

OSCAR Introduction Instruction for new users.

1. How do I log on?
 - a. In the office
 - b. Remotely

2. How do I access my schedule?

3. How do I get to my patient's chart?

4. How do I document a transaction?
 - a. SOAP note,
 - b. Order investigations,
 - c. Order labs,
 - 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. Ticklers (scheduled messages)

6. How do I access historical information?

Click on question to take you to page in document

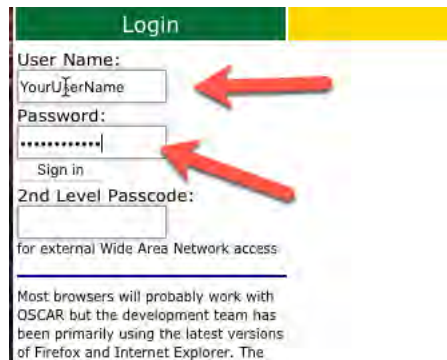
Disclaimer: This is an independent quick reference guide on getting started with Oscar that has been created by physicians, for physicians, and was not authored by your EMR vendor or issued as part of their official documentation. Your EMR vendor support desk should be the first point of contact if you have questions or need additional workflow guidance with your EMR software, and can also provide you with any official training materials or help files for your system on request.

Should you have any feedback or suggestions for improvement on this quick reference guide, please send to tbc@doctorsofbc.ca

How do I log on?

1. In the office

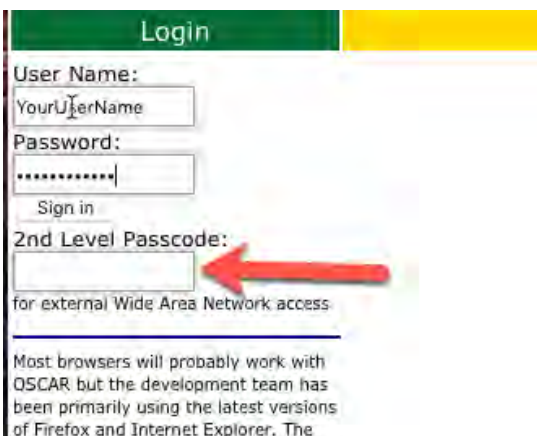
- a. You will be provided a user name (first name, e.g.) and a temporary password by the administrator. You may also need the 2nd Level Password, which will be provided. Use this to log in for the first time. You will be asked to create a new, unique password – requires at least 8 characters, no spaces, at least one upper case letter and a special symbol. Don't forget this password or you will have to start over again with a temporary password. If you fail to log in successfully after multiple attempts, you will be locked out. You will need to contact the administrator to have your account unlocked.
- b. OSCAR is displayed in a web browser, preferably FireFox. If you are using a different browser, some features may not function. Chrome is an acceptable second choice. Safari and Internet Explorer are not recommended. Find FireFox here – and download the ESR (extended support release) for your device. <https://www.mozilla.org/en-US/firefox/organizations/>
- c. You will be provided the IP address for local access to OSCAR, which will allow for server access when on the premises. If you are running a wireless device in the office, this will be the same as the Remote IP address.



The screenshot shows the OSCAR Login page. At the top, there is a green header with the word "Login" and a yellow bar to its right. Below the header, there are four input fields: "User Name:" with a placeholder "YourUserName", "Password:" with a masked password ".....", "2nd Level Passcode:" with an empty field, and a "Sign in" button. Red arrows point to the "User Name", "Password", and "2nd Level Passcode" fields. Below the "2nd Level Passcode" field, there is a note: "for external Wide Area Network access". At the bottom, there is a disclaimer: "Most browsers will probably work with OSCAR but the development team has been primarily using the latest versions of Firefox and Internet Explorer. The".

2. Remotely

- a. You will be provided an OSCAR IP address for remote access to the server. The 2nd Level Passcode is required to log in. Proceed as above.



This screenshot is identical to the one above, showing the OSCAR Login page. However, a red arrow points specifically to the "2nd Level Passcode" input field. The rest of the page, including the "User Name", "Password", "Sign in" button, and disclaimer, is the same as in the previous image.

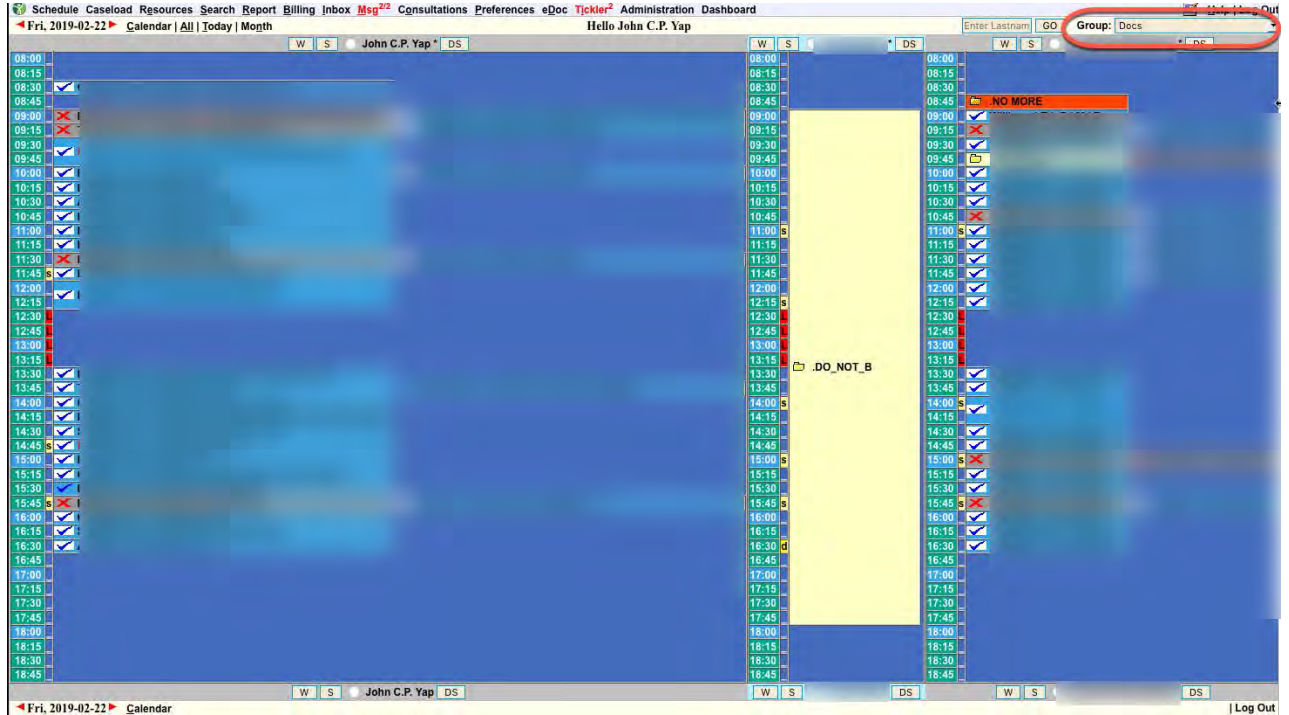
How do I log on?

HINTS:

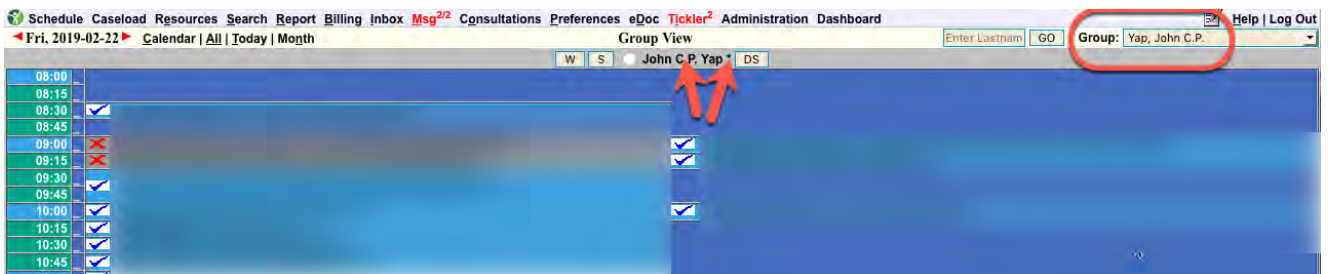
1. Consider bookmarking the IP address for OSCAR for easier access.
2. Log out of OSCAR when you are finished with it.
3. Do not share or expose your passwords in any way. IT security is paramount.
4. Do not SAVE your passwords if the browser offers this option.
5. Do not leave your laptop or workstation unlocked when unattended. Lock it out with a secure password.
6. Do not use unsecured WiFi when working remotely. Starbucks and ShawOpen are NOT acceptable!
7. Viewed files are downloaded into your designated download folder. These files contain patient-sensitive, confidential information, and should be purged at suitable intervals.
8. If you fail to log on multiple times, **your account may be locked**. You will need to contact the office administrator to unlock your account. Your Oscar Service Provider can also help. Ensure you know who these people are and how they can be contacted.

How do I access my schedule?

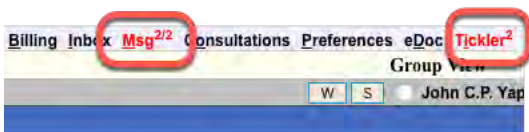
1. Once you have successfully logged in, you will be In the SCHEDULE VIEW. If you are in a multi-doctor clinic, there may be multiple schedules displayed. Change the view by using the Group filter (top right).



