

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Electronic Case Reports: Child Hepatitis

User Guide

August 2022

Copyright Notice

© 2021 Deloitte. All rights reserved.

Trademarks

"Deloitte," the Deloitte logo, and certain product names that appear in this document (collectively, the "Deloitte Marks"), are trademarks or registered trademarks of entities within the Deloitte Network. The "Deloitte Network" refers to Deloitte Touche Tohmatsu Limited (DTTL), the member firms of DTTL, and their related entities. Except as expressly authorized in writing by the relevant trademark owner, you shall not use any Deloitte Marks either alone or in combination with other words or design elements, including, in any press release, advertisement, or other promotional or marketing material or media, whether in written, oral, electronic, visual, or any other form. Other product names mentioned in this document may be trademarks or registered trademarks of other parties. References to other parties' trademarks in this document are for identification purposes only and do not indicate that such parties have approved this document or any of its contents. This document does not grant you any right to use the trademarks of other parties.

Illustrations

Illustrations contained herein are intended for example purposes only. The patients and providers depicted in these examples are fictitious. Any similarity to actual patients or providers is purely coincidental. Screenshots contained in this document may differ from the current version of the HealthInteractive asset.

Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited, a UK private company limited by guarantee ("DTTL"), its network of member firms, and their related entities. DTTL and each of its member firms are legally separate and independent entities. DTTL (also referred to as "Deloitte Global") does not provide services to clients. In the United States, Deloitte refers to one or more of the US member firms of DTTL, their related entities that operate using the "Deloitte" name in the United States and their respective affiliates. Certain services may not be available to attest clients under the rules and regulations of public accounting. Please see www.deloitte.com/about to learn more about our global network of member firms.

Document Control Information

Document Information

Document Name	Direct Data Entry for Electronic Case Reports: Child Hepatitis User Guide
Project Name	KHIE
Client	Kentucky Cabinet for Health and Family Services
Document Author	Deloitte Consulting
Document Version	2.2
Document Status	Final Draft
Date Released	8/23/2022

Document Edit History

Version	Date	Additions/Modifications	Prepared/Revised by
1.0	06/16/2022	Initial Draft	Deloitte Consulting
1.1	07/17/2022	KHIE Review	KHIE
2.0	08/02/2022	Revised Draft - Includes updates from KHIE review	Deloitte Consulting
2.1	08/23/2022	KHIE Review	KHIE
2.2	08/23/2022	Revised Draft - Includes updates from KHIE review	Deloitte Consulting
	07/29/2024	Updated KHIE Phone Number	Charlese Blair KHIE

Table of Contents

1	Introduction	5
	Overview	5
	Supported Web Browsers	5
	Mobile Device Considerations	6
	Accessing the ePartnerViewer	6
2	Logging into the ePartnerViewer	6
	Terms and Conditions of Use and Logging In.....	8
3	Understanding the Case Report Entry Dropdown Menu	10
4	Manage User Preferences.....	13
	Create Attending Physician/Clinician Details	13
	View & Edit Attending Physician/Clinician Details	16
	Delete Attending Physician/Clinician Details	17
	Filter Attending Physician/Clinician Details.....	19
	Create Person Completing Form Details	20
	View & Edit Person Completing Form Details	23
	Delete Person Completing the Form Details	24
	Filter Person Creating Form Details	25
5	Basic Features in the Case Report Entry Form	26
	Side Navigation Bar & Pagination	26
	Save Feature.....	27
	Case Report Entry Icons.....	27
	Conditional Questions	28
6	Affiliation/Organization Conditional Question	32
	Affiliation/Organization Conditional Answer: Yes	33
	Affiliation/Organization Conditional Answer: No	34
	Affiliation/Organization Validation	36
	Change Affiliation/Organization Conditional Answer: No to Yes	37
	Change Affiliation/Organization Conditional Answer: Yes to No	39
7	Dynamic Functions based on Disease/Organism	41
	Change or Save Disease/Organism Selection	41
8	Dynamic Screens for Child Hepatitis Case Report.....	44
	Laboratory Information: Dynamic Screen.....	44
	Vaccination History: Dynamic Screen	45
9	Tips for Manually Entering Case Report Data	47
10	Child Hepatitis Case Report Form	49

11 Patient Information	50
Person Completing Form Hyperlink.....	54
Attending Physician/Clinician Hyperlink.....	57
12 Laboratory Information.....	67
Adding Multiple Hepatitis Markers	70
Adding ALT.....	71
Adding AST	72
Adding Bilirubin	73
13 Exposure Information	74
14 Hospitalization, ICU & Death Information	77
15 Vaccination History	81
Vaccination History for Child Hepatitis B	81
Adding Multiple Vaccines	84
Vaccination History for Child Hepatitis C	87
16 Additional Comments	87
17 Review and Submit.....	88
Print or Download Functionality.....	88
Click Hyperlinks to Edit	93
18 Case Report User Entry Summary.....	96
Review Previously Submitted Case Reports.....	98
Copy Previously Submitted Case Reports	99
Continue In-Progress Case Reports	104
19 Technical Support.....	105
Toll-Free Telephone Support	105
Email Support.....	105

1 Introduction

Overview

This training manual covers KHIE's Direct Data Entry for Child Hepatitis Electronic Case Reports functionality in the ePartnerViewer. Users with the *Manual Case Reporter* role can submit electronic case reports from the ePartnerViewer by completing an online case report. The process generates a manual electronic initial case report (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 **not** support Microsoft Internet Explorer. To access the ePartnerViewer, Users must use a modern browser such as Google Chrome, Microsoft Edge, Apple Safari, or Mozilla Firefox.

Mobile Device Considerations

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

Accessing the ePartnerViewer

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

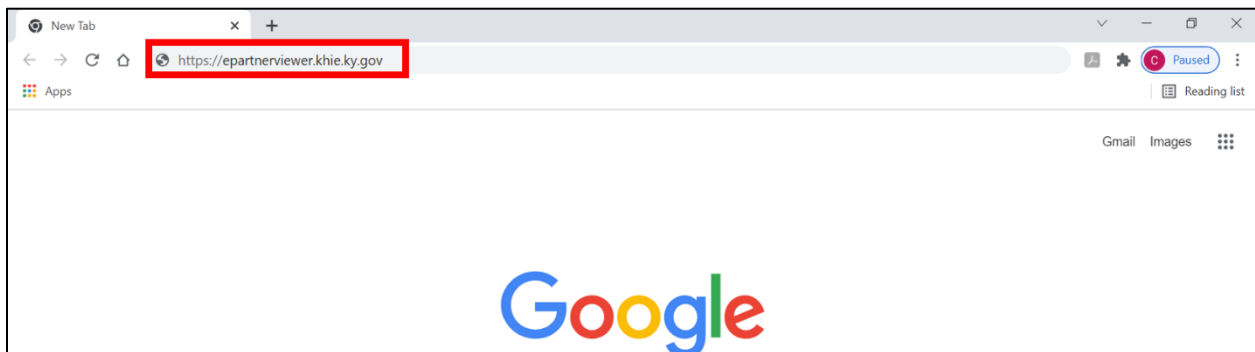
1. Users must be part of an organization with a signed Participation Agreement with KHIE.
2. Users are required to have a Kentucky Online Gateway (KOG) account.
3. Users are required to complete Multi-Factor Authentication (MFA).

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

2 Logging into the ePartnerViewer

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

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



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

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

MYKY
MyKentucky.gov

FAQ | Help | English

Welcome to the Kentucky Online Gateway

- Are you doing business in or with the Commonwealth of Kentucky?
- Are you a citizen or resident applying for or receiving benefits?
- Are you seeking government services from the Commonwealth?

If you answered "Yes" to any one of these questions, please sign into your existing Kentucky Online Gateway account or click on the button below to create an account.

SIGN IN **CREATE ACCOUNT**

State Employee Gateway Login

Login to your State Employee account using:

EMAIL ADDRESS

Please Note: If you are a State Employee, click **Email Address** under the *State Employee Gateway Login* section on the right side of the **Welcome to the Kentucky Online Gateway** screen.

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

MYKY
MyKentucky.gov

FAQ | Help | English

Citizen (or) Business Partner Sign In

Sign in with your Kentucky Online Gateway Account.

Email Address
Enter Email Address

Password [Forgot/Reset Password?](#)
Enter Password

SIGN IN

[Resend Account Verification Email](#)

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.

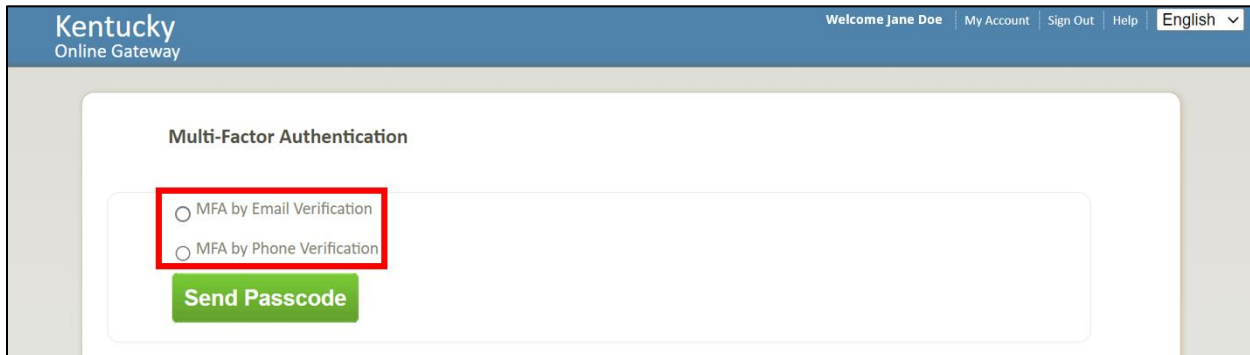
Don't already have a Kentucky Online Gateway Citizen Account?

Create An Account

[Click here to select user account type](#)

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

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



Kentucky Online Gateway

Welcome Jane Doe | My Account | Sign Out | Help | English

Multi-Factor Authentication

☒ MFA by Email Verification

☐ MFA by Phone Verification

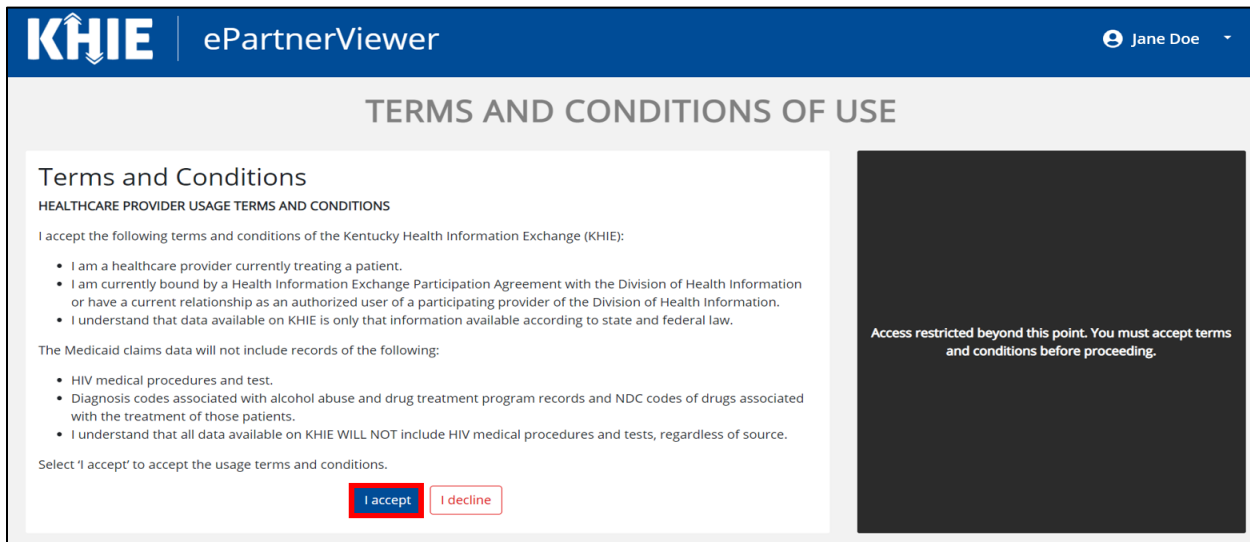
Send Passcode

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

Terms and Conditions of Use and Logging In

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

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



KHIE | ePartnerViewer

Jane Doe

TERMS AND CONDITIONS OF USE

Terms and Conditions

HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

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

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

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

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

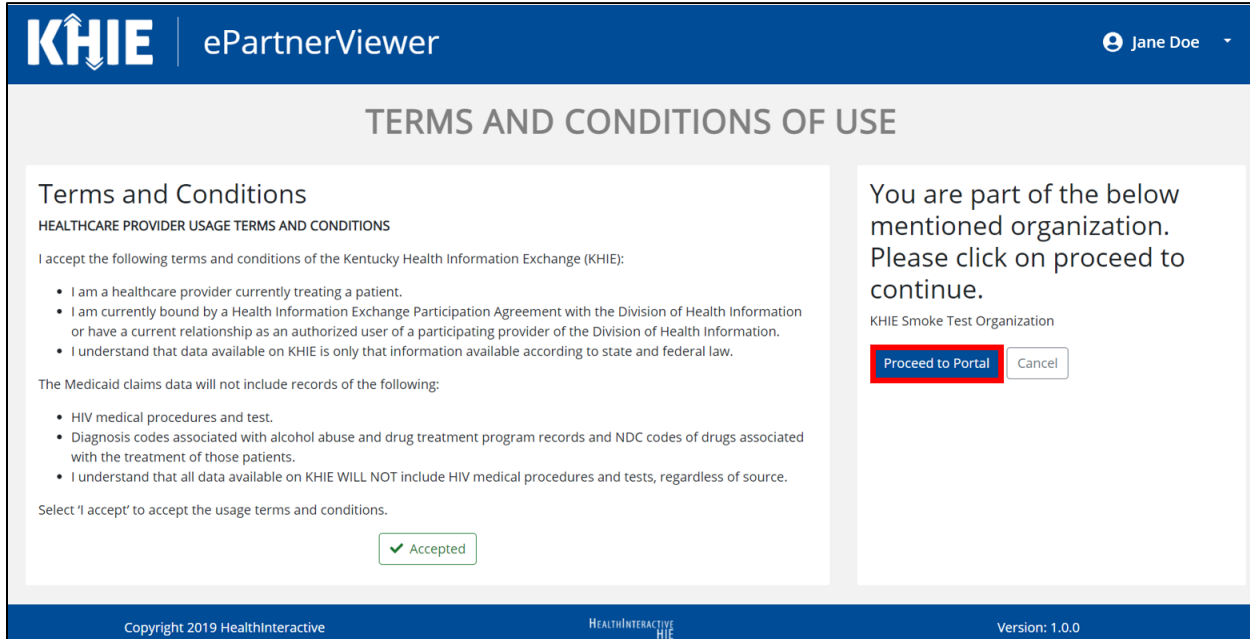
Select 'I accept' to accept the usage terms and conditions.

I accept **I decline**

Access restricted beyond this point. You must accept terms and conditions before proceeding.

