



Setup and Use the Medical Condition Record



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What is the Medical Condition Record

The Medical Condition Record is a comprehensive health record of a patient visit. The receptionist or technician may record the patient's vital signs and the doctor typically records client communications about the patient's condition, his or hers observations, a diagnosis, and a treatment plan.

The Medical Condition Record can be used as follows:

1. **As Is** — without any advanced set up. You may elect to only use parts of the MCR (i.e. to record weight history or other vital signs)
2. **As Is but setting it up “on the fly”** — You don't set up anything (protocols, etc.) in advance but you set them up as you use the MCR. For instance, if you choose several possible diagnoses on a particular visit, you would set up the protocols on those diagnoses only). Each time you create a medical condition record, you would continue to attach protocols to diagnoses as you need them.
3. **Advanced Set Up** — This takes quite a bit of time to set everything up in advance but after that's done; it could save a lot of time when you're using the Medical Condition record.

This is a resource guide for Advanced Setup procedures.

Definitions & Terms

Abnormality - anything that is abnormal within a body system.

Assess – to evaluate.

BCS – the Body Condition Score. This field allows you to assign a rating to the patient's weight condition. The ratings that are assigned are strictly user defined, and can be graphed by highlighting the BCS field then choosing Medical Condition...Graph Values. Each time a new Medical Condition entry is created for a patient, the BCS will default to a blank field.

Body Subsystems – subsystems of the main body systems (for example Trachea would be a subsystem of Respiratory).

Body Systems – main systems of the body (Circulatory, Respiratory).

Capillary Refill Time (CRT) – amount of time it takes for capillaries to refill. This is done by pressing on gums and counting the number of seconds it takes to return to the normal pink color. It is measured by >2 secs and <2 secs.

Diagnostic – treatments performed to reach a final diagnosis.

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Diagnostic Protocol – these are the treatments that the doctors will do to try and diagnose the problem. Once the treatments are done, usually the diagnosis will be found.

Pain Scale – this field allows you to assign a rating to how the patient describes the pain. The pain scale amount will be printed on the SOAP record, the Patient Chart, and Report Card. To show on the Report Card you must use the merge word <soap-painscale>.

Presenting Problems – main problems presented upon examination.

Problem History – a record of the patient’s current and past problems.

Recommendations – other diagnoses, tests, or treatments that can be performed for the chosen problem.

Rule-outs – this is the list of tentative diagnoses for a specific problem.

Tentative Diagnosis – probable diagnosis.

Therapeutic – treatments performed to ease certain symptoms.

Treatment Protocol – these are the treatments or items that the doctor will use to treat the diagnosis.

Overview of the Medical Condition Record

When accessing a Medical Condition record for the first time after updating to version 2008.1, the changes and enhancements to this area will be very evident. The tabs which previously made up each area of the SOAP have been removed to provide a continuous-page view of the information stored with the Medical Condition record. Four of the seven areas of the new Medical Condition record are displayed in a tree-style view allowing them to be expanded and collapsed. These four areas are the Problems, Assessment, Plan, and Attachments.

The arrows on the left hand side of the SOAP record are now color coded. The arrows will now indicate if there is any information attached to the Problems, Subjective, Assessment or Plan areas. This should be helpful when trying to distinguish if anything has been entered into a collapsed area.

Green – indicates information has been entered.

Red – indicates NO information has been entered.

VITAL SIGNS – Record the patient’s weight, temperature, pain scale, and other vital signs in this area. The “Post For” doctor selection has been moved to this area for easier access.

PROBLEMS – Select one or more problems associated with this visit. The problem history area displays current and past problems for the patient.

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SUBJECTIVE – Record the client’s communication about the patient’s condition.

OBJECTIVE – Record doctor’s observations about the patient’s condition.

ASSESSMENT – Record possible diagnoses (rule-outs) and final diagnoses.

PLAN – Record treatments and items for diagnosing and treating the problem.

ATTACHMENTS – This area mirrors the medical history attachment window. If you have files attached to the history entry, you will see the attached files in this area. You may also attach files in this area in the same way you attach files to the medical history attachments window.

