4Next Referral Summary Report

Currently Included Data Sections

Section Title	Section Includes	Comments	Epic Source
Patient Demographics	Name, Patient ID, Sex, DOB, Address, Home/Work/Mobile phone, Email, Race, Marital Status, Language, Religion, PCP, Emergency Contact		Admission Documentation
Insurance Information	Subscriber, Group#, Phone#		Admission Documentation
Admission Information	Unit/Bed, Admitting/Attending Provider, Service, PCP, Phone, Patient class		Admission Documentation
Admit Orders	Admit to IP, OBS, EDOBS, etc.. Medicare certification		Admit order
Specialty Equipment	Assistive Devices		Nursing Documentation
Active Infections			MD Order
Resolved Infections			Infection being resolved by MD via the problem list.
Active Isolation			MD order
Removed Isolation			MD order expiring
Restraints: Violent and Non-Violent		Each restraint section has application information followed by that episode patient monitoring info.	Nursing documents starting the restraint
Allergies as of Last Filed Date	Allergy, Allergic reaction		MD documentation
Expected Discharge Date and Time			Treatment team
Discharge Plan	D/C Plan, Anticipated Discharge Disposition, Barriers		Case Management/nursing documentation.(flowsheet)
Treatment team	Provider/contact, Supervisor, respiratory therapist		When provider assigns themselves to a patient
Care Management	Icmp info		AMB CM documentation
ACP Healthcare	Healthcare proxy, acp values,		

Proxy	goals, MOLST, legal, preferred language, problem list		
Legal Information	HCP, Decision Maker, date last filed		CM documentation(flowsheet)
Hospital Problems	Problems, Noted-resolved dates, last modified by		MD documentation of problems.
Problem List	Problems, Noted-resolved dates, last modified by		MD documentation
Current Code Status	Date Active, Code, Status, Order ID Comments, User Context		MD Order
H&P notes	Author, Service, Note time, FACT Hospitalist Attending Admit Note, Chief Complaint, ED Course, Allergies, Medications, Past Medical History, Past Surgical History, Smoking Status, Physical Exam, Data/Results		MD Documentation
PT/OT/SLP Eval/Consult notes	PT/OT/SLP consult notes	Last 48 hours	HP Documentation
PT/OT Current Functional Status	Level of independence		HP Documentation(flowsheets)
SLP Current Functional Status	Clinical Swallow Evaluation		HP Documentation(flowsheets)
PT/OT/SLP Progress Notes	Daily Treatment, Recommendations, Discharge Recommendation, Plan for Next Treatment	Last 48 hours	HP Documentation
Medications	Dose, Route, and frequency of Scheduled, Continuous and PRN Meds		MD Order and RN administration for the Med
Immunizations	Name, Date, Dose, Route, Site		IP encounter information about Pneumococcal, Influenza and Tuberculosis screening and the Historical IMM documentation
Lab Results	Up to last 2 results	Last 48 hours	Lab results via enter/edit results(either RN or Sunquest)
Micro Results		Last 10 results in past 30 days	Lab results via enter/edit results
Bowel & Bladder	Urine Assessment, Stool Assessment		Nursing documentations(flowsheets)
Diet Orders	Time Start, Time Ordered		MD Order

Respiratory Labs/Documentation	O2/mechanical ventilation	Last 48 hours	Lab results(enter/edit)
Respiratory			
Active Lines, Drains, Airways, Wounds	Name, Placement date/time/site		Nursing documenting on the LDA
Nursing Progress Notes	Author, Note Status, Editor, Note, Date filed, Vital Signs	Most recent	Nursing documentation
Provider notes	IP progress notes provider, Author, Note Status, Editor, Note, Date filed, Meds	Last 48 hours	MD Documentation
Case Management Notes	Case Management – Progress Note, Author, Note Status, Editor, Note, Date filed		CM documentation
Case Management Assessment	Case Management Assess Flow sheet		CM doc(flowsheets)
Follow-Up Information	Specialty, Contact Information		Appts booked for patient while admitted for after d/c