

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Electronic Case Reports: Child Hepatitis

User Guide

August 2022



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1 Introduction

Overview

This training manual covers KHIE's Direct Data Entry for Child Hepatitis 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 (elCR) 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:

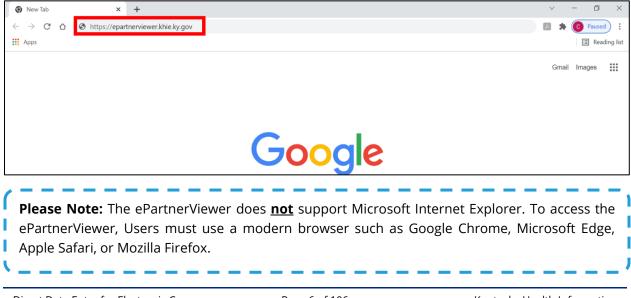
- 1. Users must be part of an organization with a signed Participation Agreement with KHIE.
- 2. Users are required to have a Kentucky Online Gateway (KOG) account.
- 3. Users are required to complete Multi-Factor Authentication (MFA).

Please Note: For specific information about creating a KOG account and how to complete MFA, please review the *ePartnerViewer Login: Kentucky Online Gateway (KOG) and Multi-Factor Authentication (MFA) Quick Reference Guide* on the KHIE website: <u>khie.ky.gov</u>

2 Logging into the ePartnerViewer

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

- 1. Before accessing the ePartnerViewer, you must log out from any active KOG session or ePartnerViewer session and close the browser window.
- 2. To navigate to the ePartnerViewer, enter the following URL in a supported browser window: https://epartnerviewer.khie.ky.gov







3. The **Welcome to the Kentucky Online Gateway** screen displays. To login to the ePartnerViewer, click **Sign In**.

MyKentucky.gov	FAQ Help Q English ¥
Welcome to the Kentucky Online Ga • Are you doing business in or with the Commonwealth of Kentucky? • Are you a citizen or resident applying for or receiving benefits? • Are you seeking government services from the Commonwealth? If you answered "Yes" to any one of these questions, please sign into your existing Kentucky Online Gateway account or click on the button below to create an account. SIGN IN CREATE ACCOUNT	teway State Employee Gateway Login Login to your State Employee account using: EMAIL ADDRESS
Please Note: If you are a State Employee, click Em <i>Gateway Login</i> section on the right side of the Wel	

- 4. The KOG Sign In screen displays. Enter your Email Address.
- 5. Enter your **Password**.
- 6. Click Sign In.

Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sign in With your Kentucky Online Gateway Account. Citizen (or) Business Partner Sign In Sig	<text><text><text></text></text></text>
Please Note: You must enter the email address a KOG account.	nd password provided when you created your

. . . .



7. **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.

N	Iulti-Factor Authentica	tion		
	MFA by Email Verification			
	Send Passcode			

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** screen displays. Privacy and security obligations are outlined for review.

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

KHIE ePartnerViewer	9 Jane Doe
TERMS AND CONDITIONS OF	USE
<section-header><section-header><section-header><section-header><list-item><list-item><list-item><list-item><list-item><list-item></list-item></list-item></list-item></list-item></list-item></list-item></section-header></section-header></section-header></section-header>	Access restricted beyond this point. You must accept terms and conditions before proceeding.
Please Note: The right side of the Portal is grayed out and displa Access is restricted beyond this point. You must accept the	



- 9. 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.)
- 10. Click **Proceed to Portal** to continue.

KHIE ePartnerViewer	Jane Doe
TERMS AND CONDITIONS OF	USE
 Determine and Conditions DEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS Laccept the following terms and conditions of the Kentucky Health Information Exchange (KHIE): 1 am a healthcare provider currently treating a patient. 1 am currently bound by a Health Information Exchange Participation 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. 1 understand that data available on KHIE is only that information available according to state and federal law. The Medicaid claims data will not include records of the following: HIV medical procedures and test. Diagnosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients. Lunderstand that all data available on KHIE WILL NOT include HIV medical procedures and tests, regardless of source. Select 'I accept' to accept the usage terms and conditions. 	You are part of the below mentioned organization. Please click on proceed to continue. KHIE Smoke Test Organization Proceed to Portal Cancel
Copyright 2019 HealthInteractive HEALTHINTERACTIVE HIE	Version; 1.0.0
Please Note: If you click Cancel , a pop-up notification displays the to be logged out. Use of the ePartnerViewer portal is subject to of Use. To proceed to the ePartnerViewer, click either Logout No	the acceptance of KHIE's Terms



3 Understanding the Case Report Entry Dropdown Menu

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

- **Case Report Forms**: Lists the different types of case reports.
- Case Report Entry User Summary: Displays all submitted and "In-Progress" case reports.
- Manage User Preferences: Offers an efficient way to enter repetitive data.

KĤIE	ePartnerViewer	Support 📢	Announcements 🕤 🌲 Adv	isories 3 😫 🔹
Patient Search	Bookmarked Patients	Event Notifications 1	Lab Data Entry 🔻	Case Report Entry -
Home				Case Report Forms
Announcement:	Have training needs? Go to the KHIE COACH	for assistance. It's located in the	e Resources section.	Case Report Entry User Summary
		•••		Manage User Preferences
myDASHBOARD				

- 1. Types of Case Reports:
- COVID-19 Case Report:
 - Designed for Users to enter COVID-19 case reports.

Please Note: For specific information about COVID-19 case reporting, please review the *Direct Data Entry for Electronic Case Reports: COVID-19 User Guide*.

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

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.*

_ _ _ _ _ _ _ _ _ _



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Perinatal Hepatitis Case Report:



 Designed for Users to enter Perinatal Hepatitis case reports. 					
	Please Note : For specific information about Perinatal Hepatitis case reporting, please review the <i>Direct Data Entry for Electronic Case Reports: Perinatal Hepatitis User Guide</i> .				
Child Hepatitis Case Report:					
 Designed for Users to enter Child Hepatitis case reports. 					
Other Reportable Conditions Case Report:					
 Designed for Users to enter Other Reportable Conditions case re 	ports.				
Please Note : For specific information about Other Reportable Condition review the <i>Direct Data Entry for Electronic Case Reports: Other Reguide</i> .					
KÊLE ePartnerViewer ^{Support}	Announcements 🔺 Advisories 🕦				
Patient Search Bookmarked Patients Event Notifications Lab Data Entr					
	ry ▼ Case Report Entry ▼				
Home	ry Case Report Entry Case Report Forms COVID-19				

QUICK SEARCH

First

Name

myDASHBOARD

Date Of

Birth

mm/dd/yyyy

Last

Name

Multi-drug Resistant Organism

Other Reportable Conditions

C Search

Perinatal Hepatitis

Child Hepatitis



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".

KĤIE	ePartnerViewer	⊻ Support	📢 Announcements 2 🔺 A	dvisories 1 💄 🔹	-	
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🔻	Case Report Entry -		
😭 Home				Case Report Forms	>	
Announcement: P	rovider Assistance Program deadline extens	ion		Case Report Entry User Summar	у	
		•••		Manage User Preferences	>	
myDASHBOARD						

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.

KĤIE	ePartnerViev	Ner 🖻 Support 📢 An	nouncei	ments 🔁 📫 A	dvisories 1 😌 🔹
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 Attend	ding Physician/Clinician Details
		myDASHBOARD		View & Edit A	ttending Physician/Clinician Details
QUICK SEARCH				Create Perso	n Completing Form Details
First	Last	Date Of	mm	View & Edit P	erson Completing Form Details
Name	Name	Birth		Create Order	ing Provider/Clinician Details
-				View & Edit O	rdering Provider/Clinician Details
BOOKMARKED PA	ATIENTS	EVENT NOTIFICATIONS	S (PAS	T 72 HOURS)	i



4 Manage User Preferences

These are your User Preferences. Prior to entering your Child Hepatitis case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen.

By entering these details here in your user preferences, you will be able to quickly select an Attending Physician/Clinician and the name of the Person Completing the Form from the dropdown menu options. These dropdown menus are located on the **Patient Information** screen of the Child Hepatitis Case Report.

Create Attending Physician/Clinician 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 ePar	tnerViewer	🖂 Support 🛛 📢 Announce	Support 📢 Announcements 🅽 🗍 Alerts 🕦 😜 🔹			
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 👻	Case Report Entry -		
A Home				Case Report Forms	>	
Announcement: eHealth Summi	t			Case Report Entry User Summary		
		•••		Manage User Preferences	>	
		myDASHBOARD				

3. To enter information about an Attending Physician/Clinician, select **Create Attending Physician/Clinician Details** from the dropdown menu.

KĤIE ePartne	erViewer		🔤 Support 📢 Ann	ouncements 🧿 🔺 Alerts 🚺 😫 🔹 👻
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry -
Home				Case Report Forms
Announcement: eHealth Summit				Case Report Entry User Summary
•				Manage User Preferences
				Create Interviewer Information Details
		myDASHBOARD		View & Edit Interviewer Information Details
QUICK SEARCH				Create Attending Physician/Clinician Details
				View & Edit Attending Physician/Clinician Details
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Create Person Completing Form Details
				View & Edit Person Completing Form Details
BOOKMARKED PATIENTS	0	EVENT NOTIFICATIONS	(PAST 72 HOURS)	ð



- 4. The **Attending Physician/Clinician** 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	e complete the form below to create an Att	tending Physician/Clinician. All fields marked with an asterisk(*) are	requirea.
		ATTENDING PHYSICIAN/CLINICIAN	
Prefix			
Dr. First M	× v	Last Name*	
Suffix			
Şele II	ct	Address 2	
III		Unit, Suite, Building, etc.	
IV		State*	Zip Code*
Jr		Select	
Sr		Email*	
(XXX)	() XXX-XXXX	name@domain.com	

6. Enter the Attending Physician/Clinician's **First Name** and **Last Name**.

Please complete the form below to create an A	ttending Physician/Clinician. All fields marked with an asterisk(*) are required.
	ATTENDING PHYSICIAN/CLINICIAN
Prefix Dr. × ~ First Name*	Last Name*
Suffix Sr X V	

7. Enter the Attending Physician/Clinician's **Address**, **City**, **State**, and **Zip Code**.

Address 1*	Address 2				
	Unit, Suite, Building, etc.				
City*	State*	Zip Code*			
	Select 🗸 🗸				



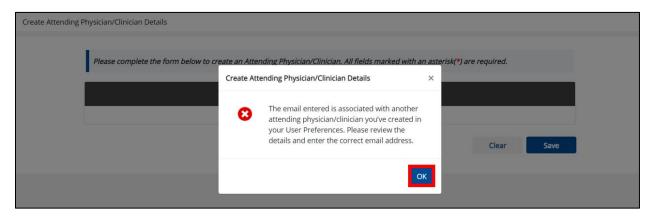
8. Enter the Attending Physician/Clinician's **Phone Number** and **Email Address**.

Phone* (XXX) XXX-XXXX	Email* name@domain.com
	ne <i>Phone</i> and <i>Email</i> fields is not entered in the s that prevents you from proceeding to the next

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

efix Dr. X V rst Name* Frank	Last Name* Costanza Address 2 1A	
rst Name* Frank Iffix Sr × ✓ Iddress 1* 1 First Street ty*	Costanza Address 2 1A	
Frank Iffix Sr X V Iddress 1* 1 First Street ty*	Costanza Address 2 1A	
uffix Sr × ↓ ✓ ddress 1* 1 First Street ty*	Address 2 1A	
Sr × ✓ Idress 1* 1 First Street	1A	
ddress 1* 1 First Street ty*	1A	
1 First Street	1A	
ty*		
-	Canada 71- 0	
-	State* Zip Co	ode*
0	KY × ~ 401	
none*	Email*	
(111) 111-1111	frank@email.com	
ase Note: If you enter an email address sician/Clinician and click Save , a pop-up d email entered is associated with anothe	isplays with an error message that state	es:
<i>ferences. Please review the details and en</i> must click OK and enter the correct emai		an/Clinicia
	ding Physician/Clinician Details scree	





10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.

Create Attending Ph	hysician/Clinician Details			
	Please complete the form below to cr	eate an Attending Physician/Clinician. All fields marked with	an aste	erisk(*) are required.
		Create Attending Physician/Clinician Details	×	
		Attending Physician/Clinician details saved successfully		
			ОК	Clear Save

View & Edit Attending Physician/Clinician Details

11. The **View & Edit Attending Physician/Clinician Details** screen displays. To edit details, click the **Edit** icon located next to the appropriate physician/clinician.

KÎLIE	ePartnerViewer	2 🖼	🛎 Support 📢 Announcements 👔 🌲 Alerts 👔 🤤		
Patient Search	Bookmarked Patients	Event Notifications Lab	Data Entry -	Case Report Entry -	
Home > View	& Edit Attending Physician/Clinician Details				
VIEW & E	DIT ATTENDING PHYSICIAN/CLINI	CIAN DETAILS			
SHOWING 2 ITEMS					
ACTIONS	NAME	EMAIL	PHONE NUMBER	÷	
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111		
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011		
	First Back	Next Last		Maximum 5 🕶 entries per page	



12. The *Update Attending Physician/Clinician 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 Sea	, arch Book	T Update Attending Physician/C	linician Details	×		Case Report Entry *
🖀 Home ゝ	View & Edit Attending Physician/Clinic	Prefix Dr. X V				
	& EDIT ATTENDING	First Name*	Last Name*			
		Frank	Costanza			
SHOWING 2 ITEMS		Suffix Sr × v				
ACTIONS	NAME	31			E NUMBER	\$
	_	Address 1*	Address 2			
	Dr. Frank Costanza, Sr	1 First Street	1A		111-1111	
	Ms. Helen Seinfeld	City*	State*	Zip Code*	789-1011	
		Lexington	кү 🛛 🕹 🗸	40123		
		Phone*	Email*			Maximum 5 👻 entries per page
		(111) 111-1111	frank@email.com			
			Cancel	Save		

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

SHOWING 2 ITEMS		Update Attending Physician/Clinician Details	×		
ACTIONS	NAME	Attending Physician/Clinician details updated successfully		¢	PHONE NUMBER
	Dr. Frank Costanza, Sr				(111) 111-1111
	Ms. Helen Seinfeld				(456) 789-1011

Delete Attending Physician/Clinician Details

14. To delete an Attending Physician/Clinician from the User Preferences, click the **Trash Bin Icon** located next to the appropriate Physician/Clinician.

Patient Sear	rch Bookmarked Pat	ients Event Notifications	Lab Data Entry	- Case Rep	ort Entry 👻	
Home 🗲 View & Edit Attending Physician/Clinician Details						
VIEW 8	EDIT ATTENDING PHYS	ICIAN/CLINICIAN DETAILS		₿ REFRESH	TAPPLY FILTE	
showing Z TEMS						
SHOWING 2 ITEMS						
SHOWING 2 ITEMS	NAME	• EMAIL	¢ PHON	IE NUMBER		
2 ITEMS	NAME Dr. Frank Costanza, Sr	EMAIL frank@email.com	- FROM	ie NUMBER 111-1111		



15. The *Delete Attending Physician/Clinician Information Details* pop-up displays. To delete the Physician/Clinician, click **OK**. Click **Cancel** if you do not want to delete the Physician/Clinician.

• VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS					CREFRESH TAPPLY FILTER		
SHOWING 1 ITEMS			Delete Attending Physician/Clinician	×			
ACTIONS	NAME			_	¢	PHONE NUMBER	\$
	Dr. Frank Costanza, Sr		Are you sure?			(111) 111-1111	
		Fin	Cancel				Maximum 5 👻 entries per page

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

If you attempt to delete an attending physician/clinician who has been selected for use in a case report that has not been completed yet, a pop-up notification will display the following message:

This attending physician/clinician information is being used in a case report that is still in progress. To delete this attending physician/clinician, please ensure that this attending physician/clinician is not being used in a case report that is in progress.

To close out of the pop-up and proceed, click **OK**.

To delete the Attending Physician/Clinician used in a case report that is still "In-Progress", you must first complete the case report.

Once the appropriate case report is complete, you can delete the Attending Physician/Clinician from your User Preferences.

SHOWING 2 ITEMS		Delete Atte	ending Physician/Clinician Details	×			
ACTIONS	NAME	0	This attending physician/clinician information is being used in one of the case reports that is		٥	PHONE NUMBER	+
	Ms. Helen Seinfeld		is being used in one of the case reports that is still in progress. To delete this attending physician/clinician, please ensure that this attending physician/clinician is not being used in any case report that is in progress.			(456) 789-1011	
	Dr. Frank Costanza, Sr					(111) 111-1111	





Filter Attending Physician/Clinician Details

16. To search for a specific Attending Physician/Clinician, click **Apply Filter**.

KĤIE	HIE ePartnerViewer			🔺 Alerts 🕦 😩 🔹			
Patient Search	Bookmarked Patients	Event Notifications Lat	o Data Entry -	Case Report Entry -			
🖀 Home 💙 View	Home > View & Edit Attending Physician/Clinician Details						
• VIEW & E	♥ VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS						
SHOWING 2 ITEMS	showing 2 ITEMS						
ACTIONS	NAME	EMAIL	PHONE NUMBER	+			
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111				
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011				
	First Back 1 Next Last Maximum 5 - entries per page						

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

KĤIE	Support 📢 Announcements 2 🔺 Alerts 1 🤤 🔹				
Patient Search	Bookmarked Patients	Event Notifications La	ib Data Entry • Case Report Entry •		
Home > View	& Edit Attending Physician/Clinician Details				
• VIEW & E	VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS				
SHOWING 2 ITEMS					
ACTIONS	NAME Enter NAME	EMAIL Enter EMAIL	PHONE NUMBER Enter PHONE NUMBER		
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111		
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011		
	First Back	1 Next Last	Maximum 5 🕶 entries per page		





Create Person Completing Form Details

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

KĤIE ePar	KHIE ePartnerViewer			ments 🔋 🌲 Alerts 🕦 😫 🔹
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 👻	Case Report Entry *
A Home				Case Report Forms
Announcement: eHealth Summit				Case Report Entry User Summary
•				Manage User Preferences
		myDASHBOARD		

3. To enter the details about the person completing the form, select **Create Person Completing Form Details** from the dropdown menu.

