

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**.