

Kentucky Health Information Exchange (KHIE)

Communicable Disease Lab Entry & Initiating Electronic Case Reports for Reportable Conditions

User Guide

August 2022





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Communicable Disease Lab Entry and Initiating Case Reports User Guide



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Communicable Disease Lab Entry and Initiating Case Reports User Guide



1 Introduction

Overview

The Kentucky Health Information Exchange (KHIE) utilizes the Kentucky Online Gateway (KOG) to authenticate if an individual is part of an organization that has access to review patient health information in KHIE. To access KHIE, Authorized Users must establish a KOG account.

As part of KHIE's ongoing updates and maintenance, additional features have been added to KHIE's Direct Lab Data Entry functionality to allow Users to enter test results for other reportable conditions. These enhancements made to the Direct Data Entry functionality allow Users with the *DDELR Submitter* user role to enter test results for any reportable condition. Additionally, Users with the *Manual Case Reporter* role have the option to submit any Case Report using information from a previously submitted Communicable Disease Lab Entry.

The purpose of this guide is to provide an overview of these changes and provide step-by-step instructions and screenshots showcasing the new features in the ePartnerViewer.

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 Edge	
Version 44+	Version 40+
Google Chrome	
Version 70+	Version 70+
Mozilla Firefox	
Version 48+	Version 48+
Apple Safari	
Version 9+	iOS 11+
lease Note: The ePartnerViewer doe	es not support Microsoft Internet Explorer. To access the
PartnerViewer, Users must use a m	odern browser such as Google Chrome, Microsoft Edge,
pple Safari, or Mozilla Firefox.	

DDE: Communicable Disease Lab Entry





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*.

2 Logging into the ePartnerViewer

Users with the *DDELR Submitter* role in the ePartnerViewer are authorized to access the Communicable Disease Lab Entry to submit test results for any reportable condition. Users with the *Manual Case Reporter* role in the ePartnerViewer are authorized to submit any Case Report for any reportable condition.

To start, 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: <u>https://epartnerviewer.khie.ky.gov</u>

• New lab × +	\vee	-	٥	\times
← → C △ S https://epartnerviewer.khie.ky.gov		C	Paused	:
Apps			Readin	ıg list
	Gma	il Imaç	jes	
Please Note: The ePartnerViewer does <u>not</u> support Microsoft Internet Explorer. To ePartnerViewer, Users must use a modern browser such as Google Chrome, Mic Apple Safari, or Mozilla Firefox.	o ace roso	cess oft E	the dge	e ,



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

MyKentu	KY cky.gov	FAQ Help 🛛 English 🗸	
	Welcome to the Kentucky Online Ga	teway	
	 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. 	State Employee Gateway Login Login to your State Employee account using: EMAIL ADDRESS	
Please Login s	Note: If you are a State Employee, click Ema section on the right side of the Welcome to t	il Address under the <i>State Employee Gaten</i> The Kentucky Online Gateway screen.	vay

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

Citizen (or) Business Part Sign in with your Kentucky Online Gateway Email Address Enter Email Address Enter Email Address Enter Password Enter Password Resend Account Verification Email	ner Sign In v Account. where the second sec	
Please Note: You must enter the e account.	Create An Account Click here to select user account mail address and password used when you created y	int type



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.

Kentu Online Ga	icky Iteway	Welcome Jane Doe	My Account	Sign Out He	lp English ∨
	Multi-Factor Authentication				
	 MFA by Email Verification MFA by Phone Verification Send Passcode				
Please I Login: H	Note : For specific information on how to complete M Kentucky Online Gateway (KOG) and Multi-Factor A	FA, please revient	ew the (MFA) Q	ePartne Duick Re	erViewer eference

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	😫 Jane Doe 🕞
TERMS AND CONDITIONS OF USE	
 Determine and conditions Determine and conditions of the Kentucky Health Information Exchange (KHIE): And unrently bound by a Health Information Exchange Participation Agreement with the Division of Health Information or have a current relationship as an acurrent year dragating of the Division of Health Information or have a current relationship as an acurrent year data wallable on KHIE is only that Information available according to state and federal law. Determine data wall not include records of the following: HV medical procedures and test. Horgonis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients. Determine that available on KHIE WILL NOT Include HV medical procedures and tests, regardless of source. Determine that accept to accept the usage terms and conditions. 	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 <i>Access is restricted beyond this point. You must accept the proceeding.</i>	ys a message that states: <i>terms and conditions before</i>



- 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	e Jane Doe		
TERMS AND CONDITIONS O	DF USE		
 Herminian Conditions Hard Conditions Hard Conditions of the Kentucky Health Information Exchange (KHE): I an a healthcare provider currently treating a patient. I an currently bound by a Health Information Exchange Participation Agreement with the Division of Health Information or have a current relations autonized user of a participating provider of the Division of Health Information to the texture relations autonized user of a participating provider of the Division of Health Information. I understand that data available on KHE is only that Information available according to state and federal law. HVI 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 thos 1. Understand that available on KHE WILL NOT include HIV medical procedures and test. Select 1 accept to accept the usage terms and conditions. 	ship as an Proceed to Portal Cancel		
Copyright 2019 HealthInteractive Histolationary Histolationary	Version: 1.0.0		
 Please Note: If you click Cancel, a pop-up notification displays that indicates that you are about to be logged out. Use of the ePartnerViewer portal is subject to the acceptance of KHIE's Terms of Use. To proceed to the ePartnerViewer, click either Logout Now or Cancel. 			



3 Understanding the Lab Data Entry Dropdown Menu

The Lab Data Entry tab dropdown menu includes the following items:

KĤIE	ePartnerViewer	Support 📢	Announcements <mark>5</mark> 🌲 Advisc	ories 🗿 😫	
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report	Entry -
Home			Covid Lab Data Entry		
Announcement:	Have training needs? Go to the KHIE COACI	H for assistance. It's located in tl	Communicable Disease Lab E	intry	View All
	J		Quick Entry for Negative COV	ID-19 Test Results	
			Lab Data Entry User Report		
	my	VDASHBOAR	Manage User Preferences	>	
OUICK SEARCH				Q ADVANCE	DSEARCH

1. COVID Lab Data Entry:

- Designed for Users to enter positive COVID-19 lab test results. However, Users can enter both positive and negative COVID-19 lab results here.
- Allows Users to enter multiple test results at the <u>same</u> time for the *same* patient.

Please Note: For specific information about COVID-19 lab reporting, please review the *Direct Data Entry User Guide, COVID-19 Variant Testing + Initiate Case Report Quick Reference Guide,* and the *Training Video: How to Use KHIE's Direct Data Entry (Lab) System* on the KHIE website.

2. Communicable Disease Lab Entry:

- Designed for Users to enter lab results for communicable diseases.
- Allows Users to enter <u>up to 70</u> observations for *multiple diseases* at the <u>same</u> time for the same patient.

3. Quick Entry for Negative COVID-19 Test Results:

- Designed for Users to enter negative test results more efficiently.
- Allows Users to enter <u>up to 10</u> negative test results for *multiple patients* at the <u>same</u> time, as long as the same details apply to all patients (i.e. the same Performing Facility, Ordering Facility/Provider, Specimen Type, Test Type, Test Name, Specimen Collection Date, and Observation Result Date).

Please Note: For specific information about COVID-19 lab reporting for negative results, please
review the *Direct Data Entry User Guide* and the *Training Video: Quick Entry for Negative COVID- 19 Test Results* on the <u>KHIE website</u>.



L



4. Lab Data Entry User Report:

 Designed to provide a quick and easy way for Users to view lab results entered during a given time frame.

5. Manage User Preferences:

- Designed as an efficient method for Users to enter repetitive data that's required throughout the entry.
- Allows Users to enter the Ordering Provider and Ordering Facility details in their User Preferences which provides the ability for Users to quickly select an Ordering Provider or Ordering Facility from the dropdown menu options.

Please Note: The existing Ordering Provider and Ordering Facility details entered for any previously submitted Lab Data Entry (i.e., COVID-19 Lab Data Entry or Quick Entry for Negative COVID-19 Test Results) will be displayed as dropdown menu options on the **Observation** screen of any new Communicable Disease Lab Entry.

This means you can select the same Ordering Provider and Ordering Facility details previouslyentered for a different lab data entry for a new Communicable Disease Lab Entry.

KĤIE	ePartnerViewe	🗧 🖂 Support 📢	Announcements 5 🐥 Advisories 3 🙁	•
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry ▼ Case Re	port Entry 🝷
Home			Covid Lab Data Entry	
Announcement:	Have training needs? Go to the KHIE COAC	H for assistance. It's located in th	Communicable Disease Lab Entry	l View All
	0		Quick Entry for Negative COVID-19 Test Resul	ts
			Lab Data Entry User Report	
	m	yDASHBOAR	Manage User Preferences	>
QUICK SEARCH			Create Ordering Provider Details	O SEARCH
First	Last	Date	View & Edit Ordering Provider Details	-
Name	Name	Birth	Create Ordering Facility Details	:n
			View & Edit Ordering Facility Details	
BOOKMARKED F	PATIENTS	EVENT NOTIFICATI	ONS (PAST 72 HOURS)	i
https://epartnep/jewer.uat.khie.healthi	nteractive pet/create-ordering-provider-details/	DTIFICATION	ORG	ANIZATION



4 Manage User Preferences

These are your User Preferences. Prior to entering your lab results, you are required to enter information about your Ordering Provider and Ordering Facility on the **Manage User Preferences** screen. By entering the Ordering Provider and Ordering Facility details here in your user preferences, you will be able to quickly select an Ordering Provider or Ordering Facility from the dropdown menu options. These dropdown menus are located on the **Observation** screen for the Communicable Disease Lab Entry.

Create Ordering Provider Details

- 1. When entering the ePartnerViewer, you must click the **Lab Data Entry** Tab located in the blue ribbon Navigation Bar at the top of the screen.
- 2. From the Lab Data Entry Tab dropdown menu, select Manage User Preferences.

KĤIE	ePartnerViewe	2r	🕽 Announcements 🧐 🌲 Advisc	ories 😮 😫	÷
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report	Entry -
A Home			Covid Lab Data Entry		
Advisory: TEST Fal	ke News Flu Outbreak on the rise		Communicable Disease Lab E	ntry	View All
		•••	Quick Entry for Negative COV	ID-19 Test Results	
			Lab Data Entry User Report		
	n	nyDASHBOAR	Manage User Preferences	>	
QUICK SEARCH				Q , advance	ED SEARCH

3. To create Ordering Provider details, you must select **Create Ordering Provider Details**.

KĤIE	ePartnerViewer	🗧 🖂 Support	Announcements 💈 🌲 Advisori	es 3 🙁 🚬 🔻
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
😭 Home			Covid Lab Data Entry	
Announcement:	Have training needs? Go to the KHIE COAC	H for assistance. It's located in th	Communicable Disease Lab Ent	ry
	0		Quick Entry for Negative COVID	-19 Test Results
			Lab Data Entry User Report	
	m	YDASHBOAR	Manage User Preferences	>
QUICK SEARCH			Create Ordering Provider Detai	ls D SEARCH
First	Last	Date	View & Edit Ordering Provider [Details
Name	Name	Birth	Create Ordering Facility Details	cn
			View & Edit Ordering Facility De	tails

DDE: Communicable Disease Lab Entry



- 4. The **Create Ordering Provider** screen displays. From here, you must enter the Ordering Provider Details. There are **mandatory** fields marked with **red asterisks** (*).
- 5. If available, select the **Prefix** and **Suffix** from the appropriate dropdown menus.

Please complete the form below to create an Ordering Provider. All fields marked with an asterisk(*) are required.								
CREATE ORDERING PROVIDER								
Prefix	Dr.	× ~						
First Name*	Niles		Last Name*	Crane				
Suffix	Select	· •						
	П							
Address 1*		_						
	Jr							
Address 2	Sr							

6. Enter the Ordering Provider's **First Name** and **Last Name**.

Home > Create or	dering provider details							
Please complete the for	m below to create an Ordering Provider. All fields marked with an asterisk(*) are required.							
CREATE ORDERING PROVIDER								
Prefix	Select V							
First Name*	Last Name*							
Suffix	Select ~							



- 7. Enter the Ordering Provider's **Address**, **City**, **State**, and **Zip Code**.
- 8. Enter the **Provider NPI**.

Address 1*		
Address 2	Unit,Suite,Building,etc.	
City*	State*	Select 🗸
Zip Code*	Phone Number	(XXX)XXX-XXXX
Provider NPI*		
Provider NPI*		

9. If available, enter the Ordering Provider's **Phone Number**.

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

Zip Code*	40601	Phone Number	(555) 202-0102	
Provider NPI*	1098765432			
				Clear Save

11. The *Create Ordering Provider Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Ordering Provider Details** screen.

Home > Create ordering provider details		
Please complete the form below to cr	aate an Ordering Provider All fields marked with an asteriskith are Create Ordering Provider Details ×	required.
	Ordering Provider Details saved successfully	
	ок	Clear
DDE: Communicable Disease Lab Entry	Page 15 of 192	Kentucky Health Information Exchange



View & Edit Ordering Provider Details

12. The **View & Edit Ordering Provider Details** screen displays. To edit an Ordering Provider's details, click the **Edit icon** located next to the appropriate Ordering Provider.

KĤIE	ePartner		e -					
Patient Search	Bookm	arked Patients	Event Notifica	tions	Lab Data Entry -	 Secure Messaging (📞 Support
🖀 Home > Vie	w ordering provider detai	ls						
• VIEW & E			R DETAILS				₿ REFR	ESH T APPLY FILTER
SHOWING 4 ITEMS								
ACTIONS	NAME 🗘	NPI 🗘	ADDRESS 1	ADDRESS 2	CITY ÷	STATE \$	ZIP CODE 🗘	PHONE NUMBER 🗢
	Dr. Niles Crane, Jr	1098765432	9876 Second Street		Frankfort	КҮ	40601	(555) 202-0102
	George Costanza	7890000	7 Festivus Road		Lexington	КҮ	40509	(555) 777-1010
	Joe Smith	98765	22 Second Avenue		Lexington	КҮ	40509	(859) 111-0000
	Fraiser Crane	123456	123 Main Street		Frankfort	KY	40601	(555) 500-5000
			First Back 1 Ne	xt Last			Maximur	n 5 🕶 entries per page

13. The *Update Ordering Provider Details* pop-up displays. You can edit the appropriate fields. Once complete, click **Save** to save the updates and close out of the pop-up.

KĤIE	ePartnei	rViev	Update	Ordering Provider Details		>				θ.
Patient Search	Bookn	narked Pati	Provider NPI*	1098765432			ure Me	essaging 🖸		📞 Support
🖀 Home 💙 Vie	ew ordering provider deta	iils								
• VIEW & E	EDIT ORDERII	NG PR	Prefix	Dr. × ~					₽ REFR	ESH T APPLY FILTER
SHOWING 4 ITEMS			First Name*	Niles	Last Name*	Crane				
ACTIONS	NAME \$	NPI					¢	ZIP CODE	÷	PHONE NUMBER 🗘
	Dr. Niles Crane, Jr	1098765	Suffix	Jr × v				40601		(555) 202-0102
	George Costanza	7890000	Address 1*	9876 Second Street	Address 2	Unit,Suite,Building,etc.		40509		(555) 777-1010
	Joe Smith	98765	City*	Frankfort	State*	KY X V		40509		(859) 111-0000
	Fraiser Crane	123456	city	Tunkor	State			40601		(555) 500-5000
			Zip Code*	40601-	Phone Number	(555) 202-0102			Maximun	n 5 👻 entries per page
Coj	oyright 2019 HealthIntera	ctive				Cancel Save		Versi	on: 1.0.0	



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

● VIEW & EDIT ORDERING PROVIDER DETAILS								
SHOWING 4 ITEMS					Update Ordering Provider Details ×			
ACTIONS	NAME	NPI	¢	ADD	Ordering Provider Details undated successfully	STATE \$	ZIP CODE	PHONE NUMBER 🗘
	Dr. Niles Crane, Jr	1098765432		9876		KY	40601	(555) 202-0102
	George Costanza	7890000		7 Fes		KY	40509	(555) 777-1010

Delete Ordering Provider Details

15. To delete an Ordering Provider from the User Preferences, click the **Trash Bin Icon** located next to the appropriate Ordering Provider.

• VIEW 8	● VIEW & EDIT ORDERING PROVIDER DETAILS ② REFRESH ▼APPLY FILTER										
showing 4 ITEMS											
ACTIONS	NAME 🗢	NPI \$	ADDRESS 1 🗘	ADDRESS 2	CITY \$	STATE \$	ZIP CODE +	PHONE NUMBER \$			
	Dr. Niles Crane, Jr	1098765432	9876 Second Street		Frankfort	KY	40601	(555) 202-0102			
	George Costanza	7890000	7 Festivus Road		Lexington	KY	40509	(555) 777-1010			
	Joe Smith	98765	22 Second Avenue		Lexington	КҮ	40509	(859) 111-0000			
	Fraiser Crane	123456	123 Main Street		Frankfort	KY	40601	(555) 500-5000			

16. The *Delete Ordering Provider Details* pop-up displays. To delete the Ordering Provider, click **OK**. **Click** Cancel if you do not want to delete the Ordering Provider.

• VIEW & E	VIEW & EDIT ORDERING PROVIDER DETAILS								
4 ITEMS Delete Ordering Provider Details ×									
ACTIONS	NAME 🗘	NPI 🗘	ADI	August 1997	STATE 🗘	ZIP CODE	PHONE NUMBER +		
	Dr. Niles Crane, Jr	1098765432	987	Are you sure?	кү	40601	(555) 202-0102		
	George Costanza	7890000	7 Fe	Cancel OK	ку	40509	(555) 777-1010		

17. To search for a specific Ordering Provider in the User Preferences, click **Apply Filter**.

Home > Vie	Home > View ordering provider details										
showing 4 ITEMS											
ACTIONS	NAME 🗘	NPI 🗘	ADDRESS 1	ADDRESS 2	CITY ÷	STATE 🗘	ZIP CODE 🗘	PHONE NUMBER 🕈			
	Dr. Niles Crane, Jr	1098765432	9876 Second Street		Frankfort	KY	40601	(555) 202-0102			
	George Costanza	7890000	7 Festivus Road		Lexington	KY	40509	(555) 777-1010			
	Joe Smith	98765	22 Second Avenue		Lexington	KY	40509	(859) 111-0000			
	Fraiser Crane	123456	123 Main Street		Frankfort	КҮ	40601	(555) 500-5000			

DDE: Communicable Disease Lab Entry



The Filter fields display. You can search by entering the Ordering Provider's *Name*, *NPI*, *Address*, *City*, *State*, *Zip Code*, and/or *Phone Number* in the corresponding Filter fields.

KĤIE	ePartnerViewer Support 📢 Announcements						Announcements <mark>(5</mark>)	🌲 Advisories ₃	e Kale Rateon.*
Patient Searc	hi li	Bookmarked Patien	ts	Event Notifications			Lab Data Entry 🕶	Ca	se Report Entry 🕶
🖀 Home >	View ordering pro	vider details							
VIEW & EDIT ORDERING PROVIDER DETAILS SHOWING GITEMS									
ACTIONS	NAME 🗘	NPI 🗘	ADDRESS 1 Enter Address 1	ADDRESS 2 Enter Address 2	CITY Enter City	+	STATE 🗘	ZIP CODE 🗘	PHONE 🗘
	Dr. Fraiser Crane, Jr	1234543210	123 Main Street	100	Frankfort		KY	40601	(555) 500-5000
	Dr. Martin Crane, Sr	1098765432	123 Frankfort Avenue	200	Frankfort		КҮ	40601	(555) 123-4000
	Dr. Niles Crane, Jr	1098765432	9876 Second Street		Frankfort		KY	40601	(555) 202-0102
	George Costanza	7890000	7 Festivus Road		Lexington		КҮ	40509	(555) 777-1010
	Joe Smith	98765	22 Second Avenue		Lexington		KY	40509	(859) 111-0000
		First	Back 1 2 Nex	t Last				Maximum	5 • entries per page

Create Ordering Facility Details

- 1. When entering the ePartnerViewer, you must click the **Lab Data Entry** Tab located in the blue ribbon Navigation Bar at the top of the screen.
- 2. From the Lab Data Entry Tab dropdown menu, select Manage User Preferences.

KĤIE	ePartnerViev	Wer 🖻 Support 📢	📢 Announcements 💈 🌲 Advisories 3				
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report	Entry -		
Home			Covid Lab Data Entry				
Advisory: TEST	T Fake News Flu Outbreak on the rise		Communicable Disease Lab E	ntry	<u>View All</u>		
		••••	Quick Entry for Negative COV				
			Lab Data Entry User Report				
		MYDASHBOAR	Manage User Preferences	>			
QUICK SEARCH				Q ADVANC	ED SEARCH		
First	Last	Date	Of mm/dd/aaa/	e e con	rch		



3. From Manage User Preferences, select **Create Ordering Facility Details**.

KĤIE	ePartnerViev	Wer 🖻 Support 📢	🖙 Support 📢 Announcements 5 🌲 Advisories 3 🔮				
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -			
Home			Covid Lab Data Entry				
Advisory: Future Al	ert		Communicable Disease Lab Entry	l View All			
		••••	Quick Entry for Negative COVID-19	Test Results			
			Lab Data Entry User Report				
		Mydashboar	Manage User Preferences	>			
QUICK SEARCH			Create Ordering Provider Details	D SEARCH			
First	Last	Date	View & Edit Ordering Provider Deta	ils			
Name	Name	Birth	Create Ordering Facility Details	n and a state of the state of t			
			View & Edit Ordering Facility Details				

- 4. The **Create Ordering Facility Details** screen displays. From here, Users must enter the Ordering Facility details. There are **mandatory** fields marked with **red asterisks** (*).
- 5. Enter the Facility Name, Address, City, State, and Zip Code.

	CREATE ORDERING FACILITY	
Facility Name*		
Address 1*		
Address 2	Unit,Suite,Building,etc.	
Address 2	Unit,Suite,Building,etc.	
Address 2 City*	Unit,Suite,Building,etc. State*	Select
Address 2	Unit,Suite,Building,etc.	Selert



- 6. If available, enter the Ordering Facility's **Phone Number**.
- 7. After completing the mandatory fields, click **Save**.

	CREATE ORDERING FACILITY									
Facility Name*	Union Medical Clinic									
Address 1*	460 Union Court									
Address 2	100									
City*	Frankfort	State*	KY	x ~						
Zip Code*	40509	Phone Number	(859) 555-4321							
				Clear Save						

8. The Create Ordering Facility Details pop-up window displays. Click **OK** to proceed to the **View & Edit Ordering Facility Details** screen.

Home > Create ordering facility details		
Please complete the form bel	ow to create an Ordering Facility. All fields marked with a Create Ordering Facility Details	h an actorick/#) ana required. ×
	Ordering Facility Details saved successfully	ОК
		Clear



View & Edit Ordering Facility Details

9. The **View & Edit Ordering Facility Details** screen displays. To edit an Ordering Facility's details, click the **Edit icon** located next to the appropriate Ordering Facility.

Image: Construction of the second sec											
Patient Search	Bookmarked	cure Messaging 🗹	📞 Support								
😭 Home 🕨 Vi	iew ordering facility details	5									
• VIEW &	EDIT ORDERI	NG FACILITY	DETAILS				ESH TAPPLY FILTER				
SHOWING 3 ITEMS											
ACTIONS	FACILITY NAME	ADDRESS 1	ADDRESS 2	CITY ÷	STATE 🗘	ZIP CODE 🗘	PHONE NUMBER 🗘				
	Union Medical Clinic	460 Union Court	100	Frankfort	KY	40509	(859) 555-4321				
	Test Community Hospital	1 First Avenue		Frankfort	KY	40601	(123) 456-7890				
	Mercy Medical Center	321 Hospital Avenue		Frankfort	KY	40601	(555) 123-4567				

10. The **Update Ordering Facility Details** pop-up displays. Users can edit the appropriate fields. Once complete, click **Save** to save the updates.

KILIE	ePartne	rviewe	r				T		6.
Patient Search	Bookmark	Update	Ordering Facility Details			×	ssaging 🖸		📞 Support
Home >	View ordering facility det	Facility Name*	Union Medical Clinic					C REFRI	SH Y APPLY FILTER
SHOWING 3 ITEMS		Address 1*	460 Union Court	Address 2	100				
ACTIONS	FACILITY NAME	Cite		Christ			CODE	¢	PHONE NUMBER 🗢
	Union Medical Clini	City	Franktort	State	K1	A Y	09		(859) 555-4321
	Test Community Hospital	Zip Code*	40509-	Phone Number	(859) 555-4321		01		(123) 456-7890
	Mercy Medical						01		(555) 123-4567
	Center		_		Canc	el Save	Ň	laximun	5 • entries per page

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

• VIEW & E	VIEW & EDIT ORDERING FACILITY DETAILS							
SHOWING			Update Ordering Facility Details	×				
3 ITEMS		Ordering Facility Details updated successfully						
ACTIONS	FACILITY NAME	ADDRESS 1			\$	ZIP CODE	PHONE NUMBER 🗘	
	Union Medical Clinic	460 Union Cou		ОК		40509	(859) 555-4321	
	Test Community	1 Eirst Avenue	Frankfort	KV		40601	(123) 456-7890	

DDE: Communicable Disease Lab Entry



Delete Ordering Facility Details

12. To delete an Ordering Facility from the User Preferences, click the **Trash Bin Icon** located next to the appropriate Ordering Facility.

• VIEW 8									
SHOWING 3 ITEMS	showing 3 ITEMS								
ACTIONS	FACILITY NAME	ADDRESS 1	ADDRESS 2	CITY \$	STATE \$	ZIP CODE \$	PHONE NUMBER 🗢		
	Union Medical Clinic	460 Union Court	100	Frankfort	КҮ	40509	(859) 555-4321		
	Test Community Hospital	1 First Avenue		Frankfort	КY	40601	(123) 456-7890		
	Mercy Medical Center	321 Hospital Avenue		Frankfort	KY	40601	(555) 123-4567		
		First Bac	k 1 Next Last			Maximun	n 5 🕶 entries per page		

13. The Delete Ordering Provider Details pop-up displays. To delete the Ordering Facility, click **OK**. Click **Cancel** if you don't want to delete the Ordering Facility.

VIEW & EDIT ORDERING FACILITY DETAILS Pelote Ordering Eacility Details X							Ŕ	REFRE	SH T APPLY FILTER
SHOWING 3 ITEMS			Are you sure?						
ACTIONS	FACILITY NAME	ADDRESS 1				\$	ZIP CODE	\$	PHONE NUMBER 🗘
	Union Medical Clinic	460 Union Cour		Cancel	ОК		40509		(859) 555-4321
	Test Community Hospital	1 First Avenue		Frankfort	КY		40601		(123) 456-7890

14. To search for a specific Ordering Facility in the User Preferences, click **Apply Filter**.

KĤIE	ePar	ePartnerViewer			nnouncements <mark>S</mark>	🔺 Advisories ₃ 🌘	9		
Patient Search	Bookr	narked Patients	Event Not	tifications	Lab Data Entry	- Cas	e Report Entry -		
🖀 Home 🕨 V	/iew ordering facility de	tails							
• VIEW &									
SHOWING 4 ITEMS	showing 4 ITEMS								
ACTIONS	FACILITY NAME	ADDRESS 1 +	ADDRESS 2	CITY 🗘	STATE 🗘	ZIP CODE 🗘	PHONE 🗢		
	General Hospital	4567 King Drive		Lexington	KY	40511	(555) 678-9000		
	Union Medical Clinic	460 Union Court	100	Frankfort	KY	40509	(859) 555-4321		
	Test Community Hospital	1 First Avenue		Frankfort	KY	40601	(123) 456-7890		
	Mercy Medical Center	321 Hospital Avenue		Frankfort	КҮ	40601	(555) 123-4567		

DDE: Communicable Disease Lab Entry





15. The Filter fields display. Search by entering the *Facility Name*, *Address*, *City*, *State*, *Zip Code*, and/or *Phone Number* in the corresponding Filter fields.

KĤIE	ePar	tnerView	ver	Support 📢 A	nnouncements <mark>5</mark>	🐥 Advisories (3) 👘	9 -	
Patient Search	Bookr	narked Patients	Event No	tifications	Lab Data Entry	- Ca	se Report Entry 🕶	
Home > V	ïew ordering facility de	tails						
VIEW & SHOWING 4 ITEMS	VIEW & EDIT ORDERING FACILITY DETAILS PREFRESH THIDE FILTER SHOWING 4 ITTEMS							
ACTIONS	FACILITY NAME	ADDRESS 1 Enter Address 1	ADDRESS 2 Enter Address 2	CITY Enter City	STATE Enter State	ZIP CODE	PHONE 🗢 Enter Phone Nu	
	General Hospital	4567 King Drive		Lexington	KY	40511	(555) 678-9000	
	Union Medical Clinic	460 Union Court	100	Frankfort	KY	40509	(859) 555-4321	
	Test Community Hospital	1 First Avenue		Frankfort	KY	40601	(123) 456-7890	
	Mercy Medical Center	321 Hospital Avenue		Frankfort	КҮ	40601	(555) 123-4567	
		First Back	1 Next Last			Maximum	5 👻 entries per page	



5 Tips for Manually Entering Lab Data

Become familiar with these tips prior to entering lab results. Please keep in mind several key notes when entering patient data:

• There are **mandatory** fields marked with **red asterisks** (*). These fields must be completed in order to proceed. In addition to completing the mandatory fields, Users are encouraged to enter as much information as possible.

<i>Please complete the form below. All fields marked with an asterisk(*) are required.</i>						
PATIENT INFORMATION						
Performing Facility Name* Select	Patient MRN* 😧					

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

1	2	3	4	5
Patient Information	Observation	Ask On Orde	An MRN or Medical Record Number is an Organization	Submit
Please complete the	form below. All	fields marked v	the identification number assigned to a patient by a healthcare organization. If	ed.
	PATI	ENT INFC	your organization does not use an MRN, you MUST create a way to uniquely identify your patient.	
Performing Facility N	lame*	P	atient MRN* 😧	•
Test Medical Cente	r	× ~		



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

City	State	KY	x ~
Zip Code	County	Şelect	- -
_		Adair	î
Phone Number	Email Address	Allen	
		Anderson	
		Ballard	
		Barren	t.
		Bath	
nteractive	HealthInteractive HIE	Bell	_ /ers

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

City		State	AR	$x \mid v$
Zip Code		County	Out Of System State	× ~
Please Note: The states. If you are	ne Kentucky Department for P e required to report results to	ublic Health does n other states, you wi	ot report test results ll be responsible to d	to other o so.

Let's Get Started with Communicable Disease Lab Entry!



6 Communicable Disease Lab Entry

User Roles Overview

The following user roles have access to either the Communicable Disease Lab Entry functionality and/or the Case Report functionality in the ePartnerViewer:

- Users with the *DDELR Submitter* role in the ePartnerViewer are authorized to access the Communicable Disease Lab Entry functionality to submit test results for any reportable condition. Users with the *DDELR Submitter* role also have access to the COVID-19 Lab Data Entry functionality to submit COVID-19 test results.
- 2. 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 Kentucky Department for Public Health (KDPH).
- 3. Only Users with **<u>both</u>** the *DDELR Submitter* role **<u>and</u>** the *Manual Case Reporter* role have access to initiate any Case Report (i.e., Other Reportable Conditions, MDRO, STD, Hepatitis, Perinatal Hepatitis, Child Hepatitis) for the applicable reportable condition(s) using the information from a previously submitted Communicable Disease Lab Entry.

Only DDELR Submitter Role	Only Manual Case Reporter Role	<u>Both</u> DDELR Submitter <u>and</u> Manual Case Reporter Roles
 User can access the	 User cannot access the	 User can access the
Communicable Disease Lab Entry	Communicable Disease Lab Entry	Communicable Disease Lab Entry
functionality to submit test results	functionality to submit test results	functionality to submit test results
for any reportable condition User cannot submit any Case	for any reportable condition User can submit any Case Report	for any reportable condition User can submit any Case Report
Reports for reportable conditions	for reportable conditions	for reportable conditions
X User <u>cannot</u> initiate any Case	✗ User <u>cannot</u> initiate any Case	✓ User can initiate any Case Report
Report from a previously submitted	Report from a previously submitted	from a previously submitted
Communicable Disease Lab Entry	Communicable Disease Lab Entry	Communicable Disease Lab Entry
,		

Please Note: Users with the *Manual Data Submission* role can access only the COVID-19 Lab Data Entry functionality to enter COVID-19 test results.

Users with the *Manual Data Submission* role **cannot** initiate a COVID-19 Case Report unless they are also provisioned with *Manual Case Reporter* role.



Communicable Disease Lab Entry Overview

The Communicable Disease Lab Entry is a five-step process where Users enter (1) Patient Information, (2) Observation Results, and answers to specific questions on the (3) Asked on Order Entry screen. The (4) **Lab Data Review** screen is where Users must review the information entered. The final step is (5) submitting the Communicable Disease Lab Entry.

😭 Home 🔸	Comm	nunicable Disease Lab Ent	ry			
		1 Patient Information	2 Observation	3 Ask On Order Entry	4 Lab Data Review	5 Submit

Users with the *DDELR Submitter* role are authorized to access the Communicable Disease Lab Entry functionality in the ePartnerViewer.

1. To enter communicable disease test results, click the **Lab Data Entry Tab** in the blue Navigation Bar at the top of the screen.

KĤIE	ePartnerViewer	Support 📢 Announcements 5 🌲 Advisories 5 S				
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -		
2						

2. Select **Communicable Disease Lab Entry** from the dropdown menu.

KĤIE	ePartnerView	'er Support 📢	Announcements 🧕 🌲 Adviso	ories 3 🔮 🔹
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry 🕶
Home			Covid Lab Data Entry	
Advisory: Euture A	ert		Communicable Disease Lab B	Entry
		••••	Quick Entry for Negative COV	ID-19 Test Results
			Lab Data Entry User Report	
	1	myDASHBOAR	Manage User Preferences	>





7 Patient Information

1. To start the Communicable Disease Lab Entry, you must complete the mandatory fields marked with **red asterisks** (*) on the **Patient Information** screen.

Datient Information	Observation Ack On (Order Entry Lab Data Benjew Submit	
Patient information	Observation Ask on t	Submit Cab Data Review Submit	
Diana and the form	alan All Calda marked with an antarial	the second second	
Please complete the form of	below. All fields marked with an asterisk	(*) are required.	
	DATIENT IN		
Performing Facility Name*		Patient MRN* 🔮	
Selection		L	
Prefix		First Name*	
Select	Ÿ	L	
Middle Initial		Last Name*	
Suffix		Social Security Number	
Select	~ ~		
Date of Birth*		Patient Sex*	
mm/dd/yyyy		Select	~
Bace		Ethnicity*	
Select	v	Select	~
			_
Address 1 🛛		Address 2	
		Unit, Suite, Building, etc.	
City		State	
		all'a Robotico	
Zip Code		County	
		Select	×
Phone Number		Email Address	
		name@domain.com	



2. Select the **Performing Facility Name** from the dropdown menu. This will be the name of the organization that resulted the lab for which you are entering results. This is usually the name of the organization with which you are associated.

PATIENT	INFORMATION
Performing Facility Name*	Patient MRN* 😧
Select	~
Diatherix Eurofins	First Name*
eICR Onboarding Regression April	
eICR Onboarding Regression Four	Last Name*
LABCORP	
Quest Diagnostics	Social Security Number
Solaris Diagnostics	
Test Medical Center	Patient Sex*

3. You must enter the **Patient Medical Record Number (MRN)**. 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.

Patient Information	Observation	Ask On Ord	er Entry Lab Data Review An MRN or Medical Record	Submit
			Number is an Organization	
Please complete the	form below. All	fields marked	specific, unique with aidentification numberguined. assigned to a patient by a healthcare organization. If	
	PATI	ENT INF	O your organization does not use an MRN, you MUST create a way to uniquely	
			identify your patient.	
Performing Facility N	lame*		Patient MRN* 🚱	
Test Medical Cente	r	× V		

4. If available, enter the appropriate **Prefix** and **Suffix** from the dropdown menus.

Prefix Select V	First Name*	
Middle Initial	Last Name*	
Select V	Social Security Number	



5. Enter the patient's First Name and Last Name. If available, enter the patient's Middle Initial.

Prefix Mr.	First Name*	
Middle Initial	Last Name*	

6. If available, enter the patient's **Social Security Number**.

s	Suffix	Social Security Number
	Select 🗸 🗸	I

- 7. Enter the patient's **Date of Birth** by clicking the *Date of Birth* field to bring up a calendar.
- You can click a **date on the calendar** or use the field dropdown menu to select the month and year. You **should ensure** you selected the correct year when using the calendar function.

Date of Birth*	Patient Sex*
01/01/1960	Select 🗸
January 1960	Ethnicity*
Su Mo Tu We Th Fr Sa	Select V
27 28 29 30 31 1 2	
3 4 5 6 7 8 9	Address 2
10 11 12 13 14 15 16	Unit, Suite, Building, etc.
17 18 19 20 21 22 23	
24 25 26 27 28 29 30	State
31 1 2 3 4 5 6	Select 🗸
Zip Code	County

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

Address 1 😧	123 Test St.	Patient Information	×	
Address 2	Unit, Suite,	The Date of Birth entered indicates that the patient is more than 100 years old. Is this correct?		
City	Frankfort	Yes	Io	× ~
Please Note : of birth is cor 100 years old	lf the date rect, click l.	of birth is incorrect, click No to enter the c (es to confirm that the patient is either un	orrect date of der one year o	birth. If the date old or more than

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8. Select the appropriate **Patient Sex** from the dropdown menu.

Date of Birth*	Patient Sex*	
01/01/1960	Select	~
Race*	Female	
Select 🗸	Male	
	Other	
Address 1 😧	Unknown	
	Unit, Suite, Building, etc.	

