# Standard Rooming / Intake Process

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| **1** | **1st Ask: Patient writes reason for visit on Patient Intake Form** |
| **2** | **ACKNOWLEDGE:** Greet patient & verify 2 patient identifiers |
| **3** | **INTRODUCE** |
| **4** | Take height and weight & record on blue form |
| **5** | **DURATION** |
| **6** | Badge into computer |
| **7** | **Note Icon:** Open Provider Note (owner is provider) p.16 |
| **8** | Verbally review the blue and yellow forms with patient p.14 |
| **9** | **Chief Complaint section**: Enter “Reason for Visit” in patient’s words (**2nd Ask**) p.18 |
| **10** | **Blue “i” Button**: verify default pharmacy or add new one p. 32 |
| **11** | **Current Meds section**: enter medication history (verify printed med list) p. 19 |
| **12** | **Allergies section**: verify existing allergies & add any new allergies p. 27 |
| **13** | **Med/Allergy Reconciliation section**: check box and any meds patient states not taking p.31 |
| **14** | **Heart Icon / Vital Signs**: enter vitals, and height & weight p. 34 |
| **15** | **Heart Icon / Clinical Quality Assessment:** document Falls & Depression screening p. 36 |
| **16** | **Social History**: If not recorded in past 24 months, enter smoking history p. 39 |
| **17** | Anticipate any exam needs |
| **18** | **3rd Ask**: Summarize “Reason for Visit” before leaving the room |
| **19** | Sign the Provider note as co-participant p. 42 |
| **20** | Badge out of computer |
| **21** | **EXPLANATION:** set expectations before leaving room. Ask if they would like water |
| **22** | **THANK YOU** |