

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Electronic Case Reports: Sexually Transmitted Diseases (STD)

User Guide

October 2021

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1 Introduction

Overview

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

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

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

Supported Web Browsers

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

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

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

Mobile Device Considerations

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

Accessing the ePartnerViewer

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

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

Please Note: For specific information about creating a KOG account and how to complete MFA, please review the *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 Sexually Transmitted Diseases (STD) 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**.

Citizen (or) Business Partner Sign In

Sign in with your Kentucky Online Gateway Account.

Email Address
jane.doe@gmail.com

Password
.....

[Forgot/Reset Password?](#)

[Resend Account Verification Email](#)

[SIGN IN](#)

WARNING

This website is the property of the Commonwealth of Kentucky. This is to notify you that you are only authorized to use this site, or any information accessed through this site, for its intended purpose. Unauthorized access or disclosure of personal and confidential information may be punishable by fines under state and federal law. Unauthorized access to this website or access in excess of your authorization may also be criminally punishable. The Commonwealth of Kentucky follows applicable federal and state guidelines to protect the information from misuse or unauthorized access.

[Don't already have a Kentucky Online Gateway Citizen Account?](#)

[Create An Account](#)

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

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

My Apps

Search for Applications [QSearch](#)

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

KHIE ePartnerViewer

The KHIE ePartnerViewer is where KHIE Participant's Authorized Users can access the patient health information available in the Kentucky Health Information Exchange.

[Launch](#)

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

Kentucky Online Gateway

Welcome | My Account | Sign Out | Help | English

Multi-Factor Authentication

☐ MFA by Email Verification

☐ MFA by Phone Verification

Send Passcode

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.

KHIE | ePartnerViewer

Mitch Cavallo

TERMS AND CONDITIONS OF USE

Terms and Conditions

HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

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

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

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

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

Select 1 accept* to accept the usage terms and conditions.

I accept | I decline

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

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

KHIE | ePartnerViewer Mitch Cavallo

TERMS AND CONDITIONS OF USE

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HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

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- 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.

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

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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.

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

KHIE | ePartnerViewer Mitch Cavallo

TERMS AND CONDITIONS OF USE

Terms and Conditions

HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

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

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

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

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

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

☒ Accepted

You are part of the below mentioned organization. Please click on proceed to continue.

KHIE Smoke Test Organization

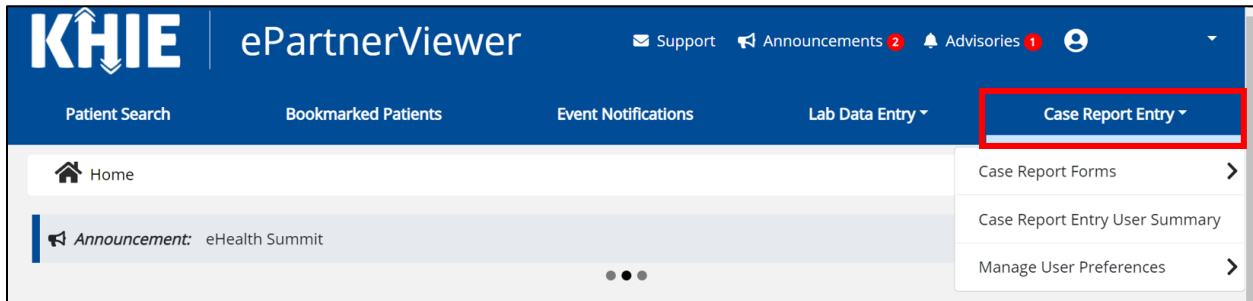
Copyright 2019 Healthinteractive Healthinteractive KHIE Version: 1.0.0

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.

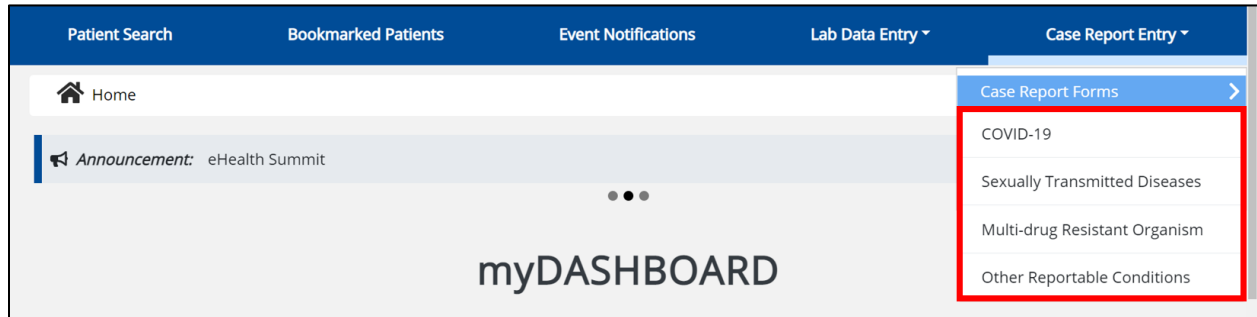
Please Note: For specific information about COVID-19 case reporting, please review the *Direct Data Entry for Electronic Case Reports: COVID-19 User Guide*.

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

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

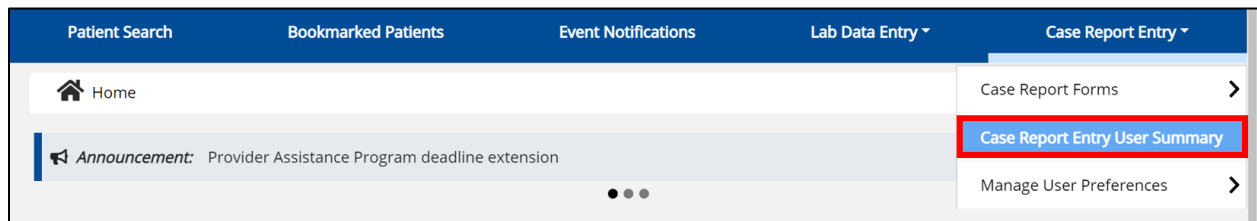
- **Other Reportable Conditions Case Report:**
 - Designed for Users to enter Other Reportable Conditions case reports.

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



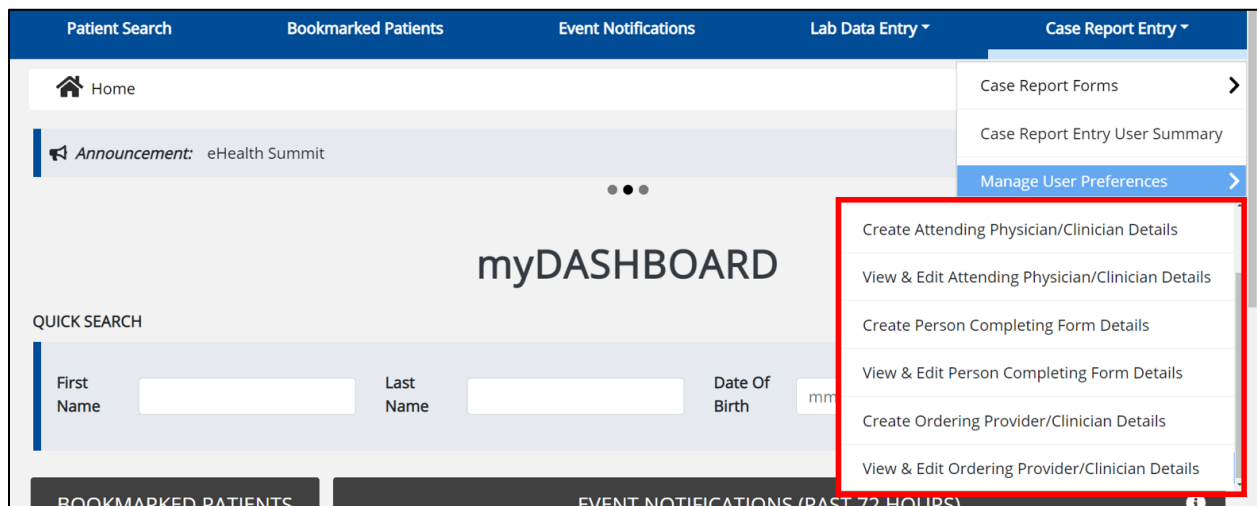
2. Case Report Entry User Summary:

- 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.

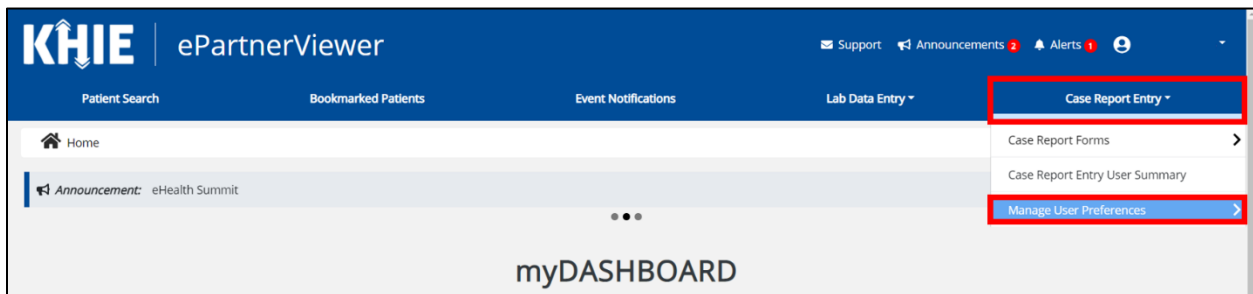


4 Manage User Preferences

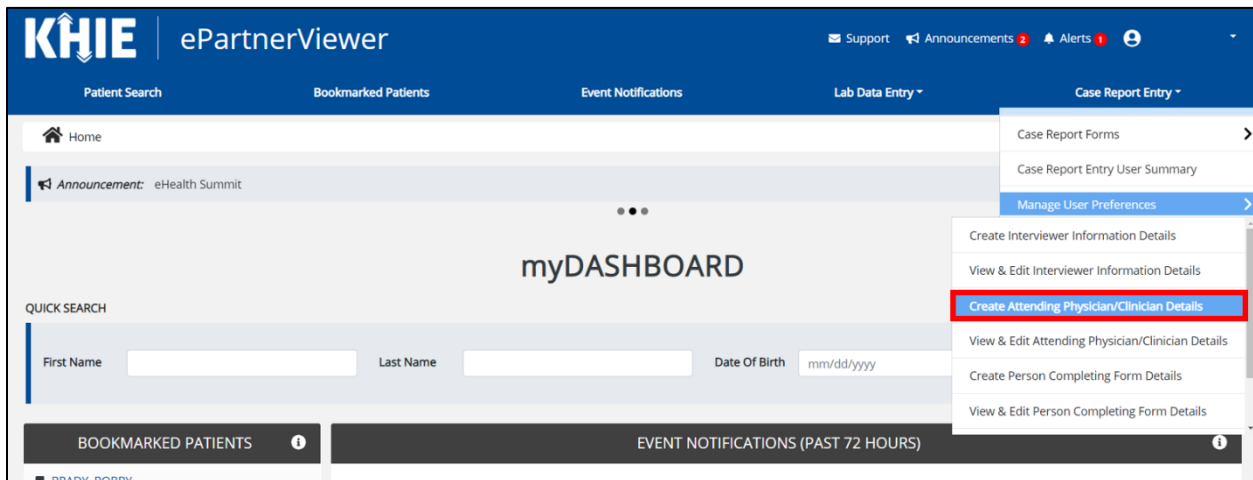
These are your User Preferences. Prior to entering your Sexually Transmitted Diseases (STD) case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in 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 STD 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.

Home > Create Attending Physician/Clinician Details

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Dr. x v

First Name*
Last Name*

Suffix
Select...
II
III
IV
Jr
Sr
(xxx) xxx-xxxx

Address 2
Unit, Suite, Building, etc.

State*
Select... v Zip Code*

Email*
name@domain.com

Clear Save

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Dr. x v

First Name*
Last Name*

Suffix
Sr x v

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

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

City*
State*
Select... v Zip Code*

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

Phone*
(xxx) xxx-xxxx

Email*
name@domain.com

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Dr. x | v

First Name*
Frank

Last Name*
Costanza

Suffix
Sr x | v

Address 1*
1 First Street

Address 2
1A

City*
Lexington

State*
KY x | v

Zip Code*
40123

Phone*
(111) 111-1111

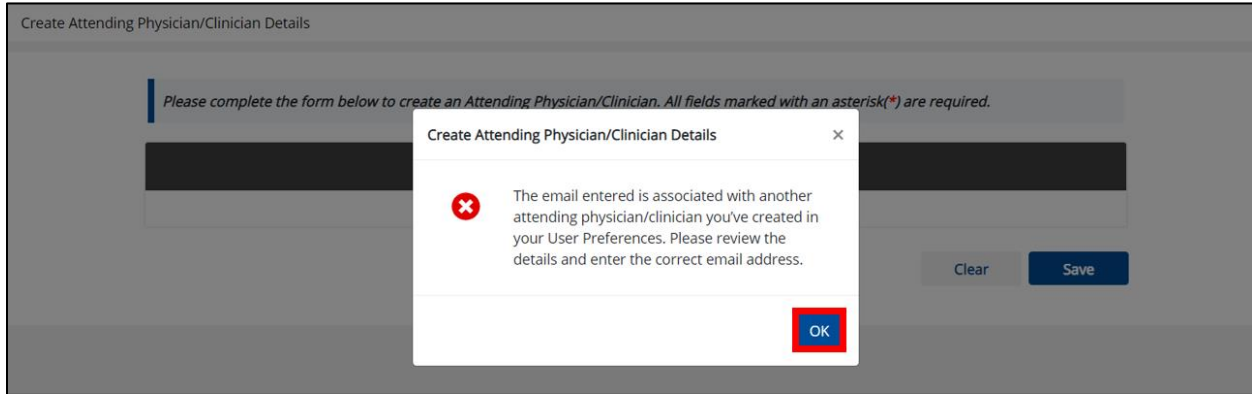
Email*
frank@email.com

Clear Save

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

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

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

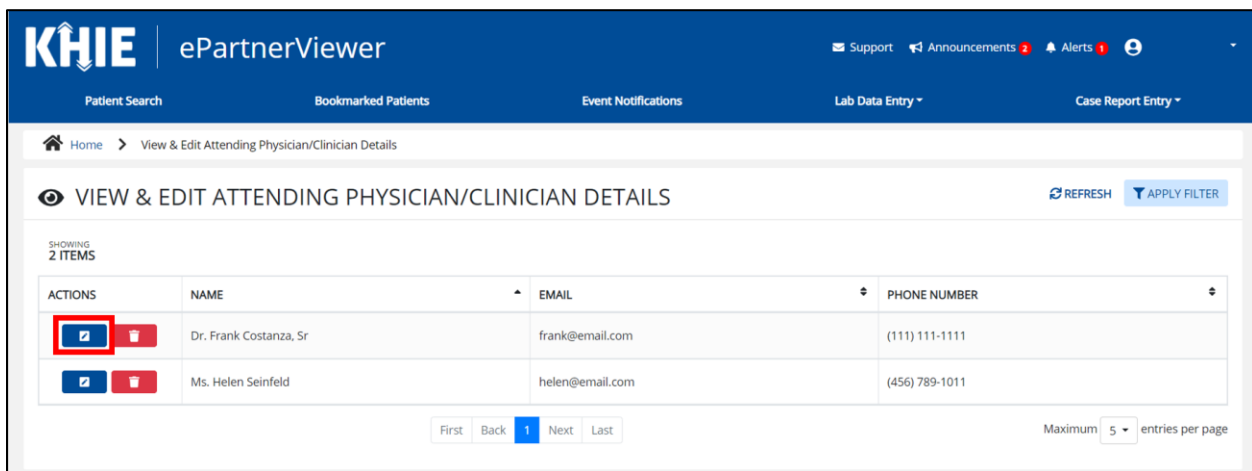


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.



