

MOIS 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. Tasks / Inbox (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 MOIS 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 RandRCommittee@doctorsofbc.ca.

MOIS EMR Introduction Instruction Sheets

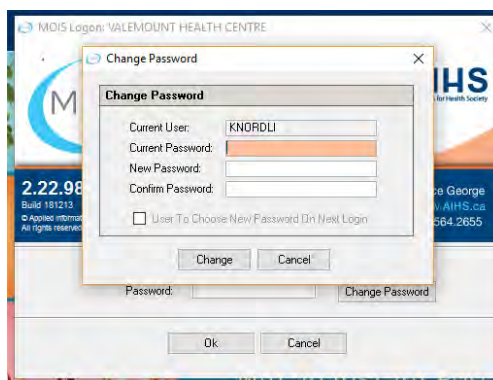
EMR Introduction Instruction Sheets for new users.

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

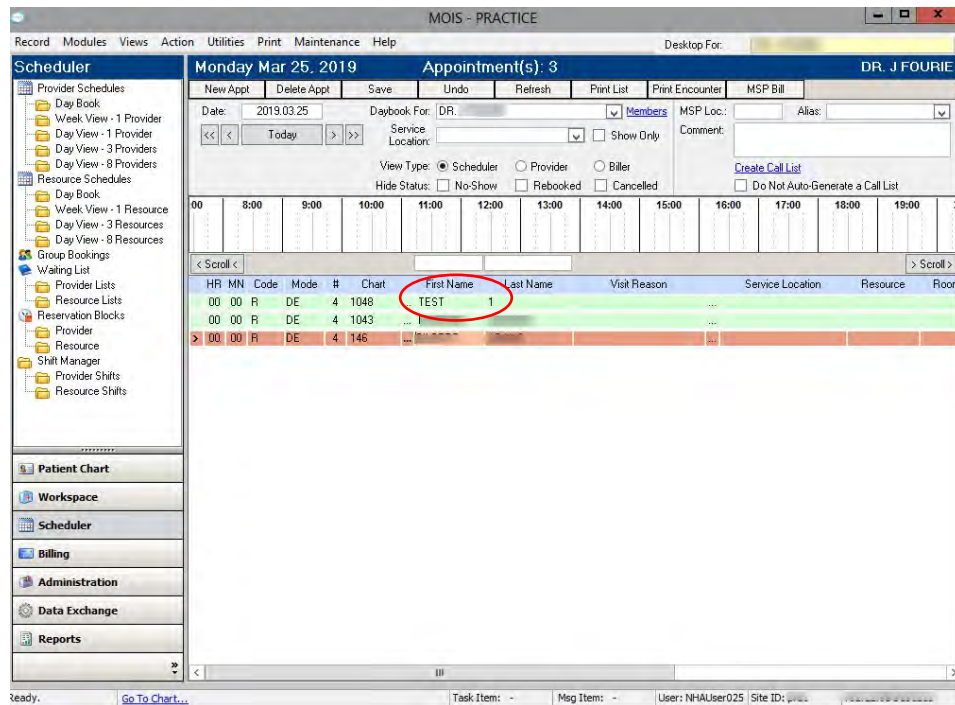
How do I access my schedule?

- i. 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

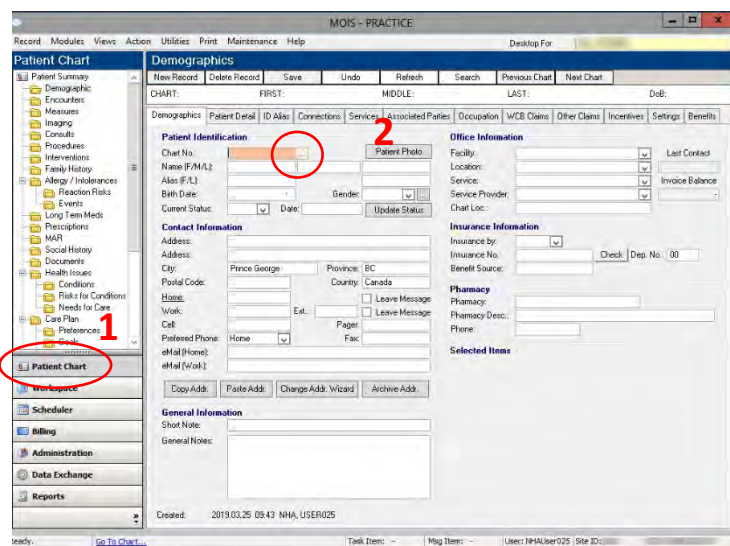
The screenshot shows the MOIS - PRACTICE software interface. On the left, the Scheduler sidebar is visible, with the 'Scheduler' option circled in red and a red '1' next to it. The main window displays the 'Provider Work Load' section, titled 'Work Load Summary for Monday March 25, 2019'. This section contains a table with columns for Provider, # of Appoints, # of Group Visits, Total Time (mins), First Appt, and Last Appt. Each row in the table has an 'Open Daybook' button to its right. One of these buttons is circled in red, with a red '2' next to it.

