

Kentucky Health Information Exchange (KHIE)

Direct Data Entry for Electronic Case Reports: Perinatal Hepatitis

User Guide

November 2021

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Document Control Information

Document Information

Document Name	Direct Data Entry for Electronic Case Reports: Perinatal Hepatitis User Guide
Project Name	KHIE
Client	Kentucky Cabinet for Health and Family Services
Document Author	Deloitte Consulting
Document Version	2.2
Document Status	Final Draft
Date Released	11/18/2021

Document Edit History

Version	Date	Additions/Modifications	Prepared/Revised by
1.0	11/8/2021	Initial Draft	Deloitte Consulting
1.1	11/12/2021	Revised Draft – KHIE Review	KHIE
2.0	11/15/2021	Revised Draft	Deloitte Consulting
2.1	11/18/2021	Revised Draft – KHIE Review	KHIE
2.2	11/18/2021	Final Draft	Deloitte Consulting

Table of Contents

1	Introduction	5
	Overview	5
	Supported Web Browsers	5
	Mobile Device Considerations	6
	Accessing the ePartnerViewer	6
2	Logging into ePartnerViewer.....	6
	Terms and Conditions of Use and Logging In.....	8
3	Understanding the Case Report Entry Dropdown Menu	10
4	Manage User Preferences.....	13
	Create Attending Physician/Clinician Details	13
	View & Edit Attending Physician/Clinician Details	16
	Delete Attending Physician/Clinician Details	17
	Filter Attending Physician/Clinician Details.....	19
	Create Person Completing Form Details.....	20
	View & Edit Person Completing Form Details.....	23
	Delete Person Completing the Form Details	24
	Filter Person Creating Form Details	25
5	Basic Features in the Case Report Entry Form	26
	Side Navigation Bar & Pagination	26
	Save Feature.....	27
	Case Report Entry Icons.....	27
	Conditional Questions	28
6	Affiliation/Organization Conditional Question	31
	Affiliation/Organization Conditional Answer: Yes	32
	Affiliation/Organization Conditional Answer: No	33
	Affiliation/Organization Validation	35
	Change Affiliation/Organization Conditional Answer: No to Yes	36
	Change Affiliation/Organization Conditional Answer: Yes to No	38
7	Dynamic Functions based on Disease/Organism	40
	Change or Save Disease/Organism Selection.....	40
8	Dynamic Screens for Perinatal Hepatitis Case Report.....	43
	Laboratory Information: Dynamic Screen.....	43
	Vaccination History: Dynamic Screen	44
9	Tips for Manually Entering Case Report Data	46
10	Perinatal Hepatitis Case Report Form	48

11 Patient Information	49
Person Completing Form Hyperlink.....	53
Attending Physician/Clinician Hyperlink.....	56
12 Laboratory Information.....	66
Adding Multiple Hepatitis Markers	69
Adding ALT.....	71
Adding AST	72
Adding Bilirubin	73
13 Applicable Symptoms.....	74
14 Medical Conditions.....	77
15 Exposure Information	79
16 Hospitalization, ICU & Death Information	85
17 Vaccination History	89
Vaccination History for Hepatitis C	89
Vaccination History for Hepatitis B	90
Adding Multiple Vaccines	93
18 Additional Comments	95
19 Review and Submit.....	95
Print or Download Functionality.....	95
Click Hyperlinks to Edit	101
20 Case Report User Entry Summary.....	104
Review Previously Submitted Case Reports.....	106
Copy Previously Submitted Case Reports	107
Continue In-Progress Case Reports	112
21 Technical Support.....	113
Toll-Free Telephone Support	113
Email Support.....	113

1 Introduction

Overview

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

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

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

Supported Web Browsers

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

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

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

Mobile Device Considerations

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

Accessing the ePartnerViewer

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

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

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

2 Logging into ePartnerViewer

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

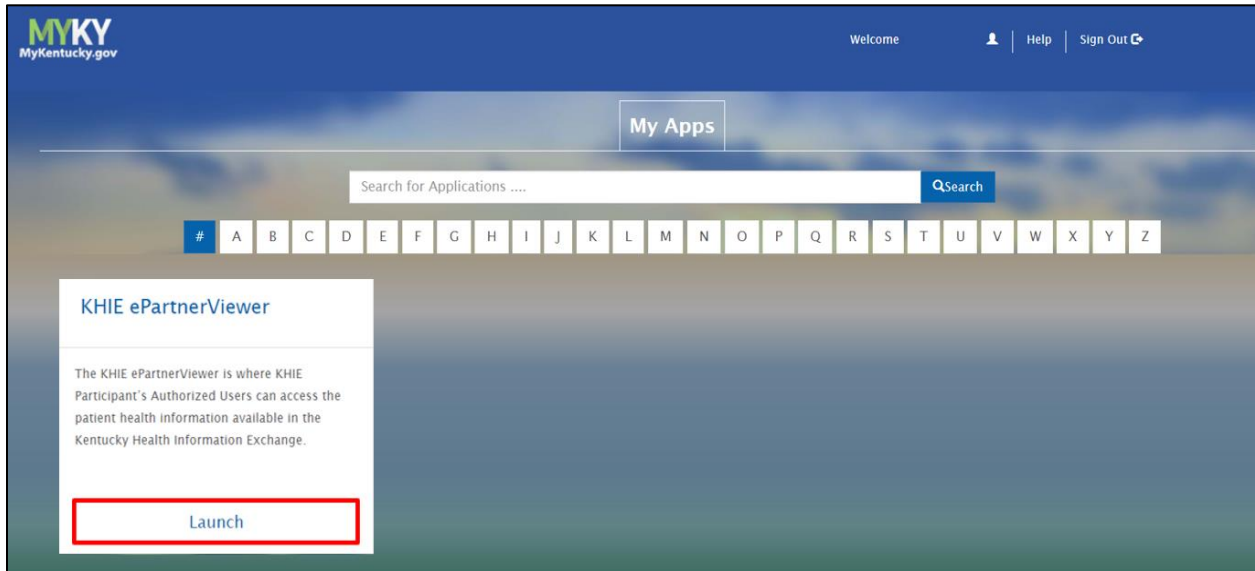
1. On the **KOG Login Page**, enter your **Email Address** and **Password**.

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

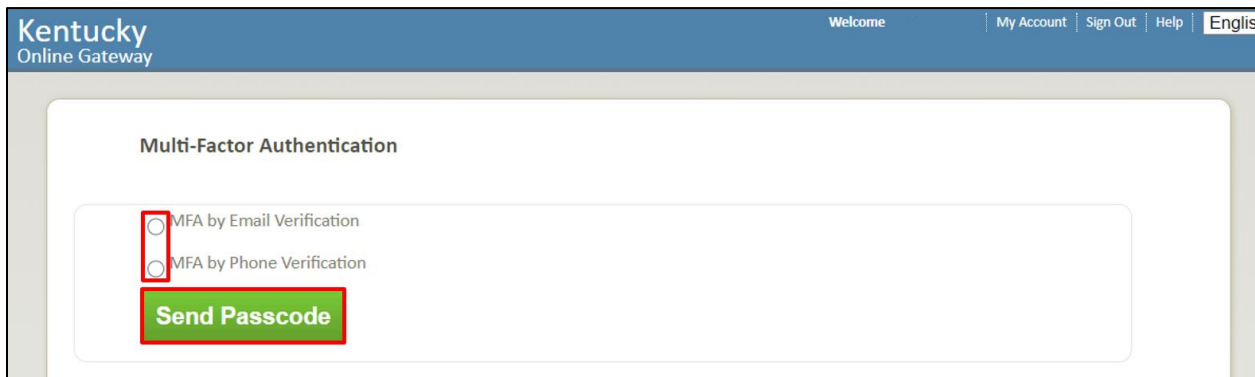
2. Click **Sign In**.

The screenshot displays the 'Citizen (or) Business Partner Sign In' page on the MyKentucky.gov website. The page has a blue header with the 'MYKY MyKentucky.gov' logo and links for 'FAQ', 'Help', and 'English'. The main content area is white with a blue border. On the left, there is a sign-in form titled 'Citizen (or) Business Partner Sign In' with the instruction 'Sign in with your Kentucky Online Gateway Account.' The form includes an 'Email Address' field with the text 'jane.doe@gmail.com' and a 'Password' field with masked characters. There is a 'Forgot/Reset Password?' link next to the password field. Below the password field is a 'SIGN IN' button. At the bottom left of the form is a 'Resend Account Verification Email' link. On the right side of the page, there is a yellow 'WARNING' box with text about the website's ownership and unauthorized access. Below the warning box is a 'Don't already have a Kentucky Online Gateway Citizen Account?' link and a 'Create An Account' button. At the bottom right of the page is a link 'Click here to select user account type'.

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



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



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

Terms and Conditions of Use and Logging In

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

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

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

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

KHIE | ePartnerViewer Mitch Cavallo

TERMS AND CONDITIONS OF USE

Terms and Conditions

HEALTHCARE PROVIDER USAGE TERMS AND CONDITIONS

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

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

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

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

Select 1 accept to accept the usage terms and conditions.

☒ Accepted

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

KHIE Smoke Test Organization

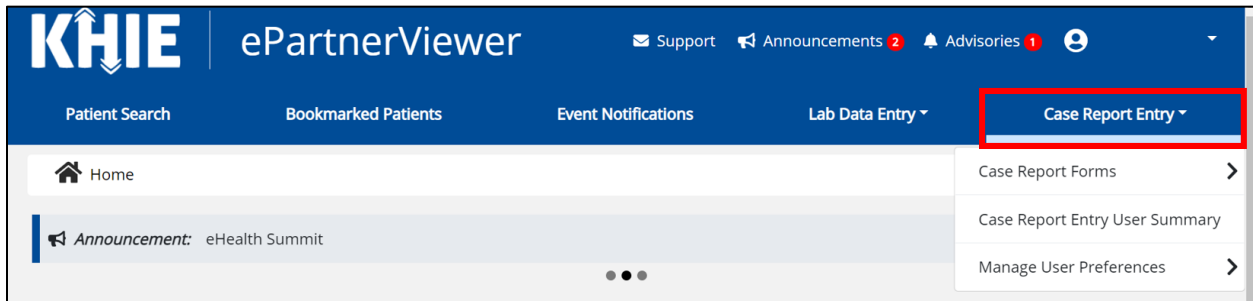
Copyright 2019 Healthinteractive HealthInteractive KHIE Version: 1.0.0

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

3 Understanding the Case Report Entry Dropdown Menu

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

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



1. Types of Case Reports:

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

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

- **Sexually Transmitted Disease (STD) Case Report:**

- Designed for Users to enter STD case reports.

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

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

- Designed for Users to enter MDRO case reports.

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

- **Perinatal Hepatitis Case Report:**

- Designed for Users to enter Perinatal Hepatitis case reports.

- **Child Hepatitis Case Report:**

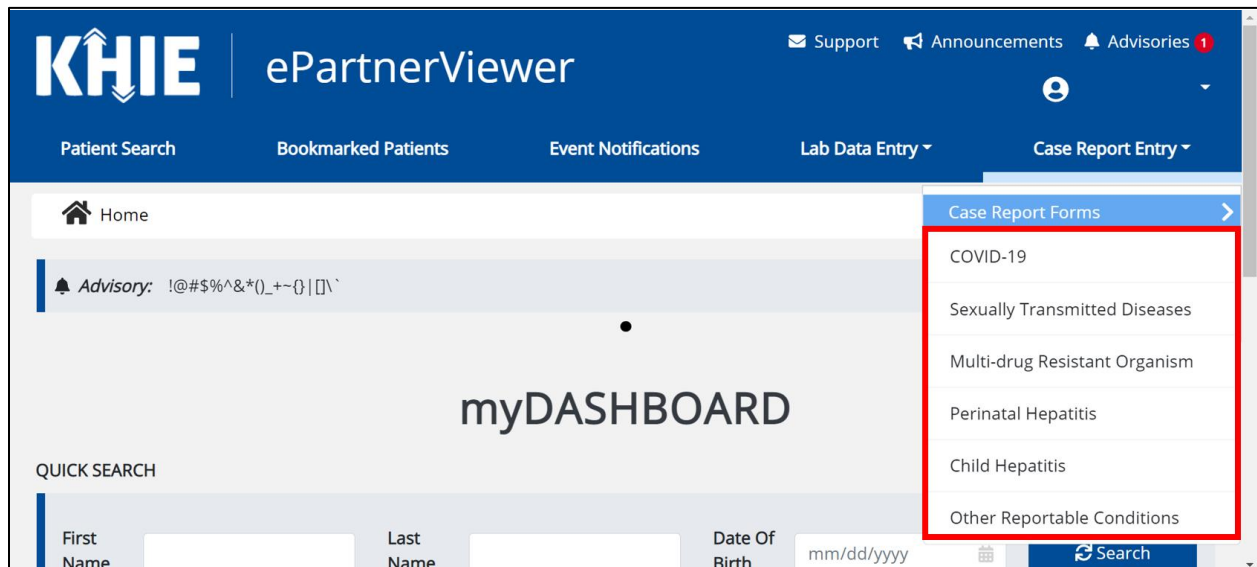
- Designed for Users to enter Child Hepatitis case reports.

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

- **Other Reportable Conditions Case Report:**

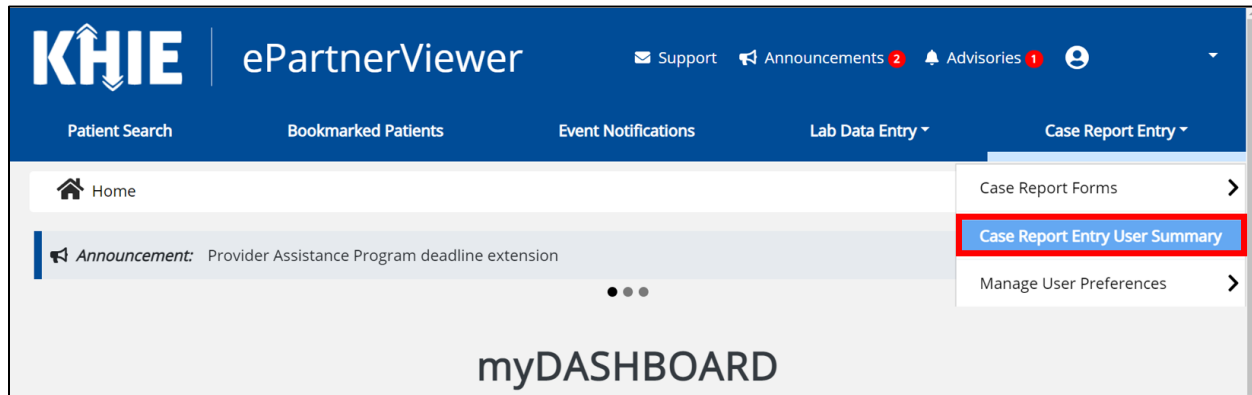
- Designed for Users to enter Other Reportable Conditions case reports.

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



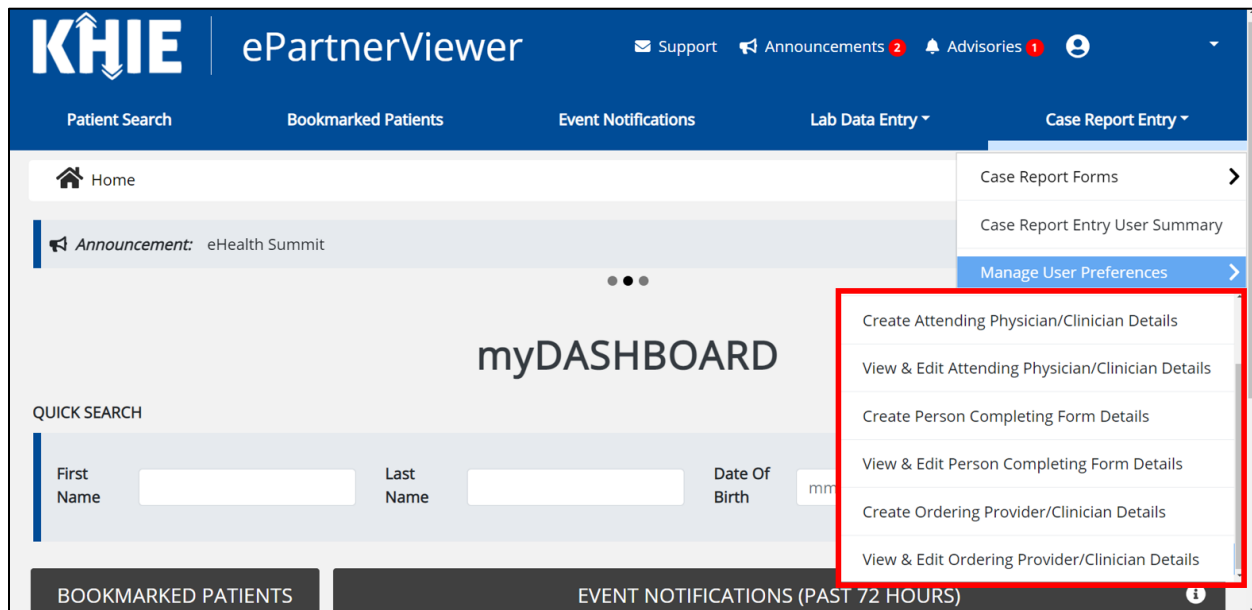
2. Case Report Entry User Summary:

- Designed to provide a quick and easy way for Users to search and view all previously initiated case reports (Submitted and In-Progress) entered during a specific date range within the last six months from the current date.
- Allows Users to view a summary of completed case reports that were previously submitted.
- Allows Users to continue entering details for case reports that are still “In-Progress”.



