From the Office of Health Informatics

Ambulatory Clinical Intake Specialty Workflow

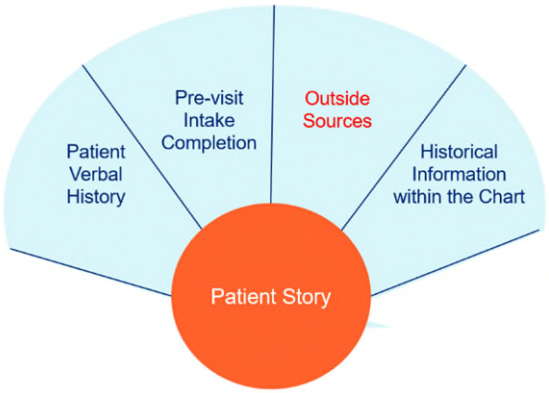
June 27, 2025

The Ambulatory Clinical Intake serves as a foundation for the patient's care encounter. The primary goal is to gather essential patient data, which will assist healthcare providers in delivering safe medical care. The following workflow uses best practice recommendations specific for Primary and Pediatric practices.

Ambulatory Clinical Workflow: The Patient Story

The ambulatory workflow intake process consists of four sources of clinical information.

- **Patient's Verbal History**
- **Pre-Visit Intake**
- **Outside Records**
- **Historical Information in Local Record**



Ambulatory clinical staff will use this information to **reconcile**, **update**, and **document** within the **Ambulatory Workflow MPage** to allow healthcare providers to deliver safe medical care to their patients.

Ambulatory Clinical Intake

STEP 1: Navigate to the Workflow MPage.

- MPage components in the menu can be arranged to fit navigation and documentation in the chart by using drag-and-drop to move them to a desired position.
- Place commonly used components at the top of the list.
- The recommended component order is…
    - Chief Complaint
    - Recommendations
    - Allergies
    - Home Medications
    - Histories
    - Vital Signs- Adding additional vital signs, measurements and pain scale assessments after the initial intake is done for that visit.
        - Use Clinical Entry Workspace (CEW) to access PowerForms for documentation.

STEP 2: Enter the **Chief Complaint** within the component on the MPage and select **Sign**.

STEP 3: Navigate to the **Recommendations** component.

- Update any recommendations, as appropriate. For more information on using Recommendations, click here.

STEP 4: Navigate to the **Allergies** component.

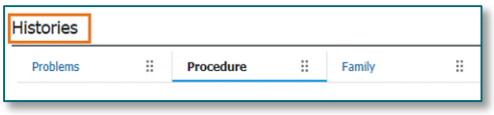
- Review and update allergies.
    - If outside records exist, a purple diamond will appear next to the label **Outside Records**. Click **View Records** to reconcile the outside allergies.
- When complete, click **Mark as Reviewed**.

STEP 5: Navigate to **Home Medications** component.

- Review and update home medication history.
    - If outside records exist, a purple diamond will appear next to the label **Outside Records**. Click **View Records** to reconcile the outside home medications.
- Click the blue **Meds History** 

hyperlink to add compliance to the remainder of home medications in the chart.
- Click **Document History** once completed.

STEP 6: Navigate to **Histories** component.



- Click the **Histories** heading in the Workflow MPage.
- All histories will be updated from the histories component with the exception of Social History. Social History is completed in the Intake form, as quality metrics are captured through the completion of the fields at the bottom of that section in the form.
    - If outside records exist, a purple diamond will appear next to the label **Outside Records** on the Procedure tab. Click **View Records** to reconcile the outside procedures.

NOTE: **For more information on reconciling outside records, click here.**

STEP 7: Navigate to **Clinical Entry Workspace (CEW)** to add appropriate Intake form. For more information on using Clinical Entry Workspace (CEW), click here.

- Navigate to the **Vital Signs** component on the MPage, if adding additional vital signs, measurements and pain scale assessments after the initial intake is done for that visit. For more information on using Vital Signs component, click here.

STEP 8: Complete the applicable fields within the Intake form for the visit type.

NOTE: **Ambulatory clinical documentation of assessments and review of systems is located in the Ambulatory Assessment iView band.**

STEP 9: Navigate to **Interactive View and I&O (iView)** on the Menu, if applicable.

- Click into the different sections to document the items applicable to the patient.
- Click the **green checkmark** to sign.