ChartMaker® Clinical Release Notes

ChartMaker® 2018 (fv6.3.0)

Added Features

- **Audit Trail –** The Audit Trail has been updated to track whenever Risk Stratification information is added, modified, or deleted for a patient via the Additional Patient Information dialog in the patient's ID tab. When an audit event occurs the Event column will display **Modified**; the Group column will display **Person**; the Audit Trail Description will display **Risk Stratification Modified**; the Old Value and New Value columns will contain the Risk Tier and Comments that were added or modified; and the **Account ID** will be listed in the Metadata column.

- **Audit Trail –** The Audit Trail has been updated to track whenever chart notes are exported for a patient using the new Export All Notes to File option. When an audit event occurs the Event column will display **Export**; the Group column will display **Note**; the Audit Trail Description will display the note title, the number of pages, and the date of export; and the **Account ID** and **File Path** to the exported note will be listed in the Metadata column.

- **Export – All Notes to File –** The system has been updated with the ability to export all chart notes to a file for a patient. To utilize this functionality, you need to be on a workstation that has the Windows 10 operating system, and as a user you need to have the Patient Data Export privilege set to **Export** or **All**. If these conditions are not met, then the export note to file options will be disabled.

  To export all notes to a file for a patient, when in the patient's chart, click **Chart** > **Export** > **All Notes to File**, or **Chart** > **Export All Notes to File**, depending upon where you are in the patient's chart. See Figure 1. You can also export all, or a selected amount of, chart notes in the Organizer. When in the Organizer, select the desired notes if applicable, then right-click on the note or notes, and then click **Export Selected Notes to File**, or **Export All Chart Notes to File**. See Figure 2.

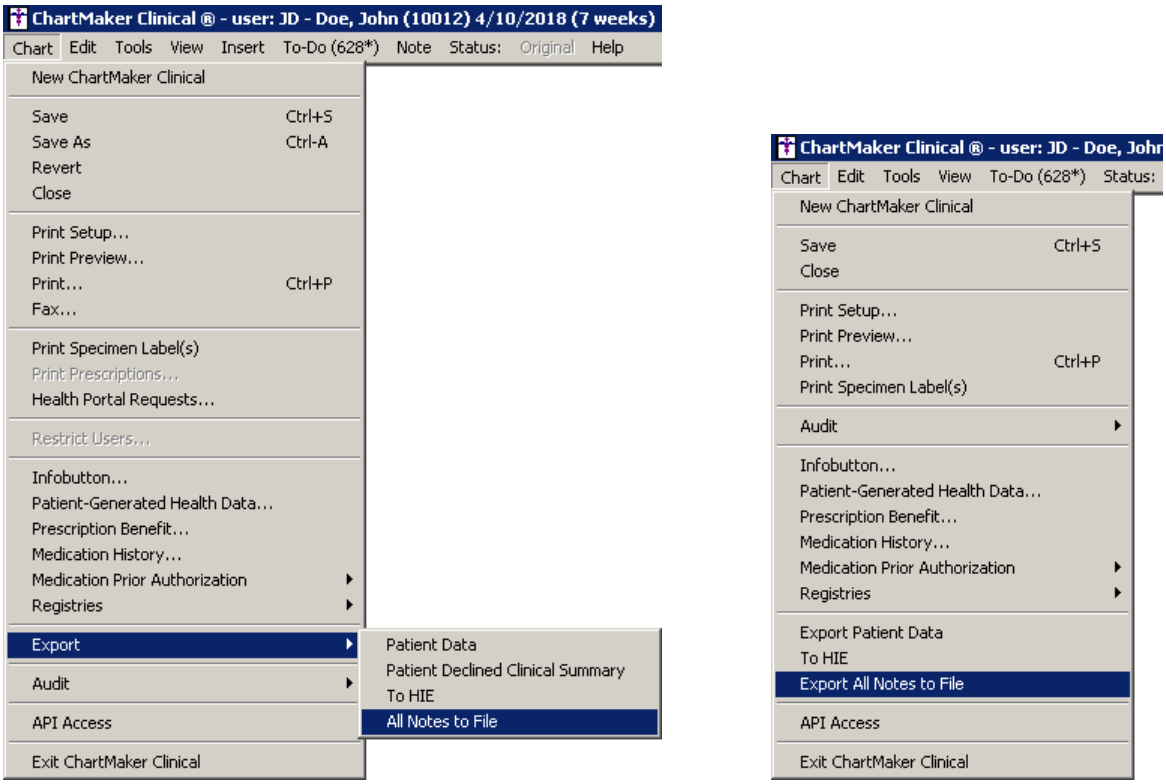

Figure 1 – Export All Notes to File Menu Options

Export – All Notes to File (continued)

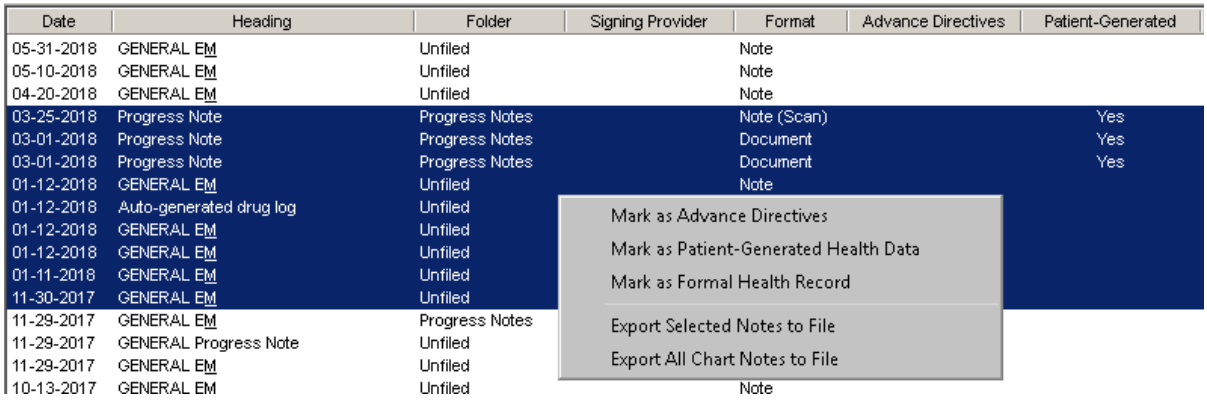

Figure 2 – Organizer – Right-Click Menu

After the applicable export option has been selected, a warning dialog will appear displaying any note types that are note supported by this export feature (e.g., Midmark notes, and unfinalized forms). After continuing, a **Note Export** dialog will appear displaying the notes to be exported. You can uncheck any notes you do not want included in the export. Likewise, you can select the **Output Folder**, which will automatically be saved (for the user that is logged in), for the next time you export notes for a patient. When the output folder and the notes are selected as desired, click the **Export** button and the system will export the notes to the selected location. When the export is complete a confirmation message will appear, and the exported chart notes will be tracked in the Audit Trail.

