

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Foodborne and Waterborne Diseases Case Reports (Salmonella paratyphi)

User Guide

March 2024

Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



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# **Document Control Information**

# **Document Information**

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## 1 Introduction

#### Overview

This training manual covers KHIE's Direct Data Entry for Foodborne and Waterborne 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 Department for Public Health (DPH). All examples and screenshots used in this guide are simulated with mock data; no Protected Health Information (PHI) is present.

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

#### Supported Web Browsers

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

Desktop Browser Version	Mobile Browser Version	
Microsoft 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 <u>ePartnerViewer Login: Kentucky Online Gateway</u> (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 Foodborne and Waterborne 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: <u>https://epartnerviewer.khie.ky.gov</u>

Tab		×	+	
C	$\triangle$	https://epart	tnerviewer.khie.ky.gov	$\mathcal{F}$
			Google	
e	Pa	rtnerViewer,	he ePartnerViewer does <u><b>not</b></u> support Microsoft Internet Explorer. To access the , Users must use a modern browser such as Google Chrome, Microsoft Edge Mozilla Firefox.	

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

States in case of	KENTUCKY	
and the second		the second se
Em	Sign in with your Kentucky Online Gateway (KOG) Account (UAT) nail Address	
	Next	Alle Barr
the second se	ate New Account send Account Verification Email	And Statements
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#### 3. Enter your **Password**. Click **Verify**.

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	****	- manual
	Verify with your password @ khie_SIT_TEST_44@mailinator.com	
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#### **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.

	KENTUCKY	
and the second	Verify it's you with a security method khie.worker@gmail.com Need Assistance?	
	Select from the following options           Image: Select from the following options           Image: Select from the following options           Image: Select from the following options	
	Get a push notification Select Okta Verify Back to sign in	
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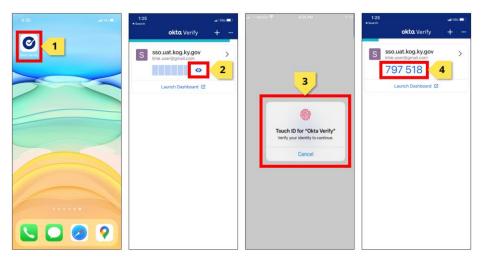
### Security Code from Okta Verify App

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**.

	KENTUCKY	
State Balance	Verify it's you with a security method (a) khie.worker@gmail.com Need Assistance?	and the second s
	Select from the following options         Image: Constraint of the select         Image: Constraint of the select </th <th></th>	
	Back to sign in English Y Help	

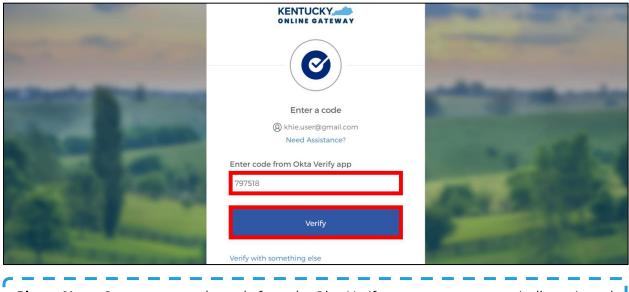
- 2. To locate the Okta Verify code, complete the following steps from your mobile device or tablet:
- <u>Step 1</u>: Open the **Okta Verify app** on your mobile device or tablet.
- <u>Step 2</u>: If the code is hidden, click the **Eye Icon** below the email address used for your KOG account.
- <u>Step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







3. 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.

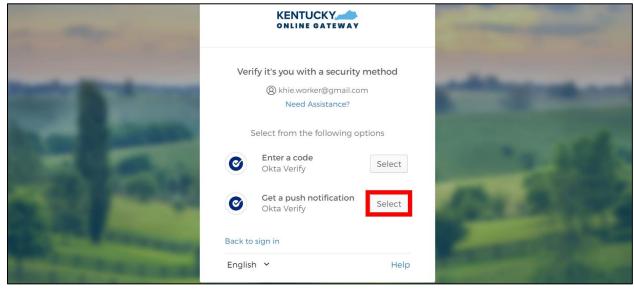


**Please Note:** Once you enter the code from the Okta Verify app, you are automatically navigated to the **Terms and Conditions of Use** screen. For more information, please review the *Terms and Conditions of Use and Logging In* sub-section of this chapter.

### 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**.



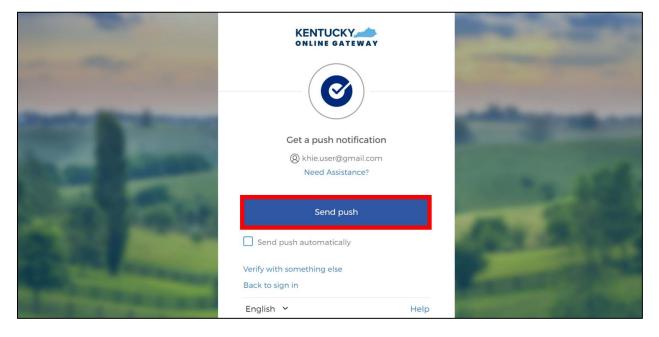
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Kentucky Health Information Exchange

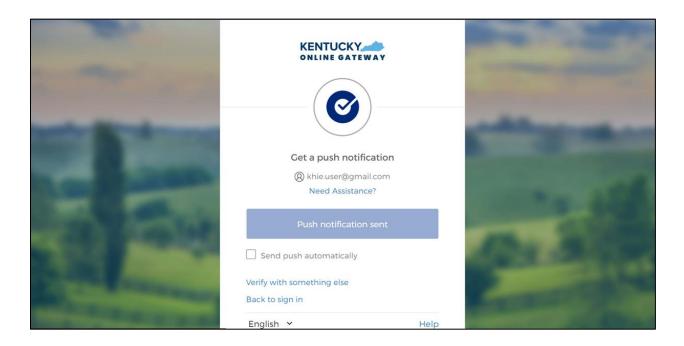




#### 2. The **Get a push notification** screen displays. Click **Send Push**.



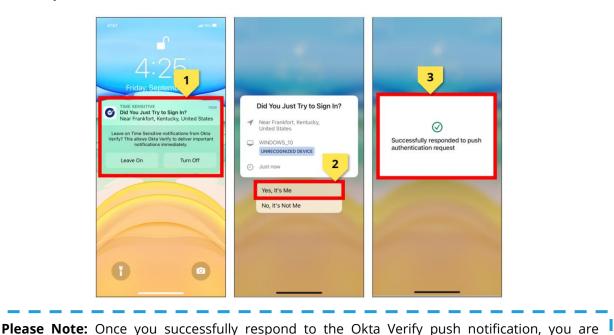
**Please Note**: Once the push notification has been successfully sent to the Okta Verify app, the **Get a push notification** screen displays a grayed out **Push notification sent** button.





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- 3. To view the Okta Verify push notification, complete the following steps from your mobile device:
- <u>Step 1</u>: 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?**".
- <u>Step 2</u>: On the notification, click the **Yes, It's Me** button.
- <u>Step 3</u>: 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.



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.

KÎJE ePartnerViewer	😫 Jane Doe 👻
TERMS AND CONDITIONS OF	USE
<ul> <li>Determs and Conditions</li> <li>DEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS</li> <li>Datacept the following terms and conditions of the Kentucky Health Information Exchange (KHIE):</li> <li>a ma healthcare provider currently treating a patien.</li> <li>a ma nealthcare provider currently treating a patien, and urrently bound by a Health Information Exchange Participating provider of the Division of Health Information in have a current relationship as an authorized user of a participating provider of the Division of Health Information in have a current relationship as an authorized user of a participating provider of the Division of Health Information.</li> <li>a Understand that data available on KHIE is only that information available according to state and federal law.</li> <li>The Medical claims data will not include records of the following:</li> <li>Altimetical procedures and test.</li> <li>Biagnosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.</li> <li>a understand that all data available on KHIE WILL NOT include HIV medical procedures and tests, regardless of source.</li> <li>Beter 1 accept' to accept the usage terms and conditions.</li> </ul>	Access restricted beyond this point. You must accept terms and conditions before proceeding.
<b>Please Note:</b> The right side of the Portal is grayed out and displa Access is restricted beyond this point. You must accept the terms and	

- 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.

<ul> <li>Terms and Conditions</li> <li>HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS</li> <li>Laccept the following terms and conditions of the Kentucky Health Information Exchange (KHIE): <ul> <li>I am a healthcare provider currently treating a patient.</li> <li>I am currently bound by a Health Information Exchange Participation Agreement with the Division of Health Information or have a current relationship as an authorized user of a participating provider of the Division of Health Information.</li> <li>I understand that data available on KHIE is only that information available according to state and federal law.</li> </ul> </li> <li>The Medicaid claims data will not include records of the following: <ul> <li>HIV medical procedures and test.</li> <li>Diagnosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.</li> <li>I understand that al data available on KHIE WILL NOT include HIV medical procedures and tests, regardless of source.</li> </ul> </li> <li>Select 'I accept' to accept the usage terms and conditions.</li> </ul>	You are part of the below mentioned organization. Please click on proceed to continue. KHIE Smoke Test Organization Proceed to Portal Cancel	
<b>Please Note</b> : If you click <b>Cancel</b> , a pop-up notification displays that indicates that you are <i>about</i> 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 <b>Logout Now</b> or <b>Cancel</b> .		



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## 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.

KĤIE	ePartnerViewer	Support 💟	📢 Announcements 🧕	Advisories 3 SIT TEST_17 •
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry <del>-</del>	Case Report Entry -
Home				Case Report Forms
Announcement: ar	nn062823			Case Report Entry User Summary
		••••		Manage User Preferences

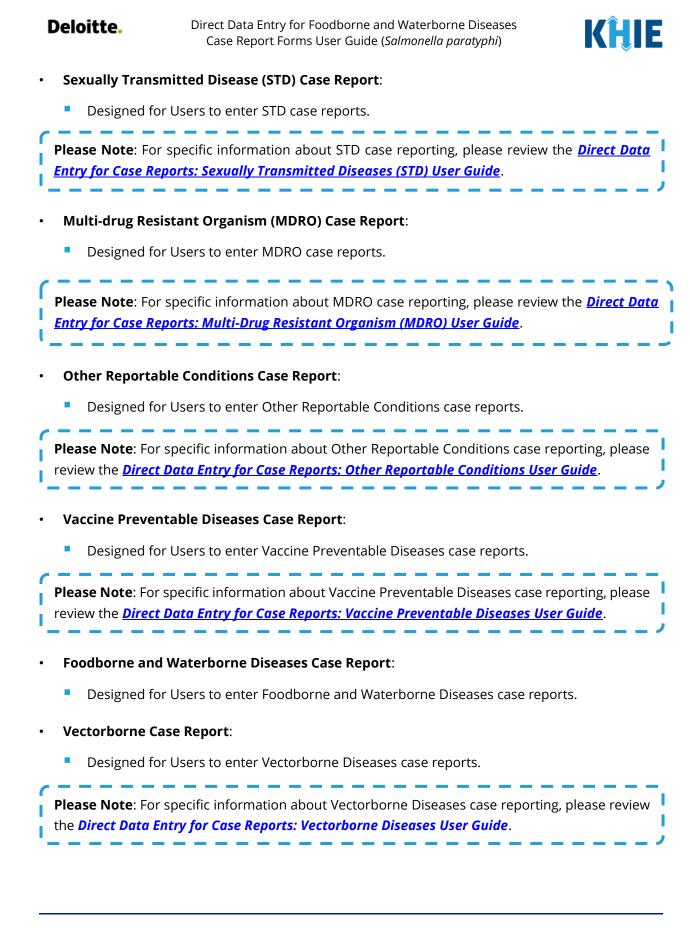
### 1. Types of Case Reports:

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Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 👻	Case Report Entry 🕶
A Home				Case Report Forms
				COVID-19
Advisory: Updated Active ad	visory on 10/7/2022 7:58:53 AM			Sexually Transmitted Diseases
				Multi-drug Resistant Organism
	r	nyDASHBOARD		Other Reportable Conditions
QUICK SEARCH				Vaccine Preventable Diseases
		Date Of		Foodborne and Waterborne Diseases
First Name	Last Name	Birth	mm/dd/yyyy	Vectorborne Diseases
				Tuberculosis
BOOKMARKED PATIE	NTS 🕄	EVENT NOTIFICATION	S (PAST 72 HOURS)	Hepatitis Case Report Forms
LAST NAME FIRST N	JAME	Thora is no data	to bo displayed	

#### 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 <u>Direct</u> Data Entry for Case Reports: COVID-19 User Guide.





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#### Tuberculosis Case Report:

Designed for Users to enter Tuberculosis case reports.

F	Please	Note:	For s	pecific	inform	ation	about	Tuberculos	is case	reporting,	please	review	the	Ì
								is User Guid						

### 2. Types of Hepatitis Case Reports:

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Patient Search		okmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry 🕶
Home					Case Report Forms
Announcement: Ann					COVID-19
Announcement: Ann	iouncement i				Sexually Transmitted Diseases
					Multi-drug Resistant Organism
			myDASHBOARD		Other Reportable Conditions
QUICK SEARCH					Vaccine Preventable Diseases
					Foodborne and Waterborne Diseases
First Name		Last Name	Date Of Birth	mm/dd/yyyy	Vectorborne Diseases
					Tuberculosis
BOOKMARKED	PATIENTS i		EVENT NOTIFICATION	S (PAST 72 HOURS)	Hepatitis Case Report Forms
LAST NAME	FIRST NAME		There is no data	to be displayed	Hepatitis, Positive Pregnant Female
HALLEY	IAN		There is no date	to be alsprayed	Perinatal Hepatitis
					Acute Hepatitis Case Report Forms
> VIEW ALL BOOKM	MARKED PATIENTS		₿ REFRESH > VIEV	ALL NOTIFICATIONS	

#### • 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 enter details for any one of the three (3) types of Acute Hepatitis case reports.





