

# Kentucky Health Information Exchange (KHIE)

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

User Guide

October 2021



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## 1 Introduction

#### Overview

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

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

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

#### Supported Web Browsers

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

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

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



#### **Mobile Device Considerations**

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

#### Accessing the ePartnerViewer

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

1. Users must be part of an organization with a signed Participation Agreement with KHIE.

- 2. Users are required to have a Kentucky Online Gateway (KOG) account.
- 3. Users are required to complete Multi-Factor Authentication (MFA).
- . -

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

## 2 Logging into ePartnerViewer

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

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

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

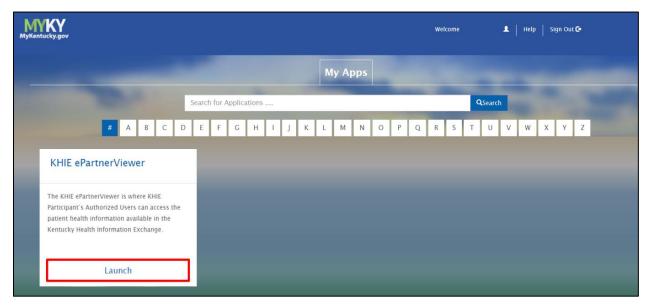
2. Click Sign In.

Mytentucky.gov	FAQ   Help   🛛 English 🗸
Citizen (or) Business Partner Sign In Sign in with your Kentucky Online Gateway Account.  Email Address Jane.doe@gmail.com Password Eorgot/Reset Password2	WARNING This website is the property of the Commonwealth of Kentucky. This is to notify you that you are only authorized to use this site, or any information accessed through this site, for its intended purpose. Unauthorized access or disclosure of personal and confidential information may be punishable by fines under state and federal law. Unauthorized access to this website or access in excess of your authorization may also be criminally punishable. The Commonwealth of Kentucky follows applicable federal and state guidelines to protect the information from misuse or unauthorized access.
SIGN IN Resend Account Verification Email	Don't already have a Kentucky Online Gateway Citizen Account? Create An Account <u>Click here to select user account type</u>

Direct Data Entry for Electronic Case Reports: COVID-19 User Guide Kentucky Health Information Exchange



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



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

Kentucky Online Gateway	Welcome	My Account Si	ign Out 🛛 Hel	Englis
Multi-Factor Authentication				
MFA by Email Verification				
Send Passcode				
Please Note: For specific information about creating a KC				
please review the <i>Kentucky Online Gateway (KOG) and l</i> <i>Reference Guide</i> .	Multi-Factor Authen	tication (N	MFA) Q	uick





#### 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.

<b>KĤIE</b> ePartnerViewer		9 Mitch Cavallo 🔸
TER	MS AND CONDITIONS OF USE	
<ul> <li>Determine and Conditions</li> <li>Determine and conditions of the Kentucky Health Information Exchange</li> <li>I are a healthcare provider currently treating a patient.</li> <li>I are nurrently bound by a Health Information Exchange Participation Agreement with authorized user of a participating provider of the Division of Health Information.</li> <li>I drestand that data available on KHIE is only that information available according.</li> <li>HIV medical procedures and test.</li> <li>I understand that data available on KHIE WILL NOT include HIV medical procedures</li> <li>Select 1 accept to accept the usage terms and conditions.</li> </ul>	h the Division of Health Information or have a current relationship as an to state and federal law. and NDC codes of drugs associated with the treatment of those patients. is and tests, regardless of source.	Access restricted beyond this point. You must accept terms and conditions before proceeding.
Copyright 2019 HealthInteractive	HealthInteractive HIE	Version: 1.0.0

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

KHIE   ePartnerViewer	S Mitch Cavalio -
TERMS AND CONDITIONS OF USE	
HATTAGE REAL CONCIDENCIATE THEME AND CONDITIONS Later the following terms and conditions of the Kentucky Health Information Exchange (KHIE): <ul> <li>an a healthcare provider currently treating a patien;</li> <li>an currently bound by a Health Information Exchange Participation Agreement with the Division of Health Information on have a current relationship as an autorized user of a participating provider of the Division of Health Information.</li> <li>and destand that data available on KHIE is only that Information available according to state and federal law.</li> <li>HIV medical procedures and test.</li> <li>Bignosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.</li> <li>Belet 1 accept to accept the usage terms and conditions.</li> </ul>	Access restricted beyond this point. You must accept terms and conditions before proceeding.
Copyright 2019 HealthInteractive HEALTHEATHER HE	Version: 1.0.0
<b>Please Note:</b> The right side of the Portal is grayed out and display <i>Access is restricted beyond this point. You must accept the terms and</i>	e e







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

KHIE ePartnerViewer	e Mitch Cavallo •
TERMS AND CONDITIONS OF USE	
Exercise Conditions Exercise Conditio	You are part of the below mentioned organization. Please click on proceed to continue. KHIE Smoke Test Organization Proceed to Portal Cancel
Copyright 2019 HealthInteractive HealthInteractive	Version: 1.0.0
<b>Please Note:</b> If you click <b>Cancel</b> , a pop-up notification displays th to be logged out. Use of the ePartnerViewer portal is subject to the ac To proceed to the ePartnerViewer, click either <b>Logout Now</b> or <b>Ca</b>	ceptance of KHIE's Terms of Use.



## 3 Understanding the Case Report Entry Dropdown Menu

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

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

KĤIE	ePartnerViewer	🖂 Support 🖷	🕽 Announcements 2 🏻 🐥 Adv	isories 🚹 😫 🔻
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry 🕶
😭 Home				Case Report Forms
Announcement: e	Health Summit			Case Report Entry User Summary
		•••		Manage User Preferences

#### 1. Types of Case Reports:

- COVID-19 Case Report:
  - Designed for Users to enter COVID-19 case reports.
- Sexually Transmitted Disease (STD) Case Report:
  - Designed for Users to enter STD case reports.

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

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

• Multi-drug Resistant Organism (MDRO) Case Report:

Designed for Users to enter MDRO case reports.

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

• Other Reportable Conditions Case Report:

Designed for Users to enter Other Reportable Conditions case reports.

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

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

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

\_\_\_\_\_



Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🔻	Case Report Entry 🕶
Home				Case Report Forms
	la althe Cruzzanit			COVID-19
Announcement: eH	leann summir	•••		Sexually Transmitted Diseases
			Multi-drug Resistant Organism	
	rr	nyDASHBOARI	C	Other Reportable Conditions
		5		

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

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🔻	Case Report Entry -
Home				Case Report Forms
Announcement: P	rovider Assistance Program deadline ext	ension		Case Report Entry User Summary
-		•••		Manage User Preferences

#### 3. Manage User Preferences:

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

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry	Case Report Entry -
😭 Home				Case Report Forms
<b>Announcement:</b> et	Health Summit			Case Report Entry User Summary
		•••	_	Manage User Preferences
			Create At	ttending Physician/Clinician Details
		myDASHBOARD	View & E	dit Attending Physician/Clinician Details
QUICK SEARCH			Create Pe	erson Completing Form Details
First	Last	Date Of		dit Person Completing Form Details
Name	Name	Birth	mm Create O	rdering Provider/Clinician Details
			View & E	dit Ordering Provider/Clinician Details
	TIENTS	EVENT NOTIFICATIONS	(ΡΔςΤ 72 ΗΟΙ	



### 4 Manage User Preferences

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

#### **Create Interviewer Information Details**

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

KĤIE	ePartnerViewer	🛛 Support 📢	Announcements 2 🐥 A	dvisories 1 😫 🔹
Patient Search	Bookmarked Patients	Event Notifications 1	Lab Data Entry 🕶	Case Report Entry 🕶
A Home				Case Report Forms
Announcement:	Provider Assistance Program deadline exten	sion		Case Report Entry User Summary
		• • •		Manage User Preferences
	my	DASHBOAR	C	
QUICK SEARCH				<b>Q</b> ADVANCED SEARCH

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

KĤIE	ePartnerView	Ver 🛛 Support 📢 Anr	nouncements	2 🌲 Advisorie	25 1 😑	•
Patient Search	Bookmarked Patients	Event Notifications 1	Lab Data I	Entry -	Case Report Entry -	
😭 Home				Case	e Report Forms	>
<b>Announcement:</b> eH	lealth Summit			Case	e Report Entry User Summa	ary
				Man	age User Preferences	>
			Cre	ate Interviewer Ir	nformation Details	
		myDASHBOARD	Viev	v & Edit Interviev	ver Information Details	- 1
QUICK SEARCH			Cre	ate Attending Phy	ysician/Clinician Details	
First	Last	Date Of		v & Edit Attendin	g Physician/Clinician Detail	ls
Name	Name	Birth	mm, Cre	ate Person Comp	leting Form Details	
			Viev	v & Edit Person C	Completing Form Details	
BOOKMARKED PA		EVENT NOTIFICATIONS	5 (PAST 72 I	HOURS)	6	



