

OSCAR Introduction Instruction for new users.

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3. How do I get to my patient's chart?
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 - c. Order labs,
 - d. Create referral letters,
 - e. Prescribe medications,
 - f. Billing/coding visits
5. How do I access my InBox (assigned transactions/tasks)?
 - a. Messaging (internal eMail)
 - b. Ticklers (scheduled messages)
6. How do I access historical information?

Click on question to take you to page in document

Disclaimer: This is an independent quick reference guide on getting started with Oscar that has been created by physicians, for physicians, and was not authored by your EMR vendor or issued as part of their official documentation. Your EMR vendor support desk should be the first point of contact if you have questions or need additional workflow guidance with your EMR software, and can also provide you with any official training materials or help files for your system on request.

Should you have any feedback or suggestions for improvement on this quick reference guide, please send to tbc@doctorsofbc.ca

How do I log on?

1. In the office

- a. You will be provided a user name (first name, e.g.) and a temporary password by the administrator. You may also need the 2nd Level Password, which will be provided. Use this to log in for the first time. You will be asked to create a new, unique password – requires at least 8 characters, no spaces, at least one upper case letter and a special symbol. Don't forget this password or you will have to start over again with a temporary password. If you fail to log in successfully after multiple attempts, you will be locked out. You will need to contact the administrator to have your account unlocked.
- b. OSCAR is displayed in a web browser, preferably FireFox. If you are using a different browser, some features may not function. Chrome is an acceptable second choice. Safari and Internet Explorer are not recommended. Find FireFox here – and download the ESR (extended support release) for your device. <https://www.mozilla.org/en-US/firefox/organizations/>
- c. You will be provided the IP address for local access to OSCAR, which will allow for server access when on the premises. If you are running a wireless device in the office, this will be the same as the Remote IP address.

The screenshot shows the OSCAR Login page. At the top is a green header with the word "Login" in white. Below the header are three input fields: "User Name:" with a placeholder "YourUserName", "Password:" with a masked password ".....", and "2nd Level Passcode:" with an empty field. A "Sign in" button is located below the password field. Two red arrows point to the "User Name" and "Password" fields. Below the passcode field, there is a link "for external Wide Area Network access". At the bottom, a disclaimer states: "Most browsers will probably work with OSCAR but the development team has been primarily using the latest versions of Firefox and Internet Explorer. The".

2. Remotely

- a. You will be provided an OSCAR IP address for remote access to the server. The 2nd Level Passcode is required to log in. Proceed as above.

This screenshot is similar to the one above, showing the OSCAR Login page. It includes the "Login" header, "User Name" and "Password" fields, the "Sign in" button, and the "2nd Level Passcode" field. A red arrow points specifically to the "2nd Level Passcode" field. The "for external Wide Area Network access" link and the disclaimer at the bottom are also present.

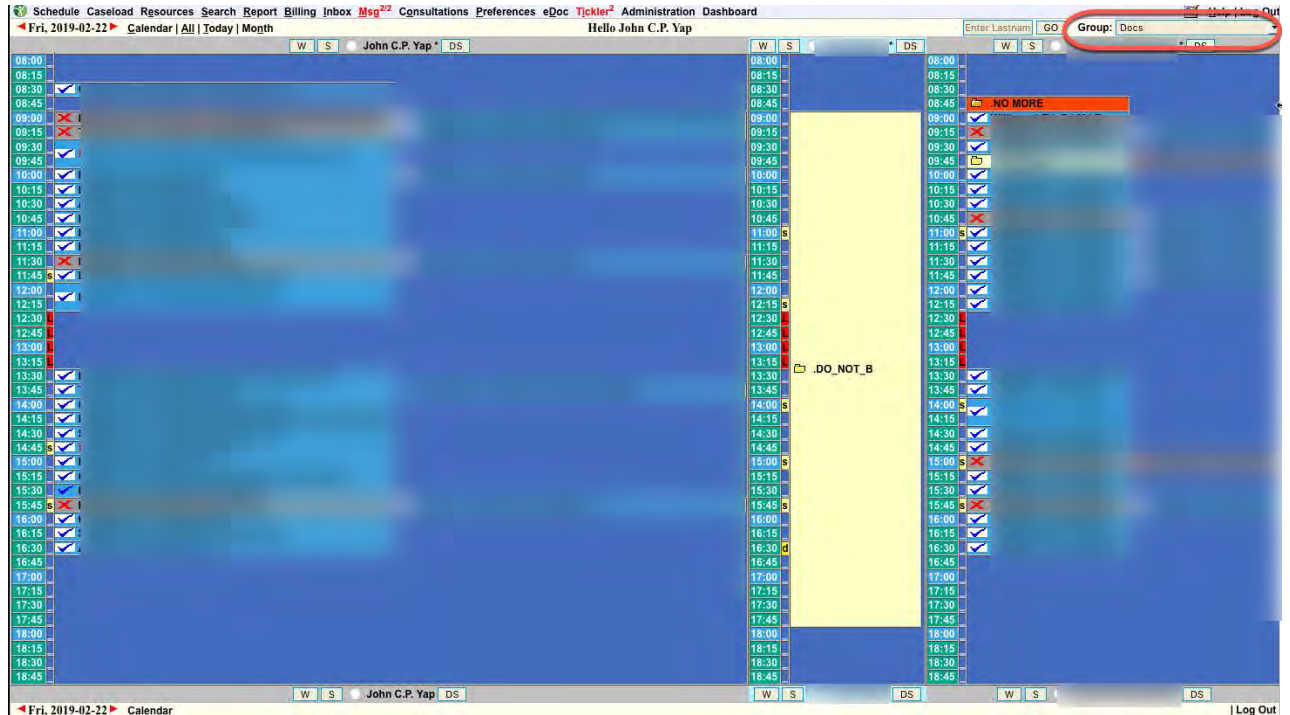
How do I log on?

HINTS:

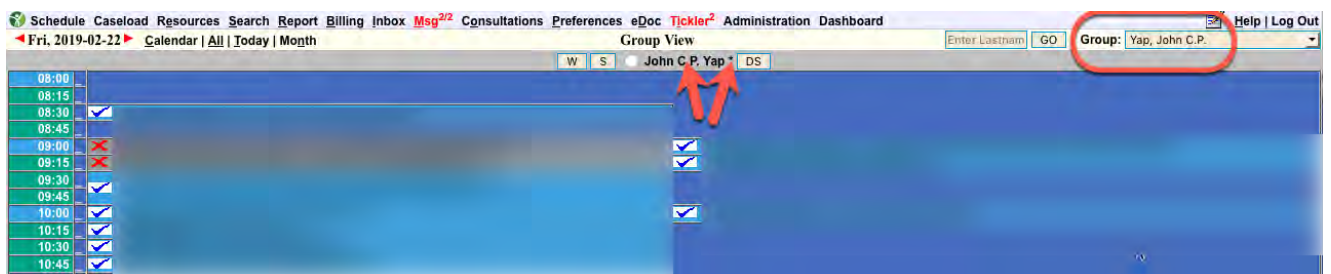
1. Consider bookmarking the IP address for OSCAR for easier access.
2. Log out of OSCAR when you are finished with it.
3. Do not share or expose your passwords in any way. IT security is paramount.
4. Do not SAVE your passwords if the browser offers this option.
5. Do not leave your laptop or workstation unlocked when unattended. Lock it out with a secure password.
6. Do not use unsecured WiFi when working remotely. Starbucks and ShawOpen are NOT acceptable!
7. Viewed files are downloaded into your designated download folder. These files contain patient-sensitive, confidential information, and should be purged at suitable intervals.
8. If you fail to log on multiple times, **your account may be locked**. You will need to contact the office administrator to unlock your account. Your Oscar Service Provider can also help. Ensure you know who these people are and how they can be contacted.

How do I access my schedule?

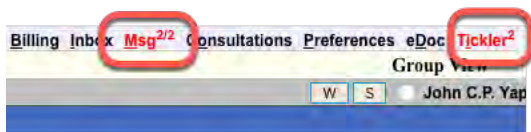
1. Once you have successfully logged in, you will be In the SCHEDULE VIEW. If you are in a multi-doctor clinic, there may be multiple schedules displayed. Change the view by using the Group filter (top right).



