

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Vaccine Preventable Diseases Case Reports (Diphtheria)

User Guide

February 2024

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1 Introduction

Overview

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

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

Supported Web Browsers

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

Desktop Browser Version	Mobile Browser Version
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 Kentucky Online Gateway (KOG) account and how to complete MFA, please review the [ePartnerViewer Login: Kentucky Online Gateway \(KOG\) and Okta Verify Multi-Factor Authentication \(MFA\) User Guide](#).

2 Logging into ePartnerViewer

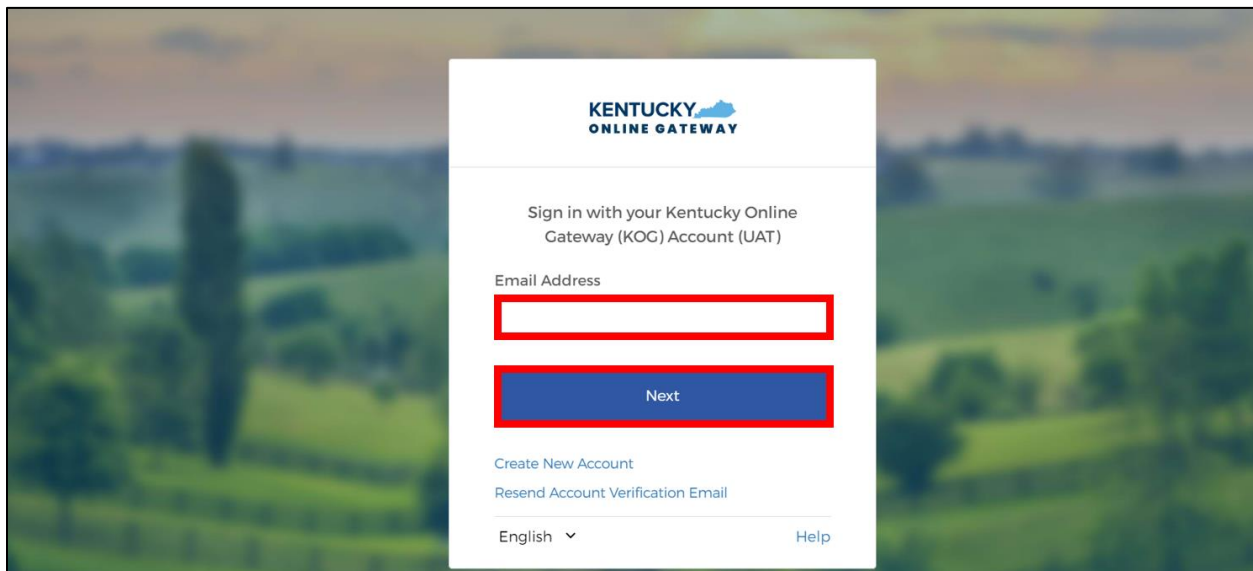
Users with the *Manual Case Reporter* role are authorized to access the Vaccine Preventable Diseases Case Report in the ePartnerViewer. You must log into your Kentucky Online Gateway (KOG) account to access the ePartnerViewer.

1. To navigate to the ePartnerViewer, enter the following **ePartnerViewer URL** in a supported browser window: <https://epartnerviewer.khie.ky.gov>



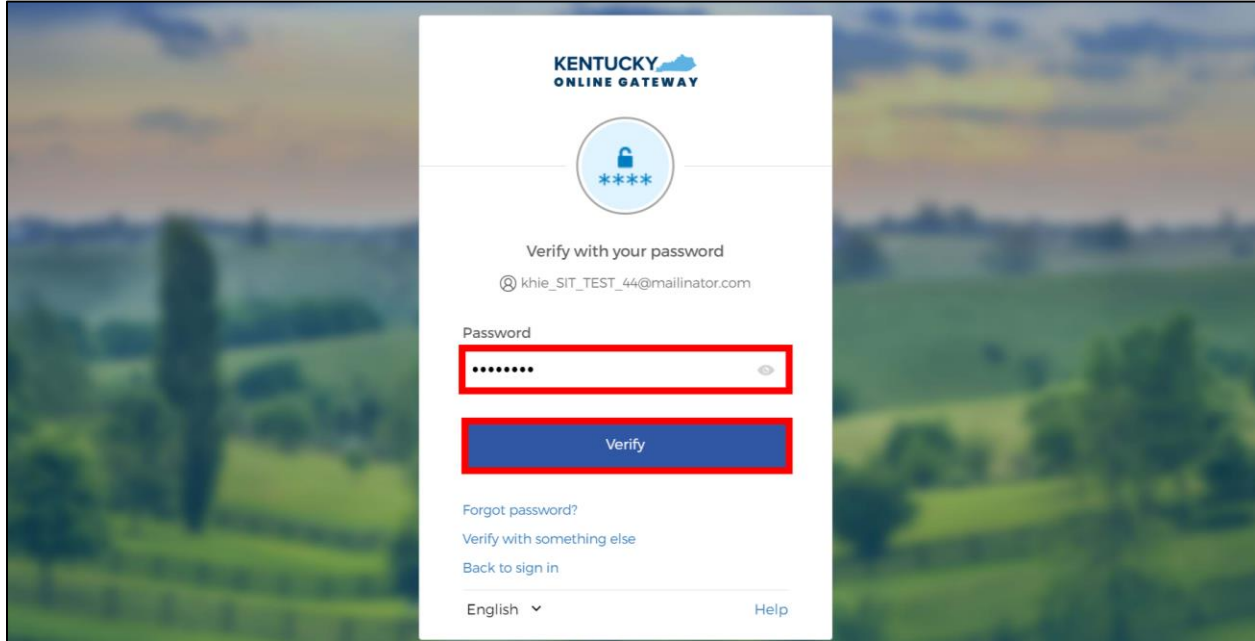
Please Note: The ePartnerViewer does **not** support Microsoft Internet Explorer. To access the ePartnerViewer, Users must use a modern browser such as Google Chrome, Microsoft Edge, Apple Safari, or Mozilla Firefox.

2. On the **KOG Login Page**, enter your **Email Address**. Click **Next**.



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

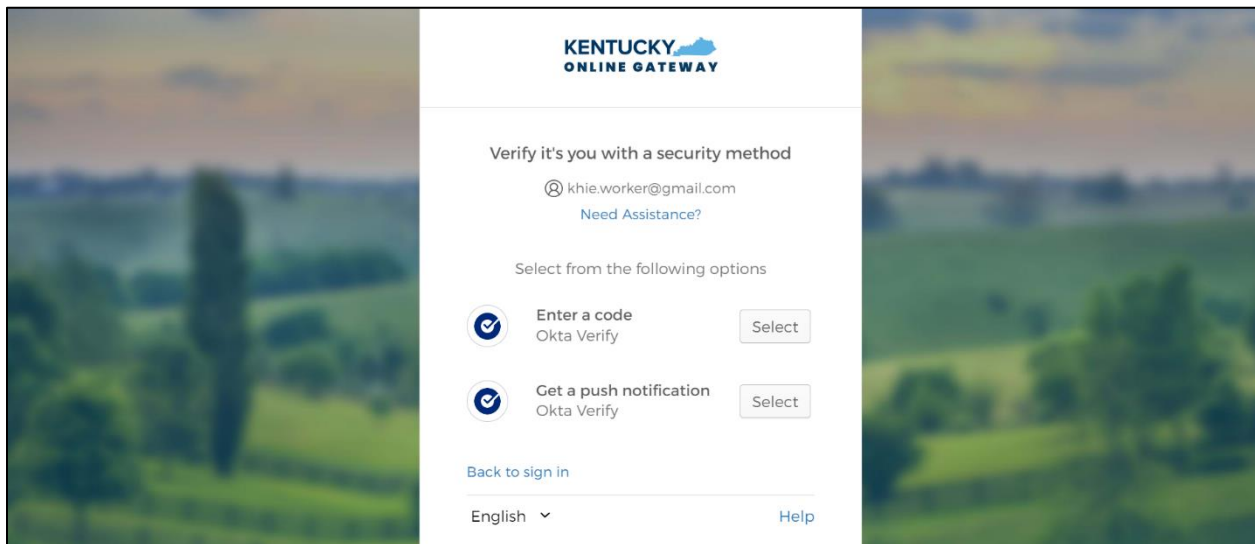
3. Enter your **Password**. Click **Verify**.



The screenshot shows the 'KENTUCKY ONLINE GATEWAY' login interface. It features a circular icon with a padlock and four asterisks. Below this, the text 'Verify with your password' is displayed, followed by the email address 'khie_SIT_TEST_44@mailinator.com'. A password field with a red border contains eight asterisks. A blue 'Verify' button with a red border is positioned below the password field. At the bottom, there are links for 'Forgot password?', 'Verify with something else', and 'Back to sign in'. A language dropdown menu is set to 'English', and a 'Help' link is in the bottom right corner.

Multi-Factor Authentication

4. After logging into KOG and verifying your password, you are automatically navigated to the **Verify it's you with a security method** screen. You will be asked to complete Multi-Factor Authentication (MFA) using Okta Verify. Users have two (2) options for completing Okta Verify MFA:
- Use a security code from the Okta Verify app.
 - Use the push notification from the Okta Verify app.

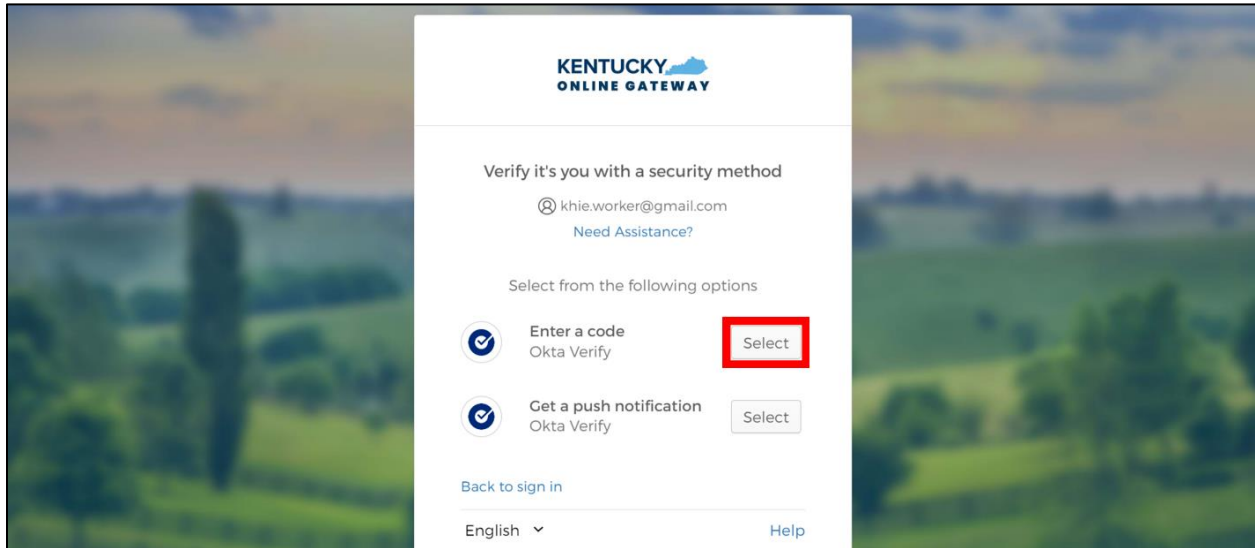


The screenshot shows the 'KENTUCKY ONLINE GATEWAY' Multi-Factor Authentication screen. It displays the text 'Verify it's you with a security method' and the email address 'khie.worker@gmail.com' with a 'Need Assistance?' link. Below this, it says 'Select from the following options'. There are two options, each with a 'Select' button: 'Enter a code Okta Verify' and 'Get a push notification Okta Verify'. At the bottom, there are links for 'Back to sign in', a language dropdown menu set to 'English', and a 'Help' link.

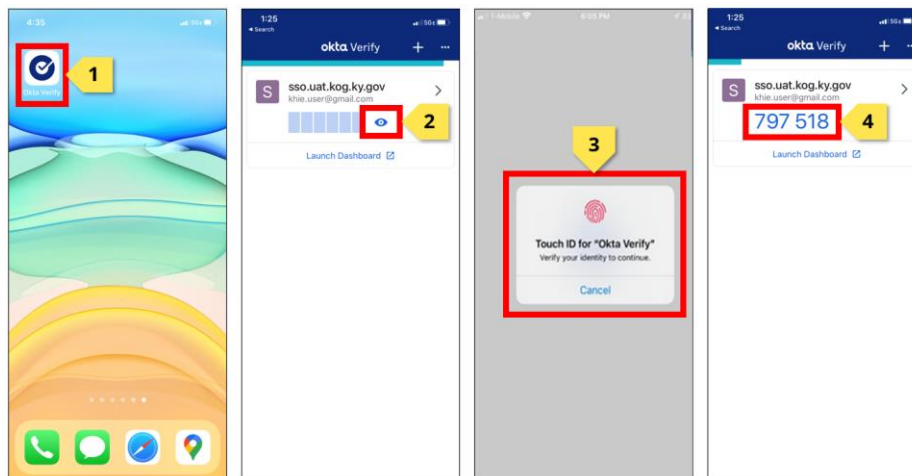
Security Code from Okta Verify App

To complete MFA using the security code from Okta Verify, complete the following steps:

1. After logging into KOG, you are navigated to the **Verify it's you with a security method** screen. Click the **Select** button next to **Enter a code**.



2. To locate the Okta Verify code, complete the following steps from your mobile device or tablet:
 - Step 1: Open the **Okta Verify app** on your mobile device or tablet.
 - Step 2: If the code is hidden, click the **Eye Icon** below the email address used for your KOG account.
 - Step 3: Verify your identity using either **Touch ID** or **Face ID**.
 - Step 4: Upon verifying your identity, the **6-digit code** displays.



- Return to the **Enter a code** screen on your computer. Enter the **6-digit code** from the Okta Verify app. Click **Verify** to proceed to the **Terms and Conditions of Use** screen of the ePartnerViewer.

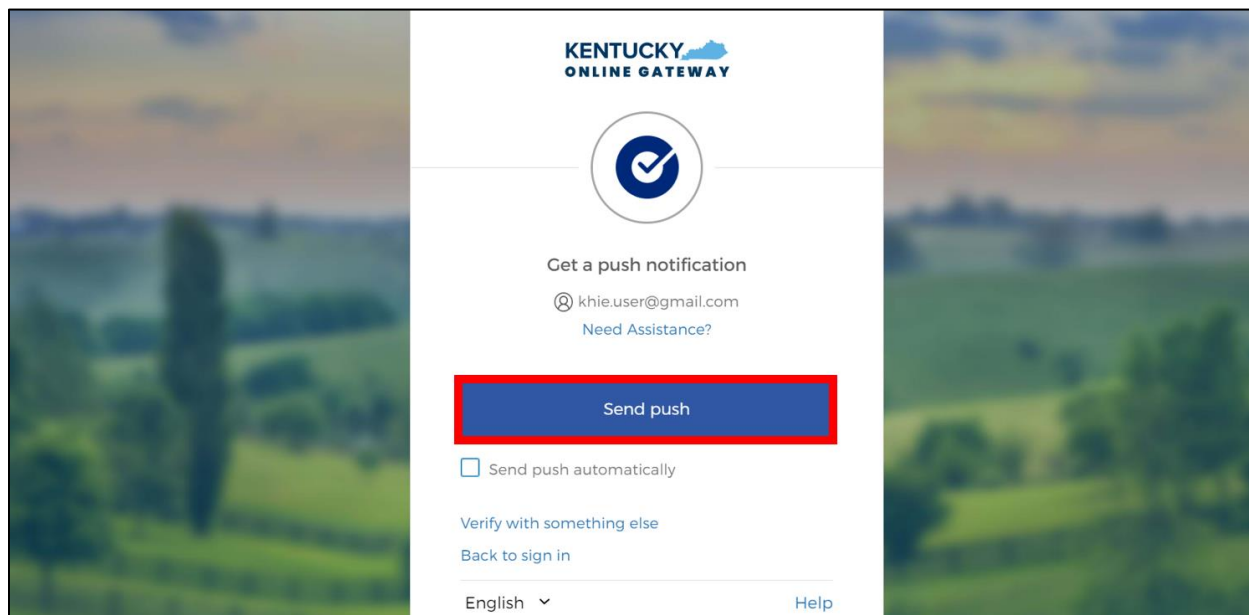
Please Note: Once you enter the code from the Okta Verify app, you are automatically navigated to the **Terms and Conditions of Use** screen. For more information, please review the *Terms and Conditions of Use and Logging In* sub-section of this chapter.