- **ID Tab – Additional Patient Information –** The Additional Patient Information dialog (accessed via the **Additional Info** button in the ID tab), has been updated with a **Risk Stratification** section that allows you to configure a **Risk Tier** and enter any **Comments** regarding the risk for the patient. This allows practices to risk stratify their patient population to adhere to CPC+ and PCMH program requirements, when applicable. See Figure 3. When a Risk Tier is selected (**Tier 1-5**, or **Not Applicable/Excluded**), that information will appear in the Patient Empanelment Report and will be used in calculating the Empaneled Rate for the practice in that report. Likewise, whenever Risk Stratification information is added, modified, or deleted for a patient, it will be tracked in the Audit Trail.

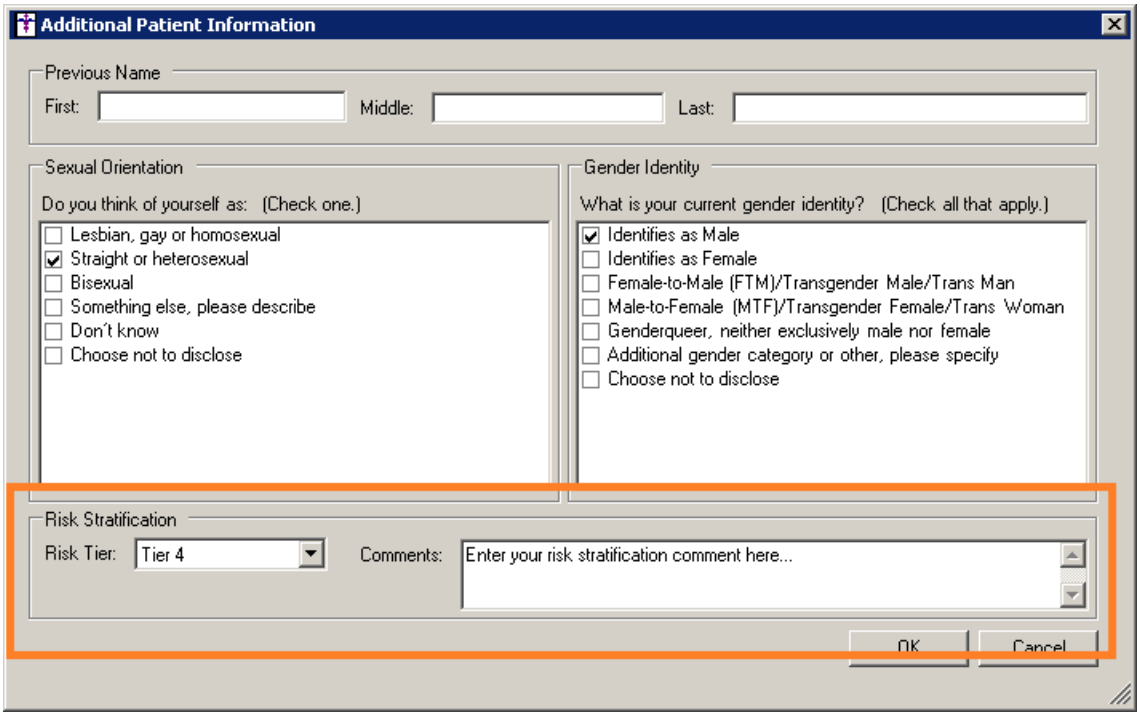

Figure 3 – ID Tab – Additional Patient Information

Added Features (continued)

- **Immunization Registry – DelVAX –** The system has been updated to download and display immunization forecast information, if available, when downloading immunization history information from DelVAX via the Registry Records dialog (**Chart** > **Registries** > **Immunization** > **View Registry Records**). Any applicable immunization forecast information will be displayed after the immunization history information. See Figure 4.

