Consultation Manager for Clinicians

Version 1.1

4th July 2023

cegedim Healthcare Solutions

Copyright © 2023 Cegedim Healthcare Solutions

All Rights Reserved

Cegedim Healthcare Solutions is the trading name of Cegedim Rx Ltd and In Practice Systems Limited.

No part of this document may be photocopied, reproduced, stored in a retrieval system or transmitted in any form or by any means, whether electronic, mechanical, or otherwise, without the prior written permission of Cegedim Healthcare Solutions.

No warranty of accuracy is given concerning the contents of the information contained in this publication. To the extent permitted by law, no liability (including liability to any person by reason of negligence) will be accepted by Cegedim Healthcare Solutions, its subsidiaries or employees for any direct or indirect loss or damage caused by omissions from or inaccuracies in this document.

Cegedim Healthcare Solutions reserves the right to change without notice the contents of this publication and the software to which it relates.

Product and company names herein may be the trademarks of their respective owners.

Registered name: Cegedim Rx Ltd. Registered number: 02855109
Registered name: In Practice Systems Limited. Registered number: 01788577
Registered address: Studio F5 Battersea Studios 1, 82 Silverthorne Road, London SW8 3HE

Website: https://www.cegedim-healthcare.co.uk/

Contents

Consultation Manager for Clinicians 4

Starting and Signing on to Vision 3 4
Vision Front Screen 5
Consultation Manager Screen Overview 6
Selecting a Patient 10
Starting a Consultation 12
Patient Preview 13
Finding Data 14
Adding Clinical Data 15
Using the Add Menu 18
Updating an Entry 21
Adding and Printing an Acute Prescription 21
Adding a Repeat Prescription 28
Issuing Repeat Prescriptions 32
Reauthorising Repeats 34
Drug Checks 35
Adding a Drug Allergy/Adverse Reaction 39
Dragging and Dropping in Consultation Manager 41
Adding a MED3 42
Displaying data as a Graph 49
Adding an Immunisation 51
Adding a Referral 53
Exiting Vision 3 55

Consultation Manager for Clinicians

Starting and Signing on to Vision 3

> **Note** - If you are in England and are logging into **Vision 3** with your Smartcard, you need to authenticate your card first by putting it in the card reader and entering your passcode.

To sign in to **Vision 3**, either:

1. From your desktop, double click **Vision 3**

.
2. The **Vision Login** screen displays:

> **Note** - If you are in England and have authenticated your Smartcard, you are taken to the **Vision 3 front screen** after double clicking on the **Vision 3** icon. You do not need to enter a password on the **Vision 3** login page.

Complete as follows:

- **Login Name** - Enter your log in name.

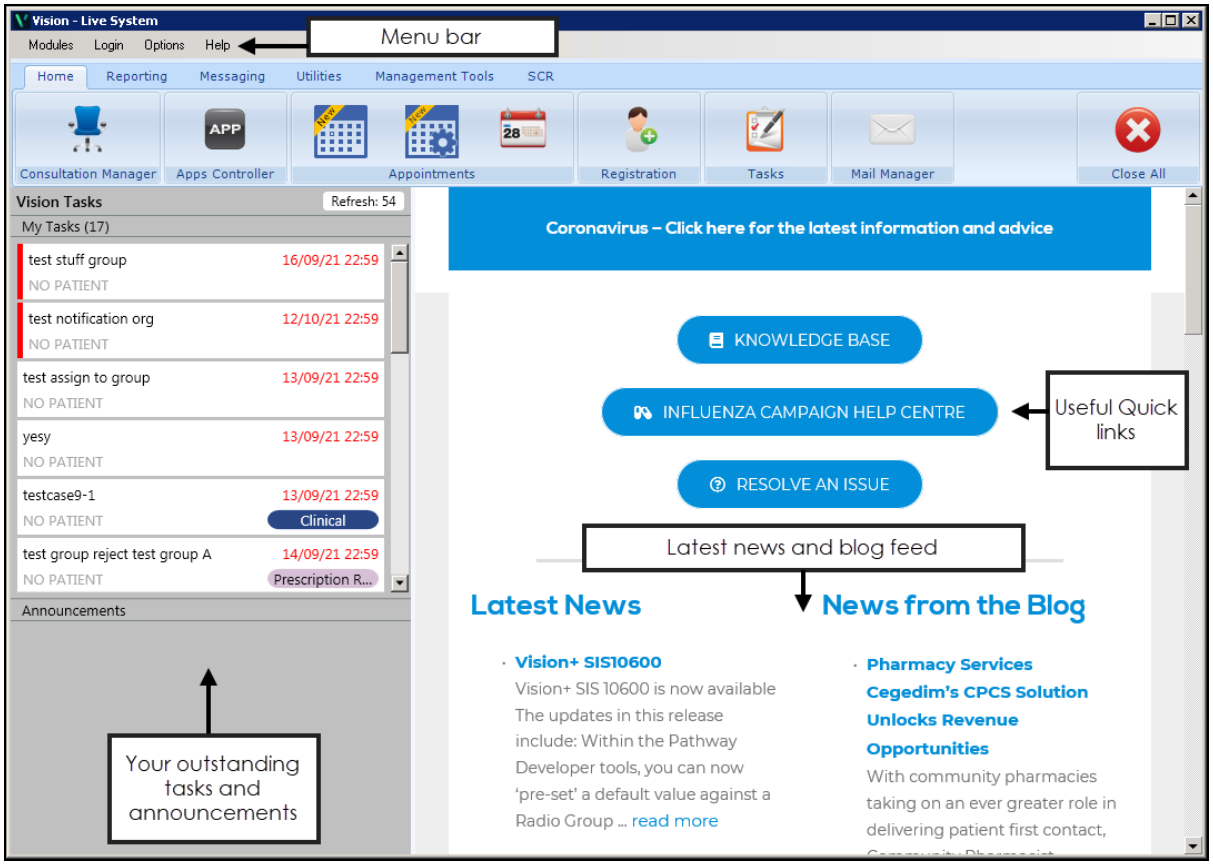
> **Training Tip** - If you cannot remember your **Login Name**, please see your System Administrator.

- **Password** - Enter your password, stars display as you type.
- **Site** - If you have more than one surgery location, select the site you are working at.

3. Select **OK**.

The **Vision 3 Front Screen** displays.

Vision Front Screen



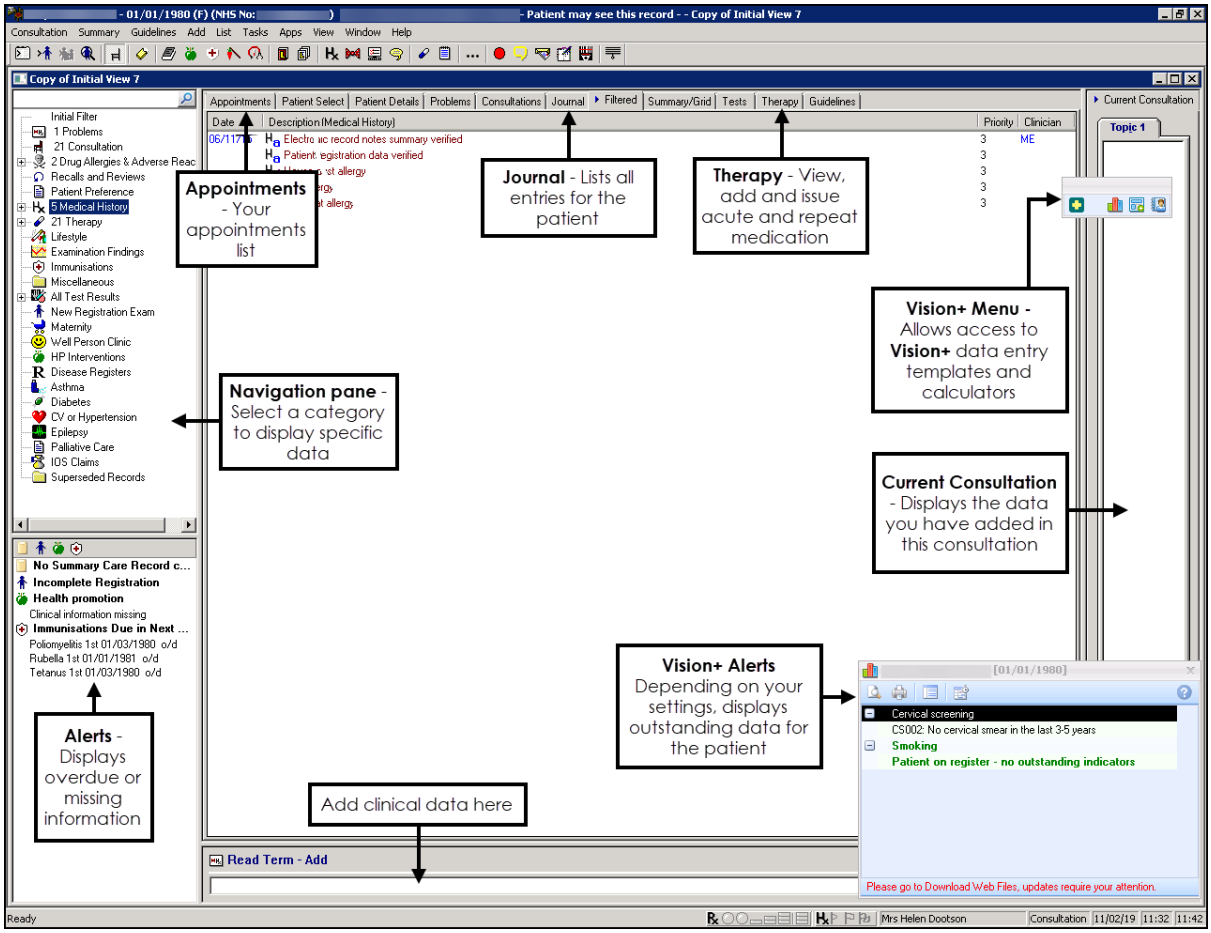
The **Vision 3 front screen** gives quick access to **Vision 3** modules.

There are five main sections:

- **Home**
- **Reporting**
- **Messaging**
- **Utilities**
- **Management Tools**
- **SCR** (England only)

Consultation Manager Screen Overview

The way **Consultation Manager** looks varies depending on your set up:



Menu, Toolbar, Shortcuts and Function Keys

You can select options from any of the following:

- Menu bar
- Toolbar icons
- Patient Record
- Keyboard

> **Note** - Most toolbar and menu options are greyed out and unusable, until you select a patient and start a consultation. You can however, view a patient's record or list existing data entries without starting a consultation.

The Consultation Manager Toolbar

To identify the options on the **Consultation Manager** toolbar, simply hover your mouse over the item required and a **Tooltip** displays the description.

It is not recommended, but you can switch off the toolbar, select **View - Toolbar** to remove the tick. If this happens in error, select **View - Toolbar** again to restore the toolbar.

The following commonly used options are available from the toolbar:

Training Tip - Alternative function keys, where available, are shown in square brackets.

- **Appointment List** - Displays your appointment list.
- **Select Patient** [F3]- Select to find a patient's record.
- **Select a Patient Group** - Select to find a predefined group of patients to work on.
- **Patient Details** - Select to view patient demographic details and maintain:
  - Contact numbers
  - Preferred/Nominated pharmacy
  - Carer information
- **Open/Close a Consultation** [F7] - Select to open or close a consultation, this displays as depressed when a consultation is open.
- **Patient Record View** [F10] - Select to display the patient record.
- **Immunisations** - Select to view and maintain the immunisation status of the selected patient.
- **Open/Close the Local Guideline Index**
- **Local Reports Index**
- **Patient Reports Index**
- **Medical History Add** - Select to add a medical history clinical term.
- **Referral Add** - Select to record a referral.

- **Therapy Acute** [F4] - Select to display the patient's acute and issued therapy.
- **Therapy Repeat** [F5] - Select to display and maintain the patient's repeat medication.
- **Electronic Test Requesting** - Select to access electronic testing services.
- / **Show/Hide sensitive data** (priority zero) - Select to hide or display priority zero **Medical History** entries on screen.
- / **Patient Warning** - Select to view or maintain warnings for the patient selected.
- **View Mail for Patient** - Select to display, read and process any incoming mail messages for the patient selected.
- **Future and Recent Appointments** - Displays any future booked appointments and any past appointments in the last month. If the patient has no previous or future appointments within this time period, you are prompted that "*nnnnnnhas no future appointments*".
- **Close All**.

Status Bar

To view the **Status Bar**, tick **View - Status Bar**. The status line at the bottom of the screen displays the following information:

- While a consultation is open, the status bar shows the GP or user, consultation type, start time and the current time. If you double click on the status bar, the **Consultation Update** screen displays which allows you to change the type of consultation, and the start and end times:

- Drug check warnings of contra-indications, interactions or drug doubling for the patient.
- Buttons displaying the current open **Vision 3** screens so you can click quickly to view one of these.
- At other times it displays the current status of the screen, for example, '*Displaying Deleted Records*', '*No Open consultation*'.

If the **Status Bar** does not display, lift the whole window up by clicking on the title bar and dragging the screen upward.

Menu, Keyboard users and Function keys

If you prefer to use the keyboard rather than the mouse, you can access menu options by first pressing Alt on your keyboard and then type the underlined letter in the main menu heading, for example, press Alt + A on your keyboard to open the **Add** menu, or Alt + C to display the **Consultation** menu. Then type the underlined letter (not necessarily the first letter) of the option you want, for example, B for **B**lood Pressure, L for Medica**l** History.

Following the usual convention, any menu option that has a bold right pointing arrow after it means there are further choices, for example, Chronic Disease Management.

The following **function keys** can also be used as short-cuts:

Key	Action
F1	Help Centre
F2	List **Medical History**
F3	Select a patient. **F3** can also be used on the **READ Term Add** screen to display the **READ dictionary** screen
F4	Lists **Therapy Script**. Then press **F4** or **Esc** to display **Acute Therapy Add**
F5	Displays **Therapy Repeats**. Then press **F5** or **Esc** for **Repeat Master Add**
F7	Start Consultation
Shift-F7	Close Consultation
F8	New Therapy
F9	Print/Issue and Print Prescription. This can be used anywhere and does not require a **Therapy** screen to be open
F10	(toggle) View Patient Record full screen (without navigation or topic panes) or normal view
Shift F12	Patient Reports
Spacebar	To select and asterisk from a Therapy Repeat list. Pressing again removes the asterisk.

