



# Electronic Medical Report

## GP Guide

### V1.1

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**Note:** All Patient information in this document is fictitious test data - Names, addresses, conditions and other patient data has been developed specifically for use in the test version of the eMR application. Any resemblance to actual persons, living or dead, or actual events is purely coincidental.

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## Product Overview

Over 2.5 million consented requests for Patient Medical Reports are received by GP Practices every year from 3rd parties outside the NHS. This additional work on already busy GP Practice, brings unnecessary pressures and the use of costly processes, long completion times and more often non-compliant data-structured reports being released to 3rd parties. eMR is an accredited FREE to use secure Web App, compatible with your existing operating system.

### Delivering **VALUE** to your Practice:

- Seconds to generate an auto-redacted clinical coded medical report.
- At a 'click' produce GDPR compliant copies of a Patient records.
- Complete reports on your tablet or phone within our secure data encryption environment.
- Generate more fee income c. £300 per hour.
- Provide a better service to your Patients.
- Instructions include viewable Patient consent.

### Delivering **ADDITIONAL** services:

- An automated electronic payment service providing Automated electronic payment service to improve cashflow and reduce administration costs.
- Intuitive dashboard process for ALL 3rd party requests.
- 'Create, Save and Submit' feature allows Practice staff to prepare reports prior to GP sign-off.
- Re-direct ALL requests through your eMR App.

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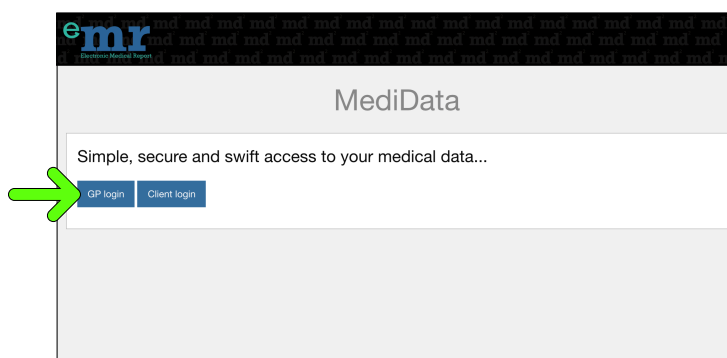
# GP/Practice User Guide

## 2.1 Logging into eMR

2.1.1 Once registered with MediData you will be provided with a login and password to access the application.

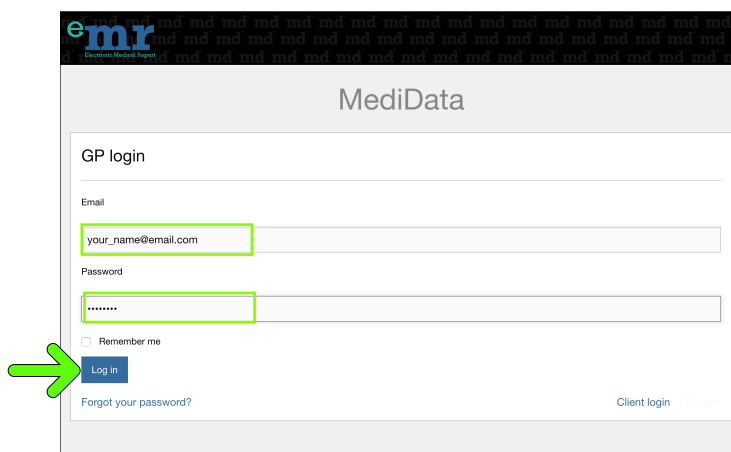
Access the MediData application by visiting <https://medi2data.net>

Click the 'GP login' button as indicated [Fig 1]



