



## EMR Quick Reference Guide

### Discharge - Discharge Summary (Including Outpatient eReferral)

All patients require:

- [Discharge summary](#) with
  - [A documented principal diagnosis](#)
  - [Discharge medication reconciliation and script](#)
  - [Follow up – documented in EMR](#)
- [eReferral for outpatient appointments in BOSSNet](#)

### Discharge Process Summary

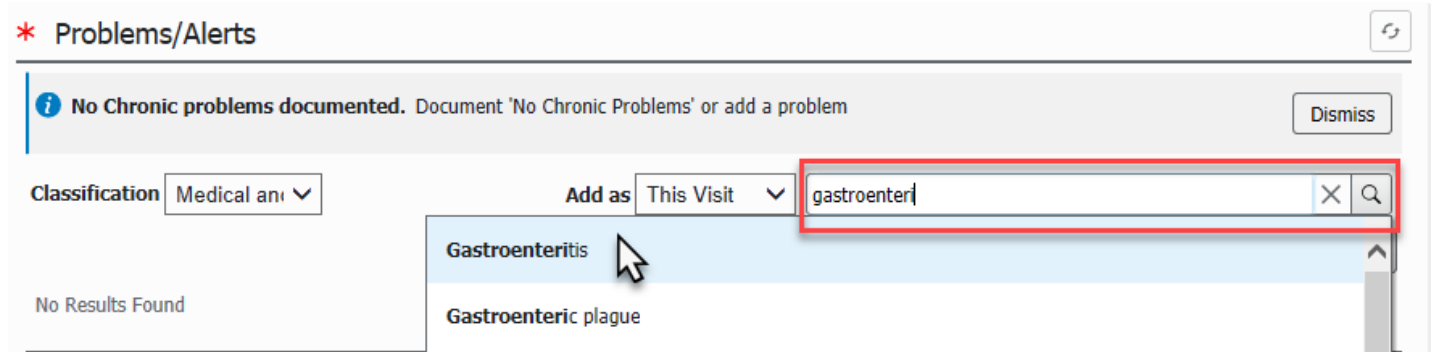
1. Select **Medical Officer View** and select the Discharge tab
  - Medication Reconciliation, Problems/Alerts and Follow up must be completed for every discharge

2. Select Medication Reconciliation
  - Refer to "[Medications – Discharge Prescriptions – Creating and Printing](#)" on the LiveEMR website

