

<b>Number</b>	<b>Category Name</b>	<b>Category Description</b>	<b>HL7 BH Conformance Profile Classification CM = Care Management</b>
	<b>Functional Requirements</b>		
<i>F01</i>	<i>Identify and maintain a client record</i>	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
<i>F02</i>	<i>Manage client demographics</i>	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
<i>F03</i>	<i>Manage diagnosis list</i>	Create and maintain client specific diagnoses.	DC \ Care Management
<i>F04</i>	<i>Manage medication list</i>	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
<i>F05</i>	<i>Manage allergy and adverse reaction list</i>	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
<i>F06</i>	<i>Manage client history</i>	Capture, review, and manage services/treatment, hospitalization information, other information pertinent to clients care.	DC \ Care Management
<i>F07</i>	<i>Summarize health record</i>		DC \ Care Management
<i>F08</i>	<i>Manage clinical documents and notes</i>	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
<i>F09</i>	<i>Capture external clinical documents</i>	Incorporate clinical documentation from external sources.	DC \ Care Management
<i>F10</i>	<i>Generate and record client specific instructions</i>	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

<b>F11</b>	<b>Order medication</b>	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
<b>F12</b>	<b>Order diagnostic tests</b>	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
<b>F13</b>	<b>Manage order sets</b>	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
<b>F14</b>	<b>Manage results</b>	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
<b>F15</b>	<b>Manage consents and authorizations</b>	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
<b>F16</b>	<b>Support for standard care plans, guidelines, protocols</b>	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
<b>F17</b>	<b>Capture variances from standard care plans, guidelines, protocols</b>	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
<b>F18</b>	<b>Support for drug interaction</b>	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

<b>F19</b>	<b>Support for medication or immunization administration or supply</b>	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by-product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
<b>F20</b>	<b>Support for non-medication ordering</b>	Referrals, care management	CM \ Clinical Decision Support
<b>F21</b>	<b>Present alerts for disease management, preventive services and wellness</b>	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
<b>F22</b>	<b>Notifications and reminders for disease management, preventive services and wellness</b>	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
<b>F23</b>	<b>Clinical task assignment and routing</b>	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

<b>F24</b>	<b>Inter-provider communication</b>	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
<b>F25</b>	<b>Pharmacy communication</b>	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
<b>F26</b>	<b>Provider demographics</b>	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
<b>F27</b>	<b>Scheduling</b>	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
<b>F28</b>	<b>Report Generation</b>	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
<b>F29</b>	<b>Health record output</b>	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

<b>F30</b>	<b>Service/treatment management</b>	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
<b>F31</b>	<b>Rules-driven financial and administrative coding assistance</b>	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
<b>F32</b>	<b>Eligibility verification and determination of coverage</b>		SS \ Administrative & Financial
<b>F33</b>	<b>Manage Practitioner/Patient relationships</b>	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
<b>F34</b>	<b>Clinical decision support system guidelines updates</b>	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
<b>F35</b>	<b>Enforcement of confidentiality</b>	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
<b>F36</b>	<b>Data retention, availability, and destruction</b>	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

<b>F37</b>	<b>Audit trails</b>	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
<b>F38</b>	<b>Extraction of health record information</b>	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
<b>F39</b>	<b>Concurrent Use</b>	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
<b>F40</b>	<b>Mandated Reporting</b>	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
<b>F41</b>	<b>Administrative A/P E.H.R. Support</b>		
<b>F42</b>	<b>Administrative A/R E.H.R. Support</b>		
<b>F43</b>	<b>Administrative Workflows E.H.R. Support</b>		
	<b>Security Requirements</b>		
<b>S01</b>	<b>Security: Access Control</b>		
<b>S02</b>	<b>Security: Authentication</b>		

<b>S03</b>	<b>Security: Documentation</b>		
<b>S04</b>	<b>Security: Technical Services</b>		
<b>S05</b>	<b>Security: Audit Trails</b>		
<b>S06</b>	<b>Reliability: Backup/Recovery</b>		
<b>S07</b>	<b>Reliability: Documentation</b>		
<b>S08</b>	<b>Reliability: Technical Services</b>		
	<b>Interoperability Requirements</b>		
<b>I01</b>	<b>Laboratory</b>		DC \ Care Management
<b>I02</b>	<b>Imaging</b>		
<b>I03</b>	<b>Medications</b>		
<b>I04</b>	<b>Clinical Documentation</b>		
<b>I05</b>	<b>Chronic Disease Management/ Patient Documentation</b>		
<b>I06</b>	<b>Secondary Uses of Clinical Data</b>		
<b>I07</b>	<b>Administrative &amp; Financial Data</b>		