3. Types of Acute Hepatitis Case Reports:

A Home				Case Report Forms
La companya				COVID-19
Announcement: Announcement 1				Sexually Transmitted Diseases
				Multi-drug Resistant Organism
	myD	ASHBOARD		Other Reportable Conditions
QUICK SEARCH				Vaccine Preventable Diseases
		Date Of		Foodborne and Waterborne Diseases
First Name	Last Name	Birth	mm/dd/yyyy	Vectorborne Diseases
				Tuberculosis
BOOKMARKED PATIENTS		EVENT NOTIFICATIONS	(PAST 72 HOURS)	Hepatitis Case Report Forms
LAST NAME FIRST NAME	There is no data to be displayed			Hepatitis, Positive Pregnant Female
HALLEY IAN		mere is no data t	o be displayed	Perinatal Hepatitis
				Acute Hepatitis Case Report Forms
> VIEW ALL BOOKMARKED PATIENTS		CREFRESH > VIEW	ALL NOTIFICATIONS	Hepatitis A
				Hepatitis B
				Hepatitis C

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*.

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#### 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.

KĤIE	ePartnerViewer	Support Support	📢 Announcements 2 🌲 Ad	visories 1 🕑 👻
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry 🕶
Home				Case Report Forms
Announcement:	Provider Assistance Program deadline extens	sion		Case Report Entry User Summary
		•••		Manage User Preferences

#### 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.

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Patient Search	Bookmarked Patien	ts Event Notifications	Lab	Data Entry 🝷	Case Report Entry 👻	
Home					Case Report Forms	
Announcement: el	Health Summit				Case Report Entry User Summary	
					Manage User Preferences	
				Create Attend	ding Physician/Clinician Details	
		myDASHBOA	RD	View & Edit A	ttending Physician/Clinician Details	
QUICK SEARCH				Create Perso	n Completing Form Details	
First	Last		Date Of	View & Edit P	erson Completing Form Details	
Name	Name	E	Birth	Create Order	ing Provider/Clinician Details	
				View & Edit C	Ordering Provider/Clinician Details	
BOOKMARKED PA	BOOKMARKED PATIENTS EVENT NOTIFICATIONS (PAST 72 HOURS)					



### 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 Foodborne and Waterborne 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.

KĤIE	ePartnerViewer	Support 📢 Announcements 🧕		Advisories			
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry <del>-</del>	Case Report Entry -			
🔺 Home				Case Report Forms			
Announcement:	ann062823			Case Report Entry User Summary			
•							
myDASHBOARD							

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

KĤIE	PartnerView	er		🗷 Support 📢 Annoui	ncements 🧕	🐥 Advisories	SIT TEST_17*
Patient Search	Bookmarked Pati	ents Event Notifications		Lab Data Entry	ž	Case Re	port Entry +
🖀 Home						Case Report For	ns >
Announcement: Annou	incement 1					Case Report Entr	ry User Summary
						Manage User Pre	eferences )
					Create Inte	rviewer Information	Details
		myDASHBO	ARD		View & Edit	Interviewer Inform	ation Details
QUICK SEARCH					Create Atte	nding Physician/Cli	nician Details
			Date Of		View & Edit	Attending Physicia	n/Clinician Details
First Name	Last	Name	Birth	mm/dd/yyyy	Create Per	son Completing For	m Details
					View & Edit	Person Completing	g Form Details
BOOKMARKED PA	TIENTS i	EVENT N	OTIFICATIO	NS (PAST 72 HOUR	S)		•



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

ATTEND	ING PHYSICIAN/CLINICIAN
Prefix	
Select 🗸	
First Name*	Last Name*
Suffix	
Select 🗸	
П	Address 2
111	Unit, Suite, Building, etc.
IV	State* Zip Code*
Jr	Select 🗸
Sr	Email
(XXX) XXX-XXXX	name@domain.com

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

Please complete the form	below to create an Attending P	<i>hysician/Clinician. All fields marked with an asterisk(*) are required.</i>					
ATTENDING PHYSICIAN/CLINICIAN							
Prefix Dr.	X V						
First Name*		Last Name*					
Suffix Sr	x   ~						



Г



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

Address 1*	Address 2	
	Unit, Suite, Building, etc.	
<u>City*</u>	State*	Zip Code*
	Select 🗸	

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

Email			
name@domain.com			
ne Phone and Email fields is not entered in the			
s that prevents you from proceeding to the next			

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

Prefix	
Dr. x   ~	
First Name*	Last Name*
Frank	Costanza
Suffix	
Sr X V	
Address 1*	Address 2
1 First Street	1A
City*	State* Zip Code*
Frankfort	KY × 40123
Phone*	Email
(555) 555-5555	frank@email.com





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

KĤIE	ePartnerViewer		Support 📢 Announcements 🧐	Advisories 4 SIT TEST_17 *
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
🖀 Home 🗲 Crea	te Attending Physician/Clinician Details			
		Create Attending Physician/Clinician Details	× risk(*) are required.	_
		Attending Physician/Clinician details saved successfu	lly	_
			OK	Save

### **View & Edit Attending Physician/Clinician Details**

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

KĤIE	ePartnerViewer	🖂 Support 🛛 📢 Annou	incements 🧿 🐥 Advisories 🤇	
Patient Search	Bookmarked Patients	Event Notifications Lab	Data Entry • Ca	ise Report Entry <del>-</del>
🖀 Home ゝ 🕚	View & Edit Attending Physician/Clinician Details			
	& EDIT ATTENDING CIAN/CLINICIAN DETAILS	5	₿ REFRESH	<b>T</b> 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 N	ext Last	Maximum 5	✓ entries per page





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

🖀 Home > V	<sup>/iew &amp; E</sup> Update Attending Physicia	an/Clinician Details	×
VIEW 8 PHYSIC	Dr. VIII		RESH TAPPLY FILTER
	First Name*	Last Name*	
SHOWING 5 ITEMS	Frank	Costanza	
ACTIONS	NAME Suffix		\$
	Dr. He Address 1*	Address 2	
	Dr. Ch 144 United St.	Unit, Suite, Building, etc.	
	City*	State*	Zip Code*
	Dr. Fra	кү 🛛 🕹 🗸	40509-
	Dr. Fre Phone*	Email	
	(859) 885-5455 John S	frankc@email.com	
	Jours		
		Cancel	Save um 5 👻 entries per page

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

SHOWING 5 ITEMS							
ACTIONS	NAME	Update Attending	g Physician/Clinician Details	×	PHONE NUMBER 🗢		
	Dr. Helen Rivera	Attending Physician/Clinician details updated successfully		(555) 555-5555			
	Dr. Charles Allen			ОК	(859) 555-5431		
	Dr. Fraiser McGill		fraisermcgill@email.com		(561) 654-4521		
	Dr. Frank Costanza, Sr		frankc@email.com		(859) 885-5455		





### **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.

KĤIE	ePartnerViewer	🗠 Support 🛛 📢 Annou	incements 🧕 🌲 Advisories 4 🛛 😔 SIT TEST_17 *
Patient Search	Bookmarked Patients	Event Notifications Lab	Data Entry • Case Report Entry •
Home > \	View & Edit Attending Physician/Clinician Details		
-	& EDIT ATTENDING CIAN/CLINICIAN DETAILS	5	CREFRESH 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 N	ext 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.

SHOWING 5 ITEMS				
ACTIONS	NAME	Delete Attending Physician/Clinician Details	×	PHONE NUMBER 🗢
	Dr. Helen Rivera	Are you sure?		(555) 555-5555
	Dr. Charles Allen			(859) 555-5431
	Dr. Fraiser McGill	Cancel OK		(561) 654-4521
	Dr. Frank Costanza, Sr	frankc@email.com		(859) 885-5455

Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



**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 one of the case reports 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.

showing 5 ITEMS		Delete Attending Physician/Clinician Details		×	
ACTIONS	NAME		This attending physician/clinician information is being used in one of the case reports that is still in progress. To delete this attending physician/clinician, please ensure that this attending physician/clinician is not being used in any case report that is in progress.		PHONE NUMBER 🗢
	Dr. Helen Rivera	still			(555) 555-5555
	Dr. Charles Allen				(859) 555-5431
	Dr. Fraiser McGill		ок		(561) 654-4521
	Dr. Frank Costanza, Sr				(859) 885-5455
	John Smith		john@mailinator.com		(555) 111-1111



### Filter Attending Physician/Clinician Details

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

(ĤIE	ePartnerViewei		Announce	ements 🧐 🌲 /	Advisories 4	
Patient Search	Bookmarked Patients	Event Notifications	Lab Dat	a Entry <del>-</del>	Case	Report Entry -
🖀 Home ゝ	View & Edit Attending Physician/Clinician Det	ails				
	& EDIT ATTENDING ICIAN/CLINICIAN DETAI	LS		£	REFRESH	APPLY FILTER
SHOWING 5 ITEMS						
ACTIONS	NAME	€ EMAIL	\$	PHONE NUMB	BER	\$
	Dr. Helen Rivera	helen@email.com		(555) 555-555	5	
	Dr. Charles Allen	callen@email.com		(859) 555-5431	1	
	Dr. Fraiser McGill	fraisermcgill@email.com		(561) 654-4521	1	
	Dr. Frank Costanza, Sr	frankc@email.com		(859) 885-5455	5	
	John Smith	john@mailinator.com		(555) 111-1111	1	

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

KĤIE	ePartnerViewer		Support 📢 Announcements 9	Advisories 🔕 💽 SIT TEST_17
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry <del>-</del>	Case Report Entry -
🖀 Home 🖒 🕅	view & Edit Attending Physician/Clinician Details			
VIEW 8 DETAIL	EDIT ATTENDING PHYSICIAN S	I/CLINICIAN		<b>REFRESH</b> HIDE FILTER
SHOWING 5 ITEMS				
ACTIONS	NAME Enter NAME	EMAIL Enter EMAIL	PHONE NUMBER	Enter 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	

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases





### **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.

KĤIE	ePartnerViewer	Support Support	📢 Announcements 🧐	🜲 Advisories 🧃 😩 SIT TEST_17 -		
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry -		
A Home				Case Report Forms		
Announcement:	ann062823			Case Report Entry User Summary		
		••••		Manage User Preferences		
myDASHBOARD						

3. To enter the details about the person completing the form, select **Create Person Completing Form Details** from the dropdown menu.

<b>KĤIE</b>   e	PartnerViewer		🖂 Support	Announce	ments 🧐	🐥 Advisories 🐴 👘	SIT TEST_17 -
Patient Search	Bookmarked Patients	Event Notifications	La	ib Data Entry <del>-</del>		Case Repo	ort Entry -
A Home						Case Report Form	s 📏
Announcement: Annou	ncement 1					Case Report Entry	User Summary
•							erences >
		myDASHBOAR	D			rviewer Information l Interviewer Informa	
QUICK SEARCH				c	Create Atte	nding Physician/Clini	cian Details
		Da	ite Of		/iew & Edit	Attending Physician/	/Clinician Details
First Name	Last Name	Bi	mm/r	dd/yyyy	Create Pers	on Completing Form	Details
				V	/iew & Edit	Person Completing	Form Details
BOOKMARKED PAT	TIENTS 🖲	EVENT NOTIFI	CATIONS (PAST	72 HOURS)			6
LAST NAME FIRS	ST NAME						



Г



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

Bullaing, etc.	
Zip Code*	
~	

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

First Nam	e*	Last Name*

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

Address 1*	Address 2 Unit, Suite, Building, etc.	
City*	State*	Zip Code*
	Select 🗸	



Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



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

Phone* (XXX) XXX-XXXX	Email name@domain.com
	ne <i>Phone</i> and <i>Email</i> fields is not entered in the that prevents you from proceeding to the next

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

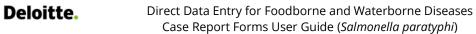
Prefix			
Mr. ×   v			
First Name*	Last Name*		
Arthur	Vandelay		
Suffix			
II ×   ~			
Address 1*	Address 2		
22 Second Avenue	Unit, Suite, Building,	etc.	
City*	State*		Zip Code*
Bowling Green	KY	×   ~	42101
Phone*	Email*		
(222) 222-2222	arhur@email.com		

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

Home > Create Person Completing Form Details			
Please complete the form below to cr	Create Person Completing Form Details	×	) are required.
	Person Completing Form details saved successfully		
		ОК	Clear Save

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases Page 29 of 107

Kentucky Health Information Exchange





### **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.

倄 Home 🖒 Vi	ew & 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					

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.

ERSON CO	Update Person Completing Form D	etails	×	
	Prefix Mr. × V			
	First Name*	Last Name*		E NUMBER
ur Vandelay, II	Arthur	Vandelay		22-2222
ty Craine, Sr	Suffix II × V			23-3210
e Doe	Address 1*	Address 2		23-1234
	22 Second Avenue	Unit, Suite, Building, etc.		
	City*	State*	Zip Code*	
	Bowling Green	KY × V	42101	
	Phone*	Email*		
	(222) 222-2222	arthur@email.com		
		Cancel	Save	





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

IAME	€ EMAIL		\$ PHONE NUMBER
lr. Arthur Vandelay, ll	Update Person Completing Form Details	×	(222) 222-2222
lr. Marty Craine, Sr	Person Completing Form details updated successfully		(555) 123-3210
liss Jane Doe		ок	(555) 123-1234
Fi	rst Back 1 Next Last		Maximu

#### **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 🖒	Home > View & Edit Person Completing Form Details							
• VIEW 8	● 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, Il	Delete Person Completing Form Details	×	(222) 222-2222
Mr. Marty Craine, Sr	Are you sure?		(555) 123-3210
Miss Jane Doe	Cancel OK		(555) 123-1234
F	rst Back <mark>1</mark> Next Last		Maximum 5 👻

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases Kentucky Health Information Exchange





**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 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 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	Delete Person Completing Form Details	×	\$ PHONE NUMBER
Mr. Arthur Vandelay, II	This person information is being used in one		(222) 222-2222
Mr. Marty Craine, Sr	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		(555) 123-3210
Miss Jane Doe	that is in progress.		(555) 123-1234
Fir		К	



Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



### **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					
O VIEW	& EDIT PERSON COMP	LETING F	ORM DETAILS	CREFRESH 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	
	Fir	rst Back 1	Next Last	Maximum 5 • entries per page	

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

• VIEW &	EDIT PERSON COMPLETING FOR	<b>REFRESH</b> HIDE FILTER				
showing 3 ITEMS						
ACTIONS	NAME Enter Name 🗢	EMAIL Enter Email 🗘	PHONE NUMBER         Enter Phone Number			
	Mr. Arthur Vandelay, Il	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	
Patient Information	⊘	Is the patient vaccinated for the condition being reported?*	
Laboratory Information	Ø	Yes No Unknown	
Applicable Symptoms	⊘	No clas Datella	
Additional Information	⊘	Vaccine Details	
Hospitalization, ICU & Death Information	0	Select	
Vaccination History			
Additional Comments	۵	If yes, please enter the number of doses: 🚱	
Review & Submit	<b>A</b>	Select	
		Date Administered (1st dose) Date Administered (2nd dose)	
		mm/dd/yyyy 🗰 🗌 Unknown 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.

