

User Tips

Narratives

To generate *narratives* for a patient you must have a minimum of a Health Questionnaire and a Clinical Evaluation form scanned.

It is important that all forms bubbled on the initial visit have the same date bubbled on them.

Minimum information you must have entered in the patient database in order to scan a form is **Patient Number and Name.**

Outcome Assessments include:

Health Status Questionnaire
Neck Pain Disability Questionnaire
Roland Morris Low Back Pain Questionnaire
Revised Oswestry Chronic Low Back Pain Questionnaire.

When using outcome assessment forms have the patient fill them out on the initial visit and any subsequent re-evaluations.

Neck Pain Disability, Revised Oswestry and Roland Morris Forms:

Side one (page1) is for the initial visit.

Side two (page 2) is to be filled out at re-evaluation time.

Daily Notes

It is not necessary to do narratives and daily notes on all your patients.

The daily notes program runs totally separate from the other forms. Therefore, you have the option to generate Daily Notes only on a patient if you want to. You must have the Patient number and Patient name entered in the database to scan these forms in.

Some general rules for this form that might be helpful to you are:

In the ***Symptoms Section***, if you bubble something in the 3rd column (Burning, Dull, Sharp, Shooting, Stinging, Throbbing), which are descriptors of pain, you must bubble pain.

You can bubble Pain without bubbling something in the third column (Burning, Dull, etc.) though.

In the ***Objective section***, if you bubble Radiate you must also bubble Tender. You can bubble Tender without bubbling Radiate though.

Using the Same as Bubbles

Symptom Section:

If you bubble the “**If your symptoms have not changed since your last visit indicate here**” bubble at the top of the form you can make some changes. You can change status (Improving, etc.). You can change frequency (Frequent, etc.). You can change degree of pain (Severe to Moderate, etc). You can also make a change in description of pain (Burning, etc.).

Modalities:

If you bubble “**Same Tx**” you cannot make any changes in this section.

Objective Section:

If you bubble **Same Assessment** you can make changes in **Leg Length Deficiency** and **Range of Motion** only.

The **SAT Except** bubble (same as treatment) on the DN3c form is to be used for the **Today's Tx General listings** on the left side of the form as well as the **3 vertebral level columns on the right** (Thrust section). If you bubble the SAT except bubble you cannot make any changes on the left side of the form only on the right side (Thrust).

If you have any questions please call or email the Training Department:

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