Push Notification from Okta Verify App

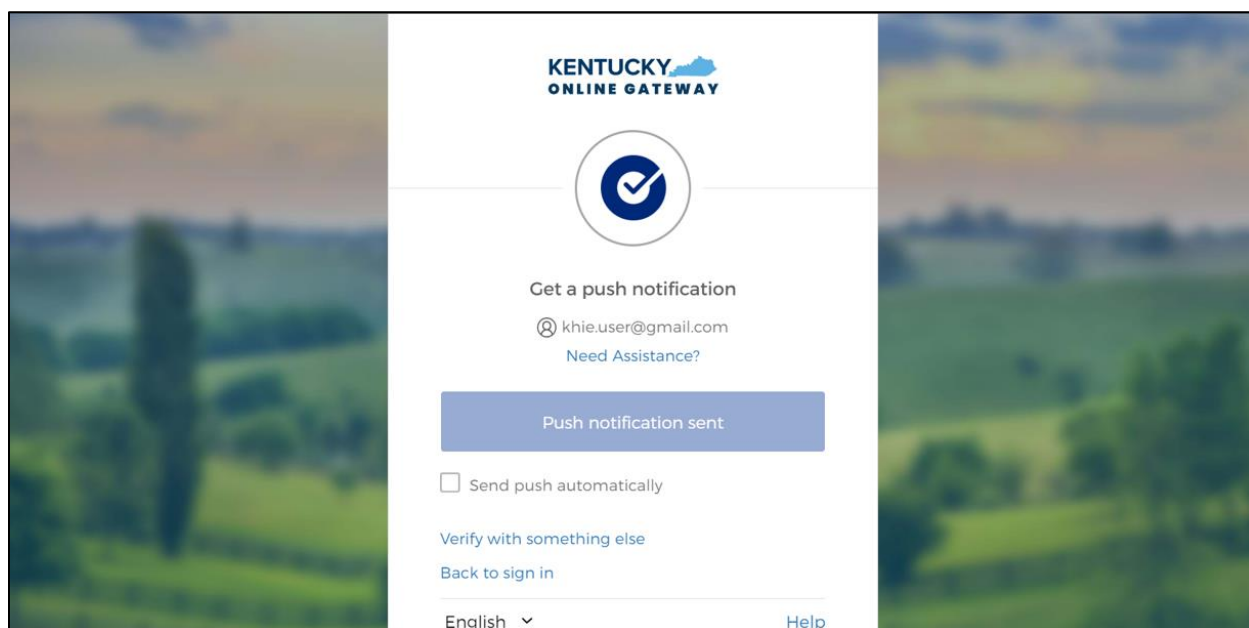
To complete MFA using a push notification from Okta Verify, complete the following steps:

- After logging into KOG, you are navigated to the **Verify it's you with a security method** screen. Click the **Select** button next to **Get a push notification**.

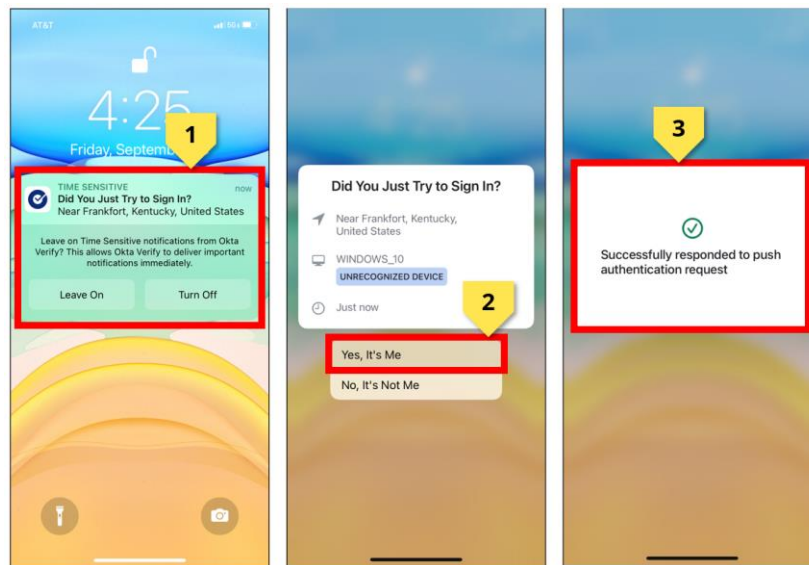
2. The **Get a push notification** screen displays. Click **Send Push**.



Please Note: Once the push notification has been successfully sent to the Okta Verify app, the **Get a push notification** screen displays a grayed out **Push notification sent** button.



3. To view the Okta Verify push notification, complete the following steps from your mobile device:
- Step 1: You will receive a push notification on your mobile device or tablet. Tap and hold the notification banner titled “**Did You Just Try to Sign In?**”.
 - Step 2: On the notification, click the **Yes, It's Me** button.
 - Step 3: A notification will appear on your mobile device screen letting you know that you have successfully responded to the push authentication request. You can now return to your computer where you will be redirected to the **Terms and Conditions of Use** screen of the ePartnerViewer.



Please Note: Once you successfully respond to the Okta Verify push notification, you are automatically navigated to the **Terms and Conditions of Use** screen of the ePartnerViewer.

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.

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

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

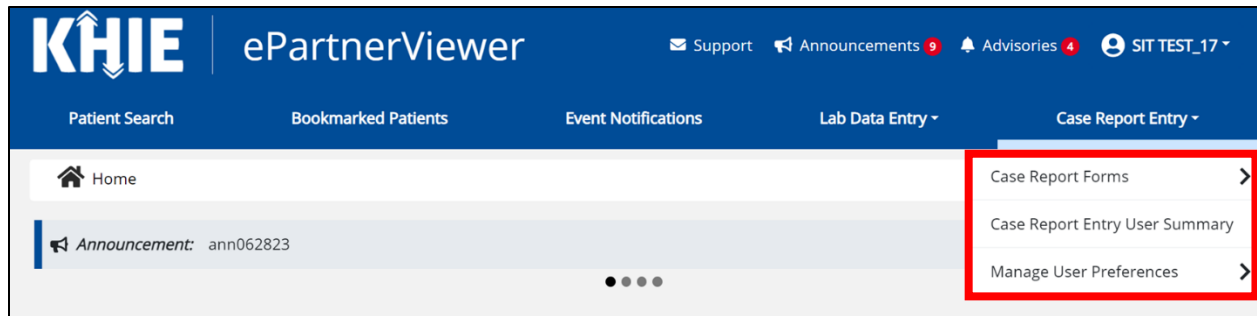
2. Once you click **I Accept**, the grayed-out section becomes visible. A message appears that indicates you are associated with an Organization. (This is the name of your organization.)
3. Click **Proceed to Portal** to continue to the ePartnerViewer application.

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

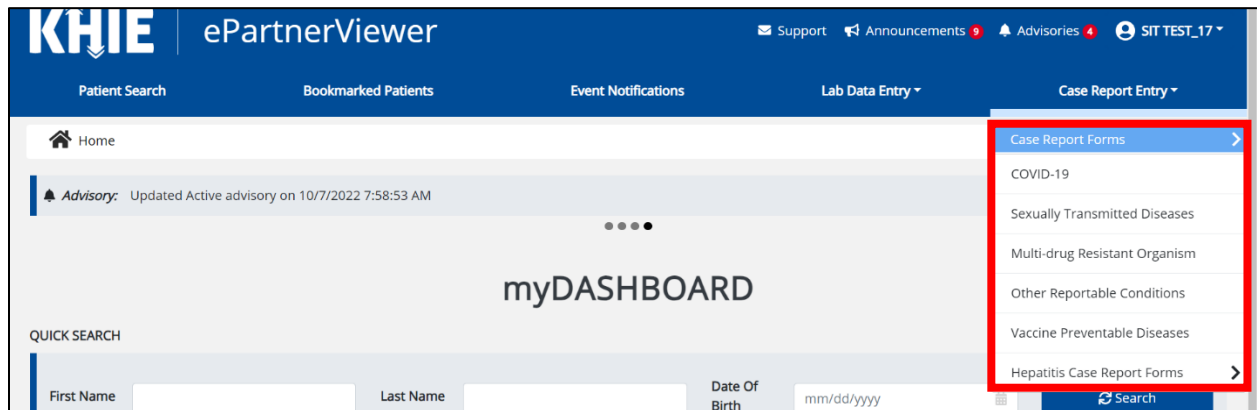
3 Understanding the Case Report Entry Dropdown Menu

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

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



1. Types of Case Reports:



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

Please Note: For specific information about COVID-19 case reporting, please review the [Direct Data Entry for Case Reports: COVID-19 User Guide](#).

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

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

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

- Designed for Users to enter MDRO case reports.

Please Note: For specific information about MDRO case reporting, please review the [Direct Data Entry for 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 Case Reports: Other Reportable Conditions User Guide](#).

- **Vaccine Preventable Diseases Case Report:**

- Designed for Users to enter Vaccine Preventable Diseases case reports.

2. Types of Hepatitis Case Reports:

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The Case Report Entry dropdown menu is open, showing a list of reportable conditions. The 'Hepatitis Case Report Forms' option is highlighted with a red box, and its sub-menu is also visible, showing 'Hepatitis, Positive Pregnant Female', 'Perinatal Hepatitis', and 'Acute Hepatitis Case Report Forms'.

- **Hepatitis Positive Pregnant Female Case Report:**

- Designed for Users to enter Hepatitis Positive Pregnant Female case reports.

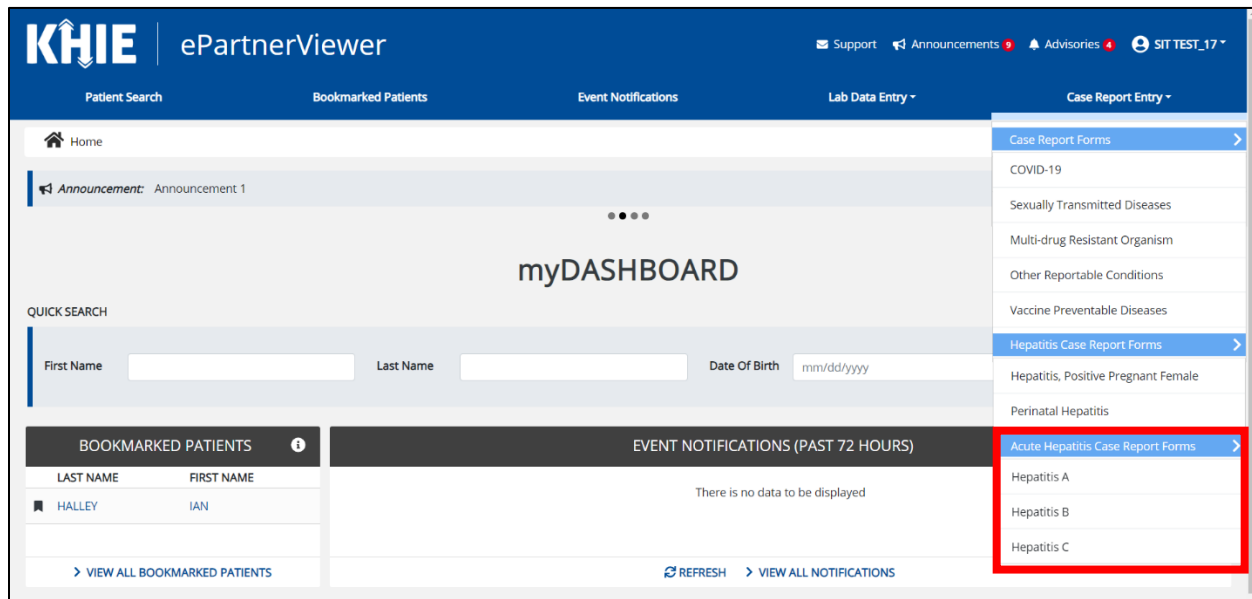
- **Perinatal Hepatitis Case Report:**

- Designed for Users to enter Perinatal Hepatitis case reports.

- **Acute Hepatitis Case Reports:**

- Designed for Users to choose between the three (3) types of Acute Hepatitis case reports.

3. Types of Acute Hepatitis Case Reports:



- **Acute Hepatitis A Case Report:**

- Designed for Users to enter Acute Hepatitis A case reports.

Please Note: For specific information about Acute Hepatitis A case reporting, please review the [Direct Data Entry for Case Reports: Acute Hepatitis A User Guide](#).

- **Acute Hepatitis B Case Report:**

- Designed for Users to enter Acute Hepatitis B case reports.

Please Note: For specific information about Acute Hepatitis B case reporting, please review the [Direct Data Entry for Case Reports: Acute Hepatitis B User Guide](#).

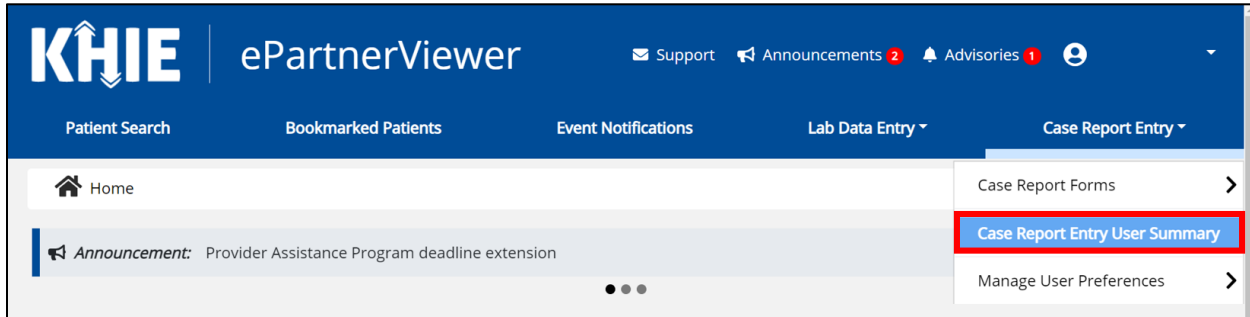
- **Acute Hepatitis C Case Report:**

- Designed for Users to enter Acute Hepatitis C case reports.

Please Note: For specific information about Acute Hepatitis C case reporting, please review the [Direct Data Entry for Case Reports: Acute Hepatitis C User Guide](#).

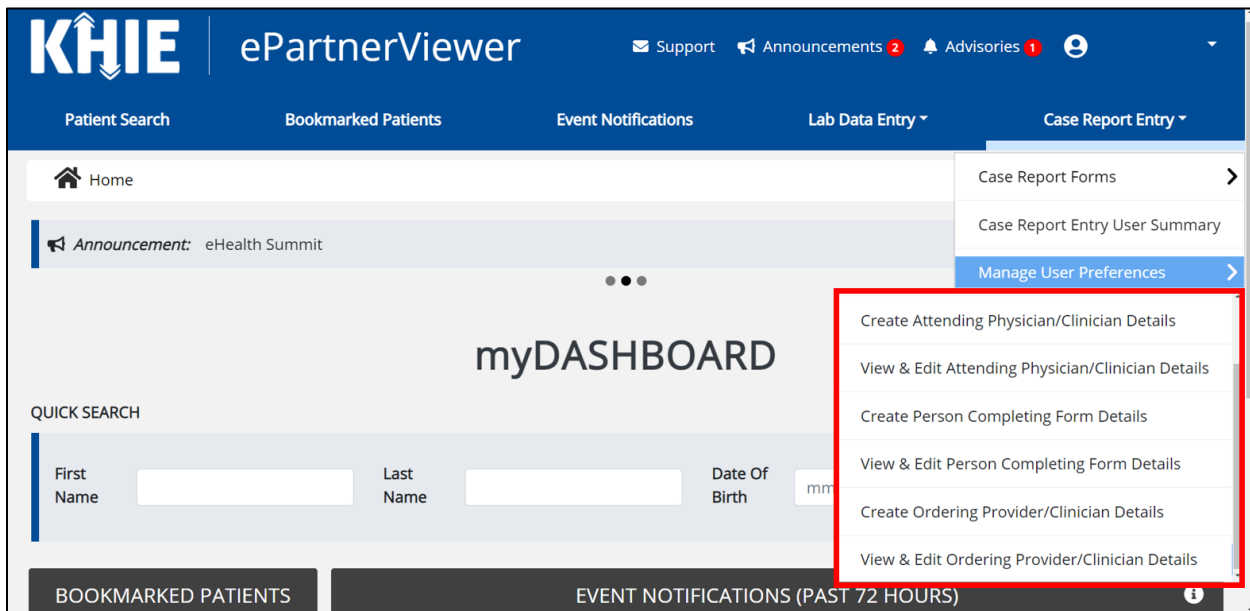
4. Case Report Entry User Summary:

- 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”.



5. 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.

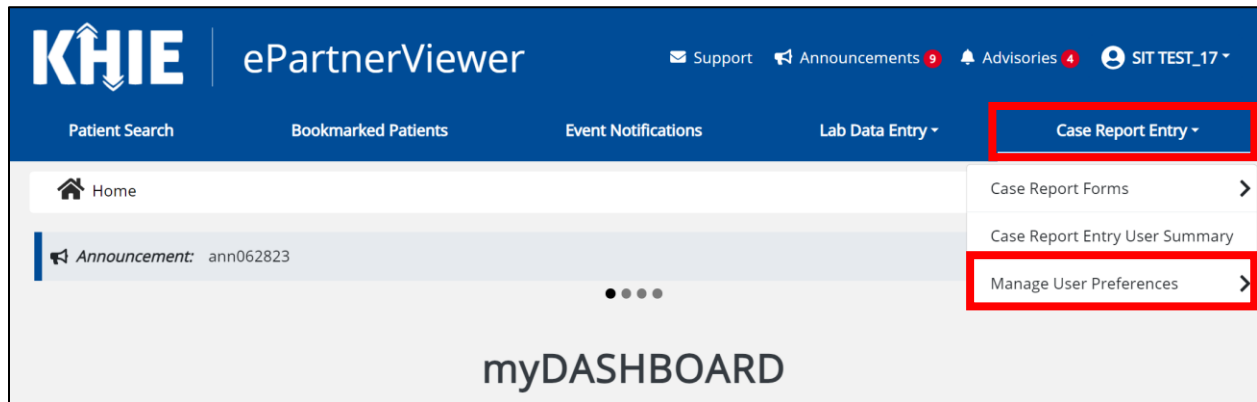


4 Manage User Preferences

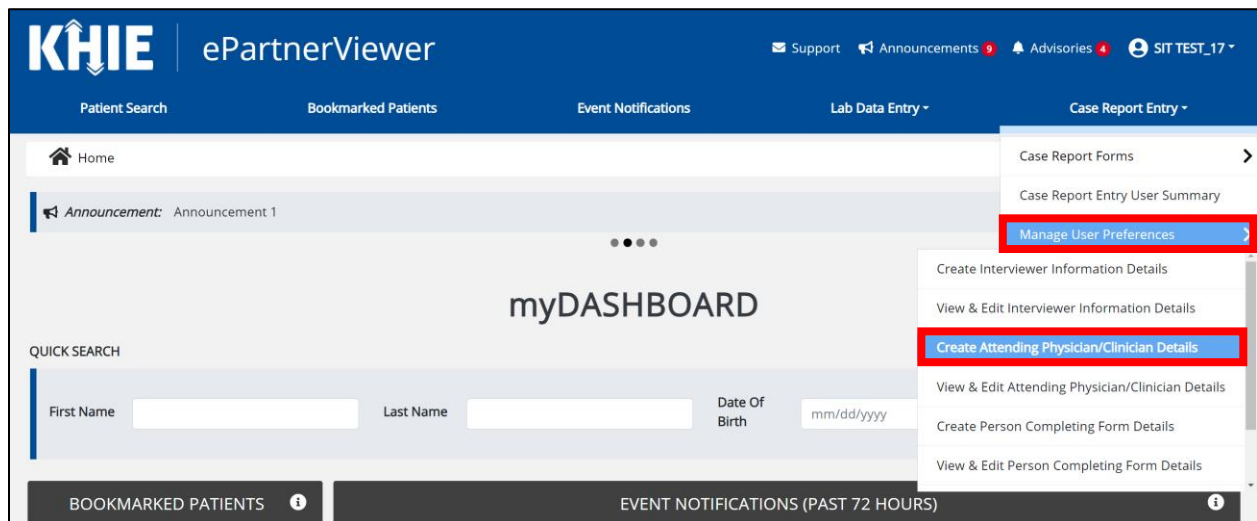
These are your User Preferences. Prior to entering your case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in your user preferences, you will be 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 Vaccine Preventable Diseases Case Report.