Please Note: The right side of the Portal is grayed out and displays a message that states: *Access is restricted beyond this point. You must accept the terms and conditions before proceeding.*

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

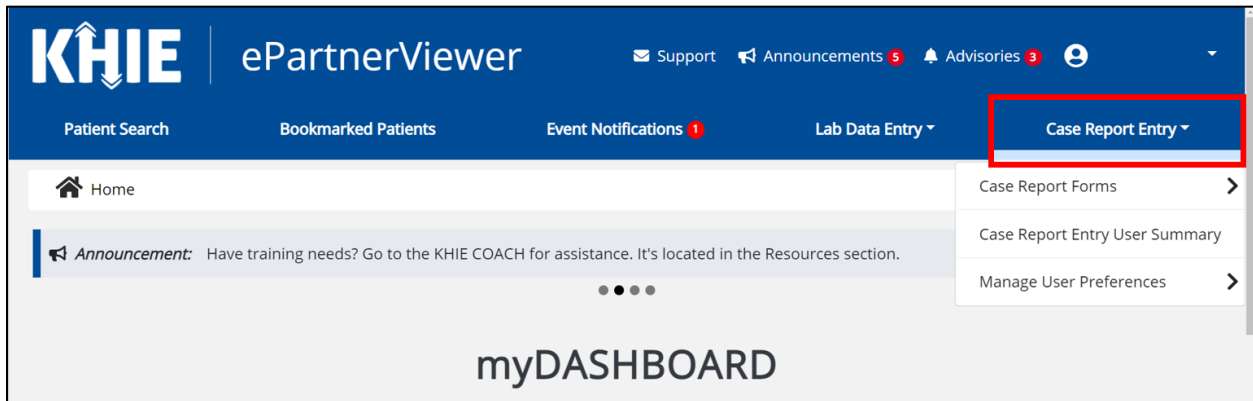


Please Note: If you click **Cancel**, a pop-up notification displays that indicates that you are *about to be logged out*. Use of the ePartnerViewer portal is subject to the acceptance of KHIE's Terms of Use. To proceed to the ePartnerViewer, click either **Logout Now** or **Cancel**.

3 Understanding the Case Report Entry Dropdown Menu

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

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



1. Types of Case Reports:

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

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

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

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

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

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

- **Perinatal Hepatitis Case Report:**

- Designed for Users to enter Perinatal Hepatitis case reports.

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

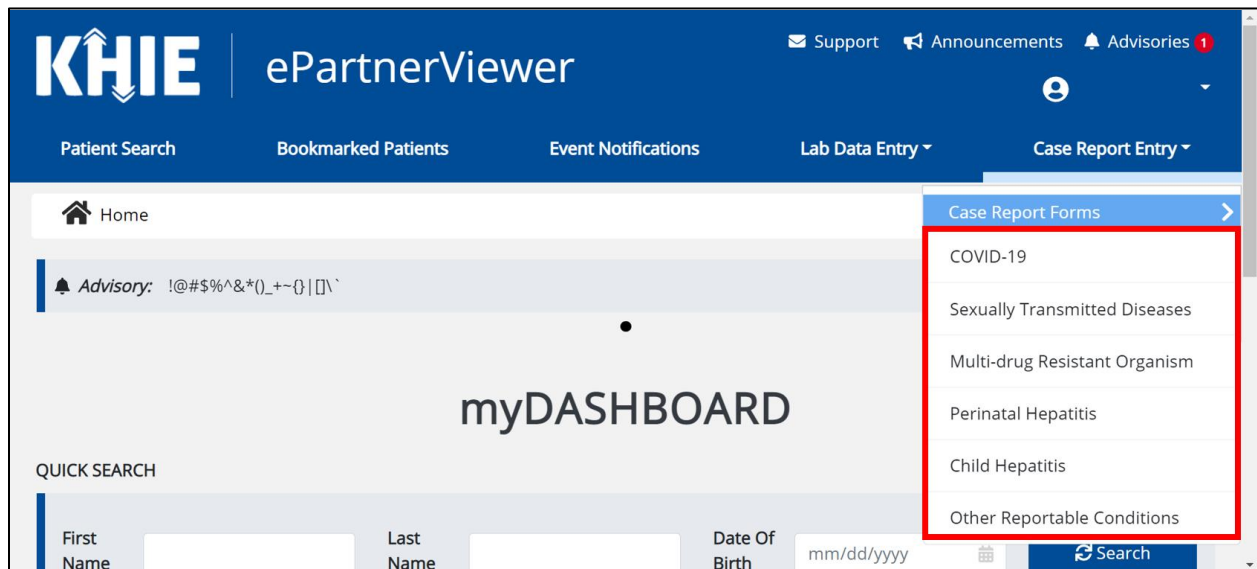
- **Child Hepatitis Case Report:**

- Designed for Users to enter Child Hepatitis case reports.

- **Other Reportable Conditions Case Report:**

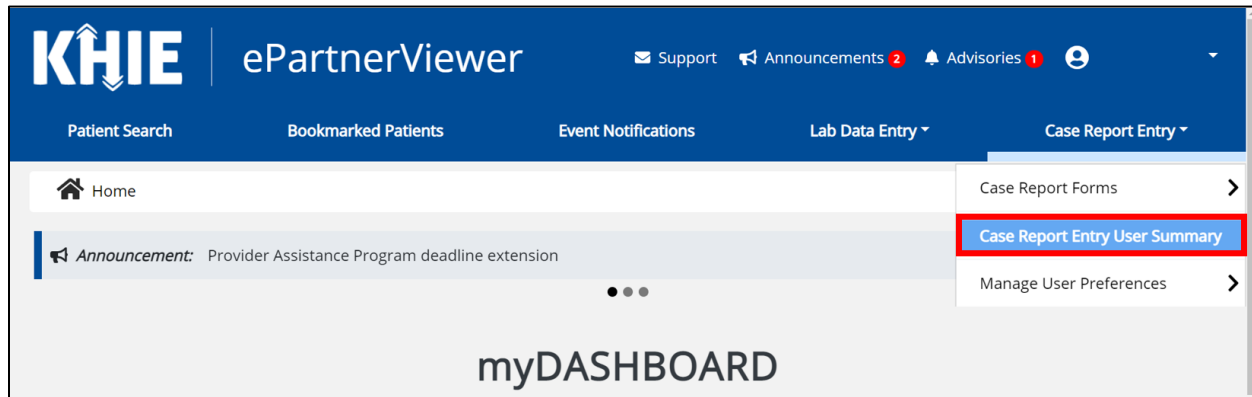
- Designed for Users to enter Other Reportable Conditions case reports.

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*.



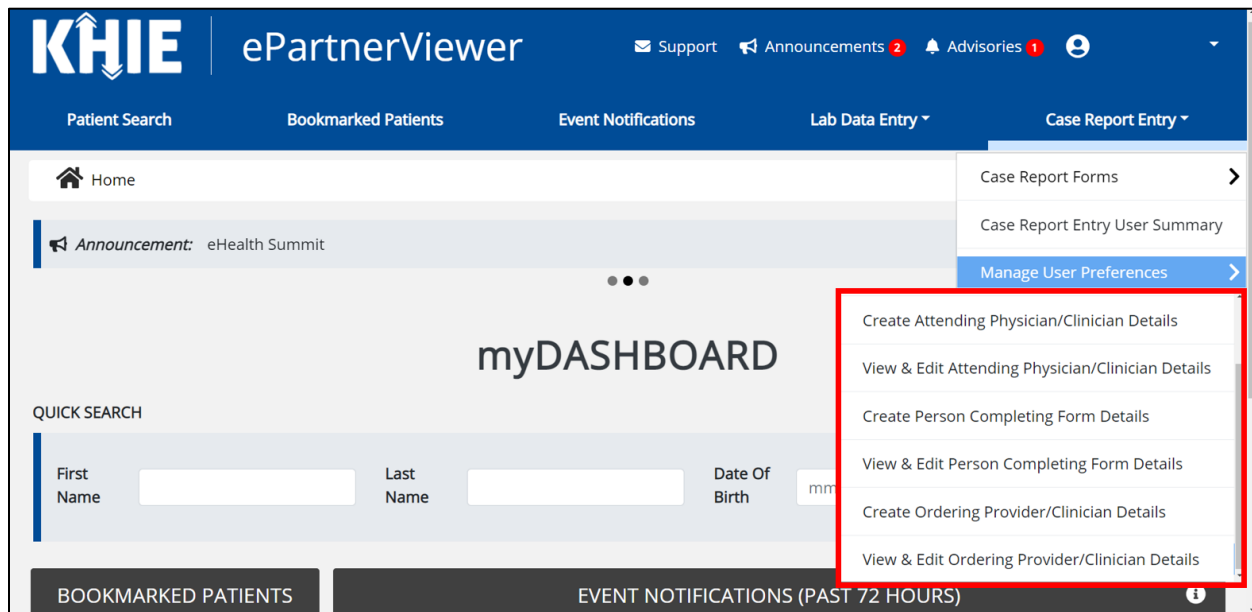
2. Case Report Entry User Summary:

- 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”.



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.



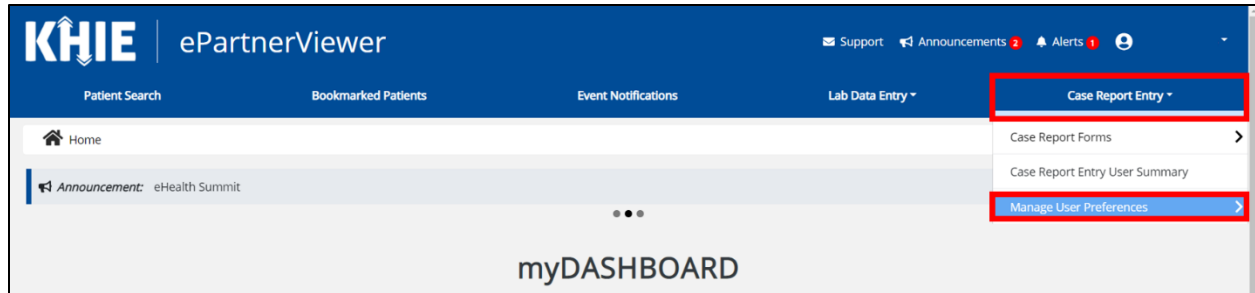
4 Manage User Preferences

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

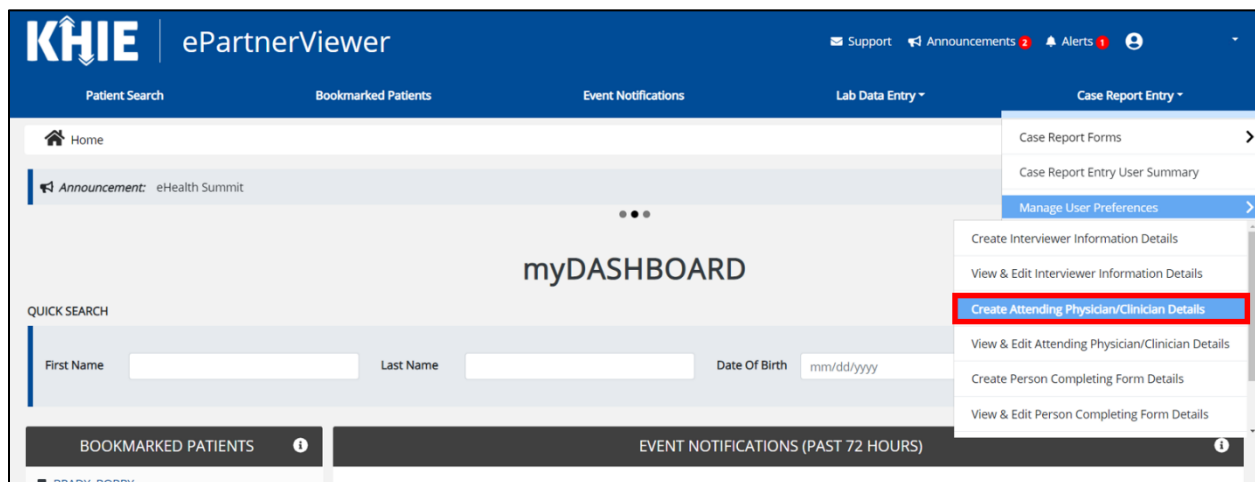
By entering these details here in your user preferences, you will be able to quickly select an Attending Physician/Clinician and the name of the Person Completing the Form from the dropdown menu options. These dropdown menus are located on the **Patient Information** screen of the Child Hepatitis Case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

Create Attending Physician/Clinician Details

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



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



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

Home > Create Attending Physician/Clinician Details

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix: Dr.

First Name*:

Last Name*:

Suffix: Select...

Address 2: Unit, Suite, Building, etc.

State*: Select...

Zip Code*:

Email*: name@domain.com

Clear Save

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix: Dr.

First Name*:

Last Name*:

Suffix: Sr

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

Address 1*:

Address 2: Unit, Suite, Building, etc.

City*:

State*: Select...

Zip Code*:

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

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

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

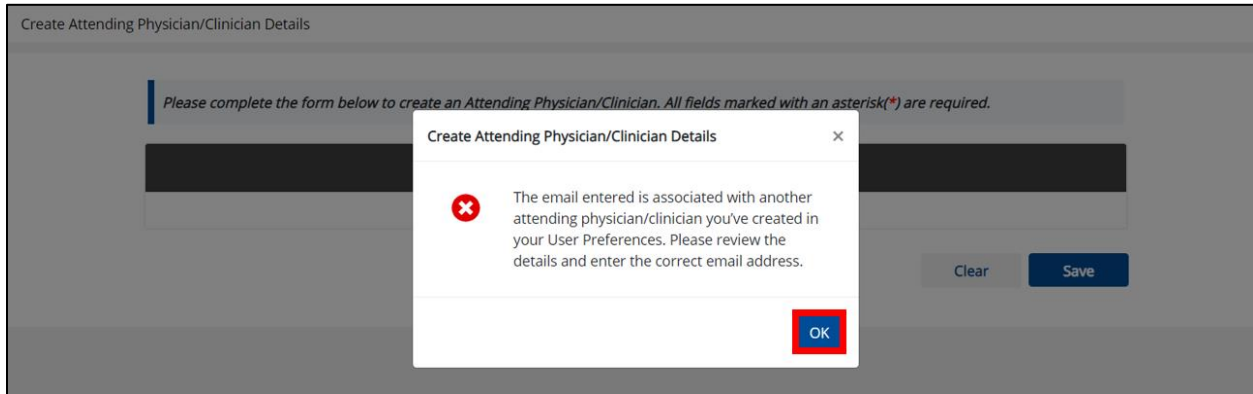
9. After completing the mandatory fields, click **Save**.

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

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

The email entered is associated with another physician/clinician you've created in your User Preferences. Please review the details and enter the correct email address.

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

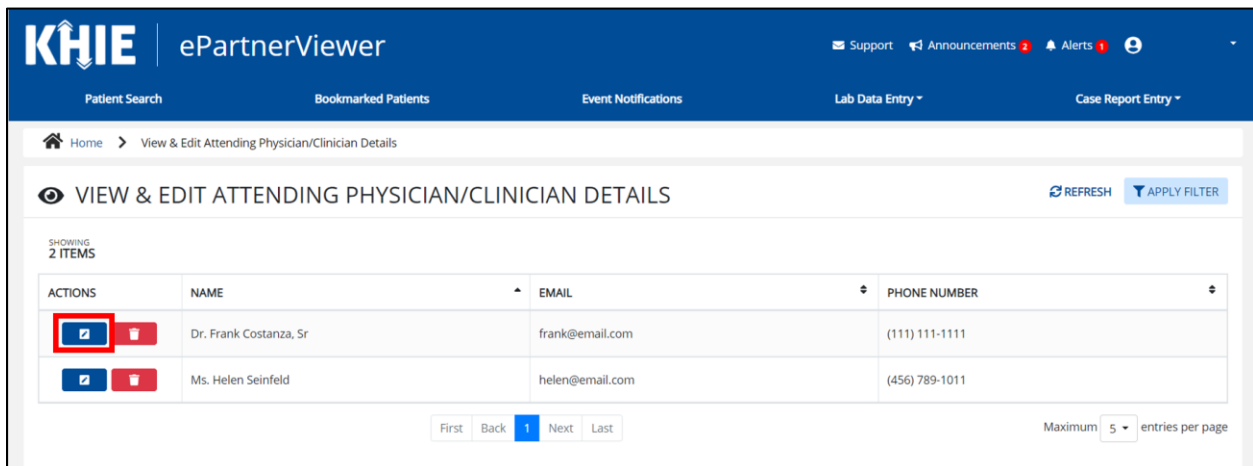


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.



