

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Case Reports: Acute Hepatitis C

User Guide

February 2023

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Document Control Information

Document Information

Document Name	Direct Data Entry for Case Reports: Acute Hepatitis C User Guide
Project Name	KHIE
Client	Kentucky Cabinet for Health and Family Services
Document Author	Deloitte Consulting
Document Version	1.0
Document Status	Finalized Draft
Date Released	02/20/2023

Document Edit History

Version	Date	Additions/Modifications	Prepared/Revised by
0.1	02/13/2023	Initial Draft	Deloitte Consulting
0.2	02/20/2023	Revised Draft – Includes recent changes related to KHIE CR-108 deployment	Deloitte Consulting
0.3	02/23/2023	KHIE Review	KHIE
1.0	02/23/2023	Finalized Draft per KHIE Review	Deloitte Consulting
1.1	05/19/2023	Added language to cover ‘needle stick injuries’	KHIE Charlese Blair
	07/29/2024	Updated KHIE Phone Number	Charlese Blair KHIE

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1 Introduction

Overview

This training manual covers KHIE's Direct Data Entry for Acute Hepatitis C 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 Kentucky Department for Public Health (KDPH). All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

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

Supported Web Browsers

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

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

Please Note: The ePartnerViewer does 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:

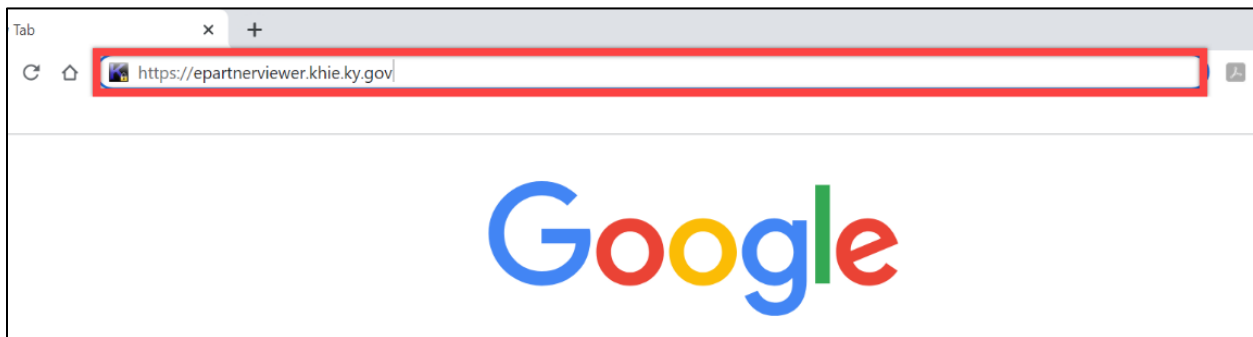
1. Users must be part of an organization with a signed Participation Agreement with KHIE.
2. Users are required to have a Kentucky Online Gateway (KOG) account.
3. Users are required to complete Multi-Factor Authentication (MFA).

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 C Case Report in the ePartnerViewer. You must log into your Kentucky Online Gateway (KOG) account to access the ePartnerViewer.

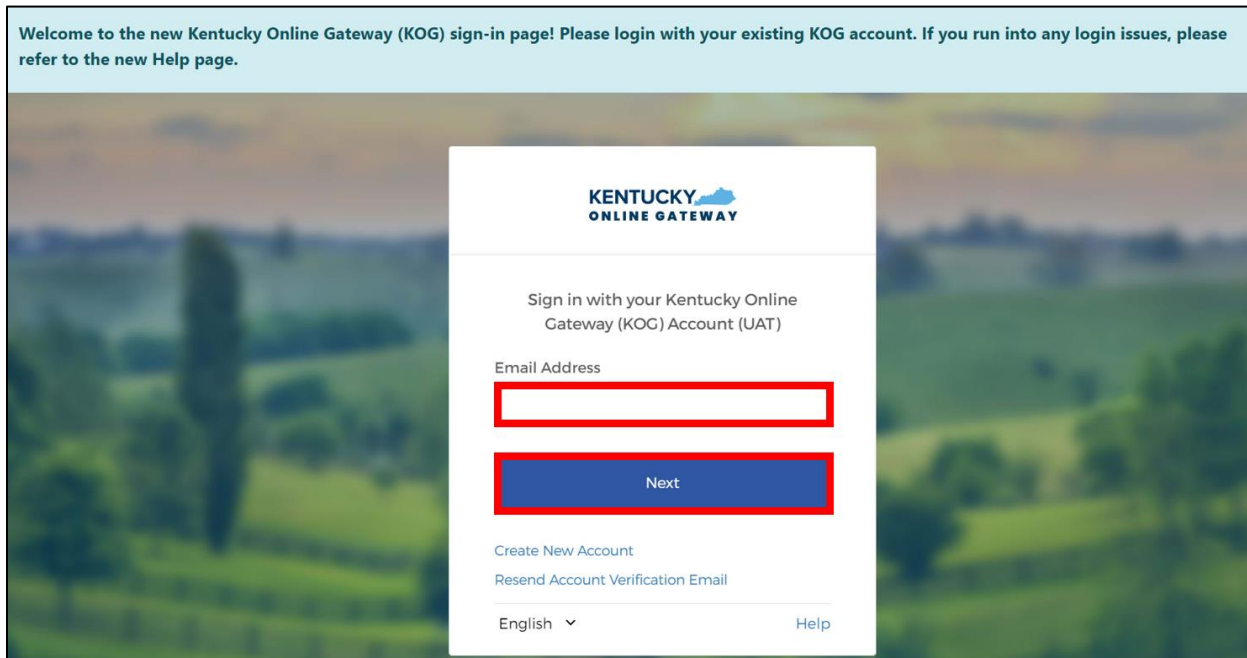
1. To navigate to the ePartnerViewer, enter the following **ePartnerViewer URL** in a supported browser window: <https://epartnerviewer.khie.ky.gov>



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.

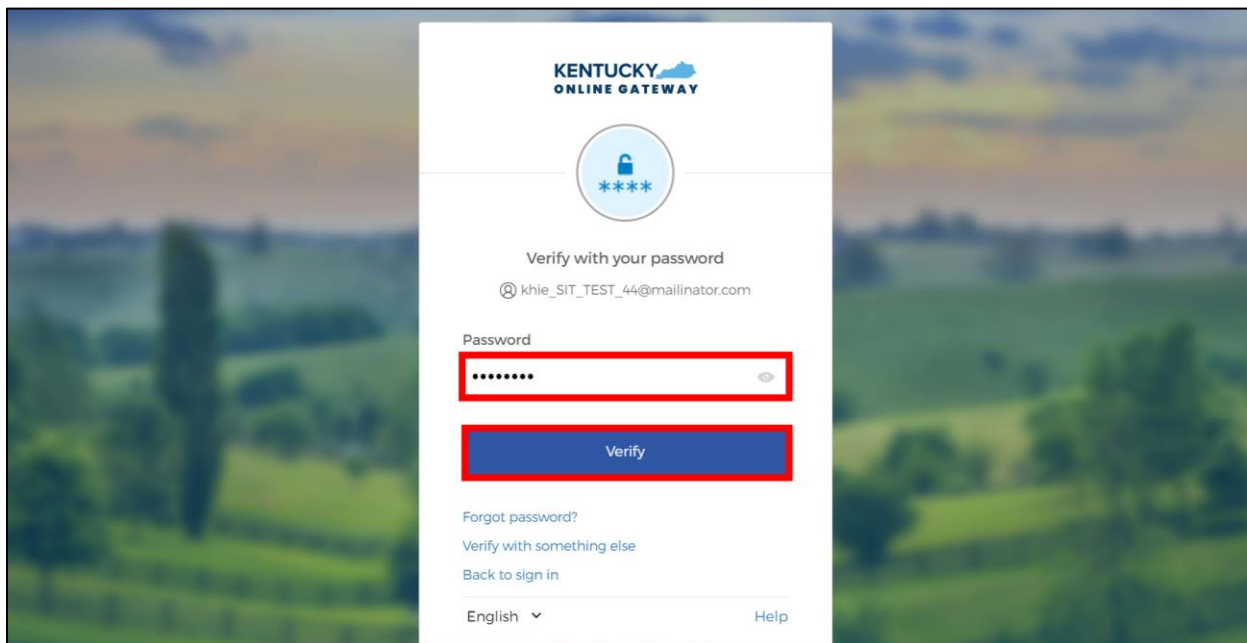
2. On the **KOG Login Page**, enter your **Email Address**. Click **Next**.

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.



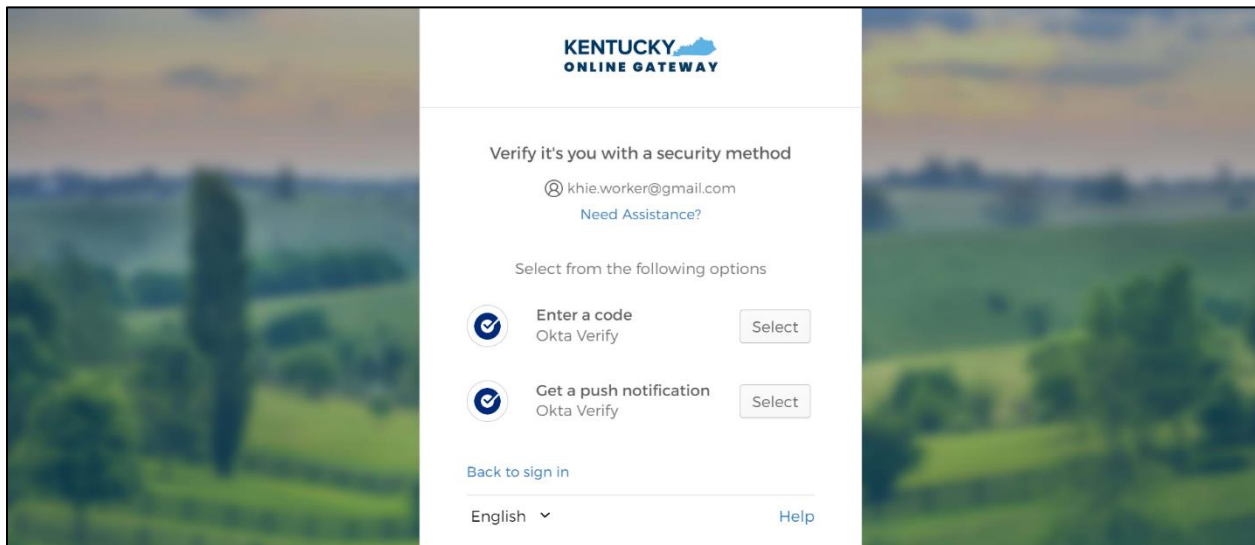
Please Note: You must enter the email address provided when creating your KOG account.

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



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:

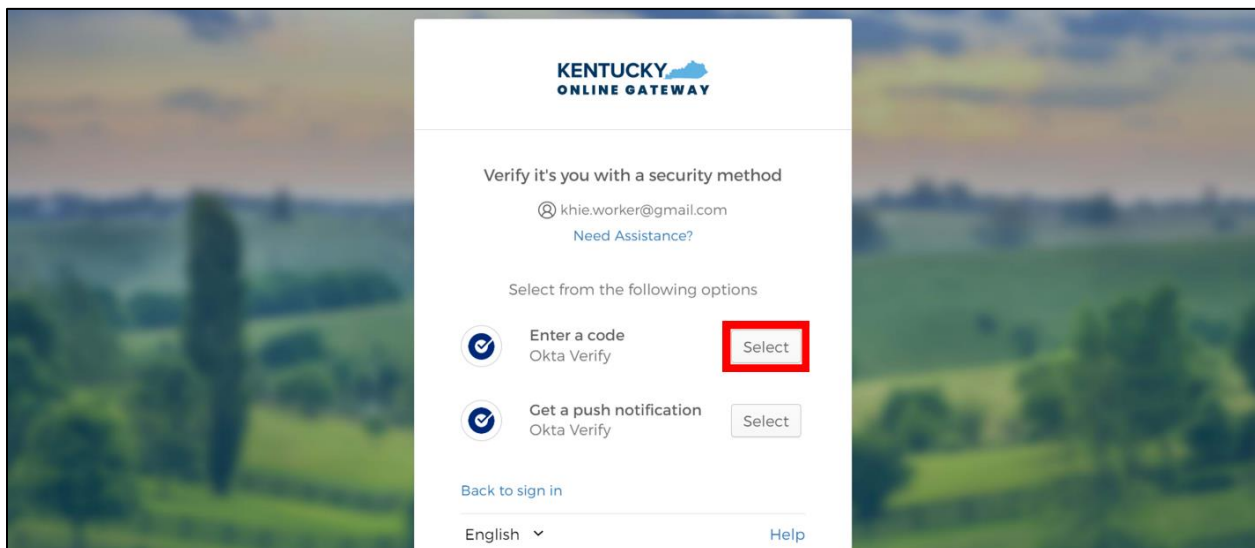
- Use a security code from the Okta Verify app.
- Use the push notification from the Okta Verify app.



