



InfoScribeTM

User Guide

Version 6.50

**(Edited for The City & County of San Francisco
Community Behavioral Health Services, July 6, 2010)**



Welcome to InfoScriber!

We are very happy to have you as a customer. We would like to take a moment to orient you to the InfoScriber System. The InfoScriber System is designed to improve the overall medication management process, leading to improved pharmaceutical treatment and patient outcomes.

About the InfoScriber System

The InfoScriber System is a secure, confidential Web-based system enabling clinicians to write and transmit electronic prescriptions, access clinical resources at the point of prescribing, and receive standard and custom reports to improve work flow efficiencies and clinical care. The System interface is designed to be user-friendly and can be utilized with an optional touch-screen overlay.

We are sure you will find that the InfoScriber System will reduce the potential for medication errors and will enhance your care team communications. Of particular interest are the organization-specific reports that the InfoScriber System can produce. These include workflow reports, prescribing patterns reports, medication schedules and medication usage.

InfoScriber Orientation

This training guide is arranged to familiarize you with the basic functions of the InfoScriber System.

If you have any questions or need assistance using the InfoScriber System, please call your [InfoScriber Liaison](#) within your facility. You may also contact our Member Support at (888) 227-6130, or e-mail us at membersupport@infoscriber.com.



Contact Member Support with any questions or concerns at (888) 227-6130.
Or you can e-mail us at membersupport@infoscriber.com.

User Training Guide

Table of Contents

<u>Sections</u>	<u>Page</u>
1. Getting Started	1
2. Prescriber’s Desktop Features	3
3. ⊕ Add New Patient Tab	17
⊕ Admin Desktop Tab	22
⊕ Admin Caseload Tab – Admin Desktop	24
4. Viewing An Individual Patient	26
5. Rx Profile Tab	28
6. ⊕ Rx Libraries Screen	30
⊕ Custom Orders Screen	32
⊕ Order Confirmation Screen	36
7. Prescriber Reasoning Assessments.....	40
8. Allergy List Tab	44
9. Rx History Tab	46
⊕ Non ISC Rx Link	48
10. Patient Demographics Tab	50
11. Edit Diagnosis Tab	52
12. Print Tab	54
13. Notes Tab.....	56
14. Close Chart and Exit Tabs	64
15. Practice Sessions	65

GETTING STARTED

Log In Screens

The VeriSign Logo is in place to help users verify that the site they have reached is, in fact, the site owned and operated by InfoScriber Corporation. The secure channel helps assure that confidential information is sent directly to our secured database.

Main Sign On Screen

- ◆ ~~At the Main Sign On Screen, you will log onto the System by entering your user name and password (you should have chosen these at the time you registered as a user), then click submit. (See Figure 1)~~
- ◆ ~~At the facility screen, choose the facility at which you are working, then click submit. (See Figure 2)~~
- ◆ ~~At the clinic screen, choose the agency/clinic within your facility (if you facility has multiple sites where patients are seen), then click submit. (See Figure 3)~~
- ◆ ~~This will take you to the Prescriber's Desktop. (See Figure 4)~~

CBHS Users Log in from Avatar

GETTING STARTED

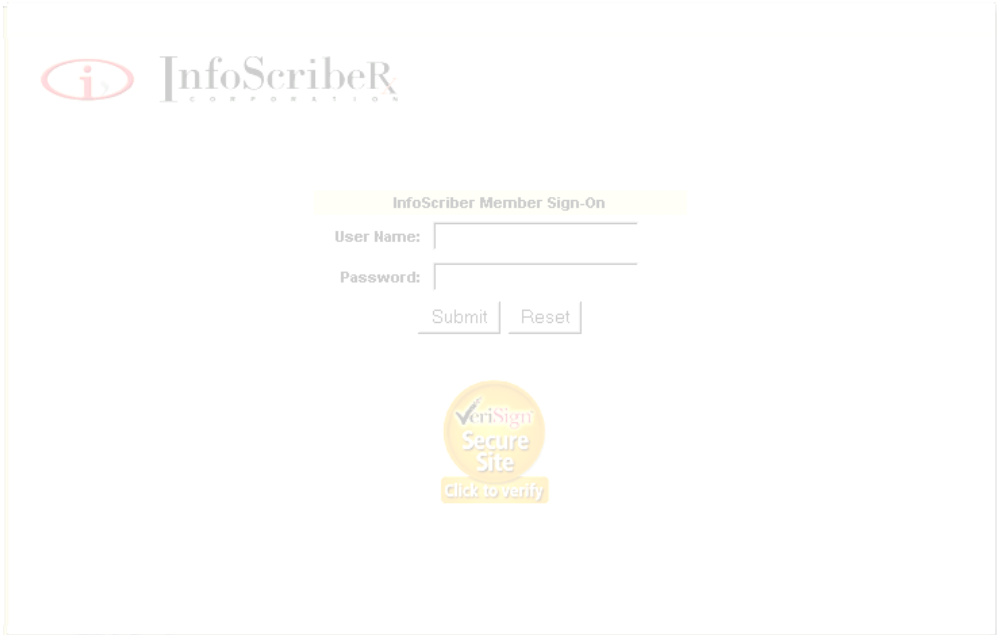


Figure 1: Main Sign On Screen



Figure 2: Facility Sign On Screen



Figure 3: Clinic/Agency Sign On Screen

Notes:

PRESCRIBER'S DESKTOP FEATURES

InBox [represented by the mailbox icon]

- ◆ This area of your Prescriber's Desktop is where your facility "Administrator" will be able to post internal staff communications. It will also be an area where your Administrator can post various links to the World Wide Web.
- ◆ Your facility can appoint one or more Administrator(s) who will be able to create and post the messages using the Administrative tool that we will provide.
- ◆ Additionally, InfoScriber will search for other exciting and relevant healthcare industry articles and news and will post them in the Inbox on a regular basis.

Envelope Icon [top of the page next to Prescriber's Desktop text]

- ◆ When a user clicks on the small envelope icon at the top of any page within the InfoScriber application, an email preaddressed to Member Support will open. By filling in the body of the email with information related to their question, suggestion, or any assistance that is needed and sending it to Member Support the user has taken the first step toward resolution. The emails go directly to InfoScriber Member Support allowing us an opportunity to provide you with expedient, quality customer service.

Please Note: When sending emails to Member Support, please include your facility name, an email address (if possible), and a phone number where we may call you if we have any questions that might help us to resolve your issue.

Standard Reports [represented by the pie chart icon]

The InfoScriber System contains a number of useful reports to assist in managing workflow, improve organizational efficiency and assist with quality improvement initiatives.

Daily Operations

a. Clozapine Pharmacy Report

The Clozapine Pharmacy Report is a refill form that agencies and offices can use for patients who are on clozapine and get regular refills of it. Because pharmacies require lab values to be included at the time of refills, the form not only includes the prescription information, but it also includes a space where the practitioner can write in WBC values and the date that the blood was drawn. The pages of the report are separated by pharmacy name thus making faxing the forms to the pharmacies easier.

Possible application for use:

- Many agencies and offices have a “clozapine clinic” where patients come on a given day to get their blood drawn in order to get their refills. Practitioners thus need to order numerous refills from the pharmacies. Thus, after the clinic, practitioners can pull up the report for a given refill period, fill in the lab values and dates and fax the forms to the pharmacies. Because most all of the pertinent information is already contained on the form, it eliminates needless time in filling out individual forms for each patient and calling them into the pharmacies.

b. Current Med Orders by Patient

The Current Medication Orders by Patient is designed as a quick way to access an individual patient’s current medications as well as viewing the most recent prescribing events that have taken place. By accessing this report, users save the time of going into the main InfoScriber application and pulling up the patient’s record. However, if the user is already in the application, he/she can print this report by clicking on the printer icon that appears on the Current Medication Profile screen to the right of the page title.

c. Faxed Order Locator Report

This report is a tool that providers can use to gain information about prescriptions that were faxed but that did not, for one reason or another, get transmitted successfully. By entering the Order ID number of the failed fax, the sender can get sufficient information to identify the order and thus print it and/or re-fax it.

Possible application for this report:

- If a faxed prescription does not get successfully transmitted, the sender will receive an email notice (to the email address provided during the registration process) telling him/her that the fax transmission failed. The email will not give the patient name, but will give the user an Order ID number. The user can then enter this number in the appropriate box on the Prescription Order Information form and obtain details about the prescription. The user can then print the prescription and/or attempt to fax again.

d. Fax Log

This report is designed to show users, for a given day, the status of faxed prescriptions that were sent to pharmacies. The report will indicate if a prescription was successfully faxed to a pharmacy or if it failed. The report is updated every ten minutes. It is important to note that the “Faxed By” column will indicate the person’s *email name* as indicated on their Provider Registration form that was completed during InfoScriber registration.

Possible application for this report:

- Users can check this report regularly to view the status of their faxed prescriptions and re-fax if necessary, by clicking on the Resend button.

e. Individual Medication Profile

This report shows a history of a specified patient’s medication regimen. This report is equivalent to the “Rx History” page within the InfoScriber application. By clicking on

the name of each medication in this report, users can read any comments that providers have documented with regards to the medication (i.e., efficacy, side effects, etc.).

Possible applications of the report:

- On-call prescribers who get paged at home with a medication order request can view a patient's medication history via their home computer. This, in turn, allows prescribers to make better clinical decisions with regards to medication management by not having to rely on memory recall.
- Providers and office staff can review a patient's medication history without the cumbersome task of locating a patient's chart.
- Providers and office staff can print copies of the reports to include in patient medical records, thus replacing the onerous process of maintaining ongoing medication lists. This report can be a useful addendum to a discharge summary, as well as to summarize the course of medication treatment for other providers involved in the patient's care and treatment.

f. List of Patients with Active Orders by Prescriber

This report lists all patients with active medication orders (i.e., those that have not expired) for a specified provider or for a specified primary prescriber.

Possible application of the report:

- This report can be used as a practitioner's caseload report in private practices and medication clinics and offices. The report can alert physicians and office staff to which patients have active medications in the InfoScriber application.

~~g. Medication Administration Record~~

~~The Medication Administration Record (MAR) is actually a form that facilities can print and use to track medications that have been administered to patients. The form follows the same design as those forms typically used in hospital, residential and outpatient settings. The fields in the form are automatically populated with pertinent patient demographic information as well as prescriber information and medication information for a selected month.~~

~~Possible application for the report:~~

CBHS use hardcopy MAR

h. Medication Education Leaflets

This feature allows users to view patient education leaflets without having to prescribe medications. To use, simply type in the first few letters of the name of the medication for which you wish to search and click on the Go button. You will be presented with a list of medications containing the letters you typed in the space. Click on the name of the medication and you will be presented with an education leaflet which you can view and print.

Possible Application for use:

This feature can be used when you want to present patients or others with information about medications without actually prescribing the medications.

~~i. Medication Prior Auth Audit Report~~

~~This report is designed for use by those facilities that have requested and use the Prior Authorization Request feature that is built into InfoScriber. This report will show the user, for a given date range, all of the Prior Authorization requests that have been submitted and the status of each.~~

~~Possible application for the report:~~

- ~~• Facilities can use this report to help manage their Prior Authorization request process. They can see at a glance which requests need to be followed up on with regards to getting approvals.~~

j. Note Audit Report

This report is designed for users who access the progress note writing feature that is built into InfoScriber. The report will indicate for a given date range, all the notes that have been completed by a specific user or by all users at a particular facility.

Possible applications for the report:

- This report can be very useful in helping clinicians remember which progress notes they have completed and which ones they still need to complete.
- This report can be useful in helping clinical managers monitor the completion of staff progress notes.

k. Pharmacy Refill Report

This report is very similar to the Clozapine Pharmacy Report except that it contains all medications that are due for refills at individual pharmacies for a specified time period. This form can be printed and faxed directly to pharmacies, thus eliminating numerous phone calls to and from the pharmacies requesting refills.

Possible application for use:

- On a given day, practitioners can print this report and fax it to the pharmacies indicated on the form. All patient refills associated with each pharmacy that are due will show up on the form.

l. Prescription Expiration Report

This report was designed as a tool to proactively manage patients' medication regimens. This report shows all medication orders that will expire within the specified period for patients on the selected practitioner's caseload. This report is especially useful for nurses, office staff, case managers or other practitioners responsible for overseeing compliance with the medication regimen.

Possible application of the report:

- Providers and office staff can quickly view patient medications that are due to expire in a given timeframe and reorder those that are needed. The reorders can be faxed directly to or called into a pharmacy. This may prevent potential gaps in patient medication regimens.

m. Prescription Refill Report

This report was also designed as a tool to proactively manage patients' medication regimens. It is particularly useful for patients who receive multiple refills on their medications. This report shows patient prescriptions that have not yet expired but require a refill from the dispensing pharmacy. The report shows all orders for patients on any practitioner's caseload, regardless of who wrote the order.

Possible application of the report:

- As is often the case with patients who require multiple refills of their medications, they do not always remember to monitor when a refill is due. Providers and office staff can quickly view patient medications that are due to be refilled in a given timeframe. They can then call the patients or send out reminders via mail to get their refills. This may help reduce last minute calls from the pharmacy when a patient needs a refill.

Quality Assurance

a. Active Rx by Dx Category Report

This report provides a facility-level view of all current active prescriptions by the diagnostic category that was indicated when the medication was prescribed. The viewer chooses the medication category they are interested in and indicates whether they want to view the report calculated by *diagnostic category* or by *drug*.

Possible applications for this report:

- The view by *diagnostic category* shows the percentage of current active prescriptions for an individual drug *across* common diagnostic categories. For example, it may indicate that in your facility 37% of your Risperdal use is targeted at bipolar disorders. The view by *drug category* indicates the percentage of active orders *within* a specific diagnostic category. For example, it may indicate that at your facility, within the Schizophrenia category, 15% of your active orders are for Clozaril, while 27% are for Zyprexa.
- A "CPN Network" view is also provided to allow you to compare your facility's prescribing patterns with the total InfoScriber network percentages. Using the above example, you can compare your 37% usage of Risperdal targeted to bipolar disorder with the CPN's 25% usage of Risperdal for bipolar disorder. Please note that the percentages may not always add to 100% due to rounding.

When printing the report, please be sure to set your print format choice on "landscape."

b. Diagnosis Report

The Diagnosis Report allows facilities to view the frequencies of diagnoses being treated at their facility. Users can indicate whether they want to see all diagnoses listed or just the ones that have been designated as a primary diagnosis. The report starts out showing diagnostic categories but can be filtered to show frequencies of individual DSM-IV diagnoses.

Possible Applications for this report:

- Regulatory and other reporting needs and requirements
- Internal quality assurance monitoring
- Internal trend monitoring

c. Dose Range Report

This is a multi-faceted report which allows clinical directors, prescribers and other interested parties to drill down from the highest level aggregate prescribing data for the facility to the most specific practitioner's comments on a particular patient's order. Users can select a medication category of interest and review the number of orders active within the target month and get aggregate information as to how they were prescribed.

Selecting a specific drug will allow the user to view each order written for that drug. The report can be sorted by any column heading. Clicking on a specific order will allow the user to drill down one level deeper and actually review the context in which the order was written and any annotation that the prescriber included.

