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## Help Guide

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## Introduction

Welcome to QuicDoc® the comprehensive documentation and outcome assessment system for the mental health professions. Use QuicDoc to document patient care from Intake to Discharge, track authorizations, maintain your appointment schedule, score and track outcome/progress measures, generate reports, and more. Complete your treatment plans and submit them on the required OTR form using QuicForms.

### About This Start-Up Guide

The Start-Up Guide serves as an introduction and contains information to get you up and running quickly. It was designed to provide the basics only. Comprehensive, context-sensitive Help is available by selecting Help Topics from the Help menu or pressing F1 from any screen. You may also visit our online [Knowledgebase](#) for up to date help guides. Throughout this guide System Administrator will be abbreviated as **SA**, and the System Administrator's logon as Administrative logon. This guide assumes you are familiar with the Microsoft Windows Operating System.

### QDPM Users

There will be some items in this guide that will not be available if you are using our billing software, QDPM. All patient demographics and scheduling **MUST BE** entered directly into the QDPM software as it is integrated with QuicDoc. Patient demographics and the schedule will be read only. Any changes that need to be made to these items, you will need to go directly into QDPM program.

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## Technical Support

If you have a question about QuicDoc, first look in:

The QuicDoc Help Guide

The QuicDoc Help Topics found in the Help menu

The QuicDoc online videos can be found at <https://www.youtube.com/user/DocuTrac/videos>

The QuicDoc online Knowledgebase found at <http://www.docutracinc.com/kb/index.php?/>

**Information to have ready:** Before you call DTI support services with a problem or a question on how to use

QuicDoc, be at your computer with QuicDoc running. Be prepared to give the following information:

- Type of computer hardware you are using.
- Version of Microsoft Windows and/or Mac OS you are using.
- Exact wording of any messages that appear on your screen.
- A complete description of what happened and what you were doing when problem occurred.
- The printer manufacturer, type, and model, if relevant to your problem.
- Your network configuration, if any.

### Support Hours

Mon - Fri: 9:00 AM to 5:00 PM, EST

If you have a problem or cannot find an answer in the Help Guide or On-Line Help: Contact TheraManager DocuTrac Support Services at 888-308-9683.

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## Running QuicDoc

Log onto QuicDoc with either the Administrative ID and Password or your User ID and Password.

The Administrative logon allows access to all patient lists, records, and to all parts of the program with the exception of Continuing Education tracking in the User window. SA tasks include:

- Register the software
- Add new users
- Set access levels
- Make users inactive or delete them
- Check users logged on to QuicDoc (network)
- Optimize and repair databases
- Set electronic records option
- Setup providers work schedules
- Reassign clients to a different provider
- View and Purge the Audit Log
- Set SA Preferences
- User Forms and Documentation Setup
- Custom Outcome Measures
- Create and Edit Document Templates

Your user logon gives you access to just your patients and the ability to create and edit notes for those patients. By default, when you open the patient information window to add new clients, you will be listed as the provider of service.


A Reminders window displays once you log onto QuicDoc. It will list your daily appointments, treatment plans that are due, authorizations with fewer than 2 weeks remaining, and tasks you have setup in the Scheduler. You can close the reminders window. You can configure QuicDoc to not display the Reminders screen at opening by visiting the **Preferences** window, from the **Setup** menu.

## Overview of QuicDoc

QuicDoc's main interface consists of five views with context sensitive menus and toolbars. The opening view is the Patient or Client window. Click to open the **Views** menu and select a view.



The vertical splitter can be resized and moved vertically to hide the patient list. You can also hide the

patient names by clicking on the  icon to the right of the **Find** box at the top of the screen. The right side, middle, horizontal splitter can also be moved to display more or less information.

Contact information, emergency information, and current diagnosis and medications for a selected client are displayed in the upper right pane.



The Find field at the top of the window allows you to quickly search the patient list for a specific name.

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## Tasks



Click to expand the Tasks list for frequently used features.



Use the Help icon at the top, right of the window to quickly access the Help files.



**Patients:** The Patient window is the opening screen in QuicDoc. You can view and access all clients along with address and phone numbers, emergency contact, session or note history, current diagnosis and medications, insurance authorizations, necessary tasks, attached documents, and any cautionary notes for a specific patient.



**Users:** The User window displays identifying information for an individual user, or with the Administrative logon, a list and information for all users including work schedules.

Continuing Education Tracking: Users can record and conveniently keep track of their continuing education units.

The program, location, dates, and number of units is all displayed in an entries list box. This feature is not available when using the Administrative logon.



**Referrals:** The Referrals window displays your Referral Source list and information you have entered for each referral. It also displays a list of all patients that were referred by the selected referral source.



**Insurance:** The Insurance window displays your Insurance Company list and information for each company. It also displays a list of patients associated with a selected company. Enter Managed Care Companies, from which you will be receiving session authorizations, as Insurance Companies. QuicDoc consolidates both managed care and insurance companies into one list.



**Pharmacies:** The Pharmacy window displays the Pharmacy list and information you have entered for each pharmacy. If applicable, Pharmacies added here are for the written prescriptions entered in QuicDoc. By default the Pharmacy window is disabled. To enable the Pharmacy, log into the SA account. Under Setup select Preferences. It will be under the Administrative tab.



## Groups



The Groups window will display a list of groups that you set up. When you click on the + next to the group name, the list expands to display the members and dates each member was added to the group.



**e-Prescribe:** The Electronic Prescribing System in QuicDoc will allow a doctor to prescribe medications and transmit them to a pharmacy using electronic connection over the internet or using automatic faxing. In addition, the prescriber may also print prescriptions. For information on e-Prescribing, please contact Sales at 800-850-8510.

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## All Views

All of the QuicDoc Views have a **Find** field in the top pane of the window, as well as a tasks side menu for frequently accessed features.

**Toolbar:** The context sensitive toolbar allows you to launch frequently used features from the main windows.

**Menus:** QuicDoc's context sensitive menus change according to the available features for the current or active window, Patients, Users, Referral Sources, or Insurance Companies.