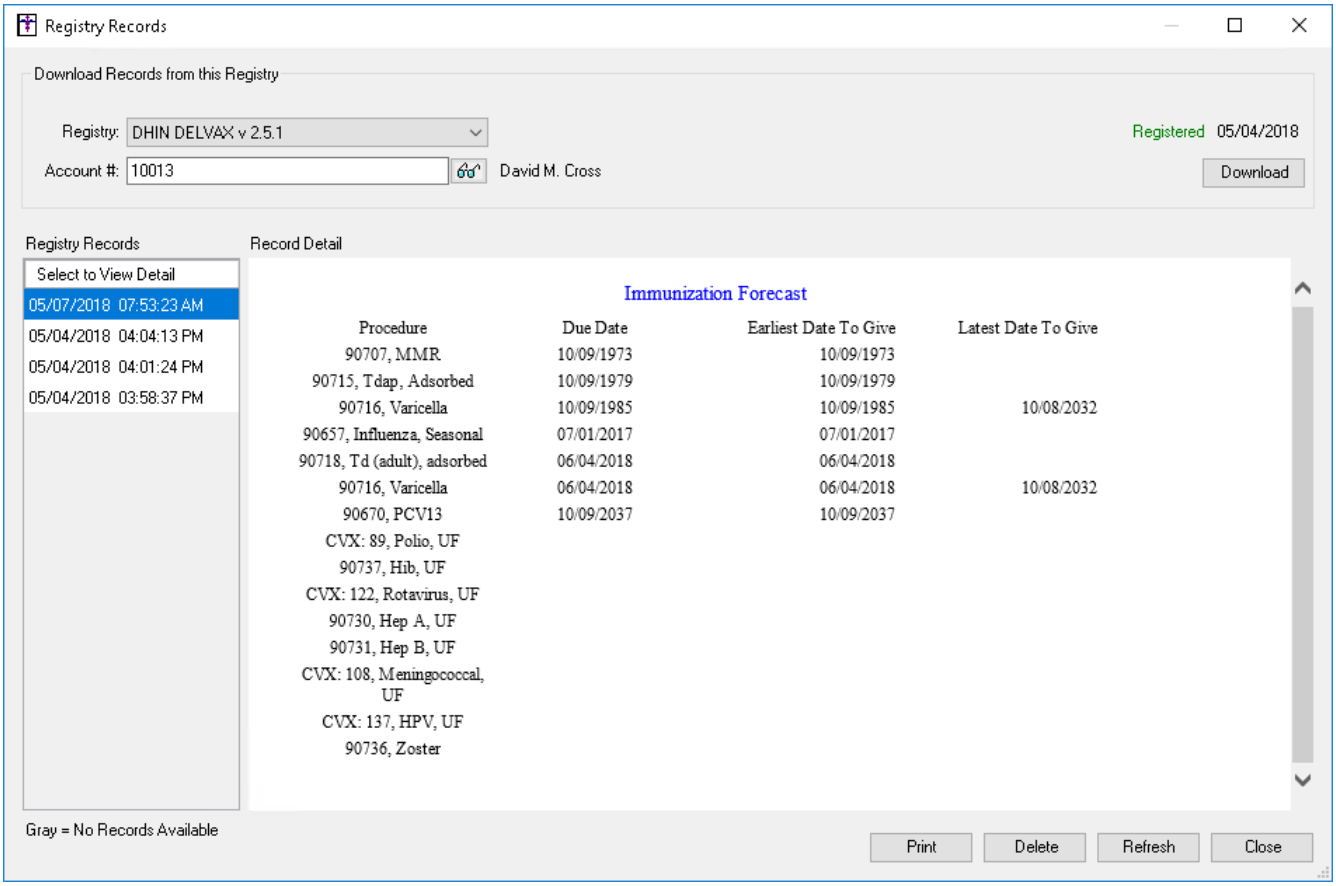

Figure 4 – Registry Records – DelVAX

Added Features (continued)

- **Immunization Registry – VIIS –** The system has been updated so that the Virginia Immunization Information System (VIIS), in conjunction with the ChartMarker® Medical Suite, utilizes 2.5.1 HL7 bidirectional messaging and exchange of vaccine (immunization) information. Once the system is set up, and you are enrolled with VIIS, immunization records will be automatically sent to the DelVAX when the immunization record is saved (via the **Next Account** button) in the Immunization sub-tab of Clinical tab in Practice Manager, or when a chart note is saved or closed in the Clinical application.

- **Immunization Registry – VIIS –** The system has been updated to download and display immunization forecast information, if available, when downloading immunization history information from VIIS via the Registry Records dialog (**Chart** > **Registries** > **Immunization** > **View Registry Records**). Any applicable immunization forecast information will be displayed after the immunization history information. See Figure 5.

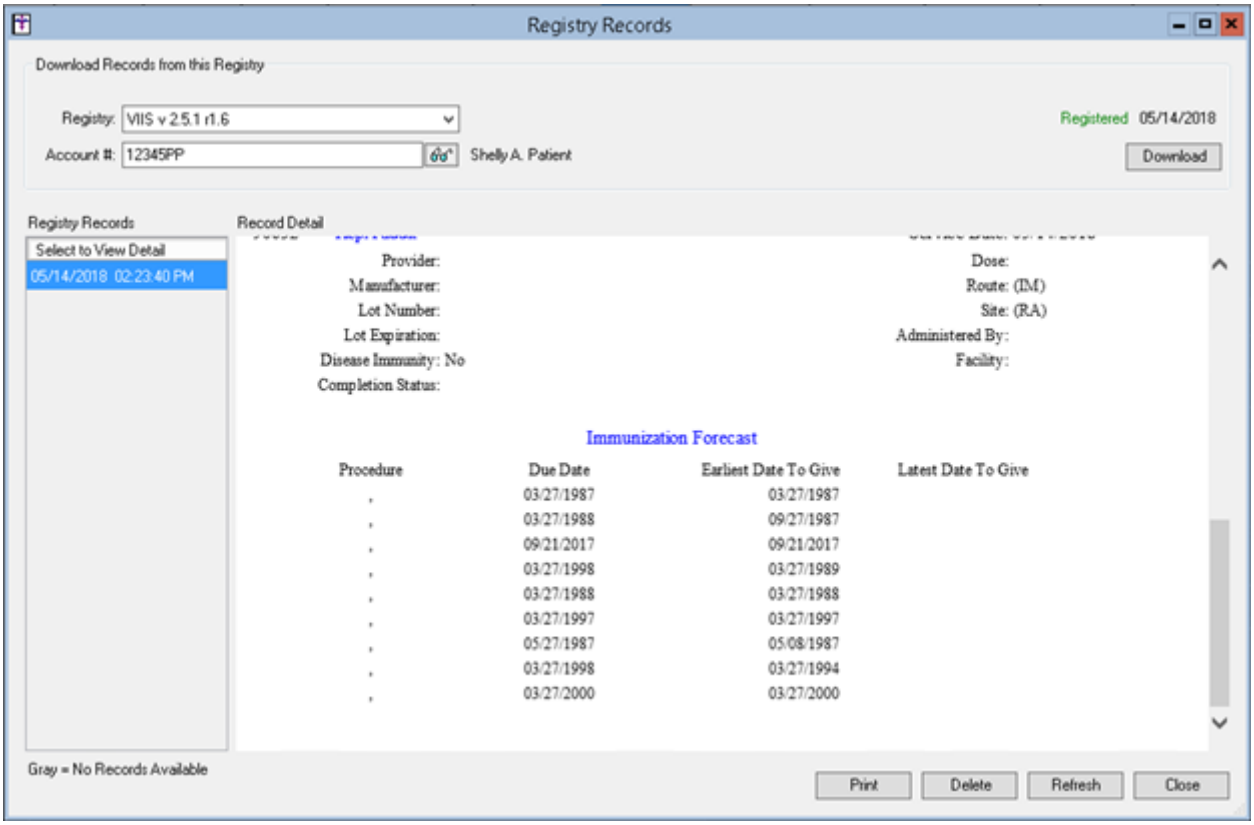

Figure 5 – Registry Records – VIIS

- **Meaning Use – CQM Import –** The CQM Import Dashboard (accessed via **Reports** > **Meaningful Use > CQM Import**), has been updated with a **Filter** button that allows access to the Quality Measure Filters dialog where you can filter by certain **Patient**, **Provider**, and **Practice** information when importing patients via the CQM Import Dashboard. See Figure 6.