Save	Previou	s	Next	

- 2. If you click on a previously completed screen on the side navigation bar, the *Save Changes* pop-up will display. You have the option to save or discard the changes on the current screen before navigating to another screen.
- If you click Yes Save and all the required fields are entered on the current screen, you will
  navigate to the intended screen. (If you have not completed all 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.

Vaccine Details			
<b>If yes, please provide vaccine name</b> Diphtheria antitoxin	Save Changes?	×	
If other, please specify: 😧	There's information on this screen that has not been saved. Do you want to save it?		
lf yes, please enter the number of d 1	No - Discard Yes - Save	]	
Date Administered (1st dose)*			Date Administered (2nd dose)



## **Case Report Entry Icons**

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

## Icon Descriptions:

Icon	Name	Description
Section 8 of 10	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 <b>Next</b> 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 Foodborne and Waterborne 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 Foodborne and Waterborne Diseases Case Report, the subsequent fields will be grayed out and disabled.

LABORATORY INFORMATION				
Patient Information	Ø	Does the patient have a lab test?*		
Laboratory Information	${ \oslash }$	Yes No Unknown		
Applicable Symptoms				
Additional Information	<b>a</b>			
Hospitalization, ICU & Death Information		Laboratory Name		
Vaccination History	<b>a</b>	Test Name Select		
Additional Comments	<b>a</b>	If other, please specify: 🚱		
Review & Submit	<b>a</b>			
		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	Ø	Does the patient have a lab test?*	
Laboratory Information	$\otimes$	Yes No Unknown	
Applicable Symptoms		Laboratory Information	
Additional Information		Laboratory Name*	
Hospitalization, ICU & Death Information	<b>A</b>	Laboratory Name"	
Vaccination History		Test Name*	~
Additional Comments	<b>a</b>	Select If other, please specify: 🚱	
Review & Submit			
		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	$\oslash$	Were symptoms present during the course of illness?*
Laboratory Information	$\odot$	Yes No Unknown
Applicable Symptoms		
Additional Information	<b>a</b>	Onset Date 🚱 mm/dd/yyyy 🏦 📃 Unknown
Hospitalization, ICU & Death Information	<b>a</b>	If symptomatic, which of the following did the patient experience during their illness?
Vaccination History	<b>a</b>	Fever
Additional Comments	<b>A</b>	Yes No Unknown If yes, please enter the highest temperature: 🖗
Review & Submit	<b>a</b>	
		Diarrhea (>3 loose stools/24hr period) Yes No Unknown If yes, please enter # of days of diarrhea: <b>O</b> Chills Yes No Unknown

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases





• 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*.

		APPLICABLE SYMPTOMS
Patient Information	Ø	Were symptoms present during the course of illness?*
Laboratory Information	Ø	Yes No Unknown
Applicable Symptoms		Onset Date 🖗
Additional Information	۵	mm/dd/yyyy 🟥 🗌 Unknown
Hospitalization, ICU & Death Information	<b>a</b>	If symptomatic, which of the following did the patient experience during their illness?
Vaccination History	<b>A</b>	Fever
Additional Comments	<b>a</b>	Yes No Unknown If yes, please enter the highest temperature: 🕑
Review & Submit	<b>A</b>	n yes, preud anter die ingrites 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 **Yes** to the conditional question at the top of the **Applicable Symptoms** screen, the subsequent fields are enabled.

		APPLICABLE SYMPTOMS
Patient Information	$\oslash$	Were symptoms present during the course of illness?*
Laboratory Information	$\oslash$	Yes No Unknown
Applicable Symptoms		
Additional Information	۵	Onset Date* 🚱 mm/dd/yyyy 🏥 🔲 Unknown
Hospitalization, ICU & Death Information	<b>A</b>	If symptomatic, which of the following did the patient experience during their illness?
Vaccination History	<b>A</b>	Fever*
Additional Comments	<b>A</b>	Yes No Unknown If yes, please enter the highest temperature: @
Review & Submit	<b>a</b>	
		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



# 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 **<u>different</u>** Affiliation/Organization to each.

Yes No		
atient ID (MRN) 🚱	Affiliation/Organization 🚱	
	Select	
Person Completing Form	Affiliation/Organization 🚱	If other, please specify: 🚱
Person Completing Form	Affiliation/Organization 🕢	If other, please specify: 😧
		If other, please specify: 😧 If other, please specify: 😮

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



## Affiliation/Organization Conditional Answer: Yes

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

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

Yes No			
Patient ID (MRN)* 😧	Affiliation/Organization* 🕄		
	Select	~	
Person Completing Formt	Affiliation/Organization 😧		If other, please specify: 🚱
Person Completing Form.	/ initiation / on game addition		
Select	Select		
Person Completing Form* Select Attending Physician/Clinician*			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 **<u>same</u>** Affiliation/Organization is applied to the Patient ID (MRN), the Person Completing Form, and the Attending Physician/Clinician.

Yes No			
Patient ID (MRN)* 😧	Affiliation/Organization* 🚱		
SK05051960	Test Medical Center	×   ~	
Person Completing Form*	Affiliation/Organization 😧		If other, please specify: 🕖
Mr. Arthur Vandelay, II (arthur@email.com) $ \times      \lor $	Test Medical Center	$\times   \sim$	
Attending Physician/Clinician*	Affiliation/Organization 🚱		If other, please specify: 🕖
Dr. Frank Costanza, Sr (frank@email.com) ×   ~	Test Medical Center	×   ~	



## Affiliation/Organization Conditional Answer: No

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

- **<u>Each</u>** of the three (3) *Affiliation/Organization* fields are enabled.
- You must individually complete **<u>each</u>** of the *Affiliation/Organization* fields respectively 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: 🔞
Select	~	Select	× .
Attending Physician/Clinician*		Affiliation/Organization* 😧	If other, please specify: 😡
Select		Select	

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

Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
SR05051960	Select 🗸	
Person Completing Form*	Afzal, Mohammad MD, Internal Medicine, LLC	lf other, please specify: 🕢
Select 🗸	eICR Onboarding Regression	
Attending Physician/Clinician*	Hilton Hospital	If other, please specify: 🚱
Select V	King's Daughters Medical Center	
	Murray-Calloway County Hospital	
Prefix	Test Medical Center	
Select V	University Of Kentucky Chandler Medical Center	

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

Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🕑
Mr. Arthur Vandelay, II (arthur@email.com) 🗙 🗸 🗸	Select 🗸 🗸	
Attending Physician/Clinician*	,	If other, please specify: 🔞
Select	eICR Onboarding Regression	n other, please specify.
Select V	Hilton Hospital	
	King's Daughters Medical Center	
Prefix	Murray-Calloway County Hospital	
Select 🗸	Test Medical Center	
First Name*	University Of Kentucky Chandler Medical Center	Last Name*
	Other	
Suffix	Date of Birth*	

Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



**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**.

Yes No		
Patient ID (MRN)* 🚱	Affiliation/Organization* 😧	
CK08101955	Baxter Hospital X	~
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify:* 😧
Mr. Arthur Vandelay, II (arth 🗙 🗸 🗸	Other ×	~

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

Patient ID (MRN)* 🚱	Affiliation/Organization* 🚱	
CK08101955	Baxter Hospital X	
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify:* 🚱
Mr. Arthur Vandelay, II (arthur@email.com) 🛛 🗙 📔	Other X	
Attending Physician/Clinician*	Affiliation/Organization* 🕢	If other, please specify: 🕖
Dr. Frank Costanza, Sr (frankc@email.com) 🛛 🗙 📔	Select	·
	Eugene Hospital	
Prefix	Evergreen General Hospital	
Select V	Green Hosp	
7 and \$1 and a \$	Heartland Clinic	Local New A
irst Name*	Hilton Hospital	Last Name*
	Howell Hospital	
Suffix	Justin Hospital	
Select	/	
Patient Sex*	Ethnicity*	Race*
Colort	Colore	



## 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?* 

Patient ID (MRN)*	Affiliation/Organization* 😧			
SK05051960	Test Medical Center	x   ~		
Person Completing Form*	Affiliation/Organization* 😧		If other, please specify:* 😧	
Mr. Arthur Vandelay, II (arthur@email.com) 🗙 📔 🗸	Other	×   ~	Test Hospital	
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: 🚱	
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🗌 🗸	Test Medical Center	x   ~		
the Affiliation/Organization same for Patient ID (Mi	N), Person Completing Form and Attending P	hysician/Clinicia	n?*	
atient ID (MRN)* 2	Affiliation/Organization* 😧			
SK05051960	Test Medical Center	X V		
erson Completing Form*	Affiliation/Organization 🚱		If other, please specify: 🚱	
Mr. Arthur Vandelay, II (arthur@email.com) 🗙 📔 🗸	Test Medical Center			
ttending Physician/Clinician*	Affiliation/Organization 🕑		If other, please specify: 🚱	
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🛛 🗸	Test Medical Center			
Is the Affiliation/Organization sam Yes No Patient ID (MRN)* SK05051960	e for Patient ID (MRN), Person ( nt Information	Completing	×	
Yes No Patient ID (MRN)* @ Patient	e for Patient ID (MRN), Person (	Completing	× ation" will	

- 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.

Patient ID (MRN)* 5	Affiliation/Organization* 😧		
SK05051960	Test Medical Center	×   ~	
erson Completing Form*	Affiliation/Organization* 🛛		lf other, please specify:* 🚱
Mr. Arthur Vandelay, II (arthur@email.com) 🗴 🛛 🗸	Other	x   ~	Test Hospital
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🗸 🗸	Test Medical Center	x v	

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	-	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*
Medical Conditions	-	Yes No
Travel Information	<b>A</b>	Patient ID (MRN)*  Patient Information  ×
Hospitalization, ICU & Death Information	<b>A</b>	SK05051960 All selections for the "Affiliation/Organization" will
Additional Information	<b>A</b>	Person Completing For selection? If other, please specify:*
Treatment Information	<b>A</b>	Mr. Arthur Vandelay.
Additional Comments	-	Attending Physician/Cli If other, please specify:  Dr. Frank Costanza, Sh (trankgemail.com) X Y lest Medical center X Y
Review and Submit	-	

- 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 a	There are errors. Please make a selection for all required fields.				
PATIENT INFORMATION					
Patient Information		Disease/Organism* 😧	Date of Diagnosis*		
Laboratory Information	<b>a</b>	Chlamydia	× V 07/23/2021	the Unknown	
Applicable Symptoms	<b>A</b>		t ID (MRN), Person Completing Form and Atten		
Medical Conditions	<b>A</b>	Yes No	it to (wikit), Person Completing Form and Atten	ung mysician/cimiciant"	
Travel Information	<b>a</b>	Patient ID (MRN)* 😧	Affiliation/Organization* 😧		
Hospitalization, ICU & Death Information	<b>A</b>	SK05051960	Select Please Enter Affiliation/Organization	~	
Additional Information			······································		





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

Is the Affiliation/Organization same for Patient ID (MRN Yes No	), Person Completing Form and Attending Physician/Clinic	ian?*
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
SK05051960	Select 🗸 🗸	
	Afzal, Mohammad MD, Internal Medicine, LLC	
Person Completing Form*	eICR Onboarding Regression	If other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@email.com) $~ imes~~$	Hilton Hospital	
Attending Physician/Clinician*	King's Daughters Medical Center	If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🛛 🗸	Murray-Calloway County Hospital	
	Test Medical Center	
Prefix	University Of Kentucky Chandler Medical Center	
Ms. × v		

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

Yes No			
Patient ID (MRN)* 😧	Affiliation/Organization* 🚱		
SK05051960	Test Medical Center	×   ×	
Person Completing Form*	Affiliation/Organization 😧		If other, please specify: 🕖
Mr. Arthur Vandelay, II (arthur@email.com) $ \times      \lor $	Test Medical Center	$\times   \sim$	
Attending Physician/Clinician*	Affiliation/Organization 🚱		lf other, please specify: 🕖
Dr. Frank Costanza, Sr (frank@email.com) × V	Test Medical Center	x   ~	





## 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.

Patient ID (MRN)* 3	Affiliation/Organization* 🚱		
SK05051960	Test Medical Center	x   ~	
Person Completing Form*	Affiliation/Organization 🚱		lf other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@email.com) $  imes                     $	Test Medical Center		
Attending Physician/Clinician*	Affiliation/Organization 🚱		lf other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗸 🗸	Test Medical Center		

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

Is the Affiliation/	Patient Information ×	nd Attending Physician/Clinician?*
Yes Patient ID (MRN) <sup>*</sup> CK08101955	All selections for the "Affiliation/Organization" will be reset. Are you sure you want to change your selection?	x   ~
Person Completi Mr. Arthur Vanc	Yes No	If other, pleas

- 2. You must individually complete **<u>each</u>** 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.
- <u>All</u> three (3) of the *Affiliation/Organization* fields are enabled. This means a different Affiliation/Organization can be selected for each field.

