

# Kentucky Health Information Exchange (KHIE)

# Direct Data Entry for Electronic Case Reports: COVID-19

User Guide

October 2021



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## **1** Introduction

## Overview

This training manual covers KHIE's Direct Data Entry for COVID-19 Electronic Case Reports functionality in the ePartnerViewer. Users with the *Manual Case Reporter* role can submit electronic case reports from the ePartnerViewer by completing an online case report. The process generates a manual electronic initial case report (eICR) which is routed to the Department for Public Health (DPH).

All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

**Please Note:** All screenshots shown throughout this document reflect how Users would interact with the ePartnerViewer while using a desktop or tablet device. While core functionality remains the same across multiple devices, interface components may vary in presentation.

## Supported Web Browsers

Users must access the ePartnerViewer with a supported web browser. The ePartnerViewer is configured to support the following modern browsers on desktop, tablet, and mobile devices:

Desktop Browser Version	Mobile Browser Version
Microsoft Internet Explorer	
Not supported	Not supported
Microsoft Edge	
Version 44+	Version 40+
Google Chrome	
Version 70+	Version 70+
Mozilla Firefox	
Version 48+	Version 48+
Apple Safari	
Version 9+	iOS 11+

**Please Note:** The ePartnerViewer does <u>not</u> support Microsoft Internet Explorer. To access the ePartnerViewer, Users must use a modern browser such as Google Chrome, Microsoft Edge, Apple Safari, or Mozilla Firefox.



## **Mobile Device Considerations**

The ePartnerViewer is based on responsive design. This means it renders in the best format based on the user's device size. Responsive design applies to mobile, tablet, and desktop devices. Tablet devices in landscape display mode are considered desktop.

#### Accessing the ePartnerViewer

To access the ePartnerViewer, users must meet the following specifications:

- 1. Users must be part of an organization with a signed Participation Agreement with KHIE.
- 2. Users are required to have a Kentucky Online Gateway (KOG) account.
- 3. Users are required to complete Multi-Factor Authentication (MFA).

**Please Note**: For specific information about creating a KOG account and how to complete MFA, please review the *Kentucky Online Gateway (KOG) and Multi-Factor Authentication (MFA) Quick Reference Guide*.

## 2 Logging into ePartnerViewer

Users with the Manual Case Reporter Role are authorized to access the COVID-19 Case Report in the ePartnerViewer. You must log into your Kentucky Online Gateway (KOG) account to access the ePartnerViewer.

1. On the **KOG Login Page**, enter your **Email Address** and **Password**.

**Please Note:** You must enter the email address and password provided when creating your KOG account.

## 2. Click Sign In.

YKentucky.gov	FAQ   Help   🍳 English 🗸
Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account.	WARNING This website is the property of the Commonwealth of Kentucky. This is to notify you that you are only authorized to use this site, or any information accessed through this site, for
Email Address jane doe#gmail.com     Password     Forgot/Reset Password?	Its intended purpose. Unauthorized access or disclosure of personal and confidential information may be punishable by fines under state and federal law. Unauthorized access to this website or access in excess of your authorization may also be criminally punishable. The Commonwealth of Kentucky follows applicable federal and state guidelines to protect the
	Information from misuse or unauthorized access.
Resend Account Verification Email	Create An Account
	Click here to select user account type



3. To navigate to the ePartnerViewer, click **Launch** on the KHIE ePartnerViewer application tile located on the **KOG Dashboard** screen.

ntucky.gov			Welcome .	💄   Help   Sign Out 🗗
		My Apps		
	Search for Applications		QSearch	and the second second
# A B C D	DEFGHIJI	L M N O P Q	R S T U	V W X Y Z
KHIE ePartnerViewer				
The KHIE ePartnerViewer is where KHIE Participant's Authorized Users can access the patient health information available in the				
Kentucky Health Information Exchange.				

4. **Multi-Factor Authentication**. After logging in, you are asked to complete Multi-Factor Authentication or MFA. You have the option to receive an MFA passcode by Email or Text.

Kentucky Online Gateway	Welcome My Account	Sign Out Help	Englis
Multi-Factor Authentication			
MFA by Email Verification MFA by Phone Verification Send Passcode			
<b>Please Note</b> : For specific information about creating a l please review the <i>Kentucky Online Gateway (KOG) and Reference Guide</i> .		•	· · ·





## Terms and Conditions of Use and Logging In

After logging into the Kentucky Online Gateway, launching the ePartnerViewer application, and completing Multi-Factor Authentication, the **Terms and Conditions of Use** page displays. Privacy and security obligations are outlined for review.

KHIE   ePartnerViewer		S Mitch Cavallo -
TERI	MS AND CONDITIONS OF USE	
<ul> <li>Herminian Conditions</li> <li>Herminian Conditions of the Kentudy Health Information Exchange (Kentudy Health Inf</li></ul>	the Division of Health Information or have a current relationship as an o state and federal law. Ind NDC codes of drugs associated with the treatment of those patients. and tests, regardless of source.	Access restricted beyond this point. You must accept terms and conditions before proceeding.
Copyright 2019 HealthInteractive	HealthInteractive HIE	Version: 1.0.0

5. You must click **I Accept** every time before accessing a patient record in the ePartnerViewer.

KHIE ePartnerViewer	9 Mitch Cavallo •		
TERMS AND CONDITIONS OF USE			
<ul> <li>Herminian and conditions</li> <li>Herminian and conditions of the Kentucky Health Information Exchange (KHIE):</li> <li>A an a healthcare provider currently treating a patient.</li> <li>A an a healthcare provider currently treating a patient.</li> <li>A an a healthcare provider currently treating a patient.</li> <li>A an currently bound by a Health Information Agreement with the Division of Health Information or have a current relationship as an authorized user of a participating provider of the Division of Health Information.</li> <li>A treating the treat available on KHIE KIE is only that information available according to state and federal law.</li> <li>HIV medical procedures and test.</li> <li>Bignosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.</li> <li>Belet 1 accept to accept the usage terms and conditions.</li> </ul>	Access restricted beyond this point. You must accept terms and conditions before proceeding.		
Copyright 2019 HealthInteractive HEALTHARTER HE	Version: 1.0.0		
<b>Please Note:</b> The right side of the Portal is grayed out and displays a message that states: Access is restricted beyond this point. You must accept the terms and conditions before proceeding.			



- 6. Once you click **I Accept**, the grayed-out section becomes visible. A message appears that indicates you are associated with an *Organization*. (This is the name of your organization.)
- 7. Click **Proceed to Portal** to continue.

KHIE   ePartnerViewer	😧 Mitch Cavalio 🔸			
TERMS AND CONDITIONS OF USE				
For the set of the	You are part of the below mentioned organization. Please click on proceed to continue. KHE Smoke Test Organization Troceed to Portal Cancel			
Copyright 2019 HealthInteractive HEALTHINTERACTION	Version: 1.0.0			
<b>Please Note:</b> If you click <b>Cancel</b> , a pop-up notification displays that indicates that you are <i>about to be logged out. Use of the ePartnerViewer portal is subject to the acceptance of KHIE's Terms of Use.</i> To proceed to the ePartnerViewer, click either <b>Logout Now</b> or <b>Cancel</b> .				



## 3 Understanding the Case Report Entry Dropdown Menu

The **Case Report Entry** tab dropdown menu includes the following options:

- **Case Report Forms** which lists the different types of case reports.
- Case Report Entry User Summary which displays all submitted and 'In Progress' case reports.
- **Manage User Preferences** which offers an efficient way to enter repetitive data.

KĤIE	ePartnerViewer	🖂 Support 🖷	🕽 Announcements 2 🌲 Ad	visories 1 🔮 🔹	
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🔻	Case Report Entry -	
Home				Case Report Forms	>
Announcement:	eHealth Summit			Case Report Entry User Summar	у
		•••		Manage User Preferences	>

## 1. Types of Case Reports:

## • COVID-19 Case Report:

Designed for Users to enter COVID-19 case reports.

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

- Sexually Transmitted Disease (STD) Case Report:
  - Designed for Users to enter STD case reports.

**Please Note**: For specific information about STD case reporting, please review the *Direct Data Entry for Electronic Case Reports: Sexually Transmitted Diseases (STD) User Guide.* 

- Multi-drug Resistant Organism (MDRO) Case Report:
  - Designed for Users to enter MDRO case reports.

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Please Note**: For specific information about MDRO case reporting, please review the *Direct Data Entry for Electronic Case Reports: Multi-Drug Resistant Organism (MDRO) User Guide*.

## • Other Reportable Conditions Case Report:

Designed for Users to enter Other Reportable Conditions case reports.

**Please Note**: For specific information about Other Reportable Conditions case reporting, please review the *Direct Data Entry for Electronic Case Reports: Other Reportable Conditions User Guide.* 

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_



Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🔻	Case Report Entry 🕶
Home				Case Report Forms
-1 4	Lookh Commit			COVID-19
Announcement: et	lealth Summit	•••		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
	rr	<b>NYDASHBOARD</b>	)	Other Reportable Conditions
		-		

## 2. Case Report Entry User Summary:

- Designed to provide a quick and easy way for Users to search and view all previously initiated case reports (submitted and in-progress) entered during a specific date range within the last six months from the current date.
- Allows Users to view a summary of completed case reports that were previously submitted.
- Allows Users to continue entering details for case reports that are still "In-Progress".

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
Home				Case Report Forms
Announcement: Pr	ovider Assistance Program deadline ext	tension		Case Report Entry User Summary
-		•••		Manage User Preferences

## 3. Manage User Preferences:

- Designed as an efficient method for Users to enter repetitive data.
- Allows Users to enter required case reporting details in their User Preferences which enables Users to quickly select the appropriate answers from the dropdown menu options.

Patient Search	Bookmarked Patients	Event Notifications	Lab	Data Entry 🝷	Case Report Entry 🕶
😭 Home					Case Report Forms
Announcement: el	Health Summit				Case Report Entry User Summary
		•••			Manage User Preferences >
				Create Atten	ding Physician/Clinician Details
		myDASHBOARD		View & Edit A	ttending Physician/Clinician Details
QUICK SEARCH				Create Perso	n Completing Form Details
First	Last	Date Of	_	View & Edit P	erson Completing Form Details
Name	Name	Birth	mm	Create Order	ing Provider/Clinician Details
				View & Edit C	Ordering Provider/Clinician Details
BOOKMARKED PA		EVENT NOTIFICATION	S (PAS		



## 4 Manage User Preferences

These are your User Preferences. Prior to entering your COVID-19 case report information, you are required to enter information about the Interviewer on the **Manage User Preferences** screen. By entering the Interviewer details here in your user preferences, you will be able to quickly select an Interviewer from the dropdown menu options. This dropdown menu is located on the **Patient Information** screen of the COVID-19 Case Report.

## **Create Interviewer Information Details**

- 1. Click the **Case Report Entry** Tab located in the blue Navigation Bar at the top of the screen.
- 2. From the dropdown menu, select Manage User Preferences.

KĤIE	ePartnerViewer	Support 📢	Announcements 2 🔺 A	dvisories 🕦 😫 👻
Patient Search	Bookmarked Patients	Event Notifications 1	Lab Data Entry 🕶	Case Report Entry -
🖀 Home				Case Report Forms
Announcement:	Provider Assistance Program deadline exten	ision		Case Report Entry User Summary
		• • •		Manage User Preferences
	my	DASHBOAR	C	
QUICK SEARCH				Q ADVANCED SEARCH

3. To enter information about an Interviewer, select **Create Interviewer Information Details** from the dropdown menu.

KĤIE	ePartnerVie	Wer 🖻 Support 📢 Anr	nouncements 🙎 🌲 /	Advisories 1 😦 🔹
Patient Search	Bookmarked Patients	Event Notifications 1	Lab Data Entry -	Case Report Entry -
🖀 Home				Case Report Forms
<b>≰ Announcement:</b> e⊦	lealth Summit			Case Report Entry User Summary
		•••		Manage User Preferences
			Create Inter	viewer Information Details
		myDASHBOARD	View & Edit	nterviewer Information Details
QUICK SEARCH			Create Atter	ding Physician/Clinician Details
First	Last	Date Of	View & Edit	Attending Physician/Clinician Details
Name	Name	Birth	Create Perso	on Completing Form Details
			View & Edit	Person Completing Form Details
BOOKMARKED PA	TIENTS	EVENT NOTIFICATIONS	(PAST 72 HOURS	i) <b>()</b>



- 4. The **Interviewer Information** screen displays. Enter the details. Mandatory fields are marked with asterisks (\*).
- 5. If available, select the appropriate **Prefix** and **Suffix** from the dropdown menus.

Please complete the form below to create an Interviewer. All fields marked with an asterisk(*) are required.					
INTERVIEWER INFORMATION					
Prefix Dr. X V					
First Name*	Last Name*				
Suffix	•				
Select 🗸 🗸					
н ш	Email* name@domain.com				
IV					
Jr	Clear Save				
Sr					

6. Enter the Interviewer's **First Name** and **Last Name**.

INTERVIEWER INFORMATION					
Prefix					
Dr.	x   ~				
First Name*		Last Name*			
FILSCINGING					
rist Name					
Hist Name					
Suffix					
	x   ~				
Suffix	x   ~	Email*			

7. Enter the Interviewer's **Phone Number** and **Email Address**.

Phone*	Email*
(XXX) XXX-XXXX	name@domain.com
	one and <i>Email</i> fields is not entered in the appropriate ou from proceeding to the next page until the format





8. After completing the mandatory fields, click **Save**.

Prefix	
Dr. × V	
First Name*	Last Name*
Jerry	Seinfeld
Suffix	
Sr X V	
Phone*	Email*
(555) 543-2100	jerry@email.com
-	address that is already associated with another interviewer an error message that states:
ick <b>Save</b> , a pop-up displays with an the email entered is associated with lease review the details and enter the bu must click <b>OK</b> and enter the co	n error message that states: <i>h another interviewer you've created in your User Preference</i> <i>he correct email address.</i> rrect email address to save the Interviewer Information deta
ick <b>Save</b> , a pop-up displays with an the email entered is associated with lease review the details and enter the ou must click <b>OK</b> and enter the co and proceed to the <b>View &amp; Edit Int</b>	n error message that states: <i>h another interviewer you've created in your User Preference</i> <i>the correct email address.</i> rrect email address to save the Interviewer Information deta <b>terviewer Information Details</b> screen.
ick <b>Save</b> , a pop-up displays with an the email entered is associated with lease review the details and enter the ou must click <b>OK</b> and enter the co and proceed to the <b>View &amp; Edit Int</b> Please complete the form below to create.	n error message that states: <i>h another interviewer you've created in your User Preference</i> <i>the correct email address.</i> rrect email address to save the Interviewer Information deta <b>serviewer Information Details</b> screen.

