MOIS Introduction Instruction for new users.

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- 3. How do I get to my patient's chart?
- 4. How do I document a transaction?
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 - b. Order investigations,
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 - d. Create referral letters,
 - e. Prescribe medications,
 - f. Billing/coding visits
- 5. How do I access my InBox (assigned transactions/tasks)?
 - a. Messaging (internal eMail)
 - b. Tasks / Inbox (scheduled messages)
- 6. How do I access historical information?

Click on question to take you to page in document

Disclaimer: Please be advised that the following materials were created by physician peer mentors and have not been endorsed or quality assured by MOIS. In order to ensure they remain relevant with any technical upgrades, they will be reviewed by physicians on an annual basis. Please send any feedback or suggestions for improvement to RandRCommittee@doctorsofbc.ca.

MOIS EMR Introduction Instruction Sheets

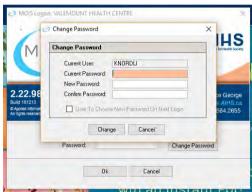
EMR Introduction Instruction Sheets for new users.

Startup FAQs

i.How do I log on?

1.In the office

- i. Double click on the MOIS icon on your desktop
- ii. The EMR login window will open



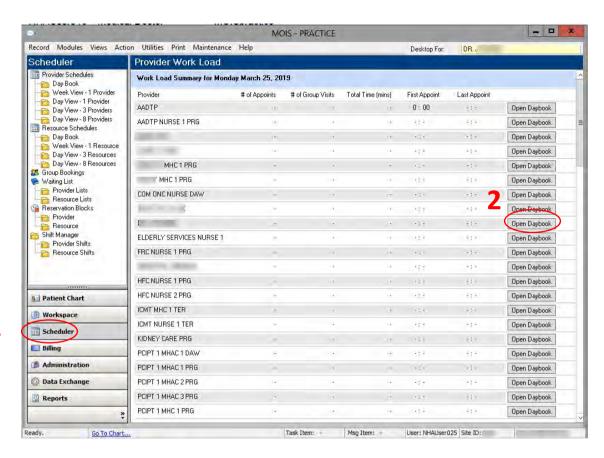
iii. Type in the User Name and Current Password given to you

2.Remotely

i. Choose MOIS icon on desktop that say MOIS Remote

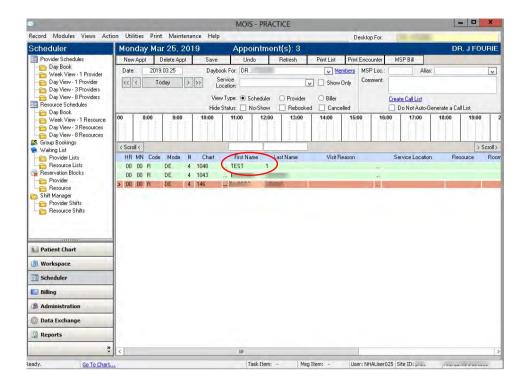
How do I access my schedule?

 When you log in, you will go to 1) an initial Provider Work Load screen, this is located in Scheduler to the left. Then find your 2) daybook and double click on Open Daybook

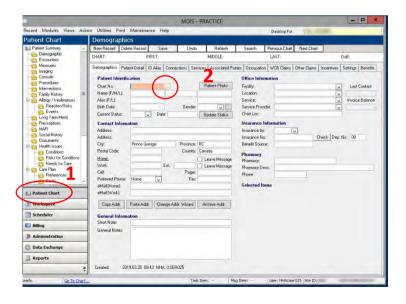


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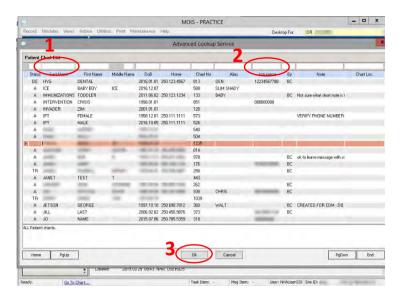
How do I get to my patient's chart?



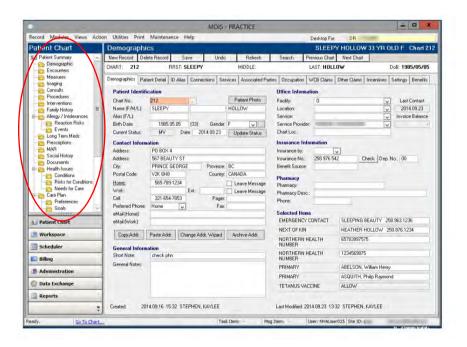
- i. From your day schedule, double click on the patient name of the chart that you want to access.
- ii. To access a file not in schedule, choose 1) Patient Chart on the left and 2) click on three dots next to chart #.



iii. Type in 1) last name or 2) PHN in appropriate row and then click OK at bottom of search box.

