AstralJet 4.1
USER MANUAL

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1.0 Introduction / Launch

1.1 Launch AstralJet

To access the AstralJet program, the user must first download the application using our one-click solution which can be found at this link: https://app1.cloudmed.net/AstralJet.emr.Client/.
Be sure your computer is current with all Microsoft updates.
Once that is done, the program will be on the computer and available for use.

A login screen will be displayed. Enter your login credentials - **Username**, **Password** and **Office Code**.

1.2 Command Dashboard

The command dashboard is used as a centralized area in the program. This is where every user starts. The command dashboard can be customized to fit each user's needs simply by adding shortcut icons onto the shortcut taskbar.

1.3 Shortcut Toolbar

1. Click on the drop down box next to the task bar and select **More Commands**

2. Choose from the left side of the screen all the shortcut commands that apply to your user roll.

3. Click **Add** to move command to the screen on the right.

4. Continue this process until you are satisfied then click **Save**.

Your options will display on the taskbar and command dashboard. You can make changes at any time just by repeating the process.

1.4 Letter Assistant

The Letter Assistant Feature allows you to write letters. You can construct your letter by using free text, inserting a template or creating a new template that can be saved and stored for future letters.

1. Click on **Letter Assistant** from Home Tab. Dialog box will appear.

2. Create your letter

3. Use Dialog Box to create new letter, or select template from pre created list, or create new template

2.0 Administration Tab

Before anyone can use the program in your office your administrator must set up your office parameters. Select Administration Tab.

2.1 Users

2.1.1 - Creating Groups
A title that you assign roles to

1. Select **Groups** from the Users Ribbon

2. Right click and select **Add New**

3. Create a group name and description

2.1.2 - Add Users
The Add User icon allows the Administrator to create user accounts.

1. Click the **User icon** from the ribbon.

2. Click the **Add** icon.

3. Enter information in all required fields.

4. In the last area on the screen enter a username and password for the user you are creating.

5. Select the group for the user.

6. Click the **Save** icon.

NOTE: Passwords must be at least 8 characters long and be a combination of numbers and letters (both upper and lower case)

2.2 Manage My Info

2.2.1 - Manage my info - *change or correct user information*

2.2.2 - Change password – *change a user's password*

1. Click the **Change My Password** item

2. Enter your current password in the Old Password field.

3. Enter your new password in the New Password field.

4. Enter you new password in the Confirm Password field.

5. Click the **Save** button.

NOTE: The Password must be at least 8 characters in length using upper and lower case numbers and letters. When a user initially logs in they will be prompted to change their password. Afterwards, if a user wants to change their password, this is the area in which to change password.

2.2.3 - E-Scripts – The E-Prescription Account is for the individual provider. The E-Prescription Account icon allows you to add E-prescribing credentials to your users within the AstralJet software. The Username, Password and External ID are initially created by the Team at Evolve Exchange. Once created, the user will have access to Dr. First.

To change the E-Prescription password for a user:

1. Click the **Administration** tab from the ribbon.

2. Click the **E-Prescriptions Account** icon. A pop-up window will be displayed

3. Select and delete the current password and enter a new password for this user.

4. Click the **OK** button. A confirmation window will be displayed.

5. Click **OK**.

2.2.4 - Claim Processing – Add provided claim processing information. This is for your Claims Clearinghouse to send claims and check eligibility.

2.2.5 - User Notifications – Occasionally you will see a pop up to notify the user of any unread messages that have been there for 24 hours or more.

2.2.6 - SOAP Template – Set-up user's preference for the opening of their SOAP note. There are several ways a provider can setup their SOAP notes: Dragon Dictation, MY Favorites, Podiatry, and Family Medicine Wizards

2.2.7 - Message Template – This is for constructing letters. Also see Letter Assistant to create templates and draft letters.

2.2.8 - Register fingerprint – This is the area where you would setup a fingerprint reader device.

2.2.9 - Speech recognition – *set dictation and command recognition*

- Once the speech recognition software has been installed the user would come to this screen to set up their profile.

- The voice command set-up is the initial screen that appears. This screen allows you to select voice commands you would most frequently use by clicking on the check boxes of the ones needed.

- The current speaker profile allows you to download the profile from the current voice recognition software so you don't have to train it all over again. Simply click on it. All the required fields will be populated, click load user and save

- Manage speaker profile allows you to select different speakers or saved profile for this user by browsing and locating the appropriate files.

- Roaming user settings would be utilized when a user is not using their frequented machine at that particular moment. The user would enable this feature, search the database for their profile, load from the database and apply.

- The next section of the ribbon is just like the training process of the speech recognition software. If the user feels like they need to add some new words or have the system recognize their voice better they would do that here.

2.3 Hardware Configuration (Used to register devices)
- Used to add scanners, printers, PACS
- Select ADD from taskbar
- Complete dialogue box

Note: you must know the IP address of the workstation

2.4 Application Configurations
This is the area where you keep track of Lab Equipment and set aside time for an appointment to use that equipment. (For example: X-ray machine. This appointment will also show on the Scheduler.
- Used for Lab configuration
- Use information provided under separate cover

2.5 Insurance Configuration

2.5.1 - Insurance Payers
This list is pre populated by the Clearinghouse. You are able to add a payer by clicking on Add and filling in the required fields.

1. Make sure that under claims related information, you click **"Professional transaction supported"** if any claims under this plan are to be electronically sent.

2. If the insurance plan is set to receive only manual claims then click on **"Manual claims only".**

3. If the insurance plan is a capitated plan click on **"Capitation".**

4. **Save**

2.5.2 - Insurance Plans
Section where the most used insurance companies may be added and fee schedules set.

1. Click **ADD**

2. Locate and select all the insurance companies you would like to appear on your list and **Save**.

3. Double click on one of the insurance companies (Note: you must show how to do the condensed CPT – list before this step in order to have a list on the left to choose from)

4. Select all the CPT codes you would use for this particular insurance company

5. Add the allowed amount for each code for this insurance payer

6. At the bottom of the right side list in bold lettering it says **"Also apply to Insurance Plans"** click on this if you would like other insurance companies to have the same allowed amounts.

7. Click **Apply**

8. The CPT codes and amounts have been added for the payers you selected

9. Continue until finished

2.6 Office Configuration
Set up of names, codes and templates

2.6.1 - Lab Equipment
This is the area where you keep track of Lab Equipment and set aside time for an appointment to use that equipment. (For example: X-ray machine). This appointment will also show on the Scheduler.
- Used for Lab configuration
- Use information provided under separate cover

The Add Lab/Equipment icon allows the administrator to create the Lab and Equipment Schedule for the office. Any item added as Lab or Equipment will also be considered a Resource for the practice and an Appointment can be scheduled for these items.

1. Click the **Lab/Equipment** icon.

2. Click the **ADD** icon. The Add Lab/Equipment pop-up will be displayed.

3. Enter all the relevant information for the item being added.

4. Select the **Category** and **Specialty**.

5. Click the **SAVE** button.

2.6.2 - Lab Tests- In House
Each practice is able to create a list of procedures that are performed in- house during an encounter with the provider. If you order a Lab, you will be able to associate that Lab with a CPT code for your charge procedures. When you order a Lab, it automatically goes to your charge procedures to charge for the visit.

1. Open the Administration toolbar by clicking the Administration tab.

2. Click the **In-House Test** icon. A small window will be displayed.

3. Enter the name of the test that is performed at your practice.

4. Click the OK button.

2.6.3 - Clinical Decision Support System - CDSS Configuration
Set up how, when and the duration of the CDSS messages using cursor, slide status bar to customize your CDSS messages, click SAVE

2.6.4 - Global Work Schedule (setup for the entire office)
The Global Work Schedule allow the practice to block selected days and times when no appointments will be made such as public holidays or days when the office is closed.

By default all weekdays (Monday - Friday) are marked as Working Days and all weekend days (Saturday and Sunday) are marked as Non-Working Days.

2.6.5 - Referral Facility
The Referral Facility icon allows the administrator to create a list of medical facilities that a patient can be sent to, or the facility that a patient is being referred from, as per the providers instructions.

