

# MedicalDirector Clinical Training for GPs

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.



# 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

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Recording measures

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Recording Immunisations

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Recording Cervical Screening

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Managing Recalls and recording contact

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Recording social and family history including  
recording alcohol and smoking

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Keeping Past History items relevant

Creating letters

Data Quality and Data Cleansing

User Preferences

My Health Record accessing & uploading

# Data Quality using coded lists, recording measures

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;

- o Mark the date and time on which the recordings were taken, and
- o 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

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

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

# Data Quality using coded lists, recording measures via Progress Notes

The Examination module of [Progress Notes](#) allows you to record the findings of a single consultation. Each tab within the Examination module contains a variety of controls for recording information, as shown in the following image.

Some data may also appear automatically on this window, if it was recorded previously using other components of Clinical, such as the [Blood Pressure](#) module.

Information recorded using any of the tools within the Examination module appears in the text box at the upper-left of the window, and upon saving is added to the [Progress Note](#) for the consultation.

The content available to this module differs depending on the patient's recorded [sex at birth](#).

The screenshot shows the 'Examination' window with the 'Eye' tab selected. The text box at the top left contains the text: 'Eye: Red Right eye. Swollen Right eye. Right eye discharge.' Below this, there are various clinical assessment tabs: General, Endocrine, CVS, Lymphatic, Respiratory, Skin, Abdomen, ENT, Eye, CNS, GU, Gynae, Musculo-skeletal, and Breast. The 'Eye' tab is active, displaying a list of symptoms for recording, organized into columns for Right and Left eyes. The symptoms include: Redness, Swelling, Discharge, Foreign body, Corneal ulcer, Proptosis, Pupil reaction: to Light, to Accommodation, Visual fields, Colour Blindness, Hyphaema, Ingrowing lashes, Ectropion, Entropion, Pterygium, Ptosis, Papilloedema, Fundus, and External Ocular Movements. Each symptom has a 'Y' or 'N' button for recording. There is also a 'Type' dropdown menu. At the bottom, there are buttons for 'Set page to NAD', 'Clear page', 'History', 'Save', and 'Cancel'. A small image of a human eye is visible in the bottom left corner of the window.

# CVD (Cardiovascular Risk Calculator) Absolute Calculator

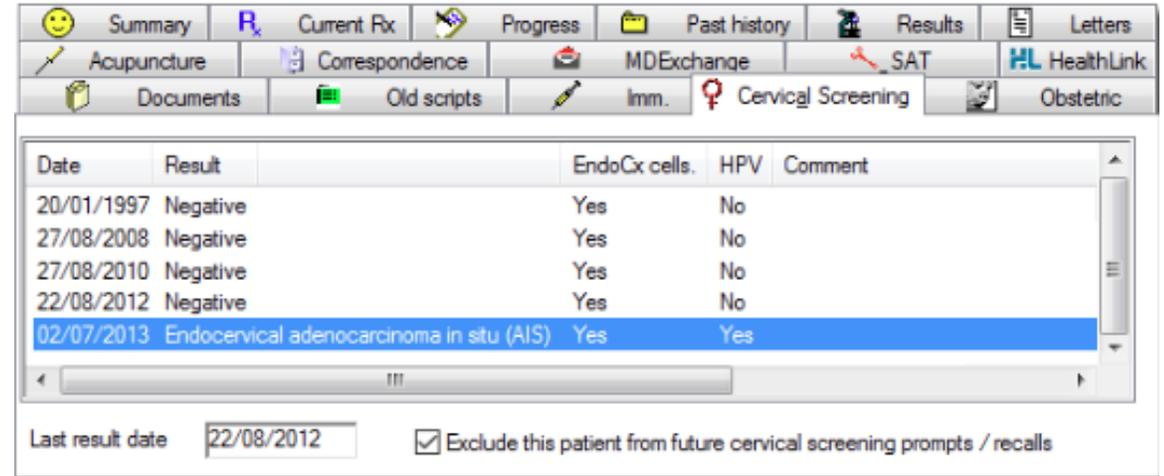
- From within the [Clinical Window](#), select **Tools > Tool Box > Cardiovascular Risk**. The **CV Risk** tab appears. Select which calculator you wish to use. If you select the Absolute calculator, the following fields will be pre-populated with data, where available:
  - Sex at Birth**. As sourced from the patient's [record](#).
  - Age**. As sourced from the patient's [record](#).
  - Systolic blood pressure**. As sourced from the most recent [blood pressure](#) 'sitting' data, recorded within the last 2 months.
  - Diastolic blood pressure**. As sourced from the most recent [blood pressure](#) 'sitting' data, recorded within the last 2 months.
  - Smoking status**. A patient who has quit smoking within the last year will be considered a smoker for the purposes of the calculator.
  - Total Cholesterol**. As sourced from the most recent Total Cholesterol data, recorded within the last 2 months.
  - HDL Cholesterol**. As sourced from the most recent HDL Cholesterol data, recorded within the last 2 months.
  - Diabetes**. As sourced from the patients past medical history, see [Absolute CVD Risk Diagnosis Descriptions](#).
- Options:
  - For patients who are automatically considered '**high risk**', simply click **Save** button to automatically document the risk value as >15% in the Tool Box. This will also add a note to the patient's [Progress Notes](#). There are no further actions required. You may exit the Tool Box.
  - For all other patients, click Absolute CVD Risk Calculator button. Proceed now to Step 3.
- Enter values for the following fields:
  - Systolic Blood Pressure - (Enter a value between 50 and 300).
  - Diastolic Blood Pressure - (Enter a value between 20 and 150).
  - Total Cholesterol - (Enter a value between 2 and 30).
  - HDL Cholesterol - (Enter a value between 0.2 and 20).
- Indicate the patient's smoking and diabetes status, and ECG LVH. Note that this is not the same as 'echo LVH' which is a lesser risk factor.
- Click **Save** button. A new entry appears within the recorded data on the right-hand side of this window. Note that this data is saved to this window for future reference, and a record is made in the patient's [Progress Notes](#).

- Low risk:** Less than 10% probability of cardiovascular disease within the next 5 years.
- Moderate risk:** 10–15% risk of cardiovascular disease within the next 5 years.
- High risk:** Greater than 15% risk of cardiovascular disease within the next 5 years.

The screenshot shows the 'Tool Box' window for the 'Cardiovascular Risk Calculator'. At the top, there is a navigation bar with a heart icon, 'Ctrl + Alt + C', and a breadcrumb trail: 'Tools > Tool Box > Cardiovascular Risk (via the Clinical Window)'. Below this, the calculator interface includes a header 'Cardiovascular Risk Calculator' and a close button 'X'. The main area contains input fields for 'Date' (26/06/2024), 'Time' (7:45:10 AM), 'Sex at Birth' (Male), 'Age' (69), 'Height' (175), and 'Patient ID' (20). A tabbed interface shows 'CV Risk' selected, with other tabs for 'Blood Glucose', 'Blood Pressure', 'ECG', 'INR', 'Renal Function', 'Respiratory', and 'Weight'. Under 'CV Risk', there are two buttons: 'Absolute CVD Risk Calculator' (highlighted) and 'Relative CVD Risk Calculator'. To the right are 'Data' and 'Graph' buttons. The 'Current Measurements' section includes input fields for 'Blood Pressure (mmHg)' (Systolic and Diastolic), 'Total Cholesterol' (mmol/L), and 'HDL Cholesterol' (mmol/L). Below these are radio buttons for 'Smoking Status' (Yes/No), 'Diabetes' (Yes/No), and 'ECG LVH' (Yes/No/Unknown). A red warning message states: 'Please note this patient does not require an absolute CVD risk assessment as they are already known to be at > 15% probability of CV disease within 5 years. More Information'. A horizontal bar chart shows risk levels: green (Low), yellow (Moderate), and red (High). Below the chart, instructions state: 'This is a calculator only. Click the Save button to save the risk percentage. Double-click a record within the table on right side to view individual measurements.' A table with columns 'Date', 'Time', 'Type', and 'Risk (%)' is present but empty. At the bottom, there are buttons for 'Clear', 'Recall', 'Print', 'Reference', 'Edit', 'View', 'Save', and 'Close'. Links for 'Patient', 'Practitioner', and 'Online Calculator' are also visible.

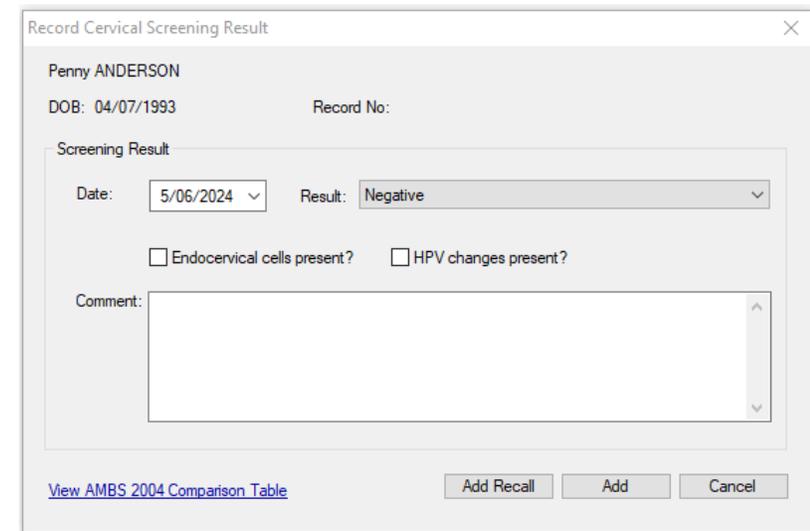
# Recording Cervical Screening via the Patient's Record

1. Select the [Cervical Screening tab](#) in the patient's [clinical record](#).
2. Either,
  - o Click 
  - o Press **F3**
  - o 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.
  - o Enter the date on which the screen was obtained from the patient.
  - o Select a result type from the list provided.
  - o Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
  - o 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 software windows. 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?  (checked)
- HPV changes present?  (unchecked)
- 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.
  - Only female or gender-neutral patients will appear in the list.
2. 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**
3. 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

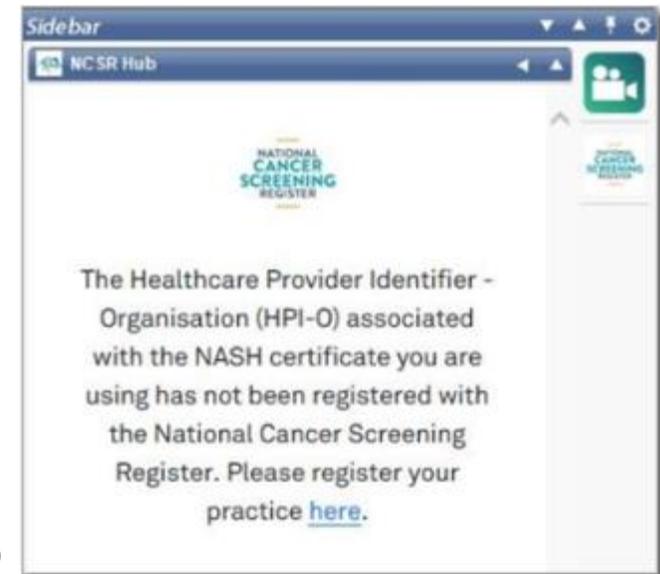
The National Cancer Screening Register enables a single electronic record for each person in Australia participating in cervical and bowel screening. The National Cancer Screening Register plays a vital role in supporting the National Cervical Screening Program (NCSP) and the National Bowel Cancer Screening 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 are no patient alerts. A table lists screening programs: Bowel (New to Screening, Due Now) and Cervical (New to Screening, DUE NOW). The NCSR History tab is active, showing a list of records with columns for Program, Date, Description, and Outcome. The records include Cervical Screening History, NBCSP - GP Assessment Report, NBCSP - Defer Cervical Program, and Correspondence. A search bar and filters for Bowel, Cervical, and Correspondence 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	<a href="#">Cervical Screening History</a>	
Bowel	29/07/2020	<a href="#">NBCSP - GP Assessment Report</a>	Not Referred For Colonoscopy
Cervical	29/07/2020	<a href="#">NBCSP - Defer Cervical Program</a>	
Correspondence	20/04/2020	<a href="#">Correspondence</a>	

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 Medicare number is 4789114590 and her date of birth is 1 August 1959. There is one patient alert. A table lists screening programs: Bowel (New to Screening, Due Now) and Cervical (Actively Screening, 25/03/2021, DUE). The Choose Form & Report tab is active, showing a list of 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 NBCSP - Cervical Program Correspondence Preference.