3. Manage User Preferences:

- Designed as an efficient method for Users to enter repetitive data.
- Allows Users to enter required case reporting details in their User Preferences which enables Users to quickly select the appropriate answers from the dropdown menu options.

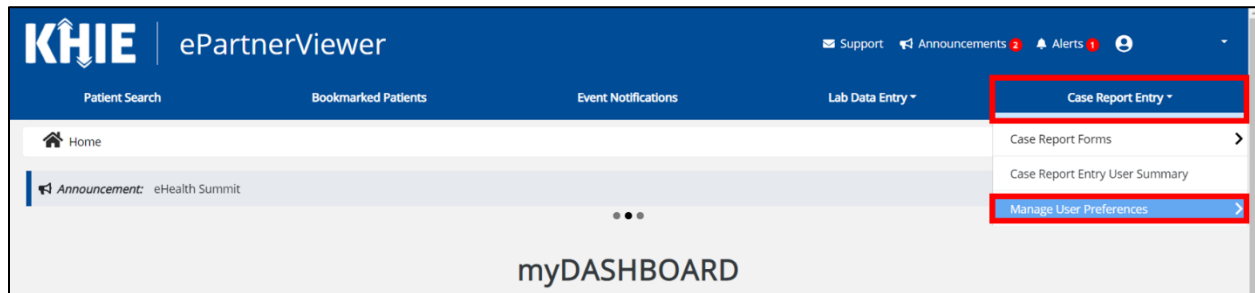


4 Manage User Preferences

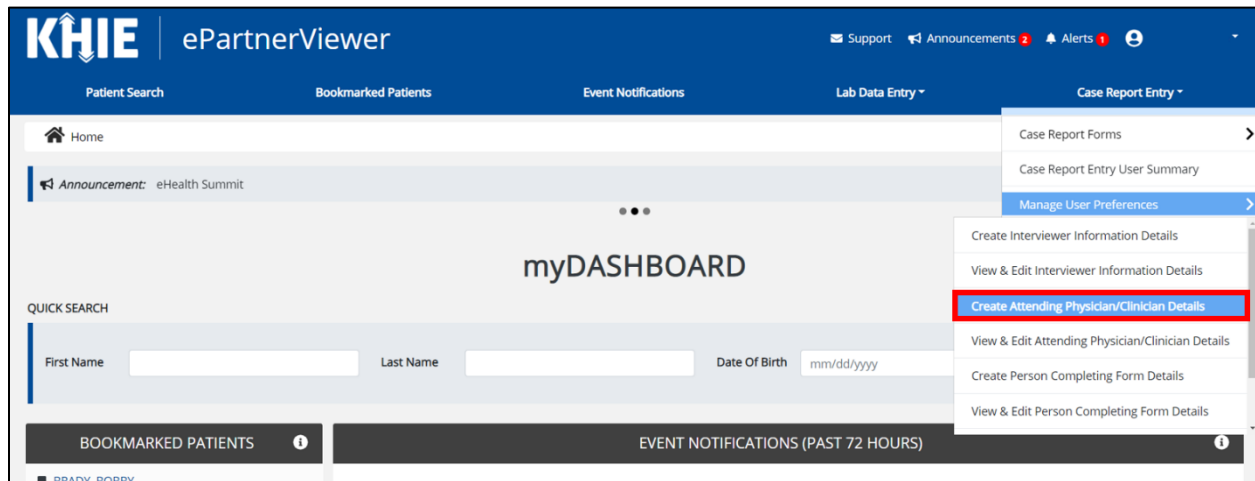
These are your User Preferences. Prior to entering your Perinatal Hepatitis case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in your user preferences,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

Create Attending Physician/Clinician Details

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



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



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

Home > Create Attending Physician/Clinician Details

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix: Dr.

First Name*:

Last Name*:

Suffix: Select... (Options: II, III, IV, Jr, Sr)

Address 2: Unit, Suite, Building, etc.

State*: Select... Zip Code*:

Email*: name@domain.com

Clear Save

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix: Dr.

First Name*:

Last Name*:

Suffix: Sr

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

Address 1*:

Address 2: Unit, Suite, Building, etc.

City*:

State*: Select... Zip Code*:

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

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

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

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

ATTENDING PHYSICIAN/CLINICIAN

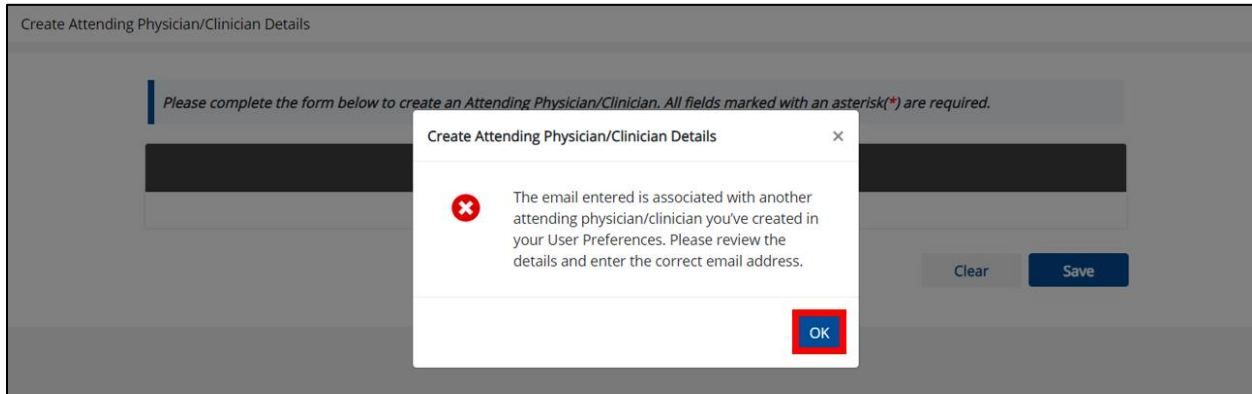
Prefix	Dr.		
First Name*	Frank	Last Name*	Costanza
Suffix	Sr		
Address 1*	1 First Street	Address 2	1A
City*	Lexington	State*	KY
		Zip Code*	40123
Phone*	(111) 111-1111	Email*	frank@email.com

Clear Save

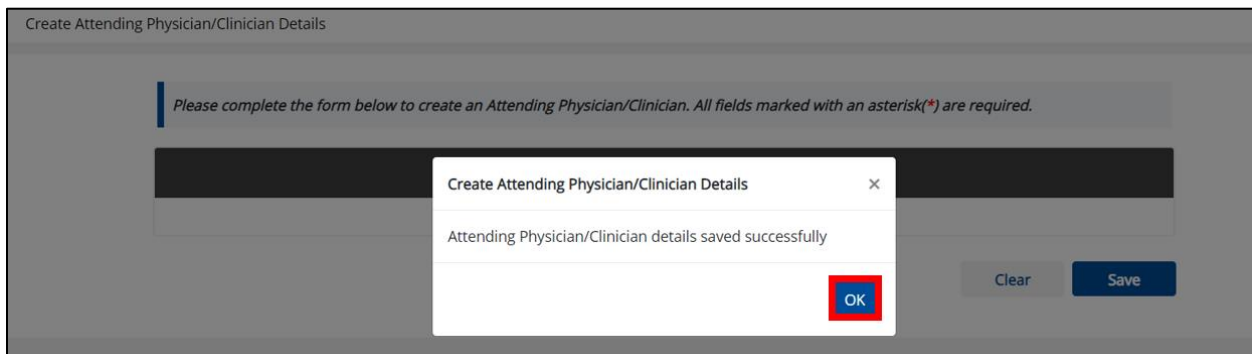
Please Note: If you enter an email address that is already associated with another Attending Physician/Clinician and click **Save**, a pop-up displays with an error message that states:

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

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

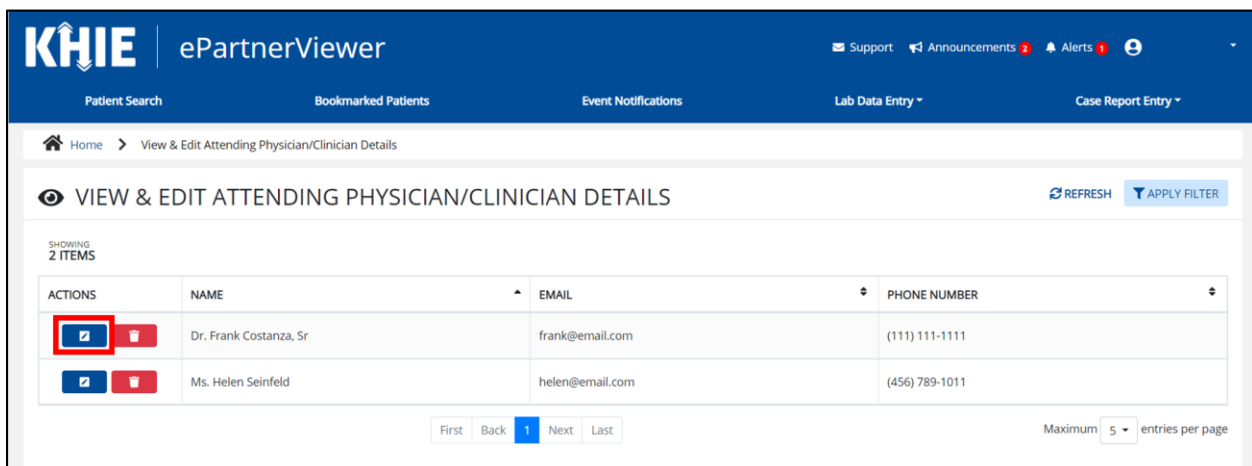


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.



View & Edit Attending Physician/Clinician Details

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



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

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

Delete Attending Physician/Clinician Details

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

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.

The screenshot shows the 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' interface. A pop-up window titled 'Delete Attending Physician/Clinician Details' is displayed in the center. The pop-up contains the text 'Are you sure?' and two buttons: 'Cancel' and 'OK'. The background interface shows a table with one item, 'Dr. Frank Costanza, Sr.', and a 'PHONE NUMBER' field with the value '(111) 111-1111'. The 'SHOWING 1 ITEMS' indicator is visible at the top left of the table.

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

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

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

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

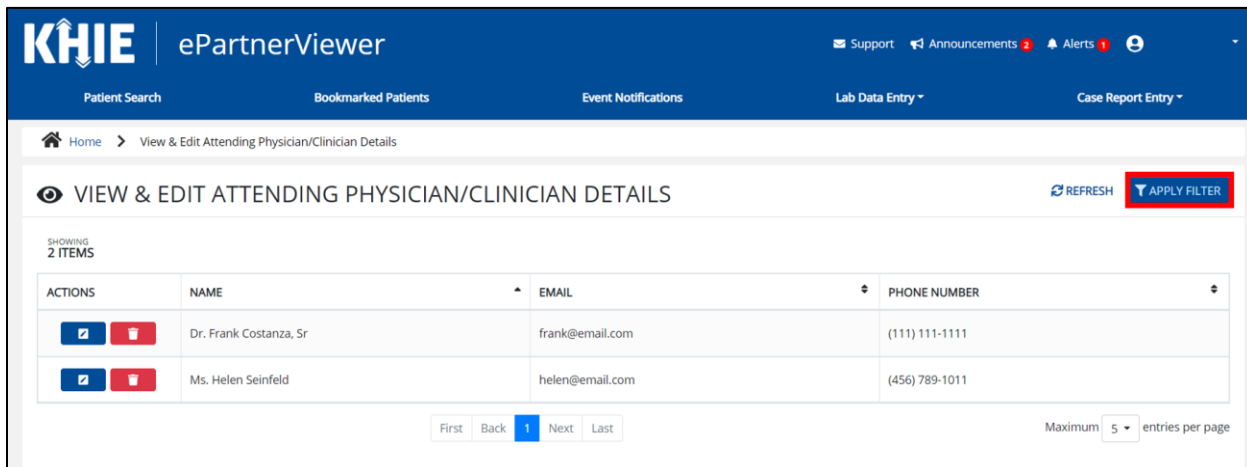
To delete the Attending Physician/Clinician used in a case report that is still "In-Progress", you must first complete the case report.

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





The screenshot shows the 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS' interface. A pop-up window titled 'Delete Attending Physician/Clinician Details' is displayed in the center. The pop-up contains a red 'X' icon and the text: '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.' The background interface shows a table with two items: 'Ms. Helen Seinfeld' and 'Dr. Frank Costanza, Sr.'. The 'SHOWING 2 ITEMS' indicator is visible at the top left of the table. The 'PHONE NUMBER' field for 'Ms. Helen Seinfeld' is '(456) 789-1011' and for 'Dr. Frank Costanza, Sr.' is '(111) 111-1111'.

Filter Attending Physician/Clinician Details

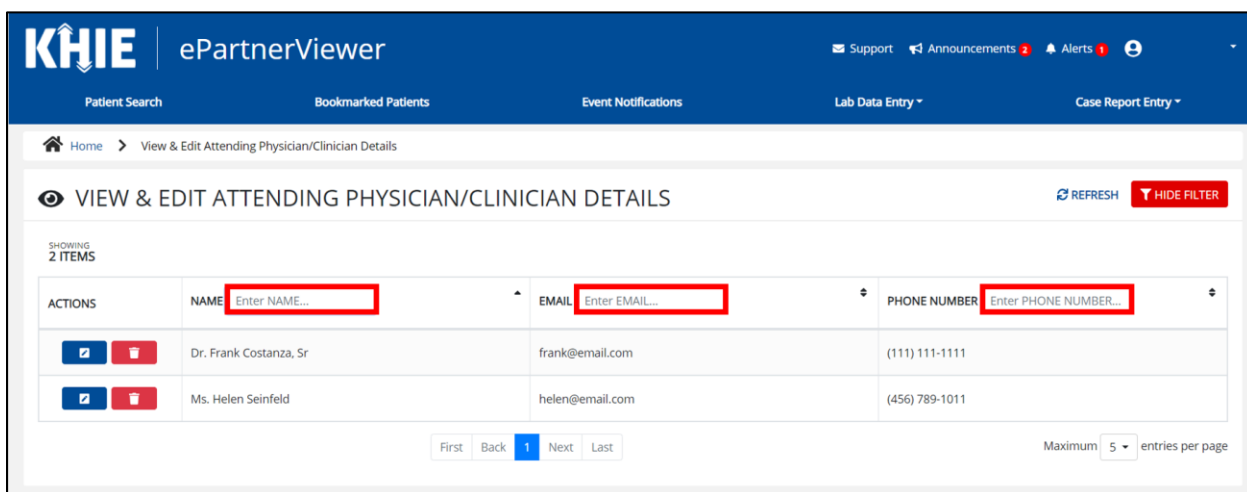
16. To search for a specific Attending Physician/Clinician, click **Apply Filter**.







The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS'. Below the title, there is a 'REFRESH' button and a red 'APPLY FILTER' button. A table displays 2 items, showing columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The table contains two rows of data: Dr. Frank Costanza, Sr. and Ms. Helen Seinfeld. At the bottom of the table, there are pagination controls (First, Back, 1, Next, Last) and a 'Maximum 5 entries per page' setting.

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

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

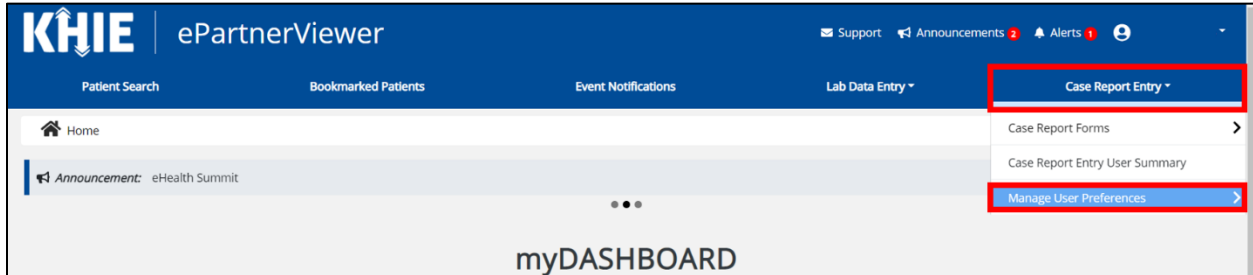


The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS'. Below the title, there is a 'REFRESH' button and a red 'HIDE FILTER' button. A table displays 2 items, showing columns for ACTIONS, NAME, EMAIL, and PHONE NUMBER. The table contains two rows of data: Dr. Frank Costanza, Sr. and Ms. Helen Seinfeld. At the bottom of the table, there are pagination controls (First, Back, 1, Next, Last) and a 'Maximum 5 entries per page' setting. The filter fields (NAME, EMAIL, PHONE NUMBER) are highlighted with red boxes.