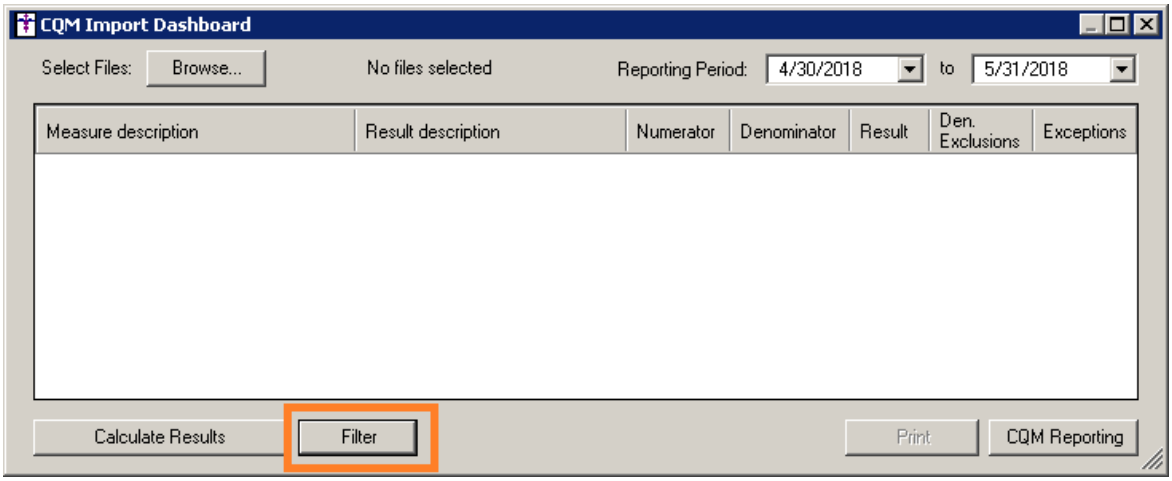

Figure 6 – CQM Import Dashboard

When in the Quality Measure Filters dialog, you can filter patients by patient age, sex, race, ethnicity, insurance payer, and/or a SNOMED code; by provider NPI number, and/or taxonomy code; or by practice Tax ID number, or address information. See Figure 7. If filter criteria is selected, only those patients that meet the criteria will be included in the import.

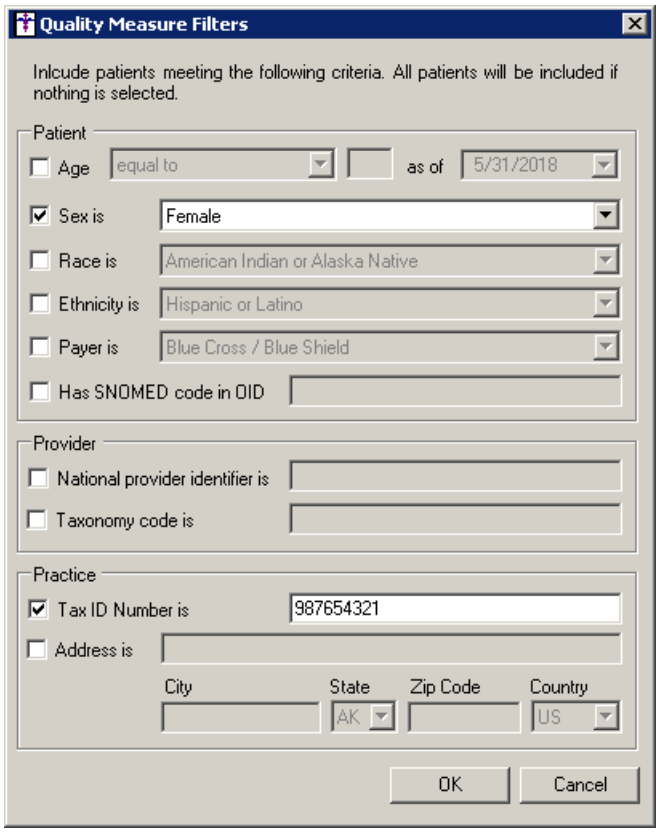

Figure 7 – Quality Measure Filters

Added Features (continued)

- **Meaningful Use Stage 3 2018 – Quality Measures –** All the Quality Measures for Meaningful Use Stage 3 2018 in the Meaningful Use Dashboard have been updated to the 2017 version for the 2018 reporting period. Do note that, for Stage 3 2018, this year (and every year) CMS has made changes to the requirements for the majority of the CQMs. In addition, the **NQF 0052 – Use of Imaging Studies for Low Back Pain** CQM has been removed and is no longer available for reporting. Please be sure to check the CQMs you are reporting to determine if changes were made that may affect your reporting and adjust accordingly.

- **MIPS Dashboard – Configuration–** The MIPS Dashboard Configuration dialog has been updated with an optional **Facility** field that allows you to select a Facility to further filter the selected measures in the MIPS Dashboard for MIPS 2017 and MIPS 2018, if applicable. See Figure 8. When a Facility is selected, it will be used as a filter on all applicable measures, for the selected Eligible Clinicians, and will appear in the in the header when printing.

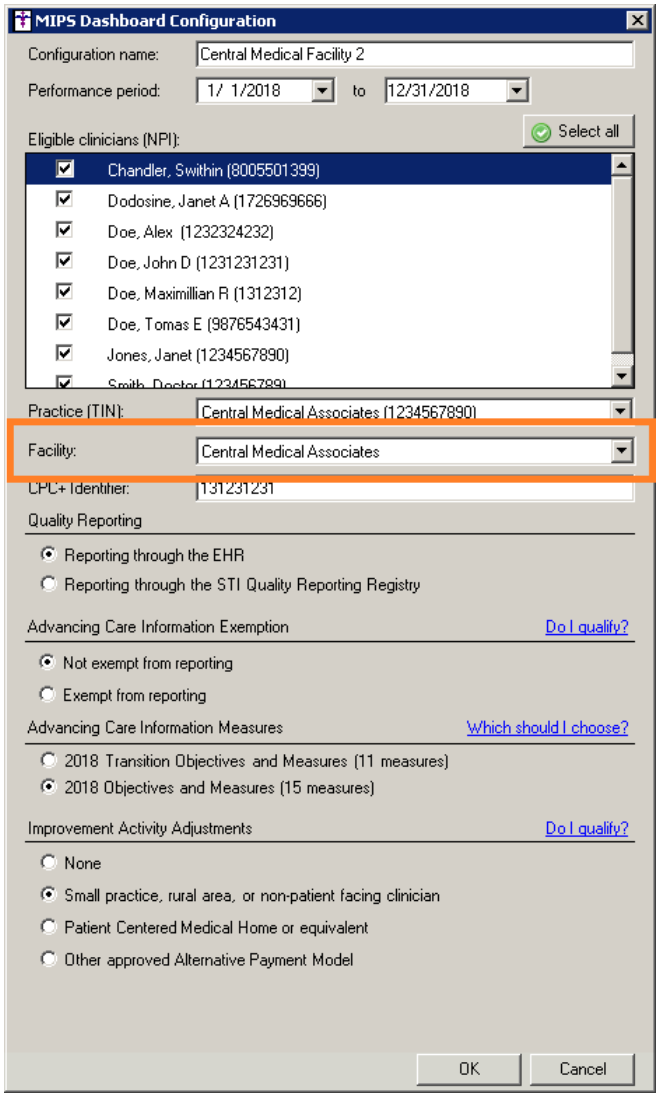

Figure 8 – MIPS Dashboard

- **MIPS Dashboard – Quality Measures –** All the Quality Measures for MIPS 2018 in the Quality Measure dialog have been updated to the 2017 version for the 2018 reporting period. Do note that, for 2018, this year (and every year) CMS has made changes to the requirements for the majority of the CQMs. In addition, the **CMS 166v6 – Use of Imaging Studies for Low Back Pain** CQM has been removed and is no longer available for reporting. Please be sure to check the CQMs you are reporting to determine if changes were made that may affect your reporting and adjust accordingly.