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	<a href="#">NBCSP - Alternative Access Model (Issue/Re-issue Kit)</a>
Bowel	<a href="#">NBCSP - Defer Bowel Program</a>
Bowel	<a href="#">NBCSP - Opt Out Bowel Program</a>
Bowel	<a href="#">NBCSP - Replacement FOBT Kit Request</a>
Bowel	<a href="#">NBCSP - Adverse Events Report</a>
Bowel	<a href="#">NBCSP - Replacement Participant Details Form Request</a>
Bowel	<a href="#">NBCSP - Histopathology Form</a>
Bowel	<a href="#">NBCSP - Colonoscopy Report</a>
Bowel	<a href="#">NBCSP - GP Assessment Report</a>
Cervical	<a href="#">NBCSP - Cervical Program Correspondence Preference</a>

# 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

# Prescribing Select Drug

There are a number of ways you can prescribe medications, all of which can only be performed from within a patient's [Clinical Window](#):

- Select the [Current Rx tab](#) and then to add a new item, click or press F3 or **+** right-click within the current medications list and select New Item from the menu. The Select Drug window appears. Proceed to Step 1 below, or
- To back-date a script, select the [Current Rx tab](#) and then to add a new item, enter the 'Script Date' as required at the bottom of the Current Rx tab, click **+** or press F3 or right-click within the current medications list and select New Item from the menu. The Select Drug window appears. Proceed to Step 1 below, or
- Prescribe from your [Drug Favourites](#) list (should you have any favourites saved), by clicking **Rx** in the toolbar. The Select Drug window appears. Proceed to Step 1 below, or
- Select a medication from within [MDref](#). Within in MDref, highlight the item you wish to prescribe and then click **Prescribe** button at the bottom-left of the MDref Explorer window. The Enter Dose window appears. Proceed to Step 2 below, or
- Select from any [Drug Protocols](#) you have created. Proceed to Step 12 below, or
- Re-prescribe from the patient's old scripts. Select the [Old Scripts tab](#), located and right-click the item you wish to re-prescribe, and select Prescribe Item from the menu that appears. Proceed to Step 2 below.

Drug name	Strength	Qty.	Rpts.	Avail.	RPBS	B.P.P.	T.G.P.	S.P.C.
ASPIRIN DISP TABLET	500mg	16		\$-OTC	No			
ASPIRIN EC CAPSULE	100mg	28		\$-OTC	No			
ASPIRIN EC CAPSULE	100mg	84	x1	\$-OTC	Yes			
ASPIRIN EC CAPSULE	100mg	140		\$-OTC	No			
ASPIRIN EC TABLET	100mg	28		\$-OTC	No			
ASPIRIN EC TABLET	100mg	60		\$-OTC	No			
ASPIRIN EC TABLET	100mg	84	x1	\$-OTC	Yes			
ASPIRIN EC TABLET	100mg	120		\$-OTC	No			
ASPIRIN EC TABLET	100mg	168		\$-OTC	No			
ASPIRIN EFF TABLET	500mg	16		\$-OTC	No			
ASPIRIN MIXTURE		200mL		\$-OTC	No			
ASPIRIN TABLET	100mg	90	x1	\$-OTC	Yes			
ASPIRIN TABLET	100mg	112	x1	RB	Yes			
ASPIRIN TABLET	100mg	112	x1	\$-OTC	Yes			

1. The Select Drug window appears. Select an item by either:

- o Typing the name of the medication into the Enter Drug Name text box (you need only type the first few letters for a search to commence), and double-clicking the drug or selecting the drug and clicking **Prescribe** button

# Prescribing Selecting Drug by Class

2. (Optional) You can further filter the list of medications by:

- o Ticking the Exclude OTC... check box to refresh the medications list to hide Over-The-Counter medications,

- o Clicking **Brands** Button to show generically equivalent brand names with the same strength as the highlighted item,

- o Clicking **Group** button to display all members of the Therapeutic Group to which the selected medication belongs. This button is only available to medications that belong to a Therapeutic Group,

- o Clicking **Current Class** button to display all items from [MDref](#) that are in the same therapeutic class as the highlighted item.

- o Right-clicking a medication, and selecting the 'Single and Multi-Ingredient Products' option, which allows you to see other medications that contain at least one of the same ingredients of the selected medication.

See [Single and Multi-Ingredient Products](#) for more information.

3. Click **Prescribe** button to prescribe your medication of choice.

4. (Optional) Once you have selected the medication, you may be notified of any possible drug interactions.

5. (Optional) If you have an existing Limited Prescription for this patient, a prompt is displayed. Select the most suitable option for your patient to continue.

- o Accessing the MDref Class Browser by clicking **Select drug by class** button and selecting a drug from there

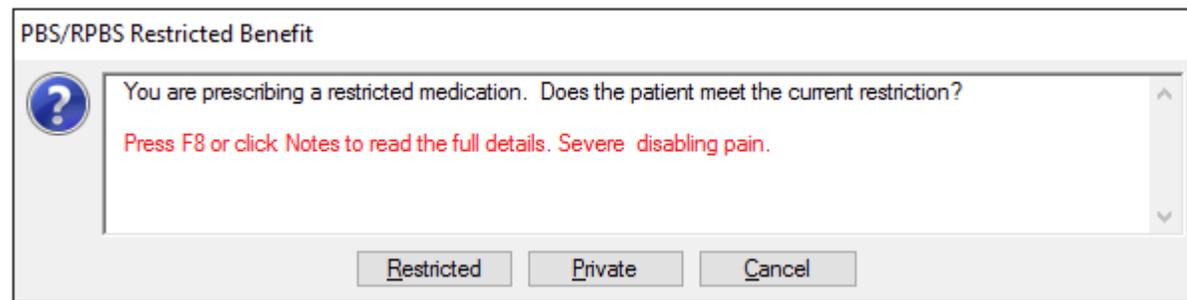
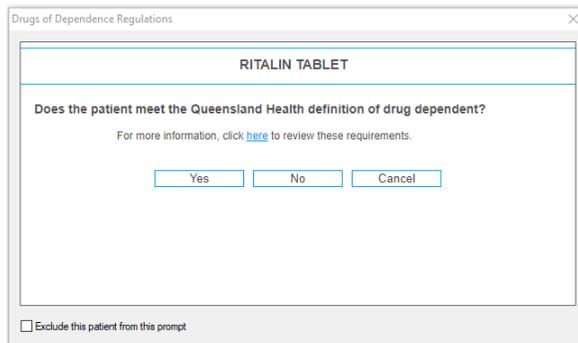
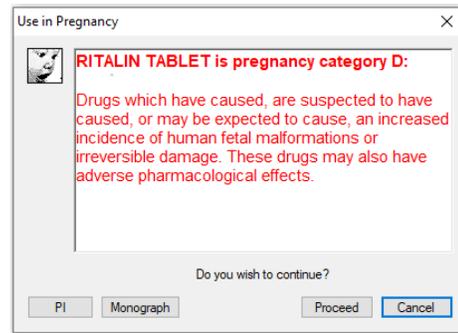
- o Displaying your [favourites](#) list by clicking

on the Select Drug window, and selecting a drug from the list that appears

- PBS - Pharmaceutical Benefits Scheme
- RPBS - Restricted Pharmaceutical Benefits Scheme
- B.P.P. - Brand Price Premium
- T.G.P. - Therapeutic Group Premium
- S.P.C. - Special Patient Contribution

Drug name	Strength	Qty.	Rpts.	Avail.	RPBS	B.P.P.	T.G.P.	S.P.C.
ASPIRIN DISP'TABLET	500mg	16		\$-OTC	No			
ASPIRIN EC CAPSULE	100mg	28		\$-OTC	No			
ASPIRIN EC CAPSULE	100mg	84	x1	\$-OTC	Yes			
ASPIRIN EC CAPSULE	100mg	140		\$-OTC	No			
ASPIRIN EC TABLET	100mg	28		\$-OTC	No			
ASPIRIN EC TABLET	100mg	60		\$-OTC	No			
ASPIRIN EC TABLET	100mg	84	x1	\$-OTC	Yes			
ASPIRIN EC TABLET	100mg	120		\$-OTC	No			
ASPIRIN EC TABLET	100mg	168		\$-OTC	No			
ASPIRIN EFF' TABLET	500mg	16		\$-OTC	No			
ASPIRIN MIXTURE		200mL		\$-OTC	No			
ASPIRIN TABLET	100mg	90	x1	\$-OTC	Yes			
ASPIRIN TABLET	100mg	112	x1	RB	Yes			
ASPIRIN TABLET	100mg	112	x1	\$-OTC	Yes			

# Drug Notifications



PBS/RPBS Codes	
PBS	Pharmaceutical Benefits Scheme unrestricted benefit
RB	Pharmaceutical Benefits Scheme restricted benefit
AUTH	Pharmaceutical Benefits Scheme Authority required
sAUTH	Pharmaceutical Benefits Scheme Streamlined Authority required
Sect. 100	Pharmaceutical Benefits Scheme Section 100 item
RPBS RB	Repatriation Pharmaceutical Benefits Scheme restricted benefit
RPBS AUTH	Repatriation Pharmaceutical Benefits Scheme Authority required
\$-Rx	Private prescription
\$-OTC	Product available without prescription
\$-HOSP	Available only through hospital pharmacies
Medicare	Item payable as a Medicare benefit
SAS	Special Access Scheme item
Unregis'd	Product not registered with TGA

# Authority Items

If a prescribed medication item requires an Authority, during the prescribing process an additional step is required; after the 'Dose/Frequency/Instructions' window has been completed, another window displays all the information that is required to obtain an Approval Number (by telephone).

