Mary L. Johnson Development and Behavior Unit
Developmental Consultation Program
&
Social-Communication and Autism Program

Procedure Manual

Version 3

CONTENTS:

ORIENTATION

MISSION: We are an academically-based, interdisciplinary professional team with regional and national leadership in developmental and behavioral pediatric health. We provide wholistic clinical service to children and families, exemplary and innovative education and training, collaborative partnerships with community agencies and services, and research that translates basic neuroscience to effective clinical practice and policy.

VISION: The Division of Developmental Medicine in the Department of Pediatrics at Stanford University and Lucile Packard Children's Hospital will be enthusiastically recognized and routinely utilized for its expertise throughout the University and Hospital, in the regional community, and at the state and national level.

VALUES: Our values include family-centered practice; culturally responsive and competent interactions; collaborative partnerships; and inclusion. We seek to serve a geographically, culturally, and socioeconomically diverse population. We use a biopsychosocial model and emphasize a child and family's functioning over categorical diagnosis.

CLINICAL APPROACH:

- We seek to practice Family Centered Care
    - By listening carefully to the chief concerns of the family and their objectives for the visit
    - By respecting families individual and cultural backgrounds and recognize culture may influence their description of their child and presentation of findings
    - By including families in the written communication of their evaluation or clinic visit
    - By partnering with families to connect to treatment services
- We construct our diagnostic evaluations by addressing the chief concerns of family and the referral questions of other professionals.
- We gather comprehensive information from multiple sources to obtain an ecological perspective of the child within the family and community, as well as to improve the efficiency and quality of clinic time together.
- We use developmental assessment measures to understand a child's behavioral profile in a developmental context.
- We value interdisciplinary team perspectives.
- We conceptualize services such as early intervention, special education, and community services as medical therapeutic interventions, therefore; we seek to collaborate with agencies and professionals that provide those services.

OUTPATIENT CLINICAL SERVICE MATRIX

	Developmental Consultation Program	Coordinated Autism Program	Preemie Graduate Services	Pre Transplant Evaluations
Patients	•Age < 6 years •Concern/evidence of developmental or behavioral delay or disorder •Genetic and metabolic issues/problems •Special arrangements with MD or Psychologist •OK by Medical Director or Program Manager	•Age < 6 years •Evidence of developmental or behavioral delays in social communication •Suspected autism •Second opinion when evaluators disagree or parents and evaluators disagree •Diagnostic focus	• Age 3-18 years • Born prematurely • Continuing problems in development or behavior	• Pre liver transplant evaluations • Inpatient or outpatient
Team	•MD (developmental-behavioral pediatrician) or NP •Psychologist •MD/NP & psychologist team •Speech and language pathologist •Social Worker •RN, CNS, Coordinator	•MD (developmental-behavioral pediatrician) •RN, CNS, Coordinator •Psychologist •Speech and Language Pathologist •MD/NP & psychologist team	•MD/NP •RN, CNS, Coordinator •Psychology •Educational specialist •Others to be determined by need	• Nurse Practitioner or Psychologist
Services	•Referral by MD, family, or community service •Visits scheduled as soon as possible after referral •No routine follow-up •Follow-up specifically to answer questions (not to check on service delivery)	•Referral by MD, family, or community service •Visits scheduled as soon as possible after referral •No routine follow-up •Follow-up specifically to answer questions, not to check on services	•Referral by MD, family, or community service •Comprehensive assessment •Follow-up as needed	• Contacted by Transplant Coordinator • Focused developmental assessment • Parent and team feedback • Community referrals

NEW CONSULTATION OFFICE INTAKE PROCESS

- **Referrals for Developmental Consultation**
  - Parent Generated
  - Primary Care Provider
  - Specialty Care Providers

- **Referrals received through**
  - LPCH OPCON
  - LPCH Referral Center

- **Providers are asked for:**
  - The consultation question and supporting information
  - Authorization

- **Parents are asked for:**
  - Complete Developmental Questionnaire
  - Send previous developmental/educational evaluations (most recent)