Additional features that work alongside the Attachments area is the Medical Condition...Report Card menu option and the Report Card button. Selecting these options will display an Open window that allows a Word form or document to be opened, modified, and saved. Modifying and saving these forms or documents will allow them to be assigned a unique name, saved to the Attachment directory specified in the Advanced Options, and then linked to the Attachments area of the Medical Condition record as well as the Medical History Attachments area from the CID.

NOTES – The Subjective, Objective, Assessment, Plan tabs and the Client Instructions area now have a maximize [+] and minimize [-] button in the upper right hand corner to expand or collapse the viewing size of each note window. Clicking the expand button will cause the associated notes window to expand vertically one line. Or the window will automatically expand to the correct size according to the amount of information entered. Each window will also re-open back to the margin settings selected when the window was closed. Meaning each area can be set differently, depending on the clinics use and preference to accommodate records.


Saving the SOAP record when closing – Using the Done button on a SOAP record automatically saves information but when closing out of a SOAP window by clicking the X button or clicking Cancel now gives the option to save. This warning message tells the user, “There are unsaved changes to the medical condition record. Do you wish to cancel?”

Clicking **Yes** will close the window and not save the changes that were made.

Clicking **No** allows the window to remain open so the user can select Done to save the changes.

Advanced Setup

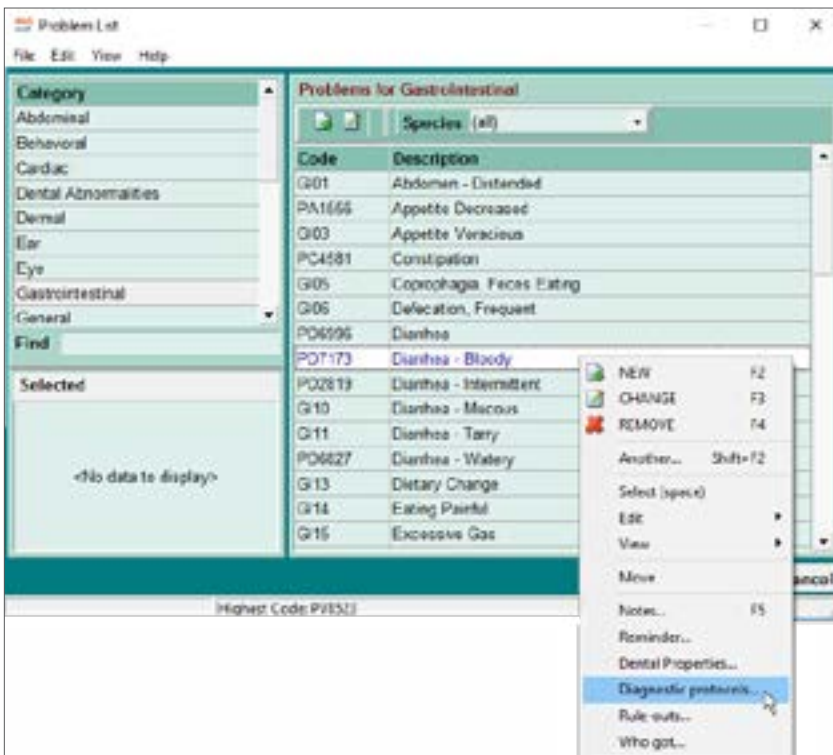
The steps below describe the advanced setup required for the **Problem, Objective, and Assessment** areas. There is no advanced setup required for the Plan area.

 The images and instructions below do not contain descriptions of actual treatments, items, problems, diagnoses, abnormalities or body subsystems. The instructions are examples of how to set up and use the Medical Condition Record.

