ELECTRONIC PORTFOLIO AND INTERNATIONAL CREDENTIALS (EPIC) CERTIFICATION PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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.

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!

Questions

1. 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

2. True or False: A Patient's Lists columns can alert you to tasks that you need to take care of before you ever open a patient's chart?

A. True

B. False

C. Only during emergency visits

D. Only for scheduled appointments

3. What additional information does the Intake/Output activity provide?

A. Patient medication schedules

B. Patient daily intake and output

C. Patient vital statistics

D. Patient emergency contacts

4. What happens when a patient order is signed?

A. Patients are automatically discharged

B. Patients are automatically added to the system list

C. Patients are removed from all lists

D. Patients are reassigned to another provider

5. 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

6. What charge should be selected for a patient with routine rounds?

A. Subsequent Hospital Care Level II

B. Subsequent Hospital Care Level I

C. Emergency Care Level I

D. Initial Hospital Care Level I

7. How can you mark notes that are no longer new to you?

A. Click the Mark as Seen button

B. Click the Time Mark

C. Click the Archive button

D. Click the Delete button

8. What should you do if you notice a mistake on the note tab?

A. Ignore it and proceed with signing

B. Contact IT for assistance

C. Go back to the original form to correct it

D. Leave a comment about the mistake

9. True or False: Administration instructions are used to send messages to the pharmacy.

A. True

B. False

C. Only for urgent messages

D. When the patient is critical

10. 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)

Answers

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

Explanations

1. 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.

2. True or False: A Patient's Lists columns can alert you to tasks that you need to take care of before you ever open a patient's chart?

A. True

B. False

C. Only during emergency visits

D. Only for scheduled appointments

The statement is true because the Patient's Lists columns are designed to provide a quick overview of important information regarding your patients at a glance. These columns can display various indicators and alerts about tasks that require your attention, such as follow-ups, required documentation, or pending tests. This functionality allows healthcare providers to prioritize their responsibilities before even accessing a patient's chart, improving workflow efficiency. While there are other options listed that specify conditions under which alerts might apply, the true nature of the Patient's Lists is to serve as an ongoing alert system regardless of whether visits are emergency-based or scheduled. This is a fundamental feature aimed at ensuring that providers are aware of their obligations in a timely manner, enhancing patient care and management.

3. What additional information does the Intake/Output activity provide?

A. Patient medication schedules

B. Patient daily intake and output

C. Patient vital statistics

D. Patient emergency contacts

The Intake/Output activity primarily tracks the patient's daily fluid consumption and excretion. This includes the measurement of all liquids taken in (intake) and all liquids expelled from the body (output). By assessing a patient's daily intake and output, healthcare providers can monitor hydration status, assess renal function, and identify any potential fluid imbalances that may arise during treatment or hospitalization. This information is critical for making informed decisions regarding patient care, managing dietary needs, and implementing appropriate therapeutic interventions. The other options do not pertain to the intake and output monitoring process. While medication schedules, vital statistics, and emergency contact information are important aspects of patient care, they do not directly relate to the measurement of fluid intake and output, which is specific to tracking a patient's hydration and elimination status. Therefore, the correct answer focuses on the unique information that the Intake/Output activity specifically provides.

4. What happens when a patient order is signed?

A. Patients are automatically discharged

B. Patients are automatically added to the system list

C. Patients are removed from all lists

D. Patients are reassigned to another provider

When a patient order is signed, it typically indicates that the order has been approved and is now actionable within the healthcare system. This action generally leads to the patient being automatically added to the system list, making their information current and ensuring that the necessary follow-ups or procedures can be carried out as per the order that was signed. This process is crucial as it helps in maintaining an organized workflow, allowing healthcare providers to track patient orders efficiently and ensure that the necessary procedures, medications, or interventions are addressed promptly. Being added to the system list allows for visibility in workflows and enables the coordination of care that is essential in clinical settings. In contrast, the other options do not accurately reflect the standard practice regarding signed patient orders. For instance, automatically discharging patients or removing them from all lists would contradict the purpose of signing an order, which is to initiate further clinical actions, rather than to end or overlook their care. Reassigning patients to another provider would only occur under specific circumstances and not as a direct consequence of signing an order. Thus, adding patients to the system list is the correct and logical outcome of signing a patient order.