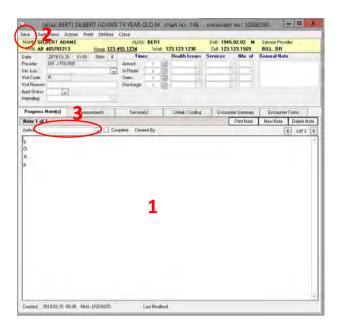


iv. Once chart is open, the default view is the demographic page. Choose which area of the chart you want to view and click on it on the options from the left.

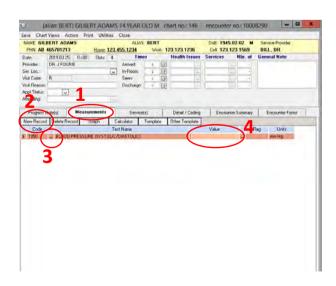


How do I document a transaction?

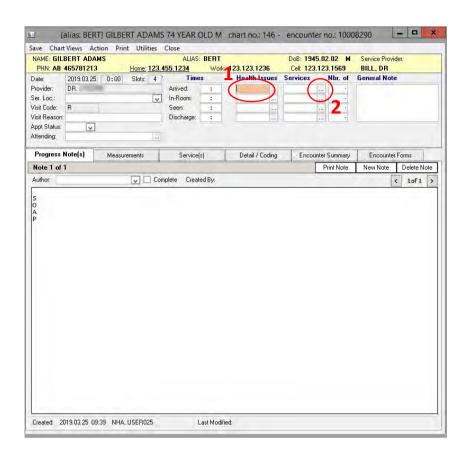
1. SOAP note, once you have double clicked on the patient in the scheduler the default open is to the encounter area of chart to dictate your 1) SOAP or transcribe. Once note is complete use 2) save button at top of chart or hot key F2 once saved it will 3) auto populate you as the author.



i. Please do not type your measurements in the SOAP field. 1) Choose Measurements
 2) New Record 3) click on the three dots to search for title of measure, once you have chosen measure 4) text value in the Value field. F2 or Save



ii. In the 1) Health Issue field enter diagnosis, search the ICD9 code with three dots, this will populate the appropriate diagnosis in the billing to MSP 2) in the services field enter the billing code searching for code with three dots.

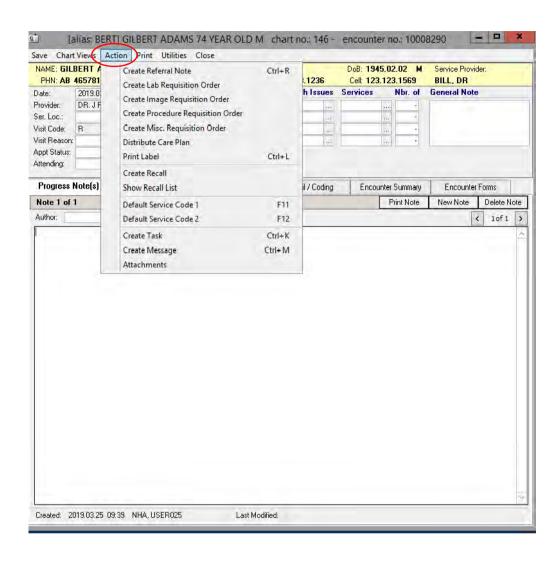


iii. Once the notes are complete 1) save 2) close the window



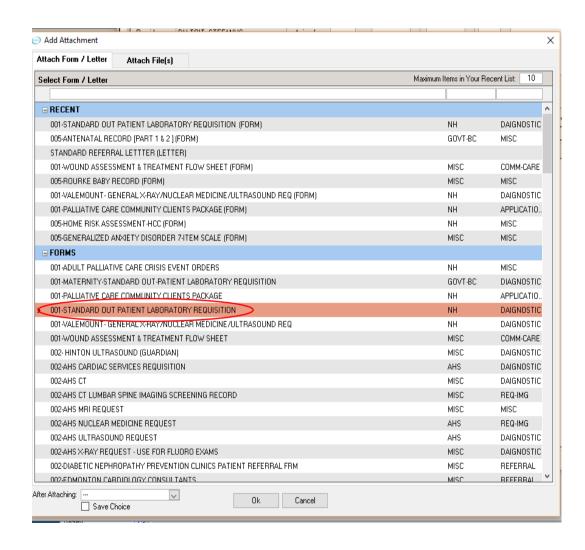
2. Order Investigations:

i. Choose Action from the options at the top of the encounter page choose your order