View & Edit Attending Physician/Clinician Details

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



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

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

Delete Attending Physician/Clinician Details

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

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

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

The screenshot shows the 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' interface. A pop-up window titled 'Delete Attending Physician/Clinician Details' is centered on the screen, asking 'Are you sure?' with 'Cancel' and 'OK' buttons. The background table lists one item: Dr. Frank Costanza, Sr. with a phone number (111) 111-1111. The interface includes a 'SHOWING 1 ITEMS' header, 'ACTIONS' column with edit and delete icons, and a 'PHONE NUMBER' column. A 'Maximum 5 entries per page' indicator is at the bottom right.

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

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

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

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

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

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

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

Filter Attending Physician/Clinician Details

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

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS'. Below the title, there is a 'REFRESH' button and a red 'APPLY FILTER' button. A table displays 2 items, with columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The table lists Dr. Frank Costanza, Sr. and Ms. Helen Seinfeld. At the bottom, there are pagination controls (First, Back, 1, Next, Last) and a 'Maximum 5 entries per page' setting.

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

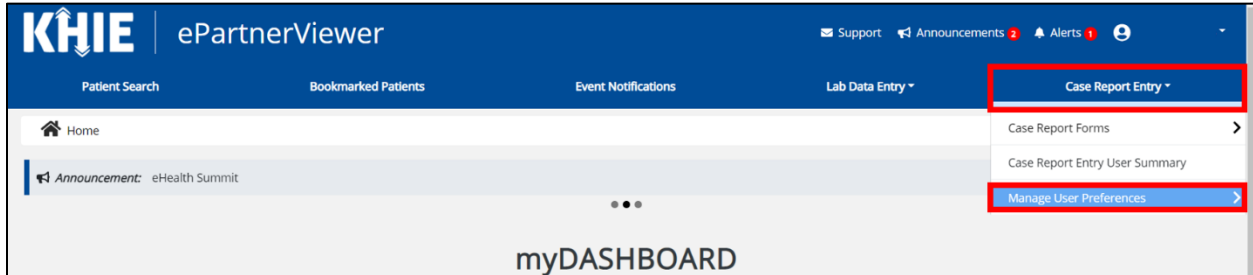
17. The Filter fields display. You can search by entering the **Attending Physician/Clinician's Name**, **Email Address**, and/or **Phone Number** in the corresponding Filter fields.

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS'. Below the title, there is a 'REFRESH' button and a red 'HIDE FILTER' button. A table displays 2 items, with columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The table lists Dr. Frank Costanza, Sr. and Ms. Helen Seinfeld. At the bottom, there are pagination controls (First, Back, 1, Next, Last) and a 'Maximum 5 entries per page' setting. The filter fields (NAME, EMAIL, PHONE NUMBER) are highlighted with red boxes.

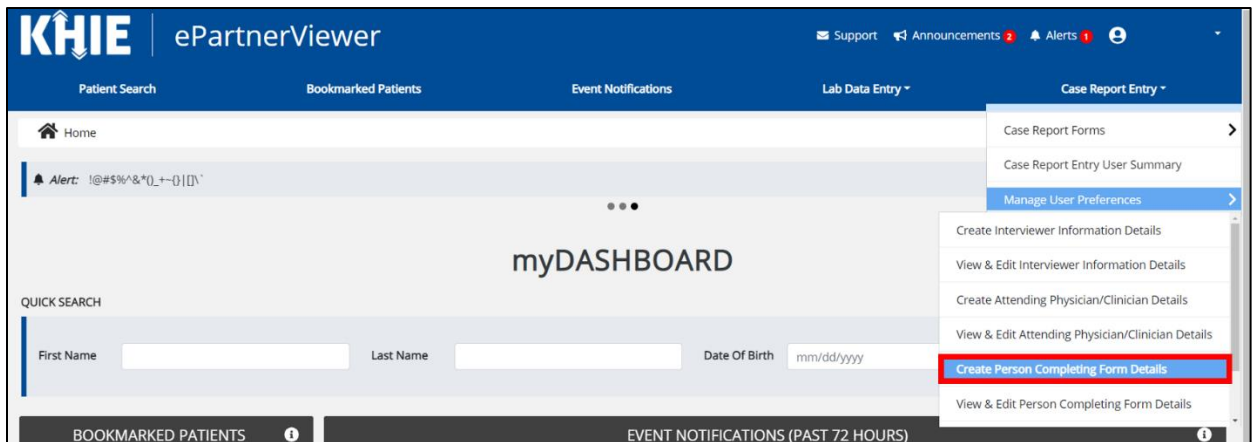
ACTIONS	NAME	EMAIL	PHONE NUMBER
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

Create Person Completing Form Details

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



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



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

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

PERSON COMPLETING FORM

Prefix: Mr. [X] [v]

First Name* [] Last Name* []

Suffix: [select...] [v]

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

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

State* [select...] [v] Zip Code* []

Email* [name@domain.com]

(xxx) xxx-xxxx

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

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

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

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

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

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

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

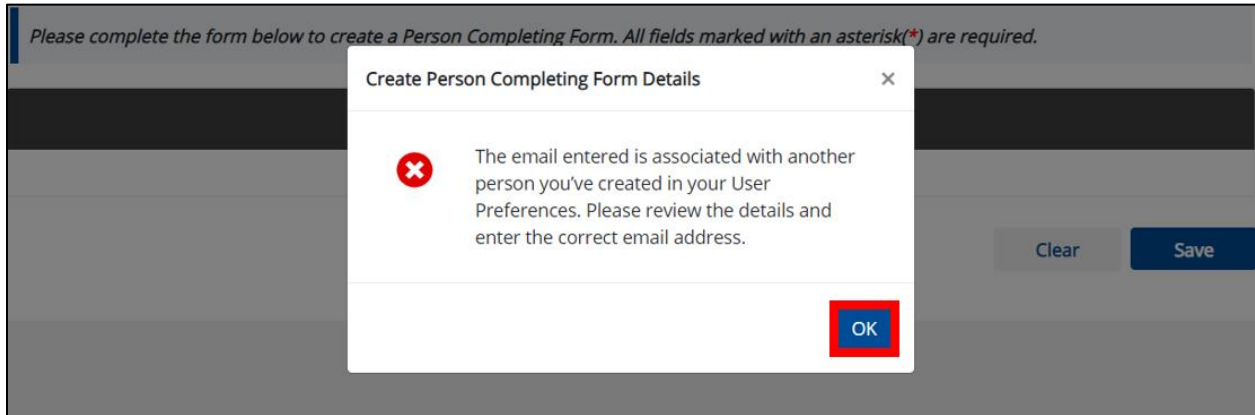
- After completing the mandatory fields, click **Save**.

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

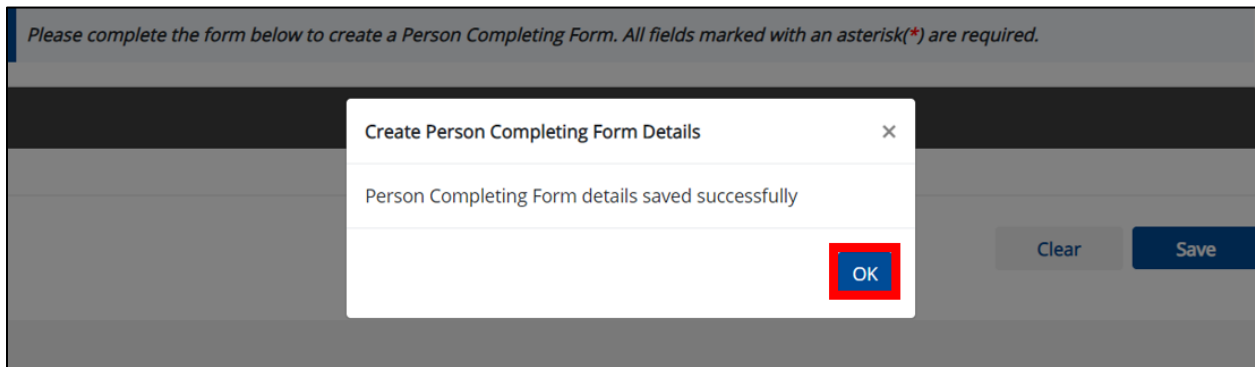
Please Note: If you enter an email address that is already associated with another Person Completing Form and click **Save**, a pop-up displays with an error message that states:

The email entered is associated with another person you've created in your User Preferences. Please review the details and enter the correct email address.

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







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



View & Edit Person Completing Form Details

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

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

First Back 1 Next Last

Maximum 5 entries per page

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

Prefix: Mr.

First Name: Arthur

Last Name: Vandelay

Suffix: II

Address 1: 22 Second Avenue

Address 2: Unit, Suite, Building, etc.

City: Lexington

State: KY

Zip Code: 40222

Phone: (222) 222-2222

Email: arthur@email.com

Cancel Save

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





Update Person Completing Form Details

Person Completing Form details updated successfully





OK


Delete Person Completing the Form Details

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

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

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

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

 Delete Person Completing Form Details

Are you sure?

Cancel

OK





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


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


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

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

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

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

 Delete Person Completing Form Details

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

OK

Filter Person Creating Form Details

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

The screenshot shows the 'VIEW & EDIT PERSON COMPLETING FORM DETAILS' page in the KHIE ePartnerViewer. The page has a blue header with the KHIE logo and navigation links. Below the header, there's a breadcrumb trail: Home > View & Edit Person Completing Form Details. The main content area has a title 'VIEW & EDIT PERSON COMPLETING FORM DETAILS' and a 'REFRESH' button. A red box highlights the 'APPLY FILTER' button. Below this, there's a table with 2 items. The table has columns: ACTIONS, NAME, EMAIL, and PHONE NUMBER. The first row is for Dr. Estelle Costanza, and the second row is for Mr. Arthur Vandelay, II. At the bottom of the table, there are pagination controls: First, Back, 1 (selected), Next, Last. A dropdown menu shows 'Maximum 5 entries per page'.

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

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

The screenshot shows the same 'VIEW & EDIT PERSON COMPLETING FORM DETAILS' page, but with filter fields added to the table headers. The 'NAME' header has a text input field 'Enter Name...', the 'EMAIL' header has a text input field 'Enter Email...', and the 'PHONE NUMBER' header has a text input field 'Enter Phone Number...'. These input fields are highlighted with red boxes. The 'APPLY FILTER' button is now labeled 'HIDE FILTER' and is also highlighted with a red box. The table content remains the same as in the previous screenshot.

ACTIONS	NAME <input data-bbox="397 1052 555 1087" type="text" value="Enter Name..."/>	EMAIL <input data-bbox="760 1052 917 1087" type="text" value="Enter Email..."/>	PHONE NUMBER <input data-bbox="1170 1052 1328 1087" type="text" value="Enter Phone Number..."/>
	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222

5 Basic Features in the Case Report Entry Form

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

Side Navigation Bar & Pagination

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

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

PERINATAL HEPATITIS CASE REPORT FORM

Section 4 of 9

Please select any underlying medical conditions and/or risk behaviors that the patient experienced during illness.

MEDICAL CONDITIONS

Did the patient have any underlying medical conditions and/or risk behaviors?*

Yes No Unknown

Substance abuse or misuse

Yes No Unknown

If yes, please specify the substance that was abused or misused: ?

Save Previous Next

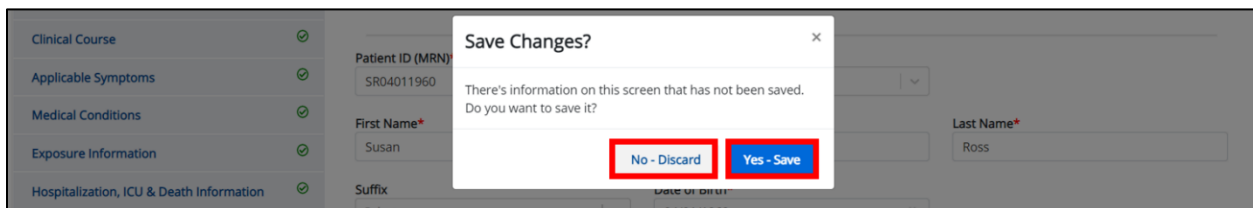
Save Feature

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

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



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



Case Report Entry Icons

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

Icon Descriptions:

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

Conditional Questions

Conditional Questions are those questions that are asked based on your responses to the previous questions. The Child Hepatitis Case Report has multiple screens with conditional questions. Based on the answer selected for conditional questions, certain subsequent fields on the screen will be enabled or grayed out and disabled. These conditional questions are found on the **Laboratory Information**, **Hospitalization, ICU & Death Information**, and **Vaccination History** screens.

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

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

CHILD HEPATITIS CASE REPORT FORM

Section 2 of 7

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Does the patient have a lab test?*

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

Hepatitis Marker

Select...

If other, please specify:

Results

Select...

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy ☐ Unknown

Specimen Collection Date

mm/dd/yyyy ☐ Unknown

Laboratory Name:

Add Hepatitis Marker

ALT

Add ALT

AST

Add AST

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

LABORATORY INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Does the patient have a lab test?*

Yes

No

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

Hepatitis Marker*

Select...

If other, please specify:

Results*

Select...

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy

Unknown

Specimen Collection Date*

mm/dd/yyyy

Unknown

Laboratory Name:*

+ Add Hepatitis Marker

ALT

+ Add ALT

AST

+ Add AST

Bilirubin

+ Add Bilirubin

Save

Previous

Next

Additionally, if **No** or **Unknown** is selected for certain conditional questions, the screen will be disabled and the subsequent fields will be marked as **No** or **Unknown**, based on the selected answer. This type of conditional question is found on the **Exposure Information** screen.

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

CHILD HEPATITIS CASE REPORT FORM Section 3 of 7

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

EXPOSURE INFORMATION

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

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

Yes **No** Unknown

Mother Hepatitis B Virus positive

Yes **No** Unknown

Mother Hepatitis C Virus positive

Yes **No** Unknown

HBV Contact Exposure

Yes **No** Unknown

HCV Contact Exposure

Yes **No** Unknown

Foreign Born

Yes **No** Unknown

If yes, please specify country: 🌐

Select... | v

Is this part of an outbreak?*

Yes **No** Unknown

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

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

EXPOSURE INFORMATION

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

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

Yes **No** **Unknown**

Mother Hepatitis B Virus positive

Yes **No** **Unknown**

Mother Hepatitis C Virus positive

Yes **No** **Unknown**

HBV Contact Exposure

Yes **No** **Unknown**

HCV Contact Exposure

Yes **No** **Unknown**

Foreign Born

Yes **No** **Unknown**

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

EXPOSURE INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

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

Yes

No

Unknown

Mother Hepatitis B Virus positive*

Yes

No

Unknown

Mother Hepatitis C Virus positive*

Yes

No

Unknown

HBV Contact Exposure*

Yes

No

Unknown

HCV Contact Exposure*

Yes

No

Unknown

Foreign Born*

Yes

No

Unknown

If yes, please specify country: ?

Select...

Is this part of an outbreak?*

Yes

No

Unknown

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

Save

Previous

Next

6 Affiliation/Organization Conditional Question

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

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

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

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

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

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

Affiliation/Organization Conditional Answer: Yes

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

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

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

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

Yes No

Patient ID (MRN)*

Affiliation/Organization* Select...

Person Completing Form*

Affiliation/Organization

If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization

If other, please specify:

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

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

Yes No

Patient ID (MRN)*

Affiliation/Organization* Test Medical Center x

Person Completing Form*

Affiliation/Organization Test Medical Center x

If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization Test Medical Center x

If other, please specify:

Affiliation/Organization Conditional Answer: No

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

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

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

Yes **No**

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization* If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization* If other, please specify:

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

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Attending Physician/Clinician*

Prefix

Affiliation/Organization dropdown menu:

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

If other, please specify:

If other, please specify:

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

Person Completing Form*

Affiliation/Organization*

Attending Physician/Clinician*

Prefix

First Name*

Suffix

Affiliation/Organization dropdown menu:

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

If other, please specify:

If other, please specify:

Last Name*

Date of Birth*

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

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

If other, please specify:* ?

