

Kentucky Health
Information Exchange
(KHIE)

**Foodborne and
Waterborne Diseases
Case Report:**

**Invasive *Cronobacter*
Among Infants**

Quick Reference Guide

June 2024

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1 Introduction

Overview

This training manual covers the unique functionalities for the Invasive *Cronobacter* Infection Among Infants condition in the Foodborne and Waterborne Diseases eICR Form in the ePartnerViewer. The Invasive *Cronobacter* Infection Among Infants condition captures the contact information of the person with whom the patient lives and contains unique validation pop-ups on the **Patient Information** screen and contains a unique **Additional Information** screen. All other screens for the Invasive *Cronobacter* Infection Among Infants condition follow the generic workflow for the Foodborne and Waterborne Diseases Case Report. For specific information about the Foodborne and Waterborne Diseases Case Report, please review the [Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases User Guide](#).

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

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

Supported Web Browsers

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

Desktop Browser Version	Mobile Browser Version
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

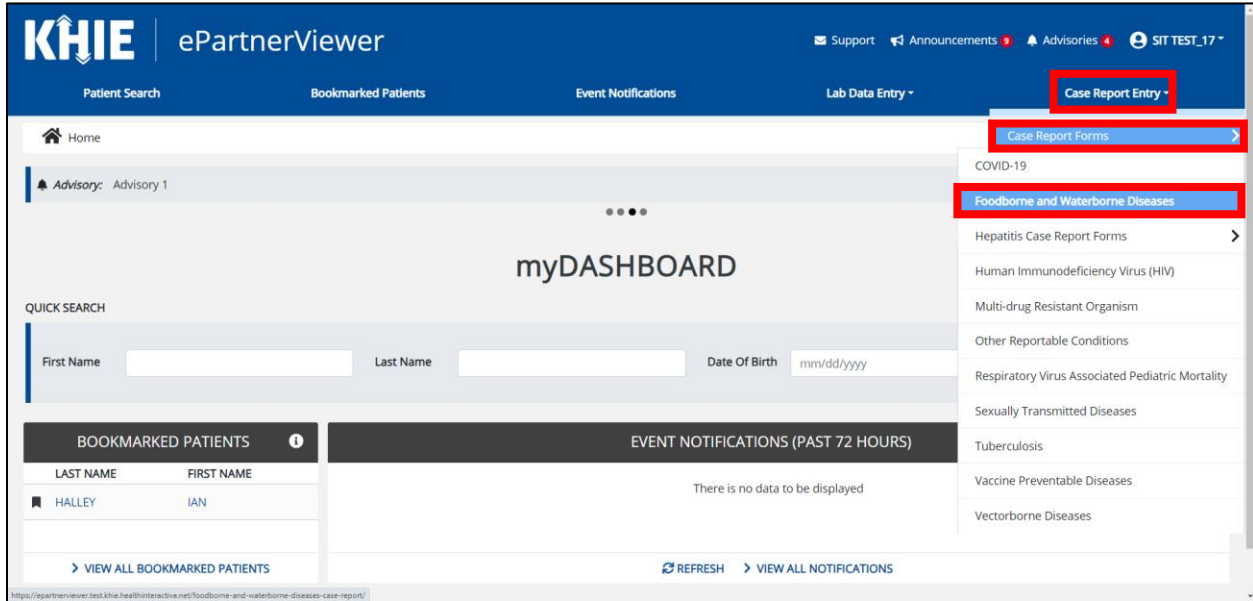
To access the ePartnerViewer, Users must meet the following specifications:

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).