🖀 Home 🕨 🕻	Create Interviewer Information Details				
	Please complete the form below to cr	pate an Intendewer. All fields marked with an asteriski Create Interviewer Information Details	*) are require ×	ed.	
		Interviewer Information Details saved successfully			
			ОК	Clear Save	





## **View & Edit Interviewer Information Details**

10. The **View & Edit Interviewer Information Details** screen displays. To edit details, click the **Edit** icon located next to the appropriate Interviewer.

SHOWING 3 ITEMS			
ACTIONS	NAME	- EMAIL	PHONE NUMBER
2	Dr. Jerry Seinfeld, Sr	jerry@email.com	(555) 543-2100
	Dr. Jason Alexander, II	jason@email.com	(123) 456-7890
	Dr. Elaine Benes	elaine@email.com	(555) 555-4321

11. The *Update Interviewer Information Details* pop-up displays. You can make any necessary edits and click **Save** to save the updates and close out of the pop-up.

Patient Search	Bq	Update Interviewer Information De	etails	×	Case Report Entry +
Home > View & E	F	Prefix Dr. X V			
		First Name*	Last Name*		
SHOWING 3 ITEMS		Suffix	Schneid		
ACTIONS NA		Sr X V		BE	ER 🗢
Dr.	. Jerry Seinfeld, S	Phone*	Email*	00	
Dr.	. Jason Alexande	(555) 543-2100	jerry@email.com	90	
Dr.	. Elaine Benes		Cancel Save	21	
		First Back 1 Next Last			Maximum 5 👻 entries per page

12. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.

A Home >	View & Edit Interviewer Information Details							
	& EDIT INTERVIEWER I	NFORMA	TION DETAILS				C REFRESH	<b>T</b> APPLY FILTER
SHOWING		Update Interv	viewer Information Details	×				
3 ITEMS		Interviewer Information details updated successfully						
ACTIONS	NAME		_		\$	PHONE NUMBER		\$
	Dr. Jerry Seinfeld, Sr			ОК		(555) 543-2100		
	Dr. Jason Alexander, II		jason@email.com			(123) 456-7890		





## **Delete Interviewer Information Details**

13. To delete an Interviewer from the User Preferences, click the **Trash Bin Icon** located next to the appropriate Interviewer.

VIEW	VIEW & EDIT INTERVIEWER INFORMATION DETAILS								
showing 3 ITEMS									
ACTIONS	NAME	• E	EMAIL \$	PHONE NUMBER \$					
	Dr. Jerry Seinfeld, Sr	j	jerry@email.com	(555) 543-2100					
	Dr. Jason Alexander, II	j	jason@email.com	(123) 456-7890					
	Dr. Elaine Benes	6	elaine@email.com	(555) 555-4321					

14. The *Delete Interviewer Information Details* pop-up displays. To delete the Interviewer, click **OK**. Click **Cancel** if you do not want to delete the Interviewer.

SHOWING 3 ITEMS		Delete Interviewer Information Details	×					
STIENIS		Are you sure?	- 1					
ACTIONS	NAME			PHONE NUMBER		\$		
	Dr. Jerry Seinfeld, Sr	Cancel		(555) 543-2100				
	Dr. Jason Alexander, II	jason@email.com		(123) 456-7890				

**Please Note**: You can delete an interviewer on the **View & Edit Interviewer** screen as long as the Interviewer has not been selected for use in another case report that is still in progress.

If you attempt to delete an Interviewer who has been selected for use in a case report that has not been completed yet, a pop-up notification displays the following message:

This interviewer information is currently being used in a case report that is still in progress. To delete this interviewer, please ensure that this particular interviewer information is not being used in a case report that has not yet been completed.

To close out of the pop-up and proceed, click **OK**. To delete the Interviewer that is being used in a case report that is in progress, you must first complete the In-Progress case report. Once the appropriate case report is complete, you may delete the Interviewer from your User Preferences.

• VIEW &	EDIT INTERVIEWER IN	Delete Inte	rviewer Information Details	×	2 REFI	RESH		R
SHOWING 2 ITEMS		8	This interviewer information is being used in one of the case reports that is still in progress. To delete this interviewer, please ensure that					
ACTIONS	NAME		this interviewer is not being used in any case report that is in progress.		\$ E-MAIL		÷	•
	Dr. Jerry Seinfeld, Sr				jerry@email.com			
	Dr. Jason Alexander, II		0	к	jason@email.com			





## Filter Interviewer Information Details

15. To search for a specific Interviewer, click **Apply Filter**.

<b>KĤIE</b>	ePartnerViewer	Support	🕈 Announcements 🗍 Advisories 🕦 🔮 🔹 🔻
Patient Search	Bookmarked Patients	Event Notifications 3 Lai	) Data Entry • Case Report Entry •
😭 Home 🖒 Vie	ew & Edit Interviewer Information Details		
• VIEW &	EDIT INTERVIEWER INFORM	ATION DETAILS	₽ REFRESH APPLY FILTER
SHOWING 3 ITEMS			
ACTIONS	NAME	- EMAIL	♦ PHONE NUMBER
	Dr. Jerry Seinfeld, Sr	jerry@email.com	(555) 543-2100
	Dr. Jason Alexander, II	jason@email.com	(123) 456-7890
	Dr. Elaine Benes	elaine@email.com	(555) 555-4321
	First Back 1	Next Last	Maximum 5 👻 entries per page

16. The Filter fields display. You can search by entering the *Interviewer's Name*, *Email Address*, and/or **Phone Number** in the corresponding Filter fields.

(ÎLIE	ePartnerViewer		🖼 Support 📢 Announcements 🌲 A	dvisories 🚹 🙁
Patient Search	Bookmarked Patients	Event Notifications 3	Lab Data Entry 👻	Case Report Entry -
🖀 Home 🖒 Vie	w & Edit Interviewer Information Details			
> VIEW &	EDIT INTERVIEWER INFORM	IATION DETAILS		
SHOWING 3 ITEMS				
ACTIONS	NAME Enter Name	EMAIL Enter Email	PHONE NUMBER EF	¢ ♦
	Dr. Jerry Seinfeld, Sr	jerry@email.com	(555) 543-2100	
	Dr. Jason Alexander, II	jason@email.com	(123) 456-7890	
	Dr. Elaine Benes	elaine@email.com	(555) 555-4321	
	First Back	1 Next Last	1	Maximum 5 👻 entries per pag



# 5 Basic Features in the Case Report Entry Form

This section describes the basic features of the Case Report Form in the ePartnerViewer.

## Side Navigation Bar & Pagination

On the left side of the Case Report, tabs are located in the **Side Navigation Bar** that provide users the ability to go to different screens within a Case Report. You can also use the pagination buttons to move to the next screen or to any previously completed screen.

- 1. Using the side navigation bar, you can navigate to any previously completed screen. Click the **hyperlink** of a previously completed screen to navigate to that specific screen.
- 2. Click **Previous** to go to the previous screen.
- 3. When all required fields have been completed on the current screen, click **Next** to proceed to next screen.

		VACCINATION HISTORY	
Patient Information	Ø	Has the patient ever received a COVID-19 vaccine?*	
SARS CoV-2 Testing	⊘	Yes No Unknown	
Clinical Course	⊘		
Applicable Symptoms	⊘	If yes, please provide vaccine name/manufacturer: 🚱 Select	
Medical Conditions	0	If other, please specify: 😡	
Exposure Information	0		
Hospitalization, ICU & Death Information	0	Date Administered (1st dose) Date Administered (2nd dose)	
Vaccination History		mm/dd/yyyy	
Additional Comments	_		
Review & Submit	۵		
		Save Previous Next	

## **Save Feature**

The **Save** feature allows Users to complete the case report in multiple sessions. You must **save** the information you entered in order to return later to the place you left off previously.

1. When all the required fields have been completed, click **Save** at the bottom of the screen to save the current section.

ls patient currer	ntly pregnant?	*		
Yes	No	Unknown		
Save				Next

2. If you click on a previously completed screen on the side navigation bar, the *Save Changes* pop-up will display. You have the option to save or discard the changes on the current screen before navigating to another screen.





- If you click Yes Save and all the required fields are entered on the current screen, you will
  navigate to the intended screen. (If you have not completed all the required fields on the current
  screen, you will not be allowed to save the data.) To navigate to the desired screen, you must first
  complete all the required fields on the current screen.
- If you click No Discard, you will navigate to the intended screen without saving any changes on the current screen. This means that none of the data entered on the current screen will be saved.

		to oversit for required.					
		PA	TIENT INF	ORMATION			
Patient Information	0	Interviewer Name*		Affiliation/Organization*			
SARS CoV-2 Testing	0	Dr. Jerry Seinfeld, Sr (jerry@email.c		Test Medical Center			x   ~
Clinical Course	0	Save Chang	es?	×			
Applicable Symptoms	0	SP04011960	on on this scre	een that has not been saved.			
Medical Conditions	0	Do you want to s	ave it?			Last Name*	
Exposure Information	0	Susan	N	o - Discard Yes - Save		Ross	
Hospitalization, ICU & Death Information	0	Suffix		Date of Dirth.			
Vaccination History	$\odot$	Select		04/01/1960			
Additional Comments	Ø	Patient Sex* Female	×   ~	Ethnicity* Not Hispanic or Latino	× ( ~	Race*	x   ~
Review & Submit							

#### Case Report Entry Icons

Case Reports may contain Icons that serve as visual indicators to draw the user's attention to specific information.

## Icon Descriptions:

	Icon	Name	Description
Section 8 of 10		Progress Bar	Indicates the percentage of completion.
		Lock	Indicates the sections that are not yet accessible; Users must enter all the required fields on the current screen and click <b>Next</b> to unlock the next screen.
	$\oslash$	Green Checkmark	Indicates the sections that are complete.

## **Conditional Questions**

Conditional Questions are those questions that are asked based on your responses to the previous questions. The COVID-19 Case Report has multiple screens with conditional questions. Based on the answer selected for conditional questions, certain subsequent fields on the screen will be enabled or grayed out and disabled.



 For example, if you select *No* or *Unknown* to the conditional question at the top of the SARS CoV-2 Testing screen of the COVID-19 Case Report, the subsequent fields will be grayed out and disabled.

	SARS CoV-2 TESTING								
Patient Information	${\boldsymbol{\oslash}}$								
SARS CoV-2 Testing		Does the patient have a lab te Yes No	Unknown						
Clinical Course	<b>A</b>								
Applicable Symptoms	<b>A</b>	If yes, please provide informat	tion for at least one test. N	NOTE: A Test Name and Test	Result are required.				
Medical Conditions	<b>A</b>	Molecular Amplification Test (I	RT PCR)						
Exposure Information	<b>A</b>	Test Name		Test Result		Filler Order/Accession Number 🚱			
Hospitalization, ICU & Death Information	_	Select		Select					
Vaccination History	_	🕀 Add Test							
Additional Comments	<b>A</b>	Serologic Test							
Review & Submit	<b>A</b>	Test Name		Test Result		Filler Order/Accession Number 🔞			
		Select		Select					
		🔂 Add Test							
		Antigen Test							
		Test Name Select		Test Result Select		Filler Order/Accession Number 😡			

• If you select **Yes** to the conditional question at the top of the **SARS CoV-2 Testing** screen, the subsequent fields are enabled.

		SARS CoV-2	2 TESTING	
Patient Information	0			
SARS CoV-2 Testing		Does the patient have a lab test?* Yes No Unknown		
Clinical Course	<b>A</b>			
Applicable Symptoms	<b>a</b>	If yes, please provide information for at least one test.	NOTE: A Test Name and Test Result are required.	
Medical Conditions	_	Molecular Amplification Test (RT PCR)		
Exposure Information	<b>A</b>	Test Name	Test Result	Filler Order/Accession Number 😧
Hospitalization, ICU & Death Information	<b>a</b>	Select v	Select v	
Vaccination History	<b>a</b>	🔂 Add Test		
Additional Comments	<b>a</b>	Serologic Test		
Review & Submit	<b>a</b>	Test Name	Test Result	Filler Order/Accession Number 🚱
		Select 🗸 🗸	Select v	
		🔂 Add Test		
		Antigen Test		
		Test Name	Test Result	Filler Order/Accession Number 🕑
		Select 🗸	Select 🗸	
		Select V	Select v	

Additionally, if **No** or **Unknown** is selected for certain conditional questions, the screen will be disabled and the subsequent fields will be marked as **No** or **Unknown**, based on the selected answer.

These conditional questions are found on the **Applicable Symptoms**, **Medical Conditions**, and the **Exposure Information** screens.

• For example, if you select *No* to the conditional question at the top of the **Applicable Symptoms** screen, all subsequent fields will be disabled and labeled as *No*.



	APPLICABLE SYMPTOMS						
Patient Information	Were symptoms present during the course of illness?*						
SARS CoV-2 Testing	Yes No Unknown						
Clinical Course	0						
Applicable Symptoms	Onset Date 🚱 mm//dd/yyyy 🕋 🗌 Unknown						
Medical Conditions	Did the patient's symptoms resolve?						
Exposure Information	A Yes No Unknown						
Hospitalization, ICU & Death Information	If yes, what was the date of symptom resolution?      mm/dd/vyyy     Unknown						
Vaccination History							
Additional Comments	If symptomatic, which of the following did the patient experience during their illness?						
Review & Submit	Fever Yes No Unknown						
	Subjective fever (felt feverish)						
	Yes No Unknown						
	Chills						
	Yes No Unknown						
	Rigors						
	Yes No Unknown						
	Muscle aches (myalgia)						
	Yes No Unknown						

• If you select **Unknown** to the conditional question at the top of the **Applicable Symptoms** screen, all subsequent fields will be disabled and labeled as **Unknown**.

	APPLICABLE SYMPTOMS
Patient Information	Were symptoms present during the course of illness?*
SARS CoV-2 Testing	Yes No Unknown
Clinical Course	Onset Date @
Applicable Symptoms	mm/dd/yyyy m Unknown
Medical Conditions	Did the patient's symptoms resolve?
Exposure Information	Yes No Unknown
Hospitalization, ICU & Death Information	If yes, what was the date of symptom resolution?      mm/dd/yyyy     Duknown
Vaccination History	
Additional Comments	If symptomatic, which of the following did the patient experience during their illness?
Review & Submit	Ever Yes No Unknown
	Subjective fever (felt feverish) Yes No Unknown Chills Yes No Unknown Rigors Yes No Unknown



• If you select **Yes** to the conditional question at the top of the **Applicable Symptoms** screen, the subsequent fields are enabled.