2. Click on your name and the adjacent star to toggle the **zoom view** and **expand reason** views.

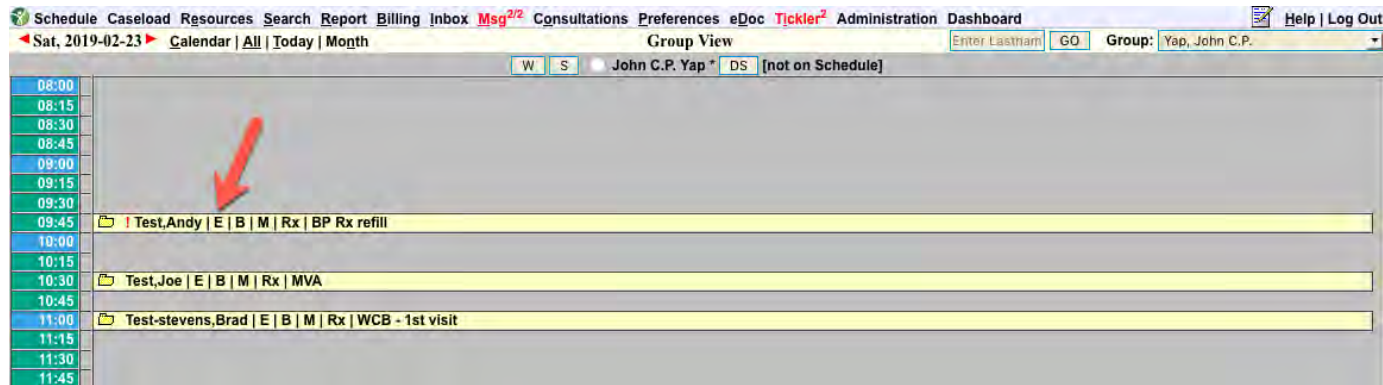


3. You will see notifications for InBox (labs, reports), Msg (internal eMail messages), and Ticklers (additional messages – usually managed by the MOAs). A red highlight indicates a new notice.



How do I get to my patient's chart?

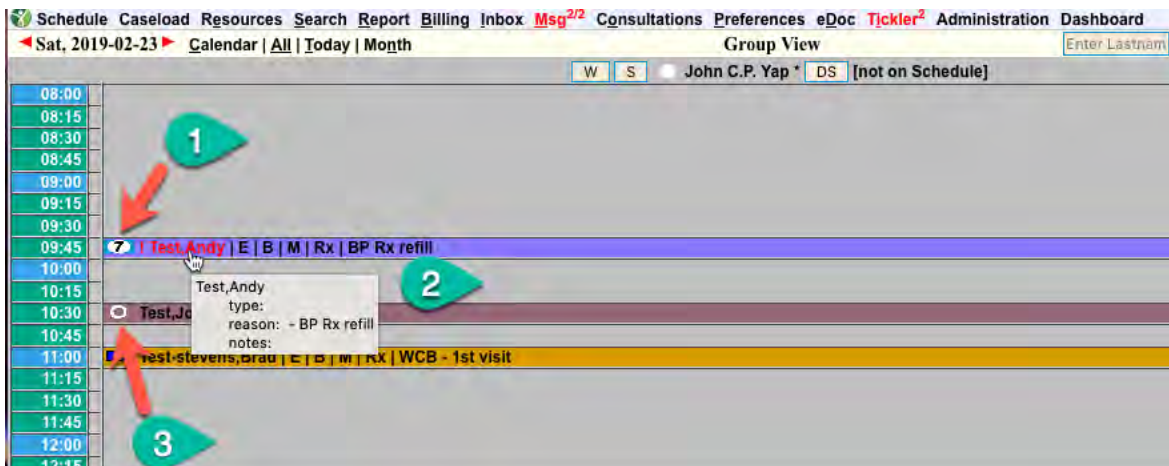
1. From the SCHEDULE VIEW (aka day sheet), click on the "E" for the patient. E = encounter



N.B. B = billing module. M = master record (demographics). Rx = prescription module. The colour and status icon may change to indicate what room the patient may be in, or whether the room is vacant.

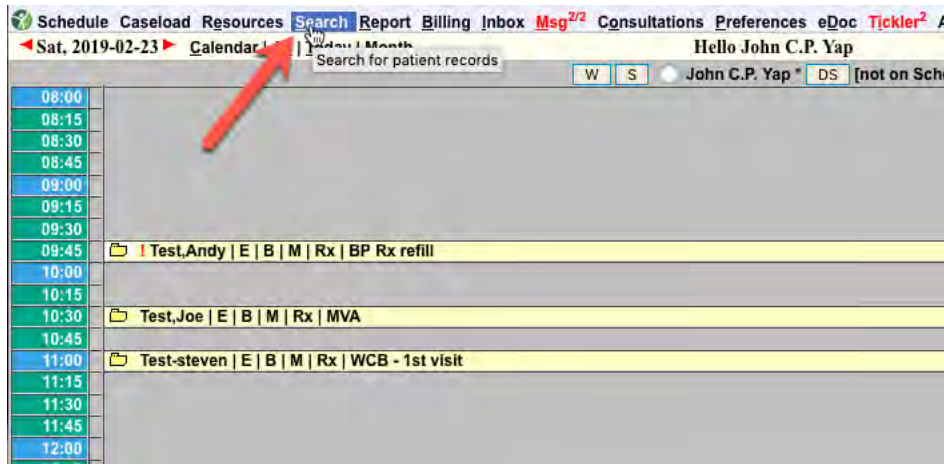
2. Colour coding may vary from one clinic to another. See below.

- (1) Patient is in room 7.
- (2) Hover over the patients name for more details if Expand Reason is toggled off.
- (3) This patient was a no-show.

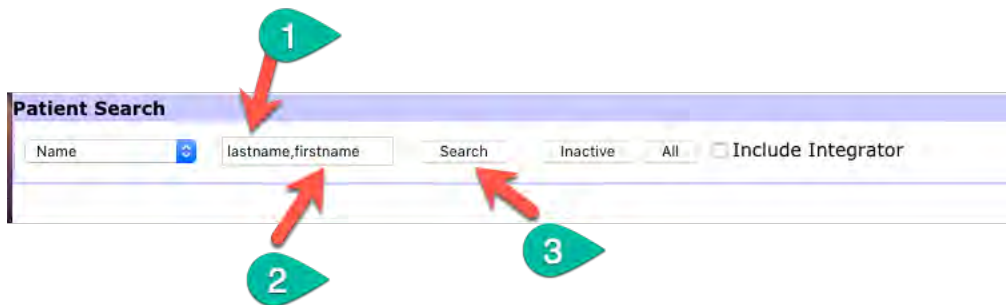


How do I get to my patient's chart?

3. If the patient is NOT on the schedule, you will have to SEARCH for the patient by name.



4. Type in the last name (1) and first name (2), separated by comma; and then click on Search (3).
HINT: the first 3 letters of the first and last names is generally all that is required.
This only searches for ACTIVE patients. Deceased, moved, fired, and inactive patients are excluded from the default search. Click "ALL" if you wish to search the entire database.

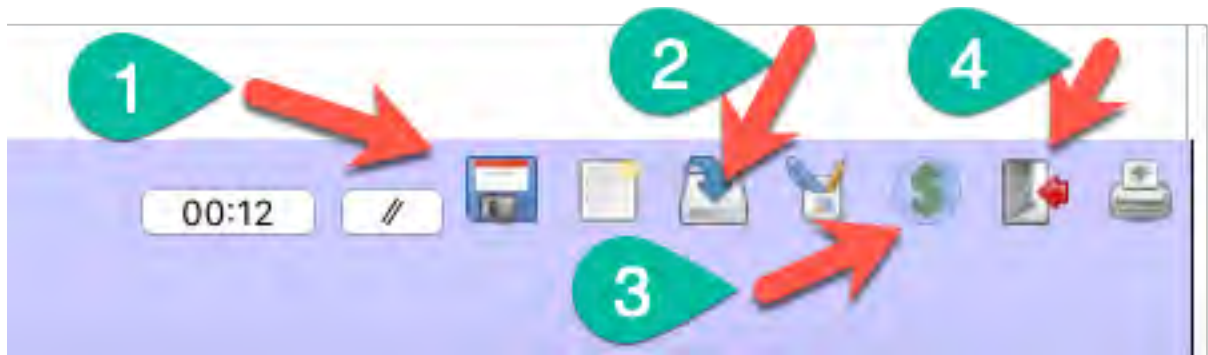


A list of matching names will be displayed below this section. Choose the appropriate chart by clicking on the "E" for encounter page.

How do I document a transaction?

1. Writing a **SOAP note**.

From the schedule, click “E”. Ensure the date on this entry matches the current date. If an earlier date is posted, you may have left an incomplete note previously. This old note must be completed and signed, otherwise you cannot proceed to write a new note, AND the other Oscar users cannot read your unsigned note. Save/sign/close the eCHART note before moving on to the next patient/chart. You return later to complete the note if desired, but ensure the chart is closed properly first.

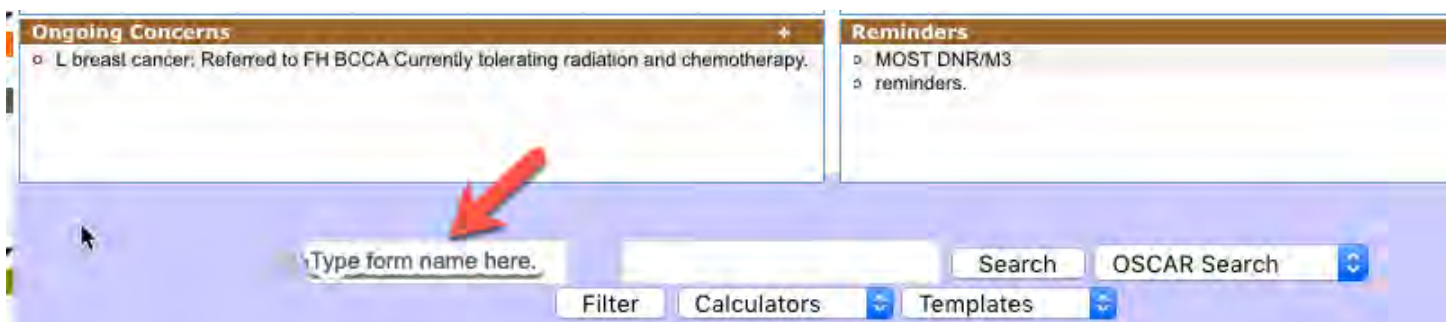


HINT: Ensure you are in the correct chart before you start and sign the note! Check the date!