View & Edit Attending Physician/Clinician Details

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







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

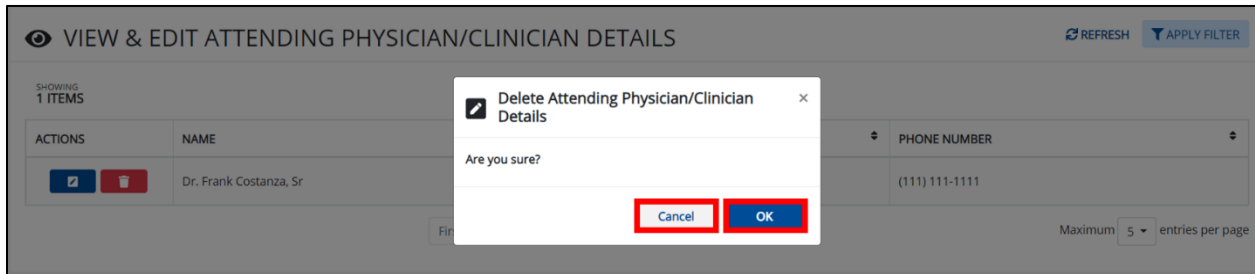
13. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.

Delete Attending Physician/Clinician Details

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

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

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



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

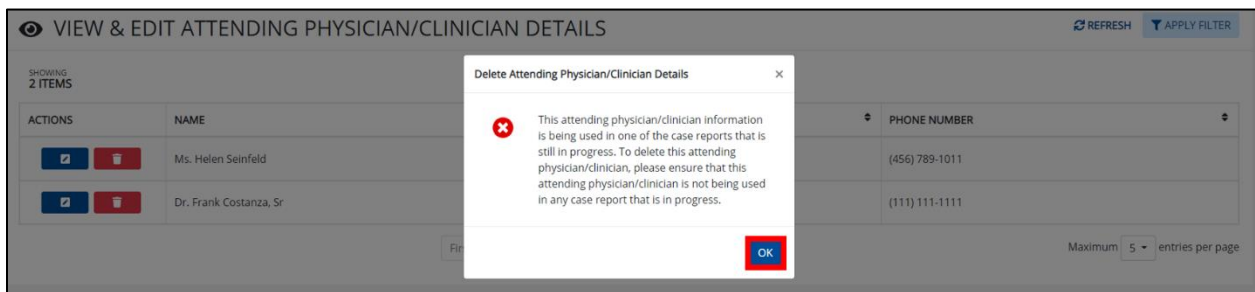
If you attempt to delete an attending physician/clinician who has been selected for use in a case report that has not been completed yet, a pop-up notification will display the following message:

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

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

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

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



Filter Attending Physician/Clinician Details

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

The screenshot shows the ePartnerViewer interface. The top navigation bar includes the KHIE logo, 'ePartnerViewer', and links for Support, Announcements (2), Alerts (1), and a user profile icon. Below this is a secondary navigation bar with links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' and includes a 'REFRESH' button and a red 'APPLY FILTER' button. Below the title, 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' (selected), 'Next', and 'Last'. To the right, it says 'Maximum 5 entries per page'.

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

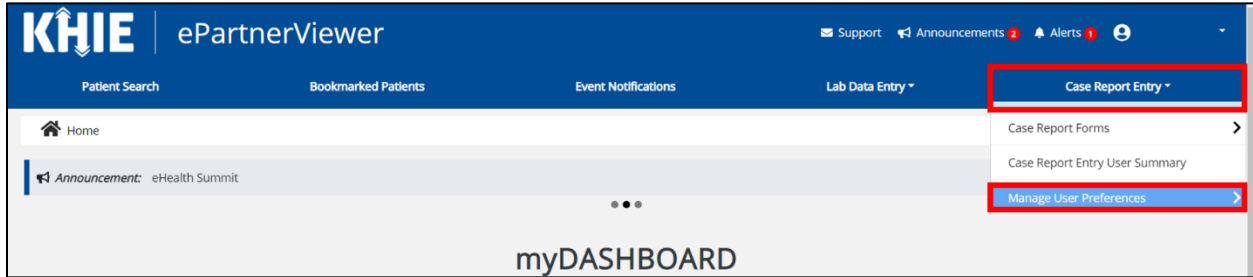
The screenshot shows the same ePartnerViewer interface as before, but with filter fields added to the table headers. The filter fields are highlighted with red boxes:

ACTIONS	NAME <input data-bbox="412 1150 561 1184" type="text" value="Enter NAME..."/>	EMAIL <input data-bbox="760 1150 909 1184" type="text" value="Enter EMAIL..."/>	PHONE NUMBER <input data-bbox="1162 1150 1312 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

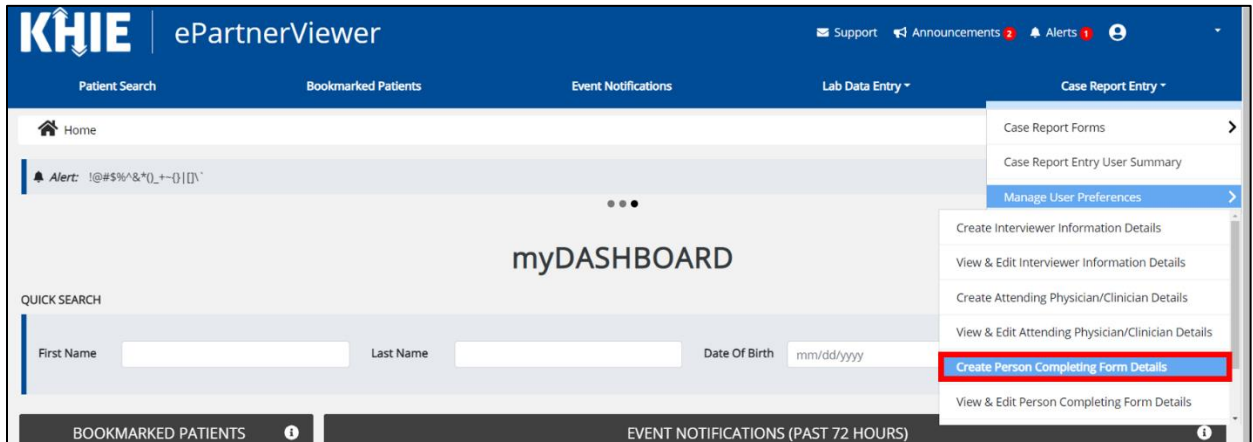
The 'APPLY FILTER' button has been replaced by a red 'HIDE FILTER' button. The pagination controls and 'Maximum 5 entries per page' text remain the same.

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.

The screenshot shows the 'PERSON COMPLETING FORM' screen. At the top, there's a message: 'Please complete the form below to create a Person Completing Form. All fields marked with an asterisk(*) are required.' The form has the following fields: Prefix (dropdown menu with 'Mr.' selected), First Name* (text input), Last Name* (text input), Suffix (dropdown menu with 'Select...' selected), Address 2 (text input with placeholder 'Unit, Suite, Building, etc.'), State* (dropdown menu with 'Select...' selected), Zip Code* (text input), and Email* (text input with placeholder 'name@domain.com'). The Prefix and Suffix dropdown menus are highlighted with red boxes.

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

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

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

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

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

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

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

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

PERSON COMPLETING FORM

Prefix
Mr. x | v

First Name*
Arthur

Last Name*
Vandelay

Suffix
II x | v

Address 1*
22 Second Avenue

Address 2
Unit, Suite, Building, etc.

City*
Lexington

State*
KY x | v

Zip Code*
40222-

Phone*
(222) 222-2222

Email*
arthur@email.com

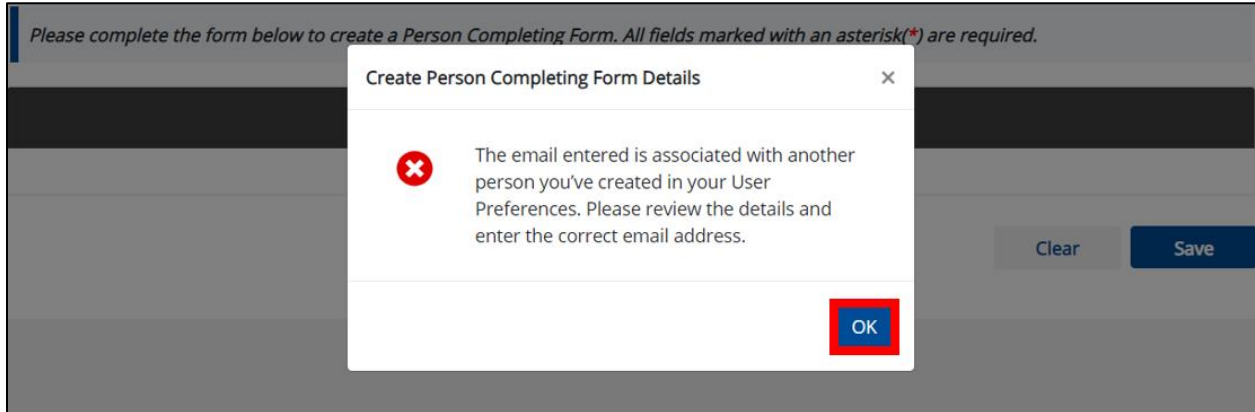
Clear

Save

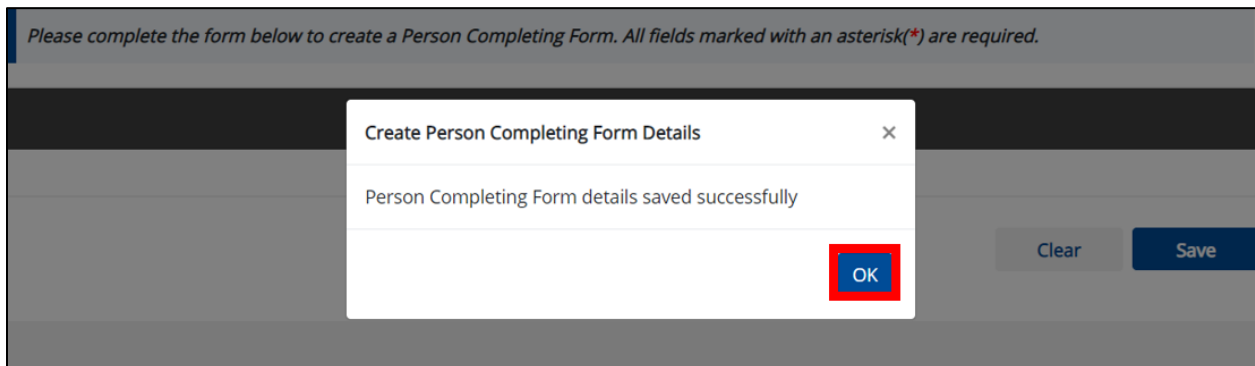
Please Note: If you enter an email address that is already associated with another Person Completing Form and click **Save**, a pop-up displays with an error message that states:

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

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



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







View & Edit Person Completing Form Details

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

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

First Back 1 Next Last

Maximum 5 entries per page

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

Update Person Completing Form Details

Prefix: Mr.

First Name: Arthur

Last Name: Vandelay

Suffix: II

Address 1: 22 Second Avenue

Address 2: Unit, Suite, Building, etc.

City: Lexington

State: KY

Zip Code: 40222

Phone: (222) 222-2222





Email: arthur@email.com

Cancel Save

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

ACTIONS	NAME	PHONE NUMBER
 	Mr. Arthur Vandelay, II	(222) 222-2222
 	Dr. Estelle Costanza	(111) 123-1111

First Back 1 Next Last

Maximum 5 entries per page

Update Person Completing Form Details

Person Completing Form details updated successfully

OK

Delete Person Completing the Form Details

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

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

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.

Delete Person Completing Form Details
Are you sure?
Cancel **OK**

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

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

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

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





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

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

Filter Person Creating Form Details





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

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

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

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

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

ACTIONS	NAME <input data-bbox="397 1024 555 1060" type="text" value="Enter Name..."/>	EMAIL <input data-bbox="755 1024 912 1060" type="text" value="Enter Email..."/>	PHONE NUMBER <input data-bbox="1166 1024 1323 1060" type="text" value="Enter Phone Number..."/>
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222

5 Basic Features of the Case Report Entry Form

This section describes the basic features of the Case Report 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.

ADDITIONAL COMMENTS

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Medical Conditions ✓

Travel Information ✓

Hospitalization, ICU & Death Information ✓

Additional Information ✓

Treatment Information ✓

Additional Comments

Review and Submit

Additional comments or notes, please specify:

0/1000 Characters

Save Previous Next

Save Feature

The **Save** feature allows Users to complete the case report 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.

Is patient currently pregnant?*

Yes No Unknown

Save Next

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

Case Report Entry Icons

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

Icon Descriptions:

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

Conditional Questions

Conditional Questions are those questions that are asked based on your responses to the previous questions. The Sexually Transmitted Diseases (STD) 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 STD Case Report, the subsequent fields will be grayed out and disabled.