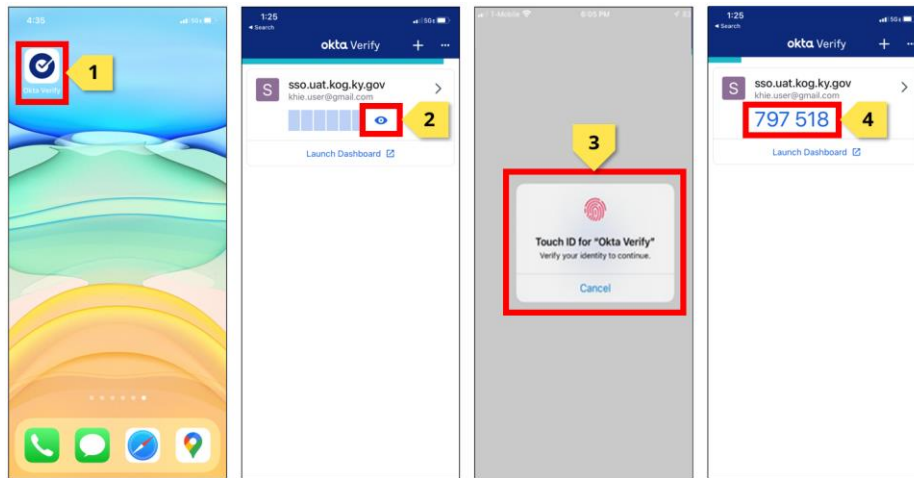
Security Code from Okta Verify App

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

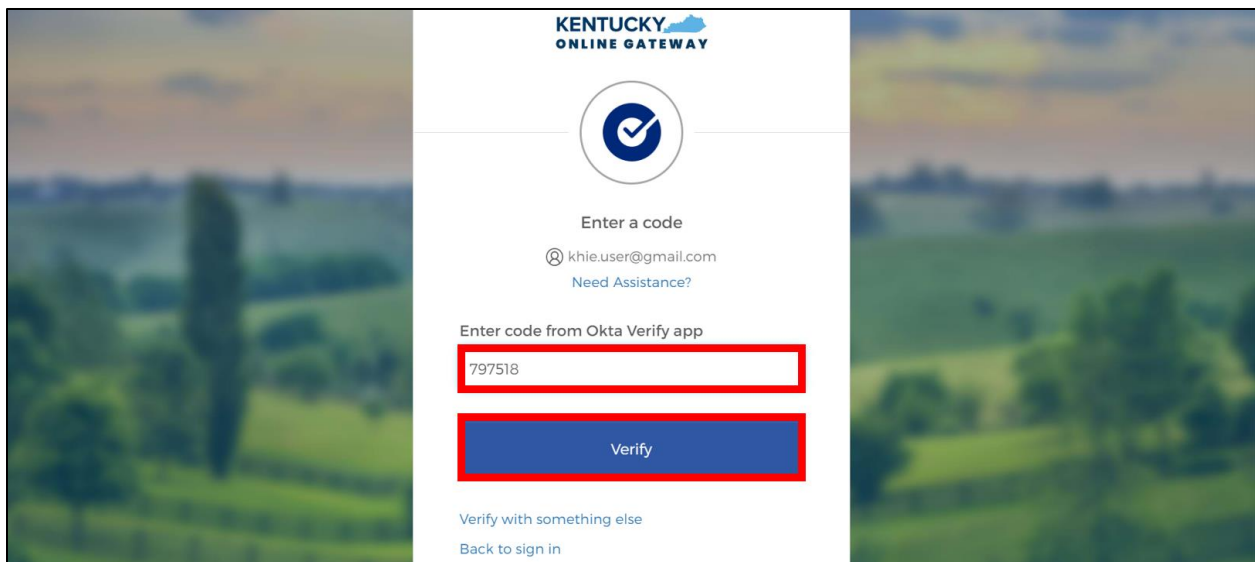
1. After logging into KOG, you are navigated to the **Verify it's you with a security method** screen. Click the **Select** button next to **Enter a code**.



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.

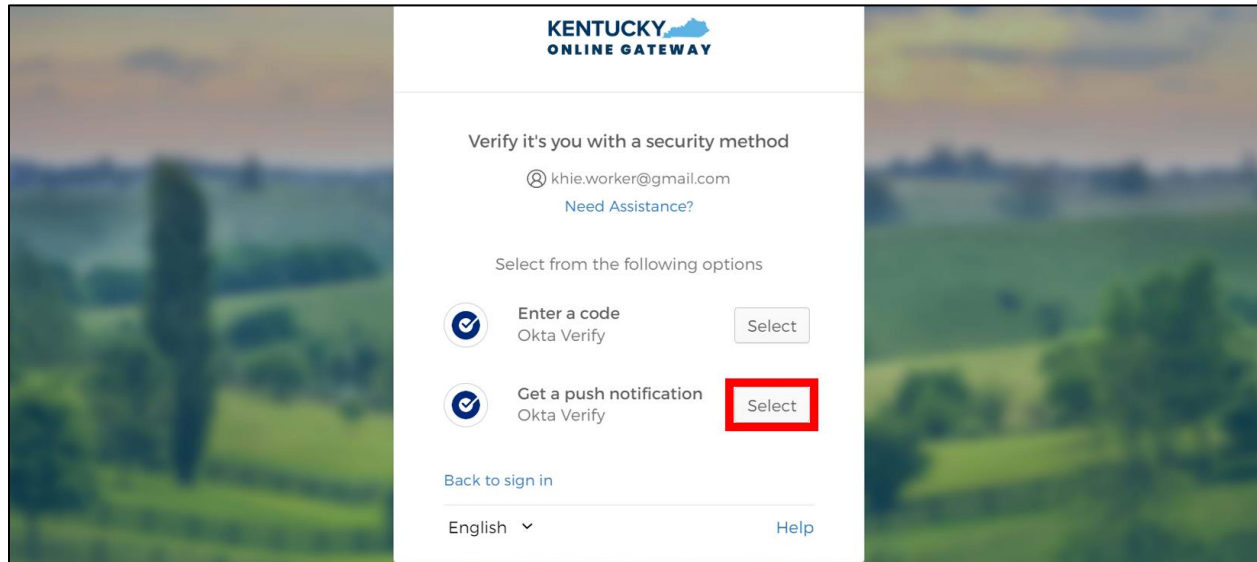


Please Note: Once you enter the code from the Okta Verify app, you are automatically navigated to the **Terms and Conditions of Use** screen. For more information, please review the *Terms and Conditions of Use and Logging In* sub-section of this chapter.

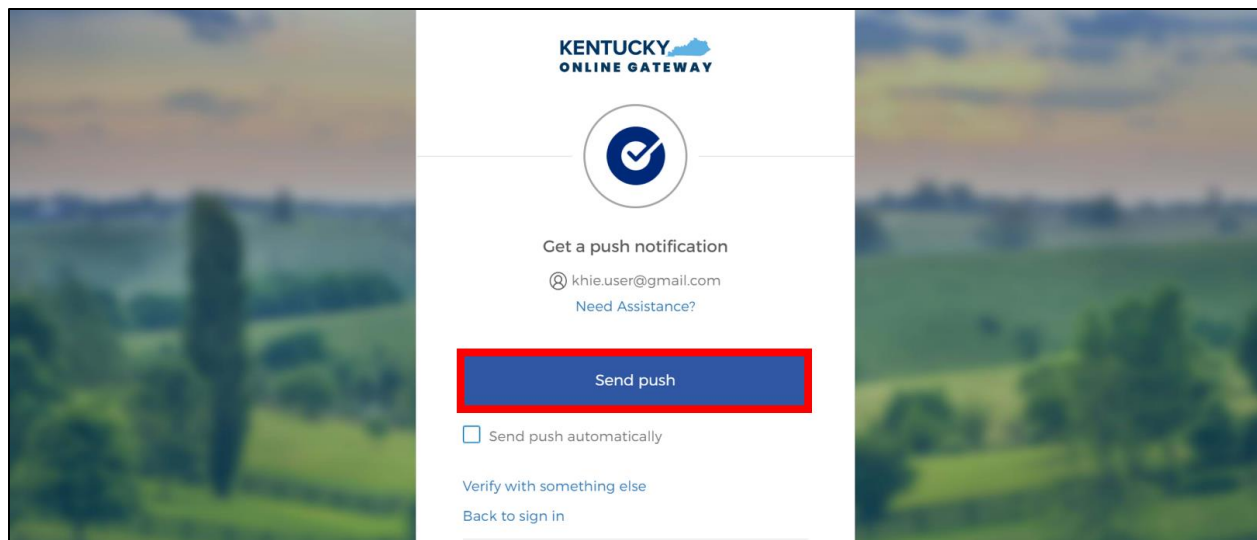
Push Notification from Okta Verify App

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

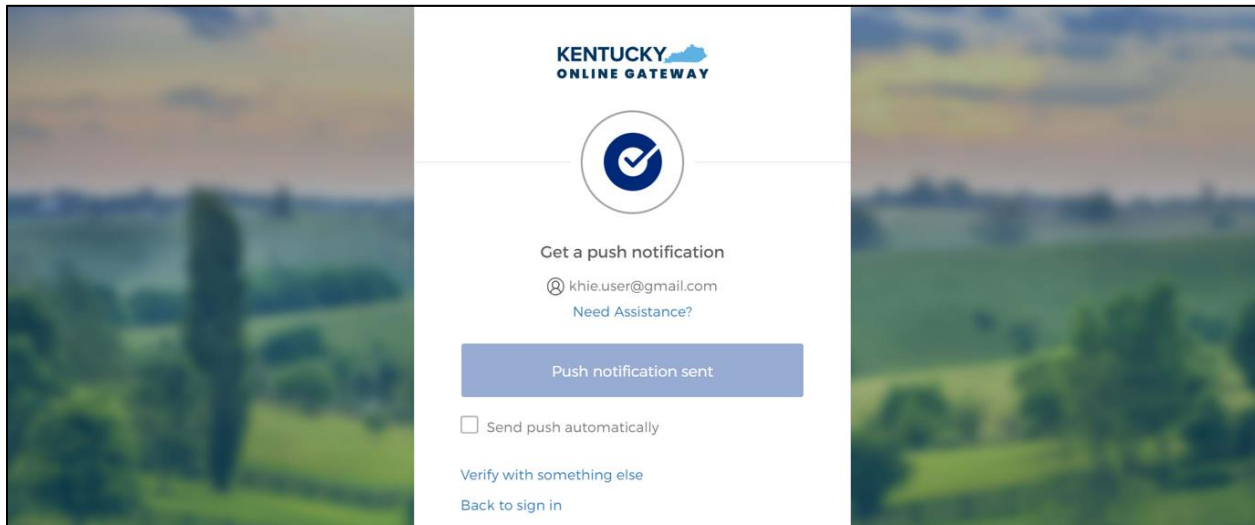
1. After logging into KOG, you are navigated to the **Verify it's you with a security method** screen. Click the **Select** button next to **Get a push notification**.



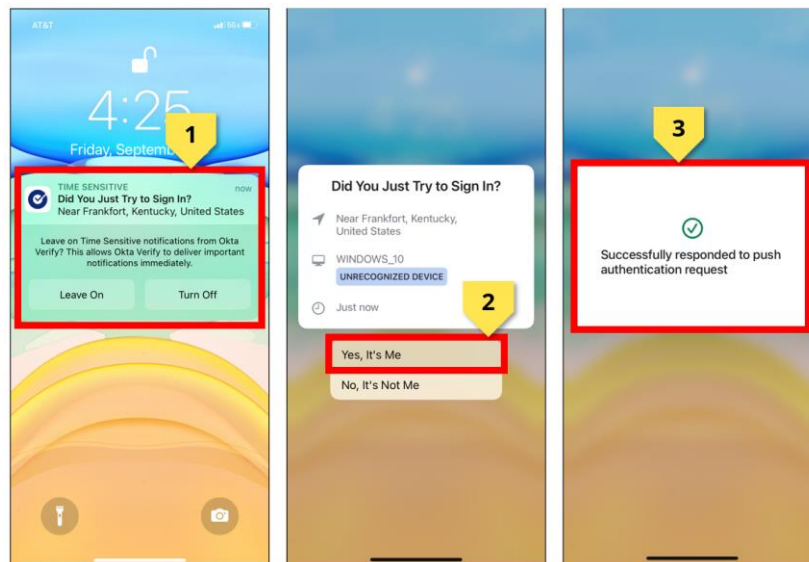
2. The **Get a push notification** screen displays. Click **Send Push**.



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.

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.

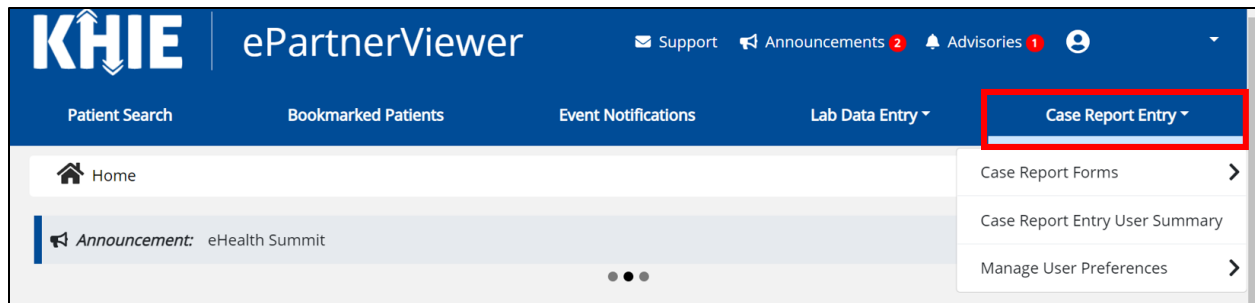
2. Once you click **I Accept**, the grayed-out section becomes visible. A message appears that indicates you are associated with an Organization. (This is the name of your organization.)
3. Click **Proceed to Portal** to continue to the ePartnerViewer application.

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*.

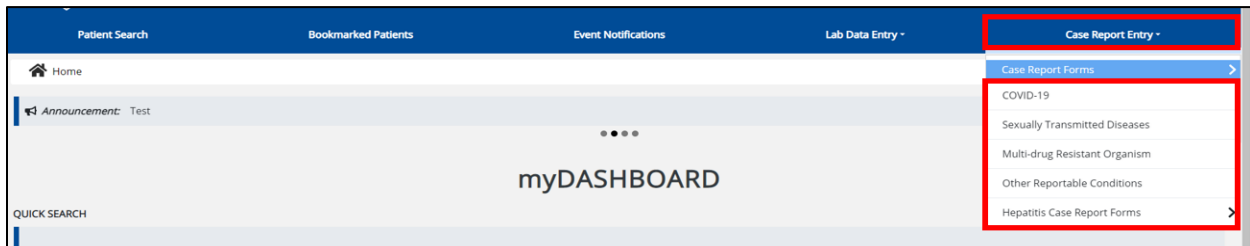
- **Multi-drug Resistant Organism (MDRO) Case Report:**
 - Designed for Users to enter MDRO case reports.

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*.