Create Attending Physician/Clinician Details

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



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



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

Home > Create Attending Physician/Clinician Details

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Select...

First Name*
Last Name*

Suffix
Select...

Address 2
Unit, Suite, Building, etc.

State*
Select...

Zip Code*
State

Email
name@domain.com

(XXX) XXX-XXXX

Clear Save

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Dr.

First Name*
Last Name*

Suffix
Sr

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

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

8. Enter the Attending Physician/Clinician's **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.

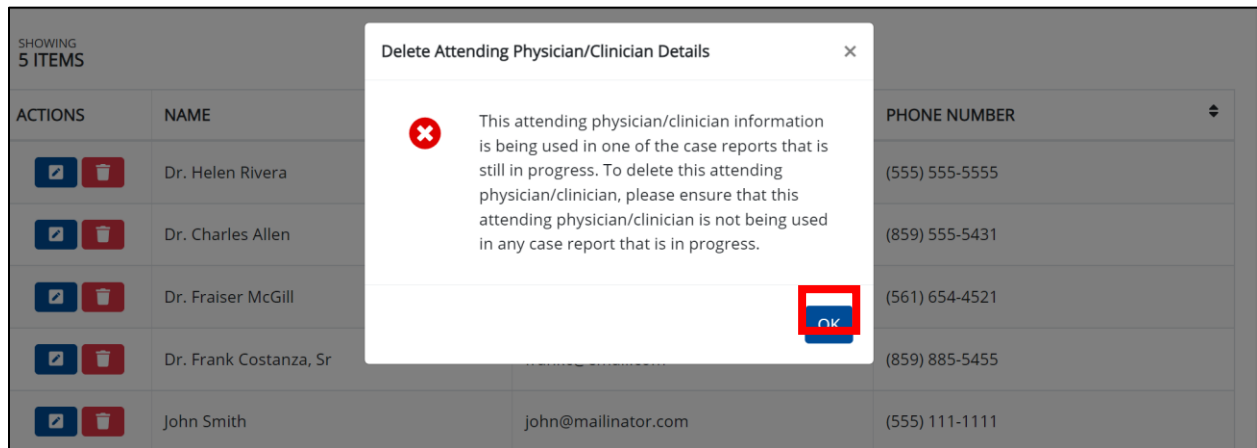
9. After completing the mandatory fields, click **Save.**

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

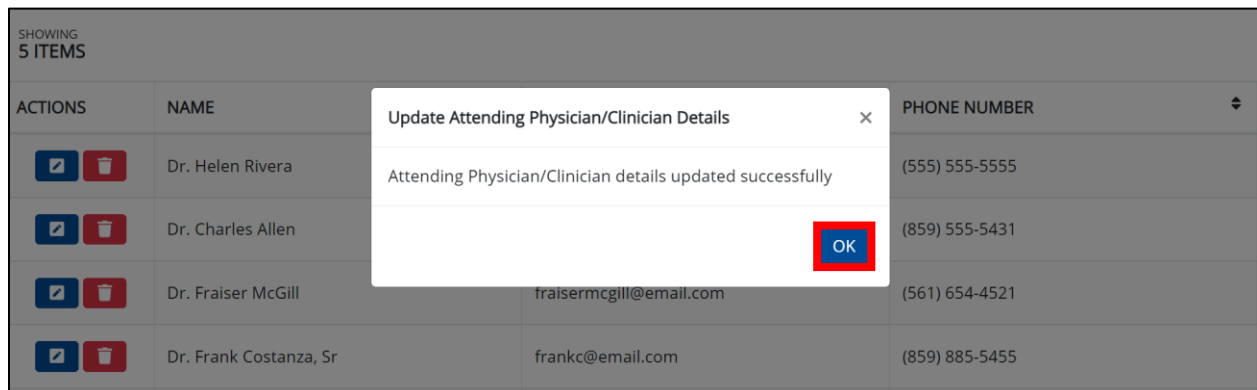
ATTENDING PHYSICIAN/CLINICIAN		
Prefix <input type="text" value="Dr."/> x v		
First Name*	Last Name*	
<input type="text" value="Frank"/>	<input type="text" value="Costanza"/>	
Suffix <input type="text" value="Sr"/> x v		
Address 1*	Address 2	
<input type="text" value="1 First Street"/>	<input type="text" value="1A"/>	
City*	State*	Zip Code*
<input type="text" value="Frankfort"/>	<input type="text" value="KY"/> x v	<input type="text" value="40123"/>
Phone*	Email	
<input type="text" value="(555) 555-5555"/>	<input type="text" value="frank@email.com"/>	
<input type="button" value="Clear"/> <input type="button" value="Save"/>		

Please Note: If you enter an email address that is already associated with another 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.

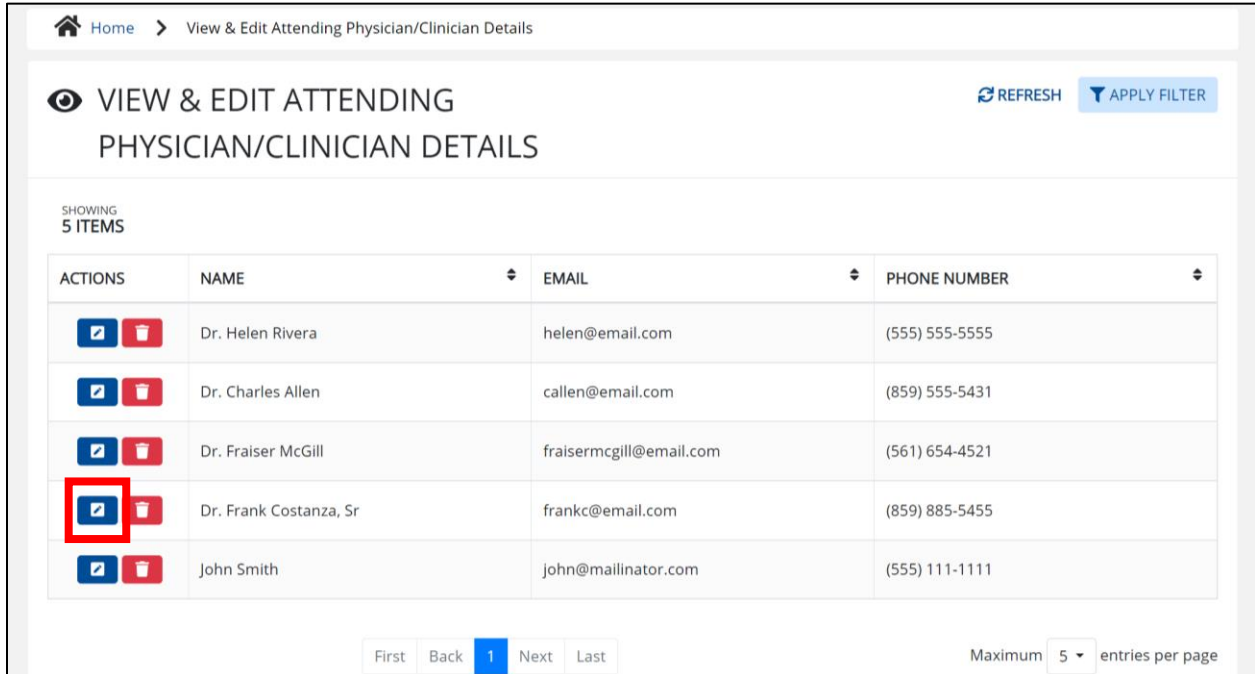


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.



View & Edit Attending Physician/Clinician Details











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



Home > View & Edit Attending Physician/Clinician Details

VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS

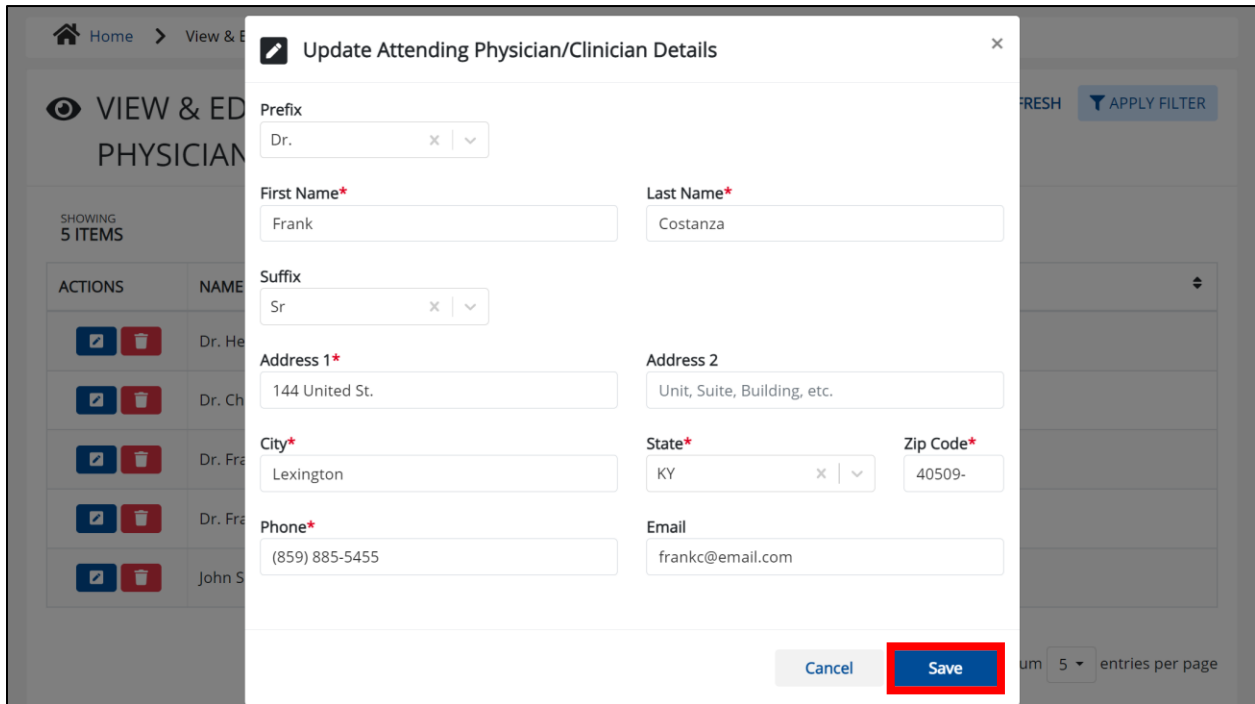
SHOWING 5 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Helen Rivera	helen@email.com	(555) 555-5555
 	Dr. Charles Allen	callen@email.com	(859) 555-5431
 	Dr. Fraiser McGill	fraisermcgill@email.com	(561) 654-4521
 	Dr. Frank Costanza, Sr	frankc@email.com	(859) 885-5455
 	John Smith	john@mailinator.com	(555) 111-1111

First Back 1 Next Last

Maximum 5 entries per page

- 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.



Home > View & Edit Attending Physician/Clinician Details

VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS

SHOWING 5 ITEMS

Update Attending Physician/Clinician Details

Prefix: Dr.

First Name*: Frank

Last Name*: Costanza

Suffix: Sr

Address 1*: 144 United St.

Address 2: Unit, Suite, Building, etc.

City*: Lexington

State*: KY

Zip Code*: 40509

Phone*: (859) 885-5455

Email: frankc@email.com

Cancel Save

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

SHOWING 5 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Dr. Helen Rivera		(555) 555-5555
	Dr. Charles Allen		(859) 555-5431
	Dr. Fraiser McGill	fraisermcgill@email.com	(561) 654-4521
	Dr. Frank Costanza, Sr	frankc@email.com	(859) 885-5455

Update Attending Physician/Clinician Details

Attending Physician/Clinician details updated successfully

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.

KHIE | ePartnerViewer

Support | Announcements 9 | Advisories 4 | SIT TEST_17

Patient Search | Bookmarked Patients | Event Notifications | Lab Data Entry | Case Report Entry

Home > View & Edit Attending Physician/Clinician Details

VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS

REFRESH | APPLY FILTER

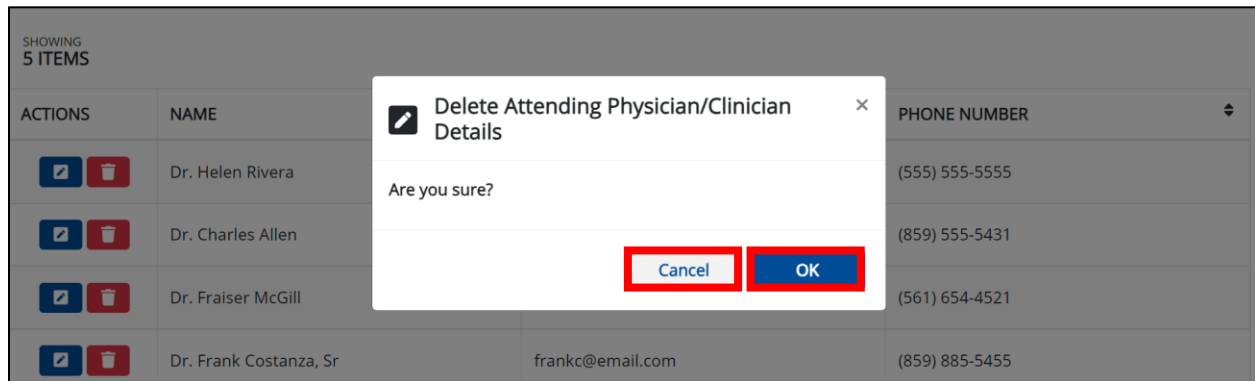
SHOWING 5 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Dr. Helen Rivera	helen@email.com	(555) 555-5555
	Dr. Charles Allen	callen@email.com	(859) 555-5431
	Dr. Fraiser McGill	fraisermcgill@email.com	(561) 654-4521
	Dr. Frank Costanza, Sr	frankc@email.com	(859) 885-5455
	John Smith	john@mailinator.com	(555) 111-1111

First | Back | 1 | Next | Last

Maximum 5 entries per page

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.



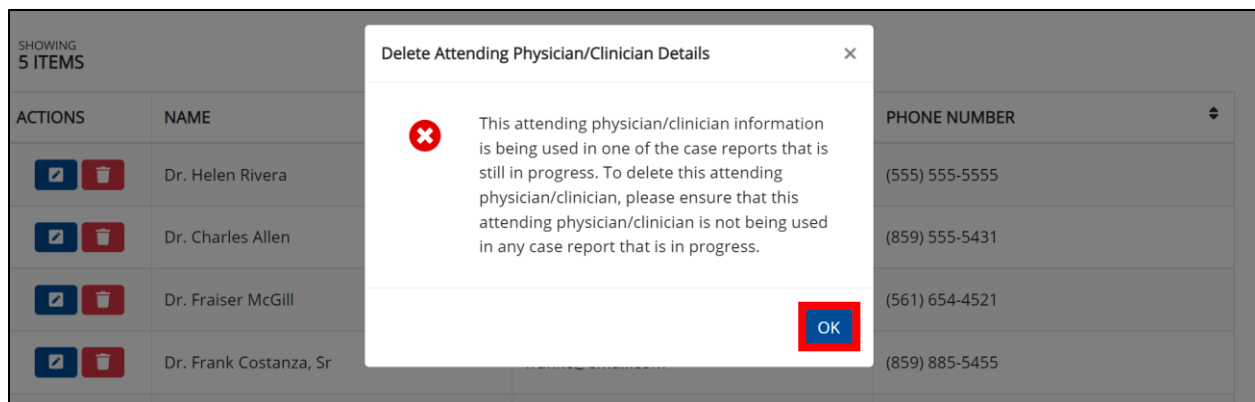
Please Note: You can delete an Attending Physician/Clinician on the **View & Edit Attending Physician/Clinician** screen as long as the Attending Physician/Clinician has not been selected for use in another case report that is still in-progress.

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 (9), Advisories (4), and SIT TEST_17. Below this is a secondary navigation bar with 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 highlighted 'APPLY FILTER' button. Below the title, it says 'SHOWING 5 ITEMS' and displays a table with columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The table lists five physicians: Dr. Helen Rivera, Dr. Charles Allen, Dr. Fraiser McGill, Dr. Frank Costanza, Sr, and John Smith.