- **Weekly phone calls (x3) to obtain information, then (x3) to attempt to schedule**
- **Once information is received from parents and providers appointment is made**

CLINICAL TEACHING ROLES

Resident Role and Expectations

- Prepare for history-taking by reviewing available records (e.g., previous assessments, Individualized Education Programs (IEPs)) before clinic
- Perform histories and exams and present findings to attending
- Collaborate with the attending to develop an assessment and plan for each patient
- Participate in documentation of visits and development of reports to referring providers

Educational Goals

The DB Peds Consultation Program experience prepares trainees to:

- Develop and refine specific history-taking and exam skills required in the evaluation of children with developmental concerns.
- Interpret developmental and psychoeducational testing reports from outside health care providers, schools, and other agencies.
- Integrate information from multiple sources (e.g., history and exam, review of outside records) in order to develop a developmental profile and individualized patient management plan
- Outline clinical features, diagnostic tools and criteria, and available treatment approaches for specific developmental disorders, including mental retardation, autism, language disorders, and cerebral palsy
- Understand the indications for and implications of medical testing (e.g. neuroimaging, genetic tests, biochemical tests) in children with developmental disabilities
- Communicate effectively with families of children who have developmental disabilities

Learning Objectives

Because of participating in the DB Peds Consultation Program, residents will be able to:

Medical Knowledge

- Outline an initial differential diagnosis for:
  - Speech delay
  - Delay in walking
  - Poor school performance
- List evidence-based investigations (neuroimaging, genetic or other testing) recommended in a child with:
  - Mental Retardation
  - Autism
  - Cerebral Palsy
- Describe the World Health Organization (WHO) international classification for functioning, disability, and health. Provide an example of how the classification can be used in creating a management plan for a child with a developmental disability
- Define, list possible etiologies, and list classifications (based on: type of muscle tone; topography of affected areas; degree of functional impairment) for Cerebral Palsy
- List the areas of impairment in a child with Autism and give examples of at least three questions that could be asked in each area
- Using the Modified Checklist for Autism in Toddlers (M-CHAT) as a guide, list four questions that could be asked in the primary-care setting to help screen a child whose parents are concerned about autism

Patient Care

- List common reasons why a child might be referred to a developmental pediatrician
- List "red flags" for language and motor development that warrant referral
- Take a through developmental history
  - Use appropriate clarifying questions to explore a "developmental" chief complaint
  - List questions that should be included in a review of systems when assessing a child with developmental delay
  - Gather family history relevant to developmental concerns and draw a three-generation pedigree
- Perform a physical examination targeted to the assessment of developmental concerns
  - Demonstrate a full pediatric neurologic examination
  - For at least four systems on physical examination (other than neurologic), describe possible associations between exam abnormalities and developmental delay
- Discuss possible implications (both positive and negative) of "labeling" a child as having autism, cerebral palsy, or developmental delay

Interpersonal and Communication Skills

- Communicate information about diagnosis and management in an empathic, non-judgmental manner that empowers families to provide optimal care for their children
- Explain to a family the implications of a developmental disability
- Demonstrate essential skills in conveying difficult news to families:
  - Listen actively and validate parents' concerns
  - Respond to parental affect and be aware of one's own affect during discussion of sensitive issues
  - Demonstrate sensitivity to cultural values
  - Recognize stages of grief and their potential impact on discussions with families

OVERALL PHYSICIAN/NURSE PRACTITIONER EXPECTATIONS

1. Arrive at clinic at 8:30
2. Review charts, prepare notes on dictation sheets & consider teaching goals
3. Speak with coordinator about children to be seen
4. Complete the evaluation
5. Consult with psychologist, social worker and therapists, as appropriate
6. Consult with Coordinator regarding check out.
7. Inform parents of recommendations
8. Arrange any follow-up visits
9. Obtain social work and therapist notes
10. Complete all dictation data fields and give copy to Coordinator before leaving clinic
11. Complete billing forms and give to Coordinator before leaving clinic
    a. CPT code: Consult by time – account for time spent in care and coordination that does not include administering any developmental assessment measures. Must include time statement at end of dictation e.g. Consult time equals 80 minutes with care and coordination time 45 minutes (greater than 50% of total consult time)
    b. May bill 96111 for Capute Scales or other standardized developmental measure, bill 96110 for screenings
    c. Diagnoses: Delayed Milestones if referred for atypical delay, may add any diagnosis made during the visit
12. Dictate and sign report within 7 days
13. Return chart to Development and Behavior office at 750 Welch Road, Suite 212, within one week