**MHSA - Behavioral Health Functional Criteria MSHA Evaluation of EHRs**  
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**DRAFT**

**Vendor Ratings Availability**

DMH EHR Functional Requirement Category Number	DMH EHR Functional Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR	Vendor Ratings Availability			
					2006	2007	2008	2009 and beyond
F-04	4.009	The system shall be able to capture, store and display medication history received electronically.		4				
F-04	4.039	CPOE eRX: The system shall provide the ability to create customized preference lists based on the clinical findings of the patient		4				
F-06	6.015	CPOE eRX: The system shall be able to display the medication history of client ordered by service provider AND other medical providers outside the clinic.		4				
F-11	11.001	The system shall be able to create prescription or other medication orders with sufficient information for correct filling and administration by a pharmacy.	The term pharmacy here refers to all entities which fill prescriptions and dispense medications including but not limited to retail pharmacies, specialty, and mail order pharmacies.	4	H			
F-11	11.002	The system shall be able to record user and date stamp for prescription related events, such as initial creation, renewal, refills, discontinuation, and cancellation of a prescription.		4	H			
F-11	11.003	The system shall be able to capture the identity of the prescribing provider for all medication orders		4				



F-11	11.013	The system shall be able to display and store information received through review of health plan/payer formulary.	If this review included medications already on the medication list, a duplicate record in the medication shall not be created (same date, medication, strength, and prescriber). Formulary checking refers to whether a particular drug is covered.-	4		L	L	H	
F-11	11.014	The system shall be able to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).		4		H			
F-11	11.015	The system shall be able to print and electronically fax prescriptions.	Appropriate audits and security shall be in place.	4		H			
F-11	11.016	The system shall be able to re-print and re-fax prescriptions.	This allows a prescription that did not come out of the printer, or a fax that did not go through, to be resent/reprinted without entering another prescription. Appropriate audits and security shall be in place.	4		?			
F-11	11.017	The system shall be able to send prescriptions electronically.	See also Category: Pharmacy communication starting with DMH Rq. Ref. CA-F227. Faxing for 2006, tentative electronic 2007 once standards are promulgated. This presupposes that the pharmacy is capable of receiving electronic prescriptions. This function relates to computer e-prescribing and not faxing. Appropriate audits and security shall be in place.	4		M	H		
F-11	11.018	The system shall be able to display a dose calculator for client-specific dosing based on weight and age.	This allows the user to enter pertinent information to calculate doses. This would be an interim step until databases are available to calculate doses automatically.	4		L	L	H	
F-11	11.019	The system shall be able to display client specific dosing recommendations based on age and weight.	This would calculate automatically from pertinent information in the chart (age and weight) and shall be in standard units and based on a standard periodicity. This is contingent upon availability of databases. We encourage their rapid development.	4		L	L	H	

F-11	11.020	The system shall be able to display client specific dosing recommendations based on renal function.	On roadmap for 2010	4					
F-11	11.021	The system shall have the ability to receive and display information about the client's financial responsibility for the prescription.	This could include co-payments or tier level of the drug obtained through an interface with a pharmacy benefits manager (PBM).	4		L	L	H	
F-11	11.022	The system shall be able to identify medication samples dispensed, including lot number and expiration date.	Lot numbers and expiration date could be entered in free text or encoded.	4		M	H		
F-11	11.023	The system shall be able to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	Very important to prescribing for pediatric and geriatric clients.	4		H			
F-11	11.024	The system shall be able to prescribe uncoded medications.	Need to find out what uncoded and coded is? Memo will look into it.	4			H		
F-11	11.028	System shall be able to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications and to customize the printed output of the prescription.	This refers to the "written" output and language on the prescription such as specific language, dispense as written. For instance, users shall be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.	4					
F-11	11.029	The system shall be able to associate a diagnosis with a prescription.		4					
F-11	11.030	The system shall be able to display the associated problem or diagnosis (indication) on the printed prescription.	At least one diagnosis shall be able to be displayed but the ability to display more than one is desirable. Associated problem or diagnosis can be non-structured data or structured data.	4			H		
F-11	11.031	The system shall have the ability to provide links to general prescribing information at the point of prescribing.		4			M	H	
F-11	11.032	The system shall be able to create provider specific medication lists of the most commonly prescribed drugs with a default dose, frequency, and quantity.		4			M	H	
F-11	11.033	The system shall be able to add reminders for necessary follow up tests based on medication prescribed.	Does not imply that this shall be an automated process.	4					
F-11	11.034	The system shall be able to automatically add reminders for necessary follow up tests based on medication prescribed.	As available through 3rd-party drug databases.	4					
F-11	11.035	The system shall trigger alerts of medication prescriptions due to expire and provide ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).		4					