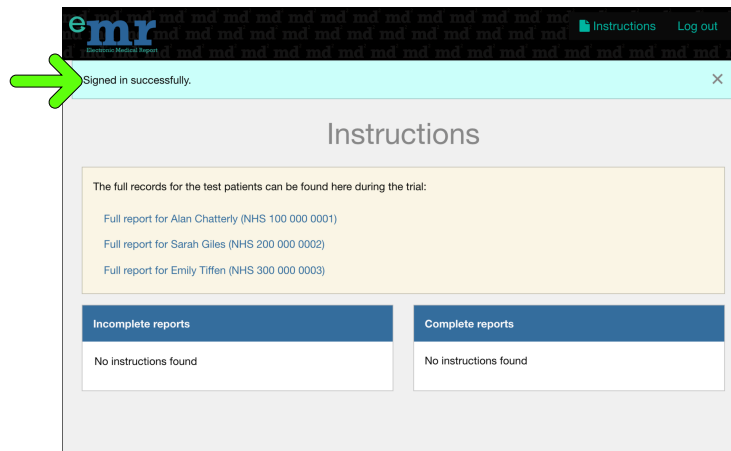
[Fig 1]

2.1.1 Enter login information and click log in [Fig 2]





[Fig 2]

2.1.3 A successful login confirmation will be displayed if login details have been entered correctly - You will now be looking at the 'Instructions' homepage for your Practice [Fig 3]



[Fig 3]


 **Trial Instructions Only** 

**NOTE:** During the trial, GPs will have access to 3 complete Patient record exports from the EMIS Test database. These Patient records can be viewed by clicking the Patient links shown below:

The full records for the test patients can be found here during the trial:

- [Full report for Alan Chatterly \(NHS 100 000 0001\)](#)
- [Full report for Sarah Giles \(NHS 200 000 0002\)](#)
- [Full report for Emily Tiffen \(NHS 300 000 0003\)](#)

These Patient records contain static information to enable GPs to compare the eMR report builder against the original Patient data.

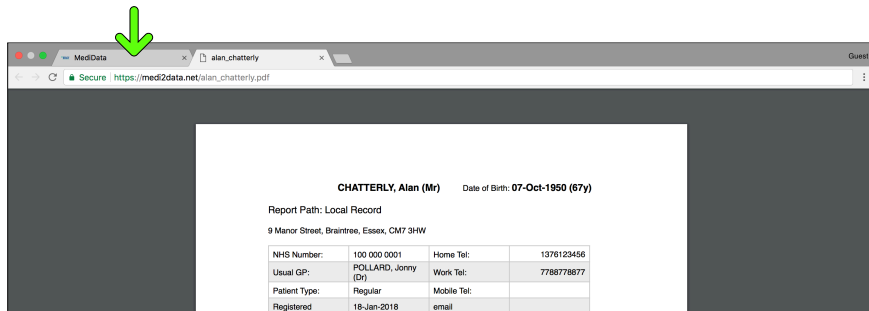
 **Secure automatic account log out**

**NOTE:** If your account is left inactive for **20 minutes** you will be logged out of the application and will have to log back in if you need to access the application.

## 2.2 Viewing trial Patient full records

The test Patient records are stored as PDFs and contain the complete, unrelated medical records for the test Patients - these reports provide a means to compare against the redacted reports you will be creating with the eMR application.

To view a Patient record click the link of Patient you want to view, a new browser window will open containing the Patient record [Fig 4] - To return to the eMR application, click on the 'MediData' tab.



