

# Kentucky Health Information Exchange (KHIE)

## **Direct Data Entry for Case Reports: Acute Hepatitis B**

### User Guide

February 2023

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### Document Information

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## 1 Introduction

### Overview

This training manual covers KHIE's Direct Data Entry for Acute Hepatitis B Case Reports functionality in the ePartnerViewer. Users with the *Manual Case Reporter* role can submit case reports from the ePartnerViewer by completing an online case report. The process generates a manual electronic initial case report (eICR) which is routed to the Department for Public Health (DPH). All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

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

### Supported Web Browsers

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

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

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

## Mobile Device Considerations

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

## Accessing the ePartnerViewer

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

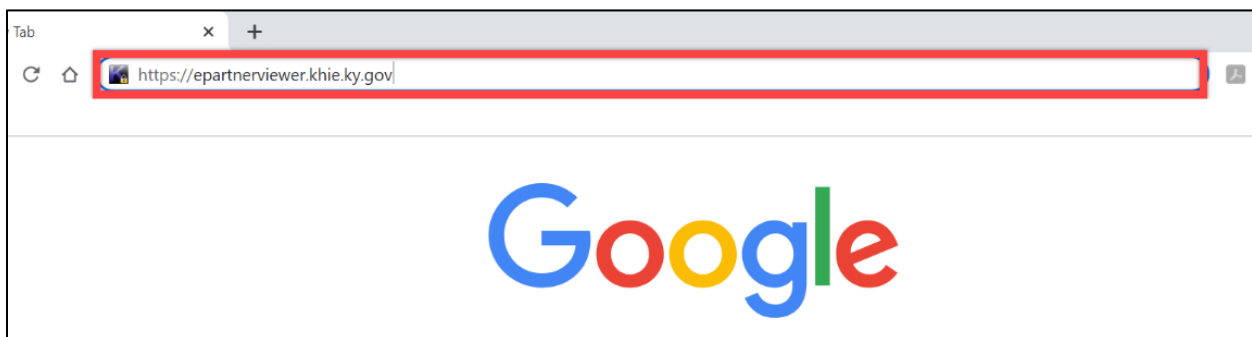
1. Users must be part of an organization with a signed Participation Agreement with KHIE.
2. Users are required to have a Kentucky Online Gateway (KOG) account.
3. Users are required to complete Multi-Factor Authentication (MFA).

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

## 2 Logging into ePartnerViewer

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


1. To navigate to the ePartnerViewer, enter the following **ePartnerViewer URL** in a supported browser window: <https://epartnerviewer.khie.ky.gov>



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

2. On the **KOG Login Page**, enter your **Email Address**. Click **Next**.

Welcome to the new Kentucky Online Gateway (KOG) sign-in page! Please login with your existing KOG account. If you run into any login issues, please refer to the new Help page.



Sign in with your Kentucky Online Gateway (KOG) Account (UAT)

Email Address


Next


[Create New Account](#)  
[Resend Account Verification Email](#)

English ▼ [Help](#)

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

3. Enter your **Password**. Click **Verify**.





Verify with your password

khie\_SIT\_TEST\_44@mailinator.com

Password

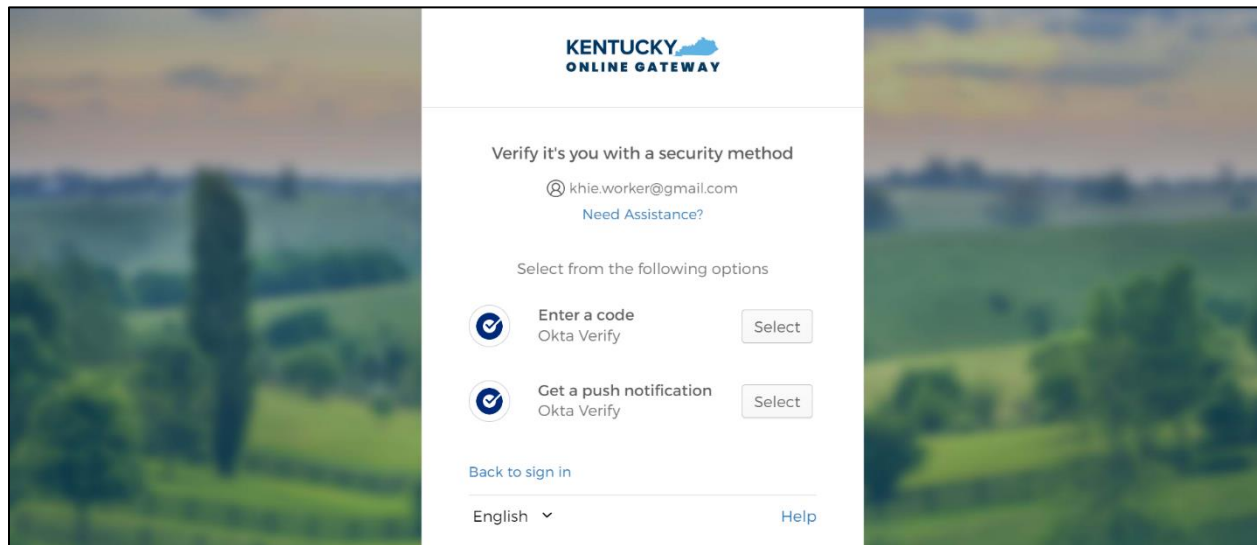
Verify

[Forgot password?](#)  
[Verify with something else](#)  
[Back to sign in](#)

English ▼ [Help](#)

4. **Multi-Factor Authentication.** After logging into KOG and verifying your password, you are automatically navigated to the **Verify it's you with a security method** screen. You will be asked to complete Multi-Factor Authentication (MFA) using Okta Verify. Users have two (2) options for completing Okta Verify for MFA:

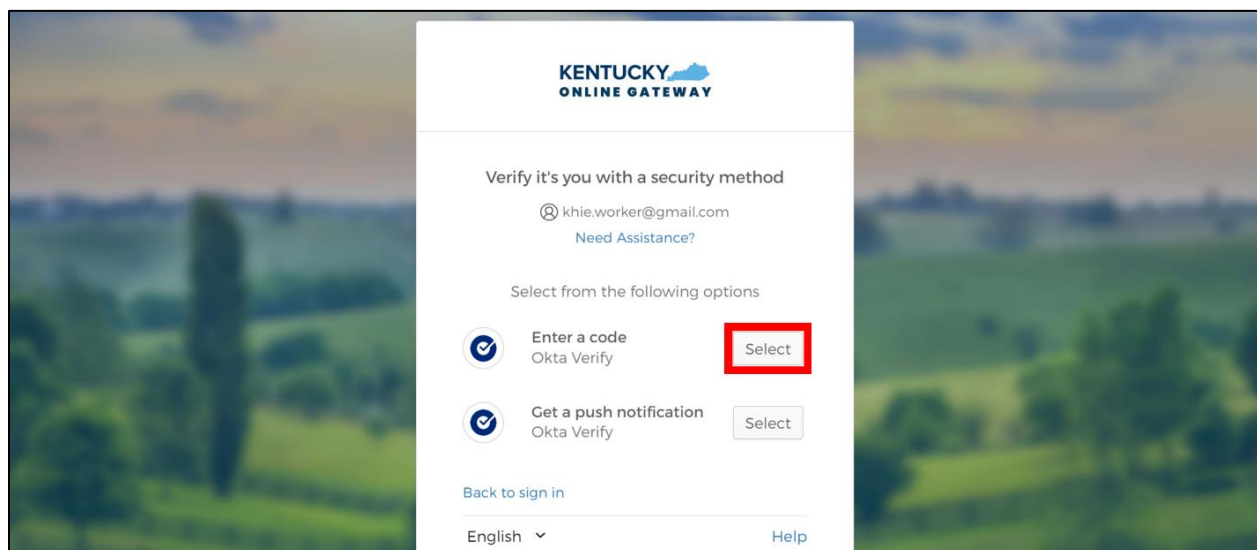
- Use a security code from the Okta Verify app.
- Use the push notification from the Okta Verify app.



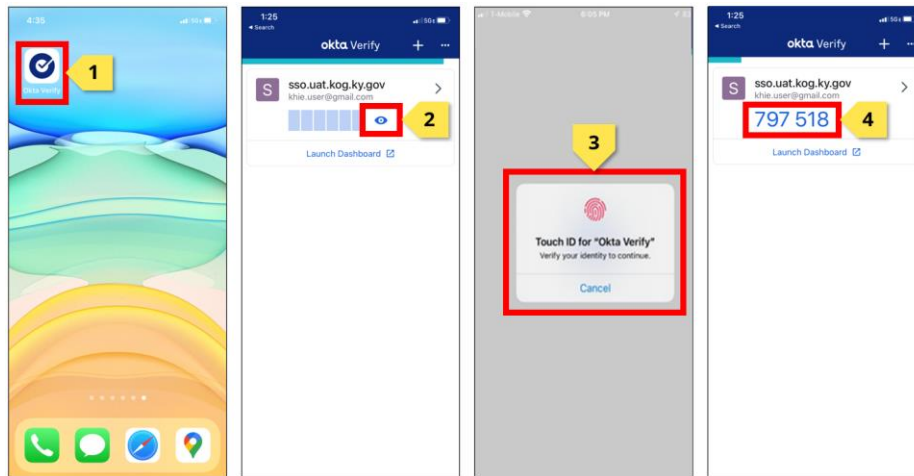
### Security Code from Okta Verify App

To complete MFA using the security code from Okta Verify, complete the following steps:

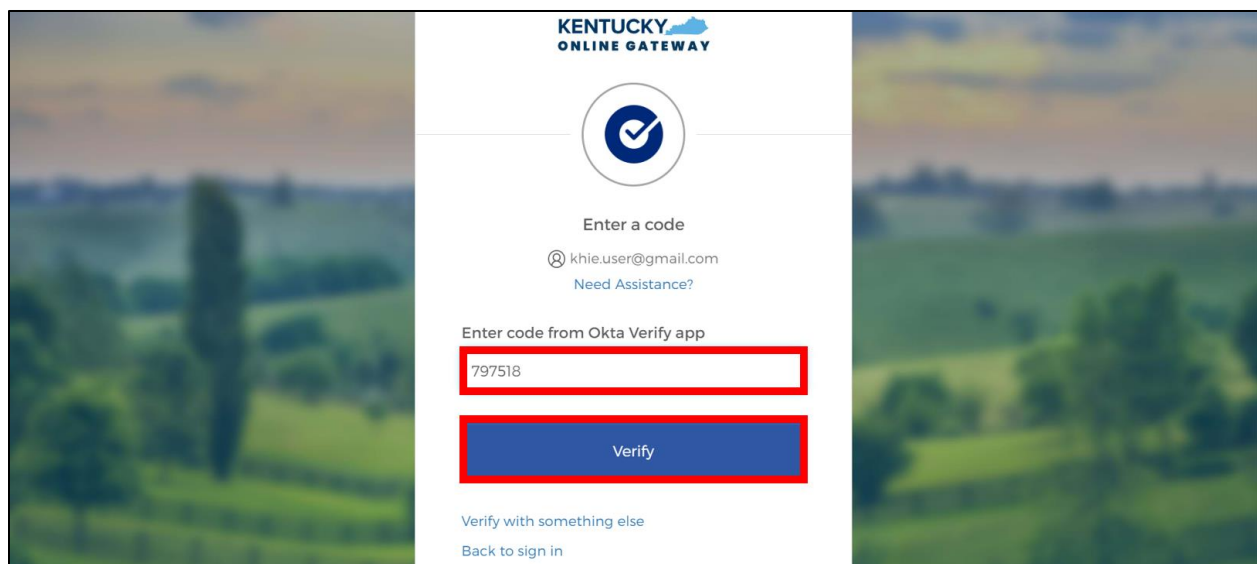
1. After logging into KOG, you are navigated to the **Verify it's you with a security method** screen. Click the **Select** button next to **Enter a code**.



2. To locate the Okta Verify code, complete the following steps from your mobile device or tablet:
- Step 1: Open the **Okta Verify** app on your mobile device or tablet.
  - Step 2: If the code is hidden, click the **Eye Icon** below the email address used for your KOG account.
  - Step 3: Verify your identity using either **Touch ID** or **Face ID**.
  - Step 4: Upon verifying your identity, the **6-digit code** displays.



3. Return to the **Enter a code** screen on your computer. Enter the **6-digit code** from the Okta Verify app. Click **Verify** to proceed to the **Terms and Conditions of Use** screen of the ePartnerViewer.

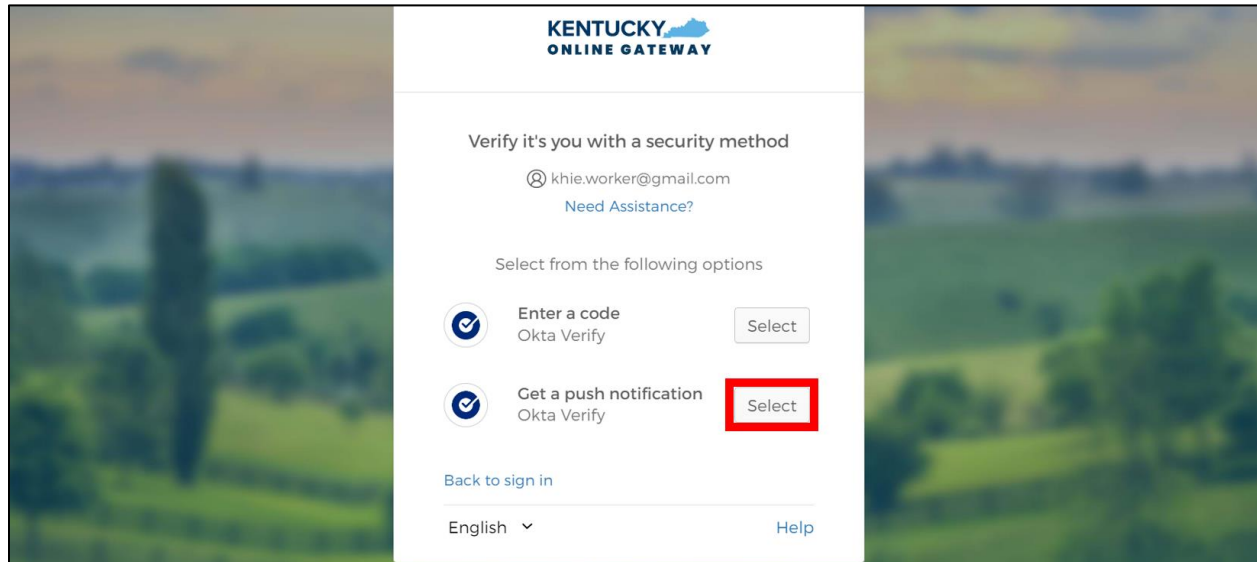


**Please Note:** Once you enter the code from the Okta Verify app, you are automatically navigated to the **Terms and Conditions of Use** screen. For more information, please review the *Terms and Conditions of Use and Logging In* sub-section of this chapter.

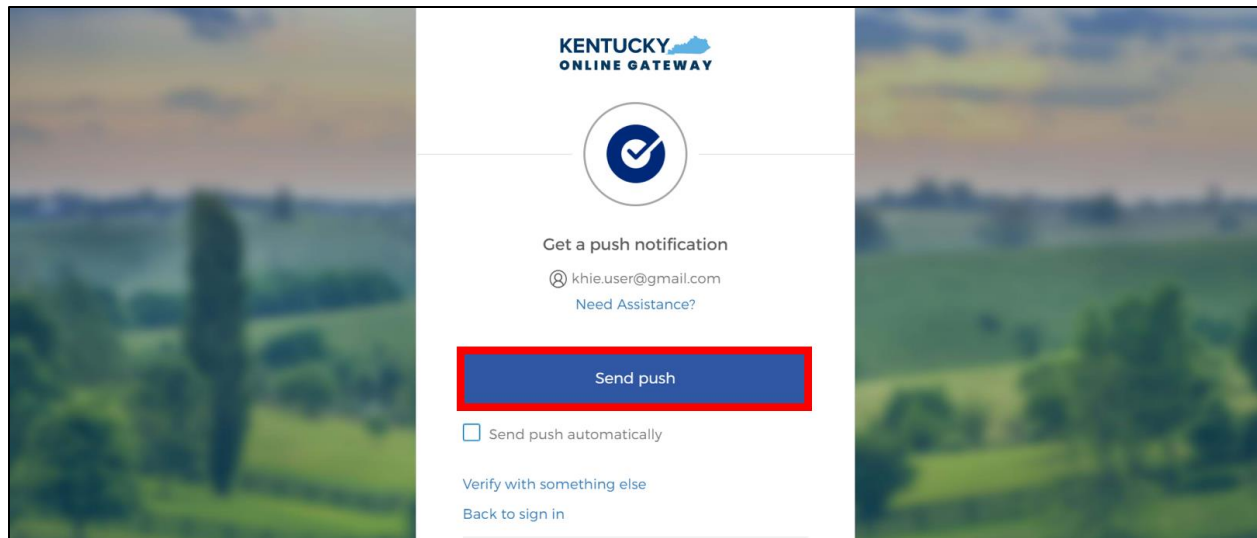
### Push Notification from Okta Verify App

To complete MFA using a push notification from Okta Verify, complete the following steps:

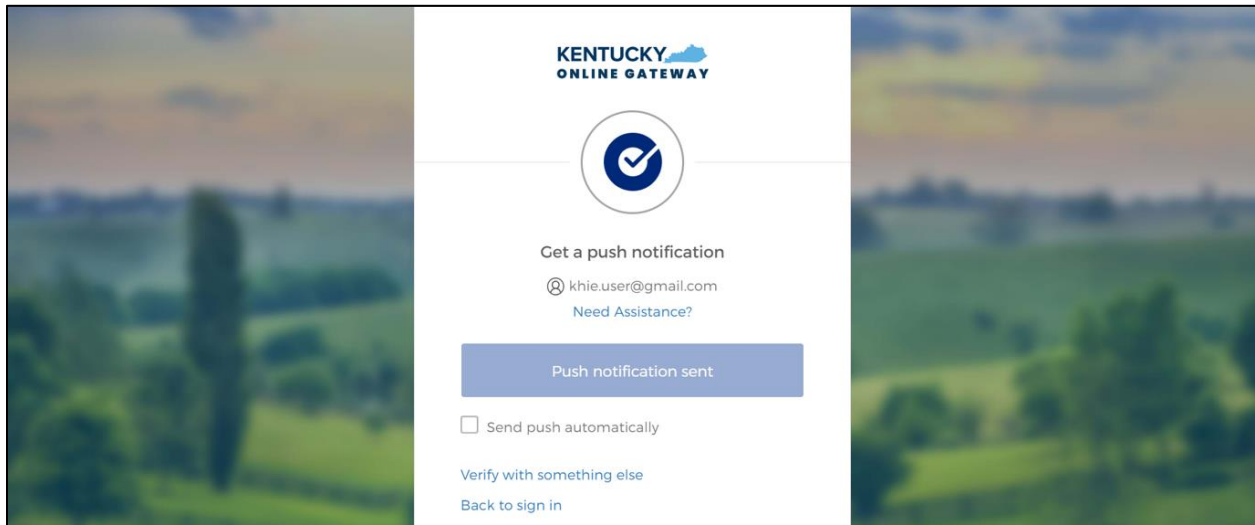
1. After logging into KOG, you are navigated to the **Verify it's you with a security method** screen. Click the **Select** button next to **Get a push notification**.



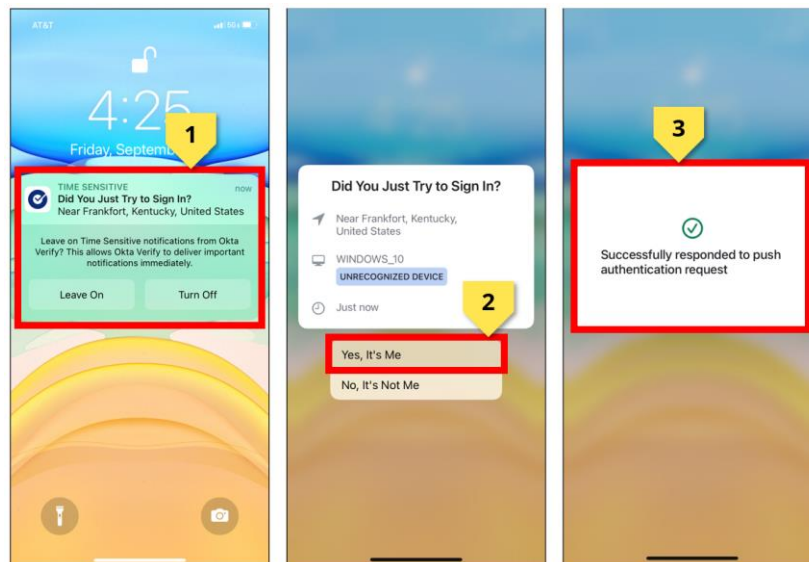
2. The **Get a push notification** screen displays. Click **Send Push**.



**Please Note:** Once the push notification has been successfully sent to the Okta Verify app, the **Get a push notification** screen of the ePartnerViewer displays a grayed out **Push notification sent** button.



3. To view the Okta Verify push notification, complete the following steps from your mobile device:
- Step 1: You will receive a push notification on your mobile device or tablet. Tap and hold the notification banner titled “**Did You Just Try to Sign In?**”.
  - Step 2: On the notification, click the **Yes, It's Me** button.
  - Step 3: A notification will appear on your mobile device screen letting you know that you have successfully responded to the push authentication request. You can now return to your computer where you will be redirected to the **Terms and Conditions of Use** screen of the ePartnerViewer.