2. Click on your name and the adjacent star to toggle the **zoom view** and **expand reason** views.

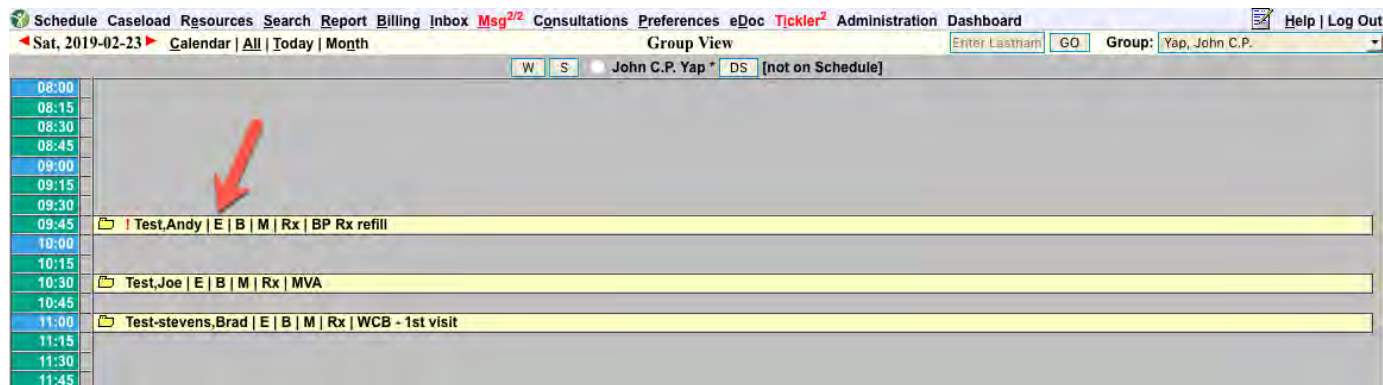


3. You will see notifications for Inbox (labs, reports), Msg (internal eMail messages), and Ticklers (additional messages – usually managed by the MOAs). A red highlight indicates a new notice.



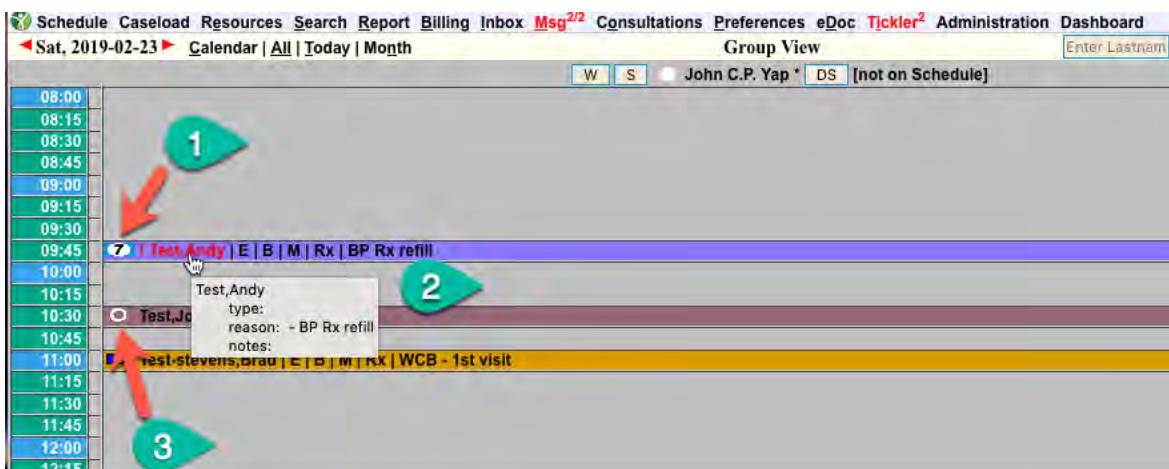
How do I get to my patient's chart?

1. From the SCHEDULE VIEW (aka day sheet), click on the "E" for the patient. E = encounter



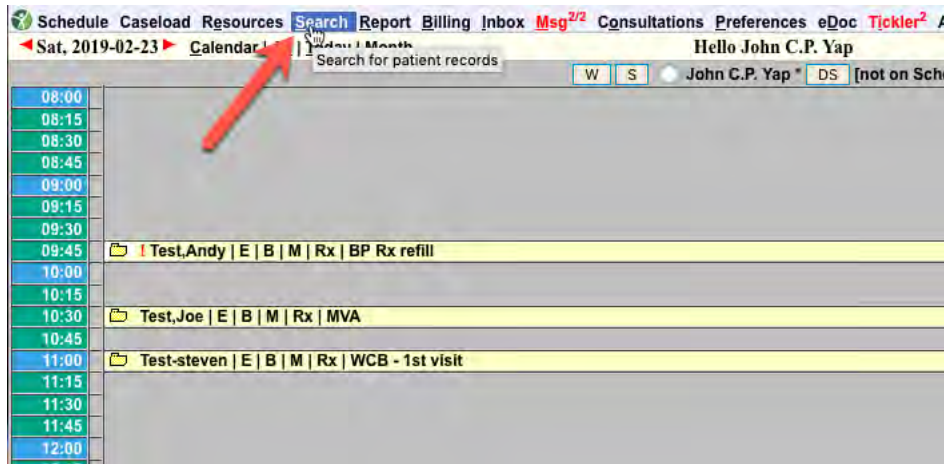
N.B. B = billing module. M = master record (demographics). Rx = prescription module. The colour and status icon may change to indicate what room the patient may be in, or whether the room is vacant.

2. Colour coding may vary from one clinic to another. See below.
 - (1) Patient is in room 7.
 - (2) Hover over the patients name for more details if Expand Reason is toggled off.
 - (3) This patient was a no-show.

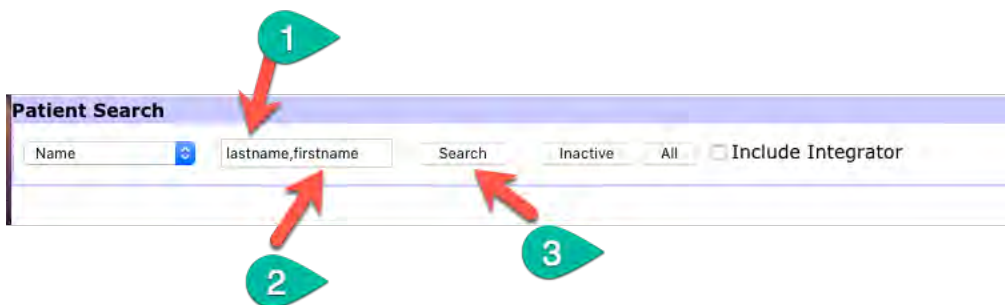


How do I get to my patient's chart?

3. If the patient is NOT on the schedule, you will have to SEARCH for the patient by name.



4. Type in the last name (1) and first name (2), separated by comma; and then click on Search (3).
HINT: the first 3 letters of the first and last names is generally all that is required.
This only searches for ACTIVE patients. Deceased, moved, fired, and inactive patients are excluded from the default search. Click "ALL" if you wish to search the entire database.

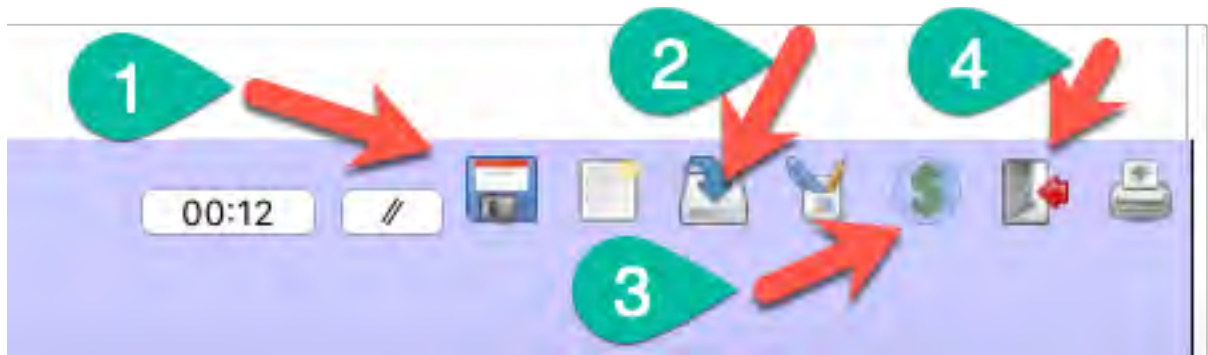


A list of matching names will be displayed below this section. Choose the appropriate chart by clicking on the "E" for encounter page.

How do I document a transaction?

1. Writing a **SOAP note**.

From the schedule, click “E”. Ensure the date on this entry matches the current date. If an earlier date is posted, you may have left an incomplete note previously. This old note must be completed and signed, otherwise you cannot proceed to write a new note, AND the other Oscar users cannot read your unsigned note. Save/sign/close the eCHART note before moving on to the next patient/chart. You return later to complete the note if desired, but ensure the chart is closed properly first.

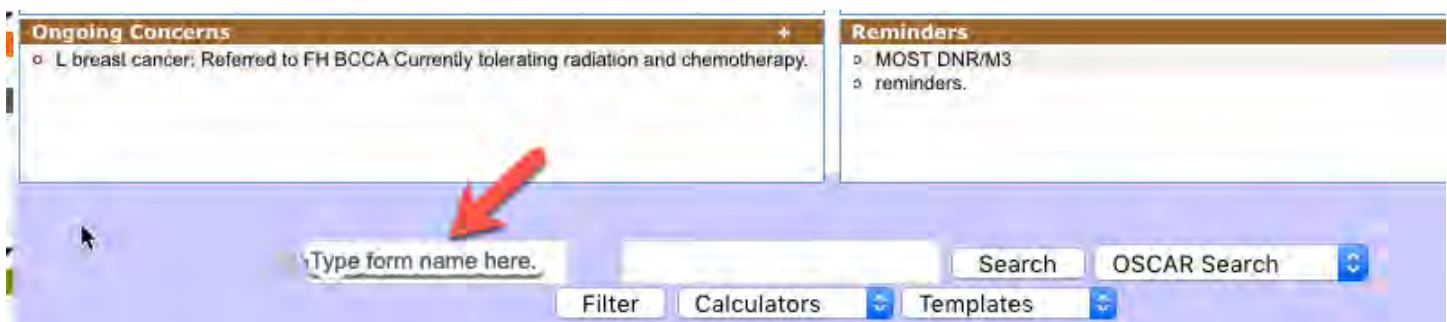


HINT: Ensure you are in the correct chart before you start and sign the note! Check the date!