				APPLICA	BLE SYMPTOMS			
Patient Information	0	Were symptoms	present du	ring the course of illne	ss?*			
SARS CoV-2 Testing	$\odot$	Yes	No	Unknown				
Clinical Course	$\odot$	-				_		
Applicable Symptoms		Onset Date* @ mm/dd/yyyy		Unknown		_ I		
Medical Conditions	<b>A</b>	Did the patient's	symptoms	resolve?* 0		- 1		
Exposure Information		Yes	No	Unknown		- 1		
Hospitalization, ICU & Death Information	_	If yes, what was t mm/dd/yyyy		symptom resolution? (	9			
Vaccination History	_							
Additional Comments	_		which of the	following did the pati	ent experience during t	heir illness?		
Review & Submit	<b>a</b>	Fever* Yes	No	Unknown		- 1		
		Subjective fever	(felt feveris)	n)*				
		Yes	No	Unknown				
		Chills*						
		Yes	No	Unknown				
		Rigors*						
		Yes	No	Unknown				
		Muscle aches (m	yalgia)*					
		Yes	No	Unknown				

## 6 Tips for Manually Entering Case Report Data

Become familiar with these tips prior to entering case reports. When entering data, please keep these key notes in mind:

 There are <u>mandatory</u> fields marked with red asterisks (\*). These fields must be completed in order to proceed. In addition to completing the mandatory fields, you are encouraged to enter as much information as possible.

Please complete the form be	low. All fields ma	rked with asterisk(*) are require	d.				
	PATIENT INFORMATION						
Patient Information		Interviewer Name*		Affiliation/Organization*			
SARS CoV-2 Testing	<b>a</b>	Select	~	Select	~.		

• *Help Icons* are available to guide you while entering data in the fields.

Please complete the form belo	ow. All fields mar	ked with asterisk(*) are required An MRN or Medical Record Number is an Organization specific, unique Identification Number		
Patient Information		assigned to a patient by a healthcare organization. If	f Affiliation/Organization*	
SARS CoV-2 Testing	<b>a</b>	Dr. your organization does not use an MRN, you MUST create a way to uniquely		×   ~
Clinical Course		identify your Patient.		
Applicable Symptoms	<b>a</b>	Patient ID (MRN)* 🚱	Prefix Select ~	



For entering address information, all States are available for selection in the *State* field dropdown menu.
 When you select the **state of Kentucky**, all Kentucky counties are available for selection in the *County* dropdown.

City	State	КҮ	×   ~
Zip Code	County	Select	<b>~</b>
Phone Number	Email Address	Adair	A
Phone Number	Ethali Address	Allen Anderson	
		Ballard	
		Barren	t
		Bath	
nteractive	HealthInteractive HIE	Bell	, /ersi

• However, when Users select **any state other than Kentucky**, the system will display the message *Out of System State* and will <u>not</u> display counties in the *County* dropdown menu.

City	Sta	ate	AR	$x \mid v$
Zip Code	Coun	nty	Out Of System State	x   ~

- 1. Enter dates by entering 2 digits for the month, 2 digits for the day, and 4 digits for the year.
- You can also click the *Date* field to bring up a calendar. You can click a **date on the calendar** or use the field dropdowns to select the month and the year.

A	dmi	ssior	n Da	te*						Discharge Date*	
	mm	/dd/	′уууу	/					🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Ī	4	_	Ju	ne 20							
	Su	Jun Mo		<b>∨</b> We	202 Th		Sa	this illness?*			
	30	31	1	2	3	4	5	Unknown			
	6	7	8	9	10	11	12	death:			
	13	14	15	16	17	18	19				
	20	21	22	23	24	25	26		🛗 🗌 Unknown		
	27	28	29	30	1	2	3				





• If the date is unknown, you have the option to click the **Unknown** checkbox.

Admission Date*			Discharge Date*	
mm/dd/yyyy		🗸 Unknown	06/20/2021	🛗 🗌 Unknown
	•			

## 7 COVID-19 Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the COVID-19 Case Report in the ePartnerViewer.

1. To enter COVID-19 case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.

<b>KĤIE</b> ePa	KHIE ePartnerViewer 🛥 Support 📢 Announc						
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 👻	Case Report Entry -			
Home				Case Report Forms			
Announcement: eHealth Sum	mit			Case Report Entry User Summary			
				Manage User Preferences			

1. Select **COVID-19** from the dropdown menu.

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry 🕶
Home				Case Report Forms
				COVID-19
Announcement: eH	lealth Summit	•••		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
	m	IYDASHBOARI	D	Other Reportable Conditions



## 8 Patient Information

COVID-19 Case Report entry is a ten-step process where Users enter (1) Patient Information, (2) SARS CoV-2 Testing, (3) Clinical Course, (4) Applicable Symptoms, (5) Medical Conditions, (6) Exposure Information, (7) Hospitalization, ICU, & Death Information, (8) Vaccination History, and (9) Additional Comments. (10) **Lab Data Review** is where Users must review the information they have entered **and** submit the COVID-19 Case Report.

	Section 1 of	10					
rked with asterisk(*) are required.							
PATIENT INFORMATION							
Interviewer Name*	Affiliation/Organization*						
Select	Select						
A							
Patient ID (MRN)* 🚱	Prefix Select						
First Name*	Middle Name	Last Name*					
<b>A</b>							
<b>≙</b> Suffix	Date of Birth*						
Select	∽ mm/dd/yyyy						
A Patient Sex*	Ethnicity*	Race*					
		Julia					
	Interviewer Name*       Select       Patient ID (MRN)* ?       Patient ID (MRN)* ?       Image: Select       Select       Select       Patient Sex*       Select	ked with asterisk(*) are required.     PATIENT INFORMATION     Affiliation/Organization*     Select     Patient ID (MRN)* @        Prefix     Select     First Name*        Middle Name     Middle Name*     Middle Name     Select     Patient ID (MRN)* @        Prefix   Select     Middle Name     Middle Name     Middle Name     Select     Patient Sex*   Select     Select <td>PATIENT INFORMATION     Interviewer Name*     Select     Select     Patient ID (MRN)*       Prefix   Select     Select     Middle Name     Last Name*     Middle Name     Select     Select.</td>	PATIENT INFORMATION     Interviewer Name*     Select     Select     Patient ID (MRN)*       Prefix   Select     Select     Middle Name     Last Name*     Middle Name     Select     Select.				

3. To start the COVID-19 Case Report entry, you must complete the mandatory fields on the **Patient Information** screen.

COVID-19 CASE REPORT FORM			S	ection 1 of 10	
Please complete the form below. All fields man	rked with as	terisk(*) are required.			
		PATIENT IN	FORMATION		
Patient Information		Interviewer Name*	Affiliation/Organization*		
SARS CoV-2 Testing		Select 🗸	Select		~
Clinical Course					
Applicable Symptoms	_	Patient ID (MRN)* 😧	Prefix Select		
Medical Conditions	_	First Name*	Middle Name		Last Name*
Exposure Information	_				
Hospitalization, ICU & Death Information		Suffix	Date of Birth*		
Vaccination History	<b>A</b>	Select 🗸	mm/dd/yyyy	Ê	
Additional Comments		Patient Sex*	Ethnicity*		Race*
Review & Submit		Select ~	Select	×	Select 🗸 🗸
Neview & Submit	_	Address 1*			
		Address 1*		Address 2 Unit, Suite, Building, etc.	
		City*		State*	Zip Code
				Select	· · ·



**Please Note:** You are required to create an *Interviewer* prior to entering COVID-19 case report information. If you access the COVID Case Report Form without entering Interviewer Information, the **Patient Information** screen is disabled and displays an error message.

You must click the **Interviewer Information hyperlink** in the error message banner to navigate to the **Interviewer Information** screen and create an *Interviewer* before entering COVID-19 Case Report details.

COVID-19 CASE REPORT FO	ORM		Section 1 of 10
To enter your Interviewer Information	n details in the User	Preferences, click on the hyperlink.	
			PATIENT INFORMATION
Patient Information		Interviewer Name*	Affiliation/Organization*
SARS CoV-2 Testing		Select	Select V
Clinical Course			
Applicable Symptoms		Patient ID (MRN)* 🕝	Prefix Select

4. Select the **Interviewer Name** from the dropdown menu.

	PATIENT INFORMATION					
Patient Information		Interviewer Name*		Affiliation/Organization*	e	
SARS CoV-2 Testing	<b>a</b>	þelect		Select		×
Clinical Course	<b>A</b>	Dr. Jason Alexander, II (jason@email.com)				
Applicable Symptoms	<b>A</b>	Dr. Jerry Seinfeld, Sr		Prefix Select	~	
Medical Conditions		(jerry@email.com) First Name*		Middle Name	Last Name	*
	••	ropriate name does n nterviewer by clicking		• •		,

#### Interviewer Name Hyperlink

5. To create a details for a new Interviewer, click the **Interviewer Name hyperlink**.

COVID-19 CASE REPC	ORT FORM			Section 1 of 10	•	
Please complete the form be	low. All fields ma	rked with an asterisk(*) are req	uired.			
		F	PATIENT INF	ORMATION		
Patient Information		Interviewer Name*		Affiliation/Organization*		
SARS CoV-2 Testing	<b>a</b>	Select	~	Select		~



- 6. Upon clicking the **Interviewer Name hyperlink**, the *Interviewer Information* Pop-Up displays. Enter the details. Mandatory fields are marked with asterisks (\*).
- 7. If available, select the appropriate **Prefix** and **Suffix** from the dropdown menus.

	Manage User Preferen	ces	×	
Please complete the form below. All f	<i>Please complete the form b are required.</i>	elow to create an Interviewer. All fields marked with an ast	erisk(*)	
Patient Information		INTERVIEWER INFORMATION		
SARS CoV-2 Testing	Prefix	-		
Clinical Course	Select 🗸 🗸	1		
Applicable Symptoms	First Name*	Last Name*		
Medical Conditions	Suffix		ame*	
Exposure Information	Select 🗸 🗸	]		
Hospitalization, ICU & Death Information		Email* name@domain.com		
Vaccination History	IV			
Additional Comments	Jr	Cancel	save	
Review & Submit	Sr	Cancel	Save	

7. Enter the Interviewer's **First Name** and **Last Name**.

First Name*	Last Name*

8. Enter the Interviewer's **Phone Number** and **Email Address**.

Phone*	Email*
(XXX) XXX-XXXX	name@domain.com
<b>Please Note:</b> If the information entered in the <i>Pho</i> format, an error message displays that prevents you error is fixed.	one and <i>Email</i> fields is not entered in the appropriate u from proceeding to the next page until the format





9. After completing the mandatory fields, click **Save**.

COVID-19 CASE REPORT FO	PM			
	Manage User Preferences		×	
Please complete the form below. All fit	Please complete the form below to cre are required.	eate an Interviewer. All fields marked with an asterisk(	*)	
Patient Information	INTERV	IEWER INFORMATION		
SARS CoV-2 Testing	Prefix			
Clinical Course	Mr. × V			
Applicable Symptoms	First Name*	Last Name* Mailman	-	
Medical Conditions		Wallman	ame*	
Exposure Information	Suffix Select			
Hospitalization, ICU & Death	Phone*	Email*		
	(555) 654-3210	newman@email.com		
Vaccination History				
Additional Comments		Cancel		
Review & Submit				

- 10. Once the new Interviewer details have been saved, the *Interviewer Name* dropdown menu is automatically updated and displays the new Interviewer Name.
- 11. Select the **new Interviewer Name** from the *Interviewer Name* dropdown menu.

		PATIENT	INFORMATION
Patient Information		Interviewer Name*	Affiliation/Organization*
SARS CoV-2 Testing	۵	Select	✓ Select ✓
Clinical Course	_	Dr. Elaine Benes (elaine@email.com)	
Applicable Symptoms	_	Dr. Jason Alexander, II (jason@email.com)	Prefix Select V
Medical Conditions	<b>A</b>	Dr. Jerry Seinfeld, Sr (jerry@email.com)	Middle Name Last Name*
Exposure Information	_	Mr. Newman Mailman	
Hospitalization, ICU & Death	<b>A</b>	(newman@email.com)	Date of Birth*
Information		Select	~ mm/dd/yyyy

11. Select the **Affiliation/Organization** from the dropdown menu.

Please complete the form below.	All fields ma	arked with asterisk(*) are required.				
	PATIENT INFORMATION					
Patient Information		Interviewer Name*	Affiliation/Organization*			
SARS CoV-2 Testing	<b>A</b>	Dr. Jerry Seinfeld, Sr (jerry@ $~\times~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~$	Select 🗸 🗸			
Clinical Course	<b>a</b>		Afzal, Mohammad MD, Internal Medicine, LLC			
Applicable Symptoms	<b>a</b>	Patient ID (MRN)* 🚱	Hilton Hospital King's Daughters Medical Center			
Medical Conditions	<b>a</b>	First Name*	Murray-Calloway County Hospital			
Exposure Information	<b>A</b>		Test Medical Center			
Hospitalization, ICU & Death Information		Suffix Select	University Of Kentucky Chandler Medical Center mm/dd/yyyy			





12. Enter the patient's **Medical Record Number** (**MRN**) in the *Patient ID (MRN)* field. An MRN is an organization specific, unique identification number assigned to a patient by a healthcare organization. If your organization does not use an MRN, you **MUST** create a way to uniquely identify your patient so that the patient is registered in the KHIE system.

		An MRN or Medical Record Number is an Organization specific, unique Identification Number	NT INFORMATION	
Patient Information		assigned to a patient by a Interveneethealthcare organization. If	Affiliation/Organization*	
SARS CoV-2 Testing	<b>a</b>	Dr. j your organization does not use an MRN, you MUST create a way to uniquely	Test Medical Center	x   ~
Clinical Course	<b>A</b>	identify your Patient.		
Applicable Symptoms	<b>a</b>	Patient ID (MRN)* 🚱	Prefix Select	
Medical Conditions				

13. If available, enter the patient's **Prefix** and **Suffix**.

Patient ID (MRN)* 😧		Prefix			
SR04011960		Select	<b>~</b>		
First Name*		Dr.		Last Name*	
		Miss			
Suffix		Mr.			
Select		Mrs.			
Patient Sex*		Ms.		Race*	
Select	~	Select		Select	~

14. Enter the patient's **First Name** and **Last Name**. If available, enter the patient's **Middle Name**.

First Name*	Middle Name	Last Name*

## 15. Enter the patient's **Date of Birth**.

Suffix		Date	of Bi	rth*					
Select			n/dd/	′УУУУ	/				<b></b>
Patient Sex*	~	4	Jun	-	ne 20 ~	<b>21</b>	1 🗸		Race*
Selection		Su	Mo	Tu	We	Th	Fr	Sa	Select
		30	31	1	2	3	4	5	
Address 1*		6 13	7 14	8 15	9 16	10 17	11 18	12 19	te, Building, etc.
		20	21		23	24		26	le, building, etc.
City*		27	28	29	30	1	2	3	Zip Code
						J	50	eet	



**Please Note**: If the patient is either under one year old or more than 100 years old, a notification pop-up will display to confirm the correct birth year has been entered or selected. You cannot proceed to the next page until updating or confirming the patient's birth year.

