



Kentucky Health Information Exchange (KHIE)

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

User Guide

October 2021

Copyright Notice

© 2021 Deloitte. All rights reserved.

Trademarks

"Deloitte," the Deloitte logo, and certain product names that appear in this document (collectively, the "Deloitte Marks"), are trademarks or registered trademarks of entities within the Deloitte Network. The "Deloitte Network" refers to Deloitte Touche Tohmatsu Limited (DTTL), the member firms of DTTL, and their related entities. Except as expressly authorized in writing by the relevant trademark owner, you shall not use any Deloitte Marks either alone or in combination with other words or design elements, including, in any press release, advertisement, or other promotional or marketing material or media, whether in written, oral, electronic, visual, or any other form. Other product names mentioned in this document may be trademarks or registered trademarks of other parties. References to other parties' trademarks in this document are for identification purposes only and do not indicate that such parties have approved this document or any of its contents. This document does not grant you any right to use the trademarks of other parties.

Illustrations

Illustrations contained herein are intended for example purposes only. The patients and providers depicted in these examples are fictitious. Any similarity to actual patients or providers is purely coincidental. Screenshots contained in this document may differ from the current version of the HealthInteractive asset.

Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited, a UK private company limited by guarantee ("DTTL"), its network of member firms, and their related entities. DTTL and each of its member firms are legally separate and independent entities. DTTL (also referred to as "Deloitte Global") does not provide services to clients. In the United States, Deloitte refers to one or more of the US member firms of DTTL, their related entities that operate using the "Deloitte" name in the United States and their respective affiliates. Certain services may not be available to attest clients under the rules and regulations of public accounting. Please see www.deloitte.com/about to learn more about our global network of member firms.

Document Control Information

Document Information

Document Name	Direct Data Entry for Electronic Case Reports: Sexually Transmitted Diseases (STD) User Guide
Project Name	KHIE
Client	Kentucky Cabinet for Health and Family Services
Document Author	Deloitte Consulting
Document Version	3.0
Document Status	Final Draft
Date Released	10/11/2021

Document Edit History

Version	Date	Additions/Modifications	Prepared/Revised by
0.1	07/26/2021	Initial Draft	Deloitte Consulting
1.0	08/06/2021	Revised Draft – Includes changes from 8/5 UAT deployment	Deloitte Consulting
1.1	08/12/2021	Revised Draft – Includes updates per internal review	Deloitte Consulting
1.2	08/30/2021	Revised Draft – Includes updates from KHIE review	Deloitte Consulting
1.3	09/11/2021	Revised Draft – Includes KHIE updates	KHIE
2.0	09/13/2021	Revised Draft – Includes updates from KHIE review	Deloitte Consulting
2.1	10/07/2021	Revised Draft – KHIE updates	KHIE
3.0	10/11/2021	Final Draft – Includes finalized updates per KHIE review	Deloitte Consulting
3.0	10/14/2021	Final	KHIE

Table of Contents

- 1 Introduction5**
 - Overview5
 - Supported Web Browsers5
 - Mobile Device Considerations.....6
 - Accessing the ePartnerViewer6
- 2 Logging into ePartnerViewer6**
 - Terms and Conditions of Use and Logging In8
- 3 Understanding the Case Report Entry Dropdown Menu10**
- 4 Manage User Preferences12**
 - Create Attending Physician/Clinician Details12
 - View & Edit Attending Physician/Clinician Details.....15
 - Delete Attending Physician/Clinician Details16
 - Filter Attending Physician/Clinician Details18
 - Create Person Completing Form Details19
 - View & Edit Person Completing Form Details22
 - Delete Person Completing the Form Details23
 - Filter Person Creating Form Details24
- 5 Basic Features of the Case Report Entry Form25**
 - Side Navigation Bar & Pagination25
 - Save Feature25
 - Case Report Entry Icons26
 - Conditional Questions.....26
- 6 Affiliation/Organization Conditional Question30**
 - Affiliation/Organization Conditional Answer: Yes31
 - Affiliation/Organization Conditional Answer: No.....32
 - Affiliation/Organization Validation.....34
 - Change Affiliation/Organization Conditional Answer: No to Yes35
 - Change Affiliation/Organization Conditional Answer: Yes to No37
- 7 Dynamic Functions based on Disease/Organism39**
 - Change or Save Disease/Organism Selection39
- 8 Dynamic Screens for STD Case Report41**
 - Laboratory Information: Dynamic Screen.....41
 - Applicable Symptoms: Dynamic Screen42
 - Additional Information: Dynamic Screen44
 - Treatment Information: Dynamic Screen46
- 9 Tips for Manually Entering Case Report Data.....47**
- 10 Sexually Transmitted Diseases Case Report Form49**

- 11 Patient Information49**
 - Person Completing Form Hyperlink..... 53
 - Attending Physician/Clinician Hyperlink..... 56
- 12 Laboratory Information64**
 - Adding Multiple Tests 68
- 13 Applicable Symptoms.....70**
- 14 Medical Conditions.....76**
- 15 Travel Information.....79**
- 16 Hospitalization, ICU & Death Information82**
- 17 Additional Information85**
 - Additional Information for Chancroid or Chlamydia..... 85
 - Additional Information for Gonorrhea 86
 - Additional Information for Syphilis..... 87
- 18 Treatment Information90**
 - Adding Multiple Treatments 92
- 19 Additional Comments.....93**
- 20 Review and Submit94**
 - Print or Download Functionality 94
 - Click Hyperlinks to Edit..... 100
- 21 Case Report User Entry Summary103**
 - Review Previously Submitted Case Reports 105
 - Continue In-Progress Case Reports 106
- 22 Technical Support106**
 - Toll-Free Telephone Support..... 106
 - Email Support 106