- (1) Save – force a save action. Usually, there is auto-save every 5 seconds, but this forces a save. The eCHART remains open.
- (2) Save, sign, and exit. Your note is now visible to all, but the visit is not billed.
- (3) Save, sign, exit, AND go to the billing.
- (4) Exit eCHART – CAUTION – your input has NOT been saved.

HINT: You may wish to do this if you have inadvertently started typing in the WRONG chart.

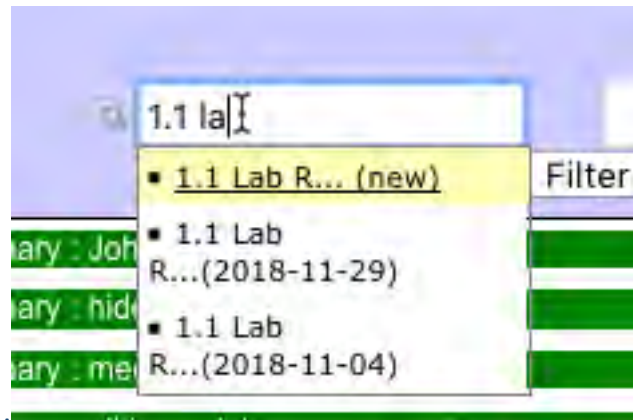
2. **Ordering tests** – lab and imaging requisitions are eFORMS. They are accessed from within the eCHART to allow for proper autopopulation. You need to ask your clinic EMR lead for the NAMES of the common imaging, lab, and other requisitions (e.g. Special Authority forms, etc.).
 - a. Use the search box and call up a specific eFORM



Type the first few letters of the eFORM name, and matching selections will appear. Choose a “new” eFORM. Selections with dates are previously completed eFORMS that are saved.

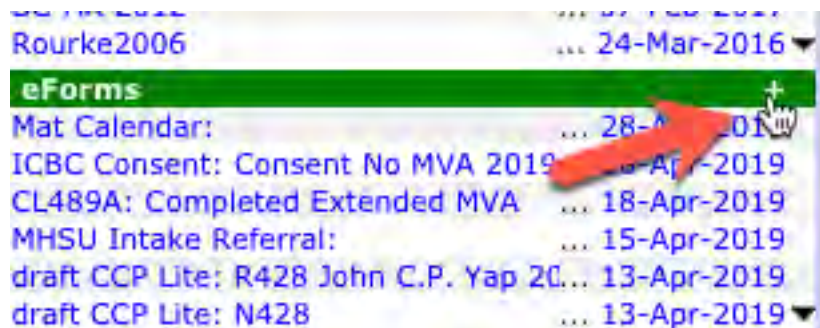
In GENERAL, do not reuse an existing eFORM to order new tests. Typing too much of the eFORM name sometimes creates an incomplete search. eFORMS with similar names cannot be found easily using this method.

One of the common eFORMS is the smart lab requisition – usually labelled 1.1 Lab requisition.



Click on the first entry (new) and the requisition will open.

- b. Search eFORM index. The entire library of eFORMS can be accessed by clicking on the plus (+) sign in the green eFORMs banner. You can then use the browser search function (Ctrl-F or Cmd-F) to find the necessary form.



HINT: ask your clinic which are the commonly used forms and make a list of their names. Some of the names may not be intuitive.

Examples: 1.1 Lab Requisition, Imaging forms (many different versions, depending on Health Authority), Special Authority (and the various sub-types), PHQ9, GAD7, MMSE, MoCA (if available), ICBC CL 489 forms, Prenatal Genetic Screening, Complex Care Plan templates, COPD advisor, Brief Pain Inventory, doctors notes (sick notes), referral to allied professionals (physio, podiatry, RMT, etc.), MOST forms, DNR forms, etc.

3. Using various **forms**.

- a. Rourke – this is a “built-in” form, not an eFORM, and is accessed somewhat differently. In this example, a Rourke form was started Sep21/17. To add MORE information to this form, click directly on this link.

GENERAL SYMPTOMS* ... 21-Apr-2018 ▼

Forms +

BC-WCB	... 19-Nov-2018
Rourke2009	... 21-Sep-2017
Annual	... 02-Jul-2017
Growth 0-36m	... 10-Feb-2017
BC-AR 2012	... 07-Feb-2017
Rourke2006	... 24-Mar-2016 ▼

eForms +

Mat Calendar:	... 28-Apr-2019
ICBC Consent: Consent No MVA 2019-04-0...	18-Apr-2019

- b. To open a new form, hover over the plus (+) sign and a drop-down menu of available forms will display. Move the mouse over the desired FORM and click on the link. You must always SAVE your work on these forms to close properly. Only the LATEST version will display in the eCHART view, but ALL versions will be saved in the background for audit purposes. The BC-WCB is a special FORM that acts as a “SOAP” note and the billing page!

GENERAL SYMPTOMS* ... 21-Apr-2018 ▼

Add Form

BC Birth Sum 2008	v-2017
BC Health Passport	p-2017
BC-AR 2012	l-2017
BC-INR	b-2017
BC-NewBorn	b-2017
BC-WCB	r-2016 ▼
Annual	+
Annual V2	r-2019
CHF	r-2019
Growth 0-36m	r-2019
Growth Charts	r-2019
ImmunAllergies	r-2019
PeriMenopausal	r-2019 ▼
Rourke2009	+

Skin: papule/plaque, Chest ... 29-Apr-2019

4. **Referral letters** (to consultants) – access this module by clicking the plus (+) link in the Consultations bar located near the bottom left margin of the eCHART.



This opens a blank consultation template, which you will have to fill in with consultant's information. This information is preset by your clinic. If you do not find the consultant in your list, ask your office manager for assistance.

(1) Choose the specialty

(2) Choose the specialist.

HINT: once the drop-down menu opens, type the first letter of the specialty or specialist (last name) that you want, and the cursor will jump to the first item with that letter.

Consultation		TEST, ANDY M 49	
Created by:	<input type="button" value="Submit Consultation Request"/> <input type="button" value="Submit Consultation Request & Print Preview"/> <input type="button" value="Submit And Fax"/>		
Status <input checked="" type="radio"/> Nothing: <input type="radio"/> Pending Specialist Callback <input type="radio"/> Pending Patient Callback <input type="radio"/> Completed Attach File to Consultation Currently Attached Files: <input type="button" value="None"/> <input type="button" value="Legend"/> <input type="button" value="Blue - Documents"/> <input type="button" value="Duplicate & Take"/>	Referring Practitioner:	Dr. John C.P. Yap	Patient: 1 TEST, ANDY
	Referral Date:	2019/4/29	Address:
	Service:	----All Services-----	Tel.No.:
	Consultant:	-----All Specialists-----	Work No.:
	Referrer Instructions		Email:
	Urgency	Non-Urgent	Birthdate:
	Phone:		Sex:
	Fax:		Health Card No.:
	Address:		Send to:
	Appointment Instructions		Appointment Notes:
Appointment Date:		Last Follow Up Date:	
Appointment Time:			
Letterhead Name:	Yap, John C.P.		

N.B. Medications and allergies autopopulate.

3

the left margin.

[Attach File to Consultation](#)

Currently Attached
Files:

None

4

Address:

Appointment Instructions

Appointment D
Appointment T

Letterhead Nar

(5) Check items you wish to add to the consultation letter. Click on the adjacent hyperlink for a preview of the item.

(6) When done, click on the “Done Close Window” button. You can always return to the attach file area to add more or remove items. Just click Done/Close to complete the task.

Documents for

Available Documents

Done Close Window

Select all

Documents

- ☐ Colonoscopy ... 10-Nov-2017
- ☒ MR head nor ... 22-Jun-2018
- ☐ US thyroid ... 15-Mar-2018
- ☒ US thyroid ... 10-Nov-2017
- ☐ US thyroid ... 08-Nov-2017
- ☐ US-guided b ... 23-May-2017
- ☐ US/FNA thry ... 16-May-2017
- ☐ RCH Booking ... 16-May-2017
- ☐ ENT D Varga ... 15-May-2017
- ☐ US-guided b ... 11-May-2017
- ☐ Echo LVEF 6 ... 22-Apr-2017

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Pattison Outpatient Centre
9750 140 Street Surrey BC, V3T0G9

COLONOSCOPY PROCEDURE REPORT

ENDOSCOPIST: [Redacted]

INDICATIONS: The patient is a [Redacted] here for a colonoscopy due to fit positive

PROCEDURE PERFORMED: Colonoscopy with polypectomy

MEDICATIONS: Fentanyl 100 mcg IV and Midazolam (Versed) 3 mg IV

PREP QUALITY: good

TECHNICAL DIFFICULTY: Easy

CONSENT: Informed consent was obtained from the patient or representative prior to the

(7) Once completed, you must save (SUBMIT) the consultation letter, or all your efforts will be lost.