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Dr. Helen Rivera	helen@email.com	(555) 555-5555
	Dr. Charles Allen	callen@email.com	(859) 555-5431
	Dr. Fraiser McGill	fraisermcgill@email.com	(561) 654-4521
	Dr. Frank Costanza, Sr	frankc@email.com	(859) 885-5455
	John Smith	john@mailinator.com	(555) 111-1111

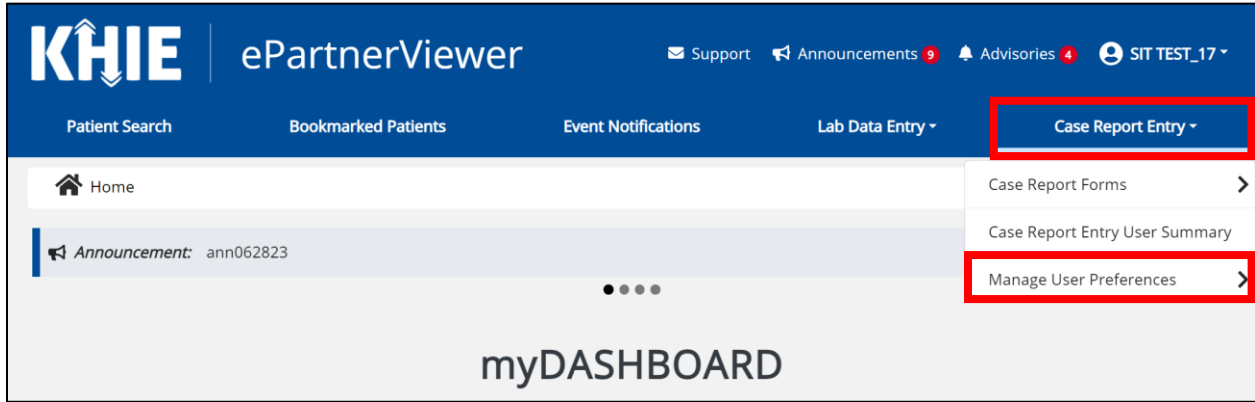
17. The Filter fields display. Search by entering the **Attending Physician/Clinician's Name, Email Address**, and/or **Phone Number** in the corresponding Filter fields.

The screenshot shows the ePartnerViewer interface with filter fields. The top navigation bar is the same as in the previous screenshot. The main content area is titled 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' and includes a 'REFRESH' button and a highlighted 'HIDE FILTER' button. Below the title, it says 'SHOWING 5 ITEMS' and displays a table with columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The table lists five physicians: Dr. Helen Rivera, Dr. Charles Allen, Dr. Fraiser McGill, Dr. Frank Costanza, Sr, and John Smith. The filter fields for NAME, EMAIL, and PHONE NUMBER are highlighted with red boxes.

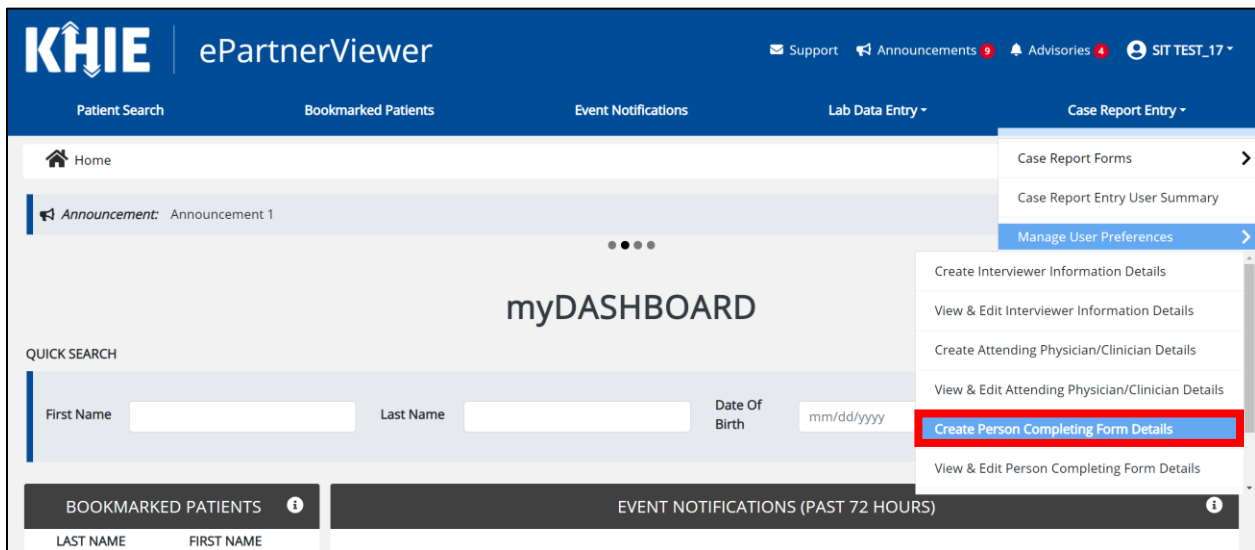
ACTIONS	NAME	EMAIL	PHONE NUMBER
	Dr. Helen Rivera	helen@email.com	(555) 555-5555
	Dr. Charles Allen	callen@email.com	(859) 555-5431
	Dr. Fraiser McGill	fraisermcgill@email.com	(561) 654-4521
	Dr. Frank Costanza, Sr	frankc@email.com	(859) 885-5455

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.



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

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

PERSON COMPLETING FORM

Prefix
Select...

First Name*
[Text Field]

Last Name*
[Text Field]

Suffix
Select...
II
III
IV
Jr
Sr

Address 2
Unit, Suite, Building, etc.

State*
Select...
Zip Code*
[Text Field]

Email*
name@domain.com

(XXX) XXX-XXXX

Clear Save

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

First Name*
[Text Field]

Last Name*
[Text Field]

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

Address 1*
[Text Field]

Address 2
Unit, Suite, Building, etc.

City*
[Text Field]

State*
Select...
Zip Code*
[Text Field]

8. Enter the **Phone Number**.
9. If available, enter the **Email Address**.

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

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

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

PERSON COMPLETING FORM

Prefix
Mr. x v

First Name*
Arthur

Last Name*
Vandelay

Suffix
II x v

Address 1*
22 Second Avenue

Address 2
Unit, Suite, Building, etc.

City*
Bowling Green

State*
KY x v

Zip Code*
42101

Phone*
(222) 222-2222

Email*
arhur@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.

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

Create Person Completing Form Details [X]

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.

[Clear] [Save] [OK]

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

NAME	EMAIL	PHONE NUMBER
Mr. Arthur Vandelay, II		(222) 222-2222
Mr. Marty Craine, Sr		(555) 123-3210
Miss Jane Doe		(555) 123-1234

Update Person Completing Form Details [X]

Person Completing Form details updated successfully

[OK]

First Back 1 Next Last Maximum 5







View & Edit Person Completing Form Details

10. 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 REFRESH APPLY FILTER

SHOWING 3 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
 	Mr. Marty Craine, Sr	marty@email.com	(555) 123-3210
 	Miss Jane Doe	jane@mailinator.com	(555) 123-1234

First Back 1 Next Last Maximum 5 entries per page

11. 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*: Bowling Green State*: KY Zip Code*: 42101

Phone*: (222) 222-2222 Email*: arthur@email.com

Cancel Save

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

NAME	EMAIL	PHONE NUMBER
Mr. Arthur Vandelay, II		(222) 222-2222
Mr. Marty Craine, Sr		(555) 123-3210
Miss Jane Doe		(555) 123-1234

Update Person Completing Form Details

Person Completing Form details updated successfully

OK

First Back 1 Next Last

Maximum

Delete Person Completing the Form Details

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 3 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	Mr. Marty Craine, Sr	marty@email.com	(555) 123-3210
	Miss Jane Doe	jane@mailinator.com	(555) 123-1234

First Back 1 Next Last

Maximum 5 entries per page

14. 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.

NAME	EMAIL	PHONE NUMBER
Mr. Arthur Vandelay, II		(222) 222-2222
Mr. Marty Craine, Sr		(555) 123-3210
Miss Jane Doe		(555) 123-1234

Delete Person Completing Form Details ✕

Are you sure?

Cancel OK

First Back 1 Next Last Maximum 5

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.

NAME	PHONE NUMBER
Mr. Arthur Vandelay, II	(222) 222-2222
Mr. Marty Craine, Sr	(555) 123-3210
Miss Jane Doe	(555) 123-1234

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

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 3 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	Mr. Marty Craine, Sr	marty@email.com	(555) 123-3210
	Miss Jane Doe	jane@mailinator.com	(555) 123-1234

First Back 1 Next Last

Maximum 5 entries per page

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 3 ITEMS

ACTIONS	NAME	EMAIL	PHONE NUMBER
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	Mr. Marty Craine, Sr	marty@email.com	(555) 123-3210
	Miss Jane Doe	jane@mailinator.com	(555) 123-1234

First Back 1 Next Last

Maximum 5 entries per page

5 Basic Features in the Case Report Entry Form

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

Side Navigation Bar & Pagination

On the left side of the Case Report, tabs 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.

VACCINATION HISTORY

Is the patient vaccinated for the condition being reported?*

Yes No Unknown

Vaccine Details

If yes, please provide vaccine name: ?

Select... | v

If other, please specify: ?

If yes, please enter the number of doses: ?

Select... | v

Date Administered (1st dose)

mm/dd/yyyy | Unknown

Date Administered (2nd dose)

mm/dd/yyyy | Unknown

Date Administered (3rd dose)

mm/dd/yyyy | Unknown

+ Add Vaccine

Save

Previous Next

Save Feature

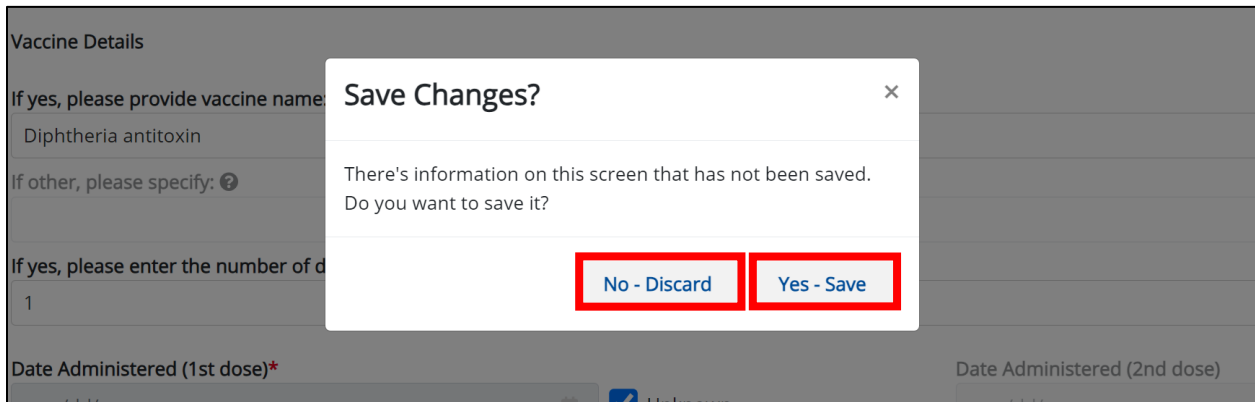
The **Save** feature allows Users to complete the case report form in multiple sessions. You must **save** the information you have entered in order to return later to the place you left off previously.

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



A screenshot of the bottom navigation bar of the application. It contains three buttons: 'Save' (highlighted with a red rectangle), 'Previous' (disabled), and 'Next' (active).

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






A screenshot of the 'Vaccine Details' screen with a 'Save Changes?' pop-up dialog. 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 rectangle. The background shows the 'Vaccine Details' form with fields for 'Vaccine name', 'Specify', 'Number of doses', and 'Date Administered'.

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 Vaccine Preventable Diseases 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** to the conditional question at the top of the **Laboratory Information** screen of the Vaccine Preventable Diseases Case Report, the subsequent fields will be grayed out and disabled.


LABORATORY INFORMATION


Patient Information 


Laboratory Information 


Applicable Symptoms

Additional Information 

Hospitalization, ICU & Death Information 

Vaccination History 

Additional Comments 

Review & Submit 

Does the patient have a lab test?*

Yes

No

Unknown

Laboratory Information

Laboratory Name

Test Name

Select...

If other, please specify: ?

Filler Order/Accession Number ?

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

LABORATORY INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name*

Test Name*

Select...

If other, please specify: ?

Filler Order/Accession Number ?

Specimen Source*

Select...

Additionally, if **No** or **Unknown** is selected for certain conditional questions, the screen will be disabled and the subsequent fields will be marked as **No** or **Unknown**, based on the selected answer. These conditional questions are found on the **Applicable Symptoms** and **Additional Information** screens.

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

APPLICABLE SYMPTOMS

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Were symptoms present during the course of illness?*

Yes **No** Unknown

Onset Date ?

mm/dd/yyyy ☐ Unknown

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

Fever

Yes **No** Unknown

If yes, please enter the highest temperature: ?

Diarrhea (>3 loose stools/24hr period)

Yes **No** Unknown

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

Chills

Yes **No** Unknown

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

The screenshot shows the 'APPLICABLE SYMPTOMS' screen. On the left is a sidebar with navigation links: Patient Information, Laboratory Information, Applicable Symptoms (highlighted), Additional Information, Hospitalization, ICU & Death Information, Vaccination History, Additional Comments, and Review & Submit. The main content area has the title 'APPLICABLE SYMPTOMS'. The first question is 'Were symptoms present during the course of illness?*' with buttons for 'Yes', 'No', and 'Unknown'. The 'Unknown' button is highlighted with a red box. Below this, the 'Onset Date' field is disabled and labeled 'Unknown'. The question 'If symptomatic, which of the following did the patient experience during their illness?' is followed by 'Fever' with 'Yes', 'No', and 'Unknown' buttons, all disabled. Below 'Fever' is a text input field for 'If yes, please enter the highest temperature:'. Then 'Diarrhea (>3 loose stools/24hr period)' with 'Yes', 'No', and 'Unknown' buttons, all disabled. Below 'Diarrhea' is a text input field for 'If yes, please enter # of days of diarrhea:'. Finally, 'Chills' with 'Yes', 'No', and 'Unknown' buttons, all disabled.

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

The screenshot shows the 'APPLICABLE SYMPTOMS' screen. On the left is a sidebar with navigation links: Patient Information, Laboratory Information, Applicable Symptoms (highlighted), Additional Information, Hospitalization, ICU & Death Information, Vaccination History, Additional Comments, and Review & Submit. The main content area has the title 'APPLICABLE SYMPTOMS'. The first question is 'Were symptoms present during the course of illness?*' with buttons for 'Yes', 'No', and 'Unknown'. The 'Yes' button is highlighted with a red box. Below this, the 'Onset Date' field is enabled and labeled 'Onset Date*'. The question 'If symptomatic, which of the following did the patient experience during their illness?' is followed by 'Fever*' with 'Yes', 'No', and 'Unknown' buttons, all enabled. Below 'Fever' is a text input field for 'If yes, please enter the highest temperature:'. Then 'Diarrhea (>3 loose stools/24hr period)*' with 'Yes', 'No', and 'Unknown' buttons, all enabled. Below 'Diarrhea' is a text input field for 'If yes, please enter # of days of diarrhea:'. Finally, 'Chills*' with 'Yes', 'No', and 'Unknown' buttons, all enabled. A red box highlights the entire section of symptom questions and answers.

6 Affiliation/Organization Conditional Question

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

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

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

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

The screenshot shows a form titled "Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*" with two buttons: "Yes" and "No". Below this, there are three rows of input fields. Each row has a label (Patient ID (MRN), Person Completing Form, Attending Physician/Clinician), a dropdown menu for "Affiliation/Organization", and a text field for "If other, please specify:". The "Yes" button is highlighted with a red border.

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

Affiliation/Organization Conditional Answer: Yes

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

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

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

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

Yes No

Patient ID (MRN)* ?

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: ?

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

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

Yes No

Patient ID (MRN)* ?

Affiliation/Organization* ? Test Medical Center x ?

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

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

Affiliation/Organization Conditional Answer: No

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

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

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

Yes **No**

Patient ID (MRN)* Affiliation/Organization*

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

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

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

Patient ID (MRN)*

Person Completing Form*

Attending Physician/Clinician*

Prefix

Affiliation/Organization*

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

If other, please specify:

If other, please specify:

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

Person Completing Form*

Attending Physician/Clinician*

Prefix

First Name*

Suffix

Affiliation/Organization*

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

If other, please specify:

If other, please specify:

Last Name*

Date of Birth*

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

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

Patient ID (MRN)* ?

Affiliation/Organization* ?

[Person Completing Form*](#)

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).

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

Person Completing Form*

Affiliation/Organization* ?

If other, please specify:* ?

Attending Physician/Clinician*

Affiliation/Organization* ?

If other, please specify: ?

Prefix

First Name*

Suffix

Patient Sex*

Ethnicity*

Race*

Last Name*

Please select the organization of the physician attending the patient.

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

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

Attending Physician/Clinician*

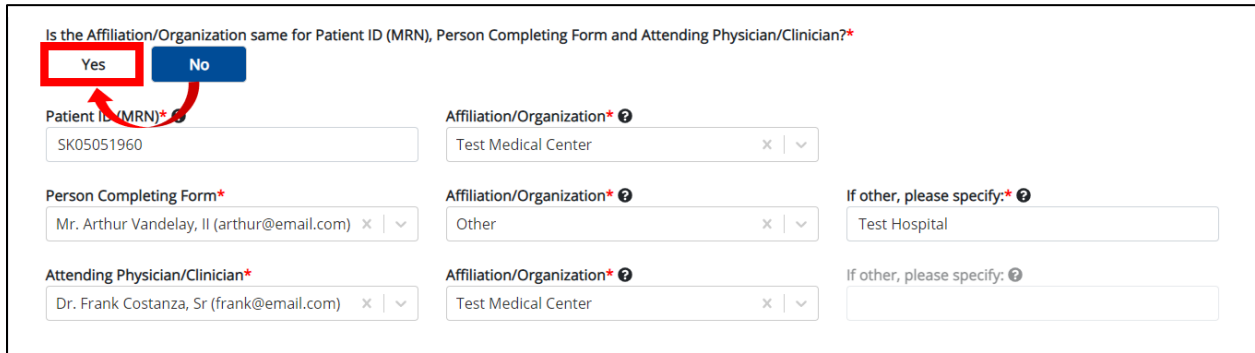
Affiliation/Organization* ?