Added Features (continued)

- **The Note Tab – Smoking History –** The Tobacco Details section of the Smoking/Tobacco Use dialog has been updated with a new **Cessation materials/counseling not done for medical reason** and corresponding date field for all newly created chart notes. Also, the **Cessation pharmacologic therapy provided** field and corresponding date field has been removed for all newly created chart notes. See Figure 9. For all previously existing notes, the legacy functionality will remain. Whenever the **Cessation materials/counseling note done for medical reason** option is selected and a corresponding date is configured, it will be included in any applicable Meaningful Use Quality Measures for the 2018 reporting period.

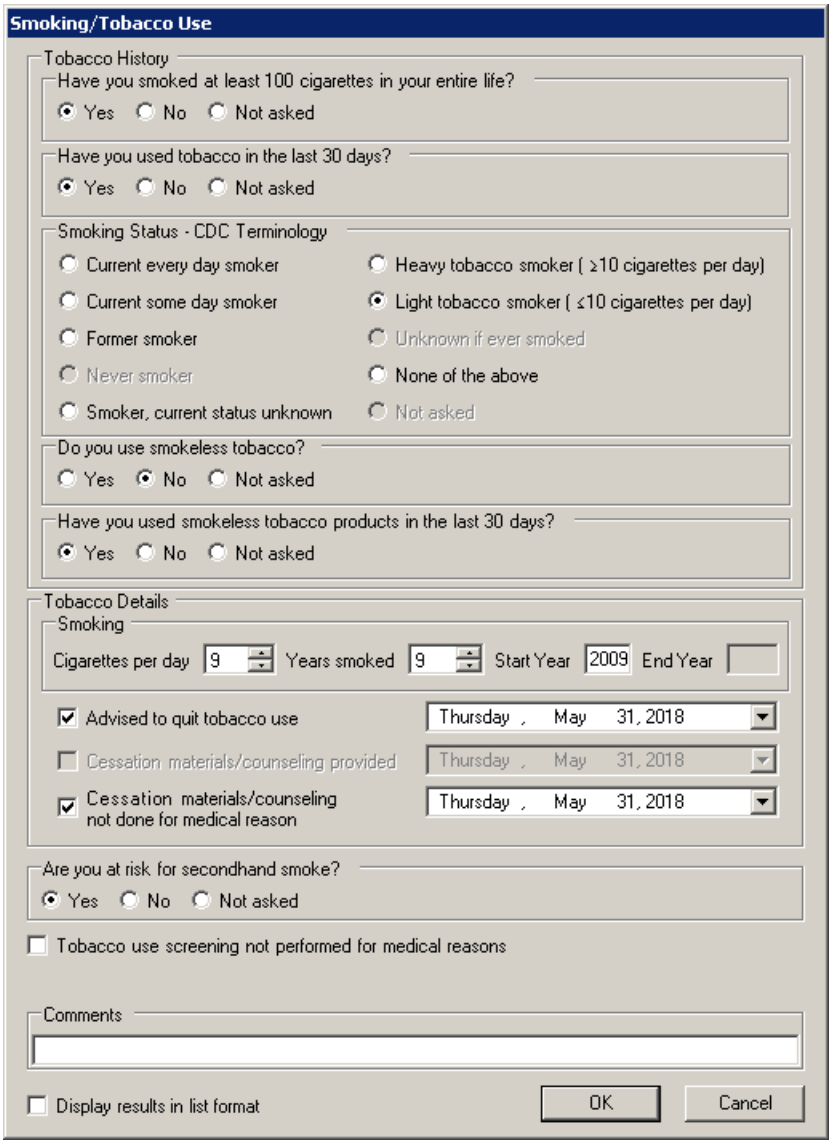

Figure 9 – Smoking/Tobacco Use

- **Reports – Patient Empanelment Report –** The system has been updated with a new **Patient Empanelment Report** dialog (accessed via **Reports** > **Patient Empanelment Report**) that allows you to run a Patient Empanelment Report to easily determine and view patients that are empaneled within the practice, as well as display an empanelment rate, to help you meet CPC+ requirements. See Figure 10. A patient is considered empaneled when a **Principal Care Provider** is entered for the patient in the ID tab in Clinical, or a **Provider** is entered for a patient in the Patient screen of Practice Manager.

  When in the Patient Empanelment Dialog, you can filter the report by **Appointment Date From**/**To**, **Empaneled Provider**, **Appointment Provider**, **Practice**, **Appointment Reason**, **Practice Manager Patient Status**, and **Risk Stratification**. After the applicable filter items are selected, you can click the **Run Report** button to generate the report for the filter criteria selected. You can sort the report by any of the column headings in the Results area. An Empaneled Rate percentage will be displayed in the bottom left of the dialog, which is the percentage of empaneled patients out the total patients returned for the selected filter criteria. You can also save the report to a file by clicking the **Save to File** button.

