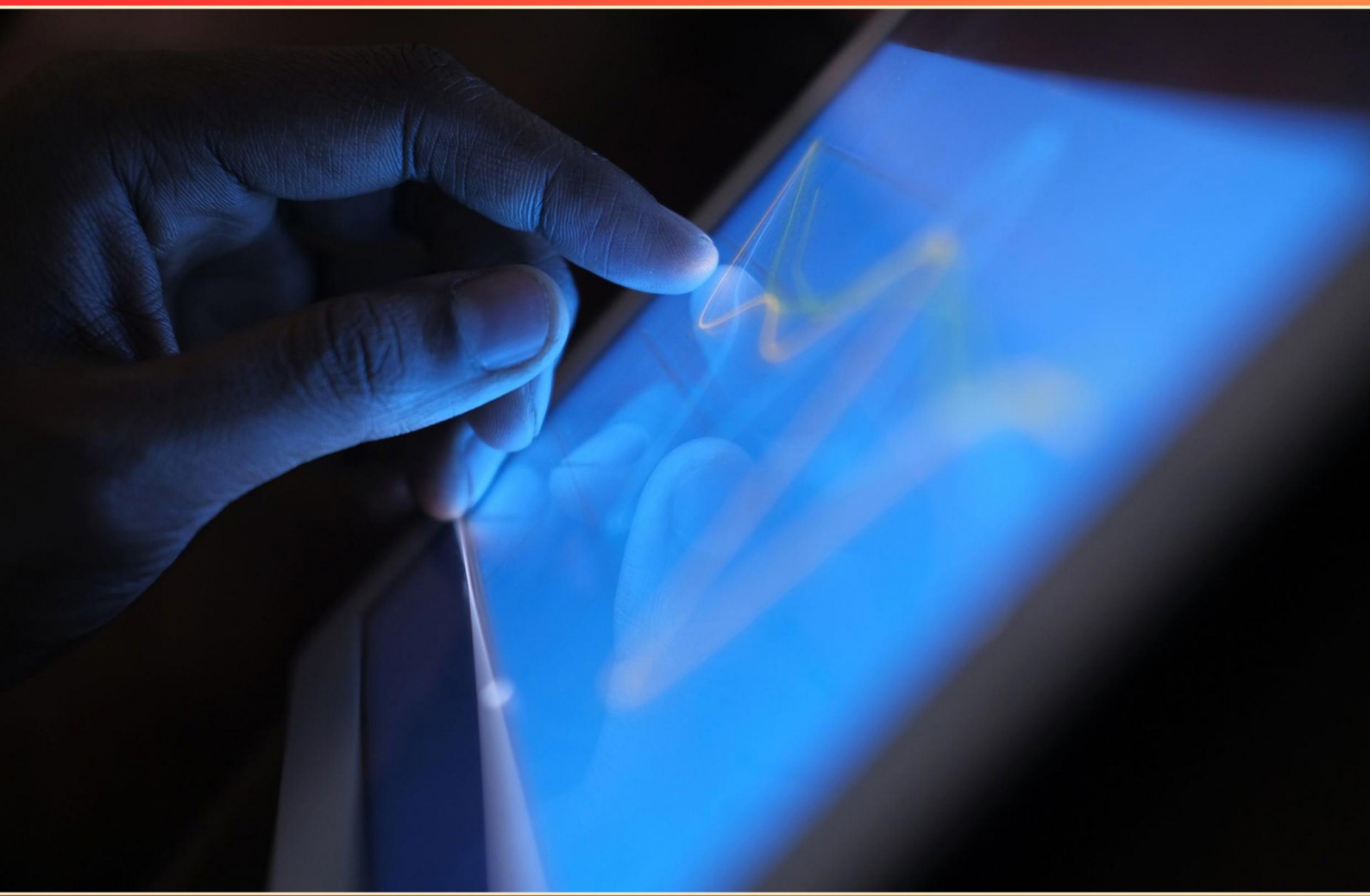
EPICCARE AMBULATORY CORE (AMB 100) CURRICULUM PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. **Which action requires the least number of steps to retrieve Richard's most recent TSH lab test information?**

   A. Use Synopsis

   B. Use Results Review

   C. Use the Lab tab in Chart Review to view an order report

   D. Use the patient information search feature

2. **Can "early childhood" be entered in the Date field for medical and surgical history items?**

   A. True

   B. False

   C. Only in specific fields.

   D. Depends on the format used.

3. **Can users run a report again before one week has passed?**

   A. Yes

   B. No

   C. Only with supervisor approval

   D. Yes, but only partially

4. **Which option is valid for completing procedure documentation?**

   A. Use SmartText as your progress note.

   B. Send charges later.

   C. Verify through a third party.

   D. Use any unapproved notes.

5. **What is the primary purpose of a patient summary in EpicCare?**

   A. To give a detailed report of past surgeries

   B. To provide a quick overview of relevant health information

   C. To document insurance information

   D. To track billing information

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6. How might a user edit a reason for visit speed button?