KHIE eParti	nerViewer		🔤 Support 📢 Announcements a 🔺 Alerts 1 🔒 🔹				
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry *			
A Home				Case Report Forms			
▲ Alert: !@#\$%^&*()_+~{}[]\`				Case Report Entry User Summary			
		•••		Manage User Preferences			
	Cre						
		myDASHBOARD		View & Edit Interviewer Information Details			
QUICK SEARCH				Create Attending Physician/Clinician Details			
				View & Edit Attending Physician/Clinician Details			
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Create Person Completing Form Details			
				View & Edit Person Completing Form Details			
BOOKMARKED PATIENTS	8	EVENT NOTIFICATIONS	(PAST 72 HOURS)	()			

- 4. The **Person Completing Form** 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 a P	Please complete the form below to create a Person Completing Form. All fields marked with an asterisk(*) are required.		
		PERSON COMPLETING FORM		
	Prefix Mr. × V			
	First Name*		Last Name*	
	Suffix þelect			
	и Ш		Address 2 Unit, Suite, Building, etc.	
	IV Ir		State*	Zip Code*
	Sr		Email*	
	(XXX) XXX-XXXX		name@domain.com	



6. Enter the **First Name** and **Last Name** of the Person completing the form.

First Name*	Last Name*	

7. Enter the Address, City, State, and Zip Code.

Address 1*	Address 2		
	Unit, Suite, Building, etc.		
City*	State*		Zip Code*
	Select	~	

8. Enter the Phone Number and Email Address.

Phone*	Email*
(XXX) XXX-XXXX	name@domain.com

Please Note: If the information entered in the *Phone* and *Email* fields is not entered in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

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

PERS	ON COMPLETING FORM		
Prefix			
Mr. × ·			
First Name*	Last Name*		
Arthur	Vandelay		
Suffix			
Ⅱ × ~			
Address 1*	Address 2		
22 Second Avenue	Unit, Suite, Building, etc		
City*	State*		Zip Code*
Lexington	KY	× ~	40222-
Phone*	Email*		
(222) 222-2222	arthur@email.com		
			Clear Save





Please Note: If you enter an email address that is already associated with another Person Completing Form and click **Save**, a pop-up displays with an error message that states:

- *The email entered is associated with another person you've created in your User Preferences. Please review the details and enter the correct email address.*
- You must click **OK** and enter the correct email address to save the Person Completing Form
 details and proceed to the **View & Edit Person Completing Form Details** screen.

Please complete the form below to create a Person Completing Form. All fields marked with an ast	erisk(*) a	are required.	
Create Person Completing Form Details	×		
The email entered is associated with another person you've created in your User Preferences. Please review the details and			
enter the correct email address.		Clear	Save
	рК		

10. The *Create Person Completing Form Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Person Completing Form Details** screen.

Please complete the form below to c	reate a Person Completing Form. All fields marked with a	n asterisk(*) are requii	red.	
	Create Person Completing Form Details	×			
	Person Completing Form details saved successfully				
		ОК		Clear	Save





View & Edit Person Completing Form Details

11. The **View & Edit Person Completing Form Details** screen displays. To edit details, click the **Edit** icon located next to the appropriate person.

Home > View 8	k Edit Person Completing Form Details		
• VIEW & EI	DIT PERSON COMPLETING FORM	DETAILS	CREFRESH TAPPLY FILTER
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL \$	PHONE NUMBER \$
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
	First Back	Next Last	Maximum 5 👻 entries per page

12. The *Update Person Completing Form Details* pop-up displays. You can make any necessary edits and click **Save** to save the updates and close out of the pop-up.

KHIE ePartnerViev	ver	2	🖾 Support 🛛 🖷	a Announcements 2	🌲 Alerts 🚹	9	
Patient Search Bookr	Update Person Completing Form D	etails	×		Case Rep	oort Entry -	
Home > View & Edit Person Completing Form D	Prefix Mr. × V						
• VIEW & EDIT PERSON COM	First Name* Arthur	Last Name* Vandelay			C REFRESH	T APPLY FILTE	R
SHOWING 2 ITEMS	Suffix II × ·						
ACTIONS NAME				IE NUMBER			\$
Mr. Arthur Vandelay, II	Address 1* 22 Second Avenue	Address 2 Unit, Suite, Building, etc.		222-2222			
Dr. Estelle Costanza	City* Lexington	State* Z	Zip Code* 40222	123-1111			
	Phone* (222) 222-2222	Emaii* arthur@email.com			Maximum 5	 entries per p 	age
		Cancel	Save				

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

• VIEW &	EDIT PERSON COMP	LETING FORM DETAILS	CREFRESH TAPPLY FILTER
SHOWING 2 ITEMS		Update Person Completing Form Details ×	
ACTIONS	NAME	Person Completing Form details updated successfully PHONE NUMB	ER ÷
	Mr. Arthur Vandelay, II	(222) 222-222:	
	Dr. Estelle Costanza	(111) 123-1111	
		First Back 1 Next Last	Maximum 5 👻 entries per page





Delete Person Completing the Form Details

14. To delete someone from the User Preferences, click the **Trash Bin Icon** located next to the appropriate person.

• VIEW & ED	DIT PERSON COMPLETING FORM	DETAILS	CREFRESH TAPPLY FILTER
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL \$	PHONE NUMBER \$
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

15. The *Person Completing Form Details* pop-up displays. To delete, click **OK**. Click **Cancel** if you do not want to delete the person completing the form.

• VIEW & E	DIT PERSON COMPLETING	FORM DETAILS			REFRESH APPLY FILTER
SHOWING 2 ITEMS		Delete Person Completing Form Details	×		
ACTIONS	NAME	Are you sure?	•	PHONE NUMBER	\$
	Mr. Arthur Vandelay, II			(222) 222-2222	
	Dr. Estelle Costanza	Cancel OK		(111) 123-1111	

Please Note: You can delete a person on the **View & Edit Person Completing Form Details** screen as long as that person has not been selected for use in a case report that is still in-progress.

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

This person completing form information is being used in a case report that is still in progress. To delete this person, please ensure that this person is not being used in any case report that is progress.

To close out of the pop-up and proceed, click **OK**.

To delete the details of a person used in a case report that is still "In-Progress", you must first complete the case report. Once the appropriate case report is complete, you can delete the Person Completing Form details from your User Preferences.

SHOWING 2 ITEMS		Delete Pe	rson Completing Form Details	×			
ACTIONS	NAME	0	This person information is being used in one		÷	PHONE NUMBER	٠
	Mr. Arthur Vandelay, Il	Ű	of the case reports that is still in progress. To delete this person, please ensure that this person is not being used in any case report			(222) 222-2222	
	Dr. Estelle Costanza		that is in progress.			(111) 123-1111	
	F	ir		ж			Maximum 5 🕶 entries per page

Direct Data Entry for Electronic Case Reports: Child Hepatitis Kentucky Health Information Exchange





Filter Person Creating Form Details

16. To search for a specific person in the User Preferences, click **Apply Filter**.

Patient Searc	ch Bookmarked Patients	Event Notifications	Lab Data Entry - Case Report Entry	y≁
Home > Vie	ew & Edit Person Completing Form Details			
VIEW &	EDIT PERSON COMPLETING F			PLY FILT
VIEVVQ	EDIT PERSON COMPLETING	-ORIVI DETAILS		
	EDIT PERSON COMPLETING P	-ORIVI DETAILS		
	EDIT PERSON COMPLETING F			
HOWING			PHONE NUMBER	
HOWING ITEMS				

17. The Filter fields display. You can search by entering the *Name*, *Phone Number*, and/or *Email Address* of the person completing the form in the corresponding Filter fields.

Ø VIEW & E	DIT PERSON COMPLETING FORM	DETAILS	
SHOWING 2 ITEMS			
ACTIONS	NAME Enter Name 🗢	EMAIL Enter Email 🕈	PHONE NUMBER Enter Phone Number
	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	First Back	Next Last	Maximum 5 🗸 entries per page



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 located in the **Side Navigation Bar** provide users the ability to go to the different screens within a Case Report. You can also use the pagination buttons to move to the next screen or to any previous 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 the next screen.

			MED	ICAL COND	ITIONS		
ient Information	⊘	Did the patient	t have any und	erlying medical	conditions and/or ri	isk behaviors?*	
ooratory Information	⊘	Yes	No	Unknown			
licable Symptoms	⊘						
dical Conditions		Substance abu	lse or misuse	Unknown			
osure Information	A	lf yes, please s	pecify the subs	stance that was	abused or misused:	0	
italization, ICU & Death mation	•						
nation History	A						
onal Comments							
ew & Submit							





Save Feature

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

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

Save	Next	

- 2. If you click on a previously completed screen on the side navigation bar, the *Save Changes* popup 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.

Clinical Course	0	Patient ID (MRN)	Save Changes? ×		
Applicable Symptoms	\odot	SR04011960	There's information on this screen that has not been saved.	~]	
Medical Conditions	\odot	First Name*	Do you want to save it?		Last Name*
Exposure Information	\odot	Susan	No - Discard Yes - Save		Ross
Hospitalization, ICU & Death Information	\odot	Suffix			

Case Report Entry Icons

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

Icon Descriptions:

lcon	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 Next 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 Child Hepatitis 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. These conditional questions are found on the **Laboratory Information**, **Hospitalization**, **ICU & Death Information**, and **Vaccination History** screens.

Please Note: The **Vaccination History** screen is disabled and does not collect vaccine information when *Child Hepatitis C* is selected as the Disease/Organism. The **Vaccination History** screen is enabled and collects information only when *Child Hepatitis B* is selected.

 For example, if you select *No* to the conditional question at the top of the Laboratory Information screen of the Child Hepatitis Case Report, the subsequent fields will be grayed out and disabled.

HILD HEPATITIS CASE R		Section 2 of 7				
Please provide laboratory inform	nation relate	rd to this case.				
		LABORATORY INFORMATION				
Patient Information	0	Does the patient have a lab test?*				
Laboratory Information		Yes No				
Exposure Information		If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin,				
Hospitalization, ICU & Death Information	A	please ensure you complete all fields for that test.				
Vaccination History	A	Hepatitis Marker				
Additional Comments	۵	Select 🗸				
Review & Submit	A	If other, please specify:				
		Select V If applicable, please enter the viral load: Test Result Date Specimen Collection Date				
		mm/dd/yyyy 🛍 🗌 Unknown mm/dd/yyyy 🛗 🗌 Unknown				
		C Add Hepatitis Marker				
		ALT				
		G Add ALT				
		AST				
		🔂 Add AST				



• If you select *Yes* to the conditional question at the top of the **Laboratory Information** screen, the subsequent laboratory-related fields are enabled.

		LABORATORY INFORMATION
Patient Information	Ø	Does the patient have a lab test?*
Laboratory Information		Yes No
Exposure Information	a	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin,
Hospitalization, ICU & Death Information		please ensure you complete all fields for that test.
Vaccination History	a	Hepatitis Marker*
Additional Comments	a	Select 🗸
Review & Submit	a	If other, please specify:
		Results* Select If applicable, please enter the viral load: Test Result Date Specimen Collection Date*
		mm/dd/yyyy Unknown Mm/dd/yyyy
		Laboratory Name:*
		C Add Hepatitis Marker
		ALT
		G Add ALT
		AST
		G Add AST
		Bilirubin
		Add Bilirubin
		Save Previous Next



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. This type of conditional question is found on the **Exposure Information** screen.

• For example, if you select *No* to the conditional question at the top of the **Exposure Information** screen, the subsequent exposure-related fields will be disabled and labeled as *No*.

CHILD HEPATITIS CASE R	EPORT F	ORM		Section 3 of 7	
Please select the information that	t the patien	was exposed to prior to illn	ess.		
	EXPOSURE INFORMATION				
Patient Information	Ø	Did the patient have any	of the following exposures in	the past 6 months?*	
Laboratory Information	\otimes	Yes No	Unknown		
Exposure Information		Mother Hepatitis B Virus	nositive		
Hospitalization, ICU & Death Information		Yes No			
Vaccination History	a	Mother Hepatitis C Virus			
Additional Comments	a		Unknown		
Review & Submit	A	HBV Contact Exposure Yes No	Unknown		
		HCV Contact Exposure Yes No	Unknown		
		Foreign Born Yes No			
		If yes, please specify cou	ntry: 🕲		
		Is this part of an outbrea	ik?*		
		Yes No	Unknown		
			name of the outbreak: 🕜		

• If you select *Unknown* to the conditional question at the top of **Exposure Information** screen, the subsequent exposure-related fields will be disabled and labeled as *Unknown*.

		EXPOSURE INFORMATION
Patient Information	Ø	Did the patient have any of the following exposures in the past 6 months?*
Laboratory Information	\odot	Yes No Unknown
Exposure Information		
Hospitalization, ICU & Death Information		Mother Hepatitis B Virus positive Yes No Unknown
Vaccination History		Mother Hepatitis C Virus positive Yes No Unknown
Additional Comments		Yes No Unknown
Review & Submit		HBV Contact Exposure Yes No Unknown
		HCV Contact Exposure
		Yes No Unknown
		Foreign Born
		Yes No Unknown





• If you select *Yes* to the conditional question at the top of the **Exposure Information** screen, the subsequent exposure-related fields are enabled.

		EXPOSURE INFORMATION
Patient Information	${\boldsymbol{\oslash}}$	Did the patient have any of the following exposures in the past 6 months?*
Laboratory Information	Ø	Yes No Unknown
Exposure Information		
Hospitalization, ICU & Death Information		Mother Hepatitis B Virus positive* Yes No Unknown
Vaccination History		Mother Hepatitis C Virus positive*
Additional Comments		Yes No Unknown
	a	HBV Contact Exposure*
Review & Submit		Yes No Unknown
		HCV Contact Exposure*
		Yes No Unknown
		Foreign Born*
		Yes No Unknown
		If yes, please specify country: 🔞
		Select 🗸
		Is this part of an outbreak?*
		Yes No Unknown
		If yes, please specify the name of the outbreak: 🚱
		Save Previous Next



6 Affiliation/Organization Conditional Question

Certain conditional questions only apply to the subsequent fields within the section. Based on the selection to a conditional question, certain subsequent fields in that section are enabled.

This applies to the conditional Affiliation/Organization question on the **Patient Information** screen:

Is the Affiliation/Organization the same for Patient ID (MRN), Person completing Form, Attending Physician/Clinician?

Based on the selected answer to the conditional question, you can apply the **same** Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician; **OR** you can apply a **<u>different</u>** Affiliation/Organization to each.

Yes No			
Patient ID (MRN) 🚱	Affiliation/Organization	0	
	Select		
erson Completing Form	Affiliation/Organization	0	If other, please specify: 🔞
Select	Select		
Attending Physician/Clinician	Affiliation/Organization	0	If other, please specify: 🚱
	Select		

- Select *Yes* to apply the <u>same</u> Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.
- Select *No* to apply <u>different</u> Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.



Affiliation/Organization Conditional Answer: Yes

If **Yes** is selected for the conditional Affiliation/Organization question, the **same** Affiliation/Organization is applied to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

- Only **one** *Affiliation/Organization* field is enabled. You must complete the Affiliation/Organization field that corresponds to the Patient ID (MRN). The *Affiliation/Organization* fields for the Person Completing Form and the Attending Physician/Clinician are disabled.
- 1. Select the Affiliation/Organization for the Patient ID (MRN) from the dropdown menu.

Yes No			
Patient ID (MRN)* 😧	Affiliation/Organization* 🚱		
	Select	~ I	
Person Completing Form*	Affiliation/Organization 🔞		lf other, please specify: 🚱
Select	Select		
Attending Physician/Clinician*	Affiliation/Organization 🔞		lf other, please specify: 🚱
Select	Select		

- Once the Affiliation/Organization is selected for the Patient ID (MRN), this selection will display in the disabled *Affiliation/Organization* fields.
- This means the **<u>same</u>** Affiliation/Organization is applied to the Patient ID (MRN), the Person Completing Form, and the Attending Physician/Clinician.

Yes No			
Patient ID (MRN)* 😧	Affiliation/Organization* 🚱		
SK05051960	Test Medical Center	x ~	
Person Completing Form*	Affiliation/Organization 🚱		If other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@email.com) $ imes \lor $	Test Medical Center	$\times \sim$	
Attending Physician/Clinician*	Affiliation/Organization 🕑		If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗸 🗸	Test Medical Center	x ~	



Affiliation/Organization Conditional Answer: No

If **No** is selected for the conditional Affiliation/Organization question, a **different** Affiliation/Organization can be applied to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

- **<u>Each</u>** of the three (3) *Affiliation/Organization* fields are enabled.
- You must complete **<u>each</u>** of the *Affiliation/Organization* fields respectively for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician.