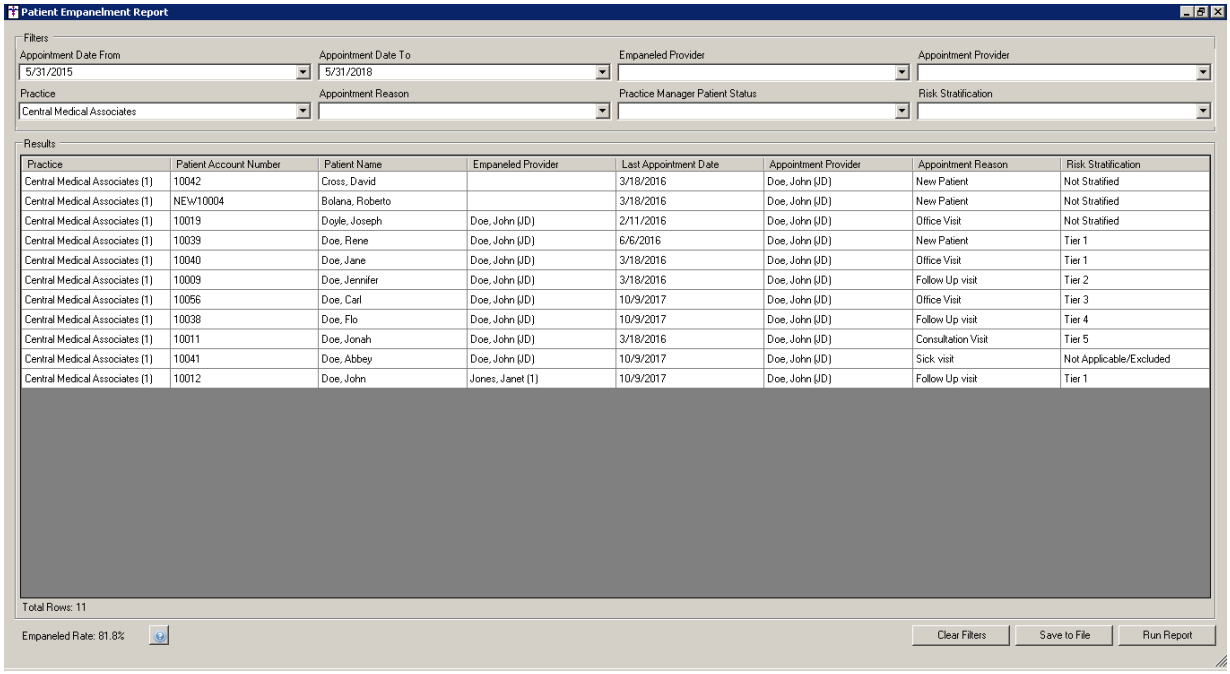

Figure 10 – Patient Empanelment Report

- **STI Quality Reporting Registry (STI MIPSPRO)** – The system has been updated to send applicable data to the STI Quality Reporting Registry (STI MIPSPRO) for those measures in the 2018 reporting period that have lookback periods associated with them.

Addendum

SureScripts® E-Prescribing Best Practice Guidelines

Below are best practices that have been developed to assist in the construction of complete, non-contradictory, and clear patient directions:

Ensure that Directions are complete and accurate

- All information in the Sig must be accurate, complete, and include all the required components written in the following order: action, dose, dose units, route, frequency, and finally auxiliary information.
    - The exception to this syntax is Sigs which simply state "Take/Use as Directed/Instructed as per manufacturer labeling."
- Information within the Sig must not conflict with itself

Example: *Use "**Take 1 tablet by mouth** daily" instead of just "Daily."*

Always qualify "...as Directed" with a source

- Statements such as "Take as directed" and "Use as instructed" should only be used when followed by a source that clearly dictates to the patient where or from whom they can obtain the specific directions.
- If a Sig builder tool is used, ensure that prescribers enter the specific source of the instruction after selecting the "Take/Use as directed/instructed" option before they can proceed with finalizing the e-prescription.

*Example: Use "Use as instructed **per instructions on package**" instead of "Use as instructed."*

Always qualify "PRN (as needed)" with an indication

- The use of "PRN" (i.e. "as needed") should only be used in conjunction with an indication.
- For all other non-PRN directions, inclusion of an indication is also recommended; alternatively, there is also a designated structured field for Diagnosis, in which ICD-10 codes may be used to communicate the appropriate diagnosis or indication relevant for the prescribed product
- If a Sig builder tool is used, ensure that the Sig builder tool requires prescribers to enter the specific indication or conditions for PRN use if the prescriber selects a "PRN" frequency

*Example: Use "Take 1 tablet by mouth every 4 hours as needed **for mild to moderate pain**" instead of "Take 1 tablet by mouth every 4 hours as needed."*

Always specify the Duration of Therapy for Acute Treatments

- Duration of therapy should **only** be specified for medications for acute treatments with a defined length of therapy, e.g., antibiotics.

Avoid Abbreviations, Acronyms or Symbols

- ISMP (Institute for Safe Medication Practices) provides the complete list of *Error-Prone Abbreviations, Symbols, and Dose Designations* that should never be used in a prescription
- If the use of Latin abbreviations is desired, the system should include the ability to expand Latin abbreviations into plain English text via keystroke accelerators. The expanded text form of the Sig should be displayed to the prescriber to ensure correct transition from abbreviations to full text

Example: *Use "**Instill 1 drop into both eyes once daily**" instead of "1 gtt ou qd."*

Never Truncate or Split Directions between multiple fields

- If the patient directions are being transmitted exceeds the 140-character limit, it should be communicated by other means, e.g. as a fax or printed handout
- Sig information should **not** be written into the Notes field if it exceeds the 140-character limit.

Send only Patient Directions (Sig) within the Directions field

- The Sig should not contain information for which another designated field exists in the SCRIPT standard (e.g. the Sig should never include the quantity, drug name, NDC or RxCUI values, or Notes to pharmacists, etc.)

*Example: Use "**Take 1 tablet by mouth once daily**" instead of "Take 1 tablet by mouth once daily. Dispense #30, 3 Refills, Thank you."*

Do not include Clinical or Prescription Information in the Notes field.

- The Notes field be used to contain information related to, but not part of the prescription. While clinical and prescription information should appear in the designated fields for these data elements, not in the Notes field.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input.

(1) Guidelines that apply to name, strength, dosage form, and quantity of drug prescribed as well as the directions for use (the "Sig")