- (1) Save – force a save action. Usually, there is auto-save every 5 seconds, but this forces a save. The eCHART remains open.
- (2) Save, sign, and exit. Your note is now visible to all, but the visit is not billed.
- (3) Save, sign, exit, AND go to the billing.
- (4) Exit eCHART – CAUTION – your input has NOT been saved.

HINT: You may wish to do this if you have inadvertently started typing in the WRONG chart.

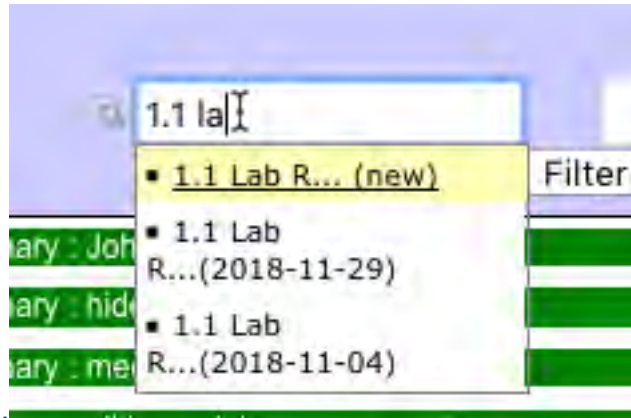
2. **Ordering tests** – lab and imaging requisitions are eFORMS. They are accessed from within the eCHART to allow for proper autopopulation. You need to ask your clinic EMR lead for the NAMES of the common imaging, lab, and other requisitions (e.g. Special Authority forms, etc.).
 - a. Use the search box and call up a specific eFORM



Type the first few letters of the eFORM name, and matching selections will appear. Choose a “new” eFORM. Selections with dates are previously completed eFORMS that are saved.

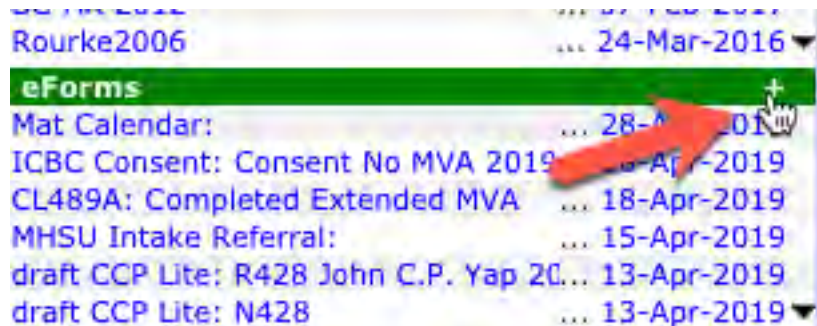
In GENERAL, do not reuse an existing eFORM to order new tests. Typing too much of the eFORM name sometimes creates an incomplete search. eFORMS with similar names cannot be found easily using this method.

One of the common eFORMS is the smart lab requisition – usually labelled 1.1 Lab requisition.



Click on the first entry (new) and the requisition will open.

- b. Search eFORM index. The entire library of eFORMS can be accessed by clicking on the plus (+) sign in the green eFORMS banner. You can then use the browser search function (Ctrl-F or Cmd-F) to find the necessary form.



HINT: ask your clinic which are the commonly used forms and make a list of their names. Some of the names may not be intuitive.

Examples: 1.1 Lab Requisition, Imaging forms (many different versions, depending on Health Authority), Special Authority (and the various sub-types), PHQ9, GAD7, MMSE, MoCA (if available), ICBC CL 489 forms, Prenatal Genetic Screening, Complex Care Plan templates, COPD advisor, Brief Pain Inventory, doctors notes (sick notes), referral to allied professionals (physio, podiatry, RMT, etc.), MOST forms, DNR forms, etc.

3. Using various forms.

- a. Rourke – this is a “built-in” form, not an eFORM, and is accessed somewhat differently. In this example, a Rourke form was started Sep21/17. To add MORE information to this form, click directly on this link.



- b. To open a new form, hover over the plus (+) sign and a drop-down menu of available forms will display. Move the mouse over the desired FORM and click on the link. You must always SAVE your work on these forms to close properly. Only the LATEST version will display in the eCHART view, but ALL versions will be saved in the background for audit purposes. The BC-WCB is a special FORM that acts as a “SOAP” note and the billing page!



4. **Referral letters** (to consultants) – access this module by clicking the plus (+) link in the Consultations bar located near the bottom left margin of the eCHART.



This opens a blank consultation template, which you will have to fill in with consultant's information. This information is preset by your clinic. If you do not find the consultant in your list, ask your office manager for assistance.

- (1) Choose the specialty
- (2) Choose the specialist.

HINT: once the drop-down menu opens, type the first letter of the specialty or specialist (last name) that you want, and the cursor will jump to the first item with that letter.

Consultation		TEST, ANDY M 49	
Created by:	<input type="button" value="Submit Consultation Request"/> <input type="button" value="Submit Consultation Request & Print Preview"/> <input type="button" value="Submit And Fax"/>		
Status	Referring Practitioner:	Dr. John C.P. Yap	Patient: 1 TEST, ANDY
<input checked="" type="radio"/> Nothing: <input type="radio"/> Pending Specialist Callback <input type="radio"/> Pending Patient Callback <input type="radio"/> Completed	Referral Date:	2019/4/29	Address: 123 Main Street New Westminster, BC,
	Service:	----All Services-----	Tel.No.: 604-555-9999
	Consultant:	-----All Specialists-----	Work No.: 604-544-6565
	Referrer Instructions		Email: test_eml@pretend.ca
	Urgency	Non-Urgent	Birthdate: 1969-06-15
	Phone:		Sex: M
	Fax:		Health Card No.: X987654321 AB
	Address:		Send to: ---- Teams ----
Attach File to Consultation Currently Attached Files: <input type="radio"/> None <input type="radio"/> Legend <input type="radio"/> Blue - Documents <input type="radio"/> Duplication Labels	Appointment Instructions		Appointment Notes:
	Appointment Date:		Last Follow Up Date:
	Appointment Time:	AM	
	Letterhead Name:	Yap, John C.P.	

(3) Add additional information that is available in the cumulative patient profile boxes by clicking on the relevant boxes. You can edit these items as needed (add new info, remove unnecessary details).

N.B. Medications and allergies autopopulate.

The image shows a screenshot of a patient profile form. It is divided into three main sections: 'Reason for Consultation', 'Pertinent clinical information:', and 'Significant concurrent problems:'. Each section has a set of tabs for navigation. The 'Pertinent clinical information:' section has tabs for 'Social History', 'Family History', 'Medical History', 'Ongoing Concerns', and 'Other Meds'. Below these are sub-tabs for 'Reminders', 'Risk Factors', 'Medications', and 'Long Term Medications'. A red arrow points from a green callout bubble containing the number '3' to the 'Medications' sub-tab.

(4) Add relevant reports and labs to consult letter by clicking the attach file hyperlink on the left margin.

The image shows a screenshot of a form with two columns. The left column contains a blue hyperlink 'Attach File to Consultation'. Below it is the text 'Currently Attached Files:' followed by a list box containing 'None'. A red arrow points from a green callout bubble containing the number '4' to the 'Attach File to Consultation' link. Below the list box are links for 'Send', 'Print', 'Labs', and 'Labs'. The right column contains a list of items: 'Address:', 'Appointment Instructions', 'Appointment D', 'Appointment T', and 'Letterhead Nar'.

(5) Check items you wish to add to the consultation letter. Click on the adjacent hyperlink for a preview of the item.

(6) When done, click on the “Done Close Window” button. You can always return to the attach file area to add more or remove items. Just click Done/Close to complete the task.

The screenshot shows a web interface titled "Documents for". On the left, there is a list of documents under the heading "Documents". A red arrow labeled "5" points to the "MR head nor" document, which is selected with a blue checkmark. Another red arrow labeled "6" points to the "Done Close Window" button at the top of the document list. To the right, there is a "Document Preview" area showing the header of a "COLONOSCOPY PROCEDURE REPORT" from Fraser Health. The report includes patient information for Pattison Outpatient Centre and details about the procedure, such as the endoscopist, indications, and medications.

(7) Once completed, you must save (SUBMIT) the consultation letter, or all your efforts will be lost.

CAUTION: Do not be tempted to open an old consultation letter for review, while creating a new consult letter. This will result in the new draft letter getting replaced by the old letter – i.e. all your work will be lost!

The screenshot shows a "Consultation" form for patient "TEST, ANDY M 49". The form is divided into several sections. On the left, there is a "Status" section with radio buttons for "Nothing:", "Pending Specialist Callback", "Pending Patient Callback", and "Completed". Below this is an "Attach File to Consultation" section. The main form area contains fields for "Referring Practitioner:" (Dr. John C.P. Yap), "Referral Date:" (2019/4/29), "Service:" (All Services), "Consultant:" (All Specialists), "Urgency" (Non-Urgent), "Phone:", "Fax:", "Address:", "Appointment Instructions", "Appointment Date:", "Appointment Time:", and "Letterhead Name:". On the right, there is a "Patient:" section with fields for "Patient:" (TEST, ANDY), "Address:", "Tel.No.:", "Work No.:", "Email:", "Birthdate:", "Sex:", "Health Card No.:", "Send to:", "Appointment Notes:", and "Last Follow Up Date:". A red arrow labeled "7" points to the "Referring Practitioner:" dropdown menu.

At this point, you should message the office staff to send the consultation letter. Do so within the patient’s chart, so all relevant information is connected to the request.

