

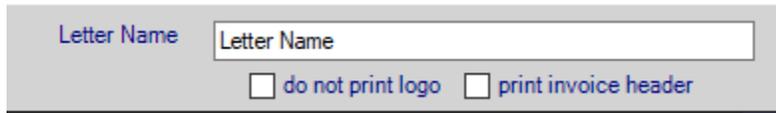
Crystal includes a Letter section which will allow you to create custom reports for your patients, without having to purchase any additional software. Common letters include exam summaries, referral letters, school/work notes etc.

Navigate to the Records section of Crystal and click on the Letter button

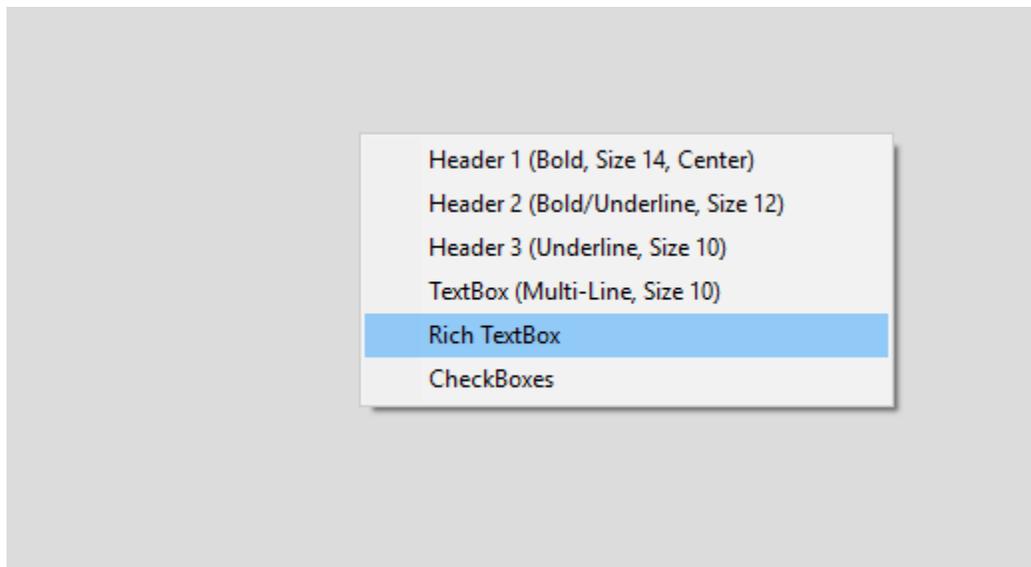


Click Admin Wizard and Create New Letter

Give the new letter a name and choose the options you would like to show/hide when the letter is printed. Checking the box at the bottom will ensure that all of the info generated comes from the same date of service.

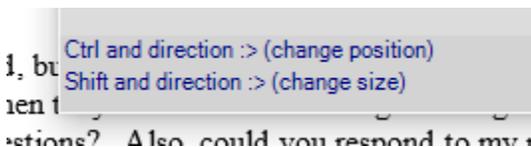


Right click in the large gray area for new text box options:



A Rich TextBox will allow you to change the font, size and text properties. The other options are pre-set.

Once a textbox is on the page, use the following commands to adjust the size and position of the box:



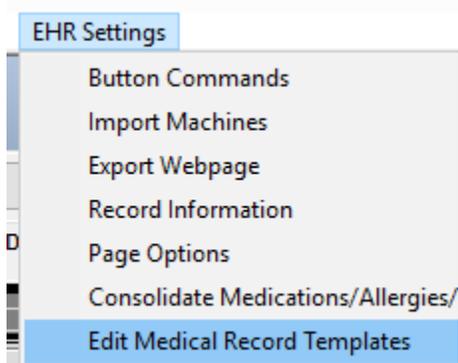
Multiple boxes can be used to help break up information on the page:

Eye Examination Report	
Patient: <first name> <last name>	DOB: <DOB>
Findings:	
1. Visual Fields : 2. Extra Ocular Movements: 3. Pupillary Reflex: 4. Ocular Alignment 5. Intraocular Pressure: 6. External Examination: 7. Internal Examination: 8. Visual Acuity: 9. Refractive Status	Adequate (<confrontations>) Adequate (<versions>) Adequate (<direct> direct/ <conse Adequate (<CT>) Adequate (OD: <OD IOP> mm Hg Adequate (no problems noted) Adequate (no problems noted) OD: 20/<BVA OD>, OS: 20/<BVA (
sphere: <refractive> cyl: <astigmatism> <presbyopia>	mild, moderate, marked OD: <sph mild, moderate, marked OD: <cyl <add>
10. Eyeglass Correction:	new Rx needed, no change, no gl recommended type of glasses: < recommended wear schedule: <v

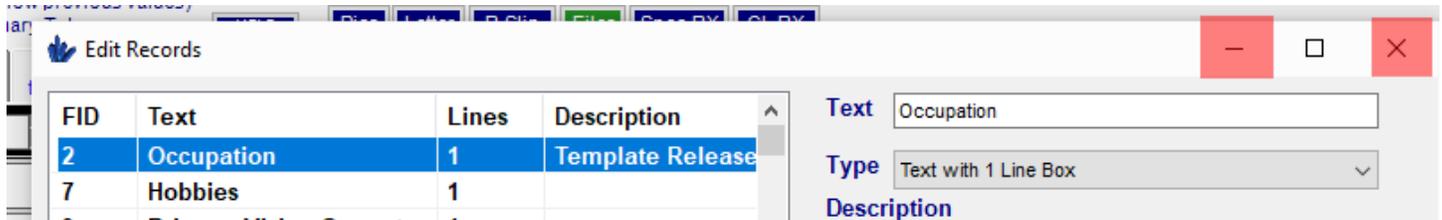
Or one large text box can be used:

Health Record	
Patient: <last name>, <first name>, DOB: <DOB> Date of Exam: <date> Exam Doctor: <Exam Doctor>	
Reason for Visit <RFV>	
Chief complaint <HPI> Location: <Location>, Severity: <Severity>, Quality: <Quality>, Duration: <D Timing: <Timing>, Context: <Context>, Modifying: <Modifying>, Associated	
Secondary complaints: <Secondary> Notes: <CC notes>	
Review of Ocular Systems: Ocular History: <ROOS> Ocular Surgery: <Ocular Sx> Ocular Meds: <Eye Meds>, Last eye exam: <LEE>, Last appointme Family Ocular History: Glaucoma: <Glaucoma>, Cataracts: <Cataracts>, Macular Degeneration: · Retinal detachments: <RD>, Crossed or Lazy eye: <Strab / Ambly> Blindn Primary Vision Correction: <Prev Correct>, Type of Contacts: <Type>, Cleaner: <Cleaner>, Wear time: <Wear Tim Notes: <CC2 Notes>	
Patient Medical History: Diabetes: <Pt Diabetes>(Year Dx: <Pt Year Dx>), HTN: <Pt Hypertension> Thyroid: <Pt Thyroid>, Cardiovascular: <Pt Cardio>, Cancer: <Pt Cancer>, Injuries, Surgeries, Hospitalization: <inj surg hosp>	

Now, it's time to start building the content of the letter. Within the Records section, enter edit mode under EHR Settings->Edit Medical Record Templates:



The edit records window can be minimized or closed



For this example, we'll look at a section of an interpretation tab. Let's say that we want this section to pull through into a report. The Field ID is the number in parenthesis which will need to go into the body of the letter.

Test (4067) [-4536106]	Date (543) [-4536106]	Reason / Diagnosis (905) [-4536106]	Cooperation (910) [-4536106]	Reliability (547) [-4536106]
1 (529)	2 (543)	3 (906)	4 (911)	5 (548)

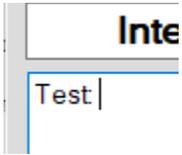
The upper portion of the letters allows you to enter the fields you would like to pull through. Click into the pattern cell and name it something relevant to the field you are pulling through. Remember that each pattern must be unique. Click into the field cell and match up the field ID from the records. You can type the number into the fields cell instead of scrolling though the list to expedite the process.