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

Race*		Ethnicity*	
Select	\sim	Select	~
American Indian or Alaska Native	-		
Asian		Address 2	
Asked but Unknown		Unit, Suite, Building, etc.	
Black or African American		State	
Native Hawaiian or Other Pacific Island	ler	Select	~
Other Race			
Unknown		Select	
White		Select	
Phone Number		Email Address	

10. If available, enter the patient's **Street Address**, **City**, **State**, **Zip Code**, and **County**.

- Enter the patient's home address. However, in cases of congregate care, you should enter the address of the nursing home, group home, or similar congregate care facility.
- Hover over the **Help Icon** to assist with entering the correct address information for the patient tested.

Use the address of the patient tested. In cases of congregate care housing, utilize the address of the	~	Social Security Number 400-12-3456		*
congregate care setting. Congregate care setting		Patient Sex*		
includes nursing homes, residential care for people		Male	× ~	
with intellectual disabilities, psychiatric treatment		Ethnicity*		
facilities, group homes, board and care homes,	× ~	Not Hispanic or Latino	× ~	
homeless shelter, foster care, or other setting.				
Address 1 😧		Address 2		- 1
1		Unit, Suite, Building, etc.		- 1
City		State		- 1
		Select		
Zip Code		County		
		Select	~	
				Ŧ



11. If available, enter the patient's **Phone Number** and **Email Address**.

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

12. When you have completed the **Patient Information** screen, click **Next** to proceed to the **Observation** screen.

0	2	3 4	- 5
Patient Information	Observation Ask On	Order Entry Lab Data Review	Submit
Please complete the form	below. All fields marked with an as	terisk(*) are required.	
	PATIENT IN	FORMATION	
Performing Facility Name	*	Patient MRN* 🚱	
Test Medical Center	× ~	CK01011960	
Prefix		First Name*	
Mr.	× ~	Cosmo	
Middle Initial		Last Name*	
А		Kramer	
Suffix		Social Security Number	
Select	v	400-12-3456	
Date of Birth*		Patient Sex*	
01/01/1960		Male	× ~
Race*		Ethnicity*	
Other Race	x ~	Not Hispanic or Latino	$\times ~ ~ \sim$
Address 1 😧		Address 2	
123 Seinfeld Lane		Unit, Suite, Building, etc.	
City		State	
Lexington		KY	× ~
Zip Code		County	
40509-		Fayette	× ~
Phone Number		Email Address	
(555) 123-1234		cosmokramer@email.com	



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8 **Observation**

Ordering Section

On the **Observation** screen, you must select <u>at least one</u> of the options available for ordering details: **EITHER** the Ordering Facility <u>OR</u> the Ordering Provider. While it is not required to select an Ordering Provider <u>and</u> an Ordering Facility, you are encouraged to select an option for both sections if the information is available. The dropdown menu options display the Ordering Provider and Ordering Facility details entered on the **Manage User Preferences** screen.

Patient Information	Observation	Ask On Order Entry	Lab Data Review	Submit
You must select at least o	ne of the options availal	ble for ordering details: Ord	dering Facility or Ordering Pi	rovider.
	70: 	ā		
		ORDERING		
Facility Name 😧		Option	1: Select the appropriate	Facility Name
Select				
Provider Name 🕢		Provider N	AND / OK	
Select		Option 2	2: Select the appropriate	Provider Name
		OBSERVATION		
Specimen Collection Date	Time*	Specimen S	ite	
mm/dd/yyyy hh:mm a		Select		
Specimen Type*		Filler Order	Number* 😧	
Select		· · ·		
Test Order LOINC*		Test Order	Name*	
Select		Select		
Test Order Date Time				
mm/dd/yyyy hh:mm a		10		
Observation 1				
Select Disease Type*		Select Conc	dition*	
Select		Select		1
Observation LOINC*		Observation	Name*	
CALLSET WATERLATE L.C. MINK.		Service at sold. A set of the	A A A BOARD A A B	





- 1. On the **Observation** screen, you must select **<u>at least one</u>** of the options available in the *Ordering* section: **Facility Name** or **Provider Name**.
 - If applicable, select the appropriate **Facility Name** from the dropdown menu.

You must select at least one of Ordering Provider. Ordering Facility details are	of the options avai	lable for ordering details: Ordering Facility or
required. Please enter your ordering facility details in the Manage User Preferences.	ORD	ERING
Facility Name 🚱	~	
General Hospital		Provider NPI
Mercy Medical Center		
Test Community Hospital		
Union Medical Clinic		

• If applicable, select appropriate **Provider Name** from the dropdown menu.

Ordering Provider details are required. Please enter your ordering provider Te details in the Manage User Preferences.	× ×	Provider NPI
Şelect		
Dr. Martin Crane, Sr		
Dr. Marty Crane, Jr		
Dr. Niles Crane, Jr		VATION
Fraiser Crane		
George Costanza		Specimen Site
Joe Smith		Select V
Specimen Type*		Filler Order Number* 😧

• Upon selecting the **Provider Name** from the dropdown menu, the *Provider NPI* field automatically populates.

Provider Name 🕢		Provider NPI	
Dr. Niles Crane, Jr	× ~	1098765432	

Communicable Disease Lab Entry and Ε **Deloitte.** Initiating Case Reports User Guide Please Note: If you click Next but do <u>not</u> select <u>at least one</u> Provider or Facility, a banner displays with a message that states: You must select at least one of the options available for ordering details: Ordering Facility or Ordering Provider. You must select a **Facility Name** and/or **Provider Name** from the appropriate dropdown menu in order to add observations or proceed to the Ask on Order Entry screen. ORDERING Facility Name 😧 Select. \sim Please Enter Facility Name Provider Name 🚱 Select.. \sim Provider NPI

Observation Section

lease Enter Provider Name

After completing the *Ordering* section, you must enter observation results in the *Observation* section.

2. Select **Specimen Collection Date Time** from the calendar and time function.

mm/dd/yyyy hh:mm a	
June 2022 Time Filler Order Nur	mber*
June 2022 6:30 AM	•
Su Mo Tu We Th Fr Sa 7:00 AM	
29 30 31 1 2 3 4 7:30 AM Test Order Nan	ne*
5 6 7 8 9 10 11 8:00 AM	
12 13 14 15 16 17 18 8:30 AM	1
19 20 21 22 23 24 25 9:00 AM	
26 27 28 29 30 1 2 9:30 AM	
10:00 AM	
10:30 AM	

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3. If available, select the appropriate **Specimen Site** from the dropdown menu.

Specimen Collection Date Time	*	Specimen Site	
07/01/2022 08:30 AM	益	Select	~
Specimen Type*		Bilateral Ears	i i
Select	~	Bilateral Eyes	
Test Order LOINC*		Bilateral Nares	
Select	 	Buttock	
Test Order Date Time		Chest Tube	
mm/dd/yyyy hh:mm a		Left Antecubital Fossa	
		Left Anterior Chest	
Observation 1		and the second se	

4. You must select a **Specimen Type** from the dropdown menu. The *Specimen Type* describes the method by which the sample was obtained.

Select	~	
Abscess	Test Order Name*	
Amniotic fluid	Select	
Aspirate		
Bile fluid		
Blood - cord		
Blood arterial		•
Blood bag	Select Condition*	
	Select	

5. Enter the Filler Order Number.

Г

#	Bilatera Number and is used to log ×
	the receipt of a specimen.
	Filler Order Number* 😧
\sim	
	~
Communicable Disease Lab Entry and Initiating Case Reports User Guide



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

6. Select the appropriate **Test Order LOINC** from the dropdown menu.

Test Order LOINC*		Test Order Name*	
Select	~	Select	
10347-3	A		
10349-9			
10709-4			
10850-6			•
10900-9		Select Condition*	
11255-7		Select	×
11469-4		Observation Name*	
	•	Select	

7. Upon selecting the Test Order LOINC, the *Test Order Name* field is automatically populated.

10347-3 X V BABESIA MICROTI IDENTIFIED X V	Test Order LOINC*		Test Order Name*	
	10347-3	× ~	BABESIA MICROTI IDENTIFIED	$\times \mid \cdot$

• You can select a different **Test Order Name** from the dropdown menu, if needed.

Test Order LOINC*		Test Order Name*
10347-3	$\times \sim$	BABESIA MICROTI IDENTIFIED 🛛 🗙 🗌 🗸
Test Order Date Time		BABESIA CABALLI AB
mm/dd/yyyy hh:mm a	Ħ	BABESIA CABALLI DNA
		BABESIA MICROTI AB
Observation 1		BABESIA MICROTI AB.IGG
Select Disease Type*		BABESIA MICROTI AB.IGM
Select	· ·	BABESIA MICROTI DNA
Observation LOINC*		BABESIA MICROTI IDENTIFIED
Select	\sim	

_ _ _ _ _ _ _ _ _



Please Note: The *Test Order Name* dropdown menu displays only the test order options that apply to the selected **Test Order LOINC**.

8. Select the **Test Order Date Time** from the calendar and time function.

Test	Oro m/d	d/yy	ate Ti /y hh:	ime mm	a		鎆		
۹ Su] M	j i une o Tu	une 20 ~	0 22 202 Th	2 🗸 Fr	Sa	Time 5:30 AM	•	
29 5	3I 6) 31 7	1 8	2 9	3 10	4 11	6:30 AM 7:00 AM	Select V	[
12 19 26	1:	3 14) 21	15 22	16 23 30	17 24 1	18 25 2	7:30 AM 8:00 AM 8:30 AM	Observation Name* Select	
20	2	/ 20	5 29	50		2	9:00 AM 9:30 AM 🔫		

9. Click the *Select Disease Type* hyperlink to view a filterable and categorized list of disease types and disease names.

Observation 1		•
Select Disease Type*	Select Condition*	
Select	✓ Select	

10. The *Test Name Details* pop-up displays the disease types, conditions, and observation names.

Test Name Details		×
SHOWING		
332 ITEMS		APPLY FILTER
DISEASE TYPE	CONDITION \$	OBSERVATION NAME
Child Hepatitis	Child Hepatitis B	ALT
Child Hepatitis	Child Hepatitis B	AST
Child Hepatitis	Child Hepatitis B	Bilirubin
Child Hepatitis	Child Hepatitis B	HEPATITIS B VIRUS CORE AB
Child Hepatitis	Child Hepatitis B	HEPATITIS B VIRUS CORE



11. To search for a specific disease type, condition, and/or observation name, click **Apply Filter**.

OBSERVATION NAME
ALT
AST
Bilirubin
HEPATITIS B VIRUS CORE AB
HEPATITIS B VIRUS CORE

12. The Filter fields display. Search by entering the *Disease Type*, *Condition*, and/or *Observation Name* in the corresponding Filter fields.

Test Name Details		\$
SHOWING 332 ITEMS		T HIDE FILTER
DISEASE TYPE • • • • • • • • • • • • • • • • • • •	CONDITION \$	OBSERVATION NAME
Child Hepatitis	Child Hepatitis B	ALT
Child Hepatitis	Child Hepatitis B	AST
Child Hepatitis	Child Hepatitis B	Bilirubin

13. Once complete, click **OK** to close out of the pop-up.

Test Name Details			×
SHOWING 5 ITEMS		T HIDE FILTER	Î
DISEASE TYPE	CONDITION	OBSERVATION NAME	•
Other	Babesiosis	Babesia <u>Microti</u>	
Other Conditions	Babesiosis	BABESIA MICROTI AB	
Other Conditions	Babesiosis	BABESIA MICROTI AB.IGG	
Other Conditions	Babesiosis	BABESIA MICROTI AB.IGM	
Other Conditions	Babesiosis	BABESIA MICROTI DNA	•
		1	ок



14. Select the appropriate **Disease Type** from the *Select Disease Type* dropdown menu.

Observation 1			C
Select Disease Type *		Select Condition*	
Select	~	Select	
Child Hepatitis		Observation Name*	
MDRO		Select	
Other Conditions			
Perinatal Hepatitis			
STD		Observation Units	
mm/dd/yyyy hh:mm a		Select	

Please Note: The *Select Disease Type* dropdown menu displays *Perinatal Hepatitis* as a dropdown option only when *Female* is selected for the *Patient Sex* field on the **Patient Information** screen. This is because Perinatal Hepatitis Case Reports apply only to female patients.

• When *Male*, *Other*, or *Unknown* is selected as the Patient Sex, the *Select Disease Type* field does <u>not</u> display *Perinatal Hepatitis* as a dropdown option.

The *Select Disease Type* dropdown menu displays *Child Hepatitis* as a dropdown option only when the patient is under 5 years old, as indicated in the *Date of Birth* field on the **Patient Information** screen.

• When the patient is over 5 years old, the *Select Disease Type* field does <u>not</u> display *Child Hepatitis* as a dropdown option.

Observation 1			•
Select Disease Type*		Select Condition*	
Select	· ·	Select	~
MDRO		Observation Name*	
Other Conditions		Select	v
STD			
Select	~		



Please Note: The *Select Condition* dropdown menu does <u>not</u> display options until the **Disease Type** has been selected. The *Select Condition* dropdown menu displays only the conditions that apply to the selected **Disease Type**.

Colort Discours Trans		Coloret Constitution t	•
Select Disease Type*		Select Condition*	
Select	\sim	Select	~
Observation LOINC*		No optio	ons

- 15. Select the appropriate **Disease Condition** from the *Select Condition* dropdown menu.
- When *Child Hepatitis* is selected as the Disease Type, the Select Condition dropdown menu displays Child Hepatitis B and C conditions.

Select Disease Type*		Select Condition*	
Child Hepatitis	$\mathbf{x} \mid \mathbf{v}$	Select	· ·
Observation LOINC*		Child Hepatitis B	
Select	~	Child Hepatitis C	
Result Type*		-	
asa Nata: The Select Disea	se Type field disp	lave Child Henetitis as a drou	



• When *MDRO* is selected as the Disease Type, the *Select Condition* dropdown menu displays MDRO conditions.

Select Disease Type *		Select Condition*	
MDRO	$\times \mid \cdot \mid$	Select	~
Observation LOINC*		Candida auris, clinical	-
Select	~	Candida auris, colonization/screening	
Result Type*		Carbapenem Resistant Acinetobacter baumannii (CRAB)	
Select Observation Result Date Time*	~	Carbapenem resistant Enterobacteriaceae (CRE)	
mm/dd/yyyy hh:mm a		Carbapenem-resistant Pseudomonas	
Reference Range		Carbananamaco producing carbananam	•

• When **Other Conditions** is selected as the Disease Type, the *Select Condition* dropdown menu displays Other Reportable Conditions.

Select 🗸
Adult Botulism
✓ Anaplasmosis
Anthrax
 Babesiosis
Brucellosis
Campylobacteriosis
Chikungunya, Neuroinvasive

• When *Perinatal Hepatitis* is selected as the Disease Type, the *Select Condition* dropdown menu displays Perinatal Hepatitis B and C conditions.

elect 🗸 🗸
erinatal Hepatitis B
erinatal Hepatitis C



Please Note: The *Select Disease Type* field displays *Perinatal Hepatitis* as a dropdown option only when *Female* is selected as the Patient Sex.

• When *STD* is selected as the Disease Type, the *Select Condition* dropdown menu displays Sexually Transmitted Disease conditions.

Select Disease Type*		Select Condition*		
× ~	Select	~		
	Chancroid			
	Chlamydia Trachomatis Infection			
	Gonorrhea			
	Syphilis			
	× ~	Select Condition* Select Chancroid Chlamydia Trachomatis Infection Gonorrhea Syphilis		

Click the *Select Condition* hyperlink to view a filterable and categorized list of disease types and disease names. This is the same *Test Name Details* pop-up that displays upon clicking the *Select Disease Type* hyperlink.

Observation 1			•
Select Disease Type*		Select Condition*	
Other Conditions	× ~	Select	~

16. Select the appropriate **Observation LOINC** from the dropdown menu.

Observation LOINC*	Observation Name*	*
Select	✓ Select	· ·
10347-3	1	
16117-4		
21089-8	Observation Units	
22106-9	Select	· ·
22107-7	Abnormal Flag	
22850-2	Select	~
22853-6		

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Please Note: The *Observation LOINC* dropdown menu does <u>not</u> display options until the **Condition** has been selected. The *Observation LOINC* dropdown menu displays only the conditions that apply to the selected **Condition**.

Observation 1		•
Select Disease Type*	Select Cor	ndition*
Select	Select	↓ ▼
Observation LOINC*	Observati	ion Name*
Select	✓ Select	· · ·
Select	~	
ase Note: Upon selecting	the Observation LOIN an applicable Observat	IC , the <i>Observation Name</i> fiel ion Name. The <i>Observation N</i>
pdown menu displays the servation LOINC.	Observation Name optic	ons that apply only to the sele
pdown menu displays the servation LOINC.	Observation Name optic	ons that apply only to the sele

17. Select the appropriate **Observation Name** from the dropdown menu. You can select a different Observation Name from the dropdown menu, if needed.

X

 \sim

BABESIA MICROTI IDENTIFIED

		Observation Name*	
10347-3	$\times $ \checkmark	BABESIA MICROTI IDENTIFIED	× ×
Result Type*		BABESIA CABALLI AB	^
Select	· ·	BABESIA CABALLI DNA	
Observation Result Date Time*		BABESIA MICROTI AB	
mm/dd/yyyy hh:mm a	ŧ	BABESIA MICROTI AB.IGG	
Reference Range		BABESIA MICROTI AB.IGM	- 1
		BABESIA MICROTI DNA	
Notes		BABESIA MICROTI IDENTIFIED	

10347-3

×



 Click the *Observation Name* hyperlink to view a filterable and categorized list of disease types and disease names. This is the same *Test Name Details* pop-up that displays upon clicking the *Select Disease Type* hyperlink.

Obs	servation LOINC*		Observation Name
10	347-3	$\times \mid \checkmark$	BABESIA MICROTI IDENTIFIED X V

18. Select the appropriate **Result Type** from the dropdown menu.

Observation LOINC*		Observation Name*	
10347-3	x ~	BABESIA MICROTI IDENTIFIED	× ~
Result Type*			
Select	~		
Coded Result		Observation Units	
Numeric		Select	
String Data		Abnormal Flag	

Result Type Dynamic Fields

The *Result Type* field is a dynamic field. Based on the selected **Result Type**, the **Observation** screen will display different subsequent fields. Prior to selecting the **Result Type**, the following subsequent fields display:

- Observation Result Date Time field (Mandatory field)
- *Observation Units* field (Optional field)

Select	\sim		
Observation Result Date Time*		Observation Units	
mm/dd/yyyy hh:mm a	ŧ	Select	~
Reference Range		Abnormal Flag	
		Coloct	



- 19. Upon selecting *Coded Results* as the Result Type, the mandatory *Observation Result* field displays.
 - You must select the appropriate **Observation Result** from the dropdown menu.

Result Type*		Observation Result*	
Coded Result	× ~	Select	~
Observation Result Date Time*		+	A
mm/dd/yyyy hh:mm a	ŧ	++	
Reference Range		+++	
		++++	
Notes		Abnormal	
		Abnormal presence of	
		Abnormal result	
V200 Characters			-

- 20. Upon selecting *Numeric* as the Result Type, the mandatory *Observation Result* textbox field displays, and the *Observation Units* field becomes mandatory.
 - You must enter the **Observation Result** in the textbox field.
 - You must select the appropriate **Observation Units** from the dropdown menu.

Result Type*		Observation Result*	
Numeric	x ~		
Observation Result Date Time*		Observation Units*	
mm/dd/yyyy hh:mm a		Select	~
Reference Range		% - Percent	
		(arb_u) - *Arbitrary unit	
Notes		(bdsk_u) - *Bodansky Units	
		(bsa) - *Body surface area	
		(cal) - *Calorie	
0/300 Characters		(cfu) - *Colony Forming Units	
		(drop) - Drop	
+ Add Observation			



- 21. Upon selecting String Data as the Result Type, the mandatory Observation Result textbox field displays.
 - You must enter the **Observation Result** in the textbox field.

String Data	× V	
Observation Result*		
Observation Result*		

22. Upon selecting *Structured Numeric* as the Result Type, the following four (4) fields display:

- *Comparator* dropdown menu (Optional) •
- Separator dropdown menu (Optional) Result Value 2 textbox (Optional) •
- *Result Value 1* textbox (Mandatory)
- Result Type* Structured Numeric X \sim Comparator Result Value 1* Select... **Result Value 2** Separator Select...
- If applicable, select the appropriate **Comparator** from the dropdown menu.
- You must enter the **Result Value 1** in the textbox field.

Result Type*	
Structured Numeric X V	
Comparator	Result Value 1*
Select 🗸 🗸	
<	Result Value 2
>	
=	Observation Units*
<	Select 🗸
>=	Abnormal Flag
<=	Select 🗸 🗸

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- If applicable, select the appropriate **Separator** from the dropdown menu.
- If applicable, enter the **Result Value 2** in the textbox field.

Structured Numeric	× V		
Comparator		Result Value 1*	
<	× ~		
Separator		Result Value 2	
Select	~		
+		Observation Units*	
:		Select	~
-		Select Abnormal Flag	~

23. Select the **Observation Result Date Time** from the calendar and time function.

mm/dd/yyyy hh:mm a		Select	~
Reference Range		Abnormal Flag	
		Select	

Please Note: The Specimen Collection Date Time cannot occur <u>after</u> the Observation Result Date Time. The Specimen Collection Date Time must occur on the <u>same date</u> or any date <u>BEFORE</u> the Observation Result Date Time.

If you enter a **Specimen Collection Date** that occurs after the **Observation Result Date**, both fields are marked as invalid. If you click **Next**, the **Observation** screen is grayed out and displays a message that states: *Specimen date cannot be later than the Observation date, please provide valid Specimen date.*

To proceed, you must enter a valid **Specimen Collection Date Time** that occurs <u>on</u> or <u>BEFORE</u> the **Observation Result Date Time**.

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[
06/30/2022 08:30 AM		Bilateral Eyes	×
Invalid Specimen Collection Date Time.			
Specimen Type*		Filler Order Number* 😧	
Cornea	× ~	07012022	
Test Order LOINC*		Test Order Name*	
10347-3	× ~	BABESIA MICROTI IDENTIFIED	×
Test Order Date Time			
06/30/2022 12:00 AM	#		
Select Disease Type*		Select Condition*	
Select Disease Type*	× [~]	Select Condition*	~
Select Disease Type * Other Conditions	x ~	Select Condition * Babesiosis	×
Select Disease Type* Other Conditions Observation LOINC*	x ~	Select Condition * Babesiosis Observation Name*	×
Select Disease Type * Other Conditions Observation LOINC* 10347-3	x ~ x ~	Select Condition * Babesiosis Observation Name * BABESIA MICROTI IDENTIFIED	×
Select Disease Type* Other Conditions Observation LOINC* 10347-3 Result Type*	x v x v	Select Condition * Babesiosis Observation Name * BABESIA MICROTI IDENTIFIED Observation Result*	×
Select Disease Type* Other Conditions Observation LOINC* 10347-3 Result Type* Coded Result	x ~ x ~ x ~	Select Condition * Babesiosis Observation Name * BABESIA MICROTI IDENTIFIED Observation Result* Positive	×
Select Disease Type* Other Conditions Observation LOINC* 10347-3 Result Type* Coded Result Observation Result Date Time*	x ~ x ~ x ~	Select Condition * Babesiosis Observation Name * BABESIA MICROTI IDENTIFIED Observation Result* Positive Deservation Units	× ×
Select Disease Type* Other Conditions Observation LOINC* 10347-3 Result Type* Coded Result Observation Result Date Time* 06/29/2022 08:00 AM	x ~ x ~ x ~	Select Condition * Babesiosis Observation Name * BABESIA MICROTI IDENTIFIED Observation Result* Positive Dbservation Units % - Percent	× × ×

24. If applicable, select the appropriate **Observation Units** from the dropdown menu.

Observation Result Date Time*	Observation Units
06/29/2022 08:00 AM	Select 🛛 🗸 🗸
Reference Range	% - Percent
	(arb_u) - *Arbitrary unit
Notes	(bdsk_u) - *Bodansky Units
	(bsa) - *Body surface area
	(cal) - *Calorie
0/300 Characters	(cfu) - *Colony Forming Units
	(drop) - Drop
Add Observation	· · · · · · · · · · · · · · · · · · ·
Type	es mandatory only when Numeric is s
Type.	

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25. If applicable, enter the **Reference Range** in the textbox field.

Reference Range	Abnormal Flag	
	Select	~]

26. If applicable, select the appropriate **Abnormal Flag** from the dropdown menu.

Abnormal Flag	
Select	· ·
Abnormal	^
Above absolute high	
Above high normal	
Above upper panic limits	
Below absolute low	
Below low normal	
Below lower panic limits	
	Abnormal Flag \$elect Abnormal Above absolute high Above high normal Above upper panic limits Below absolute low Below low normal Below lower panic limits

27. If applicable, enter **Notes about the observation** in the *Notes* textbox.

Reference Range	Abnormal Flag	
	Abnormal	× ~
Notes		
0/300 Characters		
obo characters		
•		

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Adding Multiple Observations

28. You can click **Add Observation** to log the details for multiple observations. This means that you can easily enter additional observation details on the same patient.

Observation 1 details	
21/300 Characters	
• Add Observation	

Please Note: The Communicable Disease Lab Entry allows Users to enter <u>up to 70</u> observations for multiple diseases at the same time for the same patient.

Select Disease Type *		Select Condition *	
Select	~	Select	
Observation LOINC*		Observation Name*	
Select	~	Select	~
Result Type*			
Select			
Observation Result Date Time*		Observation Units	
mm/dd/yyyy hh:mm a	曲	Select	
Reference Range		Abnormal Flag	
		Select	~
Notes			
0/300 Characters			





29. Once the **Observation** screen is complete, click **Next** to proceed to the **Ask on Order Entry** screen.

'ou must select at least one of the options available for orderin	g details: Ordering Facility or Ordering Pr	ovider.	
	ORD	ERING	
Facility Name 🖗			
Test Community Hospital	x v		
Provider Name Ø		Provider NPI	
Dr. Niles Crane, Jr	x ~	1098765432	
	OBSEF	VATION	
pecimen Collection Date Time*		Specimen Site	
07/01/2022 08:30 AM	11	Other	x ~
pecimen Type*		Filler Order Number* 🛛	
Body fluid, unsp	x ~	EB07012022	
est Order LOINC*		Test Order Name*	
10347-3	x ~	BABESIA MICROTI IDENTIFIED	x ~
est Order Date Time			
06/30/2022 12:00 PM	10		
Observation 1			•
Select Disease Type *		Select Condition *	
Other Conditions	X ~	Babesiosis	x ~
Observation LOINC*		Observation Name*	
10347-3	X ~	BABESIA MICROTI IDENTIFIED	x ~
Result Type*		Observation Result*	
Coded Result	X ~	Identified	x ~
Observation Result Date Time*		Observation Units	
07/01/2022 02:30 PM	88	% - Percent	x ~
Reference Range		Abnormal Flag	
		Abnormal	x ~
iotes			
Observation 1 details			
1/300 Characters			h
Dbservation 2 📋			0
Observation 3 📋			0
Observation 4			0

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9 Ask on Order Entry

There are a series of questions that healthcare providers may ask patients regarding communicable disease testing. Users should enter the answers to these questions on the **Ask on Order Entry** screen.

1	2	3	4	5
Patient Information	Observation	Ask On Order Entry	Lab Data Review	/ Submit
Please provide addition	hal details.			
	,	ASK ON ORDER EN	TRY	
First Test 😧	Select	· ·	HCW @ Select	· ·
Symptoms 🚱	Select	~ Hospitali	zation 🕑 Select	~
Onset Date 🚱	MM/DD/YYYY	🖮 Congr	regate 😰 Select	
ICU 😧	Select	∼ Pre	gnant 🕑 Select	~

30. Select the **appropriate answer** from the *First Test* dropdown menu to report whether this is the first time the patient has ever been tested for the reportable condition(s) of interest. The objective is to find out whether the patient has ever been tested <u>anywhere</u> not just at your organization.

Yes, if this is the first time this patient has been tested for this condition(s) of	ASK ON ORD	ER ENTRY	
interest. First Test ?	ŀ	HCW 🚱	
Select	· •	Select	~
No	ŀ	Hospitalization 😧	
Unknown		Select	
Yes	c	Congregate 😧	
mm/dd/aaa/	A.A.	Select	



31. Select the **appropriate answer** from the *Symptoms* dropdown menu to report whether the patient has symptoms related to the condition(s) of interest.

Yes, if patient has symptoms related to the condition(s) of interest.	x ~	Select	~
Symptoms 😧		Hospitalization 🚱	
Select	~	Select	
No		Congregate 😧	
Unknown		Select	V
Yes		Pregnant 🕑	

• When **Yes** is selected, the subsequent *Onset Date* field is enabled. You must enter the **Date of Onset** by entering the month, day, and year when symptoms began in the *Onset Date* field.

Symptoms 🚱		Hospitalization 🕑
Yes	× ~	Select 🗸 🗸
Onset Date @ mm/dd/yyyy		Congregate 🚱 Select
ICU 😧		Pregnant 😧
Date that symptoms began for the patient	× ~	Select 🗸
Onset Date 😧	•	Congregate 🚱
06/15/2022	÷	Select 🗸
June 2022		Pregnant 🚱
Su Mo Tu We Th F	r Sa	Sciectin
29 30 31 1 2 3	3 4	
5 6 7 8 9 1	0 11	Previous
12 13 14 15 16 1	7 18	
19 20 21 22 23 2	4 25	
26 27 28 29 30 ⁻	2 Healthi	Interactive Version

• When **No** is selected, the subsequent *Onset Date* field is grayed out and disabled.

Select	
Congregate 🕑	
Select	
Ħ	Congregate 🚱





32. Select the **appropriate answer** from the *ICU* dropdown menu to report whether the patient has been admitted or transferred to the Intensive Care Unit (ICU).

Yes, if patient has been admitted/transferred to the ICU at any time during the	× ~	Hospitalization 🕑	· ·
encounter for the reportable illness/condition that the order has been		Congregate 🚱	
placed for (suspected or diagnosed).		Select	~
		Pregnant 🚱	
Select	~	Select	~
No			
Unknown			Previous Next
Yes			

33. Select the **appropriate answer** from the *HCW* dropdown menu to report whether the Patient is a Health Care Worker (HCW).

	Yes, firs	if the person tested is a stresponder, front line	
		aff, therapist, in direct ntact with patients or in their location	
First Test 😧		HCW 0	
Yes	× ~	Select	~
Symptoms 😧		No	
Yes	× ~	Unknown	
Onset Date 🚱		Yes	
06/15/2022	ŧ	Select	
ICU 🚱		Pregnant 😧	
No	× v	Select	



J

34. Select the **appropriate answer** from the *Hospitalization* dropdown menu to report whether the patient has been hospitalized.

First Test 🚱	ASK ON OR	DE Yes, if patient has been hospitalized for the reportable illness/condition that this order has been placed for (suspected or diagnosed). When ordered during ER duration, the answer would be No.	~
Symptoms 🕑		Hospitalization 😧	
Yes	× ~	Select	~
Onset Date 😧		No	
06/15/2022		Unknown	
		Yes	
Select	V	Select	~

35. Select the **appropriate answer** from the *Congregate* dropdown menu to report whether the patient is a resident in a congregate care setting. Hovering over the **Help Icon** provides guidance to identify congregate care settings and assist with answering this question.

	ASK ON OR	Yes, if is a resident in a	
First Test @ No Symptoms @	x ~	such as: nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes,	x ~
Yes	x ~	homeless shelter, foster care, or other setting	x ~
06/15/2022	İ	Select	~
		No	
No	× ~	Unknown	
		Yes	
			Previous



- 36. Select the **appropriate answer** from the *Pregnant* dropdown menu to report the status of pregnancy for the patient.
- The *Pregnant* dropdown menu options include: *Not pregnant, Patient currently pregnant, Possible pregnancy*, or *Unknown.*

06/15/2022	Pregnant, i female a	f this individual is X			
ICU 😧	Pregnar	nt 😧			
No	× v Select				
	Not p	regnant			
	Patier	it currently pregnant			
	Possil	ole pregnancy			
	Unkne	own			
HealthInteractive	HEALTHINTERAC <u>TIVE</u>	Version: 1.0.0			
Please Note : The <i>Pregnant</i> field is enabled only when <i>Female</i> is selected for the <i>Patient Sex</i> field on the Patient Information screen. When <i>Male</i> , <i>Other</i> , or <i>Unknown</i> is selected as the Patient Sex, the <i>Pregnant</i> field is grayed out and disabled.					
ICU 🕑 No	× × se	nant 🛛			

37. Once the **Ask on Order Entry** screen is complete, click **Next** to proceed to the **Lab Data Review** screen.

> Communicable Dise	ease Lab Entry					
	1 Patient Information	Observation As		4 Lab Data Review	5	
			,			
	Please provide additional detai	ls.				
		ASK OI	N ORDER ENTI	RY		
	First Test 🚱		HCW 🚱			
	No	×	No		× ~	
	Symptoms 😧		Hospitalizatio	on 😧		
	Yes	×	Yes		× ~	
	Onset Date 😧		Congregate	9		
	06/15/2022		m No		× ~	
			Pregnant 😮			
	No	×	V Not pregnar	nt	× ~	
					Previous Next	

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10 Lab Data Review

The **Lab Data Review** screen displays a summary of the information you have entered. The **Lab Data Review** screen is not a submission of the lab results entered. Prior to submitting the lab results, review this screen to verify the accuracy of the information entered. You must click **Submit** in order to submit the Communicable Disease Lab Entry.

lease confirm lab data entries are accurate. eview page, click Next at the bottom of the :	To edit the information, click the appropriate hyp screen.	erlink or click on the navigation bar. To return to the Lab D
	LAB DATA REVIEW	
Patient Information		۰
Performing Facility Name	Patient MRN	Name
Test Medical Center	SR07061980	Miss Susan Ross
Date of Birth	Patient Sex	Race
07/06/1980	Female	White
Ethnicity	Address 1	City
Not Hispanic or Latino	77 Costanza Court	Frankfort
State	Zip Code	County
KY	40601-	Franklin
Ordering		
Facility Name	Provider Name	Provider NPI
Test Community Hospital	Dr. Fraiser Crane, Jr	1234543210
Observation		٥
Specimen Collection Date Time	Specimen Site	Specimen Type
06/27/2022 11:30 AM	Bilateral Ears	Abscess
Filler Order Number	Test Order LOINC	Test Order Name
SR06272022	10347-3	BABESIA MICROTI IDENTIFIED
Test Order Date Time 06/26/2022 1:00 PM		
Observation 1		۰
Select Disease Type	Select Condition	Observation LOINC
Perinatal Hepatitis	Perinatal Hepatitis B	10900-9
Observation Name	Result Type	Observation Result

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38. Review the *Patient Information* section.

Review page, click Next at the	bottom of the screen.		penink or click on the navigation bar.	To return to the Lab Da
Patient Information		LAB DATA REVIEW		
Performing Facility Name Test Medical Center	Patient N EB02151	IRN 970	Name Miss Elaine Benes	
Social Security Number 400-00-0000	Date of 8 02/15/19	irth 70	Patient Sex Female	
Race White	Ethnicity Not Hisp	anic or Latino	Address 1 123 Peterman Way	
Address 2 Apt. A	City Lexington	n	State KY	
Zip Code 40509-	County Fayette		Phone Number (555) 222-2222	
Email Address elainebenes@email.com				

• Click the **header** of any section to hide or display the details for that section.

		N	
Patient Information			۲
Ordering			
Ordening			
Facility Name Test Community Hospital	Provider Name Dr. Niles Crane, Jr	Provider NPI 1098765432	



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39. Review the *Ordering* section.

Ordering			
Facility Name	Provider Name	Provider NPI	
Test Community Hospital	Dr. Niles Crane, Jr	1098765432	
Please Note: If both an Review screen will displa	Ordering Facility and an Orderi	ng Provider are selected, the La	ab Data
	y the details for the Ordering Fa	acility and the Ordering Provider	

40. Review the *Observation* section.

Specimen Collection Date Time	Specimen Site	Specimen Type
07/01/2022 8:30 AM	Other	Body fluid, unsp
Filler Order Number	Test Order LOINC	Test Order Name
EB07012022	10347-3	BABESIA MICROTI IDENTIFIED
Test Order Date Time 06/30/2022 12:00 PM Observation 1		•
Select Disease Type	Select Condition	Observation LOINC
Other Conditions	Babesiosis	10347-3
Observation Name BABESIA MICROTI IDENTIFIED	Result Type Coded Result	Observation Result
Observation Result Date Time	Observation Units	Abnormal Flag
07/01/2022 2:30 PM	% - Percent	Abnormal
Notes Observation 1 details		
Observation 2		۰
Select Disease Type	Select Condition	Observation LOINC
STD	Chlamydia Trachomatis Infection	21613-5
Observation Name Chlamydia trachomatis DNA by NAA with probe detection	Result Type Coded Result	Observation Result + POSITIVE
Observation Result Date Time	Abnormal Flag	Notes
07/01/2022 3:00 PM	Abnormal	Observation 2 details

Observations in numbered order. _____/

l





41. Review the Ask on Order Entry section.

Ask On Order Entry		G	>
First Test	HCW	Symptoms	
No	No	Yes	
Onset Date	Hospitalization	Congregate	
2021/03/24	No	No	
ICU No	Pregnant Not pregnant		

Click Hyperlinks to Edit

- 42. If after reviewing, changes are required, click the corresponding **section header hyperlink** to navigate to the appropriate screen or section to edit the information.
- For example, to navigate to the **Observation** screen, click the **Observation** hyperlink in the section header.
- If multiple observations are entered, click the appropriate numbered Observation hyperlink to navigate directly to that specific Observation. For example, upon clicking the *Observation 1* hyperlink, you will be navigated directly to the *Observation 1* section of the **Observation** screen.

