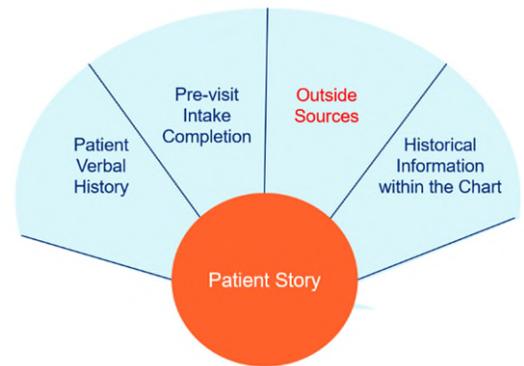


The ambulatory nursing intake serves as a foundation for the patient's care encounter. The primary goal is to gather essential patient data, which will assist healthcare providers in delivering safe medical care. The following workflow uses best practice recommendations specific for Primary and Pediatric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

Ambulatory Nursing 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.

Recommended Workflow:

1. Chief Complaint

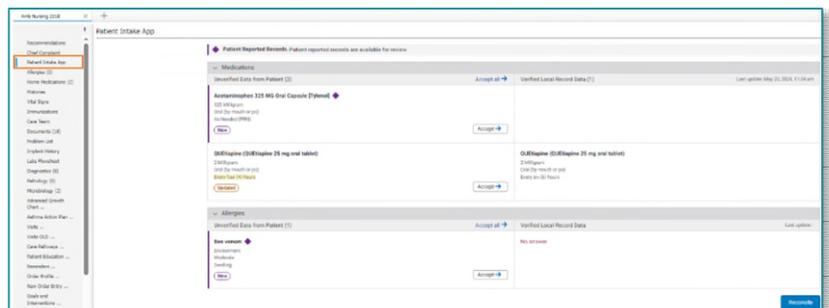
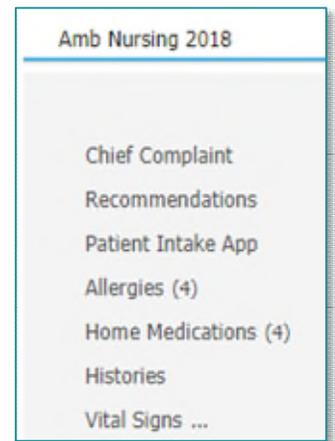
Ambulatory nursing enters the **Chief Complaint**, which displays the patient's chief complaint for the current encounter.

2. Recommendations

Navigate to the **Recommendations** component to update recommendations, as appropriate. For more information on using Recommendations, click [here](#).

3. Patient Intake App (Primary Care & Pediatrics)

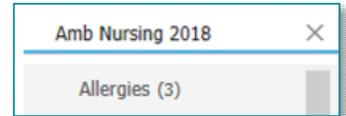
Navigate to the **Patient Intake App (Tonic)**, located within the MPage. The **Patient Intake App** is used to review answers submitted by the patient to start the reconciliation process. Open the **Patient Intake App** to reconcile patient submitted medications and allergies. For more information, click [here](#).



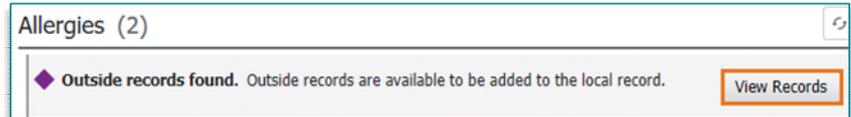
NOTE: The Patient Intake App is a component located within the Workflow MPage.

4. Allergies

If outside records exist, a  **purple diamond** appears next to the label **Outside Records**.



STEP 1: Click **View Records** to reconcile allergies.



STEP 2: Click the **Add** button or click the dropdown to view the following options:

- Add
- Add with Changes

STEP 3: Select **Add with Changes** to **modify** fields such as Category, Severity, Type, Status, and Source.

NOTE: **Required fields may be indicated when adding allergies with changes.**

STEP 4: Click **Save**.

- Added Allergies are saved to the Local Record.

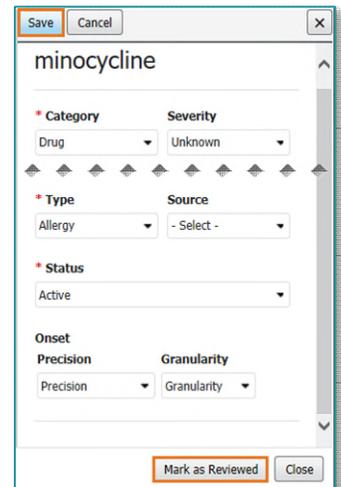
STEP 5: To **dismiss** an allergy, click the **Reject** button.

- To undo, click the **Undo** button under the **Actions** column.

STEP 6: Click **Mark as Reviewed** when completed.

NOTE: **Mark as Reviewed is now the Reconcile Action.**

NOTE: **For more information on adding Allergies, click [here](#).**



5. Home Medications

If outside records exist, a  **purple diamond** appears next to the label **Outside Records**.



STEP 1: Click **View Records** to reconcile outside home medications.

STEP 2: Click the **Add** button under the Actions column.

- The medication populates to the **right** in purple.

