

Electronic Portfolio and International Credentials (EPIC) Certification Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

- 1. What formula does Epic use to calculate Adjusted Weight?**
 - A. Ideal Weight + 0.4 * (Actual weight - Ideal Weight)**
 - B. Ideal Weight - 0.5 * (Actual weight - Ideal Weight)**
 - C. Ideal Weight + 0.2 * (Actual weight - Ideal Weight)**
 - D. Ideal Weight + 0.6 * (Actual weight - Ideal Weight)**
- 2. What information does the Preference List provide?**
 - A. Orders available at your specialty**
 - B. Patient's insurance details**
 - C. Medical history overview**
 - D. Nutritional guidelines**
- 3. What does the overview report typically show?**
 - A. Patient history and family background**
 - B. PT's treatment team, progress notes written in the last 24 hours, and orders to cosign**
 - C. General health status and medications**
 - D. Patient demographics and contact information**
- 4. True or False: A patient can have more than one Principal Problem.**
 - A. True**
 - B. False**
 - C. Only in specific cases**
 - D. Depends on the severity of the condition**
- 5. What must a physician do to properly document a consult?**
 - A. Write a consult note and submit orders**
 - B. Document outcomes of previous consults only**
 - C. Prepare a summary report instead**
 - D. Inform the patient of consult procedures**

- 6. What signifies the functionality to complete note documentation progress using NoteWriter?**
- A. Highlighted blue text**
 - B. Highlighted green text**
 - C. Highlighted peach text**
 - D. Highlighted yellow text**
- 7. Which of the following can be used to enter and manage orders?**
- A. Patient feedback tool**
 - B. Order entry**
 - C. Financial assessment software**
 - D. Electronic billing system**
- 8. What does the ED Summary provide access to?**
- A. A summary of admission history**
 - B. Information about patient medications**
 - C. Everything that happened while the patient was in the ED**
 - D. Discharge instructions for the patient**
- 9. Which of the following must a physician confirm when reviewing the patient's current conditions?**
- A. Only the most critical ailments**
 - B. The accuracy of the information documented**
 - C. The history of medication prescribed**
 - D. The patient's family medical history**
- 10. What are the tabs within a patient's chart referred to as?**
- A. Activity Tabs**
 - B. Utility Tabs**
 - C. Data Tabs**
 - D. Information Tabs**

Answers

SAMPLE

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

SAMPLE

Explanations

1. What formula does Epic use to calculate Adjusted Weight?

- A. Ideal Weight + 0.4 * (Actual weight - Ideal Weight)**
- B. Ideal Weight - 0.5 * (Actual weight - Ideal Weight)**
- C. Ideal Weight + 0.2 * (Actual weight - Ideal Weight)**
- D. Ideal Weight + 0.6 * (Actual weight - Ideal Weight)**

The correct formula for calculating Adjusted Weight according to Epic is based on a method that takes into consideration both the Ideal Weight and the deviation of Actual Weight from that Ideal Weight. The formula used, which indicates that the adjustment is made by adding a proportionate amount of the difference between the Actual Weight and Ideal Weight, is designed to reflect the effects of exceeding the Ideal Weight in a balanced manner. In this case, the chosen formula incorporates a 0.4 multiplier. This means that when Actual Weight is greater than Ideal Weight, the adjustment is thoughtful rather than extreme, providing a moderated response to the deviation. Such a calculation allows for adjustments that are significant enough to address discrepancies without being overly punitive. This approach aligns well with concepts of equity and fairness in a performance measurement system, ensuring that adjustments are not disproportionate. The use of a factor of 0.4 particularly signifies a strategic balance between keeping individuals accountable and providing a realistic measure of their weight status relative to the ideal baseline.