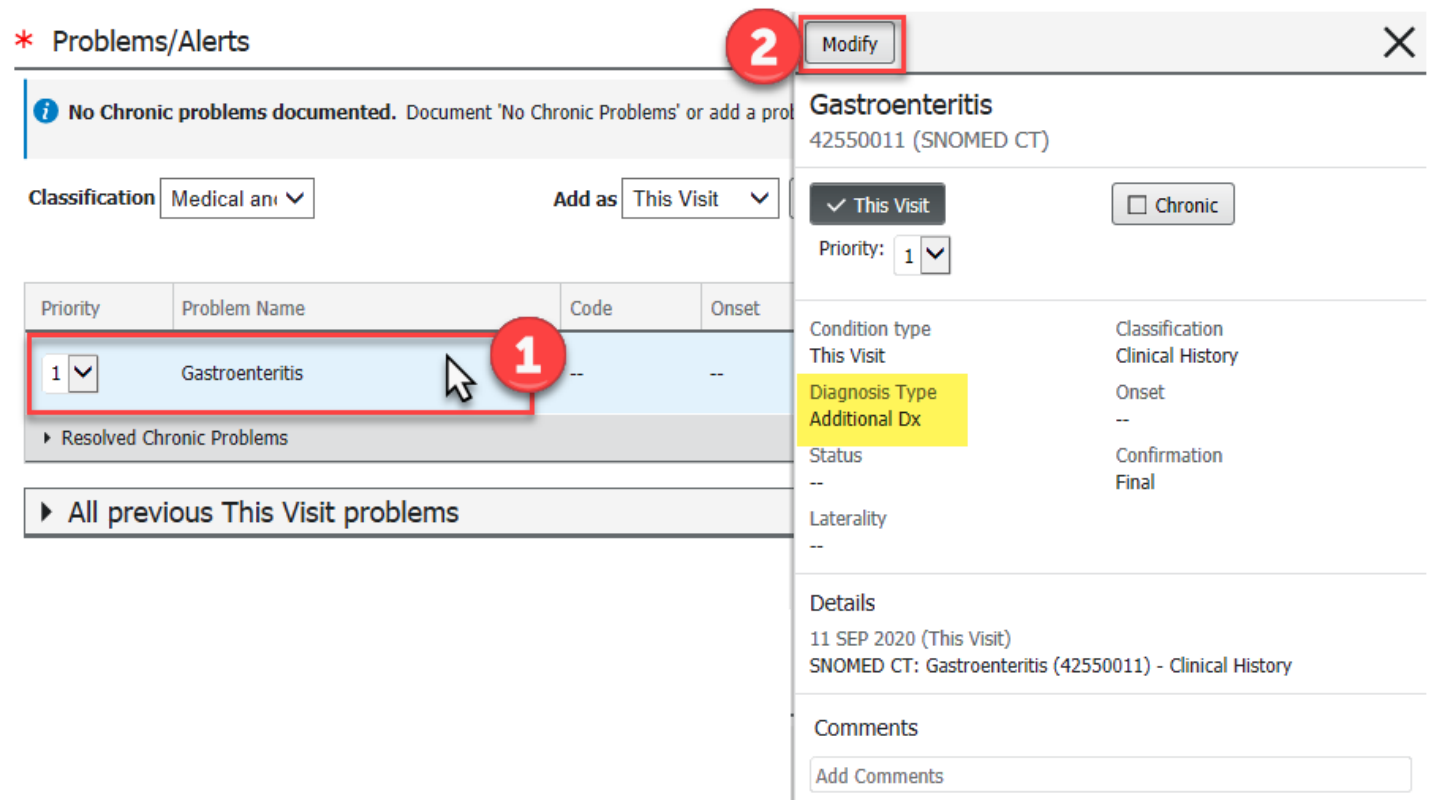
3. Continue to review and complete each component within the discharge tab page
  - Review Documents, Outstanding orders, Observations, Laboratory, Microbiology, Medical Imaging results, Enter in any patient instructions and hit save
  - Select any results to tag to add to the discharge summary document

### Document a Principal Diagnosis

4. Once at the Problems/Alerts component, Use the search box to search for you patient’s diagnosis and select from the drop down the most appropriate for your patient to add it as part of their clinical record
  - At this point, enter in any other past medical history that may have not been entered before



5. Select the added problem (in this case, Gastroenteritis). Details of the problem will appear on the right side of the window. Note here it says “Additional Dx” for diagnosis type.



- Select Modify to change the diagnosis type to “Principal Dx” and click OK

- Use the “This Visit” and “Chronic” buttons to allocate problems as an active problem during this visit only or a chronic issue. If your patient has no chronic problems, select the “No Chronic Problems” button to confirm.

### Follow-Up documentation in EMR

Outpatient referrals cannot be done in EMR at this stage. However, referrals and follow up should still be documented so that it is part of the patient’s medical record and discharge summary.

- Once you reach the “Follow-Up” component on the Discharge page  
Select “Follow up with GP” and click Modify to enter more information and Save

9. If an outpatient referral is to be made, either search for the site via “Location” or enter clinic information as free text and click “Save”.
  - Once the Follow up section is complete, it will display as a green tick in the “Check Out” menu

## Check Out



**\*\*\*NOTE\*\*\* : YOU WILL STILL NEED TO COMPLETE AN E-REFERRAL ON BOSSNET OR YOUR OUTPATIENT CLINIC REFERRAL **WILL NOT GO THROUGH.****