Possible applications for this report:

- Providers and prescribers can quickly review the prescribing patterns at their facility by each prescriber.
- Clinical directors and/or quality assurance specialists will find the report a very useful tool in their facility's QA process for medications.

This report can be used as a tool to evaluating dosing outliers including both sub-therapeutic dose range cases, and cases that exceed recommended dosing levels. This can also help support more advanced internal analyses, such as evaluation of possible correlations between medications, dosing levels and various outcome measures. (please note that dosing information is only available for medication forms selected as individual units, i.e. capsules, tablets, etc.).

d. Medication Sample/Stock Report

This report is a tracking report which tallies the amount of medications that were submitted to pharmacies and/or that were taken from the facility's sample or stock supply of medications. In addition, the report, for trending purposes, attaches a dollar amount to each of the categories. It is important to note that the numbers on this report are based on Average Wholesale Prices (AWPs) for medications used and may vary materially from a facility's actual cost of the medications prescribed.

Possible application for the report:

- Facilities can use this report to assist in tracking the amount of medications coming from their sample and stock supplies. While the report does not include a mechanism to enter beginning amounts (as in an inventory system) of sample and stock medications, it can be effectively used to monitor and track output.

e. Medication Volume Report

The Medication Volume Report is intended to give facilities and medical offices a relative overview of their medication usage by psychotropic medication category. In order to standardize the format to review medication usage a measure called Active Order

Days is used. Active Order Days are the number of days that a given patient had an active order for the medication. For example, if a patient were prescribed a medication with a 30-day duration on the 15th of the month, the medication would show up as 15 Active Order Days for the current month and 15 Active Order Days for the following month. Future revisions of this report will include Medication Volume per Patient. This per patient measure will allow comparisons in the same location over time, and comparisons with comparable treatment settings.

Possible application for the report:

- By reviewing the Medication Volume Report, providers and prescribers can get an early warning on increased use of medication types. In addition, they can see fluctuations over time with regards to medication use by category. [Note: Increases in Active Order Days will also occur when there is an influx of new patients.]

f. Polypharmacy Report

This report allows facilities to view patient cases where the practitioner has concurrently prescribed multiple medications, both within the same class and from different classes. To view the report, simply enter your parameters at the top of the report and click on the Go button. You will be presented with data showing the number of cases where the particular drug you chose is being used as a monotherapy, as well as the number of cases where the drug is being combined with other drugs. For example, if you chose the medication category of antidepressants and the medication name, Prozac, you will be presented with a series of cases of patients taking Prozac at your organization. You may see that some patients take only Prozac and you may also see that there are patients taking Prozac with a number of other medications. For example, if there is a 3 in the column labeled “Antipsychotic,” this would mean that a patient who is taking Prozac is also being prescribed 3 antipsychotic medications, as well. To see what patient it is, simply click on the number indicating the number of cases being represented and you will be able to view patient details.

Possible Application for use:

This report is useful for facilities that want to track patterns that can result in expensive and often ineffective prescribing practices.

g. Relative Medication Cost Report

This report is a companion to the Medication Volume Report described above. It is important to note that the numbers on this report are based on Average Wholesale Prices (AWPs) for medications used and may vary materially from a facility’s actual cost of the medications prescribed. The figures presented are calculated by averaging all of the AWPs for a given medication (there are usually several and can vary greatly) and arriving at a Cost per Unit. The Cost per Unit is then multiplied by the total number of units of a given medication, thus arriving at the dollar figure shown in the report for that medication class.

Possible applications for the report:

- By reviewing the Medication Cost Report, providers and prescribers can get an early warning on increased spending trends of medication types. In addition, they can see fluctuations over time with regards to medication cost by category. Providers and prescribers will find the report useful in reviewing

the relative costs over time to help analyze overall cost saving programs that may be put in place.

- Facilities and providers can use the report to evaluate changing patterns in the relative cost of pharmaceutical versus non-pharmaceutical treatment services.

h. Switching Scorecard

This report allows facilities to see how many cases they have where prescribers have switched a patient's medications within a given class of medications. Users can see when switches were made from generic to brand name drugs or vice-versa, as well as from different drugs within the same class of medications. For the purposes of this report, a switch occurs when either or both of the following criteria are met: A medication of the same category was discontinued or expired within the 14 days preceding OR following the start date of a New Start in the same medication category.

To view the report, simply enter your parameters at the top of the report and click on the Go button. If you choose a particular medication, you will be presented with data showing you how many times a patient was switched to and from the medication from another specific medication. For example, if you choose Clozaril, you will be presented with a column heading titled "Count From" and "Count To." The "Count From" column indicates the number of cases where a patient was switched from another drug (indicated on the left side of the table) to the drug you picked. The "Count To" column indicates the number of cases where a patient was switched from the drug you picked to another drug (indicated on the left side of the table). By clicking on the name of a drug, you will be presented with even more detail, including the patient on whom the switch was made.

Possible Application for use:

This report is useful for facilities that want to identify and track patterns that can result in expensive and often ineffective prescribing practices.

Security

a. Duplicate Print Audit

This report is designed to help prescribers spot unauthorized output of their orders. This report will print a list of all orders printed in a user-selected date. The report will show the Order ID number, Patient Name, SIG(s), Order Date, Print Date and Time, and the name of the person printing each copy of the order.

Possible application of this report:

- This report can be a very useful security tool for prescribers and facilities. It is recommended that each facility set up a schedule for printing and reviewing of the duplicate print audit by each designated prescriber. If any questionable duplicate printing is spotted, the report provides necessary information including the name of the person who printed the duplicate prescription information and the date and time printed.

b. Medication Order Audit by Prescriber

This report will show details for each order attributed to a given prescriber by the system for a given day. The detail includes the name of the agent who entered the order if different from the prescriber (i.e., if the prescriber entered the order for himself/herself the field will be blank), the Order Id number, Patient Name, SIG, Pharmacy Selected, Fax Number (if faxed), and whether or not a copy was printed. The prescriber will be able to view this report and verify that he/she did, indeed, authorize the orders. This process is not dissimilar from the current verbal order / telephone order process used by many practitioners, wherein the prescriber is required to sign all verbal and telephone orders within 24 hours of issuing them.

Possible application for the report:

- **This report can be a very useful security tool for prescribers and facilities.** Each morning, it is recommended that prescribers print the report for the previous day (do not use the report for same-day reporting). The prescriber will then see all of the orders that were written on behalf of him/her or by him/herself directly. The prescriber can then sign off on each of the orders that were written on behalf of him/herself and placed in a log.

c. Order Audit Report

This report is identical to the **Medication Order Audit by Prescriber** report except that it is only available for viewing by individual registered prescribers. The report will act exactly as the Medication Order Audit by Prescriber report, as described above, except that it will list all the orders written by the prescriber or on behalf of the prescriber by an agent, *since the last time the prescriber clicked on the report link*. The reason for this design is to make sure that no orders go unnoticed by prescribers who might not be able to check the report daily (i.e., part-time practitioners).

d. Prescriber Agent Authorization Report

This report is actually a form that a facility can use (or must use depending on state-specific Pharmacy Board regulations) to keep record of prescriber agents who are authorized to record medication events on behalf of a prescriber.

Possible application for this report:

- It is the responsibility of each facility to ensure that there is written authorization by each authorized Prescriber for an Agent to enter prescriptions on behalf of the Prescriber. Authorization must be obtained prior to activating an Agent in the application for the facility. The facility is responsible for ensuring that a written record of each authorization is on file at the facility at all times for each Agent with active Prescriber Agent Level access to the application. If a Prescriber at any time withdraws authorization for any designated Agent, the facility must immediately deactivate the Agent's user account within the application.

Administration

e. Facility Usage Report

This report is designed to show, by a specified date range, the frequency of total prescribing events completed at the facility. The report gives a tally of total prescribing events completed for each prescriber and prescribing agent at the facility.

Possible application of this report:

- This report is a useful tool for liaisons, administrators and trainers at facilities. The report can be used as a way to determine, by prescriber or agent, who is using the application and to what extent each is using it.

f. Non-Caseload Audit Report

The InfoScriber application allows facility administrators to restrict individual users' access to patient records. One of the restriction categories available is to allow a user to access a patient record but only after he/she gives a specific reason as to why he/she needs access. The Non-Caseload Audit Report tracks users who access such records and documents the reasons given for the need to access.

Possible application for the report:

- This report can be used by facilities' HIPAA Compliance Officers or Privacy Officers to monitor users' access to patient records.

Action Links [represented by a light bulb icon]

If this icon is red and flashing, it means that you have a personal message waiting for you from InfoScriber. Simply click on the icon to see the message that is waiting for you. Once you have clicked on the icon, the light will turn green as long as the message remains in your box. If there are no messages in your box, the light bulb icon will not be present.

InfoLinks [represented by the globe icon]

The globe icon is the **InfoLinks icon**. When you click on the icon, you will have the ability to view a number of links to Websites of interest. The Websites currently fall into five categories, Psychiatry/Mental Health, Education, General Health, Government and For Your

Information. InfoScriber Member Services will be routinely screening and posting new links to information of interest, including those pertaining to wellness management and disease management. Let us know if you have any links in which you think others would find value and we will review them.

Survey Q [represented by the ‘Q’ icon]

If this icon appears on your screen, it means that you have at least one Prescriber Reasoning Assessment (PRA) waiting for you to answer. [Note: This is an optional feature that may have been chosen by your facility.] Listed will be all PRAs that either the prescriber clicked “Later” on or that resulted from a prescriber’s agent (i.e., an RN) issuing a prescription on behalf of the prescriber and which triggered a PRA. The prescriber will have seven days to complete the PRA. After seven days, the PRA will disappear from the report and the prescriber will no longer be able to retrieve it. Also, once the prescriber has completed the PRAs on his/her list, the ‘Q’ icon will no longer appear.

View an Individual Patient

The column to the right on the Prescriber’s Desktop is where you will be able to search for existing patients in the System. (*See Figure 4*)

- ◆ In the field below Last Name, First Name, you simply type in a few letters of the patient’s last name, then click the GO button.
- ◆ You will be presented with a list of patients in the System matching your search criteria.
- ◆ You then select the patient for whom you would like to prescribe medications. Click the circle marked Active, Inactive, or All to search for patients in that category. If by chance a patient does not come up and you have the “Active” button selected, by changing your selection to the “All” button in order to view all patients in the InfoScriber System that meet your named criteria.
- ◆ Hold the cursor directly over the patient’s name to determine if the patient is the one you wish to prescribe for. The patient’s name, social security number and date of birth will appear which will help you narrow your search even further.
- ◆ Once you have found your patient in the list, simply click once on their name, and it will take you to the Rx Profile screen.

PRESCRIBER'S DESKTOP FEATURES

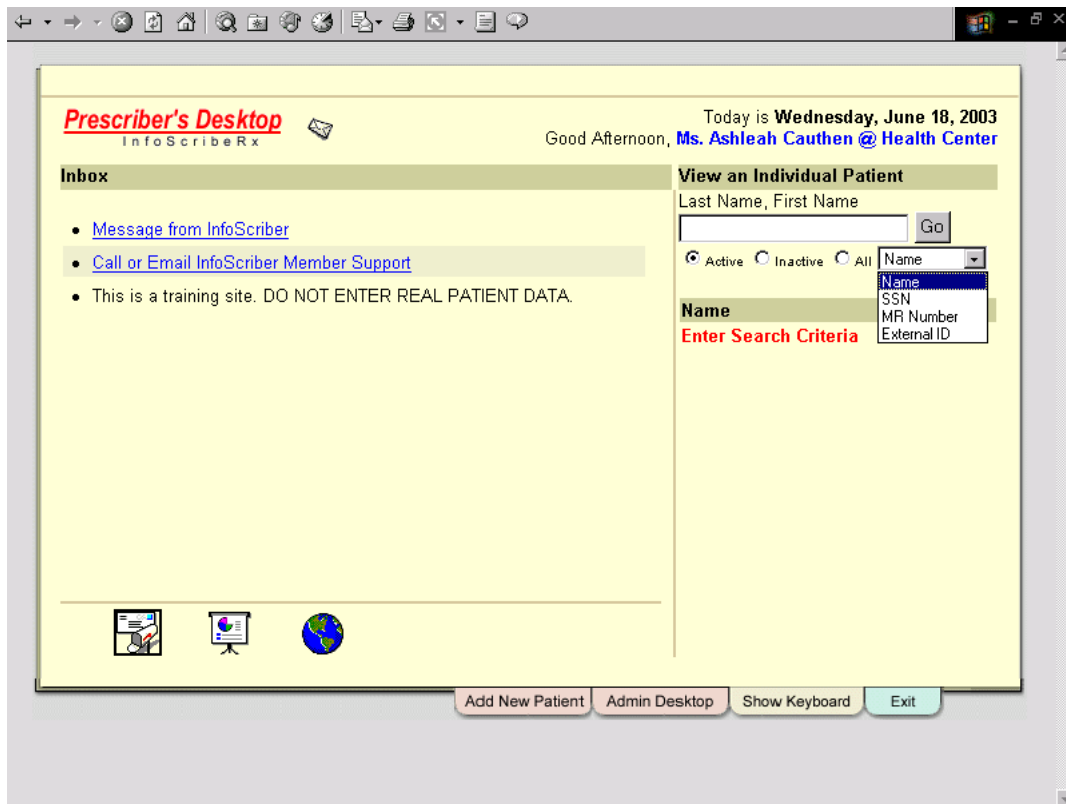


Figure 4: Prescriber's Desktop

ADD NEW PATIENT TAB

Some facilities may be able to add a new patient directly into the InfoScriber System by clicking on the tab “Add New Patient” at the bottom of the Prescriber’s Desktop. If you do not see the “Add New Patient” tab, it means your facility has chosen to use its own “Host” database to enter new patients. The new patient information will automatically go into the InfoScriber System at designated intervals. (See Figure 5) If the “Add Patient Tab” is not visible, please skip to the “Viewing an Individual Patient” section of this guide.

- ◆ Once you click on the Add New Patient, you will see the Patient Demographics screen, which is separated into 2 parts. (See Figures 5A & 5B)
- ◆ The required fields are highlighted in red, although please try and complete as much as you can in order for the data to be accurate and consistent. Don’t forget to complete all of the information on the screen. You may need to scroll down in order to view all of the data fields.
- ◆ You can navigate through this screen by clicking in each field or by hitting your TAB key on your keyboard. [Keep in mind that the ‘Health Plan’ field is where you can search for the patient’s health plan. When prescribing medications for a particular patient, the ‘formulary’ will be checked against this health plan.]
- ◆ When you have entered all of the information in all the fields, remember to click on the “SAVE” button. You can then begin prescribing medication by clicking on the Rx Profile tab on the bottom.

Patients added in Avatar

PATIENT DEMOGRAPHICS - ADD NEW PATIENT TAB

The screenshot shows a software window titled "Patient Demographics" for a patient named Janice Klann. The patient's MRN is 654321, she is female, 60 years old, and her birthdate is 12/04/1942. Her primary diagnosis is "Schizophrenia Disorganized Type". The form includes fields for personal information, contact details, physical characteristics, and medical history. A "SAVE" button is located at the bottom right of the form area.

