

MedicalDirector Training for Clinical Nurses

This is a great opportunity for new nurses and current nurses to update and refresh your skills

Grant Smith
Kylie Goodwin
Barb Repcen



An Australian Government Initiative

Acknowledgement of Country

Eastern Melbourne PHN acknowledges the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present. EMPHN is committed to the healing of country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.



Housekeeping



All attendees are muted



Q&A will be at the conclusion of this session



This session is being recorded



Audio:

Listen via your computer's speakers
Telephone Number – within the audio
section or access details supplied in
registration email



Questions:

Post your questions in the 'Questions'
section in the webinar panel or email
hello@medicaldirector.com
digitalhealth@emphn.org.au



Agenda

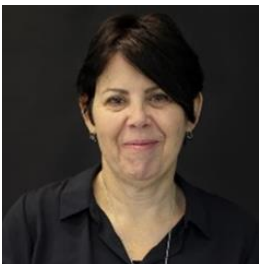
SPEAKERS:



Grant Smith,
Practice Consultant
MedicalDirector | Telstra Health



Kylie Goodwin,
Practice Consultant
MedicalDirector | Telstra Health



Barb Repcen,
Program Specialist- Digital Health
EMPHN

AGENDA:

4.3 New Enhancements

Recording measures

Recording Immunisations

Recording Cervical Screening

Managing Recalls and recording contact

Recording social and family history including
recording alcohol and smoking

Keeping past history items relevant

Creating letters

Data Quality and Data Cleansing

User Preferences

My Health Record accessing & uploading

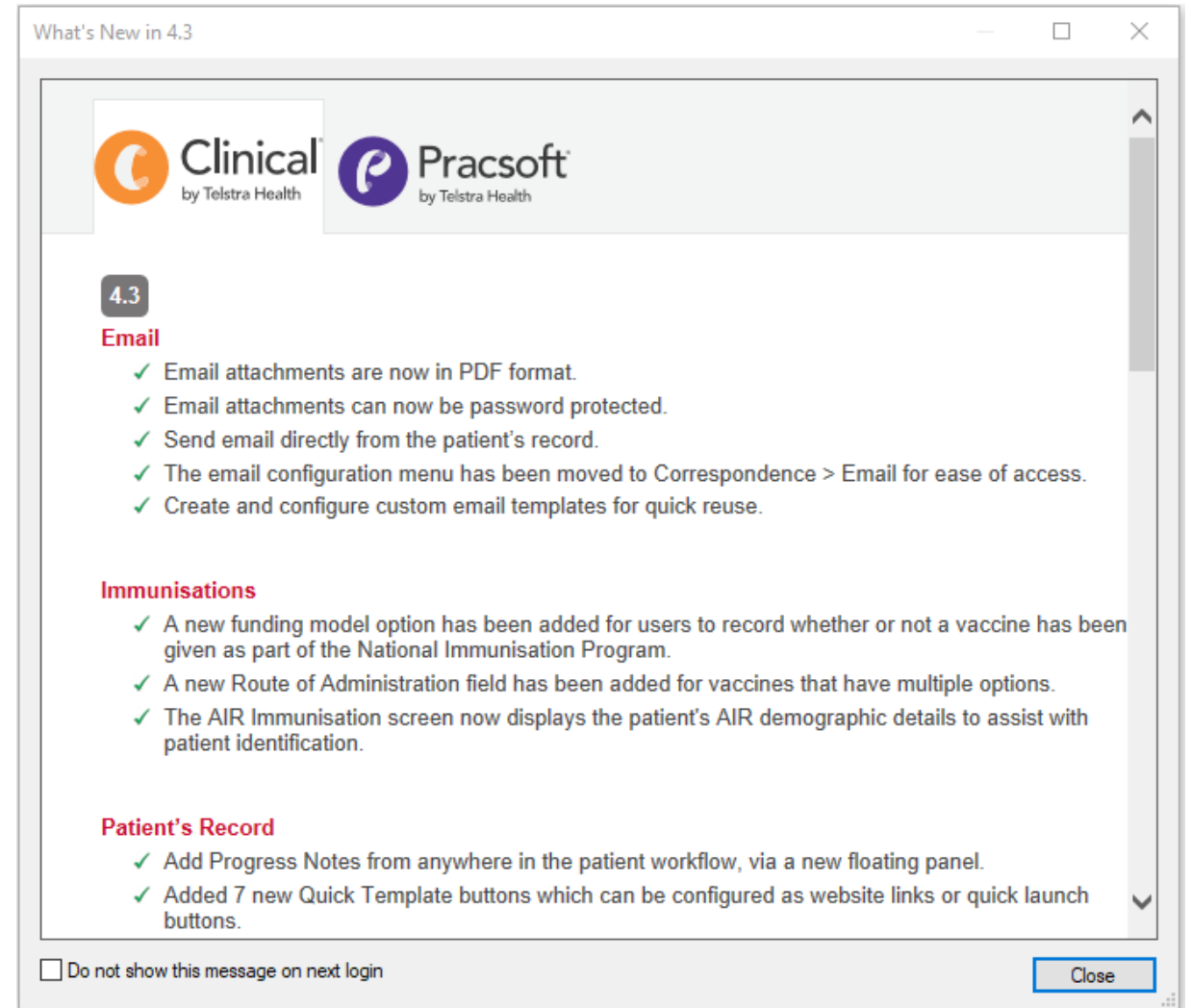
4.3 New Enhancements

Immunisations

- A new funding model option has been added for users to record whether or not a vaccine has been given as part of the National Immunisation Program
- A new Route of Administration field has been added for vaccines that have multiple options
- The AIR Immunisation screen now displays the patient's AIR demographic details to assist with patient identification

Patient's Record

- Add Progress Notes from anywhere in the patient workflow, via a new floating panel
- Added 7 new Quick Template buttons which can be configured as website links or quick launch buttons
- Keyboard shortcuts are now highlighted with an underscore, and new shortcuts have been added
- Added the option to record "No Next of Kin or Emergency Contact Provided" in the patient's record
- Updated ABS Ethnicity to the 2019 Australian Standard Classification of Cultural and Ethnic Groups



Recording Immunisations

AIR Web Services

AIR Patient Verification Check

Patient successfully verified with AIR

Notifications

- Patient has a Medical Contraindication
- Patient has a Natural Immunity
- Patient has a Vaccine Trial
- Catch-up date period has expired.

Indigenous Status

Special Risk Group

Record Medical Exemption

Record Planned Catch Up

Planned Catch Up 09/09/2022

Download Immunisation Statement

Verified AIR Patient

First Name: KOBY
Surname: EDWARDS
Date of Birth: 17/04/2012
Medicare No: 2953 70105 1
Medicare IRN: 2
Locality: MERRYLANDS
Postcode: 2160

Date	Immunisation	Sequence	Bat:	Vaccine serial number	Consent	Provided by	Vaccinator	Site	Comment	Send to AIR Status
6/09/2023	FLUQUADRI	4	1...		Consent: Parent	Parent	Dr Gavin Donnelly	Buttock L...		Transmitted
4/09/2023	BOOSTRIX						Given elsewhere			
4/09/2023	LIQUID PEDVAXHIB	1	1...		Consent: Parent	Parent	Dr Gavin Donnelly	Deltoid S...		Downloaded
8/08/2023	JESPECT	1	1				Given elsewhere			Downloaded
8/08/2023	JESPECT	1	1				Given elsewhere			Downloaded
30/06/2023	FLUAD QUAD	1			Consent: Parent	Parent	Dr Gavin Donnelly	Buttock ...		Transmitted
11/04/2023	MENINGITEC	9	1	123			Given elsewhere			Downloaded
11/03/2023	MENINGITEC	7	1	123			Given elsewhere			Downloaded
11/03/2023	MENINGITEC	7	1	123			Given elsewhere			Downloaded
7/03/2023	MENINGITEC	5	1	123			Given elsewhere			Downloaded
6/03/2023	AFLURIA QUAD (NIP	16	1	123			Given elsewhere			Downloaded
16/02/2023	HAVRIX JUNIOR	1	1				Given elsewhere			Downloaded
1/02/2023	MENINGITEC	6	1	123			Given elsewhere			Downloaded
1/02/2023	MENINGITEC	4	1	123			Given elsewhere			Downloaded
10/01/2023		15		IN...			Given elsewhere			Downloaded
21/12/2022	PFIZER COMIRNATY	3		123			Given elsewhere			Downloaded
19/12/2022		14		136			Given elsewhere			Downloaded
19/12/2022	H-B-VAX II(ADULT)	1	1...				Given elsewhere			Downloaded
29/11/2022	DUKORAL	3		S...			Given elsewhere			Downloaded
28/11/2022	DUKORAL	3		S...			Given elsewhere			Downloaded
20/10/2022		13					Given elsewhere			Downloaded
20/10/2022	NIMENRIX						Given elsewhere			Downloaded
14/10/2022	ACAM2000	1		A...			Given elsewhere			Downloaded
10/10/2022		13		N...			Given elsewhere			Downloaded
10/10/2022		12		N...			Given elsewhere			Downloaded
12/02/2022		11		P...			Given elsewhere			Downloaded

Website Feedback Help

AIR Patient Verification Check

Conduct a live patient verification check with AIR.

Record Medical Exemption

Click to record a [medical exemption](#) for the given patient.

Record Planned Catch Up

Click to record a [planned catch up](#) for the given patient.

Download Immunisation Statement

Click to download the patient's immunisation statement from AIR.

Recording Immunisations

To Record an Immunisation

- From the patient's Clinical Window, select the **Imm.** tab.
 - Then, to add an immunisation record, either
 - Click **+** on the toolbar
 - Press the **F3** key
 - Right-click in the list of immunisations (even if list is empty) and select **Record Encounter** from the pop-up menu
 - The **Vaccination** window appears.
 - Indicate whether the vaccine was administered elsewhere (Optional). This sets the Vaccinator drop-down list to 'Given Elsewhere'. The 'Vaccinator' and 'Consent provided by' fields remain disabled.
 - Indicate whether you wish to forward this vaccination data to AIR. The **Send to AIR** check box will be ticked by default, if the following rules are met;
 - Applies to any vaccine administered to a patient, that is approved for transmission by AIR.
 - The vaccine must be administered at the surgery (i.e. not 'declined' or 'given elsewhere').
 - MedicalDirector Clinical must be [configured](#) for sending vaccination data to your billing package, and;
 - If you are **linked to Pracsoft**, you must also tick the 'Create Immunisations' check box, located in [Links Options](#).
 - If you are **linked to a third-party** billing package, you must also;

Vaccination Window

Vaccine given elsewhere Vaccine administered overseas Send to AIR

Vaccinator: Dr A Practitioner (MedicalDirector Samples Database) *

Submit on behalf of: Dr A Practitioner *

Consent provided by: Patient * Vaccination declined

Date: 17/11/2023 *

Vaccine Name: *

Site:

Route of Administration:

Vaccine Type:

Sequence: *

Batch No: Store batch No

Comment: * = required fields

1 tick the 'Send details of immunisations recorded...' check box in [Advanced Link Options](#).

2 Indicate the output path location for the vaccination data your billing package will read, also located in [Advanced Link Options](#).

- Select the vaccinator from the drop-down list.
- Indicate who gave consent for the vaccination.
- Enter a date on which the immunisation was administered.
- Select the immunisation name from the list provided.
- Select the site at which the vaccination was administered.
- Indicate the [route of administration](#).
- Indicate the Type of vaccine from the list provided.
- Enter the Sequence, Batch Number and any comments (if necessary). Note that in the example above we have enforced AIR batch number validation (via [Advanced Link Options](#)) and therefore batch numbers must contain only alpha-numeric characters (no spaces or punctuation).
- (Optional) Click Mark for recall button to generate a [recall](#) notification to have the patient recalled for another immunisation in the future. ERROR: Variable (Recall_Management) is undefined.

4. Click Save button to save the immunisation record and return to the patient's record.

Recording Immunisations

To determine if a patient requires one or more vaccinations according to the National Immunisation Program Schedule, consult the Due Vaccines list on the Immunisation History tab. This list is generated in real time from the Australian Immunisations Register.

See [Recording Immunisations](#) for more information.

The Immunisations History tab displays the patient's immunisations history as recorded with the Australian Immunisation Register (AIR). History can include immunisations recorded at your practice, along with those recorded elsewhere.

- **Red** records indicate that some action is required.
- **Black** records are editable. Only immunisations administered at your practice are editable.
- **Blue** entries are those recorded with AIR, and are not editable.

The screenshot shows the 'Immunisation History' tab selected. It features two main sections: 'Due Vaccines' and 'Immunisation History'.

Disease	Dose	Due Date
Tetanus	2	05/01/2022
Diphtheria	2	05/01/2022
Pertussis	2	05/01/2022
Varicella	1	27/07/2019
Meningococcal ACWY	1	27/01/2019
Mumps	1	27/01/2019

Date	Vaccine/Brand	Dose	Status	Reason Code	Message
05/11/2021	AFLURIA QUAD	1	VALID		
05/11/2021	ADACEL	1	VALID		

Legend: Red - Action Required, Black - Editable, Blue - Not Editable

This screenshot shows a right-click context menu over a record in the 'Immunisation History' table. The record is highlighted in blue, indicating it is not editable. The context menu options are: Update Encounter, Refresh, and Store Locally.

Date	Vaccine/Brand	Dose
27/08/2023	MODERNA SPIKEVAX BIV BA.4-5	V
27/07/2023	DTBA	V
27/07/2	A (NIP)	V
27/07/2		4
27/07/2		V
09/06/2023	MODERNA SPIKEVAX	V
09/06/2023	AFLURIA QUAD (NIP)	V
13/01/2023	ASTRAZENECA VAXZEVRIA	V
11/01/2023	PFIZER COMIRNATY	V

Updating Encounters with AIR

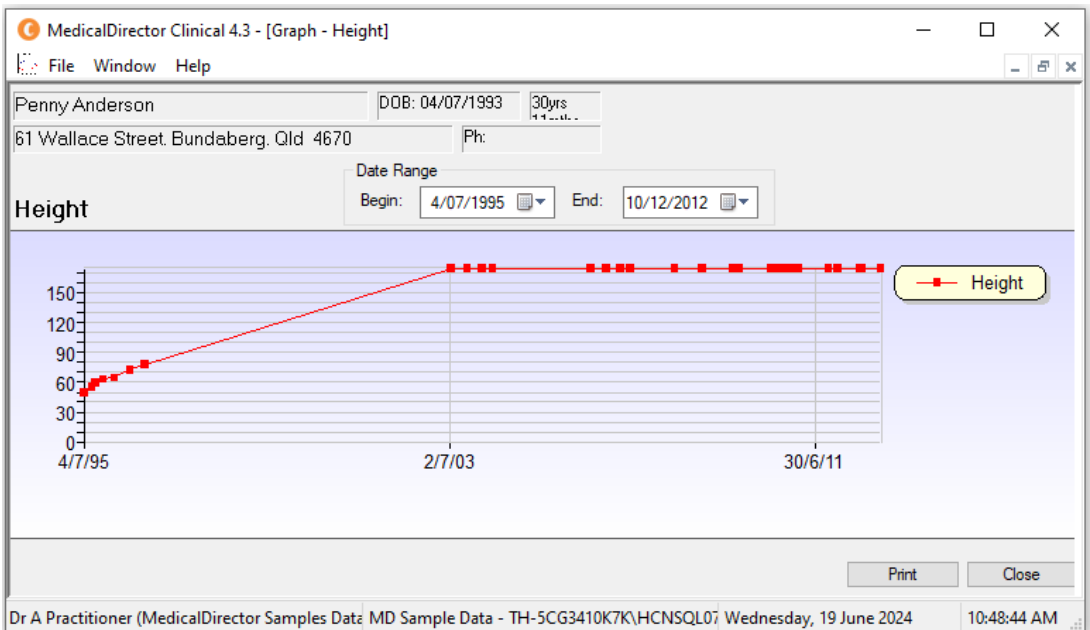
1. Select the **Immunisations History** tab.
2. Locate the record you wish to update with AIR.
3. Right-click the record and select **Update Encounter**.

Recording Measurements

Measure	04/07/1995	04/09/1995	04/10/1995	04/12/1995	05/01/1996	04/03/1996	05/01/1996
Height	50	55	60	63		64.5	
Weight	3.2	4.5	5.3	6.8	7.2		7.1
Pulse							
Systolic BP(Sitting)							
Diastolic BP(Sitting)							

The Clinical Measurements window displays the progress of a patient's various clinical measurements. Measurement data is entered via [Progress Notes](#) and various [Tools](#).

To view clinical measurements select **Clinical > Measurements** from within a patient's Clinical Window



- Measurements are listed on the left side of the window and separated into the various sections, including BMI, CVRISK, PEFR, SYSTOLIC, DIASTOLIC, for example.
- Measurement recording dates appear as column headings.
- To view specific measurements in graph form, select an entry and click **Graph**

Recording Measurements

The Tool Box is a suite of tools for recording patient readings, either calculated manually or via a [Diagnostic Devices](#), with each tool provided on a separate tab as shown in the following image.

The upper section of this window provides a means to;

- Mark the date and time on which the recordings were taken, and
- Test the tools using fictitious data ([Sex at Birth](#) and Age). Note that although you can change the patient's sex at birth and age here, these changes are not saved back to their record.

The lower section displays a selection of tool tabs. Some tabs require that you enter general data before recordings can be made. You will be prompted accordingly when this is necessary.

[Blood Glucose](#)

[Blood Pressure](#)

[Cardiovascular Risk - Absolute Calculator](#)

[Cardiovascular Risk - Relative Calculator](#)

[Electrocardiogram](#)

[INR Record](#)

[Paediatric Percentile Charts](#)

[Renal Function Calculator](#)

[Respiratory Function](#)

[Weight](#)

Tool Box X

Blood Pressure

Date: 6/06/2024 Time: 2:15:22 PM Sex at Birth: Male Age: 69 Height: 175 Patient ID: 20

Blood Glucose **Blood Pressure** CV Risk ECG INR Renal Function Respiratory Weight

Device: **Manual** Data Graph

Current Measurements View: All

Blood Pressure

Cuff Location: Unspecified

Systolic / Diastolic Pulse

Sitting:

Standing:


Lying:

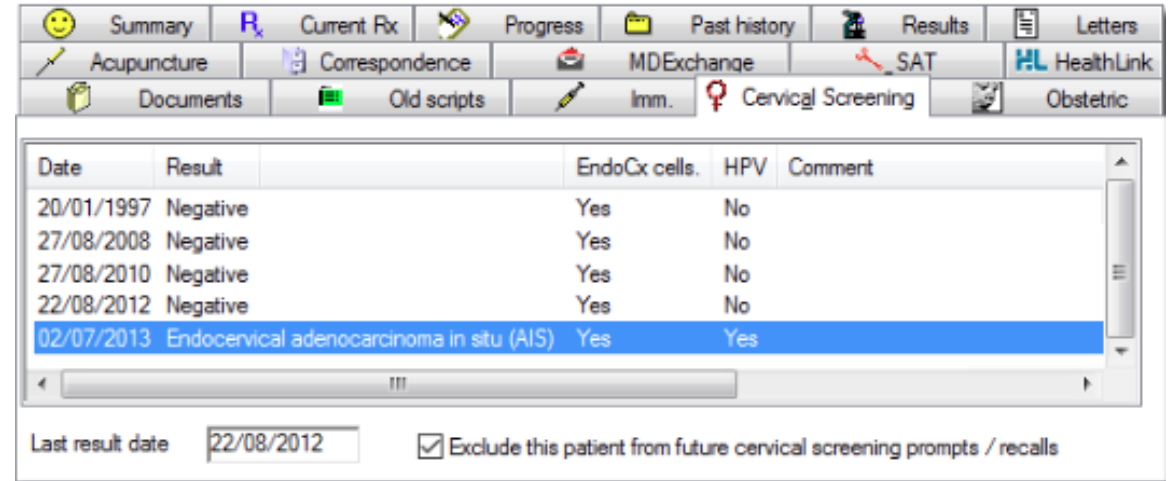
Date	Time	Location	Type	BP	Pulse	Rhyth
22/04/2005	14:31:00	Unspecif...	Sitting	130/90	84	
07/08/2006	11:11:00	Unspecif...	Sitting	130/80	82	
07/12/2006	09:13:00	Unspecif...	Sitting	130/90	82	
29/03/2007	08:31:00	Unspecif...	Sitting	130/90	82	
19/06/2007	11:15:00	Unspecif...	Sitting	130/90		
14/01/2008	08:31:00	Unspecif...	Sitting	130/90		
14/04/2008	08:31:00	Unspecif...	Sitting	120/70		
14/01/2009	08:31:00	Unspecif...	Sitting	141/87	87	
10/06/2009	14:44:38	Unspecif...	Sitting	137/80	75	
20/09/2009	11:42:00	Unspecif...	Sitting	160/99		
01/11/2009	10:49:00	Unspecif...	Sitting	137/90	81	
17/07/2010	11:29:00	Unspecif...	Sitting	130/90		
04/09/2010	10:19:00	Unspecif...	Sitting	110/60	60	
07/10/2010	13:33:00	Unspecif...	Sitting	115/70	68	
11/11/2010	10:24:00	Unspecif...	Sitting	120/70	60	
30/12/2010	09:24:00	Unspecif...	Sitting	110/70		
04/01/2011	17:31:00	Unspecif...	Sitting	120/80	60	
24/02/2011	10:49:00	Unspecif...	Sitting	120/80	60	
24/02/2011	10:51:00	Unspecif...	Sitting	130/85	60	
22/10/2011	13:35:00	Unspecif...	Sitting	120/80	60	
12/07/2012	09:09:00	Unspecif...	Sitting	115/85	60	
18/02/2013	14:12:49	Unspecif...	Sitting	115/		

Clear Record

Print Reference Edit View Save Close

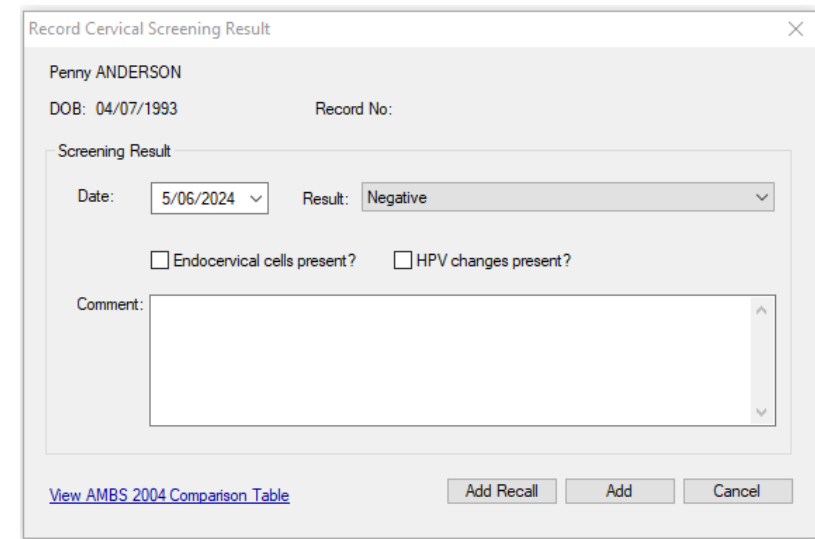
Recording Cervical Screening via the Patient's Record

1. Select the [Cervical Screening tab](#) in the patient's [clinical record](#).
2. Either,
 - Click 
 - Press **F3**
 - Right-click within the list of recorded screens and select **New Item** from the menu that appears
3. The **Record Cervical Screening Result** window appears.
 - Enter the date on which the screen was obtained from the patient.
 - Select a result type from the list provided.
 - Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
 - If you wish to generate a [Recall](#) notification for this patient, click **Add Recall**
4. Click **Add** to confirm and save your data.



