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Target Audience

This manual is intended to instruct staff and students using axiUm how to access and use the axiUm Electronic Health Record (EHR) to view and record patient data. This manual is not meant to instruct administrators on details regarding security level access or configuration of the Electronic Health Record module.

Introduction

The axiUm Electronic Health Record Module (EHR) is a patient information data entry, access, and control system developed for use in a dental school clinic environment. The purpose of the EHR is to achieve as near a paperless environment as possible while making patient information easy to find, simple to enter, and uncomplicated to control for dental school staff and students.

axiUm’s EHR combines the information available in other modules into a single dialog which can be reconfigured to display and hide information based on the workstation used and the user that is logged into axiUm.

The default EHR dialog duplex view configuration is shown above. The display is divided in half with the patient dental and medical information in the top half (the upper or chart pane) and the clinical treatment, scheduling, technical, and clerical information in the bottom half (the tab pane).
Accessing the EHR

The EHR module is accessible with the EHR icon in the axiUm main window, the Clinical - EHR menu item in the Actions menu of the main axiUm window and the EHR icon on the desktop image.

Altering the EHR View

Full view versus split view

More detail can be shown by changing the EHR from split (duplex) view to full view. The center right down arrow changes the chart pane to full view and the up arrow changes the tab pane to full view.

In full view the chart pane Alerts, Problems, Objectives, and Prev Care sections are shown in the bottom half of the window and the patient’s picture (if available) is displayed on the upper right. To close full view, click on the down arrow at the upper right corner of the EHR dialog.
The center right up arrow changes the currently selected tab dialog in the tab pane to full view. In this example the **Tx History** (treatment history) tab dialog is in full view and can show far more items in the history list than in split view. Note that the **Chart Add** tab (displayed when a new treatment is added) cannot be displayed in full view.
Note: When the odontogram is replaced by dragging and dropping a tab, it becomes the Chart tab. The Chart tab automatically moves to the upper pane whenever the Chart Add tab is selected, as it is required for treatment entry.

EHR Chart Pane Views

Any of the bottom tabs (except the Chart Add tab) can be moved to the top pane using a ‘drag and drop’ movement. Left click on a tab and while holding the mouse button down drag the tab up to the top pane of the screen, and release the mouse button. In the example shown, the treatment history tab was dragged to the upper pane and the In-Progress dialog is selected in the tab pane below.

EHR Sliding Toolbars

At the right of the screen are arrow keys that open and close the EHR sliding toolbars. To use the toolbar and have the toolbar automatically retract, hover the mouse over the left arrow and click on the toolbar item that you wish to use.

To lock the toolbar into place, left click on the left arrow. To retract a locked toolbar, click on the right arrow. The toolbar controls differ for each EHR tab and are discussed in the sections below.

Note: In 800 x 600 mode the toolbar can not be locked into place. Each tab has its own lock or slide setting. Locking the toolbar for one has no effect on the other tabs. Depending on the EHR option set by your axiUm administrator the toolbar will either default to locked, or sliding.

Using the Dental Chart
Chart Tab toolbar options

- **Clear Data**: If teeth, or specific surfaces have been selected these selections will be cleared when the user presses the Clear Data button.
- **New Record**: This icon displays Chart Add dialog in the tab pane to enter conditions, treatment and clinical notes.
- **Add Note**: This button the Select Note Type window, allowing the user to select either a general note format or SOAP note format for the note they wish to enter.
- **Show History**: The button allows the user to make some selections of what they need to see a history of, and then re-displays the chart as requested.
- **Print**: The button launches the Select Printer window to allow the user to print the odontogram and patient treatment history.
- **Patient Exposures**: The button opens the Patient Exposures window.
- **Options/Settings**: The button opens the EHR options window for the user to modify the information view of the EHR window.

Changing the Periodontal Display

By default, the EHR top pane is the Dental Chart odontogram with two Perio lines displayed for each arch.

The Perio items displayed can be changed (if the user’s security level permits) by right clicking on the Perio lines to access the change menu.

```
21 20 19 18 P17
```

The **EHR Perio Conditions to Display** window will open. Select the conditions to display for each of the available four sections using the drop down boxes and click “ok” to save changes.

**Note:** When axiUm is set to an 800 by 600 display mode Perio lines can not be displayed.
Dental Chart Controls
Right Click Options

*Select Teeth* allows the user to select a set of teeth rather than a single tooth at a time with the mouse click (the mouse probe pointer is displayed when a tooth is under the pointer) for procedure entry or condition charting.

- **All Teeth** - selects all teeth
- **Maxillary Arch** - selects all maxillary teeth
- **Mandibular Arch** - selects all mandibular teeth
- **Clear All** - deselects any teeth that have been selected

*Age Change* allows the user to chart mixed dentition. All currently selected teeth are changed between primary and permanent status. The *All Primary* sets all teeth as primary teeth.

---

**Note:** When a patient is of eight years of age or younger the chart automatically sets all teeth to primary.

- **All Permanent** sets all teeth as permanent teeth.
- **Missing** marks a selected tooth as missing. This places a symbol in the chart to indicate the tooth is not present and removes the image of the tooth.
- **Undo Missing** reverses the missing status.
- **Tooth Notes/Conditions** opens the Tooth Notes and Conditions window for entering notes and conditions specific to the selected tooth. Once an entry is made here, a red N will appear beside the tooth site number to alert the user that a note exists for this tooth site.
- **Show Tooth History** opens a tooth history window where a user can see when an extraction or an impacted condition was recorded for a specific tooth site.

---

**Show Tooth History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth</th>
<th>Extracted</th>
<th>Impacted</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/5/2008</td>
<td>Permanent</td>
<td>No</td>
<td>No</td>
<td>Burger, Tom</td>
</tr>
</tbody>
</table>

---

**Note:** When a patient is of eight years of age or younger the chart automatically sets all teeth to primary.
**Tooth Details** opens the Detail Tooth window where the user can rotate the tooth, and draw on the tooth. A single tooth must be selected in the EHR to use this tool.

The tooth is rotated by holding the CTRL key while clicking and holding the left mouse button while the user is on the tooth and moving the mouse side to side to spin the tooth on the vertical axis, and up and down to turn the tooth on the horizontal axis.

This is a valuable tool in patient education. The user can indicate what has been observed and show the patient a model of the tooth. There are ten colors ranging from dark gray to shades of red, green, and blue. Painting can be disabled to eliminate accidental changes and the erase radio button used to remove surface drawings. If odontogram treatment or condition drawings are erased accidentally closing and reselecting the EHR module will restore the tooth's display.

The Method selections of Single and Selection change the drawing methods. Single will paint only one surface polygon area at a time while the left button is held down while Selection will allow the selection of an area to paint.

**View Tooth** opens a larger image of the tooth to allow the user to show the patient some detail. This window display is enlarged by dragging and dropping the edge of the window. It the view dialog and in the dental chart the selected tooth is rotated on its vertical and horizontal axes by clicking on the tooth image and then moving the mouse while holding the mouse button.

This can also be done by double clicking a tooth and if other teeth are selected all are displayed and can be rotated in the window. Teeth in the EHR display can also be rotated using the click hold and move technique. The **Clear Data** toolbar button will reset the EHR chart tooth positions.

**Alerts, Problems, Objectives, & Prev Care Tabs**

When the EHR window is initially opened tabs for Alerts, Problems, and Objectives are visible in the top right.