Advanced Setup for the Problem Area

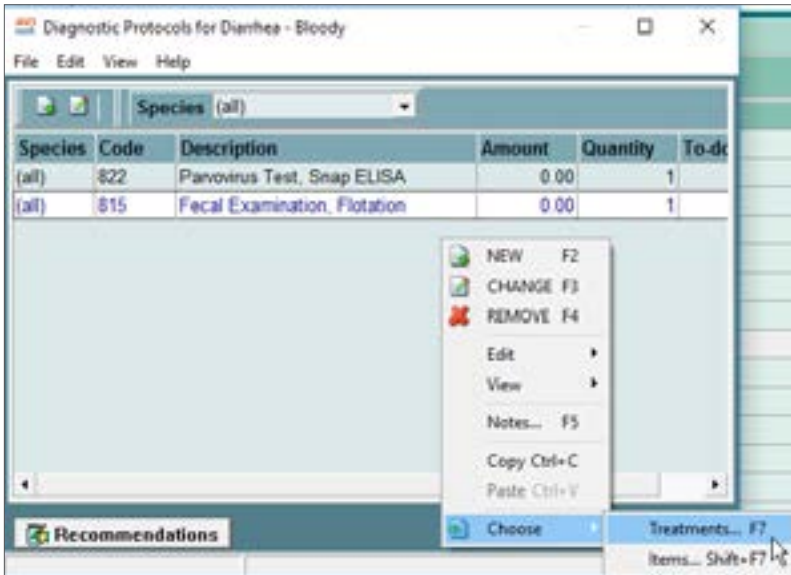
1. Set up Diagnostic Protocols on Problems

- a. Go to **Work with > Problem List**.
- b. Locate the problem.
- c. **Right-click** on the problem and click **Diagnostic protocols**.



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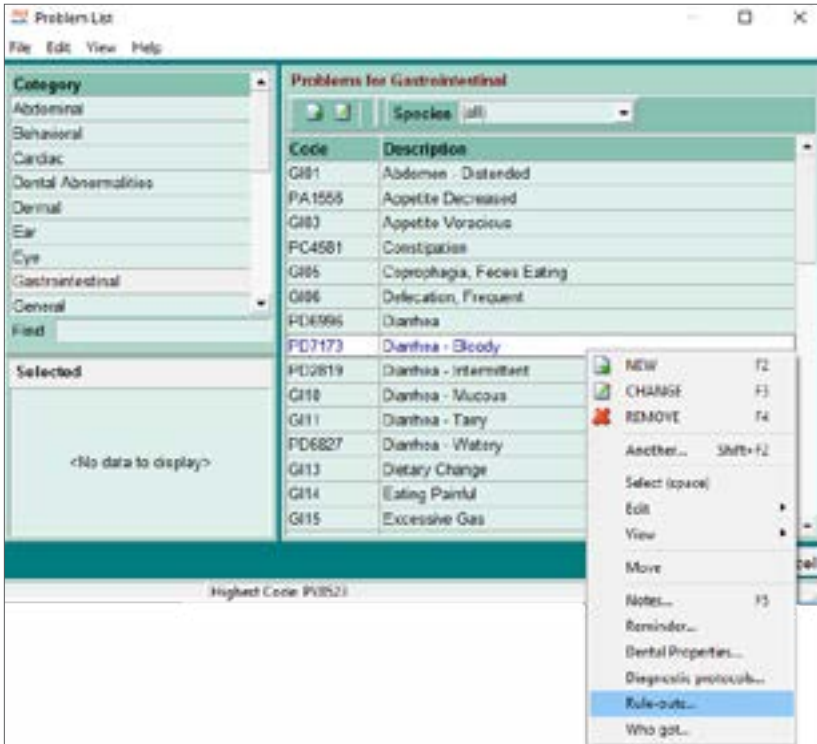
- d. In the Diagnosis Protocols window, **right-click** and click **Choose Treatments or Items**. Choose one or more treatments and/or items that you want to use to diagnose the problem. You may also Enter Recommendation Notes, if desired, by clicking the **Recommendations** button in the lower left corner of the window to open the Recommendation notes window.