Yes No			
Patient ID (MRN)* 😧		Affiliation/Organization* 😧	×
Person Completing Form*		Affiliation/Organization* 😧	lf other, please specify: 😧
Select	~	Select	
Attending Physician/Clinician*		Affiliation/Organization* 😧	If other, please specify: 🚱
Select	\sim	Select	~

1. From the dropdown menu, select the **Affiliation/Organization** for the Patient ID (MRN).

Patient ID (MRN)* 😧	Affiliation/Organization* 😧		
SR05051960	Şelect 🗸 🗸		
Person Completing Form*	Afzal, Mohammad MD, Internal Medicine, LLC	lf other, please specify: 😡	
Select 🗸	eICR Onboarding Regression		
Attending Physician/Clinician*	Hilton Hospital	lf other, please specify: 🚱	
Select V	King's Daughters Medical Center		
	Murray-Calloway County Hospital		
Prefix	Test Medical Center		
Select V	University Of Kentucky Chandler Medical Center		

2. From the dropdown menu, select the **Affiliation/Organization** for the Person Completing Form.

Person Completing Form*	Affiliation/Organization* 😧	lf other, please specify: 🔞
Mr. Arthur Vandelay, II (arthur@email.com) 🗙 🗸 🗸	Select 🗸 🗸	
	nicali monanini a moj meenarmealentej coo	
Attending Physician/Clinician*	eICR Onboarding Regression	If other, please specify: 🚱
Select 🗸	Hilton Hospital	
	King's Daughters Medical Center	
Prefix	Murray-Calloway County Hospital	
Select 🗸	Test Medical Center	
First Name*	University Of Kentucky Chandler Medical Center	Last Name*
	Other	
Suffix	Date of Birth*	



Please Note: If you select Other from the <i>Affiliation/Organization</i> dropdown menu for the Person Completing Form, the following subsequent textbox is enabled: <i>If other, please specify</i> . You must enter the name of the affiliation/organization .			
Is the Affiliation/Organization same for Patier Yes No		l Attending Physi	cian/Clinician?* Please select the organization of the person completing this form (if it is
Patient ID (MRN)* 😧	Affiliation/Organization* 😧		not listed the
CK08101955	Test Medical Center	× ~	Affiliation/Organization dropdown).
Person Completing Form*	Affiliation/Organization* 😧		If other, please specify:* 😧
Mr. Arthur Vandelay, II (arthur@em 🗴	Other	× ~	

3. From the dropdown menu, select the **Affiliation/Organization** for the Attending Physician/Clinician.

Yes No		
Patient ID (MRN)* 🚱	Affiliation/Organization* 😧	
CK08101955	Test Medical Center X V	
Person Completing Form*	Affiliation/Organization of the	If other, please specify:* 😧
Mr. Arthur Vandelay, II (arthur@em $~\times~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~$	Other physician attending the \times \checkmark	Test Hospital
Attending Physician/Clinician*	Affiliation/Organization* 2	If other, please specify: 🔞
Dr. Frank Costanza, Sr (frank@emai $ imes$ $ imes$	Select 🗸 🗸	
Prefix	Afzal, Mohammad MD, Internal Medicine, LLC	
Select ~	eICR Onboarding Regression	
First Name*	Hilton Hospital	Last Name*
TISC NAME"	King's Daughters Medical Center	
	Murray-Calloway County Hospital	
Suffix	Test Medical Center	
Select 🗸	University Of Kentucky Chandler Medical	
Patient Sex*	Ethnicity*	Race*

Please Note: If you select *Other* from the *Affiliation/Organization* dropdown menu for the Attending Physician/Clinician, the subsequent textbox is enabled: *If other, please specify*. You must enter the **name of the Affiliation/Organization**.

Attending Physician/Clinician*	Affiliation/Organization* 🚱	If other, please specify:* 😧
Dr. Frank Costanza, Sr (frank@emai 🗙 🗸 🗸	Other	× ~





Affiliation/Organization Validation

If, after completing the *Affiliation/Organization* section, you change your answer to the conditional question from **No** to **Yes** or vice versa, a pop-up will display to confirm the change in answer.

A pop-up displays with a message that states: *All selections for the "Affiliation/Organization" will be reset. Are you sure you want to change your selection?*

Patient ID (MRN)*	Affiliation/Organization* 😧			
SK05051960	Test Medical Center	x ~		
Person Completing Form*	Affiliation/Organization* 😧		If other, please specify: * 	
Mr. Arthur Vandelay, II (arthur@email.com) $\times $	Other	× ~	Test Hospital	
Attending Physician/Clinician*	Affiliation/Organization* 😧		lf other, please specify: 🚱	
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🗸 🗸	Test Medical Center	x 🗸		
	I), Person Completing Form and Attending Phy	ysician/Clinicia	in?*	
Yes No		ysician/Clinicia	in?*	
Yes No	 i), Person Completing Form and Attending Phy Affiliation/Organization* @ Test Medical Center 	ysician/Clinicia × ~	in?*	
Yes No Patient IN (MRN) * 0 SK05051960	Affiliation/Organization* 🕑		in?* If other, please specify: @	
Yes No Patient MRN	Affiliation/Organization* @ Test Medical Center			
Patient IDMRN)* 0 SK05051960 Person Completing Form*	Affiliation/Organization* 🕑 Test Medical Center Affiliation/Organization 🚱	x ~		

- To reset the Affiliation/Organization selection(s), click Yes.
- To save the selected Affiliation/Organization selection(s), click *No*.

Patient ID (MRN)* 😧	Patient	t Information	×	
SK05051960	A	All selections for the "Affiliation/Organiz be reset. Are you sure you want to chan		
Person Completing For Mr. Arthur Vandelay,		selection?		
wir. Artiful Validelay,			/es No	





Change Affiliation/Organization Conditional Answer: No to Yes

If, after completing the *Affiliation/Organization* section, you change your answer to the conditional question from *No* to *Yes*, a pop-up message will display.

Patient ID (MRN)*	Affiliation/Organization* 😧		
SK05051960	Test Medical Center	× ~	
erson Completing Form*	Affiliation/Organization* 😧		lf other, please specify:* 🚱
Mr. Arthur Vandelay, II (arthur@email.com) 🗙 🛛 🗸	Other	x ~	Test Hospital
ttending Physician/Clinician*	Affiliation/Organization* 😧		lf other, please specify: 🚱

1. To reset your previous Affiliation/Organization selections for the Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician, click **Yes** on the pop-up.

Applicable Symptoms	-	is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*
Medical Conditions	A	is the Animatorius gamzatoris same for Padent to (write), Person Compresing Portri and Attenting Physician Chindrant?" Yes No
Travel Information	۵	Patient ID (MRN)* Patient Information ×
Hospitalization, ICU & Death Information	A	SK05051960 All selections for the "Affiliation/Organization" will
Additional Information	A	Person Completing For selection? If other, please specify:* •
Treatment Information	۵	Mr. Arthur Vandelay.
Additional Comments	۵	Attending Physician/Cli If other, please specify: Dr. Frank Costanza, Sir (trankgemail.com) X Y Test Medical Center X Y
Review and Submit		

- 2. An error message prevents you from proceeding until an Affiliation/Organization is selected. You must select the **Affiliation/Organization** for the Patient ID (MRN) in order to proceed.
 - Your previous Affiliation/Organization selections for the Person Completing Form and the Attending Physician/Clinician have been reset.
 - The *Affiliation/Organization* fields for the Person Completing Form and the Attending Physician/Clinician are now blank and disabled.

There are errors. Please make a selection for all required fields.				
PATIENT INFORMATION				
Patient Information		Disease/Organism* 😧	Date of Diagnosis*	
Laboratory Information	a	Chlamydia X V	07/23/2021	Unknown
Applicable Symptoms	a	Is the Affiliation/Organization same for Patient ID (MDN)	Parcon Completing Form and Attending Division/Clin	ician 3*
Medical Conditions	a	Is the Affiliation/Organization same for Patient ID (MRN) Yes No	, Person Completing Form and Attending Physician/Clin	iciani?"
Travel Information		Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
Hospitalization, ICU & Death Information		SK05051960	Select V	
Additional Information			-	
Treatment Information	a	Person Completing Form* Mr. Arthur Vandelay, II (arthur@email.com) × >	Affiliation/Organization 🚱	lf other, please specify: 🕜
Additional Comments		Attending Physician/Clinician*	Affiliation/Organization 🚱	lf other, please specify: 🚱
Review and Submit	۵	Dr. Frank Costanza, Sr (frank@email.com) $~~\times~~ ~~\vee~$	Select v	





3. From the dropdown menu, select the Affiliation/Organization for the Patient ID (MRN).

Is the Affiliation/Organization same for Patient ID (MRN) Yes No	, Person Completing Form and Attending Physician/Clinic	ilan?*
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
SK05051960	Select 🗸 🗸	
	Afzal, Mohammad MD, Internal Medicine, LLC	
Person Completing Form*	eICR Onboarding Regression	If other, please specify: 🕜
Mr. Arthur Vandelay, II (arthur@email.com) $~\times~~$ $~\sim~$	Hilton Hospital	
Attending Physician/Clinician*	King's Daughters Medical Center	lf other, please specify: 🔞
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🗸 🗸	Murray-Calloway County Hospital	
	Test Medical Center	
Prefix	University Of Kentucky Chandler Medical Center	
Ms. × V		

- 4. The **Affiliation/Organization** selected for the Patient ID (MRN) will display in disabled *Affiliation/Organization* fields for the Person Completing Form and the Attending Physician/Clinician.
 - This means the **<u>same</u>** Affiliation/Organization will be applied to the Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician.

Yes No			
Patient ID (MRN)* 😮	Affiliation/Organization* 😧		
SK05051960	Test Medical Center	× ~	
Person Completing Form*	Affiliation/Organization 🕑		If other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@email.com) $~\times~~ ~~\sim~$	Test Medical Center	$\times \sim$	
Attending Physician/Clinician*	Affiliation/Organization 🕑		If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) × V	Test Medical Center	× ~	



Change Affiliation/Organization Conditional Answer: Yes to No

If, after completing the *Affiliation/Organization* section, you change your answer to the conditional question from *Yes* to *No*, a pop-up will display.

Patient ID (MRN)*	Affiliation/Organization* 😧		
SK05051960	Test Medical Center	× ~	
Person Completing Form*	Affiliation/Organization 🚱		lf other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@email.com) $~ imes~~$	Test Medical Center		
Attending Physician/Clinician*	Affiliation/Organization 🚱		If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗸 🗸	Test Medical Center		

1. To reset your previous Affiliation/Organization selection for the Patient ID (MRN), click *Yes* on the pop-up.

Is the Affiliation/	Patient Information ×	nd Attending Physician/Clinician?*
Yes Patient ID (MRN) [*] CK08101955	All selections for the "Affiliation/Organization" will be reset. Are you sure you want to change your selection?	x ~
Person Completi Mr. Arthur Vanc	Yes No	If other, pleas

- 2. You must complete **each** of the *Affiliation/Organization* fields corresponding to Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician.
- Your previous Affiliation/Organization selection for the Patient ID (MRN) has been reset.
- <u>All</u> three (3) of the *Affiliation/Organization* fields are enabled.
 - This means a different Affiliation/Organization can be selected for each field.

Patient ID (MRN)* 😧	Affiliation/Organization* 🚱	
CK08101955	Select	~
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Dr. Estelle Costanza (estelle@email $ imes \ arphi $	Select	· ·
Attending Physician/Clinician*	Affiliation/Organization* 😧	lf other, please specify: 🔞
Dr. Frank Costanza, Sr (frank@emai ×	Select	



3. From the dropdown menu, select the Affiliation/Organization for the Patient ID (MRN).

Is the Affiliation/Organization same for Patient Yes No	ID (MRN), Person Comp organization where the Patient ID (MRN) was assigned to the patient.	inician?*
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	
SR05051960	Select	~
Person Completing Form*	Afzal, Mohammad MD, Internal Medicine, LLC	If other, please specify: 😧
Select	eICR Onboarding Regression	
Attending Physician/Clinician*	Hilton Hospital	lf other, please specify: 🔞
Select	\sim King's Daughters Medical Center	
	Murray-Calloway County Hospital	
Prefix	Test Medical Center	
Select	University Of Kentucky Chandler Medical Center	

- 4. From the dropdown menu, select the **Affiliation/Organization** for the Person Completing Form.
- 5. From the dropdown menu, select the **Affiliation/Organization** for the Attending Physician/Clinician.

Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Mr. Arthur Vandelay, II (arthur@em $~\times~~~~$	Select 🗸	
Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@emai 🗙 🗸 🗸	Select 🗸 🗸	
Prefix	Afzal, Mohammad MD, Internal Medicine, LLC	
Select	eICR Onboarding Regression	
First Name*	Hilton Hospital King's Daughters Medical Center	Last Name*
Suffix Select v	Murray-Calloway County Hospital Test Medical Center University Of Kentucky Chandler Medical	
Patient Sex*	Ethnicitv*	Race*

Please Note: If you select **Other** from the *Affiliation/Organization* dropdown menu for the Person Completing Form or the Attending Physician/Clinician, the following subsequent textbox is enabled: *If other, please specify.* You must enter the name of the **affiliation/organization**.

Person Completing Form*	Affiliation/Organization* 🚱		If other, please specify:* 🚱
Mr. Arthur Vandelay, II (arthur@em 🗴 🗸	Other	$\times \mid \checkmark$	
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: *



7 Dynamic Functions based on Disease/Organism

Based on the **Disease/Organism** selected from the dropdown menu on the **Patient Information** screen of the Child Hepatitis Case Report, certain subsequent screens will dynamically display information that applies to the selected disease/organism. This means certain screens will display only the symptoms, lab tests, and vaccine information that apply to the selected disease/organism.

• Once the Disease/Organism selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to display only the information that applies to the selected Disease/Organism.

CHILD HEPATITIS CASE R	EPORT FORM	Section 1 of 7		
Please complete the form below.	All fields marked with an asterisk(*) are req Please select th disease/organism for you want to file this report for the pati	re rwhich s case IT INFORMATION		
Patient Information	Disease/Organism* 😧	Date of Diagnosis*		
Laboratory Information	Select	Disease/Organism options for		
Exposure Information	Child Hepatitis B	Child Hepatitis Case Reports		
Hospitalization, ICU & Death Information	Yes No	venneuri		
Vaccination History	Patient ID (MRN) 🚱	Affiliation/Organization 🚱		
Additional Comments	Person Completing Form	Affiliation/Organization 🕢 If other, please specify: 🚱		

Change or Save Disease/Organism Selection

Once you select a **Disease/Organism** from the dropdown menu, and click **Save** or **Next** on the **Patient Information** screen, a pop-up displays with a message that states:

You have selected to file this case report for [selected disease]. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report for [selected disease]?

F	First Name	Middle Name		Last Name	
		ent Information	×		
	Address 1 111 Test Si London	You have selected to file this case report for Child Hepatitis B disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for	u 1	ding, etc. X ~	Zip Code 40741-
	Allen	Child Hepatitis B disease?	No	Email name@domain.co	
	Save				Next

Direct Data Entry for Electronic Case Reports: Child Hepatitis





Please Note: All Disease/Organism selections are final. Once the selection is saved on the Patient Information screen, the subsequent dynamic screens are customized to display information that applies only to the selected Disease/Organism.
You have one more opportunity to select No to change the Disease/Organism. You can select Yes to finalize the Disease/Organism selection.

- 1. Upon clicking **Save** or **Next** at the bottom of the **Patient Information** screen, the Disease/Organism Pop-Up displays.
- 2. To change the selected Disease/Organism, click **No**.

First Name	ct info of person the child is living with: Middle Name nt Information	×	Last Name Brady	
Address 123 Ma City Lexingt County Fayette	You have selected to file this case report Child Hepatitis B disease. Please note the Will not be able to change/update Disease/Organism name after you save screen or proceed to the next screen. A sure you want to file this case report for Child Hepatitis B disease?	this re you	X V Email carol@email.com	Zip Code 40511-
	Ye	No		
Save				Next

3. Select a **different Disease/Organism** from the dropdown menu.

HILD HEPATITIS CASE RE	PORT F	ORM		Section 1 o	of 7	
Please complete the form below. All	l fields mark	ed with an asterisk(*) are required	L			
		P.	ATIENT INI	FORMATION		
Patient Information		Disease/Organism* 😧		Date of Diagnosis*		
Laboratory Information	A	Select	~	mm/dd/yyyy	iii □ (Jnknown
Exposure Information		Child Hepatitis B				
Hospitalization, ICU & Death		Child Hepatitis C		nt ID (MRN), Person Completing	g Form, and Attending	g Physician/Clinician?*

4. Once the Disease/Organism selection is complete, click **Save** to save the change or click **Next** at the bottom of the **Patient Information** screen.







5. The Disease/Organism Pop-Up displays to confirm the change in selection. Click **Yes** to save the Disease/Organism selection.

Patien	tInformation	×	
First Nan Carol Address 123 Ma City Lexingt	You have selected to file this case report for Child Hepatitis C disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Child Hepatitis C disease?	2	Last Name Brady Zip Code
County Fayette	Yes N		Email carol@email.com

6. After saving the selection, the *Disease/Organism* field is disabled and displays the selected Disease/Organism. You can no longer change the selected Disease/Organism.

CHILD HEPATITIS CASE R	EPORT F	ORM	Section 1 of 7					
Please complete the form below. A	Please complete the form below. All fields marked with an asterisk(*) are required.							
	PATIENT INFORMATION							
Patient Information	Ø	Disease/Organism* 😧	Date of Diagnosis*					
Laboratory Information		Child Hepatitis C 🗸 🗸	11/28/2021					
Exposure Information		Is the Affiliation/Organization same for Pa	ient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*					
Hospitalization, ICU & Death Information	a	Yes No	renche (mixing, renson complexing ronn, and Accending rhysiolan/clinican/					



8 Dynamic Screens for Child Hepatitis Case Report

The following screens display dynamic information based on the **Disease/Organism** selected from the dropdown menu on the **Patient Information** screen of the Child Hepatitis Case Report.

Laboratory Information: Dynamic Screen

On the **Laboratory Information** screen of the Child Hepatitis Case Report, the *Hepatitis Marker* dropdown menu displays only the hepatitis marker options that apply to the Disease/Organism selected on the **Patient Information** screen.

HILD HEPATITIS CASE R		Section 2 of 7
Please provide laboratory inform	nation relate	red to this case.
		LABORATORY INFORMATION
Patient Information	\otimes	Does the patient have a lab test?*
Laboratory Information	\odot	Yes No
Exposure Information	\odot	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin,
Hospitalization, ICU & Death Information	0	please ensure you complete all fields for that test.
Vaccination History		Hepatitis Marker*
Additional Comments	۵	Select Hepatitis Markers for
Review & Submit	A	HEPATITIS B VIRUS CORE AB Child Hepatitis B
		HEPATITIS B VIRUS CORE AB.IGG
		HEPATITIS B VIRUS CORE AB.IGM
		HEPATITIS B VIRUS DNA
		HEPATITIS B VIRUS GENOTYPE
		HEPATITIS B VIRUS LITTLE E AB
		HEPATITIS B VIRUS LITTLE E AG Specimen Collection Date*
		Laboratory Name:*
maton		
cination History	\odot	Hepatitis Marker*
itional Comments		Felect Image: Markers for
ew & Submit		HEPATITIS C VIRUS AB Child Hepatitis C
		HEPATITIS C VIRUS AB SIGNAL/CUTOFF
		HEPATITIS C VIRUS RNA
		Hepatitis C virus RNA panel
		HEPATITIS C VIRUS RRNA
		Other
		Considered Callertian Database
		Test Result Date* Specimen Collection Date*



Vaccination History: Dynamic Screen

The **Vaccination History** screen is dynamic and displays certain fields based on the Disease/Organism selected.