Patient ID (MRN)* 🚱	Affiliation/Organization* 🚱	
CK08101955	Select	· ·
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🚱
Dr. Estelle Costanza (estelle@email $ imes    imes$	Select	· ·
Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@emai × v	Select	

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases





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

Yes No	ID (MRN), Person Completing Form, and Attending Physician/Cl	n nuan (; *	
Patient ID (MRN)* 😧	Affiliation/Organization* 😧		
CR01542035	Select	~	
Person Completing Form*	Eugene Hospital	If other, please specify: 🚱	
Select	<ul> <li>Evergreen General Hospital</li> </ul>		
Attending Physician/Clinician*	Green Hosp	If other, please specify: 🕑	
Select			
	Hilton Hospital		
Prefix	Howell Hospital		
Select	Justin Hospital		
	Knight Heepitel		
First Name*	Middle Name	Last Name*	

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

Person Completing Form* Mr. Arthur Vandelay, II (arthur@em × / ✓	Affiliation/Organization* 🚱	If other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@em 🔺 🗸	Select V	
Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🔞
Dr. Frank Costanza, Sr (frank@emai 🗴 🗸	Select 🗸	
	Afzal, Mohammad MD, Internal Medicine,	
Prefix	LLC	
Select 🗸	eICR Onboarding Regression	
	Hilton Hospital	
First Name*	King's Daughters Medical Center	Last Name*
	Murray-Calloway County Hospital	
Suffix	Test Medical Center	
Select 🗸	University Of Kentucky Chandler Medical	
Patient Sex*	Ethnicity*	Race*

**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**.

erson Completing Form*	Affiliation/Organization* 🚱		If other, please specify:* 🚱
Mr. Arthur Vandelay, II (arthur@em 🗙 🗸 🗸	Other	$\times   \sim$	
ttending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: <b>* </b>





# 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 <u>mandatory</u> 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 m	arked with an asterisk(*) are required.	
	PATIENT	INFORMATION
Patient Information	Disease/Organism* 😧	Date of Diagnosis*
Laboratory Information	Select	mm/dd/yyyy

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

Please complete the form below.	All fields ma	rked with an asterisk(*) are required.	
		PATIENT INFORMATION	
Patient Information		An MRN or Medical Record Disea Number is an Organization Date of Diagnosis*	
Laboratory Information	<b></b>	Saln in specific unique mm/dd/yyyy	
Applicable Symptoms	<b>a</b>	healthcare organization. If healthcare organization does not be for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*	
Additional Information		use an MRN, you MUST create a way to uniquely	
Hospitalization, ICU & Death Information	<b>A</b>	Identify your patient       Patient ID (MRN)*        Select	

• 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*	Zip Code*
County*		one* 🚱	Email name@domain.com
Adair			
Allen Anderson	En	counter ID/Visit #* 🛛	Generate
Ballard Barren			
Bath Bell	U	iknown	



٠



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

City*	State*	Zip Code*
	AK	×   ~
County*	Phone* 😧	Email

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

Admi mm	ssior n/dd/						Discharge Date*Unknownmm/dd/yyyyImage: Market ConstraintsImage: Market Cons
Su	Jan	<b>Janu</b> uary Tu		2 <b>024</b>	4 🗸 Fr	Sa	Still hospitalized
31 7	1	2		4	5		ntensive care unit (ICU)?* Unknown
14 21	15 22	16 23	1 <b>7</b> 24	18 25	19 26	20 27	Discharge Date from ICU         Unknown         mm/dd/yyyy         Imm/dd/yyyy
28	29	30	31	1	2	3	

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

Admission Date*		Discharge Date*	
mm/dd/yyyy	🗸 Unknown	01/19/2024	Unknown
		Still hospitalized	



# 8 Foodborne and Waterborne Diseases Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the Foodborne and Waterborne Diseases Case Report Form in the ePartnerViewer.

 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.

KĤIE   ef	PartnerViewer		Support 📢 Announcements 🧕	Advisories 🧕 🕒 SIT TEST_17 *
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
A Home				Case Report Forms
Announcement: Announce	ement 1			Case Report Entry User Summary
				Manage User Preferences
		myDASHBOARI	)	
QUICK SEARCH				Q ADVANCED SEARCH
First Name	Last Name	Date Birth	roro (ddhana)	🛱 🖉 Search

2. Select **Foodborne and Waterborne Diseases** from the dropdown menu.

KĤIE	ePartner	Viewer		🐸 Support 🖣	Announcements 🧿 🌲 Advisories 🕢 😫 SIT TEST_17 -
	t Search	Bookmarked Patients	Event Notifications	Lab Data Entry 👻	Case Report Entry *
😭 Home					Case Report Forms
Announceme					COVID-19
Announceme	nc annuo2825		••••		Sexually Transmitted Diseases
					Multi-drug Resistant Organism
			myDASHBOARD		Other Reportable Conditions
QUICK SEARCH					Vaccine Preventable Diseases
					Foodborne and Waterborne Diseases
First Name		Last Name	Date Of Birth	mm/dd/yyyy	Vectorborne Diseases
					Tuberculosis
BOOK	MARKED PATIENTS	6	EVENT NOTIFICATIONS	(PAST 72 HOURS)	Hepatitis Case Report Forms
LAST NAME	FIRST NAME		There is no data to	be displayed	
HALLEY	IAN				
> VIEW	ALL BOOKMARKED PATIENTS		₽ REFRESH > VIEW A	ALL NOTIFICATIONS	





# 9 Patient Information

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

		PATIENT INF			
tient Information	Disease/Organism* 🚱		Date of Diagnosis*		
boratory Information	Select	~	mm/dd/yyyy	<b>iii</b>	Unknown
licable Symptoms					
litional Information	Is the Affiliation/Organization sam	ne for Patient ID (	MRN), Person Completing Form, and	Attending Physi	cian/Clinician?*
pitalization, ICU & Death Information			Affiliation (Organization		
cination History	Patient ID (MRN) 🚱		Affiliation/Organization @		
itional Comments	Person Completing Form		Affiliation/Organization 🚱		If other, please specify: 🔞
w & Submit	Select		Select		
	Attending Physician/Clinician		Affiliation/Organization 🚱		If other, please specify: 🚱
	Select		Select		
	Prefix				
	Select	~			
	First Name*		Middle Name		Last Name*
	Suffix		Date of Birth*		
	Select	~	mm/dd/yyyy	<b></b>	
	Patient Sex*		Ethnicity*		Race*
	Select	~	Select	~	Select





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

		PATIENT INFORMATION		
ient Information	Disease/Organism* 🚱	Date of Diagnos	is*	
oratory Information	Select	∼ mm/dd/yyyy		Unknown
cable Symptoms				
onal Information	Is the Affiliation/Organization same for Yes No	Patient ID (MRN), Person Completing	Form, and Attending Physician/Clin	ician?*
talization, ICU & Death Information	Patient ID (MRN) @	Affiliation/Organ	ization 🛛	
nation History	Pauent ID (WRRY)	Select		
ional Comments	Person Completing Form	Affiliation/Organ	ization 🔞	If other, please specify: 🚱
v & Submit		Select		v
	Attending Physician/Clinician	Affiliation/Organ	ization 🚱	If other, please specify: 🔞
	Select	Select		V
	Prefix			
	Select	~		
	First Name*	Middle Name		Last Name*
	Suffix	Date of Birth*		
	Select	∽ mm/dd/yyyy		<b></b>
	Patient Sex*	Ethnicity*		Race*
	Select	Select		∨ Select
	Address 1*		Address 2 Unit, Suite, Building	ote
	City*		State*	Zip Code*
	County*	Phone* @	1	Email name@domain.com
	Visit Type*	Encounter ID/Vi	sit # <b>* 0</b>	
	Select			Generate
	Is the patient currently pregnant?			
	Yes No Unkno			
	If yes, please enter the due date (EDC):			
		iii Unknown		

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



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**Please Note:** You are required to enter the details associated with the *Person Completing Form* and the *Attending Physician/Clinician* prior to entering Foodborne and Waterborne Diseases information.

If you access the Foodborne and Waterborne 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 Foodborne and Waterborne Diseases Case Report details.

To enter your Attending Phys	ician/Clinician	nd Person Completing Form details in the User Preferences, click	on the hyperlink.	
PATIENT INFORMATION				
Laboratory Information	A	Disease/Organism* Date of Diagnosis*	Unknown	
Applicable Symptoms	6			

2. To start the Foodborne and Waterborne Diseases Case Report entry, select the appropriate **Disease/Organism** from the *Disease/Organism* dropdown on the **Patient Information** screen.

		F	PATIENT INF	ORMATION		
Patient Information		Disease/Organism* 🚱		Date of Diagnosis*		_
Laboratory Information	<b>a</b>	Şelect	~	mm/dd/yyyy	<b></b>	Unknown
Applicable Symptoms	<b></b>	Hemolytic Uremic Syndrom	ne (HUS)			
Additional Information		Listeria, Neonatal		nt ID (MRN), Person Complet	ing Form, and Atte	nding Physician/Clinician?*
Hospitalization, ICU & Death Information	<b>a</b>	Listeriosis (Listeria) Salmonella Paratyphi		Affiliation/Organization 😧		
Vaccination History	<b>a</b>	Trichinellosis		Select		
Additional Comments		Person Completing Form Select		Affiliation/Organization 🕢		If other, please specify: 🚱
Review & Submit	<b></b>	Attending Physician/Clinician	1	Affiliation/Organization 🕑		If other, please specify: 🔞
		Select		Select		





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

Disease/Organism* 😧	Date of Diagnosis*	
Diphtheria X V	mm/dd/yyyy	iii 🗌 Unknowr

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?* 

Yes No		
Patient ID (MRN) 🚱	 Affiliation/Organization 🔞	
	Select	
Person Completing Form	Affiliation/Organization 🚱	If other, please specify: 😧
reison completing form		
Select	Select	
1 0	Select Affiliation/Organization ②	If other, please specify: 😡

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

* Yes No		
Patient ID (MRN)* 🕢	Affiliation/Organization* 🕢	
Person Completing Form*	Affiliation/Organization 😧	lf other, please specify: 🔞
Select ×	Select	If other, please specify: 🔞
Select	Select	





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

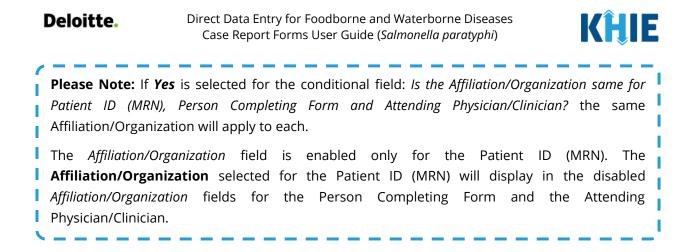
Yes No		
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
	Select 🗸	
Person Completing Form*	Affiliation/Organization* 🚱	If other, please specify: 🔞
Select	Select	

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

Patient ID (MRN)* 😧	Affiliation/Organization* 🚱	
	Select	$\sim$

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

Patient ID (MRN)* 🚱	Affiliation/Organization* 😧		
EB19039283	Select	~	
Person Completing Form*	Eugene Hospital	*	lf other, please specify: 🔞
Select 🗸 🗸	Evergreen General Hospital		
Attending Physician/Clinician*	Green Hosp		If other, please specify: 🚱
Select v	Heartland Clinic		
	Hilton Hospital		
Prefix	Howell Hospital		
Select	Knight Hospital		
	Knoll Hospital	•	



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

Yes No	
Patient ID (MRN)* 😧	Affiliation/Organization* 🕢
EB192465	Evergreen General Hospital
Person Completing Form*	Affiliation/Organization 😮
Select	Evergreen General Hospital
Jane Doe (jane@mailinator.com)	Affiliation/Organization 🔞
Mr. Marty Craine, Sr (marty@email.com)	Evergreen General Hospital

**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.

Person Completing Form*	Affiliation/Organization 😮	
Select	Select	



- 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.

Please complete the form below. All fields marked w	Manage User Preferences		×
	<i>Please complete the form below to create a Peasterisk(*) are required.</i>	erson Completing Form. All fields marked with an	
Patient Information	PERSON COM	IPLETING FORM	
Laboratory Information	Prefix		] Unknown
Applicable Symptoms	Select 🗸		cian/Clinician?*
Medical Conditions	First Name*	Last Name*	club connectors
Travel Information			
Hospitalization, ICU & Death Information	Suffix		
Additional Information	Select 🗸 🗸		If other, please specify: 🕢
Treatment Information		Address 2 Unit, Suite, Building, etc.	
Additional Comments	IV	State* Zip Code*	If other, please specify: 🕖
Review and Submit	Jr	Select	
	Sr	Email*	
	(XXX) XXX-XXXX	name@domain.com	
			Last Name*
		Cancel Save	

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

First Name*	Last Name*

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

Address 1*	Address 2	
	Unit, Suite, Building, etc.	
City*	State*	Zip Code*
	Select 🗸	

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

Phone*	 Email*		
(XXX) XXX-XXXX	name@domain.	com	
() 00 () / 00 ( / 00 0 (	hamee domain		





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

<b>A</b>	ls the Affiliation	<i>Please complete the form below to createrisk(*) are required.</i>	ate a Person Completing Form. All fields i	marked with an		
<b>a</b>	Yes					
<b>a</b>	Patient ID (MRN	PERSON	COMPLETING FORM			
<b>A</b>	EB192465	Prefix				
<b>a</b>	Person Comple	Mr. ×   ~				lf other, p
	Select	First Name*	Last Name*			
	Attending Phys	Marty	Craine			lf other, p
	Select	Suffix				
		Sr X V				
	Prefix	Address 1*	Address 2			
	Select	123 Cheers Street	Unit, Suite, Building, etc.			
	First Name*	City*	State*	Zip Code*		Last Nam
		Lexington	KY × v	40123-		
	Suffix	Phone*	Email*			
	Select	(555) 123-3210	marty@email.com			
	Patient Sex*					Race*
	Select		Cancel	Save		Select
	Address 1*			Address 2		
				Unit, Suite, Bui	lding, etc.	