5. **Prescribing Medications** – access the prescription module by clicking on the BAR labelled Medications (1), or the plus (+) sign (2). The first method brings up a “blank” template to start a new medication prescription. The second method brings up ALL the drugs labelled as long-term. In some situations, this may be desirable. The basics for prescribing are as follows:

MRP DR. JOHN C.P. YAP TEST JOE M 53 years 604-555-1123 Next Appt: | Cumulative Labs Help About
 Cell: Addr: 123 MAIN STREET, BURNABY, V1V1V1 PHN: 1234 567 X Age: 53 (DOB: 1966-03-18) eMail: test_eMail@test.com Send eMail

Preventions
 FOBT
 HZV
 RZV
 PSA
 HIV
 H1N1

Social History
 Married, wife works; 2 kids. Lives in condo;
 unemployed

Medical History
 Medical: HTN, DM, COPD.
 Surgical: tonsillectomy age 8, appendectomy 1986; ORIF fractured ankle ...
 Psychiatric: nil.
 MedHx line 4.
 Medical: adding new item.

Ongoing Concerns
 High risk of colon cancer.
 Concern about living arrangements.

Reminders
 SBE prophylaxis needed.
 Do DM labs.

Allergies
 SULFA ... 16-Nov-2011
 AMOXIL 250 CAP ... 27-Aug-2011

Medications
 Hydrem 100 mg with Testosterone
 ALTA ... 1 tablet po daily for ...
 ... 200 mg TAB 500MG Take 1 Tab ...

Other Meds
 ASA 81 mg qd

Risk Factors
 2nd hand smoke exposure.
 Pfx of DM
 Pced asthma/exposure

Search OSCAR Search
 Filter Calculators Templates

Treatment 1:
 rest

- a. Prescription writing should follow certain syntax and grammar. This is to allow Oscar to internally calculate how long the medication is intended to be used – short term, long-term, refills – all captured with the correct grammar. In a paper world, a prescription written as “Amox 500 mg tid M:21” would be understood by the pharmacist. But Oscar prefers this: “Amox 500 mg po TID for 7 days” in the instruction line.

#1. Start by searching for the desired medication. Type in the first few letters of the drug, and even the dosage, which will filter the drop-down list. It is preferable to choose the drug which has NO GENERIC PREFIX – to avoid clarification calls from the pharmacy. In the example below, Amox 500 mg is requested. Note the allergies. Avoid the use of CUSTOM DRUG as this will disable drug interaction and allergy checks.

oscarRx Patient Name: JOE TEST Age: 53 Preferred Pharmacy: Costco #051 Burnaby

Active Allergies ±
 AMOXIL 2...
 SULFA

Medical History
 Medical: HTN, DM, COPD.
 Surgical: tonsillectomy age 8, appendectomy 1986; ORIF fractured ankle 1996.
 Psychiatric: nil.
 MedHx line 4.
 Medical: adding new item.

Favorites edit copy
 ACLASTA

Drug Name: Amox Search CustomDrug Note Rese DrugOfChoice

Patient Drug
 AMOX 250 CAP 250MG
 AMOX 500 CAP 500MG
 AMOX S 125 SUS 125MG/5...
 AMOX S 250 SUS 250MG/5ML
 AMOXAPINE 100MG TABLET
 AMOXAPINE 25MG TABLET
 AMOXAPINE 50MG TABLET
 AMOXI-CLAV 500MG/125MG
 AMOXI-CLAV 875MG/125MG
 AMOXICILLIN 125MG GRANULES FOR SUSPENSION
 AMOXICILLIN 125MG POWDER FOR SOLUTION
 AMOXICILLIN 125MG POWDER FOR SUSPENSION

#2. This patient has an allergy to Amoxil, which will be highlighted once the Rx is written in full. The warning may be bypassed, if appropriate. If the tab key is used to navigate from the instruction line, the quantity will auto-calculate. If there are refills noted, the Long-Term Med button is auto-checked. The red asterisk at the end of the field opens a pop-up showing previous instructions for that same drug. This may offer some clues as to dosing. Click on a desired line if the instructions suit your needs.

Patient Name: JOE TEST Age: 53 Preferred Pharmacy: Costco #051 Burnaby

Name: AMOX 500 CAP 500MG Inactive Drug Since: Tue Apr 02 2002 more F

Allergy: AMOXIL 250 CAP Reaction:

Indication: icd9 Search Dx

Instructions: Take 1 cap po tid for 7 days

Qty/Mitte: 21 Repeats: 0 Long Term Med Short Term Med

Ingredient: AMOXICILLIN (AMOXICILLIN TRIHYDRATE) 500.0MG

Method:Take Route:po Frequency:tid Min:1 Max:1 Duration:7 DurationUnit:D Qty/Mitte:21

Drug Name: Search CustomDrug Note Rese DrugOfChoice Save And Print Save

Instruction	Special Instruction
Take 1 Tabs PO TID for 7Days	
Take 1 Tabs PO TID for 10Days	
Take 1 cap po tid for 10 days	
Take 1 Tabs PO QID for 7Days	
Take 4 Tabs PO OD 1 hour before dental work	
Take 1 cap po tid for 7 days	
AMOXICILLIN 500MG CAPSULE	

Add another medication, if desired, in the Drug Name Box at the bottom, and repeat steps #1 and #2.

#3. Refill an existing medication by highlighting the relevant checkbox(es), and clicking ReRx on one of the lines. The entire list will be loaded for review and edit. You may change instructions, quantity, etc., but you CANNOT change the drug name or dose. The drug name is associated with a specific DIN (drug identification number) and this is unique, allowing for allergy and drug interaction checks. Changing this will make the drug name a "custom drug".

Profile Legend: * Current [All](#) [Active](#) [Expired](#) [Longterm/Acute](#) [Longterm/Acute/Inactive/External](#)

Entered Date	Start Date	Days to Exp	LT Med	Medication	Represcribe	Delete	Discontinue	Reas
2017-11-16	2017-11-16	0	L	CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty:20 Repeats:0	<input checked="" type="checkbox"/> ReRx	Del	Discon	+
2017-11-16	2017-11-16	0	L	ALTACE 5MG Take 1 tablet po daily for 3 mo Qty:90 tab Repeats:3	<input checked="" type="checkbox"/> ReRx	Del	Discon	+
2016-10-06	2016-10-06	0	L	TESTOSTERONE CYPIONATE INJECTION USP 100MG Giva 160 mg i.m. q21 days for 3 months Qty:0 Repeats:0	<input type="checkbox"/> ReRx	Del	Discon	+
2015-02-03	2015-02-03	0	L	adia fast Qty:0 Repeats:0	<input type="checkbox"/> ReRx	Del	Discon	+
2015-02-03	2015-02-03	0	L	Hydram 1% cream with Testosterone 2% Apply 1 Units TOP BID PRN/Apply to affected areas/Apply sparingly Qty:30 gm Repeats:0	<input checked="" type="checkbox"/> ReRx	Del	Discon	+

When you have completed the list of medications for prescription, click "Save and Print" to see the Preview.

Name: CIPRO 500 - TAB 500MG [more](#) [F](#) [X](#)

No allergy to this drug found. Please check allergy list.

Indication: [Search Dx](#)

[Instructions:](#) Take 1 Tabs PO BID for 10 days * [?](#)

Qty/Mitte: 20 Repeats: 0 Long Term Med Short Term Med

Ingredient: CIPROFLOXACIN (CIPROFLOXACIN HYDROCHLORIDE)
Method:Take Route:PO Frequency:PID Min:1 Max:1 Duration:10 DurationUnit:D Qty/Mitte:20

Dosing Information [Refresh](#)

Clcr	Recommendation
5-30	250-500 mg po q18h

Clcr $\text{N/A} = \frac{(140 - 53[\text{age}]) \times 74.0 [\text{kg } 2017\text{-Jul-25}]}{\text{N/A sCr } [\mu\text{mol/L}]} \times 1.23$

[hide](#)

Name: ALTACE 5MG [more](#) [F](#) [X](#)

No allergy to this drug found. Please check allergy list.

Indication: [Search Dx](#)

[Instructions:](#) Take 1 tablet po daily for 3 mo * [?](#)

Qty/Mitte: 90 tab Repeats: 3 Long Term Med Short Term Med

Ingredient: RAMIPRIL
Method:Take Route:po Frequency:OD Min:1 Max:1 Duration:3 DurationUnit:M Qty/Mitte:90 tab

Name: Hyderm 1% cream with Testosterc [more](#) [F](#) [X](#)

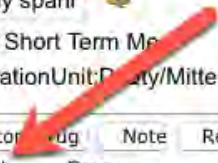
Indication: [Search Dx](#)

[Instructions:](#) Apply 1 Units TOP. BID PRNApply to affected areasApply sparir * [?](#)

Qty/Mitte: 30 gm Repeats: 2 Long Term Med Short Term Med

Method:Apply Route:TOP. Frequency:PID Min:1 Max:1 Duration:0 DurationUnit:D Qty/Mitte:30 gm

Drug Name: [Search](#) [Custom](#) [Drug](#) [Note](#) [Rese](#) [DrugOfChoice](#)
[Save And Print](#) [Save](#)



#4. The Preview allows you to return to the previous page - Edit Rx (1) - if you need to add more, change instructions, or remove an item. You can also add comments in the “Additional Notes” section (2), and this will be added to the bottom of the Rx. Examples may be: blister pack, for early refill, faxed to pharmacy, etc. You may even add a signature with your mouse in the Signature Section (3) – this needs to be saved to embed in the Rx. Usually, the Prescription is printed to paper for a “wet signature”. When satisfied with the Preview, click “Print & Paste into EMR” (4) to add the Rx list to the encounter note and Print to your local printer.