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

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

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

	INTERVIEWER INFORMATION
Prefix Dr.	x v
First Name*	Last Name*
Suffix	
Phone*	Email*
(XXX) XXX-XXXX	name@domain.com

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

Email*
name@domain.com
e Phone and Email fields is not entered in the
that prevents you from proceeding to the next



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

	I	NTERVIEWER IN	NFORMATION					
Prefix								
Dr.	×   ~							
First Name*			Last Name*					
Jerry			Seinfeld					
Suffix								
Sr	×   ~							
Phone*			Email*					
(555) 543-2100			jerry@email.com	ı				
						Clear		Save
								Save
ase Note: If you e	nter an email a	ddress that	is already a	ssociat	ed wit			
d click <b>Save</b> , a pop- e <i>email entered is a</i>	up displays with	h an error m another inte	nessage that rviewer you'i	states:		h anoth	ner inte	erviev
d click <b>Save</b> , a pop- e <i>email entered is a</i>	up displays with	h an error m another inte	nessage that rviewer you'i	states:		h anoth	ner inte	erviev
d click <b>Save</b> , a pop- e <i>email entered is a</i> ease review the detain u must click <b>OK</b> and	up displays with associated with ils and enter the denter the corre	h an error m another inte correct emai ect email adc	nessage that rviewer you'n I address. Iress to save	states: ve creat	ted in erview	h anoth your Us	ner inte	erviev feren
d click <b>Save</b> , a pop- e <i>email entered is a</i> ease review the detain u must click <b>OK</b> and	up displays with associated with ils and enter the denter the corre	h an error m another inte correct emai ect email adc	nessage that rviewer you'n I address. Iress to save	states: ve creat	ted in erview	h anoth your Us	ner inte	erviev feren
d click <b>Save</b> , a pop- e email entered is a case review the detail u must click <b>OK</b> and d proceed to the <b>Vi</b>	up displays with associated with associated with as and enter the enter the corre iew & Edit Inte	h an error m another inter correct emai ect email ado <b>rviewer Inf</b> e	nessage that rviewer you'n il address. dress to save ormation D	t states: we creat the Int <b>etails</b> s	ted in erview	h anoth your Us	ner inte	erviev feren
d click <b>Save</b> , a pop- e email entered is a ease review the detail ou must click <b>OK</b> and d proceed to the <b>Vi</b>	up displays with associated with associated with as and enter the enter the corre iew & Edit Inte	h an error m another inter correct emai ect email ado rviewer Infer Interviewer Information Do	nessage that rviewer you'n il address. dress to save ormation D d with an asterisk(*) are re etails	the Int	ted in erview	h anoth your Us	ner inte	erviev feren
ease Note: If you end click <b>Save</b> , a pop- e email entered is a case review the detail ou must click <b>OK</b> and d proceed to the <b>Vi</b>	up displays with associated with associated with as and enter the enter the corre iew & Edit Inte	h an error m another inter correct email ect email ado rviewer Infe Interviewer All fields marke Interviewer Information D	nessage that rviewer you'n i' address. dress to save ormation D d with an asterisk(*) are re etails	t states: we creat the Int <b>etails</b> s	ted in erview	h anoth your Us	ner inte	erviev feren

9. The *Create Interviewer Information Details* pop-up displays. Click **OK** to proceed to the **View & Edit Interviewer Information Details** screen.



🖀 Home 🔉	Create Interviewer Information Details			
	Please complete the form below to c	pate an Intensiewer All Balde marked with an asterick/ Create Interviewer Information Details		id.
		Create Interviewer Information Details	×	
		Interviewer Information Details saved successfully	_	
			ок	Clear Save

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

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

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

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

Patient Search	Bo	Update Interviewer Information De	etails	×	Case Report Entry 👻
倄 Home 🕨 Vi	ew & Edit Interviewer li	Prefix			
• VIEW &		Dr. × v			CREFRESH APPLY FILTER
		First Name*	Last Name*		
SHOWING		Jerry	Seinfeld		
3 ITEMS		C. His		_	
ACTIONS	NAME	Sr X V		в	ER 🗘
	Dr. Jerry Seinfeld, S	Phone*	Email*	00	
	Dr. Jason Alexande	(555) 543-2100	jerry@email.com	90	
	Dr. Elaine Benes		Cancel Save	21	
		First Back 1 Next Last			Maximum 5 👻 entries per page

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



Home > Vie	w & Edit Interviewer Information Details						
• VIEW &	EDIT INTERVIEWER IN	IFORMA	TION DETAILS			CREFRESH	<b>T</b> APPLY FILTER
SHOWING		Update Inter	viewer Information Details	×			
3 ITEMS		Interviewer Ir	nformation details updated successfully				
ACTIONS	NAME				\$ PHONE NUMBER		\$
	Dr. Jerry Seinfeld, Sr			ОК	(555) 543-2100		
	Dr. Jason Alexander, II		jason@email.com		(123) 456-7890		

#### **Delete Interviewer Information Details**

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

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

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

O VIEW & I	EDIT INTERVIEWER IN						CREFRESH	<b>T</b> APPLY FILTER
SHOWING 3 ITEMS		Delete Interviewer Information Details     Are you sure?		^				
ACTIONS	NAME	All you sure.			¢	PHONE NUMBER		¢
	Dr. Jerry Seinfeld, Sr		Cancel OK			(555) 543-2100		
	Dr. Jason Alexander, II	jason@em	nail.com			(123) 456-7890		



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

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

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

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

• VIEW &	EDIT INTERVIEWER IN	Delete Interviewer Information Details		C REFRESH	<b>Y</b> APPLY FILTER
SHOWING 2 ITEMS		This interviewer information is being used one of the case reports that is still in progr To delete this interviewer, please ensure t	ess.		
ACTIONS	NAME	this interviewer is not being used in any case report that is in progress.		\$ E-MAIL	÷
	Dr. Jerry Seinfeld, Sr		_	jerry@email.com	
	Dr. Jason Alexander, Il		ОК	jason@email.com	

### **Filter Interviewer Information Details**

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

KĤIE	ePartnerViewer	Support 📢	Announcements 🐥 Advisories 🕦 😫 🔹
Patient Search	Bookmarked Patients	Event Notifications 5 Lab I	Data Entry • Case Report Entry •
🖀 Home 🖒 Vie	w & Edit Interviewer Information Details		
• VIEW &	EDIT INTERVIEWER INFORMA	TION DETAILS	CREFRESH TAPPLY FILTER
SHOWING 3 ITEMS			
ACTIONS	NAME	EMAIL +	PHONE NUMBER \$
	Dr. Jerry Seinfeld, Sr	jerry@email.com	(555) 543-2100
	Dr. Jason Alexander, II	jason@email.com	(123) 456-7890
	Dr. Elaine Benes	elaine@email.com	(555) 555-4321
	First Back 1	Next Last	Maximum 5 🗸 entries per page

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





KĤIE	ePartnerViewer		Support 📢 Announcements 🌲 Ac	dvisories 🚹 😫 👻				
Patient Search	Bookmarked Patients	Event Notifications 6	Lab Data Entry -	Case Report Entry -				
🖀 Home 🕨 Vi	ew & Edit Interviewer Information Details							
SHOWING 3 ITEMS								
ACTIONS	NAME Enter Name	EMAIL Enter Email	PHONE NUMBER ER	ter Phone Number				
	Dr. Jerry Seinfeld, Sr	jerry@email.com	(555) 543-2100					
	Dr. Jason Alexander, II	jason@email.com	(123) 456-7890					
	Dr. Elaine Benes	elaine@email.com	(555) 555-4321					
	First Back	1 Next Last	Ν	Aaximum 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 are located in the **Side Navigation Bar** that provide users the ability to go to different screens within a Case Report. You can also use the pagination buttons to move to the next screen or to any previously completed screen.

