

# **NeoData Product Information**



# Product Description

## Overview

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The **NeoData NICU Patient Data System** is a computerized, multi-user data system designed to assist physicians and other medical care providers in the clinical management of patients from admission through discharge and to produce major NICU patient documentation, including:

- **Admission summaries**
- **Progress notes**
- **Discharge summaries**
- **Report sheets for rounds**
- **TPN and other fluid orders**

In the process, a broad range of clinical information is captured and available for data reports and analysis.

The NeoData program runs on standard PC's using the **Windows XP, or Windows Vista** operating systems. It is designed for use over a network to accommodate multiple data entry workstations.

NeoData is designed so that all data entry may be performed by the NICU medical staff on workstations located in the NICU area. Documents are printed immediately upon completion of data entry, signed, and placed directly in the patient chart. These tasks are performed as part of the daily patient care routine, in precisely the same manner as if notes were handwritten. This approach requires no dictation, filling out of forms, or involvement of clerical staff.

The NeoData system provides a number of benefits, including:

- Consistent terminology, standard formatting, and increased legibility of documentation;
- Improved tracking of data and management plans;
- Data analysis using the built-in Query and Report module;
- Support for billing operations;
- Significant time savings.

Note that NeoData is not intended to completely replace the standard paper chart. Similar to pen and paper, it is a tool for tracking information and producing paper documents for inclusion in the official chart. With no further effort, it also stores substantial amounts of information for queries and reports.

The design of NeoData is based on several major principles:

- The most reliable and efficient way to capture in computerized form large amounts of patient information for later analysis is to design a data entry system for use directly by the medical staff as part of routine patient care, since virtually all important patient information is eventually processed in some form by these personnel.
- To be consistently and reliably used, a data entry system intended for use by busy medical staff **must be perceived by its users as benefiting them directly**, such as by improving patient care or by saving time.

The requirement that a data system handle a large amount and range of information, coupled with the goal of having virtually all data entry able to be performed directly by the medical staff, demands a carefully designed system which has been proven in real-world use in active NICUs. This is what NeoData offers.

## Data Entry Screens

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NeoData includes 16 major **forms**, or data entry screens. The main screen, the [Select Patient Form](#), allows users to perform the following functions:

- Maintain a list (the **Current Patient List**) of all patients currently admitted to the NICU service;
- Select patients from the Current Patient List for data entry or viewing;
- Search for any patient previously entered into the system, including discharged patients, for data entry or viewing.

At any given time, one patient is the **currently selected patient**. To insure data integrity, only one workstation on the network can enter data for a given patient at a time.

The other 15 forms are the actual **Data Entry Forms**. While the program is running, any form may be selected by clicking on its **index tab**.

The 16 major forms and their functions are listed here; click on the form name to view a screen shot of the form:

<a href="#">Select Patient</a>	Selection of patients and management of the Current Patient List.
<a href="#">Pregnancy Information</a>	Maternal information, pregnancy, and labor.
<a href="#">Birth Information</a>	Delivery, birth information, patient identification, resuscitation, and delivery addendum.
<a href="#">Admission Information</a>	Admission information and measurements, prior hospitalizations, transport addendum, and admission addendum.
<a href="#">Physical Exam</a>	Daily measurements, vital signs, and physical findings.
<a href="#">Respiratory Support</a>	Current respiratory support settings, blood gas results, apnea and bradycardia, and ECMO information.
<a href="#">Daily Fluids</a>	IV fluids and TPN, feedings and supplements, and extensive nutritional calculations.
<a href="#">Other Daily Information</a>	Additional fluid intake information, daily progress note addendum, and procedure or supplemental progress notes.
<a href="#">Tracking Information</a>	Ophthalmologic screening, hearing screening, state newborn screening, immunizations, and discharge planning.
<a href="#">Problems and Diagnoses</a>	Problem and diagnosis list with associated medications, procedures, and plans for each problem.
<a href="#">Radiology Studies</a>	Radiologic studies.
<a href="#">Lab Results 1</a>	Hematology and chemistry lab results.
<a href="#">Lab Results 2</a>	Cultures, drug levels, and other lab results.
<a href="#">Discharge Information</a>	Discharge information, measurements, treatment, follow-up, and addendum.
<a href="#">Discharge Summary</a>	Status of ophthalmologic screening, hearing screening, state newborn screening, and immunizations as of discharge; respiratory and nutritional support chronologies during the admission.
<a href="#">Other Patient Information</a>	Final outcome and miscellaneous patient information.

At the bottom of the NeoData screen, always visible, is a **display panel** which can show any one of the following:

- Basic patient information including name, birthdate, birthweight, gestation, admission date, and admission weight;
- A section of document text for the data currently being edited as it will appear in a summary or progress note;
- Any lab results for the currently selected patient.

## Printed Documents

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NeoData generates all standard patient documentation and other reports and printouts. Examples of the **first pages** of the following documents printed by the NeoData program may be viewed by clicking on the document name:

<a href="#">Admission Summary</a>	Admission summary.
<a href="#">Progress Note</a>	Daily progress note.
<a href="#">Discharge Summary</a>	Discharge or transfer summary.
<a href="#">Round Sheets</a>	Sheets with current respiratory, fluid, laboratory, and other information for all patients in the NICU, 3-4 patients to a page. May be photocopied to give a set to each person on rounds.
<a href="#">Daily Fluid Orders</a>	Fluid orders (including TPN, other IVs, and feedings) based on the information in the <a href="#">Daily Fluids Form</a> .

**Note:** The precise page layout used for each type of document depends on a number of configuration settings. Among other options, you may configure the document to include or not include the header, footer, background frame, imprint area, logo, etc. Notice that the Admission Summary and Progress Note are formatted with these features turned on, while the Discharge Summary is formatted with most of them turned off.

## Queries and Reports

NeoData includes a powerful and flexible **Query and Report Module** which allows you to rapidly create a variety of user-defined **queries** (data searches) and **reports** (printouts of query results). With this feature, you can review and analyze patient information stored in the NeoData data file directly from within the program. Once configured, queries can be stored for repeated use.

Three different types of reports can be produced by the NeoData Query Module:

- **Spreadsheet Report:** A Spreadsheet report creates a vertical list of the patients or admissions in the Query Results list with one or more items of information for each arranged in columns. Information for a single patient or admission is displayed on a single line:

Pt Last Name	Pt First Name	Sex	Twin	Med Rec ID	Birth Date	Birth Weight	Gest Age
Patient2784		Female		27842784	5/8/04	0.547	23
Patient2764		Female		27642764	4/25/04	1.256	28
Patient2756		Female		27562756	4/18/04	1.109	28
Patient2748		Female	B	27482748	4/14/04	0.596	24
Patient2744		Female	A	27442744	4/14/04	0.749	25
Patient2728	Hannah	Female		27282728	4/6/04	1.116	31
Patient2720		Female		27202720	4/1/04	0.57	24
Patient2660		Female		26602660	3/1/04	0.573	23
Patient2476	Cierra	Female	B	24762476	1/13/04	0.79	25
Patient2456	Amber	Female	B	24562456	1/2/04	0.995	26
Patient2780		Male		27802780	5/5/04	0.856	24
Patient2672	Jamron	Male		26722672	3/11/04	1.204	28
Patient2656	Alexander	Male	B	26562656	2/26/04	1.42	32
Patient2648	Eduardo	Male	A	26482648	2/24/04	0.825	24
Patient2644	Marcus	Male		26442644	1/8/04	0.72	25

- **Statistics Report:** In a Statistics report, each cell in the report table displays statistical information pertaining to the patients or admissions which meet the cell's respective column and row conditions. A typical example of one type of Statistics report would be a crosstabulation of **admission outcomes** (discharged home, transferred, died, etc.) arranged horizontally (columns) versus **birth weight ranges** (500-1000 grams, 1001-1500 grams, etc.) arranged vertically (rows). The resulting table would show the number patients who had each particular outcome within each birth weight range:

	Discharged Home	Transfer Of Service	Acute Transfer	Convalescent Transfer	Died	Chronic Care	Totals
Birth Weight 501 - 1000	0 (0)	0 (0)	2 (3.28)	0 (0)	0 (0)	0 (0)	2 (3.28)
Birth Weight 1001 - 1500	7 (11.5)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	7 (11.5)
Birth Weight 1501 - 2000	12 (19.7)	0 (0)	0 (0)	2 (3.28)	0 (0)	0 (0)	14 (23.0)
Birth Weight 2001 - 2500	6 (9.84)	2 (3.28)	0 (0)	0 (0)	1 (1.64)	0 (0)	9 (14.8)
Birth Weight 2501 - 3000	3 (4.92)	5 (8.20)	1 (1.64)	0 (0)	0 (0)	0 (0)	9 (14.8)
Birth Weight 3001 - 3500	3 (4.92)	3 (4.92)	1 (1.64)	0 (0)	0 (0)	0 (0)	7 (11.5)
Birth Weight 3501 - 4000	3 (4.92)	5 (8.20)	0 (0)	1 (1.64)	0 (0)	0 (0)	9 (14.8)
Totals	34 (55.7)	15 (24.6)	4 (6.56)	3 (4.92)	1 (1.64)	0 (0)	57

