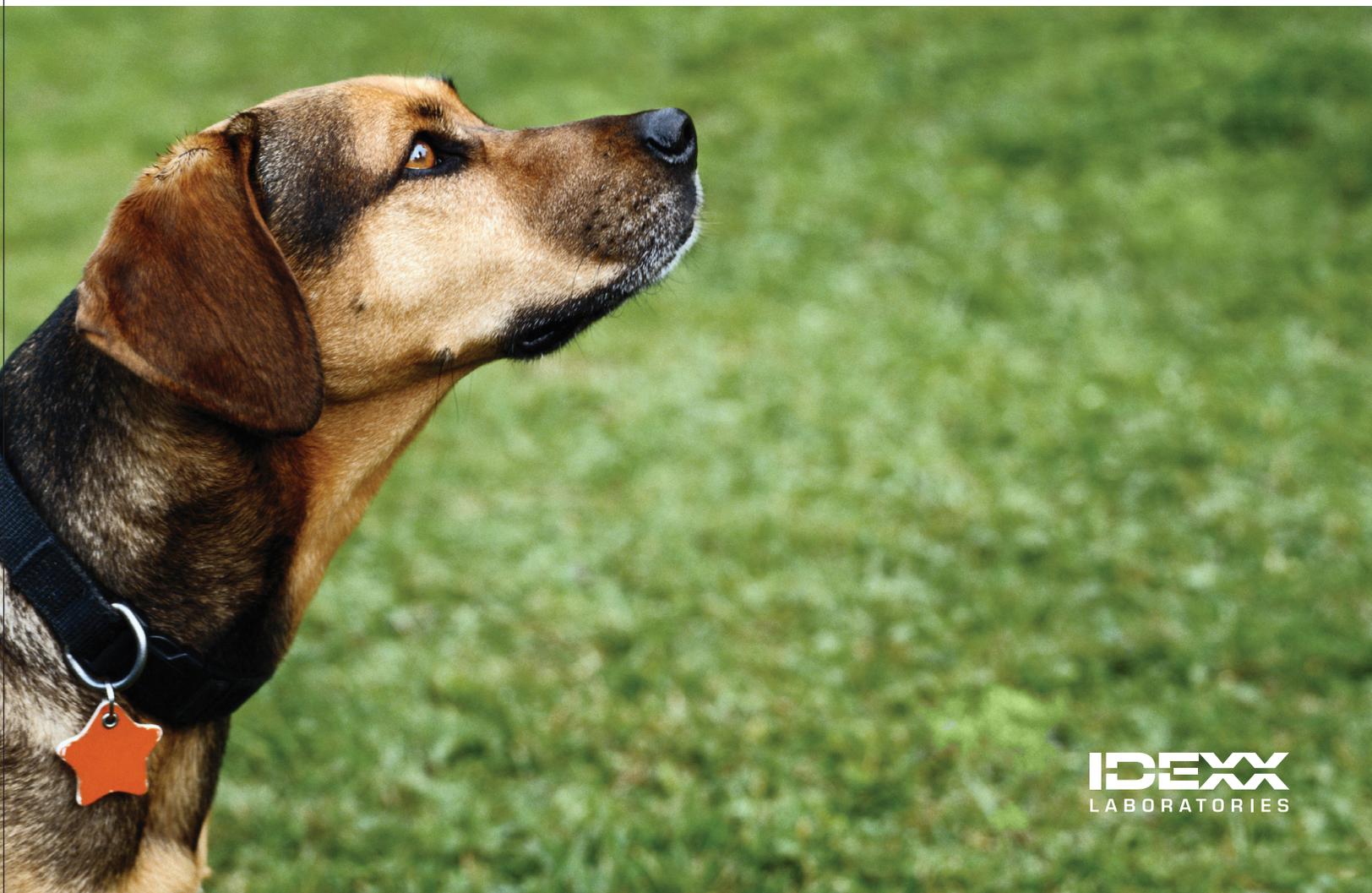


■ **IDEXX Cornerstone***
Electronic Medical Record
and Whiteboard Usage

8.3 *Participant Workbook*



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Electronic Medical Records and Whiteboard Usage

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Introduction

COURSE DESCRIPTION

Following proper setup completion, key project leaders who are moving their practice towards becoming chartless or trying to improve their efficiencies, will learn how to use the IDEXX Cornerstone* Practice Management System's powerful medical record capabilities using their real data files during this two-session course (8 hours).

PREREQUISITES

- The current version of Cornerstone installed at the practice.
- Basic Cornerstone navigation skills.
- Access to set up Cornerstone features, which means security for using electronic medical records.

GETTING STARTED

Throughout this training, you will be working in your own practice's database.

This course is most effective if you work at a Cornerstone workstation while following along in the participant workbook and completing the exercises.

TRAINING CONTENT

Content of the course includes:

- Overview and Strategy
- Check-in
- Patient Visit Documentation
- Estimates
- Patient Visit List
- Using the Whiteboard
- Invoicing and Payments
- Daily Planner

These icons are used throughout the training to provide additional information:



Important Information: Provides critical information about the topic or procedure. Read this information carefully.



Note: Provides additional information about the topic or procedure.



Tip: Provides helpful information about the topic or procedure.



[View a snippet online demonstration](#)

When you see this image placed below a lesson name, it indicates that video snippets are available online at IDEXXLearningCenter.com for topics related to this lesson.

Using Electronic Medical Records and the Electronic Whiteboard

Check-In

You'll learn these important concepts in this chapter:

- **Patient Visit Work Flow**—Understand the IDEXX Cornerstone* Practice Management System work flow.
- **Technology Overview**—Recognize technology that will be useful for a chartless practice.
- **Appointment Scheduler—New Appointments**—Schedule an appointment.
- **Check-in and Related Documents**—Develop skills to check in patients and print check-in and related reports.
- **Census List**—Access the Census List to view checked-in patients.

PATIENT VISIT WORK FLOW

The diagram on the next page illustrates IDEXX Cornerstone* Practice Management System work flows, which have the following steps.

Preventive Care and Outpatient (red line)

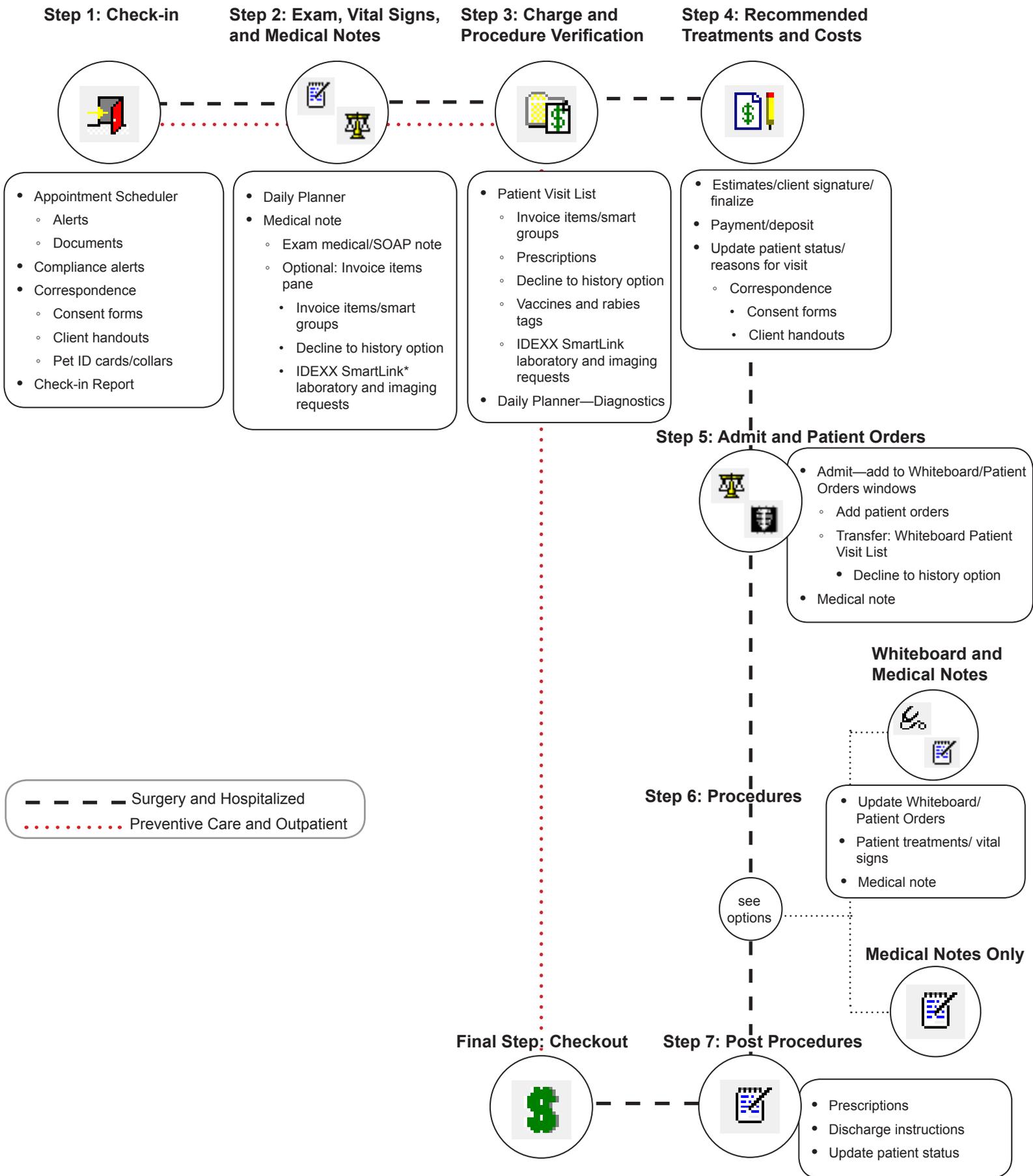
- Step 1—Check-in
- Step 2—Exam, Vital Signs, Medical Notes
- Step 3—Charge and Procedure Verification
- Step 4—Final Step—Checkout

Surgery and Hospitalized (black line)

- Step 1—Check-in
- Step 2—Exam, Vital Signs, and Medical Notes
- Step 3—Charge and Procedure Verification
- Step 4—Recommended Treatments and Costs
- Step 5—Admit and Patient Orders
- Step 6—Procedures
- Step 7—Post Procedures
- Step 8—Final Step—Checkout

Patient Visit Work Flow

This diagram illustrates key steps in the IDEXX Cornerstone* Practice Management System work flow for the two main types of patient visits.



TECHNOLOGY OVERVIEW

IDEXX SmartLink* technology allows a practice to make a diagnostic request from the IDEXX Cornerstone* Practice Management System, and at the same time charge the client. The request is automatically submitted to the in-house laboratory, reference laboratory, or digital imaging equipment without reentering the client and patient information, and then the results are transferred back to Cornerstone and into the patient file.

IDEXX SmartLink integration offers the superior advantages of captured missed charges and improved efficiencies, including the reduction of client and patient ID errors.

IDEXX SmartLink In-House Laboratory

Enter an in-house laboratory request in Cornerstone—automatically, the client is billed, and the laboratory request and information transfers to the analyzer. Results are downloaded into Cornerstone patient history.

IDEXX SmartLink Reference Laboratory

Enter a reference laboratory request in Cornerstone—automatically, the client is billed, and the laboratory request and information is printed on a LabREXX* form and sent with the sample. Results are downloaded into Cornerstone patient history.

IDEXX SmartLink Digital Imaging

Enter an imaging request in Cornerstone—automatically, the client is billed, and the imaging request and information automatically transfers to the IDEXX digital imaging equipment. Results are downloaded into Cornerstone patient history.

Additional Integrated Features

IDEXX VetConnect* PLUS

IDEXX VetConnect PLUS is a powerful web-based tool that lets you view and compare IDEXX in-house diagnostics and IDEXX Reference Laboratories data side by side. VetConnect PLUS works within the standard Cornerstone work flow for viewing results and has an enhanced format for viewing, comparing, and graphing result data. You can also visit vetconnectplus.com to view your results in a browser. Results are downloaded into Cornerstone patient history.

IDEXX Pet Health Network* Pro

IDEXX Pet Health Network Pro offers convenient online tools and services for client communication and education that strengthen the connections between your practice and your clients. Features include personalized reminders, automated communications, Petly* personalized pet pages for clients, pet health campaigns, a customizable practice website design, and editable monthly newsletter content.

Signature Capture Device

If your practice has an approved signature capture device, you can immediately have a client electronically sign a correspondence document, estimate, or an XCharge® electronic payment. An approved signature capture device is purchased separately. Signature bookmarks must be added to correspondence documents in order to add client signatures to documents.

XCharge® Payment Solutions

The Cornerstone integrated payment solution also uses electronic signature capture and offers a simple and secure solution for credit card processing initiated from Cornerstone. The third-party payment processing solution available in Cornerstone is XCharge®, developed by Accelerated Payment Technologies™.

Electronic Whiteboard Monitor

A large LCD monitor on the wall in the treatment area allows the Electronic Whiteboard to be very visible to your staff and ensure they are keeping up with patient treatments.

Scanners

Document scanners can be used to add items that cannot be downloaded or attached electronically to the patient's file. Examples include lab results from universities, emergency or referral reports, and new client registration forms.

Barcode Readers

Handheld barcode scanners allow users to scan item for inventory management and at the point of sale.

Speciality Printers

PetDetect Printer*

A simple, affordable, and professional solution to every practice's animal identification needs. This collar printer allows access to the name, cage name, medical information, and other critical data.

Zebra® P110i™ ID Card Printer

Use the printer with existing templates in Cornerstone to print patient ID cards. The P110i delivers consistent, high-quality printing and trusted dependability. The sleek design uses high strength plastics and advanced electronics for reduced size and weight with outstanding performance.

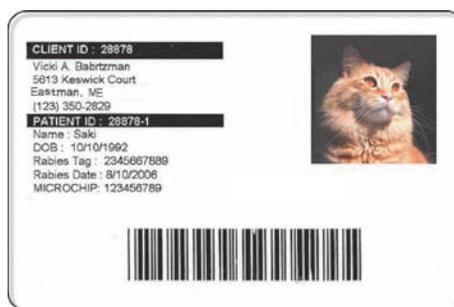
Pet ID Cards and PetDetect* Collars

Improve efficiencies at your practice by using pet ID cards and PetDetect* collars. Use PetDetect collars to aid in pet identification and scan ID cards at check-in for access to client/patient information (approved scanning device is required).

Sample ID Card



(front of two-sided card)



(back of two-sided card)

Sample Collar



PetDetect collars provide positive patient identification.

APPOINTMENT SCHEDULER—NEW APPOINTMENTS

This section highlights the Appointment Scheduler and some of its basic features.

Schedule a New Appointment

On the Patient Clipboard* window, use the Appointment Scheduler to make an appointment for your test client/patient. Accessing the Appointment Scheduler from the Patient Clipboard gives you the opportunity to check and verify client and patient information (edit if necessary) while you are talking with the client. You also have access to the client's account and patient records from this window.

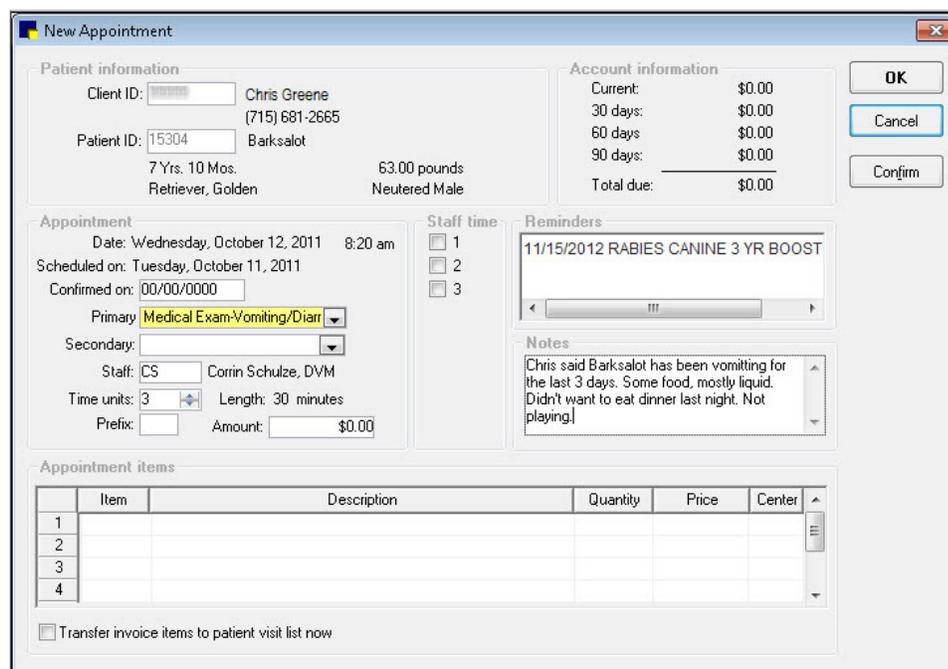
1. With a client selected in the Patient Clipboard*, right-click the patient in the **Patient list** area and select **Appointment Scheduler**.
2. Right-click the correct day and time slot. Click **Schedule** to open the new appointment window.
3. Click **Yes** to confirm the client and patient information.
4. If client, patient, or compliance alerts appear, address them and click **OK** to continue.

tip Compliance alerts show eligible services and prices—click the compliance alert to see prices and recommended services.

5. From the **Primary** list, select the primary reason for visit. If you want to add a secondary reason, type a reason in the **Secondary** box or select a reason from the list. If alert notes or questions appear, address them and click **OK** to close any alert windows.

 The primary reason is commonly used to indicate the general type of visit. The secondary reason is used to provide more detail regarding the specific problem or procedure. For example, if the primary reason is Surgery, the secondary reason might be Spay/Neuter or Hip Replacement. To set up reasons for visit, go to **Controls > Reason for Visit**.

tip The primary and secondary reasons for visit can be viewed when scheduling, at check-in, and on the Electronic Whiteboard.



New Appointment

Patient information
 Client ID: [REDACTED] Chris Greene
 (715) 681-2665
 Patient ID: 15304 Barksalot
 7 Yrs, 10 Mos. 63.00 pounds
 Retriever, Golden Neutered Male

Account information
 Current: \$0.00
 30 days: \$0.00
 60 days: \$0.00
 90 days: \$0.00
 Total due: \$0.00

Appointment
 Date: Wednesday, October 12, 2011 8:20 am
 Scheduled on: Tuesday, October 11, 2011
 Confirmed on: 00/00/0000
 Primary: Medical Exam-Vomiting/Diarr
 Secondary: [REDACTED]
 Staff: CS Corin Schulze, DVM
 Time units: 3 Length: 30 minutes
 Prefix: Amount: \$0.00

Staff time
 1
 2
 3

Reminders
 11/15/2012 RABIES CANINE 3 YR BOOST

Notes
 Chris said Barksalot has been vomiting for the last 3 days. Some food, mostly liquid. Didn't want to eat dinner last night. Not playing!

Appointment items

Item	Description	Quantity	Price	Center
1				
2				
3				
4				

Transfer invoice items to patient visit list now

 If your practice uses Pet Health Network* Pro and a client confirms an appointment on their Petly* online pet page, "By PHN Pro" is displayed in place of a staff ID next to the date in the **Confirmed on** box.

Additionally, you can review appointment requests in the Message Center (click the **Message Center**  button on the toolbar.

6. In the **Staff ID** box, press TAB to accept the default staff ID or enter a new staff ID.
7. In the **Time units** box, type the number of units for the appointment.
 -  **Tip** Time units assigned to the primary reason for visit can be modified as needed for each patient appointment.
8. In the **Prefix** box, type a 2-character prefix that will appear on the first line of the scheduled appointment.
 -  The **Prefix** box is commonly used to enter the initials of the person scheduling the appointment.
9. In the **Notes** area, type any notes regarding the appointment.
 -  These notes are saved to patient history when the patient checks in.
10. Click **OK** to add the appointment information to the Appointment Scheduler.

CHECK-IN AND RELATED DOCUMENTS

From the Appointment Scheduler, check in your test patient.

1. On the Schedule for Today window, right-click the appointment and select **Check In**.
 -  **Tip** On the right-click menu, select **Patient Clipboard**. Verify client contact information (email, phone, address) and check the patient in from the Patient Clipboard.
2. If alerts appear, address them, and then click **OK** to continue.
3. Verify the information in the **Client ID** and **Patient ID** boxes and update if necessary.
4. In the **Staff ID** box, press TAB to accept the default staff ID or enter a new staff ID for the person who is seeing the patient.
5. Verify that the reason for visit information is correct. To change it, select another reason from the **Primary** and/or **Secondary** lists.
6. If alert notes or questions appear, address them and click **OK** to continue.
 -  Steps 7-10 are optional for an outpatient visit. This information appears on the Electronic Whiteboard and the Census List.
7. Verify that the room is correct. To change it, select another room from the **Room** list.
8. Optional: From the **Ward** list, select a ward.
9. Optional: In the **Cage** text box, type a cage name.
10. Optional: From the **Status** list, select a status.
11. Optional: If this is a referral recheck, select the **Referral Recheck** check box.
 -  This feature is for patient referral tracking and reporting; it is used primarily by specialty/emergency practices.
12. Select **Inpatient** or **Outpatient**.
 -  Selecting Inpatient places the patient on the Electronic Whiteboard.
13. In the **Additional notes** and **Alert notes** areas, type any applicable information.
 -  Additional notes are saved to patient history. Alert notes are temporary patient alerts that also appear on the Whiteboard.
14. Optional: If documents are linked to the primary reason for visit, they appear in the **Documents** area. If needed, select documents to print with the Check-In Report.
 -  For instructions on completing the document, see “Create Documents and Procedure Medical Notes” on page 60 as the features and editing window are the same for documents and medical notes.
15. Optional: Verify the information in the **Check-in Date** and **Time** boxes and update if necessary.

16. Optional: In the **Weight entry** area, enter the patient's weight.
17. Optional: Click the **Travel Sheet** button to print a travel sheet with this client/patient information.
18. Click **Check-in**. If prompted to print, select **Yes** or **No**.
19. To see the appointment information, including checked-in status, point to the scheduled appointment.
 - tip** Select **Display check-in/check-out** at the bottom of the Schedule for Today window to quickly see check-in status.
20. Close the Schedule for Today window.

CENSUS LIST

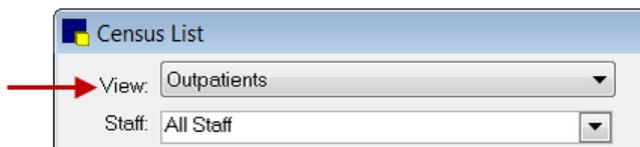
The Census List provides a listing of patients checked-in to your practice. While the Census List is used throughout the day as needed, checking in patients generally occurs upon the patient's arrival.

To quickly access the Census List, press F3.

- Shows patient's physical location/ward in the practice.
- Displays the time the patient checked in, so you can see how long the patient was in your practice.
- Indicates which staff member the patient is going to see and the reason for the visit.
- Increases awareness of clients who have NOT been checked out or invoiced.
- Decreases occurrences of staff working with the wrong patient or client.

View the Census List to see the patients that are checked into the hospital.

1. Press F3 to view the Census List.
2. From the **View** list, select **Outpatients**. Make other selections from the drop-down lists as needed.
3. Select a patient to use the **Check-in**, **Update**, and **Check-out** buttons. To view the latest data, click **Refresh**.
4. Close the Census List window.





- Use the **Additional notes** box to enter general reasons for a visit or to supply information and clarification.
- Use the **Alert notes** box to record notes that staff should see when the patient's file is accessed.
 - These comments will display when the patient's file is accessed and are not part of the patient's permanent history. They are deleted when the patient is checked out.
 - Information entered in the **Alert notes** area on the Check-in/Out window will display when other patient alerts, such as invoice, appear. They will also appear on the Electronic Whiteboard as a Whiteboard alert.
- The **Referral Recheck** check box is used by referral practices seeing a referred patient for a recheck.
 - To track referral revenue, click the add/edit RDVMs link on the Check-in window and select, update, or change the primary RDVM (revenue reporting and document bookmarks). Select the **For this visit only** check box to send communications about this visit to additional RDVMs.
- Click Travel Sheet to print a travel sheet with client/patient information. If you select a reason for visit before printing, the reason is included.
- To set printing options for the Check-in Report, go to **Controls > Defaults > Practice and Workstation > Check-in > Check-in Print Options**. Options are **Always ask**, **Always print**, or **Never print**. You can reprint the report.

Chapter Summary

You learned these important concepts in this chapter:

- **Patient Visit Work Flow**—Understand the IDEXX Cornerstone* Practice Management System work flow.
- **Technology Overview**—Recognize technology that will be useful for a chartless practice.
- **Appointment Scheduler—New Appointments**—Schedule an appointment.
- **Check-in and Related Documents**—Develop skills to check in patients and print check-in and related reports.
- **Census List**—Access the Census List to view checked-in patients.

Exam

You'll learn these important concepts in this chapter:

- **Daily Planner—Appointments and Patient Clipboard***—Access and view appointments and access the Patient Clipboard from the Daily Planner.
- **Vital Signs and Medical Notes**—Develop skills to record vital signs from a medical note.
- **Document Editor—Medical Note Functionality**—Develop skills and understand how to record medical notes and use medical note features.
- **More Medical Note Features**
- **Diagnostic Test Requests**—Decide if you want to view completed laboratory and imaging test requests on the Electronic Whiteboard.