5. 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.

6. What charge should be selected for a patient with routine rounds?

A. Subsequent Hospital Care Level II

B. Subsequent Hospital Care Level I

C. Emergency Care Level I

D. Initial Hospital Care Level I

The appropriate charge for a patient during routine rounds is Subsequent Hospital Care Level I. This charge reflects the ongoing assessment and management of a patient who is already admitted to the hospital, which is what routine rounds typically entail. During these rounds, the healthcare provider reviews the patient's progress, checks vital signs, assesses the care plan, and makes any necessary adjustments to treatment, all of which represent a continuation of care rather than a new or emergent situation. Each of the other options represents different levels of care that are not applicable to routine rounding. Emergency Care Level I would be selected in urgent situations requiring immediate attention, which does not align with the nature of routine rounds. Initial Hospital Care Level I designates the first comprehensive evaluation of a newly admitted patient, indicating that it is meant for situations when the patient is being admitted for the first time, rather than ongoing care. Subsequent Hospital Care Level II involves more complex patient management than what is typically required during routine rounds, which usually does not necessitate a higher level of assessment or intervention. Thus, Subsequent Hospital Care Level I is the most appropriate choice for routine rounds, as it accurately reflects the type of care being provided.

7. How can you mark notes that are no longer new to you?

A. Click the Mark as Seen button

B. Click the Time Mark

C. Click the Archive button

D. Click the Delete button

The correct approach for marking notes that are no longer new to you is to click the Mark as Seen button. This action signifies that you have reviewed the notes, acknowledging that they are no longer fresh or new content that requires immediate attention. This is crucial in managing your progress and ensuring that your focus remains on items that still need review or attention. In this context, the Time Mark, while potentially useful for noting when certain information was added, does not specifically address the need to mark notes as seen. The Archive button typically serves to remove items from your active view without indicating that you've already seen them, which can lead to confusion in managing your notes. The Delete button, on the other hand, is for permanently removing notes and is not relevant to simply marking them as reviewed or acknowledged. Thus, the most effective and appropriate option for marking notes as no longer new is to use the Mark as Seen function.

8. What should you do if you notice a mistake on the note tab?

A. Ignore it and proceed with signing

B. Contact IT for assistance

C. Go back to the original form to correct it

D. Leave a comment about the mistake

When you notice a mistake on the note tab, going back to the original form to correct it is essential for maintaining accuracy and integrity in documentation. The note tab is often used to provide additional information or context related to a record, and any inaccuracies could lead to misunderstandings or misinterpretations of the data. Correcting the error at the source ensures that all subsequent notes, analyses, or decisions based on that information are built on a precise foundation. This action demonstrates a commitment to quality and accuracy, which are fundamental in fields that rely on detailed record-keeping and documentation. Other approaches, such as ignoring the mistake, contacting IT, or leaving a comment, do not resolve the issue at its core. Ignoring the mistake allows potential inaccuracies to persist, which can be detrimental if the information is relied upon for decision-making. While contacting IT may be appropriate for technical issues, it does not directly address the immediate need to correct the information. Leaving a comment might provide some context about the mistake, but it does not rectify the initial error, which could lead to confusion for anyone reviewing the documentation later.

9. True or False: Administration instructions are used to send messages to the pharmacy.

A. True

B. False

C. Only for urgent messages

D. When the patient is critical

The statement "Administration instructions are used to send messages to the pharmacy" is false because administration instructions primarily serve the purpose of guiding healthcare professionals on how to properly administer medications to patients, including dosage, timing, and method of delivery. They are not specifically designed as a communication tool for messaging the pharmacy. In practice, pharmacies typically rely on prescriptions or direct communication from healthcare providers to receive medication orders or changes. Administration instructions focus more on the clinical aspect of patient care rather than serving as a mechanism for relaying information to pharmacy staff. In this context, the appropriate communication for relaying messages to the pharmacy would generally include electronic prescriptions, phone calls, or secure messaging systems rather than administration instructions, reinforcing why the statement is false.

10. 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.

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://electronicportfoliointlcredentials.examzify.com

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