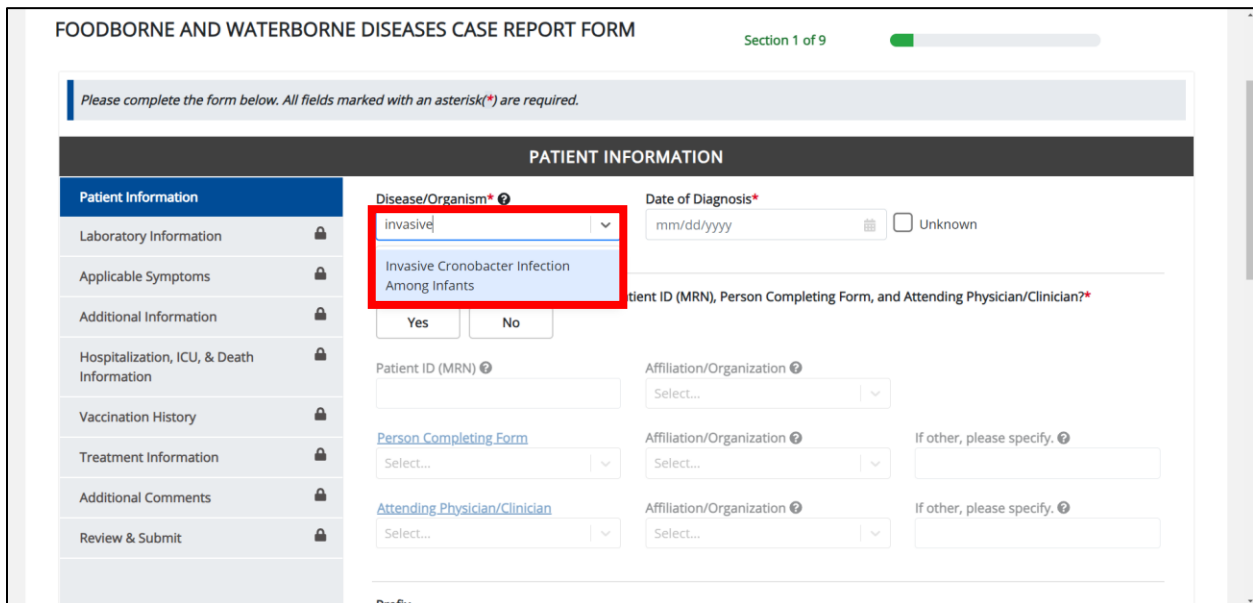
Please Note: For specific information about creating a Kentucky Online Gateway (KOG) account and how to complete MFA, please review the [ePartnerViewer Login: Kentucky Online Gateway \(KOG\) and Okta Verify Multi-Factor Authentication \(MFA\) User Guide](#).

2 Patient Information

1. To enter Foodborne and Waterborne Diseases case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.
2. Select **Foodborne and Waterborne Diseases** from the dropdown menu.



3. To start the Invasive *Cronobacter* Infection Among Infants Case Report entry, select **Invasive *Cronobacter* Infection Among Infants** from the *Disease/Organism* field on the **Patient Information** screen.



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

Disease/Organism* Invasive Cronobacter Infection Am... x | v

Date of Diagnosis* mm/dd/yyyy Unknown

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

Patient ID (MRN) Affiliation/Organization Select... | v

[Person Completing Form](#) Select... | v Affiliation/Organization Select... | v If other, please specify.

[Attending Physician/Clinician](#) Select... | v Affiliation/Organization Select... | v If other, please specify.

Prefix Select... | v

First Name* Middle Name Last Name*

Suffix Select... | v Date of Birth* mm/dd/yyyy Birth Weight lb oz

Patient Sex* Ethnicity* Race* Select... | v Select... | v Select... | v

Visit Type* Encounter ID/Visit #* Generate

With whom does the infant/child live?*

Select... | v

If other, please specify.

Please enter the contact information of the person with whom the infant/child is living.

First Name* Middle Name Last Name*

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

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

County* Phone* (XXX) XXX-XXXX Email name@domain.com

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

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

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

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

- 7. 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.

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

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

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

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

The screenshot shows a form for 'Person Completing Form'. The 'Affiliation/Organization' dropdown menu is open, displaying a list of hospitals: Eugene Hospital, Evergreen General Hospital, Green Hosp, Heartland Clinic, Hilton Hospital, Howell Hospital, and Justin Hospital. The dropdown is highlighted with a red box. Other fields include 'Person Completing Form' (Mr. Arthur Vandelay, II), 'Attending Physician/Clinician', 'Prefix', 'First Name', 'Suffix', and 'Date of Birth'.

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

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

The screenshot shows a form for 'Attending Physician/Clinician'. The dropdown menu is open, displaying a list of names: Dr. Frank Costanza, Sr (frankc@email.com) and John Smith (john@mailinator.com). The dropdown is highlighted with a red box. Other fields include 'Affiliation/Organization', 'Prefix', 'First Name', 'Suffix', and 'Date of Birth'.