**Pop-up menus** can be accessed by right clicking with your mouse. For example, right click on the patient list to display a menu that lets you edit information, find a patient, schedule tasks, etc. Right click in text fields for edit menus, or right click in the Notes History tab to create or open clinical notes.

## Documentation – Patient View

Notes and treatment plans are listed in the Patient window in a tabbed area at the bottom, right of the window for easy access. QuicDoc includes complete documentation from Intake to Discharge, including Progress Notes, DAP and SOAP formats, Treatment Plans, Inpatient and Outpatient, Missed Appointment, and Incidental Notes.

(OTR forms are listed in QuicForms.)



Additionally the tabs include a tab for the Authorizations, Tasks, and one for Documents. The Documents tab lists all files created from templates and merged with client information (e.g. Release of Information form).

QuicDoc's complete documentation also includes:

- Separate Psychotherapy Notes
- Disclosure of Protected Health Information
- QuicForms, OTR forms for Treatment Plans
- Missed Appointment Notes
- Incidental Notes
- Other - User Defined Notes



**Scheduler:** With QuicDoc's Scheduler you can create therapy and group therapy appointments, schedule events, meetings, activities, tasks, and availability. You can even schedule blocks of time for specific types of appointments, such as medical evaluations, and then create appointments within the time block. There is a room scheduler to help manage your resources. You can view your schedule by day, week, or month. There is also an all provider view.

## Assessments and Outcome Measures

QuicDoc includes outcome measures to track patient or client progress, as well as other assessment tools such as the Crisis Triage Rating Scale, a Pain and a Nutrition assessment.

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## Reports

QuicDoc will generate a number of reports based on data you enter for patients and on information you enter while documenting sessions. QuicDoc's reports include:

Quality Assessment	Outcome Measures
Demographics	Client Satisfaction
Diagnosis	Missed Appointment
Medications	Contact Hours
Referral source	Demographics Report

The Audit Log report allows you to track and audit user activity in the program. It requires the Administrative Logon. The Audit Report logging can be turned on or off by logging into SA account. Select the Setup menu, and the click on preferences. It will be located under the Administrative tab, 'Audit Report logging.'

## Tracking Features

In addition to client or patient progress and quality assessment, QuicDoc can track the following: Authorizations, Treatment Plans, Continuing Education Credits, tasks, calls, appointments, and sessions that need to be documented, Protected Health Information, client specific documents, activity in the program, and more.

## Getting Started

You can begin by setting up a report header, and you may also want to set your preferences. Then you can complete the user setup, and add insurance companies and referral sources.

### Report Header

This appears at the top of all notes and reports. You can also enter alternate headers, and change the default setting. The first header entered is the default header.

To Add a Header: Select **Report Headers** from the **Setup** menu.

Type the header in the text box. Use the Enter key to begin a new line. You can have any number of lines. Click **Save**. If you are only entering one header then click **Close** to exit.

### Alternate Report Headers

Click **New**. You will see the numbers at the top change from 1 of 1 to 2 of 2. You can have any number of Report Headers, with one being the default header. Enter another header. Click **Save**.

### Preferences

You can set preferences for Reminders, Treatment Plan notification, Links, and Tasks, as well as Administrative preferences including Electronic Records (signatures) and password options which require the Administrative logon.

To set preferences from the **Setup** menu select **Preferences**. While in the Preferences window, press **F1** for Help and detailed information regarding options.

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## Documentation Setup

You can setup Notes and Treatment Plans in QuicDoc to reflect your individual needs by selecting which clinical sections you want to appear in the listbar or side menus. For instance, if you never do Psychological Testing, you can remove that section from the menu. The Documentation Setup also allows you to create notes of your own design and name, aside from those that are in the program by default.

First familiarize yourself with the different clinical sections in QuicDoc. You will need to have entered at least one patient before you can access the Documentation area of the program. To access the setup go to **Setup...Documentation Setup** in the Patient window. You will need to logon with Administrative logon. Press F1 for help or visit our online [Knowledgebase](#) for more information on Documentation setup.

## User Forms

The User Forms option in QuicDoc allows the user to create forms or sections to be added to either a pre-existing note type or a user defined note type which will be done in the Documentation Setup. You can find the User

Forms option by going to **Setup...User Forms** while logged in with the Administrative ID. There is a tutorial on the User Forms but you can also consult the Help Files for additional questions by pressing F1 while the User

Forms screen is open or visit our online [Knowledgebase](#).

## Users



**Setup Users:** Log onto QuicDoc with the Administrative ID and password to add new users. When you add a new user, you will assign a User ID and password, and you set appropriate levels of access.

**Note:** If you are using QDPM, the provider's User setup in QuicDoc will not sync to QDPM. You will need to enter the Provider's name in both programs and **MUST** identical. When making changes

Click **Users** on the **View** menu bar or select it from the View menu.

- Click the **Tasks** sidebar to expand, and then select **Add a user**, or you can select New User from Users menu.
- Enter information in the fields. The (logon) User ID, Name, and Password are the only fields required.
  - User ID: Can be from 3 to 5 alpha numeric characters.  
The ID entered becomes the logon ID for the user to start QuicDoc. **It cannot be changed.**
  - User Name: Appears at bottom of printed notes and reports. It can be edited.
- The DEA# appears on Prescriptions when the option is selected in the Print Prescription window.

## Passwords for New Users

Enter and verify a password using 4-20 alphanumeric characters. The password can be changed later by first logging on with the password and then going to File...Administration...Change Password.

Passwords do not need to be unique however it is advisable to make all passwords unique.

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## Access Levels

By default, every new user has the highest access level (Write-Delete) assigned for each of the 9 content areas.

To modify access levels: Log into the Administrative account, from the sidebar **Tasks** menu, select **Set user access levels**.

Select access levels for the user, and click **OK** to save. See Help Files for details on setting access levels or visit our online [Knowledgebase](#).