Selecting a Patient

To select a patient from **Consultation Manager** you can use the following:

During an appointment session

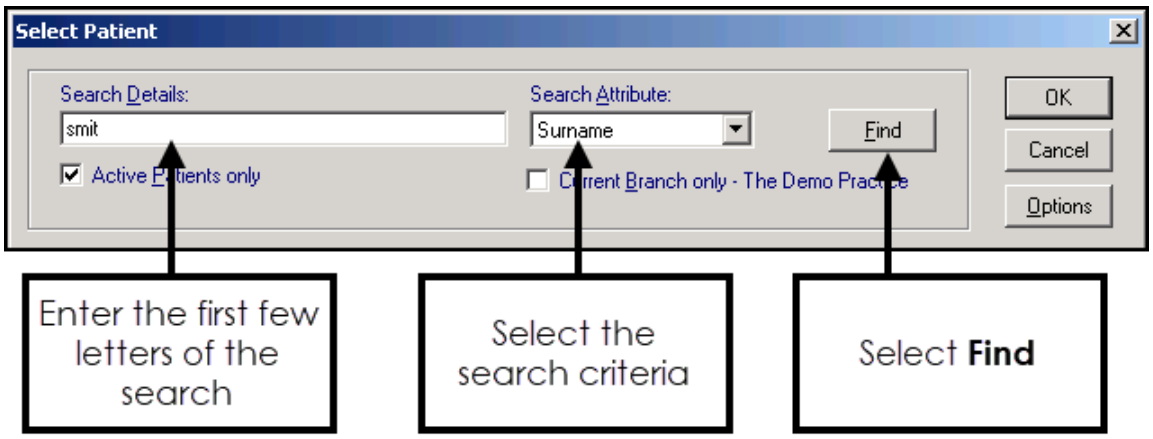
Select **Appointments List** and double click on the patient required. The patient's record displays.

> **Training Tip** - Double clicking from the **Appointment list** starts a consultation and changes the patient status to **In Consultation**.

To refresh your **Appointments List**, select **Refresh**.

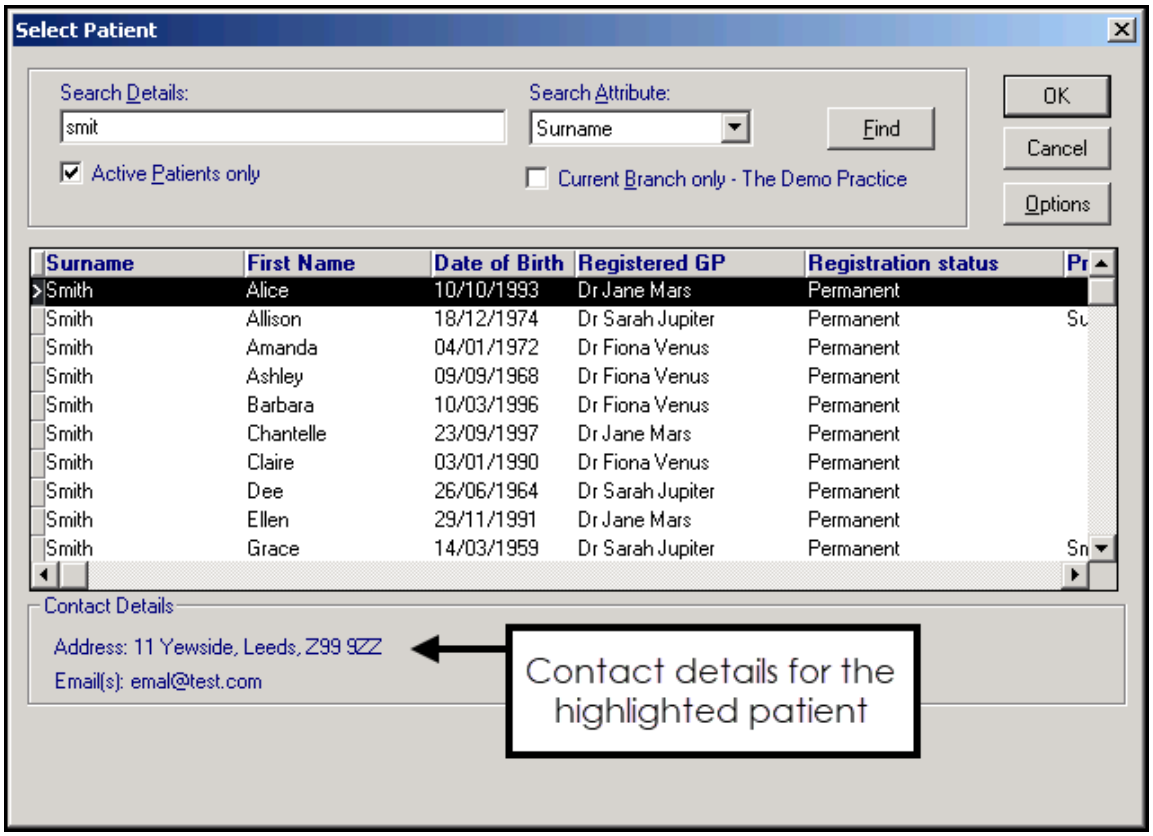
At any time

1. You can either:
   - Select **Select a Patient**,
   - Press **F3** on your keyboard, or
   - Select **Consultation - Select a Patient**.
2. The **Select Patient** screen displays, change the **Search Attribute** if required using the down arrow and then enter the first few letters of the selected criteria in **Search Details**:



3. Select **Find** Find or press **Enter** on your keyboard.

4. The **Select Patient** screen displays with the search results:



Locate the patient you require and either double click on them or highlight the patient required and select **OK**. Use the right horizontal scroll arrow to view further patient details off-screen on the right.

The patient's record displays.

Common ways to find a patient

Find by name:

- **Search Attribute** - Select **Surname**.
- **Search Details** - Enter the first few characters of the patient's surname a space and their initial.
- Select **Find**

, or press **Enter**.

Find by date of birth:

- **Search Attribute** - Select **Date of Birth**.
- **Search Details** - Enter the date of birth as n.n.nnnn, you need not enter a whole date, but just a year to list all patients born in that year, for example type in 1924 to find all patients with 1924 dates of birth.
- Select **Find**

, or press **Enter**.

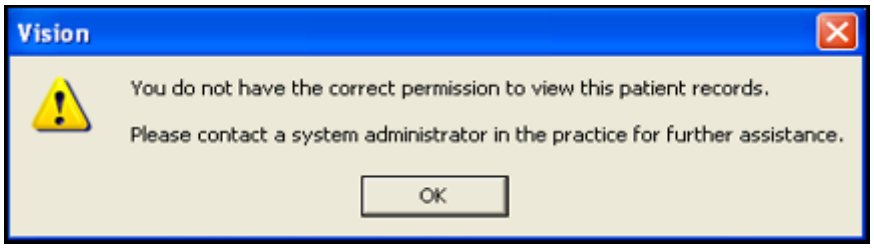
Find by NHS Number/CHI Number/H+C Number:

- **Search Attribute** - Select **NHS Number/CHI Number/H+C Number**.
- **Search Details** - Enter the number of the patient required.
- Select **Find**

, or press **Enter**.

Once the patient is selected, their name and demographic detail displays at the top of the screen.

If the patient you select is marked as a **Sensitive Patient** and you do not have permission to access them, a warning message displays, select **OK** to accept:



Starting a Consultation

You cannot add data to **Consultation Manager** until you start a consultation.

A consultation can be opened automatically when a patient is selected, or open a consultation as follows:

If no consultation is open, **Open New Consultation** displays and the status bar displays **No Open Consultation**

To open a consultation, simply select **Open New Consultation** from the toolbar.

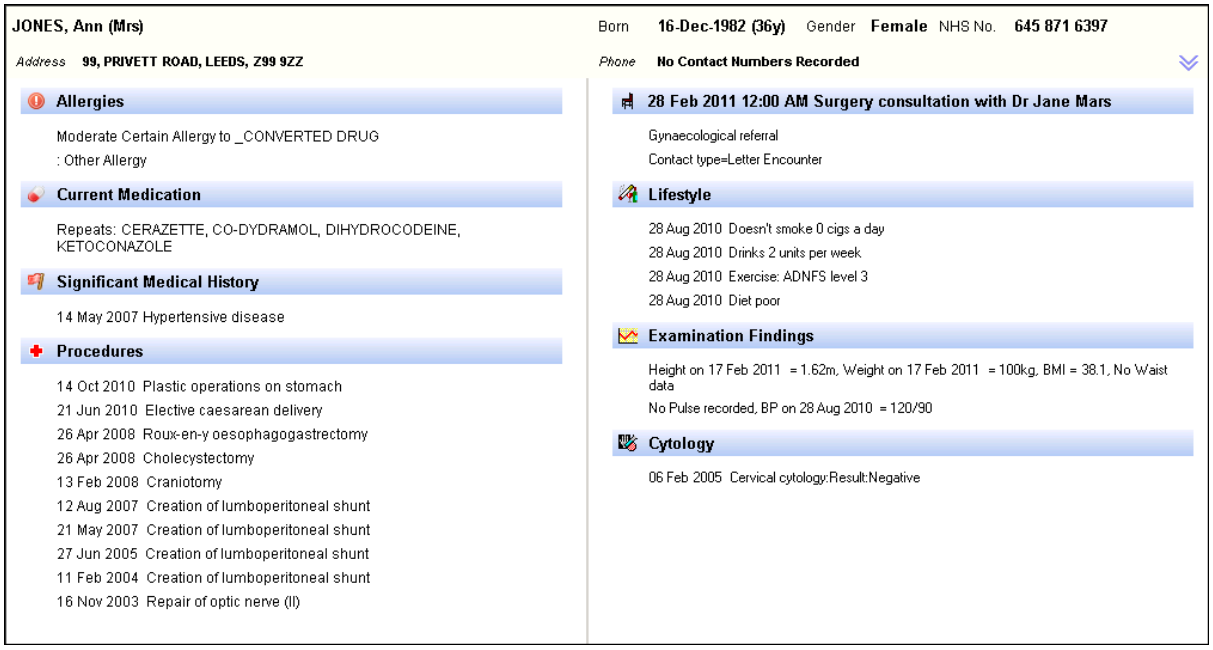
When a consultation is open:

- **Close Consultation** displays
- The status bar, at the bottom right hand side of the screen, displays your name, the type, date, open time of the consultation and the current time:

Training Tip - You can change the consultation type by double clicking on the **Consultation Type** at the bottom of the screen, for example, Video consultation.

Patient Preview

Patient Preview is designed to display a quick overview of patient details in a simple and consistent layout. It provides a snapshot of essential information on one page and allows clinicians immediate access to the most important patient data:



The data displays a pre-defined set of criteria and considers the age and sex of the patient. Some items display regardless of whether the information is recorded or not, for example, **Allergies** is always visible. Other items only show if the patient has the information recorded, for example, **Procedures** only display if the patient has had an operation or procedure.

Double click on any section of the screen for direct access to relevant parts of the patient record.

Hiding and Re-displaying Patient Preview

To hide the **Patient Preview** screen, you can either:

- Select **Patient Record View**
- Press **F10** on your keyboard, or
- Press **Esc** on your keyboard

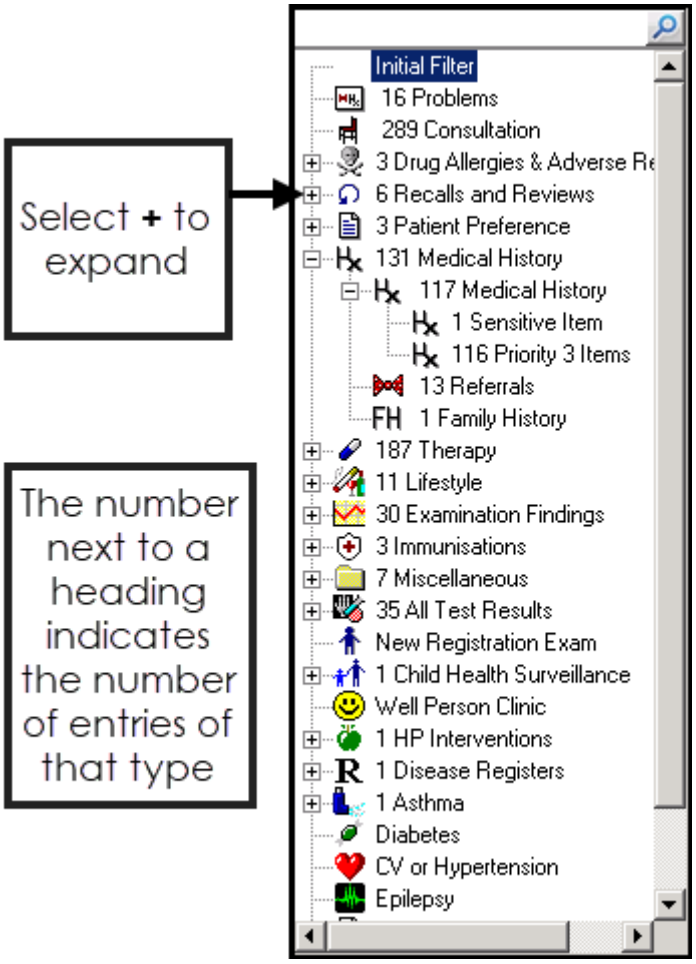
> **Note** - The **F10** key does not take you back to the **Patient Preview** screen. If you press **F10** from the patient record it toggles the navigation pane on and off.

To re-display the **Patient Preview** screen, you can either:

- Select **Summary - Patient Preview**, or
- Press the **Alt+S** keys on your keyboard and then press **W**

Finding Data

The easiest way to view clinical information in **Consultation Manager** is to use the navigation pane:



- **Search** - Enter the text to search on and press enter,
- Select **Expand** to expand a heading and to collapse a heading, or
- For keyboard users, press **Tab** to the correct section and select **>** to expand a heading and **<** to collapse a heading.

You can also use the tabs in your **Consultation Manager** view:

Remember - The tabs offered depend on your settings.

Or the options and menus at the top of the screen:

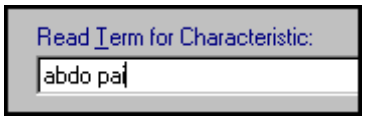
Adding Clinical Data

Data in **Vision 3** is added using Read codes, **Vision 3** dual codes all data using both Read codes and SNOMED CT.

Remember - To add data to a patient record, you must first select a patient and open an appropriate consultation.