**Please Note:** Once you successfully respond to the Okta Verify push notification, you are automatically navigated to the **Terms and Conditions of Use** screen of the ePartnerViewer.

## Terms and Conditions of Use and Logging In

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

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

**KHIE** | ePartnerViewer Jane Doe

### TERMS AND CONDITIONS OF USE

#### Terms and Conditions

HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

I accept the following terms and conditions of the Kentucky Health Information Exchange (KHIE):

- I am a healthcare provider currently treating a patient.
- I am currently bound by a Health Information Exchange Participation Agreement with the Division of Health Information or have a current relationship as an authorized user of a participating provider of the Division of Health Information.
- I understand that data available on KHIE is only that information available according to state and federal law.

The Medicaid claims data will not include records of the following:

- HIV medical procedures and test.
- Diagnosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.
- I understand that all data available on KHIE WILL NOT include HIV medical procedures and tests, regardless of source.

Select 'I accept' to accept the usage terms and conditions.

**I accept** I decline

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 displays a message that states:  
*Access is restricted beyond this point. You must accept the terms and conditions before proceeding.*

2. 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.)
3. Click **Proceed to Portal** to continue to the ePartnerViewer application.

**KHIE** | ePartnerViewer Jane Doe

### TERMS AND CONDITIONS OF USE

#### Terms and Conditions

HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

I accept the following terms and conditions of the Kentucky Health Information Exchange (KHIE):

- I am a healthcare provider currently treating a patient.
- I am currently bound by a Health Information Exchange Participation Agreement with the Division of Health Information or have a current relationship as an authorized user of a participating provider of the Division of Health Information.
- I understand that data available on KHIE is only that information available according to state and federal law.

The Medicaid claims data will not include records of the following:

- HIV medical procedures and test.
- Diagnosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.
- I understand that all data available on KHIE WILL NOT include HIV medical procedures and tests, regardless of source.

Select 'I accept' to accept the usage terms and conditions.

**Accepted**

You are part of the below mentioned organization. Please click on proceed to continue.

KHIE Smoke Test Organization

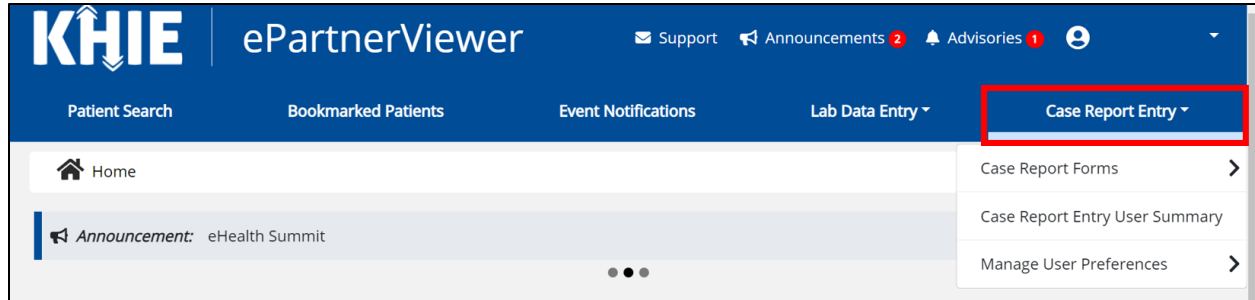
**Proceed to Portal** Cancel

**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 Case Report Entry Dropdown Menu

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

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



#### 1. Types of Case Reports:

- **COVID-19 Case Report:**
  - Designed for Users to enter COVID-19 case reports.

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

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

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

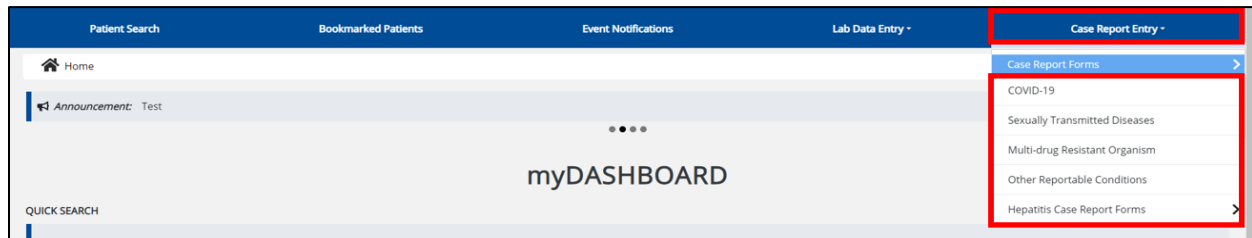
- **Multi-drug Resistant Organism (MDRO) Case Report:**
  - Designed for Users to enter MDRO case reports.

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

- **Other Reportable Conditions Case Report:**

- Designed for Users to enter Other Reportable Conditions case reports.

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



## 2. Types of Hepatitis Case Reports:

- **Perinatal Hepatitis Case Report:**

- Designed for Users to enter Perinatal Hepatitis case reports.

**Please Note:** For specific information about Perinatal Hepatitis case reporting, please review the *Direct Data Entry for Case Reports: Perinatal Hepatitis User Guide*.

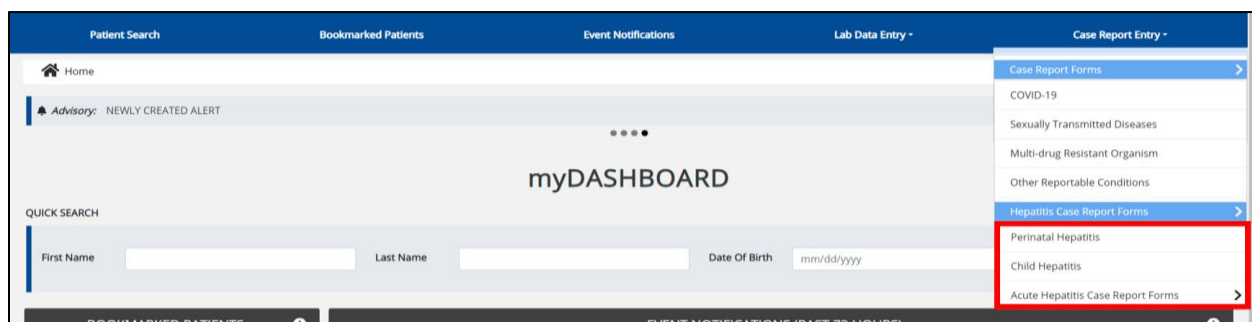
- **Child Hepatitis Case Report:**

- Designed for Users to enter Child Hepatitis case reports.

**Please Note:** For specific information about Child Hepatitis case reporting, please review the *Direct Data Entry for Case Reports: Child Hepatitis User Guide*.

- **Acute Hepatitis Case Reports:**

- Designed for Users to choose between the three (3) types of Acute Hepatitis case reports.



### 3. Types of Acute Hepatitis Case Reports:

- **Acute Hepatitis A Case Report:**

- Designed for Users to enter Acute Hepatitis A case reports.

**Please Note:** For specific information about Acute Hepatitis A case reporting, please review the *Direct Data Entry for Case Reports: Acute Hepatitis A User Guide*.

- **Acute Hepatitis B Case Report:**

- Designed for Users to enter Acute Hepatitis B case reports.

- **Acute Hepatitis C Case Report:**

- Designed for Users to enter Acute Hepatitis C case reports.

**Please Note:** For specific information about Acute Hepatitis C case reporting, please review the *Direct Data Entry for Case Reports: Acute Hepatitis C User Guide*.

**KHIE ePartnerViewer**

Support Announcements 8 Advisories 4 SIT\_TEST 44

Patient Search Bookmarked Patients Event Notifications Lab Data Entry Case Report Entry

Home

Advisory: Updated Active advisory on 10/7/2022 7:58:53 AM

**myDASHBOARD**

QUICK SEARCH

First Name Last Name Date Of Birth mm/dd/yyyy

**BOOKMARKED PATIENTS**

ARHJOHN, JIM

ABRAHAM, ALEXANDERS

**EVENT NOTIFICATIONS (PAST 72 HOURS)**

EVENT DATE	NOTIFICATION DATE	EVENT	FACILITY	NAME
01/23/2023 11:30:15 am	01/31/2023 6:25:47 am	Results Ready for Review	MCCH	BRADY, BOB

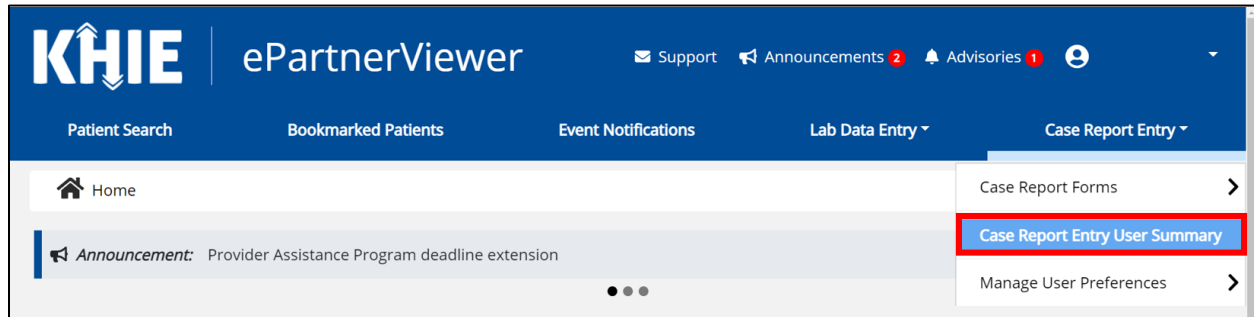
Case Report Forms

- COVID-19
- Sexually Transmitted Diseases
- Multi-drug Resistant Organism
- Other Reportable Conditions
- Hepatitis Case Report Forms
  - Perinatal Hepatitis
  - Child Hepatitis
  - Acute Hepatitis Case Report Forms
    - Hepatitis A
    - Hepatitis B
    - Hepatitis C

nator.com)

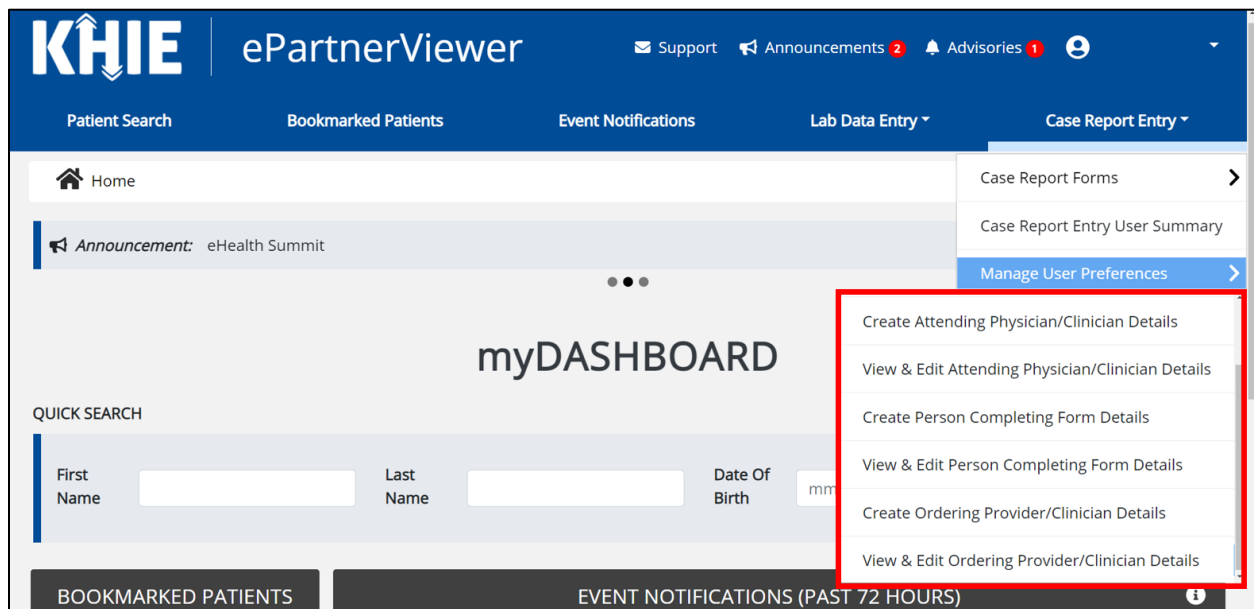
#### 4. Case Report Entry User Summary:

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



#### 5. Manage User Preferences:

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

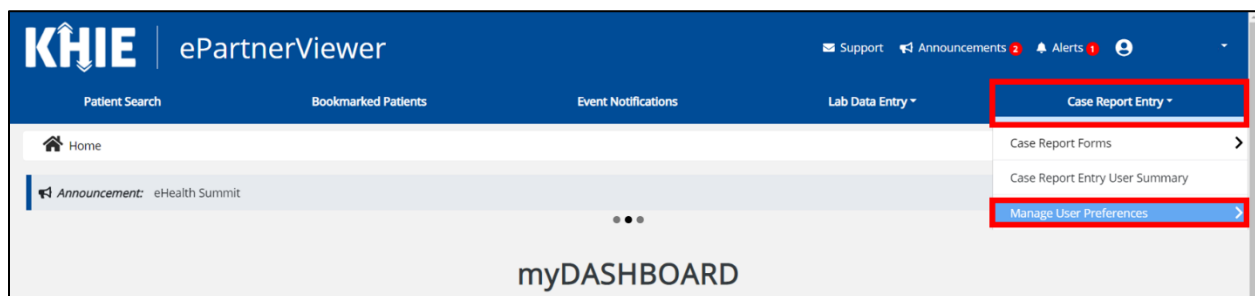


## 4 Manage User Preferences

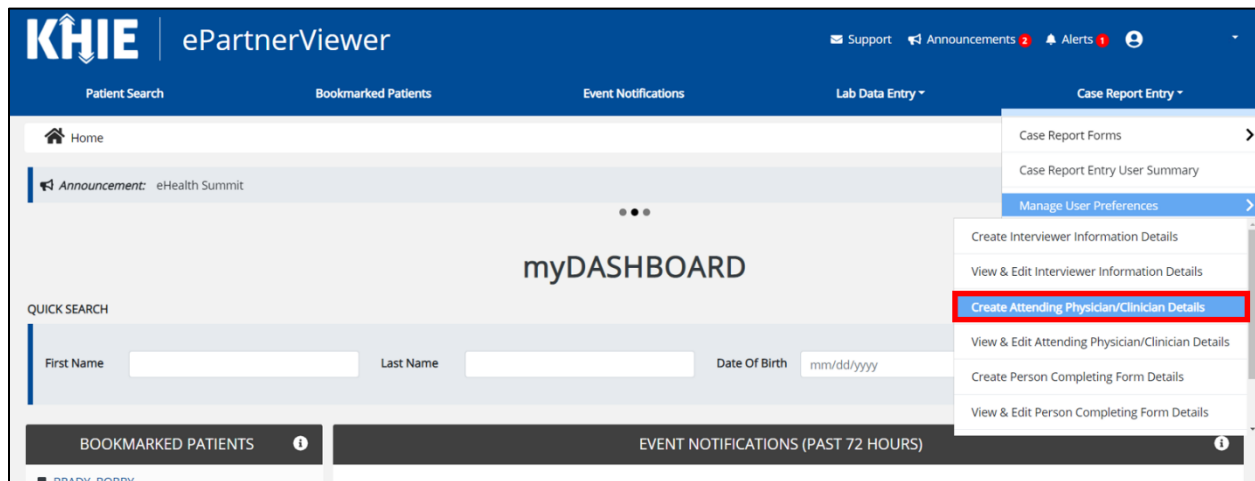
These are your User Preferences. Prior to entering your case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in your user preferences, you will be able to quickly select an Attending Physician/Clinician and the name of the Person Completing the Form from the dropdown menu options. These dropdown menus are located on the **Patient Information** screen of the Acute Hepatitis B Case Report.

### Create Attending Physician/Clinician Details

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



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



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

Home > Create Attending Physician/Clinician Details

Please complete the form below to create an Attending Physician/Clinician. All fields marked with an asterisk(\*) are required.

**ATTENDING PHYSICIAN/CLINICIAN**

Prefix: Dr.

First Name\*:

Last Name\*:

Suffix: Select... (Options: II, III, IV, Jr, Sr)

Address 2: Unit, Suite, Building, etc.

State\*: Select... Zip Code\*:

Email\*: name@domain.com

Clear Save

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

Please complete the form below to create an Attending Physician/Clinician. All fields marked with an asterisk(\*) are required.

**ATTENDING PHYSICIAN/CLINICIAN**

Prefix: Dr.

First Name\*:

Last Name\*:

Suffix: Sr

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

Address 1\*:

Address 2: Unit, Suite, Building, etc.

City\*:

State\*: Select... Zip Code\*:

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

<b>Phone*</b> <input type="text" value="(xxx) xxx-xxxx"/>	<b>Email*</b> <input type="text" value="name@domain.com"/>
--	---

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix  
Dr. x | v

First Name\*  
Frank

Last Name\*  
Costanza

Suffix  
Sr x | v

Address 1\*  
1 First Street

Address 2  
1A

City\*  
Lexington

State\*  
KY x | v

Zip Code\*  
40123

Phone\*  
(111) 111-1111

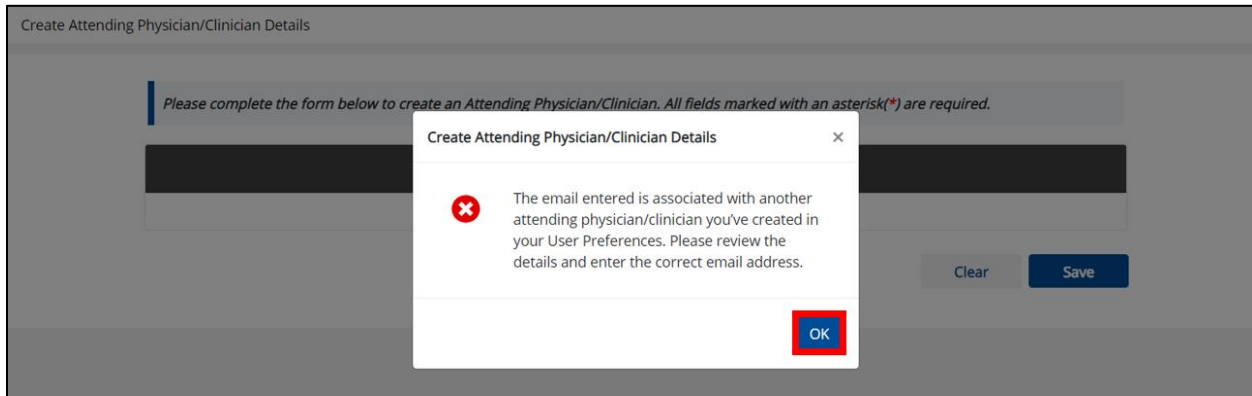
Email\*  
frank@email.com

Clear

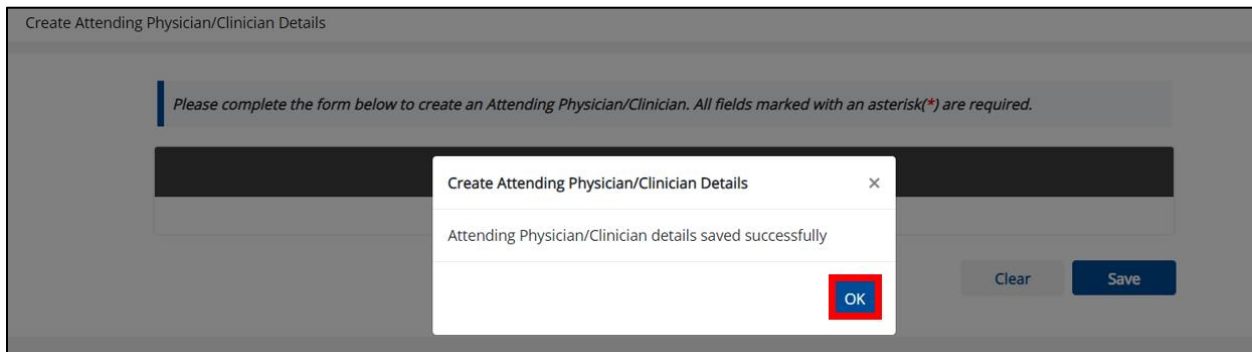
Save

**Please Note:** If you enter an email address that is already associated with another Attending Physician/Clinician and click **Save**, a pop-up displays with an error message that states:  
*The email entered is associated with another physician/clinician you've created in your User Preferences. Please review the details and enter the correct email address.*

You must click **OK** and enter the correct email address to save the Attending Physician/Clinician details and proceed to the **View & Edit Attending Physician/Clinician Details** screen.

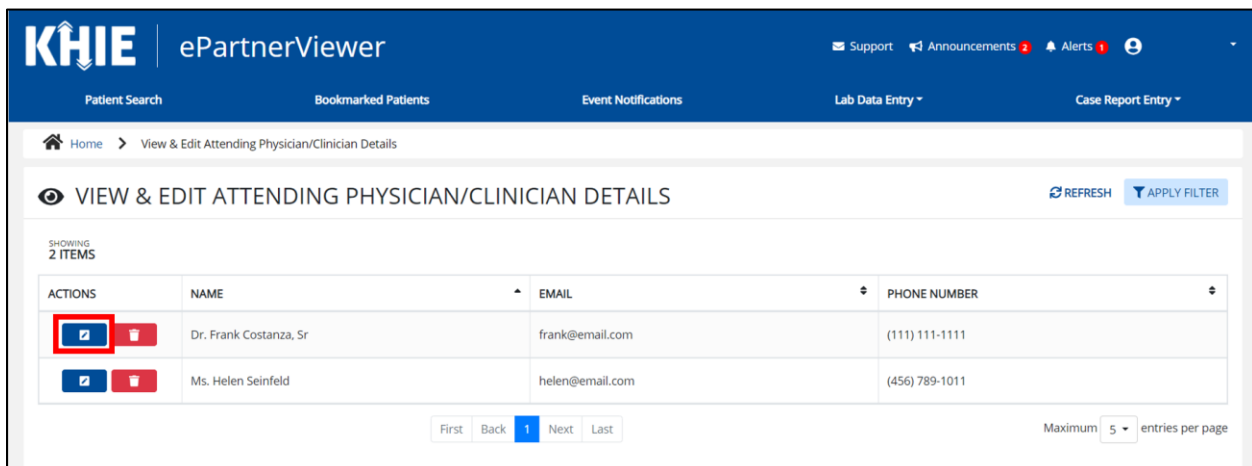


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.