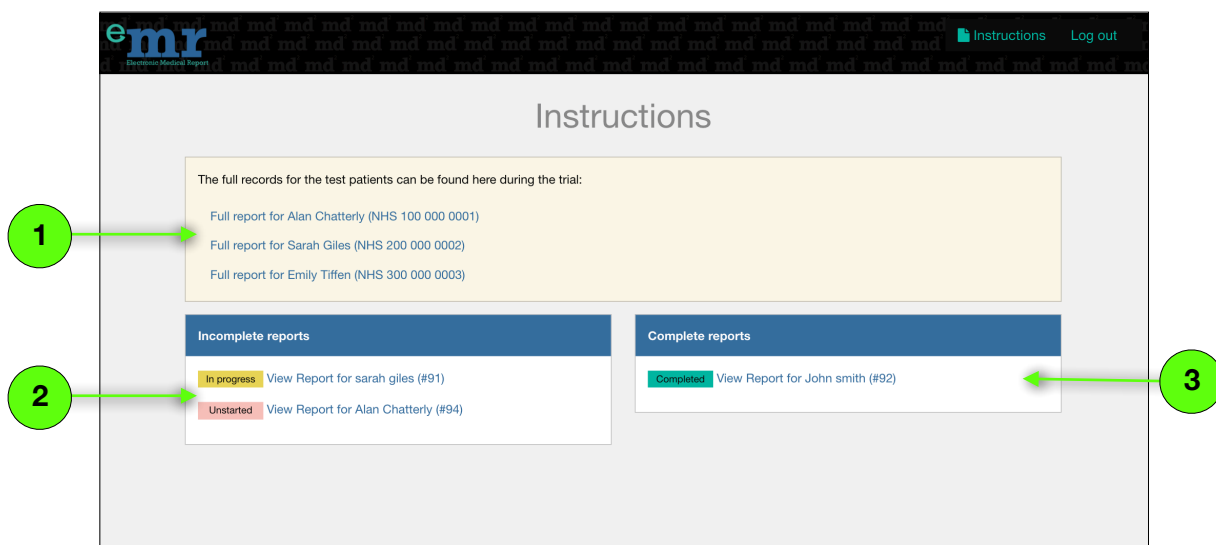
[Fig 4]

## 2.3 Instructions homepage

When logged into eMR you will be on the 'Instructions' homepage [Fig 5] - This page is your dashboard displaying key information for all outstanding Instruction request for your surgery. and the starting point for navigating through the eMR application.

The Instruction homepage displays the following information, their location is shown below:

1. Test Patient data (trial version of eMR only)
2. Access to incomplete or new reports
3. Access to completed reports



[Fig 5]

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## 2.4 Report status

Once a client has created an Instruction request, the Practice associated with the Patient will be made aware that there is an unstated Instruction waiting for them in eMR. As a GP works through the report the status will change - the three status levels are explained below:

The status levels are:

### Completed

Completed reports have been created, reviewed and signed off by a Practice. Once completed these reports become viewable to the Client that requested them.

### In progress

In progress reports are Instruction requests that have been opened by a Practice and work is underway in completing the report - they are not viewable by the Client.

### Unstarted

Unstarted reports are Instruction requests that have been sent to a Practice (including an email notification) however the Practice is yet to open the request - they are not viewable by the Client

## 2.5 Starting new Instruction

A new Instruction can be started by either clicking the link in a notification email or by selecting an 'unstarted' Instruction from the 'Instruction homepage'

## 2.6 Starting a new Instruction via an email notification

Email notifications will be sent to your Practice whenever eMR creates a new Instruction for your Practice.

An example email notification is shown below [Fig 6] - the notification emails contain a link to which will direct you to the eMR application log-in screen.



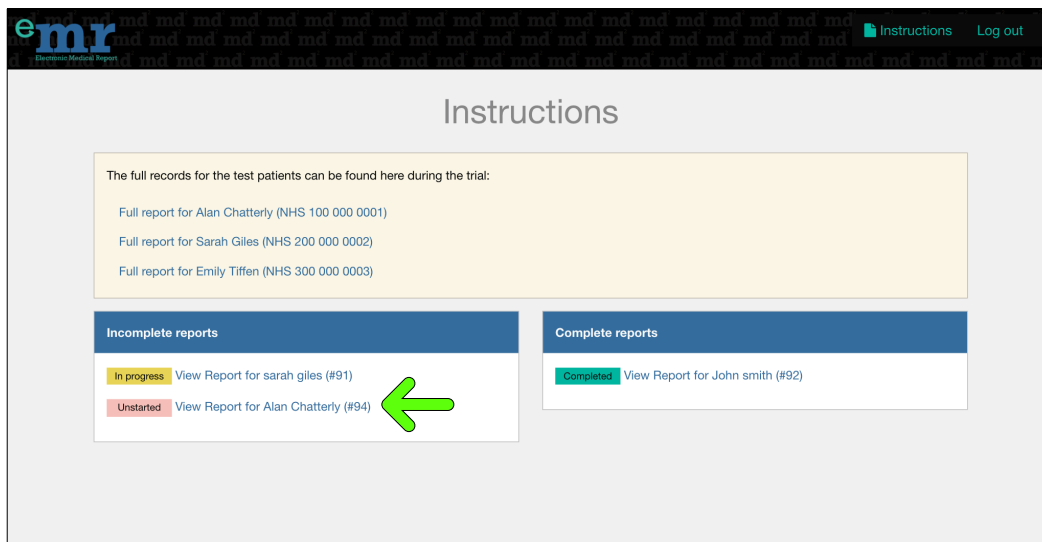
[Fig 6]