16. Select the **Patient Sex** from the dropdown menu.

Patient Sex*		Ethnicity*		Race*	
þelect	~	Select	~	Select	
Female					
Male			Address 2		
Other			Unit, Suite, Building	, etc.	
Unknown			State*		Zip Code
			Select	~	

17. Select the patient's **Ethnicity** and **Race** from the appropriate field dropdown menus.

Patient Sex*		Ethnicity*		Race*	
Female	×   ~	Not Hispanic or Latin	10 ×   ~	Select	~
				American Indian or Alaska Native	^
Address 1*			Address 2	Asian	
			Unit, Suite, Building,	Asked but Unknown	
City*			State*	Black or African American	
			Select	Native Hawaiian or Other Pacific	
County*		Phone* 😧		Islander	
Select	~	(XXX) XXX-XXXX		Other Race	
				Unknown	*

18. Enter the patient's **Street Address**, **City**, **State**, **Zip Code**, and **County**.

Address 1*		Address 2		
		Unit, Suite, Buil	ding, etc.	
City*		State*		Zip Code
		Select	✓	
County*	Phone* 😧		Email	
Select	(XXX) XXX-XXXX		name@domain.co	m



- 19. Enter the patient's **Phone Number** and **Email Address**.
- If the phone number and email address fields are not in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

321 First Street	Plea	ase enter patient's Unit, Suite,	, Building, etc.		
City*	pho	e number. If patient's one number is not ible, please enter the			Zip Code
Lexington	prov	vider's/interviewer's KY		$\times   \sim$	40321
County*		phone number.	Ema	sil	
County.			EIIId		
Fayette	$\times   \vee  $ (	XXX) XXX-XXXX	na	ame@domain.co	m

20. Select the **appropriate answer** to: *Was this person a U.S. case?* This question wants you to indicate whether the patient has tested positive for COVID-19 in the US.

County*			Phone* 😧	Email
Fayette		$\times \mid  \sim$	(555) 321-0123	patient@email.com
Was this perso	n a U.S. case?*			
Yes	No	Unknown		

21. From the dropdown menu, select the **appropriate answer** for: *Where was the patient residing at the time of illness onset?* 



• If *Other* is selected from the dropdown menu, the subsequent field is enabled. You must enter **the location where the patient was residing at the time of illness** in the subsequent textbox: *If other, please specify*.

Where was the patient residing at the time of illness onset?* Other × · ·	
If other, please specify:*	
<b>Please Note:</b> The subsequent textbox below is a dropdown menu for: <i>Where was the patient residing</i>	
Where was the patient residing at the time of illness onset?*          House/single family home         X         If other, please specify:	

22. Select the **appropriate answer** for the question: *Is the patient a healthcare worker in the United States?* 

ne patient a	nealthcare w	orker in the United	States?*
Yes	No	Unknown	

• If *No* or *Unknown* is selected, the subsequent healthcare worker-related fields are disabled.

Yes No	Unknown	
If yes, what is the patient's occ	:upation/job type? 🚱	
Select		
If other, please specify:		
If yes, what is the patient's job	setting? 🕜	





• If *Yes* is selected, the subsequent healthcare worker-related fields are enabled.

Is the patient a heal	thcare wor No	ker in the Unite	d States?*	
<b>If yes, what is the pa</b> Select	itient's occ	upation/job typ	e? <b>* </b>	
lf other, please spec	ify:			
If yes, what is the pa	itient's job	setting?* 😧		
Select If other, please spec	ify:			

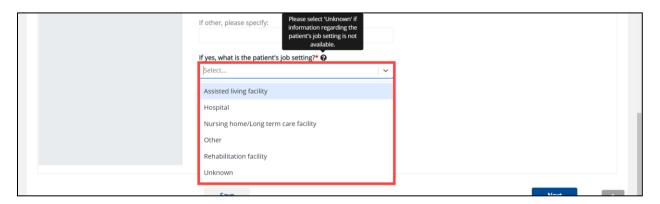
23. From the dropdown menu, select the **appropriate answer** to: *If yes, what is the patient's occupation/job type?* 

i the patient a healthcare worker in the t	ase select 'Unknown' if nformation regarding cupation/job type is not available.	
<b>yes, what is the patient's occupation/jol</b> Select	o type?* 🖗	
Environmental services		
Nurse		
Other		
Physician		
Respiratory therapist		
Unknown		

**Please Note:** If you select *Other* from the dropdown, the textbox: *If other, please specify* is enabled. You must enter the **patient's occupation/job type** in the textbox.



24. From the dropdown menu, select the **appropriate answer** to: *If yes, what is the patient's job setting?* 



• If *Other* is selected from the dropdown, the subsequent field is enabled. Enter the **patient's job setting** in the subsequent textbox: *If other, please specify*.

Dther	$\times   \sim$
f other, please specify:*	

25. Select the **appropriate answer** for *Is the patient currently pregnant?* 

ls patient curre	Is patient currently pregnant?*		
Yes	No	Unknown	
			ntly pregnant? field is enabled only when you select <b>Female</b> the <b>Patient Information</b> screen.





26. When the **Patient Information** section has been completed, click **Save** to save your progress or **Next** to proceed to the **SARS CoV-2 Testing** page.

Yes	No Unknown				
16					
	ent's occupation/job type?				
Nurse		x   ~			
If other, please specif	v:				
, caller, pladoe opeen.	,.				
f yes, what is the pati	ent's job setting?* 🚱				
Hospital		×   ~			
f other, please specif	y:				
f other, please specif	y:				
ls patient currently pr					
is patient currently pr	egnant?*				
is patient currently pr	egnant?*				
is patient currently pr	egnant?*				
If other, please specify Is patient currently pr	egnant?*			Next	



## 9 SARS CoV-2 Testing

1. On the **SARS CoV-2 Testing** screen, start by selecting the **appropriate answer** for the conditional question at the top: *Does the patient have a lab test?* 

COVID-19 CASE REPORT FORM				Section 2 of 10	
Please provide lab information.					
		SARS C	V-2 TESTING		
Patient Information	0				
SARS CoV-2 Testing	Does the Yes	patient have a lab test?* No Unknown			
Clinical Course	<u>ه</u>				
Applicable Symptoms	🔒 If yes, ple	ase provide information for at least one test. N	OTE: A Test Name an	d Test Result are required.	
Medical Conditions	A Molecular	r Amplification Test (RT PCR)			
Exposure information	Test Nam		Test Result		Filler Order/Accession Number 😡
Hospitalization, ICU & Death Information	Select		v Select		
Vaccination History	Add T	l'est			
Additional Comments	Serologic	Test			
Review & Submit	Test Nam		Test Result		Filler Order/Accession Number 🛛
	Select		v Select		
	T bbA 🛟	l'est			
	Antigen Te	est			
	Test Nam		Test Result		Filler Order/Accession Number 🚱
	Select		<ul> <li>Select</li> </ul>		

If *Yes* is selected for the conditional question, all the subsequent fields on the screen are enabled. You
must enter details for <u>at least one</u> of the options available for tests: **EITHER** Molecular Amplification
Test, Serologic Test, **AND/OR** Antigen Test.

Patient Information	$\odot$	Does the patient have a lab test?*				
SARS CoV-2 Testing			nown			
Clinical Course	_					
Applicable Symptoms	<b></b>	If yes, please provide information for	at least one test. M	NOTE: A Test Name and Test Result are requi	red.	
Medical Conditions	<b></b>	Molecular Amplification Test (RT PCR	)			
Exposure Information	<b></b>	Test Name		Test Result		Filler Order/Accession Number 🚱
Hospitalization, ICU & Death Information	<b></b>	Select	~	Select	~	
Vaccination History	<b></b>	🔂 Add Test				
Additional Comments	<b></b>	Serologic Test				
Review & Submit	_	Test Name		Test Result		Filler Order/Accession Number 😧
		Select	~	Select	~	
		🔂 Add Test				
		Antigen Test				
		Test Name		Test Result		Filler Order/Accession Number 🚱
		Select	<b>v</b>	Select		
		🔂 Add Test				

**Please Note:** If *No* or *Unknown* is selected for the conditional question at the top, all the subsequent fields on the screen are disabled.

\_\_\_\_\_

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3. If applicable, select the appropriate **Test Name** from the *Molecular Amplification Test (RT PCR)* dropdown menu.

est Name		Test Result	Filler Order/Accession Number 🚱
Select	~	Select	
Influenza virus A and B and SARS-CoV-2 (COVID-19) and Respiratory syncytial virus F panel - Respiratory specimen by NAA with	:NA		
probe detection			
Middle East respiratory syndrome coronavi (MERS-CoV) RNA [Presence] in Respiratory	rus	Test Result	Filler Order/Accession Number 😧
specimen by NAA with probe detection	_	Select	
Respiratory viral pathogens DNA and RNA			
panel - Respiratory specimen Qualitative by NAA with probe detection			

4. Select the appropriate **Test Result** from the dropdown menu.

#### 5. Enter the **Filler Order/Accession Number**.

SARS coronavirus 2 E gene [Cycle Thres ×   ~ Select	~
Add Test	
Pending	
Serologic Test Positive	
Test Name Undetermined	/Inconclusive Filler Order/Accession Number @
Select V Select	×

**Please Note:** The Filler Order Number or Lab Accession Number is typically utilized by laboratories and generally refers to the number assigned to a lab sample when it is checked in. If your organization does not log the receipt of specimens, you should create a system to uniquely track the specimen when you check it in.

- 6. If applicable, select the **Test Name** and **Test Result** from the *Serologic Test* dropdowns.
- 7. Enter the **Filler Order/Accession Number**.

est Name	Test Result		Filler Order/Accession Number 🚱
Select 🗸	Select	~	
SARS coronavirus 2 Ab [Interpretation] in Serum or Plasma			
SARS coronavirus 2 lgA Ab [Presence] in Serum or Plasma by Immunoassay			
SARS coronavirus 2 IgA Ab [Units/volume] in	Test Result		Filler Order/Accession Number 🚱
Serum or Plasma by Immunoassay	Select	~	
SARS coronavirus 2 lgG Ab [Presence] in Serum or Plasma by Immunoassay			
SARS coronavirus 2 IgG Ab [Presence] in Serum			



- 8. If applicable, select the **Test Name** and **Test Result** from the *Antigen Test* dropdowns.
- 9. Enter the Filler Order/Accession Number.

Antigen Test		
Test Name	Test Result	Filler Order/Accession Number 🕑
Select 🗸	Select 🗸	
BinaxNOW COVID Test Kit		
Influenza virus A and B and SARS-CoV+SARS- CoV-2 (COVID-19) Ag panel - Upper respiratory specimen by Rapid immunoassay		
Influenza virus A and B and SARS-CoV-2 (COVID-19) Ag panel - Upper respiratory specimen by Rapid immunoassay		Previous Next
SARS coronavirus 2 Ag [Presence] in		
Respiratory specimen by Rapid immunoassay	teractive HIE	Version: 1.0.0

#### Adding Multiple Tests

10. You can also click **Add Test** to log the details for multiple tests. This means that you can easily enter additional test results on the **same** patient.

fest Name	Test Result		Filler Order/Accession Number 🚱
SARS coronavirus 2 E gene [Cycle Thres $\times$   $\vee$	Negative	×   ~	SR03012021
🔂 Add Test			
Serologic Test			
Test Name	Test Result		Filler Order/Accession Number 😧
SARS coronavirus 2 Ab [Interpretation] i $  imes       imes $	Undetermined/Inconclusive	× v	SR03302021
Add Test Antigen Test			
Test Name	Test Result		Filler Order/Accession Number 🕑
BinaxNOW COVID Test Kit X V	Positive	×   ~	SR05082021





• To delete a test, click the Trash Bin Icon located at the bottom left.

est Name		Test Result		Filler Order/Accession Number 🚱
BinaxNOW COVID Test Kit	$\times$ $\vee$	Positive	$\times$ $\vee$	SR05082021
Test Name		Test Result		Filler Order/Accession Number 🚱
Select	~	Test Result Select	~	Filler Order/Accession Number 🕑
Select	~		~	Filler Order/Accession Number 🕑
Select	~		~	Filler Order/Accession Number 🥹
	~		v	Filler Order/Accession Number 🛛

11. Once the **SARS CoV-2 Testing** screen is complete, click **Next** to proceed to the **Clinical Course** screen.

		SARS CoV-2	2 TESTING	
Patient Information	0			
SARS CoV-2 Testing	0	Does the patient have a lab test?* Yes No Unknown		
Clinical Course	0			
Applicable Symptoms	$\otimes$	If yes, please provide information for at least one test. NOTE:	A Test Name and Test Result are required.	
Medical Conditions	$\odot$	Molecular Amplification Test (RT PCR)		
Exposure Information	$\odot$	Test Name	Test Result	Filler Order/Accession Number 😧
Hospitalization, ICU & Death Information	0	SARS coronavirus 2 E gene [Cycle Threshold #] $\times$   $\vee$	Negative X V	SR03012021
Vaccination History	0	🔂 Add Test		
Additional Comments	0	Serologic Test		
Review & Submit		Test Name	Test Result	Filler Order/Accession Number 🛛
		SARS coronavirus 2 Ab [Interpretation] in Seru $~\times~ ~~\vee~$	Undetermined/Inconclusive $\times$   $\vee$	SR03302021
		Add Test		
		Antigen Test		
		Test Name	Test Result	Filler Order/Accession Number 😧
		BinaxNOW COVID Test Kit $\qquad \times  \lor$	Positive X V	SR05082021
		Test Name	Test Result	Filler Order/Accession Number 🛛
		BinaxNOW COVID Test Kit × V	Pending ×   v	SR06222021
		<ul> <li>Add Test</li> </ul>		
		Save		Previous Next

**Please Note:** If you click **Next** but did <u>not</u> enter test details for **at least one** test, an error message displays that states: *There are errors. Please make a selection for all the required fields.* 

You must enter details for at least one **Molecular Amplification Test, Serologic Test,** and/or **Antigen Test** to proceed to the **Clinical Course** screen.

