

# Kentucky Health Information Exchange (KHIE)

## **Other Reportable Diseases Case Report: Creutzfeldt-Jakob Disease (CJD)**

### Quick Reference Guide

June 2024

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## Document Control Information

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# 1 Introduction

## Overview

This training manual covers the unique functionalities for the Creutzfeldt-Jakob Disease condition in the Other Reportable Conditions eICR Form in the ePartnerViewer. The Creutzfeldt-Jakob Disease condition contains unique **Patient Information, Additional Information, and Hospitalization, ICU, and Death Information** screens. All other screens for the Creutzfeldt-Jakob Disease condition follow the generic workflow for the Other Reportable Conditions Case Report. For specific information about the Other Reportable Conditions Case Report, please review the [Direct Data Entry for Case Reports: Other Reportable Conditions User Guide](#).

Users with the *Manual Case Reporter* role can submit case reports from the ePartnerViewer by completing an online case report. The process generates a manual electronic initial case report (eICR) which is routed to the Kentucky Department for Public Health (KDPH). All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

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

## Supported Web Browsers

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

Desktop Browser Version	Mobile Browser Version
<b>Microsoft Edge</b>	
Version 44+	Version 40+
<b>Google Chrome</b>	
Version 70+	Version 70+
<b>Mozilla Firefox</b>	
Version 48+	Version 48+
<b>Apple Safari</b>	
Version 9+	iOS 11+

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

## Mobile Device Considerations

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

## Accessing the ePartnerViewer

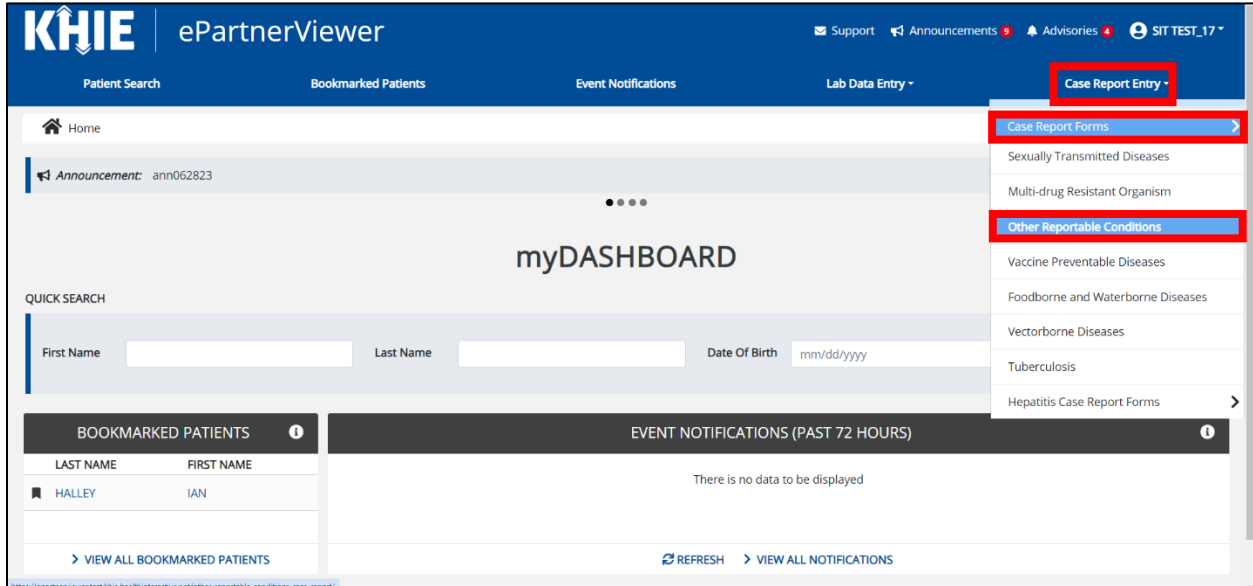
To access the ePartnerViewer, Users must meet the following specifications:

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

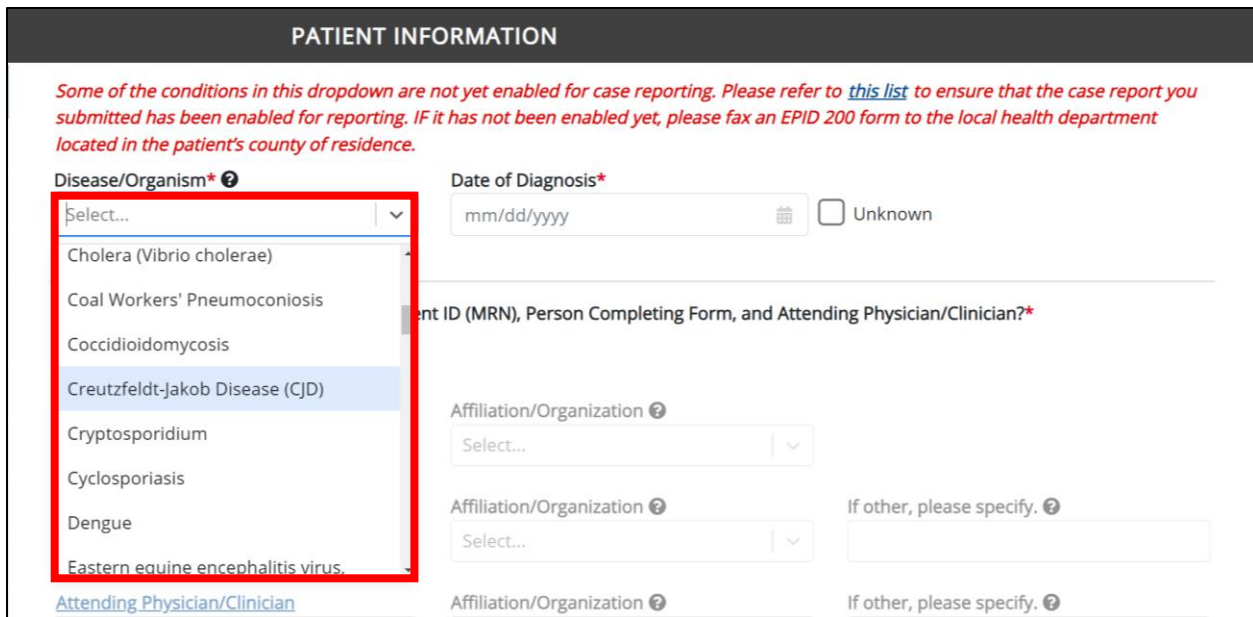
**Please Note:** For specific information about creating a Kentucky Online Gateway (KOG) account and how to complete MFA, please review the [ePartnerViewer Login: Kentucky Online Gateway \(KOG\) and Okta Verify Multi-Factor Authentication \(MFA\) User Guide](#).

## 2 Patient Information

1. To enter Other Reportable Conditions 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 **Other Reportable Conditions** from the dropdown menu.



3. To start the Creutzfeldt-Jakob Disease Case Report entry, select **Creutzfeldt-Jakob Disease** from the *Disease/Organism* field on the **Patient Information** screen.



4. You must complete the mandatory fields on the **Patient Information** screen.

**PATIENT INFORMATION**

*Some of the conditions in this dropdown are not yet enabled for case reporting. Please refer to [this list](#) to ensure that the case report you submitted has been enabled for reporting. If it has not been enabled yet, please fax an EPID 200 form to the local health department located in the patient's county of residence.*

**Disease/Organism\***    **Date of Diagnosis\***    Unknown

**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:**

**Prefix**

**First Name\***  **Middle Name**  **Last Name\***

**Suffix**  **Date of Birth\***

**Patient Sex\***  **Ethnicity\***  **Race\***

5. Enter the **Date of Diagnosis**. If the date of diagnosis is unknown, click the **Unknown** checkbox.

**Disease/Organism\***    **Date of Diagnosis\***    Unknown

6. 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? \*

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

- 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? \*

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

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

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

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

**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).

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

- 10. 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 enabled only if you selected **No** to the conditional question: *Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*

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

12. 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?*

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

14. Enter the patient's **First Name** and **Last Name**.

15. If available, enter the patient's **Middle Name**.

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

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

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

A screenshot of a patient information form. The 'Patient Sex\*' dropdown is highlighted in red. The 'Ethnicity\*' dropdown is also highlighted in red and contains the text 'Not Hispanic or Latino'. The 'Race\*' dropdown is highlighted in red and is open, showing a list of options: American Indian or Alaska Native, Asian, Asked but Unknown, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and Unknown.