CAUTION: Do not be tempted to open an old consultation letter for review, while creating a new consult letter. This will result in the new draft letter getting replaced by the old letter – i.e. all your work will be lost!

Consultation TEST, ANDY M 49

Submit Consultation Request Submit Consultation Request & Print Preview Submit And Fax

Created by:

Status

- ☒ Nothing:
- ☐ Pending Specialist Callback
- ☐ Pending Patient Callback
- ☐ Completed

[Attach File to Consultation](#)

Currently Attached Files:

- None
- Legend
- Blue - Documents

Referring Practitioner: Dr. John C.P. Yap

Referral Date: 2019/4/29

Service: All Services

Consultant: All Specialists

Referrer Instructions

Urgency: Non-Urgent

Phone:

Fax:

Address:

Appointment Instructions

Appointment Date:

Appointment Time:

Letterhead Name: Yap, John C.P.

Patient: TEST, ANDY

Address: 123 Main Street
New Westminster, BC,

Tel.No.: 604-555-9999

Work No.: 604-544-6565

Email: test_email@pretend.ca

Birthdate: 1969-06-15

Sex: M

Health Card No.: X987654321 AB

Send to: Teams

Appointment Notes:

Last Follow Up Date:

At this point, you should message the office staff to send the consultation letter. Do so within the patient’s chart, so all relevant information is connected to the request.

5. **Prescribing Medications** – access the prescription module by clicking on the BAR labelled Medications (1), or the plus (+) sign (2). The first method brings up a “blank” template to start a new medication prescription. The second method brings up ALL the drugs labelled as long-term. In some situations, this may be desirable. The basics for prescribing are as follows:

MRP DR. JOHN C.P. YAP **TEST JOE** M 53 years 604-555-1123 Next Appt:
 Cell: Addr: 123 MAIN STREET, BURNABY, V1V1V1 PHN: 1234 567 X Age: 53 (DOB: 1966-03-18) eMail: test_eMail@test.com Send eMail

Preventions **+** **Social History** **+** **Medical History** **+**

Disease Registry **+** **Ongoing Concerns** **+** **Reminders** **+**

Forms **+** **Search** **OSCAR Search** **Filter** **Calculators** **Templates**

Medications **+**

Other Meds **+**

Risk Factors **+**

- a. Prescription writing should follow certain syntax and grammar. This is to allow Oscar to internally calculate how long the medication is intended to be used – short term, long-term, refills – all captured with the correct grammar. In a paper world, a prescription written as “Amox 500 mg tid M:21” would be understood by the pharmacist. But Oscar prefers this: “Amox 500 mg po TID for 7 days” in the instruction line.

#1. Start by searching for the desired medication. Type in the first few letters of the drug, and even the dosage, which will filter the drop-down list. It is preferable to choose the drug which has NO GENERIC PREFIX – to avoid clarification calls from the pharmacy. In the example below, Amox 500 mg is requested. Note the allergies. Avoid the use of CUSTOM DRUG as this will disable drug interaction and allergy checks.

oscarRx Patient Name: JOE TEST Age: 53 Preferred Pharmacy: Costco #051 Burnaby

Active Allergies **+**

AMOXIL 2...
SULFA

Medical History

Medical: HTN, DM, COPD.
Surgical: tonsillectomy age 8, appendectomy 1986, ORIF fractured ankle 1996.
Psychiatric: nil.
MedHx line 4.
Medical: adding new item.

Favorites **edit copy**
ACLASTA

Drug Name: Amox **Search** **CustomDrug** **Note** **Rese** **DrugOfChoice**

Patient Drug

Profile

Entered Date

2017-11-11 AMOX 250 CAP 250MG
2017-11-11 AMOX 500 CAP 500MG
2017-11-11 AMOX S 125 SUS 125MG/5ML
2017-11-11 AMOX S 250 SUS 250MG/5ML
2017-11-11 AMOXAPINE 100MG TABLET
2017-11-11 AMOXAPINE 25MG TABLET
2017-11-11 AMOXAPINE 50MG TABLET
2017-11-11 AMOXI-CLAV 500MG/125MG
2017-11-11 AMOXI-CLAV 875MG/125MG
2017-11-11 AMOXICILLIN 125MG GRANULES FOR SUSPENSION
2017-11-11 AMOXICILLIN 125MG POWDER FOR SOLUTION
2017-11-11 AMOXICILLIN 125MG POWDER FOR SUSPENSION

#2. This patient has an allergy to Amoxil, which will be highlighted once the Rx is written in full. The warning may be bypassed, if appropriate. If the tab key is used to navigate from the instruction line, the quantity will auto-calculate. If there are refills noted, the Long-Term Med button is auto-checked. The red asterisk at the end of the field opens a pop-up showing previous instructions for that same drug. This may offer some clues as to dosing. Click on a desired line if the instructions suit your needs.

Patient Name: JOE TEST Age: 53 Preferred Pharmacy: Costco #051 Burnaby

Name: AMOX 500 CAP 500MG Inactive Drug Since: Tue Apr 02 2002 more F

Allergy: AMOXIL 250 CAP Reaction:

Indication: icd9 Search Dx

Instructions: Take 1 cap po tid for 7 days

Qty/Mitte: 21 Repeats: 0 Long Term Med Short Term Med

Ingredient: AMOXICILLIN (AMOXICILLIN TRIHYDRATE) 500.0MG

Method:Take Route:po Frequency:tid Min:1 Max:1 Duration:7 DurationUnit:D Qty/Mitte:21

Drug Name:

Search CustomDrug Note Rese DrugOfChoice

Save And Print Save

AMOX 500 CAP 500MG Rx Examples

Instruction	Special Instruction
Take 1 Tabs PO TID for 7Days	
Take 1 Tabs PO TID for 10Days	
Take 1 cap po tid for 10 days	
Take 1 Tabs PO QID for 7Days	
Take 4 Tabs PO OD 1 hour before dental work	
Take 1 cap po tid for 7 days	
AMOXICILLIN 500MG CAPSULE	

Add another medication, if desired, in the Drug Name Box at the bottom, and repeat steps #1 and #2.

#3. Refill an existing medication by highlighting the relevant checkbox(es), and clicking ReRx on one of the lines. The entire list will be loaded for review and edit. You may change instructions, quantity, etc., but you CANNOT change the drug name or dose. The drug name is associated with a specific DIN (drug identification number) and this is unique, allowing for allergy and drug interaction checks. Changing this will make the drug name a "custom drug".

Profile Legend: * Current All Active Expired Longterm/Acute Longterm/Acute/Inactive/External

Entered Date	Start Date	Days to Exp	LT Med	Medication	Represcribe	Delete	Discontinue	Reas
2017-11-16	2017-11-16	0	L	CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty:20 Repeats:0	<input checked="" type="checkbox"/> ReRx	Del	Discon	+
2017-11-16	2017-11-16	0	L	ALTACE 5MG Take 1 tablet po daily for 3 mo Qty:90 tab Repeats:3	<input checked="" type="checkbox"/> ReRx	Del	Discon	+
2016-10-06	2016-10-06	0	L	TESTOSTERONE CYPIONATE INJECTION USP 100MG Give 160 mg i.m. q21 days for 3 months Qty:0 Repeats:0	<input type="checkbox"/> ReRx	Del	Discon	+
2015-02-03	2015-02-03	0	L	adla fast Qty:0 Repeats:0	<input type="checkbox"/> ReRx	Del	Discon	+
2015-02-03	2015-02-03	0	L	Hydram 1% cream with Testosterone 2% Apply 1 Units TOP BID PRNApply to affected areasApply sparingly Qty:30 gm Repeats:2	<input checked="" type="checkbox"/> ReRx	Del	Discon	+








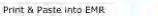






When you have completed the list of medications for prescription, click "Save and Print" to see the Preview.