**Alerts Tab**

The alerts tab shows information that is very important for a provider to be aware of prior to treating a patient. The typical alert item is an allergy, special patient status, treatment need, or financial arrangement.

The Alerts tab shows the patient medical alerts, the Patient Alerts, the Patient Needs and the Patient Office Codes, with each section separated by a blank line.

**Note:** If the Alerts tab is customized it may not display some of the alert items listed here. Please contact your axiUm administrator if you would like this changed.
To update, view, and print the items displayed here (if user security permits it), right click in the alerts area to access the menu.

To update, view, and print the items displayed here (if user security permits it), right click in the alerts area to access the menu.

Medical Alerts

Update Medical Alerts allows medical alerts to be added or removed from the patient’s record by selecting items and using the > and < buttons or double clicking list items to move medical alerts to and from the selected list on the left.

Select Medical Alert History from the right click menu to view a historical record of the medical alerts that have been entered for the patient. From within this window the user can Update Medical History, Preview (ALT-V) a report of the alerts which can then be printed or exported using the Print (ALT-P) icon. If axiUm is set up to allow alternate printer selection a Select Printer dialog will open.

The Medical Alert History dialog is also accessible by clicking on the Alert icon in the status bar. This alert is displayed in the status bar when the selected patient has alerts the user should be aware of.

Patient Alerts, Office Codes and Needs

If Update Patient Alerts or Update Patient Office Codes is selected the Patient Info - Codes tab dialog is displayed and can then be used to edit these values. If the Update Patient Needs menu item is selected the Patient Needs dialog (shown below) is displayed.
Patient needs can be assigned a status and that status changes the display behavior giving the user axiUm users need the ability to indicate which patient needs have been resolved so that only the needs which require attention are displayed. In Maintenance module - Patient tab the Need Status Code can be defined to show or not show in the EHR. Also, the status code can indicate if the need has been resolved. When a right click in the EHR Alerts tab is made an Update Patient Needs menu option is available to assign a new status to the need entry selected.

Problems Tab

The Problems tab displays all non-deleted, unresolved patient issues and problems found when charting, and when treatment planning was done for the patient. Problems are added here or entered from the Treatment Planning Module Problems sub-tab.

To update the problem items right click in the problems area to access the menu. The Show History menu option shows the changes made to the problem entries. It is not an available choice unless a problem item is selected first. No modifications can be made here.

The Update Problems dialog is used to enter new problems discovered, indicating the site (tooth number), and the area the issue was found in (Charting, forms, radiographs etc).
The problem type is prefixed with a G indicating a general problem when entered from the EHR problem tab and prefixed with a T when entered from the treatment planning module. Problems entered as G-type will automatically display in every treatment plan created for the patient. T type treatment plan problems are only listed in the specific treatment plan in which they were entered.

Note: The selectable Problem list and Problem status codes are customized by your school. If changes or additions are required please contact your axiUm administrator.

The status field indicates where the current standing of the problem (new problem, recurrent problem, resolved problem).

Objectives
The Objectives tab is used to track treatment objectives entered when charting or in the treatment planning module. Lists all non-deleted and unresolved objectives. Objectives can be added here, and can be entered from the Treatment Planning Module Objectives sub-tab.

If you wish to update the items displayed here (and your user securities permit it), right click in the objectives area to access the change menu. Select *Update Objectives* from the right click menu.

The Update Objectives window is used to enter new objectives, indicating the status of the objective.

![Update Objectives](image)

The type of objective is entered as G-General Objective when the item is entered manually, and is entered as T-<description of treatment plan> when entered from the treatment planning module. Type is set by the system, but can be modified by the user if desired.

The status field allows the user to indicate the status of the objective; for example, Patient’s objective, Treatment Objective, Financial Objective, and Resolved Objective.

**Prev Care**

There is now the ability to set up oral health maintenance cycles, in the form of axiUm Preventive Care Cycle. This is like a set of recurring recall appointments set up as a single group of planned appointments.

In Maintenance module - System tab - System Options icon - System Options window - Scheduling section, there is a Use Preventive Care checkbox. Selecting this checkbox enables the use of the Preventive Care feature.
Chart Add

The Chart Add tab is used to enter findings, dental treatments, and medical treatments on the patient record.

The Chart Add tab can have four sub-tabs (Expert, Diagnosis, Codes, and Details) for use in treatment entry. The system will open defaulted to one of these two tabs depending on an EHR Display Option selected by your axiUm administrator.

A Phase: Sequence column is displayed in the Chart Add list.

The chart shows a red X through the tooth when an extraction is planned. This is a procedure with a graphic detail type of removed. The red X disappears as soon as the planned extraction treatment is changed to completed (extractions cannot have an in-process status) and before being approved.

**Note:** The Chart Add tab can not be made full screen and can not be the top pane. When in Chart Add the Odontogram is always on top as it is required for treatment entry.

Adding treatments via Chart Add Codes tab

In the Diagnosis tab or the Code tab, select the type of entry from the radio buttons for Findings, Dental treatment and Medical treatment.

Select quick list, full list or search and browse to the item you wish to chart. The user can double click here to jump to the details tab or can proceed with the next step.

**Note:** You can select the site/surface first, then the procedure code. Once you select a procedure code, the selected site/surface changes to the corresponding color. Once you add the treatment, axiUm resets the selection.
Select the surface(s) or tooth number in the Odontogram or enter them in the details tab if the item requires these.

Select P (Planned Tx), I (In Progress Tx) or C (Complete Tx) depending on the status of the item that you wish to add.

Alternatively, select Finding if you wish to chart a pre-existing procedure, condition, material or finding for the patient.

**Conditions (Findings) Displayed Over Restorations**

The chart displays transparent cross hatch pattern that is drawn on a tooth so that the user can see an existing treatment beneath the new condition. The basic rules are that if a restoration is done the restoration treatment will show through the hatching when the restoration is planned (the yellow dot let the user know it's planned) and when the planned restoration is completed, the caries cross hatch pattern disappears because it has been resolved. When an existing restoration has a hatched condition over top this indicates there is caries over the restoration. The user can determine the restoration existed prior to the caries because there are no dots to indicate in process or completed restoration.

**Procedure Macros Codes**

Procedure Macro Codes

Procedure macro codes allow the user to select several related procedures with a single item from the Quick List sub tab of the Codes tab dialog. A macro is a collection of procedures.
When the macro is selected another dialog, the *Treatment Macro Edit* window is displayed.
Here treatments not being performed can be deleted and alternative treatments added. When finished the Treatment Macros Processing dialog allows the user to enter details for each procedure selected.

In this way the user can phase and sequence items within the macro, and indicate some custom information (like treatment location for example) as may be required by the University.

**Details Sub-Tab**

If the logged in user is a provider, the Provider field will default to the current user’s provider identity code. Otherwise, the user must enter the ID of the treating provider.

The Date field will default to current date, but can be modified if required.

Enter the procedure Code by typing it into the box, selecting it from the procedure codes list accessed via the ellipsis button, or selecting it in the codes tab. The Description field auto-fills when the procedure code is entered.

Enter the Site and surfaces if the procedure selected requires this information.

<table>
<thead>
<tr>
<th>Sites</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 32 to represent the individual permanent teeth or A through T to represent the individual primary teeth.</td>
<td>In Canada, 11-18, 21-28, 31-38 and 41-48 are valid for permanent teeth and 51-55, 61-65, 71-75 and 81-85 for primary teeth.</td>
</tr>
</tbody>
</table>
Supernumerary teeth are entered as 50 plus the tooth number for permanent teeth (for example 60) or tooth letter with S for primary teeth (for example GS).