A. Click the edit option in the summary section

B. Click on the wrench in the Visit Info section

C. Use the delete button to create a new one

D. Type directly into the button field

7. When composing a report in the Reporting Workbench, which aspect is crucial for accuracy?

A. Using proper medical terminology.

B. Providing thorough definitions for all terms.

C. Choosing correct filtering criteria for data.

D. Including patient identifiers for each record.

8. What is the primary purpose of "Clinical Documentation" in EpicCare?

A. To enhance nurse training programs

B. To accurately record patient interactions and care processes

C. To increase patient visits

D. To streamline laboratory operations

9. Which is an acceptable activity related to charge capture documentation?

A. Close an encounter.

B. Discard incomplete details.

C. Manually enter all charges.

D. Rely solely on team members to document.

10. What two actions occur when you click a button such as "Suture removal" in a NoteWriter form?

A. That procedure is ordered and signed.

B. That procedure is pended for signing later.

C. A procedure-specific note-writing form opens.

D. The Charge Capture section opens.

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Answers

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1. C
2. A
3. A
4. A
5. B
6. B
7. C
8. B
9. A
10. A

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Explanations

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1. Which action requires the least number of steps to retrieve Richard's most recent TSH lab test information?

A. Use Synopsis

B. Use Results Review

C. Use the Lab tab in Chart Review to view an order report

D. Use the patient information search feature

Retrieving Richard's most recent TSH lab test information using the Lab tab in Chart Review is a streamlined process that typically involves fewer steps compared to the other options. This method is designed specifically for accessing laboratory data, which means that the user can quickly navigate to the relevant section without needing to perform additional searches or navigation through multiple screens. Using the Lab tab in Chart Review allows you to directly access lab results in an organized format, making it efficient to find the most recent TSH test. This option prioritizes laboratory test results, reducing the likelihood of encountering unrelated information and simplifying the retrieval process. On the other hand, using Synopsis, Results Review, or the patient information search feature may involve additional steps such as filtering through different types of information or navigating through multiple screens to find specific lab results. These methods could be more comprehensive but are not as direct for the task of looking up specific lab results quickly.

2. Can "early childhood" be entered in the Date field for medical and surgical history items?

A. True

B. False

C. Only in specific fields.

D. Depends on the format used.

Entering "early childhood" in the Date field for medical and surgical history items is appropriate because this terminology allows for the documentation of significant events or conditions that occurred during that specific developmental period, rather than limiting entries to only conventional date formats. It recognizes that certain medical histories are not always defined by specific dates but can instead be characterized by broader time frames that are clinically relevant. This flexibility is important in a medical record system, as it accommodates a variety of patient histories and provides a comprehensive view of their medical background. This practice enhances the narrative aspect of patient care, allowing healthcare providers to better understand the context of a patient's health.

3. Can users run a report again before one week has passed?

A. Yes

B. No

C. Only with supervisor approval

D. Yes, but only partially

Users can indeed run a report again before one week has passed. This functionality is essential for maintaining the flexibility and responsiveness needed within the workflow of healthcare settings. It allows users to quickly access updated data without the restriction of a one-week waiting period, which can be crucial for timely decision-making and patient care. In a clinical environment, the ability to rerun reports as needed ensures that any changes in the data are reflected promptly, which can impact patient management and operational efficiency. This capability supports various scenarios such as follow-ups on treatment progress, adjustments in clinical workflows, and routine checks that require up-to-date information. Thus, users have the autonomy to access and run reports as frequently as they need in order to support their ongoing tasks, ensuring they are always working with the most current data available.

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4. Which option is valid for completing procedure documentation?

A. Use SmartText as your progress note.

B. Send charges later.

C. Verify through a third party.

D. Use any unapproved notes.

Using SmartText as your progress note is a valid choice for completing procedure documentation because SmartText is designed to streamline documentation within EpicCare by allowing providers to insert standardized text templates. This functionality enhances efficiency and ensures consistency across documentation, as it can include structured data fields that capture necessary details regarding the procedure being performed. Additionally, SmartTexts often include relevant clinical information, coding, and billing details which support accurate records and compliance with required documentation standards. Other options do not align with best practices. Sending charges later may result in billing delays or missed charges; verifying through a third party is unnecessary for documentation completeness; and using unapproved notes can lead to issues with compliance, accuracy, and data integrity. Therefore, relying on SmartText for documentation is a preferred method that supports accurate and timely clinical records in the EpicCare system.

5. What is the primary purpose of a patient summary in EpicCare?

A. To give a detailed report of past surgeries

B. To provide a quick overview of relevant health information

C. To document insurance information

D. To track billing information

The primary purpose of a patient summary in EpicCare is to provide a quick overview of relevant health information. This summary aggregates essential details such as medical history, medications, allergies, and vital signs, enabling healthcare providers to efficiently assess a patient's current health status. By presenting this critical information succinctly, the patient summary aids in clinical decision-making, enhances communication among care teams, and supports the provision of timely and effective patient care. In contrast, detailing past surgeries, documenting insurance information, and tracking billing information serve different functions within the healthcare system and do not align with the main objective of the patient summary, which is fundamentally focused on the clinical aspects of the patient's care.