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

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

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

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

Affiliation/Organization* ? Select... x v

Prefix Select... v

First Name*

Suffix Select... v

Patient Sex* Ethnicity* Race*

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

If other, please specify:* ? Test Hospital

If other, please specify: ?

Last Name*

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

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

Affiliation/Organization* ? Other x v

If other, please specify:* ?

Affiliation/Organization Validation

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

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

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

Yes **No**

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

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

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

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

Yes **No**

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

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

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

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

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

Yes **No**

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

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

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

Patient Information

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

Yes **No**

Change Affiliation/Organization Conditional Answer: No to Yes

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

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

Yes **No**

Patient ID (MRN)* SK05051960

Affiliation/Organization* Test Medical Center

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

Affiliation/Organization* Other

If other, please specify* Test Hospital

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

Affiliation/Organization* Test Medical Center

If other, please specify:

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

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

Yes **No**

Patient ID (MRN)* SK05051960

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

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

Affiliation/Organization* Test Medical Center

If other, please specify* Test Hospital

If other, please specify:

Patient Information

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

Yes **No**

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

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Disease/Organism* Chlamydia

Date of Diagnosis* 07/23/2021

Unknown

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

Yes **No**

Patient ID (MRN)* SK05051960

Affiliation/Organization* Select...

Please Enter Affiliation/Organization

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

Affiliation/Organization* Select...

If other, please specify:

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

Affiliation/Organization* Select...

If other, please specify:

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

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

Patient ID (MRN)* ⓘ
SK05051960

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

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

Prefix
Ms. x | v

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

If other, please specify: ⓘ

If other, please specify: ⓘ

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

- This means the same Affiliation/Organization will be applied to the Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician.

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

Patient ID (MRN)* ⓘ
SK05051960

Affiliation/Organization* ⓘ
Test Medical Center x | v

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

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

Affiliation/Organization ⓘ
Test Medical Center x | v

Affiliation/Organization ⓘ
Test Medical Center x | v

If other, please specify: ⓘ

If other, please specify: ⓘ

Change Affiliation/Organization Conditional Answer: Yes to No

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

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

Yes **No**

Patient ID (MRN)* SK05051960

Affiliation/Organization* Test Medical Center

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

Affiliation/Organization* Test Medical Center

If other, please specify:

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

Affiliation/Organization* Test Medical Center

If other, please specify:

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

Patient Information

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

Yes No

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

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

Yes **No**

Patient ID (MRN)* CK08101955

Affiliation/Organization* Select...

Person Completing Form* Dr. Estelle Costanza (estelle@email....)

Affiliation/Organization* Select...

If other, please specify:

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

Affiliation/Organization* Select...

If other, please specify:

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

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

Yes No

Patient ID (MRN)*

SR05051960

Person Completing Form*

Select...

Attending Physician/Clinician*

Select...

Prefix

Select...

Affiliation/Organization*

Select...

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical Center

If other, please specify:

If other, please specify:

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

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

Person Completing Form*

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

Affiliation/Organization*

Select...

If other, please specify:

Attending Physician/Clinician*

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

Affiliation/Organization*

Select...

If other, please specify:

Prefix

Select...

First Name*

Last Name*

Suffix

Select...

Patient Sex*

Ethnicity*

Race*

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

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

Person Completing Form*

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

Affiliation/Organization*

Other x | v

If other, please specify:

Attending Physician/Clinician*

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

Affiliation/Organization*

Other x | v

If other, please specify:

7 Dynamic Functions based on Disease/Organism

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

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

CHILD HEPATITIS CASE REPORT FORM

Section 1 of 7

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

Please select the disease/organism for which you want to file this case report for the patient.

Patient Information

Disease/Organism*
Select...
Child Hepatitis B
Child Hepatitis C

Date of Diagnosis*
Select...

Yes No

Patient ID (MRN)
Select...

Affiliation/Organization
Select...

Person Completing Form

Affiliation/Organization
If other, please specify:

Change or Save Disease/Organism Selection

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

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

First Name: Carol, Middle Name: , Last Name: Brady

Address 1: 111 Test S, City: London, County: Allen, Zip Code: 40741-, Email: name@domain.com

Patient Information

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

Yes No

Save Next

Please Note: All Disease/Organism selections are final. Once the selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to display information that applies only to the selected Disease/Organism.

You have one more opportunity to select **No** to change the Disease/Organism. You can select **Yes** to finalize the Disease/Organism selection.

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

The screenshot shows the 'Patient Information' screen with a pop-up dialog box. The dialog box has a yellow warning icon and the following text: 'You have selected to file this case report for Child Hepatitis B disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Child Hepatitis B disease?'. At the bottom of the dialog box are two buttons: 'Yes' (blue) and 'No' (red). The background shows a form with fields for First Name, Middle Name, Last Name, Address, City, County, Zip Code, and Email.

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

The screenshot shows the 'CHILD HEPATITIS CASE REPORT FORM' with a progress bar indicating 'Section 1 of 7'. The form has a sidebar with 'Patient Information' selected. The main content area shows the 'PATIENT INFORMATION' section with a 'Disease/Organism*' dropdown menu. The dropdown menu is open, showing 'Child Hepatitis B' and 'Child Hepatitis C' as options. The 'Child Hepatitis B' option is highlighted. The background shows a form with fields for Date of Diagnosis, Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician.*

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

The screenshot shows the bottom of the 'Patient Information' screen. There are two buttons: 'Save' (blue) and 'Next' (blue). The 'Save' button is highlighted with a red box. To the right of the 'Next' button is a grey button with an upward arrow.

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

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

8 Dynamic Screens for Child Hepatitis Case Report

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

Laboratory Information: Dynamic Screen

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

CHILD HEPATITIS CASE REPORT FORM Section 2 of 7

Please provide laboratory information related to this case.

LABORATORY INFORMATION

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

Does the patient have a lab test?*

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

Hepatitis Marker*

Select...

- HEPATITIS B VIRUS CORE AB
- HEPATITIS B VIRUS CORE AB.IGG
- HEPATITIS B VIRUS CORE AB.IGM
- HEPATITIS B VIRUS DNA
- HEPATITIS B VIRUS GENOTYPE
- HEPATITIS B VIRUS LITTLE E AB
- HEPATITIS B VIRUS LITTLE E AG

Specimen Collection Date*

mm/dd/yyyy ☐ Unknown

Laboratory Name*

Hepatitis Markers for Child Hepatitis B

Vaccination History ☒ **Additional Comments** ☒ Review & Submit ☐

Hepatitis Marker*

Select...

- HEPATITIS C VIRUS AB
- HEPATITIS C VIRUS AB SIGNAL/CUTOFF
- HEPATITIS C VIRUS RNA
- Hepatitis C virus RNA panel
- HEPATITIS C VIRUS RRNA
- Other

Test Result Date*

mm/dd/yyyy ☐ Unknown

Specimen Collection Date*

mm/dd/yyyy ☐ Unknown

Hepatitis Markers for Child Hepatitis C

Vaccination History: Dynamic Screen

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

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

CHILD HEPATITIS CASE REPORT FORM

Section 5 of 7

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

VACCINATION HISTORY

Patient Information ✓

Laboratory Information ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History

Additional Comments

Review & Submit

NOTE: No information is required to be provided on this screen. Please click on the "Next" button to proceed.

The **Vaccination History** screen does **not** collect vaccination details for **Child Hepatitis C**.

Save Previous Next

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

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

VACCINATION HISTORY

Patient Information ✓

Laboratory Information ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History

Additional Comments

Review & Submit

Has the patient ever received a Hepatitis B vaccine?*

Yes No Unknown Refuse

Vaccine Details

If yes, please provide vaccine name:*

Select...

Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.

Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)

DTaP-hepatitis B and poliovirus vaccine

DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine

Haemophilus influenzae type b conjugate and Hepatitis B vaccine

hepatitis A and hepatitis B vaccine

hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)

The **Vaccination History** screen collects the **name of the vaccine** that the patient received for **Child Hepatitis B**.

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Yes
No
Unknown
Refused

Vaccine Details

If yes, please provide vaccine name:*

hepatitis B vaccine, adolescent/high risk infant dosage

If other, please specify: ?

If yes, please enter the number of doses:*

Select...

1

2

3

4

+ Add Vaccine

For Infants born to mothers with HBV, was HBIG given?*

Yes
No
Unknown

If yes, please specify the date administered: ?

Date Administered

mm/dd/yyyy

☐ Unknown

Save
Previous
Next

The **Vaccination History** screen collects the **number of vaccine doses** that the patient received for **Child Hepatitis B**.

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Yes
No
Unknown
Refused

Vaccine Details

If yes, please provide vaccine name:*

hepatitis B vaccine, adolescent/high risk infant dosage

If other, please specify: ?

If yes, please enter the number of doses:*

4

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy

☐ Unknown

Date Administered (3rd dose)*

mm/dd/yyyy

☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy

☐ Unknown

Date Administered (4th dose)*

mm/dd/yyyy

☐ Unknown

+ Add Vaccine

The **Vaccination History** screen collects the **date(s)** the patient received **Hepatitis B vaccines**.

9 Tips for Manually Entering Case Report Data

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

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

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

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

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

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

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

An MRN or Medical Record Number is an Organization specific, unique Identification Number assigned to a patient by a healthcare organization. If your organization does not use an MRN, you MUST create a way to uniquely identify your Patient.

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

City	[Text Field]	State	KY
Zip Code	[Text Field]	County	Select...
Phone Number	[Text Field]	Email Address	[Text Field]

Adair
Allen
Anderson
Ballard
Barren
Bath
Bell

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

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

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

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

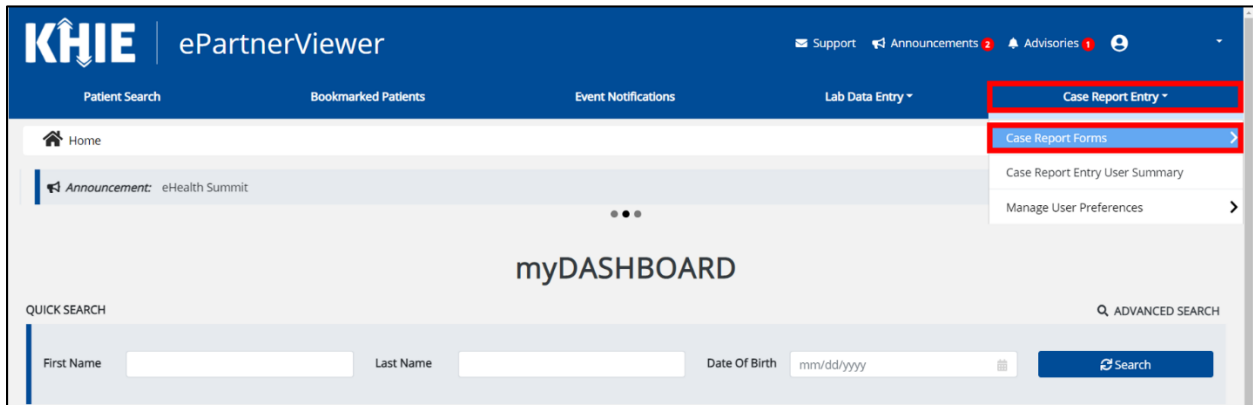
- If the date is unknown, you have the option to click the **Unknown** checkbox.

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

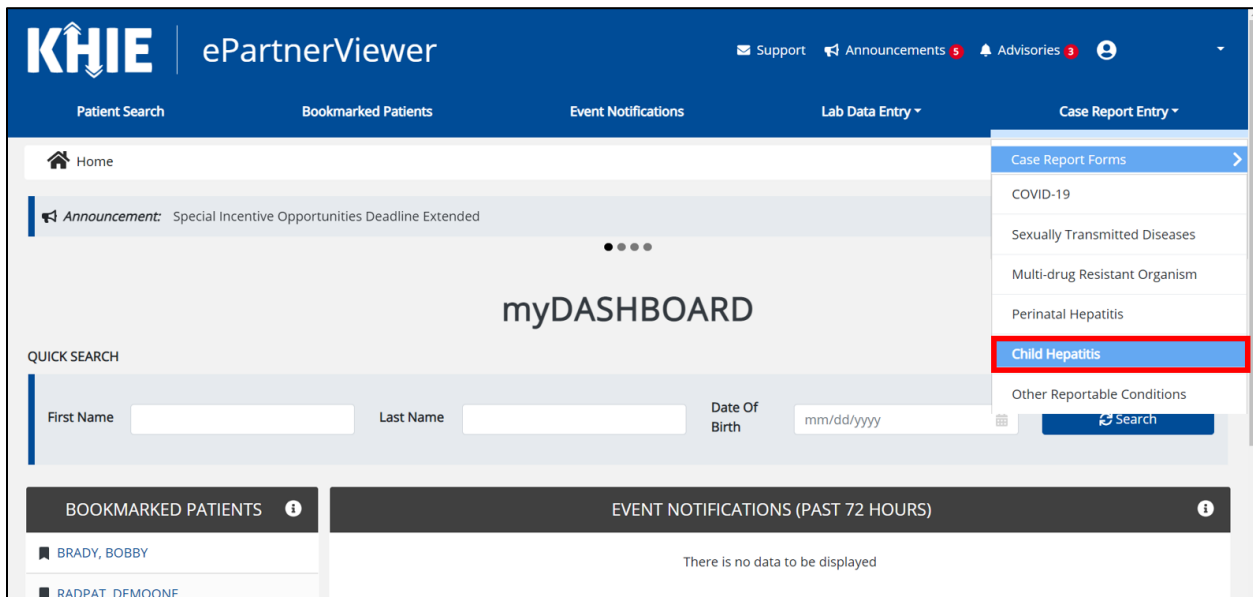
10 Child Hepatitis Case Report Form

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

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



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



11 Patient Information

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

CHILD HEPATITIS CASE REPORT FORM

Section 1 of 7

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*
Select...

Date of Diagnosis*
mm/dd/yyyy

Unknown

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

Yes No

Patient ID (MRN)
Select...

Affiliation/Organization
Select...

Person Completing Form
Select...

Affiliation/Organization
Select...

If other, please specify:

Attending Physician/Clinician
Select...

Affiliation/Organization
Select...

If other, please specify:

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

CHILD HEPATITIS CASE REPORT FORM

Section 1 of 7

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*
Select...

Date of Diagnosis*
mm/dd/yyyy

Unknown

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

Yes No

Patient ID (MRN)
Select...

Affiliation/Organization
Select...

Person Completing Form
Select...

Affiliation/Organization
Select...

If other, please specify:

Attending Physician/Clinician
Select...

Affiliation/Organization
Select...

If other, please specify:

Prefix
Select...

First Name*

Middle Name

Last Name*

Suffix
Select...

Date of Birth*
mm/dd/yyyy

Birth Weight
lbs 025

Patient Sex*
Select...

Ethnicity*
Select...

Race*
Select...

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

CHILD HEPATITIS CASE REPORT FORM Section 1 of 7

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

Please select the disease/organism for which you want to file this case report for the patient.

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Disease/Organism*

Child Hepatitis B

Child Hepatitis B

Child Hepatitis C

Date of Diagnosis*

mm/dd/yyyy

Patient ID (MRN)

Affiliation/Organization

Select...

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

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

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

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*

Select...

Date of Diagnosis*

mm/dd/yyyy

☐ Unknown

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

Yes No

Patient ID (MRN)

[Person Completing Form](#)

Select...

Attending Physician/Clinician*

Select...

If other, please specify:

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

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

Patient ID (MRN) ?