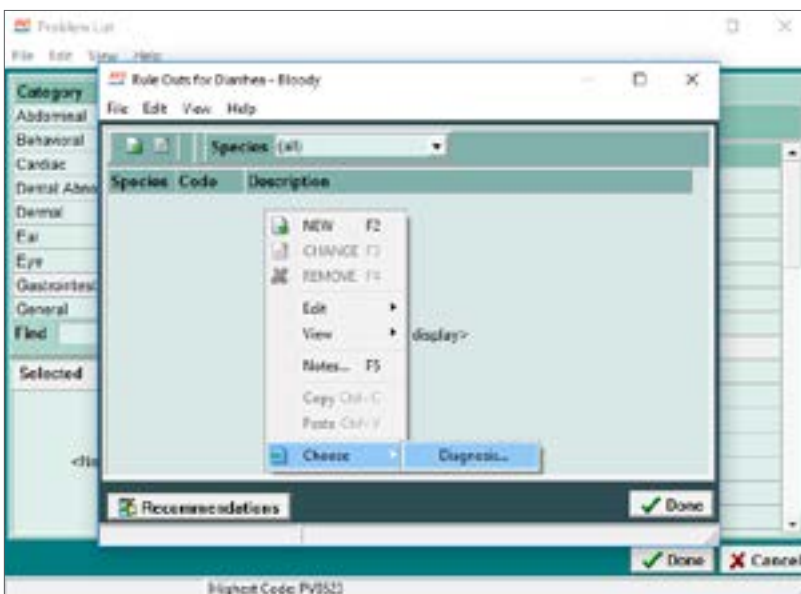
2. Set up Rule-Outs on Problems

- a. Go to **Work with > Problem List**.
- b. Locate the problem.
- c. **Right-click** on the problem and click **Rule-outs**.

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- d. In the Rule Outs window, **right-click** > **Choose Diagnosis** and choose one or more possible diagnoses for this problem. You may also Enter Recommendation Notes, if desired, by clicking the **Recommendations** button in the lower left corner of the window to open the Recommendation notes window.



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Advanced Setup for the Objective Area

The terminology of “Abnormalities” as it is used on the Patient Chart and SOAP print out can now be customized on these print-outs according to the clinics own preference. This is done now by setting up a user-defined term to replace Abnormalities.

In the **Options Maintenance Search** window, type in **Body Systems**. This will bring up the new option called “Header for the Body Systems Section on the SOAP Report .” Highlight this option and then click on the **Change** button to open the Change Option window to enter the description you wish to use.

The Abnormalities shown in the Objective area are set up in the Abnormalities and Body Subsystems System Tables.

You may customize the Objective area of the Medical Condition Record by removing or changing any of the entries in this table and you may add new ones.



If you are below version 2010 and if you've recorded information on any of the current entries and then removed them from system tables or if you change the code of the abnormality, you will lose that recorded information. If this happens, you can re-enter the code into the table and the lost data will again be available.

1. Set up Abnormalities

- a. Go to **Work With > System Tables**.
- b. Click the **Abnormalities** Table.
- c. Under Entries for Abnormalities Table, **right-click > New**. Enter the Major Body Systems or other data that you want to display as Abnormalities in the Objective area of the Medical Condition Record.

2. Set up Body Subsystems (optional)

- a. Go to **Work with > System Tables**.
- b. Click the **Body Subsystems Table**.
- c. **Right-click > New** and create new **Entries** of all the subsystems you want to attach to various body systems.
- d. Write down the codes of all the body subsystems or print the Body Subsystem Table (you will need it for Step 3)

3. (optional) Attach Body Subsystems to Abnormalities

- a. Go to **Work with > System Tables**.

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- b. Click the **Abnormalities** Table.
- c. Highlight a Body System and then **right-click > SubSystems**.
- d. **Right-click > New** and enter the first code of the Body Subsystem (use the printed subsystem table or your handwritten list of codes). Attach as many subsystems as you wish in the same manner.

Advanced Setup for the Assessment Area

1. Set up Treatment Protocols on Diagnoses
 - a. Go to **Work with > Diagnosis List**.
 - b. Locate the diagnosis.
 - c. **Right-click** on the diagnosis and click **Treatment Protocol**.
 - d. In the Protocol window, **right-click > Choose** and choose one or more Treatments and/or Items.

You may also Enter Recommendation Notes if desired by clicking the **Recommendations** button in the lower left corner of the window to open the Recommendation notes window.

Advanced Setup for the Plan Area

1. Setup default document for the Report Card- Attaching a default document can be setup in two different ways:
 - a. **Advanced Options:** From the Options Maintenance window enter “Default Report Card Document” in the Search field to attach an individual document. Highlight this name under the search window. Click the change button for the default value and put the name of the document in the value field. Click ok.
 - b. **System Tables:** From System Tables, Species Table, right-click Change on each species to attach a document. In the change species entry window select the document to attach in the Report Card field by clicking on the ... box to the right.

