



CLINICAL PROCEDURES USER MANUAL

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Revision History

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³ Patch MD*1.0*4 released.	September 2006	Alfred Bustamante
⁴ Patch MD*1.0*14 released. Added new sections for Auto Study Check-In to Ch. 3.	March 2008	Shirley Ackerman, Alfred Bustamante
⁵ Patch MD*1.0*11 released. Added new section in Ch. 3 for handling appointment no shows and cancellation with the auto study check-in. Replaced provider name in Ch. 4 with generic name.	June 2009	Shirley Ackerman, Alfred Bustamante
⁶ Patch MD*1.0*21 released. Added new section in Ch. 4 for resulting the high volume procedures. Added Ad Hoc Health Summary Components for CP reports to Ch. 5. Added Ch. 6 Report Options. Updated Ch 8 Index.	June 2010	Shirley Ackerman, Rachel Wilder

¹ Patch MD*1.0*2 July 2004 Patch 2 release added.

² Patch MD*1.0*10 March 2005 Patch 10 release added.

³ Patch MD*1.0*4 September 2006 Patch 4 release added.

⁴ Patch MD*1.0*14 March 2008 Patch release added.

⁵ Patch MD*1.0*11 June 2009 Patch release added.

⁶ Patch MD*1.0*21 June 2010 Patch release added.

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1. Introduction

Clinical Procedures (CP) is a new VistA package that provides features that can be used across clinical departments, such as general medicine, cardiology, pulmonary, women's health, neurology, and rehabilitation medicine. CP is a conduit for passing patient results, using HL7 messaging, between the vendor and VistA. Patient test results are displayed in the Computerized Patient Record System (CPRS). CP includes three modules, which are CP User, CP Manager, and CP Gateway.

CP User is the primary application that clinicians use. For example, you can place an order for a procedure, such as an EKG, through the Consults tab or Orders tab in CPRS, or Order Entry. Then you can use CP User to check in a patient and initiate the actual procedure. If the procedure is performed on a bi-directional instrument, the patient demographics are automatically transmitted to the instrument. When the procedure is complete, the result is transmitted back to VistA Imaging and attached to a TIU note/document that is associated with the original procedure order.

If the procedure is performed on a uni-directional instrument, you use CP User to match the instrument results to the requested procedure. The TIU note is created when the instrument results are submitted to VistA Imaging. Standard Consults functionality is used to complete and sign the TIU note. The main purpose of CP User is to link the results from the automated instrument to the procedure ordered through Consults in CPRS.

System managers and clinical application coordinators use CP Manager. The main purpose of this application is to add and edit automated instruments and procedures in the CP database. CP Manager is also used to configure the site files and required system parameters.

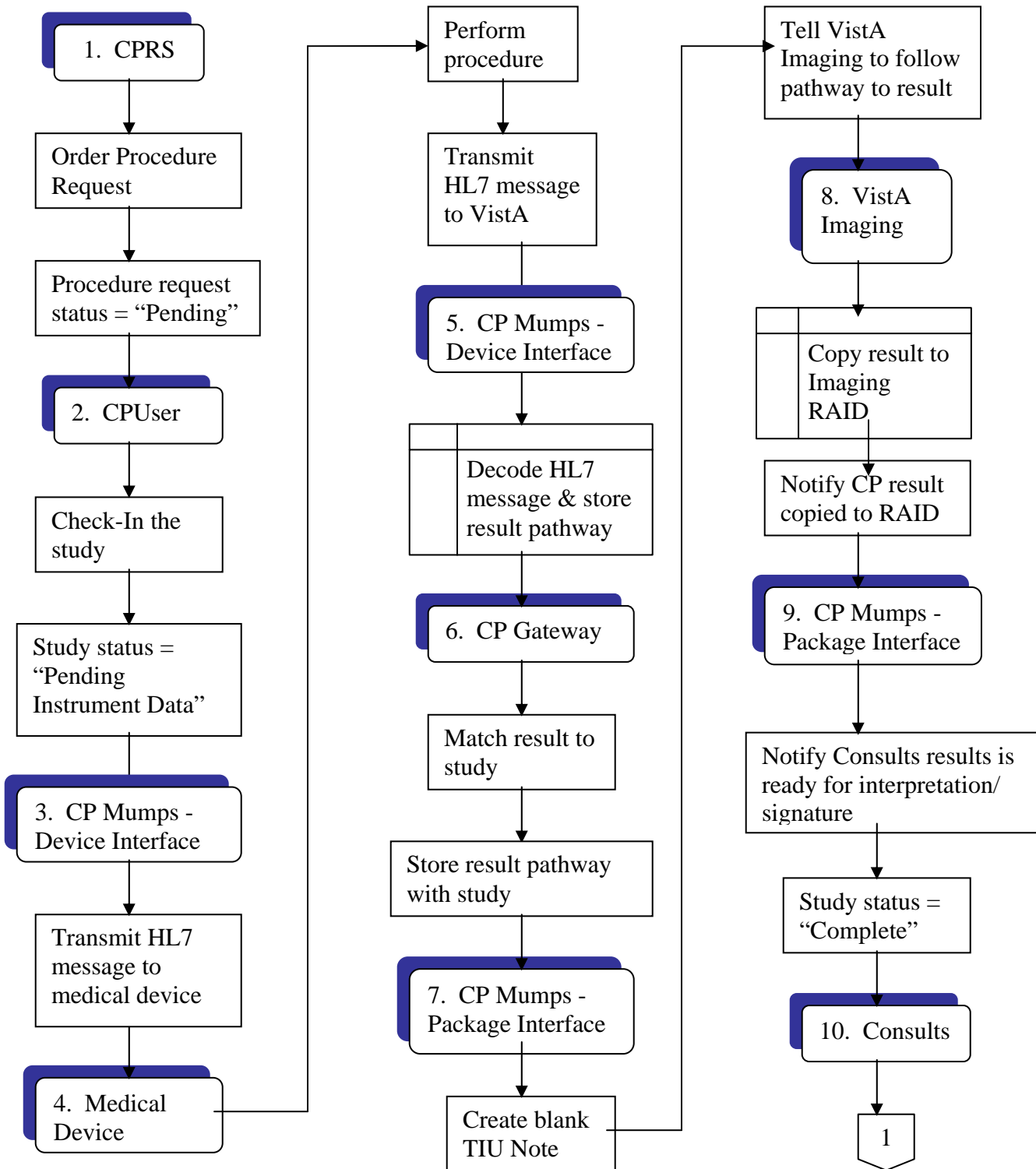
CP Gateway manages the flow of information from the instrument interfaces to CPRS. CP Gateway polls the system regularly for new data from instruments and processes this data into usable attachments for the VistA Imaging system.

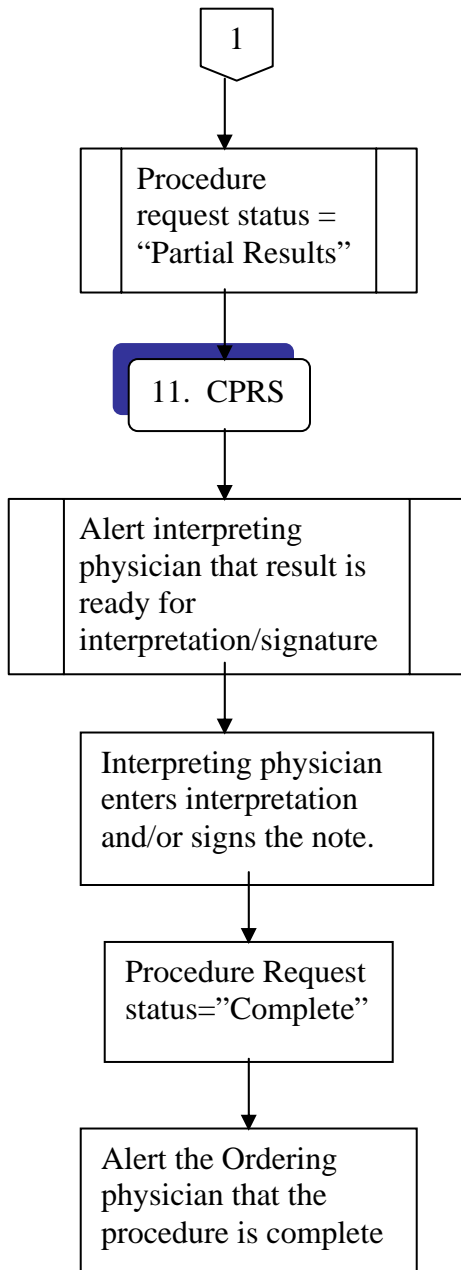
Topics discussed in this chapter are:

- [Intended Audience](#)
- [Related Manuals](#)
- [Product Benefits](#)

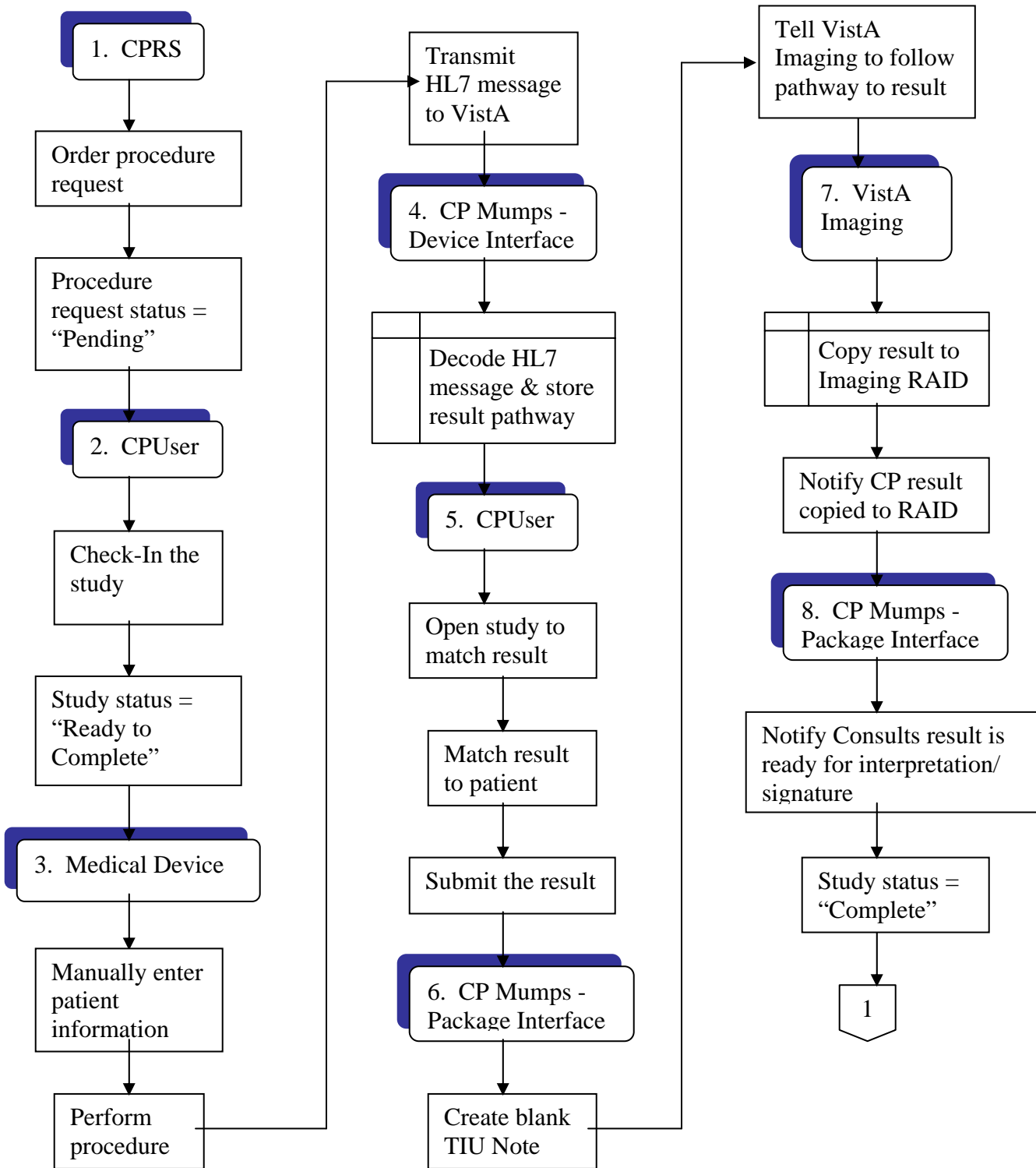
The following pages contain flowcharts explaining the bi-directional and uni-directional Clinical Procedures process flow.

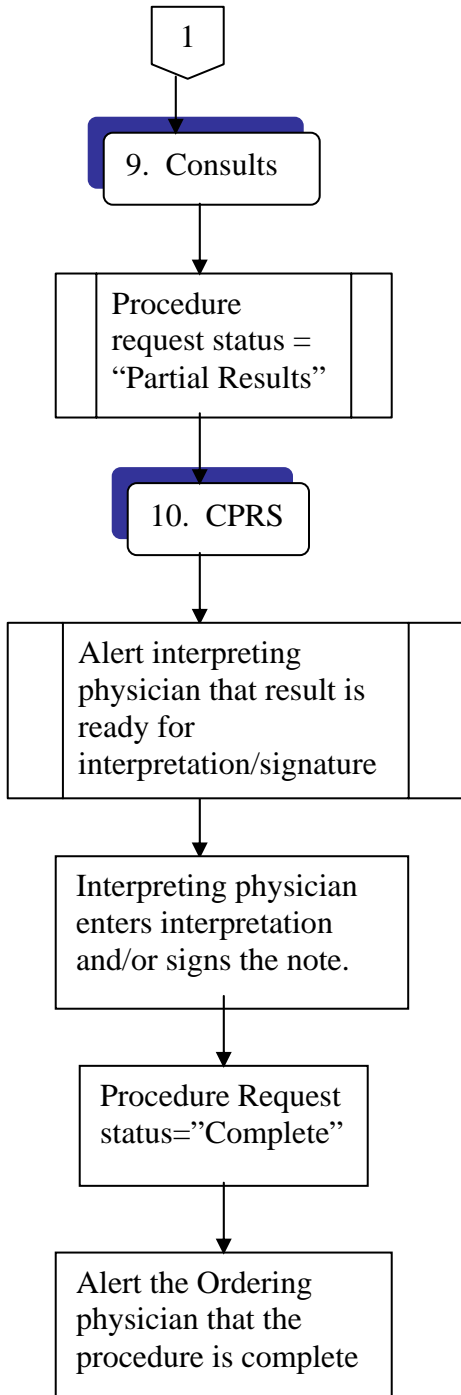
Clinical Procedures Bi-Directional Interface Process Flow:





Clinical Procedures Uni-Directional Interface Process Flow:





Intended Audience

This User Manual is intended for use by clinicians, physicians, nurses, technicians, TSO, and IRMS. End users should be familiar with the following:

- Windows operating systems
- CPRS functionality

Related Manuals

Here is a list of related manuals that you may find helpful:

Clinical Procedures Installation Guide
Clinical Procedures Technical Manual and Package Security Guide
Clinical Procedures Implementation Guide
Clinical Procedures Release Notes
CPRS User Manual
Consult/Request Tracking User Manual
Consult/Request Tracking Technical Manual
Text Integration Utilities (TIU) Implementation Guide
Text Integration Utilities (TIU) User Manual
VistA Imaging System (Clinical) User Manual

You can locate these manuals in the [VistA Documentation Library \(VDL\)](#). Select **Clinical** from the VDL web page, select the package you want, and then select the manuals. For example, you can select CPRS on the left side of the page. The list of CPRS manuals is displayed.

Product Benefits

- **Common User Interface**

Clinicians can use CPRS to enter, review, interpret, and sign CP orders. CP documents in TIU obey Authorization Subscription Utility (ASU) Business Rules. The update users functionality currently used by Consults determines which users are allowed to access or edit CP documents.

- **Integration**

Clinicians order procedures in CPRS. Orders are processed through the Consult/Request Tracking Package (Consults) and data is interpreted, entered, and displayed through CPRS. Final results of the CP procedure are displayed by VistA Imaging. Ordering, viewing, reviewing, interpreting, and signing the CP medical record is accessed through one location, the CPRS Consults tab. You use CP User to check in patients. CP User also links the result from the automated instrument to the procedure ordered through Consults.

- **Variety of Accepted File Types**

CP is able to accept data/final result report files from automated instruments. The supported imaging file types are the following:

.txt	Text files
.rtf	Rich text files
.jpg	JPEG Images
.jpeg	JPEG Images
.bmp	Bitmap Images
.tiff	TIFF Graphics (group 3 and group 4 compressed and uncompressed types)
.pdf	Portable Document Format
.html	Hypertext Markup Language

.DOC (Microsoft Word files) are not supported. Be sure to convert .doc files to .rtf or to .pdf format.

- **Links to Other Packages**

CP interfaces with packages such as Computerized Patient Record System (CPRS), Consult/Request Tracking package, Text Integration Utility package (TIU), and VistA Imaging.

- **Interface Between CP and Imaging**

Certain images such as consent forms and report objects are acquired, processed, stored, transmitted, and displayed by the VistA Imaging package. This interface between CP and Imaging replaces the existing capture interface between Medicine 2.3 and VistA Imaging.

- **Inpatient and Outpatient Workloads**

The Hospital Location, where the procedure is performed, is defined in the CP Definition file (#702.01). The hospital location determines which Encounter Form is presented to the end user. CPRS and TIU parameters allow for the configuration of TIU software to display the electronic encounter form and prompt users to enter workload data. The data is then passed to the Patient Care Encounter software (PCE) for inpatients and outpatients.

2. Working with CP User

This chapter describes how to get started with CP User.

Topics discussed in this chapter are:

- [Opening CP User](#)
- [Defining CP User Icons](#)
- [Selecting a Patient](#)
- [Defining the Parts of the Main CP User Window](#)

Opening CP User

With CP User, the result from the automated medical device is linked to the procedure that was ordered through the Consults tab.

- Double-click **CP User** on your desktop. If you are not currently logged into the Vista system, you need to enter your access and verify codes. Click **OK**. The main CP User window is displayed.

Defining CP User Icons

Select **View > Use Toolbar**.



Open Patient – Opens a new patient record.



Refresh Patient - Refreshes the currently selected patient's information.



Check-in New Study - Checks-in a patient and opens a new study.



Open Study - Opens a currently selected study.



Delete Study - Deletes a currently selected study.



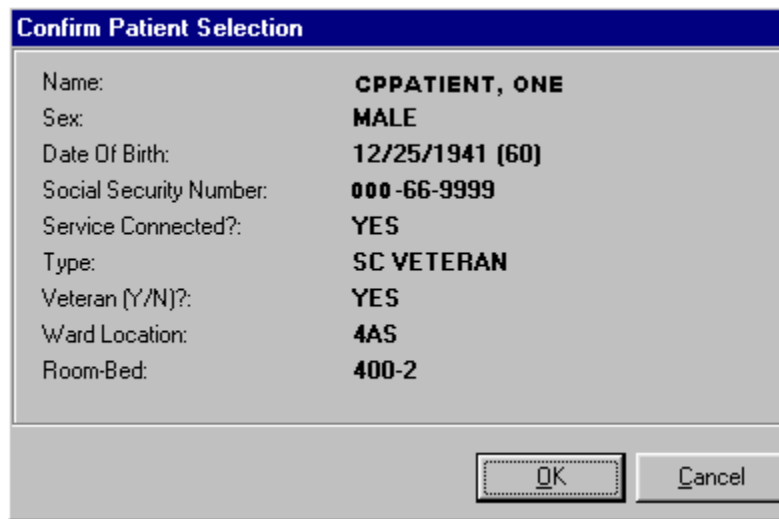
Help - Provides on-line help for this package.



Clinical Procedures Home Page - Goes to the Clinical Procedures Home Page on the Web.

Selecting a Patient

1. Open **CP User**.
2. Select **File > Open Patient**. The main CP User screen lets you select a patient that has a consult procedure ordered. You can choose **Patient**, **Team**, **Clinic**, or **Ward**.
 - Choose **Patient** if you want to select a patient by name, complete SSN, or first initial of the last name and the last four digits of the SSN.
 - Choose **Team** if you want to select a patient from a specific team list defined in the OE/RR List file (#100.21).
 - Choose **Clinic** if you want to select a patient from selected clinic appointments for a predetermined clinic and date.
 - Choose **Ward** if you want to select a patient from selected MAS wards.



The image shows a dialog box titled "Confirm Patient Selection" with a blue header. It contains a list of patient details in a two-column format. At the bottom right, there are two buttons: "OK" and "Cancel".

Field	Value
Name:	CPPATIENT, ONE
Sex:	MALE
Date Of Birth:	12/25/1941 (60)
Social Security Number:	000-66-9999
Service Connected?:	YES
Type:	SC VETERAN
Veteran (Y/N)?:	YES
Ward Location:	4AS
Room-Bed:	400-2

Figure 2-1

3. Double-click the patient's name. A confirmation screen is displayed, which shows additional information about the selected patient. See Figure 2-1. If you select a sensitive patient, a sensitive patient window is displayed indicating that the patient's information should only be accessed on a need to know basis.
4. Click **OK**. Figure 2-2, the main CP User window is displayed.

Defining the Parts of the Main CP User Window

In this main window, you can select a treating specialty from the left and view a list of procedures within that treating specialty on the right. Click the column headers to sort them in ascending or descending order.

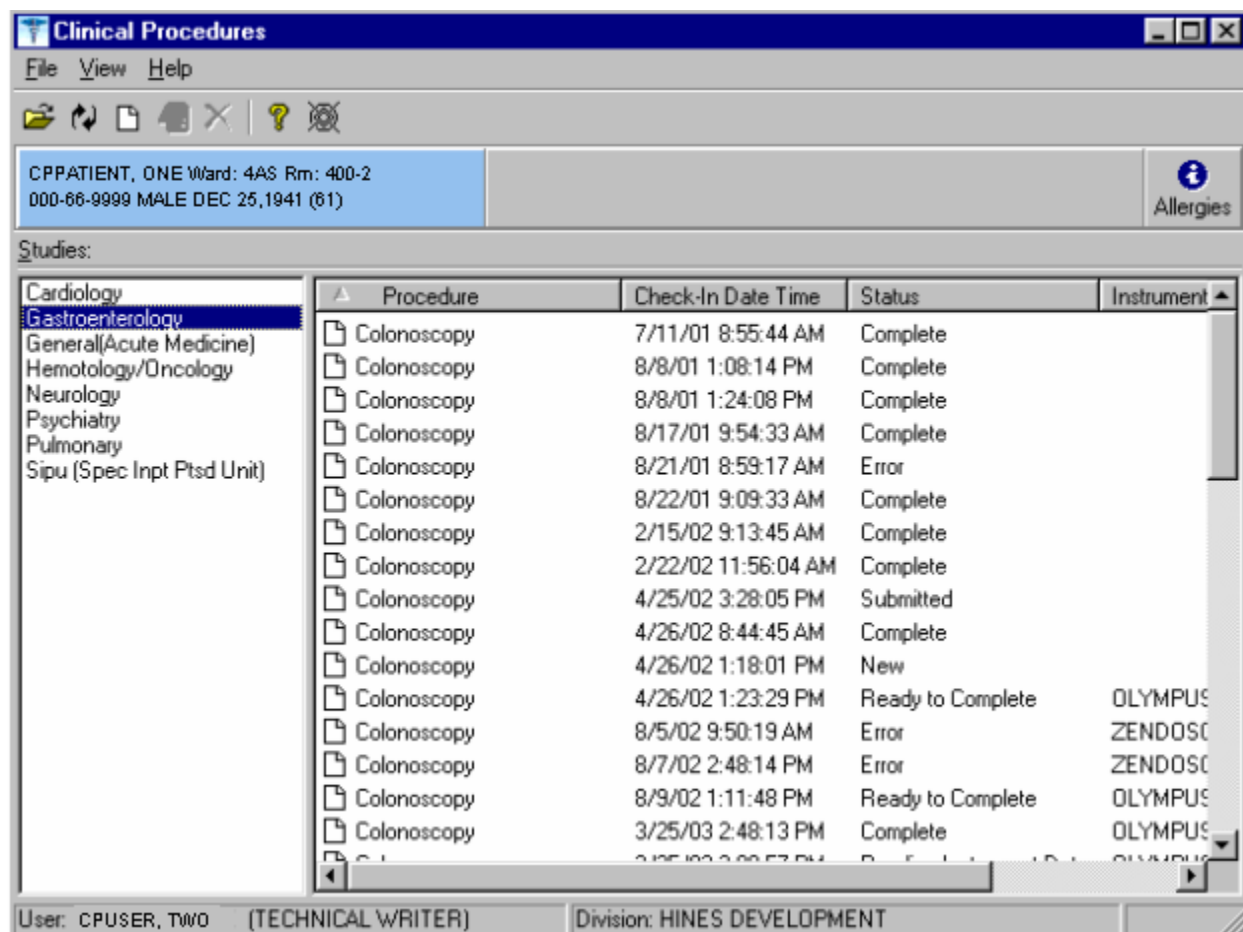


Figure 2-2

The status column displays New, Submitted, Error, Ready to Complete, Pending Instrument Data, and Complete. Here is a description of each status type in Figure 2-2.

- **New** - (The New status is only available with VistA Imaging.) A study has been requested by VistA Imaging and needs to be checked-in and submitted to an instrument. Example: You scanned in a consent form through the VistA Imaging Capture Workstation. A new CP Study record is created along with a TIU document.

- Submitted - This study has been submitted to the VistA Imaging Background Processor. The study report waits in the Imaging Background Processor queue to be copied or processed and placed on the VistA Imaging server. A study in this status is not accessible until VistA Imaging returns a status of Complete or Error and logs any errors encountered in the submission process.
- Error - This study has encountered an error while being submitted to VistA Imaging. The error may have been caused when the TIU note was created, when a visit was created, when the results were linked to the procedure, or when the attachments were sent to the VistA Imaging server. Error messages are logged with the study and can be reviewed by opening the study in an error status.
- Complete - This study has successfully created a TIU note for interpretation and images have been sent to VistA Imaging for the selected consult procedure order. If any attachments were included, they have been successfully copied to the VistA Imaging server.
- Pending Instrument Data – (This status is only valid for bi-directional instruments that have not returned results.) The procedure request has been submitted to a bi-directional instrument and is waiting for the instrument to return the results. Studies in this status should not be opened until the instrument has returned the results, assigned them to the study, and marked the study as Ready to Complete.
 - If the “Auto Submit to VistA Imaging” checkbox is selected for the associated procedure in CP Manager, the study goes to Complete.
 - If the “Auto Submit to VistA Imaging” checkbox is not selected for the associated procedure in CP Manager, the study goes to Ready to Complete.
- Ready to Complete –
When a study is done on a uni-directional instrument, the status displays as Ready to Complete.

When a study is submitted to a bi-directional instrument, the study remains in Pending Instrument Data status and changes to Ready to Complete after the study has received the data from the instrument. (Auto Submit to VistA Imaging is not selected.)

In the Ready to Complete status, you can open the study, view the Consult/Procedure order, and manually submit instrument results and external attachments to VistA Imaging.

A study can be deleted when it has a status of “Pending Instrument Data” and the user has the MD Manager key. A study should be deleted only if the study was sent to the wrong instrument, or if the patient was unable to complete the procedure. Select **File > Delete Study** and click **Delete**. A cancel order is sent to the device. If that device is not working, you must manually delete the order from the device. Refer to the manual for your specific instrument for instructions on deleting an order.

3. Clinical Procedures Process, Part 1

This chapter describes the process to follow for ordering clinical procedures. (Although you can order several types of procedures in CPRS, you must follow the steps in this chapter to order clinical procedures.) This chapter uses the example of ordering a colonoscopy test to describe the Clinical Procedures ordering process. Be sure to follow the **required** steps in sequential order. You can do the optional steps as needed.

1. [Order a consult procedure in CPRS](#). Required
2. [Check in a new study](#). Required
3. [Update study status to correct errors](#). Optional

Ordering a Consult Procedure in CPRS

This section describes how to order a CP procedure, such as a study, a test, or an invasive intervention, such as a surgical or medical procedure, through CPRS. Keep in mind that you can only order a Clinical Procedure as a procedure order and not as a consult request.

In addition to becoming familiar with the CPRS ordering process, you can learn about the interpreter, which is the new user role within ASU that supports CP. The interpreter is a new User Role created by ASU that defines a user who can interpret (sign-off or verify) the procedure's final report. Clinical application coordinators define interpreters in the Consults package.

If you are an interpreter for a specific procedure, you can receive an alert when the procedure results are ready for review. Additional comments can be added if necessary along with the Procedure Summary code and the electronic signature. The following example describes how to order a colonoscopy procedure through the CPRS Consults tab.

1. Logon to CPRS. The Patient Selection window is displayed, Figure 3-1.

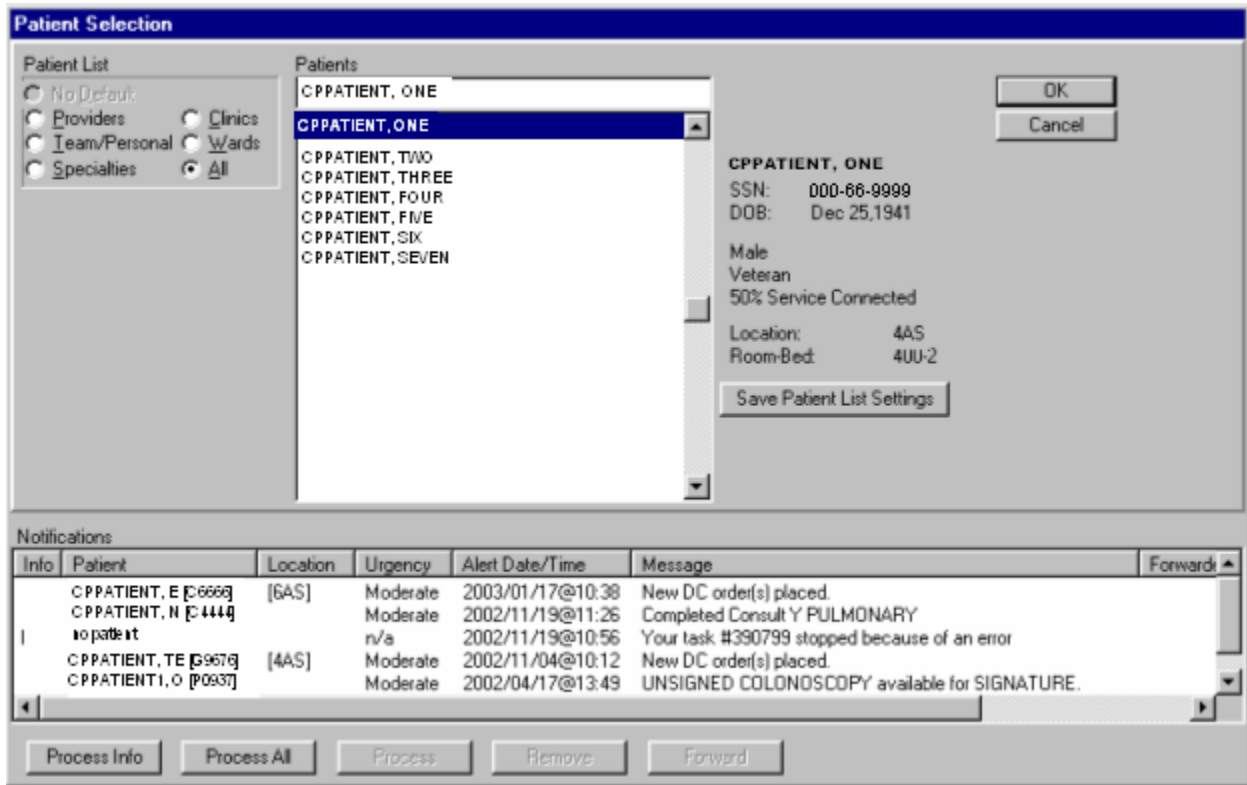


Figure 3-1

2. Select a patient. Notice that CPPATIENT, ONE is the selected patient. The Cover Sheet window is displayed, Figure 3-2.