 The Vaccination History screen is disabled and does <u>not</u> collect vaccine information when *Child Hepatitis C* is selected as the Disease/Organism.

HILD HEPATITIS CASE R		Section 5 or 7
Please provide the vaccination hi	story of the p	vaccination History
Patient Information	Ø	
Laboratory Information	\odot	NOTE: No information is required to be provided on this screen. Please click on the "Next" button to proceed.
Exposure Information	\odot	
Hospitalization, ICU & Death Information	0	The Vaccination History screen does <u>not</u> collect
Vaccination History		vaccination details for
Additional Comments	a	Child Hepatitis C.
Review & Submit		
		Save Previous Next

The **Vaccination History** screen is enabled and collects information only when *Child Hepatitis B* is selected as the Disease/Organism.

• When *Child Hepatitis B* is selected as the Disease/Organism, the **Vaccination History** collects vaccination details related to Child Hepatitis B.

Patient Information	\odot	Has the patient ever received a Hepatitis B vaccine?*				
Laboratory Information	\odot	Yes No Unknown Refused The Vaccination Hi	istory screen collects			
Exposure Information	\odot		e vaccine that the or Child Hepatitis B.			
Hospitalization, ICU & Death Information	\odot	If yes, please provide vaccine name:* @	r child hepaticis b.			
Vaccination History		Select	· ·			
Additional Comments	A	Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, H (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.	laemophilus b Conjugate			
Review & Submit	A	Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)				
		DTaP-hepatitis B and poliovirus vaccine				
		DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine				
		Haemophilus influenzae type b conjugate and Hepatitis B vaccine				
		hepatitis A and hepatitis B vaccine				
		hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)				



		VACCINATION HISTORY
Patient Information	\oslash	Has the patient ever received a Hepatitis B vaccine?*
Laboratory Information	Ø	Yes No Unknown Refused
Exposure Information	\oslash	
Hospitalization, ICU & Death Information	Ø	Vaccine Details
Vaccination History		the number of vaccine doses that the
Additional Comments	۵	patient received for Child Hepatitis B .
Review & Submit	۵	If yes, please enter the number of doses:* @
		1 2 3 4 Vaccine
		For Infants born to mothers with HBV, was HBIG given?*
		Yes No Unknown If yes, please specify the date administered: Image: Comparison of the date administered of the d
		Save Previous Next

		VACCINATION HISTORY	
Patient Information	\odot	Has the patient ever received a Hepatitis B vaccine?*	
Laboratory Information	\odot	Yes No Unknown Refused	
Exposure Information	\odot	Verder Date II	
Hospitalization, ICU & Death Information	\odot	Vaccine Details If yes, please provide vaccine name:* 🚱	x ~]
Vaccination History		hepatitis B vaccine, adolescent/high risk infant dosage	× ~
Additional Comments		n ourer, please specify. 🐨	The Vaccination History screen collects the date(s) the patient
Review & Submit	a	If yes, please enter the number of doses:* @	received Hepatitis B vaccines.
		If yes, please specify the date administered: 😧	
		Date Administered (1st dose)* mm/dd/yyyy	Date Administered (2nd dose)*
		Date Administered (3rd dose)* mm/dd/yyyy Unknown	Date Administered (4th dose)*
		Add Vaccine	



9 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 **mandatory** 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.		
		P	ATIENT INF	ORMATION	
Patient Information		Interviewer Name*		Affiliation/Organization*	
SARS CoV-2 Testing	a	Select	~	Select	~,

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

Please complete the form belo	ow. All fields ma	rked with	An MRN or Medical Record Number is an Organization		ORMATION		
Patient Information		Inten	assigned to a patient by a healthcare organization. If		Affiliation/Organization*		
SARS CoV-2 Testing	a	Dr.	your organization does not use an MRN, you MUST create a way to uniquely	× ~	Test Medical Center		X ~
Clinical Course	A	Datia	identify your Patient.	_	Deefin		
Applicable Symptoms	_	Patien			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 menu.

City	State	КҮ × ~	
Zip Code	County	Select 🗸 🗸 🗸	
		Adair	
Phone Number	Email Address	Allen	
		Anderson	
		Ballard	
		Barren t	
		Bath	
nteractive	HealthInteractive HIE	Bell	'ersi





• However, when you 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	State	AR	x ~
Zip Code	County	Out Of System State	× ~

- 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 dropdown menus to select the month and the year.

Adr	nissi	ion D	ate*					Discharge Date*	
m	m/d	ld/yy	уу				🛗 🔲 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
	_	J une	une 2	021	21 🗸				
s	-	10 T				Sa	nis illness?*		
з	3	1 1	2	3	4	5	Jnknown		
e	7	7 ε	9	10	11	12	leath:		
1	3 1	4 1	5 16	17	18	19			
2	2	1 2	2 23	24	25	26	🛗 🗌 Unknown		
2	7 2	8 2	9 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	#	Vnknown	06/20/2021	🛗 🗌 Unknown
	•			



10 Child Hepatitis Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the Child Hepatitis Case Report Form in the ePartnerViewer.

1. To enter Child Hepatitis 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.

KHIE ePar	tnerViewer		🖼 Support 📢 Announcemen	ts 🤰 🌲 Advisories 🕦 😫 📑
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry *
A Home				Case Report Forms
Announcement: eHealth Summi	it			Case Report Entry User Summary
•		• • •		Manage User Preferences
		myDASHBOARD		
QUICK SEARCH				Q ADVANCED SEARCH
First Name	Last Name	Date Of Birth	mm/dd/yyyy	🗎 🥔 Search

2. Select **Child Hepatitis** from the dropdown menu.

KÎLE e	PartnerViewer	Supp	ort 📢 Announcements 😘	🜲 Advisories 🗿 🤤 🔹
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
🖀 Home				Case Report Forms
Announcement: Special	Incentive Opportunities Deadline Extended			COVID-19
A Amouncement. Special	incentive opportantices beautine extended	••••		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
	n	nyDASHBOARD		Perinatal Hepatitis
QUICK SEARCH				Child Hepatitis
First Name	Last Name	Date Of	mm/dd/yyyy	Other Reportable Conditions
		Birth	mm/dd/yyyy	
-				
BOOKMARKED PATI	ENTS 🚯	EVENT NOTIFICATIONS	S (PAST 72 HOURS)	3
BRADY, BOBBY		There is no data t	o be displayed	
RADPAT, DEMOONE				



11 Patient Information

The Child Hepatitis Case Report Form is a seven-step process where Users enter (1) Patient Information, (2) Laboratory Information, (3) Exposure Information, (4) Hospitalization, ICU, & Death Information, (5) Vaccination History, and (6) Additional Comments. (7) **Review and Submit** is where Users must review the information entered **and** submit the Child Hepatitis Case Report.

ILD HEPATITIS CASE REPORT FORM Section 1 of 7 Please complete the form below. All fields marked with an asterisk(*) are required.								
Patient Information		Disease/Organism* 🚱		Date of Diagnosis*				
Laboratory Information	۵	Select	~	mm/dd/yyyy		Unknown		
Exposure Information	•	Is the Affiliation/Organization can	ee for Det	ient ID (MPN), Person Completi	ng Form ond	d Attending Division (Clinician)*		
Hospitalization, ICU & Death Information	A	Is the Affiliation/Organization sam	ie for Pati	ent וש (אוגא), Person Completi	ng Form, and	a Attenuing Physician/Clinician?*		
Vaccination History	A	Patient ID (MRN) 🚱		Affiliation/Organization 🚱				
Additional Comments				Select				
Review & Submit	•	Person Completing Form		Affiliation/Organization 🚱		If other, please specify: 🕖		
	-	Select		Select				
Review & Submit								
		Attending Physician/Clinician		Affiliation/Organization 🕑		If other, please specify: 🚱		

1. To start the Child Hepatitis Case Report entry, you must complete the mandatory fields on the **Patient Information** screen.

		PATIENT INF			
atient Information	Disease/Organism* 😧		Date of Diagnosis*		_
aboratory Information	Select	$ $ \sim	mm/dd/yyyy	# (Unknown
xposure Information	A				
ospitalization, ICU & Death Information	Is the Affiliation/Organization same for Yes No	or Patient ID (MRN), Person Completing Form, and Attend	ling Physician/Clin	ician?*
accination History					
ditional Comments	Patient ID (MRN) 🚱		Affiliation/Organization 🚱		
	-				
	A Deres Constanting From		A (C)		
view & Submit	Person Completing Form Select		Affiliation/Organization 🚱		If other, please specify: 😡
wiew & Submit	Select		Select		
eview & Submit	-				If other, please specify: 😡
eview & Submit	Select Attending Physician/Clinician Select		Select Affiliation/Organization @		
view & Submit	Select Attending Physician/Clinician		Select Affiliation/Organization @		
view & Submit	Select Attending Physician/Clinician Select Prefix Select		Select Affiliation/Organization @ Select		If other, please specify: 🚱
view & Submit	Select Attending Physiclan/Clinician Select Prefix		Select Affiliation/Organization @		
wiew & Submit	Select Attending Physician/Clinician Select Prefix Select		Select Affiliation/Organization @ Select		If other, please specify: 🚱



2. Select the **Disease/Organism** from the dropdown menu.

HILD HEPATITIS CASE R	EPORT F	ORM		Section 1 o	f7 🗨
<i>Please complete the form below. A</i>	ll fields mark	red with an asterisk(*) are requi Please select the disease/organism fo you want to file thi report for the pat	he or which s case ENT IN	FORMATION	
Patient Information		Disease/Organism* 😧		Date of Diagnosis*	
Laboratory Information		Child Hepatitis B	× v	mm/dd/yyyy	
Exposure Information		Child Hepatitis B			
	_	Child Hepatitis C		nt ID (MRN), Person Completing	Form, and Atten
Hospitalization, ICU & Death Information		Yes No			
Vaccination History	a	Patient ID (MRN) 😧		Affiliation/Organization 🕑	
2				Select	

Please Note: Based on the Disease/Organism selected from the dropdown menu on the Patient Information screen, certain subsequent screens will dynamically display information that applies to the selected disease/organism. This means certain screens will display only the symptoms and lab tests that apply to the selected disease/organism.

Once the Disease/Organism selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to display only the information that applies to the selected Disease/Organism. I

3. Enter the **Date of Diagnosis**.

If the date of diagnosis is unknown, click the **Unknown checkbox**.

PATIENT INFORMATION								
Patient Information		Disease/Organism* Date of Diagnosis*						
Laboratory Information		Select w mm/dd/yyyy 🛗 Unknown						
Exposure Information		Is the Affiliation/Organization same for Patient ID (MRN).						
Hospitalization, ICU & Death Information	۵	Yes No						
Vaccination History		Patient ID (MRN) 🕖 5 6 7 8 9 10 11						
Additional Comments	۵	12 13 14 15 16 17 18						
Review & Submit	۵	19 20 21 22 23 24 25 Person Completing Form 26 27 28 29 30 31 1						
		Select V						



4. Select the **appropriate answer** for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician*?

Physician/Clinician?*			
Yes No			
Patient ID (MRN) 🔞	Affiliation/Organizatior	n @	
	Select		
Person Completing Form	Affiliation/Organizatior	n (2)	If other, please specify: 🚱
	Select		·····, [·····, [·····, ···

• Click **Yes** to apply the **same** Affiliation/Organization to the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

Is the Affiliation/Organiz Yes No		atient ID (MRN), Person Comple	ting Form, and	d Attending Physician/Clinician?*
Patient ID (MRN)* 🚱		Affiliation/Organization* 😧		
		Select	$ $ \sim	
Person Completing For	<u>n</u> *	Affiliation/Organization 🕑		If other, please specify: 🚱
Select	~	Select		
Attending Physician/Clin	nician*	Affiliation/Organization 🕜		If other, please specify: 🚱
		Select		

• Click *No* to select a <u>different</u> Affiliation/Organization for the Patient ID (MRN), Person Completing Form, and the Attending Physician/Clinician.

Yes No			
Patient ID (MRN)* 🚱		Affiliation/Organization* 9	7
Person Completing Form*		Affiliation/Organization* @	If other, please specify: 🔞
Select	~	Select	
Attending Physician/Clinician *		Affiliation/Organization* 😧	If other, please specify: 🚱
Select		Select	/



5. 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.

iliation/Organization* 😮	
elect 🗸 🗸	

6. From the dropdown menu, select the **Affiliation/Organization** that applies to the Patient ID (MRN).

Patient ID (MRN)* 😧	Affiliation/Organization* 🗿	
CK08101955	þelect	· •
Person Completing Form*	Afzal, Mohammad MD, Internal Medicine	e, If other, please specify: 🕑
Attending Physician/Clinician*	elCR Onboarding Regression Hilton Hospital King's Daughters Medical Center	If other, please specify: 🛛
Prefix Select	Murray-Calloway County Hospital Test Medical Center University Of Kentucky Chandler Medica	

Please Note: If *Yes* is selected for the conditional field: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?* the same Affiliation/Organization will apply to each. The *Affiliation/Organization* field is enabled only for the Patient ID (MRN).

The **Affiliation/Organization** selected for the Patient ID (MRN) will display in the disabled *Affiliation/Organization* fields for the Person Completing Form and the Attending Physician/Clinician.

7. From the dropdown menu, select the name of the **Person Completing Form**.

Patient ID (MRN)* 🚱	Affiliation/Organization* 😧		
1111111111	Test Medical Center	× ~	
Person Completing Form*	Affiliation/Organization 😧 Test Medical Center		If other, please specify: 😧
Dr. John Watson (john.watson@bakerclinic.com)	Affiliation/Organization 😢		If other, please specify: 🚱
Select 🗸	Test Medical Center		
	•	-	<i>rson Completing Form</i> dropdown, clicking the Person Completing





Person Completing Form Hyperlink

8. To create details for a new Person Completing Form, click the **Person Completing Form** hyperlink.

Person Completing Form*		Affiliation/Organization* 😧		If other, please specify: 🔞
Select	~	Select	~	

- 9. The *Person Completing Form* Pop-Up displays. Enter the details. Mandatory fields are marked with asterisks (*).
- 10. If available, select the appropriate **Prefix** and **Suffix** from the dropdown menus.

Please complete the form below. All fields marked	Manage User Preference	es	×
riease complete die form below. Air neios market		low to create a Person Completing Form. All fields marked with an	
Patient Information	PER	RSON COMPLETING FORM	
Laboratory Information	Prefix		Unknown
Applicable Symptoms	Select ~		cian/Clinician?*
Medical Conditions	First Name*	Last Name*	
Travel Information			
Hospitalization, ICU & Death Information	Suffix		
Additional Information	Select 🗸 🗸		If other, please specify: 🔘
Treatment Information	11	Address 2 Unit, Suite, Building, etc.	
Additional Comments	III IV		If other, please specify: 🕑
Review and Submit	Jr	State* Zip Code*	
	Sr	Email*	
	(XXXX) XXX-XXXXX	name@domain.com	
			Last Name*
		Cancel Save	

11. Enter the **First Name** and **Last Name** of the Person Completing the Form.

First Name*	Last Name*	

12. Enter the Address, City, State, and Zip Code.

Address 1*	Address 2		
	Unit, Suite, Building, etc.		
City*	State*		Zip Code*
	Select	~	

13. Enter the Phone Number and Email Address of the Person Completing the Form.

Phone*	Email*
(XXX) XXX-XXXX	name@domain.com



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

Patient Information	Prefix			
Laboratory Information	Mr. × ~			Unknown
	First Name*	Last Name*		
Applicable Symptoms	Marty	Craine		clan/Clinician?*
Medical Conditions	Suffix			clan/clinician?"
Travel Information	Sr × ~			
Hospitalization, ICU & Death Information	Address 1*	Address 2		
Additional Information	123 Cheers Street	Unit, Suite, Building, etc.		If other, please specify: 😧
Treatment Information	City*	State*	Zip Code*	
Treatment Information	Lexington	KY × ×	40123-	
Additional Comments				If other, please specify: 🔞
	Phone*	Email*		
Review and Submit	(555) 123-3210	marty@email.com		

15. Once the new Person Completing Form details have been saved, the *Person Completing Form* dropdown menu is automatically updated and displays the new name of the Person Completing Form. From the dropdown menu, select the **new name of the Person Completing Form**.

		Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Additional Information		Select 🗸 🗸	Select 🗸 🗸	
Treatment Information		Dr. Estelle Costanza	Affiliation/Organization* 😧	If other, please specify: 🚱
Additional Comments	a	(estelle@email.com) Mr. Arthur Vandelay, ll	Select 🗸 🗸	
Review and Submit	A	(arthur@email.com)		
		Mr. Marty Craine, Sr (marty@email.com)		

16. If applicable, select the **Affiliation/Organization** that applies to the Person Completing the Form.

Patient ID (MRN)* 🚱	Affiliation/Organization	
CK08101955	Test Medic organization of the person × ×	
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🚱
Mr. Marty Craine, Sr (marty@email $~\times~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~$	Select 🗸 🗸	
Attending Physician/Clinician*	One	If other, please specify: 🚱
Select ~	Hilton Hospital	
	King's Daughters Medical Center	
Prefix	Murray-Calloway County Hospital	
Select ~	Test Medical Center	
First Name*	University Of Kentucky Chandler Medical Center	Last Name*
	Other	

L



Please Note: The Affiliation/Organization field that applies to the Person Completing Form is only enabled if you selected **No** to the conditional question: Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?

If *Other* is selected from the dropdown menu, the subsequent field is enabled. Enter the name of the organization associated with the person completing the form in the subsequent textbox: If other, please specify.