If other, please specify:* ?

Affiliation/Organization Validation

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

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



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

Yes **No**

Patient ID (MRN)* SK05051960

Affiliation/Organization* Test Medical Center

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

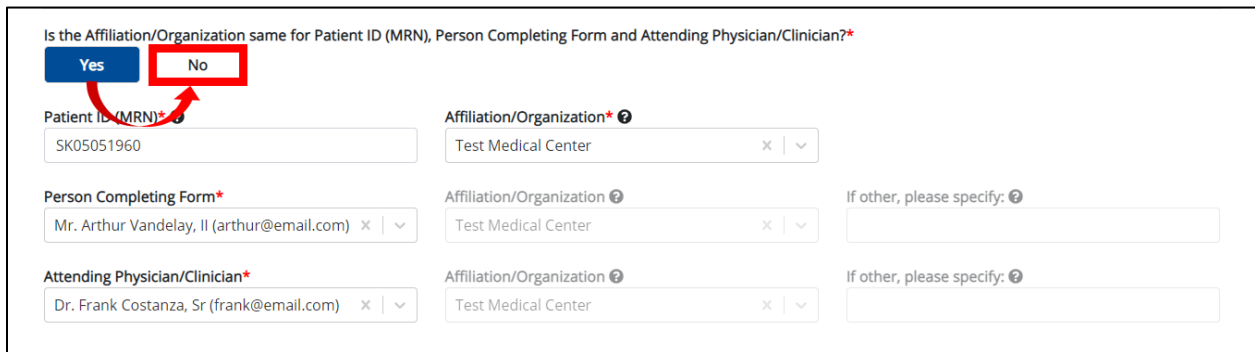
Affiliation/Organization* Other

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)

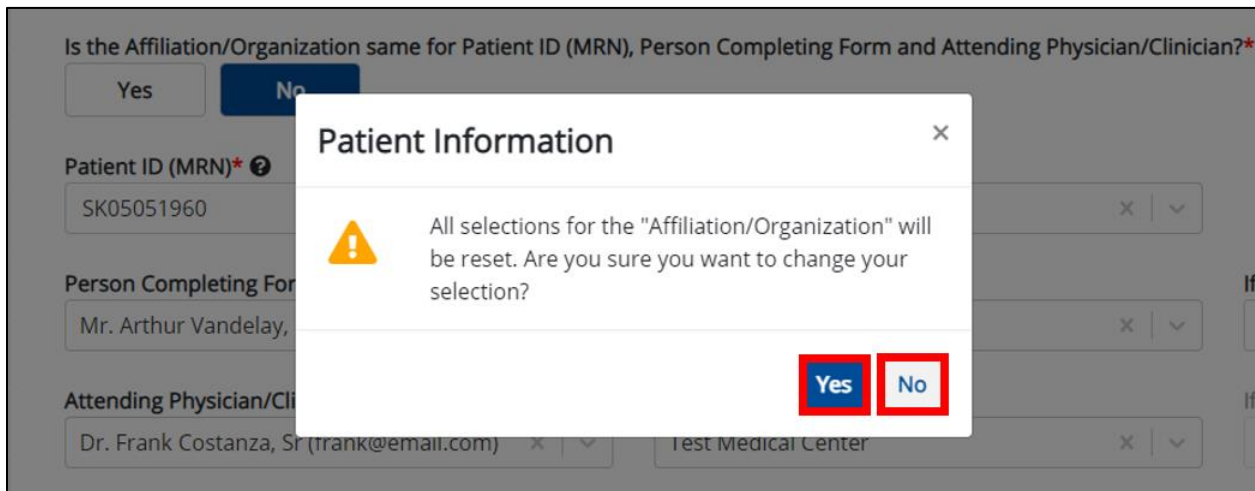
Affiliation/Organization* Test Medical Center

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

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

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 question from **No** to **Yes**, a pop-up message will display.

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

Yes **No**

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

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

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

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

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

Yes **No**

Patient ID (MRN)* SK05051960

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

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

Affiliation/Organization* Test Medical Center

If other, please specify: Test Hospital

If other, please specify:

Patient Information

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

Yes **No**

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

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

PATIENT INFORMATION

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

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

Yes **No**

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

Please Enter Affiliation/Organization

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

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

Patient ID (MRN)*

SK05051960

Person Completing Form*

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

Attending Physician/Clinician*

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

Prefix

Ms. x | v

Affiliation/Organization*

Select...

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical Center

If other, please specify:

If other, please specify:

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

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

Patient ID (MRN)*

SK05051960

Affiliation/Organization*

Test Medical Center x | v

Person Completing Form*

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

Attending Physician/Clinician*

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

Affiliation/Organization

Test Medical Center x | v

Affiliation/Organization

Test Medical Center x | v

If other, please specify:

If other, please specify:

Change Affiliation/Organization Conditional Answer: Yes to No

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

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

Yes **No**

Patient ID (MRN)* Affiliation/Organization*

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

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

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

Patient Information

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

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)* Affiliation/Organization*

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

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

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

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

Yes No

Patient ID (MRN)*
SR05051960

Person Completing Form*
Select...

Attending Physician/Clinician*
Select...

Prefix
Select...

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

If other, please specify: ?

If other, please specify: ?

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

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

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

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

Prefix
Select...

First Name*
Last Name*

Suffix
Select...

Patient Sex* Ethnicity* Race*

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

If other, please specify: ?

If other, please specify: ?

Please Note: If 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)

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

Affiliation/Organization*
Other x | v

Affiliation/Organization*
Other x | v

If other, please specify: ?

If other, please specify: ?

7 Tips for Manually Entering Case Report Data

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

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

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

PATIENT INFORMATION	
Patient Information	Disease/Organism* Diphtheria
Laboratory Information	Date of Diagnosis* 01/22/2024 <input type="checkbox"/> Unknown

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

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

PATIENT INFORMATION	
Patient Information	Disease/Organism* Diphtheria
Laboratory Information	Date of Diagnosis* 01/22/2024 <input type="checkbox"/> Unknown
Applicable Symptoms	Is this patient a resident of the State of Kentucky? <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Information	MRN or Medical Record Number* An MRN or Medical Record Number is an Organization specific, unique identification number assigned to a patient by a healthcare organization. If your organization does not use an MRN, you MUST create a way to uniquely identify your patient.
Hospitalization, ICU & Death Information	Patient ID (MRN)*
Vaccination History	Affiliation/Organization* Evergreen General Hospital

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

City* 	State* KY	Zip Code*
County* Select...	Phone* (XXX) XXX-XXXX	Email name@domain.com
Adair Allen Anderson Ballard Barren Bath Bell	Encounter ID/Visit #* <input type="checkbox"/> Generate	<input type="checkbox"/> Unknown

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

City*

State*

Zip Code*

County*

Phone*

Email

- 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

☐ Still hospitalized

Intensive care unit (ICU)?*

Discharge Date from ICU

☐ Unknown

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

Admission Date*

☒ Unknown

Discharge Date*

☐ Unknown

☐ Still hospitalized

8 Vaccine Preventable Diseases Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the Vaccine Preventable Diseases Case Report Form in the ePartnerViewer.

1. To enter Vaccine Preventable 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.

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar is blue and contains the following tabs: Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The 'Case Report Entry' tab is highlighted with a red box. Below the navigation bar, there is a 'Home' button and an 'Announcement' section. The main content area is titled 'myDASHBOARD' and includes a 'QUICK SEARCH' section with fields for First Name, Last Name, and Date Of Birth. Below the search section, there are two panels: 'BOOKMARKED PATIENTS' and 'EVENT NOTIFICATIONS (PAST 72 HOURS)'. The 'BOOKMARKED PATIENTS' panel shows a table with columns 'LAST NAME' and 'FIRST NAME', and a row with 'HALLEY' and 'IAN'. The 'EVENT NOTIFICATIONS' panel shows 'There is no data to be displayed'. On the right side of the interface, there is a dropdown menu for 'Case Report Entry' which is open, showing options: Case Report Forms, Case Report Entry User Summary, and Manage User Preferences. The 'Case Report Forms' option is highlighted with a red box.

2. Select **Vaccine Preventable Diseases** from the dropdown menu.

The screenshot shows the KHIE ePartnerViewer interface with the 'Case Report Entry' tab selected in the navigation bar. The dropdown menu for 'Case Report Entry' is open, showing options: Case Report Forms, COVID-19, Sexually Transmitted Diseases, Multi-drug Resistant Organism, Other Reportable Conditions, Vaccine Preventable Diseases, and Hepatitis Case Report Forms. The 'Vaccine Preventable Diseases' option is highlighted with a red box. The rest of the interface is the same as the previous screenshot.

9 Patient Information

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 1 of 8

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*
Select...

Date of Diagnosis*
mm/dd/yyyy

Unknown

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

Yes No

Patient ID (MRN)
Select...

Affiliation/Organization
Select...

Person Completing Form
Select...

Affiliation/Organization
Select...

If other, please specify:

Attending Physician/Clinician
Select...

Affiliation/Organization
Select...

If other, please specify:

Prefix
Select...

First Name*
Middle Name
Last Name*

Suffix
Select...

Date of Birth*
mm/dd/yyyy

Patient Sex*
Select...

Ethnicity*
Select...

Race*
Select...

Please Note: This user guide outlines the generic workflow for the **Vaccine Preventable Diseases Case Report Form**. All examples and screenshots used in this guide are simulated with the condition **Diphtheria**.

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

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

PATIENT INFORMATION

Disease/Organism*

Select...

Date of Diagnosis*

mm/dd/yyyy

Unknown

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

Yes

No

Patient ID (MRN)

Affiliation/Organization

Select...

Person Completing Form

Select...

Affiliation/Organization

Select...

If other, please specify:

Attending Physician/Clinician

Select...

Affiliation/Organization

Select...

If other, please specify:

Prefix

Select...

First Name*

Middle Name

Last Name*

Suffix

Select...

Date of Birth*

mm/dd/yyyy

Patient Sex*

Select...

Ethnicity*

Select...

Race*

Select...

Address 1*

Address 2

Unit, Suite, Building, etc.

City*

State*

Select...

Zip Code*

County*

Select...

Phone*

(xxx) xxx-xxxx

Email

name@domain.com

Visit Type*

Select...

Encounter ID/Visit #*

Generate

Is the patient currently pregnant?

Yes

No

Unknown

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

mm/dd/yyyy

Unknown

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

Please Note: You are required to enter the details associated with the *Person Completing Form* and the *Attending Physician/Clinician* prior to entering Vaccine Preventable Diseases information. If you access the Vaccine Preventable Diseases 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 Vaccine Preventable Diseases Case Report details.

- To start the Vaccine Preventable Diseases Case Report entry, select the appropriate **Disease/Organism** from the *Disease/Organism* dropdown on the **Patient Information** screen.

- Enter the **Date of Diagnosis**.

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

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

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

Patient ID (MRN) ?

Affiliation/Organization ?

Select...

▼

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

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

Patient ID (MRN)* ?

[Person Completing Form](#) *

Select...

▼

[Attending Physician/Clinician](#) *

Select...

▼

Affiliation/Organization* ?

Select...

▼

Affiliation/Organization ?

Select...

▼

If other, please specify: ?

Affiliation/Organization ?

Select...

▼

If other, please specify: ?

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

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

Patient ID (MRN)* ?

[Person Completing Form](#) *

Select...

▼

[Attending Physician/Clinician](#) *

Select...

▼

Affiliation/Organization* ?

Select...

▼

Affiliation/Organization* ?

Select...

▼

If other, please specify: ?

Affiliation/Organization* ?

Select...

▼

If other, please specify: ?

Direct Data Entry for Case Reports:
Vaccine Preventable Diseases Guide

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Kentucky Health Information
Exchange

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

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

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

Patient ID (MRN)* ? <input type="text" value="EB19039283"/>	Affiliation/Organization* ? <input type="text" value="Select..."/>	If other, please specify: ? <input type="text"/>
Person Completing Form* <input type="text" value="Select..."/>	Eugene Hospital Evergreen General Hospital Green Hosp Heartland Clinic Hilton Hospital Howell Hospital Knight Hospital Knoll Hospital	If other, please specify: ? <input type="text"/>
Attending Physician/Clinician* <input type="text" value="Select..."/>		
Prefix <input type="text" value="Select..."/>		

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.

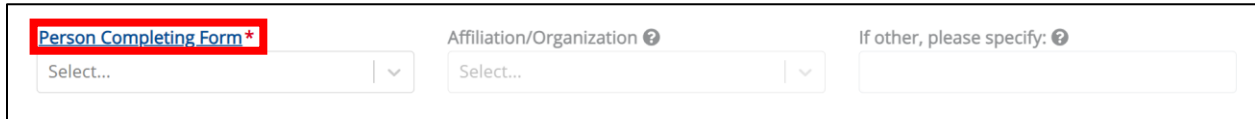
- From the dropdown menu, select the name of the **Person Completing Form**.

<input type="button" value="Yes"/> <input type="button" value="No"/>		
Patient ID (MRN)* ? <input type="text" value="EB192465"/>	Affiliation/Organization* ? <input type="text" value="Evergreen General Hospital"/>	
Person Completing Form* <input type="text" value="Select..."/>	Affiliation/Organization ? <input type="text" value="Evergreen General Hospital"/>	If other, please specify: ? <input type="text"/>
Jane Doe (jane@mailinator.com) Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization ? <input type="text" value="Evergreen General Hospital"/>	If other, please specify: ? <input type="text"/>

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

Person Completing Form Hyperlink

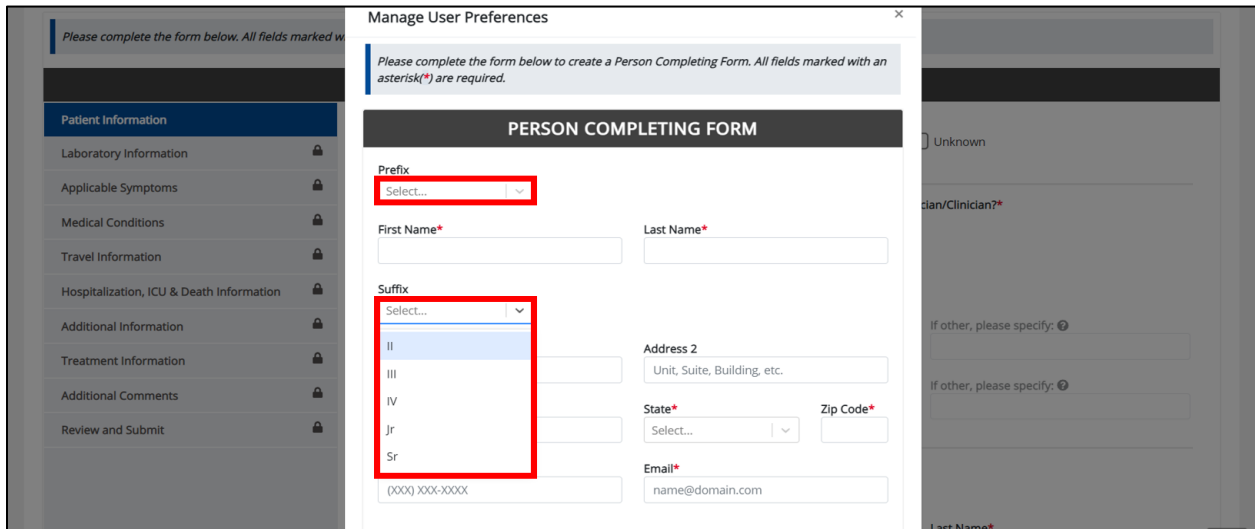
8. To create details for a new Person Completing Form, click the **Person Completing Form** hyperlink.



The screenshot shows the top navigation bar of the application. The 'Person Completing Form' link is highlighted with a red rectangular box. To its right are two dropdown menus labeled 'Affiliation/Organization' and 'If other, please specify:'. Below these are three input fields: a dropdown menu with 'Select...' text, another dropdown menu with 'Select...' text, and a text input field.

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.



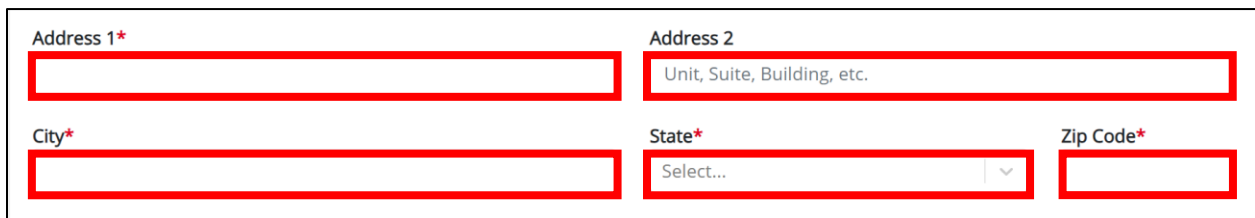
The screenshot shows the 'Person Completing Form' pop-up window. The 'Prefix' dropdown menu is highlighted with a red box, showing a list of options including 'II', 'III', 'IV', 'Jr', and 'Sr'. The 'Suffix' dropdown menu is also highlighted with a red box, showing a list of options including 'II', 'III', 'IV', 'Jr', and 'Sr'. The form includes fields for 'First Name*', 'Last Name*', 'Address 2', 'State*', 'Zip Code*', and 'Email*'. The 'First Name' and 'Last Name' fields are highlighted with red boxes.