1 Introduction

Overview

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

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

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

Supported Web Browsers

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

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

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

Mobile Device Considerations

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

Accessing the ePartnerViewer

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

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

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

2 Logging into ePartnerViewer

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

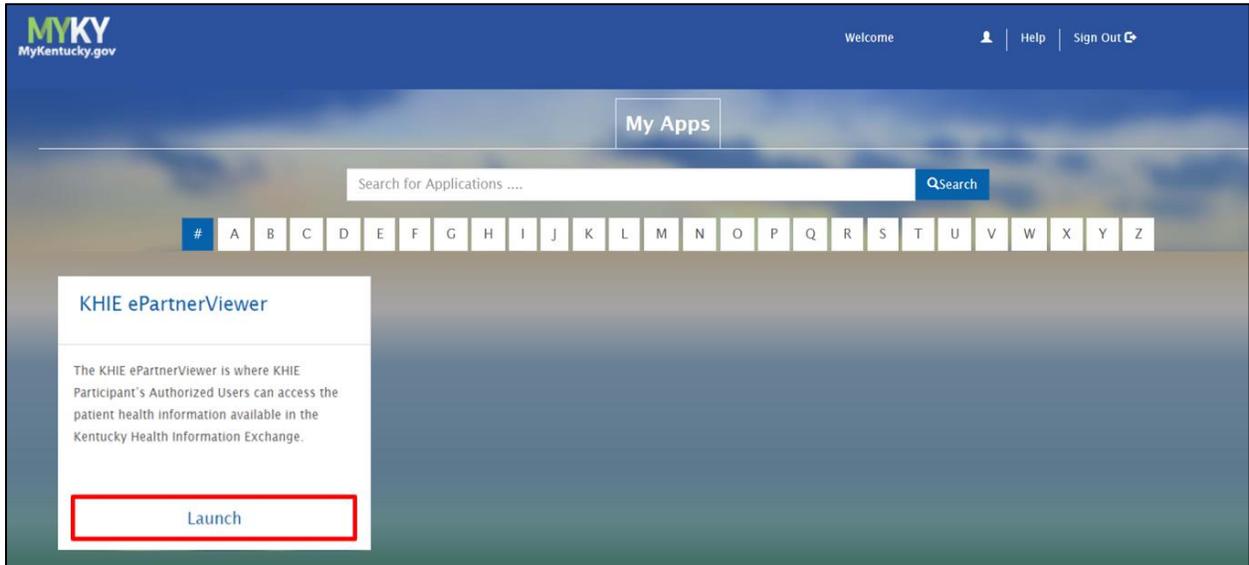
1. On the **KOG Login Page**, enter your **Email Address** and **Password**.

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

2. Click **Sign In**.

The screenshot shows the 'Citizen (or) Business Partner Sign In' page on MyKentucky.gov. The page has a blue header with the MYKY logo and navigation 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 with the following elements: a title 'Citizen (or) Business Partner Sign In', a sub-header 'Sign in with your Kentucky Online Gateway Account.', an 'Email Address' field containing 'jane.doe@gmail.com', a 'Password' field with a 'Forgot/Reset Password?' link, a 'SIGN IN' button, and a 'Resend Account Verification Email' link. On the right, there is a yellow 'WARNING' box with text about the website's property and unauthorized access. Below the warning box is a link 'Don't already have a Kentucky Online Gateway Citizen Account?' and a 'Create An Account' button. At the bottom right, there 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.



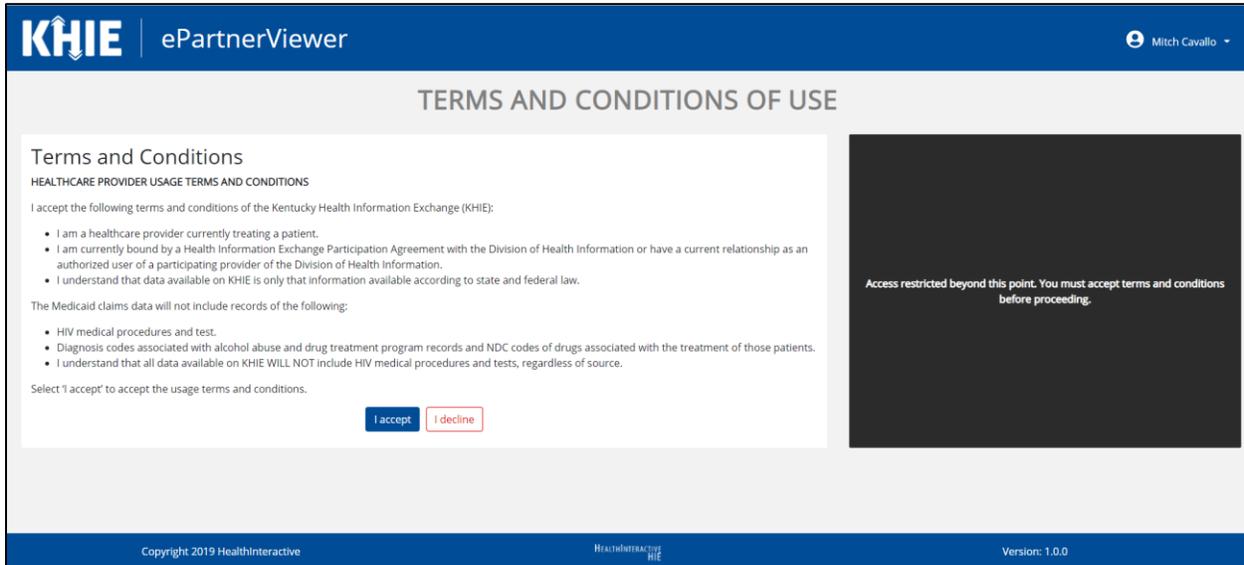
- Multi-Factor Authentication.** After logging in, you are asked to complete Multi-Factor Authentication or MFA. You have the option to receive an MFA passcode by Email or Text.



