

# Kentucky Health Information Exchange (KHIE)

## **Direct Data Entry for Electronic Case Reports: Other Reportable Conditions**

### User Guide

October 2021

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# 1 Introduction

## Overview

This training manual covers KHIE's Direct Data Entry for Other Reportable Conditions 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
<b>Microsoft Internet Explorer</b>	
Not supported	Not supported
<b>Microsoft Edge</b>	
Version 44+	Version 40+
<b>Google Chrome</b>	
Version 70+	Version 70+
<b>Mozilla Firefox</b>	
Version 48+	Version 48+
<b>Apple Safari</b>	
Version 9+	iOS 11+

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

**Mobile Device Considerations**

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

**Accessing the ePartnerViewer**

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

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

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

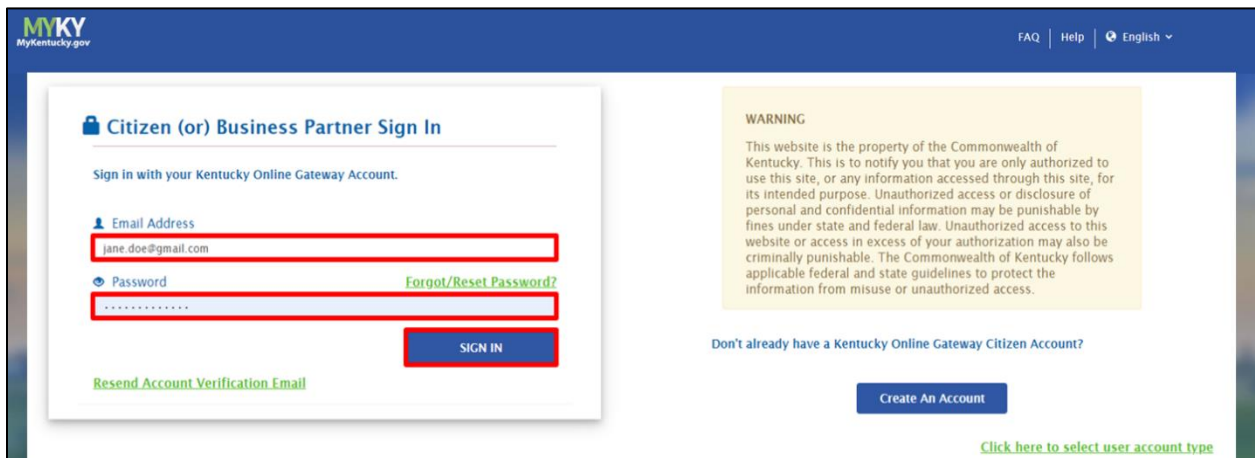
**2 Logging into ePartnerViewer**

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

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

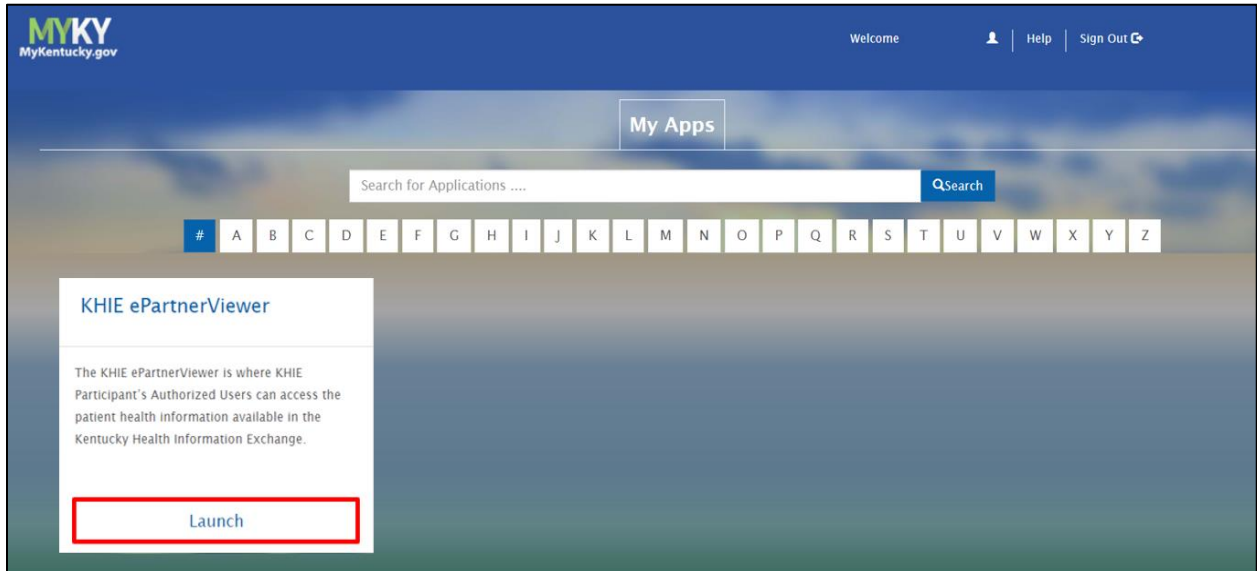
**Please Note:** You must enter the email address and password provided when creating your KOG account.

2. Click **Sign In**.

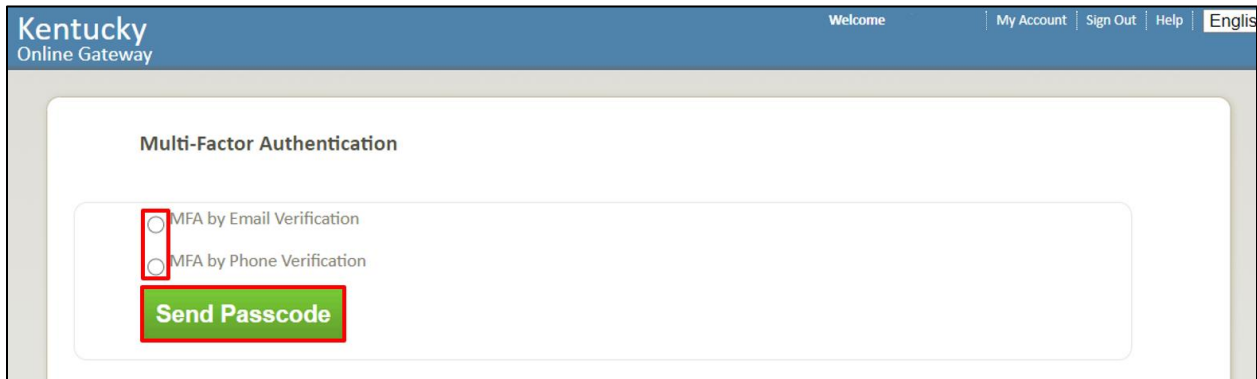




- To navigate to the ePartnerViewer, click **Launch** on the KHIE ePartnerViewer application tile located on the **KOG Dashboard** screen.



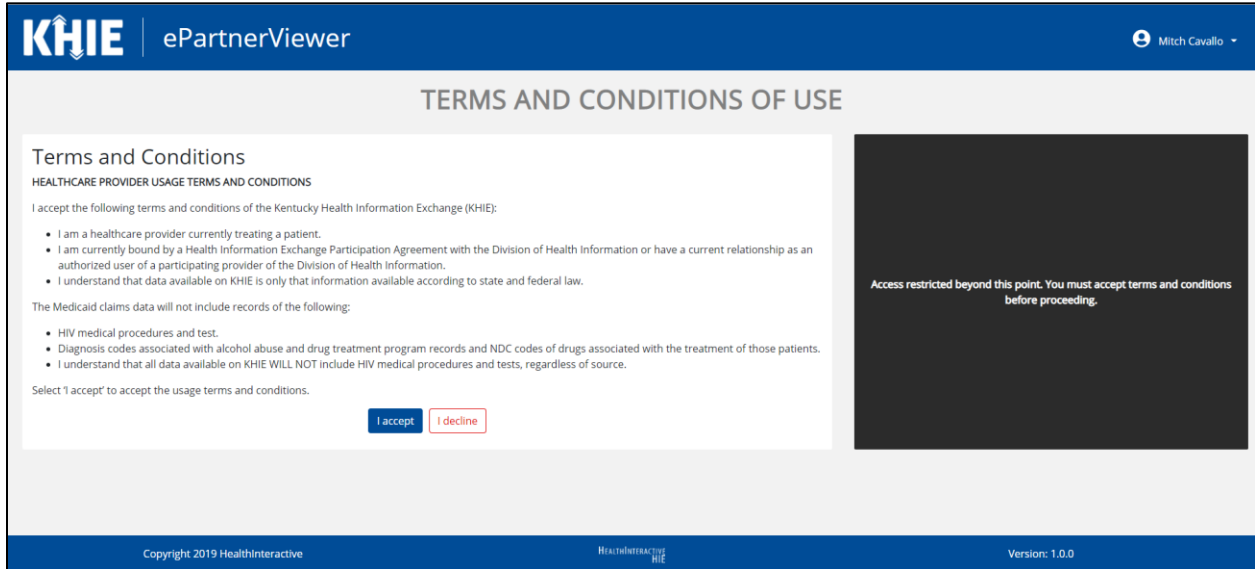
- Multi-Factor Authentication.** After logging in, you are asked to complete Multi-Factor Authentication or MFA. You have the option to receive an MFA passcode by Email or Text.



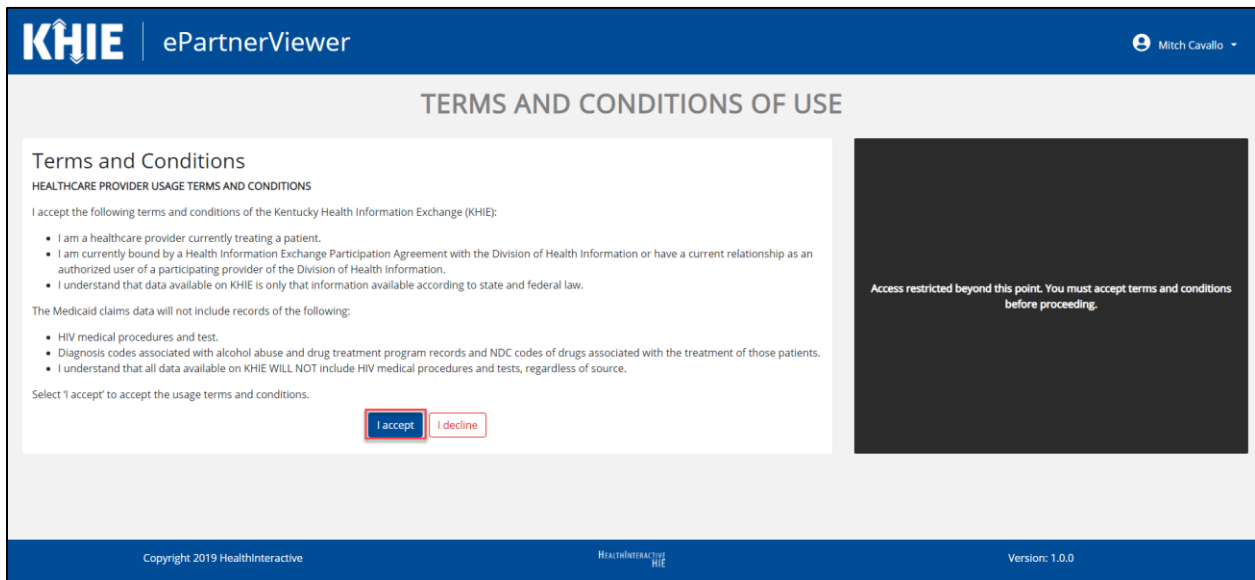
**Please Note:** For specific information about creating a KOG account and how to complete MFA, please review the *Kentucky Online Gateway (KOG) and Multi-Factor Authentication (MFA) Quick Reference Guide*.

### Terms and Conditions of Use and Logging In

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



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



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

- 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.)
- Click **Proceed to Portal** to continue.

The screenshot shows the 'Terms and Conditions of Use' page in the KHIE ePartnerViewer. The page header includes the KHIE logo and the user's name, Mitch Cavallo. The main content area is titled 'TERMS AND CONDITIONS OF USE' and contains the following text:

**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.

At the bottom of the terms section, there is a green button labeled 'Accepted'. To the right of the terms, there is a message: 'You are part of the below mentioned organization. Please click on proceed to continue.' Below this message, it says 'KHIE Smoke Test Organization' and there are two buttons: 'Proceed to Portal' (highlighted with a red box) and 'Cancel'.

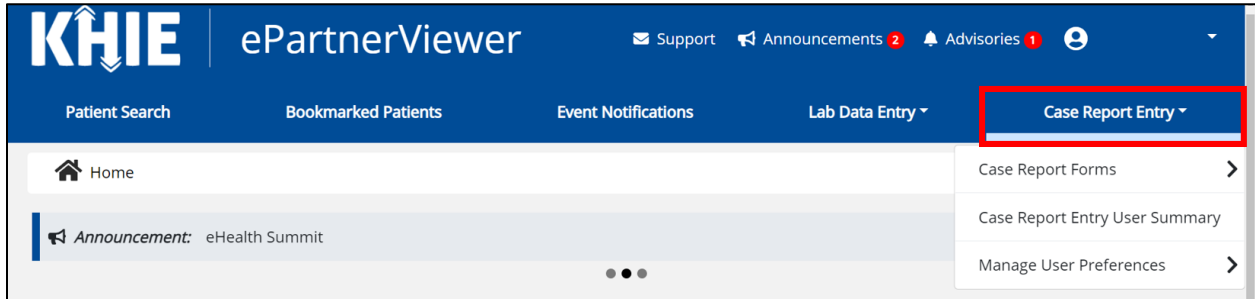
The footer of the page contains: Copyright 2019 Healthinteractive, HealthInteractive KHIE, and Version: 1.0.0.

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



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*.

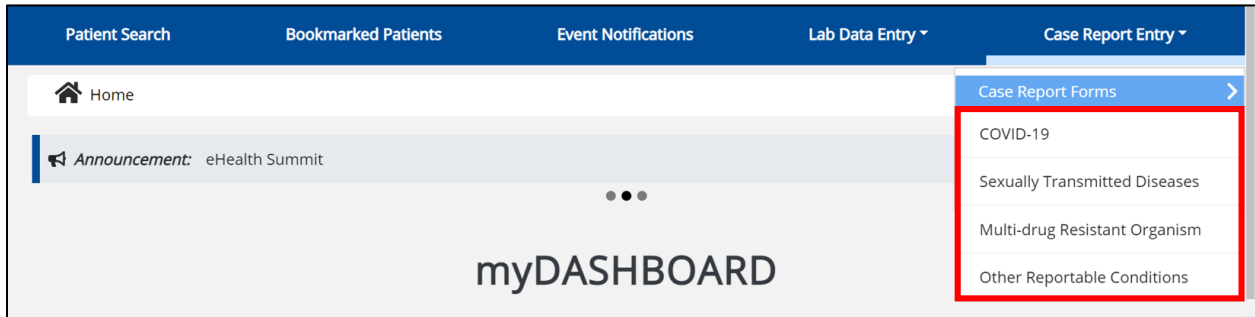
- **Sexually Transmitted Disease (STD) Case Report:**
  - Designed for Users to enter STD case reports.

**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.

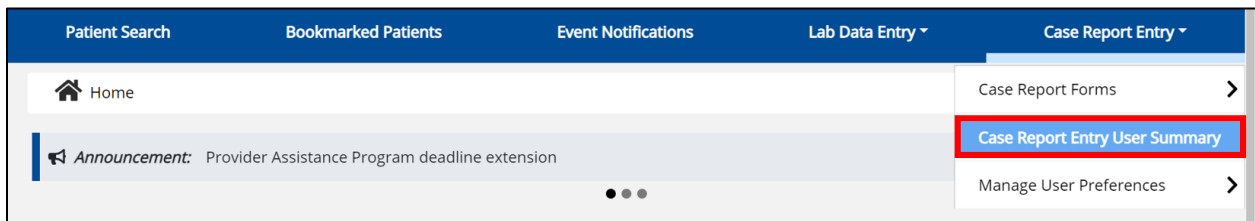
**Please Note:** For specific information about MDRO case reporting, please review the *Direct Data Entry for Electronic Case Reports: Multi-Drug Resistant Organism (MDRO) User Guide*.

- **Other Reportable Conditions Case Report:**
  - Designed for Users to enter Other Reportable Conditions case reports.



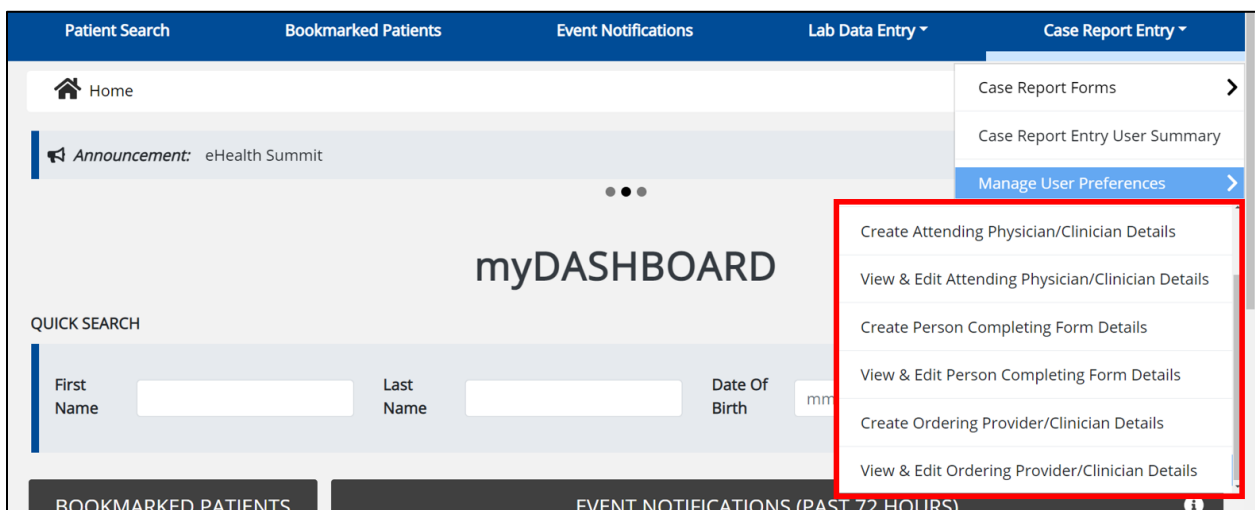
2. **Case Report Entry User Summary:**

- 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.