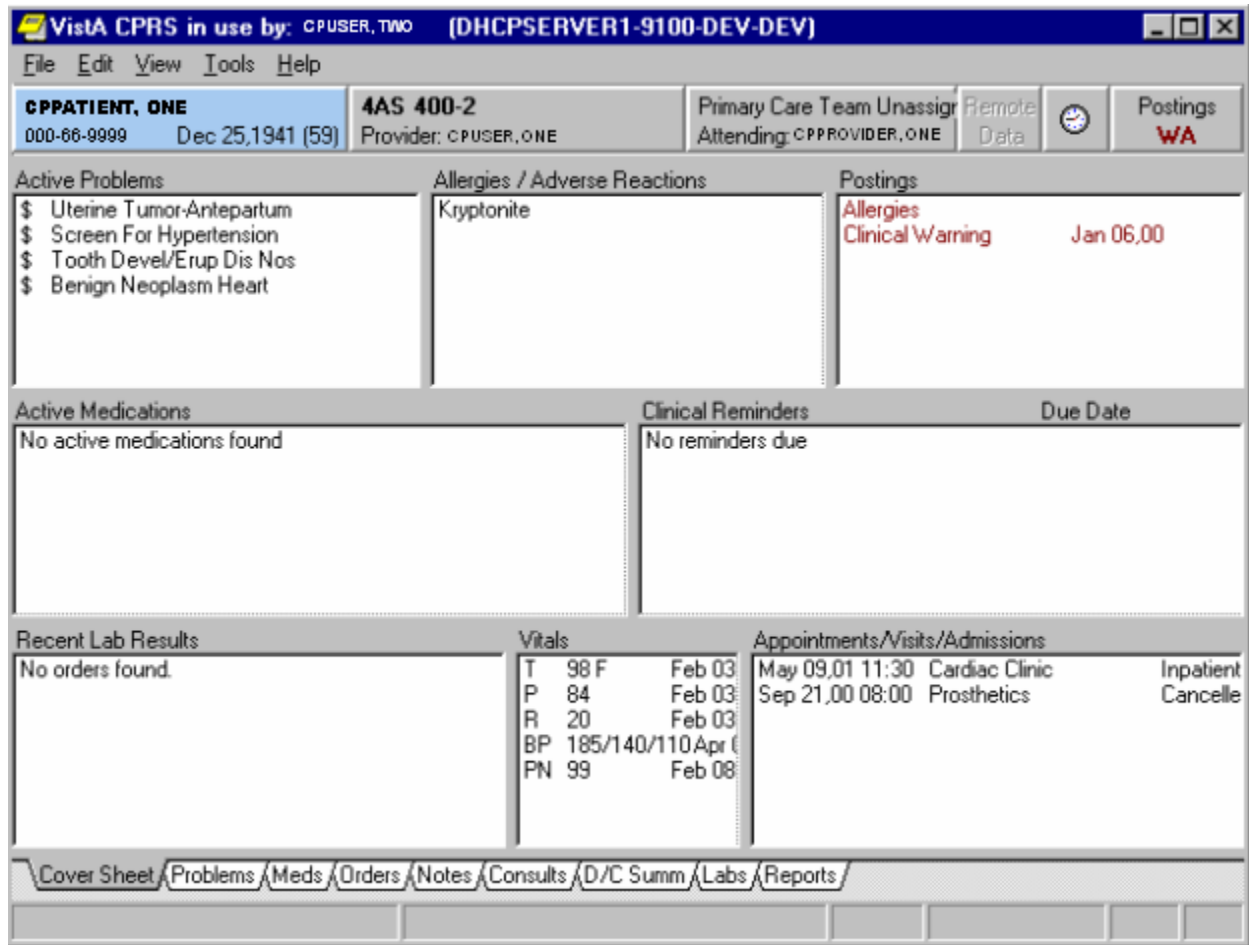


Figure 3-2

3. Click the **Consults tab** at the bottom of the window, Figure 3-3.

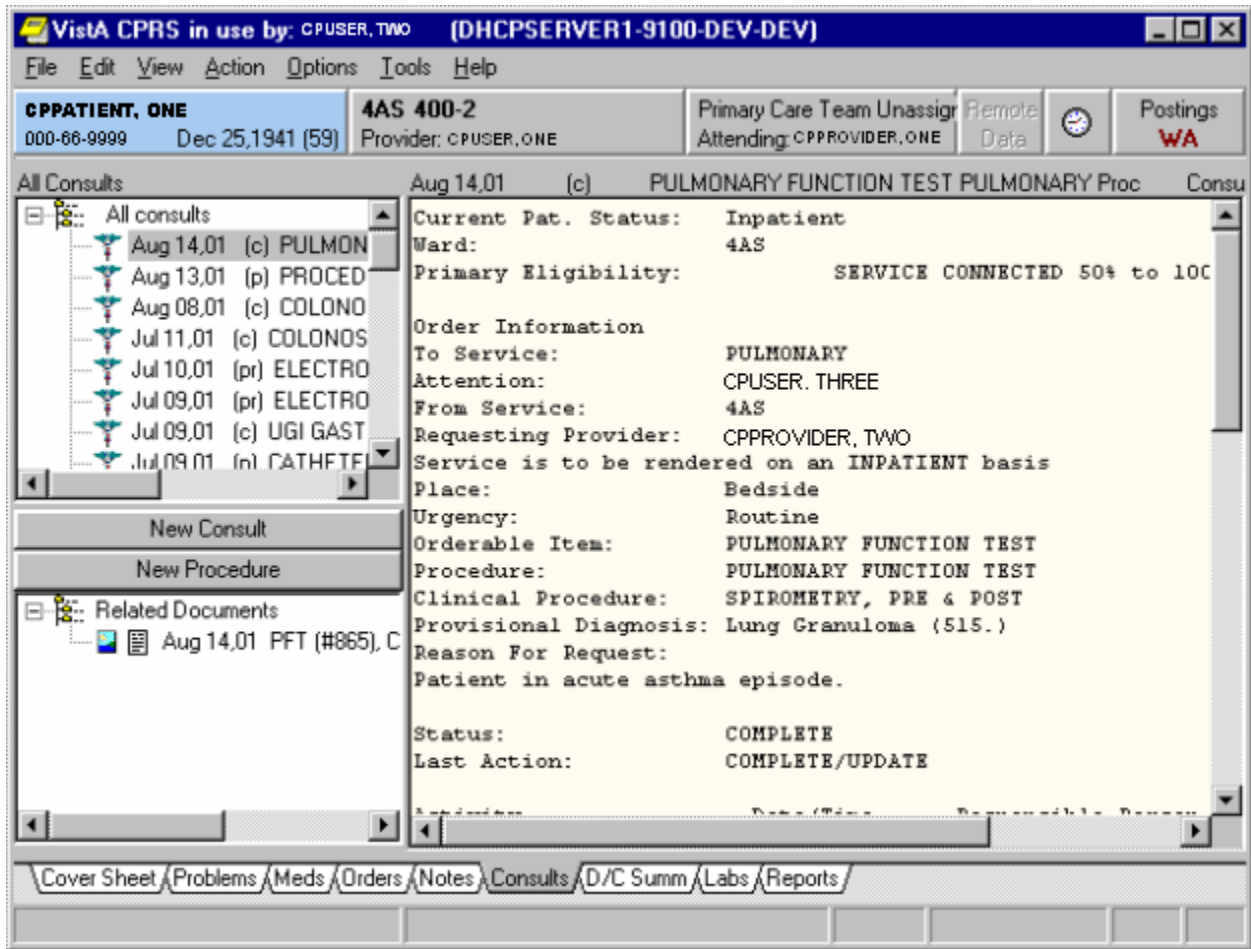


Figure 3-3

4. If you want to review an existing Consult or procedure, select one in the list from the upper left panel. The lower left panel contains any supporting documents for the selected consult or procedure, and the larger right panel contains the order details.
5. Click **New Procedure** on the left side of the Consults tab. You can also order a clinical procedure from the Orders tab. Since CPPATIENT, ONE is an inpatient, the Order a Procedure window, Figure 3-5, is displayed. Go to step 7 to order the procedure.

(If you were to select an outpatient, Figure 3-4 appears so you can enter a location. Go to step 6.)

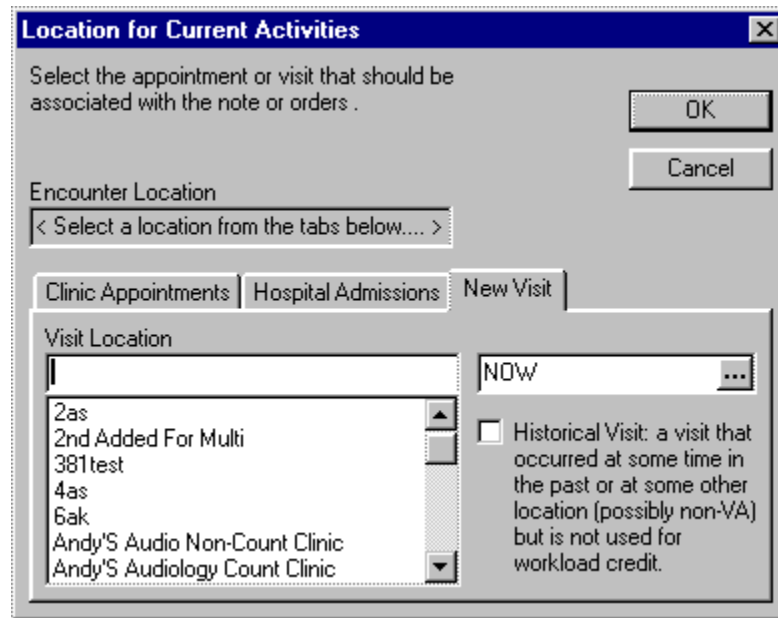


Figure 3-4

6. For Outpatients, select either the **Clinic Appointments** or **New Visit** tab.
 - Select **Clinic Appointments** if the patient already has an appointment through Scheduling.
 - Select **New Visit** if an appointment has not been made through Scheduling, and then select a location from the list of Visit Locations. The Encounter Location is filled in automatically.
 - If the patient had existing admissions, these are displayed under the Hospital Admissions tab.
 - Go to step 7 to order the procedure.

Order a Procedure

Procedure: COL <COLONOSCOPY>

Urgency: ROUTINE

Attention: CPUSER, FOUR

Service to perform this procedure: GASTROENTEROLOGY

Patient will be seen as an: Inpatient Outpatient

Place of Consultation: BEDSIDE

Provisional Diagnosis: undifferentiated abdominal pain [Lexicon]

Reason for Request: Acute abdominal pain.

COLONOSCOPY GASTROENTEROLOGY Proc BEDSIDE

Accept Order Quit

Figure 3-5

7. To order the colonoscopy procedure, select Colonoscopy from the Procedure dropdown list, Figure 3-5.
 - Complete the appropriate fields.
 - Click **Accept Order**.
 - Click **Quit**.

8. To sign the consult procedures, select **File > Review/Sign Changes**. Figure 3-6 is displayed.
 - Click the appropriate check box to select the colonoscopy.
 - Enter your electronic signature code.
 - Click **Sign** to return to the Consults tab. At this point, the procedure order is completed.

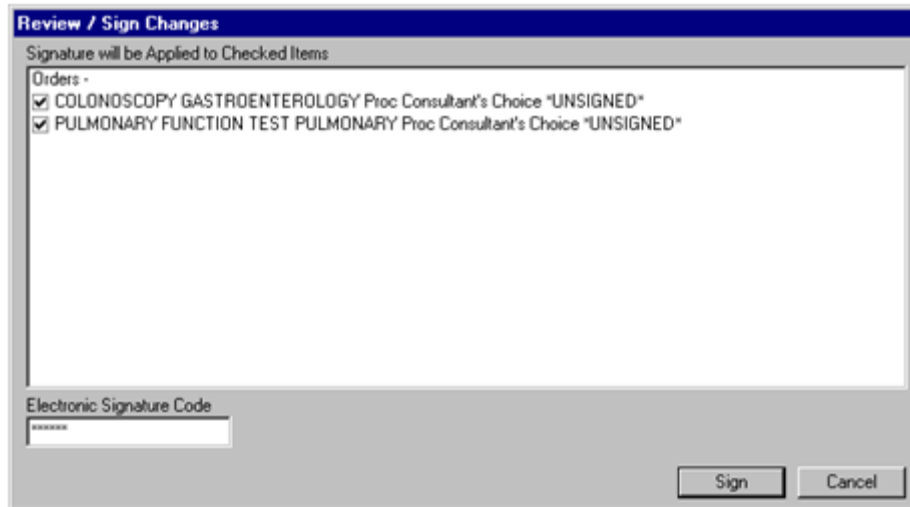


Figure 3-6

9. Click the **Orders tab** to review the ordered procedures. These procedure orders appear on the Active Orders sheet (Figure 3-7).

VistA CPRS in use by: CPUSER, TWO [DHCPSEVER1-9100-DEV-DEV]

File Edit View Action Options Tools Help

CPPATIENT, ONE 4AS 400-2 Primary Care Team Unassign Remote Postings
 000-86-9999 Dec 25,1941 (59) Provider: CPUSER,ONE Attending: CPPROVIDER,ONE Data WA

Order Sheet Active Orders (includes Pending & Recent Activity) - ALL SERVICES

Service	Order	Start / Stop	Provider	Nrs	Clk	Chart
Admit...	MRI OF HEAD	Start: 09/10/99	CPPROVIDER, T			
Transfer...	Consults GASTROENTEROLOGY Cons Bedside	Start: 06/21/01 16:12	CPPROVIDER, F			
Discharge	PARACENTESIS Cons Bedside	Start: 04/24/01 14:33	CPPROVIDER, F			
Write Orders	Consult: DENTAL TEST		CPPROVIDER, F			
Allergies	Procedur PULMONARY FUNCTION TEST	Start: 08/17/01 09:52	CPPROVIDER, T			
Diet	PULMONARY Proc Bedside					
Meds, Inpatient	COLONOSCOPY GASTROENTEROLOGY	Start: 08/17/01 09:52	CPPROVIDER, T			
Meds, Outpatient	Proc Bedside					
IV Fluids	PROCEDURE ENDOSCOPY Proc Bedside	Start: 08/13/01 16:53	CPPROVIDER, S			
Lab Tests	ELECTROCARDIOGRAM CARDIOLOGY	Start: 07/10/01 08:25	CPPROVIDER, S			
Imaging	Proc Bedside					
Consult	ELECTROCARDIOGRAM EKG ISC Proc	Start: 07/09/01 11:08	CPPROVIDER, S			
Procedure	Bedside					
Vitals	CATHETERIZATION CARDIOLOGY	Start: 07/09/01 11:08	CPPROVIDER, S			
Text Only Order	CLINIC Proc Bedside					
	CATHETERIZATION CARDIOLOGY	Start: 06/25/01 10:51	CPPROVIDER, S			
	CLINIC Proc Bedside					
	PROCEDURE ENDOSCOPY Proc Bedside	Start: 06/21/01 16:15	CPPROVIDER, F			
	COLONOSCOPY GASTROENTEROLOGY	Start: 06/06/01 13:43	CPPROVIDER, S			
	Proc Bedside					
	PULMONARY FUNCTION TEST	Start: 06/06/01 13:40	CPPROVIDER, S			
	PULMONARY Proc Bedside					
	BONE MARRROW ASPIRATE	Start: 06/06/01 15:10	CPPROVIDER, S			

Cover Sheet Problems Meds Orders Notes Consults D/C Summ Labs Reports

Figure 3-7

¹Auto Study Check-In

The auto study check in is a new enhancement introduced with patch MD*1.0*14. The site can specify a procedure to have auto study check in using the MD AUTO CHECK-IN SETUP option. Refer to the Clinical procedures Implementation Guide to set up a procedure for the auto study check-in. This new functionality can be used if the site schedules an appointment for the patient or not. If the site does not use appointments, the study will be checked in as soon as the order is requested in CPRS. The status of the study will be “Pending Instrument Data”. If the site uses appointments, the study will have a status of “New” until the day of the appointment and the status will change to “Pending Instrument Data”.

For procedures that require multiple encounters from the patient such as hemodialysis, respiratory therapy, and sleep studies, each encounter will generate a study check-in if there is an appointment scheduled for each encounter. If no appointment is used, only the initial check-in will be auto checked-in and the additional encounters will still require manual check-in.

Once a procedure is set up to use the auto study check-in functionality in the MD CHECK-IN SETUP option, the software will check-in any existing order requests with the status of “PENDING”, “ACTIVE”, and “SCHEDULED” in the Consult Request Tracking package.

If you have set up a procedure for auto check-in, you can skip the section on Check in a new study. The study will be checked-in for you when the order is requested in CPRS.

Note 1: If the patient is a no show, you must remove the study that was checked-in. You can delete the check-in in CP User or you can cancel the procedure in CPRS. If you cancel or discontinue the order in CPRS, the status of the CP study will be changed to “Cancelled”. If the appointment is rescheduled, the study will still need to be removed.

Note 2: Please make sure the studies are completed on time. If a previous study is still in “Pending Instrument Data” or “Ready to Complete” status, the subsequent study check-in for the subsequent encounter will not be effective until the previous study is complete.

Note 3: In the case of an emergency procedure, the procedure will be performed prior to the order request. The order request will be entered after the procedure and the study will be auto checked in. You will need to attach the result manually as a uni-directional interface and submit the result. Since the study is auto checked-in for the bi-directional device, you will need to clean up and remove the patient name from the selection list on the device.

In order to set up a procedure for auto-check-in, make sure you already have the procedure set up in Clinical Procedures and Consults/Request Tracking. If your site is just implementing Clinical Procedures for the first time, set up the procedure and instrument for the regular Clinical Procedure interface before implementing the procedure for auto study check-in.

¹ Patch MD*1.0*14 March 2008 Added new section for Auto Study Check in.

Auto Check-In Without Appointment

Once a procedure is set up to use the auto study check-in functionality, the software will check-in any existing order requests with the status of “PENDING,” “ACTIVE,” and “SCHEDULED” in the Consult Request Tracking package.

In this section, the following workflows are described:

- Setting Up the Procedure for auto study check-in.
- Procedure Request in CPRS.
- Confirming the auto study check-in

Setting Up the Procedure

Use the option MD AUTO CHECK-IN SETUP to indicate which procedure will use the auto check-in functionality.

Note: If your site uses appointments, schedule them **before** you enter the procedures for auto check-in. If you do not, the patients associated with those appointments will need to be manually checked in.

This option collects the following information:

- 1) Use Appointment with procedure? (Yes/No) (Required) – The default is “NO” if the site does not schedule procedures before the order is entered. Enter “YES” if the procedure appointment is scheduled before the order is entered and the ordering provider selects the appointment for the procedure during ordering in CPRS. Take the default of “NO” if the provider sometimes selects the appointment scheduled and sometime doesn’t. This prompt only applies to outpatients.
- 2) Procedure (Required) – Enter the CP Definition that will be using the auto study check-in functionality.
- 3) Schedule Appointment? (Required) – Enter 0 for None, 1 for Outpatient, 2 for Inpatient, or 3 for Both. This indicates that the site schedules appointments for inpatient, outpatients, both, or none.
- 4) Clinic (Optional) – Enter the hospital location(s) that will be used for the scheduled procedure. You can enter more than one location for a procedure. After you have entered one hospital location, you will be asked if you want to enter another.

NOTE: If no clinic is entered in the setup, CP will use the hospital location defined in the HOSPITAL LOCATION field of the CP Definition file (#702.01) as the location of the visit for the CP study check-in.

In the following example, an EKG Routine (12 Leads) procedure is set up for auto study check-in.

```

Select OPTION NAME: MD AUTO CHECK-IN SETUP          Auto Study Check-In Setup
Auto Study Check-In Setup
Use Appointment with procedure? NO// ?

Default should be 'N' as most sites do not schedule procedures
before the order is entered.  Select 'Y' if the procedure appointment
is scheduled before the order is entered and the ordering provider
selects the appointment for the procedure.
Enter either 'Y' or 'N'.

Use Appointment with procedure? NO//
Procedure: ?
Enter a CP Definition for the procedure to
have auto CP study check-in.

Answer with CP DEFINITION NAME
Do you want the entire CP DEFINITION List? y (Yes)
Choose from:
COL BIOPSY
COLONOSCOPY
EKG, ROUTINE (12 LEADS)
HEMODIALYSIS, REPEATED EVAL.
PULMONARY PROCEDURES

Procedure: EKG, ROUTINE (12 LEADS)
Schedule Appointment?: ?

REQUIRED field for the procedure to have auto CP study check-in.
Enter a "^" will exit completely.

Enter 0 if you do not schedule appointments.
1 if you only schedule appointments for outpatients.
2 if you only schedule appointments for inpatients.
3 if you schedule appointments for both 1 and 2.

Select one of the following:

0          None
1          Outpatient
2          Inpatient
3          Both

Schedule Appointment?: 0 None

Procedure:
    
```

In the example shown above, the EKG Routine (12 Leads) is set up for auto check-in without an appointment involved. The default of “NO” was entered for the question “Use Appointment with procedure?” and 0 was entered for the question “Schedule Appointment?”

Use CPManager.exe and verify for the EKG procedure that you have 1) the hospital location field filled in, 2) the Active checkbox is checked, and 3) One bi-directional instrument checkbox is checked.

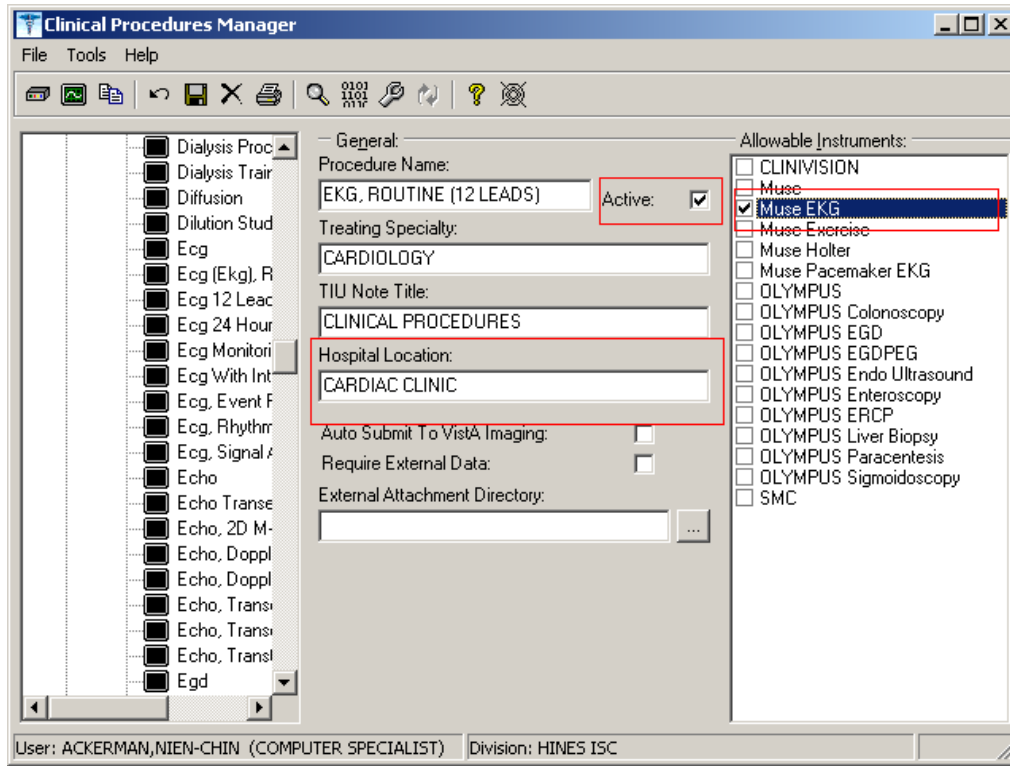


Figure 3-8

Use CP Manager.exe and verify that the Muse EKG instrument is set up. Use the Interface Analyzer button, check the instrument Muse EKG, and click Analyze. The Ready Status should be “Pass.”

Note: Make sure the instrument is Active, has a Notification Mailgroup, and HL7 link.

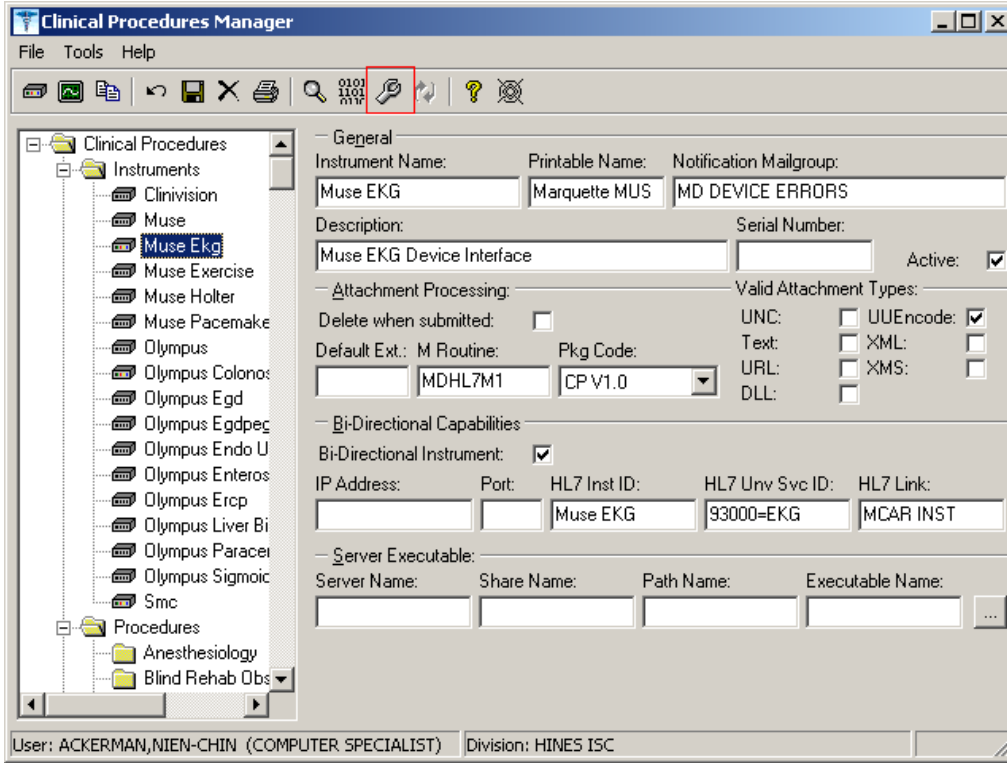


Figure 3-9

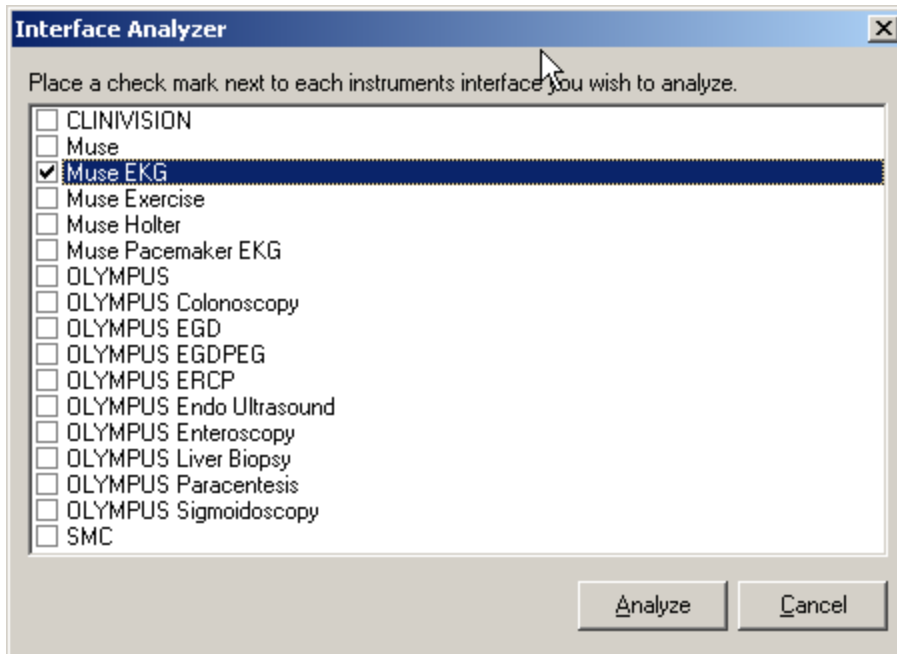


Figure 3-10

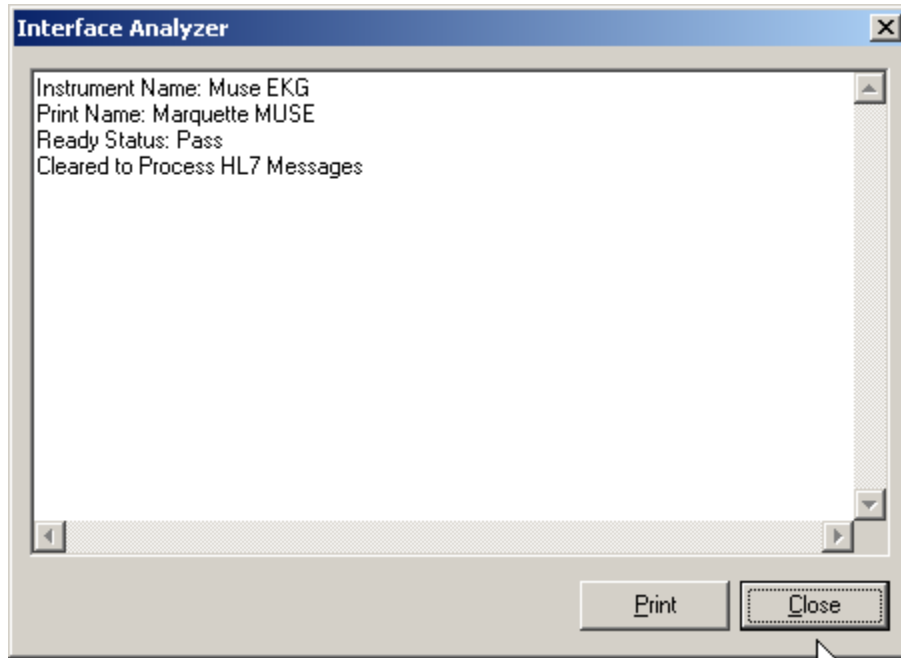


Figure 3-11

Use the GMRC PROCEDURE SETUP to verify that EKG, ROUTINE (12 LEADS) is linked to a GMRC Procedure in Consult.

```
Select OPTION NAME: GMRC PROCEDURE SETUP          Setup procedures
Setup procedures
Select Procedure:CP EKG
  1   CP EKG 12 LEAD STAT
  2   CP EKG INPATIENT,48 HRS, CONS CHOICE
  3   CP EKG INPATIENT,STAT
CHOOSE 1-5: 1  EKG 12 LEAD STAT
NAME: CP EKG 12 LEAD STAT//
INACTIVE: NO//
Select SYNONYM: EKG//
INTERNAL NAME:
Select RELATED SERVICES: CARDIOLOGY CLINIC//
TYPE OF PROCEDURE:
CLINICAL PROCEDURE: EKG, ROUTINE (12 LEADS)

PREREQUISITE:
  1>
PROVISIONAL DX PROMPT:
PROVISIONAL DX INPUT:
DEFAULT REASON FOR REQUEST:
  1>
RESTRICT DEFAULT REASON EDIT:

Orderable Item Updated
```

Procedure Request in CPRS

The procedure request is ordered and signed as you would for any other procedure in CPRS.

The screenshot shows a window titled "Order a Procedure" with the following fields and controls:

- Procedure:** CP EKG 12 LEAD STAT
- Urgency:** ROUTINE
- Attention:** (empty)
- Service to perform this procedure:** CARDIOLOGY CLINIC
- Patient will be seen as an:** Inpatient Outpatient
- Place of Consultation:** CONSULTANT'S CHOICE
- Provisional Diagnosis:** (empty) with a Lexicon button
- Reason for Request:** Request EKG procedure without appointment.
- Summary Bar:** CP EKG 12 LEAD STAT CARDIOLOGY CLINIC Proc CONSULTANT'S CHOICE
- Buttons:** Accept Order, Quit

Figure 3-12

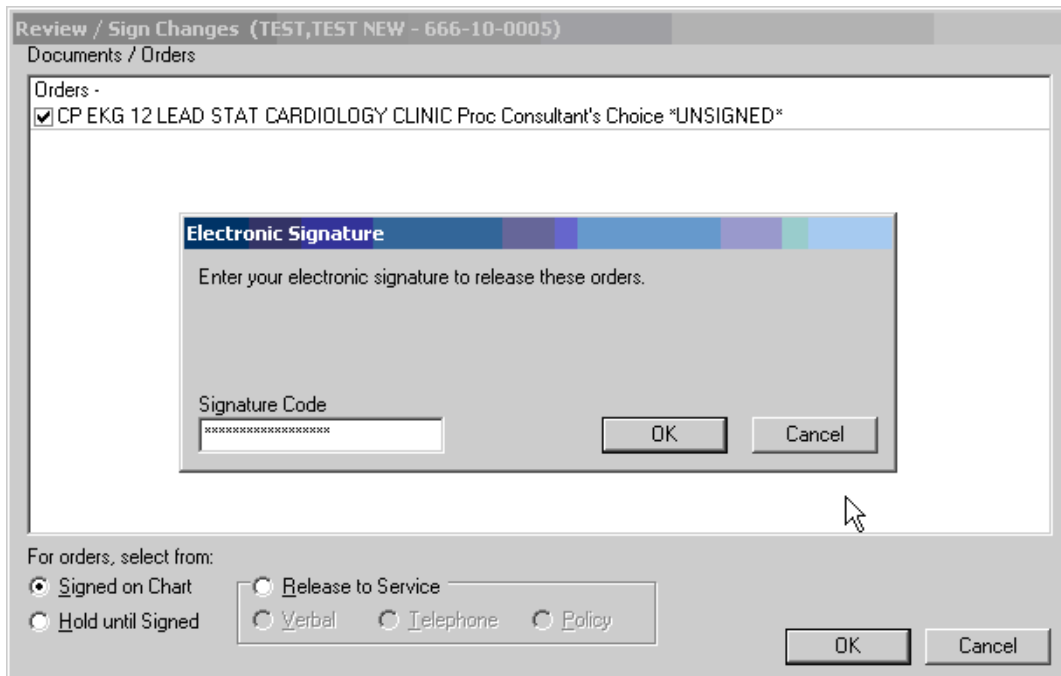


Figure 3-13

Confirm the Auto Study Check-In

Once the procedure is requested and signed in CPRS, the study for the EKG procedure will be auto checked-in in CPUSER with the status of “Pending Instrument Data”.

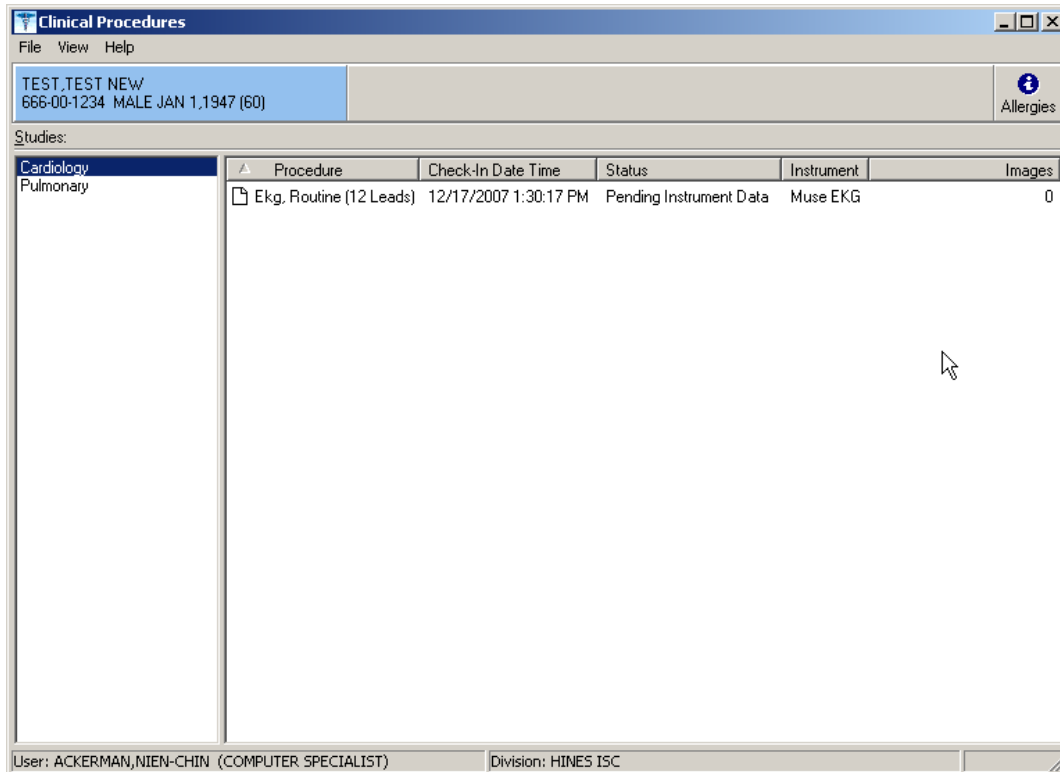


Figure 3-14

Auto Study Check-In With Appointment

If your site scheduled an appointment for the procedure, the study will be checked in and the study will not take into effect until the day of the appointment.

In this section, we will follow an example workflow of the auto study check-in for a procedure with appointment involved. In the next example, the Pulmonary Procedure is used to show the setup of the procedure for auto check-in and both inpatient and outpatient have an appointment scheduled.

A new visit is not an appointment scheduled. If your site only creates a new visit for the patient upon order request, it would not be considered an appointment scheduled.

```
Select OPTION NAME: MD AUTO CHECK-IN SETUP          Auto Study Check-In Setup
Auto Study Check-In Setup
Use Appointment with procedure? NO// ?
```

Clinical Procedures Process, Part 1

Default should be 'N' as most sites do not schedule procedures before the order is entered. Select 'Y' if the procedure appointment is scheduled before the order is entered and the ordering provider selects the appointment for the procedure.
Enter either 'Y' or 'N'.