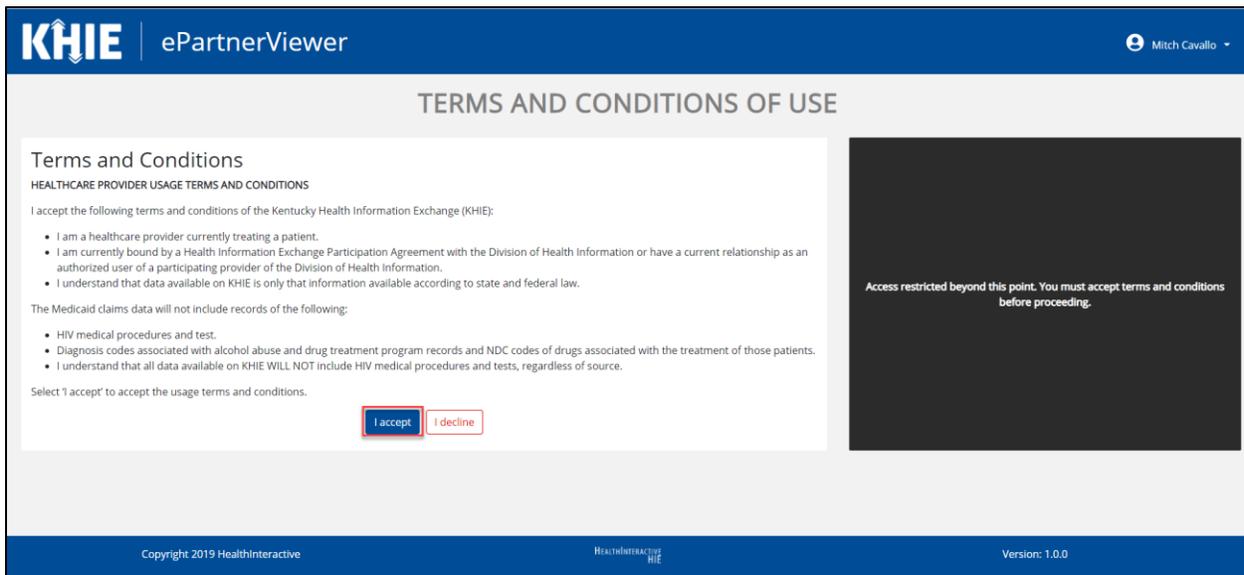
Please Note: For specific information about creating a KOG account and how to complete MFA, please review the *Kentucky Online Gateway (KOG) and Multi-Factor Authentication (MFA) Quick Reference Guide*.

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.