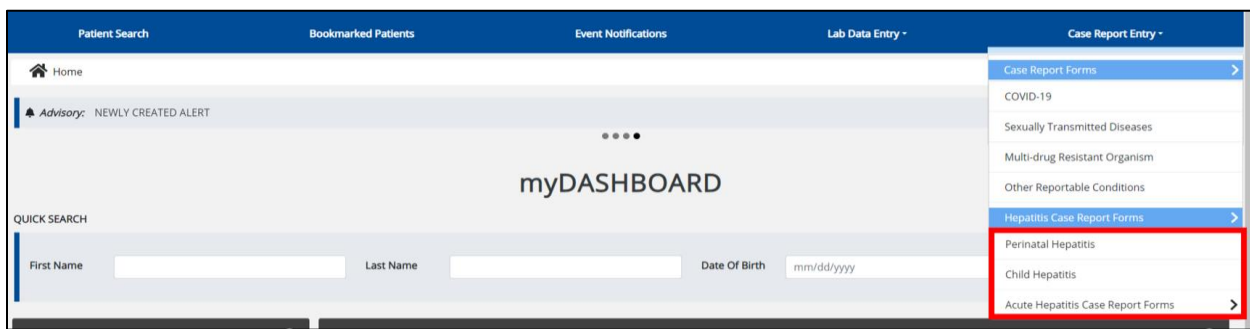
- **Child Hepatitis Case Report:**

- 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 two (2) 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 C Case Report:**

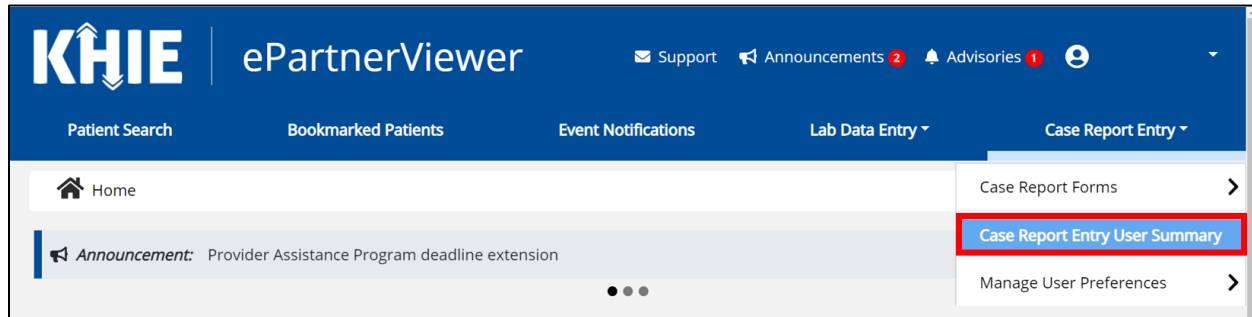
- Designed for Users to enter Acute Hepatitis C case reports.

The screenshot displays the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The Case Report Entry dropdown menu is open, showing a list of report types: COVID-19, Sexually Transmitted Diseases, Multi-drug Resistant Organism, Other Reportable Conditions, Hepatitis Case Report Forms, Perinatal Hepatitis, Child Hepatitis, and Acute Hepatitis Case Report Forms. The Acute Hepatitis Case Report Forms dropdown is further expanded, highlighting 'Hepatitis A' and 'Hepatitis C' with a red box. The main dashboard area shows a 'myDASHBOARD' header, a 'QUICK SEARCH' section with input fields for First Name, Last Name, and Date Of Birth, and two main sections: 'BOOKMARKED PATIENTS' (listing ARHJOHN, JIM; ABRAHAM, ALEXANDERS; CVVUVIXJDNDDL, QHONARTRFZCHQDQFHSO; TOWNSEND, ERIC; WAYNE, ROBERT) and 'EVENT NOTIFICATIONS (PAST 72 HOURS)' (showing 'There is no data to be displayed').

Please Note: The Acute Hepatitis B case report and the *Direct Data Entry for Case Reports: Acute Hepatitis B User Guide* will be available after 3/31/2023.

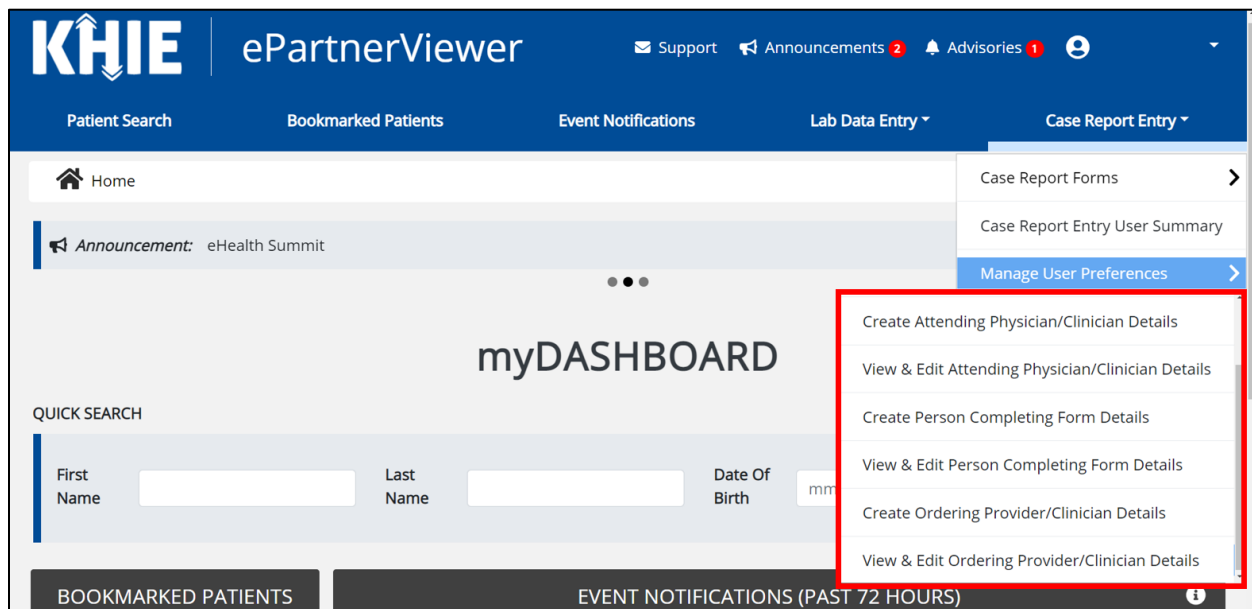
4. Case Report Entry User Summary:

- 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.

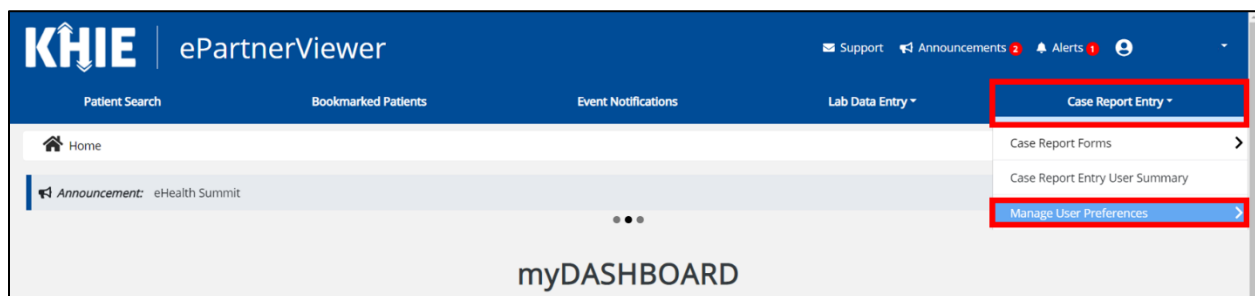


4 Manage User Preferences

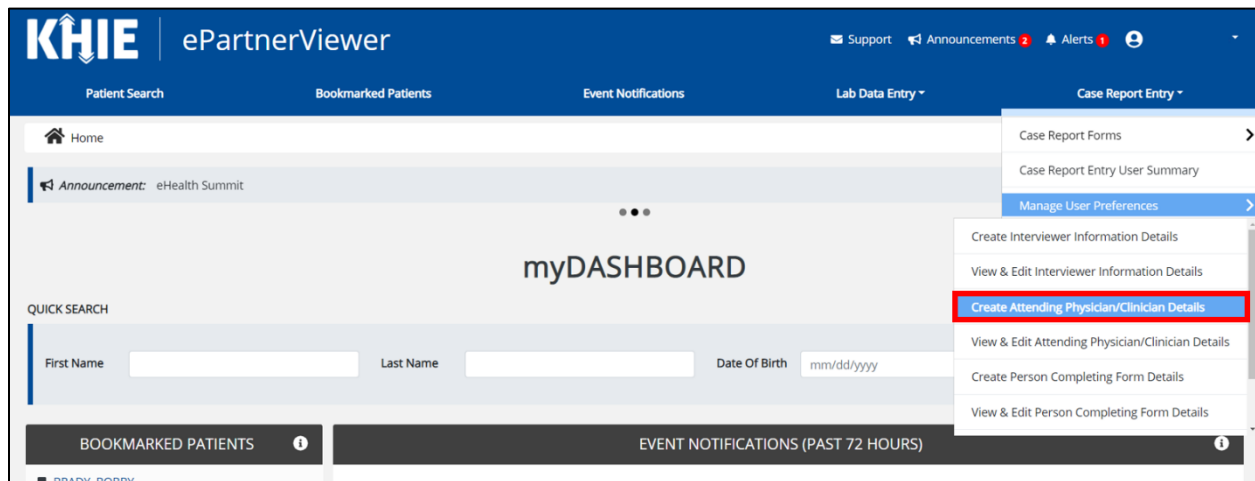
These are your User Preferences. Prior to entering your case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in your user preferences, you will be 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 C 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**.

Phone*	Email*
(xxx) xxx-xxxx	name@domain.com

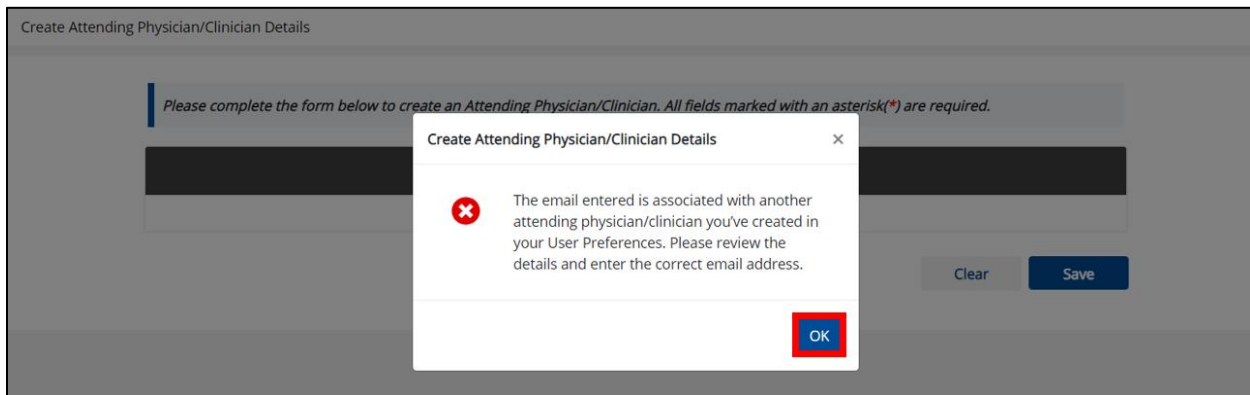
Please Note: If the information entered in the *Phone* and *Email* fields is not entered in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

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

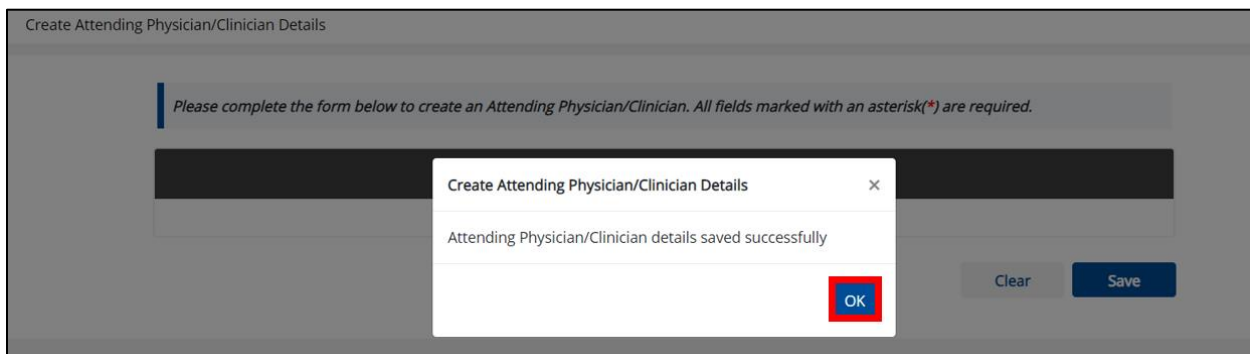
ATTENDING PHYSICIAN/CLINICIAN			
Prefix Dr. x v			
First Name* Frank		Last Name* Costanza	
Suffix Sr x v			
Address 1* 1 First Street		Address 2 1A	
City* Lexington		State* KY x v	Zip Code* 40123
Phone* (111) 111-1111		Email* frank@email.com	
			Clear Save

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.