## User/Provider Work Schedule

**Note:** If you are using QDPM, the provider's schedule will need to be setup in QDPM. Information from QuicDoc scheduler will not sync to QDPM.

To set up a user's work schedule, click the **Tasks** item **Set user work schedule**.

- Enter the start and the end times for the work days of the week. Non-working days should be left blank.
- Click in the Start field, and enter the time. The format should be hh:mm. Type the letter **a** for am and the letter **p** for pm. You do not have to type the 00 if you are entering a time on the hour. For example, simply type 09a for 9:00 am or 05p for 5:00 pm.

The work times will be indicated in the Scheduler time slots as yellow. Non-working times will be indicated as grey. The work schedule appears for each selected provider in the bottom, left pane of the Users window.

## Insurance Companies

**Note:** If you are using QDPM, you will want to setup the Insurance Companies via QDPM. This information inputted into QuicDoc will not sync to QDPM.

QuicDoc consolidates both managed care and insurance companies into one list. Insurance and managed care companies can be added 'on-the-fly' as you enter new clients, or you can set them up.

## Setup Insurance Company

Click the Insurance button on the toolbar, or select Insurance Companies from the **View** menu. From the Insurance window, click **Tasks** on the side menu to open, and then select **Add insurance co.**, or you can select

New Insurance Co from the Insurance Cos menu.

Enter information, and click **Ok** to save.

**Edit:** Double click on name in list to open information form, or click on the side **Tasks** menu item **Modify insurance info**. Make changes, and click Ok to save.

**Delete:** Select the name in the list. Select **Delete Insurance Co** from the right mouse-click menu or Insurance

Cos menu. Click **Yes** in dialog box to delete. If an insurance or managed care company is associated with one or more clients, you will not be able to delete, instead you can make the company inactive.

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## Referral Sources

**Note:** If you are using QDPM, you will want to setup the Referral Source via QDPM. This information inputted into QuicDoc will not sync to QDPM.

Referral Sources can be added 'on-the-fly' as you enter new clients, or you can set them up in the Referral Sources window.

### Setup Referral Source

Select **Referrals** from the side **View** bar or top View menu. Click **Tasks** to open the list and select **Add a referral**, or you can select New Referral Source from the top Referral Sources menu. Enter information, and click **Ok** to save.

**Edit:** Double click on name in list to open information form, or click **Modify referral information** on the **Tasks** bar.

**Delete:** Select the name in the list. Select **Delete Referral Source** from right mouse-click menu or **Referral**

**Sources** menu. Click **Yes** in dialog box to delete. If the referral source is associated with one or more clients, you will not be able to delete, instead you can make the referral source inactive.



## Patients

**Note:** If you are using QDPM, patients will be read only. You will not be able to add, delete, or edit patients from QuicDoc. Please refer to QDPM for any demographic changes.

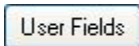
All that is required to enter a patient or client into the system is the first and last name and the provider. Other information can be added at any time. You can print a blank facesheet for your client to complete and then enter at a later time.

In the Patient window click on **Tasks** to expand the list, and then click **Add a patient**, or select **New Patient** from the **Patient** menu.

Enter information. Click on the tabs to add other information for the following categories.

- Personal tab
- Address tab
- Insurance/Referral tab
- Emergency tab

Click the button to add **Additional Information** and User Fields. Click **Ok** to save.



**User Fields:** You can set up user fields to enter other information that you wish to record. This information will appear on the patient Facesheet. Information in the User Fields will also appear in Demographics reports.

Click the User Fields button to setup fields. Press **F1** for detailed information on adding fields and pick lists for your user fields.

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**Note for Network Users:** User fields are global. If changed by anyone on the system, the change is reflected for all users and all patients. Assign the user field setup should be assigned to the SA or to one individual.



**Edit:** Click **Modify patient information** on the **Tasks** listbar, or double click on patient's name, or select the name and press Enter to open Patient Information window. Make changes, and click **OK** to save.

## Creating Notes and Treatment Plans

Once you've entered at least one patient you can begin doing intake notes, case notes, and treatment plans. You will need to log into the User created account. The SA account cannot create notes. Numerous clinical sections allows for comprehensive record keeping. Most entry is done with 'point and click' or 'drag and drop' from extensive pick lists that are easily customized. Use your tab key to move from field to field.

Depending on your system resources, QuicDoc's multi document interface allows you to have multiple notes open at the same time. You can resize windows, and close or minimize the patient window without closing your notes.

In the documentation module you can record the following:

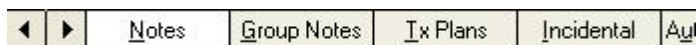
Intake Notes	Treatment Plan - Outpatient
Psychosocial History	Treatment Plan - Inpatient
Progress Notes	Discharge Notes

**Note:** Group Notes (Groups View) and Psychotherapy Notes (Documentation Menu) are entered and stored separately.

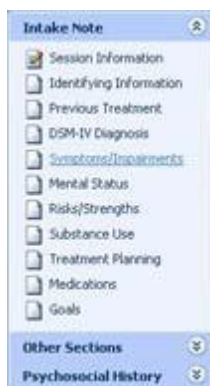
### To create notes and treatment plans:

- First select the patient or client from the list.
- Select **New** from the **Documentation** menu. Select the note type.

As notes and treatment plans are created they are listed in the Notes or Treatment Plans tabs. By clicking the heading you open the list of notes or plans. To open a note or plan, simply double click on it.



## Documentation Basics



Every note or plan type opens with either a Session Information or Discharge Information, in the case of a Discharge Note, screen to enter the date and other session information. Context sensitive instructions for entering information in the fields is displayed in green text as you move from field to field in the Session Information screen. The patient's name and the note type appear at the bottom, right of the window.

Clinical sections relevant to the note or plan type are listed on the side bar. When you click on a section, a graphic pencil appears so you can easily see which sections you've opened.

Click the headers or Bar Captions to open additional sections, such as Other Sections or Psychosocial History.