To add clinical data:

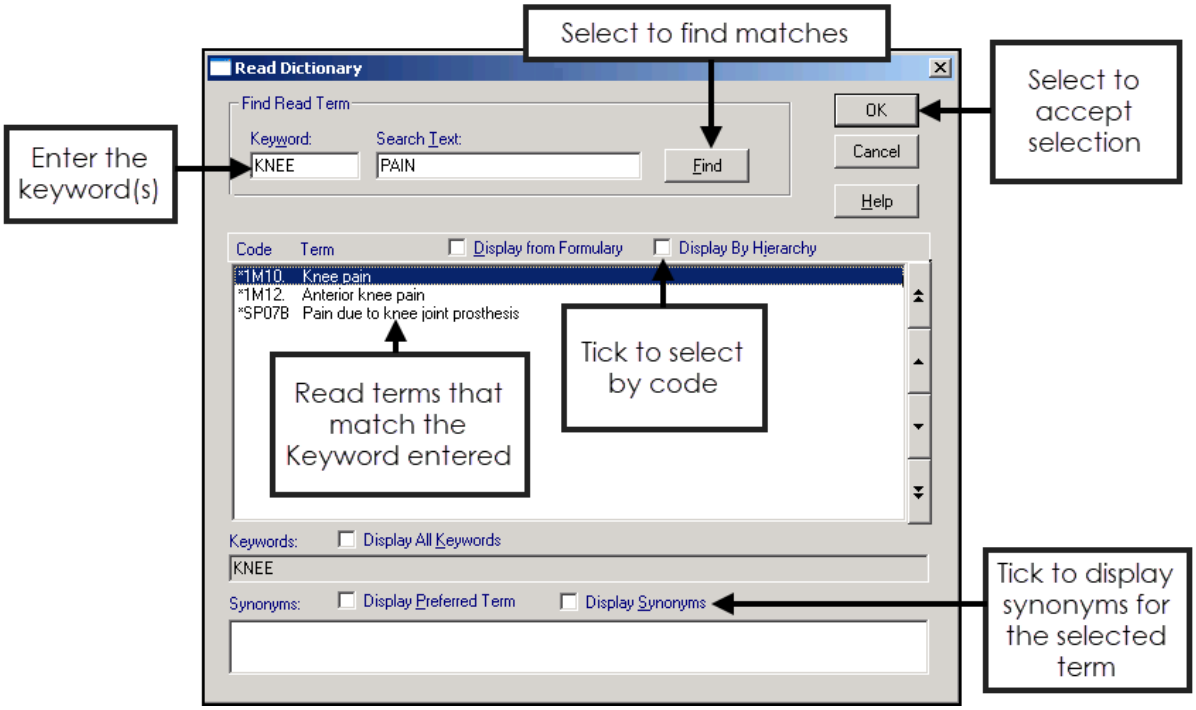
1. From **Consultation Manager**, with patient selected and a Consultation started, enter either:
   - **A keyword** - Enter one or two partial words in **Read term for Characteristic** or **Read Term - Add**, for example '*asthma*', or '*Abdo pai*' and press **Enter** on your keyboard:

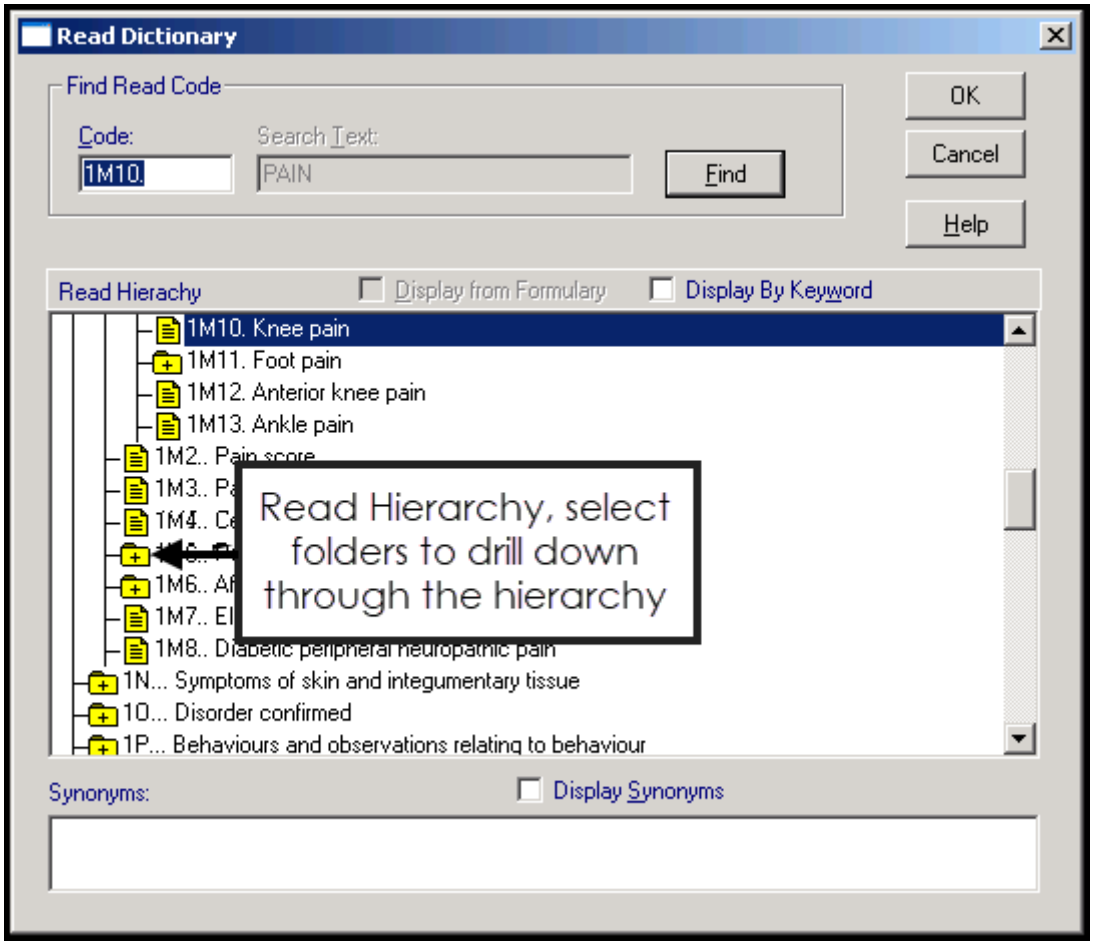


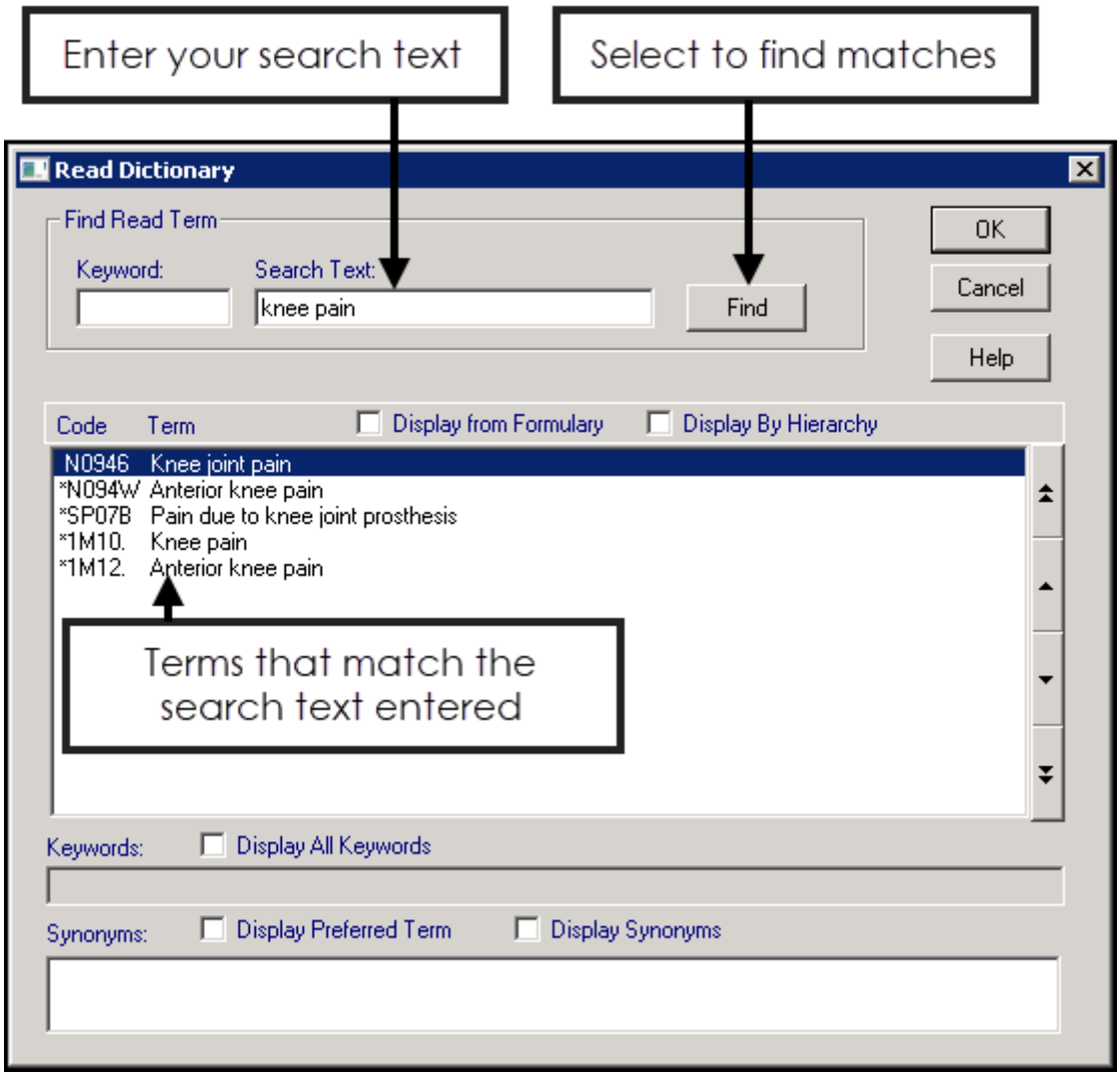
   - **A Read code** - Enter # and then the code, for example '*#H33*' for Asthma, code entry is case sensitive and press **Enter** on your keyboard:

   - **Problems** - If you are a Problem orientated practice, open the relevant Problem, add your data and it is automatically linked.
   - Or, select from the **Add** menu, see **Using the Add Menu** on page **18** for details.

2. If the appropriate term is not returned, press **F3** on your keyboard to display the **Read Dictionary** screen or simply use the up and down arrow keys to move through the offered list:





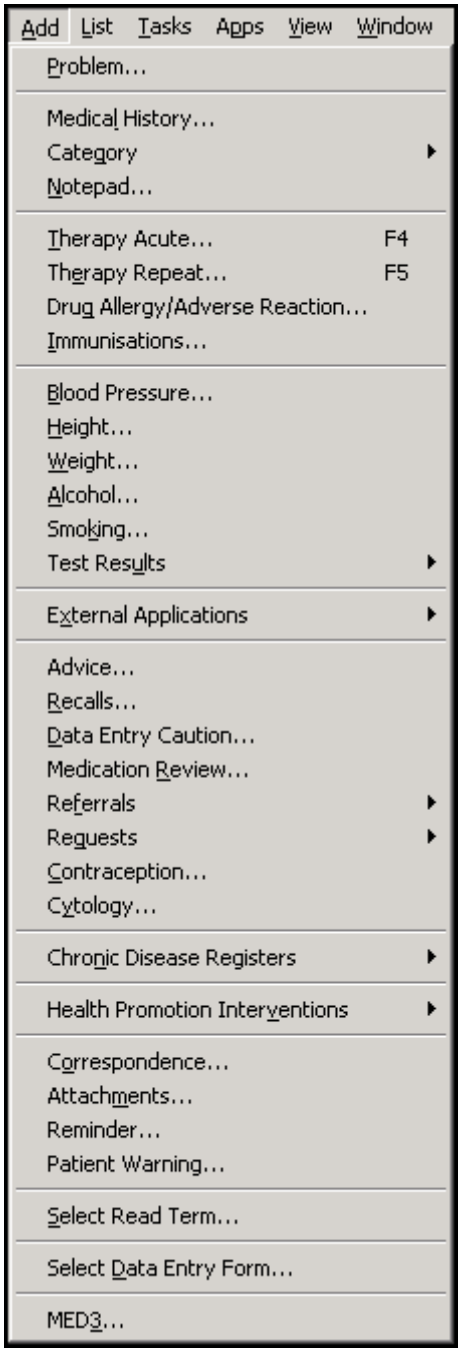


Note - If you are using the **Search Text**, a warning message displays about the time it may take, this search is actually very fast so select **Yes** to continue.

3. Simply highlight the term required and select **OK** to return to the original data entry screen or the correct structured data area (SDA).

Training Tip - **Vision+** also provides a quick data entry tool with targeted templates and reporting.

Using the Add Menu



To quickly and accurately add common structured data, you can use the **Add** menu.

From **Consultation Manager**, with the patient required selected and a Consultation started, select **Add** and then select the option required:

- **Problem** - The **Problem - Add** screen displays, complete as required.
- **Medical History** - The **History - Add** screen displays, complete as required.
- **Category** - The **History - Add** screen displays with the **Type of Characteristic** as selected, complete as required.
- **Notepad** - The **Notepad - Add** screen displays, complete as required.
- **Therapy Acute** - The **Acute Therapy - Add** screen displays, complete as required.
- **Therapy Repeat** - The **Repeat Master - Add** screen displays, complete as required.
- **Drug Allergy/Adverse Reaction** - The **Drug Allergy and Intolerance - Add** screen displays.
- **Immunisations** - The **Immunisation - Add** screen displays, see **Adding an Immunisation** on page **51** for details
- **Blood Presure** - The **Blood Pressure - Add** screen displays.
- **Height** - The **Height - Add** screen displays.
- **Weight** - The **Weight - Add** screen displays.
- **Alcohol** - The **Alcohol Consumption - Add** screen displays.
- **Smoking** - The **Smoking - Add** screen displays.
- **Test Results** - Select the test result required.
- **External Applications** - Select either:
  - **Launch** - Select either:
    - **Choose and Book Web**site - The **eReferral** screen displays
    - **LabelTrace** - The **LabelTrace** screen displays
  - **Configure**
- **Advice** - The **Advice Given - Add** screen displays.
- **Recalls** - The **Recall - Add** screen displays.
- **Data Entry Caution** - The **Caution - Add** screen displays.
- **Medication Review** - The **Medication Review - Add** screen displays.
- **Referrals** - Select either:
  - **Referral** - The **Referral - Add** screen displays.
  - **From Default** - The **Select Default** screen displays.