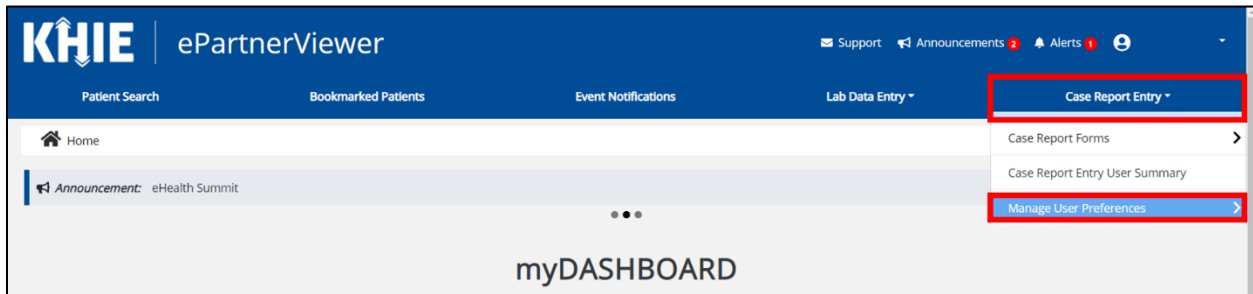


## 4 Manage User Preferences

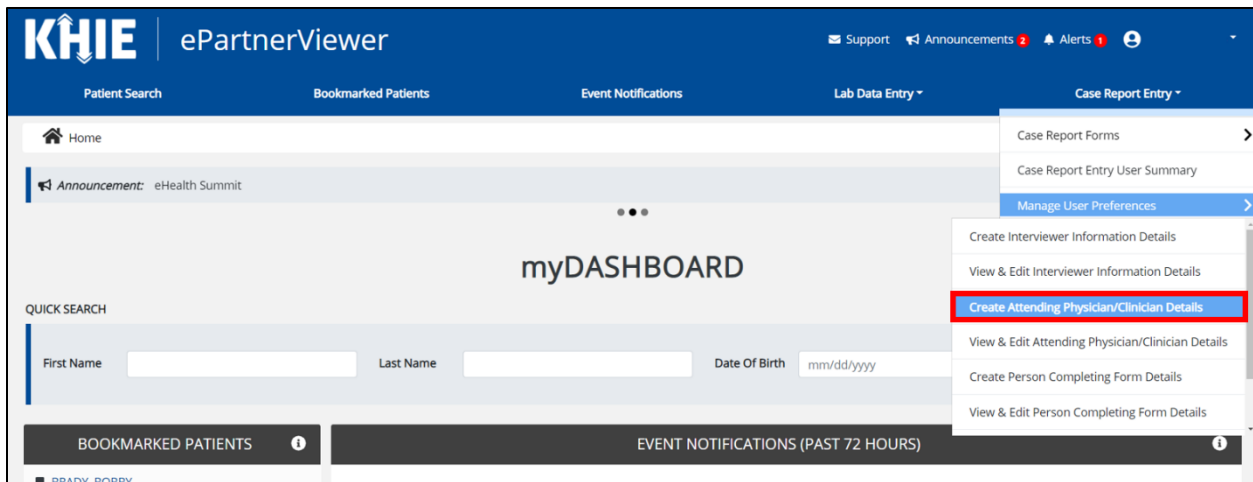
These are your User Preferences. Prior to entering your Other Reportable Conditions case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in your user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



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

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

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

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

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

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

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

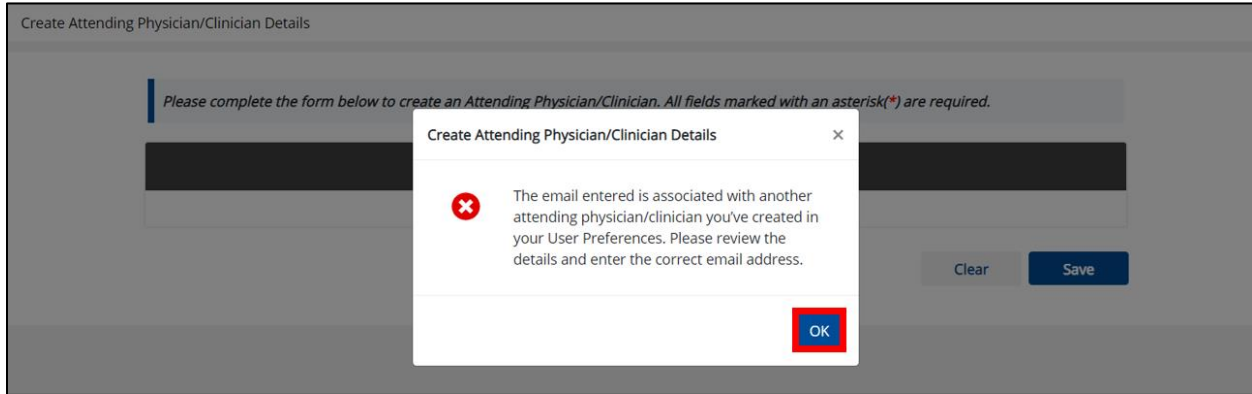
ATTENDING PHYSICIAN/CLINICIAN

Prefix <input style="width: 100%;" type="text" value="Dr."/>		
First Name* <input type="text" value="Frank"/>	Last Name* <input type="text" value="Costanza"/>	
Suffix <input style="width: 100%;" type="text" value="Sr."/>		
Address 1* <input type="text" value="1 First Street"/>	Address 2 <input type="text" value="1A"/>	
City* <input type="text" value="Lexington"/>	State* <input style="width: 100%;" type="text" value="KY"/>	Zip Code* <input type="text" value="40123"/>
Phone* <input type="text" value="(111) 111-1111"/>	Email* <input type="text" value="frank@email.com"/>	

**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.



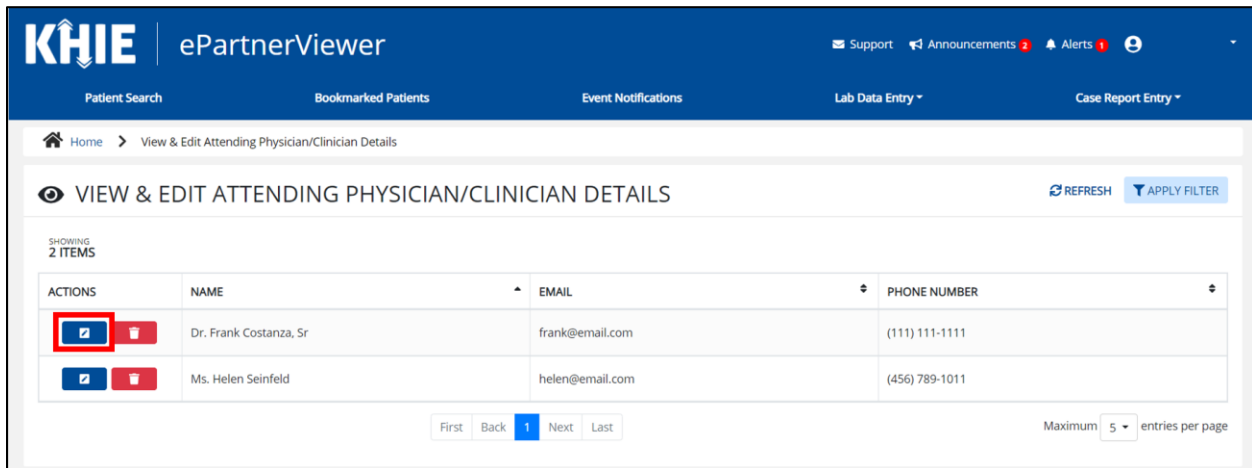


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.

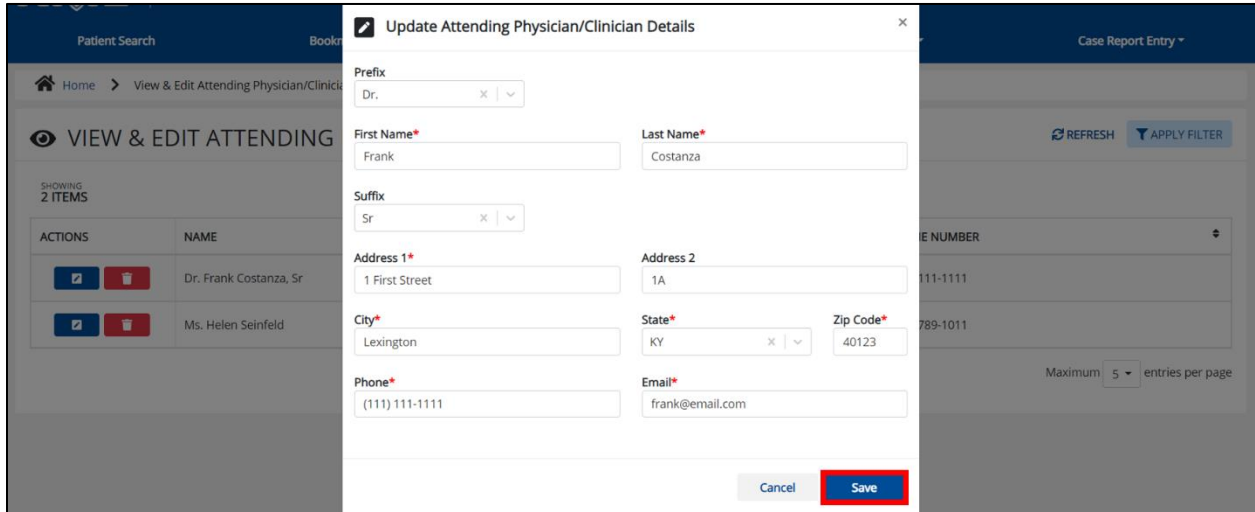


### View & Edit Attending Physician/Clinician Details

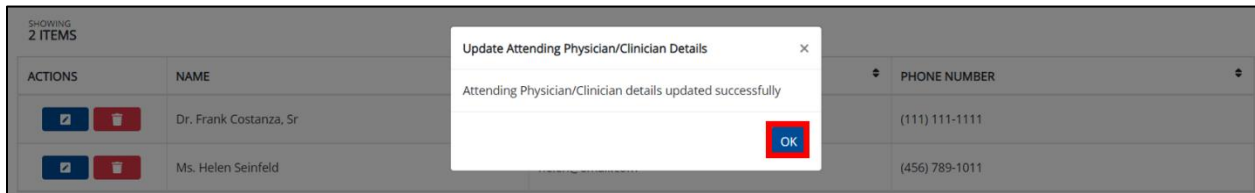
11. The **View & Edit Attending Physician/Clinician Details** screen displays. To edit details, click the **Edit** icon located next to the appropriate physician/clinician.



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.

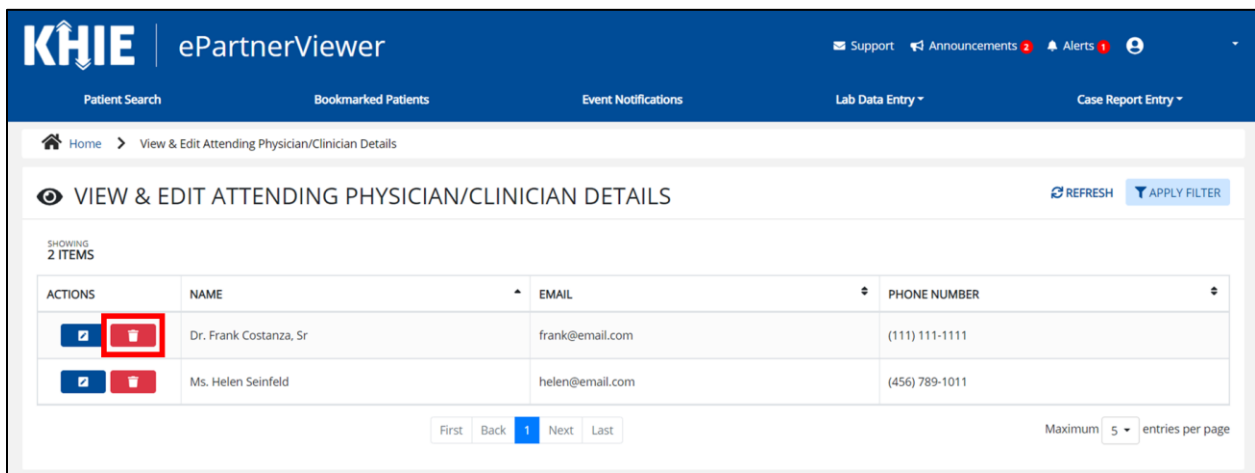


13. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.

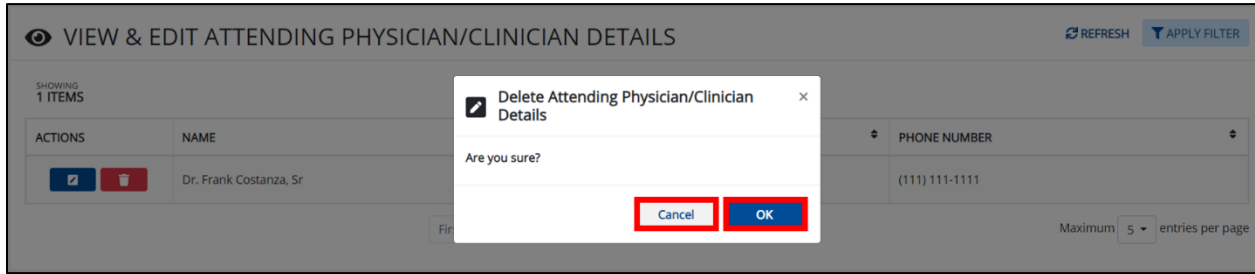


### Delete Attending Physician/Clinician Details

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



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



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

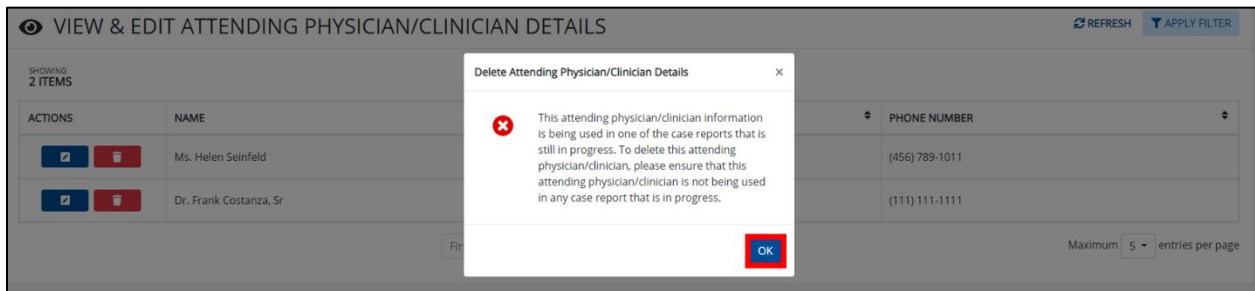
If you attempt to delete an attending physician/clinician who has been selected for use in a case report that has not been completed yet, a pop-up notification will display the following message:

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

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

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

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



### Filter Attending Physician/Clinician Details

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

The screenshot shows the ePartnerViewer interface. At the top, there is a navigation bar with the KHIE logo and 'ePartnerViewer' text. Below this, there are several menu items: 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'. There is a 'REFRESH' button and an 'APPLY FILTER' button (highlighted with a red box). Below this, it says 'SHOWING 2 ITEMS'. A table displays the following data:

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

At the bottom of the table, there are pagination controls: 'First', 'Back', '1', 'Next', 'Last'. To the right, there is a 'Maximum 5 entries per page' dropdown menu.

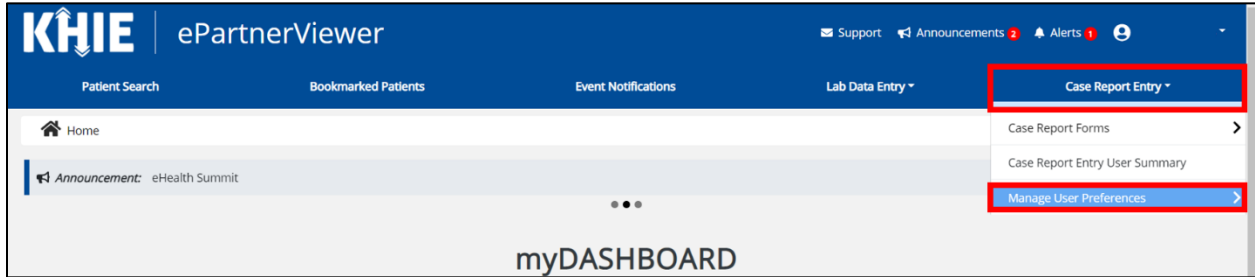
17. The Filter fields display. You can search by entering the **Attending Physician/Clinician's Name, Email Address, and/or Phone Number** in the corresponding Filter fields.

The screenshot shows the ePartnerViewer interface with filter fields. The 'HIDE FILTER' button is visible. The table has filter input fields for 'NAME', 'EMAIL', and 'PHONE NUMBER', each highlighted with a red box and containing the text 'Enter NAME...', 'Enter EMAIL...', and 'Enter PHONE NUMBER...' respectively. The data rows are the same as in the previous screenshot.