Date	Result	EndoCx cells.	HPV	Comment
20/01/1997	Negative	Yes	No	
27/08/2008	Negative	Yes	No	
27/08/2010	Negative	Yes	No	
22/08/2012	Negative	Yes	No	
02/07/2013	Endocervical adenocarcinoma in situ (AIS)	Yes	Yes	

Last result date: Exclude this patient from future cervical screening prompts / recalls



Record Cervical Screening Result

Penny ANDERSON
DOB: 04/07/1993 Record No:

Screening Result

Date: Result:

Endocervical cells present? HPV changes present?

Comment:

[View AMBS 2004 Comparison Table](#)

Recording Cervical Screening via the Holding File

1. Select **Correspondence > Check Holding File** to open the [Holding File](#).
2. From this window select which recipient will request the [Cervical Screening](#).
3. Once within the Holding File, [locate](#) and select the patient for whom you wish to manually record a cervical screening.
4. Then, select **File > Add Cervical Screening Result**. The **Record Cervical Screening Result** window appears.
 - Enter the date on which the screen was obtained from the patient.
 - Select a result type from the list provided.
 - Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
 - If you wish to generate a [Recall](#) notification for this patient, click **Add Recall**
5. Click **Add** to confirm and save your data. The result is added to the [Cervical Screening tab](#) of the patient's record.

The image shows two overlapping windows from a software application. The background window is titled 'Record Cervical Screening Result' and contains the following information:

- Patient Name: Penny ANDERSON
- DOB: 04/07/1993
- Record No: [blank]
- Screening Result: [blank]
- Date: 4/06/2024 (selected from a dropdown)
- Result: Higher Risk (selected from a dropdown)
- Endocervical cells present?
- HPV changes present?
- Comment: [text area]
- Buttons: Add Recall, Add, Cancel
- Link: [View AMBS 2004 Comparison Table](#)

The foreground window is titled 'Check Holding File' and contains a list of recipients:

- Select Recipient(s)
- All Recipients
- Dr A Practitioner (highlighted)
- Adelaide DrAddressee
- Doct Lawrence Peterson
- Dr A Breedon
- Dr Christos Pavlidis
- Dr D J Smith
- Dr E Mantzaris
- Dr James Wright
- Dr Jocelyne Atkinson
- Dr Michael S Conway
- Dr N Smyth
- Dr Pete Hentbert
- Buttons: OK, Close

Recording Cervical Screening via the Clinical Front Screen

1. From the Clinical Front Screen, select **Clinical > Cervical Screen Results > Add Result**. The **Select Patient from List** window appears.
 - Search for and open the patient record you want to add a result for. The Cervical Screening Result summary for the patient will appear.
 - Only female or gender-neutral patients will appear in the list.
3. Click **Add The Record Cervical Screening Result** window appears.
 - Enter the date on which the screen was obtained from the patient.
 - Select a result type from the list provided.
 - Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
 - If you wish to generate a Recall notification for this patient, click **Add Recall**
4. Click **Add** to confirm and save your data.

Cervical Screening Result

Name: Jennifer Andrews D.O.B: 20/04/1970 Age: 47yrs 5mths
Address: 2 Kennedy Road, Bundaberg, Qld 4670 Phone:

Date	Result	EndoCx cells.	HPV	Comment
20/01/1997	Negative	Yes	No	
27/08/2008	Negative	Yes	No	
27/08/2010	Negative	Yes	No	
22/08/2012	Negative	Yes	No	

[Add](#) [Edit](#) [Close](#)

Record Cervical Screening Result

Penny ANDERSON
DOB: 04/07/1993 Record No:

Screening Result

Date: 4/08/2024 Result: Higher Risk

Endocervical cells present? HPV changes present?

Comment:

[View AMBS 2004 Comparison Table](#) [Add Recall](#) [Add](#) [Cancel](#)

National Cancer Screening Register

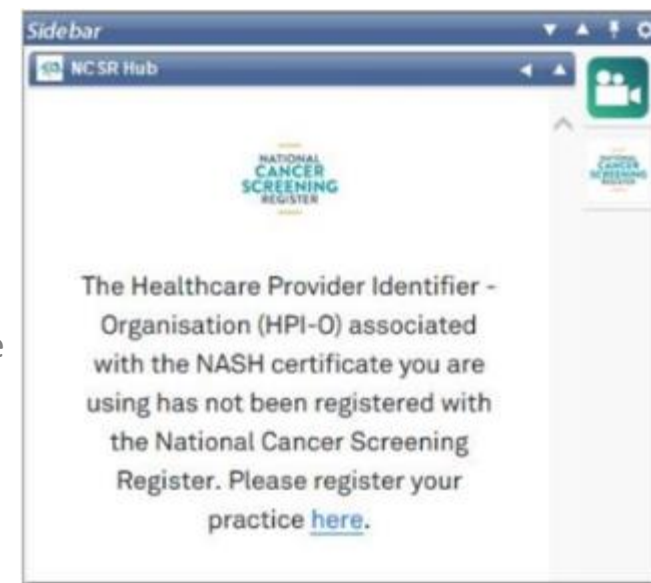
The National Cancer Screening Register enables a single electronic record for each person in Australia participating in cervical and bowel screening. The National Cancer Screening Register plays a vital role in supporting the National Cervical Screening Program (NCSP) and the National Bowel Cancer Screening Program (NBCSP). It gives healthcare providers access to their patients' health information and makes it easier for program participants to take control of their health.

Healthcare providers that have integrated their Clinical Information System with the National Cancer Screening Register, are able to interact directly with the National Cancer Screening Register from their existing software using the NCSR widget.

This enables the user to:

- Open the patient's record and view their test results, summary of the outcome and screening histories;
- View the patient's screening status and alerts;
- View the patient's next screening eligible date;
- Generate cervical screening history report;
- Submit Program forms to the Register – cervical and bowel screening program forms;
- View and update the patient's demographic details;
- Manage the patient's screening participation, including opting out, resuming participation or deferring from either the bowel or cervical screening programs;
- Cease the patient's correspondence for the cervical screening program; and
- Nominate other people to assist your patient (such as a personal representative or another Healthcare Provider).

For further assistance, you can call the contact centre on 1800 627 701. The contact centre operates Monday to Friday, between 8am and 6pm in all Australian state and territory time zones.



National Cancer Screening Register – Bowel & Cervical Screening

1. For registered patients, the widget appears as follows with the NCSR History tab presented by default. This tab contains the patient's history of screening results retained within the National Cancer Screening Register.

The screenshot shows the NCSR Hub interface for a patient named Mrs Eliza Goodwin. The patient's Medicare number is 6995081110 and her date of birth is 15 April 1964. There is a patient alert icon. Below this, a table shows screening status for Bowel and Cervical programs. The 'NCSR History' tab is selected, displaying a list of records with columns for Program, Date, Description, and Outcome. The records include Cervical Screening History, NBCSP - GP Assessment Report, NCSR - Defer Cervical Program, and Correspondence. A search bar and filter options are also visible.

Program	Status	Last Screening	Next Action
Bowel	New to Screening		Due Now (newly enrolled, eligible now)
Cervical	New to Screening		DUE NOW

Program	Date	Description	Outcome
Cervical	31/05/2021	Cervical Screening History	
Bowel	29/07/2020	NBCSP - GP Assessment Report	Not Referred For Colonoscopy
Cervical	29/07/2020	NCSR - Defer Cervical Program	
Correspondence	20/04/2020	Correspondence	

2. Switch to the **Choose Form & Report** tab to select a form/report to submit.

The screenshot shows the NCSR Hub interface for the same patient, Mrs Eliza Goodwin. The 'Choose Form & Report' tab is selected, displaying a list of available forms and reports with columns for Program and Description. The forms include NBCSP - Alternative Access Model, NBCSP - Defer Bowel Program, NBCSP - Opt Out Bowel Program, NBCSP - Replacement FOBT Kit Request, NBCSP - Adverse Events Report, NBCSP - Replacement Participant Details Form Request, NBCSP - Histopathology Form, NBCSP - Colonoscopy Report, NBCSP - GP Assessment Report, and NCSR - Cervical Program Correspondence Preference. A search bar and filter options are also visible.

Program	Status	Last Screening	Next Action
Bowel	New to Screening		Due Now (newly enrolled, eligible now)
Cervical	Actively Screening	25/03/2021	DUE

Program	Description
Bowel	NBCSP - Alternative Access Model (Issue/Re-issue Kit)
Bowel	NBCSP - Defer Bowel Program
Bowel	NBCSP - Opt Out Bowel Program
Bowel	NBCSP - Replacement FOBT Kit Request
Bowel	NBCSP - Adverse Events Report
Bowel	NBCSP - Replacement Participant Details Form Request
Bowel	NBCSP - Histopathology Form
Bowel	NBCSP - Colonoscopy Report
Bowel	NBCSP - GP Assessment Report
Cervical	NCSR - Cervical Program Correspondence Preference

National Cancer Screening Register – Bowel & Cervical Screening

3. Complete and submit the form.

NCSR Hub -- Webpage Dialog

Bowel - NBCSP - Colonoscopy Report

GOODWIN, Mrs Eliza (Female)

Date of Birth	Age	Medicare Number	Address
15 April 1964	57	6995081110	110, Bundaberg

Australian Government

NATIONAL CANCER SCREENING REGISTER

Patient details/ Referring GP Sedation Colonoscopy

Patient Details

Does the patient identify as Aboriginal or Torres Strait Islander origin? (If known)

- Aboriginal
- Torres Strait Islander
- Aboriginal and Torres Strait Islander
- Non Indigenous
- Prefer not to answer

What is the patient's Country of Origin? (if known)

What is the patient's preferred language spoken at home? (If known)

Was this a public or private patient?

- Private patient
- Public patient

Referring general practitioner

Doctor's Provider number lookup

Or tick here to manually enter provider details

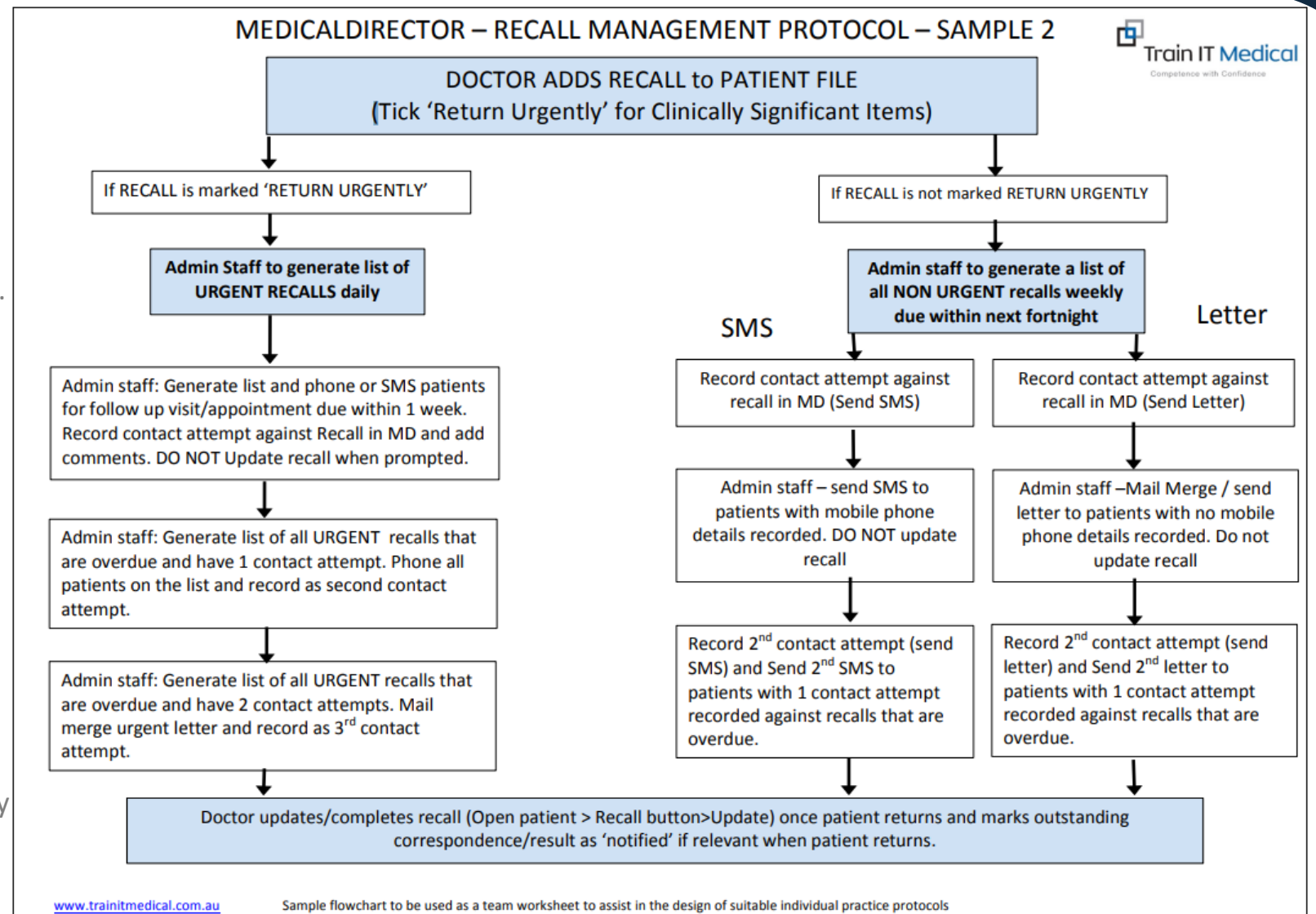
[Submit Form](#)

Managing Recalls – Sample workflow by Katrina Otto

A Recall is a patient's reminder notice to inform the patient that they are due to return to the Practice (usually so that some clinical procedure can be performed).

The Search Recalls module allows you to;

- Determine which patients are to be recalled i.e. those with current Recalls.
- Indicate that the results should include completed and/or deleted Recalls.
- Determine which patients you have already attempted to contact regarding their Recall(s).
- Record notes against Recalls. See Recall Actions for more information about these notes.
- Save your favourite Recall notification search lists.
- Print labels or conduct a mail merge for contacting patients.
- Send e-mail Recall notifications.
- Send SMS Recall notifications.
- Mark recalls as being completed, and optionally update recurring recalls.



Managing Recalls – via the Search > Recall window

A Recall is a patient's reminder notice to inform the patient that they are due to return to the Practice (usually so that some clinical procedure can be performed).

The Search Recalls module allows you to;

- Determine which patients are to be recalled i.e. those with current Recalls.
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- Save your favourite Recall notification search lists.
- Print labels or conduct a mail merge for contacting patients.
- Send e-mail Recall notifications.
- Send SMS Recall notifications.
- Mark recalls as being completed, and optionally update recurring recalls.

The screenshot shows the 'Recall Search Criteria' window with the following sections:

- Recall Reasons: 3 of 19 selected**
 - Show only reasons from active recalls
 - All Reasons
 - Selected reasons list:
 - BLOOD PRESSURE REVIEW
 - BLOOD TEST
 - DIABETES REVIEW
 - GENERAL CHECK-UP
 - GENERAL CHECKUP
 - IMMUNISATION
 - IMMUNISATION - 10 YEAR
 - IMMUNISATION - 12 MONTH
 - IMMUNISATION - 18 MONTH
 - IMMUNISATION - 2 YEAR
 - IMMUNISATION - 4 MONTH
 - IMMUNISATION - 4 YEAR
 - IMMUNISATION - 6 MONTH
- Assigned To: All Users**
 - Show only users with active recalls
 - All Users Show 'Unknown' User
 - User list table:

Name	Status
Dr A Practitioner	Active
Registered Nurse	Active
- Include inactive patients

Status

- Include deleted recalls Include completed recalls

Patient Contact

- Attempted to contact patient at least [dropdown]
- Only show patients that have attended in response to a recall

Date Range

All [dropdown] Start: [calendar] End: [calendar]

Saved Searches

Default Search	Search Name
<input checked="" type="checkbox"/>	My search criteria
<input type="checkbox"/>	Blood tests
<input type="checkbox"/>	Diabetes review for Dr A Practitioner

Buttons: Load, Save, Rename, Delete, Search, Cancel

Managing Recalls - via the Search > Recalls window

Conducting a Search for Recalls

1. From the Clinical main screen, select **Search > Recall**.
2. MedicalDirector Clinical's list of Recalls opens, and you are automatically prompted to select criteria for conducting a search of upcoming recalls, using the **Recall Search Criteria** window. See the table below for information on key features of this window.
3. Enter the criteria you wish to search for. Click **Search** button when you are ready to conduct the search.
4. The Search Recalls list becomes populated with your search results. Consult the [table below](#) for features of this window.

Show only reasons from active recalls	Tick this check box to filter the Recall Reasons list to display only reasons associated with active recalls. An 'active' recall is one that is neither completed, nor deleted. Note that enabling this check box has no impact on the search results themselves, but is provided here only for the convenience of filtering the selection list.
Attempted to contact patient at least...	When recording an Action against a Recall , you can indicate that the Action was an attempt to contact the patient about their Recall. You can instruct the Recall search module to show only those Recalls where [x] attempts to contact the patient have been made.
Only show patients that have attended...	For use at sites that run MedicalDirector Pracsoft in conjunction with Clinical. MedicalDirector Pracsoft provides a facility for indicating that a patient is returning to your practice in response to a specific Recall. By ticking this associated check box, you can instruct the Recall search module to show only those patients that have been flagged in this way.
Date Range	Allows you to specify when the recalls are due. Note that this date is not when the Recalls were created.
Saved Searches	Your search criteria can be saved. See Saving Recall Searches for more information.
Include Inactive Patients	Allows you to search for patients flagged as inactive .

Managing Recalls - via the Search > Recalls window > Upper Section

Upper Section

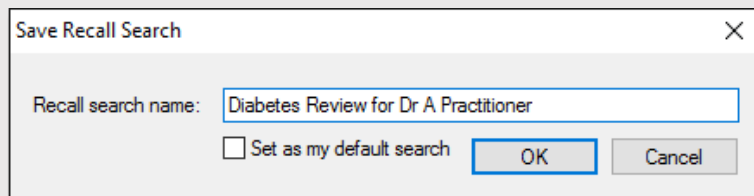
The upper section of this window displays all the Recalls that match your search criteria.

- Black entries are active (current) Recalls
- Grey entries are deleted Recalls
- Blue entries are completed Recalls

Select All / Select None

Search

Search > Save Current Search Criteria



Save Recall Search

Recall search name:

Set as my default search

OK Cancel

Refresh

Add Recall

Add Recall > Delete Recall

Open Patient

A toggle button for selecting all records, or none.

Click to call the search criteria window.

Allows you to save the criteria used to conduct the search. You will be prompted to name the search. Afterwards, this search will be available from the 'Saved Searches' section of the **Recall Search Criteria** window. See [Saving Recall Searches](#) for more information.

