Recording clinical information

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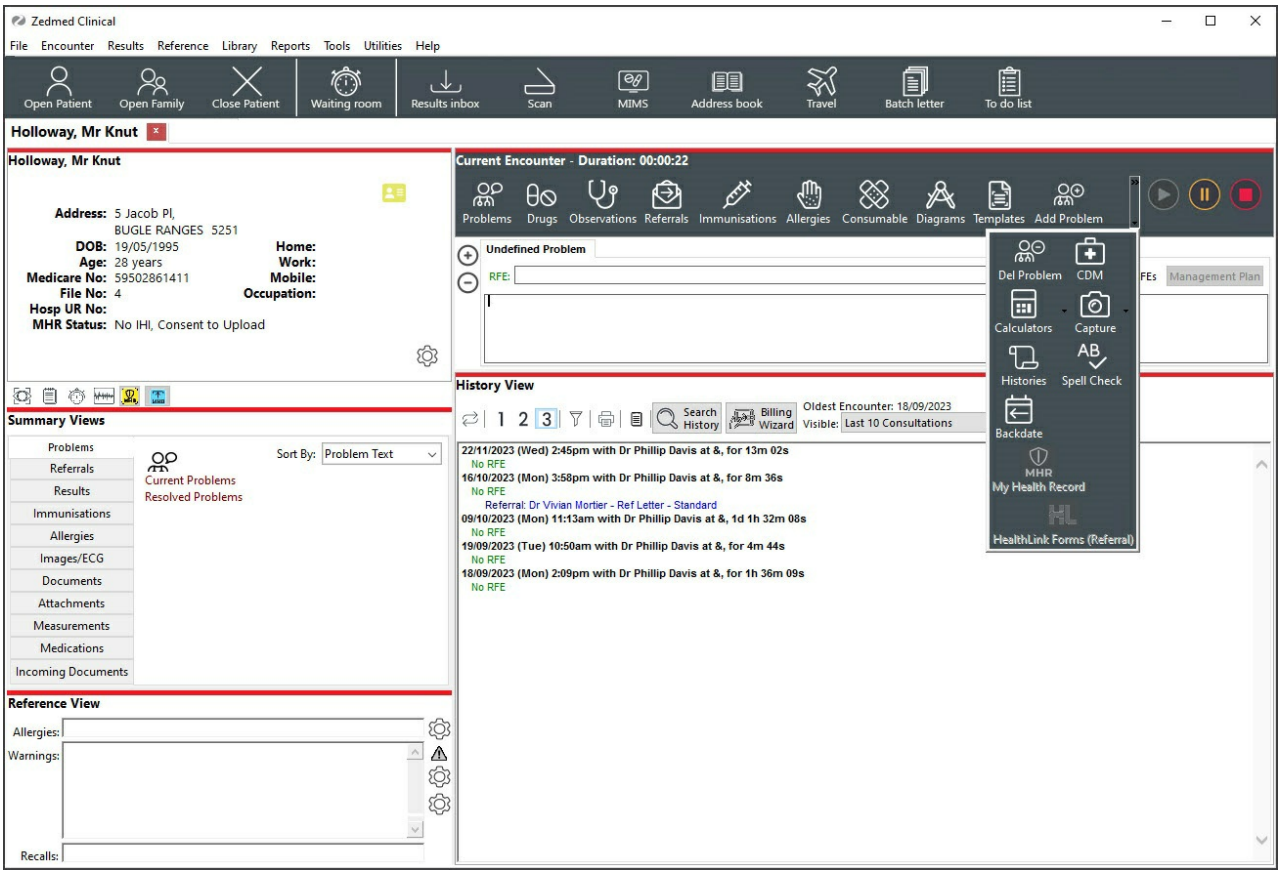
Use the Current Encounter screen to record information and access the clinical modules. This information includes the REF, your own clinical notes and entries made by the clinical modules used during an encounter. After updating the patient's record, you can add billing information and end the encounter.

Current Encounter screen

When an encounter starts, the **Current Encounter** section opens in the Clinical Records screen. The Current Encounter section is where you access clinical modules like Problems, Drugs, Observations, Referrals and Immunisations, etc, and enter the RFE (reason for encounter) and clinical notes. When you end the encounter, the information will appear in the **History View** section, and information from the clinical modules is saved to their respective tabs in the **Summary Views** section.



To learn more about the other sections, see the Navigating Clinical Records article.

RFEs & Coded RFEs

Ideally an RFE is recorded for every clinical encounter and is entered into the field provided. You can type in the RFE or tick the **Use Coded RFEs** box if your practice uses a standard set of reasons.

Coded RFEs are a good way of having a consistent set of RFEs that are used by all providers at the practice. If you use coded RFES, start typing the code and press enter when the RFE auto-fills. Coded RFEs can also be configured to add text to the clinical notes field, for example, a checklist for the condition. To enable Coded RFEs, select **Tools** menu > **Global Options** and tick **Use Coded RFEs**.

To add custom RFEs: From Clinical, select the **Tools** menu > **Clinical Setup** > **RFE codes**. Select **Add New** button. Enter the **Code** (to type in) and **Description** (which will appear in RFE field) and the **Default Notes**. The Default Notes will be automatically added to the clinical notes when if you select that RFE.

Clinical notes & Auto Text.

Type your clinical notes into the text section below the RFE. To save time, you can use the Auto Text feature, and just type in a shorthand term to add a clinical entry or checklist. For example, you could type "sore throat" to add a list of checks to complete. As noted above, you could also use the RFE "sore throat" to add a list of checks to complete.

To view the list of Auto Text shorthands available, and to add new ones, open Clinical and select the **Tools** menu > **Clinical WP Setup** > **Auto Text** and use **Add New** to add the **Shorthand** and **Longhand** text.

Updating clinical notes

You can change a clinical encounter's notes up to the end of the day it was created. To do this, start an encounter for the patient and select Continue Encounter from the dialog. You can now update your RFE, clinical notes and information entered.

The day after the clinical encounter, you can append an encounter's notes in the History View by right-clicking the encounter's date and selecting **Add Further Notes**. This opens a field that will add **New Addendum** notes into that encounter.

Problem definition

The tab you enter your REF and clinical notes into will be called **Undefined Problem**, and this can be updated with a problem definition if you use the optional **Problems** module to select a condition/diagnosis. If you do use the Problems Module, you can select an Existing or Recent problem, a Problem from the ICPC, or Manually add a problem. You can have multiple Problem tabs, each with its own RFE and clinical notes if there are multiple problems presented. The problem classification will also be added to the Problems tab in Summary Views.

Encounter workflow

A common workflow for recording information is:

1. Start the encounter with the patient.

   For a detailed explanation of how to do this, see the Start an encounter article.
2. Enter a reason for the encounter into the REF field - what the patient presented with.
3. Select the **Problems** module then locate and select the problem.

   The problem will be added to the tab, for example, "Ache; stomach" in the screenshot below.
4. Use the **Observations** module, and any other modules, as required.

   Where applicable, these modules will record information as shown in the screenshot below (RX and Referral).

5. Type your consultation notes and findings into the "free text field".

   All of this information will be saved to **History View** and **Summary Views.**

   Remember that information will be uploaded to My Health Record if the patient has registered, and these uploads can be turned off as explained in the **Patient Consent** section of the My Health Record Article.