Name:	CIPRO 500 - TAB 500MG	more F X				
No allergy to this drug found. Please check allergy list.						
Indication	icd9 Search Dx					
Instructions:	Take 1 Tabs PO BID for 10 days * ?					
Qty/Mitte:	20	Repeats: 0 <input type="checkbox"/> Long Term Med <input checked="" type="checkbox"/> Short Term Med				
Ingredient:	CIPROFLOXACIN (CIPROFLOXACIN HYDROCHLORIDE)					
Method:Take Route:PO Frequency:BID Min:1 Max:1 Duration:10 DurationUnit:D Qty/Mitte:20						
Dosing Information Refresh						
<table border="1"><thead><tr><th>Clcr</th><th>Recommendation</th></tr></thead><tbody><tr><td>5-30</td><td>250-500 mg po q18h</td></tr></tbody></table>			Clcr	Recommendation	5-30	250-500 mg po q18h
Clcr	Recommendation					
5-30	250-500 mg po q18h					
$\text{Clcr N/A} = \frac{(140 - 53[\text{age}]) \times 74.0 [\text{kg } 2017\text{-Jul-25}]}{\text{N/A sCr } [\mu\text{mol/L}]} \times 1.23$						
hide						

Name:	ALTACE 5MG	more F X
No allergy to this drug found. Please check allergy list.		
Indication	icd9 Search Dx	
Instructions:	Take 1 tablet po daily for 3 mo * ?	
Qty/Mitte:	90 tab	Repeats: 3 <input type="checkbox"/> Long Term Med <input type="checkbox"/> Short Term Med
Ingredient:	RAMIPRIL	
Method:Take Route:po Frequency:OD Min:1 Max:1 Duration:3 DurationUnit:M Qty/Mitte:90 tab		

Name:	Hyderm 1% cream with Testosterone	more F X
Indication	icd9 Search Dx	
Instructions:	Apply 1 Units TOP. BID PRNApply to affected areasApply sparir * ?	
Qty/Mitte:	30 gm	Repeats: 2 <input type="checkbox"/> Long Term Med <input type="checkbox"/> Short Term Med
Method:Apply Route:TOP. Frequency:BID Min:1 Max:1 Duration:0 DurationUnit:D Qty/Mitte:30 gm		

Drug Name:	Search Custom Drug Note Reset DrugOfChoice
Save And Print Save	

Patient Name: JOE TEST Age: 53 Preferred Pharmacy:		Printable PDF Edit Rx
	Dr. John C.P. Yap <hr/> <p style="text-align: right;">May 11, 2019</p> <p>JOE TEST DOB: Mar 18, 1966 123 MAIN STREET BURNABY, BC V1V1V1 604-555-1123 Health Ins.#1234567X</p> <hr/> <p>CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty: 20 Repeats: 0</p> <hr/> <p>ALTACE 5MG Take 1 tablet po daily for 3 mo Qty: 90 tab Repeats: 3</p> <hr/> <p>Hyderm 1% cream with Testosterone 2% Apply 1 Units TOP. BID PRN Apply to affected areas Apply sparingly Qty: 30 gm Repeats: 2</p> <hr/> <p>Signature: _____ Dr. John C.P. Yap Pract. No. 11701</p> <p style="font-size: small; margin-top: 10px;">Created by: OSCAR The open-source EMR www.oscarcanada.org</p>	<h3 style="margin-top: 0;">Actions</h3> <p>Size of Print PDF : A4 page </p> <p> </p> <p></p> <p></p> <p> </p> <p></p> <p></p> <p></p> <h3 style="margin-top: 20px;">Additional Notes to add to Rx</h3> <div style="border: 1px solid #ccc; height: 25px; width: 100%;"></div> <div style="float: right; border: 1px solid #ccc; padding: 2px 5px;">Add to Rx</div> <div style="clear: both;"></div> <h3 style="margin-top: 20px;">Signature</h3> <div style="border: 1px solid black; height: 150px; width: 100%; position: relative;">  </div> <div style="background-color: #333; color: white; padding: 5px; font-size: small;">Please sign in the box above this message.</div> <h3 style="margin-top: 20px;">Drug Information</h3> <p>CIPROFLOXACIN (CIPROFLOXACIN HYDROCHLORIDE) (CIPRO 500 - TAB 500MG)</p> <p>RAMIPRIL (ALTACE 5MG)</p>

N.B. Ensure that headers and footers are set to blank on our device. Ask your office manager for assistance to do this.

Options: ☐ Print Selection Only
☒ Ignore Scaling and Shrink To Fit Page Width

Appearance: ☐ Print Background Colors
☐ Print Background Images

Frames: ☒ As Laid Out on the Screen
☐ Fit to Page Width
☐ Fit to Page Height

Page Headers: --blank-- --blank-- --blank--
Left Center Right

Page Footers: --blank-- --blank-- --blank--

? PDF Hide Details Cancel Print

[11-May-2019 :: Tel-Progress Note]

CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty:20 Repeats:0

ALTACE 5MG Take 1 tablet po daily for 3 mo Qty:90 tab Repeats:3

Hyderm 1% cream with Testosterone 2% Apply 1 Units TOP. BID PRN Apply to affected areas Apply sparingly Qty:30 gm Repeats:2

You may reposition the list of medications anywhere in your SOAP note. Just copy/cut/paste as needed.

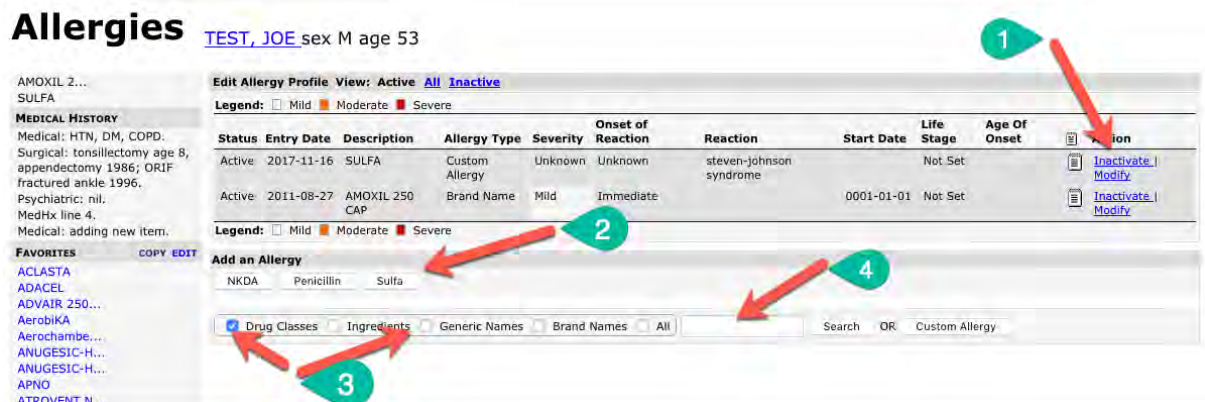
Additional features to ask your Office Manager or colleagues to demonstrate: use of custom drugs, favourites, activating long-term status, deactivating long-term status.

Key Points: Use the proper syntax when writing a prescription. Ensure a duration of use is stated. Use Long-Term or Short-Term when appropriate. Avoid use of Custom Drugs if possible. Use the prescription module to document triplicate prescriptions and even samples!

6. **Allergy Module** – noting allergies properly is critical. Use same strategy to search for the specific drug, or drug class as for writing a Rx. Avoid use of Custom Allergy – it may seem faster, but there is no internal auto-checking with custom allergies. Save Custom Allergy for special situations such as allergy to shellfish, etc.

#1. Click on the Allergy BAR, or plus (+) sign. Existing allergies are listed, and may be inactivated or modified (1) – only available in Oscar15. Some preset allergies are available as quick-pick buttons (2). Or Search (4) for the desired drug, and check off the appropriate level of search (3) – usually drug classes, generic and brand names are desirable. It is preferable to choose a drug class (e.g. Penicillin) rather than a specific drug within that class (e.g. Amox). Use Custom Allergy as a last resort.

N.B. NKDA as a “custom allergy” is allowed.



#2. Search for Ramipril: type in part of name (1), choose the categories, and click “Search” (2).



A drop-down list should appear. Choosing the class of drug is preferable – i.e. ACEI (2).

Add an Allergy

NKDA Penicillin Sulfa

☒ Drug Classes ☐ Ingredients ☒ Generic Names ☒ Brand Names ☐ All ramipr Search OR Custom Allergy

ALLERGY SEARCH RESULTS

ATC CLASS

[RAMIPRIL](#)
[RAMIPRIL AND DIURETICS](#)
[RAMIPRIL AND FELODIPINE](#)

BRAND NAME

[ACT RAMIPRIL 1.25MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 10MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 2.5MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 5MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)
[ACT RAMIPRIL 1.25MG](#) [ANGIOTENSIN-CONVERTING ENZYME INHIBITORS](#)

Click on the appropriate link, then add comment to describe the reaction (1), and other details if desired. Click “Add Allergy” (2) to save the information.

Add an Allergy

NKDA Penicillin Sulfa

Adding Allergy: ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

Comment: Cough

Start Date: (yyyy-mm-dd OR yy-mm OR yyyy)

Age Of Onset:

Life Stage: Not Set

Severity Of Reaction: Unknown

Onset Of Reaction: Unknown

Add Allergy Cancel

☒ Drug Classes ☐ Ingredients ☒ Generic Names ☒ Brand Names ☐ All ramipr Search OR Custom Allergy

Key Points: Avoid the use of Custom Drugs or Custom Allergies.

7. **Billing** – most physicians will bill themselves, after completing the note. Some private bills can be generated by the Office staff. Access the Billing Module using the Save and Bill icon in the encounter note.

