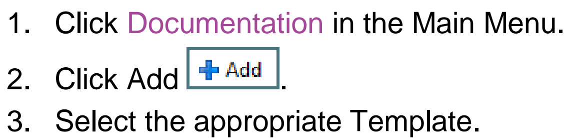
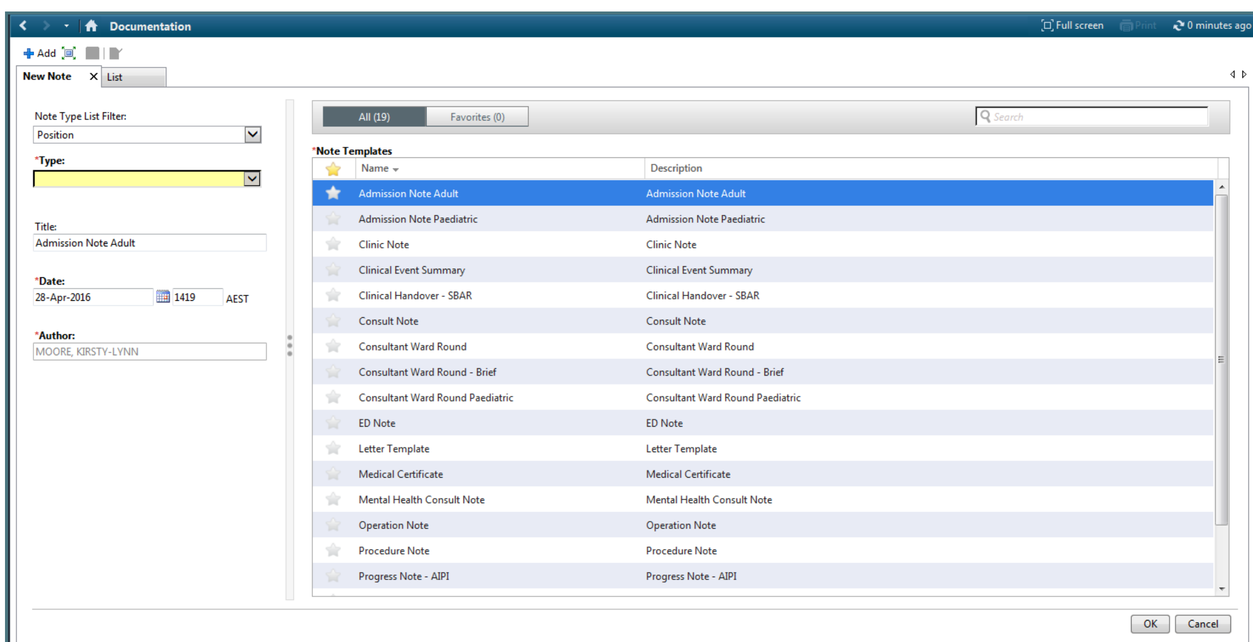
Note template contents

Care Delivery

Quick reference guide

When selecting a template, choose the most appropriate template for the patient's encounter.

1. Click Documentation in the Main Menu.
2. Click Add .
3. Select the appropriate Template.



For example:

Medical Certificate

I hereby certify that Mr/Miss (*patient name who's chart is open will be inserted*) hereinafter called the patient was admitted to the Mackay Base Hospital as a (*current encounter will be inserted*) on the (*date of encounter is populated*) suffering from (*free text field*).

The patient (*was totally / is partially) incapacitated for work, and (*is still a patient / was discharged on *free text field* the patient (*is / is not) to attend the Outpatient Deptartment and, I anticipate (*free text field*), will be unfit for duty up to and including (*free text field*).

This certificate is issued for the information of (*free text field*).