## 2.7 Starting a new Instruction from the 'Instruction' homepage

2.7.1 An unstarted Instruction can be started from the 'Instruction' homepage without the need to click the link in the notification email - This is useful if you delete the email or if you are already logged into eMR when the new Instruction comes in.

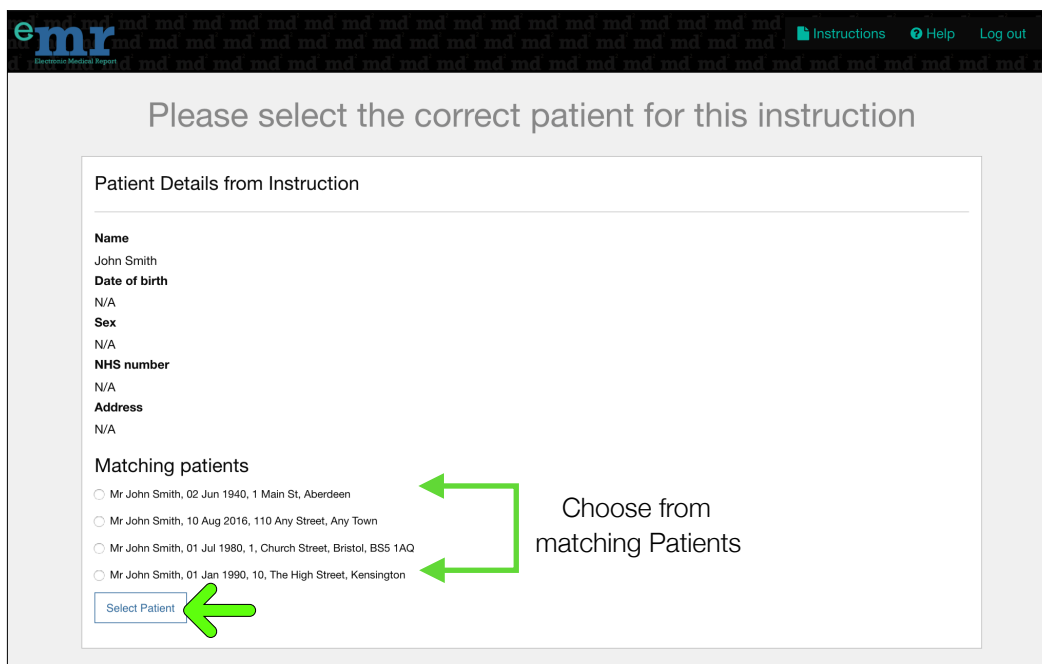
2.7.2 To pick up a new unstarted report, click the name next to the unstarted status box [Fig 7]



[Fig 7]

## 2.8 Select the matching Patient

The first step in starting a new report is to select the correct Patient record - depending on how much information has been supplied by the Client, there could be multiple potential matches. Select the correct Patient for your Practice and click 'Select Patient' [Fig 8]



[Fig 8]

## 2.9 Provisional report contents

The 'Provisional Report Contents' page is a powerful report builder that enables GPs to quickly create a Patient report containing the necessary information to fulfil a Client Instruction.

The eMR tool extracts relevant information from the Patient record and presents it in a user friendly way that enables speedy redaction and comprehensive report generation in PDF format.

The different "Provisional Report Contents" sections are explained below:

### Patient Info

Patient identification information is displayed at the top of the screen - and is always accessible by via the 'Patient Info' button on the left of the screen

### Client Info

Client name and the conditions included in Instructions are also always accessible by the 'Patient info' button.

