PCP PATIENT SUMMARY "CHEAT SHEET" FOR INTRAHEALTH TEMPLATE

Thank you for continuing to help us improve the flow of patient information into the hospital. We know it takes time, but sending in your GP Patient Summary (now called the PCP Patient Summary in Power Chart) really improves your patients' care. To help you create the summaries as quickly as possible, we have created templates for each major EMR in our community. These templates have been developed collaboratively with GPs and hospitalists who have given input on the information they need most. Although each EMR template will look different because the EMRs are different, we're designing them so they have the same structure, as much as possible, across EMRs - so the same information is at least presented in the same order when the MRP goes to read it.

We've really been leading the way in this area and in fact this IntraHealth template, the first one we have built, is the basis of ongoing provincial work on data standards. We appreciate any and all feedback so that we can continue to create and advocate for what we need to make information transfer work both for providers and our patients.

The following documents will guide you through setting up and using the IntraHealth PCP Patient Summary template for transferring information to the hospital when your patient is admitted or likely to be admitted sometime soon.

Document 1: This document outlines the various types of data the template pulls from your EMR data fields.

Document 2: This document outlines the steps you need to take to install the Patient Medical Summary and generate a Patient Summary Letter in Profile.

Please remember that Power Chart already contains hospital-based labs, imaging and consults, so you do not need to attach these. Power chart also has links to EMR Connect which allows hospital providers to access Life Lab tests. What it does **NOT** contain are **community specialist consults** which are often very helpful to the MRP.

FOR PATIENT RECORD: ATTENTION MRP - Patient Summary from Family Physician

Usual Family Doctor: «Letter.Patient.DoctorUsual.FullName»
Office Phone Number: :«Letter.LoggedOnPOS.Phone1»

Patient: «Letter.Patient.FullName»
Age: «Letter.Patient.Age» Sex: «Letter.Patient.Sex»
DOB: «Letter.Patient.DateOfBirth» PHN: «Letter.Patient.NHI_Number»
Address: «Letter.Patient.AddressPost1», «Letter.Patient.AddressPost3»,
«Letter.Patient.AddressPostState»,
«Letter.Patient.AddressPostCode»
Home Phone: «Letter.Patient.Phone1» Cell Phone: «Letter.Patient.CellPhone»
Next of Kin: «Letter.Patient.NextOfKin.FullName» Phone: «Letter.Patient.NextOfKin.Phone1»

Last Visit: «Letter.Patient.Last Arrived Appointment.Date»

Last blood pressure: «Letter.Patient.Measures("BP").Value»
(«Letter.Patient.Measures("BP").DateObserved»)
Last weight: «Letter.Patient.Measures("Weight").Value»
(«Letter.Patient.Measures("Weight").DateObserved») Last
Height: «Letter.Patient.Measures("Height").Value»
(«Letter.Patient.Measures("Height").DateObserved»)

Current Medical Problems:
«Letter.Patient.ActiveProblemsDiagnosis»

Past History:
«Letter.Patient.PastHx»
«Letter.Patient.ActiveProblemsProcedures»
«Letter.Patient.InactiveProblemsProcedures»

Current Medications:
«Letter.Patient.UsualMedication»

Allergies:
«Letter.Patient.ActiveProblemsAdverse»

Social History:
«Letter.Patient.ActiveProblemsSocialRisk»
«Letter.Patient.SocialHx»

Family History:
«Letter.Patient.FamilyHx»

Personal Habits: «Letter.Patient.SmokerType» Alcohol Use: «Letter.Patient.AlcoholType»

Advance Directives: «Letter.Patient.DoNotResuscitate»

Last eGFR:
«Letter.Patient.Macro.LATESTGFR»

GFR Date:
«Letter.Patient.Macro.LATESTGFRDATE»

GFR Result:
«Letter.Patient.Macro.LATESTGFRRESULT»

Last A1c:
«Letter.Patient.Macro.LATESTA1C»

Last HgB:
«Letter.Patient.Macro.LATESTHEMOGLOB»

MMSE Score: «Letter.Patient.Measures("MMSE Score").Value»
Date: «Letter.Patient.Measures("MMSE Score").DateObserved»

PHQ9 Score:«Letter.Patient.Measures("PHQ-9 Score").Value»
Date: «Letter.Patient.Measures("PHQ-9 Score").DateObserved»

GAD7 Score: «Letter.Patient.Measures("GAD-7 Score").Value»
Date: «Letter.Patient.Measures("GAD-7 Score").DateObserved»

MoCA Score: «Letter.Patient.Measures("MoCA Score").Value»
Date: «Letter.Patient.Measures("MoCA Score").DateObserved»

Additional Information:

The above information was reviewed by Dr. «Letter.Doctor.FullName» on «Letter.Letter.Date»
«Letter.POS.Phone2»

How to import forms

Steps to import your form into Profile

1. Goto https://www.intrahealth.com/customer-success/learning-hub/download-centre
2. Search the page for the following
   A. Document Title,
   B. Document Type,
   C. Health Region and or
   D. Province

Document Title

[   ]

Document Type *

[Requisition Form   ⌄]

Health Region

[- Any -   ⌄]

Province

[- Any -   ⌄]

[**Search**]

3. Navigate to the form that you need, "Patient Summary", and then download.
4. Once the form is downloaded, you will want to save the form to a location that you will remember.