## View & Edit Attending Physician/Clinician Details

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



12. The *Update Attending Physician/Clinician Details* pop-up displays. You can make any necessary edits and click **Save** to save the updates and close out of the pop-up.

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

### Delete Attending Physician/Clinician Details

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

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

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

The screenshot shows the 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' interface. A pop-up window titled 'Delete Attending Physician/Clinician Details' is centered, asking 'Are you sure?' with 'Cancel' and 'OK' buttons. The background table lists one item: Dr. Frank Costanza, Sr. with a phone number (111) 111-1111. The interface includes a 'SHOWING 1 ITEMS' indicator, a 'REFRESH' button, an 'APPLY FILTER' button, and a 'Maximum 5 entries per page' setting.

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

If you attempt to delete an attending physician/clinician who has been selected for use in a case report that has not been completed yet, a pop-up notification will display the following message: *This attending physician/clinician information is being used in a case report that is still in progress. To delete this attending physician/clinician, please ensure that this attending physician/clinician is not being used in a case report that is in progress.*

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

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





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

The screenshot shows the 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' interface. A pop-up window titled 'Delete Attending Physician/Clinician Details' is centered, displaying a red 'X' icon and the message: 'This attending physician/clinician information is being used in one of the case reports that is still in progress. To delete this attending physician/clinician, please ensure that this attending physician/clinician is not being used in any case report that is in progress.' The background table lists two items: Ms. Helen Seinfeld and Dr. Frank Costanza, Sr. with phone numbers (456) 789-1011 and (111) 111-1111 respectively. The interface includes a 'SHOWING 2 ITEMS' indicator, a 'REFRESH' button, an 'APPLY FILTER' button, and a 'Maximum 5 entries per page' setting.

**Filter Attending Physician/Clinician Details**





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

The screenshot shows the 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' page in the KHIE ePartnerViewer. The page has a blue header with the KHIE logo and navigation links. Below the header, there's a breadcrumb trail: Home > View & Edit Attending Physician/Clinician Details. The main content area has a title 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' and a 'REFRESH' button. A red box highlights the 'APPLY FILTER' button. Below this, there's a table with 2 items. The table has columns: ACTIONS, NAME, EMAIL, and PHONE NUMBER. The first row is for Dr. Frank Costanza, Sr. with email frank@email.com and phone (111) 111-1111. The second row is for Ms. Helen Seinfeld with email helen@email.com and phone (456) 789-1011. At the bottom, there are pagination controls: First, Back, 1, Next, Last. A dropdown menu shows 'Maximum 5 entries per page'.

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
 	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

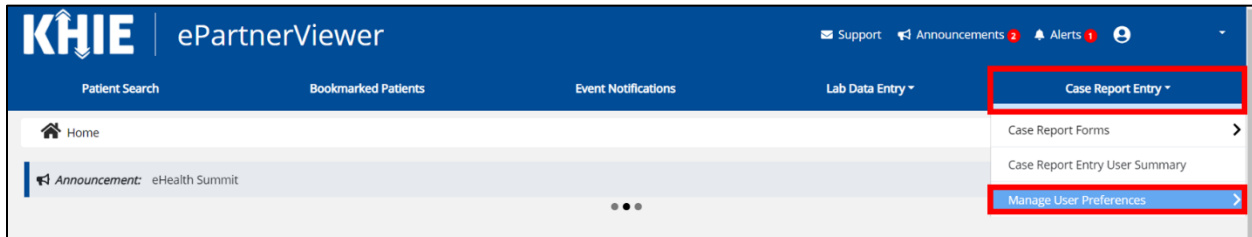
17. The Filter fields display. You can search by entering the **Attending Physician/Clinician's Name**, **Email Address**, and/or **Phone Number** in the corresponding Filter fields.

The screenshot shows the same 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' page, but with the filter fields highlighted. The 'NAME' field is labeled 'Enter NAME...', the 'EMAIL' field is labeled 'Enter EMAIL...', and the 'PHONE NUMBER' field is labeled 'Enter PHONE NUMBER...'. Each field is highlighted with a red box. The 'HIDE FILTER' button is also visible in the top right corner.

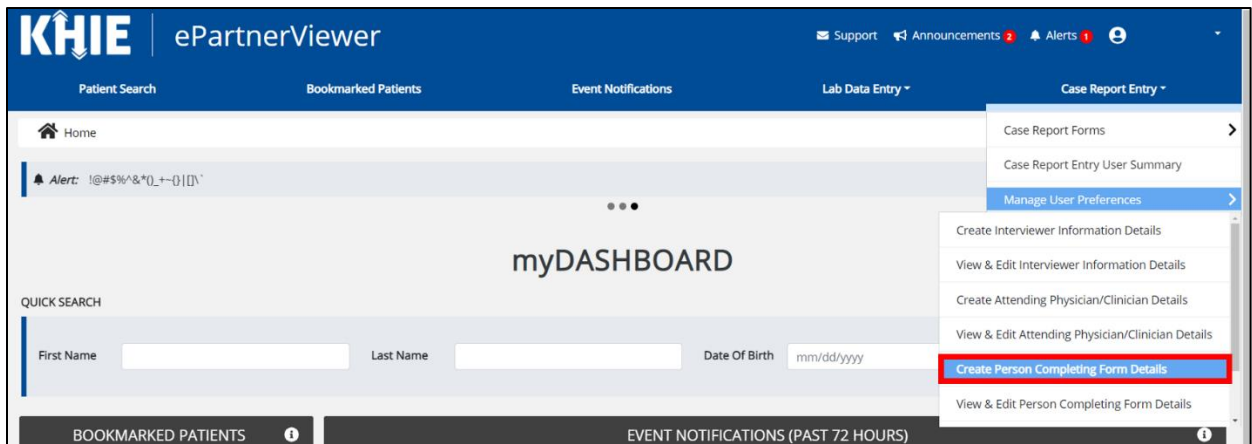
ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
 	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

## Create Person Completing Form Details

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



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



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

Please complete the form below to create a Person Completing Form. All fields marked with an asterisk(\*) are required.

### PERSON COMPLETING FORM

Prefix: Mr. [x] [v]

First Name\* [ ] Last Name\* [ ]

Suffix: [Select...] [v]

II [ ] III [ ] IV [ ] Jr [ ] Sr [ ]

Address 2: [ ] Unit, Suite, Building, etc.

State\* [Select...] [v] Zip Code\* [ ]

Email\* [ ] name@domain.com

(xxx) xxx-xxxx

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

First Name*	Last Name*
<input type="text"/>	<input type="text"/>

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

Address 1*	Address 2 Unit, Suite, Building, etc.	
<input type="text"/>	<input type="text"/>	
City*	State*	Zip Code*
<input type="text"/>	<input type="text" value="Select..."/>	<input type="text"/>

8. Enter the **Phone Number** and **Email Address.**

Phone*	Email*
<input type="text" value="(XXX) XXX-XXXX"/>	<input type="text" value="name@domain.com"/>

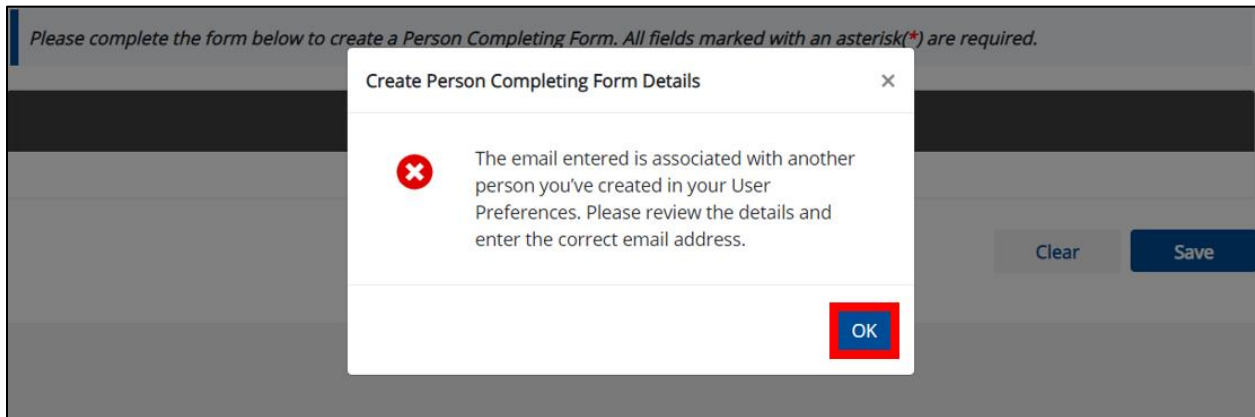
**Please Note:** If the information entered in the *Phone* and *Email* fields is not entered in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

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

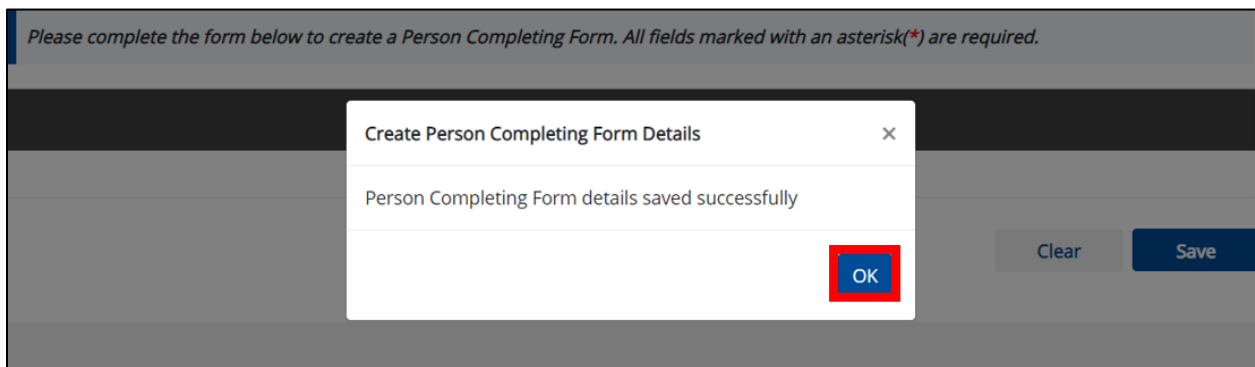
PERSON COMPLETING FORM		
Prefix <input type="text" value="Mr."/> x   v		
First Name*	Last Name*	
<input type="text" value="Arthur"/>	<input type="text" value="Vandelay"/>	
Suffix <input type="text" value="II"/> x   v		
Address 1*	Address 2 Unit, Suite, Building, etc.	
<input type="text" value="22 Second Avenue"/>	<input type="text"/>	
City*	State*	Zip Code*
<input type="text" value="Lexington"/>	<input type="text" value="KY"/> x   v	<input type="text" value="40222-"/>
Phone*	Email*	
<input type="text" value="(222) 222-2222"/>	<input type="text" value="arthur@email.com"/>	
		<input type="button" value="Clear"/> <input type="button" value="Save"/>

**Please Note:** If you enter an email address that is already associated with another Person Completing Form and click **Save**, a pop-up displays with an error message that states:  
*The email entered is associated with another person you've created in your User Preferences. Please review the details and enter the correct email address.*

You must click **OK** and enter the correct email address to save the Person Completing Form details and proceed to the **View & Edit Person Completing Form Details** screen.



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







## View & Edit Person Completing Form Details

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

First Back 1 Next Last

Maximum 5 entries per page

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

KHIE ePartnerViewer

Support Announcements Alerts

Update Person Completing Form Details

Prefix: Mr.

First Name: Arthur Last Name: Vandelay

Suffix: II

Address 1: 22 Second Avenue Address 2: Unit, Suite, Building, etc.

City: Lexington State: KY Zip Code: 40222

Phone: (222) 222-2222 Email: arthur@email.com





Cancel Save

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

First Back 1 Next Last

Maximum 5 entries per page





Update Person Completing Form Details

Person Completing Form details updated successfully





OK


## Delete Person Completing the Form Details

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS			
<div>REFRESH</div> <div>APPLY FILTER</div>			
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL	PHONE NUMBER
<div>   </div>	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
<div>   </div>	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS			
<div>REFRESH</div> <div>APPLY FILTER</div>			
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL	PHONE NUMBER
<div>   </div>	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
<div>   </div>	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

 Delete Person Completing Form Details

Are you sure?

Cancel





OK


**Please Note:** You can delete a person on the **View & Edit Person Completing Form Details** screen as long as that person has not been selected for use in a case report that is still in progress. If you attempt to delete a person who has been selected for use in a case report that has not been completed yet, a pop-up notification will display the following message:


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

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

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS			
<div>REFRESH</div> <div>APPLY FILTER</div>			
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL	PHONE NUMBER
<div>   </div>	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
<div>   </div>	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

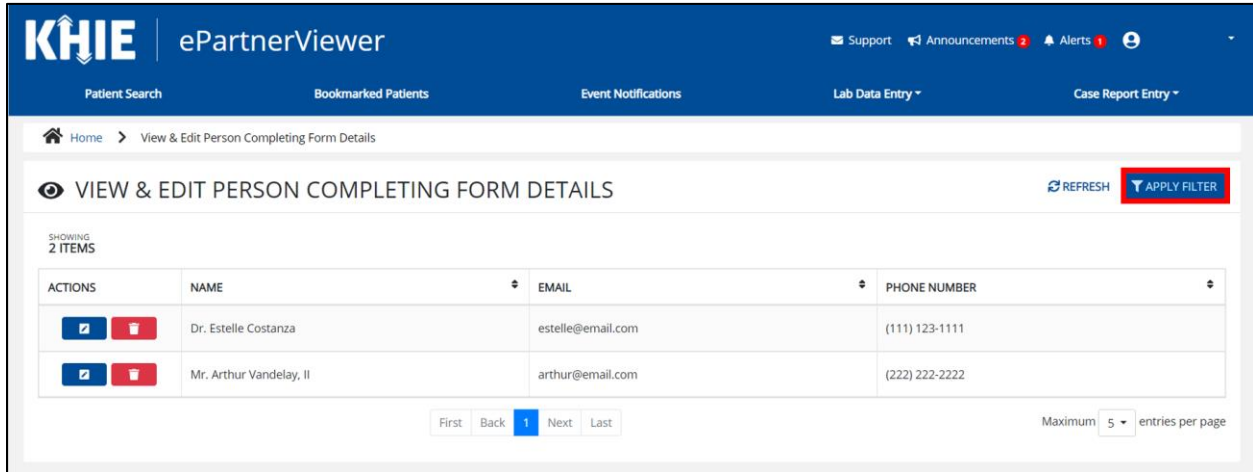
 Delete Person Completing Form Details

 This person information is being used in one of the case reports that is still in progress. To delete this person, please ensure that this person is not being used in any case report that is in progress.





OK

## Filter Person Creating Form Details

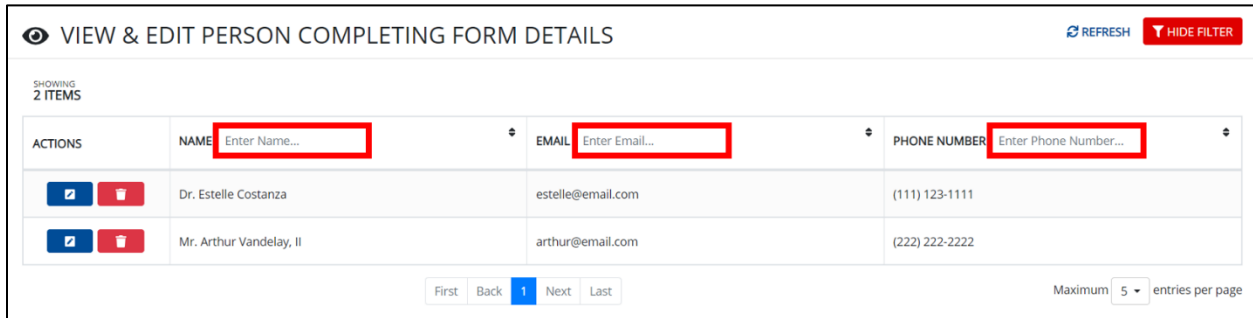
15. To search for a specific person in the User Preferences, click **Apply Filter**.







The screenshot shows the ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT PERSON COMPLETING FORM DETAILS'. Below the title, there is a 'REFRESH' button and a red 'APPLY FILTER' button. A table displays 2 items. The table has columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The first row shows Dr. Estelle Costanza with email estelle@email.com and phone number (111) 123-1111. The second row shows Mr. Arthur Vandelay, II with email arthur@email.com and phone number (222) 222-2222. At the bottom of the table, there are pagination controls: First, Back, 1 (selected), Next, Last. A dropdown menu shows 'Maximum 5 entries per page'.

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222

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



The screenshot shows the ePartnerViewer interface with filter fields. The top navigation bar is the same. The main content area is titled 'VIEW & EDIT PERSON COMPLETING FORM DETAILS'. Below the title, there is a 'REFRESH' button and a red 'HIDE FILTER' button. A table displays 2 items. The table has columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The first row shows Dr. Estelle Costanza with email estelle@email.com and phone number (111) 123-1111. The second row shows Mr. Arthur Vandelay, II with email arthur@email.com and phone number (222) 222-2222. At the bottom of the table, there are pagination controls: First, Back, 1 (selected), Next, Last. A dropdown menu shows 'Maximum 5 entries per page'. The filter fields are highlighted with red boxes: 'Enter Name...' under NAME, 'Enter Email...' under EMAIL, and 'Enter Phone Number...' under PHONE NUMBER.

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222

## 5 Basic Features in the Case Report Entry Form

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

### Side Navigation Bar & Pagination

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

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

The screenshot displays the KHIE ePartnerViewer interface for the 'ACUTE HEPATITIS B CASE REPORT FORM'. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'ACUTE HEPATITIS B CASE REPORT FORM' and indicates 'Section 6 of 8'. A side navigation bar on the left lists various sections: Patient Information, Laboratory Information, Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death Information, Vaccination History (highlighted with a red box), Additional Comments, and Review & Submit. The 'Vaccination History' section is active, showing a form for 'VACCINATION HISTORY'. It includes a question 'Has the patient ever received a Hepatitis B vaccine?' with buttons for Yes, No, Unknown, and Refused. Below this, there are fields for 'Vaccine Details', including 'If yes, please provide vaccine name' (with a dropdown menu showing 'hepatitis B vaccine, adult dosage') and 'If other, please specify'. There are also fields for 'If yes, please enter the number of doses' (with a dropdown menu showing '1') and 'If yes, please specify the date administered' (with fields for 1st, 2nd, 3rd, and 4th doses, each with a date picker and an 'Unknown' checkbox). At the bottom of the form, there is a 'Save' button and 'Previous' and 'Next' buttons (both highlighted with red boxes).

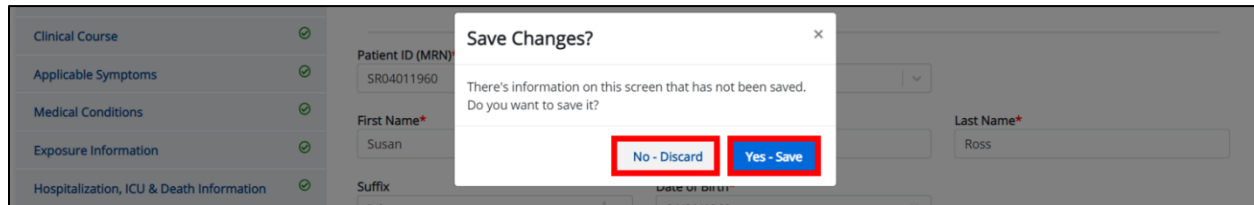
## Save Feature

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

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






2. If you click on a previously completed screen on the side navigation bar, the *Save Changes* pop-up will display. You have the option to save or discard the changes on the current screen before navigating to another screen.
- If you click **Yes - Save** and all the required fields are entered on the current screen, you will navigate to the intended screen. (If you have not completed all the required fields on the current screen, you will not be allowed to save the data.) To navigate to the desired screen, you must first complete all the required fields on the current screen.
  - If you click **No - Discard**, you will navigate to the intended screen without saving any changes on the current screen. This means that none of the data entered on the current screen will be saved.



## Case Report Entry Icons

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

### Icon Descriptions:

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

## Conditional Questions

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

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

The screenshot shows the 'LABORATORY INFORMATION' screen. On the left is a sidebar with navigation links: Patient Information, Laboratory Information (highlighted), Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death Information, Vaccination History, Additional Comments, and Review & Submit. The main content area has a header 'LABORATORY INFORMATION' and a question 'Does the patient have a lab test?\*' with 'Yes' and 'No' buttons. The 'No' button is selected and highlighted with a red box. Below the question, there is a text input field for 'Hepatitis Marker' and a dropdown for 'Results'. Further down, there is a text input field for 'Test Result Date' and a checkbox for 'Unknown', and another for 'Specimen Collection Date' and a checkbox for 'Unknown'. At the bottom, there is a text input field for 'Laboratory Name' and buttons for 'Add Hepatitis Marker', 'Add ALT', and 'Add AST'.