My end result looks like this:

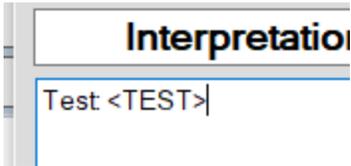
Insert	Pattern	Field	Remove
Insert	TEST	529.	Remove
Insert	DATE	543. Date - date of test 1	Remove
Insert	REASON	906. - Reason 1	Remove
Insert	COOPERATION	911. - Cooperation 1	Remove
Insert	RELIABILITY	548. - results of test 1	Remove

Next, we'll insert the patterns into the body of the letter.

You can type a label in front of the information:

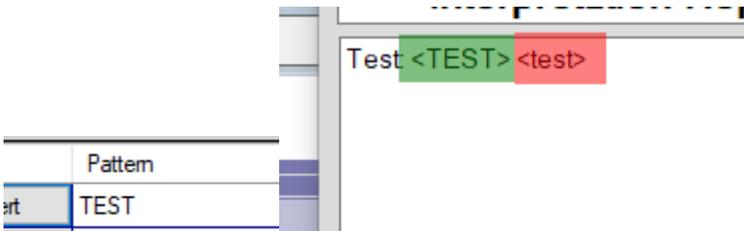


Place your cursor in front of the label and then press Insert from the upper section:



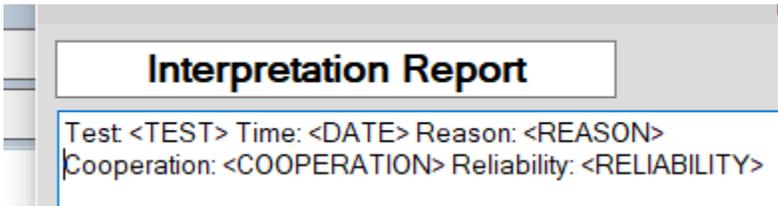
Make sure that the text inserted matches the pattern exactly.

Example, since my pattern is in all capital letters, it must match exactly in the body:



The reason I bring this up is because sometimes having the caps lock on your keyboard turned on/off will alter the way the system inserts the text 😊

Keep adding labels where necessary and inserting fields to build the body of the letter:



Note: There are fields which allow you to pull through patient information, they are at the top of the fields dropdown menu.

When the letter is complete press Save Letter Template at the bottom of the screen.

Press Close in the records to exit edit mode. You shouldn't need to save changes when prompted.

Sending record information into the letters

If the information you are sending is from today's date of service, just click the Letter button and choose the letter you would like to send the information into. If sending a previous date of service, you must choose the prior DOS from Old Records first, then Edit the record before pressing the Letter button.

Type Of Letter: Interp Report | Admin Wizard | Input Values | Show Values

do not pri

Interpretation Report

Test <TEST> Time: <DATE> Reason: <REASON>
Cooperation: <COOPERATION> Reliability: <RELIABILITY>

Click Input Values and then Send Values Back.

Patient Letters

Type Of Letter: Interp Report | Admin Wizard | Input Values | Show

Interpretation Report

Test Fundoscopy (Dialation) Time: 04/26/9999 Reason: G-suspect
Cooperation: good Reliability: good image quality

Modify the letter as needed.

From here, the letter can be printed and/or saved into the patient's Files section.

The most common buttons you'll use are Print and Save RTF

Print=prints the letter to your local printer

Print to XPS=saves the letter as an XPS document to your computer

Send to Word=converts the letter to Word format.

Create RTF=converts the letter to Rich Text format.

Save Letter=If you saved the letter as an XPS, Word or RTF document, this option allows you to upload the letter back into Crystal. You will only be able to open the file on the computer the XPX, Word or RTF document is saved.

Save RTF=Saves the letter to the patient's files section.