<table>
<thead>
<tr>
<th>UA = upper arch</th>
<th>LA = lower arch</th>
</tr>
</thead>
<tbody>
<tr>
<td>UR = upper right quadrant</td>
<td>UL = upper left quadrant</td>
</tr>
<tr>
<td>LR = lower right quadrant</td>
<td>LL = lower left quadrant</td>
</tr>
<tr>
<td>FM = full mouth</td>
<td></td>
</tr>
<tr>
<td>URS = upper right sextant</td>
<td>LRS = lower right sextant</td>
</tr>
<tr>
<td>UCS = upper central sextant</td>
<td>LCS = lower central sextant</td>
</tr>
<tr>
<td>ULS = upper left sextant</td>
<td>LLS = lower left sextant</td>
</tr>
</tbody>
</table>

**Surfaces**

- O = Occlusal
- I = Incisal
- B = Buccal
- F = Facial
- M = Mesial
- D = Distal
- L = Lingual

If required enter the **Discipline** code, **Phase**, and **Sequence** of the treatment.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Code</th>
<th>Date</th>
<th>Desc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D2140</td>
<td>11/05/2010</td>
<td>Amalgam - 1 surface</td>
</tr>
</tbody>
</table>

Select or enter responses for any custom fields that are on the bottom of the window. The example image shown here shows one custom field (Location) in use. Your university may have none or as many as four additional fields that need to be filled in.

Select P (Planned Tx), I (In Progress Tx) or C (Complete Tx) depending on the status of the item that you wish to add.

Alternatively, select Finding if you wish to chart a pre-existing procedure, condition, material or finding for the patient.

**Editing Treatments in Chart Add**

Treatment entered in the Chart Add tab can be edited if the user has not closed the Chart Add tab. To edit treatment:

1. Select the line in the list.
2. Select the details sub-tab.
3. Make modifications as required.
4. Click on the Modify record button to save the changes.
To edit treatment after the tab has been closed select the In Progress tab or Tx History tab and double click or highlight the list item and click on the Edit Record toolbar button.

**Chart Add Toolbar Options**

<table>
<thead>
<tr>
<th>Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Clear Data button" /></td>
<td>The Clear Data button clears the currently selected line. If procedures, teeth, or specific surfaces have been selected these selections will be cleared when the user presses this button.</td>
</tr>
<tr>
<td><img src="image" alt="Add Note button" /></td>
<td>The Add Note button opens the Select Note Type window, allowing the user to select either a general note format or SOAP note format for the note they wish to enter.</td>
</tr>
<tr>
<td><img src="image" alt="Add Finding button" /></td>
<td>The Add Finding button allows the user to chart the selected finding for the patient.</td>
</tr>
<tr>
<td><img src="image" alt="Add Planned Tx button" /></td>
<td>The Add Planned Tx button allows the user to enter the selected treatment as a planned treatment for the patient.</td>
</tr>
<tr>
<td><img src="image" alt="Add IN Process Tx button" /></td>
<td>The Add IN Process Tx button allows the user to enter the selected treatment as an in process treatment for the patient.</td>
</tr>
<tr>
<td><img src="image" alt="Add Complete Tx button" /></td>
<td>The Add Complete Tx button allows the user to enter the selected treatment as a completed treatment for the patient.</td>
</tr>
<tr>
<td><img src="image" alt="Modify Record button" /></td>
<td>The Modify Record button saves modifications made to the selected item.</td>
</tr>
<tr>
<td><img src="image" alt="Delete Record button" /></td>
<td>The Delete Record button allows the user to delete the currently selected record (if the user’s security level allows this).</td>
</tr>
<tr>
<td><img src="image" alt="Options/Settings button" /></td>
<td>The Options/Settings button opens the EHR options window with Chart Add tab selected.</td>
</tr>
</tbody>
</table>

Right clicking on a planned or in-process treatment displays the following menu:
Selecting In Process Treatment Visit allows a planned treatment to be changed to an in-process treatment and enter details in the following dialog:

Selecting Complete Treatments allows a planned or in-process treatment to be changed to a completed treatment and enter details in the following dialog:
Procedure Codes List Symbols

- Expands the list and displays the items beneath this node.
- Expands the list as above. The red dot indicates that steps exist beneath the node. To collapse the step list click on the plus again.
- Collapses the list and hides the items beneath this node.
- Indicates that this procedure code will draw something on the odontogram when it is used (1 = it is illustrated on the surfaces or crown, 2 = an object is drawn, 3 = the tooth will be removed).
- Indicates that the procedure will not draw on the odontogram. It will be a text entry in the chart.

AxiUm Auto Approve Mode

When a user does not require approval for adding treatments, axiUm places them in an auto-approve mode so that treatments will be automatically approved. This avoids the approval window, which is where Billing Information can be modified before it is approved.

When users not requiring approval add a treatment through the Chart Add tab, they can bypass this auto-approve mode by selecting the Edit Billing Information checkbox.

Note: This box must be checked before the treatment is added.

- Edit Billing Information

When the treatment is added, the Treatment Billing Information will display and the user can change any Billing Information fields.
Here the user can view or change the billing information for the treatment. Click the OK button approves the treatment without the need to swipe. If the user clicks on the Close button to exit this window, axiUm adds the treatment but will be unapproved.

Editing treatment has the same functionality. Before clicking the OK button, select the Edit Billing Information checkbox and the Treatment Billing information window.

**Linking Codes with EHR Forms**

Just as some procedures require consent be filled out, some procedures require that an EPR form to be completed. Treatment forms for the procedure have a "Required" option. If a user tries to complete a Procedure without the form attached then an error message is displayed and axiUm pops-up the form and forces entry.
SOAP Notes

If it is required that case notes be presented in SOAP format (the standard pre-defined sections of Subjective, Objective, Assessment, and Plan). Each section of a SOAP note needed to be selectable from a code table (like the current comment codes are), but from a table that has a tree structure like the procedure codes table. In addition to the SOAP notes axiUm has the ability to enter additional user defined note types and sections.

Setting a Practice for SOAP Note Use

In the Practice Options dialog EHR Options section SOAP notes use is set to No or Yes as the default or not.

Using SOAP Notes

When the provider clicks on the Note icon or right clicks Add Tx Note option the Select Note Type window opens for the user to indicate the type of note they wish to enter.

When the user selects SOAP Note and clicks OK, the SOAP Note window opens:
The **Date** field allows the user to identify the date of the entry, and can be back-dated to add notes for a back dated treatment.

The **User** and **Approval User** fields will display the entry user and user that approved the note once it is completed.

The user can either type the text for each of the SOAP sections, or can select from pre-defined lists of text via the ... buttons to the right. Each section can contain a combination of selected text and free-text.

If the user chooses to select from pre-defined text, they click on the ... button to the right of the section in which they want the text to appear, and the following window will open.

![Select Clinical Note Codes](image)

The user will select items from the tree list at the top of the window by clicking on the + sign to open the list, then double clicking to enter the item, or highlighting the text and clicking on the down arrow to enter them.

The lower half of the window shows the currently selected items for the note.

![SOAP Note](image)

Once all selections have been made the user will click on the OK button to save the note section and pull it in to the
previous window. The user will repeat this procedure for each of the SOAP sections until the SOAP note window is completed as shown above.

**In Progress Tab**

The In Progress tab dialog is separated into four distinct sections.