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

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

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

A screenshot of a patient information form. The 'Address 1\*' text box is highlighted in red. The 'Address 2' text box is highlighted in red and contains the text 'Unit, Suite, Building, etc.'. The 'City\*' text box is highlighted in red. The 'State\*' dropdown is highlighted in red and contains the text 'Select...'. The 'Zip Code\*' text box is highlighted in red. The 'County\*' dropdown is highlighted in red and contains the text 'Select...'. The 'Phone\*' text box is highlighted in red and contains the text '(XXX) XXX-XXXX'. The 'Email' text box is highlighted in red and contains the text 'name@domain.com'.

22. Select the **type of patient visit** from the *Visit Type* dropdown menu.

A screenshot of a patient information form. The 'Visit Type\*' dropdown is highlighted in red and is open, showing a list of options: Ambulatory, Emergency, Field, Home Health, Inpatient Acute, Inpatient Encounter, and Inpatient Non-Acute. The 'Encounter ID/Visit #' field is highlighted in red and contains the text 'Generate'.

• The *Encounter ID/Visit #* field allows Users to enter a **unique 20-digit Encounter ID/Visit #**.

A screenshot of a patient information form. The 'Visit Type\*' dropdown is highlighted in red and contains the text 'Ambulatory'. The 'Encounter ID/Visit #' field is highlighted in red and contains the text 'Generate'.

- The **Encounter ID/Visit #** hyperlink allows Users to view the *Patient Case History* which includes the historical case report details and Encounter IDs (when available) that were previously submitted for the patient. The *Patient Case History* search is based on the **Patient First Name, Last Name,** and **Patient ID (MRN)** entered.

Visit Type\* Encounter ID/Visit # ?  Generate

- The **Generate** checkbox triggers the system to generate a **unique 20-digit Encounter ID/Visit #** if the Encounter ID/Visit # is unknown.

Visit Type\* Encounter ID/Visit # ?  Generate

- Upon clicking the **Generate** checkbox, the *Encounter ID/Visit #* field will be grayed out and disabled. The *Encounter ID/Visit #* field will display the system-generated Encounter ID/Visit # only after the **Patient Information** screen has been completed and saved.

Visit Type\* Encounter ID/Visit # ?  Generate

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

Is the patient currently pregnant?\*

Yes No Unknown

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

Unknown

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

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

Is the patient currently pregnant?\*

Yes No Unknown

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

mm/dd/yyyy  Unknown

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

Is the patient currently pregnant?\*

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

24. Select the **appropriate answer** from the dropdown menu for the field: *Where is the patient currently located?*

Where is the patient currently located?\*

Select...

- Living with a family member
- Medical facility
- Patient's home address
- Other

25. Select the **appropriate answer** for the conditional question: *Is the patient's current location the same as the patient's current address?*

Is the patient's current location the same as the patient's current address?\*

Please enter the contact information and address where the patient is currently located.

Name

Address 1  Address 2

City  State  Zip Code

County  Phone  Email

26. If **No** is selected, the following fields are enabled. Enter the **contact information and address where the patient is currently located**.

Is the patient's current location the same as the patient's current address?\*

Please enter the contact information and address where the patient is currently located.

Name\*

Address 1\* Address 2  
Unit, Suite, Building, etc.

City\* State\* Zip Code\*

County\* Phone\* Email  
name@domain.com

27. Once complete, click **Next** to proceed to the **Laboratory Information** screen.

County\* Adair x | v Phone\* (555) 555-5555 Email name@domain.com

### 3 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?*

Please provide laboratory information related to this case.

**LABORATORY INFORMATION**

Patient Information <span style="float: right;">✔</span>	<div style="border: 2px solid red; padding: 5px;"><b>Does the patient have a lab test?*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></div>
<b>Laboratory Information</b>	
Applicable Symptoms <span style="float: right;">🔒</span>	
Additional Information <span style="float: right;">🔒</span>	

Laboratory Information

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

**LABORATORY INFORMATION**

Patient Information <span style="float: right;">✔</span>	<b>Does the patient have a lab test?*</b> <input checked="" type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Laboratory Information</b>	
Applicable Symptoms <span style="float: right;">🔒</span>	
Additional Information <span style="float: right;">🔒</span>	
Hospitalization, ICU, & Death Information <span style="float: right;">🔒</span>	
Vaccination History <span style="float: right;">🔒</span>	
Treatment Information <span style="float: right;">🔒</span>	
Additional Comments <span style="float: right;">🔒</span>	
Review & Submit <span style="float: right;">🔒</span>	

**Laboratory Information**

**Laboratory Name\***

**Test Name\***

  
If other, please specify. ?  
  

