LOGGING IN:
1. When you request computer lab accounts (through IT person), you will also be given access to Lytec with temporary login and password.
2. You will receive a Username (usually what you request on the form) and a TEMPORARY password for Lytec.
3. At the time of your first login, you will change the TEMP password to one of your choice.
4. On the 3-item toolbar across the top:
   a. FILE, then
   b. OPEN, then
   c. Highlight UA SPEECH CLINIC, then
   d. OPEN PRACTICE button, right side of box.
5. On the long toolbar across the top:
   a. LISTS, then
   b. PATIENTS (1st word on drop down menu), which will take you to the patient data window.
6. In Patient Data Window, enter your Patient/Client name, then
   a. Click on the magnifying glass for searching by last names; then
   b. Highlight last name; then
   c. Click OK, to bring up client data info.
7. Click on button “Edit Patient Notes” on right side of Patient Name data box. All patient/client data will already have been entered into the system by Lacy. This is why you click on “EDIT Patient Notes” to start your entry. If no patient/client data has been entered for your client, then EDIT won’t be an option. In this case, contact Lacy.

This is what you can do with the “TABS” section once you have opened client/patient data:

CONTACTS: Telephone numbers and addresses
ASSOCIATIONS: Clinical Instructor who has this client; also the name printed on the superbill/encounter form; could also be a reference to a referring physician, etc.
CUSTOM FIELDS: Family names; Case Manager name and contact
DIAGNOSTIC: Contains diagnosis code
Now that you are in a Client’s file (folder) and ready to enter a note, decide what TYPE of info/note you want to enter, so that you can choose the correct location for entry.

VERY IMPORTANT and easy to miss!

This is tricky. You have to translate YOUR purpose to the fields (“labels”) available within the system. This is the breakdown of the Lytec “labels” equated to the clinic-familiar terms:

<table>
<thead>
<tr>
<th>LYTEC TERM</th>
<th>OUR TERM</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Standard Note”</td>
<td>Client monitoring log for Left side of folder; phone calls, cancellations, etc</td>
</tr>
<tr>
<td>“Patient Consent”</td>
<td>Progress Notes: Written weekly by students in Lytec according to goals by each date seen</td>
</tr>
<tr>
<td>“Acknowledgment”</td>
<td>Paperwork completed</td>
</tr>
<tr>
<td>“Record of Authorization”</td>
<td>Not being used currently; apparently is being reserved for billing purposes</td>
</tr>
</tbody>
</table>

**CLIENT MONITORING LOG**

1. Make sure the Display boxes (bottom left of client data page) has “Standard Note” checked—VERY IMPORTANT, especially when entering info for the first time.

2. Click ADD button upper left box to ADD a new note (for the very first client entry of the semester); or
   Click EDIT button upper left box to EDIT/CHANGE the highlighted note

3. Select the type of note you’re entering in the DESCRIPTION line (Standard or Consent—for weekly progress notes by clinician)

4. Begin typing! (Content/format and “templates” is below)
   a. DATE can be entered in 3 ways:
      1. INSERT button (at top of note box)—automatically types today’s date
      2. DATE drop-down menu—choose date from calendar icon
      3. MANUALLY typing date at beginning of text of your note
   b. DESCRIPTION: Give your entry a Title

5. SAVE before exiting note window****

**PROGRESS NOTES**
Same as above (in Client Monitoring Log) EXCEPT make sure to check “Patient Consent” box, and “Patient Consent” chosen for the Description line which you have data or relevant observation information.

At the top of the semester’s progress note page, make a section for Comments. Enter, by date, specific anecdotal information or relevant behavioral observations.
CLIENT MONITORING LOG  “Standard Note”

- In Preview box, highlight a line to choose “Type of Note” (Standard) from list of entries, then click ADD button upper right

Or
- Use Display boxes lower right to check ONLY “Standard Note” (so uncheck the others); then click ADD button upper right

Now you’re in the Client Note writing box and ready to make the note entry. This is the trickiest part.
- The window box for writing ALL notes looks exactly the same and will say “Client Name-Notes” on the top blue line of the writing box for all of them.
- In order to differentiate/indicate which type of note YOU are entering (“Standard” vs. “Consent”) you MUST choose “Note Type” before writing. Note Type is a drop-down choice box.
- In DESCRIPTION line, type a description of your note, consisting of name and topic. This will always be on the index list, too, which will allow for quick find of your info later.
  Ex: Betty-Conversation

- When typing note content entry in Patient Note window, repeat the Description info in first line of the body of note:
  02/05/XX  First and Last name  Conversation with mom  During Jane’s

PROGRESS NOTES  “Patient Consent”

- Do the above, choosing “Patient Consent” as Type

- In DESCRIPTION LINE, student initials to be entered plus Prog Note Spring 20XX
  o Ex: Sally Q - Prog Note Spring 20XX

- When typing note content on Patient Note window, repeat the Description info in the first line of the body of note and use tab buttons for spacing:
  02/06/XX  Sally Q  Prog Notes Spring 20XX

- Enter goals and objectives—bold letters.
- Then, add to this same page each week, by date, making entries under each objective for which you have data or relevant observation information.
- At the top of the semester’s progress note page, make a section for Comments. Enter, by date, specific anecdotal information or relevant behavioral observations.

PROGRESS REPORTS

- Reports are typed in the Clinic Computer Lab and paper or electronic copies may be submitted.
- Progress report files are saved as: Last name [space] first name [space] clinical instructor’s initials semester full year (e.g., Smith John CIFall2012) in clinical instructor’s folder.)