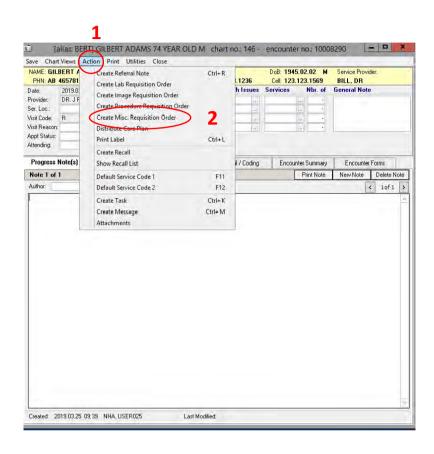
3.Labs and x-ray:

i. Once you have chosen lab or x-rays under Forms as your order click on the appropriate form and it auto populates patient info. Valemount/PG standard forms are at the top of the list and are labelled with 001 prior to form name. Print and give patient form.



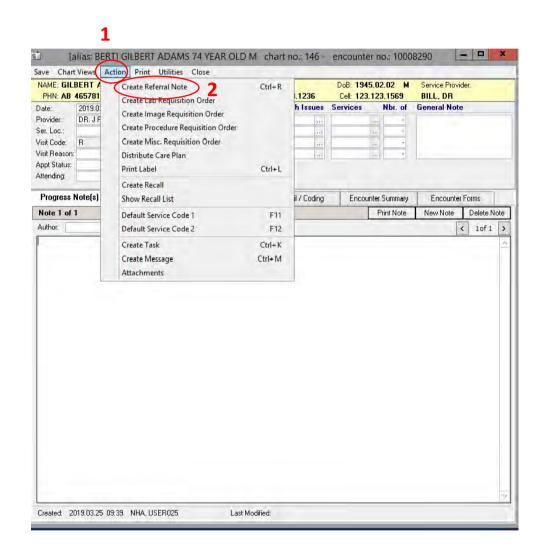
3. Forms:

i. Go to 1) Actions at top of patient chart. Choose 2) Misc. Requisition Order and all forms that are available will populate and you choose the one you want.

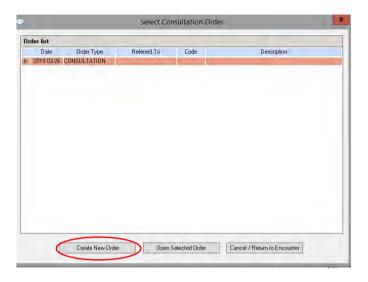


4. Referral letters:

i. Go to 1) Actions at top of chart and then 2) Create Referral Note.



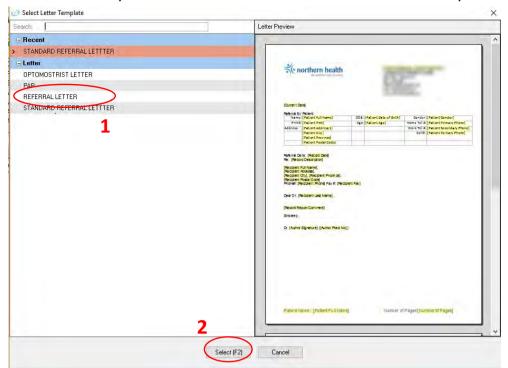
ii. Once Create Referral Note window is open, choose Create New Order



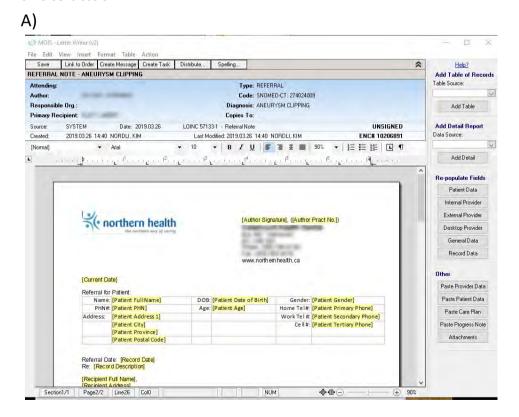
iii. Click on the three dots under 1) Description to find diagnosis 2) Go to Referred To click on three dots to find provider. 3) Type text of letter or copy in Referral Note area or cut and paste from encounter note. Once transcription is complete choose 4) Create Referral Note on the bottom of the referral

