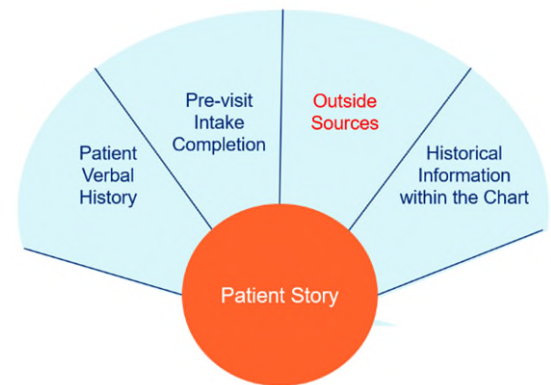**The ambulatory clinical intake serves as a foundation for the patient's care encounter. The primary goal is to gather essential patient data, which will assist healthcare providers in delivering safe medical care. The following workflow uses best practice recommendations specific for Primary and Pediatric 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 your Workflow MPage.

- ▪ MPage components in the menu can be arranged to fit the way you navigate and document 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

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.
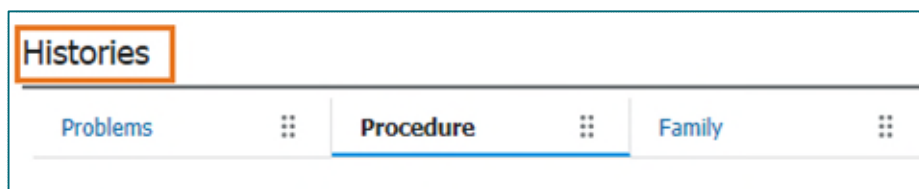
- Review and update allergies.

  - 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** [🛈 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 the **Vital Signs** component on the MPage, click the dropdown arrow and select the **appropriate Intake form**.

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 the **Vital Signs** component on the MPage, click the dropdown arrow and select the **Ambulatory Assessment**

Ambulatory Assessment   to launch iView.

- Click into the different sections to document the items applicable to your patient.

- Click the green checkmark to sign.
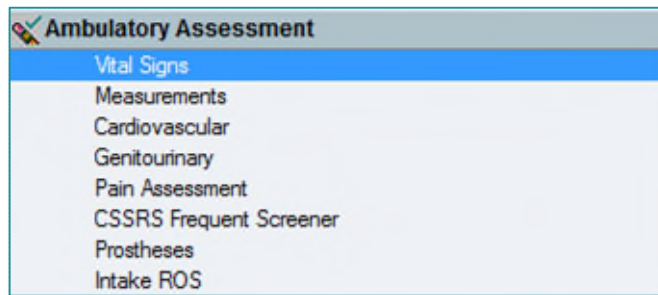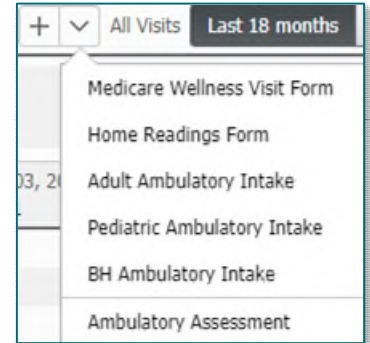
For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at:
207-973-7728 or 1-888-827-7728.