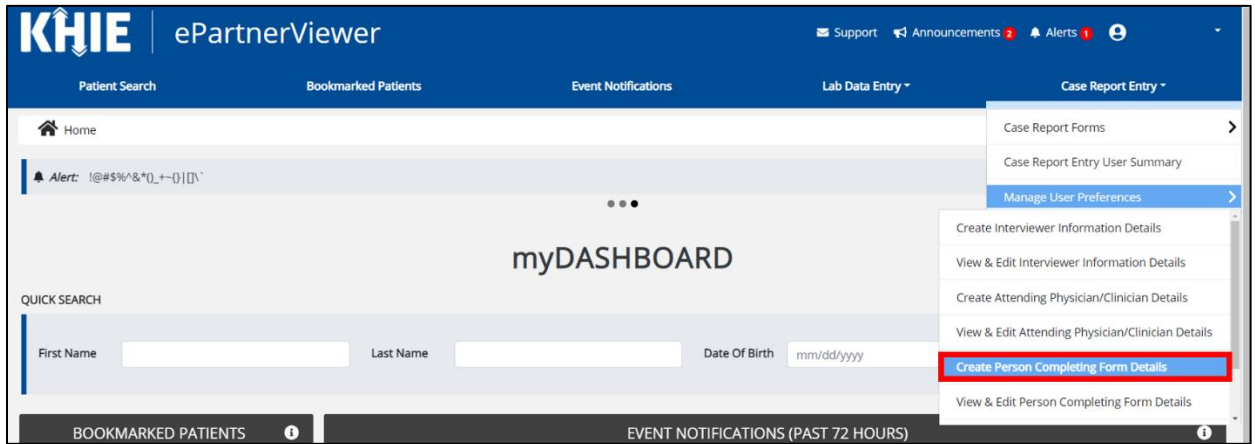
ACTIONS	NAME <input data-bbox="412 1150 561 1184" type="text" value="Enter NAME..."/>	EMAIL <input data-bbox="756 1150 906 1184" type="text" value="Enter EMAIL..."/>	PHONE NUMBER <input data-bbox="1159 1150 1308 1184" type="text" value="Enter PHONE NUMBER..."/>
	Dr. Frank Costanza, Sr	frank@email.com	(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.

First Name\*  Last Name\*

Suffix  
Select...

Address 2  
Unit, Suite, Building, etc.

State\*  Zip Code\*

Email\*  
name@domain.com

(XXX) XXX-XXXX

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

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

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

Address 1*	Address 2	
<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"/>

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

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

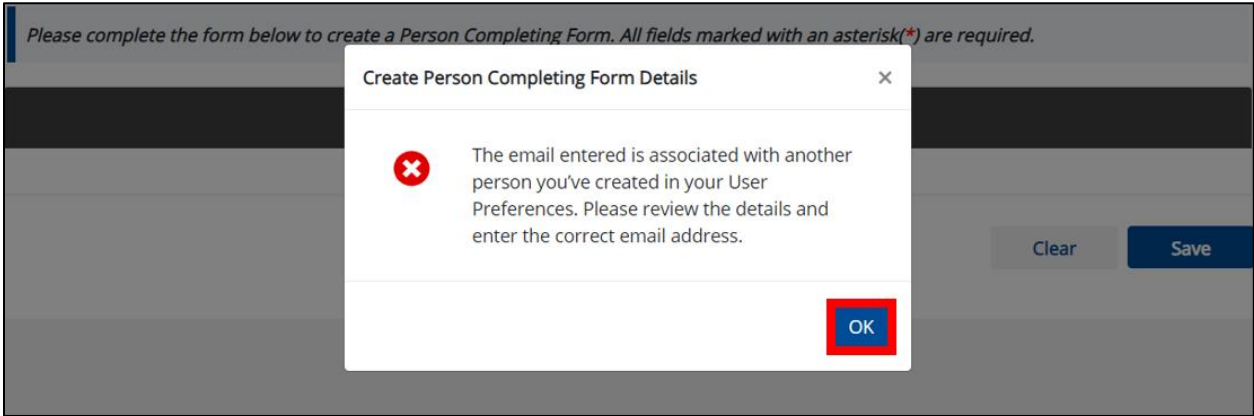
**Please Note:** If the information entered in the *Phone* and *Email* fields is not entered in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

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

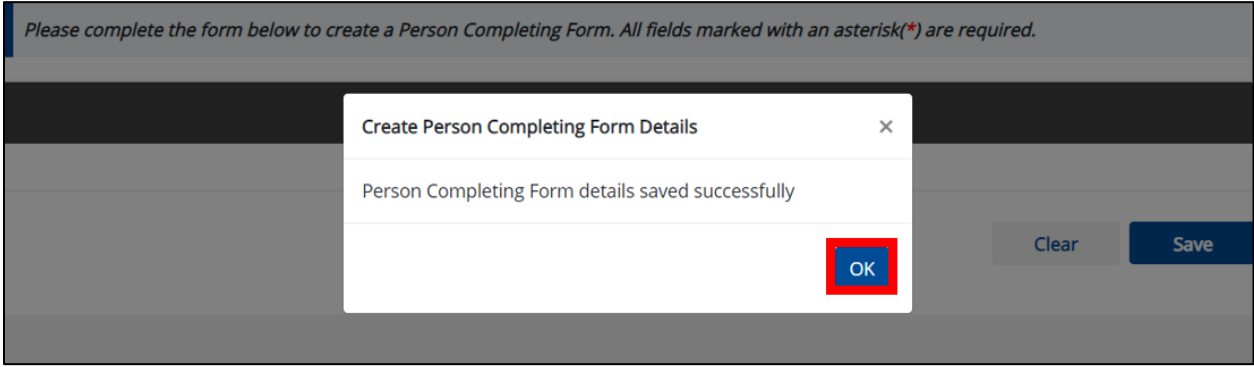
**PERSON COMPLETING FORM**

Prefix	<input style="width: 100%;" type="text" value="Mr."/>	
First Name*	<input style="width: 100%;" type="text" value="Arthur"/>	
Last Name*	<input style="width: 100%;" type="text" value="Vandelay"/>	
Suffix	<input style="width: 100%;" type="text" value="II"/>	
Address 1*	<input style="width: 100%;" type="text" value="22 Second Avenue"/>	
Address 2	<input style="width: 100%;" type="text" value="Unit, Suite, Building, etc."/>	
City*	State*	Zip Code*
<input style="width: 100%;" type="text" value="Lexington"/>	<input style="width: 100%;" type="text" value="KY"/>	<input style="width: 100%;" type="text" value="40222-"/>
Phone*	Email*	
<input style="width: 100%;" type="text" value="(222) 222-2222"/>	<input style="width: 100%;" type="text" value="arthur@email.com"/>	

**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.

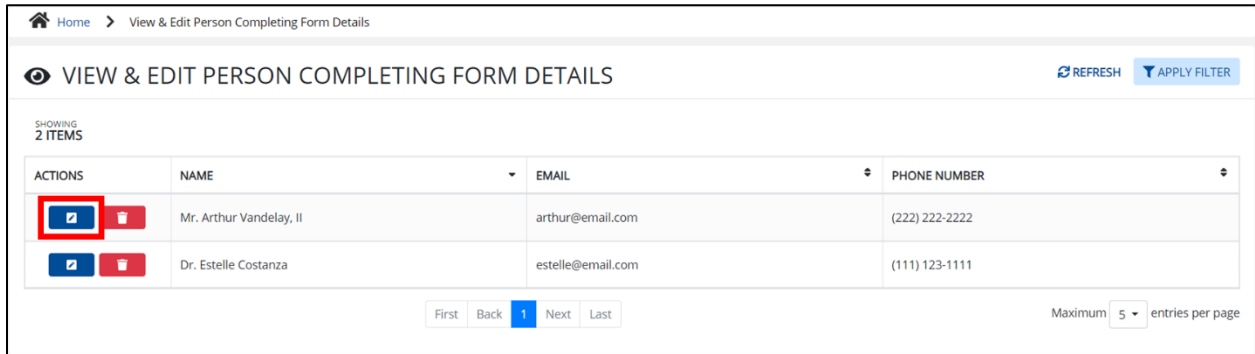


10. The *Create Person Completing Form Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Person Completing Form Details** screen.

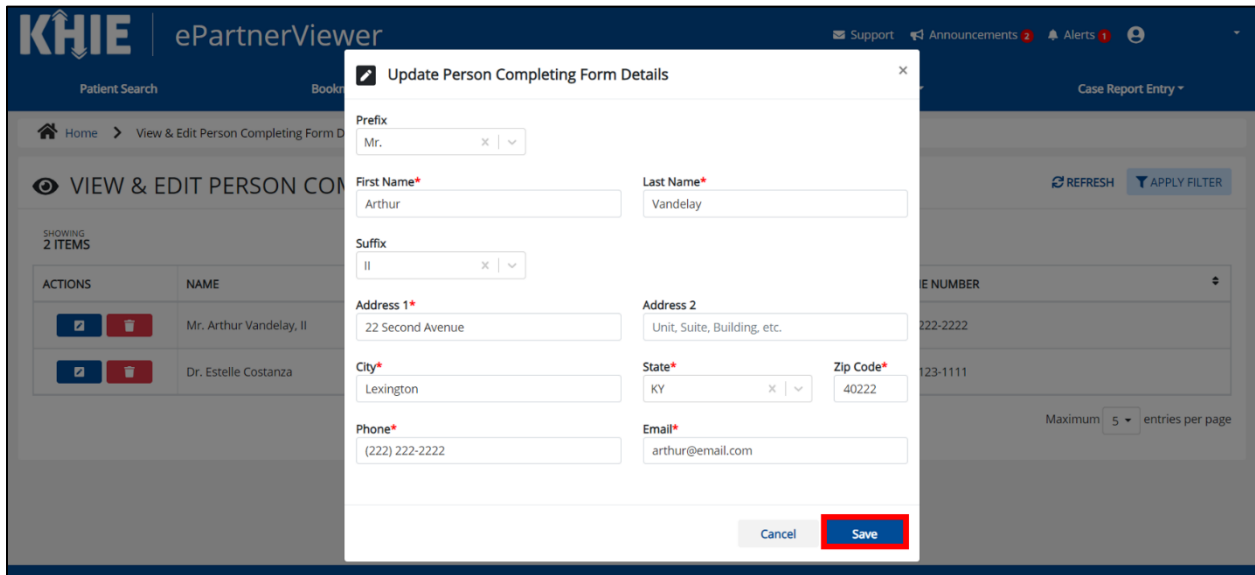


### View & Edit Person Completing Form Details

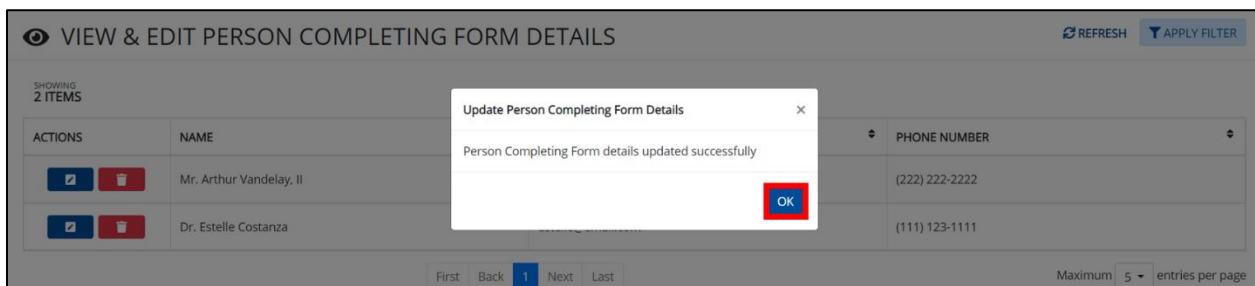
11. The **View & Edit Person Completing Form Details** screen displays. To edit details, click the **Edit** icon located next to the appropriate person.



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.



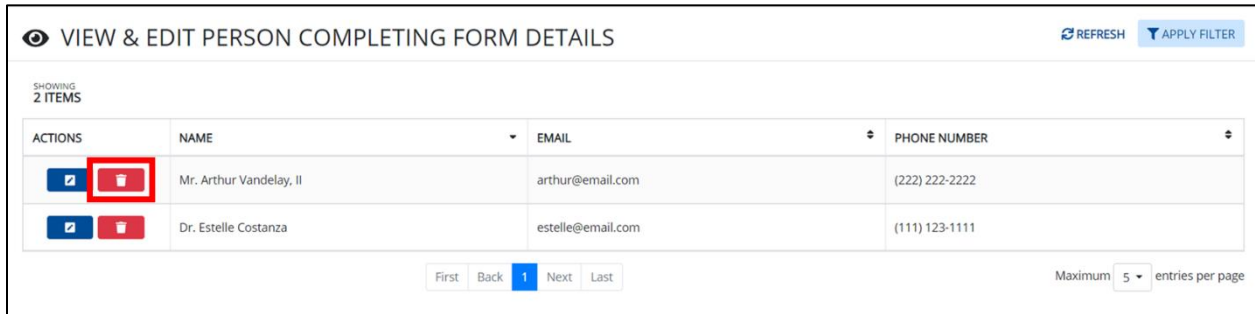
13. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.



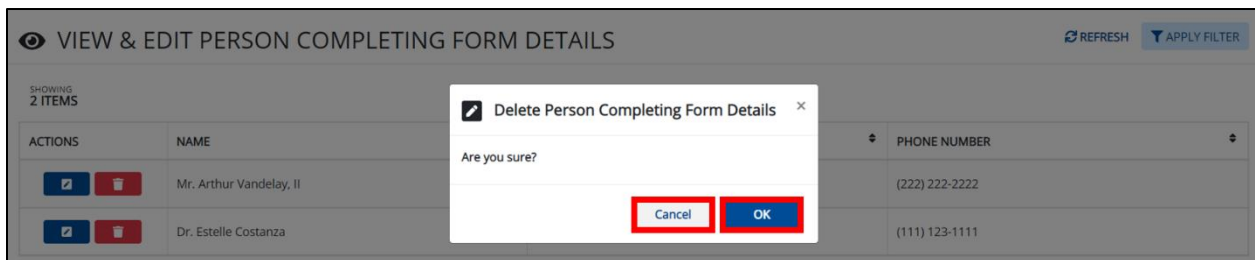


**Delete Person Completing the Form Details**

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



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.

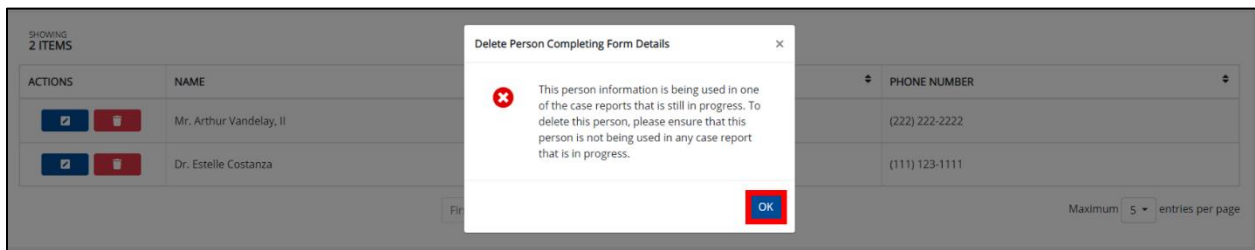


**Please Note:** You can delete a person on the **View & Edit Person Completing Form Details** screen as long as that person has not been selected for use in a case report that is still in progress.

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

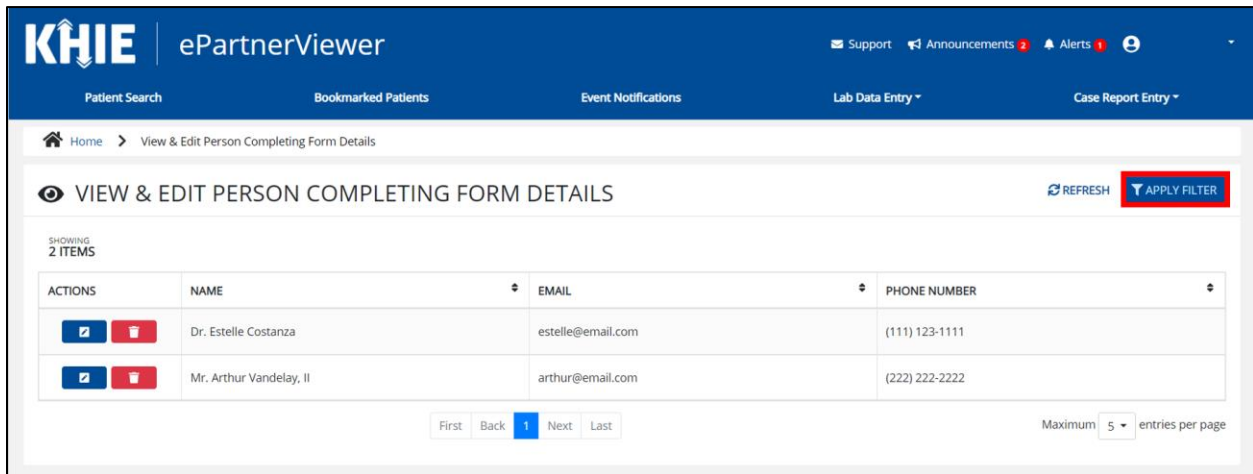
To close out of the pop-up and proceed, click **OK**.

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

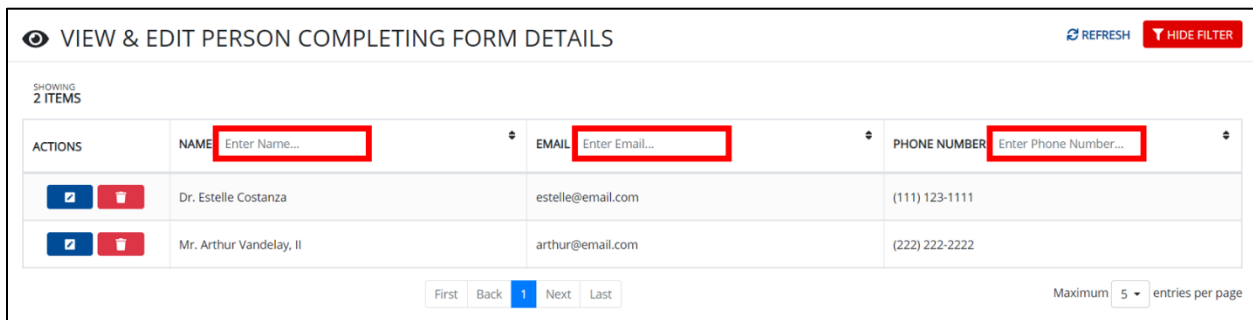


### Filter Person Creating Form Details

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



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.