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

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

#### Save Feature

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

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

Yes No Unknown Save Next	ls patient curr	ently pregnant	?*		
Save	Yes	No	Unknown		
Save					
Save					
Save		-			
	Save				Next



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

			PATIENT INF	ORMATION			
Patient Information	Ø	Interviewer Name*		Affiliation/Organization*			
SARS CoV-2 Testing	Ø	Dr. Jerry Seinfeld, Sr (jer	rry@email.c 🗙 🛛 🗸	Test Medical Center			x   ~
Clinical Course	Ø	Save	e Changes?	×			
Applicable Symptoms	0	SR04011960 There	's information on this scr	een that has not been saved.	1~]		
Medical Conditions	0		u want to save it?			Last Name*	
Exposure Information	0	Susan	N	o - Discard Yes - Save		Ross	
Hospitalization, ICU & Death Information	$\odot$	Suffix		Date OF DITUT			
Vaccination History	Ø	Select		04/01/1960			
Additional Comments	0	Patient Sex*	× [ ~	Ethnicity* Not Hispanic or Latino	x   ~	Race*	x   ~

#### **Case Report Entry Icons**

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

#### Icon Descriptions:

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





#### **Conditional Questions**

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

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

			SARS CoV-2	TESTING		
Patient Information	Ø		*			
SARS CoV-2 Testing		Does the patient have a lab test Yes No	Unknown			
Clinical Course	<b>a</b>					
Applicable Symptoms	_	If yes, please provide informatio	on for at least one test. N	NOTE: A Test Name and Test	Result are required.	
Medical Conditions	_	Molecular Amplification Test (R1	Γ PCR)			
Exposure Information	<b></b>	Test Name		Test Result		Filler Order/Accession Number 6
Hospitalization, ICU & Death Information		Select		Select		
Vaccination History	۵	🕒 Add Test				
Additional Comments	<b>A</b>	Serologic Test				
Review & Submit	<b>a</b>	Test Name		Test Result		Filler Order/Accession Number
		Select		Select		
		🔂 Add Test				
		Antigen Test				
		Test Name		Test Result		Filler Order/Accession Number 🕼

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

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



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

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

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

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

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

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

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

				APPLICAB	LE SYMPTOMS		 	
Patient Information	0	Were symptom:	s present du	ring the course of illnes	s?*			
SARS CoV-2 Testing	$\odot$	Yes	No	Unknown				
Clinical Course	$\odot$	-				_		
Applicable Symptoms		Onset Date* @ mm/dd/yyyy		Unknown				
Medical Conditions	<b>A</b>	Did the patient'	symptoms	resolve?* O				
Exposure Information		Yes	No	Unknown				
Hospitalization, ICU & Death Information	_	If yes, what was mm/dd/yyyy		symptom resolution? @				
Vaccination History	≙							
Additional Comments	_	100000000000000000000000000000000000000	which of the	following did the paties	nt experience during their i	illness?		
Review & Submit	<b>a</b>	Fever* Yes	No	Unknown				
		Subjective fever	(felt feveris)	1)*				
		Yes	No	Unknown				
		Chills*						
		Yes	No	Unknown				
		Rigors*						
		Yes	No	Unknown				
		Muscle aches (n	nyalgia)*					
		Yes	No	Unknown				

# 6 Tips for Manually Entering Case Report Data

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

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

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

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



		An MRN or Medical Reco Number is an Organizati specific, unique Identification Number		
Patient Information		assigned to a patient by Inten healthcare organization.		
SARS CoV-2 Testing	<b>A</b>	Dr. your organization does r use an MRN, you MUST create a way to uniquel	Test Medical center	x   ~
Clinical Course		identify your Patient.		
Applicable Symptoms	<b>A</b>	Patient ID (MRN)* 🕢	Prefix Select	

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

City	State	KY	x   ~
Zip Code	County	Select	<b>~</b>
Phone Number	Email Address	Adair Allen	
		Anderson	
		Ballard Barren	t
		Bath Bell	
nteractive	HealthInteractive HIE		, /ers

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

City	State	AR	×   ~
Zip Code	County	Out Of System State	×   ~

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



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dmi	ssior	n Dat	te*					Discharge Date*
mm	/dd/	′уууу	/				🛗 🗌 Unknown	mm/dd/yyyy 🗰 🗌 Unknov
4	June	Jur	ne 20 ~		1 🗸			
Su	Mo	Tu	We	Th	Fr	Sa	this illness?*	
30	31	1	2	3	4	5	Unknown	
6	7	8	9	10	11	12	death:	
13	14	15	16	17	18	19		
20	21	22	23	24	25	26	# Unknown	
27		29		1	2	3	🛗 🗌 Unknown	

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

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

## 7 COVID-19 Case Report Form

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

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

<b>KĤIE</b>   ePar	tnerViewer		Support 📢 Announcements	🔹 🔺 Advisories 🚹 😩 🔹
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 👻	Case Report Entry *
Home				Case Report Forms
Announcement: eHealth Summ	it			Case Report Entry User Summary
1				Manage User Preferences

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

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry 🕶		
Home				Case Report Forms		
				COVID-19		
Announcement: eH	Announcement: eHealth Summit					
				Multi-drug Resistant Organism		
	n	nyDASHBOARI	D	Other Reportable Conditions		



## 8 Patient Information

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

COVID-19 CASE REPORT FORM		Section 1 of	10	
Please complete the form below. All fields ma	rked with asterisk(*) are required.			
		PATIENT INFORMATION		
Patient Information	Interviewer Name*	Affiliation/Organization*		
SARS CoV-2 Testing	Select	Select		~
Clinical Course	<b>A</b>			
Applicable Symptoms	Patient ID (MRN)* 😧	Prefix Select	<b>~</b> ]	
Medical Conditions		Middle Name	Last Name*	
Exposure Information	<b>A</b>			
Hospitalization, ICU & Death Information	<b>≙</b> Suffix	Date of Birth*		
Vaccination History	Select	✓ mm/dd/yyyy	Ê	
Additional Comments	Patient Sex*	Ethnicity*	Race*	
Review & Submit	Select	Select	Select	· ·
	Address 18			

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





OVID-19 CASE REPORT FORM				Section 1 of 10		
Please complete the form below. All fields mai	rked with ast	erisk(*) are required.				
		PATIENT IN	FORMATION			
Patient Information		Interviewer Name*	Affiliation/Organization	e		
SARS CoV-2 Testing	۵	Select 🗸 🗸	Select			[ ~
Clinical Course	<b>a</b>	-				
Applicable Symptoms	<b>a</b>	Patient ID (MRN)* 🕑	Prefix Select	~		
Medical Conditions	۵	First Name*	Middle Name		Last Name*	
Exposure Information	_					
lospitalization, ICU & Death Information	۵	Suffix	Date of Birth*			
accination History	<b>A</b>	Select 🗸	mm/dd/yyyy	10		
Additional Comments		Patient Sex*	Ethnicity*		Race*	
	-	Select ~	Select	×	Select	~
Review & Submit	-					
		Address 1*		Address 2		
				Unit, Suite, Building, etc.		
		City*		State*	Zip Co	de
				Select	~	

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

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

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

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

PATIENT INFORMATION					
Patient Information		Interviewer Name*		Affiliation/Organization*	
SARS CoV-2 Testing	<b>a</b>	Şelect	· ·	Select	~
Clinical Course	<b>A</b>	Dr. Jason Alexander, II (jason@email.com)		Prefix	
Applicable Symptoms	<b></b>	Dr. Jerry Seinfeld, Sr (jerry@email.com)		Select V	
Medical Conditions	<b>a</b>	First Name*		Middle Name Last Name*	



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

#### Interviewer Name Hyperlink

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

COVID-19 CASE REPORT F	FORM	Section 1 of 10					
Please complete the form below. Al	Please complete the form below. All fields marked with an asterisk(*) are required.						
	P	PATIENT INFORMATION					
Patient Information	Interviewer Name*	Affiliation/Organization*					
SARS CoV-2 Testing	Select	Select	~				

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

	Manage User Preferenc	es	×
Please complete the form below. All	<i>fiel Please complete the form be are required.</i>	low to create an Interviewer. All fields marked with an asterisk	(*)
Patient Information		INTERVIEWER INFORMATION	
SARS CoV-2 Testing	Prefix		~
Clinical Course	Select V		
Applicable Symptoms	First Name*	Last Name*	
Medical Conditions	Suffix		ame*
Exposure Information	Select 🗸 🗸		
Hospitalization, ICU & Death nformation	11	Email*	
nformation	ш	name@domain.com	
Vaccination History	IV		
Additional Comments	Jr	Cancel Sav	zt Ve
Review & Submit	Sr		

