First Nations Health Authority
Health through wellness

PANORAMA FAMILY HEALTH DATA VIEW & ENTRY-CHECKLIST

In the **Family Health Module**, use the search page to find your client and select the row action and choose the **Family Health Client Summary.** If the client does not have a Panorama chart, **create** a client chart.

Personal and Aboriginal Information		
1	LHN > Client > Client Details > **Client Demographics**	**Edit and update *Client Demographics.*** • Ensure that Health Region Information is selected to the client's branch (location of closest Public Health Unit for client location of residence) • Ensure client address and phone numbers are updated
2	LHN > Client > Client Details > **Indigenous Information**	**Edit and update client's *Indigenous Information.*** • Complete questions and enter client's current Indigenous Organization
3.	LHN > Client > **Allergies**	**ADD ALLERGY** or **SET NO KNOWN ALLERGIES**
4.	LHN > Client > **Risk Factors**	**UPDATE or ADD client Risk Factors** • (eg. Special Population – Indigenous under 19 yrs)
Family Health Encounter		
	Menu/Actions	**Important Notes**
4.	LHN> Family Health > **Client Summary**	To **VIEW** any previous encounters, select the Family Health tab and have your client in context. • Select Client Summary. • Scroll to the *Encounters* section and select the **Assessment/UDF hyperlink** in the Assessments (Summary) column. To **UPDATE** (to edit encounter if you are the author): • From the *Family Health Client Summary Encounter* section, select the **Encounter Date hyperlink** that contains the Assessment Form/UDF requiring updating. • Scroll to bottom of screen & highlight radial button next to assessment/UDF you wish to update from **Filled Out Forms Section** and select **Update. Make changes and SAVE**
5.	To record and Encounter: LHN> **Encounter Details** >	The **Create Encounter Details** screen displays. Enter required field **(*)** details: ○ **Encounter group**: select Family Health ○ **Encounter date:** Date of encounter ○ **Encounter type:** Select from drop down list ie. clinic visit, home visit, phone call etc

		○ **Available Encounter Reasons:** Add applicable reason (not required) Click **Save.** Select **Encounter UDF** > **Row Action > Fill Out Form** Fill out form and select **SUBMIT** To create a Care Plan see Family Health User Guide

ENTRY EXTRAS:

	Menu/Actions	Important Notes
	Focus Area Summary	Gives you a quick look at areas of focus or click on **Last Assessment** for encounter details
	Link to Parent	Select **Link to Parent** to view parent encounters and links to other siblings
	View Immunization from Family Health	Select **Immunizations** to view immunization schedule. Select Client Summary (LHN) to return.
	Notes on Care Plan	Select **Notes** to view all notes (associated with care plan) recorded by nurse on client