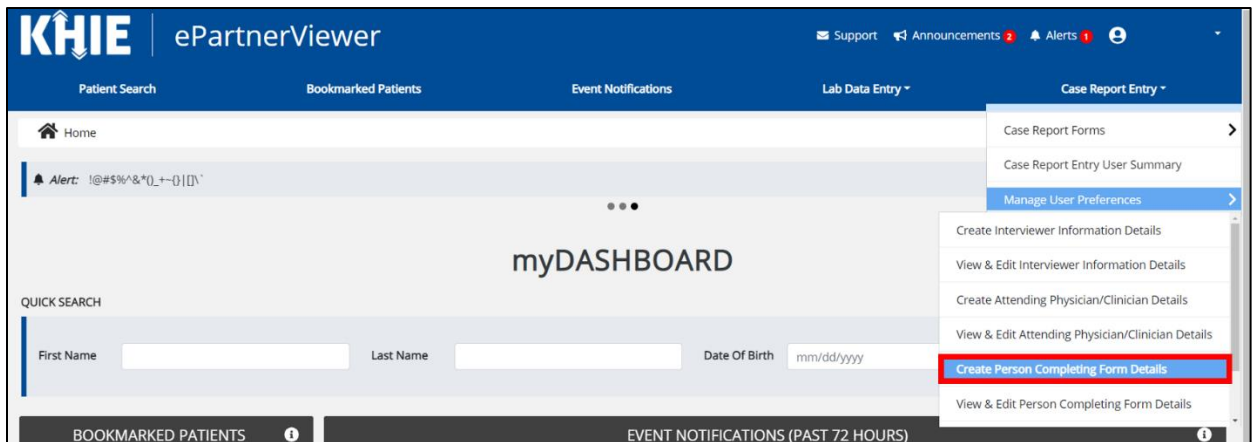
ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
 	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

Create Person Completing Form Details

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



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



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

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

PERSON COMPLETING FORM

Prefix: Mr. [X] [v]

First Name* [] Last Name* []

Suffix: [select...] [v]

II [] III [] IV [] Jr [] Sr []

Address 2: [] Unit, Suite, Building, etc.

State* [select...] [v] Zip Code* []

Email* [] name@domain.com

(xxx) xxx-xxxx

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

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

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

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

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

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

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

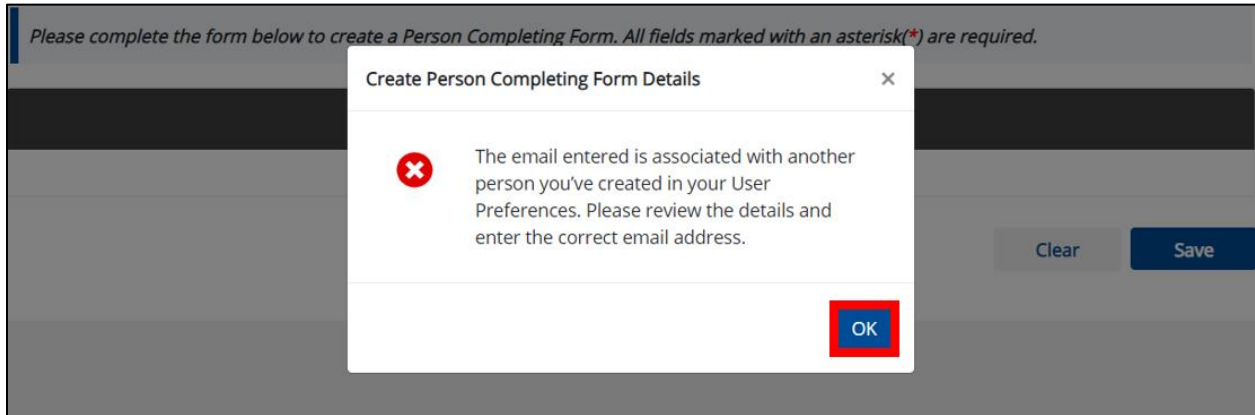
9. After completing the mandatory fields, click **Save**.

PERSON COMPLETING FORM		
Prefix <input type="text" value="Mr."/> x v		
First Name*	Last Name*	
<input type="text" value="Arthur"/>	<input type="text" value="Vandelay"/>	
Suffix <input type="text" value="II"/> x v		
Address 1*	Address 2	
<input type="text" value="22 Second Avenue"/>	<input type="text" value="Unit, Suite, Building, etc."/>	
City*	State*	Zip Code*
<input type="text" value="Lexington"/>	<input type="text" value="KY"/> x v	<input type="text" value="40222-"/>
Phone*	Email*	
<input type="text" value="(222) 222-2222"/>	<input type="text" value="arthur@email.com"/>	
		<input type="button" value="Clear"/> <input type="button" value="Save"/>

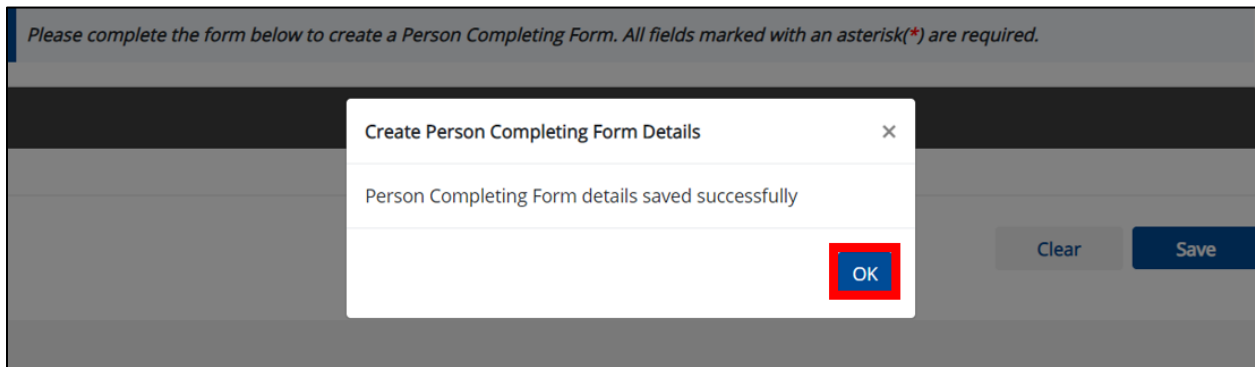
Please Note: If you enter an email address that is already associated with another Person Completing Form and click **Save**, a pop-up displays with an error message that states:

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

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



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







View & Edit Person Completing Form Details

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

Home > View & Edit Person Completing Form Details

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

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

First Back 1 Next Last

Maximum 5 entries per page

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

Update Person Completing Form Details

Prefix: Mr.

First Name: Arthur

Last Name: Vandelay

Suffix: II

Address 1: 22 Second Avenue

Address 2: Unit, Suite, Building, etc.

City: Lexington

State: KY

Zip Code: 40222

Phone: (222) 222-2222





Email: arthur@email.com

Cancel Save

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS

SHOWING 2 ITEMS

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

First Back 1 Next Last

Maximum 5 entries per page





Update Person Completing Form Details

Person Completing Form details updated successfully





OK

Delete Person Completing the Form Details

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS			
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

15. The *Person Completing Form Details* pop-up displays. To delete, click **OK**. Click **Cancel** if you do not want to delete the person completing the form.

VIEW & EDIT PERSON COMPLETING FORM DETAILS			
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

Delete Person Completing Form Details ×

Are you sure?

Cancel **OK**

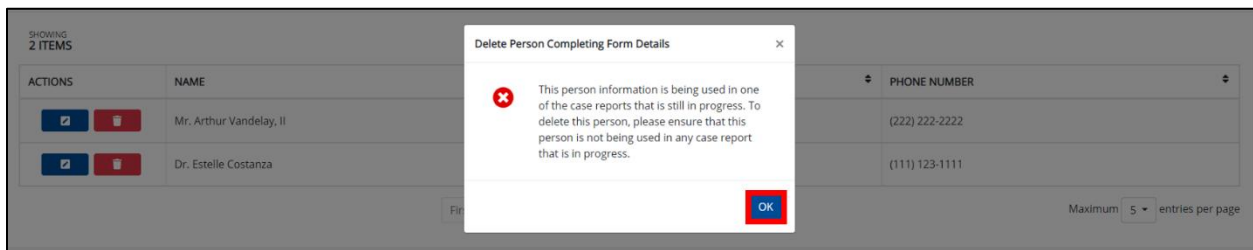



Please Note: You can delete a person on the **View & Edit Person Completing Form Details** screen as long as that person has not been selected for use in a case report that is still in-progress.

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


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

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

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

VIEW & EDIT PERSON COMPLETING FORM DETAILS			
SHOWING 2 ITEMS			
ACTIONS	NAME	EMAIL	PHONE NUMBER
 	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
 	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111

Delete Person Completing Form Details ×

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

OK

Maximum 5 entries per page

Filter Person Creating Form Details

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

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT PERSON COMPLETING FORM DETAILS'. It features a table with 2 items. The 'APPLY FILTER' button is highlighted with a red box.

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

Navigation: First Back 1 Next Last. Maximum 5 entries per page.

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

The screenshot shows the KHIE ePartnerViewer interface. The top navigation bar includes links for Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. The main content area is titled 'VIEW & EDIT PERSON COMPLETING FORM DETAILS'. It features a table with 2 items. The filter fields are highlighted with red boxes.

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

Navigation: 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.

PERINATAL HEPATITIS CASE REPORT FORM

Section 4 of 9

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

MEDICAL CONDITIONS

Patient Information ✓

Laboratory Information ✓

Applicable Symptoms ✓

Medical Conditions

Exposure Information 🔒

Hospitalization, ICU & Death Information 🔒

Vaccination History 🔒

Additional Comments 🔒

Review & Submit 🔒

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

Yes No Unknown

Substance abuse or misuse

Yes No Unknown

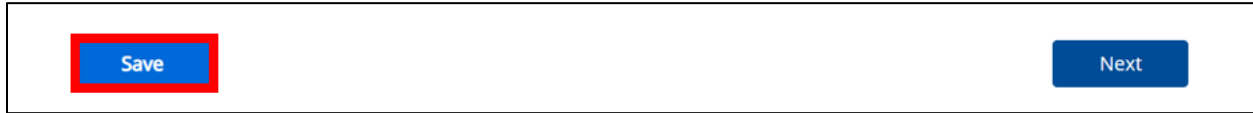
If yes, please specify the substance that was abused or misused: ?

Save Previous Next

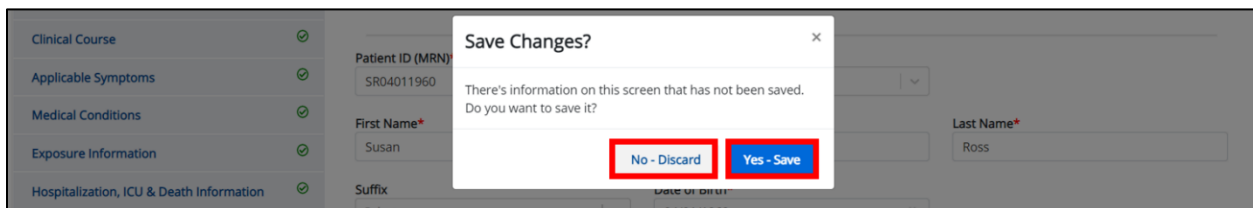
Save Feature

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.



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



Case Report Entry Icons

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

Icon Descriptions:

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

Conditional Questions

Conditional Questions are those questions that are asked based on your responses to the previous questions. The Perinatal Hepatitis 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 Perinatal Hepatitis Case Report, the subsequent fields will be grayed out and disabled.

PERINATAL HEPATITIS CASE REPORT FORM Section 2 of 9

Please provide laboratory information related to this case.

LABORATORY INFORMATION

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

Does the patient have a lab test?*

Yes **No**

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker
Select...

If other, please specify:

Results
Select...

If applicable, please enter the viral load: ?

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

LABORATORY INFORMATION

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

Does the patient have a lab test?*

Yes No

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker*

Select...

If other, please specify:

Results*

Select...

If applicable, please enter the viral load: ?

Test Result Date
mm/dd/yyyy ☐ Unknown

Specimen Collection Date*
mm/dd/yyyy ☐ Unknown

Laboratory Name:*

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

These conditional questions are found on the **Applicable Symptoms**, **Medical Conditions**, and **Exposure Information** screens.

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

The screenshot shows the 'APPLICABLE SYMPTOMS' screen. On the left is a sidebar with navigation links: Patient Information, Laboratory Information, Applicable Symptoms (selected), Medical Conditions, Exposure Information, Hospitalization, ICU & Death Information, Vaccination History, Additional Comments, and Review & Submit. The main content area starts with the question 'Were symptoms present during the course of illness?'. The 'No' button is selected and highlighted with a red box. Below this is the 'Onset Date' field, which is disabled and labeled 'No'. The section 'If symptomatic, which of the following did the patient experience during illness?' contains several symptom categories (Jaundice, Fever, Nausea, Vomiting, Abdominal Pain), each with 'Yes', 'No', and 'Unknown' buttons. All these buttons are disabled and labeled 'No'.

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

The screenshot shows the 'APPLICABLE SYMPTOMS' screen with the 'Unknown' button selected and highlighted with a red box for the question 'Were symptoms present during the course of illness?'. The 'Onset Date' field is disabled and labeled 'Unknown'. In the 'If symptomatic' section, the 'Unknown' button is selected for all symptom categories (Jaundice, Fever, Nausea, Vomiting, Abdominal Pain), and these buttons are highlighted with blue boxes.

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

APPLICABLE SYMPTOMS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Were symptoms present during the course of illness?*

Yes

No

Unknown

Onset Date* ?

mm/dd/yyyy

Unknown

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

Jaundice*

Yes

No

Unknown

Fever*

Yes

No

Unknown

Nausea*

Yes

No

Unknown

Vomiting*

Yes

No

Unknown

6 Affiliation/Organization Conditional Question

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

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

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

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

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

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

Affiliation/Organization Conditional Answer: Yes

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

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

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

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

Yes No

Patient ID (MRN)* Affiliation/Organization*

Select... Select...

Person Completing Form* Affiliation/Organization

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

Attending Physician/Clinician* Affiliation/Organization

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

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

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

Yes No

Patient ID (MRN)* Affiliation/Organization*

SK05051960 Test Medical Center x v

Person Completing Form* Affiliation/Organization

Mr. Arthur Vandelay, II (arthur@email.com) x v Test Medical Center x v If other, please specify:

Attending Physician/Clinician* Affiliation/Organization

Dr. Frank Costanza, Sr (frank@email.com) x v Test Medical Center x v If other, please specify:

Affiliation/Organization Conditional Answer: No

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

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

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

Yes **No**

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

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

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

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

Patient ID (MRN)* [?] Affiliation/Organization* [?]
SR05051960 Select...

Person Completing Form*
Select...

Attending Physician/Clinician*
Select...

Prefix
Select...

If other, please specify: [?]

If other, please specify: [?]

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

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) x Select...

Attending Physician/Clinician*
Select...

Prefix
Select...

First Name*
Last Name*

Suffix
Date of Birth*

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

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

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

If other, please specify:* ?

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

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

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center x v

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

Affiliation/Organization* ? Other x v

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

Affiliation/Organization* ? Select... x v

Prefix Select... v

First Name*

Suffix Select... v

Patient Sex* Ethnicity* Race*

Please select the organization of the physician attending the patient.

If other, please specify:* ? Test Hospital

If other, please specify: ?

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

Last Name*

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

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

Affiliation/Organization* ? Other x v

If other, please specify:* ?

Affiliation/Organization Validation

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

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

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

Yes **No**

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization*

If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization*

If other, please specify:

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

Yes **No**

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization

If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization

If other, please specify:

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

Yes **No**

Patient ID (MRN)*

Person Completing Form

Attending Physician/Clinician

Patient Information

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

Yes **No**

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

Change Affiliation/Organization Conditional Answer: No to Yes

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

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

Yes **No**

Patient ID (MRN)*
SK05051960

Affiliation/Organization*
Test Medical Center

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

Affiliation/Organization*
Other

If other, please specify*
Test Hospital

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

Affiliation/Organization*
Test Medical Center

If other, please specify:

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

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

Yes **No**

Patient ID (MRN)*
SK05051960

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

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

Affiliation/Organization*
Test Medical Center

If other, please specify*
Test Hospital

If other, please specify:

Patient Information

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

Yes **No**

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

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Disease/Organism*
Chlamydia

Date of Diagnosis*
07/23/2021

Unknown

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

Yes **No**

Patient ID (MRN)*
SK05051960

Affiliation/Organization*
Select...

Please Enter Affiliation/Organization

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

Affiliation/Organization*
Select...

If other, please specify:

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

Affiliation/Organization*
Select...

If other, please specify:

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

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

Patient ID (MRN)*

SK05051960

Person Completing Form*

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

Attending Physician/Clinician*

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

Prefix

Ms. x | v

Affiliation/Organization*

Select...

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical Center

If other, please specify:

If other, please specify:

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

- This means the same Affiliation/Organization will be applied to the Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician.

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

Patient ID (MRN)*

SK05051960

Affiliation/Organization*

Test Medical Center x | v

Person Completing Form*

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

Attending Physician/Clinician*

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

Affiliation/Organization

Test Medical Center x | v

Affiliation/Organization

Test Medical Center x | v

If other, please specify:

If other, please specify:

Change Affiliation/Organization Conditional Answer: Yes to No

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

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

Patient ID (MRN)* Affiliation/Organization*

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

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

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

Patient Information

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

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

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

Patient ID (MRN)* Affiliation/Organization*

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

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

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

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

Yes No

Patient ID (MRN)*

SR05051960

Person Completing Form*

Select...

Attending Physician/Clinician*

Select...

Prefix

Select...

Affiliation/Organization*

Select...

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical Center

If other, please specify:

If other, please specify:

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

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

Person Completing Form*

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

Affiliation/Organization*

Select...

If other, please specify:

Attending Physician/Clinician*

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

Affiliation/Organization*

Select...

If other, please specify:

Prefix

Select...

First Name*

Last Name*

Suffix

Select...

Patient Sex*

Ethnicity*

Race*

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

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

Person Completing Form*

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

Affiliation/Organization*

Other x | v

If other, please specify:

Attending Physician/Clinician*

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

Affiliation/Organization*

Other x | v

If other, please specify:

7 Dynamic Functions based on Disease/Organism

Based on the **Disease/Organism** selected from the dropdown menu on the **Patient Information** screen of the Perinatal Hepatitis Case Report, certain subsequent screens will dynamically display information that applies to the selected disease/organism. This means certain screens will display only the symptoms, lab tests, and vaccine information that apply to the selected disease/organism.

