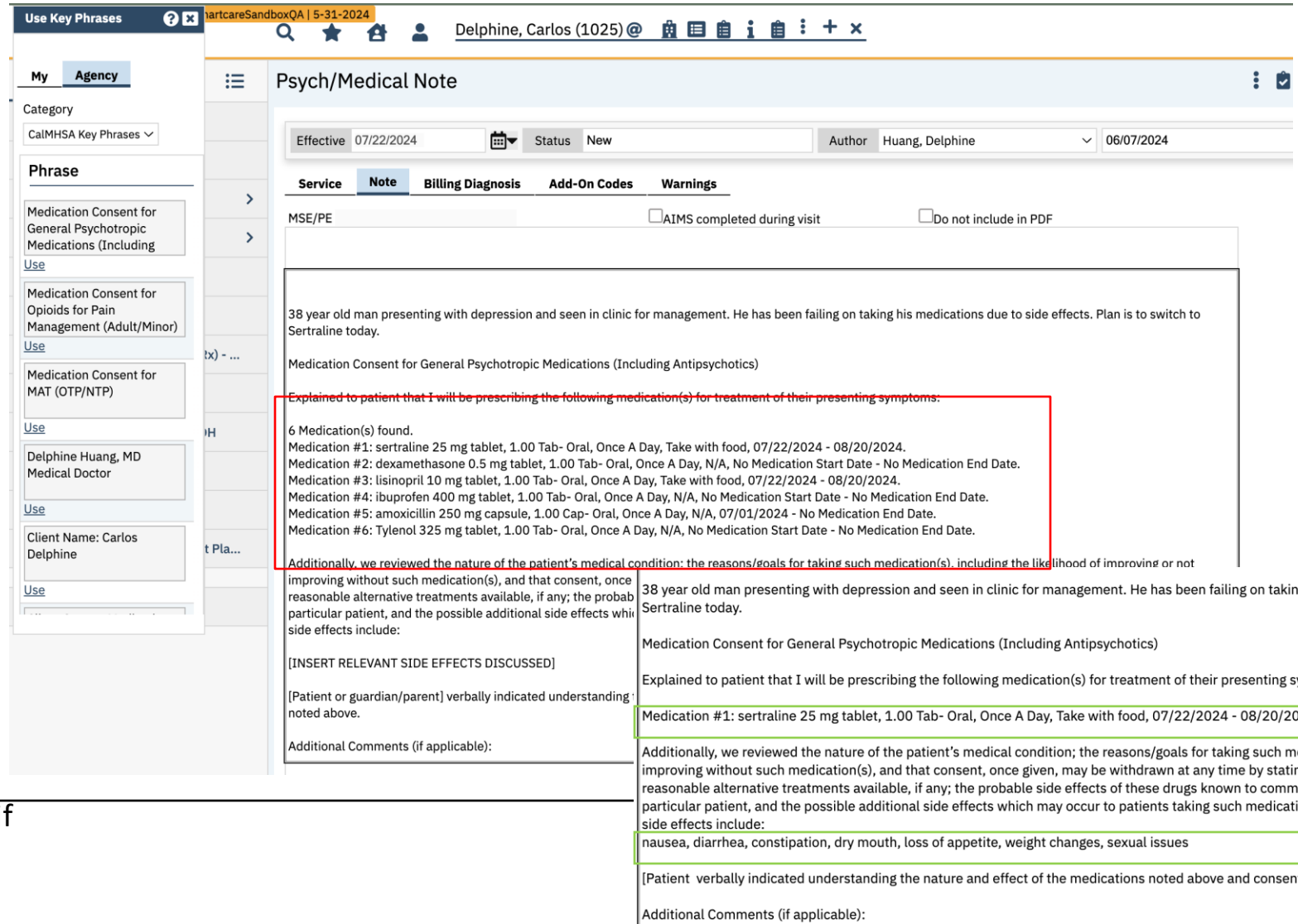
MEDICATION CONSENT KEYPHRASES





Use vetted Medication Consent Keyphrases to be efficient to document consents. Remove any medications that are not relevant if using CalMHSA's template