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

Fi	rst Name*	Last Name*



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

Phone* (XXX) XXX-XXXX	Email* name@domain.com
<b>Please Note:</b> If the information entered in the appropriate format, an error message displays	
page until the format error is fixed.	ا ر ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ

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

COVID-19 CASE REPORT FOP	M		_	_
	Manage User Preferences	×		
Please complete the form below. All fiel	Please complete the form below to creater are required.			
Patient Information	INTERVI	EWER INFORMATION		
SARS CoV-2 Testing	Prefix			
Clinical Course	Mr. × / v			
Applicable Symptoms	First Name*	Last Name* Mailman	-	
Medical Conditions	Suffix		ame*	
Exposure Information	Select V			
Hospitalization, ICU & Death Information	Phone* (555) 654-3210	Email* newman@email.com		
Vaccination History				
Additional Comments		Cancel Save	zt	
Review & Submit				

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

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

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

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

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

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

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





Patient ID (MRN)* 😧	Prefix	
SR04011960	Select	· ~
First Name*	Dr.	Last Name*
	Miss	
Suffix	Mr.	
Select	V Mrs.	
Patient Sex*	Ms.	Race*
Select	Select	Select V

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

First Name*	Middle Name	Last Name*

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

Suffix		Date	of B	irth*	;				
Select	$\sim$	mm	n/dd/	/уууу	ý				<b></b>
Patient Sex* Select	· ·	.∢ Su	Jun Mo	ne		<b>)21</b> ][202 Th		Sa	Race*
		30	31	1	2	3	4	5	
Address 1*		6 13	7 14	8 15	9	10 17	11 18	12 19	te, Building, etc.
City*		<b>20</b> 27	<b>21</b> 28	<b>22</b> 29	<b>23</b> 30	24 1	25 2	26 3	Zip Code
						-	50		

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



Patient Sex*	Ethnic	ity*	Ra	ce*	
Şelect	<ul> <li>✓</li> </ul>	ct	~ S	elect	· · ·
Female					
Male		Add	dress 2		
Other		U	nit, Suite, Building, etc.		
Unknown		Stat	te*	:	Zip Code
		Se	elect		

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

Patient Sex*	Ethnicity*		Race*
Female	X 🗸 🗸 Not Hispan	ic or Latino 🛛 🗙 📔 🗸	Select 🗸
			American Indian or Alaska Native
Address 1*		Address 2	Asian
		Unit, Suite, Building	<sup>3</sup> Asked but Unknown
City*		State*	Black or African American
		Select	Native Hawaiian or Other Pacific
County*	Phone* 🚱		Islander
Select	(XXX) XXX->	XXXX	Other Race Unknown

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

Address 1*		Address 2		
		Unit, Suite, Building,	etc.	
City*		State*	Zip	Code
		Select	~	
County*	Phone* 😧		Email	
Select	~ (XXX) XXX-XXX	(	name@domain.com	

#### 19. Enter the patient's **Phone Number** and **Email Address**.

• If the phone number and email address fields are not in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.



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321 First Street	Please enter patient's	Unit, Suite, Bu	uilding, etc.		
City*	phone number. If patient's phone number is not available, please enter the	State*			Zip Code
Lexington	provider's/interviewer's	КҮ		$\times \mid$ $\vee$	40321
County*	Phone* 😧		Email		
Fayette	× v (XXX) XXX-XXXX		name	e@domain.co	m

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

(555) 321-0123	patient@email.com

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

Yes No Unkn	information is not
βelect	· •
Acute care inpatient facility	
Apartment	
Assisted living facility	
Correctional facility	
Group home	
Homeless shelter	
Hotel/motel	

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



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

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

	Is the patient	a healthcare wo	orker in the Unit	ed States?*
	Yes	No	Unknown	
ļ				

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

Yes	No	orker in the United Unknown	
lf yes, what is th	ne patient's o	ccupation/job type?	0
Select			
lf other, please	specify:		
lf yes, what is th	ne patient's jo	b setting? 😮	

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





the patient a healthcare we Yes No	orker in the United State	·s?*	
yes, what is the patient's o	ccupation/job type?* 😧		
Select		~	
yes, what is the patient's jo	b setting? <b>* </b>		
Select		$\sim$	
other, please specify:			

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

yes, what is the patient's occupation/jo	cupation/job type is not available. b type?* ?	
Select	~	
Environmental services		
Nurse		
Other		
Physician		
Respiratory therapist		
Unknown		
ase Note: If you select Other		



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

Assisted living facility Hospital	jelect         Assisted living facility         Hospital         Nursing home/Long term care facility	Select Assisted living facility Hospital	belect       Assisted living facility       Hospital       Nursing home/Long term care facility
Assisted living facility Hospital	- Assisted living facility Hospital Nursing home/Long term care facility	Assisted living facility Hospital Nursing home/Long term care facility	Assisted living facility Hospital Nursing home/Long term care facility Other
Hospital	Hospital Nursing home/Long term care facility	Hospital Nursing home/Long term care facility	Hospital Nursing home/Long term care facility Other
Hospital	Hospital Nursing home/Long term care facility	Hospital Nursing home/Long term care facility	Hospital Nursing home/Long term care facility Other
	Nursing home/Long term care facility	Nursing home/Long term care facility	Nursing home/Long term care facility Other
			Other

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

f yes, what is the patient's occupation/job	type? <b>* </b>
Other	×   ~
If other, please specify:*	
in other, please specify.	

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

Is patient curre Yes	ntly pregnant?*	Unknown	
	•		<i>ly pregnant?</i> field is enabled only when you select <i>Female</i> on the <b>Patient Information</b> screen.

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





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

If yes, what is the patient's occupatio	n/ioh type? <b>* @</b>	
Nurse	×   ~	
f other, please specify:		
f yes, what is the patient's job settin	z? <b>* @</b> 	
Hospital f other, please specify:		
s patient currently pregnant?*		
Yes No Un	nown	

DDE for eICRs: COVID-19 User Guide

# Deloitte.



## 9 SARS CoV-2 Testing

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

COVID-19 CASE REPORT FORM				Section	n 2 of 10	
Please provide lab information.						
			SARS	CoV-2 TESTING		
Patient Information	0	_				
SARS CoV-2 Testing		Does the patient have a lab t Yes No	est?* Unknown			
Clinical Course	<b>a</b>					
Applicable Symptoms	_	If yes, please provide inform	ation for at least one test.	NOTE: A Test Name and Test Result are re	equired.	
Medical Conditions	_	Molecular Amplification Test	(RT PCR)			
Exposure Information	_	Test Name		Test Result		Filler Order/Accession Number 😡
Hospitalization, ICU & Death Information	<b>a</b>	Select		✓ Select		
Vaccination History	<b>a</b>	🔂 Add Test				
Additional Comments	_	Serologic Test				
Review & Submit	<b>A</b>	Test Name		Test Result		Filler Order/Accession Number @
		Select		Select		
		🔂 Add Test				
		Antigen Test				
		Test Name		Test Result		Filler Order/Accession Number 🚱
		Select				

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

Patient Information	$\odot$	Does the patient have a lab test	2*	
SARS CoV-2 Testing		Yes No	Unknown	
Clinical Course	<b></b>			
Applicable Symptoms	<b>a</b>	If yes, please provide informatio	on for at least one test. NOTE: A Test Name and Test Res	sult are required.
Medical Conditions		Molecular Amplification Test (RT	PCR)	
Exposure Information	<b>a</b>	Test Name	Test Result	Filler Order/Accession Number 🚱
Hospitalization, ICU & Death Information	<b></b>	Select	∨ Select	~
Vaccination History	<b></b>	🔂 Add Test		
Additional Comments	<b>a</b>	Serologic Test		
Review & Submit	<b>a</b>	Test Name	Test Result	Filler Order/Accession Number 🕑
		Select	Select	· ·
		Add Test		
		Antigen Test		
		Test Name	Test Result	Filler Order/Accession Number 🕑
		Select	Select	~
		🔂 Add Test		
Please Note: If <b>A</b> subsequent fields				onal question at the top, all the





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

est Name		Test Result		Filler Order/Accession Number 🚱
Select	~	Select	~	
Influenza virus A and B and SARS- (COVID-19) and Respiratory syncyt panel - Respiratory specimen by N	tial virus RNA			
probe detection Middle East respiratory syndrome	coropouirus			
(MERS-CoV) RNA [Presence] in Res		Test Result		Filler Order/Accession Number 🚱
specimen by NAA with probe dete	· · ·	Select	~	
Respiratory viral pathogens DNA a panel - Respiratory specimen Qua				
NAA with probe detection				

- 4. Select the appropriate **Test Result** from the dropdown menu.
- 5. Enter the Filler Order/Accession Number.