- Once the Disease/Organism selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to display only the information that applies to the selected Disease/Organism.

PERINATAL HEPATITIS CASE REPORT FORM

Section 1 of 9

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

Please select the disease/organism for which you want to file this case report for the patient.

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Disease/Organism* ?

Select...

Perinatal Hepatitis B

Perinatal Hepatitis C

Date of Diagnosis*

Disease/Organism Options for Perinatal Hepatitis Case Reports

Change or Save Disease/Organism Selection

Once you select a **Disease/Organism** from the dropdown menu, and click **Save** or **Next** on the **Patient Information** screen, a pop-up displays with a message that states:

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

Patient Information

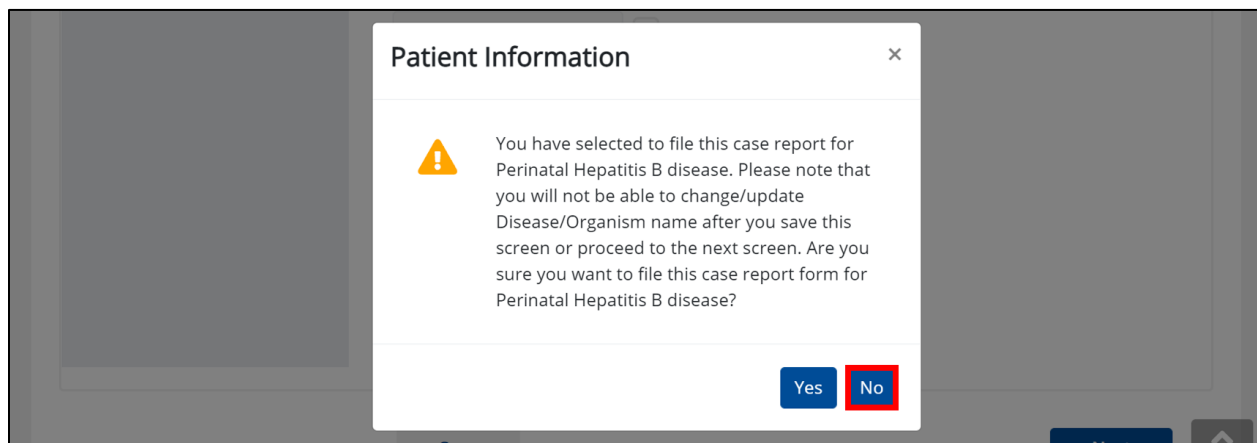
You have selected to file this case report for Perinatal Hepatitis B disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Perinatal Hepatitis B disease?

Yes No

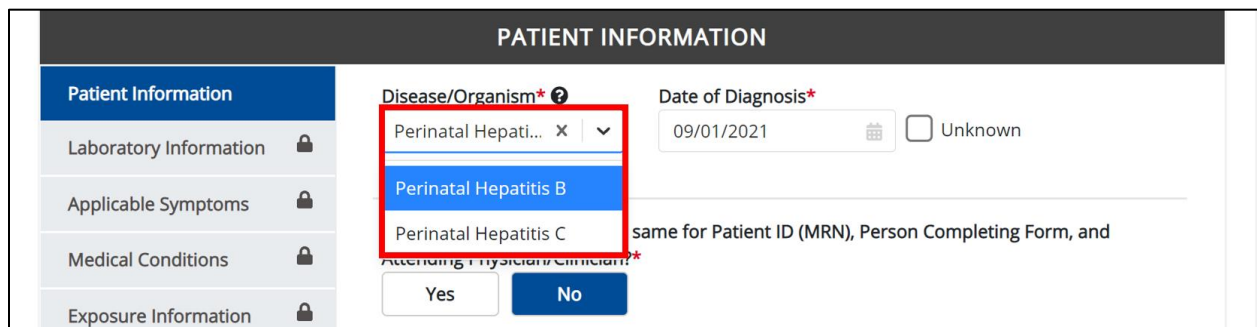
Please Note: All Disease/Organism selections are final. Once the selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to only display information that applies to the selected Disease/Organism.

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

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



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



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



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

The screenshot shows a 'Patient Information' pop-up dialog box. At the top, it says 'If yes, please enter the due date (EDC):'. Below this is a warning icon (yellow triangle with an exclamation mark) and a message: 'You have selected to file this case report for Perinatal Hepatitis C disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Perinatal Hepatitis C disease?'. At the bottom right of the dialog are two buttons: 'Yes' (highlighted with a red box) and 'No'. The background shows a blurred view of the main form with 'Save' and 'Next' buttons visible.

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

The screenshot shows the 'PERINATAL HEPATITIS CASE REPORT FORM' at 'Section 1 of 9'. A message at the top states: 'Please complete the form below. All fields marked with an asterisk(*) are required.' The form is divided into sections. The 'PATIENT INFORMATION' section is active. On the left is a sidebar with tabs: 'Patient Information' (selected), 'Laboratory Information', 'Applicable Symptoms', 'Medical Conditions', 'Exposure Information', and 'Hospitalization, ICU & Death Information'. The 'Patient Information' section contains the following fields: 'Disease/Organism*' (a dropdown menu showing 'Perinatal Hepatitis C', highlighted with a red box), 'Date of Diagnosis*' (a date field showing '09/01/2021' and an 'Unknown' checkbox), 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?*' (with 'Yes' and 'No' buttons), 'Patient ID (MRN)*' (a text field showing 'BR10291942'), and 'Affiliation/Organization*' (a dropdown menu showing 'Test Medical Ce...').

8 Dynamic Screens for Perinatal Hepatitis Case Report

The following screens display dynamic information based on the **Disease/Organism** selected from the dropdown menu on the **Patient Information** screen of the Perinatal Hepatitis Case Report.

Laboratory Information: Dynamic Screen

On the **Laboratory Information** screen of the Perinatal Hepatitis Case Report, the *Hepatitis Marker* dropdown menu displays only the hepatitis marker options that apply to the Disease/Organism selected on the **Patient Information** screen.

LABORATORY INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Does the patient have a lab test?*

Yes

No

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker*

Select...

HEPATITIS B VIRUS CORE AB

HEPATITIS B VIRUS CORE AB.IGG

HEPATITIS B VIRUS CORE AB.IGM

HEPATITIS B VIRUS DNA

HEPATITIS B VIRUS GENOTYPE

HEPATITIS B VIRUS LITTLE E AB

HEPATITIS B VIRUS LITTLE E AG

HEPATITIS B VIRUS POLYMERASE DNA

Hepatitis Markers for Hepatitis B

Specimen Collection Date*

mm/dd/yyyy

Unknown

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Hepatitis Marker*

Select...

HEPATITIS C VIRUS AB

HEPATITIS C VIRUS AB SIGNAL/CUTOFF

HEPATITIS C VIRUS RNA

Hepatitis C virus RNA panel

HEPATITIS C VIRUS RRNA

Other

Hepatitis Markers for Hepatitis C

Specimen Collection Date*

mm/dd/yyyy

Unknown

Vaccination History: Dynamic Screen

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

- The **Vaccination History** screen is disabled and does **not** collect vaccine information when **Hepatitis C** is selected as the Disease/Organism.

VACCINATION HISTORY

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

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

The **Vaccination History** screen does **not** collect vaccination details for **Hepatitis C**.

Save Previous **Next**

The **Vaccination History** screen is enabled and collects information only when **Hepatitis B** is selected as the Disease/Organism.

- When **Hepatitis B** is selected as the Disease/Organism, **Vaccination History details** related to Hepatitis B is collected.

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Yes No Unknown Refused

Vaccine Details

If yes, please provide vaccine name:* ?

Select...

Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.
Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)
DTaP-hepatitis B and poliovirus vaccine
DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine
Haemophilus influenzae type b conjugate and Hepatitis B vaccine
hepatitis A and hepatitis B vaccine
hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)

The **Vaccination History** screen collects the **name of the vaccine** that the patient received for **Hepatitis B**.

Save Previous **Next**

VACCINATION HISTORY

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

Has the patient ever received a Hepatitis B vaccine?*

Vaccine Details

If yes, please provide vaccine name:* ?

hepatitis B vaccine, unspecified formulation

If other, please specify: ?

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

Select...

1

2

3

4

⬆

+ Add Vaccine

The **Vaccination History** screen collects the **number of vaccine doses** that the patient received for **Hepatitis B**.

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

Has the patient ever received a Hepatitis B vaccine?*

Vaccine Details

If yes, please provide vaccine name:* ?

hepatitis B vaccine, unspecified formulation

If other, please specify: ?

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

4

If yes, please specify the date administered: ?

Date Administered (1st dose)*

☐ Unknown

Date Administered (3rd dose)*

☐ Unknown

Date Administered (2nd dose)*

☐ Unknown

Date Administered (4th dose)*

☐ Unknown

⬆

+ Add Vaccine

The **Vaccination History** screen collects the **date(s) of administering vaccine dose(s)** for **Hepatitis B**.

9 Tips for Manually Entering Case Report Data

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

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

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

PATIENT INFORMATION	
Patient Information SARS CoV-2 Testing	<div> <div>Interviewer Name*</div> <div>Select...</div> </div> <div> <div>Affiliation/Organization*</div> <div>Select...</div> </div>

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

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

PATIENT INFORMATION	
Patient Information SARS CoV-2 Testing Clinical Course Applicable Symptoms	<div> <div> <div>Interviewer Name*</div> <div>Dr. [Select...]</div> </div> <div> <div>Affiliation/Organization*</div> <div>Test Medical Center</div> </div> </div> <div> <div> <div>Patient ID (MRN)*</div> <div>[Select...]</div> </div> <div> <div>Prefix</div> <div>Select...</div> </div> </div>

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

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

City	<input type="text"/>	State	KY
Zip Code	<input type="text"/>	County	Select...
Phone Number	<input type="text"/>	Email Address	<input type="text"/>

Adair
Allen
Anderson
Ballard
Barren
Bath
Bell

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

City	<input type="text"/>	State	AR x v
Zip Code	<input type="text"/>	County	Out Of System State x v

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

Admission Date* <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown	Discharge Date* <input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown
<div> <div> June 2021 June 2021 Su Mo Tu We Th Fr Sa 30 31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 1 2 3 </div> <div> this illness?* Unknown death: <input type="text"/> <input type="checkbox"/> Unknown </div> </div>	

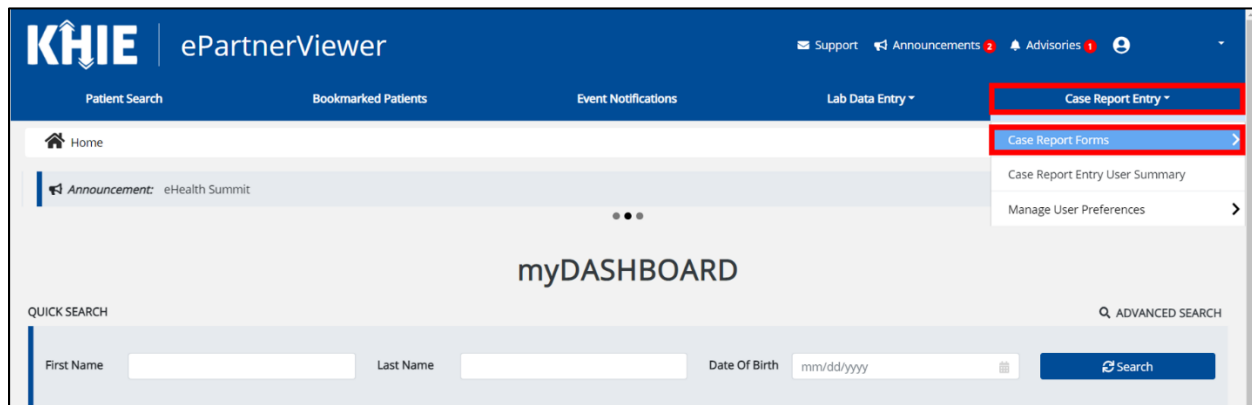
- If the date is unknown, you have the option to click the **Unknown** checkbox.

Admission Date* <input type="text" value="mm/dd/yyyy"/> <input checked="" type="checkbox"/> Unknown	Discharge Date* <input type="text" value="06/20/2021"/> <input type="checkbox"/> Unknown
---	--

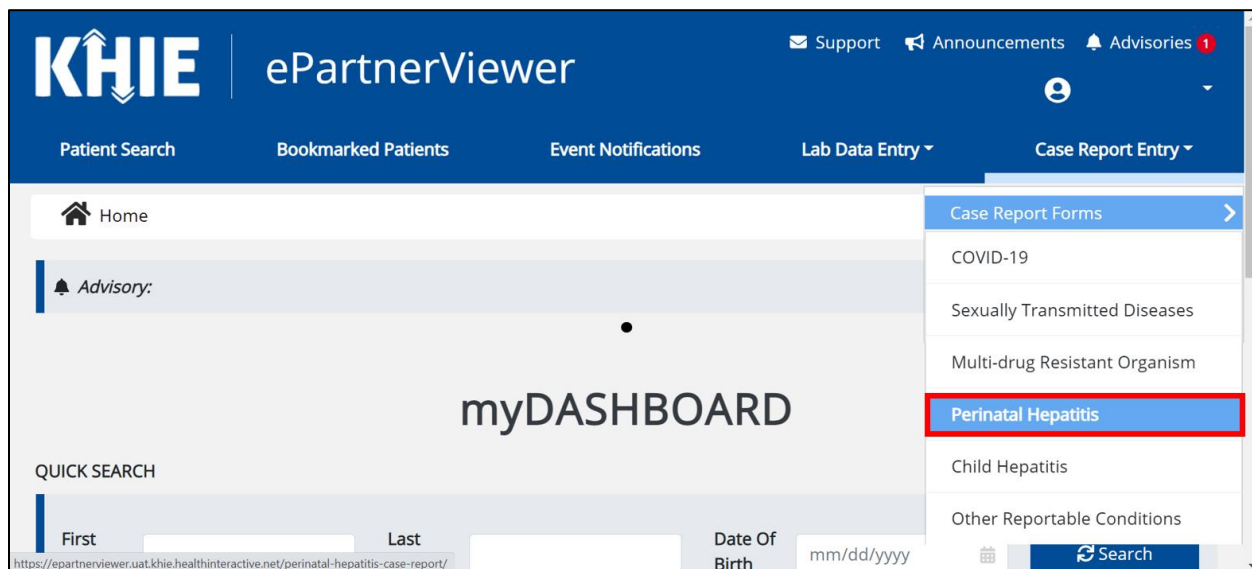
10 Perinatal Hepatitis Case Report Form

Users with the *Manual Case Reporter* Role are authorized to access the Perinatal Hepatitis Case Report Form in the ePartnerViewer.

1. To enter Perinatal Hepatitis case report information, click the **Case Report Entry** Tab in the blue Navigation Bar at the top of the screen, then select **Case Report Forms** from the dropdown menu.



2. Select **Perinatal Hepatitis** from the dropdown menu.



11 Patient Information

The Perinatal Hepatitis Case Report Form is a nine-step process where Users enter (1) Patient Information, (2) Laboratory Information, (3) Applicable Symptoms, (4) Medical Conditions, (5) Exposure Information, (6) Hospitalization, ICU, & Death Information, (7) Vaccination History, and (8) Additional Comments. (9) **Review and Submit** is where Users must review the information they have entered **and** submit the Perinatal Hepatitis Case Report.

PERINATAL HEPATITIS CASE REPORT FORM

Section 1 of 9

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

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*
Select...

Date of Diagnosis*
mm/dd/yyyy ☐ Unknown

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

Yes No

Patient ID (MRN)
Select...

Affiliation/Organization
Select...

Person Completing Form
Select...

Affiliation/Organization
Select...

If other, please specify:

Attending Physician/Clinician
Select...

Affiliation/Organization
Select...

If other, please specify:

1. To start the Perinatal Hepatitis Case Report entry, you must complete the mandatory fields on the **Patient Information** screen.

PATIENT INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Disease/Organism*
Select...

Date of Diagnosis*
mm/dd/yyyy ☐ Unknown

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

Yes No

Patient ID (MRN)
Select...

Affiliation/Organization
Select...

Person Completing Form
Select...

Affiliation/Organization
Select...

If other, please specify:

Attending Physician/Clinician
Select...

Affiliation/Organization
Select...

If other, please specify:

Prefix
Select...

First Name*
Middle Name
Last Name*

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

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

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

If you access the Perinatal Hepatitis 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*

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

PERINATAL HEPATITIS CASE REPORT FORM

Section 1 of 9

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

PATIENT INFORMATION	
Patient Information Laboratory Information Applicable Symptoms Medical Conditions Exposure Information	Disease/Organism* Select... Perinatal Hepatitis B Perinatal Hepatitis C
	Date of Diagnosis* mm/dd/yyyy
	<input type="checkbox"/> Unknown

Please select the disease/organism for which you want to file this case report for the patient.

Yes No

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

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

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

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

The screenshot shows the 'Date of Diagnosis*' field with a date input 'mm/dd/yyyy' and an 'Unknown' checkbox. A calendar widget for September 2021 is displayed, with the date '1' selected. The left sidebar contains a menu with 'Patient Information' selected, and other options like 'Laboratory Information', 'Applicable Symptoms', 'Medical Conditions', 'Exposure Information', 'Hospitalization, ICU & Death Information', and 'Vaccination History'.

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?*

The screenshot shows the conditional field 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?' with 'Yes' and 'No' buttons. Below this field are three rows of input fields for 'Patient ID (MRN)', 'Person Completing Form', and 'Attending Physician/Clinician', each with a dropdown menu for 'Affiliation/Organization' and a text field for '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.