Refreshes the window with the latest data.

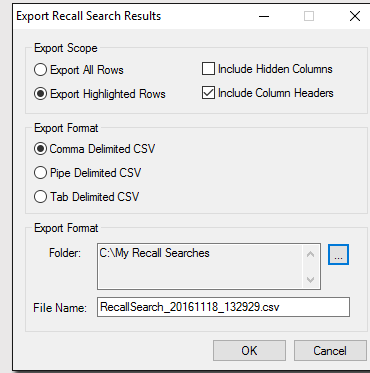
Select a patient from the list of search results, and then click this button to [record a new Recall](#) for the patient.

Deletes the selected Recall.

Opens the record of the selected patient.

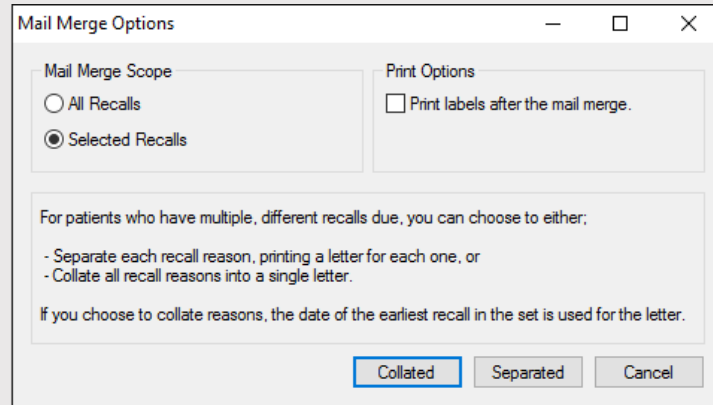
Managing Recalls - via the Search > Recalls window > Upper Section

Export



Allows you to export the list of search results.

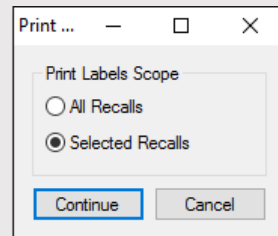
Mail Merge



Allows you to [bulk-print a letter](#) for the selected records. See also [Labels](#).


After conducting a mail merge, you will be prompted to [update](#) (complete) the recalls.

Mail Merge > Print Labels



Allows you to bulk-print address [labels](#) for the selected records. See also [Labels](#).

Managing Recalls - via the Search > Recalls window > Upper Section

Print List	Prints the list of selected recalls to the printer you have selected as your Letter Writer printer . After printing the list, you will be prompted to update (complete) the recalls.
Print List > Print List To	Print the list of selected recalls (allows you to select a printer first). After printing the list, you will be prompted to update (complete) the recalls.
Update	Allows you to update (mark as 'complete') any selected recalls. See Completing (Updating) Recalls .
Send SMS	<p>Allows you to send an SMS reminder to the selected patients, regarding their selected Recalls i.e. if a given patient has three Recalls upcoming, they will receive three SMS messages - one for each Recall. SMS messages sent from the Search Recalls window will use the 'Recall' SMS template.</p> <p>After sending an SMS, you will be prompted to update (complete) the recalls.</p>
Clear Filters	Clears all filters you have applied to the search results. If you wish to clear an individual filter, click the Remove Filter button, located within each filter window (accessed by clicking ).
Reset Window Settings	Resets the layout of this window to its defaults.

Managing Recalls - via the Search > Recalls window > Lower Section

Lower Section

The lower section (known as the Actions Pane) is split into two panels;

- The lower left-hand panel lists all the [Actions taken](#) upon the Recall selected in the upper section. In the example above we have selected a Recall for Carolina Schein in the upper section, and in the Actions Pane we can see the three Actions that have been performed against that particular Recall.
- The lower right-hand panel (known as the Details Panel) displays the basic demographics of the selected patient.

Action Taken	Displays the type of Action recorded against the Recall selected in the search results.
Date Performed	The date on which the associated Action was recorded.
Performed By	The user that recorded the associated Action.
Contact Attempt	Whether the selected action was an attempt to contact the patient.
Comments	Any comments recorded against the Action performed. Comments can be made about a Recall Action at the time you add one.
Date Deleted	The date on which a given Action was deleted.
Deleted By	The user that deleted the Action.
Print	Prints the Actions performed against a selected Recall to the printer you have selected as your Letter Writer printer .
Print > Print To...	Prints the Actions performed against a selected Recall. Allows you to select the printer to print to.

Managing Recalls - via the Search > Recalls window > Lower Section

Add

Allows you to [record a new Recall Action](#) for the selected Recall.

Edit

Allows you to edit a selected Action.

Delete

Deletes the selected Action.

Show Deleted / Hide Deleted

A toggle to show/hide deleted actions.

Hide Actions Pane

A toggle button for hiding/showing the Actions Pane. This button is only available if the lower half of this window is visible. See 'Hide Details' in this table for more information.

Hide Details Panel

A toggle button for hiding/showing the Details Panel located in the right-hand section of the Actions Pane.

Close

Closes the Search Recalls module

Managing Recalls - via the Patient's Record

- Select **Clinical > Recall**. The **Recall Items** window appears.
 - The upper section of this window lists the patient's recalls.
 - The lower section lists any recalls actions you have recorded against each of the recalls in the upper section i.e. each recall can have multiple actions recorded against it.
- Select one of the available recalls in the upper section to manage actions for.
- (optional) If the selected recall has had actions applied to it which were subsequently deleted, you can reveal these now by clicking the **Show Deleted** button. If this button is not available, it is because there are no deleted actions to reveal.
- Then to;
 - Add** a new action, click **Add**. Continue now to Step 5.
 - Edit** an existing action, select it from those available, and then click **Edit**. The **Edit Recall Action** window appears. Continue now to Step 6.
 - Delete** an existing action, select it from those available, and then click **Delete**. You will be prompted to confirm this. Note that this cannot be reversed.
- The **Add Recall Action** window appears.
- Indicate who performed the Recall Action via the associated drop-down list. Optionally, you can elect to include inactive/deleted [practitioners/users](#) in this list.
- Indicate the type of action performed. This list of hard-coded actions includes:

Consultation Other Send Email Send Fax Send Letter
Send SMS Telephone Business Telephone Home Telephone Mobile

Recall Items

Range: All End Date: 31/12/9998 Include completed and deleted recalls

Add Edit Update Delete Print List Progress Notes

Recall Reason	Due Date	Date Added	Last Action Date	Last Action By	Last Action	Once Only	Priority	Attended	Date
DIABETES REVIEW	18/02/2014	18/02/2013 2:17...	21/11/2016	Dr A Practitioner	Send Letter				
GENERAL CHECKUP	18/07/2013	18/02/2013 2:07...	18/02/2013	Dr A Practitioner	Audit	Yes			
GENERAL CHECKUP	13/02/2012	13/02/2012 2:21...	13/02/2012	Dr A Practitioner	Audit	Yes			
BLOOD PRESSURE REVIEW	12/02/2000	9/03/2004 9:00...	18/02/2013	Dr A Practitioner	Audit				18/02/2013

< >

Action Taken	Date Performed	Performed By	Contact Attempt	Comments	Date Deleted	Deleted By
Audit	18/02/2013	Dr A Practitioner	No	New recall: DIABETES REVIEW, 18/02/2014		
Send Letter	21/11/2016	Dr A Practitioner	No		21/11/2016 12:3...	Dr A Practitioner
Send Letter	21/11/2016	Dr A Practitioner	Yes			

Add Edit Delete Hide Deleted Print Close

Add Recall Action

Show inactive and deleted users

Performed By: Dr A Practitioner

Action Taken: Consultation

Date Performed: 21/11/2016

Comments:

Record this as a contact attempt

Save Cancel

- Enter the date on which the Action was performed.
- (Optional) Record a comment if desired.
- (Optional) Indicate whether you also wish this action to be recorded as an attempt to contact the patient.
- Click **Save** to save the action to the patient's recall item.

About Actions (Recall vs. Outstanding)

Recall Actions

A Recall Action is a note recorded about a Recall that typically relates to correspondence / contact regarding a Recall.

For example, if you had sent a printed Recall reminder letter to a patient, and then followed-up that letter with a phone call, you may wish to record the fact that you made the phone call. This action can be recorded against the Recall within the patient's record. A single Recall can have an unlimited number of Recall Actions recorded against it.

A Recall Action is not to be confused with an Outstanding Action (see below).

See also [Actions \(Recall\)](#)

Outstanding Actions

An Outstanding Action is a practitioner's reminder notice about a specific patient, that appears on-screen upon opening their record. You can configure Clinical to present you with a pop-up list of Outstanding Actions for a specific patient. Alternatively, you can view a list of all Outstanding Actions for all patients, and then filter that list by practitioner or by type of Action.

Outstanding Actions are designed to remind the practitioner to perform one or more clinical actions for the patient, but can be used to record any reminder notice about the patient you desire.

An Outstanding Action is not to be confused with a Recall Action (see above).

See also [Adding Outstanding Actions](#)

Generating a Recall in Insights

The following steps show how you might generate a recall for patients. In this example we are going to generate a recall for an Asthma Review for those patients who have an active condition of Asthma.

1. Select **Conditions > Respiratory Prevalence**.
2. In our example, we want to see only those patients with an active condition of 'Asthma', so we select (click) the associate column in the visualisation.
 - When you select one or more regions in this way, your selection is shown at left (i.e. "1 region selected), and you are presented with a **View** button. The list of associated patients appears.

The screenshot displays the MedicalDirector Insights interface. The top navigation bar includes 'Collection', 'Demographics', 'SNAP', 'Measures', 'Conditions', 'Medications', and 'Reporting'. The 'Conditions' dropdown menu is open, showing 'Respiratory Prevalence' selected. The main area shows a bar chart titled 'Respiratory conditions prevalence as a percentage of regular active patients' with a total filter population of 15. The chart compares 'Ever had condition' (blue bars) and 'Active condition' (green bars) for Asthma, COPD, and Other Respiratory. The 'Active condition' bar for Asthma is highlighted. A 'MedicalDirector Insights Patient Export' dialog is open, showing 'Export Patient Count' as 4 of 15 and 'Export Data Criteria' as Asthma Active condition. The patient list table is shown below.

Name	Gender	DOB
ANDERSON, David	M	4/01/1955
ANDREWS, Fred	M	23/02/1923
ANDREWS, John	M	17/06/1968
WATLAND, Henry	M	29/02/1972

Generating a Recall in Insights

Note also that you can access such lists of patients via the supplied [Reports](#):

4. Click Add Recall button You are presented with the Recall details for you to configure.
 - Indicate the Practitioner the Recall is being created on behalf of.
 - Indicate the reason for the Recall. In our example, we have selected 'Asthma Review'. If you select a reason from the list, its schedule settings are loaded for you automatically. You can modify these if you wish, and such modifications will not affect the reason definition, nor will they affect any Recalls already saved.
 - Indicate whether this is a once-only Recall, or a recurring Recall. For recurring Recalls, you must also indicate the interval between Recall visits.
 - For once-off Recalls, this is the date on which you wish the patient to return to the practice.
 - For recurring recalls, this is the date on which you wish the first return visit to occur.
 - Indicate the Recall due date.
5. Click Add Recall button. You will be prompted to confirm this action.
6. Click Yes button to confirm. The recalls are added to Clinical. See [Recalls](#) for detailed information.

Asthma (AST) Measures

	Total		Aboriginal and Torres Strait Islander		Non-Aboriginal and Torres Strait Islander		Aboriginal and Torres Strait Islander Status Unknown	
	Number	Proportion	Number	Proportion	Number	Proportion	Number	Proportion
Asthma Register								
<i>Number of clients that are coded with a diagnosis matching the Asthma definition</i>								
clients on register	7	100.0%	0	0.0%	5	71.4%	2	28.6%

MedicalDirector Insights Patient Export
Preview from visualisation: 'Respiratory conditions prevalence as a percentage of regular active patients'

Export Patient Count
4 of 15

Export Data Criteria
Asthma Active condition

Assign To
Dr A Practitioner

Due Date
12/12/2017

Return urgently
 Once only Recall

Recall Interval
3 Months

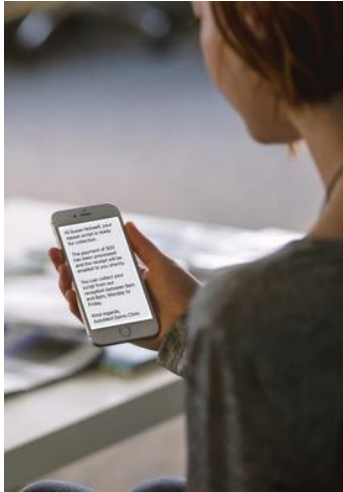
Reason
ANNUAL HEALTH ASSESSMENT
ASTHMA REVIEW
BLOOD PRESSURE REVIEW
CHOLESTEROL REVIEW
COLONOSCOPY
DEPO RALOVERA
DIABETES REVIEW
FULL MEDICAL CHECK-UP
GARDASIL DOSE 2
GARDASIL DOSE 3
GENERAL CHECK-UP
GLUCOSE
IMPLANON REPLACEMENT

Add Recall
Are you sure you want to add recall to 4 patients?

Recall & Reminders via Smart Marketplace Partner – AutoMed Systems



AutoMed Systems



AutoMed Clinical Reminder Service (Recalls)

AutoMed can create a Rule per Reminder Reason.

Optionally add a catch all Rule that will send for ALL Reminder Reasons, including new ones going forward – Nothing Gets Missed.

The doctor adds the recall to the patients file with the Reason and Due Date

AutoMed automatically sends patients an SMS, a set number of days before it is due.

Select whether to send plain or secure SMS and enter a specific message per reminder type.

Choose which reminders should send, when they should be sent and what they should say.

Set it up once and it runs automatically, no manual allocation of templates required.

Automatic 2nd Discuss SMS if patient has not booked an appointment within the required number of days.

Automatically creates mail merges, with bulk export function, for patients who can't be contacted by SMS, Opted Out, or have not attended after all contact attempts.

Optional ad-hoc 3rd SMS or restart Message Cycle per recall.

All contact attempts and correspondence saved to the patient's record.

AutoMed provides one on one Online Staff Training sessions using Clinics own data.

An Advanced Reporting feature provides real-time interactive snapshots, directly from PracSoft of all Recalls & Results, their status, contact attempts, Assoc practitioners and contact notes.

Clinical Reminders

+ Add Clinical Reminder

	Name	Description	Recall Days	Template	Submit Hours	Delete
	12mth Immunisation	12mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	<input type="checkbox"/>
	2mth Immunisation	2mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	<input type="checkbox"/>
	4-5y Immunisation	4-5y Immunisation	1	CR - Childhood Imms	Between 8 & 19	<input type="checkbox"/>
	4mth Immunisation	4mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	<input type="checkbox"/>
	6mth Immunisation	6mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	<input type="checkbox"/>
	ADF Post Discharge GP Health Assessment	Do not send	-1	Custom Message	Between 8 & 19	<input type="checkbox"/>
	Asthma review	Asthma review	7	CR - Default with Tag	Between 8 & 19	<input type="checkbox"/>
	BP Check	BP Check	7	CR - Default with Tag	Between 8 & 19	<input type="checkbox"/>
	Breast check	Breast check	7	CR - Default with Tag	Between 8 & 19	<input type="checkbox"/>
	Care plan	Care plan	1	CR - Care Plan	Between 8 & 19	<input type="checkbox"/>

AutoMed Services Overview

BENEFITS

Save time, and money outbound call costs and create revenue from Recall appointments.

AutoMed Recalls ensures that you contact all patients for upcoming reminders with specific content and rules t match, keeping your practice complaint and accreditation ready.

Recall & Reminders via Smart Marketplace Partner – Automated Systems



AutoMed Systems



AutoMed Results Service (Callbacks)

AutoMed's unique, sophisticated results messaging system automatically sends specified messages to your patients when the practitioners have reviewed correspondence or investigations and marked them as No Action, Discuss or Urgent Appointment

Messaging runs every hour during business hours.

Configurations available to include / exclude certain action types.

Ultimately the system aims to send a single message to the patient, for the highest assigned action, for a batch of results.

If your preference is that the patient receive individual messages per pathology or radiology provider, this can be configured.

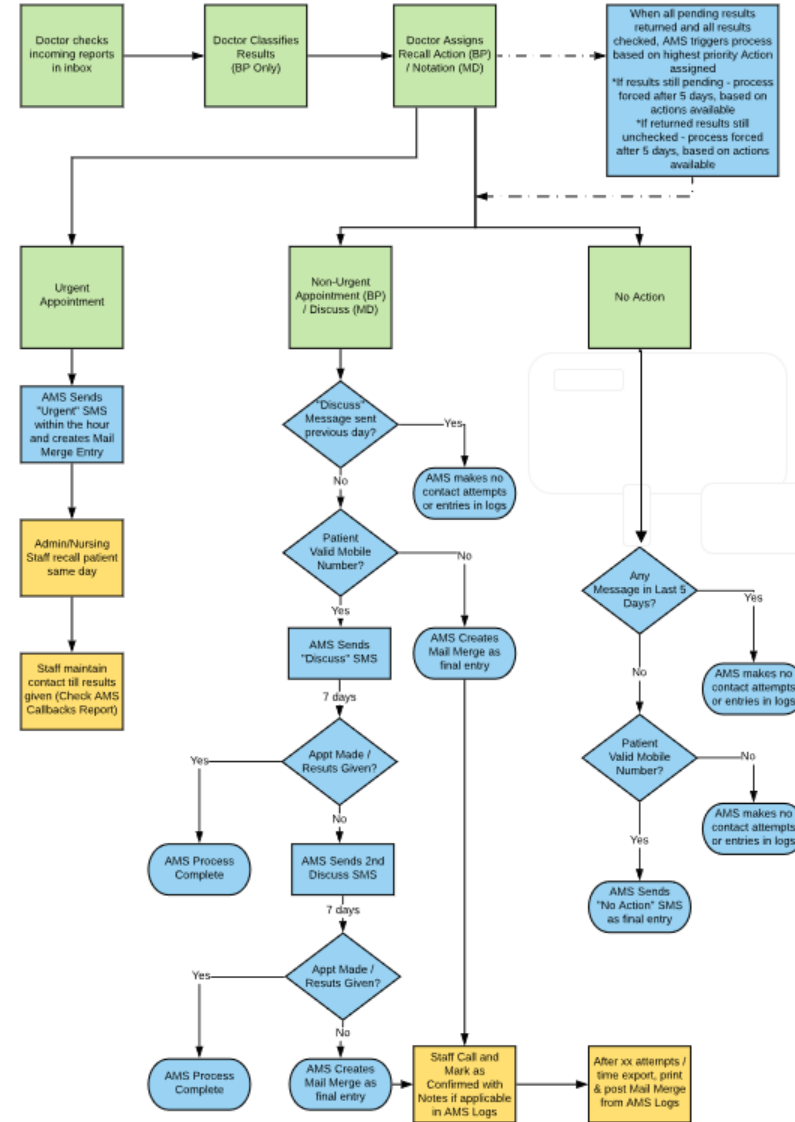
SMS can be set to insert the Doctors Comment associated with the Result to personalise the communication.

Automatic 2nd message if patient has not booked an appointment within the required number of days.

Automatically creates mail merges, with bulk export function, for patients who can't be contacted by SMS or have not attended after all contact attempts.

Comprehensive message logs All contact attempts and correspondence saved to patient's record.

The Advanced Reporting feature within AutoMed provides a real-time snapshot of all results, their current status, as well as past and upcoming appointments to provide the most comprehensive display of data integrated between AMS and PracSoft.



[AutoMed Services Brochure](#)

BENEFITS

Save Staff time and costs by reducing calls to reception regarding Results by up to 95% by keeping your patients informed as to their results and the action required.

AutoMed delivers and receives all SMS' via a Tier 1 Enterprise Message Gateway Unlimited SMS 160 -900 characters if required.

Recall & Reminders via Smart Marketplace Partner - Healthengine



Patient Recalls & Clinical Reminders with Healthengine

Automate your clinical reminders and recalls with ease

Free up valuable time across your team with quick, easy and automated patient recalls via SMS, letters or phone calls. The choice is yours. Experience the convenience of Healthengine's new and improved Recalls, tailor-made to elevate your practice efficiency.

Recalls for your practice, your way

Healthengine's Recalls puts the control in your hands for both clinical reminders and recalls. Easily set your parameters based on the needs of your patients and your own practice preferences. Choose your sequencing (e.g. two SMS sends, followed by a letter), the type of recall or clinical reminder (e.g. urgent result), specify your contact timeframes and away you go.

Reduced workload, reduced expenses

Recalls is a flexible solution, tailor made and setup for each individual practice on Healthengine. This allows you to choose the level of automation versus manual input, letting your team rapidly process recalls and clinical reminders at both pace and scale. Now you can give valuable time back to your team, allowing you to focus on providing an exceptional experience for patients.