The screenshot shows a 'Patient Info' button on the left. Below it, a box contains patient details: Mrs Sarah Giles, Date of birth: 21 Sep 1962, Sex: F, NHS number: 2000000002, Address: 33 The Crescent, Cwmbran, NP44 7JG. To the right, a 'Client Info' section shows 'Bluespot.io' and 'Requested Conditions: Asthma (disorder), History of angina pectoris (situation)'. Below these is a yellow box with 'Sensitive information instructions' and a link to 'here'.

### Sensitive Information Instructions

Please be sure to follow the advice and guidance concerning sensitive conditions - a link to the NHS SP summary code list is also provided.

## Redacting Information

Throughout the report builder, redact-able information is indicated with this icon -

Instructions on how to redact and un-redact can be viewed at any time by clicking on the 'info' icon: - to display the following Instructions [Fig 9]

The dialog box titled 'Redacting and Unredacting' contains two lines of text. The first line says 'Items with a green tick are included in the report. Click to redact them.' and has a green tick icon to its right. The second line says 'Items greyed-out are redacted from the report. Click to unredact them.' and has a greyed-out tick icon to its right.

[Fig 9]

## Patient profile

- The Patient profile is **not** redact-able.
- Contain the 3 most recent readings for each section from the past 5 years.

Patient Profile (3 most recent readings from last 5 years)			
Height	N/A	N/A	21 Sep 2017 171 cm
Weight	N/A	N/A	21 Sep 2017 59.5 kg
BMI	N/A	N/A	21 Sep 2017 20.3 kg/m2
Smoking	N/A	N/A	28 Jan 2017 Non-smoker
Alcohol	N/A	N/A	N/A
Systolic blood pressure	25 Mar 2016 148 mmHg	28 Jan 2017 136 mmHg	21 Sep 2017 155 mmHg
Diastolic blood pressure	25 Mar 2016 89 mmHg	28 Jan 2017 88 mmHg	21 Sep 2017 92 mmHg

## Significant Conditions

- Significant conditions **are** redact-able
- Any condition from the Patient history that matches the conditions included in the Instruction will be listed here
- Significant conditions are split into 'Active' and 'Past' with dates supplied for both
- Redacting a significant condition automatically removes **all associated** (by coding in EMIS) information from the other sections of the report
- Additional information can be added in the notes field - Please use the [Update Report](#) button to add these notes to the final report

### Significant Conditions i

Active

Angina pectoris (diagnosed: 28 Jan 2017) ✓

Asthma (diagnosed: 30 Jan 1980) ✓

---

Past

Angina pectoris ✓

Anxiety with depression (ended: 30 Mar 2015) ✓

---

Additional contextual information / missing problems

Further information related to this section of the report

Should a 'Significant Condition' be redacted from this section, all references to it will be removed from the report. You can unredact at any time prior to submitting the final report.

[Update Report](#)

## Medications

- Medications **are** redact-able
- Redacting a significant condition automatically removes **all associated** (by coding in EMIS) information from the other sections of the report
- Medications are split into 'Acute' and 'Repeat' and are viewable on different tabs in this section.
- Any missing medications can be manually added via the 'Add Medications' tab - mandatory fields are marked with an \*
- Additional information can be added in the notes field - use the [Update Report](#) button to add these notes to the final report

### Medications (prescribed in last 2 years) i

Acute Repeat Add medications

14 Feb 2018 - Methotrexate 2.5mg tablets, 12.5mg (Five Tablets) To ... ✓

25 Mar 2016 - Amlodipine 10mg tablets, One To Be Taken Each Day,... ✓

---

Additional contextual information

Further information related to this section of the report

[Update Report](#)

[Update Report](#)

## Allergies

- Allergies **are** redact-able
- All active allergies from the Patient record are included
- Any missing allergies can be manually added via the 'Add Allergies' tab - mandatory fields are marked with an \*

Allergies
i

Allergies
Add allergies

No allergies recorded.