- **Requests** - Select either:
  - **Requests** - The **Requests - Add** screen displays.
  - **From Default** - The **Select Default** screen displays.
  - **Print Specimen Labels** - The **Print Labels** screen displays.
  - **Electronic Requests** - Your electronic requests screen displays.
- **Contraception** - The **Contraception - Add** screen displays.
- **Cytology** - The **Cytology - Add** screen displays.
- **Chronic Disease Registers** - Select from **Asthma Register**, **Hypertension Register**, **CHD Register**, **Stroke/TIA Register**, **Diabetes Register**, **Diabetic Annual Check**, **Epilepsy Register**.
- **Health Promotion Intervention** - Select from **Smoker**, **Hypertension**, **Coronary Heart Disease**, **Stroke/TIA**, **Overweight**, **High Alcohol**, **FH Cardiovascular Disease**.
- **Correspondence** - The **Clinical Correspondence - Add** screen displays.
- **Attachments** - The **Attachment - Add** screen displays.
- **Reminder**
- **Patient Warning**
- **Prescription Note**
- **READ Term** (Alt-A, S) - Allows a READ term to be selected and then places the entry in the correct structured data area, for example, putting an entry for Peak Flow into the Peak Flow SDA.
- **Select Data Entry Form** - This displays the list of Summary or Tabbed forms for clinical entries.
- **MED3** - Medical sickness certificate.

Remember - If you are using your keyboard rather than a mouse, use any fast key indicated, for example **F4**, or hold **Alt** down, press **A**, this moves the cursor to the **Add** menu and then type the underlined letter on the menu option you require.

See Using the Add Menu in the **Consultation Manager Help Centre** for full details.

Updating an Entry

If an entry needs to be updated, for example, to correct a mistake, editing an entry is simple:

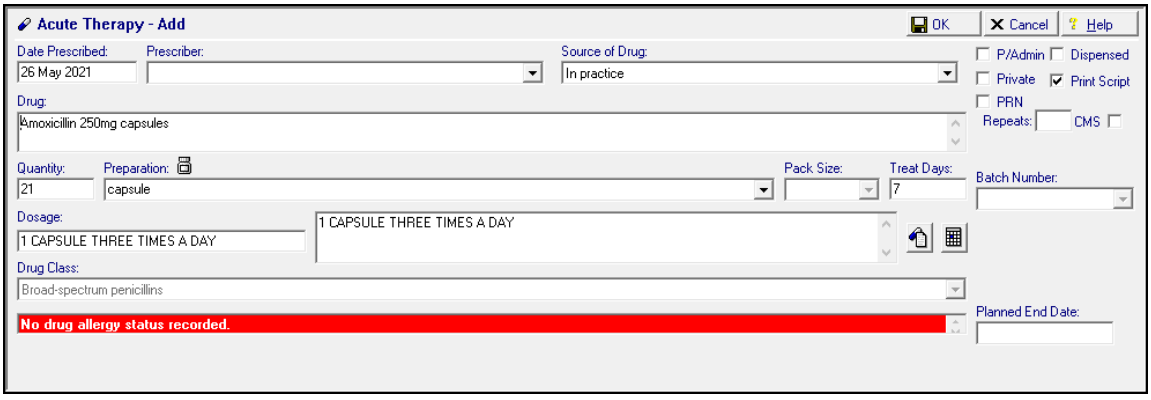
1. From **Consultation Manager**, select the patient required.
2. Right click on the entry you want to update and select **Edit**.
3. The **- Update** screen displays, update the details required.
4. Select **OK** to save and close.

> **Note** - If you update an immunisation which is part of a compound, for example MMR, the associated entries automatically update.

Adding and Printing an Acute Prescription

An acute prescription is a one-off item usually prescribed for acute conditions.

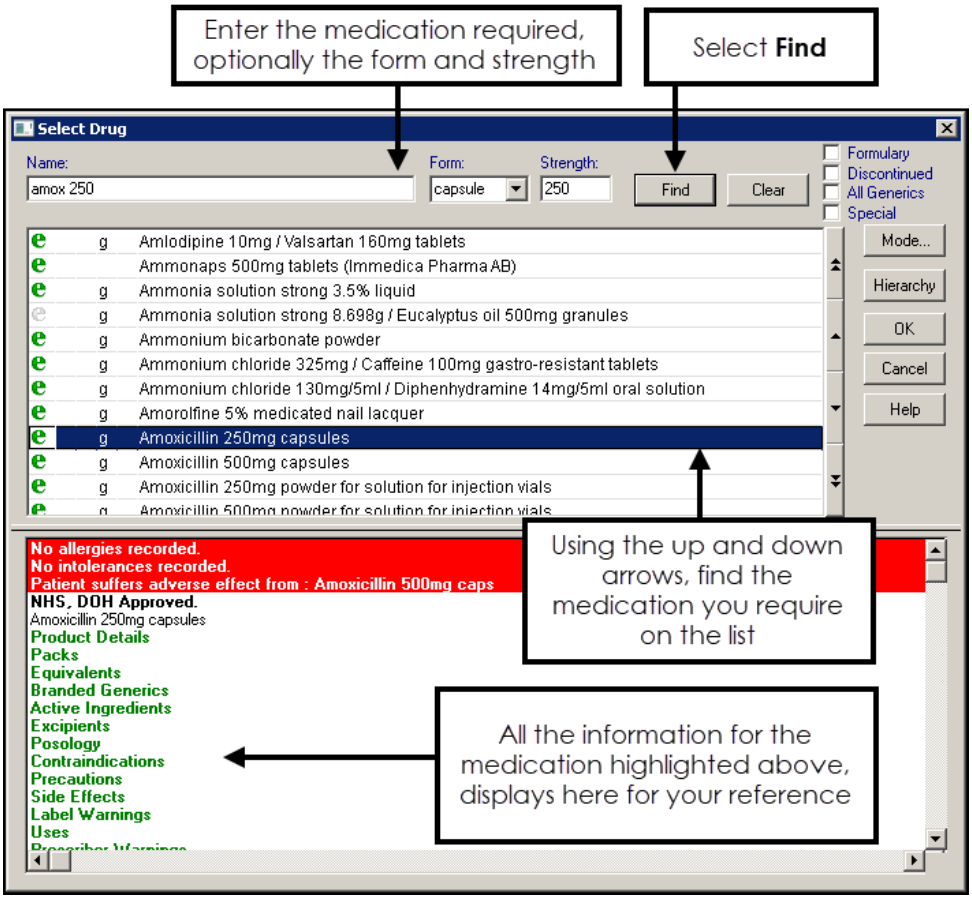
1. From **Consultation Manager**, select the patient and start a consultation.
2. Select **List Acute Therapy** , all acutes and repeat issues display.
3. Simply start typing, or press **Esc** on your keyboard, and the **Acute Therapy - Add** screen displays:



4. Complete as follows:
   - **Date Prescribed** - Defaults to today's date, update if required.
   - **Prescriber** - Defaults to the prescriber logged on, if the person logged on is not a prescriber, the **Usual GP** is the default for England, Wales and Northern Ireland, is blank in Scotland. Update if required.
   - **Capacity** (Scotland only) - This option displays if you are a non-medical prescriber with both **Independent** and **Supplementary** prescriber settings, select under which prescriber capacity you are prescribing this item.

- **Source of Drug** - Defaults to **In practice.** If you select anything other than **In practice**:
    - **Prescriber** - Becomes a free text option to record the prescriber of the medication if required. A list forms as you use this option.
    - **Organisation** - An **Organisation** option displays, record the organisation that issued the medication if required. A list forms as you use this option.
- **P/Admin** - Tick to record medication given, for example, an injection.
- **Dispensed** - Tick to record medication handed to the patient.
- **Private** - Tick to record this as a private prescription.
- **Print Script** - Remove the tick to stop this prescription being printed, for example, if it had been hand written on a visit and you are recording it.
- **PRN** - Adding a drug with an **As Needed** dosage instruction automatically selects the **PRN** option on **Therapy Add**. This enables PRN items to print separately from other items. Remove the tick to deselect, if required.
- **Repeats** - Enter the number of repeats if required, if selected this prescription becomes a Repeat Master not an acute.
- **Drug** - Enter the first three or four letters of the drug name required, optionally followed by the form and then the strength, for example '*amox cap 250*' and press **Enter** on your keyboard. The medication you require should be returned, if not either:
    - Use the up and down arrows to move through the medication list,
    - Select **Switch to generic drug**

, or
    - Press **F3** on your keyboard, the **Select Drug** screen displays:



Complete as follows:

a. **Name** - Enter the first three or four letters of the medication you require. When selecting therapy items **Vision 3** breaks down your search criteria in the following way, Name | Form | Strength, for example, '*Amox cap 250*' returns **Amoxicillin 250mg capsules**. When searching for a drug name, if an exact drug cannot be found the '*An exact drug match to the phrase entered cannot be found*'message displays:

Select **OK** to clear the message.

Important - This can cause an issue where an item name is made up from more than one word, or where a conjoining hyphen is left out, for example, if you enter '*depo prov*' **Vision 3** searches on **Name** *depo* | **Form** *prov*. As a **Form** of **Prov** does not exist, it returns the first item with a **Name** of '*depo*', hence **Depo Medrone**. You must check the item returned on a search is the item you require.

Where a drug name long, or you are not sure of the spelling, you can use '_' to replace one character, or '%' to replace multiple characters, for example:

- Entering '*depixol_c*', returns **Depixol Conc 100mg/1ml solution for injection ampoules**.
- Entering '*depo%rov*', returns **Depo-Provera 150mg/1ml suspension for injection pre-filled syringes**.

b. **Form** - Select if required.

c. **Strength** - Select if required.

d. Select **Find** and highlight the medication you require.

e. Select **OK**.

Note - Above **Drug**, if the item you select is unlicensed, **Unlicensed** displays, or if the item is highlighted as Availability Restricted within the DM+D, **Limited Availability** or **Unavailable** displays.

- **Quantity** - Enter the number or amount required.
- **Preparation** - Automatically completes with the medication default, update if required.
- **Pack Size** (optional) - Select if required.
- **Treat Days** - Automatically calculates from **Quantity** and **Dosage**.
- **Batch Number** (optional) - Select if required.
- **Dosage** - Completes with the medication default, update if required. Standard abbreviations are accepted, for example, 'One OD' displays as One Every Day', 'Two PRN' displays as 'Two When Required'.
- **Drug Class** - Completes with the medication default, update if required.
- **Additional Information** - Select to enter information to print on the right-hand side of the prescription form.
- **Instalment Dispensing** - Select to enter additional information for instalment dispensing.

5. Check the **Allergy and Intolerance** section, if there are any drug allergies recorded this section is highlighted in red.
6. Select **OK**.
7. Drug checks run, displaying any contraindications, interactions or drug doubling before you proceed with the prescription, see **Drug Checks** on page **35** for details.
8. Providing you want to proceed, select **Yes** to any warning and where appropriate enter the reason.
9. Select **Proceed**.
10. The **Therapy Records** screen re-displays, from which you can print the prescription. If you link medications to Problems, the **Add Medication to Problem** screen displays. Tick the relevant problems and select **OK**.
11. If you need to issue more than one acute medication repeat the process from step 3 above.
12. Press **F9** on your keyboard to issue.
13. The **Therapy Print Records / Prescription Manager** screen displays, all acutes added with today's date display. Check the **Authorised Signatory** and update if required. The **Authorised Signatory** prints on the prescription.
14. Press **F9** on your keyboard again to print the prescription.

If you need to prescribe an acute again, you can:

- Enter it again,

- Copy an initial acute prescription, simply right click on the item and select **Copy**, or
- Create a repeat master based on this acute, see **Creating an Acute from a Repeat Prescription** on page **27** for details.

Training Tip - You can search for appliances using their product code, in **Drug**, enter **#** followed by part or all of the product code.

Creating an Acute from a Repeat Prescription

To make an acute prescription from a repeat prescription:

1. From **Consultation Manager**, select the patient required and start a consultation if required.
2. Find an issue of the repeat you want to add as an acute, this can be from any screen.
3. Click, hold and drag the repeat issue and the floating drop target displays:

4. Drop the repeat issue on to **Prescription** .
5. The **Therapy - Add** screen displays with all the information from the acute prescription completed, update as required.
6. Select **OK** to save.
7. Press **F9** on your keyboard to issue and then press **F9** on your keyboard again to print.

Creating a Repeat from an Acute Prescription

To make a repeat prescription from an acute prescription:

1. From **Consultation Manager**, select the patient required and start a consultation if required.
2. Find the acute prescription you want to add as a Repeat Master, this can be from any screen.
3. Click, hold and drag the acute prescription and the floating drop target displays.

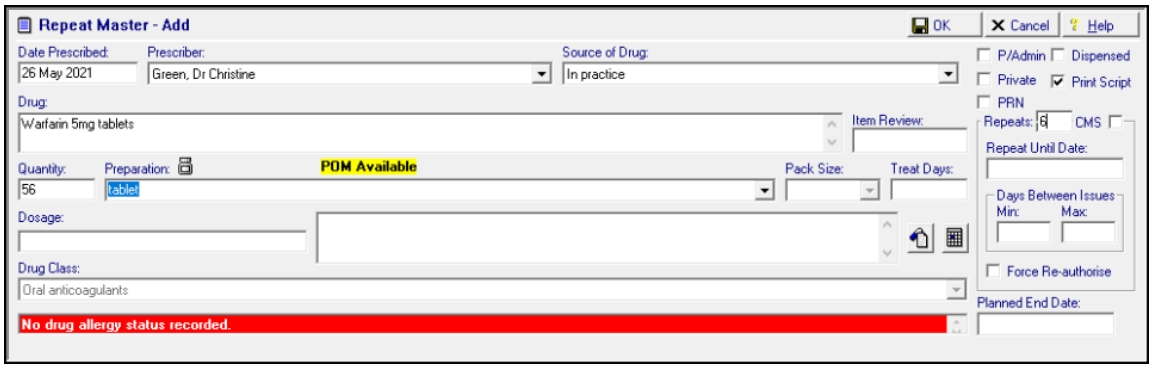
4. Drop the acute prescription on to **Prescription** .
5. The **Repeat Prescription Master - Add** screen displays with all the information from the acute prescription completed, update as required and then enter the number of repeats you are prepared to authorise.
6. Select **OK**.
7. Press **F9** on your keyboard to issue and then press **F9** on your keyboard again to print.

Adding a Repeat Prescription

A Repeat Master is created to authorise a medication for more than one issue. Each Repeat Master has either a maximum number of issues or a **Repeat Until** date before it requires reauthorising.