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**.

erson Completing Form*		Affiliation/Organization	n 🕜	If other, please specify: 😮
Select	-	Select		
Miss Jane Doe		Affiliation/Organization	n 😧	If other, please specify: 🚱
(jane@mailinator.com)		Select		
Mr. Arthur Vandelay, II	- 1			
(arthur@email.com)				
Mr. Marty Craine, Sr				
(marty@email.com)				





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

Baxter Hospital Affiliation/Organization* @	x   ~
Affiliation/Organization*	
Anniauon/organization"	If other, please specify: 🕑
< │ ~ \$elect	~
Eugene Hospital	▲ If other, please specify: 🚱
$\sim$ Evergreen General Hospital	
Green Hosp	
Heartland Clinic	
→ Hilton Hospital	
Howell Hospital	Last Name*
Justin Hospital	
Date of Birth*	
∼ mm/dd/yyyy	
<i>Organization</i> field that appl	lies to the Person Completing Form
signification neid that uppi	
	Eugene Hospital Evergreen General Hospital Green Hosp Heartland Clinic Hilton Hospital Howell Hospital Justin Hospital Date of Birth* mm/dd/yyyy

 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.*

Patient ID (MRN)* 🚱	Affiliation/Organization* 😧	
CR01542035	Baxter Hospital	x   ~
Person Completing Form*	Affiliation/Organization* 🚱	If other, please specify:* 😧
Mr. Arthur Vandelay, II (arthur@email.com) $\qquad \times \qquad \lor$	Other	x   ~
Attending Physician/Clinician *	Affiliation/Organization* 🚱	lf other, please specify: 🚱
Select 🗸 🗸	Select	✓

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.

Attending Physician/Clinician*		Affiliation/Organization*	0
Select	~ ]	Select	

- 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.

Please complete the form below. All fields m	narked with	Manage User Preferences		×	
		<i>Please complete the form below to with an asterisk(*) are required.</i>	o create an Attending Physician/Clinician. All fields m	arked	
Patient Information		ATTENDI	NG PHYSICIAN/CLINICIAN		2
Laboratory Information	<b>A</b>	Prefix			J Unknown
Applicable Symptoms	<b>A</b>	Select V			an/Clinician?*
Additional Information	<b>A</b>	First Name*	Last Name*		nvenneidnr"
Hospitalization, ICU & Death Information	<b>A</b>				
Vaccination History	<b>A</b>	Suffix			
Additional Comments	<b>A</b>	Select 🗸			If other, please specify: 😧
Review & Submit	<b>A</b>	Address 1*	Address 2		
			Unit, Suite, Building, etc.		If other, please specify: 😧
		City*	State* Zip	Code*	
			Select 🗸		
		Phone*	Email		
		(XXX) XXX-XXXX	name@domain.com		
					Last Name*
			Cancel	Save	
			Current		
		Select	mm/dd/yyyy	#	

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

First Name*	Last Name*

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

Address 1*	Address 2	
	Unit, Suite, Building, etc.	
City*	State*	Zip Code*
	Select 🗸	





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

Email*	
name@domain.com	

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

Bookma	Manage User Preferences			×
table Diseases Case Report	Please complete the form below to creativity an asterisk(*) are required.	ate an Attending Physician/Clinician. All fiel	ds marked	
LE DISEASES CASE	ATTENDING	PHYSICIAN/CLINICIAN		
elow. All fields marked with	Prefix Dr. X V			
	First Name*	Last Name*		_
<b>a</b>	Suffix			) Unknown
 	Select V	Address 2		an/Clinician?*
Information	112 Cottonwood Rd	Unit, Suite, Building, etc.		
 	City* Lexington	State*	Zip Code* 40503-	If other, please specify: 🔞
<b>A</b>	Phone* (859) 555-5431	Email callen@email.com		If other, please specify: <b>Ø</b>
		Cancel	Save	

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

Attending Physician/Clinician*	Affiliation/Organization* 🚱	lf other, please specify: 🚱
Dr. Charles Allen (callen@email.com)		
Dr. Fraiser McGill (fraisermcgill@email.com) Dr. Frank Costanza, Sr (frankc@email.com) John Smith (john@mailinator.com)	Middle Name	Last Name*

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases





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

Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Dr. Charles Allen (callen@email.com) $\qquad \qquad \qquad$	Select 🗸	
Prefix	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaaaaaaaaaa	
Select V	Baxter Hospital	
First Name*	DDE SMOKE TEST SIT NONCOVID Eugene Hospital	Last Name*
Suffix Select	Evergreen General Hospital Green Hosp Heartland Clinic	

**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*.

Attending Physician/Clinician *	Affiliation/Organization* 😧	If other, please specify:*	9			
Dr. Charles Allen (callen@email.com) $\qquad \times \qquad \smallsetminus$	Other	x   ~				
(						
Please Note: Additional info	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	Date of Birth*	
Select 🗸	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**.

Select v mm/dd/yyyy 🗰	Suffix	Date of Birth*	
	Select 🗸	mm/dd/yyyy	<b></b>

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

Patient Sex*	Ethnicity*		Race*	
βelect ✓	Select		Select	
Female				
Male		Address 2		
Other		Unit, Suite, Building, etc.		
Unknown		State*		Zip Code*
		Select	~	

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

Patient Sex*		Ethnicity*		Race*	
Select	~	Not Hispanic or Latino	x   ~	Şelect	~
				American Indian or Alaska Native	Â
Address 1*			Address 2	Asian	
			Unit, Suite, Building, etc.	Asked but Unknown	. 1
City*			State*	Black or African American	
			Select	Native Hawaiian or Other Pacific Islander	
County*		Phone* 😮		Other	
Select		(XXX) XXX-XXXX		Unknown	

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

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

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

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

City* Lexington			State*	×	Zip Code*
County*		Phone* 😧		Email	
Fayette	x   ~	(XXX) XXX-XXXX		name@domain.com	





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

Visit Type*	Encounter ID/Visit #* 🚱
Ambulatory	
Emergency	
Field	
Home Health	
Inpatient Acute	Unknown
Inpatient Encounter	
Inpatient Non-Acute	
•	Next

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

/isit Type <b>*</b>		Encounter ID/Visit <u>#</u> * 🚱	
Ambulatory	×   ~		Generate

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

Visit Type*		Encounter ID/Visit #* 😧	
Select	~		Generate





	_									
		Patient ID (N	1RN)* 😧		Prefix					
toms	<b>A</b>	EB060819	70		Select					
ns	<b>a</b>	First Name*			Middle Name			Last Name*	,	1
ation	<b>a</b>	Elaine						Benes		
C11.0										
CU &	Patient Case Hist	ory							×	
ory hents	SHOWING 2 ITEMS								<b>T</b> APPLY FILTER	~
	CREATION DATE TIME	♦ RE	PORT NAME	COND		; v	ISIT TYPE	\$	ENCOUNTER ID	
	05/31/2023 9:08 AM	Ot	her Conditions	Adult	Botulism	In	npatient Encounte	er	100000000000000073	
	05/30/2023 12:47 PM	СС	VID-19	COVID	)-19	A	mbulatory		1000000000000000072	
									ОК	
		Visit Type*			Encounter ID/Vi	<u>sit #</u> *	0		Generate	
		Inpatient	Acute	$\times$ $\vee$					J Generate	
			nt Case History v nter ID/Visit # fie			hos	e historica	al case	reports that includ	Je
-		-	pop-up is a new <i>nter ID/Visit #</i> fie					se repo	rts submitted <u>befo</u>	<u>re</u>

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

/isit Type*		Encounter ID/Visit #* 😯	
Emergency	×   ~		Generate

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

Visit Type*	Encounter ID/Visit #* 😧	
Emergency ×   ~		Cenerate





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

Yes	No	Unknown	
yes, please ei	nter the due c	date (EDC): 😧	
nm/dd/yyyy		🛗 🗌 Unknown	

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 cu Yes	No	Unknown				
lf yes, please en	ter the due da	ate (EDC):* 😮				
mm/dd/yyyy			<b></b>	Unknown		
				_		
ease Note: If A	lo or Unkno	<b>wn</b> is selected fo	or the Is the $\mu$	patient cui	rently pre	<i>gnant?</i> field, th
			•		rrently pre	<i>gnant?</i> field, th
		<b>wn</b> is selected fo f yes, please enter t	•		rrently pre	<i>gnant?</i> field, th
			•		crently pre	egnant? field, th
bsequent field i	s disabled: <i>lj</i>	f yes, please enter t	•		crently pre	egnant? field, th
	s disabled: <i>lj</i>	f yes, please enter t	•		rrently pre	egnant? field, th
bsequent field i	s disabled: /j	f yes, please enter t gnant?*	•		rrently pre	egnant? field, th
bsequent field i	s disabled: <i>lj</i>	f yes, please enter t	•		rrently pre	egnant? field, th
bsequent field i Is the patient o Yes	s disabled: /j urrently pre No	f yes, please enter t gnant?* Unknown	•		rrently pre	egnant? field, th
bsequent field i Is the patient o Yes	s disabled: /j urrently pre No	f yes, please enter t gnant?*	the due date (i		rrently pre	egnant? field, th





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.

<b>Visit Type*</b> Ambulatory	x   ~	Encounter ID/Visit <u>#</u> * 😧	Generate
Is the patient currently pregnant? Yes No UI If yes, please enter the due date (EI mm/dd/yyyy	nknown DC(): @	Unknown	
Save			Next

- 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.

Patient Sex*	Ethnicity*		
Male	Patient Information	×	
Address 1* 123 Main Street City* Lexington	You have selected to file this case report for Salmonella Paratyphi. Please note that you 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 repor form for Salmonella Paratyphi?	will	Address 2 Unit, Suite, Building, etc. State* KY
County* Jefferson Visit Type* Ambulatory	Please note that you will not be able to change/update Encounter ID/Visit # after yo save this screen or proceed to the next scre		

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# 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*?

FOODBORNE AND WA	RBORNE DISEASES CASE REPORT Section 2 of 8	
Please provide laboratory in	ation related to this case.	
	LABORATORY INFORMATION	
Patient Information	Does the patient have a lab test?*	
Laboratory Information		

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

		LABORATORY INFORMATION	
Patient Information	Ø	Does the patient have a lab test?* Yes No Unknown	
Laboratory Information			
Applicable Symptoms	<b>A</b>	Laboratory Information	
Additional Information	_		
Hospitalization, ICU & Death Information	<b></b>	Laboratory Name*	T
Vaccination History	_	Test Name*	5
Additional Comments	<b>A</b>	If other, please specify: 🔞	_
Review & Submit	_		
		Specimen Source* Select If other, please specify:  Select If other, please specify:  If other, p	
Please Note: If I	<b>Vo</b> or <b>U</b>	<b>nknown</b> is selected, all the subsequent fields on the screen are disabled	ł.





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

	Yes	nt have a lab No	Unknown			
boratory Information boratory Name*						
boratory Name*	boratory Info	ormation				
	boratory Na	me*			1	

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

aboratory Name*	
est Name*	
Select	~
Other	
Salmonella paratyphi A Ab [Presence] in Serum	
Salmonella paratyphi A H Ab [Presence] in Serum	
Salmonella paratyphi B Ab [Presence] in Serum	
Salmonella paratyphi B H Ab [Presence] in Serum	
Salmonella paratyphi B O Ab [Presence] in Serum	
Salmonella paratyphi C H Ab [Presence] in Serum	

• 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*.

Other	× ×





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

Test Name*		
Other	×	$\sim$
If other, please specify: <b>* </b>		
Other Test		
Filler Order/Accession Number 🕢		

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

Select	~
Abscess	
Amniotic fluid	
Aspirate	
Bile fluid	
Blood - cord	
Blood arterial	
Blood bag	

• 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*.

Specimen Source*	
Other	×   ~
If other, please specify:* 😧	

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

Test Result*	
Şelect	~
Negative	
Pending	
Positive	
Undetermined/Inconclusive	
Other	



Invalid Test Result Date



• 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 Name*	
Other	×   ~
If other, please specify:* 😧	

8. Enter the Specimen Collection Date.

Test Result Date*	Specimen Collection Date* mm/dd/yyyy
<b>Please Note</b> : The Specimen Collection Date car Specimen Collection Date must occur on the <b>same o</b> If you enter a Specimen Collection Date that occu marked as invalid.	<b>date</b> or any date <b><u>BEFORE</u> the Test Result Date.</b>
If you click <b>Next</b> , the <b>Laboratory Information</b> scr that states: <i>There are errors. Please make a selection</i>	
To proceed, you must enter a valid Specimen Colle Result Date.	ection Date that occurs <u>on</u> or <u>before</u> the Test
Test Result Date*	Specimen Collection Date*

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

Invalid Specimen Collection Date

Fest Result Date*		Specimen Collection Date*		
02/23/2024	🛗 🗌 Unknown	01/15/2024	🛗 🗌 Unknow	'n
Additional Information 🤪				
Additional Information 🥑				
Additional Information 😧				

Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



## **Adding Multiple Tests**

10. 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			
O Add Test			
Save		Previous	
Please Note: When you click the Add Tes	<b>st</b> 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.