1. Click the **Referral Facility** icon from ribbon.

2. Click the **ADD** icon. A pop-up window will be displayed.

3. Enter the name of the Referral Facility, Address, Phone number and Email.

4. Click **OK**.

5. Repeat for each facility to be added.

6. Click the **SAVE** button from the tool bar.

2.7 CPT/HCPCS/ICD-9 Condensed Codes
The CPT/HCPCS/ICD-9 Condensed Code list allows a practice to create a Charge Schedule / Favorites List for services it performs.

1. Select the **CPT/HCPCS/ICD-9 Condensed Codes** icon from the Administration ribbon.

2. Select either the **CPT, HCPCS or ICD-9** radio button to show the appropriate code list.

3. Use the search area to perform a search either by code or description (you may also scroll the list displayed).

4. Enter the first few characters of the code or description you are trying to find.

5. Select the code then click the "**>**" button in the middle of the screen to add the code to the condensed list (on the right box).

6. Enter the Cost associated with the code.

7. Repeat for each code that is to be added.

8. Click the **SAVE** icon.

2.7.1 - Removing a code from the Condensed list
1. Select the desired code.

2. Click the "**<**" button in the middle of the screen.

3. Repeat for all codes to be removed.

4. Click the **SAVE** icon.

2.7.2 - Removing all codes from the Condensed list

1. Click the "<<" button in the middle of the screen.

2. All codes will be removed from the condensed code list.

3. Click the **SAV**E icon.

2.7.3 - Service Type
The Service Types icon allows the administrator to select the type of service or facility when performing an eligibility check.

1. Select the **Service Types** icon from the ribbon

2. Scroll through the list of codes and descriptions on the left side of the screen.

3. Select the type desired from the list

4. Click the ">" button to add this service type to your practice list.

5. Click the **SAVE** button.

Note: The most common service type used by an ambulatory practice is 30 - Health Benefit Plan Coverage

2.7.4 - Type of Visit
A practice is able to create a list of services offered so that each appointment can be labeled appropriately in the calendar. This will show up in the scheduler to determine which type of visit the patient is coming in for (office visit, labs, etc).

1. Click the Types of Visit icon in the Administration ribbon.

2. Click the **ADD** icon.

3. Enter the name of a type of service or appointment you wish to create for your practice. eg Physical, Office Visit, Follow-up, etc.

4. Click **Enter**.

5. Repeat for as many types as needed.

6. Click the **SAVE** icon.

2.7.5 - Specialty (for the user)
Type of specialty of the doctor or provider
1. Click **ADD** icon

2. Type in the specialty name and select taxonomy code

3. Click the **SAVE** icon.

2.8 SOAP Template Manager

Set up favorite or frequently used templates of SOAP notes such as for a cold or URI.

- Category is the group type you would like your self- created templates stored under. For example, a cold or sore throat might be stored under Upper Respiratory Category for easy retrieval.
- Each provider has the ability to create personalized templates used for their SOAP notes. Easy retrieve saves time for the provider eliminating the need to recreate a SOAP for each encounter.

Note: changes can be made to your template after you retrieve it if needed. You may also choose more than (1) Template to create your SOAP note.

2.9 CDSS

2.9.1 – Set-up of Clinical Decision Support Rules
When a provider goes into the record for a particular patient and this patient falls within all the parameters of this particular rule, then the provider will get a notification dependent on how they set up their notifications (flashing status bar, bubble or dialog box).

Create your Rule

1. Click **ADD**

- The condition is the field being searched
- The operation is the equation being used
- The value is what the condition field needs to be

2. Click **NEXT**
If there are any exceptions to the previous rule then add that to this section in the same manner

3. Click **NEXT**
The rule action is what you would like the system to do once it finds a patient with this rule

4. Click **ADD**
The action would be selected and the value would be added only for those that require a number

5. Click **NEXT**

The rule properties is named, assigned to who will see it, the type of rule it is and the severity as to how it should be displayed.

3.0 Appointment Scheduler

The Scheduler is located under the Home tab. You can also access it from the Command Dashboard if you choose to load it on your customized dashboard.

Appointments with providers or other practice resources are managed in the Appointment Scheduler. Appointments are color coded depending on their status. The Schedule can be viewed by **"DAY, WEEK, MONTH"** view buttons.

The user has the following capabilities on the Appointment Scheduler
- Make an Appointment
- View an Appointment
- Appointment Details
- Confirm an Appointment
- Cancel an Appointment
- Reschedule an Appointment

3.1 Make Appointment

1. Open the Appointment Scheduler by clicking the Calendar icon.

2.Navigate to the desired appointment date and time then double-click the time slot or highlight the time slot and click add. The Appointment window will be displayed.

3. Populate the appropriate fields for the appointment - such as, Type of visit, Description, Patient Name, Time and Duration, Primary Provider and Additional Resources.

4. Click OK. A confirmation window will be displayed.

5. Click OK.

Note - *New Patient Demographics can be added at this time. You are allowed to see up to six (6) provider schedules at one time.*

3.2 View Appointments for a Provider/Resource

1. Open the Appointment Scheduler by clicking the Calendar icon.

2. Select the date or date range (depending on your calendar view) for desired appointment.

3. Click the All radio button on the left of the screen.

4. Select the Provider or Resource to be viewed, by placing a check mark in the checkbox next to the name.

5. The schedule for the providers will be displayed.

3.3 Appointment Details

1. Click the Calendar Icon on the ribbon. The Appointment scheduler screen will be displayed, showing appointments for each resource in their corresponding time slots.

2. Hover the mouse over an appointment time block. Details of the appointment such as the patient name, time and description will be displayed in a pop-up window.

3. Right click on an appointment.

4. Select Appointment Details from the options.

3.4 Confirm Appointment

A few days before a patient is scheduled to be seen in the practice, the front desk staff may begin to contact these patients to remind and confirm the appointment. This confirmation along with accompanying notes can be recorded in AstralJet.

1. Open the Appointment Scheduler by clicking the Calendar icon.

2. Locate the appointment to be confirmed.

3. Right click on the appointment.

4. Select **Confirm** from the menu. The Confirm Appointment pop-up will be displayed showing the patient's name and phone number.

5. Enter any Comments, if necessary.

6. Click OK.

7. The appointment time block will be changed to green

3.5 Cancel Appointment

If a patient contacts the practice and states they will not be at their scheduled appointment, the staff has the ability to cancel the appointment, thereby making that time slot available for another patient if needed.

1. Open the Appointment Scheduler by clicking the Calendar icon.

2. Locate the appointment to be cancelled

3. Right click on the appointment.

4. Select **Cancel** from the menu.

5. Select the **Reason** and enter any comments if necessary.

6. Click **OK**. The appointment will be change to red.

3.6 Reschedule Appointment

If a patient contacts the practice and states they need a different appointment time instead of their originally scheduled appointment, the staff has the ability to reschedule the appointment, into any other available time. This cancels the original appointment, making that time slot available for another patient if needed.

1. Open the Appointment Scheduler by clicking the Calendar icon.

2. Locate the appointment to be changed.

3. Double Click on the desired appointment.

4. Change the Date, or time field as appropriate.

5. Click the **OK**. A confirmation window will be displayed.

6. Click **OK**.

Note: The appointment time can be changed by clicking and dragging the time block to another time on the calendar.

3.7 Check-In Patient

Once a patient appointment has been made and confirmed, the patient may be checked-in upon arrival for service.

1. Click the **Calendar** icon.

2. Right click the appointment time block.

3. Select **Patient Check In** from the sub menu. The Check-In Appointment pop-up will be displayed.

4. Confirm the Patient Demographics, Insurance and Eligibility information if needed.

5. Click **OK**. If you would like to open a summary for the patient. Click Yes, in the information window, otherwise click No.

 The Appointment time block will change color to blue.

3.8 Check Eligibility

Once an Insurance company is added to the patient's file, the coverage can be verified by clicking the Check Eligibility button.

1. Click the **Medical Records** Tab.

2. Open a Patient record by double clicking on a patient **name** or selecting a patient from the list and clicking the **View Patient** icon from the ribbon.