What's new for Recalls

- PMS locations can be viewed for each patient recall
- Add patients to your block list for SMS messages
- We've reduced unnecessary notes sent to your PMS

Recalls experience in action practice efficiency

The benefits of Recalls with Healthengine:

- Unlimited SMS recalls and clinical reminders included for practices on **GP Complete**
- Free up staff time across the team by automating your recalls and clinical reminders process
- Choose, customise and edit your level of automation versus manual input
- Set your own parameters for clinical reminders, urgent and non-urgent recalls
- Choose how and when recalls and clinical reminders are sent (via SMS, letter, phone call)
- Save costs on printing and stationery with our SMS and phone call recall options
- Secure three-step ID verification for patients when receiving recalls
- Audit notes are logged automatically in your PMS for a complete audit history



Recall & Reminders via Smart Marketplace Partner - HotDoc



HotDoc

HotDoc Clinical Reminders (Recalls)

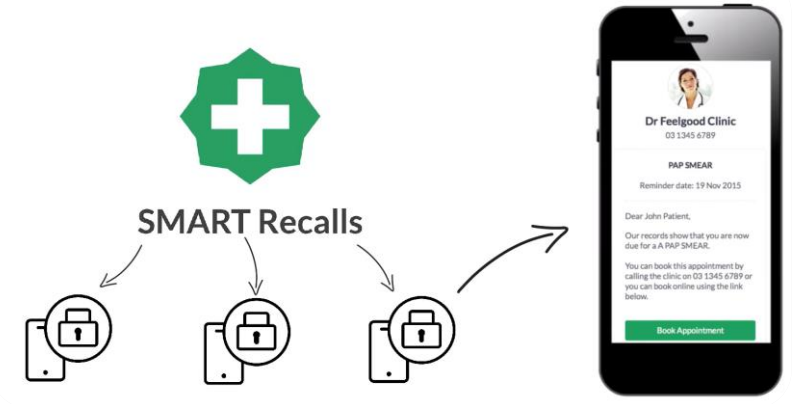
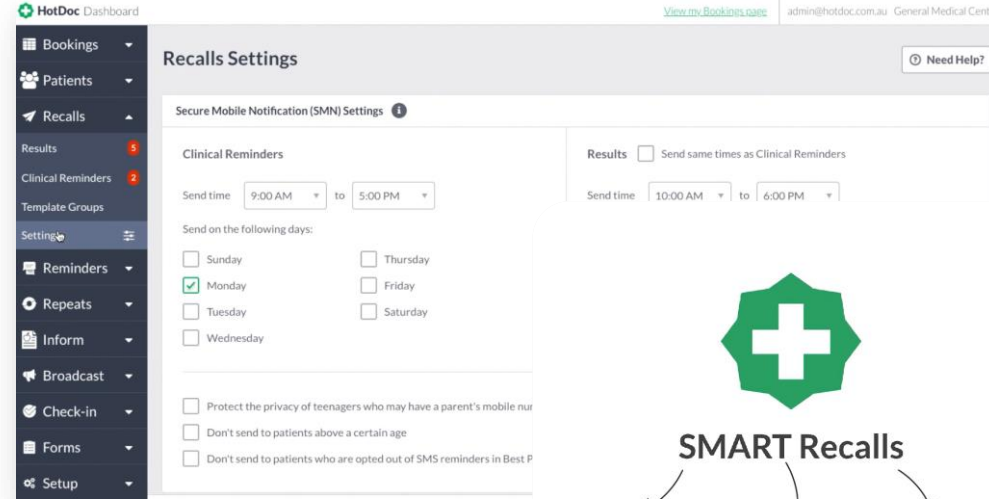
HotDoc Recalls is a system that handles both Results and Clinical Reminders and allows you to securely send SMN messages and push notifications to patients if they have an upcoming recall in their patient file.

How does it work?

1. A doctor adds a recall into a patient's record, this is usually entered with a **recall reason** and a **due date**.
2. If the recall is unresolved and has a due date within the syncing window HotDoc will bring it into the **dashboard**.
3. Once HotDoc has synced a clinical reminder into the Dashboard, it will **automatically send out** a push notification or SMN depending on whether the recall has been attached to an applicable template.

HotDoc syncs and displays the following as part of the recall:

- Patient name
- Recall Reason (as outlined in the patient record)
- Due date
- Mobile number
- Date of Birth
- Doctor performed ([if linked correctly](#))
- Patient's next appointment date



Want to learn more?

[Demo with HotDoc](#)
[HotDoc Clinics Reminders overview](#)
[How to set up recalls and clinical reminders](#)

PLUS

HotDoc users get access to the online [Academy](#) Training platform and regular [Live Training Sessions](#) to learn or refresh their recalls knowledge.

Recording Social and Family History

Data recorded here is available to the Letter Writer where it can be merged into letters and e-mail correspondence. Family History and Social History data will also appear on the [Summary](#) tab.

Item	Criteria
ADF Service	<p>Indicate the patient's service (if any) with the Australian Defence Force.</p> <p>A patient's service status;</p> <ul style="list-style-type: none">•Is displayed within the Occupation field located towards the top of the Clinical Window.•May affect whether you are prompted to perform an assessment for them upon opening their clinical record.
Update Address for All Family Members check box	Update the address details for other family members, with the details of the current patient. Clinical uses the Head of Family. setting to determine which patients are members of the same family. This option is only available when editing Patient Details from the Clinical Window .
Auto-Capitalise Names check box	Tick the Auto-Capitalise Names check box to automatically capitalise the first letter of each word you type. There are numerous windows throughout MedicalDirector Clinical that offer this functionality, including the various Options tabs.

Patient Details

Pt. Details Allergies/Adverse Reactions/Warnings Family/Social Hx Notes Smoking Alcohol Personal Details

Relationship Status: Single
Sexuality: Unknown
Occupation: Retired
ADF Service:

Family History:
Parents died due to car crash.
Brother died to a heart attack

Social History:

Ctrl + D Patient > Details

Update address for all family members
 Auto-capitalise names

Save Cancel

Recording Alcohol

The AUDIT-C assessment can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10-question AUDIT instrument. The AUDIT-C is scored on a scale of 0–12. Each AUDIT-C question has five answer choices. Points allocated are:

a = 0 points b = 1 point c = 2 points d = 3 points e = 4 points

- In men a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- In women a score of 3 or more is considered positive (same as above).

The recording of data on this tab is for your records only; it plays no part in the functioning of other modules within Clinical, except for the [Letter Writer](#) where some of this information can be merged into letters.

- Click **View Alcohol Guidelines** to open a window of [information on alcohol consumption](#).
- Click **Reference** to open the World Health Organisation's web page '[Screening and brief intervention for alcohol problems in primary health care](#)'.
- Click **New Assessment** to record a new assessment. This clears data from the window, ready for your new assessment. Once you completed the assessment, click **Save** to save the data. A new entry will be added to the list of assessments, located at the top-right of this window.
 - A note is also added to the patient's [Progress Notes](#).
 - Information you save here is reflected in the patient's [Health Assessment](#), and [ATSI Health Assessment](#) (for eligible patients).
 - The latest assessment is always displayed by default when you access the Alcohol tab.
- To view a previous assessment, locate and double-click a previous assessment from the list at the top-right of this window.
- Click **Delete** to delete a previous assessment.
- Update Address for All Family Members** check box: Update the address details for other family members with the details of the current patient. Clinical uses the Head of Family setting to determine which patients are members of the same family. This option is only available when editing Patient Details from the [Clinical Window](#).
- Auto-Capitalise Names** check box: Tick the **Auto-Capitalise Names** check box to automatically capitalise the first letter of each word you type. There are numerous windows throughout MedicalDirector Clinical that offer this functionality, including the various [Options](#) tabs.

Patient Details

Pt. Details Allergies/Adverse Reactions/Warnings Family/Social Hx Notes Smoking Alcohol Personal Details

Date of assessment: 18/02/2013

Date	Time	Score	Concerns	Comments
18/02/2013	00:00:00	3	No	No

Audit-C Assessment

1. How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times a month
 2-3 times a week 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

1 or 2 3 or 4 5 or 6
 7 to 9 10 or more

3. How often do you have six or more drinks on one occasion?

Never Less than monthly Monthly
 Weekly Daily or almost daily

Audit-C Total Score: 3

In men a score of 4 or more and in women a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. The guidelines to reduce health risks from drinking alcohol provide further assessment and treatment options.

Patient concerned about drinking?

Yes No Don't know

[View Alcohol Guidelines](#) [Reference](#) [New Assessment](#)

Currently displaying data from assessment performed on 18/02/2013. Click 'New Assessment' to conduct a new assessment.

Ctrl + D **Patient > Details**

Update address for all family members
 Auto-capitalise names

[Save](#) [Cancel](#)

Recording Smoking

The recording of data on this tab is for your records only; it plays no part in the functioning of other modules within Clinical, apart from the [Letter Writer](#) where this information can be merged into letters.

Click **View Patient Education Leaflet** to open a pre-selected PDF leaflet entitled 'Smoking - Quitting'. This leaflet is one of many [Patient Education](#) leaflets available.

Smoking cessation intervention discussed with patient check box: Ticking this box flags patients for the Smoking Cessation report found in MedicalDirector [Insights](#).

Update Address for All Family Members check box: Update the address details for other family members, with the details of the current patient. Clinical uses the Head of Family. setting to determine which patients are members of the same family. This option is only available when editing Patient Details from the [Clinical Window](#).

Tick the **Auto-Capitalise Names** check box to automatically capitalise the first letter of each word you type. There are numerous windows throughout MedicalDirector Clinical that offer this functionality, including the various [Options](#) tabs.

Patient Details

Pt. Details Allergies/Adverse Reactions/Warnings Family/Social Hx Notes Smoking Alcohol Personal Details

Date of assessment: 18/02/2013

Smoker: Smoker

Frequency: Daily

Number of cigarettes: 5

Year commenced: 1980 Duration: 44yrs

Stage of change assessment:

Last quit attempt: 06/06/2024 Never/Unknown

Duration of longest period of abstinence:

Smoking cessation intervention discussed with patient

Date	Time	Smoker	Number of Cigarettes
18/02/2013	00:00:00	Smoker	5 Daily

Comments:

View Patient Education Leaflet Reference New Assessment

Currently displaying data from assessment performed on 18/02/2013. Click 'New Assessment' to conduct a new assessment.

Update address for all family members

Auto-capitalise names

Save Cancel

Keeping Past History items relevant

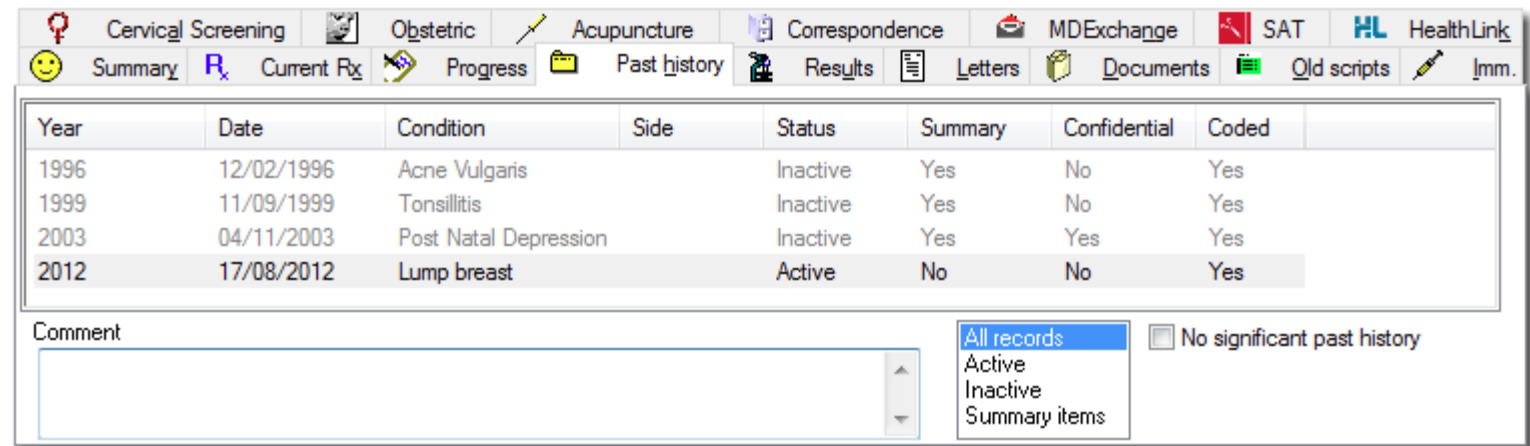
The Past History tab displays a summary of the patient's [medical history](#). This is not to be confused with a patient's clinical progress, as [recorded](#) via [Progress Notes](#).

Coded: Indicates if the diagnosis was made by selecting from the DOCLE list of diagnosis.

Comment: Displays comments relating to a given past history entry. This window is read-only.

Types of History Records: Filter the past history records by All Records, Active, Inactive (displayed in grey), or Summary

No Significant Past History: If the patient has no significant clinical history to make a note of, indicate this by ticking this check box. A prompt to remind you to check this status with your patient is managed from within [Prompt/Preventive Health Options](#). To view a percentage of patients who have not been asked about their past history status, see [Clinical Data Statistics](#). You can also print a list of patients from this search utility.






The screenshot shows a software interface with a 'Past history' tab selected. The interface includes a toolbar with various icons and a table of past history records. The table has columns for Year, Date, Condition, Side, Status, Summary, Confidential, and Coded. Below the table is a 'Comment' field and a filter dropdown menu. The filter dropdown is currently set to 'All records' and includes options for 'Active', 'Inactive', and 'Summary items'. There is also a checkbox for 'No significant past history'.

Year	Date	Condition	Side	Status	Summary	Confidential	Coded
1996	12/02/1996	Acne Vulgaris		Inactive	Yes	No	Yes
1999	11/09/1999	Tonsillitis		Inactive	Yes	No	Yes
2003	04/11/2003	Post Natal Depression		Inactive	Yes	Yes	Yes
2012	17/08/2012	Lump breast		Active	No	No	Yes

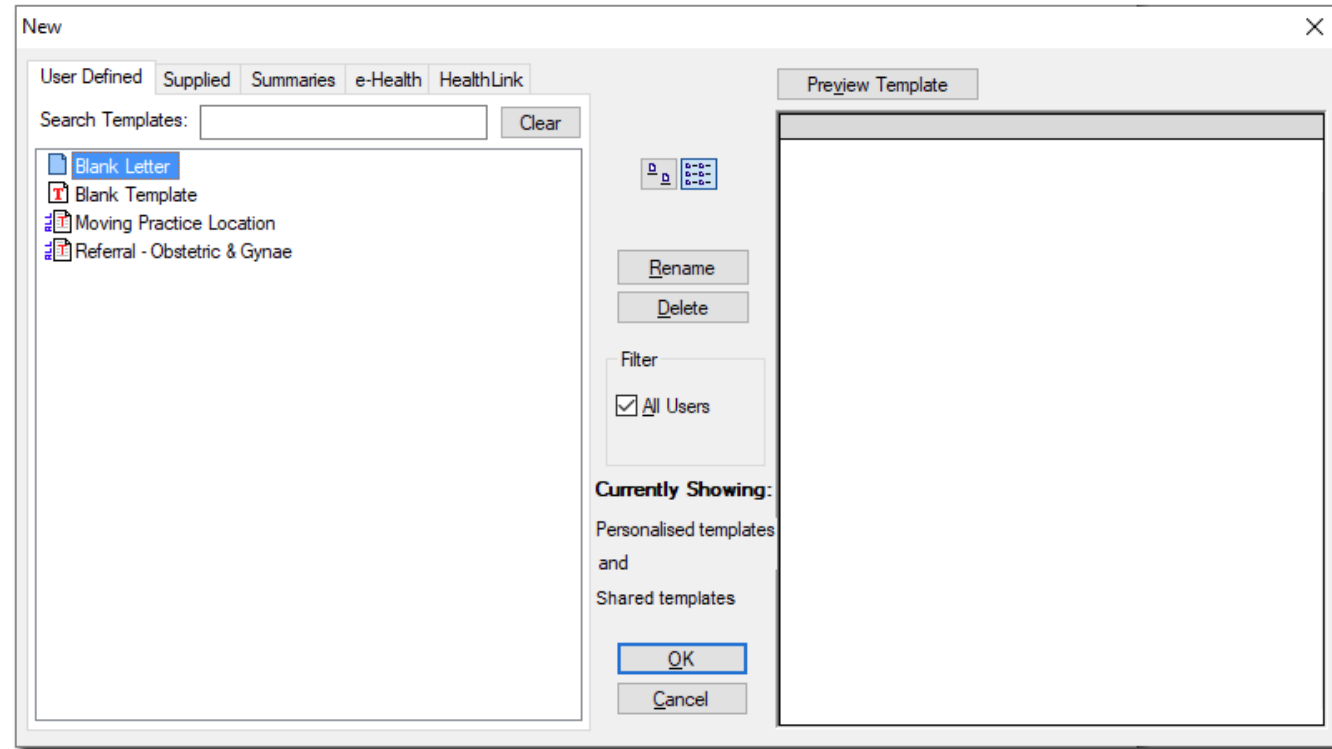
When viewing all records, inactive items are displayed in grey.

Creating letters

Letters are created and edited with the [Letter Writer](#).

1. Open the Letter Writer by either:
 - Selecting **Tools > Letter Writer** from the Clinical front screen,
 - Pressing **F8**,
 - Clicking  on the tool bar within the patient's [Clinical Window](#),
 - Selecting the [Letters tab](#) within the patient's [Clinical Window](#), and clicking the  button,
 - Selecting the [Letters tab](#) within the patient's [Clinical Window](#) and clicking **Add**.
 - Selecting the [Correspondence tab](#) within the patient's [Clinical Window](#), clicking **Add**, and selecting **Letter** from the menu that appears..
2. Within Letter Writer, to create a new letter either;
 - Click  on the tool bar, or
 - Select **File > New**, or
 - Press **CTRL+N**
3. The **New** window appears.
4. Double-click the [template](#) you wish to base the new letter on, or [create a new template](#) by selecting Blank Template. Alternatively you can search for a template using the box provided.

See [Letter Writer](#) for more information about creating and editing letters.

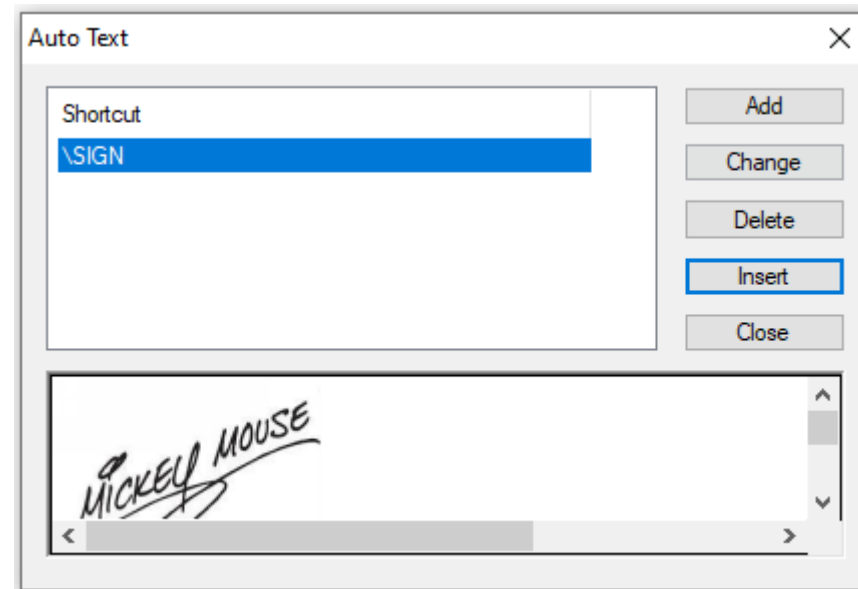


Auto Text – Adding Signature

Auto Text functionality allows you to quickly insert bodies of text into a letter using a single keyword or phrase. For example, instead of having to repeatedly type your entire salutation every time you create a new letter, you can program Letter Writer to insert it automatically upon typing a single keyword or phrase, such as 'mysalutation'.

There is no limit to the number of Auto Text entries, or the length of each entry that can be stored in Letter Writer, and you can share the Auto Text entries you create with other users.