6. How might a user edit a reason for visit speed button?

A. Click the edit option in the summary section

B. Click on the wrench in the Visit Info section

C. Use the delete button to create a new one

D. Type directly into the button field

The correct approach to editing a reason for visit speed button involves clicking on the wrench in the Visit Info section. This tool is typically associated with settings and modifications within the EpicCare system, allowing users to make adjustments to components related to patient visits, including speed buttons. When a user clicks the wrench icon, it generally opens a configuration menu where various options can be modified. This makes it the most logical choice for editing specific features, such as reason for visit speed buttons, ensuring that changes are made in the appropriate part of the interface designated for customization. Other options may suggest alternative actions that do not directly pertain to the process of editing a speed button. For example, using the delete button to create a new one may not be the most efficient method since it involves removing an existing button rather than modifying it. Additionally, typing directly into the button field may not be supported by the system for such a specific item, as predefined options often require more structured edits than direct text input would allow. Lastly, clicking the edit option in the summary section typically does not pertain to modifying interactive components like speed buttons, which are usually managed within designated settings.

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7. When composing a report in the Reporting Workbench, which aspect is crucial for accuracy?

A. Using proper medical terminology.

B. Providing thorough definitions for all terms.

C. Choosing correct filtering criteria for data.

D. Including patient identifiers for each record.

Choosing the correct filtering criteria for data is vital when composing a report in the Reporting Workbench because it directly affects the accuracy and relevance of the information being presented. Filtering criteria determine which records are included or excluded from the report, thus shaping the data set and the conclusions that can be drawn from it. If the filtering criteria are not appropriate, the report could present misleading results, potentially omitting significant data or including irrelevant information. This could impact clinical decision-making, operational assessments, or any insights that the report is intended to provide. In contrast, while proper medical terminology and thorough definitions are important for clarity and understanding, they do not influence the accuracy of the actual data being reported. Furthermore, including patient identifiers, while necessary for certain aspects of record-keeping and compliance, does not inherently affect the accuracy of the report's content regarding data analysis and interpretation. Thus, the selection of correct filtering criteria stands out as the crucial factor for ensuring the report is accurate and meaningful.

8. What is the primary purpose of "Clinical Documentation" in EpicCare?

A. To enhance nurse training programs

B. To accurately record patient interactions and care processes

C. To increase patient visits

D. To streamline laboratory operations

The primary purpose of "Clinical Documentation" in EpicCare is to accurately record patient interactions and care processes. This documentation serves as a comprehensive account of all patient-related activities, including assessments, diagnoses, treatments, and communication among healthcare providers. It is essential for ensuring continuity of care, supporting clinical decision-making, and providing a legal record that can be referred to in future encounters or in case of audits. Accurate clinical documentation also enhances the quality of patient care by allowing for better tracking of outcomes and compliance with regulatory standards. In the context of the other options, while enhancing nurse training programs or increasing patient visits may indirectly benefit from good documentation, they are not the primary focus of clinical documentation itself. Similarly, streamlining laboratory operations is a separate process that involves other specific systems and functionalities within EpicCare, not directly linked to clinical documentation.

9. Which is an acceptable activity related to charge capture documentation?

A. Close an encounter.

B. Discard incomplete details.

C. Manually enter all charges.

D. Rely solely on team members to document.

Closing an encounter is an essential activity related to charge capture documentation because it formalizes the completion of a patient visit and ensures that all relevant information, including charges, is recorded accurately. This process is crucial for billing purposes, as it allows for the finalization of the charges associated with the services rendered during the encounter. By closing the encounter correctly, healthcare providers can help prevent errors and ensure that all necessary data is submitted for future billing and reimbursement processes. This practice contributes to the overall accuracy of financial documentation within the healthcare setting.

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10. What two actions occur when you click a button such as "Suture removal" in a NoteWriter form?

A. That procedure is ordered and signed.

B. That procedure is pended for signing later.

C. A procedure-specific note-writing form opens.

D. The Charge Capture section opens.

When you click a button like "Suture removal" in a NoteWriter form, the system executes two critical actions: it orders the procedure and also signs it. This process streamlines workflow in the clinical environment by allowing the clinician to select the procedure they wish to document and authorize in a single action. Ordering the procedure is essential because it formally records the action in the patient's medical record, which subsequently ensures proper tracking and billing. Signing the order confirms that the clinician has completed the documentation and agrees with the procedure being performed. This mechanism not only aids in maintaining accurate clinical documentation but also plays a vital role in coding and compliance aspects of medical practice. The other options do not fully reflect the actions triggered by clicking the button. For instance, while pending a procedure for later signing could be relevant in different contexts, it does not apply when instantly executing the action through such a button in the NoteWriter. Additionally, opening a procedure-specific note-writing form might be part of a broader workflow, but it is not the primary immediate consequence of clicking the button. Similarly, the Charge Capture section being opened may occur but is not an inherent result of that specific button action.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://epicareamb100.examzify.com

We wish you the very best on your exam journey. You've got this!

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