OSCAR Rx
Dr. John C.P. Yap

May 11, 2019

JOE TEST DOB: Mar 18, 1966
123 MAIN STREET
BURNABY, BC V1V1V1
604-555-1123
Health Ins.#1234567X

CIPRO 500 - TAB 500MG
Take 1 Tabs PO BID for 10 days
Qty:20 Repeats:0

ALTACE 5MG
Take 1 tablet po daily for 3 mo
Qty:90 tab Repeats:3

Hyderm 1% cream with Testosterone 2%
Apply 1 Units TOP. BID PRNApply to affected areasApply sparingly
Qty:30 gm Repeats:2

Signature:
Dr. John C.P. Yap
Pract. No. 11701
Created by: OSCAR The open-source EMR www.oscarcanada.org

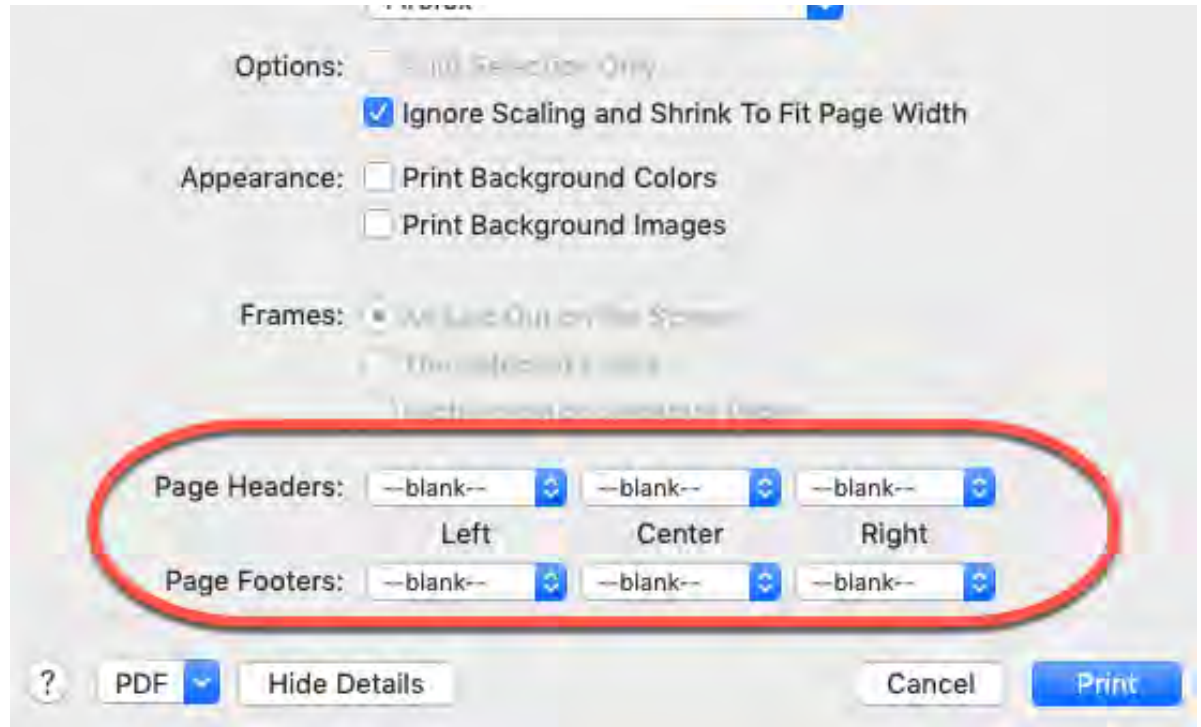
Actions
Size of Print PDF : A4 page
Print PDF
Print
Print & Paste into EMR
Create New Prescription
Close Window
Add Pharmacy Info

Additional Notes to add to Rx
Add to Rx

Signature
Please sign in the box above this message.

Drug Information
[CIPROFLOXACIN \(CIPROFLOXACIN HYDROCHLORIDE\) \(CIPRO 500 - TAB 500MG\)](#)
[RAMIPRIL \(ALTACE 5MG\)](#)

N.B. Ensure that headers and footers are set to blank on our device. Ask your office manager for assistance to do this.



[11-May-2019 .: Tel-Progress Note]

CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty:20 Repeats:0

ALTACE 5MG Take 1 tablet po daily for 3 mo Qty:90 tab Repeats:3

Hyderm 1% cream with Testosterone 2% Apply 1 Units TOP. BID PRNApply to affected areasApply sparingly Qty:30 gm Repeats:2

You may reposition the list of medications anywhere in your SOAP note. Just copy/cut/paste as needed.

Additional features to ask your Office Manager or colleagues to demonstrate: use of custom drugs, favourites, activating long-term status, deactivating long-term status.

Key Points: Use the proper syntax when writing a prescription. Ensure a duration of use is stated. Use Long-Term or Short-Term when appropriate. Avoid use of Custom Drugs if possible. Use the prescription module to document triplicate prescriptions and even samples!

6. **Allergy Module** – noting allergies properly is critical. Use same strategy to search for the specific drug, or drug class as for writing a Rx. Avoid use of Custom Allergy – it may seem faster, but there is no internal auto-checking with custom allergies. Save Custom Allergy for special situations such as allergy to shellfish, etc.

#1. Click on the Allergy BAR, or plus (+) sign. Existing allergies are listed, and may be inactivated or modified (1) – only available in Oscar15. Some preset allergies are available as quick-pick buttons (2). Or Search (4) for the desired drug, and check off the appropriate level of search (3) – usually drug classes, generic and brand names are desirable. It is preferable to choose a drug class (e.g. Penicillin) rather than a specific drug within that class (e.g. Amox). Use Custom Allergy as a last resort.

N.B. NKDA as a “custom allergy” is allowed.



Allergies

[TEST, JOE](#) sex M age 53

AMOXIL 2...
SULFA

MEDICAL HISTORY
Medical: HTN, DM, COPD.
Surgical: tonsillectomy age 8, appendectomy 1986; ORIF fractured ankle 1996.
Psychiatric: nil.
MedHx line 4.
Medical: adding new item.

FAVORITES [copy](#) [edit](#)
ACLASTA
ADACEL
ADVAIR 250...
Aerobika
Aerochambe...
ANUGESTIC-H...
ANUGESTIC-H...
APNO
ATROVENT N...

Edit Allergy Profile View: Active All Inactive
Legend: Mild Moderate Severe

Status	Entry Date	Description	Allergy Type	Severity	Onset of Reaction	Reaction	Start Date	Life Stage	Age Of Onset	Action
Active	2017-11-16	SULFA	Custom Allergy	Unknown	Unknown	steven-johnson syndrome		Not Set		Inactivate Modify
Active	2011-08-27	AMOXIL 250 CAP	Brand Name	Mild	Immediate		0001-01-01	Not Set		Inactivate Modify

Legend: Mild Moderate Severe

Add an Allergy
NKDA Penicillin Sulfa

Drug Classes Ingredients Generic Names Brand Names All

Search OR Custom Allergy

#2. Search for Ramipril: type in part of name (1), choose the categories, and click “Search” (2).

Add an Allergy
NKDA Penicillin Sulfa

Drug Classes Ingredients Generic Names Brand Names All

ramipril Search OR Custom Allergy

A drop-down list should appear. Choosing the class of drug is preferable – i.e. ACEI (2).

Add an Allergy

NKDA Penicillin Sulfa

Drug Classes Ingredients Generic Names Brand Names All ramipr Search OR Custom Allergy

ALLERGY SEARCH RESULTS

ATC CLASS

[RAMIPRIL](#)
[RAMIPRIL AND DIURETICS](#)
[RAMIPRIL AND FELODIPINE](#)

BRAND NAME

[ACT RAMIPRIL 1.25MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 10MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 2.5MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 5MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ADD RAMIPRIL 1.25MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)

Click on the appropriate link, then add comment to describe the reaction (1), and other details if desired. Click “Add Allergy” (2) to save the information.

Add an Allergy

NKDA Penicillin Sulfa

Adding Allergy: ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

Comment: (1)

Start Date: (yyyy-mm-dd OR yy-mm OR yyyy)

Age Of Onset: (2)

Life Stage:

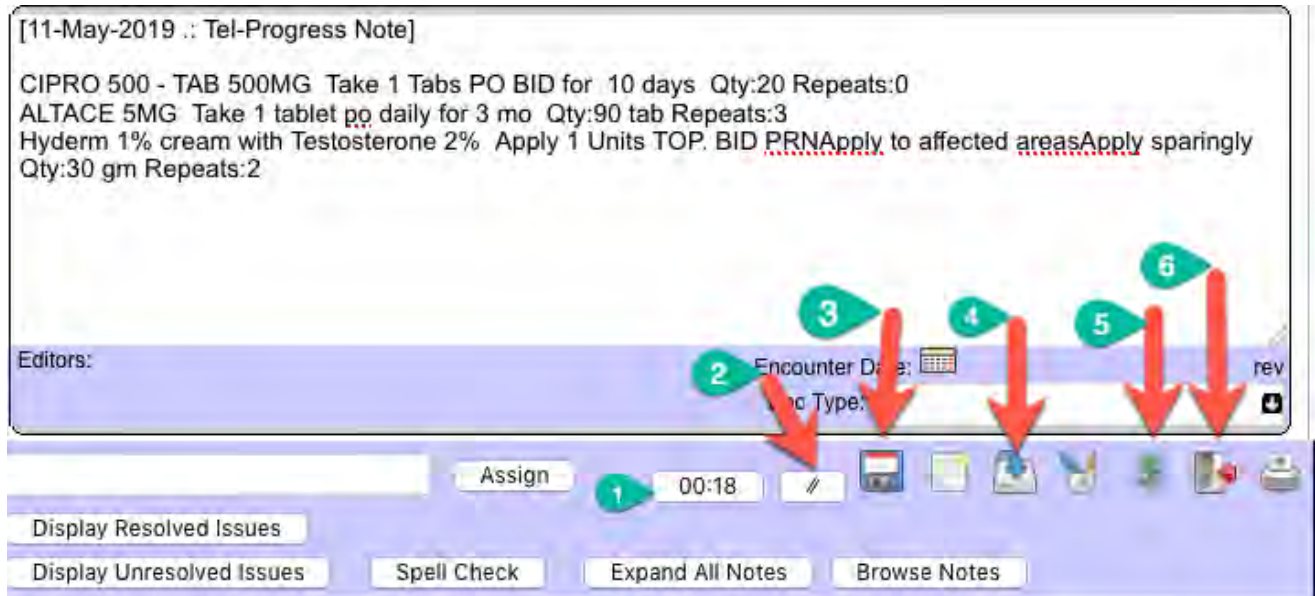
Severity Of Reaction:

Onset Of Reaction:

Drug Classes Ingredients Generic Names Brand Names All ramipr Search OR Custom Allergy

Key Points: Avoid the use of Custom Drugs or Custom Allergies.