Provider	# of Appoints	# of Group Visits	Total Time (mins)	First Appt	Last Appt	Open Daybook
AADTP	-	-	-	0 : 00	-	Open Daybook
AADTP NURSE 1 PRG	-	-	-	-	-	Open Daybook
	-	-	-	-	-	Open Daybook
	-	-	-	-	-	Open Daybook
MHC 1 PRG	-	-	-	-	-	Open Daybook
MHC 1 PRG	-	-	-	-	-	Open Daybook
COM ONC NURSE DAW	-	-	-	-	-	Open Daybook
	-	-	-	-	-	Open Daybook
	-	-	-	-	-	Open Daybook
ELDERLY SERVICES NURSE 1	-	-	-	-	-	Open Daybook
FRC NURSE 1 PRG	-	-	-	-	-	Open Daybook
	-	-	-	-	-	Open Daybook
HFC NURSE 1 PRG	-	-	-	-	-	Open Daybook
HFC NURSE 2 PRG	-	-	-	-	-	Open Daybook
ICMT MHC 1 TER	-	-	-	-	-	Open Daybook
ICMT NURSE 1 TER	-	-	-	-	-	Open Daybook
KIDNEY CARE PRG	-	-	-	-	-	Open Daybook
PCIPT 1 MHAC 1 DAW	-	-	-	-	-	Open Daybook
PCIPT 1 MHAC 1 PRG	-	-	-	-	-	Open Daybook
PCIPT 1 MHAC 2 PRG	-	-	-	-	-	Open Daybook
PCIPT 1 MHAC 3 PRG	-	-	-	-	-	Open Daybook
PCIPT 1 MHC 1 PRG	-	-	-	-	-	Open Daybook

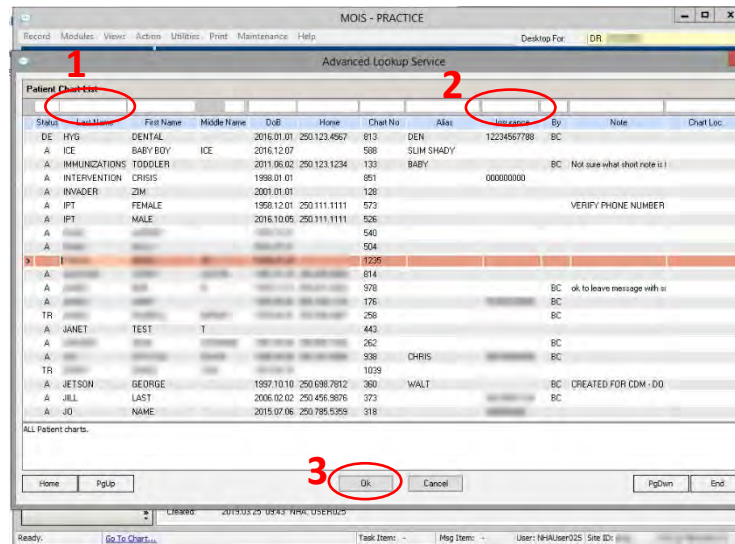
How do I get to my patient's chart?



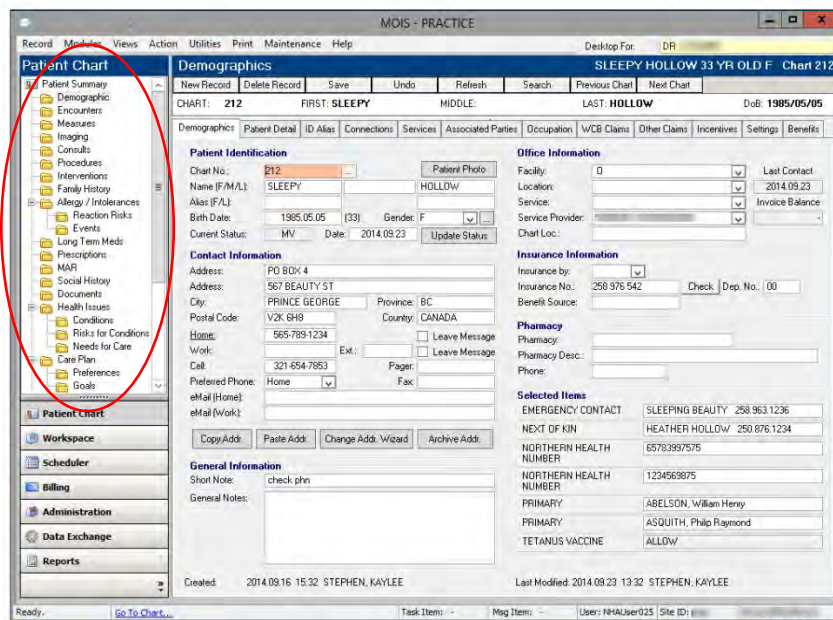
- i. From your day schedule, double click on the patient name of the chart that you want to access.
- ii. To access a file not in schedule, choose 1) Patient Chart on the left and 2) click on three dots next to chart #.



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

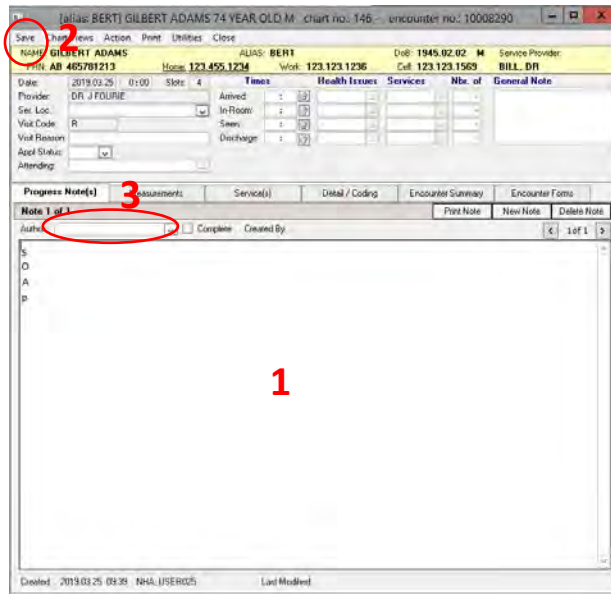


- iv. Once chart is open, the default view is the demographic page. Choose which area of the chart you want to view and click on it on the options from the left.