Patient Demographics

JANICE KLANN MR# 654321, FEMALE, 60, 12/04/1942
Schizophrenia Disorganized Type

First Name: Janice Middle Name: Alt. Phone:
Last Name: Klann Birthdate (mm/dd/yyyy): 12/04/1942 Gender: Female
Street Address: Weight: lb. Recorded:
City: State: Zip Code: Height: ft. In. Recorded:
Residential Type: Ethnicity:
 Overdose Risk Preferred Language:
Notes: Preferred Pharmacy (Name: Address) Search
Primary Prescriber: --Chosen by Patient--
SAVE

* Required fields are in RED

Rx Profile Allergy List RxHx Patient Demo Edit Dx Close Chart Print Exit Notes

Figure 5B: Patient Demo Tab

Notes:

ADMIN DESKTOP TAB

The assigned Administrator at your facility will have access to and be able to see the “Admin Desktop” tab on the Prescriber’s Desktop (if you aren’t the assigned Administrator, you can skip to the next section). The Administrator will have the ability to post internal messages. The Administrator will also be able to post various web links that would be of interest to the facility staff. These messages will appear in the InBox on the Prescriber’s Desktop.

- ◆ Click on the Admin Desktop tab from the Prescriber’s Desktop.
- ◆ At this point, you have an option to (1) post administrative messages, (2) assign or reassign caseloads, or (3) return to the Prescriber’s Desktop. (*See Figure 6A*)
- ◆ If you select the “Admin Messages” tab, the next screen that will appear will be a historical list of all the inbox messages that have been displayed on the Prescriber’s Desktop. Each message has a computer generated ID number, a start date and end date listed for the message to appear, and the first few words of the message. (*See Figure 6B*)
- ◆ If you would like to remove a message altogether, click on the “Remove” button to the left of the start date.
- ◆ To add a message, click on the “Add Message” button at the bottom left corner of the screen.
- ◆ This is where you will be able to choose a start and end date for your message to appear in the Inbox. The date fields will generate calendars from which you can swiftly select your dates. (*See Figure 6C*)
- ◆ If you choose to have your staff members link to an outside link (i.e., a World Wide Web site), you will select the box that says Outside Link.
- ◆ In the message box, you can type a brief statement summary of the article, website or link that you would like your staff to click on. This statement will appear in the Inbox at your facility, with a link to the document or website.
- ◆ In the Link field, you will need to type in the URL, (i.e. <http://www.yahoo.com>.) If you would like to link to an html document saved on your network drive, click on Browse and select the file name on your network.
- ◆ At this point, you are ready to click on Add. It will take you back to the Admin Messages (*Figure 6B*) and you will be able to see the summary of your link, along with the history of all the other messages.
- ◆ To check to see if you message was posted correctly and functions properly, click on Prescriber’s Desktop and you should be able to see your message. Click once on the “Link” and it should automatically take you to the web document.

ADMIN CASELOAD TAB – ADMIN DESKTOP

This optional feature is used to select, reassign, or remove portions of or all of the patient caseload for each physician, nurse, or other InfoScriber System user.

- ◆ Select a provider (i.e., MD, nurse, other user) from the pull down menu at the upper left hand corner of the screen. A list of all users that have been registered in the InfoScriber System for your facility will appear. Choose the name of the person for whom you wish to assign a caseload to and click the “GO” button. *(See Figure 6D)*
- ◆ The patients currently assigned to the provider will appear on the lower left hand side of the screen. Patients that need to be assigned to a provider will appear on the right hand side of the screen.
- ◆ To assign a patient to this provider, click on the patient’s name noted in the list on the right side of the screen. This patient is now assigned to the provider listed. *(See Figure 6E)*
- ◆ To remove a patient from the provider’s caseload, click in the white box to the left side of the patient’s name. A check mark will appear in the box. Click the “Delete” button to remove the patient from this provider’s caseload. *Note: Delete means “remove from caseload.” The patient information will remain in the InfoScriber System even after clicking this button.*
- ◆ To reassign a patient, click the white box on the left side of the patient’s name and click on the Reassign button. You will again be prompted to choose a provider from the pull down menu. Chose the provider to whom you wish to reassign the patient to and click the Go button. The screen will change and show you the revised list for the provider to whom you just assigned the patient.
- ◆ If you wish to reassign or remove (*Delete button*) all of the patients listed under a particular provider, click the “Select All” button. This will check all of the white boxes next to the patient names on the left side of the screen. Should you decide not to reassign or remove all of the patients, click the “Clear All” button. The “Clear All” button will work on all boxes that have been checked, treating it as an “undo” feature.
- ◆ After completing the assignment of patients, click on either the “Admin Desktop” button to return to creating messages, or click on the “Prescriber’s Desktop” button to view an individual patient.

ADMIN CASELOAD TAB – ADMIN DESKTOP

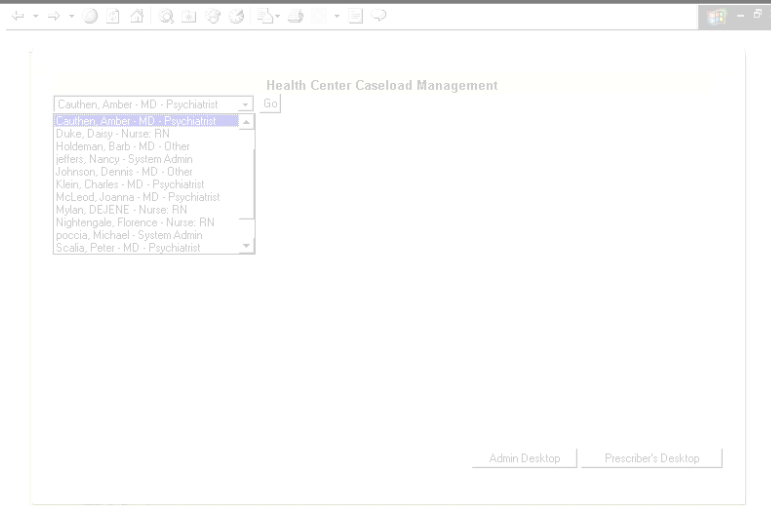


Figure 6D: Admin Caseload Tab

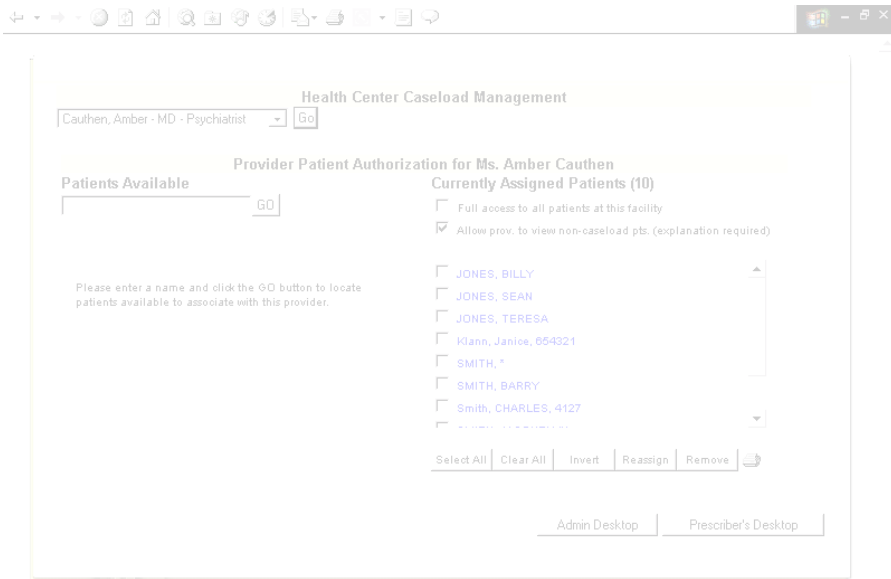


Figure 6E: Admin Caseload Assignments

Notes:

VIEWING AN INDIVIDUAL PATIENT

The Prescriber's Desktop is where you will be able to search for existing patients in your System. You will be able to pull up information about a specific patient by entering either a full or partial last name, social security number, medical record number or external ID number into the white box below "Last Name, First Name." Be sure you select the appropriate search criteria using the dropdown below the search text box. You have the capability to search all active patients, all inactive patients, or all patients with your facility with the name criteria you have specified. (See Figure 9a)

- ◆ The third column to the right on the Prescriber's Desktop is where you search for existing patients in the System.
- ◆ Click the circle marked Active, Inactive, or All to search for patients in that category. If by chance a patient does not come up and you have the "Active" button selected, try changing your selection to the "All" button in order to view all patients in the InfoScriber System that meet your named criteria.
- ◆ In the field below Last Name, First Name, you will simply type in a few characters of the patient's last name, social, medical record number or external ID number, then click GO.
- ◆ You will be presented with a list of patients in the System matching your search criteria.
- ◆ Select the patient for whom you would like to prescribe medications.
- ◆ Hold the cursor directly over the patient's name to determine if the patient is, the one you wish to prescribe for. The patient's name, social security number and date of birth will appear which will help you narrow your search even further.
- ◆ Once you have found your patient in the list, simply click once on their name, and it will bring you into their Rx Profile.
- ◆ If your facility is utilizing InfoScriber's Caseload feature to assign individual patient caseloads, you may get a message that says "No Records Found" whenever you search for a patient record. This means that the patient is not on your caseload and you have been restricted to viewing only the charts of patients assigned to your caseload. If a patient is not assigned to your caseload, but you have still been given access to the record, you may get a prompt asking you to provide a reason for viewing the chart. (see figure 9b)

VIEWING A N INDIVIDUAL PATIENT



Figure 9a: Viewing a Patient



Figure 9b: Non-Caseload Access

Rx PROFILE TAB

This is the screen from which most of your work will originate. The Current Medication Profile will list all diagnoses that are active, any known allergies, all current medications, and icons indicating if there are possible suicide risks, adverse drug to drug/food interactions, or pregnancy alerts. If there is a drug to drug/food interaction with the currently prescribed medications, one, two or three exclamation marks will appear at the bottom center of the screen indicating the severity of the interaction. You can click on the exclamation mark(s) and the interactions will appear for your review. (See Figure 10B) [Hint: You can easily access the patient's Mini Rx Profile screen by clicking on the "double head" icon on the top left of any of the prescribing event screens (See Figure 10C). If it has been indicated in the patient demographics (figure 5 B) that the patient is a possible overdose (suicide) risk a skull and crossbones will appear at the bottom of the screen. (see figure 10A) This symbol will also appear at the top left of every page. If the patient is a female, you can view possible pregnancy or lactation alerts by clicking on the female symbol at the bottom of the page. (Figure 10A) The Rx Profile screen displays action icons used to discontinue, reorder, change, and/or add (prescribe) a new medication. To discontinue a medication click on the "X" icon. To reorder a medication click on the arrows icon. To change a medication click on the triangle icon. When you click on these action icons a dark square will appear around it. To add a new medication click on the white box next to "Add New Prescription" and a checkmark will appear. **[You can perform multiple actions on the medications at the same time.]** You can also print a copy of the current active orders by clicking on the printer icon that is located right above the list of current medications (See Figure 10A).]

To Discontinue a Medication

- ◆ Click on the red "X" icon for each medication to be discontinued.
- ◆ Choose another prescribing event or click the "Go" icon. This will take you to the Order Confirmation screen.

To Reorder a Medication

- ◆ Click on the "double arrow" icon for each medication to be reordered.
- ◆ Choose another prescribing event or click the "Go" icon. This will take you to the Order Confirmation Screen.
- ◆ To edit the order date or start date of a reorder, or to edit the diagnosis for which the reorder is being prescribed, click on the word "reorder" when it appears next to the name of the medication on the *Order Confirmation screen*.

To Change a Medication

- ◆ Click on the "triangle" or "delta" icon for each medication to be changed.
- ◆ Choose another prescribing event or click the "Go" icon. This will take you to the Custom Order screen.

To Add a Medication

- ◆ Click on the white box next to "Add New Prescription" and a check mark will appear.
- ◆ Choose another prescribing event or click on the "Go" icon. This will take you to the Rx Library screen.

Rx PROFILE TAB

MARY JONES MR# 3, Female, 51, 10/17/1952
Bipolar I Disorder, Most Recent Episode Depressed, Unspecified

Current Medication Profile

Current Diagnosis	Start Date	Medication Order	End Date	Action
296.50 - Axis 1 - Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	08/25/2004	Ativan- 1 mg, TAB, PO (2)ea QAM Take at 8 AM	09/24/2004	[X] [Refresh] [Alert]
315.2 - Axis 1 - Disorder of Written Expression	08/25/2004	Celebra- 10 mg, TAB, PO (1)ea QHS	09/24/2004	[X] [Refresh] [Alert]
	04/02/2004	Haldol Decanoate- decanoate 100 mg/ml, SOLN, INJ (20)mg Q4W	05/02/2004	[X] [Refresh] [Alert]
		Sudafed Plus 1 tab BID for allergies		[X]
		PLEASE GET LABS ON NEXT VISIT (6/22/04)		[X]

Known Allergies

ASPIRIN
ST JOHNS WORT

!! ♀ ☠ NonISC Rx Add New Prescription **GO**

Rx Profile Allergy List RxHx Patient Demo Edit Dx Close Chart Print Log Off Notes

Figure 10A: Rx Profile Tab

JOHN D DOE, MALE
Schizophreniform Disorder

Medical Alerts for JOHN D DOE

Drug to Drug/Food Interactions

chlorpheniramine:hydrocodone/phenylephrine (chlorpheniramine) haloperidol: MINOR CNS-depressant and/or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects.

chlorpheniramine:hydrocodone/phenylephrine (chlorpheniramine) paroxetine: MINOR CNS-depressant and/or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects.

chlorpheniramine:hydrocodone/phenylephrine (hydrocodone) haloperidol: MINOR CNS-depressant and/or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects.

chlorpheniramine:hydrocodone/phenylephrine (hydrocodone) paroxetine: MINOR CNS-depressant and/or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects.

haloperidol paroxetine: MINOR CNS-depressant and/or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects.