Use Appointment with procedure? NO//

Procedure	Schedule Appt.	Clinic
-----	-----	-----
EKG, ROUTINE (12 LEADS)	None	None

Procedure: ?
Enter a CP Definition for the procedure to have auto CP study check-in.

Answer with CP DEFINITION NAME
Do you want the entire CP DEFINITION List? y (Yes)
Choose from:
COL BIOPSY
COLONOSCOPY
EKG, ROUTINE (12 LEADS)
HEMODIALYSIS, REPEATED EVAL.
PULMONARY PROCEDURES

Procedure: PULMONARY PROCEDURES
Schedule Appointment?: ?

REQUIRED field for the procedure to have auto CP study check-in.
Enter a "^" will exit completely.

Enter 0 if you do not schedule appointments.
1 if you only schedule appointments for outpatients.
2 if you only schedule appointments for inpatients.
3 if you schedule appointments for both 1 and 2.

Select one of the following:

0	None
1	Outpatient
2	Inpatient
3	Both

Schedule Appointment?: 3 Both

Clinic: ?
Only required, if appointments are scheduled for the procedure.
Enter the clinic used for scheduling the procedure.

Answer with HOSPITAL LOCATION NAME, or ABBREVIATION, or TEAM
Do you want the entire 112-Entry HOSPITAL LOCATION List? N

Clinic: PFT LAB

Enter another clinic for the same procedure? NO// ?

Enter either 'Y' or 'N', if you want to assign more than one clinic.

Enter another clinic for the same procedure? NO// YES

Clinic: SHIR
1 SHIRL CLINIC
2 SHIRL-2
CHOOSE 1-2: 2 SHIRL-2

Enter another clinic for the same procedure? NO//

Procedure:

Use CPManager.exe and verify for the PULMONARY PROCEDURE that you have 1) left the hospital location field blank, 2) checked the Active checkbox, and 3) checked One Bi-directional instrument checkbox.

Note: The Hospital Location field is blank because the location of the appointment will be used for workload.

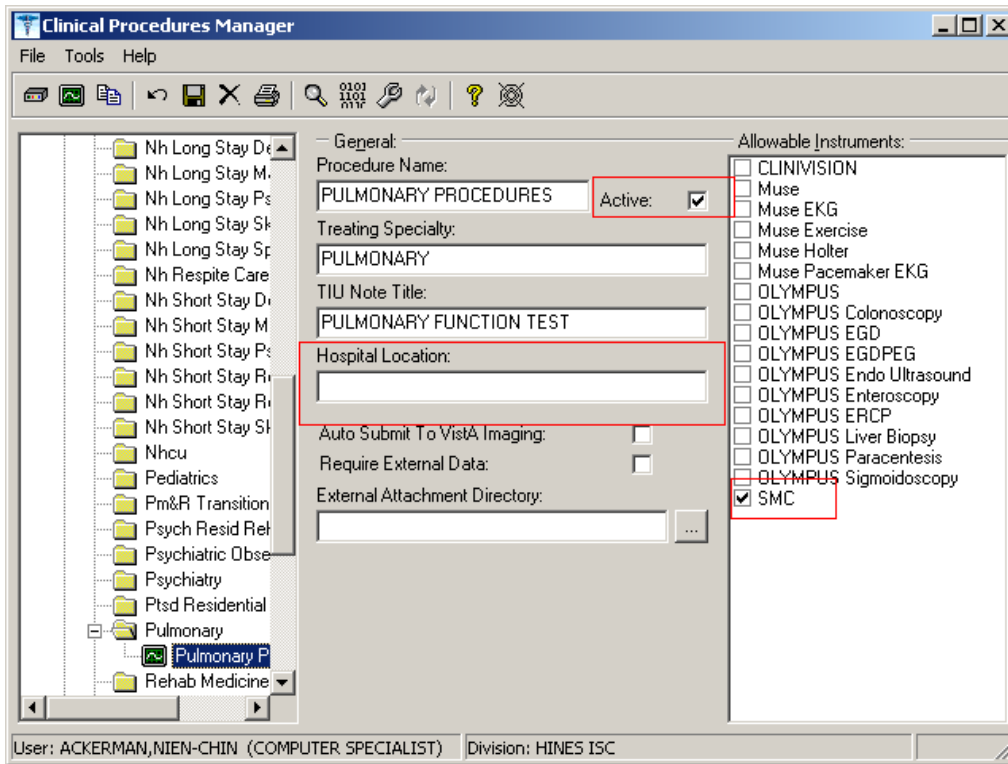


Figure 3-15

Use CP Manager.exe and verify that the SMC instrument is set up. Use the Interface Analyzer button and check the instrument SMC and click Analyze. The Ready Status should be “Pass.”

Note: Make sure the instrument is Active, has a Notification Mailgroup and an HL7 link.

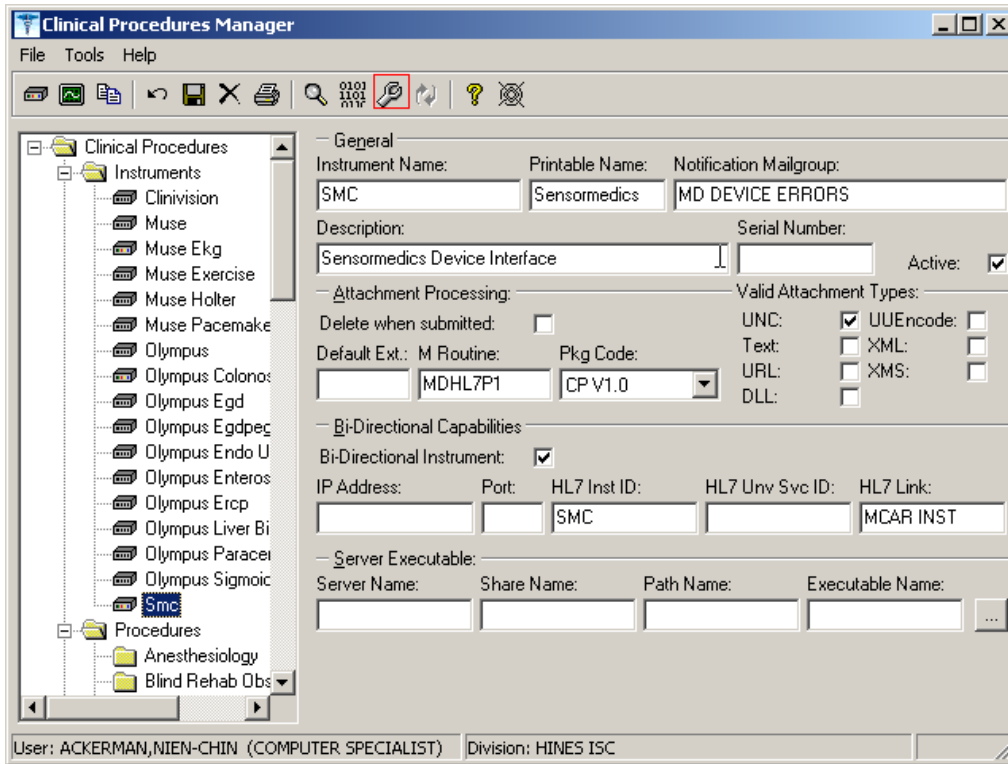


Figure 3-16

Use the option “GMRC PROCEDURE SETUP” and verify the Pulmonary procedure is linked to a GMRC Procedure. Add the text “Visit Date: |VISIT DATE|” to the first line of the DEAFULT REASON FOR REQUEST field.

```

Select OPTION NAME: GMRC PRO
  1  GMRC PROCEDURE SETUP           Setup procedures
  2  GMRC PROTOCOL DETAILED REPORT   Detailed Report of GMRC Protocols
  3  GMRC PROTOCOL LIST              List GMRC Protocols
CHOOSE 1-3: 1 GMRC PROCEDURE SETUP   Setup procedures
Setup procedures
Select Procedure:CP PULMONARY FUNCTION TEST
...OK? Yes// (Yes)

NAME: CP PULMONARY FUNCTION TEST Replace
INACTIVE: NO//
Select SYNONYM: PFT//
INTERNAL NAME:
Select RELATED SERVICES: PULMONARY//
TYPE OF PROCEDURE:
CLINICAL PROCEDURE: PULMONARY PROCEDURES

PREREQUISITE:
  1>
PROVISIONAL DX PROMPT: OPTIONAL//
PROVISIONAL DX INPUT: LEXICON//
DEFAULT REASON FOR REQUEST:
  1>Visit Date: |VISIT DATE|
  2>
  3>This is a Pulmonary Procedure.
    
```


RESTRICT DEFAULT REASON EDIT:

Orderable Item Updated

The appointment can either be scheduled prior to the order request or after the order request. The appointment has to be for a future date. In the next two figures, they show a scheduled appointment to the PFT Lab for an outpatient and a scheduled appointment to Shirl-2 for an inpatient.

Appt Mgt Module Dec 17, 2007@15:13:53 Page: 1 of 1
 Patient: TEST,D (4444) MT: REQ Outpatient
 Total Appointment Profile * - New GAF Required 11/17/07 thru 09/11/10

Clinic	Appt Date/Time	Status
1 Pft Lab	12/18/2007@10:00	Future

Enter ?? for more actions

CI Check In	CD Change Date Range	DX Diagnosis Update
UN Unscheduled Visit	EP Expand Entry	DL Wait List Display
MA Make Appointment	AE Add/Edit	DE Delete Check Out
CA Cancel Appointment	RT Record Tracking	WD Wait List Disposition
NS No Show	PD Patient Demographics	CP Procedure Update
DC Discharge Clinic	CO Check Out	PC PCMM Assign or Unassign
AL Appointment Lists	EC Edit Classification	TI Display Team Information
PT Change Patient	PR Provider Update	
CL Change Clinic	WE Wait List Entry	

Select Action: Quit//

Appt Mgt Module Dec 17, 2007@15:15:37 Page: 1 of 1
 Patient: TEST,NAJEE (8888) MT: NOT REQ Ward: 3AS
 Total Appointment Profile * - New GAF Required 11/17/07 thru 09/11/10

Clinic	Appt Date/Time	Status
1 Shirl-2	12/18/2007@11:00	Inpatient/Future

Enter ?? for more actions

CI Check In	CD Change Date Range	DX Diagnosis Update
UN Unscheduled Visit	EP Expand Entry	DL Wait List Display
MA Make Appointment	AE Add/Edit	DE Delete Check Out
CA Cancel Appointment	RT Record Tracking	WD Wait List Disposition
NS No Show	PD Patient Demographics	CP Procedure Update
DC Discharge Clinic	CO Check Out	PC PCMM Assign or Unassign
AL Appointment Lists	EC Edit Classification	TI Display Team Information
PT Change Patient	PR Provider Update	
CL Change Clinic	WE Wait List Entry	

Select Action: Quit//

When you request an order for outpatient, you will be prompted for a visit. If the ordering provider selects the appointment during ordering with the procedure, the appointment will be selected below. Otherwise, a new visit is created.

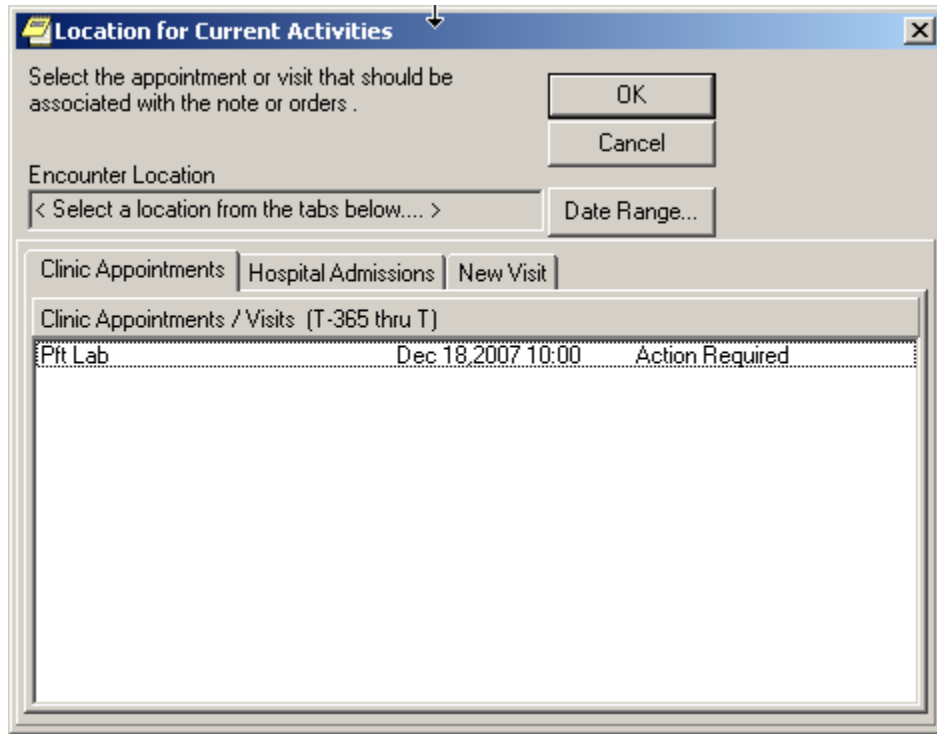


Figure 3-17

If the GMRC Procedure is set up with the Visit Date text, the visit date/time should be visible in the Reason for Request field. If the appointment is selected, the appointment date/time will be visible.

Order a Procedure

Procedure: CP PULMONARY FUNCTION TEST

Urgency: ROUTINE

Attention: [Empty]

Service to perform this procedure: PULMONARY

Patient will be seen as an: Inpatient Outpatient

Place of Consultation: CONSULTANT'S CHOICE

Provisional Diagnosis: Lung Neoplasms (162.9) [Lexicon]

Reason for Request: Visit Date: 12/17/07 14:29
This is a Pulmonary Procedure.

CP PULMONARY FUNCTION TEST PULMONARY Proc CONSULTANT'S CHOICE

Accept Order Quit

Figure 3-18

For the inpatient, the admission date/time will be visible in the Reason for Request field.

After the order is placed for both the inpatient and outpatient, the studies are checked-in for the Pulmonary Procedure in CPUser with the status of “New”.

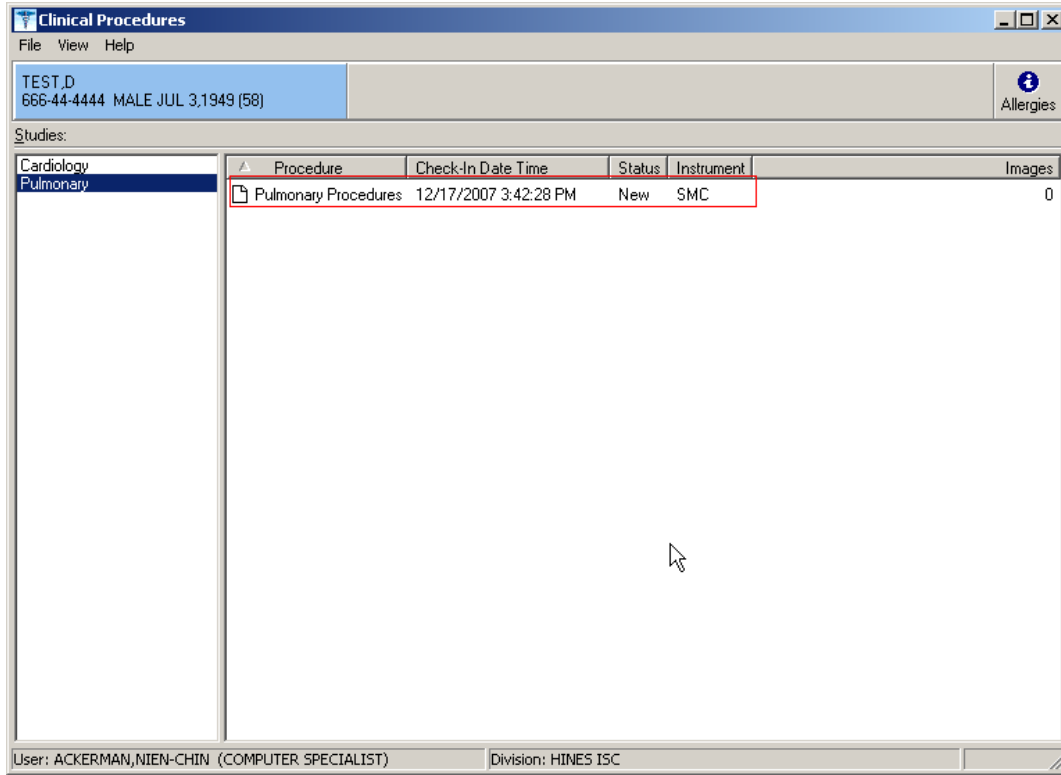


Figure 3-19

The status changes to "Pending Instrument Data" on the day of the appointment.

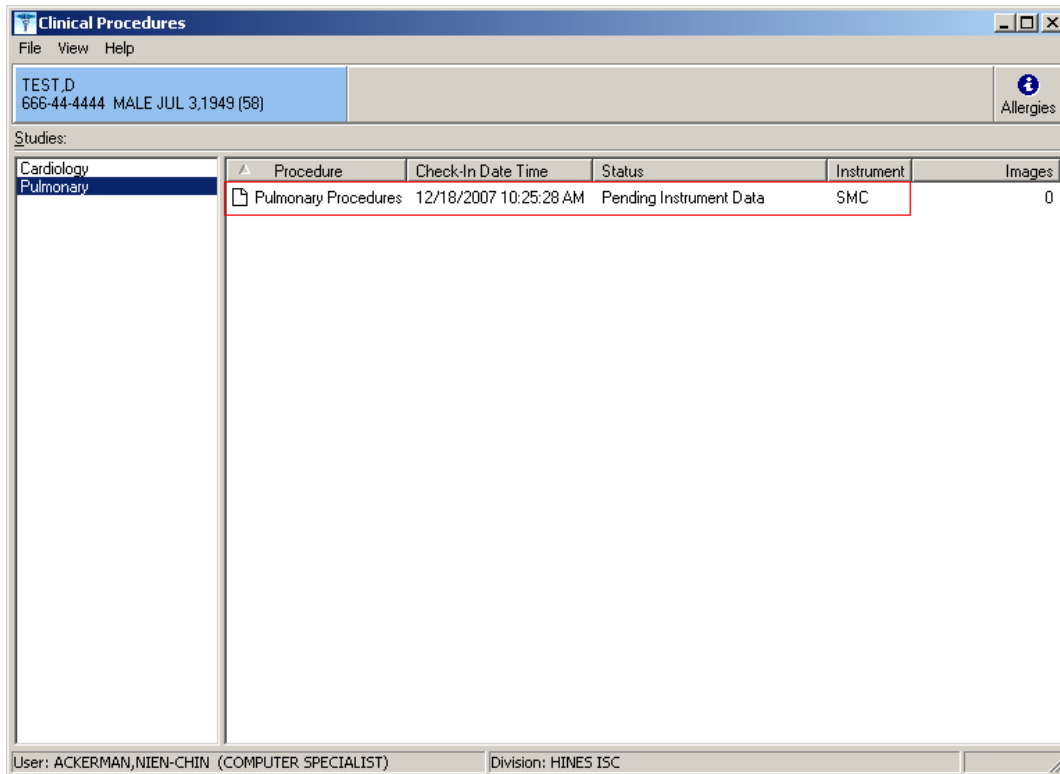


Figure 3-20

Note 1: If the status of the study does not change to “Pending Instrument Data” upon the day of the appointment, have your IRM Support check if they scheduled the two options MD SCHEDULED STUDIES and MD STUDY CHECK-IN to run daily.

Note 2: If the procedure requires multiple encounters, the subsequent appointment scheduled will generate a study checked-in on the day of the appointment. If you do not use appointments, it is recommended that you do not implement auto check-in for the procedure because you will need to manually check-in each subsequent encounter for the procedure.

Check-In a New Study

Checking in a new study is the next step in the Clinical Procedures process. You need to check in a new study in CP User after a procedure has been ordered. (Keep in mind that the CP check-in is not related to the Scheduling check-in process.)

¹If you want to link multiple results to one procedure, you can check in multiple studies for the same procedure that you ordered through Consults. A warning screen displays telling you that this consult procedure order has already been checked in (Figure 3-22). After you ensure that you have the correct consult procedure order, you can continue to check in the study. In this way, you do not have to order multiple procedure requests. In this example, the colonoscopy procedure was ordered and a new study for the colonoscopy procedure is being checked in.

1. To check in a new study, first logon to **CP User** and select the patient. Refer to [Selecting a Patient, 2-2](#).
2. Choose **File > Check in New Study** to check in the patient.

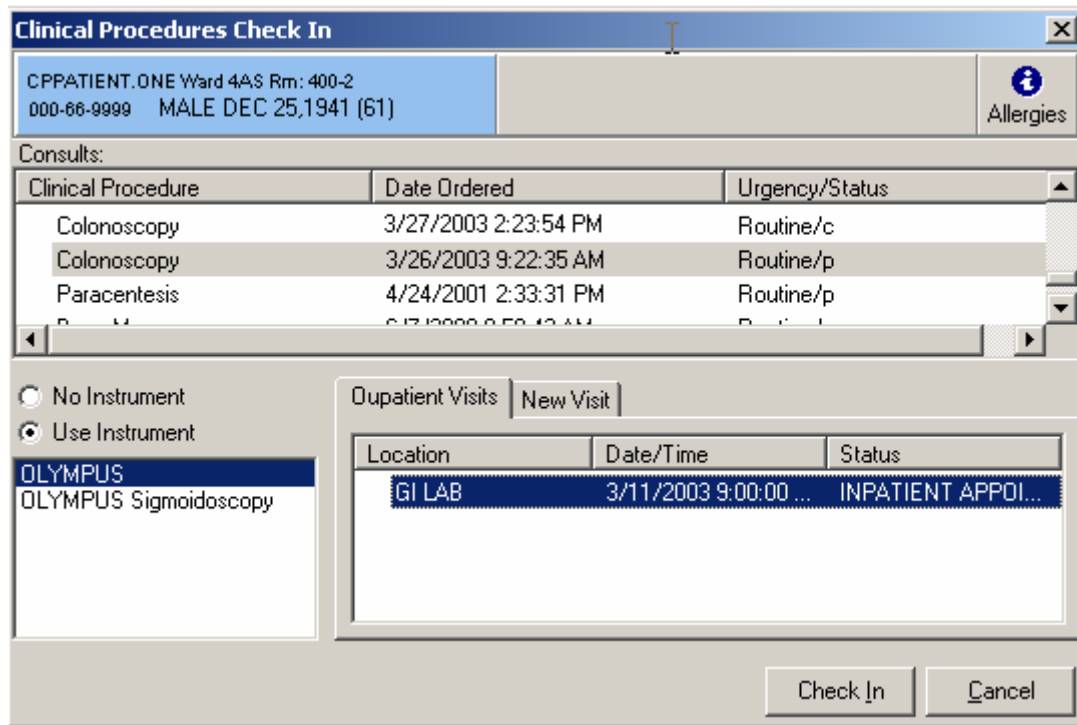


Figure 3-21

3. Select a Consult procedure order for the selected patient. See Figure 3-21. The Clinical Procedure column lists the consult procedure orders. Notice that the colonoscopy procedure is selected.

¹ Patch MD*1.0*4 September 2006 Check in multiple consult procedure orders warning screen added.

Note: You can only select from Clinical Procedure request orders that are in the Pending (p), Scheduled (s), Partial Results (pr), Complete (c), and Active (a) statuses. Discontinue (d) and Cancel statuses are excluded.

¹If the consult procedure order you selected has already been checked in, a warning screen displays (Figure 3-22). After you ensure that you have the correct consult procedure order, you can continue to check in the study.

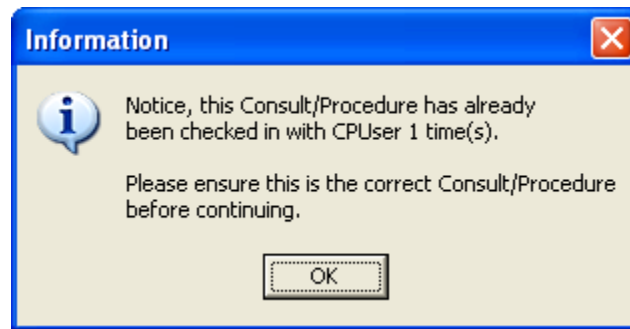


Figure 3-22

4. Depending on the consult procedure you selected, the appropriate instruments for that procedure are displayed. Click the appropriate instrument if more than one is listed, or click **No Instrument** if no instrument is associated with this procedure. OLYMPUS is the appropriate instrument in this case and is selected.
5. You must associate each CP study with a PCE visit, which is the hospital location where the procedure is performed. Required.

For the majority of TIU notes created through CP, the visit association is completed in the background. If a visit has already been recorded but the note wasn't linked (standalone visits, such as telephone or walk-in visits), you can select a visit from the Clinical Procedures Check In edit screen (Figure 3-21).

To link the CP study to the visit, select information from the Outpatients Visits tab on Figure 3-21. You can also select the New Visit tab and enter NOW for the date and time.

6. Click **Check-In**. The main CP User window, Figure 3-23, is displayed.

¹ Patch MD*1.0*4 September 2006 Check in multiple consult procedure orders warning screen added.

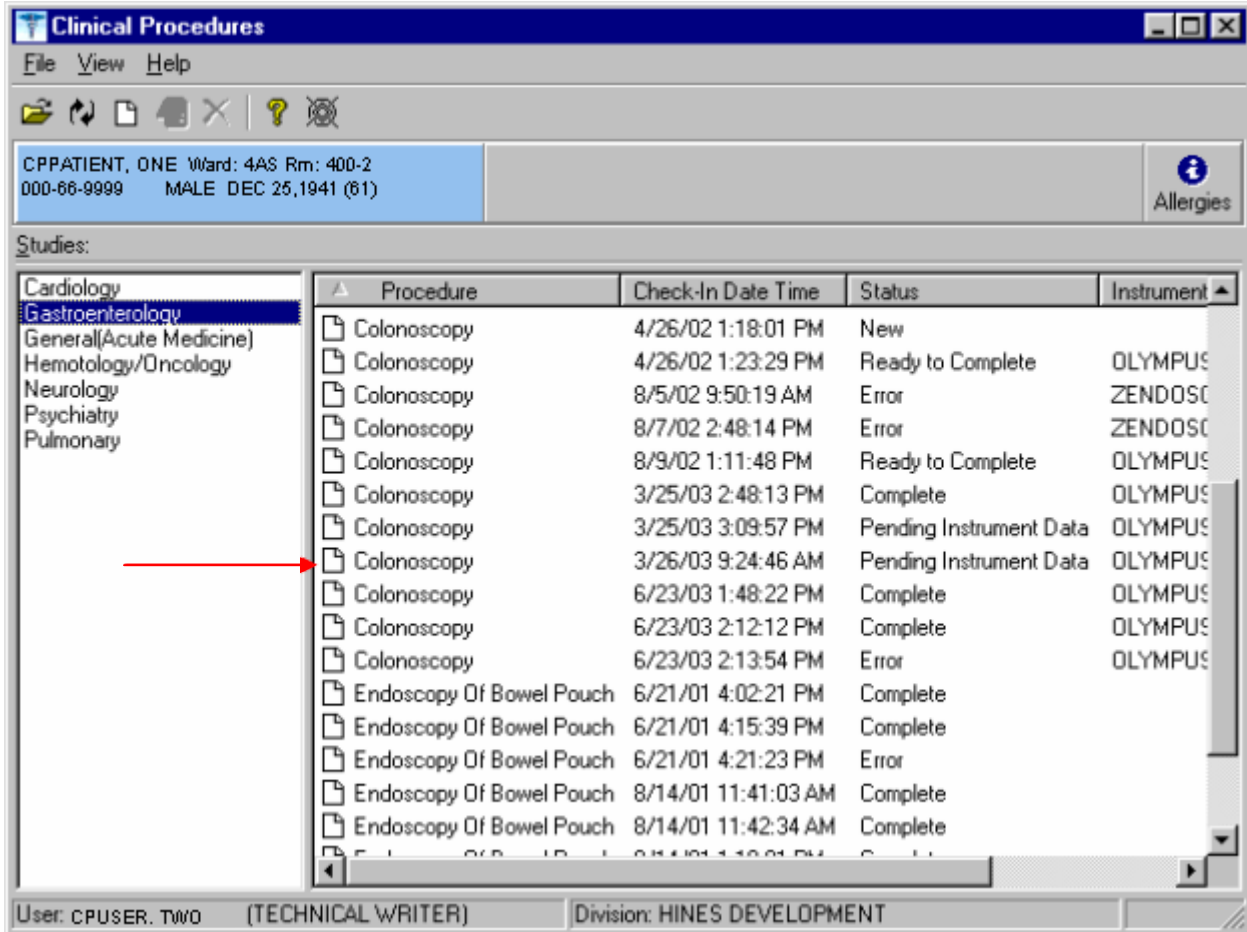


Figure 3-23

7. If the study is checked-in for an instrument with a uni-directional interface, the status is Ready to Complete. If the study is checked-in for an instrument supported by a bi-directional interface, the status is Pending Instrument Data. (Notice on Figure 3-23, the colonoscopy status for 3/25 and 3/26 is Pending Instrument Data.)
8. At this point, the clinician performs the procedure on the instrument and transmits the results back to VistA.

If the instrument is bi-directional and the Auto Submit to VistA Imaging checkbox is selected for the procedure in CP Manager, the study status changes from Pending Instrument Data to Complete. This occurs after the result has been transmitted to VistA, matched to the study, and copied over to VistA Imaging successfully. The study is ready for interpretation. At this time, the CP process is complete and attachments cannot be associated with this study. See Clinical Procedures Process, Part 2.

If the instrument is uni-directional or if the instrument is bi-directional and the Auto Submit to VistA Imaging checkbox is not selected, the study status is Ready to Complete. Go to the next step (9) to manually complete the CP process.

9. Open the study (Figure 3-23) and add the instrument results and/or external attachments. You can only open studies that have an Error, Complete, Ready to Complete, or New status. When a study is in the Ready to Complete or New status, you can open the study and finish entering any data that was missed. An example of missed data is an external attachment that was not associated with the study.
 - Open this study and add results and/or external attachments. Click **Open Study** or select **File > Open Study**. Figure 3-24 is displayed.
 - Click **+Results** to select and submit the result to Vista Imaging. Only results for the patient and instrument used for the procedure are displayed. To select multiple results, hold down the CTRL key. To select a range of results, highlight the initial result, hold down the Shift key, and then click the last result, Figure 3-25.
 - You can also click **+Files** (Figure 3-24) to add additional attachments from the External Attachment Directory. If the External Attachment Directory has not been defined for this procedure, the last directory that was accessed may be displayed. You can browse for other attachments to link to the study.

Note: If the system parameter **Allow Non-Instrument Attachments** was not selected in CP Manager, **+Files** does not appear on the Clinical Procedures Study screen, you are not permitted to associate additional attachments with the procedure.

10. Submit the study. The images are copied to the RAID and the TIU document is created and associated with the procedure order.

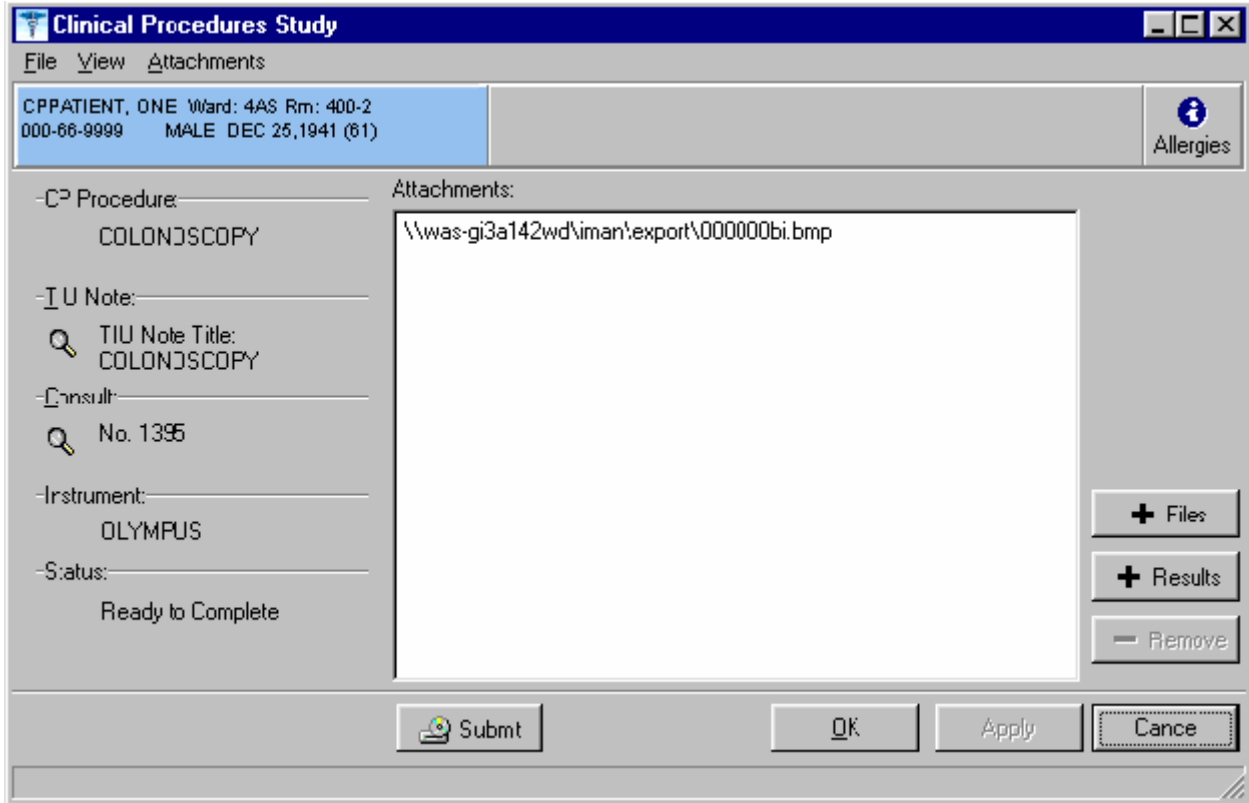


Figure 3-24

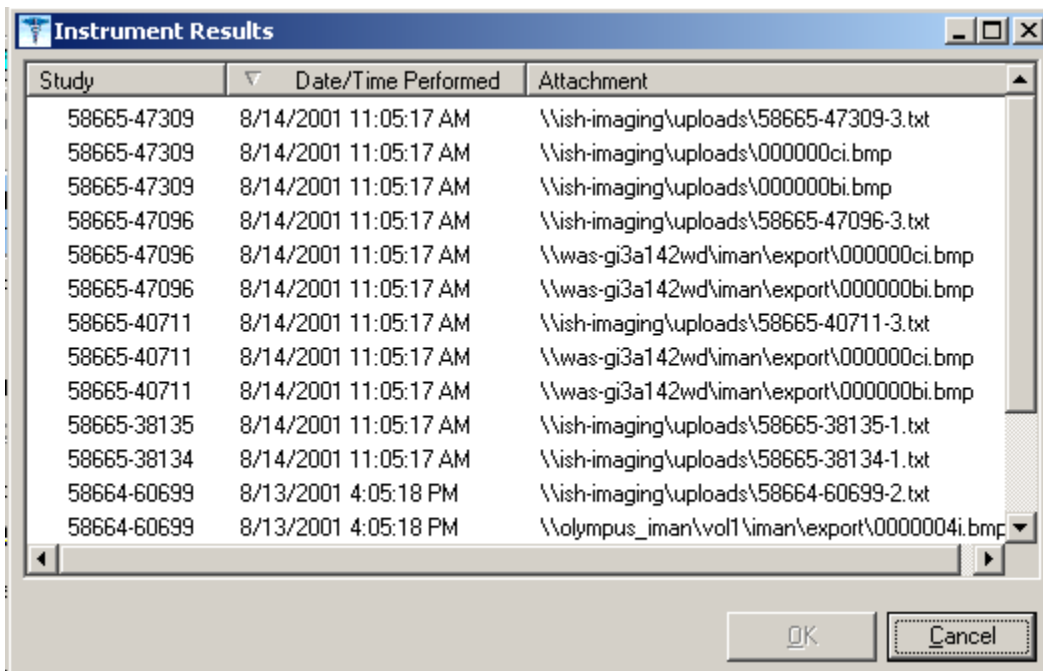


Figure 3-25

- From Figure 3-24, click the magnifying glass under TIU Note to view the TIU Note for that study if it is available. The magnifying glass for the TIU document is unavailable if the result has not been submitted to Vista imaging. Once the result is copied to Vista Imaging, you can view the TIU document of the study before or after the interpretation has been entered, Figure 3-26.