- Drug names should be spelled out in full, avoiding the use of abbreviations.
  - While it might be possible to make the case that abbreviations save time in the world of paper prescriptions, no such time savings accrue in the electronic world in which the prescriber simply picks a medication from a drug database.
  - Abbreviations can lead to a misinterpretation of the prescriber's intent, which can result in medication errors.
  - Examples:
    - Use "Hydrochlorothiazide 50 mg" instead of "HCTZ 50 mg."
    - Use "Zidovudine 300 mg" instead of "AZT 300 mg."
- Drug descriptions should include complete name, strength, strength units and dosage form information (if applicable) in the same exact order, and all should appear in one drug description field.
  - Not doing so causes problems in pharmacies due to missing data components.
  - It is preferred that either the generic or the brand name be used in the drug description, but not both. Using both unnecessarily complicates the information in the drug description field.
  - Examples:
    - Use "Doxycycline Monohydrate 50 mg oral capsule" instead of "Doxycycline caps."
    - Use "Ciprofloxacin 500 mg tablet" instead of "Ciprofloxacin tablet 500 mg."
    - Use "Atorvastatin calcium 20 mg tablet" or "Lipitor 20 mg tablet" instead of "Lipitor (Atorvastatin calcium) 20 mg tablet."
    - Drug descriptions for generic products should use the naming conventions found in the Food and Drug Administration's "Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations."
  - This helps pharmacists to accurately choose the product to be dispensed when brand names are not used.
  - Examples:
    - Use "Glipizide 10mg tablets, extended release" instead of "Glipizide TAB OSM 24 10mg."
    - Drug strength information should be consistent across all fields in which it appears.
  - The strength in the drug description should match that in the drug strength field.
  - Drug strength units in the drug description should match those in the drug strength units field. Drug strength units should not be sent in the drug strength field.
  - Example of improper use: The drug description is "Amoxicillin 500 mg oral capsule" and the drug strength field contains the value of "250."
- Dosage form codes should match the forms sent in drug description fields.
  - Example of improper use: The drug description is Amoxicillin 500 mg capsule and the dosage form code field contains "10," which is the NCPDP code that stands for tablet.
- All orders should be written using metric measurements of weight (e.g., mg, gm and kg) and volume (e.g., ml).
  - The apothecary and avoirdupois systems of weights and volumes are no longer considered appropriate in the world of pharmaceuticals.
  - Example: Use "Aspirin 81 mg" instead of "Aspirin 1 ¼ grains."
- A zero should be used before a decimal (use 0.X mg instead of .X mg), but not after (use X mg instead of X.0 mg).
  - Trailing zeros are particularly dangerous in that they can lead to ten-fold overdoses. Thus, trailing zeros should never be used.
  - Examples:
    - Use "Digoxin 0.25 mg" instead of "Digoxin .25 mg."
    - Use "Haloperidol 5 mg" instead of "Haloperidol 5.0 mg."
- Arabic (decimal) numerals are preferable to Roman numerals, and in some instances it is preferable for numbers to be spelled out.
  - Example: Use "Aspirin 325 mg" instead of "Aspirin V grains."
- Other specific abbreviation issues:
  - The term "microgram" can be abbreviated as "mcg," but it should not be abbreviated as "ug," which can easily be mistaken for the abbreviation for "mg," standing for "milligram."
  - The word "unit" should be spelled out and never abbreviated as "U" or "u."
  - "M" should not be used as an abbreviation for thousands (e.g., 5 M units), as it has been mistaken as meaning one million.
  - Do not use commas when expressing thousands as they might be misinterpreted as periods.

SureScripts® E-Prescribing Best Practice Guidelines (continued)

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

(2) Issues related specifically to the Sig field or directions for use.

- The directions for use should not be split between the Sig and Notes fields.
    - Depending upon the design of the pharmacy system and/or the effectiveness of the training of pharmacy personnel, splitting directions between the Sig and Notes fields can result in part of the directions being missed, thereby preventing complete directions from being conveyed to patients. Patients may experience significant negative therapeutic outcomes when this occurs.
    - Examples of improper use:
        - Sig field—"Take one tablet daily," Notes field—"Take only on Monday, Wednesday and Friday." NOTE: This is an actual example from a warfarin e-prescription, which if not taken according to the complete directions, could possibly result in serious patient harm.
        - Sig field—"Dissolve one tablet under the tongue every 10 minutes for chest pain," Notes field—"Call physician immediately if relief is not obtained after three doses."
        - Sig field—"Apply and rub well into affected area twice a day," Notes field—"Discontinue use and call physician if rash worsens."
        - Sig field—"One drop to eye having surgery three times daily," Notes field—"Start two days prior to surgery."
- Information in the Sig field should not conflict with information in the Notes field.
    - Conflicting information in these fields usually requires pharmacists to contact prescribers to ascertain their actual intent with respect to the directions, which compromises the efficiencies related to e-prescribing.
    - Inconsistent information in the Sig versus the Notes fields can result in incorrect directions being conveyed to patients.
    - Example of improper use: Sig field—"1 cap orally 3 times a day", Notes field—"One capsule by mouth daily."
- Care must be taken so that Sigs are not truncated because important information can be lost.
    - Example of improper use: "Take 1 tablet once a month in the am 1 hr before eating or drinking, with 1 C water. Remain upright x 1 hour and nothing by mouth, then resu"
- Sig information should be clinically correct.
    - Example: Use "Amoxicillin 500 mg Oral Capsules"—Sig "One capsule three times a day" instead of "500 caps 3 times a day."
- Directions for use should be spelled out clearly in proper English.
    - Since the pharmacist must interpret—and nearly always writes—the label in English, the use of abbreviations (particularly Latin) or symbols is unnecessary and discouraged because it can lead to medication errors.
    - Example: Use "Take 1 tablet by mouth twice a day" instead of "1 T PO BID."
- Information in the Sig field should be limited to the Sig.
    - Quantity to be dispensed should not be placed in the Sig field.
        - Example: Use "One capsule by mouth three times daily" instead of "One capsule by mouth three times daily – Disp # 30."
    - Duration of therapy should not be placed in the Sig field.
        - Example: Use "One capsule by mouth four times daily" instead of "One four times daily – Disp 10 day supply."
    - Drug description should not be placed in Sig field.
        - Example: Use "One capsule by mouth at bedtime" instead of "One by mouth at bedtime– Paxil CR 20 mg."
    - Example of improper use:
        - "One drop to eye having surgery three times daily. Start two days prior to surgery. May substitute Acular LS, Xibrom, or Voltaren if less expensive." (i.e., the indication of alternative approved drugs "May substitute Acular LS, Xibrom, or Voltaren if less expensive" should be placed in the Notes field.)
- Sigs should be complete, properly formatted, and not repeated.
    - Sig should be complete.
        - ☐ Example: Use "Apply topically to forearm three times a day" instead of "Topical each day."
    - Sig should be properly formatted.
        - ☐ Example: Use "Take one capsule three times a day" instead of "1 3 times a day."
    - Sig should not be repeated.
        - ☐ Example: Use "Take one capsule daily" instead of "1 PO QD – Take one tablet every day."
- The inclusion of the intended use or the indication for the medication in the directions for use is helpful to patients, pharmacists and other prescribers, and is strongly encouraged.
    - Intended use can help patients to organize and better understand their medications and why they are taking them.
    - Including the indication in the Sig field can help prevent dispensing errors, and it provides pharmacists with a foundation for patient counseling and medication therapy management.
    - Other prescribers may find the indication helpful when a patient brings their medication bottles with them to office visits.
    - Example: "Take according to instructions in dosepak for poison ivy rash."