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

The screenshot shows a form for 'Attending Physician/Clinician'. The 'Affiliation/Organization' dropdown menu is open, displaying a list of hospitals: Eugene Hospital, Evergreen General Hospital, Green Hosp, Heartland Clinic, Hilton Hospital, Howell Hospital, Justin Hospital, and Knight Hospital. The dropdown is highlighted with a red box. Other fields include 'Attending Physician/Clinician' (Dr. Charles Allen), 'Prefix', 'First Name', 'Suffix', 'Patient Sex', 'Ethnicity', and 'Race'.

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

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

Prefix
Select... | v

First Name* Middle Name Last Name*

Suffix
Select... | v

Date of Birth* mm/dd/yyyy [calendar icon]

Birth Weight lb oz

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

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

First Name* Middle Name Last Name*

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

Suffix Select... | v

Date of Birth* mm/dd/yyyy [calendar icon]

17. If available, enter the patient's **Birth Weight** in the *lb* and *oz* textbox fields.

Date of Birth* 04/26/2024 [calendar icon]

Birth Weight lb oz

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

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

Patient Sex* Select... | v

Ethnicity* Not Hispanic or Latino x | v

Race* Select... | v

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

City* State* Select...

County* Select... | v

Phone* (XXX) XXX-XXXX

Race* dropdown list:
American Indian or Alaska Native
Asian
Asked but Unknown
Black or African American
Native Hawaiian or Other Pacific Islander
Other
Unknown

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

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

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

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

Contact Information of the Person With Whom the Patient Lives

The Invasive *Cronobacter* Infection Among Infants Case Report captures details of the person with whom the patient lives.

21. Select the **appropriate answer** from the dropdown menu for the field: *With whom does the infant/child live?*

With whom does the infant/child live?*

Select... | v

Father

Grandparent

Mother

Other

Person with whom the infant/child is living.

Middle Name

Last Name*

Address 1*

Address 2

Unit, Suite, Building, etc.

City*

State*

Zip Code*

County*

Phone*

Email

22. If **Other** is selected from the dropdown menu, enter the **appropriate answer** in the text box: *If Other, please specify.*

With whom does the infant/child live?*

Other x | v

If other, please specify.*

23. Enter the **First Name** and **Last Name** of the person with whom the patient lives.

24. If available, enter the **Middle Name** of the person with whom the patient lives.

Please enter the contact information of the person with whom the infant/child is living.

First Name*

Middle Name

Last Name*

25. Enter the **Address, City, State, Zip Code**, and **County** of the person with whom the patient lives.

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

26. Enter the **Phone Number** of the person with whom the patient’s lives.

27. If available, enter the Email **Address** of the person with whom the patient’s lives.

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

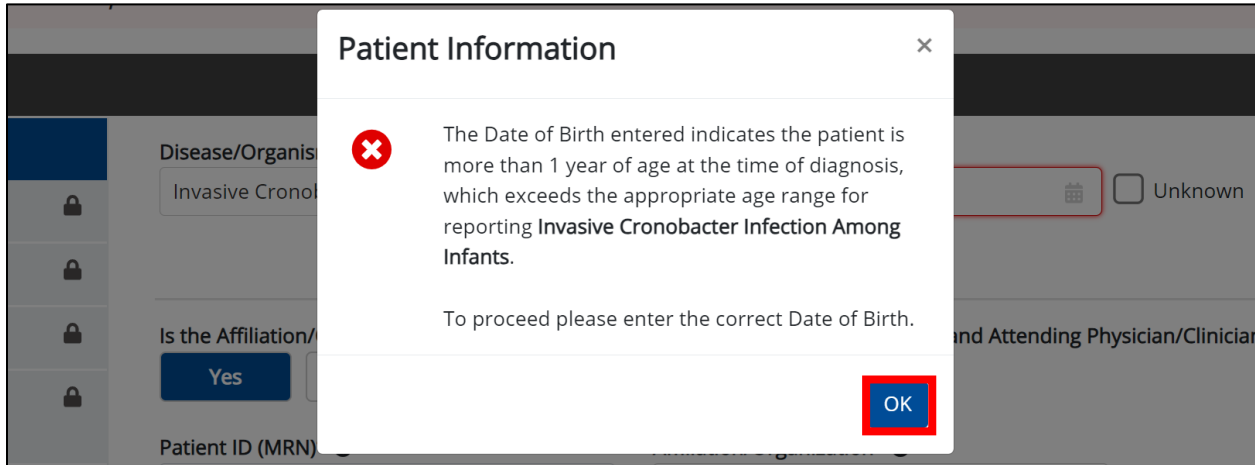
28. When the **Patient Information** screen has been completed, click **Save** to save your progress or click **Next** to proceed to the **Laboratory Information** screen.