Additional Information 🚱				
Test 1 details				
14/300 Characters				h
Laboratory Information				
Laboratory Name*				
Test Name* Select				
lf other, please specify: 🚱				
Filler Order/Accession Number 🚱				
Specimen Source*				
Select				~
If other, please specify: 🚱				
Test Result*				
Select				~
lf other, please specify: 🚱				
Test Result Date		Specimen Collection Date*		
mm/dd/yyyy	Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
Additional Information 🚱				
0/300 Characters				h
🔂 Add Test				





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

Laboratory Name*		
Test		
Test Name*		
Other	×	
f other, please specify: <b>* </b>		
Other Test		
Filler Order/Accession Number 🕑		
0101010101010		
Specimen Source*		
Other	×	
f other, please specify:* 😧 Other Specimen Source		
other specifien source		
Test Result*		
Other	×	
f other, please specify:* 🕢		
Abnormal Quantity detected greater than .009		
Test Result Date*	Specimen Collection Date*	
01/01/2024 🛗 🗌 Unknown	01/01/2024 📾 🗌 Unknown	
Additional Information 😧		
0/300 Characters		
🔂 Add Test		

#### **Deloitte.** Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



## **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*?

FOODBORNE AND W FORM	VATERI	BORNE DISEASES CASE REPORT Section 3 of 8						
Please select applicable sy	mptoms	that the patient experienced during illness.						
	APPLICABLE SYMPTOMS							
Patient Information	$\odot$	Were symptoms present during the course of illness?*						
Laboratory Information	$\odot$	Yes No Unknown						
Applicable Symptoms								
Additional Information	<b>a</b>	Onset Date @       mm/dd/yy   Unknown						

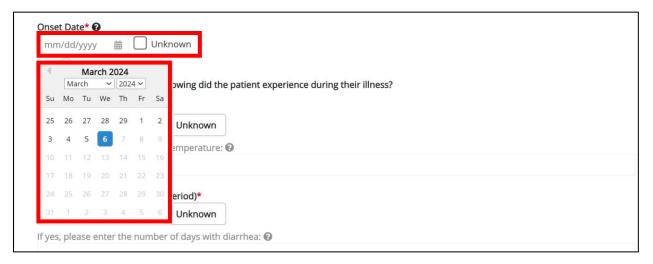
2. If **Yes** is selected for the conditional question, the subsequent fields on the screen are enabled.

		APPLICABLE SYMPTOMS
Patient Information	0	Were symptoms present during the course of illness?*
Laboratory Information	$\odot$	Yes No Unknown
Applicable Symptoms		Onset Date* 😧
Additional Information	-	mm/dd/yyyy iii Unknown
Hospitalization, ICU & Death Information	-	If symptomatic, which of the following did the patient experience during their illness?
Vaccination History	<b>a</b>	Fever*
Additional Comments	۵	Yes No Unknown If yes, please enter the highest temperature: @
Review & Submit	<b>A</b>	
		Diarrhea (>3 loose stools/24hr period)*         Yes       No         Unknown         If yes, please enter the number of days with diarrhea: @
		Abdominal cramps* Yes No Unknown
Please Note: If A	<b>lo</b> is s	elected 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*.

No Uni	known
enter the highest temp	erature

• 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*.

No	Unknown

5. To report the patient had diarrhea during the illness, select the **appropriate answer** for the field: *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*.

Yes	No	Unknown	
es, please enter	r number of da	ys with diarrhea: <b>*</b> 0	 

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

Abdominal crar	nps*		
Yes	No	Unknown	
Bradycardia*			
Yes	No	Unknown	
Constipation*			
Yes	No	Unknown	
Headache*			
Yes	No	Unknown	
Loss of appetite	e*		
Yes	No	Unknown	
Malaise*			
Yes	No	Unknown	
Non-Productive	e Cough*		
Yes	No	Unknown	
Rash*			
Yes	No	Unknown	
Sustained Feve	r*		
Yes	No	Unknown	
Weakness*			
Yes	No	Unknown	

Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



**Please Note:** This user guide shows the generic workflow for the **Foodborne and Waterborne 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 **Salmonella paratyphi**.

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

Unknown

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

Yes No Unknow
yes, please specify: <b>* </b>

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

Sustained Fever*					
Yes	No	Unknown			
Weakness*					
Yes	No	Unknown			
Did the patient hav	e any other	symptoms?*			
Yes	No	Unknown			
lf yes, please specif	fy: 😮				
Save				Previous	Next

#### **Deloitte.** Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



## 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:* 

FOODBORNE AND WA	TERBORN	IE DISEASES C	ASE REPORT FORM	Section 4 of 8
Please select the information that th	e patient was exp	osed to prior to illness.		
		ADDITI	ONAL INFORMATION	
Patient Information	$\odot$			
Laboratory Information	$\oslash$	Does any of the f Yes	ollowing apply to the patient:* No Unknown	
Applicable Symptoms	$\odot$			
Additional Information			vithin the last 30 days (outside state of normal residence)*	
Hospitalization, ICU & Death Information	A	Yes If yes, please spe	No Unknown	0
Vaccination History	6	International tra	vel within the last 30 days*	

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

		ADDITIONAL INFORMATION	
Patient Information	Ø	Does any of the following apply to the patient:*	
Laboratory Information	$\oslash$	Yes No Unknown	
Applicable Symptoms	$\oslash$		
Additional Information		Domestic travel within the last 30 days (outside state of normal residence)* Yes No Unknown	
Hospitalization, ICU & Death Information	۵	If yes, please specify state(s): @	
Vaccination History	_	Select	
Additional Comments	_	International Travel within the last 30 days* Yes No Unknown	
Review & Submit	۵	If yes, please specify country(s): @	
		Select	
		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: 🚱	

**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 la	st 30 days (outside s	ate of normal residence)*
Yes	No	Unknown	
yes, please sp	ecify state(s):	0	
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) in which the patient traveled**.

	Domestic travel within the last 30 days (outside state of normal residence)*           Yes         No         Unknown	
<b></b>	If yes, please specify state(s).* 😧	_
		· •
<b></b>		
	AL	1
	AR	
	AS	- 1
	AZ	
	<b>▲</b>	Yes No Unknown   Unknown If yes, please specify state(s):*    Select   KY   AK   AL   AR   AR   AS

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

International Tr	ravel within t	he last 30 days*
Yes	No	Unknown
yes, please sp	ecify country	y(s): 😮
Select		

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

	Yes No Unknown	
	ves, please specify country(s):* 😧	
Se	elect	~
A	FGHANISTAN	
A	ILBANIA	
A	ALGERIA	
A	MERICAN SAMOA	
A	NDORRA	
A	NGOLA	
A	NGUILLA	
		*

Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



- 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

Yes	No	Unknown			
f yes, please s	pecify the nan	ne of school/dayc	e: 🖗		
School/daycare	e employee*				
Yes	No	Unknown			
lf yes, please s	pecify the nan	ne of school/dayc	e: 🖗		
Food bandler					
Food handler*	No	Unknown			
Yes	No	Unknown			
Yes		Unknown ne of food handle	service: 😮		
Yes			service: 🚱		
Yes	pecify the nan		service: 🕲		
Yes	pecify the nan		service: 😡		
Yes If yes, please s Healthcare wo Yes	pecify the nan rker*	unknown			
Yes If yes, please s Healthcare wo Yes	pecify the nan rker*	ne of food handle			
Yes If yes, please s Healthcare wo Yes	pecify the nan rker*	unknown			
Yes If yes, please s Healthcare wo Yes	rker* No	Unknown			
Yes If yes, please s Healthcare wo Yes If yes, please s	rker* No	Unknown			



Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



Yes	No	Unknown
lf yes, please	specify the nam	ne of long-term ca
Correctional	facility resident	*
Yes	No	Unknown
lf yes, please	specify the nar	ne of correctional
Correctional	facility employe	e*
Yes	No	Unknown
lf yes, please	specify the nam	ne of correctiona
Homeless sh	elter resident*	
Yes	No	Unknown
lf yes, please	specify the nam	ne of homeless s
Homeless st	elter employee	*
Yes	No	Unknown
res		

Yes	No	Unknown			
f yes, please sj	pecify the nam	ne of college/unive	ity: 🕑		
College/univer	sity teacher*				
Yes	No	Unknown			
f yes, please s	pecify the nam	ne of college/unive	ity: 🔞		
Military*					
Yes	No	Unknown			
Yes		Unknown ne of military base			
Yes					
Yes	pecify the nam	ne of military base			
Yes f yes, please s	pecify the nam	ne of military base			
Yes f yes, please s Other congreg Yes	pecify the nam ate setting res No	ident*			
Yes f yes, please s Other congreg Yes	pecify the nam ate setting res No	ident*			
Yes f yes, please s Other congrege Yes f yes, please s	ate setting res	ident* Unknown			
Yes f yes, please s Other congreg Yes	ate setting res	ident* Unknown			

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases

Deloitte.	Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide ( <i>Salmonella paratyphi</i> )	IE
enabled for Users For example, if <b>Y</b> enabled. To proc	<b>s</b> is selected for <b>any</b> of the descriptive questions, the subsequent textbo to specify the name of the appropriate setting. <b>s</b> is selected for the <i>Healthcare worker</i> field, the subsequent textbox fie ed, you must enter the <b>name of the healthcare facility</b> in the subseque specify the name of the healthcare facility.	ld is
Healthcare worker* Yes No If yes, please specify the n	Unknown e 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?*

Yes	No	Unknown	
			· · · · · · · · · · · · · · · · · · ·
-			
Did the patient	use street dr	ugs, but not injec	:t?*

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

ls this part of a	an outbreak?*	
Yes	No	Unknown
f yes, please s	pecify the na	me 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*.

ls this part of ar	outbreak?*				
Yes	No	Unknown			
lf yes, please sp	ecify the nam	e of the outbrea	« <b>* (?</b>		

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

yes, please specify the name of the outbreak:* ②			
Save	Previous	Next	
Sare	T CONST		



# 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*?

FOODBORNE AND WA	TERBORN	E DISEASES CASE REPORT FORM	Section 5 of 8
Please select any applicable hospital	ization, ICU and dec	ath information related to this case.	
	HOS	PITALIZATION, ICU & DEATH INFORMATION	
Patient Information	$\odot$		
Laboratory Information	$\odot$	Yes   No   Unknown	
Applicable Symptoms	$\odot$		

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

		HOSPITALIZATI	ON, ICU & DEATH INFOR	MATION	
Patient Information	${}^{\oslash}$	Was the patient hospitalized?*			
Laboratory Information	$\oslash$	Yes No Uni	nown		
Applicable Symptoms	$\otimes$	If yes, please specify the hospital nar			
Additional Information	$\odot$	li yes, please specify the hospital har			
Hospitalization, ICU & Death Information		Admission Date*		Discharge Date*	
		mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Vaccination History	<b></b>			Still hospitalized	
Additional Comments	<b>A</b>				
Review & Submit	<b></b>	Was the patient admitted to an inten Yes No Uni	sive care unit (ICU)?*		
		Admission Date to ICU		Discharge Date from ICU	
		mm/dd/yyyy	iii Unknown	mm/dd/yyyy	🗰 🗌 Unknown
		If yes, please provide the date of dea	known		
		Date of Death mm/dd/yyyy	iii Unknown		

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





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 patien	t hospitalized?	*		
Yes	No	Unknown		
		,		
If yes please s	becify the hosp	pital name:* 🚱		
ii yes, please s				
n yes, please s				

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

Admission Date*		Discharge Date*		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	<b></b>	Unknown
		Still hospitalized		

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

Admission Date*		Discharge Date*	
10/01/2021	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
		Still hospitalized	

• 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*			Discharge Date*	
10/01/2021	÷	Unknown	mm/dd/yyyy	🗰 🗌 Unknown
			Still hospitalized	
	dmitted to an intensiv			
Yes	No Unkno	own		
Admission Date to	o ICU		Discharge Date from ICU	
mm/dd/yyyy		Unknown	mm/dd/yyyy	dia Unknown
Did the patient di	e as a result of this ill	ness?		
Yes	No Unkno	own		
lf yes, please prov	vide the date of death			
Date of Death				
Date of Death mm/dd/yyyy		Unknown		

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**Please Note:** The Admission Date **cannot** occur **<u>after</u>** 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	×		
Patient Information	Ø v	Was the patient	The date of hospital discharge cannot be earlier than the date of hospital admission.			
Laboratory Information	⊘	Yes		_		
Applicable Symptoms	0	6		ок		
Additional Information	$\odot$	Test Hospital	any the hospital name." 😈			
Hospitalization, ICU & Death Information		Admission Date*	and the second s	Discharge Da		a Unknown
Vaccination History		nvalid Admission Dat		Still hosp		
Additional Comments	<b>A</b>			Invalid Discharge	e Date	

There are errors. Please make a sele	ction for all req	uired fields.
		HOSPITALIZATION, ICU & DEATH INFORMATION
Patient Information	$\odot$	Was the patient hospitalized?*
Laboratory Information	$\otimes$	Yes No Unknown
Applicable Symptoms	$\odot$	If yes, please specify the hospital name:* 🕑
Additional Information	$\odot$	Test Hospital
Hospitalization, ICU & Death Information		Admission Date*         Discharge Date*           01/18/2023         Unknown         01/09/2019         Unknown
Vaccination History	<b>A</b>	Invalid Admission Date
Additional Comments	<b>a</b>	Invalid Discharge Date

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

Yes	No	Unknown			
ission Date	e to ICU			Discharge Date from ICU	
m/dd/yyyy			Unknown	mm/dd/yyyy	Unknown



٠



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**.

Yes No Unkno	own		
Admission Date to ICU*		Discharge Date from ICU*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

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

Did	d the patient	die as a resi	ult of this illness?*	
	Yes	No	Unknown	
-	es, please pr	ovide the da	ate of death:	
	nm/dd/yyyy			Unknown

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

Did the patient die as a result of this illness?*	
Yes No Unknown	
If yes, please provide the date of death:	
Date of Death*	
mm/dd/yyyy	🗄 🗌 Unknown

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

		HOSPITALIZATION, ICU	& DEATH INFO	RMATION	
Patient Information	Ø	Was the patient hospitalized?*			
Laboratory Information	$\odot$	Yes No Unknown			
Applicable Symptoms	$\otimes$	If yes, please specify the hospital name: <b>* @</b>			
Additional Information	$\odot$	General Hospital			
Hospitalization, ICU & Death Information		Admission Date* 02/22/2024	Unknown	Discharge Date* 02/25/2024	🖮 🗌 Unknown
Vaccination History	_			Still hospitalized	
Additional Comments	_				
Review & Submit	•	Was the patient admitted to an intensive care un Yes No Unknown Admission Date to ICU mm/dd/yyyy	nit (ICU)?*	Discharge Date from ICU mm/dd/yyyy	Unknown
		Did the patient die as a result of this illness?* Yes No Unknown If yes, please provide the date of death: Date of Death mm/dd/yyyy	Unknown		
		Save		1	Previous

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## 14 Vaccination History

- 1. On the **Vaccination History** screen, the following message will display: **Note:** No additional information is required on this screen. Please click on the "**Next**" button to proceed.
- 2. Click **Next** to proceed to the **Additional Comments** screen.