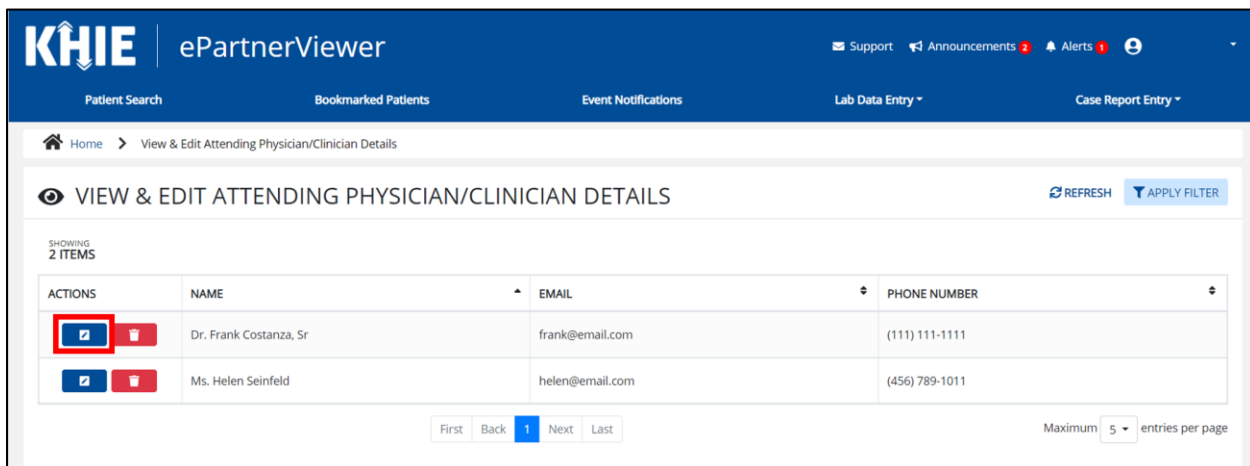


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.



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.

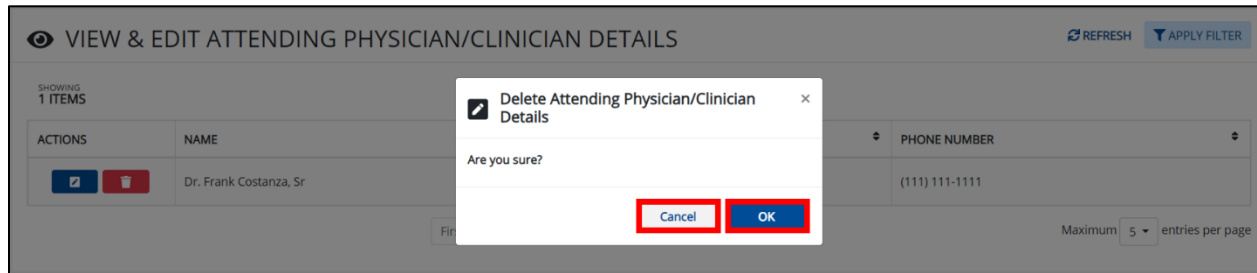
13. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.

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.



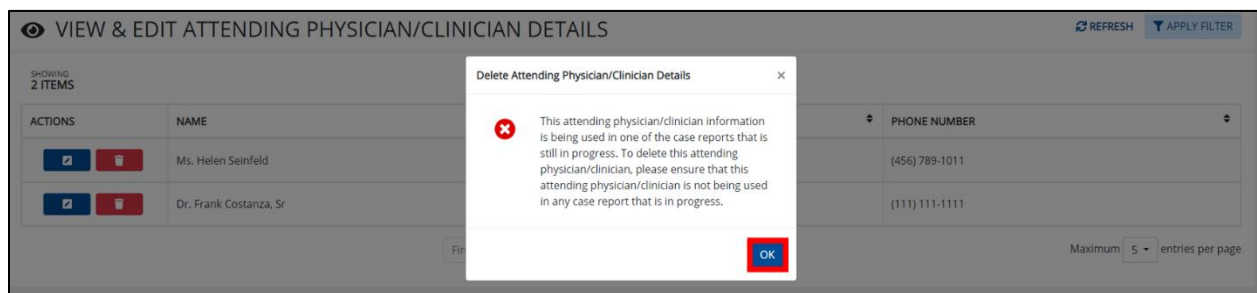
Please Note: You can delete an Attending Physician/Clinician on the **View & Edit Attending Physician/Clinician** screen as long as the Attending Physician/Clinician has not been selected for use in another case report that is still in-progress.

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.



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

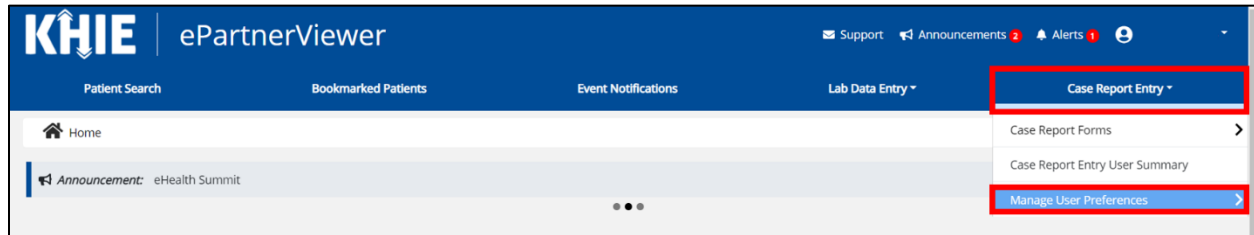
17. The Filter fields display. You can search by entering the **Attending Physician/Clinician's Name**, **Email Address**, and/or **Phone Number** in the corresponding Filter fields.

The screenshot shows the same 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' page, but with filter fields. The 'APPLY FILTER' button is now 'HIDE FILTER'. The filter fields are: NAME (Enter NAME...), EMAIL (Enter EMAIL...), and PHONE NUMBER (Enter PHONE NUMBER...). Each input field is highlighted with a red box. The table below the filter fields is the same as in the previous screenshot.

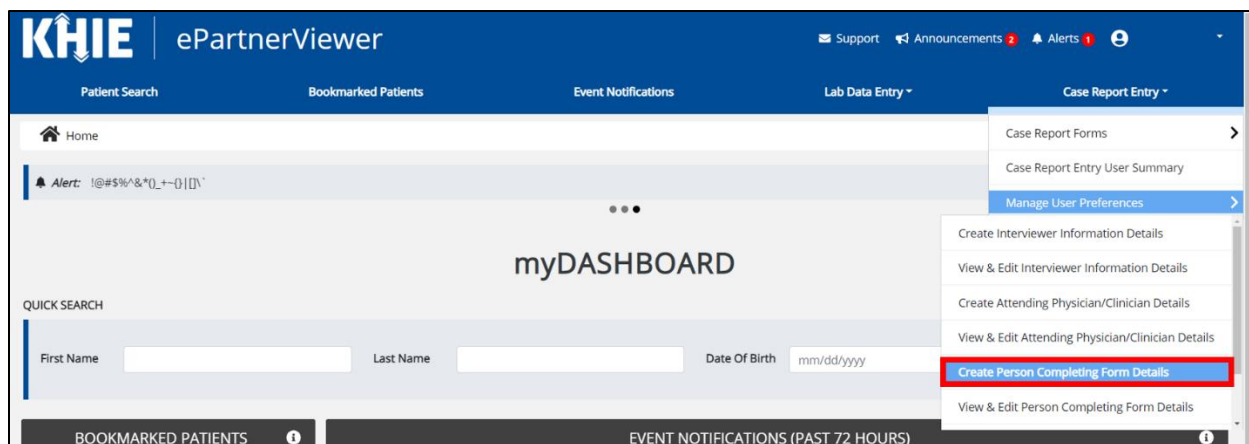
ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
 	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

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.

A screenshot of the 'PERSON COMPLETING FORM' screen. The form is titled 'PERSON COMPLETING FORM' and has a header that says 'Please complete the form below to create a Person Completing Form. All fields marked with an asterisk(*) are required.' The form contains several fields: Prefix (dropdown menu with 'Mr.' selected), First Name*, Last Name*, Suffix (dropdown menu with 'Select...' selected), Address 2 (text field), State* (dropdown menu), Zip Code* (text field), Email* (text field), and a placeholder for a phone number (xxx) xxx-xxxx. The Prefix and Suffix dropdown menus are highlighted with red boxes.

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"/>

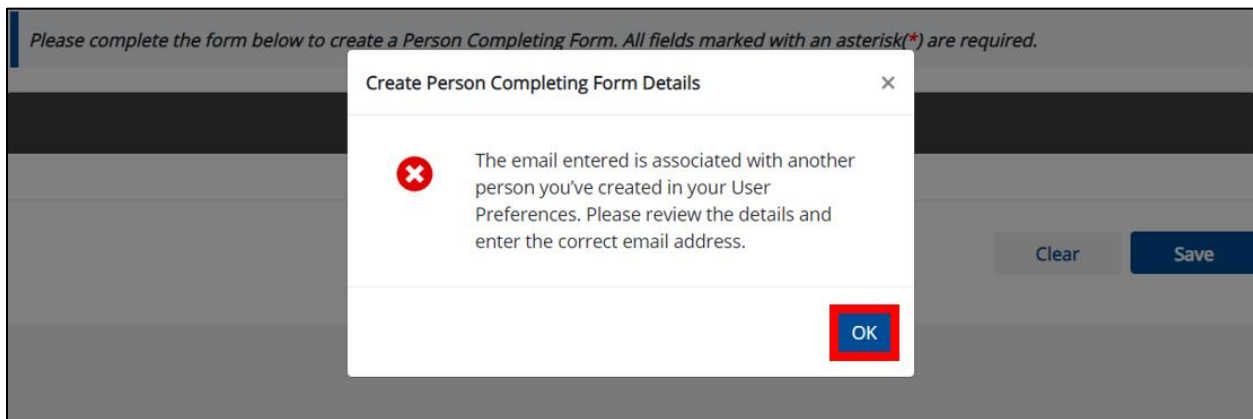
Please Note: If the information entered in the *Phone* and *Email* fields is not entered in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

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

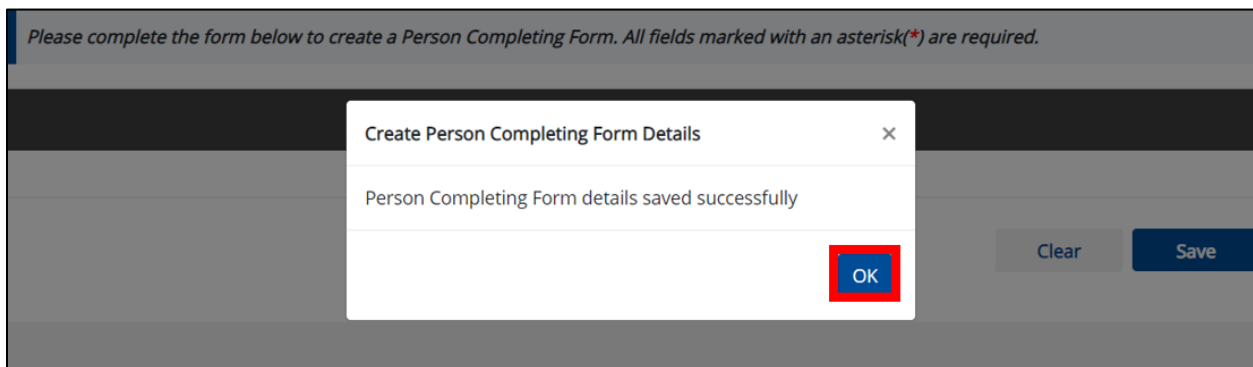
PERSON COMPLETING FORM		
Prefix <input type="text" value="Mr."/> x v		
First Name*	Last Name*	
<input type="text" value="Arthur"/>	<input type="text" value="Vandelay"/>	
Suffix <input type="text" value="II"/> x v		
Address 1*	Address 2 Unit, Suite, Building, etc.	
<input type="text" value="22 Second 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.

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**.

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

ACTIONS	NAME	PHONE NUMBER
 	Mr. Arthur Vandelay, II	(222) 222-2222
 	Dr. Estelle Costanza	(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**.

KHIE | ePartnerViewer

Support | Announcements 2 | Alerts 1

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS REFRESH **APPLY FILTER**

SHOWING 2 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
<input checked="" type="checkbox"/> <input type="checkbox"/>	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
<input checked="" type="checkbox"/> <input type="checkbox"/>	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222

First Back 1 Next Last

Maximum 5 entries per page

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.

KHIE | ePartnerViewer

Support | Announcements 2 | Alerts 1

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS REFRESH **HIDE FILTER**

SHOWING 2 ITEMS

ACTIONS	NAME <input style="border: 2px solid red;" type="text" value="Enter Name..."/>	EMAIL <input style="border: 2px solid red;" type="text" value="Enter Email..."/>	PHONE NUMBER <input style="border: 2px solid red;" type="text" value="Enter Phone Number..."/>
<input checked="" type="checkbox"/> <input type="checkbox"/>	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
<input checked="" type="checkbox"/> <input type="checkbox"/>	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222

First Back 1 Next Last

Maximum 5 entries per page

5 Basic Features in the Case Report Entry Form

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

Side Navigation Bar & Pagination

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

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

The screenshot displays the KHIE ePartnerViewer interface for the 'ACUTE HEPATITIS C 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 shows 'Section 6 of 7' with a progress bar. A sidebar on the left lists navigation options: Patient Information, Laboratory Information, Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death Information, Additional Comments (highlighted with a red box), and Review & Submit. The main form area contains a text box for 'Additional comments or notes, please specify:' and a 'Patient Notes' section. At the bottom, there are 'Save', 'Previous', and 'Next' buttons, with 'Previous' and 'Next' highlighted with red boxes.

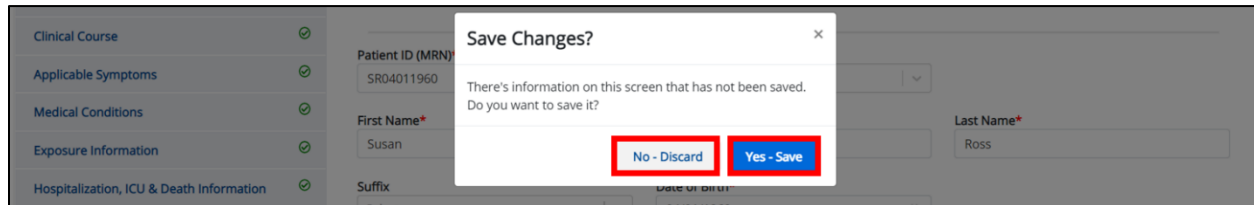
Save Feature

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

Conditional Questions

Conditional Questions are those questions that are asked based on your responses to the previous questions. The Acute Hepatitis C 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 C 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 (checked), Laboratory Information (active), Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death Information, 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 highlighted with a red box. Below the question, there is a text block: '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.' The subsequent fields (Hepatitis Marker, Results, viral load, Test Result Date, Specimen Collection Date, Laboratory Name, and Add buttons) are all grayed out and disabled.