VITALS

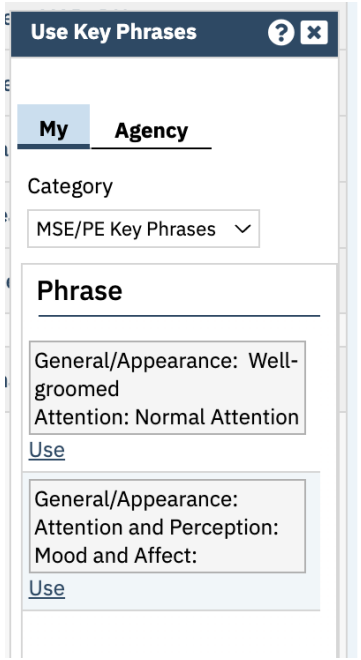
Vitals ☐ Do not include in PDF

Vital	3/14/2024	3/12/2024	
Temp. (F)	98.0 F		
Pulse (bpm)	100 bpm	80 bpm	
Blood Pressure	180 / 100 (mmHg)	120 / 80 (mmHg)	
BP Position	Standing	Sitting	
Breaths/Min	20	30	
Oxygen level	100		
Height (in)	60.00 In	60.00 In	
Weight (lbs)	200.00 lb	150.00 lb	
BMI (lbs/in2)	39.06 lbs/in2	29.29 lbs/in2	
Pain Level	5		
Pain Location	Mouth		

This section will pull the last 3 vitals within a CDAG from the “Vitals/Meaningful Use” Flowsheet or “Enter Vitals”. This information will refresh the note automatically with any added information. The “Do Not Include in PDF” functionality can be utilized.

How to Document Vitals

MSE/PE



Tylenol	325mg, Tab, Oral each Once A Day	Spanish Speaker	Patient Verbal

Vitals ☐ Do not include in PDF

Vital	3/15/2024	3/15/2024	3/15/2024
Temp. (F)			98.0 F
Pulse (bpm)		90 bpm	120 bpm
Systolic BP (mmHg)		150	180
Diastolic BP (mmHg)		90	90
Breaths/Min			100

MSE/PE ☐ AIMS completed during visit ☐ Do not include in PDF

General/Appearance: Well-groomed
Attention: Normal Attention
Perception: Normal Perception
Mood and Affect: Euthymic mood, Appropriate affect
Speech: Clear and Coherent Speech
Behavior: Calm, Cooperative, Engaged, Good Eye Contact
Thought Process: Organized and Linear Thought Content
Thought Content: No Auditory Hallucinations, No Visual Hallucinations, No Delusions,
Suicidal/Homicidal: Has SI- plans shoot himself
Insight: Normal Insight

This is a section that can be used to document the Mental Status Exam or Physical Exam. We **highly recommend creating Key Phrases** to improve efficiency.

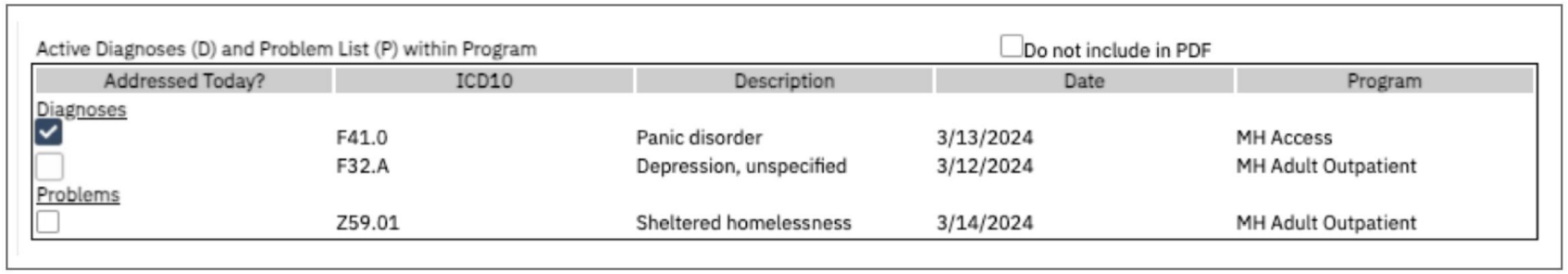
The “Do Not Include in PDF” functionality can be utilized.

AIMS Completed During Visit: The data collection should be done in the **AIMS Assessment Document** separately.

A user can choose to then mark the checkbox "AIMS completed during visit. This information will be displayed on the **Client Medical Facesheet** to notify users when it was last completed. This checkmark will NOT be retained for the subsequent note.