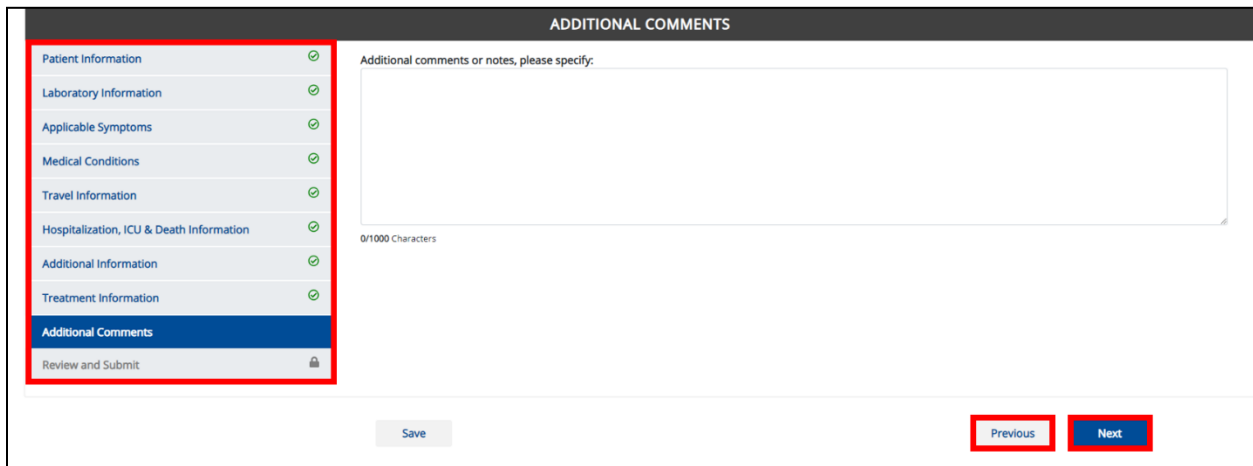
## 5 Basic Features in the Case Report Entry Form

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.

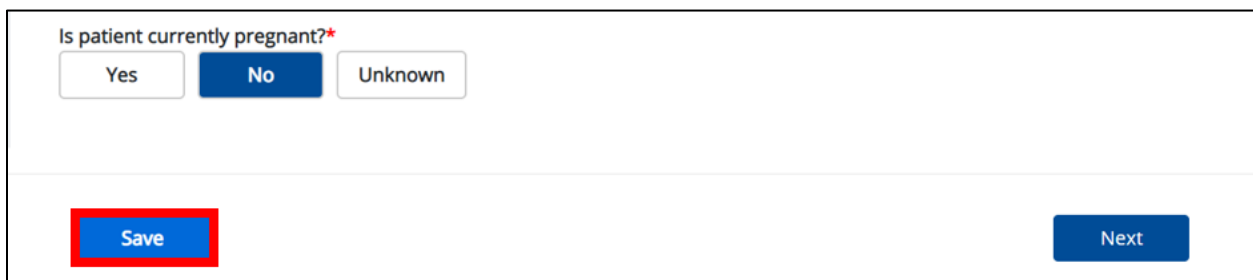
1. Using the side navigation bar, you can navigate to any previously completed screen. Click the **hyperlink** of a previously completed screen to navigate to that specific screen.
2. Click **Previous** to go to the previous screen.
3. When all required fields have been completed on the current screen,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



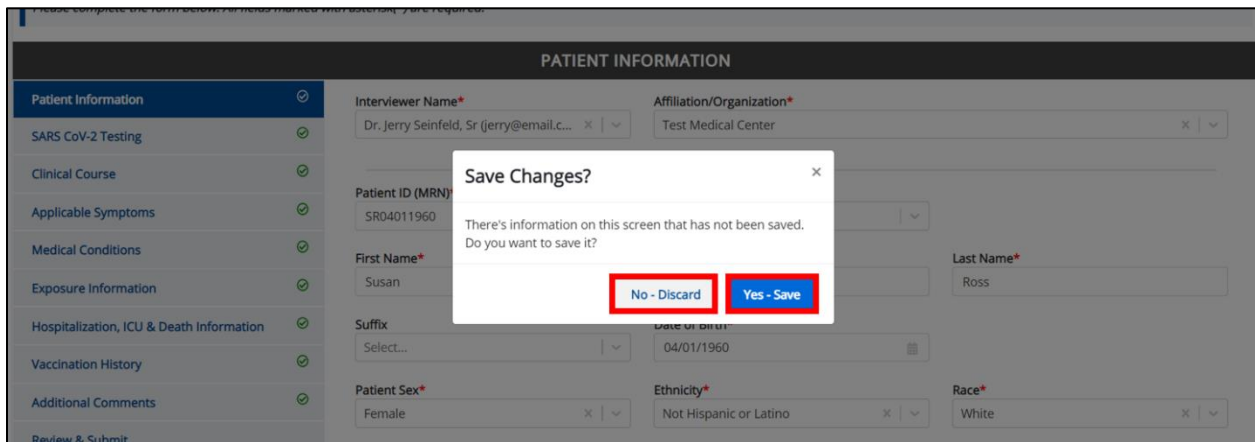
### Save Feature

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

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



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



### Case Report Entry Icons

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

#### Icon Descriptions:

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

### Conditional Questions

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

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

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 2 of 8

Please provide laboratory information related to this case.

#### LABORATORY INFORMATION

**Patient Information** ✔

**Laboratory Information**

Applicable Symptoms 🔒

Additional Information 🔒

Hospitalization, ICU & Death Information 🔒

Vaccination History 🔒

Additional Comments 🔒

Review & Submit 🔒

Does the patient have a lab test?\*

Yes  No  Unknown

Laboratory Information

Laboratory Name

Test Name

If other, please specify:

Filler Order/Accession Number

Specimen Source

If other, please specify:

Test Result

- 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**

Applicable Symptoms 🔒

Additional Information 🔒

Hospitalization, ICU & Death Information 🔒

Vaccination History 🔒

Additional Comments 🔒

Review & Submit 🔒

Does the patient have a lab test?\*

Yes  No  Unknown

Laboratory Information

**Laboratory Name\***

**Test Name\***

If other, please specify:

Filler Order/Accession Number

**Specimen Source\***

If other, please specify:

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

These conditional questions are found on the **Applicable Symptoms** and **Additional Information** screens.

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

The screenshot shows the 'APPLICABLE SYMPTOMS' form. On the left is a navigation menu with 'Applicable Symptoms' selected. The main content area has the question 'Were symptoms present during the course of illness?\*' with 'Yes', 'No', and 'Unknown' buttons. The 'No' button is highlighted in blue. Below this are several symptom categories, each with 'Yes', 'No', and 'Unknown' buttons. In this view, the 'No' buttons for 'Fever', 'Diarrhea (>3 loose stools/24hr period)', 'Chills', and 'GI symptoms' are highlighted in blue, while the 'Unknown' buttons are disabled and labeled 'Unknown'. The 'Onset Date' field is also disabled and labeled 'Unknown'.

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

The screenshot shows the 'APPLICABLE SYMPTOMS' form with 'Unknown' selected for the main question. The 'Unknown' button is highlighted in blue. In this view, the 'Unknown' buttons for 'Fever', 'Diarrhea (>3 loose stools/24hr period)', 'Chills', and 'GI symptoms' are highlighted in blue, while the 'Yes' and 'No' buttons are disabled and labeled 'Unknown'. The 'Onset Date' field is also disabled and labeled 'Unknown'.

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

**APPLICABLE SYMPTOMS**

Patient Information

Laboratory Information

**Applicable Symptoms**

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Were symptoms present during the course of illness?\*

Yes  No  Unknown

Onset Date\*   Unknown

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

Fever\*

Yes  No  Unknown

If yes, please enter the highest temperature:

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

Yes  No  Unknown

If yes, please enter # of days of diarrhea:

Chills\*

Yes  No  Unknown

GI symptoms\*

Yes  No  Unknown

## 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.

PATIENT INFORMATION

**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:** ⓘ

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



**Affiliation/Organization Conditional Answer: Yes**

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

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

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

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

Yes  No

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

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\*

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

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

**Affiliation/Organization Conditional Answer: No**

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

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

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

Yes **No**

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

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

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

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

Patient ID (MRN)\*  SR05051960

Person Completing Form\*

Attending Physician/Clinician\*

Prefix

Affiliation/Organization\*

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

If other, please specify:

If other, please specify:

2. Select the **Affiliation/Organization** for the Person Completing Form from the dropdown menu.

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

Attending Physician/Clinician\*

Prefix

First Name\*

Suffix

Affiliation/Organization\*

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

If other, please specify:

If other, please specify:

Last Name\*

Date of Birth\*

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

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

Yes  No

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

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

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

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

3. Select the **Affiliation/Organization** for the Attending Physician/Clinician 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\*

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

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

**Prefix**

**First Name\***

**Suffix**

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

Please select the organization of the physician attending the patient.

- 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 Attending Physician/Clinician, the subsequent textbox is enabled: *If other, please specify*. You must enter the **name of the Affiliation/Organization**.

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

### Affiliation/Organization Validation

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

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

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

Patient ID (MRN)\* 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?\*

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:

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

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?

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

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

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

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

Yes  No

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

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

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

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

**Patient Information**

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

Yes  No

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

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

**PATIENT INFORMATION**

Disease/Organism\*: Chlamydia | Date of Diagnosis\*: 07/23/2021

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...** (highlighted in red)  
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: \*

3. 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\*

- 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

Person Completing Form\*

Attending Physician/Clinician\*

Prefix

If other, please specify: ?

If other, please specify: ?

4. 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?\*

Yes  No

Patient ID (MRN)\*

Affiliation/Organization\*

Person Completing Form\*

Attending Physician/Clinician\*

Affiliation/Organization ?

Affiliation/Organization ?

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?\*

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

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

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

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

**Patient Information**

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

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

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

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

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

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

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

4. Select the **Affiliation/Organization** for the Person Completing Form from the dropdown menu.

5. Select the **Affiliation/Organization** for the Attending Physician/Clinician from the dropdown menu.

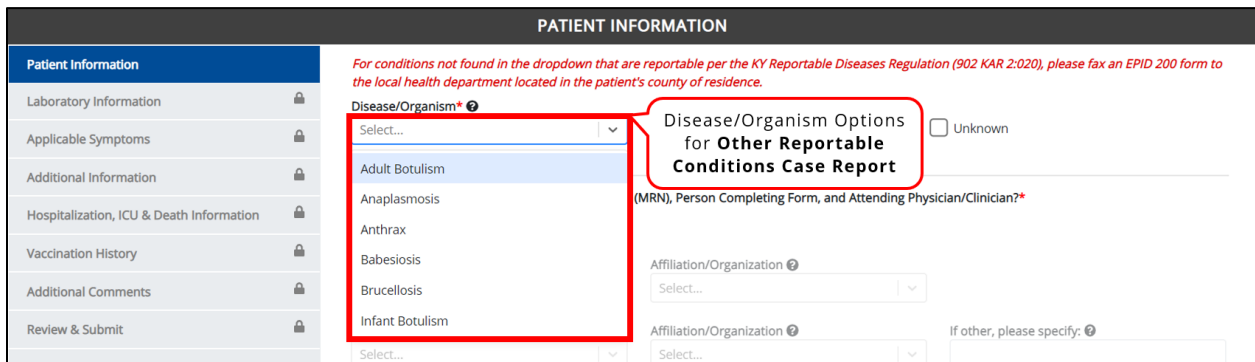
**Please Note:** If you select **Other** from the *Affiliation/Organization* dropdown menu for the Person Completing Form or the Attending Physician/Clinician, the following subsequent textbox is enabled: *If other, please specify*. You must enter the name of the **affiliation/organization**.



## 7 Dynamic Functions based on Disease/Organism

Based on the **Disease/Organism** selected from the dropdown menu on the **Patient Information** screen of the Other Reportable Conditions 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 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.

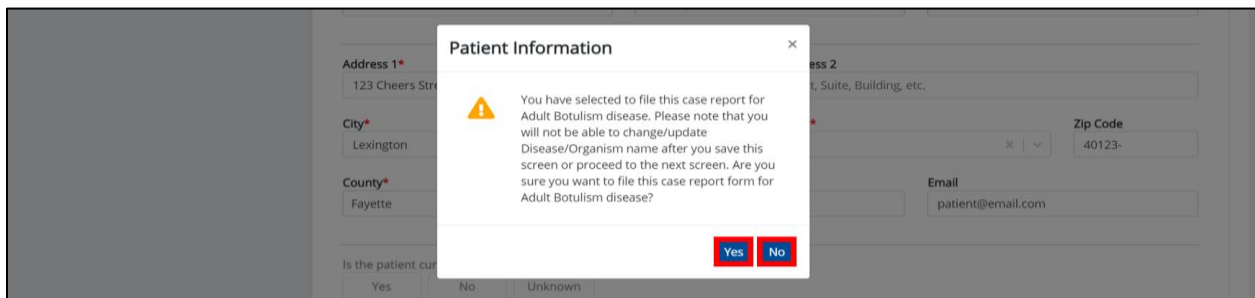


**Please Note:** For conditions not found in the *Disease/Organism* dropdown menu on the **Patient Information** screen, please fax an EPID 200 form to the local health department located in the patient’s county of residence.

### 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:

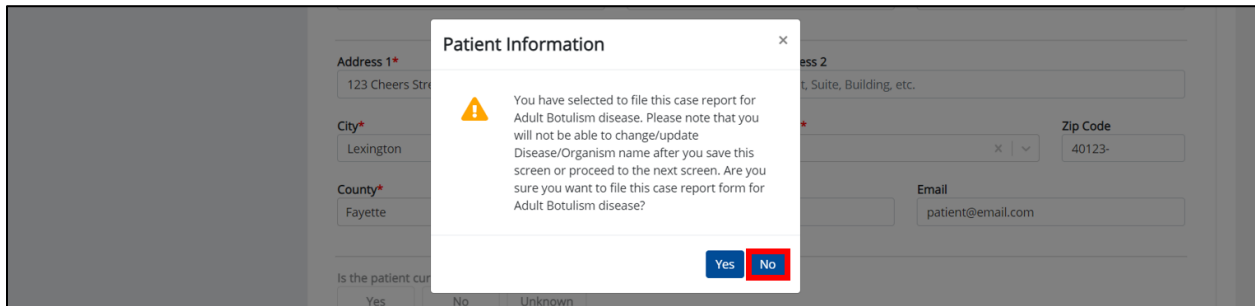
*You have selected to file this case report for [selected disease]. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report for [selected disease]?*



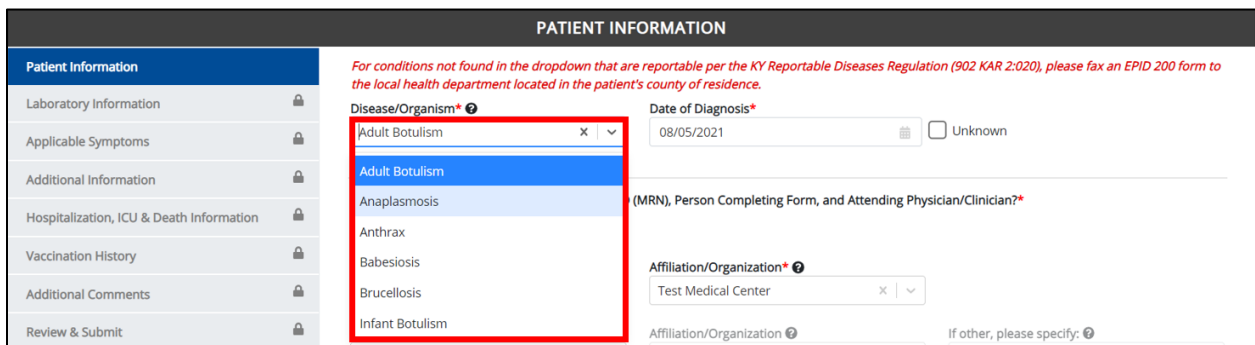
**Please Note:** All Disease/Organism selections are final. Once the selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to only display information that applies to the selected Disease/Organism.

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

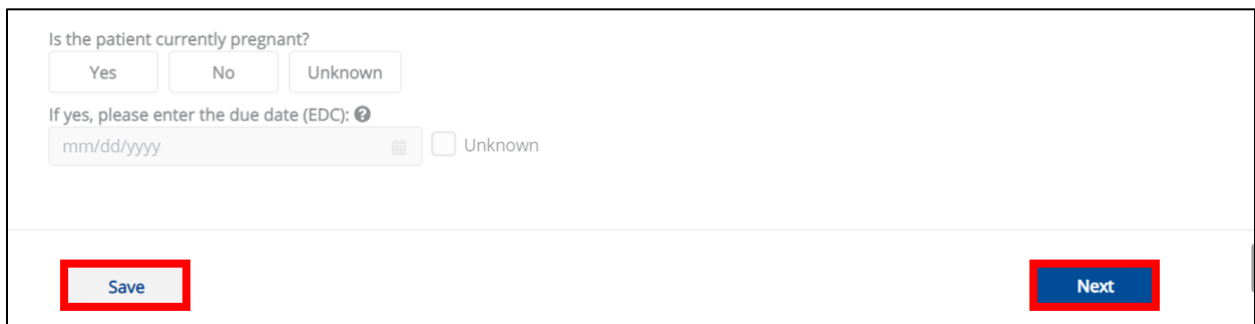
1. Upon clicking **Save** or **Next** at the bottom of the **Patient Information** screen, the Disease/Organism Pop-Up displays.
2. To change the selected Disease/Organism, click **No**.