Observation		
Specimen Collection Date Time 07/01/2022 8:30 AM	Specimen Site Other	Specimen Type Body fluid, unsp
Filler Order Number EB07012022	Test Order LOINC 10347-3	Test Order Name BABESIA MICROTI IDENTIFIED
Test Order Date Time		
Observation 1		
Select Disease Type	Select Condition	Observation LOINC
Other Conditions	Babesiosis	10347-3
Observation Name	Result Type	Observation Result
BABESIA MICROTI IDENTIFIED	Coded Result	- NEGATIVE
Observation Result Date Time	Observation Units	Abnormal Flag

DDE: Communicable Disease Lab Entry



43. Once the appropriate edits are completed on the selected screen or section, click **Next** until you navigate back to the **Lab Data Review** screen.

Select Disease Type *		Select Condition*	
Other Conditions	x ~	Babesiosis	x ~
Observation LOINC*		Observation Name *	
10347-3	x ~	BABESIA MICROTI IDENTIFIED	× ~
Result Type*		Observation Result*	
Coded Result	× ~	Identified	x ~
Observation Result Date Time*		Nothing	
07/01/2022 02:00 PM		Null	
Reference Range		Numerous	
		Peak	
Notes		Positive	
Observation 1 details		Present	
		Reactive	
21/300 Characters			
Observation 2			0
+ Add Observation			
			Drevious Ne

44. Review your edits on the **Lab Data Review** screen.

Observation 1		
Select Disease Type	Select Condition	Observation LOINC
Other Conditions	Babesiosis	10347-3
Observation Name	Result Type	Observation Result
BABESIA MICROTI IDENTIFIED	Coded Result	+ POSITIVE
Observation Result Date Time	Observation Units	Abnormal Flag
07/01/2022 2:00 PM	% - Percent	Abnormal
Notes		
Observation 1 details		
Observation 2		



45. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Communicable Disease Lab Entry.

Ask On Order Entry		۵
First Test	HCW	Symptoms
No	No	Yes
Onset Date	Hospitalization	Congregate
2021/03/24	No	No
ICU No	Pregnant Not pregnant	Previous Submit

46. All data submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Communicable Disease Lab Entry or **Submit** to finalize the Communicable Disease Lab Entry.

Onset Date 06/15/2022	Communicable Disease Lab Entry ×			
ICU 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.			
	Cancel Submit			
	Previous Submit			
Please Note: Upon clicking Submit to finalize the Communicable Disease Lab Entry submission, the Lab Data Review screen displays a pop-up notification that provides the option for Users to initiate an applicable Case Report for the same patient.				



11 Initiate Case Report from Communicable Disease Lab Entry

Initiate Feature Overview

The **Initiate** feature allows Users with **both** the *DDELR Submitter* role **and** the *Manual Case Reporter* role to initiate any applicable Case Report with information from a previously submitted Communicable Disease Lab Entry. This allows Users to copy the information from a completed Communicable Disease Lab Entry into an applicable Case Report, enter additional details, and submit the Case Report for the patient. This means that certain information entered on the Communicable Disease Lab Entry will be auto-populated in the initiated Case Report. Users can update the appropriate information and submit an applicable Case Report for the same patient.

There are three (3) methods for initiating a Case Report from a previously submitted Communicable Disease Lab Entry:

- 1. Initiate an applicable Case Report upon Communicable Disease Lab Entry submission from the **Lab Data Review** screen.
- 2. Initiate an applicable Case Report from the **Case Report Entry User Summary** screen.
- 3. Initiate an applicable Case Report from the **Lab Results Submitted by User** screen.

Communicable Disease Lab Entry Submission

These steps cover how to initiate a Case Report Form for reportable test results upon submitting a Communicable Disease Lab Entry in the ePartnerViewer. The **Lab Data Review** screen displays a popup notification that provides the option for authorized ePartnerViewer Users to initiate a Case Report upon submitting a Communicable Disease Lab Entry.

1. Once you complete the Communicable Disease Lab Entry, review the information you entered on the **Lab Data Review** screen. After verifying the information is accurate and/or the appropriate changes have been made, click **Submit** to submit the Communicable Disease Lab Entry.

First Test	HCW	Symptoms
No	No	Yes
Onset Date	Hospitalization	Congregate
2021/03/24	No	No
ICU No	Pregnant Not pregnant	Previous Submit



2. A pop-up notification displays to confirm the submission. Select **Cancel** to continue reviewing the Communicable Disease Lab Entry or **Submit** to finalize the Communicable Disease Lab Entry.

Onset Date 06/15/2022	Communicable Disease Lab Entry ×
ICU 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.
	Cancel Submit

3. Upon clicking **Submit**, the *Communicable Disease Lab Entry* pop-up notification displays to provide the option to initiate an applicable Case Report for the patient .

	Communicable Disease Lab Entry $^{ imes}$	Communicable Disease Lab Entry ×					
	Do you want to submit a Candida auris, clinical Case Report Form?	Please select the appropriate Case Report Form. Gonorrhea Perinatal Hepatitis B					
	NOTE: A Case Report Form is only required when the results are reportable. Cancel Initiate	NOTE: A Case Report Form is only required when the results are reportable. Users may select up to 5 conditions at a time. Cancel Initiate					
Please Note option(s) tha Entry.	e: The <i>Communicable Disease Lab</i> t apply to the condition(s) entered	<i>p Entry</i> pop-up displays only the on the submitted Communicable	Case Report Disease Lab				

• If the Communicable Disease Lab Entry had only <u>one</u> condition or multiple observations with the *same* condition, the pop-up notification will display with a message that states:

Do you want to submit a [selected condition] Case Report Form? **NOTE***: A Case Report Form is only required when the results are reportable.*





4. You have the option to select **Cancel** if you do not want to initiate the Case Report. To initiate the applicable Case Report for the same patient, click **Initiate**.

	No	No	Ye	25	
	or Con	nmunicable Diseas	se Lab Entr	у ×	
	ici Form NC NOTE:	ou want to submit a Candida ? A Case Report Form is required or	a auris, clinical C	Case Report	
			Cancel	Initiate Previous	Submit
Please Note : Up you are automa Disease Lab Ent	oon clicking atically navig ry. From her	Cancel on the <i>Commu</i> gated to the Patient Ir re, you can start a new	<i>unicable Dise</i> 1formation Communical	<i>ase Lab Enti</i> screen of a ble Disease	γpop-up notification, blank Communicable Lab Entry.

Upon clicking **Initiate** on the *Communicable Disease Lab Entry* pop-up notification, you are automatically navigated to the **Patient Information** screen of the selected Case Report.

- For specific information on the **Patient Information** screen of the selected Case Report, please review the appropriate *Initiate Case Report* section of this guide.
- If the Communicable Disease Lab Entry had **multiple** observations for **different conditions**, the pop-up notification will display the applicable Case Report options with a message that states:

Please select the appropriate Case Report Form. **NOTE**: A Case Report Form is required when the results are reportable. Users may select up to 5 conditions at a time.

Observation Nam Reagin Ab in Seru	^{m by} Communicable Disease Lab Entry	ion Result × TECTED
Observation Resu 07/02/2022 5:00 f	Please select the appropriate Case Report Form. Candida auris, clinical Child Hepatitis B Dengue	
Ask On Order Ent	Perinatal Hepatitis B Syphilis NOTE: A Case Report Form is required only when the results are repo	rtable.
Yes	Cancel Initi	ste

DDE: Communicable Disease Lab Entry



5. Click the **Checkbox** next to the appropriate **condition(s)** to initiate the applicable Case Report(s) for the patient. You are required to select <u>at least one</u> condition to initiate a Case Report.

Observation Name Reagin Ab in Serum by	Communicable Dis	sease Lab Entry		
Observation Result Dat 07/02/2022 5:00 PM	Please select the appropria Candida auris, clinical Child Hepatitis B Dengue	te Case Report Form.		
Ask On Order Entry	Syphilis			0
First Test Yes	NOTE: A Case Report Form is requ Users may select up to 5 condition	ired only when the results are reposed on the results are reposed on the results are reposed on the result of the reposed of the reposed of the results are reposed on the reposed on the results are reposed on the reposed on the results are reposed on the reposed on the reposed on the repose	ns	
Onset Date	Hospitalizat	ion	Congregate	

Please Note: If you clicked **Initiate** but did **not** select a condition on the *Communicable Disease Lab Entry* pop-up notification, the following error message will display:

_ _ _ _ _

Please select at least one condition to initiate elCR form.

To initiate a Case Report, you must select **<u>at least one</u>** condition on the *Communicable Disease Lab Entry* pop-up notification. If applicable, you have the option to select <u>up to 5</u> conditions.

Observation Name Reagin Ab in Serum by	Communicable Disease Lab Entry			
Observation Result Dat 07/02/2022 5:00 PM	Please select the appropriate Case Report Form. Candida auris, clinical Child Hepatitis B Dengue Perinatal Hepatitis B			
<u>Ask On Order Entry</u>	Syphilis		۵	
First Test Yes	Please select at least one condition to initiate eICR for NOTE: A Case Report Form is only required when the res are reportable. Users may select up to 5 conditions at a t	m <mark>ns</mark> sults time.		
Onset Date 06/20/2022	Cancel Initiat	ate		



6. Once you have selected <u>at least one</u> Case Report, click **Initiate** to start the applicable Case Report for the same patient.

07/02/2022 5:00 PM	Communicable Disease Lab Entry	×	
Ask On Order Entry	Please select the appropriate Case Report Form.	•	
First Test Yes	 Child Hepatitis B Dengue Perinatal Hepatitis B 	itoms	
Onset Date 06/20/2022	Syphilis NOTE: A Case Report Form is required only when the results are reportable Users may select up to 5 conditions at a time.	• regate	
ICU Yes	Cancel Initiate		

 If you selected <u>multiple</u> Case Reports and clicked **Initiate** on the *Communicable Disease Lab Entry* pop-up notification, you are automatically navigated to the **Case Report User Summary** screen.

KHIE ePartnerViewer 🕿 Support 📢 Announcements 💿 🔺 Advisories 🗩 🥹												
Patient S	earch	Bookma	irked Patients	Event Notifications			Lab I	Lab Data Entry - Case F			eport Entry -	
A Home > Case Report Entry User Summary												
CASE REPORT ENTRY USER SUMMARY												
C LAST UPDAT	CLAST UPDATED DATE RANGE Start Date 07/02/2022 End Date 07/02/2022											
SHOWING 5 ITEMS	SHOWING STITEMS											
ACTIONS	REPORT TYPE +	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION +	PATIENT MRN	FIRST NAME +	LAST NAME 🗘	DATE OF BIRTH	PATIENT SEX 🗘	STATUS 🕈	LAST UPDATED 🗘	SUBMISSION DATE \$	
Continue Delete	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		

De	loitte.
_	



Please Note: If you selected <u>only one</u> Case Report Form on the *Communicable Disease Lab Entry* pop-up notification, you are automatically navigated to the **Patient Information** screen of the selected Case Report.

For specific information on the **Patient Information** screen of the selected Case Report, please review the appropriate *Initiate Case Report* section of this guide.

Case Report Entry User Summary

Users are automatically navigated to the **Case Report User Summary** screen upon selecting <u>multiple</u> Case Report Forms on the *Communicable Disease Lab Entry* pop-up notification or upon submission of a Case Report. The **Case Report Entry User Summary** screen displays all submitted and inprogress case reports you have entered. Users must select which Case Report they wish to initiate for the patient. These steps cover how to initiate an applicable Case Report from a previously submitted Communicable Disease Lab Entry on the **Case Report User Summary** screen.

 The Case Report Entry User Summary screen displays <u>multiple</u> applicable Case Reports for the *different* conditions entered on the Communicable Disease Lab Entry submitted for the patient. You can choose which Case Report you wish to complete first for the patient.

ACTIONS REPO	ORT TYPE 🗘	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME 🗘	LAST NAME 🗘	DATE OF BIRTH	PATIENT SEX \$	STATUS 🕈	LAST UPDATED	SUBMISSION DATE \$
Continue Child	d Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue MDR Delete	80	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Perir Delete	natal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Othe Delete	er Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue STD		Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	

9. To initiate a Case Report for the patient, click **Continue** next to the appropriate *Report Type*.

Communicable Disease Lab Entry and Initiating Case Reports User Guide



	Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM
	Continue	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM
(

Please Note: Upon clicking **Continue**, you will be automatically navigated to the **Patient Information** screen of the selected Case Report.

For specific information on the **Patient Information** screen of each Case Report, please reviewthe appropriate *Initiate Case Report* section of this guide.

Lab Results Submitted by User

These steps cover how to initiate a Case Report from a previously submitted Communicable Disease Lab Entry on the **Lab Results Submitted by User** screen.

- To initiate a Case Report from a previously submitted Communicable Disease Lab Entry, click the Lab Data Entry Tab in the blue Navigation Bar at the top of the screen.
- 2. Select Lab Data Entry User Report from the dropdown menu.

KĤIE	ePartnerViewer	1	🛛 Support 📢 Announcements <mark>s</mark> 🗍	Advisories 🗃 💽 Jane Doe 👻
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
A Home			Covid Lab Data Entry	
Announcement: Ha	ave training needs? Go to the KHIE COACH for a	ssistance. It's located in the Resources sectio	Communicable Disease Lab Entry	Read More View All
		••••	Quick Entry for Negative COVID-19	Test Results
		DAGUDOAD	Lab Data Entry User Report	
		MYDASHBOARL	Manage User Preferences	>
QUICK SEARCH				Q ADVANCED SEARCH
First Name	Last Name	Date	Of mm/dd/vvvv	🛱 Search
		Birth	,,,,,	
POOVMARKED				0
BOOKMARKED	EVENT DATE	EVENT NOTIFICA	FACILITY NAME	AGE ORGANIZATION USER

3. The **Lab Results Submitted by User** screen displays. By default, the screen does not display previously submitted lab data entries. You must use the Date Range buttons to do a custom search for previous lab data entries entered within the last 6 months.



Communicable Disease Lab Entry and Initiating Case Reports User Guide



KĤIE ePartner	Viewer		🖬 Support 🛛 📢 Announcer	ments 💈 🌲 Advisories 🧃 😢 Jane Doe 🕐
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry -
Home > Lab data entry user report				
	LAB RESULTS	SUBMITTED BY JAN	IE DOE	
TIME SELECTION	Start Date MM/DD/YYYY	E	nd Date MM/DD/YYYY	🞜 Retrieve Data
	Please	select a Start and End Date to retrieve historical labo	ratory data	

- 4. To retrieve lab data entries for a specific date range within the last 6 months, enter the appropriate **Start Date** and **End Date**.
- 5. Click **Retrieve Data** to generate the lab data entries.

KHIE ePartnerVi	ewer		🕿 Support 🛛 📢 Announcements	5 🔺 Advisories 5 🕒 Jane Doe
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry *	Case Report Entry ~
Home > Lab data entry user report				
	LAB RESULTS S	UBMITTED BY JAN	E DOE	
TIME SELECTION	Start Date 06/01/2022	En En	d Date MM/DD/YYYY 🛗	C Retrieve Data
	June 2022 June v) 200 Su Mo Tu We Th 29 30 31 1 2	Fr Sa d End Date to retrieve historical labora	itory data	
	12 13 14 15 16 19 20 21 22 23 26 27 28 29 30	10 11 17 18 24 25 1 2		

Communicable Disease Lab Entry and Initiating Case Reports User Guide



6. To search for a specific lab data entry, click **Apply Filter**.

(Ĥ ll	ePar	rtnerView	er					Support 📢 Annou	ncements 💈 🌲 Advisc	ories 🗿 🙁 Jane Doe
Pati	ent Search	В	pokmarked Patients		Event Notificati	ons	Lab (Data Entry *	c	ase Report Entry *
🖌 Home	Home > Lab data entry user report									
			LAB RES	ULTS SU	BMITTED	BY JANE	DOE			
C TIME SEI	LECTION		Start Date 07	7/02/2022		End D	07/02/2022	#		₿ Retrieve Data
Click on an SHOWING 4 ITEMS	iy row to view more de	etails								Y APPLY FILTER
DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN +	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	eICR REPORT	TEST NAME	SUBMITTED DATE	CASE REPORT FORM 🗢
0	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	MDRO	BACILLUS ANTHRACIS IDENTIFIED	07/02/2022 12:30 PM	Initiate
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 10:00 AM	Partially Initiated
0	Test Medical Center	EB02151970	Elaine	Benes	02/15/1970	Female	MDRO, Other Conditions, Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 8:30 AM	Initiated
0	Test Medical Center	СК01011960	Cosmo	Kramer	01/01/1960	Male	Other Conditions, STD	BABESIA MICROTI IDENTIFIED	07/01/2022 12:30 PM	Initiated
				First Back 1	Next Last				Maximu	um 5 🕶 entries per page


 The Filter fields display. You can search by entering the *Performing Facility Name, Patient MRN, First Name, Last Name, Date of Birth, Patient Sex, Test Name, Test Result, Processed Date*, and/or *Case Report Form* in the corresponding Filter fields.

KĤII	ePar	rtnerViewe	er				3	Support 📢 Annour	ncements <mark>6</mark> 🌲 Adviso	ries 🟮 😫 Jane Doe 🦿
Pati	ent Search	Bo	ookmarked Patients		Event Notificati	ons	Lab [Data Entry -	c	ase Report Entry -
😭 Home	> Lab data entry us	er report								
			LAB RES	ULTS SU	BMITTED	BY JANE	DOE			
C TIME SEL	LECTION		Start Date 07/0	01/2022 🛗		End D	Date 07/01/2022	*		CRETRIEVE Data
Click on any SHOWING 4 ITEMS	y row to view more de	tails.								T HIDE FILTER
DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN Enter PATIENT MI	FIRST NAME	LAST NAME	DATE OF BIRTH Enter DATE OF BI	PATIENT SEX ↓ All	eICR REPORT ¢	TEST NAME +	SUBMITTED DATE	CASE REPORT FORM Enter CASE REPORT
0	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	MDRO	BACILLUS ANTHRACIS IDENTIFIED	07/02/2022 12:30 PM	Initiate
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 10:00 AM	Partially Initiated
0	Test Medical Center	EB02151970	Elaine	Benes	02/15/1970	Female	MDRO, Other Conditions, Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 8:30 AM	Initiated
0	Test Medical Center	СК01011960	Cosmo	Kramer	01/01/1960	Male	Other Conditions, STD	BABESIA MICROTI IDENTIFIED	07/01/2022 12:30 PM	Initiated
				First Back 1	Next Last				Maximu	im 5 👻 entries per page

8. To view more details on each lab entry, click the **Plus Icon** under the *Detailed View* column.

😭 Home	> Lab data entry	/ user report								
		LA	B RESU	TS SUB	MITTED	by Jane	DOE			
C TIME S	ELECTION		Start Date 06/	01/2022		End Da	te 07/02/2022	#		$oldsymbol{\mathcal{C}}$ Retrieve Data
Click on a SHOWING 7 ITEMS	any row to view more	e details								T APPLY FILTER
DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN \$	FIRST NAME 🗘	LAST NAME 🗘	DATE OF BIRTH \$	PATIENT SEX 🗘	eICR REPORT	TEST NAME 🗘		CASE REPORT FORM \$
0	Test Medical Center	WB07071987	Will	Byers	07/07/1987	Male	MDRO, Other Conditions	CLOSTRIDIUM BOTULINUM TOXIN	07/02/2022 12:30 PM	Partially Initiated
0	Test Medical Center	NW03251989	Nancy	Wheeler	03/25/1989	Female	MDRO, Other Conditions, Perinatal Hepatitis, STD	ANAPLASMA PHAGOCYTOPHIL UM AB.IGG	07/01/2022 8:15 AM	Initiate
0	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Child Hepatitis, MDRO, Other Conditions, Perinatal Hepatitis, STD	HEPATITIS B VIRUS SURFACE AB	06/10/2022 3:00 PM	Initiated
0	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	MDRO	BACILLUS ANTHRACIS IDENTIFIED	06/05/2022 10:45 AM	Initiated
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	06/01/2022 2:30 PM	Initiated
			Fi	rst Back 1 2	Next Last				Maximu	m 5 🕶 entries per page





9. The *Condition*(s), *Test Name*(s), and *Test Result*(s) for the lab entry display in the detailed view.

DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN +	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH +	PATIENT SEX +	eICR REP	ORT 🕈	TEST NAME 🗘		CASE REPORT FORM
0	Test Medical Center	WB07071987	Will	Byers	07/07/1987	Male	MDRO, O Condition	Ither ns	CLOSTRIDIUM BOTULINUM TOXIN	07/02/2022 12:30 PM	Partially Initiated
•	Test Medical Center	NW03251989	Nancy	Wheeler	03/25/1989	Female	MDRO, O Condition Perinatal Hepatitis	ther ns, , STD	ANAPLASMA PHAGOCYTOPHIL UM AB.IGG	07/01/2022 8:15 AM	Initiate
CONDITION				TEST NAME				TEST RE	SULT		
Carbapener	m resistant Enterobac	teriaceae (CRE)		Carbapenemase [Pres	sence] in Isolate			Detecte	d		
Chancroid				Haemophilus ducreyi	culture			Positive			
Babesiosis				BABESIA MICROTI IDE	NTIFIED			Identifi	ed		
Perinatal He	epatitis C			ALT				Negativ	e		
•	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Child Hep MDRO, O Condition Perinatal	oatitis, Ither ns,	HEPATITIS B VIRUS SURFACE AB	06/10/2022 3:00 PM	Initiated

10. To initiate a Case Report with the information from a completed Communicable Disease Lab Entry that has been previously submitted, click **Initiate**, located on the right side of the appropriate Communicable Disease Lab Entry.

			LAB RES	ULTS SU	BMITTED	BY JANE	DOE			
C TIME SEL	ECTION		Start Date 07/	01/2022		End D	oate 07/01/2022			CRetrieve Data
Click on any SHOWING 4 ITEMS	y row to view more de	tails								T APPLY FILTER
DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH \$	PATIENT SEX 🗘	eICR REPORT	TEST NAME 🗘		CASE REPORT FORM +
0	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	MDRO	BACILLUS ANTHRACIS IDENTIFIED	07/02/2022 12:30 PM	Initiate
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 10:00 AM	Partially Initiated
0	Test Medical Center	EB02151970	Elaine	Benes	02/15/1970	Female	MDRO, Other Conditions, Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 8:30 AM	Initiated

- 11. Upon clicking **Initiate**, the *Communicable Disease Lab Entry* pop-up notification displays to provide the option to initiate an applicable Case Report from a previously submitted Communicable Disease Lab Entry.
- If only one Case Report applies to the Communicable Disease Lab Entry, click **Initiate** to start the Case Report for the patient.

4 ITEMS								ŗ			
DETAILE	PERFORMING	PATIENT MRN	FIRST NAME	Commun	icable Diseas	e Lab Entr	y ×		TEST NAME	SUBMITTED	CASE REPORT
D VIEW	NAME 🗘	\$	¢	Do you want t	o submit a Candida	auris, clinical Ca	ase Report	Ŧ	÷	DATE -	FORM 🗘
0	Test Medical Center	GC12271965	George	Form? NOTE: A Case Rep	ort Form is required on	y when the results a	are reportable.		BACILLUS ANTHRACIS IDENTIFIED	07/02/2022 12:30 PM	Initiate
			-			Cancel	Initiate	_			
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Hepatitis, STD		BABESIA MICROTI IDENTIFIED	07/02/2022 10:00 AM	Partially Initiated

DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange





• If there are <u>multiple</u> Case Report options, click the **Checkbox** next to the appropriate **condition(s)** to initiate an applicable Case Report for the patient.

0	Center	WB07071987	Will	Communicable Disease Lab Entry ×	tions	BOTULINUM TOXIN	12:30 PM	Initiated
0	Test Medical Center	NW03251989	Nancy	Please select the appropriate Case Report Form. Babesiosis Carbapenem resistant Enterobacteriaceae (CRE)), Other tions, ital itis, STD	ANAPLASMA PHAGOCYTOPHI LUM AB.IGG	07/02/2022 12:30 PM	Initiate
0	Test Medical Center	JH05052020	Jane	Chancroid Perinatal Hepatitis C NOTE: A Case Report Form is required only when the results are reportable. Users may select up to 5 conditions at a time.	itis,), Other tions, ital itis, STD	HEPATITIS B VIRUS SURFACE AB	07/02/2022 12:30 PM	Initiated
	Test Medical			Cancel Initiate		BACILLUS		

12. To initiate a Case Report for the patient, click **Initiate**.

Test Medical Center	WB07071987	Will	Communicable Disease Lab Entry ×	RO, Other tions	CLOSTRIDIUM BOTULINUM TOXIN	07/02/2022 12:30 PM	Initiated
Test Medical Center	NW03251989	Nancy	Please select the appropriate Case Report Form. Babesiosis Carbapenem resistant Enterobacteriaceae (CRE)), Other tions, ital itis, STD	ANAPLASMA PHAGOCYTOPHI LUM AB.IGG	07/02/2022 12:30 PM	Initiate
Test Medical Center	JH05052020	Jane	Chancroid Perinatal Hepatitis C NOTE: A Case Report Form is required only when the results are reportable. Users may select up to 5 conditions at a time.	itis,), Other tions, ital itis, STD	HEPATITIS B VIRUS SURFACE AB	07/02/2022 12:30 PM	Initiated
Test Medical	GC12271965	George	Cancel Initiate Costanza 12/27/1975 Male MDP	RO	BACILLUS ANTHRACIS	07/02/2022	Initiated

Please Note: If you selected <u>multiple</u> Case Report Forms and clicked **Initiate** on the *Communicable Disease Lab Entry* pop-up notification, you are automatically navigated to the **Case Report User Summary** screen to select which Case Report to initiate for the patient.

• For specific information on the **Case Report Entry User Summary** screen, please review section 17: *Case Report Entry User Summary* of this guide.

If you initiated <u>only one</u> Case Report Form on the *Communicable Disease Lab Entry* pop-up notification, you are automatically navigated to the **Patient Information** screen of the selected Case Report.

- For specific information on the **Patient Information** screen of each Case Report, please review the appropriate *Initiate Case Report* section of this guide.
- 13. Once the Case Report has been initiated, the "Initiated" status displays under the *Case Report Form* column.

DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN +	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX 🗢	eICR REPORT	TEST NAME		CASE REPORT FORM +
0	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	MDRO	BACILLUS ANTHRACIS IDENTIFIED	07/02/2022 12:30 PM	Initiated
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 10:00 AM	Partially Initiated

DDE: Communicable Disease Lab Entry



If a Case Report has already been initiated from a completed Communicable Disease Lab Entry with <u>multiple</u> applicable Case Reports, the **Partially Initiated** button displays under the *Case Report Form* column. These steps cover how to partially initiate another Case Report from a previously submitted Communicable Disease Lab Entry with multiple applicable Case Reports on the **Lab Results Submitted by User** screen.

14. To initiate another Case Report with the information from a completed Communicable Disease Lab Entry with multiple applicable Case Reports, click **Partially Initiated**, located on the right side of the appropriate Communicable Disease Lab Entry.

Home	> Lab data entry use	er report								
			LAB RES	ULTS SU	BMITTED	BY JANE	DOE			
C TIME SEL	ECTION		Start Date 07/	01/2022	Ctrl) •	End D	oate 07/01/2022			$oldsymbol{\mathcal{B}}$ Retrieve Data
Click on any SHOWING 4 ITEMS	y row to view more de	tails		196 <u>1</u> 4 -						T APPLY FILTER
DETAILED VIEW	PERFORMING FACILITY NAME	PATIENT MRN +	FIRST NAME +	LAST NAME 🗘	DATE OF BIRTH 🗘	PATIENT SEX 🗘	eICR REPORT	TEST NAME 🗘	SUBMITTED DATE	CASE REPORT FORM
0	Test Medical Center	SR07061980	Susan	Ross	07/06/1980	Female	Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 12:30 PM	Partially Initiated
0	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	MDRO	BACILLUS ANTHRACIS IDENTIFIED	07/02/2022 10:00 AM	Initiated
•	Test Medical Center	EB02151970	Elaine	Benes	02/15/1970	Female	MDRO, Other Conditions, Perinatal Hepatitis, STD	BABESIA MICROTI IDENTIFIED	07/02/2022 8:30 AM	Initiated

15. The *Communicable Disease Lab Entry* pop-up notification displays. The Checkbox next to the previously initiated Case Report is grayed out and disabled. You must select the **enabled Checkbox** next to the appropriate **condition(s)** and click **Initiate** to begin the Case Report.

		LAB F	RESUL	TS SUBMITTED BY JANE DOE	
C TIME S	SELECTION		Start Date	Communicable Disease Lab Entry × 2022	CREtrieve Data
Click on SHOWING 4 ITEMS	any row to view r	nore details		Please select the appropriate Case Report Form. Gonorrhea Perinatal Hepatitis B	T APPLY FILTER
DETAILE D VIEW	PERFORMING FACILITY NAME 🗘	PATIENT MRN	FIRST NAME	NOTE: A Case Report Form is required only when the results are reportable. Users may select up to 5 conditions at a time.	CASE REPORT FORM •
0	Test Medical Center	SR07061980	Susan	Cancel Initiate BABESIA 07/02/2022 KUSS 07/00/1960 Permare Reparus, MICROTI 12:30 PM STD IDENTIFIED	Partially Initiated

Please Note: If you initiated <u>only one</u> Case Report Form on the *Communicable Disease Lab Entry* pop-up notification, you are automatically navigated to the **Patient Information** screen of the selected Case Report.

• For specific information on the **Patient Information** screen of each Case Report, please review the appropriate *Initiate Case Report* section of this guide.



12 Initiate Other Reportable Conditions Case Report

Upon initiating an Other Reportable Conditions Case Report on the *Communicable Disease Lab Entry* pop-up notification, Users are automatically navigated to the **Patient Information** screen of the Other Reportable Conditions Case Report.

The Other Reportable Conditions Case Report is an eight-step process where Users enter (1) Patient Information, (2) Laboratory Information, (3) Applicable Symptoms, (4) Additional Information, (5) Hospitalization, ICU & Death Information, (6) Vaccination History, (7) Additional Comments, (8) Review and Submit. The **Review & Submit** screen is where Users must review the information entered **and** submit the Other Reportable Conditions Case Report.

OTHER REPORTABLE	CONDITIO	NS CASE REPO	ORT FO	RM Section 1 of a	8	
Please complete the form	below. All fields	marked with an aste	risk(*) are i	required.		
		PA	TIENT INF	ORMATION		
Patient Information	For o fax a	onditions not found in the PID 200 form to the P	he dropdown ocal health d	<i>that are reportable per the KY R epartment located in the patient</i> .	eportable D s county of	iseases Regulation (902 KAR 2:020), please residence.
Laboratory Information	Dise	ase/Organism* 🚱	~	Date of Diagnosis*	m (Unknown
Applicable Symptoms	A					
Additional Information	A Is the	Affiliation/Organization	same for Pa	tient ID (MRN), Person Completin	g Form, and	d Attending Physician/Clinician?*
Hospitalization, ICU & Death Information	Patie	nt ID (MRN)* 🚱		Affiliation/Organization* @		
Vaccination History	A Pers	on Completing Form*		Affiliation/Organization* 🛛		If other, please specify: 🔞
Additional Comments	Sel	ect	~	Select	~	
Review & Submit	Atter Sel	nding Physician/Clinician ect	*	Affiliation/Organization* @		If other, please specify: 😡
	Prefi Mis	K IS	~			
	First	Name* ine		Middle Name		Last Name* Benes
	Suffi	ĸ		Date of Birth*		
	Sel	2CE	× .	02/15/1970		

The following Other Reportable Conditions screens display certain fields of information that have been auto-populated based on the information entered on the previously submitted Communicable Disease Lab Entry. When necessary, you can edit the auto-populated information and enter different details in any of the enabled fields.

- Patient Information screen
- Applicable Symptoms screen
- Hospitalization, ICU & Death Information screen
- Laboratory Information screen
- Additional Information screen

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Patient Information

The **Patient Information** screen auto-populates with the existing patient demographic details entered on the previously submitted Communicable Disease Lab Entry. Users can change the auto-populated information in any of the enabled fields, as applicable. Users cannot change auto-populated details in disabled fields.

Users **<u>cannot</u>** edit the following auto-populated *Disease/Organism*, *Patient ID (MRN*), *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields which are grayed out and disabled:

- Disease/Organism
- Is the Affiliation/Organization the same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
- Patient ID (MRN)

Date of Birth

- Affiliation/Organization for
 Patient MRN
- Prefix

Middle Name

Last Name

Patient Sex

Suffix

• First Name

Patient Information		For conditions not found in the	dropdowi	n that are reportable per the KY Report	able Diseases Regulation (902 KAR 2:
Laboratory Information	a	Disease/Organism* 🚱	i nealth ù	Date of Diagnosis*	nty of residence.
Applicable Symptoms		Babesiosis	\sim	mm/dd/yyyy	🛗 🗌 Unknown
Additional Information					
Hospitalization, ICU & Death Information	a	Is the Affiliation/Organization sates Yes No	me for Pa	tient ID (MRN), Person Completing Forr	m, and Attending Physician/Clinician
Vaccination History	a	Patient ID (MRN)* 🚱		Affiliation/Organization* 🚱	
Additional Commonts	_	EB02151970		Test Medical Center	~
Additional Comments	-	Person Completing Form*		Affiliation/Organization* 😯	If other, please specify: 🔞
Review & Submit		Select	~	Select	×
		Attending Physician/Clinician*		Affiliation/Organization* 😧	If other, please specify: 🔞
		Select	~	Select	×
		Prefix			
		Miss	~		
		First Name*		Middle Name	Last Name*
		Elaine			Benes
		Suffix		Date of Birth*	
		Select	V	02/15/1970	
				Palacia de	Pasat
		Patient Sex*		Ethnicity*	Race-

Please Note: The *Disease/Organism*, *Patient ID (MRN)*, *Affiliation/Organization* for Patient ID
(MRN), and patient demographic fields are the only disabled fields. All other fields on the **Patient**Information screen and all subsequent screens are enabled. You have the option to edit any of
the enabled fields on all screens of the Other Reportable Conditions Case Report.

DDE: Communicable Disease Lab Entry



- 1. You have the option to **edit the auto-populated information** in the following enabled fields:
- Ethnicity

• Phone

- Race
- Address, City, State, Zip Code, County
- Email
- Is the patient currently pregnant?

First Name*	Mildure Herine		Last Name*	
			bunus	
Select	Date of Birth*			
and the feature		10		_
Patient Sex*	Ethnicity*		Race*	
Female	Not Hispanic or Latino	× ×	White	× ×
Addrore 1*		Addrore 2		
123 Peterman Way		Apt. A		
City*		State*	Zip Code	
Lexington		KT	A V 40503-	
County*	Phone* 0		Email	
Fayette	× v (555) 222-2222		elainebenes@email.com	
If yes, please enter the due date (EDC)	Unknown			
If yes, please enter the due date (EDC) mm/dd/yyyy Save	Unknown		Next	
If yes, please enter the due date (EDC) mm/dd/yyyy Save Please Note: The /s or the Patient Se	the patient currently preg	<i>gnant?</i> field is ena nformation scr	Next bled only when Female is een of the previously su	selecte
If yes, please enter the due date (EDC) mm/dd/yyyy Save Please Note: The /s or the Patient Se Communicable Dise If Yes is selected enabled.	<i>the patient currently preg</i> <i>x</i> field on the Patient I ease Lab Entry. ed for the <i>Is the patient</i>	<i>gnant?</i> field is ena nformation scr currently pregna	Next bled only when Female is een of the previously su ant? field, the subsequent	selecte ubmitte
If yes, please enter the due date (EDC) mm/dd/yyyy Save Please Note: The /s or the Patient Se Communicable Dise If Yes is selected enabled.	<i>the patient currently preg</i> over field on the Patient I ease Lab Entry. The for the <i>Is the patient</i> is the patient for the <i>Is the patient</i> in the subsection of the for the for the for the subsection of the for the for the for the for the for the subsection of the for the fo	<i>gnant?</i> field is ena nformation scr <i>currently pregna</i> quent field: <i>If yes</i>	Next bled only when Female is een of the previously su ant? field, the subsequent of <i>please enter the due date</i>	selecte ubmitte t field e (EDC)
If yes, please enter the due date (EDC) mm/dd/yyyy Save Please Note: The /s or the Patient Se Communicable Dise If Yes is selected enabled. To proceed, enter the Is the patient current Yes	the patient currently preg x field on the Patient I ease Lab Entry. d for the <i>Is the patient</i> the Due Date in the subsection the pregnant?* No Unknown	<i>gnant?</i> field is ena nformation scr <i>currently pregna</i> quent field: <i>If yes</i>	Next Ibled only when Female is een of the previously su ant? field, the subsequent of please enter the due date	selecte ubmitte t field



- 2. To complete the Patient Information screen, you must enter the appropriate information in the mandatory blank fields marked with **red asterisks** (*), as applicable:
- Date of Diagnosis •
- Person Completing Form
- Affiliation/Organization of Person Completing • Form
- Attending Physician/Clinician
- Affiliation/Organization of Attending Physician/Clinician

		Date of Diagnosis*	
Babesiosis		mm/dd/yyyy	Unknown
Is the Affiliation/Organiz	ation san	ne for Patient ID (MRN), Person Co	mpleting Form, and Attending
Physician/Clinician?*			
Yes No			
Patient ID (MRN)* 🚱		Affiliation/Organization* 🚱	
EB02151970		Test Medical Center	
Person Completing Forr	<u>n</u> *	Affiliation/Organization* 😧	lf other, please specify: 🚱
Select	~	Select 🗸 🗸	
Attending Physician/Clir	nician*	Affiliation/Organization* 🚱	If other, please specify: 🔞
	~	Select V	
Select			

Completing Form hyperlink. Upon clicking the hyperlink, the *Person Completing Form* pop-up displays. To proceed, enter the details in the appropriate fields of the *Person Completing Form* pop-up and click **Save**.