3. Click the **Eligibility** icon from the ribbon.

4. Select the policy name to perform the eligibility check.

5. Select the **Service Type** from the list.

6. Select the **Provider Name** from the list

7. Click the **Check Eligibility** Icon. The Check Eligibility screen will be displayed.

The information returned will be the details of the patient's insurance policy

NOTE: Policies must be added for the patient BEFORE eligibility checks can be performed.

(See: Add Dependent Insurance Policy and Add Subscriber Insurance Policy)

3.9 Check-Out Patient from Scheduler

Once a patient appointment has been checked-in and the patient has been seen by the provider, the patient may be checked-out from Scheduler.

1. Open the **Appointment Scheduler** by clicking the **Calendar** icon from ribbon

2. Locate the desired patient appointment

3. Right click on the patient name

4. Select **Check Out** from the sub menu. The Check-Out appointment pop-up will be displayed.

5. Click **Ok** the appointment time block will be changed to orange

6. Select the patient again

7. Select from left side of screen the insurance to be used or cash.

8. Charges will display the dollar amount entered under the selected insurance fee or cash schedule (previously entered in Admin Set up)

9. If Charge slip needs to be edited (units, CPT codes, ICD-9 or HCPC'S) select **Edit Icon** from the ribbon

10. Dialog box will appear

11. Make changes under line item and click **Save** button

12. If charge slip is correctly completed select **Calculate** Icon from the ribbon to finalize

3.10 Referrals

Outbound
This is a referral by the office for the patient to go to another doctor/facility

1. Click on **Referrals**

2. Select **OUTBOUND** radio button

3. Summary – use this icon to attach this outbound to a particular **Date of Service**

4. Click on **Process** – A Dialog box appears

5. Complete all fields

6. Click **Ok** referral will be sent to the person it has been assigned to.

Referral can be printed so a copy can be given to the patient.

*Once the report is received double click on **OUTBOUND** referral*

1. Drop down box- enter date received and click OK

2. Highlight OUTBOUND referral

3. Click Complete

4. Scan and Attach report to patient record

- Title- Name the document
- Type-Category
- Summary-Chose date of service
- Tags-Nickname

Inbound
These are referrals received from doctors outside your practice

1. Click on **Referrals**

2. Select **INBOUND** radio button

3. Click on **Proces**s – A Dialog box appears

4. Complete all fields

5. Click **Ok**

4.0 Patient Information Tab

4.1 Demographics

4.1.1 Add New Patient
Click on the Medical Records Tab from the Ribbon

1. Click **Add New Patient** icon

2. Complete all demographic fields

3. Click **Save**

4.1.2 Social Security Number
If a patient does not have a social security number, check "No SSN", add an alternative identification number, and select they type of identification from the drop down.

4.1.3 Responsible Person
The Responsibly Person Field allows the user to enter the name of the person that will pay for the service being given at your practice. This is not to be confused with the insurance payments. Payment here, refers to a copay for an insured patient or the cost of the visit for an uninsured patient. This person can be the patient or another party such as a spouse or a parent.

1. Click the down arrow under Responsible person and select relationship.

2. If Responsible person is already entered for another patient use eyeglass search and select from list.

3. If responsible person is new to the practice click Green Add button and enter Information. Click Save

4.1.4 MRA (Medicare Risk Adjustment)
If your practice accepts patient's with an MRA insurance plan, you can easily indicate this by placing a checkmark in the MRA (Medicare Risk Adjustment) checkbox on the Demographics screen.

4.1.5 Advance Directive Documents
If your patient has completed an Advanced Directive you would enter a check mark in the box. You can also scan a copy of the forms in to the patients file if they want you to have a copy.

4.1.6 HIPPA Form
Once a patient has completed your office HIPPA Forms place a checkmark in the box.

4.2 Problem List

The Problem List is view only from the Information Tab. You must be in a Patient Summary and have User rights to enter Problems to the Patient Problem List.

4.3 Family History

The Family History screen, allows Users to document any significant illness that may be present among blood relatives in a family. You can enter the Family History from the Patient Information Tab or the Patient Summary.

1. Click the Family History icon.

2. Click the ADD button on the ribbon. A popup window will be displayed.

3. Select the Family Relative from the drop down list.

4. If the person is deceased, remove the checkmark in the Living field.

5. Enter the relevant illnesses of the family relative.

6. Click the OK button.

7. Repeat for each blood relative.

8. Click the SAVE icon.

4.4 Social History

This screen is where a patient's social history/activities are entered. e.g alcohol or tobacco usage. You can enter the Social History from the Patient Information Tab or the Patient Summary.

1. Click the **Social History** icon.

2. Enter the information gathered. ie. Tobacco and Alcohol use and frequency.

3. A miscellaneous box contains an area for you to collect other data such as organ donation and blood type.

4. Click the **SAVE** icon.

4.5 Emergency Contact

You can enter the Emergency Contacts from the Patient Information Tab or the Patient Summary.

1. Click the **Emergency Contact** icon on the ribbon.

2. Click the **ADD** icon from the ribbon. A pop-up window will be displayed.

3. If the emergency contact is an existing patient, you can click on the **search** icon to find the contact.

4. Enter the details in each field by pressing the **Tab** key or clicking each field.

ex First name, last name, phone number, etc

5. Select the relationship to the patient from the dropdown box.

6. Click the **SAVE** icon.

4.6 Immunizations

The Immunizations screen allows a provider to document any immunizations given to a patient.

You can enter Immunizations from the Patient Information Tab or the Patient Summary.

1. Click the **Immunization** icon from the ribbon.

2. Click the **ADD** button from the ribbon. A popup window will be displayed.

3. Populate each field.

4. Click the **OK** button.

5. Click the **SAVE** button.

4.7 Body Mass Index

The BMI chart is used to graphically display a patient's growth rate over time. The data used to generate the chart is gathered from the Height and Weight fields in the Vital signs screen. From the Patient Information Tab you can view only.

1. Click the **Body Mass Index** Icon. The graph will be displayed, showing the patients progression at each encounter.

2. When you are finished viewing the graph, click the **Close** button at the bottom right of the screen.

4.8 Medications

The Medication screen is view only from the Information Tab. To enter medications you must have User Rights and be in a Patient Summary.

4.9 Drug Allergies

The Drug Allergies screen is view only from the Information Tab. To enter Drug Allergies you must have User Rights and be in a Patient Summary.

4.10 Intolerance/Non Drug Allergies

You can enter Non Drug Allergies from the Patient Information Tab or the Patient Summary.

All Non Drug allergies are recorded along with the appropriate reaction.

1. Click the **Non Drug Allergies** icon from the ribbon.

2. Click the **Add** icon from the ribbon.

3. A pop-up window will be displayed.

4. Click the fields for Allergen, Interpretation, Severity, Onset Date, and Onset Date to enter the information.

5. Click the Reaction field and enter the reaction to the allergen.

6. Click the **OK** button.

7. Click the **Save** button.

4.11 Communication Log

The Communication Log stores communications and files that are specific to the selected patient. Oftentimes a practice may use this log to document phone calls to and from the patient, or a patient may request that a form be completed by the practice - a copy of the submitted form may be stored here along with the details of the request

There are 3 ways to enter a log:
- Add a Log
- Add a Log File
- Attach a File to log

4.11.1 Add Log

The Communication Log stores communications and files that are specific to the selected patient. Often times a practice may use this log to document phone calls to and from the patient.

1. Click the **Communications Log** icon from the Taskbar.

2. Click the **Add Log** icon from the Taskbar. The Communication Note window will be displayed.

3. Enter a Log title.

4. Enter details in the body field.

5. Click **OK**.

4.11.2 Add Log File

A Log file can be created by importing an existing file. This log entry will not have any notes associated to it and the complete entry is the attached file that has been imported.

1. Click the **Communication Log** icon from the ribbon.

2. Click the **Add** icon from the Taskbar. The Documents window will be displayed.

3. You may attach a file that has already been saved to your computer or directly from a scanner.

4. To attach a file that has already been saved to your computer, click the **Add** from file button.

5. Navigate to the location where the file is stored and double click the file name.

6. To attach a file directly from your scanner, click the **Scan button**.

7. Follow the prompts for your scanner.

9. Once the file has been selected or scanned, the filename will be displayed in the Documents window.

10. Click the **OK** button.

4.11.3 Attach File to Log
Once a Communication Log is created, users will be able to attach a file. This file could be incoming from the patient or some other source.