F-11	11.036	The system shall have the ability to electronically record a prescription.		4				
F-11	11.037	The system shall ensure that all electronic transactions involved with medication ordering are compliant with federal, state, and local laws, rules, and regulations.	Example: 1) HIPAA electronic transmission requirements.	4				
F-11	11.038	The system shall ensure that medication history, medication consents, service/treatment plans and recent progress notes can be easily accessed and viewed during the prescription-writing process.		4				
F-11	11.039	The system shall ensure that automated client consent forms are generated to support the prescribing process.		4				
F-11	11.040	The system shall support medication dispensing through an electronic Medication Administration Record that tracks user-defined information for all medications that have been dispensed to clients. The record notes drug allergies, chronic conditions, and other user-defined items.	This component is used primarily at inpatient facilities.	4				
F-11	11.041	The system supports standard interfaces with third party pharmacy management packages for inventory control, ordering and dispensing support.	A third party pharmacy system can either: 1) Integrate with the system's internal medication prescribing, formulary management and medication history components, or 2) Replace them with third party vendor components that are integrated into the systems electronic clinical record and practice management sub-systems.	4				
F-11	11.042	CPOE eRX: The system shall support insurance specific formulary compliance following companies like RXHub		4				
F-11	11.043	CPOE eRX: The system shall provide the ability for the patient to request eRX refills via secured web site.		4				
F-11	11.044	CPOE eRX: The system shall provide the ability to track when a patient does NOT pick up their medication from the pharmacy.		4				
F-11	11.045	CPOE eRX: The system shall provide the ability to track when a patient does NOT pick up their medication from the pharmacy.		4				
F-12	12.001	The system shall be able to order diagnostic tests, including labs and imaging studies.	This includes physicians and authorized non-physicians.	4		M	H	
F-12	12.002	The system shall be able to associate a problem or diagnosis with the order.	May associate more than one problem or diagnosis with the order.	4			H	
F-12	12.003	The system shall be able to capture the identity of the ordering provider for all test orders.		4				



F-12	12.011	The system shall be able to print out diagnostic test orders.	May be used for manual submission of orders to diagnostic tester or internal review.	4					
F-12	12.012	CPOE Laboratory Data: The system shall check for medical necessity when lab work is ordered.		4					
F-12	12.013	CPOE Laboratory Data: The system shall track all ordered tests and alert the practice if tests are not back within a specific timeline.		4					
F-12	12.014	CPOE Laboratory Data: The system shall provide support so that lab orders are based on best practices and national guidelines.		4					
F-12	12.015	CPOE Orders and Results: The system shall provide an advanced clinical orders capability based on national guidelines and following medical necessity checking.		4					
F-12	12.016	CPOE Orders and Results: The system shall track all orders and indicates when an order result is past due.		4					
F-13	13.001	The system shall be able to define a set of related orders to be subsequently ordered as a group on multiple occasions.	Does not imply that the system needs the ability to create an order set on the fly.	4		M	M	H	
F-13	13.002	The system shall be able to modify order sets.		4		M	M	H	
F-13	13.003	The system shall be able to include in an order set orders for medications, laboratory tests, imaging studies, procedures and referrals.		4		M	H		
F-13	13.004	The system shall be able to display orders placed through an order set either individually or as a group.	Need to be able to see the individual components of the order set, rather than just the name of the order set. Does not mean to break down a lab panel into individual components.	4		M	H		
F-13	13.005	The system shall allow individual items in an order set to be selected or deselected.		4		M	H		
F-14	14.004	The system shall be able to notify the relevant providers (ordering, copy to) that new results have been received electronically.	Examples of notifying the provider include but are not limited to a reference to the new result in a provider "to do" list or inbox.	4			H		
F-14	14.011	The system shall allow user acknowledgment of a result presentation.	This is separate from audit trail.	4		H			
F-14	14.012	The system shall allow secure results to be electronically received for immediate review.		4					
F-14	14.013	The system shall accept results via a bi-directional HL7 interface from all HL7 compliant/capable entities, specifically laboratory, radiology and pharmacy information systems.		4					