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



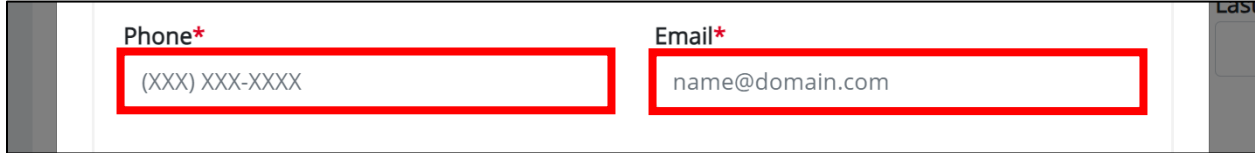
The screenshot shows the 'First Name*' and 'Last Name*' input fields. Both fields are highlighted with red rectangular boxes.

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



The screenshot shows the 'Address 1*', 'Address 2', 'City*', 'State*', and 'Zip Code*' input fields. 'Address 1' and 'Address 2' are highlighted with red boxes. 'City' and 'State' are highlighted with red boxes. 'Zip Code' is highlighted with a red box.

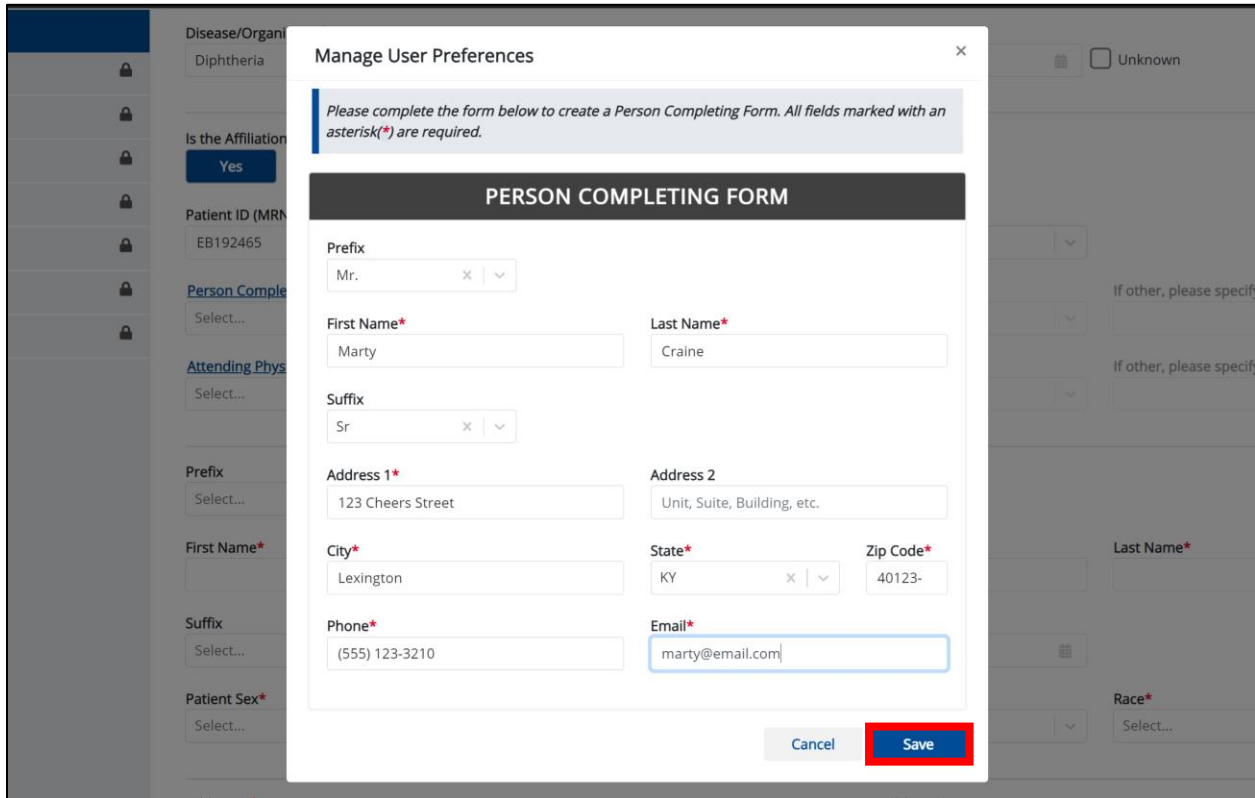
13. Enter the **Phone Number** and **Email Address**.



Phone* (XXX) XXX-XXXX

Email* name@domain.com

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



Manage User Preferences

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

PERSON COMPLETING FORM

Prefix: Mr.

First Name*: Marty

Last Name*: Craine

Suffix: Sr

Address 1*: 123 Cheers Street

Address 2: Unit, Suite, Building, etc.

City*: Lexington

State*: KY

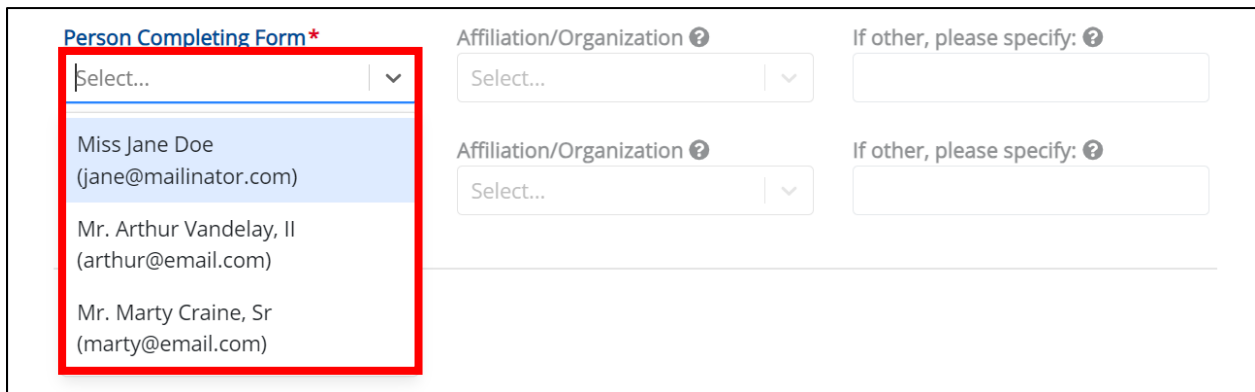
Zip Code*: 40123-

Phone*: (555) 123-3210

Email*: marty@email.com

Cancel Save

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



Person Completing Form*

Select...

Miss Jane Doe (jane@mailinator.com)

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

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

Affiliation/Organization ?

Select...

If other, please specify: ?

Affiliation/Organization ?

Select...

If other, please specify: ?

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

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

Yes No

Patient ID (MRN)* ?
EB192465

Affiliation/Organization* ?
Evergreen

Please select the organization of the person completing this form.

Person Completing Form*
Select...

Attending Physician/Clinician*
Select...

Prefix
Select...

First Name*
Last Name*

Affiliation/Organization* ?
Select...
Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaa aa
Baxter Hospital
DDE SMOKE TEST SIT NONCOVID
Eugene Hospital
Evergreen General Hospital
Green Hosp
Heartland Clinic

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

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

- 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)* ?
EB192465

Affiliation/Organization* ?
Evergreen General Hospital

Person Completing Form*
Select...

Attending Physician/Clinician*
Select...

Affiliation/Organization* ?
Other

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

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

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

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.

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

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

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

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

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

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

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

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

Bookma

able Diseases Case Report

E DISEASES CASE

elow. All fields marked with

Information

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
 x v

First Name*

Last Name*

Suffix

Address 1*

Address 2

City*

State*
 x v

Zip Code*

Phone*

Email

Cancel **Save**

Unknown

n/Clinician?*

If other, please specify: ?

If other, please specify: ?

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

Attending Physician/Clinician*

Select...

Dr. Charles Allen (callen@email.com)

Dr. Fraiser McGill (fraisermcgill@email.com)

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

John Smith (john@mailinator.com)

Affiliation/Organization* ?

Select...

If other, please specify: ?

Middle Name

Last Name*

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

Attending Physician/Clinician*

Dr. Charles Allen (callen@email.com) x | v

Prefix

Select...

First Name*

Suffix

Select...

Affiliation/Organization* ?

Select...

Afzal, Mohammad MD, Internal Medicine, LLC
aaaaaaaaaaaaaaaa aa

Baxter Hospital

DDE SMOKE TEST SIT NONCOVID

Eugene Hospital

Evergreen General Hospital

Green Hosp

Heartland Clinic

If other, please specify: ?

Last Name*

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

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

Person Completing Form*

Select...

Affiliation/Organization* ?

Other x | v

If other, please specify: * ?

Test Hospital

Attending Physician/Clinician*

Dr. Charles Allen (callen@email.com) x | v

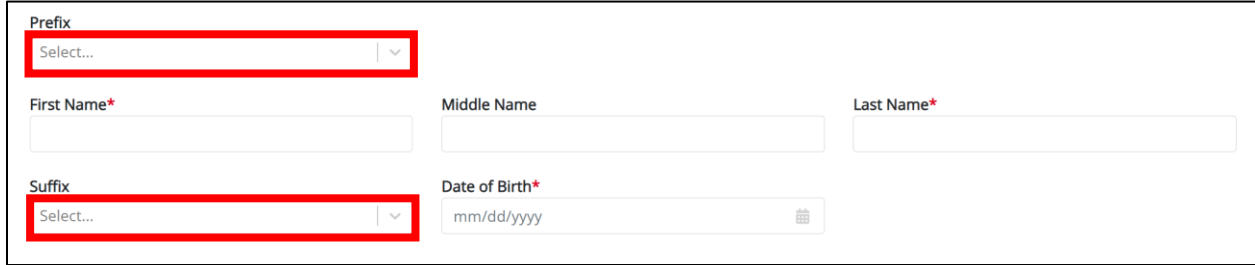
Affiliation/Organization* ?

Other x | v

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.



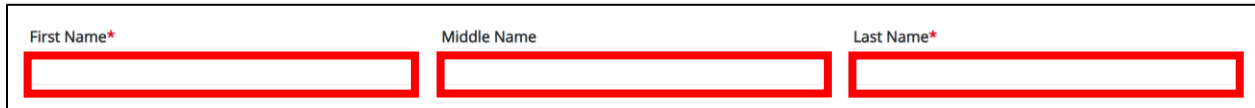
Prefix
Select...

First Name* Middle Name Last Name*

Suffix
Select...

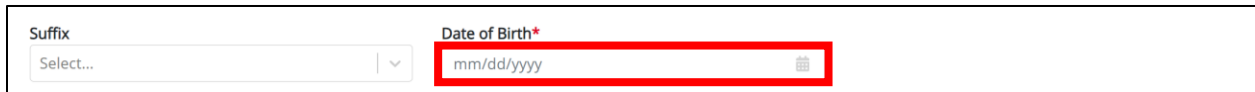
Date of Birth*
mm/dd/yyyy

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



First Name* Middle Name Last Name*

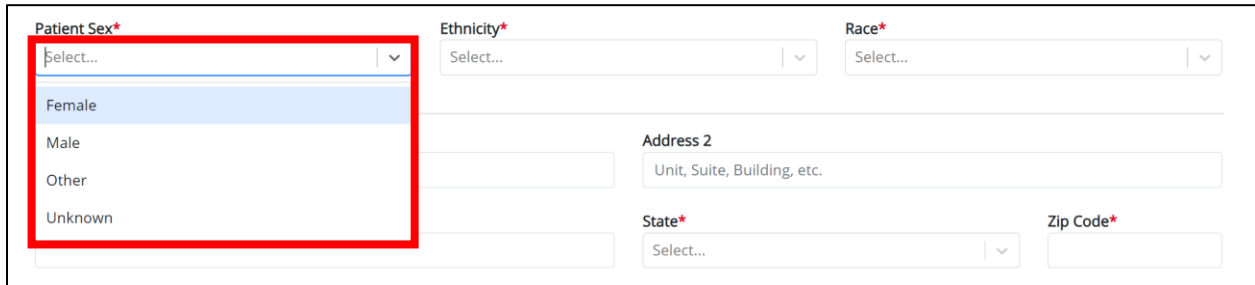
29. Enter the patient's **Date of Birth**.



Suffix
Select...

Date of Birth*
mm/dd/yyyy

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



Patient Sex*
Select...
Female
Male
Other
Unknown

Ethnicity*
Select...

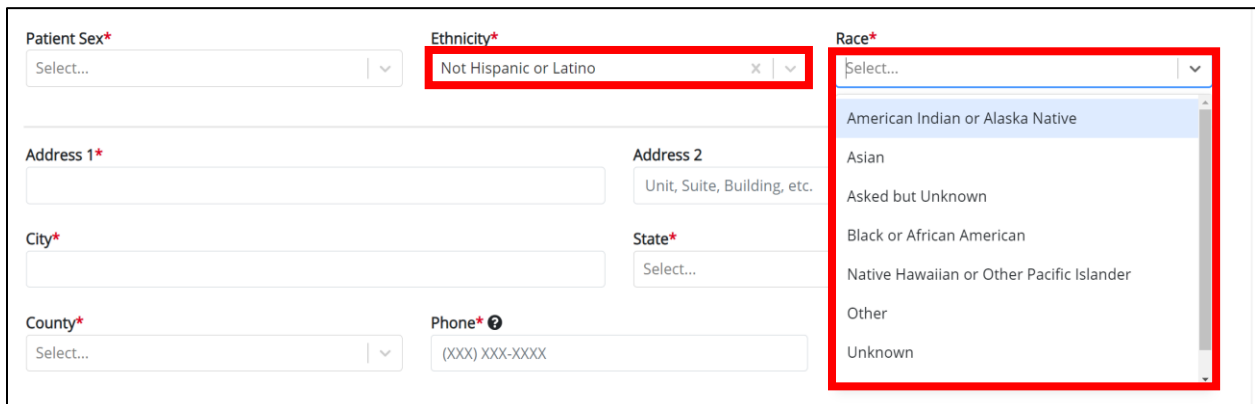
Race*
Select...

Address 2
Unit, Suite, Building, etc.

State*
Select...

Zip Code*

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



Patient Sex*
Select...

Ethnicity*
Not Hispanic or Latino

Race*
Select...
American Indian or Alaska Native
Asian
Asked but Unknown
Black or African American
Native Hawaiian or Other Pacific Islander
Other
Unknown

Address 1*
City*
County*
Select...

Address 2
Unit, Suite, Building, etc.

State*
Select...

Phone*
(XXX) XXX-XXXX

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

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

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

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

123 First Avenue
Unit, Suite, Building, etc.
City*
Lexington
State*
KY
Zip Code*
40509-
County*
Fayette
Phone*
(XXX) XXX-XXXX
Email
name@domain.com

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

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

Visit Type*
Select...
Ambulatory
Emergency
Field
Home Health
Inpatient Acute
Inpatient Encounter
Inpatient Non-Acute
Encounter ID/Visit #*
Generate
Next

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

Lexington
County*
Fayette
Phone*
(55)
Email
name@domain.com
Visit Type*
Emergency
Encounter ID/Visit #*
Generate

Enter an Encounter ID/Visit #.
If the Encounter ID/Visit # is unknown, click the Generate checkbox to create a unique Encounter ID/Visit #.

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

Visit Type* **Encounter ID/Visit #* ?** ☐ Generate

Patient ID (MRN)* ? Prefix

First Name* Middle Name Last Name*

Patient Case History

SHOWING 2 ITEMS

CREATION DATE TIME	REPORT NAME	CONDITION NAME	VISIT TYPE	ENCOUNTER ID
05/31/2023 9:08 AM	Other Conditions	Adult Botulism	Inpatient Encounter	10000000000000000073
05/30/2023 12:47 PM	COVID-19	COVID-19	Ambulatory	10000000000000000072

Visit Type* **Encounter ID/Visit #* ?** ☐ Generate

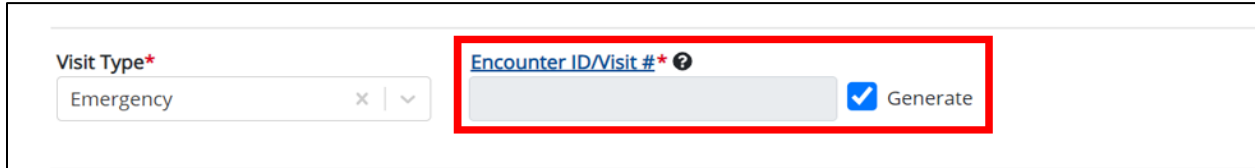
Please Note: The *Patient Case History* will display only those historical case reports that include the *Visit Type* and *Encounter ID/Visit #* field values.

The *Patient Case History* pop-up is a new feature and will **not** display case reports submitted before the *Visit Type* and *Encounter ID/Visit #* fields were included on all case reports.

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

Visit Type* **Encounter ID/Visit #* ?** ☐ Generate

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



Visit Type*
Emergency x v

Encounter ID/Visit #* ?
[Greyed out field] ☒ Generate

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



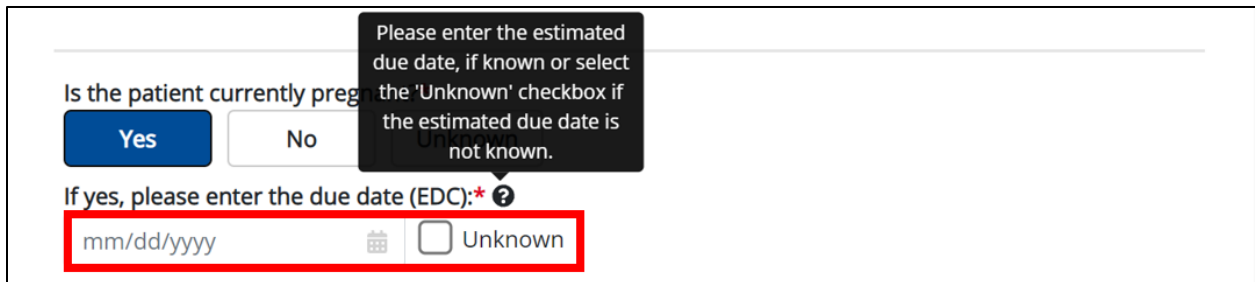
Is the patient currently pregnant?*

Yes No Unknown

If yes, please enter the due date (EDC): ?
mm/dd/yyyy [Calendar icon] ☐ Unknown

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

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




Is the patient currently pregnant?