2. What information does the Preference List provide?

- A. Orders available at your specialty**
- B. Patient's insurance details**
- C. Medical history overview**
- D. Nutritional guidelines**

The Preference List is an important component in various healthcare and administrative systems, particularly in contexts such as patient care and specialty services. It typically outlines the specific types of orders or procedures that are available within a particular specialty, effectively serving as a menu of options for healthcare providers to consider when developing treatment plans for patients. This list can help streamline decision-making processes, ensuring that practitioners are aware of the full range of services and interventions they can offer within their specialty. In this context, having access to accurate and comprehensive information about available orders supports more effective patient management and care, aligning with best practices in a specialized healthcare environment. The other options, while relevant to patient care and management, do not represent the primary focus of the Preference List. Insurance details pertain to billing and administrative processes, whereas a medical history overview focuses on the patient's past treatments and conditions, and nutritional guidelines offer dietary advice rather than procedural options related to specialty services. Therefore, the correct response highlights the focused role of the Preference List in supporting clinical decision-making within a specific specialty.

3. What does the overview report typically show?

- A. Patient history and family background
- B. PT's treatment team, progress notes written in the last 24 hours, and orders to cosign**
- C. General health status and medications
- D. Patient demographics and contact information

The overview report typically displays vital, up-to-date information regarding a patient's immediate care and progress, specifically highlighting details related to the treatment team, recent progress notes from healthcare providers, and any orders that require cosignatures. This information is crucial for healthcare professionals to coordinate care effectively, ensuring that all team members are informed about the patient's latest condition and treatment plans. Providing a comprehensive snapshot of the patient's status within a short timeframe, such as the last 24 hours, allows for timely interventions and helps maintain continuity of care. This level of detail is especially important in fast-paced healthcare environments where changes can occur rapidly and team communication is essential for optimal patient outcomes. Other options present information that may be relevant in different contexts but do not capture the immediate and actionable data that the overview report focuses on. For instance, patient history and family background (first option) are more about long-term context rather than current status, while general health status and medications (third option) may be part of the overview but do not encompass the team dynamics and documentation aspects. Meanwhile, patient demographics and contact information (fourth option) serves administrative purposes but lacks the clinical updates necessary for immediate treatment decisions.

4. True or False: A patient can have more than one Principal Problem.

- A. True
- B. False**
- C. Only in specific cases
- D. Depends on the severity of the condition

The assertion that a patient can have more than one Principal Problem is, in fact, true; hence, the correct answer would be "A. True". In clinical practice, a Principal Problem refers to the primary issue or diagnosis that a clinician focuses on when treating a patient. However, many patients present with multiple health issues or conditions that are significant enough to warrant attention. In such cases, especially when they affect treatment and management strategies, it is important to recognize and document all relevant problems. The focus on a single Principal Problem does not reflect the complexities often encountered in patient care. For effective treatment planning and healthcare delivery, practitioners are equipped to address the multifaceted nature of patient conditions. The other options would not reflect this complexity accurately. "B. False" suggests a limitation that does not exist in practice; "C. Only in specific cases" implies that there are restrictions on the circumstances under which multiple Principal Problems can be recognized, which is not typically the case; and "D. Depends on the severity of the condition" inaccurately ties the recognition of multiple problems to their severity rather than acknowledging that multiple problems can exist independently of severity.

5. What must a physician do to properly document a consult?

- A. Write a consult note and submit orders**
- B. Document outcomes of previous consults only**
- C. Prepare a summary report instead**
- D. Inform the patient of consult procedures**

To properly document a consult, it is essential for a physician to write a consult note and submit orders. This process ensures that the purpose of the consult is clearly communicated, detailing the patient's condition and the specific questions that need addressing. Additionally, the consult note serves as a formal record of the interaction between the consulting physician and the referring physician, which is crucial for continuity of care and aids in the decision-making process. Including orders in the documentation is equally important, as it specifies the necessary actions that should be taken following the consult. This not only helps in maintaining a clear outline of what has been agreed upon during the consultation but also ensures that all parties involved—healthcare providers and patients—are aligned on the next steps. The other options do not fulfill the comprehensive requirements for documenting a consult effectively. Documenting outcomes of previous consults lacks the proactive detail needed for ongoing management; a summary report may not capture the immediate needs and specific inquiries relevant to the current consultation; and merely informing the patient of consult procedures does not contribute to the formal documentation process required for proper record-keeping and clinical communication.