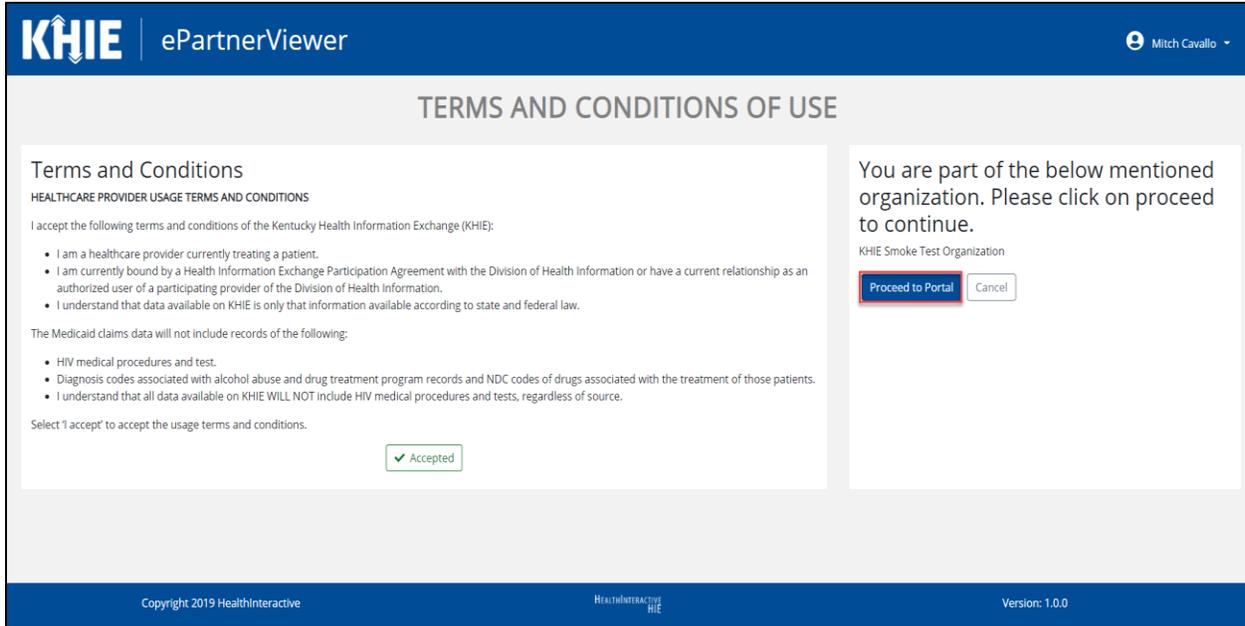


5. You must click **I Accept** every time before accessing a patient record in the ePartnerViewer.



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.

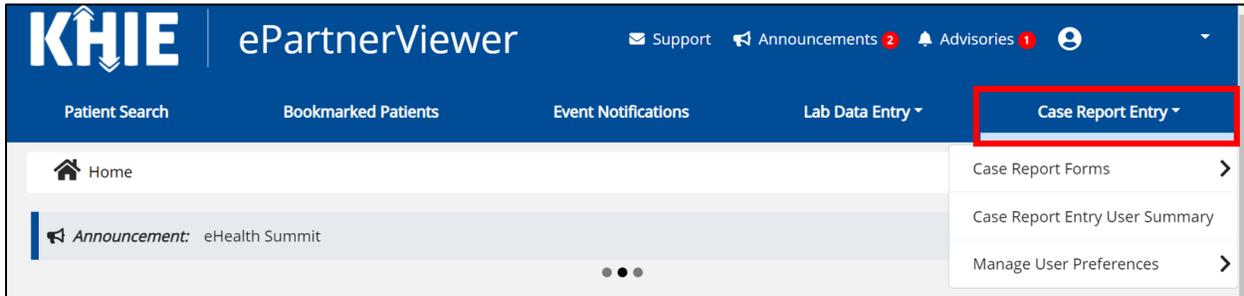


Please Note: If you click **Cancel**, a pop-up notification displays that indicates that you are *about to be logged out*. Use of the ePartnerViewer portal is subject to the acceptance of KHIE's Terms of Use. To proceed to the ePartnerViewer, click either **Logout Now** or **Cancel**.

3 Understanding the Case Report Entry Dropdown Menu

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

- **Case Report Forms** which lists the different types of case reports.
- **Case Report Entry User Summary** which displays all submitted and 'In Progress' case reports.
- **Manage User Preferences** which offers an efficient way to enter repetitive data.



1. Types of Case Reports:

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

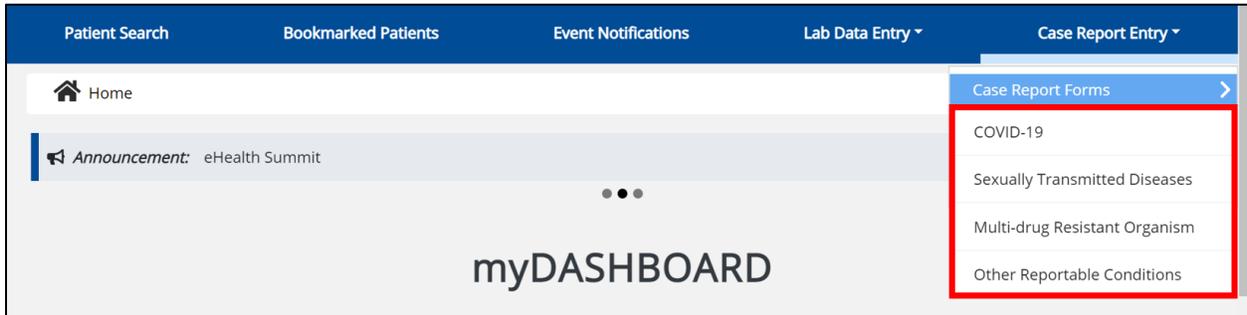
Please Note: For specific information about COVID-19 case reporting, please review the *Direct Data Entry for Electronic Case Reports: COVID-19 User Guide*.

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

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

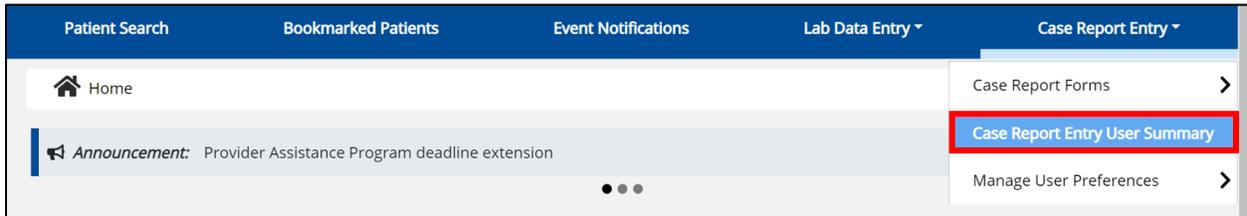
- **Other Reportable Conditions Case Report:**
 - Designed for Users to enter Other Reportable Conditions case reports.