Test Name	Test Result	Filler Order/Accession Number 😧				
SARS coronavirus 2 E gene [Cycle Thres $\times$   $\vee$	Select 🗸 🗸					
Add Test	Negative					
	Pending					
Serologic Test	Positive					
Test Name	Undetermined/Inconclusive	Filler Order/Accession Number 😧				
Select 🗸	Select 🗸					
<b>Please Note:</b> The Filler Order Number or Lab Accession Number is typically utilized by laboratories and generally refers to the number assigned to a lab sample when it is checked in. If your organization does not log the receipt of specimens, you should create a system to uniquely track the specimen when you check it in.						

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

est Name	Test Result		Filler Order/Accession Number 🚱
Select	<ul> <li>Select</li> </ul>	$\sim$	
SARS coronavirus 2 Ab [Interpretation] in Serum or Plasma	i i		
SARS coronavirus 2 IgA Ab [Presence] in Serum or Plasma by Immunoassay			
SARS coronavirus 2 lgA Ab [Units/volume] in	Test Result		Filler Order/Accession Number 🕑
Serum or Plasma by Immunoassay	Select	~	
SARS coronavirus 2 lgG Ab [Presence] in Serum or Plasma by Immunoassay			
SARS coronavirus 2 lgG Ab [Presence] in Serum			





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

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

#### Adding Multiple Tests

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

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





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

est Name		Test Result		Filler Order/Accession Number 😧
BinaxNOW COVID Test Kit	x   ~	Positive	×   ~	SR05082021
Test Name		Test Result		Filler Order/Accession Number 🕑
Select		Select	$\sim$	
Select	~	Select	~	
<b>1</b>				

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

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

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

\_ \_ \_ \_

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

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

## **10 Clinical Course**

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

COVID-19 CASE REPORT FORM					Section 3 of 10
Please provide the information pertaining to	the patient's	clinical course.			
				CI	LINICAL COURSE
Patient Information	Ø	Disease/Organ	nism*		
SARS CoV-2 Testing	Ø	COVID-19			
Clinical Course		Did the patien Yes	t develop pne No	umonia?* Unknown	
Applicable Symptoms	<b>a</b>				
Medical Conditions	_	Did the patien Yes	t receive mech	unknown	n(MV)/intubation?*
Exposure Information	_	lf yes, total day	vs with MV (#	of days):	
Hospitalization, ICU & Death Information	<b>a</b>	Select	,		
Vaccination History		Did the patien	t have an abn	ormal chest X-ray	[*
Additional Comments	۵	Yes	No	Unknown	No X-Ray Done
Review & Submit	۵				gy for their illness?*
		Yes	No	Unknown	
		Did the patien Yes	t have acute n	espiratory distres	ss syndrome?*
		Did the patien	t have an abr	ormal EKG2*	
		Yes	No	Unknown	No EKG Done
		Did the patien	t receive ECM	0?*	
		Yes	No	Unknown	





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

d the patien	t develop pneu	imonia?*
Yes	No	Unknown
Did the patien	t receive mech	anical ventilatior
Yes	No	Unknown
yes, total da	ys with MV (# c	of days):

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

Did the patient recei	No Unknown	(MV)/intubation?*	
f yes, total days with	n MV (# of days):*		
Select		~	
1-15 Days			
15 + Days		Ray Done	
Unknown		ir illness?*	
Yes	No Unknown		

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

If yes, total da 1-15 Days	iys with MV (# c		×   ~
Did the patier	nt have an abno	ormal chest X-ray	*
Yes	No	Unknown	No X-Ray Done
Did the patier	nt have another	r diagnosis/etiolog	gy for their illness?*
Yes	No	Unknown	
Did the patier	nt have acute re	espiratory distress	s syndrome?*
Yes	No	Unknown	
Did the patier	nt have an abno	ormal EKG?*	
Yes	No	Unknown	No EKG Done
Did the patier	nt receive ECMC	0?*	
Yes	No	Unknown	



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

		CLINICAL COURSE
Patient Information	Ø	Disease/Organism*
SARS CoV-2 Testing	$\otimes$	COVID-19
Clinical Course		Did the patient develop pneumonia?* Yes No Unknown
Applicable Symptoms	۵	
Medical Conditions	<b>A</b>	Did the patient receive mechanical ventilation(MV)/intubation?*           Yes         No         Unknown
Exposure Information	<b>A</b>	If yes, total days with MV (# of days);*
Hospitalization, ICU & Death Information	_	1-15 Days × V
Vaccination History	<b></b>	Did the patient have an abnormal chest X-ray?*
Additional Comments	<b>A</b>	Yes No Unknown No X-Ray Done
Review & Submit	<b></b>	Did the patient have another diagnosis/etiology for their illness?* Yes No Unknown
		Did the patient have acute respiratory distress syndrom?* Yes No Unknown
		Did the patient have an abnormal EKG?* Yes No Unknown No EKG Done
		Did the patient receive ECMO?* Yes No Unknown
		Save Previous Next

## **11 Applicable Symptoms**

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

COVID-19 CASE REPORT FORM		Section 4 of 10								
Please select applicable symptoms that the patient	experienced d	uring illness.								
APPLICABLE SYMPTOMS										
Patient Information	0	Were symptoms present during the course of illness?*								
SARS CoV-2 Testing	0	Yes No Unknown								
Clinical Course	0	Onset Date 🖗								
Applicable Symptoms		mm/dd/yyyy 👔 🗋 Unknown								
Medical Conditions	۵	Did the patient's symptoms resolve?								
Exposure Information	<b>A</b>	Yes No Unknown								
Hospitalization, ICU & Death Information	<b>A</b>	If yes, what was the date of symptom resolution?  Imm/dd/yyyy Imm/dd/yyyy Imm/dd/yyyy Imm/dd/yyyy								
Vaccination History	<b>A</b>									
Additional Comments	<b>A</b>	If symptomatic, which of the following did the patient experience during their illness?								
Review & Submit	<b>A</b>	Fever Yes No Unknown								
		Subjective fever (felt feverish)								
		Yes No Unknown								
		Chills								
		Yes No Unknown								
		Rigors								
		Yes No Unknown								
		Muscle aches (myalgia)								
		Yes No Unknown								

I I



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

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

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

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

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

V	Were symptoms present during the course of illness?*  Vec Vec Vec Vec Vec Vec Vec Vec Vec Ve												
	Onset Date* 0												
	mm/dd/yyyy 🏥 🗌							Unknown					
		June 2021			1 🕶								
	Su	Мо	Tu	We	Th	Fr	Sa	Unknown					
	30	31	1	2	3	4	5	itom resolution? 🚱					
	6	7	8	9	10	11	12	Jnknown					
	13	14	15	16	17	18	19						
	20	21	22	23	24	25	26	wing did the patient experience during their illness?					
	27	28	29	30	1	2	3						
		Yes			N	0		Unknown					





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

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

	No	Unkr	the date is not known.
what was th	e date of s	ymptom r	esolution?* @

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

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



Headache*
Yes No Unknown
Fatigue*
Yes No Unknown
Cough (new onset or worsening of chronic cough)*
Yes No Unknown
Wheezing*
Yes No Unknown
Shortness of breath (dyspnea)*
Yes No Unknown
Chest pain*
Yes No Unknown
Nausea or vomiting*
Yes No Unknown
Abdominal pain*
Yes No Unknown
Diarrhea (>3 loose stools/24hr period)*
Yes No Unknown
Did the patient have any other symptoms?*
Yes No Unknown