DAILY PLANNER—APPOINTMENTS AND PATIENT CLIPBOARD



[View a snippet online demonstration](#)

The Daily Planner window features nine tabs of information and is valuable for receptionists, technicians, and doctors to view checked-in appointments and patient information.

1. Click the **Daily Planner**  button on the toolbar.
2. In the **Staff ID** box, press TAB to accept the default staff ID or enter a new staff ID and press TAB.
3. Click the **Checked-In** tab to view checked-in appointments.



The **Checked-In** tab contains a condensed version of the information on the Census List. (F3).

4. Optional: View notes.
 - Point to the **Appointment Notes**  icon to view appointment notes for the patient.
 - Point to the **Alert Notes**  icon to view alert notes for the patient.
5. To review the information for the listed patient, right-click the appointment and select **Patient Clipboard**. If alerts display, address them then click **OK** to continue.
6. View information on the **Client Alerts** tab and the **Patient Alerts** tab (in the **Client information** and **Patient information** areas, respectively). For information that is important before beginning the appointment, view history (in the patient file area) and the **Patient Visit List** tab (in the **Patient Information** area).

VITAL SIGNS AND MEDICAL NOTES

Before or during the medical note entry, the medical team can use the vital signs feature to enter weight and vital signs. Your practice may gather weight and vital sign information in either of the following ways:

- The receptionist weighs the patient and records the weight in the Patient Check-in/out window
- OR
- The technician weighs the patient and records the weight during the medical note process.

Advantages of Using Medical Notes

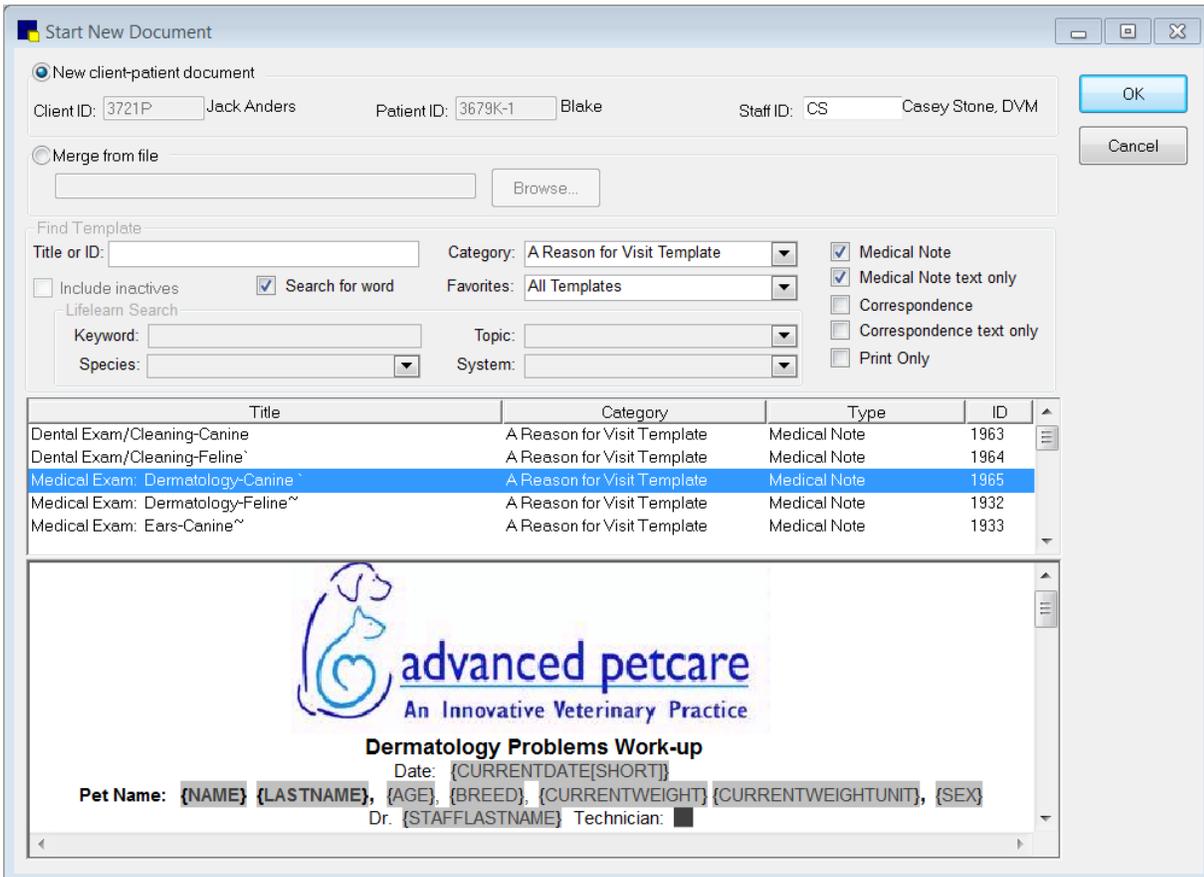
You can dedicate some pages of the document for the internal medical record and other pages for client or external purposes. This might be a procedure summary or discharge instructions, all in one document. You can also:

- Customize forms.
- Insert elements such as tables, check boxes, text input fields, and images.

- Enter invoice items in the template.
- Access and insert other Cornerstone features, such as problems, diagnosis, and vital signs.

Starting the Medical Note

1. With the client account displayed on the Patient Clipboard, right-click the patient's name and select **Medical Note** to open the Start New Document window.
 -  You can also select **Correspondence** when appropriate—follow the same steps.
2. Enter the staff ID and press TAB.
 -  The staff ID should be the doctor or “author” of the medical note, as it is recorded in history and places the medical note on the Daily Planner window for that staff ID. The staff ID *cannot* be changed once it is assigned.
3. Use one of the following options to select the medical note template:
 - If you know the exact title of the template or if you know the document ID, type it in the **Title or ID** box.
 - If you do not know the exact title but know one or more keywords included in the title, select the **Search for word** check box and type all or part of the word in the **Title or ID** box.
 - If your template is saved as a favorite, select it from the **Favorites** list.
 - Select the template from the **Categories** drop-down list.
4. Select the document from the list and click **OK**.



Start New Document

New client-patient document

Client ID: 3721P Jack Anders Patient ID: 3679K-1 Blake Staff ID: CS Casey Stone, DVM

Merge from file

Find Template

Title or ID: Category: A Reason for Visit Template Medical Note

Include inactives Search for word Favorites: All Templates Medical Note text only

Correspondence Correspondence text only

Print Only

Title	Category	Type	ID
Dental Exam/Cleaning-Canine	A Reason for Visit Template	Medical Note	1963
Dental Exam/Cleaning-Feline	A Reason for Visit Template	Medical Note	1964
Medical Exam: Dermatology-Canine	A Reason for Visit Template	Medical Note	1965
Medical Exam: Dermatology-Feline	A Reason for Visit Template	Medical Note	1932
Medical Exam: Ears-Canine	A Reason for Visit Template	Medical Note	1933

advanced petcare
An Innovative Veterinary Practice

Dermatology Problems Work-up

Date: {CURRENTDATE[SHORT]}

Pet Name: {NAME} {LASTNAME}, {AGE}, {BREED}, {CURRENTWEIGHT}, {CURRENTWEIGHTUNIT}, {SEX}

Dr. {STAFFLASTNAME} Technician: ■

Continue to next activity.

Entering Vital Signs—Weight

Use the weight window to begin adding, editing, and graphing vital signs. Vital sign entry is based on the practice's default settings.

1. Enter the recording staff's ID.
2. Enter the patient's weight, verify the weight units, and select the value rating. If applicable, type a short note.

Leave the window open for the next activity.

Entering Other Vital Signs

1. In the **Weight entry** area, click **add more Vital Signs**.
 - If vital signs are entered by both the technician and the doctor, the technician can enter through the weight entry window. The doctor can use the vital sign link in the body of the note to enter their vital signs and then merge the two entries into a single set that will be automatically imported into the medical note.
2. Enter the vital signs values, click **OK** to input the staff ID for this vitals set, and select the recording staff.
 - If a vital signs link has been included in the medical note template, you can record vital signs while working in a medical note. The recorded vital signs will populate the Patient Clipboard, and the values will be inserted into the medical note as a table.
3. Click **OK**.

Date	Staff	Weight	BodyScore9	Temp	Pulse	Resp	MM
2/11/2011	CJ		3 - Slightly Underw (L)	102.4	210	80	Pale/Anemic

Vital signs on the Patient Clipboard* window

PHYSICAL EXAMINATION FINDINGS	
Add_Vital_Signs	
Neurological Exam	Norm
1. Observations	<input type="checkbox"/>
2. Seizure	<input type="checkbox"/>
3. Cranial Nerves	<input type="checkbox"/>
4. Gait	<input type="checkbox"/>

Vital signs link in medical note

Leave the window open for the next activity.

Vital Sign Editing Rules

The ability to edit vital signs is based on the original date/time of the vital sign set. Follow these guidelines for editing existing vital signs sets:

- If the vital signs set was created within the last 24 hours, you can add values to blank vital signs and edit an existing entry (cell) in the set.
- If the vital signs set is older than 24 hours but created within the last 10 days, you can add values only to blank vital signs. Editing of existing entries is not allowed.
- If the vital signs set was created over 10 days ago, no entries or editing are allowed. The key time frames to remember are 24 hours and 10 days.
- You can void a vital sign at any time; however, it will void the entire vital sign set—you cannot void a single vital sign. Once the vital sign set is voided, you can add a new vital sign set and modify the entry date.

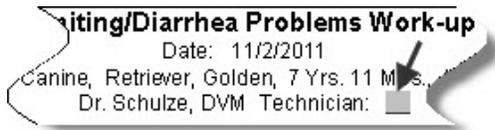
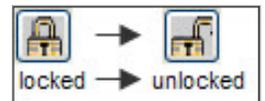
 The period of time when editing is allowed is based on the server date/time when a vital signs set is created, which is not necessarily the date/time entered by the staff member.

TASK	Within 24 hours of initial vital signs set creation	More than 24 hours after initial vital signs set creation	Within 10 days of initial vital signs set creation	More than 10 days after initial vital signs set creation
Add a new vital sign entry (blank cell) within an existing set	Yes	Yes	Yes	Not Allowed
Edit a vital sign entry (occupied cell) within an existing set	Yes	Not Allowed	Not Allowed	Not Allowed

For more information about vital signs rules and options, see “More About Vital Signs” in the Appendix.

Entering Medical Notes

1. Lock the medical note so that you can automatically advance through the input fields and check boxes.
2. To record the technician in the Technician field of the medical note, double-click in the first input field, and then press TAB to advance to the next field.



3. Ask and answer the questions in the History area.

History (Subjective):		Vomiting		Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>	How often is your pet vomiting? 3X/day	<input type="checkbox"/>	<input type="checkbox"/>	How often
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Are there large volumes of vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	Is there
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Are there pieces of whole food in the vomit?	<input type="checkbox"/>	<input type="checkbox"/>	Is there
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Exposure to any chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	Current
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Any missing toys?	<input type="checkbox"/>	<input type="checkbox"/>	Any rec
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Noticed any blood in vomit?	<input type="checkbox"/>	<input type="checkbox"/>	Recent in
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Eating Changes? <input type="checkbox"/> Increased <input checked="" type="checkbox"/> Decreased	<input type="checkbox"/>	<input type="checkbox"/>	Cachex

4. Record the physical exam findings. This example is from a sample gastrointestinal medical note.

Gastrointestinal Exam and Findings:	
Abdominal Wall	Remarks
<input type="checkbox"/> Pain	
<input type="checkbox"/> Trauma	
<input type="checkbox"/> Hernia	
<input type="checkbox"/> Redness	
<input type="checkbox"/> Other	
Gastrointestinal	
<input type="checkbox"/> Cyanosis	
<input type="checkbox"/> Respiratory difficulty	
<input checked="" type="checkbox"/> Pain	
<input checked="" type="checkbox"/> Increased/decreased gut sounds	increased
<input checked="" type="checkbox"/> Dehydration	
<input type="checkbox"/> Muscle atrophy	
<input type="checkbox"/> Palpable mass	
<input type="checkbox"/> Melena	
<input type="checkbox"/> Clumped intestines	
<input type="checkbox"/> Other	

Leave the window open for the next activity.

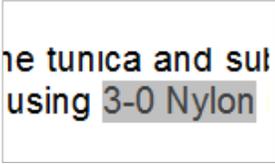
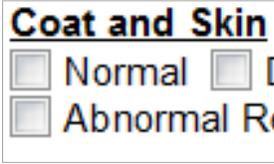
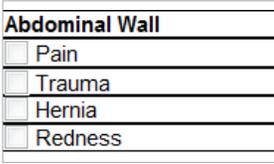
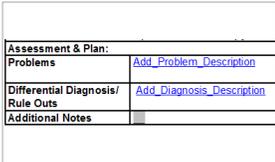
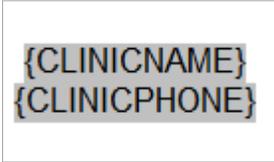
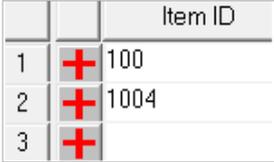
Document Editor—Medical Note Functionality

Keep the following information in mind when working with medical notes in the Cornerstone Editor:

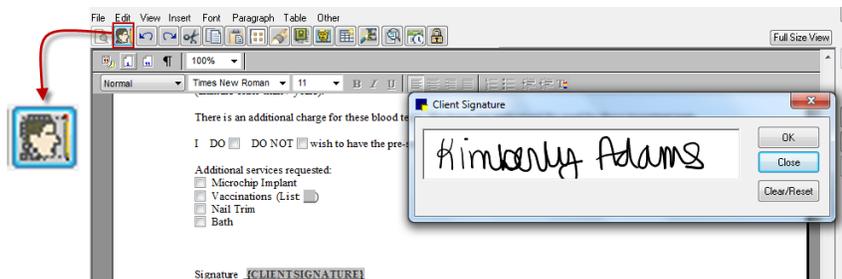
- Click the **Lock** button  to limit entries.
 - **First Entry**—For locked documents, double-click the first text input field and enter the text.
 -  During document setup, select the first cursor position and lock the document. The first entry position will already be selected.
 - **TAB**—Press the TAB key to advance to subsequent fields, making entries as you proceed.
 - **Unlock**—To enter information in other locations, unlock the document .
 - **Spacebar**—Press the spacebar to select a check box.
- Use the Cornerstone Editor toolbar, menu bar, or right-click menu to insert medical record features (pictured below).
 - **Table**—When working in a table, only the menu bar and toolbar are available.
 - **Problem**—Insert a problem link. This also populates the **Problems** tab on the Patient Clipboard*.
 - **Diagnosis**—Insert a diagnosis link. You can also link documents to a specific diagnosis so the documents print when you use that diagnosis. This also populates the Dx tab on the Patient Clipboard.
- To expand the editor pane, grab the **Splitter Bar** and move it up or down or click **Full Size View** (at the top right corner of the editor pane).
- Double-click the client banner or patient banner to open the Client Information or Patient Information windows.

Medical Record Features

These features are available for correspondence and medical notes.

Text Input Fields	Check Boxes	Tables	Images	Email/Fax and PHN Share
				
Diagnosis and Problem Links	Bookmarks	Invoice Items	Attachments	
				

Client Signature



Entering Invoice Items

About Invoice Items on the Medical Note

You can use the following methods for entering invoice items while creating medical notes:

- Add default invoice items to the template so that when a template is opened during the exam, the normal protocol and charges appear.
 -  You'll experience differences when the invoice items are set with a blank status rather than a recommended status.
- Enter the invoice items when completing the medical note.
- Wait to enter the charges in the next step of the process, on the Patient Visit List.

Your key leaders will make a decision about entering invoice items on medical notes based on the following advantages and potential gaps:

Advantages

- Invoice items and medical notes can be entered on one window.
- Staff can later review the medical note and related invoice items in history together.
-  If invoice items and pricing change outside the medical note, the changes won't be reflected in the medical note.

Potential Gaps

- **Patient Visit List Changes Don't Change Medical Note Entries**—If changes or additions are made to the Patient Visit List, they do not “sweep back” and change the medical note entries. You must enter the change manually in the medical note.
- **Declined Recommendations—No Blue Line**—If you decline a recommendation and then make a notation on the blue line, the notation will not be available in the Cornerstone Editor window, as a declined recommendation is not included.
- **Estimates Don't Flow to Medical Note**—If your practice's standard process is to create and finalize estimates, be aware that finalized estimate charges don't flow to medical notes. Your practice team must delete duplicate charges created by having both a finalized estimate as well as medical note invoice items. You can also change estimate default settings so that the finalized charges are not transferred to the Patient Visit List window (**Controls > Defaults > Practice and Workstation > Estimates**).

Invoice Items Tab

The **Invoice Items** tab is located near the bottom of the Cornerstone Editor window.

 Point to the gray bar between the document editor and the tab area until you see a cursor with a double arrow. Click and drag up to increase the size of the pane.

To add an invoice item at the time of use and save the medical note:

 Add invoice items and smart groups to the medical note template to automatically add those items to the medical note.

1. In the first blank row, double-click or press F2 in the **Item ID** column, and then select the invoice item.
2. To set the invoice item status, click the gray box to the left of the **Item ID** column. Options are **Blank**, **Recommended**, **Accepted**, **Performed**, **Declined**, and **Declined to history**.

 Click **Travel Sheet** to select multiple items from a specific list.

Invoice Items (12)		Attachments		
		Item ID	Description	Qty
5		VTREAT	Vomiting Treatment	1.00
6		IVFLUID	IV Fluid Group	1.00
7		IVCP	I.V. Catheter Placement	1.00
8		F	IV Set/Cath & Fluids - 500 ml	1.00

3. Optional: In the **Hx description** box, type a description for the patient's history. The history description is part of the in line history entry in the patient's file.
4. Optional: Select the **Alert** check box to place a permanent red highlight in the patient history for this medical entry.
5. Select the status of the medical note. Options are **Draft**, **Tentative**, or **Final**. The default status is **Tentative**.
6. Click **OK** to save and close the medical note.

 If any special actions appear, complete them and then click **Continue**; the medical note will close. If you complete the special actions at this time, they will not be available on the Electronic Whiteboard, so you must determine at which time you need to complete them. Some examples of special actions are lab request, image request, prescription label, vaccine tag, update microchip ID, and print document.

 To delete an item from the **Invoice Items** tab, highlight the quantity for that item and press CTRL + D.

Medical Note Quick Text

In addition to using medical note templates, you can use the medical note quick text feature. This option offers a fast and simple medical note for adding information to a patient's medical record. Select the **Medical Note Quick Text** option, enter your staff ID, and immediately start typing your notes in the Cornerstone Editor.

 The quick text feature allows text entry **ONLY**. Links, images, tables, and some bookmarks are not available.

1. With the patient's record open on the Patient Clipboard, right-click the patient's name and select **Medical Note Quick Text**.
2. Enter the staff ID and click **OK**.
3. If prompted for weight, complete the weight entry information and click **OK**.



4. In the white work area, type the medical notes into the template.

 Set a default document for your Medical Note Quick Text template at **Controls > Defaults > Practice and Workstation > Documents**. Customize your Quick Text templates at **Lists > Templates**.

5. After you enter the medical note text, select the document status. Options are **Draft**, **Tentative**, and **Final**.

 Draft and tentative documents appear in the Daily Planner window until they are finalized.

6. Optional: In the **Hx description** box, type a history description.
7. Optional: Select the **Alert** check box to place a permanent red highlight on this entry in patient history (title line only). Use text color to highlight the body of the note as needed for additional alert information. You can also change the text color for the entire note to enhance it when viewing patient history.
8. Optional: Select the **Autofinalize in (#) days** check box and enter the number of days.
9. Click **OK** to save and close the medical note.

View Text Only Medical Notes

Text only medical notes allow full in line viewing of text only document contents on the Patient Clipboard* window. This means that you can quickly view any text only medical note directly on the **Text** tab or **Medical Notes** tab in the patient history area without having to open the document in a separate preview or editor window. You can also point to the quick text medical note to view the note in the **Summary** tab.

SOAP

Subjective:
Still getting a Significant bit of debris out of the ear. She states he is eating well, still taking medications daily as previously prescribed.

Objective:
bar, mild yellow debris in right ear, dental tartar, myasthenia gravis

Assessment:
myasthenia gravis - stable, under therapy. Mild otitis right ear - under therapy.

Plan:
Completed physical exam. recheck right ear. Recommend switch pt to TrizEDTA ear cleaner and refill Baytril. Client to clean ears with TrizEDTA ear cleaner as regular cleaning while under therapy and treat with 4-5 drops of baytril daily for one week and recheck ear. Demonstrated to client in the room how to clean the ears with a wet cotton ball and massage. Told client not to use q-tips to clean ears. Recommend

Example of a quick text medical note using text input fields

Debbie Cabe - Patient Clipboard

Client: Debbie Cabe, Pet Owner
 Client ID: 8951, Balance Due: \$0.00, Accept All Payments
 Patient Search: (715) 605-2681 (Home), Total Patients: 1, Active Patients: 1

Client information
 Kimberly Adams, 7965 West White, Eau Claire, WI 54703, debbie@yahoo.com
 Status: Active, Class: Pet Owner, Referred: 0 clients, Referred by: 5325 Katie Jacks, Home Practice: 1

Patient list
 Ima, Canine, Poodle Mix, Male

Patient information
 ID: 15295, Inpatient, Name: Ima, Status: Active, Class: Breeding Pet, Sex: Male, Birthdate: 4/30/2008, Breed: Poodle Mix, 3 Yrs. 2 Mos., Color: Black, 24.8 pounds, Ward: , Markings: , Cage:

Medical Notes
 Date: 5/26/2011, Staff: CS, Expanded History
 SOAP: recheck on right ear - TENTATIVE
 SUBJECTIVE: still getting a significant bit of debris out of the ear. She states he is eating well, still taking medications daily as previously prescribed.
 OBJECTIVE: bar, mild yellow debris in right ear, dental tartar, myasthenia gravis
 ASSESSMENT: myasthenia gravis - stable, under therapy. mild otitis right ear - under therapy.
 DIAGNOSIS: Otitis Externa Myasthenia Gravis
 PLAN: Completed physical exam, recheck right ear. Recommend switch pt to TrizEDTA ear cleaner and refill Baytril. Client to clean ears with TrizEDTA ear cleaner as regular cleaning while under therapy and treat with 4-5 drops of baytril daily for one week and recheck ear. Demonstrated to client in the room how to clean the ears with a wet cotton ball and massage. Told client not to use q-tips to clean ears. Recommend slow massaging motion upward to help loosen and lift the debris from the lower canal. If pet's ear is better then decrease baytril to EOD for 2 weeks, then every third day, etc. May even consider a pulse therapy strategy.
 Staff: CS

Rows 2 to 2 of 2

Find, Find Next, Go to Date, Print History, Preview, Hide Whiteboard Notes, Hide voided items

MORE MEDICAL NOTE FEATURES

Automatically Print a Linked Diagnosis Document from a Medical Note

When adding a medical note for a patient, if you insert a diagnosis code that has been preconfigured to link to a particular document in Cornerstone (**Lists > Diagnostic Codes > Diagnostic Code Setup**), the Diagnosis Document window opens.

If you click **Yes** to print the linked diagnosis document, the Staff Selection window opens.

After entering the staff ID, one of the following will happen:

- If the linked diagnosis document is a medical note or correspondence document, the document prints on the default printer.
- If the linked diagnosis document is a LifeLearn® client handout, the document opens in Microsoft® Word. You can then print the document directly from Microsoft Word.

Annotate Medical Note Images

To edit a picture or make annotations to a picture (available only at time of use):



Any edits or annotations you make to a picture within a document are associated only with that document and will not be reflected outside of the document (will not change the original picture saved in the patient record).

1. Double-click the inserted image (not a pasted image) that you want to edit. The image opens in the Image Viewer window.

2. Use the Image Viewer tools to make annotations and edit the image, and then close the Image Viewer window
3. Click **Yes** to save changes. The Image Viewer closes and the edited image is displayed.