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There are errors. Please make a selection for a	all required fie	elds.
		SARS CoV-2 TESTING
Patient Information	Ø	
SARS CoV-2 Testing	Ø	Does the patient have a lab test?*           Yes         No         Unknown
Clinical Course	$\odot$	
Applicable Symptoms	$\odot$	If yes, please provide information for at least one test. NOTE: A Test Name and Test Result are required.
Medical Conditions	$\odot$	Molecular Amplification Test (RT PCR)
Exposure Information	$\odot$	Test Name     Test Result     Filler Order/Accession Number I       Select     V     Select
Hospitalization, ICU & Death Information	$\odot$	Select
Vaccination History	$\odot$	• Add Test
Additional Comments	$\odot$	Serologic Test
Review & Submit		Test Name Test Result Filler Order/Accession Number 🚱
		Select V Select V
		Add Test
		Antigen Test
		Test Name Test Result Filler Order/Accession Number 😡
		Select
		Add Test

## **10** Clinical Course

1. On the **Clinical Course** screen, select the **appropriate answer** for *Did the patient develop pneumonia?* 

COVID-19 CASE REPORT FORM					Section 3 of 10
Please provide the information pertaining to	the patient's	clinical course.			
				CI	LINICAL COURSE
Patient Information	Ø	Disease/Organ	ism*		
SARS CoV-2 Testing	Ø	COVID-19			
Clinical Course		Did the patient	t develop pne No	umonia?* Unknown	
Applicable Symptoms	۵	Yes			1
Medical Conditions	۵	Did the patient Yes	receive mech	Unknown	n(MV)/intubation?*
Exposure Information	۵	lf yes, total day	s with MV (#	of days):	
Hospitalization, ICU & Death Information	۵	Select	o marini (o	o, aayo,.	
Vaccination History	<b>a</b>	Did the patient	t have an abn	ormal chest X-ray	/?*
Additional Comments	۵	Yes	No	Unknown	No X-Ray Done
Review & Submit	<b>A</b>				bgy for their illness?*
		Yes	No	Unknown	
		Did the patient	t have acute r	espiratory distres	ss syndrome?*
		Yes	No	Unknown	
		Did the patient	t have an abn	ormal EKG?*	
		Yes	No	Unknown	No EKG Done
		Did the patient	receive ECM	D?*	
		Yes	No	Unknown	





2. Select the **appropriate answer** for *Did the patient receive mechanical ventilation (MV)/intubation?* 

Yes	No	Unknown		
d the patient	receive mech	anical ventilation(	V)/intubation?*	

• If *Yes* is selected, the subsequent field is enabled. From the dropdown menu, select the **appropriate answer** for *If yes, total days with MV (# of days)*.

		anical ventilation(I	MV)/intubation?*
Yes	No	Unknown	
f yes, total days	with MV (# of	f days):*	
Select			~
1-15 Days			
15 + Days			Ray Done
Unknown			ir illness?
Yes	No	Unknown	

- 3. Select the **appropriate answers** for the following questions:
- Did the patient have an abnormal chest X-ray?
- Did the patient have another diagnosis/etiology for their illness?
- Did the patient have acute respiratory distress syndrome?
- Did the patient have an abnormal EKG?
- Did the patient receive ECMO?

			x
oid the patien	t have an abno	rmal chest X-ray	?*
Yes	No	Unknown	No X-Ray Done
· · ·			gy for their illness?*
Yes	No	Unknown	
		spiratory distres	s syndrome?*
oid the patien Yes	t have acute re No	unknown	s syndrome?*
Yes		Unknown	s syndrome?*
Yes	No	Unknown	s syndrome?* No EKG Done
Yes Did the patien	No t have an abno	Unknown	
Yes Did the patien Yes	No t have an abno	Unknown ormal EKG?* Unknown	



4. Once complete, click **Next** to proceed to the **Applicable Symptoms** screen.

		CLINICAL COURSE
Patient Information	Ø	Disease/Organism*
SARS CoV-2 Testing	$\odot$	COWID-19
Clinical Course		Did the patient develop pneumonia?* Yes No Unknown
Applicable Symptoms	<b>A</b>	
Medical Conditions	<b>A</b>	Did the patient receive mechanical ventilation(MV/intubation?*           Yes         No         Unknown
Exposure Information	<b>A</b>	If yes, total days with MV (# of days):*
Hospitalization, ICU & Death Information	<b>A</b>	1-15 Days ×   ~
Vaccination History	_	Did the patient have an abnormal chest X-ray?*
Additional Comments	_	Yes No Unknown No X-Ray Done
Review & Submit	<b></b>	Did the patient have another diagnosis/etiology for their illness?* Yes No Unknown
		Did the patient have acute respiratory distress syndrome?* Yes No Unknown
		Did the patient have an abnormal EKG?* Yes No Unknown No EKG Done
		Did the patient receive ECMO?* Yes No Unknown
		Save Previous Next

## **11 Applicable Symptoms**

1. On the **Applicable Symptoms** screen, select the **appropriate answer** for the conditional question at the top: *Were symptoms present during the course of illness?* 

COVID-19 CASE REPORT FORM		Section 4 of 10									
Please select applicable symptoms that the patient	Please select applicable symptoms that the patient experienced during illness.										
APPLICABLE SYMPTOMS											
Patient Information	0	Were symptoms present during the course of illness?*									
SARS CoV-2 Testing	${}^{\oslash}$	Yes No Unknown									
Clinical Course	$\odot$	Onset Date 🖗									
Applicable Symptoms		mm/dd/yyyy 👔 🗋 Unknown									
Medical Conditions	<b>a</b>	Did the patient's symptoms resolve? 🚱									
Exposure Information	<b>A</b>	Yes No Unknown									
Hospitalization, ICU & Death Information	_	If yes, what was the date of symptom resolution? @ mm/dd/yyyy Unknown									
Vaccination History	<b>A</b>										
Additional Comments	<b>A</b>	If symptomatic, which of the following did the patient experience during their illness?									
Review & Submit	<b>a</b>	Fever Yes No Unknown									
		Subjective fever (feit feverish)									
		Yes No Unknown									
		Chills									
		Yes No Unknown									
		Rigors									
		Yes No Unknown									
		Muscle aches (myalgia)									
		Yes No Unknown									



2. If *Yes* is selected for the conditional question, all the subsequent fields on the screen are enabled.

Patient Information	$\odot$	Were symptoms present during the course of illness?*
SARS CoV-2 Testing	Ø	Yes No Unknown
Clinical Course	Ø	
		Onset Date* 🛛
Applicable Symptoms		mm/dd/yyyy 📸 🔲 Unknown
Medical Conditions		Did the patient's symptoms resolve?* 🚱
Exposure Information	<b>a</b>	Yes No Unknown
Hospitalization, ICU & Death Information	≙	If yes, what was the date of symptom resolution?  mm/dd/yyyy Unknown
Vaccination History	<b>a</b>	
Additional Comments	<b></b>	If symptomatic, which of the following did the patient experience during their illness?
Review & Submit	<b></b>	Fever* Yes No Unknown
		Subjective fever (felt feverish)*
		Yes No Unknown
		Chills* Yes No Unknown
		Rigors* Yes No Unknown
		Muscle aches (myalgia)* Yes No Unknown

- 3. Enter the **Onset Date** for the symptoms.
- If the onset date is unknown, click the **Unknown** checkbox.

Ň	Ple	Vec ase s	elect form	'Unk	N	o 'if		the course of illness?* Unknown
	nse	t Dat		_				
		n/dd/				益	1 1	Unknown
. <u>1</u>			,,,,,					
- 1	4	_	-	ne 20		_		ve?* 😧
		Jun			202			Unknown
	Su	Mo	Tu	We	Th	Fr	Sa	
	30	31	1	2	3	4	5	itom resolution? 🚱
	6	7	8	9	10	11	12	Jnknown
	13	14	15	16	17	18	19	
	20	21	22	23	24			wing did the patient experience during their illness?
	27		29	30	1	2	3	
	,	Yes			N	0		Unknown



- 4. Select the **appropriate answer** for *Did the patient's symptoms resolve?*
- If the patient's symptoms are not resolved at the time of visit, select No.
- If it is unknown whether the patient's symptoms are resolved, select **Unknown**.
- If the patient's symptoms are resolved at the time of visit, select Yes.

5. If *Yes* is selected, the subsequent field is enabled. Enter the **date of symptom resolution** in the subsequent field *If yes, what was the date of symptom resolution?* 

Yes	No	Unkr	Please select 'Unknown' if the date is not known.	
s, what wa	s the date of s	ymptom r	esolution?* @	
m/dd/yyyy		Unknow		

6. If the patient is symptomatic, select the **appropriate answers** for the following to indicate the symptoms the patient experienced during illness.

Additional Comments	<b>≙</b>	If symptomatic	, which of the	e following did the pa	ient experience during their illness	57	
		Fever*					
Review & Submit		Yes	No	Unknown			
		Subjective feve	r (felt feveris	h)*			
		Yes	No	Unknown			
		Chills*					
		Yes	No	Unknown			
		Rigors*					
		Yes	No	Unknown			
		Muscle aches (	myalgia)*				
		Yes	No	Unknown			
		Runny nose (rf	inorrhea)*				
		Yes	No	Unknown			
		Sore throat*					
		Yes	No	Unknown			
		New olfactory	and taste disc	order(s)*			
		Yes	No	Unknown			
		Headache*					
		Yes	No	Unknown			



Headache*					
Yes	No	Unknown			
	110				
Fatigue*					
Yes	No	Unknown			
Cough (new onset o	or worsen	ing of chronic cough)*			
Yes	No	Unknown			
Wheezing*					
Yes	No	Unknown			
Shortness of breath	n (dyspne	a)*			
Yes	No	Unknown			
Chest pain*					
Yes	No	Unknown			
Nausea or vomiting	•				
Yes	No	Unknown			
Abdominal pain*					
Yes	No	Unknown			
Diarrhea (>3 loose :	stools/24	nr period)*			
Yes	No	Unknown			
Did the patient hav	e any oth	er symptoms?*	•		
Yes	No	Unknown			

7. Select the **appropriate answer** for *Did the patient have any other symptoms*?

toms?* known			
-----------------	--	--	--

• If *Yes* is selected, the subsequent field is enabled. Enter **additional symptoms** in the textbox.

Did the pare Please enter "Unknown" if proms?* Yes this information is not available. If yes, please specify:*	

8. Once complete, click **Next** to proceed to the **Medical Conditions** screen.

Abdominal pain*		
Yes No Unknown		
Diarrhea (>3 loose stools/24hr period)*		
Yes No Unknown		
Did the patient have any other symptoms?*		
Yes No Unknown		
If yes, please specify: 🔞		
		\$
Save	Previous Next	



# **12 Medical Conditions**

1. On the **Medical Conditions** screen, select the **appropriate answer** for the conditional question at the top: *Did the patient have any underlying medical conditions and/or risk behaviors?* 

COVID-19 CASE REPORT FORM		Section 5 of 10
Please select any underlying medical condition	as and/or risk	behaviors that the patient experienced during illness.
		MEDICAL CONDITIONS
Patient Information	${\boldsymbol{ \oslash}}$	Did the patient have any underlying medical conditions and/or risk behaviors?*
SARS CoV-2 Testing	$\oslash$	Yes No Unknown
Clinical Course	${\boldsymbol{ \oslash}}$	
Applicable Symptoms	${\boldsymbol{ \oslash}}$	If yes, which one of the following underlying medical conditions and/or risk behaviors applies to the patient?
Medical Conditions		Diabetes Mellitus Yes No Unknown
Exposure Information	<b>A</b>	Hypertension
Hospitalization, ICU & Death Information	_	Yes No Unknown
Vaccination History	_	Severe obesity (BMI>40)
Additional Comments	<b>A</b>	Yes No Unknown
Review & Submit		Cardiovascular disease Yes No Unknown

2. If *Yes* is selected for the conditional question, all the subsequent fields on the screen are enabled.

Patient Information	0	Did the patien	t have any und	derlying medical conditi	ns and/or risk behaviors?*	
SARS CoV-2 Testing	Ø	Yes	No	Unknown		
Clinical Course	Ø					
Applicable Symptoms	Ø	If yes, which o	ne of the follo	wing underlying medica	conditions and/or risk behaviors appli	ies to the patient?
Medical Conditions		Diabetes Melli				
Exposure Information	<b>A</b>	Yes	No	Unknown		
Hospitalization, ICU & Death Information	<b>A</b>	Hypertension <sup>4</sup> Yes	No	Unknown		
Vaccination History	<b>A</b>	Severe obesity	(BMI>40)*			
Additional Comments	<b>A</b>	Yes	No	Unknown		
Review & Submit	۵	Cardiovascula	r disease*			
		Yes	No	Unknown		
		Chronic renal	disease*			
		Yes	No	Unknown		
		Chronic liver d	isease*			
		Yes	No	Unknown		
		Chronic lung d	lisease (asthm	a/emphysema/COPD)*		
		Yes	No	Unknown		

**Please Note:** If *No* is selected for the conditional question, all subsequent fields are disabled and marked with *No*.

If **Unknown** is selected for the conditional question, all subsequent fields are disabled and marked as **Unknown**.



- 3. To indicate the underlying medical conditions and/or risk behaviors that apply to the patient, select the **appropriate answers** for the following:
- Diabetes Mellitus ٠
- Hypertension •

•

- Severe obesity (BMI>40)
- Cardiovascular disease Chronic renal disease •
- Chronic liver disease

- Chronic lung disease (asthma/emphysema/COPD) •
- Immunosuppressive condition •
- Autoimmune condition
- Current smoker •
- Former smoker ٠
- Substance abuse or misuse ٠

Applicable Symptoms	0	If yes, which on	e of the follo	wing underlying n	medical
		Diabetes Mellit	us*		
Medical Conditions		Yes	No	Unknown	
Exposure Information	<b>a</b>	Hypertension*			
Hospitalization, ICU & Death Information	_	Yes	No	Unknown	
Vaccination History	<b>A</b>	Severe obesity	(BMI>40)*		
Additional Comments	<b></b>	Yes	No	Unknown	
Review & Submit	<b>A</b>	Cardiovascular	disease*		
		Yes	No	Unknown	
		Chronic renal d	lisease*		
		Yes	No	Unknown	
		Chronic liver di	sease*		
		Yes	No	Unknown	
		Chronic lung di	sease (asthm	a/emphysema/CC	COPD
		Yes	No	Unknown	
		Immunosuppre	essive conditi	on*	
		Yes	No	Unknown	
		Autoimmune o	ondition*		
		Yes	No	Unknown	
		Current smoke	r*		
		Yes	No	Unknown	
		Former smoke	*		
		Yes	No	Unknown	
		Substance abu	se or misuse		
		Yes	No	Unknown	

4. Select the appropriate answer for Disability (neurologic, neurodevelopmental, intellectual, physical, vision, or hearing impairment).



• If *Yes* is selected for *Disability*, the subsequent field is enabled. Enter **patient's disability** in the subsequent textbox.

Disability in Please enter "Unknown" if pemental, intellectual, physical, vision or hearing impairment)* Yes this information is not available. If yes, please specify:* ?	

- 5. Select the **appropriate answer** for the *Psychological/psychiatric condition*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **patient's psychological/psychiatric condition** in the subsequent textbox: *If yes, please specify*.

Yes	No	Unknown	
Hearing Imp	pairment		
incoming inte	pullinent		
sychological	/psychiatric c	andition*	
sychological			
	No	Unknown	
Yes	NO		
Yes			

- 6. Select the **appropriate answer** for the *Other chronic diseases*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **patient's chronic diseases** in the subsequent textbox: *If yes, please specify*.

onic diseas	c3					
	No	Unknown				
		Onknown				
specify:	0					

- 7. Select the **appropriate answer** for the *Other underlying condition or risk behavior*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **patient's underlying condition(s) or risk behavior(s)** in the subsequent textbox: *If yes, please specify*.
- 8. Once complete, click **Next** to proceed to the **Exposure Information** screen.

Yes	No l	Unknown			
es, please sp	ecify: 🚱				



### **13 Exposure Information**

There are a series of questions regarding COVID-19 exposure that healthcare providers may ask patients. You must enter answers to these questions on the **Exposure Information** page.