- The Authority Number displayed is the 'Script Number', which must be quoted if you are required to (or choose to) obtain telephone approval.
- The Approval Number can be entered manually into the Approval Number text box if you are required to telephone for an approved number. Alternatively, using Medicare Australia's Streamlined Authority system, an Approval Number may be generated automatically for eligible medications. You can always change this number if you need to use a different Approval Number. Once changed manually, clicking **Use Default Number** button will reset the Approval Number to the default as dictated by Medicare Australia's Streamlined Authority system.
- If an Approval Number is entered, it is printed on the prescription. If it is not entered immediately, and telephone approval is subsequently obtained, it can be hand-written on the prescription in the appropriate places after the prescription has been printed.
- Some medications deemed eligible for Medicare Australia's Streamlined Authority system have multiple Approval Numbers associated with them that you can choose from. When these medications are prescribed, a **View List** button appears (in place of **Use default number** button shown in the image). On clicking **View List** button you will be presented with the Available Approvals window from which you can select an appropriate Approval Number.
- The quantity and number of repeats can be altered if necessary. For medications deemed eligible for Medicare Australia's Streamlined Authority system you can decrease the quantity and repeats without affecting the pre-generated Approval Number. Increasing these figures will require that you obtain an Approval Number.
- Check boxes are provided on this window to allow the Authority to be marked to indicate if a previous Authority has been obtained, and whether the prescription is to be sent to the patient or returned to the practitioner.
- Buttons allow you to choose whether the item is to be printed as an Authority prescription or as a Private prescription. If Private is chosen, the drug's code is changed from 'A' to '\$', and it is printed on a private prescription.
- If **Authority** button is clicked, the item is printed as an Authority prescription. The text appearing in the edit box is printed on the Medicare Australia copy of the prescription as the Indication for Authority. This text can be edited if required. For example, some drugs require the date of an endoscopy to be added to the indication. In other cases, the same item may have multiple approved indications. The text should be edited so that the appropriate indication is displayed. When **Authority** button is clicked, the edited text is stored in that patient's record so that when subsequent Authority prescriptions are written, the text does not need to be re-edited.
- When the Authority prescription is printed, the third (Medicare Australia/DVA copy) and fourth (Practitioner's copy) copies of the prescription are printed on the white space below the original and duplicate. As MedicalDirector Clinical also keeps a copy of the prescription, it is not necessary for the prescriber to keep the printed fourth copy, however Medicare Australia requires it to be printed.
- Because of space limitations, it is not possible to put lengthy instructions on authority prescriptions, and they are truncated to fit into the available space.

Phone Approval Hotline 1800 888 333

**PATIENT DETAILS**

Name: Jennifer Andrews  
Address: 2 Kennedy Road, Bundaberg, Qld 4670

Medicare Number: 3500 26512 1 / 2  
Pension/DVA Number:  
Authority Number: 10002802  
Prescriber Number: 2173711

**ABILIFY TABLET 10mg**

Dose: 1 stat p.r.n.

Quantity: 30  
Default Qty: 30  
Repeats: 5  
Default Rpts: 5  
Approval Number: 10023

This item satisfies the requirements of Medicare Australia's Streamlined Authority system. Under this system, MedicalDirector Clinical can provide you with the required approval number. The approval number has been entered for you. Click the Authority button to proceed or enter an alternative approval number provided by Medicare Australia.

Text to appear on new prescription: Schizophrenia

Authority - RB Restriction: Schizophrenia

Send directly to patient?  Previous Authority?

AusDI content is accessed daily by



17,500+ GPs across  
4,500+ practices in their  
MedicalDirector Clinical and  
Helix prescribing software



11,000+ dentists and  
350+ nursing homes



Universities, public and private  
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Find the most recent documents sourced directly from pharmaceutical manufacturers in pdf format.

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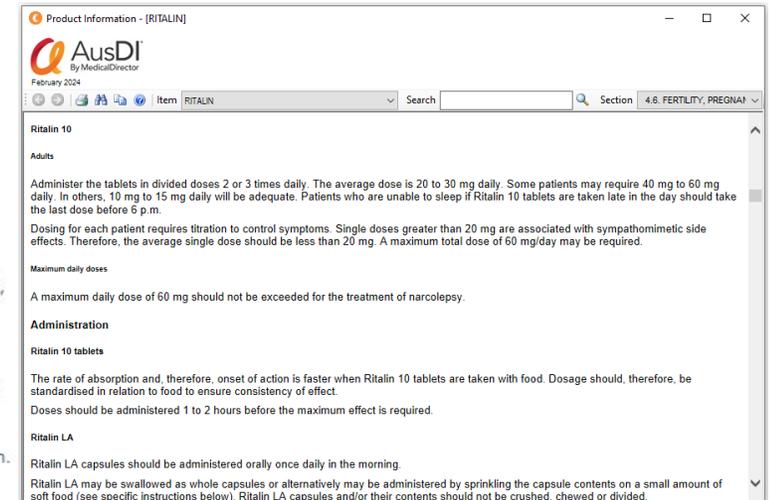
Identify clinically significant drug-drug, drug-food and drug-complementary medicine interactions, duplicate therapy warnings and shared adverse effects.



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The most comprehensive guide to administering oral medicines to people who have swallowing difficulties or an enteral feeding tube.

Brought to you by the Society of Hospital Pharmacists of Australia (SHPA)



Product Information - [RITALIN]

AusDI By MedicalDirector  
February 2024

Item: RITALIN | Search: | Section: 4.6. FERTILITY, PREGNANCY

**Ritalin 10**

Adults

Administer the tablets in divided doses 2 or 3 times daily. The average dose is 20 to 30 mg daily. Some patients may require 40 mg to 60 mg daily. In others, 10 mg to 15 mg daily will be adequate. Patients who are unable to sleep if Ritalin 10 tablets are taken late in the day should take the last dose before 6 p.m.

Dosing for each patient requires titration to control symptoms. Single doses greater than 20 mg are associated with sympathomimetic side effects. Therefore, the average single dose should be less than 20 mg. A maximum total dose of 60 mg/day may be required.

**Maximum daily doses**

A maximum daily dose of 60 mg should not be exceeded for the treatment of narcolepsy.

**Administration**

**Ritalin 10 tablets**

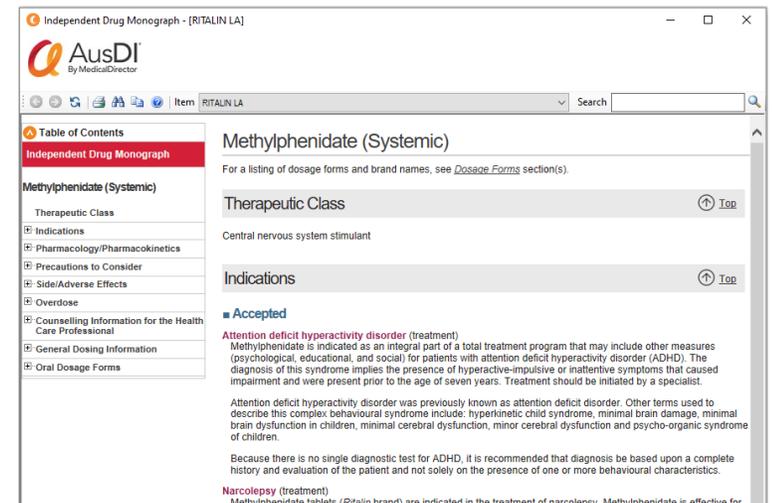
The rate of absorption and, therefore, onset of action is faster when Ritalin 10 tablets are taken with food. Dosage should, therefore, be standardised in relation to food to ensure consistency of effect.

Doses should be administered 1 to 2 hours before the maximum effect is required.

**Ritalin LA**

Ritalin LA capsules should be administered orally once daily in the morning.

Ritalin LA may be swallowed as whole capsules or alternatively may be administered by sprinkling the capsule contents on a small amount of soft food (see specific instructions below). Ritalin LA capsules and/or their contents should not be crushed, chewed or divided.



Independent Drug Monograph - [RITALIN LA]

AusDI By MedicalDirector

Item: RITALIN LA | Search: |

**Table of Contents**

- Independent Drug Monograph
- Methylphenidate (Systemic)
  - Therapeutic Class
  - Indications
  - Overdose
  - Counselling Information for the Health Care Professional
  - General Dosing Information
  - Oral Dosage Forms

**Methylphenidate (Systemic)**

Therapeutic Class: Central nervous system stimulant

Indications: Accepted

**Attention deficit hyperactivity disorder (treatment)**

Methylphenidate is indicated as an integral part of a total treatment program that may include other measures (psychological, educational, and social) for patients with attention deficit hyperactivity disorder (ADHD). The diagnosis of this syndrome implies the presence of hyperactive-impulsive or inattentive symptoms that caused impairment and were present prior to the age of seven years. Treatment should be initiated by a specialist.

Attention deficit hyperactivity disorder was previously known as attention deficit disorder. Other terms used to describe this complex behavioural syndrome include: hyperkinetic child syndrome, minimal brain damage, minimal brain dysfunction in children, minimal cerebral dysfunction, minor cerebral dysfunction and psycho-organic syndrome of children.

Because there is no single diagnostic test for ADHD, it is recommended that diagnosis be based upon a complete history and evaluation of the patient and not solely on the presence of one or more behavioural characteristics.

**Narcolepsy (treatment)**

Methylphenidate tablets (Ritalin brand) are indicated in the treatment of narcolepsy. Methylphenidate is effective for

# Prescribing Product Information, Prescribing options & more

- The Enter Dose window appears. It is within this window that you record data about the dosage of the medication you are prescribing. You can also access [Product Information](#) about the medication via **PI** button.
- Set the dosage (using the [Dose Calculator](#) if desired).
- Select a frequency.
- Indicate instructions as required, from either the list provided or by using [stored text](#) from the MedicalDirector Clinical Glossary.
- Choose a [Route of Administration](#) from the list provided.
- Select one of the Purpose of Action options, including:
  - Product Advised here. Allows you to recommend a medication that does not require a script to be printed, such as cough syrup.
  - Product Supplied here. Allows you to administer a medication without printing a script. For example, you may wish to administer a medication that you stock at your practice.
- Select the Duration of Medication; Long Term or Limited. The default is Limited, which can be altered via [Prescribing Options](#).
- Long Term. Allows you to prescribe an on-going medication. When the medication runs out it is assumed it will be renewed (e.g. insulin injections for diabetes). Long Term medications remain on the [Current Rx tab](#) until [manually deleted](#).

- Limited. Allows you to issue the prescription for once-off or limited duration medication (e.g. cough medicine). Limited medications remain on the [Current Rx tab](#) even when the estimated duration expires, at which time a prompt will notify you of the [cessation](#) upon opening the patient's record.

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'.
- Frequency:** A list of 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 'Ni' (selected).
- Instructions:** A list of options including 'Ni' (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).
- ePrescribing Options:** Includes 'Send to MyHealthRecord' (checked), 'Active Ingredient Prescribing' (checkboxes for 'Include brand name on script' and 'Brand substitution not allowed'), and 'Exclude from Active Script List' (checkbox).
- Direct Dispense:** Includes 'Direct Dispense (Do not provide to patient, provide directly to pharmacy)' and 'Script Owing (Medication already supplied)' (checkbox).
- Other options:** 'Unusual dosage' (checkbox), 'Pharmacy to dispense' (text field), 'Add to favourites' (checkbox), 'Save as default' (checkbox), and 'Start date of medication' (3/05/2022).

# Prescribing Active ingredient, Brand, Favourites & more

- (Optional) Tick the MyHealthRecord Consent check box to indicate that you have the patient's consent to add details of this prescribed medication to the patient's [My Health Record](#) record. An indication of the patient's consent is displayed under the MyHealthRecord Consent column on the [Current Rx](#) tab.