Allergy Reaction Alerts

Print Close

Figure 10B: Drug to Drug/Food Interaction Screen

Mini Rx Profile -- Web Page Dialog

MARY JONES
MR# 343362 Gender: Female
Age: 29 BirthDate: 1/1/1975

INFO CHANNEL -

Current Diagnosis	Start Date	Medication Order	End Date
300.21 - Axis 1 - Separation Anxiety Disorder	01/23/2004	Ativan- 2 mg, TAB, PO (1)ea QAM	02/22/2004
ISC5 - Axis 4 - Housing problems	01/23/2004	Effexor XR- 150 mg, ERC, PO (1)ea QAM	02/22/2004

Known Allergies

Sulfacet Sodium
Tylenol Allergy Sinus Caplet

CLOSE

Figure 10C: Mini Rx Profile

Notes:

Rx LIBRARIES SCREEN

The Rx Libraries feature is a valuable tool for prescribing new medications. It allows you to search four different libraries: My Practice, My Group, InfoScriber Practice, and All Drugs. Each library is built automatically by monitoring the ways that prescribers prescribe medications over time for specific diagnoses. “My Practice” will list all of the ways you prescribe a medication, listing the most common ways first. “My Group” will list all of the ways the prescribers in your facility have prescribed a medication, listing the most common ways first. “InfoScriber Practice” will do the same for all prescribers in the country who are using the InfoScriber System, while “All Drugs” will list all FDA approved drugs. This screen will also check against a patient’s formulary. *You will be taken to this screen (Rx Libraries) when you add a new medication or change a medication.*

To Search Rx Library (My Practice, My Group, or InfoScriber Practice)*(See Figure 10D)*

- ◆ Click on the library button you would like to search: “My Practice” or “My Group” or “InfoScriber Practice.”
- ◆ Enter in the first few letters of the drug name you would like to search in the “Drug Name” box to the right of the libraries.
- ◆ If you would like to search by Drug name AND Dx, click on the drop down menu below the “Drug Name” to chose the patient’s diagnosis for which the drug is being prescribed.
- ◆ Click on the “Search” button. A list of dosing patterns will appear on the lower quadrant of the screen. If you would like to delete any of these entries, click on the red X to the left of the entry.
- ◆ Click once on the desired dosing pattern. It will be added to the prescription pad on the top right of the screen.
- ◆ Repeat the above five steps until you have added all the drugs you would like to prescribe for this patient. Click on the “Submit Order” button.
- ◆ This will take you to the Order Confirmation screen.

To Search Rx Library (All Drugs)

- ◆ Click on the “All Drugs” library button.
- ◆ Enter in the first few letters of the drug name you would like to search in the “Drug Name” box to the right of the libraries.
- ◆ Click the “Search” button. A list of drugs will appear on lower quadrant of the screen.
- ◆ Click on the drug you would like to prescribe. It will appear on the prescription pad on the top right of the screen.
- ◆ Repeat the above four steps until you have added all the drugs you would like to prescribe for this patient. Then click the “Custom Order” button.

- ◆ This will take you to the Custom Orders screen.

Rx LIBRARIES SCREEN

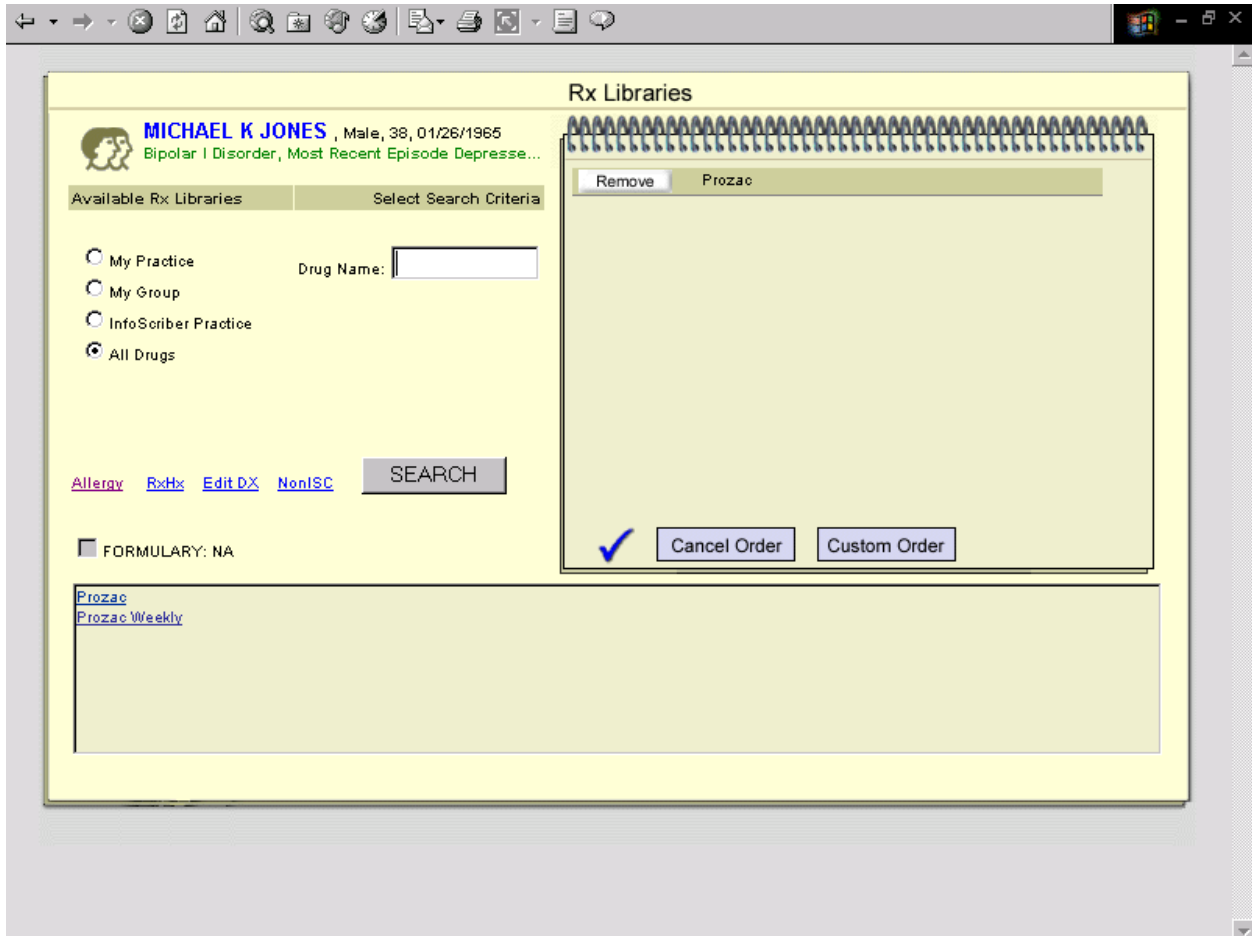


Figure 10D: Rx Profile – Rx Libraries

The blue checkmark to the left of the Cancel Order button allows users to check for possible Drug/ Food to Drug interactions based upon what is currently being ordered for this patient.

Notes:

CUSTOM ORDERS SCREEN

The Custom Orders screen is used to assign a strength, dose, schedule, start date, and end date for each medication. This screen has a unique Titration Wizard and Special Instructions box which allows you to enter specific notes regarding each medication. *You will be taken to this screen (Custom Orders) when you are changing an existing schedule for a prescription or adding a new medication.*

The Custom Orders screen has links to the Allergy, RxHx, Edit Dx, and NonISC pages. There is also a link to the Dosage Forms Abbreviations (Abbr.) definitions. This lists the most common dosing form abbreviations (i.e. TAB=tablet, CAP=capsule) and their definitions. These links allow the user to move through the application to these pages without losing the work that has been done on the current prescribing event.

Custom Orders– No Titrations

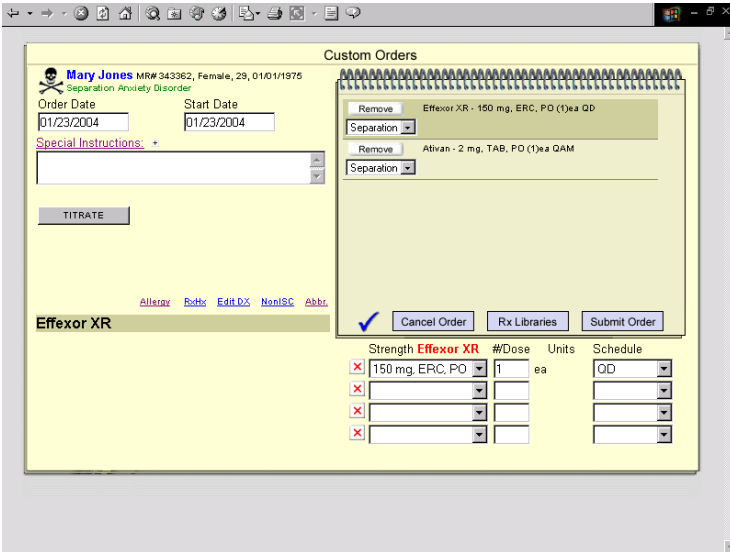
- ◆ The medication listed first on the prescription pad will be the first one to be dosed. Click on the “Diagnosis” drop down menu and choose the diagnosis for which you want to prescribe the medication. (See Figure 10E)
- ◆ Click on the “Strength” drop down menu and choose the strength for the medication you are prescribing.
- ◆ In the box labeled “# / Dose” enter the quantity for each individual dose.
- ◆ If you prescribe a medication other than in a pill, capsule, or tablet form, a drop down menu called “Units” will appear to the right of “#/Dose.” You may choose the following dosing units: mg, ml, units, cc, or ea.
- ◆ Click on the “Schedule” box drop down menu and choose the schedule for the medication you are prescribing.
- ◆ If you would like to change the “order date” and/or “start date” click on the appropriate white box in the upper left corner of the screen and a calendar will appear. Select a date from the calendar.
- ◆ Click in the white box labeled “Special Instructions” to add any special instructions for the medication you are prescribing.
- ◆ If there are multiple drugs on the prescription pad, click on the next drug listed on the pad that you want to dose; it should now be highlighted on the tan bar. Repeat the above steps for each drug that needs to be dosed.

- ◆ Click on the “Submit Order” button when you are finished dosing all medications. This will take you to the Order Confirmation screen.

Custom Orders – Titrations and Tapers

- ◆ The medication listed first on the prescription pad will be the first one to be dosed. Click on the “Diagnosis” drop down menu and choose the diagnosis for which you want to prescribe the medication. (*See Figure 10E*)
- ◆ If you would like to titrate the medication, click on the “Titrate” button. (*See Figure 10F*)
- ◆ Enter the number of days for the first step of the titration in the white box below “days in this step.”
- ◆ Choose the “Strength,” “Dose,” “Units,” and “Schedule” from the scroll down menu on the lower right side of the screen.
- ◆ Click on the “>>” (next) button located in the titration steps area.
- ◆ Repeat the titration steps. Complete the number of day to clicking the “>>” button until the last step of the titration. Click on either the “Taper” button (indicating a downward titration) or on the “Titrate” button (indicating an upward titration). Click on the “Finish” button. This will complete the titration or taper steps for this medication.
- ◆ Note: If while completing the steps of a titration you would like to cancel a step, click on the “Cancel Step” button. If you would like to move backwards through the titration to see previous steps, click on the “<<” button.
- ◆ If you would like to change the “order date” and/or “start date” click on the appropriate white box and a calendar will appear. Click on the desired date from the calendar.
- ◆ Click in the white box labeled “Special Instructions” to add any special instructions for the medication you are prescribing. Users can either type in Special Instructions manually or choose them from your Special Instructions Library by clicking on the Special Instructions text above the white box. Users can also create their own Special Instructions Library by first typing the special instructions into the white box and then clicking on the small white box containing a plus (+) sign above the special instructions box. Special Instruction Libraries can also be set up during registration or by editing your user registration. (*See InfoScriber Registration Guide for instructions*)
- ◆ If there are multiple drugs on the prescription pad area of the screen, click on the next drug on the pad for which you would like to dose; it should now be highlighted. Repeat the above dosing steps for each drug that needs to be dosed.
- ◆ Click on “Submit Order” when you have finished dosing all medications. This will take you to the Order Confirmation screen. (*see Figure 10H*)

CUSTOM ORDERS SCREEN



Notes:

Figure: 10F – Custom Orders - Titrations

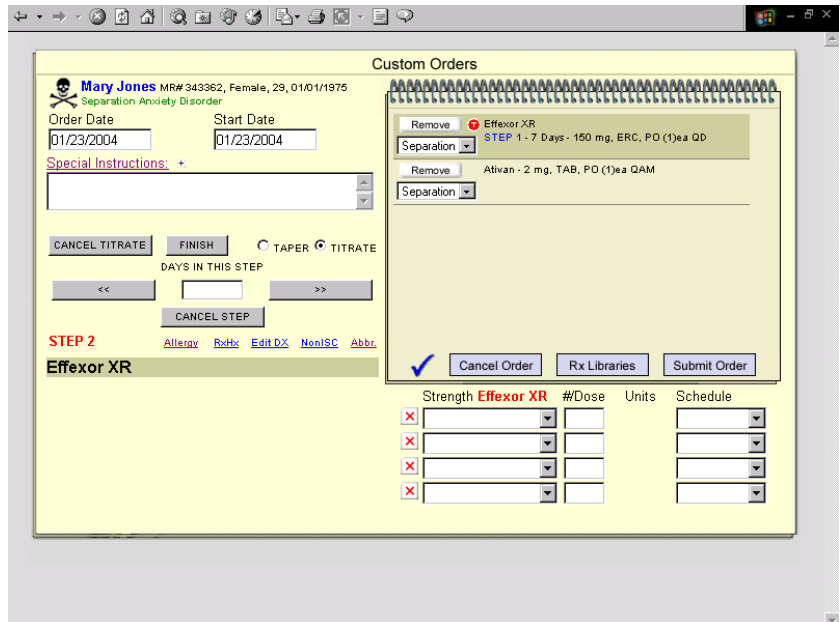


Figure: 10F – Custom Orders - Titrations

ORDER CONFIRMATION SCREEN

The Order Confirmation screen (*Figure 10J*) is equipped with a Virtual Pharmacist. Drug interactions, allergy reactions, and pregnancy alerts will be checked at the point of prescribing. It is on this screen that the number of days a prescription is intended to last, as well as the number of refills, can be changed. The Order Confirmation screen will allow you to indicate whether the medications should come from sample, stock, or to be dispensed as written (DAW). This screen will list the pharmacies in your area and will default to the patient's pharmacy of choice as indicated in their demographic screen. The Order Confirmation screen gives you the ability to edit and/or accept the order and print and/or fax a prescription. *You will be taken to the Order Confirmation when you are reordering, changing, and/or adding a new medication.*

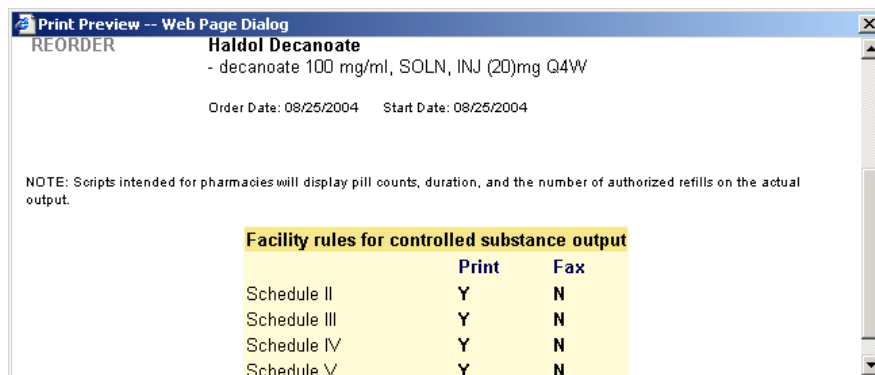
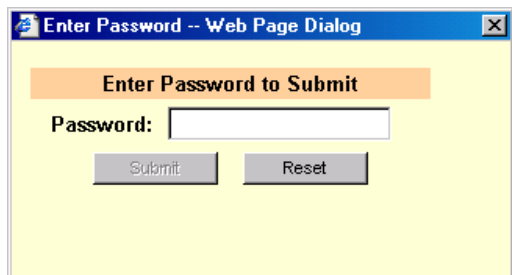
To Confirm an Order

- ◆ Look at the Virtual Pharmacist. When an interaction is detected the warning will be highlighted. Click on the warning to read the interactions. To view the interactions on a larger screen, click on the “□” button at the lower left corner of the Virtual Pharmacist. Interaction warnings will appear in order of severity with the most severe ones listed first. This information is updated monthly by InfoScriber.
- ◆ If you would like to change the number of days or refills click the white box on the item you would like to change and enter the new number.
- ◆ If you would like to change the number of units, or to indicate the number of units which will come from sample or stock, click on the “Units” button. Enter the numbers in the appropriate white boxes and click “Submit.”
- ◆ If this is a “Refill” and today is not the correct reorder date, you can change the date to reflect the actual date the medication was reordered by clicking on the red “Reorder” to the left of the medication name. This will allow you the option of changing the date.
- ◆ If you would like to dispense the drug as written, click on the box marked “DAW” and a check mark will appear.
- ◆ If this is a medication for which you would like to print patient education material, click on the box marked “Leaflet” and a check mark will appear. *Note: Patient education materials are available for most, but not all, medications.*
- ◆ If this is a medication for which you would like to print a patient informed consent form, click on the box marked “PC” and a check mark will appear. *Note: Printing the patient consent form automatically produces an educational leaflet for the patient.*
- ◆ You will be listed as the prescriber. If you are not authorized to prescribe medication and are acting on behalf of an authorized prescriber, click on the scroll down menu and click on the appropriate prescriber.

