

## Logician Physician Guide

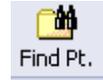


Logician Support: Email: [logiciansupport@peds.uab.edu](mailto:logiciansupport@peds.uab.edu); Phone: 996-7770

**Password:** expires every 90 days; case sensitive; must be 6-30 characters (special characters allowed but not required). To change password: Login to Logician; select the red exit button (this takes you to the login screen, the new password button will no longer be grayed out). Click on new password button; follow prompts.



New Password...



**Find patient:** On task bar, under “Actions” choose “find patient”  
Search by name or by “SMS MRN”  
Enter information and click “Search”  
Match on at least 2 identifiers (name / DOB / MRN)  
Click “okay”

### NOTES

#### Resident role / To start note:

##### 1. Choose “Update”

- Choose “New” (if there are existing/open documents on your patient)
- Choose note type – INPT for general wards teams notes
- Click on ellipsis beside “visit ID” – choose “inpatient admission”; click okay



##### 2. H&P (INPT-Inpatient Admission H&P)

- **Reminder – choose visit ID**
- Add room # and unit (when available)
- Complete cc and HPI
- The ROS should be *complete*. ROS can be typed in HPI or recorded on ROS tab. Once ROS is complete, click box “Pertinents for ROS per HPI or as below”.
- PMH / FHx / SocHx / DevHx tab
  - “Unobtainable” = there was no one to ask (explain why in comments box)
  - Include dosages on home meds
- VS / PE tab
  - This tab has shortcut to the housestaff website
- Diagnosis tab – add diagnoses by clicking on “Update problems”
  - Click “new”
  - For “custom list”, choose “IN-General Inpatient” or click on “Reference List” for master list
  - Type diagnosis in blank (under “custom list”) and pick from pull-down list
  - Choose onset date or choose “approximate”
  - Click on “Save and continue” or “OK”
- Labs tabs
  - Choose from standard flowsheets; click on “Create table” to include all data or click on date to include column (you can choose multiple flowsheets)
  - You can type results in blank
  - 2<sup>nd</sup> labs tab contains blanks for typing or pasting lab or imaging results
- Assessment / Plan (A/P) tab
  - Type assessment in large blank
  - Click on relevant system; type A/P in comments box under each system
  - Enter your name and attending’s name in blanks at bottom

- Click on “Close”, “End Update”, click on “sign clinical list changes” (clinical list changes includes allergies, medications, and diagnoses)
- Change provider name to attending and Route note to attending (check box beside attending name)
- You can remove providers from routing list by clicking on “remove”
- Click on “hold document”



### 3. Progress Note (INPT-Daily Progress Note)

- **Reminder – choose visit ID**
- Enter room number and unit
- HPI tab -- Type in subjective information
- VS tab
  - Enter VS and I’s and O’s
  - UOP will be calculated in cc/kg/hr
- Exam tab – complete PE
- Diagnosis tab – see instructions under H&P
- Labs tabs – see instructions under H&P
- Plan tab
  - To carry forward the previous Assessment, click on box “Set current assessment to previous assessment” – then **EDIT your comments**
  - Click on relevant system and type assessment/plan in comments box under each system
  - Enter your name and attending’s name in blanks at bottom
- Click on “Close”, “End Update”, click on “sign clinical list changes”
- Change provider name to attending and Route note to attending
- Click on “hold document”

**Attending tasks on logician notes:** Review resident’s note; make changes if necessary and give feedback to resident

- Click on Attending tab
- Choose ONE Primary diagnosis and any appropriate secondary diagnoses
- If all appropriate diagnoses are not listed, add diagnoses by clicking on “update problems” (see “diagnosis tab” under resident section)
- Click on box beside “I have seen . . .”
- Type information in comments boxes.
- Review information on what has been entered into note (“audit” section is in red). Provide feedback to resident when information entered is incomplete.
- Click on appropriate billing level
- Click on “Send flag to billing department”
- “Close”
- (Note that there is a link to the Medicaid Continuity of Care document.)
- “End update” and sign (make sure that you are the provider on the note).