7. **Billing** – most physicians will bill themselves, after completing the note. Some private bills can be generated by the Office staff. Access the Billing Module using the Save and Bill icon in the encounter note.



- (1) Timer – click to paste start/stop time into the bottom of your current encounter note. N.B. Timer restarts at current time if you leave/close note and return, so activate the start time early by clicking this button when needed.
- (2) Timer pause/restart.
- (3) Force save – note will be saved, but not signed. Usually not needed, as auto-save is activated every 5 seconds, or so.
- (4) Save and exit – forces a full save, signature and time stamp added, and encounter note is closed. To further edit this note, you have to return to encounter page and click “edit” link in the top right corner of this note.
- (5) Save Sign & Bill – once the note is complete, you can save and go directly to the billing page. Once you click this icon, the chart is closed and cannot be viewed.
HINT: make sure you remember what the diagnosis is – for the billing page!
- (6) Exit – use if you DO NOT WISH TO SAVE ANY OF YOUR CHANGES, and wish to close the note. Very useful if you are typing in the wrong chart! This is the proper way to leave a note without saving any foot print of your actions – if you are typing in the wrong chart.
HINT: if the note belongs in a DIFFERENT CHART – select and copy the work to PASTE into the correct chart! Do this before you EXIT the wrong chart.

On clicking Save Sign & Bill – the billing page opens:

Patient: TEST, JOE Age: 53 Invoice List Patient Status: Test Roster Status Assigned Physician: Yap, John C.P.

Billing Form: GP general practice Billing Physician: Yap, John C.P. Billing Type: Bill MSP Clarification Code: VANCOUVER Service Location: A|Practitioner's Office - In Community

Service Date: 2019-05-11 Service to date/After Hours: 7 Time Call: Start (HHMM 24hr): End (HHMM 24hr): Dependent: No Sub Code: O - Normal Payment Method: ELECTRONIC Facility:

Office Visits	Description	\$Fee	Complex Fees	Description	\$Fee	Other	Description	\$Fee
<input type="checkbox"/> 15300	VISIT IN OFFICE (AGE 50-59)	34.62	<input type="checkbox"/> 00043	ANTICOAGULATION THERAPY BY TELEPHONE	6.95	<input type="checkbox"/> 13070	IN OFFICE ASSESSMENT IN ASSOC WITH A WSBC SERVICE	16.36
<input type="checkbox"/> 15301	COMPLETE EXAMINATION IN OFFICE (AGE 50-59)	76.83	<input type="checkbox"/> 13005	ADVICE ABOUT A PATIENT IN COMMUNITY CARE	15.72	<input type="checkbox"/> 13075	IN OFFICE ASSESSMENT IN ASSOC WITH AN ICBC SERVICE	16.36
<input type="checkbox"/> 15320	INDIVIDUAL COUNSELLING IN OFFICE (AGE 50-59)	60.23	<input type="checkbox"/> 14540	INSERTION INTRAUTERINE CONTRACEPTIVE DEVICE (IUD)	42.94	<input type="checkbox"/> 14029	ALLIED CARE PROVIDER PRACTICE CODE	0.00
<input type="checkbox"/> 00103	HOME VISIT(SERVICE RENDERED BETWEEN 0800-2300HRS)	115.15	<input type="checkbox"/> 14560	ROUTINE PELVIC EXAM INCLUDING PAP	31.46	<input type="checkbox"/> 14043	GP MENTAL HEALTH PLANNING FEE	100.00
			<input type="checkbox"/> 14066	PERSONAL HEALTH RISK ASSESSMENT	50.00	<input type="checkbox"/> 14050	GP ANNUAL CHRONIC CARE INCENTIVE-(DIABETES MELLITU	125.00
			<input type="checkbox"/> 14070	GP ATTACHMENT PARTICIPATION FEE	0.00	<input type="checkbox"/> 14051	GP ANNUAL CHRONIC CARE INCENTIVE-HEART FAILURE	125.00
			<input type="checkbox"/> 14033	ANNUAL COMPLEX CARE MANAGEMENT FEE	315.00	<input type="checkbox"/> 14052	GP ANNUAL CHRONIC CARE INCENTIVE-HYPERTENSION	50.00
			<input type="checkbox"/> 14075	GP ATTACHMENT COMPLEX CARE MANAGEMENT FEE	315.00	<input type="checkbox"/> 14053	GP ANNUAL CHRONIC CARE INCENTIVE - COPD	125.00
			<input type="checkbox"/> 14076	GP ATTACHMENT TELEPHONE MANAGEMENT FEE	20.00	<input type="checkbox"/> 13228	COMMUNITY BASED GP: HOSPITAL VISIT	29.85
			<input type="checkbox"/> 14077	GP ATTACHMENT PATIENT CONFERENCE FEE	40.00	<input type="checkbox"/> 13338	COMMUNITY BASED GP,1ST FAC VISIT OF DAY BONUS,EXTR	38.10
			<input type="checkbox"/> 14078	GP EMAIL/TEXT/TELEPHONE MEDICAL ADVICE RELAY FEE	7.00	<input type="checkbox"/> 13339	COM BASED GP,1ST HOSP VISIT OF DAY BONUS, EXTRA	29.85
			<input type="checkbox"/> 00190	ELECTROSURG./CRYOTHERAPY FOR REMOVAL OF WARTS ETC.	31.46	<input type="checkbox"/> 00114	VISIT NURSING HOME ONE OR MULTIPLE PATIENTS	36.13
			<input type="checkbox"/> 13620	EXCISION TUMOR OF SKIN/SCAR UP TO 5CM	66.02	<input type="checkbox"/> 00115	NURSING HOME VISIT - 1 PATIENT WHEN SPECIALLY CALL	115.15
			<input type="checkbox"/> 15120	PREGNANCY TEST, IMMUNOLOGIC, URINE	11.59	<input type="checkbox"/> 13334	LTC FACILITY VISIT-FIRST VISIT OF DAY BONUS,EXTRA	34.06
			<input type="checkbox"/> 15130	URINALYSIS - SCREENING	2.17	<input type="checkbox"/> 13605	ABSCESS - SUPERFICIAL	44.26
			<input type="checkbox"/> 00034	INJECTION SUBCUTANEOUS	11.31	<input type="checkbox"/> 13611	MINOR LACERATION/FOREIGN BODY REQUIRING ANAES.	66.02
			<input type="checkbox"/> 00044	MINI TRAY FEE	5.19	<input type="checkbox"/> 15039	GP POINT OF CARE (POC) TESTING FOR METHADONE	12.75
			<input type="checkbox"/> 00090	MAJOR TRAY	31.21	<input type="checkbox"/> 15040	GP TESTING FOR HEPATITIS B, HEPATITIS C, HEPATITIS D, HEPATITIS E, HEPATITIS G, HEPATITIS H, HEPATITIS I, HEPATITIS J, HEPATITIS K, HEPATITIS L, HEPATITIS M, HEPATITIS N, HEPATITIS O, HEPATITIS P, HEPATITIS Q, HEPATITIS R, HEPATITIS S, HEPATITIS T, HEPATITIS U, HEPATITIS V, HEPATITIS W, HEPATITIS X, HEPATITIS Y, HEPATITIS Z	12.75
			<input type="checkbox"/> 00010	INJECTION, INTRAMUSCULAR	11.31	<input type="checkbox"/> 00039	METHADONE OR BUPRENORPHINE/NALOXONE TREATMENT ONLY	23.60
			<input type="checkbox"/> 00015	INJECTION, INTRA-ARTICULAR - ALL OTHER JOINTS	16.92	<input type="checkbox"/> 03333	NO CHARGE REFERRAL	0.00

Referral Doctor: [code search] Referral Type: Refer To

Recent Referral Doctors Used: none Referral Doctor on Master Record: none

Other service/procedure/premium codes Unit: [code search]

Diagnostic Code: [dx code search] 311.41M, 460.51M, 286.59M, 848.85M

Short Claim Note: [No Correspondence] Ignore Warnings

Billing Notes (Notes are for internal use and will not be sent to MSP)

Continue Cancel

(7) Choose the visit fee – usually preset for appropriate age-based adjustment.

(8) Add referral physician name if making referral.

HINT: type part of last name and first name, separated by comma to generate drop-down list. Most of the time, the referral type is “Refer To”. An error may occur if this is not selected.

(9) Fee code – either generated by quick pick in (7), or added manually.

HINT: you can search with a key word (start typing part of word and hit enter).

(10) Diagnostic code – enter appropriate ICD-9 code, or search using key word (start typing part of word and hit enter).

(11) Choose a previously used diagnostic code from the list.

HINT: hover over the code to see the text describing the code.

(12) Click “Continue” to see billing preview page.

oscarBC Billing

Patient Information

Patient Name: JOE TEST Patient PHN: 1234567X Health Card Type: BC
 Patient DoB: 19660318 Patient Age: 53 Patient Sex: M
 Patient Address: 123 MAIN STREET City: BURNABY Postal: V1V1V1

Billing Information

Billing Type: MSP Service Location: AllPractitioner's Office - In Community Clarification Code: 00IVANCOUVER
 Service Date: 2019-05-11 Service To Date: After Hours: No Time Call: Start Time: End Time:
 Billing Provider: Yap, John C.P. App 13 Provider: Dependent: 00 Sub Code: 0 Creator: Yap, John C.P.
 Short Note: Payment Method: ELECTRONIC ICBC claim #:00000000

Service Code	Description	Unit	Fee	Total
15300	VISIT IN OFFICE (AGE 50-59)	1.0	34.62	34.62
				34.62

Diagnostic Code

311 DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED

notes

Internal Notes

(13) Ensure the proper Billing Provider is named, and the date is correct. Default date is TODAY.