Clicking on the Report Card button will open a Windows Open dialog box with the document automatically selected and ready to print.

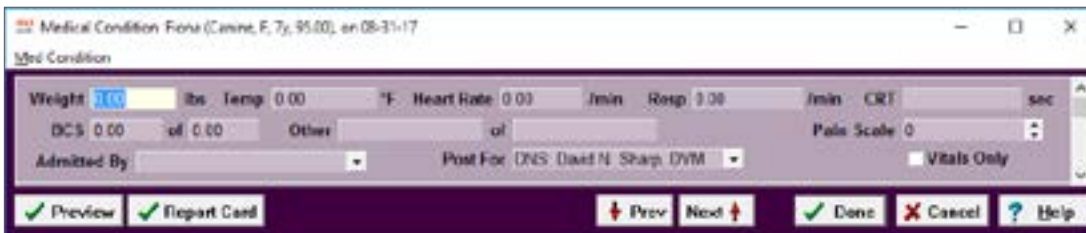
 **When a species specific document has been setup it will take precedence over the Advanced Options default document.**


2. Posting in reverse order from the SOAP- This option defaults to False. To change the default value to True go to Option Maintenance window and enter “Post From Plan to Medical History in Reverse Order in the Search field. Click the change button for the default value and select True in the value field. Click OK.

Using the Medical Condition Record

You may use the parts of the Medical Condition Record in any way you wish but the instructions below provide an orderly way to enter information.

- In **Medical History**, right-click and click on **Med condition**.



 The Med Condition window can be resized. Place your mouse over the bottom border of the window until you get the double re-size arrow. Click and drag up and down to adjust the size of the window.

1. Enter Vital Signs

- a. Enter Weight, Temp, Heart rate, Resp. rate, CRT (capillary refill time), BCS, Pain Scale and any Other information) by tabbing through the fields in order.

Holding your cursor over the Weight field will display a tooltip window with the entire weight history of the selected patient. This tooltip will list the date each weight was taken and the weight that was recorded for each date.

The BCS and Other vital sign fields have a second field that allows a High score or value to be specified. Example: If you score your patients BCS on a scale of 1 to 5, you can specify the patient's actual BCS in the first field and the high value (5) in the second. You can specify a default **high** value in the Options Maintenance window.

The Admitted By field will default to contain the doctor assigned to the patient's check-in.

- b. Enter client communications in the Subjective area (previously named Chief Complaint and Client Communications).

2. Select one or more Problems

- a. Click the Green right-pointing Arrow to expand the Problem tree and display the Presenting Problem and Problem History areas.

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Before Expanding

The screenshot shows a software window titled "Medical Condition: Fiona (Canine, F, Ty, 95.00), on 08-31-17". The form contains various fields for patient information and vital signs, including Weight (98.00 lbs), Temp (100.00 °F), Heart Rate (100.00 /min), Resp (100.00 /min), CRT (100 sec), BCS (100.00 of 100.00), and Pain Scale (0). Below these fields is a "Problems" section with a green plus icon and a list of expandable categories: Subjective, Objective, Assessment, Plan, and Attachments. At the bottom, there are buttons for "Preview", "Report Card", "Prev", "Next", "Done", "Cancel", and "Help".

After Expanding

The screenshot shows the same software window as above, but with the "Problems" section expanded. It now displays two sub-sections: "Presenting problem(s)" and "Problem History". The "Presenting problem(s)" section has a table with columns for "Code" and "Description", but it currently shows "<no data to display>". The "Problem History" section has a table with columns for "Opened" and "Op Description", showing a single entry: "08-06-17" and "DII: Rubbing Against Objects". The "Problems" section also shows the expanded list of categories: Subjective, Objective, Assessment, Plan, and Attachments. The bottom buttons remain the same.

- b. You may choose problems in one of three ways:
 - 1) In the Presenting problems field or the box below it **right-click** > **Choose** problem to go to the Problem List and select the problem(s).
 - 2) **Type** at least **the first three letters** of the problem. It acts as a “find” field and will drop down a list to choose from.
 - 3) If you’re seeing the patient for a problem that is already in their problem history, you can **right-click** on the problem in the Problem History area and click **Add To Problems**.