Yes No Patient ID (MRN)* 🚱	Affiliation/Organization* 🕢		Please enter the organization of the person completing this form (if it is not listed in the
CK08101955	Test Medical Center	× ~	Affiliation/Organization dropdown).
Person Completing Form*	Affiliation/Organization* 😧		If other, please specify:* (2)
Mr. Marty Craine, Sr (marty@email 🗴 🗸	Other	$\times \sim$	
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: 🔞
Select V	Select		

17. Select the Attending Physician/Clinician from the dropdown menu.

Person Completing Form *	Affiliation/Organization 🚱	
Dr. John Watson (john.watson@bakerclin 🗴 🗸 🧹	Test Medical Center	
Attending Physician/Clinician*	Affiliation/Organization 🕑	
þr. John Watson (john.watson@bakerclin 🗙 🗸	Test Medical Center	
Dr. John Watson (john.watson@bakerclinic.com)		
Please Note: If the appropriate name does		
dropdown, you must create details for a r	new Attending Physician/Clini	cian by clicking
Attending Physician/Clinician hyperlink.		





Attending Physician/Clinician Hyperlink

18. To create a new Attending Physician/Clinician, click the **Attending Physician/Clinician hyperlink**.

Attending Physician/Clinician*		Affiliation/Organization	* 0	If other, please specify: 🚱	
Select	· ·	Select	~		

- 19. The *Attending Physician/Clinician* Pop-Up displays. Enter the details. Mandatory fields are marked with asterisks (*).
- 20. If available, select the appropriate **Prefix** and **Suffix** from the dropdown menus.

		Manage User Preferences		×	
Patient Information		Please complete the form below to create ar	n Attending Physician/Clinician. All fields marked		Unknown
Laboratory Information	A	with an asterisk(*) are required.	0,		
Applicable Symptoms		ATTENDING PH	YSICIAN/CLINICIAN		cian/Clinician?*
Medical Conditions	a				
Travel Information	a	Prefix Select			
Hospitalization, ICU & Death Information	A	First Name*	Last Name*		
Additional Information	A	First Name*			If other, please specify:* 😧
Treatment Information		Suffix			Test Hospital
Additional Comments	A	Select 🗸 🗸			If other, please specify: 😡
Review and Submit		Address 1*	Address 2		
			Unit, Suite, Building, etc.		
		City*	State* Zip Code*		
					Last Name*
		Phone*	Email*		
		(XXX) XXX-XXXX	name@domain.com		

21. Enter the Attending Physician/Clinician's **First Name** and **Last Name**.

First Name*	Last Name*

22. Enter the Address, City, State, and Zip Code.

Address 1*	Address 2		
	Unit, Suite, Building, etc.		
City*	State*	Zip Code*	
	Select	$ $ \sim	

23. Enter the Attending Physician/Clinician's **Phone Number** and **Email Address**.

Phone*	Email*	
(XXX) XXX-XXXX	name@domain.com	



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

	ATT	ENDING PHYSICIAN/CLINICIAN		
Patient Information	Prefix			
Laboratory Information	▲ Dr. × ∨			Unknown
Applicable Symptoms	A First Name*	Last Name*		
Medical Conditions	Fraiser	Crane		cian/Clinician?*
Travel Information	Suffix			
Hospitalization, ICU & Death Information	Address 1*	Address 2		
Additional Information	a 123 Cheers Street	Unit, Suite, Building,	, etc.	If other, please specify: 😧
Treatment Information	City*	State*	Zip Code*	
Additional Comments	Lexington	KY	40123-	If other, please specify: 😧
Review and Submit	A Phone*	Email*		
	(555) 555-4321	fraisercrane@email.	.com	
			Cancel Save	Last Name*

25. Once the new Attending Physician/Clinician details have been saved, the *Attending Physician/Clinician* dropdown menu is automatically updated and displays the new Attending Physician/Clinician. Select the **new Attending Physician/Clinician** from the dropdown menu.

Treatment Information		Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🔞
Additional Comments		Şelect 🗸 🗸 🗸	Select 🗸 🗸	
Review and Submit		Dr. Fraiser Crane (fraisercrane@email.com)		
		Dr. Frank Costanza, Sr (frank@email.com) Ms. Helen Seinfeld (helen@email.com)	Middle Name	Last Name*

26. If applicable, select the **Affiliation/Organization** that applies to the physician attending the patient.

Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Dr. Fraiser Crane (fraisercra $ imes$ $ imes$	Select 🗸 🗸	
	Twenty One	
Prefix	Hilton Hospital	
Select 🗸 🗸	King's Daughters Medical Center	
First Name*	Murray-Calloway County Hospital	Last Name*
	Test Medical Center	
	University Of Kentucky Chandler	
Suffix	Medical Center	
Select 🗸	Other	



Please Note: The Affiliation/Organization field that applies to the Attending Physician/Clinician is enabled only when you select **No** to the conditional question: *Is the Affiliation/Organization same* for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician? J

- If *Other* is selected from the dropdown menu, the subsequent field is enabled. You must enter the name of the organization associated with the attending physician/clinician in the subsequent textbox: If other, please specify.

Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify:* 😧	
Dr. Fraiser Crane (fraisercra $ imes$ $ imes$	Other	× ~		
	mation on the Affilia			
Please Note: Additional infor	mation on the Amila	ation/Orga	nization section of the F	Patient

27. If available for the patient, select the **Prefix** and **Suffix** from the dropdown menus.

Prefix Select	~		
First Name*		Middle Name	
Bobby			
Suffix		Date of Birth* 😧	
Select	× .	01/01/2018	ŧ

28. Enter the patient's First Name and Last Name. If available, enter the patient's Middle Name and Maiden Name.

Prefix				
Select	~			
First Name*		Middle Name	Last Name*	
Bobby			Brady	

29. Enter the patient's Date of Birth.

First Name*		M This case report form should only be used to file		Last Name*	
Bobby		case report for infants and child below 5 year of age.		Brady	
Suffix		Date of Birth* 😧		Birth Weight	
Jr	\times \vee	mm/dd/yyyy	喆	lbs	OZS



Please Note: If the patient is over 5 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. See screenshot below.

Report Form			
EPORT FORM	ĺ	Patient Information	× ⁷
lection for all requir	ed fields.	The Date of Birth entered indicates that patient' age is more than 5 years old. Note that this form can only be used to file case report for infants a child aged 5 and under.	n
A	Disease/Organi: Child Hepatitis	0	K 🗍 Unknown
•	Is the Affiliation/	Organization same for Patient ID (MRN), Person Completing	Form, and Attending Physician/Clinician?*
pop-up will	display to co	nt is either under one year old or more than onfirm the correct birth year has been ente e until updating or confirming the patient's b	red or selected. You cannot

30. If available, enter the patient's **Birth Weight** in pounds and ounces in the appropriate fields.

Date of Birth* 😧	Birth Weight	
01/01/2018	lbs	OZS

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

Patient Sex*	Ethnicity*	R	ace*	
Select 🗸	Select	· ·	Select	~
Female				
Male	SS			
Other	Middle Name	L	ast Name*	
Unknown				

l____

_



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

Patient Sex*		Ethnicity*		Race*	
Male	$\times \mid \checkmark$	Not Hispanic or Latino	\times \sim	White	× ~
Please Note: In	the Child Hepat	itis Case Report, Use	rs must ente	r the contact in	formation for the
patient's mother	or the contact	information for the p	batient's guar	rdian, if the pat	tient's guardian is

33. Enter the contact information for the patient's mother.

irst Name*	Middle Name		Last Name*	
ddress 1*		Address 2		
		Unit, Suite, Bui	ilding, etc.	
îity*		State*		Zip Code
		Select	~	
County*	Phone* 🚱		Email	
Select	~ (XXX) XXX-XXX	24	name@domain	60.00

34. Enter the **Current Legal First Name** and **Last Name of the patient's mother**. If available, enter the **Middle Name**.

Mother's Current Legal Nam	e and Address	
First Name*	Middle Name	Last Name*

35. Enter the mother's Address, City, State, Zip Code, and County.

		- -	
City*		State*	Zip Code
County*	Phone* 😧	Em	nail
Select	✓ (XXX) XXX-XXXX	r	name@domain.com



- 36. Enter the mother's **Phone Number**.
- 37. If available, enter the mother's **Email Address**.

Address 1*	Please, enter	Address 2			
123 Main Street number		er of the child's Unit, Suite, Building, etc.			
City*	mother. If t number is no please en	t available, State*		Zip Code	
Lexington	provider's/in	terviewer's KY	$\times $ \vee	40511-	
County*	phone nu Phone* (Email		
Fayette	× v (XXX) XX	X-XXXX	name@domain.cor	n	

38. Select the **appropriate answer** to *Does the patient have Neonatal Abstinence Syndrome?*

	stinence Syndrome?*
No	hknown

39. From the dropdown menu, select the **appropriate answer** to the question: *Who does the* infant/child live with?

Yes	oUnknown		
/ho does the infant/ch	nild live with?*		
Select	~		
Father			
Grandparent			
Mother			
Other	hild is living with:		
Unknown	Middle Name	Last Name*	

Please Note: If the User selects *Other* in response to the conditional question *Who does the* Infant/Child live with?, then the following subsequent field is enabled. Users must enter the description of whom the infant/child is living with (i.e., Legal Guardian, etc.) in the subsequent field: *If other, please specify*. ·_____





Other	× ~	
(I	*	
ther, please specify:	*	
	*	
o ther, please specify .egal Guardian	*	

Please Note: If the User selects *Mother* in response to the question *Who does the Infant/Child live with?*, then the subsequent contact information fields for the person the child is living with are automatically populated with the patient's mother's contact information.

This means the patient's mother's contact information previously entered in the *Mother's Current Legal Name and Address* section is automatically populated in the *Please enter the contact info of person the child is living with* section.

Mother	× V			
If other, please specify:				
Please enter contact info of	f person the child is living wi	th:		
First Name	Middle Na		Last Name	
Carol	Anne		Brady	
Address 1		Address 2		
123 Main Street		Apt. 1		
City		State		Zip Code
Lexington		KY		40511-
	Phone 😮		Email	
County	Priorie G			

Please Note: If the User selects <u>any option</u> other than *Mother* in response to *Who does the infant/child live*?, then the subsequent section is enabled. The User must complete the fields in the subsequent section: *Please enter the contact info of person the child is living with*.

_ _ _ _





If other, please specify:					
Please enter contact info o	of person the ch	ild is living with			
First Name*	i person are en	Middle Name		Last Name*	
Address 1*			Address 2		
			Unit, Suite, Bui	lding, etc.	
City*			State*		Zip Code
			Select	~	
County*		Phone* 😯		Email	

40. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Laboratory Information** screen.

son the child is living with:				
son the child is living with:				
son the child is living with				
son the child is hving with.				
Middle Name		Last Name		
Anne	Anne		Brady	
	Address 2			
	Apt. 1			
	State		Zip Code	
	KY		40511-	
Phone 🔞		Email		
× v (555) 123-12	34	carol@email.com		
	Anne Phone @	Anne Address 2 Apt. 1 State KY Phone	Anne Brady Address 2 Apt. 1 State KY X V Phone Email	

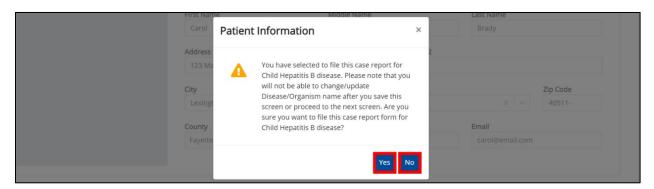
Direct Data Entry for Electronic Case Reports: Child Hepatitis Kentucky Health Information Exchange



Please Note: Once you select a Disease/Organism from the dropdown menu and click **Save** or **Next** on the **Patient Information** screen, a pop-up displays with a message that states:

You have selected to file this case report for [selected disease]. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for [selected disease]?

To save the selected Disease/Organism and proceed to the **Laboratory Information** page, click **Yes**. To change the selected Disease/Organism, click **No**.



41. To change the selected Disease/Organism, click **No** on the Disease/Organism Pop-Up.

First Nam	e Middle Name		 Last Name
Carol	Patient Information	×	
Address 123 Ma City Lexingt County	You have selected to file this case report for Child Hepatitis B disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Child Hepatitis B disease?	2	Zip Code X V 40511- Email
Fayette	Yes	0	

42. If changing the selection, select a different **Disease/Organism** from the dropdown menu.

		PATIENT IN	IFORMATION
Patient Information		Disease/Organism* 😧	Date of Diagnosis*
Laboratory Information		Child Hepatitis C 🛛 🗙 🗸 🗸	04/01/2022 🛗 🗌 Unknown
Exposure Information		Child Hepatitis B	
Hospitalization, ICU & Death Information	A	Child Hepatitis C Yes No	atient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*
Vaccination History		Patient ID (MRN)*	Affiliation/Organization* Test Medical Center
Additional Comments	۵	BB01152020	Test Medical Center × ~



43. Once the Disease/Organism selection is complete, click **Save** to save the change or click **Next** at the bottom of the screen.

		~
Save	Next	

44. The Disease/Organism Pop-Up displays to confirm the change in Disease/Organism selection. To save the selected Disease/Organism, click **Yes**.

Please er	Patient Information ×	
First Nan Carol Address 123 Ma City Lexing	You have selected to file this case report for Child Hepatitis C disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Child Hepatitis C disease?	Last Name Brady 2 Zip Code X V V 40511-
County Fayette	Yes No	Email carol@email.com

45. Upon clicking *Yes* to save the selection, the *Disease/Organism* field is disabled and displays the selected Disease/Organism. You can no longer change the selected Disease/Organism.

CHILD HEPATITIS CASE	REPORT FORM	Section 1	of 7
Please complete the form belo	ow. All fields marked with an asterisk(*) are re	equired.	
	F	PATIENT INFORMATION	
Patient Information Laboratory Information	Disease/Organism* Child Hepatitis C	Date of Diagnosis*	Unknown
the subsequent dy	ynamic screens are cus		the Patient Information screen, ly the information that applies to
the selected Disea	ise/Organism.		

46. Click **Next** to proceed to the **Laboratory Information** screen.

ounty	Phone 🔞	Email
Fayette	× 🗸 (555) 123-1234	carol@email.com
Fayette	× v (555) 123-1234	carol@email.com
Save		Next
Save		



12 Laboratory Information

1. On the **Laboratory Information** screen, select the **appropriate answer** for the conditional question at the top: *Does the patient have a lab test?*

ILD HEPATITIS CASE R Please provide laboratory inform	Section 2 of 7	
Please provide laboratory inform	un relateu to uns case.	
	LABORATORY INFORMATION	
Patient Information	Does the patient have a lab test?*	
Laboratory Information	Yes No	
exposure Information	lf yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin,	
Hospitalization, ICU & Death nformation	Please ensure you complete all fields for that test.	
accination History	A Hepatitis Marker	
Additional Comments	Select 🗸	
Review & Submit	f other, please specify:	
	Results	
	Select V	
	If applicable, please enter the viral load: 🚱	
	Test Result Date Specimen Collection Date	
	mm/dd/yyyy 🚔 🗌 Unknown mm/dd/yyyy 🚔 🗋 Unknown	
	Laboratory Name:	
	Add Hepatitis Marker	
	ALT	
	G Add ALT	
	AST	
	Add AST	
	Bilirubin	
	Add Bilirubin	
	Save Previous Next	
ease Note: If Ye	s selected for the conditional question at the top of the Laboratory	-
formation scree	the subsequent lab-related fields on the screen are enabled. You mus	t
ter details for a l	o test.	

DDE for elCRs: Child Hepatitis User Guide



Patient Information	\odot	Does the patient have a lab test?*
Laboratory Information		Tes
Exposure Information	A	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin,
Hospitalization, ICU & Death Information		please ensure you complete all fields for that test.
Vaccination History	A	Hepatitis Marker*
Additional Comments		Select v
Review & Submit	A	If other, please specify:
		Results*
		Select 🗸 🗸
		If applicable, please enter the viral load: 😧
		Test Result Date Specimen Collection Date* mm/dd/yyyy Imm/dd/yyyy Imm/dd/yyy Imm/dd/yyyy Imm/dd/yyy Imm/dd/yyy Imm/dd/yyyy Imm/dd/yyy Imm/dd/yyyy Imm/dd/yyyy </th
		Laboratory Name:*
	_	
Please Note: If A	<i>lo</i> or <i>U</i>	Inknown is selected, all the subsequent fields on the screen are disabled.

2. Select the appropriate **Hepatitis Marker** from the dropdown menu.

Yes No	
If yes, at least one Hepatitis Marker test is required. If please ensure you complete all fields for that test.	f you choose to enter additional test results such as ALT, AST, or Bilirubi
Hepatitis Marker*	
Select	~
HEPATITIS C VIRUS AB	
HEPATITIS C VIRUS AB SIGNAL/CUTOFF	
HEPATITIS C VIRUS RNA	
Hepatitis C virus RNA panel	
HEPATITIS C VIRUS RRNA	
Other	
Test Result Date	Specimen Collection Date*
ease Note: The <i>Hepatitis Marker</i> drop	down menu displays only the hepatitis marker optic
	ted on the Patient Information screen.

٠



If *Other* is selected from the dropdown menu, the subsequent field is enabled. Enter the **name of the hepatitis marker** in the subsequent textbox: *If other, please specify*.

Other	× ~
	1
other, please specify:*	

3. Select the appropriate **Test Result** from the *Results* dropdown menu.

Select		
Negative		
Pending		
Positive	Specimen Collection	Date*
Undetermined/Inconclusive	mm/dd/yyyy	🛗 🗌 Unknowr

• If *Pending* is selected from the *Results* dropdown menu, the subsequent field is disabled: *Test Result Date.*

Pending	$\times \mid \sim$		
f applicable, please enter th	ie viral load: 😧		
Test Result Date		Specimen Collection	Date*

4. If applicable, enter the **viral load** in the textbox: *If applicable, please enter the viral load.*

Results*	Please enter the viral load	
Positive	or enter 'Unknown' if viral load is not known.	
If applicable place	e enter the viral load: 😧	
ii applicable, please		
li applicable, please		





- 5. If applicable, enter the **Test Result Date**.
- 6. Enter the Specimen Collection Date.