DIAGNOSES AND PROBLEMS LIST

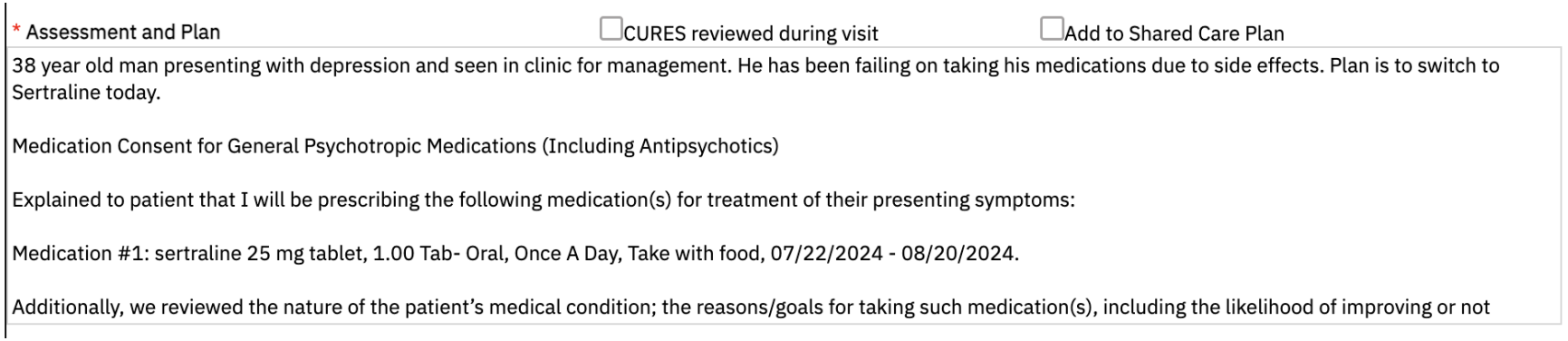
- This section captures the client's diagnoses and problem list from any programs that are within the same CDAG. The active diagnosis captured by Diagnosis Document is included in the diagnosis sub-section. Also, any problems that are documented in the Client Problem List are demarcated in the Problem's subsection.
- Any common ICD10s are grouped together.
- The date represents the most recent entry for that ICD10 code.
- You can checkmark the issues that were addressed at the visit.
- Any selection will NOT retain its checkmark for the subsequent note.



Active Diagnoses (D) and Problem List (P) within Program ☐ Do not include in PDF

Addressed Today?	ICD10	Description	Date	Program
Diagnoses				
☑	F41.0	Panic disorder	3/13/2024	MH Access
☐	F32.A	Depression, unspecified	3/12/2024	MH Adult Outpatient
Problems				
☐	Z59.01	Sheltered homelessness	3/14/2024	MH Adult Outpatient

ASSESSMENT AND PLAN


* Assessment and Plan ☐CURES reviewed during visit ☐Add to Shared Care Plan

38 year old man presenting with depression and seen in clinic for management. He has been failing on taking his medications due to side effects. Plan is to switch to Sertraline today.

Medication Consent for General Psychotropic Medications (Including Antipsychotics)

Explained to patient that I will be prescribing the following medication(s) for treatment of their presenting symptoms:

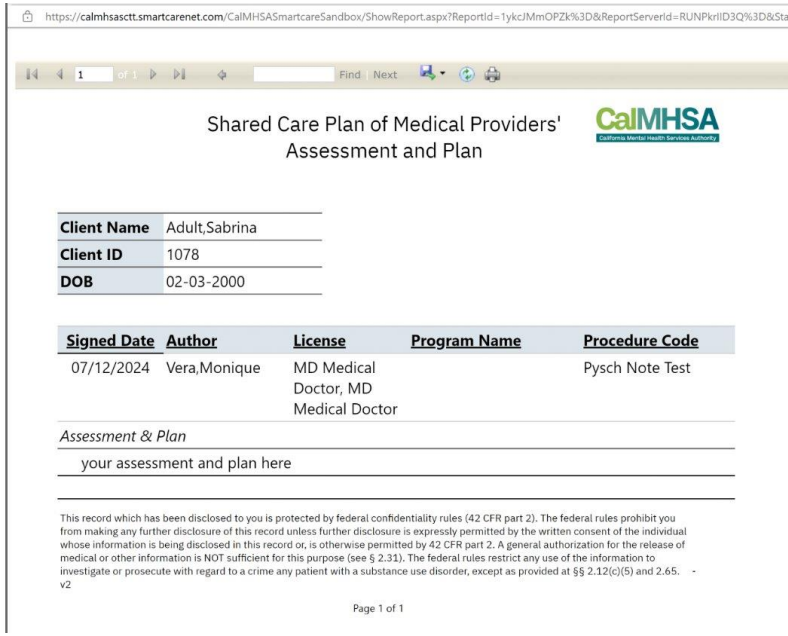
Medication #1: sertraline 25 mg tablet, 1.00 Tab- Oral, Once A Day, Take with food, 07/22/2024 - 08/20/2024.