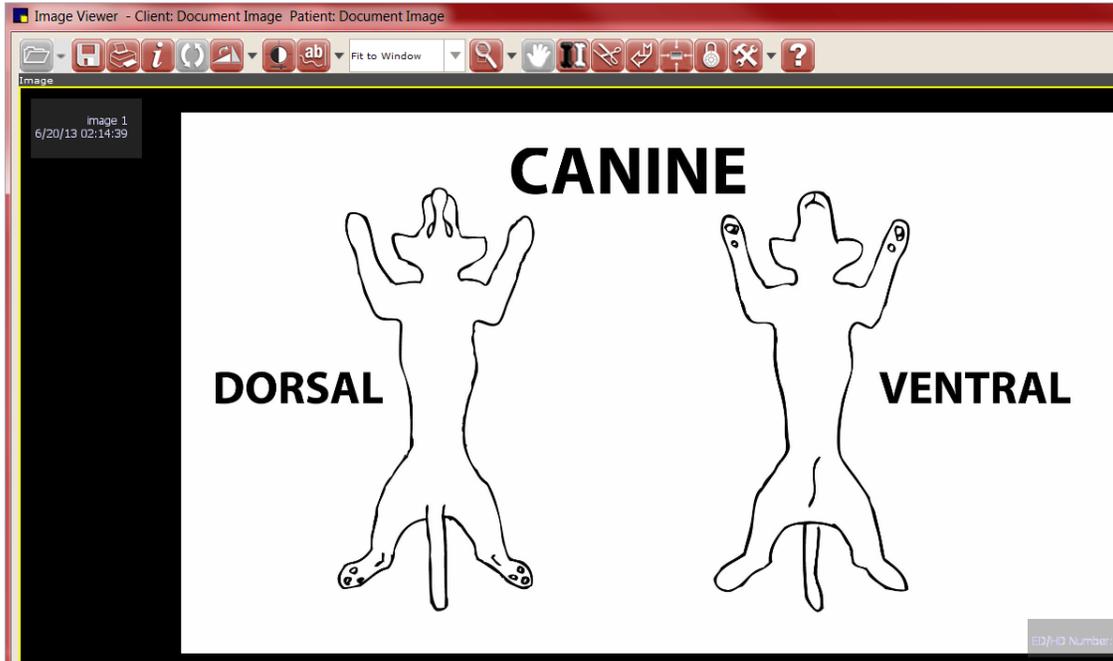
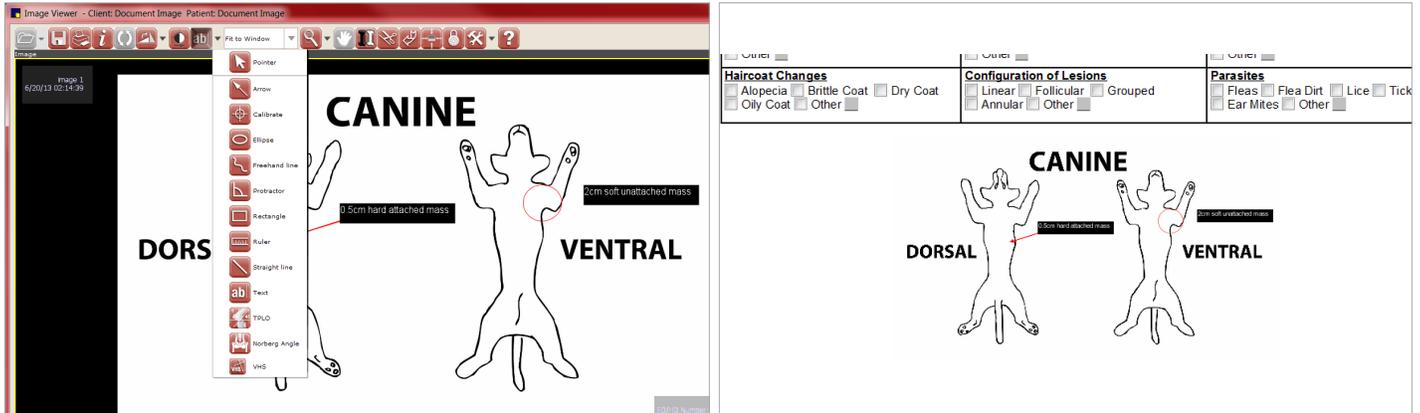


Image Viewer



Annotation tool menu and annotated image

Annotated image in medical note

DIAGNOSTIC TEST REQUESTS

Decisions will need to be made for handling diagnostic requests when using the Electronic Whiteboard. If you want to view a completed test on the Whiteboard, you must have the appropriate diagnostic request special action attached.

To view completed diagnostic tests on the Electronic Whiteboard:

1. Finalize estimates and select **Continue** on the Special Action window.
2. Enter patient orders.
3. Transfer diagnostic items(s) from the Whiteboard Patient Visit List to the patient orders.
4. Complete patient treatments.
5. Click **Process** on the Special Action window to send the diagnostic request to the IDEXX VetLab* Station, Imaging Dashboard window, or to generate the IDEXX LabREXX* test request form and show the diagnostic request as completed.

- OR -

1. Finalize estimates and click **Process** on the Special Action window to send the diagnostic request to the IDEXX VetLab Station, Imaging Dashboard, or to generate the IDEXX LabREXX test request form.
2. Enter nonbillable patient orders for diagnostic request.
3. Use the blue line to note which tests will be run, how much blood to draw, radiograph position, etc.
4. Complete patient treatments.

If you do not want to view completed diagnostic tests on the Electronic Whiteboard:

1. Finalize estimates and click **Process** on the Special Action window to send the diagnostic request to the IDEXX VetLab* Station, Imaging Dashboard, or to generate the IDEXX LabREXX* test request form.
2. The charge will be found on the Patient Visit List and will not need to be transferred to the Whiteboard.

Chapter Summary

You learned these important concepts in this chapter:

- **Daily Planner—Appointments and Patient Clipboard***—Access and view appointments and access the Patient Clipboard from the Daily Planner.
- **Vital Signs and Medical Notes**—Develop skills to record vital signs from a medical note.
- **Document Editor—Medical Note Functionality**—Develop skills and understand how to record medical notes and use medical note features.
- **More Medical Note Features**
- **Diagnostic Test Requests**—Decide if you want to view completed laboratory and imaging test requests on the Electronic Whiteboard.

Charge and Procedure Verification

You'll learn these important concepts in this chapter:

- **Patient Visit List**—Features, benefits, and work flow of the Patient Visit List (PVL) window.
- **Vaccinations and Rabies Certificates**—Complete the Vaccine Tag window and understand how the inventory setup and default settings can positively affect efficiency.
- **Prescriptions**—Create a prescription for a pharmaceutical item in inventory.
- **Daily Planner Diagnostics**—View, schedule, and complete call backs for laboratory results and reports.
- **Other Procedural Steps**

PATIENT VISIT LIST

The Patient Visit List window provides a holding area for recommended procedures and/or charges that have not been billed. This feature is used for the patient visit step of entering charges or for verifying procedures and charges.

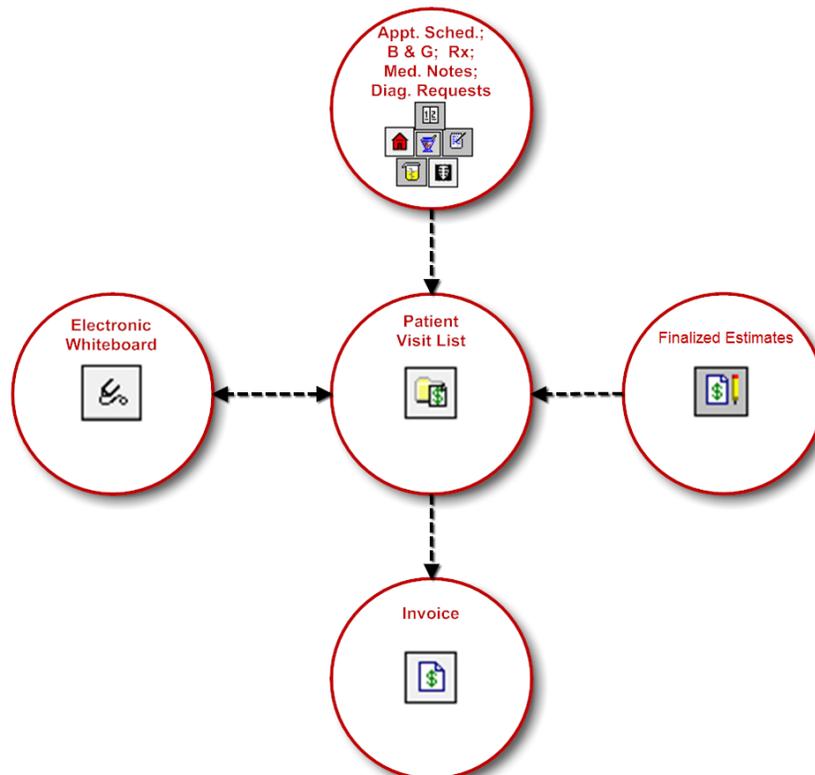
To open the Patient Visit List window, with the patient selected on the Patient Clipboard* window, right-click and select **Patient Visit List**.

In this lesson, we'll cover the following:

- Work flow and functionality
- Charge sources
- Using the Patient Visit List window

Patient Visit List Work Flow and Functionality

This diagram shows how charges flow to the Patient Visit List:



Use the Patient Visit List (PVL) window to do the following:

- View patient and client information, including the accounts receivable balance.
- View the invoice items, their source, and total charges on the Patient Visit List, excluding declined or declined to history invoice item amounts.
- Decline to history, including writing a comment on the blue line.
 - 📄 When an item is declined to history, anything written in the blue line is saved to patient history.
- Use the last blue line to indicate to staff the patient is ready to go home (RTGH).
- Delete invoice items (select invoice item ID and press CTRL + D).
- Change a departing instruction or create a prescription.
- Arrange the invoice items in a particular order.

Patient information
 ID: 6692 Barksalot
 9 Yrs. 4 Mos. 24 pounds 3
 Retriever, Golden Male

Owner information
 Owner: Kimberly Adams \$0.00
 Credit code: Accept All Payments
 Payment: 10/7/2012 \$769.56 Cash

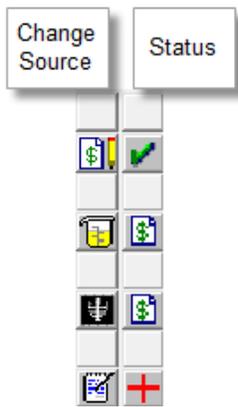
Item ID	Description	Qty	Amount	Disc	Tax	Staff	Ctr	Date
DENT	Dental - Canine	1.00	\$68.00	No	No	CS	H	10/10/2012
Estimate # 29								
82	Canine Snap cPL Pancreatic Lipase Test	1.00	\$48.00	No	No	JB	H	10/16/2012
Lab Request								
22	Xray Digital 1-3 Views	1.00	\$98.50	No	No	CS	H	11/01/2012
IDEXX SmartLink Image Request								
100	IDEXX Biopsy (1 Tissue)	1.00	\$98.50	No	No	CS	H	04/17/2013
1004	Lg - Ex Uro - ABD +C - VD (10 min)	1.00	\$30.00	No	No	CS	H	04/17/2013
				No	No			
				No	No			
				No	No			
				No	No			

Include recommended Total: 343.00
 Include accepted Discounts: 0.00
 Include performed Taxes: 0.00
 Display blue comment line Total: 343.00

Charge Source and Status

Use the illustrations below to learn the charge source and status icons.

The two columns of icons displayed to the left of the Item ID column are the Charge Source icons and the Status icons.



The **Charge Source** icons help you identify how the item was added to the Patient Visit List (PVL). If there is no source icon, the item was added directly to the Patient Visit List.

The **Status** icons show the standing of each charge on the Patient Visit List. Depending on the source of the items, some items may automatically appear with a certain status. You can change the status for any item. The table below describes each **Status** icon.

Status of items on a PVL:



Recommended

The item has been recommended but not yet accepted.



Accepted

The item has been accepted but not yet performed.



Performed

The item has been administered or performed.



Declined

The item has been declined and will be deleted when the items are transferred to the invoice. There will be no history entry.



Declined to History

The item has been declined by the client and will be deleted when the items are transferred to the invoice. A history entry indicating the item was recommended but declined will be recorded.

VACCINATIONS AND RABIES CERTIFICATES

When a vaccine is administered to a patient and the client is charged for it, you will record vaccine information and produce rabies certificates through the vaccine tag special action. This feature allows the automatic generation of vaccine information for yearly, multiple year, and species scenarios when entering charges on the Patient Visit List or invoice.

An invoice item can include vaccine information, such as producer, brand, type, expiration date, lot number, and manner of administration (such as subcutaneously or intramuscular). Additionally, when staff members begin using a new tray or bottle for a specific vaccine, they can add the new expiration date and lot number, which is then automatically added to the list.

 This feature can be set up for vaccines other than rabies. It can be set up for any adult boosters that are good for at least one year. This allows the practice to record the vaccine sticker information found on the vaccine vial that they may previously have placed in the chart.

You must complete vaccine tag setup before you can complete this exercise. See “Setting Up Vaccine Information” in the Appendix for more information.

1. With the patient selected in the Patient Clipboard* window, right-click the patient and select **Patient Visit List**.
2. Add items to the Patient Visit List, including a rabies vaccination item. The Vaccine Tag window opens.

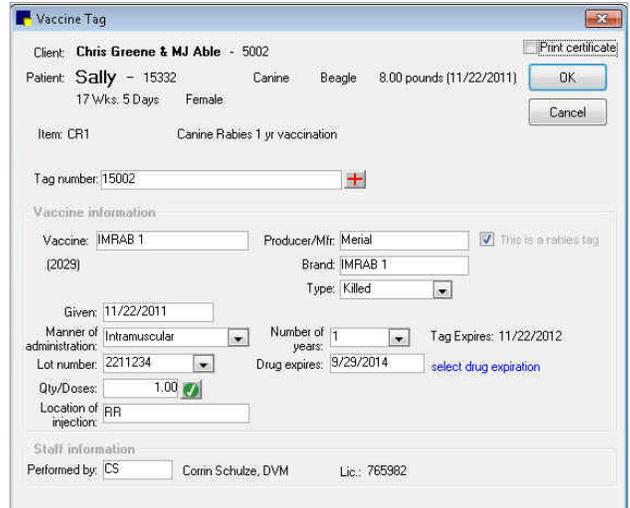
3. In the tag number box, type the number or click the **Auto Increment**  button to generate the tag number (last user number +1).

 For non rabies vaccines, type the vaccine name (e.g., BORD, FELV).

4. Verify or enter information in the following fields:

- **Vaccine**
- **Producer/Mfr**
- **Brand**
- **Type**
- **Given**
- **Manner of administration**
- **Number of years**
- **Lot number**—Based on how your vaccine tag items are set up, you can manually add a new expiration date/lot number combination if they do not appear in the drop-down list. The expiration date/lot number will be added to those available for the inventory item.
- **Drug expires**—Accept the date listed or click the **select drug expiration** link and select the date. If the appropriate date does not appear on the list, type it in the box.
- **Qty/Doses**
- **Location of injection**

 Carefully enter rabies information. If you are the person entering a new lot number (the number is not already available in the list) subsequent users will use the information you set up.



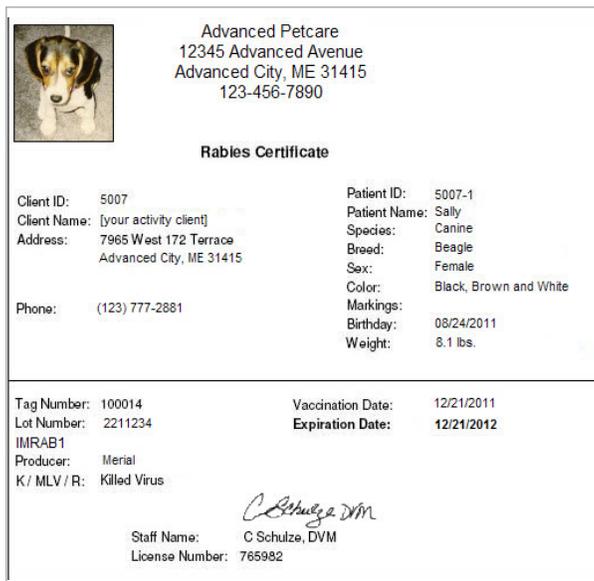
5. In the **Performed by** box, enter the appropriate staff ID and press TAB.

6. To print this certificate now, select the **Print certificate** check box (based on vaccine item setup).

7. Click **OK**.

8. Optional: To view the vaccine information, in the **Patient information** area on the Patient Clipboard, click the **Tags/Microchip ID** tab  and double-click the tag number or vaccine you want to view. Then, click **Close**.

Continue to next activity.

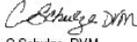


Advanced Petcare
12345 Advanced Avenue
Advanced City, ME 31415
123-456-7890

Rabies Certificate

Client ID: 5007	Patient ID: 5007-1
Client Name: [your activity client]	Patient Name: Sally
Address: 7965 West 172 Terrace Advanced City, ME 31415	Species: Canine
	Breed: Beagle
	Sex: Female
Phone: (123) 777-2881	Color: Black, Brown and White
	Markings:
	Birthday: 08/24/2011
	Weight: 8.1 lbs.

Tag Number: 100014	Vaccination Date: 12/21/2011
Lot Number: 2211234	Expiration Date: 12/21/2012
IMRAB1	
Producer: Merial	
K / MLV / R: Killed Virus	

Staff Name: 
C Schulze, DVM
License Number: 765982

Example shows a certificate that has been customized to add a signature.

PRESCRIPTIONS

1. In the first blank row, double-click or press F2 in the **Item ID** column, and then select the medication.
2. Tab to the **Qty** column and enter the appropriate quantity to dispense.
3. On the line for this item, click the **Prescription**  button. If prompted that the quantity is 1, select an answer to open the Prescription Information window.
 -  With the prescription label special action, the Prescription Information window opens when you add the item to the PVL.
4. Verify or enter information in the following fields, if applicable:
 - **Quantity**
 - **Refills/Refill as needed**
 - **Date provided**
 - **Expiration date**—If an expiration date is not listed/selected and your practice uses Cornerstone inventory, the expiration date from the item’s record (if recorded) will be used on the prescription label. The expiration date that prints on the prescription label represents the expiration date of the drug (the inventory item) not the date the prescription expires. However, if your practice has set prescription expiration dates to be overridden by a maximum number of months, that override date will be listed on the label. Go to **Controls > Defaults > Practice and Workstation > Prescriptions** and select the **Override expiration date** check box to allow entry of an override date.
 -  By default, prescriptions expire if you try to create a refill more than 12 months after the last refill. When using the override expiration date option, prescriptions expire in the time period that equals the number of months that you override.
 - **Prescribed by**
 - **Filled by**
 -  Go to **Controls > Defaults > Practice and Workstation > Prescriptions** and select the **Filled by staff** check box if this field is required.
5. In the **Instruction ID** box, double-click or press F2 and select an appropriate instruction. Or, accept the instruction listed and click **OK** when the prescription information is complete.
6. Click **OK** to save the label information.
7. Accept or modify the printing information and click **OK**.

Advanced Petcare		
12345 Advanced Ave.		
Advanced City, MA 31415		
(123) 456-7890		
<hr/>		
4/18/2013	Leonard E. Aagard, DVM	
1	Kimberly Adams	Barksalot
Rx#: 7505	Canine	Retriever, Golden
GIVE ONE CAPSULE EVERY 8 HOURS UNTIL GONE.		
Expires: 1/1/2015	Refills: 0	
Quantity: 30	Amitriptyline tablet 50 mg	

8. Close the Prescription window.

DAILY PLANNER DIAGNOSTICS



Use the **Diagnostics** tab on the Daily Planner window to view laboratory requests and results and assign laboratory result call backs and other calls that need to be made to technicians.

- Laboratory results and call backs can also be viewed from the Message Center (no doctor sort option is available) by clicking the **Message Center** button on the toolbar.

Patient ID	Patient Name	Prac	Lab ID	Type	Date	Call Backs		
Owner Name	Req ID	Template	Staff ID	Status	Date	Staff ID		
3679K-1 Anders, Jack	Blake	1	IDEXX 3679K-1	Pending Req	02/16/2012 CS			
3679K-1 Anders, Jack	Blake	1	IDEXX 3679K-1	Pending Req	05/15/2012 LP			
3679K-1 Anders, Jack	Blake	1	IDEXX 3679K-1	Pending Req	05/16/2012 CS			
2245 Dahlberg, Pat	Callie	1	IDEXX 2245	Pending Req	01/30/2013 CS			
15259 Adams, Kimberly	Casey	1	INCLINIC 3236	Report	04/19/2013 JB	Open...	04/20/13	JC
3596 Adams, Kimberly	Hooch	1	INCLINIC 3235	Report	04/19/2013 LP	Open...	04/20/13	JC
120Q-1 Powers, Karl	Twister	1	IDEXX 120Q-1	Pending Req	05/03/2012 LP			
120Q-1 Powers, Karl	Twister	1	IDEXX 120Q-1	Pending Req	05/23/2012 CS			

Diagnostics Tab—View and Update Laboratory Requests and Results

- Click the **Daily Planner** button on the toolbar.
- In the **Staff ID** box, press TAB to accept the default staff ID or enter a new staff ID.
- Click the **Diagnostics** tab.
- In the **Date range for posted results** area, select the date range of the posted laboratory results to review.
 - Set the default number of days in the Daily Planner default settings (**Controls > Defaults > Practice and Workstation > Daily Planner**).
- In the **Other types to include** area, select the check boxes for the laboratory types you want to view.
 - Set default types to include in the Daily Planner default settings.
- Once you have set the date range and types, you can view all existing laboratory results/requests and their current call back status for the selected staff member (or for all staff by selecting the **View for all staff check box**). Right-click a report, request or result and select an option; depending on the laboratory type/call back status, the following options may be available:
 - Select **Update Lab Request** to open and update a pending laboratory request. Click the magnifying glass icon to view the requested tests.
 - Select **Update Lab Result** to open and update a recently received laboratory result.

- Select **Update Call Back** to open the Patient Reminders window and update an open or pending call back.
- Select **Patient Clipboard** to open the patient's record in the Patient Clipboard* window.
- Select **New Lab Request** to open the New Lab Request window to enter a laboratory request.
- Select **Refresh** (at any time) to add the most current results for the selected date range to the tab.

Diagnostics Tab—Working with Call Backs

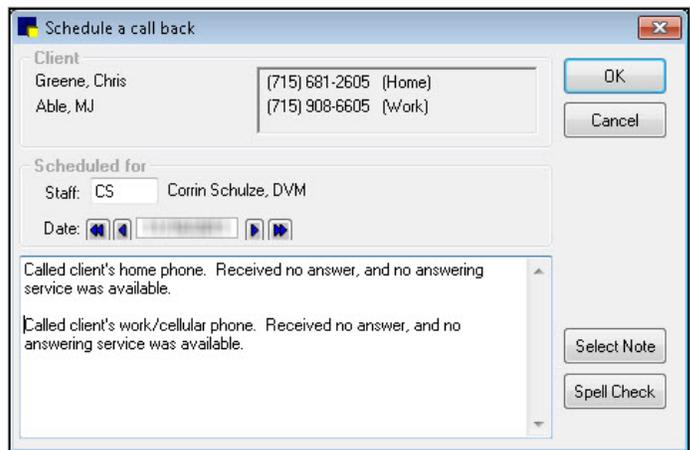
The **Diagnostics** tab conveniently provides a single location for managing laboratory call backs. The **Call Backs—Status, Date, and Staff ID** columns let you to keep track of laboratory call backs and access call back options with a single click.

Call Now—Make a First Call Back Immediately

1. Click the blank button in the **Status** column associated with the laboratory result or report and select **Call now**. The Call Now window opens.
 -  Schedule and make call backs using the laboratory report rather than individual laboratory results.
2. In the **Staff ID** box, enter ID of the staff member who is making the call.
3. Depending on the result of your call, from the **Status** list, select **Open, Pending, or Completed**.
4. Optional: Type a note in the text entry area, or click **Select Note** to choose the note from a list. Double-click the note's description to select it, and modify as needed. (e.g., double-click **Left message @ home**).
 -  Set up notes at **Lists > Call Back Notes**.
5. Click **OK**.

Schedule a Call Back

1. Click the **Blank Status** button associated with the laboratory result or report and select **Schedule a call back**. The Schedule a Call Back window opens.
2. In the **Staff ID** box enter the ID of the staff member you are scheduling to make the call.
3. Enter the date for the scheduled call back.
4. Type a note in the text entry area, or click **Select Note** to choose the note from a list and modify as needed.
5. Click **OK**.
6. Once the call back is scheduled, and after refreshing the Daily Planner window, the staff member can view and process the call back from the Daily Planner **Call Backs** tab.



Update an Open or Pending Call Back

1. Click the **Open** or **Pending** status button associated with the laboratory result. The Note for (laboratory callback item) Lab Call Back window opens.
2. In the **Staff ID** box, enter ID of the staff member who is making the call.
3. Depending on the result of your call, from the **Status** list, select **Open, Pending, or Completed**.
4. Type a note in the text entry area, or click **Select Note** to choose the note from a list and modify as needed.
5. Click **OK**.

Viewing Notes for a Completed Call Back

Click the **Completed** status button associated with the laboratory result. All associated call back notes display in a view-only window. Call back notes are also available in patient history.

OTHER PROCEDURAL STEPS

This lesson contains additional Patient Visit List (PVL) window procedures.

Completing Special Actions from the Patient Visit List

1. With the patient selected in the Patient Clipboard* window, right-click the patient and select **Patient Visit List**.
2. Click **Special**.
3. Process applicable special actions (e.g., laboratory request, print document, vaccine tag, etc.).
4. Click **OK**.

Adding Departing Instructions from the Patient Visit List

1. In the Patient Visit List window, click the **Departing Instructions** button  for an item. The Departing Instructions window opens.
2. Double-click in the **ID** field to locate and select a departing instruction.
3. Click **OK**.



You can link departing instructions to specific invoice items.

Viewing and Updating a Specific Patient Visit List

1. With the patient selected in the Patient Clipboard window, right-click the patient and select **Patient Visit List**.
2. Continue adding items or updating items as needed.
3. Click **OK**.

