Reviewing and Editing the Note

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After you stop recording, EverHealth Scribe drafts your note and the visit's diagnoses. This article covers the review tools for the note: plain-language edits, Regenerate, and the formatting preferences Scribe learns. It also covers the short checklist worth running before every send. For the diagnosis side, see Diagnoses in EverHealth Scribe.

Scribe drafts, you decide: read the note, fix anything by editing directly or telling Scribe what to change in plain language, and send it only when it reflects the visit.

The three views

- **Transcript** shows what was said during the visit. Use it when you want to verify where a detail in the note came from.
- **Note** is the drafted clinical note, organized into the sections you already use: History of Present Illness, Review of Systems, Physical Exam, Assessments, and Treatment Plan.
- **Diagnoses** is the coded picture of the visit: the conditions you addressed, the ICD-10 codes attached to each, and the Assessment and Plan that goes with them. See Diagnoses in EverHealth Scribe.

Your editing tools

Edit directly	Click into the note and change the text, the same as any document.
Tell Scribe in plain language	Use the text box at the bottom of the Note tab: "Change weight loss to weight gain," "Shorten the HPI." Scribe updates the note for you.
Regenerate	Not quite right overall? Select **Regenerate** and Scribe redrafts the note from the visit.
Copy or print	Use the copy icon on any section to grab just that text, or **Print** for a full copy.
Thumbs up / thumbs down	Tells the Scribe team what's working and flags drafts that miss. Your feedback shapes what improves next.

Scribe learns your style

The edits and formatting preferences you set during review aren't one-time fixes. Scribe learns them and applies them to your next drafts, so notes arrive closer to how you'd write them with each visit.

What to double-check, every time

You own the note

You own the note and the codes. Scribe produces a draft. You review and edit it before signing, the same standard you apply to any documentation. Give special attention to:

- Medications and doses
- Numbers and lab values
- Left vs. right
- Negations: "denies" vs. "has"
- The diagnoses and their codes: specificity you can support, and any causal relationship the

description claims

You can also make corrections within OfficeEMR before you sign off on the note — the draft in the chart is editable like any other template content.

When it looks right

Check the **Diagnoses** tab as well, then select **Send to EHR**. Scribe writes the narrative into the chart tabs that your practice configured in OfficeEMR and the diagnoses to the patient's Problem List.