- **Multiline Report:** Like a Spreadsheet report, a Multiline report creates a vertical list of the patients or admissions in the Query Results list. However, the information for each patient or admission can be displayed over multiple lines. In addition, Multiline reports can include one or more Subreports; these are supplemental tables of information (lab results, medications and dosages, etc.) that are included in each patient or admission section. In the example below, 6 report columns (on 2 lines) and 2 subreports (medications and procedures) are included in the report:

Last Name	First Name	Sex	Twin	Admission ID		
Patient2652		Male		27342734		
<b>Current Diagnoses</b>						
hydronephrosis, apnea of prematurity, gastroesophageal reflux, bronchopulmonary dysplasia, at risk for RSV						
Admission Medications	Start Date	End Date	Dose	Admission Procedures	Date	Comments/Results
ampicillin	2/26/04	2/28/04	185mg IV q 12hr	surfactant therapy	2/26/04	1st dose at 70 minutes of life; 2 doses total
gentamicin	2/26/04	2/28/04	8.3mg IV x1 dose	volume expansion	2/26/04	NS 10cc/kg
caffeine citrate	2/26/04	4/5/04	12mg IV q12 hrs.			
Last Name	First Name	Sex	Twin	Admission ID		
Patient2660		Female		27422742		
<b>Current Diagnoses</b>						
bronchopulmonary dysplasia, apnea of prematurity, necrotizing enterocolitis, status post ileostomy, nutritional support, retinopathy of prematurity stage 1						
Admission Medications	Start Date	End Date	Dose	Admission Procedures	Date	Comments/Results
ampicillin	3/1/04	3/3/04	57mg IV q12hrs	surfactant therapy	3/1/04	first dose at 20 min of age; 2 doses total
gentamicin	3/1/04	3/3/04	2.8mg IV x1 dose	UAC placement	3/1/04	
Aquaphor	3/1/04	3/11/04	to skin per protocol	volume expansion	3/1/04	10cc/kg normal saline x2
phenobarbital	3/1/04	3/1/04	6mg IV x1	blood transfusion	3/1/04	
dopamine	3/1/04	3/3/04	3mcg/kg/min	UVC placement	3/1/04	
				phototherapy	3/1/04	restarted: 11:30, 12/2

In addition, queries can be generated using **Microsoft Access** or most other Windows-based data management software. Access is a particularly good choice since it is both powerful and easy-to-use, includes extensive querying capabilities and excellent support for the industry-standard SQL language, and can be used with both **Access** and **SQL Server** databases.

## Other Features

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Some of the other features of the NeoData program are listed here. If the name of the feature is underlined, you may click on the name to see an example:

<a href="#"><u>Billing Support</u></a>	Automatic and manual entry of CPT billing codes and printout of weekly charge sheets and other billing reports.
<a href="#"><u>TPN Worksheet</u></a>	Complete TPN order entry module with built-in overrange warnings.
<a href="#"><u>Nutritional Calculations</u></a>	On-screen display of extensive nutritional calculations, based on the information in the <a href="#"><u>Daily Fluids Form</u></a> . These may also be included on the <b>Growth Charts</b> .
<b>Vermont Oxford Database Support</b>	Direct interface to the Vermont Oxford Network's <b>eNICQ</b> software providing automated enrollment of eligible patients and extraction of most VON data items from the inpatient database.
<b>Weekly Patient Summaries</b>	Printout of weekly patient summaries for billing support or for updates to referring physicians.
<b>FollowUp Clinic Module</b>	Patient enrollment, information tracking, and printout of clinic visit summaries.
<a href="#"><u>Growth Charts</u></a>	On-screen display and printout of growth and nutritional intake charts using various time scales.
<b>Lab Results Graphs</b>	On-screen display and printout of graphs of various lab values (e.g., WBC, serum sodium, arterial pO <sub>2</sub> ).
<b>Blood Gas Module</b>	Complete data entry system for blood gas results designed for use by NICU blood gas lab personnel; includes automated transfer of specimen results from a blood gas analyzer.
<b>Macros</b>	Predefined blocks of text which can be entered into a field with a few mouse clicks.
<b>Templates</b>	Predefined entries for entire groups of fields (physical exam, xrays, procedures) which can be recalled with a few mouse clicks.
<b>Spelling Checker</b>	Spell checking as data is entered with full control over which fields are checked.
<a href="#"><u>Patient Alerts</u></a>	Display informational messages, reminders, or warnings, and optionally insert standard text into progress notes, based on current patient status.
<b>Consults</b>	Enter information on consults outside the NICU (delivery room attendance, normal nursery consults, prenatal consults, etc.) and print notes for the chart. Billing charges can be entered and charge sheets printed for each consult.
<b>Management Protocols</b>	On-screen display of patient management protocols and/or any other text documents.
<b>Address List</b>	Rapid entry and recall of names and addresses.
<a href="#"><u>Calculators</u></a>	Medication drip calculator, gestational age calculator, standard arithmetic calculator, and general-purpose formula evaluator.
<b>Patient Export/Import</b>	Exporting and importing of patient information to or from an external file for use when transferring a patient between facilities.
<b>Support for Multiple NICU Teams</b>	Support for multiple teams or services with separate patient lists, creation and storage of <b>multiple progress notes per day</b> , and support for different user categories (e.g., Attendings, Residents, NNP's) with different data entry privileges and different progress notes.

## Configuration

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Given the complexity of a data system which attempts to capture most of the patient information handled by the NICU medical team each day, the ability to configure, or adapt, the program to the needs and work habits of a given NICU is crucial to the usefulness of the program. The program allows a **system administrator** (that person or persons responsible for the installation and management of the system) to configure the program in a number of ways.

Adding configurability to the program is and will continue to be an ongoing priority for MetaSoft. We welcome suggestions from users as to which features might be made configurable; wherever possible, we will add such capabilities as each new version is developed.

Some of the available configuration settings are listed below:

### General Program Behavior

- Patient identifier definitions
- Data entry customizations
- Macro definitions
- Control over which data items are carried forward from day to day
- Spell checking settings

### Data Entry Screens

- Number and order of data screens
- Organization of fields within screens
- Ability to create new data screens and to add new fields

### Documents

- Fonts, margins, borders, logos, imprint areas, barcodes, and other formatting options
- Control over document sections, their headings, and their order within the document
- Customization of most document text
- Creation of electronic documents for inclusion in hospital CPR
- Customization of [Round Sheets](#)

### Fluids

- Data entry customizations for TPN and other IVs
- Content of [Daily Fluid Orders](#)
- TPN additive defaults (vitamins, trace elements, etc.)
- Out-of-range alerts for nutritional calculations (e.g., total potassium)

### Drop-down Lists

- Content of all drop-down lists
- List names

### Field Parameters

- On-screen field labels
- Drop-down lists associated with text fields

- Out-of-range alerts for numeric fields
- Field status (normal, disabled, hidden, or required)

**Billing Features**

- Customization of the [Daily Charge Sheet](#)
- Automatic entry of bundled and procedure charges

**Security**

- Password protection of access to configuration screens and other functions
- Program login settings
- User login names and passwords
- User categories and associated privileges for all program functions
- Database type and login settings
- Auditing of logins, data viewing, and data entry

## HL7 Interface

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The **NeoData HL7 Module** is an optional add-on tool for exchanging information with other hospital systems.

NeoData uses the HL7 standard so that it can exchange information with any system that also supports HL7. This means that separate links to different hospital information systems (HIS) such as Cerner, EPIC, Meditech, etc. are not necessary. A single interface serves the purpose of linking to all these systems.

The **NeoData HL7 Module** supports the receipt of admissions and some labs and the sending of Patient Note text.

The **NeoData HL7 Module** receives admission information from the hospital system and converts it into a format that can be used by NeoData. The user can review admissions that were received from the interface and accept or reject the information that was received. They can also add to the information as they accept the patient into NeoData.

The **NeoData HL7 Module** receives lab values for existing patients from the hospital system and converts them into a format that can be used by NeoData. The lab values are made available for review by a clinician. In many cases, not all lab values will be accepted - just those that are appropriate for that day's progress note.

The core of NeoData provides the ability to generate electronic versions of patient notes and save them as files. These files can be in different formats such as RTF (Microsoft Word) and PDF (Adobe Acrobat). These files can be import into the hospital system for storage or even for electronic signatures.

HL7 also provides a standard for exchanging patient notes. The **NeoData HL7 Module** uses that standard to provide a means to send the text of a Patient Note directly to the hospital system.

For more information on the **NeoData HL7 Module**, including the detailed HL7 specification, contact Isoprime Sales at 630-955-0022.

## Licensing & Pricing

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### Licensing

Licensing for the NeoData system is per NICU. The software may be installed on any number of computers and may be used by any number of people as long as all operations are in support of a licensed NICU and the terms of the license are otherwise protected.

Several different licenses are available based on the maximum daily census which can reasonably be expected in your NICU. Note that you will need a license for the **maximum** number of patients expected on any given day. See the **Pricing** section below.