This check box is only available if the following conditions have been met;

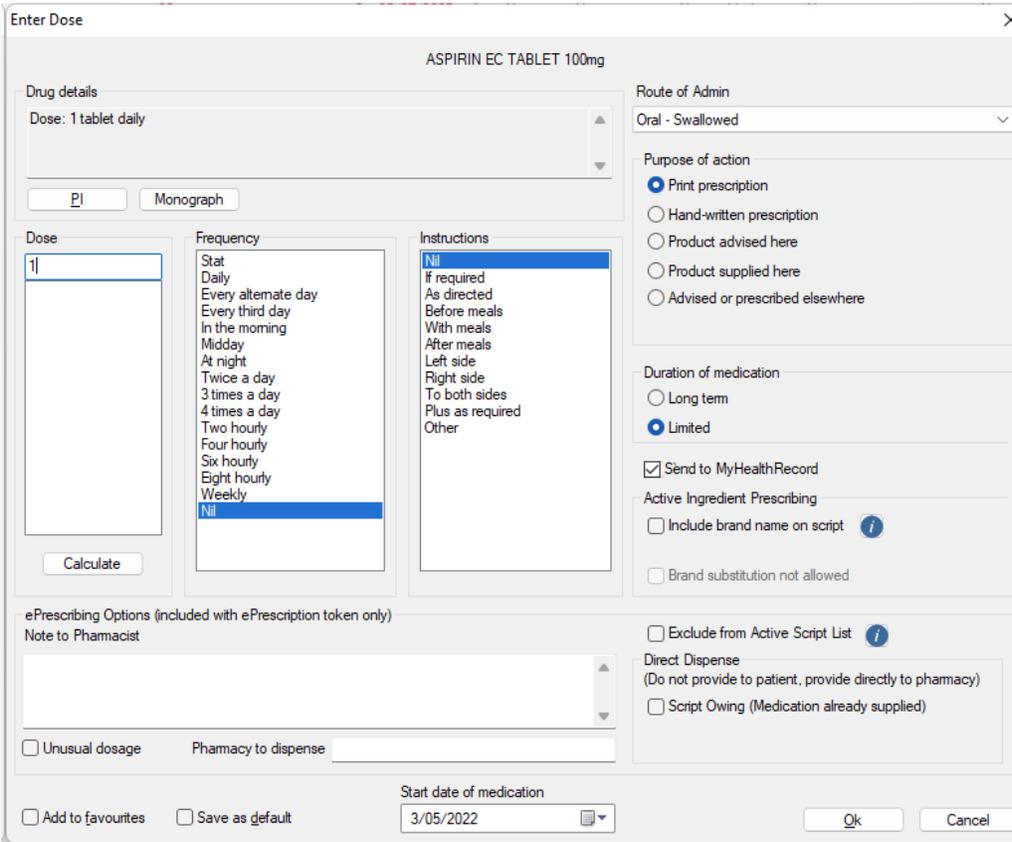
- You have [enabled My Health Record](#)
- You have [enabled ePrescribing](#)

This check box is ticked by default, unless the patient has set their record privacy to 'non-advertised' via the My Health Record consumer portal (a check for this setting is made upon opening the patient's record in MedicalDirector Clinical). If during the consultation the patient changes their mind, and grants consent to upload a given medication to their My Health Record, you can tick this check box now. Under such circumstances, patient consent must be granted per medication i.e. this check box will be un-ticked for subsequent medications until such a time as the patient logs onto the consumer portal and changes their record privacy.

Scripts approved for uploading to the My Health Record System in this manner are transferred when you print the script.

- (Optional) Tick the Include Brand Name on Script check box if you wish to print the medication's associate brand name on the script. See [Active Ingredient Prescribing](#) for more information.
- (Optional) Tick the Brand Substitution Not Allowed check box if required.
- (Optional) Tick the Exclude from Active Script check box
- (Optional) Tick the Script Owing check box to print a QR code to fax/email the pharmacy directly, instead of handing to the patient.
- (Optional) Tick the Add to Favourites check box to add the drug to a [favourites list](#), which is accessible when prescribing via .

- (Optional) Ticking the Save as Default check box saves the dosage, instructions and duration so they are available next time the drug is selected.
- Record the start date of the medication. The default date is the current date.
- Click **OK** button when you are ready to continue.



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

- Drug details:** Shows 'Dose: 1 tablet daily' and buttons for 'PI' and 'Monograph'.
- 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).
- Active Ingredient Prescribing:** Checkboxes for 'Send to MyHealthRecord' (checked), 'Include brand name on script' (unchecked), and 'Brand substitution not allowed' (unchecked).
- ePrescribing Options (included with ePrescription token only):** Includes a 'Note to Pharmacist' text area, 'Exclude from Active Script List' (unchecked), 'Direct Dispense (Do not provide to patient, provide directly to pharmacy)' (unchecked), and 'Script Owing (Medication already supplied)' (unchecked).
- Other options:** 'Unusual dosage' (unchecked), 'Pharmacy to dispense' (text field), 'Add to favourites' (unchecked), 'Save as default' (unchecked), and 'Start date of medication' (3/05/2022).
- Buttons:** 'Calculate', 'Ok', and 'Cancel'.

# Prescribing Drug Quantity & Repeats

25. You will be prompted to confirm the [drug quantity and repeats](#). Modify if necessary and click **OK** button to continue.

This prompt will differ slightly, depending on whether you are prescribing a limited or regular medication. It is possible to disable the prompt for regular medications via [Prescribing Options](#).

26. (Optional) If you are prescribing a PBS/RPBS Restricted Benefit medication, you will be prompted accordingly. See [PBS/RPBS Restricted Benefit Medications](#) for further information.

**Drug Quantity & Repeats**

**Quantity**  
30 Default = 30  
Quantity in words  
[ ]

**Repeats**  
0 Default = 0  
Days between repeats  
[ ]

Anticipated completion of treatment (days)  
[ ] Default = 30

Use defaults?

**Completion date**  
Select the anticipated date of completion for the treatment

April 2022  
Mon Tue Wed Thu Fri Sat Sun  
18 26 27 28 29 30 1  
19 2 3 4 5 6 7 8  
Today: 26/04/2022

Ok Cancel

# Prescribing

27. The Reason for Medication window appears, prompting you to record a reason for the medication. This is optional, so if you wish not to record a reason click Close. See also the Diagnosis Coder.

If you choose to enter a reason, either;

- o Pick a hard-coded reason by typing the first few letters of the reason into the Pick from List (Coded) text box, and then selecting the reason from those that appear in the corresponding list, or
- o Enter a custom reason by selecting the Free Text (Uncoded) option and then typing the reason into the corresponding text box, or
- o Select an existing reason from the Existing Past Medical History Items list.
- o The following options are also available from this window:
  - Save in Past Medical History check box. Ticking this check box will save the Reason for Medication to the patient's Past History tab. Enabling this check box also makes available the Active, Confidential and Summary check boxes.
  - Save as Reason for Contact check box. Ticking the Save as Reason for Contact check box will add a corresponding note to the patient's Progress Notes.
  - Left and Right check boxes. The Left and Right check boxes allow items to be marked as either on the left side of the body, right side of the body or by ticking both, bilateral.
  - Active check box. Ticking this check box will save the Reason for Prescription to the patient's Past History tab and flag it as an active condition.
  - Confidential check box. Ticking the Confidential check box prevents the item from being printed on letters, Pathology/Radiology requests, or in printed history summaries for the patient's chart. It is provided so that sensitive items (e.g. termination of pregnancy) will not appear on a referral for an eye examination, for example.
  - Summary check box. The Summary check box allows items to be marked as summary items. They will appear on printed summaries and on letters/request forms (provided they have not been marked as Confidential). If not marked as a summary item, the item will appear on-screen, but will not appear on any printed output. This prevents the printed summaries, letters and request forms from becoming too lengthy with relatively trivial entries. i.e. only items of significant importance in the patient's Past History should be marked as Summary items.

28. Click OK button when you are ready to continue.

29. The Select Drug window reappears, awaiting further prescriptions (this functionality can be disabled via Prescribing Options).

- o Proceed with the prescribing of further items if you wish, or click Close to cease.
- o Prescriptions that you have added now appear within the patient's Current Medications List (Current Rx tab), and are flagged as ready for printing.

30. Print scripts as required.

Reason for Medication

Enter Reason for Medication

Pick from list (coded) headac

- Headache
- Headache - Cervicogenic
- Headache - chronic
- Headache - Cluster
- Headache - Coital
- Headache - Icecream
- Headache - Migraine
- Headache - Post Head Injury
- Headache - Sinus

Free text (uncoded)

Left  Right

Active  Confidential  Summary

Comment:

Existing Past Medical History items

Condition
Acne vulgaris
Common cold
Facelift
Haematemesis

Save in Past Medical History  Save as reason for contact

OK Close

# Paperless Electronic Prescribing

You can indicate whether the patient wants the medication to appear on their active script list.

The screenshot shows the 'Enter Dose' window for ASPIRIN EC TABLET 100mg. The 'Drug details' section shows 'Dose: 1 tablet daily'. The 'Route of Admin' is 'Oral - Swallowed'. The 'Purpose of action' is 'Print prescription'. The 'Duration of medication' is 'Limited'. The 'Active Ingredient Prescribing' section has 'Include brand name on script' checked. The 'ePrescribing Options' section has 'Exclude from Active Script List' checked and highlighted with a yellow box. The 'Direct Dispense' section has 'Script Owing (Medication already supplied)' checked. The 'Start date of medication' is 3/05/2022.

When an item is marked as 'Script Owing' on the Enter Dose window, only paper tokens will be permitted (no SMS or email).

The screenshot shows the 'Enter Dose' window for ASPIRIN EC TABLET 100mg. The 'Drug details' section shows 'Dose: 1 tablet daily'. The 'Route of Admin' is 'Oral - Swallowed'. The 'Purpose of action' is 'Print prescription'. The 'Duration of medication' is 'Limited'. The 'Active Ingredient Prescribing' section has 'Include brand name on script' checked. The 'ePrescribing Options' section has 'Exclude from Active Script List' checked. The 'Direct Dispense' section has 'Script Owing (Medication already supplied)' checked and highlighted with a yellow box. The 'Start date of medication' is 3/05/2022.

# Paperless Electronic Prescribing



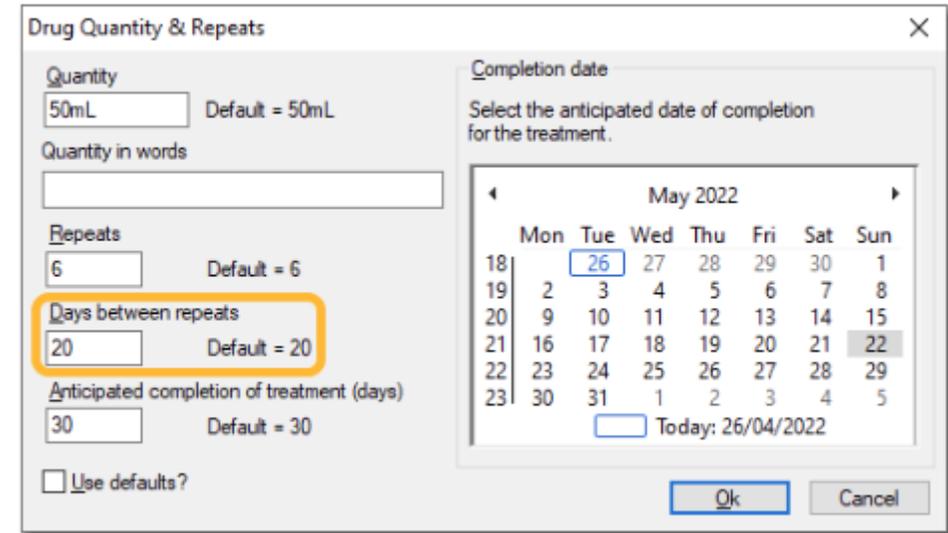
State / Territory Legislation Requirements

Legislation requires that the following is completed.