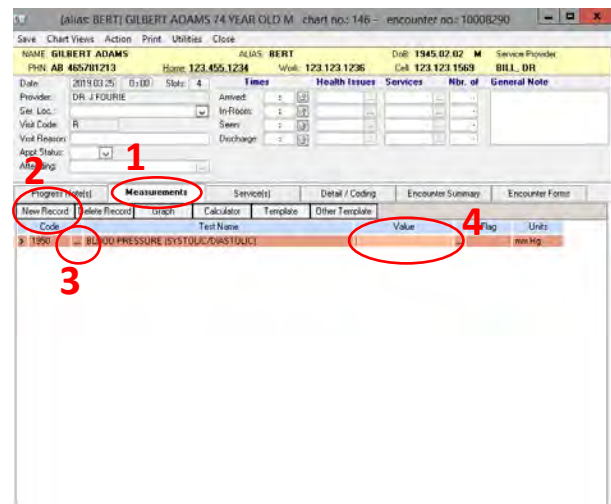


How do I document a transaction?

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.



- 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.

The screenshot shows a medical software window for patient GILBERT ADAMS. At the top, the patient's name and alias are listed. Below this, there are fields for Date, Time, Slots, and various visit codes. The 'Health Issues' and 'Services' columns are highlighted with red circles and numbered 1 and 2 respectively. The 'General Note' field contains the text 'S O A P'. The window title bar indicates the patient's chart number and encounter number.

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

This screenshot is identical to the one above, but with the 'Save' and 'Close' buttons in the top-left corner highlighted with red circles and numbered 1 and 2 respectively. The 'Health Issues' and 'Services' columns are still highlighted with red circles and numbered 1 and 2 respectively. The 'General Note' field still contains the text 'S O A P'.

2. Order Investigations:

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

The screenshot displays a medical software window titled "[alias: BERT] GILBERT ADAMS 74 YEAR OLD M chart no.: 146 - encounter no.: 10008290". The window has a menu bar with "Save", "Chart Views", "Action", "Print", "Utilities", and "Close". The "Action" menu is open, listing various options with keyboard shortcuts: "Create Referral Note (Ctrl+R)", "Create Lab Requisition Order", "Create Image Requisition Order", "Create Procedure Requisition Order", "Create Misc. Requisition Order", "Distribute Care Plan", "Print Label (Ctrl+L)", "Create Recall", "Show Recall List", "Default Service Code 1 (F11)", "Default Service Code 2 (F12)", "Create Task (Ctrl+K)", "Create Message (Ctrl+M)", and "Attachments".

The main interface shows patient information: NAME: GILBERT ADAMS, PHN: AB 465781, Date: 2019.03.25, Provider: DR. J. F. BILLY, Ser. Loc.: R, Visit Code: R, Visit Reason: , Appt Status: , Attending: . Patient details include DoB: 1945.02.02 M, Service Provider: BILL, DR, and Cell: 123.123.1569. A table with columns "h Issues", "Services", "Nbr. of", and "General Note" is visible. At the bottom, it shows "Created: 2019.03.25 09:39 NHA, USER025" and "Last Modified:".

3.Labs and x-ray:

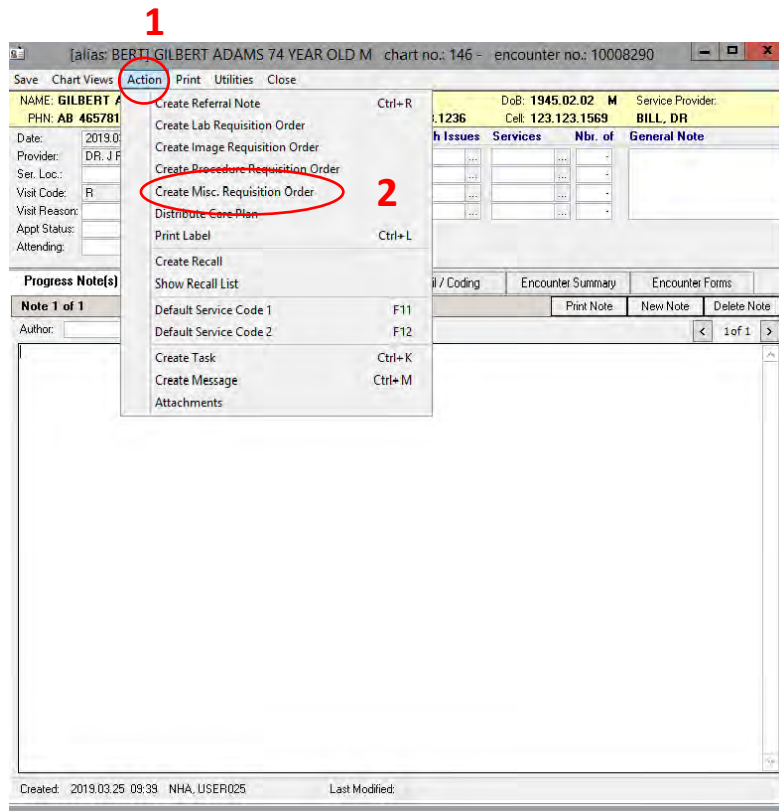
- i. Once you have chosen lab or x-rays under Forms as your order click on the appropriate form and it auto populates patient info. Valemount/PG standard forms are at the top of the list and are labelled with 001 prior to form name. Print and give patient form.

The screenshot shows a software window titled "Add Attachment" with two tabs: "Attach Form / Letter" (selected) and "Attach File(s)". Below the tabs is a search bar and a "Select Form / Letter" section with a "Maximum Items in Your Recent List" of 10. The list is divided into two sections: "RECENT" and "FORMS". The "FORMS" section is expanded, showing a list of forms with columns for form name, location, and category. The first form in the "FORMS" section, "001-STANDARD OUT PATIENT LABORATORY REQUISITION", is highlighted with a red circle. At the bottom of the window, there is a dropdown menu for "After Attaching:", a "Save Choice" checkbox, and "Ok" and "Cancel" buttons.