- [Managing Auto Text](#)
- [Creating and Editing Auto Text](#)

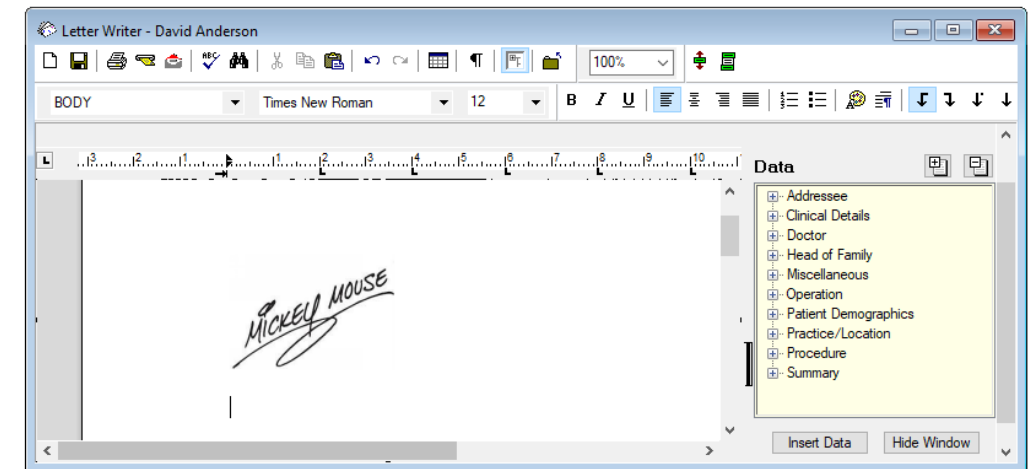
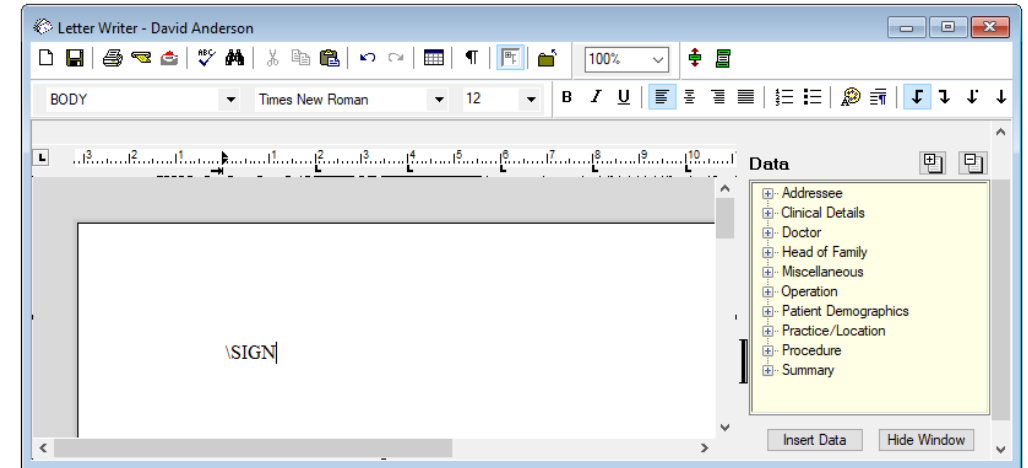


1. From within Letter Writer, either;
 - Select **Edit > Auto Text**
 - Press **Ctrl+T**
2. The **Auto Text** window appears.
3. From here you can;
 - Add a new Auto Text entry (eg \SIGN)
 - Change an existing Auto Text entry (see below for detailed information)
 - Delete an existing Auto Text entry, by selecting it in the Shortcut window and clicking **Delete** button.
 - Insert an existing Auto Text entry, by selecting it in the Shortcut window and clicking Insert button or a Picture of your signature by pasting and edit size.

Auto Text – Adding Signature

The following example shows how you can also insert Auto Text into your document by typing the keyword shortcut associated with that Auto text entry.

This example uses a keyword shortcut of **\SIGN**. Upon typing this keyword, Letter Writer would detect that the text you typed may relate to one of the Auto Text entries you have created, and display a pop-up window containing the associated Auto Text. If you wanted to add the Auto Text to your document, you would simply press the Enter key on your keyboard, and the Auto Text would be added to the page automatically, as shown below.



My Health Record Accessing

With Clinical configured correctly, you can access a patient's My Health Record documentation via the My Health Record menu within the patient's [Clinical Window](#). You will be presented with the My Health Record window, an example of which is shown below.

Note that when you first access the My Health Record system, you will be prompted to complete your user name details. You will only be asked this once.

Allows you to gain access to documents that have been password-protected by the patient - it is the patient who controls access to their My Health Record documentation.

Any document can be applied one of two access levels;

- Open: the document is unrestricted.
- Code: the document requires an access code to view/download.

Click the Change/Gain Access button, and then select from the three Access Type options;

- Open Access: no access code required.
- Access Code: enables the Access Code field in which you must enter the access code the patient provided you.

•Emergency: grants you access to password-restricted documents for five days. To be used in an emergency when the patient cannot be contacted. A record of the document being accessed in this fashion may be sent to the patient.

The screenshot shows a web application window titled "My Health Record for IHI: 8003 6023 4655 6635". It displays a list of documents with columns for Document Date, Service Date, Document, Organisation, Organisation Type, Author, Size, and Saved In MD. The selected document is a Shared Health Summary from 23-Sep-2016, authored by Dr Tobias Rodger. Below the list, a preview of the document is shown, including patient details (Ms Haimi INGLETON, DoB 12 Dec 1993) and the clinic name (The Clinic). The document is generated from MedicalDirector. At the bottom, there are buttons for "Create Clinical Document", "Supersede", "Remove from My Health Record", "Save in MD", and "Close".

Document Date	Service Date	Document	Organisation	Organisation Type	Author	Size	Saved In MD
14-Oct-2016	14-Oct-2016	e-Referral	Millennium Health Service	Other Healthcare Servic...	Ellison, Christine	12.1 KB	Not Saved
13-Oct-2016	13-Oct-2016	Shared Health Summary	Millennium Health Service	Other Healthcare Servic...	Ellison, Christine	11.2 KB	Not Saved
13-Oct-2016	13-Oct-2016	Shared Health Summary	Millennium Health Service	Other Healthcare Servic...	Ellison, Christine	11.0 KB	Not Saved
13-Oct-2016	13-Oct-2016	Shared Health Summary	Millennium Health Service	Other Healthcare Servic...	Ellison, Christine	11.0 KB	Not Saved
23-Sep-2016	23-Sep-2016	Shared Health Summary	DHSITESTORGZI87	General Practice	Rodger, Tobias	9.5 KB	Not Saved

Shared Health Summary | 23 Sep 2016 | Ms Haimi INGLETON | DoB 12 Dec 1993 (22y) | SEX Female | IHI 8003 6023 4655 6635

START OF DOCUMENT

The Clinic
Author: Dr Tobias Rodger (General Medical Practitioner)
Phone: 07 4152 6398

Generated From: MedicalDirector®

Adverse Reactions
None known

Medications


Buttons: Create Clinical Document, Supersede, Remove from My Health Record, Save in MD, Close

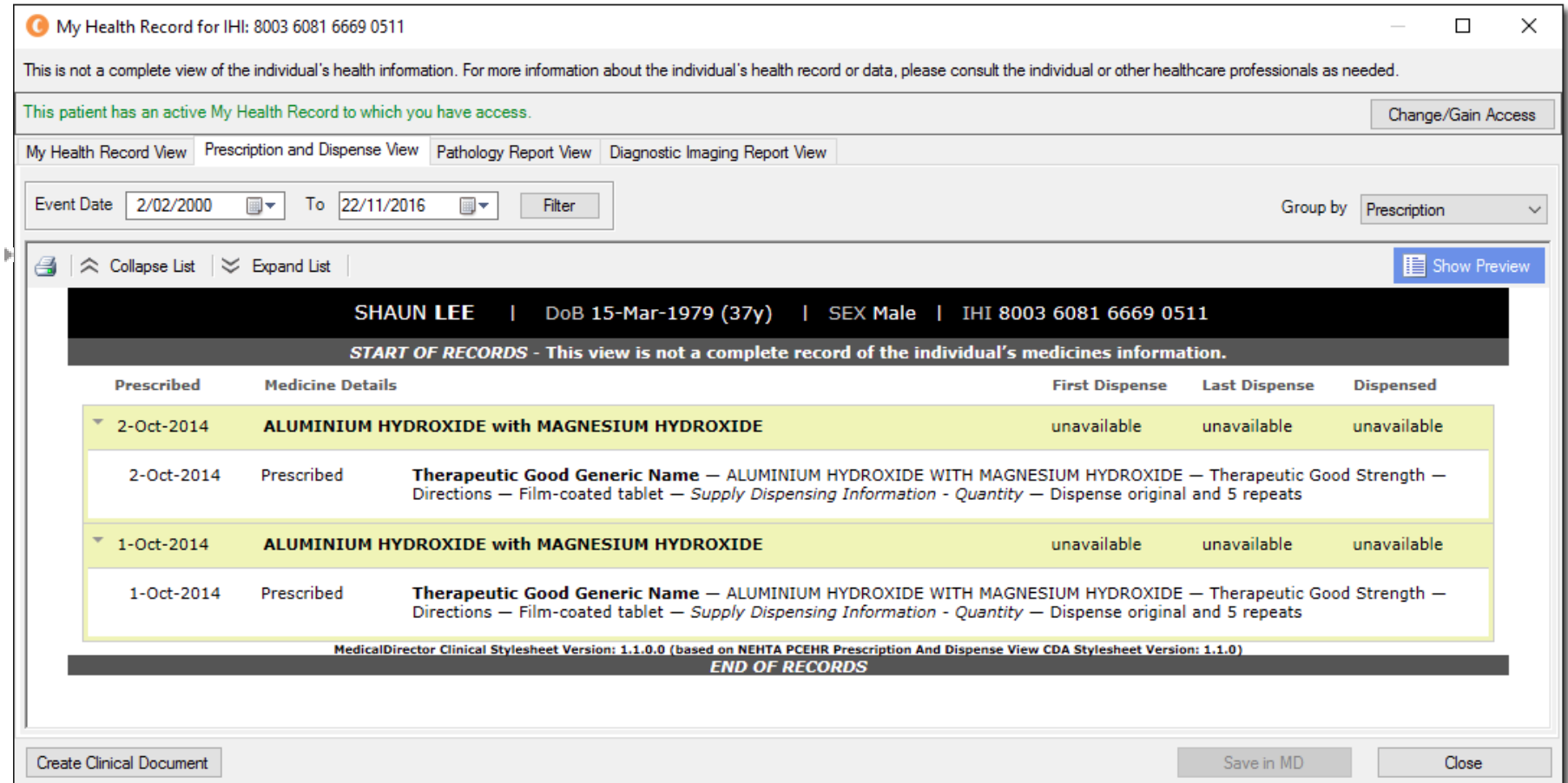
Removes a selected document from the My Health Record system. This is only available if you are the creator of the original document, or it was created by another user from the same Practice (i.e. with the same Practice HPI-O recorded via Tools > Options > [Practice tab](#)).

My Health Record accessing Prescription & Dispense

The Prescription and Dispense View tab lists prescribed/dispensed medications that the patient has granted consent to upload to the My Health Record System. Consent is typically indicated via the Enter Dose window during the [prescribing process](#), but can also be granted/revoked afterwards by right-clicking an item on the [CurrentRx tab](#) and clicking the My Health Record Consent entry from the menu that appears. This functionality requires that you have enable [ePrescribing](#).

To view a medication on this window;

1. First, expand the medication details by clicking the  button at the far left end of the medication row.
2. Secondly, click the medication details. The script details will be revealed



The screenshot shows the 'My Health Record for IHI: 8003 6081 6669 0511' interface. It features a navigation bar with tabs for 'My Health Record View', 'Prescription and Dispense View', 'Pathology Report View', and 'Diagnostic Imaging Report View'. The 'Prescription and Dispense View' is active. Below the navigation bar, there are filters for 'Event Date' (2/02/2000 to 22/11/2016) and a 'Group by' dropdown set to 'Prescription'. A 'Show Preview' button is visible on the right. The main content area displays patient information: SHAUN LEE, DoB 15-Mar-1979 (37y), SEX Male, IHI 8003 6081 6669 0511. A warning message states: 'START OF RECORDS - This view is not a complete record of the individual's medicines information.' Below this is a table with columns: Prescribed, Medicine Details, First Dispense, Last Dispense, and Dispensed. Two rows are shown for 'ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE' prescribed on 2-Oct-2014 and 1-Oct-2014. The 'Medicine Details' column is expanded for both rows, showing: 'Therapeutic Good Generic Name — ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE — Therapeutic Good Strength — Directions — Film-coated tablet — Supply Dispensing Information - Quantity — Dispense original and 5 repeats'. At the bottom of the table, it says 'MedicalDirector Clinical Stylesheet Version: 1.1.0.0 (based on NEHTA PCEHR Prescription And Dispense View CDA Stylesheet Version: 1.1.0)'. The interface ends with 'END OF RECORDS' and buttons for 'Create Clinical Document', 'Save in MD', and 'Close'.

Prescribed	Medicine Details	First Dispense	Last Dispense	Dispensed
2-Oct-2014	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE	unavailable	unavailable	unavailable
2-Oct-2014	Prescribed Therapeutic Good Generic Name — ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE — Therapeutic Good Strength — Directions — Film-coated tablet — Supply Dispensing Information - Quantity — Dispense original and 5 repeats			
1-Oct-2014	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE	unavailable	unavailable	unavailable
1-Oct-2014	Prescribed Therapeutic Good Generic Name — ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE — Therapeutic Good Strength — Directions — Film-coated tablet — Supply Dispensing Information - Quantity — Dispense original and 5 repeats			

My Health Record accessing Pathology Report

My Health Record for IHI: 8003 6081 6669 0511

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed.

This patient has an active My Health Record to which you have access. [Change/Gain Access](#)

My Health Record View | Prescription and Dispense View | **Pathology Report View** | Diagnostic Imaging Report View

Specimen Collection Date: 02-Feb-2000 To 22-Nov-2016 Filter Group by: No Grouping Search: Organisation: ALL Clear

Collapse List Expand List Show Preview

SHAUN LEE | DoB 15-Mar-1979 | SEX Male | IHI 8003 6081 6669 0511

Tests Found: 15 Tests Matching: 15

START OF RECORDS

Specimen Collected Date	Report Date	Pathology Organisation	Requesting Organisation	Pathology Discipline	Test Name	Test Status	Report ID
10-Dec-2014	12-Dec-2014	Burrill Lake Medical	Bodalla Clinic	Hematology	Blood Test	Final	123A45
31-Aug-2014	04-Sep-2014	Coomerante Hospital	E L C Coomera Centre	Chemistry	Serum chemistry test	Final	14P0175
09-Jun-2014	12-Jun-2014	Burrill Lake Medical	Bodalla Clinic	Hematology	Blood test	Final	14F007
01-Mar-2014	02-Mar-2014	Burrill Lake Medical	Bodalla Clinic	Hematology	Blood test	Final	WA08666
10-Jan-2014	12-Jan-2014	Coomerante Hospital	Bodalla Clinic	Hematology	Blood test	Final	14P1050

Create Clinical Document Save in MD Close

My Health Record accessing Diagnostic Imaging Report

My Health Record for IHI: 8003 6081 6669 0511

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed.

This patient has an active My Health Record to which you have access. Change/Gain Access

My Health Record View Prescription and Dispense View Pathology Report View **Diagnostic Imaging Report View**

Event Date 22-Nov-2009 To 22-Nov-2016 Filter Group by No Grouping Search Organisation ALL Clear

Collapse List Expand List Show Preview

SHAUN LEE | DoB 15-Mar-1979 | SEX Male | IHI 8003 6081 6669 0511

Examinations Found: 51 Examinations Matching: 51

START OF RECORDS

Imaging Date	Organisation	Examination	Modality	Anatomical Region	Anatomical Location	Laterality
16-Apr-2015	New Organisation	Pelvis X-ray (procedure)	Pelvis X-ray (procedure)	Pelvis	Entire thorax (body structure)	Right and left (qualifier value)
16-Apr-2015	New Organisation	Plain chest X-ray (procedure)	Radiographic imaging procedure (procedure)	N/A	Chest/Thorax Bi-Lateral	N/A
16-Apr-2015	New Organisation	Plain chest X-ray (procedure)	Radiographic imaging procedure (procedure)	N/A	Chest/Thorax Bi-Lateral	N/A
16-Apr-2015	New Organisation	Plain chest X-ray (procedure)	Radiographic imaging procedure (procedure)	N/A	Chest/Thorax Bi-Lateral	N/A
01-Mar-2015	Medicare 205	Plain chest X-ray	Radiographic	Chest/Thorax Bi-Lateral	Entire thorax (body structure)	Right and left

Create Clinical Document Save in MD Close

My Health Record uploading while Prescribing

With a patient's consent, prescriptions can be uploaded to their My Health Record. The upload occurs automatically when you print a script. Consent is typically indicated via the Enter Dose window during the [prescribing process](#), but can also be granted/revoked afterwards by right-clicking an item on the [CurrentRx tab](#) and clicking the My Health Record Consent entry from the menu that appears.

The National Prescription and Dispense Repository (NPDR) is a subset of a patient's My Health Record and allows for the creation of an online medication history (for both prescriptions and dispensing). Transfer of medications in this way requires you are registered for ePrescribing and have enabled eRx Script Exchange.

Prerequisites:

- Practitioner is registered for ePrescribing. See [ePrescribing Configuration for instructions](#).
- My Health Record is configured correctly. See [Configuring MedicalDirector Clinical for My Health Record for instructions](#).
- Practitioner has indicated their participation in My Health Record. See [below for details](#).

For further information regarding the NPDR, please refer to the following link:

www.ehealth.gov.au/internet/ehealth/publishing.nsf/Content/faqs-hcp-managing#anchor11

The screenshot shows the 'Enter Dose' window for 'ASPIRIN EC TABLET 100mg'. The window is divided into several sections:

- Drug details:** Shows 'Dose: 1 tablet daily' and buttons for 'PI' and 'Monograph'.
- Dose:** A text input field containing '1' and a 'Calculate' button.
- Frequency:** A list of frequency options including 'Stat', 'Daily', 'Every alternate day', 'Every third day', 'In the morning', 'Midday', 'At night', 'Twice a day', '3 times a day', '4 times a day', 'Two hourly', 'Four hourly', 'Six hourly', 'Eight hourly', 'Weekly', and 'Nil' (which is selected).
- Instructions:** A list of instruction options including 'Nil' (selected), 'If required', 'As directed', 'Before meals', 'With meals', 'After meals', 'Left side', 'Right side', 'To both sides', 'Plus as required', and 'Other'.
- Route of Admin:** A dropdown menu set to 'Oral - Swallowed'.
- Purpose of action:** Radio buttons for 'Print prescription' (selected), 'Hand-written prescription', 'Product advised here', 'Product supplied here', and 'Advised or prescribed elsewhere'.
- Duration of medication:** Radio buttons for 'Long term' and 'Limited' (selected).
- Send to MyHealthRecord:** A checked checkbox.
- Active Ingredient Prescribing:** A checked checkbox for 'Include brand name on script' and an unchecked checkbox for 'Brand substitution not allowed'.
- Exclude from Active Script List:** An unchecked checkbox.
- Direct Dispense:** A section with the note '(Do not provide to patient, provide directly to pharmacy)' and an unchecked checkbox for 'Script Owing (Medication already supplied)'.
- ePrescribing Options:** A section with a 'Note to Pharmacist' text area, an unchecked checkbox for 'Unusual dosage', and a 'Pharmacy to dispense' dropdown menu.
- Start date of medication:** A date field set to '3/05/2022'.
- Footer:** Checkboxes for 'Add to favourites' and 'Save as default', and 'Ok' and 'Cancel' buttons.

My Health Record uploading Documents

1. [Create a CDA document](#) via one of the supplied e-Health templates in [Letter Writer](#).
2. Then, within the patient's record, locate the document you wish to upload. Documents can reside on either of the [Correspondence](#), [Documents](#), [Results](#) or [Letters](#) tabs.
3. Click Send To **MyHealthRecord** button. You will be presented with a preview of the document.
4. If you are satisfied that this is the document you wish to upload, click Send on the preview window.
5. The upload will commence and you will be notified upon completion. The 'My Health Record Status' and 'My Health Record Activity Date' columns within the correspondence tabs of the patient's record will indicate the selected document's My Health Record status.

The screenshot displays a medical software interface with a menu bar at the top containing options like Summary, Current Rx, Progress, Past history, Results, Letters, Documents, Qld scripts, Imm., Cervical Screening, Obstetric, Correspondence, MDEXchange, and HealthLink. Below the menu is a toolbar with actions such as Preview - Full, Hide Preview, Clear Filters, Move Location, Document Details, Send SMS, Send Email, Scan, Import, Print, Add, Delete, Search, Clear Search, Refresh, and Send To MyHealthRecord. The main area is divided into two panes. The left pane shows a table of 19 records with columns for Date Checked, Checked By, Date Collected, Date Requested, and Sender/Provider. The right pane shows patient details for Jennifer Andrews, including birthdate (20/04/1970), age (Y42), and sex (Female). Below the patient details is a detailed view of a 'CUMULATIVE SERUM' test result, listing various blood chemistry markers such as Sodium, Potassium, Chloride, Bicarbonate, Glucose, Urea, Creatinine, and Bilirubin, along with their units and reference ranges.