Tip: It is suggested that you create a new folder (Forms) on your desktop and place the form there

5. Locate the file and then extract the forms from the zipped file that was downloaded
6. Open Profile and navigate to ***Organization/ Import & Export/ Import Jajja File***
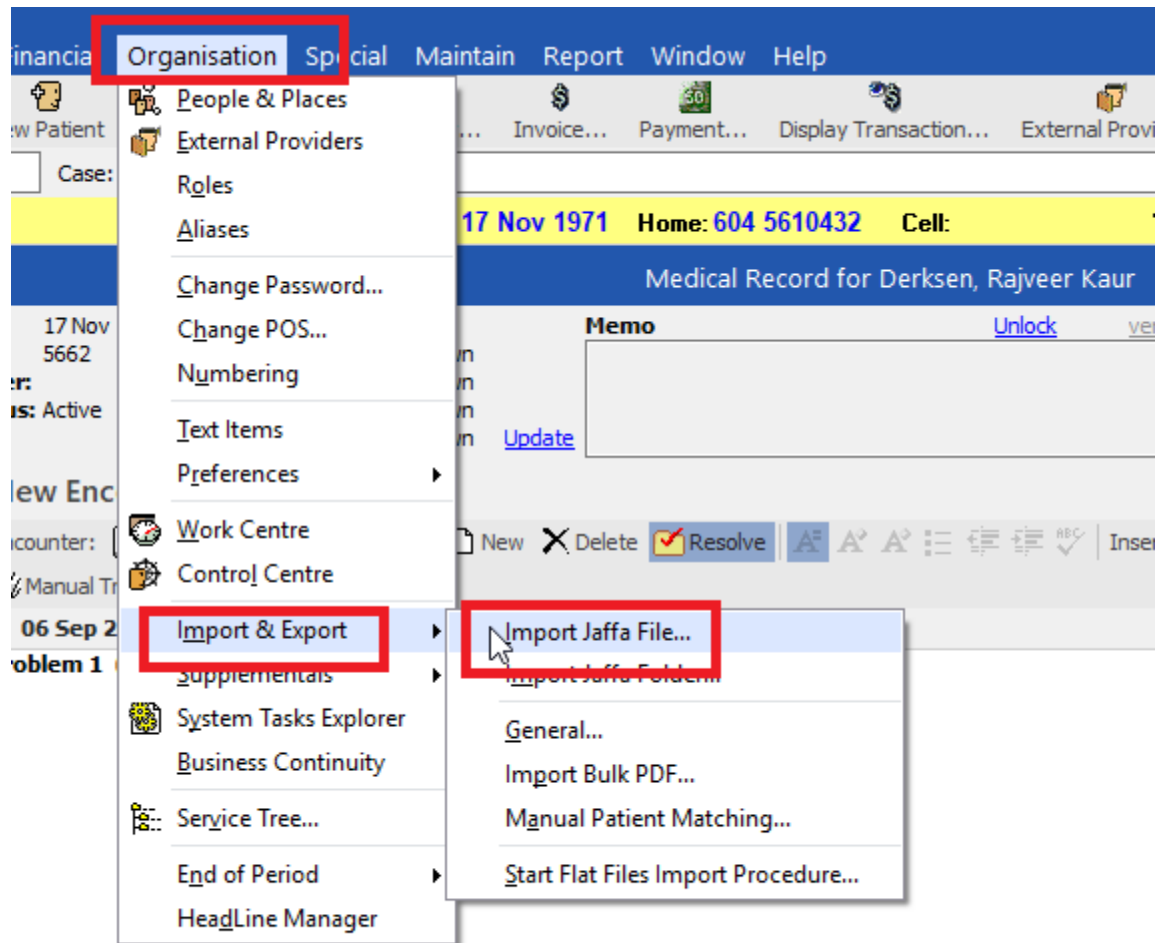
7. Navigate to the file location

Note: If you used the last tip the path will be similar to this (C:\Users\ ***usersname***\Desktop\Forms
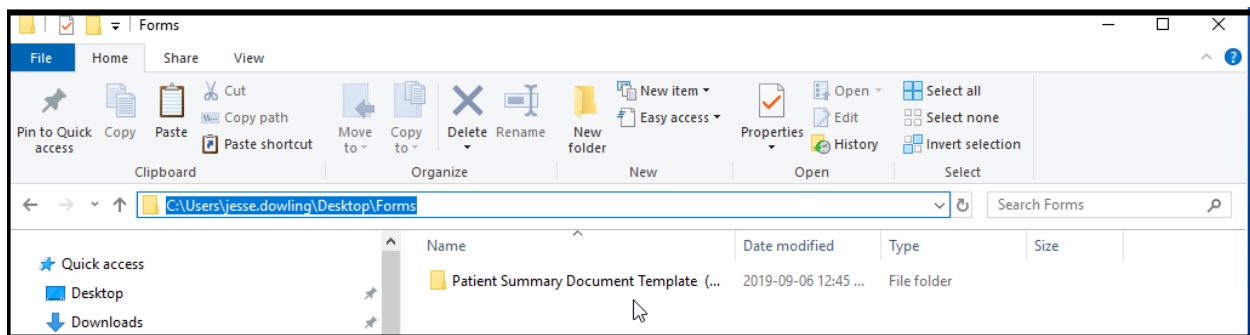
8. Once the file has been uploaded you can then locate the form in:
New encounter/ Letter/ Browse/ Referrals/ All Docs/ Patient Summary