A **license agreement** signed by both parties is required. A **maintenance agreement** is an integral part of each license; this agreement provides for unlimited technical support and program upgrades. Your site will be invoiced for an annual maintenance fee based on the amount of the original license fee. The first maintenance fee is due 12 months after signing of the license agreement.

**Multi-site licensing** is available with pricing discounts for the additional units.

### Pricing

<u>License</u>	<u>License Fee</u>	<u>Maintenance Fee</u>
<b>Core System License</b> (Uses Access or SQL Server database engine)		
Limited (15 beds)	\$10,000	\$1,500
Limited (25 beds)	\$12,000	\$1,800
Limited (45 beds)	\$15,000	\$2,250
Unlimited	\$18,000	\$2,700
<b>HL7 Interface Module</b>		
One test server and one production server	\$7,000	\$1,050
<b>Multi-Site</b>		
Contact Isoprime Sales	630-955-0022	

## Using the Demo Program

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Isoprime provides a **Demonstration Version** of NeoData free of charge; you may request a copy on our [web site](#) or by contacting [Isoprime](#).

### After installing the demo program:

1. Review the **Installation Notes**.
2. Review the **Getting Started Tutorial**. The tutorial can be accessed from within the program itself via the **Help menu**.
3. Familiarize yourself with the **NeoData Help document**. The Help document can be accessed by selecting **NeoData Help** from the NeoData Demonstration program folder or from within the program itself via the **Help menu**.
4. For information on configuring the program, see the chapter titled **System Administration** in the Help document.

**Note: Administration functions** and **billing functions** each require a **password**; these passwords are case-insensitive (they may be entered in either uppercase or lowercase) and may be changed if desired. The default passwords are:

**Administration Password:** nicu4321

**Billing Password:** charges

## Further Information

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### Isoprime Web Site:

If you are interested in a more detailed look at the NeoData system, we recommend that you obtain a copy of the [Demonstration Version](#) of the program. You can request a copy of the demo program on our web site at:

<http://www.isoprime.com>

### Contacting Isoprime:

If you have any other questions, you can contact Isoprime as follows

<b>Address:</b>	Isoprime Corporation 4300 Commerce Court Suite 315 Lisle, IL 60532
<b>Office Phone:</b>	630-955-0022
<b>Office Fax:</b>	630-955-0088
<b>Email:</b>	isosupport@isoprime.com

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# Sample Data Screens

## Select Patient Form

NeoData - Neodata.mdb

File Edit View Procedures Tools Help

Exit All Forms ShortCuts Macros SamplePatient Fe 1234567

Forms	Current Patients	Move	Remove	Refresh	Other																																																																																								
<ul style="list-style-type: none"> <li>SelfPt</li> <li>Preg</li> <li>Birth</li> <li>Admit</li> <li>Exam</li> <li>Resp</li> <li>Fluids</li> <li>Daily</li> <li>Track</li> <li>Diags</li> <li>XRay</li> <li>Lab1</li> <li>Lab2</li> <li>Disch</li> <li>Summ</li> <li>Other</li> </ul>	<table border="1"> <thead> <tr> <th>Bed</th> <th>Last Name</th> <th>Sx</th> <th>Tw</th> <th>Med Rec ID</th> <th>Admission ID</th> <th>Birth Date</th> <th>Admit Date</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>SamplePatient</td> <td>Fe</td> <td></td> <td>6053433</td> <td>1234567</td> <td>4/3/04</td> <td>4/3/04</td> </tr> <tr> <td>2</td> <td>Patient1</td> <td>Ma</td> <td></td> <td>373373</td> <td>1800001</td> <td>3/29/04</td> <td>3/29/04</td> </tr> <tr> <td>3</td> <td>Patient2</td> <td>Ma</td> <td>A</td> <td>376012</td> <td>1800002</td> <td>4/30/04</td> <td>4/30/04</td> </tr> <tr> <td>4</td> <td>Patient6</td> <td>Ma</td> <td></td> <td>376337</td> <td>1800006</td> <td>5/3/04</td> <td>5/3/04</td> </tr> <tr> <td>5</td> <td>Patient2</td> <td>Ma</td> <td>B</td> <td>376013</td> <td>1800003</td> <td>4/30/04</td> <td>5/9/04</td> </tr> <tr> <td>6</td> <td>Patient4</td> <td>Fe</td> <td></td> <td>365932</td> <td>1800004</td> <td>3/21/04</td> <td>3/21/04</td> </tr> <tr> <td>7</td> <td>Patient5</td> <td>Fe</td> <td></td> <td>371136</td> <td>1800005</td> <td>5/7/04</td> <td>5/17/04</td> </tr> <tr> <td>8</td> <td>Patient7</td> <td>Ma</td> <td></td> <td>378929</td> <td>1800007</td> <td>6/2/04</td> <td>6/6/04</td> </tr> <tr> <td>9</td> <td>Patient8</td> <td>Ma</td> <td></td> <td>379037</td> <td>1800008</td> <td>6/7/04</td> <td>6/7/04</td> </tr> <tr> <td>10</td> <td>Patient9</td> <td>Ma</td> <td></td> <td>374606</td> <td>1800009</td> <td>3/19/04</td> <td>4/13/04</td> </tr> </tbody> </table>	Bed	Last Name	Sx	Tw	Med Rec ID	Admission ID	Birth Date	Admit Date	1	SamplePatient	Fe		6053433	1234567	4/3/04	4/3/04	2	Patient1	Ma		373373	1800001	3/29/04	3/29/04	3	Patient2	Ma	A	376012	1800002	4/30/04	4/30/04	4	Patient6	Ma		376337	1800006	5/3/04	5/3/04	5	Patient2	Ma	B	376013	1800003	4/30/04	5/9/04	6	Patient4	Fe		365932	1800004	3/21/04	3/21/04	7	Patient5	Fe		371136	1800005	5/7/04	5/17/04	8	Patient7	Ma		378929	1800007	6/2/04	6/6/04	9	Patient8	Ma		379037	1800008	6/7/04	6/7/04	10	Patient9	Ma		374606	1800009	3/19/04	4/13/04				
Bed	Last Name	Sx	Tw	Med Rec ID	Admission ID	Birth Date	Admit Date																																																																																						
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9	Patient8	Ma		379037	1800008	6/7/04	6/7/04																																																																																						
10	Patient9	Ma		374606	1800009	3/19/04	4/13/04																																																																																						

All Current Patients  
 Patient Search:  
 Last Name:   
 First Name:   
 Sex:   
 Med Rec ID:   
 Admission ID:   
 Birth Date:   
 To:   
 Admit Date:   
 To:   
 Disch Date:   
 To:   
 Multiple Births   
 Readmissions   
 Current Inpatients

**Patient Name:** SamplePatient, Nichole (Girl)      **Current Age:** 0 days  
**Med Rec ID:** 6053433      **Admission ID:** 1234567  
**Birth Date:** 4/3/04      **Admission Date:** 4/3/04  
**Birth Weight:** 0.852 kg      **Admission Weight:** 0.852 kg  
**Gestation At Birth:** 27 weeks 0 days      **Current Gestation:** 27 weeks 0 days  
**Mother's Name:** SamplePatient, Donna

Function:    
 Spell Check   
 03-Apr-2004 14:40:44

## Pregnancy Information Form

NeoData - Neodata.mdb				
File Edit View Procedures Tools Help				
Exit All Forms ShortCuts Macros		SamplePatient Fe 1234567		
<b>Forms</b> SelPt Preg Birth Admit Exam Resp Fluids Daily Track Diags XRay Lab1 Lab2 Disch Summ Other	<b>Maternal Information</b> Mat Last Name: SamplePatient Mat First Name: Donna Mat Admission ID: 1234566 Mat Med Rec ID: Mat Birth Date: 6/16/83 Mat Age: 20 Gravida: 3 Para: 3 Term: Preterm: Abortus: Living: SSN: 227-74-6218 Marital Status: City: Jeffersonville State: VA County: Jefferson ZipCode: 22222		<b>Pregnancy and Labor</b> Mat Transfer From: Birth Hospital: Jefferson Regional Medical Center Primary OB: Delivering OB: EDC: 4/9/02 Gestation by OB: wk: 27 d: Labor: spontaneous Prenatal Care: adequate Steroid Doses: 4 Last Date: 4/1/04 Tocolysis: terbutaline VO Steroids: Pregnancy Complications: bleeding pregnancy-induced hypertension Pregnancy Medications: antihypertensive medication Labor Complications: premature onset of labor partial abruption Labor Medications: Pregnancy and Labor Addendum: Mother was admitted on the morning of delivery with bleeding. Ultrasound showed a partial abruption and an emergency cesarean section was done.	
	<b>Maternal Lab Results</b> Blood Type: A pos Syphilis Ab: nonreactive On: 11/4/03 HBsAg: negative On: 11/4/03 HIV: negative On: 11/4/03 Rubella: immune On: 11/4/03 GBS Culture: On: Other Maternal Lab Results:			
	<b>Patient Name:</b> SamplePatient, Nichole (Girl) <b>Med Rec ID:</b> 6053433 <b>Birth Date:</b> 4/3/04 <b>Birth Weight:</b> 0.852 kg <b>Gestation At Birth:</b> 27 weeks 0 days <b>Mother's Name:</b> SamplePatient, Donna		<b>Current Age:</b> 0 days <b>Admission ID:</b> 1234567 <b>Admission Date:</b> 4/3/04 <b>Admission Weight:</b> 0.852 kg <b>Current Gestation:</b> 27 weeks 0 days	
			Function: Off Refresh Spell Check Calc 03-Apr-2004 14:40:44	