Yes No Unknown

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

If yes, please enter the due date (EDC):* ?
mm/dd/yyyy [Calendar icon] ☐ Unknown

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



Is the patient currently pregnant?*

Yes No Unknown

If yes, please enter the due date (EDC): ?
mm/dd/yyyy [Calendar icon] ☐ Unknown

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

38. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following messages to confirm the selected **Disease/Organism** and the **Encounter ID/Visit #** for the case report:

- *You have selected to file this case report for [selected Disease/Organism]. 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 [Disease/Organism]?*
- *Please note that you will not be able to change/update Encounter ID/Visit # after you save this screen or proceed to the next screen.*

39. To proceed, click **Yes** on the *Patient Information* pop-up to confirm the selected **Disease/Organism** and the **Encounter ID/Visit #**. Clicking **Yes** will save the completed **Patient Information** screen.

10 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?*

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 2 of 8

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information ☒

Laboratory Information

Applicable Symptoms ☐

Additional Information ☐

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name

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

LABORATORY INFORMATION

Patient Information ☒

Laboratory Information

Applicable Symptoms ☐

Additional Information ☐

Hospitalization, ICU & Death Information ☐

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name*

Test Name*

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

+ Add Test

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

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

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name*

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

Laboratory Information

Laboratory Name*

Lab Test

Test Name*

Select...

Corynebacterium diphtheriae toxin Ab [Presence] in Serum

Corynebacterium diphtheriae [Presence] in Specimen by Organism specific culture

Diphtheria identified in Isolate by Organism specific culture

Other

- If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Test Name** in the subsequent textbox: *If other, please specify.*

Test Result*

Other

Please enter the test result information like reference range, physical quantity etc, if applicable

If other, please specify:*

- If applicable, enter the **Filler Order/Accession Number** in the textbox.

Test Name*

Other

If other, please specify:*

Other Test

Please enter filler order number or accession number.

Filler Order/Accession Number ?

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

The screenshot shows a web form with a field labeled "Filler Order/Accession Number" containing the text "010101010101010". Below this is a dropdown menu labeled "Specimen Source*". The dropdown is open, showing a list of options: "Select...", "Abscess", "Amniotic fluid", "Aspirate", "Bile fluid", "Blood - cord", "Blood arterial", and "Blood bag". The "Select..." option is currently selected and highlighted in blue. A red rectangular box is drawn around the entire dropdown menu area.

- If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Specimen Source** in the subsequent textbox: *If other, please specify.*

The screenshot shows the "Specimen Source*" dropdown menu with "Other" selected. A tooltip message is displayed over the dropdown, stating: "Please enter the specimen name/description if it is not listed in the Specimen Source dropdown list." Below the dropdown is a text input field labeled "If other, please specify:*". A red rectangular box is drawn around this text input field.

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

The screenshot shows a web form with a dropdown menu labeled "Test Result*". The dropdown is open, showing a list of options: "Select...", "Negative", "Pending", "Positive", "Undetermined/Inconclusive", and "Other". The "Select..." option is currently selected and highlighted in blue. A red rectangular box is drawn around the entire dropdown menu area.

- If **Other** is selected from the dropdown menu, the subsequent field is enabled. You must enter the **Test Result** in the subsequent textbox: *If other, please specify.*

Test Result*
Other

Please enter the test result information like reference range, physical quantity etc, if applicable

If other, please specify:* ?
Abnormal Quantity detected greater than .009

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

Test Result Date*
mm/dd/yyyy

Specimen Collection Date*
mm/dd/yyyy

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*
01/01/2024
Invalid Test Result Date

Specimen Collection Date*
01/04/2024
Invalid Specimen Collection Date

9. If applicable, enter **additional notes about the lab tests** in the *Additional Information* textbox.

If other, please specify:* ?
Abnormal Quantity detected greater than .009

Test Result Date*
01/01/2024

Specimen Collection Date*
01/01/2024

Additional Information ?
0/300 Characters

+ Add Test

Adding Multiple Tests

- Click **Add Test** to log the details for multiple tests. This means that you can easily enter additional test details on the same patient.

Additional Information ?

Test 1 details

14/300 Characters

+ Add Test

Save Previous Next

Please Note: When you click the **Add Test** button, at least one lab test section must be entered.

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

Test 1 details

14/300 Characters

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

+ Add Test

Save Previous Next

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

Laboratory Information

Laboratory Name*

Test

Test Name*

Other

If other, please specify:*

Other Test

Filler Order/Accession Number ?

010101010101010

Specimen Source*

Other

If other, please specify:*

Other Specimen Source

Test Result*

Other

If other, please specify:*

Abnormal Quantity detected greater than .009

Test Result Date*

01/01/2024

Unknown

Specimen Collection Date*

01/01/2024

Unknown

Additional Information ?

0/300 Characters

+ Add Test

Save

Previous

Next

11 Applicable Symptoms

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM Section 3 of 8

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms

Additional Information 🔒

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date ?

mm/dd/yyyy 📅 ☐ 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

Additional Information 🔒

Hospitalization, ICU & Death Information 🔒

Vaccination History 🔒

Additional Comments 🔒

Review & Submit 🔒

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date* ?

mm/dd/yyyy 📅 ☐ Unknown

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

Fever*

Yes No Unknown

If yes, please enter the highest temperature: 🌡️

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

Yes No Unknown

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

Chills*

Yes No Unknown

Cough*

Yes No Unknown

Dysphagia (difficulty swallowing)*

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**.

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

APPLICABLE SYMPTOMS

Were symptoms present during the course of illness?*

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

Onset Date* ?

mm/dd/yyyy ☐ Unknown

January 2024

Su	Mo	Tu	We	Th	Fr	Sa
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	31	1	2	3

Following did the patient experience during their illness?

Temperature: ?

Period)*

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

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

Fever*

If yes, please enter the highest temperature: ?

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

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

Fever*

If yes, please enter the highest temperature: * ?

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

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

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

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

 If yes, please enter number of days with diarrhea:*

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

Chills*

Cough*

Dysphagia (difficulty swallowing)*

Exudate Over Tonsils, Pharynx Or Larynx*

Fatigue*

Headache*

Hoarseness*

Lymphadenopathy*

Malaise*

Nausea*

Runny Nose*

Shortness of Breath*

Skin Rash*

Skin Ulcer*

Sore throat*

Weakness*

Please Note: This user guide shows the generic workflow for the **Vaccine Preventable Diseases Case Report Form**. The **Applicable Symptoms** screen dynamically populates symptoms based on the selected condition. All examples and screenshots used in this guide are simulated with the condition **Diphtheria**.

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

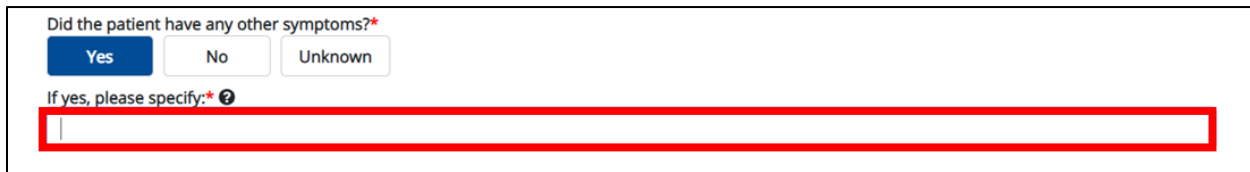


Did the patient have any other symptoms?*

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*.

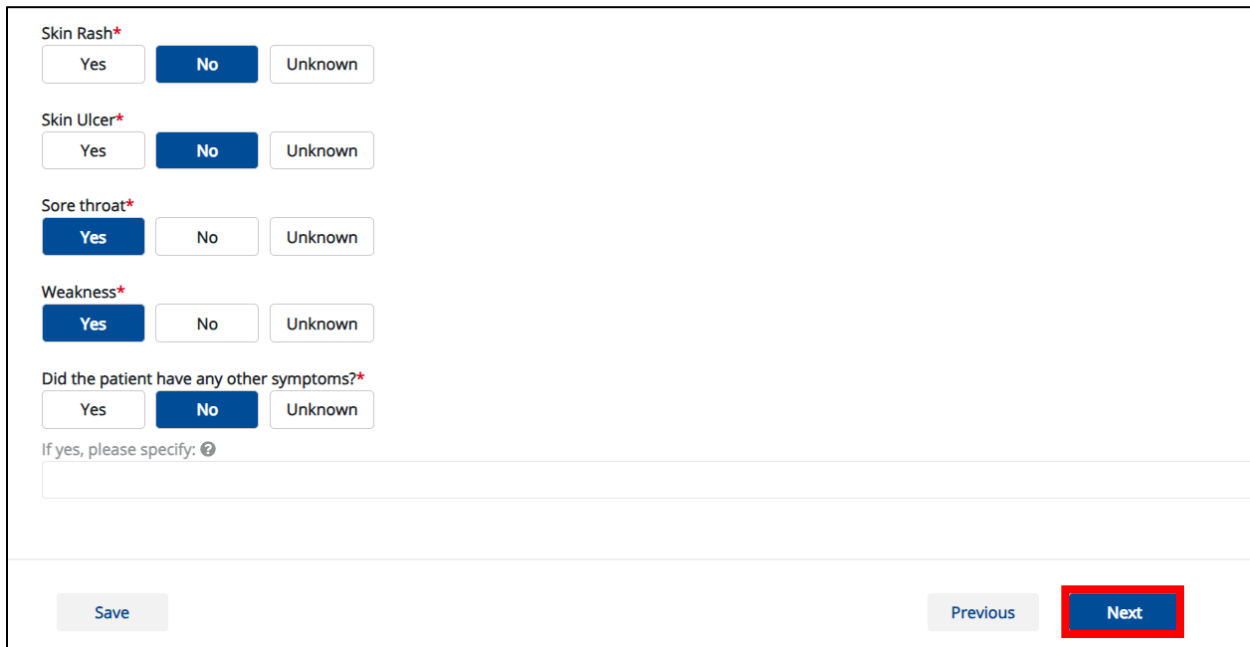


Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify: ?

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



Skin Rash*

Yes No Unknown

Skin Ulcer*

Yes No Unknown

Sore throat*

Yes No Unknown

Weakness*

Yes No Unknown

Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify: ?

Save Previous Next

12 Additional Information

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM Section 4 of 8

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

ADDITIONAL INFORMATION

- Patient Information ✓
- Laboratory Information ✓
- Applicable Symptoms ✓
- Additional Information**
- Hospitalization, ICU & Death Information 🔒

Does any of the following apply to the patient?*

Yes No Unknown

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

Yes No Unknown

If yes, please specify state(s):

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

ADDITIONAL INFORMATION

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

Does any of the following apply to the patient?*

Yes No Unknown

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

Yes No Unknown

If yes, please specify state(s):

International travel within the last 30 days*

Yes No Unknown

If yes, please specify country(s):

School/daycare attendee*

Yes No Unknown

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

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

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

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

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

Yes No Unknown

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

Select...

KY
AK
AL
AR
AS
AZ
CA

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

International travel within the last 30 days*

Yes No Unknown

If yes, please specify country(s):

- 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 in which the patient traveled**.

International travel within the last 30 days*

Yes No Unknown

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

Select...

AFGHANISTAN
ALBANIA
ALGERIA
AMERICAN SAMOA
ANDORRA

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

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

School/daycare attendee*

Yes No Unknown

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

School/daycare employee*

Yes No Unknown

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

Food handler*

Yes No Unknown

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

Healthcare worker*

Yes No Unknown

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

Long-term care facility resident*

Yes No Unknown

If yes, please specify the name of long-term care facility: ?

Long-term care facility employee*

Yes No Unknown

If yes, please specify the name of long-term care facility: ?

Correctional facility resident*

Yes No Unknown

If yes, please specify the name of correctional facility: ?

Correctional facility employee*

Yes No Unknown

If yes, please specify the name of correctional facility: ?

Homeless shelter resident*

Yes No Unknown

If yes, please specify the name of homeless shelter: ?

Homeless shelter employee*

Yes No Unknown

If yes, please specify the name of homeless shelter: ?

College/university student*

Yes No Unknown

If yes, please specify the name of college/university: ?

College/university teacher*

Yes No Unknown

If yes, please specify the name of college/university: ?

Military*

Yes No Unknown

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

Other congregate setting resident*

Yes No Unknown

If yes, please specify the name of other congregate setting: ?

Other congregate setting employee*

Yes No Unknown

If yes, please specify the name of other congregate setting: ?

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

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

Healthcare worker*

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

6. Select the **appropriate answer** for the field: *Did the patient inject drugs not prescribed by a doctor?*

7. Select the **appropriate answer** for the field: *Did the patient use street drugs, but not inject?*

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

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

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

Is this part of an outbreak?*

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

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

Is this part of an outbreak?*

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

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

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

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

Unknown

Save Previous **Next** ↑

13 Hospitalization, ICU & Death Information

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 5 of 8

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Additional Information ☒

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name: ?

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Additional Information ☒

Hospitalization, ICU & Death Information

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name:*

Admission Date* mm/dd/yyyy ☐ Unknown

Discharge Date* mm/dd/yyyy ☐ Unknown

☐ Still hospitalized

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

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

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

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

Was the patient hospitalized?*

Yes No Unknown

Please enter the name of the hospital where the patient is/was hospitalized.

If yes, please specify the hospital name:*

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

Admission Date* <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div>	Discharge Date* <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div> <div style="margin-top: 5px;"> <input type="checkbox"/> Still hospitalized </div>
--	--

5. Enter the patient's hospitalization **Discharge Date**.
 - If the patient is still hospitalized, click the **Still Hospitalized** checkbox.

Admission Date* <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> 10/01/2021 📅 <input type="checkbox"/> Unknown </div>	Discharge Date* <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div> <div style="border: 1px solid #ccc; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> Still hospitalized </div>
--	--

- 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* <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> 10/01/2021 📅 <input type="checkbox"/> Unknown </div>	Discharge Date* <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div> <div style="border: 1px solid #ccc; padding: 2px; margin-top: 5px;"> <input checked="" type="checkbox"/> Still hospitalized </div>
Was the patient admitted to an intensive care unit (ICU)?* <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Yes No Unknown </div>	
Admission Date to ICU <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div>	Discharge Date from ICU <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div>
<div style="border: 1px solid #ccc; padding: 5px; margin-bottom: 5px;"> Did the patient die as a result of this illness? <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Yes No Unknown </div> </div> <p style="margin-top: 5px;">If yes, please provide the date of death:</p> <p>Date of Death</p> <div style="border: 1px solid #ccc; padding: 2px; display: flex; align-items: center;"> mm/dd/yyyy 📅 <input type="checkbox"/> Unknown </div>	

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

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

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

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

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

Hospitalization, ICU & Death Information

Was the patient hospitalized? **Yes**

If yes, please specify the hospital name:

Admission Date* ☐ Unknown
Invalid Admission Date

Discharge Date* ☐ Unknown
☐ Still hospitalized
Invalid Discharge Date

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Was the patient hospitalized?* **Yes**

If yes, please specify the hospital name:*

Admission Date* ☐ Unknown
Invalid Admission Date

Discharge Date* ☐ Unknown
☐ Still hospitalized
Invalid Discharge Date

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

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

Admission Date to ICU ☐ Unknown

Discharge Date from ICU ☐ Unknown

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

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

Admission Date to ICU*

☐ Unknown

Discharge Date from ICU*

☐ Unknown

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

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

If yes, please provide the date of death:

Date of Death

☐ Unknown

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

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

If yes, please provide the date of death:

Date of Death*

☐ Unknown

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

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Additional Information ☒

Hospitalization, ICU & Death Information

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Was the patient hospitalized?*

If yes, please specify the hospital name:*

Admission Date*

☐ Unknown

Discharge Date*

☐ Unknown

☐ Still hospitalized

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

Admission Date to ICU

☐ Unknown

Discharge Date from ICU

☐ Unknown

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

If yes, please provide the date of death:

Date of Death

☐ Unknown

14 Vaccination History

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 6 of 8

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

VACCINATION HISTORY

Is the patient vaccinated for the condition being reported?*

Yes No Unknown

Vaccine Details

If yes, please provide vaccine name: ?

Select...

If other, please specify: ?

If yes, please enter the number of doses: ?

Select...

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

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

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

+ Add Vaccine

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 6 of 8

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

VACCINATION HISTORY

Is the patient vaccinated for the condition being reported?*

Yes No Unknown

Vaccine Details

If yes, please provide vaccine name: * ?

Select...

If other, please specify: ?

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

Select...

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

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

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

+ Add Vaccine

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

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

Vaccine Details

Please select the vaccine that was administered to the patient.

If yes, please provide vaccine name:* ?

Select...

- Diphtheria antitoxin
- DT (pediatric)
- DT, IPV adsorbed
- DTaP
- DTaP, 5 pertussis antigens
- DTaP, unspecified formulation
- DTaP,IPV,Hib,HepB

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

If yes, please provide vaccine name:* ?

Other

If other, please specify:* ?

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

Select...

4. For the subsequent textbox field: *If yes, please enter the number of doses*, select the **number of doses received** from the dropdown menu: *If yes, please enter the number of doses.*

Vaccine Details

If yes, please provide vaccine name:* ?

Diphtheria antitoxin

If other, please specify: ?

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

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

Select...

- 1
- 2
- 3

+ Add Vaccine

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

Vaccine Details

If yes, please provide vaccine name:* ⓘ
Diphtheria antitoxin x | v

If other, please specify: ⓘ

If yes, please enter the number of doses:* ⓘ
1 x | v

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

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

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

+ Add Vaccine

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

If yes, please enter the number of doses:* ⓘ
2 x | v

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

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

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

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

If yes, please enter the number of doses:* ⓘ
3 x | v

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

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

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

Adding Multiple Vaccines

- Click **Add Vaccine** to log the details for multiple vaccines.