- ◆ The pharmacy indicated on the patient demographic screen is the patient’s default pharmacy. If you would like to change it, click on the scroll down arrow and choose another pharmacy.

To Accept an Order

- ◆ To **Preview** a script before you Print or Fax, click on the printer Icon to the right of the NONE option. This will allow you to see your order and your facilities printing privileges broken out by Schedule of Medication. (Figure 10I) **Note: All Schedules will be written out (ie. Every Morning instead of QAM) and all Units will list both Alpha and numerically (ie. 30 (thirty)) when the script prints.**
- ◆ Click the white bubble to indicate if you would like to print or fax the prescription. Click on the bubble “None” if you do not want any output.
- ◆ If you would like supporting documents to print, indicate which documents by clicking in the white boxes next to “Chart” to get a chart copy of the prescription; click the “Active” box to get a report showing the patient’s current active medications; click the “Hist” box to get a report showing the most recent orders that have been written for the patient. [Note: if you would like a report showing the entire history of orders written, click on the Print tab at the bottom of the screen and choose the appropriate option on that screen. For more details, see the Print Tab section of this manual.]
- ~~◆ If the “Note” icon has a check mark in it, it means that a medication progress note has been chosen by your administrator as the default note associated with prescribing events. Here you have an opportunity to complete a note. [Note: Only one note type per agency can be chosen as a default note. In other words, each prescriber cannot have his/her own unique note format set as a default. For more information on the progress note feature, go to the Notes section of this manual.]~~
- ◆ If the prescription is complete and satisfactory click on the “Accept Order” tab. If you chose to print the prescription, the Print Administration screen will appear first (See Figure 11A) and the print manager box second. (See Figure 11B) Click the “OK” button on the print manager box to complete the printing.
- ◆ If you chose to enter a password (see InfoScriber Registration Guide) every time that you submit an order, a screen like the one below will appear prompting you to enter your password. (Figure 10H)



PRINT ADMINISTRATION SCREEN

The Print Administration screen appears when you accept an order or prescription on the Order Confirmation screen. (See Figure 11A) A second screen, the Print Confirmation screen (See Figure 11B) will appear atop the first. This screen is used to confirm the requested prescription to print. You will need to click OK or Print on your printer's print confirmation screen in order to send the print job to your printer.

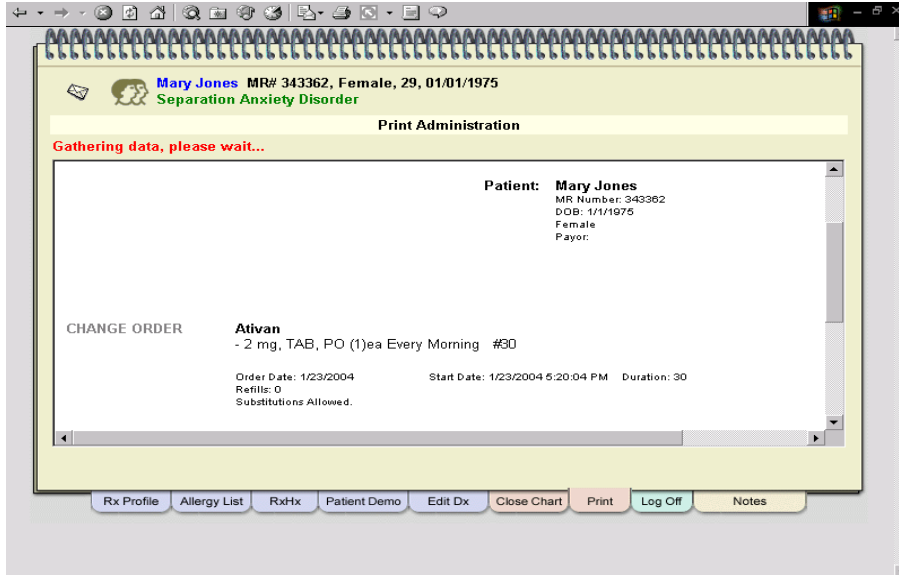


Figure 11A: Print Administration Screen

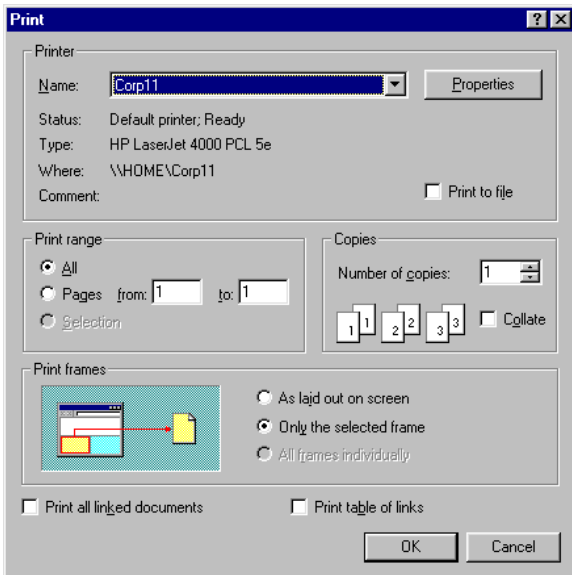


Figure 11B: Print Confirmation Screen

Notes

PRESCRIBER REASONING ASSESSMENTS

(Optional Feature)

This is an optional feature that organizations may choose to use. The InfoScriber Query System is designed to gather information about the thoughts behind the prescriptions that you, (an authorized prescriber), write. The queries within the program were created and refined through feedback from clinicians in the field. They are meant to answer questions about the typical prescription process, the reasons why specific medications are used, factors that may influence the choice of a medication, and other details regarding medication usage. All of the questions can be answered using the point and click method — no written responses are ever required of you, the prescriber.

These queries are not a required portion of the application. If you would prefer to get these and are not, or if you would prefer to not get them and are getting them, please let your liaison know so that appropriate action can be taken to meet your needs.

When the prescriber receives a question he or she is being asked to provide data on the reason why action is being taken on a given patient. The following actions may result in the launch of a query:

- ◆ A prescription for a new medication
- ◆ A discontinuation of a current medication
- ◆ A change in a current medication order

Some queries have the option of choosing multiple answers (*See Figure 12A*). For example, when prescribing a new medication the prescriber may be asked to decide which symptoms he or she is targeting with the medication. At the top of the screen the prescriber is asked to choose all of the symptoms that apply. When the prescriber is given the option of checking multiple boxes, careful thought should be given to the answers and each applicable box checked. Some of the questions about new orders ask whether factors such as the patient's functional impairment influenced the choice of the medication. Note that for this and several other questions about new orders, near the end of each set of choices the prescriber will have the option of indicating that 'none' of the choices listed influenced his or her decision, or the option of indicating that a factor 'other' than those listed influenced his or her choice.

On other screens, the prescriber's choices will be limited to only one option. For example, at the top of the medication discontinuation question screen he or she is told to choose the answer that fits. (*See Figure 12B*) The questions were designed for efficiency and ease of completion and therefore may not include all of the choices a practitioner feels are important in choosing a medication. When asked to choose only one answer, the prescriber should choose the one answer that most closely approximates his or her reasoning, or if none appears to fit, choose the "other" option.

New Prescriptions

When a new prescription is written the prescriber will be asked the following questions:

- ◆ ~~Whether the new medication is a switch to a generic for the same compound~~
- ◆ ~~The symptoms being targeted by the medication~~
- ◆ ~~Any safety/side effect issues that contributed to the choice of medication~~
- ◆ ~~Whether there were other reasons that impacted the decision~~

Change Prescription

~~When the prescriber orders a change in a medication a single question will ask for the general reason for the change in the medication order. Depending on the general reason selected, there may be one additional follow up question~~

Medication Discontinuation

~~The discontinuation of a current medication will result in the following questions:~~

- ◆ ~~Whether the prescriber is discontinuing the medication to switch to a generic version of the same compound~~
- ◆ ~~The primary reason for the discontinuation of the medication~~
- ◆ ~~Any additional factors that contributed to the decision~~

Postponing Questions

~~It is recognized that there may be situations in which the prescriber may not have the time to complete the questions when they appear on the computer screen. When this occurs, click the "Later" button and the question will be sent to the Prescriber's Survey Queue (located on the Prescriber's Desktop screen). They will remain in the Queue for 72 hours.~~

ALLERGY LIST TAB

All of the patient's known allergies are entered into the Allergy List section of the InfoScriber System. They are used as a crosscheck against the medications prescribed by the physicians. (See Figure 13) A drug to drug/food interactions icon will be displayed on the Rx Profile screen if a new medication reacts with any of the patient's allergies listed.

Medication Allergies

- ◆ Enter the medication to which the patient is allergic in the Medication Search box. Click the "Search" button.
- ◆ The medications that match or partially match your search criteria will appear in the box at the lower left quarter of the screen. Click once on the medication to which the patient is allergic. If the medication is not listed at the bottom of the screen (this will happen with most herbals) it can be entered as a non-medication allergy. (See Non-Medication Allergies)
- ◆ The medication selected will now appear at the top of the screen. You will see the drug name, the date the allergy was added to the InfoScriber System, and a tablet icon to add comments.
- ◆ To enter a comment, click on the white table icon that appears to the right of the listed allergy. Another small box will appear. This is here where you will enter all pertinent information regarding the allergy and how the patient reacts.

Non-Medication Allergies

- ◆ Click on the Non Med radial button.
- ◆ Type in the name of the Non Medication Allergy in the white box.
- ◆ Click on the Add Allergy button.
- ◆ The non-medication allergy will now appear at the top of the screen. You will see the allergy, the date the allergy was added to the InfoScriber System, and a tablet icon to add comments.
- ◆ **A red checkmark in a white box icon will appear next to the name of the non-med allergy to let you know that the item is not being checked for interaction and allergy alerts.**

- ◆ Allergies can be listed or removed at any time, although it is recommended that this step precede prescribing, in order to alert the prescriber to possible reactions to new prescriptions.
- ◆ The comments listed for each allergy are accessible at any time from this screen. Simply click on the small notepad icon to the right of the allergy. The box with additional information entered by the physician will once again appear to view and add comments.

Note: To remove an allergy, click on the red X to the left of the allergy.

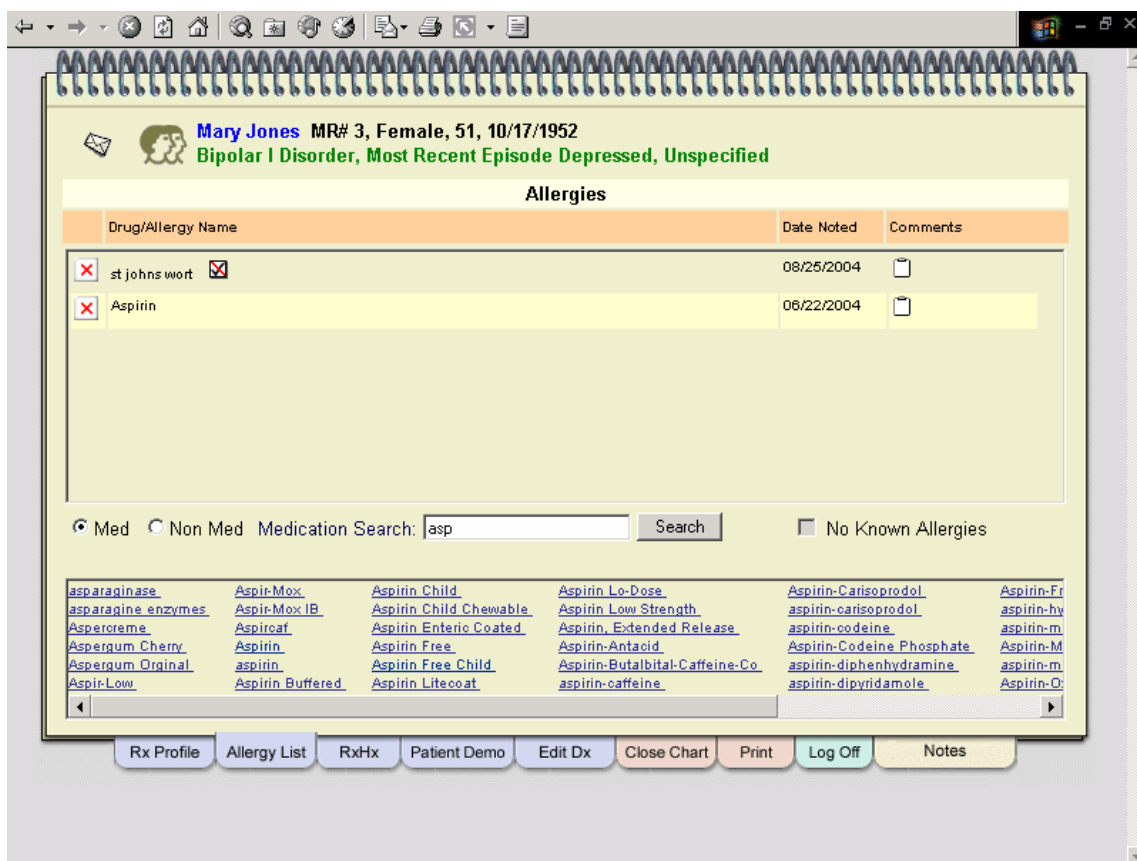


Figure 13: Allergy List Tab

Rx HISTORY TAB

The entire history of medications prescribed for the patient can be viewed on the Rx History screen. Columns can be sorted by clicking on the blue column headings.