1. On the **Exposure Information** page, select the **appropriate answer** to the conditional question at the top: *In the 14 days prior to illness onset, did the patient have any of the following exposures?* 

COVID-19 CASE REPORT FORM		Section 6 of 10	
Please select the information that the patient was exp	osed to prio	r to illness.	
		EXPOSURE INFORMATION	
Patient Information	0	In the 14 days prior to illness onset, did the patient have any of the following exposures:*	
SARS CoV-2 Testing	0	Yes No Unknown	
Clinical Course	$\odot$	Domestic travel (outside state of normal residence)	
Applicable Symptoms	0	Yes No Unknown	
Medical Conditions	0	If yes, please specify states: 🛛	
Exposure Information		Select	
Hospitalization, ICU & Death Information	<b>a</b>	International Travel Yes No Unknown	
Vaccination History	_	If yes, please specify country(s): 🚱	
Additional Comments	_	Select	
Review & Submit	۵	Cruise ship or vessel travel as passenger or crew member Yes No Unknown If yes, please specify cruise ship: ©	

2. If *Yes* is selected for the conditional question, the subsequent fields on the screen are enabled.

		EXPOSURE INFORMATION
Patient Information	0	In the 14 days prior to illness onset, did the patient have any of the following exposures:*
SARS CoV-2 Testing	0	Yes No Unknown
Clinical Course	$\odot$	Domestic travel (outside state of normal residence)*
Applicable Symptoms	0	Yes No Unknown
Medical Conditions	0	If yes, please specify states: 😡
Exposure Information		Select
Hospitalization, ICU & Death Information	<b>A</b>	International Travel* Yes No Unknown
Vaccination History	-	If yes, please specify country(s): @
Additional Comments	_	Select
Review & Submit	<b>A</b>	Cruise ship or vessel travel as passenger or crew member* Yes No Unknown If yes, please specify cruise ship: •
		Is the workplace critical Infrastructure (e.g. healthcare setting, grocery store)* Yes No Unknown If yes, please specify workplace setting:

**Please Note:** If *No* is selected for the conditional question, the subsequent fields are disabled and marked with *No*.

If **Unknown** is selected for the conditional question, the subsequent fields are disabled and marked as **Unknown**.





3. Select the **appropriate answer** for *Domestic travel (outside state of normal residence)*.

		EXPOSURE INFORMATION
Patient Information	$\odot$	In the 14 days prior to illness onset, did the patient have any of the following exposures:*
SARS CoV-2 Testing	0	Yes No Unknown
Clinical Course	0	Domestic travel (outside state of normal residence)*
Applicable Symptoms	0	Yes No Unknown
Medical Conditions	0	If yes, please specify states: 🚱
Exposure Information		Select Y

• If *Yes* is selected, the subsequent field is enabled. From the multi-select dropdown menu, select the **state(s) that the patient traveled to**.

Select KY			~
AK			
AL			
AR			
AS			
AZ			
CA			

#### 4. Select the **appropriate answer** for the *International Travel*.

Yes	No Unkno	wn	
yes, please spe	cify states:* 🚱		
CA × AR × N	× VV		×
ternational Tra	vel*		
Voc	No Unkny		
Yes	No Unkno	wn	



• If *Yes* is selected, the subsequent field is enabled. From the multi-select dropdown menu, select the country or countries that the patient traveled to.

Please select "Unknown" if hternational Travel* the country in which the patient travelled is not known. Yes, please specify country(s):* ?	
Select	~
AFGHANISTAN	
ALBANIA	
ALGERIA	
AMERICAN SAMOA	
ANDORRA	
ANGOLA	
ANGUILLA	

- 5. Select the **appropriate answer** for the *Cruise ship or vessel travel as passenger or crew member*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **name of the cruise ship** in the subsequent textbox: *If yes, please specify cruise ship*.

f yes, please s BAHAMAS, THE	pecify country		x   ~
ruise ship or		s passenger or c	rew member*
	No	Unknown	

- 6. Select the **appropriate answer** for *Is the workplace critical infrastructure (e.g. healthcare setting, grocery store)*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **patient's workplace setting** in the subsequent textbox: *If yes, please specify workplace setting*.

fes	No	Unknown	
		ce setting: 🔞	

- 7. Select the **appropriate answer** for the *Airport/airplane*.
- If **Yes** is selected, the subsequent field is enabled. Enter the name of the **appropriate airline(s)** in the subsequent textbox: *If yes, please specify airline(s)*.

Yes	No	Unknown		
	sific airlin o(a);	0		
, please spec	cify airline(s):	0		



- 8. Select the **appropriate answer** for *Adult congregate living facility (nursing, assisted living or long-term care facility)*.
- If **Yes** is selected, the subsequent field is enabled. Enter the name of the **appropriate adult congregate living facility** in the subsequent textbox: *If yes, please specify nursing, assisted living, or long-term care facility*.



- 9. Select the **appropriate answer** for *School/university/childcare center*.
- If **Yes** is selected, the subsequent field is enabled. Enter the name of the **school/university/childcare center name** in the subsequent textbox: *If yes, please specify school/university/childcare center*.

Yes No Unknown	No Unknown

- 10. Select the **appropriate answer** for *Correctional facility*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **name of the correctional facility** in the subsequent textbox: *If yes, please specify name of correctional facility*.

Correctional fac	ility* No	Unknown			
yes, please sp	ecify name of cor	rectional facility: 🤇			
Jes, pieuse spi	celly nume of cor	rectoriar facility.	·		

- 11. Select the **appropriate answer** for *Community event/mass gathering*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **name of the community event/mass** gathering in the subsequent textbox: *If yes, please specify name of community event/mass gathering*.

Yes	No	Unknown			
e plassa e	necify name	of community e	ent/mass gathering: 🔞		



- 12. Select the appropriate answer for Animal with confirmed or suspected COVID-19.
- If *Yes* is selected, the subsequent field is enabled. Enter the **details of the animal with confirmed or suspected COVID-19** in the subsequent textbox: *If yes, please specify*.

No Unkn	Unknown
ify: @	Olikin

13. Select the appropriate answer for Contact with a known COVID-19 case (probable or confirmed).



• If *Yes* is selected, the subsequent field is enabled. Select **type(s) of contact** from the multi-select dropdown menu for *If yes, please specify what type of contact?* 

Yes	No Unknown	
yes, please sp	pecify what type of contact?*	
Select		~
Community-a	issociated	
Healthcare-as	ssociated (patient, visitor, healthcare worker)	
Household co	potact	

14. Select the **appropriate answer** for *Unknown exposures in the 14 days prior to illness onset*.

• If *Yes* is selected, the subsequent field is enabled. Enter the **details of unknown exposures** in the subsequent textbox: *Other unknown exposures, please specify*.

yes, please specif	fy what type of contact?*		
Healthcare-associat	ed (patient, visitor, healthcare worker)	× Community-associated ×	×
nknown exposure	es in the 14 days prior to illness o	nset*	
Vec	No		
Yes	NO		



- 15. Select the **appropriate answer** for *Other exposures*.
- If *Yes* is selected, the subsequent field is enabled. Enter the **details of other exposures** in the subsequent textbox: *If yes, please specify*.

Other exposures* Yes No	Unknown			٦
If yes, please specify: 🥹				

- 16. Select the **appropriate answer** for *Is this part of an outbreak*?
- If *Yes* is selected, the subsequent field is enabled. Enter the **name of the outbreak** in the subsequent textbox: *If yes, please specify the name of the outbreak*.
- 17. Once complete, click Next to proceed to the Hospitalization, ICU & Death Information page.

		spected COVID-19*					
Yes	No	Unknown					
f yes, please s	pecify: 🕜						
		10 (	for a first of the				
Yes	No	-19 case (probable or Unknown	confirmed)*				
		pe of contact?*					
Healthcare-ass	sociated (patient,	, visitor, healthcare worke	) × Community-associa	ated ×			× V
Unknown expo	osures in the 1	4 days prior to illness	onset*				
Yes	No						
Other unknow	n exposures, p	please specify: 🔞					
Other exposur	′es*						
Yes	No	Unknown					
lf yes, please s	pecify: 🔞						
	pecilit C						
s this part of a	an outbreak*						
Yes	No	Unknown					
lfves please s	necify the nam	ne of the outbreak: 🔞					
il yes, picase si	peeny the num						
Save					Previous	Next	



# 14 Hospitalization, ICU & Death Information

1. On the **Hospitalization**, **ICU & Death Information** screen, select the **appropriate answer** for the conditional question at the top: *Was the patient hospitalized?* 

COVID-19 CASE REPORT FORM		Section 7 of 10
Please select any applicable hospitalization, IC	U and death inform	nation related to this case.
		HOSPITALIZATION, ICU & DEATH INFORMATION
Patient Information	0	Was the patient hospitalized?*
SARS CoV-2 Testing	$\odot$	Yes No Unknown
Clinical Course	$\odot$	
Applicable Symptoms	0	If hospitalized, was a translator required? Yes No Unknown
Medical Conditions	$\odot$	If yes, please specify which language 🚱
Exposure Information	0	
Hospitalization, ICU & Death Information		If hospitalized, please provide admission and discharge dates:
Vaccination History	<b>A</b>	Admission Date Discharge Date Discharge Date
Additional Comments	_	
Review & Submit	<u></u>	Was the patient admitted to an intensive care unit (ICU)?       Yes     No       Unknown
		If admitted to an ICU, please provide admission and discharge dates:       Admission Date     Discharge Date       mmi/dd/yyyy     Unknown     mmi/dd/yyyy
		Did the patient die as a result of this illness?*       Yes     No       Unknown

• If *Yes* is selected for the conditional question, all subsequent hospitalization-related fields are enabled.

	HOSPITALIZATION, ICU & DEATH INFORMATION	
Patient Information	Was the patient hospitalized?*	
SARS CoV-2 Testing	Yes No Unknown	
Clinical Course	If hospitalized, was a translator required?*	
Applicable Symptoms	Yes No Unknown	
Medical Conditions	If yes, please specify which language 🛛	
Exposure Information		
Hospitalization, ICU & Death Information	If hospitalized, please provide admission and discharge dates:	
Vaccination History	Admission Date* Discharge Date* Unknown Unknown Unknown Unknown	
Additional Comments		
Revlew & Submit	Was the patient admitted to an intensive care unit (ICU)?*       Yes     No       Unknown   If admitted to an ICU, please provide admission and discharge dates:	
	Admission Date Discharge Date Infinition Dis	
	Did the patient die as a result of this liftness?*           Ves         No         Unknown           If yes, please provide the date of death:	-

**Please Note:** If **No** or **Unknown** is selected for the conditional question, all subsequent hospitalization-related fields are disabled. Death-related questions are not impacted by the selected answer for the conditional question: *Was the patient hospitalized?* 

\_ \_ \_ \_ \_



- 2. Select the **appropriate answer** for *If hospitalized, was a translator required?*
- If *Yes* is selected, the subsequent field is enabled. Enter the **appropriate language** in the subsequent textbox: *If yes, please specify which language*.

Was the patient h Yes	ospitalized?* No Unknown		
If hospitalized, wa	as a translator required?* No Unknown		
If yes, please spec	cify which language 🚱		

3. Enter the patient's hospitalization **Admission Date** and **Discharge Date**.

dmi	ssior	n Da	te*		_			Discharge Date*	
mm	/dd/	/уууу	/				🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
4	Jun	-	ne 20 ~	<b>21</b>	~	٦			
Su	Mo	Tu		Th		29	ntensive care unit (ICU)?*		
30	31	1	2	3	4	5	Unknown		
6	7	8	9	10	11	12	vide admission and discharge dates:		
13	14	15	16	17	18	19	_	Discharge Date	
20	21	22	23	24		26	🛗 🗌 Unknown		🖮 🗌 Unknown
				1	2	3	🛗 🗌 Unknown	mm/dd/yyyy	Inknown

**Please Note:** The Admission Date **cannot** occur <u>after</u> the Discharge Date. The Admission Date must occur on the **same date** or any date **BEFORE** the Discharge Date. If you enter an Admission Date that occurs after the Discharge Date and clicks **Next**, both fields are marked as invalid; the screen is grayed out and displays a pop-up message that states:

The date of hospital discharge cannot be earlier than the date of hospital admission.

To proceed, you must click **OK**, and enter a valid Discharge Date that occurs **on** or **after** the Admission Date.

COVID-19 CASE REPORT F	ORM			s	ection 7 of	10
There are errors. Please make a sele	ection for all requ	lired fields.		TALIZATION, ICU & DEATH MATION	×	
		ŀ		The date of hospital discharge cannot be		
Patient Information	0	Was the patient	8	earlier than the date of hospital admissio		
SARS CoV-2 Testing	$\odot$	Yes			ок	
Clinical Course	0				OK	
Applicable Symptoms	$\odot$	If hospitalized, w Yes	as a translat No	or required?* Unknown		
Medical Conditions	0	If yes, please spe	cify which la	nguage 🕢		



If hospitalized, please provide ad	mission and discharge dates:		
Admission Date*		Discharge Date*	
04/21/2021	🛗 🗌 Unknown	04/20/2021	🛗 🗌 Unknown
Invalid Admission Date		Invalid Discharge Date	

- 4. Select the **appropriate answer** for *Was the patient admitted to an intensive care unit (ICU)?*
- If *Yes* is selected, the subsequent ICU *Admission Date* and *Discharge Date* fields are enabled. Enter the **ICU Admission Date** and the **ICU Discharge Date**.

Yes No	Unknown		
f admitted to an ICU, please p	rovide admission and discharge dates:		
If admitted to an ICU, please p Admission Date	rovide admission and discharge dates:	Discharge Date	

- 5. Select the **appropriate answer** for *Did the patient die as a result of this illness?*
- If *Yes* is selected, the subsequent *Date of Death* field is enabled. Enter the **patient's date of death**.

Did the patier	it die as a resul	lt of this illness?*	
Yes	No	Unknown	
lf yes, please j	provide the dat	te of death:	
Date of Death			
mm/dd/yyyy	/		🗌 Unknown

6. Once complete, click **Next** to proceed to the **Vaccination History** screen.

Hospitalization, ICU & Death Information	If hospitalized, please provide admission and discharge dates:	04/22/2021
Vaccination History Additional Comments	Admission Date*     04/21/2021     Unknown	Discharge Date* 04/22/2021
Review & Submit	Was the patient admitted to an intensive care unit (ICU)?*     Yes No Unknown      If admitted to an ICU, please provide admission and discharge dates:     Admission Date     mm/dd/yyyy     Unknown	Discharge Date
	Did the patient die as a result of this illness?*          Yes       No       Unknown         If yes, please provide the date of death:         Date of Death       mm/dd/yyyy       Unknown	
	Save	Previous Next



## **15 Vaccination History**

1. On the **Vaccination History** screen, select the **appropriate answer** for the conditional question at the top: *Has the patient ever received a COVID-19 vaccine?* 

COVID-19 CASE REPORT FORM	Section 8 of 10	
Please provide the vaccination history of th	nt related to this case.	
	VACCINATION HISTORY	
Patient Information	Has the patient ever received a COVID-19 vaccine?*	
SARS CoV-2 Testing	Yes No Unknown	
Clinical Course		
Applicable Symptoms	If yes, please provide vaccine name/manufacturer:  Select	
Medical Conditions	If other, please specify; 😡	
Exposure Information		
Hospitalization, ICU & Death Information	Date Administered (1st dose) Date Administered (2nd dose)	
Vaccination History	mm/dd/yyyy 📋 🗌 Unknown mm/dd/yyyy 📺 🗌 Unknown	
Additional Comments		
Review & Submit		
	Save Previous Next	

• If *Yes* is selected for the conditional question, the subsequent fields on the screen are enabled.