1. Open the Patient Record by double clicking on the patient's **name** from the Patient List screen.

2. Click the **Communication Log** icon from the ribbon.

3. Select the log that the file will be attached.

4. Click the **Attach** icon from the ribbon. The Documents window will be displayed.

5. You may attach a file that has already been saved to your computer or directly from a scanner.

6. To attach a file that has already been saved to your computer, click the **Add** from file button.

7. Navigate to the location where the file is stored and double click the file name.

8. To attach a file directly from your scanner, click the **Scan** button.

9. Follow the prompts for your scanner.

10. Once the file has been selected or scanned, the filename will be displayed in the Documents window.

11. Click the **OK** button.

4.11.4 Delete Log
A log may be deleted if is no longer needed or was added in error.

1. Select the log to be deleted.

2. Click the **Delete** icon from the ribbon. A confirmation window will be displayed.

3. Click the **Yes** button. The log will be removed.

4.12 Insurance

4.12.1 Add Subscriber Insurance Policy

Patient insurance information is stored as a part of the patient record. This allows for the practice to verify coverage and perform eligibility checks at the time of, or prior to service being rendered.

1. Open the patient record by double clicking on a **Patient's Name**.

2. Select the **Insurance** icon from the ribbon.

3. Click the **Add** as Subscriber icon.

4. Search for the Insurance Company Name or Payer ID by clicking the **Search** icon.

5. If you would also like to perform an Eligibility Check for this policy, search and enter the Payer ID and name in the Eligibility Check field.

6. Populate all required fields flagged with a red exclamation (!).

7. Click the **Save** button. A confirmation window will be displayed.

8. Click the **OK** button.

9. If the patient has more than one (1) insurance policy, be sure to add all the policies.

4.12.2 Add Dependent Insurance Policy

1. Open the patient record by double clicking on a patient's name.

2. Select the Insurance icon from the ribbon.

3. Click the Add as Dependent icon.

4. Search for the name of the Subscriber in the patient list. If the Subscriber is not listed, click the Add icon and enter the demographic details of the subscriber.

5. Search for the Insurance Company Name or Payer ID by clicking the search icon. This is the payer where a claim will be submitted.

6. To perform an Eligibility Check for this policy, search and enter the Payer ID and name in the Eligibility Check field. Populate all required fields flagged with a red exclamation (**!**). Click the Save button. A confirmation window will be displayed. Click the OK button. If the patient has more than one (1) insurance policy, be sure to add all the policies.

4.12.3 Remove Insurance Company

If a policy was added in error or is no longer active, the user can remove or disable the policy in the patient's file.

1. Open the patient record by double clicking on a **Patient's Name**.

2. Select the **Insurance** icon from the ribbon.

3. Select the policy to be removed or disabled from the list of policies on the right.

4. Click the **Delete** icon

You can also check eligibility by clicking the appropriate icon in the ribbon.

Note: You cannot delete an Insurance Company that has charges associated with it. You can only inactivate the Insurance Company.

4.13 External Registration

This feature is for use with a PACS system. The provider would need to register the patient with the PACS system.

4.14 Medical History

The Medical History screen is view only from the Information Tab. To enter Medical History information you must have User Rights and be in a Patient Summary or Date of Service.

4.15 Surgical History

The Surgical History screen is view only from the Information Tab. To enter Surgical History information you must have User Rights and be in a Patient Summary.

4.16 Documents

4.16.1 Add from File

Documents and files can be added to a patient's medical record by scanning or attaching an existing file.

1. Open a patient record

2. Click the **Documents** icon from the ribbon.

3. A list of all documents associated with the patient's file will be displayed.

4. Click the **Add** from File icon from the ribbon.

5. From the pop-up window, navigate to the location of the file you are attaching.

6. Double click on the desired file. The New Document window will be displayed. There are four fields at the top of the screen. The title is populated with the filename. You may change the name if you wish.

7. Click the **Type field** and select a type from the drop-down.

8. Click the **Summary field** and select a summary date and time from the drop-down.

9. Enter any tags needed in the **Tag field**.

10. Click the **Save** button. A confirmation window will be displayed.

11. Click **OK**.

4.16.2 Scan Document
Documents and files can be added to a patient's medical record by scanning or attaching an existing file.

1. Open a **Patient Record**.

2. Click the **Documents** icon from the ribbon.

3. A list of all documents associated with the patient's file will be displayed.

4. Click the **Add** from Scanning Device icon from the ribbon.

5. Follow the prompts to capture the image from your scanner. (This will vary based on the specific hardware install at your practice).

6. The New Document window will be displayed. There are four fields at the top of the screen. The title is populated with the filename.

7. Click the **Type field** and select a type from the drop-down.

8. Click the **Summary field** and select a summary date and time from the drop-down.

9. Enter any tags needed in the Tag field.

10. Click the **Save** button. A confirmation window will be displayed.

11. Click **OK**.

4.16.3 View Documents
Documents can be viewed by following the directions below.

1. Open a patient record

2. Click the **Documents** icon from the ribbon.

3. A list of all documents associated with the patient's file will be displayed.

4. Select a document from the list. The viewer will open and the image of the file displayed.

5. If the file is a Dicom (Radiology or similar) clicking the Details icon will allow the user to view additional tag information about the image.

4.17 Patient Education

While in a patients Summary you are able to produce patient education information to give to a patient. You are able to create information regarding the patients' diagnosis, medications or lab test. Select Patient Education from the ribbon, expand the box for either DX, Meds or Labs. Click on selection and education info will display. Print and provide patient with copies.

Note: Patients can receive an electronic copy through the Patient Portal.

4.18 Print Screen

AstralJet allows the user to print some screens from the patient file. If the Print icon on the ribbon is active, clicking it will print the screen being viewed.

4.19 Potential Patients

This section is located under the Medical Records Tab and is used when converting an existing EMR to our AstralJet Software.

1. Select Import Patient information icon and follow the Patient Information Import Wizard steps.

2. Your patients are stored under the Potential Patient icon.

3. As patients come to your practice you would then convert the patient from a potential patient to a current patient. This prevents patients who are no longer current from residing in your current patient file.

Note: This is not intended to be used without direct guidance and assistance from Training Staff.

5.0 Summary / Date of Service

The summary page provides a snapshot of the patient information including the Drug Allergies, Non-Drug Allergies, Medication List and Problem List.

5.1 Notes

The Note section of AstalJet allows the provider or other medical staff to make additional notes about a patient outside of the SOAP.

1. Click the **Note** icon from the ribbon.

2. Enter the note in the lower half of the screen.

3. Click the **Save** button. A confirmation window will be displayed.

4. Click **OK**. The note will be stamped with the username and the date and time of the note.

5.2 Drug Allergies

Drug Allergies must be recorded for a patient before any prescriptions can be written. All drug allergies are recorded along with the appropriate reaction. This allows for the application to check each prescription written and warn the provider of potential adverse reactions.

1. Open a patient record by double clicking the **Patient Name** from the list.

2. Click the **Drug Allergies** Box on the Screen.

3. If the patient has no known drug allergies, click the link " **Indicate No Known Drug Allergies**

(NKDA)".

4. If the patient has drug allergies click the drop down field Select Common Allergy and select the allergy.

5. Click the **Add** Common Allergy button.

6. If the allergen needed is not listed, enter the name of the Allergy needed in the Allergy field.

7. Click the **Find** button. A list of matching allergens will be displayed.

8. Click the desired allergen from the list.

10. Click the "**Done with Allergies**" button.

NOTE: Allergies added using free text entry and not chosen from a specific link or dropdown menu will not perform drug-allergy interaction checking.

5.3 Non-Drug Allergies

All non-drug allergies are recorded along with the appropriate reaction.

1. Open a patient record by double clicking the **Patient Name** from the list.

2. Click the **Non Drug Allergies** Box on the Screen.

3. Click the **Add** icon from the ribbon (Edit box must be opened), a pop-up window will be displayed.

4. Click **Eyeglass** in the field for Allergy Type and select from condensed list, if list does not have what you are looking for, click add button in pop up screen and a full selection will display.