Person Completing Form*		Affiliation/Organization* 🚱	If other, please specify: 🚱
Select	~	Select	
		<u></u>	

L

J

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Patient Information	D	PERSON CO	MPLETING FORM	
Laboratory Information	Pre	fix		Unknown
Exposure Information	Se Se	lect v		linician?*
Hospitalization, ICU & Death Information	Firs	t Name*	Last Name*	
Vaccination History	Pi Pi			
Additional Comments	▲ Se	lect v		
Review & Submit	Add	Iress 1*	Address 2	If other, please specify: 😡
			Unit, Suite, Building, etc.	
	City	*	State* Zip Cod	if other, please specify: 😡
			Select V	
	Pi Pho	ne* XXI XXX-XXXX	Email*	
	Fi		Crewit C	Last Name*
			Cancel	
Diesse Note: If the	annronria	ta nama doas	not display in the	Attending Physician/Clinician
	appi opria			
dropdown menu, you	i must cre	ate details for a	new Attending Ph	iysician/Clinician by clicking the
Attending Physicia	n/Clinicia	n hyperlink.	Upon clicking t	he hyperlink, the Attending
<i>Physician/Clinician</i> po	op-up disp	lays. Enter the	details in the appr	ropriate fields of the Attending
Physician/Clinician	po-up and	click Save .		
				
Attending Physician/Clinicia	n*	Affiliation/Organiza	ation* 😧	If other, please specify: 🚱
Select		Select		······, -····, -·····, •
Jelect		Select	1	

		ATTENDING PHY	SICIAN/CLINICIAN	
Patient Information Laboratory Information		Prefix		Unknown
Exposure Information	A Is	First Name*	Last Name*	linician?*
Hospitalization, ICU & Death Information	A			
Vaccination History	Pa	Suffix		
Additional Comments	A	Select V		
Review & Submit	A P	Address 1*	Address 2 Unit, Suite, Building, etc.	if other, please specify: 😡
	A	City*	State* Zip Code*	If other, please specify: 😡
	Pi	Phone* (2003) 200-2000(Email* name@domain.com	
	FI		Cancel Save	Last Name* Hopper

Please Note: If **Other** is selected from one of the *Affiliation/Organization* dropdown menus for the Person Completing Form or the Attending Physician/Clinician, the subsequent textbox field is enabled.

To proceed, you must enter the name of the **organization associated with the person completing the form** and/or the **organization associated with the Attending Physician/Clinician** in the subsequent textbox: *If other, please specify.*

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Person Completing Form*	Affiliation/Organization* 😧	If other, please specify:* 🝞
Mr. Arthur Vandela $ imes$ $ imes$	Other × ×	

3. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Laboratory Information** screen.

OTHER REPORTABLE CON	NDITIONS CASE REPO	ORT FO	RM Sec	tion 1 of 8		
Please complete the form below.	All fields marked with an aste	erisk(*) are i	required.			
	PA	TIENT INF	ORMATION			
Patient Information	For conditions not found in the fax an EPID 200 form to the k	he dropdown local health d	that are reportable p epartment located in t	er the KY Reportable L the patient's county of	Diseases Regulation (90 residence.	2 KAR 2:020), please
Laboratory Information	Disease/Organism* 🚱 Babesiosis	~	Date of Diagnosis*		Unknown	
Applicable Symptoms						
Additional Information	Is the Affiliation/Organization Yes No	same for Pa	tient ID (MRN), Person	n Completing Form, an	d Attending Physician/C	Clinician?*
Hospitalization, ICU & $lacksquare$ Death Information	Patient ID (MRN)* 🕑		Affiliation/Organiza	ntion* 0		
	EB02151970		Test Medical Cent	ter 🗸 🗸		
Vaccination History	Person Completing Form*		Affiliation/Organiza	ation* 😧	If other, please spec	cify: 🕖
Additional Comments	Select	•	Select	· · · •		
Review & Submit	Attending Physician/Clinician Select	I *	Affiliation/Organiza	ation* 😧	If other, please spec	cify: 🎯
	Prefix					
	Miss					
	First Name*		Middle Name		Last Name*	
	Elaine				Benes	
	Suffix		Date of Birth*			
	Select		02/15/1970			
	Patient Sex*		Ethnicity*		Race*	
	Female		Not Hispanic or Li	atino × ~	White	$\times \mid \cdot$
	Address 1*			Address 2		
	123 Peterman Way			Apt. A		
	Citv*			State*		Zip Code
	Lexington			KY	x ~	40509-
	County*		Phone* 😧		Email	
	Fayette	$\times \mid \sim$	(555) 222-2222		elainebenes@ema	ail.com
	Is the patient currently pregn	unt?*	1			
	If yes, please enter the due d	ate (EDC): 62	·			
	mm/dd/yyyy	iii (Unknown			
	Save					Next

DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange



Laboratory Information

The **Laboratory Information** screen displays details about the laboratory test that have been autopopulated based on the information previously entered on the Communicable Disease Lab Entry.

- 4. You have the option to **edit the auto-populated information** in the following enabled fields:
- Does the patient have a lab test?
- Laboratory Name
- Test Name
- Filler Order/Accession Number
- Specimen Source

- Test Result
- Test Result Date
- Specimen Collection Date
- Additional Information

OTHER REPORTABLE COND	ITIONS CA	SE REPORT FORM	Section 2 of 8	
Please provide laboratory information	on related to this	case.		
		LABORATORY INFORMA	ATION	
Patient Information	0	Does the patient have a lab test?*		
Laboratory Information		Yes No Unknown		
Applicable Symptoms	۵	Laboratory Information		
Additional Information		Laboratory Information		
Hospitalization, ICU & Death Information		General Hospital		
Vaccination History	a	Test Name*	x v	
Additional Comments		If other, please specify: @		
Review & Submit	a			
		Specimen Source* Abscess If other, please specify: Test Result* Other If other, please specify: Detected Test Result Date* O7/02/2022 Unknown Additional Information Observation 3 - Other Conditions details 40/300 Characters	x v x v x v	
		Add Test		
		Save	Previous Next	



• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Laboratory Information** screen: *Does the patient have a lab test?*

LABORAT	ORY INFORMATION		LABORATORY I	NFORMATION
Does the patient have a lab test?* Yes No U	Jnknown	Does the patie Yes	nt have a lab test?* No Unknown	1
Please Note: If <i>No</i> or Laboratory Information	Unknown is selected f n screen, the subsequer	or the condint fields are di	tional question at sabled.	the top of the
	LABORATORY I	NFORMATION		
Patient Information	Does the patient have a lab test?*			
Laboratory Information	Yes No Unknown			
Applicable Symptoms				
Additional Information	Laboratory Information			
Hospitalization, ICU & Death Information	Laboratory Name			
Vaccination History				
Additional Comments	Test Name Select			
	If other, please specify: 😡			
	Filler Order/Accession Number 😡			
	Specimen Source			
	If other, please specify: @			
	Test Denult			
	Select			
	If other, please specify: 🚱			
	Test Result Date		pecimen Collection Date	
	Additional Information 🧐			
				*
	0/300 Characters			Æ

- If you change the selection for the conditional question, a pop-up notification will display with a message that states: *Please note that all selections on this screen will be reset. Are you sure you want to change your response?*
- To reset the previous selection for the conditional question, click **Yes** on the pop-up notification.

Hospitalization, ICU & Death Information	a	Genera	Laboratory Information ×
Vaccination History	۵	Test Nam Dengue	Please note that all selections on the screen will be reset. Are you sure you want to change your
Additional Comments	۵	If other, p	response?
Review & Submit	۵		Yes No
		Filler Ord	





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

Additional Information 😧	
Lab Test Result Details	
23/300 Characters	
O Add Test	
Save	Previous Next

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

poratory Name*			
st Name*			
Select			~
f other, please specify: 🛛			
iller Order/Accession Number			
Specimen Source*			
Select			~
if other, please specify: 🔞			
Test Result*			
Test Result* Select			×
Test Result* Select If other, please specify: @			∨
Test Result* Select If other, please specify: @ Test Result Date		Specimen Collection Date*	▼
Test Result* Select If other, please specify: @ Test Result Date mm/dd/yyyy	🛗 🗌 Unknown	Specimen Collection Date* mm/dd/yyyy	Unknown
Test Result* Select f other, please specify: Fest Result Date mm/dd/yyyy Additional Information	iii Unknown	Specimen Collection Date* mm/dd/yyyy	Unknown
Test Result* Select If other, please specify: @ Test Result Date mm/dd/yyyy Additional Information @	📋 🗌 Unknown	Specimen Collection Date* mm/dd/yyyy	Unknown
Test Result* Select If other, please specify: @ Test Result Date mm/dd/yyyy Additional Information @	📋 🗌 Unknown	Specimen Collection Date* mm/dd/yyyy	i Unknown
Test Result* Select f other, please specify: @ Test Result Date mm/dd/yyyy Additional Information @	📋 🗌 Unknown	Specimen Collection Date* mm/dd/yyyy	☐ Unknown



6. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Applicable Symptoms** screen.

OTHER REPORTABLE COND	ITIONS CA	SE REPORT FORM Section 2 of 8	
Please provide laboratory information	on related to this	s case.	
		LABORATORY INFORMATION	
Patient Information	\otimes	Does the patient have a lab test?*	
Laboratory Information		Yes No Unknown	
Applicable Symptoms			
Additional Information		Laboratory Information	_
Hospitalization, ICU & Death Information	۵	Laboratory Name* General Hospital	
Vaccination History		Test Name*	
	۵	Dengue virus IgM Ab [Titer] in Serum	\sim
Additional Comments	-	If other, please specify: 🛛	
		Filler Order/Accession Number ● H07012022 Specimen Source* Abscess X If other, please specify: ● Test Result* Other X If other, please specify: ● Detected Test Result Date* 07/02/2022 Image: Optimized Conditions details 40/2000 Characters	
		Save Previous Next	



Applicable Symptoms

The **Applicable Symptoms** screen asks questions about the patient's symptoms.

- 7. You have the option to **edit the auto-populated information** in the following enabled fields:
- Were symptoms present during the course of illness? Onset Date

THER REPORTABLE COND	DITIONS CA	SE REPORT FORM	Section 3 of 8	
Please select applicable symptoms to	hat the patient	experienced during illness.		
		APPLICAE	BLE SYMPTOMS	
Patient Information	0	Were symptoms present during the course of	of illness?*	
Laboratory Information	0	Yes No Unknown		
Applicable Symptoms		and a state of the		
Additional Information	a	06/20/2022		
Hospitalization, ICU & Death Information		If symptomatic, which of the following did th	e patient experience during their illness?	
Vaccination History	a	Fever*		
Additional Comments	_	If ves, please enter the highest temperature:	ø	
Review & Submit	۵	n jes, presse enter ere ngress temperature	•	
		If yes, please enter # of days of diarrhea: @		
		Yes No Unknown		
		Nausea*		
		Yes No Unknown		
		Plasma leakage*		
		Yes No Unknown		
		Rash*		
		Restlessness/irritable* Yes No Unknown		
		Yes No Unknown		
			j	

Please Note: If the patient was marked as symptomatic on the Communicable Disease Lab Entry, the selection for the conditional question at the top of the **Applicable Symptoms** screen is autopopulated as **Yes**: *Were symptoms present during the course of illness?*

• If **Yes** is selected for the conditional question at the top of the **Applicable Symptoms** screen, the subsequent fields are enabled.

If an onset date for symptoms was entered on the Communicable Disease Lab Entry, the same date is auto-populated for the *Onset Date* field on the **Applicable Symptoms** screen.

_ _ _ _ _



• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Applicable Symptoms** screen: *Were symptoms present during the course of illness?*

APPLICABLE SYMPTOMS	APPLICABLE SYMPTOMS
Were symptoms present during the course of illness?* Yes No Unknown	Were symptoms present during the course of illness?* Yes Unknown

- If you change the selection for the conditional question, a pop-up notification will display with a message that states: *Please note that all selections on this screen will be reset. Are you sure you want to change your response?*
- To reset the previous selection for the conditional question, click **Yes** on the pop-up notification.



Please Note: If *No* is selected for the conditional question at the top of the **Applicable Symptoms** screen, all subsequent fields are disabled and marked with *No*.

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

	APPLICABLE SYMPTOMS
Patient Information	Were symptoms present during the course of illness?*
Laboratory Information	O Yes No Unknown
Applicable Symptoms	Oncet Date @
Additional Information	mm/dd/yyyy Unknown
Hospitalization, ICU & Death Information	▲
Vaccination History	If symptomatic, which of the following did the patient experience during their illness?
Additional Comments	Yes No Unknown
Review & Submit	If yes, please enter the highest temperature: 🕑
	Diarrhea (-3 loose stools/24hr period) Yes No Unknown If yes, please enter # of days of diarrhea: @
	Yes No Unknown
	Chills Yes No Unknown
	Conjunctival infection Yes No Unknown



- 8. To complete the **Applicable Symptoms** screen, you must select the **appropriate answers** for the mandatory enabled fields marked with **red asterisks** (*).
- 9. Once the appropriate edits and additions have been made, click **Next** to proceed to the **Additional Information** screen.

			AF	PLICABLE SYN	IPTOMS				
itient Information	⊘ w	ere sympto	ms present du	iring the course of i	Iness?*				
boratory Information	0	Yes	No	Unknown					
policable Symptoms									
iditional information	0	nset Date*	0						
	-	06/20/2022	Un Un	known					
ospitalization, ICU & Death formation	Ifs	ymptomatic	, which of the	following did the pa	tient experience during	g their illness?			
ccination History	₽ Fev	Yes	No	Unknown					
ditional Comments		es, please e	nter the highe	st temperature: 🛛					
view & Submit									
	Dia	rrhea (>3 lo	ose stools/24h	nr period)*					
		Yes	No	Unknown					
	Ify	es, please e	nter # of days	of diarrhea: 😡					
	Chi	lls*							
		Yes	No	Unknown					
	м	yalgia*							
		Yes	No	Unknown					
	R	ash*							
	Ĩ	Yes	No	Unknown					
	Pi	aore*							
		Yes	No	Unknown					
		romboore	nenia*						
	ľ.	Yes	No	Unknown					
		d the entire	at have any oth	ar sumstame?*					
	D	Yes	No	Unknown					
	If	yes, please	specify: 🞯						
		tapanén transision							
		6 mm					Developer		
		Save					Previous	Next	

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Additional Information

The **Additional Information** screen collects additional details about the patient and displays information that has been auto-populated based on the previously submitted Communicable Disease Lab Entry.

10. You have the option to **edit the auto-populated information** in the following enabled fields:

- Does any of the following apply to the patient?
- Long-term care facility resident

• Healthcare Worker

THER REPORTABLE COND	TIONS CASE REPORT FORM Section 4 of 8	
Please select the information that the	patient was exposed to prior to illness.	
-	ADDITIONAL INFORMATION	
Patient Information	Obes any of the following apply to the patient:*	
Laboratory Information	Ves No Unknown	
Applicable Symptoms		
Additional Information	Yes No Unknown	
Hospitalization, ICU & Death Information	f yes, please specify state(s): Select	
Vaccination History	International Travel within the last 30 days*	
Additional Comments	Yes No Unknown	
Review & Submit	If yes, please specify country(s): Select	
	Yes No Unknown If yes, please specify the name of food handler service: If yes, please specify the name of food handler service:	
	Healthcare worker* Yes No Unknown If yes, please specify the name of healthcare facility:* @	
	Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: @	
	Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: @	

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Additional Information** screen: *Does any of the following apply to the patient?*

ADDITIONAL INFORMATION	ADDITIONAL INFORMATION
Does any of the following apply to the patient:* Yes No Unknown	Does any of the following apply to the patient:* Yes No Unknown



- If you change the selection from Yes to No or Unknown, or vice versa for the conditional question, a pop-up notification will display a message that states: Please note that all selections on this screen will be reset. Are you sure you want to change your response?
- To reset the previous selection for the conditional question, click *Yes* on the pop-up notification.

Applicable Symptoms	Ø	Domesti	Additional Information	۲. ۲
Additional Information		Yes		
Hospitalization, ICU & Death Information	a	lf yes, ple	Please note that all selections on the screen will be reset. Are you sure you want to change your response?	
Vaccination History	a	Internati		
Additional Comments	a	Yes	Tes	
·				

Please Note: If *No* is selected for the conditional question at the top of the **Additional Information** screen, 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**.

The outbreak-related question at the bottom of the screen is not impacted by the selected answer for the conditional question: *Does any of the following apply to the patient?*

Did	i the patient	use street dru	igs, but not inject?	
	Yes	No	Unknown	
Is th	his part of a	n outbreak?*		
ls ti	his part of a	n outbreak?*		
is ti	his part of a Yes	No	Unknown	
is the	his part of a Yes	No	Unknown	

- You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the following autopopulated fields:
 - Healthcare Worker

• Long-term care facility resident

If ye please specify the name of healthcare facility:* Long-term care facility resident* Yes No Unknown If ye please specify the name of long-term care facility:* If yes, please specify the name of healthcare facility: Yes No Unknown If yes, please specify the name of healthcare facility: Yes No Unknown If yes, please specify the name of long-term care facility: Yes No Unknown If yes, please specify the name of long-term care facility: Yes No Unknown If yes, please specify the name of long-term care facility: Yes No Unknown If yes, please specify the name of long-term care facility: Yes	Healthcare worker* Yes No Unknown	Healthcare worker* Yes No Unknown
Long-term care facility resident* Long-term care facility resident* Yes No Unknown If yes, please sperify the name of long-term care facility:* ? If yes, please sperify the name of long-term care facility: ?	If ye, please specify the name of healthcare facility:* 😧	If yes, pluise specify the name of healthcare facility: 😧
Yes No Unknown If yes, please specify the name of long-term care facility:* @ If yes, please specify the name of long-term care facility: @	Long-term care facility resident*	Long-term care facility resident*
If yes, please specify the name of long-term care facility:	Yes No Unknown	Yes No Unknown
	If yeaplease spectry the name of long-term care facility:* 😧	If yes, plaise spenty the name of long-term care facility: 🚱



Please Note: If **Yes** is selected for **any** of the descriptive questions, the subsequent textbox is enabled for Users to specify the name of appropriate setting.

For example, if *Yes* is selected for the *Healthcare worker* field, the subsequent textbox field is
enabled. To proceed, you must enter the name of the healthcare facility in the subsequent
field: *If yes, please specify the name of the healthcare facility*.

lealthcare work	er*			 	
Yes	No	Unknown			
yes, please spe	cify the nam	ne of healthcare facility:*)		

11. To complete the **Additional Information** screen, select the **appropriate answers** for the blank enabled fields to indicate descriptions that apply to the patient.

	Domestic travel within the last 30 days (outside state of normal residence)*	
dditional Information	Yes No Unknown	
ospitalization, ICU & Death Information	If yes, please specify state(s): •	
accination History	Select_	
accination risks y		
dditional Comments	Yes No Unknown	
eview & Submit	▲ If yes, please specify country(s): ●	
	Select	
	School/disurane attendee*	
	Yes No Unknown	
	If yes, please specify the name of school/daycare: @	
	That have short a compare of more the	
	School daycare employee* Yes No Unknown	
	Liver, please specific the same of school/degrapser Q	
	n yes, preuze speciny une name en acheor outjeane. 👽	
	Food handler*	
	TES THU UNIXAVITY	
	if yes, please specify the name of food handler service: 🖗	
	Healthcare worker*	
	Yes No Unknown	
	If yes, please specify the name of healthcare facility: 🕑	
	If yes, please specify the name of healthcare facility: 🛛	
	If yes, please specify the name of healthcare facility:	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Ves No Unknown If yes, please specify the name of long-term care facility:*	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:*	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* Long-term care facility:*	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* Long-term care facility:* Long-term care facility employee* Yes No Unknown	
	If yes, please specify the name of healthcare facility: ● Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* ● Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: ●	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* Yes No Unknown If yes, please specify the name of long-term care facility: If yes, please specify the name of long-term care facility:	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* Yes No Unknown If yes, please specify the name of long-term care facility:	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?*	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown Did the patient use street drugs, but not inject?* Yes No Unknown	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: Did the patient lnject drugs not prescribed by a doctor?* Yes No Unknown Did the patient use street drugs, but not inject?* Yes No Unknown	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: Ves No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown Did the patient use street drugs, but not inject?* Yes No Unknown	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown Did the patient use street drugs, but not inject?* Yes No Unknown St this part of an outbreak?*	
	If yes, please specify the name of healthcare facility: Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility: Long-term care facility employee* Yes No Unknown If yes, please specify the name of long-term care facility: Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown Did the patient use street drugs, but not inject?* Yes No Unknown Is this part of an outbreak?* Yes No Unknown	

DDE: Communicable Disease Lab Entry



Please Note: If **Yes** is selected for **any** of the descriptive questions, the subsequent textbox is enabled for Users to specify the name of appropriate setting. To proceed, you must enter the **name of the setting** in the subsequent textbox field: *If yes, please specify*.

12. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Hospitalization**, **ICU & Death Information** screen.

THER REPORTABLE CONDITI	DNS CASE REPORT FORM Section 4 of 8
Please select the information that the pa	ient was exposed to prior to illness.
	ADDITIONAL INFORMATION
Patient Information	Does any of the following apply to the patient:*
Laboratory Information	Yes No Unknown
Applicable Symptoms	0
Idditional Information	Domestic travel within the last 30 days (outside state of normal residence)*
Inspitalization, ICLL& Death Information	Yes No Unknown
accination History	
dditional Comments	International Travel within the last 30 days*
adduonal Comments	Yes No Unknown
leview & Submit	If yes, please specify country(s):* BAHAMAS, THE × ×
	School/daycare attendee* Yes No Unknown If yes, please specify the name of school/daycare: @
	School/daycare employee* Yes No Unknown If yes, please specify the name of school/daycare: @
	Food handler* Yes No Unknown If yes, please specify the name of food handler service:
	Healthcare worker* Yes No Unknown If yes, please specify the name of healthcare facility: @
	Long-term care facility resident* Yes No Unknown If yes, please specify the name of long-term care facility:* • • Test Facility •
	Ves No Unknown If yes, please specify the name of long-term care facility: @
	Did the patient inject drugs not prescribed by a doctor?* Yes No Unknown
	Did the patient use street drugs, but not inject?* Yes No Unknown
	Is this part of an outbreak?* Yes No Unknown If yes, please specify the name of the outbreak:* O Unknown
	Save Previous Next

DDE: Communicable Disease Lab Entry





Hospitalization, ICU & Death Information

The Hospitalization, ICU & Death Information screen displays details about a patient's hospitalizations that have been auto-populated based on the previously submitted Communicable Disease Lab Entry.

13. You have the option to edit the auto-populated information in the following enabled fields:

Was the patient hospitalized? Was the patient admitted to an intensive care unit (1

'CU)?

	HOSE	ITALIZATION	I, ICU & DEATH INFORM	MATION		
Was the patier Yes	nt hospitalized No	?* Unknown				
lf yes, please s	pecify the hos	pital name:* 😡				
Admission Dat	e*		📾 🗌 Unknown	Discharge Date* mm/dd/yyyy	#	Unknown
				Still hospitalized		
Was the patier Yes	nt admitted to No	an intensive care Unknown	unit (ICU)?*	Still hospitalized		
Was the patier Yes Admission Dat mm/dd/yyyy	nt admitted to No e to ICU*	an intensive care Unknown	unit (ICU)?*	Discharge Date from ICU*	11	Unknown
Was the patier Yes Admission Dat mm/dd/yyyy	nt admitted to No e to ICU* t die as a resul	an intensive care Unknown t of this illness?*	unit (ICU)?*	Discharge Date from ICU*		Unknown
Was the patier Yes Admission Dat mm/dd/yyyy Did the patien Yes	nt admitted to No e to ICU* t die as a resul No	an intensive care Unknown t of this illness?* Unknown	unit (ICU)?*	Still hospitalized Discharge Date from ICU* mm/dd/yyyy	ŝ	Unknown
Was the patien Yes Admission Dat mm/dd/yyyy Did the patien Yes If yes, please p Date of Death	t admitted to No t die as a resul No rovide the dat	an intensive care Unknown t of this illness?* Unknown e of death:	unit (ICU)?*	Still hospitalized Discharge Date from ICU* mm/dd/yyyy		Unknown

Please Note: If the Communicable Disease Lab Entry indicated that the patient was hospitalized, the selection for the conditional question at the top of the Hospitalization, ICU & Death Information screen is auto-populated as Yes: Was the patient hospitalized?

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

If the Communicable Disease Lab Entry indicated that the patient was admitted to the ICU, the selection for the ICU-related question is auto-populated as Yes: Was the patient admitted to an intensive care unit (ICU)?

If **Yes** is selected for the ICU-related question, the subsequent Admission Date and Discharge Date fields are enabled.

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Vas the patient admitted to	an intensive care unit (ICU)?*		
Yes No	Unknown		
dmission Date to ICU*		Discharge Date from ICU*	
mm/dd/yyyy	🛗 🗌 Unknov	wn mm/dd/yyyy	🛗 🗌 Unknown

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Hospitalization**, **ICU & Death Information** screen: *Was the patient hospitalized*?

HOSPI	TALIZATIO	ON, ICU & DEATH INFORMATION		HOSPITALIZATION, I	CU & DEATH INFORMATION
Was the patient hospitalized?* Yes No	Unknown		Was the pat	ient hospitalized?* No Unknown	
 Please Note: If Hospitalization, and ICU-related f Death-related Was the patie 	<i>No</i> or ICU & ields and d quest	Unknown is selected f Death Information scre re disabled. ions are not impacted by <i>pitalized?</i>	or the co een, the su the select	onditional question ibsequent hospitaliz ed answer for the co	at the top of the ation-related fields onditional question:
				AATION	
	0	HOSPITALIZATION, ICO	& DEATH INFORM	MATION	
Patient Information	0	Was the patient hospitalized?* Yes No Unknown			
Laboratory Information	S				
Applicable Symptoms	\odot	If yes, please specify the hospital name: 🛿			
Additional Information	\odot				
Hospitalization, ICU & Death Information		Admission Date		Discharge Date	
Vaccination History	a	mm/dd/yyyy	Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Additional Comments	a			Still hospitalized	
Review & Submit	A	Was the patient admitted to an intensive care unit (IC Yes No Unknown Admission Date to ICU mm/dd/yyyy	U)?	Discharge Date from ICU mm/dd/yyyy	Unknown
		Ves No Unknown If yes, please provide the date of death: Date of Death			

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the ICU-related question: *Was the patient admitted to an intensive care unit (ICU)*?

Was the patient	admitted to a	an intensive care	unit (ICU)?*	Was the patient	t admitted to	an intensive care	unit (ICU)?*
Yes	No	Unknown		Yes	No	Unknown	
Admission Date	to CU*			Admissio, Date	e to ICI		
mm/dd/yyyy			🛗 🗌 Unknown	mm/dd/yyyy			time Unknown

DDE: Communicable Disease Lab Entry

Deloitte.	Communicable Initiating Case	Disease Lab Entry and Reports User Guide	KHIE
Please Note: If <i>Yes</i> is sele <i>Discharge Date</i> fields	ected for the ICU-rela are enabled.	ited question, the subsec	quent <i>Admission Date</i> and
To proceed, enter th appropriate fields.	e Admission Date	to ICU and the Dischar	ge Date from ICU in the
Was the patient admitted to an intensive Yes No Admission Date to ICU* mm/dd/yyyy	care unit (ICU)?* n	Discharge Date from ICU* mm/dd/yyyy	🖮 🗌 Unknown

- 14. To complete the Hospitalization, ICU & Death Information screen, you must complete the following mandatory fields marked with **red asterisks** (*), if enabled:
 - If yes, please specify hospital name •
- Admission Date to ICU ٠

Discharge Date from ICU

- Admission Date
- Discharge Date

•

HOSPITALIZATION	HOSPITALIZATION, ICU & DEATH INFORMATION						
Was the patient hospitalized?* Yes No Unknown							
If yes, please specify the hospital name:* 😧							
Test							
Admission Date* 06/27/2022	📾 🗌 Unknown	Discharge Date* 06/29/2022 Still hospitalized	🗰 🗌 Unknown				
Was the patient admitted to an intensive care Yes No Unknown	unit (ICU)?*						
Admission Date to ICU* mm/dd/yyyy	🛗 🗌 Unknown	Discharge Date from ICU* mm/dd/yyyy	Dunknown				
Did the patient die as a result of this illness?* Yes No Unknown							

Did the patient die as a result of this illness?

If yes, please provide the date of death:

Date of Death

time Unknown

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Admission Date*		Discharge Date*	
01/03/2022	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
		🗸 Still hospitalized	
Was the patient admitted	to an intensive care unit (ICU)?*		
Yes No	Unknown		
Admission Date to ICU		Discharge Date from ICU	
mm/dd/yyyy	🗰 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown
Yes No	Unknown		
f yes, please provide the d	ate of death:		
Date of Death			

Please Note: If **Yes** is selected for the field: *Did the patient die as a result of this illness*?, the subsequent field is enabled.

To proceed, enter the **Date of Death** in the subsequent enabled field: *Date of Death.*

Yes	No	Unknown		
lf yes, please pr	ovide the dat	te of death:		
Date of Death*				



15. Once the appropriate edits and additions have been made, click **Next** to proceed to the **Vaccination History** screen.

THER REPORTABLE CONDI	TIONS CASE REPORT FORM		Section 5 of 8	
Please select any annlicable bosnitali	ration ICI and death information related to this case			
riease select any applicable hospitaliz	HOSPITA	LIZATION, ICU & DEATH INFORM	MATION	
Patient Information	Ø Was the patient hospitalized?*			
Laboratory Information	⊘ Yes No	Unknown		
Applicable Symptoms	0			
Additional Information	If yes, please specify the hospital Test	name: * 		
Hospitalization, ICU & Death Informat	ion Admission Date*		Discharge Date*	
Vaccination History	66/27/2022	iii Unknown	06/29/2022	🛗 🗌 Unknown
Additional Comments	≙		Still hospitalized	
Review & Submit	Was the patient admitted to an in Yes No Admission Date to ICU* 06/28/2022	itensive care unit (ICU)?* Unknown	Discharge Date from ICU* 06/29/2022	iii Unknown
	Yes No If yes, please provide the date of Date of Death mm/dd/yyyy	Unknown death:		
	Save		Pre	evious Next
Please Note : Th Other Reportabl the Communical	ne subsequent Vaccinat e Conditions Case Repo ble Disease Lab Entry.	tion History and a	Additional Comme any auto-populated	e nts screens of the d information from
 To proceed, screen. Once 	you must enter the ar e complete, click Next u	opropriate inform	nation in the enab o the Review and S	oled fields on each ubmit screen.
For specific info Case Report, ple <i>Conditions User</i>	rmation on how to com ease review the <i>Direct D</i> <i>Guide</i> on the <u>KHIE web</u>	plete these screer <i>Data Entry for Elect</i> <u>site</u> .	ns of the Other Rep tronic Case Reports	ortable Conditions : Other Reportable



Review and Submit: Other Reportable Conditions Case Report

Once the appropriate edits and additions have been made on all the Other Reportable Conditions Case Report screens, you will be navigated to the **Review and Submit** screen. The **Review and Submit** screen displays the summary of the information you have entered. Prior to submitting the Other Reportable Conditions Case Report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report.

16. Review the information on the **Review and Submit** screen.

OTHER REPORTABLE CONDITIONS CAS	SE REPORT FO	RM	Section 8 of 8			
Please review your information before submitting.						
		REV	IEW & SUBMIT			
Patient Information	0				-	
Laboratory Information	0				Print Print	Lownload
Applicable Symptoms	0	Patient Information				۵
Additional Information	0					
Hospitalization, ICU & Death Information	0	Disease/Organism Babesiosis	Date of Diagnosis 07/01/2022			
Vaccination History	0	Is the Affiliation/Organization same for Patient ID (MRN), Per-	son Completing Form, and Attending Physician/Clinician?			
Additional Comments	0	Patient ID (MRN)	Affiliation/Organization			
Review & Submit		CK01011960 Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Test Medical Center Affiliation/Organization Test Medical Center			
		Attending Physician/Clinician Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization Test Medical Center			
		Prefix Mr.				
		First Name Cosmo	Middle Name A	Last Name Kramer		
		Suffix II	Date of Birth 01/01/1960			
		Patient Sex Male	Ethnicity Not Hispanic or Latino	Race White		
		Address 1 123 Seinfeld Lane	Address 2 Apt. 1			
		City Lexington	State KY	Zip Code 40509-		
		County Fayette	Phone (123) 456-7890	Email cosmokramer@email.co	n	

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

Additional Comments	۵
Additional comments or notes, please specify: Additional patient notes	
Previous	*

18. 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.

Admission Date to 10/01/2021	Case Report Entry ×	Discharge Date from ICU 10/02/2021
Did the patient di 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 Hi	Cancel Submit	٥

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

Admission Date to IC 10/01/2021	Case Report Entry	×	Discharge Date from ICU 10/02/2021	
Did the patient die as No	Case Report Entry Saved Successfully			
Vaccination Histo	ок			•

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 where the submitted case report displays.

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

• For specific information on the **Case Report Entry User Summary** screen, please review section 17: *Case Report Entry User Summary* of this guide.

KHIE ePartnerVie	wer		🛎 Support 🛛 📢 Announcement	s 💲 🌲 Advisories 🗿 🧕 Jane Doe 👻
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry -
Home > Case Report Entry User Summary				
	CASE REPORT	FENTRY USER SU	MMARY	
LAST UPDATED DATE RANGE	Start Date 07/02/2022	ti e e e e e e e e e e e e e e e e e e e	nd Date 07/02/2022 🛗	C Retrieve Data
SHOWING 1 ITEMS				T APPLY FILTER
ACTIONS REPORT TYPE	RGANISM AFFILIATION/ PATIENT MRN ORGANIZATION + PATIENT MRN	FIRST NAME + LAST NAME	DATE OF BIRTH PATIENT \$ SEX \$ STATUS \$	LAST UPDATED + SUBMISSION DATE +
View Other Conditions Dengue Copy Copy	Test Medical Center JH05052020	Jane Hopper	05/05/2020 Female Complete	07/02/2022 07/02/2022 1:00 PM 1:00 PM
	First Back 1	lext Last		Maximum 5 • entries per page
Copyright 2019 HealthInteractive		HealthInteractive HIE		/ersion: 1.0.0



13 Initiate Sexually Transmitted Disease Case Report

Upon initiating a Sexually Transmitted Diseases (STD) Case Report on the *Communicable Disease Lab Entry* pop-up notification, Users are automatically navigated to the **Patient Information** screen of the Sexually Transmitted Diseases Case Report.

The STD Case Report is a ten-step process where Users enter (1) Patient Information, (2) Laboratory Information, (3) Applicable Symptoms, (4) Medical Conditions, (5) Travel Information, (6) Hospitalization, ICU & Death Information, (7) Additional Information, (8) Treatment Information, (9) Additional Comments, and (10) Review and Submit. The **Review & Submit** screen is where Users must review the information entered and submit the STD Case Report.

ricase complete the form below. All f	ieus markeu with an asterisk(") are required.		
	PATIENT I	NFORMATION	
Patient Information	Disease/Organism* 🛛	Date of Diagnosis*	_
Laboratory Information	Chlamydia Trachomatis Infection	mm/dd/yyyy 🏥	Unknown
Applicable Symptoms		Detion ID (LIDAD Desson Completion Form and	Attending Diversion (Clinician St
Medical Conditions	Yes No	reatient in (MKN), Person Completing Form, and	Attenuing Physician/Clinician?*
Travel Information	Patient ID (MRN)* @	Affiliation/Organization*	
Hospitalization, ICU & Death	▲ EB02151970	Test Medical Center	
	Person Completing Form*	Affiliation/Organization* 🕜	If other, please specify: 🔞
Additional Information	Select	Select 🗸	
Treatment Information	Attending Physician/Clinician*	Affiliation/Organization* 🛛	If other, please specify: 🚱
Additional Comments	Select	Select 🗸	
Review and Submit	A		
	Prefix		
	Miss		
	First Name*	Middle Name	Last Name*
	Elaine		Benes
	Suffix	Date of Birth*	
	Colort	02/15/1970 #	

The following STD Case Report screens display certain fields of information that have been autopopulated based on the information entered on the previously submitted Communicable Disease Lab Entry. When necessary, you can change the auto-populated information and enter different details in any of the enabled fields.

- Patient Information screen
 Applicable Symptoms screen
- Laboratory Information screen
 Hospitalization, ICU & Death Information screen

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Patient Information

The **Patient Information** screen auto-populates with the existing patient demographic details entered on the previously submitted Communicable Disease Lab Entry. Users can change the auto-populated information in any of the enabled fields, as applicable. Users cannot change auto-populated details in disabled fields.

Users **<u>cannot</u>** edit the following auto-populated *Disease/Organism*, *Patient ID (MRN*), *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields which are grayed out and disabled:

- Disease/Organism
- Patient ID (MRN)

Affiliation/Organization for Patient

- Is the Affiliation/Organization the same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
- MRN
- Date of Birth

٠

- First Name
- Middle Name

- Last Name
- Prefix
- Suffix
- Patient Sex

PA	TIENT INF	ORMATION	
Disease/Organism* 🕢 Syphilis		Date of Diagnosis* mm/dd/yyyyy	📾 🗌 Unknown
Is the Affiliation/Organization same	for Patient ID) (MRN), Person Completing Form, and Attend	nding Physician/Clinician?*
Yes No			
Patient ID (MRN)* 🕑		Affiliation/Organization* 🕑	
JH05052020		Test Medical Center	
Person Completing Form*		Affiliation/Organization* 🛛	If other, please specify: 😡
Select	· ·	Select	~
Attending Physician/Clinician*		Affiliation/Organization* 🛛	If other, please specify: 🚱
Select	~	Select	v
Prefix			
Select	V		
First Name*		Middle Name	Last Name*
Jane			Hopper
Suffix		Date of Birth*	
Select	\sim	05/05/2020	······································
Patient Sex*		Ethnicity*	Race*

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Please Note: The *Disease/Organism*, *Patient ID (MRN)*, *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields are the only disabled fields. All other fields on the **Patient Information** screen and all subsequent screens are enabled. You have the option to edit any of the enabled fields on all screens of the STD Case Report.