The screenshot displays the 'LABORATORY INFORMATION' screen. On the left is a sidebar with navigation links: Patient Information, Laboratory Information (selected), Applicable Symptoms, Medical Conditions, Travel Information, Hospitalization, ICU & Death Information, Additional Information, Treatment Information, Additional Comments, and Review and Submit. The main content area features a conditional question: 'Does the patient have a lab test?'. Below this question are three buttons: 'Yes', 'No', and 'Unknown'. The 'No' and 'Unknown' buttons are highlighted with a red box. Below the buttons, the form fields for 'Laboratory Information' (Laboratory Name, Test Name, Filler Order/Accession Number, Specimen Source, and Test Result) are visible but appear to be disabled or grayed out.

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

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

These conditional questions are found on the **Applicable Symptoms**, **Medical Conditions**, and **Travel Information** screens of the STD Case Report.

- For example, if you select **No** to the conditional question at the top of the **Medical Conditions** screen of the STD Case Report, all subsequent fields will be disabled and labeled as **No**.

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

MEDICAL CONDITIONS	
Patient Information	<p>Did the patient have any underlying medical conditions and/or risk behaviors?[*]</p> <p>Yes No Unknown</p>
Laboratory Information	
Applicable Symptoms	
Medical Conditions	<p>Which of the following conditions did the patient experience during illness?</p> <p>Neurologic impairment</p> <p>Yes No Unknown</p> <p>If yes, please specify: <input type="text"/></p>
Travel Information	
Hospitalization, ICU & Death Information	
Additional Information	
Treatment Information	<p>Vision impairment</p> <p>Yes No Unknown</p> <p>If yes, please specify: <input type="text"/></p>
Additional Comments	
Review and Submit	<p>Substance abuse or misuse</p> <p>Yes No Unknown</p> <p>If yes, please specify the substance that was abused or misused: <input type="text"/></p> <p>Immunosuppressive condition</p> <p>Yes No Unknown</p>

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

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

MEDICAL CONDITIONS

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

Yes

No

Unknown

Which of the following conditions did the patient experience during illness?

Neurologic impairment*

Yes

No

Unknown

If yes, please specify:

Vision impairment*

Yes

No

Unknown

If yes, please specify:

Substance abuse or misuse*

Yes

No

Unknown

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

Immunosuppressive condition*

Yes

No

Unknown

If yes, please specify:

6 Affiliation/Organization Conditional Question

Certain conditional questions apply only to the subsequent fields within the section. Based on the selection to the 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, and Attending Physician/Clinician?

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

The screenshot displays the 'PATIENT INFORMATION' form. At the top, there are two fields: 'Disease/Organism*' with a dropdown menu showing 'Chlamydia' and 'Date of Diagnosis*' with a date picker showing '07/23/2021' and an 'Unknown' checkbox. Below these, a red rectangular box highlights the conditional question: 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*' with 'Yes' and 'No' buttons. Underneath the box, there are three rows of fields. The first row has 'Patient ID (MRN)*' and 'Affiliation/Organization*'. The second row has 'Person Completing Form' and 'Affiliation/Organization*', with an additional 'If other, please specify:' field. The third row has 'Attending Physician/Clinician' and 'Affiliation/Organization*', also with an 'If other, please specify:' field. All dropdown menus are currently set to 'Select...'.

- Select **Yes** to apply the **same** Affiliation/Organization 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 enabled 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* ?

Attending Physician/Clinician* ?

If other, please specify: ?

- Once the Affiliation/Organization is selected for the Patient ID (MRN), the 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* ?

Attending Physician/Clinician* ?

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 selected for the Patient ID (MRN), the Person Completing the Form, and the Attending Physician/Clinician.

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

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

Yes **No**

Patient ID (MRN)* ? Affiliation/Organization* ?
 Select... Select...

Person Completing Form* Affiliation/Organization* ?
 Select... Select... If other, please specify: ?

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

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

Patient ID (MRN)* ? Affiliation/Organization* ?
 SR05051960 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

Person Completing Form*
 Select... If other, please specify: ?

Attending Physician/Clinician*
 Select... If other, please specify: ?

Prefix
 Select...

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

Person Completing Form* Affiliation/Organization* ?
 Mr. Arthur Vandelay, II (arthur@email.com) x 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

Attending Physician/Clinician*
 Select... If other, please specify: ?

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

First Name* Last Name*
 Suffix Date of Birth*

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

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

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

Affiliation/Organization* ? Select... v

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)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

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

Affiliation/Organization* ? Select... v

Prefix Select... v

First Name*

Suffix Select... v

Patient Sex* Ethnicity* Race*

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

If other, please specify: ? Test Hospital

If other, please specify: ?

Last Name*

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

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

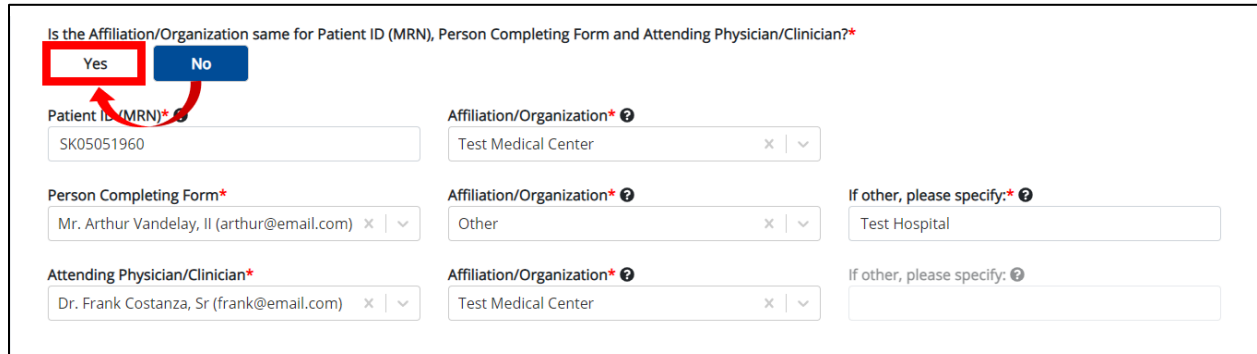
Affiliation/Organization* ? Other x v

If other, please specify: ?

Affiliation/Organization Validation

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

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



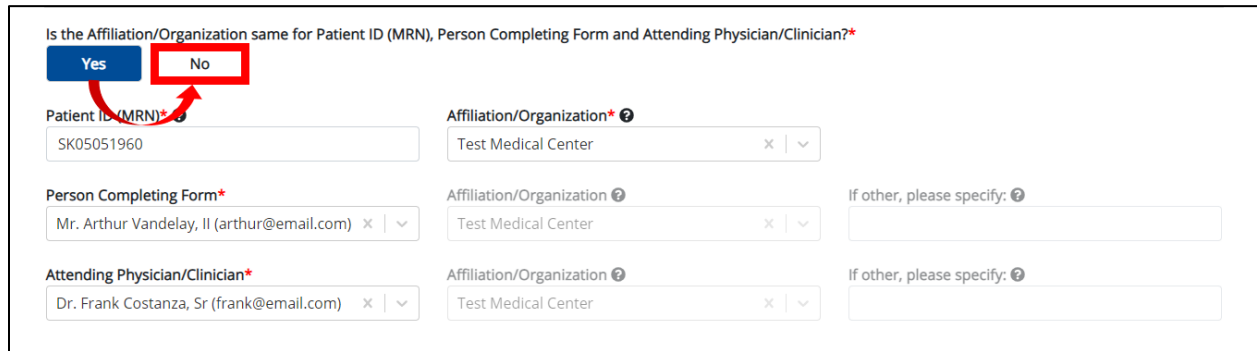
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*

Yes **No**

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

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

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



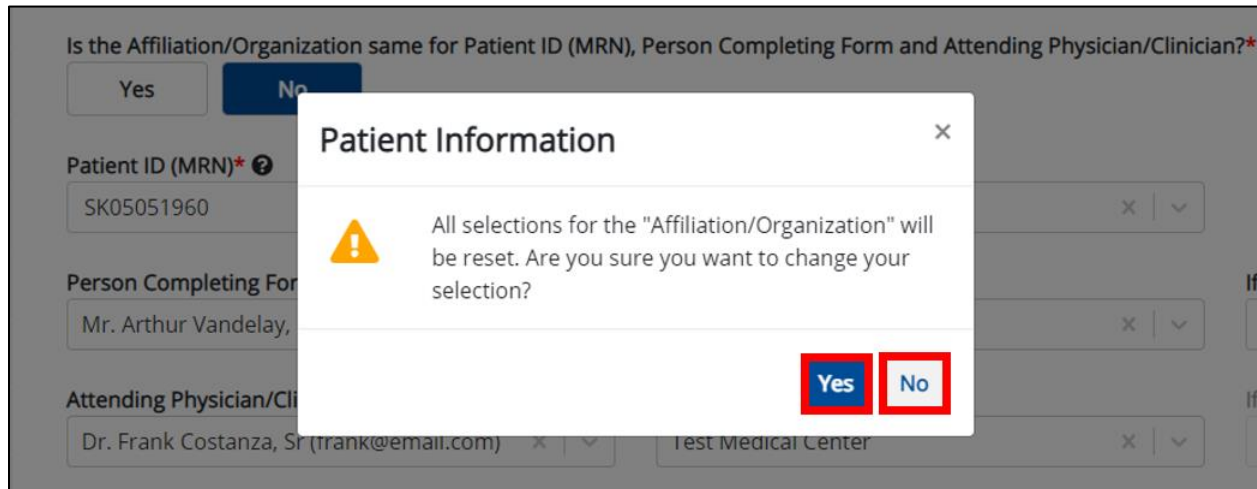
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*

Yes **No**

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

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

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



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

Yes **No**

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

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

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

Patient Information

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

Yes **No**

- 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 Affiliation/Organization 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.

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

Yes **No**

Patient ID (MRN)* SK05051960

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

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

Affiliation/Organization* Test Medical Center

If other, please specify: Test Hospital

If other, please specify:

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 ☐ Unknown

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

Yes **No**

Patient ID (MRN)* SK05051960 Affiliation/Organization* Select... Please Enter Affiliation/Organization

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

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

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?*

Patient ID (MRN)*

SK05051960

Person Completing Form*

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

Attending Physician/Clinician*

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

Prefix

Ms. x | v

Affiliation/Organization*

Select...

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

If other, please specify:

If other, please specify:

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?*

Patient ID (MRN)*

SK05051960

Affiliation/Organization*

Test Medical Center x | v

Person Completing Form*

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

Attending Physician/Clinician*

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

Affiliation/Organization

Test Medical Center x | v

Affiliation/Organization

Test Medical Center x | v

If other, please specify:

If other, please specify:

Change Affiliation/Organization Conditional Answer: Yes to No

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

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

Yes **No**

Patient ID (MRN)*
SK05051960

Affiliation/Organization*
Test Medical Center

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

Affiliation/Organization*
Test Medical Center

If other, please specify:

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

Affiliation/Organization*
Test Medical Center

If other, please specify:

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

Patient Information

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

Yes **No**

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

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

Yes **No**

Patient ID (MRN)*
CK08101955

Affiliation/Organization*
Select...

Person Completing Form*
Dr. Estelle Costanza (estelle@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)* ?
SR05051960

Person Completing Form*
Select...

Attending Physician/Clinician*
Select...

Prefix
Select...

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

If other, please specify: ?
If other, please specify: ?

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

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.

Patient ID (MRN)* ?
CK08101955

Affiliation/Organization* ?
Test Medical Center

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

Affiliation/Organization* ?
Select...

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

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

Prefix
Select...

First Name*
Last Name*

Suffix
Select...

Patient Sex* Ethnicity* Race*

If other, please specify: ?
If other, please specify: ?

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

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

Affiliation/Organization* ?
Other

If other, please specify: ?*

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

Affiliation/Organization* ?
Other

If other, please specify: ?*

7 Dynamic Functions based on Disease/Organism

Based on the **Disease/Organism** selected from the dropdown menu on the **Patient Information** screen of the Sexually Transmitted Disease (STD) Case Report, certain subsequent screens will dynamically display information that applies to the selected disease/organism. This means certain screens will display only the symptoms, lab tests, treatment information, and additional information that applies 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.

The screenshot shows the 'PATIENT INFORMATION' screen. On the left is a sidebar with links: Patient Information, Laboratory Information, Applicable Symptoms, Medical Conditions, Travel Information, and Hospitalization, ICU & Death Information. The main area has a 'Disease/Organism' dropdown menu with a red box around it. The dropdown is open, showing options: 'Select...', 'Chancroid', 'Chlamydia Trachomatis Infection', 'Gonorrhea', and 'Syphilis'. A callout box points to the dropdown with the text: 'Disease/Organism Options for Sexually Transmitted Diseases Case Report'. Other fields include 'Unknown' (checkbox), '(MRN), Person Completing Form, and Attending Physician/Clinician?*', and 'Affiliation/Organization' with a 'Select...' dropdown.

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:

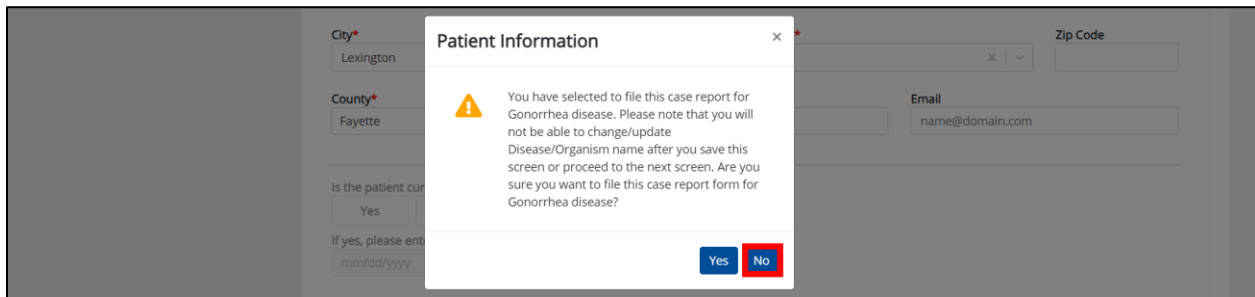
You have selected to file this case report for [selected disease]. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report for [selected disease]?

The screenshot shows a pop-up dialog box titled 'Patient Information' with a close button (X). It contains a warning icon and the following text: 'You have selected to file this case report for Gonorrhea 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 Gonorrhea disease?'. At the bottom are 'Yes' and 'No' buttons. The background shows a blurred view of the Patient Information form with fields for City (Lexington), County (Fayette), Email (name@domain.com), and Zip Code.

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**.