**Filler Order/Accession Number ?**

**Specimen Source\***

  
If other, please specify. ?  
  

**Test Result\***

  
If other, please specify. ?  
  

Test Result Date   Unknown

Specimen Collection Date\*   Unknown

**Additional Information ?**

  
0/300 Characters

+ Add Test



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

**LABORATORY INFORMATION**

- Patient Information ✔
- Laboratory Information** ✔
- Applicable Symptoms ✔
- Additional Information ✔
- Hospitalization, ICU, & Death Information ✔
- Vaccination History ✔
- Treatment Information ✔
- Additional Comments
- Review & Submit 🔒

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

---

**Laboratory Information**

**Laboratory Name\***

**Test Name\***

If other, please specify. ?

**Filler Order/Accession Number ?**

**Specimen Source\***

If other, please specify. ?

**Test Result\***

If other, please specify. ?

Test Result Date   Unknown

Specimen Collection Date\*   Unknown

**Additional Information ?**

0/300 Characters

+ Add Test

## 4 Applicable Symptoms

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

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

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

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

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

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

Fever\*

If yes, please enter the highest temperature. ?

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

Fever\*

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

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

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

If yes, please enter the number of days with diarrhea. ?

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

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

If yes, please enter the number of days with diarrhea.\* ?

6. Select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

<b>Akinetic mutism*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Hyperreflexia*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Anxiety*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Myoclonus*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Ataxia*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Rapidly progressive dementia*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Chorea*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Spasticity*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Depression*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Visual deficits*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Dysesthesia*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Weakness*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Extrapyramidal signs*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	

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

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

If yes, please specify. ⓘ

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

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

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

If yes, please specify.\* ⓘ

## 5 Additional Information

The Creutzfeldt-Jakob Disease Case Report captures the patient’s medical testing details.

1. On the **Additional Information** screen, select the **appropriate answer** for the field: *Was the patient seen by a neurologist?*

**ADDITIONAL INFORMATION**

Medical Testing

Was the patient seen by a neurologist?\*

Yes  No  Unknown

2. Select the **appropriate answer** for the conditional question: *Were any electroencephalograms (EEGs) performed?*

Were any electroencephalograms (EEGs) performed?\*

Yes  No  Unknown

Did a radiologist or neurologist report that an EEG was indicative of a CJD diagnosis?

Yes  No  Unknown

If yes, please specify EEG interpretation.

0/500 Characters

3. If **Yes** is selected for the *Were any electroencephalograms (EEGs) performed?* field, the following fields are enabled:
  - *Did the radiologist or neurologist report that an EEG was indicative of a CJD diagnosis?*
  - *If Yes, please specify the EEG interpretation.*

Were any electroencephalograms (EEGs) performed?\*

Yes  No  Unknown

Did a radiologist or neurologist report that an EEG was indicative of a CJD diagnosis?\*

Yes  No  Unknown

If yes, please specify EEG interpretation.

0/500 Characters

- 4. Select the **appropriate answer** for the field: *Did the radiologist or neurologist report that an EEG was indicative of a CJD diagnosis?*

Did a radiologist or neurologist report that an EEG was indicative of a CJD diagnosis?\*

<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
--------------------------------------	--------------------------	-------------------------------

- 5. If applicable, enter the **EEG interpretation** in the textbox for the field: *If yes, please specify the EEG interpretation.*

If yes, please specify EEG interpretation.

0/500 Characters

- 6. Select the **appropriate answer** for the conditional question: *Were any MRIs performed?*

Were any MRIs performed?\*

<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
--------------------------------------	--------------------------	-------------------------------

Did a radiologist or neurologist report that an MRI was indicative of a CJD diagnosis?

<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
---------------------------	--------------------------	-------------------------------

If yes, please specify MRI interpretation.

0/500 Characters

- 7. If **Yes** is selected for the *Were any MRIs performed?* field, the following fields are enabled:

- *Did the radiologist or neurologist report that an MRI was indicative of a CJD diagnosis?*
- *If yes, please specify MRI interpretation.*

Were any MRIs performed?\*

<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
--------------------------------------	--------------------------	-------------------------------

Did a radiologist or neurologist report that an MRI was indicative of a CJD diagnosis?\*

<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
--------------------------------------	--------------------------	-------------------------------

If yes, please specify MRI interpretation.