5. Click **Eyeglass** in the field for Allergen and select from condensed list, if list does not have what you are looking for, click add button in pop up screen and a full selection will display.

6. Continue completing fields.

7. Click the **OK** button.

5.4 Medication List

AstralJet allows users to enter all a patient's current and past medications.

NOTE: Adding medications in this area does NOT mean you are writing a prescription.

1. Open a patient record.

2. Click the Medication List Box on the Screen.

3. Click ADD and enter the name of the medication a patient is currently on or has taken in the past.

4. Click the Find button.

5. Select the correct medication and strength from the list.

6. Enter the details such as Sig, Duration etc.

7. Enter the Date Started, Date Filled and Date Stopped in the appropriate fields (if the date is today, click the today link).

8. Click the Continue button. The medication is then added to the patient meds list as a current or past drug.

5.5 Problem List

The Problem List allows the provider to enter the diagnosis for the patient being treated. Diagnosis entered here are automatically stored in the patients record. ICD-9 codes will be automatically mapped to SNOMED codes (required to generate a CCDA).

1. Click the **Problem List** icon.

2. Click the **Add** button on the ribbon. A pop-up window will be displayed.

3. Click the **"+" Add button** to search for the desired diagnosis.

4. Search for the desired diagnosis. This can be done either by code number or name, simply enter the code in the first field and press the **ENTER** key, or enter the first few characters of the diagnosis name in the second field and press the **ENTER** key.

5. A list of diagnosis' matching the search criteria will be displayed. Select the desired diagnosis.

6. The select diagnosis will be populated in the field. You may now enter additional information such as **Remarks/Date Onset**.

7. Click the **OK** button.

8. Repeat for each diagnosis needed for the patient.

5.6 Review of Systems (ROS)

The Review of Systems (ROS) allows the provider to document all the complaints of the patient in a simple and concise manner. The screen is divided into systems and each system has individual elements with abnormalities to be attached if there is a complaint.

Note: The software defaults to WNL if no documentation is entered

1. Click the **Review of Systems** icon.

2. Select the System to be documented.

3. If all elements of the system are within normal limits (WNL), place a check mark in the checkbox labeled **Within Normal Limits**.

If there are abnormalities to be documented:

1. Remove the **WNL** checkmark from that system.

2. Place a check mark next to the element of the system, a drop down box will display to the right.

3. Select from the list the reported abnormality.

4. Repeat steps 3 and 4 for each system to be documented.

5. Click the **SAVE** Icon.

5.7 Clinical Instructions

This area is for the provider to make a note of the instructions provided to the patient.

5.8 Vital Signs

The user can enter vital signs taken during an encounter (office visit) with the patient. Not all fields need to be populated. Each practice has their own requirements regarding what vital signs are recorded during an encounter.

NOTE: The Height and Weight Chart is generated from the information entered in the Height and Weight fields on this screen.

1. Click the **Vital Signs** icon.

2. Enter the vital signs taken in the appropriate fields.

3. Enter the patient's temperature

4. Enter the patient's blood pressure

5. Enter the patients Respiration

6. Enter the patients pulse rate

7. Enter the patient's Weight

8. Enter the patient's Height

NOTE: Vital Signs may be added to the SOAP note by Importing. (See: Importing Vital Signs)

5.9 Plan of Care

This screen is divided into 3 panes: Goals/Intructions, Patient Decision Aides and Preventative Health. Simply click on the add icon to enter information into any of these areas.

5.10 Patient Education

There are 2 ways to get patient education information- "**Patient Information**" or "**Info Button**".

1. By selecting a problem for the "**Problem List**" pane and pressing "**Info Button**" on the ribbon, information for that particular condition will be displayed.

2. By clicking on the "**Patient Education**" item in the ribbon, the patient problems, medications and labs will appear in the left column. Links will appear in each category that provide the relevant information.

5.11 Medical History

Used for entering the patient's Medical History manually.

5.12 Surgical History
Used for entering patients Surgical History manually.

5.13 Diagnostics
This is where you order diagnostic lab tests and view results for the patient. To get information about a particular result, select the result and click the "Info Button" on the ribbon.

5.13.1 To order a lab test:
1. Click on the "**Add**" icon on the ribbon.

2. Select the **lab company**

3. Select the person the order is assigned to

4. Enter any instructions and a description of the lab test

5. Add the **lab test** to be performed

6. Select the **specimen source** at the bottom of the screen

7. Select the **problem** associated with this test

The lab test will now appear on the main diagnostics page and a message will be sent to the person that was assigned the test. The lab test result will appear in the results pane once available and the provider will receive a notification message. There is also the option to add lab test results manually.

5.13.2 To manually enter a lab result:
1. Click the "**Attach Lab Result**" icon in the ribbon.

2. Enter the test information.

3. Click "**Add**" in the lower right hand corner of the dialog box to add the result

4. Click **OK**

5. Once a lab test is complete, select the test and click "**Complete**" in the ribbon.

5.13.3 Order an in-house test:
If there is a procedure that is done in the practice, the provider may place an order for this during an encounter and assign this order to a staff member.

1. Click the **In-House Test** icon from the ribbon.

2. Click the **Order** icon or **Order Test** button.

3. Highlight all In-house tests being ordered.

4. Click the drop down arrow in the **Assigned To** field. Select a user from the list.

5. Enter a **description** in the description field.

6. Click the **Send** button.

5.13.4 Complete In-House Test

Once an In-house test has been completed, the user assigned to perform the test may enter a completed date.

NOTE: Only the assigned user is able to complete an In-house test.

1. Select the In-house test that has been completed.

2. Click the **Complete** icon from the ribbon. The current date will be place in the completed field.

5.13.5 Attach Report to In-House Test

A user is able to attach a document to an In-house test, once that test has been completed.

1. Select the completed In-house test.

2. Click the **Attach** icon from the ribbon. The Documents window will be displayed

3. Select a file to be attached, or Scan a document using a scanner, or **Add** an existing file already stored on your computer.

4. If you, Select a file to be attached from the list, double click on the file name displayed on the screen

5. If you Scan a document using a scanner, click the **Scan** button and follow the prompts for capturing the image.

6. If you Add an existing file, Click the **Add File** button. From the pop-up window, navigate to the location of the file you are attaching. Double click on the desired file.

7. The New Document window will be displayed. There are four fields at the top of the screen. The title is populated with the filename.

8. Click the **Type field** and select a type from the drop-down.

9. Click the **Summary field** and select a summary date and time from the drop-down.

10. Enter any tags needed in the Tag field.

11. Click the **Save** button. A confirmation window will be displayed.

12. Click **OK**.

5.14 Claim Details

On this screen you can enter any additional information you would like to include on the claim. The layout of the form is similar to the HCFA form.

5.15 Narcotics Wizard (Agreement)

If you are a practice that writes Narcotics this Wizard will assist you with your Patient Agreement and your documentation.

1. Enter Type of Patient

2. Select if past medical records are available to review

3. Alcohol Abuse

4. Substance Abuse

5. Review current and past medications

6. Import Diagnosis

7. Enter parameters of pain

8. Enter effect on physical functionality

9. Enter effects on psychological functionality

10. Prescribe RX

5.16 SOAP

5.16.1 Add SOAP Note

The SOAP screen allow the provider to document the visit and later print the details. Once the note is completed the Summary of the encounter can be finalized.

The SOAP note can be entered by:

- Voice Recognition
- Customized Templates
- Primary Care Wizard

While documenting a SOAP note a provider may need to view the previous notes.

1. On the SOAP screen click the **View Previous** Notes button.

2. The SOAP notes of the last visit will be displayed.

3. Continue to click the **View Previous Notes** button to see all SOAP notes.

NOTE: To "flip" forward through the notes click the View Next Note button.

5.16.2 Voice Recognition
Select Dragon Dictation from the drop down box on SOAP NOTE

1. Open a Patient record.

2. Click the **Date of Service** Icon. A List of encounters for the patient will be displayed.

3. Click the **Summary** Icon from the ribbon.

4. Click the SOAP icon. Enter the appropriate details in the fields:

- History of Present Illness (HPI) - Subjective.
- Exam/Findings - Objective.
- Assessment/Plan.
- Plan Reminder for Future Note.