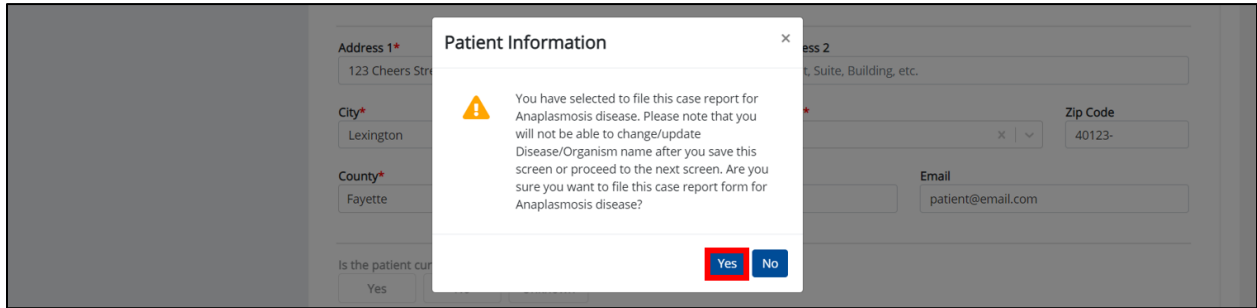
3. Select a **different Disease/Organism** from the dropdown menu.



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.



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



- 6. 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 Other Reportable Conditions 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 Other Reportable Conditions Case Report.

### Laboratory Information: Dynamic Screen

On the **Laboratory Information** screen, the *Test Name* dropdown menu displays only the test name options that apply to the Disease/Organism selected on the **Patient Information** screen.

Vaccination History

Additional Comments

Review & Submit

Test Name\*

Select...

- CLOSTRIDIUM BOTULINUM TOXIN
- CLOSTRIDIUM BOTULINUM TOXIN A
- CLOSTRIDIUM BOTULINUM TOXIN A+B+E
- CLOSTRIDIUM BOTULINUM TOXIN B
- CLOSTRIDIUM BOTULINUM TOXIN E
- CLOSTRIDIUM BOTULINUM TOXIN F
- Other

Test Names for Adult Botulism

Vaccination History

Additional Comments

Review & Submit

Test Name\*

Select...

- ANAPLASMA PHAGOCYTOPHILUM AB.IGG
- ANAPLASMA PHAGOCYTOPHILUM AB.IGM
- ANAPLASMA PHAGOCYTOPHILUM DNA
- Other

Test Names for Anaplasmosis

Specimen Source\*

Vaccination History

Additional Comments

Review & Submit

Test Name\*

Select...

- BACILLUS ANTHRACIS AB
- BACILLUS ANTHRACIS AG
- BACILLUS ANTHRACIS IDENTIFIED
- Other

Test Names for Anthrax

Specimen Source\*

Vaccination History

Additional Comments

Review & Submit

Test Name\*

Select...

- BABESIA CABALLI AB
- BABESIA CABALLI DNA
- BABESIA MICROTI AB
- BABESIA MICROTI AB.IGG
- BABESIA MICROTI AB.IGM
- BABESIA MICROTI DNA
- BABESIA MICROTI IDENTIFIED

Test Names for Babesiosis

Vaccination History

Additional Comments

Review & Submit

**Test Names for Brucellosis**

**Test Name\***

Select...

- BRUCELLA ABORTUS AB
- BRUCELLA ABORTUS AB.JGA
- BRUCELLA ABORTUS AB.JGA+IGG+IGM
- BRUCELLA ABORTUS AB.JGG
- BRUCELLA ABORTUS AB.JGM
- BRUCELLA ABORTUS DNA
- BRUCELLA CANIS AB
- BRUCELLA CANIS AB.IGG

Vaccination History

Additional Comments

Review & Submit

**Test Names for Infant Botulism**

**Test Name\***

Select...

- CLOSTRIDIUM BOTULINUM TOXIN
- CLOSTRIDIUM BOTULINUM TOXIN A
- CLOSTRIDIUM BOTULINUM TOXIN A+B+E
- CLOSTRIDIUM BOTULINUM TOXIN B
- CLOSTRIDIUM BOTULINUM TOXIN E
- CLOSTRIDIUM BOTULINUM TOXIN F
- Other

**Applicable Symptoms: Dynamic Screen**

The **Applicable Symptoms** screen displays common fields for **all** of the Other Reportable Conditions selected as the Disease/Organism. The **Applicable Symptoms** screen displays additional symptoms that apply to the selected Disease/Organism.

- The **Applicable Symptoms** screen displays the common fields below for **all** Disease/Organism selections:
  - *Fever*
  - *Diarrhea (>3 loose stools/24 hour period)*
  - *Did the patient have any other symptoms?*

- The **Applicable Symptoms** screen also displays additional symptoms that apply to the Disease/Organism selected.

Blurry vision*	Yes	No	Unknown	Ocular palsy (Difficulty moving the eyes)*	Yes	No	Unknown
Difficulty breathing*	Yes	No	Unknown	Ptosis (drooping eyelids)*	Yes	No	Unknown
Diplopia (double vision)*	Yes	No	Unknown	Slurred speech*	Yes	No	Unknown
Dysphagia (difficulty swallowing)*	Yes	No	Unknown	Stomach Pain*	Yes	No	Unknown
Muscle weakness*	Yes	No	Unknown	Symmetric, descending flaccid paralysis*	Yes	No	Unknown
Nausea*	Yes	No	Unknown	Vomiting*	Yes	No	Unknown

Applicable Symptoms for **Adult Botulism**

Abdominal swelling*	Yes	No	Unknown	Diarrhea, may be bloody*	Yes	No	Unknown	Myalgia*	Yes	No	Unknown	Shortness of Breath*	Yes	No	Unknown
Abscess at injection site*	Yes	No	Unknown	Dizziness*	Yes	No	Unknown	Nausea*	Yes	No	Unknown	Sore throat*	Yes	No	Unknown
Blisters or Bumps at injection site*	Yes	No	Unknown	Extreme fatigue*	Yes	No	Unknown	Neck gland swelling*	Yes	No	Unknown	Stomach Pain*	Yes	No	Unknown
Blisters or Bumps on skin*	Yes	No	Unknown	Fainting*	Yes	No	Unknown	Painful swallowing*	Yes	No	Unknown	Sweats (Drenching)*	Yes	No	Unknown
Chills*	Yes	No	Unknown	Flushing face*	Yes	No	Unknown	Painless sore w/black center at injection site*	Yes	No	Unknown	Swelling around sore*	Yes	No	Unknown
Confusion*	Yes	No	Unknown	Headache*	Yes	No	Unknown	Painless ulcer w/a black center*	Yes	No	Unknown	Vomiting*	Yes	No	Unknown
Cough*	Yes	No	Unknown	Hoarseness*	Yes	No	Unknown	Red eyes*	Yes	No	Unknown				

Applicable Symptoms for **Anthrax**

Anorexia*	Yes	No	Unknown	Decrease hematocrit*	Yes	No	Unknown	GI symptoms*	Yes	No	Unknown	Photophobia*	Yes	No	Unknown
Chills*	Yes	No	Unknown	Depression*	Yes	No	Unknown	Hepatomegaly*	Yes	No	Unknown	Sore throat*	Yes	No	Unknown
Conjunctival infection*	Yes	No	Unknown	Elevated serum creatinine and BUN levels*	Yes	No	Unknown	Jaundice*	Yes	No	Unknown	Splenomegaly*	Yes	No	Unknown
Cough*	Yes	No	Unknown	Emotional lability*	Yes	No	Unknown	Malaise*	Yes	No	Unknown	Sweats*	Yes	No	Unknown
Dark urine*	Yes	No	Unknown	Fatigue*	Yes	No	Unknown	Mildly elevated Liver Enzymes*	Yes	No	Unknown	Thrombocytopenia*	Yes	No	Unknown

Applicable Symptoms for **Babesiosis**

<b>Anorexia (loss of appetite)*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Liver, spleen swelling*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Arthritis*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Malaise*</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>Myalgia*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Endocarditis*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Neurologis symptoms*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Fatigue*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Sweats*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Headache*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<b>Tisticle, scrotum swelling*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

Applicable Symptoms for **Brucellosis**

<b>Constipation*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Difficulty breathing*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Face showing less expression than usual*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Loss of tone (floppy baby)*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Poor feeding (poor latch/poor suck)*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Ptosis (drooping eyelids)*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Pupils that are slow to react to light*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<b>Weak cry*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

Applicable Symptoms for **Infant Botulism**



## 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. x v

Affiliation/Organization\*  
Test Medical Center x v

Patient ID (MRN)\* ?

Prefix  
Select...

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

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

City

State KY x v

Zip Code

County Select... v

Phone Number

Email Address

Adair  
Allen  
Anderson  
Ballard  
Barren  
Bath  
Bell

interactive HEALTHINTERACTIVE HIE /ersi

- 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  State

Zip Code  County

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

Admission Date\*   Unknown

Discharge Date\*   Unknown

June 2021  
Su Mo Tu We Th Fr Sa  
30 31 1 2 3 4 5  
6 7 8 9 10 11 12  
13 14 15 16 17 18 19  
20 21 22 23 24 25 26  
27 28 29 30 1 2 3

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

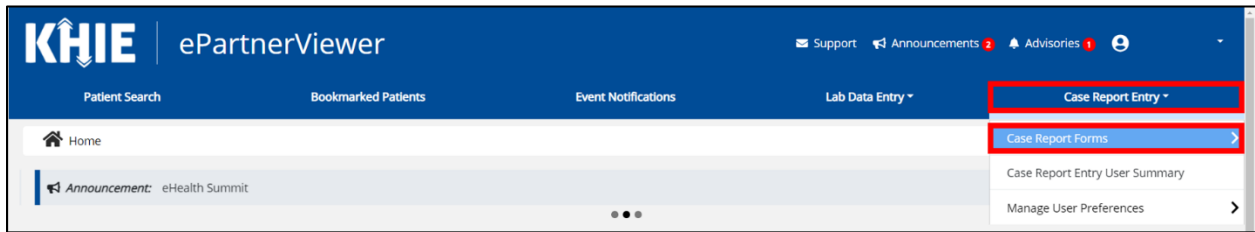
Admission Date\*   Unknown

Discharge Date\*   Unknown

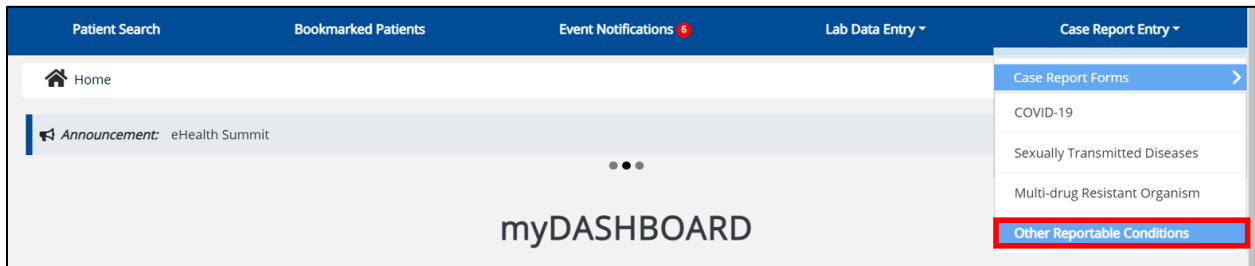
## 10 Other Reportable Conditions Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the Other Reportable Conditions Case Report Form in the ePartnerViewer.

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.



## 11 Patient Information

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

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 1 of 8

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

### PATIENT INFORMATION

*For conditions not found in the dropdown that are reportable per the KY Reportable Diseases Regulation (902 KAR 2:020), please fax an EPID 200 form to the local health department located in the patient's county of residence.*

**Patient Information** (highlighted in red box)

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

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:

1. To start the Other Reportable Conditions Case Report entry, you must complete the mandatory fields on the Patient Information screen.

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 1 of 8

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

### PATIENT INFORMATION

*For conditions not found in the dropdown that are reportable per the KY Reportable Diseases Regulation (902 KAR 2:020), 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?\***

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:

**Prefix**

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

**Please Note:** You are required to enter the details associated with the *Person Completing Form* and the *Attending Physician/Clinician* prior to entering Other Reportable Conditions case report information.

If you access the Other Reportable Conditions Case Report without previously entering these details, the **Patient Information** screen is disabled and displays an error message.

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

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 1 of 8

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

### PATIENT INFORMATION

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

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

Yes  No

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



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

**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

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

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

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?*

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

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

Yes  No

Patient ID (MRN)\* ⓘ

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?\*

Yes  No

Patient ID (MRN)\* ⓘ

Person Completing Form\*

Attending Physician/Clinician\*

Affiliation/Organization\* ⓘ

Affiliation/Organization\* ⓘ  If other, please specify: ⓘ

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\* ⓘ

- 6. 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).

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.

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

**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

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

9. The *Person Completing Form* Pop-Up displays. Enter the details. Mandatory fields are marked with asterisks (\*).

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

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

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

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

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. Select the **new name of the Person Completing Form** from the dropdown menu.

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)\*  Affiliation/Organization\*

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

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

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

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

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

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

Ms. Helen Seinfeld  
(helen@email.com)

First Name\* Middle Name Last Name\*

**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**.

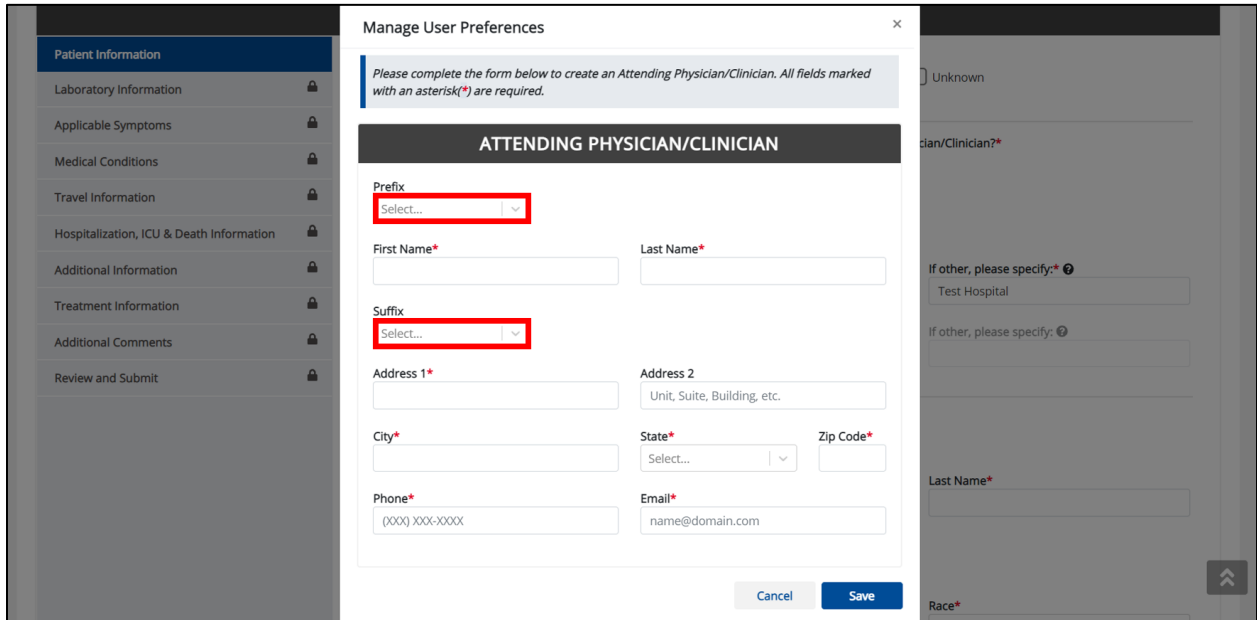
### Attending Physician/Clinician Hyperlink

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

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

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

- 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.



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

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

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

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

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

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

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

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\*: Fraiser

Last Name\*: Crane

Suffix: Select...

Address 1\*: 123 Cheers Street

Address 2: Unit, Suite, Building, etc.

City\*: Lexington

State\*: KY

Zip Code\*: 40123-

Phone\*: (555) 555-4321

Email\*: fraisercrane@email.com

Buttons: Cancel, 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.

Attending Physician/Clinician\*

Affiliation/Organization\* ?

If other, please specify: ?

Dr. Fraiser Crane (fraisercrane@email.com)

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

Ms. Helen Seinfeld (helen@email.com)

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

Attending Physician/Clinician\*

Affiliation/Organization\* ?

If other, please specify: ?

Dr. Fraiser Crane (fraisercrane...)

Prefix: Select...

First Name\*

Suffix: Select...

Twenty One

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical Center

Other

Last Name\*

**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.*

**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.

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

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

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

A screenshot of a form with three dropdown menus: Patient Sex\*, Ethnicity\*, and Race\*. The Patient Sex\* dropdown is open, showing options: Female, Male, Other, and Unknown. A red box highlights the dropdown menu.

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

A screenshot of a form with several fields. The Patient Sex\* dropdown is set to 'Female'. The Ethnicity\* dropdown is open and set to 'Not Hispanic or Latino'. The Race\* dropdown is open, showing options: American Indian or Alaska Native, Asian, Asked but Unknown, Black or African American, Native Hawaiian or Other Pacific Islander, Other Race, and Unknown. Red boxes highlight the Ethnicity\* and Race\* dropdown menus.

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

A screenshot of a form with several fields. Address 1\* and Address 2 (Unit, Suite, Building, etc.) are highlighted with red boxes. City\* is highlighted with a red box. State\* is a dropdown menu highlighted with a red box. Zip Code is highlighted with a red box. County\* is a dropdown menu highlighted with a red box. Phone\* (format: (XXX) XXX-XXXX) and Email (format: name@domain.com) are also visible.

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

A screenshot of a form with several fields. Address 1\* is '123 West 81st Street'. City\* is 'Lexington'. County\* is 'Fayette'. State\* is 'KY'. Zip Code is '40123'. Phone\* (format: (XXX) XXX-XXXX) and Email (format: name@domain.com) are highlighted with red boxes. A dark grey tooltip box is present over the Phone\* field with the text: 'Please enter patient's phone number. If patient's phone number is not available, please enter the provider's/interviewer's phone number.'

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

**Please Note:** The field *Is the patient currently pregnant?* is enabled only when you select **Female** from the *Patient Sex* dropdown menu on the **Patient Information** screen.