Column headings include:

- ◆ Rx Description
- ◆ Prescriber Name
- ◆ Status (i.e., Active, Changed or Re-ordered, or Discontinued)
- ◆ Start Date of the medication
- ◆ End Date of the medication

This screen is a record that can be used when considering any changes or continuation of medications. (*See Figure 14A*)

This screen may also contain a few icons to help the practitioner understand the history of the orders:

- A telephone icon means that a prescriber's agent noted the prescription in the system rather than the prescriber him or herself
 - A dot with the letter 'T' in it means the order was a titration
 - A check mark with a red line through it means the Virtual Pharmacist is not checking it for interactions or allergies
 - A note pad icon means a practitioner has written a disposition note about the medication
- ◆ To view a specific medication order ~~and/or to write a disposition note about the medication,~~ click on the name of the medication.
 - ◆ A smaller screen called Patient Medication Details (*See Figure 14B*) will pop up and give you information, such as dose and strength, the diagnosis, limited patient demographics, and information about the prescribing physician.
 - ◆ Comments can be added to this screen at the bottom.
 - ◆ By clicking on the print button, you can print the Patient Medication Details screen.
 - ◆ A medication education leaflet can be printed by clicking on the Print Leaflet button.
 - ◆ At the top right of the screen is a link to "Non-ISC Rx." The function of this link will be covered in the next section.

Rx HISTORY TAB

RACHELLE JONES, FEMALE, 55, 01/14/1948
Dementia of the Alzheimer's Type, With Early Onset, With Depressed Mood [NonISC Rx](#)

Rx Description	Prescriber	Status	Start Date	End Date
Haldol - 5 mg, TAB, PO (1)ea QHS	Cauthen, A	Active	07/25/2003	08/22/2003
Ativan - 2 mg, TAB, PO (1)ea QAM	Cauthen, A	Active	07/25/2003	08/22/2003
Prozac - 20 mg, CAP, PO (2)ea QAM	Cauthen, A	Active	07/25/2003	08/22/2003
Lanoxin - 0.125 mg, TAB, PO (1)ea QAM	Yelverton, A	System Discontinue	04/01/2002	04/29/2002
Premarin - 0.625 mg, TAB, PO (1)ea QAM	Yelverton, A	System Discontinue	04/01/2002	04/29/2002
Nonvasc - 10 mg, TAB, PO (1)ea QAM	Yelverton, A	System Discontinue	04/01/2002	04/29/2002
Toprol XL - 100 mg, ERT, PO (1)ea QAM	Yelverton, A	System Discontinue	04/01/2002	04/29/2002
Lipitor - 20 mg, TAB, PO (1)ea QAM	Yelverton, A	System Discontinue	04/01/2002	04/29/2002
Coumadin - 3 mg, TAB, PO (1)ea QOD - 3 mg, TAB, PO (0.5)ea QOD	Yelverton, A	System Discontinue	04/01/2002	04/29/2002

Rx Profile Allergy List **RxHx** Patient Demo Edit Dx Close Chart Print Log Off Notes

Figure 14A: Rx Hx Tab

Medication Details - Microsoft Internet Explorer

Patient Medication Details

Prescriber: MD, Test
NA
Tel: NA
FAX: NA
DEA#: NA

Patient: John D Doe
123 Main Street, Apt. #3
Anywhere IA 52249
Tel: 3195551212
DOB: NA
SSN: 483961445
Gender: male

Hydrocodone HD - 2 mg-1.67 mg-5 mg/5 ml, LIQ, PO (1)cc, BID

Order Date: 08/21/2000
Start Date: 08/21/2000
Duration: 30 Days
Refills: 0

Dispense as written Y/N?: N
Med Box Y/N?: N

Special Instructions:
Prescribing Diagnosis: Schizophreniform Disorder
Verbal Order entered by:
Comments:

Add Comment Print Print Label Close

Figure 14B – Patient Medication Details

Notes:

NON-ISC Rx LINK

The Non-ISC Rx (meaning a non-InfoScriber prescription) link is helpful for a number of different prescribing tasks. Medications or remedies that are purchased over the counter can be listed here to check for any drug interactions as new prescriptions are added in the Rx Profile. This area can also be used to enter in prescription drugs given to the patient by a physician outside your facility InfoScriber network. (See Figure 14C). This feature can also be used to post messages on the Current Medication Profile page (see Non-Med Non-ISC below).

From the Current Medication Profile page click once on the blue “Non-ISC Rx” link at the bottom right of the page next to the ‘Add New Prescription box. From the Rx History page click once on the blue “Non-ISC Rx” link at the upper right hand corner.

Non-ISC Medications

- ◆ Indicate Medication by clicking on the “Med” radial dot. In the box marked “Medication Search,” enter in the name or partial description of the drug for which you are searching. Click the “Search” button.
- ◆ A list of medications that meet your search criteria will appear at the bottom of the screen. Select the proper medicine from the list at the bottom of the screen by clicking on it. The drug will then be transferred to the top of the screen into the box marked “Drug Name.” If the search indicates that no such drug or remedy was found, it simply means the program does not recognize the drug or remedy. **You may still add this drug or remedy to the patient’s record by using the “Non-Med” option.** (See Non-Med Non-ISC on next page)
- ◆ If the drug is experimental, click the “Investigational” button.
- ◆ Enter a Start Date in the designated field. Enter in an End Date if applicable.
- ◆ Click the “Add” button
- ◆ If you have any comments about this drug, such as the name and telephone number of the person who prescribed it, enter those in Comments by clicking on the white tablet icon to the right of the drug.
- ◆ Repeat the above steps for all of the patient’s Non-ISC medications.
- ◆ Click CLOSE to leave the page
- ◆ **[Please note:** drug to drug/food interactions will not be checked against a drug or remedy that the System does not recognize.] This will be indicated by a red checkmark in a white box to the right of the entry. This will appear on both the Non-ISC page and the Rx Profile.

Non-Med Non-ISC (i.e., posting messages on the Current Med Profile Page)

- ◆ To enter a non-medication Non-ISC entry, select “Non Med” using the radial dot.
- ◆ Type the information in the white box at the top of the screen and then follow the directions for regular Non-ISC med entry given above.

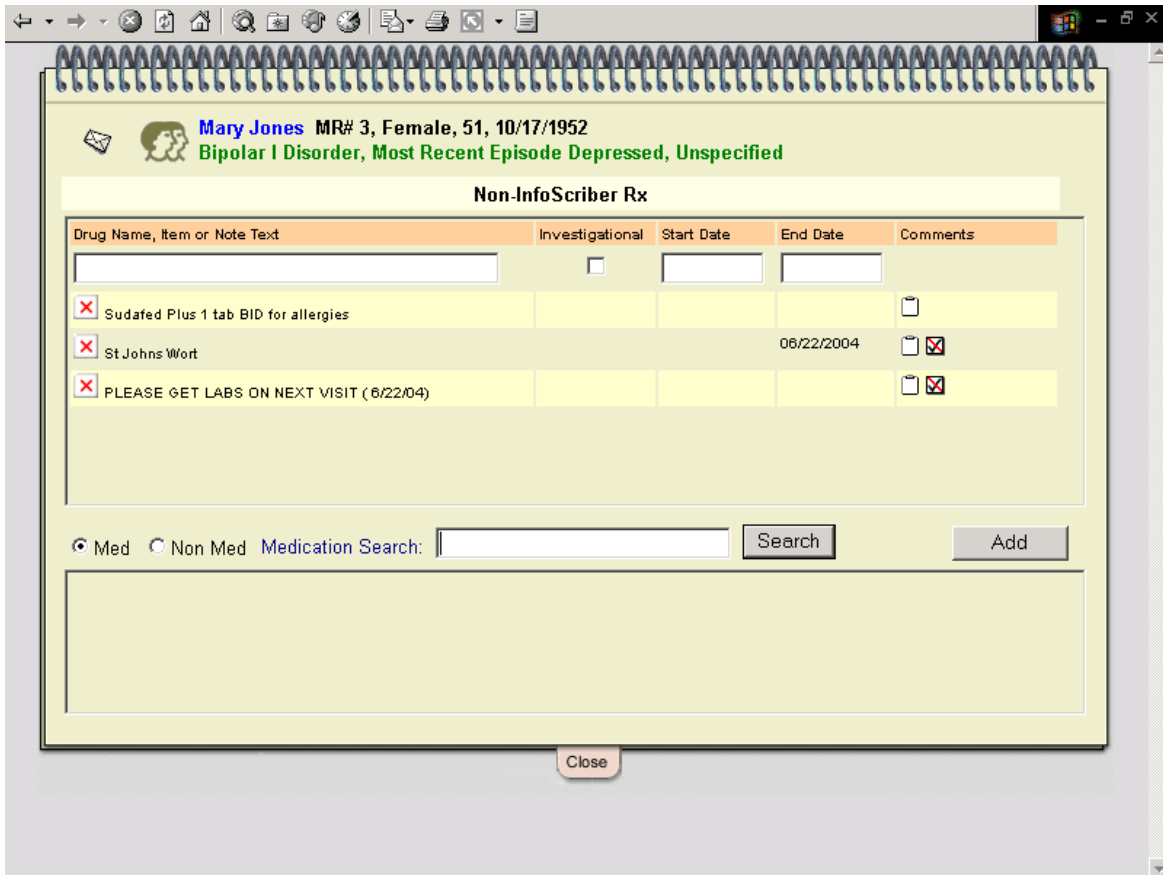


Figure 14C: Non-ISC Rx Link

Notes:

PATIENT DEMOGRAPHICS TAB

Pertinent information about the patient is located under the “Patient Demo” tab. The patient’s insurance information and pharmacy of choice will be entered here as well. Several fields must be completed in order for the InfoScriber System to accept the record, such as First Name, Last Name and Gender. (See Figure 15)

- ◆ ~~The patient’s First Name, Last Name, Gender, and Social Security Number should have already been entered when the patient was first seen and recorded in the InfoScriber System. You can skip to the next blank field by hitting the TAB button on your keyboard.~~
- ◆ ~~Complete as many fields as possible in order to allow other clinicians who may treat or interact with the patient to have full access to all pertinent information.~~
- ◆ ~~After the first series of demographics have been filled in, scroll down to the lower half of the screen and continue to fill in the remaining data. There is a box on the lower left side where you may add notes about the patient that other clinicians who treat him or her may need.~~
- ◆ ~~***Special Hint: Be sure to fill in the Preferred Pharmacy field and the Primary Prescriber field; this will save you a lot of time later!***~~
- ◆ ~~After filling in all the required fields, click on the Save button at the lower right corner of the screen. Your information will be saved although the screen will not change. To move to another screen, click on one of the tabs along the bottom of the screen.~~

Demographics entered into Avatar

PATIENT DEMOGRAPHICS TAB

Mary Jones MR# 3, Female, 51, 10/17/1952
Bipolar I Disorder, Most Recent Episode Depressed, Unspecified

Patient Demographics

Street Address: 123 Oak Street	Weight: lb. Recorded:
City: Patchogue	Height: ft. in. Recorded:
State: NY	Ethnicity: Black/African-American
Zip Code: 11772	Preferred Language: English
Residential Type: [Dropdown]	Preferred Pharmacy (Name: Address): CSM-SD Test Pharmacy: 5120 Shoreham Place Search
<input checked="" type="checkbox"/> Overdose Risk	Primary Prescriber: Klein, Charles Treatment Team
Notes: Test Patient	Primary Payor: Blue Cross Blue Shield of Tennessee Blue
External ID (unique patient ID in source database): 3	
Delete Patient Merge Patient	Save

Rx Profile Allergy List RxHx Patient Demo Edit Dx Close Chart Print Log Off Notes

Figure 15: Patient Demo Tab

Notes:

EDIT DIAGNOSIS TAB

The Edit Diagnosis tab is used for both initial entry of diagnoses and diagnoses updates. The primary diagnosis is listed as well as any secondary or tertiary diagnoses, including any provisional (or rule-out) diagnoses that may be needed. The physician can choose between ICD-9 and DSM-IV diagnoses as well as the codes for each. The code and description will be listed on the screen (including the Axis for DSM-IV diagnoses), as well as any notes or observations regarding each diagnosis. (See Figure 16)

- ◆ Choose ICD-9 or a DSM-IV Axis from the drop-down list located at the left lower third of the screen.
- ◆ Type in the code for the diagnosis you wish to assign in the box marked Code, or type in an abbreviated description of the diagnosis in the Description box. Click the “Search” button.
- ◆ Select the proper diagnosis from the list at the bottom of the screen by clicking once on it. The diagnosis will then be transferred to the top of the screen under “Code and Description.”
- ◆ Repeat the above steps for as many diagnoses as are appropriate for the patient.
- ◆ Choose a primary diagnosis by clicking the button for Primary Dx next to the appropriate diagnosis. Click the check box next to any Provisional diagnoses as well. *Note: One diagnosis must be listed as primary to proceed.*
- ◆ By clicking the “Details” box next to each diagnosis, you may enter in any information related to a specific diagnosis you have chosen. This information will then show up under the name of the diagnosis on the Current Medication Profile screen.

Diagnosis entered into Avatar

Notes:

PRINT TAB

The Print Administration screen is a historical log of all prescribing events. This screen allows you to print and/or fax additional copies of any confirmed orders or print additional medication notes associated with orders. Each order is identified by the date and time of the prescribing event. You can select to print a chart copy and/or a prescription copy, as well as a medication note if one is available. Medication notes *in this section of the application* are only available for printing if the patient was selected to be in the survey pool (refer to Prescriber Reasoning Assessments section). If a medication note is not available, a red line will appear through the note icon indicating you cannot print the note. Other progress notes may be available by clicking on the Notes tab.

(See Figure 17A)

- ◆ Verify that you are reprinting the correct Rx by clicking on the camera icon to the left of the script. An Order Detail will appear, letting you view the order.
- ◆ Once you have chosen which script to reprint, select from the available prints by clicking in the appropriate white box. A check mark will appear. *Note: You can click on multiple boxes*
- ◆ You will also have the option to choose fax from the drop-down menu. If you choose fax before clicking GO, you will get a screen that gives you the option to change the pharmacy to which you are faxing. *(See Figure 17C)*
- ◆ Click the “Go” button.