Viewing and Updating Multiple Patient Visit Lists

1. Click the **Daily Planner**  button on the toolbar.
2. Select the **View for all staff** check box and click the **Patient Visit List** tab .
3. Click headers to sort list by client or patient information. Double-click any item to open the Patient Visit List window.
4. Continue adding items or updating items as needed.
5. Click **OK** to save and return to the **Patient Visit List** tab in the Daily Planner window.

Viewing Prescriptions

1. With the patient selected in the Patient Clipboard, in the patient history area, click the **Rx** (prescriptions) tab.
2. Right-click the prescription and select **View**. The Prescription Information—View window opens.
3. Click **Print**, **Preview**, or **Cancel**.

Renewing Prescriptions

1. With the patient selected in the Patient Clipboard, in the patient history area, click the **Rx** (prescriptions) tab.
2. Right-click the prescription that needs to be renewed and select **Renew**. The Prescription Information—Renew window opens.
3. Make any necessary modifications to any available fields.
4. Click **OK**, and then click **OK** to print.

Refilling Prescriptions

To refill a prescription, it must have refills available.

1. With the patient selected in the Patient Clipboard, in the patient history area, click the **Rx** (prescriptions) tab.
2. Right-click the prescription that needs to be renewed and select **Refill**. The Prescription Information—Refill window opens.
3. Make any necessary modifications to any available fields.
4. Click **OK**, and then click **OK** to print.

Correcting Prescriptions

1. With the patient selected in the Patient Clipboard, in the patient history area, click the **Rx** (prescriptions) tab.
2. Right-click the prescription that needs to be renewed and select **Correct**. The Prescription Information—Renew window opens.
3. Make any necessary modifications to any available fields.
4. Click **OK**, and then click **OK** to print.



When correcting a prescription that is already on the Patient Visit List, to avoid missed charges, ensure the **Apply to invoice** check box is selected.

Voiding Prescriptions

1. With the patient selected in the Patient Clipboard, right-click the patient and select **Patient Visit List**.
2. In the patient history area, select the **Rx** (prescriptions) tab.
3. Right-click the prescription that needs to be renewed and select **Void**.
4. If a confirmation message appears, click **Yes** to continue.
5. Click **OK**, and then click **OK** to print.



The prescription is automatically “hidden” in the patient history area. Clear the **Hide Voided Items** check box to view voided items.

Chapter Summary

You learned these important concepts in this chapter:

- **Patient Visit List**—Features, benefits, and work flow of the Patient Visit List (PVL) window.
- **Vaccinations and Rabies Certificates**—Complete the Vaccine Tag window and understand how the inventory setup and default settings can positively affect efficiency.
- **Prescriptions**—Create a prescription for a pharmaceutical item in inventory.
- **Daily Planner Diagnostics**—View, schedule, and complete call backs for laboratory results and reports.
- **Other Procedural Steps**

Recommended Treatments and Costs

You'll learn these important concepts in this chapter:

- **Estimate**—Create and customize an estimate.
- **Preadmit Process**—Update the reason for visit.
- **Other Procedural Steps**

ESTIMATE

A detailed estimate provides your client with a realistic idea of the range of expenses that may be incurred for a patient requiring outpatient and/or hospitalized (inpatient) care and services.

Item ID	Description	Qty - Low	Qty - High	Low Price	High Price	Staff	Center	Disc	Tax	Date
1	1842 Fecal analysis	1.00	1.00	\$23.90	\$23.90	CS	H	No	Yes	11/22/2011
2	RADABS Radiology Abdominal Study (Lateral/VC	1.00	1.00	\$180.00	\$180.00	CS	H	No	Yes	11/22/2011
3	VTREAT Vomiting Treatment					CS	H	No	No	11/22/2011
4	IV Fluid Group	1.00	1.00	\$0.00	\$0.00	CS	H	No	No	11/22/2011
5	I.V. Catheter Placement	1.00	2.00	\$26.00	\$52.00	CS	H	No	No	11/22/2011
6	IV Set/Cath & Fluids - 500 ml	1.00	1.00	\$43.00	\$43.00	CS	H	No	No	11/22/2011
7	IV Pump per day	1.00	2.00	\$38.00	\$76.00	CS	H	No	No	11/22/2011
8	Lactated Ringers	1.00	2.00	\$30.00	\$60.00	CS	H	No	Yes	11/22/2011
9	Cerenia Injectable	1.00	4.00	\$34.75	\$139.00	CS	H	No	No	11/22/2011
10	Canine i/d can 13oz	1.00	3.00	\$1.90	\$5.70	CS	H	No	Yes	11/22/2011
11	H30 Hospitalization	1.00	2.00	\$30.00	\$60.00	CS	H	No	No	11/22/2011
12								No	No	00/00/0000

Travel Sheet Total - Low: \$425.30 Total - High: \$659.90

Estimates are created from the Estimate window, which is divided into these areas:

Client/patient information area

- **Client ID**—Contains the client ID.
- **Name**—Displays the client's name.
- **Patient ID**—Contains the patient ID.

Estimate information area

- **Estimate #**—Contains the estimate number assigned by the IDEXX Cornerstone* Practice Management System (existing estimates). Double-click or press F2 to search for and select an existing estimate from the Estimate List. This field is left blank when creating new estimates, since estimate numbers are assigned automatically by Cornerstone when the estimate is saved.
- **Description**—Enter text describing the purpose for the estimate.



The description is easily viewed from both **Estimates** tabs in the Patient Clipboard* window and is saved to patient history when electronically signed by the client.

Estimate window buttons

- **OK**—Save the estimate.
- **Cancel**—Exit the Estimate window without saving.
- **Print**—Print an existing estimate.
- **E-Mail**—Email an estimate.
- **Finalize**—Finalize a tentative estimate.
- **Up/Down arrows**—Move a selected invoice item up/down in the list.
- **Travel Sheet**—Open the Travel Sheet selection window.

Invoice item list grid

- **Item ID**—Contains the invoice item ID.
- **Qty. Low/Qty. High**—Enter numbers to set the low/high quantities for the invoice item.
- **Staff**—List the staff member’s ID to associate with the invoice item.
- **Disc.**—Select the **No** or **Yes** button to indicate if a discount should be applied to the invoice item.
- **Date**—The date the invoice item was added to the estimate.
- **Description**—Contains the invoice item’s description.
- **Low Price/High Price**—Enter values for the low/high prices for the invoice item.
- **Center**—Contains the revenue center’s ID.
- **Tax**—Select the **No** or **Yes** button to indicate if tax should be applied to the invoice item.

Electronic Estimate Signatures

Using the Cornerstone system, your clients can view an on-screen estimate and electronically sign the estimate using a supported signature capture device or tablet PC. Signed estimates are automatically finalized and saved to patient history. On the Patient Clipboard* window and estimate-related windows throughout Cornerstone, the **Signature**  icon displays next to estimates that have been electronically signed.



Signed estimates are permanently saved to patient history.

Creating a New Estimate

1. With the patient selected in the Patient Clipboard* window, right-click the patient and select **Estimate**.
 2. In the **Estimate #** box, press TAB.
 3. In the **Description** box, type a description for the estimate. This description does not print on the estimate but is used in the list of estimates for this patient and in patient history when the estimate is electronically signed.
- tip** Add the initials of the person creating the estimate in case there are any questions.
4. Tab to the first **Item ID** field in the grid. Items can be added using the following methods:
 - To add an individual item, double-click or press F2, and then search the Invoice Item List by description.
 - Use a smart group (e.g., dental group).
 - Click **Travel Sheet** to select items from one or more travel sheets.

5. Update the estimate details (quantity, price, etc.) as needed.

DENTA	DENTAL GROUP					14	H	No
	EXAMINATION PRESURGICAL	1.00	1.00	\$0.00	\$0.00	14	H	No
	IDEXX Chem 21 w/ Comp. CBC	1.00	1.00	\$116.98	\$116.98	14	H	No
	IV CATHETER PLACEMENT	1.00	1.00	\$20.00	\$20.00	14	H	No
	IV FLUID PUMP	1.00	1.00	\$7.00	\$7.00	14	H	No
	ANESTHESIA ISO >100 lbs	1.00	1.00	\$90.00	\$90.00	14	H	No
	Dental Grade 2 Canine	1.00	1.00	\$61.00	\$61.00	14	H	No
	PROPHY POLISH	1.00	1.00	\$25.00	\$25.00	14	H	No
	FLUORIDE TREATMENT	1.00	1.00	\$7.00	\$7.00	14	H	No
	Antirobe 150 mg (Clindamycin)	14.00	28.00	\$38.00	\$66.00	14	H	No

6. Click **OK** to save the estimate when the information is complete.

7. In the Save Estimate window, the following options are available:

- **Preview/Signature**

- **Save and continue**

- **Print estimate**—Select this check box to print the estimate.

- **Copies**—Enter the number of copies to print.

- **Message**—Select a message to print on the estimate. You can change a message and select additional messages.

- **E-Mail estimate**—Select this check box to print the estimate.

- **Save estimate for ___ days**—Edit the number of days the estimate remains in the system until being closed by the end of day process. The estimate expiration date prints on the estimate. Unsigned estimates are no longer stored after this date. Signed estimates are stored until you purge them.

- **Finalize estimate**—Select this check box to manually finalize the estimate.

8. Click **Options** to change the transfer and print options, and then click **OK**. You must have appropriate security to access the options.

- Selections in the **Transfer to patient visit list** area determine the prices that transfer.

- Selections in the **Print prices** area determine the prices that will print on the estimate.

- Selections in the **Print** area determine both detailed item lines and the final total or only the final total prints.

9. In the Save Estimate window, click **OK**.

10. Based on your practice's estimate default settings, you may be prompted to transfer items to the Patient Visit List. Click **Yes** to transfer the items.



This process places the items from the estimate onto the Patient Visit List (PVL). Later you will transfer items from the PVL to the Patient Orders window.

11. On the Special Actions window, click **Continue**; special actions will be completed at a later time.

PREADMIT PROCESS

Updating the information for checked-in patients throughout the patient's visit helps keep your team current with patient cases. Doctors and technicians routinely use the Check-in Report to provide information relating to the visit, the patient's history, and the client's account. You can update a checked-in patient using the Appointment Scheduler, Census List, or Patient Clipboard* windows.

In this activity, you'll use the **Check-in** tab on the Patient Clipboard to update your test patient's hospitalized status to inpatient so the patient appears on the Electronic Whiteboard window without patient orders (you'll work on those orders soon).

1. With the patient selected in the Patient Clipboard, click the **Check-in** tab , right-click in the **Check-in** tab's work area and select **Update**.
OR
Right-click the patient and select **Check-in**.
 2. In the **Staff ID** box, press TAB to accept the default staff ID or enter a new staff ID.
 3. Verify that the correct reason is selected in the **Reason for Visit—Primary** list; select another reason if necessary.
 4. Address any client/patient prompts and click **OK**.
 5. Verify that the correct room is selected in the **Room** list; select another room if necessary.
 6. Optional: From the **Ward** list, select the ward.
 7. Optional: In the **Cage** box, type a cage name.
 8. Optional: From the **Status** list, select a status.
 The status defaults to inpatient when checked in as an inpatient unless updated from the Patient Orders window.
 9. If this is a referral recheck, select the **Referral Recheck** check box.
 10. Select **Inpatient**.
 Select Inpatient to add the patient to the Electronic Whiteboard. The patient will have no patient orders until orders are entered.
- Outpatient
 Inpatient
11. Optional: In the **Additional notes** and **Alert notes** areas, enter notes.
 Alert notes appear on the Whiteboard.
 12. Optional: Linked documents display in the **Documents** area. Select documents to print with the Check-in Report.
 13. Optional: In the **Weight entry** area, enter the patient's weight.
 14. Optional: Change the information in the **Check-in Date** and **Time** boxes.
 15. Optional: Click **Travel Sheet** to print a travel sheet with this client/patient information.
 16. Click **Update**.
 17. If prompted, click **Yes** or **No** to print the Check-In Report.
 To include patient referral information on the Check-in Report, go to **Controls > Defaults > Practice and Workstation > Check-in > Check-in Print Options**. Then, select the **Patient referrals** check box and a date range.

OTHER PROCEDURAL STEPS

Updating Tentative Estimates

1. With the patient selected in the Patient Clipboard* window, click the **Estimates** tab .
2. Double-click the estimate to update.
3. In the **Estimate #** box, press TAB. The estimate information appears.
4. Update the necessary information on the estimate.
5. Click **OK** to save changes.

Creating Additional Estimates

1. With the patient selected in the Patient Clipboard, right-click and select **Estimate**.
2. In the **Description** box, type a description for the estimate.
3. Add invoice items to the estimate.
4. Click **OK** to save the estimate.
5. In the Save Estimate window, select the appropriate options and click **OK**.
 Click **Options** to change the transfer and print options. Click **OK** to save the estimate with the new selections.

Selecting Multiple Estimate Messages

1. Create the estimate. After clicking **OK** to save the estimate, the Save Estimate window opens.
2. Click **Messages**.
3. Enter the ID of the first message, or double-click or press F2 to select from a list of your practice's messages.
4. If needed, click **Note** to make changes or add information to the message text.
5. Add additional messages as needed. Click the arrow buttons at the bottom of the window to change the order in which the messages display.
6. To print the messages on a different page than the estimate, select the **Print estimate messages on a separate page** check box.
7. Click **OK** to return to the Save Estimate window.

Emailing Estimates

To email estimates, use the desktop email client, which can be set up under **Lists > Practice**. You must have access to the Internet and a valid email account.

1. Open the estimate to email.
2. In the **Estimate #** box, press TAB. The estimate information appears.
3. Click **E-mail**.
4. Click **E-mail** to continue, or change the estimate message and then click **Email**. The Communications window opens.
5. Select the **Email** check box.
6. The subject is automatically entered. In the **Recipients** area, add any recipients. To add the client, select the **Add Client** check box.
7. In the **Messages** area, type any notes.

8. In the **Estimates** area, ensure the estimate is attached.
9. Click **Send** to send the email.

Finalizing Estimates

1. With the patient selected in the Patient Clipboard* window, click the **Estimates** tab .
2. Double-click the estimate to update.
3. In the **Estimate #** box, press TAB. The estimate information appears.
4. Click **Finalize**.
5. In the Save Estimate window, make any necessary changes and click **OK**.

Electronically Signing an Estimate

Depending on your practice default settings, you can capture a client signature as well as a witness signature using an approved signature capture device.

1. With the estimate details listed, from the Save Estimate window, select **Preview/Signature**.
2. Review the on-screen estimate with the client, then click **Signature**.
 - If using a connected signature capture device, a signature box displays. Ask the client to sign in the box, then click **OK** to insert the signature into the estimate.
 - If using a tablet PC, ask the client to sign directly on the **Authorized Signature** line.
3. To add a witness signature, repeat the client signature steps.
4. Once estimate is signed, it is automatically finalized and saved to patient history.
5. Signed estimates display on the **Estimates** tabs in the Patient Clipboard* window. A signature icon displays next to the estimate description.

Using Travel Sheets

1. In an estimate, patient order, invoice, document invoice item pane, or on the Patient Visit List window, click **Travel Sheet**.
2. Select a travel sheet.
3. Minimize the selection list or view a specific classification of items. For quick selection, click the classification name in the left column.
4. To select an item, click it. The quantity will change to 1. Click again to add to the quantity; right-click to reduce the quantity. You can select one or multiple items from one or more classifications or travel sheets.
 -  You can select items from more than one travel sheet. Just select a different travel sheet from the list and follow steps 3-4.
5. When all items have been selected, click **Transfer** to send the items to the estimate, patient order, invoice, or on the Patient Visit List window.
6. In the Enter a Staff ID window, enter a staff ID and click **OK**.

Chapter Summary

You learned these important concepts in this chapter:

- **Estimate**—Create and customize an estimate.
- **Preadmit Process**—Update the reason for visit.
- **Other Procedural Steps**

Admit and Patient Orders

You'll learn these important concepts in this chapter:

- **Electronic Whiteboard**—Learn about the features and benefits of the Electronic Whiteboard window, including the basic Whiteboard work flow, how the Whiteboard fits into the equation of automating charges, and creating Whiteboard nonbillable items that make the Whiteboard easy to use.
- **Patient Orders and Whiteboard Patient Visit List**—Learn how to enter patient orders by adding invoice items and smart groups and by transferring charges from the Whiteboard patient visit list.

CORNERSTONE ELECTRONIC WHITEBOARD



[View a snippet online demonstration](#)

Electronic Whiteboard (Main Grid) Window

The Electronic Whiteboard window provides a centralized view of patients' treatment schedules and statuses. Also known as the "main grid," this window acts as a key entry point to ordering and editing treatments. The Whiteboard allows quick access to important patient information at a glance, while also offering more detailed information on scheduled treatments and flexible date/time viewing options.

Practices that integrate the Whiteboard into their practice find it to be:

- A quick way to prescribe a treatment or follow a treatment protocol.
- A highly visible, easy way for staff to track and record patient care.
- An improved method to automate billing and capture charges based on provided care.
- A convenient location to record detailed care information into the medical record.

The screenshot displays the Electronic Whiteboard interface for Thursday, September 01, 2011. The main grid shows patient treatment blocks for various animals. Annotations point to specific features:

- Patient column sort options:** Located at the top left of the patient list.
- Go to Now button:** A button in the top header area.
- Show & edit Whiteboard filters:** A button in the top header area.
- Detailed patient treatment blocks:** A callout box pointing to a specific treatment entry for a patient.
- Alert column:** A callout box pointing to the rightmost column containing alerts like 'URG TODAY: NPO' and 'Caution: GOWN/GLOVE'.
- patient columns:** A callout box pointing to the patient information column on the left.

Patient Column Sort Options

The **Sort** list allows you to sort the Whiteboard Patients column by:

- Patient Name
- Client Name
- Reason for Visit
- Check-in Date/Time
- Doctor
- Hospital Status
- Treatments for Current Hour
- Treatments for Next Hour

 Patients flagged as critical display at the top of the **Patients** column on the Whiteboard regardless of the selected sort order, with the exception of the Treatments for Current Hour/Next Hour sort orders, where critical patients display at the top only if they have treatments for that hour.

 The sort order defaults to Patient Name unless a different default sort option has been specified in workstation defaults (set up workstation defaults at **Controls > Defaults > Practice and Workstation > Workstation**).

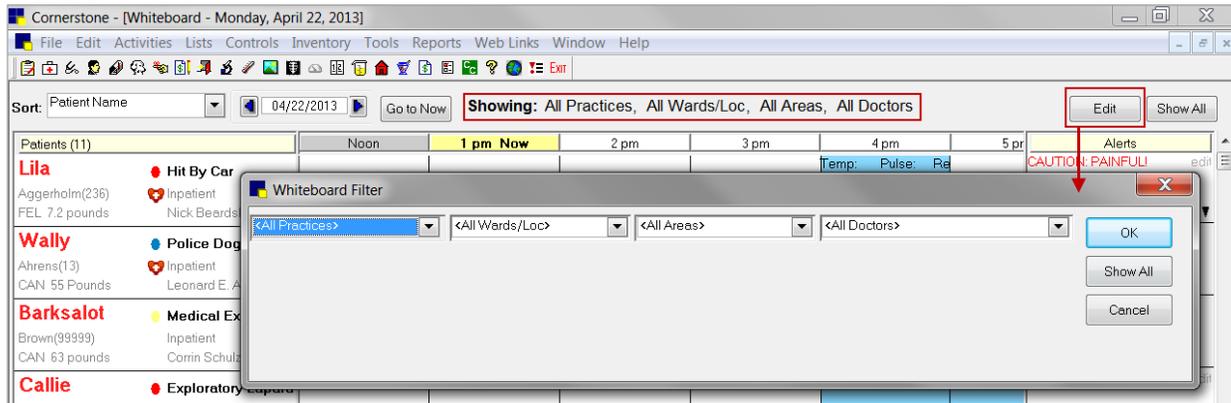
Go to Now Button

Click the **Go to Now** button to quickly reset the grid to the current day and hour.



Show and Edit Whiteboard Filters

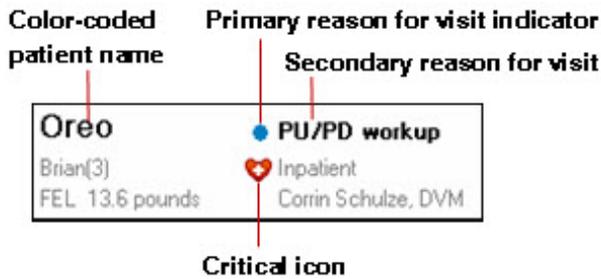
The **Showing** area at the top of the window displays all currently selected filters, with an **Edit** button that allows you to access the Whiteboard Filter options.



 The **Practice** list is available only for practices using the multi-location single database feature.

Patients Column

The **Patients** column to the left of the grid displays any patient marked as an inpatient upon check in. The patient information blocks in the **Patients** column provide an at-a-glance view of important patient information.



Patient Column Features	Description
Color-coded patient name	Color coding of the patient name helps to identify the status of the patient or the status of the patient’s treatment orders. <ul style="list-style-type: none"> • Yellow —Indicates the patient does not have any treatment orders assigned OR is on the Whiteboard past the expected discharge date. • Red —Indicates the patient has overdue treatment orders. • Black —Indicates the patient’s treatments are up to date.
Primary and secondary reasons for visit	The color-coded dot indicates the primary reason for visit and the adjacent bold text provides the secondary reason. If a secondary reason is not assigned, the primary reason text displays.
Critical icon	If the patient has been flagged as critical on the Patient Orders window or during check-in, the Critical icon displays next to the patient status.

The number shown in parentheses at the top of the **Patients** column indicates the current number of patients on the Whiteboard (note that any currently selected filters may affect the number shown).

Additional Patient Information

To view additional patient information, rest the mouse pointer on a patient block. A pop-up window displays patient order information pertaining to the visit and includes the pet’s picture (if one is included in the patient record).



Oreo (2517)
 Cage:4
 Feline Spayed Female
 Shorthair, Domestic Black & White
 14 Yrs. 5 Mos.

critical

Reason for visit: Internal Medicine
 Secondary reason for visit: PU/PD workup
 Date admitted: 7/7/2011
 Expected discharge date: 7/11/2011
 Supervising doctor: Corrin Schulze, DVM
 Current care doctor: Corrin Schulze, DVM

Detailed Patient Treatment Blocks

Patient treatment blocks include detailed information on each treatment scheduled for the time block, as well as a new pop-up window that provides an even greater level of detail.

On-the-minute scheduling

Completed treatments checked

Pop-up window provides details on all treatments for the hour

Color coding indicates status of each treatment

G.R. Romeo
Practice: THE GOOD VETERINARY HOSPITAL

Overdue
:15 Rimadyl 100mg Chewable tablet, 1 each

To Do
Cephalexin capsules 250mg, 1 each

Completed
✓ IV Cath/Fluids - Surgical, 1 , Cont
✓ IV Pump per day, 1 , Cont

To sort treatments, go to the Patient Orders and change the numbers in the left column.

Feature	Description
Popup window provides details on all treatments for the hour	If more than three treatments are scheduled for a patient during the hour, a down arrow ▼ displays in the block to indicate there are more treatments to view. Rest the mouse pointer on the treatment block to view a popup window providing the list of treatments scheduled to be performed for the patient in this time slot. The popup window lists treatments broken out into groupings of Overdue (always displayed at the top), To Do, Completed, and Did Not Perform.
Check mark displays next to completed treatments	In both the treatment block and the popup window, a check mark ✓ displays next to any completed treatments.
Color coding indicates status of each treatment line within a block	Color coding indicates the status of each treatment line: Green ■ = Completed Bright blue ■ = Scheduled Light blue ■ = Continuous or Until Completed Red ■ = Overdue Gray ■ = Discontinued or Did not perform
Order of treatment lines within a block based on numbering of left column on Patient Orders window	The treatment lines listed within a block are ordered according to the numbering of the invoice items in the left-most column on the Patient Orders window.

Alerts Column

The **Alerts** column on the Electronic Whiteboard window allows you to add, edit, and view selected types of patient alerts.