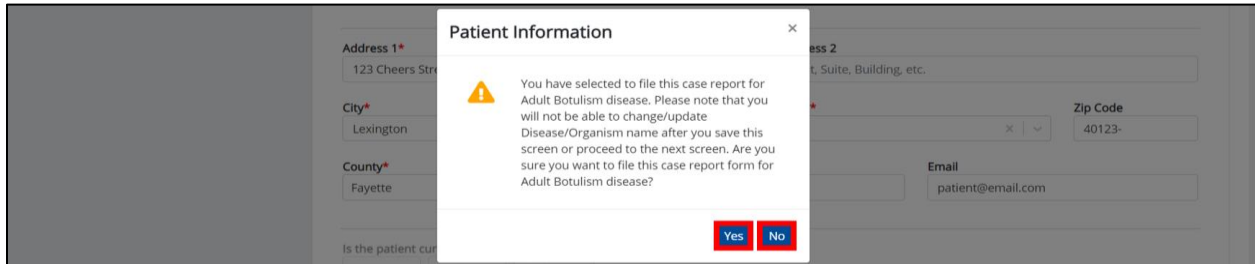
If **Yes** is selected, the subsequent field is enabled. You must enter the **estimated due date (EDC)** in the subsequent field: *If yes, please enter the due date (EDC)*. If the due date is unknown, click the **Unknown checkbox**.

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

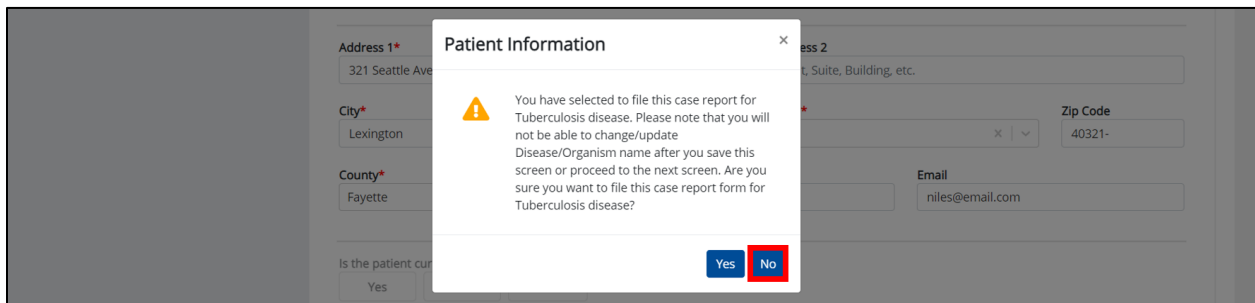


**Please Note:** Once you select a Disease/Organism from the dropdown menu and click **Save** or **Next** at the bottom of the **Patient Information** screen, a pop-up displays with a message that states: *You have selected to file this case report for [selected disease]. Please note that you will not 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]?*

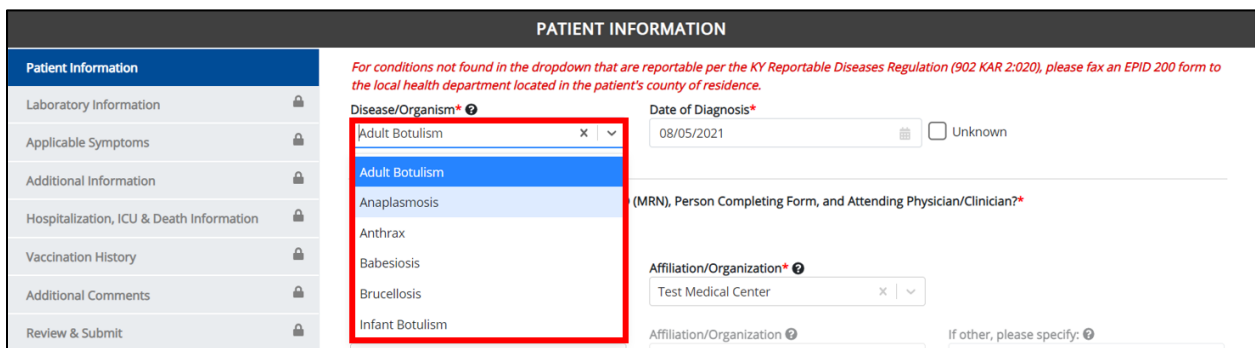
To save the selected Disease/Organism and proceed to the **Laboratory Information** page, click **Yes**. To change the selected Disease/Organism, click **No**.



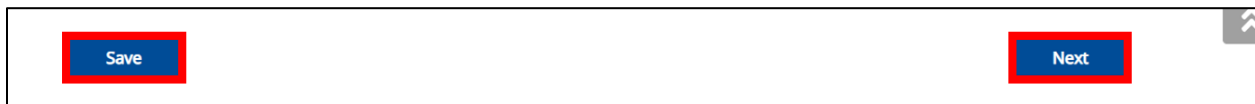
36. To change the selected Disease/Organism, click **No** on the Disease/Organism Pop-Up.



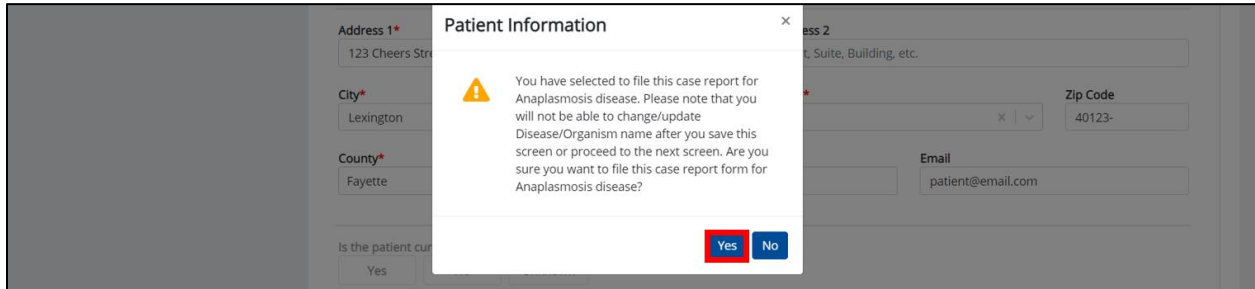
37. If changing the selection, select a different **Disease/Organism** from the dropdown menu.



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



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

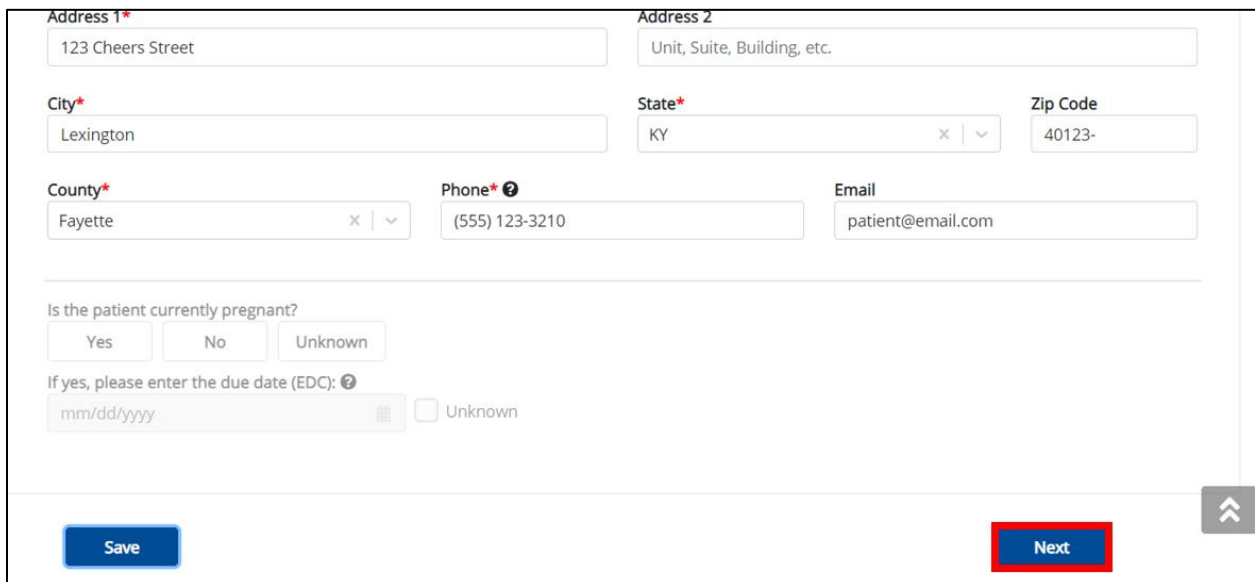


40. Upon clicking **Yes** to save the selection, the *Disease/Organism* field is disabled and displays the selected Disease/Organism. You can no longer change the selected Disease/Organism.



**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.

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



## 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?*

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 2 of 8

Please provide laboratory information related to this case.

### LABORATORY INFORMATION

Patient Information

**Laboratory Information**

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

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:

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

Patient Information

**Laboratory Information**

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

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

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

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

Does the patient have a lab test?\*

---

Laboratory Information

Laboratory Name\*

4. Select the appropriate **Test Name** from the dropdown menu.

Test Name\*

Select...

- ANAPLASMA PHAGOCYTOPHILUM AB.IGG
- ANAPLASMA PHAGOCYTOPHILUM AB.IGM
- ANAPLASMA PHAGOCYTOPHILUM DNA
- Other

Specimen Source\*

**Please Note:** The *Test Name* dropdown menu displays only the test name 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 **test name/description** in the subsequent *textbox*: *If other, please specify.*

Test Name\*

Other

Please enter the test name/description if it is not listed in the Test Name dropdown list.

If other, please specify: ?

5. Enter the **Filler Order/Accession Number**.

If other, please specify: ?

Please enter filler order number or accession number.

Filler Order/Accession Number ?

**Please Note:** The Filler Order Number or Lab Accession Number is typically utilized by laboratories and generally refers to the number assigned to a lab sample when it is checked in. If your organization does not log the receipt of specimens, you should create a system to uniquely track the specimen when you check it in.

6. Select the **Specimen Source** from the dropdown menu.

- If **Other** is selected from the dropdown menu, the subsequent field is enabled. Enter the **Specimen Name/Description** in the subsequent textbox: *If other, please specify.*

7. Select the **Test Result** from the dropdown menu.

- If **Other** is selected from the dropdown menu, the subsequent field is enabled. Enter **test result information** in the subsequent textbox: *If other, please specify.*

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

8. If applicable, enter the **Test Result Date**.
9. Enter the **Specimen Collection Date**.

**Please Note:** The Specimen Collection Date cannot occur **after** the Test Result Date. The Specimen Collection Date must occur on the **same date** or any date **BEFORE** the Test Result Date. If you enter a Specimen Collection Date that occurs **after** the Test Result Date, both fields are marked as invalid. If you click **Next**, the **Laboratory Information** screen displays an error banner with a message that states: *There are errors. Please make a selection for all required fields.*


10. In the *Additional Information* textbox, enter **additional notes about the lab test**, if applicable.

### Adding Multiple Tests

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

Additional Information ⓘ  
Lab Test Result Details  
23/300 Characters  
**+ Add Test**

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

Laboratory Information ⓘ   
Laboratory Name\*  
Test Name\*  
Select... | v  
If other, please specify: ⓘ  
Filler Order/Accession Number ⓘ  
Specimen Source\*  
Select... | v  
If other, please specify: ⓘ  
Test Result\*  
Select... | v  
If other, please specify: ⓘ  
Test Result Date: mm/dd/yyyy  Unknown  
Specimen Collection Date\*: mm/dd/yyyy  Unknown  
Additional Information ⓘ

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

Filler Order/Accession Number ⓘ  
FC20210805

Specimen Source\*  
Blood arterial x | v  
If other, please specify: ⓘ

Test Result\*  
Positive x | v  
If other, please specify: ⓘ

Test Result Date\* 08/05/2021  Unknown Specimen Collection Date\* 08/04/2021  Unknown

Additional Information ⓘ  
Lab Test Details  
16/300 Characters

+ Add Test

Save Previous **Next** ↑



### 13 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?*

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 3 of 8

Please select applicable symptoms that the patient experienced during illness.

#### APPLICABLE SYMPTOMS

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

**Were symptoms present during the course of illness?\***

Yes  No  Unknown

Onset Date   Unknown

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

**Fever**

Yes  No  Unknown

If yes, please enter the highest temperature:

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

Yes  No  Unknown

If yes, please enter # of days of diarrhea:

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

#### APPLICABLE SYMPTOMS

**Were symptoms present during the course of illness?\***

Yes  No  Unknown

Onset Date   Unknown

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

**Fever\***

Yes  No  Unknown

If yes, please enter the highest temperature:

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

Yes  No  Unknown

If yes, please enter # of days of diarrhea:

**Blood in Stool\***

Yes  No  Unknown

**Leg Cramps\***

Yes  No  Unknown

**Muscle Pain\***

Yes  No  Unknown

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

Yes  No  Unknown

If yes, please specify:

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

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

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

- 4. If the patient is symptomatic, select the **appropriate answer** for the *Fever* field.

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

- 5. Select the **appropriate answer** for the *Diarrhea (>3 loose stools/24hr period)* field.

- If **Yes** is selected for the *Diarrhea (>3 loose stools/24hr period)* field, the subsequent field is enabled. Enter the **number of days of diarrhea** in the subsequent textbox: *If yes, please enter the # of days of diarrhea.*

**Please Note:** The **Applicable Symptoms** screen only lists symptoms that apply to the Disease/Organism selected.

- If the patient is symptomatic for **Adult Botulism**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

<p><b>Blurry vision*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Ocular palsy (Difficulty moving the eyes)*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Difficulty breathing*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Ptosis (drooping eyelids)*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Diplopia (double vision)*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Slurred speech*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Dysphagia (difficulty swallowing)*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Stomach Pain*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Muscle weakness*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Symmetric, descending flaccid paralysis*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Nausea*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Vomiting*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

Applicable Symptoms for **Adult Botulism**

- If the patient is symptomatic for **Anaplasmosis**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

<p><b>Chills*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Mild to moderate elevated liver enzymes*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>GI symptoms*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Myalgia*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Leukopenia*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Rash*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Malaise*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Rigors*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
<p><b>Mild Anemia*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<p><b>Thrombocytopenia*</b></p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

Applicable Symptoms for **Anaplasmosis**

8. If the patient is symptomatic for **Anthrax**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Abdominal swelling*	Diarrhea, may be bloody*	Myalgia*	Shortness of Breath*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Abscess at injection site*	Dizziness*	Nausea*	Sore throat*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Blisters or Bumps at injection site*	Extreme fatigue*	Neck gland swelling*	Stomach Pain*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Blisters or Bumps on skin*	Fainting*	Painful swallowing*	Sweats (Drenching)*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Chills*	Flushing face*	Painless sore w/black center at injection site*	Swelling around sore*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Confusion*	Headache*	Painless ulcer w/a black center*	Vomiting*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Cough*	Hoarseness*	Red eyes*	
Yes No Unknown	Yes No Unknown	Yes No Unknown	

Applicable Symptoms for **Anthrax**

9. If the patient is symptomatic for **Babesiosis**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Anorexia*	Decrease hematocrit*	GI symptoms*	Photophobia*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Chills*	Depression*	Hepatomegaly*	Sore throat*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Conjunctival infection*	Elevated serum creatinine and BUN levels*	Jaundice*	Splenomegaly*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Cough*	Emotional lability*	Malaise*	Sweats*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown
Dark urine*	Fatigue*	Mildly elevated Liver Enzymes*	Thrombocytopenia*
Yes No Unknown	Yes No Unknown	Yes No Unknown	Yes No Unknown

Applicable Symptoms for **Babesiosis**

10. If the patient is symptomatic for **Brucellosis**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Anorexia (loss of appetite)*	Fatigue*	Myalgia*
Yes No Unknown	Yes No Unknown	Yes No Unknown
Arthritis*	Headache*	Neurologis symptoms*
Yes No Unknown	Yes No Unknown	Yes No Unknown
Depression*	Liver, spleen swelling*	Sweats*
Yes No Unknown	Yes No Unknown	Yes No Unknown
Endocarditis*	Malaise*	Tisticle, scrotum swelling*
Yes No Unknown	Yes No Unknown	Yes No Unknown

Applicable Symptoms for **Brucellosis**

11. If the patient is symptomatic for **Infant Botulism**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Constipation*	Poor feeding (poor latch/poor suck)*
<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Difficulty breathing*	Ptosis (drooping eyelids)*
<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Face showing less expression than usual*	Pupils that are slow to react to light*
<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Loss of tone (floppy baby)*	Weak cry*
<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>

Applicable Symptoms for **Infant Botulism**

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

Did the patient have any other symptoms?\*

If yes, please specify: ?

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

Did the patient have any other symptoms?\*

If yes, please specify: \* ?

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

Rash\*

Rigors\*

Thrombocytopenia\*

Did the patient have any other symptoms?\*

If yes, please specify: ?

## 14 Additional Information

1. On the **Additional Information** screen, select the appropriate answer for the conditional question at the top: *Do any of the following apply to the patient?*

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 4 of 8

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

### ADDITIONAL INFORMATION

Patient Information	✔	<b>Does any of the following apply to the patient:*</b> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Laboratory Information	✔	
Applicable Symptoms	✔	
<b>Additional Information</b>		
Hospitalization, ICU & Death Information	🔒	
Vaccination History	🔒	
Additional Comments	🔒	
Review & Submit	🔒	

Domestic travel within the last 30 days (outside state of normal residence)

If yes, please specify state(s): Ⓔ  
Select... [dropdown]

International Travel within the last 30 days

If yes, please specify country(s): Ⓔ  
Select... [dropdown]

School/daycare attendee

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

### ADDITIONAL INFORMATION

Patient Information	✔	<b>Does any of the following apply to the patient:*</b> <input checked="" type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Laboratory Information	✔	
Applicable Symptoms	✔	
<b>Additional Information</b>		
Hospitalization, ICU & Death Information	🔒	
Vaccination History	🔒	
Additional Comments	🔒	
Review & Submit	🔒	

**Domestic travel within the last 30 days (outside state of normal residence)\***

If yes, please specify state(s): Ⓔ  
Select... [dropdown]

**International Travel within the last 30 days\***

If yes, please specify country(s): Ⓔ  
Select... [dropdown]

**School/daycare attendee\***

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

**School/daycare employee\***

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

**Food handler\***

If yes, please specify the name of food handler service: Ⓔ

**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. Select the **appropriate answer** for the field: *Domestic travel within the last 30 days (outside state of normal residence)*.