- 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 highlighted by a red box. The subsequent fields (Hepatitis Marker, Results, viral load, Test Result Date, Specimen Collection Date, Laboratory Name, and Add buttons) are all enabled and active. A red rectangular box highlights the entire section of these fields.

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 C CASE REPORT FORM Section 3 of 7

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS

Patient Information ✓
Laboratory Information ✓
Applicable Symptoms
Exposure Information 🔒
Hospitalization, ICU & Death Information 🔒
Additional Comments 🔒
Review & Submit 🔒

Were symptoms present during the course of illness?*

Yes **No** Unknown

Onset Date ☐ Unknown

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

Fever

Yes **No** Unknown

If yes, please enter the highest temperature:

Diarrhea (>3 loose stools/24hr period)

Yes **No** Unknown

If yes, please enter # of days of diarrhea:

Abdominal pain

Yes **No** Unknown

Anorexia

Yes **No** Unknown

Clay Colored Stools

Yes **No** Unknown

Dark urine

Yes **No** Unknown

Elevated ALT > 200

Yes **No** Unknown

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

APPLICABLE SYMPTOMS

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

Were symptoms present during the course of illness?*

Yes No **Unknown**

Onset Date ☐ Unknown

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

Fever

Yes No **Unknown**

If yes, please enter the highest temperature:

Diarrhea (>3 loose stools/24hr period)

Yes No **Unknown**

If yes, please enter # of days of diarrhea:

Abdominal pain

Yes No **Unknown**

Anorexia

Yes No **Unknown**

Clay Colored Stools

Yes No **Unknown**

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

ACUTE HEPATITIS C CASE REPORT FORM

Section 3 of 7

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms

Exposure Information ☐

Hospitalization, ICU & Death Information ☐

Additional Comments ☐

Review & Submit ☐

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

Clay Colored Stools*

☐ 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 displays 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 input fields. The first row is for "Patient ID (MRN)" with a text input and an "Affiliation/Organization" dropdown. The second row is for "Person Completing Form" with a dropdown, an "Affiliation/Organization" dropdown, and a text input labeled "If other, please specify:". The third row is for "Attending Physician/Clinician" with a dropdown, an "Affiliation/Organization" dropdown, and a text input labeled "If other, please specify:". All dropdown menus show "Select..." as the current selection.

- 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*

Affiliation/Organization ? Test Medical Center x

If other, please specify: ?

Attending Physician/Clinician*

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*

Select... Select...

Person Completing Form* Affiliation/Organization*

Select... Select... If other, please specify:

Attending Physician/Clinician* Affiliation/Organization*

Select... Select... If other, please specify:

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

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:

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

Person Completing Form*

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

Attending Physician/Clinician*

Select...

Prefix

Select...

First Name*

Suffix

Affiliation/Organization*

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)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization*

If other, please specify:

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

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Disease/Organism* Chlamydia Date of Diagnosis* 07/23/2021

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*

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*

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...  

Attending Physician/Clinician*


Dr. Frank Costanza, Sr (frank@emai...  

Prefix


Select... 


First Name*

Suffix

Select... 

Patient Sex*

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: 

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: 

Last Name*

Race*

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

Person Completing Form*

Mr. Arthur Vandelay, II (arthur@em...  

Attending Physician/Clinician*

Dr. Frank Costanza, Sr (frank@emai...  

Affiliation/Organization* 

Other  

If other, please specify: 

Affiliation/Organization* 

Other  

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 an asterisk(*) are required.

PATIENT INFORMATION	
Patient Information Laboratory Information	Disease/Organism* Hepatitis C
Date of Diagnosis* mm/dd/yyyy	

- 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	
Patient Information SARS CoV-2 Testing Clinical Course Applicable Symptoms	Internist Dr. [Name] Patient ID (MRN)* Prefix 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		State	KY
Zip Code		County	Select...
Phone Number		Email Address	

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 x v
Zip Code	<input type="text"/>	County	Out Of System State x v

- 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.

Admission Date* <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown	Discharge Date* <input type="text" value="mm/dd/yyyy"/>
--	---

June 2021

June 2021

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.

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

8 Acute Hepatitis C Case Report Form

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

1. To enter Acute Hepatitis C 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 left side, there is a "QUICK SEARCH" section with input fields for First Name, Last Name, and Date Of Birth. Below this is a "BOOKMARKED PATIENTS" section with a list of patients: ARHJOHN, JIM; ABRAHAM, ALEXANDERS; CVVUVIXJNDTL, QHONARTFZCHQDQFH50; and TOWNSEND, ERIC. On the right side, the "Case Report Entry" dropdown menu is open, showing a list of options: Case Report Forms, COVID-19, Sexually Transmitted Diseases, Multi-drug Resistant Organism, Other Reportable Conditions, Hepatitis Case Report Forms, Perinatal Hepatitis, Child Hepatitis, and Acute Hepatitis Case Report Forms. The "Hepatitis Case Report Forms" option is highlighted with a red box.

3. Click **Acute Hepatitis Case Report Forms**. Select **Hepatitis C** from the sub-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 left side, there is a "QUICK SEARCH" section with input fields for First Name, Last Name, and Date Of Birth. Below this is a "BOOKMARKED PATIENTS" section with a list of patients: ARHJOHN, JIM; ABRAHAM, ALEXANDERS; CVVUVIXJNDTL, QHONARTFZCHQDQFH50; TOWNSEND, ERIC; and WAYNE, ROBERT. On the right side, the "Case Report Entry" dropdown menu is open, showing a list of options: Case Report Forms, COVID-19, Sexually Transmitted Diseases, Multi-drug Resistant Organism, Other Reportable Conditions, Hepatitis Case Report Forms, Perinatal Hepatitis, Child Hepatitis, and Acute Hepatitis Case Report Forms. The "Acute Hepatitis Case Report Forms" option is highlighted with a red box. Below this option, a sub-dropdown menu is open, showing a list of options: Hepatitis A and Hepatitis C. The "Hepatitis C" option is highlighted with a red box.

9 Patient Information

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

ACUTE HEPATITIS C CASE REPORT FORM

Section 1 of 7

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

Additional Comments

Review & Submit

Disease/Organism*
Hepatitis C

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: ?
Select...

Attending Physician/Clinician
Select...

Affiliation/Organization ?
Select...

If other, please specify: ?
Select...

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

PATIENT INFORMATION

Disease/Organism*
Hepatitis C

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: ?
Select...

Attending Physician/Clinician
Select...

Affiliation/Organization ?
Select...

If other, please specify: ?
Select...

Prefix
Select...

First Name*
Select...

Middle Name
Select...

Last Name*
Select...

Suffix
Select...

Date of Birth*
mm/dd/yyyy

Patient Sex*
Select...

Ethnicity*
Select...

Race*
Select...

Address 1* [Red Box]

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

City* [Red Box]

State* [Red Box]

Zip Code* [Red Box]

County* [Red Box]

Phone* [Red Box]

Email [name@domain.com]

Is the patient currently pregnant?

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

Prior Hepatitis C Diagnosis* [Red Box]

If yes, please enter the date of diagnosis:
 ☐ 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 C case report information. If you access the Acute Hepatitis C 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 C 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 [Selected]
 Laboratory Information [Locked]
 Appointment Scheduling [Locked]

Disease/Organism* [Select...]
 Date of Diagnosis* [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 C]

Date of Diagnosis* [Red Box]
 ☐ 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: ?

4. 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.

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

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

Patient ID (MRN)* ? <input type="text" value="CK08101955"/>	Affiliation/Organization* ? <input type="text" value="Select..."/>	If other, please specify: ? <input type="text"/>
Person Completing Form* <input type="text" value="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: ? <input type="text"/>
Attending Physician/Clinician* <input type="text" value="Select..."/>		
Prefix <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.

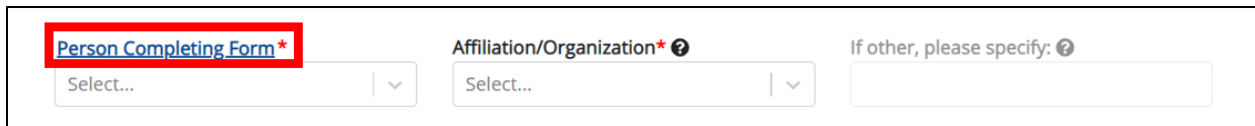
6. From the dropdown menu, select the name of the **Person Completing Form**.

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"/>		
Patient ID (MRN)* ? <input type="text" value="CK08101955"/>	Affiliation/Organization* ? <input type="text" value="Test Medical Center"/>	
Person Completing Form* <input type="text" value="Select..."/>	Affiliation/Organization ? <input type="text" value="Test Medical Center"/>	If other, please specify: ? <input type="text"/>
Dr. Estelle Costanza (estelle@email.com) Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization ? <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.

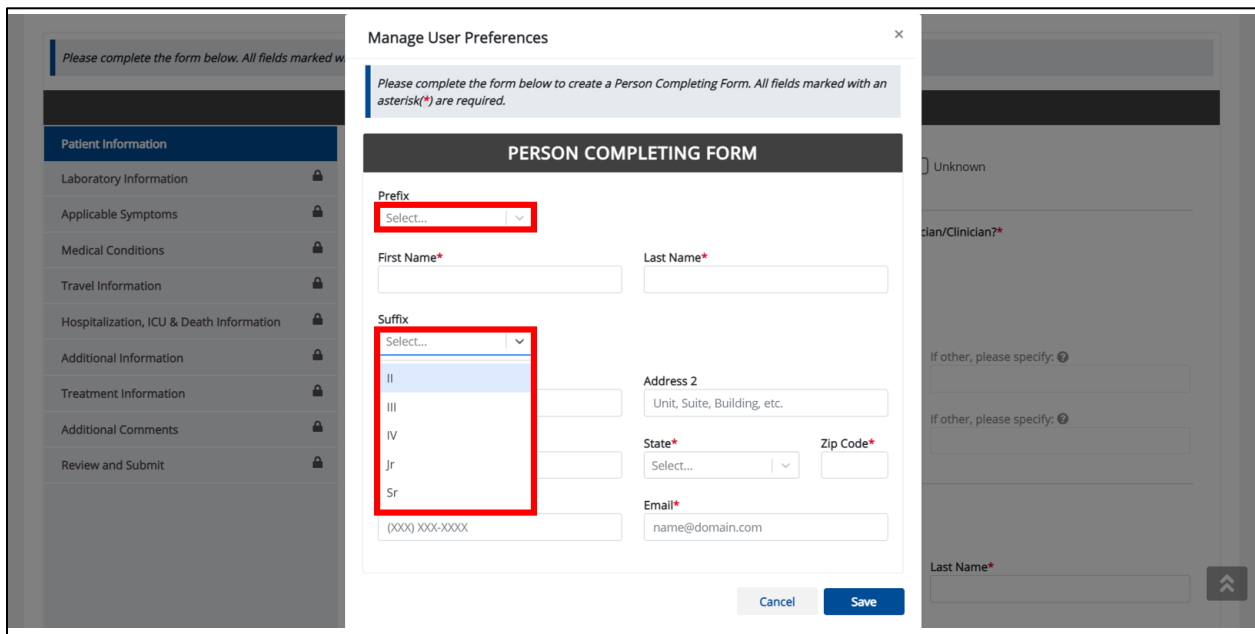
Person Completing Form Hyperlink

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



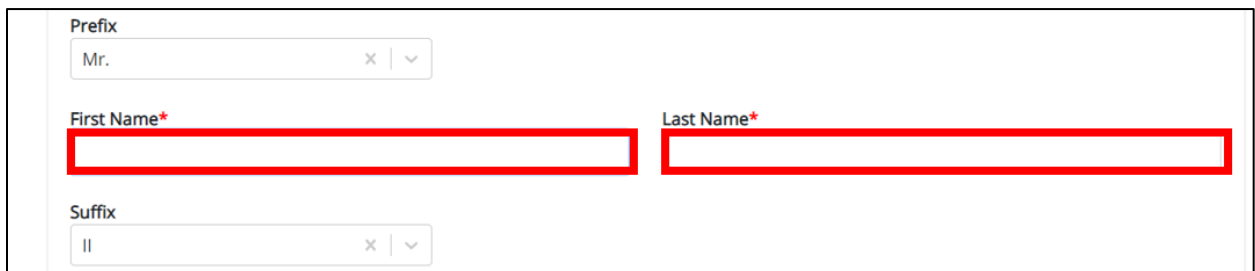
The screenshot shows the top navigation bar of the application. The 'Person Completing Form*' link is highlighted with a red rectangular box. To its right are two dropdown menus labeled 'Affiliation/Organization*' and 'If other, please specify:'. Both dropdowns have 'Select...' as the current selection.

- 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 'Manage User Preferences' pop-up window titled 'PERSON COMPLETING FORM'. The window contains several fields: 'Prefix' (dropdown, highlighted with a red box), 'First Name*' (text field), 'Last Name*' (text field), 'Suffix' (dropdown, highlighted with a red box), 'Address 2' (text field), 'State*' (dropdown), 'Zip Code*' (text field), and 'Email*' (text field). The 'Prefix' dropdown is currently set to 'Select...'. The 'Suffix' dropdown is currently set to 'II'. 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'. There are 'Cancel' and 'Save' buttons 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 'Prefix' dropdown is set to 'Mr.'. The 'First Name*' and 'Last Name*' text fields are highlighted with red rectangular boxes. 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*	Zip Code*	
	Select...		

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

Phone*	Email*
(XXX) XXX-XXXX	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.**

Person Completing Form* Select... Dr. Estelle Costanza (estelle@email.com) Mr. Arthur Vandelay, II (arthur@email.com) Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization* ? Select... Affiliation/Organization* ? Select...	If other, please specify: ? If other, please specify: ?
--	--	--




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


Date of Birth* 




Last Name* 




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).