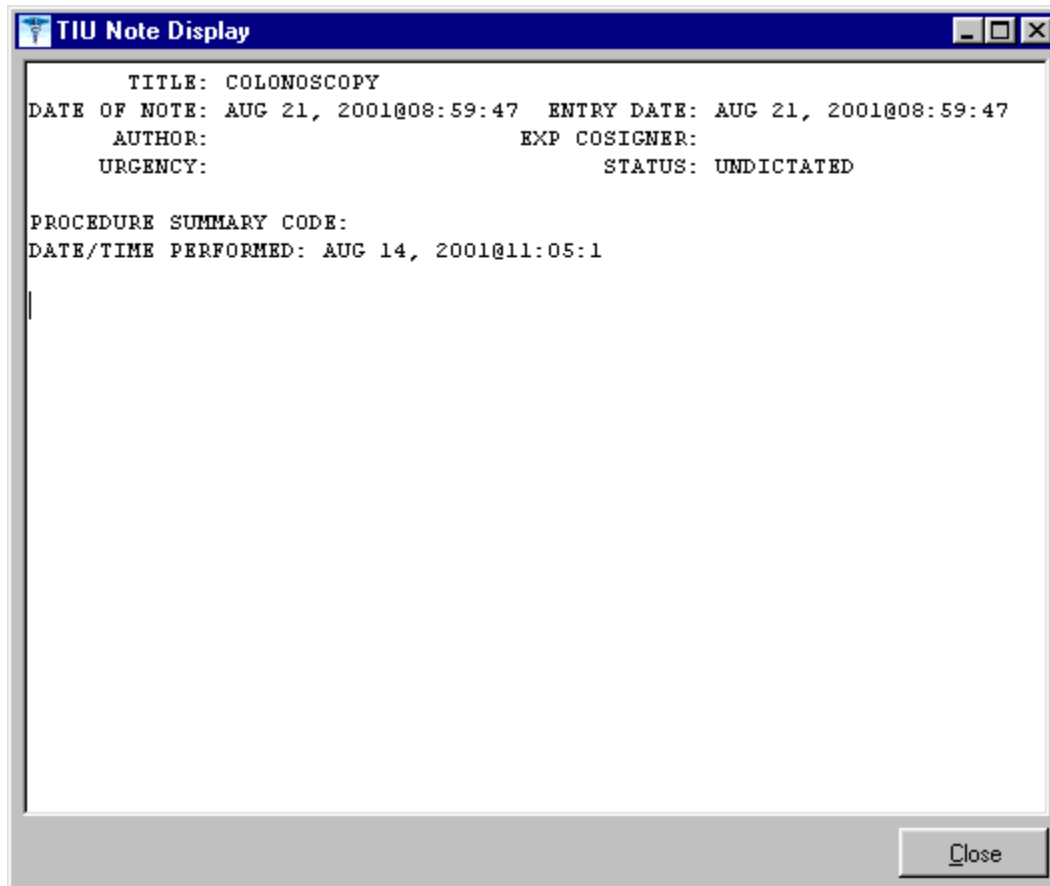


Figure 3-26

- From Figure 3-24, you can also click the magnifying glass under Consult to view the Consult report for that study.

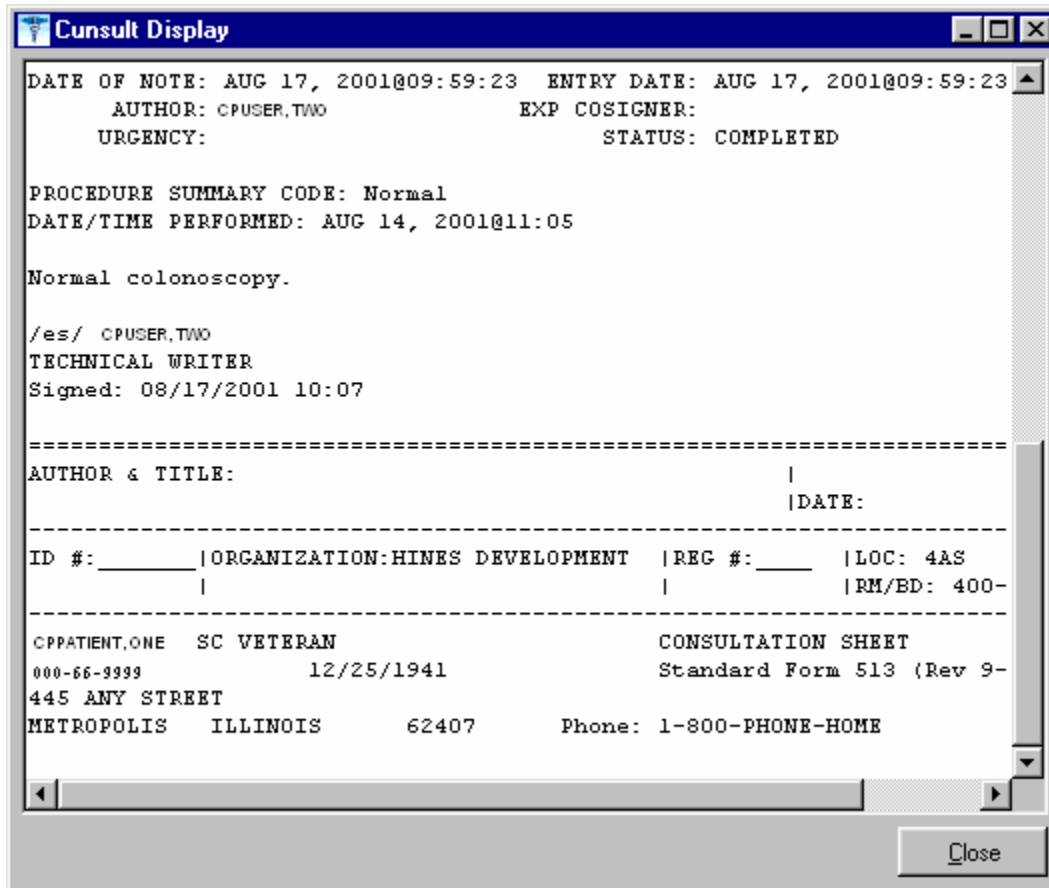


Figure 3-27

Updating Study Status to Correct Errors

If you open a study in the Error status and have the MD MANAGER key, the Update Study Status window is displayed. You must have the MD Manager key to access the Update Study Status menu option. See your clinical application coordinator or IRM for access to Update Study Status.

You can use Update Study Status to change the status of any study. Be careful when changing the status of a study. With Update Study Status, you can force a status change of a study if a problem occurs that you cannot fix with the Open a Study option.

1. Select **File > Update Study Status**, Figure 3-28.
2. Select the status you want to change and click **OK**.
3. After you change the status, choose **File > Open a Study** and click **Submit** to resubmit the study.

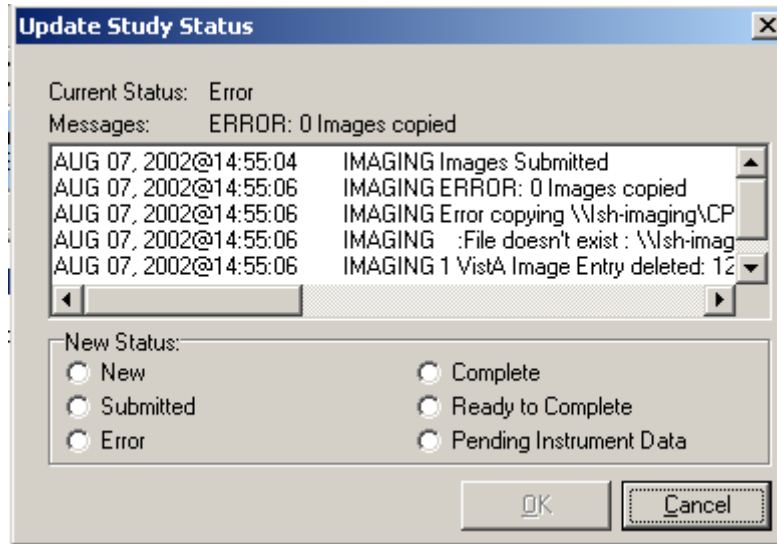


Figure 3-28

¹Appointment No Shows and Cancellation

When an appointment is scheduled for a future date/time, the appointment can later be cancelled or the appointment can be changed to “No show” because the patient was a no show for the appointment. With patch MD*1.0*11, an option called MD PROCESS NOSHOW/CANCEL was introduced. Once scheduled to run daily, it will pick up the no show and cancelled appointments and cancel the associated CP study that was created.

Figure 3-29 shows a study with the status of “New” created from an auto study check-in.

¹ Patch MD*1.0*11 June 2009 Add new section on appointment no show and cancellation.

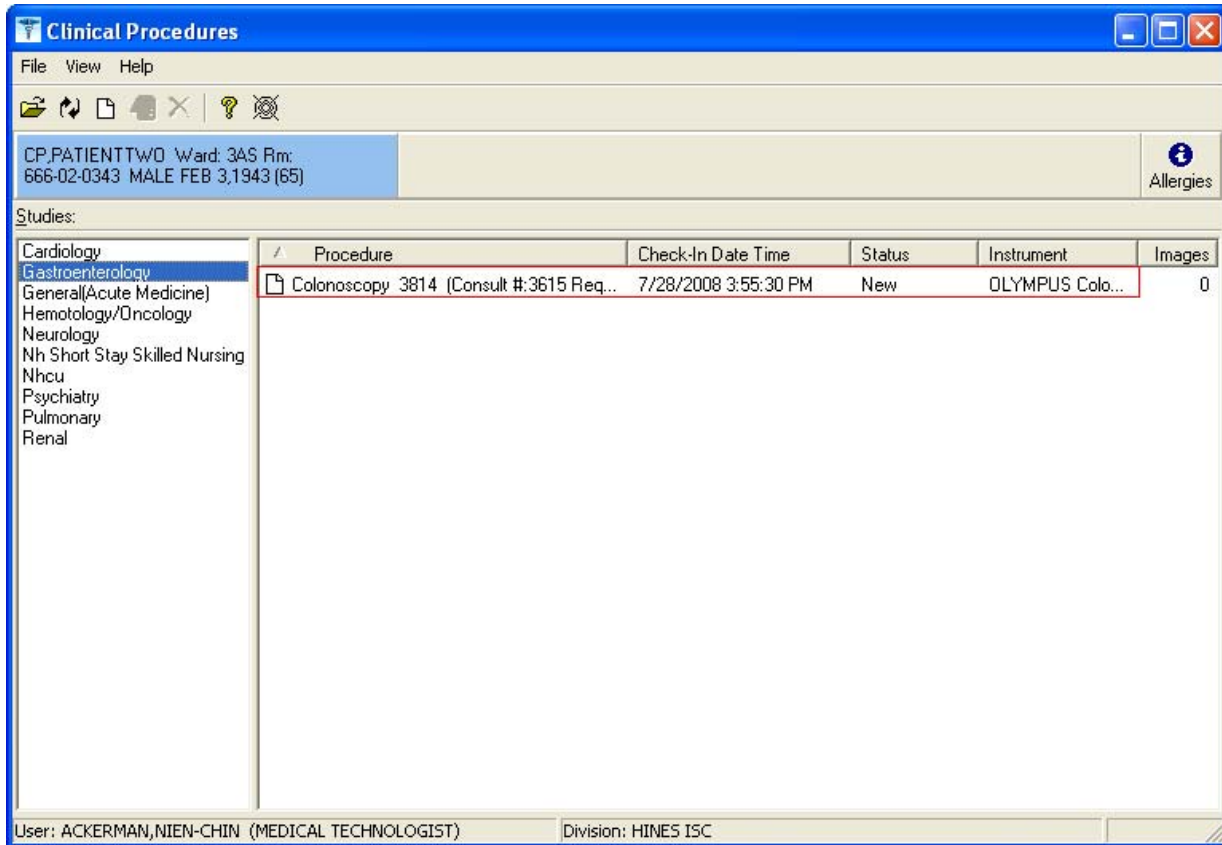


Figure 3-29

The patient has an appointment scheduled shown in Figure 3-30 for the procedure in Figure 3-29.

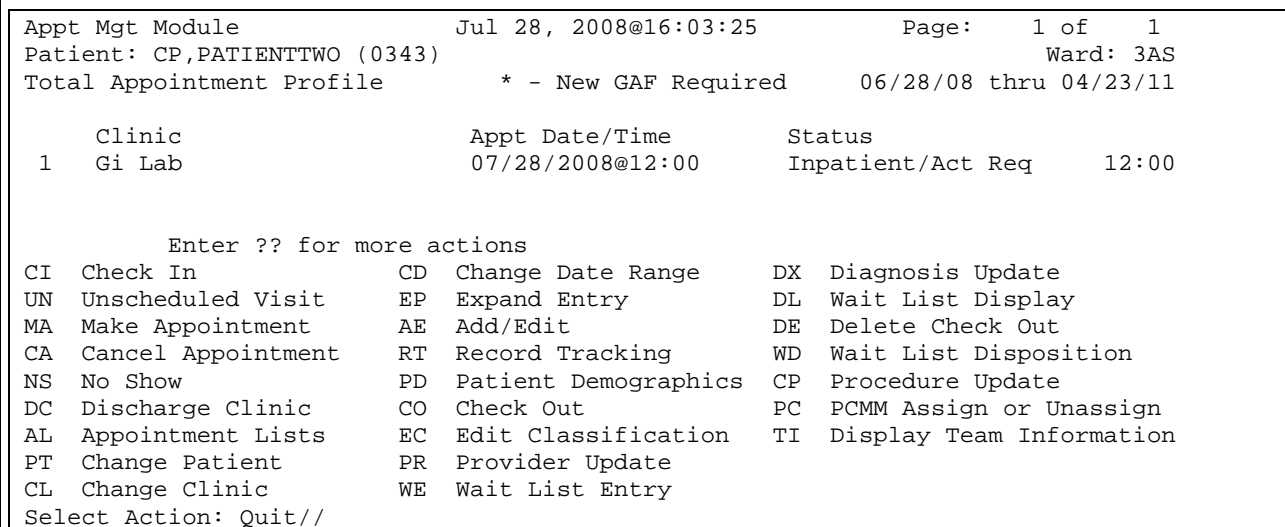


Figure 3-30

The appointment was cancelled and re-booked in Figure 3-31.

Appt Mgt Module		Jul 28, 2008@16:09:29	Page: 1 of 1
Patient: CP,PATIENTTWO (0343)			Ward: 3AS
Total Appointment Profile		* - New GAF Required	06/28/08 thru 04/23/11

	Clinic	Appt Date/Time	Status
1	Gi Lab	07/28/2008@12:00	Cancelled By Patient
2	Gi Lab	08/08/2008@08:00	Inpatient/Future

Enter ?? for more actions

CI Check In	CD Change Date Range	DX Diagnosis Update
UN Unscheduled Visit	EP Expand Entry	DL Wait List Display
MA Make Appointment	AE Add/Edit	DE Delete Check Out
CA Cancel Appointment	RT Record Tracking	WD Wait List Disposition
NS No Show	PD Patient Demographics	CP Procedure Update
DC Discharge Clinic	CO Check Out	PC PCMM Assign or Unassign
AL Appointment Lists	EC Edit Classification	TI Display Team Information
PT Change Patient	PR Provider Update	
CL Change Clinic	WE Wait List Entry	

Select Action: Quit//

Figure 3-31

Figure 3-32 shows the study cancelled by the task MD PROCESS NOSHOW/CANCEL and a new study was generated for the re-booking of the new appointment.

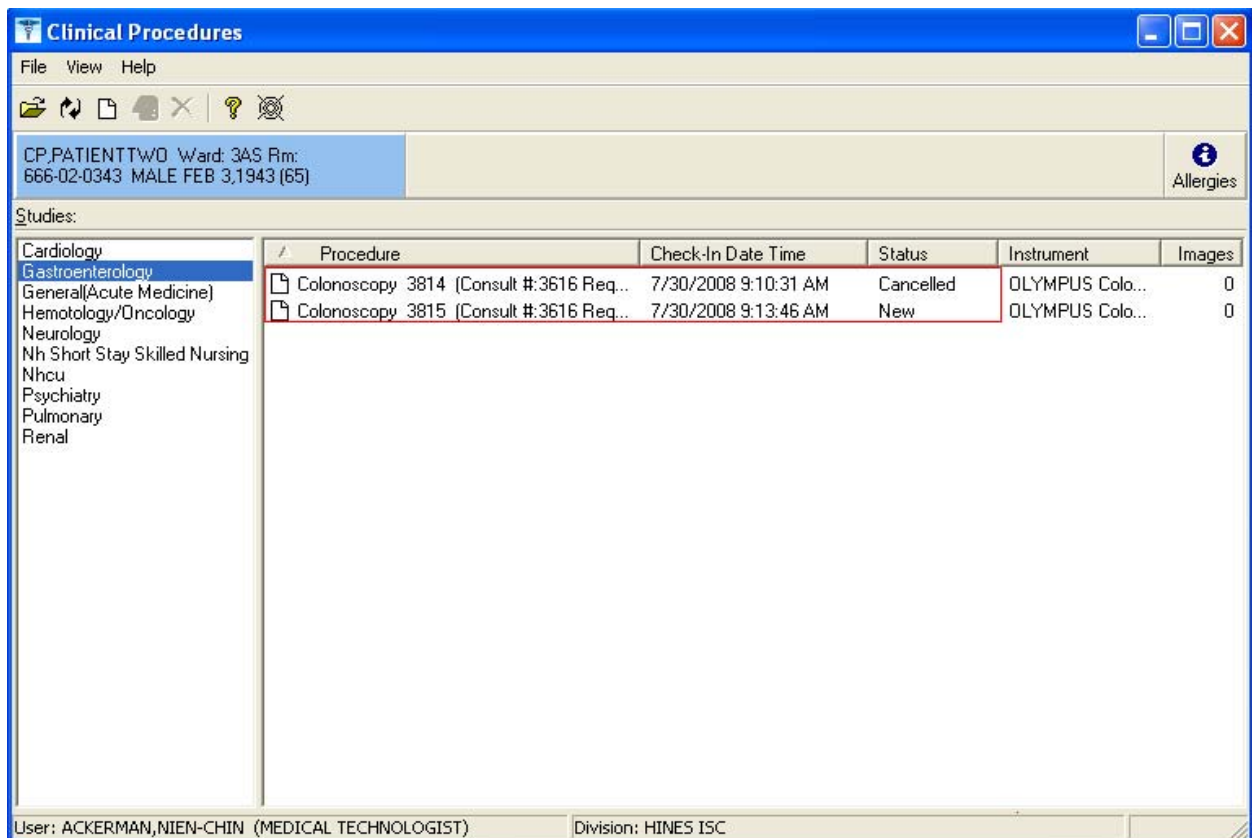



Figure 3-32

Note: If during appointment cancellation, no re-booking was selected, the user will need to remove the new study created.

Figure 3-33 shows an example of an appointment with a status of a “No Show” and no auto re-booking of a future appointment.

Appt Mgt Module		Jul 30, 2008@09:27:55	Page: 1 of 1
Patient: CPPATIENT,ONE (0001)			Outpatient
Total Appointment Profile		* - New GAF Required	06/30/08 thru 04/25/11
Clinic	Appt Date/Time	Status	
1 Gi Lab	07/30/2008@10:00	No-show	
Enter ?? for more actions			
CI Check In	CD Change Date Range	DX Diagnosis Update	
UN Unscheduled Visit	EP Expand Entry	DL Wait List Display	
MA Make Appointment	AE Add/Edit	DE Delete Check Out	
CA Cancel Appointment	RT Record Tracking	WD Wait List Disposition	
NS No Show	PD Patient Demographics	CP Procedure Update	
DC Discharge Clinic	CO Check Out	PC PCMM Assign or Unassign	
AL Appointment Lists	EC Edit Classification	TI Display Team Information	
PT Change Patient	PR Provider Update		
CL Change Clinic	WE Wait List Entry		
Select Action: Quit//			

Figure 3-33

Figure 3-34 shows the study cancelled for the appointment with “No Show” and a new study is created. The user can highlight the study with “New” status and click  button to delete it or select the **File**|| Delete Study to remove it.

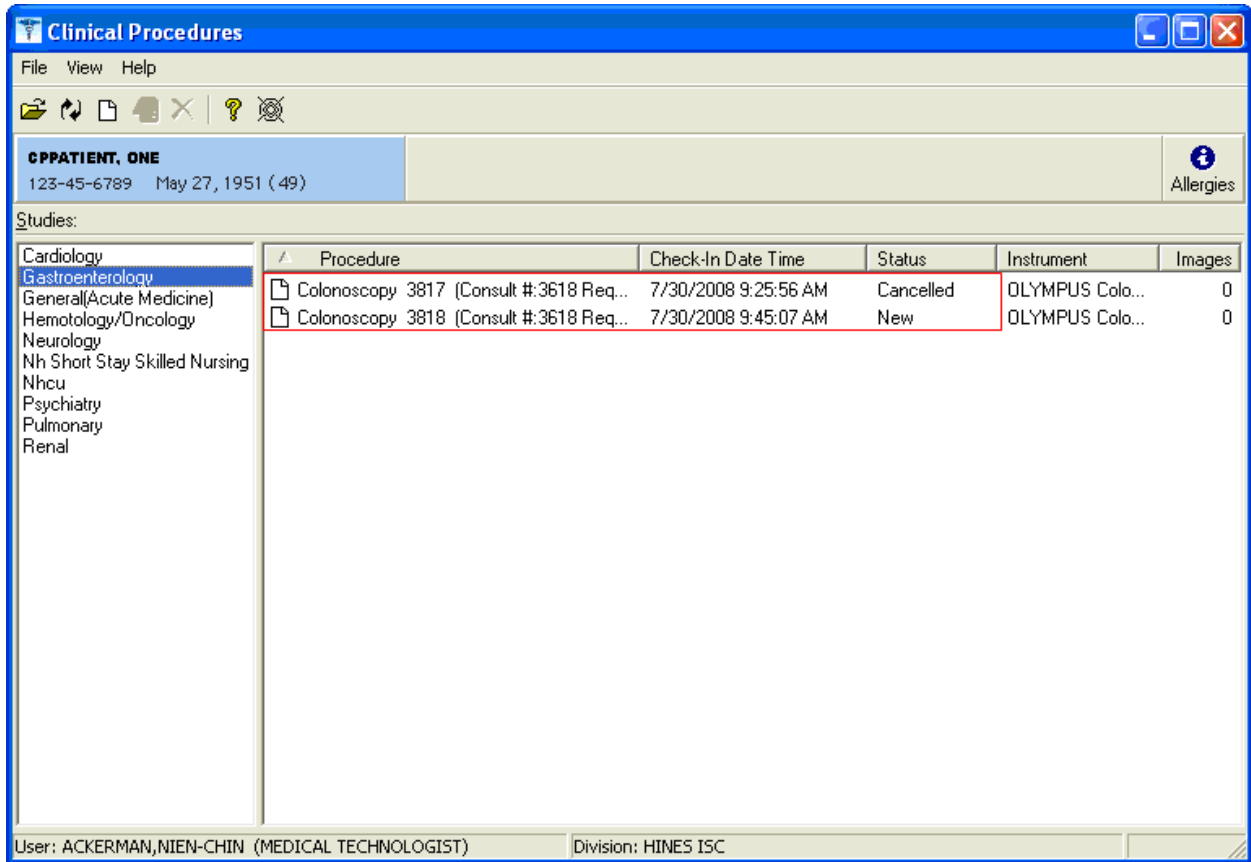


Figure 3-34

4. Clinical Procedures Process, Part 2

This chapter describes the process to follow for completing clinical procedures. (This chapter uses the example of completing a colonoscopy to describe the Clinical Procedures process.) Be sure to follow the **required** steps in sequential order. You can do the optional steps as needed.

4. [Complete the Procedure](#). Required
 - a. [Enter an Interpretation into the TIU note](#). Required
 - b. [Enter Encounter information](#). Required for workload counts
 - c. [Sign off](#). Required
5. [View Clinical Procedures results](#). Optional
6. [Link consent forms and images to Clinical Procedures documents](#). Optional

Completing the Procedure

To complete the procedure, you need to enter the interpretation into the TIU note, enter encounter information, and sign off. In this example, the colonoscopy study is being completed.

Entering the interpretation into the TIU Note

1. Logon to **CPRS**. The Patient Selection screen is displayed, Figure 4-1.

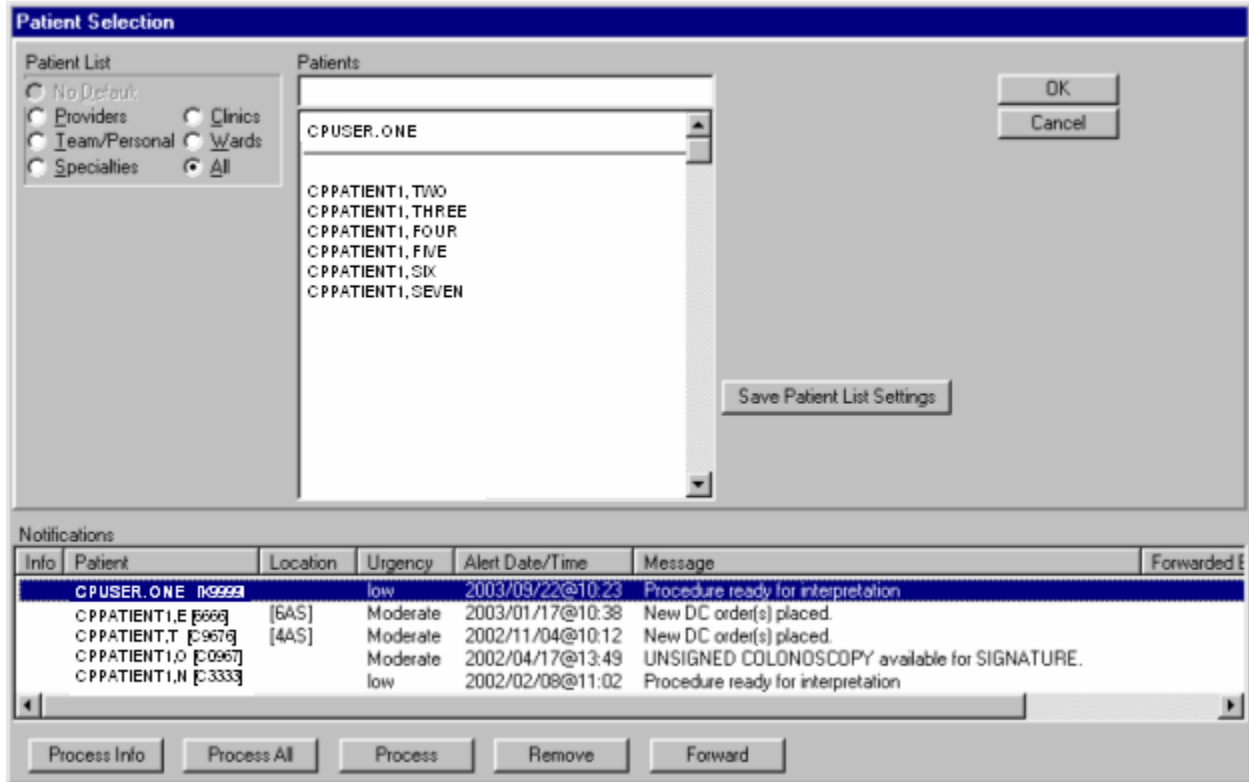


Figure 4-1

2. In the Notifications box at the bottom of the screen, patients are listed with “Procedure ready for interpretation”.
 - Click **Process Info** if you want to process an informational alert (see left column under Notifications, Figure 4-1).
 - Click **Process All** if you want to process all of the items listed.
 - Click **Process** if you want to process an item through the Consults tab.
 - Click **Remove** if you want to remove an item from the list.
 - Click **Forward** if you want to forward the item to another person.

As part of this example, the patient, CPPATIENT, ONE, is selected. To view results through Consults, click **Process**. The Consults tab is displayed.

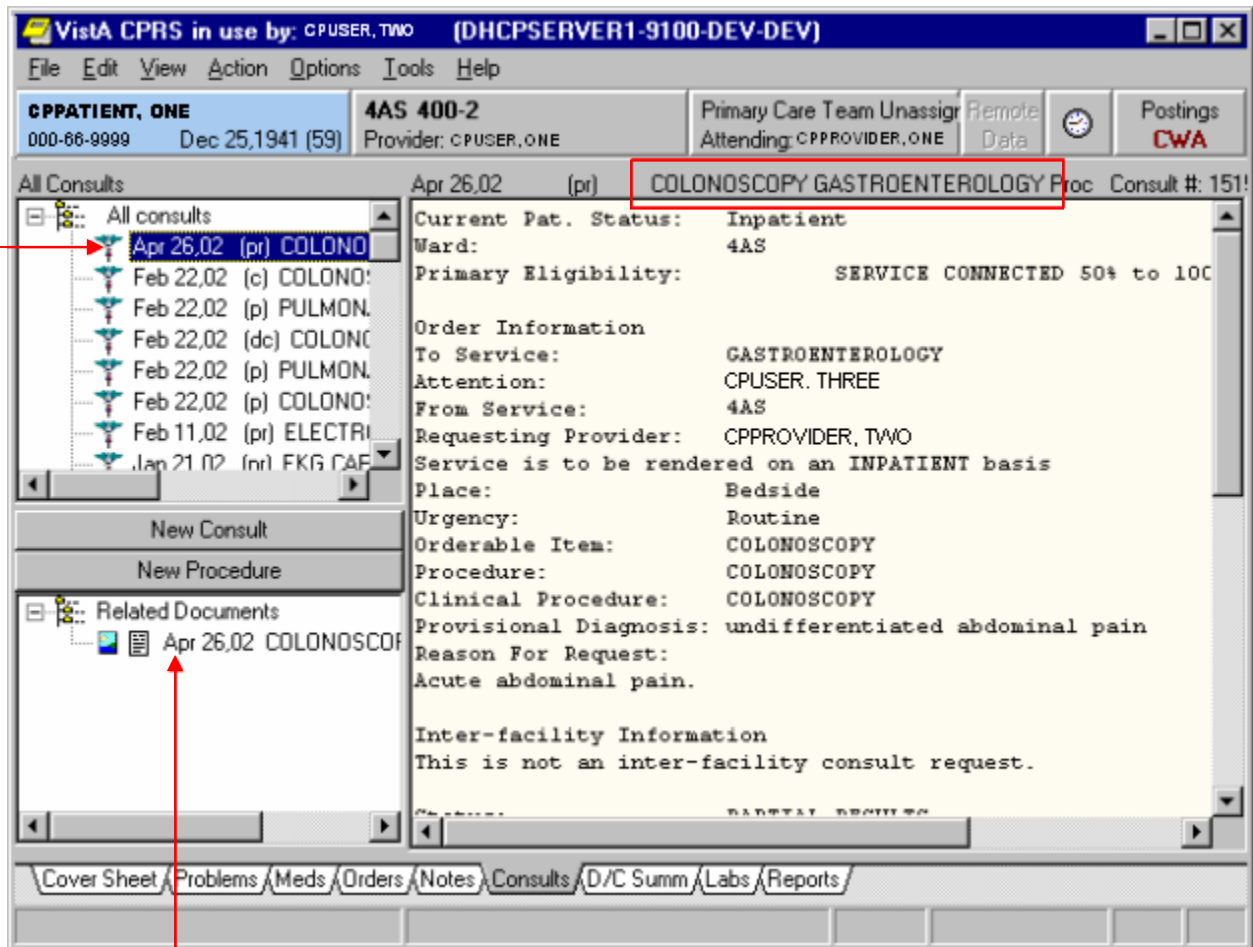


Figure 4-2

Note the image and note document within the Related Documents window (Figure 4-2).

The consult procedure now has a status of partial results (pr). The CP document has the TIU note title.