Affiliation/Organization ?

[Person Completing Form](#)

Affiliation/Organization ?

If other, please specify: ?

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

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

Patient ID (MRN)* ?

[Person Completing Form](#)*

[Attending Physician/Clinician](#)*

Affiliation/Organization* ?

Affiliation/Organization ?

If other, please specify: ?

Affiliation/Organization ?

If other, please specify: ?

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

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

Patient ID (MRN)* ?

Affiliation/Organization* ?

[Person Completing Form](#)*

Affiliation/Organization* ?

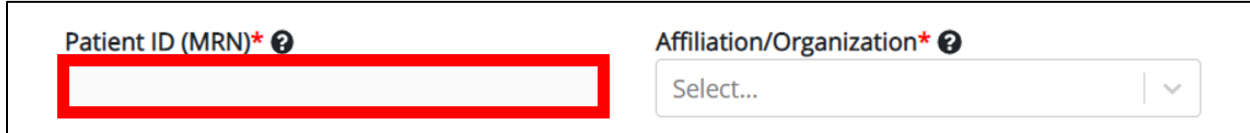
If other, please specify: ?

[Attending Physician/Clinician](#)*

Affiliation/Organization* ?

If other, please specify: ?

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

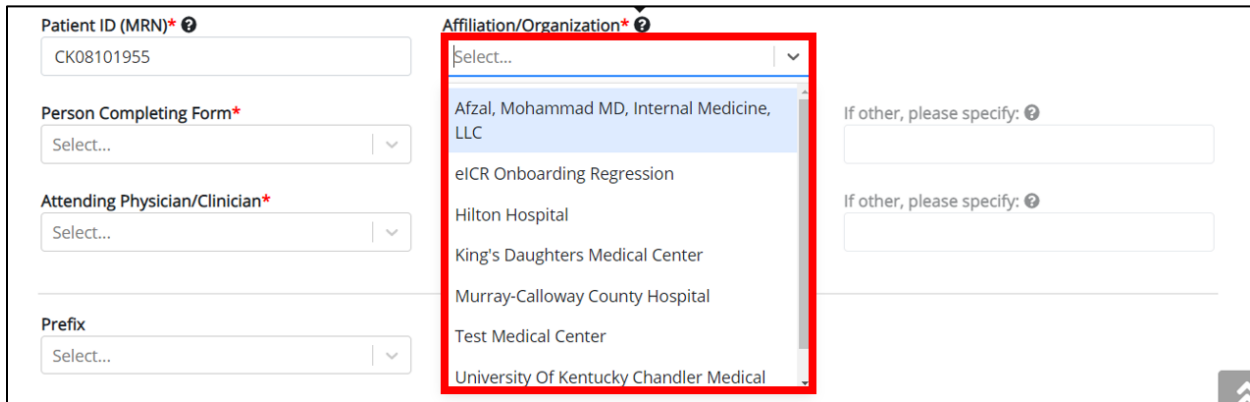


Patient ID (MRN)* ?

Affiliation/Organization* ?

Select...

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



Patient ID (MRN)* ?

CK08101955

Person Completing Form*

Select...

Attending Physician/Clinician*

Select...

Prefix

Select...

Affiliation/Organization* ?

Select...

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

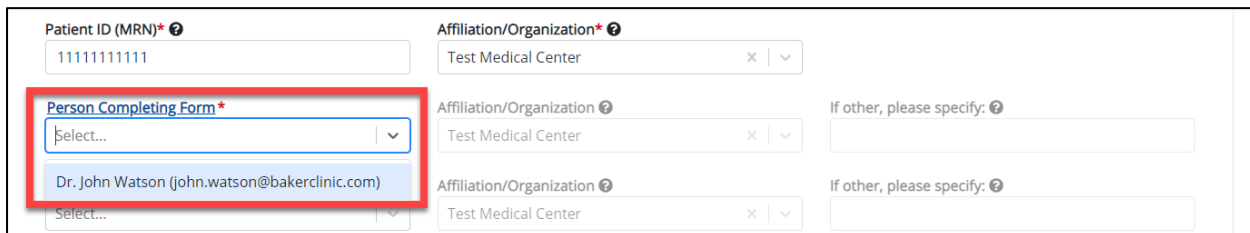
If other, please specify: ?

If other, please specify: ?

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

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

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



Patient ID (MRN)* ?

1111111111

Affiliation/Organization* ?

Test Medical Center

Person Completing Form*

Select...

Dr. John Watson (john.watson@bakerclinic.com)

Affiliation/Organization ?

Test Medical Center

If other, please specify: ?

Affiliation/Organization ?

Test Medical Center

If other, please specify: ?

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

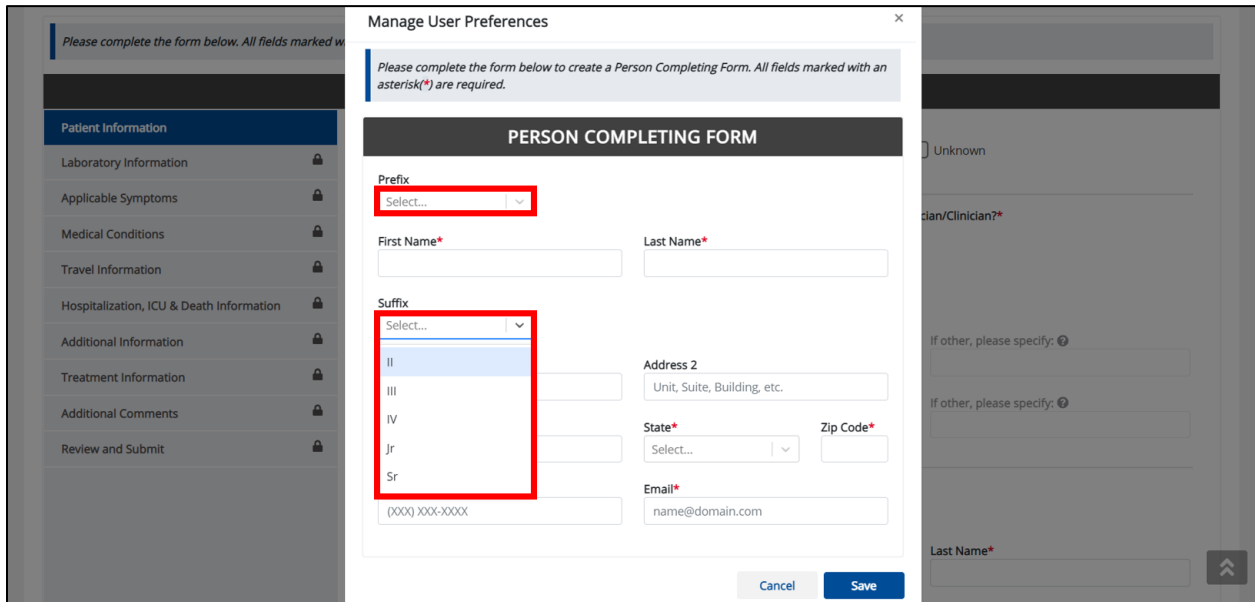
Person Completing Form Hyperlink

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



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

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



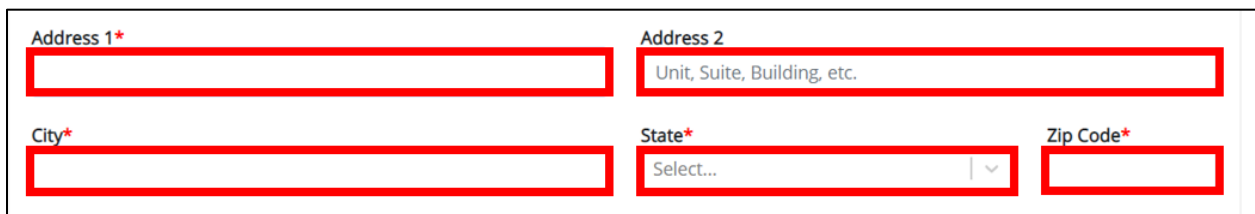
The screenshot shows a 'PERSON COMPLETING FORM' pop-up window. The 'Prefix' dropdown is highlighted with a red box, showing 'Select...' as the current selection. The 'Suffix' dropdown is also highlighted with a red box, showing a list of options: 'II', 'III', 'IV', 'Jr', and 'Sr'. The 'Jr' option is currently selected. The form includes fields for 'First Name*', 'Last Name*', 'Address 2' (Unit, Suite, Building, etc.), 'State*' (a dropdown menu), 'Zip Code*', 'Email*', and a phone number field with a placeholder '(XXX) XXX-XXXX'. There are 'Cancel' and 'Save' buttons at the bottom right.

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



The screenshot shows the 'First Name*' and 'Last Name*' input fields. Both fields are highlighted with red rectangular boxes. The 'First Name*' field has a placeholder text 'First Name*' and the 'Last Name*' field has a placeholder text 'Last Name*'. There are also 'Cancel' and 'Save' buttons at the bottom right.

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



The screenshot shows the 'Address 1*', 'Address 2' (Unit, Suite, Building, etc.), 'City*', 'State*' (a dropdown menu), and 'Zip Code*' input fields. All five fields are highlighted with red rectangular boxes. The 'Address 1*' field has a placeholder text 'Address 1*' and the 'Address 2' field has a placeholder text 'Unit, Suite, Building, etc.'. The 'City*' field has a placeholder text 'City*', the 'State*' field has a placeholder text 'Select...', and the 'Zip Code*' field has a placeholder text 'Zip Code*'. There are also 'Cancel' and 'Save' buttons at the bottom right.

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



The screenshot shows the 'Phone*' and 'Email*' input fields. Both fields are highlighted with red rectangular boxes. The 'Phone*' field has a placeholder text '(XXX) XXX-XXXX' and the 'Email*' field has a placeholder text 'name@domain.com'. There are also 'Cancel' and 'Save' buttons at the bottom right.

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

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

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

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

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

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

Yes No

Patient ID (MRN)*
CK08101955

Affiliation/Organization*
Test Medical Center

Person Completing Form*
Mr. Marty Craine, Sr (marty@email...)

Affiliation/Organization*
Other

Attending Physician/Clinician*
Select...

Affiliation/Organization*
Select...

If other, please specify:*

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

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

Person Completing Form*
Dr. John Watson (john.watson@bakerclin...)

Affiliation/Organization*
Test Medical Center

Attending Physician/Clinician*
Dr. John Watson (john.watson@bakerclin...)

Affiliation/Organization*
Test Medical Center

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

Attending Physician/Clinician Hyperlink

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

The screenshot shows a button labeled "Attending Physician/Clinician*" with a red border. To its right are two dropdown menus: "Affiliation/Organization*" and "If other, please specify:". Both dropdowns have "Select..." as the current selection. A third empty text input field is also present.

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

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

The screenshot shows a "Manage User Preferences" pop-up window. The title bar says "Manage User Preferences". Below the title bar is a message: "Please complete the form below to create an Attending Physician/Clinician. All fields marked with an asterisk(*) are required." The form is titled "ATTENDING PHYSICIAN/CLINICIAN". It contains several fields: "Prefix" (dropdown, red border), "First Name*" (text input, red border), "Last Name*" (text input, red border), "Suffix" (dropdown, red border), "Address 1*" (text input, red border), "Address 2" (text input, placeholder "Unit, Suite, Building, etc."), "City*" (text input, red border), "State*" (dropdown, red border), "Zip Code*" (text input, red border), "Phone*" (text input, placeholder "(xxx) xxx-xxxx", red border), and "Email*" (text input, placeholder "name@domain.com", red border). A sidebar on the left lists various information categories like "Patient Information", "Laboratory Information", etc.

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

The screenshot shows two text input fields: "First Name*" and "Last Name*", both with red borders.

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

The screenshot shows four input fields: "Address 1*" (text input, red border), "Address 2" (text input, placeholder "Unit, Suite, Building, etc."), "City*" (text input, red border), "State*" (dropdown, red border), and "Zip Code*" (text input, red border).

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

The screenshot shows two input fields: "Phone*" (text input, placeholder "(xxx) xxx-xxxx", red border) and "Email*" (text input, placeholder "name@domain.com", red border).

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

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

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

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

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

Attending Physician/Clinician * Dr. Fraiser Crane (fraiserkra... x v	Affiliation/Organization* ? Other x v	If other, please specify:* ? <input type="text"/>
--	---	---

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

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

Prefix <input type="text" value="Select..."/>	
First Name* <input type="text" value="Bobby"/>	Middle Name <input type="text"/>
Suffix <input type="text" value="Select..."/>	Date of Birth* ? <input type="text" value="01/01/2018"/>

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

Prefix <input type="text" value="Select..."/>		
First Name* <input type="text" value="Bobby"/>	Middle Name <input type="text"/>	Last Name* <input type="text" value="Brady"/>

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

First Name* <input type="text" value="Bobby"/>	Middle Name <input type="text"/>	Last Name* <input type="text" value="Brady"/>
Suffix <input type="text" value="Jr"/>	Date of Birth* ? <input type="text" value="mm/dd/yyyy"/>	Birth Weight <input type="text" value="lbs"/> <input type="text" value="OZS"/>

Please Note: If the patient is over 5 years old, a notification pop-up will display to confirm the correct birth year has been entered or selected. You cannot proceed to the next page until updating or confirming the patient's birth year. See screenshot below.

The screenshot shows a 'Patient Information' pop-up window with a red 'X' icon. The message reads: 'The Date of Birth entered indicates that patient's age is more than 5 years old. Note that this form can only be used to file case report for infants and child aged 5 and under.' There is an 'OK' button at the bottom right of the pop-up. In the background, the 'REPORT FORM' is visible, showing fields for 'Disease/Organism' (Child Hepatitis) and 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?'

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

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

The screenshot shows the 'Birth Weight' section of the form. It has two input fields: 'lbs' and 'OZS'. The 'lbs' field is highlighted with a red rectangle. To the left is the 'Date of Birth*' field with a calendar icon and the value '01/01/2018'.

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

The screenshot shows the 'Patient Sex*' dropdown menu open. The options are: 'Select...', 'Female', 'Male' (highlighted with a blue background), 'Other', and 'Unknown'. The dropdown menu is outlined with a red rectangle. To the right are the 'Ethnicity*' and 'Race*' dropdown menus, both showing 'Select...'. Below these are the 'Middle Name' and 'Last Name*' input fields.

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

Patient Sex* <input type="text" value="Male"/>	Ethnicity* <input type="text" value="Not Hispanic or Latino"/>	Race* <input type="text" value="White"/>
--	--	--

Please Note: In the Child Hepatitis Case Report, Users must enter the contact information for the patient's mother or the contact information for the patient's guardian, if the patient's guardian is different than the patient's mother.

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

Mother's Current Legal Name and Address

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

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

Mother's Current Legal Name and Address

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

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

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

36. Enter the mother's **Phone Number**.

37. If available, enter the mother's **Email Address**.

Address 1*
123 Main Street

City*
Lexington

County*
Fayette

Address 2
Unit, Suite, Building, etc.

State*
KY

Zip Code
40511-

Phone* ?
(XXX) XXX-XXXX

Email
name@domain.com

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

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

Does the patient have Neonatal Abstinence Syndrome?*

Yes No Unknown

Who does the infant/child live with?*

Select...

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

Does the patient have Neonatal Abstinence Syndrome?*

Yes No Unknown

Who does the infant/child live with?*

Select...