The screenshot shows a medical encounter note interface. At the top, the title is "[11-May-2019 :: Tel-Progress Note]". Below this, the medical history is listed: "CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty:20 Repeats:0", "ALTACE 5MG Take 1 tablet po daily for 3 mo Qty:90 tab Repeats:3", and "Hyderm 1% cream with Testosterone 2% Apply 1 Units TOP. BID PRN Apply to affected areas Apply sparingly Qty:30 gm Repeats:2". Below the history, there is a section for "Editors:" and "Encounter Date:" with a calendar icon. To the right of the date field is a "rev" button. Below the date field is a "Type:" field. At the bottom of the interface, there is a toolbar with several buttons: "Assign", "00:18" (timer), a double-slash icon, a printer icon, a document icon, a mail icon, a person icon, a gear icon, and a "rev" button. Below the toolbar, there are four buttons: "Display Resolved Issues", "Display Unresolved Issues", "Spell Check", and "Expand All Notes". At the bottom right, there is a "Browse Notes" button. Numbered callouts 1 through 6 are placed over the interface: 1 points to the "00:18" timer button, 2 points to the "Assign" button, 3 points to the double-slash icon, 4 points to the printer icon, 5 points to the mail icon, and 6 points to the "rev" button in the top right corner.

- (1) Timer – click to paste start/stop time into the bottom of your current encounter note. N.B. Timer restarts at current time if you leave/close note and return, so activate the start time early by clicking this button when needed.
- (2) Timer pause/restart.
- (3) Force save – note will be saved, but not signed. Usually not needed, as auto-save is activated every 5 seconds, or so.
- (4) Save and exit – forces a full save, signature and time stamp added, and encounter note is closed. To further edit this note, you have to return to encounter page and click “edit” link in the top right corner of this note.
- (5) Save Sign & Bill – once the note is complete, you can save and go directly to the billing page. Once you click this icon, the chart is closed and cannot be viewed.
HINT: make sure you remember what the diagnosis is – for the billing page!
- (6) Exit – use if you DO NOT WISH TO SAVE ANY OF YOUR CHANGES, and wish to close the note. Very useful if you are typing in the wrong chart! This is the proper way to leave a note without saving any foot print of your actions – if you are typing in the wrong chart.
HINT: if the note belongs in a DIFFERENT CHART – select and copy the work to PASTE into the correct chart! Do this before you EXIT the wrong chart.

On clicking Save Sign & Bill – the billing page opens:

Patient: TEST, JOE Age: 53 Invoice List Patient Status: Test Roster Status Assigned Physician: Yap, John C.P.

Billing Form: GP general practice Billing Physician: Yap, John C.P. Billing Type: Bill MSP Clarification Code: VANCOUVER Service Location: A)Practitioner's Office - In Community

Service Date: 2019-05-11 Service to date/After Hours: 7 Time Call: Start (HHMM 24hr): End (HHMM 24hr): Dependent: No Sub Code: O - Normal Payment Method: ELECTRONIC Facility:

Office Visits	Description	\$Fee	Complex Fees	Description	\$Fee	Other	Description	\$Fee
<input type="checkbox"/> 15300	VISIT IN OFFICE (AGE 50-59)	34.62	<input type="checkbox"/> 00043	ANTICOAGULATION THERAPY BY TELEPHONE	6.95	<input type="checkbox"/> 13070	IN OFFICE ASSESSMENT IN ASSOC WITH A WSBC SERVICE	16.36
<input type="checkbox"/> 15301	COMPLETE EXAMINATION IN OFFICE (AGE 50-59)	76.83	<input type="checkbox"/> 13005	ADVICE ABOUT A PATIENT IN COMMUNITY CARE	15.72	<input type="checkbox"/> 13075	IN OFFICE ASSESSMENT IN ASSOC WITH AN ICBC SERVICE	16.36
<input type="checkbox"/> 15320	INDIVIDUAL COUNSELLING IN OFFICE (AGE 50-59)	60.23	<input type="checkbox"/> 14540	INSERTION INTRAUTERINE CONTRACEPTIVE DEVICE (IUD)	42.94	<input type="checkbox"/> 14029	ALLIED CARE PROVIDER PRACTICE CODE	0.00
<input type="checkbox"/> 00103	HOME VISIT(SERVICE RENDERED BETWEEN 0800-2300HRS)	115.15	<input type="checkbox"/> 14560	ROUTINE PELVIC EXAM INCLUDING PAP	31.46	<input type="checkbox"/> 14043	GP MENTAL HEALTH PLANNING FEE	100.00
			<input type="checkbox"/> 14066	PERSONAL HEALTH RISK ASSESSMENT	50.00	<input type="checkbox"/> 14050	GP ANNUAL CHRONIC CARE INCENTIVE-(DIABETES MELLITU	125.00
			<input type="checkbox"/> 14070	GP ATTACHMENT PARTICIPATION	0.00	<input type="checkbox"/> 14051	GP ANNUAL CHRONIC CARE INCENTIVE-HEART FAILURE	125.00
			<input type="checkbox"/> 14033	ANNUAL COMPLEX CARE MANAGEMENT FEE	315.00	<input type="checkbox"/> 14052	GP ANNUAL CHRONIC CARE INCENTIVE-HYPERTENSION	50.00
			<input type="checkbox"/> 14075	GP ATTACHMENT COMPLEX CARE MANAGEMENT FEE	315.00	<input type="checkbox"/> 14053	GP ANNUAL CHRONIC CARE INCENTIVE - COPD	125.00
			<input type="checkbox"/> 14076	GP ATTACHMENT TELEPHONE MANAGEMENT FEE	20.00	<input type="checkbox"/> 13228	COMMUNITY BASED GP: HOSPITAL VISIT	29.85
			<input type="checkbox"/> 14077	GP ATTACHMENT PATIENT CONFERENCE FEE	40.00	<input type="checkbox"/> 13338	COMMUNITY BASED GP,1ST FAC VISIT OF DAY BONUS,EXTR	38.10
			<input type="checkbox"/> 14078	GP EMAIL/TEXT/TELEPHONE MEDICAL ADVICE RELAY FEE	7.00	<input type="checkbox"/> 13339	COM BASED GP,1ST HOSP VISIT OF DAY BONUS, EXTRA	29.85
			<input type="checkbox"/> 00190	ELECTROSURG./CRYOTHERAPY FOR REMOVAL OF WARTS ETC.	31.46	<input type="checkbox"/> 00114	VISIT NURSING HOME ONE OR MULTIPLE PATIENTS	36.13
			<input type="checkbox"/> 13620	EXCISION TUMOR OF SKIN/SCAR UP TO 5CM	66.02	<input type="checkbox"/> 00115	NURSING HOME VISIT - 1 PATIENT WHEN SPECIALLY CALL	115.15
			<input type="checkbox"/> 15120	PREGNANCY TEST, IMMUNOLOGIC, URINE	11.59	<input type="checkbox"/> 13334	LTC FACILITY VISIT-FIRST VISIT OF DAY BONUS,EXTRA	34.06
			<input type="checkbox"/> 15130	URINALYSIS - SCREENING	2.17	<input type="checkbox"/> 13605	ABSCESS - SUPERFICIAL	44.26
			<input type="checkbox"/> 00034	INJECTION SUBCUTANEOUS	11.31	<input type="checkbox"/> 13611	MINOR LACERATION/FOREIGN BODY REQUIRING ANAES.	66.02
			<input type="checkbox"/> 00044	MINI TRAY FEE	5.19	<input type="checkbox"/> 15039	GP POINT OF CARE (POC) TESTING FOR METHADONE	12.75
			<input type="checkbox"/> 00090	MAJOR TRAY	31.21	<input type="checkbox"/> 15040	GP TESTING FOR OPIOIDS, OXYCONDONE	12.75
			<input type="checkbox"/> 00010	INJECTION, INTRAMUSCULAR	11.31	<input type="checkbox"/> 00039	METHADONE OR BUPRENORPHINE/NALOXONE TREATMENT ONLY	23.60
			<input type="checkbox"/> 00015	INJECTION, INTRA-ARTICULAR - ALL OTHER JOINTS	16.92	<input type="checkbox"/> 03333	NO CHARGE REFERRAL	0.00

Referral Doctor: Referral Type: Refer To Select Type

Recent Referral Doctors Used: none Referral Doctor on Master Record: none

Other service/procedure/premium codes Unit:

Diagnostic Code:

Short Claim Note: ☐ Ignore Warnings

Billing Notes (Notes are for internal use and will not be sent to MSP):

(7) Choose the visit fee – usually preset for appropriate age-based adjustment.

(8) Add referral physician name if making referral.

HINT: type part of last name and first name, separated by comma to generate drop-down list. Most of the time, the referral type is “Refer To”. An error may occur if this is not selected.

(9) Fee code – either generated by quick pick in (7), or added manually.

HINT: you can search with a key word (start typing part of word and hit enter).

(10) Diagnostic code – enter appropriate ICD-9 code, or search using key word (start typing part of word and hit enter).

(11) Choose a previously used diagnostic code from the list.

HINT: hover over the code to see the text describing the code.