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

The screenshot shows the 'LABORATORY INFORMATION' screen with the 'Yes' button selected for the question 'Does the patient have a lab test?\*', which is highlighted with a red box. The subsequent fields are enabled and highlighted with a red border: 'Hepatitis Marker\*' (dropdown), 'Results\*' (dropdown), 'If applicable, please enter the viral load:?' (text input), 'Test Result Date\*' (text input with 'Unknown' checkbox), 'Specimen Collection Date\*' (text input with 'Unknown' checkbox), and 'Laboratory Name:\*' (text input). The sidebar and other elements are the same as in the previous screenshot.

Additionally, if **No** or **Unknown** is selected for certain conditional questions, the screen will be disabled and the subsequent fields will be marked as **No** or **Unknown**, based on the selected answer. These conditional questions are found on the **Applicable Symptoms** and **Exposure Information** screens.

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

ACUTE HEPATITIS B CASE REPORT FORM Section 3 of 8

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS	
Patient Information	Were symptoms present during the course of illness? <sup>**</sup>
Laboratory Information	Yes <b>No</b> Unknown
Applicable Symptoms	Onset Date <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown
Exposure Information	If symptomatic, which of the following did the patient experience during their illness?
Hospitalization, ICU & Death Information	Fever
Vaccination History	Yes <b>No</b> Unknown
Additional Comments	If yes, please enter the highest temperature: <input type="text"/>
Review & Submit	Diarrhea (>3 loose stools/24hr period)
	Yes <b>No</b> Unknown
	If yes, please enter # of days of diarrhea: <input type="text"/>
	Abdominal pain
	Yes <b>No</b> Unknown
	Anorexia
	Yes <b>No</b> Unknown
	Clay Colored Stools
	Yes <b>No</b> Unknown
	Dark urine
	Yes <b>No</b> Unknown
	Elevated ALT > 100
	Yes <b>No</b> Unknown
	Fatigue
	Yes <b>No</b> Unknown

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

APPLICABLE SYMPTOMS	
Patient Information	Were symptoms present during the course of illness? <sup>**</sup>
Laboratory Information	Yes No <b>Unknown</b>
Applicable Symptoms	Onset Date <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown
Exposure Information	If symptomatic, which of the following did the patient experience during their illness?
Hospitalization, ICU & Death Information	Fever
Vaccination History	Yes No <b>Unknown</b>
Additional Comments	If yes, please enter the highest temperature: <input type="text"/>
Review & Submit	Diarrhea (>3 loose stools/24hr period)
	Yes No <b>Unknown</b>
	If yes, please enter # of days of diarrhea: <input type="text"/>
	Abdominal pain
	Yes No <b>Unknown</b>
	Anorexia
	Yes No <b>Unknown</b>

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

Patient Information
Laboratory Information
**Applicable Symptoms**
Exposure Information
Hospitalization, ICU & Death Information
Vaccination History
Additional Comments
Review & Submit

### APPLICABLE SYMPTOMS

Were symptoms present during the course of illness?\*

**Yes** No Unknown

Onset Date\*  
mm/dd/yyyy 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: @

**Abdominal pain\***

Yes No Unknown

**Anorexia\***

Yes No Unknown

**Arthralgia\***

Yes No Unknown

**Clay Colored Stools\***

Yes No Unknown

**Dark urine\***

Yes No Unknown

**Elevated ALT > 200\***

Yes No Unknown

**Elevated Bilirubin > 3.0\***

Yes No Unknown

**Fatigue\***

Yes No Unknown

**Headache\***

Yes No Unknown

**Jaundice\***

Yes No Unknown

**Malaise\***

Yes No Unknown

**Muscle aches (myalgia)\***

Yes No Unknown

**Nausea\***

Yes No Unknown

**Vomiting\***

Yes No Unknown

**Did the patient have any other symptoms?\***

Yes No Unknown

If yes, please specify: @

## 6 Affiliation/Organization Conditional Question

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

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

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

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

The screenshot shows a form titled "Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?\*" with "Yes" and "No" buttons. Below the question, there are three rows of fields. The first row is for "Patient ID (MRN)" with a text input field and an "Affiliation/Organization" dropdown menu. The second row is for "Person Completing Form" with a dropdown menu, an "Affiliation/Organization" dropdown menu, and a text input field labeled "If other, please specify:". The third row is for "Attending Physician/Clinician" with a dropdown menu, an "Affiliation/Organization" dropdown menu, and a text input field labeled "If other, please specify:". All dropdown menus are currently set to "Select...".

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

### Affiliation/Organization Conditional Answer: Yes

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

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

1. Select the **Affiliation/Organization** for the Patient ID (MRN) from the dropdown menu.

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

**Yes** No

Patient ID (MRN)\* ?

Affiliation/Organization\* ? Select...

Person Completing Form\*

Affiliation/Organization ?

If other, please specify: ?

Attending Physician/Clinician\*

Affiliation/Organization ?

If other, please specify: ?

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

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

**Yes** No

Patient ID (MRN)\* ?

Affiliation/Organization\* ? Test Medical Center x

Person Completing Form\* Mr. Arthur Vandelay, II (arthur@email.com) x

Affiliation/Organization ? Test Medical Center x

If other, please specify: ?

Attending Physician/Clinician\* Dr. Frank Costanza, Sr (frank@email.com) x

Affiliation/Organization ? Test Medical Center x

If other, please specify: ?


### Affiliation/Organization Conditional Answer: No


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

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



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

Yes **No**



Patient ID (MRN)\* 

Affiliation/Organization\* 


Person Completing Form\*


Affiliation/Organization\*   If other, please specify: 

Attending Physician/Clinician\*

Affiliation/Organization\*   If other, please specify: 

1. Select the **Affiliation/Organization** for the Patient ID (MRN) from the dropdown menu.

Patient ID (MRN)\* 

Affiliation/Organization\* 


Person Completing Form\*


Attending Physician/Clinician\*

Prefix

**Affiliation/Organization dropdown menu:**

- Select...
- Afzal, Mohammad MD, Internal Medicine, LLC
- eICR Onboarding Regression
- Hilton Hospital
- King's Daughters Medical Center
- Murray-Calloway County Hospital
- Test Medical Center
- University Of Kentucky Chandler Medical Center

If other, please specify: 

If other, please specify: 

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


Person Completing Form\*

Attending Physician/Clinician\*

Prefix


First Name\*


Suffix

Affiliation/Organization\* 

**Affiliation/Organization dropdown menu:**

- Select...
- eICR Onboarding Regression
- Hilton Hospital
- King's Daughters Medical Center
- Murray-Calloway County Hospital
- Test Medical Center
- University Of Kentucky Chandler Medical Center
- Other

If other, please specify: 

If other, please specify: 

Last Name\*

Date of Birth\*

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

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

Yes No

Patient ID (MRN)\* ? CK08101955

Affiliation/Organization\* ? Test Medical Center x v

Person Completing Form\* Mr. Arthur Vandelay, II (arthur@em... x v)

Affiliation/Organization\* ? Other x v

If other, please specify:\* ?

Please select the organization of the person completing this form (if it is not listed the Affiliation/Organization dropdown).

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

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

Yes No

Patient ID (MRN)\* ? CK08101955

Affiliation/Organization\* ? Test Medical Center x v

Person Completing Form\* Mr. Arthur Vandelay, II (arthur@em... x v)

Affiliation/Organization\* ? Other x v

Attending Physician/Clinician\* Dr. Frank Costanza, Sr (frank@emai... x v)

Affiliation/Organization\* ? Select... x v

Prefix Select... v

First Name\*

Suffix Select... v

Patient Sex\* Ethnicity\* Race\*

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

If other, please specify:\* ? Test Hospital

If other, please specify: ?

Last Name\*

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

Attending Physician/Clinician\* Dr. Frank Costanza, Sr (frank@emai... x v)

Affiliation/Organization\* ? Other x v

If other, please specify:\* ?

### Affiliation/Organization Validation

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

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

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

Patient ID (MRN)\*

Affiliation/Organization\*

Person Completing Form\*

Affiliation/Organization\*

If other, please specify:

Attending Physician/Clinician\*

Affiliation/Organization\*

If other, please specify:

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

Patient ID (MRN)\*

Affiliation/Organization\*

Person Completing Form\*

Affiliation/Organization

If other, please specify:

Attending Physician/Clinician\*

Affiliation/Organization

If other, please specify:

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

Patient ID (MRN)\*

Person Completing Form

Attending Physician/Clinician

Affiliation/Organization

If other, please specify:

**Patient Information**

⚠ All selections for the "Affiliation/Organization" will be reset. Are you sure you want to change your selection?

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

### Change Affiliation/Organization Conditional Answer: No to Yes

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

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

**Yes** **No**

Patient ID (MRN)\* SK05051960 Affiliation/Organization\* Test Medical Center

Person Completing Form\* Mr. Arthur Vandelay, II (arthur@email.com) Affiliation/Organization\* Other If other, please specify\* Test Hospital

Attending Physician/Clinician\* Dr. Frank Costanza, Sr (frank@email.com) Affiliation/Organization\* Test Medical Center If other, please specify:

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

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

**Yes** **No**

Patient ID (MRN)\* SK05051960 Affiliation/Organization\* Test Medical Center

Person Completing Form\* Mr. Arthur Vandelay, II (arthur@email.com) Affiliation/Organization\* Other If other, please specify\* Test Hospital

Attending Physician/Clinician\* Dr. Frank Costanza, Sr (frank@email.com) Affiliation/Organization\* Test Medical Center If other, please specify:

**Patient Information**

All selections for the "Affiliation/Organization" will be reset. Are you sure you want to change your selection?

**Yes** **No**

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

There are errors. Please make a selection for all required fields.

**PATIENT INFORMATION**

Disease/Organism\* Chlamydia Date of Diagnosis\* 07/23/2021 ☐ Unknown

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

**Yes** **No**

Patient ID (MRN)\* SK05051960 Affiliation/Organization\* Select... Please Enter Affiliation/Organization

Person Completing Form\* Mr. Arthur Vandelay, II (arthur@email.com) Affiliation/Organization\* Select... If other, please specify:

Attending Physician/Clinician\* Dr. Frank Costanza, Sr (frank@email.com) Affiliation/Organization\* Select... If other, please specify:

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

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

Patient ID (MRN)\*

SK05051960

Person Completing Form\*

Mr. Arthur Vandelay, II (arthur@email.com) x | v

Attending Physician/Clinician\*

Dr. Frank Costanza, Sr (frank@email.com) x | v

Prefix

Ms. x | v

Affiliation/Organization\*

Select...

- Afzal, Mohammad MD, Internal Medicine, LLC
- eICR Onboarding Regression
- Hilton Hospital
- King's Daughters Medical Center
- Murray-Calloway County Hospital
- Test Medical Center
- University Of Kentucky Chandler Medical Center

If other, please specify:

If other, please specify:

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

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

Patient ID (MRN)\*

SK05051960

Person Completing Form\*

Mr. Arthur Vandelay, II (arthur@email.com) x | v

Attending Physician/Clinician\*

Dr. Frank Costanza, Sr (frank@email.com) x | v

Affiliation/Organization\*

Test Medical Center x | v

Affiliation/Organization

Test Medical Center x | v

Affiliation/Organization

Test Medical Center x | v

If other, please specify:

If other, please specify:

### Change Affiliation/Organization Conditional Answer: Yes to No

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

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

**Yes** **No**

Patient ID (MRN)\*  Affiliation/Organization\*

Person Completing Form\*  Affiliation/Organization\*  If other, please specify:

Attending Physician/Clinician\*  Affiliation/Organization\*  If other, please specify:

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

**Patient Information**

All selections for the "Affiliation/Organization" will be reset. Are you sure you want to change your selection?

**Yes** **No**

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

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

**Yes** **No**

Patient ID (MRN)\*  Affiliation/Organization\*

Person Completing Form\*  Affiliation/Organization\*  If other, please specify:

Attending Physician/Clinician\*  Affiliation/Organization\*  If other, please specify:

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

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

Yes No

Patient ID (MRN)\*  
SR05051960

Person Completing Form\*  
Select...

Attending Physician/Clinician\*  
Select...

Prefix  
Select...

Affiliation/Organization\*  
Select...  
Afzal, Mohammad MD, Internal Medicine, LLC  
eICR Onboarding Regression  
Hilton Hospital  
King's Daughters Medical Center  
Murray-Calloway County Hospital  
Test Medical Center  
University Of Kentucky Chandler Medical Center

If other, please specify: ?  
If other, please specify: ?

Please select the organization where the Patient ID (MRN) was assigned to the patient.

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

Person Completing Form\*  
Mr. Arthur Vandelay, II (arthur@em... x | v)

Attending Physician/Clinician\*  
Dr. Frank Costanza, Sr (frank@emai... x | v)

Prefix  
Select...

First Name\*  
Last Name\*

Suffix  
Select...

Patient Sex\* Ethnicity\* Race\*

Affiliation/Organization\*  
Select...  
Afzal, Mohammad MD, Internal Medicine, LLC  
eICR Onboarding Regression  
Hilton Hospital  
King's Daughters Medical Center  
Murray-Calloway County Hospital  
Test Medical Center  
University Of Kentucky Chandler Medical

If other, please specify: ?  
If other, please specify: ?

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

Person Completing Form\*  
Mr. Arthur Vandelay, II (arthur@em... x | v)

Attending Physician/Clinician\*  
Dr. Frank Costanza, Sr (frank@emai... x | v)

Affiliation/Organization\*  
Other

Affiliation/Organization\*  
Other

If other, please specify: ?  
If other, please specify: ?

## 7 Tips for Manually Entering Case Report Data

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

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

Please complete the form below. All fields marked with asterisk(\*) are required.

PATIENT INFORMATION	
<b>Patient Information</b> SARS CoV-2 Testing	<b>Interviewer Name*</b> Select...
	<b>Affiliation/Organization*</b> Select...

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

Please complete the form below. All fields marked with asterisk(\*) are required.

PATIENT INFORMATION	
<b>Patient Information</b> SARS CoV-2 Testing Clinical Course Applicable Symptoms	<b>Interviewer Name*</b> Dr. [Select...]
	<b>Affiliation/Organization*</b> Test Medical Center
<b>Patient ID (MRN)*</b>	<b>Prefix</b> Select...

An MRN or Medical Record Number 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.

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

City	<input type="text"/>	State	KY
Zip Code	<input type="text"/>	County	Select...
Phone Number	<input type="text"/>	Email Address	<input type="text"/>

Adair  
Allen  
Anderson  
Ballard  
Barren  
Bath  
Bell

- However, when you 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	<input type="text"/>	State	AR <span>x</span> <span>▼</span>
Zip Code	<input type="text"/>	County	Out Of System State <span>x</span> <span>▼</span>

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

<b>Admission Date*</b> <input type="text" value="mm/dd/yyyy"/> <span>📅</span> <input type="checkbox"/> Unknown	<b>Discharge Date*</b> <input type="text" value="mm/dd/yyyy"/> <span>📅</span>																																										
<div> <div> <div>June 2021</div> <div>June 2021</div> <table border="1"> <thead> <tr> <th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> </thead> <tbody> <tr> <td>30</td><td>31</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr> <td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td></tr> <tr> <td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td></tr> <tr> <td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td></tr> <tr> <td>27</td><td>28</td><td>29</td><td>30</td><td>1</td><td>2</td><td>3</td></tr> </tbody> </table> </div> <div> <b>this illness?*</b>  <input type="text" value="Unknown"/> </div> <div> <b>death:</b>  <input type="text"/> <span>📅</span> <input type="checkbox"/> Unknown         </div> </div>		Su	Mo	Tu	We	Th	Fr	Sa	30	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3
Su	Mo	Tu	We	Th	Fr	Sa																																					
30	31	1	2	3	4	5																																					
6	7	8	9	10	11	12																																					
13	14	15	16	17	18	19																																					
20	21	22	23	24	25	26																																					
27	28	29	30	1	2	3																																					

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

<b>Admission Date*</b> <input type="text" value="mm/dd/yyyy"/> <span>📅</span> <input checked="" type="checkbox"/> Unknown	<b>Discharge Date*</b> <input type="text" value="06/20/2021"/> <span>📅</span> <input type="checkbox"/> Unknown
--	---

## 8 Acute Hepatitis B Case Report Form

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

1. To enter Acute Hepatitis B case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.
2. Select **Hepatitis Case Report Forms** from the dropdown menu.

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar is blue and contains the following tabs: Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The Case Report Entry tab is highlighted with a red box. Below the navigation bar, the main content area is titled "myDASHBOARD". On the right side, a dropdown menu is open for the Case Report Entry tab. The menu items are: Case Report Forms (highlighted with a red box), COVID-19, Sexually Transmitted Diseases, Multi-drug Resistant Organism, Other Reportable Conditions, Hepatitis Case Report Forms (highlighted with a red box), Perinatal Hepatitis, Child Hepatitis, and Acute Hepatitis Case Report Forms. The main content area also includes a QUICK SEARCH section with input fields for First Name, Last Name, and Date Of Birth, and a BOOKMARKED PATIENTS section with a list of patient names.

3. Click **Acute Hepatitis Case Report Forms**. Select **Hepatitis B** from the sub-dropdown menu.

The screenshot shows the KHIE ePartnerViewer interface with the Case Report Entry dropdown menu open. The "Acute Hepatitis Case Report Forms" option is highlighted with a red box. A sub-dropdown menu is visible, showing the following options: Hepatitis A, Hepatitis B (highlighted with a red box), and Hepatitis C. The main content area of the interface remains the same as in the previous screenshot.

## 9 Patient Information

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

ACUTE HEPATITIS B CASE REPORT FORM

Section 1 of 8

Please complete the form below. All fields marked with an asterisk(\*) are required.

**PATIENT INFORMATION**

**Patient Information**

Laboratory Information

Applicable Symptoms

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism\*  
Hepatitis B

Date of Diagnosis\*  
mm/dd/yyyy

☐ Unknown

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

Patient ID (MRN) ?  
Select...

Affiliation/Organization ?  
Select...

[Person Completing Form](#)  
Select...

Affiliation/Organization ?  
Select...

If other, please specify: ?  
Text field

[Attending Physician/Clinician](#)  
Select...

Affiliation/Organization ?  
Select...

If other, please specify: ?  
Text field

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

**PATIENT INFORMATION**

Disease/Organism\*  
Hepatitis B

Date of Diagnosis\*  
mm/dd/yyyy

☐ Unknown

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

Patient ID (MRN) ?  
Select...

Affiliation/Organization ?  
Select...

[Person Completing Form](#)  
Select...

Affiliation/Organization ?  
Select...

If other, please specify: ?  
Text field

[Attending Physician/Clinician](#)  
Select...

Affiliation/Organization ?  
Select...

If other, please specify: ?  
Text field

Prefix  
Select...

First Name\*  
Text field

Middle Name  
Text field

Last Name\*  
Text field

Suffix  
Select...

Date of Birth\*  
mm/dd/yyyy

Patient Sex\*  
Select...

Ethnicity\*  
Select...

Race\*  
Select...

Address 1\*

Address 2  Unit, Suite, Building, etc.

City\*

State\*  Select...

Zip Code\*

County\*  Select...

Phone\*  (xxx) xxx-xxxx

Email  name@domain.com

Is the patient currently pregnant?

If yes, please enter the due date (EDC):  mm/dd/yyyy ☐ Unknown

**Prior Hepatitis B Diagnosis\***

If yes, please enter the date of diagnosis:  mm/dd/yyyy ☐ Unknown

**Please Note:** You are required to enter the details associated with the *Person Completing Form* and the *Attending Physician/Clinician* prior to entering Acute Hepatitis B case report information. If you access the Acute Hepatitis B Case Report without previously entering these details, the **Patient Information** screen is disabled and displays an error message.

You must click the hyperlink associated with the **Person Completing Form** and the **Attending Physician/Clinician** located in the error message banner to navigate to the appropriate **User Preferences** screens and create the *Person Completing Form* and *Attending Physician/Clinician* before entering Acute Hepatitis B Case Report details.

To enter your **Attending Physician/Clinician** and **Person Completing Form** details in the User Preferences, click on the hyperlink.

**PATIENT INFORMATION**

Patient Information

Laboratory Information   mm/dd/yyyy ☐ Unknown

## 2. Enter the **Date of Diagnosis**.

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

**PATIENT INFORMATION**

Disease/Organism\*  Hepatitis B

Date of Diagnosis\*  mm/dd/yyyy ☐ Unknown

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

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

Yes No

Patient ID (MRN) ? Affiliation/Organization ?

Person Completing Form ? Affiliation/Organization ? If other, please specify: ?

Attending Physician/Clinician ? Affiliation/Organization ? If other, please specify: ?

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

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

Yes No

Patient ID (MRN)\* ? Affiliation/Organization\* ?

Person Completing Form\* ? Affiliation/Organization ? If other, please specify: ?

Attending Physician/Clinician\* ? Affiliation/Organization ? If other, please specify: ?

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

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

Yes No

Patient ID (MRN)\* ? Affiliation/Organization\* ?

Person Completing Form\* ? Affiliation/Organization\* ? If other, please specify: ?

Attending Physician/Clinician\* ? Affiliation/Organization\* ? If other, please specify: ?