The screenshot shows a form field titled "Domestic travel within the last 30 days (outside state of normal residence)\*". Below the title are three radio button options: "Yes", "No", and "Unknown". The "No" option is selected. Below these options is a label "If yes, please specify state(s):" followed by a multi-select dropdown menu currently showing "Select...".

- If **Yes** is selected for the *Domestic travel (outside state of normal residence)* field, the subsequent *If yes, please specify state(s)* field is enabled. From the multi-select dropdown menu, select the **state(s) the patient traveled**.

The screenshot shows the same form field as above, but now the "Yes" option is selected. The "If yes, please specify state(s):" dropdown menu is open, displaying a list of state abbreviations: KY, AK, AL, AR, AS, AZ, and CA. The dropdown menu is highlighted with a red border.

4. Select the **appropriate answer** for the field: *International Travel within last 30 days*.

The screenshot shows a form field titled "International Travel within the last 30 days\*". Below the title are three radio button options: "Yes", "No", and "Unknown". The "No" option is selected. Below these options is a label "If yes, please specify country(s):" followed by a multi-select dropdown menu currently showing "Select...".

- If **Yes** is selected, the subsequent field *If yes, please specify country(s)* is enabled. From the multi-select dropdown menu, select the **country or countries the patient traveled**.

International travel\*  Please select 'Unknown' if the country in which the patient travelled is not known.

Yes

If yes, please specify country(s):\* ?

Select...

- AFGHANISTAN
- ALBANIA
- ALGERIA
- AMERICAN SAMOA
- ANDORRA
- ANGOLA
- ANGUILLA



5. Select the **appropriate answers** for the following fields to indicate descriptions that apply to the patient:

- *School/daycare attendee*
- *School/daycare employee*
- *Food handler*
- *Healthcare worker*
- *Long-term care facility resident*
- *Long-term care facility employee*
- *Correctional facility resident*
- *Correction facility employee*
- *Homeless shelter resident*
- *Homeless shelter employee*
- *College/University student*
- *Substance abuse or misuse*
- *Military*
- *Other congregate setting resident*
- *Other congregate setting employee*

**School/daycare attendee\***  
 Yes  No  Unknown  
If yes, please specify the name of school/daycare: ?

**School/daycare employee\***  
 Yes  No  Unknown  
If yes, please specify the name of school/daycare: ?

**Food handler\***  
 Yes  No  Unknown  
If yes, please specify the name of food handler service: ?

**Healthcare worker\***  
 Yes  No  Unknown  
If yes, please specify the name of healthcare facility: ?

**Long-term care facility resident\***  
 Yes  No  Unknown  
If yes, please specify the name of long-term care facility: ?

**Long-term care facility employee\***  
    
If yes, please specify the name of long-term care facility: ?

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

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

**Homeless shelter resident\***  
    
If yes, please specify the name of homeless shelter: ?

**Homeless shelter employee\***  
    
If yes, please specify the name of homeless shelter: ?

**College/university student\***  
    
If yes, please specify the name of college/university: ?

**College/university teacher\***  
    
If yes, please specify the name of college/university: ?

**Military\***  
    
If yes, please specify the name of military base: ?

**Other congregate setting resident\***  
    
If yes, please specify the name of other congregate setting: ?

**Other congregate setting employee\***  
    
If yes, please specify the name of other congregate setting: ?

**Please Note:** If **Yes** is selected for **any** of the descriptive questions, the subsequent textbox is enabled for Users to specify the name of appropriate setting.

For example, if **Yes** is selected for the *Healthcare worker* field, the subsequent textbox field is enabled. To proceed, you must enter the **name of the healthcare facility** in the subsequent field: *If yes, please specify the name of the healthcare facility.*

Healthcare worker\*

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

[Empty text input field]

- 6. Select the **appropriate answer** for the field: *Did the patient inject drugs not prescribed by a doctor?*
- 7. Select the **appropriate answer** for the field: *Did the patient use street drugs, but not inject?*

Did the patient inject drugs not prescribed by a doctor?\*

Did the patient use street drugs, but not inject?\*

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

Is this part of an outbreak?\*

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

[Empty text input field]

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

Is this part of an outbreak?\*

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

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

[Empty text input field]

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

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

Unknown

Save Previous **Next** [Up arrow]

## 15 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?*

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 5 of 8

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

### HOSPITALIZATION, ICU & DEATH INFORMATION

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

**Was the patient hospitalized?\***

Yes  No  Unknown

If yes, please specify the hospital name:

Admission Date:   Unknown      Discharge Date:   Unknown

Still hospitalized

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

Yes  No  Unknown

Admission Date to ICU:   Unknown      Discharge Date from ICU:   Unknown

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

Yes  No  Unknown

If yes, please provide the date of death:

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

### HOSPITALIZATION, ICU & DEATH INFORMATION

**Was the patient hospitalized?\***

Yes  No  Unknown

If yes, please specify the hospital name:

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

Still hospitalized

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

Yes  No  Unknown

Admission Date to ICU:   Unknown      Discharge Date from ICU:   Unknown

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

Yes  No  Unknown

If yes, please provide the date of death:

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

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

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

A tooltip box says: "Please enter the name of the hospital where the patient is/was hospitalized." Below it, a text input field is highlighted with a red border. The text above the field reads: "If yes, please specify the hospital name:\* ?"

- 4. Enter the patient’s hospitalization **Admission Date**.

The form shows "Admission Date\*" with a red-bordered input field containing "mm/dd/yyyy" and an "Unknown" checkbox. To the right is "Discharge Date\*" with a similar input field and "Unknown" checkbox, and a "Still hospitalized" checkbox. Below is a calendar for July 2021 with the 23rd highlighted. Other fields include "Intensive care unit (ICU)\*" with an "Unknown" dropdown and "Discharge Date from ICU" with a "mm/dd/yyyy" input field and "Unknown" checkbox.

- 5. Enter the patient’s hospitalization **Discharge Date**.

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

The form shows "Admission Date\*" with the value "07/23/2021" and an "Unknown" checkbox. To the right, "Discharge Date\*" has a red-bordered input field with "mm/dd/yyyy" and an "Unknown" checkbox. Below it, the "Still hospitalized" checkbox is also highlighted with a red border.

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

Admission Date\*   Unknown  Discharge Date\*   Unknown  Still hospitalized

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

Admission Date to ICU   Unknown  Discharge Date from ICU   Unknown

Did the patient die as a result of this illness?

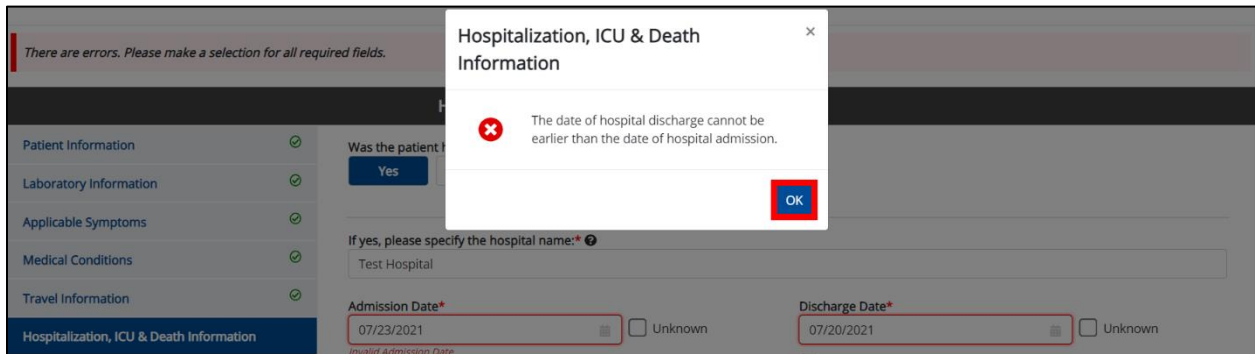
If yes, please provide the date of death:  
Date of Death   Unknown

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

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

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

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



Admission Date\*   Unknown  Discharge Date\*   Unknown

*Invalid Admission Date*  Still hospitalized *Invalid Discharge Date*

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

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

Admission Date to ICU Discharge Date from ICU

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

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

Admission Date to ICU\* Discharge Date from ICU\*

Unknown   Unknown

7. 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:

- 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

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

**HOSPITALIZATION, ICU & DEATH INFORMATION**

Patient Information

Laboratory Information

Applicable Symptoms

Additional 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\*   Unknown

Discharge Date\*   Unknown

Still hospitalized

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

Admission Date to ICU\*   Unknown

Discharge Date from ICU\*   Unknown

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

If yes, please provide the date of death:

Date of Death

Unknown

Save Previous **Next**



## 16 Vaccination History

1. On the **Vaccination History** screen, select the **appropriate answer** for the conditional question at the top: *Is the patient vaccinated for the condition being reported?*

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 6 of 8

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

### VACCINATION HISTORY

Patient Information	✓	<b>Is the patient vaccinated for the condition being reported?*</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Laboratory Information	✓	
Applicable Symptoms	✓	
Additional Information	✓	
Hospitalization, ICU & Death Information	✓	
<b>Vaccination History</b>		
Additional Comments	🔒	
Review & Submit	🔒	

Vaccine Details

If yes, please provide vaccine name:

If other, please specify:

If yes, please enter the number of doses:

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

Date Administered (3rd dose)   Unknown

[+ Add Vaccine](#)

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

VACCINATION HISTORY

Patient Information	✓	<b>Is the patient vaccinated for the condition being reported?*</b> <input checked="" type="radio"/> <b>Yes</b> <input type="radio"/> No <input type="radio"/> Unknown
Laboratory Information	✓	
Applicable Symptoms	✓	
Additional Information	✓	
Hospitalization, ICU & Death Information	✓	
<b>Vaccination History</b>		
Additional Comments	🔒	
Review & Submit	🔒	

Vaccine Details

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

If other, please specify:

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

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

Date Administered (3rd dose)   Unknown

[+ Add Vaccine](#)

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

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

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

4. Select the **number of doses that the patient received**: *If yes, please enter the number of doses.*

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

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

If yes, please enter the number of doses: **2**

Date Administered (1st dose)\*: mm/dd/yyyy  Unknown

Date Administered (2nd dose)\*: mm/dd/yyyy  Unknown

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

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

If yes, please enter the number of doses: **3**

Date Administered (1st dose)\*: mm/dd/yyyy  Unknown

Date Administered (2nd dose)\*: mm/dd/yyyy  Unknown

Date Administered (3rd dose)\*: mm/dd/yyyy  Unknown

### Adding Multiple Vaccines

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

**VACCINATION HISTORY**

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

**Vaccination History**

Additional Comments

Review & Submit

Is the patient vaccinated for the condition being reported?\*

Vaccine Details

If yes, please provide vaccine name:\*

Other

If other, please specify:\*

Test Vaccine Name

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

1


Date Administered (1st dose)\*: 07/31/2021  Unknown


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

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


**+ Add Vaccine**

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


Vaccine Details 

If yes, please provide vaccine name:\* 


Select... | v


If other, please specify: 


\_\_\_\_\_


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

Select... | v

Date Administered (1st dose)    Unknown

Date Administered (2nd dose)    Unknown


Date Administered (3rd dose)    Unknown


 Add Vaccine


Save Previous Next


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


VACCINATION HISTORY


Patient Information 


Laboratory Information 


Applicable Symptoms 

Additional Information 

Hospitalization, ICU & Death Information 

**Vaccination History** 


Additional Comments 

Review & Submit 

Is the patient vaccinated for the condition being reported?\*

Yes  No  Unknown


Vaccine Details

If yes, please provide vaccine name:\* 


Other x | v


If other, please specify:\*


Test Vaccine Name


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

1 x | v

Date Administered (1st dose)\*    Unknown

Date Administered (2nd dose)    Unknown

Date Administered (3rd dose)    Unknown

 Add Vaccine

Save Previous **Next**

## 17 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.

## 18 Review and Submit

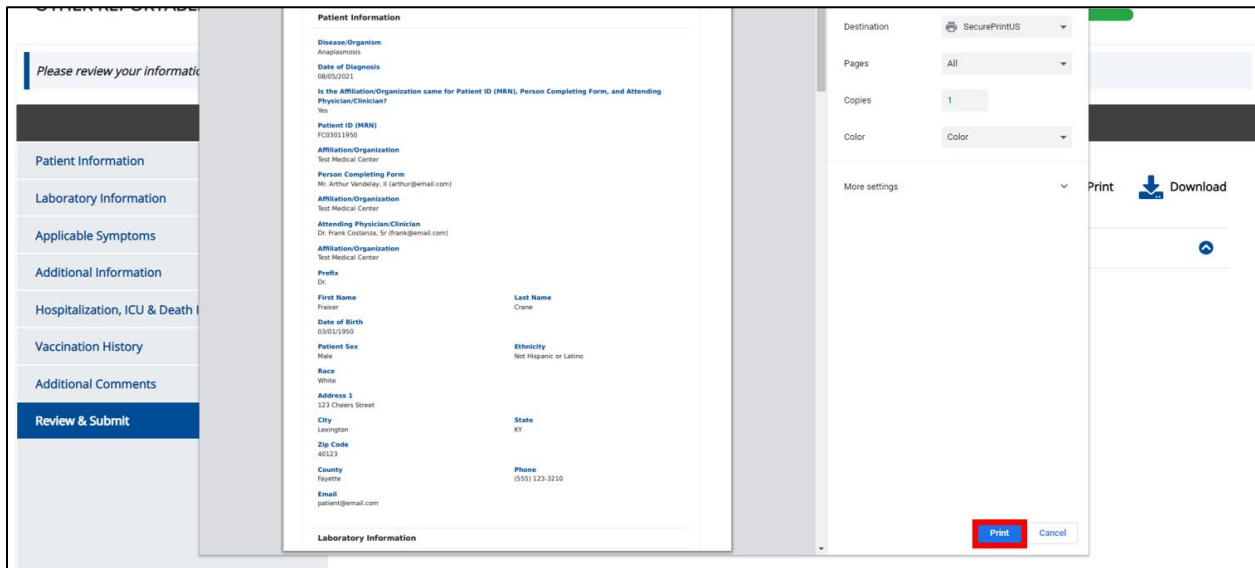
The **Review and Submit** screen displays a summary of the information you have entered. Prior to submitting the case report, review the information on this screen to verify its accuracy. You must click **Submit** to submit the case report form.

### Print or Download Functionality

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

Patient Information	
Disease/Organism	Date of Diagnosis
Anaplasmosis	08/05/2021
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?	
Yes	
Patient ID (MRN)	Affiliation/Organization
FC03011950	Test Medical Center
Person Completing Form	Affiliation/Organization

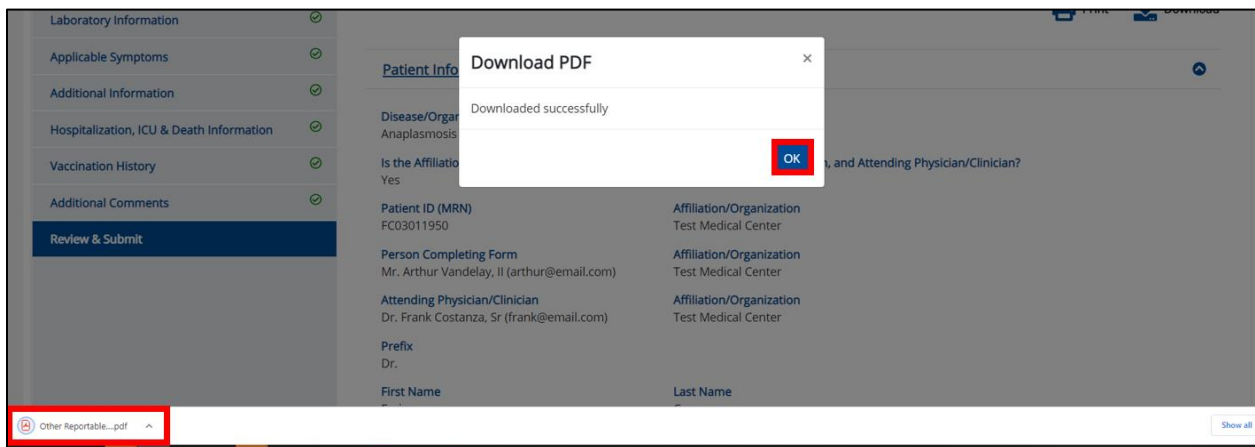
- Upon clicking **Print**, a *Print Preview* will display. Click **Print** to print the case report.