0/500 Characters

- 8. Select the **appropriate answer** for the field: *Did the radiologist or neurologist report that an MRI was indicative of a CJD diagnosis?*

Did a radiologist or neurologist report that an MRI was indicative of a CJD diagnosis?\*

<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
--------------------------------------	--------------------------	-------------------------------

9. If applicable, enter the **MRI interpretation** in the textbox for the field: *If yes, please specify MRI interpretation.*

If yes, please specify MRI interpretation.

0/500 Characters

10. Select the **appropriate answer** for the conditional question: *Was a brain biopsy performed?*

Was a brain biopsy performed?\*

Yes	No	Unknown
-----	----	---------

Were biopsy specimens sent to the National Prion Disease Pathology Surveillance Center?

Yes	No	Unknown
-----	----	---------

11. If **Yes** is selected, select the **appropriate answer** for the field: *Were biopsy specimens sent to the National Prion Disease Pathology Surveillance Center?*

Was a brain biopsy performed?\*

Yes	No	Unknown
-----	----	---------

Were biopsy specimens sent to the National Prion Disease Pathology Surveillance Center?\*

Yes	No	Unknown
-----	----	---------

12. Select the **appropriate answer** for the conditional question: *Were any other types of testing performed to diagnose CJD in the patient?*

Were any other types of testing performed to diagnose CJD in the patient?\*

Yes	No	Unknown
-----	----	---------

If yes, please specify the kinds of tests performed and the test results.

0/500 Characters

13. If **Yes** is selected, enter the **types of testing and test results obtained to diagnose Creutzfeldt-Jakob Disease in the patient** in the textbox for the field: *If yes, please specify the kinds of tests performed and the test results.*

Were any other types of testing performed to diagnose CJD in the patient?\*

Yes	No	Unknown
-----	----	---------

If yes, please specify the kinds of tests performed and the test results.\*

0/500 Characters

### Patient History

The Creutzfeldt-Jakob Disease Case Report captures patient history details.

- 14. Select the **appropriate answer** for the conditional question: *Is there history of a definite or probable case of prion disease in a blood relative?*

Patient History

Is there history of a definite or probable case of prion disease in a blood relative?\*

Yes     No     Unknown

If yes, please specify the relationship to the patient.

Select... | ▾

- 15. If **Yes** is selected, select the **appropriate answer** from the dropdown menu for the field: *If yes, please specify the relationship to the patient.*

If yes, please specify the relationship to the patient.\*

Select... | ▾

- Child
- Cousin
- Grandparent
- Great-grandparent
- Niece or nephew
- Parent
- Sibling



16. The following question displays on the **Additional Information** screen: *Did the patient undergo any of the following surgical procedures before the onset of the current illness?* Select the **appropriate answers** for the following fields to indicate the patient’s surgical procedures:

- *Brain surgery*
- *Spinal surgery*
- *Eye surgery*

Did the patient undergo any of the following surgical procedures before the onset of the current illness?

**Brain surgery\***

Year of Surgery  
YYYY

**Spinal surgery\***

Year of Surgery  
YYYY

**Eye surgery\***

Year of Surgery  
YYYY

17. If **Yes** is selected for the conditional fields, enter the **Year of Surgery** in the textbox for the field: *Year of Surgery*.

Did the patient undergo any of the following surgical procedures before the onset of the current illness?

**Brain surgery\***

**Year of Surgery\***  
YYYY

**Spinal surgery\***

**Year of Surgery\***  
YYYY

**Eye surgery\***

**Year of Surgery\***  
YYYY

18. The following question displays on the **Additional Information** screen: *Did the patient ever receive any of the following?* Select the **appropriate answers** for the following fields to indicate the allografts and procedures received by the patient:

- *A dura mater allograft*
- *A corneal allograft*
- *Human derived pituitary growth hormone*

Did the patient ever receive any of the following?

**A dura mater allograft\***

Year Received

YYYY

**A corneal allograft\***

Year Received

YYYY

**Human derived pituitary growth hormone\***

Year First Received      Year Last Received

YYYY                      YYYY

19. If **Yes** is selected for the conditional fields *A dura mater allograft* or *A corneal allograft*, enter the **Year Received** in the textbox for the field: *Year Received*.

20. If **Yes** is selected for the conditional field *Human derived pituitary growth hormone*, enter the **Year First Received** and **Year Last Received** in the textboxes for the fields: *Year First Received* and *Year Last Received*

Did the patient ever receive any of the following?