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

<b>Patient ID (MRN)*</b> ? <input type="text"/>	<b>Affiliation/Organization*</b> ? <input type="text" value="Select..."/>
--	--

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

<b>Patient ID (MRN)*</b> ? <input type="text" value="CK08101955"/>	<b>Affiliation/Organization*</b> ? <div> <input type="text" value="Select..."/> <ul style="list-style-type: none"> <li>Afzal, Mohammad MD, Internal Medicine, LLC</li> <li>eICR Onboarding Regression</li> <li>Hilton Hospital</li> <li>King's Daughters Medical Center</li> <li>Murray-Calloway County Hospital</li> <li>Test Medical Center</li> <li>University Of Kentucky Chandler Medical</li> </ul> </div>	If other, please specify: ? <input type="text"/>
<b>Person Completing Form*</b> <input type="text" value="Select..."/>		If other, please specify: ? <input type="text"/>
<b>Attending Physician/Clinician*</b> <input type="text" value="Select..."/>		
<b>Prefix</b> <input type="text" value="Select..."/>		

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

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

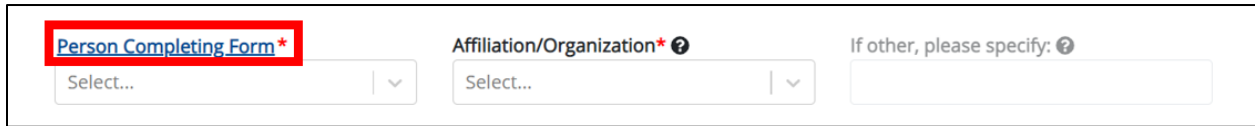
- From the dropdown menu, select the name of the **Person Completing Form**.

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?* <input type="button" value="Yes"/> <input type="button" value="No"/>		
<b>Patient ID (MRN)*</b> ? <input type="text" value="CK08101955"/>	<b>Affiliation/Organization*</b> ? <input type="text" value="Test Medical Center"/>	
<b>Person Completing Form*</b> <div> <input type="text" value="Select..."/> <ul style="list-style-type: none"> <li>Dr. Estelle Costanza (estelle@email.com)</li> <li>Mr. Arthur Vandelay, II (arthur@email.com)</li> </ul> </div>	<b>Affiliation/Organization</b> ? <input type="text" value="Test Medical Center"/>	If other, please specify: ? <input type="text"/>
	<b>Affiliation/Organization</b> ? <input type="text" value="Test Medical Center"/>	If other, please specify: ? <input type="text"/>

**Please Note:** If the appropriate name does not display in the *Person Completing Form* dropdown, you must create details for a new Person Completing Form by clicking the **Person Completing Form hyperlink**.

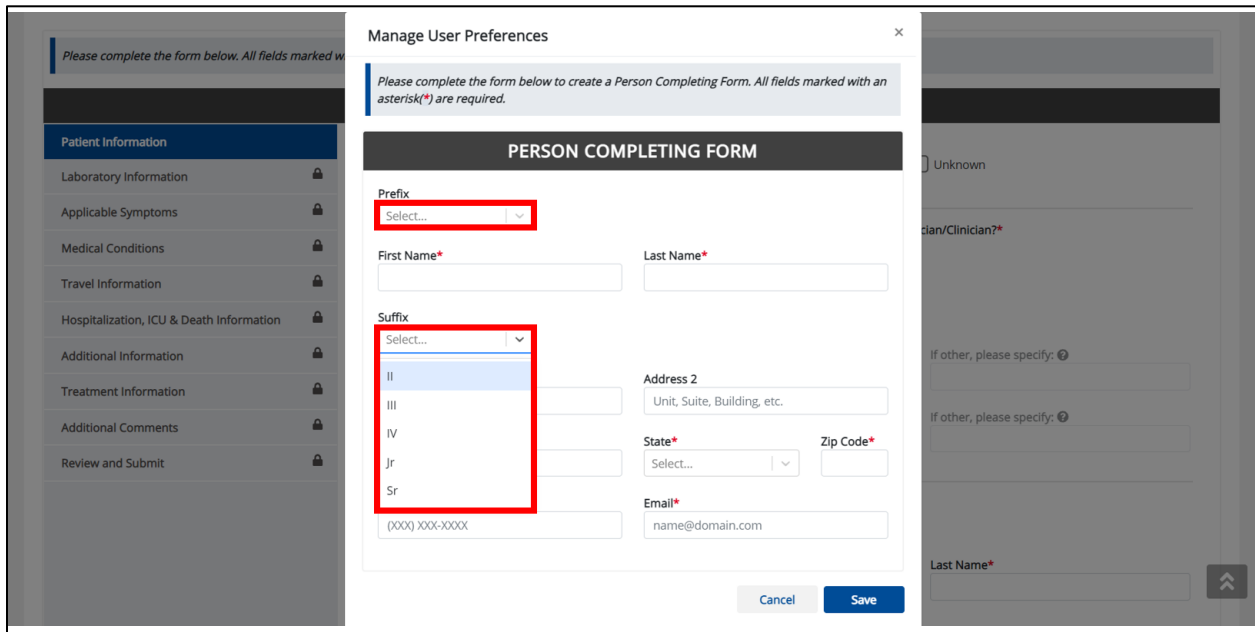
### Person Completing Form Hyperlink

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



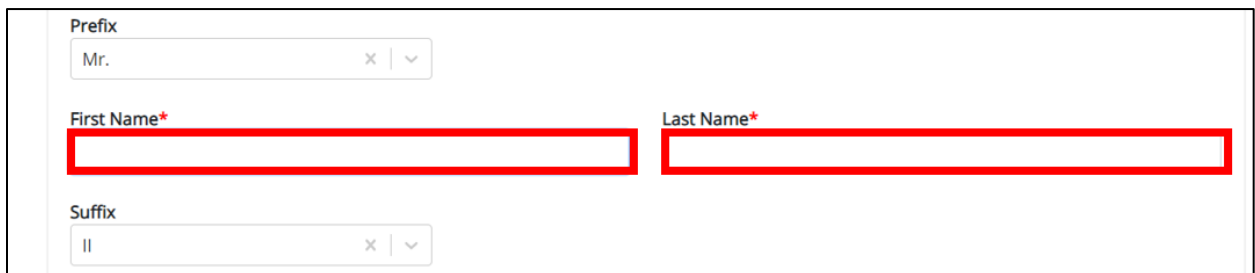
The screenshot shows the top navigation bar of the application. The link 'Person Completing Form\*' is highlighted with a red rectangular box. To its right are two dropdown menus labeled 'Affiliation/Organization\*' and 'If other, please specify:'. Both dropdowns have 'Select...' as the current selection.

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



The screenshot shows a 'PERSON COMPLETING FORM' pop-up window. The 'Prefix' dropdown is highlighted with a red box, showing 'Select...' as the current selection. The 'Suffix' dropdown is also highlighted with a red box, showing a list of options: II, III, IV, Jr, and Sr. The 'First Name\*' and 'Last Name\*' fields are empty. The 'Address 2' field contains 'Unit, Suite, Building, etc.'. The 'State\*' dropdown is set to 'Select...'. The 'Zip Code\*' field is empty. The 'Email\*' field contains 'name@domain.com'. The 'Cancel' and 'Save' buttons are at the bottom right.

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



The screenshot shows the 'PERSON COMPLETING FORM' pop-up window. The 'First Name\*' and 'Last Name\*' fields are highlighted with red rectangular boxes. The 'Prefix' dropdown is set to 'Mr.' and the 'Suffix' dropdown is set to 'II'.

11. Enter the **Address, City, State,** and **Zip Code.**

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

12. Enter the **Phone Number** and **Email Address.**

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

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

Please complete the form below. All fields marked with an asterisk(\*) are required.

PERSON COMPLETING FORM

Prefix  
Mr.

First Name\*  
Marty

Last Name\*  
Craine

Suffix  
Sr.

Address 1\*  
123 Cheers Street

Address 2  
Unit, Suite, Building, etc.

City\*  
Lexington

State\*  
KY

Zip Code\*  
40123-

Phone\*  
(555) 123-3210

Email\*  
marty@email.com


Cancel Save




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

Travel Information	Patient ID (MRN)*	Affiliation/Organization*	
Hospitalization, ICU & Death Information		Affiliation/Organization*	If other, please specify:
Additional Information	Person Completing Form*	Affiliation/Organization*	If other, please specify:
Treatment Information	Dr. Estelle Costanza (estelle@email.com)	Affiliation/Organization*	
Additional Comments	Mr. Arthur Vandelay, II (arthur@email.com)		
Review and Submit	Mr. Marty Craine, Sr (marty@email.com)		
	First Name*	Middle Name	Last Name*




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



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

Patient ID (MRN)\* 


Affiliation/Organization\*   
  


**Please select the organization of the person completing this form.**



Person Completing Form\*   
  


Affiliation/Organization\*   
 


**One**  
 Hilton Hospital  
 King's Daughters Medical Center  
 Murray-Calloway County Hospital  
 Test Medical Center  
 University Of Kentucky Chandler Medical Center  
 Other

If other, please specify: 


If other, please specify: 


Attending Physician/Clinician\*   
 

Prefix  
 

First Name\* 

Suffix


Last Name\* 




Date of Birth\* 




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




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

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



Patient ID (MRN)\* 



Affiliation/Organization\*   
  


Person Completing Form\*   
  


Affiliation/Organization\*   
  

**Please enter the organization of the person completing this form (if it is not listed in the Affiliation/Organization dropdown).**

Attending Physician/Clinician\*   
 

Affiliation/Organization\*   
 

If other, please specify: 

If other, please specify: 

16. Select the **Attending Physician/Clinician** from the dropdown menu.

**Please Note:** If the appropriate name does not display in the Attending Physician/Clinician dropdown, you must create details for a new Attending Physician/Clinician by clicking the **Attending Physician/Clinician hyperlink**.

### Attending Physician/Clinician Hyperlink

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

18. The *Attending Physician/Clinician* Pop-Up displays. Enter the details. Mandatory fields are marked with asterisks (\*).

19. If available, select the appropriate **Prefix** and **Suffix** from the dropdown menus.

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

First Name*	Last Name*
<input type="text"/>	<input type="text"/>

21. Enter the **Address, City, State,** and **Zip Code**.

Address 1*	Address 2 Unit, Suite, Building, etc.	
<input type="text"/>	<input type="text"/>	
City*	State*	Zip Code*
<input type="text"/>	Select...   v	<input type="text"/>

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

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

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

Patient Information  
Laboratory Information  
Applicable Symptoms  
Medical Conditions  
Travel Information  
Hospitalization, ICU & Death Information  
Additional Information  
Treatment Information  
Additional Comments  
Review and Submit

### ATTENDING PHYSICIAN/CLINICIAN

Prefix  
Dr. x | v  
First Name\*  
Fraiser  
Last Name\*  
Crane  
Suffix  
Select... | v  
Address 1\*  
123 Cheers Street  
Address 2  
Unit, Suite, Building, etc.  
City\*  
Lexington  
State\*  
KY x | v  
Zip Code\*  
40123-  
Phone\*  
(555) 555-4321  
Email\*  
fraisercrane@email.com  
Cancel Save

Unknown  
Attending Physician/Clinician\*  
If other, please specify: ?  
If other, please specify: ?  
Last Name\*

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

Treatment Information	Attending Physician/Clinician*	Affiliation/Organization* ?	If other, please specify: ?
Additional Comments	Select...   v	Select...   v	<input type="text"/>
Review and Submit	<div>Dr. Fraiser Crane (fraisercrane@email.com)</div> <div>Dr. Frank Costanza, Sr (frank@email.com)</div> <div>Ms. Helen Seinfeld (helen@email.com)</div>	Middle Name	Last Name*
		<input type="text"/>	<input type="text"/>

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

The screenshot shows the 'Attending Physician/Clinician' section of a form. The 'Affiliation/Organization' dropdown menu is open, displaying a list of options: 'Select...', 'Twenty One', 'Hilton Hospital', 'King's Daughters Medical Center', 'Murray-Calloway County Hospital', 'Test Medical Center', 'University Of Kentucky Chandler Medical Center', and 'Other'. The dropdown is highlighted with a red box. To the left, the 'Attending Physician/Clinician' field contains 'Dr. Fraiser Crane (fraiserkra...)' and the 'Prefix' field is set to 'Select...'. To the right, the 'Last Name' field is empty.

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

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

The screenshot shows the 'Affiliation/Organization' section for two users. For the 'Person Completing Form' (Mr. Marty Craine, Sr), the 'Affiliation/Organization' dropdown is set to 'Other' and the 'If other, please specify' field contains 'Test Hospital'. For the 'Attending Physician/Clinician' (Dr. Fraiser Crane), the 'Affiliation/Organization' dropdown is also set to 'Other', and the 'If other, please specify' field is empty and highlighted with a red box.

**Please Note:** Additional information on the Affiliation/Organization section of the **Patient Information** screen is covered in *Section 6 Affiliation/Organization Conditional Question.*

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

The screenshot shows the 'Prefix' and 'Suffix' dropdown menus. Both are highlighted with red boxes. The 'Prefix' dropdown is set to 'Select...' and the 'Suffix' dropdown is also set to 'Select...'. The 'First Name' field is empty, the 'Middle Name' field is empty, and the 'Last Name' field is empty. The 'Date of Birth' field is set to 'mm/dd/yyyy'.

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

First Name*	Middle Name	Last Name*
<input type="text"/>	<input type="text"/>	<input type="text"/>

28. Enter the patient's **Date of Birth**.

Suffix	Date of Birth*
<input type="text" value="Select..."/>	<input type="text" value="mm/dd/yyyy"/>

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

Patient Sex\*

Select...

▼

Female

Male

Other

Unknown

Ethnicity\*

Select...

▼

Race\*

Select...

▼

Address 2

Unit, Suite, Building, etc.

State\*

Select...

▼

Zip Code\*

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

<b>Patient Sex*</b>	<b>Ethnicity*</b>	<b>Race*</b>
Female	Not Hispanic or Latino	Select...
		American Indian or Alaska Native
		Asian
		Asked but Unknown
		Black or African American
		Native Hawaiian or Other Pacific Islander
		Other
		Unknown

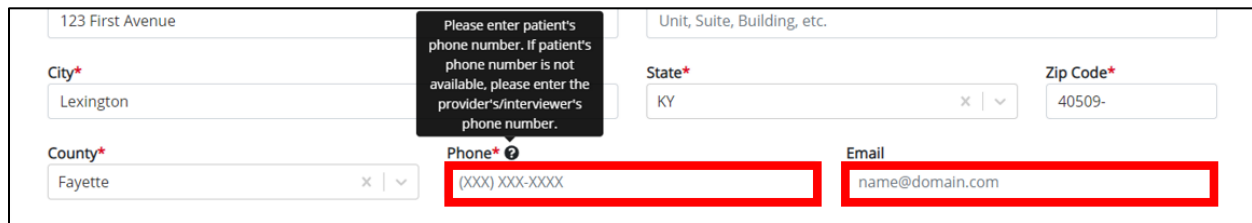
<b>Address 1*</b>	<b>Address 2</b>
	Unit, Suite, Building, etc.
<b>City*</b>	<b>State*</b>
	Select...
<b>County*</b>	<b>Phone* ?</b>
Select...	(XXX) XXX-XXXX

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

Address 1*		Address 2	
<input type="text"/>		<input type="text" value="Unit, Suite, Building, etc."/>	
City*	State*	Zip Code	
<input type="text"/>	<input type="text" value="Select..."/>	<input type="text"/>	
County*	Phone* ?	Email	
<input type="text" value="Select..."/>	<input type="text" value="(XXX) XXX-XXXX"/>	<input type="text" value="name@domain.com"/>	

32. Enter the patient's **Phone Number**.

33. If available, enter the patient's **Email Address**.



123 First Avenue

City\* Lexington

County\* Fayette

Unit, Suite, Building, etc.

State\* KY

Zip Code\* 40509-

Phone\* (XXX) XXX-XXXX

Email name@domain.com

Please enter patient's phone number. If patient's phone number is not available, please enter the provider's/interviewer's phone number.

34. If applicable, select the **appropriate answer** to *Is the patient currently pregnant?*



Is the patient currently pregnant?\*

Yes No Unknown

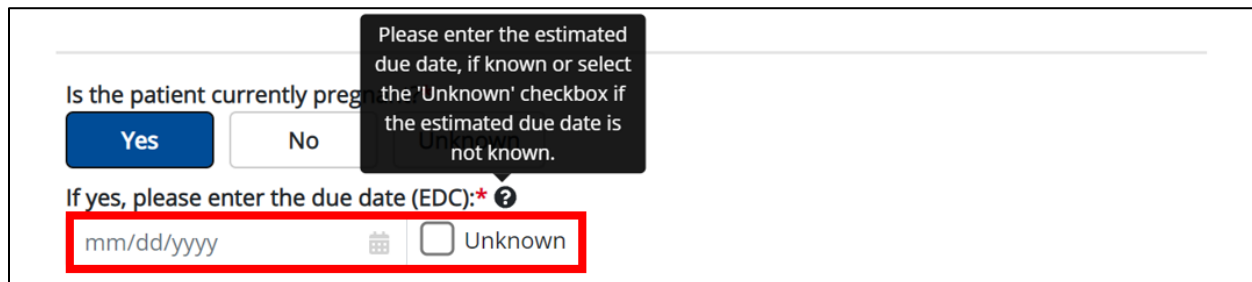
If yes, please enter the due date (EDC): ?

mm/dd/yyyy

Unknown

**Please Note:** The *Is the patient currently pregnant?* field is only enabled when the *Patient Sex* field is marked as **Female**.

- If **Yes** is selected for the *Is the patient currently pregnant?* field, the subsequent field is enabled. Enter the **estimated due date (EDC)** in the subsequent field: *If yes, please enter the due date (EDC)*. If the due date is unknown, click the **Unknown checkbox**.



Is the patient currently pregnant?

Yes No

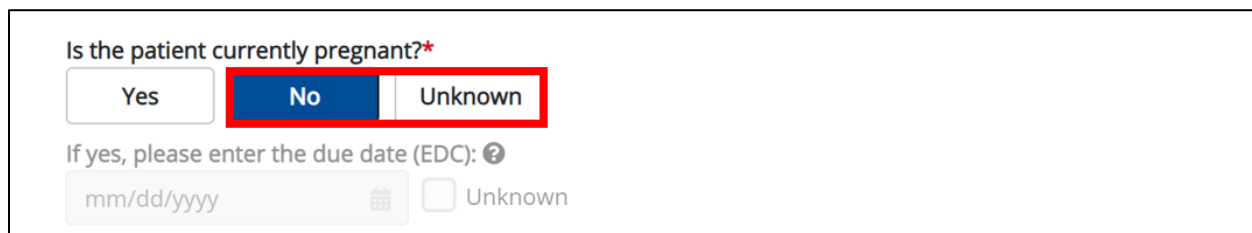
If yes, please enter the due date (EDC):\* ?

mm/dd/yyyy

Unknown

Please enter the estimated due date, if known or select the 'Unknown' checkbox if the estimated due date is not known.

**Please Note:** If **No** or **Unknown** is selected for the *Is the patient currently pregnant?* field, the subsequent field is disabled: *If yes, please enter the due date (EDC)*.



Is the patient currently pregnant?\*

Yes No Unknown

If yes, please enter the due date (EDC): ?

mm/dd/yyyy

Unknown

35. Select the **appropriate answer** to *Prior Hepatitis B Diagnosis*.

Prior Hepatitis B Diagnosis\*

Yes No Unknown

If yes, please enter the date of diagnosis ?

mm/dd/yyyy ☐ Unknown

- If **Yes** is selected for the *Prior Hepatitis B Diagnosis* field, the subsequent field is enabled. Enter the **Date of Diagnosis** in the subsequent field. If the date of diagnosis is unknown, click the **Unknown** checkbox.

Prior Hepatitis B Diagnosis\*

Yes No Unknown

If yes, please enter the date of diagnosis\* ?

mm/dd/yyyy ☐ Unknown

**Please Note:** If **No** or **Unknown** is selected for the *Prior Hepatitis B Diagnosis* field, the subsequent field is disabled: *If yes, please enter the date of diagnosis*.

Prior Hepatitis B Diagnosis\*

Yes No Unknown

If yes, please enter the date of diagnosis ?

mm/dd/yyyy ☐ Unknown

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

Elaine Benes

Suffix Select... Date of Birth\* 02/15/1990

Patient Sex\* Female Ethnicity\* Not Hispanic or Latino Race\* White

Address 1\* 123 Main Street Address 2 .2

City\* Lexington State\* KY Zip Code\* 40511-

County\* Fayette Phone\* (555) 234-5678 Email elaine@mailinator.com

Is the patient currently pregnant?\*

Yes No Unknown

If yes, please enter the due date (EDC)\* ?

03/08/2023 ☐ Unknown

Prior Hepatitis B Diagnosis\*

Yes No Unknown

If yes, please enter the date of diagnosis\* ?

mm/dd/yyyy ☒ Unknown

Save Next

## 10 Laboratory Information

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

The screenshot shows the 'LABORATORY INFORMATION' screen. On the left is a sidebar with navigation options: Patient Information, Laboratory Information (selected), Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death Information, Vaccination History, Additional Comments, and Review & Submit. The main content area has a header 'LABORATORY INFORMATION' and a question 'Does the patient have a lab test?' with 'Yes' and 'No' buttons. The 'Yes' button is highlighted with a red box. Below the question, there is a text box for 'Hepatitis Marker' and a 'Results' dropdown menu. Further down, there are fields for 'Test Result Date' and 'Specimen Collection Date', both with 'Unknown' checkboxes. At the bottom, there are 'Add Hepatitis Marker', 'Add ALT', 'Add AST', and 'Add Bilirubin' buttons.

2. If **Yes** is selected, the subsequent lab-related fields on the screen are enabled. You must enter details for a lab test.