Form Name	Location	Category
001-STANDARD OUT PATIENT LABORATORY REQUISITION (FORM)	NH	DAIGNOSTIC
005-ANTENATAL RECORD (PART 1 & 2) (FORM)	GOVT-BC	MISC
STANDARD REFERRAL LETTTER (LETTER)		
001-WOUND ASSESSMENT & TREATMENT FLOW SHEET (FORM)	MISC	COMM-CARE
005-ROURKE BABY RECCRD (FORM)	MISC	MISC
001-VALEMOUNT- GENERAL X-RAY/NUCLEAR MEDICINE/ULTRASOUND REQ (FORM)	NH	DAIGNOSTIC
001-PALLIATIVE CARE COMMUNITY CLIENTS PACKAGE (FORM)	NH	APPLICATIO..
005-HOME RISK ASSESSMENT-HCC (FORM)	NH	MISC
005-GENERALIZED ANXIETY DISORDER 7-ITEM SCALE (FORM)	MISC	MISC
FORMS		
001-ADULT PALLIATIVE CARE CRISIS EVENT ORDERS	NH	MISC
001-MATERNITY-STANDARD OUT-PATIENT LABORATORY REQUISITION	GOVT-BC	DIAGNOSTIC
001-PALLIATIVE CARE COMMUNITY CLIENTS PACKAGE	NH	APPLICATIO..
001-STANDARD OUT PATIENT LABORATORY REQUISITION	NH	DAIGNOSTIC
001-VALEMOUNT- GENERAL X-RAY/NUCLEAR MEDICINE/ULTRASOUND REQ	NH	DAIGNOSTIC
001-WOUND ASSESSMENT & TREATMENT FLOW SHEET	MISC	COMM-CARE
002- HINTON ULTRASOUND (GUARDIAN)	MISC	DAIGNOSTIC
002-AHS CARDIAC SERVICES REQUISITION	AHS	DAIGNOSTIC
002-AHS CT	MISC	DAIGNOSTIC
002-AHS CT LUMBAR SPINE IMAGING SCREENING RECORD	MISC	REQ-IMG
002-AHS MRI REQUEST	MISC	MISC
002-AHS NUCLEAR MEDICINE REQUEST	AHS	REQ-IMG
002-AHS ULTRASOUND REQUEST	AHS	DAIGNOSTIC
002-AHS X-RAY REQUEST - USE FOR FLUORO EXAMS	MISC	DAIGNOSTIC
002-DIABETIC NEPHROPATHY PREVENTION CLINICS PATIENT REFERRAL FRM	MISC	REFERRAL
002-EDMONTON CARDIOLOGY CONSULTANTS	MISC	REFERRAL

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.

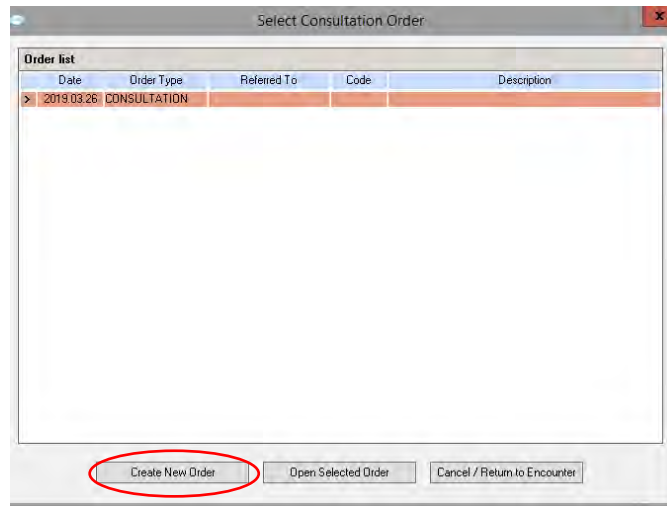
1

The screenshot shows a medical software window titled "[alias: BERT] GILBERT ADAMS 74 YEAR OLD M chart no.: 146 - encounter no.: 10008290". The window has a menu bar with "Save", "Chart Views", "Action", "Print", "Utilities", and "Close". The "Action" menu is open, showing a list of options: "Create Referral Note" (highlighted with a red circle and the number "2"), "Create Lab Requisition Order", "Create Image Requisition Order", "Create Procedure Requisition Order", "Create Misc. Requisition Order", "Distribute Care Plan", "Print Label" (with "Ctrl+L"), "Create Recall", "Show Recall List", "Default Service Code 1" (with "F11"), "Default Service Code 2" (with "F12"), "Create Task" (with "Ctrl+K"), "Create Message" (with "Ctrl+M"), and "Attachments".

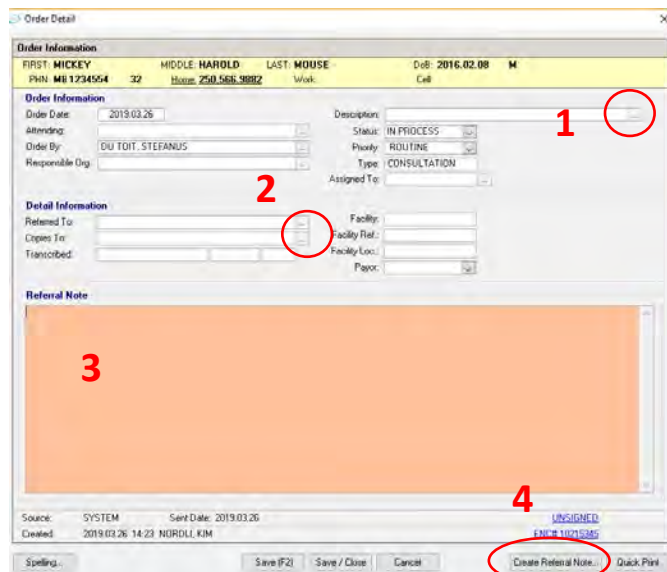
The main area of the window displays patient information: NAME: GILBERT ADAMS, PHN: AB 465781, Date: 2019.03.25, Provider: DR. J. F. [Name], Ser. Loc.: [Field], Visit Code: R, Visit Reason: [Field], Appt Status: [Field], Attending: [Field]. To the right, there is a section for "Service Provider" with fields for "Cell: 123.123.1569" and "BILL, DR". Below this is a table with columns "Issues", "Services", "Nbr. of", and "General Note".