**A dura mater allograft\***

**Year Received\***

YYYY

**A corneal allograft\***

**Year Received\***

YYYY

**Human derived pituitary growth hormone\***

**Year First Received\***      **Year Last Received\***

YYYY                      YYYY

21. Select the **appropriate answer** for the conditional question: *Did the patient ever donate blood?*

Did the patient ever donate blood?\*

Yes  No  Unknown

If yes, please specify the name of the city and state in which the patient last donated blood.

0/200 Characters

Date of Last Donation

mm/dd/yyyy  Unknown

22. If **Yes** is selected for *Did the patient ever donate blood?* the following fields are enabled:

- *If yes, please specify the name of the city and state in which the patient last donated blood.*
- *Date of Last Donation*

Did the patient ever donate blood?\*

Yes  No  Unknown

If yes, please specify the name of the city and state in which the patient last donated blood.

0/200 Characters

Date of Last Donation\*

mm/dd/yyyy  Unknown

23. If known, enter the **location details of where the patient last donated blood** in the textbox for the field: *If yes, please specify the name of the city and state in which the patient last donated blood.*

If yes, please specify the name of the city and state in which the patient last donated blood.

0/200 Characters

24. Enter the **Date of Last Donation**. If the Date of Last Donation is unknown, click the **Unknown** checkbox.

Date of Last Donation\*

mm/dd/yyyy  Unknown

25. Select the **appropriate answer** for the conditional question: *Did the patient live or travel (including military service) in Europe between 1980 and 1996?*

Did the patient live or travel (including military service) in Europe between 1980 and 1996?\*

Yes  No  Unknown

If yes, please specify the years in which the patient lived or traveled in Europe. Please select all that apply.

Select...

If yes, please specify the countries in which the patient lived or traveled in Europe. Please select all that apply.

Select...

26. If **Yes** is selected for the *Did the patient live or travel (including military service) in Europe between 1980 and 1996?* field, the following fields are enabled:

- *If yes, please specify the years in which the patient lived or traveled in Europe. Please select all that apply.*
- *If yes, please specify the countries in which the patient lived or traveled in Europe. Please select all that apply.*

Did the patient live or travel (including military service) in Europe between 1980 and 1996?\*

Yes  No  Unknown

If yes, please specify the years in which the patient lived or traveled in Europe. Please select all that apply.

Select...

If yes, please specify the countries in which the patient lived or traveled in Europe. Please select all that apply.

Select...

27. Select the **appropriate answer(s)** from the multiselect dropdown menu for the field: *If yes, please specify the years in which the patient lived or traveled in Europe. Please select all that apply.*

If yes, please specify the years in which the patient lived or traveled in Europe. Please select all that apply.

Select...

1980

1981

1982

1983

1984

1985

1986

Please include additional information (e.g., area hunted, year hunted), if applicable.

28. Select the **appropriate answer(s)** from the multiselect dropdown menu for the field: *If yes, please specify the countries in which the patient lived or traveled in Europe. Please select all that apply.*

If yes, please specify the countries in which the patient lived or traveled in Europe. Please select all that apply.

Select...

- Albania
- Andorra
- Austria
- Belarus
- Belgium
- Bosnia and Herzegovina
- Bulgaria

29. Select the **appropriate answer** for the conditional question: *Did the patient ever hunt deer or elk?*

Did the patient ever hunt deer or elk?\*

Yes  No  Unknown

If yes, please specify the states in which the patient hunted. Please select all that apply.

Select...

Please include additional information (e.g., area hunted, year hunted), if applicable.

0/200 Characters

30. If **Yes** is selected for the *Did the patient ever hunt deer or elk?* field, the following fields are enabled:

- *If yes, please specify the states in which the patient hunted. Please select all the apply.*
- *Please include additional information (e.g., area hunted, year hunted), if applicable.*

Did the patient ever hunt deer or elk?\*

Yes  No  Unknown

If yes, please specify the states in which the patient hunted. Please select all that apply.

Select...

Please include additional information (e.g., area hunted, year hunted), if applicable.

0/200 Characters

31. Select the **appropriate answer(s)** from the multiselect dropdown menu for the field: *If yes, please specify the states in which the patient hunted. Please select all that apply.*

If yes, please specify the states in which the patient hunted. Please select all that apply.

Select...

- KY
- AK
- AL
- AR
- AS
- AZ
- CA

Was the meat known to have tested positive for Chronic Wasting Disease (CWD)?