## Birth Information Form

NeoData - Neodata.mdb
SamplePatient Fe 1234567

File Edit View Procedures Tools Help
Exit All Forms ShortCuts Macros

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Fluids
- Daily
- Track
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ
- Other

**Delivery**

Duration RDM:

Amniotic Fluid:

Presentation:

Delivery:

Anesthesia:

Indications for C/Section:

Delivery Site:

**Birth Information**

Pt Last Name:

Pt First Name:

Med Rec ID:  Other ID:

Sex:  Twin:

Birth Date:  Birth Order: #  of

Birth Time:  Gestation: wk:  d:

Birth Weight:  kg

Birth Length:  cm Growth:

Birth HeadCirc:  cm Race:

**Resuscitation**

Apgars: 1 Min:  5 Min:  10 Min:  Died in DR:

Cord Gases: pH  pCO2  pO2  HCO3  BE

Venous/Unspec:

Arterial:

DR Condition:

DR Treatment:

Delivery Addendum:

CRIB Acuity Score:  [CRIB Worksheet](#)

**Patient Name:** SamplePatient, Nichole (Girl)

**Med Rec ID:** 6053433

**Birth Date:** 4/3/04

**Birth Weight:** 0.852 kg

**Gestation At Birth:** 27 weeks 0 days

**Mother's Name:** SamplePatient, Donna

**Current Age:** 0 days

**Admission ID:** 1234567

**Admission Date:** 4/3/04

**Admission Weight:** 0.852 kg

**Current Gestation:** 27 weeks 0 days

Function:  [Refresh](#)

Spell Check [Calc](#)

03-Apr-2004 14:40:44

## Admission Information Form

NeoData - Neodata.mdb
\_ □ ×

File Edit View Procedures Tools Help

Exit All Forms ShortCuts Macros SamplePatient Fe 1234567

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Fluids
- Daily
- Track
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ
- Other

**Admission Information**

Admission Type: following delivery

Admission ID: normal nursery

Admission #: acute transport

Admission Time: chronic transport

Admission Time: admission from home

Admission Time: transfer of service

Admission Indications: prematurity

Admission Indications: respiratory distress

Referring Ped:

Referring Serv:

Referring Hosp:

Admit Weight: 0.852 kg

Admit Length: 34.0 cm

Admit HeadCirc: 25.0 cm

Admit Attending MD: William W. Lowe, MD

Admit Prepared By:

**Other Admissions**

Hospital	Admit Date	Disch Date

**Addenda**

Transport Addendum:

Admission Addendum: On admission to the NICU, the patient was pink with mild respiratory distress. She was placed on a ventilator.

<b>Patient Name:</b> SamplePatient, Nichole (Girl)	<b>Current Age:</b> 0 days	<b>Function:</b> Off
<b>Med Rec ID:</b> 6053433	<b>Admission ID:</b> 1234567	<input type="button" value="Refresh"/>
<b>Birth Date:</b> 4/3/04	<b>Admission Date:</b> 4/3/04	<input checked="" type="checkbox"/> Spell Check
<b>Birth Weight:</b> 0.852 kg	<b>Admission Weight:</b> 0.852 kg	<input type="button" value="Calc"/>
<b>Gestation At Birth:</b> 27 weeks 0 days	<b>Current Gestation:</b> 27 weeks 0 days	03-Apr-2004 14:40:44
<b>Mother's Name:</b> SamplePatient, Donna		

Physical Exam Form

NeoData - Neodata.mdb

File Edit View Procedures Tools Help

Exit Progress Note ShortCuts Macros Date 4/10/04 7d 28wk0d SamplePatient Fe 1234567

Forms SelPt Exam Resp Fluids Daily Track Diags XRay Lab1 Lab2	<b>Daily Measurements</b> Curr Weight: 0.909 kg Prev Weight: 0.872 kg On: 4/9/04 Change: Up 37g Length: 34.5 cm Service: 1 HeadCirc: 25.7 cm Pain Score:	<b>Physical Findings</b> HEENT: soft and flat fontanelle overlapping sutures Resp: good air exchange bilaterally fine scattered crackles good respiratory effort Cardiac: normal sinus rhythm good perfusion strong and equal pulses Abd: soft and nondistended abdomen moderately decreased bowel sounds	GU: Neuro: responsive but quiet mental status decreased tone generally Neck & Spine: Extrem: Skin:	
	<b>Vital Signs</b> Overall Status: Type of Bed: Temperature: normal Heart Rate: 152-168 Resp Rate: 40-60 Blood Press: 52/32 Urine Output: 4.3ml/kg/h Gluc Screen: 80-120mg% Stool: none in 48 hours Urinalysis: 1+ proteinuria Condition: pink quiet Resp Distress: minimal	clavicular fracture cystic hygroma cervical meningocele thoracic meningocele lumbar meningocele lipomeningocele swelling of the neck webbing of the neck loose skin over the neck hyperextension of the spine	<input type="checkbox"/> Normal Exam <input type="checkbox"/> Except For Above Findings <input type="checkbox"/> Exam Unchanged	Exam Templates    Clear All Fields
	HEENT: Soft and flat fontanelle and overlapping sutures. RESPIRATORY: Good air exchange bilaterally, fine scattered crackles and good respiratory effort. CARDIAC: Normal sinus rhythm, good perfusion and strong and equal pulses. ABDOMEN: Soft and nondistended abdomen and moderately decreased bowel sounds. NEUROLOGIC: Responsive but quiet mental status and decreased tone generally.	Function: Text    Refresh <input checked="" type="checkbox"/> Spell Check    Calc 10-Apr-2004 14:40:44		

## Respiratory Support Form

NeoData - Neodata.mdb
Date: 4/10/04 7d 28wk0d SamplePatient Fe 1234567

Exit Progress Note ShortCuts Macros

**Respiratory Support**  Print This Group

Support: ventilator Since: 4/3/04

**Oxygen**  
 FIO2: 0.21 min Flow: 6.0 ml or liter  
 FIO2: max INO: ppm

**Jet Ventilation**  
 PIP: cmH2O  
 Rate: IT: sec

**PEEP**  
 PEEP: 4 cm H2O

**Conventional Ventilation**  
 PIP: 14 Pr Supp:  
 Tid Vol: ml ml/kg  
 Rate: 20 IT: 0.5 sec  
 Mode: MAP: cmH2O

**Oscillator Ventilation**  
 Mean Press: Amplitude: cmH2O  
 Frequency: Hz

**Other**  
 Other Settings:  
 O2 Sats:

**Apnea and Bradycardia**  Print This Group

Apnea: 2  
 Brady Without Apnea: 1

**ECMO**  Print This Group

Started: At: Hours:  
 Ended: At:  
 Access: Wound:  
 Flow: ml/min  
 SvO2: %  
 Gases: pCO2: pO2:  
 Coags: ACT: sec Fibr: mg/dl  
 Carbogen: Flow: L/min CO2: %

**Blood Gases**  Show All Print: Last 2 Items

Date	Time	Type	pH	pCO2	pO2	HCO3	BE	Support	FIO2	Flow	PEEP	PIP	TV	Rate	IT	Mode
4/7/04	03:55	CBG	7.313	32	30	18.0	-8.6	ventilator	0.21	6.0	4	14	20	0.4	IMV	
4/8/04	19:47	CBG	7.318	30	59	15.3	-9.1	ventilator	0.21	6.0	4	14	20	0.4	IMV	
4/9/04	04:02	CBG	7.317	33	48	16.8	-7.9	ventilator	0.21	6.0	4	14	20	0.4	IMV	
4/9/04	08:40	ABG	7.271	28	87	13.1	-12.1	ventilator	0.21	6.0	4	14	20	0.4	IMV	
4/9/04	20:05	CBG	7.3	33	41	16.1	-8.9	ventilator	0.21	6.0	4	14	20	0.4	IMV	
4/10/04	03:47	CBG	7.309	33	42	16.5	-8.4	ventilator	0.21	6.0	4	14	20	0.4	IMV	
4/10/04	17:03	CBG	7.292	38	44	18.1	-7.5	ventilator	0.21	6.0	4	14	20	0.4	IMV	