1. You have the option to **edit the auto-populated information** in the following enabled fields:

- Ethnicity
- Race

- Phone
- Email
- Address, City, State, Zip Code, County
- Is the patient currently pregnant?

Patient Sex*	Ethnicity*		Race*	
Female	Not Hispanic or Latin	x - ×	White	× ~
Address 1*		Address 2		
123 Hawkins Lane		Unit, Suite, Building, e	tc.	
City*		State*		Zip Code
Frankfort		KY	× ~	40601-
County*	Phone* 😧		Email	
Fayette	× v (555) 555-5555		eleven@email.com	
f yes, please enter the due da mm/dd/yyyy	te (EDC):			
If yes, please enter the due da mm/dd/yyyy Please Note: The <i>Is</i> or the <i>Patient Se</i> .	te (EDC): to the patient currently pregnary training on the Patient Inf	<i>ant?</i> field is enab formation scree	led only when F en of the prev	emale is selecteriously submitte
f yes, please enter the due da mm/dd/yyyy Please Note: The <i>Is</i> for the <i>Patient Se</i> . Communicable Dise	te (EDC): the patient currently pregnation on the Patient Inf trase Lab Entry.	<i>ant?</i> field is enab formation scree	led only when F en of the prev	Temale is selecter iously submitte
Please Note: The <i>Is</i> or the <i>Patient Se</i> . Communicable Dise	te (EDC): the patient currently pregna the patient on the Patient Inf the Lab Entry. the <i>Is the patient currently</i>	ant? field is enab	led only when F en of the prev the subsequent	field is enabled
If yes, please enter the due da mm/dd/yyyy Please Note: The <i>Is</i> for the <i>Patient Se</i> . Communicable Dise F Yes is selected for	the patient currently pregnation of the patient currently pregnation of the patient information of the patient information of the patient currently of the ls the patient currently of the subsequences of the	ant?field is enab formation scree pregnant?field, t	led only when F en of the prev	field is enabled
f yes, please enter the due da mm/dd/yyyy Please Note: The <i>Is</i> for the <i>Patient Se</i> . Communicable Dise Yes is selected for o proceed, enter th	te (EDC): The patient currently pregnation of the patient line of the patient line of the patient line of the patient currently of the ls the patient currently of the Due Date in the subseque	ant?field is enab f ormation scree pregnant?field, f ent field: <i>If yes, p</i>	led only when F en of the prev the subsequent	f emale is selecte iously submitte field is enabled
If yes, please enter the due da mm/dd/yyyy Please Note: The <i>ls</i> for the <i>Patient Se</i> . Communicable Dise Yes is selected for to proceed, enter th	te (EDC): C the patient currently pregna to the patient currently pregna to field on the Patient Inf trase Lab Entry. the <i>Is the patient currently</i> the Due Date in the subseque	<i>ant?</i> field is enab f ormation scree <i>pregnant?</i> field, f ent field: <i>If yes, p</i>	led only when F en of the prev the subsequent	field is enabled
If yes, please enter the due da mm/dd/yyyy Please Note: The <i>Is</i> for the <i>Patient Se</i> . Communicable Dise Yes is selected for to proceed, enter the Is the patient current	the patient currently pregnation of the patient currently pregnation of the patient information of the patient information of the patient currently of the ls the patient currently of the patient resubsequently pregnant?*	<i>ant?</i> field is enab f ormation scree <i>pregnant?</i> field, t ent field: <i>If yes, p</i>	led only when F en of the prev the subsequent	female is selecte iously submitte field is enabled e due date (EDC,
If yes, please enter the due da mm/dd/yyyy Please Note: The <i>Is</i> for the <i>Patient Se</i> . for municable Dise F Yes is selected for to proceed, enter the Is the patient current Yes	te (EDC): The patient currently pregnation of the patient line of the patient line of the patient line of the patient currently of the list the patient currently of the Due Date in the subsequently pregnant?*	<i>ant?</i> field is enab formation scree <i>pregnant?</i> field, t ent field: <i>If yes, p</i>	led only when F en of the prev the subsequent	female is selecter iously submitter field is enabled
If yes, please enter the due da mm/dd/yyyy lease Note: The <i>Is</i> or the <i>Patient Se</i> . ommunicable Dise <i>Yes</i> is selected for o proceed, enter the Is the patient current Yes	the patient currently pregnations field on the Patient Inf asse Lab Entry. the <i>Is the patient currently</i> the Due Date in the subsequently No Unknown	<i>ant?</i> field is enab f ormation scree <i>pregnant?</i> field, t ent field: <i>If yes, p</i>	led only when F en of the prev the subsequent	f emale is selecte iously submitte field is enabled e due date (EDC)



- 2. To complete the **Patient Information** screen, you must **enter the appropriate information** in the mandatory blank fields marked with **red asterisks** (*), as applicable:
 - Date of Diagnosis
 - Person Completing Form
 - Affiliation/Organization of Person Completing Form
- Attending Physician/Clinician
- Affiliation/Organization of Attending Physician/Clinician

Disease/Organism* 🚱		Date of Diagnosis*		
Syphilis		mm/dd/yyyy	₩ (Unknown
s the Affiliation/Organization sam	e for Patient ID	(MRN), Person Completing Form, and	d Attending Ph	ysician/Clinician?*
Yes				
Patient ID (MRN)* 🚱		Affiliation/Organization* 🕑		
JH05052020		Test Medical Center	· ·	
		Affiliation/Organization* 🕑		lf other, please specify: 🚱
Person Completing Form*		Select	· · ·	
Person Completing Form* Select	~	Select		
Person Completing Form* Select Attending Physician/Clinician*	· ·	Affiliation/Organization* 😧		If other, please specify: 🚱

Please Note: If the appropria Attending Physician/Clinician	ate name does not display in t dropdown menus, you must c	he <i>Person Completing Form</i> or reate details for a new Person
Completing Form or a new Atte	ending Physician/Clinician.	
To create details for a new hyperlink. Upon clicking the second sec	v Person Completing Form, clic ne hyperlink, the <i>Person Comple</i>	k the Person Completing Form <i>ting Form</i> pop-up displays.
 To create details for a Physician/Clinician hyperl pop-up displays. 	a new Attending Physician/C ink. Upon clicking the hyperlink,	Clinician, click the Attending the <i>Attending Physician/Clinician</i>
To proceed, enter the details in	the appropriate fields of the po	p-up and click Save .
×		/
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Select 🗸	Select V	
Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Select v	Select 🗸	

DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange



3. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Laboratory Information** screen.

		PATII	ENT INF	ORMATION			
tient Information		Disease/Organism* 🛛		Date of Diagnosis*			
boratory Information	a	Chlamydia Trachomatis Infecti	on 🗸 🗸	mm/dd/yyyy	#	Unknown	
plicable Symptoms	A						
edical Conditions	a	Is the Affiliation/Organization sa	me for Pat	ient ID (MRN), Person (Completing Form, and	Attending Physician/Cli	tician?*
avel Information		Patient ID (MRN)* @		Affiliation/Organizati	ion* Ø		
ospitalization, ICU & Death	A	EB02151970		Test Medical Cente	r V		
ormation		Person Completing Form*		Affiliation/Organizati	on* 😧	If other, please specify	y: 😧
ditional Information		Select	$ $ \sim	Select	~		
eatment Information	a	Attending Physician/Clinician*		Affiliation/Organizati	ion* 0	If other, please specif	y: 🚱
ditional Comments	a	Select	v	Select	~		
view and Submit	a						
		Prefix					
		141123					
		Elaine		Middle Name		Benes	
		Suffix		Date of Birth*			
		Select	~	02/15/1970			
		Patient Sex*		Ethnicity*		Race*	
		Female		Not Hispanic or Lating	o X I V	White	x ~
		123 Peterman Way			Address 2 Apt. A		
		City*			State*		Zip Code
		Lexington			KY	× ~	40509-
		County*		Phone* 😧		Email	
		Fayette	$\times \mid$ \sim	(555) 222-2222		elainebenes@email.co	om
		to the period correctly present 24					

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Laboratory Information

The **Laboratory Information** screen displays details about the laboratory test that have been autopopulated based on the information previously entered on the Communicable Disease Lab Entry.

- 4. You have the option to **edit the auto-populated information** or **enter the appropriate information** in the following enabled fields:
- Does the patient have a lab test?
- Laboratory Name
- Test Name
- Filler Order/Accession Number
- Specimen Source

- Test Result
- Test Result Date
- Specimen Collection Date
- Additional Information

LABORATORY INFORMATION	
Does the patient have a lab test?* Yes No Unknown	
Laboratory Information	
Laboratory Name*	
General Hospital	
Test Name*	
Reagin Ab in Serum by RPR	x ~
If other, please specify: 🚱	
Filler Order/Accession Number 😧	
JH07012022	
Specimen Source*	
Abscess	x ~
If other, please specify: 😡	
Test Result*	
Other	x ~
If other, please specify:* 😧	
Detected	
Test Result Date*	Specimen Collection Date*
07/02/2022 🛗 🗌 Unknown	07/01/2022 🛗 🗌 Unknown
Additional Information 🚱	
Observation 5 - STD details	
27/300 Characters	iditional Information
Add Test	



• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Laboratory Information** screen: *Does the patient have a lab test?*

LA Does the patient have a la Yes No	BORA	TORY INFORMATION LABORATORY INFORMATION * Does the patient have a lab test?* Unknown Yes	
Please Note: If <i>N</i> Laboratory Inforn	o or natio	Unknown is selected for the conditional question at the top of the subsequent fields are disabled.	e
Patient Information	Ø		
Laboratory Information		Yes No Unknown	
Applicable Symptoms	a		
Medical Conditions	_	Laboratory Information	
Travel Information	a	Laboratory Name	
Hospitalization, ICU & Death Information		Test Name	
Additional Information		Select	
Treatment Information		If other, please specify: O	
Additional Comments	۵	Filler Order/Accession Number 🚱	
	0		

- If you change the selection for the conditional question, a pop-up notification will display with a message that states: *Please note that all selections on this screen will be reset. Are you sure you want to change your response?*
- To reset the previous selection for the conditional question, click **Yes** on the pop-up notification.

Hospitalization, ICU & Death Information	۵	Genera Laboratory Information ×	
Vaccination History	۵	Test Nar Please note that all selections on the screen will be reset. Are you sure you want to change your	×
Additional Comments	A	If other, response?	
Review & Submit	A	Yes No	
		Filler Ord	

5. You also have the option to click **Add Test** to add additional tests for the patient.

Ad	dditional Information 🚱			
(Observation 2 details			
21/	/300 Characters			
C	Add Test			
		_		~
	Save	Previous	Next	

DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange





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

Laboratory Information	
Laboratory Name*	
Test Name*	
Select	✓
f other, please specify: 🔞	
iller Order/Accession Number 🕢	
Select	~
f other, please specify: 😡	
Fest Result*	

6. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Applicable Symptoms** screen.

SEXUALLY TRANSMITTED DISEAS	SES CASE REPORT FORM			Section 2 of 10			
Please provide laboratory information related	d to this case.						
		LABORATOR	Y INFORMATION				
Patient Information	⊘ Does the patient have a	lab test?*					
Laboratory Information	Yes No	Unknown					
Applicable Symptoms	A						
Medical Conditions	Laboratory Information						_
Travel Information	General Hospital						
Hospitalization, ICU & Death Information	Test Name*						
Additional Information	Reagin Ab in Serum by	/ RPR				×	\sim
Treatment Information	If other, please specify:	0					
Additional Comments							-
Review and Submit	Filler Order/Accession M	lumber 🛛					
Review and Submit							
	Specimen Source*					x	~
	If other, please specify:	0					-
	Test Result*						
	Other					×	\sim
	If other, please specify:	0					
	Detected						
	Test Result Date*			Specimen Collection Date*			
	07/02/2022	#	Unknown	07/01/2022	🛗 🗌 Unknown		
	Additional Information	ด					
	Observation 5 - STD d	etails					
	27/300 Characters		Г	Additional Information			
	🔂 Add Test						
	Save				Previous Next		
Communicable Disease Lab Entry and Initiating Case Reports User Guide



Applicable Symptoms

The **Applicable Symptoms** screen asks questions about the patient's symptoms.

- 7. You have the option to **edit the auto-populated information** in the following enabled fields:
- Were symptoms present during the course of illness?
 Onset Date

	APPLICABLE SYMPTOMS
Were symptoms Yes	present during the course of illness?* No Unknown
Onset Date* 🚱	iii Unknown
If symptomatic,	which of the following did the patient experience during their illness?
Yes	No Unknown
If yes, please sp	cify the location on the body (select all that apply): 🚱
If other, please s	pecify: 😧
Fever*	
Yes	No Unknown
lf yes, please en	er the highest temperature: 🚱

Please Note: If the patient was marked as symptomatic on the Communicable Disease Lab Entry, the selection for the conditional question at the top of the **Applicable Symptoms** screen is autopopulated as **Yes**: *Were symptoms present during the course of illness?*

• If *Yes* is selected for the conditional question at the top of the **Applicable Symptoms** screen, the subsequent fields are enabled.

If an onset date for symptoms was entered on the Communicable Disease Lab Entry, the same date is auto-populated for the *Onset Date* field on the **Applicable Symptoms** screen.

DDE: Communicable Disease Lab Entry



• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Applicable Symptoms** screen: *Were symptoms present during the course of illness?*

APPLICABLE SYMPTOMS	APPLICABLE SYMPTOMS
Were symptoms present during the course of illness?* Yes No Unknown	Were symptoms present during the course of illness?* Yes Unknown

- If you change the selection for the conditional question, a pop-up notification will display with a message that states: *Please note that all selections on this screen will be reset. Are you sure you want to change your response?*
- To reset the previous selection for the conditional question, click *Yes* on the pop-up notification.

Medical Conditions	A	Did the pa	Applicable Symptoms	×
Exposure Information Hospitalization, ICU & Death Information	•	If yes, wha	Please note that all selections on the screen will b reset. Are you sure you want to change your response?)e
Vaccination History	A	If symptor	Yes No	,
Additional Comments		Fever*		

Please Note: If *No* is selected for the conditional question at the top of the **Applicable Symptoms** screen, all subsequent fields are disabled and marked with *No*.

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

APPLICABLE SYMPTOMS
Were symptoms present during the course of illness?* Yes No Unknown
Onset Date 🖗 🔛 Unknown
If symptomatic, which of the following did the patient experience during their illness? Fever Yes No Unknown
If yes, please enter the highest temperature: 😯
Diarrhea (>3 loose stools/24hr period) Yes No Unknown If yes, please enter # of days of diarrhea: @





8. To complete the **Applicable Symptoms** screen, you must select the **appropriate answers** for the mandatory symptom fields marked with **red asterisks** (*).

		APPLICABLE SYMPTOMS	
Were symptom	s present dur	ng the course of illness?*	
Yes	No	Unknown	
Oncet Date: 0			
06/20/2022	iii (Unknown	
If symptomatic,	which of the	' ollowing did the patient experience during their illness?	
Rash*			
Yes	No	Unknown	
If yes, please sp	ecify the loca	ion on the body (select all that apply): 🚱	
Select			
If other, please	specify: 🕜		
Fever*			
Yes	No	Unknown	
If yes, please er	iter the highe	it temperature: 🖗	
Diarrhan (>2 los	se stools /24	r nariadht	
Yes	No	Unknown	
If yes, place or	tor # of days	of diardaas Q	
Alopecia* Yes	No	Unknown	
Condylomata lat	a of vulva*	Linknown	
	110		
Inguinal lympha	denopathy*		
Yes	NO	Unknown	
Rash of seconda	ry syphilis*		
Yes	No	Unknown	
Uveitis*			
Yes	No	Unknown	
Did the patient h	have any othe	r symptoms?*	
Yes	No	Unknown	
If yes, please sp	ecify: 🔞		
ease No	te: The	symptom fields on the Applicable Symptoms screen	varv based on t
		Suprementation and the trephone of information of the	





9. Once the appropriate edits and additions have been made, click **Next** to proceed to the **Medical Conditions** screen.

SEXUALLY TRANSMITTED DISEAS	ES CASE REPORT FC	RM		s	Section 3 of 10		
Please select applicable symptoms that the p	atient experienced during illr	less.					
			APPLICABL	E SYMPTOMS			
Patient Information	Were sympt	oms present du	uring the course of illness	:7*			
Laboratory Information	⊘ Yes	No	Unknown				
Applicable Symptoms							
Medical Conditions	Onset Date 06/20/202	0 2 m	Unknown				
Travel Information	A		_				
Hospitalization, ICU & Death Information	if symptoma	itic, which of th	e following did the patier	nt experience during their illn	iess?		
Additional Information	Rash*	No	Unknown				
Treatment Information	If yes, please	e specify the loo	ation on the body (select	t all that apply):* 😡			
Additional Comments	Arm × H	ands x					, X ×
Deview and Submit	If other, plea	ise specify: 🔞					
Review and Subrine	-						
	Yes	No	Unknown				
	If yes, please	enter the high	est temperature:* 😧				
	101						
	Diarrhea (>3	loose stools/2	4hr period)*				
	If yes, please	enter # of day	s of diarrhea:* 9				
	3						
	Alopecia*						
	Yes	No	Unknown				
	Condylomat	a lata of vulva* No	Unknown				
	Inquiral hos	obadaponatha	•				
	Yes	No	Unknown				
	Rash of seco	ndary syphilis*					
	Yes	No	Unknown				
	Uveitis*						
	Yes	No	Unknown				
	Did the patie	ent have any ot	her symptoms?*				
	Yes	No	Unknown				
	If yes, please Unknown	specify:					
	Savi	2				Previous	Next
				· · · · · · · · · · · · · · · · · · ·			
Please Note: The s	ubsequent N	Aedica	al Conditio	ons and Tra	vel Inform	ation screens	of the STD
Case Report do <u>no</u>	<u>t</u> include an	y auto	-populated	d informatio	on from the	e Communicab	le Disease
		-					

Lab Entry.

 To proceed, you must enter the appropriate information in the enabled fields on each screen. Once complete, click Next until you navigate to the Hospitalization, ICU & Death Information screen.





Hospitalization, ICU & Death Information

The Hospitalization, ICU & Death Information screen displays details about a patient's hospitalizations that have been auto-populated based on the previously submitted Communicable Disease Lab Entry.

10. You have the option to edit the auto-populated information in the following enabled fields:

Was the patient hospitalized? Was the patient admitted to an intensive care unit (1

	HOSP	ITALIZATION	I, ICU & DEATH INFORM	MATION	
Was the patier	t hospitalized?	*	1		
Yes	No	Unknown			
lf yes, please s	pecify the hosp	oital name: * 			
Admission Dat	e*			Discharge Date*	
mm/dd/yyyy			🛗 🗌 Unknown	mm/dd/yyyy	Unknown
Was the patier	admitted to a	an intensive care	unit (ICU)?*	Still hospitalized	
Was the patier Yes Admission Dat	nt admitted to a No e to ICU*	an intensive care Unknown	unit (ICU)?*	Discharge Date from ICU*	
Was the patier Yes Admission Dat	It admitted to a No e to ICU*	an intensive care Unknown	unit (ICU)?*	Discharge Date from ICU*	Unknown
Was the patien Yes Admission Dat mm/dd/yyyy	It admitted to a No e to ICU*	an intensive care Unknown	unit (ICU)?*	Discharge Date from ICU*	Unknown
Was the patier Yes Admission Dat mm/dd/yyyy Did the patien Yes	t admitted to a No e to ICU* die as a result No	an intensive care Unknown t of this illness?* Unknown	unit (ICU)?*	Discharge Date from ICU*	Unknown
Was the patien Yes Admission Dat mm/dd/yyyy Did the patien Yes If yes, please p	it admitted to a No e to ICU* : die as a result No rovide the date	an intensive care Unknown t of this illness?* Unknown e of death:	unit (ICU)?*	Discharge Date from ICU*	Unknown
Was the patier Yes Admission Dat mm/dd/yyyy Did the patien Yes If yes, please p Date of Death	t admitted to a No e to ICU* t die as a result No rovide the date	an intensive care Unknown t of this illness?* Unknown e of death:	unit (ICU)?*	☐ Still hospitalized Discharge Date from ICU* mm/dd/yyyy	Unknown

Please Note: If the Communicable Disease Lab Entry indicated that the patient was hospitalized, the selection for the conditional question at the top of the Hospitalization, ICU & Death Information screen is auto-populated as Yes: Was the patient hospitalized?

If Yes is selected for the conditional question at the top of the screen, the subsequent hospitalization-related fields and ICU-related fields are enabled.

If the Communicable Disease Lab Entry indicated that the patient was admitted to the ICU, the selection for the ICU-related question is auto-populated as Yes: Was the patient admitted to an intensive care unit (ICU)?

If **Yes** is selected for the ICU-related question, the subsequent Admission Date and Discharge Date fields are enabled.

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Was the patient admitted to an inte	nsive care unit (ICU)?*		
Yes No Ur	ıknown		
Admission Date to ICU*		Discharge Date from ICU*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Hospitalization**, **ICU & Death Information** screen: *Was the patient hospitalized*?

HOSPITALIZATION, ICU & DEATH INFORMATION	HOSPITALIZATION, ICU & DEATH INFORMATION
Was the patient hospitalized?* Yes No Unknown	Was the patient hospitalized?* Yes No Unknown
Please Note: If <i>No</i> or <i>Unknown</i> is selected f Hospitalization, ICU & Death Information scree and ICU-related fields are disabled.	or the conditional question at the top of the en, the subsequent hospitalization-related fields
• Death-related questions are not impacted by <i>Was the patient hospitalized?</i>	the selected answer for the conditional question:

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the ICU-related question: *Was the patient admitted to an intensive care unit (ICU)*?

Was the patient admitted to an intensive care unit (ICU)?* Yes No Unknown Admission Date to CU* mm/dd/yyyy Unknown	Was the patient admitted to an intensive care unit (ICU)?* Yes No Unknown Admission Date to ICU mm/dd/yyyy Unknown
 Please Note: If Yes is selected for the ICU-related Discharge Date fields are enabled. 	d question, the subsequent <i>Admission Date</i> and
To proceed, enter the Admission Date to IC appropriate fields.	U and the Discharge Date from ICU in the
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



- 11. To complete the **Hospitalization**, **ICU & Death Information** screen, you must complete the following mandatory fields marked with **red asterisks** (*), if enabled:
- If yes, please specify hospital name
- Admission Date
- Discharge Date

- Admission Date to ICU
- Discharge Date from ICU
- Did the patient die as a result of this illness?

		Unknown	Discharge Date* 06/29/2022	iii Unknown
			Still hospitalized	
o an intensive car	e unit (ICU)?	*		
Unknown				
			Discharge Date from ICU*	
	*) Unknown	mm/dd/yyyy	🛗 🗌 Unknown
ult of this illness?	*			
Unknown	1			
ate of death:				
he Still H o	ospital	lized checkbe	ox is selected, the subse	equent death-related field
he Still H o	ospital	l ized checkbe result of this	ox is selected, the subse s illness?	equent death-related field
he Still H e	ospital lie as a	lized checkbe result of this	ox is selected, the subse s <i>illness?</i> Discharge Date*	equent death-related field
he Still H o	ospital	ized checkber issult of this	ox is selected, the subse s illness? Discharge Date* mm/dd/yyyy	equent death-related field
he Still H o	ospital lie as a	ized checkber <i>result of this</i>	ox is selected, the subse s illness? Discharge Date* mm/dd/yyyy	equent death-related field
he Still H o	ospital lie as a	l ized checkbe result of this	ox is selected, the subsets illness? Discharge Date* mm/dd/yyyy	equent death-related field
he Still H o	ospital lie as a	Unknown lized checkbe result of this) Unknown are unit (ICU)?*	ox is selected, the subsets illness? Discharge Date* mm/dd/yyyy Still hospitalized	equent death-related field
he Still H	ospital die as a mtensive c	Unknown lized checkburesult of this) Unknown care unit (ICU)?*	ox is selected, the subsets illness? Discharge Date* mm/dd/yyyy	equent death-related field
he Still H o e patient d nitted to an in No	ospital die as a	Unknown iized checkbu result of this) Unknown are unit (ICU)?*	ox is selected, the subsets illness? Discharge Date* mm/dd/yyyy Still hospitalized	equent death-related field
	o an intensive car Unknown ult of this illness? Unknown ate of death:	o an intensive care unit (ICU)? Unknown iiii illness?* Unknown ate of death:	o an intensive care unit (ICU)?* Unknown Unknown ult of this illness?* Unknown ate of death:	On Known On Known

If yes, please provide the date of death:

Please Note: If **Yes** is selected for the field: *Did the patient die as a result of this illness*?, the subsequent field is enabled. To proceed, enter the **Date of Death** in the subsequent enabled field: *Date of Death*.

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Yes	No	Unknown	
lf yes, please pr	rovide the dat	te of death:	
Date of Death*			
Date of Death			

12. Once the appropriate edits and additions have been made, click **Next** to proceed to the **Additional Information** screen.

SEXUALLY TRANSMITTED DISEAS	ies case ref	PORT FORM			Section 6 of 10		
Please select any applicable hospitalization,	ICU and death info	ormation related to this case	2.				
		HOS	PITALIZATION,	ICU & DEATH INFOR	MATION		
Patient Information	Ø	Was the patient hospitalized	l?*				
Laboratory Information	\odot	Yes No	Unknown				
Applicable Symptoms	⊘						
Medical Conditions	\otimes	If yes, please specify the hos Test Hospital	pital name:* 😧				
Travel Information	0	Admission Date*			Discharge Date*		
Hospitalization, ICU & Death Information		07/01/2022		🛗 🗌 Unknown	07/03/2022		Unknown
Additional Information	۵				Still hospitalized		
Treatment Information	A			the other thanks			
Additional Comments	A	Yes No	Unknown				
Review and Submit	A	Admission Date to ICU*			Discharge Date from ICU*		_
		07/02/2022		iii Unknown	07/03/2022		Unknown
		Did the patient die as a resu Yes No If yes, please provide the da Date of Death mm/dd/yyyy	It of this illness?* Unknown te of death:	Unknown			
		Save				Previous	Next

Please Note: The subsequent **Additional Information**, **Treatment Information**, and **Additional Comments** screens of the STD Case Report do <u>not</u> include any auto-populated information from the Communicable Disease Lab Entry.

• To proceed, you must enter the **appropriate information** in the enabled fields on each screen. Once complete, click **Next** until you navigate to the **Review and Submit** screen.

For specific information on how to complete these screens of the STD Case Report, please review the *Direct Data Entry for Electronic Case Reports: Sexually Transmitted Diseases User Guide* on the KHIE website.



Review and Submit: STD Case Report

Once the appropriate edits and additions have been made on all the STD Case Report screens, you will be navigated to the **Review and Submit** screen. The **Review and Submit** screen displays the summary of the information you have entered. Prior to submitting the STD Case Report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report.

13. Review the information on the **Review and Submit** screen.

EXUALLY TRANSMITTED DISEASES	S CASE REPO	PRT FORM	Section 10 of 10		•
Please review your information before submitting	g.				
		REVIE	EW & SUBMIT		
Patient Information	0			_	
aboratory Information	0			Print	L Downlo
pplicable Symptoms	Ø	Patient Information			
Medical Conditions	0				
ravel Information	0	Disease/Organism Syphilis	Date of Diagnosis 07/01/2022		
lospitalization, ICU & Death Information	0	Is the Affiliation/Organization same for Patient ID (MRM	N), Person Completing Form, and Attending Physician/Clinician?		
dditional Information	0	Patient ID (MRN)	Affiliation/Organization		
reatment Information	0	JH05052020	Test Medical Center		
dditional Comments	Ø	Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center		
eview and Submit		Attending Physician/Clinician Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization Other	If other, please specify: General Hospital	
		First Name Jane	Last Name Hopper		
		Date of Birth 05/05/2020			
		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White	
		Address 1 123 Hawkins Lane			
		City Frankfort	State KY	Zip Code 40601-	

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

Additional Comments	0
 Additional comments or notes, please specify: Additional patient notes	
Previous	\$

15. 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.

Tes Admission I 10/01/2021	te to IC Case Report Entry	Discharge Date from ICU 10/02/2021
Did the pati No	t die as 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.	
Vaccinatio	Histo Cancel Submit	٥

Communicable Disease Lab Entry and Initiating Case Reports User Guide



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

			Admission Date to IC 10/01/2021 Did the patient die as No Vaccination Histo	Case Report	t Entry	O	× Discharge D 10/02/2021	ate from ICU			۵
Pleas auton • Fc se	e Note : C natically na or specific ection 17: <i>C</i>	licking Ok vigate you informatic <i>Case Repor</i>	C when the Ca to the Ca on on the <i>rt Entry U</i> .	ne case ase Rep Case I ser Sun	e report port Entr Report E nmary of	entry ha y User S ntry Us this guid	as beer Summa ser Sum de.	n subr ry scr nmary	nitted een. v scree	succes en, plea	sfully will se review
`											
KĤII Pati	ePartr	nerViewer Bookma	rked Patients		Event Notifications		⊠ S Lab Da	Support 📢 / ata Entry -	nnouncements	s s 🌲 Advisories Case	3 😫 Jane Doe 🔻 Report Entry *
KHUI Pati	ePartr	I erViewer Bookma r Summary	rked Patients	REPORT	Event Notifications	JSER SU	∎ s Lab D. MMARY	iupport ≰ 1 <i>A</i> ata Entry •	nnouncements	5 🌒 🌲 Advisories Case	1) 😧 Jane Doe 👻 Report Entry *
Rational Control Contr	ePartr Ient Search Case Report Entry Use	I erViewer Bookma 'Summary	rked Patients CASE R Start Date	REPORT 07/02/2022	Event Notifications	JSER SU	Lab D. MMARY	iupport v 1 / ata Entry • , 2022	nnouncements	: • Advisories	 Jane Doe Report Entry Reprint Entry
Pate Pate Home LAST UP SHOWING 1 ITEMS	ePartr ient Search Case Report Entry Use	erViewer Bookma 'Summary	rked Patients CASE R Start Date	REPORT 07/02/2022	Event Notifications	ISER SU	Lab D MMARY	Support v1 A	nnouncements	case	Jane Doe ▼ Report Entry * Ø Retrieve Data ▼ APPLY FILTER
Pate Pate	ePartr lent Search Case Report Entry User DATED DATE RANGE REPORT TYPE	CerViewer Bookma rSummary Disease/ ORGANISM	rked Patients CASE R Start Date	REPORT 07/02/2022 PATIENT MRN	Event Notifications	JSER SU	Lab D MMARY and Date 07/02/2	support 43 / sta Entry * 2022 PATIENT SEX \$	nnouncements	Case	 Jane Doe Jane Doe Report Entry * Retrieve Data APPLY FILTER SUBMISSION DATE SUBMISSION DATE
Pati Pati Home LAST UP SHOWING 1 ITEMS ACTIONS View Copy	ePartr ient Search Case Report Entry Use PATED DATE RANGE REPORT TYPE • STD	DISEASE/ ORGANISM	rked Patients CASE F Start Date AFFILIATION/ ORGANIZATION • Test Medical Center	REPORT 07/02/2022 PATIENT MRN JH05052020	Event Notifications	JSER SU E LAST NAME • Hopper	Lab D MMARY and Date 07/02/2 DATE OF BIRTH 05/05/2020	Attentry - Attentry - 2022 - PATIENT SEX - Female	nnouncements	Advisories Case Case LAST UPDATED 07/02/2022 1:00 PM	 Jane Doe Report Entry Retrieve Data Reply FILTER SUBMISSION DATE • 07/02/2022 100 PM



14 Initiate Multi-Drug Resistant Organism Case Report

Upon initiating a Multi-Drug Resistant Organism (MDRO) Case Report on the *Communicable Disease Lab Entry* pop-up notification, Users are automatically navigated to the **Patient Information** screen of the MDRO Case Report.

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

ULTI-DRUG RESISTANT OR	GANISM CASE REPORT FO	DRM	Section 1 of	6	
Please complete the form below. All fields m	arked with an asterisk(*) are required.				
		PATIENT INF	ORMATION		
Patient Information	MDRO Type*			_	
Laboratory Information	Candida auris, clinical				
Exposure Information	lf other, please specify: 🕑				
Hospitalization, ICU, Disposition & Death Information	Grganism Name*			Date of Di	agnosis*
Additional Comments	Select			/mm/dd/	/yyy 🐘 🗌 Unknown
Review and Submit	If other, please specify: @				
	Patient ID (MRN)* 🚱 JH05052020		Affiliation/Organization* 🕢 Test Medical Center	~	
	Person Completing Form*		Affiliation/Organization* 🕑		If other, please specify: 😡
	Person Completing Form* Select	¥	Affiliation/Organization* @ Select	~	If other, please specify: 😡
	Person Completing Form * Select Attending Physician/Clinician *	~	Affiliation/Organization* 🚱 Select Affiliation/Organization* 🚱	~	If other, please specify: 😧 If other, please specify: 🕲
	Person Completing Form * Select Attending Physician/Clinician * Select	~	Affiliation/Organization* Select Affiliation/Organization* Select	v v	If other, please specify: 😡
	Person Completing Form * Select Attending Physician/Clinician * Select Prefix	v v	Affiliation/Organization* Select Affiliation/Organization* Select	v v	If other, please specify: $oldsymbol{\Theta}$ If other, please specify: $oldsymbol{\Theta}$
	Person Completing Form * Select Attending Physician/Clinician * Select Prefix Select	v v	Affiliation/Organization* Select Affiliation/Organization* Select	v v	If other, please specify: 😡 If other, please specify: 😡
	Person.Completing.Form* Select Attending.Physician/Clinician* Select Prefix Select First Name*	v v	Affiliation/Organization* Select Affiliation/Organization* Select	v v	If other, please specify: 😡
	Person.Completing.Form* Select Attending.Physician/Clinician* Select Prefix Select First Name* Jane		Affiliation/Organization* Select Affiliation/Organization* Select	v v	If other, please specify: If other, please specify: If other, please specify: It state the specify state specify state specify specific
	Person.Completing.Form* Select Attending.Physician/Clinician* Select Prefix Select First Name* Jane Suffix		Affiliation/Organization* Select Affiliation/Organization* Select Middle Name Date of Birth*	v v	If other, please specify: If other, please specify: Last Name* Hopper

The following MDRO Case Report screens display certain fields of information that have been autopopulated based on the information entered on the previously submitted Communicable Disease Lab Entry. When necessary, you can change the auto-populated information and enter different details in any of the enabled fields.

- Patient Information screen
- Hospitalization, ICU, Disposition & Death Information screen
- Laboratory Information screen

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Patient Information

The **Patient Information** screen auto-populates with the existing patient demographic details entered on the previously submitted Communicable Disease Lab Entry. Users can change the auto-populated information in any of the enabled fields, as applicable. Users cannot change auto-populated details in disabled fields.

Users **<u>cannot</u>** edit the following auto-populated *MDRO Type*, *Patient ID (MRN)*, *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields which are grayed out and disabled:

- MDRO Type
- Is the Affiliation/Organization the same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
- Patient ID (MRN)
- Affiliation/Organization for Patient ID (MRN)

MULTI-DRUG RESISTANT ORGANISM CASE REPORT FORM

• Date of Birth

- First Name
- Middle Name
- Last Name
- Prefix
- Suffix
- Patient Sex

		PATIENT IN	FORMATION		
Patient Information	MDRO Type*				
aboratory Information	Candida auris, clinical			\sim	
xposure Information	If other, please specify: @				
Hospitalization, ICU, Disposition & Death					
normation	Organism Name*			Date of Di	
Additional Comments				- min da	
Review and Submit	If other, please specify: @				
		(D-1'+ I		and Attack dia - Dh	
	Is the Affiliation/Organization	n same for Patient IL	(MRN), Person Completing Form,	and Attending Ph	lysician/Clinician?*
	Patient ID (MRN)* 🚱		Affiliation/Organization* 🚱		
	JH05052020		Test Medical Center	~	
	Person Completing Form*		Affiliation/Organization* 🕜		If other, please specify: 🚱
	Select	~	Select	~	
	Attending Physician/Clinician	n*	Affiliation/Organization* 😧		If other, please specify: 🚱
	Select		Select	~	
	Prefix				
	Select	~			
	First Name*		Middle Name		Last Name*
	Jane				Hopper
	Culley		Date of Birth		
	Select		05/05/2020		
				-10	
	Patient Sex*		Ethnicity*		Race*
	Female		Not Hispanic or Latino	X Y	white × ~
	Address 1*		Adda	ecs 2	
	right call 1		Addit		

Please Note: The *Disease/Organism*, *Patient ID (MRN)*, *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields are the only disabled fields. All other fields on the **Patient Information** screen and all subsequent screens are enabled. You have the option to edit any of the enabled fields on all screens of the MDRO Case Report.

DDE: Communicable Disease Lab Entry

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Communicable Disease Lab Entry and Initiating Case Reports User Guide

Is the patient currently pregnant?