Visit Type*	Encounter ID/Visit #*	<input checked="" type="checkbox"/> Generate
<input type="text" value="Ambulatory"/>	<input type="text"/>	
With whom does the infant/child live?*		
<input type="text" value="Mother"/>		
If other, please specify. <input type="text"/>		
Please enter the contact information of the person with whom the infant/child is living.		
First Name*	Middle Name	Last Name*
<input type="text" value="Jane"/>	<input type="text"/>	<input type="text" value="Doe"/>
Address 1*	Address 2	
<input type="text" value="1 First Street"/>	<input type="text" value="Unit, Suite, Building, etc."/>	
City*	State*	Zip Code*
<input type="text" value="Frankfort"/>	<input type="text" value="KY"/>	<input type="text" value="40601-"/>
County*	Phone*	Email
<input type="text" value="Franklin"/>	<input type="text" value="(555) 000-0000"/>	<input type="text" value="name@domain.com"/>
<input type="button" value="Save"/>	<input type="button" value="Next"/>	

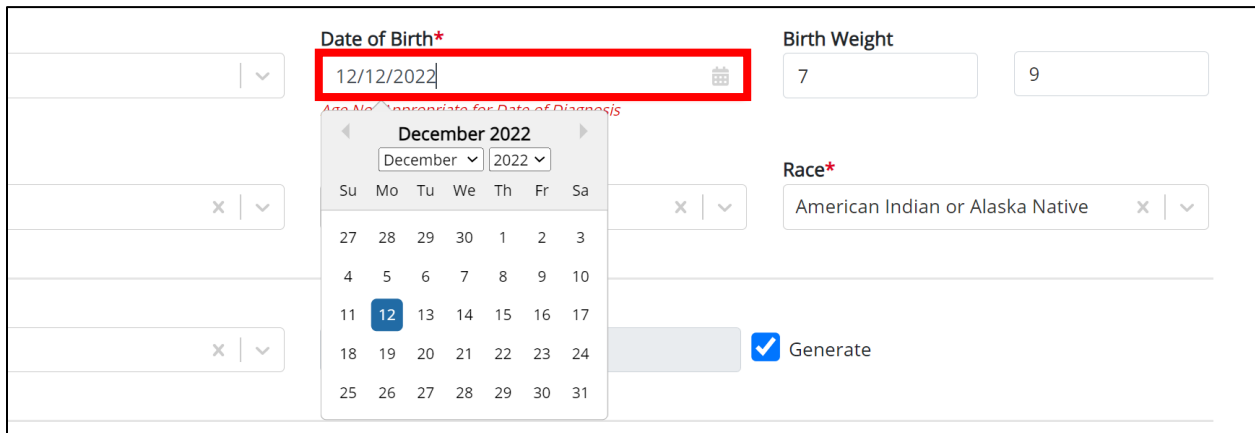
29. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Birth entered indicates the patient is older than 1 year of age.

- *The Date of Birth entered indicates the patient is more than 1 year of age at the time of diagnosis, which exceeds the appropriate age range for reporting **Invasive Cronobacter Infection Among Infants**. To proceed please enter the correct Date of Birth.*