At the bottom of the window, there is a "Progress Note(s)" section with "Note 1 of 1" and an "Author:" field. The status bar at the very bottom shows "Created: 2019.03.25 09:39 NHA, USER025" and "Last Modified:".

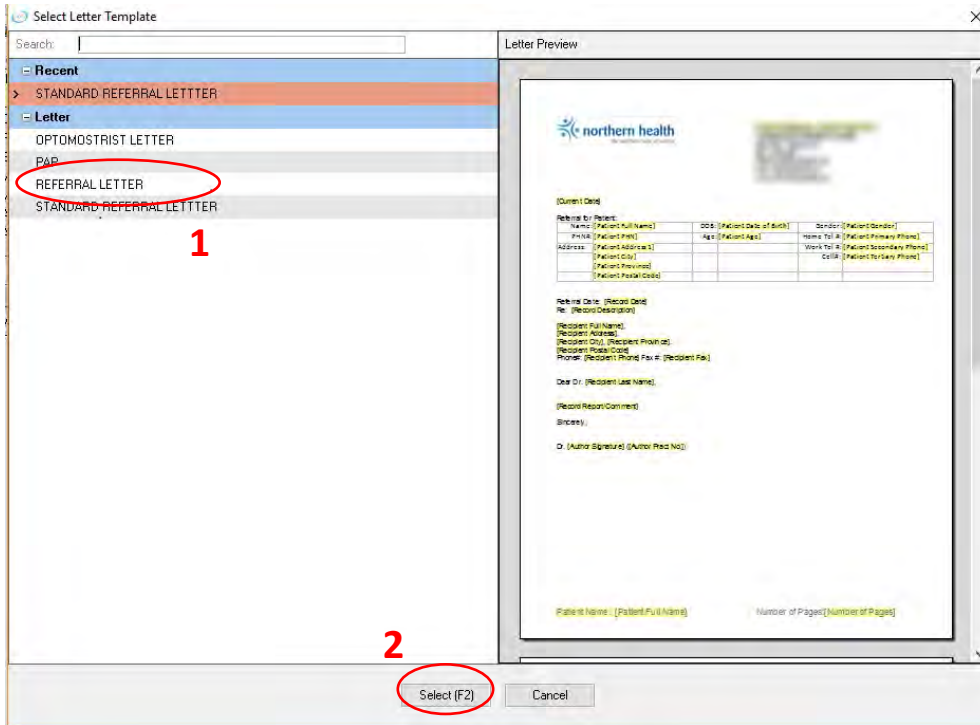
- ii. Once Create Referral Note window is open, choose Create New Order



- 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

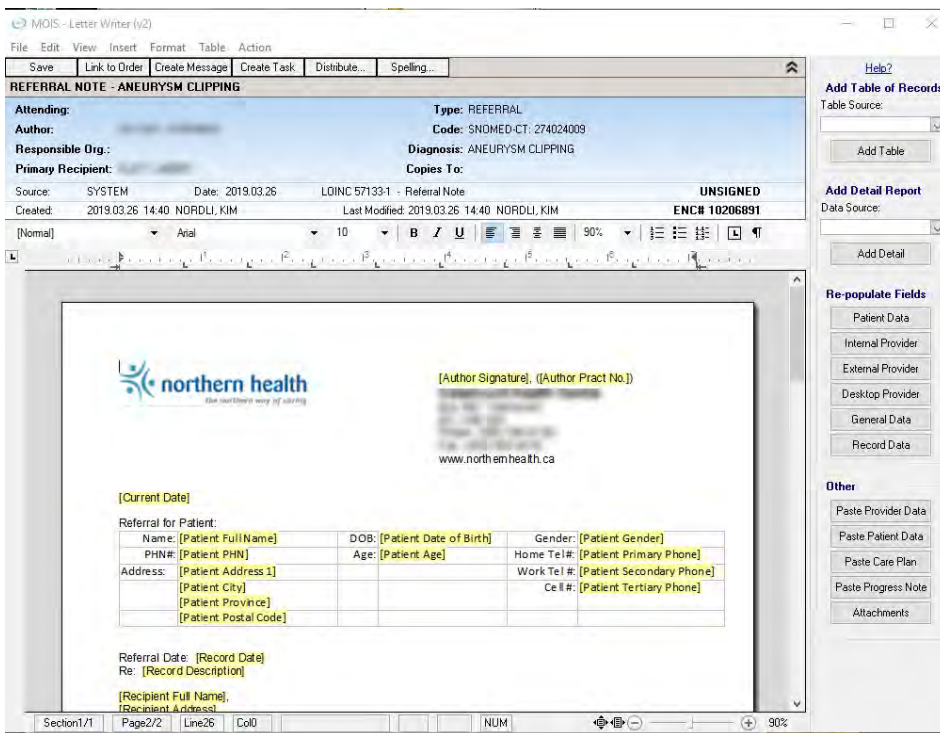


iv. Then choose 1) Standard Referral Letter from “Letter” list 2) Select



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.