The screenshot shows the 'Yes' button selected for the conditional field. The 'Patient ID (MRN)', 'Person Completing Form', and 'Attending Physician/Clinician' fields are highlighted with a red box, indicating they are the focus of the next step.

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

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

Yes **No**

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

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

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

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

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

Select...

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

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

CK08101955

Person Completing Form* Select...

Attending Physician/Clinician* Select...

Prefix Select...

Afzal, Mohammad MD, Internal Medicine, LLC

eICR Onboarding Regression

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical

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

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

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

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

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization

If other, please specify:

Dr. Estelle Costanza (estelle@email.com)

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

Affiliation/Organization

If other, please specify:

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

Person Completing Form Hyperlink

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

[Person Completing Form*](#)

Affiliation/Organization*

If other, please specify:

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

Manage User Preferences

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

PERSON COMPLETING FORM

Prefix

First Name*

Last Name*

Suffix

Address 2

State*

Zip Code*

Email*

Cancel Save

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

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

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

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

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

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

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

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

Additional Information	Person Completing Form* Select... Dr. Estelle Costanza (estelle@email.com) Mr. Arthur Vandelay, II (arthur@email.com) Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization*? Select... If other, please specify: ?
Treatment Information		Affiliation/Organization*? Select... If other, please specify: ?
Additional Comments		
Review and Submit		

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

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center

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

Attending Physician/Clinician* Select... | v

Prefix Select... | v

First Name*

Suffix

Date of Birth*

Affiliation/Organization* ?

Select...

One

Hilton Hospital

King's Daughters Medical Center

Murray-Calloway County Hospital

Test Medical Center

University Of Kentucky Chandler Medical Center

Other

If other, please specify: ?

If other, please specify: ?

Last Name*

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

- If **Other** is selected from the dropdown menu, the subsequent field is enabled. Enter the name of the **organization associated with the person completing the form** in the subsequent textbox: *If other, please specify.*

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

Yes No

Patient ID (MRN)* ? CK08101955

Affiliation/Organization* ? Test Medical Center

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

Attending Physician/Clinician* Select... | v

Affiliation/Organization* ? Other

If other, please specify: ?

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

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

Please Note: If the appropriate name does not display in the Attending Physician/Clinician dropdown, you must create details for a new Attending Physician/Clinician by clicking the **Attending Physician/Clinician hyperlink**.

Attending Physician/Clinician Hyperlink

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

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

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

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

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

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

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

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

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

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

<ul style="list-style-type: none"> Patient Information Laboratory Information Applicable Symptoms Medical Conditions Travel Information Hospitalization, ICU & Death Information Additional Information Treatment Information Additional Comments Review and Submit 	<h3>ATTENDING PHYSICIAN/CLINICIAN</h3>		
	Prefix Dr. <input type="text"/>		
	First Name* Fraiser	Last Name* Crane	
	Suffix Select... <input type="text"/>		
	Address 1* 123 Cheers Street	Address 2 Unit, Suite, Building, etc.	
	City* Lexington	State* KY <input type="text"/>	Zip Code* 40123- <input type="text"/>
	Phone* (555) 555-4321	Email* fraisercrane@email.com	
	<input type="button" value="Cancel"/> <input type="button" value="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.

<ul style="list-style-type: none"> Treatment Information Additional Comments Review and Submit 	Attending Physician/Clinician* <input type="text"/>	Affiliation/Organization* <input type="text"/>	If other, please specify: <input type="text"/>
	Dr. Fraiser Crane (fraisercrane@email.com)		
	Dr. Frank Costanza, Sr (frank@email.com) Ms. Helen Seinfeld (helen@email.com)		
	Middle Name <input type="text"/>	Last Name* <input type="text"/>	

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

The screenshot shows a form section for 'Attending Physician/Clinician *'. The 'Affiliation/Organization *' dropdown menu is open, displaying a list of options: 'Select...', 'Twenty One', 'Hilton Hospital', 'King's Daughters Medical Center', 'Murray-Calloway County Hospital', 'Test Medical Center', 'University Of Kentucky Chandler Medical Center', and 'Other'. The dropdown is highlighted with a red border. To the right, there is a text box labeled 'If other, please specify: ?' and a 'Last Name *' field.

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.*

The screenshot shows the 'Affiliation/Organization *' dropdown menu with 'Other' selected. The 'If other, please specify: * ?' text box is highlighted with a red border, indicating where the user should enter the organization name.

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.

The screenshot shows a form section for patient information. The 'Prefix' and 'Suffix' dropdown menus are highlighted with red borders. The 'Prefix' dropdown shows 'Select...' and the 'Suffix' dropdown shows 'Select...'. Other fields include 'First Name *', 'Middle Name', 'Last Name *', and 'Maiden Name'.

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

First Name*	Middle Name	Last Name*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Suffix Select... ▼	Maiden Name	
	<input type="text"/>	

Please Note: Other case reports do not include the *Maiden Name* field. Perinatal Case Reports include the *Maiden Name* field because Perinatal Hepatitis applies only to female patients who are either pregnant or postpartum.

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

Date of Birth*	Ethnicity*	Race*
<input type="text" value="10/29/1990"/>	Select... ▼	Select... ▼

Please Note: If the patient is either under one year old or more than 100 years old, a notification pop-up will display to confirm the correct birth year has been entered or selected. You cannot proceed to the next page until updating or confirming the patient's birth year.

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

Date of Birth*	Ethnicity*	Race*
<input type="text" value="10/29/1990"/>	<input type="text" value="Not Hispanic or Latino"/>	<input type="text" value="Select..."/>
<div> <div> Address 1* <input type="text"/> </div> <div> City* <input type="text"/> </div> <div> County* Select... ▼ </div> </div> <div> <div> Address 2 Unit, Suite, Building <input type="text"/> </div> <div> State* Select... </div> <div> Phone* ? (XXX) XXX-XXXX </div> </div>		
<div> <div> American Indian or Alaska Native </div> <div> Asian </div> <div> Asked but Unknown </div> <div> Black or African American </div> <div> Native Hawaiian or Other Pacific Islander </div> <div> Other </div> </div>		

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

Address 1* <input type="text"/>		Address 2 <input type="text"/>	
City* <input type="text"/>		State* <input type="text"/>	Zip Code <input type="text"/>
County* <input type="text"/>	Phone* <input type="text"/>		Email <input type="text"/>

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

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

Address 1* <input type="text"/>		Address 2 <input type="text"/>	
City* <input type="text"/>		State* <input type="text"/>	Zip Code <input type="text"/>
County* <input type="text"/>	Phone* <input type="text"/>		Email <input type="text"/>

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

Is the patient currently pregnant?* <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
If yes, please enter the due date (EDC): <input type="text"/> <input type="checkbox"/> Unknown

Please Note: In all other case report forms, the *Is the patient currently pregnant?* field is only enabled when the *Patient Sex* field is marked as **Female**.

The Perinatal Hepatitis Case Report does not include the *Patient Sex* field because Perinatal Hepatitis only applies to female patients that are either pregnant or postpartum. By default, the Perinatal Case Report Form assumes that the patient sex is female.

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

This screenshot shows the 'Is the patient currently pregnant?' field with 'Yes' and 'No' buttons. A tooltip points to the 'Unknown' checkbox, stating: 'Please enter the estimated due date, if known or select the 'Unknown' checkbox if the estimated due date is not known.' Below the buttons, the text 'If yes, please enter the due date (EDC):*' is followed by a date input field (mm/dd/yyyy) and an 'Unknown' checkbox. The date input field and the 'Unknown' checkbox are highlighted with a red box.

Please Note: If **Yes** is selected for the *Is the patient currently pregnant?* field, the subsequent postpartum-related field is disabled: *Is the patient postpartum?*

This screenshot shows the form with 'Yes' selected for 'Is the patient currently pregnant?'. The 'If yes, please enter the due date (EDC):*' field is active, showing '11/12/2021' and an 'Unknown' checkbox. The 'Is the patient postpartum?' field is disabled, with 'Yes', 'No', and 'Unknown' buttons. The 'Is the patient postpartum?' field and its buttons are highlighted with a red box.

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

Additionally, if **No** or **Unknown** is selected for the *Is the patient currently pregnant?* field, the postpartum-related field is enabled: *Is the patient postpartum?*

This screenshot shows the form with 'No' selected for 'Is the patient currently pregnant?'. The 'If yes, please enter the due date (EDC):*' field is disabled. The 'Is the patient postpartum?*' field is active, with 'Yes', 'No', and 'Unknown' buttons. The 'Is the patient postpartum?*' field and its buttons are highlighted with a red box.

35. If applicable, select the **appropriate answer** to *Is the patient postpartum?*

Is the patient postpartum?*

If yes, please enter the date of delivery: ?

☐ Unknown

- If **Yes** is selected for the *Is the patient postpartum?* field, the subsequent field is enabled. Enter the **date of delivery** in the subsequent field: *If yes, please enter the date of delivery*. If the date of delivery is unknown, click the **Unknown checkbox**.

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

☐ Unknown

Is the patient postpartum?*

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

If yes, please enter the date of delivery: * ?

☐ Unknown

Please Note: If **Yes** is selected for the *Is the patient postpartum?* field, the pregnancy-related field is disabled: *Is the patient currently pregnant?*

36. Select the **appropriate answer** to *Does the patient have a history of incarceration?*

Does the patient have a history of incarceration?*

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.

The screenshot shows the 'Patient Information' form with the following fields and options:

- Is the patient currently pregnant?***
- If yes, please enter the due date (EDC):* ?**
 ☐ Unknown
- Is the patient postpartum?**
- If yes, please enter the date of delivery: ?**
 ☐ Unknown
- Does the patient have a history of incarceration?***

At the bottom, the **Save** and **Next** buttons are highlighted with red rectangles.

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

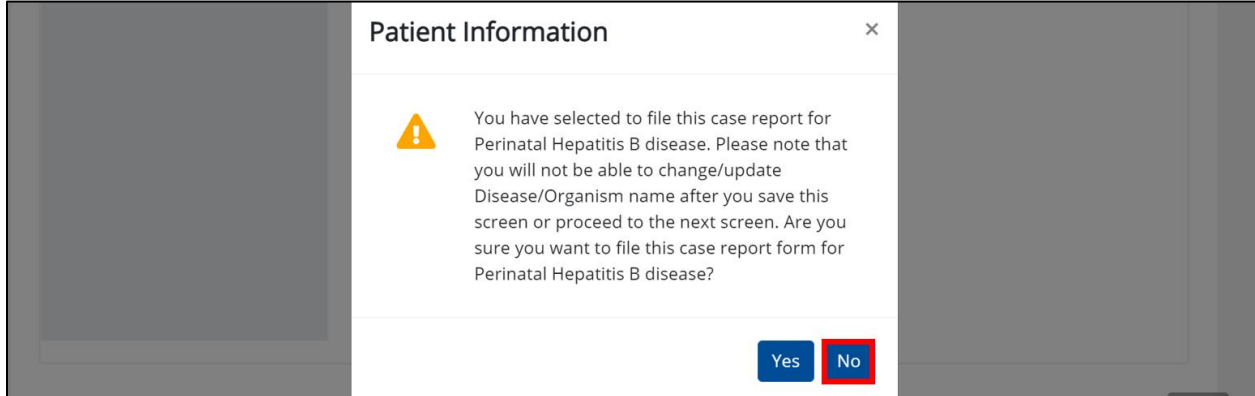
To save the selected Disease/Organism and proceed to the **Laboratory Information** page, click **Yes**. To change the selected Disease/Organism, click **No**.

The screenshot shows a 'Patient Information' dialog box with a warning icon and the following text:

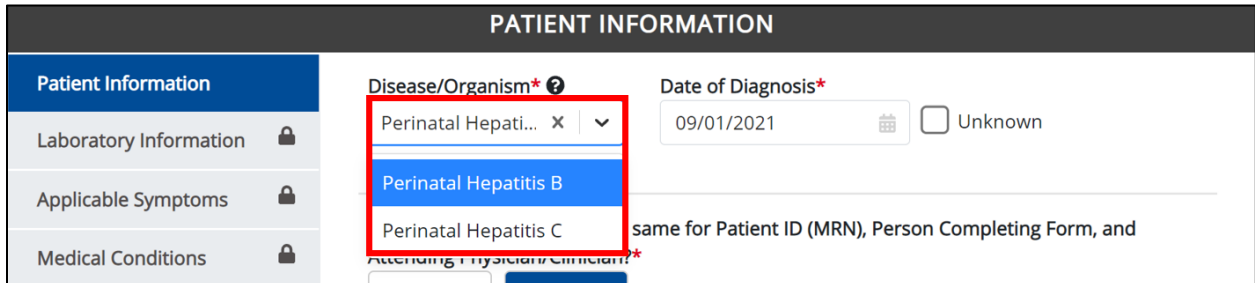
You have selected to file this case report for Perinatal Hepatitis B disease. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report form for Perinatal Hepatitis B disease?

At the bottom, the **Yes** and **No** buttons are highlighted with red rectangles.


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



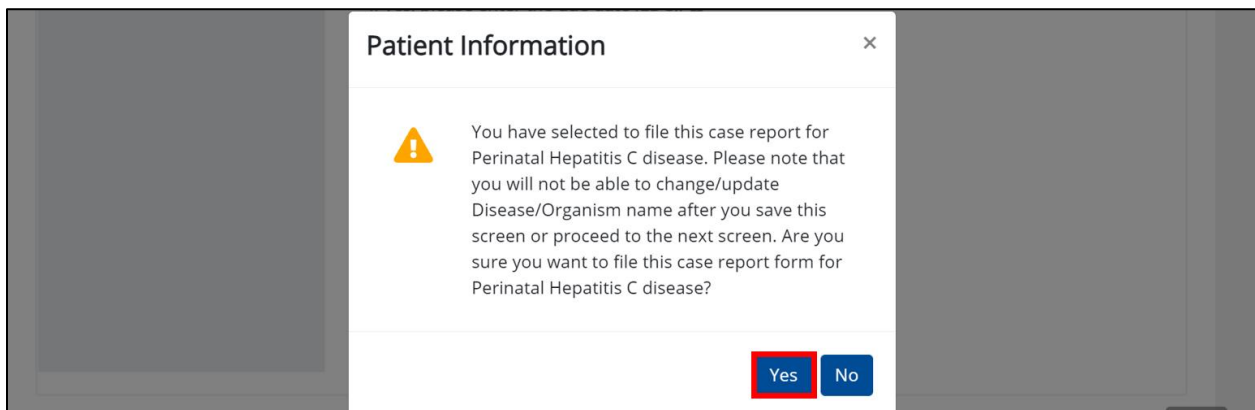
39. If changing the selection, select a different **Disease/Organism** from the dropdown menu.



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



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



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

PATIENT INFORMATION	
Patient Information ✓	Disease/Organism* ⓘ Perinatal Hepatitis C ▼
Laboratory Information	Date of Diagnosis* 09/01/2021 ⓘ <input type="checkbox"/> Unknown

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

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

Is the patient currently pregnant?*	
Yes	No Unknown
If yes, please enter the due date (EDC):* ⓘ	
11/12/2021 ⓘ	<input type="checkbox"/> Unknown
Is the patient postpartum?*	
Yes	No Unknown
If yes, please enter the date of delivery: ⓘ	
mm/dd/yyyy ⓘ	<input type="checkbox"/> Unknown
Does the patient have a history of incarceration?*	
Yes	No Unknown
Save	Next ⓘ

12 Laboratory Information

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

PERINATAL HEPATITIS CASE REPORT FORM Section 2 of 9

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information	✓
Laboratory Information	
Applicable Symptoms	🔒
Medical Conditions	🔒
Exposure Information	🔒
Hospitalization, ICU & Death Information	🔒
Vaccination History	🔒
Additional Comments	🔒

Does the patient have a lab test?*

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker
Select...

If other, please specify:

Results

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

LABORATORY INFORMATION

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

Does the patient have a lab test?*

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker*

Select...

If other, please specify:

Results*

Select...

If applicable, please enter the viral load: ⓘ

Test Result Date
mm/dd/yyyy ☐ Unknown

Specimen Collection Date*
mm/dd/yyyy ☐ Unknown

Laboratory Name:*

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

3. Select the appropriate **Hepatitis Marker** from the dropdown menu.

The screenshot shows the 'Patient Information' tab selected in the left sidebar. The main content area has a section titled 'Does the patient have a lab test?*' with 'Yes' and 'No' buttons. Below this, a note states: 'If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.' The 'Hepatitis Marker*' dropdown menu is open, showing options: 'Select...', 'HEPATITIS C VIRUS AB', 'HEPATITIS C VIRUS AB SIGNAL/CUTOFF', 'HEPATITIS C VIRUS RNA', 'Hepatitis C virus RNA panel', 'HEPATITIS C VIRUS RRNA', and 'Other'. The 'Other' option is highlighted. Below the dropdown, there are fields for 'Test Result Date' and 'Specimen Collection Date*'. A red box highlights the dropdown menu.

Please Note: The *Hepatitis Marker* dropdown menu displays only the hepatitis marker options that apply to the Disease/Organism selected on the **Patient Information** screen.

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

The screenshot shows the 'Hepatitis Marker*' dropdown menu with 'Other' selected. Below the dropdown, the text 'If other, please specify:*' is followed by a red-bordered text input field.

4. Select the appropriate **Test Result** from the *Results* dropdown menu.

The screenshot shows the 'Results*' dropdown menu open, displaying options: 'Select...', 'Negative', 'Pending', 'Positive', and 'Undetermined/Inconclusive'. The 'Negative' option is highlighted. Below the dropdown, there is a 'Laboratory Name:*' text input field. To the right, there is a 'Specimen Collection Date*' field with a date input 'mm/dd/yyyy' and a calendar icon, and an 'Unknown' checkbox.