- **Today's Activities**: Lists all activity for the current date. This is based on a set up option and will display only specific activities that the administrator of your system has defined to display here.

- **Pending Treatments**: Lists all treatment that is pending for the patient. For example, all planned procedures, and all in-progress work. If there are pending appointments, these will also be displayed.

- **Health Summary**: Can be set up to display in summary form the significant findings from any Electronic Form the administrator of your system specifies. Health History is read-only.

- **Radiographs**: The right of the screen will display the most current images for the selected patient. If there is pending treatment for tooth site 28, and there is a radiograph on file of tooth site 28, this will be displayed.
If there are other radiographs on file that the user would like to see (and securities are set to allow it), the user can right click on the radiograph to access the Select Image to Display window. This window can be sorted by any of the three column headings by clicking on a heading to re-sort the list. When an item in the list is selected a preview of the radiograph will be shown to the right. To select the image for use in the In Progress tab, highlight the image in the list and click Ok.

Note: In 800 x 600 mode radiographs can not be displayed in this dialog.

### Progress Tab Toolbar Options

- **Prepare the window for treatment entry.** The Create a New Record button causes the lower half of the window to jump to the Chart Add tab for the user to enter conditions, treatment and clinical notes.

- **Add a New Note button** opens the Select Note Type window, allowing the user to select either a general note format or SOAP note format for the note they wish to enter.

- **Edit Record button** allows the user to make some modifications to the selected item.

- **Delete Record button** allows the user to delete the currently selected record (if their security allows this).

- **Start Check icon** launches a preview of the Start Check report (if appointment for today). This is mainly for instructors to be able to review the items in the start check.

- **Estimate button** allows the user to print a treatment estimate for the patient. This can be printed for all or a selected number of procedures.

- **Treat Specific Consent button** allows the user to capture a treatment specific consent.
Right-click options for the In Progress tab:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Tx Note</td>
<td>Enabled if a treatment line is selected. Opens the note window for the user to add a note.</td>
</tr>
<tr>
<td>Edit Tx Note</td>
<td>Enabled if a note line is selected. Opens the Note window in edit mode.</td>
</tr>
<tr>
<td>Assign Phase/Sequence</td>
<td>Enabled when a planned treatment line is selected. This can be done for several lines at once by multi-selecting the treatment lines and then assigning phase and sequence.</td>
</tr>
<tr>
<td>Add Lab</td>
<td>Enabled when a procedure that requires a lab is selected. Opens the Lab Procedure Selection window.</td>
</tr>
<tr>
<td>Show Steps</td>
<td>Enabled if Show Steps is on. Refreshes the list and shows procedure steps.</td>
</tr>
<tr>
<td>Hide Steps</td>
<td>Enabled if Hide Steps is on. Refreshes the list and hides procedure steps.</td>
</tr>
</tbody>
</table>

axiUmm Treatment Statuses (All Modules)

<table>
<thead>
<tr>
<th>Code</th>
<th>Status Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Planned</td>
</tr>
<tr>
<td>I</td>
<td>In-Process</td>
</tr>
<tr>
<td>C</td>
<td>Completed</td>
</tr>
<tr>
<td>A</td>
<td>A condition (finding)</td>
</tr>
<tr>
<td>E</td>
<td>A pre-existing treatment (finding)</td>
</tr>
<tr>
<td>V</td>
<td>An Ortho visit</td>
</tr>
<tr>
<td>S</td>
<td>A suspended treatment, usually preceded by the status of the treatment before it was marked as suspended. For example: P-S (Suspended planned treatment), or I-S (Suspended in-process treatment).</td>
</tr>
</tbody>
</table>

Treatment History Tab

The Treatment History tab allows the user to quickly and easily select from pre-defined views of the history via a Views list in a right side panel as shown below. The user can click on a column heading to sort the treatment history by that columns data.
The Views list contains “Station View” as the first entry, plus any custom views defined and set up by your axiUm admin. To change the view, click on the view name in the Views list on the right. The window will refresh and display the view requested.

The Views list is in a slider pane so the user can size the History list once a view has been selected. Site field displays "All" or comma delimited sites if sites selected (like “11, 12, or 13”). Site “…” button calls Select Sites dialog.

From and To fields are read only, and are set by the selected view. They can be changed by clicking on the ellipsis button and selecting another date.

The History window sizes to a smaller width list when the toolbar is pulled out. If the option to ‘Sort planned treatments to the end of the list” in EHR options is on, to make the information in the treatment history window easier to read, planned treatments are sorted to the bottom of the list and are separated from the other items by a blank line.

The user can edit records in the treatment history window by double clicking on the individual line to be modified. Double clicking a treatment line opens the edit treatment window.

Double clicking a Treatment Note line opens the Note window.
Note that the time and date of the note entry is recorded and displayed in the upper right of the dialog to satisfy JCAHO (Joint Commission on Accreditation of Healthcare Organizations) requirements.

Double clicking an appointment line opens the Scheduler window with the appointment history list for the selected patient.

Double clicking a recall appointment line opens the Patient Recalls window.

The control and shift keys can be used with mouse clicks or pointer keys to select several TX History list items for deletion. Actions are limited to deletion only when several items are selected.

### Treatment History Tab Colors

<table>
<thead>
<tr>
<th>Color</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Approved treatment and / or approved clinical notes.</td>
</tr>
<tr>
<td>Black with strike-out lines</td>
<td>Treatment and / or clinical notes that have been deleted internally by axiUm. (For example as treatment moves from planned to completed axiUm strikes out the planned line and adds a new line for the completed treatment).</td>
</tr>
<tr>
<td>Blue</td>
<td>Un-approved treatment and / or un-approved clinical notes.</td>
</tr>
<tr>
<td>Green</td>
<td>Appointment or recall information line.</td>
</tr>
<tr>
<td>Gray</td>
<td>Deleted line.</td>
</tr>
</tbody>
</table>

The scheduler symbol ![scheduler symbol] will appear in the treatment history list beside a treatment record that has been tied to an appointment in the Scheduler window.

### Treatment History Tab Toolbar Options

Prepares the window for treatment entry. The Create a New Record button causes the lower half of the window to jump to the Chart Add tab for the user to enter conditions, treatment and clinical notes.
The Add a New Note button opens the Select Note Type window, allowing the user to select either a general note format or SOAP note format for the note they wish to enter.

The Edit Record button allows the user to make some modifications to the selected item.

The Delete Record button allows the user to delete the currently selected record (if their security allows this).

The print button launches the Select Printer window to allow the user to print the odontogram and patient treatment history.

The Estimate button allows the user to print a treatment estimate for the patient. This can be printed for all or a selected number of procedures.

The Treatment consent button allows the user to capture a treatment specific consent.

The Options/Settings button opens the EHR options window with Tx History tab selected.