A)



B)

Letter Setup

FIRST: MICKEY MIDDLE: HAROLD LAST: MOUSE DoB: 2016-02-08 M
PHN: MB1234554 32 Home: 250.566.9882 Work: Cell:

Letter Details
Author: [Redacted]
Primary Recipient: [Redacted]

Patient Records

Section	Records		Action		Attachments	
	Available	Selected			Available	Selected
IMAGES	7	-	<input type="radio"/> Select All	<input checked="" type="radio"/> Choose	Choose Records	-
MEASURES	350	-	<input type="radio"/> Select All	<input checked="" type="radio"/> Choose	Choose Records	-
HEALTH ISSUES	24	20	<input checked="" type="radio"/> Select All	<input type="radio"/> Choose	<input type="checkbox"/> Include Stopped Records	-
CONSULT	13	-	<input type="radio"/> Select All	<input checked="" type="radio"/> Choose	Choose Records	-
PROCEDURE	4	-	<input type="radio"/> Select All	<input checked="" type="radio"/> Choose	Choose Records	-
PRESCRIPTIONS	202	-	<input type="radio"/> Select All	<input checked="" type="radio"/> Choose	Choose Records	-
LT MEDS	23	10	<input checked="" type="radio"/> Select All	<input type="radio"/> Choose	<input type="checkbox"/> Include Stopped Records	-
ALLERGIES	8	8	<input checked="" type="radio"/> Select All	<input type="radio"/> Choose		-
ATTACHMENT REVIEW	-	-	No Attachments Available			-

Continue (F2) Cancel

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

MOIS - Letter Writer (v2)

File Edit View Insert Format Table Action


1 Save 2 Link to Order Create Message Create Task Distribute... Spelling...

REFERRAL NOTE - ANEURYSM CLIPPING

Attending: [Redacted] Type: REFERRAL
Author: [Redacted] Code: SNOMED-CT: 274024009
Responsible Org.: [Redacted] Diagnosis: ANEURYSM CLIPPING
Primary Recipient: [Redacted] Copies To: [Redacted]

Source: SYSTEM Date: 2019.03.26 LDINC 57133-1 Referral Note UNSIGNED
Created: 2019.03.26 14:50 Last Modified: 2019.03.26 15:00 ENC# 10206891

[Normal] Arial 10 Bold Italic Underline 90%


www.northernhealth.ca

2019-03-26

Referral for Patient:

Name: Mouse, Mickey Harold	DOB: 2016-02-08	Gender: Male
PHN#: 1234554	Age: 3 YR 1 MTH OLD	Home Tel #: 250.566.9882
Address: 1440 Fake Ave.		Work Tel #:
VALEMOUNT		Cell #:
BC		
V0E 220		

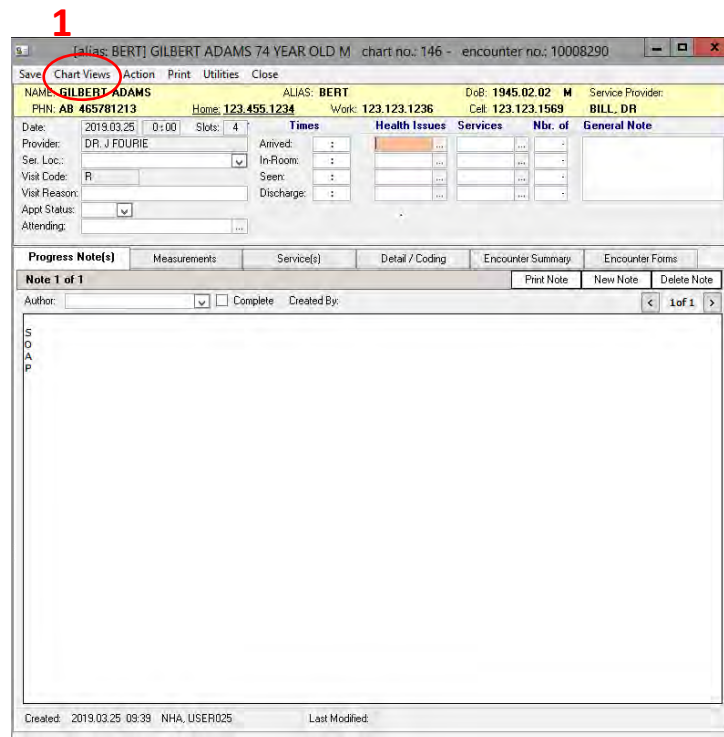
Referral Date: 2019/03/26
Re: ANEURYSM CLIPPING
OTHER HEALTH AUTHORITY,

Section1/71 Page1/3 Line6 Col4 NUM 90%

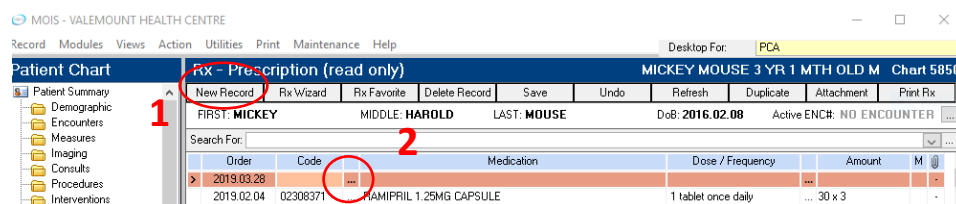
Help?
Add Table of Records
Table Source: [Dropdown]
Add Table
Add Detail Report
Data Source: [Dropdown]
Add Detail
Re-populate Fields
Patient Data
Internal Provider
External Provider
Desktop Provider
General Data
Record Data
Other
Paste Provider Data
Paste Patient Data
Paste Care Plan
Paste Progress Note
Attachments

5. Prescriptions

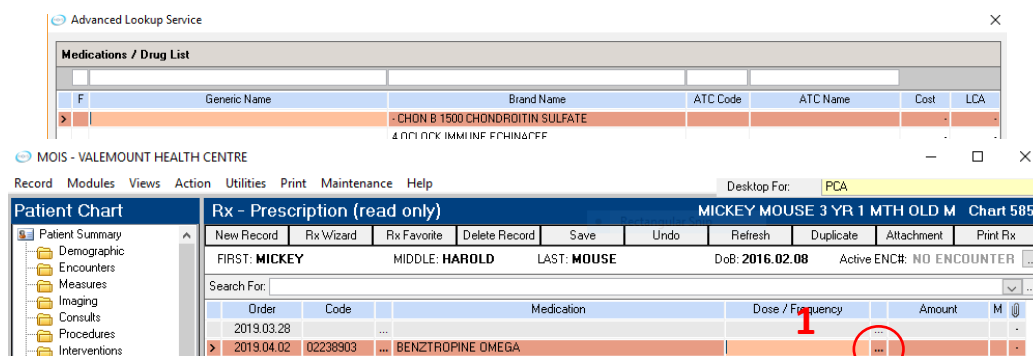
- i. Go to 1) Chart Views then prescription or use hot keys ALT S