STEP 3: **Scroll down** to see the medication details.

STEP 4: The following medication details can be updated:

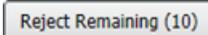
- Dose
- Route
- Frequency
- Duration

NOTE: Medications older than six months or medications with an inactive status do not appear for reconciliation review. Click "All" in the Date Range dropdown or the Inactive dropdown under Status.

STEP 5: Update **Compliance** then click **Save**.

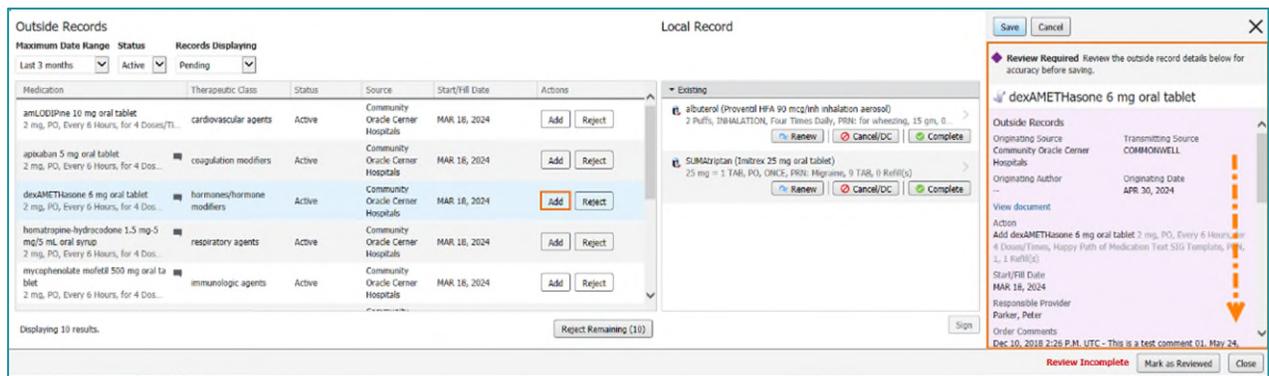
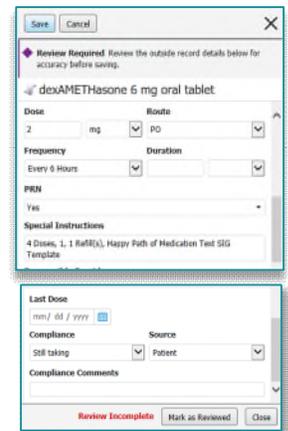
- The medication is added to the **Local Record**.

STEP 6: Click **Reject Remaining** for medications that are no longer active.



STEP 7: Click **Mark as Reviewed** when completed.

NOTE: **Mark as Reviewed** is now the **Reconcile Action**.



STEP 8: Update **Compliance** then click **Save**.

- The medication is added to the **Local Record**.

STEP 9: To dismiss a medication, click the **Reject** button under the Actions column.

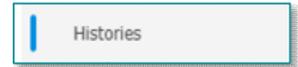


NOTE: If a medication was rejected in error, click *undo* next to **Reject**.

6. Histories (Procedures)

If outside procedure history records exist, a  **purple diamond** appears on the **Procedure** tab as well as the label, **Outside Records**. Only procedure history will appear for outside records.

STEP 1: To reconcile procedures, navigate to the **Histories** component within the Amb Nursing 2018 Workflow MPage.

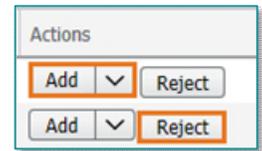


STEP 2: Click the **View Records** button from the top right of the screen.



- Local Records open to the right.
- Outside records open to the left of the screen.

STEP 3: Review the patient's procedure history and click the **Add** button or click the dropdown to view the following options:



- Add
- Add with Changes

STEP 4: Select **Add with Changes** to modify fields such as Procedure Date/Time, Laterality, Ranking, and Comments.

STEP 5: Click **Save**.

- The procedure is added to the local record.

STEP 6: To dismiss a procedure, click the **Reject** button.

STEP 7: Click **Reject Remaining** for procedures that may be duplicate or already exist within the local record. 

NOTE: A deduplication and filtering process exists.

STEP 7: Once reconciliation is complete, click **Mark as Reviewed**.

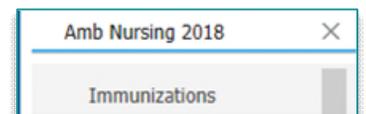
NOTE: Mark as Reviewed is now the Reconcile Action.

NOTE: Family history will continue to be updated from the History component. Social history is completed within the Intake form, as quality metrics are captured through the completion of the fields contained within that form.

NOTE: The Problems tab position can be moved by clicking and dragging with the mouse. Click the Exit button to Save.

7. Immunizations

Within the Immunization component, use the Import button to pull the patient's recorded vaccines and forecasted immunizations from the Maine Immunization Information System (ImmPact) registry into the patient's record. For more information, click [here](#).



8. Vital Signs

Navigate to the **Vital Signs** component of the AMB Nursing 2018 MPage, click the dropdown and select the appropriate intake form.

NOTE: The section must be clicked for review for data to flow from the virtual patient intake (Tonic). For more information, click [here](#).