<table>
<thead>
<tr>
<th>Treatment History Tab Right-Click Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Tx Note</td>
</tr>
<tr>
<td>Edit Tx Note</td>
</tr>
<tr>
<td>Add/Edit Tx Form</td>
</tr>
<tr>
<td>Complete Treatments</td>
</tr>
<tr>
<td>In Process Tx Visit</td>
</tr>
<tr>
<td>Tx Consent History</td>
</tr>
<tr>
<td>View Details</td>
</tr>
<tr>
<td>Follow up visit</td>
</tr>
<tr>
<td>Redo Step Treatment</td>
</tr>
<tr>
<td>Resolve Condition</td>
</tr>
<tr>
<td>Assign Phase/Sequence</td>
</tr>
<tr>
<td>Add Lab</td>
</tr>
<tr>
<td>Edit Lab Order</td>
</tr>
<tr>
<td>Print Labels</td>
</tr>
<tr>
<td>View Details</td>
</tr>
<tr>
<td>View Appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabled if a treatment line is selected. Opens the note window for the user to add a note.</td>
</tr>
<tr>
<td>Enabled if a note line is selected. Opens the Note window in edit mode.</td>
</tr>
<tr>
<td>See below.</td>
</tr>
<tr>
<td>Change one or more selected treatments to completed from planned status or in process</td>
</tr>
<tr>
<td>Change a treatment to in process from planned status</td>
</tr>
<tr>
<td>View the treatment consent form signed by the patient</td>
</tr>
<tr>
<td>Displays the selected treatment details in the View Treatment dialog</td>
</tr>
<tr>
<td>NY Medicaid only. Allows the user to indicate that a follow up visit occurred for the Medicaid patient.</td>
</tr>
<tr>
<td>Enabled if an in-process stepped procedure is selected. Allows the user to re-do the treatment step.</td>
</tr>
<tr>
<td>Enabled if a condition line is selected. Marks the condition as resolved.</td>
</tr>
<tr>
<td>Enabled when a planned treatment line is selected. This can be done for several lines at once by multi-selecting the treatment lines and then assigning phase and sequence.</td>
</tr>
<tr>
<td>Enabled when a procedure that requires a lab is selected. Opens the Lab Procedure Selection window.</td>
</tr>
<tr>
<td>Enabled when a lab order line is selected. Opens the Lab Order Details window.</td>
</tr>
<tr>
<td>Enabled when a lab order line is selected. Allows the user to print the lab order labels.</td>
</tr>
<tr>
<td>Enabled when a note line is selected. Opens the note window in read only mode.</td>
</tr>
<tr>
<td>Enabled when an appointment line is selected. Opens the Scheduler window with the</td>
</tr>
</tbody>
</table>
Appointment history list for the selected patient.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Appt Request</td>
<td>Enabled when a planned treatment line is selected. Opens the New Appointment Request window.</td>
</tr>
<tr>
<td>Make Appointment</td>
<td>Enabled when a planned treatment line is selected. Opens the Scheduler window with the New Appointment window open to add an appointment for the patient.</td>
</tr>
</tbody>
</table>

## The Add or Edit Treatment Form Menu Option

An axiUm user can attach an EPR form to a treatment by right clicking on the treatment and selecting the Add/Edit Tx Form menu option.

![EPR Form Setup](image)

This enables the user to tie an EPR form to a specific treatment. Endo work often requires extra information that can currently only be captured in an EPR form. Without the link between the Endo treatment and the form page that describes the specific treatment there is missing information when reviewing a chart.

To be used an EPR form needs to be defined as owned by a treatment. The form is then selected in the EPR Forms dialog with the Owner List selection set to treatment and the Procedures... button is then selected.

This displays the Form Definition (by Procedure) dialog. Here treatment codes are assigned access to the form. There is an option to set the form as the default for the procedure which is useful if the procedure can access more than one form.

![Form Definitions (by Procedure)](image)

Forms can be set up to be for specific treatments, such as all Endo procedures can use a specific form which wouldn’t be available to other procedures.

Once one or more EPR treatment forms are created that a procedure has access to a right click in the Tx history or In Progress tab allows the user to add a form for that treatment.

When an EPR form attached to a treatment the user will see at the beginning of the treatment Description in the Treatment History list a little white Form icon indicating that there is a form attached to that particular treatment. This only appears if you do not have the Show Forms option selected for that View. If the Show Full Notes/Forms is on the form is shown below the treatment it’s attached to. The form will be in a ‘note type format, however double
clicking on it will open and display the form in normal EPR format. Alternatively the user can right click on the treatment and select the **Add/Edit Tx** form option.

### Treatment Consents

The treatment without consent icon 🗝️ appears next to the procedure code on unapproved treatments in the EHR - Tx History tab.

- **Treatment Consents**
  - The treatment without consent icon 🗝️ appears next to the procedure code on unapproved treatments in the EHR - Tx History tab.
  - **Tx History** displays the consent required icon for rows that are currently unapproved. However, if the treatment has never been approved, it will not be displayed. An approved treatment has to be of status P or I (planned or in-process) to display the consent required icon, but the unapproved treatment can be P, I or C (completed).
  - If the site of a treatment is changed the Treatment Consent is voided, forcing a new contract to be signed by the patient.

### Add Patient Consent

To add a treatment consent select the 🗝️ icon on the status bar to display the **Add Patient Consent** dialog.

### Select Treatments for Consent

Select the date, consent form to use, the expiry date for the consent, and the section and sub tab of the patient attachments that the consent will be located. Selecting the **OK** button then displays the **Select Treatments for Consent** dialog. In this dialog one or more of the treatments that require consent can be selected. The consent form is then displayed and when closed one or more signature input dialogs are displayed to capture the patient’s and other person’s signature’s as the form is designed to require.
Forms Tab

Note: For information on forms (i.e. using EPR forms), refer to the Patient Attachment module. Also refer to the EPR Forms Reports manual and the EPR Form Design manual.

Exan recognizes the increased complexity of protecting patients’ privacy while managing access to, and release of information about patients. In order to maintain the standards of the Health Information Portability and Accountability Act (HIPAA), security measures must be undertaken in order to ensure the privacy of the patient information. Adherence to your organization’s policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the healthcare organization’s information privacy practices is mandatory within axiUm.

axiUm's EPR Forms dialog is an electronic representation of the various forms typically filled out in order to assess the ASA score for a patient, record medical / dental history, record and describe biopsy plans etc. For a new patient the window will open with a blank list. For a patient that has been seen previously, the window will open with the last entered form displayed.

The Forms tab displays all EPR (Electronic Patient Record) forms that have been attached to the patient record, and allows the user to add additional forms as needed. When the tab is selected, if the user has a default form defined in EHR display Options and patient has a form of that type attached, it loads the latest form on file of that type for the patient. Otherwise, it loads the last used form for that patient.

![Forms Tab Image](image)

Change **Date** (top left) shows the date of the most recent change for the selected form.
Patient ASA displays the calculated ASA score value for the patient. This is based on a form page being defined as an ASA form page with ASA values identified for the appropriate question lines.

Forms on File (upper right) lists all forms patient has on file. When forms are multi-instance type forms, and patient has more than one the description of the form is listed with a ‘+’ sign beside the description. If the user clicks on the ‘+‘, the tree expands and a sub list of the dates on which forms of this type were attached will be displayed. When the user clicks on the form description the list will display the multiple instances for the user to choose the appropriate specific form.

If Ortho type form selected, the patient’s primary Faculty is displayed.
If Perio type form selected, the patient’s Perio Type plus its combo box, and Perio Prognosis plus its combo box are displayed.

Approvals are performed in the EHR Forms by clicking on the “Approve” button to open the Form Approval window. Once in this approval window the user can choose to approve the current page or all pages, and swipe their card to perform the approval.

Forms Tab Toolbar Options

- Add a new EPR form to the patient’s record
- The Show History button allows the user to make some selections of what they need to see a history of, and then re-displays the chart as requested.
- The print button opens the Print EPR Form window to allow the user to print the currently selected form data as a report.

Adding a Form

Select the icon to create a new form.