		VACCII	NATION HISTORY		
Patient Information	$\oslash$				
Laboratory Information	$\oslash$	NOTE: No additional info	ormation is required on this scre	een. Please click on the " <b>Next</b>	" button to proceed.
Applicable Symptoms	$\oslash$				
Additional Information	$\oslash$				
Hospitalization, ICU & Death Information	$\oslash$				
Vaccination History					
Additional Comments	8				
Review & Submit					



# **15** Additional Comments

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

FOODBORNE AND W	ATERBORN	IE DISEASES CASE REPORT FORM	Section 7 of 8
Please add any additional comments	related to this cas	ie.	
		ADDITIONAL COMMENTS	
Patient Information	$\oslash$		
Laboratory Information	$\odot$	Additional comments or notes, please specify:	
Applicable Symptoms	$\otimes$		
Additional Information	$\odot$		
Hospitalization, ICU & Death Information	$\oslash$		
Vaccination History	$\oslash$	0/1000 Characters	
Additional Comments			
Review & Submit	8		
		Save	Previous



## 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.

Please review your information b	Please review your information before submitting.				
		REVIEW & S	SUBMIT		
Patient Information	$\oslash$				
Laboratory Information	$\oslash$	Print			
Applicable Symptoms	$\oslash$	Patient Information	8		
Additional Information	$\oslash$	<u>r adent mornaton</u>			
Hospitalization, ICU & Death Information	Ø	Disease/Organism Salmonella Paratyphi	Date of Diagnosis Unknown atient ID (MRN), Person Completing Form, and Attending Physician/Clinician?		
Vaccination History	$\oslash$	Yes	auencib (wikiy), Person completing Porn, and Attenuing Physician/Clinician		
Additional Comments	$\oslash$	Patient ID (MRN) SK05051960	Affiliation/Organization Baxter Hospital		
Review & Submit		Person Completing Form Miss lane Doe (iane@mailinator.com)	Affiliation/Organization Baxter Hospital		

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

Patient Information		Print	2 sheets of pa
Disease/Organism Salmonella Paratyphi		Destination	SecurePrint
Pate of Diagnosis Inknown			
	Patient ID (MRN), Person Completing Form, and Attending	Pages	All
ent ID (MRN) 501960			
on/Organization lospital		Copies	1
son Completing Form ; Jane Doe (jane@mailinator.com)			
liation/Organization ter Hospital		Color	Color
tending Physician/Clinician Charles Allen (callen@email.com)			
iliation/Organization kter Hospital		More setting	qs
Name	Last Name Doe		-
of Birth 1996			
Sex	Ethnicity Hispanic or Latino		
e			
ddress 1 23 Main Street			
ngton	State KY		
Code 11-			
<b>ity</b> tte	Phone (222) 222-2222		
i <b>it Type</b> ergency			
incounter ID/Visit # .00000000000000000777			
			Print Cance

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

Please review your information	n before submi	ting.		
		<b>REVIEW &amp; SUBMIT</b>		
Patient Information	$\otimes$		_	
Laboratory Information	$\odot$		Print	L. Download
Applicable Symptoms	$\oslash$	Patient Information		۵

- 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.

				Downloads	
FOODBORNE AND	WATERE	ORNE DISEASES CASE REPORT	۲ Section 8 o	What do you want to do	o with Foodborne And
FORM			Section 6 0	Open	Save as 🗸 🗸
-				See more	
Please review your informa	ation before	submitting.			
		REVIEW & SUBM	ЛІТ		
Patient Information	$\odot$				
Laboratory Information	$\odot$			8	Print 🛃 Download
Applicable Symptoms	$\odot$	Patient Information			0
Additional Information	$\odot$				
Hospitalization, ICU &	$\odot$		<b>te of Diagnosis</b> Iknown		
Death Information		Is the Affiliation/Organization same for	Patient ID (MRN), P	erson Completing Fo	rm, and Attending
Vaccination History	$\odot$	Physician/Clinician?			
Additional Comments	$\odot$	Download PDF		×	
Review & Submit		Downloaded successfully			
				ок	
		Attending Physician/Clinician Aff	iliation/Organizatio	in	

• 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.

≡	Foodborne And Waterborne Diseases Case Report Form.pdf 1 / 4   - 150% +   🗄 👌	Ŧ	ē	
			ĺ	
	Patient Information			
	Disease/Organism			
	Salmonella Paratyphi			





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

		REVIEW & SUBMIT
Patient Information	$\oslash$	
Laboratory Information	$\otimes$	📑 Print 🛛 📩 Download
Applicable Symptoms	$\oslash$	Patient Information
Additional Information	$\odot$	
Hospitalization, ICU & Death Information	$\oslash$	Laboratory Information
Vaccination History	$\oslash$	Does the patient have a lab test?
Additional Comments	$\oslash$	Yes
Review & Submit		Laboratory Information
		Laboratory Name Lab X

3. Review the Patient Information section.

Patient Information		0
<b>Disease/Organism</b> Salmonella Paratyphi	<b>Date of Diagnosis</b> Unknown	
Is the Affiliation/Organization same for Pa Yes	tient ID (MRN), Person Completing Fo	rm, and Attending Physician/Clinician?
Patient ID (MRN) SK0501960	Affiliation/Organization Baxter Hospital	
Person Completing Form Miss Jane Doe (jane@mailinator.com)	Affiliation/Organization Baxter Hospital	
Attending Physician/Clinician Dr. Charles Allen (callen@email.com)	Affiliation/Organization Baxter Hospital	
<b>First Name</b> John	Last Name Doe	
<b>Date of Birth</b> 1996/12/19		
<b>Patient Sex</b> Male	<b>Ethnicity</b> Hispanic or Latino	<b>Race</b> White
Address 1 123 Main Street		
<b>City</b> Lexington	<mark>State</mark> KY	<b>Zip Code</b> 40511-
<b>County</b> Fayette	Phone (222) 222-2222	
<b>Visit Type</b> Emergency	Encounter ID/Visit # 1000000000000000777	



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4. Review the *Laboratory Information* section.

Hospitalization, ICU & Death Information	$\odot$	Laboratory Information		۵
Vaccination History	$\odot$	Does the patient have a lab test?		
Additional Comments	$\odot$	Yes		
Review & Submit		Laboratory Information		
		Laboratory Name Lab X		
		Test Name Salmonella paratyphi A Ab [Presence] in Serum		
		Filler Order/Accession Number 01010101		
		Specimen Source Abscess		
		Test Result Positive		
		<b>Test Result Date</b> 2024/01/25	Specimen Collection Date 2024/01/22	

5. Review the *Applicable Symptoms* section.

Applicable Symptoms	۵
Were symptoms present during the course of illness? Yes	
Onset Date Unknown	
If symptomatic, which of the following did the patient experience during their illness?	
Fever No	
Diarrhea (>3 loose stools/24hr period) No	
Abdominal cramps No	
Bradycardia Yes	
Constipation No	
Headache Yes	
Loss of appetite Yes	
Malaise Unknown	
Non-Productive Cough No	
Rash Yes	
Sustained Fever No	
Weakness Yes	
Did the patient have any other symptoms? No	





6. Review the *Additional Information* section.

Additional Information
Does any of the following apply to the patient: Yes
Domestic travel within the last 30 days (outside state of normal residence) No
International Travel within the last 30 days No
School/daycare attendee No
School/daycare employee No
Food handler No
Healthcare worker No
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
Military No
Other congregate setting resident Yes
If yes, please specify the name of other congregate setting: Retail mall worker
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?



Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



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

Hospitalization, ICU & Death Information		•
Was the patient hospitalized?		
Yes		
If yes, please specify the hospital name:		
Baxter Hospital		
Admission Date	Discharge Date	
2024/01/28	2024/01/30	
Was the patient admitted to an intensive care unit (ICU)?		
No		
Did the patient die as a result of this illness?		
No		

8. Review the Additional Comments section.

Additional Comments	٥
Additional comments or notes, please specify: Patient Notes	
	_

#### **Click Hyperlinks to Edit**

- 9. 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.

		REVIEV	/ & SUBMIT
Patient Information	$\odot$		
Laboratory Information	$\odot$		🖶 Print 🛛 📩 Downloa
Applicable Symptoms	$\odot$	Patient Information	٥
Additional Information	$\odot$	ratient mornation	•
Hospitalization, ICU & Death Information	$\odot$	Disease/Organism Salmonella Paratyphi	Date of Diagnosis Unknown
Vaccination History	$\oslash$	Is the Affiliation/Organization sa Yes	ne for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician
Additional Comments	$\oslash$	Patient ID (MRN) 1243285	Affiliation/Organization Baxter Hospital
Review & Submit		Person Completing Form Miss Jane Doe	Affiliation/Organization Baxter Hospital

Direct Data Entry for Case Reports: Foodborne and Waterborne Diseases Page 94 of 107

Kentucky Health Information Exchange





10. 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.

	Disease/Organism* 😧	Date	of D	iagn	osis*				
0	Salmonella Paratyphi 🛛 🗸	mr	n/dd/	<i>(</i> yyy)	/				🛗 🗌 Unknown
0									
0	Is the Affiliation/Organization same for	Su							ing Form, and Attending Physician/Clinician?
0	Yes No	28	29 5	30 6			2 9	3 10	
	Patient ID (MRN)* 🔞	. 11	12	13	14	15	16	17	
0	1243285	18	19	20	21		23	24	~
0	Person Completing Form*	25	26	27	28	29 	1	2	If other, please specify: 🔞
	9 9 9 9 9	<ul> <li>Is the Affiliation/Organization same for</li> <li>Yes No</li> <li>Patient ID (MRN)* ?</li> <li>1243285</li> </ul>	<ul> <li>Is the Affiliation/Organization same for P</li> <li>Yes No</li> <li>Patient ID (MRN)* @</li> <li>1243285</li> <li>18</li> </ul>	2       Is the Affiliation/Organization same for P       Su       Mo         ★       Yes       No       28       29         2       Yes       No       4       5         Patient ID (MRN)*         11       12         1243285       18       19       25       26	Is the Affiliation/Organization same for P       Su       Mo       Tu         Yes       No       4       5       6         Patient ID (MRN)* €       11       12       13         1243285       18       19       20         25       26       27	Is the Affiliation/Organization same for P         *         Yes         No         Patient ID (MRN)*          1243285	Is the Affiliation/Organization same for P       Su       Mo       Tu       We       Th         Yes       No       28       29       30       31       1         4       5       6       7       8         Patient ID (MRN)* ②       1243285       18       19       20       21       22         25       26       27       28       29       30       31       1	Is the Affiliation/Organization same for P         *         Yes       No         Patient ID (MRN)* ?         1243285	Yes       No         Patient ID (MRN)*       No         1243285       12

11. 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*.

Review & Submit	Jane	Save Changes?	×	~	n otner, please specify: <b>G</b>
<u>Atter</u> Johr		There's information on this screen that has not been saved. Do you want to save it?		~	If other, please specify: 😧
	Prefix	No - Discard Yes - Save			

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

REVIEW & SUBMIT						
Patient Information	$\oslash$					
Laboratory Information	$\oslash$		🖶 Print 🛛 📩 Download			
Applicable Symptoms	$\oslash$	Patient Information	<b>\</b>			
Additional Information	$\oslash$					
Hospitalization, ICU & Death Information	$\oslash$	Disease/Organism Date of Diagnosis Salmonella Paratyphi 2024/01/31 Is the Affiliation/Organization same for Patient ID (MRN), Person Completin	a Form and Attending Division (Clinician)			
Vaccination History	$\oslash$	Yes	ig rorm, and Adending Physician/Clinician?			

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

Patient Notes		
	Previous	Submit





• 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.

	Case Report Entry	×
Ad	All data submissions are final. Please ensure that your data a accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.	IS
Add Pat	Cancel Submi	3
	ce a case report has been submitted, it is final. Should inaccurate information, please use the <b>Support Tab</b> i ation.	-

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

	Case Report Entry ×	
<u>Ac</u>	Case Report Entry Saved Successfully	
Ad Par	ОК	
	licking <b>OK</b> when the case report entry has been submitte avigate you to the <b>Case Report Entry User Summary</b> screen.	d successfully will

# Congratulations! You have submitted the Foodborne and Waterborne Diseases Case Report using KHIE's Direct Data Entry functionality.

Please visit the KHIE website at <u>https://khie.ky.gov/Public-Health/Pages/Electronic-Case-</u> <u>Reporting-.aspx</u> 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.

LAST UPD	ATED DATE RANG	E	Start Date	02/21/2024	<b>#</b>	E	nd Date 02/21/2	2024	曲		🔁 Retrieve Data
SHOWING 3 ITEMS											T 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	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01

- 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.

LAST UPDA	TED DATE RANG	E	Start Date	02/21/2024	2024	E	nd Date 02/21/3	2024			<i>₿</i> Retrieve Data	
SHOWING 3 ITEMS				February V Su Mo Tu We	2024 🗸						T APPLY FILTER	
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	28 29 30 31 4 5 6 7	1 2 3 8 9 10 E 🕈	LAST NAME 🗘	DATE OF BIRTH \$	PATIENT SEX 🗘	STATUS 🕈	LAST UPDATED 🗘	SUBMISSION DATE	
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	_	15         16         17           22         23         24           29         1         2	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13	
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05	
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01	



Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



**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 ENTR	RY USER SUMMARY	
LAST UPDATED DATE RANGE	Start Date 02/21/2020	End Date 02/21/2024	🔁 Retrieve Data
Please select a Start Date that is within the last six months from	today's date.		