32. If applicable, enter the **patient's additional hunting details** in the textbox for the field: *Please include additional information (e.g., area hunted, year hunted), if applicable.*

Please include additional information (e.g., area hunted, year hunted), if applicable.

0/200 Characters

33. Select the **appropriate answer** for the conditional question: *Did the patient ever eat deer or elk meat?*

Did the patient ever eat deer or elk meat?\*

Yes	No	Unknown
-----	----	---------

Was the meat known to have tested positive for Chronic Wasting Disease (CWD)?

Yes	No	Unknown
-----	----	---------

If yes, please specify the states where the consumed deer or elk meat came from. Please select all that apply.

Select...

Please include additional information (e.g., area meat originated in, year consumed), if applicable.

0/200 Characters

34. If **Yes** is selected for the *Did the patient ever eat deer or elk meat?* field, the following fields are enabled:

- *Was the meat known to have tested positive for Chronic Wasting Disease (CWD)?*
- *If yes, please specify the states where the consumed deer or elk meat came from. Please select all that apply.*
- *Please include additional information (e.g., area meat originated in, year consumed), if applicable.*

Was the meat known to have tested positive for Chronic Wasting Disease (CWD)?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
------------------------------	-----------------------------	----------------------------------

If yes, please specify the states where the consumed deer or elk meat came from. Please select all that apply.

Select...

Please include additional information (e.g., area meat originated in, year consumed), if applicable.

0/200 Characters

35. Select the **appropriate answer** for the field: *Was the meat known to have tested positive for Chronic Wasting Disease (CWD)?*

Was the meat known to have tested positive for Chronic Wasting Disease (CWD)?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
------------------------------	-----------------------------	----------------------------------

36. Select the **appropriate answer(s)** from the multiselect dropdown menu for the field: *If yes, please specify the states where the consumed deer or elk meat came from. Please select all that apply.*

If yes, please specify the states where the consumed deer or elk meat came from. Please select all that apply.

Select...

- KY
- AK
- AL
- AR
- AS
- AZ
- CA

Save Previous Next

37. If applicable, enter **additional information about the deer or elk meat** in the textbox for the field: *Please include additional information (e.g., area meat originated in, year consumed), if applicable.*

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

Please include additional information (e.g., area meat originated in, year consumed), if applicable.

0/200 Characters

Save Previous **Next**

## 6 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?*

The screenshot shows the 'HOSPITALIZATION, ICU, & DEATH INFORMATION' form. The left sidebar contains a navigation menu with items: Patient Information, Laboratory Information, Applicable Symptoms, Additional Information, Hospitalization, ICU, & Death Information (highlighted), Vaccination History, Treatment Information, Additional Comments, and Review & Submit. The main content area has a title bar 'HOSPITALIZATION, ICU, & DEATH INFORMATION'. Below the title bar, the question 'Was the patient hospitalized?\*' is highlighted with a red box. It has three radio button options: 'Yes', 'No', and 'Unknown'. Below this question is a text input field for 'If yes, please specify the hospital name.\*'. Further down, there are date pickers for 'Admission Date' and 'Discharge Date', each with an 'Unknown' checkbox. A 'Still hospitalized' checkbox is also present. Below these are more questions: 'Was the patient admitted to an intensive care unit (ICU)?\*' with 'Yes', 'No', and 'Unknown' options; 'Admission Date to ICU' and 'Discharge Date from ICU' with date pickers and 'Unknown' checkboxes; and 'Did the patient die as a result of this illness?\*' with 'Yes' and 'No' options, followed by a 'Date of Death' field.

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

This screenshot shows the same form as above, but with the 'Yes' radio button selected for the 'Was the patient hospitalized?\*' question. The 'If yes, please specify the hospital name.\*' field is now active and highlighted with a red box. The 'Admission Date\*' and 'Discharge Date\*' fields are also active and highlighted with a red box. The 'Admission Date to ICU' and 'Discharge Date from ICU' fields are also active. The 'Still hospitalized' checkbox is now checked. The 'Was the patient admitted to an intensive care unit (ICU)?\*' question and its options are also active. The 'Date of Death' field is also active.