From the Form Type drop down list select the form that you wish to add. If selecting a ‘multi page’ form like a biopsy form, enter a unique description and click “Ok”. The date can be changed for when the form was filled in the case where a paper form is being transcribed from an earlier date. The creation date of the form, the date of the form’s creation, cannot be altered.
To record the patient’s response to each question, click on the question in the answer column and then fill in the response. In order to properly calculate the ASA score every question in an ASA form page should be answered.

**Entering Answers**

Questions that require a long response will initially look like a highlighted line:

<table>
<thead>
<tr>
<th>Form Question</th>
<th>Answer</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
<td>Dental History</td>
<td>Clinical Exam</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Pulse</td>
<td>Temperature</td>
</tr>
<tr>
<td>Are you under a physician’s care at present? (If yes, why?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been a hospital patient, undergone any surgery or suffered from an</td>
<td></td>
<td></td>
</tr>
<tr>
<td>condition? (If yes, indicate your year and reason for your hospitalization.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently taking any kinds of prescription or non-prescription drugs on</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To enter the text of the answer, click once on the space bar on your keyboard, or double click the question line. This will open the answer field in “edit” mode:

When the response is complete click on the <esc> key, or click on the down arrow key, or using the mouse highlight the next question line to exit “edit mode”.

To respond to a Yes / No type question click with the mouse on the response desired or using the keyboard enter a ‘Y’ for Yes, an ‘N’ for No or ‘U’ for Unanswered. If you are using the keyboard to enter data, the system will auto advance to the next line once the selection is made.

A question that has an image associated with it will be displayed in the list with a Pen 🆙 icon to the left of the text. To access the graphic image double click on the question line, or click on the spacebar on the keyboard.

The image will open in an image editor window.
The user can select a line depth and color, to draw on the image.
Click on “Ok” once the image is complete to save changes and close the window.
Calculated fields in the EPR are represented by a ‘Calculator’ icon. To force the system to perform the calculation, double click on the question line, or click on the spacebar.

Questions that, when answered, have sub-questions that then have to be answered, have an information icon beside the question name.

Checklist questions with a checklist icon next to the name will pop up a list of answers to be checked off when the spacebar is pressed or the question double clicked.

Warning: If a faculty member denies an EPR form by clicking the Deny button on the Form Approval window, axiUm clears ALL answers in the current page or all pages (whichever option you selected).

ASA Calculation
Once all questions have been responded to in a form that has ASA score questions, left click on the Patient ASA arrow to move the calculated ASA score to the patient record.

Attachments to an EPR Form
Attachment questions have a paper clip icon before the question text. When selected and the spacebar is pressed or the question double clicked the EPR Form Attachment dialog is displayed.
A file can be selected to be attached or an image can be scanned directly into the form as an attachment.

Adding a Signature

When a form is created and requires one or more signatures the Sig. Required button will be blue. Selecting this button will display the signature dialogs for the patient or other party to sign.

If a question is edited the form will require a new set of required signatures.

Editing an Existing Form

If changes are required to a form select the plus icon next to the form name and the date of the form to be edited.

Click on the question that requires editing. Record the new response.
For yes/no/unanswered questions, if the response entered is the same as its previous value, the response will be written out and an audit trail will be created. The original response will be archived and a new record will be created with the new response. For all other question types if the response is to remain the same but you wish to record the fact that it was asked of the patient on today’s date highlight the question and press <CTRL> + R.
Printing The EPR Form

Some EPR forms may have been set up with Custom Reports that will take some information provided in the EPR and display it formatted in a different manner. To access one of these reports click on the “print” icon. The Print EPR From window will open.

Select ‘Standard Report’ or select from the list of available Custom Reports. Click ‘Preview’ to view the report or ‘Print’ to send the report immediately to the printer.

Attachments Tab

This tab lists attachments for the patient organized by the attachment sections along the far left. Attachment sections and tabs are customized by your axiUm administrator.
Beside the attachment section there will be a bracketed number indicating the number of attachments currently in each section.

**Attachments Tab Toolbar Options**

<table>
<thead>
<tr>
<th>Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Create a New Record" /></td>
<td>The Create a New Record button opens the appropriate window to allow the user to add a consent, attachment, image, or document. The window that opens is dependent on the selected attachment section.</td>
</tr>
<tr>
<td><img src="image" alt="Edit Record" /></td>
<td>The Edit Record button allows the user to make some modifications to the selected item.</td>
</tr>
<tr>
<td><img src="image" alt="Delete Record" /></td>
<td>The Delete Record button allows the user to delete the currently selected record (if their security allows this).</td>
</tr>
<tr>
<td><img src="image" alt="Preview Report" /></td>
<td>The preview report button allows the user to view the selected report.</td>
</tr>
<tr>
<td><img src="image" alt="Print" /></td>
<td>The print button launches the Select Printer window to allow the user to print the currently selected attachment.</td>
</tr>
<tr>
<td><img src="image" alt="Add Scanned Record" /></td>
<td>The Add Scanned record button opens the Add Patient Attachment window to allow the user to browse to a file that has been scanned and temporarily stored, so that they can attach it to the patient record. If the Attachment Description field is blank then axiUm will default the description to the Attachment file name.</td>
</tr>
<tr>
<td><img src="image" alt="Scan to Files" /></td>
<td>The Scan to Files button launches the TWAIN driver for the scanner attached to the system and allows the user to capture and then store the file in the patient record.</td>
</tr>
</tbody>
</table>

**Attachments Tab Right-Click Options**

- **Move to another tab**: Opens the Move Attachment Items window to allow the user to specify the section and tab to move the selected attachment to.
- **Print List**: Prints the currently selected list of attachments.
- **Show Deleted**: Enabled if Hide Deleted is on. Refreshes the list and displays deleted records.
- **Hide Deleted**: Enabled if Show Deleted is on. Refreshes the list and hides deleted records.

**Perio(dontal) Tab**

This tab displays the last Perio chart for one arch at a time, with the ability to move arches up and down with the click of a button. This is text data only. Sizing the window up will give the ability to view the entire mouth at once.

**Note:** In 800 x 600 mode the EHR Periodontal tab can not be displayed and the Perio module must be used.

To the right of the Perio display a description of the currently selected Perio exam is present with the **PSR score** for the patient.
As new Perio records are added, items are added to the list of Perio Exams on the right. Each exam is shown with the entry date and a description of the exam type. The user can toggle between exams by clicking on the date field in the list for the desired exam date.

The Perio statistical **Summaries** are displayed in a sub-tab. The system can optionally display several perio stats here for the user.

### Perio Tab Toolbar Options

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Image]</td>
<td>Opens the Add Perio window for the user to enter Perio condition information.</td>
</tr>
<tr>
<td>![Image]</td>
<td>The Show History button allows the user to make some selections of what they need to see a history of, and then re-displays the chart as requested.</td>
</tr>
<tr>
<td>![Image]</td>
<td>Opens the Perio Chart for the user to add / review information.</td>
</tr>
<tr>
<td>![Image]</td>
<td>The compare form button opens the Periodontics Comparison Settings window to allow the user to view changes in Perio conditions over time.</td>
</tr>
</tbody>
</table>
The View Statistics button allows the user to view a crystal report of the Perio Statistics for the patient.

The print button launches the Select Printer window to allow the user to print the odontogram and patient treatment history.

Perio Tab Right Click Options

Tooth Notes/Conditions
Enabled when the user right clicks on a tooth number. Opens the Tooth Notes/Conditions window to allow the user to add a note or condition for the currently selected tooth.

Imaging Tab
The imaging tab allows the user to view the current patients’ images that are contained in the radiographic package in use at the school.