Father

Grandparent

Mother

Other

Unknown

Child is living with:

Middle Name

Last Name*

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

Who does the infant/child live with?*

Other x | v

If other, please specify:*

Legal Guardian

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

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

Who does the infant/child live with?*

Mother x | v

If other, please specify:

Please enter contact info of person the child is living with:

First Name	Middle Name	Last Name
Carol	Anne	Brady
Address 1		Address 2
123 Main Street		Apt. 1
City	State	Zip Code
Lexington	KY x v	40511-
County	Phone ?	Email
Fayette x v	(555) 123-1234	carol@email.com

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

Who does the infant/child live with?*

Father x | v

If other, please specify:

Please enter contact info of person the child is living with:

First Name* Middle Name Last Name*

Address 1* Address 2

City* State* Zip Code

County* Phone* ? Email

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

Who does the infant/child live with?*

Mother x | v

If other, please specify:

Please enter contact info of person the child is living with:

First Name Middle Name Last Name

Address 1 Address 2

City State Zip Code

County Phone ? Email

Save Next

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

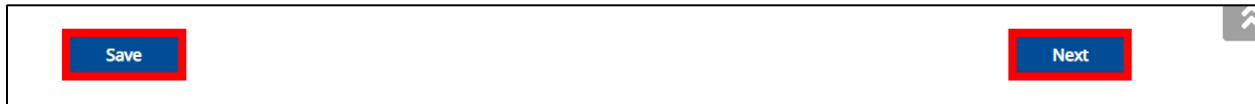
You have selected to file this case report for [selected disease]. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for [selected disease]?

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

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

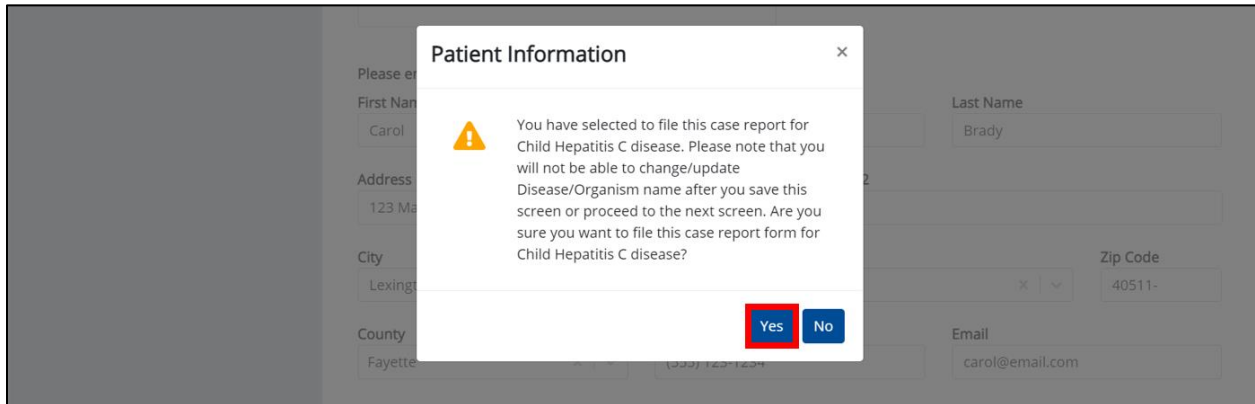
42. If changing the selection, select a different **Disease/Organism** from the dropdown menu.

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



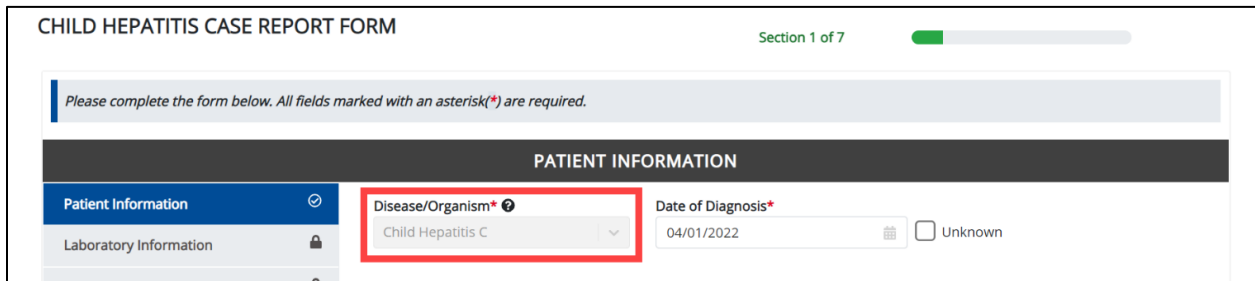
A screenshot of the bottom of a form. There are two buttons: 'Save' on the left and 'Next' on the right. Both buttons are highlighted with a red rectangular border.

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



A screenshot of a 'Patient Information' pop-up dialog box. The dialog box has a title bar with a close button. Inside, there is a yellow warning icon and a message: 'You have selected to file this case report for Child Hepatitis C disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Child Hepatitis C disease?'. At the bottom right of the dialog box are two buttons: 'Yes' (highlighted with a red border) and 'No'.

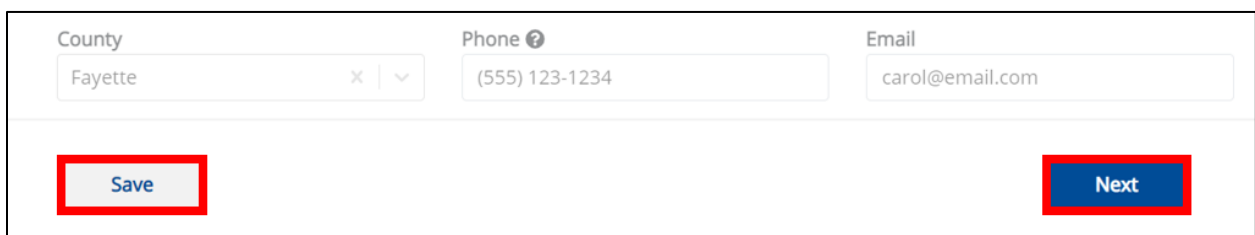
45. Upon clicking **Yes** to save the selection, the *Disease/Organism* field is disabled and displays the selected Disease/Organism. You can no longer change the selected Disease/Organism.



A screenshot of the 'CHILD HEPATITIS CASE REPORT FORM', Section 1 of 7. The screen shows a 'PATIENT INFORMATION' section. On the left is a sidebar with 'Patient Information' selected. The main area has a 'Disease/Organism*' dropdown menu with 'Child Hepatitis C' selected (highlighted with a red border). To the right is a 'Date of Diagnosis*' field with '04/01/2022' and an 'Unknown' checkbox.

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

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



A screenshot of the bottom of the 'Patient Information' screen. It shows fields for 'County' (Fayette), 'Phone' ((555) 123-1234), and 'Email' (carol@email.com). At the bottom are two buttons: 'Save' on the left and 'Next' on the right. Both buttons are highlighted with a red rectangular border.

12 Laboratory Information

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

CHILD HEPATITIS CASE REPORT FORM Section 2 of 7

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information

Laboratory Information

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Does the patient have a lab test?*

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

Hepatitis Marker
Select...

If other, please specify:

Results
Select...

If applicable, please enter the viral load:

Test Result Date ☐ Unknown Specimen Collection Date ☐ Unknown

Laboratory Name:

Add Hepatitis Marker

ALT
 Add ALT

AST
 Add AST

Bilirubin
 Add Bilirubin

Please Note: If **Yes** is selected for the conditional question at the top of the **Laboratory Information** screen, the subsequent lab-related fields on the screen are enabled. You must enter details for a lab test.

Patient Information	Does the patient have a lab test?*
Laboratory Information	<input checked="" type="button" value="Yes"/> <input type="button" value="No"/>
Exposure Information	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.
Hospitalization, ICU & Death Information	
Vaccination History	
Additional Comments	
Review & Submit	

Hepatitis Marker*

Select... ▼

If other, please specify:

Results*

Select... ▼

If applicable, please enter the viral load: ?

Test Result Date mm/dd/yyyy ☐ Unknown

Specimen Collection Date* mm/dd/yyyy ☐ Unknown

Laboratory Name:*

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

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

Does the patient have a lab test?*

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

Hepatitis Marker*

Select... ▼

- HEPATITIS C VIRUS AB
- HEPATITIS C VIRUS AB SIGNAL/CUTOFF
- HEPATITIS C VIRUS RNA
- Hepatitis C virus RNA panel
- HEPATITIS C VIRUS RRNA
- Other

Test Result Date

Specimen Collection Date*

Please Note: The *Hepatitis Marker* dropdown menu displays only the hepatitis marker options that apply to the Disease/Organism selected on the **Patient Information** screen.

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

Hepatitis Marker*

Other x | v

If other, please specify:*

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

Results*

Select... v

Negative

Pending

Positive

Undetermined/Inconclusive

Specimen Collection Date*

mm/dd/yyyy ☐ Unknown

Laboratory Name:*

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

Results*

Pending x | v

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy ☐ Unknown

Specimen Collection Date*

mm/dd/yyyy ☐ Unknown

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

Results*

Positive

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

If applicable, please enter the viral load: ?

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

Test Result Date* <div style="border: 1px solid #ccc; padding: 5px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div>	Specimen Collection Date* <div style="border: 1px solid #ccc; padding: 5px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div>
---	---

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

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

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

Test Result Date* <div style="border: 1px solid #ccc; padding: 5px; display: flex; align-items: center;"> 07/23/2021 📅 <input type="checkbox"/> Unknown </div> <small>Invalid Test Result Date</small>	Specimen Collection Date* <div style="border: 1px solid #ccc; padding: 5px; display: flex; align-items: center;"> 07/26/2021 📅 <input type="checkbox"/> Unknown </div> <small>Invalid Specimen Collection Date</small>
---	---

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

Laboratory Name:*

Adding Multiple Hepatitis Markers

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

Laboratory Name:*

Test Lab

+ Add Hepatitis Marker

ALT

+ Add ALT

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

Laboratory Name:^{*}

Test Lab

Hepatitis Marker:^{*}

Select... | v

If other, please specify:

Results:^{*}

Select... | v

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy

☐ Unknown

Specimen Collection Date:^{*}

mm/dd/yyyy

☐ Unknown

Laboratory Name:^{*}

+ Add Hepatitis Marker

Adding ALT

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

+ Add Hepatitis Marker

ALT

+ Add ALT

AST

+ Add AST

Bilirubin

+ Add Bilirubin

Save

Previous

Next

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

ALT


Units/Liter

Units/Liter

Test Result Date*
☐ Unknown


Specimen Collection Date*
☐ Unknown

Laboratory Name:*




Adding AST

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

 Add ALT

AST

 Add AST

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

AST


Units/Liter

Units/Liter

Test Result Date*
☐ Unknown

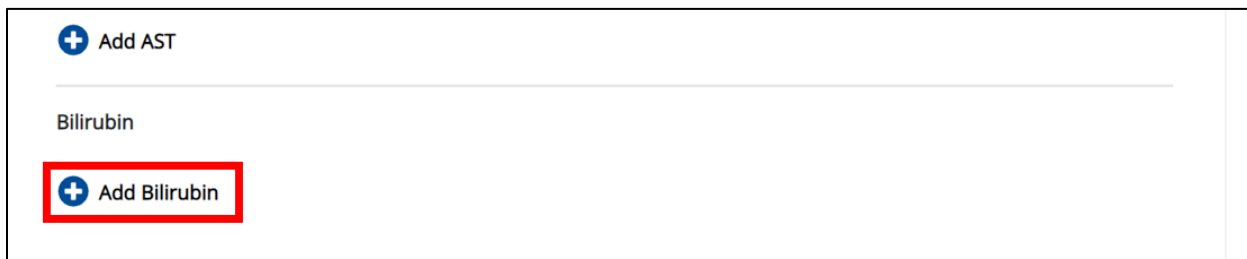
Specimen Collection Date*
☐ Unknown

Laboratory Name:*



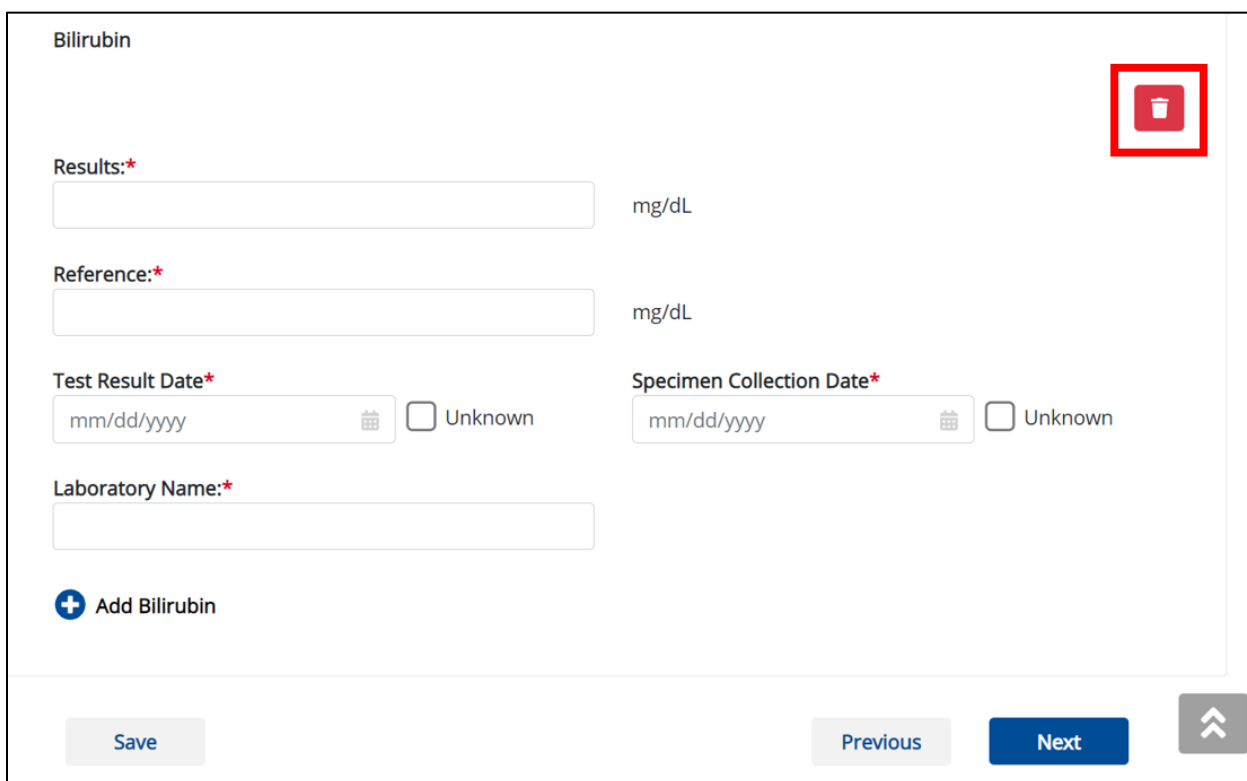
Adding Bilirubin

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



This screenshot shows a form titled 'Add AST'. Below the title, there is a text input field containing the word 'Bilirubin'. At the bottom of the form, there is a button labeled '+ Add Bilirubin', which is highlighted with a red rectangular box.

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



This screenshot shows the 'Bilirubin' form. At the top right, there is a trash bin icon, which is highlighted with a red rectangular box. The form contains several input fields: 'Results:*' (with a unit of 'mg/dL'), 'Reference:*' (with a unit of 'mg/dL'), 'Test Result Date*' (with a date picker and an 'Unknown' checkbox), 'Specimen Collection Date*' (with a date picker and an 'Unknown' checkbox), and 'Laboratory Name:*'. At the bottom left, there is a '+ Add Bilirubin' button. At the bottom right, there are 'Save', 'Previous', 'Next', and a double-up arrow button.

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



This screenshot shows the 'Add Bilirubin' form. At the bottom right, there is a 'Next' button, which is highlighted with a red rectangular box. Other buttons visible are 'Save', 'Previous', and a double-up arrow button.

13 Exposure Information

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

CHILD HEPATITIS CASE REPORT FORM Section 3 of 7

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

EXPOSURE INFORMATION

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

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

Mother Hepatitis B Virus positive

Mother Hepatitis C Virus positive

HBV Contact Exposure

HCV Contact Exposure

Foreign Born

If yes, please specify country: ?