## Consultations

- Consultations **are** redact-able
- Any consultation from the Patient history that match the conditions included in the Instruction will be listed here
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report

Consultations (matched from the last 5 years)
i

04 Feb 2018 - eMR Medidata (General Medical Practitioner) ✓

**Document:** Neurology

**Additional:** Generalised convulsive epilepsy

04 Feb 2018 - eMR Medidata (General Medical Practitioner) ✓

**Problem:** Generalised convulsive epilepsy

04 Oct 2016 - eMR Medidata (General Medical Practitioner) ✓

**Problem:** Generalised convulsive epilepsy

**Assessment:** Epilepsy monitoring. Epilepsy medication review. Medication review done

**Additional:** Patient advised to inform DVLA. Patient on maximal tolerated anticonvulsant therapy. Patient advised about alcohol. Contraception counselling

**Examination:** No seizures on treatment. Last fit. 6 U/week

**Follow up:** Epilepsy monitoring

**Medication:** (NOT ISSUED) Levetiracetam 500mg tablets Two To Be Taken Twice A Day, 120 tablet

Additional contextual information / missing consultations

Further information related to this section of the report

Update Report

## Bloods

- Bloods are **not** redact-able
- All available blood test results - 3 most recent readings - will be displayed.
- Additional information can be added in the notes field - Please use the Update Report button to add these notes to the final report

Bloods (3 most recent readings)


<b>Sodium</b>	N/A	09 Aug 2017 135 mmol/L	06 Feb 2018 134 mmol/L
<b>Potassium</b>	N/A	09 Aug 2017 3.9 mmol/L	06 Feb 2018 4.4 mmol/L
<b>Urea</b>	N/A	09 Aug 2017 4.8 mmol/L	06 Feb 2018 3.4 mmol/L
<b>Creatinine</b>	N/A	09 Aug 2017 76 umol/L	06 Feb 2018 46 umol/L
<b>Bilirubin</b>	N/A	N/A	14 Jul 2017 49 umol/L
<b>ALP</b>	N/A	N/A	14 Jul 2017 96 IU/L
<b>ALT</b>	N/A	N/A	14 Jul 2017 35 IU/L
<b>Albumin</b>	N/A	N/A	14 Jul 2017 39 g/L
<b>Gamma-GT</b>	N/A	N/A	14 Jul 2017 35 IU/L
<b>LDL</b>	N/A	N/A	06 Feb 2018 3.2 mmol/L

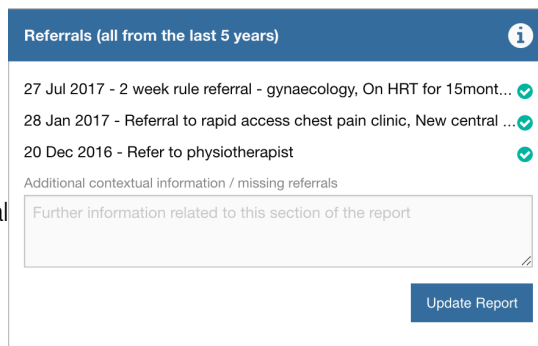
Additional contextual information

Further information related to this section of the report



Update Report

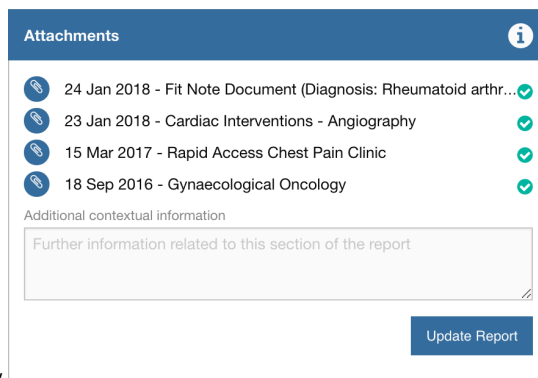
## Referrals

- Referrals **are** redact-able
- All available referrals from the last 5 years will be displayed.
- Additional information can be added in the notes field - Please use the  button to add these notes to the final report



