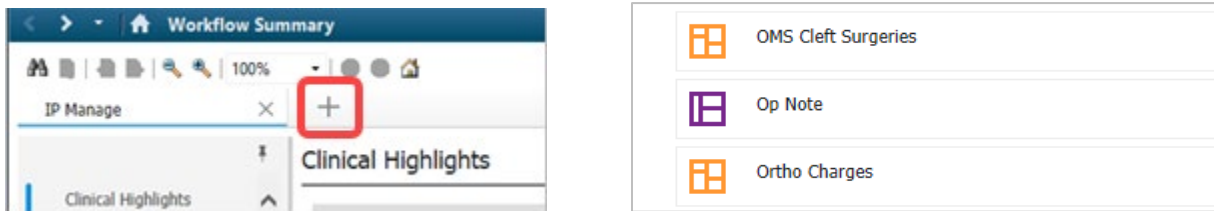


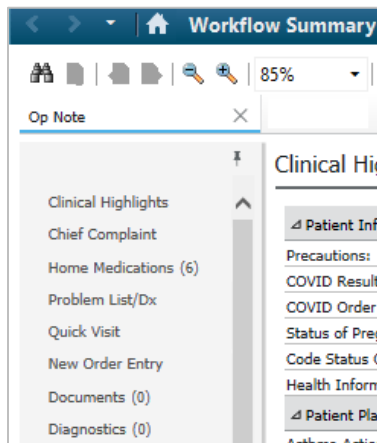
## Op Note Workflow Summary Setup

The Operative Procedure Report is a post-surgery requirement. If this note is not completed after the surgery or is dictated, an Immediate Post Op Note or brief note needs to be completed before the patient transfer of care. The link to this note can be found below the Operative Procedure Report note link on the Workflow Summary.

1. Click + and select **Op Note** to add the Workflow Summary.

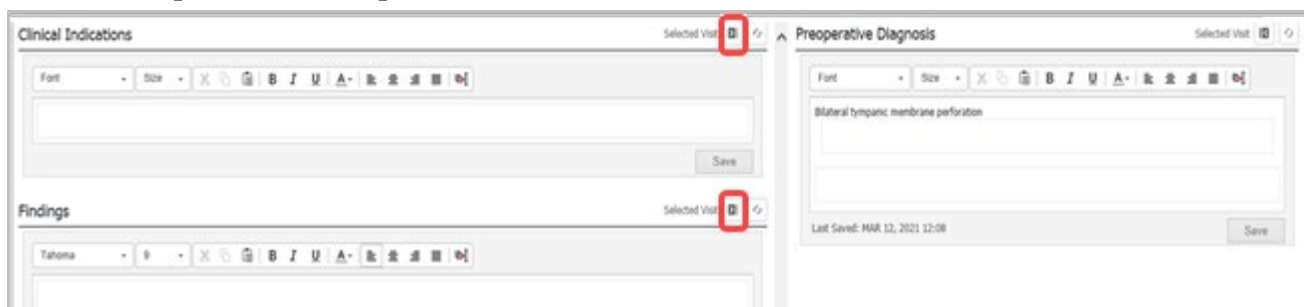


2. The **Op Note Workflow Summary** facilitates chart review and note creation. Rearrange the chart review components by dragging and dropping them into a preferred order. See suggested menu order below.



3. The **Op Note Workflow** offers a split screen view. To create the split screen, click the grey right arrow on the following scratchpads:

- Preoperative Diagnosis
- Indications (optional)
- Findings
- Description of Procedure
- Postoperative Plan (optional)



**Op Note Documentation Workflow**

1. Use the **Problem List/DX** component to view and manage multiple problems/diagnoses.
  1. Add a new problem/diagnosis by entering the diagnosis name into the search field. Select the appropriate diagnosis name to add it to the problem list.
  2. Each clinician can create their own priority list by adjusting the priority of the diagnoses. The prioritized problems will flow into the **Operative/Procedure Report**.
  3. Click the action buttons to check/uncheck the type of problem
    - **This Visit:** The diagnosis is relevant for this visit only
    - **Chronic:** An ongoing problem that is not managed during this visit. Click **Resolve** if no longer active.
    - **This Visit and Chronic:** The diagnosis for this visit and an ongoing problem managed at this visit.
  4. Click the down arrow on **Medical and Patient State** and select **All** to view confidential problems (optional).

The screenshot shows the 'Problem List/Dx' interface. At the top, there is a 'Classification' dropdown set to 'Medical an' (callout 4), an 'Add as' dropdown set to 'This Visit' (callout 1), and an 'Add problem' search field (callout 1). Below this is a table with columns: Priority, Problem Name, Code, Onset, Classif..., and Actions. The table lists three problems: 'Chronic middle ear infection' (Priority 1, Code H66.90, Onset MAR 10, 2021, Medical), 'Chronic adenoiditis' (Priority --, Code J35.02, Onset --, Medical), and 'Diabetes type I' (Priority --, Code --, Onset MAR 10, 2021, Medical). Each problem has two buttons in the Actions column: 'This Visit' (callout 3) and 'Chronic'. The 'Diabetes type I' row also has a 'Resolve' button. Below the table are two expandable sections: 'Resolved Chronic Problems' and 'All previous This Visit problems'.