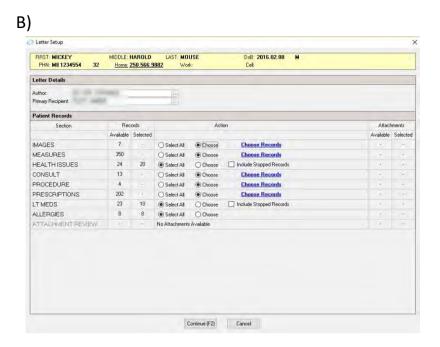


iv. Then choose 1) Standard Referral Letter from "Letter" list 2) Select

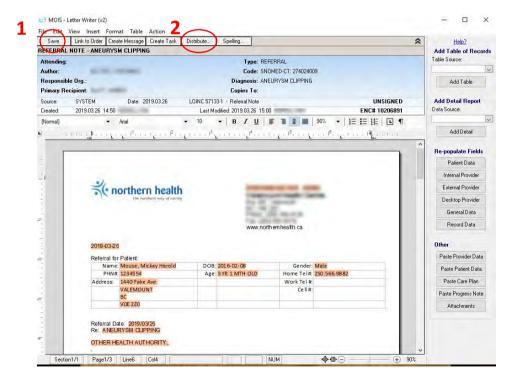


v. A) Referral letter with letter head and provider address is present with the text of the letter. You see this screen for a moment and then B) the list of options to add to the letter. Everything with a black dot is defaulted but you can pick and choose what you want to attach.



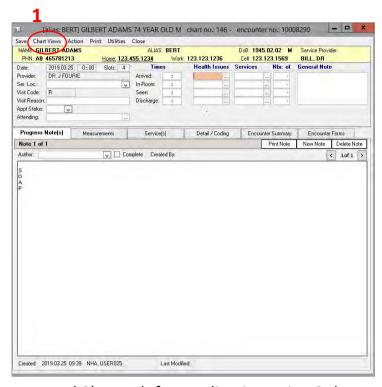


vi. 1) Save letter 2) Create a task to MOA or distribute via CDX or fax



5. Prescriptions

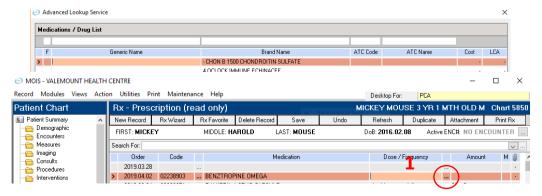
i. Go to 1) Chart Views then prescription or use hot keys ALT S



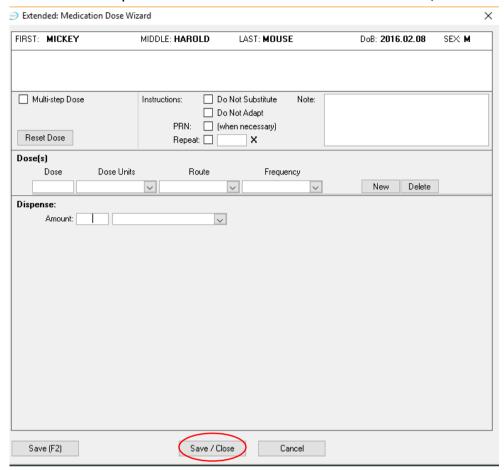
- ii. Choose 1) New record 2) search for medication using 3 dots
- iii. Type in medication name and once you find what medication you want to select click on OK at bottom of page. Once selected then choose 1) Dose/Frequency



iv. Type in medication name and once you find what medication you want to select click on OK at bottom of page. Once selected then choose 1) Dose/Frequency



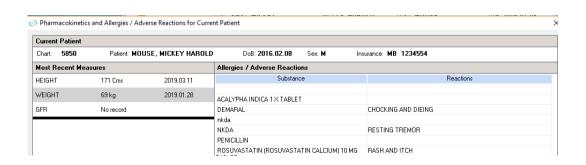
v. Once this window opens fill in dose etc. and then select Save/Close



vi. Choose 1) Print RX

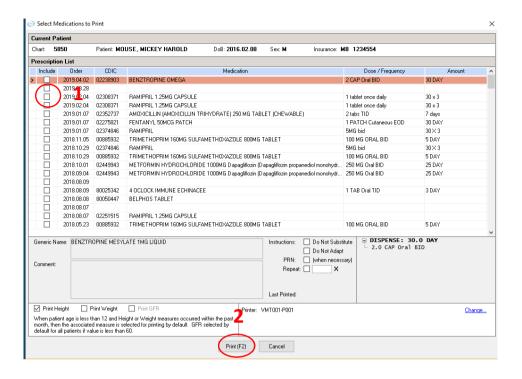


vii. A window then opens with Pharmacokinetics and Allergies/Adverse Reactions for Current Patient. You can close this window with the close button at the bottom of the page.