<b>Patient Name:</b> SamplePatient, Nichole (Girl)	<b>Current Age:</b> 7 days	<b>Function:</b> Off <span style="float: right;">Refresh</span>
<b>Med Rec ID:</b> 6053433	<b>Admission ID:</b> 1234567	<input checked="" type="checkbox"/> Spell Check <span style="float: right;">Calc</span>
<b>Birth Date:</b> 4/3/04	<b>Admission Date:</b> 4/3/04	10-Apr-2004 14:40:44
<b>Birth Weight:</b> 0.852 kg	<b>Admission Weight:</b> 0.852 kg	
<b>Gestation At Birth:</b> 27 weeks 0 days	<b>Current Gestation:</b> 28 weeks 0 days	
<b>Mother's Name:</b> SamplePatient, Donna		

### Daily Fluids Form

NeoData - Neodata.mdb

File Edit View Procedures Tools Help

Exit Progress Note ShortCuts Macros Date 4/10/04 7d 28wk0d SamplePatient Fe 1234567

**Forms**

- SelfPt
- Exam
- Resp
- Fluids
- Daily
- Track
- Diags
- XRay
- Lab1
- Lab2

**Total Fluids**

Curr Weight:  kg  
 Old:  kg

Calc Weight:  kg  
 Old:

Tot Fluids:  ml/kg/d  
 Old:

Enter Actual Volume

**New Enteral Fluids (use drag & drop to change order of fluids)**

Date	Formula/Supplement	Strength kcal/oz	Amount	Units	Schedule	Time hours	Route	Incr To ml	Incr By
4/10/04	Enfamil Premature 24	12.0	1.0	ml	continuous (6/2)	24.0	OG		

**Old Enteral Fluids (use drag & drop to copy Old fluids to New)**

4/8/04	Sterile Water		0.5	ml	continuous (6/2)	24.0	OG		
4/9/04	Enfamil Premature 24	6.0	1.0	ml	continuous (6/2)	24.0	OG		

**New IV Fluids**

Date	Dex gm/dl	Dex gm/kg	Normal Saline	Normal NaAc	AA gm/kg	Lipid gm/kg	Lipid Conc	NaCl mEq/kg	NaAc mEq/kg	NaPh mEq/kg	KCl mEq/kg	KAc mEq/kg	KPh mEq/kg	Ca mEq/kg	Mg mEq/kg	Hep U/ml	Rate ml/h	Time hours	Route
4/10/04	11.0	11.3			2.0			1.0	2.0		1.0		1.5	1.5	0.25	0.50	3.9	24.0	PCVC
4/10/04						2.53	20%										0.5	23.0	

**Old IV Fluids (use drag & drop to copy Old fluids to New)**

4/8/04	12.0				2.5			1.0	1.0			0.5	1.0	1.5	0.2	0.50	4.1		PIV
4/8/04						2.32	20%										0.4	24.0	
4/9/04	12.5				2.5			2.0	3.0				1.5	1.5	0.2	0.50	3.9		PIV
4/9/04						2.2	20%										0.4	24.0	

Date	Time	Na	K	Cl	CO2	BUN	Creat	Gluc	Ca	Phos	Mg	Anion Gap	Other
4/8/04	04:10	135	4.6										
4/9/04	05:00	128	4.9	104	14.0	6	1.1	49	9.7	4.1	2.3		
4/10/04	05:00	126	5.0	103	14.0	6	1.1	86	9.2				
4/10/04	09:23	130											

Function: Chemistry 1

Spell Check

10-Apr-2004 14:40:44

## Other Daily Information Form

NeoData - Neodata.mdb

File Edit View Procedures Tools Help

Exit All Forms ShortCuts Macros Date 4/10/04 7d 28wk0d SamplePatient Fe 1234567

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Fluids
- Daily**
- Track
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ
- Other

**Other Fluid Information**  Print This Group

Actual Intake Prev 24h: 133.0 ml Total 146.0 ml/kg/d

Actual Output Prev 24h: 69.0 ml Total 3.2 ml/kg/hr

Tolerating Feeds:

Oral Feeding Schedule:

Tolerating Oral Feeds:

Fluids Comments:

Fluids Plans:

**Other Daily Information**

Daily Addendum:

Attending Addendum:

Daily Attending MD:

Progress Note Prepared By:

Report Sheet Memos:

**Supplemental Notes** Add Delete Refresh Preview Print Templates

Date	Time	Note Type	Procedure	Attending MD	Prepared By	Comments
4/10/04	14:30	procedure	central venous catheter (percutaneous)	William W. Lowe, MD	Preparer #2	The site was prepared with iodine s without difficulty. The patient tolerat

**Patient Name:** SamplePatient, Nichole (Giri) **Current Age:** 7 days

**Med Rec ID:** 6053433 **Admission ID:** 1234567

**Birth Date:** 4/3/04 **Admission Date:** 4/3/04

**Birth Weight:** 0.852 kg **Admission Weight:** 0.852 kg

**Gestation At Birth:** 27 weeks 0 days **Current Gestation:** 28 weeks 0 days

**Mother's Name:** SamplePatient, Donna

Function:  Refresh

Spell Check Calc

10-Apr-2004 14:40:44

### Tracking Information Form

NeoData - Neodata.mdb
Date: 6/6/04 64d 36wk1d SamplePatient Fe 1234567

File Edit View Procedures Tools Help
Exit All Forms ShortCuts Macros

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Fluids
- Daily
- Track
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ
- Other

**Tracking**  Print This Group

ROP screen indicated 7/15/97  
hearing screen indicated at 6 months adjusted age  
intracranial screen not indicated

Circumcision Date:

ROP screen indicated  
ROP screen not indicated  
hearing screen indicated  
hearing screen not indicated  
newborn screen indicated  
newborn screen not indicated  
car seat screen indicated  
car seat screen not indicated  
intracranial screen indicated  
intracranial screen not indicated

**Screening Studies**

Date	Study Name	Results
4/24/04	Newborn Screen	all normal results A repeat hemoglobin screen is needed 4 mos
5/25/04	Hearing Screen	normal
6/6/04	ROP Screen	Stage 1 ROP Zone 2-3 bilaterally

**Immunization/Prophylaxis**  Add  Delete  Refresh  Print

Date	Immunization	Next Due
6/2/04	Hepatitis B	4/14/02
6/2/04	DPT	5/15/02
6/2/04	HiB	5/15/02

**Discharge Planning**  Print This Group

home monitor indicated  
home oxygen not indicated

Discharge MD:

Discharge Plans:

<b>Patient Name:</b> SamplePatient, Nichole (Girl)	<b>Current Age:</b> 64 days	<b>Function:</b> Off <input type="button" value="Refresh"/>
<b>Med Rec ID:</b> 6053433	<b>Admission ID:</b> 1234567	<input checked="" type="checkbox"/> Spell Check <input type="button" value="Calc"/>
<b>Birth Date:</b> 4/3/04	<b>Admission Date:</b> 4/3/04	<b>06-Jun-2004 14:40:44</b>
<b>Birth Weight:</b> 0.852 kg	<b>Admission Weight:</b> 0.852 kg	
<b>Gestation At Birth:</b> 27 weeks 0 days	<b>Current Gestation:</b> 36 weeks 1 days	
<b>Mother's Name:</b> SamplePatient, Donna		

## Problems and Diagnoses Form

NeoData - Neodata.mdb
Date: 6/6/04 64d 36wk1d
SamplePatient Fe 1234567

File Edit View Procedures Tools Help
Exit Discharge ShortCuts Macros

Diagnoses	System	Modifier	Severity	Onset	Resolved	
respiratory distress syndrome	01:Resp		moderate	4/3/04	4/9/04	
possible sepsis - ruled out	03:Infect			4/3/04	4/5/04	
physiologic jaundice	07:Hepatic			4/3/04	4/16/04	
patent ductus arteriosus	02:Cardiac			4/4/04	4/7/04	
apnea of prematurity	05:Neuro			4/7/04		
pulmonary insufficiency of prematurity	01:Resp		mild	4/9/04	6/1/04	
nutritional support	16:FEN			4/10/04	4/17/04	

Comments: No clinical signs of PDA were noted following the second course of indomethacin.

Status:

Meds And Procs  
 Old Comments  
 Final Comments

Plans:

Medications	Start Date	Time	End Date	Dose	Days	Assoc Diagnosis
indomethacin	4/4/04		4/5/04		1 total	patent ductus arteriosus
indomethacin	4/6/04		4/7/04		1 total	patent ductus arteriosus

Procedures	Date	Time	End Date	Comments/Results	Assoc Diagnosis
echocardiogram	4/4/04		4/4/04	moderate PDA with left to right shunt; mil	patent ductus arteriosus
echocardiogram	4/5/04		4/5/04	small to moderate PDA with left to right s	patent ductus arteriosus
echocardiogram	4/7/04		4/7/04	normal; no PDA	patent ductus arteriosus

**PATENT DUCTUS ARTERIOSUS**  
 ONSET: 4/4/04 RESOLVED: 4/7/04  
 MEDICATIONS: Indomethacin from 4/4/04 to 4/5/04 (1 days total); Indomethacin from 4/6/04 to 4/7/04 (1 days total).  
 PROCEDURES: Echocardiogram on 4/4/04 (moderate PDA with left to right shunt; mild TR); Echocardiogram on 4/5/04 (small to moderate PDA with left to right shunt); Echocardiogram on 4/7/04 (normal; no PDA).

