



EHR



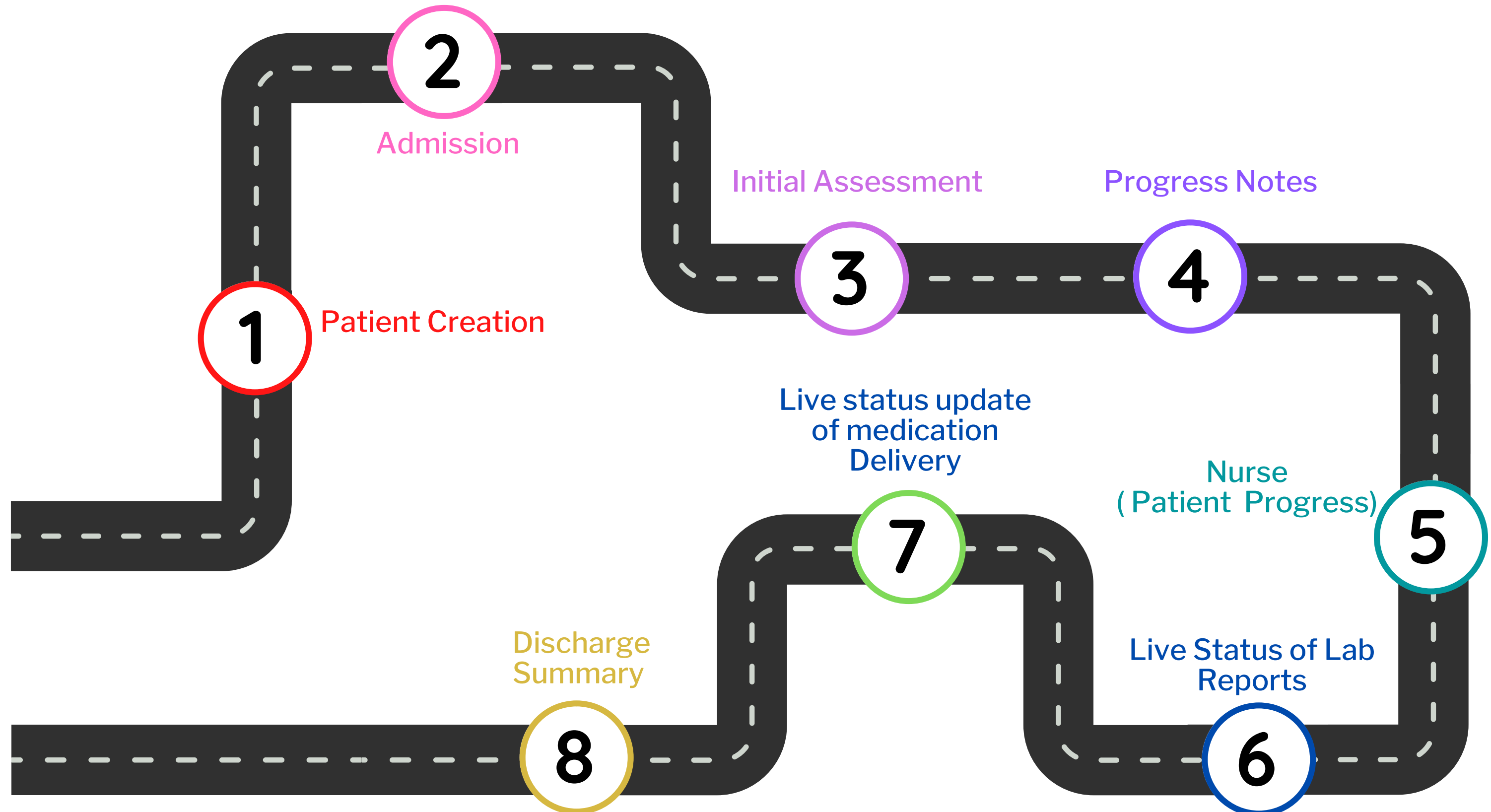
ELECTRONIC + HEALTH RECORD



FHIR Ready



EHR Application Workflow



Patient Registration

Patient Particulars

Patient Name * :

DOB: * :

Relation * :

Father Husband Guardian

Religion :

Select | v

Education :

Select | v

Blood group * :

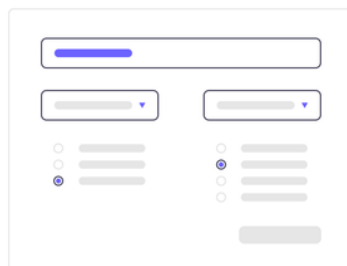
Select | v

Ration Card :

Annual Income :

Select... | v

Email :



- Register a patient
- We can Add , Edit and delete patients information (Role based access)
- Create a unique identification number as per your requirement
- We can also Integrate ABDM - ABHA creation

Patient Admission Page

SHOBANA SRIDHAR | F | -78

Treating / Admission Department * :

Select

Date of admission * :

13-Feb-2023

Category * :

Select

Floor No * :

Select

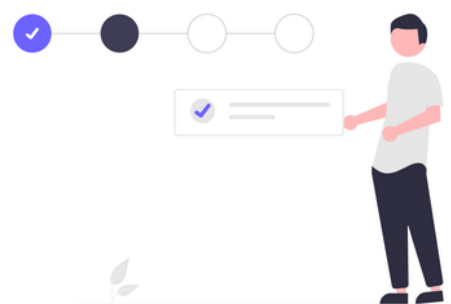
Room No * :

Select...