To create a Repeat Master:

1. From **Consultation Manager**, select the patient and start a consultation if required.
2. Select **List Repeat Therapy** .
3. Simply start typing, or press **Esc** on your keyboard and the **Repeat Master - Add** screen displays:

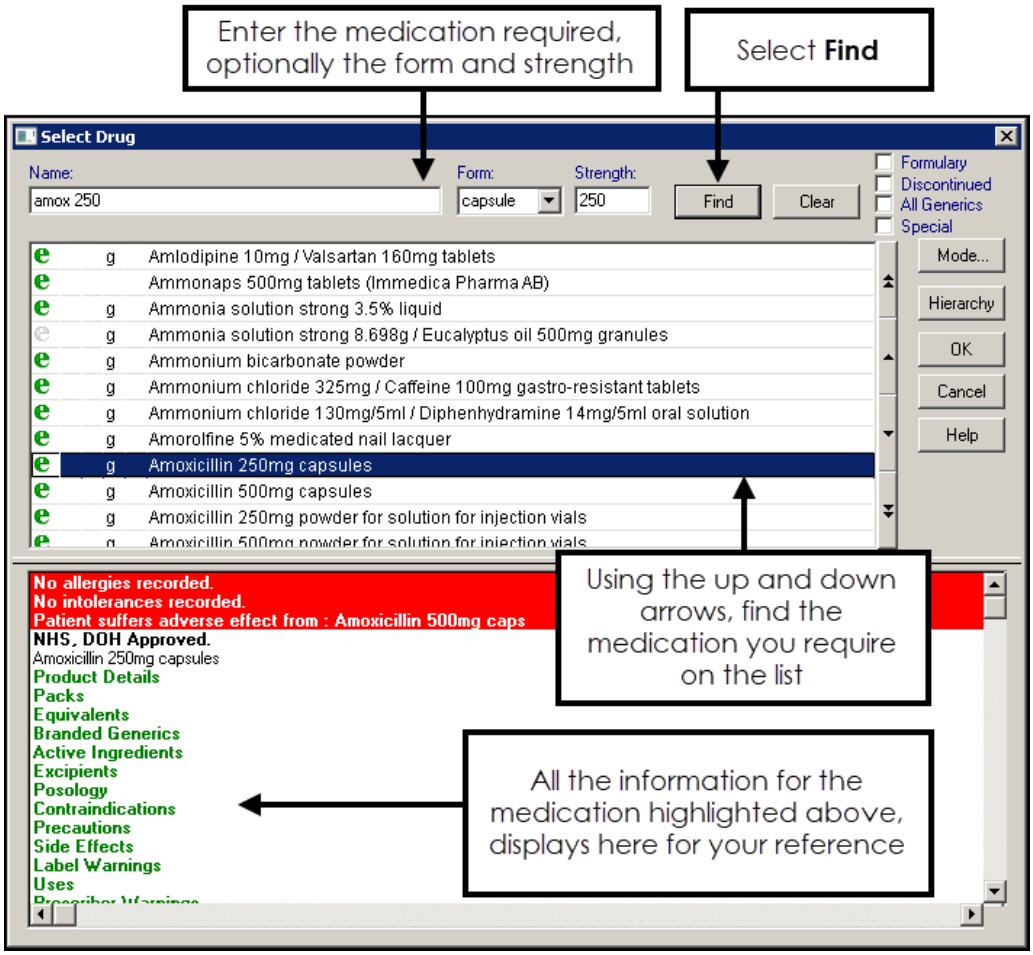


Complete as follows:

- **Date Prescribed** - Defaults to today's date, update if required.
- **Prescriber** - Defaults to the prescriber logged on, if the person logged on is not a prescriber, the **Usual GP** is the default for England, Wales and Northern Ireland, however it is blank in Scotland. Update as required.
- **Source of Drug** - Defaults to **In practice.** If you select anything other than **In practice**:
    - **Prescriber** - Becomes a free text option to record the prescriber of the medication if required. A list forms as you use this option.
    - **Organisation** - Becomes a free text option to record the organisation of the prescriber if required. A list forms as you use this option.
- **P/Admin** - Tick to record medication given for example an injection.
- **Dispensed** - Tick to record medication handed to the patient.
- **Private** - Tick to record this as a private prescription.
- **Print Script** - Remove tick to stop this prescription being printed, for example if it had been hand written on a visit and you are recording it.

- **PRN** - Adding a drug with an **As Needed** dosage instruction automatically selects the **PRN** option on **Therapy Add**. This enables PRN items to print separately from other items. Remove the tick to deselect, if required.
- **Repeats** - Enter the number of repeats you are authorising, this cannot be greater than your personal **Repeat Limit**.
- **Batch** - Tick to make this an eRD (England)/Serial Prescribing (Scotland.
- **Repeat Until Date** - Enter an end date or date offset for example '3m' for three months if required.
- **Days Between Issues** - Enter number of days if required:
    - **Min** - Minimum number of days between issues.
    - **Max** - Maximum number of days between issues.
- **Force Re-authorise** - Tick to restrict reauthorisation to clinical staff with a GMP number recorded.
- **Planned End Date** - If you have a plan to stop supplying this medication at a specific time, you can enter that date here.
- **Drug** - Enter the first three or four letters of the drug name required, optionally followed by the form and then the strength, for example '*amox cap 250*' and press **Enter** on your keyboard. The medication you require should be returned, if not either:
    - Use the up and down arrows to move through the medication list.
    - Select **Switch to generic drug**

, or
    - Press **F3** on your keyboard, the **Select Drug** screen displays:



Complete as follows:

- **Name** - Enter the first three or four letters of the medication you require. When selecting therapy items **Vision 3** breaks down your search criteria in the following way,
  Name | Form | Strength, for example, '*Amox cap 250*' returns **Amoxicillin 250mg capsules**.

> **Important** - This can cause an issue where an item name is made up from more than one word, or where a conjoining hyphen is left out, for example, if you enter '*depo prov*' **Vision 3** searches on **Name** *depo* | **Form** *prov*. As a **Form** of **Prov** does not exist, it returns the first item with a **Name** of '*depo*', hence **Depo Medrone**. You must check the item returned on a search is the item you require.

Where a drug name long, or you are not sure of the spelling, you can use '_' to replace one character, or '%' to replace multiple characters, for example:

- Entering '*depixol_c*', returns **Depixol Conc 100mg/1ml solution for injection ampoules**.

- Entering '*depo%rov*', returns **Depo-Provera 150mg/1ml suspension for injection pre-filled syringes**.

- **Form** - Select if required.
- **Strength** - Select if required.
- Select **Find** and highlight the medication you require.
- Select **OK**.

Note - If the item you select is unlicensed, **Unlicensed** displays above **Drug**.

- **Item Review** - Select to set an individual medication item review, the date defaults to your practice offset, update as required.
- **Quantity** - Enter the number or amount required.
- **Preparation** - Completes with the medication default, select **Pack Details** to select the pack size as appropriate.
- **Pack Size** (optional) - Select if required.
- **Treat Days** - Automatically calculates from **Quantity** and **Dosage**.
- **Dosage** - Completes with the medication default, update if required, standard abbreviations are accepted, for example, '*One OD*' displays as '*One Every Day*', '*Two PRN*' displays as '*Two When Required*'.
- **Drug Class** - Completes with the medication default, update if required.
- **Additional Information** - Select to enter information to print on the right-hand side of the prescription form.
- **Instalment Dispensing** - Select to enter additional information for instalment dispensing.

4. Check the **Allergy and Intolerance** section, if there are any drug allergies recorded this section highlights in red.
5. Select **OK**.
6. Drug Checks are made. Any contraindications, interactions or drug doubling warnings display, see **Drug Checks** on page **35** for details.
7. Providing you want to proceed, select **Yes** to any warning and where appropriate enter the reason.
8. Select **Proceed**.

9. If you link medications to Problems, the **Add Medication to Problem** screen displays. Tick the relevant problems and select **OK**.

The new repeat master can now be issued, see **Issuing Repeat Prescriptions** on page **32**.

Issuing Repeat Prescriptions

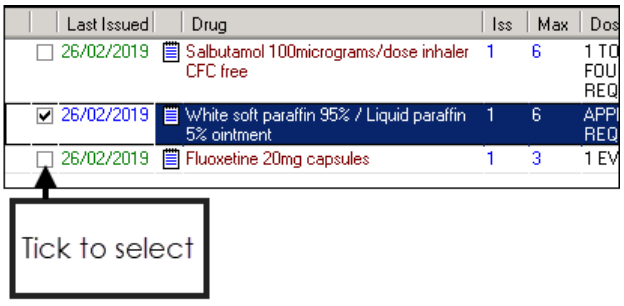
To issue a repeat prescription:

1. From **Consultation Manager**, select the patient and start a consultation if required.

> **Note** - If you are a non-clinician issuing repeat scripts and this is a new consultation, keep the consultation statistics accurate by changing the **Consultation Type** to **Repeat Issue**.

2. Select **List Repeat Therapy** .

3. Tick the medications you want to issue, or choose **Select All** from the toolbar:



> **Training Tip** - You can use **Select All** and then remove the tick if you want to issue all bar one or two repeats on a patient record.

4. Press **F9** on your keyboard, **Print** or **Finalise** (England, Wales, Northern Ireland) **Close** (Scotland) to issue.
5. Check the **Doctor to Sign Prescription** is correct, if not update as required.
6. Press **F9** on your keyboard, **Print** or **Finalise** (England, Wales, Northern Ireland) **Close** (Scotland) to print.

If the requested item(s) is not shown, select **Filter Expired Repeats** and **Filter Inactive Repeats** to give a list of valid repeats (leave **Filter Valid** repeats undepressed).

> **Note** - **PRN** items print on a separate prescription, provided you have switched this option on in **Management Tools** - **Control Panel** - **File Maintenance**.

If the required items still do not display, there may be an expired item that needs reauthorising, see **Reauthorising Repeats** on page **34** for details.

Repeat Master Icons

- **Valid repeat master** - Can be issued
- **Expired repeat master** - Needs reauthorising
- **Inactivated repeat master**
- **Prescribed outside of the practice**
- **Batch repeat master**

Reauthorising Repeats

Once a repeat master has been issued a maximum number of times or reaches its **Repeat Until Date**, then it expires. **Expired repeat master** displays in front of the medication name in the **Repeats** list in **Therapy**.

To reauthorise an expired repeat master:

1. From the **Therapy** tab, select **Repeats**.
2. Tick the item(s) to reauthorise.
3. Select **Reauthorise**.
4. If you have selected:
   - **One item** - The **Reauthorised Repeat Master - Add** screen displays and allows you to make changes if required, select **OK**.
   - **More than one item** - You are run through the **Problem** screens if you use them, select for each medication as appropriate, the **Reauthorised Repeat Master - Add** screen does not display.
5. The item(s) are now reauthorised ready for issuing.

Note - If you are a non-clinician and cannot reauthorise a repeat master, this may be because **Force Re-authorise** was ticked on the original Repeat Master. In this case, only prescribers can reauthorise the repeat.

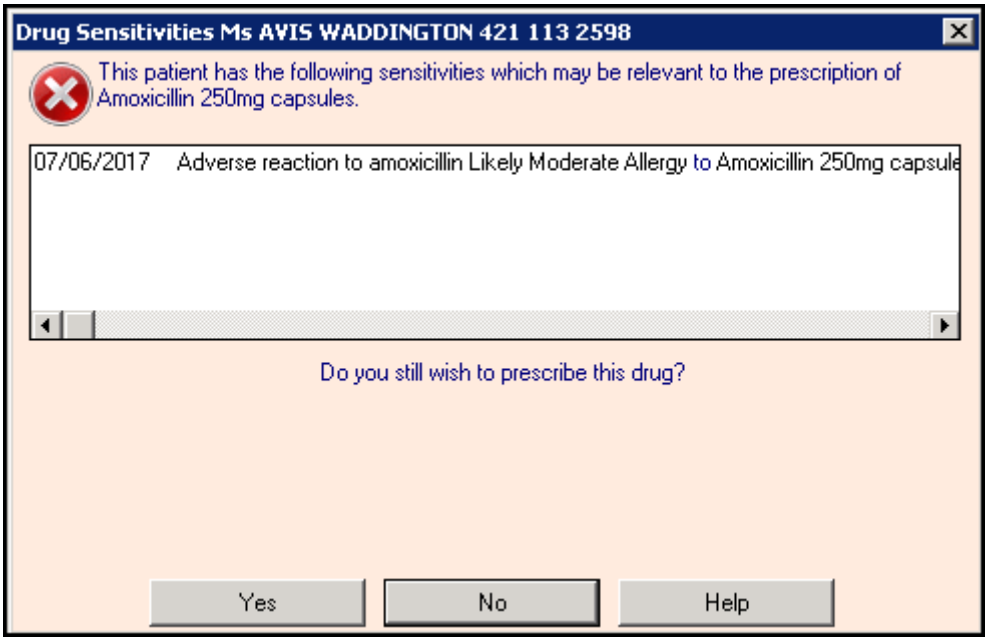
Training Tip - To turn a repeat therapy into a PRN prescription, you must **Reauthorise** it.

Drug Checks

Once a medication is added, drug checks automatically run:

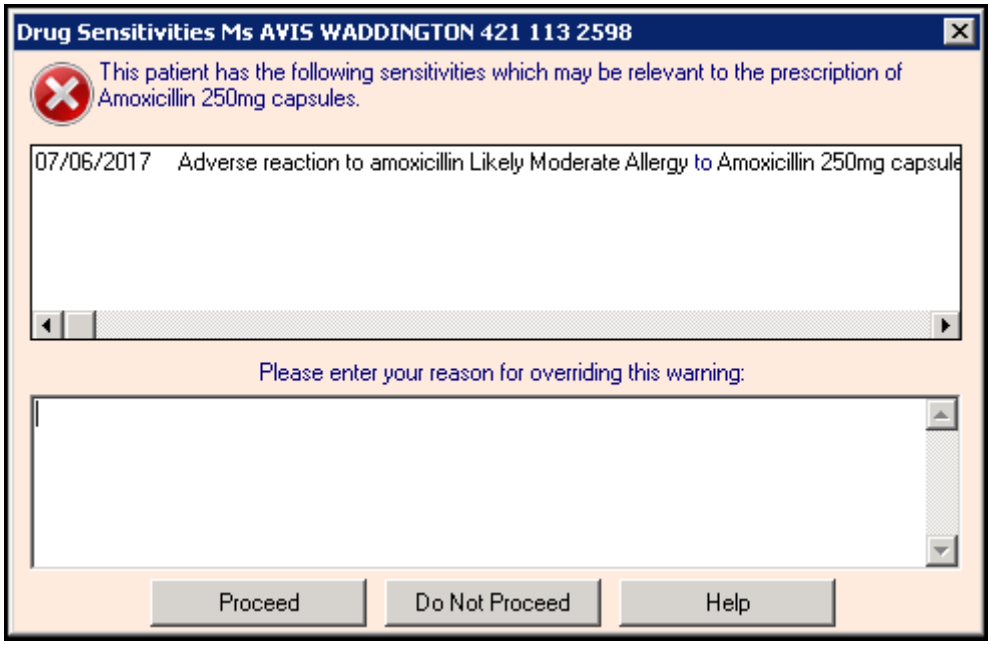
Drug Allergy or Adverse Reaction

If you add a medication to which the patient has a **Drug Allergy** or **Adverse Reaction** recorded, the **Drug Sensitivities** warning screen displays:



Select either:

- **No** - You are returned to the **Therapy - Add** screen to select another drug.
- **Yes** - To prescribe the drug. '*Please enter your reason for overriding this warning*' displays, you have the option of entering free text to record why you are prescribing a drug to which the patient has an allergy/intolerance. A reason is not mandatory, but it is strongly recommended:



Select either:

- **Proceed** - To add the drug to the patient record, or
- **Do Not Proceed** - To return to **Therapy - Add** where you can select another drug.

