Chart View –

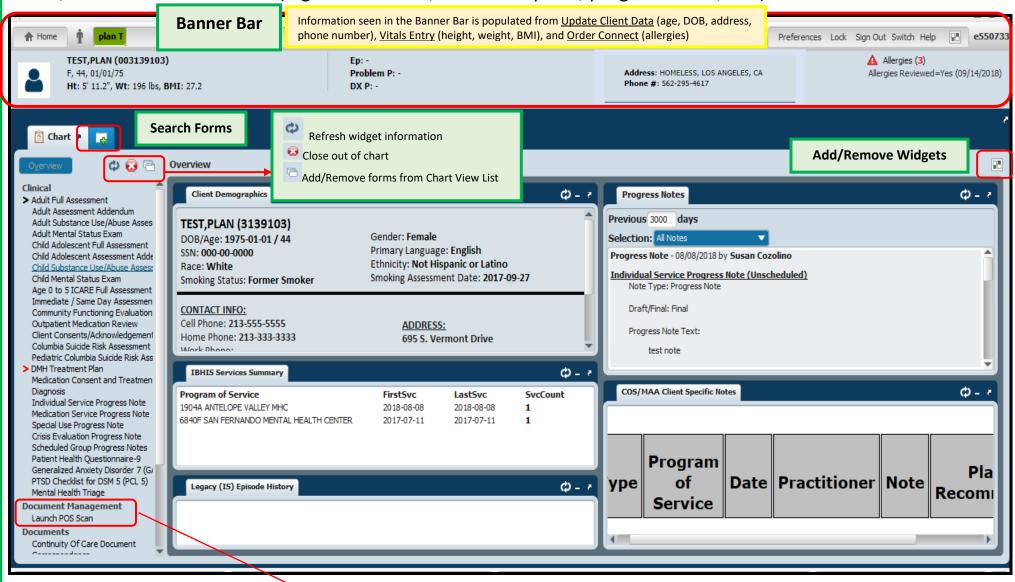View/read clinical documents (e.g. assessments, treatment plans, progress notes, etc.)

Recommended Chart View List of Documents:

- Full Assessment (Adult, Child, Immediate/Same Day, ICARE 0-5)
- Assessment Addendum (Adult and Child)
- Mental Status Exam (Adult and Child)
- Community Functioning Evaluation
- DMH Client Treatment Plan
- Medication Consent/MSS Treatment Plan
- Diagnosis
- Individual Service Progress Note
- Scheduled Group Service Progress Note
- Crisis Evaluation Progress Note
- Special Use Progress Note
- Medication Service Progress Note
- Patient Health Questionnaire – 9 (PHQ-9)
- Generalized Anxiety Disorder 7 (GAD 7)
- PTSD Checklist (PCL 5)
- Mental Health Triage

Banner Bar

Information seen in the Banner Bar is populated from Update Client Data (age, DOB, address, phone number), Vitals Entry (height, weight, BMI), and Order Connect (allergies)

Home | plan T

Preferences   Lock   Sign Out   Switch   Help   e550733

TEST,PLAN (003139103)
F, 44, 01/01/75
Ht: 5' 11.2", Wt: 196 lbs, BMI: 27.2

Ep: -
Problem P: -
DX P: -

Address: HOMELESS, LOS ANGELES, CA
Phone #: 562-295-4617

⚠ Allergies (3)
Allergies Reviewed=Yes (09/14/2018)

Chart

Search Forms

Add/Remove Widgets

↻ Refresh widget information
✖ Close out of chart
▢ Add/Remove forms from Chart View List

Overview

Overview

Clinical
> Adult Full Assessment
  Adult Assessment Addendum
  Adult Substance Use/Abuse Asses
  Adult Mental Status Exam
  Child Adolescent Full Assessment
  Child Adolescent Assessment Adde
  Child Substance Use/Abuse Asses
  Child Mental Status Exam
  Age 0 to 5 ICARE Full Assessment
  Immediate / Same Day Assessmen
  Community Functioning Evaluation
  Outpatient Medication Review
  Client Consents/Acknowledgemen
  Columbia Suicide Risk Assessment
  Pediatric Columbia Suicide Risk Ass
> DMH Treatment Plan
  Medication Consent and Treatmen
  Diagnosis
  Individual Service Progress Note
  Medication Service Progress Note
  Special Use Progress Note
  Crisis Evaluation Progress Note
  Scheduled Group Progress Notes
  Patient Health Questionnaire-9
  Generalized Anxiety Disorder 7 (G
  PTSD Checklist for DSM 5 (PCL 5)
  Mental Health Triage

Document Management
  Launch POS Scan

Documents
  Continuity Of Care Document

Client Demographics

TEST,PLAN (3139103)
DOB/Age: 1975-01-01 / 44
SSN: 000-00-0000
Race: White
Smoking Status: Former Smoker

Gender: Female
Primary Language: English
Ethnicity: Not Hispanic or Latino
Smoking Assessment Date: 2017-09-27

CONTACT INFO:
Cell Phone: 213-555-5555
Home Phone: 213-333-3333
Work Phone:

ADDRESS:
695 S. Vermont Drive

IBHIS Services Summary

Program of Service	FirstSvc	LastSvc	SvcCount
1904A ANTELOPE VALLEY MHC	2018-08-08	2018-08-08	1
6840F SAN FERNANDO MENTAL HEALTH CENTER	2017-07-11	2017-07-11	1

Legacy (IS) Episode History

Progress Notes

Previous 3000 days
Selection: All Notes

Progress Note - 08/08/2018 by Susan Cozolino

Individual Service Progress Note (Unscheduled)
  Note Type: Progress Note

  Draft/Final: Final

  Progress Note Text:

    test note

COS/MAA Client Specific Notes

ype	Program of Service	Date	Practitioner	Note	Pla Recomm

Scan any paper documents via **Launch POS Scan**

Chart View –

View/read clinical documents (e.g. assessments, treatment plans, progress notes, etc.)

Overview – takes you back to the Chart View Widgets

- **Current** shows you the most recent document
- **History** shows you all past documents

Practitioner who submitted/electronically signed the document, and **date** the document was submitted/electronically signed

- **Edit** – allows you to edit the form if it is in draft
- **Print** – allows you to print the Chart View version of the document
- **Report** – allows you to print the Report version of the document (*recommended when providing documents to clients or for audits*)

Certain forms (e.g. diagnosis, progress notes, etc.) may be **episodic.** Make sure to select the **LE00019 Episode** to view documents submitted and completed by DMH

When viewing **progress notes**, filters can be used to find specific notes (e.g. notes written by a specific program, from a specific practitioner, within a date range, etc.)

Any paper documents scanned into IBHIS can be viewed. Clinical paper documents such as any assessments or other clinical tools should be available under **DMH Clinical**. Signed paper consents and acknowledgement should be available under **HIPAA Forms/Consents/Acknowledgments**.