MD/NP Documentation of the Visit

1. Mechanics of Dictation
    a. Phone 497-8278
    b. Clinic number for IDC is 223, work type is 13#
    c. Please say the date of service at the beginning of your dictation
    d. If you are a Fellow who saw the patient with an Attending Physician, or Nurse Practitioner, please state that and the name of that provider that the report should also go to at that beginning of the dictation.
    e. Read the dictation form or complete a comparable written template
    f. Send an external carbon copy to the parents
    g. Send an external copy to any agencies currently involved with the child if consent obtained
    h. Press 5 (6 for STAT) at end of dictation
    i. Write the job number on your dictation sheet.
    j. For Fellows: Do not sign your dictation sheet; FORWARD document to Attending or NP to sign. (See E-sign/modify document instructions attached)
    k. Reports that are not signed will not be sent out of the system and may impact referral process.
    l. Charts should be returned within a week to the office at 750 Welch Road, suite 212.

PHYSICIAN AND NP ROLES AND RESPONSIBILITIES

Clinical Evaluation: The physician either begins the visit or follows the psychologist. The physician obtains the following:

Identification

1. Demographic information
    a. Child's name
    b. Chronological age and Adjusted age
    c. Gestational age at birth and Birth Weight
2. Informants: Note who accompanies the child: parents/guardians, other family members, representatives of community agencies
3. Note if interpreter was used and the interpreter's name

Chief concern:

For Consultations: thank the referring provider for the consultation and clarify the consult question

Interval history

1. Subsequent medical visits, hospitalizations, operations
2. Results of sensory evaluations as needed
    a. Confirm that hearing testing was normal at 4 month visit and within first year
    b. Confirm repeat hearing test for children with CMV, PPHN, ECMO in second year
    c. Document Vision and eye examinations
3. Use of community-based services
4. Feeding history
5. Sleeping history
6. Developmental capabilities at present
7. Behavior and temperament

Social history (If SW not available)

1. Members of the household
2. Notable stresses and coping strategies (Parental depression, Economic hardship, Drug and alcohol use/abuse, Family violence)
3. Attachment and other social relationships

Family history

1. Developmental disorders
2. Behavioral problems
3. Mental health disorders
4. Other

Review of systems:

Constitutional	GI
Nervous system: seizures	GU
Eyes	MS
Ears, nose, throat	Endocrine: growth
Heart	Psychiatric: behavior
Lungs	Other

Physical exam

1. General appearance
2. Growth parameters
    a. Measurement--length, weight, head circumference
    b. % for chronological age, % for adjusted age
    c. % Weight for Height
3. General findings
    a. Head: cranial shape/sutures/fontanels
    b. Lungs and Heart
    c. Abdomen
4. Neurological examination
    a. Cranial nerves
    b. Active tone
    c. Passive tone
    d. Strength
    e. Deep tendon reflexes
    f. Primitive reflexes

Developmental evaluation

1. Perform Capute Scales (CLAMS and CAT) and other appropriate measures unless child scheduled for Psychological Evaluation

Formulation of Plan and Communication with Parents:

1. Address parental concerns
2. Refer to appropriate community services in consultation with Coordinator. Families should be presented with their options i.e. community resources versus private insurance. We now have a handout that explains what to expect from the agencies after a referral is made. The coordinator can assure that the family understands their requirements to obtain services.
3. Provide counseling for abnormal findings in consultation with Therapists
4. Discuss and plan for adjustment to diagnosis
5. Arrange subsequent visit or community referral as a function of age, location, findings
6. Discuss whether follow-up is indicated