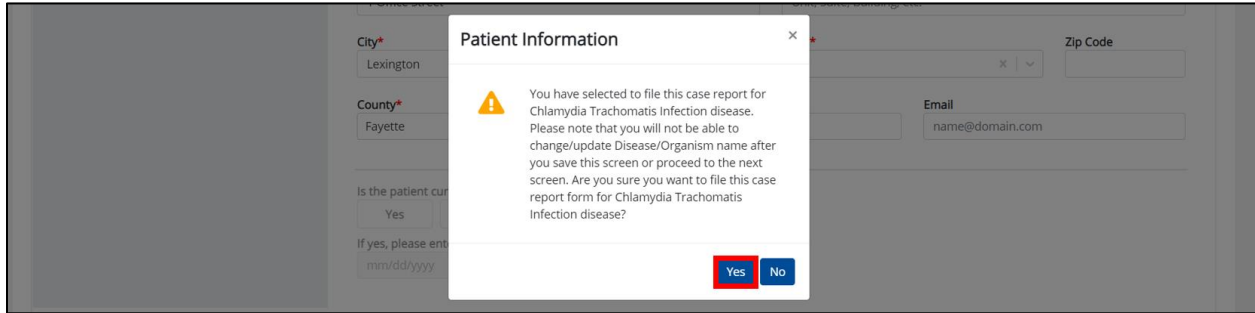
3. Select a different **Disease/Organism** from the dropdown menu.

Patient Information Laboratory Information Applicable Symptoms Medical Conditions Travel Information Hospitalization, ICU & Death Information	Disease/Organism* Select... Chancroid Chlamydia Trachomatis Infection Gonorrhea Syphilis	Date of Diagnosis* mm/dd/yyyy <input type="checkbox"/> Unknown
(MRN), Person Completing Form, and Attending Physician/Clinician* Affiliation/Organization Select...		

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.

Save	Next
-------------	-------------

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



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

PATIENT INFORMATION	
<div>Patient Information</div> <div>Laboratory Information</div>	<div> Disease/Organism* Chlamydia Trachomatis Infection </div> <div> Date of Diagnosis* mm/dd/yyyy </div> <div> <input checked="" type="checkbox"/> Unknown </div>

8 Dynamic Screens for STD 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 STD 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.

Hospitalization, ICU & Death Information	
<div>Additional Information</div> <div>Treatment Information</div> <div>Additional Comments</div> <div>Review and Submit</div>	<div> Test Name* Select... </div> <div> Haemophilus ducreyi culture Haemophilus ducreyi DNA by NAA Other </div>

Hospitalization, ICU & Death Information	
<div>Additional Information</div> <div>Treatment Information</div> <div>Additional Comments</div> <div>Review and Submit</div>	<div> Test Name* Select... </div> <div> Chlamydia trachomatis Ag Chlamydia trachomatis culture Chlamydia trachomatis DNA by NAA with probe detection Chlamydia trachomatis rRNA by NAA with probe detection Chlamydia trachomatis+Neisseria gonorrhoeae DNA by Probe and target amplification method Other </div>

The screenshot shows the 'Test Name*' dropdown menu for Gonorrhea. The menu is open, displaying a list of test names. A red box highlights the dropdown menu, and a callout bubble points to it with the text 'Test Names for Gonorrhea'.

Test Name*

Select...

- Chlamydia trachomatis and Neisseria gonorrhoeae rRNA panel - by Probe and target amplification method
- Chlamydia trachomatis+Neisseria gonorrhoeae DNA by Probe and target amplification method
- Neisseria gonorrhoeae by Organism specific culture
- Neisseria gonorrhoeae DNA by Probe and signal amplification method
- Neisseria gonorrhoeae DNA by Probe and target amplification method
- Neisseria gonorrhoeae rRNA by NAA with probe detection
- Neisseria gonorrhoeae rRNA by Probe
- Other

The screenshot shows the 'Test Name*' dropdown menu for Syphilis. The menu is open, displaying a list of test names. A red box highlights the dropdown menu, and a callout bubble points to it with the text 'Test Names for Syphilis'.

Test Name*

Select...

- Reagin Ab in Serum by RPR
- Reagin Ab in Serum by VDRL
- Treponema pallidum Ab in Body fluid
- Treponema pallidum Ab in Cerebral spinal fluid
- Treponema pallidum Ab in Serum by Agglutination
- Treponema pallidum Ab in Serum by Immunoassay
- Treponema pallidum Ab in Serum by Immunoblot
- Treponema pallidum Ab in Serum by Immunoassay

Applicable Symptoms: Dynamic Screen

The **Applicable Symptoms** screen displays common fields for **all** of the Sexually Transmitted Diseases 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 selected Disease/Organisms:
 - *Rash*
 - *Fever*
 - *Diarrhea (>3 loose stools/24 hour period)*
 - *Did the patient have any other symptoms?*

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

APPLICABLE SYMPTOMS

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date*

mm/dd/yyyy Unknown

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

Rash*

Yes No Unknown

If yes, please specify the location on the body (select all that apply):

Select...

If other, please specify:

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:

Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify:

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

If yes, please enter # of days of diarrhea:

Painful Ulcer(s)*

Yes No Unknown

Tender Inguinal lymphadenopathy*

Yes No Unknown

Did the patient have any other symptoms?*

Yes No Unknown

Applicable Symptoms for **Chancroid**

If yes, please enter # of days of diarrhea:

Cervical Discharge*

Discharge from Eye*

Discharge from Throat*

Dysuria*

Pain in Urethra*

Rectal Discharge*

Urethral Discharge*

Vaginal Discharge*

Did the patient have any other symptoms?*

⬆

Applicable Symptoms for
**Chlamydia Trachomatis
Infection**

Cervical Discharge*

Discharge from Eye*

Discharge from Throat*

Dysuria*

Inflammation of Pelvic Area*

Pain in Urethra*

Rectal Discharge*

Urethral Discharge*

Vaginal Discharge*

Did the patient have any other symptoms?*

⬆

Applicable Symptoms
for **Gonorrhea**

Alopecia*
Yes No Unknown

Chancre, Sore or Lesion*
Yes No Unknown

Condylomata lata of penis*
Yes No Unknown

Condylomata lata of perianal skin*
Yes No Unknown

Condylomata lata of vulva*
Yes No Unknown

Inguinal lymphadenopathy*
Yes No Unknown

Rash of secondary syphilis*
Yes No Unknown

Uveitis*
Yes No Unknown

Applicable Symptoms for **Syphilis**

Additional Information: Dynamic Screen

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

- The **Additional Information** screen is disabled and does **not** collect information when **Chancroid** or **Chlamydia Trachomatis Infection** is selected as the Disease/Organism.

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 7 of 10

Please select any additional information that pertains to this case.

ADDITIONAL INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Medical Conditions ☒

Travel Information ☒

Hospitalization, ICU & Death Information ☒

Additional Information ☒

Treatment Information ☐

Additional Comments ☐

Review and Submit ☐

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

The **Additional Information** screen does **not** collect details for **Chancroid** and **Chlamydia Trachomatis Infection**

Save Previous Next

The **Additional Information** screen is enabled and collects information only when **Gonorrhea** or **Syphilis** is selected as the Disease/Organism.

- When **Gonorrhea** is selected as the Disease/Organism, **Additional Information** related to drug resistance is collected.

- When **Syphilis** is selected, **Additional Information** related to the stage of syphilis and previous treatment information is collected.

Treatment Information: Dynamic Screen

On the **Treatment Information** screen, the *Medications* dropdown menu displays only the test name options that apply to the Disease/Organism selected.

Hospitalization, ICU & Death Information ☒

Additional Information ☒

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

Azithromycin 1000 MG

Ceftriaxone

Ciprofloxacin 500 MG

Erythromycin 500 MG

Other

Unknown

Additional Information ⓘ

Duration* ⓘ

Medications for Chancroid

Hospitalization, ICU & Death Information ☒

Additional Information ☒

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

Azithromycin 1000 MG

Doxycycline hyclate 100 MG Oral Tablet

Erythromycin 500 MG

Levofloxacin 500 MG

Ofloxacin 300 MG

Other

Unknown

Additional Information ⓘ

Duration* ⓘ

Medications for Chlamydia Trachomatis Infection

Hospitalization, ICU & Death Information ☒

Additional Information ☒

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

100 ML gentamicin 1.2 MG/ML Injection

Azithromycin 1000 MG

Azithromycin 250 MG Oral Tablet

Azithromycin 500 MG Oral Tablet

Cefixime 400 MG [Suprax]

Ceftriaxone 1000 MG

Ceftriaxone 2000 MG

Ceftriaxone 250 MG

Additional Information ⓘ

Duration* ⓘ

Medications for Gonorrhea

Hospitalization, ICU & Death Information ☒

Additional Information ☒

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

Aqueous crystalline penicillin G

Benzathine Penicillin G

Bicillin L-A

Doxycycline

Other

Unknown

Additional Information ⓘ

Duration* ⓘ

Medications for Syphilis

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

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.

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

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

City State

Zip Code County

Phone Number Email Address

Adair
Allen
Anderson
Ballard
Barren
Bath
Bell

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

City State

Zip Code County

- 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**.

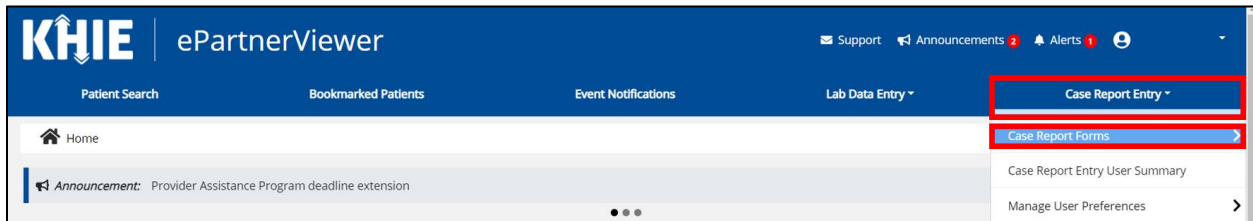
Admission Date* ☒ Unknown

Discharge Date* ☐ Unknown

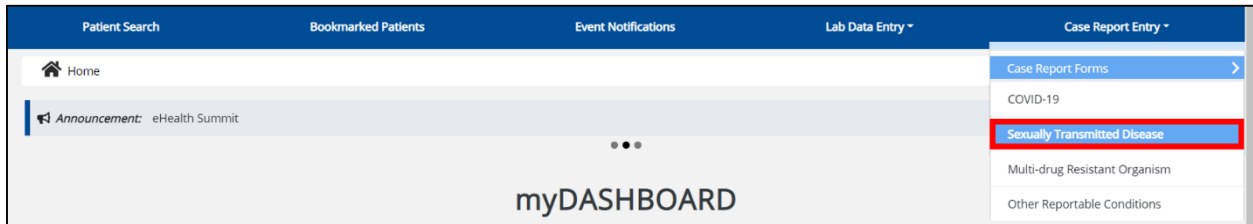
10 Sexually Transmitted Diseases Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the Sexually Transmitted Diseases (STD) Case Report in the ePartnerViewer.

1. To enter Sexually Transmitted Diseases 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 **Sexually Transmitted Disease** from the dropdown menu.



11 Patient Information

Sexually Transmitted Diseases (STD) Case Report entry is a ten-step process where Users enter (1) Patient Information, (2) Laboratory Information, (3) Applicable Symptoms, (4) Medical Conditions, (5) Travel Information, (6) Hospitalization, ICU, & Death Information, (7) Additional Information, (8) Treatment Information, and (9) Additional Comments. (10) **Review and Submit** is where Users must review the information they have entered **and** submit the STD Case Report.

1. To start the Sexually Transmitted Disease Case Report, you must complete the mandatory fields on the **Patient Information** screen.

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 1 of 10

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

PATIENT INFORMATION		
Patient Information	Disease/Organism*	Date of Diagnosis*
Laboratory Information	Select...	mm/dd/yyyy <input type="checkbox"/> Unknown
Applicable Symptoms	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*	
Medical Conditions	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Travel Information	Patient ID (MRN)*	Affiliation/Organization*
Hospitalization, ICU & Death Information	Select...	Select...
Additional Information	Person Completing Form	Affiliation/Organization* If other, please specify: *
Treatment Information	Select...	Select...
Additional Comments	Attending Physician/Clinician	Affiliation/Organization* If other, please specify: *
Review and Submit	Select...	Select...
Prefix		
Select...		
First Name*	Middle Name	Last Name*
Select...		
Suffix	Date of Birth*	
Select...	mm/dd/yyyy	
Patient Sex*	Ethnicity*	Race*
Select...	Select...	Select...

Please Note: You are required to enter the details associated with the *Person Completing Form* and the *Attending Physician/Clinician* prior to entering Sexually Transmitted Diseases (STD) case report information.

If you access the STD 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 STD Case Report details.

Home > Sexually Transmitted Diseases Case Report Form

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 1 of 10

To enter you [Attending Physician/Clinician](#) and [Person Completing Form](#) details in the User Preferences, click on the hyperlink.

PATIENT INFORMATION		
Patient Information	Disease/Organism*	Date of Diagnosis*
Laboratory Information	Select...	mm/dd/yyyy <input type="checkbox"/> Unknown

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Disease/Organism* ?

Select...

Chancroid

Chlamydia Trachomatis Infection

Gonorrhea

Syphilis

Disease/Organism Options for Sexually Transmitted Diseases Case Report

(MRN), Person Completing Form, and Attending Physician/Clinician?*

Unknown

Affiliation/Organization ?

Select...

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

Once the Disease/Organism selection is saved on the **Patient Information** screen, the

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

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

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Disease/Organism* ?

Chlamydia

Date of Diagnosis*

mm/dd/yyyy

Unknown

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

Yes No

Patient ID (MRN) ?

Person Completing Form

Select...

Attending Physician/Clinician*

If other, please specify: ?

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

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

Yes **No**

Patient ID (MRN) ?

Affiliation/Organization ?

Select...

Person Completing Form

Select...

Affiliation/Organization ?

Select...

If other, please specify: ?

Attending Physician/Clinician

Select...

Affiliation/Organization ?

Select...

If other, please specify: ?

- 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)* ②

Person Completing Form*

Attending Physician/Clinician*

Affiliation/Organization* ②

Affiliation/Organization ②

Affiliation/Organization ②

If other, please specify: ②

If other, please specify: ②

- 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)* ②

Person Completing Form*

Attending Physician/Clinician*

Affiliation/Organization* ②

Affiliation/Organization* ②

Affiliation/Organization* ②

If other, please specify: ②

If other, please specify: ②

If other, please specify: ②

- 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.

If other, please specify: ②

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

Yes No

Patient ID (MRN)* ②

Affiliation/Organization* ②

CK08101955

Select...

