



# HEALTHe NL HELP PAGES

## Clinical Documents and Discharge Summaries

Newfoundland and Labrador Centre for Health Information

## Help Files

Click on any of the help files listed below for information on that topic.

1. on the Medication Profile tab. To learn more about this, see section: Prescription Summary

### Understanding and reading the reports

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## Understanding and reading the reports

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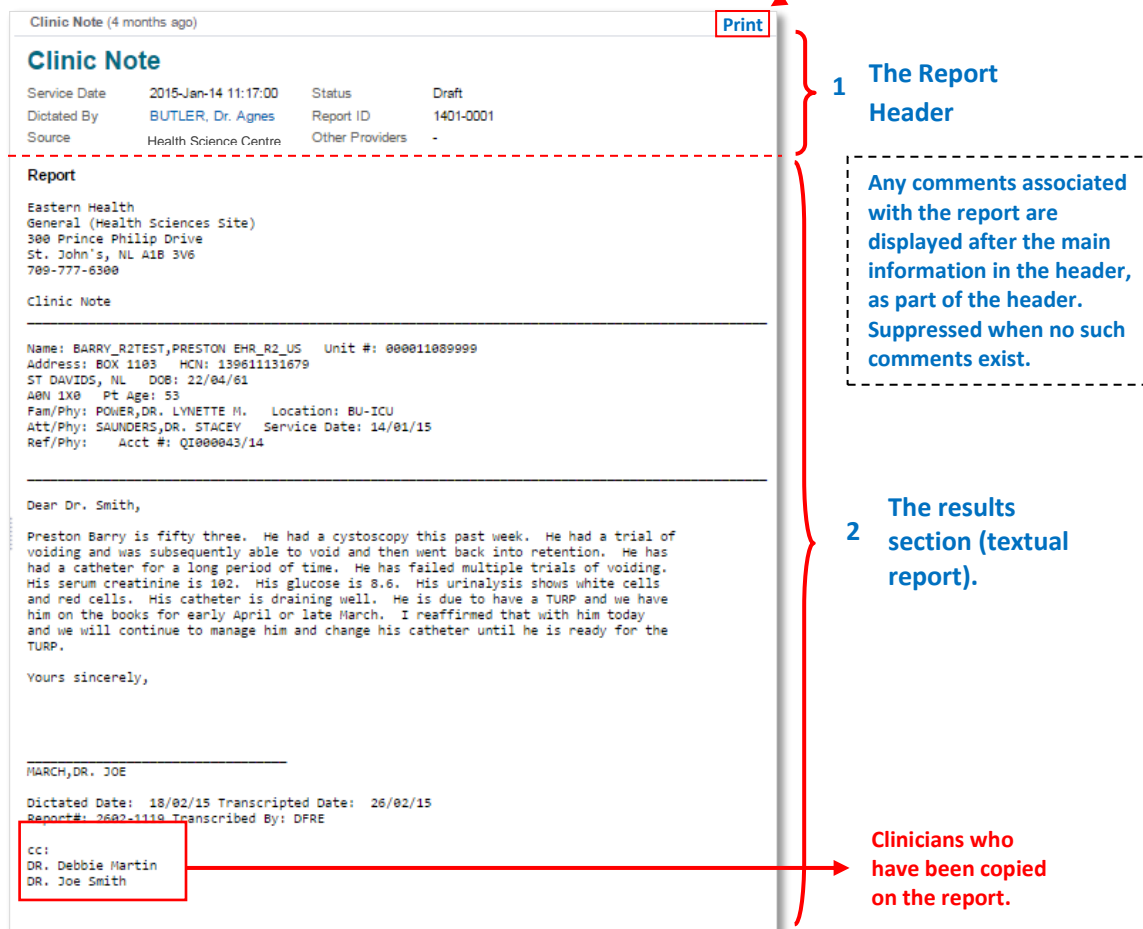
### 1. Clinical Documents and Discharge Summaries

Clinical Documents and Discharge summaries are included in the “Clinical Documents” and “Discharge Summary” categories respectively. Discharge summaries are a type of clinical document, but are displayed in separate category of the CDV tree due to a clinical design decision giving faster access to them. They are displayed as links in the CDV tree. The title of each report link in the CDV tree indicates the name of the report, and the results section displays the dictated report.

A Clinical document report contains the following sections (*Figure 31*):

- 1) The Report Header Section
- 2) The Results (textual report) section

To print the report click here.



**Clinic Note** (4 months ago) Print

Service Date	2015-Jan-14 11:17:00	Status	Draft
Dictated By	BUTLER, Dr. Agnes	Report ID	1401-0001
Source	Health Science Centre	Other Providers	-

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**Report**

Eastern Health  
General (Health Sciences Site)  
300 Prince Philip Drive  
St. John's, NL A1B 3V6  
709-777-6300

Clinic Note

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Name: BARRY\_R2TEST,PRESTON EHR\_R2\_US Unit #: 000011009999  
Address: BOX 1103 HCN: 139611131079  
ST DAVIDS, NL DOB: 22/04/61  
A0N 1X0 Pt Age: 53  
Fam/Phy: POWER,DR. LYNETTE M. Location: BU-ICU  
Att/Phy: SAUNDERS,DR. STACEY Service Date: 14/01/15  
Ref/Phy: Acct #: QI000043/14

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Dear Dr. Smith,

Preston Barry is fifty three. He had a cystoscopy this past week. He had a trial of voiding and was subsequently able to void and then went back into retention. He has had a catheter for a long period of time. He has failed multiple trials of voiding. His serum creatinine is 102. His glucose is 8.6. His urinalysis shows white cells and red cells. His catheter is draining well. He is due to have a TURP and we have him on the books for early April or late March. I reaffirmed that with him today and we will continue to manage him and change his catheter until he is ready for the TURP.