Authorisation number

A medical practitioner must hold a State / Territory issued number(s) in order to prescribe restricted medicines in that State or Territory. In order to prescribe restricted medicines the in-date State or Territory number that you hold must be entered into the field above and is needed by State legislation to endorse each restricted medication to be prescribed.

When an item is a Schedule 8 (S8) medication, you will be prompted for an approval / authority / warrant / permit number.



Drug Quantity & Repeats

Quantity  
 Default = 50mL

Quantity in words

Repeats  
 Default = 6

**Days between repeats**  
 Default = 20

Anticipated completion of treatment (days)  
 Default = 30

Use defaults?

Completion date  
Select the anticipated date of completion for the treatment.

May 2022							
	Mon	Tue	Wed	Thu	Fri	Sat	Sun
18		26	27	28	29	30	1
19	2	3	4	5	6	7	8
20	9	10	11	12	13	14	15
21	16	17	18	19	20	21	22
22	23	24	25	26	27	28	29
23	30	31	1	2	3	4	5

- When an item is a Schedule 4B (NSW) or Schedule 4D (TAS) medication (e.g. TESTOSTERONE CREAM), altering the number of repeats activates the 'Days between repeats' field on the 'Drug Quantity & Repeats' window. This is existing behaviour for S8 items but was expanded to include the S4B and S4D.

# Paperless Electronic Prescribing

The Prescription Preview window additionally provides the options to SMS or Email an electronic token or print a paper token.

- A suggested delivery method will be preselected for you. This selection is determined by [information found in the patient's record](#), with priority going to SMS followed by Email and then Printed media.

If the user has [specified a Prescriber Type](#) other than 'Medical Practitioner' or 'Nurse', and their state is either ACT or SA, 'Restricted Use For' information appears on prescriptions.

SMS fees are subsidised until 31 July, 2027. Please enable SMS via Settings > Centre, before government subsidies expire, to continue to provide patients with SMS prescription delivery.

Prescription Preview - Rowan Bartlett

Deliver prescription token by

SMS \* Register

SMS is free until 30 September 2020, in light of COVID-19.

Email \*

Paper Token (Letter Printer)

Printed Prescription (Script Printer)

Note: The prescription shown is only a preview using a paper script format to make the review of the medications easy to read.

\* Urgent supply / owing scripts: A paper token will be printed when an urgent supply / owing script needs to be given to the pharmacy. Do not provide it to the patient. No electronic token will be sent to the patient.

Prescription 1 of 1

PBS/DVA AUTHORITY SCRIPT No: 0009988  
Dr A. Practitioner  
Shop 4, 12 Heidke St. Kiama. 2533  
Phone: 0212345678

Prescriber Number 2999609

Patient's Medicare No: 123456789011 1

Pharmaceutical benefits entitlement No.  PBS Safety Net entitlement cardholder  Concessional or dependent RPBS beneficiary or PBS Safety Net concession cardholder

Patient's name Mr John Patient  
Address 123 Walker Street  
Demotown 2350 Send to Patient [Y]

Date 5/06/2020  
PBS X RPBS  Brand substitution not permitted

Script No: 12345678

TESTOSTERONE CREAM 5%  
1 daily m.d.u.

Qty: 50mL 6 repeats.  
1 Item Repeat Interval: 20  
Dr A. Practitioner  
MBBS

Authority Approval No: X123Z  
Qty: 50mL 6 repeats.  
Previous Authority? [N]

ePrescription  
Conformance ID: MedicalDirector Clinical|3.18.0.0  
HPI-O: 8003624900021871  
HPI-I: 8003619900014033

By clicking OK I acknowledge that the prescriptions are true and correct.  
(Use the Next button above to review all prescriptions before clicking OK) OK Cancel

# Keeping Medications Current

Once Real Time Prescription Monitoring is enabled, the practitioner will be prompted with the Real Time Prescription Monitoring warning when S8 drugs and other high risk medicines such as benzodiazepines, zolpidem or zopiclone, quetiapine and codeine are prescribed.

## Real Time Prescription Monitoring Notifications

The practitioner will get a Real Time Prescription Monitoring prompt after performing the following on any S8 drugs and other high risk medicines such as benzodiazepines, zolpidem or zopiclone, quetiapine and codeine.

- When adding drugs to the [Current Rx tab](#).
- When Changing 'Dose' in Current Rx tab
- When Changing 'Quantity' in Current Rx tab
- When Changing 'Strength' in Current Rx tab
- When re-prescribing a current high-risk medication via the patient's [Old Scripts Tab](#)

See [Managing and Modifying Current Prescriptions](#)

The screenshot shows a medical software interface with a menu bar at the top containing options like 'Cervical Screening', 'Obstetric', 'Acupuncture', 'Correspondence', 'MDEXchange', 'SAT', and 'HealthLink'. Below the menu is a toolbar with icons for 'Summary', 'Current Rx', 'Progress', 'Past history', 'Results', 'Letters', 'Documents', 'Old scripts', and 'Imm.'. The main area displays a table of current prescriptions:

#	Drug name	Strength	Dose	Freq	Instructions	Route	Qty	R. Int.	Rpt.
	VENTOLIN CFC-FREE INHALER	100mcg/dose	2 puffs	q.4.h.	p.r.n.	inhale	2*200 do..		0
	VIAGRA TABLET	50mg	2		p.r.n.	oral	4		0
	CETAPHIL CLEAR SKIN ACNE..		1	mane	p.r.n.	Topical	1		0

Below the table, there is a 'Script date' field set to '15/07/2014' and several checkboxes: 'Brand substitution not allowed' and 'Not taking any medications'. At the bottom right, there are status indicators: 'Red - Overdue' and 'Blue - almost due'.

The screenshot shows a medical software interface with a menu bar at the top containing options like 'Acupuncture', 'Correspondence', 'MDEXchange', 'SAT', and 'HealthLink'. Below the menu is a toolbar with icons for 'Documents', 'Old scripts', 'Imm.', 'Cervical Screening', and 'Obstetric'. The main area displays a table of old scripts:

Date	Item	Strength	Dose	Frequency	Instructions	Route	Unusual D
10/12/2012	VENTOLIN CFC-FREE INHALER	100mcg/dose				Inhale	No
10/06/2011	PANADEINE FORTE TABLET	500mg/30mg	2	q.i.d.	m.d.u.	Oral	No
10/06/2008	VENTOLIN CFC-FREE INHALER	100mcg/dose				Inhale	No
10/06/2008	KEFLEX CAPSULE	250mg	1			Oral	No
22/03/2007	KEFLEX CAPSULE	250mg	1			Oral	No

Below the table, there is a 'Show deleted scripts' checkbox and two buttons: 'View' and 'Prescribe'.

# Keeping Medications Current

A **GREEN** notification will appear in the following situations:

- When there has not been a prescription issued/dispensed for a monitored medicine in the last 6 months or
- When prescriptions for a monitored medicine in the last 6 months have been issued by the same prescriber/medical practice, and there are no alerts

When use of Real Time Prescription Monitoring becomes mandatory, prescribers/pharmacists will not be required to click on the notification to review the patient history.

An **AMBER** notification will appear in the following situations:

- When prescriptions for a monitored medicine in the last 6 months have been issued by more than one prescriber/medical practice or
- When the daily morphine equivalent dose (calculated based on an average over the last 90 days) is between 50mg and 100mg MED daily (i.e. a medium risk dose)

When use of Real Time Prescription Monitoring becomes mandatory, prescribers/pharmacists will be required to click on the notification to review the patient history to assess whether it is safe or appropriate to prescribe/dispense a medicine.

A **RED** notification will appear in the following situations:

- Patient has active alerts within the last 3 month (90 days)

A RED notification will appear when there is a current alert relating to the prescribing/dispensing history of a patient.

These alerts are:

- Multiple provider episodes: When prescriptions from 4 or more prescribers/medical practices or 4 or more pharmacies have been recorded in Real Time Prescription Monitoring within the last 90 days.
- High-risk drug combinations: When prescriptions for certain drug combinations have been recorded in Real Time Prescription Monitoring within the last 90 days.
  - Methadone + a benzodiazepine
  - Methadone + a long-acting opioid
  - Fentanyl + a benzodiazepine
  - Fentanyl + a long-acting opioid
- Opioid dose threshold: When the daily morphine equivalent dose (calculated based on an average over the last 90 days) exceeds 100mg MED daily (i.e. a high risk dose).

When use of Real Time Prescription Monitoring becomes mandatory, prescribers/pharmacists will be required to click on the notification to review the patient history to assess whether it is safe or appropriate to prescribe/dispense a medicine.



# Reviewing Results via Holding file

## Holding File for All Patients

1. Select Correspondence > Check Holding File (All Patients).
2. You will be prompted to select one or more recipients whose results you wish to examine.
3. From this window select the recipient(s) whose results you wish to examine:
  - o Select a single recipient by clicking their name, and then clicking OK to open the Holding File to display only their results. Alternatively you can double-click a name to simultaneously select them and open the Holding File.
  - o Select multiple recipients by clicking each name. To deselect a name, simply click it again. Then, click OK to open the Holding File to display only the results of the selected recipients.
  - o Select all recipients by clicking the All Recipients option. Clicking OK then opens the Holding File to display results for all recipients. Alternatively you can double-click the All Recipients option to simultaneously select all recipients and open the Holding File.

Note that, as making a selection from this window locks the results associated with the selected recipient, it is recommended that you select only a specific recipient, as selecting All Recipients will prevent others from accessing any results whilst you have the Holding File open.

4. You will then be presented with the Holding File.
5. (Optional) Upon opening the Holding File, the first result in the list is automatically selected and displayed. If Clinical cannot determine which patient the result relates to, you will be prompted to either add a new patient to the database (by clicking Add New button, or select from a list of patients the result could possibly belong to, as seen in the following example.

6. Within the Holding File you can check-off Results. See Checking Off New Results for information.
7. Review the table below for information on using the Holding File.

See [Filtering/Searching Correspondence Records](#) for more information.

The screenshot shows the 'Holding File' window with a table of 8 records. The first record is selected, and its details are shown on the right. A 'Check Holding File' dialog box is open, showing a list of recipients to select from.