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

The screenshot shows a form with the following fields:

- Patient ID (MRN)***: CK08101955
- Person Completing Form***: Select...
- Attending Physician/Clinician***: Select...
- Prefix**: Select...
- Affiliation/Organization***: A dropdown menu is open, showing a list of options: Afzal, Mohammad MD, Internal Medicine, LLC; eICR Onboarding Regression; Hilton Hospital; King's Daughters Medical Center; Murray-Calloway County Hospital; Test Medical Center; University Of Kentucky Chandler Medical.
- If other, please specify:** (Two empty text boxes)
- First Name***, **Middle Name**, **Last Name***: (Empty text boxes)

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

The *Affiliation/Organization* field is enabled only for the Patient ID (MRN).

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

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

The screenshot shows a form with the following fields:

- Person Completing Form***: A dropdown menu is open, showing a list of options: Dr. Estelle Costanza (estelle@email.com); Mr. Arthur Vandelay, II (arthur@email.com).
- Affiliation/Organization***: Select... (Two instances)
- If other, please specify:** (Two empty text boxes)

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

Person Completing Form Hyperlink

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

The screenshot shows a form with the following fields:

- Person Completing Form***: A button with the text "Person Completing Form*" is highlighted with a red box.
- Affiliation/Organization***: Select... (Two instances)
- If other, please specify:** (Two empty text boxes)

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.

The screenshot shows a 'Manage User Preferences' dialog box. The 'PERSON COMPLETING FORM' section is active. It contains the following fields:

- Prefix:** A dropdown menu with 'Select...' as the current selection. A red box highlights this dropdown.
- First Name*:** A text input field.
- Last Name*:** A text input field.
- Suffix:** A dropdown menu with 'Select...' as the current selection. A red box highlights this dropdown, and a list of options (II, III, IV, Jr, Sr) is visible below it.
- Address 1:** A text input field.
- Address 2:** A text input field with placeholder text 'Unit, Suite, Building, etc.'
- City:** A text input field.
- State*:** A dropdown menu with 'Select...' as the current selection.
- Zip Code*:** A text input field.
- Phone:** A text input field with placeholder text '(XXX) XXX-XXXX'.
- Email*:** A text input field with placeholder text 'name@domain.com'.

At the bottom of the dialog are 'Cancel' and 'Save' buttons.

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

This screenshot shows two text input fields: 'First Name*' and 'Last Name*'. Both fields are empty and highlighted with red boxes.

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

This screenshot shows five input fields: 'Address 1*', 'Address 2' (with placeholder 'Unit, Suite, Building, etc.'), 'City*', 'State*' (with a dropdown arrow), and 'Zip Code*'. All fields are empty and highlighted with red boxes.

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

This screenshot shows two input fields: 'Phone*' (with placeholder '(XXX) XXX-XXXX') and 'Email*' (with placeholder 'name@domain.com'). Both fields are empty and highlighted with red boxes.

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)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

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* Select... v

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

Ms. Helen Seinfeld (helen@email.com)

Affiliation/Organization* ? Select... v

If other, please specify: ?

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* Mr. Marty Craine, Sr (marty... x v)

Affiliation/Organization* ? Other x v

If other, please specify:* ? Test Hospital

Attending Physician/Clinician* Select... v

Affiliation/Organization* ? Select... v

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.

Manage User Preferences

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Select...

First Name* Last Name*

Suffix
Select...

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

City* State* Zip Code*
Select...

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

Cancel Save

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

First Name* Last Name*

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

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

City* State* Zip Code*
Select...

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

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

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

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

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

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

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

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.

The screenshot shows a form with fields for Patient Sex*, Ethnicity*, and Race*. The Patient Sex* dropdown menu is open, showing options: Female, Male, Other, and Unknown. The dropdown is highlighted with a red box. Other fields include Address 2, State*, and Zip Code.

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

The screenshot shows the form with Patient Sex* set to Female. The Ethnicity* dropdown is open and set to 'Not Hispanic or Latino'. The Race* dropdown is open and set to 'American Indian or Alaska Native'. Both dropdowns are highlighted with red boxes. Other fields include Address 1*, Address 2, City*, State*, County*, and Phone*.

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

The screenshot shows the form with Address 1*, City*, State*, Zip Code, and County* fields highlighted with red boxes. Address 2 is 'Unit, Suite, Building, etc.'. Phone* is '(XXX) XXX-XXXX' and Email is 'name@domain.com'.

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

The screenshot shows the form with Phone* and Email fields highlighted with red boxes. A tooltip is visible over the Phone* field, stating: 'Please enter patient's phone number. If patient's phone number is not available, please enter the provider's/interviewer's phone number.' Address 1 is '123 West 81st Street', City is 'Lexington', County is 'Fayette', State is 'KY', and Zip Code is '40123'.

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



Is the patient currently pregnant?*

Yes No Unknown

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

mm/dd/yyyy ☐ Unknown

Please Note: The 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**.



Is the patient currently pregnant?*

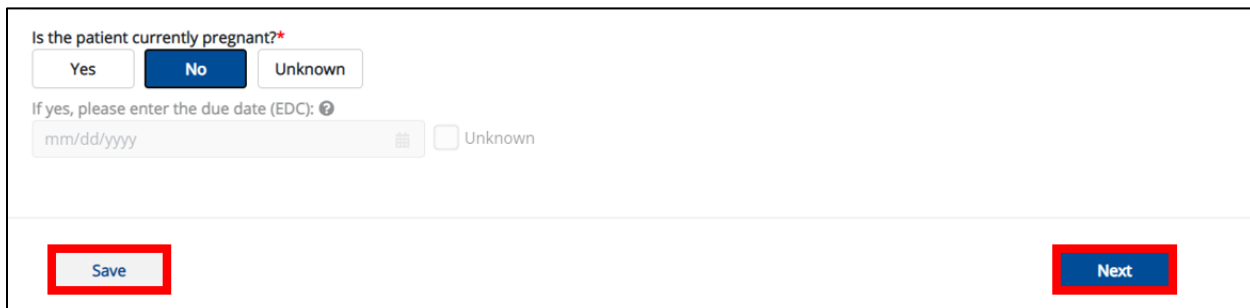
Yes No Unknown

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

mm/dd/yyyy ☐ Unknown

Please enter the estimated due date, if known or select the 'Unknown' checkbox if the estimated due date is not known.

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



Is the patient currently pregnant?*

Yes No Unknown

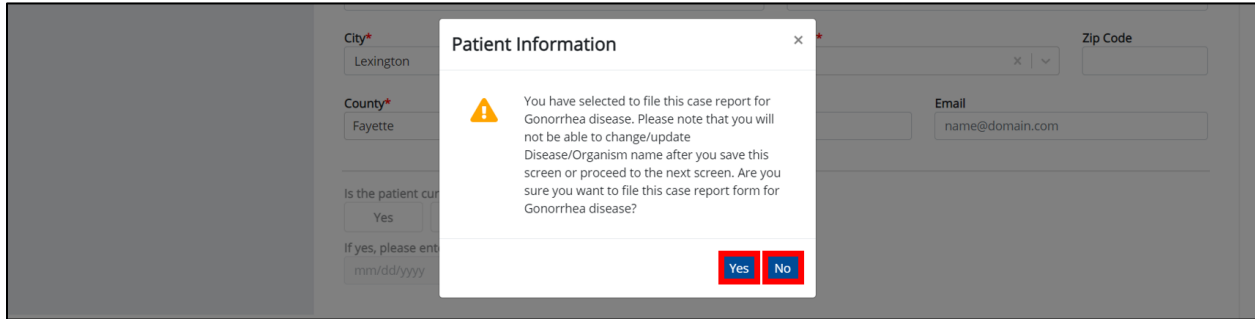
If yes, please enter the due date (EDC): ?

mm/dd/yyyy ☐ Unknown

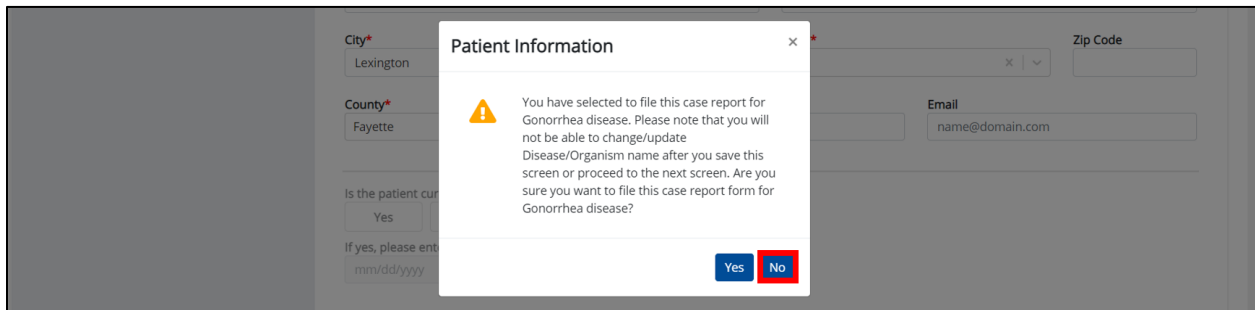
Save Next

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]?*

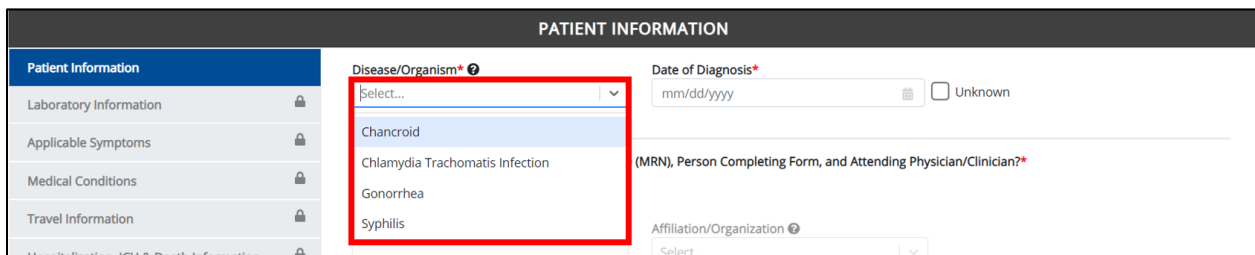
To save the selected Disease/Organism and proceed to the **Laboratory Information** page, click **Yes**. To change the selected Disease/Organism, click **No**.



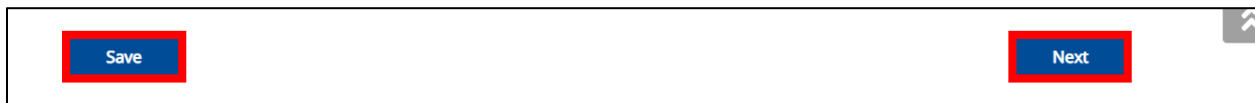
35. To change the selected Disease/Organism, click **No** on the Disease/Organism Pop-Up.



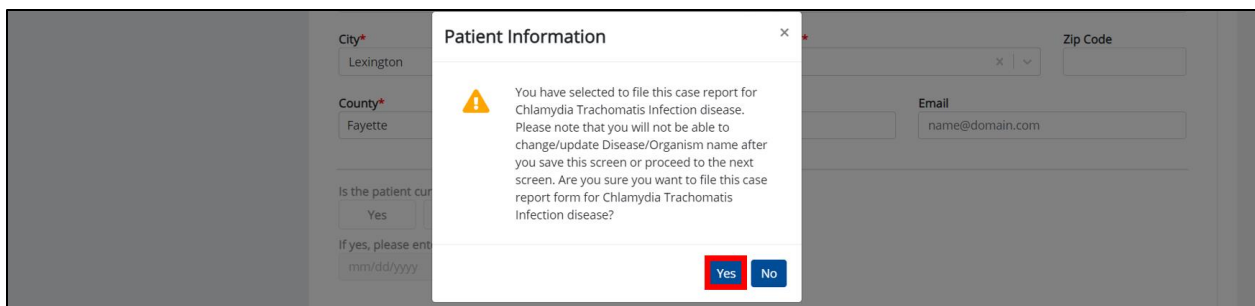
36. If changing the selection, select a different **Disease/Organism** from the dropdown menu.



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



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



39. 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.

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 1 of 10

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

PATIENT INFORMATION	
Patient Information Laboratory Information Applicable Symptoms	Disease/Organism* Chlamydia Trachomatis Infection Date of Diagnosis* mm/dd/yyyy <input checked="" type="checkbox"/> Unknown

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.

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

Patient Sex* Male	Ethnicity* Not Hispanic or Latino	Race* White
Address 1* 123 Cheers Street		Address 2 Unit, Suite, Building, etc.
City* Lexington	State* KY	Zip Code 40123-
County* Fayette	Phone* (555) 123-3210	Email patient@email.com
Is the patient currently pregnant? <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>		
If yes, please enter the due date (EDC): mm/dd/yyyy <input type="button" value="Calendar"/> <input type="checkbox"/> Unknown		
<input type="button" value="Save"/>		<input checked="" type="button" value="Next"/>

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?*

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 2 of 10

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name

Test Name

Select...

If other, please specify: ?

Filler Order/Accession Number ?

Specimen Source

Select...

If other, please specify: ?

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

LABORATORY INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name*

Test Name*

Select...

If other, please specify: ?

Filler Order/Accession Number ?

Specimen Source*

Select...

If other, please specify: ?

Test Result*

Select...

If other, please specify: ?

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

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

Laboratory Information

Laboratory Name*

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

Test Name*

Select...

- Chlamydia trachomatis Ag
- Chlamydia trachomatis culture
- Chlamydia trachomatis DNA by NAA with probe detection
- Chlamydia trachomatis rRNA by NAA with probe detection
- Chlamydia trachomatis+Neisseria gonorrhoeae DNA by Probe and target amplification method
- Other

If other, please specify: ?

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: *

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

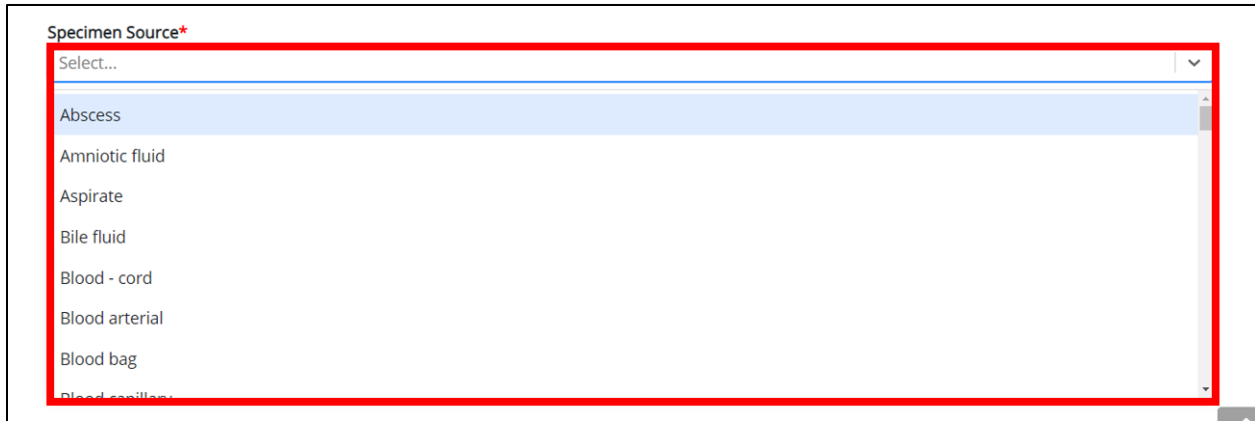
If other, please specify: *

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.