Billing

1. Consultation
2. New patient visit
3. Follow-up visit
4. ICD-9
    a. Code as specifically as possible (use 700 codes rather than 300 codes whenever possible)
        i. Examples: Hydrocephalus (331.4), Hypotonia (781.3), Hypertonicity (728.9)
        ii. Include codes for functional issues and growth: Failure to Thrive (783.41), Feeding Problem (783.3), Insomnia, unspecified (780.52)
    b. Number codes in order of importance
    c. If no specific issues:
        i. Delayed Milestones or lack of normal physiological development (783.42)

PSYCHOLOGISTS ROLES AND RESPONSIBILITIES

1. Time of Arrival
   Families are scheduled for an 8:30 a.m. appt and told to arrive by 8:15am. Psychologists should arrive by 8:15 a.m. in order to prepare for evaluation. Charts should be available for additional review on the counter near the dry erase board. As much as possible review your case ahead of time. If charts are not present, please contact the main office, 650.725.8995 and ask that someone bring the charts.

2. Assignment of Cases
   Unless a family requests a particular psychologist, or have seen one previously, assignment of cases is determined prior to clinic by LPCH psychologist. Psychologists are notified about patient's they are assigned regarding name and medical record number, so that they can online review the records prior to clinic if they cannot come to the office to review the complete shadow chart. Some records may not have been scanned into the electronic medical record by the time the patient is seen. Factors such as apparent "complexity" of the case and the time available for the psychologist (e.g., another commitment scheduled immediately afterwards) can be taken into consideration. Dr. Brentar has Preemie Graduate Services patients scheduled specifically for him and the PNP working with his will provide information prior to the clinic visit day.

3. Evaluation flow
   The psychologist is generally the first to see the child. The psychologist usually spends approximately 1.5 hours with the child and family members. At 10:00am the psychologist returns to the chart room and provides a verbal "progress report." The progress report either communicates that enough information has been gathered to determine impressions up to that point, or, communicates the need for more time due to the complexity of the case. The Coordinator is responsible for managing clinic flow. Therefore, it is important to let the Coordinator know if more time is needed for further testing, interview etc. so that she can pace the M.D. Once the psychologist is ready for the case conference, the M.D., Coordinator, and any other relevant party, listen to the psychologist's impressions. The psychologist usually informs the team members of what areas are particularly important to focus on for the remainder of the visit. The psychologist then completes all scoring, cleans and secures testing items to designated storage, and begins report writing while the M.D. does his/her evaluation of the child.

   After the M.D. has completed his/her evaluation a case conference to discuss impressions and plan takes place with: MD, Coordinator, and relevant parties, and a decision is made as to who will provide the family feedback. In most cases the psychologist provides the family feedback about impressions and recommendations. Once the feedback is complete, if time and flow allows; the Coordinator follows-up with the family and provides the family with information about lab or imaging

studies, resources and referral process, team contact information, consents for copies of reports to be sent to providers/agencies, and follow-up appointments. Release of info is the responsibility of the provider (MD) & coordinator of the clinic unless the patient is a psychologist only visit. If the Coordinator is not available in the clinic the psychologist needs to obtain consent. Anne is to f/u with legal re: if a second consent / release of info is needed when psychology test data is contained within.

4. Billing

   Psychologists obtain a billing sheet from the Coordinator, fill it out, and return it to the Coordinator before leaving the clinic. Psychologists are to indicate up to three relevant diagnoses located on the back of the billing sheet.

   If we are billing for a Consultation; we need to use the language, "Thank you for the referral for _____ to provide consultation regarding _____".

   On the yellow sheet: you put the dx (e.g., ASD) when appropriate. If there is no diagnosis, it is acceptable to put the "referral concern" -- making sure the assessment / dictated report reflects why the assessment addressed / targeted the referral question. There is no check box for no diagnosis. Heidi to obtain information from Lynn Wagner with the Society for DBP so that we can update our billing sheets with additional ICD9 choices.