## Attachments

- Attachments **are** redact-able
- All attachments from the Patient history that match the conditions included in the Instruction will be listed here
- Attachments that are not redacted will be included in the final record as appendices
- The attachments can be viewed in full by clicking on the attachment icon: 
- Viewing attachments will either open a new browser window or download them directly to your PC
- Additional information can be added in the notes field - Please use the  button to add these notes to the final report



## 2.10 Updating & viewing draft report

Once you have redacted all irrelevant information and added any additional information you are ready to view the final (draft) report - being viewing the report, click the 'Update Report' button, then click the 'View Report' button <sup>[Fig 10]</sup> to be taken from the Provisional report to the Final report



[Fig 10]

## 2.11 Final medical report

4.12.1 The final medical report is still viewable inside the application along with any additional attachments as appendices.

The report viewer has the following functionality shown below [Fig 11]

1. Return to full medical report (if viewing additional attachment)
2. View individual attachments
3. Disclaimer - this **must** be completed before the report can be submitted - tick 'agree' and add name of person completing the report
4. Edit report button - takes you **back** to the 'Provisional Report Contents' page
5. Submit button - send the finished medical report to the Client
6. Download PDF medical report
7. Print medical report

Please note:

- You must sign off and submit the report at the bottom of this page to complete the instruction.
- The name of the signing off GP will appear where the placeholder [GP\_NAME] is once the report is submitted

**Medical Report**

04 Feb 2018 - Neurology

11 Jul 2017 - Fit Note Document  
(Diagnosis: Painless Jaundice;  
Duration 11-Jul-2017 - 16-Jul-2017)

report.pdf 1 / 6

Signed off by:  
[GP\_NAME], The Hollies

### Medical Report

**Patient Details**

Name: Mrs Emily Tiffen Date of birth: 03 Aug 1979  
Sex: F Address: Basement Flat, 23 Park Street, Bath, BA1 2TE  
NHS number: 3000000003

**Instruction Details**

Requesting Party: Bluespot.io  
Requested Conditions: Epilepsy (disorder)  
Reference Number:

**Patient Profile (3 most recent readings from last 5 years)**

Height	N/A	N/A	N/A
Weight	N/A	N/A	N/A
BMI	N/A	N/A	N/A
Smoking	N/A	N/A	06 Feb 2018 Current non-smoker
Alcohol	N/A	N/A	06 Feb 2018 Social drinker
Systolic blood pressure	N/A	17 May 2018	17 Oct 2014

**Disclaimer**

I confirm that this medical report is an accurate reflection of the information in the electronic medical records for the requested conditions of interest at the time of preparation. This report does not include undisclosed conditions, undisclosed symptoms, future conditions, information not relevant to the sought after conditions of interest, information which the patient has not consented to be disclosed, nor information absent from the patient's electronic medical records. Information provided in this report does not guarantee any future state of health or illness.

Agree

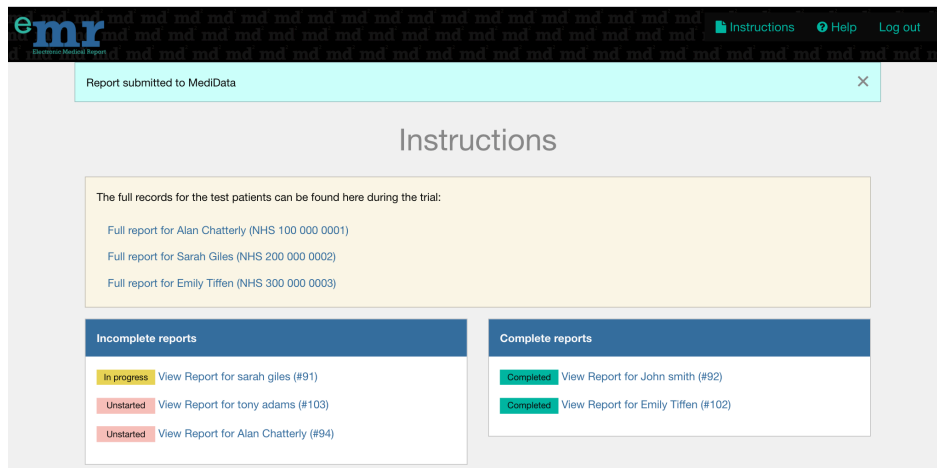
GP

Or sign off as locum GP

Edit Report Submit Report

[Fig 11]