Chart Copy Reports: Facilities also have the option of printing two prescription related reports along with the actual prescriptions. The first report is called Active Orders. This report shows the patient’s active medications at the time the prescription is written. The second report is called the Orders History. This report shows the history of orders written for the patient

Notes:

PRINT TAB

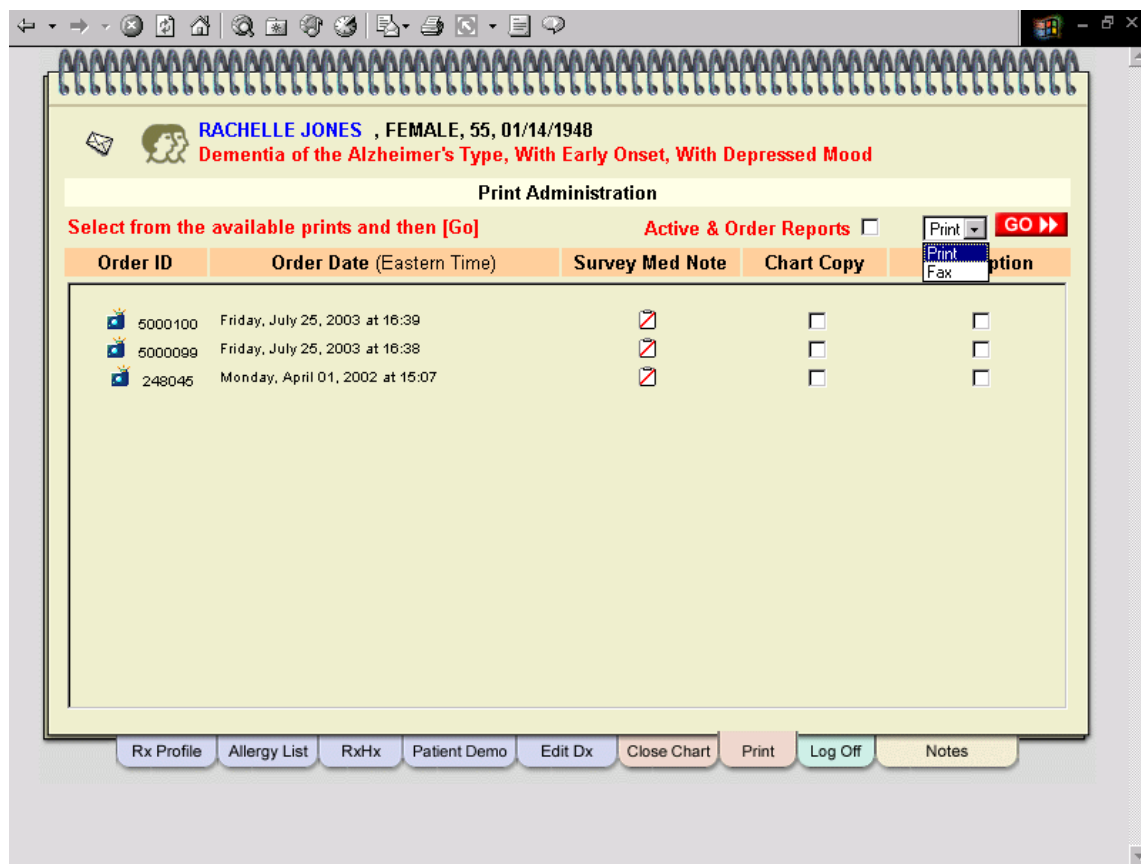


Figure 17A: Print Tab

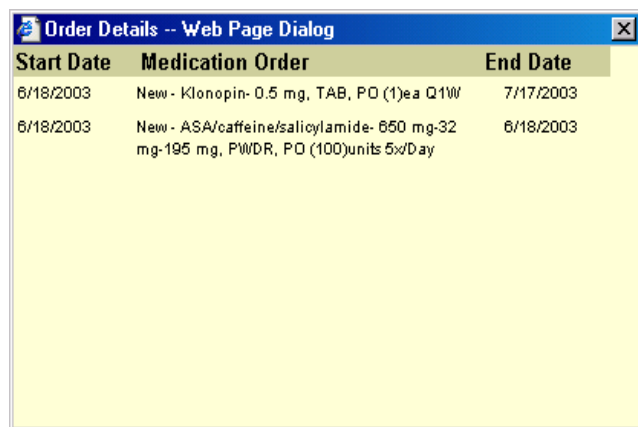


Figure 17B: Order Details

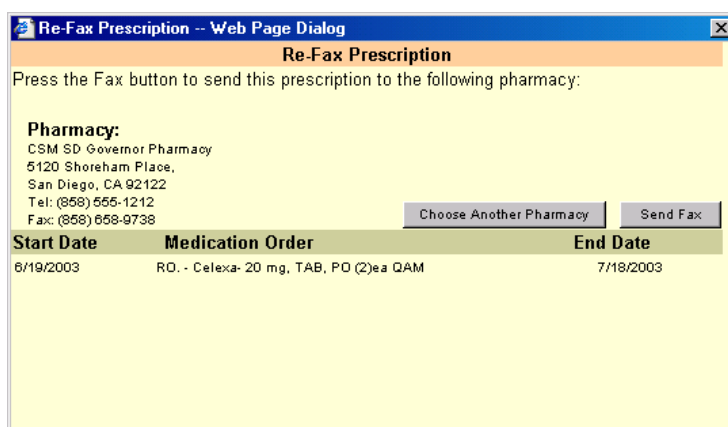


Figure 17C: Re-Fax Prescription

NOTES TAB

The Notes screen allows the user to complete the various types of notes created by their organization as well as allowing the user to view a library of all previously completed notes. This screen allows you to complete new notes and print additional copies of or modify previously completed notes. If a note is available to view, a camera icon will appear to the left of the name of the note. To view a note, click on the camera icon next to the note.

(See Figure 18)

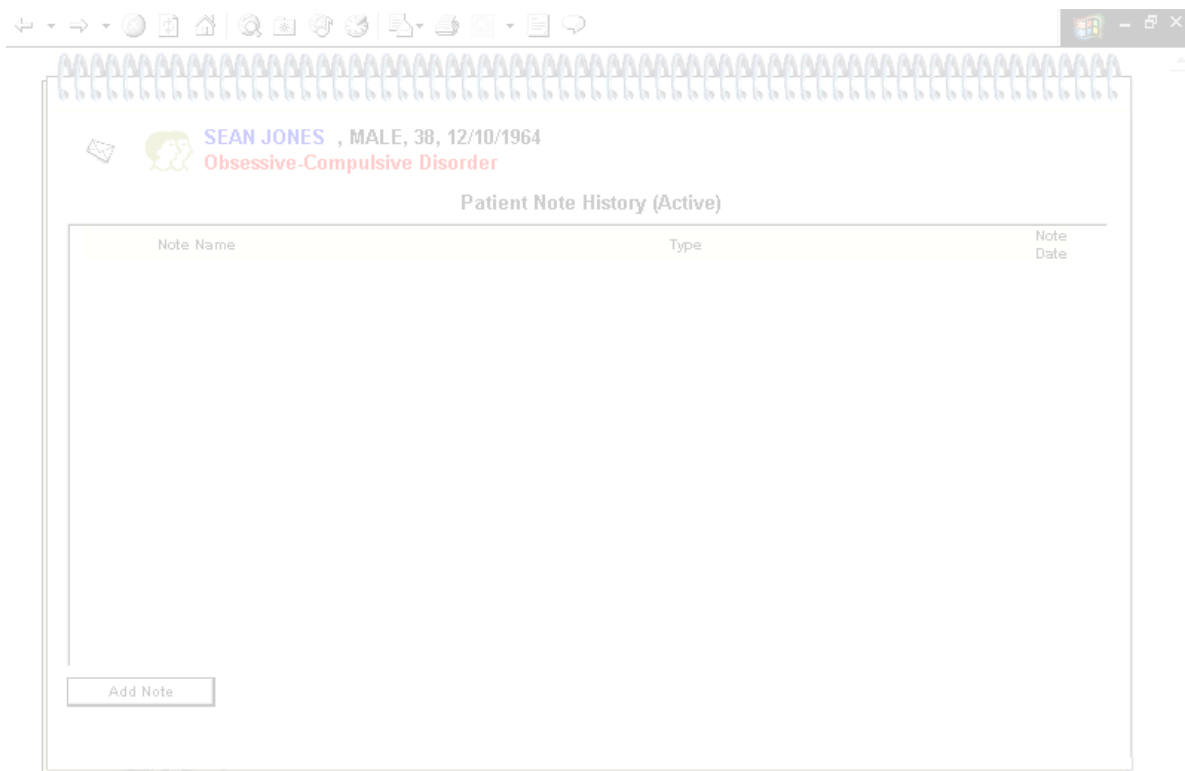
There are a couple of ways to complete a note for a patient.

- ◆ Complete a note from the Notes tab.
- ◆ Complete a note at the time of a medication order.

To create a note from the Notes tab:

- ◆ Click on Add Note *(See Figure 18)*
- ◆ Choose the Note Type from the dropdown menu. The notes in this list are notes that have been created specifically for your organization by your organization's InfoScriber administrator. If you would like additional note types included here, contact your administrator.

All documentation made in Avatar



(Figure 18, Progress Note)

- ◆ ~~Complete the questions in the note. Some of these questions may be multiple choice, and some may be free text (you will be able to fill in a narrative answer for these). (See Figure 19)~~

SEAN JONES , MALE, 38, 12/10/1964
Obsessive-Compulsive Disorder

Edit Patient Note

OUTPATIENT CLINIC PROGRESS NOTE FOR SEAN JONES

Note Label
Outpatient Clinic Progress Note - 6/25/2003

Primary Prescriber
Primary Care Physician

Note Date
6/25/2003

Associate this note with a medication order
 Display allergies

Length of Session

15 minutes
 30 minutes
 45 minutes

Submit Cancel Print

(Figure 19, Progress Note)

- ◆ ~~Depending on how your note was designed by your administrator, you may be able to choose at the time of note completion to associate this note with a medication order. To do this, check the box **associate this note with a medication order**. An Rx Order History screen will appear. (See Figure 20)~~



(Figure: 20, Rx Order History screen)

- ◆ Choose the medication order(s) you would like to associate by checking the white box and then clicking Submit. The order that is associated with this note will now appear in red on the note screen. (See Figure 21)

Notes:

EILEEN K KLOEFEL MR# 12345, FEMALE, 41, 08/13/1961
 Schizoaffective Disorder

Edit Patient Note

Note Label: OUTPATIENT CLINIC PROGRESS NOTE FOR EILEEN KLOEFEL

Note Label: Outpatient Clinic Progress Note - 6/16/2003

Primary Prescriber: Klein, Charles Primary Care Physician: _____

Note Date: 6/16/2003

Associate this note with a medication order
 OrderID: 5000008 RO. Cardec - 8 mg-120 mg, ERT, PO (1)ea QHS, RO. Celexa - 20 mg, TAB, PO (2)ea QAM, Chg. Clozaril - 100 mg, TAB, PO (2)ea QPM

Display allergies

Length of Session

15 minutes
 30 minutes
 45 minutes

Submit Cancel Print

(Figure 21, Medication order indicated in red)

- ◆ Once you have completed the note, click on Submit. (Note: Be sure that Print is checked or unchecked according to your preference)
- ◆ If the Electronic Signature option was chosen when your administrator created this note, an e-signature box will appear (Figure 22). Fill in your InfoScriber password (the same one you use when you first log into the InfoScriber application) to “sign” your note.

-- Web Page Dialog

Note E-Signature

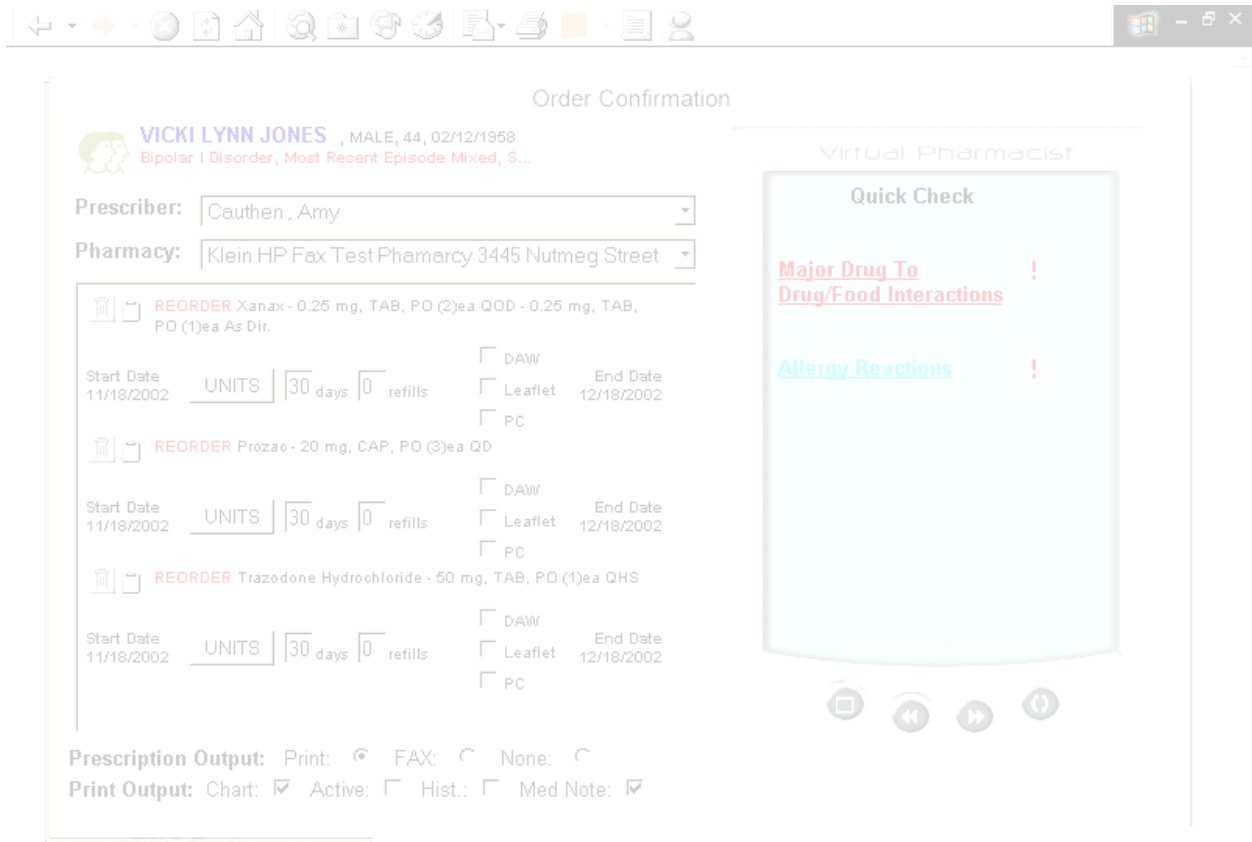
Password: _____

Submit Reset

(Figure 22: E-signature for note)

To complete a note during a prescribing event:

- ◆ ~~Complete your medication order as you normally would.~~
- ◆ ~~If a note has been chosen by your administrator as the default note associated with prescribing events, you will have an option on the Order Confirmation page to complete a note. [Note: Only one note type per organization can be chosen as a default note. In other words, each prescriber cannot have his/her own unique note format set as a default.]~~
- ◆ ~~Be sure the box is checked. (See Figure 23)~~
- ◆ ~~The Note will appear on the screen after you click Submit.~~
- ◆ ~~Complete the note just as you would if you had chosen to complete the note from the Notes tab. (See Figures 19-22)~~