Yours sincerely,

---

MARCH,DR. JOE

Dictated Date: 18/02/15 Transcribed Date: 26/02/15  
Report#: 2602-1118 Transcribed By: DFRE

cc:  
DR. Debbie Martin  
DR. Joe Smith

1 The Report Header

Any comments associated with the report are displayed after the main information in the header, as part of the header. Suppressed when no such comments exist.

2 The results section (textual report).

Clinicians who have been copied on the report.

Figure 1: Clinic Document Example

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## 1.1 Clinical Documents and Discharge Summaries Header

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A Clinical Document displays the following information in the header section: *(Figure 32)*

1. **Report Title.** This is the title of the report. **E.g.** Clinic Note
2. **Report Title (Bigger Font and blue).** This is the title of the report. **E.g.** Clinic Note
3. **Service Date:** This is the date and time the patient was seen by the clinician – generally, for outpatient and ER visits, this is the admission date. In case of a Discharge Summary, Date and time the patient was discharged. **E.g.** 2015-Jan-14 11:17:00
4. **Dictated By:** The name of the clinician who dictated the report. **E.g.** Butler, Agnes  
Please note the Clinician name is a **hyperlink** to allow the user (when clicked) to view details on the provider in a popup window.
5. **Source:** The site associated with the result. **E.g.** Health Science Centre
6. This is the **age of the report**, calculated with the date from the report in the CDV tree. It appears in brackets next to the Report title **E.g.** (2 months ago)
7. **Status:** This is the Report Status. **E.g.** Draft. See [“CDV Tree Report Status Indicators and Read/Unread Reports”](#) for details on report Status for Clinical Documents.
8. **Report ID:** The order number associated in the source system. **E.g.** 1401-0001
9. **Other Providers:** The names of providers associated with the report or the patient record, not necessarily the clinicians that were copied in the report. To see the name of the clinicians who have been copied on the report refer to the “CC” section found at the bottom of the results section of the report *(Figure 27)*. When no Other Providers exist for the report, a dash is displayed instead to indicate no value.  
**E.g.** “-“in the example below no Other Providers exist that is why a dash is indicated.
10. **Comments:** Any comments associated with the report. They are automatically displayed after all other header fields. Suppressed when no such comments exist.

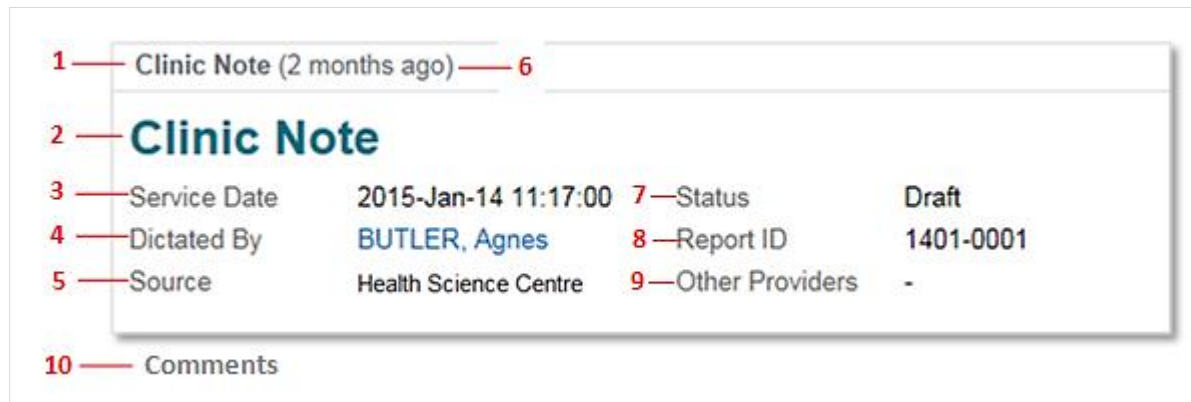


Figure 2: Clinical Document Report Header Example

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## 1.2 Clinical Documents and Discharge Summaries Results Section

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The Results Section displays the textual dictated report (*Figure 31*). The textual report is displayed as stored. The report text is displayed in a fixed font. It does not include a **result status**. As indicated in the section above, report status is displayed in the header.

In the case that a report has been cancelled, the header of the report is displayed but the textual report is not shown. Instead, the following is displayed:

```
Unavailable  
Cancelled. Report is not available.
```

In the case that a report is pending, the header of the report is displayed but the textual report is not shown. Instead, the following is displayed:

```
Unavailable  
Pending report
```

In the case that a report has been retracted (pull back a report from view), the header of the report is displayed but the textual report is not shown. Instead, the following is displayed:

```
Unavailable  
Retracted – please refer to the Meditech source system to view the report.
```

Please  
note

```
IMPORTANT: HEALTHe NL consolidates information from various source systems province-wide. While efforts are made to ensure accuracy and completeness, HEALTHe NL is not exhaustive and should not be relied upon as a sole information source in providing care. Patient data may exist in other health databases.
```

that at the bottom of each Clinical Document and Discharge Summary appears the disclosure shown below.

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