Important - You are prevented from prescribing an item which has a **Potentially Fatal** record with the following message on a Drug Sensitivities screen, '*It will not be possible to prescribe this item due to the presence of potentially fatal reactions*'.

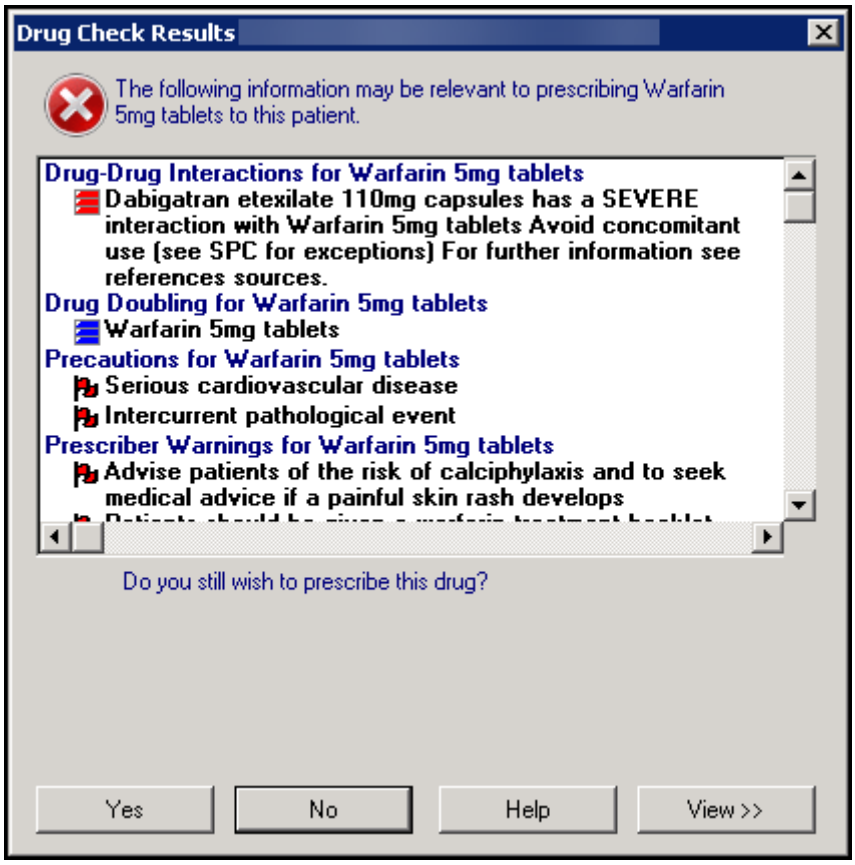
An audit trail of any free text entered or whether you have bypassed the opportunity to enter free text can be found in **Management Tools** - **Event Log** under **Reason for Drug Warning override**:

- **Medium Level Warning** - If you prescribe a drug to which the patient has an allergic severity of Minimal, Mild or Moderate recorded.
- **High Level Warning** - If you prescribe a drug to which the patient has an allergic severity of Severe or Very Severe recorded.

See **Adding a Drug Allergy/Adverse Reaction** on page **39** for details.

Interactions, Contraindications, Precautions, Drug Doubling or Prescriber Warnings

If there are any Interactions, Contraindications, Precautions, Drug Doubling or Prescriber Warnings the **Drug Check Results** screen displays:



All warnings are mirrored on the status bar at the bottom of the **Consultation Manager** screen

Interactions -

The circles and bars warn of drug interactions between the drug currently selected and the patient's existing therapy:

- **Green light** - No Drug Interactions.
- **Yellow light** - Context sensitive interactions exist, for example elderly or females, those on digoxin.
- **Single red bar** - Warning that mild interaction exist.
- **Two red bars** - Avoid if possible, serious interaction exist.
- **Three red bars** – Warning that a life threatening interaction exist.

Contraindications -

Contraindications are checked against the patient's clinical record and includes precautions, prescriber warnings, special morbidities such as pregnancy and lactation and similar name warnings.

Contraindications show as flags on the right on the status bar:

- **Green flag** - No contraindications exist.
- **Yellow flag** - General contraindications warnings exist.
- **Red Flag** - Patient specific contraindications exist.

Drug Doubling -

Checks are made for drug doubling, this looks at the patient's current therapy for medication that has the same ingredients, is in the same action group, or is the same drug, as the therapy being added.

The doubling drug check warnings are shown as a series of blue bars:

- **One blue bar** - Same action group.
- **Two blue bars** - Same ingredient.
- **Three blue bars** - Same drug.

If you want to continue to prescribe this drug:

1. Select **Yes** if you want to continue to prescribe this drug.
2. Depending on the settings selected in **Consultation - Options - Setup - Drug Check - Drug Warnings - Override Confirmation Required**, the **Please enter your reason for overriding this warning** screen may display. Enter the reason for the override and select **Proceed** to continue. An audit trail of any free text entered or whether you have bypassed the opportunity to enter free text can be found in **Management Tools** - **Event Log** under **Reason for Drug Warning override**.

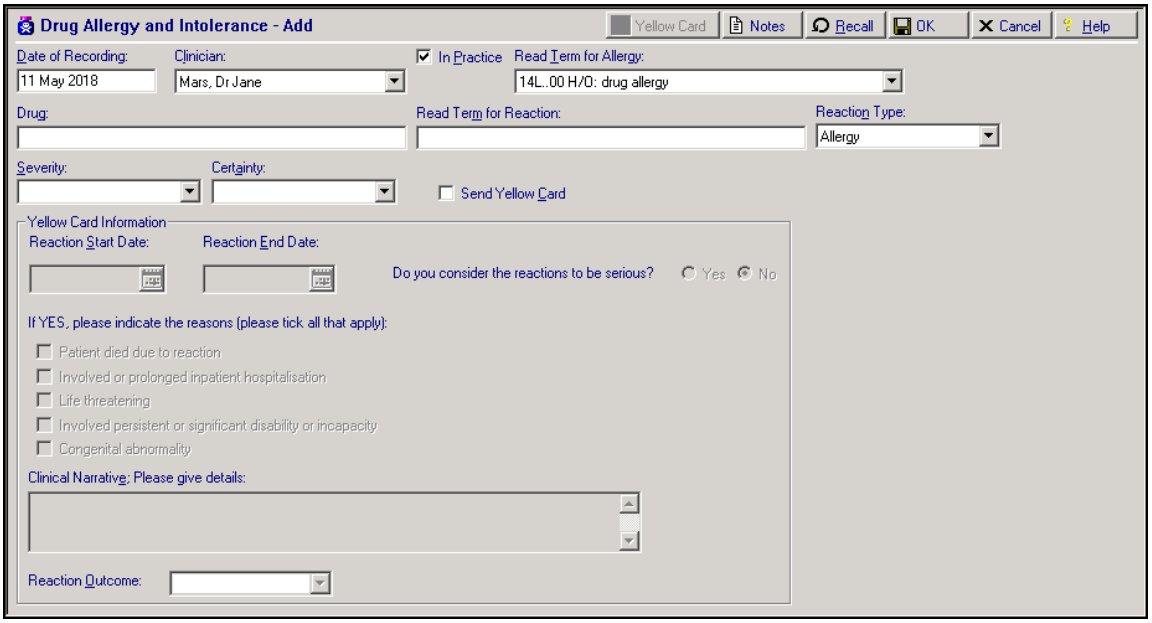
Note - You can select the drug check display on the status bar at any time, if it is not greyed out, to re-display the **Drug Check Results** screen.

Adding a Drug Allergy/Adverse Reaction

Where an adverse reaction to a drug, immunisation or device is diagnosed or suspected, the diagnosis or symptom should be recorded in the **Drug Allergy and Intolerance** Structured Data Area (SDA). You can also create a **Yellow Card** from here which electronically sends Yellow Card information to the MHRA. Where medication is changed because of an adverse reaction or side effects, the indication for any new drugs should be entered.

To add a drug allergy:

1. From **Consultation Manager**, select the patient required and start a consultation if required.
2. Select **Add - Drug Allergy/Adverse Reaction**.
3. The **Drug Allergy and Intolerance - Add** screen displays:



Complete the following as required:

- **Date of Recording** - Defaults to today, update if required.
- **Clinician** - Update if required.
- **In Practice** - If this is a history of previous allergy or intolerance, then enter the approximate date and remove the tick from **In Practice**.
- **READ Term for Allergy** - Select a Read term for the allergy from the list.
- **Drug Name** - Enter the drug details and press enter to search the drug dictionary or double click in **Drug**, and select the drug to which the patient is allergic to from the drug list. In **Name** on the **Drug Select** screen, enter the drug name, for example, amoxicillin, and select **Find**, locate the drug required and then select **OK**.
- **READ Term for Reaction** (optional) - Find and enter a Read code for the patient's reaction to the drug.
- **Reaction Type** - Select as appropriate.

- **Severity** - Select as appropriate.

> **Note** - **Vision 3** prevents you from prescribing an item with a **Potentially Fatal** flag.

- **Certainty** - Select as appropriate.
- **Send Yellow Card** - Tick to create and send an electronic Yellow Card Report.

4. Select **OK** to save and close.

Other ways to add **Drug Allergy and Adverse Reaction** entries include:

- Right click **Navigation Pane - Drug Allergy and Adverse Reaction**.
- **An existing entry** - Simply right click on the entry and select **Add**.

Dragging and Dropping in Consultation Manager

Problem Orientated Records

Any data can be dragged from a tab and dropped on to a problem within the **Problem** tab, allowing you to quickly move data from one area to another. Among the advantages this gives you is the ability to:

- Copy data from the current consultation into multiple problems.
- Copy and move data from one problem to another.
- Select multiple existing data items and use them to generate a new problem.

Floating Drag and Drop Target

If you select and drag and item, a floating target displays:

Drop the item on to:

- **Another** - Make a copy of the selected entry with today's date.
- **Make a referral for this item** - Make a referral using the selected entry details.
- **Set up a recall for this item** - Make a recall using the selected entry details.
- **Guideline** - If a Guideline is triggered by the Read code of the selected entry, display the guideline.
- **Prescription** - Depending on the type of prescription you are dropping, either:
  - Creates a repeat master based on the selected acute prescription, or
  - Creates an acute issue based on the selected repeat issue.
- **Copy to Windows clipboard** - Copy the selected entry or entries for pasting elsewhere.

The target always appears above and to the left of the cursor where space permits or close to the cursor in any available space. Select the spacebar to hide the drop target.

Adding a MED3

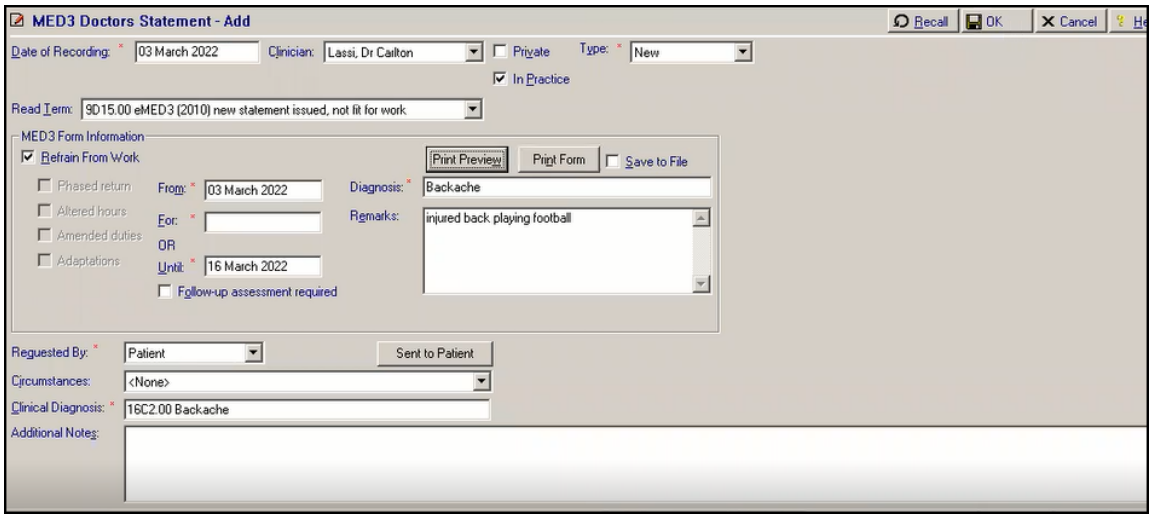
To create an electronic MED3 Doctors Statement:

1. From **Consultation Manager**, select the patient required and open a consultation if required.
2. Enter the consultation details as per your usual practice protocols.

> **Note** - If you open an active problem, the **Problem Header** Read term is used to populate **Diagnosis**. See **MED3 Information** on page **44** and **Additional Information** on page **46** for further details.