If other, please specify:* 

Attending Physician/Clinician* 
 

Affiliation/Organization* 
 

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		
<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"/>	

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.

First Name*

Fraiser

Address 1*

123 Cheers Street

City*

Lexington

Phone*

(555) 555-4321

Last Name*

Crane

Address 2

Unit, Suite, Building, etc.

State*

KY

Zip Code*

40123-

Email*

fraisercrane@email.com

Suffix

Select...

Cancel

Save

Unknown

ian/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	<input type="text" value="Select..."/>		<input type="text" value="Select..."/>		<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>					

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 (fraisercra...)' 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 of which are highlighted with red boxes. The 'Prefix' dropdown is set to 'Select...' and the 'Suffix' dropdown is also set to 'Select...'. Below these, the 'First Name', 'Middle Name', and 'Last Name' fields are 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* **Ethnicity*** **Race***

Select... Select... Select...

Female
Male
Other
Unknown

Address 2
Unit, Suite, Building, etc.

State* **Zip Code***

Select... Select...

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

Patient Sex*	Ethnicity*	Race*
Female	Not Hispanic or Latino	Select...
Address 1*		Address 2
		Unit, Suite, Building, etc.
City*	State*	
	Select...	
County*	Phone*	
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"/>	
City*	State*	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
County*	Phone* ?	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

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

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

123 First Avenue

City* Lexington

State* KY

Zip Code* 40509-

County* Fayette

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 Unknown

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 C Diagnosis*.

Prior Hepatitis C Diagnosis*

If yes, please enter the date of diagnosis ?

☐ Unknown

- If **Yes** is selected for the *Prior Hepatitis C 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 C Diagnosis*

If yes, please enter the date of diagnosis ?

☐ Unknown

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

Prior Hepatitis B Diagnosis*

If yes, please enter the date of diagnosis ?

☐ 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.

County*

Phone* ?

Email

Is the patient currently pregnant?

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

☐ Unknown

Prior Hepatitis C Diagnosis*

If yes, please enter the date of diagnosis ?

☐ Unknown

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?*

ACUTE HEPATITIS C CASE REPORT FORM Section 2 of 7

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information
Laboratory Information **Selected**
Applicable Symptoms
Exposure Information
Hospitalization, ICU & Death Information
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
Select...

Results
Select...

If applicable, please enter the viral load:

Test Result Date
mm/dd/yyyy ☐ Unknown

Specimen Collection Date
mm/dd/yyyy ☐ Unknown

Laboratory Name:

Add Hepatitis Marker

ALT

Add ALT

AST

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

LABORATORY INFORMATION

Patient Information
Laboratory Information **Selected**
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*
Select...

Results*
Select...

If applicable, please enter the viral load:

Test Result Date*
mm/dd/yyyy ☐ Unknown

Specimen Collection Date*
mm/dd/yyyy ☐ Unknown

Laboratory Name*

Add Hepatitis Marker

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.

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.

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

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

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

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.

Test Result Date* 07/23/2021 <input type="checkbox"/> Unknown <small>Invalid Test Result Date</small>	Specimen Collection Date* 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:^{*}

Test Lab

Hepatitis Marker^{*}

Select...

Results^{*}

Select...

If applicable, please enter the viral load: ?

Test Result Date^{*}

mm/dd/yyyy

☐ Unknown

Specimen Collection Date^{*}

mm/dd/yyyy

☐ Unknown

Laboratory Name:^{*}

+ Add Hepatitis Marker

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:^{*}

Units/Liter

Reference:^{*}

Units/Liter

Test Result Date^{*}

mm/dd/yyyy

☐ Unknown

Specimen Collection Date^{*}

mm/dd/yyyy

☐ Unknown

Laboratory Name:^{*}

Adding AST

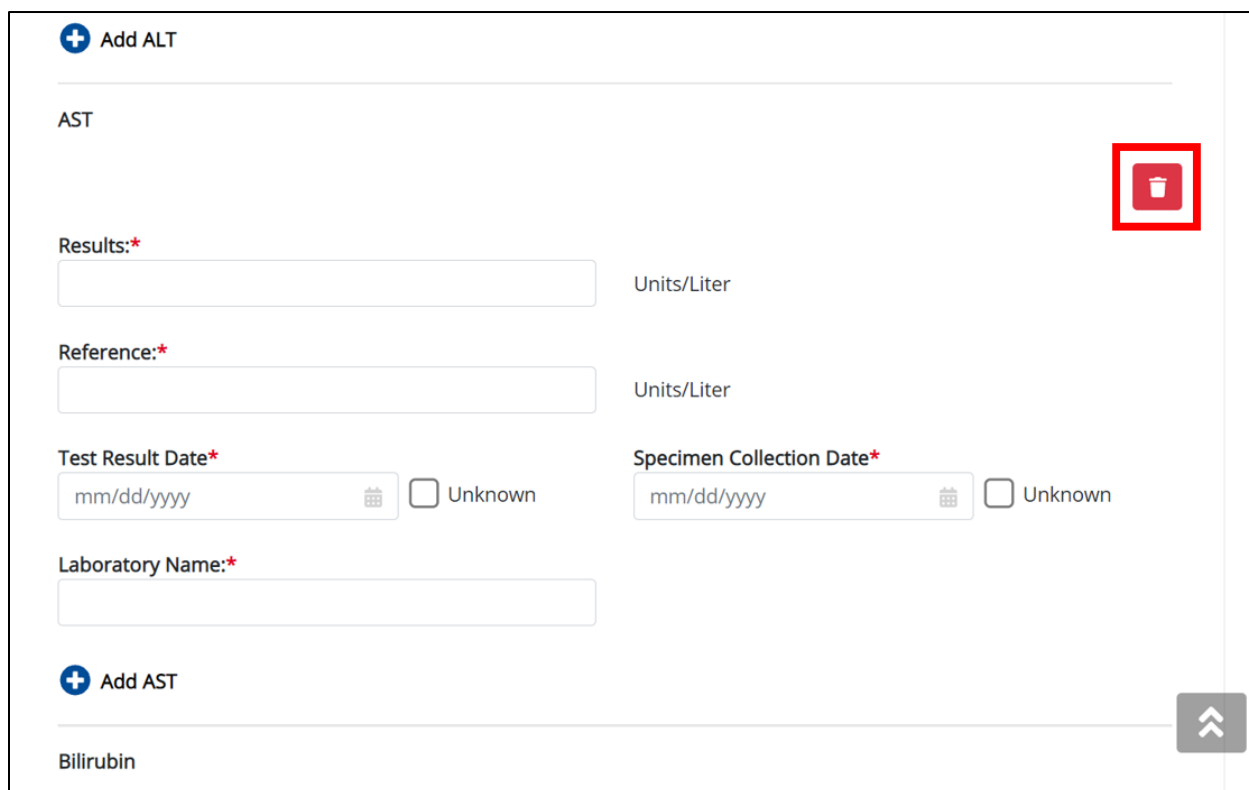
11. You can click **Add AST** to log the details for an AST.



AST

Bilirubin

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



AST

Results:*

Reference:*

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 C CASE REPORT FORM
Section 2 of 7

Please provide laboratory information related to this case.

Patient Information
Laboratory Information
Applicable Symptoms
Exposure Information
Hospitalization, ICU & Death Information
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 Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker*
Hepatitis C virus Ab [Units/volume] in Serum

Results*
Positive

If applicable, please enter the viral load:

Test Result Date*
01/20/2023
Unknown
Specimen Collection Date*
01/16/2023
Unknown

Laboratory Name*
Test Laboratory

Add Hepatitis Marker

ALT
Add ALT

AST
Add AST

Bilirubin
Add Bilirubin

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 C CASE REPORT FORM Section 3 of 7

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS

Patient Information

Laboratory Information

Applicable Symptoms

Exposure Information

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date ⓘ
mm/dd/yyyy ☐ Unknown

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

APPLICABLE SYMPTOMS

Patient Information

Laboratory Information

Applicable Symptoms

Exposure Information

Hospitalization, ICU & Death Information

Additional Comments

Review & Submit

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

Clay Colored Stools*

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: ⓘ

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 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 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 C**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

- Abdominal pain
- Anorexia
- Clay Colored Stools
- Dark Urine
- Elevated ALT > 200
- Elevated Bilirubin >3.0
- Fatigue
- Headache
- Jaundice
- Malaise
- Muscle aches (myalgia)
- Nausea
- Vomiting

Abdominal pain*

Headache*

Anorexia*

Jaundice*

Clay Colored Stools*

Malaise*

Dark urine*

Muscle aches (myalgia)*

Elevated ALT > 200*

Nausea*

Elevated Bilirubin > 3.0*

Vomiting*

Fatigue*

- 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: * ?

- 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

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 C CASE REPORT FORM Section 4 of 7

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

EXPOSURE INFORMATION	
Patient Information	Did the patient have any of the following exposures in the past 6 months?*
Laboratory Information	Yes No Unknown
Applicable Symptoms	
Exposure Information	Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)
Hospitalization, ICU & Death Information	Yes No Unknown
Additional Comments	If yes, please specify workplace setting: ?
Review & Submit	Adult congregate living facility (nursing, assisted living or long-term care facility)
	Yes No Unknown
	If yes, please specify the nursing, assisted living or long-term care facility: ?
	Correctional facility
	Yes No Unknown
	If yes, please specify the name of correctional facility: ?
	Known contact with same diagnosis or similar symptoms
	Yes No Unknown
	If yes, please specify the relationship: ?
	If yes, please enter the name and contact information: ?
	First Name, Last Name, Phone Number, Email Address, etc.
	Incarceration
	Yes No Unknown
	If yes, please specify: ?

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

EXPOSURE INFORMATION

Patient Information	Did the patient have any of the following exposures in the past 6 months?*
Laboratory Information	Yes No Unknown
Applicable Symptoms	
Exposure Information	Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)*
Hospitalization, ICU & Death Information	Yes No Unknown
Additional Comments	If yes, please specify workplace setting: ?
Review & Submit	Adult congregate living facility (nursing, assisted living or long-term care facility)*
	Yes No Unknown
	If yes, please specify the nursing, assisted living or long-term care facility: ?
	Correctional facility*
	Yes No Unknown
	If yes, please specify the name of correctional facility: ?
	Known contact with same diagnosis or similar symptoms*
	Yes No Unknown
	If yes, please specify the relationship: ?
	If yes, please enter the name and contact information: ?
	First Name, Last Name, Phone Number, Email Address, etc.

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?*

Sexually Transmitted Infections History

Is this part of an outbreak?*

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

3. 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: * ?

4. 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)*

Yes No Unknown

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

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

Correctional facility*

Yes No Unknown

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*

Yes No Unknown

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

If yes, please specify name of correctional facility: ?

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

Known contact with same diagnosis or similar symptoms*

Yes No Unknown

If yes, please specify the relationship: ?

If yes, please enter the name and contact information: ?

First Name, Last Name, Phone Number, Email Address, etc.

- 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.*

Known contact with same diagnosis or similar symptoms*

If yes, please specify the relationship:* ?

If yes, please enter the name and contact information:* ?

First Name, Last Name, Phone Number, Email Address, etc.

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

Incarceration*

If yes, please specify: ?

If yes, please provide the history of 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.*

Incarceration*

If yes, please specify:* ?

If yes, please provide the history of incarceration:* ?

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

IV Drug Use*

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*

If yes, please specify details:* ?

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

Other Illicit Drug use*

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:* ?

- Select the **appropriate answer** for the field: *Exposure to Hepatitis C virus.*

Exposure to Hepatitis C virus*

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

Tattoos*

If yes, please specify the setting: ?

- 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 **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: ?

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

Piercings*

If yes, please specify the setting: ?

Select...

If other, please specify: ?

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

Select...

If other, please specify: ?

- 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*

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*

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): ?

Select...

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*.

Piercings*

Yes No Unknown

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):*

Select...

Arm

Face

Feet

Hands

Leg

Penis

Rectum

Yes No Unknown

- 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*

Yes No Unknown

If yes, please specify the setting:*

Licensed parlor

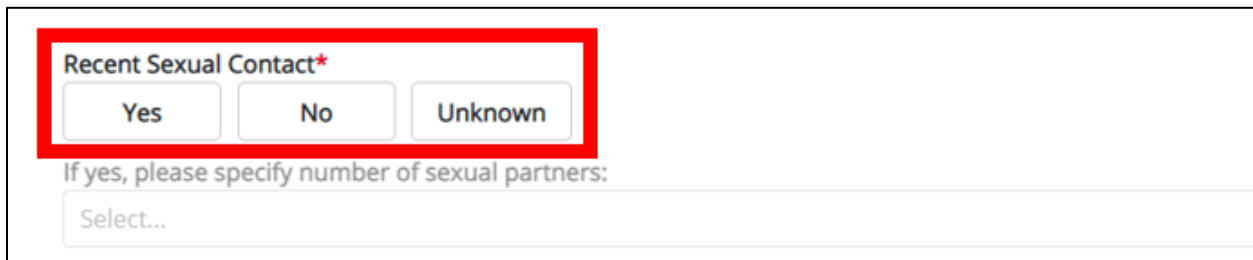
If other, please specify: ?

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:*

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



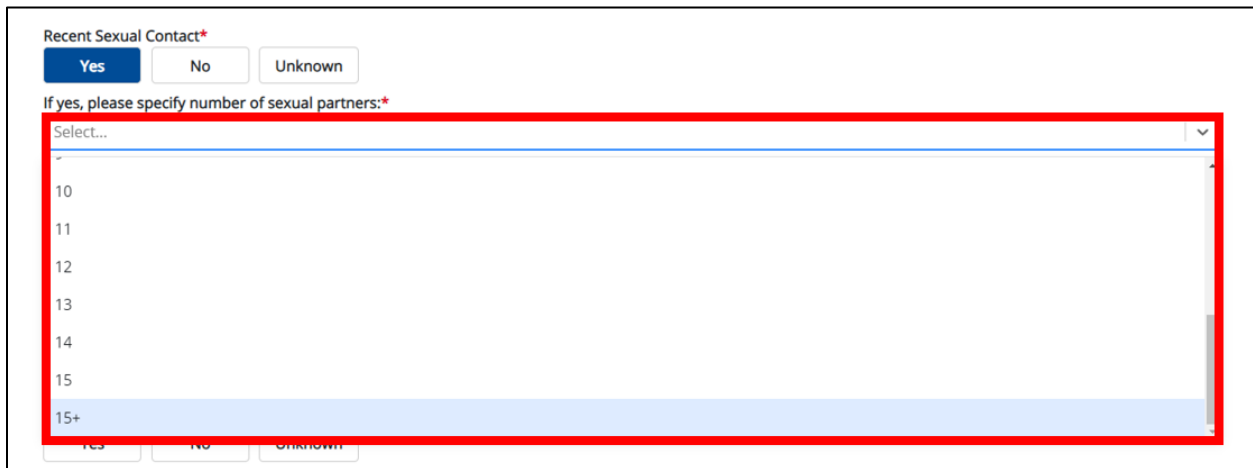
Recent Sexual Contact*

Yes No Unknown

If yes, please specify number of sexual partners:

Select...