Date Checked	Checked By	Date Collected	Date Requested	Sender/Provider	Rec
22/08/2012	DR A PRACTITIONER	17/08/2012	17/08/2012	Demotown Pathology	DR
22/08/2012	DR A PRACTITIONER	17/08/2012	17/08/2012	Demotown Pathology	DR
22/08/2012	DR A PRACTITIONER	17/08/2012	17/08/2012	Demotown Pathology	DR
22/08/2012	DR A PRACTITIONER	17/08/2012	17/08/2012	Demotown Pathology	DR
22/08/2012	DR A PRACTITIONER	17/08/2012	17/08/2012	Demotown Pathology	DR
27/08/2010	DR A PRACTITIONER	25/08/2010	25/08/2010	Demotown Pathology	DR
27/08/2008	DR A PRACTITIONER	14/07/2008	14/07/2008	Demotown Pathology	DR
7/12/2006	DR A PRACTITIONER	5/12/2006	5/12/2006	Demotown Pathology	DR
12/10/2006	DR A PRACTITIONER	10/10/2006	10/10/2006	Demotown Pathology	DR
12/10/2006	DR A PRACTITIONER	10/10/2006	10/10/2006	Demotown Pathology	DR
12/10/2006	DR A PRACTITIONER	10/10/2006	10/10/2006	Demotown Pathology	DR
21/03/2005				Dr A Practitioner	Wor
14/02/2003				Dr A Practitioner	
11/09/1999				Dr A Practitioner	
12/07/1999				Dr A Practitioner	Mat
16/04/1998	DR A PRACTITIONER	15/04/1998	15/04/1998	Demotown Pathology	DR
16/04/1998	DR A PRACTITIONER	15/04/1998	14/04/1998	Demotown Pathology	DR

Start Patient : Andrews, Jennifer
2 Kennedy Road, Bundaberg QLD 4670
Birthdate: 20/04/1970 Age: Y42 Sex at Birth: Female
Telephone:

Your Reference :
Lab Reference : 52-0631718

Subject : E/LFT (MASTER)
Lab. Reference: 52-0631718-25T-0
Requested: 17/08/2012
Performed: 17/08/2012
Sender/Provider: Demotown Pathology

CUMULATIVE SERUM

Sodium	139	mmol/L	(137-147)
Serum Potassium	4.6	mmol/L	(3.5-5)
Chloride	99	mmol/L	(96-109)
Bicarbonate	29	mmol/L	(25-33)
Other Anions	16	mmol/L	(4-17)
Glucose	4.2	mmol/L	(3-7.7)
Urea	4.5	mmol/L	(2-7)
Serum Creatinine	60	umol/L	(40-110)
Serum Uric Acid	0.27	mmol/L	(0.14-3.35)
Total Bilirubin	6	umol/L	(2-20)
Total Alk. Phosphatase	93	U/L	(30-115)
Gamma G.T.	24	U/L	(0-45)
ALT	25	U/L	(0-45)
AST	24	U/L	(0-41)
LD	219	U/L	(80-250)
Serum Calcium	2.39	mmol/L	(2.25-2.65)
Corrected Calcium	2.32	mmol/L	(2.25-2.65)
Serum Phosphate	1.5	mmol/L	(0.8-1.5)
Total Protein	71	g/L	(60-82)
Serum Albumin	45	g/L	(35-50)
Globulins	26	g/L	(20-40)
Cholesterol	6.3	mmol/L	(3.6-6.9)
Triglycerides	1.6	mmol/L	(0.3-4)
eGFR	>>90	mL/min/1.73 som	

My Health Record Saving, Superseded or Removed

1. Within the patient's record, select the My Health Record menu. You will be presented with the My Health Record window.
2. Locate and select the document you wish to download.
3. Click **Save in MD** button.
 - If the document is of type 'Shared Health Summary' or 'Event Summary' it is saved to the Documents tab of the patient record. Documents of type 'e-Referral' or 'Specialist Letter' are saved to the Letters tab.
 - If the document already exists in the patient's record (it has already been downloaded from My Health Record), you will be notified accordingly.
 - If the document already exists in the patient's record, but on the My Health Record system there is a newer version of it, the document will be downloaded to the patient's record, and the older version will be retained within the patient's record for historical purposes.
 - The 'My Health Record Status' and 'My Health Record Activity Date' columns within the Documents/Letters tabs will indicate the selected document's My Health Record status, such as 'Uploaded', 'Downloaded', 'Superseded', or 'Removed'.

The screenshot displays the 'My Health Record for IHI: 8003 6080 0002 4042' window. It features a navigation bar with tabs for 'My Health Record View', 'Prescription and Dispense View', 'Pathology Report View', and 'Diagnostic Imaging Report View'. Below this is a table of documents with columns for Document Date, Service Date, Document, Organisation, Organisation Type, Author, Size, and Saved In MD. A context menu is open over the document dated 24-Feb-2014, showing options: 'Save in MD', 'Remove from PCEHR', and 'Supersede'. The detailed view below shows an 'e-Referral' for 'Mr Lindsay BLANTON' dated '28 Mar 2014'. The author is 'Dr Alfonso Terri-Anne (General Medical Practitioner)'. The document title is 'MedicalDirector Demo - David Harris'. At the bottom, there are buttons for 'Create Clinical Document', 'Supersede', 'Remove from My Health Record', 'Save in MD', and 'Close'.

Document Date	Service Date	Document	Organisation	Organisation Type	Author	Size	Saved In MD
05-Dec-2013			MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	12.9 KB	Not Saved
05-Dec-2013	1:		MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.0 KB	Not Saved
16-Dec-2013	2:		MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.6 KB	Not Saved
24-Feb-2014			MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.7 KB	Not Saved
24-Feb-2014		Event Summary	MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.7 KB	Not Saved
24-Feb-2014		Shared Health Summary	MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	11.5 KB	Not Saved



Clinical communities

Better management of patient outcome as a result of safer and better quality communication between clinicians involved in patient care. Proactively manage patients between consultation.



Clinical education

Targeted interventions enable better patient outcomes by empowering clinicians with AI-driven health care alerts and educational material. Provide seamless, high reach on-demand educational content or targeted in consult decision support for clinicians.



Patient and physician education

Free and easy access to a wide range of high quality and up-to-date fact sheets from Australia's leading health organisations within your clinical management software.



Patient engagement

Assisting patients in making efficient appointment bookings, conducting telehealth appointments, pay and be reimbursed for services securely and efficiently. Digitally connecting patients and carers managing chronic conditions.



Reporting

Transform your practice from the inside out with powerful practice intelligence and analytics tools. Gain valuable insights into your practice and use this data to help improve efficiency, increase billings and improve quality of patient care.

Key features

- ✓ Streamline every aspect of a medical practice with a suite of healthcare management tools.
- ✓ Tailor clinical IT systems to your needs with a growing partner ecosystem.
- ✓ Benefit from seamless onboarding, advanced technology, security and governance, and scalability

Introducing Telstra Health Smart Marketplace – a reimagined suite of healthcare management tools for General Practitioners and Practice Managers.

This all-inclusive ecosystem empowers medical professionals with a comprehensive suite of tools designed to streamline every aspect of their practice.

Manage your practice your way, with tailored solutions from Smart Marketplace. Smart Marketplace offers a growing partner ecosystem that enables you to tailor your clinical IT systems with innovative solutions suited to the unique needs of your practice. Smart Marketplace is comprised of an array of health technology partners who offer the highest standard in innovation, service and reliability.

Each Smart Marketplace partner is handpicked for their proven effectiveness and innovation.

MedicalDirector Care – Introducing MedicalDirector Care Plan

Care plans are an important tool to support patients with chronic health conditions, but they can be complicated and time-consuming. This webinar shows you how MedicalDirector Care is making care plans simple and easy to manage while promoting compliance with Medicare.

Join this webinar to learn:

- How care plans benefit patients, practitioners and practices
- How MedicalDirector Care is taking the hassle out of creating, tracking, reviewing and updating care plans
- How to use the templates in MedicalDirector Care to create powerful care plans that will support your patients throughout their healthcare journey.

With MedicalDirector Care at your fingertips, empowering your patients to live their healthiest lives has never been easier. Check out our webinar and you'll soon see why!

The screenshot displays the MedicalDirector Clinical 3.19 BETA 2 interface for a patient named Mrs Julie Andrews (84yrs 7mths). The patient's details include DOB: 03/03/1936, Gender: Female, and Occupation: MedicalDirector Care. The interface shows a list of medications:

#	Drug name	Strength	Dose	Freq
1	LIPITOR TABLET	10mg	1	daily
2	MAREVAN TABLET	1mg	1	
3	MAREVAN TABLET	3mg	1	
4	VENTOLIN CFC-FREE INHALER	100mcg/dose ...	1	daily

The 'PATIENT CONSENT' dialog box is open, displaying the following text:

Your doctor would like to create a care plan for you using a solution developed by MedicalDirector. This care plan will be populated with your personal health information.

Data uploaded to MedicalDirector Care will be stored within a cloud solution located within Australia. Data may be accessed or used by MedicalDirector, for the purpose of operating, maintaining and administering the Care solution.

You consent to the collection, use, storage and disclosure of your personal and sensitive information, including health information (**personal health information**) by MedicalDirector in order to create and manage your care plan and for purposes set out in this Consent and in MedicalDirector's Privacy Policy.

Your care plan will also be shared with other health professionals or carers that you nominate. You can grant or withdraw consent to the sharing of your care plan with such individuals at your discretion by notifying your healthcare practitioner.

All personal health information which is included in your care plan whether by you, your doctor or another health professional can be viewed by all parties with access to your care plan. If there is any personal health information you do not wish to be included in your care plan, you must advise your doctor and other relevant health professionals.

You can request access to, and (subject to any retention requirements under law) request the deletion of, your personal health information which is held by MedicalDirector at any time.

The dialog box includes a 'Consent given' checkbox, 'BACK' and 'CREATE' buttons, and a 'Safe & Secure Logout' link. The interface also shows a 'CARE PLANNING' sidebar and a 'PATIENT CONSENT' section in the main content area.

MedicalDirector Care – Setup Care Plans

Before you Begin

- o The MedicalDirector Care widget requires MedicalDirector Clinical 3.18 or later.
- o You will need to install the MedicalDirector Care Widget. See [Managing Widgets](#) for instructions.
- o You will need to [create and save a default eSignature](#).
- o The MedicalDirector Care widget requires Google Chrome, Microsoft Edge, or Mozilla Firefox

CARE ESIGNATURES

Default eSignature Preview

The default eSignature can be changed by choosing one of the tabs below. To set the default ensure that you tick 'Use as default eSignature' and click Save.

Upload eSignature Draw eSignature

Upload eSignature image requirements

- The maximum width and height of the image cannot be greater than 400 x 100 pixels respectively.
- Size of the uploaded image cannot be greater than 1 MB.
- Supported image types (.BMP, .JPG, .JPEG, and .PNG).

Choose File No file chosen

UPLOAD ESIGNATURE CLEAR

Uploaded eSignature Preview

Dr A Practitioner

Use as default eSignature

SAVE DELETE ESIGNATURE

Create an eSignature

- For information about electronic signatures, see [Electronic Signatures](#).
 - Note that an electronic signature is only effective if the person receiving it (e.g. a specialist) accepts the signature in that form.
1. Open the MedicalDirector Care widget from the [Sidebar](#) and select **User Settings**.
 2. Locate and click the eSignatures settings button, as shown below.
 - o If this is the first time you have created an eSignature, the **Default eSignature Preview** window will be blank, as shown in the example.
 3. Select either the **Upload eSignature** tab or the **Draw eSignature** tab to enter a new eSignature.
 - o The **Upload eSignature** tab allows you to upload an image of a signature that you already have saved on your computer.
 - o The **Draw eSignature** tab allows you to create a new eSignature, manually, by using your finger or stylus on a touch-screen or tablet.
 4. You will be presented with a preview of the eSignature, and prompted to use it as the default. Tick the **Use as Default eSignature** checkbox to confirm.
 5. The eSignatures settings window will now display your default selected eSignature. This will be used for all future Care Plans created in MedicalDirector Care, unless you choose to delete it and create a new one. No other configuration is required.

MedicalDirector Care – Create a Care Plans

Obtain consent, review the patient's health summary and choose focus areas. Assign team members and generate documentation.

Overview

1. Obtain the patient's consent.
2. Assign the primary GP.
3. Discuss and record the patient's overarching goal.
4. Review the patient's health summary.
5. Select a template and choose focus areas.
6. Customise care plan to suit the patient.
7. Set goals, tasks and metrics.
8. Assign team members, generate referrals.
9. Set tracking and billing options.
10. Generate a printed care plan.

MedicalDirector Care is able to create printed care plans.

Care plan - Health summary

CAREPLAN
Horatio Farnswell

TO BE REVIEWED 10/06/2018

PATIENT'S GOAL
I would like to be able to play basketball with my kids again and be able to improve my overall health.

PATIENT DETAILS
Gender: Male
Date of Birth: 07/06/1967
Address: 1 Fair Road, Wily Wily, NSW 2256
Phone: +61 9300 0000
Mobile: N/A
Medicare Number: 9999-00000-0
Allergies: Shellfish, Peanuts, Glutens, Chlamy, Sulphonam, Tetracycline
Smoking: Non-Smoker
Alcohol: 2-3 drinks per week

CAREPLAN MEMBERS

Dr Name	Role	Contact
Dr John Everyman	General Practitioner	0400 000 000
Dr Nicole Everywoman	Dietician	0400 000 000
Dr Nick Notarsalastama	Exercise Therapist	0400 000 000
Dr Jeff Coppiler	Podiatrist	0400 000 000

MEDICATIONS

Drug name	Directions	Condition/s
ACEPURINER Tablet 100mg	1 Daily	Hypertension
ADREN Tablet 100mg	1 Daily	Hypercholesterolaemia
BICOR Tablet 10mg	1 In the morning	Hypercholesterolaemia
CAQUET Tablet 5mg/50mg	1 Daily	Hypercholesterolaemia
COMBODL Tablet 10mg	1 In the morning	Hypercholesterolaemia
DIABEX XR Tablet 500mg	1 Twice a day	Diabetes Mellitus Type II
ESTROX Tablet 10mg	1 Daily	Diabetes Mellitus Type II
ADREN Tablet 100mg	1 Daily	Hypercholesterolaemia
BICOR Tablet 10mg	1 In the morning	Hypercholesterolaemia

CONDITIONS

- 1992 Diabetes Mellitus - Type II
- 1995 Hypercholesterolaemia
- 1995 Hypertension
- 1995 Ischaemic Heart Disease
- 2004 Frozen Shoulder
- 2010 Obstructive Sleep Apnoea
- 2013 Allergic Rhinitis
- 2013 Ectropion (Bilateral)
- 2013 QV (Left Ventricular Failure)

Created by Dr Practitioner
200 Rumburg Street, Rumburg QLD 4012 | +61 245 500 0000

Care plan – Focus areas

CAREPLAN

CHOL	3.6	16/06/2012
HDL	N/A	N/A
LDL	N/A	N/A

Hypercholesterolaemia

Goal	Task	Provider
Cholesterol < 4.0, HDL > 1.0, LDL < 2.0, TG < 1.5.	Refer to Dietician for advice and education; reduction in saturated fats.	Dr. A. Practitioner GP
	Review: Every 3 months	05/12/2018 Mary Bloggs Dietician
	Advise on cholesterol lowering foods.	Dr. A. Practitioner GP
	Review: Every 3 months	05/12/2018 Mary Bloggs Dietician
	Medication review	Dr. A. Practitioner GP
	Review: Every 3 months	05/12/2018

Comments: --

Reilly Andrews CAREPLAN 05/12/2018

CAREPLAN

BP	135/75	16/02/2013
PULSE	60	16/02/2013

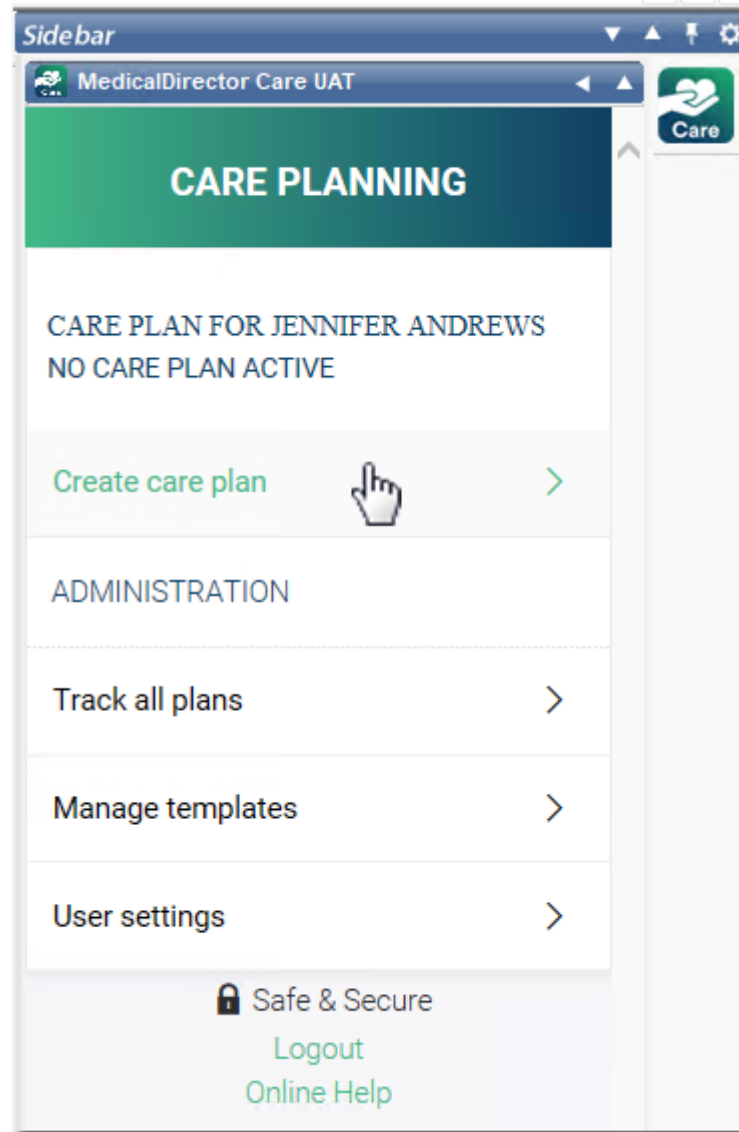
Hypertension

Goal	Task	Provider
BP < 130/90.	Review medications	Dr. A. Practitioner GP
	Review: Every 1 months	05/12/2018
	Low salt diet	Dr. A. Practitioner GP
	Review: Every 1 months	05/12/2018
	Regular exercise	Dr. A. Practitioner GP
	Review: Every 1 months	05/12/2018
	Weight loss	Dr. A. Practitioner GP
	Review: Every 1 months	05/12/2018
	Create a diet plan to include a low salt diet	Mary Bloggs Dietician
	Review: Every 1 months	05/12/2018 Dr. A. Practitioner GP
		05/12/2018

MedicalDirector Care – Create a Care Plans

Launch a care plan, obtain patient consent and discuss the patient's overarching health goal

1. From within the patient's record, open the MedicalDirector Care widget from the Sidebar and choose **Create Care Plan**.
2. Gain the patient's consent to create a care plan.
3. Click create button o You may be required to log into the MD Care site.
 - o The **Care Plan Setup** will commence.
4. You will be presented with the **Patient Consent** window where you can review the conditions of consent.
 - o This step can be skipped and recorded later in the patient dashboard.
5. Click **Select Primary GP>** button to continue.
 - o On the **Select Primary GP** window, accept the default healthcare professional selected or choose another.
6. Click the associated **Goal** button to continue. You are presented with an opportunity to record the patient's goal, in their words.
7. **Click Health Summary >** button Review the patient's health summary, select a template and choose focus areas.



- o All data appearing in the Health Summary is taken directly from MedicalDirector Clinical. As such, MedicalDirector Clinical remains the source of truth for the care plan. If data needs to be corrected, correct it in Clinical and relaunch the care plan. Review Conditions (past medical history), Medications, Allergies, Immunisations, Family History and Social History. Ensure the data is correct and is suitable for sharing with team members outside the practice. Use the check boxes to decide what will (and won't) be shown on the care plan.
- o The data chosen in the previous screens all make up the patient summary part of the care plan, including:
 - The patient's goal.
 - Social and family history.
 - Patient demographic details.
 - Medications.
 - Conditions (Past medical history).
8. After navigating the patient's Health Summary and making modifications as required, click **Plan Details >** button to choose a plan template that suits this patient.
 - o The **Supplied** tab on this window contains supplied templates.
 - o Supplied templates can be **modified** to suit your practice's needs. **Modified** templates appear in the **Customised** tab.
9. Select a plan to customise.
10. Click **Create Plan>** button to create the care plan.

MedicalDirector Care – Create a Care Plans

11. You can set goals, tasks and metrics for each focus area.

- o Health summary pages.
- o Focus areas pages.
- o Care plan.
- o Roles and team members & team member documentation.
- o Admin tasks (billing and reminders).
- o Finalise and generate the care plan document.
- o Timeline of all consult notes, correspondence, pathology and imaging results for this patient.
- o Goal progress.
- o Clinical goals for the patient.
- o Automatically pre-fills latest metrics and measurements retrieved from MedicalDirector Clinical, minimising data entry errors.