Date Collected	Date Requested	Result	Patient	Subject
15/02/2013	15/02/2013		ANDERSON, David	E/LFT (MASTER)
9/04/2004	9/04/2004		ANDREWS, Maureen	HIP X-RAY
15/02/2013	15/02/2013		ANDERSON, David	LIPID STUDIES
27/02/2013	27/02/2013		ANDREWS, Julie	PROTHROMBIN ORA
20/02/2013	20/02/2013		ANDREWS, Julie	PROTHROMBIN ORA
13/02/2013	13/02/2013		ANDREWS, Julie	PROTHROMBIN ORA
6/02/2013	6/02/2013		ANDREWS, Julie	PROTHROMBIN ORA
30/01/2013	30/01/2013		ANDREWS, Julie	PROTHROMBIN ORA

**Check Holding File**

Select Recipient(s)

- All Recipients
- A Practitioner
- Dr A Breedon
- Dr A Practitioner HI7
- 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
- Dr Q S Dang

**Holding File Details:**

Start Patient : Anderson, David  
61 Wallace St, BUNDABERG QLD 4670  
Birthdate: 04/01/1955 Age: Y58 Sex: Male  
Telephone: 07 4152 5555

Your Reference :  
Lab Reference : 84-4687074

**Subject:** E/LFT (M)  
**Lab. Reference:** 84-46870  
**Requested:** 15/02/20  
**Performed:** 15/02/20  
**Sender/Provider:** Demotow

Test	Value	Unit	Reference Range
E/LFT (MASTER)			
Sodium	138	mmol/L	(137-147)
Serum Potassium	4.5	mmol/L	(3.5-5)
Chloride	100	mmol/L	(96-109)
Bicarbonate	30	mmol/L	(25-33)
Other Anions	13	mmol/L	(4-17)
Glucose	5.5	mmol/L	(3-7.7)
Urea	5.2	mmol/L	(2-7)
Serum Creatinine	67	umol/L	(40-110)
Serum Uric Acid	0.3	mmol/L	(0.14-3.35)
Total Bilirubin	14	umol/L	(2-20)
Total Alk. Phosphatase	61	U/L	(30-115)
Gamma G.T.	14	U/L	(0-45)
ALT	11	U/L	(0-45)
AST	16	U/L	(0-41)
LD	115	U/L	(80-250)
Serum Calcium	2.38	mmol/L	(2.25-2.65)
Corrected Calcium	2.39	mmol/L	(2.25-2.65)
Serum Phosphate	0.9	mmol/L	(0.8-1.5)
Total Protein	72	g/L	(60-82)
Serum Albumin	42	g/L	(35-50)
Globulins	30	g/L	(20-40)
Cholesterol	3.6	mmol/L	(3.6-6.5)
Triglycerides	0.4	mmol/L	(0.3-4)
eGFR	>^90	mL/min/1.73 sqm	

# 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
<a href="#">ADF Service</a>	Indicate the patient's service (if any) with the Australian Defence Force.  A patient's service status;  •Is displayed within the Occupation field located towards the top of the <a href="#">Clinical Window</a> .  •May affect whether you are <a href="#">prompted</a> to perform an assessment for them upon opening their clinical record.
<b>Update Address for All Family Members</b> 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 <a href="#">Clinical Window</a> .
<b>Auto-Capitalise Names</b> 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 <a href="#">Options</a> 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:

Update address for all family members  
 Auto-capitalise names

Save Cancel

Ctrl + D Patient > Details

# 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.

The screenshot shows the 'Patient Details' window with the 'Smoking' tab selected. The window contains the following elements:

- Assessment Fields:** Date of assessment (18/02/2013), Smoker (Smoker), Frequency (Daily), Number of cigarettes (5), Year commenced (1980), Duration (44yrs), Stage of change assessment (dropdown), Last quit attempt (06/06/2024), and a checked box for 'Never/Unknown'.
- Table:** A table with columns: Date, Time, Smoker, Number of Cigarettes. It contains one row: 18/02/2013, 00:00:00, Smoker, 5 Daily.
- Buttons:** View Patient Education Leaflet, Reference, New Assessment, Delete, Save, Cancel.
- Checkboxes:**  Smoking cessation intervention discussed with patient,  Update address for all family members,  Auto-capitalise names.
- Footer:** A message: 'Currently displaying data from assessment performed on 18/02/2013. Click 'New Assessment' to conduct a new assessment.'
- Navigation:** A pencil icon, 'Ctrl + D', and 'Patient > Details' buttons.

# Recording Allergies/Adverse Reactions/Warnings

F7 or Allergies/Warnings (via the Clinical Window)

Patient Details

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

Allergies / Adverse Reactions

Item	Reaction	Severity	Type	Date Recorded	Recorded by	Status
DUST MITE			Allergy	25/06/2012	Dr A Practitioner	Active
GRASSES			Allergy	25/06/2012	Dr A Practitioner	Active

No Known Allergies / Adverse Reactions     Show History           

Warnings

Drug dependent     Elite sportsperson     Breast feeding

Update address for all family members     Auto-capitalise names       

1. Select the Allergies/Adverse Reactions/Warnings tab within the Patient Details window.
2. Click Add The Add Allergy / Adverse Reaction window appears.
3. Add the source of the allergy:

- Enter Allergy by Drug

- Enter Allergy by Class

- Enter Allergy by Other: Allows you to free-type an allergy not necessarily related to a particular drug or class. You can also use this option to be more specific. For example if you wanted to record an allergy to EXELON you would normally use the 'By Drug' option and simply look for EXELON. However, if the patient was allergic to only the patch variety of EXELON, you could use the 'Other' option instead, and enter 'EXELON Patch'.

4. Describe the nature of the reaction.
5. Indicate the Type of reaction
6. Indicate the Severity of the reaction.

Click OK to confirm your input. Allergies added will be visible at the top-left of the patient's Clinical Window.

To view a percentage of patients who have not been asked about their allergy/adverse reaction status, see [Patient's with Non-Entered Clinical Data](#). You can also print a list of patients from this search utility.

## Items of Interest on this window

No Known Allergies / Adverse Reactions	By ticking this check box you will remove and delete all currently-recorded known allergies and/or drug reactions for this patient. This happens immediately upon ticking the check box, and is not reversible.
Warnings Section	Add free-text warnings to this section. Warnings added will be visible at the top-left of the patient's Clinical Window.  Ticking this check box will;
Drug dependent	<ul style="list-style-type: none"> <li>•Insert an entry into the 'Actions' header of the current <a href="#">Progress Note</a>.</li> <li>•Display "Drug Dependent" on the Warning section in the patient's <a href="#">record</a>.</li> </ul>
Elite Sportsperson	This provides warnings when prescribing drugs that are banned in sport.
Breast Feeding	The Breast Feeding check box only appears for female patients within the configured age group.
Update Address for All Family Members	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 <a href="#">Clinical Window</a> .
Auto-Capitalise Names	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 <a href="#">Options</a> tabs.

# Recording reason for visit

The Reason for Contact module allows you to enter a diagnosis into the [Progress Notes](#), using the DOCLE coded list of conditions that is also used in the [Past Medical History](#) section of Clinical.

1. Select the [Progress tab](#) in the patient's [clinical record](#).
2. Click **Reason** button. The **Reason for Contact** window appears.
3. Enter the first few letters of the procedure name in the **Pick from List (uncoded)** text box. A list of procedures that start with the letters entered is displayed. The list of procedures changes dynamically as text characters are entered or deleted. Alternatively you can select from previous procedures or conditions listed in the **Existing Past Medical History Items** list.
4. Double-click the required item from the list of choices. Alternatively you can either select from previous procedures or conditions listed in the **Existing Past Medical History Items** list or free-type a **Reason for Contact** into the **Free Text** text box.

## 5. Optional Modifications:

- By default the procedure is marked as Active. To change this, clear the **Active** check box.
- Select either Left or Right or both to mark whether the procedure is for the Left, Right or both sides.
- By default, the check boxes are set so the record is saved in the Past Medical History list and as the primary Reason for visit. Clear these check boxes if required.
- To list this procedure on printed letters and summaries, select the **Summary** check box.

Consultation date: 06/10/2016  
Visit type: Surgery Consultation  
Thursday October 6 2016 09:26:29  
Dr A Practitioner  
Visit type: Surgery Consultation  
Reason for contact: Headache  
Actions: Prescription added: ASPIRIN DISPTABLET 300mg 2

Date	Recorded by:	Reason for contact	Start
25/08/2008	Dr A Practitioner	Pap smear	11:13:36
25/08/2010	Dr A Practitioner		11:16:48
17/08/2012	Dr A Practitioner	Lump breast	11:22:58
22/08/2012	Dr A Practitioner	Phone Results Consultation	11:35:04
06/10/2016	Dr A Practitioner	Surgery Consultation	09:26:29

Friday August 17 2012 11:22:58  
Dr A Practitioner  
Patient indicated she located a lump in the right breast. Performed biopsy. Last mamogram was 18months ago and was all clear.  
Patient was also due for papsmear next week. Performed test.  
Examination:  
General:

Reason for contact

Enter reason for contact

Pick from list (coded) an

- Anabolic agent prescription
- Anaemia
- Anaemia - aplastic
- Anaemia - B12 Deficiency
- Anaemia - blood loss
- Anaemia - chronic disease
- Anaemia - chronic renal failure
- Anaemia - Folate Deficiency
- Anaemia - haemorrhagic

Free text (uncoded)

Left  Right

Active  Confidential  Summary

Comment:

Differential diagnosis  Save in Past Medical History

Existing Past Medical History items

- Condition
- Asthma
- Diabetes Mellitus
- Eczema
- Gluten enteropathy
- Migraine
- Tonsillectomy
- UTI

OK Close

# 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.

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

Comment

No significant past history

All records  
Active  
Inactive  
Summary items

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

# 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 displays the 'My Health Record for IHI: 8003 6023 4655 6635' window. At the top, there is a warning: '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.' Below this, a green message states: 'This patient has an active My Health Record to which you have access.' A 'Change/Gain Access' button is located to the right of this message.

The main content area is divided into tabs: 'My Health Record View', 'Prescription and Dispense View', 'Pathology Report View', and 'Diagnostic Imaging Report View'. Under the 'My Health Record View' tab, there are filters for 'Show Recent Shared Health Summary', 'Show Medicare Records', 'Show Medicine Records', 'Reset All Filters', and 'List is Filtered By: Document Date (In Last 3 Months), Document'. A 'Show Preview' button is also present.

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

Below the table, there is a 'Show More' button. The selected document is a 'Shared Health Summary' dated '23 Sep 2016' by 'Ms Haimi INGLETON', born '12 Dec 1993 (22y)', female, with IHI '8003 6023 4655 6635'. The document title is 'START OF DOCUMENT'.

The document content includes:

- The Clinic**  
Author: Dr Tobias Rodger (General Medical Practitioner)  
Phone: 07 4152 6398
- Adverse Reactions**  
None known
- Medications**