Additionally, we reviewed the nature of the patient's medical condition; the reasons/goals for taking such medication(s), including the likelihood of improving or not

- This section can be used to capture the Assessment / Plan.
- There is a checkbox for you to capture if "CURES was reviewed during visit". This information will also be displayed in the **Client Medical Facesheet** so other users know when it was last completed. The check. Any selection will NOT retain its checkmark for the subsequent note.
- When the "Add to Shared Care Plan" checkbox is marked, it compiles any author that wants to contribute this visit's plan to a singular report, CalMHSA 100 Shared Care Plan Report, to help consolidate important plans in one place. It also will be pushing to a future "Shared Treatment Plan" that will allow multidisciplinary teams to share their plans and to help with minimizing redundancy. The "Shared Treatment Plan" is planned to be released in 2026.
- The "Delete From Note" functionality is available.

CURES + ADD SHARED CARE PLAN

- **Documentation of CURES** being reviewed can be checked. This information will be displayed on the Client Medical Facesheet. This checkmark will NOT be retained for the subsequent note.
- **Add to Shared Care Plan:** This is optional, as we are still building out a future-state Shared Care Plan/Treatment Plan to be more collaborative and efficient in data collecting and data sharing.
  - The goal is that for facilities that use a shared care plan or treatment plan, individual's plans can feed into the document to reduce the need for double entry.
  - For now, if the box is checked, this saves to the Shared Care Plan Report which is a compilation of individual's psych medical note's A/P sections to facilitate ease of reading of all provider's A/Ps



https://calmhsasctt.smartcarenet.com/CalMHSASmartcareSandbox/ShowReport.aspx?ReportId=1ykcJMmOPZk%3D&ReportServerId=RUNPkrIID3Q%3D&Sta

1 of 1 Find Next

Shared Care Plan of Medical Providers' Assessment and Plan

CalMHSA

Client Name	Adult,Sabrina
Client ID	1078
DOB	02-03-2000

Signed Date	Author	License	Program Name	Procedure Code
07/12/2024	Vera,Monique	MD Medical Doctor, MD Medical Doctor		Pysch Note Test

Assessment & Plan

your assessment and plan here

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. - v2

Page 1 of 1

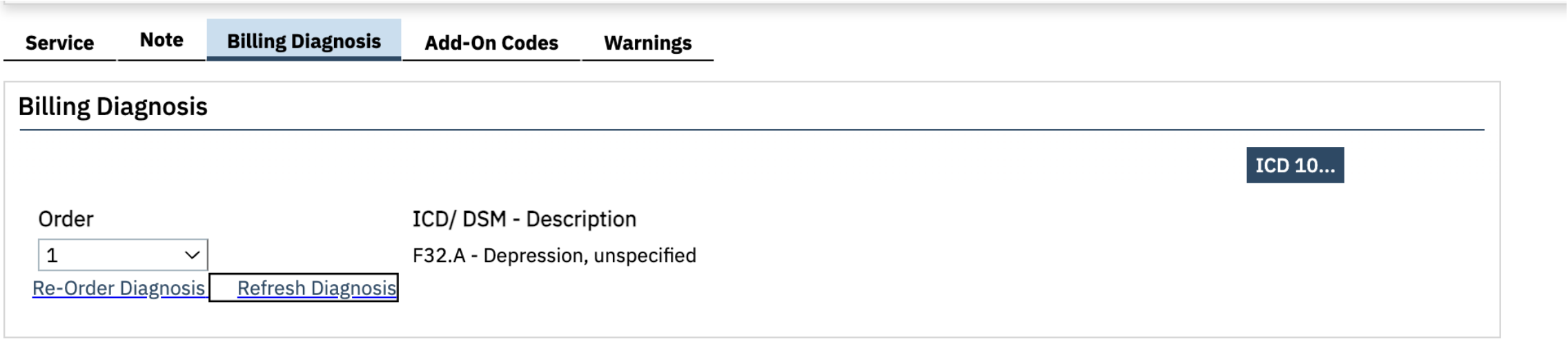
ADDITIONAL INFORMATION

This section is a flexible section for authors to capture information that does not fit in any above section but should be included. (For example: attending attestation, client’s timeline within the program, family conversations, follow-up information). The “Delete From Note" functionality is available.