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

Results*

Pending

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy

Unknown

Specimen Collection Date*

mm/dd/yyyy

Unknown

5. If applicable, enter the **viral load** in the textbox: *If applicable, please enter the viral load*.

Results*

Positive

Please enter the viral load or enter 'Unknown' if viral load is not known.

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy

Unknown

Specimen Collection Date*

mm/dd/yyyy

Unknown

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

7. Enter the **Specimen Collection Date**.

Test Result Date*

mm/dd/yyyy

Unknown

Specimen Collection Date*



mm/dd/yyyy

Unknown

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

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

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

Test Result Date* <input type="text" value="07/23/2021"/>  <input type="checkbox"/> Unknown <small>Invalid Test Result Date</small>	Specimen Collection Date* <input type="text" value="07/26/2021"/>  <input type="checkbox"/> Unknown <small>Invalid Specimen Collection Date</small>
---	---

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


Laboratory Name:*

Adding Multiple Hepatitis Markers

9. You can click **Add Hepatitis Marker** to log the details for multiple hepatitis markers. This means that you can easily enter additional hepatitis markers on the same patient.

Laboratory Name:*

Test Lab

 **Add Hepatitis Marker**

ALT

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

Laboratory Name:^{*}

Test Lab

Hepatitis Marker:^{*}

Select... | v

If other, please specify:

Results:^{*}

Select... | v

If applicable, please enter the viral load: ?

Test Result Date

mm/dd/yyyy

☐ Unknown

Specimen Collection Date:^{*}

mm/dd/yyyy

☐ Unknown

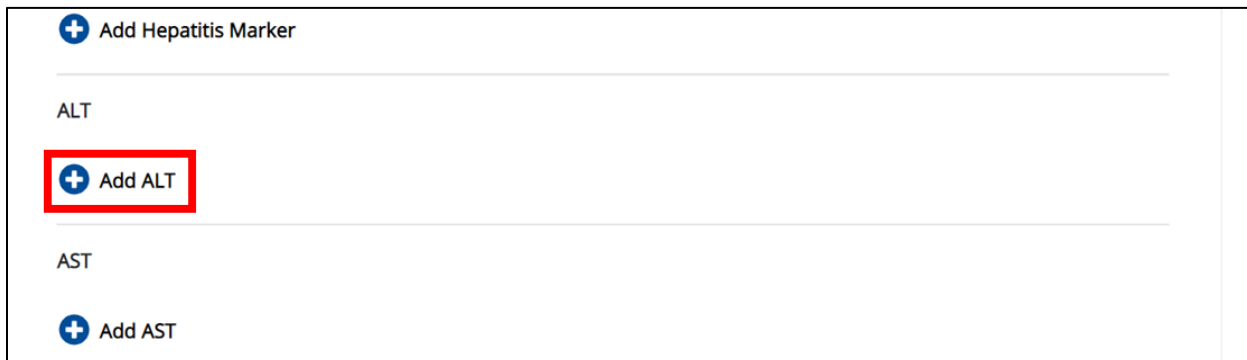
Laboratory Name:^{*}

+ Add Hepatitis Marker

ALT

Adding ALT

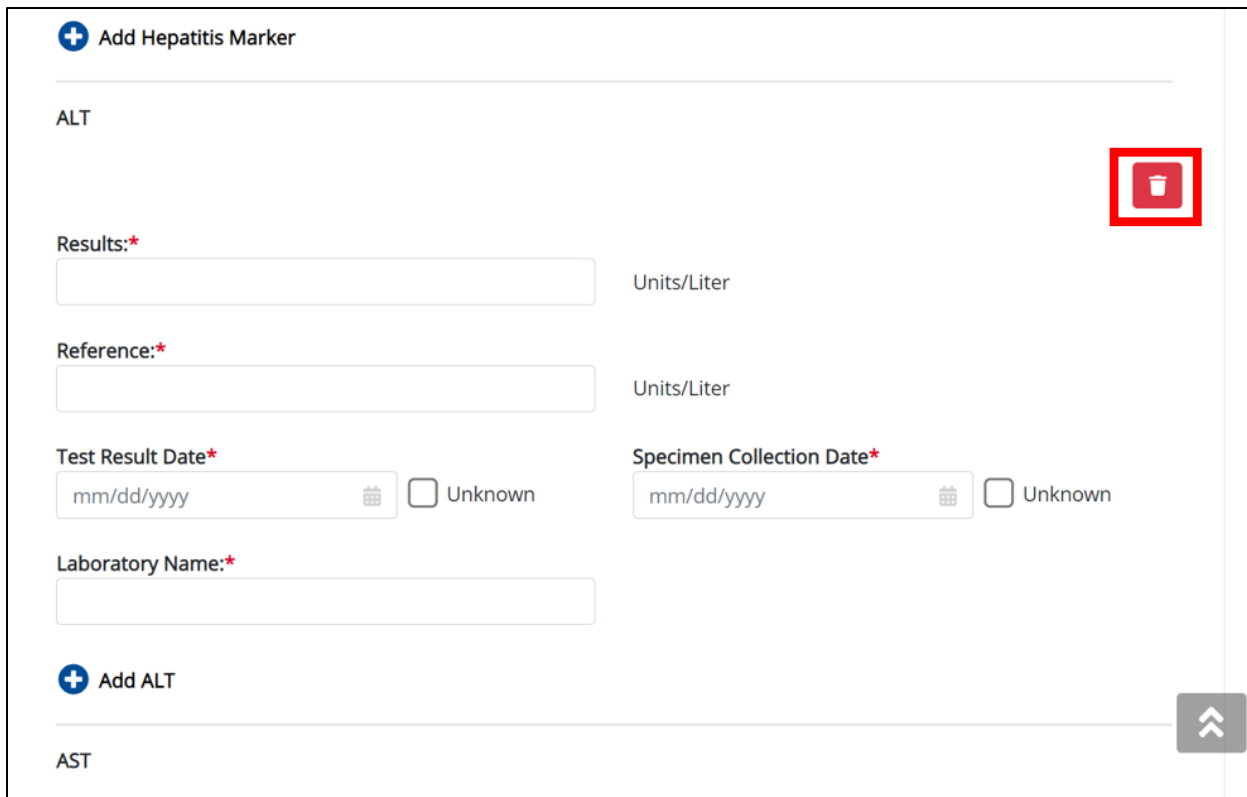
10. You can click **Add ALT** to log the details for an ALT.




ALT

AST

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



ALT



Results:*

Units/Liter

Reference:*

Units/Liter

Test Result Date*

☐ Unknown

Specimen Collection Date*

☐ Unknown

Laboratory Name:*

AST

Adding AST

11. You can click **Add AST** to log the details for an AST.

AST

Bilirubin

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

AST

Results:*

Units/Liter

Reference:*

Units/Liter

Test Result Date*

☐ Unknown

Specimen Collection Date*

☐ Unknown

Laboratory Name:*

Bilirubin

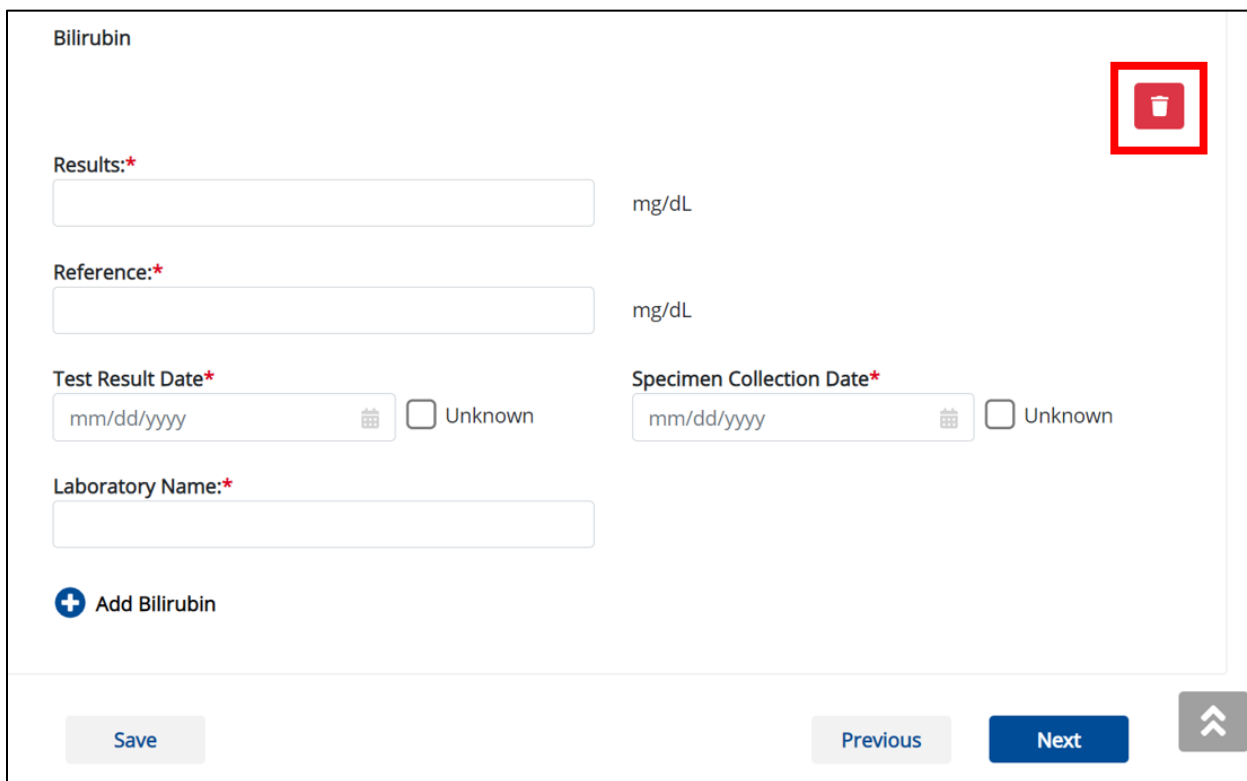
Adding Bilirubin

12. You can also click **Add Bilirubin** to log the details for Bilirubin.




This screenshot shows a form titled 'Add AST'. Below the title, there is a text input field containing the word 'Bilirubin'. At the bottom of the form, there is a button labeled '+ Add Bilirubin', which is highlighted with a red rectangular box.

- To delete the Bilirubin details, click the **Trash Bin Icon** located at the top right.



This screenshot shows the 'Bilirubin' form. At the top right of the form, there is a red trash bin icon, which is highlighted with a red rectangular box. The form contains several input fields: 'Results:*' (with a unit of 'mg/dL'), 'Reference:*' (with a unit of 'mg/dL'), 'Test Result Date*' (with a date picker and an 'Unknown' checkbox), 'Specimen Collection Date*' (with a date picker and an 'Unknown' checkbox), and 'Laboratory Name:*'. At the bottom left of the form, there is a button labeled '+ Add Bilirubin'. At the bottom right, there are three buttons: 'Save', 'Previous', and 'Next' (which is highlighted with a red rectangular box), and a grey button with an upward arrow icon.

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



This screenshot shows the 'Add Bilirubin' form. At the bottom right of the form, there are three buttons: 'Save', 'Previous', and 'Next' (which is highlighted with a red rectangular box), and a grey button with an upward arrow icon.

13 Applicable Symptoms

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

PERINATAL HEPATITIS CASE REPORT FORM Section 3 of 9

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS	
Patient Information	<p>Were symptoms present during the course of illness?*</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>Onset Date </p> <p><input type="text" value="mm/dd/yyyy"/> <input type="checkbox"/> Unknown</p> <p>If symptomatic, which of the following did the patient experience during illness?</p> <p>Jaundice</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p>
Laboratory Information	
Applicable Symptoms	
Medical Conditions	
Exposure Information	
Hospitalization, ICU & Death Information	
Vaccination History	

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

PERINATAL HEPATITIS CASE REPORT FORM Section 5 of 9

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

EXPOSURE INFORMATION	
Patient Information	<p>Did the patient have any of the following exposures in the past 6 months?*</p> <p><input checked="" type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>Adult congregate living facility (nursing, assisted living, or long-term care facility)*</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>If yes, please specify nursing, assisted living or long-term care facility: </p> <p><input type="text"/></p> <p>Correctional facility*</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>If yes, please specify name of correctional facility: </p> <p><input type="text"/></p> <p>IV Drug Use*</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>Sexually Transmitted Infections History*</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>Multiple Sex Partners*</p>
Laboratory Information	
Applicable Symptoms	
Medical Conditions	
Exposure Information	
Hospitalization, ICU & Death Information	
Vaccination History	
Additional Comments	
Review & Submit	

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

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

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

4. If the patient is symptomatic for **Hepatitis B** or **Hepatitis C**, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:

Please Note: The **Applicable Symptoms** screen lists the same symptoms when **Hepatitis B** or **Hepatitis C** is selected as the Disease/Organism.

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

Did the patient have any other symptoms?*

If yes, please specify: ?

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

Did the patient have any other symptoms?*

If yes, please specify: * ?

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

Fatigue*

Myalgia*

Loss of Appetite*

Did the patient have any other symptoms?*

If yes, please specify: * ?

Diarrhea

14 Medical Conditions

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

PERINATAL HEPATITIS CASE REPORT FORM Section 4 of 9

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

MEDICAL CONDITIONS

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

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

Substance abuse or misuse

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

2. If **Yes** is selected for the conditional question, the subsequent field on the screen is enabled: *Substance abuse or misuse*.

MEDICAL CONDITIONS

Patient Information	✓
Laboratory Information	✓
Applicable Symptoms	✓
Medical Conditions	
Exposure Information	🔒
Hospitalization, ICU & Death Information	🔒

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

Substance abuse or misuse*

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

Please Note: If **No** is selected for the conditional question, the subsequent *Substance abuse or misuse* field is disabled and marked with **No**.

If **Unknown** is selected for the conditional question, the subsequent *Substance abuse or misuse* field is disabled and marked as **Unknown**.

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

The screenshot shows the 'MEDICAL CONDITIONS' section of the form. On the left, a sidebar lists various information categories: Patient Information, Laboratory Information, Applicable Symptoms, Medical Conditions (highlighted), Exposure Information, and Hospitalization, ICU & Death. The main content area contains the question 'Did the patient have any underlying medical conditions and/or risk behaviors?*' with three buttons: 'Yes' (highlighted with a red box), 'No', and 'Unknown'. Below this, the 'Substance abuse or misuse*' field has three buttons: 'Yes' (highlighted with a red box), 'No', and 'Unknown' (also highlighted with a red box). A text input field below these buttons is labeled 'If yes, please specify the substance that was abused or misused: ?'.

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

This screenshot shows the same 'MEDICAL CONDITIONS' form, but with 'Yes' selected for both the initial question and the 'Substance abuse or misuse' field. The text input field 'If yes, please specify the substance that was abused or misused: ?' is now highlighted with a red box. A tooltip message appears over the 'Unknown' button for the 'Substance abuse or misuse' field, stating: 'Please enter 'Unknown' if the information on substance is not available.'

4. Once complete, click **Next** to proceed to the **Exposure Information** screen.

The screenshot shows the 'MEDICAL CONDITIONS' form with all fields completed. The 'Substance abuse or misuse' field is set to 'Yes', and the text box contains the word 'Unknown'. At the bottom of the form, there are three buttons: 'Save', 'Previous', and 'Next' (highlighted with a red box). A small upward-pointing arrow icon is visible in the bottom right corner.

15 Exposure Information

1. On the **Exposure Information** screen, select the **appropriate answer** for the conditional question at the top: *Did the patient have any of the following exposures in the past 6 months?*

PERINATAL HEPATITIS CASE REPORT FORM

Section 5 of 9

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

EXPOSURE INFORMATION

Did the patient have any of the following exposures in the past 6 months?*

Yes No Unknown

Adult congregate living facility (nursing, assisted living, or long-term care facility)

Yes No Unknown

If yes, please specify nursing, assisted living or long-term care facility: ☺

Correctional facility

Yes No Unknown

If yes, please specify name of correctional facility: ☺

IV Drug Use

Yes No Unknown

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

EXPOSURE INFORMATION

Did the patient have any of the following exposures in the past 6 months?*

Yes No Unknown

Adult congregate living facility (nursing, assisted living, or long-term care facility)*

Yes No Unknown

If yes, please specify nursing, assisted living or long-term care facility: ☺

Correctional facility*

Yes No Unknown

If yes, please specify name of correctional facility: ☺

IV Drug Use*

Yes No Unknown

Sexually Transmitted Infections History*

Yes No Unknown

Multiple Sex Partners*

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

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

Outbreak-related questions are not impacted by the selected answer for the conditional question: *Did the patient have any of the following exposures in the past 6 months?*

Foreign Born

If yes, please specify country: ?

Select... | v

Is this part of an outbreak?*

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

3. Select the **appropriate answer** for the field: *Adult congregate living facility (nursing, assisted living, or long-term care facility).*

Adult congregate living facility (nursing, assisted living, or long-term care facility)*

If yes, please specify nursing, assisted living or long-term care facility: ?

- If **Yes** is selected for the *Adult congregate living facility (nursing, assisted living, or long-term care facility)* field, the subsequent field is enabled. Enter the **name of the nursing, assisted living, or long-term care facility** in the subsequent textbox: *If yes, please specify nursing, assisted living or long-term care facility.*

Adult congregate living facility (nursing, assisted living, or long-term care facility)*

Please enter 'Unknown' if information of Adult congregate living facility is not available.

If yes, please specify nursing, assisted living or long-term care facility: * ?

4. Select the **appropriate answer** for the field: *Correctional facility.*

Correctional facility*

If yes, please specify name of correctional facility: ?