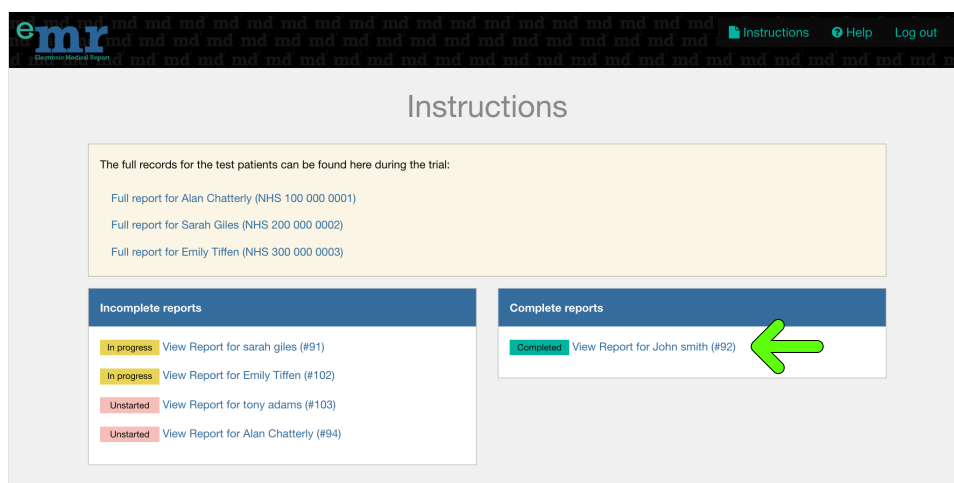
4.12.2 Following a submission of a completed medical report you will be redirect back to the 'Instruction' homepage and a 'Report submitted to MediData' confirmation message will be displayed. The submitted medical report will be listed in the 'Completed Reports' section [Fig 12]



[Fig 12]

## 2.12 Viewing submitted medical reports

Although a medical report can still be viewed by a GP after it has been completed, as the disclaimer has been signed and the final report has been submitted to the Medidata, it will no longer be in an editable format. To view completed medical reports, visit and click the Patient name in the 'Completed Reports' section [Fig 13], this will take you to the report view page [Fig 14]



[Fig 13]

emr Electronic Medical Report Instructions Help Log out

## Final Report

**Medical Report**

- 28 Jul 2017 - Audiology investigation record
- 13 Jun 2017 - PDF attachment
- 13 Jun 2017 - PDF attachment
- 13 Jun 2017 - PDF attachment
- 22 May 2017 - Clinical Letter Forthraeth Hospital Oral microbiology Smelly Breath
- 22 May 2017 - Attachment
- 22 May 2017 - Attachment
- 22 May 2017 - Attachment
- 22 May 2017 - Attachment
- 22 May 2017 - Attachment
- 22 May 2017 - Attachment
- 22 May 2017 - Attachment

report.pdf 1 / 6

Signed off by:  
Dr Michael Mennessi, The  
Hollies

### Medical Report

**Patient Details**

**Name:** Mr John Smith      **Date of birth:** 02 Jun 1940  
**Sex:** M      **Address:** 1 Main St, Aberdeen  
**NHS number:** 1441457895

**Instruction Details**

**Requesting Party:** Bluespot.io  
**Requested Conditions:** Diabetes mellitus (disorder)  
**Reference Number:**

**Patient Profile (3 most recent readings from last 5 years)**

Height	N/A	N/A	N/A
Weight	N/A	N/A	N/A
BMI	N/A	N/A	N/A
Smoking	N/A	N/A	N/A
Alcohol	N/A	N/A	N/A
Systolic blood pressure	N/A	N/A	23 Sep 2016 120 mmHg

[Fig 14]