Use of ChiroUp in CMRs & ROF

Prior to CMR of a New Patient case – Establish the primary Diagnosis(es) for the patient, based on findings from the initial evaluation. Critically evaluate the Diagnosis-based Condition Reference Protocol through www.chiroup.com.

Log-in to: www.chiroup.com

Print one copy of the Condition Reference Protocol (Sharpen My Clinical Skills - Condition Reference – Area - Condition) from ChiroUp.com

Confirm your diagnosis based on the information within the Condition Reference Protocol. Indicate the information in the Condition Reference report that influenced your treatment plan decisions by highlighting, underlining and making notes on the report.

Create a Patient Specific Condition Report for your patient through ChiroUp.com.

"Add Condition Report" – Complete necessary fields – Print 2 copies of the Report.

*Populate the Patient Name fields: patient's first/last initial in the first name space and the full EHR number in the last name space

Formulate and document the Patient Care Plan in the EHR.

Bring each report with you to the CMR to discuss with your clinician – Complete CMR

Intern and Clinician Sign the ChiroUp Forms prior to Scanning into Patient's EHR

Have the "Condition Report" and ePSS scanned into the patient's EHR file (Front Desk/Cashier/ Clinic Admin Assistant - Patient name on all pages)

Marked and signed Diagnosis-based Condition Reference Protocol to Clinic Admin Assistant with the completed CMR Grading Form.

ROF – Report clinical findings, the information in the care plan and the ChiroUp reports to the patient and document in the patient chart that this was performed.

Grad. Date	**CMR ChiroUp Requirement(s) Starting Fall 2017**	**Grad. Req.**
Fall 2017	None - Voluntary	NO
Spring 2018	1 Condition Report and 1 Condition Reference for at least 1 New Patient Case Management	YES
Summer 2018 And Beyond	1 Condition Report and 1 Condition Reference for **ALL 5** New Patient Case Managements	YES