5. Report Writing

   All reports must be inserted into the LPCH Cerner electronic medical record system. LPCH requires that there is a dictation on the day of the clinic visit that can be associated with the bill. This can be a “place holder” for a word document to be inserted at a later time. To dictate call (650) 497-8278 and enter your dictation number at the prompt, the clinic code is 223. Unless decided differently by parties involved, the psychologist will combine the MD and Psychology reports and any other team member’s dictated note. The psychologist’s role will be to combine & edit reports, although there still needs to be a final decision re: this in clinic; sometimes when the child's situation is more medically involved, it makes more sense for the MD to take this responsibility. If billing for a Consultation the letter should go to the referring provider (not always an MD) and the Primary Care Provider 2 MDs (referrals involved), it's fine to dictate: Dear Drs. Smith & Johnson

   MD/NPs need to dictate a stand alone letter to the referent if they are going to bill for a Consultation. These letters will include a brief summary or conclusion of the psychological evaluation, but not the full details that will be found in the combined report. Reports should not be copied for combination until Finalized by the author.

<u>The MD/NP dictates the following sections</u>:

- Identification
- Chief Concerns

- Target Problems
- Current Functioning
- Past medical History
- Medication History
- Family and Social History
- Review of Systems
- Developmental History
- Physical Examination
- Neurological Assessment
- Impressions (combine with psychologist)
- Recommendations (combine with psychologist)

The psychologist dictates:

- Preschool & School History
- Previous Evaluations and Service History
- Developmental History pertaining to Autism DX
- Observations and Psychological Evaluation
- Impressions (combine with MD/NP)
- Recommendations (combine with MD/NP)

To copy a template report from Word to Cerner the font should be changed to Courier New-size 9 font. Tables will copy, but highlights, shading, and italics do not copy well. To make the combining of reports easier, please begin all major sections with Title CAPs followed by a colon e.g. BEHAVIORAL OBSERVATIONS:

Cerner now has a new capability to accommodate sensitive information that is to be in the electronic medical record, but not released in the report. To dictate this information," start confidential dictation", and "end confidential dictation". The transcription service will take the contents between the two indicators and create a separate report in work type 20 for you. The two reports will be in your inbox to sign. Each report will cross reference each other. You must you canned phrase, "start confidential dictation", and "end confidential dictation" to guarantee that a separate report will be generated. You cannot request a cc to the parent when using this function. Avoid including sensitive information if it is not relevant to the current condition, or the report may be viewed by agencies.

Please be sure to dictate all of the consented copies at the end of the letters. We do not cc agencies when making a referral. because the agency letter will go out with the referral information and not separately from Medical Records. The agencies that the family wants the report to go to is communicated from the MD/NP to the psychologist and Coordinator at the case conference above to ensure consent is obtained and all letters include appropriate carbon copies. The reports are expected to be "Finalized" within 2 weeks of the clinic visit.

6. Protocol

   On the day of the clinic visit put a registration sticker on a manila folder (the folders are located with the psychological testing manuals) to store the testing protocol. Only testing protocols should be placed in the manila folder. These folders will be cataloged in a data safe storage box and sent to a storage facility. It is important to get protocols back as soon as reports are finalized so that they can be stored by date of service period and relocated with ease if they are needed. Please bring protocols back every week to the office or give them to the Coordinator (after you have placed them in a manila folder and labeled with a sticker). All other documentation that supports your evaluation conclusions and treatment recommendations (e.g., previous evaluations etc) should be stickered and indicated that they go to Medical Records. A LPCH psychologist will return these documents to the main office to be sent to Medical Records.

7. Clinic Wrap Up

   Maintain inventory of all psychometric tools and protocols; notify Manager if a re-order of supplies is needed

   Make sure testing kit items are clean and locked away at end of visit.