30. Click **OK** to close the *Patient Information* pop-up.



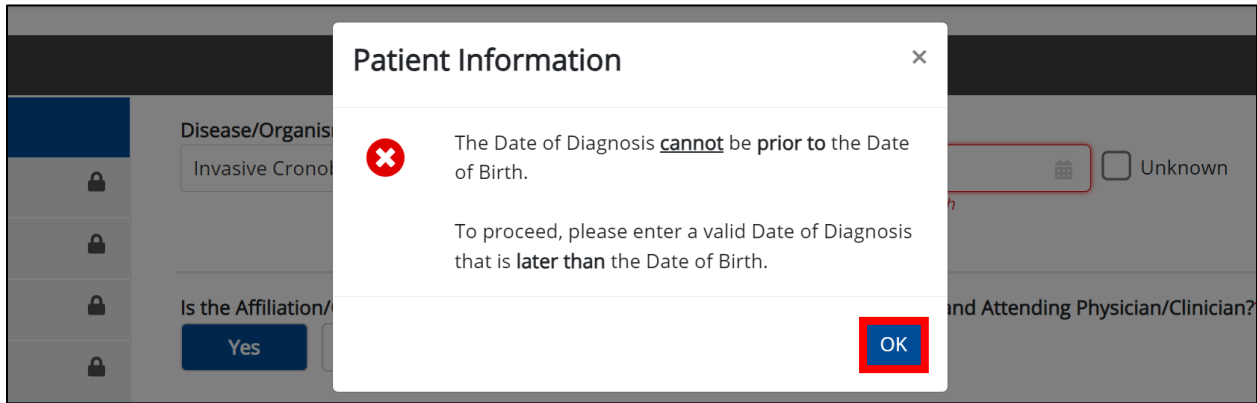
31. To proceed with the Invasive *Cronobacter* Infection Among Infants Case Report, enter the **appropriate Date of Birth** in the *Date of Birth* field to indicate that the patient is younger than 1 year of age.



32. Upon clicking **Save** or **Next**, the *Patient Information* pop-up displays the following message when the Date of Diagnosis entered occurs before the patient's Date of Birth.

- *The Date of Diagnosis cannot be prior to the Date of Birth. To proceed, please enter a valid Date of Diagnosis that is later than the Date of Birth.*

33. To update the Date of Diagnosis, click **OK** to close the *Patient Information* pop-up.



34. Enter the appropriate Date of Diagnosis.

PATIENT INFORMATION		
Disease/Organism* Invasive Cronobacter Infection Among I...	Date of Diagnosis* 05/01/2023 <small>Date cannot be prior to the Date of Birth</small>	<input type="checkbox"/> Unknown
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician? <input checked="" type="button" value="Yes"/> <input type="button" value="No"/>		
Patient ID (MRN)* JD01012024	Affiliation/Organization* Afzal, Mohammad MD, Internal Medicin...	
Person Completing Form* Dr. Niles Crane (niles@mailinator.com)	Affiliation/Organization Afzal, Mohammad MD, Internal Medicin...	If other, please specify.
Attending Physician/Clinician* Dr. Frasier Crane (frasier@mailinator.co...	Affiliation/Organization Afzal, Mohammad MD, Internal Medicin...	If other, please specify.
Prefix Select...		
First Name* John	Middle Name	Last Name* Doe
Suffix Select...	Date of Birth* 01/01/2024	Birth Weight 7 5
Patient Sex* Male	Ethnicity* Not Hispanic or Latino	Race* White

3 Laboratory Information

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

FOODBORNE AND WATERBORNE DISEASES CASE REPORT FORM Section 2 of 9

Please provide laboratory information related to this case.

LABORATORY INFORMATION

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

Does the patient have a lab test?*

Yes No Unknown

Laboratory Information

Laboratory Name

Test Name

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

LABORATORY INFORMATION

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

Does the patient have a lab test?*

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 Unknown

Specimen Collection Date* Unknown

Additional Information

0/300 Characters

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

Laboratory Information

Laboratory Name*
Test Lab

Test Name*
Other

If other, please specify.*
Other Test

Filler Order/Accession Number
101101101

Specimen Source*
Blood

If other, please specify.

Test Result*
Positive

If other, please specify.

Test Result Date*
05/23/2024 Unknown

Specimen Collection Date*
05/07/2024 Unknown

Additional Information
0/300 Characters

+ Add Test

Save Previous **Next**

4 Applicable Symptoms

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

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

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

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

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

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

Fever*

If yes, please enter the highest temperature. ?

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

Fever*

If yes, please enter the highest temperature.* ?