(12) Click “Continue” to see billing preview page.

oscarBC Billing					
Patient Information					
Patient Name:	JOE TEST	Patient PHN:	1234567X	Health Card Type:	BC
Patient DoB:	19660318	Patient Age:	53	Patient Sex:	M
Patient Address:	123 MAIN STREET	City:	BURNABY	Postal:	V1V1V1
Billing Information					
Billing Type:	MSP	Service Location:	At Practitioner's Office - In Community	Clarification Code:	00IVANCOUVER
Service Date:	2019-05-11	Service To Date:	After Hours: No	Time Call:	Start Time: End Time:
Billing Provider:	Yap, John C.P.	Appointed Provider:	13	Dependent:	00
Short Note:					ICBC claim #:00000000
Service Code	Description	Unit	Fee	Total	
15300	VISIT IN OFFICE (AGE 50-59)	1.0	34.62	34.62	
Diagnostic					
Code	Description				
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED				
notes					
Internal Notes					
<div style="text-align: right;"> Go Back Another Bill Save Bill Cancel </div> <div style="text-align: right;"> 14 15 16 </div>					

(13) Ensure the proper Billing Provider is named, and the date is correct. Default date is TODAY.

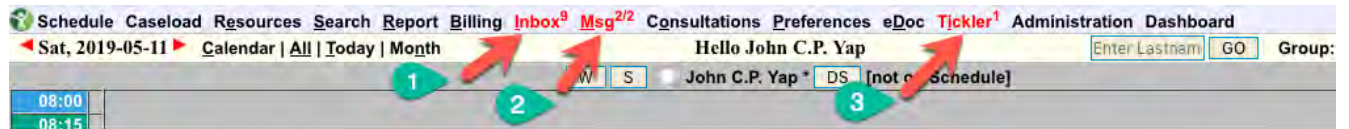
(14) If there is an error, "Go Back" returns you to the previous page to make changes.

(15) Click to save this claim, and create **ANOTHER** bill for the SAME patient. Example – bill an office visit for WSBC, and then bill a second item for MSP service on the same day.

(16) Save Bill – click to save and close the billing module.

Cancel and leave if you do not wish to bill at this time.

8. **Messages, Inbox, Ticklers:** this is how Oscar notifies the user about tasks, messages, and reports.

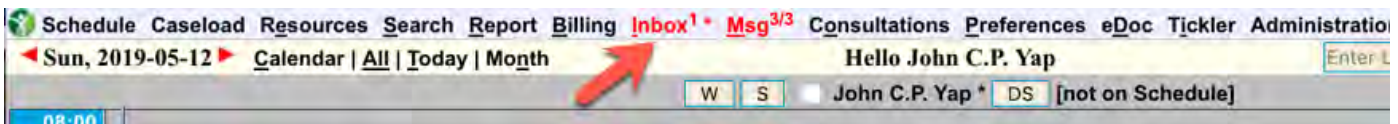


(1) Inbox items include labs and scanned documents. This indicates there are 9 items pending for review.

(2) Msg items are internal eMail type messages between Oscar user(s) who have Oscar accounts. You can use this to send a message to YOURSELF, to complete a task.

(3) Ticklers are TIMED/SCHEDULED messages between Oscar users which can be set for a future date, or for TODAY. They are usually reminders scheduled for a future date – e.g. next Pap, etc.

- a. **InBox** – this is where you will find new reports for your review and acknowledgement. These includes labs, imaging reports, consultations, insurance request, etc.



#1. There is one Inbox item to be processed Click on the Inbox link to show the List View.



#2. **List** mode shows every item in a separate line. The left margin is sorted alphabetically by last name. Click here to see JUST the items associated with that patient. Or click on the main screen to see each item one at a time. Click on the Preview button to switch to Preview mode.



#3. **Preview** mode has the advantage of showing the document in the main window. You can scroll down to read additional pages, etc. You can scroll on the larger window to go to the next patient report, also in Preview Mode. The best way to experience Preview Mode is to click on the left side margin – any order is fine – to display the report, read, review, and then act on and acknowledge the report.

Preview-Expand

Acknowledge Comment Forward Print Msg Tickler E-Chart Req# Recall Label

Version: v1 v2 v3 All

Patient Name: Home Phone: F
Date of Birth: Work Phone: C
Age: Sex: Patient Location: FHAM
Health #

Requesting Client: JOHN YAP

Version: v3	John C.P. Yap : Not Acknowledged 12-May-19 00:30, no comment
Version: v2	John C.P. Yap : Acknowledged 05-May-19 19:53, no comment
Version: v1	John C.P. Yap : Acknowledged 05-May-19 09:47, no comment

(1) **Acknowledge** – to note you have reviewed the report and file it in chart. This should be done last, as it will close the report after. You may be asked to add a comment to this report on filing. This can be left blank.

(2) **Msg** – send message related to the report. **HINT:** you can remind yourself to follow up in some way.

(3) **Tickler** – set up a scheduled memo related to this report.

(4) Enter a **label** to better describe the report. After you type in label, click on the blue “label” button to save it. **HINT:** use abbreviations, and develop a logical format. There is limited space to display this label in the eCHART. You can change the label as often as you wish.

HINT: if the result needs to be highlighted for another physician who does not appear in the CC chain (top right), click on the **Forward** button, and a pop-up will allow you to send the result to another physician **within** the clinic. You may wish to also **Msg** the other physician to note your concern.

- b. **Msg** – this is similar to internal eMAIL, which can be sent to single or multiple recipients, including yourself as a reminder. A Msg can be non-linked to a patient, such as an announcement to the office of a meeting, e.g. Creating a Msg with a patient's chart will link that message to that patient, so it is easier for the recipient to open the chart. See all messages linked to the patient by clicking the Messenger Bar (1). Create a Msg by clicking the plus (+) sign (2) in the Messenger Bar.



This screenshot shows the 'Create a Message' form within the 'Messenger' interface. The form has a blue header bar with the title 'Create a Message'. Below the header are three buttons: 'Back To Inbox', 'Clear New Message', and 'Exit Messenger'. The form is divided into two main sections: 'Recipients' on the left and 'Message' on the right. The 'Recipients' section has a 'Send Message' button (circled in red) and a list of recipients with checkboxes. The 'Message' section has a 'Subject' field (labeled with a red arrow and '1') and a large text area for the message body (labeled with a red arrow and '2'). The text area contains the placeholder text 'Add more details here'. The recipients list includes 'RemoteLocations', 'Oscar Users', 'Exceptional', 'admin', 'NWFP_doc', 'Residents', 'Locum', and 'QI Project'. A red arrow labeled '3' points to the 'Exceptional' recipient, and another red arrow labeled '4' points to the 'admin' recipient.

(1) Every message must have a **subject**. This line is displayed in the eCHART. Keep the subject discrete. Example – see lab – if you want a colleague to review an important lab result related to that patient.

(2) The body of the message can be more detailed, or can be a blank **space**. It cannot be totally blank, however.

(3) Choose a specific recipient, or group of recipients. See the individuals in a group by clicking on the plus (+) sign.

(4) Choose the entire group if desired – e.g. all doctors, all MOAs. Each clinic will define their own groups.

HINT: if your name does not appear here, you need to speak to the Office Manager or IT support.

When you have completed the Msg, click **“Send Message”**. The **“Send & Archive”** button is used when you **RESPOND** to a message that is sent to you.

- c. **Ticklers** are generally created by the MOAs to recall patients as per screening protocol, or when the MD requests a **future** follow-up appointment. They are also used as reminders for appointments, etc. They are **ALWAYS** linked to a patient, and must be created from within the patient’s eCHART or master demographic page.

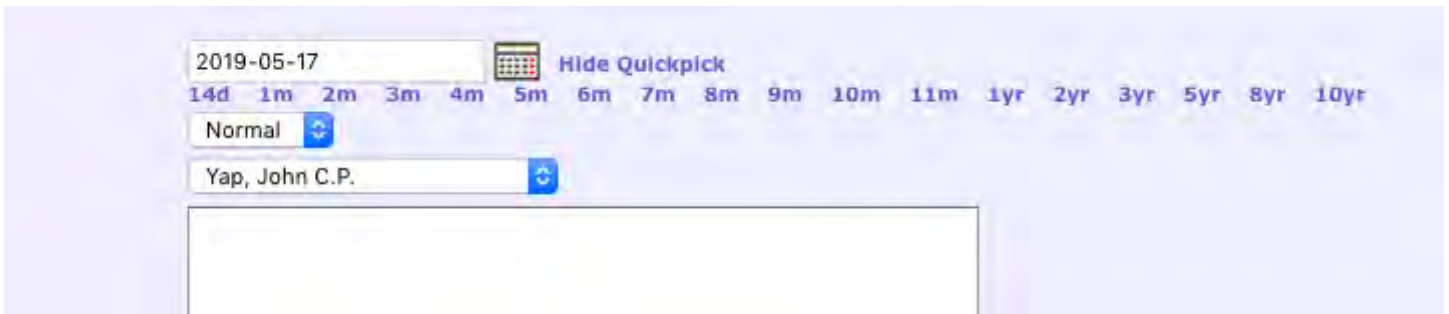
Click on the plus (+) sign on the Tickler bar.