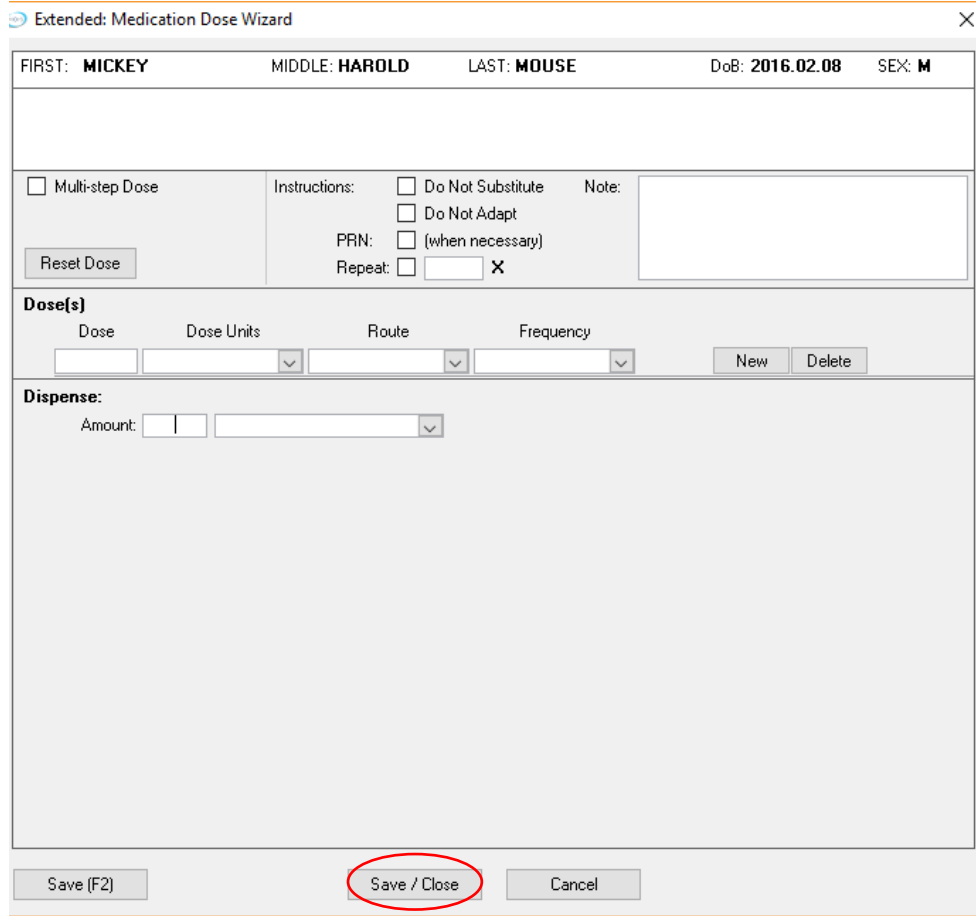
- ii. Choose 1) New record 2) search for medication using 3 dots
- iii. Type in medication name and once you find what medication you want to select click on OK at bottom of page. Once selected then choose 1) Dose/Frequency



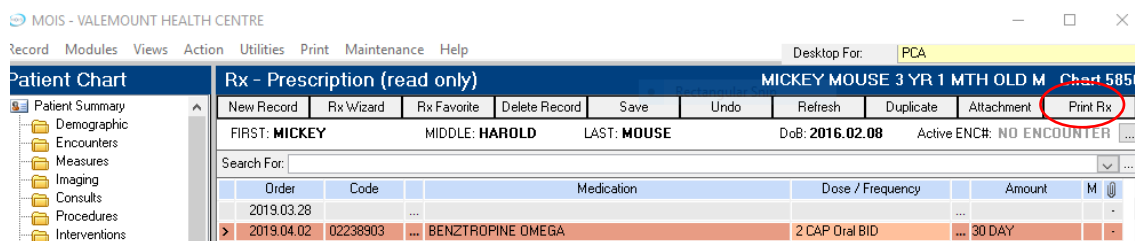
- iv. Type in medication name and once you find what medication you want to select click on OK at bottom of page. Once selected then choose 1) Dose/Frequency



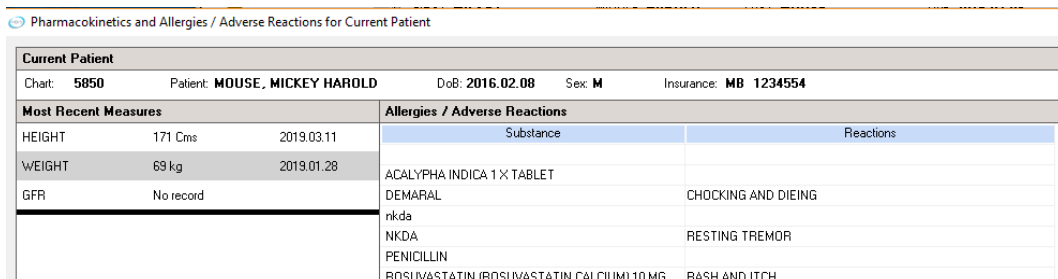
v. Once this window opens fill in dose etc. and then select Save/Close



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

Select Medications to Print

Current Patient
 Chart: 5850 Patient: MOUSE, MICKEY HAROLD DoB: 2016.02.08 Sex: M Insurance: MB 1234554