This screenshot shows the same 'LABORATORY INFORMATION' screen, but now the 'Yes' button is selected and highlighted with a red box. The subsequent lab-related fields are also highlighted with a red box, including the 'Hepatitis Marker' dropdown, the 'Results' dropdown, the 'Test Result Date' and 'Specimen Collection Date' fields with their 'Unknown' checkboxes, and the 'Laboratory Name' text field. The 'Add Hepatitis Marker' button is visible at the bottom.

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

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

**Hepatitis Marker\***

Select...

- HEPATITIS B VIRUS CORE AB.IGM
- Hepatitis B virus core IgM Ab [Presence] in Body fluid
- Hepatitis B virus core IgM Ab [Presence] in Serum or Plasma by Immunoassay
- Hepatitis B virus DNA [Mass/volume] in Serum
- Hepatitis B virus surface Ag [Presence] in Body fluid
- Hepatitis B virus surface Ag [Presence] in Cerebral spinal fluid
- Hepatitis B virus surface Ag [Presence] in Serum

**Specimen Collection Date\***

mm/dd/yyyy ☐ Unknown

**Please Note:** The *Hepatitis Marker* dropdown menu displays only the hepatitis marker options that apply to the selected Acute Hepatitis Case Report.

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

**Hepatitis Marker\***

Hepatitis A virus IgM Ab [Presence] in Body fluid

**Results\***

Select...

- Negative
- Positive
- Undetermined/inconclusive

**Specimen Collection Date\***

mm/dd/yyyy ☐ Unknown

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

**Results\***

Positive

Please enter the viral load or enter 'Unknown' if viral load is not known.

If applicable, please enter the viral load: ?

6. If applicable, enter the **Test Result Date**.

7. Enter the **Specimen Collection Date**.

**Test Result Date\***

mm/dd/yyyy ☐ Unknown

**Specimen Collection Date\***

mm/dd/yyyy ☐ Unknown

**Please Note:** The Specimen Collection Date cannot occur **after** the Test Result Date. The Specimen Collection Date must occur on the **same date** or any date **BEFORE** the Test Result Date. If you enter a Specimen Collection Date that occurs **after** the Test Result Date, both fields are marked as invalid.

If you click **Next**, the **Laboratory Information** screen displays an error banner with a message that states: *There are errors. Please make a selection for all required fields.*

To proceed, you must enter a valid Specimen Collection Date that occurs **on** or **before** the Test Result Date.

<b>Test Result Date*</b> 07/23/2021 <input type="checkbox"/> Unknown <small>Invalid Test Result Date</small>	<b>Specimen Collection Date*</b> 07/26/2021 <input type="checkbox"/> Unknown <small>Invalid Specimen Collection Date</small>
--	--

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

**Laboratory Name:\***

### Adding Multiple Hepatitis Markers

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

**Laboratory Name:\***

Test Lab

**+ Add Hepatitis Marker**

ALT

**+ Add ALT**

AST

**+ Add AST**

Bilirubin

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

Laboratory Name:<sup>\*</sup>

Test Lab

Hepatitis Marker<sup>\*</sup>

Select...

Results<sup>\*</sup>

Select...

If applicable, please enter the viral load: ?

Test Result Date<sup>\*</sup>

mm/dd/yyyy

☐ Unknown

Specimen Collection Date<sup>\*</sup>

mm/dd/yyyy

☐ Unknown

Laboratory Name:<sup>\*</sup>

## Adding ALT

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

+ Add Hepatitis Marker

ALT

+ Add ALT

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

ALT

Results:<sup>\*</sup>

Units/Liter

Reference:<sup>\*</sup>

Units/Liter

Test Result Date<sup>\*</sup>

mm/dd/yyyy

☐ Unknown

Specimen Collection Date<sup>\*</sup>

mm/dd/yyyy

☐ Unknown

Laboratory Name:<sup>\*</sup>

## Adding AST

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



---

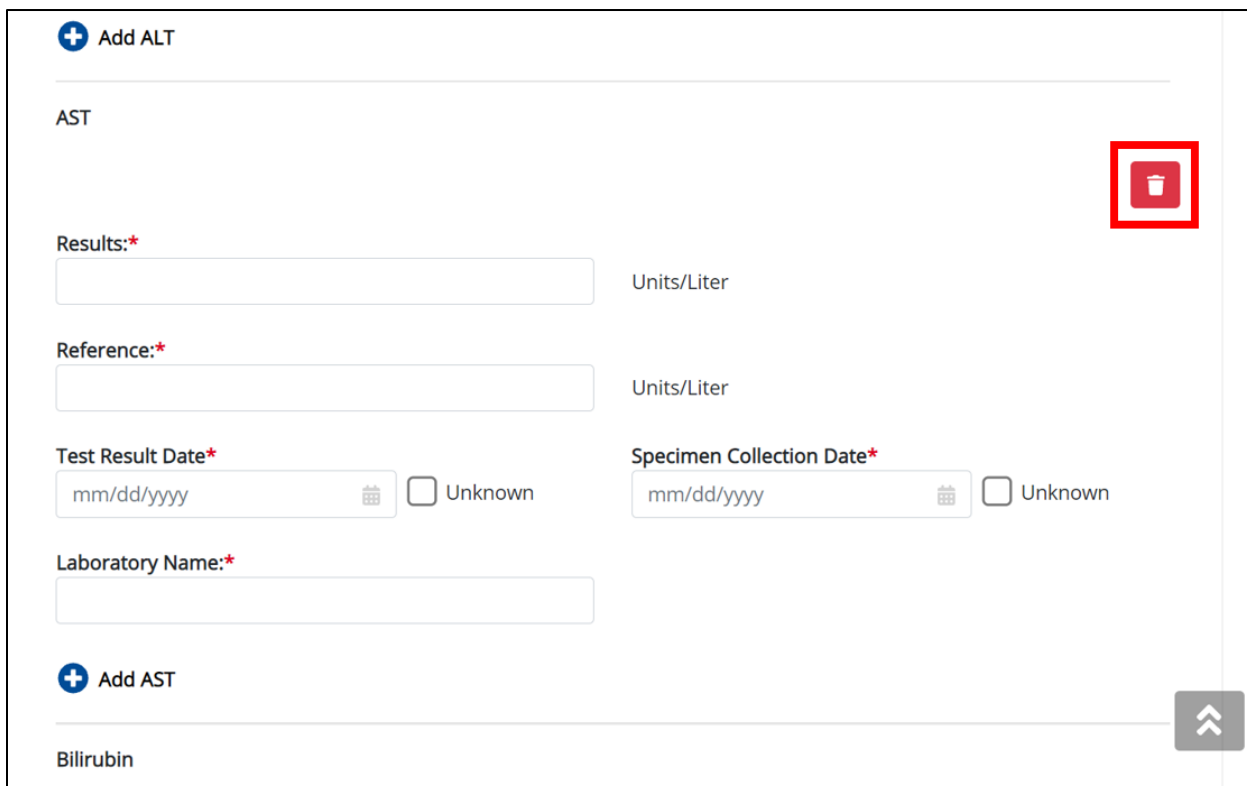
AST

---

Bilirubin

---

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



---

AST

Results:\*

Units/Liter

Reference:\*

Units/Liter

Test Result Date\*

☐ Unknown

Specimen Collection Date\*

☐ Unknown

Laboratory Name:\*

---

Bilirubin

## Adding Bilirubin

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

Laboratory Name:\*

Test Lab

+ Add AST

Bilirubin

+ Add Bilirubin

Save

Previous

Next

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

Bilirubin

Results:\*

mg/dL

Reference:\*

mg/dL

Test Result Date\*

mm/dd/yyyy

Unknown

Specimen Collection Date\*

mm/dd/yyyy

Unknown

Laboratory Name:\*

+ Add Bilirubin

Save

Previous

Next

- Once the **Laboratory Information** screen is complete, click **Next** to proceed to the **Applicable Symptoms** screen.

ACUTE HEPATITIS B CASE REPORT FORM
Section 2 of 8

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information
Laboratory Information
Applicable Symptoms
Exposure Information
Hospitalization, ICU & Death Information
Vaccination History
Additional Comments
Review & Submit

Does the patient have a lab test?

Yes

No

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Billirubin, please ensure you complete all fields for that test.

Hepatitis Marker

Hepatitis B virus core IgM Ab [Presence] in Body fluid

Results

Positive

If applicable, please enter the viral load:

Test Result Date

01/27/2023

Unknown

Specimen Collection Date

01/25/2023

Unknown

Laboratory Name

Test Lab

Add Hepatitis Marker

ALT

Add ALT

AST

Add AST

Billirubin

Add Billirubin

Save

Previous

Next

## 11 Applicable Symptoms

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

ACUTE HEPATITIS B CASE REPORT FORM Section 3 of 8

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS	
Patient Information	Were symptoms present during the course of illness?*
Laboratory Information	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Applicable Symptoms</b>	Onset Date
Exposure Information	<input type="text" value="mm/dd/yyyy"/> <input type="button" value="Unknown"/>

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

APPLICABLE SYMPTOMS	
Patient Information	Were symptoms present during the course of illness?*
Laboratory Information	<input checked="" type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Applicable Symptoms</b>	Onset Date
Exposure Information	<input type="text" value="mm/dd/yyyy"/> <input type="button" value="Unknown"/>
Hospitalization, ICU & Death Information	If symptomatic, which of the following did the patient experience during their illness?
Vaccination History	Fever*
Additional Comments	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Review & Submit	If yes, please enter the highest temperature: <input type="text"/>
	Diarrhea (>3 loose stools/24hr period)*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	If yes, please enter # of days of diarrhea: <input type="text"/>
	Abdominal pain*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Elevated ALT > 100*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Fatigue*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Headache*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Jaundice*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Malaise*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Muscle aches (myalgia)*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Nausea*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Vomiting*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	Did the patient have any other symptoms?*
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
	If yes, please specify: <input type="text"/>

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

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

3. Enter the **Onset Date** for the symptoms.

- If the onset date is unknown, click the **Unknown checkbox**.

4. To report if the patient had a fever during their illness, select the **appropriate answer** for the field: *Fever*.

- If **Yes** is selected, the subsequent field is enabled. Enter the **patient's highest temperature** in the subsequent textbox: *If yes, please specify.*

5. To report if the patient had diarrhea during their illness, select the **appropriate answer** for the field: *Diarrhea (>3 loose stools/24hr period).*

Diarrhea (>3 loose stools/24hr period)\*

If yes, please enter # of days of diarrhea: ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **number of days of diarrhea** in the subsequent textbox: *If yes, please enter # of days of diarrhea.*

Diarrhea (>3 loose stools/24hr period)\*

If yes, please enter # of days of diarrhea: ?

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

- |                       |                          |
|-----------------------|--------------------------|
| • Abdominal pain      | • Headache               |
| • Anorexia            | • Jaundice               |
| • Clay Colored Stools | • Malaise                |
| • Dark Urine          | • Muscle aches (myalgia) |
| • Elevated ALT > 100  | • Nausea                 |
| • Fatigue             | • Vomiting               |

Abdominal pain\*

Headache\*

Anorexia\*

Jaundice\*

Clay Colored Stools\*

Malaise\*

Dark urine\*

Muscle aches (myalgia)\*

Elevated ALT > 100\*

Nausea\*

Fatigue\*

Vomiting\*

7. To report additional symptoms not listed on the screen, select the **appropriate answer** for the field: *Did the patient have any other symptoms?*

Did the patient have any other symptoms?\*

If yes, please specify: ?

- If **Yes** is selected, the subsequent field is enabled. Enter the **patient's other symptoms** in the subsequent textbox: *If yes, please specify.*

Did the patient have any other symptoms?\*

If yes, please specify: \* ?

8. Once complete, click **Next** to proceed to the **Exposure Information** screen.

Patient Information ☒

Laboratory Information ☒

**Applicable Symptoms**

Exposure Information ☐

Hospitalization, ICU & Death Information ☐

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Were symptoms present during the course of illness?\*

Onset Date\* ?

01/03/2023  ☐ Unknown

If symptomatic, which of the following did the patient experience during their illness?

Fever\*

If yes, please enter the highest temperature: \* ?

101

Diarrhea (>3 loose stools/24hr period)\*

If yes, please enter # of days of diarrhea: \* ?

1

Abdominal pain\*

Anorexia\*

Arthralgia\*

Jaundice\*

Malaise\*

Muscle aches (myalgia)\*

Nausea\*

Vomiting\*

Did the patient have any other symptoms?\*

If yes, please specify: \* ?

Unknown

Save Previous **Next**

## 12 Exposure Information

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

ACUTE HEPATITIS B CASE REPORT FORM Section 4 of 8

Please select the information that the patient was exposed to prior to illness.

### EXPOSURE INFORMATION

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

**Exposure Information**

Hospitalization, ICU & Death Information 🔒

Vaccination History 🔒

Additional Comments 🔒

Review & Submit 🔒

Did the patient have any of the following exposures in the past 6 months?\*

Domestic travel (outside state of normal residence)

If yes, please specify state:

Select...

Date of Departure mm/dd/yyyy ☐ Unknown Date of Arrival mm/dd/yyyy ☐ Unknown

Add Domestic Travel

International travel

If yes, please specify country:

Select...

Date of Departure mm/dd/yyyy ☐ Unknown Date of Arrival mm/dd/yyyy ☐ Unknown

Add International Travel

Cruise or vessel travel as passenger or crew member

If yes, please specify cruise ship:

Date of Departure mm/dd/yyyy ☐ Unknown Date of Arrival mm/dd/yyyy ☐ Unknown

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

### EXPOSURE INFORMATION

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

**Exposure Information**

Hospitalization, ICU & Death Information 🔒

Vaccination History 🔒

Additional Comments 🔒

Review & Submit 🔒

Did the patient have any of the following exposures in the past 6 months?\*

Domestic travel (outside state of normal residence)\*

If yes, please specify state:

Select...

Date of Departure mm/dd/yyyy ☐ Unknown Date of Arrival mm/dd/yyyy ☐ Unknown

Add Domestic Travel

International travel\*

If yes, please specify country:

Select...

Date of Departure mm/dd/yyyy ☐ Unknown Date of Arrival mm/dd/yyyy ☐ Unknown

Add International Travel

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

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

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

How many male sex partners did the patient have?  
Select...

How many female sex partners did the patient have?  
Select...

**Is this part of an outbreak?\***

Yes No Unknown

If yes, please specify the name of the outbreak: ?

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

**Domestic travel (outside state of normal residence)\***

Yes No Unknown

If yes, please specify state:  
Select...

Date of Departure ?  
mm/dd/yyyy [calendar icon] ☐ Unknown

Date of Arrival ?  
mm/dd/yyyy [calendar icon] ☐ Unknown

+ Add Domestic Travel

- If **Yes** is selected for the *Domestic travel (outside state of normal residence)* field, the subsequent fields are enabled:
- Select the **state that the patient traveled to** from the subsequent dropdown menu: *If yes, please specify state*.
- Enter the **Date of Departure** and the **Date of Arrival** in the appropriate fields.

**Domestic travel (outside state of normal residence)\***

Yes No Unknown

If yes, please specify state:\*

Select...

Date of Departure\* ?  
mm/dd/yyyy [calendar icon] ☐ Unknown

Date of Arrival\* ?  
mm/dd/yyyy [calendar icon] ☐ Unknown

+ Add Domestic Travel

## Adding Multiple Domestic Travel Details

4. You can click **Add Domestic Travel** to log the dates of travel for multiple domestic trips. This means that you can enter additional states that the patient has traveled to in the past 6 months.

Domestic travel (outside state of normal residence)\*

If yes, please specify state:\*

CO

Date of Departure\*

12/24/2022 ☐ Unknown

Date of Arrival\*

01/01/2023 ☐ Unknown

Add Domestic Travel

- To delete an additional domestic travel section, click the **Trash Bin Icon** located at the top right.

Domestic travel (outside state of normal residence)\*

If yes, please specify state:\*

CO

Date of Departure\*

12/24/2022 ☐ Unknown

Date of Arrival\*

01/01/2023 ☐ Unknown

Domestic Travel Details

If yes, please specify state:\*

Select...

Date of Departure\*

mm/dd/yyyy ☐ Unknown

Date of Arrival\*

mm/dd/yyyy ☐ Unknown

Add Domestic Travel

5. Select the **appropriate answer** for the field: *International travel*.

If yes, please specify state:\*

AR

Date of Departure\*

11/24/2022 ☐ Unknown

Date of Arrival\*

11/26/2022 ☐ Unknown

Add Domestic Travel

**International travel\***

If yes, please specify country:

Select...

Date of Departure

mm/dd/yyyy ☐ Unknown

Date of Arrival

mm/dd/yyyy ☐ Unknown

Add International Travel

- If **Yes** is selected for the *International travel* field, the subsequent fields are enabled:
- Select the **country that the patient traveled to** from the subsequent dropdown menu: *If yes, please specify country.*
- Enter the **Date of Departure** and the **Date of Arrival** in the appropriate fields.

International travel\*

**Yes** No Unknown

If yes, please specify country:\*

Select...

Date of Departure\* ? mm/dd/yyyy ☐ Unknown

Date of Arrival\* ? mm/dd/yyyy ☐ Unknown

+ Add International Travel

### Adding Multiple International Travel Details

- You can click **Add International Travel** to log the dates of travel for multiple international trips. This means that you can enter additional countries that the patient has traveled to in the past 6 months.

International travel\*

**Yes** No Unknown

If yes, please specify country:\*

AUSTRALIA x v

Date of Departure\* ? 10/03/2022 ☐ Unknown

Date of Arrival\* ? 10/10/2022 ☐ Unknown

+ Add International Travel

- To delete an additional domestic travel section, click the **Trash Bin Icon** located at the top right.

International travel\*

**Yes** No Unknown

If yes, please specify country:\*

AUSTRALIA x v

Date of Departure\* ? 10/03/2022 ☐ Unknown

Date of Arrival\* ? 10/10/2022 ☐ Unknown

International Travel Details

If yes, please specify country:\*

GREECE x v

Date of Departure\* ? 09/19/2022 ☐ Unknown

Date of Arrival\* ? 09/23/2022 ☐ Unknown

+ Add International Travel

7. Select the **appropriate answer** for the field: *Cruise or vessel travel as passenger or crew member*.

- If **Yes** is selected for the *Cruise or vessel travel as passenger or crew member* field, the subsequent fields are enabled:
- Enter the **name of the cruise ship or vessel** in the subsequent textbox field: *If yes, please specify cruise ship*.
- Enter the **Date of Departure** and the **Date of Arrival** in the appropriate fields.

### Adding Multiple Cruise or Vessel Travel Details

8. You can click **Add Cruise or Vessel Travel** to log the dates of travel for multiple cruise or vessel trips. This means that you can enter additional cruises or vessels where the patient traveled as a passenger or crew member in the past 6 months.


- To delete an additional cruise or vessel travel section, click the **Trash Bin Icon** located at the top right.

Cruise or vessel travel as passenger or crew member\*

If yes, please specify cruise ship:\*

Carnival Liberty


Date of Departure\*  ☐ Unknown  ☐ Unknown

Cruise or Vessel Travel Details 

If yes, please specify cruise ship:\*

Royal Caribbean Cruise

Date of Departure\*  ☐ Unknown  ☐ Unknown

 Add Cruise or Vessel Travel

9. Select the **appropriate answer** for the field: *Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)?*

Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)\*

If yes, please specify workplace setting: ?

- If **Yes** is selected for the *Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)* field, the subsequent field is enabled. Enter the **name of the workplace setting** in the subsequent textbox: *If yes, please specify the name of workplace setting.*

Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)\*

If yes, please specify workplace setting:\*

10. Select the **appropriate answer** for the field: *Adult congregate living facility (nursing, assisted living or long-term care facility).*

Adult congregate living facility (nursing, assisted living or long-term care facility)\*

If yes, please specify the nursing, assisted living or long-term care facility: ?

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

Adult congregate living facility (nursing, assisted living or long-term care facility)\*

If yes, please specify the nursing, assisted living or long-term care facility:\* ?

- Select the **appropriate answer** for the field: *School/daycare.*

School/daycare\*

If yes, please specify the name of the school/daycare: ?

- If **Yes** is selected for the *School/daycare* field, the subsequent field is enabled. Enter the **name of the school/daycare** in the subsequent textbox: *If yes, please specify the name of the school/daycare.*

School/daycare\*

If yes, please specify the name of the school/daycare:\* ?

- Select the **appropriate answer** for the field: *Correctional facility.*

Correctional facility\*

If yes, please specify name of correctional facility: ?

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

Correctional facility\*

Please enter 'Unknown' if information of correctional facility is not available.

If yes, please specify name of correctional facility:\* ?

13. Select the **appropriate answer** for the field: *Known contact with same diagnosis or similar symptoms*.

- If **Yes** is selected for the *Known contact with same diagnosis or similar symptoms* field, the subsequent fields are enabled:
- Enter the **patient's relationship to the contact** in the subsequent textbox: *If yes, please specify the relationship*.
- Enter the **contact's first and last name and contact information (e.g., Phone Number, Email Address)** in the subsequent textbox: *If yes, please enter the name and contact information*.

14. Select the **appropriate answer** for the field: *Incarceration*.

- If **Yes** is selected for the *Incarceration* field, the subsequent fields are enabled:
- Enter the **patient's incarceration details** in the subsequent textbox: *If yes, please specify*.
- Enter the **patient's history of incarceration** in the subsequent textbox: *If yes, please provide the history of incarceration*.

15. Select the **appropriate answer** for the field: *Foreign Born*.

Foreign Born\*

Yes No Unknown

If yes, please specify country: ?