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

Yes No Unknown yes, please specify: 🖗
--

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

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

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

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



## **12 Medical Conditions**

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

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

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

Patient Information	0	Did the patient	have any un	derlying medical co	ditions and/or risk behaviors?*
SARS CoV-2 Testing	0	Yes	No	Unknown	
Clinical Course	$\odot$				
Applicable Symptoms	Ø	If yes, which or	ne of the follo	wing underlying m	lical conditions and/or risk behaviors applies to the patient?
Medical Conditions		Diabetes Mellitus* Yes No Unknown			
Exposure Information	۵			Unknown	
Hospitalization, ICU & Death Information	<b>A</b>	Hypertension* Yes	No	Unknown	
Vaccination History	<b>A</b>	Severe obesity (BMI>40)*			
Additional Comments	<b>A</b>	Yes	No	Unknown	
Review & Submit	<b>a</b>	Cardiovascular	disease*		
		Yes	No	Unknown	
		Chronic renal o	lisease*		
		Yes	No	Unknown	
		Chronic liver di	sease*		
		Yes	No	Unknown	
		Chronic lung di	isease (asthm	a/emphysema/CO	*((
		Yes	No	Unknown	
	_	_	_		<u></u>
Please Note: If No disabled and mark			or th	e condi	onal question, all subsequent fields are
lf <b>Unknown</b> is seled and marked as <b>Unl</b>			condit	ional qu	estion, all subsequent fields are disabled



- 3. To indicate the underlying medical conditions and/or risk behaviors that apply to the patient, select the **appropriate answers** for the following:
  - Diabetes Mellitus
  - Hypertension
  - Severe obesity (BMI>40)
  - Cardiovascular disease
  - Chronic renal disease
  - Chronic liver disease

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

Applicable Symptoms	Ø	If yes, which one of the following underlying medical conditions and/or risk behaviors applies to the patient?					
		Diabetes Mellitus*					
Medical Conditions		Yes	No	Unknown			
Exposure Information	<b>a</b>	Hypertension					
Hospitalization, ICU & Death Information	<b>a</b>	Yes	No	Unknown			
Vaccination History	<b></b>	Severe obesity	(BMI>40)*				
Additional Comments	<b>a</b>	Yes	No	Unknown			
Review & Submit	<b></b>	Cardiovascular	r disease*				
		Yes	No	Unknown			
		Chronic renal	disease*				
		Yes	No	Unknown			
		Chronic liver d	isease*				
		Yes	No	Unknown			
		Chronic lung d	lisease (asthr	a/emphysema/COI	(סי		
		Yes	No	Unknown			
		Immunosuppressive condition*					
		Yes	No	Unknown			
		Autoimmune o	condition*				
		Yes	No	Unknown			
		Current smoke	er*				
		Yes	No	Unknown			
		Former smoke	er*				
		Yes	No	Unknown			
		Substance abu	ise or misuse				
		Yes	No	Unknown			

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

Substance abuse or misuse* Yes No	Unknown
Disability (neurologic, neurod Yes No	levelopemental, intellectual, physical, vision or hearing im Unknown
yes, please specify: 🚱	



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

Disability (Please enter 'Unknown' lifpemental, intellectual, physical, vision or hearing impairment)* Yes this information is not available. If yes, please specify:* ?	

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

Disability (neurolog Yes	No	pemental, intel nknown	tual, physical, :	vision or hearing	g impairment)*			
If yes, please speci	fy: <b>* </b>							
Hearing Impairm	ent							
Psychological/psyc Yes	No	* nknown						

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

1	No	University		
/es	No	Unknown	wn	

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

Other underly	ing condition	or risk behavior*							
Yes	No	Unknown							
If yes, please s	pecify: 😡								
Save						Previous	Next		\$

#### **13 Exposure Information**

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

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

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

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

		EXPOSURE INFORMATION
Patient Information	Ø	In the 14 days prior to illness onset, did the patient have any of the following exposures:*
SARS CoV-2 Testing	$\otimes$	Yes No Unknown
Clinical Course	Ø	Domestic travel (outside state of normal residence)*
Applicable Symptoms	$\otimes$	Ves No Unknown
Medical Conditions	Ø	If yes, please specify states: 🖸
Exposure Information		Select
Hospitalization, ICU & Death Information	۵	International Travel* Yes No Unknown
Vaccination History	۵	If yes, please specify country(s): @
Additional Comments	<b>a</b>	Select
Review & Submit	<b></b>	Cruise ship or vessel travel as passenger or crew member*       Yes     No       Unknown
		Is the workplace critical Infrastructure (e.g. healthcare setting, grocery store)* Yes No Unknown If yes, please specify workplace setting:
		If yes, please specify workplace setting: 🖸

1



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

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





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

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

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

Select		
<y AK</y 		
AL		
AR		
AS		
AZ		
CA		
20 		

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

Yes No Unknown	
yes, please specify states:* 🛛	
CA × AR × NV ×	x
nternational Travel*	
nternational Travel* Yes No Unknown f yes, please specify country(s): @	





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

Yes patient travelled is not known.	
yes, please specify country(s):* 🚱	
AFGHANISTAN	
ALBANIA	
ALGERIA	
AMERICAN SAMOA	
ANDORRA	
ANGOLA	
ANGUILLA	

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



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



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

No Unknown
No Unknown





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

es	No	Unknown	
.5	NU	Unknown	

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

Yes No Unknown If yes, please specify name of school/university/childcare center: @	ildcare center*			
If yes, please specify name of school/university/childcare center: $oldsymbol{\Theta}$	No Unknown	known		
	name of school/university/child	/university/childcare center: 😮		

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

Yes	No	Unknown		
nlassa sn	ecify name o	f correctional facility: 🕼		

11. Select the **appropriate answer** for *Community event/mass gathering*.

• If **Yes** is selected, the subsequent field is enabled. Enter the **name of the community event/mass gathering** in the subsequent textbox: *If yes, please specify name of community event/mass gathering*.

Charlowin		
f an an an in the second for a second band a second		
	f community quant/mass gathering:	f community event/mass gathering: 🚱



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

Yes	No	Unknown
es, please specif	y: 🔞	

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

ontact with a k	nown COVID	)-19 case (probable	e or confirmed)*
Yes	No	Unknown	
yes, please sp Select	ecify what ty	pe of contact?	

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

Yes No Unknown	
yes, please specify what type of contact?*	
Şelect	
Community-associated	
Healthcare-associated (patient, visitor, healthcare worker)	
Household contact	

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

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

Yes	No	Unknown		
yes, please spe	cify what t	ype of contact?*		
Healthcare-asso	ciated (patier	t, visitor, healthcare worker)	<ul> <li>Community-associated ×</li> </ul>	×
Inknown expos	ures in the	14 days prior to illness o	iset*	
		14 days prior to illness o	iset*	
Inknown expos Yes	ures in the No	14 days prior to illness o	set*	



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

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

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

Animal with con	firmed or suspected COVID-19*	
Yes	No Unknown	
lf yes, please sp	ecify: 🕑	
	nown COVID-19 case (probable or confirmed)*	
Yes	No Unknown	
f yes, please sp	ecify what type of contact?*	
Healthcare-asso	ciated (patient, visitor, healthcare worker) × Community-associate	× ×
	ures in the 14 days prior to illness onset*	
Yes	No	
Other unknown	exposures, please specify: 🚱	
Other exposure	s*	
Yes	No Unknown	
f yes, please sp	ecify: 😧	
s this part of ar	outbreak*	
Yes	No Unknown	
f ves, please sp	ecify the name of the outbreak: 🚱	
r yes, preuse sp		
Save		Previous Next



## 14 Hospitalization, ICU & Death Information

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

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

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

		HOSPITALIZATION, ICU & DEATH INFORMATION
Patient Information	0	Was the patient hospitalized?*
SARS CoV-2 Testing	0	Yes No Unknown
Clinical Course	0	
Applicable Symptoms	0	If hospitalized, was a translator required?* Yes No Unknown
Medical Conditions	0	If yes, please specify which language 🚱
Exposure Information	0	
Hospitalization, ICU & Death Information		If hospitalized, please provide admission and discharge dates:
Vaccination History	۵	Admission Date* Discharge Date*
Additional Comments	<b>a</b>	
Review & Submit	<u></u>	Was the patient admitted to an intensive care unit (ICU)?*         Yes       No         Unknown         If admitted to an ICU, please provide admission and discharge dates:         Admission Date       Discharge Date         mmr/dd/yyyy       Unknown         Did the patient die as a result of this illness?*         Yes       No         Unknown
hospitalization-rel	ated	r <b>Unknown</b> is selected for the conditional question, all subsequent fields are disabled. Death-related questions are not impacted by the conditional question: <i>Was the patient hospitalized?</i>

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

Was the patient hosp Yes	italized?* No Unknown		
	NoUnknown		
If yes, please specify	which language 🕼		