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



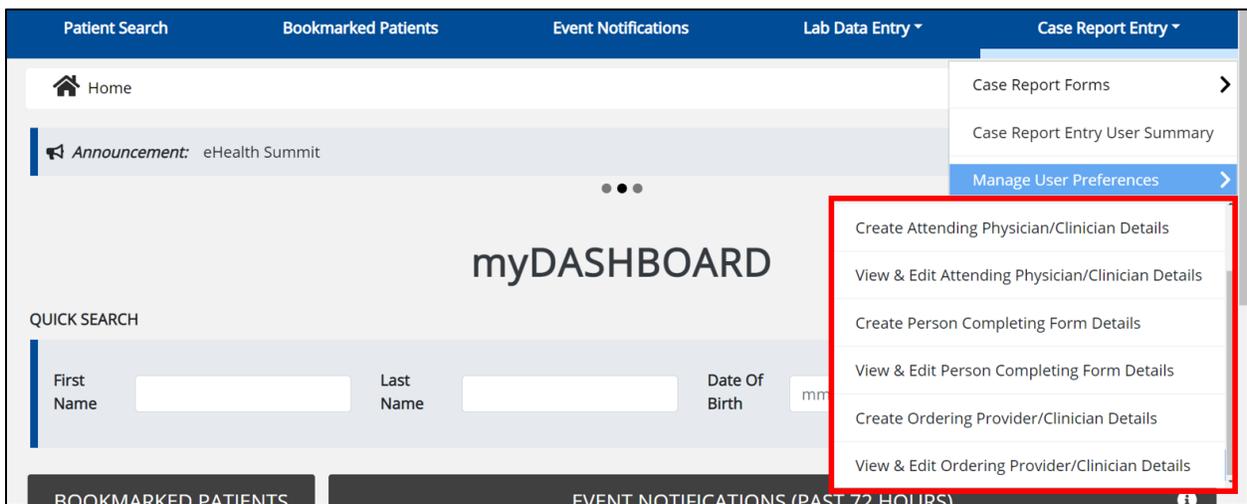
2. Case Report Entry User Summary:

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



3. Manage User Preferences:

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

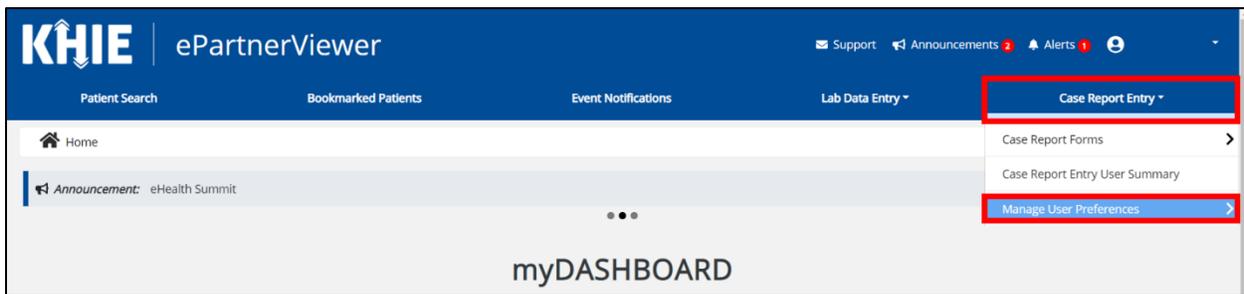


4 Manage User Preferences

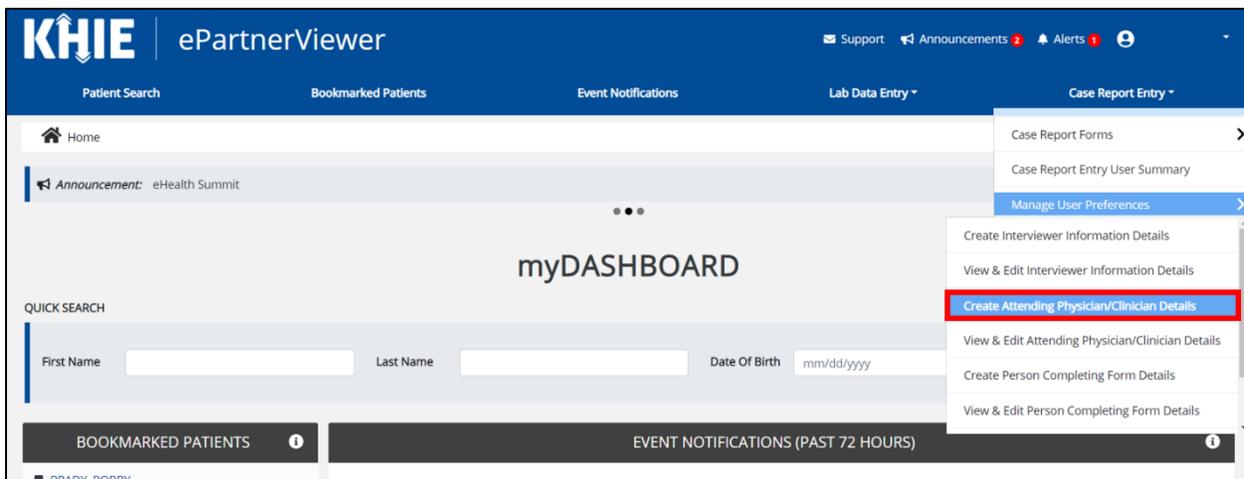
These are your User Preferences. Prior to entering your Sexually Transmitted Diseases (STD) case report information, you are required to enter information about the Attending Physician/Clinician and the Person Completing Form on the **Manage User Preferences** screen. By entering these details here in your user preferences, you will be able to quickly select an Attending Physician/Clinician and the name of the Person Completing the Form from the dropdown menu options. These dropdown menus are located on the **Patient Information** screen of the STD Case Report.