Prescription List

Include	Order	CDIC	Medication	Dose / Frequency	Amount
<input checked="" type="checkbox"/>	2019.04.02	02238903	BENZTROPINE OMEGA	2 CAP Oral BID	30 DAY
<input type="checkbox"/>	2019.03.28				
<input type="checkbox"/>	2019.02.04	02308371	RAMIPRIL 1.25MG CAPSULE	1 tablet once daily	30 x 3
<input type="checkbox"/>	2019.02.04	02308371	RAMIPRIL 1.25MG CAPSULE	1 tablet once daily	30 x 3
<input type="checkbox"/>	2019.01.07	02352737	AMOXCILLIN (AMOXCILLIN TRIHYDRATE) 250 MG TABLET (CHEWABLE)	2 tabs TID	7 days
<input type="checkbox"/>	2019.01.07	02275821	FENTANYL 50MCG PATCH	1 PATCH Cutaneous EOD	30 DAY
<input type="checkbox"/>	2019.01.07	02374846	RAMIPRIL	5MG bid	30 X 3
<input type="checkbox"/>	2018.11.05	00885932	TRIMETHOPRIM 160MG SULFAMETHOXAZOLE 800MG TABLET	100 MG ORAL BID	5 DAY
<input type="checkbox"/>	2018.10.29	02374846	RAMIPRIL	5MG bid	30 X 3
<input type="checkbox"/>	2018.10.29	00885932	TRIMETHOPRIM 160MG SULFAMETHOXAZOLE 800MG TABLET	100 MG ORAL BID	5 DAY
<input type="checkbox"/>	2018.10.01	02449943	METFORMIN HYDROCHLORIDE 1000MG Dapagliflozin (Dapagliflozin propanediol monohydr...	250 MG Oral BID	25 DAY
<input type="checkbox"/>	2018.09.04	02449943	METFORMIN HYDROCHLORIDE 1000MG Dapagliflozin (Dapagliflozin propanediol monohydr...	250 MG Oral BID	25 DAY
<input type="checkbox"/>	2018.08.09	80025342	4 OCLOCK IMMUNE ECHINACEE	1 TAB Oral TID	3 DAY
<input type="checkbox"/>	2018.08.08	80050447	BELPHOS TABLET		
<input type="checkbox"/>	2018.08.07				
<input type="checkbox"/>	2018.08.07	02251515	RAMIPRIL 1.25MG CAPSULE		
<input type="checkbox"/>	2018.05.23	00885932	TRIMETHOPRIM 160MG SULFAMETHOXAZOLE 800MG TABLET	100 MG ORAL BID	5 DAY

Generic Name: BENZTROPINE MESYLATE 1MG LIQUID
 Instructions: Do Not Substitute Do Not Adapt PRN: (when necessary) Repeat: X
 Comment:
 Last Printed:
 Dispense: 30.0 DAY 2.0 CAP Oral BID

Print Height Print Weight Print GFR
 Printer: VMT001-F001
 When patient age is less than 12 and Height or Weight measures occurred within the past month, then the associated measure is selected for printing by default. GFR selected by default for all patients if value is less than 60.

Print (F2) Cancel

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.

[alias: MIKE] MICKEY MOUSE 3 YEAR OLD M chart no.: 5850 - encounter no.: 10217126

Save Chart Views Action Print Utilities Close

NAME: MICKEY MOUSE ALIAS: MIKE DoB: 2016.02.08 M Service Provider:
 PHN: MB 1234554 32 Home: 250.566.9882 Work: Cell:

Date:	2019.04.02	0:00	Slots:	3	Times	Health Issues	Services	Nbr. of	General Note
Provider:	PCA	Arrived:	:			-	
Ser. Loc.:		In-Room:	:					-	
Visit Code:	R	Seen:	:					-	
Visit Reason:		Discharge:	:					-	
Appt Status:									
Attending:									

Progress Note(s) Measurements Service(s) Detail / Coding Encounter Summary Encounter Forms

Note 1 of 1 Print Note New Note Delete Note

Author: Complete Created By: 1 of 1

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

MOIS - Universal Search Window

Select from Code System(s) [All](#) [Clear](#)

ICD-9
 MSP-DIAGCODE
 SNOMED-CT

Filter to Reference Set(s) [All](#) [Clear](#)

HEALTH CONCERNS
 HEALTH CONCERNS (BC)

Parameters

Code is

Category is like

Status is Active Inactive Either

Limit

Search For:

Term	Category	Code	Code System
1ST DEG BURN SHOULDER	DIAGNOSIS	94315	ICD-9
2ND DEG BURN TRUNK NOS	DIAGNOSIS	94220	ICD-9
AB NOS W COMPL NEC-UNSP	DIAGNOSIS	63770	ICD-9

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

MOIS - PRACTICE

Record Modules Views Action Utilities Print Maintenance Help Desktop For: DR. J FOURIE

Workspace

- Workspace Summary
- Basket
- Measures
- Imaging
- Consults
- Procedures
- Documents
- Facility Admissions
- Progress Note
- Orders
- Task List
- Inbox** (2)
- Sent Tasks
- Message Board
- Inbox
- Sent Messages
- My Settings
- Workspace

Task Inbox Your Workspace

New Delete Save Undo Refresh Change W/S Open Chart Close Window View: View 1

Search For:

P	Due	Patient	Task	Assignee	Ack.	Comp.	Created	Created By
			CHECK TIRE PRESSURE		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
W	2018.12.18	TUTTLE, JAMES COLIN	LTC AX FOR PROCESSING ASAP	LUN	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	2017-03-24	MUSHUMANSKI, KA

Detail Follow Up Notes (0)

Assigned To: User: NHA, USER021 AND / OR User Group:

Chart: T114 DELANEY, BETTY

Priority: Low Medium High V. High

Due: 2018.07.25 Group:

Status: Acknowledged 2019.02.13 NHA, USER021 Created By: NHA, USER023
 Completed 2019.02.13 NHA, USER021 2018.07.25 - Wednesday

Task: CHECK TIRE PRESSURE

Detail:

Created: 2018.07.25 15:39 NHA, USER023 Last Modified: 2019.02.13 12:03 NHA, USER021

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