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

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

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

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

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

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

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

Brain abscess*	Yes	No	Unknown	Poor feeding*	Yes	No	Unknown
Excessive crying*	Yes	No	Unknown	Seizures*	Yes	No	Unknown
Fatigue*	Yes	No	Unknown	Sepsis*	Yes	No	Unknown
Meningitis*	Yes	No	Unknown	Urinary tract infection*	Yes	No	Unknown
Necrotizing enterocolitis*	Yes	No	Unknown				

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

Did the patient have any other symptoms?*

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.*

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

Did the patient have any other symptoms?*

Yes No Unknown

If yes, please specify.* ?

Other symptoms

Save Previous Next

5 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?*

The screenshot shows the 'ADDITIONAL INFORMATION' screen. On the left is a sidebar with menu items: Patient Information (checked), Laboratory Information (checked), Applicable Symptoms (checked), **Additional Information** (selected), Hospitalization, ICU, & Death Information (locked), Vaccination History (locked), Treatment Information (locked), Additional Comments (locked), and Review & Submit (locked). The main content area has a header 'ADDITIONAL INFORMATION' and a question: 'Does any of the following apply to the patient?*' with three buttons: 'Yes', 'No', and 'Unknown'. This question and its buttons are highlighted with a red box. Below the question are several conditional fields: 'School/daycare attendee' with 'Yes', 'No', and 'Unknown' buttons; 'If yes, please specify the name of school/daycare.'; 'Was the infant fed formula up to 7 days before illness onset?' with 'Yes', 'No', and 'Unknown' buttons; 'Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.' with a 'Select...' dropdown; 'If other, please specify.'; and 'If known, please provide detailed information about infant feeding.' with a text area.

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

This screenshot shows the 'ADDITIONAL INFORMATION' screen after the 'Yes' button for the top question has been selected. The 'Yes' button is now highlighted in blue. The 'School/daycare attendee*' question and its 'Yes', 'No', and 'Unknown' buttons are highlighted with a red box. The 'Was the infant fed formula up to 7 days before illness onset?*' question and its 'Yes', 'No', and 'Unknown' buttons are also highlighted with a red box. The sidebar and other conditional fields are visible as in the previous screenshot.

3. Select the **appropriate answer** for the field: School/daycare attendee.

ADDITIONAL INFORMATION

Does any of the following apply to the patient?*

School/daycare attendee*

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

4. If **Yes** is selected, enter the **name of the school/daycare** in the textbox for the field: *If yes, please specify the name of school/daycare.*

ADDITIONAL INFORMATION

Does any of the following apply to the patient?*

School/daycare attendee*

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

5. Select the **appropriate answer** for the field: *Was the infant fed formula up to 7 days before illness onset?*

Was the infant fed formula up to 7 days before illness onset?*

Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.

Select...

If other, please specify.

If known, please provide detailed information about infant feeding. ?

0/1000 Characters

6. If **Yes** is selected, the subsequent fields are enabled.

Was the infant fed formula up to 7 days before illness onset?*

Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.

Select...

If other, please specify.

If known, please provide detailed information about infant feeding.

0/1000 Characters

7. If applicable, select the **appropriate answers** from the dropdown menu for the field: *Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.*

Was the infant fed formula up to 7 days before illness onset?*

Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.

Select...

- Liquid
- Powder
- Other Fortifier

0/1000 Characters

8. If **Other** is selected, enter the **other fortifier** in the textbox for the field: *If other, please specify.*

Was the infant fed formula up to 7 days before illness onset?*

Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.

Powder x Other Fortifier x

If other, please specify.*

- 9. If known, enter **information about infant feeding** in the textbox for the field: *If known, please provide detailed information about infant feeding.*

Was the infant fed formula that was a powder, liquid, or other fortifier? Please select all that apply.

Powder x Other Fortifier x

If other, please specify.*

Other Fortifier

If known, please provide detailed information about infant feeding. ?

0/1000 Characters

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

Is this part of an outbreak?*

Yes No Unknown

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

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

Is this part of an outbreak?*

Yes No Unknown

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

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

Is this part of an outbreak?*

Yes No Unknown

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

Save Previous Next

Please Note: From this point forward, the workflow screens are the same as Foodborne and Waterborne Diseases Case Reports. For more information, please review the [Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases User Guide](#).

6 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.