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

Admission Date*								Discharge Date*	
mm/dd/yyyy 🛗 🚺 Unknown							🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
4	Jun	-	ne 20 ~	<b>21</b>	•				
Su	Mo	Tu	We	Th	Fr	Sa	tensive care unit (ICU)?*		
30	31	1	2	3	4	5	Unknown		
6	7	8	9	10	11	12	vide admission and discharge dates:		
13	14	15	16	17	18	19	-		
20	21	22	23	24		26		Discharge Date	
				_		3	🛗 🔛 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

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

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

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



COVID-19 CASE REPORT	FORM				Section 7 of 10		
There are errors. Please make a se	lection for all requ	ired fields	OSPITALIZATION	I, ICU & DEATH	×		
Patient Information	0	Was the patient h		ospital discharge cannot be ne date of hospital admissio			
SARS CoV-2 Testing	Ø	Yes			ок		
Clinical Course	0	If hospitalized, was a t	randator required?*				
Applicable Symptoms	$\odot$		Vo Unknown				
Medical Conditions	0	If yes, please specify v	hich language 😡				
If hospitalized, please prov	vide admissio	n and discharge da	ites:				
Admission Date* 04/21/2021 Invalid Admission Date		🛗 🗌 Unkr	nown	Discharge Date* 04/20/2021 Invalid Discharge Da		<u></u>	Unknown

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

f admitted to an ICU, please provide	admission and discharge dates:	

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

Yes	No	Unknown			
lf yes, please p	rovide the da	te of death:			
Date of Death					

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



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Hospitalization, ICU & Death Information		If hospitalized, please provide admission and	discharge dates:	04/22/2021	
Vaccination History	<b>A</b>	Admission Date*		Discharge Date*	
		04/21/2021	🗰 🗌 Unknown	04/22/2021	🗰 🗌 Unknown
Additional Comments	₽				
Review & Submit	<b>A</b>	Was the patient admitted to an intensive care Yes No Unknown	unit (ICU)?*		
		Yes No Unknown If admitted to an ICU, please provide admissio	on and discharge dates:		
		Admission Date		Discharge Date	
		mm/dd/yyyy	Unknown	mm/dd/yyyy	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	🟥 🗌 Unknown		
		Save			Previous Next
1					100 0.02



# **15 Vaccination History**

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

COVID-19 CASE REPORT FORM				Section 8 of 10			
Please provide the vaccination history of th	patient related to this case.						
		VACCINA	TION HISTORY				
Patient Information	⊘ Has the patient	ever received a COVID-19 vac	cine?*				
SARS CoV-2 Testing	⊘ Yes	No Unknown					
Clinical Course	Ø						
Applicable Symptoms	Select	vide vaccine name/manufact	urer: 🕼				
Medical Conditions		pecify: 🕑					
Exposure Information	$\odot$						
Hospitalization, ICU & Death Information	Date Administer			Date Administered (2nd do	se)		
Vaccination History	mm/dd/yyyy		Unknown	mm/dd/yyyy		Unknown	
Additional Comments	<b></b>						
Review & Submit	<b>•</b>						
	Save				Previous	Next	

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

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

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





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

Yes	No Unknown Please select 'Other' if the name of vaccine is not listed in the dropdown ovide vaccine name/manufacturer:* ?	
Select		~
Moderna COVI	ID-19 Vaccine	
Pfizer COVID-1	19 Vaccine	
	D-19 Vaccine (Johnson and Johnson)	
Janssen COVID		

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

Dther	

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

0	Date	Adm	inist	tered	l (1st	t dos	se)*		Date Administered (2nd d	lose)	
	mm	n/dd/	<i>′</i> уууу	/				🛗 🗌 Unknown	mm/dd/yyyy	i H	Unknown
I	4	Jun	Jur	ne 20 ~	<b>21</b>	1 🗸					
	Su	Мо	Tu	We	Th	Fr	Sa				
	30	31	1	2	3	4	5				
	6	7	8	9	10	11	12				
	13	14	15	16	17	18	19				
	20	21	22	23	24	25	26			Previous	Next
	27	28	29		1	2	3				



Please Note: The Date Administered (1<sup>st</sup> dose) cannot occur after the Date Administered (2<sup>nd</sup> dose). The Date Administered (1st dose) must occur at least 21 days **BEFORE** the Date Administered (2<sup>nd</sup> dose), depending on the vaccine. If the User enters a Date Administered (1<sup>st</sup> dose) that occurs after Date Administered (2<sup>nd</sup> dose) and clicks **Next**, both fields are marked as invalid; the screen is grayed out and displays a popup message that states: *The administration date of second dose cannot be earlier than administration date of* 1<sup>*st*</sup> *dose.* To proceed, the click **OK**, then enter a valid Date Administered ( $2^{nd}$  dose) that occurs **after** the Date Administered (1<sup>st</sup> dose). There are errors. Please make a selection for all required fields. × VACCINATION HISTORY The administration date of second dose cannot be 63 earlier than administration date of 1st Dose  $\odot$ Patient Information Has the patient  $\odot$ SARS CoV-2 Testing Clinical Course If yes, please provide vaccine name/manufacturer:\* @  $\odot$ Applicable Symptoms Pfizer COVID-19 Vaccine  $\odot$ Medical Conditions If other, please specify: 🚱 Exposure Information  $\odot$ Date Administered (1st dose)\* Date Administered (2nd dose) Hospitalization, ICU & Death Information 🛗 🗌 Unknown 🛗 🗌 Unknown

ate Administered (1st dose)*		Date Administered (2nd dose)	
05/30/2021	Unknown	05/21/2021	🛗 🗌 Unknown
valid Date Administered (1st dose)		Invalid Date Administered (2nd dose)	

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

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

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## **16 Additional Comments**

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

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

#### 17 Review & Submit

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

#### Print or Download Functionality

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

COVID-19 CASE REPORT FORM				Section 10 of 10			
Please review your information before submitting.							
		REVIEW &					
Patient Information	$\odot$						
SARS CoV-2 Testing	0					🖶 Print	Download
Clinical Course	0	Patient Information					۵
Applicable Symptoms	0						
Medical Conditions	0	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organizati Test Medical Center	ion			
Exposure Information	${\boldsymbol{\oslash}}$	Patient ID (MRN) SR04011960	Prefix Miss				
Hospitalization, ICU & Death Information	${\boldsymbol{ \oslash}}$	First Name	Last Name				
Vaccination History	$\odot$	Susan Date of Birth	Ross				
Additional Comments	${\boldsymbol{\oslash}}$	04/01/1960					
Review & Submit		Patient Sex Female	Ethnicity Not Hispanic or Latir	10	Race White		
		Address 1 123 First Street					



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

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

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

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

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



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

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

📓 Welcome to Kentucky Online Ga: 🗙 📙 KHIE Portal 🛛 🗴 😒 COVID-19 Case Report Form.pdf 🗴 -	+		<b>o</b> – a ×
$\leftrightarrow$ $\rightarrow$ C $\triangle$ ( File   C;/Users, /Downloads/COVID-19%20Case%20Report%20Form.pdf			🖈 💶 🛛 🛠 🙆 Paused) 🗄
			_
	1 / 6   - 100% +   🗄 🔊		± ē :
a a a a a a a a a a a a a a	Patient Information Interviewer Name Or. Jerry Seinfeld, Sr (jerryBenall.com) Affiliation/Organization Fast Medical Center Patient 10 (HINI) Ssolod 11900 First Name Sustan Date of Sinth Object of Sinth Object of Sinth Fersias Fersias Fersias	Profix Miss Last Name Ross Ethnicity Not Hispanic or Latino	

4. Review the *Patient Information* section.

SARS CoV-2 Testing	0				Print	
Clinical Course	0	Patient Information				
Applicable Symptoms	0	Parent monthaton				
Medical Conditions	0	Interviewer Name Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center			
Exposure Information	0	Patient ID (MRN) SR04011960	Prefix Miss			
Hospitalization, ICU & Death Information	0	First Name	Last Name			
Vaccination History	0	Susan	Ross			
Additional Comments	0	Date of Birth 04/01/1960				
Review & Submit		Patient Sex Female	Ethnicity Not Hispanic or Latino	Race		
		Address 1 123 First Street		0.000074		
		City Lexington	State KY	<b>Zip Code</b> 40321		
		County Fayette	Phone (555) 321-0123	Email patient1@email.com		
		Was this person a U.S. case? Yes				
		Where was the patient residing at the time of illness onset? House/single family home				
		Is the patient a healthcare worker in the United States? Yes				
		If yes, what is the patient's occupation/job type? Nurse				
		If yes, what is the patient's job setting? Hospital				
		Is patient currently pregnant? No				