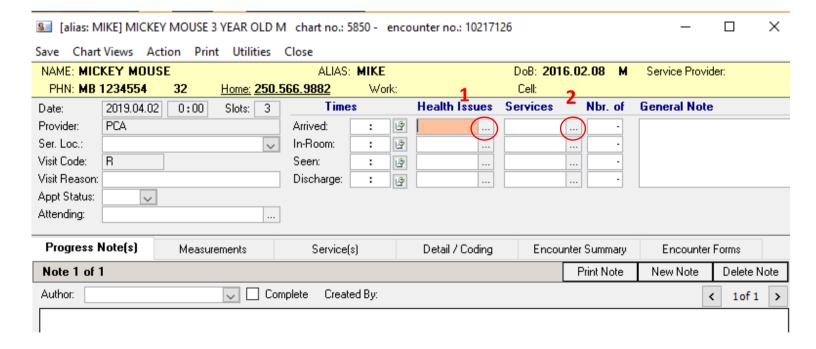
viii. Once the print window is open 1) click in the box the prescription you wish to print.

Then click 2) Print

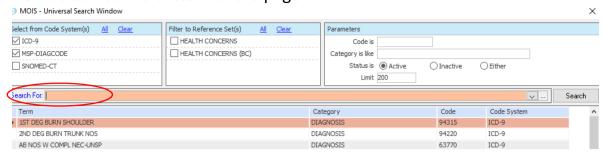


7.Billing/coding

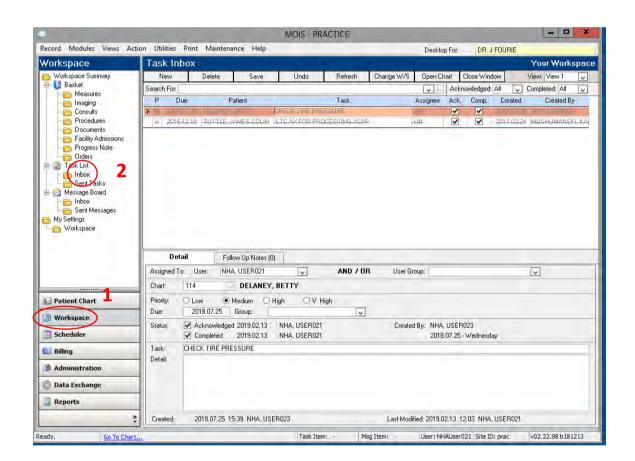
i. In the 1) Health Issue field enter diagnosis, search the ICD9 code with three dots, this will populate the appropriate diagnosis in the billing to MSP 2) in the services field enter the billing code searching for code with three dots.



ii. This search box then opens to 1) search for diagnosis/service, once selected click on OK button at the bottom of the page.

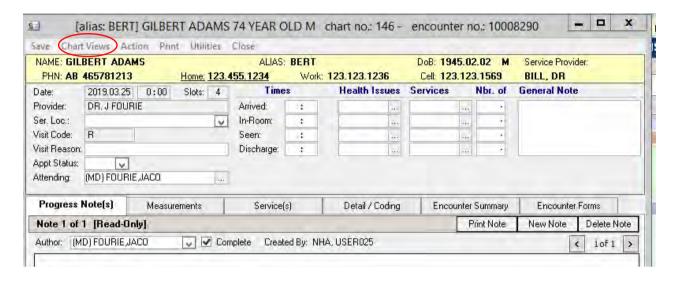


8. How do I access my inbox (assigned transactions/tasks)?

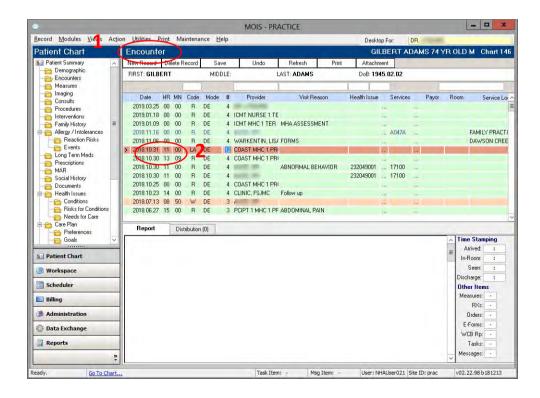


9. How do Laccess historical information?

i. You can access all historical information from the various areas of the chart at the top of the encounter note page click on 1) Chart Views.



ii. From 1) Patient Chart area you can choose where you want to find historical data under a specific folder such as 2) Long Term Med List



For more detailed information, please go to Help then User Manual