Create Attending Physician/Clinician Details

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



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



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

Home > Create Attending Physician/Clinician Details

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Dr. x | v

First Name* Last Name*

Suffix
Select...
II
III
IV
Jr
Sr
(XXX) XXX-XXXX

Address 2
Unit, Suite, Building, etc.

State* Select... | v Zip Code*

Email*
name@domain.com

Clear Save

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

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

ATTENDING PHYSICIAN/CLINICIAN

Prefix
Dr. x | v

First Name* Last Name*

Suffix
Sr x | v

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

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

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

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

Phone* 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.

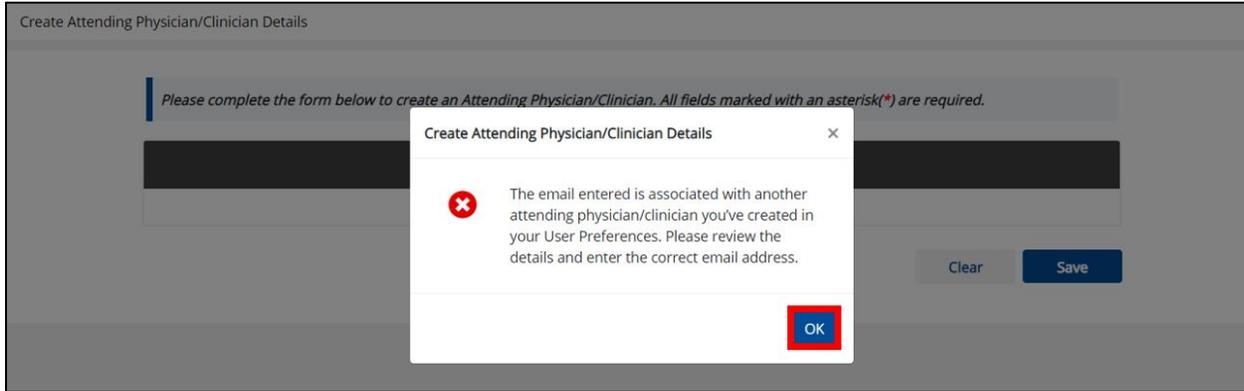
9. After completing the mandatory fields, click **Save**.

ATTENDING PHYSICIAN/CLINICIAN

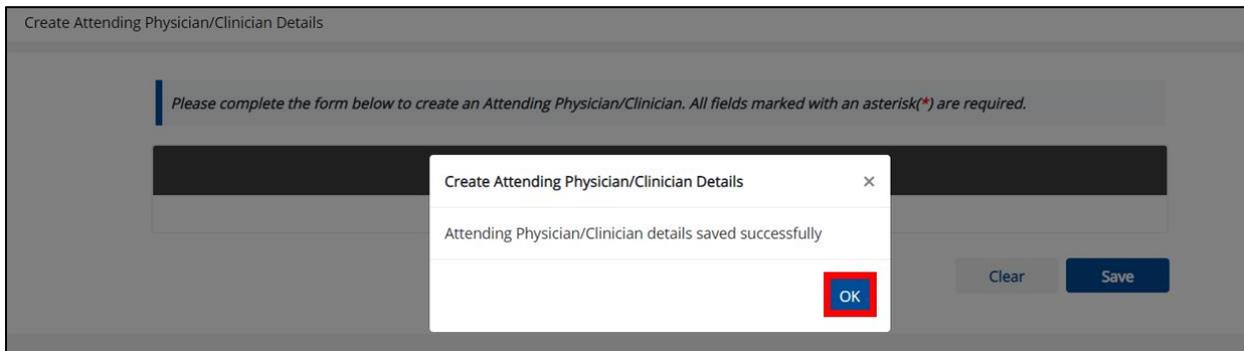
Prefix <input style="border: 1px solid #ccc;" type="text" value="Dr."/>		
First Name* <input style="border: 1px solid #ccc;" type="text" value="Frank"/>	Last Name* <input style="border: 1px solid #ccc;" type="text" value="Costanza"/>	
Suffix <input style="border: 1px solid #ccc;" type="text" value="Sr"/>		
Address 1* <input style="border: 1px solid #ccc;" type="text" value="1 First Street"/>	Address 2 <input style="border: 1px solid #ccc;" type="text" value="1A"/>	
City* <input style="border: 1px solid #ccc;" type="text" value="Lexington"/>	State* <input style="border: 1px solid #ccc;" type="text" value="KY"/>	Zip Code* <input style="border: 1px solid #ccc;" type="text" value="40123"/>
Phone* <input style="border: 1px solid #ccc;" type="text" value="(111) 111-1111"/>	Email* <input style="border: 1px solid #ccc;" type="text" value="frank@email.com"/>	

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.