3. Click the CP title in the Related Documents window. The CP document is displayed in the right window, Figure 4-3.

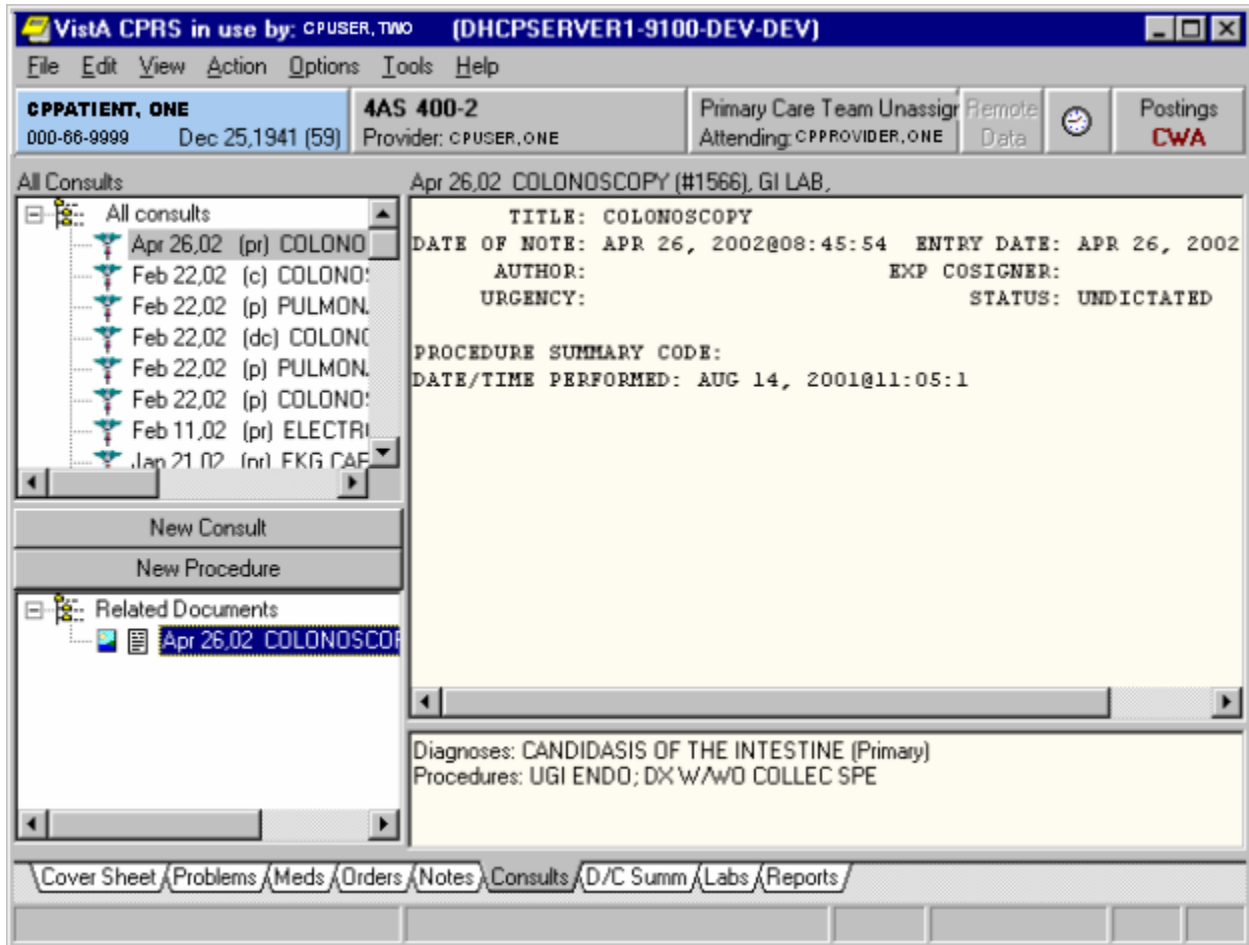


Figure 4-3

The Author is not defined, Figure 4-3. This note is automatically created when the instrument result is sent and submitted and an author does not exist. The Interpreter who is interpreting the result is the default Author. The status of the document is always UNDICTATED when the results are ready for interpretation.

4. To select the results that you want to interpret, choose **Action > Consult Results > Complete/Update Results**, Figure 4-4.

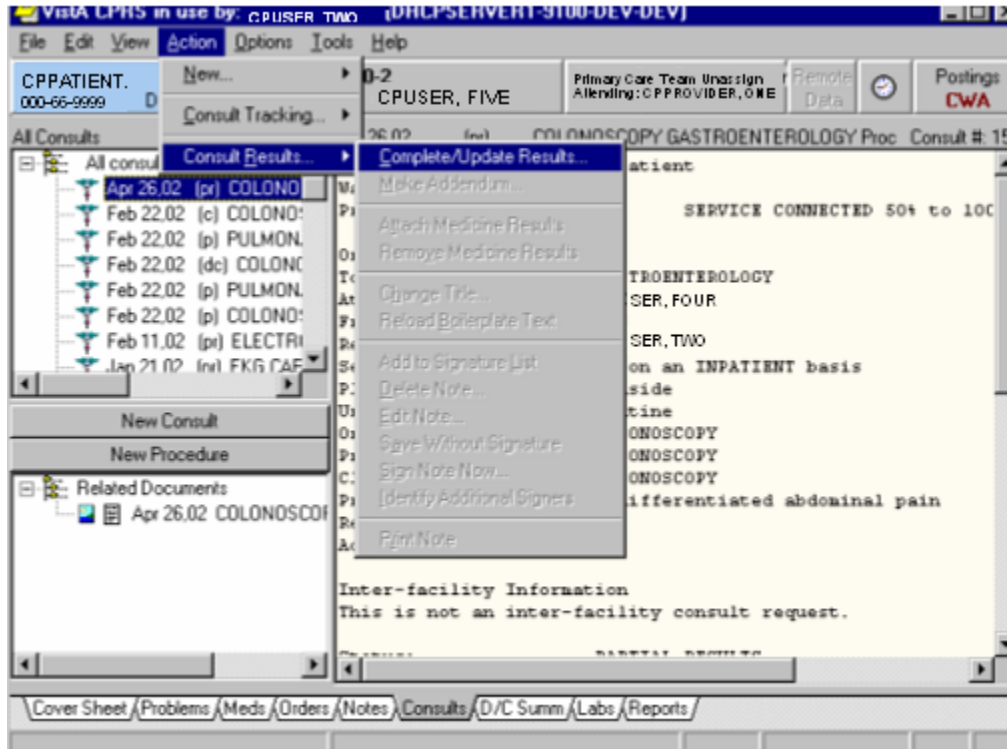


Figure 4-4

Note: To interpret the result, select the Complete/Update Results option. The **Enter Required Fields** dialog box is displayed, Figure 4-5. The interpreter’s name displays by default in the Author field.

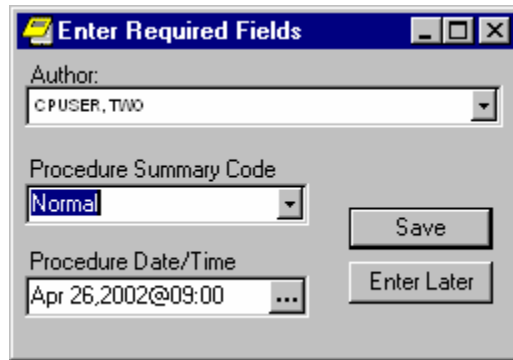


Figure 4-5

5. Select the appropriate **Procedure Summary Code** from the list (Figure 4-5). The Procedure Summary Codes include Abnormal, Normal, Borderline, and Incomplete.
6. Enter a **Procedure Date/Time**. Depending on the instrument, the Procedure Date/Time is passed in the HL7 message from the instrument. As the interpreter, you can accept the default. If the instrument does not pass the Procedure Date/Time, the interpreter has to enter a Procedure Date/Time.

The Procedure Summary Code and Procedure Date/Time are required fields for the initial note that you are editing.

If you close the **Enter Required Fields** dialog box without entering the requested information, CPRS prompts the interpreter again.

Any subsequent note created on the same procedure after this initial note does not require the Procedure Summary Code and Procedure Date/Time fields. The fields are optional on subsequent notes.

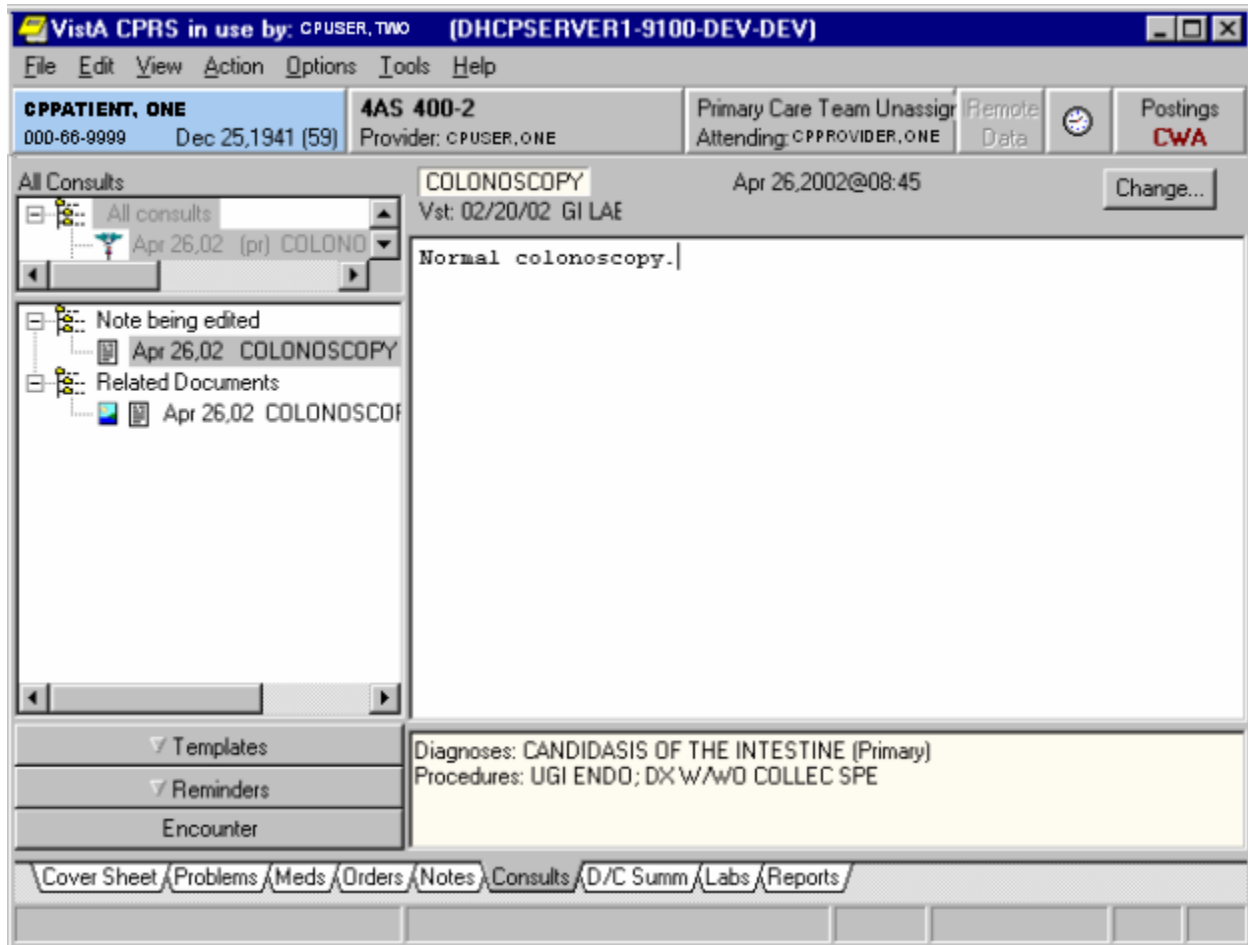


Figure 4-6

7. Enter an interpretation in the space on the right side of the screen for the highlighted (current) consult procedure (Figure 4-6).

Entering Encounter Information

You can now enter encounter form information.

8. To enter the encounter information and complete the consult procedure, you must select **Action > Consult Results > Sign Note Now**.

You can also select the **Encounter** drawer (Figure 4-6) to enter encounter information.

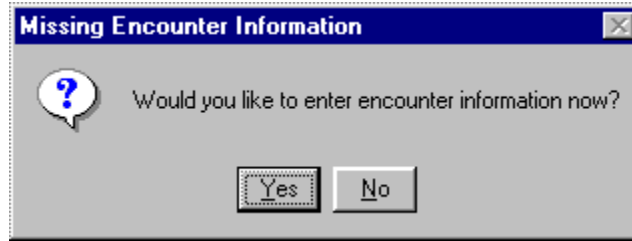


Figure 4-7

This window (Figure 4-7) asks if you want to enter encounter information now. Figure 4-7 is displayed depending on how CPRS parameters are set. See the Implementation Guide for information on defining CPRS parameters.

9. Click **Yes** to enter encounter information, or click **No** to skip this step. If you choose No, you can enter the information at a later time. In this example, the Yes button is clicked and encounter information is entered.

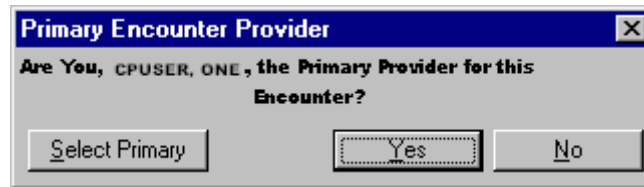


Figure 4-8

Figure 4-8 allows you to verify the primary provider for this encounter form.

10. Click **Yes**.

CPRS brings up the Encounter Form that was set up for the Hospital Location, where the procedure was performed. The **Visit Type** tab is displayed.

11. Enter appropriate information for visit type. For example, in Figure 4-9, the following information was entered:

Type of Visit. Established Patient

Section Name. Intermediate Exam 11-19 Min.

Visit Related to Service Connected Condition. Yes

Current providers for this encounter. ¹CPUSER, ONE

¹ Patch MD*1.0*11 June 2009 Replaced provider name with generic name.

Encounter Form for GI LAB (Feb 20,2002@09:00)

Visit Type | Diagnoses | Procedures | Vitals | Immunizations | Skin Tests | Patient Ed | Health Factors | Exams

Type of Visit

NEW PATIENT
ESTABLISHED PATIENT
CONSULTATIONS

Section Name

<input type="checkbox"/> Brief Exam	1-5 Min	99211
<input type="checkbox"/> Limited Exam	6-10 Min	99212
<input checked="" type="checkbox"/> Intermediate Exam	11-19 Min	99213
<input type="checkbox"/> Extended Exam	20-30 Min	99214
<input type="checkbox"/> Comprehensive Exam	31+ Min	99215

Service Connection & Rated Disabilities

Service Connected: 50%
PTERYGIUM (10% NSC)

Visit Related To

<input checked="" type="checkbox"/> Service Connected Condition
<input type="checkbox"/> Agent Orange Exposure
<input type="checkbox"/> Ionizing Radiation Exposure
<input type="checkbox"/> Environmental Contaminants
<input type="checkbox"/> MST
<input type="checkbox"/> Head and/or Neck Cancer

Available providers

- CPPROVIDER, TWO
- CPPROVIDER, SEVEN
- CPPROVIDER, EIGHT
- CPPROVIDER, NINE
- CPPROVIDER, TWO**
- CPPROVIDER, TEN
- CPPROVIDER1, ONE
- CPPROVIDER1, TWO
- CPPROVIDER1, THREE
- CPPROVIDER1, FOUR

Current providers for this encounter

- CPPROVIDER, TWO**

Buttons: Add, Remove, Primary, OK, Cancel

Figure 4-9

12. Click the **Diagnoses** tab.

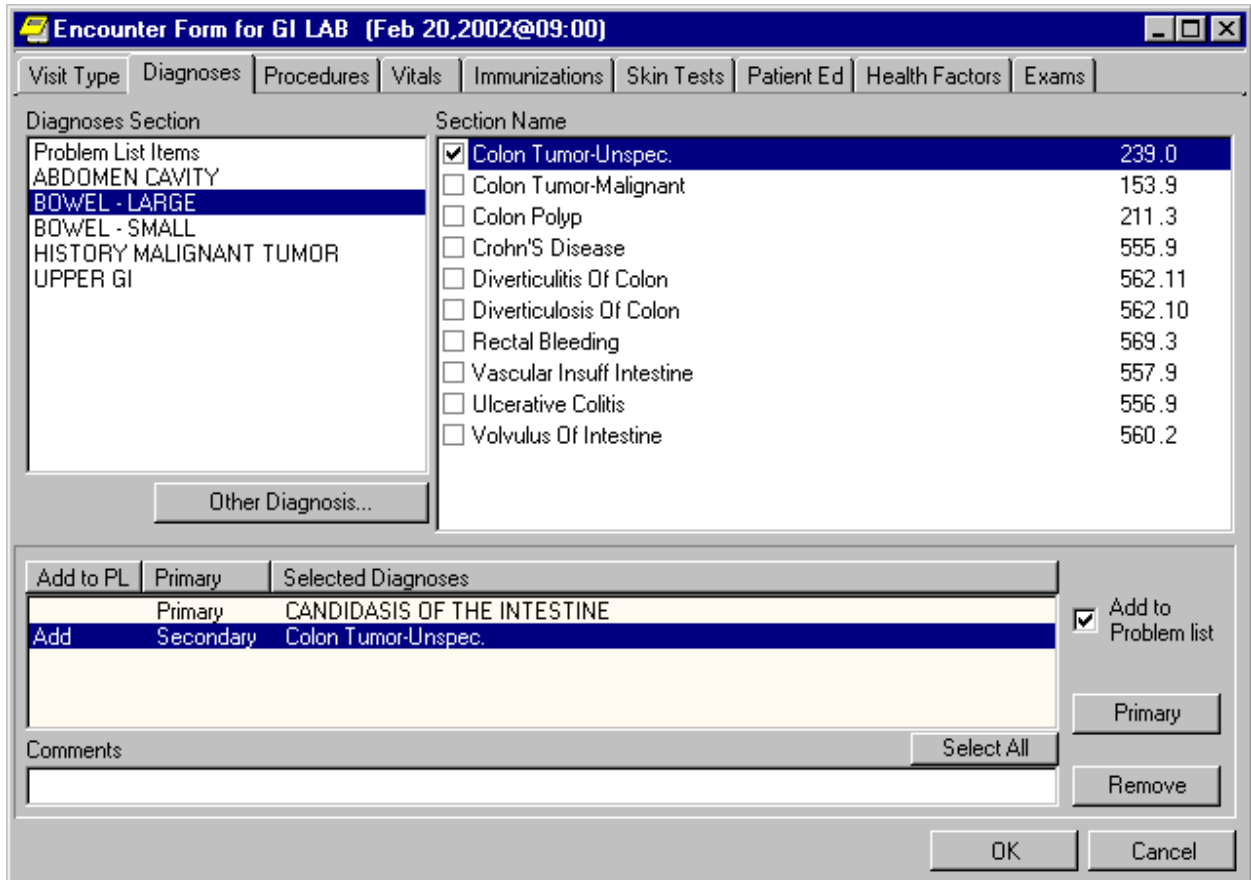


Figure 4-10

13. Enter appropriate information for diagnoses. See Figure 4-10.

14. Click the **Procedures** tab.

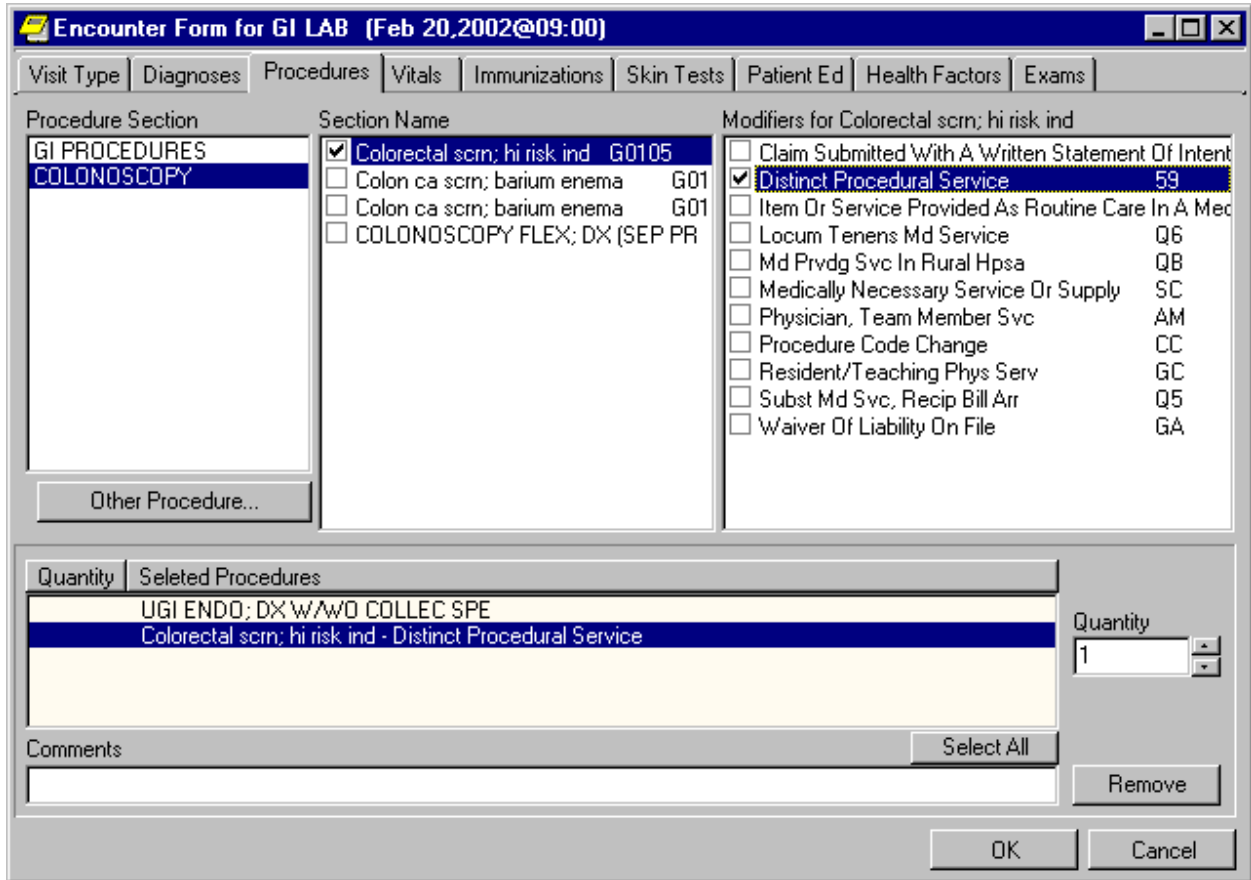


Figure 4-11

15. Enter appropriate procedure information. See Figure 4-11.

16. Click the **Exams** tab.

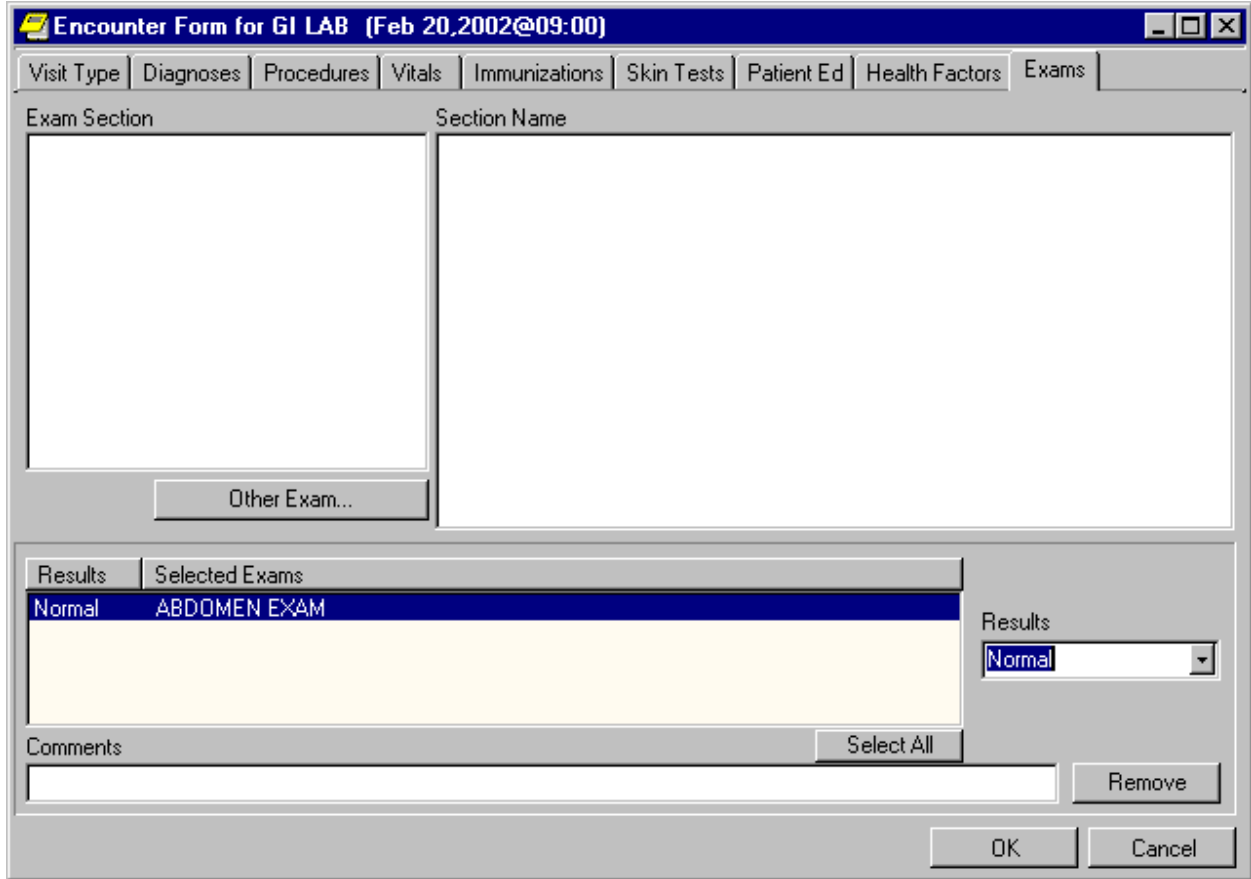


Figure 4-12

17. Enter appropriate exam information. (See Figure 4-12.) Click **OK** to return to the Consults tab.

Signing Off

18. To complete the consult procedure, select **Action > Consult Results > Sign Note Now**.

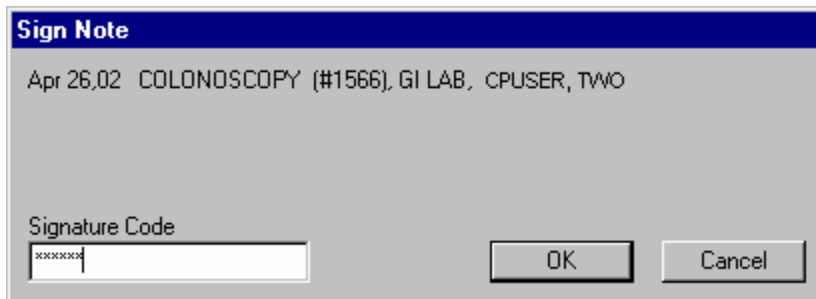


Figure 4-13

19. Enter your electronic signature to sign the TIU note and complete the consult procedure.

20. Click **OK**.

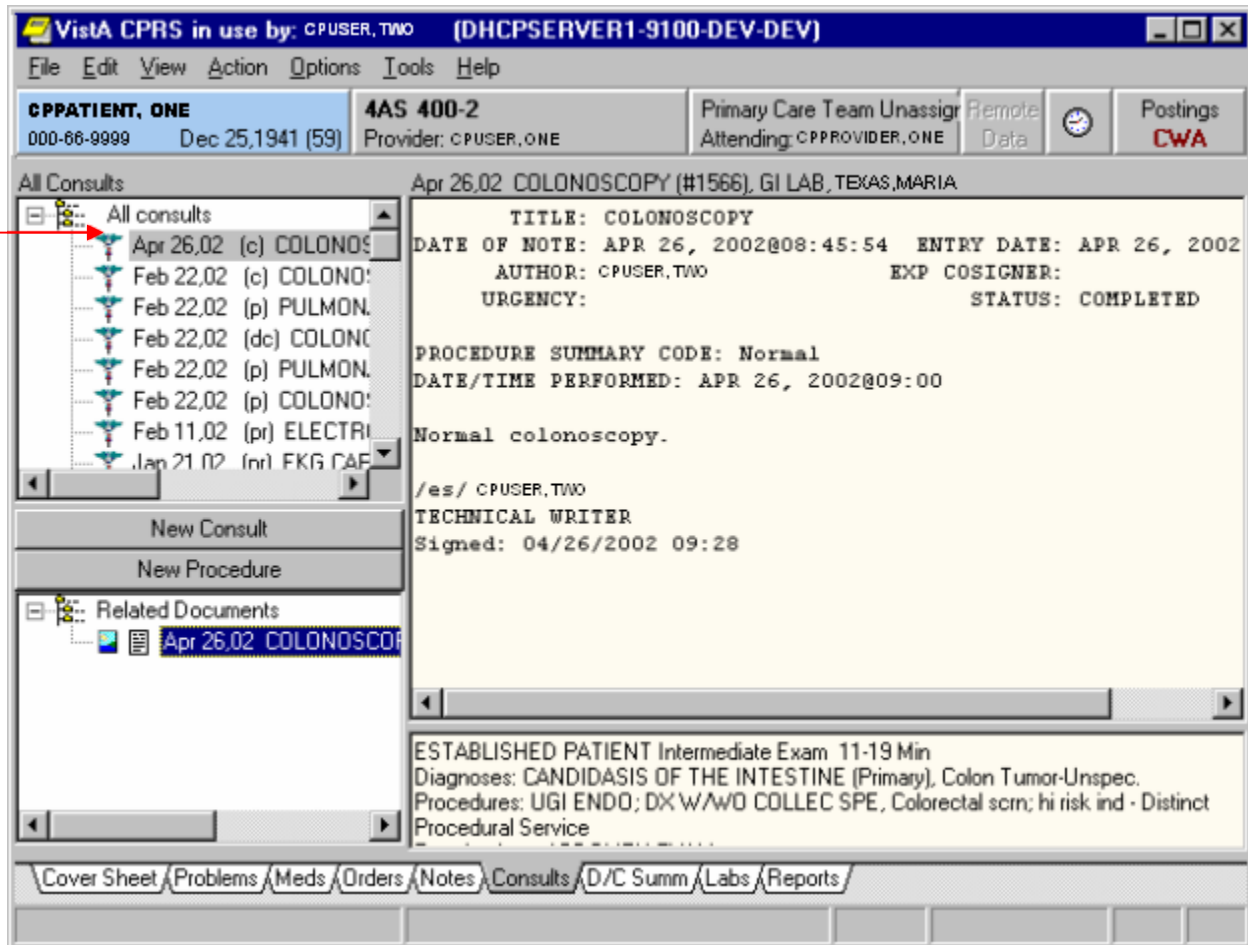


Figure 4-14

- The consult procedure now has a status of complete (Figure 4-14).
- The procedure location (GI LAB in Figure 4-14) is used for workload reporting.
- The workload for the procedure goes through the standard TIU interface with PCE (Patient Care Encounter).

Even though the consult is complete, you can still attach additional files and studies to the same order.

1 Resulting High Volume Procedures

Patch MD*1.0*21 streamlines the process for high volume procedures such as the electrocardiograms. It reduces the steps for entering the interpretations and completing the procedure request for results that have been verified on the medical device.

Make sure the Clinical Application Coordinator and IRM Programmer Support follow the High Volume Procedure Checklist in Appendix E – High Volume Procedure Checklist of the Clinical Procedures Implementation Guide to implement a high volume procedure. Once you set up a procedure, you can use this functionality.

Do not setup a procedure for high volume, if you do not want to use the auto closure functionality and there is no text impression from the device. You should use the regular CP process.

There are multiple ways that the high volume procedure can be processed. The table below shows the different ways:

<u>Procedure</u>	<u>Text</u>	<u>Setup</u>
Any	No	Auto Closure with Proxy User
EKG(Muse)	Yes	Auto Closure with Proxy User, Auto Closure with Muse interpreter, or Significant Findings
Any	Yes	Auto Closure with Proxy User or Significant Findings

Once the procedure is performed and transmitted to VistA, Clinical Procedures will create the note with four lines of text and administratively close the note. This first example shows a procedure with no text and it is auto closed by the proxy user with administrative closure.

```

LOCAL TITLE: CP TEST TITLE
STANDARD TITLE: CARDIOLOGY ATTENDING NOTE
DATE OF NOTE: MAR 17, 2009@09:42:05  ENTRY DATE: MAR 17, 2009@09:42:05
      AUTHOR: CLINICAL,DEVICE PRO  EXP COSIGNER:
      URGENCY:                      STATUS: COMPLETED

** DOCUMENT IN VISTA IMAGING **
SEE FULL REPORT IN VISTA IMAGING

SIGNATURE NOT REQUIRED
SEE SIGNATURE IN VISTA IMAGING

Administrative Closure: 03/17/2009
                        by:
                        Clinical,Device Proxy Service
    
```

¹ Patch MD*1.0*21 June 2010 Add Resulting High Volume Procedures section to Chapter 4.

If a procedure is set to get the text impression, Clinical Procedures will add the text into the note and administratively close the note. This functionality will only work if the medical device is capable of sending the text impression and the result is the final result and was verified on the device. Otherwise, the text will not be included in the note.