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Enter Note Data Preview the Note



## Note View

The Note view contains the clinical sections for entering data. You can arrange the clinical sections of your note or treatment in a specific order when generating it. You can also customize the side listbar for specific sections to be listed. See Help Files for details on setting note types or visit our online [Knowledgebase](#).

To generate and print your note, from the Note view select **File...Generate Note...** See below Generate Note/Report.

## Preview

While doing a note or treatment plan, click **Preview** for an instant view of your note's progress. Preview generates your note at any point during the process or at completion. If you find that a section that was just filled out is not showing on the Preview go back to the Note view and click on the first section of the note so that the section that was just filled out is saved and then click on the Preview tab again, you should see that section show up at that point.

From the **Note** View or the **Preview** you can send your note or treatment report to one of the following:



Word Processor




Printer



Portable Document Format (Adobe® PDF)

Select **File...Send to...** Your note or report is generated as you see it in the Preview window. If you send it to a printer or a PDF file, you will not be able to edit it.

## Options for Generate Note/Report in Word Processor

Click  the icon at the top of the **Preview** window, or from **Notes** window, select **File...Generate Note...** to open the Generate Note/Report window to select and order the sections you want to include, as well as select page headers and other options, then send to a word processor. If you have a set order of clinical sections that you like to use each time you generate a note or report, you can set up sequences and save time when generating your notes. Click **Create Sequences** to set up.

You may edit it or attach another file to your note by sending it to the Word Processor. However, be aware that changes made in the word processor will **NOT** be reflected back to the database. For example, if you change the

Diagnosis in the word processor, it will not be changed in the database. To change the record in the database, click on Note, open the appropriate clinical section, and make any necessary changes.

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From the **Generate Note/Report** window, select the note sections you want to include by clicking on the section and then clicking **Add**. If you have created your own report sequences, you can select one from the sequence drop-down list.

To include all sections, click **Add All**. To remove a section, select it from the sequence list, and click **Remove**. To reorder sections in the sequence list,

select a section and use the **Up** or **Down** buttons to change the order.


Select the **Page Header** text (e.g. Client Name and ID) to appear at the top of each page of the note or treatment report.

If you have not setup a Report Header or want to change the Report Header click **Set Report Header** (blue text at bottom, center of window). The Report Header appears on the first page, at the top of your notes or reports.

Click **Patient Info Preferences** (blue text at bottom, right of window) to set the information you would like to appear for each note at the top of page 1 (e.g. patient's age, address, etc.)


Select **Generate** to send it to the word processor.

## Documentation Pick Lists

 Click on the pick list icon in the upper right corner of a screen, when available, to edit a list while doing your documentation. Press **F1** while in the Edit list window for Help on adding, deleting, and editing items in the list. All pick lists can also be accessed from **Setup** menu and select **Clinical Lists**.

## Spell check

For Intake, Progress, Discharge Notes, and Treatment Plans: While your cursor is in any text field or drop-

down field, select **Spell Check** from the File menu, or click the **Spell Check**  icon. Spell Check checks only active fields.

You will need to move your cursor from field to field to spell check all text fields. To replace a misspelled word, select a correction from the Suggestions list, if listed, and click **Change**. Click **Change All** if there is more than one instance of the misspelled word. You can also type your correction in the field, and click **Change**.


Click **Ignore** or **Ignore All** to ignore the misspelled word. Click **Add** to add an identified misspelled word to the Dictionary.

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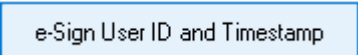
## Electronic Signatures

By default, the note signature is turned off. An admin will need to log in, go to **Setup**, and select **Preferences**. Under the **Administrative** tab, there is a section called **Electronic Record**. You will want to enable electronic signatures and/or require supervisor sign off.

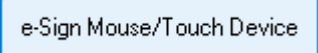
**Note:** If you are using QDPM, **ALL NOTES** must be signed in QuicDoc for them to be sent over to QDPM. If notes are not signed, the charges will not sync to QDPM.

Once a note is completed and is ready to be signed, click on the  icon. The Sign Note box will appear. Here you can add/remove required signatures for providers and non-providers.

There are 3 different types of Electronic Signatures:

 this will use the current user that is logged into QuicDoc ID. It will use the date and time that it was signed.

 you may use a Topaz signature pad to sign notes. Please contact Support at 888-308-9683 for more details and system requirements before purchasing a signature pad.

 this will allow the users to use the mouse or touch pad to sign a note.

## Supervisor Signatures

Only one supervisor can be set for a user. To setup a supervisor, login using an admin account. Under **Users**, select the user in the list, and click on **Modify user information**. Select the **Supervisor** in the dropdown menu.


If you have custom notes, you will need to also allow supervisor signatures for these notes. Login using an admin, under the **Setup** menu, select **Documentation Setup**, and click on **QuicDoc Documentation**. Select a **Note Type** and make sure that the **Supervisor Must Sign** is checked. Click **Save**.


**Note:** Once a clinical notes and reports are committed or electronically signed, they cannot be deleted or modified. Any information that needs to be updated on a note must be entered into the **Addendum**.

For more information on Electronic signatures, Supervisor signatures, or Addendums please visit our online [Knowledgebase](#).

## Intake Note

Select the patient or client, then from the Documentation menu select New...Intake Note.

 By default, the Intake Sections are displayed on the side listbar under the Intake Note header. Click the bar to open the sections list, and then click on a section name, such as Previous Treatment, to open the corresponding screen.

 Click on the caption bar labeled Other Sections at the bottom of the listbar, and then click a section to open a corresponding screen.

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### Psychosocial Histo...

Click on the caption bar labeled Psychosocial History at the bottom of the listbar, then click a section to open it.

You do not have to complete all sections. Once you have familiarized yourself with the sections, you can determine which areas you want to address. You do not have to go to every screen, or fill in every field. However, since the symptoms and treatment goals pick lists are based on the diagnosis(es) you enter, it is generally best to record the patient's diagnosis before addressing the symptoms and goals.

Remember sections can be removed, added, or reordered. Please visit our online [Knowledgebase](#) for more information.