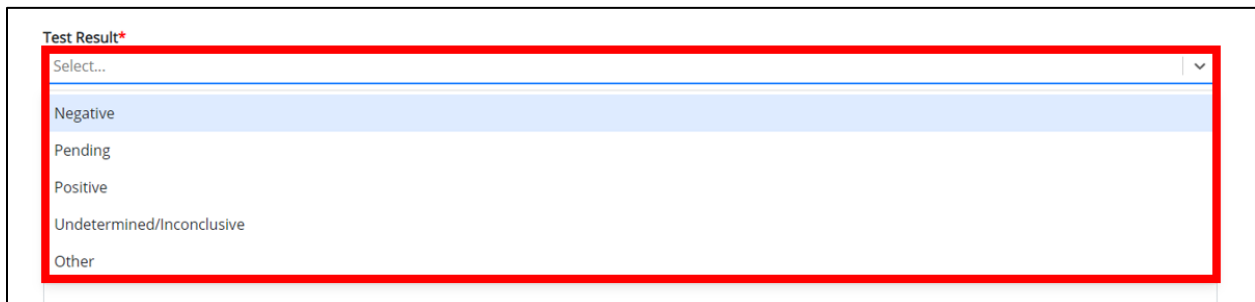
5. Select the **Specimen Source** from the dropdown menu.



- 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.*



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



- If **Other** is selected from the dropdown menu, the subsequent field is enabled. Enter **the 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*.

Test Result*

Pending

If other, please specify:

Test Result Date

mm/dd/yyyy

☐ Unknown

Specimen Collection Date*

mm/dd/yyyy

☐ Unknown

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

8. Enter the **Specimen Collection Date**.

Test Result Date*

07/26/2021

☐ Unknown

Specimen Collection Date*

mm/dd/yyyy

☐ Unknown

July 2021

Su	Mo	Tu	We	Th	Fr	Sa
27	28	29	30	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	31

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

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

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

Test Result Date*

07/23/2021

☐ Unknown

Invalid Test Result Date

Specimen Collection Date*

07/26/2021

☐ Unknown

Invalid Specimen Collection Date

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

Please enter any additional information you would like to provide about the Lab test result. Ex. Physical Quantity, value, unit, Reference Range etc.

Test Result*
07/30/2021 ☐ Unknown

Specimen Collection Date*
07/29/2021 ☐ Unknown

Additional Information ?
0/300 Characters

Adding Multiple Tests

10. 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

Save Previous Next

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

Laboratory Information

Laboratory Name*

Test Name*
Select...

If other, please specify: ?

Filler Order/Accession Number ?

Specimen Source*
Select...

If other, please specify: ?


Test Result*
Select...

If other, please specify: ?

Test Result Date
mm/dd/yyyy ☐ Unknown

Specimen Collection Date*
mm/dd/yyyy ☐ Unknown

Additional Information ?
0/300 Characters



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

Specimen Source*
Blood arterial

If other, please specify: ?

Test Result*
Positive

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?*

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 3 of 10

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms

Medical Conditions ☐

Travel Information ☐

Hospitalization, ICU & Death Information ☐

Additional Information ☐

Treatment Information ☐

Additional Comments ☐

Review and Submit ☐

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date mm/dd/yyyy ☐ Unknown

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

Rash

Yes No Unknown

If yes, please specify the location on the body (select all that apply):

Select...

If other, please specify:

Fever

Yes No Unknown

If yes, please enter the highest temperature:

Diarrhea (>3 loose stools/24hr period)

Yes No Unknown

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

APPLICABLE SYMPTOMS

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms

Medical Conditions ☐

Travel Information ☐

Hospitalization, ICU & Death Information ☐

Additional Information ☐

Treatment Information ☐

Additional Comments ☐

Review and Submit ☐

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date* mm/dd/yyyy ☐ Unknown

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

Rash*

Yes No Unknown

If yes, please specify the location on the body (select all that apply):

Select...

If other, please specify:

Fever*

Yes No Unknown

If yes, please enter the highest temperature:

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

Yes No Unknown

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**.

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

3. If the patient is symptomatic, select the **appropriate answer** for the *Rash* field.

- If **Yes** is selected for the *Rash* field, the subsequent field is enabled. Enter **the location(s) of the rash** in the subsequent multi-select dropdown menu: *If other, please specify the location on the body.*

- If **Other** is selected from the multi-select dropdown menu, the subsequent field is enabled. Enter **the location(s) of the rash** in the subsequent textbox: *If other, please specify.*

- 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.*

- 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 displays additional symptoms that apply to the Disease/Organism selected.

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

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

Painful Ulcer(s)*

Yes No Unknown

Tender Inguinal lymphadenopathy*

Yes No Unknown

Did the patient have any other symptoms?*

Yes No Unknown

Applicable Symptoms for **Chancroid**

7. If the patient is symptomatic for Chlamydia Trachomatis Infection, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

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

Cervical Discharge*

Yes No Unknown

Discharge from Eye*

Yes No Unknown

Discharge from Throat*

Yes No Unknown

Dysuria*

Yes No Unknown

Pain in Urethra*

Yes No Unknown

Rectal Discharge*

Yes No Unknown

Urethral Discharge*

Yes No Unknown

Vaginal Discharge*

Yes No Unknown

Did the patient have any other symptoms?*

Yes No Unknown

Applicable Symptoms for **Chlamydia Trachomatis Infection**

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

Cervical Discharge*		
Yes	No	Unknown
Discharge from Eye*		
Yes	No	Unknown
Discharge from Throat*		
Yes	No	Unknown
Dysuria*		
Yes	No	Unknown
Inflammation of Pelvic Area*		
Yes	No	Unknown
Pain in Urethra*		
Yes	No	Unknown
Rectal Discharge*		
Yes	No	Unknown
Urethral Discharge*		
Yes	No	Unknown
Vaginal Discharge*		
Yes	No	Unknown

Applicable Symptoms for **Gonorrhea**

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

Alopecia*		
Yes	No	Unknown
Chancre, Sore or Lesion*		
Yes	No	Unknown
Condylomata lata of penis*		
Yes	No	Unknown
Condylomata lata of perianal skin*		
Yes	No	Unknown
Condylomata lata of vulva*		
Yes	No	Unknown
Inguinal lymphadenopathy*		
Yes	No	Unknown
Rash of secondary syphilis*		
Yes	No	Unknown
Uveitis*		
Yes	No	Unknown

Applicable Symptoms for **Syphilis**

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

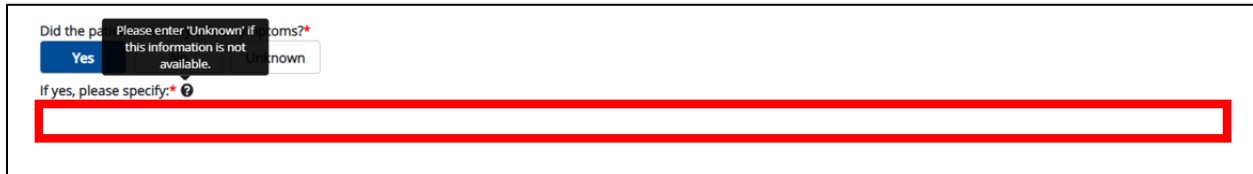


Did the patient have any other symptoms?*

Yes No Unknown

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.*



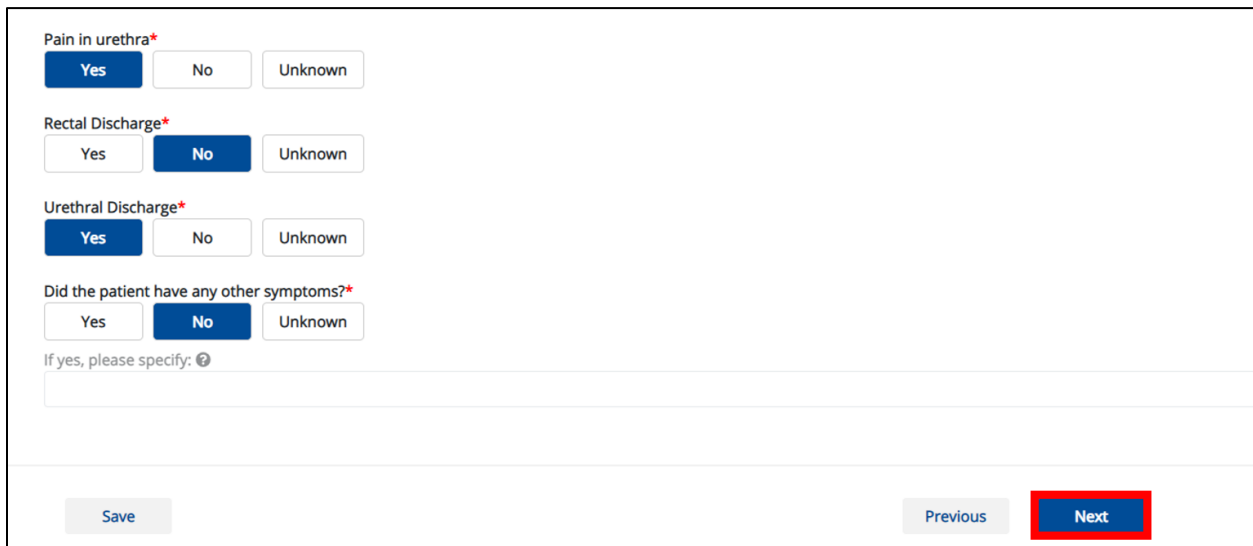
Did the patient have any other symptoms?*

Please enter 'Unknown' if this information is not available.

Yes No Unknown

If yes, please specify: ?

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



Pain in urethra*

Yes No Unknown

Rectal Discharge*

Yes No Unknown

Urethral Discharge*

Yes No Unknown

Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify: ?

Save Previous Next

14 Medical Conditions

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 4 of 10

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

MEDICAL CONDITIONS

Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Medical Conditions	
Travel Information	🔒
Hospitalization, ICU & Death Information	🔒
Additional Information	🔒
Treatment Information	🔒
Additional Comments	🔒
Review and Submit	🔒

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

Yes No Unknown

Which of the following conditions did the patient experience during illness?

Neurologic impairment

Yes No Unknown

If yes, please specify: 🗨

Vision impairment

Yes No Unknown

If yes, please specify: 🗨

Substance abuse or misuse

Yes No Unknown

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

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

MEDICAL CONDITIONS

Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Medical Conditions	
Travel Information	🔒
Hospitalization, ICU & Death Information	🔒
Additional Information	🔒
Treatment Information	🔒
Additional Comments	🔒
Review and Submit	🔒

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

Yes No Unknown

Which of the following conditions did the patient experience during illness?

Neurologic impairment*

Yes No Unknown

If yes, please specify: 🗨

Vision impairment*

Yes No Unknown

If yes, please specify: 🗨

Substance abuse or misuse*

Yes No Unknown

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

Immunosuppressive condition*

Yes No Unknown

If yes, please specify: 🗨

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

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

3. Select the **appropriate answer** for the *Neurologic Impairment* field.

Which of the following conditions did the patient experience during illness?

Neurologic impairment*

☐ Yes ☐ No ☐ Unknown

If yes, please specify: ?

- If **Yes** is selected for the *Neurologic Impairment* field, the subsequent field is enabled. Enter the **details of the neurologic impairment** in the subsequent textbox: *If other, please specify*.

Which of the following conditions did the patient experience during illness?

Neurologic impairment*

☒ Yes ☐ No ☐ Unknown

If yes, please specify: *

4. Select the **appropriate answer** for the *Vision Impairment* field.

Vision impairment*

☐ Yes ☐ No ☐ Unknown

If yes, please specify: ?

- If **Yes** is selected for the *Vision Impairment* field, the subsequent field is enabled. Enter the **details of the vision impairment** in the subsequent textbox: *If other, please specify*.

Vision impairment*

☒ Yes ☐ No ☐ Unknown

If yes, please specify: *

5. Select the **appropriate answer** for the *Substance abuse or misuse* field.

Substance abuse or misuse*

☐ Yes ☐ No ☐ Unknown

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

- If **Yes** is selected for the *Substance abuse or misuse* field, the subsequent field is enabled. Enter the **details of the substance** in the subsequent textbox: *If yes, please specify the substance that was abused or misused*.

Substance abuse or misuse*

☒ Yes ☐ No ☐ Unknown

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

6. Select the **appropriate answer** for the *Immunosuppressive* field.

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

Immunosuppressive condition*

Yes No Unknown

If yes, please specify: ?

⏮

- If **Yes** is selected for the *Immunosuppressive* field, the subsequent field is enabled. Enter the **details of the immunosuppressive condition** in the subsequent textbox: *If other, please specify.*

Immunosuppressive condition*

Yes No Unknown

If yes, please specify: * ?

7. Once the **Medical Conditions** screen is complete, click **Next** to proceed to the **Travel Information** screen.

MEDICAL CONDITIONS

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Medical Conditions

Travel Information 🔒

Hospitalization, ICU & Death Information 🔒

Additional Information 🔒

Treatment Information 🔒

Additional Comments 🔒

Review and Submit 🔒

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

Yes No Unknown

Which of the following conditions did the patient experience during illness?

Neurologic impairment*

Yes No Unknown

If yes, please specify: ?

Vision impairment*

Yes No Unknown

If yes, please specify: ?

Substance abuse or misuse*

Yes No Unknown

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

Unknown

Immunosuppressive condition*

Yes No Unknown

If yes, please specify: ?

Save Previous **Next** ⏮

15 Travel Information

1. On the **Travel Information** screen, select the **appropriate answer** for the conditional question at the top: *Does the patient have a travel history within the last 12 months?*

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 5 of 10

Please provide the travel history of the patient within the last 12 months.

TRAVEL INFORMATION

Does the patient have a travel history within the last 12 months?*

Yes No Unknown

Domestic travel (outside state of normal residence)

Yes No Unknown

If yes, please specify state(s): ?