Test Result Date* mm/dd/yyyy	Specimen Collection Date* mm/dd/yyyy
Specimen Collection Date must occur on the <u>sa</u>	cannot occur after the Test Result Date. The <u>me date</u> or any date <u>BEFORE</u> the Test Result Date. occurs after the Test Result Date, both fields are
If you click Next , the Laboratory Information that states: <i>There are errors. Please make a se</i>	screen displays an error banner with a message <i>lection for all required fields</i> .
To proceed, you must enter a valid Specimen Result Date.	Collection Date that occurs <u>on</u> or <u>before</u> the Test
Test Result Date* 07/23/2021 Invalid Test Result Date	Specimen Collection Date* 07/26/2021 Unknown Invalid Specimen Collection Date

7. Enter the **Laboratory Name** in the textbox.

Laboratory Name:*	

Adding Multiple Hepatitis Markers

8. You can click **Add Hepatitis Marker** to log the details for multiple hepatitis markers. This means that you can easily enter additional hepatitis markers on the same patient.

Laboratory Name:*		
Test Lab		
Add Hepatitis Marker		
ALT		
🔂 Add ALT		



• To delete an additional hepatitis marker, click the **Trash Bin Icon** located at the top right.

Laboratory Name:*			
Test Lab			
Hepatitis Marker*			
Select	· ·		
f other, please specify:			
Results*			
Select	~		
f applicable, please enter the vi	ral load: 😧		
Fest Result Date		Specimen Collection Date*	
mm/dd/yyyy	time Unknown	mm/dd/yyyy	iii Unknown
.aboratory Name:*			
aboratory Name."			
•			
🕂 Add Hepatitis Marker			

Adding ALT

9. You can click **Add ALT** to log the details for an ALT.

Add Hepatitis Marker			
ALT			
G Add ALT			
AST			
G Add AST			
Bilirubin			
Add Bilirubin			
Save	Previous	Next	\$





• To delete an ALT, click the **Trash Bin Icon** located at the top right.

ALT	
Results:*	Units/Liter
Reference:*	Units/Liter
Test Result Date*	Specimen Collection Date* mm/dd/yyyy Imm/dd/yyyy
Laboratory Name:*	

Adding AST

10. You can click **Add AST** to log the details for an AST.

🕂 Add ALT			
AST			
Add AST			

• To delete an AST, click the **Trash Bin Icon** located at the top right.

AST	
Results:*	Units/Liter
Reference:*	Units/Liter
Test Result Date*	Specimen Collection Date* mm/dd/yyyy Imm/dd/yyyy
Laboratory Name:*	



Adding Bilirubin

11. You can also click **Add Bilirubin** to log the details for Bilirubin.

Add AST	
Bilirubin	
G Add Bilirubin	

• To delete the Bilirubin details, click the **Trash Bin Icon** located at the top right.

Bilirubin	
Results:*	mg/dL
Reference:*	mg/dL
Test Result Date*	Specimen Collection Date* mm/dd/yyyyy
Laboratory Name:*	
🛨 Add Bilirubin	
Save	Previous Next

12. Once the **Laboratory Information** screen is complete, click **Next** to proceed to the **Exposure Information** screen.

🔂 Add Bilirubin			
Save	Previous	Next	\$



13 Exposure Information

1. On the **Exposure Information** screen, select the **appropriate answer** for the conditional question at the top: *Did the patient have any of the following exposures in the past 6 months*?

CHILD HEPATITIS CASE R	EPORT F	ORM			Section 3 of 7		
Please select the information that	at the patient	was exposed to p	rior to illness				
			EX	POSURE INFO	RMATION		
Patient Information	\odot	Did the patient	have any of	the following expo	sures in the past 6 months?	•	
Laboratory Information	\odot	Yes	No	Unknown			
Exposure Information		Mother Hepati	tis D Virus po	sitius			
Hospitalization, ICU & Death Information		Yes	No	Unknown			
Vaccination History	a	Mother Hepati					
Additional Comments		Yes	No	Unknown			
		HBV Contact Ex	xposure				
Review & Submit		Yes	No	Unknown			
		HCV Contact Ex	xposure				
		Yes	No	Unknown			
		Foreign Born					
		Yes	No	Unknown			
		If yes, please s	pecify country	y: 🔞			
		Select					
		Is this part of a	n outbreak?*	,			
		Yes	No	Unknown			
		If yes, please s	pecify the nai	ne of the outbrea	c 🔞		

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

Patient Information	0	Did the patient have any of the following exposures in the past 6 months?*	
Laboratory Information	\oslash	Yes No Unknown	
Exposure Information			
Hospitalization, ICU & Death Information	a	Mother Hepatitis B Virus positive* Yes No Unknown	
Vaccination History		Mother Hepatitis C Virus positive*	
Additional Comments		Yes No Unknown	
Review & Submit	A	HBV Contact Exposure* Yes No Unknown	
		HCV Contact Exposure*	
		Yes No Unknown	
		Foreign Born*	
		Yes No Unknown	
		If yes, please specify country: 🚱	_
		Select	× .
		Is this part of an outbreak?*	
		Yes No Unknown	





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**.

Outbreak-related questions are not impacted by the selected answer for the conditional question: Did the patient have any of the following exposures in the past 6 months?

- 3. If applicable, select the **appropriate answer** to the field: *Mother Hepatitis B Virus positive*.
- 4. If applicable, select the **appropriate answer** to the field: *Mother Hepatitis C Virus positive*.
- If applicable, select the **appropriate answer** to the field: *HBV Contact Exposure*. 5.
- 6. If applicable, select the **appropriate answer** to the field: *HCV Contact Exposure*.

have any of t	he following exposu	es in the past 6 months?*	
No	Unknown		
s B Virus pos	sitive*		
No	Unknown		
s C Virus pos	iitive*		
No	Unknown		
oosure*			
No	Unknown		
oosure*			
No	Unknown		
No	Unknown		
	No s B Virus pos No s C Virus pos No posure* No posure*	No Unknown s B Virus positive* No No Unknown s C Virus positive* No No Unknown posure* No No Unknown posure* No No Unknown	s B Virus positive* No Unknown s C Virus positive* No Unknown posure* No Unknown posure* No Unknown

7. If applicable, select the **appropriate answer** for the conditional question: *Foreign Born*.

Yes	No	Unknown	
yes, please s	pecify country	/: 🕜	
Select			

٠



If *Yes* is selected for the *Foreign Born* field, the subsequent field is enabled. Select the **name of the country** from the subsequent dropdown menu: *If yes, please specify country*.

Foreign Born* Please select 'Unknown' if information of the country of birth is not available.	
If yes, please specify country:* 🖗	
Select	~
AFGHANISTAN	
ALBANIA	
ALGERIA	
AMERICAN SAMOA	
ANDORRA	
ANGOLA	
ANGUILLA	

8. Select the **appropriate answer** for the field: *Is this part of an outbreak?*

/es	No	Unknown
es, please sp	ecify the nam	ne of the outbrea

 If *Yes* is selected for the *Is this part of an outbreak?* field, the subsequent field is enabled. Enter the name of the outbreak in the subsequent textbox: *If yes, please specify the name of the outbreak*.

	Please enter 'Unknown' if	
Yes No	the details of outbreak is not available.	

10. Once complete, click **Next** to proceed to the **Hospitalization**, **ICU**, and **Death Information** screen.

Is this part of an outbreak?* Yes No Unknown If yes, please specify the name of the outbreak: @	
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*?

HILD HEPATITIS CASE R	PORT FORM Section 4 of 7
Please select any applicable hos	lization, ICU and death information related to this case.
	HOSPITALIZATION, ICU & DEATH INFORMATION
Patient Information	Was the patient hospitalized?*
Laboratory Information	Ves No Unknown
Exposure Information	©
Hospitalization, ICU & Death Information	If yes, please specify the hospital name: 🕢
Vaccination History	Admission Date Discharge Date
Additional Comments	Still hospitalized
Review & Submit	<u>ــــــــــــــــــــــــــــــــــــ</u>
	Was the patient admitted to an intensive care unit (ICU)? Yes No Unknown Admission Date to ICU Discharge Date from ICU mm/dd/yyyy Image: Constraint of the second sec
	Did the patient die as a result of this illness?* Yes No Unknown If yes, please provide the date of death: Date of Death

2. If *Yes* is selected for the conditional question, the subsequent hospitalization-related fields and ICU-related fields on the screen are enabled.

Patient Information	\odot	Was the patient hospitalized?*	
Laboratory Information	\odot	Yes No Unknown	
Exposure Information	\odot	If yes, please specify the hospital name:* 🚱	
Hospitalization, ICU & Death Information		n yes, please speciny the hospital hame:"	
Vaccination History	a	Admission Date*	Discharge Date*
Additional Comments	A		Still hospitalized
Review & Submit			
		Was the patient admitted to an intensive care unit (ICU)?* Yes No Unknown Admission Date to ICU Unknown	Discharge Date from ICU
		Was the patient admitted to an intensive care unit (ICU)?* Yes No Unknown	
		Admission Date to ICU mm/dd/yyyy	Discharge Date from ICU mm/dd/yyyy



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

3. If the patient has been hospitalized, enter the **name of the hospital where the patient is/was hospitalized** in the textbox: *If yes, please specify the hospital name*.

Yes	No	Please enter the name of
		the hospital where the patient is/was hospitalized.
lf yes, please spe		

4. Enter the patient's hospitalization **Admission Date**. If the Admission Date is unknown, click the **Unknown** checkbox.

Admission Date*		Discharge Date*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown

- 5. Enter the patient's hospitalization **Discharge Date**.
- If the patient is still hospitalized, click the **Still Hospitalized** checkbox.

Admission Date*		Discharge Date*	
10/01/2021	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
		Still hospitalized	

• If the **Still Hospitalized** checkbox is selected, the subsequent death-related field is disabled: *Did the patient die as a result of this illness?*

Admission Date*		Discharge Date*	
01/03/2022	🛗 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown
		Still hospitalized	
Was the patient adm	itted to an intensive care unit (ICU)?	?*	
Yes	No Unknown		
Admission Date to IC	U	Discharge Date from ICU	
mm/dd/yyyy	the Unknown	mm/dd/yyyy	Unknown



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 click **Next**, both fields are marked as invalid, and 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.

HILD HEPATITIS CASE REPORT FORM			Section 4 of 7	
There are errors. Please make a selection for all required	I fields.			
		HOSPITALIZATION, ICU & DEATH INFORMATIO	N	
Patient Information	Was the patient hospitalized?*			
Laboratory Information	Yes No Unknown		_	
Exposure Information	If yes, please specify the hospital name:* (Information	×	
Hospitalization, ICU & Death Information	Baker Clinic			
Vaccination History	Admission Date*	The date of hospital discharge cannot be earlier than the date of hospital admission.	Discharge Date*	
Additional Comments	11/28/2021 Invited Admission Date		11/05/2021	📋 🗌 Unknown
Review & Submit		ОК	Still hospitalized	
	Was the patient admitted to an intensive of Yes No Unknown			
	Admission Date to ICU		Discharge Date from ICU	
HILD HEPATITIS CASE REPORT FORM				
ALL PREPARING CASE REPORT FORM			Section 4 of 7	

Patient Information	0	HOSPITALIZATION, ICU & I	DEATH INFORMATION		
aboratory Information	0	Yes No Unknown			
Exposure Information	0				
Hospitalization, ICU & Death Information		If yes, please specify the hospital name:* 🕢 Baker Clinic			
Vaccination History	a	Admission Date*	Discharg		
Additional Comments	_	11/28/2021	Unknown 11/05/		Unknown
Review & Submit			Still Invalid Dis	hospitalized charge Date	
		Was the patient admitted to an intensive care unit (ICU)?*			
		Yes No Unknown Admission Date to ICU mm/dd/yyyy	Unknown mm/dr	e Date from ICU	Unknown

6. Select the **appropriate answer** for the field: *Was the patient admitted to an intensive care unit (ICU)*?



as the patien	t admitted to	an intensive ca	re unit (ICU)?*		
Yes	No	Unknown			
dmission Date	e to ICU			Discharge Date from ICU	
mm/dd/yyyy			Unknown	mm/dd/yyyy	Unknown

• If *Yes* is selected, the subsequent *Admission Date to ICU* and *Discharge Date from ICU* fields are enabled. Enter the dates for the **Admission Date to ICU** and the **Discharge Date from ICU**.

Admission Date to ICU* Discharg	rge Date from ICU*
mm/dd/yyyy 🛗 🗌 Unknown mm/d	dd/yyyy 🖮 🗌 Unknown

7. If applicable, select the **appropriate answer** for the field: *Did the patient die as a result of this illness*?

Did th	ne patier	nt die i	as a res	ult of	this illness?	
	Yes		No		Unknown	
f yes,	, please	provid	le the d	ate o	f death:	
Date	of Death	٦				
mm	/dd/yyy					Unknown

• If *Yes* is selected, the subsequent *Date of Death* field is enabled. Enter the patient's **Date of Death**.

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

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



		HOSPITALIZATION, ICU & DEATH INFOR	MATION
Patient Information	\otimes	Was the patient hospitalized?*	
Laboratory Information	0	Yes No Unknown	
Exposure Information	\oslash		
Hospitalization, ICU & Death Information	Ø	If yes, please specify the hospital name:* Test Hospital	
Vaccination History	Ø	Admission Date*	Discharge Date*
Additional Comments	0	01/03/2022 🛗 🗌 Unknown	01/10/2022 iii Unknown
Review & Submit			
		Was the patient admitted to an intensive care unit (ICU)?* Yes No Unknown	
		Admission Date to ICU*	Discharge Date from ICU*
		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

15 Vaccination History

The **Vaccination History** screen is dynamic and displays fields depending on the Disease/Organism selected on the **Patient Information** screen of the Child Hepatitis Case Report. The **Vaccination History** screen collects details only when *Child Hepatitis B* is selected as the Disease/Organism.

Vaccination History for Child Hepatitis B

When *Child Hepatitis B* is selected as the Disease/Organism, the **Vaccination History** screen collects vaccine details for the patient.

1. Select the **appropriate answer** to the conditional question at the top: *Has the patient ever received a Hepatitis B vaccine?*





		V	ACCINATI	ON HISTORY			
atient Information	Ø	Has the patient ever receive	d a Hepatitis	B vaccine?*			
aboratory Information	${}^{\oslash}$	Yes No	Unknow	vn Refused			
xposure Information	${ \oslash }$						
lospitalization, ICU & Death	Ø	Vaccine Details					
nformation	Ū	If yes, please provide vaccin	e name: 🔞				
accination History		Select					
dditional Comments		If other, please specify: 🚱					
aditional Comments				-			
eview & Submit		If yes, please enter the num	ber of doses	0			
		If yes, please specify the dat	e administer	ed Q			
		Date Administered (1st dose			Date Administered (2nd dos	e)	
		mm/dd/yyyy		Unknown	mm/dd/yyyy		Unknown
		Date Administered (3rd dos	e)		Date Administered (4th dos	e)	
		mm/dd/yyyy		Unknown	mm/dd/yyyy		Unknown
		🚯 Add Vaccine					
		For Infants born to mothers	with HBV, w	as HBIG given?*			
		Yes No	Unknow	vn			



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

		VACCINATION HISTORY
Patient Information	\otimes	Has the patient ever received a Hepatitis B vaccine?*
Laboratory Information	\oslash	Yes No Unknown Refused
Exposure Information	\oslash	Vaccine Details
Hospitalization, ICU & Death Information	\oslash	If yes, please provide vaccine name:* 🚱
Vaccination History		Select V
Additional Comments		· · · · · · · · · · · · · · · · · · ·
Review & Submit	a	If yes, please enter the number of doses:* Select
		If yes, please specify the date administered: 🚱
		Date Administered (1st dose) Date Administered (2nd dose)
		mm/dd/www mm/dd/www mm/dd/www

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

2. Select the **appropriate vaccine** from the dropdown menu: *If yes, please provide vaccine name*.

_ _ _ _

Patient Information	\odot	Has the patient ever received a Hepatitis B vaccine?*	
Laboratory Information	\odot	Yes No Unknown Refused	
Exposure Information	\odot	Vaccine Details	
Hospitalization, ICU & Death Information	0	lf yes, please provide vaccine name:* 🕢	
Vaccination History		Select	×
Additional Comments		Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.	
Review & Submit	a	Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)	
		DTaP-hepatitis B and poliovirus vaccine	
		DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine	
		Haemophilus influenzae type b conjugate and Hepatitis B vaccine	
		hepatitis A and hepatitis B vaccine	
		hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)	

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

the name of vaccine is not known.	× ~
ase specify:* 🚱	
e enter the number of doses:* 🚱	
-	
	the name of vaccine is not known.





• From the dropdown menu: *If yes, please enter the number of doses*, select the **number of doses** that the patient received for the selected vaccine.

hepatitis B vaccine, adolesce	nt/high risk infant dosage	× ~
f other, please specify: 😧	Please select the number of doses that the patient received for the selected vaccine.	
f yes, please enter the number Select	er of doses:* 🤪	~
		•
		*
1		, ,
1 2		
1 2 3		

If **1** is selected as the number of doses, the *Date Administered (1st dose)* field is enabled. Enter the **Date Administered (1st Dose)**.

1			X \
lf yes, please specify the d Date Administered (1st do		Date Administered (2nd do	ose)
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	time Unknown
Date Administered (3rd d	ose)	Date Administered (4th do	se)
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

If 2 is selected as the number of doses, both of the subsequent fields are enabled: Date Administered (1st dose) and Date Administered (2nd dose). Enter the Date Administered (1st dose) and Date Administered (2nd dose) in the appropriate fields.

