Avatar User Guide:

Adult/Older Adult Assessment (Short)

City and County of San Francisco
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Purpose:

The purpose of this document is to guide users step-by-step through the process of creating an Adult/Older Adult Assessment (Short) electronic record in the Avatar system. The Adult/Older Adult Assessment determines the level of clinical care needed for adult clients.

Note that this is not the ANSA (a separate assessment located on the Adult Treatment Plan).
Finding the Adult/Older Adult Assessment (Short) Form:

*Adult/Older Adult Assessment (Short)* form can be accessed three ways:

1: Add the assessment to “My Forms”.

- Click the edit link on upper right of “My Forms”.
- Type text for searching.
- Double-click on “Adult/Older Adult Assessment (Short)” form.
- Click “Save” button.
2: Use the **Browse Forms** menu from the **Home View** to navigate to assessment.
3: Use **Search Forms** tool at the Home View:

Search **“Adult/Older Adult Assessment (Short)” form.**
Below, select client:

Search by typing client’s last name, social security, or ID #. Double-click on the client name.
Section 1: PRESENTING PROBLEM

1. Note that RED colored text indicates item must be completed in order to submit (save record), even in draft. Failure to complete all RED items in assessment will prompt an error message when you click “Submit” button. Additionally, CBHS requires completion of all fields, when submitting as “Final”.

2. Enter date of assessment. Double-click to view calendar. T and Y buttons to immediate right are for “Today” and “Yesterday”, respectively. After assessment is submitted (saved to Avatar) as “Draft”, “Final” or “Pending Approval”, date cannot be changed.

3. Single-click (click) grey bar to reveal complete list of programs. Select your program from drop-down list.

TIP – After clicking on grey bar; If you then begin to type a word, you will see section of list showing corresponding program names.
2. "Draft" is pre-selected by Avatar as default. Instructions and implications for selecting among options in this part of assessment will be described on page 21 of this document.

3. This box is used to describe the client’s presentation during the last 30 days (recent and relevant issues). This section helps to establish medical necessity and should be used to justify your diagnosis by describing the signs and symptoms.

**TIP** – Click on the help light bulb to the right of any field for specific field information.

**TIP** – Use the Text Editor Icon to the right of any text box to view and edit text in an enlarged window.
Section 2 - Risk Assessment

4. Select as appropriate (Yes/No). To de-select or to erase, click “F5” function key. Note that “Yes” may activate as “required” subsequent follow-up sections in assessment.

5. Describe/use to elaborate details noted above.
Section 3: Criminal Justice History

If yes, describe involvement/incidents (including dates, types of crimes or incidents of violence, involvement in parole/probation, and hx of incarceration, if any)

Criminal Justice History

- Criminal Justice History - Current
  - Yes
  - No

- Criminal Justice History - Past
  - Yes
  - No
Section 4 - Psychiatric History of Client and Family

10. You may type numbers or letters in ‘Number of hospitalizations and stays’ field.
Section 5 - Substance Abuse

11. Note that the Substance Abuse section is divided further into 3 sub-sections, the first 2 of which are visible on this page.

12. If selecting check-box “Other”, then type the names of other substances. If “Other” is not selected above, then this box remains disabled.

13. Enter measure of time in years, months, or days, or a combination.
14. Note that 3rd sub-section is viewable on this page. Sub-sections 1 and 2 have been collapsed. Clicking the triangle will reveal or display corresponding section.
Section 6 - Medical History

15. Type name and or location of site where client receives primary care.

16. Type 10 digit number beginning with area code, without dashes or parenthesis.
Section 7 - Medications

Medications

Medications (Include all current medications, name of prescriber and known allergies (per client report).

Include previous medications and OTC medications if relevant. Also note medication adherence issues.)

Psychotropic

Non-psychotropic
Section 8 - Mental Status

Mental Status


TIP – If you click the Favorites icon, the assessment will be added to “My Forms”.

TIP – If you click the Close All Forms icon, all open forms will be closed without saving.

TIP – If you click the Close icon, the assessment will close without saving.
Section 9 - Psychosocial and Family History
Section 10 - Client Strengths

17. Type inside this text box to describe/elaborate on details. The instruction for 1-3 coding, in bold text above, is applicable for radio button selection – not part of this assessment.
Section 11 - Clinical Impression, Recommendation, Disposition

Clinical Impression, Recommendation, Disposition

Clinical impression, recommendation, disposition (including medical necessity; hypothetical reasons / context for presenting problem, disposition)
**Finalizing the Assessment:**

- Return to “Section 1” in order to submit your Assessment as a record saved in the Avatar system.
- “Draft” allows you to return to assessment for further editing. A draft assessment is not considered complete. Select “Final” when you have completed assessment. A “Final” assessment cannot be edited further.
- Interns ready to submit for approval must select “Pending Approval” instead of “Final”.
- Interns Only! After selecting “Pending Approval” above; click on grey bar and select name of supervisor to approve your assessment. WARNING: Leaving this box blank with “Pending Approval” selected, will prevent your supervisor from accessing and approving. If your supervisor name does not appear, call Avatar Help at 255-3788.
- Interns Only! After selecting “Supervisor to Notify” above, type comment to supervisor.
- TIP – content in “Supervisor to Notify Outgoing Comments” box may be visible to outside personnel (e.g., auditors). This box is also part of the medical record.
Viewing a report of your assessment:

1. On your home page, at the “Search Forms” screen, type all or part of “Adult/Older Adult Init Assess SHORT Rpt”.
2. Enter Client Name when prompted and then the screen, below will appear.
3. Click “Yes” in the Form Return box to return to form after report runs. This will allow you to rerun report.
4. Click “OK” in the Avatar 2011 – Download Report and wait until the report downloads. You only need to do this the first time report is viewed at your computer.
5. The actual report is displayed below:

To exit the report: Click (only once, do NOT double-click!!) the white X on the Red button located at far upper-right.