Depending on your setup, the **Alerts** column may display the following types of alerts:

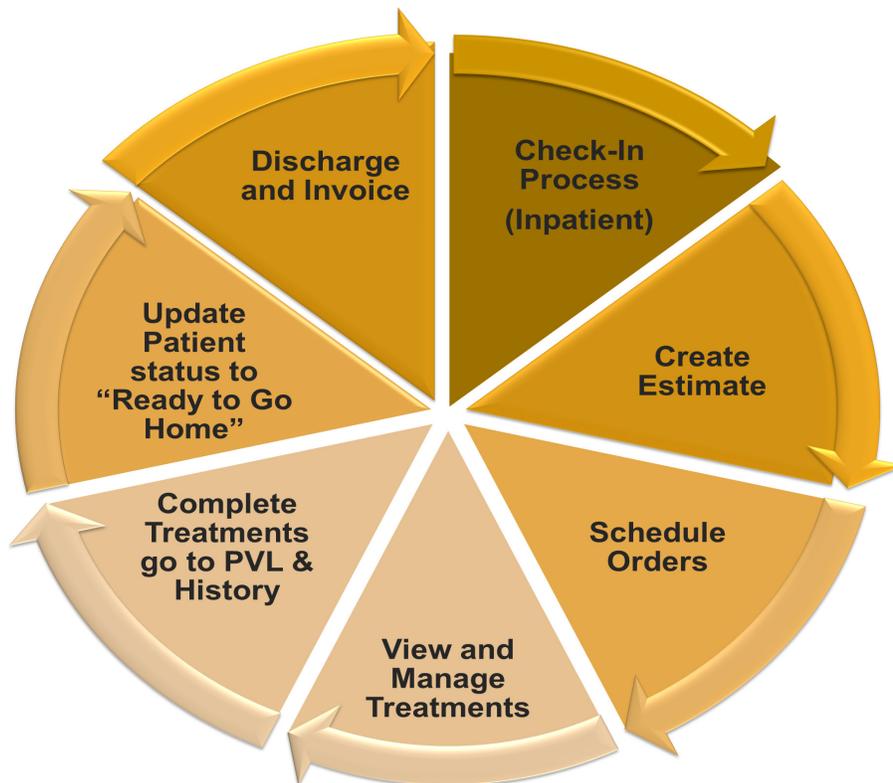
- Alerts from the Whiteboard Alerts List
- Patient prompt alerts
- Patient classification alerts
- Alerts manually entered on the Patient Check-in/out window
- Alerts manually entered on the Whiteboard window



If more than three alerts exist for a patient, a down arrow displays in the block to indicate there are more alerts to view. Rest the mouse pointer on the alert block to view the patient's full alert. You can manually enter alerts to display in the **Alerts** column for the patient on the Whiteboard window. You can also change the order of the alerts as they are listed in the **Alerts** block, remove an alert so it does not display in the block, and edit a manually entered alert.

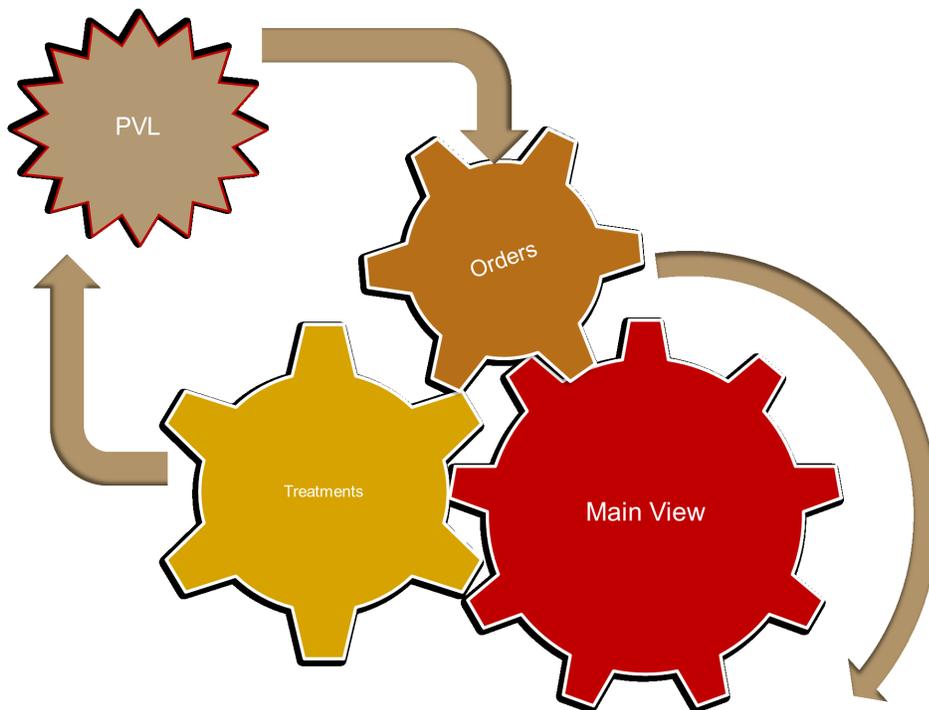
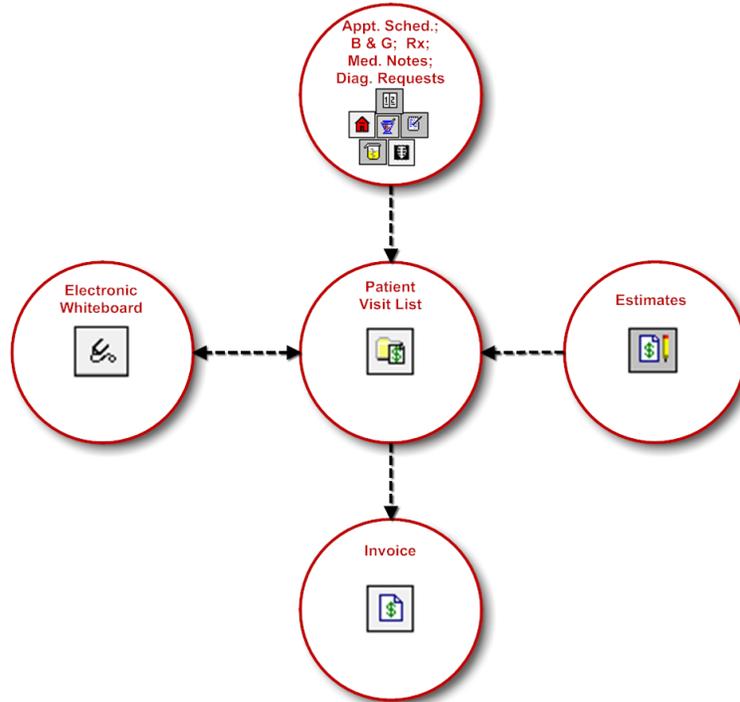
Electronic Whiteboard Work Flow Overview

The IDEXX Cornerstone* Practice Management System's Electronic Whiteboard work flow (see image below) works in this manner: Add invoice items and smart groups on the Patient Orders window, possibly transferring in treatments from finalized estimates or other sources found on a Whiteboard patient visit list, then back to the Patient Orders window to complete the details. After initial orders are entered, staff monitor the main Whiteboard hourly grid to identify when treatments are to be completed, then double-click the treatment to open the Patient Treatments window to complete the treatment and record any detail care information. The end result is the recorded detailed care information with staff, time, and applicable charge.



Automating Charges

Before we get started in the Patient Orders window, it's important to understand how the Electronic Whiteboard fits into the equation of automating and capturing charges. When you select quantities, billing, and frequencies on the Patient Orders window, it affects the charges that flow to the Patient Visit List. Referring to the illustration below, charges are entered as you complete treatments, and you manage the billing of those final charges on the Patient Visit List, along with other charge types. Notice the way that the arrows flow—some flow in one direction and some are bidirectional.



Whiteboard Groups

An efficient way to use the Electronic Whiteboard is to designate certain Whiteboard groups to be used within this powerful feature. This makes the patient order entry process quick and facilitates adding nonbillable items to the Whiteboard.

Electronic Whiteboard Nonbillable Items	
<input type="checkbox"/> Administer Medication	<input type="checkbox"/> Monitor Appetite and Drinking
<input type="checkbox"/> Blood Draw	<input type="checkbox"/> Monitor Fluids
<input type="checkbox"/> Call Client	<input type="checkbox"/> Monitor Urination
<input type="checkbox"/> Remove Catheter	<input type="checkbox"/> Take Radiograph
<input type="checkbox"/> Check Bandage	<input type="checkbox"/> Vital Signs
<input type="checkbox"/> Check Stool	<input type="checkbox"/> Walk
<input type="checkbox"/> Check for Vomiting	<input type="checkbox"/> Water
<input type="checkbox"/> Check Incision	<input type="checkbox"/> Clean Cage/Change Litter
<input type="checkbox"/> Feed	<input type="checkbox"/> Procedure (a placeholder for the main procedure)
<input type="checkbox"/> Feed (Owner Food)	



Select the **Miscellaneous** check box to allow customized descriptions when using on the Patient Orders window.

PATIENT ORDERS AND ELECTRONIC WHITEBOARD PATIENT VISIT LIST



[View a snippet online demonstration](#)

Beginning the Patient Orders

In this activity, you'll locate your test patient on the Electronic Whiteboard and enter the patient orders.

1. On the Patient Clipboard* window, select the patient, right-click, and select **Electronic Whiteboard > Patient Orders**.



You can access patient orders from the Patient Clipboard, as well as from the main Whiteboard window.

The screenshot displays two patient lists. The first list includes 'Barksalot' (Brown, 99999, 63 pounds) and 'Callie' (Dahlberg, 1379, 35 pounds). A context menu is open over 'Callie', showing options: 'Patient Treatments', 'Patient Orders' (highlighted), 'Patient Clipboard', and 'Patient Visit List'. Another menu is visible on the left side of the interface, also with 'Patient Orders' selected.

Patient Orders—Header

This table explains the key header information and how to best use the fields.

Patient ID	<p>Indicates which patient's orders are being scheduled.</p> <p>Depending on how you accessed the Patient Orders window, the patient may already be selected. If not, in the Patient ID field, type the patient ID, or double-click or press F2 to search for and select the patient from the Patient List.</p> <p>With the patient ID specified, the patient's name, client name, client ID, age weight, and body score (if activated), species, breed, and sex information displays.</p>
Vital Signs/Weight button 	<p>Allows you to access the Vital Signs window to update weight and/or other vital signs for the patient.</p> <p> The button displays in red/yellow  as an alert if at least one vital sign (other than weight and body score) has not been entered for the patient within the past 10 days.</p>
Status	<p>Indicates the patient's standing in the hospital. Options include:</p> <ul style="list-style-type: none"> • Inpatient—Patient is currently being treated. • Ready to go home—Patient's treatments are completed. • Discharged—Client has been invoiced and the patient has been checked out of the hospital (or was manually removed from the Whiteboard). • Any custom status that has been set up for the hospital. <p> A custom status will be considered equal to the "Ready to go home" status only if it contains one of the following keywords: Ready, Home, Pick, Release, or Discharge.</p>
Critical	<p>Select this check box if you want to flag a patient as critical and display the Critical icon  for the patient on all Electronic Whiteboard windows, the Check-in/out window and the Census List window.</p> <p>Patients flagged as critical display at the top of the Patients column on the Whiteboard, regardless of the selected sort order, with the exception of the Treatments for Current Hour/Next Hour sort orders, where critical patients display at the top only if they have treatments for that hour.</p>
Primary Reason for Visit	<p>The general type of problem or procedure requiring the patient to be hospitalized (e.g., Dental, Emergency, Surgery).</p> <p>Depending on the color assigned to this reason during setup (in Controls > Appointment Scheduler > Reason for Visit), a color-coded circle appears with the patient information on the Whiteboard and Patient Treatments window to indicate the reason for visit.</p>
Secondary Reason for Visit	<p>The secondary reason for visit can be used to indicate the specific problem or procedure requiring the patient to be hospitalized (e.g., Extraction, Vomiting, Spay). If a secondary reason for visit is specified, it displays with the patient information on the Whiteboard and Patient Treatment windows.</p> <p> A primary reason must first be specified to activate the secondary reason field. The secondary reason can then be selected from the predefined drop-down list, or staff can manually enter a different secondary reason.</p>
Admit date/time	<p>Indicates when the patient is admitted to the hospital.</p>

Discharge date	Indicates when the patient is scheduled to leave the hospital. (By default, the Cornerstone system inserts the date three days after the admit date; you can change the discharge date once it is inserted. You cannot change the system setting.)  Recurring treatments (e.g., BID) follow the patient discharge date unless ordered for a specific duration other than the discharge date.
Supervising Doctor	The doctor who admits the patient and is the overriding decision maker for the case.
Current Care Doctor	The doctor who assumes care of the patient if there is a shift change or if the supervising doctor is unavailable. Based on the practice default Whiteboard settings, charges from the Whiteboard are assigned to supervising doctor, current care doctor, or the doctor who performed the treatment.)
Cage	Specific cage or location where the patient will be located while hospitalized.
Ward	General location where the patient will be staying while hospitalized.  This can also be used as a Whiteboard filter.
Alert	Indicates any Whiteboard-specific patient alerts.

2. Update this information as needed:
 - Patient ID, Patient Name, and Client ID
 - Patient Status
 - Optional: Select the **Critical** check box to flag a patient as critical and display the Critical icon .
 - Primary and Secondary Reasons for Visit. The primary and secondary reasons for visit are listed (if they were previously selected). A primary reason must first be specified in order to activate the secondary reason field.
3. Optional: Accept or modify the information in the **Admit Date** and **Admit Time** boxes.
4. Optional: Accept or modify the date in the **Discharge Date** box.
5. In the **Supervising** and **Current Care** boxes, enter the staff IDs for the appropriate doctors.
6. In the **Cage** box, type the cage information. This is typically used to add a cage number and other information.
7. From the **Ward** list, select the ward.

Patient Orders—Body

Enter your invoice items and groups with the information from the table below in mind.



If a smart group or invoice item has been previously added to the Patient Orders window, the information “memorized” from the last time that the invoice item or group was used will automatically appear.

Quantity	The quantity for the treatment.				
Billing	Billing choices affect the number of times an item is added to the Patient Visit List				
	<i>Examples of billing choices:</i>				
	Billing Type[†]	Frequency	Number of Days	Quantity Charged**	Total Invoice Lines
	1 Line Each Time	BID	2	4	4
	1 Line Each Day	BID	2	4	2
	1 Line Each Visit	BID	2	4	1
No Billing or Inventory Reduction	BID	2	0	0	
[†] Each day/visit options are for service type items only. **The quantity charged to the patient.					

Category	The category selection affects how the treatment line displays in the Patient Treatments column on the Whiteboard.
Frequency	<p>How often the treatment should be performed. Many commonly used frequencies are provided, including:</p> <ul style="list-style-type: none"> • Continuous—Treatment is continued until the end of the specified duration occurs, the treatment is discontinued, or the patient is checked out. Continuous treatment time blocks display with a light blue background on the Whiteboard. <ul style="list-style-type: none">  If continuous frequency is used on a billable item, the patient visit list is charged with every instance of a completed treatment. • Until Completed—Used when a time for completion cannot be assigned based on the type of action or treatment (e.g., staff needs to obtain a urine sample). When this option is selected, Until Completed displays on the Whiteboard until the item is processed once. Then, the treatment will be marked Completed at the time staff processes the order. • One time—Treatment is added for the start date and time indicated on the order. • Every __ hours—Treatment is added for the start date and time listed on the order and for every number of hours indicated until the discharge date. • Every __ days—Treatment is added for the start date and time listed on the order and for every number of days indicated until the discharge date. <ul style="list-style-type: none">  An overdue notice is not applicable to Continuous and Until Completed frequencies.  One Time and Every __ hours/days frequencies display an overdue notice once the scheduled time is past.
Note	Used to indicate whether an additional Whiteboard medical note entry is required when the selected treatment is marked as Completed or Did not perform . The default note includes a date/time stamp and the staff member who performed the treatment.
Vital Signs	Select this check box for items requiring the staff to check and record vital signs.
PRN	Select this check box for treatments as needed. Used in addition to preset time frequency types (e.g., BID, TID). Treatments will not be listed as overdue.
Dose Now	For treatments to be performed once immediately; then follow regularly scheduled frequency. Used in addition to preset time type frequencies (e.g., BID, TID).
Start Date/Time Duration	Affects initial start and how long you'll see the treatment on the Whiteboard. Used in addition to frequency. Start date and time default to current day and hour. Duration can be set in days/hours if it will differ from the discharge date. Often used in conjunction with the continuous frequency.
Blue Line	Use the blue line to enter such information as fluid type and fluid drip rates. The information entered on the blue line as special orders is saved to the patient's electronic medical record when your staff completes the treatment.
Area	OPTIONAL: Select an area that the patient order is for. Areas can be departments, tasks, or specific staff. This information can be used as a filter for the main Whiteboard view.
Staff Classification	OPTIONAL: Select a staff classification completing the treatment. This information can be used as a filter for the Whiteboard Treatment Report.

<p>Alerts</p>	<p>If Whiteboard alerts exist for the patient, you can view and edit those alerts from the Patient Orders window.</p> <p>If there is more than one alert for the patient, a down arrow ▼ displays to the right of the Alerts field to indicate there are more alerts to view. Rest the mouse pointer on the displayed alert to view the patient’s full alert list in a pop-up window.</p> <p>To open the Whiteboard Alerts window to edit or add to the patient’s alert list, click the blue edit link located to the right of the Alerts field).</p>																											
<p>Left Column for Numbering Patient Treatment Orders</p>	<p>To specify the order in which treatments should display on the Whiteboard and Patient Treatments windows, renumber them as needed by changing the numbers in the left column. The order of treatments specified on the Patient Orders window is the order that will be used to display the treatment lines in the patient’s treatment block for each hour on the Whiteboard.</p> <p>To renumber a treatment order line, change the number in the left column and press TAB.</p> <p> For group items, you cannot change the order of the individual items until after the patient orders have been saved by clicking OK on the Patient Orders window. You can then reopen the window and reorder the individual items as desired.</p>																											
<p>No Billing icon </p>	<p>If an item’s Billing field is set to No billing or inventory reduction, the No Billing icon  displays in the blue line below the line item as a reminder to staff. This icon also appears on the Patient Treatments window for the order item.</p> <p>When the Patient Orders item is set to No billing or inventory reduction, the invoice item is not pulled from inventory and the client is not charged.</p>																											
<p>Schedule treatments using incremental (on-the-minute) time scheduling</p>	<p>You can specify a start time using incremental (on-the-minute) times (e.g., 10:15 AM, 2:30 PM). The incremental treatment times will show on the Patient Treatments window and the Whiteboard window.</p> <p> If you want to enter orders for a treatment needing to be completed every ___ minutes within a single hour—for example, a glucose curve test every 10 minutes—you would need to add a separate treatment order line for each occurrence.</p> <p>So for the glucose curve example, the orders would look like this on the Patient Orders window:</p> <table border="1" data-bbox="381 1365 576 1554"> <thead> <tr> <th>e</th> <th>Start</th> <th>Di</th> </tr> <tr> <th>v</th> <th>Date</th> <th>Time</th> <th>Day</th> </tr> </thead> <tbody> <tr> <td></td> <td>07/21/2011</td> <td>05:10 PM</td> <td></td> </tr> <tr> <td></td> <td>07/21/2011</td> <td>05:20 PM</td> <td></td> </tr> <tr> <td></td> <td>07/21/2011</td> <td>05:30 PM</td> <td></td> </tr> </tbody> </table> <p>...and like this on the Whiteboard grid’s treatment block:</p> <table border="1" data-bbox="381 1638 560 1774"> <thead> <tr> <th></th> <th>5 pm</th> </tr> </thead> <tbody> <tr> <td>:10</td> <td>Glucose curve test</td> </tr> <tr> <td>:20</td> <td>Glucose curve test</td> </tr> <tr> <td>:30</td> <td>Glucose curve test</td> </tr> </tbody> </table> <p>If an incremental time is specified, the treatment line turns red as overdue on the Whiteboard when that specific time passes (not at the end of the hour, as with nonincremental treatment times).</p>	e	Start	Di	v	Date	Time	Day		07/21/2011	05:10 PM			07/21/2011	05:20 PM			07/21/2011	05:30 PM			5 pm	:10	Glucose curve test	:20	Glucose curve test	:30	Glucose curve test
e	Start	Di																										
v	Date	Time	Day																									
	07/21/2011	05:10 PM																										
	07/21/2011	05:20 PM																										
	07/21/2011	05:30 PM																										
	5 pm																											
:10	Glucose curve test																											
:20	Glucose curve test																											
:30	Glucose curve test																											

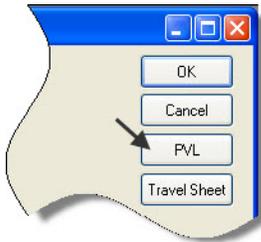
 Additional items may also be added from:

- **Patient Visit List**—Click **PVL**, and then select the check boxes in the **Ord** column for the items to be added to patient orders. When the appropriate check boxes have been selected, click **Order**.
- **Travel Sheet**—Click **Travel Sheet**, and then select the travel sheet from which you'll make selections. Make your selections and click **Transfer** for the items to be added to the patient orders. For more information, see "Using Travel Sheets" on page 40.

8. Click **PVL**.



Click the PVL button to access and transfer items into the Patient Orders window from the Whiteboard Patient Visit List.



9. View items to transfer to the Patient Orders window; scroll up to see the entire list.
10. Review and delete duplicate items as appropriate. (Duplicate items are displayed in a burgundy font.) To delete, select the item ID to be deleted and press CTRL + D.
11. Change the status of items as needed.



Only items with a status of recommended or accepted can be transferred to the Patient Orders window.

12. In the **Ord** column, select the check boxes for the items you want to move from the Patient Visit List (PVL) window, appointment items, and the medical note to the Patient Orders window. Remember items that were placed on the PVL from appointment items, the medical note, and the finalized estimate. If appropriate, select the **Select All** check box to select all of the items on the PVL; you can deselect items if necessary. If items are already marked as "performed," they cannot be transferred from the Whiteboard Patient Visit List to the Patient Orders window.



13. Click **Order**.



14. In the Patient Orders window, make any needed changes to the order details. See the sample below.

	Item ID	Item Description	Quantity	Billing	Category	Frequency	Note		PRN	Now	Date
19	1842	Fecal analysis	1.00	1 line each time	Diagnostics	Until Complete	Not required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20	RADABS	Radiology Abdominal Study (Lateral/VD)	1.00	1 line each time	Diagnostics	Until Complete	Not required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21	IVCP	I.V. Catheter Placement	2.00	1 line each time	Treatments	Until Complete	Not required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22	F	IV Set/Cath & Fluids - 500 ml	1.00	1 line each time	Treatments	Until Complete	Not required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23	IVP	IV Pump per day	2.00	1 line each time	Treatments	SID 1x per day	Not required	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24	1909	Lactated Ringers	2.00	1 line each time	Medications	BID 2x per day	Not required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25	CEREN	Cerenia Injectable	4.00	1 line each time	Medications	BID 2x per day	Not required	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
26	CID	Canine i/d can 13oz	3.00	1 line each time	Medications	BID 2x per day	Not required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27	H30	Hospitalization	2.00	1 line each time	Professional Set	Every 24 hrs	Not required	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

15. Add other items to Patient Orders window as needed.
 - Double-click or press F2 in the next available **Item ID** field to add an invoice item or smart group.
 - Click **Travel Sheet** to add items from a travel sheet.
16. In the Patient Orders window, make any changes to the order details. This includes information in the **Billing Category, Frequency, and Note** columns.
17. Add blue line communications as needed.
18. Update patient orders information as needed. For example, select one or more of the **Vital Signs, PRN, or Dose Now** check boxes.
19. Update the **Start Date/Time** and **Duration** fields as needed. Assign an area to each patient order (based on your practice setup) to create an additional Whiteboard filter. OPTIONAL: Assign a staff classification for completing the treatment.
20. Click **OK** to save the patient order and close the Patient Orders window.
21. From the Patient Orders window, once you click **OK**, patient orders cannot be deleted but they can be discontinued.

Prescriptions

There are two ways to handle items with dispensing fees on the Whiteboard.

If	Then
You dose from a prescribed bottle	<p>Create a prescription label for the medication from the Patient Clipboard* window or Patient Visit List window, or enter the medication in the Patient Orders to be completed one time. This bills the medication and creates the prescription label (if the prescription label special action is being used) when your staff completes the treatment.</p> <p>If your practice does not bill for giving medication, enter an order for a nonbillable service. If needed, use the blue line to communicate administration specifics. Set the frequency to how often the medication should be given.</p>
You dose medication as needed from a common vial	<p>In the Patient Orders window, enter the medication to be administered with the appropriate frequency. Dispensing items should also be created and attached to the appropriate inventory items to ensure your full dispensing fee will not be charged each time you administer the medication. Dispensing items allow the staff a choice on the dispensing fee that will be added to the medication price.</p> <p>Dispensing Item Examples: Meds To Go Home, Meds Admin In Hospital, etc.</p>

Chapter Summary

You learned these important concepts in this chapter:

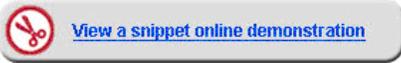
- **Electronic Whiteboard**—Learn about the features and benefits of the Electronic Whiteboard window, including the basic Whiteboard work flow, how the Whiteboard fits into the equation of automating charges, and creating Whiteboard nonbillable items that make the Whiteboard easy to use.
- **Patient Orders and Whiteboard Patient Visit List**—Learn how to enter patient orders by adding invoice items and smart groups and by transferring charges from the Whiteboard patient visit list.

Procedures

You'll learn this important concept in this chapter:

- **Patient Treatments**—View and navigate the main Electronic Whiteboard window, perform other tasks such as update patient orders and view a Patient Treatment Report, view detailed patient treatment information, enter vital signs and complete treatments, and discontinue treatments and remove them from the Whiteboard.

PATIENT TREATMENTS



The Electronic Whiteboard window is a highly visible and easy way for staff to view, track, and record patient care. You'll learn how to view the main Whiteboard and record the completion of patient treatments—even several treatments at once (per patient).

View and Navigate—Main Whiteboard Window

Use the main Whiteboard window to view the entire Whiteboard patient list. The number of patients you can view depends on the orientation and resolution of the monitor and whether or not you are using a normal workstation monitor or a large Whiteboard monitor. The main Whiteboard listing displays in patient alphabetical order by default; however, patients marked as critical display at the top of the list.