Category II—Prescription Data Elements Requiring Extra Care and Attention When Input. (Continued)

- The instruction "take as directed" is rarely appropriate and should be avoided by prescribers.
    - Such an instruction assumes an understanding on the part of the patient that may not exist, and even if it does, will very likely be short lived.
    - Using the term "take as directed" provides little information upon which the pharmacist can base their counseling of the patient.

(3) Proper use of the Notes field (referred to as "free text" in the NCPDP SCRIPT Standard).

- Prescription information that has a designated, standardized data field should not be placed in the Notes field.
    - For example, neither the drug name, strength nor quantity should be placed in the Notes field because there are specific fields in the NCPDP SCRIPT Standard for these data elements. This is important because if this information isn't placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
- Clinical information that has a designated, standardized data field should not be placed in the Notes field.
    - As with prescription information, the clinical information should appear in the designated fields for these data elements. This is important because if this information isn't placed in the fields in which pharmacy personnel are trained to look for it, it might be missed.
- Reserve use of the Notes field for information related to, but not part of, the prescription.
    - For example, a comment such as: "Please have the patient call the office when they have finished taking this prescription" would be an appropriate use of the Notes field.
- To reiterate, as mentioned above, the directions for use should not be split between the Sig and Notes fields nor should the information in the Sig field conflict with information in the Notes Field.
    - The former can lead to critical information being missed by pharmacy personnel and possibly not being transmitted to the patient, and the latter normally requires pharmacists to contact the prescriber to clarify their intent, thereby compromising the potential efficiencies of e-prescribing.

(4) Refills authorized, if any

- Although allowed both by convention and NCPDP SCRIPT, the indication of "PRN" (refill as needed) is not considered to be good practice and should be discouraged.
    - Example: Use "Refill 11 times" instead of "Refill PRN."

(5) Other items unique to electronic prescribing.

- Representative NDC number requirements.
    - Representative NDC numbers, which contain 11 digits, must be correct, as incorrect representative NDC numbers may cause drug identification problems in the receiving pharmacies.
    - Representative NDC numbers must be current and included in e-prescription messages unless the items do not have assigned NDCs.
- Quantity Qualifiers must be correctly associated with drug descriptions.
    - Correct mapping procedures are available in the Units of Measure table, which can be found in the NCPDP External Code List and the Surescripts Implementation Guides.
    - Where possible, quantities should reflect the actual metric quantity to be dispensed.
        - Example: Use "Amoxicillin 250mg/5ml, 150 ml" instead of "Amoxicillin 250mg/5ml, 1 bottle."
    - The use of "ZZ", "EA" and "00" should be limited to instances in which none of the available qualifiers in the Units of Measure table can be applied.
        - ☐ Examples of improper use: Drug description—Amoxicillin 500 mg Oral Capsule, Quantity 30 and Quantity Qualifier sent "ZZ"—mutually defined, "EA"—each or "00"—unspecified instead of "AV"—capsules.

Category III—Prescription Common Mistakes

Even though providers using the ChartMaker Medical Suite strive to be accurate in entering information for E-prescription, there are common mistakes made that can easily be corrected. Please read through the examples below in order to understand E-prescription best practices.

(1) Incorrect or incorrectly formatted SIG

This occurs when the appropriate dose is entered incorrectly. The following examples demonstrate typical errors:

Category III—Prescription Common Mistakes (continued)

Drug Description	SIG	Notes	Nomenclature Description	Comment
Combivent Respimat 20 mcg-100 mcg/actuation Aerosol Inhaler	Spray 1 aerosol with adapter (gram) puff(s) 4 times a day		Incorrect or incorrectly formatted SIG	"1 aerosol" is not an appropriate dose for Combivent
Advair HFA 115 mcg-21 mcg/actuation Aerosol Inhaler	Take 2 aerosol with adapter (gram) puff(s) twice a day		Incorrect or incorrectly formatted SIG	"2 aerosol" is not an appropriate dose for Advair HFA
ProAir HFA 90 mcg/actuation Aerosol Inhaler	Take 2 puffs puff(s) q 4-6 hrs prn cough or wheeze or before exercise		Incorrect or incorrectly formatted SIG	Part of the patient instructions are duplicated
Proctosol HC 2.5 % Rectal Cream	Apply 1 cream (gram) rectally 4 times a day		Incorrect or incorrectly formatted SIG	"1 cream" is not an appropriate dose for Proctosol
dicyclomine 10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Three times a day	prn as directed	Incorrect or incorrectly formatted SIG	SIG should be free of all extraneous characters All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Lotrel 5 mg-10 mg capsule	Take 1 capsule (hard, soft, etc.) orally Daily	Name Brand Medically Nec.	Incorrect or incorrectly formatted SIG; Conflicting or Supplementary Drug Substitution information in the Notes	SIG should be free of all extraneous characters All Drug Substitution information should be sent in its designated field; No parts of the Drug Substitution information should be in the Notes
Suprax 400 mg capsule	Take 1 capsule (hard, soft, etc.) orally qd		Incorrect or incorrectly formatted SIG; Incorrect, Missing or Incomplete Dosage Form sent in Drug Description	SIG should be free of all extraneous characters - Suprax 400mg is not available in capsule form; Appropriate dosage form: **Oral Tablet**

Category III—Prescription Common Mistakes (continued)

(2) Incomplete SIG

The following examples indicate incomplete SIG:

Drug Description	SIG	Comment
Suprep 17.5 gram-3.13 gram-1.6 gram Oral Solution	Take 1 solution, reconstituted, oral orally As Needed	SIG should include the **dose, route and frequency** of the prescribed medication
Coumadin 4 mg tablet	Take 2 tablet orally as directed	SIG should include the **dose, route and frequency** of the prescribed medication
Zithromax Z-Pak 250 mg tablet	Take 1 tablet orally As Directed	SIG should include the **dose, route and frequency** of the prescribed medication

Category III—Prescription Common Mistakes (continued)

(3) Conflicting or Supplementary SIG information included in the Notes

Drug Description	SIG	Notes	Comment
nystatin 100,000 unit/gram Topical Ointment	Apply 1 ointment (gram) topically Twice a day	FOR CORNER OF LIP	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
metformin 500 mg tablet	Take 1 TABLET orally bid	*take 1 tablet daily for 1 month, then increase to 1 tablet twice a day	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Augmentin 875 mg-125 mg tablet	Take 1 tablet orally Every 12 hours	x 5 days	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes
Mobic 7.5 mg tablet	Take 1 tablet orally twice a day	as needed	All patient instructions should be sent in their designated SIG field; No parts of the SIG should be in the Notes