## Factor 4: Documenting clinical advice in the medical record

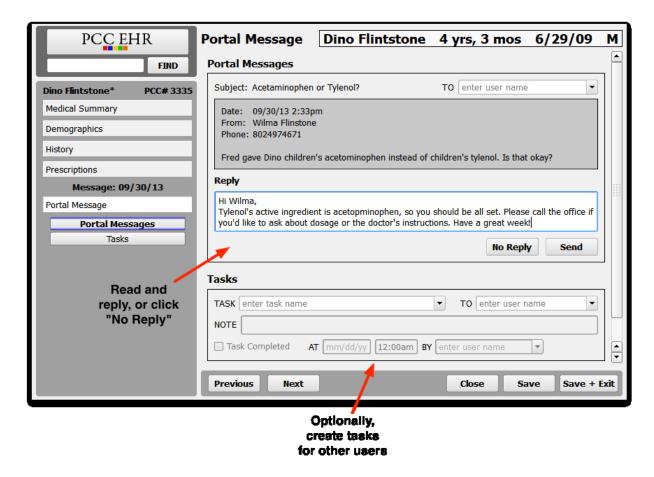
The practice would document their process for documenting clinical advice in the medical record.

Here is an example of where phone advice would be documented in PCC EHR:

Phone Notes	Mic	key Mouse	10 yr	s, 4 mos	4/24/03	M
Recent and Upcoming Appointments  Last Visit: none  Last Physical: none  Next Physical Due: none  Scheduled Appointments: none						
Contact						
Call Taken By Tim Proctor	•	Call	Taken At	09/19/13	10:25am	
Caller's Name unknown	_	Re	ationship	select relati	onship to	
Return Phone	+	Needs To Be	Signed By	select a pro	vider	<b>-</b>
Subject Phone Note						***

The detailed advice would be documented in the "Phone Note" text field and a summary or subject of the note would go in the "Subject" field.

Here is an screenshot showing how clinical advice by secure electronic message would be documented in PCC EHR:



The date and time of the response would be documented once the reply was sent or saved.

A history of phone encounters, messages, and visits are stored in a "Visit history index" within the patient chart. The screenshot below shows this visit history index filtered to show only phone encounters and electronic messages. Once the user selects an entry in the index, the detail for the entry is displayed above including the documented advice given for the phone encounter and/or messages.