By default this tab opens with the intraoral images displayed. The user can choose between intraoral images, panoramic images and digital photos by clicking on the corresponding button.

This tab displays radiographic images for the current patient in an image mount. Also displays intra-oral images and optionally video images (if supported by the imaging capture application). This is an optional billable module of the software.

Imaging Tab Toolbar Options

The magnify button changes the cursor into a magnifying glass that can be held over the image to enlarge a portion of it. To view the magnification, hold the left mouse button down.

The Reload Images button is used to refresh the view of the current images. If images are captured when this window is open, they will not be shown until the view is refreshed.
The Full Size View icon opens the currently selected image in its original size.

The Start Imaging Software button launches the imaging application associated to the button by your axiUm administrator.

The Options/Settings button opens the EHR options window with Imaging tab selected.

**Tx (Treatment) Plan Tab**

Treatment Planning is an optional module and may not be available. The Tx Plan tab contains a series of sub-tabs that allow the user to work through the development of a treatment plan for the patient. For details on Treatment Planning please request a copy of the Treatment Planning document from your axiUm administrator.

**Note:** When treatment is added the system will automatically revert back to a split screen view if the user had been in full screen mode. This is so that the user can click on the odontogram to select teeth / surfaces while treatment planning.
Labs Tab

Lab orders are created in conjunction with treatment procedures that require the lab work. axiUm’s Lab Order module allows these lab records orders to be created, altered, managed, charged and reported.

The Labs tab contains a list of Lab Orders for the current patient.

<table>
<thead>
<tr>
<th>In Progress</th>
<th>Trx History</th>
<th>Trx Plan</th>
<th>Forms</th>
<th>Attachments</th>
<th>Pres</th>
<th>Labs</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order#</td>
<td>Case#</td>
<td>Date</td>
<td>Lab Proc</td>
<td>Site(s)</td>
<td>Discipline</td>
<td>Lab</td>
<td>Completed</td>
</tr>
</tbody>
</table>

Labs Tab Toolbar Options

- The Create a New Record button opens the Add Lab Order window for the provider to create a new lab order.
- The Edit Record button opens the lab order details window and allows the user to make some modifications to the selected item. For example, they may need to re-do a portion of the lab work.
- The Remake Lab Order button opens the Remake Lab order window to allow the user to create a new prescription for the lab work.
- The Delete Record button allows the user to delete the currently selected record (if their security allows this).
- The preview report button allows the user to view the selected lab order prescription.
- The print button launches the Select Printer window to allow the user to print the lab order.
- The EPR Forms button opens the Lab Order EPR Forms window for the currently selected lab order.

Labs Tab Right Click Options

Print History
This menu option opens the Lab order Printout History window for the user to review a history of the print jobs done for this lab order.

**Adding a Lab Order**

Select the add icon to display the *Add Lab Order* dialog.

- **Patient**: Disabled field, displays the patient's name with the patient's chart number in brackets.
- **Discipline**: (Optional field) indicates the discipline category under which this lab procedure falls.
- **Is Ortho**: The *Is Ortho* check box indicates that this lab order is for an Orthodontic procedure.
- **Procedure**: Indicates the ADA procedure(s) that triggered this lab order. Select the planned and approved procedure(s) from the ... button.
- **Lab Proc**: Indicates the lab procedure being ordered. A description of the lab procedure code is shown to the right.
- **Open Date**: Disabled field, displays the creation date of the lab order.
- **Student Remake**: Disabled field, if checked indicates this order is a student remake. A student remake occurs when a student needs to re-do a lab order.
- **Lab Remake**: Disabled field, if checked indicates this order is a lab remake. A lab remake occurs when a lab technician requests to re-process a lab order.
- **Charges Waived**: If checked indicates the charges are to be waived for this order.
- **Remake Order**: If the order is a remake, the original lab order number will be displayed here.
- **Order #**: This field displays the order number. This is an internally generated number and is a disabled field so it cannot be changed.
- **Case #**: Case number for lab tracking purposes. This number is generated within axiUm but can be edited if required.
- **Lab**: (Optional field) indicates the laboratory this order is to be sent to.
- Enter the required information such as the procedure the lab is for, the lab procedure to be done, and which lab will do the work. Select the *Is Ortho* check box if this is an orthodontic lab. Select the *Is Charges Waived* check box if there will be no charge for the lab. The *Case #* is set automatically but can be edited.

If one or more lab procedures are associated with that procedure only those will be shown in the *Lab Treatment Selection* dialog list if the lab was already created with the procedure.
If not, the **Lab Procedure Selection** dialog will be shown with the labs available for selection.

If no lab procedure code is associated with the selected procedure can be chosen from the **Procedure Codes List** dialog that will be displayed instead.
Press **OK** when complete and the *Lab Order Details* dialog is displayed.

**Lab Order Dialog - Order Section**

*Patient*: Disabled field, displays the patient’s name with the patient’s chart number in brackets.

*Discipline*: (Optional field) indicates the discipline category under which this lab procedure falls.
Is Ortho: The Is Ortho check box indicates that this lab order is for an Orthodontic procedure.

Procedure: Indicates the ADA procedure(s) that triggered this lab order. Select the planned and approved procedure(s) from the ... button.

Lab Proc: Indicates the lab procedure being ordered. A description of the lab procedure code is shown to the right.

Open Date: Disabled field, displays the creation date of the lab order.

Student Remake: Disabled field, if checked indicates this order is a student remake. A student remake occurs when a student needs to re-do a lab order.

Lab Remake: Disabled field, if checked indicates this order is a lab remake. A lab remake occurs when a lab technician requests to re-process a lab order.

Charges Waived: If checked indicates the charges are to be waived for this order.

Remake Order: If the order is a remake, the original lab order number will be displayed here.

Order #: This field displays the order number. This is an internally generated number and is a disabled field so it can not be changed.

Case #: Case number for lab tracking purposes. This number is generated within axiUm but can be changed if required.

Lab: (Optional field) indicates the laboratory this order is to be sent to.
The box below Lab indicates whether the lab is Pending Approval or Approved.

The Order section will be filled in from the Lab Order window and will be disabled with the exception of the scroll bars on the Procedure section if multiple procedures are associated with this lab order.

Lab Order Details Dialog - Order Item section

Provider: This field will be defaulted to your name.

Redo: If checked indicates this lab is a redo. The field to the right will indicate the redo number.

Lab Item: This number indicates the current line item of the lab order.

Internal Note: Contains any notes for the person processing the lab order.

Details: Contains the lab prescription information.

Lab Order Details Dialog - Expected section

Expected: Defaults to the date this lab is expected to be completed.

Creating Lab Orders

Lab orders are created by selecting the ‘Labs’ tab in the EHR dialog and selecting a plus icon to display the Add Lab Order dialog.
To add a lab order, first select one or more treatment procedure(s) that requires a lab order. The search (ellipse ...) button next to the Procedure list opens the Planned / In Process Treatments dialog that will display a list of all treatment procedures that require a lab.

To add a lab order, first select one or more treatment procedure(s) that requires a lab order. The search (ellipse ...) button next to the Procedure list opens the Planned / In Process Treatments dialog that will display a list of all treatment procedures that require a lab.

Selecting a treatment that requires a Lab Order

Lab Procedure Selection

The next step is to associate the treatment(s) listed above with the correct lab procedure. Note that this may have already been done when the treatment was added. If so, the lab procedure will be displayed in the Lab Proc field. If this field is blank, type in or select the lab procedure from the ellipse ... button which opens the Lab Procedure Selection dialog.