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

Correctional facility*

Please enter 'Unknown' if information of correctional facility is not available.

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

5. Select the **appropriate answers** for the following fields to indicate the applicable exposures that the patient experienced in the past 6 months:

- *IV Drug Use*
- *Sexually Transmitted Infections History*
- *Multiple Sex Partners*
- *Intranasal Drug Use*
- *HIV Exposure*
- *HBV Contact Exposure*
- *HCV Contact Exposure*

Review & Submit

IV Drug Use*

Yes No Unknown

Sexually Transmitted Infections History*

Yes No Unknown

Multiple Sex Partners*

Yes No Unknown

Intranasal Drug Use*

Yes No Unknown

HIV Exposure*

Yes No Unknown

HBV Contact Exposure*

Yes No Unknown

HCV Contact Exposure*

Yes No Unknown

Tattoos*

6. Select the **appropriate answer** for the field: *Tattoos*.

Tattoos*

Yes No Unknown

If yes, please specify the setting: ?

Select...

- If **Yes** is selected for the *Tattoos* field, the subsequent field is enabled. Select the **setting of the tattoo** from the subsequent dropdown menu: *If yes, please specify the setting*.

Tattoos*

Yes No

Please select 'Other' if the setting is not listed.

If yes, please specify the setting: * ?

Select...

Corrections setting

Homemade/Unlicensed artist

Licensed parlor

Other

Select...

- If **Other** is selected from the *If yes, please specify the setting* dropdown menu, the subsequent field is enabled. Enter the **setting of the tattoo** in the subsequent textbox: *If other, please specify.*

Tattoos*

Yes No Unknown

If yes, please specify the setting:* ?

Other

If other, please specify:* ?

- Select the **appropriate answer** for the field: *Piercings*.

Piercings*

Yes No Unknown

If yes, please specify the setting: ?

Select...

- If **Yes** is selected for the *Piercings* field, the subsequent field is enabled. Select the **setting of the piercing** from the subsequent dropdown menu: *If yes, please specify the setting.*

Piercings*

Yes

Please select 'Other' if the setting is not listed.

If yes, please specify the setting:* ?

Select...

Corrections setting

Homemade/Unlicensed artist

Licensed parlor

Other

If yes, please specify country: ?

Select...

- If **Other** is selected from the *If yes, please specify the setting* dropdown menu, the subsequent field is enabled. Enter the **setting of the piercing** in the subsequent textbox: *If other, please specify.*

Piercings*

Yes No Unknown

If yes, please specify the setting:* ?

Other

If other, please specify:* ?

- Select the **appropriate answer** for the field: *Foreign Born*.

Foreign Born*

Yes No Unknown

If yes, please specify country: ?

Select...

- If **Yes** is selected for the *Foreign Born* field, the subsequent field is enabled. Select the **country that the patient was born in** from the subsequent dropdown menu: *If yes, please specify country.*

Foreign Born*

Yes No Unknown

If yes, please specify country:* ?

Select...

AFGHANISTAN

ALBANIA

ALGERIA

AMERICAN SAMOA

ANDORRA

ANGOLA

ANGUILLA

Please select 'Unknown' if information of the country of birth is not available.

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

Is this part of an outbreak?*

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

- If **Yes** is selected for the *Is this part of an outbreak?* field, the subsequent field is enabled. Enter the **name of the outbreak** in the subsequent textbox: *If yes, please specify the name of the outbreak.*

Is this part of an outbreak?*

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

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

10. Once complete, click **Next** to proceed to the **Hospitalization, ICU, and Death Information** screen.

Piercings*

If yes, please specify the setting: * ?

Other

If other, please specify: * ?

Unknown

Foreign Born*

If yes, please specify country: * ?

KOREA, REPUBLIC OF

Is this part of an outbreak?*

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

Save Previous **Next**

16 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?*

PERINATAL HEPATITIS CASE REPORT FORM Section 6 of 9

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

HOSPITALIZATION, ICU & DEATH INFORMATION

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

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name:

Admission Date ☐ Unknown Discharge Date ☐ Unknown

☐ Still hospitalized

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

Yes No Unknown

Admission Date to ICU ☐ Unknown Discharge Date from ICU ☐ Unknown

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

Yes No Unknown

If yes, please provide the date of death:

Date of Death

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

HOSPITALIZATION, ICU & DEATH INFORMATION

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

Was the patient hospitalized?*

Yes No Unknown

If yes, please specify the hospital name:

Test Hospital

Admission Date* ☐ Unknown Discharge Date* ☐ Unknown

☐ Still hospitalized

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

Yes No Unknown

Admission Date to ICU ☐ Unknown Discharge Date from ICU ☐ Unknown

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

Yes No Unknown

If yes, please provide the date of death:

Date of Death

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

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

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

Was the patient hospitalized?*

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

If yes, please specify the hospital name:*

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

Admission Date*

☐ Unknown

Discharge Date*

☐ Unknown

☐ Still hospitalized

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

Admission Date*

☐ Unknown

Discharge Date*

☐ 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?*

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Additional Comments

Review & Submit

Admission Date*

☐ Unknown

Discharge Date*

☐ Unknown

☒ Still hospitalized

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

Admission Date to ICU

☐ Unknown

Discharge Date from ICU

☐ Unknown

Did the patient die as a result of this illness?

If yes, please provide the date of death:

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

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

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

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

PERINATAL HEPATITIS CASE REPORT FORM

Section 6 of 9

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

Hospitalization, ICU & Death Information

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

OK

Was the patient hospitalized?*

Yes

If yes, please specify the hospital name:*

Test Hospital

Admission Date*

10/01/2021

Invalid Admission Date

Discharge Date*

09/30/2021

Invalid Discharge Date

Still hospitalized

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Exposure Information

Hospitalization, ICU & Death Information

Vaccination History

Was the patient hospitalized?*

Yes

No

Unknown

If yes, please specify the hospital name:*

Test Hospital

Admission Date*

10/01/2021

Invalid Admission Date

Discharge Date*

09/30/2021

Invalid Discharge Date

Still hospitalized

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

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

Yes

No

Unknown

Admission Date to ICU

mm/dd/yyyy

Unknown

Discharge Date from ICU

mm/dd/yyyy

Unknown

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

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

Admission Date to ICU*

☐ Unknown

Discharge Date from ICU*

☐ Unknown

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

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

If yes, please provide the date of death:

Date of Death

☐ Unknown

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

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

If yes, please provide the date of death:

Date of Death*

☐ Unknown

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

HOSPITALIZATION, ICU & DEATH INFORMATION

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Additional Information ☒

Hospitalization, ICU & Death Information

Vaccination History ☐

Additional Comments ☐

Review & Submit ☐

Was the patient hospitalized?*

If yes, please specify the hospital name:*

Admission Date*

☐ Unknown

Discharge Date*

☐ Unknown

☐ Still hospitalized

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

Admission Date to ICU*

☐ Unknown

Discharge Date from ICU*

☐ Unknown

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

If yes, please provide the date of death:

Date of Death

☐ Unknown

17 Vaccination History

The **Vaccination History** screen is dynamic and displays fields depending on the Disease/Organism selected on the **Patient Information** screen of the Perinatal Hepatitis Case Report. The **Vaccination History** screen collects details only when Hepatitis B is selected as the Disease/Organism.

Vaccination History for Hepatitis C

The **Vaccination History** screen is disabled and does **not** collect information when Hepatitis C is selected as the Disease/Organism.

1. If **Hepatitis C** is selected as the Disease/Organism, the **Vaccination History** screen displays message that states: *No information is required to be provided on this screen. Please click the "Next" button to proceed.*
2. To proceed to the **Additional Comments** screen, click **Next**.

PERINATAL HEPATITIS CASE REPORT FORM

Section 7 of 9

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

VACCINATION HISTORY

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

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

The **Vaccination History** screen does **not** collect vaccination details for **Hepatitis C**.

Save Previous **Next** ↑

Vaccination History for Hepatitis B

When **Hepatitis B** is selected as the Disease/Organism, the **Vaccination History** screen collects vaccine details for the patient.

1. Select the **appropriate answer** to the conditional question at the top: *Has the patient ever received a Hepatitis B vaccine?*

VACCINATION HISTORY

Patient Information ☒ Laboratory Information ☒ Applicable Symptoms ☒ Medical Conditions ☒ Exposure Information ☒ Hospitalization, ICU & Death Information ☒ **Vaccination History** ☐ Additional Comments ☐ Review & Submit ☐

Has the patient ever received a Hepatitis B vaccine?*

Vaccine Details

If yes, please provide vaccine name: ?
Select...

If other, please specify: ?

If yes, please enter the number of doses: ?
Select...

If yes, please specify the date administered: ?

Date Administered (1st dose) ☐ Unknown

Date Administered (2nd dose) ☐ Unknown

Date Administered (3rd dose) ☐ Unknown

Date Administered (4th dose) ☐ Unknown

+ Add Vaccine

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

VACCINATION HISTORY

Patient Information ☒ Laboratory Information ☒ Applicable Symptoms ☒ Medical Conditions ☒ Exposure Information ☒ Hospitalization, ICU & Death Information ☒ **Vaccination History** ☐ Additional Comments ☐ Review & Submit ☐

Has the patient ever received a Hepatitis B vaccine?*

Vaccine Details

If yes, please provide vaccine name: ?*

Select...

If other, please specify: ?

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

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose) ☐ Unknown

Date Administered (2nd dose) ☐ Unknown

Date Administered (3rd dose) ☐ Unknown

Date Administered (4th dose) ☐ Unknown

+ Add Vaccine

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

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

VACCINATION HISTORY

Has the patient ever received a Hepatitis B vaccine?*

Vaccine Details

Please select the vaccine that was administered to the patient.

If yes, please provide vaccine name: *?

Select...

- Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Inactivated Poliovirus, Haemophilus b Conjugate (Meningococcal Protein Conjugate), and Hepatitis B (Recombinant) Vaccine.
- Diphtheria, pertussis, tetanus, hepatitis B, Haemophilus Influenza Type b, (Pentavalent)
- DTaP-hepatitis B and poliovirus vaccine
- DTP- Haemophilus influenzae type b conjugate and hepatitis b vaccine
- Haemophilus influenzae type b conjugate and Hepatitis B vaccine
- hepatitis A and hepatitis B vaccine
- hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)

+ Add Vaccine

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

If yes, please provide vaccine name: *?

Other

Please enter "Unknown" if the name of vaccine is not known.

If other, please specify: *?

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

Select...

- From the dropdown menu: *If yes, please enter the number of doses,* select the **number of doses that the patient received for the selected vaccine.**

If yes, please provide vaccine name: *?

hepatitis B vaccine, adult dosage

If other, please specify: ?

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

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

Select...

- 1
- 2
- 3
- 4

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

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

1

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

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

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

2

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

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

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

3

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy ☐ Unknown

+ Add Vaccine

- If **4** is selected as the number of doses, the following subsequent fields are enabled: *Date Administered (1st dose)*, *Date Administered (2nd dose)*, *Date Administered (3rd dose)*, and *Date Administered (4th dose)*. Enter the **Date Administered (1st dose)**, **Date Administered (2nd dose)**, **Date Administered (3rd dose)**, and **Date Administered (4th dose)** in the appropriate fields.

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

4

If yes, please specify the date administered: ?

Date Administered (1st dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (2nd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)*

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)*

mm/dd/yyyy ☐ Unknown

+ Add Vaccine

Adding Multiple Vaccines

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

VACCINATION HISTORY

Patient Information ☒

Laboratory Information ☒

Applicable Symptoms ☒

Medical Conditions ☒

Exposure Information ☒

Hospitalization, ICU & Death Information ☒

Vaccination History

Additional Comments ☐

Review & Submit ☐

Has the patient ever received a Hepatitis B vaccine?*

Yes No Unknown Refused

Vaccine Details

If yes, please provide vaccine name:* ?

hepatitis B vaccine, adult dosage

If other, please specify: ?

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

1

If yes, please specify the date administered: ?

Date Administered (1st dose)*

09/01/2021 ☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy ☐ Unknown

Date Administered (4th dose)


mm/dd/yyyy ☐ Unknown

+ Add Vaccine

Save Previous Next

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

Vaccine Details



If yes, please provide vaccine name: * ?

Select...

If other, please specify: ?

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

Select...

If yes, please specify the date administered: ?

Date Administered (1st dose)

mm/dd/yyyy

☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy

☐ Unknown

+ Add Vaccine


Save

Previous

Next

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

Vaccine Details



If yes, please provide vaccine name: * ?

hepatitis B vaccine, unspecified formulation

If other, please specify: ?

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

1

If yes, please specify the date administered: ?

Date Administered (1st dose)*

08/15/2021

☐ Unknown

Date Administered (2nd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (3rd dose)

mm/dd/yyyy

☐ Unknown

Date Administered (4th dose)

mm/dd/yyyy

☐ Unknown

+ Add Vaccine

Save

Previous

Next

18 Additional Comments

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

PERINATAL HEPATITIS CASE REPORT FORM Section 8 of 9

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

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

Additional comments or notes, please specify:

0/1000 Characters

Save
Previous
Next

19 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.

PERINATAL HEPATITIS CASE REPORT FORM Section 9 of 9

Please review your information before submitting.

REVIEW & SUBMIT

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

Print
Download

[Patient Information](#)

Disease/Organism	Date of Diagnosis
Perinatal Hepatitis C	09/01/2021
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?	
No	
Patient ID (MRN)	Affiliation/Organization
BR10291942	Test Medical Center
Person Completing Form	Affiliation/Organization
Mr. Marty Craine, Sr (marty@email.com)	Other
If other, please specify: Test Hospital	

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

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

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

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

3. Review the information.

Perinatal Hepatitis Case Report Form.pdf

1 / 4 | 100% + -

Patient Information

Disease/Organism
Perinatal Hepatitis C

Date of Diagnosis
09/01/2021

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

Patient ID (MRN)
BR10291942

Affiliation/Organization
Test Medical Center

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

Affiliation/Organization
Other

If other, please specify:
Test Hospital

Attending Physician/Clinician
Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization
Test Medical Center

First Name
Susan

Last Name
Ross

Suffix
Sr

Date of Birth
10/29/1942

Ethnicity
Not Hispanic or Latino

Race
Unknown

Address 1
123 Painting Lane

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

Applicable Symptoms ✓

Medical Conditions ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments ✓

Review & Submit

Patient Information

Disease/Organism
Perinatal Hepatitis C

Date of Diagnosis
09/01/2021

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

Patient ID (MRN)
BR10291942

Affiliation/Organization
Test Medical Center

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

Affiliation/Organization
Other

If other, please specify:
Test Hospital

Attending Physician/Clinician
Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization
Test Medical Center

Applicable Symptoms ✓

Medical Conditions ✓

Exposure Information ✓

Hospitalization, ICU & Death Information ✓

Vaccination History ✓

Additional Comments ✓

Review & Submit

Laboratory Information

Does the patient have a lab test?
Yes

Hepatitis Marker
Hepatitis C virus RNA panel

Results
Positive

Test Result Date
09/01/2021

Specimen Collection Date
08/28/2021

Laboratory Name:
Test Lab

Hepatitis Marker
HEPATITIS C VIRUS AB

4. Review the *Patient Information* section.

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

REVIEW & SUBMIT

Print
Download

Patient Information

Disease/Organism
Perinatal Hepatitis C
Date of Diagnosis
09/01/2021

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

Patient ID (MRN)
8R10291942
Affiliation/Organization
Test Medical Center

Person Completing Form
Mr. Marty Crane, Sr (marty@email.com)
Affiliation/Organization
Other
If other, please specify:
Test Hospital

Attending Physician/Clinician
Dr. Fraiser Crane (fraisercrane@email.com)
Affiliation/Organization
Test Medical Center

First Name
Susan
Last Name
Ross

Suffix
Sr

Date of Birth
10/29/1942
Ethnicity
Not Hispanic or Latino
Race
Unknown

Address 1
123 Painting Lane

City
Frankfort
State
KY
Zip Code
40601

County
Franklin
Phone
(555) 555-5555
Email
bob@email.com

Is the patient currently pregnant?
No

Is the patient postpartum?
No

Does the patient have a history of incarceration?
No

Laboratory Information

5. Review the *Laboratory Information* section.

Patient Information
Laboratory Information
Applicable Symptoms

Does the patient have a lab test?
Yes

Hepatitis Marker
Hepatitis C virus RNA panel
Results
Positive
Test Result Date
09/01/2021
Specimen Collection Date
08/28/2021

Laboratory Name:
Test Lab

Hepatitis Marker
HEPATITIS C VIRUS AB
Results
Pending
Specimen Collection Date
09/10/2021

Laboratory Name:
Test Lab

Applicable Symptoms

Were symptoms present during the course of illness?
Yes

Direct Data Entry for Electronic Case Reports: Perinatal Hepatitis

Page 98 of 113

Kentucky Health Information Exchange

6. Review the *Applicable Symptoms* section.

Applicable Symptoms

Were symptoms present during the course of illness?
Yes

Onset Date
Unknown

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

Jaundice
Yes

Fever
Yes

Nausea
Yes

Vomiting
Yes

Abdominal Pain
Yes

Dark Urine
No

Light Colored Stools
No

Fatigue
Yes

Myalgia
No

Loss of Appetite
Yes

Did the patient have any other symptoms?
Yes

If yes, please specify:
Diarrhea

7. Review the *Medical Conditions* section.

Medical Conditions

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

Substance abuse or misuse
Yes

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

8. Review the *Exposure Information* section.

Exposure Information

Did the patient have any of the following exposures in the past 6 months?
Yes

Adult congregate living facility (nursing, assisted living, or long-term care facility)
Yes

If yes, please specify nursing, assisted living or long-term care facility:
Test Long-Term Care Facility

Correctional facility
No

IV Drug Use
Unknown

Sexually Transmitted Infections History
Yes

Multiple Sex Partners
Yes

Intranasal Drug Use
Yes

HIV Exposure
No

HBV Contact Exposure
No

HCV Contact Exposure
Yes

Tattoos
Yes

If yes, please specify the setting:
Licensed parlor

Piercings
Yes

If yes, please specify the setting:
Other

If other, please specify:
Unknown

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

Hospitalization, ICU & Death Information

Was the patient hospitalized?
Yes

If yes, please specify the hospital name:
Test Hospital

Admission Date
07/26/2021

Discharge Date
07/30/2021

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

Admission Date to ICU
07/26/2021

Discharge Date from ICU
07/27/2021

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

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

Vaccination History

Is the patient vaccinated for the condition being reported?
Yes

Vaccine Details

If yes, please provide vaccine name:
Other

If other, please specify:
Unknown

If yes, please enter the number of doses:
1

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

Please Note: The **Vaccination History** screen is enabled and collects information only when **Hepatitis B** is selected as the Disease/Organism.