VACCINATION HISTORY								
Patient Information	$\odot$	Has the patient ever received a COVID-19 vaccine?*						
SARS CoV-2 Testing	$\odot$	Yes No Unknown						
Clinical Course	$\odot$							
Applicable Symptoms	0	If yes, please provide vaccine name/manufacturer:* 🚱 Select						
Medical Conditions	$\oslash$	If other, please specify: 🕑						
Exposure Information	0							
Hospitalization, ICU & Death Information	$\odot$	Date Administered (1st dose)* Date Administered (2nd dose)						
Vaccination History		mm/dd/yyyy 🌐 🗋 Unknown mm/dd/yyyy 🛗 🗋 Unknown						
Additional Comments	-							
Review & Submit	<b>A</b>							

Please Note: If *No* or *Unknown* is selected for the conditional question, all subsequent fields are disabled.





2. If **Yes** is selected for the conditional question, the subsequent field is enabled. From the dropdown menu, select the **appropriate vaccine**: *If yes, please provide vaccine name/manufacturer*.

Has the patient ever received a COVID-19 vaccine?*         Yes       No         Unknown       Please select 'Other' if the name of vaccine is not listed in the dropdown         f yes, please provide vaccine name/manufacturer:*       Image: Comparison of the provide vaccine name/manufacture:*						
Select	~					
Moderna COVID-19 Vaccine						
Pfizer COVID-19 Vaccine						
Janssen COVID-19 Vaccine (Johnson and Johnson)						
Other						

• If *Other* is selected, the subsequent field is enabled. Enter the **name of the vaccine** in the textbox: *If yes, please specify*.

×   ~

- 3. In the field for *Date Administered (1<sup>st</sup> Dose)*, enter the **date the first dose was administered**.
- 4. If applicable, enter the **date the second dose was administered** in the field: *Date Administered* (2<sup>nd</sup> Dose).

	Date Administered (1st dose)*					e)*		Date Administered (2nd dose)				
	mm/dd/yyyy							🛗 🗌 Unknown		mm/dd/yyyy		🛗 🗌 Unknown
	4	Jun	Jur	ne 20 ~	<b>21</b>	1 🕶						
i	Su	Мо	Tu	We	Th	Fr	Sa					
	30	31	1	2	3	4	5					
	6	7	8	9	10	11	12					
	13	14	15	16	17	18	19					
	20	21	22	23	24	25	26				Previous	Next
	27	28	29		1	2	3					





<b>Please Note:</b> The Date Administered (1 <sup>st</sup> dose) <u>cannot</u> occur <u>after</u> the Date Administered (2 <sup>nd</sup> dose). The Date Administered (1 <sup>st</sup> dose) must occur at least 21 days <b>BEFORE</b> the Date Administered (2 <sup>nd</sup> dose), depending on the vaccine.								
						ered (2 <sup>nd</sup> dose) and s a pop-up message		
The administration	date o	f second dose	cannot be e	arlier than a	administration dat	te of 1 <sup>st</sup> dose.		
To proceed, the clic Administered (1 <sup>st</sup> d		then enter a v	alid Date Ad	ministered	(2 <sup>nd</sup> dose) that oc	curs <b>after</b> the Date		
There are errors. Please make a selection		d fields. VACCII	NATION HISTORY The administration date earlier than administrat	e of second dose canno	× the			
Patient Information	0	Has the patient e			ок			
SARS CoV-2 Testing	0							
Clinical Course Applicable Symptoms	©	If yes, please provide vaccine Pfizer COVID-19 Vaccine	name/manufacturer:* 🗲	)				
Medical Conditions	$\odot$	If other, please specify: 🚱						
Exposure Information	$\odot$							
Hospitalization, ICU & Death Information	$\odot$	Date Administered (1st dose			Date Administered (2nd dose)			
Vaccination History	⊘	05/30/2021 Invalid Date Administered (1st dose		Jnknown	05/21/2021 Invalid Date Administered (2nd dose)	Unknown		
Date Administered (1st dos	e)*			Date Administe	red (2nd dose)			
05/30/2021		🛗 🗌 Unkno	own	05/21/2021		🛗 🗌 Unknown		
Invalid Date Administered (1st dos	e)			Invalid Date Admini	istered (2nd dose)			

5. Once complete, click **Next** to proceed to the **Additional Comments** screen.

		VACCINATION HISTORY	
Patient Information	$\otimes$	Has the patient ever received a COVID-19 vaccine?*	
SARS CoV-2 Testing	$\odot$	Yes No Unknown	
Clinical Course	$\odot$	· · · · · · · · · · · · · · · · · · ·	
Applicable Symptoms	$\odot$	If yes, please provide vaccine name/manufacturer:* 🚱 Pfizer COVID-19 Vaccine	×   ~
Medical Conditions	$\otimes$	If other, please specify: 😡	
Exposure Information	$\otimes$		
Hospitalization, ICU & Death Information	$\otimes$	Date Administered (1st dose)* Date Administered (2nd dose)	
Vaccination History	$\otimes$	05/30/2021 💼 Unknown 06/21/2021 💼 Unknown	
Additional Comments	$\odot$		
Review & Submit			
		Save Previous Next	



### **16 Additional Comments**

- 1. On the Additional Comments screen, if applicable, enter additional notes about the patient.
- 2. Once complete, click Next to proceed to the **Review & Submit** screen.

COVID-19 CASE REPORT FORM		Section 9 of 10
Please add any additional comments related	d to this	case.
		ADDITIONAL COMMENTS
Patient Information	$\oslash$	Additional comments or notes, please specify:
SARS CoV-2 Testing	$\odot$	
Clinical Course	$\odot$	
Applicable Symptoms	$\otimes$	
Medical Conditions	$\otimes$	
Exposure Information	$\otimes$	0/1000 Characters
Hospitalization, ICU & Death Information	$\otimes$	
Vaccination History	$\oslash$	
Additional Comments		
Review & Submit		
		Save Previous Next

#### 17 Review & Submit

The **Review & Submit** screen displays a summary of the information you've entered. Prior to submitting the case report, review the information on this screen to verify its accuracy. You must click **Submit** in order to submit the case report.

#### **Print or Download Functionality**

1. Click **Print** to print the case report.

COVID-19 CASE REPORT FORM			Section 10 of 10		
Please review your information before submitting.					
		RE	VIEW & SUBMIT		
Patient Information	0				2
SARS CoV-2 Testing	0				Print 🛃 Download
Clinical Course	0	Patient Information			٥
Applicable Symptoms	Ø				
Medical Conditions	0	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center		
Exposure Information	0	Patient ID (MRN) SR04011960	Prefix Miss		
Hospitalization, ICU & Death Information	0	First Name	Last Name		
Vaccination History	$\odot$	Susan Date of Birth	Ross		
Additional Comments	${}^{\oslash}$	04/01/1960			
Review & Submit		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White	
		Address 1 123 First Street			



• Upon clicking **Print**, a Print Preview will display. Click **Print** to print the case report.

COVID-19 CASE REPORT F	Patient Information		Destination	SecurePrintUS	*		
Please review your information before	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com) Affiliation/Organization		Pages	All	Ŧ		
-	Test Medical Center						
	Patient ID (MRN) SR04011960	Prefix Miss	Copies	1			
Patient Information	First Name Susan	Last Name Ross	Color	Color	_		
SARS CoV-2 Testing	Date of Birth 04/01/1960		Color	Color	*	Print	🛃 Download
SARS COV-2 Testing	Patient Sex Female	Ethnicity Not Hispanic or Latino					
Clinical Course	Race White		More settings		~		0
Applicable Symptoms	Address 1 123 First Street						
Medical Conditions	City Lexington	State KY					
Exposure Information	Zip Code 40321						
	County Fayette	Phone (555) 321-0123					
Hospitalization, ICU & Death Informat	Email patient1@email.com						
Vaccination History	Was this person a U.S. case? Yes						
Additional Comments	Where was the patient residing at the time of House/single family home	illness onset?					
Review & Submit	Is the patient a healthcare worker in the Unite Yes	ed States?					
	If yes, what is the patient's occupation/job typ Nurse	se?					
G	If yes, what is the patient's job setting? Hospital						
	Is patient currently pregnant?						
G							
G	Sars CoV-2 Testing						
	Does the patient have a lab test? Yes			Print	Cancel		
	res		 *				

2. Click **Download** to download a PDF version of the case report.

		RE	VIEW & SUBMIT			
Patient Information	0				_	
SARS CoV-2 Testing	0				Print	Download
Clinical Course	0	Patient Information				۵
Applicable Symptoms	0					
Medical Conditions	$\odot$	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center			
Exposure Information	0	Patient ID (MRN) SR04011960	Prefix Miss			
Hospitalization, ICU & Death Information	0	First Name	Last Name			
Vaccination History	$\odot$	Susan Date of Birth	Ross			
Additional Comments	0	04/01/1960				
Review & Submit	j	Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White		

- Once the download is complete, a pop-up will display. Click **OK** to close out of the pop-up.
- To view the downloaded case report, click the **PDF icon** at the bottom left.

Clinical Course	0	Patient Information				۵
Applicable Symptoms	0					
Medical Conditions	0	Interviewer Name Dr. jerry Seinfeld. Sr (jerry@	Download PDF	×		
Exposure Information	0	Patient ID (MRN) SR04011960	Downloaded successfully			
Hospitalization, ICU & Death Information	Hospitalization, ICU & Death Information					
Vaccination History	0	Susan	OK			
Additional Comments	0	Date of Birth 04/01/1960				
Review & Submit		Patient Sex Female		Ethnicity Not Hispanic or Latino	Race White	
		Address 1 123 First Street				
		City Lexington		State KY	Zip Code 40321	
		County Fayette		Phone (555) 321-0123	Email patient1@email.com	
		Was this person a U.S. case Yes	?			
		Where was the patient resid	ding at the time of illness onset?			
OVID-19 Case Repdf						Show all X



- A PDF of the case report will display in a separate tab. Click the **Download Icon** at the top right to download a PDF version of the case report to your computer.
- 3. Review the information.

📓 Welcome to Kentucky Online Gal X 📙 KHIE Portal X 🤤 COVID-19 Case Report Form.pdf X +	F		o – ø ×
← → C ① File   C:/Users, /Downloads/COVID-19%20Case%20Report%20Form.pdf			🖈 💶 🗵 🛛 🏂 💽 Paused) 🗄
COVID-19 Case Report Form.pdf	1 / 6   - 100% +   🗄 🛇		± ē :
Image: Section of the section of th	Patient Information Interviewer Name Dr. Jerry Seinfläg, GrienryBenall.com) Affiliation/Organization Its: Medical Centerie Patient D (HRN) StradD1140 Date of Birth Ov40/21/5960 Patient Sex Female Race	Prefix Miss Last Name Ross Ethnicity Not Hispanic or Latino	

4. Review the Patient Information section.

SARS CoV-2 Testing	Ø				Print	1
Clinical Course	0	Patient Information				
Applicable Symptoms	0	Fatert Invitious				
Medical Conditions	0	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center			
Exposure Information	0	Patient ID (MRN) SR04011960	Prefix Miss			
Hospitalization, ICU & Death Information	0	First Name	Last Name			
Vaccination History	0	Susan Date of Birth	Ross			
Additional Comments	0	04/01/1960				
Review & Submit		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White		
		Address 1 123 First Street		000003		
		City Lexington	State KY	<b>Zip Code</b> 40321		
		County Fayette	Phone (555) 321-0123	Email patient1@email.com		
		Was this person a U.S. case? Yes				
		Where was the patient residing at the time of illness onset? House/single family home				
		Is the patient a healthcare worker in the United States? Yes				
		If yes, what is the patient's occupation/job type? Nurse				
		If yes, what is the patient's job setting? Hospital				
		Is patient currently pregnant? No				

• Click the **caret icon** on any section header to hide or display the details for that section.

Patient Information			۵
<b>Interviewer Name</b> Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center		
Patient ID (MRN) SR04011960	<b>Prefix</b> Miss		
First Name Susan	Last Name Ross		
Date of Birth 04/01/1960			
Patient Sex Female	<b>Ethnicity</b> Not Hispanic or Latino	Race White	



Patient Information	۲
Sars CoV-2 Testing	۵
Does the patient have a lab test? Yes	

5. Review the Sars CoV-2 Testing section.

Sars CoV-2 Testing		
Does the patient have a lab test? Yes		
Molecular Amplification Test (RT PCR)		
Test Name SARS coronavirus 2 E gene [Cycle Threshold #] in Unspecified specimen by NAA with probe detection	Test Result Negative	Filler Order/Accession Number SR03012021
Serologic Test		
Test Name SARS coronavirus 2 Ab [Interpretation] in Serum or Plasma	Test Result Undetermined/Inconclusive	Filler Order/Accession Number SR03302021
Antigen Test		
Test Name BinaxNOW COVID Test Kit	Test Result Positive	Filler Order/Accession Number SR05082021
BinaxNOW COVID Test Kit	Pending	SR06222021

6. Review the *Clinical Course* section.

<u>Clinical Course</u>	0
Disease/Organism COVID-19	
Did the patient develop pneumonia? Yes	
Did the patient receive mechanical ventilation(MV)/intubation? Yes	
If yes, total days with MV (# of days): 1-15 Days	
Did the patient have an abnormal chest X-ray? Unknown	
Did the patient have another diagnosis/etiology for their illness? No	
Did the patient have acute respiratory distress syndrome? Unknown	
Did the patient have an abnormal EKG? No EKG Done	
Did the patient receive ECMO? No	





7. Review the *Applicable Symptoms* section.

Applicable Symptoms	۵
Were symptoms present during the course of illness? Yes	
Onset Date 06/10/2021	
Did the patient's symptoms resolve? No	
If symptomatic, which of the following did the patient experience during their illness?	
Fever Yes	
Subjective fever (felt feverish) Yes	
Chills Yes	
Rigors No	
Muscle aches (myalgia) No	
Runny nose (rhinorrhea) No	
Sore throat No	
New olfactory and taste disorder(s) No	
Headache Yes	
Fatigue Yes	
Cough (new onset or worsening of chronic cough) Yes	
Wheezing Yes	
Shortness of breath (dyspnea) Yes	
Chest pain No	
	-