## Progress Notes

Select the patient or client then from the Documentation menu select New...Progress Note.

Progress Note sections are listed under the side listbar. Click on a section such as Interventions on the listbar to open the corresponding window.

### Optional Sections

Optional Sections is located at the bottom of the listbar, Click on it to open. These sections contain information addressed at Intake which can be updated in progress notes. For instance, you may want to rate the symptoms and impairments to track improvement during treatment. Or, you may want to record progress toward treatment goals.

Familiarize yourself with the sections to determine which areas you want to address. You don't have to go to every screen, or fill in every field. You can optionally enter a **SOAP** note.

Remember sections can be removed, added, or reordered. Please visit our online [Knowledgebase](#) for more information.

## Separate Psychotherapy Notes

QuicDoc provides separate Psychotherapy Notes for therapists to keep sensitive information separate from the clients' records. Psychotherapy Notes can be password protected. To enter separate notes, select **Psychotherapy Notes** from the **Documentation** menu. Press F1 for detailed help in entering notes.

## Treatment Plans

First select the patient or client, then from the **Documentation** menu select **New...Treatment Plan...Outpatient** or **Inpatient**.

### Notes Treatment Plans Inci

As treatment plans are created, they are listed for each client in the Treatment Plans tab at the bottom right of the patient window. Click on the Header to open the list.

**Inpatient:** The Inpatient Treatment Plan uses a Problem-Oriented approach, Problems with associated objectives, interventions or treatment modalities and the staff responsible. It contains a section for Hospital Justification, and a Summary section for discharge criteria, disposition, and a listing of the treatment team.

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**Outpatient:** The Outpatient Treatment Plan by default contains the same clinical sections as the Intake Note, and it has the same sections contained in Optional Sections of the Progress Note.

If you've completed an Intake Note on the patient, or updated those sections in the Progress Note, your most recent data will appear for updating in the Treatment Plan. Other clinical sections are listed on the left in the listbar. Click on a section to open the corresponding window. Other Sections can be accessed by clicking on the side caption or header labeled **Other Sections**, and then clicking a section to open the corresponding window.

## Discharge Notes

First select the patient or client, and then from the **Documentation** menu select **New...Discharge Note**. Enter the Provider, Program, and the Discharge Date in the Discharge/ Session Information screen. Click an option for Discharge Status and for Discharge Condition. From the drop down pick list select a Reason for Discharge, or you may type in the field.

For Total Sessions Seen, select either Total Sessions or Hospital Days, and then click the Calculate button. Only documented sessions, as well as the Intake will be included in this number. You can override the number by simply typing in the field.

Discharge Recommendations

Click the tabs for Discharge Recommendations and Summary to complete the Discharge/Session information. Additionally other documentation sections can be addressed at discharge.

A Discharge Note must be entered before creating a new incident.

## Batch Printing Clinical Notes and Treatment Plans

You can batch print notes listed in the Notes History, Treatment Plans, or Incidental tabs, in the Patient window. Batch printed notes and reports are generated from the database. You cannot edit nor order the note sections. All sections that were addressed when the note(s) were created will be printed. If you want to edit and control the order of note sections, generate each note individually and send to the word processor. To print a 'Selected' note, or to 'Batch' print all notes from the Patient window, select **File...Print...Notes**.

### Print Selected Note

Select the client whose note you wish to print. In Notes, Treatment Plans, or Incidental tab, click on the Note or Report to select it. Select File...Print...Notes. Click **OK** in the Print Notes dialog box to send the note to a preview window for printing.

**Note:** By default the first note or report in the tab is automatically selected, be sure the note you want to print is selected.

### Print All Notes or Notes in a Date Range

Click the **All Notes** option to batch print all notes or reports in the selected tab (Notes, Treatment Plans, or Incidental) for the patient, or click the **Notes** and specify a **From** and a **To** date.

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**Set a Header.** If there is no option for a header, or none appears in the Select Note Header area, then none was setup. If there is more than one header, use the browse arrows to display the header you want to use.

Click in the checkbox if you want to have a '**Page Break between notes.**'

Click **OK** to send notes to a print preview. Click Print to print the note(s), and Click Close to exit.

## **Group Notes**

Before setting up a Group, be sure that the Leader and Co-Leader, if applicable, have been setup as Users in QuicDoc. For more information on Groups, please visit our online [Knowledgebase](#).

**Note:** If you are using QDPM, Group note charges will not sync to QDPM. All charges for Groups must be entered manually into QDPM.

Click **Groups** on the side listbar under **Views**, or select Groups from the top View menu.

### **Setup a Group**

To setup a group, from the **Groups** menu select **New Group**. Enter a **Name** for the group and enter a description in the text field.

Use the drop down pick lists to enter a **Leader** and a **Co-Leader**, assuming that the therapists have been added in the User setup.

Select a **Note Type** from the drop down list as this is required to save the Group.

Note the **Active** checkbox, and be sure it is checked. You can un-check once the group terminates.

### **Add Members to Group**

Click the **Add** button in the **Group Therapy** setup window to enter group members. Drag names from the **Patient List** to the **Group Members List**, and click **Ok** to save.

**Search:** If the client list is long, you can search for a specific client by typing in the **Search** field, and clicking on the binoculars.

Once set up, the group is listed along with the group members in the left pane of the Groups main window under

**Group Listing.** Click the + plus next to the group name to expand and display the list of members. Click again to collapse the list.

**Edit Group Information and Membership:** To edit the group name, the leaders, or the membership right click on the group name and select Edit Group, or select it from the Groups menu.

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## Member Status

To view or change a member's **Active and Inactive Status**: Double-click on the member's name in the group listing, and check or uncheck the Active checkbox.

To change the status from Active to **Inactive**, un-check the Active checkbox. Enter a date in the **Ended Group** date field to record the date the client terminated the group.

## Creating Group Notes

First select the group name in the list. From the **Group Notes** menu, select New **Group Note**.