- If **Yes** is selected for the *Foreign Born* field, the subsequent field is enabled. Select the **country that the patient was born in** from the subsequent dropdown menu: *If yes, please specify country*.

Foreign Born\*

Yes

Please select 'Unknown' if information of the country of birth is not available.

If yes, please specify country: \*

Select...

AFGHANISTAN

ALBANIA

ALGERIA

AMERICAN SAMOA

ANDORRA

ANGOLA

ANGUILLA

16. Select the **appropriate answer** for the field: *IV Drug Use*.

IV Drug Use\*

Yes No Unknown

If yes, please specify details: ?

- If **Yes** is selected for the *IV Drug Use* field, the subsequent field is enabled. Enter the **patient's IV drug use details** in the subsequent textbox: *If yes, please specify details*.

IV Drug Use\*

Yes No Unknown

If yes, please specify details: \*

17. Select the **appropriate answer** for the field: *Other Illicit Drug Use*.

Other Illicit Drug use\*

Yes No Unknown

If yes, please specify details: ?

- If **Yes** is selected for the *Other Illicit Drug Use* field, the subsequent field is enabled. Enter the **patient's other illicit drug use details** in the subsequent textbox: *If yes, please specify details.*

Other Illicit Drug use\*

If yes, please specify details:\* ?

18. Select the **appropriate answer** for the field: *Exposure to Hepatitis B virus.*

Exposure to Hepatitis B virus\*

Tattoos\*

19. Select the **appropriate answer** for the field: *Tattoos.*

Tattoos\*

If yes, please specify the setting:\* ?

Select...

If other, please specify:\* ?

- If **Yes** is selected for the *Tattoos* field, the subsequent field is enabled. Select the **setting of the tattoo** from the subsequent dropdown menu: *If yes, please specify the setting.*

Tattoos\*

Please select 'Other' if the setting is not listed.

If yes, please specify the setting:\* ?

Select...

Corrections setting

Homemade/Unlicensed artist

Licensed parlor

Other

If yes, please specify the setting:\* ?

Select...

- If **Other** is selected from the *If yes, please specify the setting* dropdown menu, the subsequent field is enabled. Enter the **setting of the tattoo** in the subsequent textbox: *If other, please specify.*

Tattoos\*

If yes, please specify the setting:\* ?

Other

If other, please specify:\* ?

20. Select the **appropriate answer** for the field: *Piercings*.

Piercings\*

Yes No Unknown

If yes, please specify the setting: ?

- If **Yes** is selected for the *Piercings* field, the subsequent field is enabled. Select the **setting of the piercing** from the subsequent dropdown menu: *If yes, please specify the setting*.

Piercings\*

Yes No Please select 'Other' if the setting is not listed.

If yes, please specify the setting: \*

Select...

Corrections setting

Homemade/Unlicensed artist

Licensed parlor

Other

- If **Other** is selected from the *If yes, please specify the setting* dropdown menu, the subsequent field is enabled. Enter the **setting of the piercing** in the subsequent textbox: *If other, please specify*.

Piercings\*

Yes No Unknown

If yes, please specify the setting: \*

Other

If other, please specify: \*

If the patient has any needle stick injuries, please specify the location on the body (select all that apply): \*

**Please Note:** Currently, *needle stick injury* and *piercings* are not listed separately. To report a needle stick injury, select "yes" to *Piercings*.

- If neither piercing nor needle stick injury is applicable, please select "other" and enter *not applicable* in the *If other, please specify* textbox field.
- If applicable, select the **appropriate location(s) on the body where the needle stick injury occurred** from the multi-select dropdown menu: *If the patient has any needle stick injuries, please specify the location on the body*.

If yes, please specify the setting:\* ?

Licensed parlor

If other, please specify: ?

Please select all body parts where the injury occurred. If the body part is not listed, please select 'Other' and enter the body part in the text box below.

If the patient has any needle stick injuries, please specify the location on the body (select all that apply):\* ?

Select...

- Arm
- Face
- Feet
- Hands
- Leg
- Penis
- Rectum

- If **Other** is selected from the *If the patient has any needle stick injuries, please specify the location on the body* dropdown menu, the subsequent field is enabled. Enter the **location(s) on the body where the needle stick injury occurred** in the subsequent textbox: *If other, please specify.*

Piercings\*

If yes, please specify the setting:\* ?

Licensed parlor

If other, please specify: ?

If the patient has any needle stick injuries, please specify the location on the body (select all that apply):\* ?

Arm x Leg x Other x

If other, please specify:\* ?

21. Select the **appropriate answer** for the field: *Recent Sexual Contact*.

**Recent Sexual Contact\***

If yes, please specify number of sexual partners:

- If **Yes** is selected for the *Recent Sexual Contact* field, the subsequent field is enabled. Select the **number of sexual partners** from the subsequent dropdown menu: *If yes, please specify number of sexual partners.*

Recent Sexual Contact\*

If yes, please specify number of sexual partners:\*

Select...

10

11

12

13

14

15

15+

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

Is this part of an outbreak?\*

If yes, please specify the name of the outbreak: ?

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

Is this part of an outbreak?\*

Please enter 'Unknown' if the details of outbreak is not available.

If yes, please specify the name of the outbreak: \* ?

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

Exposure to Hepatitis B virus\*

Tattoos\*

If yes, please specify the setting: ?

Other x | v

If other, please specify: ?

Unknown

Piercings\*

If yes, please specify the setting: ?

Licensed parlor x | v

If other, please specify: ?

If the patient has any needle stick injuries, please specify the location on the body (select all that apply): ?

Arm x Leg x Other x x | v

If other, please specify: ?

Unknown

Recent Sexual Contact\*

If yes, please specify number of sexual partners:\*

8 x | v

Is this part of an outbreak?\*

If yes, please specify the name of the outbreak: ?

Save Previous **Next**

## 13 Hospitalization, ICU & Death Information

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

**HOSPITALIZATION, ICU & DEATH INFORMATION**

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Exposure Information ☒

**Hospitalization, ICU & Death Information**

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Was the patient hospitalized?\*

Yes No Unknown

If yes, please specify the hospital name:

Admission Date  ☐ Unknown Discharge Date  ☐ Unknown

☐ Still hospitalized

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

Yes No Unknown

Admission Date to ICU  ☐ Unknown Discharge Date from ICU  ☐ Unknown

Did the patient die as a result of this illness?\*

Yes No Unknown

If yes, please provide the date of death:

Date of Death  ☐ Unknown

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

**HOSPITALIZATION, ICU & DEATH INFORMATION**

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Exposure Information ☒

**Hospitalization, ICU & Death Information**

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Was the patient hospitalized?\*

**Yes** No Unknown

If yes, please specify the hospital name:

Admission Date\*  ☐ Unknown Discharge Date\*  ☐ Unknown

☐ Still hospitalized

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

Yes No Unknown

Admission Date to ICU  ☐ Unknown Discharge Date from ICU  ☐ Unknown

Did the patient die as a result of this illness?\*

Yes No Unknown

If yes, please provide the date of death:

Date of Death  ☐ Unknown

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

Death-related questions are not impacted by the selected answer for the conditional question: *Was the patient hospitalized?*

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

Was the patient hospitalized?\*

Please enter the name of the hospital where the patient is/was hospitalized.

If yes, please specify the hospital name:\*

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

Admission Date\*

Discharge Date\*

☐ Still hospitalized

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

Admission Date\*

Discharge Date\*

☐ Still hospitalized

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

Admission Date\*

Discharge Date\*

☒ Still hospitalized

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

Admission Date to ICU

Discharge Date from ICU

Did the patient die as a result of this illness?

If yes, please provide the date of death:

Date of Death

**Please Note:** The Admission Date **cannot** occur **after** the Discharge Date. The Admission Date must occur on the **same date** or any date **BEFORE** the Discharge Date.

If you enter an Admission Date that occurs after the Discharge Date and clicks **Next**, both fields are marked as invalid, and the screen is grayed out and displays a pop-up message that states:

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

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

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

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

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

Admission Date to ICU\*

☐ Unknown

Discharge Date from ICU\*

☐ Unknown

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

Did the patient die as a result of this illness?\*

If yes, please provide the date of death:

Date of Death

☐ Unknown

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

Did the patient die as a result of this illness?\*

If yes, please provide the date of death:

Date of Death\*

☐ Unknown

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Exposure Information ☒

**Hospitalization, ICU & Death Information**

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Was the patient hospitalized?\*

If yes, please specify the hospital name:\*

Admission Date\*

☐ Unknown

Discharge Date\*

☐ Unknown

☐ Still hospitalized

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

Admission Date to ICU

☐ Unknown

Discharge Date from ICU

☐ Unknown

Did the patient die as a result of this illness?\*

If yes, please provide the date of death:

Date of Death

☐ Unknown

## 14 Vaccination History

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

ACUTE HEPATITIS B CASE REPORT FORM Section 6 of 8

Please provide the vaccination history of the patient related to this case.

### VACCINATION HISTORY

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

**Vaccination History**

Additional Comments 🔒

Review & Submit 🔒

**Has the patient ever received a Hepatitis B vaccine?\***

☐ Yes
 ☐ No
 ☐ Unknown
 ☐ Refused

Vaccine Details

If yes, please provide vaccine name: ?

Select...

If other, please specify: ?

If yes, please enter the number of doses: ?

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose)

mm/dd/yyyy 📅 ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy 📅 ☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy 📅 ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy 📅 ☐ Unknown

+ Add Vaccine

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

### VACCINATION HISTORY

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

**Vaccination History**

Additional Comments 🔒

Review & Submit 🔒

**Has the patient ever received a Hepatitis A vaccine?\***

☒ Yes
 ☐ No
 ☐ Unknown
 ☐ Refused

Vaccine Details

**If yes, please provide vaccine name:\*** ?

Select...

If other, please specify: ?

**If yes, please enter the number of doses:\*** ?

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose)

mm/dd/yyyy 📅 ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy 📅 ☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy 📅 ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy 📅 ☐ Unknown

+ Add Vaccine

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

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

Vaccine Details

Please select the vaccine that was administered to the patient.

If yes, please provide vaccine name:\* ?

Select...

- Hep B, unspecified formulation
- hepatitis A and hepatitis B vaccine
- hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)
- Hepatitis B vaccine (recombinant), CpG adjuvanted
- Hepatitis B vaccine (recombinant), 3-antigen, Al(OH)<sub>3</sub> adjuvanted
- hepatitis B vaccine, adult dosage
- hepatitis B vaccine, dialysis patient dosage

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

If yes, please provide vaccine name:\* ?

Other

If other, please specify:\* ?

If yes, please enter the number of doses:\* ?

Select...

4. Select the **number of doses that the patient received for the selected vaccine** from the dropdown menu: *If yes, please enter the number of doses.*

Vaccine Details

If yes, please provide vaccine name:\* ?

hepatitis B vaccine, adult dosage

If other, please specify: ?

Please select the number of doses that the patient received for the selected vaccine.

If yes, please enter the number of doses:\* ?

Select...

- 1
- 2
- 3
- 4

+ Add Vaccine

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

If yes, please provide vaccine name:\* ?

hepatitis B vaccine, adult dosage

If other, please specify: ?

If yes, please enter the number of doses:\* ?

1

If yes, please specify the date administered: ?

**Date Administered (1st dose)\***

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

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

If yes, please enter the number of doses:\* ?

2

If yes, please specify the date administered: ?

**Date Administered (1st dose)\***

mm/dd/yyyy ☐ Unknown

**Date Administered (2nd dose)\***

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

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

If yes, please enter the number of doses:\* ?

3

If yes, please specify the date administered: ?

**Date Administered (1st dose)\***

mm/dd/yyyy ☐ Unknown

**Date Administered (2nd dose)\***

mm/dd/yyyy ☐ Unknown

**Date Administered (3rd dose)\***

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

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

If yes, please enter the number of doses:\* ?

4

If yes, please specify the date administered: ?

**Date Administered (1st dose)\***

mm/dd/yyyy ☐ Unknown

**Date Administered (2nd dose)\***

mm/dd/yyyy ☐ Unknown

**Date Administered (3rd dose)\***

mm/dd/yyyy ☐ Unknown

**Date Administered (4th dose)\***

mm/dd/yyyy ☐ Unknown

+ Add Vaccine

### Adding Multiple Vaccines

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

**VACCINATION HISTORY**

Has the patient ever received a Hepatitis B vaccine?\*

Yes No Unknown Refused

Vaccine Details

If yes, please provide vaccine name:\* ?

hepatitis B vaccine, adult dosage

If other, please specify: ?

If yes, please enter the number of doses:\* ?

1

If yes, please specify the date administered: ?

**Date Administered (1st dose)\***

01/16/2023 ☐ Unknown

**Date Administered (2nd dose)**

mm/dd/yyyy ☐ Unknown

**Date Administered (3rd dose)**

mm/dd/yyyy ☐ Unknown

**Date Administered (4th dose)**


mm/dd/yyyy ☐ Unknown

+ Add Vaccine

Save Previous Next

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

Vaccine Details



If yes, please provide vaccine name:\*

Select...

If other, please specify:

If yes, please enter the number of doses:\*

Select...

If yes, please specify the date administered:

Date Administered (1st dose)

mm/dd/yyyy

☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy

☐ Unknown

+ Add Vaccine

Save

Previous

Next

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

VACCINATION HISTORY

Has the patient ever received a Hepatitis B vaccine?\*

Yes

No

Unknown

Refused

Vaccine Details

If yes, please provide vaccine name:\*

hepatitis B vaccine, adult dosage

If other, please specify:

If yes, please enter the number of doses:\*

1

If yes, please specify the date administered:

Date Administered (1st dose)\*

01/16/2023

☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy

☐ Unknown

+ Add Vaccine

Save

Previous

Next

## 15 Additional Comments

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

ACUTE HEPATITIS B CASE REPORT FORM

Section 7 of 8

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments

Review & Submit

Additional comments or notes, please specify:

0/1000 Characters

Save Previous Next

## 16 Review and Submit

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

### Print or Download Functionality

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

ACUTE HEPATITIS B CASE REPORT FORM

Section 8 of 8

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments ✓

Review & Submit

Print Download

Patient Information

Disease/Organism Hepatitis B Date of Diagnosis 2023/01/23

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

Patient ID (MRN) EB02151990 Affiliation/Organization Hilton Hospital

Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com) Affiliation/Organization Hilton Hospital

Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com) Affiliation/Organization Hilton Hospital

First Name Elaine Middle Name Marie Last Name Benes

Date of Birth 1990/02/15

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

ACUTE HEPATITIS B CA

Please review your information

Patient Information

Laboratory Information

Applicable Symptoms

Exposure Information

Hospitalization, ICU & Death

Vaccination History

Additional Comments

Review & Submit

Patient Information

Disease/Organism

Hepatitis B

Date of Diagnosis

01/23/2023

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

Yes

Patient ID (MRN)

1582111590

Affiliation/Organization

Hilton Hospital

Person Completing Form

Mr. Anthony Vandelay (anthony.vandelay@gmail.com)

Affiliation/Organization

Hilton Hospital

Attending Physician/Clinician

Dr. Eleanor Crane (eleanor.crane@gmail.com)

Affiliation/Organization

Hilton Hospital

First Name

Elaine

Middle Name

Marie

Last Name

Barnes

Date of Birth

01/15/1990

Patient Sex

Female

Ethnicity

Not Hispanic or Latino

Race

Other

Address 1

123 Second Avenue

Address 2

Apt. 2B

City

Lexington

State

KY

Zip Code

40511

County

Fayette

Phone

(555) 222-2345

Email

elaine@gmailinator.com

Is the patient currently pregnant?

Yes

If yes, please enter the due date (EDC)

Destination

SecurePrintUS

Pages

All

Copies

1

Color

Color

More settings

Print

Cancel

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

REVIEW & SUBMIT	
Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Exposure Information	✓
Hospitalization, ICU & Death Information	✓
Vaccination History	✓
Additional Comments	✓

 Print
  Download

---

Patient Information 

Disease/Organism	Date of Diagnosis
Hepatitis B	2023/01/23
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?	
Yes	
Patient ID (MRN)	Affiliation/Organization

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

The screenshot displays the 'REVIEW & SUBMIT' interface of the 'Acute Hepatitis B...' application. On the left, a sidebar lists various information sections, with 'Review & Submit' currently selected. The main area shows patient details for a specific case, including MRN, contact information, and medical history. A 'Download PDF' modal is active, confirming the download. The bottom of the screen features a taskbar with the application icon and name, and a 'Show all' button.

Section	Status
Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Exposure Information	✓
Hospitalization, ICU & Death Information	✓
Vaccination History	✓
Additional Comments	✓
Review & Submit	Active

**Download PDF Dialog:**

- Downloaded successfully
- OK

**Downloaded PDF:** Acute Hepatitis B...pdf

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

Acute Hepatitis B Case Report Form.pdf

1 / 5 125%

**Patient Information**

**Disease/Organism**  
Hepatitis B

**Date of Diagnosis**  
01/23/2023

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

**Patient ID (MRN)**  
EB02151990

**Affiliation/Organization**  
Hilton Hospital

**Person Completing Form**  
Mr. Arthur Vandelay (arthur.vandelay@email.com)

**Affiliation/Organization**  
Hilton Hospital

**Attending Physician/Clinician**  
Dr. Frasier Crane (frasier.crane@email.com)

**Affiliation/Organization**  
Hilton Hospital

**First Name**  
Elaine

**Middle Name**  
Marie

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

**REVIEW & SUBMIT**

Print Download

**Patient Information**

**Disease/Organism**  
Hepatitis B

**Date of Diagnosis**  
2023/01/23

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

**Patient ID (MRN)**  
EB02151990

**Affiliation/Organization**  
Hilton Hospital

**Person Completing Form**  
Mr. Arthur Vandelay (arthur.vandelay@email.com)

**Affiliation/Organization**  
Hilton Hospital

**Attending Physician/Clinician**  
Dr. Frasier Crane (frasier.crane@email.com)

**Affiliation/Organization**  
Hilton Hospital

**REVIEW & SUBMIT**

Print Download

**Patient Information**

**Laboratory Information**

**Does the patient have a lab test?**  
Yes

**Hepatitis Marker**  
Hepatitis A virus (IgM Ab [Presence] in Body fluid)

**Results**  
Positive

**Test Result Date**  
2023/01/18

**Specimen Collection Date**  
2023/01/16

3. Review the *Patient Information* section.

<p>Exposure Information <input checked="" type="checkbox"/></p> <p>Hospitalization, ICU &amp; Death Information <input checked="" type="checkbox"/></p> <p>Vaccination History <input checked="" type="checkbox"/></p> <p>Additional Comments <input checked="" type="checkbox"/></p> <p><b>Review &amp; Submit</b></p>	<p><b>Patient Information</b></p> <p>Disease/Organism: Hepatitis B</p> <p>Date of Diagnosis: 2023/01/23</p> <p>Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes</p> <p>Patient ID (MRN): EB02151990</p> <p>Affiliation/Organization: Hilton Hospital</p> <p>Person Completing Form: Mr. Arthur Vandelay (arthur.vandelay@email.com)</p> <p>Affiliation/Organization: Hilton Hospital</p> <p>Attending Physician/Clinician: Dr. Frasier Crane (frasier.crane@email.com)</p> <p>Affiliation/Organization: Hilton Hospital</p> <p>First Name: Elaine</p> <p>Middle Name: Marie</p> <p>Last Name: Benes</p> <p>Date of Birth: 1990/02/15</p> <p>Patient Sex: Female</p> <p>Ethnicity: Not Hispanic or Latino</p> <p>Race: Other</p> <p>Address 1: 123 Second Avenue</p> <p>Address 2: Apt. 2B</p> <p>City: Lexington</p> <p>State: KY</p> <p>Zip Code: 40511</p> <p>County: Fayette</p> <p>Phone: (555) 222-2345</p> <p>Email: elaine@mailinator.com</p> <p>Is the patient currently pregnant? Yes</p> <p>If yes, please enter the due date (EDC): 2023/03/08</p> <p>Prior Hepatitis B Diagnosis: Yes</p> <p>If yes, please enter the date of diagnosis: Unknown</p>
---	---

4. Review the *Laboratory Information* section.

<p>Hospitalization, ICU &amp; Death Information <input checked="" type="checkbox"/></p> <p>Vaccination History <input checked="" type="checkbox"/></p> <p>Additional Comments <input checked="" type="checkbox"/></p> <p><b>Review &amp; Submit</b></p>	<p><b>Laboratory Information</b></p> <p>Does the patient have a lab test? Yes</p> <p>Hepatitis Marker: Hepatitis B virus core IgM Ab [Presence] in Body fluid</p> <p>Results: Positive</p> <p>Test Result Date: 2023/01/27</p> <p>Specimen Collection Date: 2023/01/25</p> <p>Laboratory Name: Test Laboratory</p>
---	--

5. Review the *Applicable Symptoms* section.

<p>Additional Comments <input checked="" type="checkbox"/></p> <p><b>Review &amp; Submit</b></p>	<p><b>Applicable Symptoms</b></p> <p>Were symptoms present during the course of illness? Yes</p> <p>Onset Date: Unknown</p> <p>If symptomatic, which of the following did the patient experience during their illness?</p> <p>Fever: Yes</p> <p>If yes, please enter the highest temperature: 101</p> <p>Diarrhea (&gt;3 loose stools/24hr period): Yes</p> <p>If yes, please enter # of days of diarrhea: 1</p> <p>Abdominal pain: Yes</p> <p>Anorexia: No</p> <p>Clay Colored Stools: Yes</p> <p>Dark urine: Yes</p> <p>Elevated ALT &gt; 100: No</p> <p>Fatigue: Yes</p> <p>Headache: Yes</p> <p>Jaundice: No</p> <p>Malaise: Unknown</p> <p>Muscle aches (myalgia): Yes</p> <p>Nausea: No</p> <p>Vomiting: Yes</p>
--	--

6. Review the *Exposure Information* section.

Exposure Information

Did the patient have any of the following exposures in the past 6 months?  
Yes

Domestic travel (outside state of normal residence)  
Yes

Domestic Travel Details

If yes, please specify state:  
CO

Date of Departure  
2022/12/24

Date of Arrival  
2023/01/01

Domestic Travel Details

If yes, please specify state:  
AR

Date of Departure  
2022/11/25

Date of Arrival  
2023/01/28

International travel  
Yes

International Travel Details

If yes, please specify country:  
AUSTRALIA

Date of Departure  
2022/10/03

Date of Arrival  
2022/10/10

International Travel Details

If yes, please specify country:  
GREECE

Date of Departure  
2022/09/19

Date of Arrival  
2022/09/29

Cruise or vessel travel as passenger or crew member  
Yes

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

Hospitalization, ICU & Death Information

Was the patient hospitalized?  
Yes

If yes, please specify the hospital name:  
General Hospital

Admission Date  
2022/12/30

Discharge Date  
2023/01/02

Was the patient admitted to an intensive care unit (ICU)?  
No

Did the patient die as a result of this illness?  
No

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

Vaccination History

Has the patient ever received a Hepatitis B vaccine?  
Yes

Vaccine Details

If yes, please provide vaccine name:  
hepatitis B vaccine, adult dosage

If yes, please enter the number of doses:  
1

If yes, please specify the date administered:

Date Administered (1st dose)  
2023/01/16

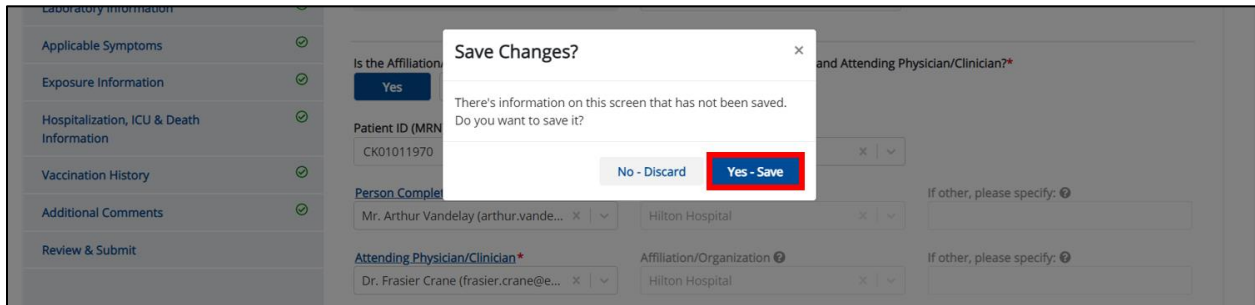
9. Review the *Additional Comments* section.