MLC:

Yes No

- Admit in patients
- Assign a floor, ward, room, bed for patients
- We can add , edit and delete Patients admission (Role based access)
- We can also Create a unique in patient identification number as per your requirement



Initial Assessment

Vital Parameters

Primary Assessment

Airway*

Airway Patency Patent Not Patent

Breathing*

Respiratory Rate /min Not Palpable (NP)

Respiration Type

Select Here

Spo2 % On Room Air % [0 - 100%]

Select Here

Circulation*

HR/Pulse Rate /BPM Absent

- Patient's Initial assessment is recorded here
- We can Add , Edit and delete Patients Initial assessment (Role based access)
- Includes chief complaint, history of primary illness, past medical and surgical History, family history, past history allergies, covid vaccine history, drug history, educational and social history, Psychological Status, Functional Status, General Physical Examination, Vital Parameters, Working/Provisional Diagnosis, (Ix) Investigations, Px (Prognosis), Pertinent Clinical Finding, Consents Form
- Fields can be customised



Progress Notes

Dx (Diagnosis)

S.No	Diagnosis	

Ix (Investigations)

S.No	Investigations	

- Patient's Progress recorded here
- We can Add , Edit and delete Patients Progress Notes (Role based access)
- Includes chief complaint, history of primary illness, Vital Parameters, Working/Provisional Diagnosis, (Ix) Investigations, Px (Prognosis), Medication (Rx)and Referral
- Handover to next duty doctor
- Fields can be customised



Pharmacy

Prescribed Medicine ABDUR M | M | V0016361 | 202212151512 GROUND FLOOR | WARD10 | ROOM1 | BED14

#	Doctor	Form	Drug Name	Dosage	Regimen	Days	Quantity	Quantity Given	Dispense	Status
1	madhan kumar	Capsule	Amphotericin B a) Amphotericin B (conventional) b) Lipid Amphotericin B c) Liposomal Amphotericin B	54 undefined	Once a week	4 Months	120	120	<input type="text"/>	Delivered ✓
2	madhan kumar	Capsule	Actinomycin D	5 dose	1-0-1	2 Months	120	78	<input type="text"/>	Partial Delivered ✓
3	madhan kumar	Syrup	5-Fluorouracil	5 ml	5days/week	1 Year	1825	1825	<input type="text"/>	Delivered ✓

[Submit](#)

- View medication prescribed by doctors
- Dispense Medication to patient
- Update delivery status



Nurse Station Primary Care

Spo2(%)	0 %
RBS/ sugars(mg/dl.)	0
Insulin (in IU)	0

- Patient's Progress recorded here
- Primary care which includes Heart rate, Systemic Blood pressure, IV access (Peripheral line/CVPline/Arterial-line), Respiratory Rate, Peripheral Pulse, Spo2(%), RBS/ sugars(mg/dl.), Insulin, Temperature, Mode of Ventilation, Tidal volume, Fio2 (21% - 100%), Peep, Airway Pressure, Rate Of Respiration, Intake Output, Hand Over Notes, Completed Tasks, Handover checklist, Medication to be administered to patient, Special Instructions
- Fields can be customised



Nurse Station Secondary Care

Blood transfusion

Yes No

Remarks if any :

Accessories

ET-Size :

CVP-Line : Established Not done

Site :

- Patient's Progress recorded here
- Secondary care which includes Blood transfusion, Peripheral Line Observation Chart, DVT-Risk Assessment Chart, Detailed Pain Assessment, Restrain Assessment, Braden Risk Assessment Scale for bed scores, Ventilated Patient Activity Chart, Pressure Ulcer Assessment, Instruction Ordered by Doctor, Pain Assessment, Bio-Medical Equipment check list, Investigation Check List, Hand Wash/Hand Rub Chart, Aldrete Score, Phlebitis Score, Modified Early Warning System(MEWS) Score
- Fields can be customised



Laboratory

Prescribed tests

Tests: 0 Biocryst -Day 10

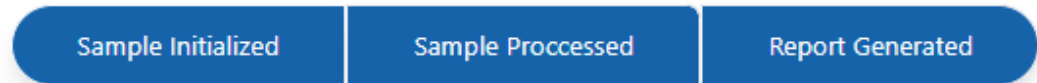
Test Prescribed By: madhan kumar S

Observation:

Status:

Report Generated ▾

Upload document



Documents:

File name	Size	Actions
1671704171503.png	7.64 KB	
Screenshot (1).png	199.63 KB	

Close

- Receive lab test from doctor
- Update status of reports



Discharge Summary

1. Registration Details

Patient name : Durga

Age : 28

Sex : Female

Marriage status : Unmarried

Father/husband /guardian name : Murali

UHID : 2022010000000

Treating/ Admission Department : Lorem ipsum dolor sit amet,

Ward name/number : 2

Treating Doctors/ consultants : Dr. Akash

MLC : yes/Lorem ipsum dolor sit amet, consectetur

Date of discharge : 25/ 10 / 2022

Diagnosis

- 1 Bilateral Pneumonia with effusion
- 2 Acute on CKD
- 3 Hypertension
- 4 Moderate AR, Severe MR

Summary

Admission diagnosis : Lorem ipsum dolor sit amet, consectetur

Most Responsible Diagnosis (MRDx) : Diagnosis/ICD Code

Past medical illness : Diseases name, Duration, Days

- Discharge summary includes patient details, Investigation, Discharge Medication, Follow up, summary, and Referral
- Fields can be customised





+ ELECTRONIC HEALTH RECORD

FEATURES

- Patient Registration
- Appointment
- Admission
- Initial Assessment
- Patient Progress Notes
- Doctor Management
- Nurse Station Management
- Discharge Summary
- Pharmacy Order Management
- Laboratory Report Management
- FHIR / HL7 Integration
- ABDM - ABHA Number Creation





Electronic Health + Record Software



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