The Group, the Leader, and the Co-Leader names, (if entered at setup) as well as the Date are automatically filled. Change the date if different.

Use the drop down pick list to select a program, if applicable.

The Length field is automatically calculated, once you enter the Start and End times.

## Set Attendance

Group members are listed with a set of check boxes next to each name. By default all members are checked as Attended.

Select Missed, Cancelled, or Not Scheduled for any member where it is appropriate.

If Attended is selected, you can do a group note. If Missed or Cancelled is selected, you can write a note indicating the reason. If Not Scheduled is selected, no note will be required.

## General Group Note

Group Notes consists of two sections. A **Group Information** section that has the date, time, program, and the attendance status. The other section is **Group Note Content**. You will enter the session notes in this section.

Enter **Themes, Interventions**, and/or **Content** for the group session. You may click on the **Note for All Members** which will allow you to enter all information for the themes, interventions and content for all members of the group. To assist with spelling errors QuicDoc's Group Notes has spell check as you go. When completed, click the **Next** button to save the group note.

The Details section is for each patient and must be entered for all members.

Interactions with other Members/Leader(s)  
Level of Participation  
Symptoms/Problem Focus/Behavioral Change

Click on the member's name in the list on the left to access that member's note to add patient specific details.

Close out of the note to **Save**.

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Notes are listed in the lower right pane of the main QuicDoc interface under the Group Notes tab. You can open a Group Note listed here by double-clicking on it.

### Create Individual Notes only for a Group Session

If you wish to enter notes for each individual member in the group, and do not want to include a generalized note, do not use the **'Note for All Members.'** You will enter the session information in all the required text fields.

**Print:** To print group notes for all members, click the **Print All Notes** button. Selecting this will print what has been entered in both the **General** and **Details** tab for each member. If you have entered a Missed or Cancelled note for a member, this will also print.

Clicking the **Print Selected** button will print what has been entered in both the General and Details tab for the member selected in the list.


### QuicForms Treatment Plans

Use QuicForms to import your data from QuicDoc onto insurance or managed care company's required treatment plan form. QuicForms comes with a number of OTR forms which will need to be installed before they can be used. When opening QuicForms for the first time, follow the instructions on the screen to install form files.

To open QuicForms from QuicDoc: Click the QuicForms icon on the toolbar, or select QuicForms from the **Documentation** menu.

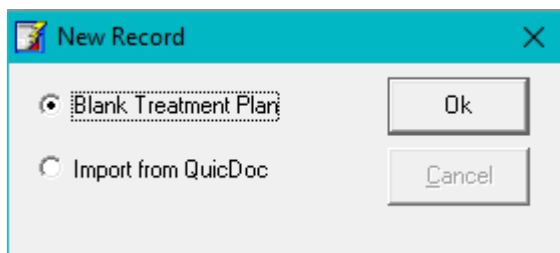
### Filling Out Forms

Once forms are installed they are listed in the QuicForms opening screen, in the left side pane. Click on a form to view it. Since forms can be similar, you can preview the form before opening it. When you open a new form you have the option to import information from QuicDoc, or to fill out the form from scratch. Forms have pick lists and calendars for quick entry.

To open a form, click on it to select it, then click the **Open**  button on the toolbar, or select **File...Open**.

### To Import from QuicDoc

Select Import from QuicDoc in the New Record window when opening a new form. This allows you to import data from one of the notes or treatment plans previously entered in QuicDoc.



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Select a client from the list of patients/clients.

Next, select the Note/Plan Type to import (e.g. Intake, Progress, Treatment Plan, or Discharge Note). You will then see a list of dates for possible notes or plans to import.

Under **Select Note/Plan Type**, click on the row with the date of the note or plan you want to use to import the data. Click **OK**.

**Note:** All required data may not transfer to a particular form due to differing formats used to store

QuicDoc's data. Also, there may be some data which QuicDoc does not collect. However, much of the basic data will be transferred.

Many of the form fields have pick lists and calendars making it easy to fill in the forms. The status bar at the bottom of the form indicates if the field has an associated pick list or calendar. To access the pick list or calendar, double-click in the field or press **F8**.

All forms included in QuicForms function in the same way. Use the **TAB** key to move from field to field, or click in a field. When a field is active, it will change color. Check boxes can be selected/de-selected by clicking them with the left mouse button.


Since the form is larger than the size of the screen, you can scroll horizontally or vertically by using the scroll bars at the bottom and to the right of the form. Clicking on the arrows on the bar moves the form slowly. Clicking between the arrows and button on the bar moves the form more quickly.

To display the next or previous page, click on the Page number buttons at the bottom of the form.

**Note:** When entering data in multi-line text boxes, if the height of the text is higher than the height of the box or scrolls below the text box, the entire text will be printed on an additional page, appended to the form.

### New Treatment Plan Record

Once a form has been opened and saved, the next time you open that form you will see you're previously saved treatment plan(s). To create a new record:

 Click **New Plan** on the Navigation toolbar, or select **Records...Go to...New Record**.

Select the option to **Import from QuicDoc** or to open a **Blank Treatment Plan**.

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## Saving



To save the treatment plan record in QuicForms, do one of the following: To save a plan you have completed, select **Records...Save** or click on the Save icon on the toolbar.

Each treatment plan form has its own database to store plans. A database is a collection of information stored as individual records. QuicForms automatically creates a database, and the first record in the database, when you open the form for the first time. Each time you do a new plan, it becomes a record in that form's database. Form databases are installed in the QuicDoc/Data folder.

### Problem-oriented format

Some OTR forms require use of a problem-oriented format. That is, entry of one or more problems, and for each, associated goals, objectives, and interventions. When importing from QuicDoc, this data will come from the Problems-Objectives-Interventions section of QuicDoc. Otherwise, goals and interventions will come from the Treatment Goals and Treatment Planning sections respectively.

### Navigating Saved Plans



Each new plan is added to the end of the database record set. You will notice that when you create a new plan or save a plan the record count at the top of the

screen changes. The Record Count (Record 3 of 3 in the example) on the navigation bar displays the number of records in the current database. You can go to a specific treatment plan by opening the form and using the record navigator, pictured above, to move to the desired record, or use the find feature to locate a record.