- 1. You have the option to **edit the auto-populated information** in the following enabled fields:
- Ethnicity
- Race

Phone

•

- Email
- Address, City, State, Zip Code, County

Select	~		
First Name*	Middle Name	La	st Name*
Jane		ł	Hopper
Suffix	Date of Birth*		
Select	05/05/2020		
Patient Sex*	Ethnicity*	Ra	Albita
rellate	Not Hispanic of Lat		white ^ *
Address 1*		Address 2	
123 Hawkins Lane		Unit, Suite, Building, etc.	
		5	
City*		State*	Zip Code
Hankion		KI	40001-
County*	Phone* 😧	En	nail
Fayette	× v (555) 555-5555		eleven@email.com
Is the patient currently pregnant	(?*		
Is the patient currently pregnant Yes No	:?* Unknown		
Is the patient currently pregnant Yes No If yes, please enter the due date	(EDC): @		
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy	(EDC): @		
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy	(EDC): @		
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>ls tl</i>	(EDC): @ Unknown	<i>nant?</i> field is enabled	only when Female is selected
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>Is th</i> or the <i>Patient Sex</i>	(EDC): The patient currently pregrifield on the Patient In	<i>nant?</i> field is enabled f ormation screen	only when Female is selecte of the previously submitte
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>Is tl</i> or the <i>Patient Sex</i> ommunicable Diseas	(EDC): the patient currently preginger field on the Patient In se Lab Entry.	<i>nant?</i> field is enabled I formation screen	only when Female is selecte of the previously submitte
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy lease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Diseas	(EDC): The patient currently pregrifield on the Patient In se Lab Entry. the <i>Is the patient current</i>	<i>nant?</i> field is enabled formation screen	only when Female is selecter of the previously submitter e subsequent field is enable
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Ilease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Disease <i>Yes</i> is selected for the o proceed enter the	the patient currently pregr field on the Patient In se Lab Entry.	<i>hant?</i> field is enabled formation screen <i>by pregnant?</i> field, the	only when Female is selecter of the previously submitte e subsequent field is enable
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Ilease Note: The <i>Is th</i> for the <i>Patient Sex</i> formmunicable Disease Yes is selected for the o proceed, enter the	te patient currently pregr field on the Patient In se Lab Entry. he <i>Is the patient currently</i> Due Date in the subseque	<i>nant?</i> field is enabled f ormation screen <i>ly pregnant?</i> field, the uent field: <i>If yes, plea</i>	only when Female is selecte of the previously submitte e subsequent field is enable ase enter the due date (EDC,
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Disease <i>Yes</i> is selected for the o proceed, enter the	(EDC): Contract of the patient currently pregrifield on the Patient In se Lab Entry. The <i>Is the patient currently</i> be <i>Is the patient currently</i> be an	<i>nant?</i> field is enabled f ormation screen <i>ly pregnant?</i> field, the uent field: <i>If yes, plea</i>	only when Female is selecter of the previously submitte e subsequent field is enable ase enter the due date (EDC)
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Disease Yes is selected for the o proceed, enter the Is the patient currently	(EDC): the patient currently pregination of the patient in the patient in the subsequence of the patient in the subsequence of the patient?*	<i>nant?</i> field is enabled f ormation screen <i>ly pregnant?</i> field, the uent field: <i>If yes, plea</i>	only when Female is selecte of the previously submitte e subsequent field is enable ase enter the due date (EDC)
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Ilease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Disease <i>Yes</i> is selected for the o proceed, enter the Is the patient currently Yes N	(EDC): the patient currently pregn field on the Patient In se Lab Entry. he <i>Is the patient currently</i> Due Date in the subsequence y pregnant?* No Unknown	<i>nant?</i> field is enabled f ormation screen <i>ly pregnant?</i> field, the uent field: <i>If yes, plea</i>	only when Female is selecte of the previously submitte e subsequent field is enable ase enter the due date (EDC)
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Disease <i>Yes</i> is selected for the o proceed, enter the Is the patient currently Yes N	the patient currently pregri field on the Patient In se Lab Entry. he <i>Is the patient currently</i> Due Date in the subsequence y pregnant?* No Unknown	<i>nant?</i> field is enabled I formation screen <i>ly pregnant?</i> field, the uent field: <i>If yes, plea</i>	only when Female is selecter of the previously submitter e subsequent field is enabler ase enter the due date (EDC)
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Iease Note: The <i>Is th</i> or the <i>Patient Sex</i> formunicable Disease <i>Yes</i> is selected for the o proceed, enter the Is the patient currently Yes N If yes, please enter the	the patient currently pregrifield on the Patient Inse Lab Entry. The Js the patient currently pregrifield on the Patient Inse Lab Entry. The Js the patient currently Due Date in the subsequence of the patient currently of the patient current of the subsequence of the patient of the subsequence of the subse	<i>nant?</i> field is enabled f ormation screen <i>ly pregnant?</i> field, the uent field: <i>If yes, plea</i>	only when Female is selecte of the previously submitte e subsequent field is enable ase enter the due date (EDC)
Is the patient currently pregnant Yes No If yes, please enter the due date mm/dd/yyyy Ilease Note: The <i>Is th</i> or the <i>Patient Sex</i> ommunicable Disease <i>Yes</i> is selected for the o proceed, enter the Is the patient currently Yes N If yes, please enter the mm/dd/yyyy	Present currently pregn ie Dotte in the subsequent be patient currently pregn field on the Patient In se Lab Entry. he <i>Is the patient currently</i> Due Date in the subsequent y pregnant?* No Unknown e due date (EDC):* ?	<i>hant?</i> field is enabled formation screen <i>ly pregnant?</i> field, the Jent field: <i>If yes, plea</i>	only when Female is selecte of the previously submitte e subsequent field is enable ase enter the due date (EDC)



To complete the **Patient Information** screen, you must **enter the appropriate information** in the mandatory blank fields marked with **red asterisks** (*), as applicable:

- Organism Name
- Date of Diagnosis
- Person Completing Form
- Affiliation/Organization of Person Completing
 Form
- Attending Physician/Clinician
- Affiliation/Organization of Attending Physician/Clinician

PATIENT IN	FORMATION			
MDRO Type*				
Candida auris, clinical	1			
If other, please specify: 🚱				
Organism Name*		Date of Di	agnosis*	
βelect	~	mm/dd/	уууу	🟥 🗌 Unknown
Infection caused by Candida auris				
Infection caused by Candida auris Is the Affiliation/Organization same for Patient II Yes No Patient ID (MRN)* @	D (MRN), Person Completing Form, a Affiliation/Organization* @	nd Attending Ph	ysician/Clinician?*	
Infection caused by Candida auris Is the Affiliation/Organization same for Patient II Yes No Patient ID (MRN)* @ JH05052020	D (MRN), Person Completing Form, a Affiliation/Organization* @ Test Medical Center	nd Attending Ph	ysician/Clinician?*	
Infection caused by Candida auris Is the Affiliation/Organization same for Patient II Yes No Patient ID (MRN)* @ JH05052020 Person Completing Form *	D (MRN), Person Completing Form, a Affiliation/Organization* @ Test Medical Center Affiliation/Organization* @	nd Attending Ph	ysician/Clinician?* If other, please	specify: @
Infection caused by Candida auris Is the Affiliation/Organization same for Patient II Yes No Patient ID (MRN)* @ JH05052020 Person Completing Form* Select	D (MRN), Person Completing Form, a Affiliation/Organization* @ Test Medical Center Affiliation/Organization* @ Select	nd Attending Ph	ysician/Clinician?* If other, please	specify:
Infection caused by Candida auris Is the Affiliation/Organization same for Patient II Yes No Patient ID (MRN)* JH05052020 Person Completing Form* Select Attending Physician/Clinician*	D (MRN), Person Completing Form, a Affiliation/Organization* @ Test Medical Center Affiliation/Organization* @ Select Affiliation/Organization* @	nd Attending Ph	ysician/Clinician?* If other, please If other, please	specify: @

Communicable Disease Lab Entry and **Deloitte.** Initiating Case Reports User Guide Please Note: If the appropriate name does not display in the Person Completing Form or Attending Physician/Clinician dropdown menus, you must create details for a new Person Completing Form or new Attending Physician/Clinician. To create details for a new Person Completing Form, click the Person Completing Form hyperlink. Upon clicking the hyperlink, the *Person Completing Form* pop-up displays. To create details for a new Attending Physician/Clinician, click the Attending **Physician/Clinician** hyperlink. Upon clicking the hyperlink, the *Attending Physician/Clinician* pop-up displays. To proceed, enter the details in the appropriate fields of the pop-up and click **Save**. Person Completing Form* Affiliation/Organization* 🕑 If other, please specify: 🚱 \sim \sim Select Select...

Affiliation/Organization* 😧

Select...

 \sim

Attending Physician/Clinician*

Select...

If other, please specify: 🔞

 \sim



2. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Laboratory Information** screen.

		PATIENT INF				
tient Information		MDRO Type*				
boratory information	a	Candida auris, clinical				
posure Information	_	If other, please specify: 😡				
snitalization. ICLI. Disposition & Death	A					
ormation		Organism Name*		Date of Diag	nosis*	
ditional Comments	a	Infection caused by Candida auris		× ~ 07/01/202		known
view and Submit	_	If other, please specify: 😡				
		Is the Affiliation/Organization same for Patient ID (MRM Yes No	N), Person Completing Form, and	Attending Physician/Clini	ician?*	
		Patient ID (MRN)* 🛛	Affiliation/Organization* 🚱			
		JH05052020	Test Medical Center	~		
		Person Completing Form *	Affiliation/Organization* 🚱		If other, please specify: @	
		Mr. Arthur Vandelay, II (arthur@email.co × V	Test Medical Center	x ~		
		Attending Physician/Clinician*	Affiliation/Organization*	V Lu	If other, please specify:* @	
		Dr. Frank Costanza, Sr (rank@email.com) ×	Other	^ I *	General Hospital	
		Prefix				
		Select				
		First Name*	Middle Name		Last Name*	
		Jane			nopper	
		Suffix	Date of Birth*			
		Patient Sex*	Not Hispanic or Latino	× ~	Race*	×
		Address 1*		Address 2		
		123 Hawkins Lane		Unit, Suite, Building, etc.		
		City*		State*	Z	ip Code
		Frankfort		KY	X V	40601-
		County*	Phone* @		Email	
		Fayette ×	(555) 555-5555		eleven@email.com	
		Is the patient currently pregnant?* Yes No Unknown If yes, please enter the due date (EDC): @				



Laboratory Information

The **Laboratory Information** screen displays details about the laboratory test that have been autopopulated based on the information previously entered on the Communicable Disease Lab Entry.

3. You have the option to **edit the auto-populated information** in the following enabled fields:

- Does the patient have a lab test?
- Laboratory Name
- Test Name
- Filler Order/Accession Number
- Specimen Source

IULTI-DRUG RESISTANT	DRGANISM CASE REPORT FORM Section 2 of 6	
Please provide laboratory information relate	to this case.	
	LABORATORY INFORMATION	
Patient Information	Does the patient have a lab test?*	
Laboratory Information	Yes No Unknown	
Exposure Information	A	
Hospitalization, ICU, Disposition & Death	Laboratory Information	
Information	Laboratory Name*	
Additional Comments	General Hospital	
eview and Submit	Ordering Provider/Clinician*	
	Select V	
	Test Name*	
	Candida auris ITS2 gene (Presence) in Unspecified specimen by NAA with probe detection	x ~
	If other, please specify:	
	Miles Andreitheannaise Mannahan 🖨	
	Hier Graer/Accession Number &	
	Specimen Source*	×
	ADSCess	~ I ·
	Ir orner, piease speciry: 👽	
	Varia Manuslak	
	Other	×
	If other, please specify;* 😡	
	Detected	
	Tect Result Date* Specimen Collection Date*	
	07/02/2022 D1known 07/01/2022	nknown
	Tuna of Cultura	
	Select	
	Location of the patient at the time of specimen collection*	
	If other, please specify, 🖗	
	n warne) produk inportuj t 👟	
	Facility Name/Location* Facility County*	
	Select	\
	Additional Information	
	Observation 2 - MDRO details	
	O Add Test	
	Is this part of an outbreak?*	
	Yes No Unknown	
	If yes, please specify the name of the outbreak: 🚱	

Test Result Date
 Specimen Collection Date

Test Result

• Additional Information



• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Laboratory Information** screen: *Does the patient have a lab test?*

LABO Does the patient have a lab t Yes No Please Note: If <i>No</i>	est?* Unknown	LABORATORY INFORMATION Does the patient have a lab test?* Yes No Unknown Image: Colspan="2">Open and the colspan="2" The colspan="2" The colspan" The c
Laboratory Informa	tion screen, the subseque	nt fields are disabled.
MULTI-DRUG RESISTANT OR Please provide laboratory information relate	GANISM CASE REPORT FORM and to this case. LABORATORY	Section 2 of 6
Patient Information	Does the patient have a lab test?* Yes No Unknown	
Exposure Information	Laboratory Information Laboratory Name	
Information	Ordering Provider/Clinician	
Additional Comments Review and Submit	Extenses Select.	
	If other, please specify:	

- If you change the selection for the conditional question, a pop-up notification will display with a message that states: *Please note that all selections on this screen will be reset. Are you sure you want to change your response?*
- To reset the previous selection for the conditional question, click **Yes** on the pop-up notification.

Hospitalization, ICU & Death Information	۵	Genera	Laboratory Information ×
Vaccination History	۵	Test Nam Dengue	Please note that all selections on the screen will be
Additional Comments		If other, p	response?
Review & Submit	a	Filler Orc	Yes No
Please Note: If Ot menus, the subse To proceed, you enabled: <i>If other,</i>	t her is quent must <i>please</i>	selected textbox enter t e specify.	from the <i>Test Name, Specimen Source</i> , or <i>Test Result</i> dropdown fields are enabled. The appropriate details in the subsequent textbox field(s), if



Test Name*		
Other		x ~
If other, please specify:*		

- 4. You must **enter the appropriate information** in the following blank fields, as applicable:
 - Ordering Provider/Clinician
 - Type of Culture (Optional)

- Facility Name/Location
- Facility County
- Location of patient at the time of specimen collection

Ordering Provider/Clinician*				
Select				
Fest Name*				
Candida auris ITS2 gene [Presence] in C	Unspecified specimen by NAA with p	probe detection		x Y
f other, please specify:				
Filler Order/Accession Number 🚱				
JH07012022				
Specimen Source*				
Abscess				× ~
if other, please specify: 😡				
Test Result*				
Other				x ~
lf other, please specify:* 🚱				
Detected				
Test Result Date*		Specimen Collection Date*		
07/02/2022	🛗 🗌 Unknown	07/01/2022	📋 🗌 Unk	nown
Type of Culture				
Select	~			
Location of the patient at the time of spe	cimen collection*			
Select		~ ·		
If other, please specify: 😡				
Facility Name/Location* 🚱			Facility County* 😧	
			Select	~
Additional Information 😧				
Observation 2 - MDRO details				

|--|

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Please Note: If the appropriate name does not display in the *Ordering Provider/Clinician* dropdown menu, you must create details for a new Ordering Provider/Clinician by clicking the **Ordering Provider/Clinician hyperlink**. Upon clicking the hyperlink, the *Ordering Provider/Clinician* pop-up displays. To proceed, enter the details in the appropriate fields of the *Ordering Provider/Clinician* pop-up and click **Save**.

General Hospital

Ordering Provider/Clinician*

Please Note: If *Other healthcare setting* is selected from the *Location of the patient at the time of specimen collection* dropdown menu, the subsequent textbox field is enabled.

To proceed, you must **enter the name of the healthcare setting** in the subsequent textbox field: *If other, please specify*.

her healthcare setting	× ~	
han alaan aanif a t O		

5. You also have the option to click **Add Test** to add additional tests for the patient.

Observation 2 details			
21/300 Characters			
Add Test			
Save	Previous	Next	

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

Laboratory Information	
Laboratory Name*	
Ordering Provider/Clinician *	
Select ~	
Test Name*	
Select	~
If other, please specify:	
Filler Order/Accession Number 🔞	





- 6. To complete the **Laboratory Information** screen, you must **enter the appropriate information** in the mandatory blank fields marked with **red asterisks** (*):
- Is this part of an outbreak?

• Was the organism previously identified?

Is this part of an outbreak?	*	
Yes No	Unknown	
n yes, please specify the ha	me or the outpreak.	
Was the organism previous	ly identified?*	
Yes No	Unknown	
ii yes, piease provide the da	ne.	
mm/dd/yyyy	🛗 🗌 Unknown	
Save		Previous
field is enabled. T textbox field: <i>If ot</i>	es is selected for the <i>Is this part of</i> To proceed, you must enter the r <i>ther, please specify the name of the</i>	<i>an outbreak?</i> field, the subsequent textbox name of the outbreak in the subsequent <i>outbreak</i> .
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7. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Exposure Information** screen.

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	pitalization. ICU. Disposition & Death	Laboratory Information		
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Fet Name* Get check Get check Fet Check Fet Check Fet Check Get check		Dr. Niles Crane, II (nilescrane@email.com)	x v	
candid auto Diak/reserved by Mak with pothe detection in Positive Eliod culture Finder::::::::::::::::::::::::::::::::::::		Test Name*		
<pre>former</pre>		Candida auris DNA [Presence] by NAA with probe detection in Positive blood culture		×
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Add Test Is this part of an outbreak?* Yes No Unknown If yes, please specify the name of the outbreak;* Was the organism previously identified?* Yes, please provide the date;* 64:27/2022 Unknown		Test Result Date* 0700220022 Type of Culture Clinical Cocation of the patient at the time of specimen collection* Acute Care hospital (inpatient) If other, please specify: @ Facility Name/Location* General Hospital Additional Information @ Observation 2 - MDRO details	Specimen Collection Date*	nown X
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To proceed, you must enter the **appropriate information** in the enabled fields on the screen. Once complete, click **Next** to navigate to the subsequent **Hospitalization**, **ICU & Death Information** screen.



Hospitalization, ICU, Disposition & Death Information

The **Hospitalization**, **ICU**, **Disposition & Death Information** screen displays details about a patient's hospitalizations that have been auto-populated based on the previously submitted Communicable Disease Lab Entry.

- 8. You have the option to **edit the auto-populated information** in the following enabled fields:
 - Was the patient hospitalized at the time of specimen collection?
 - Was the patient admitted to an intensive care unit (ICU)?

		HOSPITALIZATION	N, ICU, DISPOSITION & DEATH	INFORMATION	
atient Information	Ø	Was the patient hospitalized at time	of specimen collection?*		
aboratory Information	0	Yes No Ur	iknown		
xposure Information	0				
ospitalization, ICU, Disposition & De	eath	If yes, please specify the hospital na	me:* 😡		
dditional Comments		If hospitalized, please specify the ty	pe of facility that the patient was admitte	ed from:*	
niew and Cubmit	_	Select			
view and submit	-	Facility Name:* 🛛			
		Admission Date*		Discharge Date*	
		mm/dd/yyyy	🗎 🗌 Unknown	mm/dd/yyyy	🗎 🗌 Unknov
				Still hospitalized	Expired
		If expired, please provide the date of	of death:		
		Date of Death			
		mm/dd/yyyy	Unknown		
		If discharged, please specify the loc	ation:		
		Select			
		Please specify the name of the facil	ty/location where the patient has been d	lischarged to: 😡	
		Please specify the name of the facili Was the receiving facility notified of Yes No Ur	ty/location where the patient has been d the patient's MDRO? known	lischarged to: 🛛	
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DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange



Please Note : If the Communicable Disease La the selection for the conditional question at the Death Information screen is auto-populated <i>specimen collection?</i>	b Entry indicated that the patient was hospitalized, he top of the Hospitalization, ICU, Disposition & as Yes : <i>Was the patient hospitalized at the time of</i>
If Yes is selected for the conditional que hospitalization-related fields and ICU-related fields and ICU-re	estion at the top of the screen, the subsequent ed fields are enabled.
If the Communicable Disease Lab Entry indicatesselection for the ICU-related question is auto-<i>intensive care unit (ICU)?</i>	ated that the patient was admitted to the ICU, the populated as Yes : <i>Was the patient admitted to an</i>
 If Yes is selected for the ICU-related questing <i>Discharge Date</i> fields are enabled. To proceed and the Discharge Date from ICU in the area 	ion, the subsequent <i>Admission Date</i> and ceed, you must enter the Admission Date to ICU appropriate fields.
Was the patient admitted to an intensive care unit (ICU)?* Yes No Unknown Admission Date to ICU* mm/dd/yyyy Unknown	Discharge Date from ICU* mm/dd/yyyy

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Hospitalization**, **ICU**, **Disposition & Death Information** screen: *Was the patient hospitalized at the time of specimen collection*?

Was the patien	t hospitalized	at time of specimen collec	tion?*	Was the patient	hospitalized	at time of speci	men collection?*
Yes	No	Unknown		Yes	No	Unknown	
)						•

Please Note: If *No* or *Unknown* is selected for the conditional question at the top of the **Hospitalization**, **ICU**, **Disposition & Death Information** screen, the subsequent hospitalization-related fields and ICU-related fields are disabled.

• The *Was the patient previously hospitalized at your facility within the last 6 months*? field is <u>not</u> impacted by the selected answer for the conditional question: *Was the patient hospitalized at the time of specimen collection?*

Communicable Disease Lab Entry and Initiating Case Reports User Guide



		HOSPITALIZATION, ICU, DISPOSITION & DEATH INFORMATION	
Patient Information	0	Was the patient hospitalized at time of specimen collection?*	
Laboratory Information	0	Yes No Unknown	
Exposure Information	8		
Hospitalization, ICU, Disposition & Death Information		n yes, prease speciny the nospital name. 😿	
Additional Comments	۵	If hospitalized, please specify the type of facility that the patient was admitted from:	
Review and Submit	۵		
		Facility Name: 😡	
		Please specify the name of the facility/location where the patient has been discharged to:	
		Yes No Unknown	
		Was the patient admitted to an intensive care unit (ICU)? Yes No Admission Date to ICU Discharge Date from ICU min/idd/yyyy IIII Unknown Yas the patient previously hospitalized at your facility within the last 6 months?* Yes No Unknown	
		If yes, please specify the hospital name: $m O$	_

- You must enter the appropriate information in the mandatory fields marked with red asterisks (*), if enabled:
- If yes, please specify the hospital name
- If hospitalized, please specify the type of facility that the patient was admitted from.
- Facility Name
- Admission Date

Discharge Date

HOSPITALIZATION, ICU, DISPOSITION & DEAT	H INFORMATION
Was the patient hospitalized at time of specimen collection?* Yes No Unknown	
If yes, please specify the hospital name:* 🛛	
If nospitalized, please specify the type of facility that the patient was admit Select	ited from:*
Facility Name:*	
Admission Date*	Discharge Date*
mm/dd/yyyy 🛗 🗌 Unknown	mm/dd/yyyy 🚔 🗌 Unknown
	Still hospitalized Expired
If expired, please provide the date of death:	
Date of Death	





- If *Long Term Care Facility, Other Health Care Facility*, or *Other* is selected from the *If hospitalized, please specify the type of facility that the patient was admitted from* dropdown menu, the subsequent field is enabled.
 - To proceed, you must enter the **name of the facility that the patient was admitted from** in the subsequent enabled field: *Facility Name*.

If hospitalized, please specify the type of	f facility that the patient was admitted fro		
Long Term Care Facility			X V
Facility Name:* 🛿			
Please Note: If <i>Home</i> i the patient was admitte	s selected from the <i>lf l</i> ed from dropdown mer	nospitalized, please sp iu, the subsequent Fac	<i>ecify the type of facility tha</i> <i>cility Name</i> field is disabled.
If discharged, please specify the location	*		× ~
Please specify the name of the facility/lo	cation where the patient has been dischar	ged to: 🚱	
lease Note: If the pat	ient is deceased, click	the Expired Checkbo	x below the <i>Discharge Dat</i>
eia. Upon clicking the	Expired Checkbox, t	ne subsequent death-	related field is enabled. I
proceed, enter the Dat	e of Death in the subse	quent field: <i>Date of De</i>	eath.
		Still benitalized	Evpired
		Still hospitalized	Z Expired
If expired, please provide the date	of death:	Still hospitalized	Z Expired
If expired, please provide the date Date of Death* mm/dd/yyyy	of death:	Still hospitalized	Expired
If expired, please provide the date Date of Death* mm/dd/yyyy	of death:	Still hospitalized	Expired
If expired, please provide the date Date of Death* mm/dd/yyyy	of death:	Still hospitalized	Expired
If expired, please provide the date Date of Death* mm/dd/yyyy	of death:	Still hospitalized	Expired Expired
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel	of death: Unknown ering the Discharge Da ated field is enabled. S	te , the subsequent <i>Da</i> Select the type of loc	Expired Expired Expired Expired Expired
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel	of death: Unknown ering the Discharge Da ated field is enabled. So charged please specify	Still hospitalized te , the subsequent <i>Da</i> Select the type of loc <i>the location</i>	Expired Expire
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel tropdown menu: <i>If disc</i>	of death: Unknown ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized te , the subsequent <i>Da</i> Select the type of loc <i>the location.</i>	Expired Expire
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel tropdown menu: <i>If disc</i>	of death: ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized te , the subsequent <i>Da</i> Select the type of loc <i>the location.</i>	Expired Expire
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent while the discharge-rel propdown menu: <i>If disc</i>	of death: iii Unknown ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized te , the subsequent <i>Da</i> Select the type of loc <i>the location.</i>	Expired Expire
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel propdown menu: <i>If disc</i> Date of Death mm/dd/yyyy	of death:	Still hospitalized Still hospitalized Select the type of loc <i>the location.</i>	Expired Expire
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel tropdown menu: <i>If disc</i> Date of Death mm/dd/yyyy If discharged, please specify the location Select	of death: ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized te , the subsequent <i>Da</i> Select the type of loc <i>the location.</i>	Expired Exp
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel lropdown menu: <i>If disc</i> Date of Death mm/dd/yyyy	of death: ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized	Expired Expire
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel dropdown menu: <i>If disc</i> Date of Death mm/dd/yyyy If discharged, please specify the locatio Select Home	of death: iii Unknown ering the Discharge Da ated field is enabled. S charged, please specify iii Unknown	Still hospitalized	Expired
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel Iropdown menu: <i>If disc</i> Date of Death mm/dd/yyyy If discharged, please specify the locatio Select Home Long Term Care Facility	of death: ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized	Expired ate of Death field is disable ation from the subsequer
If expired, please provide the date Date of Death* mm/dd/yyyy Please Note: Upon ent vhile the discharge-rel lropdown menu: <i>If disc</i> Date of Death mm/dd/yyyy If discharged, please specify the locatio Select Home Long Term Care Facility Other Health Care Facility	of death: ering the Discharge Da ated field is enabled. S charged, please specify	Still hospitalized	Expired Exp





- If *Long Term Care Facility, Other Health Care Facility*, or *Other* is selected from the *If discharged, please specify the location* dropdown menu, the subsequent fields are enabled.
 - To proceed, you must **enter the appropriate information** in the subsequent fields:
 - *Please specify the name of the facility/location where the patient has been discharged to.*
 - Was the receiving facility notified of the patient's MDRO?

If discharged, please specify the location:* Long Term Care Facility X
Please specify the name of the facility/location where the patient has been discharged to:* General Hospital Was the president facility petified of the patient's MDDO2*
Yes No Unknown
Please Note : If <i>Home</i> is selected from the <i>If discharged, please specify the location</i> dropdown menu, the subsequent fields are disabled:
• Please specify the name of the facility/location where the patient has been discharged to.
• Was the receiving facility notified of the patient's MDRO?
If discharged, please specify the location:* Home X V
Please specify the name of the facility/location where the patient has been discharged to: 🚱
Was the receiving facility notified of the patient's MDRO?
Yes No Unknown

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the ICU-related question: *Was the patient admitted to an intensive care unit (ICU)*?

Was the patient	admitted to	an intensive care	unit (ICU)?*	Was the patient	admitted to	an intensive care	unit (ICU)?*
Yes	No	Unknown		Yes	No	Unknown	
Admission Date	to CU*			Admissio, Date	to ICI		
mm/dd/yyyy			🛗 🗌 Unknown	mm/dd/yyyy			Unknown

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Please Note: If Yes is select Discharge Date fields a	cted for the ICU-rela are enabled.	ated question, the subse	quent <i>Admission Date</i> and
To proceed, enter the appropriate fields.	Admission Date to	ICU and the Discharge	Date from ICU in the
Was the patient admitted to an intensive ca Yes No Unknown Admission Date to ICU* mm/dd/yyyy	ire unit (ICU)?*	Discharge Date from ICU* mm/dd/yyyy	🖮 🗌 Unknown

10. To complete the **Hospitalization**, **ICU**, **Disposition & Death Information** screen, you must complete the following mandatory fields marked with **red asterisks** (*), if enabled:

•

- Admission Date to ICU
- Discharge Date from ICU
- *Was the patient previously hospitalized at your facility within the last 6 months?*

Was the patient admitted to an intensive Yes No Unkno	e care unit (ICU)?* wn		
Admission Date to ICU*		Discharge Date from ICU*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 📃 Unknown
Was the patient previously hospitalized Yes No Unkno	at your facility within the last 6 months	*	
If yes, please specify the hospital name:	0		

- If **Yes** is selected for the *Was the patient previously hospitalized at your facility within the last 6 months*? field, the subsequent fields are enabled. To proceed, you must **enter the appropriate information** in the subsequent enabled fields:
 - If yes, please specify the hospital name. Discharge Date
 - Admission Date



Communicable Disease Lab Entry and Initiating Case Reports User Guide



yes, please provide admission a	and discharge dates:			_
Imission Date* mm/dd/yyyy	🖮 🗌 Unknown	Discharge Date* mm/dd/yyyy	🛗 🗌 Unknown	
Add Additional Hospitalizatio	on Date			
Save			Previous Next	
Save			Previous Next	

f yes, please specify the hospital nam	e: 😡		
f yes, please provide admission and d	lischarge dates:		
dmission Date		Discharge Date	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Add Additional Hospitalization Da	ite		

11. You also have the option to click **Add Additional Hospitalization Date** to add additional hospitalization dates if the patient has been hospitalized at your facility multiple times within the last 6 months.

Admission Date*		Discharge Date*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Add Additional Hospitalization	Date		
Add Additional Hospitalization	Date		



Communicable Disease Lab Entry and Initiating Case Reports User Guide



Was the patient previously hospitalized	at your facility within the last 6 month	5?*	
Yes No Unkno	wn		
If yes, please specify the hospital name:	* 0		
Test Hospital			
If yes, please provide admission and dis	charge dates:		
Admission Date*		Discharge Date*	
mm/dd/yyyy	🌐 🗹 Unknown	04/01/2021	🛗 🗌 Unknown
Admission Date*		Discharge Date*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Add Additional Hospitalization Date			
Save			Previous





12. Once the appropriate edits and additions have been made, click **Next** to proceed to the **Additional Comments** screen.

		HOSPITALIZATION	N, ICU, DISPOSITION & DEATH II	NFORMATION		
itient Information	Ø	Was the patient hospitalized at time of spe	cimen collection?*			
boratory Information	0	Yes No Unknown				
posure information	0					
roitalization I/11 Disperition & Death		If yes, please specify the hospital name:* 🚱	•			
mation		General Hospital				
litional Comments	a	If hospitalized, please specify the type of fa	cility that the patient was admitted from:*			
iew and Submit		Long Term Care Facility				×
		Facility Name:* 🕖				
		Test Facility				
		Admission Date*		Discharge Date*		
		06/30/2022	🛗 🗌 Unknown	07/02/2022	iii Unknown	
				Still hospitalized	Expired	
		If expired, please provide the date of death	Σ.			
		Date of Death				
		mm/dd/yyyy	Onknown			
		If discharged, please specify the location:*				
		Long Term Care Facility				×
		Please specify the name of the facility/locat	ion where the patient has been discharged	to:* 🚱		
		General Hospital				
		Was the receiving facility notified of the pat	ient's MDRO?*			
		Yes No Unknown				
		Was the patient admitted to an intensive ca	are unit (ICU)?*			
		Yes No Unknown				
		Admission Date to ICU*		Discharge Date from ICU*		
		07/01/2022	111 Unknown	07/02/2022	Unknown	
		Was the patient previously hospitalized at y	our facility within the last 6 months?*			
		Yes No Unknown				
		If yes, please specify the hospital name:* @				
		General Hospital				
		If yes, please provide admission and discha	rge dates:			
				Discharge Date*		
		Admission Date*		pipeliai Re pare.		

Please Note: The subsequent **Additional Comments** screen of the MDRO Case Report does <u>not</u> include any auto-populated information from the Communicable Disease Lab Entry.

• To proceed, enter the **additional information** in the enabled textbox field. Once complete, click **Next** to navigate to the **Review and Submit** screen.

For specific information on how to complete these screens of the MDRO Case Report, please review the *Direct Data Entry for Electronic Case Reports: Multi-Drug Resistant Organism User Guide* on the KHIE website.



Review and Submit: MDRO Case Report

Once the appropriate edits and additions have been made on all the MDRO Case Report screens, you will be navigated to the **Review and Submit** screen. The **Review and Submit** screen displays the summary of the information you have entered. Prior to submitting the MDRO Case Report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report.

13. Review the information on the **Review and Submit** screen.

ULTI-DRUG RESISTANT ORGANIS	M CASE REF	PORT FORM	Section 6 of 6		•
Please review your information before submitting	ç.				
		REVIE	EW & SUBMIT		
Patient Information	0				101
aboratory Information	0			Print	Download
xposure Information	0	Datient Information			•
lospitalization, ICU, Disposition & Death Iformation	0	MDRO Type			W
dditional Comments	0	Candida auris, clinical			
Review and Submit		Organism Name Infection caused by Candida auris Is the Affiliation/Organization same for Patient ID (MRI	Date of Diagnosis 07/01/2022 NJ, Person Completing Form, and Attending Physician/Clinician?		
		Patient ID (MRN) JH05052020	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 Other	If other, please specify: General Hospital	
		First Name Jane	Last Name Hopper		
		Date of Birth 05/05/2020			
		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White	
		Address 1 123 Hawkins Lane			
		City	State	Zin Code	

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

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

15. 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.

Admissi 06/15/2	Case Report Entry ×	rge Date 2021
Additio	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.	0
Addition Patient I	Cancel Submit	

DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange



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

			Admission Date to IC 10/01/2021 Did the patient die as No Vaccination Histo	Case Report	t Entry y Saved Successfu	lly	0	× Discharge D 10/02/2021	Date from ICU			0
Please automa • For <i>Ca</i> :	Note : Cl atically nav specific ir <i>se Report</i> :	icking O vigate yo nformatio <i>Entry Use</i>	K when thu to the C arbon on the C arbon o	he case ase Rep Case Re ry sectio	e repor port En eport Ei on of th	t e tr <u></u> nt	entry ha y User S ry User guide.	as beer Summa Summa	n subr ry scr ary sc	mitted reen. reen ,	l success please re	fully will eview the
KĤU Patient	ePar	tnerViev Bookm	VET arked Patients		Event Notifica	ations	ī	Support	ata Entry -	ncements 5	Advisories 3	O Jane Doe 👻 🖓
THOME	 Case Report Entry I 	Jser Summary	CASE RE	EPORT	ENTRY	ſι	JSER SI	UMMA	RY			
C LAST UPI	DATED DATE RAN	GE	Start Date	07/02/2022			Er	nd Date (^{07/02}	/2022			C Retrieve Data
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	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane		Hopper	05/05/2020	Female	Complete	07/02/2022 1:00 PM	07/02/2022 1:00 PM
			First	Back 1 Nex	xt Last						Maximum 5	 entries per page
	Copyright 2019 Heal	thInteractive			HealthInterac	HIE					Version: 1.0.0	



15 Initiate Perinatal Hepatitis Case Report

Upon initiating a Perinatal Hepatitis Case Report on the *Communicable Disease Lab Entry* pop-up notification, Users are automatically navigated to the **Patient Information** screen of the Perinatal Hepatitis Case Report.

The Perinatal Hepatitis Case Report is a nine-step process where Users enter (1) Patient Information, (2) Laboratory Information, (3) Applicable Symptoms, (4) Medical Conditions, (5) Exposure Information, (6) Hospitalization, ICU & Death Information, (7) Vaccination History, (8) Additional Comments, (9) Review and Submit. The **Review & Submit** screen is where Users must review the information entered and submit the Perinatal Hepatitis Case Report.

		PAT		ORMATION		
Patient Information		Disease/Organism* 0		Date of Diagnosis*		
Laboratory Information	۵	Perinatal Hepatitis 8	Υ.	mm/dd/yyyy	節	Unknown
Applicable Symptoms						
Medical Conditions	۵	Is the Affiliation/Organization Yes No	same for Pa	tient ID (MRN), Person Completing	; Form, ar	d Attending Physician/Clinician?*
Exposure Information	_	Patient ID (MRN)*		Affiliation/Organization* 🚱		
Hospitalization, ICU & Death Information	A	EB02151970		Test Medical Center	~	
		Person Completing Form*		Affiliation/Organization* 😧		If other, please specify: 😡
vaccination History		Select	~	Select	×.	
Additional Comments	-	Attending Physician/Clinician*		Affiliation/Organization* 🚱		If other, please specify: 😡
Review & Submit		Select	×	Select	1	
		Prefix				
		Miss	Ŷ			
		First Name*		Middle Name		Last Name*
		Flaine				Benes

The following Perinatal Hepatitis Case Report screens display certain fields of information that have been auto-populated based on the information entered on the previously submitted Communicable Disease Lab Entry. When necessary, you can change the auto-populated information and enter different details in any of the enabled fields.

- Patient Information screen
- Applicable Symptoms screen
- Hospitalization, ICU & Death Information screen
- Laboratory Information screen
- Additional Information screen

Patient Information

The **Patient Information** screen auto-populates with the existing patient demographic details entered on the previously submitted Communicable Disease Lab Entry. Users can change the auto-populated information in any of the enabled fields, as applicable. Users cannot change auto-populated details in grayed out and disabled fields.