1. Click the **Whiteboard** button  on the toolbar.

Patients (11)	8 am	9 am Now	10 am	11 am	Noon	1 pm	Alerts
Lila Aggerholm(236) FEL 7.2 pounds Nick Beardsley, DVM Hit By Car Inpatient	Oxygen Therapy IV Set/Cath & Fluids - 5 IV Pump per day	Oxygen Therapy IV Set/Cath & Fluids - 5 IV Pump per day	Oxygen Therapy IV Set/Cath & Fluids - 5 IV Pump per day	Oxygen Therapy IV Set/Cath & Fluids - 5 IV Pump per day	Oxygen Therapy IV Set/Cath & Fluids - 5 IV Pump per day	Oxygen Therapy IV Set/Cath & Fluids - 5 IV Pump per day	CAUTION: PAINFUL! Immune Suppressed Monitor Ins and Outs
Wally Ahrens(13) CAN 55 Pounds Leonard E. Aagard, D Police Dog - Consul Inpatient	:30 Office exam :30 IV Cath/Fluids - Sur	:30 Hospitalization :30 Office exam :30 IV Cath/Fluids - Sur	:30 Office exam :30 IV Cath/Fluids - Sur	:30 Office exam :30 IV Cath/Fluids - Sur	:30 Office exam :30 IV Cath/Fluids - Sur	:30 Office exam :30 IV Cath/Fluids - Sur	enter alert
Barksalot Brown(99999) CAN 63 pounds Corrin Schulze, DVM Medical Exam-Vom Inpatient	Walk (Whiteboard)				Walk (Whiteboard)		enter alert
Callie Dahlberg(1379) CAN 35 pounds Sabrina Barnwell, DVM Exploratory Lapara Inpatient				CBC Cephalexin capsules 5			SURGERY Today, NPO
Izzie Zemora(14) Inpatient							Allergies: yes Fractious: Yes

- Point to a patient in the grid to see the patient information box.
- Use the date filter to navigate to treatments for the previous day and next day.
- Click **Go to Now** to reset the grid to the current hour and day. The current hour column header displays in bold black text on a yellow background with **Now** appearing to the right of the hour.
- Select doctors, wards, and use the areas filter.
 - **Doctors**—Shows the number of doctor procedures based on current care doctor assigned per patient.
 - **Wards**—Shows the number of patients in a selected area.
 - **Areas**—Shows the number of laboratory tests that technicians needs to complete. You can show select tasks, department, or staff, based on how the area is set up.

Refer to the **Showing** area at the top of the window to view currently selected filters. Click **Edit** to open the Whiteboard Filter window.

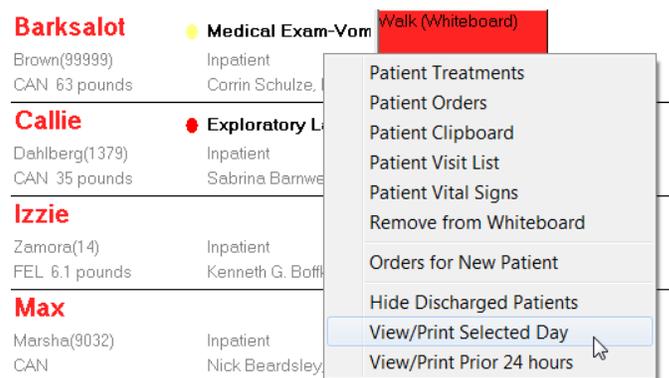
- Learn the treatment codes and colors.
-  Whiteboard colors cannot be modified.

Treatment Code	Color
Scheduled	Bright Blue
Continuous and Until Completed	Light Blue
Completed	Green
Overdue	Red
Disc (Discontinued) and DNP (Did Not Perform)	Gray

Other Tasks—Update Patient Orders and View Patient Treatment Report

- Right-click the patient and select **Patient Orders**.
- Update patient orders as needed. For example, change the start time.
- Click **OK** to close the Patient Orders window.
- In the Whiteboard window, right-click the patient, and select **View/Print Selected Day**. The Whiteboard Treatment Report window opens.
- Make selections and click **Preview**.

tip To view all entered/modified orders for a patient, view the Whiteboard Patient Orders Report (**Reports > Patient > Whiteboard Patient Orders Report**). The report indicates “changed by” based on the user logged in at the workstation.



The screenshot shows a patient list with the following entries:

- Barksalot** (Medical Exam-Vom): Brown(99999), CAN 63 pounds, Inpatient, Corrin Schulze.
- Callie** (Exploratory L...): Dahlberg(1379), CAN 35 pounds, Inpatient, Sabrina Barnwe.
- Izzie**: Zamora(14), FEL 6.1 pounds, Inpatient, Kenneth G. Boff.
- Max**: Marsha(9032), CAN, Inpatient, Nick Beardsley.

A context menu is open over the patient list, showing options: Patient Treatments, Patient Orders, Patient Clipboard, Patient Visit List, Patient Vital Signs, Remove from Whiteboard, Orders for New Patient, Hide Discharged Patients, **View/Print Selected Day** (highlighted), and View/Print Prior 24 hours.

View Detailed Patient Treatment Information and Complete Treatments

Wally - Patient Treatments - Tuesday, April 23, 2013

Wally (62)
 Ahrens, Johnny (13) (715) 268-3417
 11 Yrs. 5 Mos. 55 Pounds
 CAN Shepherd, German Neutered Male

Police Dog- Consult
 Admit: 04/20/2013
 Discharge: 04/25/2013
 Status: Inpatient

Supervising Dr: Leonard E. Aagard
 Current Care Dr: Leonard E. Aagard
 Cage: 12 Ward: Treatment Area 1

Hide discontinued Hide completed
 Show only treatments for day

04/23/2013 <All Areas> <All Staff Classifications>

Treatments	6 am	7 am	8 am	9 am	10 am	11 am	Noon	1 pm
Treatments for 9 am								
Office exam Qty: 1 [None]	:30 UC							
Hospitalization Qty: 1 [None]				Overdue				
IV Cath/Fluids - Surgical Qty: 1 [None]	:30 Cont							
Vital Signs								
Diagnostics								
Office exam Qty: 1 [None]	:30 UC							
Treatments								
Hospitalization Qty: 1								
Medications								
Daily Care								
IV Cath/Fluids - Surgical Qty: 1 [None]	:30 Cont	:30 Cont	:30					
Rimadyl 100mg Chewable tablet				Overdue				

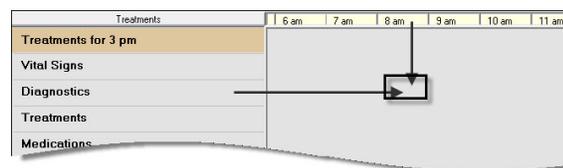
Patient Treatment Report - sorted by patient, date, hour
 04/23/13 to 04/23/13

62 Wally 11 Yrs. 5 Mos. CAN Shepherd, German 55 Pounds Supervising Dr: Leonard E. Aagard, DVM Cage: 12
 13 Johnny Ahrens (715) 268-3417 Current Care Dr: Leonard E. Aagard, DVM

Tuesday, April 23	Treatment (Item ID)	Staff Classification	Area	Category	Notes
12 am	Qty: ___ Init: ___ Office exam (OE)		Hospitalized/Sick	Diagnostics	
	Time: _____ UNTILCOMP				
	Qty: ___ Init: ___ IV Cath/Fluids - Surgical (FLUIDS)			Daily Care	
	Time: _____ CONTINUOUS				
01 am	Qty: ___ Init: ___ Office exam (OE)		Hospitalized/Sick	Diagnostics	
	Time: _____ UNTILCOMP				
	Qty: ___ Init: ___ IV Cath/Fluids - Surgical (FLUIDS)			Daily Care	
	Time: _____ CONTINUOUS				
02 am	Qty: ___ Init: ___ Office exam (OE)		Hospitalized/Sick	Diagnostics	
	Time: _____ UNTILCOMP				
	Qty: ___ Init: ___ IV Cath/Fluids - Surgical (FLUIDS)			Daily Care	
	Time: _____ CONTINUOUS				
03 am	Qty: ___ Init: ___ Office exam (OE)		Hospitalized/Sick	Diagnostics	

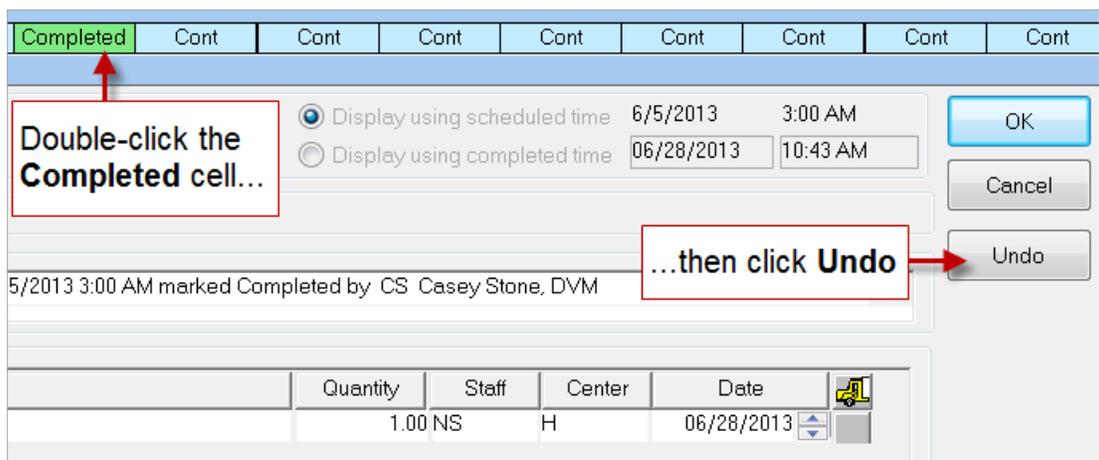
After your patient orders or treatments are entered, the medical team can use the report we previewed to view treatments. The entry of completed treatments might occur in the following ways:

- Your technicians carry a tablet PC during treatments and complete them in Cornerstone in real time.
 - Your technicians print a Patient Treatment Report from Cornerstone and attach to each cage.
 - Using your practice's own treatment sheets, the technicians complete the treatments, and then go to a workstation and mark all treatments as completed at the same time.
- Close the report.
 - Open the Patient Treatments window by double-clicking the grid for the time/date slot for your selected patient.
 - To complete single treatments.
 - In the grid, double-click in the box (cell) that represents the time and selected treatment you are documenting as complete.
 - In the window that opens in the lower portion of the screen for completing a patient treatment, enter the staff ID of the person performing the treatment (this will be saved to patient history).



To view special orders from the blue line, click the note icon  next to the treatment description.

- c. Select **Completed** or **Did not perform**.
 - d. Select **Display using scheduled time** or **Display using completed time**.
 - e. Enter any additional Whiteboard medical notes.
 - f. Before you click **OK**, review the item pane for your treatment to ensure accurate staff billing. This can be manually updated as needed.
 - g. Click **Process** to process any designated special actions.
10. To complete multiple treatments at the same time, press SHIFT and select consecutive treatments or press CTRL and select nonconsecutive treatments.
- a. Right-click and select **Process Selected Treatments**. Enter the completion details as appropriate.
 -  When completing multiple treatments, the staff ID is copied to all treatments and cannot be changed.
 - b. Click **OK** after completing the first treatment. The next treatment in the selected group will appear, copying all previous details. Click **OK** after each subsequent treatment until all are completed.
 -  You can undo a treatment you have marked as completed. Double-click the completed treatment and click **Undo**. In the Undo Treatment window, enter the staff ID and a reason for change. This comment is saved to history and any associated charge on the Patient Visit List window is removed.



11. In the Patient Treatment window, enter vital signs for the patient in one of two ways:
- Method 1 (vital signs action assigned from patient orders or a special action)—Double-click in a time slot area on the grid for a TPR, Take Vitals, or similar treatment, enter the treatment completion information and click **OK**. The Vital Signs window opens.
 - OR
 - Method 2—Click the **Vital Signs** icon in the patient header of the treatment window to open the Vital Signs window. Then, click the **more vital signs** link.
 - a. Enter the vital signs and click **OK** to save the data set.
 - b. Enter the staff ID, click **OK**, and close the Vital Signs window.
12. Complete additional treatments as needed.
13. Close the appropriate windows.

Discontinue Treatments and Remove from Whiteboard

Occasionally, you may have a treatment that is no longer valid. Some reasons might be that the doctor has received laboratory results and will take a different course of action, the treatment wasn't needed, or the treatment was accidentally entered on the Patient Orders window.

1. Right-click the patient and select **Patient Orders**.
2. Right-click anywhere on a treatment line, and select **Discontinue Treatment**. Repeat if necessary.
3. Click **OK** to save and close the Patient Orders window.



Discontinued steps can be restarted by following the same steps. Care must be taken when restarting treatments, as any treatments scheduled between discontinuing and restarting will show as overdue.

Item ID	Item Description	Quantity	Billing	Category	Frequency
5	FLUID: IV Cath/Fluids -	1.00	1 line each	Daily Care	Continuous
6	RIM Ri				
7	RIM10(Ri				
8	MORP Morphine Injecti	1.00	1 line each	Daily Care	One time
9	LACSN Laceration repe	1.00	1 line each	Treatments	One time
10	WALK Walk (Whitebo	1.00	1 line each	Daily Care	Every 6 hrs

Discontinued treatment appears in light gray text. Right-click and select Restart treatment to add back.

Change Patient Status

When the status of the patient is updated during the patient's visit, staff are informed and can easily access details about the patient's visit. When clients call to check on their pets, your staff will have information readily available to provide. Change the patient's status in the Patient Orders window.

1. In the Electronic Whiteboard window, right-click the patient and select **Patient Orders**.
2. From the **Status** list, select a status.
3. Click **OK**.



Based on practice default settings, staff may receive an alert when invoicing if a patient does not have a ready to go home status.

Barksalot Greene(5002) CAN 73 pounds	→	Medical Exam-Vom Ready to go home Corinn Schutze, DVM
--	---	---

Remove Patient from the Whiteboard

On occasion, a patient may need to be removed from the Whiteboard before being invoiced. Most commonly, this happens for a patient that was added to the Whiteboard by mistake.

1. On the Electronic Whiteboard window, right-click the patient's name and select **Remove from Whiteboard**.
OR
On the Patient Orders window, on the far right side, click the **Remove from Whiteboard** button.
2. Accept the existing status or select a new status for the patient from the **Status** list.
3. When prompted that the patient will be removed from the Whiteboard, click **Yes** to continue. The patient no longer appears on the Whiteboard.

4. Close the Whiteboard window.

 Completed treatments and charges are not affected when you manually remove a patient from the Whiteboard.

Hide Completed and Discontinued Treatments

Use the **Hide discontinued** and/or the **Hide completed** check boxes to hide the completed and discontinued treatments on the Patient Orders and Patient Treatments windows.



Chapter Summary

You learned this important concept in this chapter:

- **Patient Treatments**—View and navigate the main Electronic Whiteboard window, perform other tasks such as update patient orders and view a Patient Treatment Report, view detailed patient treatment information, enter vital signs and complete treatments, and discontinue treatments and remove them from the Whiteboard.

Post Procedures

You'll learn these important concepts in this chapter:

- **Create Documents and Procedure Medical Notes**—Start a medical note, and attach documents and update other important medical records that the medical team might need post procedure.
- **Take Home Prescriptions**—Navigate to the Prescription window through the Patient Clipboard* window.
- **Post Procedure Updates**—View remaining laboratory results and set up call backs.
- **Complete Procedure Medical Notes**—Access a medical note from the Daily Planner to complete it.

CREATE DOCUMENTS AND PROCEDURE MEDICAL NOTES

After a procedure, your medical team will need to prepare or update medical records and client documents so that:

- Drop-offs are ready for pickup by midday.
- Hospitalization, boarding care, and treatments continue to be documented.
- Client discharge instructions are prepared.

Use the following Cornerstone templates and ideas to accomplish these tasks for a high level of efficiency and patient care. This prevents misplaced documents and ensures legible records are accessible to the entire team:

- Sample discharge Instructions
- Customize an IDEXX Cornerstone* Practice Management System procedure document (e.g., Dental Exam/Cleaning-Canine) so the first pages are the internal medical note and the last page is a client procedure report or discharge instructions.

You'll also want to do one of the following:

- Locate and use a Cornerstone template.
- Scan and attach handwritten completed forms to the medical record.

To locate a template:

1. With the patient selected in the Patient Clipboard* window, right-click and select **Correspondence or Medical Note**. The Start New Document window opens.
2. Address any alerts that appear and click **OK**.
3. In the **Staff ID** box, press TAB to accept the default staff ID or enter a new staff ID.
4. With the **Search for word** check box selected, type a keyword in the **Title or ID** box, select the document, and click **OK**.
5. View the template in full size or normal view, and update as needed.
6. Click **OK** to save the document or medical note to the patient history.

TAKE HOME PRESCRIPTIONS

Technicians will need to have take-home prescriptions ready for pick-up. Because technicians see many patients in a day and are very busy, it helps to start from the Patient Clipboard* window so they can view the pet picture and ensure they have the right patient selected before filling prescriptions.

Use one of the following methods for filling prescriptions from the Patient Clipboard window:

Method A	Method B
<ol style="list-style-type: none"> 1. With the patient selected in the Patient Clipboard* window, right-click the patient and select Patient Visit List. 2. Review for any pharmacy items not yet performed. Performed pharmacy items are indicated with the Prescription button  as the source icon. 3. To create a label for existing items not yet completed, do one of the following: <ul style="list-style-type: none"> • Click Special to process prescription label special actions if linked to pharmacy items. • Click the Prescription button to open the Prescription Information window. 4. If a new medication is needed, add it directly to the Patient Visit List (PVL) by entering the item ID and quantity. If using special actions, the Prescription Information window will open automatically; otherwise, click the Prescription button. 5. Update prescription details. Your practice may be using the Cornerstone system to track inventory and your administrator may have configured the system for staff to enter all or part of these inventory details; if so, enter lot and/or expiration dates. 6. In the Prescribed by and Filled by boxes, enter the appropriate staff IDs. 7. Enter the prescription instructions, and then click OK. 	<ol style="list-style-type: none"> 1. Click the Patient Clipboard button  on the toolbar. 2. Enter or find your client. 3. Select the correct pet and click the Patient Information tab  so you can view the patient picture. 4. Right-click the patient and click Prescribe. The Prescription Information window opens. 5. In the Item ID box, enter the item. Then, in the Quantity box, enter the quantity to prescribe. Your practice may be using the Cornerstone system to track inventory and your administrator may have configured the system for staff to enter all or part of these inventory details; if so, enter lot and/or expiration dates. 6. In the Prescribed by and Filled by boxes, enter the appropriate staff IDs. 7. Enter the prescription instructions, and then click OK.

POST PROCEDURE UPDATES

The doctor should view remaining laboratory results and ensure the appropriate call backs are assigned to the technician.

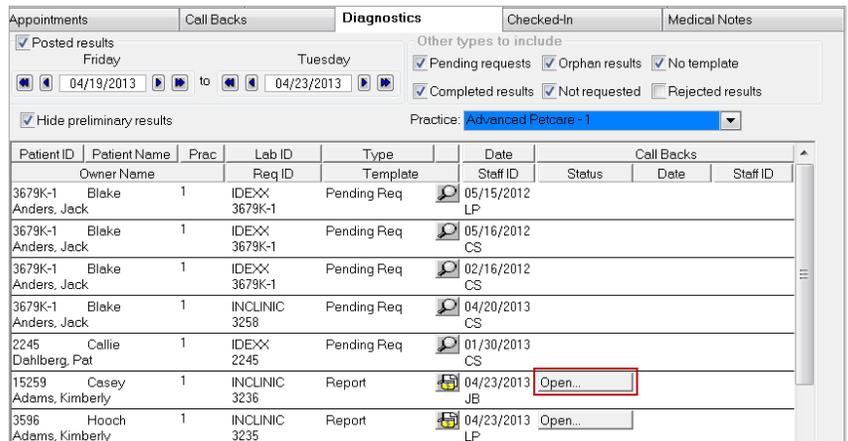
 Laboratory results and call backs can also be viewed from the Message Center (no doctor sort option is available) by clicking the **Message Center**  button on the toolbar.

1. Click the **Daily Planner** button  on the toolbar.
2. Enter the staff ID and press TAB. Optional: to view results for all staff, select the **View for all staff** check box.
3. Click the **Diagnostics** tab.
4. Enter the dates to view.
5. Select the check boxes for the types of results/requests to view from this tab. Options are: **Posted results**, **Pending requests**, **Completed results**, **Orphan results**, **Not requested**, **No template**, and **Rejected** results.

- View the results then close them.
- Click **Close**.

Update a Laboratory Call Back

- From the **Diagnostics** tab on the Daily Planner window, make the selections for staff, dates, and types as in the previous activity.
- In the **Status** column under the laboratory report for the patient, click **Open**.
- In the Note window, complete the information, add a note, and click **OK** to save the call back information.



PROCEDURE MEDICAL NOTES

Using the Daily Planner window, the doctor and technician can access the medical notes they started and/or completed.

- Click the **Daily Planner** button  on the toolbar.
- Enter the staff ID and press TAB to view your Daily Planner items or “to do” list.
- Double-click the tentative medical note that you want to complete and finalize.
- Enter any remaining information for the medical note.
 - tip** History (Hx) descriptions (e.g., dental w/2 extractions) appear on the Daily Planner window instead of the document template name (e.g., canine dental).
- Select **Final**.
- Click **OK** to close and finalize the medical note.
 - tip** To share discharge instructions or procedure notes with client electronically, email or share the finalized document.
- Click **Close**.



Chapter Summary

You learned these important concepts in this chapter:

- Create Documents and Procedure Medical Notes**—Start a medical note, and attach documents and update other important medical records that the medical team might need post procedure.
- Take Home Prescriptions**—Navigate to the Prescription window through the Patient Clipboard* window.
- Post Procedure Updates**—View remaining laboratory results and set up call backs.
- Complete Procedure Medical Notes**—Access a medical note from the Daily Planner to complete it.

Final Step—Check Out

You'll learn these important concepts in this chapter:

- **Invoicing**—Using the Invoice window, invoice the client, create a recheck appointment, and take a client payment.
- **Reminders**—After invoicing, review the reminders and appointments with the client.

INVOICING

When the patient is ready to go home, you'll want to understand or ensure the following:

- All charges are entered and have been verified by the medical team.
- All special actions have been performed.
 - 📄 Some special actions are set to process at a time other than when posting an invoice.
- The IDEXX Cornerstone* Practice Management System has updated the reminder information and the patient's medical file.
- Invoices with departing instructions are generated.
- Understand the unique options on the Invoice window.
- If tracking quantities on hand, Cornerstone will deplete or subtract inventory item quantities.
- Invoicing adds the invoice total to the practice's sales totals.
- Invoicing adds the invoice total to the client's account receivable balance and account history.

To create an invoice:

1. With the patient selected in the Patient Clipboard*, right-click the patient and select Patient Visit List.

Patient Visit List - Wally

Patient information
ID: 62 Wally
11 Yrs. 5 Mos. 55 Pounds
Shepherd, German Neutered Male

Owner information
Owner: Johnny Ahrens \$0.00
Credit code: Accept All Payments
Payment

Item ID	Description	Qty	Amount	Disc	Tax	Staff	Ctr	Date
H30	Hospitalization	1.00	\$30.00	No	No	LP	H	01/30/2013
LACSM	Laceration repair - Conservative	1.00	\$60.00	No	No	LP	H	01/30/2013
PSE	Pre-surgical Exam	1.00	\$75.00	No	No	LP	H	01/30/2013
A51	Anesthesia first procedure 51-80 lb	1.00	\$91.00	No	No	LP	H	01/30/2013
MORPHI	Morphine Injection	1.00	\$9.50	No	No	LP	H	01/30/2013
				No	No			
				No	No			
				No	No			

Include recommended
 Include accepted
 Include performed
 Display blue comment line

Total: 265.50
Discounts: 0.00
Taxes: 0.00
Total: 265.50

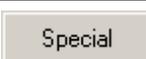
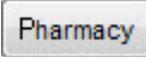
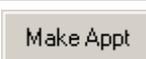
Buttons: OK, Cancel, Perform, Sort by Date, Departing, Pharmacy, Special, Travel Sheet, Print, Invoice (highlighted), Up/Down arrows.

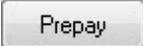
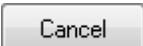
2. Use the scroll bar to view all of the items on the patient visit list
 - Look at the “include” check boxes to verify which items will be transferred to the invoice. Select or clear check boxes as appropriate.
 - Optional: Update the status of items by selecting a new status in the **Status** column. Right-click the item’s status to access the list then select the new status.
 - Change item details as appropriate.
 - Click **Invoice** to move the items from the Patient Visit List to the invoice.
 - If prompted with alerts, address them and click **OK**.
 - If prompted to enter notes for a call back reminder, enter or select a note and click **OK**.
3. If there are additional patients to invoice, you’ll see a special action for their patient visit list. Process the patient visit list action to open the Patient Visit List window. Items on this patient’s visit list will display (if there are any). Update the status of the items as needed and click **Transfer**.

<input checked="" type="checkbox"/> Include recommended
<input checked="" type="checkbox"/> Include accepted
<input checked="" type="checkbox"/> Include performed
<input checked="" type="checkbox"/> Display blue comment line

Invoice Window Buttons

Use the table below to learn the invoice screen button functions.