Note: The **Records...Go to** menu corresponds to the navigation buttons on the toolbar.

### Duplicate

QuicForms make it very easy to update a previously saved treatment plan. You can duplicate an existing plan and eliminate double entry of information which remains constant.

When first opening QuicForms, select the Treatment Plan you want to use from the list of treatment plans, and click the **Open** button on the toolbar. Use the navigation bar at the top to select the record that you want to duplicate.

Select **Duplicate** from the **Records** menu.

The original plan will be duplicated and added to the end of the database. You can then make changes to update the plan, and save it.

### QuicForms Preferences

To set preference options in QuicForms including printer offsets, select **File... Preferences**. Press **F1** for Help on options.

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## Adjust Field Positions

On some forms, the field positions may not be perfectly aligned or when printing the form, the data alignment may be off. This can be corrected by adjusting field positions and re-saving the form file.

Select **Adjust Field Positions** from the QuicForms **Tools** menu. Use the arrows on the Nudge Pad for positioning. Press F1 for Help.

## Deleting a Record of a Treatment Plan

To delete a record, go to the record in QuicForms that you want to delete. Select **Delete** from the **Records** menu, or press **Ctrl + d**.

## Spell Check

To spell check all text on a page, select **Tools...Spell...Check Page**, or select **Check Field** for checking a specific field.

## Outcome Measures

QuicDoc includes built-in measures to track progress and evaluate treatment outcomes for your clients. In addition you can enter scores for any measure, including user-defined, and QuicDoc will track client progress, as well as generate aggregate reports and graphs for that measure. For more information on Outcome Measures, please visit our online [Knowledgebase](#).

### To Print Copies of Measures for patients to fill out:

QuicDoc comes with the following built-in measures:

- Health Status Questionnaire (HSQ)
- Outcome Questionnaire-45 (OQ-45)
- Timberlawn Child Functioning Scale

Select **Print... Measures**, Forms, Letters from the **File** menu, or click the Print button on the toolbar.

Following are the names of forms and measures you can print:

- Patient Satisfaction Survey.rtf
- Health Status Questionnaire.rtf
- OQ45.rtf
- Timberlawn Child Functioning Scale Parent Version.rtf
- Timberlawn Child Functioning Scale Therapist Version.rtf
- Crisis Triage Rating Scale.rtf

Select the file from the list of files in the Documents tab in QuicDoc, and double click Open. The document opens in QuicWord. Select **Print** from the word processor **File** menu. Print one or more copies.

You can also open the word processor from the **Write** menu to print measures.

Select **Open** from the QuicWord **File** menu.

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## Other Measures

In addition you can set up your own measures. QuicDoc also provides screens with scale names and fields for entering the score or rating, T scores, Raw scores, or in the case of the Zung Depression Scale the SDS Index.

QuicDoc does not score and interpret these measures, but you can administer them and enter the results so that

QuicDoc will track progress. The following are pre-defined measures listed in the Measures pick list window:

- Addictions Severity Index
- Basis 32
- Beck Depression Scale
- Geriatric Depression Scale - Long Form
- Geriatric Depression Scale - Short Form
- SCL-90-R
- Zung Depression Scale

## Setup outcome measures

Select the patient. From the **Assessments** menu select **Outcome Measures**.  
Click the **Add** button.

Double click on a measure to select it from the Measure list, or highlight it and click **Select**. There is no limit to the number of measures you can use. You can even use other measures that are not in QuicDoc. First, you will need to set them up as user-defined measures. They will then be added to the Measures list.

Score the measure after setting it up for the patient. Only when a measure is scored does it becomes associated with the patient. If you select a measure for a patient, then close the Outcome Measures window before scoring it, the measure will not be listed when you open the form again.

## Score Measures

To score, select the patient, then select the measure to score from the Outcome Measures window, Assessment menu.

Click the blue underlined text **Score**.

Enter the date.

Enter the phase of treatment: 1 baseline, 2 progress, or 3 discharge.

To associate the scores with a particular session, click down arrow in the Assoc. with session field, and select a date from the drop down pick list which displays all documented sessions. The corresponding session number for the date selected is entered in the field.

Enter item responses or scale scores. For measures in QuicDoc, enter the responses in the questionnaire; for Pre-Defined or User Defined measures, enter the scores.

Select **Save** for questionnaires, or **OK** to save scores entered.

Click the blue underlined word **Review** for a report and graph of the measure.

## User Defined Measures

You can setup your own measures to use, and QuicDoc will provide the forms for entering scores, and will generate graphs and reports. Click **Add** as you would to select a measure.

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User Defined...

In the Measures window click the User Defined...button.

The screenshot shows the 'Outcome Measure Setup' dialog box. It has a title bar with a close button. The main area contains:  
- Measure Name: CAFAS (dropdown)  
- Score Type: Rating (dropdown)  
- Range of Scores: 0 to 31 (text boxes)  
- Scales: A list box with columns 'ID' and 'Scale Name'. It is currently empty.  
- Buttons: New, Save, Delete, Edit, Add, Remove, Help, Cancel.  
- At the bottom, there are input fields for ID (containing 'TS') and Scale Name (containing 'Total Score').

Click **New** in Outcome Measure Setup.

Enter the following information:

**Measure Name:** Enter name of measure you want to use.

**Score Type:** Enter Type of Score (e.g., T-score) from drop down list. If not listed, type it in.

**Range of Scores:** (e.g., from 0 To 50). Enter lowest and highest number of scores for all scales and subscales.

For example, a measure may have three subscales with scores in different ranges: the first with a range from 10 to 20, the second from 0 to 20, and the third from 10 to 30. The Range of Scores would be from 0 to 30, the lowest and highest scores of all three subscales.