Select... | v

Is this part of an outbreak?*

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

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

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

Mother Hepatitis B Virus positive*

Mother Hepatitis C Virus positive*

HBV Contact Exposure*

HCV Contact Exposure*

Foreign Born*

If yes, please specify country: ?

Select... | v

Is this part of an outbreak?*

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

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

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

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

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

Mother Hepatitis B Virus positive*

Mother Hepatitis C Virus positive*

HBV Contact Exposure*

HCV Contact Exposure*

Foreign Born*

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

Foreign Born*

If yes, please specify country: ?

Select... | v

Is this part of an outbreak?*

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

The screenshot shows the 'Foreign Born*' field with a 'Yes' button selected. A tooltip above the dropdown menu reads: 'Please select 'Unknown' if information of the country of birth is not available.' Below the field, the text 'If yes, please specify country:* ?' is displayed. The dropdown menu is open, showing a list of countries: AFGHANISTAN, ALBANIA, ALGERIA, AMERICAN SAMOA, ANDORRA, ANGOLA, and ANGUILLA. The entire dropdown menu is highlighted with a red border.

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

The screenshot shows the 'Is this part of an outbreak?*' field with three buttons: 'Yes', 'No', and 'Unknown'. The 'Yes' button is highlighted with a red border. Below the field, the text 'If yes, please specify the name of the outbreak: ?' is displayed, followed by a text input field.

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

The screenshot shows the 'Is this part of an outbreak?*' field with three buttons: 'Yes', 'No', and 'Unknown'. The 'Yes' button is selected. A tooltip above the 'Unknown' button reads: 'Please enter 'Unknown' if the details of outbreak is not available.' Below the field, the text 'If yes, please specify the name of the outbreak:* ?' is displayed, followed by a text input field. The text input field is highlighted with a red border.

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

The screenshot shows the 'Is this part of an outbreak?*' field with three buttons: 'Yes', 'No', and 'Unknown'. The 'No' button is selected. Below the field, the text 'If yes, please specify the name of the outbreak: ?' is displayed, followed by a text input field. At the bottom of the form, there are three buttons: 'Save', 'Previous', and 'Next'. The 'Next' button is highlighted with a red border.

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?*

CHILD HEPATITIS CASE REPORT FORM Section 4 of 7

Please select any applicable hospitalization, ICU and death information related to this case.

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information	✓	<div>Was the patient hospitalized?*</div> <div>Yes No Unknown</div> <div>If yes, please specify the hospital name: *</div> <div>Admission Date: mm/dd/yyyy [calendar] [] Unknown Discharge Date: mm/dd/yyyy [calendar] [] Unknown</div> <div><input type="checkbox"/> Still hospitalized</div> <div>Was the patient admitted to an intensive care unit (ICU)?</div> <div>Yes No Unknown</div> <div>Admission Date to ICU: mm/dd/yyyy [calendar] [] Unknown Discharge Date from ICU: mm/dd/yyyy [calendar] [] Unknown</div> <div>Did the patient die as a result of this illness?*</div> <div>Yes No Unknown</div> <div>If yes, please provide the date of death:</div> <div>Date of Death</div>
Laboratory Information	✓	
Exposure Information	✓	
Hospitalization, ICU & Death Information		
Vaccination History	🔒	
Additional Comments	🔒	
Review & Submit	🔒	

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

Patient Information	✓	<div>Was the patient hospitalized?*</div> <div>Yes No Unknown</div> <div>If yes, please specify the hospital name: *</div> <div>Admission Date*: mm/dd/yyyy [calendar] [] Unknown Discharge Date*: mm/dd/yyyy [calendar] [] Unknown</div> <div><input type="checkbox"/> Still hospitalized</div> <div>Was the patient admitted to an intensive care unit (ICU)?*</div> <div>Yes No Unknown</div> <div>Admission Date to ICU: mm/dd/yyyy [calendar] [] Unknown Discharge Date from ICU: mm/dd/yyyy [calendar] [] Unknown</div> <div>Was the patient admitted to an intensive care unit (ICU)?*</div> <div>Yes No Unknown</div> <div>Admission Date to ICU: mm/dd/yyyy [calendar] [] Unknown Discharge Date from ICU: mm/dd/yyyy [calendar] [] Unknown</div>
Laboratory Information	✓	
Exposure Information	✓	
Hospitalization, ICU & Death Information		
Vaccination History	🔒	
Additional Comments	🔒	
Review & Submit	🔒	

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

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

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

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

- Enter the patient's hospitalization **Discharge Date**.

- If the patient is still hospitalized, click the **Still Hospitalized** checkbox.

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

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

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

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

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

CHILD HEPATITIS CASE REPORT FORM

Section 4 of 7

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name:*

Baker Clinic

Admission Date*

11/28/2021

Discharge Date*

11/05/2021

Still hospitalized

Invalid Discharge Date

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

Yes No Unknown

Admission Date to ICU

mm/dd/yyyy

Discharge Date from ICU

mm/dd/yyyy

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

CHILD HEPATITIS CASE REPORT FORM

Section 4 of 7

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name:*

Baker Clinic

Admission Date*

11/28/2021

Discharge Date*

11/05/2021

Still hospitalized

Invalid Discharge Date

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

Yes No Unknown

Admission Date to ICU

mm/dd/yyyy

Discharge Date from ICU

mm/dd/yyyy

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

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

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

Yes No Unknown

Admission Date to ICU

mm/dd/yyyy

Discharge Date from ICU

mm/dd/yyyy

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

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

Admission Date to ICU*

☐ Unknown

Discharge Date from ICU*

☐ Unknown

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

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

If yes, please provide the date of death:

Date of Death

☐ Unknown

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

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

If yes, please provide the date of death:

Date of Death*

☐ Unknown

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information ☒

Laboratory Information ☒

Exposure Information ☒

Hospitalization, ICU & Death Information ☒

Vaccination History ☒

Additional Comments ☒

Review & Submit

Was the patient hospitalized?*

If yes, please specify the hospital name:*

Test Hospital

Admission Date*

01/03/2022 ☐ Unknown

Discharge Date*

01/10/2022 ☐ Unknown

☐ Still hospitalized

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

Admission Date to ICU*

01/08/2022 ☐ Unknown

Discharge Date from ICU*

01/10/2022 ☐ Unknown

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

If yes, please provide the date of death:

Date of Death

☐ Unknown

Save Previous **Next**

15 Vaccination History

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

Vaccination History for Child Hepatitis B

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

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

CHILD HEPATITIS CASE REPORT FORM Section 5 of 7

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

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Vaccine Details

If yes, please provide vaccine name:

If other, please specify:

If yes, please enter the number of doses:

If yes, please specify the date administered:

Date Administered (1st dose)	<input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown	Date Administered (2nd dose)	<input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown
Date Administered (3rd dose)	<input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown	Date Administered (4th dose)	<input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown

+ Add Vaccine

For Infants born to mothers with HBV, was HBIG given?*

If yes, please specify the date administered:

Date Administered ☐ Unknown

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

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Yes No Unknown Refused

Vaccine Details

If yes, please provide vaccine name:*

Select...

If other, please specify: ?

If yes, please enter the number of doses:*

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose) Date Administered (2nd dose)

mm/dd/yyyy Unknown mm/dd/yyyy Unknown

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

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

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Yes No Unknown Refused

Vaccine Details

If yes, please provide vaccine name:*

Select...

Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.

Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)

DTaP-hepatitis B and poliovirus vaccine

DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine

Haemophilus influenzae type b conjugate and Hepatitis B vaccine

hepatitis A and hepatitis B vaccine

hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)

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

If yes, please provide vaccine name:*

Other Please enter 'Unknown' if the name of vaccine is not known.

If other, please specify:*

If yes, please enter the number of doses:*

Select...

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

If yes, please provide vaccine name:* ?

hepatitis B vaccine, adolescent/high risk infant dosage x | v

If other, please specify: ?

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

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

Select...

1

2

3

4

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

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

1 x | v

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy [calendar icon] ☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy [calendar icon] ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy [calendar icon] ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy [calendar icon] ☐ Unknown

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

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

2 x | v

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy [calendar icon] ☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy [calendar icon] ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy [calendar icon] ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy [calendar icon] ☐ Unknown

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

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

3

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

+ Add Vaccine

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

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

4

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)*

mm/dd/yyyy ☐ Unknown

+ Add Vaccine

Adding Multiple Vaccines

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

Date Administered (3rd dose)*

06/15/2021 ☐ Unknown

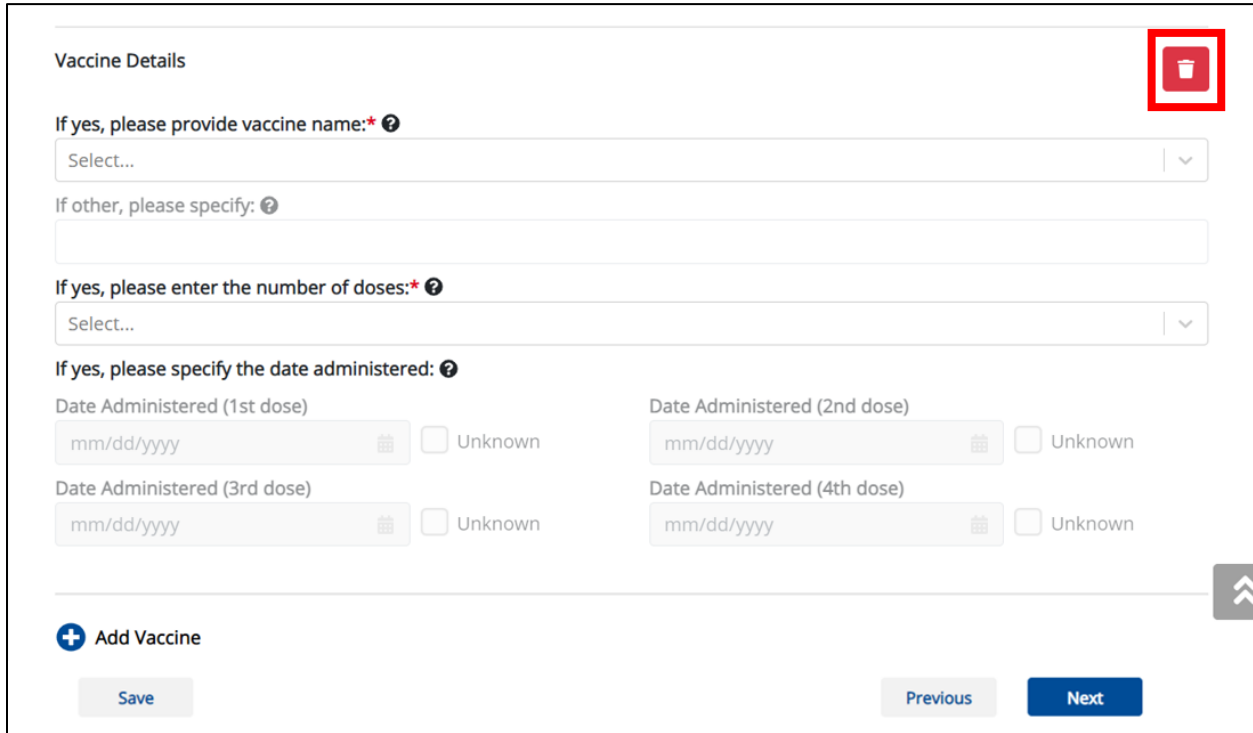
Date Administered (4th dose)*

12/20/2021 ☐ Unknown

+ Add Vaccine

For Infants born to mothers with HBV, was HBIG given?*

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



Vaccine Details

If yes, please provide vaccine name: * ?

Select...

If other, please specify: ?

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

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose) mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose) mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose) mm/dd/yyyy ☐ Unknown

Date Administered (4th dose) mm/dd/yyyy ☐ Unknown

+ Add Vaccine

Save Previous Next

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



+ Add Vaccine

For Infants born to mothers with HBV, was HBIG given?*

Yes No Unknown

If yes, please specify the date administered: ?

Date Administered mm/dd/yyyy ☐ Unknown

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



For Infants born to mothers with HBV, was HBIG given?*

Yes No Unknown

If yes, please specify the date administered: ?

Date Administered mm/dd/yyyy ☐ Unknown

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

CHILD HEPATITIS CASE REPORT FORM
Section 5 of 7

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

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Yes
No
Unknown
Refused

Vaccine Details

If yes, please provide vaccine name:*

hepatitis B vaccine, adolescent/high risk infant dosage

If other, please specify:

If yes, please enter the number of doses:*

4

If yes, please specify the date administered:

Date Administered (1st dose)*
06/01/2020
Unknown

Date Administered (2nd dose)*
12/10/2020
Unknown

Date Administered (3rd dose)*
06/15/2021
Unknown

Date Administered (4th dose)*
12/20/2021
Unknown

+ Add Vaccine

For Infants born to mothers with HBV, was HBIG given?*

Yes
No
Unknown

If yes, please specify the date administered:

Date Administered
06/30/2020
Unknown

Save
Previous
Next

Vaccination History for Child Hepatitis C

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

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

VACCINATION HISTORY

Patient Information ✓

Laboratory Information ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History

Additional Comments

Review & Submit

NOTE: No information is required to be provided on this screen. Please click on the "Next" button to proceed.

The **Vaccination History** screen does **not** collect vaccination details for **Child Hepatitis C**.

Save Previous Next

16 Additional Comments

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

CHILD HEPATITIS CASE REPORT FORM

Section 6 of 7

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information ✓

Laboratory Information ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments

Review & Submit

Additional comments or notes, please specify:

0/1000 Characters

Save Previous Next

17 Review and Submit

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

Print or Download Functionality

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

CHILD HEPATITIS CASE REPORT FORM Section 7 of 7

Please review your information before submitting.

REVIEW & SUBMIT

<div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;">Patient Information ✓</div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;">Laboratory Information ✓</div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;">Exposure Information ✓</div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;">Hospitalization, ICU & Death Information ✓</div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;">Vaccination History ✓</div> <div style="background-color: #f2f2f2; padding: 5px; margin-bottom: 5px;">Additional Comments ✓</div> <div style="background-color: #0056b3; color: white; padding: 5px; margin-bottom: 5px;">Review & Submit</div>	<div style="text-align: right; margin-bottom: 20px;"> Print Download </div> <div style="margin-bottom: 10px;"> Patient Information </div> <table style="width: 100%;"> <tr> <td style="width: 50%;"> Disease/Organism Child Hepatitis B </td> <td style="width: 50%;"> Date of Diagnosis Unknown </td> </tr> <tr> <td colspan="2"> Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes </td> </tr> <tr> <td> Patient ID (MRN) HEPB20220510 </td> <td> Affiliation/Organization Test Medical Center </td> </tr> <tr> <td> Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com) </td> <td> Affiliation/Organization Test Medical Center </td> </tr> <tr> <td> Attending Physician/Clinician </td> <td> Affiliation/Organization </td> </tr> </table>	Disease/Organism Child Hepatitis B	Date of Diagnosis Unknown	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes		Patient ID (MRN) HEPB20220510	Affiliation/Organization Test Medical Center	Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center	Attending Physician/Clinician	Affiliation/Organization
Disease/Organism Child Hepatitis B	Date of Diagnosis Unknown										
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes											
Patient ID (MRN) HEPB20220510	Affiliation/Organization Test Medical Center										
Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center										
Attending Physician/Clinician	Affiliation/Organization										

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

HEPATITIS

Patient Information

Disease/Organism
Perinatal Hepatitis C

Date of Diagnosis
09/01/2021

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
No

Patient ID (MRN)
BR10291942

Affiliation/Organization
Test Medical Center

Person Completing Form
Mr. Marty Crane, Sr (marty@email.com)

Affiliation/Organization
Other

If other, please specify:
Test Hospital

Attending Physician/Clinician
Dr. Fraser Crane (frasercrane@gmail.com)

Affiliation/Organization
Test Medical Center

First Name Bob	Last Name Ross
Suffix Sr	
Date of Birth 10/29/1942	Ethnicity Not Hispanic or Latino
Race Unknown	
Address 1 123 Painting Lane	
City Frankfort	State KY
Zip Code 40601	
County Franklin	Phone (555) 555-5555
Email bob@email.com	

Is the patient currently pregnant?
No

Is the patient postpartum?
No

Destination SecurePrintUS

Pages All

Copies 1

Color Color

More settings

Print
Cancel


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

- 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.