VACCINATION HISTORY

Is the patient vaccinated for the condition being reported?*

Yes

No

Unknown

Vaccine Details

If yes, please provide vaccine name:*

Diphtheria antitoxin

If other, please specify: ?

If yes, please enter the number of doses:*

3

Date Administered (1st dose)*

mm/dd/yyyy

Unknown

Date Administered (2nd dose)*

mm/dd/yyyy

Unknown

Date Administered (3rd dose)*

mm/dd/yyyy

Unknown

+

 Add Vaccine

Save

Previous

Next

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

Vaccine Details

If yes, please provide vaccine name:*

Select...

If other, please specify: ?

If yes, please enter the number of doses:*

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose)

mm/dd/yyyy

Unknown

Date Administered (2nd dose)

mm/dd/yyyy

Unknown

Date Administered (3rd dose)

mm/dd/yyyy

Unknown

Date Administered (4th dose)

mm/dd/yyyy

Unknown

+

 Add Vaccine

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

VACCINATION HISTORY

Is the patient vaccinated for the condition being reported?*

Yes

No

Unknown

Vaccine Details

If yes, please provide vaccine name:*

Diphtheria antitoxin

If other, please specify:

If yes, please enter the number of doses:*

3

Date Administered (1st dose)*

mm/dd/yyyy

Unknown

Date Administered (2nd dose)*

mm/dd/yyyy

Unknown

Date Administered (3rd dose)*

mm/dd/yyyy

Unknown

+ Add Vaccine

Save

Previous

Next

15 Additional Comments

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

KHIE | ePartnerViewer

Support Announcements 9 Advisories 4 SIT TEST_17

Patient Search Bookmarked Patients Event Notifications Lab Data Entry Case Report Entry

Home > Vaccine Preventable Diseases Case Report Form

VACCINE PREVENTABLE DISEASES CASE REPORT FORM Section 7 of 8

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

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

Additional comments or notes, please specify:

0/1000 Characters

Save Previous **Next**

16 Review and Submit

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

Print or Download Functionality



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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 8 of 8

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information	✓	 Print  Download
Laboratory Information	✓	
Applicable Symptoms	✓	
Additional Information	✓	
Hospitalization, ICU & Death Information	✓	
Vaccination History	✓	
Additional Comments	✓	
Review & Submit		

Patient Information

Disease/Organism: Diphtheria Date of Diagnosis: 2024/01/19

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

Patient ID (MRN): E90193B8 Affiliation/Organization: Evergreen General Hospital

Person Completing Form: Jane Doe (jane@mailinator.com) Affiliation/Organization: Evergreen General Hospital

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 8 of 8

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information

Disease/Organism: Diphtheria Date of Diagnosis: 01/19/2024

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

Patient ID (MRN): E90193B8 Affiliation/Organization: Evergreen General Hospital

Person Completing Form: Jane Doe (jane@mailinator.com) Affiliation/Organization: Evergreen General Hospital

Attending Physician/Clinician: John Smith (john@mailinator.com) Affiliation/Organization: Evergreen General Hospital

First Name: John Last Name: Doe

Date of Birth: 12/15/1997 Ethnicity: Not Hispanic or Latino

Patient Sex: Male Race: White

Address 1: 123 Main Street City: Lexington State: KY Zip Code: 40511

Country: Fayetteville Phone: (555) 555-5555

Visit Type: Ambulatory Encounter ID/Visit #: G

Laboratory Information

Print 2 sheets of paper

Destination: SecurePrint

Pages: All

Copies: 1

Color: Color

More settings

Print Cancel

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 8 of 8

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Additional Information	✓

[Patient Information](#)

Print Download

- 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 top right.

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 8 of 8

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Additional Information	✓
Hospitalization, ICU & Death Information	✓
Vaccination History	✓

[Patient Information](#)

Disease/Organism: Diphtheria

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

Download PDF

Downloaded successfully

OK

Print Download

- 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.

Vaccine Preventable Diseases Case Report Form (1).pdf

1 / 4 | 100% + -

Download

Patient Information

Disease/Organism
Diphtheria

Date of Diagnosis
01/19/2024

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

Patient ID (MRN)
E90193B8

Affiliation/Organization
Evergreen General Hospital

Person Completing Form
Jane Doe (jane@mailinator.com)

Affiliation/Organization
Evergreen General Hospital

- 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	✓
Additional Information	✓
Hospitalization, ICU & Death Information	✓
Vaccination History	✓
Additional Comments	✓
Review & Submit	

Print
 Download

[Patient Information](#)

[Laboratory Information](#)

Does the patient have a lab test?
Yes

Laboratory Information

Laboratory Name
Laboratory X

Test Name
Diphtheria identified in Isolate by Organism specific culture

3. Review the *Patient Information* section.

[Patient Information](#)

Disease/Organism Diphtheria	Date of Diagnosis 2024/01/19
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes	
Patient ID (MRN) E90913B8	Affiliation/Organization Evergreen General Hospital
Person Completing Form Jane Doe (jane@mailinator.com)	Affiliation/Organization Evergreen General Hospital
Attending Physician/Clinician John Smith (john@mailinator.com)	Affiliation/Organization Evergreen General Hospital
First Name John	Last Name Doe
Date of Birth 1997/01/19	
Patient Sex Male	Ethnicity Not Hispanic or Latino
	Race White
Address 1 123 Main Street	
City Lexington	State KY
	Zip Code 40511-
County Fayette	Phone (555) 555-5555
Visit Type Ambulatory	Encounter ID/Visit # G

4. Review the *Laboratory Information* section.

Hospitalization, ICU & Death Information	<u>Laboratory Information</u>
Vaccination History	<div style="border: 2px solid red; padding: 5px;"> <p>Does the patient have a lab test? Yes</p> <hr/> <p>Laboratory Information</p> <p>Laboratory Name Laboratory X</p> <p>Test Name Diphtheria identified in Isolate by Organism specific culture</p> <p>Specimen Source Abscess</p> <p>Test Result Pending</p> <p>Specimen Collection Date 2024/01/09</p> </div>
Additional Comments	
Review & Submit	

5. Review the *Applicable Symptoms* section.

Additional Comments	<u>Applicable Symptoms</u>
Review & Submit	<div style="border: 2px solid red; padding: 5px;"> <p>Were symptoms present during the course of illness? Yes</p> <p>Onset Date 2024/01/02</p> <p>If symptomatic, which of the following did the patient experience during their illness?</p> <p>Fever No</p> <p>Diarrhea (>3 loose stools/24hr period) No</p> <p>Chills Yes</p> <p>Cough Yes</p> <p>Dysphagia (difficulty swallowing) Yes</p> <p>Exudate Over Tonsils, Pharynx Or Larynx No</p> <p>Fatigue Yes</p> <p>Headache No</p> <p>Hoarseness No</p> <p>Lymphadenopathy No</p> <p>Malaise No</p> <p>Nausea No</p> <p>Runny Nose No</p> <p>Shortness of Breath Yes</p> <p>Skin Rash No</p> <p>Skin Ulcer No</p> <p>Sore throat No</p> <p>Weakness No</p> <p>Did the patient have any other symptoms? No</p> </div>

6. Review the *Additional Information* section.

<u>Additional Information</u>	
Does any of the following apply to the patient:	
Yes	
Domestic travel within the last 30 days (outside state of normal residence)	
Yes	
If yes, please specify state(s):	
KY	
International Travel within the last 30 days	
No	
School/daycare attendee	
No	
School/daycare employee	
No	
Food handler	
No	
Healthcare worker	
Yes	
If yes, please specify the name of healthcare facility:	
General Hospital	
Long-term care facility resident	
No	
Long-term care facility employee	
No	
Correctional facility resident	
No	
Correctional facility employee	
No	
Homeless shelter resident	
No	
Homeless shelter employee	
No	
College/university student	
No	
College/university teacher	
No	
Military	
No	
Other congregate setting resident	
No	
Other congregate setting employee	
No	
Did the patient inject drugs not prescribed by a doctor?	
No	
Did the patient use street drugs, but not inject?	
No	
Is this part of an outbreak?	
No	

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

Hospitalization, ICU & Death Information

Was the patient hospitalized?

Yes

If yes, please specify the hospital name:

Evergreen Hospital

Admission Date

2024/01/04

Discharge Date

2024/01/06

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

No

Did the patient die as a result of this illness?

No

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

Vaccination History

Is the patient vaccinated for the condition being reported?

Yes

Vaccine Details

If yes, please provide vaccine name:

Diphtheria antitoxin

If yes, please enter the number of doses:

1

Date Administered (1st dose)

Unknown

9. Review the *Additional Comments* section.

Additional Comments

Additional comments or notes, please specify:

Patient Notes

Click Hyperlinks to Edit

- 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.

VACCINE PREVENTABLE DISEASES CASE REPORT FORM Section 8 of 8

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information	✓	<p>Patient Information</p> <p>Disease/Organism: Diphtheria Date of Diagnosis: 2024/01/19</p> <p>Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? Yes</p> <p>Patient ID (MRN): E90913B8 Affiliation/Organization: Evergreen General Hospital</p> <p>Person Completing Form: Jane Doe (jane@mailinator.com) Affiliation/Organization: Evergreen General Hospital</p>
Laboratory Information	✓	
Applicable Symptoms	✓	
Additional Information	✓	
Hospitalization, ICU & Death Information	✓	
Vaccination History	✓	
Additional Comments	✓	
Review & Submit		<p>Print Download</p>

- 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.

VACCINE PREVENTABLE DISEASES CASE REPORT FORM Section 1 of 8

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

PATIENT INFORMATION

Patient Information	<p>Disease/Organism* ? Diphtheria</p> <p>Date of Diagnosis* 01/12/2024 <input type="checkbox"/> Unknown</p> <p>Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? * <input type="button" value="Yes"/> <input type="button" value="No"/></p> <p>Patient ID (MRN)* ? E90913B8</p> <p>Person Completing Form* Jane Doe (jane@mailina...)</p> <p>Affiliation/Organization* Evergreen General Hos...</p> <p>If other, please specify: ?</p>
Laboratory Information	✓
Applicable Symptoms	✓
Additional Information	✓
Hospitalization, ICU & Death Information	✓
Vaccination History	✓
Additional Comments	✓
Review & Submit	

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

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

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

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

The screenshot shows a web form titled "Is the patient vaccinated for the condition being reported?" with a "Yes" response. Below this is a "Vaccine Details" section. A modal dialog box titled "Case Report Entry" is overlaid on the form. The dialog contains the 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", both of which are highlighted with red rectangles.

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

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

This screenshot shows the same "Case Report Entry" dialog box as the previous one, but now it displays the message "Case Report Entry Saved Successfully" in the center. The "OK" button at the bottom right is highlighted with a red rectangle.

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

Congratulations! You have submitted the Vaccine Preventable Diseases Case Report using KHIE's Direct Data Entry Functionality.

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

17 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. Use the Date Range buttons to do a custom search for previous case reports entered within the last 6 months.

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE

Start Date End Date

[Retrieve Data](#)

SHOWING 4 ITEMS

[APPLY FILTER](#)

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorerl	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

First [Back](#) [1](#) [Next](#) Last

Maximum entries per page

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE

Start Date End Date

[Retrieve Data](#)

SHOWING 4 ITEMS

[APPLY FILTER](#)

January 2024

Su	Mo	Tu	We	Th	Fr	Sa
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	31	1	2	3

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorerl	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

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: 01/23/2020 End Date: 01/23/2024 Retrieve Data

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

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date: 01/23/2024 End Date: 01/23/2024 Retrieve Data

SHOWING 4 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Soreri	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date: 01/23/2024 End Date: 01/23/2024 Retrieve Data

SHOWING 4 ITEMS HIDE FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Soreri	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

Review Previously Submitted Case Reports

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

CASE REPORT ENTRY USER SUMMARY

🕒 LAST UPDATED DATE RANGE

Start Date01/23/2024📅

End Date01/23/2024📅

🔄 Retrieve Data

SHOWING 4 ITEMS

🔼 APPLY FILTER

ACTIONS	REPORT TYPE ⚙	DISEASE/ ORGANISM ⚙	AFFILIATION/ ORGANIZATION ⚙	PATIENT MRN ⚙	FIRST NAME ⚙	LAST NAME ⚙	DATE OF BIRTH ⚙	PATIENT SEX ⚙	STATUS ⚙	LAST UPDATED ⚙	SUBMISSION DATE ⚙
<div>View</div> <div>Copy</div>	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
<div>View</div> <div>Copy</div>	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
<div>View</div> <div>Copy</div>	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorerl	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
<div>View</div> <div>Copy</div>	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

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

Patient S

Home

LAST UPDA

SHOWING 4 ITEMS

ACTIONS

View

Copy

View

Copy

View

Copy

Case Report Details

Print
 Download

Patient Information

Disease/Organism: Diphtheria

Date of Diagnosis: 2024/01/07

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

Patient ID (MRN): KW01202654

Affiliation/Organization: Baxter Hospital

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

Affiliation/Organization: Baxter Hospital

Attending Physician/Clinician: Dr. Fraiser McGill (fraisermcgill@email.com)

Affiliation/Organization: Baxter Hospital

First Name: Morgan

Last Name: Williams

Date of Birth: 1949/06/09

Patient Sex: Male

Ethnicity: Not Hispanic or Latino

Race: White

Address 1: 879 Kentucky Road

OK

Copy Previously Submitted Case Reports

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

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

KHIE

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Home > Case Report Entry User Summary

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE
Start Date: 01/23/2024
End Date: 01/23/2024
Retrieve Data

SHOWING 3 ITEMS
APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorrell	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

First Back 1 Next Last
Maximum 5 entries per page

Please Note: Clicking **Copy** will automatically navigate you to the **Patient Information** screen of the Vaccine Preventable Diseases Case Report.

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

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

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

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

VACCINE PREVENTABLE DISEASES CASE REPORT FORM Section 1 of 8

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Additional Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*
Diphtheria

Date of Diagnosis*
01/07/2024

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

Patient ID (MRN)*
KW01202654

Affiliation/Organization*
Baxter Hospital

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

Affiliation/Organization*
Baxter Hospital

Attending Physician/Clinician*
Dr. Fraiser McGill (fraisermcgill@e...)

Affiliation/Organization*
Baxter Hospital

Prefix
Select...

First Name*
Morgan

Middle Name

Last Name*
Williams

Suffix
Select...

Date of Birth*
06/09/1949

Patient Sex*
Male

Ethnicity*
Not Hispanic or Latino

Race*
White

Address 1*
879 Kentucky Road

Address 2
Unit, Suite, Building, etc.

City*
Corbin

State*
KY

Zip Code*
40701-

County*
Owsley

Phone*
(535) 323-23

Email
morgan@email.com

Visit Type*
Field

Encounter ID/Visit #*
100000000000000000617

Is the patient currently pregnant?

If yes, please enter the due date (EDC):
mm/dd/yyyy

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

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

Is the patient currently pregnant?

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

☐ Unknown

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

LABORATORY INFORMATION

Does the patient have a lab test?*

Laboratory Information

Laboratory Name*

Corp Lab

Test Name*

Corynebacterium diphtheriae [Presence] in Specimen by Organism specific culture

If other, please specify: ?

Filler Order/Accession Number ?

Specimen Source*

Lymph node aspirate

If other, please specify: ?

Test Result*

Positive

If other, please specify: ?

Test Result Date*

01/03/2024 ☐ Unknown

Specimen Collection Date*

12/31/2023 ☐ Unknown

Additional Information ?

0/300 Characters

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

[illegible]

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

Vaccination History

Additional Comments

Additional comments or notes, please specify:

Additional Patient Notes

Previous

Submit

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

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

The screenshot shows a 'Case Report Entry' modal dialog box with 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.' The dialog has 'Cancel' and 'Submit' buttons. The background form shows fields for 'Was the patient admitted to an intensive care unit (ICU)?', 'Admission Date to ICU', 'Discharge Date from ICU', and 'Did the patient die as a result of the disease?'. The 'Submit' button is highlighted with a red box.

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

The screenshot shows a 'Case Report Entry' modal dialog box with the text: 'Case Report Entry Saved Successfully'. The dialog has an 'OK' button. The background form is the same as the previous screenshot, but the 'Submit' button is no longer visible.

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

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

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Support | Announcements | Advisories | SIT TEST_17

Patient Search | Bookmarked Patients | Event Notifications | Lab Data Entry | Case Report Entry

Home > Case Report Entry User Summary

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE: Start Date: 01/23/2024 End Date: 01/23/2024 Retrieve Data

SHOWING 4 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorerl	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

First Back Next Last

Maximum 5 entries per page

Continue In-Progress Case Reports

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

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

SHOWING 5 ITEMS APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
Continue UNABLE	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorerl	1995/04/15	Male	In Progress	2024/01/23 13:41	
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:39	2024/01/23 13:39
View Copy	Vaccine Preventable Diseases	Diphtheria	Baxter Hospital	KW01202654	Morgan	Williams	1949/06/09	Male	Complete	2024/01/23 13:17	2024/01/23 13:17
View Copy	Vaccine Preventable Diseases	Diphtheria	Howell Hospital	HF78451265	Lucas	Sorerl	1995/04/15	Male	Complete	2024/01/23 13:06	2024/01/23 13:06
View Copy	Vaccine Preventable Diseases	Diphtheria	Swanlake Clinic	EB16589435	Shawna	Smith	1984/08/13	Female	Complete	2024/01/23 13:02	2024/01/23 13:02

First Back 1 Next Last Maximum 5 entries per page

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

Home > Vaccine Preventable Diseases Case Report Form

VACCINE PREVENTABLE DISEASES CASE REPORT FORM

Section 7 of 8

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

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

Additional comments or notes, please specify:

0/1000 Characters

Save Previous Next

18 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.