12. Review and edit patient clinical goals if required.

The screenshot displays the MedicalDirector Care interface for a patient named Jennifer Andrews. The patient's details include a date of birth of 20/04/1970 (50) and a residential address of 2 Kennedy Road Bundaberg QLD 4670. The interface is divided into several sections:

- Navigation Menu (Left):** Includes options for Health Summary, Medications, Allergies, Immunisations, Family History, Social History, Patient Problems, Needs or Relevant Conditions, and Multidisciplinary Care Plan (with sub-options for Lifestyle, Biomedical, and Pharmacological).
- Progress Indicators (Top):** Shows steps for Care Plan (completed), Team Members (warning), Admin Tasks (3), Generate Plan (4), and a Next button.
- Main Content Area:**
 - Patient Problems, Needs or Relevant Conditions:** Labeled "LIFESTYLE (GENERAL HEALTH)".
 - Goals:** Lists goals such as "Education on Condition", "Weight Management", "Healthy Eating", "Physical Activity and Exercise", and "Mobility, Balance and Flexibility". It includes a "GOAL PROGRESS" section and a "REMOVE GOAL" button.
 - Goals and Health Needs:** Contains the text "Educate patients regarding their role in optimally managing their condition."
 - Metrics and Measurements:** Includes "VIEW HISTORY" and "ADD METRIC" buttons.
 - Tasks & Correspondence:** Includes "ADD TASK" and "VIEW HISTORY" buttons.
 - Warning:** A message states "Unassigned roles - Click here to assign team members to roles."
 - Buttons:** "PENDING" and "COMPLETED" buttons are visible at the bottom.
- Patient Timeline (Right):** A vertical timeline of events including:
 - 01/10/2020: Dr A Practitioner
 - 22/08/2012: DR A PRACTITIONER, CYTOLOGY NON-GYNAE
 - 22/08/2012: DR A PRACTITIONER, PAP SMEAR
 - 22/08/2012: Dr A Practitioner, Phone Results Consultation
 - 22/08/2012: Dr A Practitioner, Photo
 - 17/08/2012: DR A PRACTITIONER, MASTER FULL BLOOD COUNT
 - 17/08/2012: DR A PRACTITIONER

MedicalDirector Care – Create a Care Plans

13. Review and edit patient metrics if required.

- o The metrics are pre-defined as part of a template.
- o For each metric selected, all available measurements will be automatically imported from MedicalDirector Clinical.
- o Only the most recent measurements are shown here. To see older measurements click **View History**.
- o To add a new metric, click **Add Metric**.

METRICS AND MEASUREMENTS			VIEW HISTORY	ADD METRIC
HEIGHT 175 cm 18/02/2013	WEIGHT 78 Kg 18/02/2013	BMI 25.5 kg/m2 18/02/2013		
TARGET	TARGET	TARGET >= 20 AND <= 25		
WAIST 91 cm 18/02/2013				
TARGET <= 94				

MedicalDirector Care – Create a Care Plans

14. Review and edit tasks if required.

- Completed tasks will show in the Completed view.
- Task descriptions can be changed, roles added or removed and the duration and due dates can be set (if required).
- There are two default roles; GP and Patient.
- Tasks can be assigned more than one role. Assign roles to providers in the Team Members page.

TASKS & CORRESPONDENCE

Tasks Team Correspondence

Unassigned roles - [Click here](#) to assign team members to roles.

PENDING COMPLETED

DESCRIPTION	HOW OFTEN	DUE	PROVIDER	COMPLETE
Lifestyle modifications as advised by Dietician and Exercise Physiologist.	Every 6 months	01/04/2021	Dietician, Exercise Physiologist, GP	<input type="checkbox"/> ⋮
Maintain your weight /prevent weight gain by eating healthy and doing at least 30 minutes of physical activity on most days.			Patient	<input type="checkbox"/> ⋮

Add/Edit Task

TASK DESCRIPTION

Lifestyle modifications as advised by Dietician and Exercise Physiologist.

For patient tasks, avoid jargon and abbreviations. Be specific with the tasks e.g. "Exercise at least 20 mins a day, 5 days a week."

PROVIDERS

Dietician x Exercise Physiologist x GP x

Search and add one or more roles that will be responsible for this task (includes "Patient" and "GP")

HOW OFTEN

ONGOING RECURRING ONCE

Review Every Interval 6 months from now

CANCEL SAVE

MedicalDirector Care – Create a Care Plans

15. Assign team members and generate referrals.

1. Via the **Team Members** list located in the left-hand margin of this window, select the type of healthcare professional you wish to assign to the care plan. In the example below, we have selected Physiotherapist.

- The Team Members list is dynamic, based on the roles you assigned to the various tasks of the care plan.
- The list of available healthcare professionals/providers is drawn from the MedicalDirector Clinical [Address Book](#).

15b. Click Assign Provider to locate and select a healthcare provider of the type you wish to add to your team.

- Click **Assign** button against the provider you wish to select.

You will be returned to the Team Members page where your selected provider now appears.

The screenshot displays the MedicalDirector Care interface for a patient named David Anderson. The interface is divided into several sections:

- Header:** Patient information (DAVID ANDERSON, 04/01/1955 (65), 61 Wallace Street Bundaberg QLD 4670) and navigation tabs (Care Plan, Team Members, Admin Tasks, Generate Plan, NEXT).
- Team Members List (Left):** A list of healthcare professionals with their roles and status (Unassigned). The selected role is **PHYSIOTHERAPIST**.
- Main Content Area:** Displays the details for the selected role, including an 'Assign Provider' button and a 'Documentation' tab. A message states: 'Click documentation tab for generating team participation letter and referral form.'
- Assign Provider Dialog (Right):** A search window for team members. It includes a search bar with the letter 'P' and a 'RESULT' section listing several providers with 'ASSIGN' buttons next to them:
 - Sally Physio (PHYSIOTHERAPIST)
 - Practice Manager (PRACTICE MANAGER)
 - Jonathon WILLIS (Paediatrics)
 - Paul SHEPHERD (Anaesthetics)
- Activity Stream (Far Right):** A vertical timeline showing key events: 'Creation & patient consent' (01/10/2020), 'Last update', and 'Review due' (Not Set).

MedicalDirector Care – Create a Care Plans

16. Optionally generate a Team Participation letter and an Allied Health Referral letter. Select the **Documentation** tab and click **Generate** button

REGISTERED NURSE (MEDICAL PRACTICE)

Sally Physio

Role Documentation

Generate Team Participation letter and Allied Health Services Under Medicare (EPC) form for this provider.

GENERATE

Team Participation Letter

Generate Team Participation letter (including fax back form) for the following tasks:

- Educate patients regarding their role in optimally managing their condition.
- Advice regarding safe alcohol intake.
- Regular routine bloods reviews.
- Monitor and screen health status.
- Educate patient about the importance of adhering to prescribed treatment and correct use of medications to minimise side effects.
- Ensure immunisations are up to date.

ADDITIONAL NOTES

Allied Health Letter

Two or more collaborating health or care providers are part of the care team and thus this care plan is eligible to claim for TCA services.

Generate Allied Health Services Under Medicare (EPC) referral form

Allocated Visits

1 Visit 2 Visit 3 Visit 4 Visit 5 Visit

Set the number of allocated medicare visits for this provider

Automatically save generated documents to the Patient file

Cancel Generate

DOCUMENTS

Recent Older Documents

DOCUMENT	DATE CREATED	VIEW / PRINT	SAVE TO PATIENT RECORD
Ahp Letter	Today	VIEW / PRINT	SAVE TO PATIENT RECORD
Team participation Letter	Today	VIEW / PRINT	SAVE TO PATIENT RECORD

Australian Government
Department of Health

Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form.

To be completed by referring GP:

Form 100
Patient has GP Management Plan (Form 721) AND Team Care Arrangements (Form 723) OR
GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's medical/dental care facility (Form 721)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's case plan to this form.
Medicare rebates and Private Health Insurance benefits cannot generally be claimed for these services.
Patients should be advised that they must obtain their services as the referer.

GP details

Practitioner Number: [0][0][0][0][0][0][0][0]
Name: Dr A. P. Anderson
Address: 200 Bourke Street
Postcode: 4070

Patient details

Medicare Number: [0][0][0][0][0][0][0][0][0][0] Patient's ref No: [0][0][0][0][0][0]
First Name: David
Surname: ANDERSON
Address: 81 Wallace Street
Postcode: 4070

Allied Health Professional (AHP) patient referred to: (Please specify name or type of AHP)

Name: Sally Physio
Address: [0][0][0][0][0][0][0][0] Postcode: [0][0][0][0]

Referral details – Please use a separate copy of the referral form for each type of service

Single patients may receive Medicare rebates for up to 10 allied health services (with a category 20). Please indicate the number of services requested by setting the number in the 'No. of Services' column next to the relevant AHP.

No. of Services	AHP Type	Item Number	No. of Services	AHP Type	Item Number	No. of Services	AHP Type	Item Number
	Aboriginal Health Worker	1090		Chiropractor	1094		Physiotherapist	1092
	Audiologist	1093		Manual Health Worker	1095		Podiatrist	1091
	Chiropract	1092		Occupational Therapist	1098		Psychologist	1096
	Chiropractor	1094		Optometrist	1097		Speech Pathologist	1099
	Diabetes Educator	1095		Orthoptist	1096			

Referring General Practitioner's Signature: [Signature] Date Signed: [Date]

The AHP must provide a written report to the patient's GP after the first service review, and make effort if clinically necessary.
Allied health providers should retain the referral form for monitoring and Department of Human Services (DHS) audit purposes.
This form may be downloaded from the Department of Health website at www.health.gov.au/referralservices/forms

THIS FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

17. Optionally view/print an Allied Health Services referral letter and/or Team Participation letter.

MedicalDirector Care – Create a Care Plans

18. Set tracking and billing options.

- o Assign to another member of the practice to review once the care plan has been finished (optional).
- o Set the care plan type (optional). Each type has pre-set expected MBS item code(s). These are tracked on the patient and practice dashboards, using billing data extracted from Pracsoft.
- o Set the review period which will control when the next review for the care plan is due (optional). Upcoming and overdue care plans show in the practice dashboard.

ASSIGN FOR FOLLOW-UP

Assign this care plan to another team member in your practice for review.

TO BE REVIEWED BY
Dr A Practitioner

Select a team member to review the care plan

MESSAGE
Care plan has been completed and is ready for review please.

Write a brief message to the reviewer

TRACK BILLING

Track the billing progress of this care plan

Two or more collaborating health or care providers are part of the care team and thus this care plan is eligible to claim for TCA services.

CARE PLAN TYPE
GPMP + TCA

Select the care plan type (for billing tracking purposes)

721 723

MedicalDirector Care – Create a Care Plans

19. Generate a printed care plan.

o Finalise the care plan and generate the care plan document. The care plan will automatically be saved to MedicalDirector Clinical.

o View or print the generated care plan and (optionally) save to the patient record if it has not been previously saved. The goals, metrics, tasks and correspondence shown in the previous screens are used to create the printed version of the care plan.

SET REVIEW PERIOD

Create a reminder within the care plan system to review the care plan

REVIEW AGAIN IN

Select a review period for this care plan

Enter review interval
6 months

GENERATE PLAN UPDATE CARE PLAN

Changes to the care plan will not be shared to team members unless it is published.

Care plan documents will be generated automatically.
A new progress note will be created automatically, summarising the changes to the care plan.

Automatically save generated documents to the Patient file

GENERATE

Click Generate to create a patient care plan. Each new care plan is \$15.00, billed monthly by MedicalDirector, subject to change.

CARE PLAN DOCUMENTS

Recent Older Documents

Press Generate to create new care plan documents and share changes with team members.

DOCUMENT	DATE CREATED	
CarePlan_GA_20201002_v1.pdf	Today	VIEW / PRINT SAVE TO PATIENT RECORD

SAVE ALL

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

MedicalDirector Care comes provided with a variety of care plan templates, and you can create your own by using one of the supplied templates as a base. The following instructions cover creating new templates and can assist with editing templates you have already created.


1. From the MedicalDirector Care widget, select **Manage Templates**.
2. The **Template Management** window appears. By default, you are presented with the **Supplied** tab as shown in the example below. The **Customised** tab is where your customised templates will appear once you have created one. To create your first customised template, you must first select a supplied template to base it on. In our example, we are going to select the **Multidisciplinary Care Plan** template as shown in the example below.


The screenshot displays the MedicalDirector Care interface. On the right, a 'CARE PLANNING' menu is open, showing options: 'ADMINISTRATION', 'Track all plans', 'Manage templates' (highlighted with a hand cursor), and 'User settings'. The main window is titled 'TEMPLATE MANAGEMENT' and features a 'CARE' sidebar with icons for home, list, clock, edit, settings, help, and power. The main content area has a 'SELECT A TEMPLATE' section with two tabs: 'Supplied' (active) and 'Customised'. Under the 'Supplied' tab, a card for 'Multidisciplinary Care Plan' is visible, described as 'Concise care plan for multiple chronic conditions'.

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

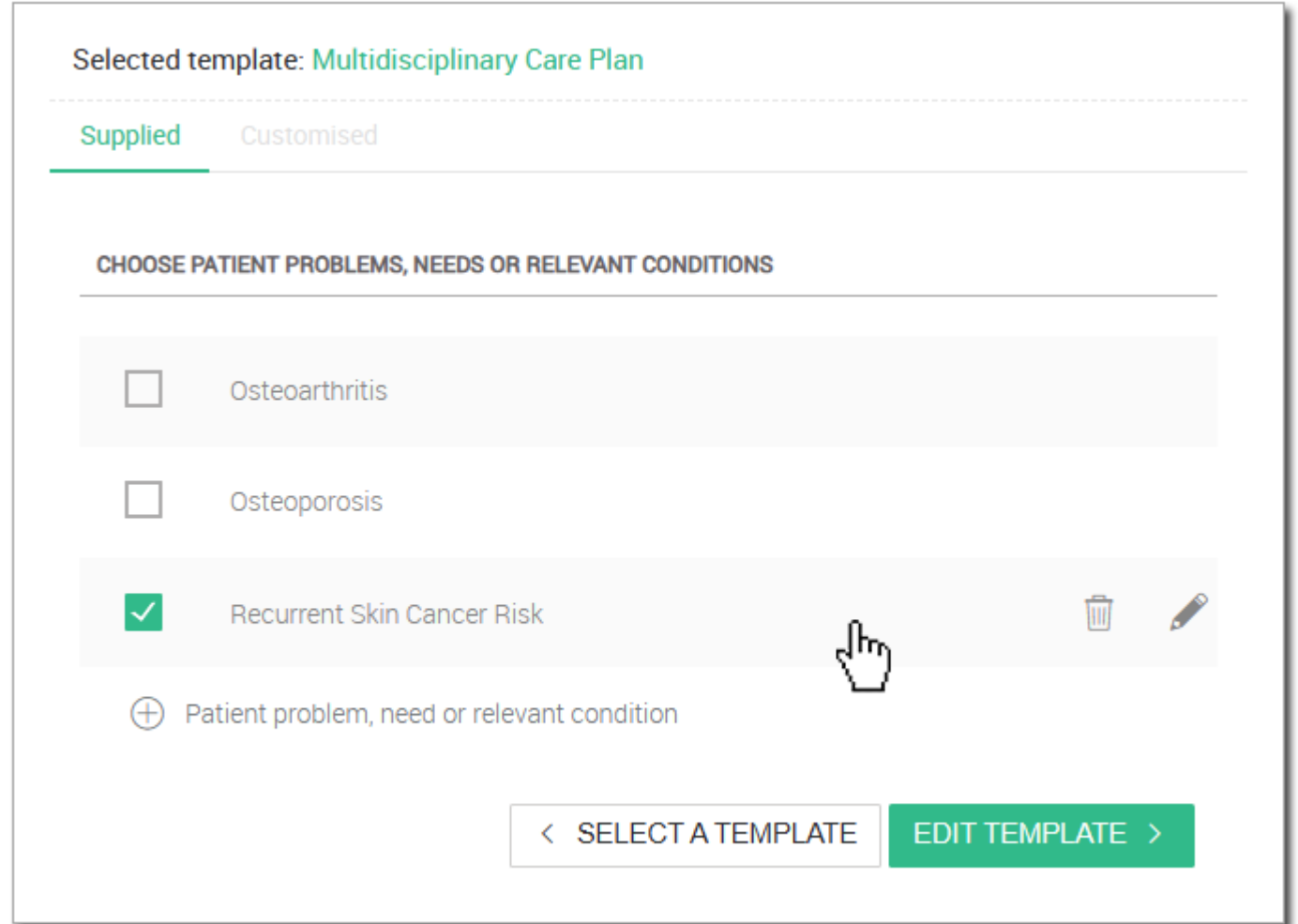
3. After selecting a base for your new template, you will be presented with a list of patient problems, needs and conditions to choose from which can be added to your *new* template.

- Select 1 or more items to add to your new template.

- You can rename as existing item by clicking its associate  button.

- You can create a new item by clicking  Patient problem, need or relevant condition




4. In our example, we have selected 'Recurrent Skin Cancer Risk'. Select at least one item to add to your new template, and click **Edit Template** button.



Selected template: **Multidisciplinary Care Plan**

Supplied Customised

CHOOSE PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

- Osteoarthritis
- Osteoporosis
- Recurrent Skin Cancer Risk  
-  Patient problem, need or relevant condition

< SELECT A TEMPLATE **EDIT TEMPLATE** >

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

5. You will be presented with the details of your first selected item. In our example, it's the Recurrent Skin Cancer Risk item.

The screenshot displays the 'TEMPLATE MANAGEMENT' interface for a 'MULTIDISCIPLINARY CARE PLAN'. At the top right, there are navigation buttons: '< BACK' and a green 'SAVE TEMPLATE' button with a checkmark icon.

The main content area is split into two panels. The left panel, titled 'PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS', shows a list of items under the heading 'MULTIDISCIPLINARY CARE PLAN'. The items are 'Obesity' and 'Recurrent Skin Cancer Risk', with the latter highlighted in a light blue rounded rectangle. A pencil icon is visible next to the list.

The right panel, titled 'PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS', displays the details for the selected 'RECURRENT SKIN CANCER RISK' item. It includes a 'GOALS' section with a 'Skin Cancer' goal, a plus icon, and a green arrow icon. Below this is a 'GOAL PROGRESS' section with a 'REMOVE GOAL' button (trash icon). At the bottom, there is a 'GOALS AND HEALTH NEEDS' section with a text box containing 'Early detection and Treatment'.

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

6. If you have selected multiple items to edit, you can toggle between them via the panel on the left of the window. In the following example we want to edit our Obesity plan details, so we select it here.

7. At the top of the window, you are presented with the various goals associated with the item you selected. The example below shows our Obesity item and 3 goals we have associated with it: Bio-Medical Blood Checks, Blood Pressure, and Cardiovascular Risk.

- o Add a goal by clicking
- o Switch between goals by clicking the title.

8. Under each goal are associated Progress, Health Needs, Metrics and Measurements, and Tasks.

PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

MULTIDISCIPLINARY CARE PLAN

Obesity
Recurrent Skin Cancer Risk

PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

OBESITY

GOALS

Bio-Medical Blood Checks Blood Pressure Cardiovascular Risk

GOAL PROGRESS REMOVE GOAL

GOALS AND HEALTH NEEDS

BP- to acceptable national target (less than 130)
Your target: Less than 130/80

METRICS AND MEASUREMENTS ADD METRIC

HEIGHT	WEIGHT	BP
- cm	- Kg	- mmHg
TARGET	TARGET	TARGET <= 135/85

TASKS ADD TASK

DESCRIPTION	HOW OFTEN	DUE	PROVIDER
BP- to acceptable national target (less than 130)	Every 6 months		GP/Registered Nurse (Medical Practice)
20+ minutes exercise, 5 days a week	Every 6 months		Exercise Physiologist

PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

OBESITY

GOALS

Bio-Medical Blood Checks Blood Pressure Cardiovascular Risk

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

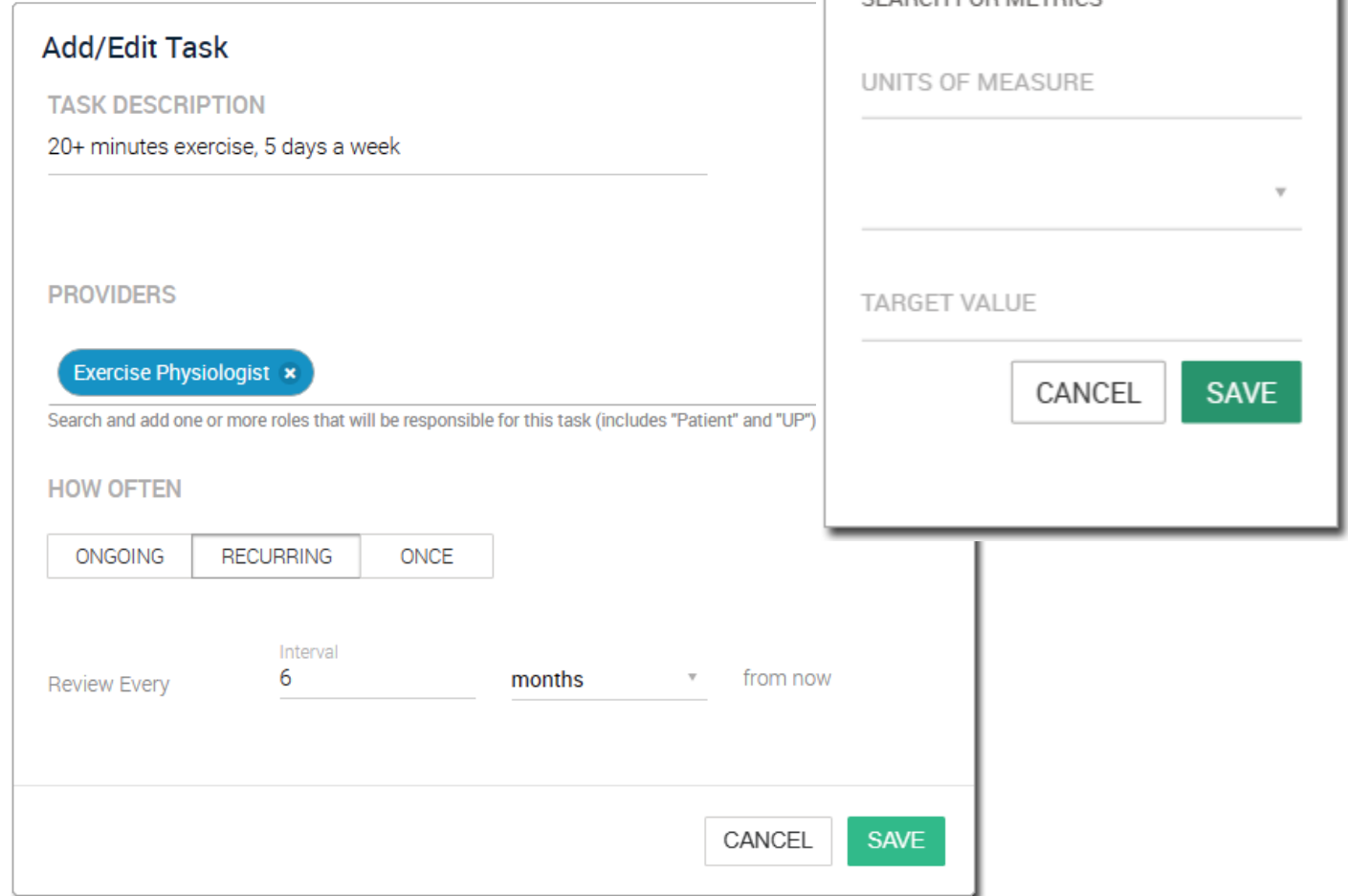
9. You can edit each section of the goal. For example, to add a new metric, click

 **ADD METRIC**

10. Similarly, you can insert additional tasks, click

 **ADD TASK**

11. When you have finished editing the template, click **Save Template** button located at the top-right of the editing window.