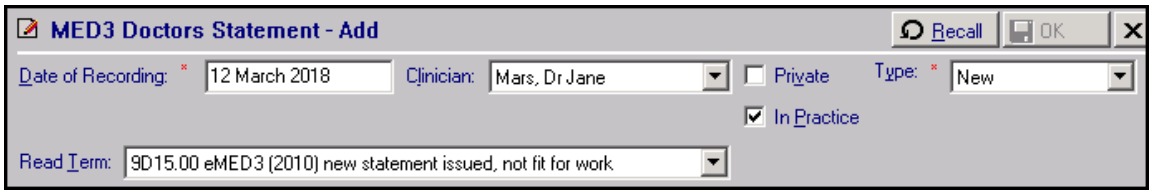
3. Once the consultation information is recorded, either:
   - Right click on a journal entry and select **Create MED3**.
   - Select **Add - MED3**, remember you can use **Alt + A** then **Alt + 3** on your keyboard.
   - Enter one of the qualifying MED3 Read terms, see **MED3 Standard Information** on page **43.**
   - Right click on any existing MED3 data entry and select one of the following options:
     - **Create MED3**
     - **Follow-on MED3**

4. The **MED3 Doctors Statement - Add** screen displays:



The MED3 Doctor's Statement form consists of four sections which should be completed:

MED3 Standard Information



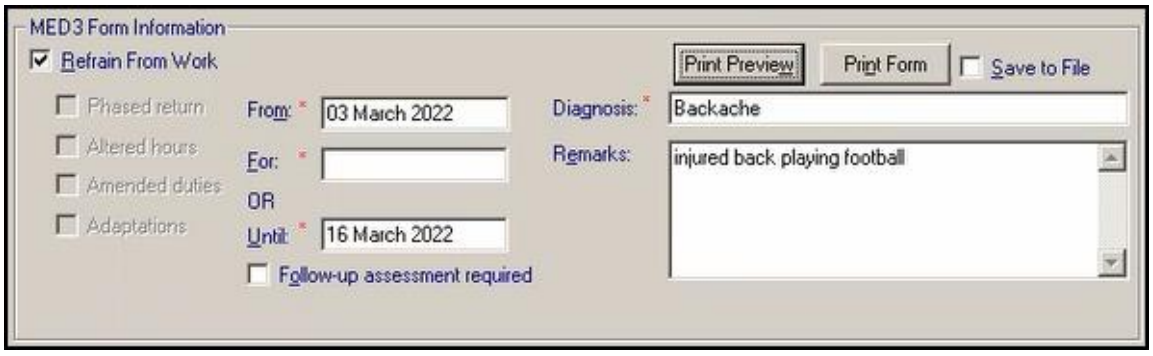
Standard information consists of:

- **Date of Recording** (mandatory) - The date of the examination triggering the MED3 to be issued, automatically defaults to the current date. There is no limit to how far back the date can be, however, if the date is 26 weeks or more from the current date a warning displays, select **Yes** to continue or **No** to return to re-enter the date.
- **Clinician** (mandatory) - Select the GP authorising the MED3.
- **Private** - Tick to indicate the certificate or patient is private.
- **In Practice** - Tick to record the place of the recording.
- **Type** (mandatory) - Select from:
    - **New** - To create a new MED3 form to be printed and given to the patient.
    - **Issued by hand** - To record the details of a MED3 you have handwritten.
- **Read Term** - The list available varies depends on the **Type** and **Refrain from work** selections. Select the appropriate MED3 Read Term from the available list.

MED3 Information

The **MED3 Form Information** section (excluding follow-up assessment details) prints on the MED3 form:

> **Note** - **Print Preview** and **Print Form** remain inactive until the criteria required is met.



- **Refrain from Work** - Ticked by default, indicating that the patient is not fit for work.

> **Note** - It is a DWP regulation that when you record a period of absence of under 15 days, the **From** and **Until** dates are mandatory.

- **From** - Defaults to today, it should be the date that the MED3 starts, updated if required.
- **For** - Enter the period the patient should refrain from work. You can use the abbreviated date format, for example 7d (7 days), 1w (1 week) or 1m (1 month) but no more than a three digit number can be entered.

  You can also record an indefinite period, type **i** or **indefinite** in **For** and press enter. You are prompted: *'The period you have entered is valid if the patient has been unfit for work for 6 months prior to assessment. Click Yes to confirm if this is correct of click No to re-enter.'*, select **Yes** to continue.
- **Until** - Enter the exact date the patient should refrain from work until or use the abbreviated date format, for example 1w, the date is then automatically calculated.

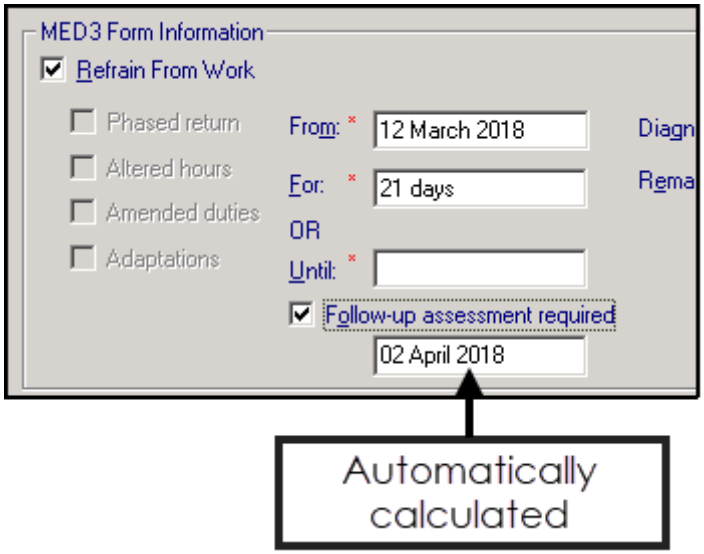
  If you enter a **For** or **Until** time period longer than 3 months or 13 weeks from the date of recording, the *'The period you have entered is valid if the patient has been unfit for work for 6 months prior to assessment. Click* ***Yes*** *to confirm if this is correct of click No to re-enter.'* message displays, select **Yes** to continue.

Note - You must enter a duration or date into **For** or **Until** if you want to print the MED3. You are only permitted to fill in one of these options, so typing into either blanks out the other.

- **Diagnosis** (mandatory) - Diagnosis may initially be populated. If you add a **Clinical Diagnosis**, the Read term is copied to **Diagnosis**. You can delete the existing entry and enter free text if appropriate.

Note - On opening the MED3 form, a Read code may display in **Clinical Diagnosis** and the Read term added as free text to **Diagnosis**. If you have a problem open, the problem header Read code is used, if no problem is open and a single Medical History is added in the current consultation, the Read term is used to populate the diagnosis fields. If you create a new MED3 using an existing Medical History, the form is populated with the Read term from the entry used.

- **Remarks** - You can enter free text if required (up to 800 characters). If you have selected **Refrain from Work** this is optional. If you deselected **Refrain from Work** remarks are mandatory.
- **Follow-up assessment required** - Tick if you need to re-assess the patient's fitness for work at the end of this statement. This option is unavailable without a **For** or **Until** date. You are prompted '*The patient needs to be assessed again at the end of the period. Please arrange to review them.*', select **OK** to continue. You cannot enter a follow-up date in the past. The follow-up date automatically calculates and displays. The printed MED3 Statement shows that a review is required. In you can create a search to find any follow-up dates that are due:



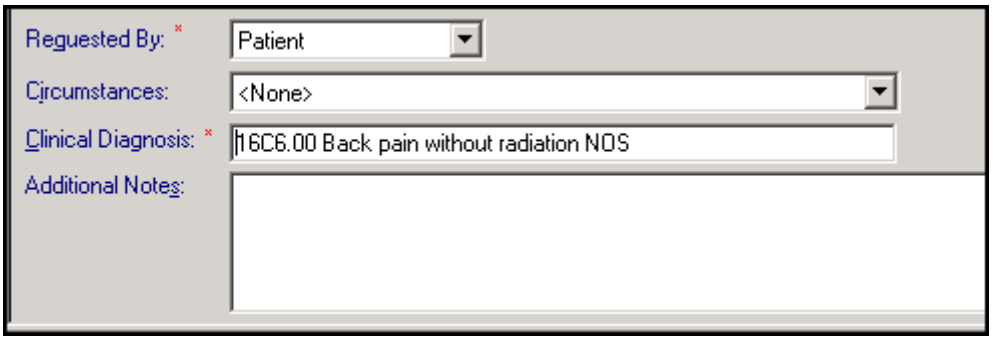
- Deselect **Refrain from Work** to indicate that the patient may be fit for work. The following optional selections can be made to indicate which (if any) work adjustments you feel would be beneficial to the patient. Tick one or more boxes:
    - **Phased return** (optional) - Tick to indicate the patient may benefit from a phased return to work.
    - **Altered hours** (optional) - Tick to indicate the patient may benefit from altered working hours.
    - **Amended duties** (optional) - Tick to indicate the patient may benefit from amended duties to enable them to return to work.
    - **Adaptations** (optional) - Tick to indicate the patient requires workplace adaptations to enable them to return to work.

  If you have deselected **Refrain from Work**, **For** and **Until** are disabled and **Remarks** becomes mandatory, the Read code changes to **9D16.00 - eMED3 (2010) new statement issued, may be fit for work**. A more appropriate Read code can be selected from the drop-down list if required.

Remember - The **MED3 Form Information** contains the details that print, however excludes follow-up assessment details.

Additional Information

The **Additional information** section allows you to record additional details, the information can then be viewed from **Consultation Manager** as part of the MED3 entry but is not included on the printed MED3 form:



Complete as follows:

- **Requested by** (mandatory) - Defaults to **Patient**, update as required.
- **Circumstances** - You can record additional information regarding the MED3 request. Select from the available list.
- **Clinical Diagnosis** (mandatory) - This may populate automatically. If not already populated, you can add a clinical diagnosis in the usual way. If a free text comment has not been added, the selected Read term is copied to **Diagnosis**.

- **Additional Notes** - You can enter free text if required.

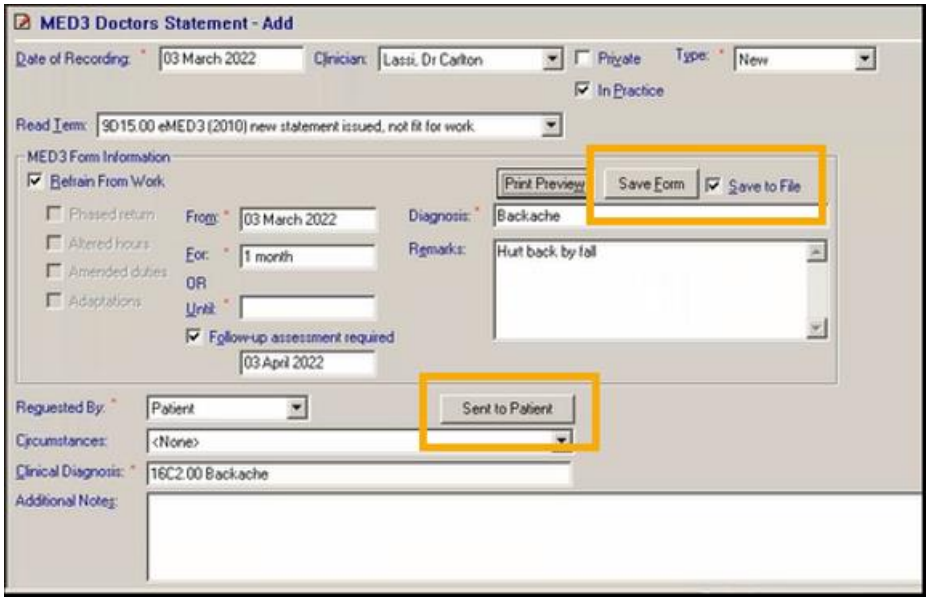
Remember - The information recorded under the **Additional Information** section of the electronic MED3 is for patient record purposes only, it is not printed on the MED3 form.

Saving an Electronic Version

To save an electronic version for sending and marking as sent:

a. Once the MED3 data entry form is complete, **Save to File** is ticked by default and **Save Form** displays.

b. Select **Save Form**:



c. The file saves in P:\WORDPROC\EMED3\User login name\EMED3_NNNNNNNNNN_Forename_Surname_YYYYMMDD_hhmmss.pdf where:

- User login name is your Vision 3 log in name.
- NNNNNNNNNN is the patient's NHS Number in England, Wales and Northern Ireland or CHI Number in Scotland.
- Forename_Surname is the forname and surname of the patient.
- YYYYMMDD is the date created.
- hhmmss is the time created.

You can access this from your **File Explorer** to, for example, attach to an email.

Note - If you edit an existing **MED3**, **Vision 3** creates a new file with the relevant file name.

d. To record you have sent this **MED3** electronically, select **Sent to Patient**. The date, time and '*MED3 form sent to patient*' automatically displays in **Additional Notes**.

Printing the MED3 Form

To print a MED3 form:

a. Once the MED3 data entry form is complete, select **Print Preview**.

b. The MED3 displays as PDF document, check the details.

c. Select **Close**.

d. Remove the tick in **Save to File**.

e. Select **Print Form**

and the MED3 is sent directly to the printer.

f. If the MED3 fails to print, select **Print Form**

again. You are asked '*This form has already been printed previously. Is this a re-print Operation?*', select **Yes** to reprint.

g. The reprint is sent directly to the printer.

h. Now, check the MED3 details on the data entry form, add any additional information required, then select **OK** to save.

The printed MED3 includes a 2D Barcode containing all the information that is printed on the form plus a unique ID at the bottom of the form. The unique ID is an identifier for the practice, it does not contain any patient information. This is also stored in the patient record and can be viewed from the MED3 audit trail.

The **Print Preview** and **Print Form** options are inactive if:

- If you have chosen the Read code **9D1B.00 MED3 (2010) not issued to patient**.
- There is no diagnosis and/or **Refrain from Work** is ticked with no date.

Note - MED3 data entries can be filtered in **Consultation Manager** by selecting **Miscellaneous** from the navigation pane.

Wales Only

For practices in Wales, when you select **Print Form** you are prompted to select the appropriate language for the MED3:

- **English** - To print the MED3 in English.
- **Welsh** - To print the MED3 in Welsh. If Welsh is selected, the data transferred from **Vision 3** for example Diagnosis remains in English.