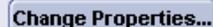
## **DISCHARGE NOTIFICATION LETTER**

Resident or Medical Student role (Start Discharge Notification Letter on admission; enter data throughout hospitalization 0:

- “Update”; Choose “INPT-Discharge Notification Letter”
- ◆ Select visit ID
- ◆ Fill in blanks as appropriate; delete blanks that are not used; need to include PCP name and city
- ◆ At bottom of note, fill in name of attending and resident; delete names and contact information for non-team members
- ◆ Nurse case manager can fill in follow-up appointments
- ◆ Indicate whether or not PCP will be ALSO receiving a dictated discharge summary (or whether this will be the only discharge document)
- ◆ “End Update” and “hold” until day of discharge

**On day of discharge:**

- Open and complete document.
- You can write prescriptions within the discharge notification letter – generates more legible copy and leaves record in logician medication list (but cannot be done until day of discharge). See below.
- With note open, click on “Change properties” button to change date (change time if necessary – date/time cannot be set into the future)



- ◆ End Update; change provider to your attending and route
- ◆ Your attending will sign and route this document for faxing to the PCP. Note that some patients will be sufficiently complicated that PCP will also need a phone call to discuss patient’s clinical course!
- ◆ Note that discharge notification letter can serve as brief discharge note for patients with stay  $\leq 2$  days

Attending role in the Discharge Notification Letter:

- Open note and review information; make corrections as needed
- “End Update” and sign note
- Once signed, route to WARDS SUPPORT (click on “New” and choose “Wards Support”) – this will result in letter being faxed to PCP

**Adding Medications / Printing Prescriptions:**

**While in an update click the Meds button:**

**To ADD a new Medication:**



1. Click **New**.
2. Choose a Custom Medicine dropdown list or search using Reference List (any change to a medicine description will make it an uncoded med and disables Drug/Allergy checking).
3. Complete the instructions, duration, quantity to dispense, and refills.
4. Authorized By should be a physician.
5. To enter multiple meds, click ‘Save & Continue’. When done click **OK**.
6. To print and sign scripts now, click **Print Rx** (Otherwise, scripts will print when the clinical list changes are signed).

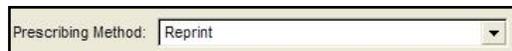
**To CHANGE a Medication:** Highlight existing medication and click Change; enter changes and click OK.

**To INACTIVATE a Medication:** Highlight existing Med and click **Remove**. Select Reason for Removal from list. Verify/enter End Date. Click ‘OK’.

**To REFILL an existing medication:** Within the update, click on Refill.



**To REPRINT a prescription:** (Can be done either in the existing update, full append to a signed note or with the Refill button.)

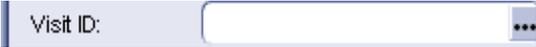


Prescribing Method: Reprint

1. Highlight active medication and click **Change**
2. If needed, make changes to instructions
3. Re-enter Quantity and Refill information
4. In the dropdown box for Prescribing Method select **Reprint** (see below)
5. Repeat steps 1-4 for all prescriptions needing reprint and then click OK
6. Click **Print Rx**

**Helpful tips for using logician:**

**Adding visit ID later:**

- With note open, click on  “change properties”; add visit ID
- OR right click on the note (in list), select “change properties.” Then click on (...) beside “visit id” and choose the inpatient admission.

**Note that visit ID is required in order to have document cross into Eclipsis!**

**To copy lab or imaging results into note:**

- Highlight document containing desired information
- Click on document viewer (at top of viewer window, to the right); you can minimize the window and then copy selected pieces without needing to open and close windows in the note



**Sending flags:**

- Open patient’s chart
- Click on “New” icon
- Enter person to whom you want to send the flag; enter information and “Send”

**Routing documents:**

- Highlight document in list
- Click on “Route” and enter name of desired recipient



**Setting macros**

- Choose “Options” on taskbar
- Select “Quick Text”
- Choose “personal use”
- Enter abbreviation and text for macro
- Click “add”, then “close”

**Deleting flags:**

- Click on “Alert/Flags” tab
- Choose “Options” on taskbar, then “Organize”
- Click **off** “view removed alerts/flags”; Click **on** “save as my preference”, then “OK”

**Appending notes (adding info to a completed document):**

- Highlight document in list; click on “Append”