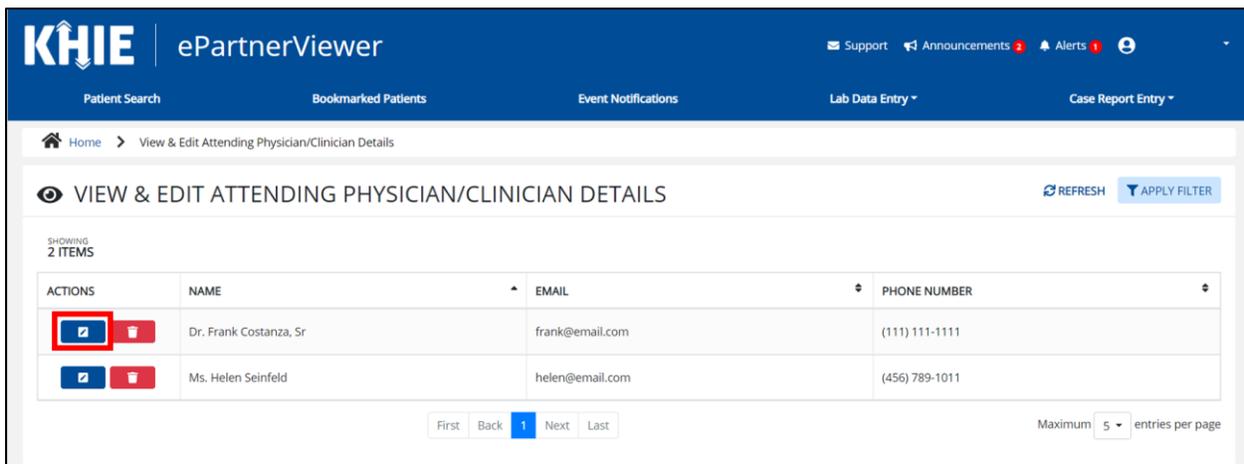


10. The *Create Attending Physician/Clinician Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Attending Physician/Clinician Details** screen.

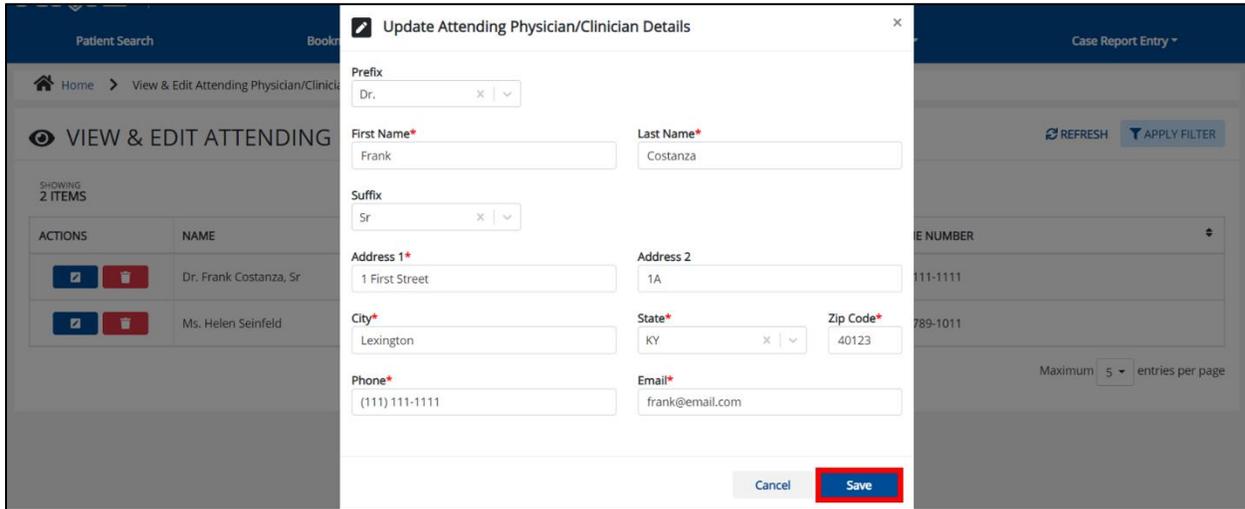


View & Edit Attending Physician/Clinician Details

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.

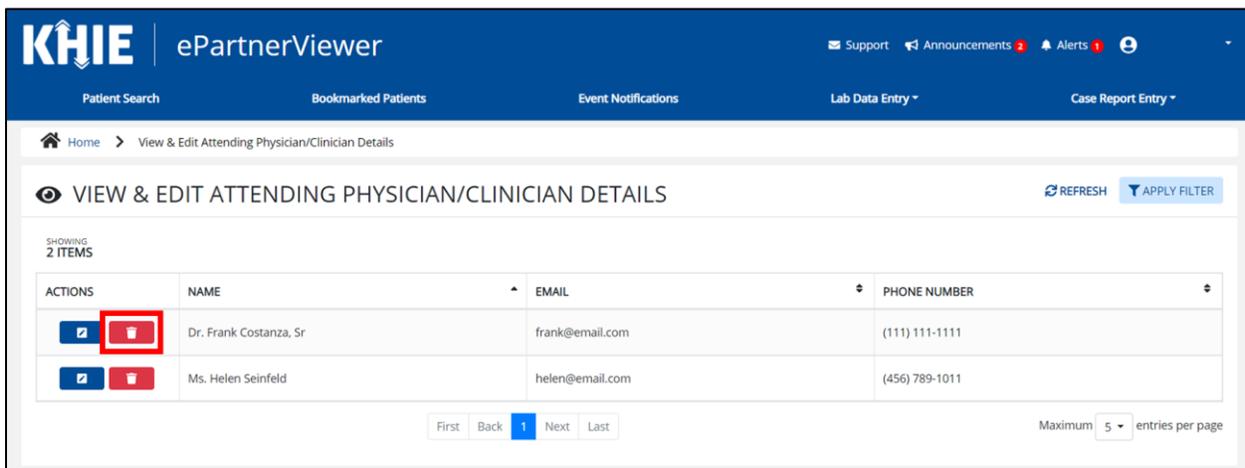


13. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.