Select...

International travel

Yes No Unknown

If yes, please specify country(s): ?

Select...

Save Previous Next

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

TRAVEL INFORMATION

Does the patient have a travel history within the last 12 months?*

Yes No Unknown

Domestic travel (outside state of normal residence)*

Yes No Unknown

If yes, please specify state(s): ?

Select...

International travel*

Yes No Unknown

If yes, please specify country(s): ?

Select...

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

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

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

Domestic travel (outside state of normal residence)*


Yes No Unknown

If yes, please specify state(s): ?

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**.

Domestic travel (date of departure and state in which the patient travelled is not known)*

If yes, please specify state(s):* 

Select...

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

4. Select the **appropriate answer** for the *International travel* field.

International travel*

Yes

No

Unknown

If yes, please specify country(s):

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 that the patient traveled**.

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

☒ Yes ☐ No

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

Select...

AFGHANISTAN

ALBANIA

ALGERIA

AMERICAN SAMOA

ANDORRA

ANGOLA

ANGUILLA

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 5 of 10

Please provide the travel history of the patient within the last 12 months.

TRAVEL INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Does the patient have a travel history within the last 12 months?*

Yes No Unknown

Domestic travel (outside state of normal residence)*

Yes No Unknown

If yes, please specify state(s):*

CA CO

International travel*

Yes No Unknown

If yes, please specify country(s):*

CANADA MEXICO

Save

Previous

Next

16 Hospitalization, ICU & Death Information

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 6 of 10

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information	Was the patient hospitalized?*
Laboratory Information	Yes No Unknown
Applicable Symptoms	If yes, please specify the hospital name: *
Medical Conditions	Admission Date mm/dd/yyyy [] Unknown Discharge Date mm/dd/yyyy [] Unknown
Travel Information	Still hospitalized
Hospitalization, ICU & Death Information	Was the patient admitted to an intensive care unit (ICU)?
Additional Information	Yes No Unknown
Treatment Information	Admission Date to ICU mm/dd/yyyy [] Unknown Discharge Date from ICU mm/dd/yyyy [] Unknown
Additional Comments	Did the patient die as a result of this illness?*
Review and Submit	Yes No Unknown
	If yes, please provide the date of death:
	Date of Death mm/dd/yyyy [] Unknown

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information	Was the patient hospitalized?*
Laboratory Information	Yes No Unknown
Applicable Symptoms	If yes, please specify the hospital name: *
Medical Conditions	Admission Date* mm/dd/yyyy [] Unknown Discharge Date* mm/dd/yyyy [] Unknown
Travel Information	Still hospitalized
Hospitalization, ICU & Death Information	Was the patient admitted to an intensive care unit (ICU)?*
Additional Information	Yes No Unknown
Treatment Information	Admission Date to ICU mm/dd/yyyy [] Unknown Discharge Date from ICU mm/dd/yyyy [] Unknown
Additional Comments	Did the patient die as a result of this illness?*
Review and Submit	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?

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

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

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

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

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

Admission Date* <input type="text" value="07/26/2021"/> <input type="checkbox"/> Unknown	Discharge Date* <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Still hospitalized
Was the patient admitted to an intensive care unit (ICU)?* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>	
Admission Date to ICU <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown	Discharge Date from ICU <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown
Did the patient die as a result of this illness? <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/> If yes, please provide the date of death:	

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

If you enter an Admission Date that occurs after the Discharge Date and click **Next**, both fields are marked as invalid and an error banner displays with a 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

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

Hospitalization, ICU & Death Information

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

If yes, please specify the hospital name:

Admission Date* ☐ Unknown
Invalid Admission Date

Discharge Date* ☐ Unknown
☐ Still hospitalized
Invalid Discharge Date

Admission Date* <input type="text" value="07/23/2021"/> <input type="checkbox"/> Unknown <i>Invalid Admission Date</i>	Discharge Date* <input type="text" value="07/20/2021"/> <input type="checkbox"/> Unknown <input type="checkbox"/> Still hospitalized <i>Invalid Discharge Date</i>
---	--

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)?* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
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 **Admission Date to ICU** and the **Discharge Date from ICU**.

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

Yes No Unknown

Admission Date to ICU* mm/dd/yyyy ☐ Unknown

Discharge Date from ICU* mm/dd/yyyy ☐ Unknown

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

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

Yes No Unknown

If yes, please provide the date of death:

Date of Death* mm/dd/yyyy ☐ Unknown

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

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

Yes No Unknown

If yes, please provide the date of death:

Date of Death* mm/dd/yyyy ☐ Unknown

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

Review and Submit

Admission Date to ICU mm/dd/yyyy ☐ Unknown

Discharge Date from ICU mm/dd/yyyy ☐ Unknown

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

No Yes Unknown

If yes, please provide the date of death:

Date of Death mm/dd/yyyy ☐ Unknown

Save Previous **Next**

17 Additional Information

The **Additional Information** screen is dynamic and displays fields depending on the Disease/Organism selected on the **Patient Information** screen of the STD Case Report. The **Additional Information** screen collects details only when Gonorrhea or Syphilis is selected as the Disease/Organism.

Additional Information for Chancroid or Chlamydia

The **Additional Information** screen is disabled and does **not** collect information when Chancroid or Chlamydia Trachomatis Infection is selected as the Disease/Organism.

1. If Chancroid or Chlamydia Trachomatis Infection is selected as the Disease/Organism, the **Additional Information** screen displays message that states: *No information is required to be provided on this screen. Please click the "Next" button to proceed.*
2. To proceed to the **Treatment Information** screen, click **Next**.

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 7 of 10

Please select any additional information that pertains to this case.

ADDITIONAL INFORMATION	
Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Medical Conditions	✓
Travel Information	✓
Hospitalization, ICU & Death Information	✓
Additional Information	
Treatment Information	🔒
Additional Comments	🔒
Review and Submit	🔒

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

The **Additional Information** screen does **not** collect details for **Chancroid** and **Chlamydia Trachomatis Infection**

Please Note: The **Additional Information** screen is enabled and collects information only when **Gonorrhea** or **Syphilis** is selected as the *Disease/Organism*.

Additional Information for Gonorrhea

When **Gonorrhea** is selected as the Disease/Organism, **Additional Information** related to drug resistance is collected.

1. Select the **appropriate answer** to the conditional question at the top: *Is there any additional information that you would like to provide?*

ADDITIONAL INFORMATION	
Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓

Is there any additional information that you would like to provide?*

Please select the resistance:

- If **Yes** is selected, the subsequent field is enabled. From the multi-select dropdown menu, choose the **type(s) of resistance**.

- If **Other** is selected, the subsequent field is enabled. Enter the **resistance details** in the subsequent textbox: *If other, please specify.*

2. Once the resistance information for Gonorrhea is entered, click **Next** to proceed to the **Treatment Information** screen.

Additional Information for Syphilis

When **Syphilis** is selected, **Additional Information** related to the previous treatment and the stage of syphilis is collected.

1. Select the **appropriate answer** to the conditional question at the top: *Is there any additional information you would like to provide?*

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 7 of 10

Please select any additional information that pertains to this case.

ADDITIONAL INFORMATION	
Patient Information	<input checked="" type="checkbox"/>
Laboratory Information	<input checked="" type="checkbox"/>
Applicable Symptoms	<input checked="" type="checkbox"/>
Medical Conditions	<input checked="" type="checkbox"/>
Travel Information	<input checked="" type="checkbox"/>
Hospitalization, ICU & Death Information	<input checked="" type="checkbox"/>
Additional Information	<input checked="" type="checkbox"/>
Treatment Information	<input type="checkbox"/>
Additional Comments	<input type="checkbox"/>
Review and Submit	<input type="checkbox"/>

Is there any additional information that you would like to provide?*

Yes No Unknown

Please select the stage:

Select...

If other, please specify:

Was previous treatment given for this infection?

Yes No Unknown

If yes, please give an approximate date and place?

Date mm/dd/yyyy ☐ Unknown Place

- If **Yes** is selected, the subsequent field is enabled. From the dropdown menu, select the **stage of Syphilis**.

ADDITIONAL INFORMATION

Is there any additional information that you would like to provide?*

Yes No Unknown

Additional Information on the **stage of Syphilis**

Please select the stage:*

Select...

Congenital

Early Latent

Late or Unknown

Primary

Secondary

Other

mm/dd/yyyy ☐ Unknown

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

Please select the stage:*

Other

If other, please specify:*

- Select the **appropriate answer** to the conditional question: *Was previous treatment given for this infection?*

Was previous treatment given for this infection?*

Yes No Unknown

Additional Information on **previous treatment** for **Syphilis**

If yes, please give an approximate date and place:

Date mm/dd/yyyy ☐ Unknown Place

- If **Yes** is selected, the subsequent fields are enabled. Enter the **Date of Previous Treatment** in the subsequent field: *Date*. If available, enter the **Place of Previous Treatment** in the subsequent textbox: *Place*.

Additional Information

Treatment Information

Additional Comments

Review and Submit

Was previous treatment given for this infection?*

Yes No Unknown

If yes, please give an approximate date and place:

Date* mm/dd/yyyy ☐ Unknown Place

Save Previous Next

- Once the stage and previous treatment information for Syphilis is entered, click **Next** to proceed to the **Treatment Information** screen.

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 7 of 10

Please select any additional information that pertains to this case.

ADDITIONAL INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Is there any additional information that you would like to provide?*

Yes No Unknown

Please select the stage:*

Congenital

If other, please specify:

Was previous treatment given for this infection?*

Yes No Unknown

If yes, please give an approximate date and place:

Date* mm/dd/yyyy ☒ Unknown Place Treatment Facility

Save Previous Next

18 Treatment Information

1. On the **Treatment Information** screen, select the **appropriate answer** for the conditional question at the top: *Is the patient undergoing any treatment for this disease?*

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 8 of 10

Please provide any treatment information related to this case.

TREATMENT INFORMATION

<ul style="list-style-type: none"> Patient Information ✓ Laboratory Information ✓ Applicable Symptoms ✓ Medical Conditions ✓ Travel Information ✓ Hospitalization, ICU & Death Information ✓ Additional Information ✓ Treatment Information Additional Comments 🔒 Review and Submit 🔒 	<p>Is the patient undergoing any treatment for this disease?*</p> <p> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/> </p> <hr/> <p>Treatment Information</p> <p>Treatment Date *</p> <p>mm/dd/yyyy <input type="text"/> <input type="checkbox"/> Unknown</p> <p>Medication *</p> <p>Select... <input type="text"/></p> <p>If other, please specify: <input type="text"/></p> <p>Frequency *</p> <p>Select... <input type="text"/> Duration ? <input type="text"/></p> <p>If the frequency is other, please specify: ? <input type="text"/></p> <p>Additional Information ? <input type="text"/></p>
---	---

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

TREATMENT INFORMATION

<ul style="list-style-type: none"> Patient Information ✓ Laboratory Information ✓ Applicable Symptoms ✓ Medical Conditions ✓ Travel Information ✓ Hospitalization, ICU & Death Information ✓ Additional Information ✓ Treatment Information Additional Comments 🔒 Review and Submit 🔒 	<p>Is the patient undergoing any treatment for this disease?*</p> <p> <input checked="" type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/> </p> <hr/> <p>Treatment Information</p> <p>Treatment Date*</p> <p>mm/dd/yyyy <input type="text"/> <input type="checkbox"/> Unknown</p> <p>Medication*</p> <p>Select... <input type="text"/></p> <p>If other, please specify: <input type="text"/></p> <p>Frequency*</p> <p>Select... <input type="text"/> Duration * ? <input type="text"/></p> <p>If the frequency is other, please specify: ? <input type="text"/></p> <p>Additional Information ? <input type="text"/></p> <p>0/300 Characters</p>
---	--

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

If the patient is undergoing treatment, enter the **Treatment Date**.

Treatment Date*

mm/dd/yyyy ☐ Unknown

July 2021

Su	Mo	Tu	We	Th	Fr	Sa
27	28	29	30	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	31

Duration* ?

Specify: ?

2. Select the **Medication** from the dropdown menu.

Medication*

Select...

- Azithromycin 1000 MG
- Erythromycin 500 MG
- Ofloxacin 300 MG
- Other
- Unknown

Duration* ?

Please Note: The *Medication* dropdown menu displays only the medication options that apply to the Disease/Organism selected.

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

Medication*

Other

If other, please specify:*

3. Select the **Frequency** from the dropdown menu.

Frequency*

Select...

- Daily
- Every 4 hours
- Every 6 hours
- Every 8 hours
- Every 12 hours
- Four times a day-QID
- Once

Duration* ?

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

Frequency* Other Please enter 'Unknown' if the frequency is not known. x v Duration* ?

If the frequency is other, please specify: ?

4. Enter the **duration of the medication** in the *Duration* field.

Medication* Azithromycin 1000 MG x v Please enter the duration of the medication. Ex. free fill for # of Days, free fill for # of Weeks etc. Or, enter 'Unknown' if the duration is not known.

If other, please specify:

Frequency* Daily x v Duration* ?

If the frequency is other, please specify: ?

5. If applicable, enter the **additional information about the patient's treatment** in the *Additional Information* textbox.

Frequency* Daily x v Please enter any additional information (if not already provided above), you would like to provide about patient's treatment with the selected Medication. Ex. Dose, Route Duration* ? Free Fill for 30 Days

If the frequency is other, please specify: ?

Additional Information ?

0/300 Characters

Adding Multiple Treatments

6. You may also click **Add Treatment** to log the details for multiple treatments.

Additional Information ?

Additional Treatment Details

28/300 Characters

+ Add Treatment

Save Previous Next

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

Treatment Information

Treatment Date*

mm/dd/yyyy ☐ Unknown

Medication*

Select... | v

If other, please specify:

Frequency*

Select... | v

Duration* ?


If the frequency is other, please specify: ?


Additional Information ?

0/300 Characters

+ Add Treatment

Save Previous Next





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

Treatment Information

Treatment Date*

06/28/2021

Unknown

Medication*

Unknown

If other, please specify:

Frequency*

Daily

If the frequency is other, please specify: ?

Duration* ?

Unknown

Additional Information ?

0/300 Characters

+ Add Treatment

Save

Previous

Next

19 Additional Comments

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 9 of 10

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Additional comments or notes, please specify:

0/1000 Characters

Save

Previous

Next

20 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.

Print or Download Functionality

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 10 of 10



Please review your information before submitting.