Users **<u>cannot</u>** edit the following auto-populated *Disease/Organism*, *Patient ID (MRN*), *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields which are grayed out and disabled:

- Disease/Organism
- Is the Affiliation/Organization the same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
- Patient ID (MRN)
- Affiliation/Organization for Patient
 MRN
- Date of Birth
- First Name

•

• Middle Name

- Last Name
- Prefix
- Suffix
- Patient Sex

Disease/Organism* 2		Date of Diagnosis*		
Perinatal Henatitis B	~	mm/dd/www	⇒ [Unknown
r enhaurnepadus b		inin daryyyy		
Is the Affiliation/Organization same	for Patient ID (MRN), Person Completing Form, and Attending Ph	nysician/Clini	cian?*
Yes No				
		Affiliation (Organization + 9		
		Amiliation/Organization*		
JH05052020		Test Medical Center		
Person Completing Form*		Affiliation/Organization* 😧		If other, please specify: 🚱
Select	~	Select	\sim	
Attending Physician/Clinician*		Affiliation/Organization* 🚱		lf other, please specify: 🚱
Select	~	Select	×	
Drafix				
Soloct				
Select				
First Name*		Middle Name		Last Name*
Jane				Hopper
Suffix		Maiden Name		
Select	~			
Date of Birth*		Ethnicity*		Race*
		-		



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Please Note: The *Disease/Organism*, *Patient ID (MRN)*, *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields are the only disabled fields. All other fields on the **Patient Information** screen and all subsequent screens are enabled. You have the option to edit any of the enabled fields on all screens of the Perinatal Hepatitis Case Report.

1. You have the option to **edit the auto-populated information** in the following enabled fields:

• Ethnicity

Phone

• Race

- FIIONE
- Email
- Address, City, State, Zip Code, County
- Is the patient currently pregnant?

Suffix		Date of Birth*			
Select		05/05/2020			
Patient Sex*		Ethnicity*		Race*	
Female		Not Hispanic or Latir	о × ~	White	x ~
Address 1*			Address 2		
123 Hawkins Lane			Unit, Suite, Building,	etc.	
City*			State*		Zip Code
Frankfort			KY	$\times \mid \checkmark$	40601-
County*		Phone* 😧		Email	
Fayette	× ~	(555) 555-5555		eleven@email.com	
		()			
Is the patient currently pre	egnant?*				
Yes No	Unknown				
If ves, please enter the due	e date (EDC): 🔞				

Please Note: The *Is the patient currently pregnant?* field is enabled only when *Female* is selected for the *Patient Sex* field on the **Patient Information** screen of the previously submitted Communicable Disease Lab Entry.

• If **Yes** is selected for the *Is the patient currently pregnant?* field, the subsequent field is enabled.

To proceed, enter the **Due Date** in the subsequent field: *If yes, please enter the due date (EDC)*.


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Yes	No	Unknown		
es, please er	ter the due o	date (EDC): * 		

- 2. You must **enter the appropriate information** in the mandatory blank fields marked with **red asterisks** (*):
 - Date of Diagnosis
 - Person Completing Form
 - Affiliation/Organization of Person Completing Form
- Attending Physician/Clinician
- Affiliation/Organization of Attending Physician/Clinician

PA	TIENT INF	ORMATION		
Disease/Organism* 🕑 Perinatal Hepatitis B		Date of Diagnosis* mm/dd/yyyy		Unknown
Is the Affiliation/Organization same for Pa Yes No Patient ID (MRN)* JH05052020	atient ID (MRN), Person Completing Form, and Attending I Affiliation/Organization* @ Test Medical Center	Physician/Clin	ician?*
Person Completing Form *	~	Affiliation/Organization* 🛛		If other, please specify: 😡
Attending Physician/Clinician* Select	· ~	Affiliation/Organization* 😧		If other, please specify: 😡

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Please Note: If the appropriate name does not display in the *Person Completing Form* or *Attending Physician/Clinician* dropdown menus, you must create details for a new Person Completing Form or new Attending Physician/Clinician.
To create details for a new Person Completing Form, click the **Person Completing Form** hyperlink. Upon clicking the hyperlink, the *Person Completing Form* pop-up displays.
To create details for a new Attending Physician/Clinician, click the **Attending** Physician/Clinician hyperlink. Upon clicking the hyperlink, the *Attending Physician/Clinician* pop-up displays.
To proceed, enter the details in the appropriate fields of the pop-up and click **Save**.

Patient ID (MRN)* 🚱	Affiliation/Organization* 🚱	
JH05052020	Test Medical Center	
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🚱
Select 🗸	Select v	
Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Select	Select V	

- 3. To complete the **Patient Information** screen, you must **select the appropriate answer** for the mandatory blank fields marked with **red asterisks** (*), if enabled:
- Is the patient postpartum?
- Does the patient have a history of incarceration?

the patient c	urrently pregr	hant?*				
Yes	No	Unknown				
yes, please e	nter the due d	late (EDC): 🕜				
mm/dd/yyyy				Unknown		
			1			
the patient p	ostpartum?*					
Yes	No	Unknown	L			
yes, please e	nter the date o	of delivery: 🕜	•			
mm/dd/yyyy				Unknown		
			_			
oes the patie	nt have a histo	ory of incarceration	on?*			
Yes	No	Unknown				

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Please Note : If Yes is selected for the <i>Is t</i> postpartum-related field is disabled: <i>Is the</i>	<i>he patient currently pregnant?</i> field, the subsequent <i>patient postpartum?</i>
Is the patient currently pregnant?* Yes No Unknown	
If yes, please enter the due date (EDC):* ? 11/12/2021Image: the state of the stat	
Is the patient postpartum? Yes No Unknown]
If yes, please enter the date of delivery: mm/dd/yyyy	
Please Note : If <i>No</i> or <i>Unknown</i> is selected subsequent due date-related field is disable	d for the <i>ls the patient currently pregnant?</i> field, the ed: <i>If yes, please enter the due date (EDC)</i> .
Additionally, the postpartum-related field i <i>patient currently pregnant</i> ? field.	s enabled if No or Unknown is selected for the <i>ls the</i>
Is the patient currently pregnant?*	
Yes No Unknown	
If yes, please enter the due date (EDC): 🔞	
mm/dd/yyyy	
Is the patient postpartum?* Yes No Unknown	

4. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Laboratory Information** screen.



Communicable Disease Lab Entry and Initiating Case Reports User Guide



ease complete the form below. All fields ma	rked with an asterisk(*) are required.					
		PATIENT IN	FORMATION			
tient Information	Disease/Organism* 🔞		Date of Diagnosis*			
aboratory Information	Perinatal Hepatitis B	~	06/02/2022	=	Unknown	
opplicable Symptoms	A					
Aedical Conditions	Is the Affiliation/Organization	on same for Patient ID (MRI	N), Person Completing Form, a	nd Attending Physician/Clir	nician?*	
waarura lafarmatiaa						
sposure information	Patient ID (MRN)*		Affiliation/Organization* @			
lospitalization, ICU & Death Information	in Jinosozozo		rest medical certer			
accination History	Person Completing Form* Dr. Estelle Costanza (estella)	le@email.com) × V	Affiliation/Organization* G	× ~	If other, please specify: 😡	
dditional Comments						
Review & Submit	Attending Physician/Clinica Dr. Fraiser Crane (fraiserc	n* rane@email.c × ~	Affiliation/Organization* 6	× ~	General Hospital	9
	Suffix Select		Maiden Name		торре	
	Select					
	Date of Birth*		Ethnicity*		Race*	
	05/06/2020	*	Mat Hispapis or Latino	V V	Mbito	v Lu.
	Address 1*			Address 2		
	123 Hawkins Lane			Unit, Suite, Building, etc.		
	City*			State*		Zip Code
	Franktore			KI	× •	40601-
	County*	v Lu	Phone* @		Email	
	rayette		(555) 555-5555		elevengemail.com	
	Is the patient currently preg Yes No	nant? Unknown				
	mm/dd/yyyy	m (Unknown			
	Yes No If yes, please enter the date	Unknown of delivery:* 🚱				
	06/27/2022	₩ (Unknown			
	Does the patient have a hist Yes No	ory of incarceration?* Unknown				

Laboratory Information

The **Laboratory Information** screen displays details about the laboratory test that have been autopopulated based on the information previously entered on the Communicable Disease Lab Entry.

- 5. You have the option to **edit the auto-populated information** in the following enabled fields:
- Does the patient have a lab test?
- Hepatitis Marker
- Results

- Test Result Date
- Specimen Collection Date
- Laboratory Name



Communicable Disease Lab Entry and Initiating Case Reports User Guide



PERINATAL HEPATITIS CASE R	EPORT I	FORM	Sec	tion 2 of 9			
Please provide laboratory information related	d to this case.						
		LABORA	TORY INFORMATION				
Patient Information	Ø	Does the patient have a lab test?*					
Laboratory Information		Yes No					
Applicable Symptoms	A	If yes, at least one Hepatitis Marker test is rec	uired. If you choose to enter addition	al test results such as A	LT, AST, or Bilirubin, plea	ise ensure you complete all	l fields for
Medical Conditions	_	that test.					
Exposure Information	_	Hanathia Markash					
Hospitalization, ICU & Death Information	A	HEPATITIS B VIRUS CORE AB.IGM	x ~				
Vaccination History	a	If other, please specify:					
Additional Comments	a	Devilet					
Review & Submit	a	Positive	x ~				
		If applicable, please enter the viral load: 🚱					
		Test Result Date* 07/02/2022	iii Unknown	Specimen Collection 07/01/2022	n Date*	iii 🗍 Unknown	
		Laboratory Name:*					
		General Hospital					
		Add Hepatitis Marker					
		ALT					
		G Add ALT					
		AST					
		+ Add AST					
		Bilirubin					
		🔂 Add Bilirubin					

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Laboratory Information** screen: *Does the patient have a lab test?*

LABORATORY INFORMATION	LABORATORY INFORMATION
Does the patient have a lab test?* Yes No Unknown	Does the patient have a lab test?* Yes No Unknown
Please Note: If <i>No</i> or <i>Unknown</i> is selected for Laboratory Information screen, the subsequer	or the conditional question at the top of the nt fields are disabled.





6. You have the option to click **Add Hepatitis Marker** to log the details for multiple hepatitis markers for the patient.

Positive X V	
applicable, please enter the viral load: 🕑	
est Result Date*	Specimen Collection Date*
07/02/2022 🛗 🗌 Unknown	07/01/2022 🛗 🗌 Unknown
aboratory Name:*	
General Hospital	
Add Hepatitis Marker	
epatitis Marker*	
Select 🗸	
other, please specify:	
esults*	
Select 🗸 🗸	
applicable, please enter the viral load: 🛛	
est Result Date	Specimen Collection Date*
mm/dd/yyyy 🛗 Unknown	mm/dd/yyyy 🛗 🗌 Unknown
aboratory Name:*	
Add Hepatitis Marker	J
LT	
Add ALT	

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• You also have the option to click **Add ALT** to log the details for an ALT.

ALT				
AST				
•				
Add AST				
				_
Add Hepatitis Marker				
IT.				-
lesultes.				
lesuits.~		Units/Liter		
eference:*				
		Units/Liter		
est Result Date*		Specimen Collection Date*		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
aboratory Name:*				
Add ALT				
-				
ST				
Add AST				
ilirubin				

Add ALT	
AST	
• Add AST	
Bilirubin	
Add Bilirubin	

Communicable Disease Lab Entry and Initiating Case Reports User Guide



ST	
esults:*	Linits/Liter
	onito/Ekci
eference:*	Units/Liter
est Result Date*	Specimen Collection Date*
mm/dd/yyyy 🛗 🗌 Unknown	mm/dd/yyyy 🛗 🗌 Unknown
aboratory Name:*	
Add AST	
Add AST	

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

Save		Previous	Next	
Add Hepatitis Marker				
ALT				
🛨 Add ALT				
ST				
Add AST				
Bilirubin				
Results:*	mg/dl			
Results:*	mg/dL			
Results:*	mg/dL mg/dL			
Results:* Reference:* Fest Result Date* mm/dd/yyyy Duknown	mg/dL mg/dL Specimen Collection Date* mm/dd/yyyy	100 100	Unknown	





7. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Applicable Symptoms** screen.

PERINATAL HEPATITIS CASE	REPORT FO	DRM Section 2 of 9	
Please provide laboratory information rela	ated to this case.		
		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 ensure you
Medical Conditions	a	complete all fields for that test.	
Exposure Information	a		
Hospitalization, ICU & Death		Hepatitis B virus core AB × ✓	
Vaccination History	a	If other, please specify:	
Additional Comments		Deculte*	
Review & Submit		Positive × ~	
		Unknown Test Result Date* O7/02/2022 Unknown O7/01/2022 Caboratory Name:* General Hospital Add Hepatitis Marker ALT AST AAdd ALT Billrubin Add AST Billrubin Add Billrubin	te*
		Save	Previous Next

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Applicable Symptoms

The **Applicable Symptoms** screen asks questions about the patient's symptoms.

- 8. You have the option to **edit the auto-populated information** in the following enabled fields:
 - Were symptoms present during the course of illness? Onset Date

PERINATAL HEPATITIS CASE R	EPORT	FORM				Section 3 of 9				
Please select applicable symptoms that the p	atient exper	ienced during illne	<i>SS</i> .							
				APPLIC	ABLE SYMPTOMS					
Patient Information	Ø	Were symptor	ms present d	uring the course of il	ness?*					
Laboratory Information	Ø	Yes	No	Unknown						
Applicable Symptoms										
Medical Conditions	۵	06/20/2022	9 iii	Unknown						
Exposure Information	a	If symptomati	c which of th	e following did the r	atient experience during	a illnose?				
Hospitalization, ICU & Death Information	۵	Jaundice*	c, which of u	e tollowing did the p	atient experience during	giintessr				
Vaccination History	a	Yes	No	Unknown						
Additional Comments	۵	Fever*								
Review & Submit	۵	Yes	No	Unknown						
		Nausea*	No	Haknowa						
		Abdominal Pa	int	OINIOWI						
		Yes	No	Unknown						
		Dark Urine*								
		Yes	No	Unknown						
		Light Colored	Stools*							
		Yes	No	Unknown						
		Fatigue*								
		Yes	No	Unknown						
		Myalgia*								
		Yes	No	Unknown						
		Loss of Appeti	ite*							
		Yes	No	Unknown						
		Did the patien	t have any of	her symptoms?*						
		If ves, please s	specify: @	Unknown						
		Save					P	revious	Next	

Please Note: If the patient was marked as symptomatic on the Communicable Disease Lab Entry, the selection for the conditional question at the top of the **Applicable Symptoms** screen is autopopulated as **Yes**: *Were symptoms present during the course of illness?*

• If *Yes* is selected for the conditional question at the top of the **Applicable Symptoms** screen, the subsequent fields are enabled.

If an onset date for symptoms was entered on the Communicable Disease Lab Data Entry, the same date is auto-populated for the *Onset Date* field on the **Applicable Symptoms** screen.



- 9. You have the option to **edit the auto-populated information** in the enabled fields.
- You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Applicable Symptoms** screen: *Were symptoms present during the course of illness?*

APPLICABLE SYMPTOMS	APPLICABLE SYMPTOMS
Were symptoms present during the course of illness?* Yes No Unknown	Were symptoms present during the course of illness?* Yes No Unknown

- If you change the selection for the conditional question, a pop-up notification will display with a message that states: *Please note that all selections on this screen will be reset. Are you sure you want to change your response?*
- To reset the previous selection for the conditional question, click *Yes* on the pop-up notification.



Please Note: If *No* is selected for the conditional question at the top of the **Applicable Symptoms** screen, all subsequent fields are disabled and marked with *No*.

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

	APPLICABLE SYMPTOMS
Patient Information	Were symptoms present during the course of liness?*
Laboratory Information	Yes No Unknown
Applicable Symptoms	
Additional Information	mm/dd/yyyy Duknown
Hospitalization, ICU & Death Information	If a metamotic which of the following did the activate providence devices their linear?
Vaccination History	Fymptomatic, which or the following the patient experience during their himess?
Additional Comments	Yes No Unknown
Review & Submit	▲ If yes, please enter the highest temperature: ●
	Dlarrhea (>3 loose stools/24hr period) Yes No Unknown If yes, please enter # of days of diarrhea: @
	Anoresia Yes No Unknown Chills
	Yes No Unknown





10. To complete the **Applicable Symptoms** screen, you must select the **appropriate answers** for the mandatory symptom fields marked with **red asterisks** (*).

	No	Unknown	
	No	Unknown	
s	No	Unknown	
ninal Pair	•		
es	No	Unknown	
ine*			
Yes	No	Unknown	
ht Colored S	ools*		
Yes	No	Unknown	
igue*			
Yes	No	Unknown	
valgia*			
Yes	No	Unknown	
ss of Appetite	*		
Yes	No	Unknown	
the natient	have any oth	er symptoms?*	
Yes	No	Unknown	
please sp	ecify: 🚱		
Save			Previous





11. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Medical Conditions** screen.

Please select applicable symptoms that the p			Section 3 of 9		
	itient experienced during illness.				
		APPLICABLE SYMPT	OMS		
Patient Information	⊘ Were symptoms present	during the course of illness?*			
Laboratory Information	⊘ Yes No	Unknown			
Applicable Symptoms					
Medical Conditions	Onset Date* Onset Date* Onset Date*	Unknown			
Exposure Information	If symptomatic, which of t	the following did the patient experience	during illness?		
Hospitalization, ICU & Death Information	▲ Jaundice*				
Vaccination History	Yes No	Unknown			
Additional Comments	Fever*	Unknown			
eview & Submit					
	Yes No	Unknown			
	Abdominal Pain*				
	Yes No	Unknown			
	Dark Urine*				
	Yes No	Unknown			
	Light Colored Stools*	Unknown			
		UNKNOWN			
	Fatigue*	Unknown			
	Musician				
	Yes No	Unknown			
	Loss of Appetite*				
	Yes No	Unknown			
	Did the patient have any o	other symptoms?*			
	Yes No	Unknown			
	If yes, please specify:* Unknown				
	Save			D	
				Previous	Next





Exposure Information

The **Exposure Information** screen collects exposure details about the patient and displays information that has been auto-populated based on the previously submitted Communicable Disease Lab Entry.

12. You have the option to **edit the auto-populated information** in the following enabled fields:

- Did the patient have any of the following exposures in the past 6 months?
- Adult congregate living facility (nursing, assisted living, or long-term care facility)

ERINATAL HEPATTIS CA	SE REPORT FORM Section 5 of 9	
Please select the information that the patien	it was exposed to prior to illness.	
	EXPOSURE INFORMATION	
atient Information	Did the patient have any of the following exposures in the past 6 months?*	
aboratory Information	Yes No Unknown	
pplicable Symptoms	0	
Medical Conditions	Adult congregate living facility (nursing, assisted living, or long-term care facility)*	
xposure Information	If yes, please specify nursing, assisted living or long-term care facility: 😜	
ospitalization, ICU & Death Information	▲	
accination History	Correctional facility*	
dditional Comments	Yes No Unknown	
nden # Echenik	If yes, prease specify name or correctional facility:	
EVIEW of SUDMIC	- V Drue Use*	
	Yes No Unknown	
	Sexually Transmitted Infections History*	
	Yes No Unknown	
	Multiple Sex Partners*	
	Yes No Unknown	
	Intranasal Drug Use*	
	Yes No Unknown	
	HIV Exposure*	
	Yes No Unknown	
	HBV Contact Exposure*	
	Yes No Unknown	
	HCV Contact Exposure*	
	Yes No Unknown	
	Tattoos*	
	Yes No Unknown	
	If yes, please specify the setting: Solect	
	If other, please specify: @	
	Piercings*	
	Yes No Unknown	
	If yes, please specify the setting: Solect	
	If other, please specify: @	
	Foreign Born*	
	Yes No Unknown	

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• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Exposure Information** screen: *Did the patient have any of the following exposures in the past 6 months?*

EXPOSURE INFORMATION	EXPOSURE INFORMATION
Did the patient have any of the following exposures in the past 6 months?* Yes No Unknown	Did the patient have any of the following exposures in the past 6 months?* Yes No Unknown

- If you change the selection from Yes to No or Unknown, or vice versa for the conditional question, a pop-up notification will display a message that states: Please note that all selections on this screen will be reset. Are you sure you want to change your response?
- To reset the previous selection for the conditional question, click *Yes* on the pop-up notification.

Applicable Symptoms	0	Adult congregat	Expos	ure Information	×
Medical Conditions	Ø	Yes	Δ	Please note that all selections on the screen will	il be
Exposure Information Hospitalization, ICU & Death	a	ir yes, piease sp		reset. Are you sure you want to change your response?	
Information Vaccination History	a	Correctional fac Yes		Yes	No
Please Note: If <i>I</i> Information scree	Vo is en, the	selected f subseque	or tl nt fie	ne conditional question lds are disabled and mar	n at the top of the Exposure rked with No .
If Unknown is sele marked as Unknow	ected f vn .	for the co	nditio	onal question, the subse	equent fields are disabled and
The outbreak-relat for the conditional	ed que questi	estion at th ion: <i>Does a</i>	e bot <i>any c</i>	tom of the screen is not in If the following apply to t	mpacted by the selected answer the patient?

Yes No Unknown	
If yes, please specify country: 😡	
Select	\sim
Is this part of an outbreak?*	
Yes No Unknown	
If yes, please specify the name of the outbreak: $oldsymbol{0}$	

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the auto-populated field: *Adult congregate living facility (nursing, assisted living, or long-term care facility)*





Please Note: If **Yes** is selected for **any** of the descriptive questions, the subsequent textbox is enabled for Users to specify the name of appropriate setting.

For example, if **Yes** is selected for the *Adult congregate living facility (nursing, assisted living, or long-term care facility)* field, the subsequent textbox field is enabled.

To proceed, you must enter the **name of the living facility** in the subsequent field: *If yes, please specify the nursing, assisted living or long-term care facility*.



13. To complete the **Exposure Information** screen, select the **appropriate answers** for the blank enabled fields to indicate descriptions that apply to the patient.

pitalization, ICU & Death Information	Connection	d facility d	
nation History	A Yes	No	Unknown
iditional Comments	▲ If yes, please	e specify name of	correctional fac
edares B. C. domit	A		
eview & Submit	-		
	IV Drug Use	No	Linknown
	Tes	THU I	OT INT OWN
	Sexually Tr	ansmitted Infection	s History*
	Yes	No	Unknown
	Multiple Se	x Partners*	
	Yes	No	Unknown
	Intranasal	Drug Use*	
	Yes	No	Unknown
	HIV Exposu	re*	
	Yes	No	Unknown
	HBV Conta	rt Exposure*	
	Yes	No	Unknown
	HCV Conta	tt Exposure*	
	Yes	No	Unknown
	Tattoos*		
	Yes	No	Unknown
	If yes, plea	se specify the setti	ng: Ø
	Select		
	If other, pl	ease specify: 😡	
	Discriment		
	Piercings*	No	Unknown
	If yes, play	se specify the setti	0
	Select	se specity the setti	2.0
	If other, pl	ease specify: 🖗	
	in during the	and speed of the	
	Foreign Bo	m•	Helener
	Yes	No	Unknown
	If yes, plea	se specify country:	0
	select		
	Is this part	of an outbreak?*	
	Yes	No	Unknown
	If yes, plea	se specify the nam	e of the outbrea

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 Please Note: If Yes is selected for the Correctional Facility, Tattoos, Piercings, Foreign Born, or Is this part of an outbreak? fields, the subsequent field is enabled for Users to specify the name of appropriate setting. To proceed, you must enter the appropriate setting in the subsequent field: If yes, please specify.
Correctional facility* Yes No Unknown If yes, please specify name of correctional facility:* @
Yes No Unknown If yes, please specify the setting:* If other, please specify: If other, please specify: If other, please specify:
Piercings* Yes No Unknown If yes, please specify the setting:* If other, please specify:
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:* @ Pleases Nota: If Other is solocited from one of the /f yes, please specify the sotting drondown
The set in Uther is selected from one of the <i>If yes, please specify the setting</i> dropdown menus for the <i>Tattoos</i> field or the <i>Piercings</i> field, the subsequent textbox field is enabled. To proceed, enter the appropriate setting in the subsequent textbox: <i>If other, please specify</i> .

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Yes No Unknown	
f yes, please specify the setting:* 🕑	
Other	× ×
other, please specify:* 🚱	
tiercings*	
tiercings* Yes No Unknown	
Yes No Unknown fyes, please specify the setting:* @	
Yes No Unknown fyes, please specify the setting:* @ Other	x v
Yes No Unknown f yes, please specify the setting:* Image: Comparison of the setting:* Other Image: Comparison of the setting:* f other Image: Comparison of the setting:*	x v

14. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Hospitalization**, **ICU & Death Information** screen.

PERINATAL HEPATITIS CA	ASE REPORT FORM	Section 5 of 9	
Please select the information that the patient	nt was exposed to prior to illness.		
	EXPOSURE IN	NFORMATION	
Patient Information	Did the patient have any of the following exposures in the past 6 mon	nths?*	
Laboratory Information	Ves No Unknown		
Anniirahla Sumetome	0		
Medical Conditions	Adult congregate living facility (nursing, assisted living, or long-term ca	are facility)*	
Exposure Information	If yes, please specify nursing, assisted living or long-term care facility. ⁴	* 9	
Hospitalization I/TLR Death Information	Long-Term Care Facility		
Vasienation Uistees	Correctional facility*		
vaccination Pistory	Yes No Unknown		
Additional Comments	If yes, please specify name of correctional facility.* Unknown		
	W Drug Use* No Unknown Yes No Unknown Sexually Transmitted Inflections History* Yes No Yes No Unknown Multiple Ser Partners* No Unknown HEV Contact Exposure* Unknown HCV Contact Exposure* Unknown Tottoos* No Unknown My explases specify the setting* • Uberned parlor If other, plases specify • Unknown My explases specify country: • Select Is this part of an outbreak?* Unknown		x v x v
	Save	Previous Next	^





Hospitalization, ICU & Death Information

The **Hospitalization**, **ICU & Death Information** screen displays details about a patient's hospitalizations that have been auto-populated based on the previously submitted Communicable Disease Lab Entry.

15. You have the option to **edit the auto-populated information** in the following enabled fields:

- Was the patient hospitalized?
- *Was the patient admitted to an intensive care unit (ICU)?*

PERINATAL HEPATITIS CASE	REPORT FORM			Section 6 of 9		
Please select any applicable hospitalization	n, ICU and death information related to this case	е.				
	HOSPI	TALIZATION, IC	U & DEATH INFOR	RMATION		
Patient Information		ized?*	1			
Laboratory Information	⊘ Yes No	Unknown				
Applicable Symptoms	⊘	hospital name: t O				
Medical Conditions	Ø Ø	nospital name:" 😈				
Exposure Information	⊘ Admission Date*			Discharge Date*		
Hospitalization, ICU & Death	mm/dd/yyyy		Unknown	mm/dd/yyyyy		Unknown
Information	0			Still hospitalize	ed	
Vaccination History						
Additional Comments	Was the patient admittee	d to an intensive care Unknown	unit (ICU)?*			
Review & Submit	Admission Date to ICU*			Discharge Date fro	om ICU*	
	mm/dd/yyyy	=	Unknown	mm/dd/yyyyy		Unknown
	Did the patient die as a r	esult of this illness?*				
	Yes No	Unknown				
	If yes, please provide the	e date of death:				
	Date of Death					
	mm/dd/yyyy		Unknown			

Please Note: If the Communicable Disease Lab Entry indicated that the patient was hospitalized, the selection for the conditional question at the top of the **Hospitalization**, **ICU & Death Information** screen is auto-populated as **Yes**: *Was the patient hospitalized?*

• If **Yes** is selected for the conditional question at the top of the screen, the subsequent hospitalization-related fields and ICU-related fields are enabled.

If the Communicable Disease Lab Entry indicated that the patient was admitted to the ICU, the selection for the ICU-related question is auto-populated as **Yes**: *Was the patient admitted to an intensive care unit (ICU)?*

If *Yes* is selected for the ICU-related question, the subsequent *Admission Date* and *Discharge Date* fields are enabled. To proceed, you must enter the **Admission Date to ICU** and the
 Discharge Date from ICU in the appropriate fields.

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Yes	No	Unknown			
mission Date	to ICU*			Discharge Date from ICU*	
mm/dd/yyyy			🛗 🚺 Unknown	mm/dd/yyyy	🛗 🚺 Unknown

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the conditional question at the top of the **Hospitalization**, **ICU & Death Information** screen: *Was the patient hospitalized*?

HOSPITALIZATIO	N, ICU & DEATH INFORMATION		HOSPITALIZATION, ICU & DEATH INFORMATION	ON
Was the patient hospitalized?* Yes No Unknown		Was the pate Yes	ntient hospitalized?*	
 Please Note: If No or Hospitalization, ICU & and ICU-related fields and Death-related quest Was the patient hos 	Unknown is selected for Death Information screate disabled. The disabled is a not impacted by <i>pitalized?</i>	for the co een, the su the select	onditional question at the top of th ubsequent hospitalization-related field ted answer for the conditional question	าe ds n:
	HOSPITALIZATION, ICU	& DEATH INFORM	ΜΑΤΙΟΝ	
Patient Information	Was the patient hospitalized?*			
Laboratory Information 🔗	Yes No Unknown			
Applicable Symptoms				
Additional Information	If yes, please specify the hospital name: 🚱			
Hospitalization, ICU & Death Information				
Vaccination History	Admission Date	Unknown	mm/dd/yyyy	
Additional Comments			Still hospitalized	
	Was the patient admitted to an intensive care unit (IC	U)?		
	Yes No Unknown			
	Admission Date to ICU	Unknown	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		

• You can change the selection from **Yes** to **No** or **Unknown**, or vice versa for the ICU-related question: *Was the patient admitted to an intensive care unit (ICU)*?

Was the patient	admitted to	an intensive care	unit (ICU)?*	Was the patient	admitted to	an intensive care	unit (ICU)?*
Yes	No	Unknown		Yes	No	Unknown	
Admission Date	to CU*			Admissio, Date	to ICU		
mm/dd/yyyy			iii Unknown	mm/dd/yyyy			Unknown

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Kentucky Health Information Exchange

Deloitte.	Communicable D Initiating Case F	isease Lab Entry ar Reports User Guide	nd	KHIE
Please Note: If Yes is selec Discharge Date fields a	ted for the ICU-relate re enabled.	ed question, the su	bsequent <i>Admissi</i>	<i>ion Date</i> and
To proceed, enter the appropriate fields.	Admission Date to	ICU and the Disc	:harge Date from	ו ICU in the
Was the patient admitted to an intensive car Yes No Unknown Admission Date to ICU* mm/dd/yyyy	e unit (ICU)?*	Discharge Date from ICI mm/dd/yyyy	U*	Unknown

- 16. To complete the **Hospitalization**, **ICU & Death Information** screen, you must complete the following mandatory fields marked with **red asterisks** (*), if enabled:
- If yes, please specify hospital name
- Admission Date to ICU

- Admission Date
- Discharge Date

- Discharge Date from ICU
- Did the patient die as a result of this illness?

🗰 🗌 Unknown	Discharge Date* 06/29/2022 Still hospitalized	🛗 🗌 Unknown
unit (ICU)?*		
iii Unknown	Discharge Date from ICU*	🛗 🗌 Unknown
Unknown		
		Discharge Date* O6/29/2022 Still hospitalized unit (ICU)?* Discharge Date from ICU* mm/dd/yyyy

|--|

Communicable Disease Lab Entry and Initiating Case Reports User Guide



01/03/2022		🛗 🗌 Unknown	mm/dd/yyyy 🛗 🗌 Unknown
			Still hospitalized
Was the patient a	dmitted to a	an intensive care unit (ICU))?*
Yes	No	Unknown	
Admission Date to	o ICU		Discharge Date from ICU
mm/dd/yyyy		Olikilowi	
Did the patient die	as a result	of this illness?	
Yes	No	Unknown	
lf yes, please provi	de the date	of death:	
Date of Death			
mm/dd/yyyy		time Unknown	

Yes	No	Unknown	
f yes, please p	rovide the dat	te of death:	
Date of Death			





17. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Vaccination History** screen.

PERINATAL HEPATITIS CASI	E REPORT	FORM		Section 6 of 9	
Please select any applicable hospitalization	ion, ICU and deat	h information related to this case.			
		HOSPITALIZATI	ON, ICU & DEATH INFO	RMATION	
Patient Information	0	Was the patient hospitalized?*			
Laboratory Information	\odot	Yes No Uni	known		
Applicable Symptoms	0	If yes, please specify the hospital nam	ne:* 0		
Medical Conditions	\odot	General Hospital			
Exposure Information	Ø	Admission Date*		Discharge Date*	
Hospitalization, ICU & Death Information		00/2//2022		Still hospitalized	
Vaccination History	A	Was the estiant admitted to an interes			
Additional Comments	A	Yes No Unk	nown		
Review & Submit	A	Admission Date to ICU* 06/29/2022	Unknown	Discharge Date from ICU* 06/30/2022	11 Unknown
		Did the patient die as a result of this I Yes No Unku If yes, please provide the date of deat Date of Death mm/dd/www	liness?* nown h: Unknown		
		Save			Previous Next

Please Note: The subsequent **Vaccination History** and **Additional Comments** screens of the Perinatal Hepatitis Case Report do <u>not</u> include any auto-populated information from the Communicable Disease Lab Entry.

• To proceed, you must enter the **appropriate information** in the enabled fields on each screen. Once complete, click **Next** until you navigate to the **Review and Submit** screen.

For specific information on how to complete these screens of the Perinatal Hepatitis Case Report, please review the *Direct Data Entry for Electronic Case Reports: Perinatal Hepatitis User Guide* on the **KHIE website**.



Review and Submit: Perinatal Hepatitis Case Report

Once the appropriate edits and additions have been made on all the Perinatal Hepatitis Case Report screens, you will be navigated to the **Review and Submit** screen. The **Review and Submit** screen displays the summary of the information you have entered. Prior to submitting the Perinatal Hepatitis Case Report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report.

18. Review the information on the **Review and Submit** screen.

Please review your information before submit	tting.				
		REVIEW	& SUBMIT		
Patient Information	0				
Laboratory Information	0			Print	Download
Applicable Symptoms	\odot	Patient Information			0
Medical Conditions	0	- duche information			
Exposure Information	0	Disease/Organism Perinatal Hepatitis B	Date of Diagnosis 06/02/2022		
Hospitalization, ICU & Death Information	0	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending P	hysician/Clinician?	
Vaccination History	Ø	Patient ID (MRN)	Affiliation/Organization		
Additional Comments	Ø	JH05052020	Test Medical Center		
Review & Submit		Person Completing Form Dr. Estelle Costanza (estelle@email.com)	Affiliation/Organization Test Medical Center		
and a second		Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Other	If other, please specify: General Hospital	
		First Name	Last Name		
		Jane	Hopper		
		Date of Birth 05/05/2020	Ethnicity Not Hispanic or Latino	Race White	
		Address 1 123 Hawkins Lane			
		City	State	Zip Code	

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

Additional Comments	۵
 Additional comments or notes, please specify: Additional patient notes	
Previous	*

20. 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.

res Admission Date to IC 10/01/2021	Case Report Entry ×	Discharge Date from ICU 10/02/2021
Did the patient die as 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 Histo	Cancel Submit	٥

DDE: Communicable Disease Lab Entry

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

	Admission Date to IC 10/01/2021 Did the patient die as No Vaccination Histo	Case Report Entry Case Report Entry Saved Success	fully	× Discharge Date from ICU 10/02/2021		۵
 Please Note: Clicking automatically navigate For specific inform section 17: <i>Case R</i> 	g OK when the you to the C anation on the deport Entry U	he case repo ase Report Ei Case Report Ser Summary	rt entry ha ntry User S : Entry Use of this guid	as been subr Summary scr er Summary le.	nitted success een. screen , pleas	fully will e review
KHIE ePartnerVie	Wer Bookmarked Patients	Event Notifi	cations	🐸 Support 📢 A Lab Data Entry -	nnouncements 5 🌲 Advisories 3 Case Re	port Entry *
Home > Case Report Entry User Summary	CASE F	REPORT ENTR	Y USER SUI	MMARY		
LAST UPDATED DATE RANGE	Start Date	07/02/2022	Er	nd Date 07/02/2022		₿ Retrieve Data
showing 1 ITEMS						T APPLY FILTER
ACTIONS REPORT TYPE	RGANISM AFFILIATION/	PATIENT MRN FIRST NAME	LAST NAME	DATE OF BIRTH PATIENT \$ SEX \$	STATUS + LAST UPDATED +	SUBMISSION DATE +
View Perinatal Hepatitis Perinatal H Copy <th>epatitis B Test Medical Center</th> <th>JH05052020 Jane</th> <th>Hopper</th> <th>05/05/2020 Female</th> <th>Complete 07/02/2022 1:00 PM</th> <th>07/02/2022 1:00 PM</th>	epatitis B Test Medical Center	JH05052020 Jane	Hopper	05/05/2020 Female	Complete 07/02/2022 1:00 PM	07/02/2022 1:00 PM
	First	t Back 1 Next Last			Maximum	5 • entries per page
Copyright 2019 HealthInteractive		HealthInter	active HIE		Version: 1.0.0	



16 Initiate Child Hepatitis Case Report

Upon initiating a Child Hepatitis Case Report on the *Communicable Disease Lab Entry* pop-up notification, Users are automatically navigated to the **Patient Information** screen of the Child Hepatitis Case Report.

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.