Function:  
 Refresh  
 Spell Check Calc  
06-Jun-2004 14:40:44

## Radiology Studies Form

NeoData - Neodata.mdb
File Edit View Procedures Tools Help

Exit
All Forms
ShortCuts
Macros
Date
4/10/04 7d 28wk0d
SamplePatient Fe 1234567

Forms	Radiology Studies					Studies To Display
	Date	Time	Category	Study Name	Results	
SelfPt	4/3/04	10:40	Chest	chest xray	severe reticulogranularity decreased expansion ET tube in good position UAC at T6	<input type="radio"/> Chest Xrays
Preg	4/3/04	11:20	Cranial	cranial ultrasound	normal findings	<input type="radio"/> Abdominal Xrays
Birth	4/4/04	05:30	Chest	babygram	diffuse haziness bilaterally fluid in the fissures normal heart size	<input type="radio"/> Cranial Studies
Admit	4/5/04	05:00	Chest	chest xray	ET tube in good position bilaterally hazy interstitial streakiness decreased expansion	<input type="radio"/> Other Studies
Exam	4/6/04	13:20	Cranial	cranial ultrasound	normal heart size normal findings	<input checked="" type="radio"/> All Studies
Resp	4/7/04	05:40	Chest	chest xray	clearing of mild haziness bilaterally ET slightly high normal expansion	
Fluids	4/9/04	05:00	Chest	chest xray	normal heart size essentially clear lung fields	
Daily						
Track						
Diags						
XRay						
Lab1						
Lab2						
Disch						
Summ						
Other						

<b>Patient Name:</b> SamplePatient, Nichole (Girl)	<b>Current Age:</b> 7 days	<b>Function:</b> Off
<b>Med Rec ID:</b> 6053433	<b>Admission ID:</b> 1234567	<input type="button" value="Refresh"/>
<b>Birth Date:</b> 4/3/04	<b>Admission Date:</b> 4/3/04	<input checked="" type="checkbox"/> Spell Check <input type="button" value="Calc"/>
<b>Birth Weight:</b> 0.852 kg	<b>Admission Weight:</b> 0.852 kg	
<b>Gestation At Birth:</b> 27 weeks 0 days	<b>Current Gestation:</b> 28 weeks 0 days	
<b>Mother's Name:</b> SamplePatient, Donna		<b>10-Apr-2004 14:40:44</b>

### Lab Results 1 Form

NeoData - Neodata.mdb
Date: 4/10/04 7d 28wk0d    SamplePatient Fe 1234567

Exit    All Forms    ShortCuts    Macros

Forms    **Hematology**     Show All    ± Print: Last 2 Items    Add Delete Refresh Print

Date	Time	WBC x10 <sup>6</sup>	Hgb gm/dl	Hct %	Plat x10 <sup>3</sup>	S	B	L	M	Eo	Ba	AL	Me	My	NRBC	Retic %	Other
4/3/04	22:00	10.9	13.4	40.4	285	52	0	41	4	2	1				2		
4/4/04	05:00	10.1	15.0	44.4	260	52	1	44	3								
4/5/04	05:00	10.8	13.4	39.8	206	41	1	50	6	2							
4/6/04	05:00			50.0													
4/9/04	07:45	8.0	14.9	44.5	263	30	2	54	12	2							
4/10/04	05:00	12.0	13.4	39.5	325	18	16	44	17	5							

Forms    **Chemistry 1**     Show All    ± Print: Last 2 Items    Add Delete Refresh Print

Date	Time	Na mEq/l	K mEq/l	Cl mEq/l	CO2 mEq/l	BUN mg/dl	Creat mg/dl	Gluc mg/dl	Ca mg/dl	Phos mg/dl	Mg mEq/l	Anion Gap	Other
4/6/04	20:00	138	5.3	111	18.0	7	1.0	81				14.3	
4/7/04	07:15	137	4.5	111	17.0	7	1.0	101				13.5	
4/8/04	04:10	135	4.6										
4/9/04	05:00	128	4.9	104	14.0	6	1.1	49	9.7	4.1	2.3	14.9	
4/10/04	05:00	126	5.0	103	14.0	6	1.1	86	9.2			14.0	
4/10/04	09:23	130											

Forms    **Chemistry 2**     Show All    ± Print: None    Add Delete Refresh Print

Date	Time	TBili mg/dl	DBili mg/dl	Trig mg/dl	AlkPh U/L	TProt g/dl	Alb g/dl	AST U/L	ALT U/L	GGT U/L	Other
4/4/04	05:05	3.3	0.1								
4/5/04	05:00	2.9	0.0								
4/6/04	05:00	4.6	0.0	54	180	4.6	2.5	50		156	
4/7/04	07:16	3.2	0.2								
4/8/04	04:10	3.4	0.1								
4/9/04	05:00	4.1	0.0	122	284	4.6	2.6	35		122	

<b>Patient Name:</b> SamplePatient, Nichole (Girl)	<b>Current Age:</b> 7 days	<b>Function:</b> Off
<b>Med Rec ID:</b> 6053433	<b>Admission ID:</b> 1234567	<span>Refresh</span>
<b>Birth Date:</b> 4/3/04	<b>Admission Date:</b> 4/3/04	<input checked="" type="checkbox"/> Spell Check <span>Calc</span>
<b>Birth Weight:</b> 0.852 kg	<b>Admission Weight:</b> 0.852 kg	
<b>Gestation At Birth:</b> 27 weeks 0 days	<b>Current Gestation:</b> 28 weeks 0 days	
<b>Mother's Name:</b> SamplePatient, Donna		<b>10-Apr-2004 14:40:44</b>

### Lab Results 2 Form

NeoData - Neodata.mdb
File Edit View Procedures Tools Help

Exit
All Forms
ShortCuts
Macros
Date
4/10/04 7d 28wk0d
SamplePatient Fe 1234567

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Fluids
- Daily
- Track
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ
- Other

Cultures				
Date	Time	Culture Type	Result	Comments
4/3/04	09:50	blood	negative	
4/3/04	11:30	urine BAD	negative	
4/3/04	11:20	blood	negative	
4/10/04	09:45	blood	negative	

Drug Levels					
Date	Time	Drug Type	Interval	Level	Comments
4/4/04	10:00	gentamicin		24	1.3
4/10/04		vancomycin		24	10.8

Other Labs				
Date	Time	Lab Type	Results	Comments
4/3/04	09:50	Blood Type	A positive	
4/3/04	09:50	Direct Coombs	negative	
4/3/04	09:50	RPR	non reac	
4/4/04		Urine Drug Screen	neg	
4/4/04		MecStat	negative	

<p><b>Patient Name:</b> SamplePatient, Nichole (Girl)</p> <p><b>Med Rec ID:</b> 6053433</p> <p><b>Birth Date:</b> 4/3/04</p> <p><b>Birth Weight:</b> 0.852 kg</p> <p><b>Gestation At Birth:</b> 27 weeks 0 days</p> <p><b>Mother's Name:</b> SamplePatient, Donna</p>	<p><b>Current Age:</b> 7 days</p> <p><b>Admission ID:</b> 1234567</p> <p><b>Admission Date:</b> 4/3/04</p> <p><b>Admission Weight:</b> 0.852 kg</p> <p><b>Current Gestation:</b> 28 weeks 0 days</p>	<p>Function:</p> <p>Off <span style="float: right;">Refresh</span></p> <p><input checked="" type="checkbox"/> Spell Check <span style="float: right;">Calc</span></p> <p style="text-align: right; font-weight: bold;">10-Apr-2004 14:40:44</p>
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## Discharge Information Form

NeoData - Neodata.mdb

File Edit View Procedures Tools Help

Exit Discharge ShortCuts Macros SamplePatient Fe 1234567

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ

**Discharge Information**

Disch Type: discharged home

Disch Date: 6/6/04 Time:

Disch MD: Dr. Smith

Trans Hosp:

Indications for Transfer:

Cause of Death:

Discharge Problems: apnea of prematurity stage 1 ROP

Disch Weight: 2.265 kg

Disch Length: 45.5 cm

Disch HeadCirc: 32.0 cm

Circumcision Date:

Qualifies for Clinic:

**Extract**

**Treatment and Follow-Up**

Discharge Resp Support: room air

Discharge Feedings: Similac w/Fe ad lib

Disch Meds: Vitamin E 25IU PO qd

Disch Equip: apnea monitor

Disch Apptmts: Ophthalmology  
Developmental Clinic  
Home Health Nursing  
Physical Therapy

Other Follow-Up:

Discharge Addendum:

Discharge Attending MD: William W. Lowe, MD

Discharge Prepared By:

Discharge Summary Copies To: Dr. Smith

**Patient Name:** SamplePatient, Nichole (Girl) **Current Age:** 64 days

**Med Rec ID:** 6053433 **Admission ID:** 1234567

**Birth Date:** 4/3/04 **Admission Date:** 4/3/04

**Birth Weight:** 0.852 kg **Admission Weight:** 0.852 kg

**Gestation At Birth:** 27 weeks 0 days **Current Gestation:** 36 weeks 1 days

**Mother's Name:** SamplePatient, Donna

Function: Off Refresh

Spell Check Calc

06-Jun-2004 14:40:44



## Other Patient Information Form

NeoData - Neodata.mdb
\_ \_ X

File Edit View Procedures Tools Help

Exit All Forms ShortCuts Macros
SamplePatient Fe 1234567

**Forms**

- SelfPt
- Preg
- Birth
- Admit
- Exam
- Resp
- Fluids
- Daily
- Track
- Diags
- XRay
- Lab1
- Lab2
- Disch
- Summ
- Other

**Maternal Information**

SSN:  Marital Status:

Address1:

Address2:

City:  State:

County:  ZipCode:

Phone:

Maiden Name:

Social History:

Feeding Intention:

**Miscellaneous Patient Information**

Name Change 1:

Change Date 1:

Name Change 2:

Change Date:

Pt Insurance:

Insured SSN:

Alias:

**Final Patient Outcome**

Final Outcome Type:

Final Outcome Date:  Time:

Final Weight:  kg

Final Length:  cm

Final Head Circ:  cm

Final Hospital:

Final Resp Support:

Final Discharge Equipment:

Data Complete:

**Patient Name:** SamplePatient, Nichole (Girl)

**Med Rec ID:** 6053433

**Birth Date:** 4/3/04

**Birth Weight:** 0.852 kg

**Gestation At Birth:** 27 weeks 0 days

**Mother's Name:** SamplePatient, Donna

**Current Age:** 64 days

**Admission ID:** 1234567

**Admission Date:** 4/3/04

**Admission Weight:** 0.852 kg

**Current Gestation:** 36 weeks 1 days

Function:

Spell Check

06-Jun-2004 14:40:44



**Progress Note**

Cape Fear Valley Medical Center	
<b>SAMPLEPATIENTFE 1234567</b>	<b>PROGRESS NOTE PAGE 1 OF 2</b>
<b>04/10/2004</b>	
<p><b>Saturday, April 10, 2004</b>  <b>Printed: 7/5/04 10:51h</b></p> <p>AGE: 7d. ADJ GEST AGE: 28wk 0d. WEIGHT: 0.909kg (Up 37g).</p> <p><b>VITAL SIGNS &amp; PHYSICAL EXAM</b>            WEIGHT: 0.909kg LENGTH: 34.5cm HC: 25.7cm            TEMP: Normal HR: 152-168 RR: 40-60 BP: 52/32 URINE OUTPUT: 4.3ml/kg/h. GLUCOSE SCREENING: 80-120mg%. STOOL: None in 48 hours. URINALYSIS: 1+proteinuria.            CONDITION: Pink and quiet in minimal.            HEENT: Soft and flat fontanelle and overlapping sutures.            RESPIRATORY: Good air exchange bilaterally, fine scattered crackles and good respiratory effort.            CARDIAC: Normal sinus rhythm, good perfusion and strong and equal pulses.            ABDOMEN: Soft and nondistended abdomen and moderately decreased bowel sounds.            NEUROLOGIC: Responsive but quiet mental status and decreased tone generally.</p> <p><b>LABORATORY STUDIES</b>            4/9/04 07:45h: WBC:8.0X10<sup>3</sup> Hgb:14.9 Hct:44.5 PL:263X10<sup>3</sup> S30 B:2 L:54 M:12 Eo:2            4/10/04 05:00h: WBC:12.0X10<sup>3</sup> Hgb:13.4 Hct:39.5 Ph:325X10<sup>3</sup> S:18 B:16 L:44 M:17 Eo:5            4/10/04 05:00h: Na:126 K:5.0 Cl:103 CO2:14.0 BUN:6 Creat:1.1 Gluc:86 Ca:9.2            4/10/04 09:23h: Na:130            4/10/04 09:45h: blood culture: negative</p> <p><b>RADIOLOGY STUDIES</b>            Cranial ultrasound on 4/6/04 at 13:20h: Normal findings.            Chest xray on 4/9/04 at 05:00h: Essentially clear lung fields.</p> <p><b>CURRENT MEDICATIONS</b>            Caffeine citrate 8.5mg IV q12h started on 4/7/04 (completed 3 of 57 days)            Vancomycin 17.5mg IV q24h started on 4/9/04 (completed 1 days)            Cefotaxime 4.5mg IV q12h started on 4/9/04 (completed 1 days)</p> <p><b>RESPIRATORY SUPPORT</b>            SUPPORT: Ventilator since 4/3/04            FIO2: 0.21 RATE: 20 PIP: 14cmH2O PEEP: 4cmH2O IT: 0.30sec FLOW: 60/min            CBG 4/10/04 03:42h: pH:7.309 pCO2:33 pO2:42 Bicarb:16.5 BE:-8.4            CBG 4/10/04 17:03h: pH:7.292 pCO2:38 pO2:44 Bicarb:18.1 BE:-7.5</p> <p><b>CURRENT PROBLEMS &amp; DIAGNOSES</b>  <b>PULMONARY INSUFFICIENCY OF PREMATURITY MILD</b>            ONSET: 4/9/04 STATUS: Evolving            PROCEDURES: Blood transfusions (multiple) on 4/4/04 (last transfused 5/23).  <b>SUSPECTED SEPSIS</b>            ONSET: 4/10/04 STATUS: Active            MEDICATIONS: Vancomycin 17.5mg IV q24h started on 4/9/04 (completed 1 days); Cefotaxime 4.5mg IV q12h started on 4/9/04 (completed 1 days).            COMMENTS: Patient was started on antibiotics because of a change in respiratory status in conjunction with an abnormal CBC.            PLANS: Continue antibiotics and follow drug levels.  <b>AT RISK FOR APNEA</b>            ONSET: 4/7/04 STATUS: Active            MEDICATIONS: Caffeine citrate 8.5mg IV q12h started on 4/7/04 (completed 3 of 57 days).            COMMENTS: Started on caffeine on 4/18/97 in anticipation of extubation.</p>	
<b>SAMPLEPATIENTFE 1234567</b>	<b>PROGRESS NOTE PAGE 1 OF 2</b>
<b>04/10/2004</b>	
 <b>Jefferson Regional Medical Center</b>	<p><b>SamplePatient, Nichole (Girl)</b>  <b>Admission ID: 1234567</b>  <b>Birth Date: 4/3/04</b>  <b>Admit Date: 4/3/04</b></p>

## Discharge Summary

SAMPLEPATIENT FE 123456DISCHARGE SUMMARY PAGE 1 OF 4

06/06/2004

NAME: Sample Patient, Nichole (GIRL)  
 ADMITTED: 4/3/04  
 DISCHARGED: 6/6/04

ADMISSION ID: 1234567  
 MED REC ID: 6053433

### PREGNANCY & LABOR

G/P: G3 P3.

PRENATAL LABS: BLOOD TYPE A pos. SYPHILIS SCREEN: Nonreactive on 11/4/03. HEPATITIS SCREEN: Negative on 11/4/03. HIV SCREEN: Negative on 11/4/03. RUBELLA SCREEN: ~~Immune~~ on 11/4/03.

ESTIMATED DATE OF DELIVERY: 4/9/02. ESTIMATED GESTATION BY OE: 27 weeks. PRENATAL CARE

Adequate. PREGNANCY COMPLICATIONS: Bleeding and pregnancy-induced hypertension. PREGNANCY

MEDICATIONS: Antihypertensive medication. ANTENATAL STEROID DOSES: 4.

LABOR: Spontaneous. TOCOLYSIS: Terbutaline. BIRTH HOSPITAL: Jefferson Regional Medical Center. LABOR & DELIVERY COMPLICATIONS: Premature onset of labor and partial abruption.

Mother was admitted on the morning of delivery with bleeding. Ultrasound showed a partial abruption and an emergency cesarean section was done.

### BIRTH

DATE: 4/3/04 TIME: 09:23 hours

WEIGHT: 0.852kg LENGTH: 34.0cm HC: 25.0cm

GEST AGE: 27 weeks GROWTH: AGA

RUPTURE OF MEMBRANES: At delivery. AMNIOTIC FLUID: Clear. PRESENTATION: Vertex DELIVERY:

Emergency cesarean section. INDICATION: Suspected abruption. SITE: In the delivery room. ANESTHESIA: General

APGARS: 8 at 1 minute, 8 at 5 minutes. CORD pH: 7.29. CONDITION AT DELIVERY: Active, cyanotic and responsive.

TREATMENT AT DELIVERY: Stimulation, oral suctioning and endotracheal tube ventilation.

The infant was vigorous at birth with good spontaneous activity and respiratory effort, but air exchange was poor. She was suctioned and given free-flow O2, then intubated with a 2.5 ETT.

### ADMISSION

ADMISSION DATE 4/3/04 TIME: 09:30 hours

ADMISSION TYPE: Immediately following delivery. FOLLOW-UP PHYSICIAN: Dr. Smith. ADMISSION

INDICATIONS: Prematurity and respiratory distress.