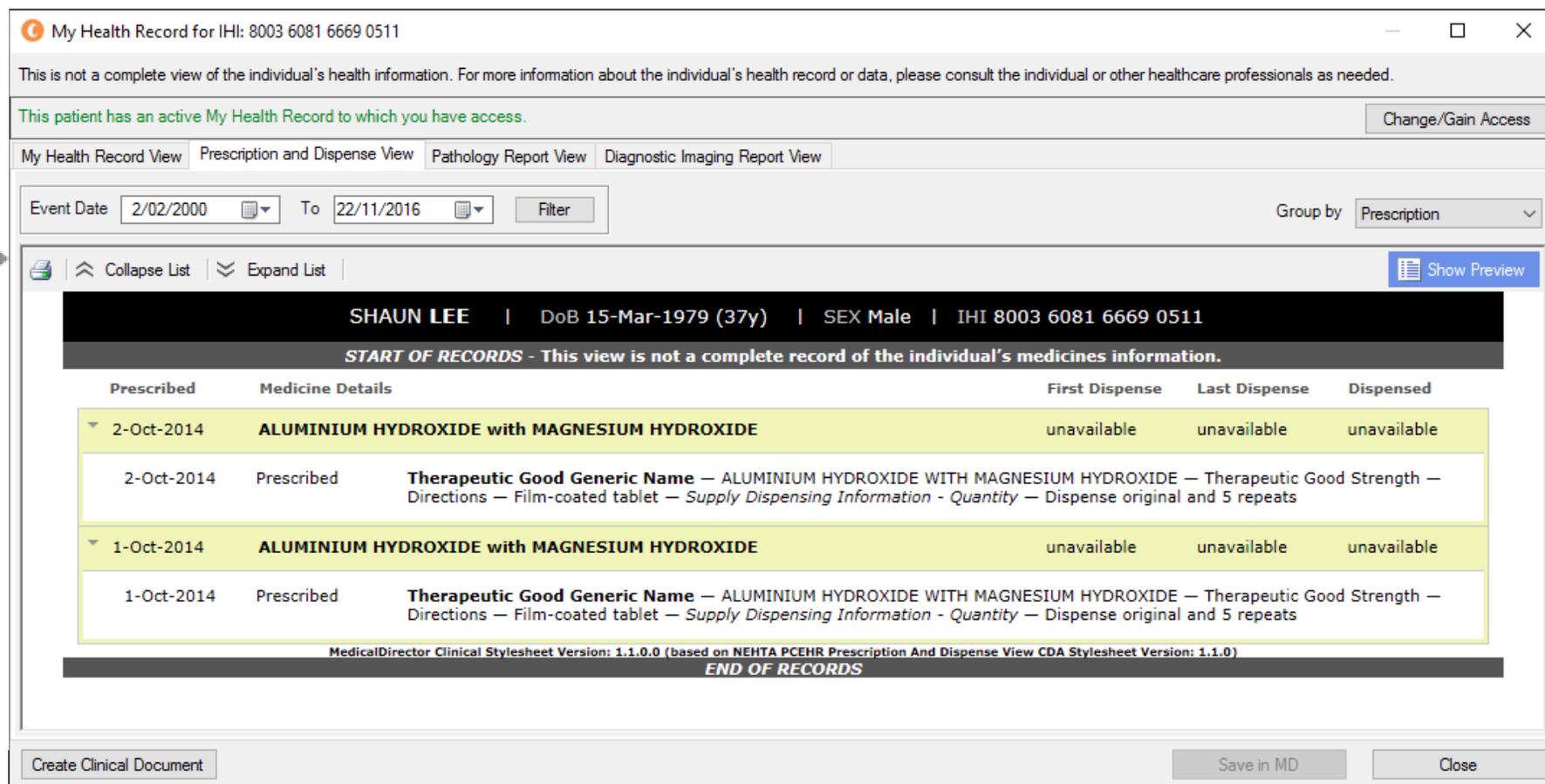
At the bottom of the window, there are buttons for 'Create Clinical Document', 'Supersede', 'Remove from My Health Record', 'Save in MD', and 'Close'.

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 date filters for 'Event Date' (2/02/2000 to 22/11/2016) and a 'Filter' button. A 'Group by' dropdown is set to 'Prescription'. The main content area displays a table of prescriptions for 'SHAUN LEE' (DoB 15-Mar-1979, 37y, SEX Male, IHI 8003 6081 6669 0511). The table has columns for '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'. The interface also includes 'Collapse List' and 'Expand List' buttons, a 'Show Preview' button, and a footer with 'Create Clinical Document', 'Save in MD', and 'Close' buttons.

Prescribed	Medicine Details	First Dispense	Last Dispense	Dispensed
2-Oct-2014	<b>ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE</b>	unavailable	unavailable	unavailable
2-Oct-2014	Prescribed <b>Therapeutic Good Generic Name</b> — ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE — Therapeutic Good Strength — Directions — Film-coated tablet — Supply Dispensing Information - Quantity — Dispense original and 5 repeats			
1-Oct-2014	<b>ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE</b>	unavailable	unavailable	unavailable
1-Oct-2014	Prescribed <b>Therapeutic Good Generic Name</b> — 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 305	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](http://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:** Dose: 1 tablet daily. Buttons for 'PI' and 'Monograph' are visible.
- Dose:** A text box containing '1' and a 'Calculate' button below it.
- 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).
- ePrescribing Options (included with ePrescription token only):**
  - Send to MyHealthRecord
  - Active Ingredient Prescribing
    - Include brand name on script
    - Brand substitution not allowed
  - Exclude from Active Script List
- Direct Dispense:** (Do not provide to patient, provide directly to pharmacy)
  - Script Owing (Medication already supplied)
- Unusual dosage
- Pharmacy to dispense: [text box]
- Start date of medication: 3/05/2022
- Buttons: 'Add to favourites', 'Save as default', 'Ok', and 'Cancel'.

# 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, age, sex, and telephone number. Below the patient details is a detailed view of a 'CUMULATIVE SERUM' test result, listing various blood chemistry values 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 Date, Service Date, Document, Organisation, Organisation Type, Author, Size, and Saved In MD. A context menu is open over the document dated 16-Dec-2013, showing options: 'Save in MD', 'Remove from PCEHR', and 'Supersede'. The 'Supersede' option is highlighted. Below the table, a detailed view of an 'e-Referral' document is shown for 'Mr Lindsay BLANTON' on '28 Mar 2014'. The document is titled 'MedicalDirector Demo - David Harris' and is authored by 'Dr Alfonso Terri-Anne (General Medical Practitioner)'. At the bottom of the window, 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

# 4.3 New Enhancements

## Patient's Record

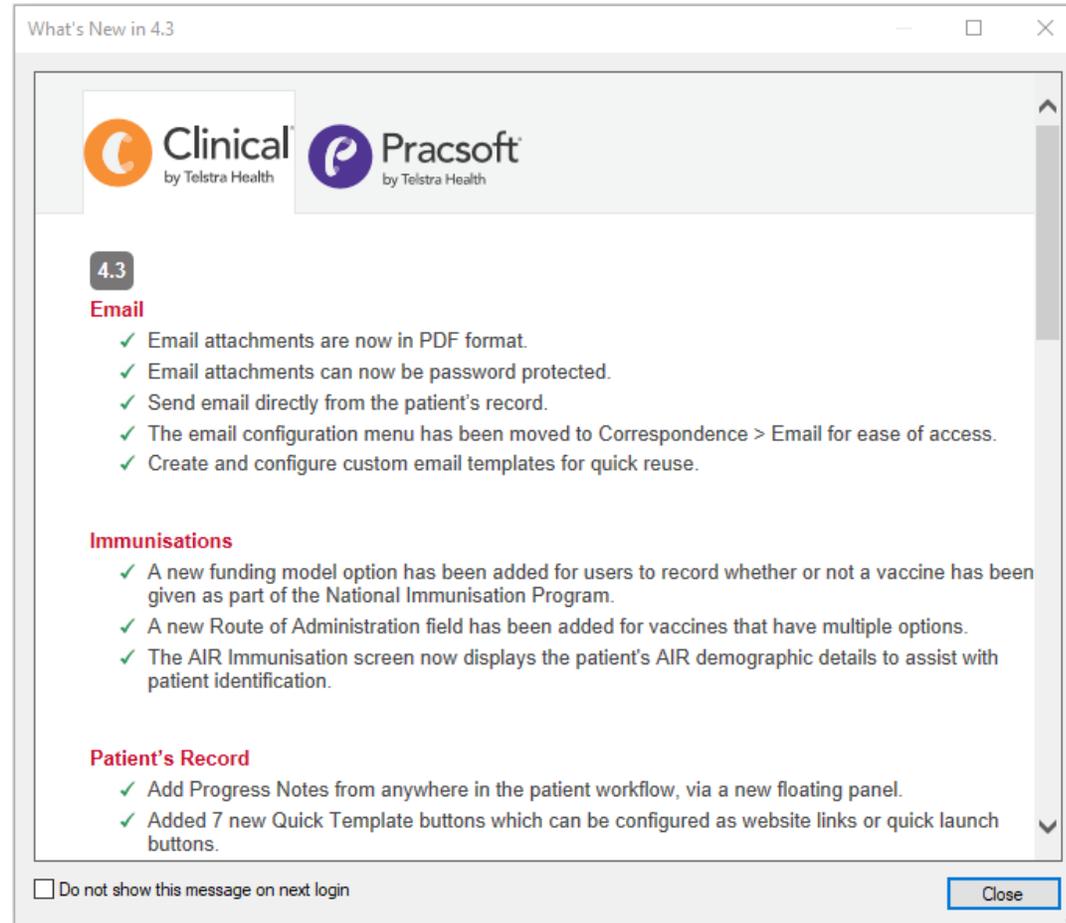
- Add Progress Notes from anywhere in the patient workflow, via a new floating panel.
- Added 7 new Quick Template buttons which can be configured as website links or quick launch buttons.
- Keyboard shortcuts are now highlighted with an underscore, and new shortcuts have been added.

When opening the Holding File from within a patient's record, the data is filtered automatically to show results for the selected patient.

- The web URL links in the CVD Risk Assessment screen have been updated to more modern resources.

## Prescribing

- You can now search for a drug based on the characters in the search box existing anywhere in the drug name rather than just at the beginning.



- When an Electronic Paperless Prescription with repeats is cancelled after the original has been dispensed, the repeats are now also cancelled.

## Email

- Email attachments are now in PDF format.
  - Email attachments can now be password protected.
  - Send email directly from the patient's record.
  - The email configuration menu has been moved to Correspondence > Email for ease of access.
  - Create and configure custom email templates for quick reuse.
- Improved the loading speed of the holding file when many results are present.

## Key features

- ✓ Targeted decision support
- ✓ Streamline medication orders and deliveries
- ✓ Support more patients
- ✓ Refer patients the right way
- ✓ Everything you need in one place

## Introducing Telstra Health Smart Clinician – 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. From Visual Dashboards that provide at-a-glance insights into patient health trends, to Telehealth capabilities that enable virtual consultations, and a Patient Portal ensuring seamless patient engagement. With additional features like Program Finder, Care coordination, Clinical Support, Communications, and Research tools, Telstra Health Smart Clinician stands as an indispensable asset for modern healthcare.



### Smart Care

Smart Care makes it easy to set up, populate and review care plans, while promoting compliance with Medicare. Customise templates to suit the needs of your practice and start empowering even more patients to monitor and manage their health.



### Smart Clinical Decision Support

Smart Clinical Decision Support utilises AI-driven educational information, empowering clinicians to make informed decisions efficiently. Each concise, structured message focuses on early detection and preventive measures for chronic illnesses in patients.



### Smart Research

Smart Research makes it easy for you to access the latest medical research and clinical knowledge from anywhere, anytime.



### Smart Visual Dashboards

Smart Visual Dashboards provide intuitive practice insights, reducing wait times and improving patient experiences. Our revenue reporting tool forecasts income, cuts admin overheads, transforming healthcare practices.



### Smart Telehealth

Smart Telehealth integrates into your clinical workflow, enabling practitioners to access patient health records within MedicalDirector Clinical and Helix. Simplify processes for better care remotely.