F-14	14.020	The system shall be able to accept, store in the client's record, and display clinical results received through an interface with an external source.	Moved from Capture External Clinical Documents: 9.007. In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others.	4		L	H		
F-14	14.021	The system shall be able to receive, store in the client's record, and display discrete lab results received through an electronic interface.	Was Capture External Clinical Documents: 9.002. This may be an external source such as a commercial lab or through an interface with on site lab equipment.	4		H			
F-14	14.022	CPOE Laboratory Data: The system shall automatically post results in patient chart and send a note/message to the provider/nurse based on practice alerts guidelines.		4					
F-14	14.023	CPOE Laboratory Data: The system shall provide the ability to visually compare labs results to prescriptions.		4					
F-14	14.024	CPOE Laboratory Data: The system shall provide the ability to combine results from different labs using the same format.		4					
F-14	14.025	CPOE Laboratory Data: The system shall provide the ability to combine results from different labs using the same format.		4					
F-15	15.008	The system shall be able to prompt user for medication consent as prescription is being written.		4					
F-18	18.001	The system shall check for potential interactions between medications to be prescribed and current medications and trigger an alert to a user at the time of medication ordering if potential interactions exist.	This reduces risk of inappropriate prescribing, prevents pharmacy call backs, and can reduce malpractice liability.	4		M	H		
F-18	18.002	The system shall check for potential interactions between medications to be prescribed and medication allergies and non medication allergies listed in the record and trigger an alert to a user at the time of medication ordering if potential interactions exist.		4		M	H		
F-18	18.003	The system shall be able to prescribe a medication despite alerts for interactions and/or allergies being present.		4		L	L	H	
F-18	18.004	The system shall be able to set the severity level at which drug interaction warnings shall be displayed.		4		L	L	H	
F-18	18.006	The system shall be able to document at least one reason for overriding any drug-drug or drug-allergy interaction warning triggered at the time of medication ordering.	Necessary for medico-legal purposes.	4		M	H		
F-18	18.007	The system shall trigger proactive alerts, for clients on a given medication when they are due for required laboratory or other diagnostic studies, to monitor for therapeutic or adverse effects of the medication.	Limited to availability of databases.	4		L	M	H	

F-18	18.008	The system shall , at the time of medication ordering, trigger an alert to a provider that based on the results of a laboratory test, the client may be at increased risk for adverse effects of the medication.	Limited to availability of databases.	4					
F-18	18.009	The system shall check whether a medication being prescribed has been noted to be ineffective for the client in the past, and trigger an alert to a user at the time of medication ordering if noted ineffectiveness exists.	This criterion assumes that at the time a medication was discontinued, it was marked "ineffective."	4		L	M	H	
F-18	18.010	The system shall display, on demand, potential interactions on a client's medication list, even if a medication is not being prescribed at the time.		4		M	H		
F-18	18.011	The system shall trigger drug-disease interaction alerts at the time of medication ordering.	Within the limitations of available databases.	4			M	H	
F-18	18.012	The system shall trigger drug-disease interaction alerts at the time of entering a problem.		4					
F-18	18.013	The system shall be able to view the rationale for triggering a drug interaction alert.	Drug reference information typically provided by drug database vendors is an example of the source to obtain the rationale.	4				H	
F-18	18.014	The system shall trigger alerts based on client age.	This could be based on user defined medication lists or on standard lists such as the Beers lists.	4			M	H	
F-18	18.015	The system shall interface with third party databases that support automated drug interaction checking to be performed during the prescribing process.		4					
F-18	18.016	The system shall support accessibility of drug specific education materials from third party databases.		4					
F-18	18.017	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction and allergy checking will not be performed against the uncoded or free text medication.	Moved from Manange Medication List: 4.019	4				H	
F-18	18.018	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication.	Moved from Order Medication: 11.025.	4				H	
F-18	18.019	The system shall be able to update drug interaction databases.	Moved from Order Medication: 11.026.  This includes updating or replacing the database with a current version.	4					

