QUICK GUIDE TO DOCUMENTATION TABS IN EHR TUTOR

A reference for navigating charts

Below is a summary of what you'll find within the documentation tabs in an EHR Tutor **inpatient** chart. Note that some tabs are associated with patient **sex and age**, so they might not appear in the chart you're working in.

Important! Before leaving a tab, you must click SAVE to save any data you entered or edited.

TIP: To navigate a chart more easily, expand the chart's window, so that the full navigation menu appears on the left!

Tab Name	Description
Patient Summary	The information displayed here is **read only**. Data entered in *other* tabs—Primary Concern, Vital Signs, Allergies, Orders, Labs—displays automatically in this tab.
Patient Information	Edit the name, sex assigned at birth, gender identity, age, provider, code status, and comments.
Results	Enter lab and test results. • **Labs:** Hematology, Blood Typing, HbA1c, Chemistry, Lipid Panel, Coagulation, Arterial Blood Gasses, Cardiac Enzymes, BNP, Other Labs, Urinalysis (UA), Prenatal Labs • **Imaging/Diagnostic Tests:** view and record results of imaging and diagnostic tests
Provider	• **Chief Complaint & History of Present Illness:** Admission Problems, History of Present Illness/ Injury • **Birth Summary**: Record birth information for newborn patients • **History*:** Past Medical History, Past Surgical History, Pregnancy History, Family History, Social/ Environmental Safety Screening, Substance Use, Impairments **Flexes to Pediatric History based on age* • **Review of Systems:** Constitutional, Eyes, Ears, Nose, Throat, Cardiovascular, Respiratory, Genitourinary, Gastrointestinal, Male Urinary, Gynecological, Musculoskeletal, Skin, Neurological, Psychological, Hematologic/Lymphatic
Allergies & Home Medications	Enter allergens and home medications.
Immunization Record	Enter vaccine administration information. Access Immunization Schedules from CDC.
Development and Screenings	Add development milestones and screenings for pediatric patients.
Notes Narrative will be written in this section	Enter a free-form text note or view a previous note. Used by all members of the interprofessional team, such as Providers, Nurses, Physical Therapists, Anesthesiologists, Dietitians, and Social Workers. Includes several types of notes, such as Progress Note, History and Physical, Procedure Note, Surgical Note, Consult Note, and more.
Flowsheets	• **Birth Summary**: Record birth information for newborn patients • **Admission*:** Informant(s), Admission Problems, History of Present Illness/Injury, Allergies (*connected to Allergies & Home Medications tab),* Admission Data, Additional Demographic Info, Home Medication List (*connected to Allergies & Home Medications tab*), Past Medical History, Past Surgical History, Family History, Immunization Screen, Social/Environmental Safety Screening, Substance Use, Impairments **Flexes to Newborn Admission or Pediatric Admission based on age* • **Gestational Age**: Record maturity and growth information for newborn patients • **Vital Signs:** flexes to Vital Signs/Measurements based on age • **Assessment*:** Head, Face, Anterior Fontanel, Neck; Eyes, Ears, Nose, Throat; Neurological Group; Glasgow Coma Scale; Respiratory; Cardiac; Peripheral Vascular; Integumentary; Braden Scale; Musculoskeletal; Morse Fall Scale; Gastrointestinal; Genitourinary; Pain Assessment. **Flexes to Newborn Assessment based on age* • **Other Screen/Scales:** Clinical Institute Withdrawal of Alcohol Scale (Revised)