In the Lab Procedure selection dialog the Lab procedure(s) associated with this treatment will be shown in the Procedure list. Lab Orders that are already created will be shown in the bottom list. Lab procedures can be set to a Planned or In Process status.

More than one treatment procedure can be associated with a single lab order, but only one lab procedure can be selected.

If the treatment procedure has a defined lab procedure the lab procedure will be automatically selected by the Add Lab order dialog.

If the lab procedure is not already added by the user and in the EHR treatment list the lab procedure will NOT be added to the EHR TX History list when the lab order is created.

If the treatment procedure does not have a defined lab procedure the lab procedure will need to be found and selected by the user.

Only one lab procedure can be selected. Selecting a lab procedure and selecting OK will automatically bring up the Lab Order Details dialog.

A lab order is made up of lab items. The Details note area must be filled in, describing the lab order requirements before a lab item can be added to the list. More than one lab item can be added at a time, but this is not desirable or recommended. The first item needs to be completed before the second can dealt with (approved, sent out, etcetera) and the next item is usually determined by the outcome of a preceding item.
Lab Order Details

After adding details the add icon will add the lab. Lab orders can be edited by double clicking the lab procedure in the EHR Labs list or selecting the edit icon. Once a lab order is created, the lab procedure linked to the treatment can not be changed.

Lab Procedures - A Special Case

There is a special case when selecting lab procedures for a treatment requiring a lab:

1. There exists a treatment requiring a lab that already has a lab procedure created for it.
2. The axiUm user then adds another treatment requiring a lab that does NOT have a lab procedure defined.

Add Lab Order Dialog
When the user creates the lab order for this second treatment, the Lab Proc field is empty because there is no lab procedure yet created. Selecting the search (...) button for the Lab Proc field and this opens the Lab Treatment Selection window which lists all the other lab treatments that have been started.

![Lab Treatment Selection](image)

**Lab Treatment Dialog Selection - Existing Lab Procedures Exist**

The user then has to select the 'Procedure' button to proceed to the 'Lab Procedure Selection' window (see dialog 6) to select a new Lab Procedure. However, the user can also select a listed lab procedure to be used for the lab order and associated with the treatment requiring a lab as long as the lab procedure is not part of a currently open lab.

![Lab Treatment Selection](image)

**Lab Treatment Selection Dialog - The Lab procedure is already part of an active lab order**

This allows several treatments requiring a lab to be associated to one lab procedure, although each treatment requiring a lab will have an individual lab order.

### Approving Lab Procedures and Approving Lab Orders

Lab orders and Lab Procedures are approved separately and for different reasons.

Lab procedures are like the treatments they are linked to. A change to a detail or to the status will require the lab procedure to be approved if the user requires treatment approval. Approval of lab procedures is done in the 'Check Out Patient' dialog in the same way treatments are approved.(accessed from the Rolodex as a right click on the patient listing as the Approve / Check Out menu item or the blue patient chart number area in the status bar).

Lab orders need to be approved when created, or when Redone in the 'Lab Order Details' dialog. If not approved from the EHR Labs tab dialog, the lab order will not show up in the lab tracking module.

### Changing a Lab Order Status and Changing a Lab Procedure Status

Lab procedure status is controlled by the linked treatment procedure. When the treatment is changed from Planned to In Process the lab also changes. However, if a lab order is created for a lab procedure and the lab order is not complete, neither the treatment nor the lab procedure can be completed. A lab procedure does not require the creation of a lab order. If no lab order was created then this rule does not apply and the lab procedure is not affected by this situation.

The Lab Order status is controlled by the Lab Tracking Module. Lab tracking controls the flow of lab order status from "requested" status to "out to the lab" status to "in from the lab" status and, finally, complete.
If a lab order is ‘In’ from the lab and the treatment procedure status is set to Completed, the lab procedure will also be completed and the lab order will be set to a Completed status too, once the completed treatment and lab procedures are approved (if required).

**Redone versus Remade**

Lab order items can be Redone. The Redo button closes a lab order item and creates a new item that again has Requested status. This is done when a lab item did not turn out exactly right, needs a change or requires more work. The new item goes through the process of being Requested and In, sent Out and In Progress, and then In and Complete.

In the EHR Lab tab dialog the same button is a Remake.

**Lab Order Remake Dialog**

A remake is a complete restart of a lab process. This is used when the lab needs to be completely restarted. It’s the same as creating a new lab order except that the remake flags can be set, indicating if the student or the lab required the remake. The old lab order is closed and can not be deleted.
Lab Order Details Dialog - Supplements Section

**Supplements:** To add a supplement to the lab order, click on the ... button to the right of **Supplements** in the lower half of the window. The Supplement Codes window will open:

Double click on the supplement that you wish to add to the order. Focus will return to the lab order window. With the supplement you selected now visible in the cell click on the **Add** button to add it in to the order.

To modify existing items in the order, highlight the item line within the lower list and make changes to the record as needed. Then left click on the **Modify** icon (picture of a file folder with a check mark on it), to save the changes.

To add a new item to the lab order, first left click on the **Clear Data** icon (picture of light bulb) to clear the data. Fill in the fields as needed and left click on the **Add** icon (picture of a file folder with a ‘+’ sign on it) to save the item and add it to the lower list.

Lab Order EPR Form Pages

To open the Lab order EPR form pages click on the EPR Forms icon. Select a lab form from the drop down list.

The selected lab form will open allowing you to fill in the necessary data and draw on any images to indicate the specifics of work that needs to be performed. These forms can be printed and sent with the lab, or can be used simply as reference tools for reporting purposes. In either case, the form becomes a part of the permanent clinical record for the patient.
Printing Lab Orders

To preview the lab order form click on **Preview Form** icon with a lab order highlighted in the lower list. The system will launch a print preview of the lab order.

To print the lab form without previewing click on **Print Form** icon with a lab order highlighted in the lower list. The system will launch a print of the lab order.

To print the lab label click on **Print Label** icon with a lab order highlighted in the lower list. The system will launch a print preview of the lab order label.

A Lab Order Form Sample:

```
LAB ORDER

Supplemental: Slides

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
<th>Order Details</th>
<th>Approved By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3/21/2009</td>
<td>The initial prescription from the lab order</td>
<td>N. Smith</td>
</tr>
</tbody>
</table>
```
Prescriptions Tab

Note: For information on prescription writing, refer to the Prescription Writing manual.

The Prescriptions tab contains a list of prescriptions that have been written for the currently selected patient.

<table>
<thead>
<tr>
<th>Date</th>
<th>Drug</th>
<th>Dose</th>
<th>Total</th>
<th>Provider</th>
<th>Provider Name</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/26/2009</td>
<td>Amoxicillin</td>
<td>125 mg/5ml</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/26/2009</td>
<td>Amoxicillin</td>
<td>125 mg/5ml</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prescriptions Tab Toolbar Options

- The Create a New Record button opens the Patient Prescription Entry window for the provider to write a patient prescription.
- The Void button opens the Void Patient Prescription window. To void the prescription the user must enter a reason for the void.

Prescriptions Tab Right Click Options

<table>
<thead>
<tr>
<th>View Details</th>
<th>Opens the Patient Prescription Entry window in read only mode.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reprint Prescription</td>
<td>Opens the Select Printer window to allow the user to select a printer, and re-print the prescription.</td>
</tr>
</tbody>
</table>