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- c. You will be prompted to post this problem to the patients Medical History, click **Yes**. (If you selected more than one problem, additional prompts will appear).

This will also enter the problem in the patient's Problem Histories window.

3. Record Examination Findings in the Objective Area

- a. If you have Abnormalities set up, you can check the appropriate abnormality boxes. The comment field will default to contain the words "Not Examined" until you click a box and then it will default to "Normal" as a finding. You may also type a note in the field or right-click in the field and click Notes to open a standard note window.
- b. If you also have Body Subsystems attached to Abnormalities and you check an Abnormality box, the Body Subsystem box will appear below the Abnormality for you to check if you've also examined that body subsystem.
- c. Doing a **right-click > Notes** is no longer necessary to enter notes for specific abnormalities. A smaller note window will now open when an abnormality box is checked or with a single click in the abnormality note field.

If body sub-systems were used within your SOAP records prior to updating to version 183, but due to the changes are no longer needed, an option is available that allows the displaying of the sub-systems to be turned off. Setting the new **Advanced Option > Show Body Sub-systems** to **False** will prevent all sub-systems (on past and future SOAP records) from being displayed.

4. Review and Accept Diagnostic Protocol (treatments and items used to diagnose the problem)

- a. **Right-click** on the problem and click **Review protocol**.
- b. The **Diagnostic Protocols** for the Problem will appear. Review recommendations, if necessary, by clicking the **Recommendations** button in the Diagnostic Protocol window. Click **Done**.
- c. If you want to perform the treatments and items listed in the Diagnostic Protocol window, **right-click** on the Problem and click **Accept protocol**.

The Plan section will automatically expand and the protocols for this problem will appear as Diagnostic treatments and items (identified in light violet color).

You may remove any of these codes from the Plan section or you may choose other treatments and items to assist you in making a final diagnosis by right-clicking in this area and choosing the appropriate entry. You may also Decline codes, Create, or Choose an Estimate, make Entry notes, post to the Whiteboard etc.

5. Review and Accept Rule-Outs (possible diagnoses)

- a. **Right-click** on the Problem and click **Review rule-outs**.
- b. The Rule-outs window for that problem will appear for your review. If you wish to view Recommendations, click the **Recommendations** button. When finished, click **Done**.
- c. **Right-click** on the Problem and click **Accept rule-outs**.

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The Assessment section will automatically expand and the Rule-outs (possible diagnoses) for this problem will appear in light violet color.

You may remove any of these codes from the Assessment section or you may choose other possible rule-outs by right-clicking in this area and choosing the appropriate entry. You may also Reject or Re-activate a rule-out etc.

6. Post Diagnostic treatments/items to Medical History

As you perform a Treatment or dispense an Item in an effort to diagnose the problem you will right-click on that code and post it to Medical History.

After the number of times the treatment or item has been administered (posted) meets the specified number of times it was to be administered (quantity), the treatment or item will appear grayed out in the list.

7. Eliminate rule-outs (possible diagnoses)

To reject a rule out, **right-click** on the rule out in the Assessment section and click **Reject Rule-out**. You may also right-click on the diagnosis and enter Rule-out notes (why you rejected this diagnosis).

8. Accept a Final Diagnosis

a. When you've arrived at a final diagnosis, **right-click** on the diagnosis in the Assessment section and click **Accept as Diagnosis**. You'll be asked to confirm this action, click **Yes**.

The final diagnosis will appear in dark violet color.

b. **Right-click** on the final Diagnosis and click **Review protocol** (these are treatments and items used to treat the problem).

The Treatment Protocol window for that diagnosis will appear for your review. If you wish to review Recommendations, click the **Recommendations** button. When finished, click **Done**.

c. **Right-click** again and click **Accept Protocol**.

This will add the Treatments & Items from the Protocol onto the PLAN tab and the entries will appear in dark violet color.

9. Post Therapeutic Treatments/Items to Medical History

As treatments are performed and items are dispensed, **right-click** on the code and click **Post** to post to medical history.