If yes, please enter the nu	mber of doses:* 😯		х
lf yes, please specify the d	ate administered: 😧		
Date Administered (1st do	se)*	Date Administered (2nd o	lose)*
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown
Date Administered (3rd do	ose)	Date Administered (4th d	ose)
mm/dd/yyyy	🗰 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

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If **3** is selected as the number of doses, the following subsequent fields are enabled: *Date Administered (1st dose), Date Administered (2nd dose),* and *Date Administered (3rd dose).* Enter the **Date Administered (1st dose), Date Administered (2nd dose)**, and **Date Administered (3rd dose)** in the appropriate fields.

ate Administered (1st dos	ie)*	Date Administered (2nd dose)*		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
ate Administered (3rd dos	se)*	Date Administered (4th do	ose)	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown	

If *4* is selected as the number of doses, the following subsequent fields are enabled: *Date Administered (1st dose), Date Administered (2nd dose), Date Administered (3rd dose), and Date Administered (4th dose). Enter the Date Administered (1st dose), Date Administered (2nd dose), Date Administered (3rd dose), and Date Administered (4th dose) in the appropriate fields.*

f yes, please specify the date a			
Date Administered (1st dose)*		Date Administered (2nd dose)*
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Date Administered (3rd dose)*	r	Date Administered (4th dose)	*
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

Adding Multiple Vaccines

• You can also click **Add Vaccine** to log the details for multiple vaccines.





Date Administered (3rd do	ose)*	Date Administered (4th	dose)*
06/15/2021	🛗 🗌 Unknown	12/20/2021	🛗 🗌 Unknown
Add Vaccine			
For Infants born to mothe	rs with HBV, was HBIG given?*		

• To delete an additional vaccine, click the **Trash Bin Icon** located at the top right.

f yes, please provide vaccine na	me:* 😧				
Select	•				~
f other, please specify: 🕑					
f yes, please enter the number	of doses:	* 0			
Select					\sim
f yes, please specify the date ac	Iminister	ed: 🕜			
Date Administered (1st dose)			Date Administered (2nd dose)		
mm/dd/yyyy		Unknown	mm/dd/yyyy	Unknown	
Date Administered (3rd dose)			Date Administered (4th dose)		
mm/dd/yyyy		Unknown	mm/dd/yyyy	Unknown	

3. Select the **appropriate answer** for the conditional question: *For infants born to mothers with HBV, was HBIG given*?

🔒 Add Va	accine		
For Infants	born to moth	ers with HBV,	was HBIG giver
Yes	No	Unkno	own
		date administe	ered: 🕜
Date Admir	histered		
mm/dd/y	ууу		Unknov

If **Yes** is selected for the conditional question, the subsequent field is enabled: *If yes, please specify the date administered.* Enter the **Date Administered**.

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Yes	No	Unknown	
lf yes, please sp	ecify the date	e administered:	0
	rod		
Date Administer	eu		

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

HILD HEPATITIS CASE RI	EPORT FO	RM	S	Section 5 of 7		
Please provide the vaccination his	istory of the pa	tient related to this case.				
		VACCIN	ATION HISTORY			
Patient Information	\odot	Has the patient ever received a Hepa	ititis B vaccine?*			
Laboratory Information	\odot	Yes No Un	known Refused			
Exposure Information	\odot					
Hospitalization, ICU & Death Information	Ø	Vaccine Details If yes, please provide vaccine name:	P			
Vaccination History		hepatitis B vaccine, adolescent/high	n risk infant dosage		× ~	
Additional Comments	A	If other, please specify: 🚱				
Review & Submit	A	If yes, please enter the number of do	oses:* 🕜		x ~	
		If yes, please specify the date admin	stered: 🚱			
		Date Administered (1st dose)*		Date Administered (2nd dose)*		
			Unknown	12/10/2020	iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	
		Date Administered (3rd dose)*	Unknown	Date Administered (4th dose)* 12/20/2021	🛗 🗌 Unknown	
		Add Vaccine				
			known			
		If yes, please specify the date admin Date Administered 06/30/2020	istered: 🖗			
		Save		Previo	ous Next	



Vaccination History for Child Hepatitis C

The **Vaccination History** screen is disabled and does <u>**not**</u> collect information when *Child Hepatitis C* is selected as the Disease/Organism.

- 1. If *Child Hepatitis C* is selected as the Disease/Organism, the Vaccination History screen displays message that states: *No information is required to be provided on this screen. Please click the "Next" button to proceed.*
- 2. To proceed to the Additional Comments screen, click Next.

	VACCINATION HISTORY
\otimes	
\odot	NOTE: No information is required to be provided on this screen. Please click on the "Next" button to proceed.
\odot	
\odot	The Vaccination History screen does <u>not</u> collect
	vaccination details for
	Child Hepatitis C.
	
	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.

CHILD HEPATITIS CASE R	EPORT FO	DRM Section 6 of 7
Please add any additional comm	ents related to	o this case.
		ADDITIONAL COMMENTS
Patient Information	\odot	Additional comments or notes, please specify:
Laboratory Information	\odot	
Exposure Information	\odot	
Hospitalization, ICU & Death Information	\odot	
Vaccination History	\odot	
Additional Comments		0/1000 Characters
Review & Submit	a	
		Save Previous Next



17 Review and Submit

The **Review and Submit** screen displays a summary of the information you have entered. Prior to submitting the case report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report form.

Print or Download Functionality

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

CHILD HEPATITIS CASE I	CHILD HEPATITIS CASE REPORT FORM Section 7 of 7								
Please review your information b	efore submitt	ing.							
		REVIEV	/ & SUBMIT						
Patient Information	Ø		_						
Laboratory Information	\odot		6	Print 🛃 Download					
Exposure Information	\odot	Patient Information		0					
Hospitalization, ICU & Death Information	\odot	Disease/Organism	Date of Diagnosis						
Vaccination History	\odot	Child Hepatitis B	Unknown						
Additional Comments	\odot	Yes	or Patient ID (MRN), Person Completing Form, and Attending F	nysician/Clinician?					
Review & Submit		Patient ID (MRN) HEPB20220510	Affiliation/Organization Test Medical Center						
		Person Completing Form Mr. Arthur Vandelay, Il (arthur@email.com)	Affiliation/Organization Test Medical Center						
		Attending Physician/Clinician	Affiliation/Organization						

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

HEPATIT	Patient Information		Destination	SecurePrintUS	•	
	Disease/Organism Perinatal Hepatitis C		Destination	- Seculer mitos		
ur informatio	Date of Diagnosis 09/01/2021		Pages	All	•	
	Is the Affiliation/Organization same for Patient ID (MR Physician/Clinician? No	tN), Person Completing Form, and Attending	Copies	1	- 5	
	Patient ID (MRN) BR10291942		Color	Color	•	
ion	Affiliation/Organization Test Medical Center				- 5	
	Person Completing Form Mr. Marty Craine, Sr (marty@email.com)		More settings		~ Dr	int 👤 Download
mation	Affiliation/Organization Other				Pr	int 📩 Download
toms	If other, please specify: Test Hospital				_	
com5	Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)					0
ns	Affiliation/Organization Test Medical Center					
ation	First Name Bob	Last Name Ross				
ation	Suffix Sr					
CU & Death I	Date of Birth 10/29/1942	Ethnicity Not Hispanic or Latino				
pry	Race Unknown					
n y	Address 1 123 Painting Lane					
hents	City Frankfort	State KY				
	Zip Code 40601				<i>r</i> :	
	County Franklin	Phone (555) 555-5555				
	Email bob@email.com					
	Is the patient currently pregnant? No			Print Can	el	
	Is the patient postpartum?					

Direct Data Entry for Electronic Case Reports: Child Hepatitis





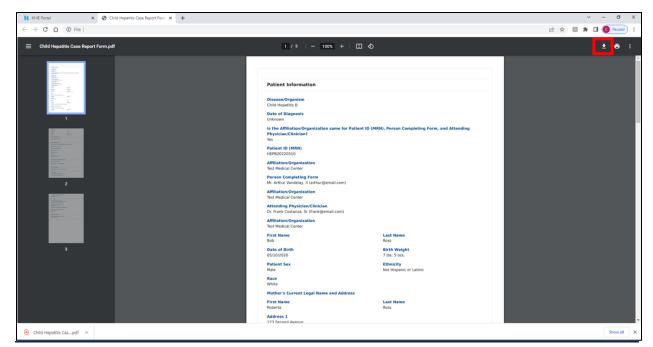
2. Click **Download** to download a PDF version of the case report.

		REVIEW & SUBMIT		
Patient Information	${\boldsymbol{ \oslash}}$		_	
Laboratory Information	\odot		Print	Download
Exposure Information	\odot	Patient Information		0
	0			•

- 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.

		REVIEW	/ & SUBMIT		
Patient Information	\odot			_	
Laboratory Information	\odot	Download PDF	×	🖶 Print 📩 Dow	nload
Exposure Information	\odot	Patie Downloaded successfully			0
Hospitalization, ICU & Death Information	0	Diseas	ок		
Vaccination History	\odot	Child I			
Additional Comments	0	Is the Affiliation/Organization same f Yes	or Patient ID (MRN), Person Completing Form,	and Attending Physician/Clinician?	
Review & Submit		Patient ID (MRN) HEPB20220510	Affiliation/Organization Test Medical Center		
		Person Completing Form Mr. Arthur Vandelay, Il (arthur@email.com)	Affiliation/Organization Test Medical Center		
		Attending Physician/Clinician	Affiliation/Organization		
Hepatitis Caspdf 🔷					1

- 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.



Direct Data Entry for Electronic Case Reports: Child Hepatitis Page 90 of 106

Kentucky Health Information Exchange



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

Applicable Symptoms	\oslash	Patient Information			
Medical Conditions	\odot				
Exposure Information	\oslash	Disease/Organism Perinatal Hepatitis C	Date of Diagnosis 09/01/2021		
Hospitalization, ICU & Death Information	\odot	Is the Affiliation/Organization same for Patient ID No	0 (MRN), Person Completing Form, and Atte	ending Physician/Clinician?	
Vaccination History	\odot	Patient ID (MRN)	Affiliation/Organization		
Additional Comments	\oslash	BR10291942	Test Medical Center		
Review & Submit		Person Completing Form Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization Other	If other, please specify: Test Hospital	
		Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Test Medical Center		
Applicable Symptoms	\odot	Patient Information			٢
Medical Conditions	\oslash				-
Exposure Information	\oslash	Laboratory Information			\odot
Hospitalization, ICU & Death Information	\odot				
Vaccination History	\oslash	Does the patient have a lab test? Yes			
Additional Comments	${\boldsymbol{ \oslash}}$				
Review & Submit		Hepatitis Marker Hepatitis C virus RNA panel			
		Results Positive			

4. Review the *Patient Information* section.

aboratory information	-	Patient Information			
xposure Information	0	Disease/Organism	Date of Diagnosis		
ospitalization, ICU & Death Information	0	Child Hepatitis C	04/01/2022		
ccination History	0	Is the Affiliation/Organization same for Patient ID (Yes	MRN), Person Completing Form, and Attending P	hysician/Clinician?	
ditional Comments	0	Patient ID (MRN)	Affiliation/Organization		
view & Submit	n	BB01152020	Test Medical Center		
		Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center		
		Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Test Medical Center		
		First Name Bobby	Last Name Brady		
		Suffix Jr	Date of Birth 01/15/2020	Birth Weight 7 Ibs, 5 ozs,	
		Patient Sex Male	Ethnicity Not Hispanic or Latino	Race White	
		Mother's Current Legal Name and Address			
		First Name Carol	Middle Name Anne	Last Name Brady	
		Address 1 123 Main Street	Address 2 Apt. 1		
		City Lexington	State KY	Zip Code 40511	
		County Fayette	Phone (555) 123-1234	Email carol@email.com	
		Does the patient have Neonatal Abstinence Syndro Yes	ome?		
		Who does the infant/child live with? Mother			
		Contact info of person the child is living with:			
		First Name Carol	Middle Name Anne	Last Name Brady	
		Address 1 123 Main Street	Address 2 Apt. 1		
		City Lexington	State KY	Zip Code 40511	
		County Fayette	Phone (555) 123-1234	Email carol@email.com	





5. Review the Laboratory Information section.

Laboratory Information		۵
Does the patient have a lab test? Yes		
Hepatitis Marker HEPATITIS C VIRUS AB		
Results Positive		
Test Result Date 03/28/2022	Specimen Collection Date 03/28/2022	
Laboratory Name: Test Lab		
Hepatitis Marker HEPATITIS C VIRUS AB SIGNAL/CUTOFF		
Results Pending		
Specimen Collection Date 03/29/2022		
Laboratory Name: Test Lab		

6. Review the *Exposure Information* section.

Review & Submit	Exposure Information	٢
	Did the patient have any of the following exposures in the past 6 months? No	
	Mother Hepatitis B Virus positive No	
	Mother Hepatitis C Virus positive No	
	HBV Contact Exposure No	
	HCV Contact Exposure No	
	Foreign Born No	
	Is this part of an outbreak? No	

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

Review & Submit	Exposure Information		۲
	Hospitalization, ICU & Death Information		۵
	Was the patient hospitalized? Yes		
	If yes, please specify the hospital name: Test Hospital		
	Admission Date 01/03/2022	Discharge Date 01/10/2022	
	Was the patient admitted to an intensive care unit (ICU)? Yes		
	Admission Date to ICU 01/08/2022	Discharge Date from ICU 01/10/2022	
	Did the patient die as a result of this illness? No		





8. If applicable, review the *Vaccination History* section.

Vaccination History	0
Has the patient ever received a Hepatitis B vaccine? Yes	
103	
Vaccine Details	
If yes, please provide vaccine name: hepatitis B vaccine, adolescent/high risk infant dosage	
If yes, please enter the number of doses: 1	
If yes, please specify the date administered:	
Date Administered (1st dose) 11/20/2020	
Vaccine Details	
If yes, please provide vaccine name: hepatitis B vaccine, pediatric or pediatric/adolescent dosage	
If yes, please enter the number of doses: 1	
If yes, please specify the date administered:	
Date Administered (1st dose) 04/15/2021	
For Infants born to mothers with HBV, was HBIG given? Yes	
If yes, please specify the date administered:	
Date Administered Unknown	
Additional Comments	۵

Please Note: The Vaccination History screen is enabled and collects information only when
 Child Hepatitis B is selected as the Disease/Organism.

9. Review the Additional Comments section.

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





Click Hyperlinks to Edit

- 10. 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 the side navigation bar.

CHILD HEPATITIS CASE I	REPORT F	ORM	Section 7 of 7
Please review your information b	efore submitt	ing.	
		REVIEV	V & SUBMIT
Patient Information	ø		
Laboratory Information	\odot		🔒 Print 🛛 🛃 Download
Exposure Information	\odot	Patient Information	۵
Hospitalization, ICU & Death Information	0	Disease/Organism	Date of Diagnosis
Vaccination History	\odot	Child Hepatitis B	Unknown
Additional Comments	\odot	Is the Affiliation/Organization same Yes	for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
Review & Submit		Patient ID (MRN) HEPB20220510	Affiliation/Organization Test Medical Center
		Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center
		Attending Physician/Clinician Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization Test Medical Center

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

		PATIENT INF	FORMATION	
Patient Information	Ø	Disease/Organism* 😧	Date of Diagnosis*	
Laboratory Information	\odot	Child Hepatitis B 🗸 🗸	06/01/2020	🛗 🗌 Unknown
Exposure Information	\odot			
Hospitalization, ICU & Death Information	\odot	Is the Affiliation/Organization same for Pa Yes No	atient ID (MRN), Person Completing I	Form, and Attending Physician/Clinician?*
Vaccination History	\odot	Patient ID (MRN)* 😧	Affiliation/Organization* 😧	
Vaccination History		Patient ID (MRN)* 🚱 HEPB051020	•	x ~
	0 0	HEPB051020	Test Medical Center	
Additional Comments			Test Medical Center	× │ ∽ If other, please specify: ❷
Vaccination History Additional Comments Review & Submit		HEPB051020 Person Completing Form*	Test Medical Center	If other, please specify: 🚱



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

		arked with an asterisk(*) are required.			
		PATIENT	INFORMATION		
Patient Information	Ø	Disease/Organism* 😧	Date of Diagnosis*		
Laboratory Information	\odot	Save Changes?		× (Unknown
Exposure Information	\odot				
Hospitalization, ICU & Death Information	Ø	Is the Aff There's information on thi Yes Do you want to save it?	s screen that has not been saved.	Form, and	d Attending Physician/Clinician?*
Vaccination History	Ø	Patient II HEPBO:	No - Discard Yes - Save		
Additional Comments	\odot		Affiliation/Organization		If other please specific Q
Review & Submit		Mr. Arthur Vandelay, II (art ×			n outer, please specify.
	0	Person Completing Form*	Affiliation/Organization @	x v	If other, please specify: 😡
		Attending Physician/Clinician*	Affiliation/Organization 🚱		If other, please specify: 📀

13. Review your edits on the **Review and Submit** screen.

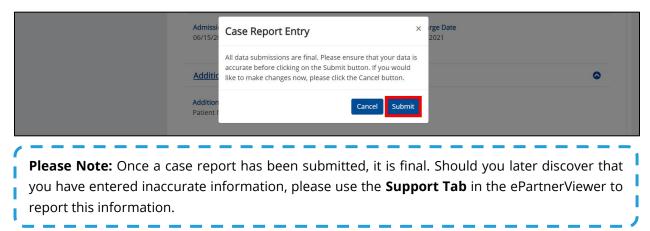
CHILD HEPATITIS CASE I	REPORT F	ORM	Section 7 of 7
Please review your information b	efore submitt	ing.	
		REVIE	W & SUBMIT
Patient Information	\odot		
Laboratory Information	\odot		Print 🛃 Download
Exposure Information	\odot	Patient Information	•
Hospitalization, ICU & Death Information	\otimes	Disease/Organism	Date of Diagnosis
Vaccination History	\odot	Child Hepatitis B	06/01/2020 for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
Additional Comments	\odot	Yes	to raden to (whith, reson completing room, and Attending Physicial/Clinician
Review & Submit		Patient ID (MRN) HEPB051020	Affiliation/Organization Test Medical Center

14. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Child Hepatitis Case Report Entry.

Additional Comments			٥
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 Case Report or click **Submit** to submit the report.



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

Admissi 06/15/20	Case Report Entry ×		rge Date 2021
Additic Addition	Case Report Entry Saved Successfully		٥
Patient I.			