On admission to the NICU, the patient was pink with mild respiratory distress. She was placed on a ventilator.

### ADMISSION PHYSICAL EXAM

WEIGHT: 0.852kg LENGTH: 34.0cm HC: 25.0cm

TEMP: 97.2. HR: 160. RR: 44. BP: 39/24. GLUCOSE SCREENING: 40-80mg%.

CONDITION: Pink and quiet in mild.

HEENT: Soft and flat fontanelle, opposed sutures, ET tube in place, red reflex bilaterally and patent nares.

RESPIRATORY: Mild-moderate retractions, good air exchange bilaterally and moderate scattered rales.

CARDIAC: Normal sinus rhythm, good perfusion, strong and equal pulses and no murmur.

ABDOMEN: Soft and nondistended abdomen and no organomegaly.

GU: Normal preterm female features and patent anus.

NEUROLOGIC: Responsive mental status, normal muscle tone for gestational age, fair Moro reflex and good grasp reflex.

EXTREMITIES: No hip click.

### ADMISSION LABORATORY STUDIES

4/3/04 09:50h: WBC:9.0X10<sup>3</sup> Hgb:14.3 Hct:43.4 PL:274X10<sup>3</sup> S:19 B:4 L:62 M:7 Eo:4 AL:4 NRBC:8

4/3/04 22:00h: WBC:10.9X10<sup>3</sup> Hgb:13.4 Hct:40.4 PL:285X10<sup>3</sup> S:52 B:0 L:41 M:4 Eo:2 Ba:1 NRBC:2

4/3/04 22:00h: Na:134 K:4.3 Ca:8.5

4/3/04 22:00h: TBil:3.0 DBil:0.1

4/3/04 09:50h: RPR: nonreactive

4/3/04 09:50h: Direct Coombs: negative

4/3/04 09:50h: Blood Type: A pos

### RESOLVED DIAGNOSES

RESPIRATORY DISTRESS SYNDROME MODERATE

ONSET: 4/3/04 RESOLVED: 4/9/04

PROCEDURES: UAC placement from 4/3/04 to 4/6/04; Surfactant therapy from 4/3/04 to 4/4/04 (4 doses).

SAMPLEPATIENT FE 123456DISCHARGE SUMMARY PAGE 1 OF 4

06/06/2004

Round Sheets

05/10/2004	PAGE 1 OF 3	05/10/2004
<p><b>SAMPLE PATIENT FE (NICHOLS) 1234567</b>    <b>WT:1.499 (Up 62g)</b>    <b>AGE:37d</b>    <b>GAge:27w0d</b>  <b>Adj GA:32w2d</b>    <b>BWT:0852kg</b>    503:1h</p> <p><b>RESP:</b> Nasal CPAP 21% PEEP 7    CBG 5/9 00:10 7.425/47.50/80.66.9</p> <p><b>OLD:</b> FEEDS E24PFe 24kc 28.0ml OG q3h feeds    NaCl 10.5mEq OG q3h feeds    156m 1125kc</p> <p><b>NEW:</b> FEEDS E24PFe 24kc 25.0ml OG q3h feeds    133m 1107kc</p> <p><b>IMACS:</b> PIP ApneaPrem    ROP Stage 1    hypnatremia</p> <p><b>MEBS:</b> caff:33/57    VhE:17    NaCl Suppl 6/6</p> <p><b>HEME:</b> 5/8 04:30: Hct:41.5</p> <p><b>CHEM1:</b></p> <p><b>CHEM2:</b></p> <p><b>HUS:</b> HUS 4/13: No hem critique.</p> <p><b>SCRN:</b> NERN 4/24 All norm al results and Aracet hemoglobin screen needed 4 mos after last transfusion.</p> <p><b>TRACK:</b> Photo? Y/N    Last Apnea: 2/18    Last Brady: 2/17</p>		
<p><b>PATIENT MA 1800001</b>    <b>WT:1.050 (Up 24g)</b>    <b>AGE:42d</b>    <b>GAge:25w0d</b>  <b>Adj GA:31w0d</b>    <b>BWT:0692kg</b></p> <p><b>RESP:</b> Room air</p> <p><b>OLD:</b> FEEDS E24PFe 27kc 8.5ml OG 6/2    149m 1134kc</p> <p><b>NEW:</b> FEEDS E24PFe 27kc 9.0ml OG 6/2    154m 1139kc</p> <p><b>IMACS:</b> EPD LVH Anemia Prem    ApneaPrem    inspiral hemoh    ROP Stage 1</p> <p><b>MEBS:</b> deameth:28/42    caff:26/38    VhE:25</p> <p><b>HEME:</b> 5/8 06:30: Hct:39.0</p> <p><b>CHEM1:</b> 5/10 05:00: Na:136</p> <p><b>CHEM2:</b></p> <p><b>HUS:</b> HUS 4/26: Normal findings.</p> <p><b>SCRN:</b> NERN 4/15: Low T4, normal TSH    ROP 5/8 Stage 1    ROP Zone 2-3    OU</p> <p><b>TRACK:</b> Photo? Y/N    Last Apnea: 2/15    Last Brady: 2/16</p>		
<p><b>PATIENT MA A 1800002</b>    <b>WT:1.215 (Up 25g)</b>    <b>AGE:10d</b>    <b>GAge:28w0d</b>  <b>Adj GA:29w3d</b>    <b>BWT:1180kg</b></p> <p><b>RESP:</b> Room air</p> <p><b>OLD:</b> TPN-PIV D110 AA2.0 Na:1.0 K:0.0 IVL1.21    150m 1108kc</p> <p>FEEDS S24P 24kc 120ml OG q3h feeds incr 14m 1</p> <p><b>NEW:</b> TPN-PIV D110 AA1.8 Na:1.0 K:0.0 IVL1.19    150m 1115kc</p> <p>FEEDS S24P 24kc 150ml OG q3h feeds incr 18m 1</p> <p><b>IMACS:</b> PIP ApneaPrem    Breysoundre    maternal drug abuse</p> <p><b>MEBS:</b> caff:10/31</p> <p><b>HEME:</b> 5/8 05:20: Hct:45.0</p> <p><b>CHEM1:</b> 5/10 05:00: Na:138    K:5.3    Cl:109    CO2:18.0    BUN:5    Cr:0.8    Gl:78    Ca:9.5</p> <p><b>CHEM2:</b> 5/10 05:00: TB:4.6    DB:0.0</p> <p><b>CULT:</b> 4/30 bld=egative    4/30 bld=egative    4/30 urRAD=egative    5/4 bld=egative    5/5 bld=egative</p> <p><b>DVLS:</b> 5/1 gent(24)=1.1</p> <p><b>HUS:</b> HUS 5/10: Normal findings.</p> <p><b>TRACK:</b> Photo? Y/N    24h Apnea: 1    Last Brady: 2/15</p>		
05/10/2004	PAGE 1 OF 3	05/10/2004

## Daily Fluid Orders

**NAME: SamplePatient, Nichole (Girl)**      **DATE: 4/10/04**      **Fluids: 135ml/kg/d**      **Page 1**  
**ADMISSION ID: 1234567**      **TIME: 10:57hr**      **Weight: 0.909kg**  
**MED REC ID: 6053433**

**IV Fluid #1: TPN via PCVC to infuse at 3.9 ml/h over 24 hours (102.5 ml/kg)**

Dextrose:	11 gm/100ml	(11.3 gm/kg)
TrophAmine 10%:	2 gm/kg	(1.95 gm/100ml)
NaCl:	1 mEq/kg	(0.98 mEq/100ml)
Na Acetate:	2 mEq/kg	(1.95 mEq/100ml)
KCl:	1 mEq/kg	(0.98 mEq/100ml)
K Phosphate:	1.5 mEq/kg as K+	(1.46 mEq/100ml as K+)
Calcium:	1.5 mEq/kg	(1.46 mEq/100ml)
OR Ca Elemental:	30 mg/kg	(29.25 mg/100ml)
Magnesium:	0.25 mEq/kg	(0.24 mEq/100ml)
OR Mg Elemental:	3.05 mg/kg	(2.97 mg/100ml)
Heparin:	0.5 Units/ml	(50 Units/100ml)
MVI Pediatric:	1.5 ml	(1.61 ml/100ml)
PTE4+Se (3:1):	0.4 ml/kg	(0.39 ml/100ml)
Cysteine HCl:	56 mg/kg	(54.61 mg/100ml) (28 mg/gm AA)

**IV Fluid #2: IV Lipid to infuse at 0.5 ml/h over \*23\* hours (12.7 ml/kg)**

Concentration:	20%
Amount:	11.5 ml over 23h      (2.53 gm/kg)

**Feeding #1**

Formula:	Erfamil Premature 24
Strength:	12kcal/oz (0.5 strength)
Amount:	1ml OG hourly 6 hours on, 2 hours off

Signature:

Page 1



**SamplePatient, Nichole (Girl)**  
**Admission ID: 1234567**  
**Birth Date: 4/3/04**  
**Admit Date: 4/3/04**



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