Additional Information

☐ Do not include in PDF

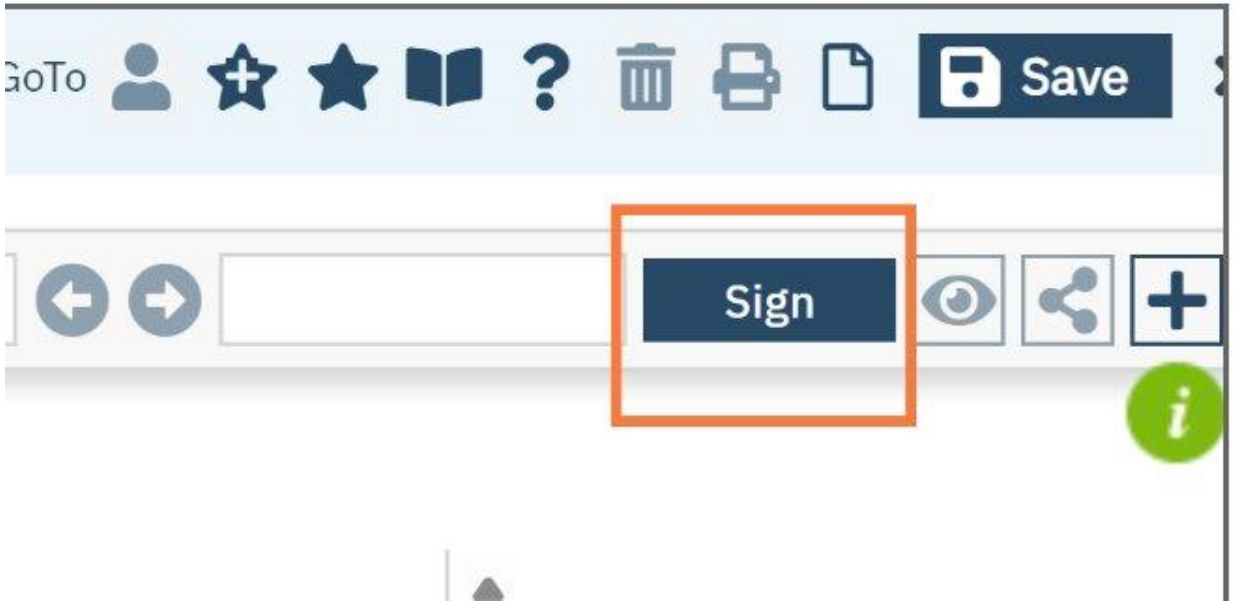
BILLING DIAGNOSIS



- Autopopulates from Diagnosis Document and is program specific
- No change in functionality here, as previously done.

COMPLETING NOTE

- Sign note by clicking on "Sign"
- Review PDF



Amend, Assign Co-signer and Proxy/Reviewer Functionality

- How to Amend a Signed Document
- How to Add a Co-Signer to a Document
- Various Proxy Roles Functionalities
- Reviewer Process Add On for End Users
- Reviewer Process Add On for Supervisors and Reviewers