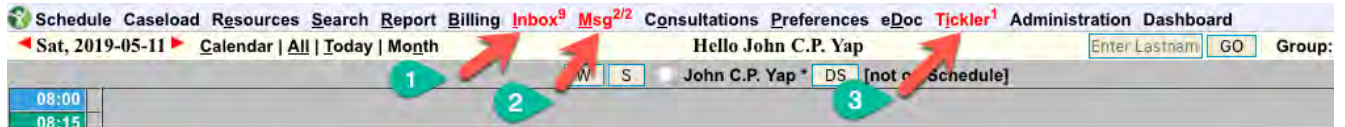
(14) If there is an error, "Go Back" returns you to the previous page to make changes.

(15) Click to save this claim, and create **ANOTHER** bill for the SAME patient. Example – bill an office visit for WSBC, and then bill a second item for MSP service on the same day.

(16) Save Bill – click to save and close the billing module.

Cancel and leave if you do not wish to bill at this time.

8. **Messages, Inbox, Ticklers:** this is how Oscar notifies the user about tasks, messages, and reports.



(1) Inbox items include labs and scanned documents. This indicates there are 9 items pending for review.

(2) Msg items are internal eMail type messages between Oscar user(s) who have Oscar accounts. You can use this to send a message to YOURSELF, to complete a task.

(3) Ticklers are TIMED/SCHEDULED messages between Oscar users which can be set for a future date, or for TODAY. They are usually reminders scheduled for a future date – e.g. next Pap, etc.

a. **InBox** – this is where you will find new reports for your review and acknowledgement. These includes labs, imaging reports, consultations, insurance request, etc.



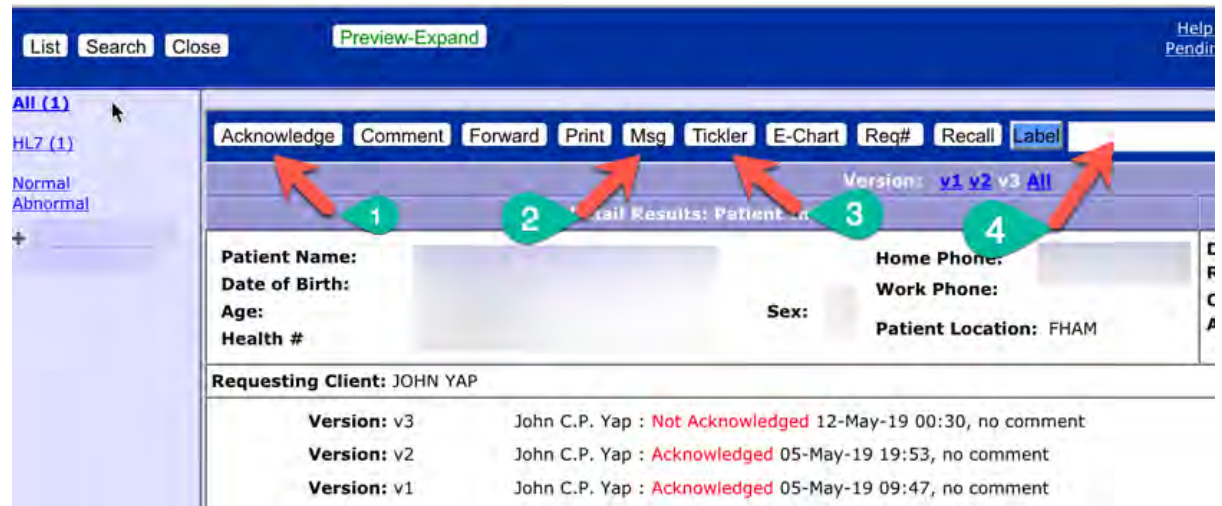
#1. There is one Inbox item to be processed Click on the Inbox link to show the List View.



#2. **List** mode shows every item in a separate line. The left margin is sorted alphabetically by last name. Click here to see JUST the items associated with that patient. Or click on the main screen to see each item one at a time. Click on the Preview button to switch to Preview mode.



#3. **Preview** mode has the advantage of showing the document in the main window. You can scroll down to read additional pages, etc. You can scroll on the larger window to go to the next patient report, also in Preview Mode. The best way to experience Preview Mode is to click on the left side margin – any order is fine – to display the report, read, review, and then act on and acknowledge the report.



(1) **Acknowledge** – to note you have reviewed the report and file it in chart. This should be done last, as it will close the report after. You may be asked to add a comment to this report on filing. This can be left blank.

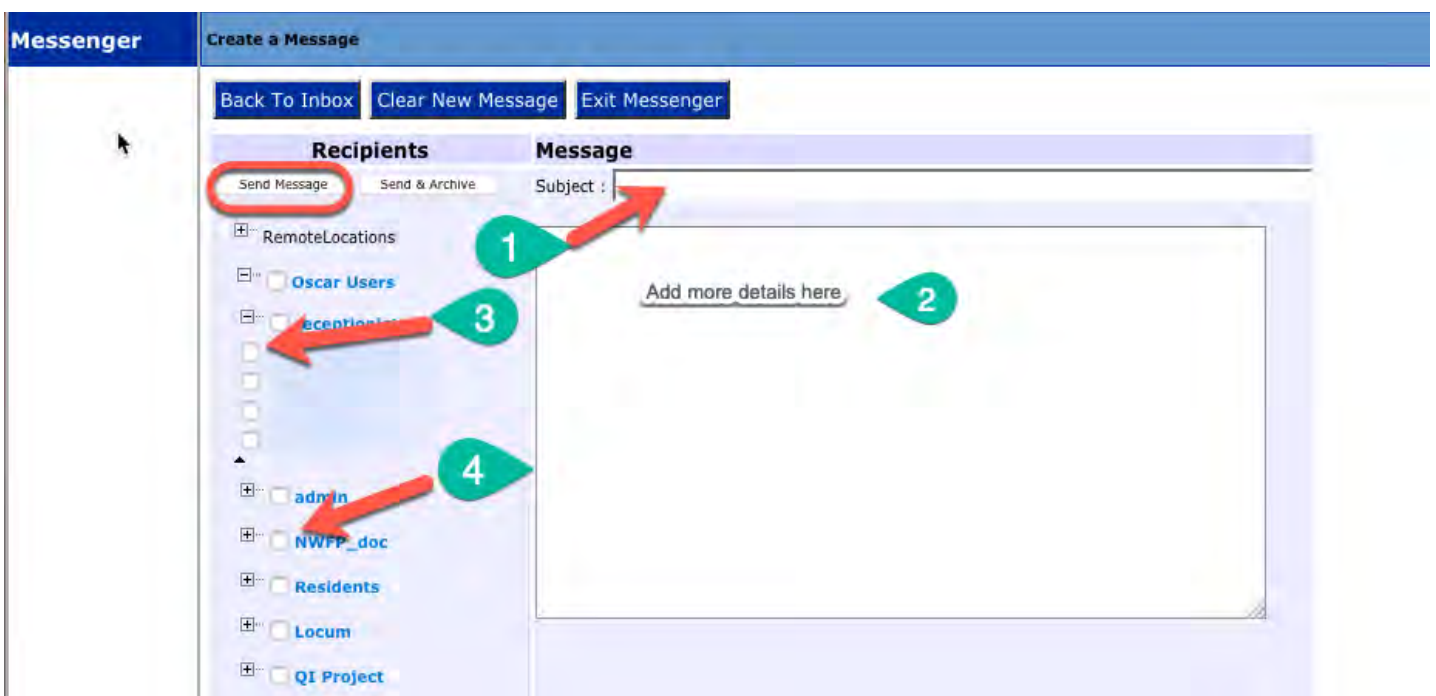
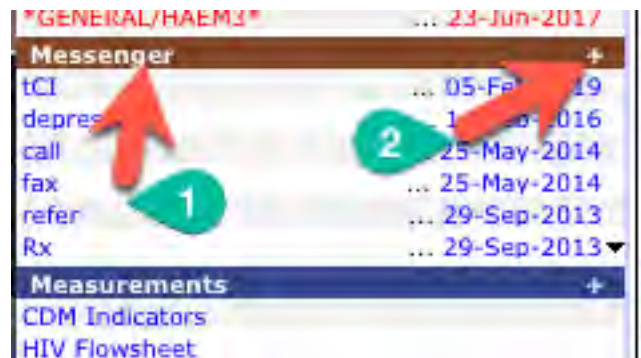
(2) **Msg** – send message related to the report. **HINT:** you can remind yourself to follow up in some way.

(3) **Tickler** – set up a scheduled memo related to this report.

(4) Enter a **label** to better describe the report. After you type in label, click on the blue “label” button to save it. **HINT:** use abbreviations, and develop a logical format. There is limited space to display this label in the eCHART. You can change the label as often as you wish.

HINT: if the result needs to be highlighted for another physician who does not appear in the CC chain (top right), click on the **Forward** button, and a pop-up will allow you to send the result to another physician **within** the clinic. You may wish to also **Msg** the other physician to note your concern.

- b. **Msg** – this is similar to internal eMAIL, which can be sent to single or multiple recipients, including yourself as a reminder. A Msg can be non-linked to a patient, such as an announcement to the office of a meeting, e.g. Creating a Msg with a patient’s chart will link that message to that patient, so it is easier for the recipient to open the chart. See all messages linked to the patient by clicking the Messenger Bar (1). Create a Msg by clicking the plus (+) sign (2) in the Messenger Bar.



(1) Every message must have a **subject**. This line is displayed in the eCHART. Keep the subject discrete. Example – see lab – if you want a colleague to review an important lab result related to that patient.

(2) The body of the message can be more detailed, or can be a blank **space**. It cannot be totally blank, however.

(3) Choose a specific recipient, or group of recipients. See the individuals in a group by clicking on the plus (+) sign.