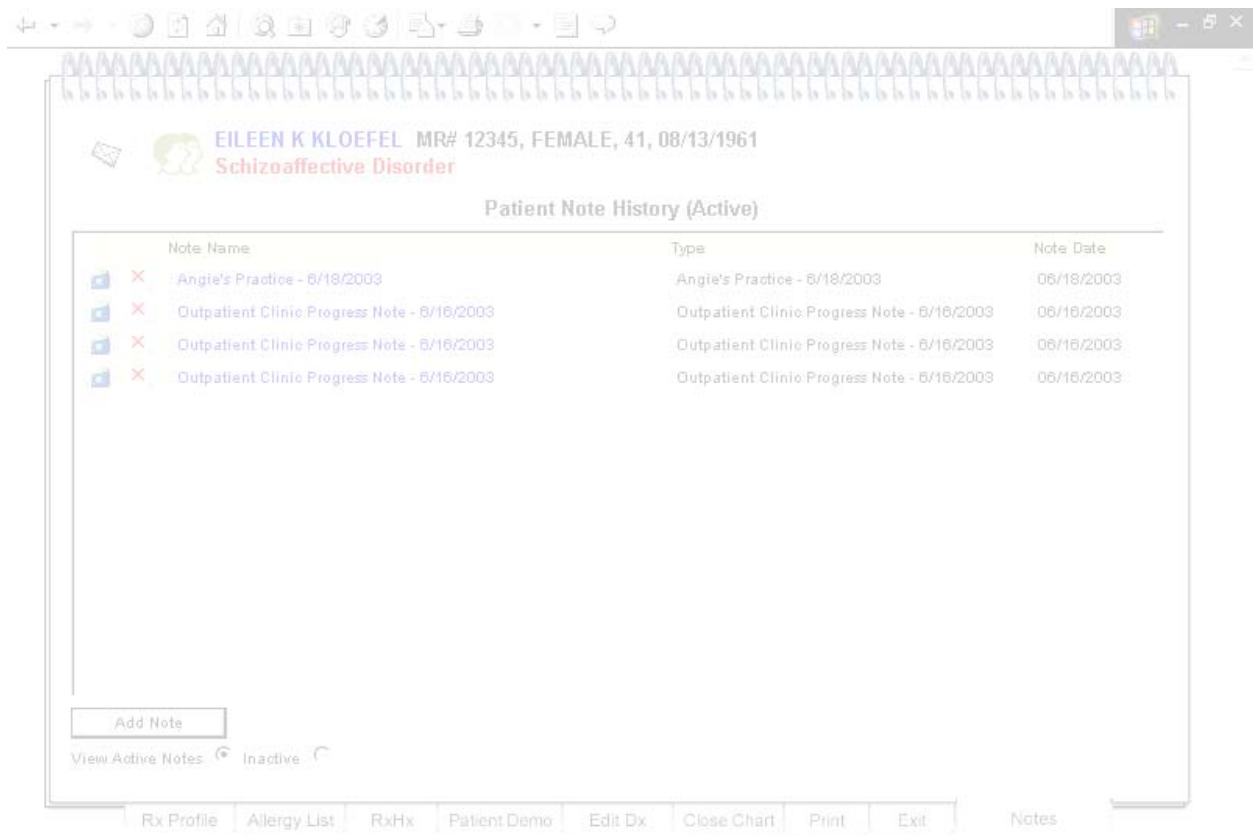


(Figure 23, Order Confirmation)

To Edit a Previously Completed Note

Completed notes may be edited, however, all edits will automatically be marked as such and will automatically indicate who made the edit and when it occurred.

- ◆ Click on the Notes tab.



(Figure 24, Notes tab)

- ◆ Choose which note you would like to edit by clicking on link for the note (the name of the note in blue). You may choose to View Active Notes or Inactive Notes.
- ◆ Edit the incorrect information. InfoScriber will “strike through” the edited information and show the new information with the date and name of the person who made the modification AFTER the note is submitted. (See Figure 25) The person editing the note will be required to sign the note (assuming the e signature function was chosen for the note). To review the updated note click on the note label from the Notes tab and view the note.



(Figure 25; Modified Note)

To print a copy of a previous note:

- ◆ Click on the Notes tab.
- ◆ Indicate which note you would like to print by clicking on the camera icon to the left. (See Figure 24)

PRACTICE SESSION #1

[This case scenario should not be considered medically accurate in terms of medications prescribed or dosages of such. The medications used in this case scenario were chosen in order to solicit a variety of responses from the InfoScriber System in order to help train the user.]

Practice Case Scenario #1:

A 25-year-old male is referred to a psychiatrist's office. His demographics are as follows:

Name: [Make up a name]
SSN: [Make up a Social Security number]
DOB: 3/10/75
Address: 473 Maple Court
San Diego, CA 92463
Home Tel: 619-298-2473
Ethnicity: African-American
Eligibility: Not Applicable
Weight: 165
Height: 5' 10"
Preferred Pharmacy: [Choose any]
Formulary: [Choose any]

Upon questioning, that patient states he is allergic to Dilantin.

Visit #1

During the visit the psychiatrist diagnoses the patient as follows:

Axis I: Schizoaffective Disorder (primary)
Alcohol Dependence (dual)
Axis II: Antisocial Personality Disorder (secondary)
Axis III: Seizure Disorder (Diseases of the Nervous System and Sense Organs) (tertiary)
Hypertension (Diseases of the Circulatory System)(tertiary)
Axis IV: Occupational Problems (tertiary)
Problems Related to Interaction with the Legal System/Crime (tertiary)
Axis V: 50 (tertiary)

After the office visit, the psychiatrist writes the following orders:

- Lithium 300 mg tablet extended release PO QD; 30-day supply, no refills, substitutions allowed. [The psychiatrist believes that this medication will help stabilize the patient's mood disorder—Schizoaffective Disorder.]

- Depakote 1500 mg PO QHS; 15-day supply, no refills, dispense as written. [The psychiatrist believes that this medication will help stabilize the patient's mood disorder—Schizoaffective Disorder.]
- Zyprexa 20 mg PO QHS; 15-day supply, no refills, substitutions allowed. [The psychiatrist believes that this medication will help stabilize the patient's mood disorder—Schizoaffective Disorder.]
- Next appointment: 2 weeks

Visit #2

During the next visit, the psychiatrist learns that the patient's presenting symptoms continue and makes a change with respect to the Zyprexa. The order reads:

- Increase Zyprexa to 25 mg PO QHS; 15-day supply, no refills, substitutions allowed.
- Next appointment: 2 weeks

Visit #3

During the next visit, the physician learns that the patient has not had good compliance in taking the Zyprexa and thus his symptoms are not subsiding. The psychiatrist writes the following orders:

- Discontinue Zyprexa due to compliance problems.
- Begin Prolixin decanoate 25 mg IM Q4weeks, beginning today, no refills, dispense as written. [The psychiatrist believes that this medication will help reduce the patient's psychotic symptoms.]
- Reorder lithium
- Next appointment: 2 weeks

Visit #4

During the next office visit, the patient claims he has gained 8 pounds since taking the medications. His weight is now 173. The psychiatrist writes the following orders:

- Discontinue Depakote due to weight gain
- Begin HCTZ (hydrochlorothiazide) 12.5 mg PO Qday; 30-day supply, 1 refill, substitutions allowed. [The psychiatrist believes that this will help reduce the patient's fluid retention.]
- Next appointment: 2 weeks

After reading the interaction alert, the psychiatrist amends order to read:

- Discontinue Depakote due to weight gain
- Begin Lasix 40 mg PO Qday; 30-day supply, 1 refill, dispense as written. [The psychiatrist believes that this will help reduce the patient's fluid retention.]
- Next appointment: 2 weeks

PRACTICE SESSION #2

[This case scenario should not be considered medically accurate in terms of medications prescribed or dosages of such. The medications used in this case scenario were chosen in order to solicit a variety of responses from the InfoScriber System in order to help train the user.]

Practice Case Scenario #2:

Patient Demographics:

Name: [Make up a name]
Address: 123 Main Street, San Diego, CA 92101
Phone: 619-555-1212
SS#: [Make one up]
Birthdate: 3/10/80
Gender: Male
Ethnicity: Caucasian
Eligibility: Not applicable
Weight: 190 lbs.
Height: 5' 10"
Preferred Pharmacy: [Choose Any]
Formulary: [Choose Any]

Visit #1

A 20-year old male is referred to the physician's practice with an established medical diagnosis of Non Insulin Dependent Diabetes Mellitus (NIDDM) and presents with a 6-month history of progressive social withdrawal and decreased self-care. It is reported that during the last 2 months he has been having increasingly bizarre behavior and ideation. Upon examination, he is noted to appear disheveled, malodorous and with generally incoherent speech. His emotions are flat except for occasional verbal outbursts at unseen stimuli. The patient's weight is noted to be 190 pounds. After the interview, the presumptive diagnosis is made:

Axis I: Schizophrenia, disorganized type
Axis II: No diagnosis
Axis III: NIDDM [This is a disease of the blood.]
Axis IV: Problems related to interaction with the legal System/crime
Axis V: Current: 35

The physician's orders read as follows:

- Risperidal 3 mg 1 tablet PO BID [Prescribed for the Schizophrenia]
- Glucophage 500 mg one tablet PO with breakfast and two tablets PO with dinner [Prescribed for the NIDDM.]

Visit #2

The patient returns with his caretaker (mother) one week later after having had contact by telephone with the physician since the initial visit. The patient is reported to be having less verbal outbursts, however, he continues to appear to respond to internal stimuli. An additional observation reveals that the patient is appearing to be restless, cannot sit still and is often pacing. A presumptive diagnosis of Acute Akathesia is made and the following orders are given:

- Cogentin 2 mg PO BID [*Prescribed for the Acute Akathesia.*]

Visit #3

The patient presents again two weeks later with clear lessening of pacing, improved sleep and mild lessened preoccupation with internal stimuli. The patient's weight has increased to 200 pounds. The caretaker and patient both report that the patient has been notably constipated and complains about difficulty with urination. The physician attributes the constipation and problems with urination to the Cogentin and orders the following medication changes:

- Discontinue Cogentin
- Benadryl 25 mg 1 capsule PO BID [For the side effects of the medications previously prescribed.]
- Fasting plasma glucose and glycosylated hemoglobin results to be called to MD once reviewed. [This is a lab order and does not get entered into InfoScriber.]

Visit #4

The patient returns two weeks later with continued lessened thought disorganization, however, with persistent deficit symptoms. The patient is still noted to have cognitive rigidity. The patient is also noted to have seen endocrinologist who noted an elevated fasting plasma glucose and has increased the patient's Glucophage to 2000mg QD. The psychiatrist orders the following:

- Reorder Risperdal 3 mg one tablet PO BID
- Increase Benadryl to 25 mg one tablet PO TID
- Monitor for signs of urinary retention/constipation [This does not get entered in InfoScriber].
- Increase Glucophage to 500 mg two tablets PO with breakfast and two tablets PO with dinner.
- Weigh again at next appointment [This does not get entered in InfoScriber].



If at any time you feel frustrated or don't understand, please, **don't give up!** Ask for help or contact your internal facility InfoScriber Liaison. You may also contact InfoScriber Member Services Support department at (888) 227-6130. Or e-mail us at membersupport@infoscriber.com.

PRACTICE SESSION #3: TITRATION

[This case scenario should not be considered medically accurate in terms of medications prescribed or dosages of such. The medications used in this case scenario were chosen in order to solicit a variety of responses from the InfoScriber System in order to help train the user.]

Practice Case Scenario #3:

Patient Demographics:

Name: [Make up a name]
Address: 1298 Palm Court
San Diego, CA 92115
Phone: 858-555-1212
Birthdate: 2/09/55
SS#: [Make up a number]
Gender: Female
Ethnicity: Puerto Rican
Weight: 140 lbs.
Height: 5' 7"
Preferred Pharmacy: [Choose any pharmacy]
Formulary: [Choose any payor]

Visit #1

A 45-year old female is referred to the physician's practice. She presents with an established diagnosis:

Axis I: Bipolar Affective Disorder, most recent episode mixed severe without psychotic features
Axis II: Borderline Personality Disorder
Axis III: None
Axis IV: Problems with primary support group
Axis V: Current: 40

During the office visit, it is noted that she has had multiple acute psychiatric hospitalizations and has also had multiple trials of psychotropic medications. Her current presentation is of a one-week period of decreased sleep, flight of ideas and pressured speech. She is noted to concurrently be demonstrating a depressed mood, recurrent thoughts of death, excessive guilt, and moderate agitation. Prior episodes of psychosis are noted. The patient's weight is noted to be 140 pounds. The physician agrees with the established diagnosis and the following orders are given:

- Depakote 500 mg PO BID [Prescribed for her Axis I diagnosis.]
- Depakote level post one week [This is a lab order and does not get entered into InfoScriber.]
- Paxil 20 mg PO QHS [Prescribed for her Axis I diagnosis.]

Visit #2

The patient returns one week later. The Depakote level is barely measurable and she is noted to have increasingly psychomotor acceleration. In addition, she is now manifesting loose associations and her behavior is increasingly disorganized. The patient's husband notes that the patient has been inconsistent in taking her medications and he was not certain that he could adequately supervise the patient with her medication compliance. It is noted that the patient has previously required the use of decanoate medications to assure medication compliance. The physician's orders reads as follows:

- Discontinue Paxil
- Haldol 5 mg PO BID x 1 week, then discontinue [This is prescribed for her Axis I diagnosis.]
- Cogentin 1 mg PO BID [This is prescribed for the side effects of medications.]
- Haldol Decanoate 50 mg IM STAT [This is prescribed for her Axis I diagnosis.]
- Haldol 5 mg PO QDAY PRN for agitation [This is prescribed for her Axis I diagnosis.]
- Repeat decanoate level in one week [This is a lab order and does not get entered into InfoScriber.]

Visit #3

The patient presents five days later with notable lessening of psychomotor acceleration. However, she still persists in her dysfunctioning as previously described. It is noted that the patient is increasingly compliant with her medications. The physician decides to keep the orders as written and follows up with a decanoate level.

Two days later the patient's decanoate level comes back is low therapeutically. The patient is still presenting with the symptomatology noted previously. The physician's orders read as follows:

- Increase Depakote 500 mg PO TID
- Repeat Depakote level in one week [This is a lab order and does not get entered into InfoScriber.]
- Proceed with D/C of oral Haldol
- Repeat Haldol Decanoate one week from today
- Continue use of Haldol PRN as previously noted.
- Begin Paxil 20 mg PO QHS [This is prescribed for her Axis I diagnosis.]

Visit #4

The patient returns one week later. She is notably improving with no re-emergence of thought disorder, her sleep is improving, and her agitation has lessened. The patient does continue with a depressive presentation. The patient and husband express their concern about the continued use of Haldol given their awareness of the risk of tardive dyskinesia. An additional concern expressed is of the patient's weight gain of 10 pounds; the patient now weighs 150 pounds. The physician notes their concern. The physician's orders read as follows:

- Discontinue Haldol PRN
- Seroquel 50 mg PO BID x 1 week [This is prescribed for her Axis I diagnosis.]
- Seroquel 100 mg PO BID week 2 and thereafter [This is prescribed for her Axis I diagnosis.]
- Proceed with Haldol Decanoate 50 mg IM today [This is prescribed for her Axis I diagnosis.]



If at any time you feel frustrated or don't understand, please, **don't give up!**
Contact Member Support with any questions or concerns at (888) 227-6130.
Or you can e-mail us at membersupport@infoscriber.com.