- 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.

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


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

Disease/Organism	Date of Diagnosis		
Perinatal Hepatitis C	09/01/2021		
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?			
No			
Patient ID (MRN)	Affiliation/Organization		
BR10291942	Test Medical Center		
Person Completing Form	Affiliation/Organization	If other, please specify:	
Mr. Marty Craine, Sr (marty@email.com)	Other	Test Hospital	
Attending Physician/Clinician	Affiliation/Organization		
Dr. Fraiser Crane (fraisercrane@email.com)	Test Medical Center		

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

Laboratory Information	
Does the patient have a lab test?	
Yes	
Hepatitis Marker	
Hepatitis C virus RNA panel	
Results	Positive

4. Review the *Patient Information* section.

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

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

5. Review the *Laboratory Information* section.

Laboratory Information

Does the patient have a lab test?

Yes

Hepatitis Marker

HEPATITIS C VIRUS AB

Results

Positive

Test Result Date

03/28/2022

Specimen Collection Date

03/28/2022

Laboratory Name:

Test Lab

Hepatitis Marker

HEPATITIS C VIRUS AB SIGNAL/CUTOFF

Results

Pending

Specimen Collection Date

03/29/2022

Laboratory Name:

Test Lab

6. Review the *Exposure Information* section.

Review & Submit

Exposure Information

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

No

Mother Hepatitis B Virus positive

No

Mother Hepatitis C Virus positive

No

HBV Contact Exposure

No

HCV Contact Exposure

No

Foreign Born

No

Is this part of an outbreak?

No

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

Review & Submit

Exposure Information

Hospitalization, ICU & Death Information

Was the patient hospitalized?

Yes

If yes, please specify the hospital name:

Test Hospital

Admission Date

01/03/2022

Discharge Date

01/10/2022

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

Yes

Admission Date to ICU

01/08/2022

Discharge Date from ICU

01/10/2022

Did the patient die as a result of this illness?

No

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

[Vaccination History](#)

Has the patient ever received a Hepatitis B vaccine?

Yes

Vaccine Details

If yes, please provide vaccine name:

hepatitis B vaccine, adolescent/high risk infant dosage

If yes, please enter the number of doses:

1

If yes, please specify the date administered:

Date Administered (1st dose)

11/20/2020

Vaccine Details

If yes, please provide vaccine name:

hepatitis B vaccine, pediatric or pediatric/adolescent dosage

If yes, please enter the number of doses:

1

If yes, please specify the date administered:

Date Administered (1st dose)

04/15/2021

For Infants born to mothers with HBV, was HBIG given?

Yes

If yes, please specify the date administered:

Date Administered

Unknown

[Additional Comments](#)

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

9. Review the *Additional Comments* section.

[Additional Comments](#)

Additional comments or notes, please specify:

Patient Notes

Previous

Submit

Click Hyperlinks to Edit

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

CHILD HEPATITIS CASE REPORT FORM Section 7 of 7

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information ✓

Laboratory Information ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments ✓

Review & Submit

Print
 Download

[Patient Information](#)

Disease/Organism Child Hepatitis B	Date of Diagnosis Unknown
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes	
Patient ID (MRN) HEPB20220510	Affiliation/Organization Test Medical Center
Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center
Attending Physician/Clinician Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization Test Medical Center

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

CHILD HEPATITIS CASE REPORT FORM Section 1 of 7

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

PATIENT INFORMATION

Patient Information ✓

Laboratory Information ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments ✓

Review & Submit

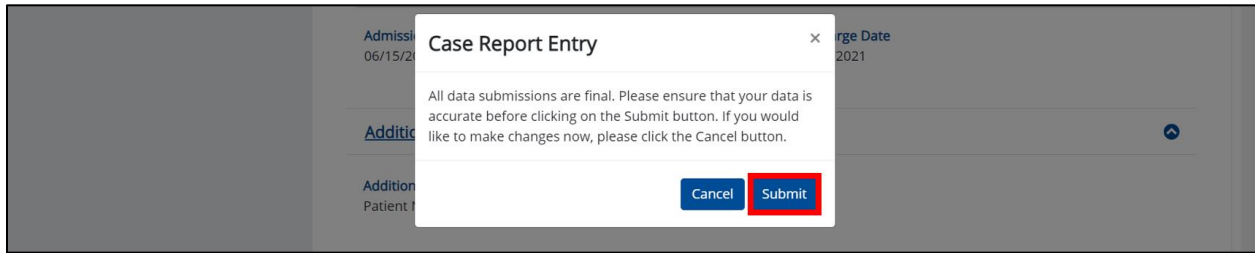
Disease/Organism* ⓘ Child Hepatitis B	Date of Diagnosis* 06/01/2020 <input type="checkbox"/> Unknown
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?* <input checked="" type="button" value="Yes"/> <input type="button" value="No"/>	
Patient ID (MRN)* ⓘ HEPB051020	Affiliation/Organization* ⓘ Test Medical Center
Person Completing Form* Mr. Arthur Vandelay, II (art...	Affiliation/Organization ⓘ Test Medical Center <small>If other, please specify: ⓘ</small>
Attending Physician/Clinician* Dr. Frank Costanza, Sr (fran...	Affiliation/Organization ⓘ Test Medical Center <small>If other, please specify: ⓘ</small>

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

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

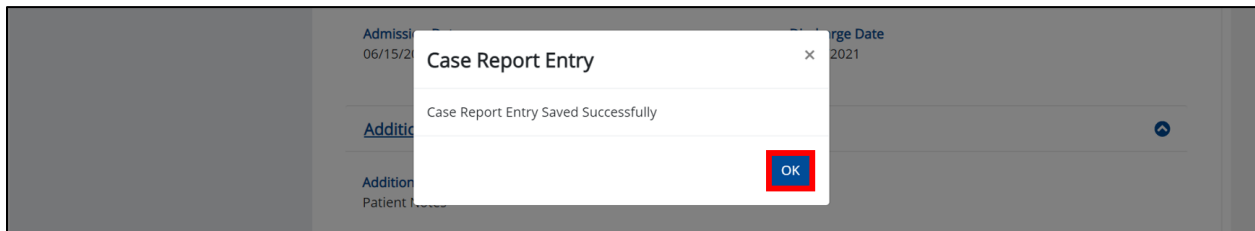
14. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Child Hepatitis Case Report Entry.

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



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

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



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

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

Please visit the KHIE website at <https://khie.ky.gov/COVID-19/Pages/Electronic-Case-Reporting-.aspx> 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.

The screenshot shows the 'CASE REPORT ENTRY USER SUMMARY' screen. At the top, there's a navigation bar with 'ePartnerViewer' and various links like 'Support', 'Announcements', 'Advisories', and 'Home'. Below the navigation bar, there's a breadcrumb trail: 'Home > Case Report Entry User Summary'. The main heading is 'CASE REPORT ENTRY USER SUMMARY'. Below this, there's a section for 'LAST UPDATED DATE RANGE' with 'Start Date' set to '10/01/2021' and 'End Date' set to '10/01/2021'. A 'Retrieve Data' button is to the right. Below the date range, it says 'SHOWING 1 ITEMS' and 'APPLY FILTER'. The main table has columns: ACTIONS, REPORT TYPE, DISEASE/ ORGANISM, AFFILIATION/ ORGANIZATION, PATIENT MRN, FIRST NAME, LAST NAME, DATE OF BIRTH, PATIENT SEX, STATUS, LAST UPDATED, and SUBMISSION DATE. The first row shows: View, Copy, Perinatal Hepatitis, Perinatal Hepatitis C, Test Medical Center, BR10291942, Susan, Ross, 10/29/1990, Female, Complete, 10/01/2021 12:30 PM, 10/01/2021 12:30 PM. At the bottom, there are pagination controls: 'First', 'Back', '1', 'Next', 'Last', and 'Maximum 5 entries per page'.

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

This screenshot shows the same 'CASE REPORT ENTRY USER SUMMARY' screen, but with the 'Start Date' changed to '09/01/2021' and the 'End Date' changed to '10/01/2021'. A calendar overlay for 'September 2021' is visible, showing the dates from 29 to 30. The 'Retrieve Data' button is highlighted. The table below still shows the same case report for Perinatal Hepatitis C.

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

This screenshot shows the 'CASE REPORT ENTRY USER SUMMARY' screen after clicking the 'Retrieve Data' button. The 'Start Date' is '09/01/2021' and the 'End Date' is '10/01/2021'. The 'Retrieve Data' button is highlighted. The table below still shows the same case report for Perinatal Hepatitis C.

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

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

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE

Start Date End Date

Retrieve Data

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

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

LAST UPDATED DATE RANGE

Start Date End Date

Retrieve Data

Apply Filter

SHOWING 7 ITEMS

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

First Back 1 2 Next Last

Maximum 5 entries per page

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

SHOWING 7 ITEMS

Hide Filter

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

Review Previously Submitted Case Reports

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

LAST UPDATED DATE RANGE

Start Date

09/01/2021

End Date

10/01/2021

Retrieve Data

SHOWING
5 ITEMS

APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<div><div>View</div><div>Copy</div></div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
<div><div>Continue</div></div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Daphne	Crane	01/15/1992	Female	In Progress	09/24/2021 01:45 PM	
<div><div>Continue</div></div>	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	

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

KHIE

Case Report Details

Print

Download

x

Patient Information

Disease/Organism
Perinatal Hepatitis C

Date of Diagnosis
09/20/2021

Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?
No

Patient ID (MRN)
BR10291942

Affiliation/Organization
Test Medical Center

Person Completing Form
Mr. Marty Craine, Sr (marty@email.com)

Affiliation/Organization
Other

If other, please specify:
Test Hospital

Attending Physician/Clinician
Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization
Test Medical Center

First Name
Susan

Last Name
Ross

Suffix
Sr

Race
Unknown

Date of Birth
10/29/1990

Ethnicity
Not Hispanic or Latino

Address 1
123 Painting Lane

OK

Copy Previously Submitted Case Reports

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

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

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Daphne	Crane	01/15/1992	Female	In Progress	10/01/2021 01:45 PM	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM

Please Note: Clicking **Copy** will automatically navigate you to the **Patient Summary** screen.

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

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

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*

Perinatal Hepatitis C

Date of Diagnosis*

09/20/2021

Unknown

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

Yes No

Patient ID (MRN)*

BR10291942

Affiliation/Organization*

Test Medical Center

Person Completing Form*

Mr. Marty Craine, Sr (marty@email.com)

Affiliation/Organization*

Other

If other, please specify:*

Test Hospital

Attending Physician/Clinician*

Dr. Fraiser Crane (fraisercrane@email.co...)

Affiliation/Organization*

Test Medical Center

If other, please specify:*

Prefix

Select...

First Name*

Bob

Middle Name

Last Name*

Ross

Suffix

Sr

Maiden Name

Date of Birth*

10/29/1990

Ethnicity*

Not Hispanic or Latino

Race*

Unknown

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

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

The screenshot displays the 'PATIENT INFORMATION' form. On the left is a sidebar with a list of tabs: Patient Information, Laboratory Information, Applicable Symptoms, Medical Conditions, Exposure Information, Hospitalization, ICU & Death Information, Vaccination History, Additional Comments, and Review & Submit. The main form area contains various input fields. Red boxes highlight specific sections where fields are disabled:

- Top Right:** A box around the 'Date of Diagnosis*' field (09/20/2021) and the 'Unknown' checkbox.
- Middle Left:** A box around the 'Person Completing Form*' dropdown menu, which currently shows 'Mr. Marty Craine, Sr (marty@email.com)'.
- Middle Left:** A box around the 'Attending Physician/Clinician*' dropdown menu, which currently shows 'Dr. Fraiser Crane (fraisercrane@email.co...'.
- Bottom:** A large box around the entire address section, including 'Address 1*', 'City*', 'County*', 'State*', 'Zip Code', 'Phone*', 'Email', and pregnancy/postpartum status questions.

Other visible fields include 'Disease/Organism*' (Perinatal Hepatitis C), 'Affiliation/Organization*' (Test Medical Center), 'Patient ID (MRN)*' (BR10291942), 'Prefix', 'First Name*' (Susan), 'Middle Name', 'Last Name*' (Ross), 'Suffix', 'Maiden Name', 'Date of Birth*' (10/29/1998), 'Ethnicity*' (Not Hispanic or Latino), and 'Race*' (Unknown).

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

Is the patient currently pregnant?

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

Is the patient postpartum?*

If yes, please enter the date of delivery: *

Does the patient have a history of incarceration?*

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

LABORATORY INFORMATION

Does the patient have a lab test?*

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

Hepatitis Marker*

Hepatitis C virus RNA panel

If other, please specify:

Results*

Positive

If applicable, please enter the viral load: ?

Test Result Date*

Specimen Collection Date*

Laboratory Name:*

Test Lab

+ Add Hepatitis Marker

ALT

+ Add ALT

AST

+ Add AST

Bilirubin

+ Add Bilirubin

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

REVIEW & SUBMIT

Print

Download

Patient Information

Disease/Organism

Perinatal Hepatitis C

Date of Diagnosis

09/20/2021

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

No

Patient ID (MRN)

BR10291942

Affiliation/Organization

Test Medical Center

Person Completing Form

Mr. Marty Craine, Sr (marty@email.com)

Affiliation/Organization

Other

If other, please specify:

Test Hospital

Attending Physician/Clinician

Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization

Test Medical Center

First Name

Bob

Last Name

Ross

Suffix

Sr

Date of Birth

10/29/1942

Ethnicity

Not Hispanic or Latino

Race

Unknown

Address 1

123 First Avenue

City

Frankfort

State

KY

Zip Code

40601

County

Franklin

Phone

(555) 555-5555

Email

susan@email.com

Is the patient postpartum?

Yes

If yes, please enter the date of delivery:

11/05/2021

Does the patient have a history of incarceration?

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

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

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

Additional comments or notes, please specify:

Additional Patient Notes

Previous

Submit

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

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

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

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

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

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	SR10291990	Susan	Ross	10/29/1990	Female	Complete	10/03/2021 2:30 PM	10/03/2021 2:30 PM

Continue In-Progress Case Reports

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

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

CASE REPORT ENTRY USER SUMMARY

🕒 LAST UPDATED DATE RANGE

Start Date09/01/2021📅

End Date10/01/2021📅

🔄 Retrieve Data

SHOWING
5 ITEMS

🔼 APPLY FILTER

ACTIONS	REPORT TYPE ⌵	DISEASE/ ORGANISM ⌵	AFFILIATION/ ORGANIZATION ⌵	PATIENT MRN ⌵	FIRST NAME ⌵	LAST NAME ⌵	DATE OF BIRTH ⌵	PATIENT SEX ⌵	STATUS ⌵	LAST UPDATED ⌵	SUBMISSION DATE ⌵
<div>ViewCopy</div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
<div>Continue</div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Daphne	Crane	01/15/1992	Female	In Progress	09/24/2021 01:45 PM	
<div>Continue</div>	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	

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

Home > Perinatal Hepatitis Case Report Form

PERINATAL HEPATITIS CASE REPORT FORM

Section 8 of 9

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

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

Additional comments or notes, please specify:

0/1000 Characters

Previous Next

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 KHIESupport@ky.gov.

Please Note: To seek assistance or log issues, you can use the **Support Tab** located in the blue navigation bar at the top of the screen in the ePartnerViewer.