CLINIC COORDINATOR ROLES AND RESPONSIBILITIES

1. Intake review
2. Chart review and communication with team
3. Clinic Flow and communication between team members
4. Case conferencing to determine best plan for referrals and connection to resources
   a. The coordinator helps determine appropriate community resource referrals and make sure the necessary paperwork gets completed
   b. Coordinates labs and imaging
   c. In the event of a referral, the coordinator should meet the family to help prepare them with the course of events to follow.
5. Both physicians and the coordinator should assure that the LPCH Consent/Release of information form includes any Agencies to be cc and any new referral agencies.
6. The coordinator collects the data fields/copy of dictation sheet and billing forms by the end of the session.
7. The coordinator will make referrals and arrange for children to receive early intervention.
8. The coordinator tracks lab results and notifies MDs/NPs of abnormal results and sends a letter to the family for negative results

OVERALL SOCIAL WORK AND SPEECH PATHOLOGIST EXPECTATIONS

1. Arrive at clinic at 8:30
2. Review entire day's case schedule
3. Plan with MD/PNP & coordinator flow of evaluation
4. Indicate with circle on board with a circle, patients being seen, mark with an X after consult
5. Give MD/NP completed consultation form
6. Bill as per dept/discipline protocol
7. Provide family with appropriate handouts and resource information not in standard package

Social Worker Role & Responsibility

The Social Worker is a member of the interdisciplinary team. She meets with any families that request to meet with her or that the physicians or psychologists request she meet with due to concerns with support and/or resource needs. The social worker completes a psychosocial assessment including family structure, what services the family is linked with, how the family is coping following hospitalization or new diagnosis, area support system, and any concerns that the family may have. The social worker will assess family needs and assist the family in obtaining appropriate community resources. The social worker may have ongoing contact with the family following the appointment, or there may be no needs identified during the clinic visit which does not require follow-up. Families are always encouraged to call the social worker if they have questions, concerns, or needs following the clinic visit with the social worker or medical team. The social worker consults with the team following her visit and updates them with psychosocial concerns and resources provided. A psychosocial assessment or follow-up note are written in Cerner for access by the medical team.

Speech Pathologist Role and Responsibility

INVENTORY OF TOOLS

- Bayley Scales of infant Development-III
- Vineland Adaptive Behavior Survey-II
- MULLEN
- BATELLE
- BRIGANCE
- CDI
- WPPSI
- Weschler
- CBCL
- MCHAT
- CSBS
- NEPSY
- Woodcock Johnson
- Leiter

- **LUCILE PACKARD CHILDREN'S HOSPITAL**

DICTATION INSTRUCTIONS

Inside LPCH Dial: 78278 or 278
Outside LPCH Dial: (650) 497-8278

- Enter your Physician ID Number followed by the "#" sign
- When prompted press 1 for Dictate or 3 for Listen
- **Enter Clinical Area Code** followed by the "#" sign – 223 for DBP (formerly Infant Development)

Inpatient	1	SDC	3
Adolescent Medicine	200	Nephrology	96
Allergy/Immunology	202	Neuro Oncology	269
BMT	40	Neurology	97
Cardiology	42	Neurosurgery	100
Cardiovascular Transplant	211	OB	270
Craniofacial Anomalies	209	OB Genetics	236
Craniosynostosis	210	OB PDC	271
Dermatology	57	Occupational Therapy	242
Diabetes	213	Oncology	103
Eating Disorders	215	Ophthalmology	65
Endocrinology	61	Orthopedics	243
ENT	62	Pain Management	111
Gastroenterology	67	Pediatric Clinical Research	272
Genetic Counseling	268	Physical Therapy	118
Genetics	72	Plastic Surgery	119
Hand	77	Primary Care	125
Hematology	78	Pulmonary	127
Infant Development	223	Rheumatology	80
Infectious Disease	81	Speech Therapy	261
Kidney Transplant	86	Urology	148
Liver Transplant	88	Vascular Malformation	267

- **Enter Work Type Number** followed by the "#" sign

History & Physical	2	Off Service Summary	9
Progress Note	3	Clinic Visit	10
Inpatient Consultation	4	EEG	11
Operative Report	5	Clinic Procedure	12
Inpatient Letter	6	Outpatient Letter	13
Discharge Summary	7	Outpatient Consultation	14
Transfer Summary	8	Clinic Note	15