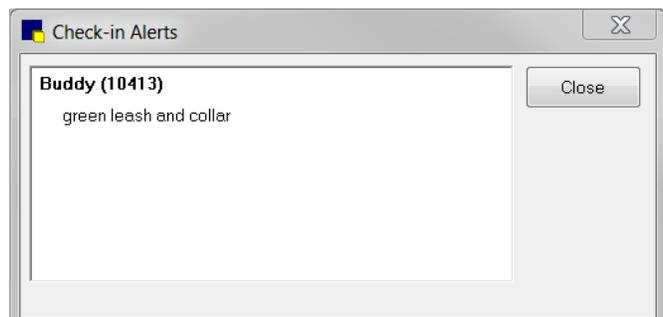
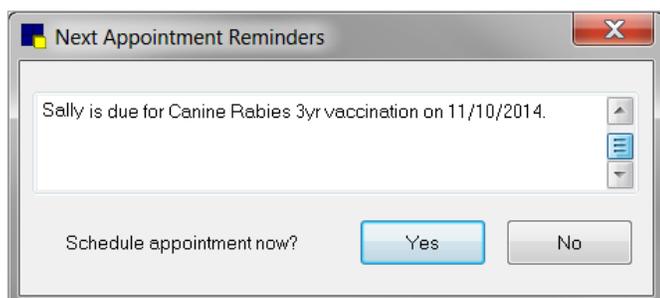
Bottom Buttons	Function
	If laboratory work has been added to the invoice and a laboratory request has not already been entered, or if you need to add additional laboratory tests onto a pending request, click Lab Work . For more information, please refer to the appropriate laboratory training guide (<i>IDEXX SmartLink InHouse Laboratory Training, IDEXX SmartLink Reference Laboratory Training, Canada East/West Reference Laboratory Training</i>).
	To create a prescription instruction for a prescription that is on this invoice, select the item ID code for this item and click Rx Label .
	If the Special button is enabled, it indicates the invoice includes invoice items with special actions to process.
	Click Departing to view the departing instructions that are linked to items on the invoice. You can add departing instructions to this list while you are invoicing. Press F2 or double-click to select from the Departing Instructions list. To modify a departing instruction, click the Note button and make appropriate changes. Instructions are modified for only that instance.
	If you have purchased the Veterinary Pharmacy Reference® (VPR), click Pharmacy to print Client Information Sheets and Drug Information Sheets.
	Click Make Appt to open the Appointment Scheduler, where you can search for an available appointment slot and schedule an appointment. Appointments scheduled during the invoicing process print on the client invoice.
	Click Travel Sheet to select invoice items from a travel sheet.
	Click Copy To to copy invoice items from one patient to another.
	Click Post to finalize the invoice and continue to the Payment window.
	Click Save to save invoices as open so you can make changes or add to the invoice. Items on saved invoices are not counted as revenue at the end of the day until the invoice is posted.

	<p>Click Prepay to apply a deposit to the invoice. This feature may be used with large animal, equine, or other situations where a client is making a payment prior to services being rendered (such as on an estimate for today's visit) or when a client does a large amount of business within a month and wants to be billed only monthly. An invoice can be opened at the beginning of the month (or at the first visit of the month), saved, added to during the month and either closed during end of month processing or posted before end of month processing is run.</p>
	<p>Click Discount to apply a manual discount to the entire invoice total.</p>
	<p>Click Print to print the invoice. You will be prompted to first save the invoice; the invoice must be saved before it will print. This feature is helpful if the client would like to see a copy of the invoice prior to paying.</p>
	<p>Click Void to void the invoice. Depending on your practice setup, this may be a management feature only, based on security setup.</p>
	<p>Click Cancel to cancel the invoice and send invoice items back to the Patient Visit List window (if generated from that window). If cancelled, any changes added since the invoice was last saved are canceled.</p>
	<p>Use the arrow buttons to reposition the items on an invoice.</p>

4. Enter additional invoice items for the patients as needed.
5. Perform other functions such as discounts, taxes, verify inventory details, process special actions, or make an appointment. The **Disc** and **Tax** columns indicate which items are automatically discounted or taxed for this client (based on taxes and discounts set up and applied).

Optional:

- a. At the bottom of the invoice, click **Make Appt.** The Appointment Scheduler window opens.
 - b. Click **Go To**, enter the date and make the appointment.
 - c. Click **OK** to save the appointment information.
 - d. **Close** the Appointment Scheduler window.
6. Click **Post**. Address any special actions or open patient visit lists for other patients.
 7. Accept or modify the invoice information, and click **OK**. The Payment window opens.
 8. If your practice uses the cashier password feature, enter your cashier password and press TAB.
 9. Enter the payment amount, using a decimal point for uneven dollar amounts, and press TAB.
OR
Right-click in the amount field and select **Invoice Balance** or **Client Balance** to have the amount fill in automatically. This helps to reduce entry errors.
 10. From the **Payment Type** list, select the payment type, If required, answer the payment type prompt.
 11. Press TAB to the **Change given** field and verify the **Balance after payments** amount.
 12. Click **Post**. Based on your practice settings, the Next Appointment Reminders window opens; click **Yes** to schedule an appointment or **No** to close the window. Address any check-in alerts and click **Close**.





Peak Time Invoicing Shortcut

1. Click the **Daily Planner** button  on the toolbar.
2. Select the **View for all staff** check box and click the **Patient Visit List** tab.
3. Click **Patient Name** or **Client Name** to sort the list by patient or client information. Then, double-click any line to open the Patient Visit List window for that patient.
4. Review items, and add or update items as needed.
5. Click **Invoice**, and then post and accept payment as usual.
6. After the invoice is posted, you are returned to the **Patient Visit List** tab on the Daily Planner window. Now you are ready to invoice the next client.

Notes

- When invoicing cash clients, remember that you can't track the history. If there is a possibility that the person will return, set up an account so there will be history.
- If a client has more than 20 pets, double-click in the **Patient ID** field to search for the patient.
- When using a miscellaneous code, the description you type in the invoice will appear in the patient's history. However, in reports listing the code, the description will remain "miscellaneous."

REMINDERS

At the end of a patient's visit, after invoicing, review the patient's reminders with the client to confirm time lines and expectations. Access them from the **Reminders** tab on the Patient Clipboard* window.

Review Reminders

1. Check to see if there are reminders that need to be created or deleted.
 - Does the client want to be reminded to purchase more food in a few weeks?
 - Are there future preventive care or other services or laboratory tests that need a reminder?
 - Are there reminders that need their dates changed?
2. Does the client want a printed copy of their reminders?

Patient information					
Item ID	Description	Type	Date	Staff	
DRQA	Corona Annual Vaccination	Letter	4/3/2012	LP	
A	Fecal float exam-Recheck	Letter	4/3/2012	LP	
WT	Heartworm test (antigen)	Letter	4/3/2012	LP	
HPPA	DHPP Annual Vaccination	Letter	4/3/2012	LP	
11	Canine Rabies 1 yr vaccination	Letter	4/3/2012	LP	
AP4	Snap4DX (HW/E. Canis/Anap./Lyme)	Letter	4/3/2012	LP	
DRD6	Bordetella Adult - every 6 months	Letter	4/3/2012	LP	
67	Annual Baseline Exam	Letter	4/3/2012	LP	

Review Appointments



[View a snippet online demonstration](#)

What appointments need to be set for upcoming dates?

- Laboratory work
- Rechecks and follow ups
- Suture removal
- Preventive care visits
- Future services
- Ongoing therapy services (remember to use the copy/paste feature)

Date	Time	I/O	Reason	Room
05/16/2011	09:00 AM		Lab Work	Dr. Schulze

To review appointments and reminders:

1. With the patient selected in the Patient Clipboard* window, click the **Reminders** tab .
2. Right-click in the work area and select **Update** to view the reminders.
 - To add a reminder, click the **Item ID** field in the next blank line and add the reminder information. Ensure you select the correct reminder type tab (**Letter** or **Call Back**) when manually adding reminders.
 - To delete a reminder, select the **Item ID** field and press CTRL + D.
 - To change a reminder date, select the **Item ID** and click **Change Date**; then change the date information.
 - To print reminders, click **Print** and then select one of the following options to print the Reminder Letter Report:
 - **Client All Patients > Reminder Letter Report**—Prints the report for all clients.
 - **Selected Patient Only > Reminder Letter Report**—Prints the report for the selected patient.
 - To print a linked customized vaccine certificate, select **Print > Health Certificate**.
 -  To link a vaccination certificate to the practice, go to **Controls > Defaults > Practice and Workstation > Practice**, and then double-click or press F2 in the Health Certificate Document box to select a certificate.
 - Click **OK** to save the reminders.
3. With the patient selected, click the **Appointments** tab .
4. View and confirm the patient's appointments.
5. Close the Patient Clipboard window.



To close all open windows, from the menu, select **Window > Close All** OR press ALT + W + A.

Checking out Patients Using the Census List

1. Press F3 to access the Census List.
2. Select the client.
3. Click **Check-out**.
4. Click **Yes** to confirm the check out.
5. Click **OK**.

Update an Open or Pending Call Back

1. Click the **Daily Planner** button on the toolbar , and then click the **Call Backs** tab.
2. Right-click the patient and select **Update**. The Patient Reminders window opens.
3. In the **Note** column for the patient, click the **Open** button. The Note for (item) opens.
4. In the **Staff ID** box, enter ID of the staff member who is making the call.
5. Depending on the result of your call, from the **Status** list, select **Open**, **Pending**, or **Completed**.
6. Type a note in the text entry area, or click **Select Note** to choose the note from a list and modify as needed.
7. Click **OK**.

Chapter Summary

You learned these important concepts in this chapter:

- **Invoicing**—Using the Invoice window, invoice the client, create a recheck appointment, and take a client payment.
- **Reminders**—After invoicing, review the reminders and appointments with the client.

Appendix

More About Vital Signs

The Vital Signs window includes the following fields and options:

Field/Option	Description
Hide voided records	When selected, voided vital signs sets (columns) do not display on the Vital Signs window.
Vital Signs column <i>(static left column)</i>	Displays weight and all other vital signs activated in Vital Signs setup.
Create new Vital Signs set column <i>(right column)</i>	Allows you to add a new set of vital signs for a patient.
Inactive (I) vital sign	Inactive vital signs are listed on the Vital Signs window only if that patient has historic values for that vital sign. Inactive vital signs are marked with an “(I)” after the name.
“?” link	For Alphanumeric List and Numeric List vital signs, click this link to view the list values and their extended descriptions, if any.
Graph button	For Numeric and Numeric List vital signs, click this button to view the patient data in a graph and print the graph.
Comments icon	Displays when a comment is associated with the entry. Point to the icon to view the comment text.
Red abnormal indicator	Abnormal vital sign entries—those marked as High (H), Low (L), or Abnormal (A)—display in bold red text.
Refresh button	After edits or updates have been made and saved for a patient (at this workstation or elsewhere in the practice), click this button to ensure you are viewing the most recent data for the patient.

The **Create new Vital Signs set** column includes the following fields and options:

Field/Option	Description
Date/Time/Staff ID cell	This cell expands automatically when any other Create new... vital sign entry cell is selected. The Date/Time/Staff ID fields are required for each set of vital signs. Note that you cannot enter a date/time that is in the future or greater than 10 days old.
Text entry box or selection list	Depending on the vital sign type (Alphanumeric, Numeric List, etc.), the data entry/selection field may appear as a text box or a list.
“?” link	For Alphanumeric List and Numeric List vital signs, click this link to view the list values and their extended descriptions, if any.
Normal list	If the vital sign value is abnormal for this patient, alert staff by selecting High , Low , or Abnormal from the drop-down list. A selection other than Normal will cause the value to display in bold red, along with an H, L, or A designation.
Enter comment	Type vital sign comments in the text box as needed (limited to 30 characters). The icon displays for an entry if a comment is associated with it.
None for species	This text appears in a cell if the species has not been associated with a list for that vital sign. (To add the species to a list: Select Lists > Vital Signs/Weight , select the vital sign and click Update , select a list, and then select the applicable species to associate it with the list.)

Electronic Whiteboard Setup and Usage

Quick Reference Guide

Electronic Whiteboard Setup

The setup portion of this document provides best practice setup tips that help you:

- Customize Alerts
- Customize Areas
- Add New Categories
- Add New Frequencies
- Add New Patient Hospital Statuses
- Customize Wards/Locations
- Create Secondary Reasons for Visit
- Create Electronic Whiteboard Invoice Items

Customize Alerts

Use Electronic Whiteboard alerts to ensure your staff is aware of important information regarding your patients. Patient prompts and patient classifications can be set as Whiteboard alerts. You can also create or manually add Whiteboard alerts on the fly.

- Review patient user-defined prompts and set appropriate prompts as alerts. Prompt color can be also be modified and will show on the Whiteboard.
- Review patient classifications and set appropriate classifications as alerts.
- Create Whiteboard alerts.

Examples:

- DNR
- NPO
- Isolation Protocol
- Nurse's Name

Customize Areas

Areas can be used as a secondary function of wards/locations as below. The Electronic Whiteboard can be filtered by area. An area can be assigned to each line item on the Patient Orders window (optional).

- Use as service/treatment types to quickly view the Whiteboard for specific task lists.

Examples:

- Labs
- Rads
- Exams

- Use as staff responsibility list to quickly view tasks by staff:

Examples:

- Doctor
- Technician

- Use as a location or department in hospital.

Examples:

- Treatment
- Isolation
- Boarding

Add New Categories

The Electronic Whiteboard comes with categories already set up. Common categories we have seen added are:

- Bathing
- Grooming
- Fluids

Add New Frequencies

The Electronic Whiteboard comes with frequencies already set up. Frequencies can be set to recur every day or every x number of days. After working with our clients, we've discovered there are some frequencies that could be added to enhance the functionality:

Frequency	Example Treatment
<input type="checkbox"/> SID PM	Medications, feeding, etc.
<input type="checkbox"/> Every 2 hours (even)	Diagnostic testing to be completed starting on even hours
<input type="checkbox"/> Every 2 hours (odd)	Diagnostic testing to be completed starting on odd hours
<input type="checkbox"/> Hourly	Monitoring critical patient and able to receive overdue notices if a treatment is missed.
<input type="checkbox"/> Every 2 days	Medication every other day

It has also been useful to include the times in the frequency description (e.g., SID 8a, BID 7a, 5p)

Add New Patient Hospital Statuses

To alert staff of the status of hospitalized patients, consider creating new patient hospital statuses to meet your needs. The patient hospital status can be updated throughout the patient's stay in your practice.

-  Additional statuses will be treated as "ready to go home" if the following keywords are included in the description: home, ready, discharge, release, or pick.

Examples:

- In Surgery or Under Anesthesia
- Patient Care Level for Emergency Cases
- Boarding
- Boarding/Meds
- In Recovery or Anesthetic Recovery
- Doctor to Discharge
- Needs Discharge Appointment
- Discharge Appointment Made

Customize Wards/Locations

Wards/locations are used to notify staff where the patient is located in your practice, to filter the main Whiteboard view and to filter Whiteboard reports. Wards/locations can be updated throughout the patient's stay if necessary. There are two ways wards are generally used.

- Specific Areas of Practice**—For practices with more than one treatment area or who need to know exactly at which location the patient is staying, specific wards/locations can be created.

Examples:

- ICU
- Treatment
- Isolation
- Boarding

- Departments**—General wards are created when practices do not want to specify areas (ICU, isolation, treatment, etc.) of the practice where the patient will stay. These practices want to use the wards/locations to determine if the patient is a hospitalized or boarding patient.

Examples:

- Boarding Hospital

Create Secondary Reasons for Visit

To avoid staff having to select from a long list of secondary reasons, you may want to set up the predefined list with only the most common secondary reasons and instruct staff to type other secondary reasons as needed.

Examples:

- Hit by Car Barium Series
 TPLO Glucose Curve

Create Electronic Whiteboard Invoice Items

- Create Electronic Whiteboard invoice item classification.
 Create Electronic Whiteboard invoice items. (Refer to your current paper treatment sheet.)

Examples:

- | | |
|--|--|
| <input type="checkbox"/> Walk | <input type="checkbox"/> Check for Vomiting and Diarrhea |
| <input type="checkbox"/> Feed (Hospitalized Patient) | <input type="checkbox"/> Take Radiograph |
| <input type="checkbox"/> Water | <input type="checkbox"/> Check Incision |
| <input type="checkbox"/> TPR Monitoring | <input type="checkbox"/> Call Owner—Status Update |
| <input type="checkbox"/> Monitor Appetite and Drinking | <input type="checkbox"/> Blood Draw |
| <input type="checkbox"/> Monitor Fluids/Check Catheter | <input type="checkbox"/> Remove Catheter |
| <input type="checkbox"/> Check Bandage | <input type="checkbox"/> Administer Medication |

- Assign pricing, if applicable; there does not need to be a price associated with these items unless they are billable.

 Nonbillable treatments show on the Whiteboard and not on the invoice.

- Set patient order defaults for Electronic Whiteboard invoice items.

 Patient order defaults can be set by modifying a specific item through **Lists > Invoice Item > Whiteboard** tab or multiple items through **Tools > Invoice Item Setup**.

- Create Whiteboard travel sheet, if applicable.

- Create Whiteboard smart groups, if applicable.

Examples:

- Admit Patient Orders Inpatient Care

Electronic Whiteboard Usage

The usage portion of this document provides best practice usage tips for:

- Diagnostic Test Requests (IDEXX SmartLink* In-house Laboratory and IDEXX SmartLink*Digital Imaging)
- Patient Orders Tips—Blue Line
- Prescriptions
- Items with Special Pricing
- Patient Order Treatment Schedule

Diagnostic Test Requests

Decisions will need to be made for handling diagnostic requests with the use of the Whiteboard. Ask yourself the following question:

Do I want to use the Electronic Whiteboard to see if the diagnostic test has been completed?



Prerequisite: Invoice items must have appropriate diagnostic request special actions attached.

<p>Yes</p>	<ol style="list-style-type: none"> 1. Finalize estimates and select Continue on the Special Action window. 2. Enter patient orders. 3. Transfer diagnostic items(s) from the Whiteboard Patient Visit List (PVL) to the patient orders. 4. Complete patient treatments. 5. Click Process on the Special Action window to send the diagnostic request to the IDEXX VetLab* Station, Imaging Dashboard window, or to generate the IDEXX LabREXX* test request form and show the diagnostic request as completed. <p>- OR -</p> <ol style="list-style-type: none"> 1. Finalize estimates and click Process on the Special Action window to send the diagnostic request to the IDEXX VetLab Station, Imaging Dashboard, or to generate the IDEXX LabREXX test request form. 2. Enter nonbillable patient orders for diagnostic request. 3. Use the blue line to note which tests will be run, how much blood to draw, radiograph position, etc. 4. Complete patient treatments.
<p>No</p>	<ol style="list-style-type: none"> 1. Finalize estimates and click Process on the Special Action window to send the diagnostic request to the IDEXX VetLab Station, Imaging Dashboard, or to generate the IDEXX LabREXX test request form. 2. The charge will be found on the Patient Visit List and will not need to be transferred to the Whiteboard.

Patient Orders Tips—Blue Line

Use the blue lines to communicate treatment details to your staff that are not included in the invoice item description. The information entered on the Patient Orders blue line will be saved to the patient's electronic medical record when your staff completes the treatment.

Invoice Item	Example Blue Line Note
<input type="checkbox"/> Fluid Administration	Fluid Rate: 60 mL/hr for 2 hours
<input type="checkbox"/> Eye or Ear Medications (e.g., Ointment)	Right eye, left eye, both eyes
<input type="checkbox"/> Boarding—Admin Meds	Amoxicillin 100 mg; 2 tabs BID
<input type="checkbox"/> Boarding—Special Diet	Owner brought treats—treat BID
<input type="checkbox"/> Radiograph Initial View	VD, Lat Abdomen, Qty: 2

Prescriptions

There are two ways to handle items with dispensing fees on the Whiteboard. Ask yourself these questions:

Do you dose from a prescribed bottle?

1. Create a prescription label for the medication from the Patient Clipboard* or Patient Visit List **OR** enter the medication in the Patient Orders window to be completed one time. This will bill the medication and create the prescription label (if the prescription label special action is being used) when your staff completes the treatment.
2. Attach the prescription label special action on the invoice item's **Special Actions** tab.
3. Enter an order for a nonbillable service to give the medication with a note on the blue line to denote how much medication. Set the frequency to how often the medication should be given.

Do you dose medication as needed from a common vial?

Enter the medication in the Patient Orders window to be administered with the appropriate frequency. Dispensing items should also be created and attached to the appropriate inventory items to ensure your full dispensing fee will not be charged each time you administer the medication. Dispensing items allow the staff a choice on the dispensing fee that will be added to the medication price.

Dispensing Item Examples:

- Meds To Go Home Meds Admin In Hospital

Dispensing items are created in the invoice item list.

Items with Special Pricing

When transferred from PVL to Whiteboard, items with special pricing will revert to original price upon completion from Whiteboard. This includes:

- Estimate Markup %
- Manually changed prices on estimate/PVL
- Smart groups with markdown/markup

Suggestions until future release:

- Consider removing estimate markup % from invoice items
- Leave “special price” items on PVL and add as nonbillable items on the Patient Orders window
- Groups must be moved and completed as an entity for special pricing to remain intact (including group header line)
- Alternately, adjust groups to not use markdown/markup feature
- Always check/update final PVL pricing before posting to invoice (compare to finalized estimate)

Patient Order Treatment Schedule

Vital Signs

- Used to bring up the Vital Signs window when item completed on Patient Treatments window
- Use blue line to detail specific vitals to be recorded

PRN

- Used in addition to frequency
- For treatments to be performed only “as needed”
- Treatments will not list as overdue

Dose Now

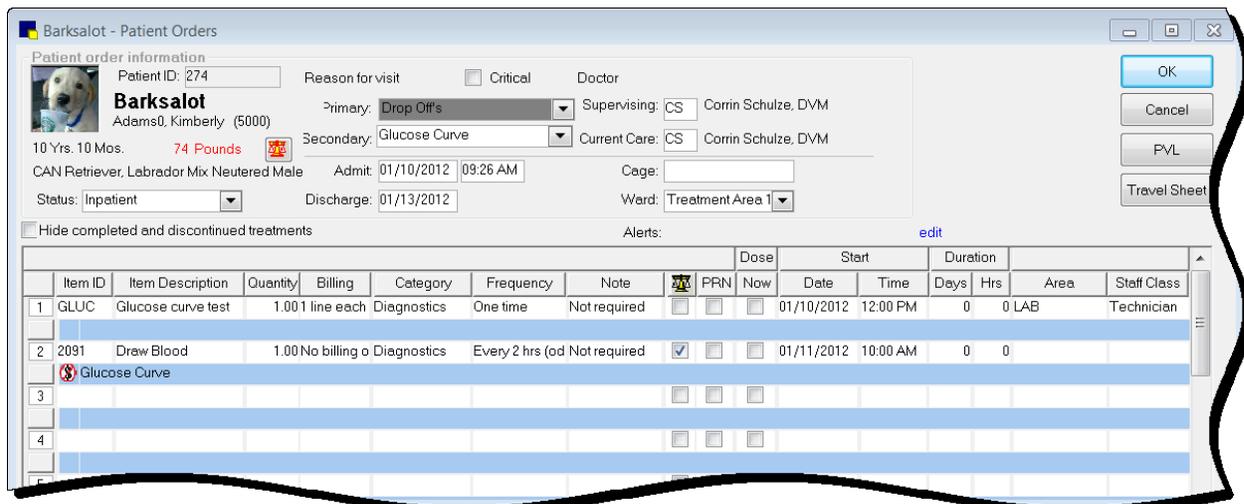
- Used in addition to frequency
- For treatments to be performed now, then follow regularly scheduled frequency

Start Date/Times

- Used in addition to frequency
- Can set specific dates/start times for each treatment in hour and minute increments

Duration

- Used in addition to frequency
- Can set specific duration in days/hours for treatments
- Often used in conjunction with the “continuous” frequency

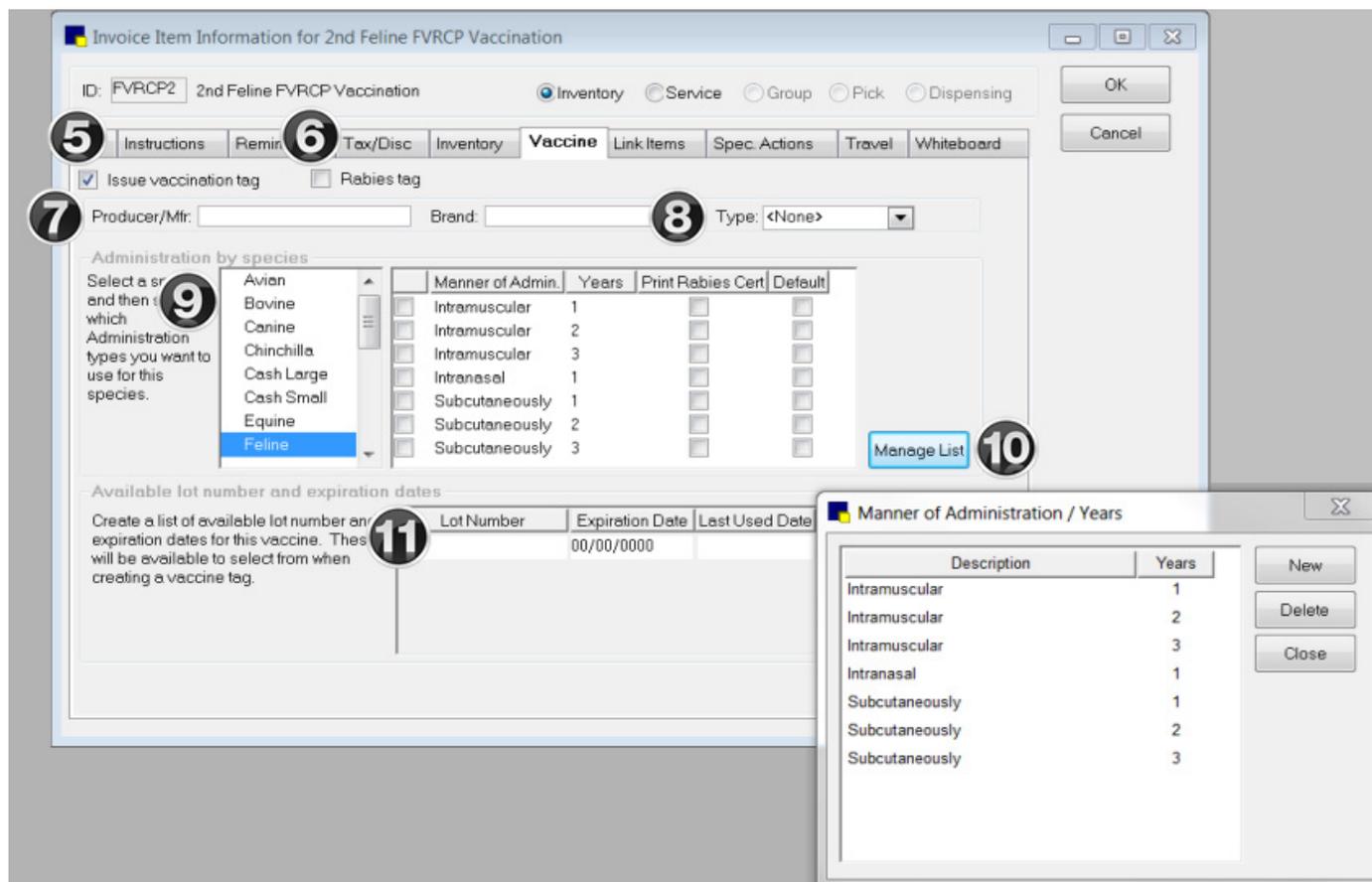


Setting up Vaccine Information

This lesson provides information needed to complete the **Vaccine** tab on the Invoice Item Information window.