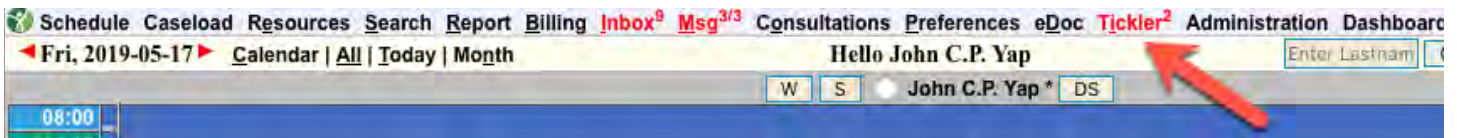
Default date is today (1). This can be changed with direct entry, or by clicking Show Quickpick (4). The default recipient of the Tickler is the current user (2). Click on this box to reveal other recipients.

HINT: click on the first letter of the last name to jump directly to that section of the list. Example – clicking M will bring up MOA, etc.

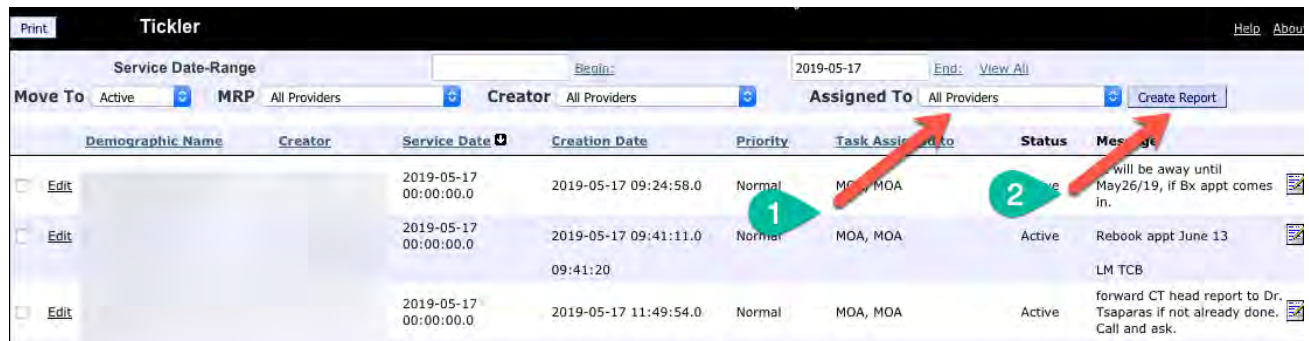
Add relevant details in the subject box (3). Click on Submit and EXIT (5) to send.



Click on the appropriate Quickpick link to fast forward to that date. Click on the calendar icon to choose a specific date from current month. N.B. This is less efficient in most cases.



Any Ticklers currently directed to you will be announced from the schedule page. There are 2 Ticklers pending action. As well as 9 Inbox items, and 3 messages, in the example above.



Demographic Name	Creator	Service Date	Creation Date	Priority	Task Assigned to	Status	Message
<input type="checkbox"/> Edit		2019-05-17 00:00:00.0	2019-05-17 09:24:58.0	Normal	MOA, MOA	Active	Will be away until May26/19, if Bx appt comes in.
<input type="checkbox"/> Edit		2019-05-17 00:00:00.0	2019-05-17 09:41:11.0	Normal	MOA, MOA	Active	Rebook appt June 13
<input type="checkbox"/> Edit		2019-05-17 00:00:00.0	2019-05-17 11:49:54.0	Normal	MOA, MOA	Active	LM TCB
<input type="checkbox"/> Edit		2019-05-17 00:00:00.0	2019-05-17 11:49:54.0	Normal	MOA, MOA	Active	forward CT head report to Dr. Tsaparas if not already done. Call and ask.

Click on the Tickler link on the menu bar, and the Tickler module appears. The default view shows Ticklers assigned to ALL PROVIDERS. Filter down to Ticklers for you by clicking on the Assigned To drop-down menu (1), and the clinic list will appear.

HINT: click on the first letter of your last name to jump to your section.

Highlight your name, and click Create Report (2) to see only those Ticklers assigned to you.

NOTE: the ticklers set for today (current) are at the top. Older ticklers (potentially overdue) are at the bottom. Future ticklers are not displayed, unless the END DATE is changed for that future date.

How do I access historical information?

Almost all relevant historical information is accessible from the eCHART page. This requires some degree of planning, organization and maintenance.

The screenshot displays the eCHART patient record for DR. JOHN C.P. YAP, TEST, JOE, M 53 years, 604-555-1123. The interface is divided into several sections, with numbered callouts (1-13) highlighting specific areas of interest:

- 1. Preventions:** A list of preventive services including FOBT, HZV, RZV, PSA, HIV, and H1N1.
- 2. Disease Registry:** A list of chronic conditions such as CHRONIC BRONCHITIS*, CHR PULMONARY HEART DIS*, HUMAN IMMUNO VIRUS DIS, CHRONIC PAIN SYNDROME, ESSENTIAL HYPERTENSION*, and ATRIAL FIBRILLATION.
- 3. Social History:** Information about the patient's social background, including marital status, children, and employment.
- 4. Medical History:** A list of past medical conditions, including HTN, DM, COPD, and a history of tonsillectomy and ORIF.
- 5. Medications:** A list of current and past medications, including ALTACE 5MG, CIPRO 500, and ASA 81 mg qd.
- 6. Documents:** A list of scanned documents, including skin ulcer reports, test photos, and lab results.
- 7. Lab Result:** A section for digital lab results, including a "GENERAL/HAEM3" test.
- 8. Messages:** A list of messages, including a consent form and a report from the Insurance (Vehicle) Act.
- 9. Measurements:** A section for clinical measurements, including CDM Indicators, HIV Flowchart, INR Flowchart, and Chronic Obstructive Pulmonary.
- 10. Consultations:** A list of consultations, including Cardiology, General Surgery, Allergy, and Addiction Medicine.
- 11. HRM Documents:** A section for Human Resources Management documents, including PNR and Register for PHR.
- 12. Risk Factors:** A list of risk factors, including 2nd hand smoke exposure, Phx of DM, and Past asbestos exposure.
- 13. Family History:** A section for family history, including Mother, testing again, sister, and Uncle.

Vaccines and various health-related screening found in the Preventions module (1). Major conditions are noted in the Disease Registry (2). Some of the disease conditions will trigger relevant chronic disease flow sheets (e.g. HTN, DM, etc.). The library of used eFORMS found here (3). Some of the eFORMS are clinical calculators (MMSE, PHQ9, etc.) and the scores will usually be displayed in this index. Scanned documents will be listed here (4), in order of observed date. If the titles are properly labelled, you may not need to open the document to read the entire contents. Click on the hyperlink to see the full document. Click on the down arrow to open the index fully and show all the documents as titles. Click on the document BAR, and you will open the Document Library – which provides even more details. Most lab results will be displayed here (5). These are digital labs, not scanned from paper. The titles are not as helpful, unfortunately. Hover over the plus (+) sign of Lab Results to show labs in a different Display mode. Row Display is especially useful. Clicking on a lab result will generally create a report of ALL values for that specific item. This is useful to assess trends. The list of messages appears here (6), in chronological order, newest at the top. The measurements module is a very important one (7). Discrete measurements (labs, vital signs, MMSE score, etc.) are either manually added here, or automatically added by Oscar. Hopefully, your clinic has relevant measurement groups set up for you.

HINT: It is PREFERABLE to input vital signs in the measurement area, rather than typing them into the encounter note. Once the VS are saved in measurements, they get pasted into the encounter note for you anyway!

The list of consultation referral letters is found here (8). The cumulative patient profile (CPP) encompasses the 4 boxes here (9), and the additional boxes in the right margin (12) and (13). If there are important clinical details relevant for optimal care of the patient, they should be highlighted here. Add a new line (bullet) by clicking on the plus (+) sign. Add to an existing line simply by clicking on the line to open an edit window. Don't forget to SAVE the changes before closing, otherwise your work is not recorded.

Allergies (10) and Medication list (11) are found on the right margin. A down arrow in the bottom corner indicates more entries that are hidden. Click the arrow to show the hidden entries.

HINT: if a title seems incomplete, make the entire window bigger by dragging the browser size larger in the horizontal plane. Hovering your mouse over the title will enable a pop-up showing more of the title.

Oscar should be relatively intuitive to use, with most of the necessary information accessible from the eCHART view. Take care to ensure you are in the correct chart. Exit from the chart with the proper icon if not. Ensure you sign and save your note when done. If incomplete, or additional details are required, you can always re-open the old note and EDIT (top right corner of the note field) the note further. Each time you sign and save the note, an additional signature and time stamp is added. Pay special attention to how you write prescriptions – ensure a duration is specified so Oscar will know whether the medication is short, mid, or long-term. Ensure each eFORM or FORM you create is submitted (saved) or all your work will be lost, and there will be an incomplete audit trail. Please use the measurement function to record relevant discrete data (BP, Ht, Wt, etc).