Please Note: Clicking **OK** when the case report entry has been submitted successfully will automatically navigate you to the **Case Report Entry User Summary** screen.

Congratulations! You have submitted the Child Hepatitis 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	tnerView	er				🖂 Supp	oort 📢 Anr	nouncements	🔺 Advisories 1	9
Patient S	earch	Bookmar	ked Patients		Event Notificatio	ns	Lab D	ata Entry 🕶		Case Rej	oort Entry -
Home >	Case Report Entry U	Jser Summary									
			CASE RE	PORT	ENTRY	USER S	UMMA	RY			
LAST UPD	TED DATE RANG	GE	Start Date	10/01/2021	ŧ	E	nd Date 10/01/	2021	#		🕄 Retrieve Data
SHOWING 1 ITEMS											APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME	DATE OF BIRTH 🗘	PATIENT SEX 🗘	STATUS	LAST UPDATED 🕈	SUBMISSION DATE +
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
			First	Back <mark>1</mark> Nex	t 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	EP	0	RT	Ē	N	T	RY	ίι	JSER SL	JMMA	RY				
LAST UPD	ATED DATE RANG	GE	Start Date	09/0	01/20	021	_	i				Er	nd Date 10/01	/2021	曲		C Retrieve Da	ata
SHOWING 1 ITEMS					Sep Mo	eptemi tember Tu V 31	• 20 Ve Tł	021 v h F	r Sa	۰.							T APPLY FILTE	āR
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM 🗘	AFFILIATION/ ORGANIZATION	19	20	14 1 21 2	22 23	6 1 3 2	4 2	8	÷	LAST NAME	DATE OF BIRTH 🗘	PATIENT SEX ◆	STATUS \$	LAST UPDATED 🗘	SUBMISSION DATE	•
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	26	27	28 2	29 30	0 1	1 2	2		Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM	

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

			CASE RE	PORT	ENTRY	USER SI	JMMAI	RY			
LAST UPDA	TED DATE RANG	GE	Start Date	09/01/2021	#	E	nd Date 10/01	/2021	#		🕄 Retrieve Data
SHOWING 1 ITEMS											T APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM \$	AFFILIATION/ ORGANIZATION \$	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH 🗘	PATIENT SEX 🗘	STATUS	LAST UPDATED 🕈	SUBMISSION DATE +
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM

Direct Data Entry for Electronic Case Reports: Child Hepatitis



The following error me	Date must be within the last six months from the current date. ssage displays when Users search for a Start Date that occurred more lease select a Start Date that is within the last six months from today?	
·		,
	CASE REPORT ENTRY USER SUMMARY	
LAST UPDATED DATE RANGE	Start Date 12/01/2020 🚔 End Date 07/29/2021 🚔 🖉 Retrieve Date	ta

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

tart Date that is within the last six m

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

today's date.

TITEMS											T APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION ÷	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🕈	DATE OF BIRTH +	PATIENT SEX \$	STATUS	LAST UPDATED	SUBMISSION DATE
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	EB01011990	Elaine	Benes	01/01/1990	Female	In Progress	10/01/2021 12:30 PM	10/01/2021 12:30 PM
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	09/24/2021 01:45 PM	09/24/2021 01:45 PM
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	НерС	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Monica	Gellar	01/15/1992	Female	Complete	09/17/2021 10:12 AM	09/17/2021 10:12 AM
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Daphne	Moon	04/22/1994	Female	In Progress	09/15/2021 03:52 PM	

 The Filter fields display. You can search by entering the *Report Type, Disease/Organism, 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.

	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN \$	FIRST NAME	LAST NAME	DATE OF BIRTH 🗘	PATIENT SEX \$	STATUS \$	LAST UPDATED	SUBMISSION DATE
ACTIONS	Enter Report	Enter Disease/	Enter Affiliation	Enter Pat	Enter First Na	Enter Last	Enter Date	All ¥	Enter :	All	All
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	EB01011990	Elaine	Benes	01/01/1990	Female	In Progress	10/01/2021 12:30 PM	10/01/2021 12:30 PM
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	09/24/2021 01:45 PM	09/24/2021 01:45 PM
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	НерС	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Monica	Gellar	01/15/1992	Female	Complete	09/17/2021 10:12 AM	09/17/2021 10:12 AM
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Daphne	Moon	04/22/1994	Female	In Progress	09/15/2021 03:52 PM	

Direct Data Entry for Electronic Case Reports: Child Hepatitis





Review Previously Submitted Case Reports

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

			CASE RE	PORT	ENTRY l	JSER SI	JMMAI	RY			
LAST UPDA	TED DATE RAN	GE	Start Date	09/01/2021	#	Er	nd Date 10/01/	2021	#	I	🕄 Retrieve Data
SHOWING 5 ITEMS											APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION 🗘	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH 🗢	PATIENT SEX 🗘	STATUS	LAST UPDATED	SUBMISSION DATE 🗘
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	НерС	Daphne	Crane	01/15/1992	Female	In Progress	09/24/2021 01:45 PM	
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	

- 2. 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.
- 3. Click **OK** to close out of the pop-up.

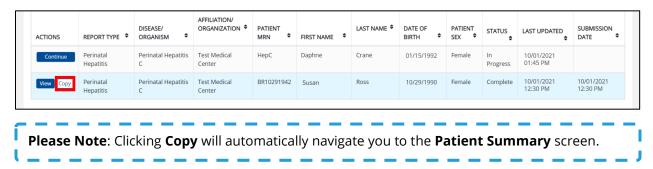
KĤIE	Case Report Details		Print 🛃 Dow	nload ×
Patient Se	Dation information			Êntry -
🖀 Home 🗲	Patient Information			©
	Disease/Organism Perinatal Hepatitis C	Date of Diagnosis 09/20/2021		
	Is the Affiliation/Organization same for Patient ID (M No	IRN), Person Completing Form, and Attending Physician/Clinician?		
LAST UPDA	Patient ID (MRN) BR10291942	Affiliation/Organization Test Medical Center		Retrieve Data
SHOWING 5 ITEMS	Person Completing Form Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization Other	lf other, please specify: Test Hospital	PPLY FILTER
	Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Test Medical Center		JBMISSION
ACTIONS	First Name Susan	Last Name Ross		ATE 🗢
View Copy	<mark>Suffix</mark> Sr			0/25/2021 50 PM
Continue	Date of Birth 10/29/1990	Ethnicity Not Hispanic or Latino	Race Unknown	
Continue	Address 1 123 Painting Lane			,
Continue				ОК
	Staphylococcus			



Copy Previously Submitted Case Reports

The **Copy** feature allows Users to copy the information from a completed case report, make edits, then submit a new case report for the same patient. That means you can copy the information from a previously submitted case report into a new case report, update the appropriate information, then submit as a new case report for the patient.

1. To copy the information from a completed case report that has been previously submitted, click **Copy** located next to the appropriate case report.



By default, the **Patient Summary** screen displays the information entered on the previously submitted case report. Users can change the information entered in any of the enabled fields and submit a new case report for the patient. However, Users **cannot** change the disease/organism, affiliation/organization, and patient demographic fields which are grayed out and disabled:

- Disease/Organism
- Patient ID (MRN)
- Affiliation/Organization
- Prefix
- Suffix

- First Name
- Middle Name
- Last Name
- Maiden Name
- Date of Birth

tory Information able Symptoms able Symptoms all Conditions bl Conditions conditions conditions conditions conditions conditions conditions conditions conditions con	t Information	Disease/Organism* 😧	Date of Diagnosis*	
I Conditions is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician ²⁺ Yes No Patient ID (MRN)* @ Affiliation/Organization* @ Patient ID (MRN)* @ Patien	tory Information	Perinatal Hepatitis C	09/20/2021	iii Unknown
I conditions Ves No Patient ID (MRN)* ● Patient ID (MRN)* ● <td>ble Symptoms</td> <td></td> <td>Parlant ID (1010), Damas Consulation From and the all</td> <td></td>	ble Symptoms		Parlant ID (1010), Damas Consulation From and the all	
Patient ID (MRN)* @ Affiliation/Organization* @ Iization, ICU & Death Information BR10291942 tion History Person Completing Form* hr. Marty Craine, Sr (marty@email.com) X Attending Physician/Clinician* Dr. Fraiser Crane (fraisercrane@email.co X Prefix Select First Name* Bob Suffix Soffix	Conditions		Patient ID (MKN), Person Completing Form, and Attendi	ng Physician/Clinician (*
tion History ti	re Information	Patient ID (MRN)* 🕢	Affiliation/Organization* 😧	
Mr. Marty Craine, Sr (marty@email.com) x v Other Test Hospital Mr. Marty Craine, Sr (marty@email.com) x v Other Test Hospital Attending Physician/Clinician* Affiliation/Organization* @ If other, please specify: @ Dr. Fraiser Crane (fraisercrane@email.com, x v Test Medical Center If other, please specify: @ Prefix Select V First Name* Middle Name Bos Suffix Siffix Maiden Name Sr Siffix Maiden Name	lization, ICU & Death Information	▲ BR10291942	Test Medical Center	~
Nation Nation R Submit Attending Physician/Clinician* Prefix Select Prefix Select Prefix Bob Suffix Suffix Sr	tion History			If other, please specify:* 🚱
k Submit Dr. Fraiser Crane (fraisercrane@email.co ×) v Test Medical Center v location of the sector of the sec	al Comments	Mr. Marty Craine, Sr (marty@email.co	m) × V	∼ Test Hospital
Dr. Fraiser Crane (fraisercrane@email.co ×) Test Medical Center Prefix Select First Name* Bob Suffix Suffix Sr	& Submit			If other, please specify: 🔞
Select Image: Select First Name* Last Name* Bob Ross Suffix Maiden Name Sr Image: Sr		Dr. Fraiser Crane (fraisercrane@email	.co X V Test Medical Center	~
First Name* Middle Name Last Name* Bob Ross Suffix Malden Name Sr I				
Bob Ross Suffix Maiden Name Sr V		Select		
Suffix Malden Name			Middle Name	
Sr V		Bob		Ross
Date of Birth* Ethnicity* Race*		Suffix	Maiden Name	
Date of Birth* Ethnicity* Race*		21		
10/29/1942 Not Hispanic or Latino X V Unknown				



Please Note: The Disease/Organism, Affiliation/Organism, and the patient demographic fields are the only disabled fields. All other fields on the **Patient Information** screen and all subsequent screens are enabled. You can edit any of the enabled fields on all screens.

2. To submit a new case report with updated information, **edit the appropriate information** in the enabled fields, as applicable.

	PATIENT I	NFORMATION			
Patient Information	Disease/Organism* 🕢	Date of Diagnosis*			
Laboratory Information	Perinatal Hepatitis C	09/20/2021	a	Unknown	
Applicable Symptoms	A				
Medical Conditions	Is the Affiliation/Organization same for Patient ID (M Yes No	RN), Person Completing Form, and	Attending Physician/Clinici	an?*	
Exposure Information	Patient ID (MRN)* 🚱	Affiliation/Organization* 🚱			
Hospitalization, ICU & Death Information	■ BR10291942	Test Medical Center			
Vaccination History	Person Completing Form*	Affiliation/Organization* 🛛		If other, please specify:* 😡	
Additional Comments	Mr. Marty Craine, Sr (marty@email.com) × ·	Other		Test Hospital	
Review & Submit	Attending Physician/Clinician*	Affiliation/Organization* @ Test Medical Center		If other, please specify: 😡	
	Dr. Fraiser Crane (fraisercrane@email.co × v	Test Medical Center	~		
	Prefix				
	Select ~				
	First Name*	Middle Name		Last Name*	
	Susan			Ross	
	Suffix	Maiden Name			
	Date of Birth*	Ethnicity*		Race*	
	10/29/1990		x ~	Unknown	x ~
	Address 1*		Address 2		
	123 Painting Lane		Unit, Suite, Building, etc.		
	City*		State*		Zip Code
	Frankfort		KY	x v	40601-
	County*	Phone* 0		Email	
	Franklin ×			bob@email.com	
	Is the patient postpartum? Yes No Unknown If yes, please enter the date of delivery: @ mm/dd/yyyy	Unknown			
	Does the patient have a history of incarceration?* Yes No Unknown				





3. Once the appropriate edits have been made, click **Next** to proceed to the **Laboratory Information** screen.

ls the patient currently pregnant? Yes No Unknown		
If yes, please enter the due date (EDC): 🔞		
mm/dd/yyyy	iii Unknown	
Is the patient postpartum?* Yes No Unknown If yes, please enter the date of delivery:* 11/05/2021 Does the patient have a history of incarceration?* Yes No Unknown	1 Unknown	
Save		Next

- 4. On each subsequent screen, **edit the appropriate information** in the enabled fields, as applicable.
- 5. Once the appropriate edits have been made on the subsequent screens, click **Next** until you navigate back to the **Review and Submit** screen.

		LABORATORY INFORMATION	
Patient Information	0	Does the patient have a lab test?*	
Laboratory Information		Yes No	
Applicable Symptoms	A	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please	e ensure you complete all fields for that test.
Medical Conditions	A		
Exposure Information	A	Hepatitis Marker*	
Hospitalization, ICU & Death Information	A	Hepatitis C virus RNA panel $\qquad \times \mid \vee $	
Vaccination History	۵	If other, please specify:	
Additional Comments		Results*	
Review & Submit	۵	Positive × v	
		If applicable, please enter the viral load: 🛛	
		Test Result Date* Specimen Collection Date* 09/01/2021 08/28/2021	🛗 🗌 Unknown
		Laboratory Name:* Test Lab	
		iezr ran.	
		Add Hepatitis Marker	
		ALT	
		O Add ALT	
		AST	
		Add AST	
		Bilirubin	
		O Add Bilirubin	
		Save	Previous
		Jave	Previous





6. Review your edits on the **Review and Submit** screen.

REVIEW & SUBMIT								
		Print	📩 Do					
Patient Information								
Disease/Organism Perinatal Hepatitis C	Date of Diagnosis 09/20/2021							
Is the Affiliation/Organization same for Patient ID (MRN No	I), Person Completing Form, and Attending Physician/Clinician?							
Patient ID (MRN) BR10291942	Affiliation/Organization Test Medical Center							
Person Completing Form Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization Other	If other, please specify: Test Hospital						
Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Test Medical Center							
First Name Bob	Last Name Ross							
Suffix Sr								
Date of Birth 10/29/1942	Ethnicity Not Hispanic or Latino	Race Unknown						
Address 1 123 First Avenue								
City Frankfort	State KY	Zip Code 40601						
County Franklin	Phone (555) 555-5555	Email susan@email.com						
Is the patient postpartum? Yes								
If yes, please enter the date of delivery: 11/05/2021								
Does the patient have a history of incarceration?								

Please Note: In the example edit above, the User changed the patient's status from pregnant to postpartum. The User changed the selection for the *Is the patient currently pregnant*?field from *Yes* to *No* which enabled the subsequent postpartum field.

The User entered postpartum details by selecting **Yes** for the *Is the patient postpartum*? field and entering the **date of delivery**.

7. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Child Hepatitis Case Report Entry.

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



Please Note: The new case report is not a continuation of the previously submitted case report.

_ _ _ _ _

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

	mitted to an intensive care unit (ICU)?	
Yes Admission Date to 10/01/2021	Case Report Entry ×	Discharge Date from ICU 10/02/2021
Did the patient die No	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.	
Vaccination His	Cancel Submit	•

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

	Yes	ted to an intensive care unit (iCO)?		
	Admission Date to IC 10/01/2021	Case Report Entry	× Discharge Date from IO 10/02/2021	U
	Did the patient die as No	Case Report Entry Saved Successfully		
	Vaccination Histo		ок	0
	Tacanadori mato			
<u> </u>				
Please Note: Clicking O	K when t	he case report entry l	has been sul	omitted successfully will
automatically navigate yo	u to the C a	ase Report Entry User	Summary so	reen.
·				/

10. On the **Case Report Entry User Summary** screen, review the new case report submission.

(ĤIE	ePartnerViewer								ouncements	🐥 Advisories 1	θ	
Patient S	iearch	Bookmarked Patients				ations	Lab Data Entry -			Case Report Entry -		
🖀 Home ゝ	Case Report Entry U	Jser Summary										
			CASE RE	PORT	ENTRY	USER SU	JMMAF	RY				
LAST UPD	ATED DATE RANG	GE	Start Date	10/03/2021	#	Er	nd Date 10/03/	2021	#		🕄 Retrieve Data	
SHOWING 1 ITEMS											APPLY FILTER	
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM 🗘	AFFILIATION/ ORGANIZATION 🗢	PATIENT MRN 🗘	FIRST NAME	LAST NAME ♥	DATE OF BIRTH 🗘	PATIENT SEX 🗘	STATUS \$	LAST UPDATED 🕈	SUBMISSION DATE 🗘	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	SR10291990	Susan	Ross	10/29/1990	Female	Complete	10/03/2021 2:30 PM	10/03/2021 2:30 PM	



Continue In-Progress Case Reports

The **Save** feature allows Users 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 have entered in order to return later to the section where you left off.

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

			CASE RE	PORT	ENTRY L	JSER SI	JMMAI	RY			
C LAST UPDATED DATE RANGE Start Date 09/01/2021 Crd Date 10/01/2021 Crd Date 10/01/2021											
SHOWING STIFEMS											
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM +	AFFILIATION/ ORGANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH +	PATIENT SEX 🗘	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	НерС	Daphne	Crane	01/15/1992	Female	In Progress	09/24/2021 01:45 PM	
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	

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

Home > Perinatal Hepatitis Case Rep	ort Form							
PERINATAL HEPATITIS CASE REPORT FORM								
Please add any additional comments relate	d to this	ase.						
		ADDITIONAL COMMENTS						
Patient Information	\otimes	Additional comments or notes, please specify:						
Laboratory Information	\otimes							
Applicable Symptoms	\otimes							
Medical Conditions	\otimes							
Exposure Information	\otimes							
Hospitalization, ICU & Death Information	\otimes	0/1000 Characters	(k					
Vaccination History	0							
Additional Comments								
Review & Submit	a							
		Save	Previous Next					



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 <u>KHIESupport@ky.gov</u>.