## 3. Click **Retrieve Data** to display the search results.

4. To search for a specific case report, click **Apply Filter**.

LAST UPD	TED DATE RANG	E	Start Date	02/21/2024	<b></b>	E	nd Date 02/21/	2024	<b></b>		₿ Retrieve Data
SHOWING 3 ITEMS											<b>T</b> 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	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01

5. The Filter fields display. 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.

		-		AFFILIATION/									
	REPORT TYPE	۰	DISEASE/ ORGANISM	ORGANIZATION	PATIENT MRN *	FIRST NAME	LAST NAME \$	DATE OF BIRTH	PATIENT SEX	STATUS *	LAST UPDATED	۰	SUBMISSION DATE
TIONS	Enter Report Type		Enter Disease/ Organism.	Enter Affiliation/ Organiza	Enter Patient MR	Enter First Name	Enter Last Name	Enter Date Of Birth	All ~	Enter Status	All	*	All
View Copy	Foodborne and Waterborne Diseases		Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13		2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases		Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05		2024/02/21 13:05
View	Foodborne and Waterborne Diseases		Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01		2024/02/21 13:01



## **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.

LAST UPD	ATED DATE RANG	E	Start Date	02/21/2024	<b>#</b>	E	nd Date 02/21/	2024	<b>#</b>		
SHOWING 3 ITEMS											<b>T</b> 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	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01

- 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.

	Case Report Details		Print	L Download	×	) SIT T
Patient Se					í	rt Entry
Home	Patient Information			٥		
	Disease/Organism Salmonella Paratyphi	Date of Diagnosis 2024/02/21				
	Is the Affiliation/Organization same for Patient No	ID (MRN), Person Completing Form, and Attending Physician/Clinici	an?			
AST UF	Patient ID (MRN) GP55329784	Affiliation/Organization Violet Hospital				trieve [
	Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Evergreen General Hospital				IDE FIL
	Attending Physician/Clinician Dr. Helen Rivera (helen@email.com)	Affiliation/Organization Evergreen General Hospital				SUBMIS
IONS	<b>First Name</b> Jose	<b>Last Name</b> Varga			7	N DATE All
View Copy				ок		2024/02 13:13



## **Copy Previously Submitted Case Reports**

The **Copy** feature allows Users to copy the information from a completed case report, make edits, and then submit 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.

SHOWING 3 ITEMS											<b>T</b> 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	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01
			First	Back 1 Ne	xt Last					Maximum 5	- entries per pa
			FILSE	Dack I Ne	XL Last					Maximum	entres per



By default, the **Patient Information** screen displays the information entered on the previously submitted Foodborne and Waterborne Diseases case report. Users can change the information entered in any of the enabled fields and submit a new Foodborne and Waterborne 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

FOODBORNE AND WATER	RBORNE DISE	ASES CASE REPORT FOR	RM Section 1 of 8	•	
Please complete the form below.	All fields marked witi	h an asterisk(*) are required.			
		PATIEN	T INFORMATION		
Patient Information		ease/Organism* 😧	Date of Diagnosis*		
Laboratory Information	▲ Sa	lmonella Paratyphi	02/21/2024	±	Unknown
Applicable Symptoms	<b>≙</b>	a Affiliation/Organization came fo	or Patient ID (MRN), Person Completing Fo	orm and Att	anding Physician (Clinician 2*
Additional Information	<b>≙</b>	Yes No	in Patient ib (wirkly, Person completing ry	orni, and Add	
Hospitalization, ICU & Death	Pati	ient ID (MRN)* 😧	Affiliation/Organization* 😧		
Vaccination History	G	P55329784	Violet Hospital		
Additional Comments	0	son Completing Form*	Affiliation/Organization* 😮	_	If other, please specify: 🚱
		r. Arthur Vandelay, II (arthu 🗙 🛛	✓ Evergreen General Hospital		
Review & Submit		ending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: 🔞
	Dr	r. Helen Rivera (helen@ema X	✓ Evergreen General Hospital		
	Pre	fix			
	Se	lect	~		
	Firs	t Name*	Middle Name		Last Name*
	Jo	se			Varga
	Suf		Date of Birth*		
	Se	lect	∨ 05/11/1964		
		ient Sex*	Ethnicity*		Race*
	M	ale	→ Hispanic or Latino	×   ~	Other X V

**Please Note**: The Disease/Organism, Affiliation/Organism, 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.





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

		PATI	ENT INF	ORMATION			
Patient Information		Disease/Organism* 😧		Date of Diagnosis*			
Laboratory Information	<b>a</b>	Salmonella Paratyphi		02/21/2024	₩ (	Unknown	
Applicable Symptoms							
		Is the Affiliation/Organization same for	Patient ID	(MRN), Person Completing Form	, and Attending Ph	ysician/Clinician?*	
Additional Information	<b></b>	Yes No					
Hospitalization, ICU & Death Information	<b></b>	Patient ID (MRN)* 🚱		Affiliation/Organization* 🚱			
	0	GP55329784		Violet Hospital			
Vaccination History	<b></b>	Person Completing Form*		Affiliation/Organization* 🚱		If other, please specify:	0
Additional Comments	_	Mr. Arthur Vandelay, II (arthur@e	x   ~	Evergreen General Hospital	$\sim$		
Review & Submit	<b>a</b>	Attending Physician/Clinician*		Affiliation/Organization* 🕑		If other, please specify:	0
		Dr. Helen Rivera (helen@email.com)	x   ~	Evergreen General Hospital	~		-
		Prefix					
		Select					
		First Name*		Middle Name		Last Name*	
		Jose				Varga	
		Suffix		Date of Birth*			
		Select		05/11/1964			
		Patient Sex*		Ethnicity*		Race*	
		Male	~	Hispanic or Latino	× v	Other	×
		Address 1*		Add	ress 2		
		345 Park Street			nit, Suite, Building, e	etc.	
		City*		Stat	e*		Zip Code*
		Somerset		KY		×   ~	42501-
		Countral		Phone t O		[	
		County*	x   ~	Phone* ② (777) 777-7777		Email name@domain.com	
		Pulaski					

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

I





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

Is the patient cu	rrently pregn	ant?			
Yes	No	Unknown			
If yes, please ent	er the due da	ate (EDC): 😮			
mm/dd/yyyy			Unknown		
Save					

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

Part we de devoteré ve de	FOODBORNE AND WATERBORNE DIS	EASES CASE REPORT FORM		Section 2 of 8		
Piceter Information     Additional Information     Additional Information     Applicable Symptoms     Additional Information     Propirationation     Additional Information       Contraction Information   Additional Information    Additional Information   Additional Information    Provide Additional Information   Information Information    File Order/Accession Number Information   Specimen Source*    Specimen Collection Date*  Quantoms Additional Information Information Information Information Information Provide Additional Information	Please provide laboratory information related to the	is case.				
Likotratop Unformation   Addisonal Information   Addisonal Information   Varcelandom Nistlang   Varcelandom Nistlang   Addisonal Information   Addisonal Information   Addisonal Information   Addisonal Information   Addisonal Information   Addisonal Information   Beneree & Submit   File Content State Specify @ File Content Specify @ <		LABORATO	DRY INFORMATION			
Applicule generation   Applicule generation   Additional formation   Inoptilization, IU & Death Information   Additional formation   Inoptilization, IU & Death Information   Additional formation   Inoptilization, IU & Death Information   I	Patient Information					
Additional Information   Additional Information   Vectoration Hatsoy   Additional Commercia   Review & Submit	Laboratory Information	Yes No Unknown				
Additional Information	Applicable Symptoms					
Hospitalization (U. & Death Information   Additional Commets   Additional Commets   Review & Submit     Information Summet as pretry @     Filer Order/Accession Number @   Secture   Secture   Secture   Information Query @     Secture   Information Query @     Test Result     Secture   Information Query @     Test Result     Secture   Information Query @     Test Result     Secture   Information Query @     Secture   Information Query @     Test Result   Negative   Negative   Secture   Information Query @   Test Result   Negative   Secture   QUERY Query @   Information @     Output   Output   Information @     Secture   Information @	Additional Information					- 1
Additional Conventes   Additional Conventes   Review & Submit     If ether, plasas specify: @     Filer Order/Accession Number @   Specime Source* Sietes If ether, plasas specify: @ Test Result   Test Result   Nagable   If other, plasas specify: @   Test Result Date*   02/05/2024   Unknown   Differ Order/Accession Number @   Specime Collection Date*   02/05/2024   Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Unknown Differ Collection Date* 02/05/2024 Differ Col	Hospitalization, ICU & Death Information					
Additional Comments A     Review & Submit     Sementer & Submit     If other, places specify: @     Test Result     OUDDOUCLE     OUDDOUCLE     OUDDOUCLE     OUDDOUCLE     OUDDOUCLE     OUDDOUCLE     OUDDOUCLE     OUDDOUCLE	Vaccination History	Test Name*				
Retev & Subnit     Filer Order/Accession Number ●     Specimen Source*   Select   If other, please specify: ●     Test Result Date*   02/07/2024     Specimen Collection Date*   02/07/2024     Outstress     03/0 Outstress	Additional Comments				x   •	~
Specimen Source*  Select If other, please specify:  Test Result Negative X V  ff other, please specify:  Dest Result Date*  Outprime Collection Date*  O	Review & Submit	If other, please specify: 🚱				
Save Previous Next		Specimen Source* Select If other, please specify: ♥ Test Result* Negative If other, please specify: ♥ Test Result Date* 02/07/2024 Additional Information ♥	Unknown		x	
		Save			Previous	



Direct Data Entry for Foodborne and Waterborne Diseases Case Report Forms User Guide (*Salmonella paratyphi*)



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

Applicable Symptoms	$\odot$	Patient Information			0
Additional Information	$\odot$				
Hospitalization, ICU & Death Information	Ø	Disease/Organism Salmonella Paratyphi	Date of Diagnosis 2024/02/21		
Vaccination History	Ø	Is the Affiliation/Organization same for Patient II No	0 (MRN), Person Completing Form, and Attending F	Physician/Clinician?	
Additional Comments	Ø	Patient ID (MRN) GP55329784	Affiliation/Organization Violet Hospital		
Review & Submit	D	Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Evergreen General Hospital		
		Attending Physician/Clinician Dr. Helen Rivera (helen@email.com)	Affiliation/Organization Evergreen General Hospital		
		First Name Jose	Last Name Varga		
		Date of Birth 1964/05/11			
		Patient Sex Male	Ethnicity Hispanic or Latino	Race Other	
		Address 1 345 Park Street			
		City Somerset	State KY	<b>Zip Code</b> 42501	
		County Pulaski	Phone (754) 665-4984		
		Visit Type Ambulatory	Encounter ID/Visit # 10000000000000000779		

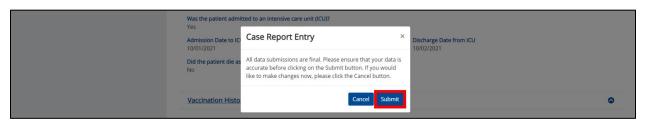
7. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Foodborne and Waterborne Diseases Case Report Entry.

Vaccination History		0				
Additional Comments		۵				
Additional comments or notes, please specify: Additional Patient Notes						
	Previous Subm	nit				
<b>Please Note:</b> The new case report is <u>not</u> a continuation of the previously submitted case report for the patient.						





8. 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.



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

Yes	nitted to an intensive care unit (iCO)?		
Admission Date to 1 10/01/2021	Case Report Entry	× Discharge Date from ICU 10/02/2021	
Did the patient die No	as Case Report Entry Saved Successfully		
Vaccination Hist	o	ОК	۵
~			
Please Note: Clicking OK when	the case report en	try has been submitted :	successfully will
automatically navigate you to the	Case Report Entry L	<b>Jser Summary</b> screen.	
·			/

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

			CASE R	EPORT	ENTRY	USER SI	JMMAR	Y			
C LAST UPD	ATED DATE RANG	E	Start Date	02/21/2024		E	nd Date 02/21/	2024	<b>#</b>	l	€ Retrieve Data
SHOWING 4 ITEMS											T 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	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:38	2024/02/21 13:38
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	ЈОНИ	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01



## **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.

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN 🗘	FIRST NAME	LAST NAME	DATE OF BIRTH 🗘	PATIENT SEX 🗘	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
Continue Delete	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Knoll Hospital	DE64530215	Caroline	q	1989/10/30	Female	In Progress	2024/02/21 13:17	
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Violet Hospital	GP55329784	Jose	Varga	1964/05/11	Male	Complete	2024/02/21 13:13	2024/02/21 13:13
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Evergreen General Hospital	EK4016790	Susanne	Smith	1976/08/04	Female	Complete	2024/02/21 13:05	2024/02/21 13:05
View Copy	Foodborne and Waterborne Diseases	Salmonella Paratyphi	Baxter Hospital	1243285	JOHN	DOE	1996/12/19	Male	Complete	2024/02/21 13:01	2024/02/21 13:01

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

FOODBORNE AND WATE	COODBORNE AND WATERBORNE DISEASES CASE REPORT FORM						
Please add any additional comments related to this case.							
		ADDITIONAL COMMENTS					
Patient Information	${\boldsymbol{ \oslash}}$	Additional comments or notes, please specify:					
Laboratory Information	${\boldsymbol{ \oslash}}$						
Applicable Symptoms	${\boldsymbol{ \oslash}}$						
Additional Information	$\oslash$						
Hospitalization, ICU & Death Information	$\odot$						
Vaccination History	$\odot$	0/1000 Characters					
Additional Comments							
Review & Submit	<b>A</b>						
		Save Previous Next					





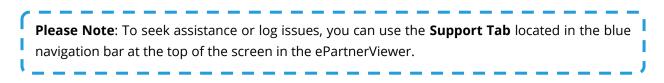
# 18 Technical Support

#### **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 <u>KHIESupport@ky.gov</u>.



K	<b>E</b> eP	PartnerViewer		Support 📢 Announcements 9	Advisories 4 SIT TEST_17 •
	Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry <del>-</del>	Case Report Entry -
Â	Home				