**Please Note:** If **No** or **Unknown** is selected for the conditional question, all subsequent hospitalization-related and ICU-related fields are disabled. Death-related questions are not impacted by the selected answer for the conditional question: *Was the patient hospitalized?*

Admission Date\* 04/29/2024  Unknown

Discharge Date\* mm/dd/yyyy  Unknown

Still hospitalized

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

Admission Date to ICU mm/dd/yyyy  Unknown

Discharge Date from ICU mm/dd/yyyy  Unknown

Did the patient die as a result of this illness?

If yes, please provide the date of death.  
Date of Death mm/dd/yyyy

**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.

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

Hospitalization, ICU & Death Information

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

OK

Admission Date\* 01/31/2024  Unknown  
*Invalid Admission Date*

Discharge Date\* 01/29/2024  Unknown  
*Invalid Discharge Date*

Still hospitalized

<b>Hospitalization, ICU &amp; Death Information</b>	<b>Admission Date*</b> 01/31/2024 <input type="checkbox"/> Unknown <small>Invalid Admission Date</small>	<b>Discharge Date*</b> 01/29/2024 <input type="checkbox"/> Unknown <input type="checkbox"/> Still hospitalized <small>Invalid Discharge Date</small>
Vaccination History		
Treatment Information		

3. Select the **appropriate answer** for the conditional question: *Did the patient die as a result of this illness?*

<b>Did the patient die as a result of this illness?</b> <input type="button" value="Yes"/> <input type="button" value="No"/>
<small>If yes, please provide the date of death.</small>
Date of Death mm/dd/yyyy
Was an autopsy performed? <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

4. If **Yes** is selected for the *Did the patient die as a result of this illness* field, the following fields are enabled:

- *If yes, please provide the date of death.*
- *Was an autopsy performed?*

<b>Did the patient die as a result of this illness?*</b> <input checked="" type="button" value="Yes"/> <input type="button" value="No"/>
<small>If yes, please provide the date of death.</small>
Date of Death* mm/dd/yyyy
Was an autopsy performed?*
<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

5. Enter the **Date of Death** in the textbox for the field: *If yes, please provide the date of death.*

<b>Did the patient die as a result of this illness?*</b> <input checked="" type="button" value="Yes"/> <input type="button" value="No"/>
<small>If yes, please provide the date of death.</small>
<b>Date of Death*</b> mm/dd/yyyy

6. Select the **appropriate answer** for the field: *Was an autopsy performed?*

Was an autopsy performed?\*

Yes	No	Unknown
-----	----	---------

7. If **Yes** is selected for the *Was an autopsy performed* field, the following fields are enabled:

- *If yes, please provide the date of autopsy.*
- *Please include the findings from the histopathology report.*
- *Were autopsy specimens sent to the National Prion Disease Pathology Surveillance Center?*

Was an autopsy performed?\*

If yes, please provide the date of autopsy.

Date of Autopsy\*

mm/dd/yyyy  Unknown

Please include the findings from the histopathology report.\*

0/1000 Characters

Were autopsy specimens sent to the National Prion Disease Pathology Surveillance Center?\*

If yes, please provide the date.

Specimen Collection Date

mm/dd/yyyy  Unknown

8. Enter the **Date of Autopsy** for the field: *If yes, please specify the date of autopsy.* If the date of autopsy is unknown, click the **Unknown** checkbox.

If yes, please provide the date of autopsy.

Date of Autopsy\*

mm/dd/yyyy  Unknown

- 9. Enter the **histopathology report details** in the textbox for the field: *Please include the findings from the histopathology report.*

Please include the findings from the histopathology report.\*

0/1000 Characters

- 10. Select the **appropriate answer** for the conditional question: *Were autopsy specimens sent to the National Prion Disease Pathology Surveillance Center?*

Were autopsy specimens sent to the National Prion Disease Pathology Surveillance Center?\*

Yes	No	Unknown
-----	----	---------

If yes, please provide the date.

Specimen Collection Date

mm/dd/yyyy   Unknown

- 11. If **Yes** is selected, enter the **Specimen Collection Date** for the field: *If yes, please provide the date.* If the specimen collection date is unknown, click the **Unknown** checkbox.

If yes, please provide the date.

Specimen Collection Date\*

mm/dd/yyyy   Unknown

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

Specimen Collection Date\*

06/04/2024   Unknown

Save Previous **Next**

**Please Note:** From this point forward, the workflow screens are the same as Other Reportable Conditions Case Reports. Please review the [Direct Data Entry for Case Reports: Other Reportable Conditions User Guide](#) for more information.

## 7 Technical Support

### Toll-Free Telephone Support

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

### Email Support

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

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