5. You can import the Vital signs, Problem List, Family, Social, Medical and Surgical History along with ROS's.

- Click the "**Import** " Button.
- Select from the Dialogue Box what you want to be entered into your SOAP note
- Click **Next**
- Click **Import**

5.16.3 Templates
Select Apply Template button

If the physician feels they type or dictate the same thing repeatedly, they can set up templates under Administration tab and select them at this time.

Note: If you want to use this selection all the time you can click remember this setting and click Apply.

You can import the Vital signs, Problem List, Family, Social, Medical and Surgical History along with ROS's.

1. Click the "**Import** " Button.

2. Select from the Dialogue Box what you want to be entered into your SOAP note

3. Click **Next**

4. Click **Import**

5.16.4 Primary Care Wizard (Code Pilot)

Select Primary Care Wizard from the SOAP note page.

1. Click **Next** in the dialog box

2. Select **Visit Type**-New or Established

3. Select **Presenting Problems**-choose appropriate category

4. Select **Date Reviewed/Ordered**-choose appropriate category

5. Select **Management Options-**divided into quadrants-you may only make one selection

- Top Left-Severe
- Bottom Left-mild
- Top Right-minor
- Bottom Right-minor

6. Click Next

The next screen will show a preselected E & M code. This is only a suggestion according to the information from the previous screen.

1. Click **Complaint**

2. Select from the Drop Down box-the patient complaints

3. Click **Next**

4. Make **HPI selections**, selections will open boxes for specificity

5. NEED signifies how many options are needed and HAVE signifies how many options you have selected

6. Click **Next**

This screen is Present, Family and Social History. If the physician has reviewed these already you can click the Reviewed By Physician box.

- Social History-Click Include
- Medical History-Select Medical or Surgical
- Family History-Click Include

1. Click **Next**

2. R.O.S. – if you have already done this you can skip it but if this is your only mode documentation you would need to complete this section.

3. Click **Next**

Subjective

1. Additional Information – any information you would like to appear in the Subjective Box you would enter here

2. Click **Next**

Examination

1. Click **Vitals** – previously added Vitals will appear here

2. Click **Constitution** – make your selection

3. Continue through all options and make your selections

4. Click **Next**

Objective

1. Additional information – any information you would like to appear in the Objective Box you would enter here.

2. Click Next

Diagnosis

1. If you know the diagnosis code enter it here

2. Click the arrow to move the diagnosis into the diagnosis box

3. Repeat for all diagnoses

If you don't know the code, click on the **Glass Icon** and Search

4. Click Next

Note: *If you want to import all of the diagnosis codes, click the Green Down Arrow*

Orders/ Assessment

1. Select **Labs and Diagnostic** tests to be ordered, reviewed or performed

2. Interpretation – click box if you have interrupted any Labs or x-rays

3. History Summary- click box if you have reviewed old records or obtained history other than from the patient.

4. Click **Next**

5. Plan- shows options for future plans for the patient. Make your selections

6. Click **Next**

7. View completed note and click **Save**

5.16.5 Plan Reminder for Future Note

Plan Reminder for Future Note allows the provider to add a reminder that will automatically populate in the SOAP screen for a future visit.

1. Open/Create a Soap Note for a patient (see: Add SOAP Note)

2. In the **Plan Reminder for Future Note** field, enter the reminder.

3. Click the **SAVE** button.

5.16.6 Print SOAP

SOAP notes may be printed once the provider has populated saved the fields on the SOAP screen.

1. Open a patient record.

2. Click the **Date of Service** icon from the ribbon.

3. Select an **In Process Summary** from the list.

4. Click the **SOAP** icon from the ribbon.

5. Click the **Print** icon from the ribbon.

5.17 Charged Procedures

Once the problem list has been populated all the diagnoses will be automatically added to the Charged Procedures screen. The Charged Procedures Screen is created to act like the superbill currently used by your office. Essentially the provider is adding the level of service given, and ordered procedures, then associating these with the diagnoses from the problem list.

The Charged Procedures screen allows the provider to:

1. Add appropriate E/M and CPT codes to selected diagnosis.

2. Add appropriate HCPCS codes to selected diagnosis.

3. Add appropriate Modifier codes to selected CPT's and HCPCS.

5.17.1 Add EM and CPT Codes:

1. Problem List must be populated and saved prior to creating charge slip.

2. Click the **Charge Capture** icon the ribbon.

3. In the upper portion of the screen will be all the diagnosis added from the problem list. Select the row below the Diagnosis that will be associated with the procedure.

4. Click the **EM/CPT** radio button to add the EM or CPT codes for that diagnosis.

5. Click the Add **"+"** button just below the radio buttons.

6. Search for the desired EM or CPT. This can be done either by code number or name.

To search by code number, enter the code in the first field and press the **ENTER** key

To search by name, enter the first few characters of the procedure name in the second field and press the **ENTER** key.

- A list matching the search criteria will be displayed. Select the desired procedure.
- The code will now be attached to the diagnosis of the patient.
- Repeat for as many codes as is needed.
- Click the **Save** icon on the ribbon.

5.17.2 Add HCPCS Codes:
1. Problem List must be populated and saved prior to creating charge slip.

2. Click the **Charge Capture** icon the ribbon.

3. In the upper portion of the screen will be all the diagnosis added from the problem list. Select the row below the Diagnosis that will be associated with the procedure.

4. Click the **HCPCS** radio button to add the HCPCS codes for that diagnosis.

5. Click the Add **"+"** button just below the radio buttons.

6. Search for the desired **HCPCS**. This can be done either by code number or name.

To search by code, enter the code in the first field and press the **ENTER** key.

To search by name, enter the first few characters of the name in the second field and press the

ENTER key.

- A list matching the search criteria will be displayed. Select the desired procedure.
- The code will now be attached to the diagnosis of the patient.
- Repeat for as many codes as is needed.

5.17.3 Add Modifiers:
When completing the Charged Procedures screen, modifiers may be added to follow proper billing and coding protocols.

1. Select a **procedure** from the lower half of the screen.

2. The Add button will become active. Click the **Add** button.

3. Search for the desired **Modifier**. This can be done either by code number or name.

To search by code, enter the code in the first field and press the **ENTER** key.

To search by name, enter the first few characters of the name in the second field and press the

ENTER key.

- A list matching the search criteria will be displayed. Select the desired modifier.
- The code will now be attached to the procedure.
- Repeat for as many modifiers as is needed.

5.17.4 Remove EM/CPT code and Modifiers:
A user is able to remove a code or modifier that has been added in error to the Charged Procedures screen.

1. Click on the **code** you wish to remove. (Select EM and CPT codes from the top half of the screen, and HCPCS from the bottom half of the screen)

2. Click the **Remove** button, be sure to use the remove button from the same part of the screen you are working in.

4. Enter a **Log title**.

5. Enter details in the body field.

6. Click **OK**.

A Log file can be created by importing an existing file. This log entry will not have any notes associated to it.

5.18 Finalize Summary
Once a provider has completed documenting an encounter, the note can be finalized. This means that the provider has "locked" the note and no further changes can be made.

1. Click the Date of Service icon from the ribbon. The Date of Service screen will be displayed.

2. Open an In Process Summary by double clicking or selecting it, then click the Summary icon from the ribbon.

3. The Summary screen will be displayed. The Summary shows the patients Drug and Non-Drug Allergies, Medication List and Problem list for an encounter.

4. Enter Remarks if desired.

5. Click the SAVE button.

6. Click the Finalize icon from the ribbon.

5.18.1 Append Finalized Summary

In the event that a provider needs to make changes to a finalized summary, the note may be appended.

1. Open patient record.

2. Click the **Date of Service** icon from the ribbon.

3. Select the **Finalized Summary**.

4. Right click on the summary and select **Review Summary**.

5. The Summary screen will be displayed.

6. Make the appropriate changes in each section - this includes clicking icons such as the **Soap** or **Problem list** and making changes.