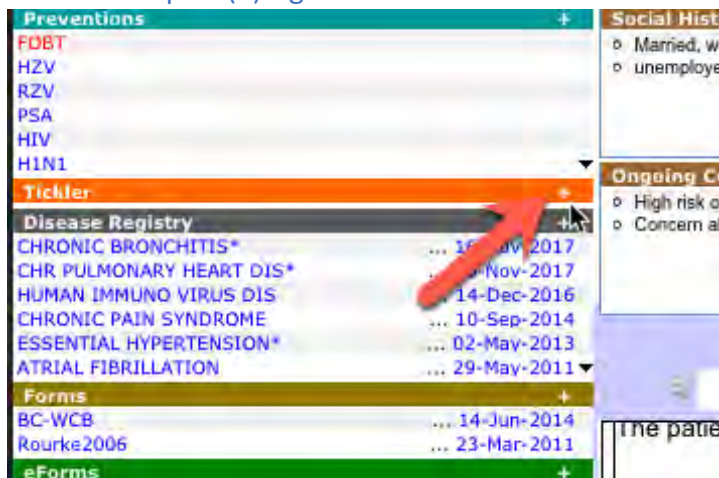
(4) Choose the entire group if desired – e.g. all doctors, all MOAs. Each clinic will define their own groups.

HINT: if your name does not appear here, you need to speak to the Office Manager or IT support.

When you have completed the Msg, click **“Send Message”**. The **“Send & Archive”** button is used when you **RESPOND** to a message that is sent to you.

- c. **Ticklers** are generally created by the MOAs to recall patients as per screening protocol, or when the MD requests a **future** follow-up appointment. They are also used as reminders for appointments, etc. They are **ALWAYS** linked to a patient, and must be created from within the patient’s eCHART or master demographic page.

Click on the plus (+) sign on the Tickler bar.



The screenshot shows the 'Tickler' creation form. The form has a light blue background and contains the following fields and controls:

- Demographic Name:** A text box containing 'TEST, JOE' and a 'Search' button.
- Chart No:** A text box containing '2019-05-17' and a 'Show Quickpick' button.
- Service Date:** A date picker set to '2019-05-17'.
- Priority:** A dropdown menu set to 'Normal'.
- Task Assigned to:** A dropdown menu set to 'Yap, John C.P.'.
- Reminder Message:** A large text area for entering the reminder message.
- Buttons:** 'Cancel and EXIT' and 'Submit and EXIT' buttons at the bottom.

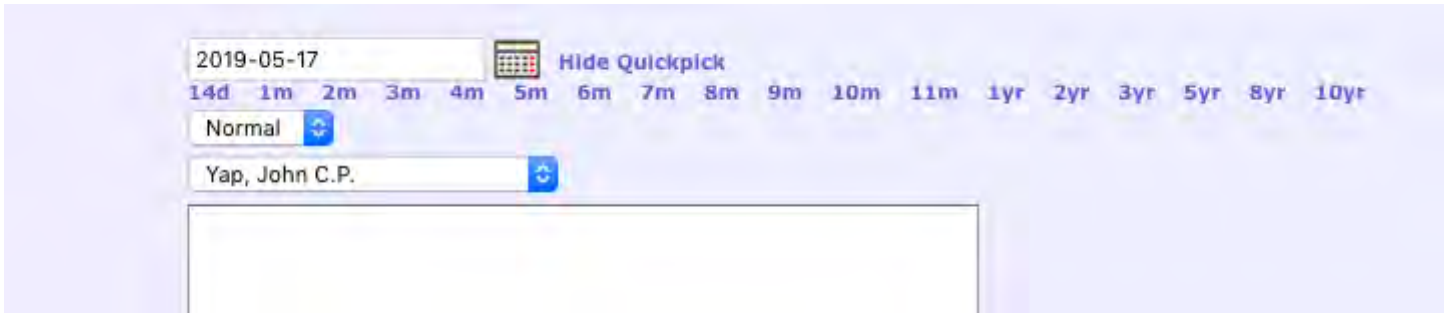
Numbered callouts (1-5) with red arrows point to the following elements:

- 1: The 'Service Date' field.
- 2: The 'Task Assigned to' dropdown menu.
- 3: The 'Reminder Message' text area.
- 4: The 'Show Quickpick' button.
- 5: The 'Submit and EXIT' button.

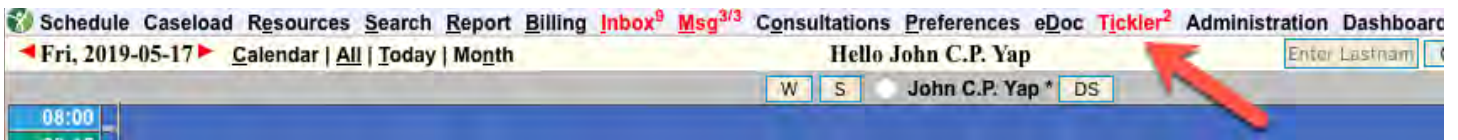
Default date is today (1). This can be changed with direct entry, or by clicking Show Quickpick (4). The default recipient of the Tickler is the current user (2). Click on this box to reveal other recipients.

HINT: click on the first letter of the last name to jump directly to that section of the list. Example – clicking M will bring up MOA, etc.

Add relevant details in the subject box (3). Click on Submit and EXIT (5) to send.



Click on the appropriate Quickpick link to fast forward to that date. Click on the calendar icon to choose a specific date from current month. N.B. This is less efficient in most cases.



Any Ticklers currently directed to you will be announced from the schedule page. There are 2 Ticklers pending action. As well as 9 InBox items, and 3 messages, in the example above.

Demographic Name	Creator	Service Date	Creation Date	Priority	Task Assigned to	Status	Message
		2019-05-17 00:00:00.0	2019-05-17 09:24:58.0	Normal	MOA, MOA	2	will be away until May26/19, if Bx appt comes in.
		2019-05-17 00:00:00.0	2019-05-17 09:41:11.0	Normal	MOA, MOA	Active	Rebook appt June 13
		2019-05-17 00:00:00.0	2019-05-17 11:49:54.0	Normal	MOA, MOA	Active	LM TCB forward CT head report to Dr. Tsaparas if not already done. Call and ask.

Click on the Tickler link on the menu bar, and the Tickler module appears. The default view shows Ticklers assigned to ALL PROVIDERS. Filter down to Ticklers for you by clicking on the Assigned To drop-down menu (1), and the clinic list will appear.

HINT: click on the first letter of your last name to jump to your section.

Highlight your name, and click Create Report (2) to see only those Ticklers assigned to you.

NOTE: the ticklers set for today (current) are at the top. Older ticklers (potentially overdue) are at the bottom. Future ticklers are not displayed, unless the END DATE is changed for that future date.

How do I access historical information?

Almost all relevant historical information is accessible from the eCHART page. This requires some degree of planning, organization and maintenance.

The screenshot shows the eCHART interface for patient TEST, JOE M, 53 years old. The interface is divided into several sections: Preventions, Social History, Medical History, Disease Registry, Ongoing Concerns, Reminders, Forms, Documents, Lab Results, Messages, Measurements, Consultations, and HRM Documents. Red arrows point to specific features: 1. Preventions (Vaccines and health-related screening); 2. Disease Registry (Major conditions); 3. Forms (Library of used eFORMS); 4. Documents (Scanned documents); 5. Lab Results (Digital labs); 6. Messages (List of messages in chronological order); 7. Measurements (Discrete measurements); 8. Consultations (Discrete consultations); 9. Search bar; 10. Allergies; 11. Medications; 12. Risk Factors; 13. Family History.

Vaccines and various health-related screening found in the Preventions module (1). Major conditions are noted in the Disease Registry (2). Some of the disease conditions will trigger relevant chronic disease flow sheets (e.g. HTN, DM, etc.). The library of used eFORMS found here (3). Some of the eFORMS are clinical calculators (MMSE, PHQ9, etc.) and the scores will usually be displayed in this index. Scanned documents will be listed here (4), in order of observed date. If the titles are properly labelled, you may not need to open the document to read the entire contents. Click on the hyperlink to see the full document. Click on the down arrow to open the index fully and show all the documents as titles. Click on the document BAR, and you will open the Document Library – which provides even more details. Most lab results will be displayed here (5). These are digital labs, not scanned from paper. The titles are not as helpful, unfortunately. Hover over the plus (+) sign of Lab Results to show labs in a different Display mode. Row Display is especially useful. Clicking on a lab result will generally create a report of ALL values for that specific item. This is useful to assess trends. The list of messages appears here (6), in chronological order, newest at the top. The measurements module is a very important one (7). Discrete measurements (labs, vital signs, MMSE score, etc.) are either manually added here, or automatically added by Oscar. Hopefully, your clinic has relevant measurement groups set up for you.

HINT: It is PREFERABLE to input vital signs in the measurement area, rather than typing them into the encounter note. Once the VS are saved in measurements, they get pasted into the encounter note for you anyway!

The list of consultation referral letters is found here (8). The cumulative patient profile (CPP) encompasses the 4 boxes here (9), and the additional boxes in the right margin (12) and (13). If there are important clinical details relevant for optimal care of the patient, they should be highlighted here. Add a new line (bullet) by clicking on the plus (+) sign. Add to an existing line simply by clicking on the line to open an edit window. Don't forget to SAVE the changes before closing, otherwise your work is not recorded.

Allergies (10) and Medication list (11) are found on the right margin. A down arrow in the bottom corner indicates more entries that are hidden. Click the arrow to show the hidden entries.

HINT: if a title seems incomplete, make the entire window bigger by dragging the browser size larger in the horizontal plane. Hovering your mouse over the title will enable a pop-up showing more of the title.

Oscar should be relatively intuitive to use, with most of the necessary information accessible from the eCHART view. Take care to ensure you are in the correct chart. Exit from the chart with the proper icon if not. Ensure you sign and save your note when done. If incomplete, or additional details are required, you can always re-open the old note and EDIT (top right corner of the note field) the note further. Each time you sign and save the note, an additional signature and time stamp is added. Pay special attention to how you write prescriptions – ensure a duration is specified so Oscar will know whether the medication is short, mid, or long-term. Ensure each eFORM or FORM you create is submitted (saved) or all your work will be lost, and there will be an incomplete audit trail. Please use the measurement function to record relevant discrete data (BP, Ht, Wt, etc).