Click Hyperlinks to Edit

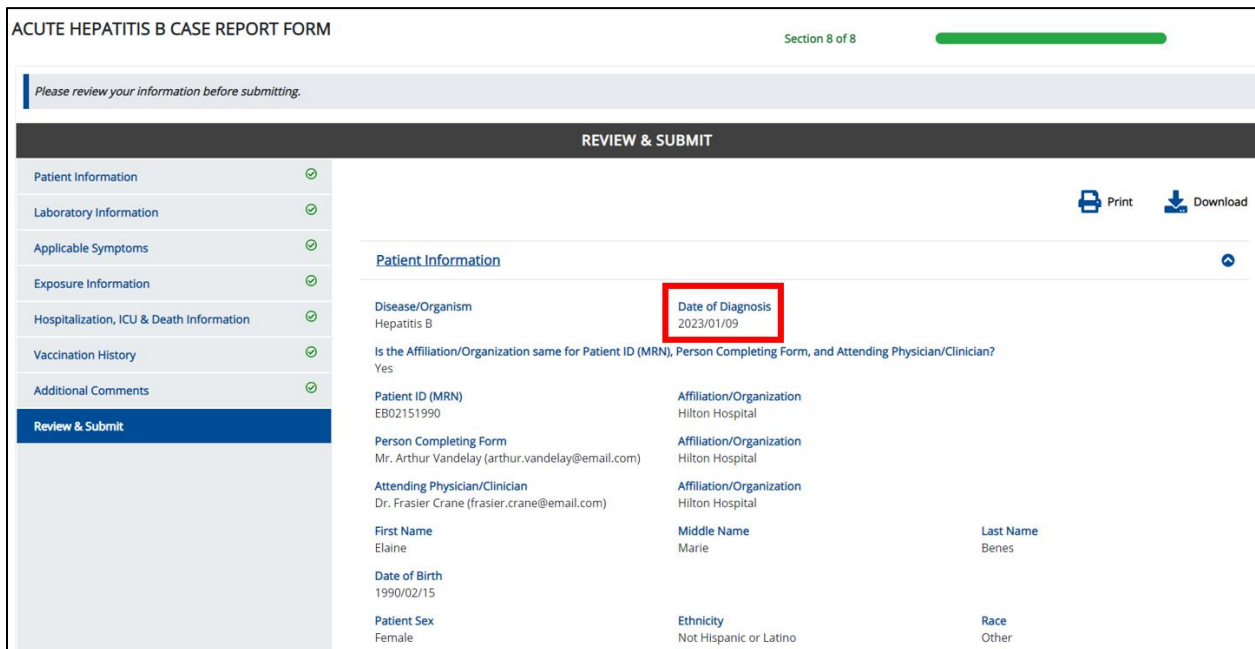
10. If after reviewing, changes are required, click the corresponding **section header hyperlink** or the **side navigation bar tab** to navigate to the appropriate screen or section to edit the information.
- Click the **section header hyperlink** or the **side navigation bar tab** to navigate to the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

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

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



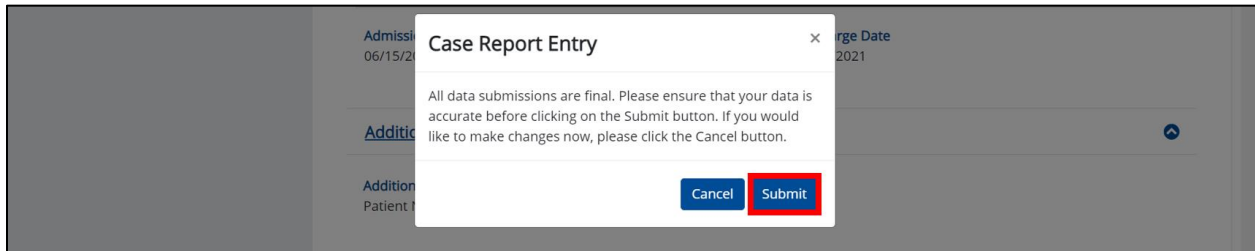
13. Review your edits on the **Review and Submit** screen.



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

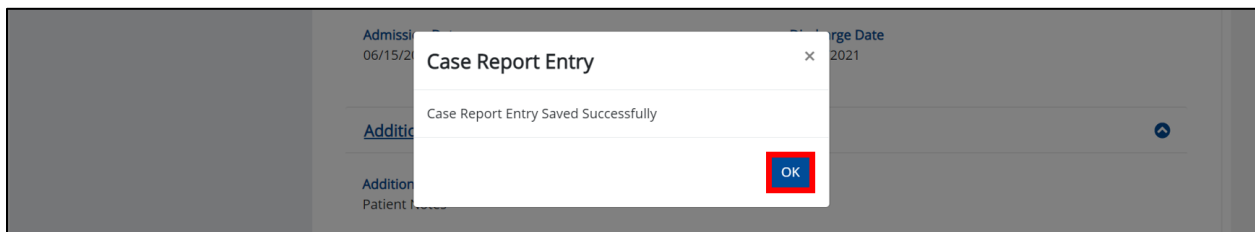


- All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Case Report or click **Submit** to submit the report.



**Please Note:** Once a case report has been submitted, it is final. Should you later discover that you have entered inaccurate information, please use the **Support Tab** in the ePartnerViewer to report this information.

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



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

**Congratulations! You have submitted the Acute Hepatitis B Case Report using KHIE's Direct Data Entry Functionality.**

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

## 17 Case Report User Entry Summary

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

**CASE REPORT ENTRY USER SUMMARY**

LAST UPDATED DATE RANGE Start Date: 02/07/2023 End Date: 02/07/2023 Retrieve Data

SHOWING 4 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:24 PM	2023/02/07 3:24 PM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC	TC 506419MRN	Sarah	Marshman	1979/01/31	Male	Complete	2023/02/07 5:23 AM	2023/02/07 5:23 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis B	Hepatitis B	Afzal, Mohammad MD, Internal Medicine, LLC	HEPB02072301	Percy	Peters	2018/02/07	Female	Complete	2023/02/07 5:22 AM	2023/02/07 5:22 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC	CD02072301	Edmond	Erickson	2021/02/18	Male	Complete	2023/02/07 3:06 AM	2023/02/07 3:06 AM

First Back 1 Next Last Maximum 5 entries per page

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

**CASE REPORT ENTRY USER SUMMARY**

LAST UPDATED DATE RANGE Start Date: 01/01/2023 End Date: 02/01/2023 Retrieve Data

SHOWING 2 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Hilton Hospital	TC 506449MRP	Josephine	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC	TC 506449MRP	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM

**Please Note:** The **Start Date** must be within the last six months from the current date.

The following error message displays when Users search for a Start Date that occurred more than six months ago: *Please select a Start Date that is within the last six months from today's date.*

To proceed, you must enter a **Start Date** that occurred within the last six months.

### CASE REPORT ENTRY USER SUMMARY

🕒 LAST UPDATED DATE RANGE
Start Date 
End Date 
Retrieve Data

• Please select a Start Date that is within the last six months from today's date.

- Click **Retrieve Data** to display the search results.
- To search for a specific case report, click **Apply Filter**.

### CASE REPORT ENTRY USER SUMMARY

🕒 LAST UPDATED DATE RANGE
Start Date 
End Date 
Retrieve Data

SHOWING 32 ITEMS
APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	TC506409MR NPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
<a href="#">Continue</a> <a href="#">Delete</a>	Acute Hepatitis A	Hepatitis A	DDE SMOKE TEST SIT NONCOVID	TC506405MR N	Oswald	Webb	1998/01/01	Male	In Progress	2023/01/27 7:44 AM	
<a href="#">Continue</a> <a href="#">Delete</a>	MDRO	Candida auris, colonization/screening	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	dafsf	sdfsfds	fdsfdsfd	2023/01/01	Male	In Progress	2023/01/27 7:43 AM	

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

### CASE REPORT ENTRY USER SUMMARY

🕒 LAST UPDATED DATE RANGE
Start Date 
End Date 
Retrieve Data

SHOWING 32 ITEMS
HIDE FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
	Enter Report Ty	Enter Disease/ Or	Enter Affiliation/ C	Enter Patie	Enter First Nam	Enter Last N	Enter Date C	All	Enter St	All	All
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
<a href="#">View</a> <a href="#">Copy</a>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	TC506409MR NPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
<a href="#">Continue</a> <a href="#">Delete</a>	Acute Hepatitis A	Hepatitis A	DDE SMOKE TEST SIT NONCOVID	TC506405MR N	Oswald	Webb	1998/01/01	Male	In Progress	2023/01/27 7:44 AM	

## Review Previously Submitted Case Reports

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

SHOWING 4 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<b>View</b> Copy	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:24 PM	2023/02/07 3:24 PM
<b>View</b> Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	TC 506419MRN	Sarah	Marshman	1979/01/31	Male	Complete	2023/02/07 5:23 AM	2023/02/07 5:23 AM
<b>View</b> Copy	Acute Hepatitis B	Hepatitis B	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	HEPB020723 01	Percy	Peters	2018/02/07	Female	Complete	2023/02/07 5:22 AM	2023/02/07 5:22 AM
<b>View</b> Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	CD02072301	Edmond	Erickson	2021/02/18	Male	Complete	2023/02/07 3:06 AM	2023/02/07 3:06 AM

First Back 1 Next Last Maximum 5 entries per page

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

**Case Report Details** Print Download OK

**Patient Information**

Disease/Organism: Hepatitis B      Date of Diagnosis: 2023/01/09

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

Patient ID (MRN): EB02151990      Affiliation/Organization: Hilton Hospital

Person Completing Form: Mr. Arthur Vandelay (arthur.vandelay@email.com)      Affiliation/Organization: Hilton Hospital

Attending Physician/Clinician: Dr. Frasier Crane (frasier.crane@email.com)      Affiliation/Organization: Hilton Hospital

First Name: Elaine      Middle Name: Marie      Last Name: Benes

Date of Birth: 1990/02/15

Patient Sex: Female      Ethnicity: Not Hispanic or Latino      Race: Other

Address 1:      Address 2:

## Copy Previously Submitted Case Reports

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

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

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CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE
Start Date 02/07/2023
End Date 02/07/2023
Retrieve Data

SHOWING 4 ITEMS
APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:24 PM	2023/02/07 3:24 PM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	TC 506419MRN	Sarah	Marshman	1979/01/31	Male	Complete	2023/02/07 5:23 AM	2023/02/07 5:23 AM
View Copy	Acute Hepatitis B	Hepatitis B	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	HEPB020723 01	Percy	Peters	2018/02/07	Female	Complete	2023/02/07 5:22 AM	2023/02/07 5:22 AM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	CD02072301	Edmond	Erickson	2021/02/18	Male	Complete	2023/02/07 3:06 AM	2023/02/07 3:06 AM

First Back 1 Next Last
Maximum 5 entries per page

**Please Note:** Clicking **Copy** will automatically navigate you to the **Patient Information** screen of the Acute Hepatitis B Case Report.

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

- *Disease/Organism*
- *Patient ID (MRN)*
- *Affiliation/Organization*
- *Prefix*
- *Suffix*
- *First Name*
- *Middle Name*
- *Last Name*
- *Date of Birth*
- *Patient Sex*

ACUTE HEPATITIS B CASE REPORT FORM

Section 1 of 8

Please complete the form below. All fields marked with an asterisk(\*) are required.

### PATIENT INFORMATION

<b>Patient Information</b>	<b>Disease/Organism*</b>	<b>Date of Diagnosis*</b>
Laboratory Information	Hepatitis B	01/09/2023 <input type="checkbox"/> Unknown
Applicable Symptoms	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*	
Exposure Information	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hospitalization, ICU & Death Information	<b>Patient ID (MRN)*</b>	<b>Affiliation/Organization*</b>
Vaccination History	1802151990	Hilton Hospital
Additional Comments	<b>Person Completing Form*</b>	<b>Affiliation/Organization*</b>
Review & Submit	Mr. Arthur Vandelay (arthur.vandelay@e... x v)	Hilton Hospital <input type="checkbox"/> If other, please specify: ?
	<b>Attending Physician/Clinician*</b>	<b>Affiliation/Organization*</b>
	Dr. Frasier Crane (frasier.crane@email.c... x v)	Hilton Hospital <input type="checkbox"/> If other, please specify: ?
	<b>Prefix</b>	
	Select...	
	<b>First Name*</b>	<b>Middle Name</b>
	Elaine	Marie
	<b>Suffix</b>	<b>Last Name*</b>
	Select...	Benes
	<b>Date of Birth*</b>	
	02/15/1990	
	<b>Patient Sex*</b>	<b>Ethnicity*</b>
	Female	Not Hispanic or Latino x v
		<b>Race*</b>
		Other x v
	<b>Address 1*</b>	<b>Address 2</b>
	123 Second Avenue	Apt. 2B
	<b>City*</b>	<b>State*</b>
	Lexington	KY x v
	<b>County*</b>	<b>Zip Code*</b>
	Fayette x v	40511- x v
	<b>Phone*</b>	<b>Email</b>
	(555) 222-2345	elaine@mailinator.com
	<b>Is the patient currently pregnant?*</b>	
	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
	<b>If yes, please enter the due date (EDC)*</b>	
	03/08/2023 <input type="checkbox"/> Unknown <input type="checkbox"/>	
	<b>Prior Hepatitis B Diagnosis*</b>	
	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
	<b>If yes, please enter the date of diagnosis*</b>	
	mm/dd/yyyy <input type="checkbox"/> Unknown <input checked="" type="checkbox"/>	

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

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

ACUTE HEPATITIS B CASE REPORT FORM

Section 1 of 8

Please complete the form below. All fields marked with an asterisk(\*) are required.

**PATIENT INFORMATION**

**Patient Information**

Laboratory Information

Applicable Symptoms

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism\*  
Hepatitis B

Date of Diagnosis\*  
01/09/2023

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

Yes No

Patient ID (MRN)\*  
EB02151990

Affiliation/Organization\*  
Hilton Hospital

Person Completing Form\*  
Mr. Arthur Vandelay (arthur.vandelay@e...)

Attending Physician/Clinician\*  
Dr. Frasier Crane (frasier.crane@email.c...)

Affiliation/Organization\*  
Hilton Hospital

Prefix  
Select...

First Name\*  
Elaine

Middle Name  
Marie

Last Name\*  
Benes

Suffix  
Select...

Date of Birth\*  
02/15/1990

Patient Sex\*  
Female

Ethnicity\*  
Not Hispanic or Latino

Race\*  
Other

Address 1\*  
123 Second Avenue

Address 2  
Apt. 2B

City\*  
Lexington

State\*  
KY

Zip Code\*  
40511-

County\*  
Fayette

Phone\*  
(555) 222-2345

Email  
elaine@mailinator.com

Is the patient currently pregnant?\*

Yes No Unknown

If yes, please enter the due date (EDC):\*  
03/08/2023

Prior Hepatitis B Diagnosis\*

Yes No Unknown

If yes, please enter the date of diagnosis\*  
mm/dd/yyyy

Save

Next

**Please Note:** The *Is the patient currently pregnant?* field is only enabled when the *Patient Sex* field is marked as **Female**.

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

If yes, please enter the due date (EDC):\*

☐ Unknown

Prior Hepatitis B Diagnosis\*

If yes, please enter the date of diagnosis

☐ Unknown

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

ACUTE HEPATITIS B CASE REPORT FORM

Section 2 of 8

Please provide laboratory information related to this case.

**LABORATORY INFORMATION**

Patient Information

**Laboratory Information**

Applicable Symptoms

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Does the patient have a lab test?\*

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 that test.

Hepatitis Marker\*

Hepatitis B virus core IgM Ab [Presence] in Body fluid

Results\*

Positive

If applicable, please enter the viral load:

Test Result Date\*

☐ Unknown

Specimen Collection Date\*

☐ Unknown

Laboratory Name:\*

Test Laboratory

+ Add Hepatitis Marker

ALT

+ Add ALT

AST

+ Add AST

Bilirubin

+ Add Bilirubin

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

**Please Note:** In the example edit above, the User changed the selection for the *Prior Hepatitis B Diagnosis* field from **Yes** to **No**.

If **No** or **Unknown** is selected for the *Prior Hepatitis B Diagnosis* field, the subsequent field is disabled: *If yes, please enter the date of diagnosis*.

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

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

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

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

**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.

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

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CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE

Start Date02/07/2023

End Date02/07/2023

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SHOWING 5 ITEMS

APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<div>View</div> <div>Copy</div>	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:56 PM	2023/02/07 3:56 PM
<div>View</div> <div>Copy</div>	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:24 PM	2023/02/07 3:24 PM
<div>View</div> <div>Copy</div>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	TC 506419MRN	Sarah	Marshman	1979/01/31	Male	Complete	2023/02/07 5:23 AM	2023/02/07 5:23 AM
<div>View</div> <div>Copy</div>	Acute Hepatitis B	Hepatitis B	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	HEPB02072301	Percy	Peters	2018/02/07	Female	Complete	2023/02/07 5:22 AM	2023/02/07 5:22 AM
<div>View</div> <div>Copy</div>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa	CD02072301	Edmond	Erickson	2021/02/18	Male	Complete	2023/02/07 3:06 AM	2023/02/07 3:06 AM

First

Back

1

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Maximum5entries per page

## Continue In-Progress Case Reports

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

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

SHOWING 6 ITEMS

APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<div>Continue</div> <div>Delete</div>	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	In Progress	2023/02/07 3:58 PM	
<div>View</div> <div>Copy</div>	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:56 PM	2023/02/07 3:56 PM
<div>View</div> <div>Copy</div>	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	Complete	2023/02/07 3:24 PM	2023/02/07 3:24 PM
<div>View</div> <div>Copy</div>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	TC 506419MRN	Sarah	Marshman	1979/01/31	Male	Complete	2023/02/07 5:23 AM	2023/02/07 5:23 AM
<div>View</div> <div>Copy</div>	Acute Hepatitis B	Hepatitis B	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	HEPB020723 01	Percy	Peters	2018/02/07	Female	Complete	2023/02/07 5:22 AM	2023/02/07 5:22 AM

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

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### ACUTE HEPATITIS B CASE REPORT FORM

Section 7 of 8

Please add any additional comments related to this case.

#### ADDITIONAL COMMENTS

Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Exposure Information	✓
Hospitalization, ICU & Death Information	✓
Vaccination History	✓
<b>Additional Comments</b>	
Review & Submit	🔒

Additional comments or notes, please specify:

Patient Notes

13/1000 Characters

Save Previous Next

## 18 Technical Support

### Toll-Free Telephone Support

For questions and assistance regarding the ePartnerViewer, please call 1 (800) 633-6283.

### Email Support

To submit questions or request support regarding the ePartnerViewer, please email [KHIESupport@ky.gov](mailto:KHIESupport@ky.gov).

**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.