7. Click the **SAVE** Button.

NOTE: You will not be able to re-finalize your summary. The column labeled Date Updated will reflect the date and time of the change you made.

6.0 E-Prescribing

AstralJet allows providers to create and send prescriptions electronically.

NOTE: You must enter drug allergy information for the patient before writing prescriptions.

1. Open a patient record.

2. Click the **Manage Prescriptions** icon from the ribbon.

3. Click the **Prescribe** link. (Optional)

4. Select the pharmacy where the prescription is to be sent.

5. In the **Prescribe a Medication** area enter the name of the medication to be prescribed.

6. Click the **Find** button, a list of matching medications of various doses will be displayed.

7. Select the desired medication and dose.

8. Enter all the appropriate fields - Sig, Duration, Quantity, Refills, Instructions etc.

9. Click the **Continue** button. A preview of the prescription will be displayed.

10. If the information displayed is correct click the **OK** button.

11. You will be returned to the Prescribe a Medication area. If you need to add additional medications repeat the above steps.

12. Scroll down to the Pending Prescriptions for this patient section. There will be a check mark next to each prescription.

13. Enter your electronic signature.

14. Click one of the submission options - Send, Send and Print, Print w/o sending, Sign w/o sending

6.1 Add Favorite Medication while Prescribing

Medications that are orders frequently by a provider can be added as a Favorite selected from a predefined list, making ordering these medications faster and more efficient.

1. Order a medication as you normally would. (See E-Prescribing).

2. On the Review Prescription screen click the **Add to Favorites** button.

3. The Add Favorite Prescription screen will be displayed.

4. The name of the medication and dosing information will be defaulted as the name of the prescription. You may change this if you desire.

5. Select the list this prescription should be added - **My List** or **Practice List**.

6. Click the **Create** button.

7. You will then be able to complete the prescription for the patient

6.2 Rx Options

The options area of the E-Prescribing module allows for the user to do some administrative and set-up functions relating to the E-Prescribing.

1. Change Password

2. Configure Formularies

3. Favorite Prescription

4. Pharmacy Data

5. Preferences - User

6. Preferences - Practice

7. Activity Report

8. Drug Report

9. Decision Report

10. Periodic Report

11. Pharmacy Report

6.2.1 Change Signature Password

Each Provider has been assigned a secret signature password to sign each prescription ordered for patients. Providers are able to change their password.

1. Click the **Options** link.

2. Click the **Change Password** link.

3. Enter the current signature password in the appropriate field.

4. Enter the new signature password in the appropriate field.

5. Click the **Change** button.

6.2.2 Add Favorite Prescription

Before a provider begins prescribing medications for patients, the Favorites List can be created to allow for faster prescribing.

1. Click the **Options** link.

2. Click the **Favorite Prescription** link.

3. In the Drug Name field enter the name of the medication you wish to add to the favorites list.

4. Click the **Find** button.

5. A list of matching medications and doses will be displayed. Select the appropriate medication.

6. Populate all information desired - Sig, Duration, etc - if this is consistent with your prescribing methods.

7. Click the **Continue** button.

8. Select the list this prescription should be added **- My List** or **Practice List.**

9. Click the **Create** button.

6.3 Manage Meds

AstralJet allows users to enter a patient's current and past medications.

NOTE: Adding medications in this area does NOT mean you are writing a prescription.

1. Open a patient record.

2. Click the **Manage Prescriptions** icon from the ribbon.

3. Click the **Manage Meds** link.

4. In the **Patient Medication Report Area**, enter the name of the medication a patient is currently on or has taken in the past.

5. Click the **Find** button.

6. Select the correct medication and strength from the list.

7. Enter the details such as Sig, Duration etc.

8. Enter the **Date Started**, **Date Filled** and **Date Stopped** in the appropriate fields (if the date is today, click the today link).

9. Click the **Continue** button. The medication is then added to the patient meds list as a current or past drug.

6.4 Pending Rx

Once a prescription is written for a patient it must be signed and submitted so that it will be filled.

1. Click the **Pending Rx** link at the top of the screen. If there are prescriptions to be signed - The link might read "Pending Rx (2)" the number indicates how many prescriptions are ready to be signed and submitted.

2. In the Pending Prescriptions for this Patient area there will be the list of medications you have prescribed, but not yet signed and submitted.

3. Remove the check mark from any prescription that you do not wish to sign.

4. Enter your **Signature Password** in the field.

5. Select one of the submit options - Send, Send and Print, Print w/o Sending, Sign w/o sending.

NOTE:

1. *Send* - *will electronically submit the prescription to the selected pharmacy. It will NOT print the prescription.*

2. *Send and Print* - *will electronically submit the prescription to the selected pharmacy and Print*

a copy of the prescription(s)

3. *Print w/o Sending* - *will print the prescription, but the patient will have to take that copy to the* pharmacy to have it filled.

4. *Sign w/o sending* - *will sign the prescription only. It will not be sent to the pharmacy and it will not be printed.*

6.5 Renewal Requests

For electronic renewal requests generated from pharmacies, AstralJet's e-prescribing will display how many renewal requests are pending for the patient in the Navigation Bar.

1. Click the **Renewal Requests** link to see the details of the pending electronic renewal requests. The link might read "Renewal Requests (3)" showing the number of requests to be addressed.

2. Select the **Action** for each request from the drop down options.

3. Select a note to the pharmacist from the dropdown, if desired, to explain the action chosen or free text a comment in the box to the right.

4. When finished taking an action on each renewal request, enter your **signature password** in the field.

5. Click the **Perform** button. If a policy was added in error or is no longer active, the user can remove or disable the policy in the patient's file.

7.0 Tasks

A user can send or assign specific tasks to other users within the practice.

To access the Task function:

1. Click the **Task** icon from the ribbon.

NOTE: *If you are in a patient record, the tasks listed will be related only to that patient.*

1. Open a patient record.

2. Click the **Medical Records** tab.

3. Click the **Task** icon.

The Task screen allows users to:

- Add Task
- Complete Task
- Edit Task
- Cancel Task

7.1 Add Task

A user can send or assign specific tasks to other users within the practice.

1. Click the **Add** icon from the ribbon.

2. Click the drop down for the **Assigned To** Field. Select the user that you are assigning the task.

3. Enter text in the body of the **Description** field.

4. Click the **Save** icon.

7.2 Cancel Task

In the event that an assigned task is no longer needed, the originator of the task may cancel the assignment.

1. Select a task from the list.

2. Click the **Cancel** icon from the ribbon.

7.3 Complete Task

Once the assigned task has been completed, the user assigned to perform the task may change the status to complete.

1. Select a task from the list.

2. Click the **Complete** icon from the ribbon.

7.4 Edit Task

If a task has been created but there may be some errors in the text, the user originating the task may edit the task sent.

1. Open the task list by clicking the **Task** icon from the Medical Records menu.

2. Select a task from the list.

3. Click the **Edit** icon from the ribbon.

4. Make the appropriate changes to the task.

5. Click **Save**.

8.0 Messaging

8.1 Send Message

AstralJet allows users to be able to communicate with each other by sending messages with the program. Messages are used to alert a provider that patient is waiting to be seen in a room, or to tell a technician that a patient needs a test or procedure.

1. Click the **Messenger** tab.

2. Click the **Send** icon. The Send Message window will be displayed.

3. Click the **"TO"** button. A list of Users will be displayed.

4. Select the recipient for your message.

5. Enter a **Subject** in the Subject field.

6. Enter text in the body of the message area.

7. Click the **"Send"** button.

8.2 Retrieve Message

The user is able to view or retrieve any message that is sent to their inbox.

1. Click the **Messenger** tab.

2. Click the **Show** icon from the ribbon. A list of messages will be displayed in the lower portion of the screen

3. Select a message to be viewed. The contents of the message will be displayed in the right side of the screen.

8.3 Reply to Message

Once a message is sent to a user, a flashing envelope in the lower right corner of the screen alerts the user that there are messages to be retrieved.

1. Open a message.

2. Click the **Reply** button. The Send Message window will be displayed.

3. Enter the desired text in the body of the message area.

4. Click the **Send** button.

8.4 Archive Message

Archiving Messages allows the user to keep old messages, in a place outside of the Message Inbox.