# Smart Bar - Tools available in Smart Clinician



**Now Available**

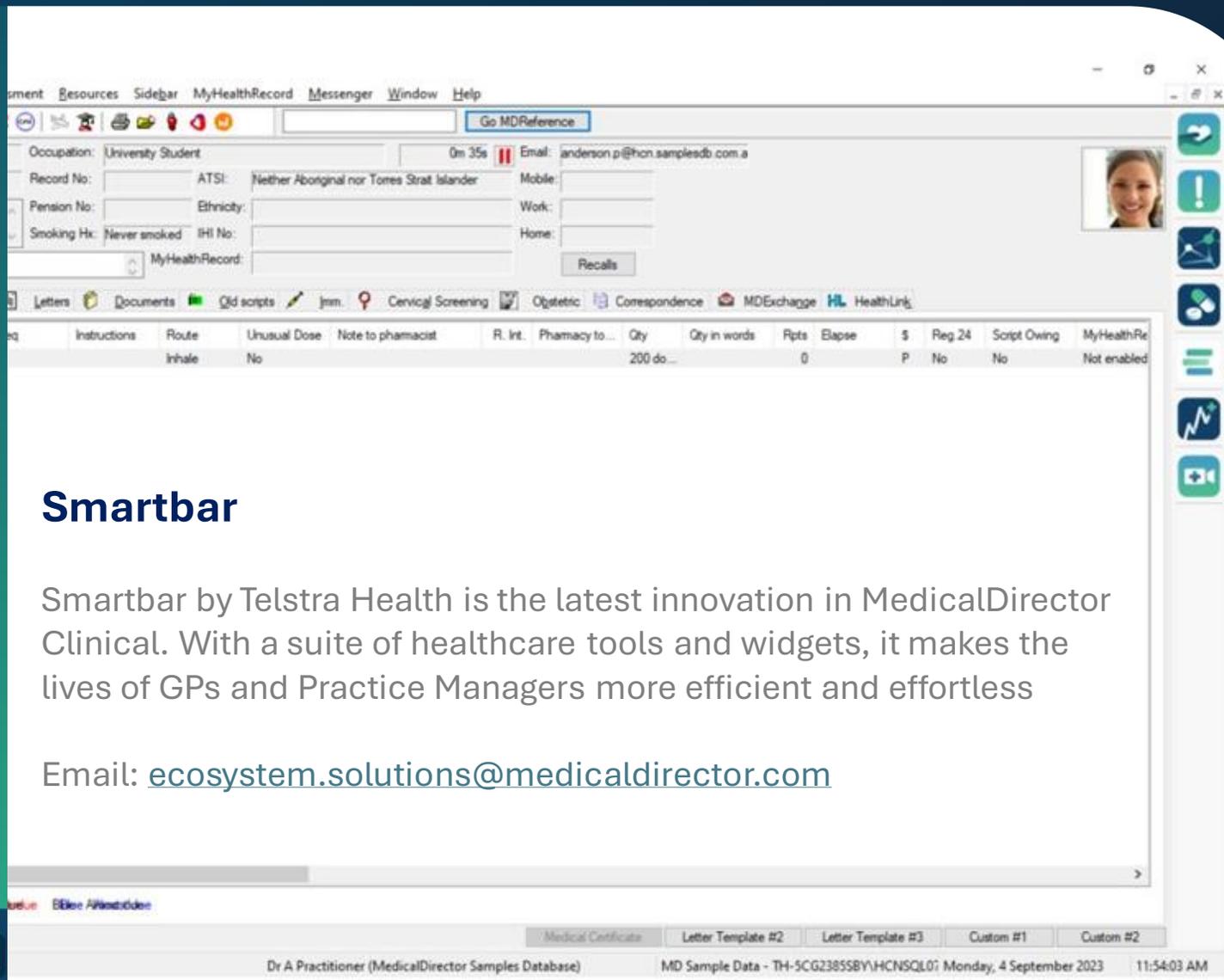
- Careplanning (In Beta)**  
Create, track and share care plans efficiently.
- Smart Clinical Support**  
In-consult clinical decision support information (RACGP CPD accredited content coming soon).
- Telehealth**  
Consult with patients remotely.
- Research**  
On-demand CPD accredited content such as CPD courses and aggregated data insights.
- Scripts (In Beta)**  
Easily share all e-script tokens via a single patient portal.
- Visual Dashboards (Coming soon to Smartbar. Available now in Pracsoft)**  
Turn your data into actionable insights available in consult.

**Coming Soon**

- Scribe (Beta coming late 2024)**  
Record your clinical notes in a more intelligent way with the latest in AI-driven clinical notes.
- Seek**  
Identify patients who are eligible for health programs, clinical trials and research studies.
- Connect (Beta coming late 2024)**  
In-consult ability to send e-referrals directly to pathology and radiology providers.

**Want to learn more about your Smartbar and our Smart Manager Community?**  
Contact us for more info and to enquire about participating in Beta programs.

[Get in touch](#)



## Smartbar

Smartbar by Telstra Health is the latest innovation in MedicalDirector Clinical. With a suite of healthcare tools and widgets, it makes the lives of GPs and Practice Managers more efficient and effortless

Email: [ecosystem.solutions@medicaldirector.com](mailto:ecosystem.solutions@medicaldirector.com)

**Q1.** Trouble shooting uploading shared summaries to my health record. Why do some not work?

**Answer:**

Regarding the issue with viewing **Discharge summaries\Uploading to My Health Record**, please do the following; Press the Windows key and R

•Browse to; C:\windows\assembly\GAC\_32 (you can only get there by browsing)

Add:

•C:\Windows\[Microsoft.NET](#)\assembly\GAC\_32\Hcn.Cda.Generator\v4.0\_1.0.0.0\_\_d6b06804ccddb90\Hcn.Cda.Generator.dll

•C:\Program Files (x86)\Health Communication Network\Medical Director\Plugins\Hcn.Sidebar.Plugin\FiddlerCore.dll

In the Sophos dashboard, please add the general exception and exceptions for each individual PC as well.

Each of the DLLs may require re-application after this has been applied.

May require a repair of the MedicalDirector National eHealth plugins and the MedicalDirector sidebar plugin

Open Control Panel > Programs and features

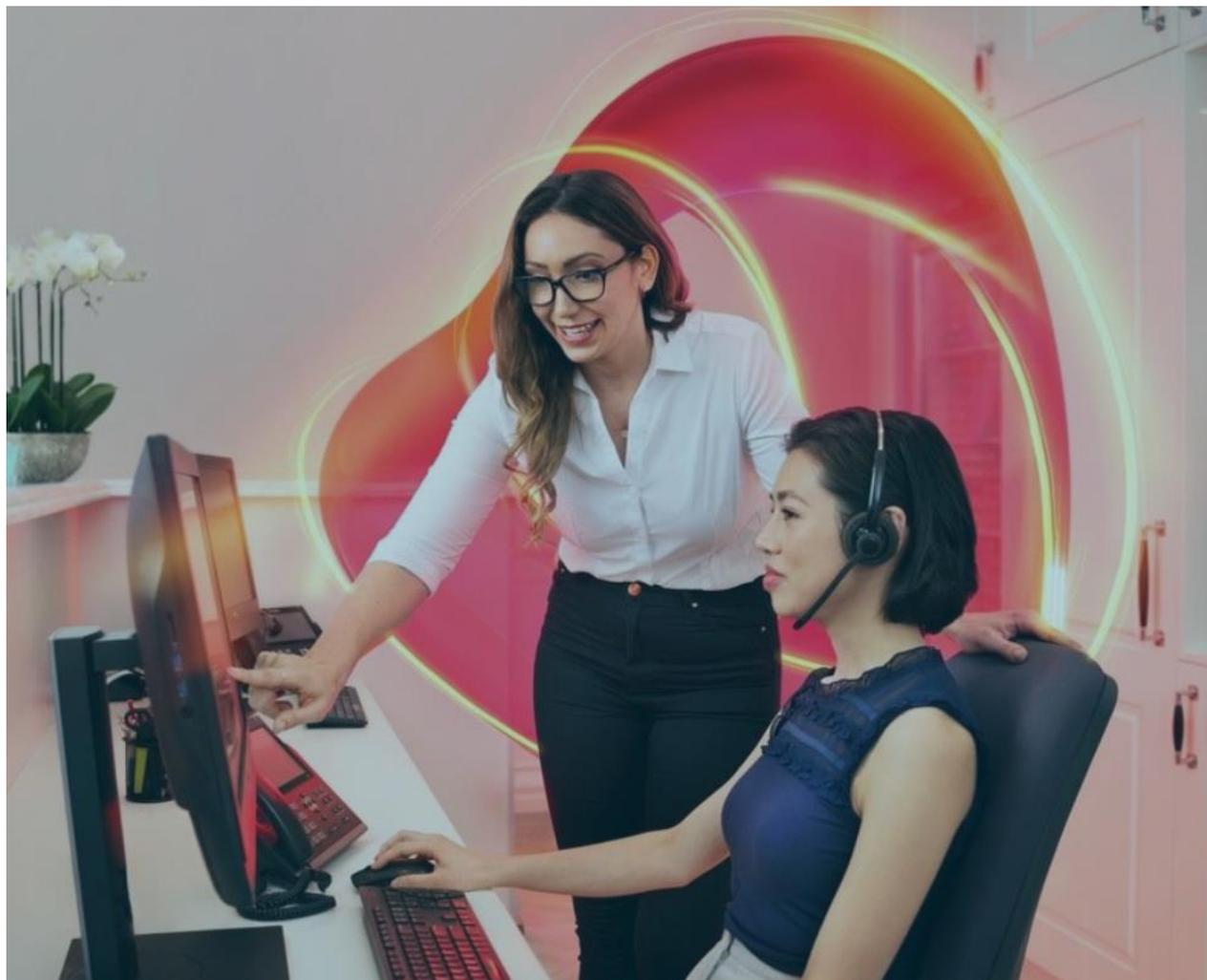
Find the program and right click and repair

Check Firewall Rules for MedicalDirector Software

[Antivirus Exceptions for MedicalDirector Software](#)

[Environmental Configurations for MedicalDirector Services](#)

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P: (03) 9046 0300

[emphn.org.au](http://emphn.org.au)

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# MedicalDirector Resources

[Clinical and Pracsoft version 4.3: The latest upgrade of Telstra Health's GP software](#)

[Harnessing the power of your practice data](#)

[Introducing MedicalDirector Care – Making Care Plans easy](#)

[Preparing your practice for ePrescribing](#)

[Introducing Telehealth in MedicalDirector Clinical](#)

## **MyMedicare resources:**

[Australian Government Department of Health and Aged Care – MyMedicare](#)

[MyMedicare webinar – 22 August 2023 | Australian Government Department of Health and Aged Care](#)

[Services Australia MyMedicare Learning Resource](#)

[Services Australia Checklist and steps to register for MyMedicare on the Organisation Register](#)

[Information for patients on MyMedicare – Australian Government Department of Health and Aged](#)

[Care](#)

[MyMedicare – Health Professional Education Resources](#)

[MyMedicare – Overview](#)

[MyMedicare – Managing patient registrations](#)

[MedicalDirector Clinical and Pracsoft version 4.3 upgrade](#)

[MyMedicare Import Wizard for Clinical version 4.3](#)

# Upcoming Webinars

## MedicalDirector Training for Clinical Nurses

Dates: Time: Location: Enquiries:  
Wednesday 7 August 2024 12pm - 2pm Online webinar Digital Health  
digitalhealth@emphn.org.au

- 4.3 New Enhancements
- Recording measures
- Recording Immunisations
- Recording Cervical Screening
- Managing Recalls and recording contact
- Recording social and family history
- Recording Alcohol and Smoking
- Keeping past history items relevant
- Creating letters
- Data Quality and Data Cleansing
- User Preferences
- My Health Record accessing & uploading



Register using the QR code or visit  
[www.emphn.org.au/newsevents/events/detail/25920](http://www.emphn.org.au/newsevents/events/detail/25920)

## MedicalDirector Training for Advanced Practice Managers

Dates: Time: Location: Enquiries:  
Thursday 8 August 2024 12pm - 2pm Online webinar Digital Health  
digitalhealth@emphn.org.au

- Data Quality and Data Cleansing
- 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



Register using the QR code or visit  
[www.emphn.org.au/newsevents/events/detail/25924](http://www.emphn.org.au/newsevents/events/detail/25924)

# 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