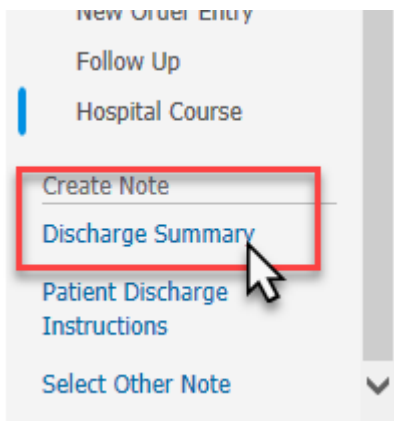
## Discharge Summary

10. Enter the patient’s hospital course summary in to the “Hospital Course” Section and save.
  - This box allows for multiple users to collaborate and save notes without adding to the patient’s official medical record until the final discharge summary is completed.
  - This is the recommended way to start and prepare your discharge summaries and allow for a colleague to edit, review and then submit the discharge summary.

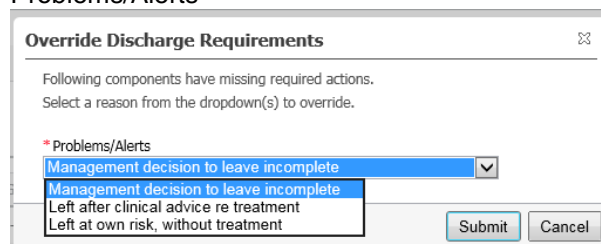
## Hospital Course

Selected Visit

11. After saving, Select “Discharge Summary” under ‘Create Note’ to generate the Discharge Summary document



At this stage, if you have forgotten to complete steps to enter a Principal and Final diagnosis, you will receive this prompt. Please click Cancel and navigate to Problems/Alerts



- At this point, the pathology results you tagged earlier will autopopulate whilst microbiology and radiology reports will be available on the left hand side of the window for you to drag it to insert into the appropriate section.

The screenshot shows a 'Discharge Summary' window. On the left, a 'Tagged Text' box contains the text 'XRAY Chest THIS IS A TEST REPORT' dated 27/08/2018 12:23. On the right, the 'Radiology Reports' section contains the text 'THIS IS A TEST REP...' dated 27/08/2018 12:23 AEST. The window also displays patient information, admission details, and a table of pathology results.

Test Name	Test Result	Date/Time
INR	1.6 (High)	22/08/2018 09:59 AEST

- Review your document and make any final edits in this window.
- Click on "Sign/Submit" then "Sign & Print" or "Sign".

This document is the patient's official discharge summary. A copy will be sent to the patient's GP as registered in iPM and a copy will also be uploaded to myHR if the patient has consented to myHR.

## eReferrals for Outpatient Appointments in BOSSnet

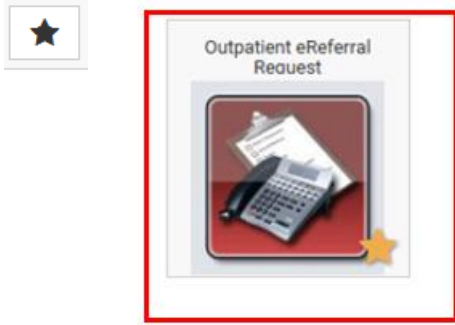
At this stage, any patient referrals for outpatient clinic appointments must be completed in BOSSNet.


- Select the BOSSnet link from the Navigation bar to open the patient's record within the BOSSnet application
- The BOSSnet chart for this patient will open up




The screenshot shows the BOSSnet application interface. The patient record for Evelyn Lopes (URN: 1563779) is displayed. A red box highlights a 'CONFIDENTIAL' warning: 'CONFIDENTIAL To be used only by authorized personnel'. The interface includes a navigation bar, a search bar, and a list of active alerts.

- Click on the black star in the top right corner and search for Outpatient eReferral Request (Selecting the yellow star on the lower corner of the icon will save this as a favourite)



- Click this  icon at the top of the page to ensure you are in the correct encounter.
- Complete the mandatory fields – Provider number, Referrer’s Specialty, Clinic and Timeframe.

- Click the ISBAR box and complete the mandatory fields – Diagnosis & Current problem, Background & Assessment, Reason. Click “Save & Exit” and “Submit”

- This icon  will take you back to the EMR from BOSSnet.