- 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*

Yes No Unknown

If yes, please specify number of sexual partners:*

Select...

10

11

12

13

14

15

15+

14. Select the **appropriate answer** for the field: *Sexually Transmitted Infections History*.



Sexually Transmitted Infections History*

Yes No Unknown

Is this part of an outbreak?*

Yes No Unknown

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



Is this part of an outbreak?*

Yes No Unknown

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:*

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

Exposure to Hepatitis C virus*

Tattoos*

If yes, please specify the setting:*

If other, please specify: *

Piercings*

If yes, please specify the setting:*

If other, please specify: *

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

If other, please specify:*

Recent Sexual Contact*

If yes, please specify number of sexual partners:*

Sexually Transmitted Infections History*

Is this part of an outbreak?*

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

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

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name: ?

Admission Date mm/dd/yyyy [calendar icon] [Unknown] Discharge Date mm/dd/yyyy [calendar icon] [Unknown]

Still hospitalized

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

Yes No Unknown

Admission Date to ICU mm/dd/yyyy [calendar icon] [Unknown] Discharge Date from ICU mm/dd/yyyy [calendar icon] [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 mm/dd/yyyy [calendar icon] [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

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name: ?

Admission Date* mm/dd/yyyy [calendar icon] [Unknown] Discharge Date* mm/dd/yyyy [calendar icon] [Unknown]

Still hospitalized

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

Yes No Unknown

Admission Date to ICU mm/dd/yyyy [calendar icon] [Unknown] Discharge Date from ICU mm/dd/yyyy [calendar icon] [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 mm/dd/yyyy [calendar icon] [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?*

- 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:*

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

Admission Date*

☐ Unknown

Discharge Date*

☐ Unknown

☐ Still hospitalized

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

Admission Date*

☐ Unknown

Discharge Date*

☐ Unknown

☐ Still hospitalized

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

Admission Date*

☐ 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

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.

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

Hospitalization, ICU & Death Information

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

OK

Was the patient hospitalized? **Yes**

If yes, please specify the hospital name:

Admission Date* ☐ Unknown
Invalid Admission Date

Discharge Date* ☐ Unknown
☐ Still hospitalized
Invalid Discharge Date

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Was the patient hospitalized? **Yes**

If yes, please specify the hospital name:

Admission Date* ☐ Unknown
Invalid Admission Date

Discharge Date* ☐ Unknown
☐ Still hospitalized
Invalid Discharge Date

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

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

Admission Date to ICU ☐ Unknown

Discharge Date from ICU ☐ Unknown

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

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 **Additional Comments** 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 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.

Home > Acute Hepatitis C Case Report Form

ACUTE HEPATITIS C CASE REPORT FORM

Section 6 of 7

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Additional Comments ✓

Review & Submit

Additional comments or notes, please specify:

Patient Notes

13/1000 Characters

Save Previous **Next**

15 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 C CASE REPORT FORM

Section 7 of 7

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Additional Comments ✓

Review & Submit

[Patient Information](#)

Disease/Organism: Hepatitis C

Date of Diagnosis: Unknown

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

Patient ID (MRN): GC03281970

Affiliation/Organization: Hilton Hospital

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

Affiliation/Organization: Hilton Hospital

Print Download

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

The screenshot shows the 'Review & Submit' page. On the left is a sidebar with navigation links: Patient Information, Laboratory Information, Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death, Vaccination History, Additional Comments, and Review & Submit (highlighted). The main area displays patient information for a Hepatitis C case. Fields include: Disease/Organism (Hepatitis C), Date of Diagnosis (01/23/2023), Patient ID (MRN) (58231990), Affiliation/Organization (Hilton Hospital), Person Completing Form (Mr. Arthur Vandelay), and Attending Physician/Clinician (Dr. Frasier Crane). Patient details include First Name (George), Middle Name (None), Last Name (Barnes), Date of Birth (02/15/1990), Patient Sex (Female), Ethnicity (Not Hispanic or Latino), Race (Other), Address 1 (123 Second Avenue, Lexington, KY 40511), Address 2 (Apt. 2B), City (Lexington), State (KY), Zip Code (40511), County (Fayette), Phone (555-222-2345), Email (evaine@mailinator.com), and Is the patient currently pregnant? (Yes). A 'Print' button is highlighted with a red box at the bottom right.

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

This screenshot shows the 'REVIEW & SUBMIT' page with a checklist of sections: Patient Information, Laboratory Information, Applicable Symptoms, Exposure Information, Hospitalization, ICU & Death Information, and Additional Comments, all marked with green checkmarks. On the right, there are 'Print' and 'Download' buttons. The 'Download' button is highlighted with a red box. Below the checklist, the 'Patient Information' section is expanded, showing details like Disease/Organism (Hepatitis C), Date of Diagnosis (Unknown), and Affiliation/Organization (Hilton Hospital).

- 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.

This screenshot shows the 'REVIEW & SUBMIT' page with a 'Download PDF' pop-up dialog box in the center. The dialog box says 'Downloaded successfully' and has an 'OK' button highlighted with a red box. In the bottom left corner of the page, a PDF file icon labeled 'Acute Hepatitis C...pdf' is highlighted with a red box. The background shows the same patient information as the previous screenshots.

- 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.

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

3. Review the *Patient Information* section.

[Patient Information](#)

Disease/Organism Hepatitis C	Date of Diagnosis Unknown
--	-------------------------------------

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

Patient ID (MRN) GC03281970	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 George	Last Name Costanza
-----------------------------	------------------------------

Date of Birth
1970/03/28

Patient Sex Male	Ethnicity Not Hispanic or Latino	Race White
----------------------------	--	----------------------

Address 1
321 W Third Street

City Frankfort	State KY	Zip Code 40601-
County Franklin	Phone (555) 777-6543	Email george@mailinator.com

Prior Hepatitis C Diagnosis
Yes

If yes, please enter the date of diagnosis
2023/01/13

[Laboratory Information](#)

4. Review the *Laboratory Information* section.

[Patient Information](#)

[Laboratory Information](#)

Does the patient have a lab test?
Yes

Hepatitis Marker
Hepatitis C virus Ab [Units/volume] in Serum

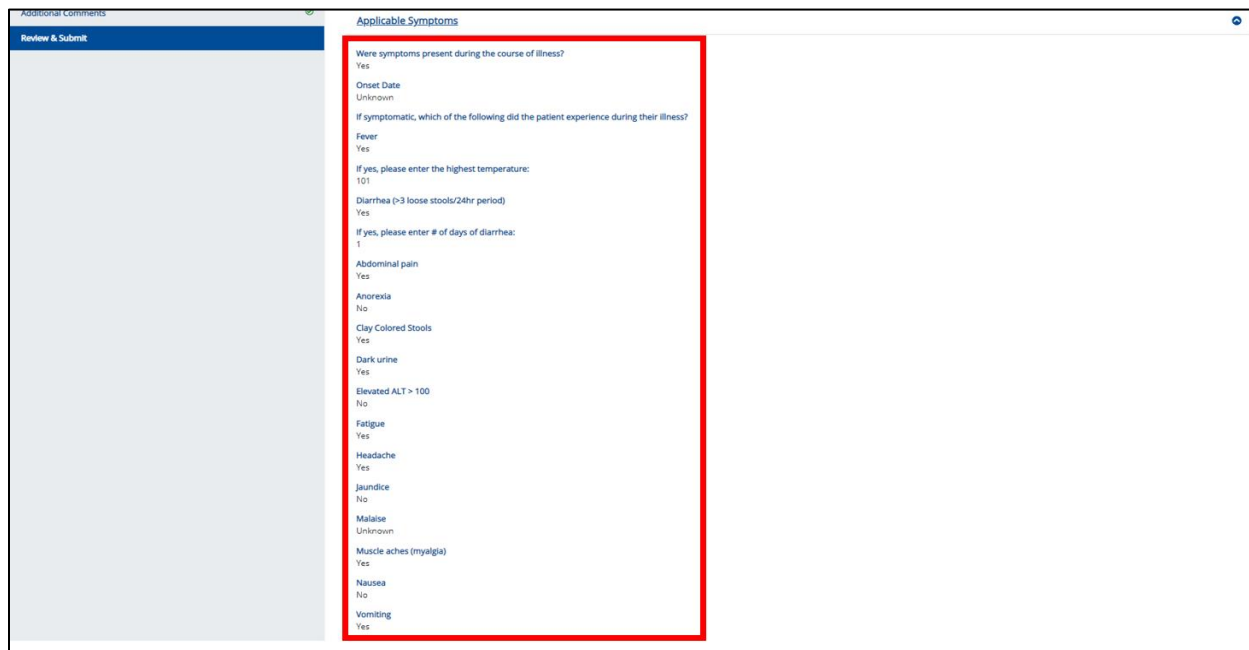
Results
Positive

Test Result Date 2023/01/20	Specimen Collection Date 2023/01/16
---------------------------------------	---

Laboratory Name:
Test Laboratory

[Applicable Symptoms](#)

5. Review the *Applicable Symptoms* section.



Applicable Symptoms

Were symptoms present during the course of illness?
Yes

Onset Date
Unknown

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

Fever
Yes

If yes, please enter the highest temperature:
101

Diarrhea (>3 loose stools/24hr period)
Yes

If yes, please enter # of days of diarrhea:
1

Abdominal pain
Yes

Anorexia
No

Clay Colored Stools
Yes

Dark urine
Yes

Elevated ALT > 100
No

Fatigue
Yes

Headache
Yes

Jaundice
No

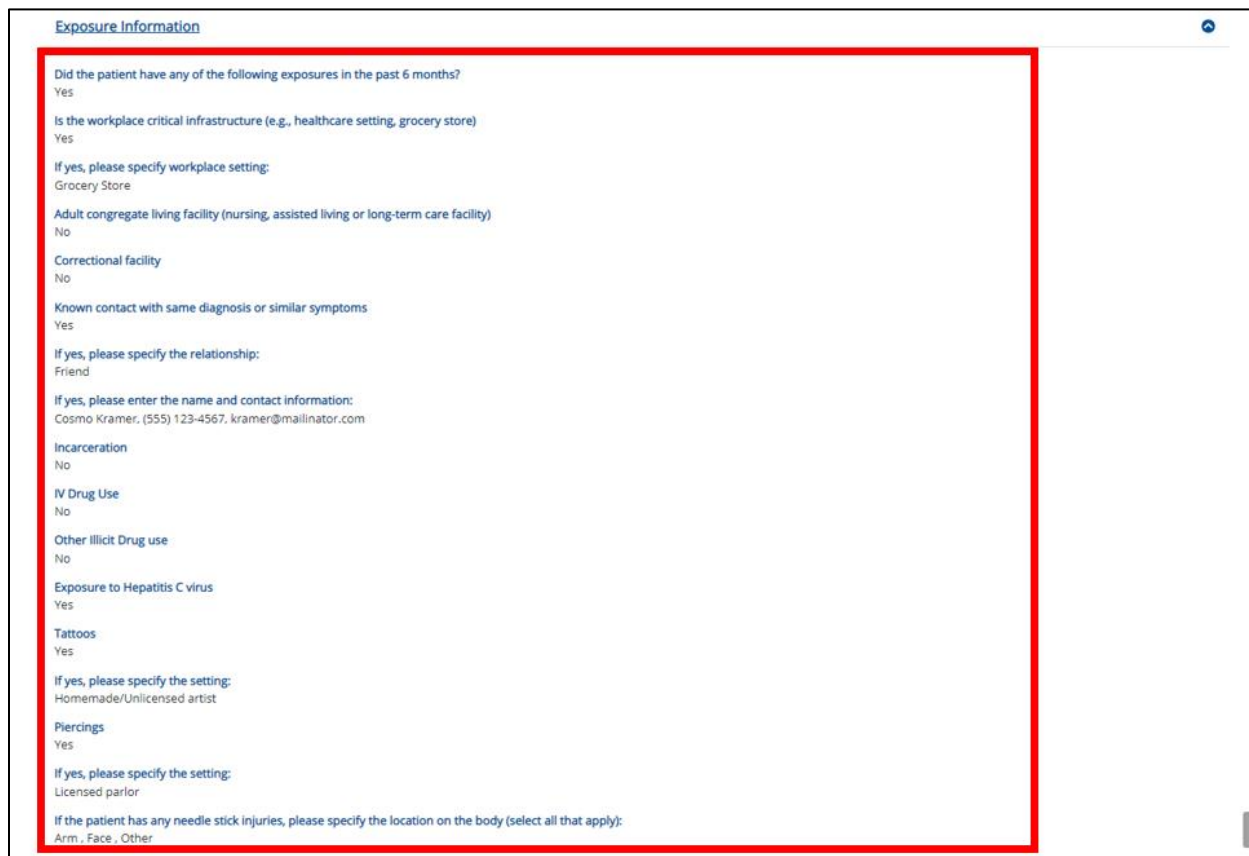
Malaise
Unknown

Muscle aches (myalgia)
Yes

Nausea
No

Vomiting
Yes

6. Review the *Exposure Information* section.



Exposure Information

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

Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)?
Yes

If yes, please specify workplace setting:
Grocery Store

Adult congregate living facility (nursing, assisted living or long-term care facility)
No

Correctional facility
No

Known contact with same diagnosis or similar symptoms
Yes

If yes, please specify the relationship:
Friend

If yes, please enter the name and contact information:
Cosmo Kramer, (555) 123-4567, kramer@mailinator.com

Incarceration
No

IV Drug Use
No

Other Illicit Drug use
No

Exposure to Hepatitis C virus
Yes

Tattoos
Yes

If yes, please specify the setting:
Homemade/Unlicensed artist

Piercings
Yes

If yes, please specify the setting:
Licensed parlor

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

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. Review the *Additional Comments* section.