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

Patient Information			٢
<b>Interviewer Name</b> Dr. Jerry Seinfeld, Sr (jerry@email.com)	Affiliation/Organization Test Medical Center		
Patient ID (MRN) SR04011960	Prefix Miss		
First Name Susan	Last Name Ross		
Date of Birth 04/01/1960			
Patient Sex Female	Ethnicity Not Hispanic or Latino	Race White	
Patient Information			٢
Sars CoV-2 Testing			٥
Does the patient have a lab test? Yes			

5. Review the Sars CoV-2 Testing section.

Sars CoV-2 Testing			4
Does the patient have a lab test? Yes			
Molecular Amplification Test (RT PCR)			
Test Name	Test Result	Filler Order/Accession Number	
SARS coronavirus 2 E gene [Cycle Threshold #] in	Negative	SR03012021	
Unspecified specimen by NAA with probe detection			
Serologic Test			
Test Name	Test Result	Filler Order/Accession Number	
SARS coronavirus 2 Ab [Interpretation] in Serum or Plasma	Undetermined/Inconclusive	SR03302021	
Antigen Test			
Test Name	Test Result	Filler Order/Accession Number	
BinaxNOW COVID Test Kit	Positive	SR05082021	
BinaxNOW COVID Test Kit	Pending	SR06222021	

6. Review the *Clinical Course* section.





Clinical Course	٥
Disease/Organism COVID-19	
Did the patient develop pneumonia? Yes	
Did the patient receive mechanical ventilation(MV)/intubation? Yes	
If yes, total days with MV (# of days): 1-15 Days	
Did the patient have an abnormal chest X-ray? Unknown	
Did the patient have another diagnosis/etiology for their illness? No	
Did the patient have acute respiratory distress syndrome? Unknown	
Did the patient have an abnormal EKG? No EKG Done	
Did the patient receive ECMO?	

7. Review the *Applicable Symptoms* section.

Applicable Symptoms	٥
Were symptoms present during the course of illness? Yes	
Onset Date 06/10/2021	
Did the patient's symptoms resolve? No	
If symptomatic, which of the following did the patient experience during their illness?	
Fever Yes	
Subjective fever (felt feverish) Yes	
Chills Yes	
Rigors No	
Muscle aches (myalgia) No	
Runny nose (rhinorrhea) No	
Sore throat No	
New olfactory and taste disorder(s) No	
Headache Yes	
Fatigue Yes	
Cough (new onset or worsening of chronic cough) Yes	
Wheezing Yes	
Shortness of breath (dyspnea) Yes	
Chest pain No	







8. Review the *Medical Conditions* section.

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





9. Review the *Exposure Information* section.

Exposure Information	٥	•
In the 14 days prior to illness onset, did the patient have any of the following exposure of Yes		
Domestic travel (outside state of normal residence) Yes		
If yes, please specify states: CA , AR , NV		
International Travel Yes		
lf yes, please specify country(s): BAHAMAS. THE , CANADA		
Cruise ship or vessel travel as passenger or crew member No		
Is the workplace critical infrastructure (e.g. healthcare setting, grocery store) Yes		
lf yes, please specify workplace setting: Hospital		
Airport/airplane Yes		
If yes, please specify airline(s): Deita		
Adult congregate living facility (nursing, assisted living or long-term care facility) No		
School/university/childcare center No		
Correctional facility No		
Community event/mass gathering No		
Animal with confirmed or suspected COVID-19 No		
Contact with a known COVID-19 case (probable or confirmed) Yes		
l <b>f yes, please specify what type of contact?</b> Healthcare-associated (patient, visitor, healthcare worker) , Community-associated		\$

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

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





11. Review the Vaccination History section.

Vaccination History		0
Has the patient ever received a COVID-19 vaccine? Yes		
If yes, please provide vaccine name/manufacturer: Pfizer COVID-19 Vaccine		
Date Administered (1st dose) 05/30/2021	Date Administered (2nd dose) 06/21/2021	

12. Review the Additional Comments section.

Additional Comments			٥	
Additional comments or notes, please specify: Patient Notes			\$	\$
	Previous	Submit		

#### Click Hyperlinks to Edit

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

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



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

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

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

		PATIENT INFORMATION	
Patient Information	Ø	Interviewer Name* Affiliation/Organization*	
SARS CoV-2 Testing	0	Dr. Jerry Seinfeld, Sr (jerry@email.c., X   ~ ) Test Medical Center X   ~	
Clinical Course	Ø	Save Changes? ×	
Applicable Symptoms	$\odot$	SR04011960 There's information on this screen that has not been saved.	
Medical Conditions	Ø	Do you want to save it? First Name* Last Name*	
Exposure Information	$\oslash$	Susan No - Discard Yes - Save	
Hospitalization, ICU & Death Information	$\oslash$	Suffix Date of Drivin	
Vaccination History	$\odot$	Select 🗸	

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

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



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

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

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

	vaccination	THISTOLY		•
	Has the patie	Case Report Entry	×	
	Yes If yes, please Pfizer COVID- Date Adminis 05/30/2021	like to make changes now, please click the Ca	n. If you would ncel button.	e Administered (2nd dose) 21/2021
-	•			Should you later discover that <b>Tab</b> in the ePartnerViewer to

report this information.

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

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

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

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



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

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

ratient	Search	Bookma	rked Patients		Event Notification	is <mark>1</mark> )	Lab Data	Entry -	Case	e Report Entry 🕶
Home	Case Report Entry	User Summary								
				FRODT				/		
			CASE R	EPORT	ENTRY	USER SUI	VIVIARY	ſ		
LAST UPE	DATED DATE RAN	GE	Start Date	e 06/24/2021	曲	End [	Date 06/24/2021	1 #		2 Retrieve Data
	CASE AST UPDATED DATE RANGE Star TRMS TIONS REPORT TYPE * AFFILIATION/OR GANIZATION * PATIENT MR									
ITEMS									₽ REFRESH	T APPLY FILTER
	REPORT TYPE +		PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH *	PATIENT SEX	STATUS 🗘	₽ REFRESH	T APPLY FILTER
		GANIZATION +	PATIENT MRN + SR04011960	FIRST NAME +	LAST NAME *	DATE OF BIRTH \$ 04/01/1960		STATUS ÷ Complete	LAST UPDATED	

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

			CASE R	EPORT	ENTRY	USER SUI	MMARY	<i>'</i>		
LAST UPD	ATED DATE RAN	GE	Start Date	06/24/2021	曲	End [	Date 06/24/2021	曲		2 Retrieve Data
SHOWING 2 ITEMS				∮ <b>June 20</b> June ❤ Su Mo Tu We	2021 🗸				₿ REFRESH	<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN +	30 31 1 2 6 7 8 9	3 4 5 10 11 12	DATE OF BIRTH	PATIENT SEX	STATUS +	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	13 14 15 16 20 21 22 23 27 28 29 30	24 25 26	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM
Continue	COVID-19	Test Medical Center	CK01231955	Cosmo	Kramer	01/23/1955	Male	In Progress	06/24/2021 2:22 PM	

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

			CASE R	EPORT I	ENTRY	USER SUI	MMARY	1		
LAST UPD	ATED DATE RAN	GE	Start Date	e 06/21/2021		End D	06/24/2021	#		₿ Retrieve Data
SHOWING 2 ITEMS									₿ REFRESH	<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
View	COVID-19	Test Medical Center	SR04011960	Susan	Ross	04/01/1960	Female	Complete	06/24/2021 4:13 PM	06/24/2021 4:13 PM

Direct Data Entry for Electronic Case Reports: COVID-19 User Guide



**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 R	EPORT I	ENTRY	USER SUI	MMARY	7		
C LAST UPD	ATED DATE RAN	GE	Start Date	12/03/2020		End D	oate 06/25/2021	#		2 Retrieve Dat
Please select a	Start Date that is with	nin the last six month	s from today's date.							
SHOWING 2 ITEMS									2 REFRESH	
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
Continue	COVID-19	Test Medical Center	GC05281960	George	Costanza	05/28/1960	Male	In Progress	06/25/2021 2:24 PM	
	COVID-19	Test Medical	JD06201965	lane	Doe	06/20/1965	Female	Complete	06/25/2021 1:53	06/25/2021 1:53 P

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

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

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

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





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

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

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

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

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



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

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

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

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

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

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

# **19 Technical Support**

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

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

#### **Email Support**

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

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.

