NextGen School Physical Workflow Defined

First, ensure the **Urgent Care** specialty is configured properly to best utilize the KBM when completing a school physical.

1. Access NextGen Ambulatory EHR and open the Workflow module.
2. Open your patient's chart and be sure to complete the 4-point check.
3. Click **Templates** Icon and double-click ***Home Page** template
4. From the **Specialty** list, select **Urgent Care.**
5. From the **Visit Type**, select **School Physical**

DOCUMENT PATIENT DETAILS

Next, document the patient's information such as their vital signs, allergies, medications, and the reason for the visit.

1. Click the **Intake** tab and expand the **General** panel.
    a. Select **Established Patient** or **New Patient**.
    b. Click **Historian** and select the relationship of the historian.
2. Expand the **Reason for Visit** panel.
    a. Select the patient's chief complaints.
    b. Select HPI (History of Present Illness) details.
    c. Document **Intake Comments**, if applicable.
3. Expand the **Vital Signs** panel.
    a. To document a new vital sign, click **Add**
4. Expand the **Medications** panel.
    a. To add or update medications based on the patient's current medication list, click **Add/Update.**
    b. Select **Summary of care received, No medications in encounter,** and **Medications reconciled**, if required.
5. Expand the **Allergies** panel.
    a. To add new allergies, click **Add.** If the allergy is not listed, go to the Allergy module to add it.
    b. To document comments, click **Comment.**
    c. Select **No known allergies, Reviewed, updated** or **Reviewed, no changes** as applicable.
6. Expand the **Orders** panels.
    a. If an in-house test is needed at this time, click Standing Orders to order and document diagnostic history details.

    b.   Click **Lab/Radiology Order Processing, Order Management, Immunizations** and **Tasks** and documents as applicable.

Expand the **Review of Systems** panel and document ROS and click **Generate Intake Notes** to generate an intake note.

DOCUMENT PATIENT HISTORIES DETAILS

1. Click the **Histories** tab and review the details.
2. Expand the **Problem List** panel.
    a. To launch the Problems Module and add new clinical problems, click **Add.**
3. Expand the **Medical/Surgical/Interim** panel.
    a. To input new medical and surgical history details, click **Add.**
    b. To input information about hospital stays, ER visits or important encounters that have occurred, click **Interim History**
4. Expand the **Diagnostic Studies** panel.
    a. Select the patient's chief complaints.
    b. To document important diagnostic studies, click **Add**
5. Expand the **Family** panel.
    a. To input relevant family history details, click **Add**
    b. If there is nothing to document, click **No Relevant Family History.**
    c. Click **Adopted – No Family History Known** if this applies to the patient.
6. Expand the **Social** panel.
    a. Select the section that needs to be documented.
    b. To input new information, click **Add.**
    c. To add details those are confidential, click **Confidential History.**
7. To determine the level of detail that should be included in the final document for this encounter, click **History Review** at the top of the template.
8. To generate intake note, click **Intake Note.**

DOCUMENT SOAP DETAILS

1. From the SOAP tab and expand the **Reason for Visit panel**.
    a. To document new or updated HPI details, select any existing chief complaints listed in the grid and enter the details.
    b. Add any new chief complaints for the patient.
2. Expand **Review of Systems** panel.
    a. To document details for all systems, click **Urology-ROS.**
    b. To add specific details to one system at a time, click each individual system.

3. Expand the **Vital Signs** panel.
    a. Review vital signs added during this encounter.
    b. To input new information, click **Add.**
    c. To modify vital sign details, select a vital signs entry, and then click **Edit.**
4. Expand the **Physical Exam** panel.
    a. To document details for all areas of the body, click **Additional** and select **One Page Exam**.
    b. To input details specific to one area at a time, click each exam template and select the details.
5. Expand the Assessment/Plan panel.
    a. To add or update assessment details, click **Add/Update.**
        i. To input all assessments for the visit, click **Assessments**.
        ii. To create orders for each assessment, select the **My Plan** tab.
        iii. To create orders, click **Labs, Diagnostics, Office Procedures,** and **Referrals** and document the order details.
    b. To put the patient on a health promotion plan, click **My Plan** tab, click **Health Promotion Plan** and then document the health promotion plan details.
    c. To schedule any procedures for the visit, click the **Procedures Scheduling** button.

DOCUMENT FINALIZE DETAILS

1. Click the **Finalize** tab.
2. Verify that all assessments are added to the **Today's Assessment** panel.
    a. To document any assessments that were missed, click **Add**.
3. Expand the **Provider Sign Off** panel and choose the physician sign off option if a supervising physician is required for sign off purposes.
4. Expand the **Evaluation and Management Coding** panel.
    a. Select the complexity of medical decision making.
    b. To determine the E/M Code based on documentation, click **Calculate Code.**

If a different code other than the calculated code is needed choose the code from the available fields before clicking **Submit Code**.

    c. To submit the codes to the procedure module and PM system, click **Submit Code**.
5. Generate the **Master Document**.
    a. Based on the configurations, the Master Document is generated when the code is submitted.
    b. If the document is not automatically generated, click **Generate Note**, select **Master Documents**, and click **OK.**
    c. To generate additional documents, click **Generate Note** and select the document type.

DOCUMENT PATIENT CHECKOUT DETAILS

1. Click the **Checkout** tab and expand the **Today's Orders** panel.
    a. Select the order type from the list.
    b. All the displayed order types have specific options and details to complete. Note the buttons and options that appear when each order type is selected.
    c. Document any orders that are complete or updated.
2. Expand the **Given to Patient/Verified** panel.
    a. Document any items that were given to the patient.
    b. To generate the patient plan, click **Patient Plan**.