Priority	Problem Name	Code	Onset	Classif...	Actions
1	Chronic middle ear infection	H66.90 (ICD...	MAR 10, 2021	Medical	<input checked="" type="checkbox"/> This Visit <input type="checkbox"/> Chronic
--	Chronic adenoiditis	J35.02 (ICD-...	--	Medical	<input checked="" type="checkbox"/> This Visit <input type="checkbox"/> Chronic
--	Diabetes type I	--	MAR 10, 2021	Medical	<input type="checkbox"/> This Visit <input checked="" type="checkbox"/> Chronic <a href="#">Resolve</a>

Resolved Chronic Problems

All previous This Visit problems

**Op Note Workflow Summary Setup**

2. **Quick Visit** is a way to quickly add a diagnosis and documentation for your procedure.
  1. Locate your specialty and select the appropriate procedure.
  2. Select the appropriate This Visit Problem or select None to display only the prioritized problems on the problem list.
  3. Select the Findings.
  4. Select the Description of Procedure.
  5. Click Submit. The dot phrase templates will flow into their corresponding scratchpad.

The screenshot shows the 'Quick Visit' form. At the top right is a 'Submit' button with a red circle and the number 5. Below it is a section for 'Existing Documentation' with a red circle and the number 2. The main area is divided into two columns. The left column has a 'Specialty' dropdown set to 'All' and a 'Search Quick Visits' field. Below this is a list of procedures under the 'ENT Surgery' category, with a red circle and the number 1 next to the 'ENT Surgery' header. The right column has a 'This Visit Problem' section with a red circle and the number 2, a 'Findings' section with a red circle and the number 3, and a 'Description of Procedure' section with a red circle and the number 4.

**Note:** On a desktop, using the F9 key will reposition the cursor from dropdown to dropdown to quickly complete documentation. Using the F3 key will cursor from underscore to underscore.

The screenshot shows the 'Description of Procedure' form. At the top right is a 'Selected Visit' dropdown. Below this is a text area containing a template for a procedure description. The text is as follows: 'The patient was brought to the operating room and placed supine on the operating room table. The head was placed into extension with a shoulder roll and wrapped in the usual fashion. A mouth gag was placed into the oral cavity and put into suspension. The soft palate was inspected and palpated and found to be free of evidence of submucous clefting. A latex-free catheter was passed into the bilateral nasal passage and brought out through the oral cavity to retract the soft palate. The adenoid was removed under indirect vision using a microdebrider and the nasopharynx packed with tonsil sponges. The nasopharyngeal packing was then removed and hemostasis was obtained in the nasopharynx using monopolar suction cautery. The bilateral nasal passages were irrigated with normal saline to remove clot and any residual fragments of adenoid and the oropharynx was suctioned. The nasopharynx was carefully inspected and final hemostasis was obtained with electrocautery. An orogastric tube was passed and suctioned. The gag was removed.' The words 'bilateral' and 'microdebrider' are highlighted with red boxes. At the bottom right is a 'Save' button.

**Op Note Workflow Summary Setup**

- Free text to complete the optional component fields: **Clinical Indications** and **Postoperative Plan**.  
**Note:** Sections that are not required do not need to be removed. If there is no documentation, the header will not display on the signed note.

The screenshot shows two side-by-side text input areas. The left area is titled 'Clinical Indications' and the right area is titled 'Postoperative Plan (not required)'. Both areas have a dropdown menu with 'Tahoma' selected and a small '9' icon. Below each dropdown is a large text area for free text entry.

- Select **Operative/Procedure Report** located on the bottom of the **Op Note Workflow**.

The screenshot shows a vertical list of options: 'Description of Procedure', 'Postoperative Plan (not required)', 'Create Note', 'Operative/Procedure Report', and 'Select Other Note'. The 'Operative/Procedure Report' option is highlighted with a red box.

- Review the note and click **Sign/Submit** if you are the surgeon of record.  
If you are an assistant resident, fellow, or NP, click **Save** and **Close** then **Forward**.
- From the **Sign/Submit Note** window, the **Title** of the note can be changed to match the procedure name. Click **Sign**.

The screenshot shows the 'Sign/Submit Note' window. It has a 'Type' dropdown set to 'Operative/Procedure Report' and a 'Note Type List Filter' dropdown set to 'Personal'. The 'Title' field is highlighted with a red box and contains the text 'Operative/Procedure Report'. The 'Date' field is set to '3/8/2021' and the 'Time' field is set to '15:11 CST'. At the bottom right, the 'Sign' button is highlighted with a red box.