6. What signifies the functionality to complete note documentation progress using NoteWriter?

- A. Highlighted blue text**
- B. Highlighted green text**
- C. Highlighted peach text**
- D. Highlighted yellow text**

The functionality to complete note documentation progress using NoteWriter is indicated by highlighted peach text. This color-coding serves as a visual cue to the user, signaling that the documentation is complete. In many digital documentation tools, specific colors are utilized to denote different stages or statuses of a document, and in this case, the choice of peach as an indicator for completed documentation helps in quickly identifying sections that require no further action. This is particularly useful in healthcare and other professional settings where efficient documentation is essential. The distinct choice of peach over other colors allows for a unique identification that can help minimize confusion during the note-taking process.

7. Which of the following can be used to enter and manage orders?

- A. Patient feedback tool**
- B. Order entry**
- C. Financial assessment software**
- D. Electronic billing system**

The option that is most suited for entering and managing orders is order entry. This system is designed specifically for the input, tracking, and management of orders, which can be related to various aspects such as medication, laboratory tests, or other services within a healthcare setting. It allows healthcare providers to efficiently document and process orders and ensures that they can be communicated effectively to the relevant departments for fulfillment. Order entry systems are integrated with electronic health records (EHR) and other health information systems, thus promoting accuracy and legibility, minimizing errors that can arise from handwritten orders. This capability is crucial in clinical environments where timely and accurate information can directly impact patient care. While patient feedback tools, financial assessment software, and electronic billing systems serve important functions within healthcare management, they do not specifically focus on the order management process. Patient feedback tools are geared towards collecting and analyzing patient experiences, financial assessment software is used for evaluating the financial health of the healthcare institution, and electronic billing systems handle the processes related to billing patients and managing claims. These functions are integral to the operation of a healthcare provider but do not encompass the specific needs of order entry and management.

8. What does the ED Summary provide access to?

- A. A summary of admission history**
- B. Information about patient medications**
- C. Everything that happened while the patient was in the ED**
- D. Discharge instructions for the patient**

The ED Summary provides a comprehensive overview of the patient's experience while in the Emergency Department (ED). This includes detailed documentation of all events, assessments, interventions, and outcomes related to the patient's visit. By summarizing everything that happened during the visit, healthcare providers can quickly reference crucial information, which aids in continuity of care, facilitates communication between different departments, and enhances treatment planning. This holistic view is essential for understanding the patient's condition, decisions made during the visit, and any follow-up care that may be required. It ensures that all relevant data is easily accessible to clinicians reviewing the patient's chart, whether for subsequent care or for analysis of the episode of care.

9. Which of the following must a physician confirm when reviewing the patient's current conditions?

- A. Only the most critical ailments**
- B. The accuracy of the information documented**
- C. The history of medication prescribed**
- D. The patient's family medical history**

When a physician reviews a patient's current conditions, it is essential to confirm the accuracy of the information documented. This verification is crucial to ensure that treatment decisions are based on reliable and correct data. Inaccurate documentation can lead to misdiagnoses, inappropriate treatments, and potentially harmful outcomes for the patient. Verifying documented information helps provide a clear picture of the patient's health status, including any past medical histories, current ailments, medications, and other relevant details that contribute to effective patient care. It facilitates better communication within the healthcare team and improves continuity of care, ensuring that each provider has the most accurate and up-to-date information available. In contrast, while the other options may contribute to a comprehensive understanding of the patient's condition, they do not address the fundamental need for confirming the documentation's accuracy, which is a linchpin in effective medical practice.

10. What are the tabs within a patient's chart referred to as?

- A. Activity Tabs**
- B. Utility Tabs**
- C. Data Tabs**
- D. Information Tabs**

The correct terminology for the tabs within a patient's chart is often referred to as "Activity Tabs." These tabs are designed to organize different types of information and activities related to patient care, such as medication history, lab results, treatment plans, and progress notes. By using activity tabs, healthcare providers can efficiently navigate through the patient's information and quickly access the relevant data needed for decision-making and patient management. The other choices, while they may seem plausible, do not accurately represent the standard terminology used in medical records systems. Utility Tabs, Data Tabs, and Information Tabs do not specifically define the segmented areas of a patient's chart in the same way that Activity Tabs do, which are primarily focused on the activities and medical interventions pertaining to the patient's care. Understanding this distinction is crucial for effectively using electronic health records (EHR) systems in clinical settings.