F-18	18.020	The system shall trigger an alert to a user if the drug interaction information is outdated.	Moved from Order Medication: 11.027.  The drug database shall have an "expiration date" based on the frequency of their updates such that when that date has passed, an alert is triggered to the user.	4			L	H		
F-18	18.021	The system shall allow the provider to prioritize/rank the importance of the interactions and/or warnings.	Moved from 4.036.	4						
F-21	21.017	CPOE Orders and Results: The system shall provide Health Maintenance alerts that are automatically provided based on patient conditions and orders that are pre-identified based on national guidelines.		4						
F-24	24.016	The system shall export daily eligibility files and import explanation of benefits (EOB) files to and from pharmacy benefits management companies that contract with the county.		4						
F-24	24.017	The system shall import pharmacy benefits management company EOB files, and appropriately, forward related billing to Medi-Cal and other insurance companies for counties that have assumed risk for pharmacy benefits.		4						
F-25	25.001	The system shall have the ability to provide electronic communication between prescribers and pharmacies or other intended recipients of the medication order.	Until electronic standards are established, FAX is a suitable means of transmission.	4			L	H		
F-25	25.002	The system shall be able to electronically communicate from the prescriber to the pharmacy an initial medication order as well as renewals of an existing order.		4			L	H		
F-25	25.003	The system shall have the ability to electronically communicate cancellations from the prescriber to the pharmacy.		4						
F-25	25.004	The system shall be able to capture and display any renewal requests received electronically from or on behalf of any dispensing entity.	This refers to e-prescribing.	4			L	L	H	
F-25	25.005	The system shall be able to capture and display notification of prior authorizations received electronically from or on behalf of any dispensing entity.	Dependent upon standards development and availability	4						
F-32	32.022	CPOE Laboratory Data: The system shall have the ability to match lab orders to insurance plan requirements and be able to print out an Advance Beneficiary Notice (ABN) if not covered.		4						
F-43	43.067	The system shall be able to interface with a number of key internal and external ordering applications through a standard bi-directional HI7 interface.	Includes medication, laboratory, and diagnostic test ordering.	4						

F-43	43.068	The system shall have the capacity to print orders for manual transmission.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.069	The system shall be able to fax orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.070	The system shall be able to require that all orders be digitally signed at the completion of each order.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.071	The system shall be able to accept orders from multiple locations.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.072	The system shall be able to assign and display an order number for active, hold and pending orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.073	The system shall require that during ordering entry the user acknowledge all error or alert messages prior to being allowed to continue with the data entry function.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.074	The system shall allow the user to accept, override, or cancel and order.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.075	The system shall require the user to enter a justification for overriding, changing, or canceling and order prior to being allowed to continue with the order entry process.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.076	The system shall include a visual indication of orders in need of review.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.077	The system shall detect and display duplicate orders issuing visual and auditory warnings, and allows the user to override the warning after entering a justification for the override.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.078	The system shall include the ability to define order sets for each provider service/treatment department. containing all information specific to one order	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.079	The system shall contain all information specific to one order in one display screen, displaying a list of tests and service/treatments from which to placate one or more orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.080	The system shall display the most commonly used orders to assist in entering orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.081	The system shall display all order sets, including their components by any of the following: Procedure, provider, diagnosis, date.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.082	The system shall be able to specify selected orders and recurring orders.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.083	The system shall allow providers to inquire on the details of an order.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.084	The system shall be able to access the order inquiry function while in the order entry function.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.085	The system shall display all the detail data associated with the order, including demographics, order parameters, electronic signatures and order status.	Includes medication, laboratory, and diagnostic test ordering.	4					

F-43	43.086	The system shall display order summaries on demand to allow the clinician to review/correct all orders prior to transmitting/printing the orders for processing by the receiving entity.	Includes medication, laboratory, and diagnostic test ordering.	4					
F-43	43.090	CPOE Orders and Results: The system shall route orders and results to the appropriate care giver based on practice-specific guidelines.		4					

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