- **Enter 8 DIGIT MRN** followed by the "#" sign

- **To begin dictation press "2"**

- Press "2" to **pause dictation** and "2" again to resume dictation

- **Review Dictation** by pressing "3" once or several times to incrementally rewind with auto playback
    - Press "77" to **rewind to the beginning of the report** with auto playback
    - Press "44" to **go to the end of the report**
    - Press "2" to resume dictation, otherwise may dictate over dictation

- **To Edit**, locate unwanted dictation by review functions above and press "2" again to dictate over unwanted dictation

- Press "5" to **Disconnect**

- **To Dictate a new report of the same work type**, press "8#" to finish the current report, then enter Clinical Area Code followed by the "#" key. Enter Work Type followed by the "#" key and then enter the MRN followed by the "#" key.

- **To Dictate a new work type**, press "8" and enter the new work type number followed by the "#" key, then enter MRN followed by the "#" key

- If you would like to **switch to Listen mode** before disconnecting, complete your dictation by pressing "8". When you hear the clinic prompt press "*1" and then "3" to enter listen mode

- At the **Beginning of EACH Dictation** please state:
    - Date of Service
    - Your name and title
    - Patient name (with spelling)
    - MRN
    - Attending physician name
    - Name and full address of any agency/person who is to receive a copy of the report

- Press "6" at any time during dictation **to indicate a STAT priority** and call HIMS at 497-8611 to apprise department of STAT dictation

- **Keypad Controls**

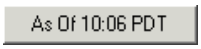
Stop Playback	2	Go to Beginning	77
Reverse w/ Auto Play	3	Reverse to Impression	*9
Advance to Impression	9	Listen to Report, New Patient	#
Disconnect	5	Listen Next Report, Same Pt	8
Go to End	44		

E-SIGN / MODIFY DOCUMENT

Documents can only be modified when in "Preliminary" status (attending MD has not yet signed).

1. Log into Cerner In Box.
2. From the "Documents to Sign" or "Forwarded Documents to Sign" folder, double-click on document to open.
3. Review for corrections and enter modifications.
4. Click **OK & Next** to open next document

   - OR -

   Click **OK** and then **Cancel** to return to In Box.
5. Click the **As Of** 

button. Document(s) should disappear from the In Box.

ADD AN ADDENDUM

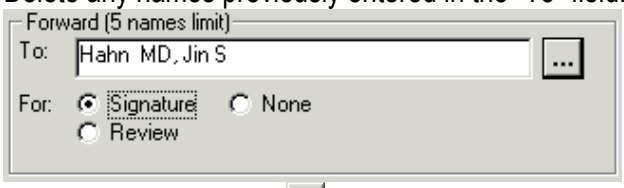
An addendum can be added to a document only after it has been finalized by the attending

1. Open document from PowerChart through the Clin Documents tab.
2. Right-click on document and select **Modify Document.**
3. Scroll to the end of the document and begin typing after ***Insert Addendum Here:.**
4. Click **Sign.**
5. For residents and fellows requiring a co-signature, follow instructions for forwarding a document to the attending for signature.

FORWARD DOCUMENT FOR SIGNATURE

1. Open document from In Box or Clin Documents tab.
2. Right-click on document (if opened through Clin Documents), and select **Forward.**
3. Select **Forward Only**

4. Delete any names previously entered in the "To" field.



5. Click the ellipses button  .
6. Select **Global Address Book** under "Show names from".
7. Enter recipient's last name. **Do not press "Enter".**
8. Select name and click the right arrow button.
9. Repeat steps 7 – 8 to add more names.
10. Click **OK.**
11. Select **Signature.** *Selecting **Signature** will add a signature line for the recipient, forcing him/her to e-sign the document.*
12. Enter a comment if needed.
13. Click **OK.**

Document will appear in the recipient's In Box under the "Fowarded Documents to Sign" folder.