1. Open the **Message Inbox** or **Outbox**.

2. Select a message to be archived.

3. Click the **Archive** button.

4. The message will be moved from the Inbox (or Outbox) to the archived messages box.

8.5 Delete Message

If a message is no longer needed, the user has the ability to delete the message.

1. Select the message to be deleted.

2. Click the **Delete** icon. A confirmation message will be displayed

3. Click **"YES".**

9.0 Documents

9.1 Attach Document

Documents and files can be added to a patient's medical record by scanning or attaching an existing file.

1. Open a patient record

2. Click the **Documents** icon from the ribbon.

3. A list of all documents associated with the patient's file will be displayed.

4. Click the **Add from File** icon from the ribbon.

5. From the pop-up window, navigate to the location of the file you are attaching.

6. Double click on the desired file. The New Document window will be displayed. There are four fields at the top of the screen. The title is populated with the filename. You may change the name if you wish.

7. Click the **Type** field and select a type from the drop-down.

8. Click the **Summary field** and select a summary date and time from the drop-down.

9. Enter any tags needed in the Tag field.

10. Click the **Save** button. A confirmation window will be displayed.

11. Click **OK**.

9.2 Scan Document

Documents and files can be added to a patient's medical record by scanning or attaching an existing file.

1. Open a patient record.

2. Click the **Documents** icon from the ribbon.

3. A list of all documents associated with the patient's file will be displayed.

4. Click the **Add from Scanning Device** icon from the ribbon.

5. Follow the prompts to capture the image from your scanner. (This will vary based on the specific hardware install at your practice).

6. The New Document window will be displayed. There are four fields at the top of the screen. The title is populated with the filename.

7. Click the **Type** field and select a type from the drop-down.

8. Click the **Summary** field and select a summary date and time from the drop-down.

9. Enter any tags needed in the **Tag** field.

10. Click the **Save** button. A confirmation window will be displayed.

11. Click **OK**.

9.3 View Documents

The Documents icon allows the user to add or view files that are attached to the patient record. Documents and files can be added to a patient's medical record by scanning or attaching an existing file. Documents can be viewed by following the directions below.

1. Open a patient record

2. Click the **Documents** icon from the ribbon.

3. A list of all documents associated with the patient's file will be displayed.

4. Select a document from the list. The viewer will open and the image of the file displayed.

5. If the file is a Dicom (Radiology or similar) clicking the Details icon will allow the user to view additional tag information about the image.

10.0 REPORTS

AstralJet contains two types of reports:

General Reports – Parameters are preset

- Medical Records
- Financials
- Operations
- Labs
- Lists
- System

Advanced Reports - Customized parameters

- Create your own Report

The user is able to view and export reports based on the data entered in AstralJet.

1. Click the **Reports** tab from the menu bar.

2. The ribbon will show two icons available for use:

- View Reports.
- Export Report

10.1 View Reports

The user is able to generate and view reports based on the data entered in AstralJet.

1. Click the **Reports** tab from the menu bar.

2. Click the **View Reports** icon from the ribbon. A list of pre-defined reports will be displayed.

3. Select the report desired.

4. Select the criteria for generating the report.

5. Click the **Generate Report** button.

10.2 Export Report

Once a report has been created and viewed, it can be exported outside the AstralJet application to a selected format.

1. Generate the Report. (See: *View Reports*)

2. Click the **Export** button and select the format from the drop down options

3. The **Save As** window will be displayed.

4. Navigate to the folder location were the file is to be saved.

5. Enter the name of the file.

6. Click the **Save** button.

10.3 General Reports: Medical Records

10.3.1 Narcotics Prescribed Summary
 Displays the patients that have been prescribed narcotics and the percentage represented in the practice. To see the patients names click the parameter value box, and generate the report.

To generate the report, click on the **Generate Report** icon at the top of the screen after choosing a Not Seen From date.

NOTE: *To report accurate information you must use the E-Prescribe module.*

10.3.2 Patient Immunization Report
The Patient Immunization Report shows all immunizations for the selected patient. The report includes the patient's name, medical record number, social security number, the immunization along with the CPT code, date of service, dose, route, site, lot manufacturer, lot number, lot expiration date, created by, and created date, and an immunization schedule.

How to generate the report:

- To generate the report, select a patient and click on the **Generate Report** icon at the top of the screen.

How to select a patient:

- To select a patient, click on the **patient look up** button. Click on the patient you would like to run the report for and click ok.

10.3.3 Patient Medication List Report
The Patient Medication List Report shows all the medications that the patients at the practice are and/or were taking. The report includes the patient name, medical record number, name of the medication, start date, stop date and the provider who last updated it. The report is sorted alphabetically according to the patient's last name.

How to filter by medication:

- Click in the **Medication Name** parameter field and enter the medication name.

How to include free text or discontinued medications:

- To include free text or discontinued medications, put a check mark next to the parameter preferred.

How to filter by the provider:

1. Click on the drop down on the **Provider** parameter.

2. Select a provider.

3. Once selected, the provider will populate in the parameter.

How to filter by patients:

1. Click on the **look up** button by the Patients' parameter

2. Select the patients by putting a check mark next to the patient's name. The selected patients will show on the bottom of the patient lookup window.

3. Patients can be searched by opening the search function at the top of the patient look up window.

4. When finished selecting the patients, click **OK** and the selected patients will populate in the patients parameter value field.

How to generate the report:

- To generate the report, click on the **Generate Report** icon at the top of the screen.

- To generate a full list of medications for the practice, select **Al**l for the Provider parameter, put a check mark for the include Free Text Medications and include Discontinued Medications parameters, and leave the Medication Name and Patients parameters blank.

10.3.4 Patient Recall
The Patient Recall Report shows the patients that haven't been seen since a date chosen by the user. This report is sorted alphabetically according to the first name of the patient.

How to choose a Not Seen From date:

- To choose a **Not Seen From** date, click on the calendar and select a date or click on the date field and enter a date.

How to generate the report:

- To generate the report, click on the Generate Report icon at the top of the screen after choosing a Not Seen From date.

10.3.5 Patient Record
The Patient Record report is used to create a report of the entire record for the selected patient. You can select patient, generate report and copy to a disk for manual transfer of records.

10.3.6 Patient Search
The Patient Search report gives you detailed information concerning the selected patient including patient demographics, problems, family history, social history, allergies, and medications. This report also allows you to search patients by above parameters.

- To select a patient, click on the **patient look up** button. Click on the patient you would like to run the report for and click **ok**.
- To search by another criteria, select and enter parameters, and click **OK**.

How to generate the report:

- To generate the report, select a patient and click on the **Generate Report** icon at the top of the screen.

10.3.7 Patients
The Patient List report shows a list of patients within the practice. The report includes the patient's medical record number, name, gender, address, phone number, e-mail address (if provided by the patient), and their primary physician. The report is sorted alphabetically by the last name of the patient.

How to filter patients:

1. Click on the **look up** button by the Patients' parameter

2. Select the patients by putting a check mark next to the patient's name. The selected patients will show on the bottom of the patient lookup window.

3. Patients can be searched by opening the search function at the top of the patient look up window.

4. When finished selecting the patients, click **OK** and the selected patients will populate in the patients parameter value field.

5. To generate the report, click on the **Generate Report** icon at the top of the screen. To generate a full list of patients for the practice, leave the patient parameter field blank.

10.3.8 Physician Encounter

The Physician Encounter Report shows you a list of patients seen by each provider and can be searched by a particular date or range of dates.

1. Select a single Provider or search all providers

2. Enter a single **date** or a date range

3. Click **OK**

4. To generate the report, click on the Generate Report icon at the top of the screen.

10.3.9 CPT Code List

Creates a list of patients by CPT codes by specified date range.

10.4 Advanced Report

The Advanced Report allows the User to create customized reports.

1. Select Reports tab

2. Click Advanced Reports Icon

3. In Advanced Search field select "and" or "or" from the drop down box

4. Click Add Condition Button

5. Set up your parameters; add as many as needed

6. Click the Generate Report Icon from the ribbon

10.5 General Reports: Financial

Located in Practice Management section of Manual