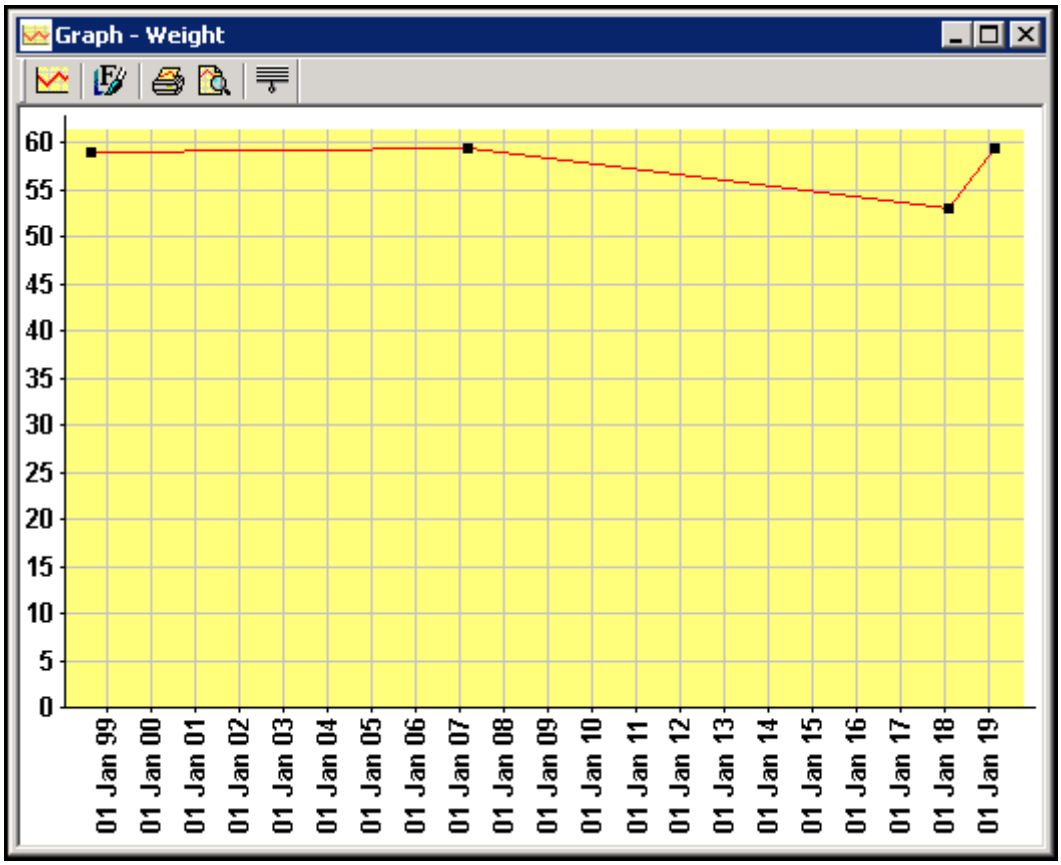
Note - Read terms and items selected from drop-down lists cannot be printed in Welsh. However if Welsh comments are added to **Remarks**, they are shown in Welsh on the printed form.

5. Complete as appropriate, mandatory entries are marked with a red asterisk.
6. Finally, select **OK** to save.

Displaying data as a Graph

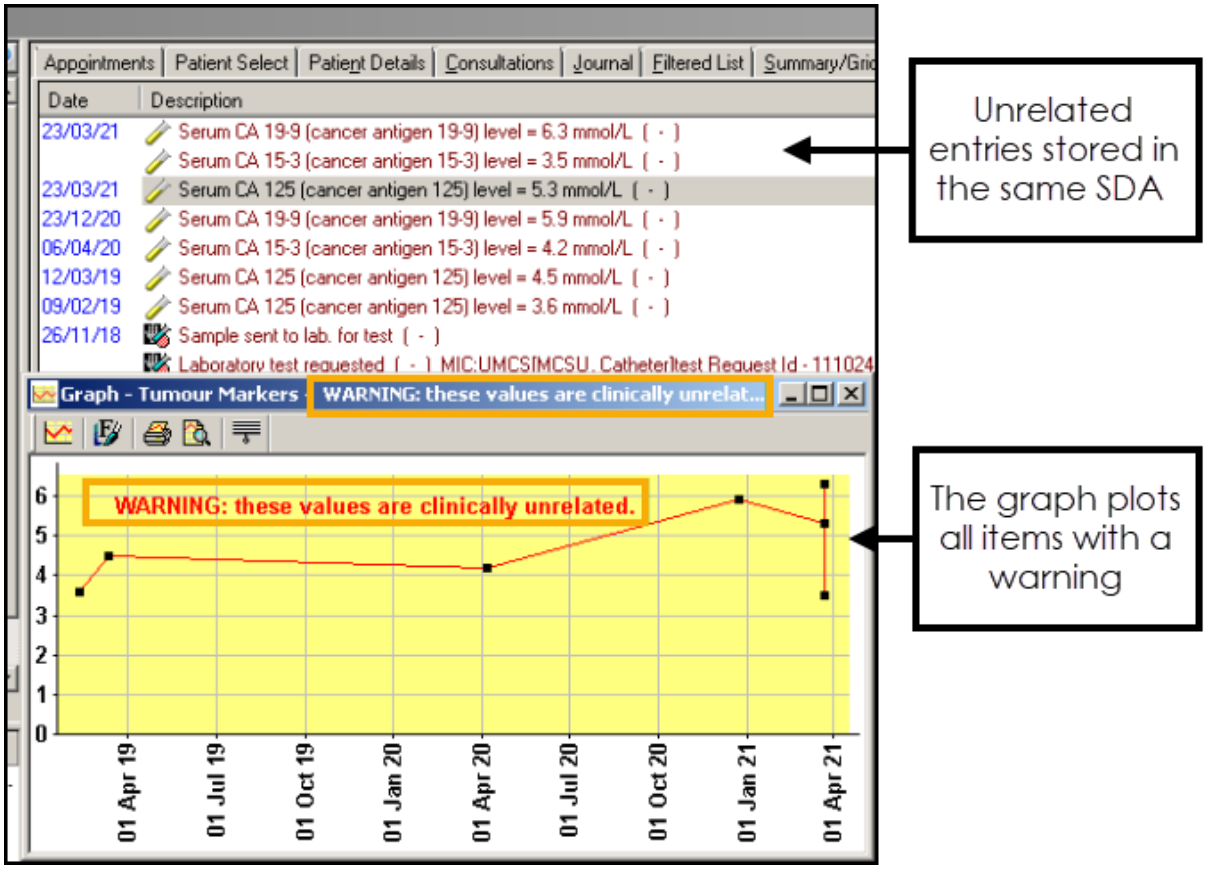
All numerical data can display as a graph, this is a useful way to monitor trends:

1. From **Consultation Manager**, select the patient required.
2. Highlight any numerical value within the patient record, right click and select **Graph:**



3. From the graph you can:
    - Expand the area you are interested, click hold and drag around the area you are interested in.
    - **Show Full Graph** - Select to display the full graph.
    - **Print** - Select to print the graph.
    - **Print Preview** - Select to view the print before printing.
4. Finally, select **Close** to exit.

If you select to graph data that is stored in the same Structured Data Area (SDA) as data with different clinical terms, or data with the same clinical term but different units of measure, a warning displays. The warning displays on the graph, within the graph header and on the bottom toolbar and notifies you that the graph may not be a true representation of the data selected:



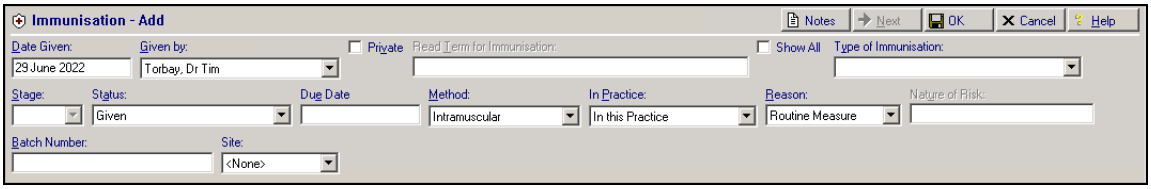
Adding an Immunisation

The **Immunisation - Add** screen is used to:

- Record immunisations given
- Refusals to start or complete a course
- Immunisations advised

To record immunisations:

1. From **Consultation Manager**, select the patient and start a consultation if required.
2. Select **Add - Immunisations**, remember you can press **Alt+A** then **Alt+I** if using the keyboard.
3. The **Immunisation - Add** screen displays:



Complete as follows:

- **Date Given** - Defaults to today's date, update as required.
- **Given by** - Defaults to the staff member or GP signed on for the current session, update as required.
- **Private** - Defaults to unticked, tick if you are recording a private immunisation.
- **READ Term for Immunisation** - Disabled until **Type of Immunisation** is selected, it is then updated with the Read code and description relevant to the immunisation selected.
- **Show All** - Default unticked, so only current immunisations display in **Type of Immunisation**. Tick to display all immunisation options, including historical options in the **Type of Immunisation** list.
- **Type of Immunisation** - Select from the list of immunisations.
    - **Stage** - Depending on the immunisation, select from the available list as required, for example **1st**, **2nd** or **Booster**.
    - **Status** - Defaults to **Given**, select from the available list as required.

Remember - It is important to record that a patient has refused an immunisation.

- **Due Date** - Automatically entered based on the **Type of Immunisation** and **Stage** selected, update as required. If you have selected **Advised** in **Status**, remove the due date. The *'It is usual to enter a due date for [immunisation]'. Do you wish to continue. Yes/No' message* displays if you try to save *a* an immunisation with no due date, select **Yes** to continue.
- **Method** - Defaults to **Intramuscular**, select from the available list if required.
- **In Practice** - Defaults to **In this Practice**, select from the available list if required.
- **Reason** - Defaults to **Routine Measure**, or select from the available list if required:
    - **Epidemic** - For local outbreaks of disease, as directed by the Community Physician.
    - **Special Risk Group** - If selected the **Nature of Risk** must be entered.
    - **Traveller** - If selected, **Nature of Risk** changes to **Country**, select from the available list as required.
- **Nature of Risk/Country** - Enter as appropriate.
- **Batch Number** - A free text entry, enter if required.
- **Site** - Select from the available list if required.
- **Notes**

- Select to enter free text comments if required.
- **Next**

- Select if the vaccination entered is multi-stage, and you want to enter the next stage at the same time. A new **Immunisation - Add** screen displays with the same **Type of Immunisation** selected, ready to enter the subsequent stage.

4. Select **OK** to save and close.

Please note the following:

- If you are adding a Tetanus or Cholera booster for an adult, you are reminded if you have not entered the first, second and third stages, select **Yes** to continue. There is no obligation to record the previous stages.
- If you are adding an immunisation before the due date of an existing immunisation of the same kind, a warning displays.
- If you are adding an **Advised** status, a *'It is usual to enter a due date for [immunisation] . Do you wish to continue. Yes/No'* message displays, simply select **Yes**.

Adding a Referral

To add a referral:

From **Consultation Manager**, select the patient required and start a Consultation if required.

Scotland and Northern Ireland

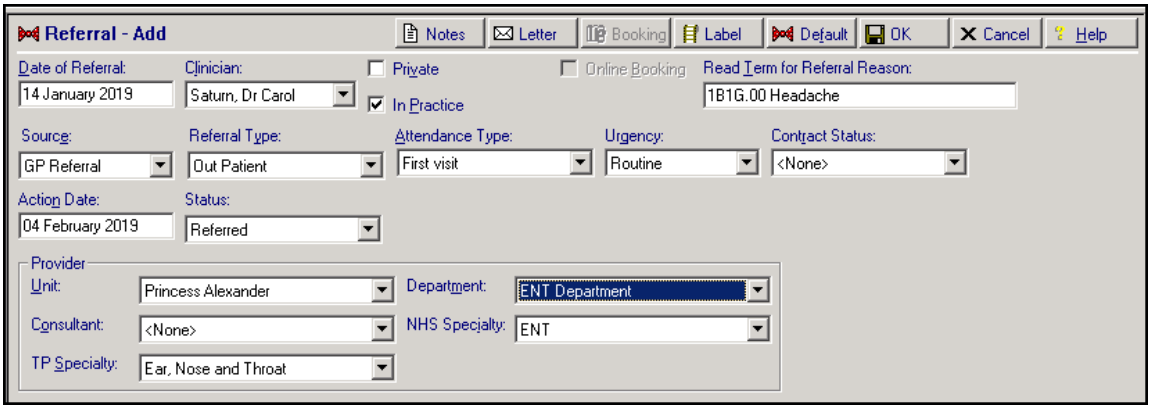
- Select **Summary - SCI Gateway** and complete as required.

Wales

- Select **Summary - WCCG** and complete as required.

England

1. Select **Add - Referral**, remember you can press **Alt** + **A** and then **Alt** + **F** if using the keyboard.
2. Select either:
   - **Referrals** - The **Referral - Add** screen displays.
   - **From Default** - The **Select Default** screen displays, select the Default referral required.
3. The **Referral - Add** screen displays:



Complete as required

- **Date of Referral** - Defaults to today's date, update as required.
- **Clinician** - Defaults to the staff member or GP signed on for the current session, update as required.
- **Private** - Defaults to unticked, tick if you are recording a private referral.
- **In Practice** - Ticked by default, remove tick to record referral was recorded out of the practice.
- **Online Booking** - Tick to access the eReferral Services web page, make an appointment request or booking and allocate a unique booking reference number (UBRN).
- **Read Term for Referral Reason** - Select a Read code in the usual way.
- **Source** - Select as appropriate.

- **Referral Type** - Select from the list available as appropriate.
- **Attendance Type** - Select as appropriate.
- **Urgency** - Select as appropriate, **Urgency** is updated to **<None>** if you select **Online Booking**, update before selecting **OK**. The urgency is then copied to the e-Referral Service.
- **Contract Status** - Select if required.
- **Action Date** - The date by which you would expect treatment to have started. Enter a time period here, for example, 7D for seven days, or 3M for three months. Action dates can be searched on, there are no actions triggered once overdue.
- **Status** - Select if required.
- **Booking Reference** - If this is an eReferral the UBRN displays.
- **Unit** - Select a provider.
- **Department** - Select if required.
- **Consultant** - Select if required.
- **NHS Specialty** - Select if required, you can analyse referrals by specialty on the **Referrals Report**.
- **TP Specialty** - Select as required.
- **Notes**

- Select to add free text if required, text can be copied and pasted into **Notes**.
- **Letter**

- Select to create a referral letter.
- **Label**

- Select to print a label for this referral, check the number of labels is correct and select **OK**.
- **Default**

- Select to use or set up a default referral.

4. Select **OK** to save and close.

Other ways to add referrals include:

- **Add Referral** from the toolbar.
- **Click, Drag and Drop** - Click on the entry you want to create a referral for, hold your click and release over **Make a referral for this item** on the floating tool bar. The Read Term for Referral Reason is completed automatically using this method.
- Simply right click on an existing referral and select **Add**.

From the **Journal** or **Filtered** tabs, select **More…** to view the details of the referral.

Exiting Vision 3

It is important you log out of **Vision 3** each night as staying logged in can interfere with automatic processes.

To exit **Vision 3** either:

- From the **Vision 3 Front screen**, select **Close All**

to close down all open modules within **Vision 3** and then select **Close** ☒.

  or,

- Simply select **Close** ☒.