The next example shows the administratively closed note by the proxy user with the text impression added in the note for an EKG.

```

LOCAL TITLE: CP MUSE EKG
STANDARD TITLE: CARDIOLOGY NOTE
DATE OF NOTE: MAR 17, 2009@08:41:49  ENTRY DATE: MAR 17, 2009@08:41:49
      AUTHOR: CLINICAL,DEVICE PRO  EXP COSIGNER:
      URGENCY:                      STATUS: COMPLETED

PROCEDURE SUMMARY CODE: Machine Resulted
DATE/TIME PERFORMED: MAR 17, 2009@08:40:5

** DOCUMENT IN VISTA IMAGING **
SEE FULL REPORT IN VISTA IMAGING

SIGNATURE NOT REQUIRED
SEE SIGNATURE IN VISTA IMAGING

** (Muse EKG(Bi-Directional))  AUTO-INSTRUMENT DIAGNOSIS **

Procedure: 93000  12 Lead ECG

Date Verified: Oct 15, 1998@15:04:18

93000.2  Ventricular Rate:    67      BPM

Administrative Closure: 03/17/2009
                        by:
                        Clinical,Device Proxy Service

```

The following example shows an EKG note with the text added, but the note was auto closed by the interpreter on the Muse:

```

LOCAL TITLE: CP MUSE EKG
STANDARD TITLE: CARDIOLOGY NOTE
DATE OF NOTE: JUL 01, 2009@12:00:29  ENTRY DATE: JUL 01, 2009@12:00:29
      AUTHOR: MUSE,INTERPRETER  EXP COSIGNER:
      URGENCY:                      STATUS: COMPLETED

PROCEDURE SUMMARY CODE: Machine Resulted
DATE/TIME PERFORMED: AUG 04, 2008@09:00:4

** DOCUMENT IN VISTA IMAGING **
SEE FULL REPORT IN VISTA IMAGING

SIGNATURE NOT REQUIRED
SEE SIGNATURE IN VISTA IMAGING

** (Muse EKG(Bi-Directional))  AUTO-INSTRUMENT DIAGNOSIS **

Procedure: 93040  12 Lead ECG

Release Status: Released Off-Line Verified
Date Verified: Aug 04, 2008@09:43:06
Interpreter: MUSE,INTERPRETER

93000.2  Ventricular Rate:    69      BPM

```

Clinical Procedures Process, Part 2

```

93000.3  Atrial Rate:           69      BPM
93000.4  P-R Interval:         140     ms
93000.5  QRS Duration:         100     ms
93000.6  Q-T Interval:         386     ms
93000    QTC Calculation(Bezet):413    ms
93000.12 Calculated P Axis:     75     degrees
93000.13 Calculated R Axis:     72     degrees
93000.14 Calculated T Axis:     72     degrees
Normal sinus rhythm
Normal ECG

Administrative Closure: 07/01/2009
                        by: INTERPRETER MUSE
                        INTERPRETER
    
```

The fourth example shows a procedure with the text of the result added to the significant findings of the consult and the note remains in the “Undictated” status. This example is the Detailed Consult that has the significant findings and the note displayed:

```

Current Pat. Status:  Outpatient
Primary Eligibility:  SC LESS THAN 50%

Order Information
To Service:          CARDIOLOGY
From Service:        CARDIOLOGY
Requesting Provider: ACKERMAN,TEST
Service is to be rendered on an OUTPATIENT basis
Place:               Consultant's choice
Urgency:             Routine
Orderable Item:      CP EP
Procedure:            CP EP
Clinical Procedure:  EP
Reason For Request:  Colon exam.

Inter-facility Information
This is not an inter-facility consult request.

Status:              COMPLETE
Last Action:         COMPLETE/UPDATE
Significant Findings: YES

Facility
Activity              Date/Time/Zone      Responsible Person  Entered By
-----
CPRS RELEASED ORDER  06/25/09 16:44     ACKERMAN,TEST     ACKERMAN,TEST
SIG FINDING UPDATE   06/25/09 17:00     CLINICAL,DEVICE P CLINICAL,DEVICE P
                    (entered) 06/25/09 16:46
** DOCUMENT IN VISTA IMAGING **
SEE FULL REPORT IN VISTA IMAGING

** (DMS (EP)) AUTO-INSTRUMENT DIAGNOSIS **

Procedure: 99999 Patient Demographics

PT-HT-CM:           183.00 Cm
PT-WT-KG:           86.60 Kg
PT-BSA:             2.09 m2
PT-SEX:             M
PT-AGE:             57.07 Years
Procedure: 99999 Case Demographics

STUDYUID:           3081204124528
STUDYNUM:           DMS_11716
CVIS-MODE:          1
Procedure: 99999 Event Log

EVENT:              Protocol: Baseline
    
```

```

EVENT:          _____Pre-Case Documentation_____
EVENT:          Patient Arrives
EVENT:          Patient on Table
EVENT:          Pre-Procedure Teaching Performed
EVENT:          Patient Verbalized Understanding of Procedure
EVENT:          Consent Signed \T\ On Chart
EVENT:          History \T\ Physical On Chart
EVENT:          Armband Checked \T\ On Patient
EVENT:          _____
EVENT:          No Known Drug Allergies
EVENT:          Patient Allergies:
EVENT:          IV's Infusing:
EVENT:          IV Site:
EVENT:          Pre-Case Conscious Sedation Assessment
EVENT:          Pre-Procedure Pulses Checked
EVENT:          _____
EVENT:          Lab Results Checked
EVENT:          Physician Called
EVENT:          Patient Prepped \T\ Draped In Usual Manner
EVENT:          12-Lead Print
EVENT:          _____EP Procedure_____
EVENT:          Physician Arrived
EVENT:          SpO2 99%; HR 88 bpm; 121/88/109 NBP; RR 19/min
EVENT:          Case Event - Diagnostic EP
EVENT:
Case Event Type:Diagnostic EP,Physician:smith,john

EVENT:          HR 87 bpm; ***/***/*** NBP; RR 19/min
EVENT:          Case Start
EVENT:          Fentanyl IV 5 mcg
EVENT:          Midazolam IV 6 mg
EVENT:          Procedure: EP Study with Induction
EVENT:          Lidocaine Administrered to:
EVENT:          Percutaneous Puncture to:
EVENT:          Sheath Inserted
EVENT:          8F SR3 8F sheath
EVENT:          Catheter Inserted
EVENT:          Quadrapolar EP catheter
EVENT:          Conduction Intervals
EVENT:
Case Event Type:Interventional EP,Physician:smith,john

EVENT:          Arrhy : Tachy
EVENT:          Arrhy : Terminated
EVENT:          SpO2 94%; HR 187 bpm; 166/110/133 NBP; RR 20/min
EVENT:          Arrhy : Tachy
EVENT:          Arrhy : Terminated
EVENT:          Arrhy : Tachy
EVENT:          Arrhy : Terminated
EVENT:          Procedure: Mapping
EVENT:          Procedure: Electrophysiologic Ablation
EVENT:          5031TM Ablation catheter
EVENT:          _____Post Case Documentation_____
EVENT:          Case End
EVENT:          Sheaths Pulled \T\ Manual Pressure Applied
EVENT:          Sheaths Sutured In Place
EVENT:          Post Case Conscious Sedation Assessment
EVENT:          Post Procedure Pulses Checked
EVENT:          _____
EVENT:          Hemostasis Obtained
EVENT:          Dressing Applied to the Site
EVENT:          Post Procedure Teaching Performed
EVENT:          Patient Verbalizes Understanding of Teaching
EVENT:          Report Called To:
EVENT:          Patient Transferred To:
Procedure: 99999 Conscious Sedation

CS-ACT-PRE:
      2 - Able to move 4 extremities voluntarily or on command

CS-ACT-POST:

```

Clinical Procedures Process, Part 2

```
0 - Unable to move extremities voluntarily or on command
CS-RESP-PRE:                2 - Able to breathe deeply and cough freely
CS-RESP-POST:               1 - Dyspnea or limited breathing
CS-CIRC-PRE:                2 - BP +/- 20% of pre-anesthetic level
CS-CIRC-POST:               1 - BP +/- 20% to 49% of pre-anesthetic level
CS-CONS-PRE:                2 - Fully Awake
CS-CONS-POST:               1 - Arousable on calling
CS-O2SAT-PRE:
    2 - Able to maintain O2 saturation greater than 92% on room air
CS-O2SAT-POST:
    1 - Needs O2 inhalation to maintain O2 Saturation greater than 90%
CS-SCORE-PRE:                10
CS-SCORE-POST:               4
Procedure: 99999  XRay Summary

XRAY-FLTIME:                 22.00   min
XRAY-FLDOSE:                 cGycm2
XRAY-CINEDOSE:               cGycm2
XRAY-TOTDOSE:                cGycm2
XRAY-CINEFRAME:
XRAY-INTFLTIME:              10.00
XRAY-DIAGFLTIME:             12.00
XRAY-TOTALRUNS:
Procedure: 99999  DICOM

Event_DICOM_Study:
    1.2.840.113619.6.209.2667640736.933319371.3302940589.266219474

Procedure: 99999  Reports
Procedure: 99999  Custom_Fields
Procedure: 99999  Registry_Fields
Procedure: 99999  Registry_Fields
Procedure: 0      Study Events
Procedure: 0      Study Events
Procedure: 0      Study Events
Procedure: 99999

COMPLETE/UPDATE      12/04/08 12:10      CLINICAL,DEVICE P  ACKERMAN,TEST
                    (entered) 06/25/09 17:20
                    Note# 5835

Note: TIME ZONE is local if not indicated

Significant Findings: **Yes**
-----

LOCAL TITLE: CP CARDIOLOGY
DATE OF NOTE: JUN 25, 2009@16:46:33  ENTRY DATE: JUN 25, 2009@16:46:33
AUTHOR:
EXP COSIGNER:
URGENCY:
STATUS: UNDICTIONATED

PROCEDURE SUMMARY CODE: Machine Resulted
DATE/TIME PERFORMED: DEC 04, 2008@12:10:0

=====
===== END =====
```

Once the note is complete, the Procedure request will be complete.

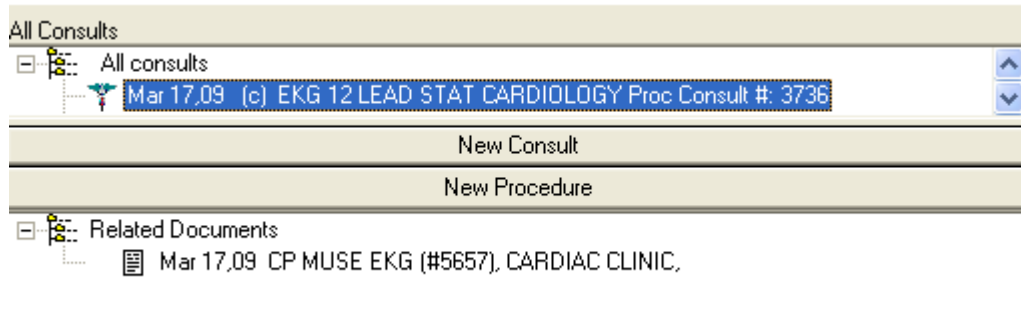


Figure 4-15

On the Consults tab in Computerized Patient Record System (CPRS), the technician can create an addendum to the note and enter the encounter form information. Highlight the note that was administratively closed. Use the “Action” pull down menu and select Consult Results and then select Make Addendum.

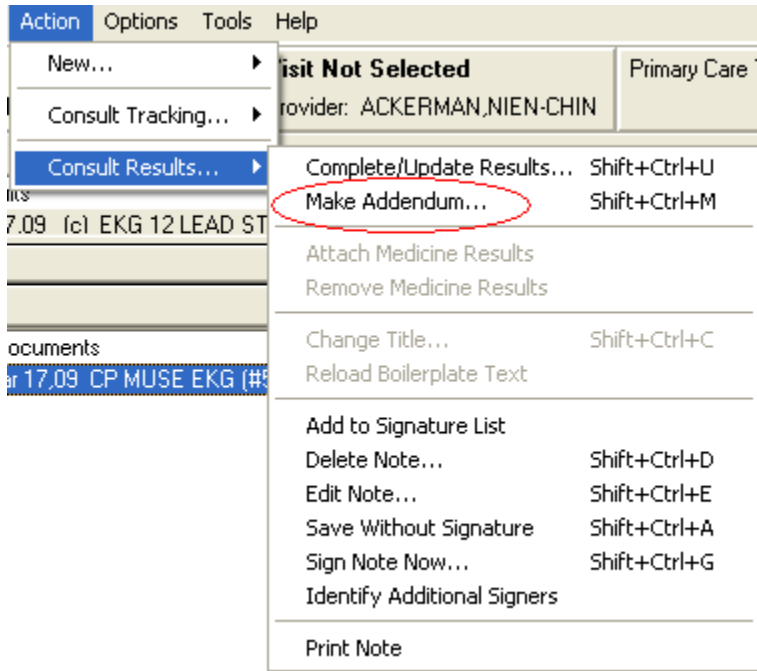


Figure 4-16

Click on the Encounter button to bring up the Encounter form for the workload.

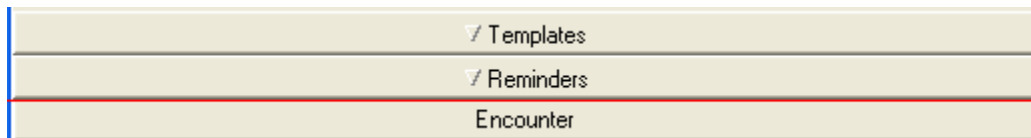


Figure 4-17

If you used a Consults title for the note, the note will appear in both the Notes and Consults tab. On the Notes tab, you will be able to see the individual note without the procedure request. You can highlight the note and click the “Encounter” button to launch the Encounter form.

Note: If you used a Consult title for the note, the Procedure Summary Code and Date/Time Performed will not be displayed on the note.

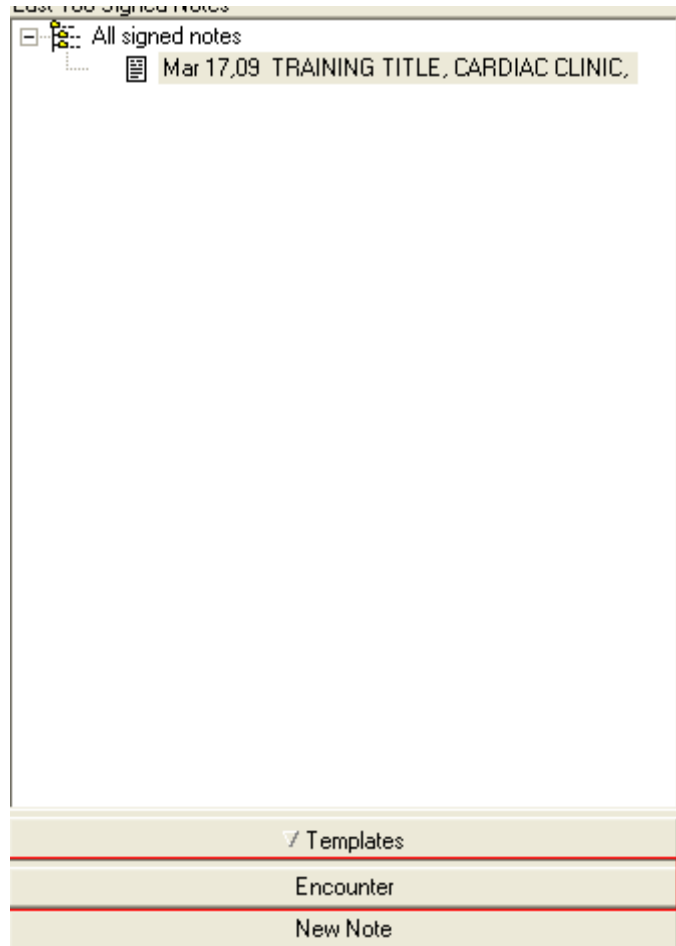


Figure 4-18

```
LOCAL TITLE: CP TEST TITLE
STANDARD TITLE: CARDIOLOGY ATTENDING NOTE
DATE OF NOTE: MAR 17, 2009@09:42:05  ENTRY DATE: MAR 17, 2009@09:42:05
AUTHOR: CLINICAL,DEVICE PRO  EXP COSIGNER:
URGENCY:                               STATUS: COMPLETED

** DOCUMENT IN VISTA IMAGING **
SEE FULL REPORT IN VISTA IMAGING

SIGNATURE NOT REQUIRED
SEE SIGNATURE IN VISTA IMAGING

** (Muse EKG(Bi-Directional))  AUTO-INSTRUMENT DIAGNOSIS **

Procedure: 93000  12 Lead ECG
```

```
Date Verified: Oct 15, 1998@15:04:18
93000.2 Ventricular Rate:    67      BPM
Administrative Closure: 03/17/2009
                        by:
                        Clinical,Device Proxy Service
```

If you setup the procedure with the text to be entered as significant findings, you will see the Detailed Consult on the Consults tab and in the Procedure (local only) component on the Reports tab of CPRS.

Viewing Clinical Procedures Results

You can go to VistA Imaging to view results. If you as the interpreter did not interpret the result right after the procedure was performed, you may want to view the results before you enter an interpretation. In the colonoscopy example, the interpretation was entered in Figure 4-6.

1. Logon to CPRS.
2. Select **Tools > VistA Imaging Display**, Figure 4-19. The patient's Abstract list is displayed, Figure 4-20.

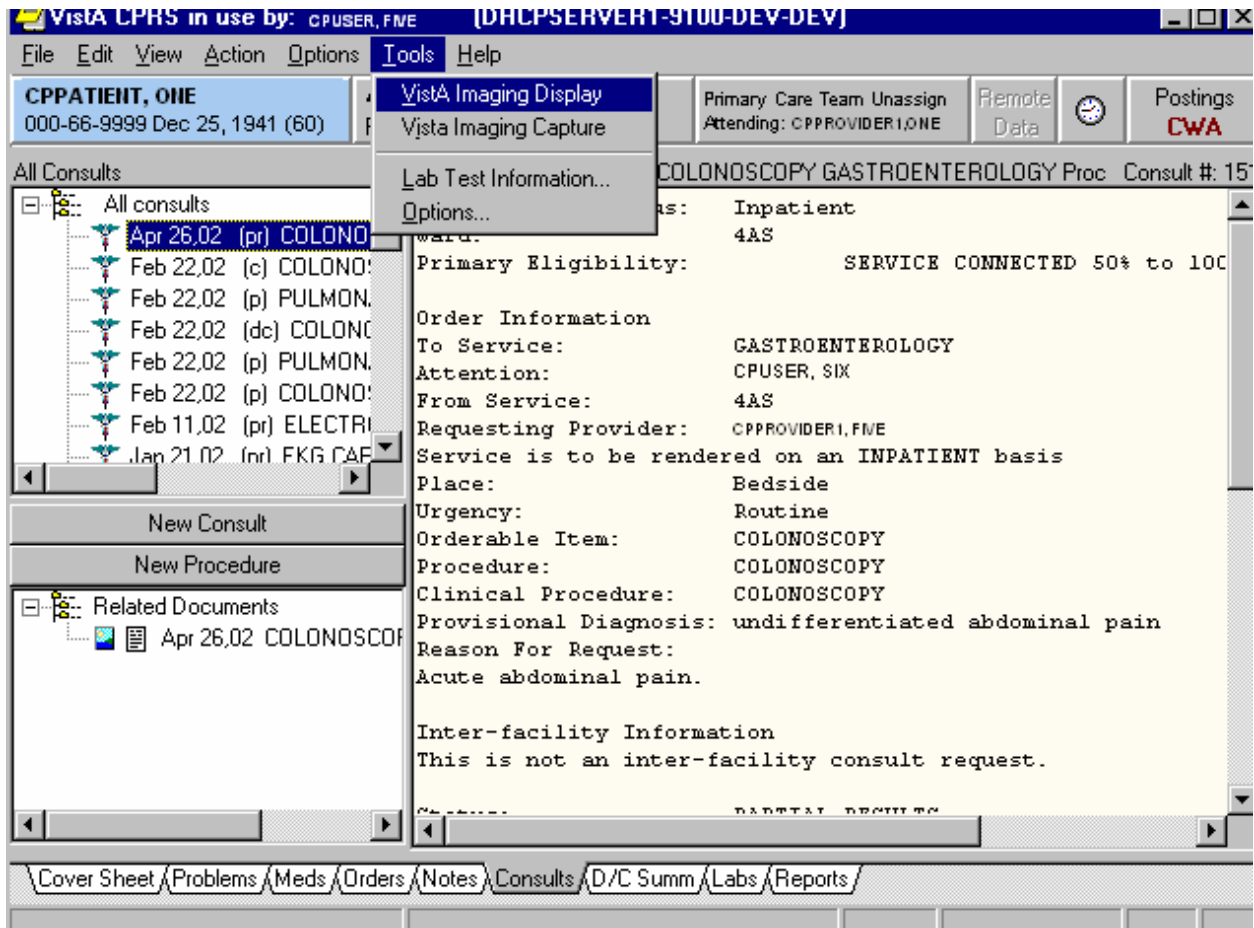


Figure 4-19

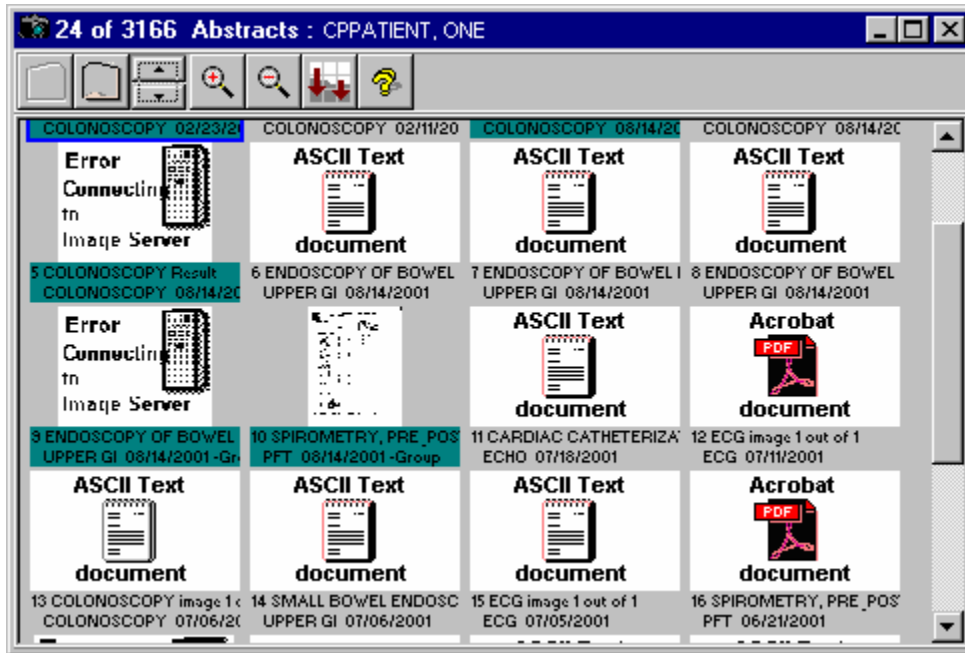


Figure 4-20

Note: VistA Imaging accepts procedure results in .bmp, jpg, jpeg, html, .pdf, .rft, tiff, and .txt formats.

1. Select **View > Clinical Procedures** to view Clinical Procedures document titles. The list of CP documents for the patient is displayed. (Figure 4-21).

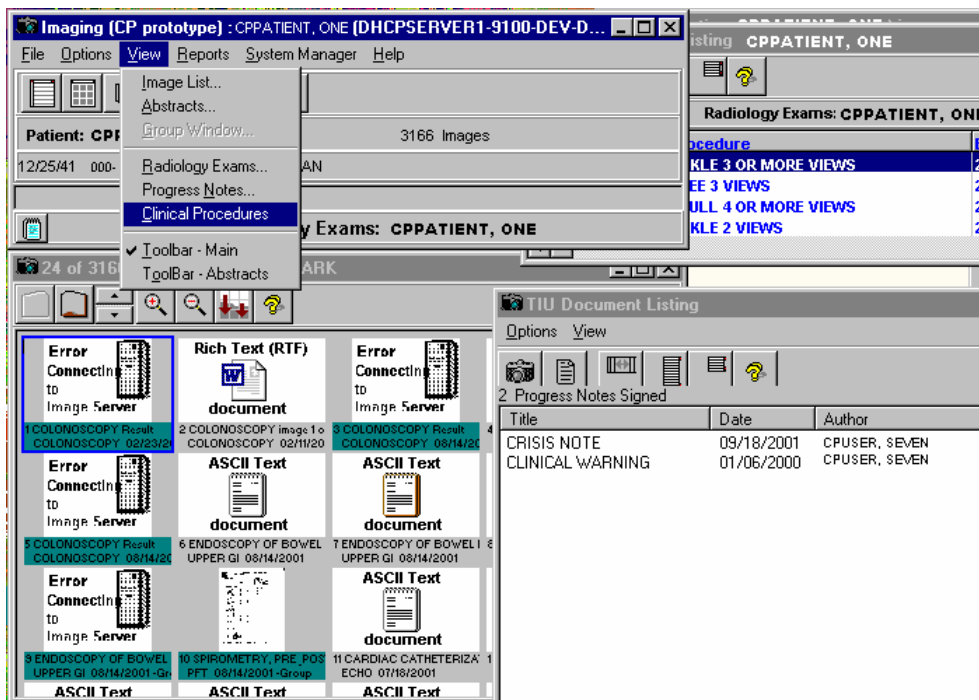


Figure 4-21

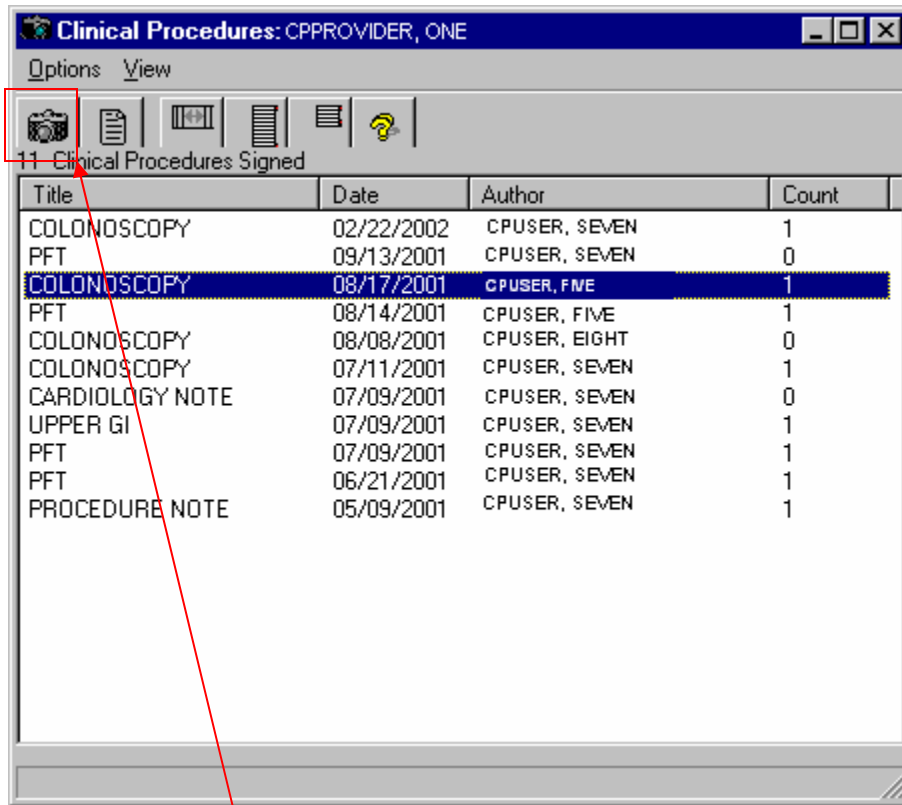


Figure 4-22

2. Click a document title, and then click the camera icon to display the associated images for that CP document, Figure 4-22.

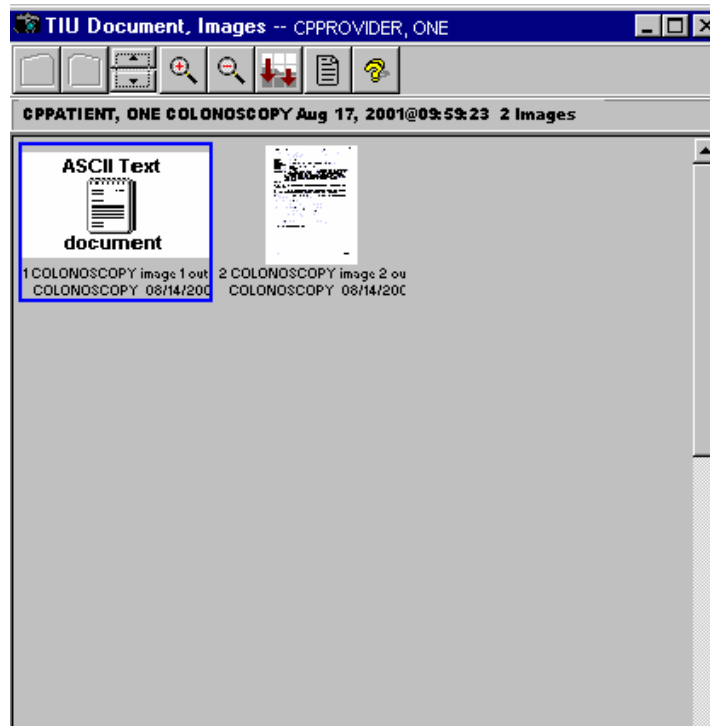


Figure 4-23

3. Double-click the abstract to open the result file, (Figure 4-23).
4. In the screen where the CP documents are listed, Figure 4-22, click the CP title, and then click the report icon next to the camera. The TIU Note is displayed, Figure 4-24.

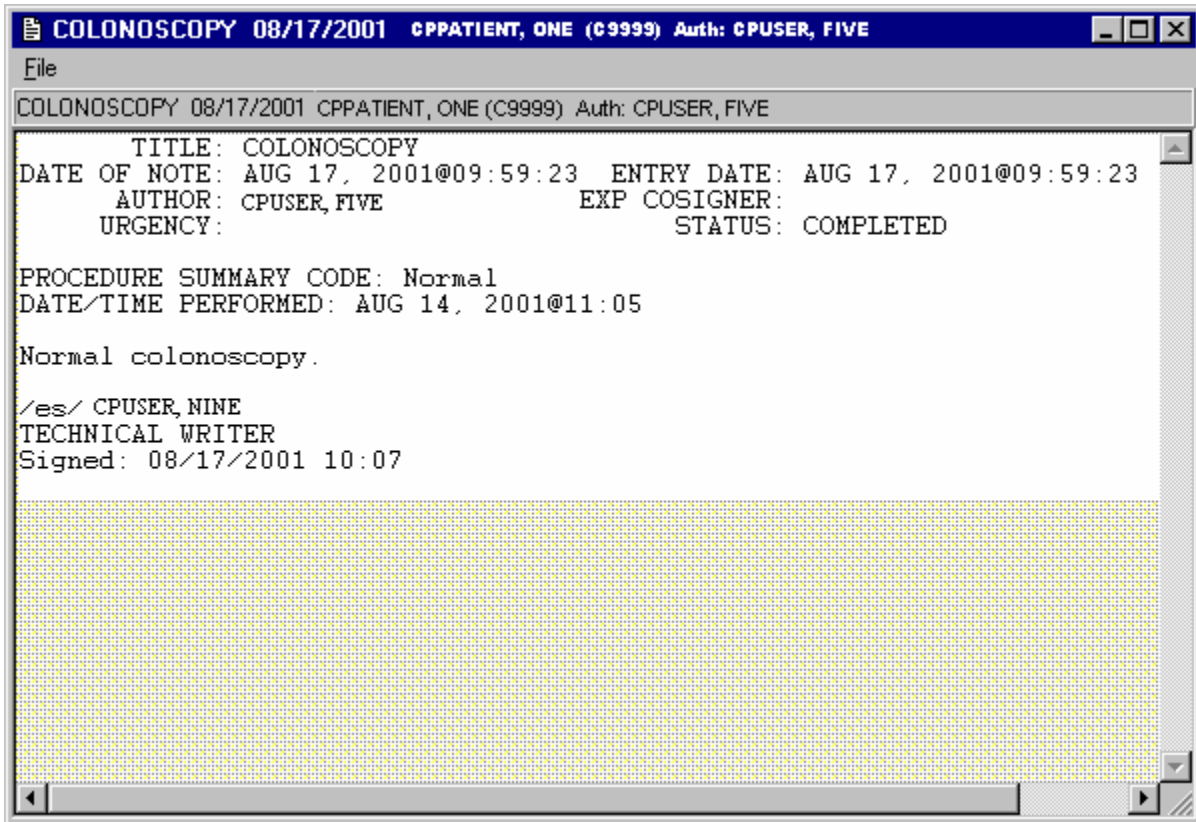


Figure 4-24

Figure 4-24 is an example of a document that has been interpreted and signed.

If you launch Imaging Display before the document is interpreted, the Author field is undefined and the status is UNDICTIONATED. Some users may want to view the results before interpreting.

Linking Consent Forms and Images to CP Documents

As the interpreter, you can link a consent form or other images to CP documents by using VistA Imaging Capture. VistA Imaging Capture software can capture clinical images or scanned documents and attach them to Clinical Procedures. Refer to the VistA Imaging 3.0 MAG*3.0*7 Patch Document at the following website:

<http://vaww.va.gov/imaging/3.0patches.htm>

5. 1 Viewing the Reports

After installing the Medicine patch MC*2.3*39 and the Clinical Procedures (CP) patch MD*1.0*2, you can view the CP interpretations, which are TIU documents, along with Medicine reports on the Computerized Patient Record System (CPRS) Reports tab.

Four changes are introduced with patches MC*2.3*39 and MD*1.0*2.

- On the CPRS Reports tab the Medicine folder has been renamed Medicine/CP.
- The CP procedure interpretations have been added to the list of Medicine procedures for viewing and displaying on the CPRS Reports tab.
 - Only completed and signed CP procedures are displayed for CP reports.
 - Unless you are a Subspecialty or a Manager key holder within the Medicine package, only released and verified Medicine procedures are displayed for Medicine reports. However, if the View All field for a specific procedure in the Procedure/Subspecialty (#697.2) file is set to Yes, then all Medicine procedures of that type display.
 - If you are a Subspecialty key holder within the Medicine package you can view all statuses of Medicine procedures for that subspecialty.
 - If you are a Manager key holder within the Medicine package you can view all statuses of Medicine procedures.
- ²The Medicine View file (#690.2) controls which fields are displayed in the Medicine reports except for the Procedures (local only) report. Because of the numerous background calculations in the PFT report, this report remains unchanged.
- You can configure the Medicine Report to display in CPRS. See [Configuring the Medicine Report to Display in CPRS](#).

The difference between a Medicine Report and a CP Report is that all CP interpretations have a consult number associated with them. The interpretation is the TIU document. Medicine reports may have a consult procedure request number depending on whether the report was associated with a consult request or not. Another difference is that the Medicine report displays the discrete data entered through the Medicine package.

You can print these reports by first viewing the report, opening the File menu, and clicking Print. Then select a Windows printer to print the report.

The Abnormal, Full Captioned, Full Report, Procedures (local only), and Procedures reports display a message at the end of each procedure, which indicates if there are images associated with that procedure. The text is as follows:

NOTE: Images are associated with this procedure.
Please use Imaging Display to view the images.

¹ Patch MD*1.0*2 July 2004 Viewing the Reports chapter added.

² Patch MD*1.0*10 March 2005 Change dealing Medicine View file.

Viewing the Reports

After installing MD*1.0*2, your Medicine/CP folder will look similar to the following. (Click on a report to view the new format):

Clinical Reports

Medicine/CP

[Abnormal](#)

[Brief Report](#)

[Full Captioned](#)

[Full Report](#)

[Procedures \(local only\)](#)

[Procedures](#)

Some of these reports are also located under the Health Summary folder:

Health Summary

Ad Hoc Report

Medicine Abnormal Brief [MEDA]

Medicine Brief Report [MEDB]

Medicine Full Captioned [MEDC]

Medicine Full Report [MEDF]

Medicine Summary [MEDS] – This is a listing of procedure headings that fall within a specified date range.

The Procedures (local only) report can also be found under the list of Available Reports.

Abnormal

This report shows all Medicine and CP interpretations that have a Procedure Summary Code of Abnormal. The name of the report, selected date range and maximum number of occurrences (Max/site) appear above the report.

Medicine/CP Abnormal [From: May 4, 2003 to May 3, 2004] Max/site: 10

Printed for data from 05/04/2003 to 05/03/2004 05/03/2004 13:16
 ***** CONFIDENTIAL SUMMARY pg. 1 *****
 CPPATIENT1, TEN 000-00-0110 3AS DOB: 02/03/1943

----- MEDA - Med Abnormal -----

----- COLONOSCOPY APR 16, 2004@15:38 ABNORMAL -----

APPOINTMENT DATE/TIME: 4/16/04@15:38
 MEDICAL PATIENT: CPPATIENT1, TEN
 PROTOCOL: STOMACH TEST
 EGD SIMPLE PRIMARY EXAM: Y
 LAB OR XRAY: LAB
 OCCULT BLOOD:
 SPECIMEN COLLECTION:
 INDICATION COMMENT: TESTING

LOCATION EVALUATED:
 COLON ASCENDING
 GROSS: ABSENCE
 MEASUREMENT:
 IMPRESSION:
 FELLOW:
 SUMMARY: ABNORMAL
 PRIMARY DIAGNOSIS:
 PROCEDURE SUMMARY: TESTING THE PROCEDURE

INSTRUMENT:
 SCOPE 1
 ENDOSCOPIST: CPROVIDER1, SEVEN
 WHERE PERFORMED:
 WARD/CLINIC: GI LAB
 TIME STARTED: 0600
 TIME COMPLETED: 1000
 URGENCY OF PROCEDURE: ELECTIVE
 PREPARATION DIET: CLEAR LIQUIDS
 DIET COMMENT:
 ENEMAS: PHOSPHASODA
 COMMON BILE DUCT SIZE (mm):
 PANCREATIC DUCT SIZE (mm):
 DEPTH OF INSERTION:
 POST-PROC INSTRUMENT CLEANSING:
 SECOND FELLOW:

INSTRUCTIONS TO PATIENT:

----- PULMONARY FUNCTION TEST MAR 16, 2004@13:40 ABNORMAL -----

Viewing the Reports

SEX: M AGE: 61 90 in/160 lb AMBIENT: 35C/600T
 RACE: WHITE, NOT OF HISPANIC ORIGIN TECH: CPUSER, TEN
 SMOKER CURRENT BRONCHODILATOR USE EFFORT: GOOD

CONSULT DX:

COUGH
 ASTHMA
 INTERSTITIAL LUNG DISEASE

.....
 UNITS PRED ACTUAL %PRED PREV1 PREV2 CI
 VOLUMES.....