11. Review the *Additional Comments* section.

Additional Comments

Additional comments or notes, please specify:
Patient Notes

Previous Submit

Click Hyperlinks to Edit

12. 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.

PERINATAL HEPATITIS CASE REPORT FORM Section 9 of 9

Please review your information before submitting.

REVIEW & SUBMIT

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

Patient Information ↶

Disease/Organism
Perinatal Hepatitis C

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

Patient ID (MRN)
BR10291942

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

Attending Physician/Clinician
Dr. Fraiser Crane
(fraisercrane@email.com)

Date of Diagnosis
09/01/2021

Affiliation/Organization
Test Medical Center

Affiliation/Organization
Other

Affiliation/Organization
Test Medical Center

Print

Download

13. 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.

PERINATAL HEPATITIS CASE REPORT FORM Section 1 of 9

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

PATIENT INFORMATION

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

Disease/Organism*

Perinatal Hepatitis C

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

Yes

Patient ID (MRN)*

BR10291942

Person Completing Form*

Mr. Marty Craine, Sr (marty...

Attending Physician/Clinician*

Dr. Fraiser Crane (fraisercr...

Date of Diagnosis*

09/20/2021 ☐ Unknown

September 2021

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

Affiliation/Organization*

Test Medical Center

If other, please specify:*

Test Hospital

If other, please specify:

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

PATIENT INFORMATION

Patient Information ☒ Laboratory Information ☒ Applicable Symptoms ☒ Medical Conditions ☒ Exposure Information ☒ Hospitalization, ICU & Death Information ☒ Vaccination History ☒ Additional Comments ☒

Disease/Organism* Perinatal Hepatitis C Date of Diagnosis* 09/20/2021

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

Patient ID BR10291942

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

Affiliation/Organization* Other

If other, please specify* Test Hospital

Attending Physician/Clinician* Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization* Test Medical Center

If other, please specify*

Save Changes?

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

No - Discard Yes - Save

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

PERINATAL HEPATITIS CASE REPORT FORM Section 9 of 9

Please review your information before submitting.

REVIEW & SUBMIT

Patient Information ☒ Laboratory Information ☒ Applicable Symptoms ☒ Medical Conditions ☒ Exposure Information ☒ Hospitalization, ICU & Death Information ☒ Vaccination History ☒ Additional Comments ☒ Review & Submit

Patient Information

Disease/Organism Perinatal Hepatitis C Date of Diagnosis 09/20/2021

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

Patient ID (MRN) BR10291942 Affiliation/Organization Test Medical Center

Person Completing Form Mr. Marty Craine, Sr (marty@email.com) Affiliation/Organization Other If other, please specify: Test Hospital

Attending Physician/Clinician Dr. Fraiser Crane (fraisercrane@email.com) Affiliation/Organization Test Medical Center

If other, please specify:

Print Download

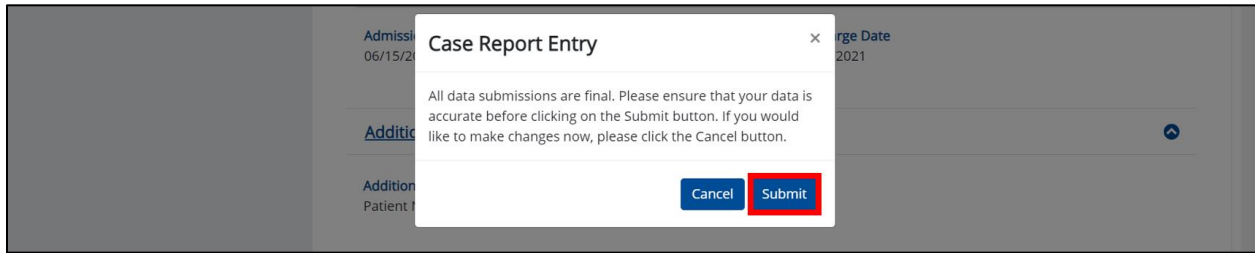
16. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Perinatal Hepatitis Case Report Entry.

Additional Comments

Additional comments or notes, please specify:
Patient Notes

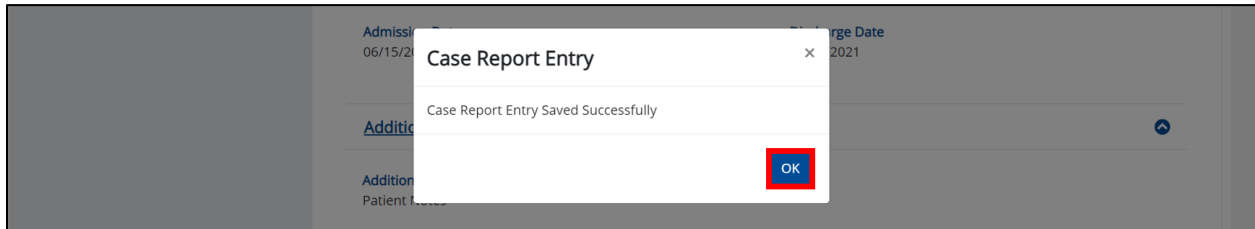
Previous Submit

- 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.



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

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



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

Congratulations! You have submitted the Perinatal Hepatitis Case Report using KHIE's Direct Data Entry Functionality.

Please visit the KHIE website at <https://khie.ky.gov/COVID-19/Pages/Electronic-Case-Reporting-.aspx> to access additional training resources and find information on reporting requirements from the Kentucky Department for Public Health.

20 Case Report User Entry Summary

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

The screenshot shows the 'CASE REPORT ENTRY USER SUMMARY' screen. At the top, there's a navigation bar with 'Patient Search', 'Bookmarked Patients', 'Event Notifications', 'Lab Data Entry', and 'Case Report Entry'. Below this, a breadcrumb trail shows 'Home > Case Report Entry User Summary'. The main heading is 'CASE REPORT ENTRY USER SUMMARY'. A filter section labeled 'LAST UPDATED DATE RANGE' has 'Start Date' set to '10/01/2021' and 'End Date' set to '10/01/2021'. A 'Retrieve Data' button is to the right. Below the filter, it says 'SHOWING 1 ITEMS' and 'APPLY FILTER'. The main table has columns: ACTIONS, REPORT TYPE, DISEASE/ ORGANISM, AFFILIATION/ ORGANIZATION, PATIENT MRN, FIRST NAME, LAST NAME, DATE OF BIRTH, PATIENT SEX, STATUS, LAST UPDATED, and SUBMISSION DATE. The first row shows: View, Copy, Perinatal Hepatitis, Perinatal Hepatitis C, Test Medical Center, BR10291942, Susan, Ross, 10/29/1990, Female, Complete, 10/01/2021 12:30 PM, 10/01/2021 12:30 PM. At the bottom, there are pagination controls: First, Back, 1, Next, Last, and a dropdown for 'Maximum 5 entries per page'.

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

This screenshot shows the same screen as the previous one, but with a date range filter applied. The 'Start Date' is now '09/01/2021' and the 'End Date' is '10/01/2021'. A calendar dropdown for 'September 2021' is open, showing the dates from 29 to 30. The 'Retrieve Data' button is highlighted. The table below still shows the same case report for Perinatal Hepatitis C.

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

This screenshot shows the screen after clicking the 'Retrieve Data' button. The 'Start Date' is '09/01/2021' and the 'End Date' is '10/01/2021'. The 'Retrieve Data' button is highlighted. The table below still shows the same case report for Perinatal Hepatitis C.

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.*

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE

Start Date 12/01/2020 End Date 07/29/2021 Retrieve Data

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

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

LAST UPDATED DATE RANGE

Start Date 09/01/2021 End Date 10/01/2021 Retrieve Data

APPLY FILTER

SHOWING 7 ITEMS

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	EB01011990	Elaine	Benes	01/01/1990	Female	In Progress	10/01/2021 12:30 PM	10/01/2021 12:30 PM
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	09/24/2021 01:45 PM	09/24/2021 01:45 PM
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Monica	Gellar	01/15/1992	Female	Complete	09/17/2021 10:12 AM	09/17/2021 10:12 AM
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Daphne	Moon	04/22/1994	Female	In Progress	09/15/2021 03:52 PM	

First Back 1 2 Next Last

Maximum 5 entries per page

5. The Filter fields display. You can 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.

SHOWING 7 ITEMS

HIDE FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
	Enter Report	Enter Disease/	Enter Affiliation	Enter Pat	Enter First Na	Enter Last	Enter Date	All	Enter :	All	All
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	EB01011990	Elaine	Benes	01/01/1990	Female	In Progress	10/01/2021 12:30 PM	10/01/2021 12:30 PM
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	09/24/2021 01:45 PM	09/24/2021 01:45 PM
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Monica	Gellar	01/15/1992	Female	Complete	09/17/2021 10:12 AM	09/17/2021 10:12 AM
Continue	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Daphne	Moon	04/22/1994	Female	In Progress	09/15/2021 03:52 PM	

Review Previously Submitted Case Reports

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE

Start Date

09/01/2021

End Date

10/01/2021

Retrieve Data

SHOWING
5 ITEMS

APPLY FILTER

ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
<div>View</div> <div>Copy</div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
<div>Continue</div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Daphne	Crane	01/15/1992	Female	In Progress	09/24/2021 01:45 PM	
<div>Continue</div>	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	

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

Download

Patient Information

Disease/Organism

Perinatal Hepatitis C

Date of Diagnosis

09/20/2021

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

No

Patient ID (MRN)

BR10291942

Affiliation/Organization

Test Medical Center

Person Completing Form

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

Affiliation/Organization

Other

If other, please specify:
Test Hospital

Attending Physician/Clinician

Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization

Test Medical Center

First Name

Susan

Last Name

Ross

Suffix

Sr

Date of Birth

10/29/1990

Ethnicity

Not Hispanic or Latino

Race

Unknown

Address 1

123 Painting Lane

OK

Copy Previously Submitted Case Reports

The **Copy** feature allows Users to copy the information from a completed case report, make edits, 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, update the appropriate information, 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.

ACTIONS	REPORT TYPE	DISEASE/ORGANISM	AFFILIATION/ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
Continue	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Daphne	Crane	01/15/1992	Female	In Progress	10/01/2021 01:45 PM	
View Copy	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM

Please Note: Clicking **Copy** will automatically navigate you to the **Patient Summary** screen.

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

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

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

Disease/Organism*
Perinatal Hepatitis C

Date of Diagnosis*
09/20/2021

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

Patient ID (MRN)*
BR10291942

Affiliation/Organization*
Test Medical Center

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

Affiliation/Organization*
Other

Attending Physician/Clinician*
Dr. Fraiser Crane (fraisercrane@email.co...

Affiliation/Organization*
Test Medical Center

Prefix
Select...

First Name*
Bob

Middle Name

Last Name*
Ross

Suffix
Sr

Maiden Name

Date of Birth*
10/29/1990

Ethnicity*
Not Hispanic or Latino

Race*
Unknown

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 all screens.

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

PATIENT INFORMATION				
Patient Information Laboratory Information Applicable Symptoms Medical Conditions Exposure Information Hospitalization, ICU & Death Information Vaccination History Additional Comments Review & Submit	Disease/Organism* Perinatal Hepatitis C	Date of Diagnosis* 09/20/2021	<input type="checkbox"/> Unknown	
	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?			
	Yes <input type="button"/> No <input type="button"/>			
	Patient ID (MRN)* BR10291942	Affiliation/Organization* Test Medical Center		
	Person Completing Form* Mr. Marty Craine, Sr (marty@email.com)	Affiliation/Organization* Other	If other, please specify:* Test Hospital	
	Attending Physician/Clinician* Dr. Fraiser Crane (fraisercrane@email.co...)	Affiliation/Organization* Test Medical Center	If other, please specify:*	
	Prefix Select...			
	First Name* Susan	Middle Name	Last Name* Ross	
	Suffix	Maiden Name		
	Date of Birth* 10/29/1990	Ethnicity* Not Hispanic or Latino	Race* Unknown	
Address 1* 123 Painting Lane		Address 2 Unit, Suite, Building, etc.		
City* Frankfort	State* KY	Zip Code 40601-		
County* Franklin	Phone* (555) 555-5555	Email bob@email.com		
Is the patient currently pregnant?* Yes <input type="button"/> No <input type="button"/> Unknown <input type="button"/>				
If yes, please enter the due date (EDC):* 11/12/2021				
Is the patient postpartum? Yes <input type="button"/> No <input type="button"/> Unknown <input type="button"/>				
If yes, please enter the date of delivery:* mm/dd/yyyy				
Does the patient have a history of incarceration?* Yes <input type="button"/> No <input type="button"/> Unknown <input type="button"/>				

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

Is the patient currently pregnant?

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

Is the patient postpartum?*

If yes, please enter the date of delivery: *

Does the patient have a history of incarceration?*

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

LABORATORY INFORMATION

Does the patient have a lab test?*

If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.

Hepatitis Marker*

Hepatitis C virus RNA panel

If other, please specify:

Results*

Positive

If applicable, please enter the viral load: ?

Test Result Date*

09/01/2021

Specimen Collection Date*

08/28/2021

Laboratory Name:*

Test Lab

+ Add Hepatitis Marker

ALT

+ Add ALT

AST

+ Add AST

Bilirubin

+ Add Bilirubin

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

REVIEW & SUBMIT

Print

Download

Patient Information

Disease/Organism

Perinatal Hepatitis C

Date of Diagnosis

09/20/2021

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

No

Patient ID (MRN)

BR10291942

Affiliation/Organization

Test Medical Center

Person Completing Form

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

Affiliation/Organization

Other

If other, please specify:

Test Hospital

Attending Physician/Clinician

Dr. Fraiser Crane (fraisercrane@email.com)

Affiliation/Organization

Test Medical Center

First Name

Bob

Last Name

Ross

Suffix

Sr

Date of Birth

10/29/1942

Ethnicity

Not Hispanic or Latino

Race

Unknown

Address 1

123 First Avenue

City

Frankfort

State

KY

Zip Code

40601

County

Franklin

Phone

(555) 555-5555

Email

susan@email.com

Is the patient postpartum?

Yes

If yes, please enter the date of delivery:

11/05/2021

Does the patient have a history of incarceration?

Please Note: In the example edit above, the User changed the patient's status from pregnant to postpartum. The User changed the selection for the *Is the patient currently pregnant?* field from **Yes** to **No** which enabled the subsequent postpartum field.

The User entered postpartum details by selecting **Yes** for the *Is the patient postpartum?* field and entering the **date of delivery**.

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

Additional comments or notes, please specify:

Additional Patient Notes

Previous

Submit

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

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.

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

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

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	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	SR10291990	Susan	Ross	10/29/1990	Female	Complete	10/03/2021 2:30 PM	10/03/2021 2:30 PM

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.

CASE REPORT ENTRY USER SUMMARY

🕒 LAST UPDATED DATE RANGE

Start Date09/01/2021📅

End Date10/01/2021📅

🔄 Retrieve Data

SHOWING
5 ITEMS

🔼 APPLY FILTER

ACTIONS	REPORT TYPE ⌵	DISEASE/ ORGANISM ⌵	AFFILIATION/ ORGANIZATION ⌵	PATIENT MRN ⌵	FIRST NAME ⌵	LAST NAME ⌵	DATE OF BIRTH ⌵	PATIENT SEX ⌵	STATUS ⌵	LAST UPDATED ⌵	SUBMISSION DATE ⌵
<div>ViewCopy</div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	BR10291942	Susan	Ross	10/29/1990	Female	Complete	10/01/2021 12:30 PM	10/01/2021 12:30 PM
<div>Continue</div>	Perinatal Hepatitis	Perinatal Hepatitis C	Test Medical Center	HepC	Daphne	Crane	01/15/1992	Female	In Progress	09/24/2021 01:45 PM	
<div>Continue</div>	Perinatal Hepatitis	Perinatal Hepatitis B	Test Medical Center	HepB1	Rachel	Green	07/27/1993	Female	In Progress	09/20/2021 04:40 PM	

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

Home > Perinatal Hepatitis Case Report Form

PERINATAL HEPATITIS CASE REPORT FORM

Section 8 of 9

Please add any additional comments related to this case.

ADDITIONAL COMMENTS

Patient Information ☒
Laboratory Information ☒
Applicable Symptoms ☒
Medical Conditions ☒
Exposure Information ☒
Hospitalization, ICU & Death Information ☒
Vaccination History ☒
Additional Comments ☒
Review & Submit

Additional comments or notes, please specify:

0/1000 Characters

Previous Next

21 Technical Support

Toll-Free Telephone Support

For questions and assistance regarding the ePartnerViewer, please call 1 (877) 651-2505.

Email Support

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

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