*Strike out whichever is not applicable (signature) Date: (*pre populated field*)

Name of Template	Heading	Sub Heading	Populated
Admission Note Paediatric	Presenting complaint		Yes
	History of present illness		Yes
	Past medical history	Active and Chronic	Yes
	Surgical history		Yes
	Allergies		Yes
	Social history		Yes
	Family history		Yes
	Immunisations		
	Birth history		
	Physical examination		Yes
	Developmental history		
	Pathology results		
	Radiology results		Yes
	Assessment and management plan		Yes

Name of Template	Heading	Sub Heading	Pre-Populated
Clinic Note	Presenting complaint		Yes
	History of present illness		Yes
	Past medical history	Active and Chronic	Yes
	Surgical history		Yes
	Allergies		Yes
	Social history		Yes
	Family history		Yes
	Immunisations		
	Physical examination	Observations & Measurement	Yes
	Pathology results		Yes
	Radiology Results		Yes
	Assessment and management plan		Yes
Clinical Event Summary	Summary of care		yes
	Health status	Principal and other diagnosis	Yes
		Past medical history – ongoing	Yes
		Historical	Yes
		Allergies and adverse reactions	Yes
		Procedure history	
	Pathology results		
	Radiology results		Yes
	Discharge information	Follow-up	
		Appointments on discharge	
	Management plan		
	Estimated discharge date		Yes
	Document author		Yes

Name of Template	Heading	Sub Heading	Pre-Populated
Clinical Handover - SBAR	Situation		
	Background		
	Assessment		
	Recommendation		
Consult Note	Presenting complaint		Yes
	Reason for consultation		
	History of present illness		Yes
	Review of systems		
	Past medical history	Active and Chronic	Yes
	Surgical history		Yes
	Allergies		Yes
	Social history		Yes
	Family history		Yes
	Immunisations		
	Physical examination		Yes
	Pathology results		
	Radiology results		Yes
	Assessment and management plan		Yes
Consultant Ward Round	Day of admission		Yes
	Consultants		Yes
	Past medical history	Active and Chronic	Yes
	Progress		
	Assessment and management plan		Yes
	Estimated discharge date		Yes
Consultant Ward Round Brief	Day of admission		Yes
	Consultants		Yes
	Notes		
	Estimated discharge date		Yes

Name of Template	Heading	Sub Heading	Pre-Populated
Consultant Ward Round Paediatric	Day of admission		Yes
	Consultants		
	Current concerns or reason for consultation		
	Past medical history	Active and Chronic	Yes
	Issues raised by patient or family		
	Review of progress – Response to treatment		
	Examination		
	Vital signs		Yes
	Physical examination		
	CEWT Score		
	Assessment and management plan		Yes
	Discharge planning		Yes
	Estimated discharge date		
ED Note	Presenting complaint		
	History of present illness		
	Past medical history	Active and Chronic	Yes
	Surgical history		
	Allergies		Yes
	Social history		
	Family history		
	Immunisations		
	Physical examination	Observations & Measurements	
	Pathology results		
	Radiology results		
	Assessment and management plan		

Name of Template	Heading	Sub Heading	Pre-Populated
Letter Template	Presenting complaint		
	Past medical history	Active and Chronic	Yes
	Allergies		Yes
	Assessment and management plan		
Mental Health Consult Note	Background		
	Reason for admission		Yes
	Reason for referral		
	Findings on assessment		
	Past medical history	Active and Chronic	Yes
	Mental state		
	Impressions		
	Recommendations		
Operation Note	Operation		
	Surgeon(s) and Anaesthetist(s)		Yes
	Findings		
	Technique		
	Post operation management plan		
Procedure Note	Procedure name		
	Consent		
	Indication		
	Location		
	Ultrasound guidance (yes/no)		
	Pre-procedure examination	Procedural sedation	
		Technique	
	Post–procedure examination	Complications	
		Total Time	
	Findings		
	Assessment and management plan		Yes

Name of Template	Heading	Sub Heading	Pre-Populated
Progress Note - AIPI	Assessment		
	Interpretation		
	Planning		
	Intervention		
Progress Note – Blank	**This is a free text box**		
SOAP	Subjective		
	Objective		
	Assessment and management plan		
Telephone Record SBAR	Introduction (who initiated phone call, contact details of caller)		
	Situation (reason for telephone contact)		
	Background		
	Assessment and management plan		
	Recommendation or response (include advice given)		