8. Review the *Medical Conditions* section.

Medical Conditions	٥
Did the patient have any underlying medical conditions and/or risk behaviors? Yes	
If yes, which one of the following underlying medical conditions and/or risk behaviors applies to the patient?	
Diabetes Mellitus No	
Hypertension No	
Severe obesity (BMI>40) No	
Cardiovascular disease No	
Chronic renal disease Unknown	
Chronic liver disease Unknown	
Chronic lung disease (asthma/emphysema/COPD) No	
Immunosuppressive condition No	
Autoimmune condition No	
Current smoker No	
Former smoker Unknown	
Substance abuse or misuse Unknown	
Disability (neurologic, neurodevelopemental, intellectual, physical, vision or hearing impairment) Yes	
l <b>f yes, please specify:</b> Hearing Impairment	
Psychological/psychiatric condition No	-
Other chronic diseases No	2





9. Review the *Exposure Information* section.

Exposure Information	
In the 14 days prior to illness onset, did the patient have any of the following exposun : Yes	
Tes Domestic travel (outside state of normal residence) Yes	
If yes, please specify states: CA , AR , NV	
International Travel Yes	
If yes, please specify country(s): BAHAMAS. THE , CANADA	
Cruise ship or vessel travel as passenger or crew member No	
Is the workplace critical Infrastructure (e.g. healthcare setting, grocery store) Yes	
If yes, please specify workplace setting: Hospital	
Airport/airplane Yes	
If yes, please specify airline(s): Delta	
Adult congregate living facility (nursing, assisted living or long-term care facility) No	
School/university/childcare center No	
Correctional facility No	
Community event/mass gathering No	
Animal with confirmed or suspected COVID-19 No	
Contact with a known COVID-19 case (probable or confirmed) Yes	
If yes, please specify what type of contact? Healthcare-associated (patient, visitor, healthcare worker), Community-associated	

10. Review the Hospitalization, ICU & Death Information section.

Hospitalization, ICU & Death Information		٥
Was the patient hospitalized? Yes		
If hospitalized, was a translator required? No		
If hospitalized, please provide admission and discharge dates:		
Admission Date 04/21/2021	Discharge Date 04/22/2021	
Was the patient admitted to an intensive care unit (ICU)? No		
Did the patient die as a result of this illness? No		





11. Review the *Vaccination History* section.

Vaccination History		G
Has the patient ever received a COVID-19 vaccine? Yes		
If yes, please provide vaccine name/manufacturer: Pfizer COVID-19 Vaccine		
Date Administered (1st dose) 05/30/2021	Date Administered (2nd dose) 06/21/2021	

12. Review the Additional Comments section.

Additional Comments			۵	
Additional comments or notes, please specify: Patient Notes				\$
	Previous	Submit		

#### **Click Hyperlinks to Edit**

- 13. If after reviewing, changes are required, click the corresponding **section header hyperlink** or the **side navigation bar tab** to navigate to the appropriate screen or section to edit the information.
- Click the **section header hyperlink** or the **side navigation bar tab** to navigate to the intended page. For example, to navigate to the **Patient Information** screen, click the **Patient Information hyperlink** in the section header or on the side navigation bar.

		RE	VIEW & SUBMIT			
Patient Information	0				_	
SARS CoV-2 Testing	Ø				📑 Print	Downloa
Clinical Course	0	Patient Information				۵
Applicable Symptoms	$\odot$	rateremoniation				•
Medical Conditions	Ø	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center			
Exposure Information	0	Patient ID (MRN) SR04011960	Prefix Miss			
Hospitalization, ICU & Death Information	0	First Name	Last Name			
Vaccination History	0	Susan	Ross			
Additional Comments	Ø	Date of Birth 04/01/1960				
Review & Submit		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White		
		Address 1 123 First Street				



14. Once the appropriate edits have been made, click the **Review & Submit** tab on the side navigation bar to navigate back to the **Review & Submit** screen.

		PATIENT INF	ORMATION	
Patient Information	Ø	Interviewer Name*	Affiliation/Organization*	
SARS CoV-2 Testing	$\otimes$	Dr. Jerry Seinfeld, Sr (jerry@email.c $~\times~~ ~~\vee~$	Test Medical Center	×   ~
Clinical Course	$\odot$			
Applicable Symptoms	Ø	Patient ID (MRN)* Ø SR04011960	Prefix Select	
Medical Conditions	$\oslash$	First Name*	Middle Name	Last Name*
Exposure Information	$\otimes$	Susan	Anne	Ross
Hospitalization, ICU & Death Information	$\otimes$	Suffix	Date of Birth*	
Vaccination History	$\otimes$	Select 🗸	04/01/1960	
Additional Comments	0	Patient Sex* Female ×   ~	Ethnicity*           Not Hispanic or Latino         ×         ~	Race*       White     ×
Review & Submit	_			
		Address 1*	Address 2	

15. The *Save Changes* pop-up displays. To save the edits and navigate back to the **Review & Submit** screen, click **Yes – Save**. To discard the edits, click **No – Discard**.

			PATIENT INF	ORMATION			
Patient Information	ø	Interviewer Name*		Affiliation/Organization*			
SARS CoV-2 Testing	Ø	Dr. Jerry Seinfeld, Sr (jer	ry@email.c ×   ~	Test Medical Center	_		
Clinical Course	$\odot$	Patient ID (MRN)	e Changes?		×		
Applicable Symptoms	ø	SP04011960	s information on this scr	een that has not been saved.	~		
Medical Conditions	$\odot$	Do you First Name*	u want to save it?			Last Name*	
Exposure Information	Ø	Susan	N	o - Discard Yes - Save		Ross	
Hospitalization, ICU & Death Information	$\odot$	Suffix			•		
Vaccination History	$\odot$	Select		04/01/1960			

16. Review your edits on the **Review & Submit** screen.

		REVIEW	& SUBMIT			
Patient Information	0					-
SARS CoV-2 Testing	0				Print	Download
Clinical Course	$\odot$	Patient Information				•
Applicable Symptoms	0	ratent monnation				
Medical Conditions	$\odot$	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center			
Exposure Information	$\odot$	Patient ID (MRN) SR04011960	Prefix Miss			
Hospitalization, ICU & Death Information	$\odot$	First Name	Middle Name	Last Name		
Vaccination History	$\odot$	Susan Date of Birth	Anne	Ross		
Additional Comments	ø	04/01/1960				
Review & Submit		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White		

this information.



17. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the COVID-19 Case Report Entry.

Additional comments or notes, please specify: Patient Notes			
	Previous	Submit	*

• All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the COVID-19 Case Report or click **Submit** to submit the report.

vaccination	listory	
Has the patient	Case Report Entry ×	
Yes If yes, please pr Pfizer COVID-15 Date Administe 05/30/2021	All data submissions are final. Please ensure that your data is accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.	ite Administered (2nd dose) /21/2021
•		hould you later discover that you in the ePartnerViewer to report

18. Click **OK** to acknowledge the case report entry has been submitted successfully.

	Vaccination H	listory		0
	Has the patient Yes	Case Report Entry	×	
	<b>If yes, please pr</b> Pfizer COVID-19	Case Report Entry Saved Successfully		
	Date Administe 05/30/2021		ОК	ite Administered (2nd dose) /21/2021
<pre>c</pre>				
		when the case report entry Case Report Entry User Sum		been submitted successfully will <b>y</b> screen.

# Congratulations! You have submitted the COVID-19 Case Report using KHIE's Direct Data Entry Functionality.

Please visit the KHIE website at <u>https://khie.ky.gov/COVID-19/Pages/Electronic-Case-Reporting-.aspx</u> to access additional training resources and find information on reporting requirements from the Kentucky Department for Public Health.



## **18 Case Report User Entry Summary**

The **Case Report Entry User Summary** screen displays all submitted and in-progress case reports you have entered. By default, the **Case Report Entry User Summary** screen displays the case reports from the last updated date. You can use the Date Range buttons to do a custom search for previous case reports entered within the last 6 months.

KĤIE	ePar	tnerViev	ver				➡ Support	📢 Announcer	ments 😦 🌲 Alerts	2 Ø – *
Patient S	Search	Bookma	rked Patients		Event Notification	s 🟮	Lab Data	Entry -	Cas	e Report Entry 👻
😭 Home ゝ	Case Report Entry	User Summary								
			CASE R	EPORT	ENTRY	USER SUI	MMARY	/		
C LAST UPD	ATED DATE RAN	GE	Start Dat	e 06/24/2021	#	End [	Date 06/24/2021	i #		2 Retrieve Data
SHOWING 2 ITEMS									C REFRESH	APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN *	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	
			First	Back 1 Next	Last				Maximum	5 • entries per page

1. To retrieve case reports for a specific date range within the last 6 months, enter the appropriate **Start Date** and **End Date**.

			CASE R	EPORT	ENTRY	USER SU	MMARY	/		
LAST UPD	DATED DATE RAN	GE	Start Date	06/24/2021	曲	End [	Date 06/24/2021	曲		2 Retrieve Data
SHOWING 2 ITEMS				June 20	2021 🗸					T APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	30 31 1 2 6 7 8 9	3 4 5 🜩 10 11 12	DATE OF BIRTH	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	13         14         15         16           20         21         22         23           27         28         29         30	17 18 19 24 25 26 1 2 3	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	

2. Click **Retrieve** to generate the case reports.

			CASE R	EPORT	ENTRY	USER SUI	MMARY	/		
LAST UP	DATED DATE RAN	GE	Start Date	06/21/2021		End [	06/24/2021			$oldsymbol{\mathcal{C}}$ Retrieve Data
SHOWING 2 ITEMS									₽ REFRESH	T APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME	DATE OF BIRTH 🗘	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM



**Please Note:** The **Start Date** must be within the last six months from the current date. The following error message displays when Users search for a Start Date that occurred more than six months ago: Please select a Start Date that is within the last six months from today's date. To proceed, you must enter a Start Date that occurred within the last six months. CASE REPORT ENTRY USER SUMMARY LAST UPDATED DATE RANGE Start Date 12/03/2020 End Date 06/25/2021 益 C Retrieve Data CREFRESH TAPPLY FILTER 2 ITEMS PATIENT SEX AFFILIATION/OR LAST NAME 🗘 LAST UPDATED SUBMISSION DATE DATE OF BIRTH ¢ GANIZATION + PATIENT MRN + FIRST NAME + STATUS ACTIONS REPORT TYPE

Costanza

05/28/1960

Male

In Progress

06/25/2021 2:24

1:53 06/25/2021 1:53 PM

			Center							PM
	View	COVID-19	Test Medical Center	JD06201965	Jane	Doe	06/20/1965	Female	Complete	06/25/2021 1 PM

George

3. Click **Retrieve Data** to display the search results.

Test Medical

COVID-19

Continue

4. To search for a specific case report, click **Apply Filter**.

GC05281960

LAST UPD	ATED DATE RAN	GE	Start Date	06/21/2021	<b>#</b>	End E	06/24/2021	<b>#</b>		C Retrieve Data
HOWING BITEMS									CREFRESH	<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	
Continue	COVID-19	Test Medical Center	GC05281960	George	Costanza	05/28/1960	Male	In Progress	06/21/2021 3:04 PM	

 The Filter fields display. You can search by entering the *Report Type, Affiliation/Organization, Patient MRN, First Name, Last Name, Date of Birth, Patient Sex, Status, Last Updated Date,* and/or *Submission Date* in the corresponding Filter fields.

			CASE R	EPORT I	ENTRY	USER SUI	MMARY	/		
S LAST UPD	ATED DATE RAN	GE	Start Dat	e 06/21/2021		End D	06/24/2021	<b>#</b>		CRETRIEVE Data
SHOWING 3 ITEMS									C REFRES	H THIDE FILTER
ACTIONS	REPORT TYPE + Enter Report -	AFFILIATION/OR GANIZATION €nter Affiliatic	PATIENT MRN 🕈	FIRST NAME 🕈	LAST NAME 🕈	DATE OF BIRTH Enter Date Of Bir	All	STATUS 🕈 Enter Statu	All	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	





#### **Review Previously Submitted Case Reports**

6. To review a summary of a complete case report that has been previously submitted, click **View** located next to the appropriate case report.

			CASE R	EPORT I	ENTRY	USER SUI	MMARY	/		
LAST UPDATED DATE RANGE			Start Date	06/21/2021	<b>#</b>	End D	Date 06/24/2021	#		C Retrieve Data
SHOWING 3 ITEMS									C REFRESH	<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN ÷	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	
Continue	COVID-19	Test Medical Center	GC05281960	George	Costanza	05/28/1960	Male	In Progress	06/21/2021 3:04 PM	
			First	Back 1 Next	Last				Maximum	5 👻 entries per pa

- 7. The Case Report Details pop-up displays a summary of the previously submitted case report.
  - Click **Print** to print the case report.
  - Click **Download** to download a PDF version of the case report.
- 8. Click **OK** to close out of the pop-up.

KĤIE	Case Report Details		🕒 Print 🛃 D	ownload ×
Patient Se	Patient Information			Entry *
	<b>Interviewer Name</b> Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center		
	Patient ID (MRN) SR04011960	Prefix Miss		
LAST UPDA	First Name Susan	Middle Name Ann	Last Name Ross	Retrieve Data
SHOWING 3 ITEMS	Date of Birth 04/01/1960			PPLY FILTER
ACTIONS	Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White	SSION DATE
View	Address 1 123 First Street			2021 4:13 PM
Continue	City Lexington	State KY	<b>Zip Code</b> 40321	
Continue	County Fayette	Phone (555) 321-0123	Email patient1@email.com	
Continue	Was this person a U.S. case?			
				<b>OK</b> entries per page



#### **Continue In-Progress Case Reports**

The **Save** feature allows you to complete the case report in multiple sessions. That means you can start a case entry, save it, and then return later to complete it. You must save the information you entered in order to return to the section where you left off.

9. To continue working on a case report that is currently in-progress, click **Continue** located next to the appropriate case report.

					Luna anna anna anna					
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	
Continue	COVID-19	Test Medical Center	GC05281960	George	Costanza	05/28/1960	Male	In Progress	06/21/2021 3:04 PM	

10. Clicking **Continue** automatically navigates to the section of the case report where you left off.

COVID-19 CASE REPORT F	ORM		Section 4 of 10					
Please select applicable symptoms that the patient experienced during illness.								
APPLICABLE SYMPTOMS								
Patient Information	$\odot$	Were symptom:	s present dur	ing the course of illness?*				
SARS CoV-2 Testing	$\odot$	Yes	No	Unknown				
Clinical Course	0	Onset Date 😡						
Applicable Symptoms		mm/dd/yyyy		Unknown				

# **19 Technical Support**

#### **Toll-Free Telephone Support**

For questions and assistance regarding the ePartnerViewer, please call 1 (877) 651-2505.

#### **Email Support**

To submit questions or request support regarding the ePartnerViewer, please email KHIESupport@ky.gov.