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

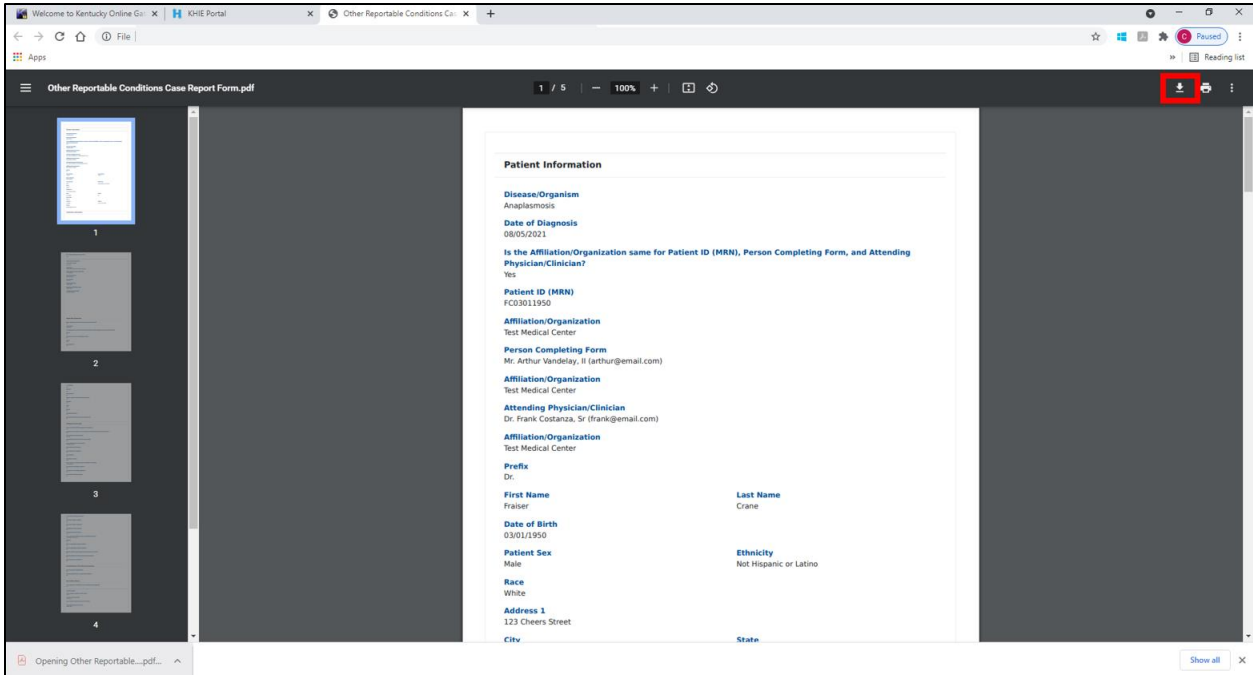


- Once the download is complete, a pop-up will display. Click **OK** to close out of the pop-up.
- To view the downloaded case report, click the **PDF** icon at the bottom left.



- 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.




Laboratory Information	✓	Print	Download
Applicable Symptoms	✓	<b>Patient Information</b>	
Additional Information	✓		
Hospitalization, ICU & Death Information	✓	<b>Laboratory Information</b>	
Vaccination History	✓		
Additional Comments	✓		
<b>Review &amp; Submit</b>			
		<p>Does the patient have a lab test? Yes</p> <hr/> <p><b>Laboratory Information</b></p> <p>Laboratory Name Test Lab</p> <p>Test Name ANAPLASMA PHAGOCYTOPHILUM DNA</p>	

4. Review the *Patient Information* section.

Applicable Symptoms	✓	<b>Patient Information</b>																														
Additional Information	✓	<p>Disease/Organism: Anaplasmosis      Date of Diagnosis: 08/05/2021</p> <p>Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes</p> <table border="0"> <tr> <td>Patient ID (MRN): FC03011950</td> <td>Affiliation/Organization: Test Medical Center</td> <td colspan="2"></td> </tr> <tr> <td>Person Completing Form: Mr. Arthur Vandelay, II (arthur@email.com)</td> <td>Affiliation/Organization: Test Medical Center</td> <td colspan="2"></td> </tr> <tr> <td>Attending Physician/Clinician: Dr. Frank Costanza, Sr (frank@email.com)</td> <td>Affiliation/Organization: Test Medical Center</td> <td colspan="2"></td> </tr> </table> <p>Prefix: Dr.</p> <table border="0"> <tr> <td>First Name: Fraiser</td> <td>Last Name: Crane</td> <td colspan="2"></td> </tr> </table> <p>Date of Birth: 03/01/1950</p> <table border="0"> <tr> <td>Patient Sex: Male</td> <td>Ethnicity: Not Hispanic or Latino</td> <td>Race: White</td> <td></td> </tr> </table> <p>Address 1: 123 Cheers Street</p> <table border="0"> <tr> <td>City: Lexington</td> <td>State: KY</td> <td>Zip Code: 40123</td> <td></td> </tr> </table> <table border="0"> <tr> <td>County: Fayette</td> <td>Phone: (555) 123-3210</td> <td>Email: patient@email.com</td> <td></td> </tr> </table>			Patient ID (MRN): FC03011950	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			First Name: Fraiser	Last Name: Crane			Patient Sex: Male	Ethnicity: Not Hispanic or Latino	Race: White		City: Lexington	State: KY	Zip Code: 40123		County: Fayette	Phone: (555) 123-3210	Email: patient@email.com	
Patient ID (MRN): FC03011950	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																															
First Name: Fraiser	Last Name: Crane																															
Patient Sex: Male	Ethnicity: Not Hispanic or Latino	Race: White																														
City: Lexington	State: KY	Zip Code: 40123																														
County: Fayette	Phone: (555) 123-3210	Email: patient@email.com																														
Hospitalization, ICU & Death Information	✓																															
Vaccination History	✓																															
Additional Comments	✓																															
<b>Review &amp; Submit</b>																																

5. Review the *Laboratory Information* section.



Laboratory Information 

Does the patient have a lab test?  
Yes

---

**Laboratory Information**

**Laboratory Name**  
Test Lab

**Test Name**  
ANAPLASMA PHAGOCYTOPHILUM DNA


**Filler Order/Accession Number**  
FC20210805

**Specimen Source**  
Blood arterial

**Test Result**  
Positive

**Test Result Date** 08/05/2021      **Specimen Collection Date** 08/04/2021

**Additional Information**  
Lab Test Details



6. Review the *Applicable Symptoms* section.

**Applicable Symptoms**

Were symptoms present during the course of illness?  
Yes

**Onset Date**  
Unknown

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

**Fever**  
No

**Diarrhea (>3 loose stools/24hr period)**  
No

**Chills**  
Yes

**GI symptoms**  
Yes

**Leukopenia**  
No

**Malaise**  
Yes

**Mild Anemia**  
Yes

**Mild to moderate elevated liver enzymes**  
Yes

**Myalgia**  
Yes

**Rash**  
Yes

**Rigors**  
No

**Thrombocytopenia**  
No

Did the patient have any other symptoms?  
No

7. Review the *Additional Information* section.

**Additional Information**

Does any of the following apply to the patient:  
Yes

Domestic travel within the last 30 days (outside state of normal residence)  
Yes

If yes, please specify state(s):  
AR, CA

International Travel within the last 30 days  
Yes

If yes, please specify country(s):  
AUSTRALIA

School/daycare attendee  
No

School/daycare employee  
No

Food handler  
No

Healthcare worker  
Yes

If yes, please specify the name of healthcare facility:  
Test Medical Clinic

Long-term care facility resident  
No

Long-term care facility employee  
No

Correctional facility resident  
No

Correctional facility employee  
No

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

**Hospitalization, ICU & Death Information**

Was the patient hospitalized?  
Yes

If yes, please specify the hospital name:  
Test Hospital

Admission Date	Discharge Date
07/26/2021	07/30/2021

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

Admission Date to ICU	Discharge Date from ICU
07/26/2021	07/27/2021

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

9. Review the *Vaccination History* section.

**Vaccination History**

Is the patient vaccinated for the condition being reported?  
Yes

**Vaccine Details**

If yes, please provide vaccine name:  
Other

If other, please specify:  
Unknown

If yes, please enter the number of doses:  
1

Date Administered (1st dose)  
08/02/2021

10. Review the *Additional Comments* section.

**Additional Comments**

Additional comments or notes, please specify:  
Patient Notes

Previous Submit

### Click Hyperlinks to Edit

- 11. 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.

Please review your information before submitting.

**REVIEW & SUBMIT**

Print Download

**Patient Information**

[Patient Information](#)

<b>Disease/Organism</b> Anaplasmosis	<b>Date of Diagnosis</b> 08/05/2021
<b>Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?</b> Yes	
<b>Patient ID (MRN)</b> FC03011950	<b>Affiliation/Organization</b> Test Medical Center
<b>Person Completing Form</b> Mr. Arthur Vandelay, II (arthur@email.com)	<b>Affiliation/Organization</b> Test Medical Center
<b>Attending Physician/Clinician</b> Dr. Frank Costanza, Sr (frank@email.com)	<b>Affiliation/Organization</b> Test Medical Center

12. 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.

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 1 of 8

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

### PATIENT INFORMATION

*For conditions not found in the dropdown that are reportable per the KY Reportable Diseases Regulation (902 KAR 2:020), please fax an EPID 200 form to the local health department located in the patient's county of residence.*

<b>Patient Information</b> ✓	Disease/Organism*	Date of Diagnosis*	<input type="checkbox"/> Unknown
Laboratory Information ✓	Anaplasmosis	08/05/2021	
Applicable Symptoms ✓	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*		
Additional Information ✓	<input checked="" type="button" value="Yes"/> <input type="button" value="No"/>		
Hospitalization, ICU & Death Information ✓	Patient ID (MRN)*	Affiliation/Organization*	
Vaccination History ✓	FC03011955	Test Medical Center	
Additional Comments ✓	Person Completing Form*	Affiliation/Organization	If other, please specify:
<b>Review &amp; Submit</b>	Mr. Arthur Vandelay, II (arthur@em...	Test Medical Center	

13. 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**.

PATIENT INFORMATION

*For conditions not found in the dropdown that are reportable per the KY Reportable Diseases Regulation (902 KAR 2:020), please fax an EPID 200 form to the local health department located in the patient's county of residence.*

<b>Patient Information</b> ✓	Disease/Organism*	Date of Diagnosis*	<input type="checkbox"/> Unknown
Laboratory Information ✓	Anaplasmosis	08/05/2021	
Applicable Symptoms ✓	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*		
Additional Information ✓	<input checked="" type="button" value="Yes"/> <input type="button" value="No"/>		
Hospitalization, ICU & Death Information ✓	Patient ID (MRN)	Affiliation/Organization	
Vaccination History ✓	FC03011955	Test Medical Center	
Additional Comments ✓	Person Completing Form*	Affiliation/Organization	If other, please specify:
Review & Submit	Mr. Arthur Vandelay, II (arthur@em...	Test Medical Center	

**Save Changes?**

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

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

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 8 of 8

Please review your information before submitting.

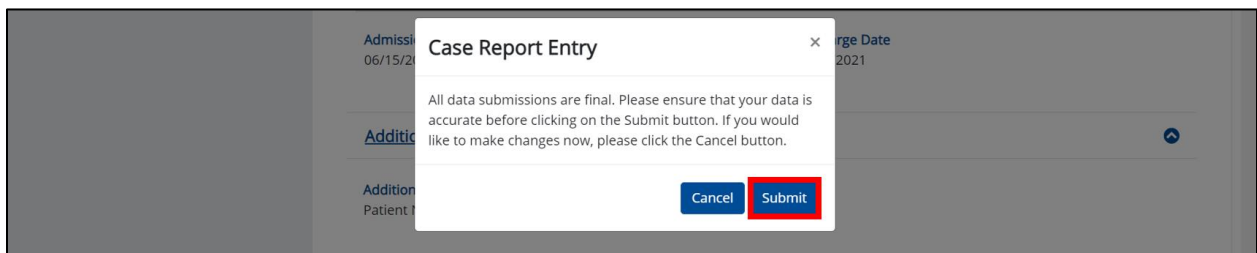
### REVIEW & SUBMIT

<b>Patient Information</b> ✓	Print  Download		
Laboratory Information ✓	<a href="#">Patient Information</a>		
Applicable Symptoms ✓	Disease/Organism	Date of Diagnosis	
Additional Information ✓	Anaplasmosis	08/05/2021	
Hospitalization, ICU & Death Information ✓	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?		
Vaccination History ✓	Yes		
Additional Comments ✓	Patient ID (MRN)	Affiliation/Organization	
<b>Review &amp; Submit</b>	FC03011955	Test Medical Center	
	Person Completing Form	Affiliation/Organization	
	Mr. Arthur Vandelay, II (arthur@email.com)	Test Medical Center	

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

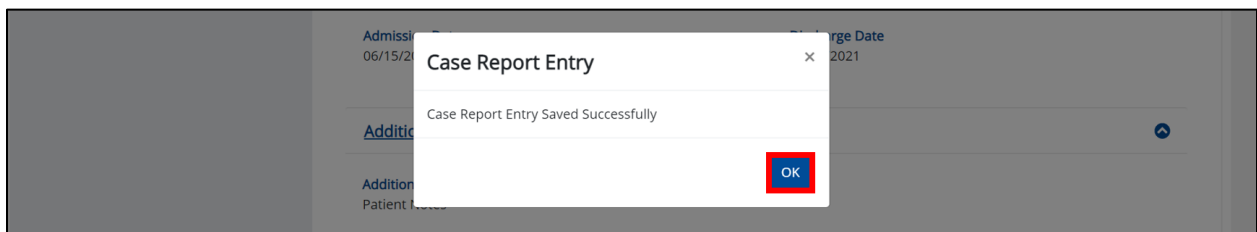


- All case report submissions are final. You have one more opportunity to select **Cancel** to continue reviewing the Case Report or click **Submit** to submit the report.



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

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



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

**Congratulations! You have submitted the Other Reportable Conditions 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.

## 19 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' page. At the top, there is a navigation bar with 'Patient Search', 'Bookmarked Patients', 'Event Notifications', 'Lab Data Entry', and 'Case Report Entry'. Below this is a breadcrumb trail: 'Home > Case Report Entry User Summary'. The main heading is 'CASE REPORT ENTRY USER SUMMARY'. Underneath, there is a filter section for 'LAST UPDATED DATE RANGE' with 'Start Date' set to '07/29/2021' and 'End Date' set to '07/29/2021'. A 'Retrieve Data' button is to the right. Below the filter, it says 'SHOWING 1 ITEMS' and 'APPLY FILTER'. The main table has columns: ACTIONS, REPORT TYPE, AFFILIATION/OR GANIZATION, PATIENT MRN, FIRST NAME, LAST NAME, DATE OF BIRTH, PATIENT SEX, STATUS, LAST UPDATED, and SUBMISSION DATE. One row is visible with a 'View' button. At the bottom, there are navigation buttons: 'First', 'Back', '1', 'Next', 'Last', and a 'Maximum 5 entries per page' dropdown.

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 is similar to the previous one but shows a calendar pop-up for the date range. The 'Start Date' is now '07/26/2021' and the 'End Date' is '07/29/2021'. The calendar shows 'July 2021' with days from 27 to 31. The table below still shows the same data row. The 'Retrieve Data' button is highlighted in red in the original image.

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

**CASE REPORT ENTRY USER SUMMARY**

LAST UPDATED DATE RANGE    Start Date: 07/27/2021    End Date: 07/29/2021    Retrieve Data

SHOWING 1 ITEMS    APPLY FILTER

ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<span style="border: 1px solid blue; padding: 2px;">View</span>	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM

First   Back   1   Next   Last    Maximum 5 entries per page

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

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

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

**CASE REPORT ENTRY USER SUMMARY**

LAST UPDATED DATE RANGE    Start Date: 12/01/2020    End Date: 07/29/2021    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**.

**CASE REPORT ENTRY USER SUMMARY**

LAST UPDATED DATE RANGE    Start Date: 07/26/2021    End Date: 07/29/2021    Retrieve Data

SHOWING 3 ITEMS    APPLY FILTER

ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<span style="border: 1px solid blue; padding: 2px;">View</span>	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
<span style="border: 1px solid blue; padding: 2px;">Continue</span>	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
<span style="border: 1px solid blue; padding: 2px;">View</span>	STD	Test Medical Center	SK05051960	Susan	Ross	05/05/1960	Female	Complete	07/28/2021 7:00 PM	07/28/2021 7:00 PM

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



### CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date: 07/26/2021 End Date: 07/29/2021 Retrieve Data

SHOWING 3 ITEMS HIDE FILTER

ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<a href="#">View</a>	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
<a href="#">Continue</a>	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
<a href="#">View</a>	STD	Test Medical Center	SK05051960	Susan	Ross	05/05/1960	Female	Complete	07/28/2021 7:00 PM	07/28/2021 7:00 PM

First Back 1 Next Last Maximum 5 entries per page

### Review Previously Submitted Case Reports

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

### CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date: 07/26/2021 End Date: 07/29/2021 Retrieve Data

SHOWING 3 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<a href="#">View</a>	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
<a href="#">Continue</a>	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
<a href="#">View</a>	STD	Test Medical Center	SK05051960	Susan	Ross	05/05/1960	Female	Complete	07/28/2021 7:00 PM	07/28/2021 7:00 PM

First Back 1 Next Last Maximum 5 entries per page

- 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.
- Click **OK** to close out of the pop-up.

Case Report Details

Print Download

Patient Information

MDRO Type  
Candida auris, clinical

Organism Name  
Infection caused by Candida auris

Date of Diagnosis  
07/23/2021

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

Patient ID (MRN)  
CK08101955

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

First Name  
Cosmo

Middle Name  
Newman

Last Name  
Kramer

Suffix  
III

Date of Birth  
08/10/1955

Patient Sex

Ethnicity

Race

OK

### 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.

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

ACTIONS	REPORT TYPE ^	AFFILIATION/OR GANIZATION ↕	PATIENT MRN ↕	FIRST NAME ↕	LAST NAME ↕	DATE OF BIRTH ↕	PATIENT SEX ↕	STATUS ↕	LAST UPDATED ↕	SUBMISSION DATE ↕
<a href="#">View</a>	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
<a href="#">Continue</a>	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
<a href="#">View</a>	STD	Test Medical Center	SK05051960	Susan	Ross	05/05/1960	Female	Complete	07/28/2021 7:00 PM	07/28/2021 7:00 PM

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

OTHER REPORTABLE CONDITIONS CASE REPORT FORM Section 7 of 8

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information <span style="float: right; color: green;">✔</span>	Additional comments or notes, please specify: <div style="border: 1px solid #ccc; height: 100px; width: 100%;"></div> <p style="font-size: small; margin-top: 5px;">0/1000 Characters</p>
Laboratory Information <span style="float: right; color: green;">✔</span>	
Applicable Symptoms <span style="float: right; color: green;">✔</span>	
Additional Information <span style="float: right; color: green;">✔</span>	
Hospitalization, ICU & Death Information <span style="float: right; color: green;">✔</span>	
Vaccination History <span style="float: right; color: green;">✔</span>	
Additional Comments	

## 20 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.