INERT GAS DILUTION 6/30/03 6/6/02
 (NOTES): TEST INERT GAS
 TLC L 10.53 9.00 85.5 5.00 8.00 9.09
 VC L 7.76 3.00 38.7 7.00 7.00
 FRC L 4.38 4.00 91.4 3.00 6.50 U 5.42
 RV L 2.80 5.00 178.3 4.00 4.00 U 3.68
 RV/TLC % 56

BODY BOX 6/30/03 6/6/02
 (NOTES): TEST BODY BOX
 TLC L 10.53 3.00 28.5 7.00 9.90 9.09
 VC L 7.76 2.00 25.8 6.00 7.00
 FRC L 4.38 4.00 91.4 4.00 6.00 U 5.42
 RV L 2.80 5.00 178.3 2.00 5.00 U 3.68
 RV/TLC % 167

NITROGEN WASH OUT 6/6/02 5/31/02
 (NOTES): TEST NITROGEN WASH OUT
 TLC L 10.53 7.00 66.5 6.00 7.00 9.09
 VC L 7.76 4.00 51.5 5.50 6.00
 FRC L 4.38 3.00 68.6 4.00 4.00 U 5.42
 RV L 2.80 2.00 71.3 3.00 3.00 U 3.68
 RV/TLC % 29

X-RAY PLANIMETRY 6/6/02 5/30/02
 (NOTES): TEST X-RAY
 TLC L 10.53 5.00 47.5 7.00 9.00 9.09
 VC L 7.76 4.00 51.5 6.40 6.00
 FRC L 4.38 7.00 160.0 3.00 4.00 U 5.42
 RV L 2.80 8.00 285.2 1.00 5.00 U 3.68
 RV/TLC % 160

UNITS PRED ACTUAL %PRED PREV1 PREV2 CI
 FLOWS.....

MACHINE: FLOW TURBINE

STANDARD STUDY 6/6/02 5/30/02
 (NOTES): TEST STANDARD
 FVC L 7.76 4.30 55.4 8.00 9.00
 FEV1 L 5.79 2.20 38.0 6.00 4.00 4.94
 PF L/SEC 10.986 3.200 29.1 5.000 5.000 8.02
 FEF25-75 L/SEC 4.478 4.500 100.5 4.000 15.000 2.81
 MVV L/MIN 211.72 3.00 1.4 4.00 10.00 163.87
 FEV1/FVC % 51

AFTER INHALATION CHALLENGE 6/6/02 5/31/02

(NOTES): AFTER INHALATION										
FVC	L	7.76	7.00	90.2	8.00	9.00				
FEV1	L	5.79	4.00	69.1	7.00	8.00	4.94			
PF	L/SEC	10.986	3.000	27.3	6.000	7.000	8.02			
FEF25-75	L/SEC	4.478	5.000	111.6	5.000	10.000	2.81			
MVV	L/MIN	211.72	3.00	1.4	4.00	50.00	163.87			
FEV1/FVC	%		57							
AFTER EXERCISE					6/6/02	5/31/02				
FVC	L	7.76	5.00	64.4	8.00	9.90				
FEV1	L	5.79	3.00	51.9	7.00	8.00	4.94			
PF	L/SEC	10.986	2.000	18.2	6.000	7.000	8.02			
FEV1/FVC	%		60							
DIFFUSION.....										
METHOD: STEADY STATE										
DLCO-SB	L	37.16	33.00	88.8	6/30/03	6/6/02				
Corr DLCO for HB & COHB:		37.16	32.55	87.6	45.00	50.00	29.18			
BLOOD GASES.....										
STUDY TYPE	pH	pCO2	pO2	O2HB	COHB	MHB	HB	Fio2	A-aO2	QS/QT
(NORMAL)	7.36-7.44	36-44	80-100	>88%	<3%	<2%			<22	
100% O2 STUDY	7.000	0.0	0.0	4.0%	0.0%	0.0%	3.0	0.500	277	
PATIENT TEMPERATURE (C): 35										
MAX EXERCISE	8.000	44.0	3.0	53.0%	33.0%	23.0%	15.4	0.343	132	
PATIENT TEMPERATURE (C): 30										
(NOTES): TEST QS										
SUPPLEMENTAL	8.000	9.0	0.0	67.0%	0.0%	56.0%	0.0	0.900	486	
PATIENT TEMPERATURE (C): 32										
POST EXERCISE	7.456	99.0	345.0	78.0%	45.0%	45.0%	15.1	1.000	84	0.52
PATIENT TEMPERATURE (C): 33										
(NOTES): TEST QS										
SPECIAL STUDIES.....										
MAXIMUM PRESSURES					6/30/03	6/6/02				
(NOTES): 44										
PiMAX	cmH2O		5.00		99.00	68.00				
MECHANICS					6/30/03	6/6/02				
Raw	cmH2O/L/S		4.00		15.00	10.00				
SGaw	L/S/cmH2O		0.30		0.30	0.20				
Cst	4cmH2O		0.50		1.00	0.40				
SMALL AIRWAY					6/30/03	6/6/02				
Cdyn	L/cmH2O		0.40		1.00	0.45				
FEF50 He-Air	L/Sec		45.00		45.00	56.00				
VISOV	L		3.00		5.00	5.00				
CV	L		5.00		4.00	5.00				
CV/VC	%		2.50							
CV/TLC	%		1.67							
VISOV/CV	%		0.60							
EXERCISE					6/30/03	6/6/02				
(NOTES): Insert note here										

Viewing the Reports

VE _{max} (BTPS)	L	44.00	90.00	90.00
BR	L	34.00	50.00	50.00
VD/VT MAX	L	0.70		0.43
VE _{rest} (BTPS)	ml/beat	3.00	35.00	30.00
EKG		ABNORMAL		
W _{max}	wrpm/min	2.00	100.00	245.00
WRI/WRT	watts/min	3.00	35.00	40.00
Max Speed	mph	15.00	20.00	15.00
TOTAL TIME	min	100.00	100.00	600.00
Exercise Testing Mode: BIKE ERGOMETER				
REASON(S) FOR STOPPING:				
		Patient cannot work on Bike Treadmill anymore. he will work on something different such as a Cardioglider.		
INTERPRETATION:				
COMMENTS AND RECOMMENDATIONS:				
INTERPRETED BY:				
		SMITH, JOE		
PREDICTED VALUE FORMULAS USED				
TLC		.078*HT-7.3	BOREN & KORY '66	
VC		.06*HT-(.0214*AGE)-4.65	CRAPO '81	
FRC		.032*HT-2.94	BOREN & KOREY '66	
RV		.019*HT+(.0115*AGE)-2.24	BOREN & KORY '66	
FVC		.06*HT-(.0214*AGE)-4.65	CRAPO '81	
FEV ₁		.0414*HT-(.0244*AGE)-2.190	CRAPO '81	
PF		3.9*HT-(3*AGE)-49.36/60	FERRIS '64	
FEF ₂₅₋₇₅		.0204*HT-(.038*AGE)+2.133	CRAPO '81	
MVV		1.356*HT-(1.26*AGE)-21.4	BOREN & KOREY '66	
DLCO-SB		12.9113-(.229*AGE)+(.1672*HT)	MILLER '83	
COHB CORR.		ACT*(1+(COHB/100))	MORRIS '85	
HB CORR.		HB+10.22/(1.7*HB)*ACT	COTES '72	
NOTE: HT=height, WT=weight, ACT=actual measurement value				
*** END ***** CONFIDENTIAL SUMMARY pg. 1 *****				

Brief Report

This report lists all procedures (Medicine and CP) that fall within a specified date range and the maximum number of occurrences (Max/site). The name of the report, selected date range and maximum number of occurrences (Max/site) appear above the report. These procedures are listed according to Consult Number, Completed Procedures, Date/Time Performed, and Procedure Code (also known as Procedure Summary Code).

Medicine/CP Brief Report [From: May 4, 2003 to May 3, 2004] Max/site: 10

Printed for data from 05/04/2003 to 05/03/2004		05/03/2004 13:22	
***** CONFIDENTIAL SUMMARY pg. 1 *****			
CPPATIENT1, TEN	000-00-0110	3AS	DOB: 02/03/1943
----- MEDB - Med Brief Report -----			
CONSULT NUMBER	COMPLETED PROCEDURES	DATE/TIME PERFORMED	PROCEDURE CODE
-----	-----	-----	-----
	COLONOSCOPY	APR 16, 2004@15:38	ABNORMAL
	PULMONARY FUNCTION TEST	MAR 30, 2004@13:43	
	PULMONARY FUNCTION TEST	MAR 16, 2004@13:40	ABNORMAL
	ELECTROPHYSIOLOGY	JUN 30, 2003@10:40	ABNORMAL
	PULMONARY FUNCTION TEST	JUN 30, 2003@09:37	NORMAL
*** END ***** CONFIDENTIAL SUMMARY pg. 1 *****			

Full Captioned

This report shows all Medicine and CP reports within a specified date range and the maximum number of occurrences (Max/site). The name of the report, selected date range and maximum number of occurrences (Max/site) appear above the report. Fields that do not contain data within the Medicine reports do not display.

Medicine/CP Full Captioned [From: May 20, 2003 to May 19, 2004] Max/site: 10

```

Printed for data from 05/20/2003 to 05/19/2004                                05/19/2004 14:54
***** CONFIDENTIAL SUMMARY pg. 1 *****
CPPATIENT1, TEN      000-00-0110      3AS      DOB: 02/03/1943

----- MEDC - Med Full Captioned -----

-----
                COLONOSCOPY                        APR 16,2004@15:38      ABNORMAL
-----

APPOINTMENT DATE/TIME:    4/16/04@15:38
MEDICAL PATIENT:        CPPATIENT1, TEN
PROTOCOL:                STOMACH TEST
EGD SIMPLE PRIMARY EXAM:  Y
LAB OR XRAY:             LAB
INDICATION COMMENT:      TESTING

LOCATION EVALUATED:
  COLON ASCENDING
  GROSS: ABSENCE
SUMMARY: ABNORMAL
PROCEDURE SUMMARY:      TESTING THE PROCEDURE

INSTRUMENT:
  SCOPE 1
ENDOSCOPIST:            CPPROVIDER1, SEVEN
WARD/CLINIC:            GI LAB
TIME STARTED:           0600
TIME COMPLETED:        1000
URGENCY OF PROCEDURE:    ELECTIVE
PREPARATION DIET:       CLEAR LIQUIDS
ENEMAS:                 PHOSPHASODA

-----
                PULMONARY FUNCTION TEST            MAR 30,2004@13:43
-----

SEX: M  AGE: 61          85 in/167 lb          AMBIENT: 35C/600T
RACE: WHITE, NOT OF HISPANIC ORIGIN          TECH: CPUSER, TEN
NON-SMOKER          CURRENT BRONCHODILATOR USE  EFFORT: GOOD

CONSULT DX:
      COUGH
.....

                UNITS      PRED      ACTUAL      %PRED      PREV1      PREV2      CI
VOLUMES.....
      BODY BOX
      TLC      L      9.54      2.00      21.0      3.00      7.00      8.10
      VC      L      7.00      3.00      42.9      2.00      6.00
    
```

FRC	L	3.97	4.00	100.8	4.00	4.00	U	5.01
RV	L	2.56	5.00	195.0	5.00	2.00	U	3.44
RV/TLC	%		250					
INTERPRETATION:								
COMMENTS AND RECOMMENDATIONS:								
INTERPRETED BY:								
PREDICTED VALUE FORMULAS USED								
TLC		.078*HT-7.3			BOREN & KORY '66			
VC		.06*HT-(.0214*AGE)-4.65			CRAPO '81			
FRC		.032*HT-2.94			BOREN & KOREY '66			
RV		.019*HT+(.0115*AGE)-2.24			BOREN & KORY '66			
FVC		.06*HT-(.0214*AGE)-4.65			CRAPO '81			
FEV1		.0414*HT-(.0244*AGE)-2.190			CRAPO '81			
PF		3.9*HT-(3*AGE)-49.36/60			FERRIS '64			
FEF25-75		.0204*HT-(.038*AGE)+2.133			CRAPO '81			
MVV		1.356*HT-(1.26*AGE)-21.4			BOREN & KOREY '66			
DLCO-SB		12.9113-(.229*AGE)+(.1672*HT)			MILLER '83			
COHB CORR.		ACT*(1+(COHB/100))			MORRIS '85			
HB CORR.		HB+10.22/(1.7*HB)*ACT			COTES '72			
NOTE: HT=height,WT=weight,ACT=actual measurement value								

PULMONARY FUNCTION TEST			MAR 16,2004@13:40			ABNORMAL		

SEX: M	AGE: 61	90 in/160 lb		AMBIENT: 35C/600T				
RACE: WHITE, NOT OF HISPANIC ORIGIN		SMOKER			TECH: CPUSER, TEN EFFORT: GOOD			
CURRENT BRONCHODILATOR USE								
CONSULT DX:								
COUGH								
ASTHMA								
INTERSTITIAL LUNG DISEASE								
.....								
	UNITS	PRED	ACTUAL	%PRED	PREV1	PREV2	CI	
VOLUMES.....								
INERT GAS DILUTION					6/30/03	6/6/02		
(NOTES): TEST INERT GAS								
TLC	L	10.53	9.00	85.5	5.00	8.00		9.09
VC	L	7.76	3.00	38.7	7.00	7.00		
FRC	L	4.38	4.00	91.4	3.00	6.50	U	5.42
RV	L	2.80	5.00	178.3	4.00	4.00	U	3.68
RV/TLC	%		56					
BODY BOX					6/30/03	6/6/02		
(NOTES): TEST BODY BOX								
TLC	L	10.53	3.00	28.5	7.00	9.90		9.09
VC	L	7.76	2.00	25.8	6.00	7.00		
FRC	L	4.38	4.00	91.4	4.00	6.00	U	5.42
RV	L	2.80	5.00	178.3	2.00	5.00	U	3.68
RV/TLC	%		167					
NITROGEN WASH OUT					6/6/02	5/31/02		
(NOTES): TEST NITROGEN WASH OUT								
TLC	L	10.53	7.00	66.5	6.00	7.00		9.09

Viewing the Reports

VC	L	7.76	4.00	51.5	5.50	6.00				
FRC	L	4.38	3.00	68.6	4.00	4.00	U	5.42		
RV	L	2.80	2.00	71.3	3.00	3.00	U	3.68		
RV/TLC	%		29							
X-RAY PLANIMETRY					6/6/02	5/30/02				
(NOTES): TEST X-RAY										
TLC	L	10.53	5.00	47.5	7.00	9.00		9.09		
VC	L	7.76	4.00	51.5	6.40	6.00				
FRC	L	4.38	7.00	160.0	3.00	4.00	U	5.42		
RV	L	2.80	8.00	285.2	1.00	5.00	U	3.68		
RV/TLC	%		160							
	UNITS	PRED	ACTUAL	%PRED	PREV1	PREV2	CI			
FLOWS.....										
MACHINE: FLOW TURBINE										
STANDARD STUDY					6/6/02	5/30/02				
(NOTES): TEST STANDARD										
FVC	L	7.76	4.30	55.4	8.00	9.00				
FEV1	L	5.79	2.20	38.0	6.00	4.00		4.94		
PF	L/SEC	10.986	3.200	29.1	5.000	5.000		8.02		
FEF25-75	L/SEC	4.478	4.500	100.5	4.000	15.000		2.81		
MVV	L/MIN	211.72	3.00	1.4	4.00	10.00		163.87		
FEV1/FVC	%		51							
AFTER INHALATION CHALLENGE					6/6/02	5/31/02				
(NOTES): AFTER INHALATION										
FVC	L	7.76	7.00	90.2	8.00	9.00				
FEV1	L	5.79	4.00	69.1	7.00	8.00		4.94		
PF	L/SEC	10.986	3.000	27.3	6.000	7.000		8.02		
FEF25-75	L/SEC	4.478	5.000	111.6	5.000	10.000		2.81		
MVV	L/MIN	211.72	3.00	1.4	4.00	50.00		163.87		
FEV1/FVC	%		57							
AFTER EXERCISE					6/6/02	5/31/02				
FVC	L	7.76	5.00	64.4	8.00	9.90				
FEV1	L	5.79	3.00	51.9	7.00	8.00		4.94		
PF	L/SEC	10.986	2.000	18.2	6.000	7.000		8.02		
FEV1/FVC	%		60							
DIFFUSION.....										
METHOD: STEADY STATE										
					6/30/03	6/6/02				
DLCO-SB	L	37.16	33.00	88.8	45.00	50.00		29.18		
Corr DLCO for HB & COHB:		37.16	32.55	87.6						
BLOOD GASES.....										
STUDY TYPE	pH	pCO2	pO2	O2HB	COHB	MHB	HB	Fio2	A-aO2	QS/QT
(NORMAL)	7.36-7.44	36-44	80-100	>88%	<3%	<2%			<22	
100% O2 STUDY	7.000	0.0	0.0	4.0%	0.0%	0.0%	3.0	0.500	277	
PATIENT TEMPERATURE (C): 35										
MAX EXERCISE	8.000	44.0	3.0	53.0%	33.0%	23.0%	15.4	0.343	132	
PATIENT TEMPERATURE (C): 30										
(NOTES): TEST QS										
SUPPLEMENTAL	8.000	9.0	0.0	67.0%	0.0%	56.0%	0.0	0.900	486	
PATIENT TEMPERATURE (C): 32										
POST EXERCISE	7.456	99.0	345.0	78.0%	45.0%	45.0%	15.1	1.000	84	0.52

PATIENT TEMPERATURE (C): 33
 (NOTES): TEST QS

UNITS	ACTUAL	PREV1	PREV2
SPECIAL STUDIES.....			
MAXIMUM PRESSURES (NOTES): 44		6/30/03	6/6/02
PiMAX cmH2O	5.00	99.00	68.00
MECHANICS		6/30/03	6/6/02
Raw cmH2O/L/S	4.00	15.00	10.00
SGaw L/S/cmH2O	0.30	0.30	0.20
Cst 4cmH2O	0.50	1.00	0.40
SMALL AIRWAY		6/30/03	6/6/02
Cdyn L/cmH2O	0.40	1.00	0.45
FEF50 He-Air L/Sec	45.00	45.00	56.00
VISOV L	3.00	5.00	5.00
CV L	5.00	4.00	5.00
CV/VC %	2.50		
CV/TLC %	1.67		
VISOV/CV %	0.60		
EXERCISE		6/30/03	6/6/02
(NOTES): Insert note here			
VEmax(BTPS) L	44.00	90.00	90.00
BR L	34.00	50.00	50.00
VD/VT MAX L	0.70		0.43
VERest(BTPS) ml/beat	3.00	35.00	30.00
EKG	ABNORMAL		
Wmax wrpm/min	2.00	100.00	245.00
WRI/WRT watts/min	3.00	35.00	40.00
Max Speed mph	15.00	20.00	15.00
TOTAL TIME min	100.00	100.00	600.00

Exercise Testing Mode: BIKE ERGOMETER

REASON(S) FOR STOPPING:

Patient cannot work on Bike Treadmill anymore.
 he will work on something different such as a
 Cardiogliders.

INTERPRETATION:

COMMENTS AND RECOMMENDATIONS:

INTERPRETED BY:

CPUSER, TEN

PREDICTED VALUE FORMULAS USED

TLC	.078*HT-7.3	BOREN & KORY '66
VC	.06*HT-(.0214*AGE)-4.65	CRAPO '81
FRC	.032*HT-2.94	BOREN & KOREY '66
RV	.019*HT+(.0115*AGE)-2.24	BOREN & KORY '66
FVC	.06*HT-(.0214*AGE)-4.65	CRAPO '81
FEV1	.0414*HT-(.0244*AGE)-2.190	CRAPO '81
PF	3.9*HT-(3*AGE)-49.36/60	FERRIS '64
FEF25-75	.0204*HT-(.038*AGE)+2.133	CRAPO '81
MVV	1.356*HT-(1.26*AGE)-21.4	BOREN & KOREY '66

Viewing the Reports

```
DLCO-SB          12.9113-(.229*AGE)+(.1672*HT) MILLER '83
COHB CORR.      ACT*(1+(COHB/100))           MORRIS '85
HB CORR.        HB+10.22/(1.7*HB)*ACT       COTES '72
NOTE: HT=height,WT=weight,ACT=actual measurement value
*** END ***** CONFIDENTIAL SUMMARY pg. 1 *****
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Full Report

This report shows all Medicine and CP reports within a specified date range and the maximum number of occurrences (Max/site). The name of the report, selected date range and maximum number of occurrences (Max/site) appear above the report. All data fields, including null values, are displayed.

Medicine/CP Full Report [From: May 20, 2003 to May 19, 2004] Max/site: 10

Printed for data from 05/20/2003 to 05/19/2004 05/19/2004 13:25
 ***** CONFIDENTIAL SUMMARY pg. 1 *****
 CPPATIENT1, TEN 000-00-0110 3AS DOB: 02/03/1943

----- MEDF - Med Full Report -----

 COLONOSCOPY APR 16,2004@15:38 ABNORMAL

APPOINTMENT DATE/TIME: 4/16/04@15:38
 MEDICAL PATIENT: CPPATIENT1, TEN
 PROTOCOL: STOMACH TEST
 EGD SIMPLE PRIMARY EXAM: Y
 LAB OR XRAY: LAB
 OCCULT BLOOD:
 SPECIMEN COLLECTION:
 INDICATION COMMENT: TESTING

LOCATION EVALUATED:
 COLON ASCENDING
 GROSS: ABSENCE
 MEASUREMENT:
 IMPRESSION:

FELLOW:
 SUMMARY: ABNORMAL
 PRIMARY DIAGNOSIS:
 PROCEDURE SUMMARY: TESTING THE PROCEDURE

INSTRUMENT:
 SCOPE 1
 ENDOSCOPIST: CPROVIDER1, SEVEN
 WHERE PERFORMED:
 WARD/CLINIC: GI LAB
 TIME STARTED: 0600
 TIME COMPLETED: 1000
 URGENCY OF PROCEDURE: ELECTIVE
 PREPARATION DIET: CLEAR LIQUIDS
 DIET COMMENT:
 ENEMAS: PHOSPHASODA
 COMMON BILE DUCT SIZE (mm):
 PANCREATIC DUCT SIZE (mm):
 DEPTH OF INSERTION:
 POST-PROC INSTRUMENT CLEANSING:
 SECOND FELLOW:

INSTRUCTIONS TO PATIENT:

 PULMONARY FUNCTION TEST MAR 30,2004@13:43

Viewing the Reports

SEX: M AGE: 61 85 in/167 lb AMBIENT: 35C/600T
 RACE: WHITE, NOT OF HISPANIC ORIGIN TECH: CPUSER1, ONE
 NON-SMOKER CURRENT BRONCHODILATOR USE EFFORT: GOOD

CONSULT DX:

COUGH

	UNITS	PRED	ACTUAL	%PRED	PREV1	PREV2	CI
VOLUMES.....							
BODY BOX					3/16/04	6/30/03	
TLC	L	9.54	2.00	21.0	3.00	7.00	8.10
VC	L	7.00	3.00	42.9	2.00	6.00	
FRC	L	3.97	4.00	100.8	4.00	4.00	U 5.01
RV	L	2.56	5.00	195.0	5.00	2.00	U 3.44
RV/TLC	%		250				

INTERPRETATION:

COMMENTS AND RECOMMENDATIONS:

INTERPRETED BY:

PREDICTED VALUE FORMULAS USED

TLC	.078*HT-7.3	BOREN & KORY '66
VC	.06*HT-(.0214*AGE)-4.65	CRAPO '81
FRC	.032*HT-2.94	BOREN & KOREY '66
RV	.019*HT+(.0115*AGE)-2.24	BOREN & KORY '66
FVC	.06*HT-(.0214*AGE)-4.65	CRAPO '81
FEV1	.0414*HT-(.0244*AGE)-2.190	CRAPO '81
PF	3.9*HT-(3*AGE)-49.36/60	FERRIS '64
FEF25-75	.0204*HT-(.038*AGE)+2.133	CRAPO '81
MVV	1.356*HT-(1.26*AGE)-21.4	BOREN & KOREY '66
DLCO-SB	12.9113-(.229*AGE)+(.1672*HT)	MILLER '83
COHB CORR.	ACT*(1+(COHB/100))	MORRIS '85
HB CORR.	HB+10.22/(1.7*HB)*ACT	COTES '72

NOTE: HT=height, WT=weight, ACT=actual measurement value

 PULMONARY FUNCTION TEST MAR 16,2004@13:40 ABNORMAL

SEX: M AGE: 61 90 in/160 lb AMBIENT: 35C/600T
 RACE: WHITE, NOT OF HISPANIC ORIGIN TECH: CPUSER, TEN
 SMOKER CURRENT BRONCHODILATOR USE EFFORT: GOOD

CONSULT DX:

COUGH
 ASTHMA
 INTERSTITIAL LUNG DISEASE

	UNITS	PRED	ACTUAL	%PRED	PREV1	PREV2	CI
VOLUMES.....							
INERT GAS DILUTION					6/30/03	6/6/02	
(NOTES): TEST INERT GAS							
TLC	L	10.53	9.00	85.5	5.00	8.00	9.09

VC	L	7.76	3.00	38.7	7.00	7.00		
FRC	L	4.38	4.00	91.4	3.00	6.50	U	5.42
RV	L	2.80	5.00	178.3	4.00	4.00	U	3.68
RV/TLC	%		56					
BODY BOX					6/30/03	6/6/02		
(NOTES): TEST BODY BOX								
TLC	L	10.53	3.00	28.5	7.00	9.90		9.09
VC	L	7.76	2.00	25.8	6.00	7.00		
FRC	L	4.38	4.00	91.4	4.00	6.00	U	5.42
RV	L	2.80	5.00	178.3	2.00	5.00	U	3.68
RV/TLC	%		167					
NITROGEN WASH OUT					6/6/02	5/31/02		
(NOTES): TEST NITROGEN WASH OUT								
TLC	L	10.53	7.00	66.5	6.00	7.00		9.09
VC	L	7.76	4.00	51.5	5.50	6.00		
FRC	L	4.38	3.00	68.6	4.00	4.00	U	5.42
RV	L	2.80	2.00	71.3	3.00	3.00	U	3.68
RV/TLC	%		29					
X-RAY PLANIMETRY					6/6/02	5/30/02		
(NOTES): TEST X-RAY								
TLC	L	10.53	5.00	47.5	7.00	9.00		9.09
VC	L	7.76	4.00	51.5	6.40	6.00		
FRC	L	4.38	7.00	160.0	3.00	4.00	U	5.42
RV	L	2.80	8.00	285.2	1.00	5.00	U	3.68
RV/TLC	%		160					
		UNITS	PRED	ACTUAL	%PRED	PREV1	PREV2	CI
FLOWS.....								
MACHINE: FLOW TURBINE								
STANDARD STUDY					6/6/02	5/30/02		
(NOTES): TEST STANDARD								
FVC	L	7.76	4.30	55.4	8.00	9.00		
FEV1	L	5.79	2.20	38.0	6.00	4.00		4.94
PF	L/SEC	10.986	3.200	29.1	5.000	5.000		8.02
FEF25-75	L/SEC	4.478	4.500	100.5	4.000	15.000		2.81
MVV	L/MIN	211.72	3.00	1.4	4.00	10.00		163.87
FEV1/FVC	%		51					
AFTER INHALATION CHALLENGE					6/6/02	5/31/02		
(NOTES): AFTER INHALATION								
FVC	L	7.76	7.00	90.2	8.00	9.00		
FEV1	L	5.79	4.00	69.1	7.00	8.00		4.94
PF	L/SEC	10.986	3.000	27.3	6.000	7.000		8.02
FEF25-75	L/SEC	4.478	5.000	111.6	5.000	10.000		2.81
MVV	L/MIN	211.72	3.00	1.4	4.00	50.00		163.87
FEV1/FVC	%		57					
AFTER EXERCISE					6/6/02	5/31/02		
FVC	L	7.76	5.00	64.4	8.00	9.90		
FEV1	L	5.79	3.00	51.9	7.00	8.00		4.94
PF	L/SEC	10.986	2.000	18.2	6.000	7.000		8.02
FEV1/FVC	%		60					
DIFFUSION.....								
METHOD: STEADY STATE								
DLCO-SB	L	37.16	33.00	88.8	45.00	50.00		29.18

Viewing the Reports

Corr DLCO for HB & COHB: 37.16 32.55 87.6											
BLOOD GASES.....											
STUDY TYPE	pH	pCO2	pO2	O2HB	COHB	MHB	HB	FiO2	A-aO2	QS/QT	
(NORMAL)	7.36-7.44	36-44	80-100	>88%	<3%	<2%			<22		
100% O2 STUDY	7.000	0.0	0.0	4.0%	0.0%	0.0%	3.0	0.500	277		
PATIENT TEMPERATURE (C): 35											
MAX EXERCISE	8.000	44.0	3.0	53.0%	33.0%	23.0%	15.4	0.343	132		
PATIENT TEMPERATURE (C): 30											
(NOTES): TEST QS											
SUPPLEMENTAL	8.000	9.0	0.0	67.0%	0.0%	56.0%	0.0	0.900	486		
PATIENT TEMPERATURE (C): 32											
POST EXERCISE	7.456	99.0	345.0	78.0%	45.0%	45.0%	15.1	1.000	84	0.52	
PATIENT TEMPERATURE (C): 33											
(NOTES): TEST QS											
SPECIAL STUDIES.....											
UNITS							ACTUAL		PREV1		PREV2
MAXIMUM PRESSURES											
(NOTES): 44											
PiMAX	cmH2O						5.00	6/30/03	99.00	6/6/02	68.00
MECHANICS											
Raw	cmH2O/L/S						4.00	6/30/03	15.00	6/6/02	10.00
SGaw	L/S/cmH2O						0.30		0.30		0.20
Cst	4cmH2O						0.50		1.00		0.40
SMALL AIRWAY											
Cdyn	L/cmH2O						0.40	6/30/03	1.00	6/6/02	0.45
FEF50 He-Air	L/Sec						45.00		45.00		56.00
VISOV	L						3.00		5.00		5.00
CV	L						5.00		4.00		5.00
CV/VC	%						2.50				
CV/TLC	%						1.67				
VISOV/CV	%						0.60				
EXERCISE											
(NOTES): Insert note here											
VEmax(BTPS)	L						44.00	6/30/03	90.00	6/6/02	90.00
BR	L						34.00		50.00		50.00
VD/VT MAX	L						0.70				0.43
VERest(BTPS)	ml/beat						3.00		35.00		30.00
EKG											
ABNORMAL											
Wmax	wrpm/min						2.00		100.00		245.00
WRI/WRT	watts/min						3.00		35.00		40.00
Max Speed	mph						15.00		20.00		15.00
TOTAL TIME	min						100.00		100.00		600.00
Exercise Testing Mode: BIKE ERGOMETER											
REASON(S) FOR STOPPING:											
Patient cannot work on Bike Treadmill anymore. he will work on something different such as a Cardiogliders.											
INTERPRETATION:											
COMMENTS AND RECOMMENDATIONS:											

INTERPRETED BY:

CPUSER, TEN

PREDICTED VALUE FORMULAS USED

TLC	.078*HT-7.3	BOREN & KORY '66
VC	.06*HT-(.0214*AGE)-4.65	CRAPO '81
FRC	.032*HT-2.94	BOREN & KOREY '66
RV	.019*HT+(.0115*AGE)-2.24	BOREN & KORY '66
FVC	.06*HT-(.0214*AGE)-4.65	CRAPO '81
FEV1	.0414*HT-(.0244*AGE)-2.190	CRAPO '81
PF	3.9*HT-(3*AGE)-49.36/60	FERRIS '64
FEF25-75	.0204*HT-(.038*AGE)+2.133	CRAPO '81
MVV	1.356*HT-(1.26*AGE)-21.4	BOREN & KOREY '66
DLCO-SB	12.9113-(.229*AGE)+(.1672*HT)	MILLER '83
COHB CORR.	ACT*(1+(COHB/100))	MORRIS '85
HB CORR.	HB+10.22/(1.7*HB)*ACT	COTES '72

NOTE: HT=height,WT=weight,ACT=actual measurement value

*** END ***** CONFIDENTIAL SUMMARY pg. 1 *****

Procedures (local only)

This report component lists all Medicine and CP procedures for a selected patient in CPRS. The Procedures (local only) list contains the following column elements: Procedure Date/Time, Medicine Procedure Name, and Report Status (also known as the Procedure Summary Code).

Medicine/CP Procedures (local only)					
Procedure Date/Time	Medicine Procedure Name	Report Status	[+]		
04/16/2004 15:38	COLONOSCOPY	ABNORMAL	[+]		
03/30/2004 13:43	PULMONARY FUNCTION TEST		[+]		
03/16/2004 13:40	PULMONARY FUNCTION TEST	ABNORMAL	[+]		
07/23/2003 09:00	BRONC W/BRONC WASHING	NORMAL	[+]		
06/30/2003 10:40	ELECTROPHYSIOLOGY	ABNORMAL	[+]		
06/30/2003 09:37	PULMONARY FUNCTION TEST	NORMAL	[+]		

The Procedure Date/Time column lists the procedures in chronological order. Both the Medicine and CP procedures are listed together. After you select the procedure that you want to view, the report is displayed in the lower-right portion of your screen. If you see an interpretation (TIU document), then you are viewing a CP procedure, otherwise you are viewing a Medicine procedure.

Here is an example of a CP Report.

```

Pg. 1
                                HINES VAMC
                                SPIROMETRY, PRE and POST
CPPATIENT1, TEN      000-00-0110      DOB: FEB 3,1943  (61) 3AS
-----
                                TITLE: HISTORICAL PROCEDURE REPORT
DATE OF NOTE: JUL 03, 2003@13:46      ENTRY DATE: JUL 03, 2003@13:46:22
AUTHOR: CPUSER1, ONE      EXP COSIGNER:
URGENCY:      STATUS: COMPLETED

PROCEDURE SUMMARY CODE: Abnormal
DATE/TIME PERFORMED: JUL 03, 2003@13:45

TEST

/es/ CPUSER1, ONE
MEDICAL SPECIALIST
Signed: 03/12/2004 11:04
-----
                                TITLE: PFT
DATE OF NOTE: JUL 03, 2003@13:53      ENTRY DATE: JUL 03, 2003@13:53
AUTHOR:      EXP COSIGNER:
URGENCY:      STATUS: UNDICTIONATED

PROCEDURE SUMMARY CODE:
DATE/TIME PERFORMED: JUL 03, 2003@13:45
-----

```

TITLE: PFT
DATE OF NOTE: JUL 03, 2003@14:34:32 ENTRY DATE: JUL 03, 2003@14:34:32
AUTHOR: EXP COSIGNER:
URGENCY: STATUS: UNDICTATED

PROCEDURE SUMMARY CODE:
DATE/TIME PERFORMED: JUL 03, 2003@13:45

=====

NOTE: Images are associated with this procedure.
Please use Imaging Display to view the images.

Viewing the Reports

Here is an example of a Medicine Report.