Vaccines should be set up as a service item linked to an inventory tracking item. Vaccine information is set up on the inventory item, and the special action is associated with the service item.

The numbers on the image below correspond to the steps in the inventory item procedure.



- On the menu bar, select **Lists > Invoice Item**.
- In the **Description** box, type characters for the item you are searching for.
- Select the invoice item you are going to work with and click **Update**.
- Click the **Vaccine** tab.
- Select the **Issue vaccination tag** check box to enable the vaccine tag settings.
 - The **Issue vaccination tag** and **Rabies tag** check boxes will be selected automatically if the Vaccine Tag special action has been set up for the inventory item.
- If this is a rabies vaccine (vs. a non-rabies large animal vaccine), select the **Rabies tag** check box. This flags the item as a rabies vaccine to be added to the Rabies Tag Report, which is available for those practices required to submit rabies tag information to a state agency. Selecting this check box will also display the **Print certificate** check box on the Vaccine Tag window.
- In the **Producer/Mfr.** and **Brand** boxes, type the product and manufacturer information for this vaccine so staff will not need to complete this information manually when generating a vaccine tag at invoice time.

8. In the **Type** list, select the applicable vaccine type (**Killed**, **MLV**, etc.)
9. In the **Administration by species** area, do the following:
 - a. In the list on the left, select the species for which you want to set up rabies/vaccine tag defaults.
 - b. In the adjacent check box selection area on the right, select all possible manner of administration/years combinations that apply to this vaccine and species by selecting the applicable check box in the far left column. All combinations selected here will be available for selection from drop-down lists on the Vaccine Tag window.
 - c. If you want the **Print certificate** check box to be selected by default on the Vaccine Tag window at invoice time for a selected manner of administration/years combination, select the **Print Rabies Cert.** check box next to the applicable combination.
 - d. If you want to designate a particular manner of administration/years combination as the default for this species, select the **Default** check box next to the applicable combination. This default combination will automatically populate the **Manner of administration** and **Number of years** fields on the Vaccine Tag window at invoice time (although you can select different settings from the drop-down lists, if necessary).
10. To add or delete manner of administration/years combinations, click **Manage List**. The Manner of Administration/ Years window opens with all existing combinations listed.
 - a. To add a new combination, click **New**, select the appropriate **Manner of Admin.** and **Years** settings, and click **OK**.
 -  For the **Years** setting, if the number of years can vary, you can set the years to **Ask**, which will require staff to input the years manually on the Vaccine Tag window at invoice time.
 - b. To remove a combination, select the combination in the list and click **Delete**. When you are prompted to confirm the deletion, click **Yes**.
 - c. When you are finished, click **Close**. Any Manner of Administration/Years combinations you added or deleted will be reflected in the list available on the Vaccine tab.
11. In the **Available lot number and expiration dates** area, create a list of valid lot numbers and expiration dates for this vaccine. This information will be available for selection from the **Lot number** and **Drug expires** fields on the Vaccine Tag window.
 -  The Lot Number/Expiration Date settings are not available if lot numbers and expiration dates are tracked through Cornerstone inventory and controlled by consumption.
12. Click **OK** to save your changes, or click another tab to add more information for the item.
 -  Once the inventory item is set up with vaccine information, link to the appropriate service item. For the service item, on the **Spec. Actions** tab, select the **Vaccine Tag** special action, and select **Immediately on invoice/PVL** from the **When to apply** list.

IDEXX Cornerstone In-House Laboratory Work Flow

Step 1 Create new laboratory request.

General Form
For Laboratory Use Only

Clinic Information
Advanced Petcare
12345 Advanced Ave. Advanced City, MA 01415
Voice: (123) 456-7890
Fax:
clinicEmail
Account # 263175

Patient Information
Please fax duplicate results to:
Fax#1
Fax#2
Patient ID 36796-1
Owner Last Name Acorns
Patient Name Blake
Sex Female Intact
Species Canine
DOB 10/10/2011
Age
Breed Pitg
Staff

TEST CODE DESCRIPTION
300 CBC, Comprehensive

SPECIMEN REQUIREMENTS
1 mL LTT, two blood smears

Step 2 Print label and collect sample(s).



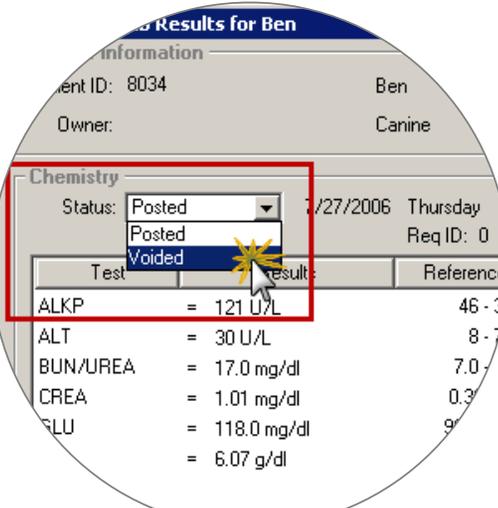
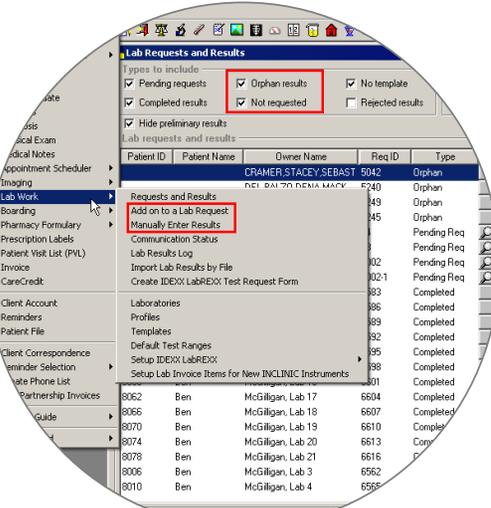
Step 3 Run the test using the IDEXX VetLab* Station.



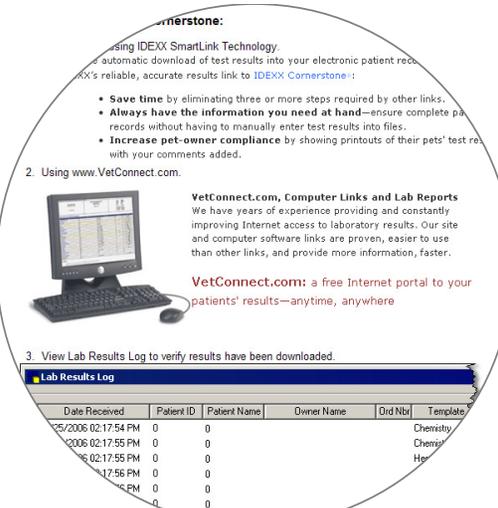
Other Tasks

Create a new profile, manually enter results, add onto a lab request, resolve orphan or not requested results, and/or reprint forms or labels.

Step 5 View results.

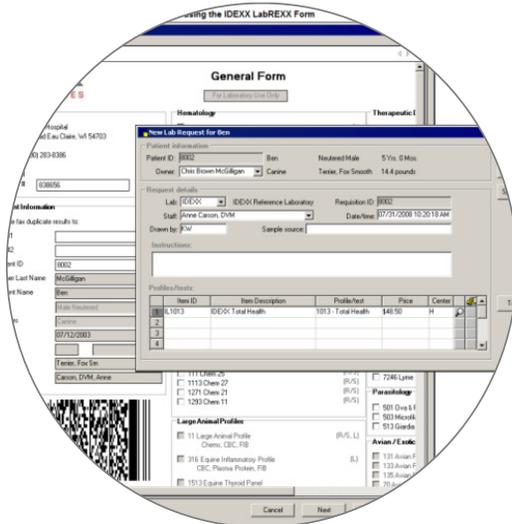


Step 4 Automatically download results.

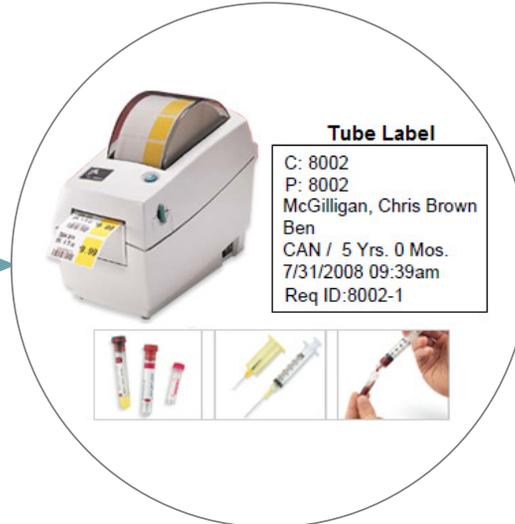


IDEXX Cornerstone Reference Laboratory Work Flow

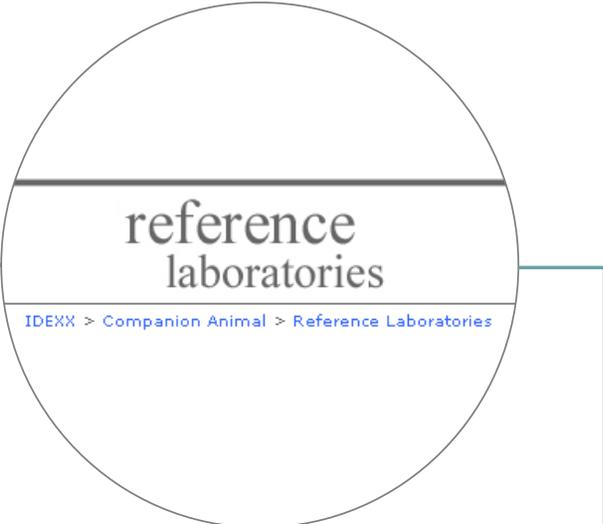
Step 1 Create new laboratory request.



Step 2 Print label and collect sample(s).

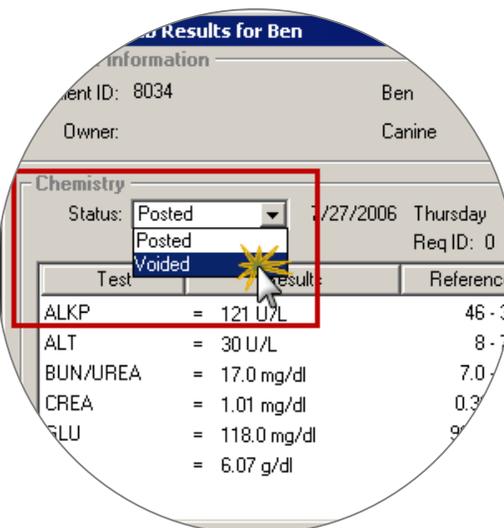
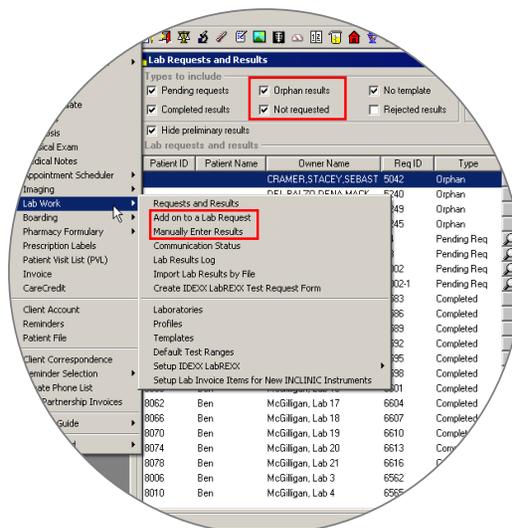


Step 3 Send sample(s) to IDEXX Reference Laboratories for analysis.

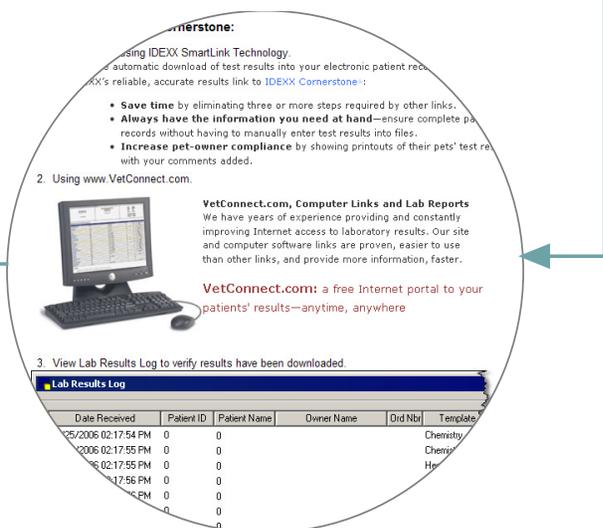


Other Tasks Create a new profile, manually enter results, add onto a lab request, resolve orphan or not requested results, and/or reprint forms or labels.

Step 5 View results.

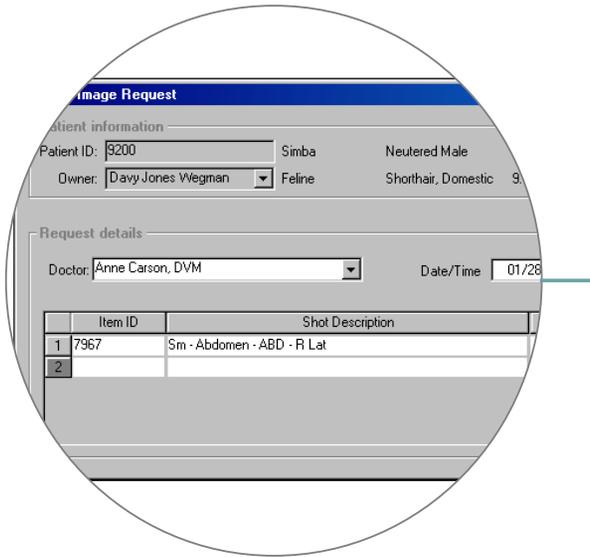


Step 4 Automatically download results.



IDEXX Cornerstone Imaging Work Flow

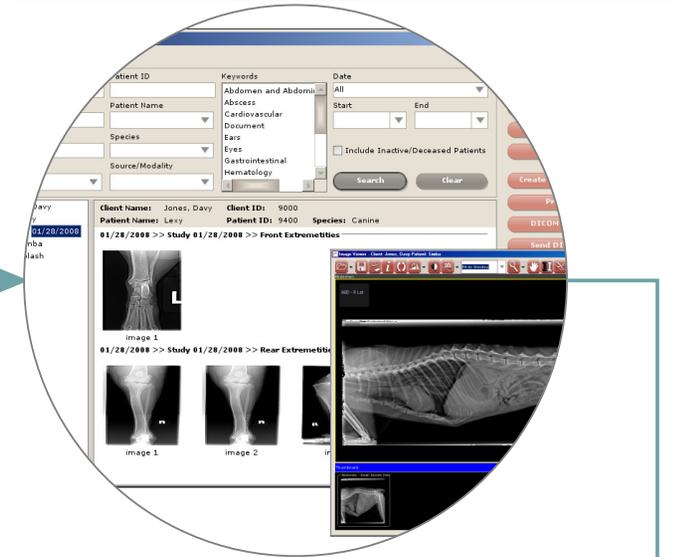
Step 1 Create new image request.



Step 2 Capture images.

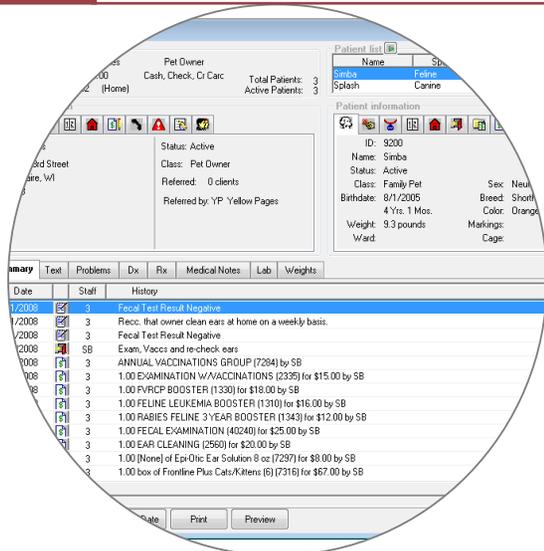


Step 3 View images from the Image Viewer.



Other Tasks

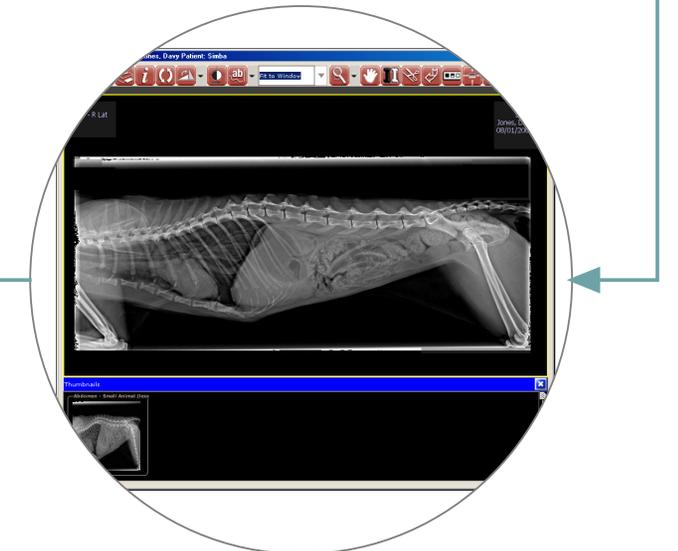
View images in patient history, review image status, charge for not requested images, cancel an image request, change pricing during invoicing.



Step 5 Send images to telemedicine.



Step 4 Enhance images.



Skill Assessment and Evaluation

Electronic Medical Records and Whiteboard Usage Skill Assessment

Practice Name: _____

Your Name: _____

Completion Date: _____

Instructions: After completing your training, please read each of the following skill assessment statements and evaluate your ability to perform each task. Mark only one X for each skill statement.

	Can Perform	Can Perform but NOT Using	Cannot Perform	Not Applicable
1. I can create a new appointment.				
2. I can check-in a patient.				
3. I can access the Census List.				
4. I can access the Appointment tab of the Daily Planner.				
5. I can enter a patient's vital signs.				
6. I can access the Patient Visit List.				
7. I can create a vaccinations and rabies certificate.				
8. I can access the Diagnostics tab of the Daily Planner.				
9. I can create an estimate.				
10. I can process a payment / deposit.				
11. I can change a patient's checked-in status from outpatient to hospitalized.				
12. I can access the Electronic Whiteboard.				
13. I can create patient orders.				
14. I can move orders from the Whiteboard—Patient Visit List to the Patient Orders window.				
15. I can mark patient treatments as complete.				
16. I can update correspondence documents.				
17. I can create a take home prescription.				
18. I can invoice a patient.				
19. I can update patient reminders.				

Results of the Skill Assessment

_____ Can Perform

_____ Can Perform but not Using

_____ Cannot Perform

_____ Not Applicable

Please return this Skill Assessment using one of the following methods:

Return this information to:

Cornerstone Education Department at CornerstoneCoach@idexx.com.

Mail this information to:

IDEXX Laboratories

Attn: Cornerstone Education Department/Gina Toman

One IDEXX Drive

Westbrook, Maine 04092

Electronic Medical Records and Whiteboard Usage Evaluation

We value your opinion! - Tell us what you think about the Electronic Medical Records and Whiteboard Usage course.

Practice: _____

Date: _____

Trainer: _____

Feedback received from you regarding the training is vital to our continued improvement.

Course Description

Following proper setup completion, key project leaders who are moving their practice towards becoming chartless or trying to improve their efficiencies, will learn how to use Cornerstone's powerful medical record capabilities within their real data files. Topics include:

- Overview and Strategy
- Check-In
- Patient Visit Documentation
- Estimates
- Patient Visit List
- Using the Whiteboard
- Invoicing and Payments
- Daily Planner

1. How likely would you be to recommend an IDEXX Cornerstone course to a friend or colleague?

1 Not Likely.....										Likely 10
1	2	3	4	5	6	7	8	9	10	
<input type="radio"/>										

2. For us to better understand the opinions of our participants, please explain why you selected the rating above?

3. The prerequisites for this course are:

- The most current version of Cornerstone installed at practice.
- Basic Cornerstone navigation.
- Access to set up Cornerstone features, which means security for electronic medical record setup.
- Basic Cornerstone setup knowledge: invoice items, departing instructions, and prescription instructions.

Indicate which participants were ready for and met the prerequisites for this course.

Please select all that apply.

- Our practice All other practices Some other practices

Electronic Medical Records and Whiteboard Usage Evaluation

4. How was the length of the course?

- Too short
 Too long
 Just right

Additional Comments:

5. Referring to the items listed below, did we meet your expectations:

	No										Yes
	1	2	3	4	5	6	7	8	9	10	N/A
The course content matched the course description.	<input type="radio"/>										
The course materials were professional looking.	<input type="radio"/>										
The course materials provided contained valuable content.	<input type="radio"/>										
The trainer arrived well prepared & Used appropriate examples.	<input type="radio"/>										
The trainer used effective communication skills.	<input type="radio"/>										
The trainer answered all of my questions effectively.	<input type="radio"/>										
As a result of this course we can expand our use of Cornerstone's features.	<input type="radio"/>										
This course provided a good value for the cost.	<input type="radio"/>										

Additional Comments:

6. Did you follow along with the participant workbook during the course presentation?

- Yes** - I followed the participant workbook the majority of the time.
 No - I didn't use the participant workbook.
 Sometimes - I used the participant workbook some, but not most, of the time.

If **No** or **Sometimes**, why not?

Electronic Medical Records and Whiteboard Usage Evaluation

8. What was the most valuable aspect of this course?

9. What suggestions do you have for future revisions of this course?

10. Using the roles listed, count and record how many participants (from your practice) attended some, or all, of this course. If someone holds more than one of these roles, record their primary role only.

Primary Roles	Number of participants with this primary role that attended this course
Veterinarian	
Technician or Nurse	
Reception or Client Services	
Office, Practice or Business Manager	
Practice Owner	
Other (List role and record Number)	
Other (List role and record Number)	

Thank you! We appreciate your feedback.

Testimonial Permission:

(Please check the box below)

Please have an IDEXX Computer Systems Representative contact me to discuss featuring my comments in promotional materials.

Please Print:

Your Name: _____

Practice Name: _____

Practice City, State: _____

Practice Telephone #: _____

Reminder: Please return this Evaluation using one of the following methods:

Return this information to:

Cornerstone Education Department at CornerstoneCoach@idexx.com.

Mail this information to:

IDEXX Laboratories
Attn: Cornerstone Education Department/Gina Toman
One IDEXX Drive
Westbrook, Maine 04092