REVIEW & SUBMIT																					
Patient Information	<div style="text-align: right;">  Print  Download </div>																				
Laboratory Information																					
Applicable Symptoms																					
Medical Conditions																					
Travel Information																					
Hospitalization, ICU & Death Information																					
Additional Information																					
Treatment Information																					
Additional Comments																					
Review and Submit	<p>Patient Information</p> <table border="0"> <tr> <td>Disease/Organism</td> <td>Date of Diagnosis</td> </tr> <tr> <td>Chlamydia</td> <td>07/23/2021</td> </tr> <tr> <td colspan="2">Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?</td> </tr> <tr> <td colspan="2">Yes</td> </tr> <tr> <td>Patient ID (MRN)</td> <td>Affiliation/Organization</td> </tr> <tr> <td>SK05051960</td> <td>Test Medical Center</td> </tr> <tr> <td>Person Completing Form</td> <td>Affiliation/Organization</td> </tr> <tr> <td>Mr. Arthur Vandelay, II (arthur@email.com)</td> <td>Test Medical Center</td> </tr> <tr> <td>Attending Physician/Clinician</td> <td>Affiliation/Organization</td> </tr> <tr> <td>Dr. Frank Costanza, Sr (frank@email.com)</td> <td>Test Medical Center</td> </tr> </table>	Disease/Organism	Date of Diagnosis	Chlamydia	07/23/2021	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?		Yes		Patient ID (MRN)	Affiliation/Organization	SK05051960	Test Medical Center	Person Completing Form	Affiliation/Organization	Mr. Arthur Vandelay, II (arthur@email.com)	Test Medical Center	Attending Physician/Clinician	Affiliation/Organization	Dr. Frank Costanza, Sr (frank@email.com)	Test Medical Center
Disease/Organism	Date of Diagnosis																				
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Attending Physician/Clinician	Affiliation/Organization																				
Dr. Frank Costanza, Sr (frank@email.com)	Test Medical Center																				

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Please review your information before submitting.

REVIEW & SUBMIT																																																									
Patient Information	<div style="text-align: right;">  Print  Download </div>																																																								
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Disease/Organism	Date of Diagnosis																																																								
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Attending Physician/Clinician	Affiliation/Organization																																																								
Dr. Frank Costanza, Sr (frank@email.com)	Test Medical Center																																																								
Prefix	Last Name																																																								
Mr.	Ross																																																								
First Name	Date of Birth																																																								
Susan	05/05/1960																																																								
Patient Sex	Ethnicity																																																								
Female	Not Hispanic or Latino																																																								
Race																																																									
Other																																																									
Address 1	State																																																								
15151 Avenue	KY																																																								
City	Zip Code																																																								
Lexington	40505																																																								
County	Phone																																																								
Fayette	(555) 555-0000																																																								
Email																																																									
scott@email.com																																																									
Is the patient currently pregnant?																																																									
No																																																									



Destination: SecurePrintUS

Pages: All

Copies: 1

Color: Color

More settings

 **Print**
 **Download**

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

REVIEW & SUBMIT	
Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Medical Conditions	✓
Travel Information	✓
Hospitalization, ICU & Death Information	✓
Additional Information	✓

 Print
  Download

Patient Information

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

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

Yes

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

- 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.

Applicable Symptoms
Medical Conditions
Travel Information
Hospitalization, ICU & Death Information
Additional Information
Treatment Information
Additional Comments
Review and Submit

Patient Information

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

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

Yes

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

Person Completing Form	Affiliation/Organization
Mr. Arthur Vandelay, II (arthur@email.com)	Test Medical Center

Attending Physician/Clinician	Affiliation/Organization
Dr. Frank Costanza, Sr (frank@email.com)	Test Medical Center

Prefix

Ms.

First Name	Last Name
Susan	Ross

Date of Birth

07/23/2021

Download PDF

Downloaded successfully

OK

Sexually Transmitt...pdf

Show all

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

- Review the information.

Sexually Transmitted Diseases Case Report Form.pdf

1 / 4 100%

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

Patient ID (MRN)
SK05051960

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

Prefix
Ms.

First Name
Susan

Last Name
Ross

Date of Birth
05/05/1960

Patient Sex
Female

Ethnicity
Not Hispanic or Latino

Race

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

REVIEW & SUBMIT

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Medical Conditions ✓

Travel Information ✓

Hospitalization, ICU & Death Information ✓

Additional Information ✓

Treatment Information ✓

Additional Comments ✓

Review and Submit

Print Download

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

Patient ID (MRN)
SK05051960

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

Prefix
Ms.

REVIEW & SUBMIT

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Medical Conditions ✓

Travel Information ✓

Hospitalization, ICU & Death Information ✓

Additional Information ✓

Treatment Information ✓

Additional Comments ✓

Review and Submit

Print Download

Laboratory Information

Does the patient have a lab test?
Yes

Laboratory Information

Laboratory Name
Test Laboratory

Test Name
Chlamydia sp Ag [Presence] in Urethra

4. Review the *Patient Information* section.

Applicable Symptoms	✓
Medical Conditions	✓
Travel Information	✓
Hospitalization, ICU & Death Information	✓
Additional Information	✓
Treatment Information	✓
Additional Comments	✓
Review and Submit	

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

Patient ID (MRN)
SK05051960

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

Prefix
Ms.

First Name
Susan

Last Name
Ross

Date of Birth
05/05/1960

Patient Sex
Female

Ethnicity
Not Hispanic or Latino

Race
Other

Address 1
55 Fifth Avenue

City
Lexington

State
KY

Zip Code
40555

County
Fayette

Phone
(555) 555-0000

Email
susan@email.com

Is the patient currently pregnant?
No

5. Review the *Laboratory Information* section.

Laboratory Information

Does the patient have a lab test?
Yes

Laboratory Information

Laboratory Name
Test Laboratory

Test Name
Chlamydia sp Ag [Presence] in Urethra

Filler Order/Accession Number
SR07232021

Specimen Source
Urine

Test Result
Positive

Test Result Date
07/26/2021

Specimen Collection Date
07/23/2021

Laboratory Information

Laboratory Name
Laboratory 2

Test Name
Chlamydia trachomatis [Presence] in Rectum by Organism specific culture

Filler Order/Accession Number
SR07262021

Specimen Source
Stool

Test Result

6. Review the *Applicable Symptoms* section.

Additional Information	✓
Treatment Information	✓
Additional Comments	✓
Review and Submit	

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?

Rash
Yes

If yes, please specify the location on the body (select all that apply):
Leg , Torso

Fever
Yes

If yes, please enter the highest temperature:
Unknown

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

Pain in urethra
Yes

Rectal Discharge
No

Urethral Discharge
Yes

Did the patient have any other symptoms?
No

7. Review the *Medical Conditions* section.

Additional Comments	✓
Review and Submit	

Medical Conditions

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

Which of the following conditions did the patient experience during illness?

Neurologic impairment
No

Vision impairment
No

Substance abuse or misuse
Yes

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

Immunosuppressive condition
No

8. Review the *Travel Information* section.

Travel Information

Does the patient have a travel history within the last 12 months?
Yes

Domestic travel (outside state of normal residence)
Yes

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

International travel
Yes

If yes, please specify country(s):
CANADA , MEXICO

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

10. If applicable, review the *Additional Information* section.

Hospitalization, ICU & Death Information

Was the patient hospitalized?
Yes

If yes, please specify the hospital name:
Test Hospital

Admission Date: 07/23/2021 Discharge Date: 07/24/2021

Was the patient admitted to an intensive care unit (ICU)?
No

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

Additional Information

Treatment Information

Please Note: The **Additional Information** screen is enabled and only collects information when **Gonorrhea** or **Syphilis** is selected as the Disease/Organism.

11. Review the *Treatment Information* section.

Treatment Information

Is the patient undergoing any treatment for this disease?
Yes

Treatment Information

Treatment Date: 07/26/2021

Medication: Azithromycin 1000 MG

Frequency: Daily Duration: Free Fill for 30 Days

Additional Information: Additional Treatment Details

Treatment Information

Treatment Date: 06/28/2021

Medication: Unknown

Frequency: Daily Duration: Unknown

12. Review the *Additional Comments* section.

[Additional Comments](#)

Additional comments or notes, please specify:
Additional Comments

[Previous](#) [Submit](#)

Click Hyperlinks to Edit

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

REVIEW & SUBMIT

[Patient Information](#) [Laboratory Information](#) [Applicable Symptoms](#) [Medical Conditions](#) [Travel Information](#) [Hospitalization, ICU & Death Information](#)

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

[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

14. 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.

PATIENT INFORMATION

[Patient Information](#) [Laboratory Information](#) [Applicable Symptoms](#) [Medical Conditions](#) [Travel Information](#) [Hospitalization, ICU & Death Information](#) [Additional Information](#) [Treatment Information](#) [Additional Comments](#) [Review and Submit](#)

Disease/Organism*: Chlamydia Date of Diagnosis*: 07/23/2021 ☐ Unknown

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

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: *

Prefix: Ms. First Name*: Susan Middle Name*: Marie Last Name*: Ross

15. 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**.

The screenshot shows a 'Save Changes?' modal dialog box in the center. The dialog contains the text: 'There's information on this screen that has not been saved. Do you want to save it?'. Below the text are two buttons: 'No - Discard' and 'Yes - Save'. The 'Yes - Save' button is highlighted with a red border. In the background, a form is visible with the following fields: Disease/Organism (Chlamydia), Date of Diagnosis (07/23/2021), Patient ID (MRN) (SK05051960), Affiliation/Organization (Test Medical Center), Person Completing Form (Mr. Arthur Vandelay, II), and Attending Physician/Clinician (Dr. Frank Costanza, Sr.).

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

The screenshot shows the 'REVIEW & SUBMIT' screen. The left sidebar contains a list of sections: Patient Information, Laboratory Information, Applicable Symptoms, Medical Conditions, Travel Information, Hospitalization, ICU & Death Information, Additional Information, Treatment Information, Additional Comments, and Review and Submit. The main content area displays the following information: Disease/Organism (Chlamydia), Date of Diagnosis (07/23/2021), Patient ID (MRN) (SK05051960), 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), Prefix (Ms.), First Name (Susan), Middle Name (Marie), Last Name (Ross), and Date of Birth (05/05/1960). The 'Middle Name' field is highlighted with a red box.

17. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Sexually Transmitted Disease (STD) Case Report Entry.

The screenshot shows the 'Additional Comments' section. It contains a text area with the placeholder text 'Additional comments or notes, please specify:'. Below the text area are two buttons: 'Previous' and 'Submit'. The 'Submit' button is highlighted with a red border.

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

The screenshot shows a 'Case Report Entry' dialog box with a close button (X) in the top right corner. The dialog contains the following text: 'All data submissions are final. Please ensure that your data is accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.' At the bottom of the dialog are two buttons: 'Cancel' and 'Submit'. The 'Submit' button is highlighted with a red square. In the background, a form titled 'Additional Treatment Details' is visible, showing fields for 'Treatment Date' (06/28/2021), 'Medication' (Unknown), 'Frequency' (Daily), and 'Duration' (Unknown).

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.

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

The screenshot shows the 'Case Report Entry' dialog box after a successful submission. The text inside the dialog now reads: 'Case Report Entry Saved Successfully'. The 'OK' button at the bottom right is highlighted with a red square. The background form 'Additional Treatment Details' remains visible with the same values as in the previous screenshot.

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

Congratulations! You have submitted the Sexually Transmitted Disease (STD) 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.

21 Case Report User Entry Summary

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

The screenshot shows the 'CASE REPORT ENTRY USER SUMMARY' screen. At the top, there's a navigation bar with 'Patient Search', 'Bookmarked Patients', 'Event Notifications', 'Lab Data Entry', and 'Case Report Entry'. Below this, a breadcrumb trail shows 'Home > Case Report Entry User Summary'. The main heading is 'CASE REPORT ENTRY USER SUMMARY'. Underneath, there's a section for 'LAST UPDATED DATE RANGE' with 'Start Date' and 'End Date' both set to '07/29/2021'. A 'Retrieve Data' button is on the right. Below this, it says 'SHOWING 1 ITEMS' and an 'APPLY FILTER' button. 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. The first row shows a 'View' button, 'MDRO', 'Test Medical Center', 'CK08101955', 'Cosmo', 'Kramer', '08/10/1955', 'Male', 'Complete', '07/29/2021 4:05 PM', and '07/29/2021 4:05 PM'. At the bottom, there are navigation buttons: 'First', 'Back', '1', 'Next', 'Last'. A 'Maximum 5 entries per page' dropdown is also present.

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

This screenshot shows the same screen as before, but with a date picker open for the 'Start Date' field. The date picker is set to 'July 2021' and shows a calendar grid. The 'End Date' field remains '07/29/2021'. The 'Retrieve Data' button is still visible. The table below shows the same data as the previous screenshot.

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

This screenshot shows the screen after clicking the 'Retrieve Data' button. The 'Start Date' field now shows '07/27/2021' and the 'End Date' field shows '07/29/2021'. The 'Retrieve Data' button is highlighted with a red border. The table below shows the same data as the previous screenshots.

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

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

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE
Start Date
End Date
Retrieve Data

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

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE
Start Date
End Date
Retrieve Data

SHOWING 3 ITEMS
APPLY FILTER

ACTIONS	REPORT TYPE	AFFILIATION/ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
Continue	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
View	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

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
End Date
Retrieve Data

SHOWING 3 ITEMS
HIDE FILTER

ACTIONS	REPORT TYPE	AFFILIATION/ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
	<input type="text" value="Enter Report"/>	<input type="text" value="Enter Affiliatic"/>	<input type="text" value="Enter Patient"/>	<input type="text" value="Enter First Na"/>	<input type="text" value="Enter Last"/>	<input type="text" value="Enter Date Of Bir"/>	<input type="text" value="All"/>	<input type="text" value="Enter Statu"/>	<input type="text" value="All"/>	<input type="text" value="All"/>
View	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
Continue	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
View	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 Date07/26/2021End Date07/29/2021

Retrieve Data

SHOWING 3 ITEMS

APPLY FILTER

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

FirstBack1NextLast

Maximum5 entries per page

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

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

Male

Ethnicity

White

Race

White

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 ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
Continue	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
View	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.

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM

Section 8 of 10

Please provide any treatment information related to this case.

TREATMENT INFORMATION

Patient Information ☒
Laboratory Information ☒
Applicable Symptoms ☒
Medical Conditions ☒
Travel Information ☒
Hospitalization, ICU & Death Information ☒
Additional Information ☒
Treatment Information ☒

Is the patient undergoing any treatment for this disease?*

Treatment Information

Treatment Date ☐ Unknown

Medication

If other, please specify:

22 Technical Support

Toll-Free Telephone Support

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

Email Support

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

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