### ID and Scale Names:

Enter ID and Scale Name in the fields at the bottom of the form. Click **Add** to add to the Scales list box. Click **Save** after entering all required information for the measure. Click **New** to add another measure, or **Cancel** to close the setup form. Forms for entering scores are generated when you select the measures for scoring.

## Score and Print Patient Satisfaction Survey

Select **Patient Satisfaction Survey, New** from **Assessments** menu.

### Enter Information:

Date: Enter patient's Discharge date or approximate Discharge date.

Provider: If access to All Providers is allowed, there will be a drop down list to select the provider. Otherwise, the field will display the name for the logged on user.

Program: Select from drop down list.

Insurance Co.: Select from drop down list.

The information is used to filter reports and graphs.

### Enter Scores:

Enter a rating for each item.

### Calculate and Save Survey Scores:

Click **Save** to calculate scores. Scores are displayed at the bottom of the form.

**Note:** Individual survey results can only be printed at the time the scores are calculated.

Click **Print** to print the survey results with item ratings, total score, and sub scale scores.

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## QuicDoc Scheduler



Launch the Scheduler from the toolbar or the **File** menu. You can view the schedule in the following ways:  
Day view, Week view, Month view, and All Providers view (requires Administrative logon or access rights).

**Note:** If you are using QDPM, the scheduler will be read only. You will not be able to add, delete, or edit appointment from the QuicDoc Scheduler. Please refer to QDPM for any appointments or demographic changes.

Click to expand the **Views** side listbar and select a view, or select it from the View menu.

This start-up guide will cover just the basics of entering an appointment and then making it a repeating appointment. QuicDoc's Scheduler has many features including appointment status with a checked-in feature, room scheduler, event scheduler, group therapy appointments, appointment slips, scheduling availability and blocks of time, reports, tasks and numerous other features.

### Creating an appointment

**Note:** If you are using QDPM, the scheduler will be read only. You will not be able to schedule an appointment in the QuicDoc Scheduler. Please refer to QDPM on creating, deleting, or editing any appointments or demographics.

Click a time slot while in the day or week view in the Scheduler, and then drag your mouse to select a time block.



From the **Appointments** menu, select **New Appointment**, or right click for a pop-up menu. You can also click the Add Appointment button on the toolbar.

Select **Schedule Patient**. You can also schedule a Group, Event, Appointment Types, or Availability.

### Schedule a Patient

**Note:** If you are using QDPM, the scheduler will be read only. You will not be able to schedule an appointment in the QuicDoc Scheduler. Please refer to QDPM on creating, deleting, or editing any appointments or demographics.



If scheduling a client that has already been entered in QuicDoc, click the drop-down arrow, to the right of the Patient field and select the name from the list. If not on the list, you can add a new client from the **New**

**Appointment** window. Click the **Add New Patient** button. The first name, last name and the provider are the only required fields to add the patient. Once you have added the patient, click Ok to save. To enter complete information for the patient, go to QuicDoc's main Patients window.

Enter additional information (e.g., status, service, location) and the Start and End Times.

You can simultaneously schedule a room for the appointment. See the Help files or our online [Knowledgebase](#) for more information.

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## Repeating Appointments

**Note:** If you are using QDPM, the scheduler will be read only. You will not be able to set repeating appointments in QuicDoc Scheduler. Please refer to QDPM on creating, deleting, or editing any appointments or demographics.

Click on the appointment after it is created to select it. Then right click for a pop-up menu and select **Repeating Appointment**, or select it from the Appointments menu.

### Pattern of Repeating Appointment

Select an option for daily, weekly, monthly, or yearly.

**Daily:** Select an option for Every weekday, or Every\_\_\_ day. The Every\_\_\_day option allows you to enter a number for the frequency, for example if you want to set up an appointment for every 2 or every 3 days which includes week ends.

**Weekly:** Allows you to set up the frequency, as well as the day on which you want to schedule the appointment, for example - every second week on a Tuesday.

**Monthly:** If you want an appointment for a specific date each month, such as on the 15th, enter the number in the Day field. If you want the appointment scheduled for every month, be sure the number 1 is in the month(s) field.

Note: if you enter 30 for the day, and February falls within the parameter of the repeating appointments, there will be not appointment scheduled in February, since there is no 30th of February.

Select the second option if you want the appointment to fall within a specific week of the month, for example the second Wednesday of each month. Select the week and the day from the drop down pick lists. If you want the appointment scheduled for every month, be sure the number 1 is in the month(s) field.

**Note:** Be careful in scheduling a specific day within the first and last weeks of the month since the selected day may not fall within that week on every month.

**Yearly:** To select a specific month for the appointment, click the first option and select the month from the drop down pick list. To select a specific day, such as the second Tuesday in March, select the week from the drop down pick list. Then select the day from the drop down pick list. Then select the month from the drop down pick list.

### Date Range

Enter a Start Date; by default the selected appointment's date is displayed.

Enter an end number to End After a specific number of Occurrences, or you can enter an End Date.

### Sample Dates

Click the **Sample Dates** button after you have setup your repeating appointment to view the dates.

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## Backup Recommendations

Back up your data on a daily basis. If your computer has more than one hard drive, back up onto a drive other than the one in which your working data is stored. If you have only one hard drive, back up onto an external drive. Remember, an important reason for backing up data is to protect against a hard drive failure.

We recommend that you make backups daily on external drive to keep in the office as well as off site.

Minimally, at least once a month, make a backup copy to keep off your premises.

### Backup Utility

QuicDoc cannot be running when you backup the databases. If QuicDoc, QuicForms, or the QuicDoc Scheduler is running, select Exit from the File menu. If running on a network, make sure all users are logged off of QuicDoc before running the backup program.

If you use any attachments, you will also want to backup this location to an external drive. To find your attachment location, log into the SA account, go to Preferences, and under the Administrative tab there will be an attachment location.

For assistance on backing up your database and QuicDoc files, please visit our online [Knowledgebase](#).

**Note:** If you are using our Cloud services, we have the worry-free automatic backup and disaster recovery provided for you. You do not need to worry on backing up your QuicDoc attachments or database.

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