```
Pg. 1                      HINES VAMC                      05/03/04 13:30
      ELECTROPHYSIOLOGY REPORT - RELEASED ON-LINE VERIFIED
CPPATIENT1, TEN      000-00-0110                      DOB: FEB 3,1943 (61) 3AS
-----
DATE/TIME:      6/30/03@10:40
MEDICAL PATIENT: CPPATIENT1, TEN
WARD/CLINIC:    CARDIAC CLINIC
CARDIAC DX:     AORTIC STENOSIS
REASON FOR STUDY:  AGINA PROBLEMS.

SYMPTOM:
  UNSTABLE ANGINA

RISK FACTOR:
  CARDIOMEGALY (X-RAY)

ARRHYTHMIA DX:
  HEART BLOCK-MOBITZ II

HX:
  This is the HX text.

-----
              R e p o r t   R e l e a s e   S t a t u s
-----
Current      Date      Person Who
Report       Status   Last Changed      Date of      Report
Status       Changed  The Status        Entry        Version
=====
RELEASED ON-LINE VERIFIED
              6/30/03  NA JACKSONS      6/30/03      1 of 1
```


Procedures

This report component lists Medicine and CP procedures for a selected patient visiting your facility, who is typically seen at another facility. You can view a patient's data from a remote facility, which is called remote data viewing.

Medicine/CP Procedures [From: Aug 12,2000 to May 18,2003] Max/site:10			
Procedure Date/Time	Medicine Procedure Name	Summary	Detailed Report
12/04/2002 09:00	BRONC W/BRONC WASHING	No Summary	: ...
09/10/2002 12:00	ECG	No Summary	: ...
05/29/2002 11:08	ECHO	No Summary	: ...
07/19/2002 17:00	LAPARASCOPY	No Summary	Protocol: ...
05/28/2002 14:00	PULMONARY PROCEDURES	No Summary	: ...
05/28/2002 14:00	SPIROMETRY, PRE and POST	No Summary	: ...
05/28/2002 14:00	SPIROMETRY, PRE and POST	No Summary	: ...

The procedures are listed in chronological order within a specified date range and a maximum number of occurrences (Max/site). The name of the report, selected date range and maximum number of occurrences (Max/site) appear above the procedure list.

Procedure Date/Time	09/02/2003 16:30
Medicine Procedure Name	ECHO
Summary	No Summary
Detailed Report	:

TITLE: ECHO EXAM	
DATE: MAR 05, 2002@08:53:14	ENTRY
AUTHOR: CPUSER1, ONE	EXP COSIGNER:
URGENCY: COMPLETED	STATUS:
PROCEDURE SUMMARY CODE: Abnormal	
DATE/TIME PERFORMED: MAR 04, 2002@12:21	
test	
/es/ CPUSER1, TWO	
MEDICAL SPECIALIST	
Signed: 03/05/2002 12:06	

TITLE: ECHO EXAM	

Viewing the Reports

```
DATE OF NOTE: SEP 02, 2003@15:48:49 ENTRY
DATE: SEP 02, 2003@15:48:49
AUTHOR: EXP COSIGNER:
URGENCY: STATUS:
UNDICTATED
PROCEDURE SUMMARY CODE:
DATE/TIME PERFORMED: SEP 02, 2003@16:30
=====
Facility: SUPPORT ISC
=====
```

Configuring the Medicine Report to Display in CPRS

¹The Medicine View file (#690.2) controls which fields are displayed in the Medicine reports except for the Procedures (local only) report. You can add and delete fields in the procedure type view template, which is located in the Medicine View file. When you edit the template, the Medicine reports within the Procedures (local only), Medicine/CP tree listing and the Health Summary reports are affected.

If the report does not display, be sure the procedure that you want to display is entered in the PROCEDURE field for the appropriate template.

You can use FileMan to add fields to the Medicine View file. The following are examples of adding a multiple field and a single field to a print template.

- Here is an example of how to add field #37.1, which is a sub-file (multiple field) to the Full GI Medicine View entry.

VA FileMan 22.0

Select OPTION: **1** ENTER OR EDIT FILE ENTRIES

INPUT TO WHAT FILE: HEALTH SUMMARY COMPONENT// **690.2** MEDICINE VIEW
(36 entries)

EDIT WHICH FIELD: ALL// **<RET>**

Select MEDICINE VIEW PRINT VIEW TEMPLATE NAME: **Full GI**
ENDOSCOPY/CONSULT

PRINT VIEW TEMPLATE NAME: Full GI// **<RET>**

PRIMARY FILE: ENDOSCOPY/CONSULT// **<RET>**

Select FIELD NUMBER: 203// **<RET>**

FIELD NUMBER: 203// **<RET>**

ORDER ENTRY USAGE: UNKNOWN// **<RET>**

ASTM: **<RET>**

VALUE TYPE: **<RET>**

UNITS: **<RET>**

RANGES: **<RET>**

SEG: **<RET>**

PIECE: **<RET>**

CODING METHOD: **<RET>**

Select FIELD NUMBER: **37.1**

Are you adding '37.1' as a new FIELD NUMBER (the 46TH for this MEDICINE VIEW)? No// **y** (Yes)

FIELD NUMBER ASTM: **<RET>**

ORDER ENTRY USAGE: **<RET>**

ASTM: **<RET>**

VALUE TYPE: **<RET>**

UNITS: **<RET>**

RANGES: **<RET>**

SEG: **<RET>**

¹ Patch MD*1.0*10 March 2005 Change dealing Medicine View file.

Viewing the Reports

```
PIECE: <RET>
CODING METHOD: <RET>
Select FIELD NUMBER: <RET>
Select SUB-FILE: 699.19// <RET>
SUB-FILE: 699.19// <RET>
Select SUB-FIELD: .01// <RET>
SUB-FIELD: .01// <RET>
ORDER ENTRY USAGE: <RET>
ASTM: <RET>
VALUE TYPE: <RET>
UNITS: <RET>
RANGES: <RET>
SEG: <RET>
PIECE: <RET>
CODING: <RET>
Select SUB-FIELD: <RET>
Select SUB-FILE: 699.04
Are you adding '699.04' as a new SUB-FILE (the 23RD for this MEDICINE
VIEW)? No// Y (Yes)
Select SUB-FIELD: .01
Are you adding '.01' as a new SUB-FIELD (the 1ST for this SUB-FILE)? No// Y
(Yes)
SUB-FIELD ASTM: <RET>
ORDER ENTRY USAGE: <RET>
ASTM: <RET>
VALUE TYPE: <RET>
UNITS: <RET>
RANGES: <RET>
SEG: <RET>
PIECE: <RET>
CODING: <RET>
Select SUB-FIELD: <RET>
Select SUB-FILE: <RET>
Select PROCEDURE: GEN// ?
Answer with PROCEDURE
Choose from:
COL
EGD
ERC
GEN
GIENDO
LAP
LV PARAC
PARAC
VAS

You may enter a new PROCEDURE, if you wish

Answer with PROCEDURE/SUBSPECIALTY NAME, or GLOBAL LOCATION, or
TYPE OF PROCEDURE, or PRINT NAME
Do you want the entire 83-Entry PROCEDURE/SUBSPECIALTY List? N (No)
Select PROCEDURE: GEN// <RET>
Type: Full// <RET>

Select MEDICINE VIEW PRINT VIEW TEMPLATE NAME: <RET>
```

- Here is an example of how to add a single field #204.5 to the Full GI Medicine View file (#690.2).

```

Select MEDICINE VIEW PRINT VIEW TEMPLATE NAME:      Full GI
ENDOSCOPY/CONSULT
PRINT VIEW TEMPLATE NAME: Full GI// <RET>
PRIMARY FILE: ENDOSCOPY/CONSULT// <RET>
Select FIELD NUMBER: 37.1// <RET>
  FIELD NUMBER: 37.1// <RET>
  ORDER ENTRY USAGE: <RET>
  ASTM: <RET>
  VALUE TYPE: <RET>
  UNITS: <RET>
  RANGES: <RET>
  SEG: <RET>
  PIECE: <RET>
  CODING METHOD: <RET>
Select FIELD NUMBER: 204.5
Are you adding '204.5' as a new FIELD NUMBER (the 47TH for this MEDICINE
VIEW)? No// Y (Yes)
  FIELD NUMBER ASTM: <RET>
  ORDER ENTRY USAGE: <RET>
  ASTM: <RET>
  VALUE TYPE: <RET>
  UNITS: <RET>
  RANGES: <RET>
  SEG: <RET>
  PIECE: <RET>
  CODING METHOD: <RET>
Select FIELD NUMBER: <RET>
Select SUB-FILE: 699.04// <RET>
  SUB-FILE: 699.04// <RET>
  Select SUB-FIELD: .01// <RET>
    SUB-FIELD: .01// <RET>
    ORDER ENTRY USAGE: <RET>
    ASTM: <RET>
    VALUE TYPE: <RET>
    UNITS: <RET>
    RANGES: <RET>
    SEG: <RET>
    PIECE: <RET>
    CODING: <RET>
  Select SUB-FIELD: <RET>
  Select SUB-FILE: <RET>
  Select PROCEDURE: GEN// <RET>
  Type: Full// <RET>

Select MEDICINE VIEW PRINT VIEW TEMPLATE NAME: <RET>

```

¹Ad Hoc Health Summary Components for CP Reports

A patient at a site can have multiple procedures performed. Over a certain period of time, this would make it difficult for the physician to search through the Clinical Reports for Medicine/CP Reports in CPRS. With patch MD*1*21, the site can setup an Ad Hoc Health Summary component for a specific procedure such as Electrocardiogram. The component would be used to group the CP reports for that procedure. This way, the physician can just look through the reports for a specific procedure. If your site has certain procedures that are high volume, you can set this up. Please contact your IRM programmer and Clinical Application Coordinator and have them refer to Step 3 – Create Ad Hoc Health Summary Component for CP of Chapter 10 - Setting Up CPRS for Clinical Procedures in the Clinical Procedures Implementation Guide for the setup.

The next few screen captures depict an example Ad Hoc HS component that was created for the EKG reports:

Select Reports tab in CPRS and select Ad Hoc Report within the Health Summary tree view.

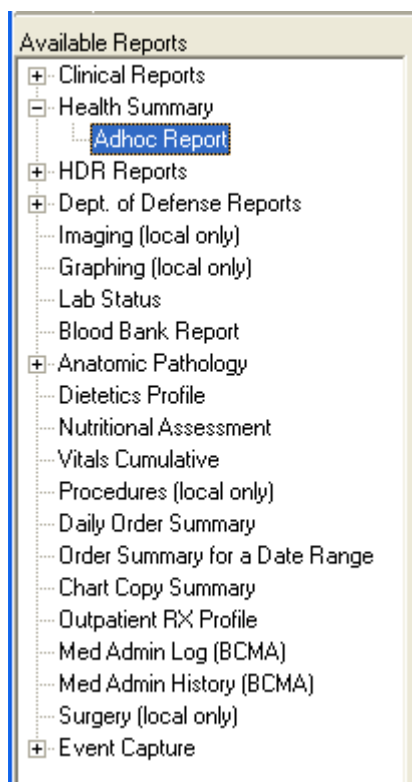


Figure 5-1

¹ Patch MD*1.0*21 June 2010 – Ad Hoc Health Summary Components For CP reports.

Once you click the Ad Hoc Report, an Ad Hoc Health Summary window opens as demonstrated below:

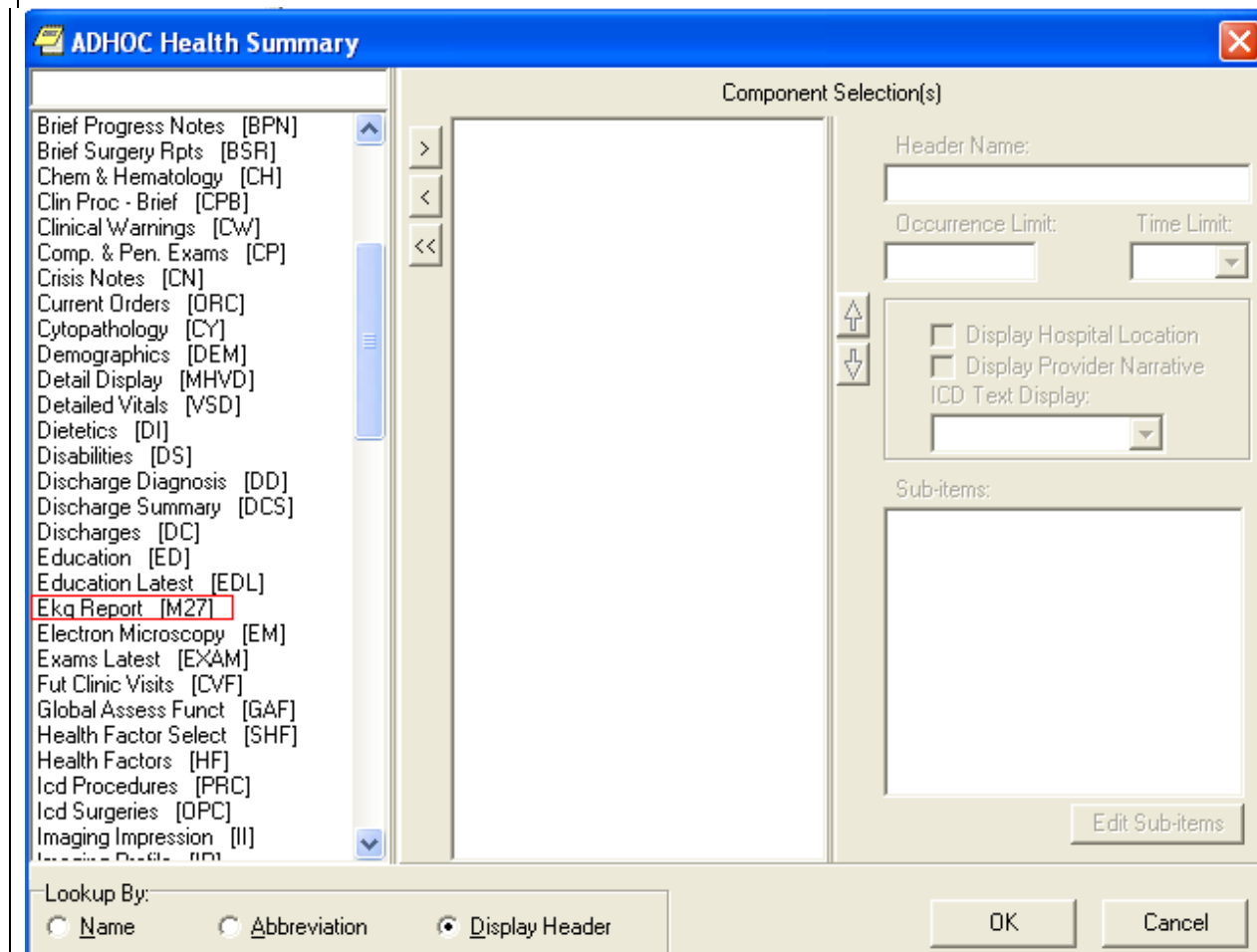


Figure 5-2

Find the Health Summary component that you want and select it. Enter the Occurrence Limit and Time Limit that you want. The Occurrence Limit field is the number of reports that you want displayed and the Time Limit is the date range to find the report such as 1Y (1 year). Once you clicked the “OK” button, you should generate only EKG reports found for that occurrence and time limit.

6. Report Options

The option Print list of Procedure with incomplete workload [MD PROC W/INCOMPLETE WORKLOAD] prints a list of procedures that have incomplete workload information for a date range. This date range used is the date/time performed of the CP Result Report. The list is sorted alphabetically by the Facility Treating Specialty and then alphabetically by the procedure name. Within the procedure, a list of records with the visit date/time, patient name (last four of the social security number), Consult request number, Text Integration Utility (TIU) note number, and the missing data (Diagnosis, Current Procedure Terminology (CPT), or Provider) is generated. This list can be used to let the Clinical Application Coordinator (CAC) know which study does not have the workload data entered. All missing data should be entered by the CAC for the incomplete procedures using the Patient Care Encounter (PCE) option PCE Encounter Data Entry – Supervisor [PXCE ENCOUNTER ENTRY SUPER].

The input information needed to run the option is the following:

1. Start Date – the starting date of the date/time performed of the CP Result Report.
2. End Date – the ending date of the date/time performed of the CP Result Report.
3. Facility Treating Specialty – enter a facility treating specialty or “ALL” for all Facility Treating Specialties.
4. List Printer – enter a printer device to print the list or “HOME” for on screen display.

Following is an example of running the option.

```
Select OPTION NAME: MD PROC W/INCOMPLETE WORKLOAD Print list of Procedure
with incomplete workload
Print list of Procedure with incomplete workload

Select Start Date: T-365 (APR 07, 2009)

Select End Date: T (APR 07, 2010)

Select Facility Treating Specialty (or ALL): ALL

Select LIST Printer: HOME// 0;80;9999 TELNET

Apr 07, 2010 3:29:20 pm Page 1

P R O C E D U R E S W I T H I N C O M P L E T E W O R K L O A D

CARDIOLOGY

Visit D/T Patient Consult # TIU # MISSING
-----
PROCEDURE: CARDIAC CATHETERIZATION
```

¹ Patch MD*1.0*21 June 2010 Added Report Options chapter.

Report Options

07/14/05@17:19	CPPATIENT,ONE (0000)	2618	4281	Diagnosis CPT Provider
07/15/05@09:56	CPPATIENT,TWO (0001)	2620	4248	Diagnosis CPT Provider
Apr 07, 2010 3:29:20 pm				Page 2
P R O C E D U R E S W I T H I N C O M P L E T E W O R K L O A D				
C A R D I O L O G Y				
Visit D/T	Patient	Consult #	TIU #	MISSING

PROCEDURE: EKG, ROUTINE (12 LEADS)				
04/13/09@09:37	CPPATIENT,THREE (0002)	3757	5694	Diagnosis CPT Provider
04/13/09@10:22	CPPATIENT,FOUR (0003)	3758	5695	Diagnosis CPT
04/20/09@09:46	CPPATIENT,FIVE (0004)	3760	5698	Diagnosis CPT
04/20/09@10:25	CPPATIENT,SIX (0005)	3761	5699	Diagnosis CPT
04/21/09@16:18	CPPATIENT,SEVEN (0006)	3762	5702	Diagnosis CPT

The Clinical Procedures Studies List [MD STUDIES LIST] option generates a report which lists all studies associated with the consult requests. The report should be sent to a 132 column printer. This list includes consult requests that are in an active, pending, partial result, or complete status. Any consult request that has a complete status with a request date over a year ago will be screened out of the list. The list is sorted by Facility Treating Specialty and then by the medical device name. The report displays the following information:

1. Patient – name of patient
2. ID# - Patient last four numbers of the social security number.
3. Consult # - consult request number
4. Req'd. Date/Time – date/time of consult request
5. Urgency – the consult urgency (routine, emergency, stat...etc)
6. Procedure –CP Definition name
7. CP Status – the status of the CP study (Pending, Complete, Ready)

8. Check-In Date/Time – date/time of study check-in

The input information needed to run the option is the following:

1. Facility Treating Specialty – enter a facility treating specialty or “ALL” for all facility treating specialties
2. List printer – enter a 132 column printer for the report.

```
Select OPTION NAME: MD STUDIES LIST Clinical Procedures Studies List
Clinical Procedures Studies List

Select Facility Treating Specialty (or ALL): GASTROENTEROLOGY GASTROENTEROLOGY GAS

The report requires a 132 column printer.

Select LIST Printer: HOME// 0;132;9999 TELNET
```

The screen capture in the next page shows a sample run of the Clinical Procedures Studies List.

Report Options

r 07, 2010 4:16:34 pm		C L I N I C A L P R O C E D U R E S S T U D I E S L I S T					Page 1	
GASTROENTEROLOGY								
AXIOM Sensis (Bi-Directional)								
=====								
Patient	ID#	Consult #	Reqd. Date/Time	Urgency	Procedure	CP Status	Check-In Date/Time	

CPPATIENT,EIGHT	0007	3317	1/9/07 11:12:37 am	Routine	COLONOSCOPY	Compl	1/9/07 11:18:14 am	
CPPATIENT,NINE	0008	3318	1/9/07 11:22:22 am	Routine	COLONOSCOPY	Compl	1/9/07 11:23:54 am	
CPPATIENT,TEN	0009	3317	1/9/07 11:12:37 am	Routine	COLONOSCOPY	Compl	1/9/07 11:24:43 am	
CPPATIENT,ONE	0010	3317	1/9/07 11:12:37 am	Routine	COLONOSCOPY	Compl	1/9/07 11:26:16 am	
CPPATIENT,TWO	0011	3318	1/9/07 11:22:22 am	Routine	COLONOSCOPY	Compl	1/9/07 11:28:45 am	
CPPATIENT,THREE	0012	2725	9/2/05 12:30:59 pm	Routine	COLONOSCOPY	Error	9/2/05 12:32:07 pm	
CPPATIENT,FOUR	0013	2767	9/20/05 10:05:21 am	Routine	COLONOSCOPY	Compl	9/20/05 10:05:51 am	
CPPATIENT,FIVE	0014	3642	10/29/08 2:17:56 pm	Routine	COLONOSCOPY	Compl	10/29/08 3:08:13 pm	
CPPATIENT,SIX	0015	3794	5/1/09 11:04:33 am	Routine	COLONOSCOPY	Ready	5/18/09 11:31:02 am	
CPPATIENT,SEVEN	0016	1039	9/20/01 9:36:47 am	Routine	COLONOSCOPY	Compl	9/21/01 11:53:01 am	
CPPATIENT,EIGHT	0017	1602	8/2/02 1:26:03 pm	Routine	COLONOSCOPY	Compl	8/2/02 1:41:48 pm	
CPPATIENT,NINE	0018	2412	4/25/05 8:12:16 am	Routine	COLONOSCOPY	Compl	5/19/05 11:11:28 am	
CPPATIENT,TEN	0019	687	3/14/01 8:10:34 am	Routine	COLONOSCOPY	Error	3/14/01 8:10:51 am	
CPPATIENT,ONE	0020	716	3/21/01 10:04:54 am	Routine	COLONOSCOPY	Compl	3/21/01 10:08:49 am	
CPPATIENT,TWO	0021	731	3/22/01 8:43:03 am	Routine	COLONOSCOPY	Compl	3/22/01 4:05:21 pm	
CPPATIENT,THREE	0022	1480	4/19/02 1:14:29 pm	Routine	COLONOSCOPY	Compl	4/19/02 1:17:11 pm	
CPPATIENT,FOUR	0023	1500	4/24/02 1:25:38 pm	Routine	COLONOSCOPY	Compl	5/7/02 1:18:31 pm	
CPPATIENT,FIVE	0024	2073	5/21/04 10:23:36 am	Routine	COLONOSCOPY	Ready	5/21/04 10:23:56 am	
CPPATIENT,SIX	0025	3457	9/25/07 9:35:45 am	Routine	COLONOSCOPY	Pendi	9/25/07 9:35:45 am	
CPPATIENT,SEVEN	0026	3454	9/24/07 11:35:44 am	Routine	COLONOSCOPY	Pendi	9/24/07 11:35:44 am	
CPPATIENT,EIGHT	0027	912	6/19/01 8:07:11 am	Routine	COLONOSCOPY	Compl	6/19/01 2:20:56 pm	
CPPATIENT, NINE	0028	912	6/19/01 8:07:11 am	Routine	COLONOSCOPY	Compl	6/19/01 2:22:06 pm	
CPPATIENT,TEN	0029	926	6/22/01 2:11:39 pm	Routine	COLONOSCOPY	Compl	6/22/01 2:20:50 pm	

Apr 07, 2010 4:16:34 pm		C L I N I C A L P R O C E D U R E S S T U D I E S L I S T						Page
2								
GASTROENTEROLOGY								
CTX (Bi-Directional)								
=====								
Patient	ID#	Consult #	Reqd. Date/Time	Urgency	Procedure	CP Status	Check-In Date/Time	

-								
CPPATIENT,EIGHT	0008	1602	8/2/02 1:26:03 pm	Routine	COLONOSCOPY	Error	8/2/02 1:55:54 pm	
Apr 07, 2010 4:16:34 pm		C L I N I C A L P R O C E D U R E S S T U D I E S L I S T						Page
3								
GASTROENTEROLOGY								
DMS (Bi-Directional)								
=====								
Patient	ID#	Consult #	Reqd. Date/Time	Urgency	Procedure	CP Status	Check-In Date/Time	

-								
CPPATIENT,ONE	0001	3866	6/24/09 9:10:57 am	Routine	COLONOSCOPY	Compl	6/24/09 9:14:38 am	
CPPATIENT,TWO	0002	1359	1/28/02 9:16:32 am	Routine	COLONOSCOPY	Pendi	7/1/09 2:33:46 pm	
CPPATIENT,THREE	0003	1870	8/19/03 1:03:29 pm	Routine	COLONOSCOPY	Pendi	7/1/09 2:34:02 pm	
CPPATIENT,FOUR	0004	3900	7/1/09 2:34:03 pm	Routine	COLONOSCOPY	Pendi	7/1/09 2:34:03 pm	
CPPATIENT,FIVE	0005	1240	12/3/01 3:09:21 pm	Routine	COLONOSCOPY	Pendi	7/1/09 2:33:56 pm	
CPPATIENT,SIX	0006	1347	1/16/02 1:37:51 pm	Routine	COLONOSCOPY	Pendi	7/1/09 2:33:48 pm	
CPPATIENT,SEVEN	0007	826	4/16/01 11:49:05 am	Routine	COLONOSCOPY	Pendi	7/1/09 2:33:42 pm	

7. Glossary

Access Code A unique sequence of characters known by and assigned only to the user, the system manager and/or designated alternate(s). The access code (in conjunction with the verify code) is used by the computer to identify authorized users.

Action A functional process that a clinician or clerk uses in the TIU computer program. For example, "Edit" and "Search" are actions. Protocol is another name for Action.

ADP Coordinator/ADPAC/Application Coordinator Automated Data Processing Application Coordinator. The person responsible for implementing a set of computer programs (application package) developed to support a specific functional area such as clinical procedures, PIMS, etc.

Application A system of computer programs and files that have been specifically developed to meet the requirements of a user or group of users.

Archive The process of moving data to some other storage medium, usually a magnetic tape, and deleting the information from active storage in order to free-up disk space on the system.

ASU Authorization/Subscription Utility, an application that allows sites to associate users with user classes, allowing them to specify the level of authorization needed to sign or order specific document types and orderables. ASU is distributed with TIU in this version; eventually it will probably become independent, to be used by many VistA packages.

Attachments Attachments are files or images stored on a network share that can be linked to the CP study. CP is able to accept data/final result report files from automated instruments. The file types that can be used as attachments are the following:

.txt	Text files
.rtf	Rich text files
.jpg	JPEG Images
.jpeg	JPEG Images
.bmp	Bitmap Images
.tiff	TIFF Graphics (group 3 and group 4 compressed and uncompressed types)
.pdf	Portable Document Format
.html	Hypertext Markup Language

.DOC (Microsoft Word files) are not supported. Be sure to convert .doc files to .rtf or to .pdf format.

Background Processing Simultaneous running of a "job" on a computer while working on another job. Examples would be printing of a document while working on another, or the software might do automatic saves while you are working on something else.

Backup Procedures The provisions made for the recovery of data files and program libraries and for restart or replacement of ADP equipment after the occurrence of a system failure.

Boilerplate Text A pre-defined TIU template that can be filled in for Titles, Speeding up the entry process. TIU exports several Titles with boilerplate text which can be modified to meet specific needs; sites can also create their own.

Browse Lookup the file folder for a file that you would like to select and attach to the study. (e.g., clicking the “...” button to start a lookup).

Bulletin A canned message that is automatically sent by MailMan to a user when something happens to the database.

Business Rule Part of ASU, Business Rules authorize specific users or groups of users to perform specified actions on documents in particular statuses (e.g., an unsigned TIU note may be edited by a provider who is also the expected signer of the note).

Class Part of Document Definitions, Classes group documents. For example, “CLINICAL PROCEDURES” is a class with many kinds of Clinical Procedures notes under it. Classes may be subdivided into other Classes or Document Classes. Besides grouping documents, Classes also store behavior which is then inherited by lower level entries.

Consult Referral of a patient by the primary care physician to another hospital service/ specialty, to obtain a medical opinion based on patient evaluation and completion of any procedures, modalities, or treatments the consulting specialist deems necessary to render a medical opinion.

Contingency Plan A plan that assigns responsibility and defines procedures for use of the backup/restart/recovery and emergency preparedness procedures selected for the computer system based on risk analysis for that system.

CP Clinical Procedures.

CP Definition CP Definitions are procedures within Clinical Procedures.

CP Procedure A procedure whose data is stored in the Clinical Procedures package.

CP Study A CP study is a process created to link the procedure result from the medical device or/and to link the attachments browsed from a network share to the procedure order.

CPRS Computerized Patient Record System. A comprehensive VistA program, which allows clinicians and others to enter and view orders, Progress Notes and Discharge Summaries (through a link with TIU), Problem List, view results, reports (including health summaries), etc.

¹ Patch MD*1.0*2 July 2004 New Glossary term added.

Data Dictionary A description of file structure and data elements within a file.

Device A hardware input/output component of a computer system (e.g., CRT, printer).

Document Class Document Classes are categories that group documents (Titles) with similar characteristics together. For example, Cardiology notes might be a Document Class, with Echo notes, ECG notes, etc. as Titles under it. Or maybe the Document Class would be Endoscopy Notes, with Colonoscopy notes, etc. under that Document Class.

Document Definition Document Definition is a subset of TIU that provides the building blocks for TIU, by organizing the elements of documents into a hierarchy structure. This structure allows documents (Titles) to inherit characteristics (such as signature requirements and print characteristics) of the higher levels, Class and Document Class. It also allows the creation and use of boilerplate text and embedded objects.

Edit Used to change/modify data typically stored in a file.

Field A data element in a file.

File The M construct in which data is stored for retrieval at a later time. A computer record of related information.

File Manager or FileMan Within this manual, FileManager or FileMan is a reference to VA FileMan. FileMan is a set of M routines used to enter, edit, print, and sort/search related data in a file, a database.

File Server A machine where shared software is stored.

Gateway The software that performs background processing for Clinical Procedures.

Global An M term used when referring to a file stored on a storage medium, usually a magnetic disk.

GUI Graphical User Interface - a Windows-like screen that uses pull-down menus, icons, pointer devices, and other metaphor-type elements that can make a computer program more understandable, easier to use, allow multi-processing (more than one window or process available at once), etc.

Interpreter Interpreter is a user role exported with USR*1*19 to support the Clinical Procedures Class. The role of the Interpreter is to interpret the results of a clinical procedure. Users who are authorized to interpret the results of a clinical procedure are sent a notification when an instrument report and/or images for a CP request are available for interpretation. Business rules are used to determine what actions an interpreter can perform on a document of a specified class, but the interpreter themselves are defined by the Consults application. These individuals are 'clinical update users' for a given consult service.

IRMS Information Resource Management Service.

Kernel A set of software utilities. These utilities provide data processing support for the application packages developed within the VA. They are also tools used in configuring the local computer site to meet the particular needs of the hospital. The components of this operating system include: MenuMan, TaskMan, Device Handler, Log-on/Security, and other specialized routines.

LAYGO An acronym for Learn As You Go. A technique used by VA FileMan to acquire new information as it goes about its normal procedure. It permits a user to add new data to a file.

M Formerly known as MUMPS or the Massachusetts (General Hospital) Utility Multi-Programming System. This is the programming language used to write all VistA applications.

MailMan An electronic mail, teleconferencing, and networking system.

| **¹Medicine Procedure** A procedure who's data is stored in the Medicine package.

Menu A set of options or functions available to users for editing, formatting, generating reports, etc.

Module A component of a software application that covers a single topic or a small section of a broad topic.

Namespace A naming convention followed in the VA to identify various applications and to avoid duplication. It is used as a prefix for all routines and globals used by the application.

Network Server Share A machine that is located on the network where shared files are stored.

Notebook This term refers to a GUI screen containing several tabs or pages.

OI Office of Information, formerly known as Chief Information Office Field Office, Information Resource Management Field Office, and Information Systems Center.

¹ Patch MD*1.0*2 July 2004 New Glossary term added.

Option A functionality that is invoked by the user. The information defined in the option is used to drive the menu system. Options are created, associated with others on menus, or given entry/exit actions.

Package Otherwise known as an application. A set of M routines, files, documentation and installation procedures that support a specific function within VistA.

Page This term refers to a tab on a GUI screen or notebook.

Password A protected word or string of characters that identifies or authenticates a user, a specific resource, or an access type (synonymous with Verify Code).

Pointer A special data type of VA FileMan that takes its value from another file. This is a method of joining files together and avoiding duplication of information.

Procedure Request Any procedure (EKG, Stress Test, etc.) which may be ordered from another service/specialty without first requiring formal consultation.

Program A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

Queuing The scheduling of a process/task to occur at a later time. Queuing is normally done if a task uses up a lot of computer resources.

RAID Redundant Array of Inexpensive Drives. Imaging uses this to store images.

| ¹Remote Data Viewing The act of viewing a patient's data from a remote facility.

Result A consequence of an order. Refers to evaluation or status results. When you use the Complete Request (CT) action on a consult or request, you are transferred to TIU to enter the results.

<RET> Carriage return.

Routine A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

Security Key A function which unlocks specific options and makes them accessible to an authorized user.

Sensitive Information Any information which requires a degree of protection and which should be made available only to authorized users.

¹ Patch MD*1.0*2 July 2004 New Glossary term added.

Site Configurable A term used to refer to features in the system that can be modified to meet the needs of each site.

Software A generic term referring to a related set of computer programs. Generally, this refers to an operating system that enables user programs to run.

Status Symbols Codes used in order entry and Consults displays to designate the status of the order.

Task Manager or TaskMan A part of Kernel which allows programs or functions to begin at specified times or when devices become available. See Queuing.

Title Titles are definitions for documents. They store the behavior of the documents which use them.

TIU Text Integration Utilities.

User A person who enters and/or retrieves data in a system, usually utilizing a CRT.

User Class User Classes are the basic components of the User Class hierarchy of ASU (Authorization/Subscription Utility) which allows sites to designate who is authorized to do what to documents or other clinical entities.

User Role User Role identifies the role of the user with respect to the document in question (e.g., Author/Dictator, Expected Signer, Expected Cosigner, Attending Physician, etc.).

Utility An M program that assists in the development and/or maintenance of a computer system.

Verify Code A unique security code which serves as a second level of security access. Use of this code is site specific; sometimes used interchangeably with a password.

VistA Veterans Health Information Systems and Technology Architecture.

Workstation A personal computer running the Windows 9x or NT operating system.

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