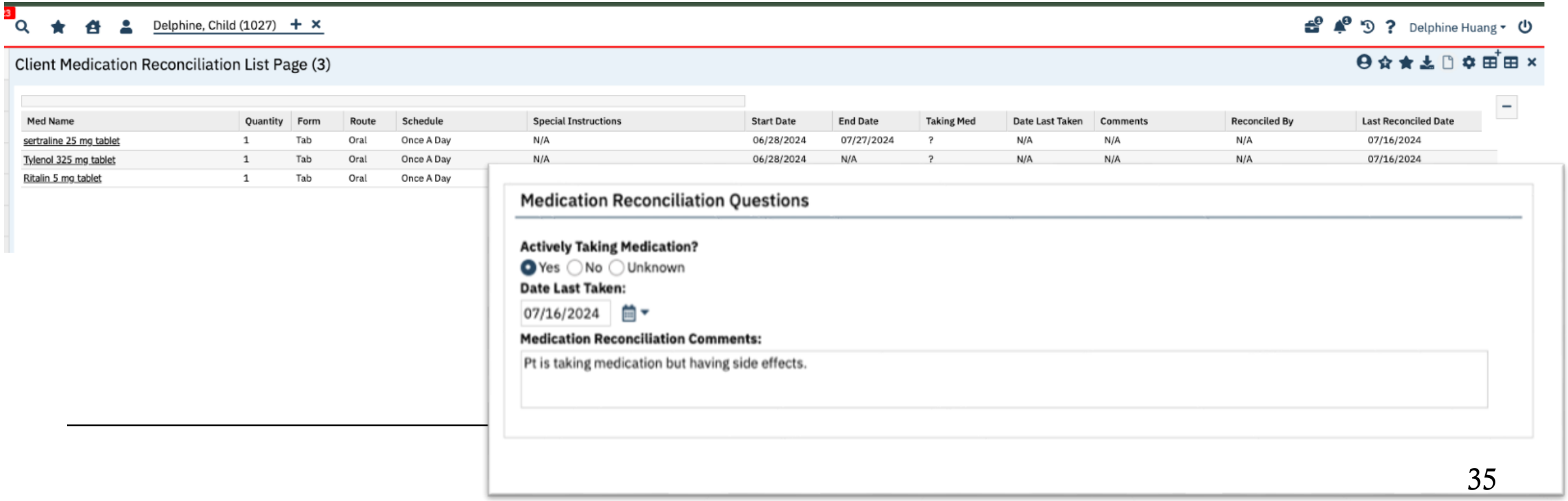
OTHER MEDICAL WORKFLOWS

- Medication Reconciliation/Adherence
- Discharge/Aftercare Summary
- Assigned Documents
- Key inpatient/CSU Specific Screens

MEDICATION RECONCILIATION

Nursing/ medical staff can use this screen capture if a patient is taking medications or not. It will pull current medications or expired medications within last 1 year.

How to Complete a Medication Reconciliation



DISCHARGE/ AFTERCARE SUMMARY

How to Get a Summary of Care - very extensive details

How to Complete the Discharge Instructions - pt focused

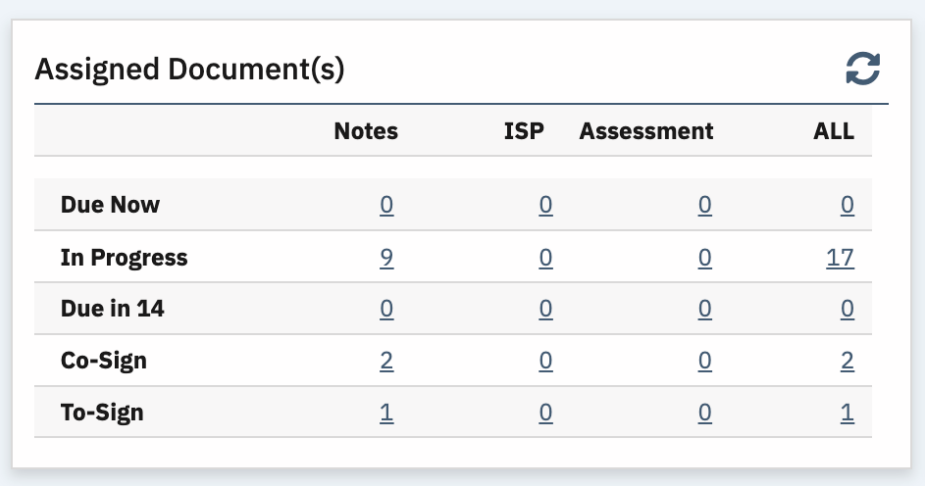
How to Complete the Discharge Summary- Text with some medical data

How to Create the Aftercare Discharge Summary Medical Report includes the Discharge Summary's text + medical relevant information (including changes to medications) , can be used for patients and/or transfer of care to other providers.

ASSIGNED DOCUMENTS

Use this to see what to-do's you may need including outstanding notes /documents under Assigned Documents Widget on the provider dashboard.

You can view any document that you are the author under:
How to View Your Documents



INPATIENT SPECIFIC DOCS

- Inpatient Comprehensive List
- CSU Guides
- CalMHSA 113 – Inpatient/CSU Client Face Sheet Report (My Office)
- CalMHSA MAR Report
- Medication Reconciliation
- Shift/Rounding Report
- Nutritional Screening
- Personal Effects Inventory