[Additional Comments](#)

Additional comments or notes, please specify:
Patient Notes

Click Hyperlinks to Edit

9. 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.

ACUTE HEPATITIS C CASE REPORT FORM

Section 7 of 7

Please review your information before submitting.

REVIEW & SUBMIT

[Patient Information](#) ✓

[Laboratory Information](#) ✓

[Applicable Symptoms](#) ✓

[Exposure Information](#) ✓

[Hospitalization, ICU & Death Information](#) ✓

[Additional Comments](#) ✓

Review & Submit

[Print](#) [Download](#)

[Patient Information](#)

Disease/Organism: Hepatitis C Date of Diagnosis: Unknown

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

Patient ID (MRN): GC03281970 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: George Last Name: Costanza

Date of Birth: 1970/03/28

10. 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.

ACUTE HEPATITIS C CASE REPORT FORM

Section 1 of 7

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

PATIENT INFORMATION

Patient Information (selected)

Laboratory Information

Applicable Symptoms

Exposure Information

Hospitalization, ICU & Death Information

Additional Comments

Review & Submit (highlighted)

Disease/Organism*
Hepatitis C

Date of Diagnosis*
01/20/2023

Unknown

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

Yes No

Patient ID (MRN)*
GC03281970

Person Completing Form*
Mr. Arthur Vandelay (arthur.vande...)

Attending Physician/Clinician*
Hilton Hospital

Affiliation/Organization*
Hilton Hospital

If other, please specify:

11. 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**.

Save Changes?

There's information on this screen that has not been saved. Do you want to save it?

No - Discard Yes - Save

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

ACUTE HEPATITIS C CASE REPORT FORM

Section 7 of 7

Please review your information before submitting.

REVIEW & SUBMIT

Print Download

Patient Information

Disease/Organism
Hepatitis C

Date of Diagnosis
2023/01/20

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

Patient ID (MRN)
GC03281970

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
George

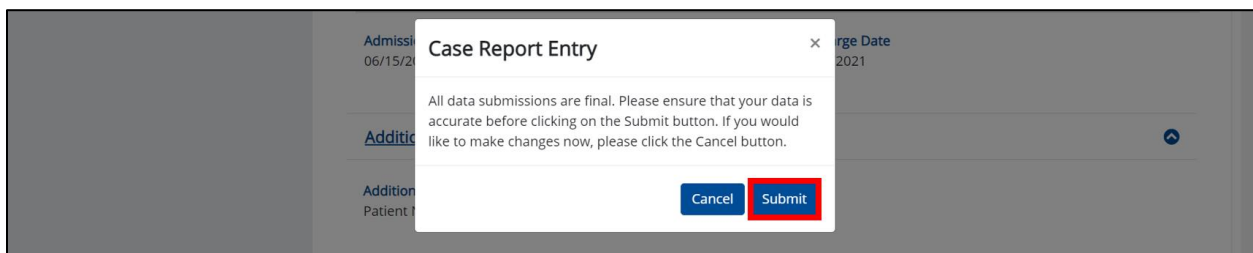
Last Name
Costanza

Date of Birth
1970/03/28

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

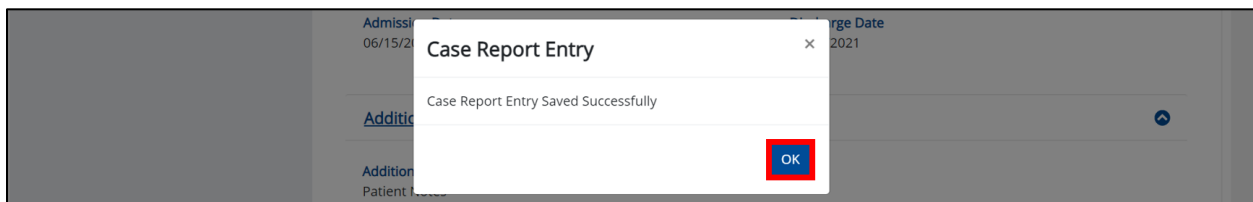


- All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Case Report or click **Submit** to submit the report.



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.

14. 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 C 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.

16 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 7 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 C	Hepatitis C	Hilton Hospital	GC03281970	George	Costanza	1970/03/28	Male	Complete	2023/02/07 6:49 PM	2023/02/07 6:49 PM
Continue Delete	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	1990/02/15	Female	In Progress	2023/02/07 4:14 PM	
View Copy	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
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 aaaaaaaaaaaaaaaaaa	TC 506419MRN	Sarah	Marshman	1979/01/31	Male	Complete	2023/02/07 5:23 AM	2023/02/07 5:23 AM

First Back 1 2 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
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital			Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
View Copy	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

First Back 1 Next Last Maximum 5 entries per page

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

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

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

CASE REPORT ENTRY USER SUMMARY			
LAST UPDATED DATE RANGE		Start Date 12/01/2020	End Date 07/29/2021
<div> Retrieve Data </div>			
<div> • Please select a Start Date that is within the last six months from today's date. </div>			

- 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 01/01/2023	End Date 02/01/2023	<div> Retrieve Data </div>							
<div> SHOWING 32 ITEMS APPLY FILTER </div>											
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 Copy </div>	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
<div> View Copy </div>	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa aa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 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 01/01/2023	End Date 02/01/2023	<div> Retrieve Data </div>							
<div> SHOWING 32 ITEMS HIDE FILTER </div>											
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
<div> View Copy </div>	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
<div> View Copy </div>	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa aa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
<div> View Copy </div>	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa aa	TC506409MR NPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
<div> Continue Delete </div>	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 7 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 C	Hepatitis C	Hilton Hospital	GC03281970	George	Costanza	03/28/1970	Male	Complete	02/07/2023 6:49 PM	02/07/2023 6:49 PM
Continue Delete	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	02/15/1990	Female	In Progress	02/07/2023 4:14 PM	
View Copy	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	02/15/1990	Female	Complete	02/07/2023 3:56 PM	02/07/2023 3:56 PM
View Copy	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	02/15/1990	Female	Complete	02/07/2023 3:24 PM	02/07/2023 3:24 PM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	TC 506419MRN	Sarah	Marshman	01/31/1979	Male	Complete	02/07/2023 5:23 AM	02/07/2023 5:23 AM

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 C Date of Diagnosis: 01/20/2023

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

Patient ID (MRN): GC03281970 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: George Last Name: Costanza

Date of Birth: 03/28/1970

Patient Sex: Male Ethnicity: Not Hispanic or Latino Race: White

Address 1

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.

CASE REPORT ENTRY USER SUMMARY

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

SHOWING 7 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 C	Hepatitis C	Hilton Hospital	GC03281970	George	Costanza	03/28/1970	Male	Complete	02/07/2023 6:49 PM	02/07/2023 6:49 PM
Continue Delete	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	02/15/1990	Female	In Progress	02/07/2023 4:14 PM	
View Copy	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	02/15/1990	Female	Complete	02/07/2023 3:56 PM	02/07/2023 3:56 PM
View Copy	Acute Hepatitis B	Hepatitis B	Hilton Hospital	EB02151990	Elaine	Benes	02/15/1990	Female	Complete	02/07/2023 3:24 PM	02/07/2023 3:24 PM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	TC 506419MRN	Sarah	Marshman	01/31/1979	Male	Complete	02/07/2023 5:23 AM	02/07/2023 5:23 AM

First Back 1 2 Next Last Maximum 5 entries per page

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

By default, the **Patient Information** screen displays the information entered on the previously submitted Acute Hepatitis C case report. Users can change the information entered in any of the enabled fields and submit a new Acute Hepatitis C 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 C CASE REPORT FORM

Section 1 of 7

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

PATIENT INFORMATION

Patient Information	Disease/Organism*	Date of Diagnosis*
Laboratory Information	Hepatitis C	01/20/2023
Applicable Symptoms	<input type="checkbox"/> Unknown	
Exposure Information	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?	
Hospitalization, ICU & Death Information	<input type="button" value="Yes"/> <input type="button" value="No"/>	
Additional Comments	Patient ID (MRN)*	Affiliation/Organization*
Review & Submit	GC03281970	Hilton Hospital
	Person Completing Form*	Affiliation/Organization*
	Mr. Arthur Vandelay (arthur.vandelay@e...)	Hilton Hospital
	Attending Physician/Clinician*	Affiliation/Organization*
	Dr. Frasier Crane (frasier.crane@email.c...)	Hilton Hospital
	Prefix	
	First Name*	Middle Name
	George	
	Suffix	Last Name*
		Costanza
	Date of Birth*	
	03/28/1970	
	Patient Sex*	Ethnicity*
	Male	Not Hispanic or Latino
		Race*
		White
	Address 1*	Address 2
	321 W Third Street	Unit, Suite, Building, etc.
	City*	State*
	Frankfort	KY
	County*	Zip Code*
	Franklin	40601
	Phone*	Email
	(555) 777-6543	george@mailinator.com
	Is the patient currently pregnant?	
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	
	If yes, please enter the due date (EDC):	
	mm/dd/yyyy	
	Prior Hepatitis C Diagnosis*	
	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	
	If yes, please enter the date of diagnosis:	
	mm/dd/yyyy	

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 C CASE REPORT FORM

Section 1 of 7

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

Additional Comments

Review & Submit

Disease/Organism*

Hepatitis C

Date of Diagnosis*

01/20/2023

Unknown

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

Yes No

Patient ID (MRN)*

GC03281970

Affiliation/Organization*

Hilton Hospital

Person Completing Form*

Mr. Arthur Vandelay (arthur.vandelay@e... x v

Attending Physician/Clinician*

Dr. Frasier Crane (frasier.crane@email.c... x v

Affiliation/Organization

Hilton Hospital

If other, please specify:

Prefix

Select...

First Name*

George

Middle Name

Last Name*

Costanza

Suffix

Select...

Date of Birth*

03/28/1970

Patient Sex*

Male

Ethnicity*

Not Hispanic or Latino x v

Race*

White x v

Address 1*

321 W Third Street

Address 2

Unit, Suite, Building, etc.

City*

Frankfort

State*

KY x v

Zip Code*

40601- x v

County*

Franklin x v

Phone*

(555) 777-6543

Email

george@mailinator.com

Is the patient currently pregnant?

Yes No Unknown

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

mm/dd/yyyy

Unknown

Prior Hepatitis C Diagnosis*

Yes No Unknown

If yes, please enter the date of diagnosis*

mm/dd/yyyy

Unknown

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 C 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 C CASE REPORT FORM Section 2 of 7

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information ☒ **Laboratory Information** ☒ **Applicable Symptoms** ☐ **Exposure Information** ☐ **Hospitalization, ICU & Death Information** ☐ **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 C virus Ab [Units/Volume] in Serum

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.

ACUTE HEPATITIS C CASE REPORT FORM Section 7 of 7

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Exposure Information ☒

Hospitalization, ICU & Death Information ☒

Additional Comments ☒

Review & Submit

Print
 Download

Patient Information

Disease/Organism	Date of Diagnosis	
Hepatitis C	01/20/2023	
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?		
Yes		
Patient ID (MRN)	Affiliation/Organization	
GC03281970	Hilton Hospital	
Person Completing Form	Affiliation/Organization	
Mr. Arthur Vandelay (arthur.vandelay@email.com)	Hilton Hospital	
Attending Physician/Clinician	Affiliation/Organization	
Dr. Frasier Crane (frasier.crane@email.com)	Hilton Hospital	
First Name	Last Name	
George	Costanza	
Date of Birth		
03/28/1970		
Patient Sex	Ethnicity	Race
Male	Not Hispanic or Latino	White
Address 1		
321 W Third Street		
City	State	Zip Code
Frankfort	KY	40601
County	Phone	Email
Franklin	(555) 777-6543	george@mailinator.com
Prior Hepatitis C Diagnosis		
No		

Laboratory Information

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

If **No** or **Unknown** is selected for the *Prior Hepatitis C 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 C Case Report Entry.

Additional Comments

Additional comments or notes, please specify:

Additional Patient Notes

Previous
Submit
⬆

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

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 C	Hepatitis C	Hilton Hospital	GC03281970	George	Costanza	03/28/1970	Male	Complete	02/13/2023 4:04 PM	02/13/2023 4:04 PM

Continue In-Progress Case Reports

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

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

Home > Case Report Entry User Summary

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date 02/13/2023 End Date 02/13/2023 Retrieve Data

SHOWING 3 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
Continue Delete	Acute Hepatitis C	Hepatitis C	Hilton Hospital	GC03281970	George	Costanza	03/28/1970	Male	In Progress	02/13/2023 4:06 PM	
View Copy	Acute Hepatitis C	Hepatitis C	Hilton Hospital	GC03281970	George	Costanza	03/28/1970	Male	Complete	02/13/2023 4:04 PM	02/13/2023 4:04 PM
Continue Delete	MDRO	Candida auris, clinical	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa aa	4535fd021323	jsvxelogkswyhnp kohwehtafblmz ydftrxzqhwkgsfa btmkucxwjlhhebj	lcrmsitaaywo upfvlwqepens qbpqfviwyscs hktcpzxiqkqi qthytkoehm	01/31/2007	Male	In Progress	02/13/2023 2:58 AM	

First Back 1 Next Last Maximum 5 entries per page

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

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

Home > Acute Hepatitis C Case Report Form

ACUTE HEPATITIS C CASE REPORT FORM

Section 6 of 7

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Exposure Information ☒

Hospitalization, ICU & Death Information ☒

Additional Comments

Review & Submit

Additional comments or notes, please specify:

Patient Notes

13/1000 Characters

Save Previous Next

17 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.

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.