Add/Edit Task

TASK DESCRIPTION
20+ minutes exercise, 5 days a week

PROVIDERS
Exercise Physiologist ✕
Search and add one or more roles that will be responsible for this task (includes "Patient" and "UP")

HOW OFTEN
ONGOING RECURRING ONCE
Review Every Interval 6 months from now

METRICS
SEARCH FOR METRICS
UNITS OF MEASURE
TARGET VALUE
CANCEL SAVE

CANCEL SAVE

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

12. You will be prompted to name the new template, and optionally give it a description.

13. Click **Save** button to save your customised template. Your new template now appears within the Customised list.

The screenshot displays the 'CARE' application interface. On the left is a vertical navigation bar with icons for home, list, clock, edit, settings, help, and power. The main content area is titled 'TEMPLATE MANAGEMENT' and features a 'SELECT A TEMPLATE' section with two tabs: 'Supplied' and 'Customised'. The 'Customised' tab is active, showing a list of templates:

- Coronary Heart Disease
New Coronary Heart Disease Template
Last Edited 08/09/2022
- My Template
New Template
Last Edited 03/07/2023

Overlaid on the right is a 'Save Custom Care Plan Template' dialog box. It contains the following elements:

- Close button (X)
- Section: 'Save Changes to an Existing Template'
- Radio button for 'Multidisciplinary Care Plan' with subtext: 'Concise care plan for multiple chronic conditions.'
- Checked radio button for 'Create a New Custom Template'
- Text input field for 'TEMPLATE NAME' containing 'My Template'
- Text input field for 'TEMPLATE DESCRIPTION' containing 'New Template'
- Subtext: 'Provide a description for this template'
- 'CANCEL' and 'SAVE' buttons at the bottom right.

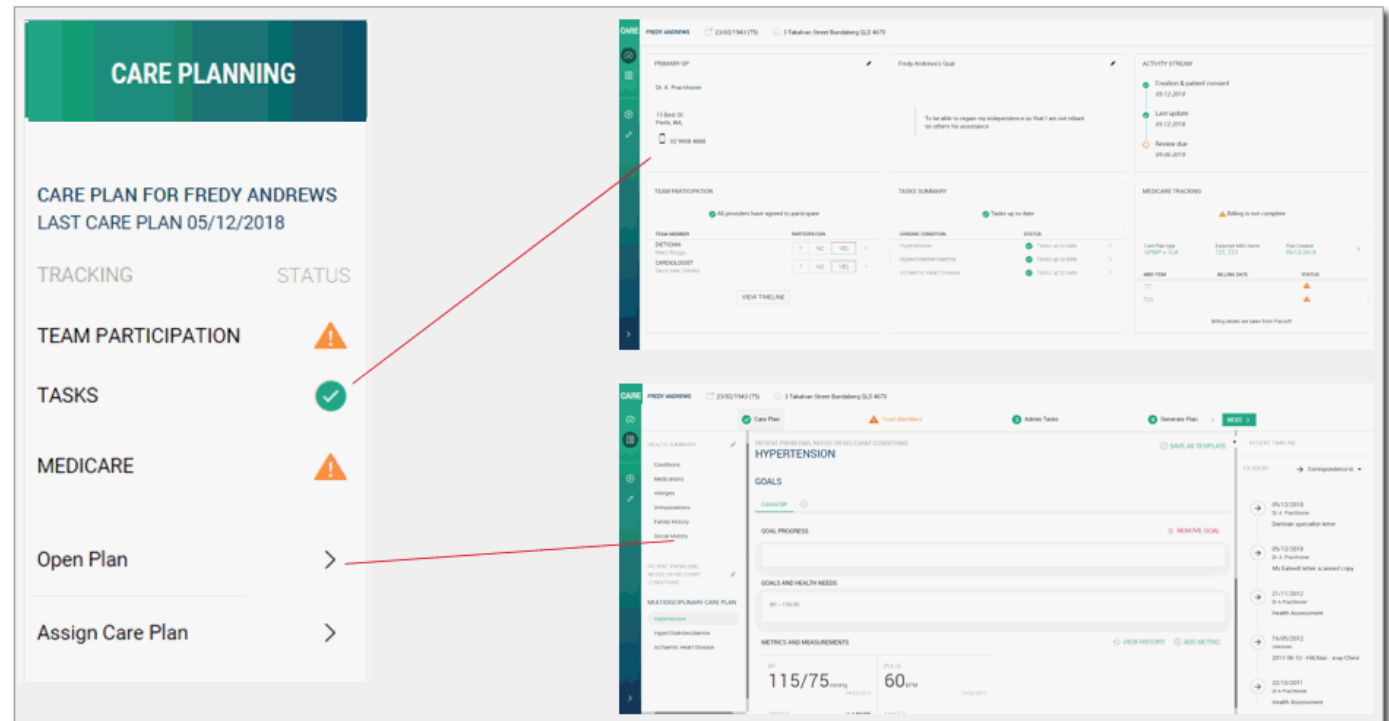
MedicalDirector Care – Review a Care Plans

Overview

1. Review correspondence, pathology and imaging results since the last care plan.
2. Record the patient's progress and track due tasks.
3. Review the team members and generate any required documentation.
4. Set tracking and billing options. Generate a printed care plan, if required.

Step-by-Step

1. Review correspondence, pathology and imaging results since the last care plan.
 - Open a patient's care plan by clicking on the tracking summary part of the widget or by clicking Open Plan.

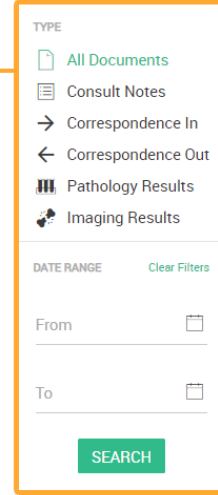
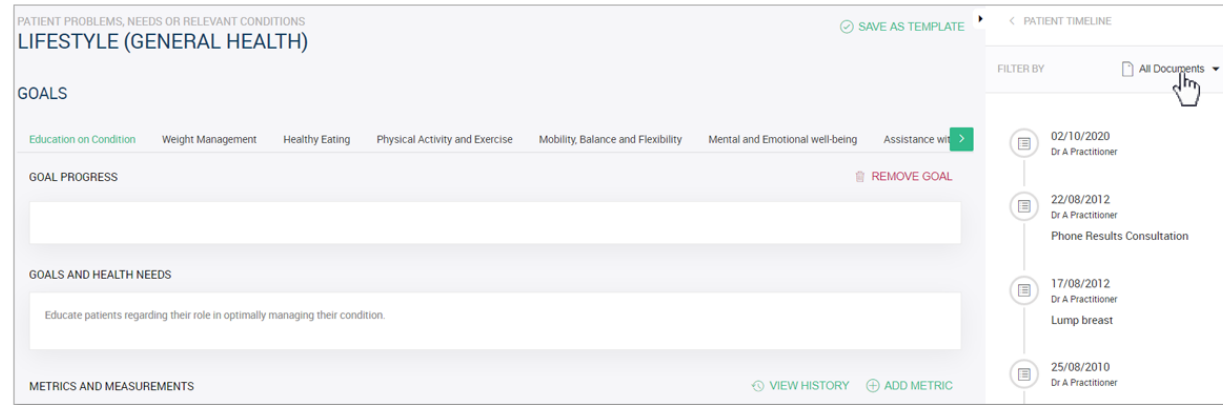


MedicalDirector Care – Review a Care Plans

- o View summary details about the care plan with the patient dashboard.

The patient dashboard provides a summary view of the care plan including:

- Primary GP.
- Patient demographic details.
- The patient’s overarching goal.



- Critical dates including the date of the first care plan, when it was last updated and when the care plan is next due for review.
 - Team member participation status.
 - Tasks status.
 - Billing status.
- o The patient timeline represents all the documents which are stored in MedicalDirector Clinical for this patient.
 - You can filter by document type or change the date range, to limit the amount of documents shown. Note: the From Date filter will automatically populate with the date of the last care plan to ensure that only the documents which were created since the last care plan are shown.

MedicalDirector Care – Review a Care Plans

Document navigation:

The screenshot illustrates the document navigation interface in MedicalDirector Care. It features a central patient timeline and a document list on the right. Callouts highlight key navigation elements:

- Hide/Show Document Panel:** A callout pointing to a vertical bar on the left side of the interface.
- Return to the Patient Timeline:** A callout pointing to a left-pointing arrow icon at the top of the patient timeline.
- Skip to next/previous document:** A callout pointing to up and down arrow icons at the top of the patient timeline.
- Click to display a document:** A callout pointing to a document entry in the list on the right.

The patient timeline shows a document for **Wednesday August 22 2012** at **11:35:04** by **Dr A Practitioner**. The document content includes:

- Phone consultation after results returned from Lab.
- Discussed results. Patient will keep an eye on the lump and come back if it changes
- Reason for contact:** Phone Results Consultation
- Actions:**
 - Result notified by Dr A Practitioner - PAP SMEAR 17/08/2012
 - Result notified by Dr A Practitioner - CYTOLOGY NON-GYNAE 17/08/2012
 - Result notified by Dr A Practitioner - MASTER IRON STUDIES 17/08/2012
 - Result notified by Dr A Practitioner - MASTER FULL BLOOD COUNT 17/08/2012
 - Result notified by Dr A Practitioner - ELFT (MASTER) 17/08/2012
 - Removed recall for PAP SMEAR on 20/08/2012.

The document list on the right shows a filter set to **All Documents** and two entries:

- 02/10/2020** by **Dr A Practitioner**
- 22/08/2012** by **Dr A Practitioner** for **Phone Results Consultation** (highlighted with a callout).

The patient timeline also displays the date **22/08/2012**, the title **Consult Notes Results**, and the subtitle **Phone Results Consultation**. Below this, it identifies the **PRACTITIONER** as **Dr A Practitioner** and provides a **LINK DOCUMENT** option. An **Assigned Tasks** section is also visible at the bottom.

MedicalDirector Care – Review a Care Plans

- You can link the team member who authored the document (or role) and then provide a summary of their correspondence.

22/08/2012
Consult Notes Results
Phone Results Consultation

PRACTITIONER
Dr A Practitioner

LINK DOCUMENT
Registered Nurse (Aged Care)

Assigned Tasks

LIFESTYLE (GENERAL HEALTH)/ASSISTANCE WITH DAILY LIVING
Advice on how to optimise and preserve independence with home assistance including support group or links to community services.

SUMMARY

- Linked documents (with summary) show in the Team Correspondence tab. Click **View** to view the original document.

TASKS & CORRESPONDENCE ADD TASK

Tasks Team Correspondence

SUMMARY	DATE	LINKED DOCUMENTS
REGISTERED NURSE (MEDICAL PRACTICE) (SUSAN CHARLTON) TEAM PARTICIPATION ACCEPTED 01/10/2020	02/10/2020	22/08/2012 Phone Results Consultation View

2. Update progress notes and review tasks.

- Record progress notes for this focus area here.

GOAL PROGRESS REMOVE GOAL

MedicalDirector Care – Review a Care Plans

TASKS & CORRESPONDENCE + ADD TASK

Tasks Team Correspondence

PENDING COMPLETED

DESCRIPTION	HOW OFTEN	DUE	PROVIDER	COMPLETE ⓘ
Educate patients regarding their role in optimally managing their condition.	Every 12 months	02/10/2021	GP, Registered Nurse (Medical Practice)	<input type="checkbox"/> ⋮
Know how to optimally monitor and manage your condition.	Every 12 months	02/10/2021	Patient	<input type="checkbox"/> ⋮

- Mark as complete any tasks which have been done and add any new tasks which should be done on an ongoing basis, should be done by a specific date or tasks which should be reviewed periodically to measure progress.
- Tasks which have been marked as complete show in the Completed view.

MedicalDirector Care – Review a Care Plans

3. Check team members status, track the plan and set review dates, generate documentation.
 - Review and update team members.
 - If needed, generate new referrals or team participation letters.

The image displays two screenshots of the MedicalDirector web application interface, illustrating the process of reviewing and generating documentation for a care plan.

Top Screenshot: The left sidebar shows a list of team members under the heading "TEAM MEMBERS". The members listed are: REGISTERED NURSE (MEDICAL PRACTICE) Susan CHARLTON, DIETICIAN, EXERCISE PHYSIOLOGIST, OCCUPATIONAL THERAPIST, OSTEOPATH, and PHYSIOTHERAPIST. Each member's name is followed by an "Unassigned" status tag. The "PHYSIOTHERAPIST" entry is highlighted with a green background. The main content area is titled "PHYSIOTHERAPIST" and shows an "Unassigned" status. Below this, there are two tabs: "Role" (selected) and "Documentation". A green "Assign Provider" button is visible. At the bottom, a message reads: "Click documentation tab for generating team participation letter and referral form."

Bottom Screenshot: The left sidebar is identical to the top screenshot, but the "PHYSIOTHERAPIST" entry now shows the name "Paul SHEPHERD" and is highlighted. The main content area is also titled "PHYSIOTHERAPIST" and shows the name "Paul SHEPHERD". The "Documentation" tab is now selected. A green "GENERATE" button is visible. Below the button, a message reads: "Generate Team Participation letter and Allied Health Services Under Medicare (EPC) form for this provider." At the bottom of the main content area, the word "DOCUMENTS" is visible.

MedicalDirector Care – Review a Care Plans

- o Track this plan to ensure it is billed.

TRACK BILLING

Track the billing progress of this care plan

Two or more collaborating health or care providers are part of the care team and thus this care plan is eligible to claim for TCA services.

CARE PLAN TYPE
GPMP + TCA

Select the care plan type (for billing tracking purposes)

721 723 + ADD MBS ITEM

- o Set an interval for the next review.

SET REVIEW PERIOD

Create a reminder within the care plan system to review the care plan

REVIEW AGAIN IN
Select a review period for this care plan

Enter review interval
6 months

- o Generate the care plan for your records.

GENERATE PLAN
UPDATE CARE PLAN

Changes to the care plan will not be shared to team members unless it is published. **GENERATE**

Care plan documents will be generated automatically.
A new progress note will be created automatically, summarising the changes to the care plan.

Automatically save generated documents to the Patient file

Click Generate to create a patient care plan. Each new care plan is \$15.00, billed monthly by MedicalDirector, subject to change.

MedicalDirector Care – Track Care Plans

- o Review upcoming, overdue and in-progress care plans.
- o Ensure the correct billing has been done in a timely manner.

The practice dashboard tracks all care plans. The practice dashboard will track all care plans that:

- o Are overdue.
- o Are coming up for review.
- o Have been assigned to a user in the practice.
- o Have been started but not yet finalised.
- o Are awaiting on all team members to agree to participate.
- o Have not been fully billed.
- o Are complete, with no outstanding issues.

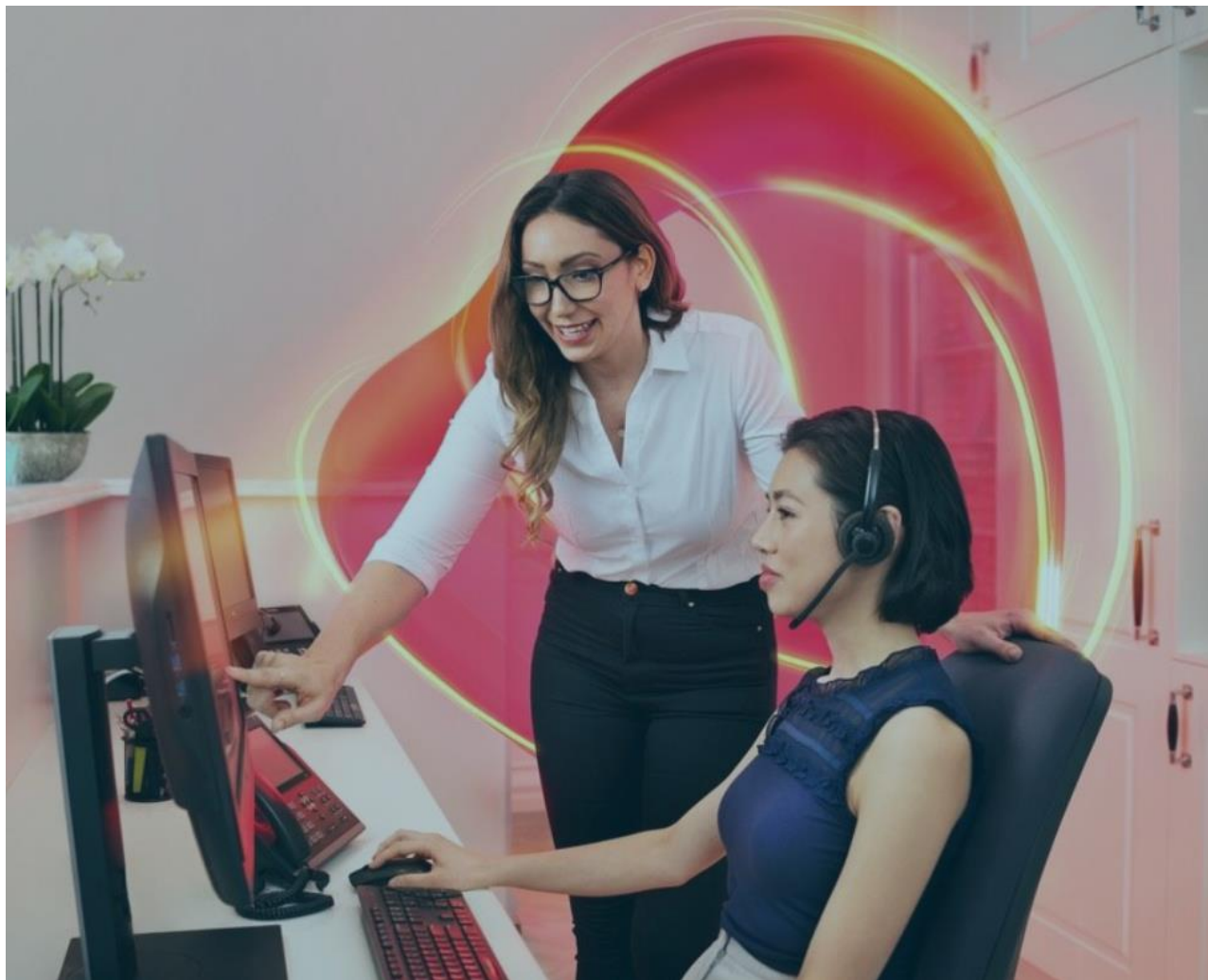
FRIDAY 02 OCTOBER 2020
CARE PLAN TRACKING

Overdue	Upcoming	Assigned	In Progress	Team Participation	Tasks	Billing	Completed
1 in October 1 in total	3 in Next 3 months	2 in total	0 in total	6 participating	0 in total	5 in total	0 in total

Overdue Care Plans

DUE DATE	PATIENT NAME	LAST REVIEWED	RESPONSIBLE	ASSIGNED TO	PLAN TYPE	TEAM PARTICIPATION	TASKS	BILLING	ACTIONS
OCTOBER 2020 1 OVERDUE									
02/10/2020	Anna Andrews	01/10/2020	Dr A Practitioner	--	--	⚠	✅	⚠	⋮

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- 4.3 Enhancements
- Template Management
- Sending Emails
- My Health Record - NASH - Setup requirements
- Patient Search Utility
- MD Utilities
- Setting up permissions and configuring users
- Managing the appointment types



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Thank you

A recording & slides of this session and feedback form will be delivered to your inbox shortly.



Kylie Goodwin
Practice Consultant
MedicalDirector | Telstra Health