Please complete the form belo	ow. All fields marked with an as	sterisk(*) are re	equired.			
	РА	TIENT INFO	ORMATION			
Patient Information	Disease/Organism* 🕢 Child Hepatitis B		Date of Diagnosis* mm/dd/yyyy		Unknown	
Laboratory Information	Is the Affiliation/Organization same for Pati	ient ID (MRN), Person Comp	leting Form, and Attending Physician	VCInician?*		
Exposure Information	Yes No Patient ID (MRN)* •		Affiliation/Organization* 🖗			
Hospitalization, ICU & Death Information	Person Completing Form* Select		Affiliation/Organization* © Select		if other, please specify: O	
Vaccination History	Attending Physician/Clinician*		Affiliation/Organization* 0 Select		If other, please specify: 😡	
Additional Comments	Prefix Select					
Review & Submit	First Name*		Middle Name		Last Name*	
					nopper	
	Suffix Select		Date of Birth*		Birth Weight	025
	Defend ford		Disal di a			
	Female		Not Hispanic or Latino	X V	White	×
	Mother's Current Legal Name and Address First Name*		Middle Name		Last Name*	
	Address 1* 123 Hawkins Lane			Address 2 Unit, Suite, Building, etc.		
	City*			State*	والغ	Zip Code
	County*		Phone* 0		Email	

The following Child Hepatitis Case Report screens display certain fields of information that have been auto-populated based on the information entered on the previously submitted Communicable Disease Lab Entry. When necessary, you can change the auto-populated information and enter different details in any of the enabled fields.

- Patient Information screen
 Hospitalization, ICU & Death Information screen
- Laboratory Information screen

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Patient Information

The **Patient Information** screen auto-populates with the existing patient demographic details entered on the previously submitted Communicable Disease Lab Entry. Users can change the auto-populated information in any of the enabled fields, as applicable. Users cannot change auto-populated details in grayed out and disabled fields.

Users **<u>cannot</u>** edit the following auto-populated *Disease/Organism*, *Patient ID (MRN*), *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields which are grayed out and disabled:

- Disease/Organism
- Patient ID (MRN)

Middle Name

- Is the Affiliation/Organization the same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
- Affiliation/Organization for Patient MRN
- Prefix /

Last Name

- Date of Birth
- First Name

- Suffix
- Patient Sex

	PATIENT INFORMATION		
Disease/Organism* 🚱	Date of Diagnosis*		
Child Hepatitis B	∼ mm/dd/yyyy	11 Unknown	
Is the Affiliation/Organization same for Patio	et ID (MRN) Person Completing Form and Attending Physician/Clinici		
Yes No	ic to (mixing, reason completing rorm, and Attending russician clinica	112 -	
Patient ID (MRN)* 🕑	Affiliation/Organization* 🚱		
JH05052020	Test Medical Center		
Person Completing Form*	Affiliation/Organization* @	If other, please specify: 😧	
Select	Select	×	
Attending Physician/Clinician*	Affiliation/Organization* @	If other, please specify: 🚱	
Select	Select	·	
Prefix			
Select	~		
First Name*	Middle Name	Last Name*	
Jane		Hopper	
Suffix	Date of Birth* 🚱	Birth Weight	
Select	05/05/2020	lbs	
	Ethnicity*	Race*	
Patient Sex*	connecty		
Patient Sex* Female	 ✓ Not Hispanic or Latino 	× ~ White	×

Please Note: The *Disease/Organism*, *Patient ID (MRN)*, *Affiliation/Organization* for Patient ID (MRN), and patient demographic fields are the only disabled fields. All other fields on the **Patient**Information screen and all subsequent screens are enabled. You have the option to edit any of the enabled fields on all screens of the Child Hepatitis Case Report.

Communicable Disease Lab Entry and Initiating Case Reports User Guide



- 1. You have the option to **edit the auto-populated information** in the following enabled fields:
- Ethnicity
 - Phone

•

- Race Email
- Address, City, State, Zip Code, County

Female	Not Hispanic or Lat	tino	K V		x ~
Mother's Current Legal Name and Address First Name*	Middle Name		Last Name*		
Address 1*		Address 2			
123 Hawkins Lane		Unit, Suite, Buil	ding, etc.		
City*		State*		Zip Code	
Frankfort		KY		× ~ 40601-	
County*	Phone* 😧		Email		
Fayette	(555) 555-5555		eleven@er	nail.com	

- 2. To complete the **Patient Information** screen, you must **enter the appropriate information** in the mandatory blank fields marked with **red asterisks** (*), as applicable:
- Date of Diagnosis
- Person Completing Form
- Affiliation/Organization of Person Completing
 Form
- Affiliation/Organization of Attending Physician/Clinician
- Mother's First Name
- Mother's Last Name

• Attending Physician/Clinician

P	ATIENT INF	ORMATION		
Disease/Organism* 😧 Child Hepatitis B		Date of Diagnosis* mm/dd/yyyy		Unknown
Is the Affiliation/Organization same for Yes No	Patient ID (MRN	N), Person Completing Form, and Attendi	ing Physician/Clini	cian?*
		Affiliation (Organization + O		
Patient ID (MKN)* Ø		Amilation/Organization-		
JH05052020		Test Medical Center		_
JH05052020 Person Completing Form*		Affiliation/Organization* Affiliation/Organization*	~	if other, please specify: 🔞
JH05052020 Person Completing Form* Select	~	Affiliation/Organization* Select	~	lf other, please specify: 😡
Person Completing Form* Select	×	Affiliation/Organization* Select	~ ~	If other, please specify: 🚱 If other, please specify: 🚱

DDE: Communicable Disease Lab Entry



Communicable Disease Lab Entry and Initiating Case Reports User Guide



	Ethnicity*	Race*	
~	Not Hispanic or Latino	× ~ White	x ~
2291			
635	Middle Name	Last Na	ime*
	Addree	~ ²	
	Addres	52	
	Unit,	Suite, Building, etc.	
	State*		Zip Code
	10/		M L 10001
	ress	Vot Hispanic or Latino Verss Middle Name Addres Unit, State*	Vot Hispanic or Latino X V White Yess Middle Name Last Na Address 2 Unit, Suite, Building, etc. State*

Please Note: If the appropriate name does not display in the *Person Completing Form* or *Attending Physician/Clinician* dropdown menus, you must create details for a new Person Completing Form or new Attending Physician/Clinician.

- To create details for a new Person Completing Form, click the **Person Completing Form hyperlink**. Upon clicking the hyperlink, the *Person Completing Form* pop-up displays.
- To create details for a new Attending Physician/Clinician, click the **Attending Physician/Clinician** hyperlink. Upon clicking the hyperlink, the *Attending Physician/Clinician* pop-up displays.

To proceed, enter the details in the appropriate fields of the pop-up and click **Save**.

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

Person Completing Form*		Affiliation/Organization* 😧		If other, please specify: 😡
Select	~	Select	~	
Attending Physician/Clinician*		Affiliation/Organization* 2		If other, please specify: 🚱
Select	\sim	Select	· ~	

- 3. You must select the **appropriate answers** for the following mandatory fields:
- Does the patient have Neonatal Abstinence Syndrome?
 Who does the infant/child live with?

Communicable Disease Lab Entry and Initiating Case Reports User Guide



No U	stinence Syndrome?* nknown			
nfant/child live with	?*			
		n.		
		Middle Name		Last Name*
you must e Jardian, et	requent field nter the des c.) in the sub	scription of th scription of th	e person with 1: <i>If other, please</i>	whom the infant/child is living specify.
ne infant/chi				
	ld live with?*	x ~		
	No U Ifant/child live withit is: If Other is powing subs you must e uardian, etr	No Unknown	No Unknown	No Unknown

Please Note: If *Mother* is selected in response to the question *Who does the Infant/Child live with?*, then the subsequent contact information fields for the person with whom the child is living 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.

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Communicable Disease Lab Entry and Initiating Case Reports User Guide



if other, please specify:					
Please enter contact info of	person the child is living with:				
First Name	Middle Name		Last Name		
Carol	Anne	Anne		Brady	
Address 1		Address 2			
123 Main Street		Apt. 1			
City		State		Zip Code	
Lexington		KY		40511-	
County	Phone 😰		Email		

Please Note: If *Father*, *Grandparent*, *Other*, or *Unknown* is selected in response to *Who does the infant/child live*?, then the subsequent section is enabled.

_ _ _ _ _ _ _ _ _ _

To proceed, you must complete the fields in the subsequent section: *Please enter the contact info of person the child is living with*.

Father	X V				
f other, please specify:					
Please enter contact info of	person the ch	ild is living with:			
First Name*		Middle Name		Last Name*	
Address 1*			Address 2		
			Unit, Suite, Bu	uilding, etc.	
City*			State*		Zip Code
			Select		~
Countv*		Phone* 😧		Email	

DDE: Communicable Disease Lab Entry

Kentucky Health Information Exchange



4. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Laboratory Information** screen.

ise complete the form below. All fields mark	ked with an asterisk(*) are required.				
				_	
		PATIENT INFORM	TION		
ent Information	Disease/Organism* 😡	Date	of Diagnosis*		-
oratory Information	Child Hepatitis B	~ mn	v/dd/yyyyy	0	Unknown
osure Information	Is the Affiliation/Organization same	for Patient ID (MRN), Perso	on Completing Form, ar	nd Attending Physician/Cl	inician?*
pitalization, ICU & Death Information	Yes No				
destine Ulstee	Patient ID (MRN)* O	Affili	ation/Organization* 😡		
anadon matory	JH05052020	Tes	t Medical Center	\sim	
Itional Comments	Person Completing Form*	Affili	ation/Organization* 😡		If other, please specify: O
ew & Submit	Select	V Sel	ect	~]
	Attending Physician/Clinician*	Affili	ation/Organization* 😡		If other, please specify: 😡
	Select	∨ Sel	ect	~	
	Drafix				
	Select				
	First Name*	Midd	le Name		Last Name*
					. compare
	Suffix	Date	of Birth* 😧		Birth Weight
	Select	~ 09/	05/2020		lbs 025
	Patient Sex*	Ethn	icity*		Race*
	Female	✓ Not	Hispanic or Latino	x ~	White ×
	Mother's Current Legal Name and J First Name*	Address Midd	le Name		Last Name*
	Mother's Current Legal Name and J First Name* Address 1*	Address Midd	le Name	Address 2	Last Name*
	Mother's Current Legal Name and A First Name* Address 1* 123 Hawkins Lane	Nddress Midd	le Name	Address 2 Unit, Suite, Building, et	Last Name*
	Mother's Current Legal Name and A First Name* Address 1* 123 Hawkins Lane City*	Address Midd	le Name	Address 2 Unit, Suite, Building, et State*	Last Name*
	Mother's Current Legal Name and A First Name* Address 1* 123 Hawkins Lane City* Frankfort	Address Midd	le Name	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and A First Name* Address 1* 123 Hawkins Lane City* Frankfort County*	Address Midd	le Name	Address 2 Unit, Suite, Building, et State* KY	Last Name* .c. Zip Code .c. 40601- Email
	Mother's Current Legal Name and A First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette	Address Mide	le Name e* € 5) 555-5555	Address 2 Unit, Suite, Building, et State* KY	Last Name* Ic. X Email eleven@email.com
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un	Address Mide	le Name e* O 5) 555-5555	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with?	Address Mide	le Name e* •	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select	Address Mide	le Name e* •	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select	Address Mide	le Name e* •	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select	Address Mide Mide Phor X V (55 stinence Syndrome?* Nnown V V	le Name e* Q 5) 555-5555	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select	Address Mide	le Name	Address 2 Unit, Suite, Building, et State* KY	Last Name* IC. Zip Code 40601- Email eleven@email.com
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select If other, please specify: Please enter contact info of person First Name*	Address Mide Mide Phor X V (55 titinence Syndrome?* the child is living with: Midd	le Name e* •	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select If other, please specify: Please enter contact info of persons First Name*	Address Mide Mide Phor K V (55 titinence Syndrome?* the child is living with: Midd	le Name	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select If other, please specify: Please enter contact info of persons First Name* Address 1*	Address Mide Mide Phor K V (55 titinence Syndrome?* the child is living with: Midd	le Name	Address 2 Unit, Suite, Building, et State* KY	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select If other, please specify: Please enter contact info of persons First Name* Address 1*	Address Mide Mide Phor K V (55 stinence Syndrome?* the child is living with: Midd	le Name	Address 2 Unit, Suite, Building, et State* KY Address 2 Unit, Suite, Building, et	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select If other, please specify: Please enter contact info of persons First Name* Address 1*	Address Mide Mide Phor K V (55 stinence Syndrome)* * the child is living with: Midd	le Name	Address 2 Unit, Suite, Building, et State* KY Address 2 Unit, Suite, Building, et State*	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Un Who does the infant/child live with? Select If other, please specify: Please enter contact info of person of First Name* Address 1* City*	Address Mide Mide Phor X V Phor X V (55 stinence Syndrome)* * the child is living with: Midd	le Name	Address 2 Unit, Suite, Building, et State* KY Address 2 Unit, Suite, Building, et State* Select	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abi Yes No Ur Who does the infant/child live with? Select If other, please specify: Please enter contact info of person i First Name* Address 1*	Address Mide	le Name	Address 2 Unit, Suite, Building, et State* KY Address 2 Unit, Suite, Building, et State* Select	Last Name*
	Mother's Current Legal Name and J First Name* Address 1* 123 Hawkins Lane City* Frankfort County* Fayette Does the patient have Neonatal Abs Yes No Ur Who does the infant/child live with? Select If other, please specify: Please enter contact info of person First Name* Address 1* City* County*	Address Mide	le Name	Address 2 Unit, Suite, Building, et State* KY Address 2 Unit, Suite, Building, et State* Select	Last Name*

Communicable Disease Lab Entry and Initiating Case Reports User Guide



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Laboratory Information

The **Laboratory Information** screen displays details about the laboratory test that have been autopopulated based on the information previously entered on the Communicable Disease Lab Entry.

5. You have the option to **edit the auto-populated information** in the following enabled fields:

- Does the patient have a lab test?
- Hepatitis Marker
- Results

- Test Result Date
- Specimen Collection Date
- Laboratory Name

		LABORATORY INFORMATION
Patient Information	0	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, please ensure you complete all fields for
Hospitalization, ICU & Death Information	A	that test.
Vaccination History	A	
Additional Comments	A	Hepatitis Marker* HEPATITIS B VIRUS SURFACE AB × ·
Review & Submit	A	If other, please specify:
		Results*
		rosuve A V
		Test Result Date* Specimen Collection Date*
		07/01/2022
		Laboratory Name:*
		General Hospital
		🚱 Add Hepatitis Marker

Please Note: If *No* or *Unknown* is selected for the *Does the patient have a lab test*? question at the top of the **Laboratory Information** screen, all subsequent fields are disabled and grayed out.

6. You have the option to click **Add Hepatitis Marker** to log multiple hepatitis markers.

_ _ _ _ _ _ _ _ _ _

Hepatitis Marker*			
Select		~	
If other, please specify:			
Soloct			
Select		<u> </u>	
If applicable, please enter the viral load: 🚱			
Test Result Date		Specimen Collection Date*	
mm/dd/yyyy	iii Unknown	mm/dd/yyyy	🛗 🗌 Unknown

DDE: Communicable Disease Lab Entry



7. You also have the option to click Add ALT, Add AST, and/or Add Bilirubin.

ALT
G Add ALT
AST
Add AST
Bilirubin
Add Bilirubin

8. Once the appropriate edits and additions have been made in the enabled fields, click **Next** to proceed to the **Exposure Information** screen.

CHILD HEPATITIS CASE REPORT FOR	A Section 2 of 7
Please provide laboratory information related to	is case.
	LABORATORY INFORMATION
Patient Information	O 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, please ensure you complete all fields for
Hospitalization, ICU & Death Information	▲ that test.
Vaccination History	A
Additional Comments	Hepatitis Rarker* HEPATITIS R VIDUS SUPEACE AR
Review & Submit	f other, please specify:
	Results*
	Positive X V
	n applicable, please enter une virai road.
	Test Result Date* Specimen Collection Date*
	07/01/2022 Unknown 07/01/2022
	Laboratory Name:*
	General Hospital
	Add Hepatitis Marker
	ALT
	Add ALI
	AST
	Add AST
	Bilirubin
	Add Bilirubin
	Save Previous Next

Please Note: The subsequent **Exposure Information** screen of the Child Hepatitis Case Report does **not** include any auto-populated information from the Communicable Disease Lab Entry.

To proceed, you must enter the **appropriate information** in the enabled fields on each screen. Once complete, click **Next** to navigate to the **Hospitalization**, **ICU & Death Information** screen.

DDE: Communicable Disease Lab Entry

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Hospitalization, ICU & Death Information

The **Hospitalization**, **ICU & Death Information** screen displays details about a patient's hospitalizations that have been auto-populated based on the previously submitted Communicable Disease Lab Entry.

- 9. You have the option to **edit the auto-populated information** in the following enabled fields:
- Was the patient hospitalized?
- *Was the patient admitted to an intensive care unit (ICU)?*

		HOSPITALIZATION, ICU & DEATH	INFORMATION
atient Information	0	Was the patient hospitalized?*	
aboratory Information	0	Yes No Unknown	
xposure Information	0		
ospitalization, ICU & Death Informati	on	ir yes, piease specity the nospital name:" 😡	
accination History	₽	Admission Date*	Discharge Date*
dditional Comments	۵.	mm/dd/yyyy 🌐 🗌 Unknowr	n mm/dd/yyyy 📾 🗌 Unknown
eview & Submit	A		Still hospitalized
		Was the patient admitted to an intensive care unit (ICU)?*	
		Yes No Unknown	
		Admission Date to ICU*	Discharge Date from ICU*
		mm/dd/yyyy 🌐 🗌 Unknowr	n mm/dd/yyyy 🏥 🗌 Unknown

Please Note: If the Communicable Disease Lab Entry indicated that the patient was hospitalized, the selection for the conditional question at the top of the **Hospitalization**, **ICU & Death Information** screen is auto-populated as **Yes**: *Was the patient hospitalized*?

• If **Yes** is selected for the conditional question at the top of the screen, the subsequent hospitalization-related fields and ICU-related fields are enabled.

If the Communicable Disease Lab Entry indicated that the patient was admitted to the ICU, the selection for the ICU-related question is auto-populated as **Yes**: *Was the patient admitted to an intensive care unit (ICU)?*

• If **Yes** is selected for the ICU-related question, the subsequent *Admission Date* and *Discharge Date* fields are enabled. To proceed, you must enter the **Admission Date to ICU** and the **Discharge Date from ICU** in the appropriate fields.

Communicable Disease Lab Entry and Initiating Case Reports User Guide



Was the patient admitted to an Yes No	n intensive care unit (ICU)?* Unknown		
Admission Date to ICU*		Discharge Date from ICU*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🚺 Unknown
Please Note: If A Hospitalization, In and ICU-related fie	<i>lo</i> or <i>Unknown</i> is select CU & Death Information elds are disabled.	red for the conditional question of the subsequent ho	uestion at the top of the ospitalization-related fields
Death-related <i>Was the patier</i>	questions are not impacte <i>nt hospitalized?</i>	d by the selected answer fo	or the conditional question:

- 10. To complete the **Hospitalization**, **ICU & Death Information** screen, you must complete the following mandatory fields marked with **red asterisks** (*), if enabled:
- If yes, please specify hospital name
- Admission Date
- Discharge Date

- Admission Date to ICU
- Discharge Date from ICU
- Did the patient die as a result of this illness?

Admission Date"		Discharge Date*	
06/27/2022	🛗 🗌 Unknown	06/29/2022	🛗 🗌 Unknown
		Still hospitalized	
Was the patient admitted to an inte	nsive care unit (ICU)?*		
Yes No Ur	hknown		
Admission Date to ICU*		Discharge Date from ICU*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Did the natient die as a result of thi	s illness?*		
Yes No Ur	hknown		
If yes, please provide the date of de	ath		
11 UNV 1100/2018 11010/01/08 11/08 11/08 11/08 11/08	dui.		
in yes, preuse provide the date of de			
Communicable Disease Lab Entry and Initiating Case Reports User Guide



Admission Date*		Discharge Date*	
01/03/2022	🛗 🗌 Unknown	mm/dd/yyyy	Unknown
		✓ Still hospitalized	
Was the patient admitted to	an intensive care unit (ICU)?*		
Yes No	Unknown		
Admission Date to ICU		Discharge Date from ICU	J
mm/dd/vvvv	d Unknown	mm/dd/vvvv	Unknown
man and the second s	6.1.1. III		
Did the patient die as a result	of this illness?		
Yes No	Unknown		
Yes No	Unknown selected for the field:	Did the patient die as	<i>a result of this illness</i> ?, th
Yes No If yes please provide the date Please Note: If <i>Yes</i> is ubsequent field is ena	Unknown selected for the field: abled.	Did the patient die as	<i>a result of this illness</i> ?, th
Yes No If yes please provide the date Please Note: If <i>Yes</i> is ubsequent field is ena	Unknown selected for the field: abled.	<i>Did the patient die as</i>	<i>a result of this illness</i> ?, th
Yes No If yes please provide the date Please Note: If Yes is ubsequent field is ena	Selected for the field: abled.	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No If yes please provide the date Please Note: If Yes is ubsequent field is ena to proceed, enter the I	Selected for the field: abled. Date of Death in the su	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No If yes please provide the date Please Note: If Yes is ubsequent field is ena o proceed, enter the I	Selected for the field: abled. Date of Death in the su	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No If we please provide the date Please Note: If Yes is ubsequent field is ena o proceed, enter the I	Unknown selected for the field: abled. Date of Death in the su	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No	Unknown selected for the field: abled. Date of Death in the su	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No If yes please provide the date Please Note: If Yes is ubsequent field is ena to proceed, enter the I Did the patient die as a result of this Yes No Un	Unknown selected for the field: abled. Date of Death in the su sillness?*	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No If yes please provide the date Please Note: If Yes is ubsequent field is ena to proceed, enter the I Did the patient die as a result of this Yes No Un f yes, please provide the date of de	Unknown selected for the field: abled. Date of Death in the su sillness?*	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>
Yes No If yes please provide the date Please Note: If Yes is ubsequent field is ena To proceed, enter the I Did the patient die as a result of this Yes No Un f yes, please provide the date of de Date of Death*	Unknown selected for the field: abled. Date of Death in the su sillness?*	<i>Did the patient die as</i> ubsequent enabled field	<i>a result of this illness</i> ?, th d: <i>Date of Death.</i>



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11. Once the appropriate edits and additions have been made, click **Next** to proceed to the **Vaccination History** screen.

CHILD HEPATITIS CASE REPORT	FORM		Section 4 of 7	
Please select any applicable hospitalization	n, ICU and death information related to this case.			
	HOSPITA	LIZATION, ICU & DEATH INFORM	MATION	
Patient Information	✓ Was the patient hospitalized?*			
Laboratory Information	⊘ Yes No	Unknown		
Exposure Information	⊘			
Hospitalization, ICU & Death Information	in yes, please specify the hospital	name." U		
Vaccination History	Admission Date*		Discharge Date*	
Additional Comments	mm/dd/yyyy	iii Unknown	mm/dd/yyyy 🛗 🗌 Unknow	'n
Review & Submit	₽		Still hospitalized	
	Admission Date to ICU* mm/dd/yyyy Did the patient die as a result of t Yes No If yes, please provide the date of Date of Death mm/dd/yyyy	Intersection Inte	Discharge Date from ICU* mm/dd/yyyy	n
	Save		Previous Next	
Please Note : The Child Hepatitis (Communicable Di	subsequent Vaccina Case Report do <u>no</u> sease Lab Entry.	tion History and <u>t</u> include any a	Additional Comments screer auto-populated information fr	ns of the rom the
• To proceed, y	ou must enter the a	ppropriate infor	mation in the enabled fields	on each

Review and Submit: Child Hepatitis Case Report

Once the appropriate edits and additions have been made on all the Child Hepatitis Case Report screens, you will be navigated to the **Review and Submit** screen. The **Review and Submit** screen displays the summary of the information you have entered. Prior to submitting the Other Reportable Conditions Case Report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report.

screen. Once complete, click **Next** until you navigate to the **Review and Submit** screen.



12. Review the information on the **Review and Submit** screen.

CHILD HEPATITIS CASE REPORT FO	RM		Section 7 of 7		
Please review your information before submitting	2				
		REVIEW	& SUBMIT		
atient Information	0			Print	
iboratory Information	0				
posure Information	0	Patient Information			0
spitalization, ICU & Death Information	0				-
ccination History	0	Disease/Organism Child Hepatitis B	Date of Diagnosis 06/02/2022		
ditional Comments	0	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending	g Physician/Clinician?	
eview & Submit		No			
		Patient ID (MRN) JH05052020	Affiliation/Organization Test Medical Center		
		Person Completing Form Dr. Estelle Costanza (estelle@email.com)	Affiliation/Organization Test Medical Center		
		Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Other	If other, please specify: General Hospital	
		First Name Jane	Last Name Hopper		
		Date of Birth 05/05/2020	Ethnicity Not Hispanic or Latino	Race White	
		Address 1 123 Hawkins Lane			
		City	State	Zip Code	

13. 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: Additional patient notes			
	Previous	Submit	*

14. 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.

1es Adm 10/0	nission Date to ICI 01/2021	Case Report Entry ×	Discharge Date from ICU 10/02/2021
Did t No	the patient die as	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.	
Yac	cination Histo	Cancel Submit	0

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

Admis 10/01/	ssion Date to ICI /2021	Case Report Entry	×	Discharge Date from ICU 10/02/2021	
Did th No	ne patient die as	Case Report Entry Saved Successfully			
Vacci	ination Histo	ок			0



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.

 For specific information on the Case Report Entry User Summary screen , please review section 17: Case Report Entry User Summary of this guide.

Patient S	earch	Bookma	arked Patients		Event Notifications		Lab D	ata Entry 👻		Case Rep	ort Entry 🕶
Home >	Case Report Entry User	r Summary									
			CASE R	EPORT	ENTRY U	ISER SU	MMARY	,			
LAST UPDATED DATE RANGE Start Date 07/02/2022											2 Retrieve Da
HOWING ITEMS											T APPLY FILTE
CTIONS	REPORT TYPE +	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX \$	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
View Copy	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Complete	07/02/2022 12:30 PM	07/02/2022 1:45 PM
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	



17 Case Report Entry User 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	ePartr	erViewer					⊠ S	upport 📢 A	nnouncements	5 🌲 Advisories 3	e -
Patient S	earch	Bookma	rked Patients		Event Notifications	Event Notifications Lab [Case Rep	ort Entry *
🖀 Home ゝ	Case Report Entry User	Summary									
			CASE R	EPORT	ENTRY U	JSER SU	MMARY	7			
C LAST UPDAT	ED DATE RANGE		Start Date	07/02/2022	#	I	nd Date 07/02/	2022			₿ Retrieve Data
SHOWING 5 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	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Complete	07/02/2022 12:30 PM	07/02/2022 12:30 PM
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 11:00 AM	
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 10:30 AM	
Continue Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/01/2022 10:00 AM	
Continue Delete	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 9:30 AM	
			First	Back 1 Ne	ext Last					Maximum	; entries per page

- 1. Users are automatically navigated to the **Case Report User Summary** screen upon completing one of the following actions:
- Initiating <u>multiple</u> Case Report Forms when a Communicable Disease Lab Entry has been submitted successfully.

	Communicable Disease Lab Entry	×	
Ask On Order Entry First Test Yes	 Please select the appropriate Case Report Form. Candida auris, clinical Child Hepatitis B Dengue Perinatal Hepatitis B 	•	toms
Onset Date 06/20/2022	Syphilis NOTE: A Case Report Form is required only when the results are reportable. Users may select up to 5 conditions at a time.	·	regate
ICU	Cancel Initiate		



_ J

• Clicking **OK** on the *Case Report Entry* pop-up when the Case Report has been submitted successfully from the **Review and Submit** screen.

Admission Date to IC 10/01/2021	Case Report Entry ×	Discharge Date from ICU 10/02/2021									
Did the patient die as No	Case Report Entry Saved Successfully										
Vaccination Histo	ОК	0									
Please Note: Users with the Manua	Please Note : Users with the <i>Manual Case Reporter</i> role have the access to the Case Report Entry										
User Summary screen at any time											

 To navigate to the Case Report Entry User Summary screen at any time, click the Case Report Entry Tab in the blue Navigation Bar at the top of the screen.

_ _ _ _ _ _ _

3. Select **Case Report Entry User Summary** from the dropdown menu.

KĤIE ePar	tnerViewer		Support 📢 Announcements 🧐	3 🔺 Advisories 🕄 🕘 Jane Doe	•
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry +	
A Home				Case Report Forms	>
Advisory: Euture Alert				Case Report Entry User Summary	
		••••		Manage User Preferences	>
		myDASHBOARD			

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

CASE REPORT ENTRY USER SUMMARY																		
LAST UPDATED DATE RANGE Start D					01/20)21		Ê	1		End Date 10/01/2021 💼					-	C Retrieve Data	
					Sept	eptem tember	ber 2	021	•	Þ.								
SHOWING 1 ITEMS				Su 29	Mo 30	Tu V 31	Ve T	"h F 2	Fr s	Sa 4							T APPLY FILTER	
ACTIONS REPORT TYPE ACTIONS REPORT TYPE			AFFILIATION/ ORGANIZATION	5 12 19	6 13 20	7 14 1 21 2	8 ! 15 1 22 2	9 1 16 1 23 2	10 1 17 1 24 2	11 18 25	¢	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 3	30	1	2		Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM	

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

CASE REPORT ENTRY USER SUMMARY										
LAST UPDATED DATE RANGE	Start Date 09/01/2021	End Date 10/01/2021	🞜 Retrieve Data							
SHOWING 1 ITEMS			T APPLY FILTER							



6. To delete an initiated Case Report for the patient, click **Delete** next to the appropriate *Report Type*.

ITEMS											▼ APPLY FILTER
CTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX \$	STATUS \$	LAST UPDATED	SUBMISSION DATE
Continue Delete	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	

7. The *Case Report Deletion* pop-up displays. To delete the Case Report, click **Confirm**. Click **Cancel** if you do not want to delete the Case Report.

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	Case Report Deletion ×	OF 1 \$	PATIENT SEX 🗢	STATUS	LAST UPDATED	SUBMISSION DATE +
Continue Delete	Child Hepatitis	Child Hepatitis B	Test Medical Center	Please confirm to delete	72020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	Cancel	/2020	Female	In Progress	07/02/2022 12:30 PM	



8. To search for a specific Case Report, click **Apply Filter**.

KÎLIE	ePartn	erViewer		2	Support 📢	Announcemer	nts 💈 🌲 Advisories 🕻	9				
Patient S	earch	Bookma	arked Patients		Event Notification	s	Lab I	Data Entry -		Case R	eport Entry ~	
🖀 Home ゝ	Case Report Entry User	Summary										
			CASE R	EPORT	ENTRY L	JSER SU	MMARY	7				
LAST UPDAT	ED DATE RANGE		Start Date	07/02/2022	#	1	End Date 07/02/	2022			2 Retrieve Dat	a
SHOWING 14 ITEMS											T APPLY FILTER	2
ACTIONS	REPORT TYPE +	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX 🗘	STATUS 🔻	LAST UPDATED	SUBMISSION DATE	¢
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	GC12271965	George	Costanza	12/27/1975	Male	In Progress	07/02/2022 12:30 PM		
			First Back	1 2 3 Ne	xt Last					Maximum	• entries per p	page

9. The Filter fields display. Search by entering the *Report Type*, *Disease/Organism*, *Affiliation/Organization*, *Patient MRN*, the patient's *First Name*, *Last Name*, *Date of Birth*, *Patient Sex*, *Status*, *Last Updated*, and/or *Submission Date* in the corresponding Filter fields.

KĤIE	ePartr	erViewer		😂 Support 📢 Announcements 🕽 🌲 Advisories 🕽 😧 👻							
Patient S	iearch	Bookma	arked Patients		Event Notification	ations Lab Data f		Data Entry -	lata Entry - Case		eport Entry ~
😭 Home 🖒	Case Report Entry Use	Summary									
			CASE R	EPORT	ENTRY L	JSER SU	MMARY	7			
LAST UPDAT	ED DATE RANGE		Start Date	07/02/2022	**	E	ind Date 07/02/	2022			CRETRIEVE Data
SHOWING 14 ITEMS											
ACTIONS	REPORT TYPE +	DISEASE/ ORGANISM Enter Disease/ Or	AFFILIATION/ ORGANIZATION Enter Affiliation/ (PATIENT MRN Enter Patie	FIRST NAME	LAST NAME + Enter Last Na	DATE OF BIRTH	PATIENT SEX ♀ All ✓	STATUS • Enter St	All v	SUBMISSION DATE ≑ All ~
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	



Review Previously Submitted Case Reports

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

KĤIE	ePartner	Viewer						🐸 Support	📢 Announcer	ments 👂 🌲 Advisories	9 9 -
Patient S	earch	Bookma	irked Patients		Event Notifications		Lab D	ata Entry -		Case Rep	ort Entry -
😭 Home 🖒	Case Report Entry User	r Summary									
			CASE R	EPORT	ENTRY U	ISER SU	MMARY	,			
LAST UPDAT	ED DATE RANGE		Start Date	07/02/2022	#	E	nd Date 07/02/	2022			$oldsymbol{\mathcal{C}}$ Retrieve Data
SHOWING 5 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	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Complete	07/02/2022 12:30 PM	07/02/2022 1:45 PM
Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	Other Conditions	Dengue	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	
Continue Delete	STD	Syphilis	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	

11. 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.
- 12. Click **OK** to close out of the pop-up.

KĤIE	Case Report Details		🔒 Print	Download ×
Patient Se	Patient Information			Entry ▼
	Disease/Organism Child Hepatitis B	Date of Diagnosis Unknown		
	Is the Affiliation/Organization same for Patient ID (MRN), Person Con No	pleting Form, and Attending Physician/Clinician?		
CLAST UPDATED	Patient ID (MRN) JH05052020	Affiliation/Organization Test Medical Center		🔁 Retrieve Data
SHOWING 5 ITEMS	Person Completing Form Dr. Estelle Costanza (estelle@email.com)	Affiliation/Organization Test Medical Center		T APPLY FILTER
ACTIONS	Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com)	Affiliation/Organization Test Medical Center		JBMISSION DATE
View	First Name Jane	Last Name Hopper		7/20/2022 6:03 PM
Сору	Date of Birth 05/05/2020			
Continue Delete	Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White	
Continue	Mother's Current Legal Name and Address	Last Name		
Delete	Terry	lves		
Continue	Address 1 123 Hawkins Lane			
Delete	City Frankfort	State KY	Zip Code 40601	
Continue Delete				ок

DDE: Communicable Disease Lab Entry



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. This 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.

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

Home > Case Report Entry User Summary												
CASE REPORT ENTRY USER SUMMARY												
	S LAST UPDATED DATE RANGE Start Date 07/02/2022									CRetrieve Data		
	showing 5 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	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Complete	07/02/2022 12:30 PM	07/02/2022 1:45 PM
	Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM	

Please Note: Clicking **Copy** will automatically navigate you to the **Patient Information** screen of the appropriate Case Report. By default, the **Patient Information** screen displays autopopulated information entered on the previously submitted case report.

You have the option to edit the auto-populated information entered in any of the enabled fields and submit a new case report for the patient.

• For specific information on the **Patient Information** screen of each Case Report, please review the appropriate *Initiate Case Report* section of this guide.

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 of the Patient ID (MRN)
- Prefix
- Suffix

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

Communicable Disease Lab Entry and Initiating Case Reports User Guide



	PATIENT INF	ORMATION		
Disease/Organism* 🕑 Perinatal Hepatitis B	~	Date of Diagnosis* mm/dd/yyyy	📾 🗌 Unknown	
Is the Affiliation/Organization same	for Patient ID (MRN), Person Completing Form, and Attending Ph	hysician/Clinician?*	
Patient ID (MRN)* 🚱		Affiliation/Organization* 🚱		
JH05052020		Test Medical Center		
Person Completing Form*		Affiliation/Organization* 😧	If other, please specify: 🚱	
Select	~	Select		
Attending Physician/Clinician*		Affiliation/Organization* 🛛	If other, please specify: 🔞	
Select	~	Select		
Prefix				
Select	\sim			
First Name*		Middle Name	Last Name*	
Jane			Hopper	
Suffix		Maiden Name		
Select	~			
Date of Birth*		Ethnicity*	Race*	

Initiate Case Report

14. To complete a Case Report that has been previously initiated for the patient, click **Continue** next to the appropriate *Report Type*.

CASE REPORT ENTRY USER SUMMARY													
	LAST UPDAT	ED DATE RANGE		Start Date	7/02/2022	#	E	nd Date 07/02/	2022			CRETRIEVE Data	
	SHOWING 5 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	Child Hepatitis	Child Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	Complete	07/02/2022 1:45 PM	07/02/2022 1:45 PM	
	Continue Delete	MDRO	Candida auris, clinical	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		
	Continue Delete	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	JH05052020	Jane	Hopper	05/05/2020	Female	In Progress	07/02/2022 12:30 PM		



Please Note: Upon clicking **Continue**, you will be automatically navigated to the **Patient Information** screen of the selected Case Report. By default, the **Patient Information** screen displays auto-populated information entered on the previously submitted Communicable Disease Lab Entry.

• For specific information on the **Patient Information** screen of each Case Report, please review the appropriate *Initiate Case Report* section of this guide.

18 Technical Support

Toll-Free Telephone Support

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

Email Support

To submit questions electronically or request support regarding the ePartnerViewer, please email <u>KHIESupport@ky.gov</u>.

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Please Note: To seek assistance or log issues, you can use the **Support Tab** located in the blue navigation bar at the top of the screen in the ePartnerViewer.

KĤIE	ePartnerViewer	Support	📢 Announcements ち 🌲 Advisories 3	9	
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🗸	Case Report Entry -	