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Tab Name	Description
	• **Daily Care:** Safety/Environment, Mobility, Nutrition, Hygiene • **Intake and Output*:** Oral Intake, IV Intake, Intake/Output Totals, Output (mL), Unmeasured Output **Flexes to Feeding/Intake and Output based on age* • **Interventions (Lines, Drains, *etc.*):** IVs/Lines, Urinary Catheters, Gastric Tubes, Drains, Chest Tube, Enema • **Wounds/Incisions/Ostomies:** Wounds, Incisions, Ostomies. • **Respiratory Interventions:** Ventilator, Endotracheal Tube, Chest Tube, Tracheostomy Care • **Blood Administration:** Pre-Transfusion Information, Vital Signs, Transfusion Information • **Stroke Scale:** National Institutes of Health Stroke Scale • **Restraints:** Restraints, Assessment and Monitoring, CMS (color, motion, sensation), Discontinued Restraint • **Behavioral Health:** Risk Status, Mental Status, Sleep Pattern, Safety, Family & Visitors, Behavioral Health Notes • **Preoperative Checklist:** Preop Patient Information, Medical Documentation, Surgical Information, Preoperative Checklist • **Patient Registration:** Patient Registration, Person Responsible for Bill, Emergency Contact Information, Primary Insurance, Secondary Insurance
Screenings	Includes the following: • **CAGE-AID Questionnaire:** Assess for alcohol and substance use disorders. • **Mood Disorder Questionnaire (MDQ):** Identifies bipolar disorder. • **Fall Risk Assessment:** Assesses history of falls and current risk factors. • **Malnutrition Screening Tool (MST):** Identifies risk for malnutrition, including weight loss, appetite, eating habits. • **Hamilton Anxiety Rating Scale (HAM-A):** Measures level of anxiety as mild, moderate, or severe. • **Patient Health Questionnaire (PHQ-9):** Identifies presence and severity of depression from minimal to severe. • **Suicide Assessment Five-step Evaluation and Triage (SAFE-T):** Identifies level of suicide risk and suggests interventions. Five steps include risk factors, protective factors, suicide inquiry, risk level/interventions, document. • **Abnormal Involuntary Movement Scale (AIMS):** Detect and measure severity of Tardive Dyskinesia. Includes facial and oral movements, extremity movements, trunk movements, global judgments, dental status, movement during sleep. • **Edinburg Postnatal Depression Scale (EPDS):** Identifies postpartum depression by evaluating how the patient has felt during the previous week. • **Alcohol Use Disorders Identification Test (AUDIT):** Assesses alcohol consumption, drinking behaviors, alcohol-related problems. • **Smoking Cessation Questionnaire:** Assesses previous and current tobacco or other nicotine product use. • **Wound Assessment:** The physical characteristics of a wound and surrounding tissue, including edema and pain. • **Braden Scale:** Identifies risk for a pressure injury. • **Pediatric Coma Scale:** Assesses level of consciousness in pediatric patients.
MAR (Medication Administration Record)	From this tab, you can view all ordered medications (medication order information is automatically transferred to the MAR from a signed Order), as well as document medication administration.
Orders	View, enter, or manage orders. Includes all orders, such as, labs, medications, diets, procedures.
Patient Education	Enter learner assessment and patient education documentation.
SBAR	Add giver and receiver of report using standard SBAR format (situation, background, assessment, recommendation).
Care Plan	Enter care plan information and indicate status of care plan (ongoing or resolved).

Tab Name	Description

Obstetrics	• **OB Prenatal Visit:** Prenatal Labs, Urine Reagent Strip, Prenatal Assessment
	• **OB Admission:** *General admission data can be documented on the Admission flowsheet tab.*
	  ○ OB Admission (includes LMP, EDD), Pregnancy History, Prenatal Labs, Fetal Assessment Test(s)
	• **Labor Assessment**
	  ○ Vital Signs, Gestational Hypertension Assessment, Fetal Assessment, Uterine Activity, Cervical Exam, Interventions, OB Notes
	• **Birth Summary**
	  ○ Birth Information (Vaginal Birth, Cesarean Birth), Other Procedures, Labor Times, Apgar, Newborn Information, Personnel Present at Birth
	• **OB Postpartum**
	  ○ Postpartum, Fundal Assessment, Peripheral Vascular, Postnatal Depression Scale (EPDS), Rho(D) immune globulin

Discharge	• **Discharge Information:** includes date, time, condition, disposition • **Summary of Stay** • **Discharge Orders/Instructions:** includes activity, diet, when to notify provider, newly prescribed medications to take at home, medications to continue taking at home as previously prescribed, changes to previously prescribed home medications. • **Discharge Medication Reconciliation:** discontinued medications and where/how new prescriptions were sent.
Barcode	This page allows you to print barcodes for the chart—both the unique barcode for the chart's MRN and barcodes for any ordered medications—that can then be scanned when administering medications.