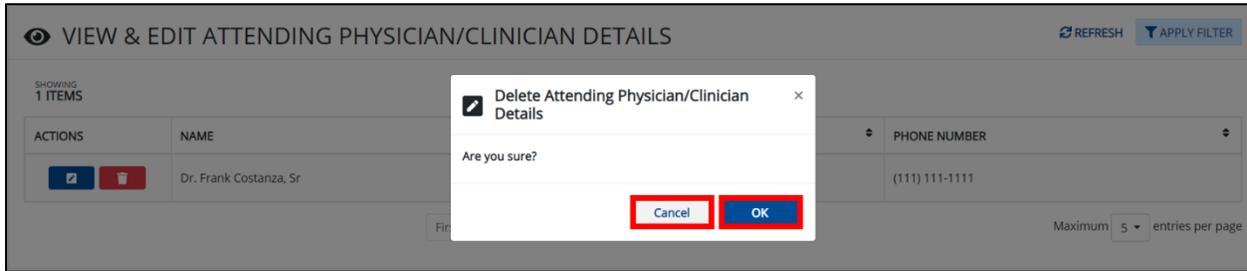


Delete Attending Physician/Clinician Details

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.



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

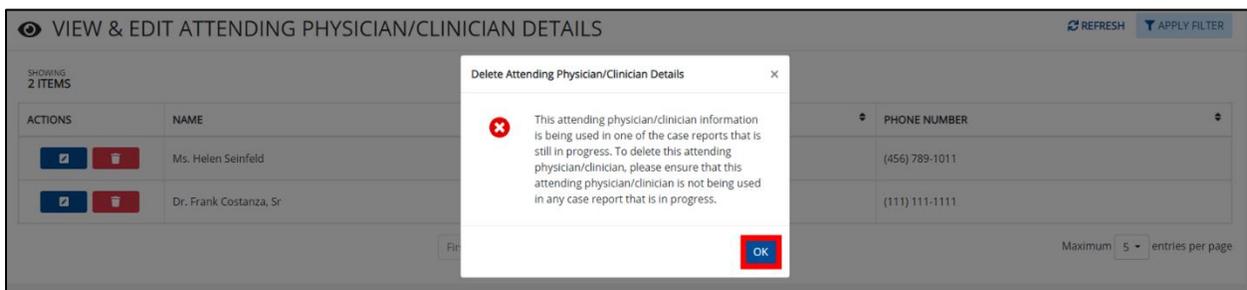
If you attempt to delete an attending physician/clinician who has been selected for use in a case report that has not been completed yet, a pop-up notification will display the following message:

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

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

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

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



Filter Attending Physician/Clinician Details

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

The screenshot shows the ePartnerViewer interface. At the top, there's a navigation bar with the KHIE logo and 'ePartnerViewer' text. Below it are several menu items: 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'. There are 'REFRESH' and 'APPLY FILTER' buttons. Below this, it says 'SHOWING 2 ITEMS'. A table lists two items:

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

At the bottom of the table, there are pagination controls: 'First', 'Back', '1', 'Next', 'Last'. To the right, it says 'Maximum 5 entries per page'.

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

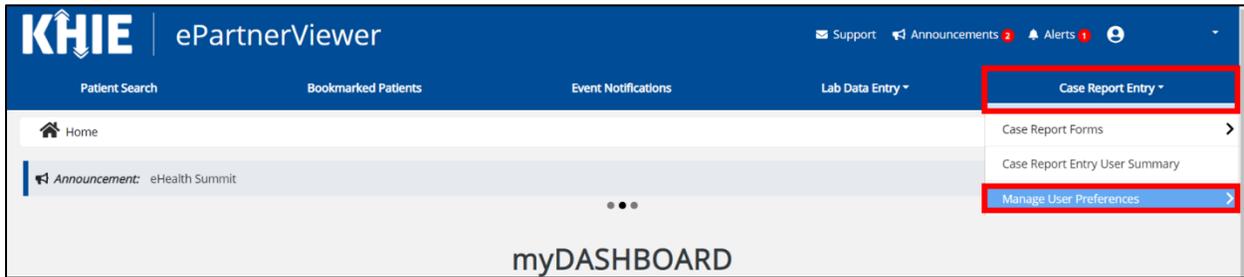
This screenshot is similar to the previous one, but the 'APPLY FILTER' button has been replaced by a 'HIDE FILTER' button. The table headers now have input fields for filtering:

ACTIONS	NAME <input data-bbox="373 1134 560 1165" type="text" value="Enter NAME..."/>	EMAIL <input data-bbox="722 1134 909 1165" type="text" value="Enter EMAIL..."/>	PHONE NUMBER <input data-bbox="1161 1134 1347 1165" type="text" value="Enter PHONE NUMBER..."/>
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011

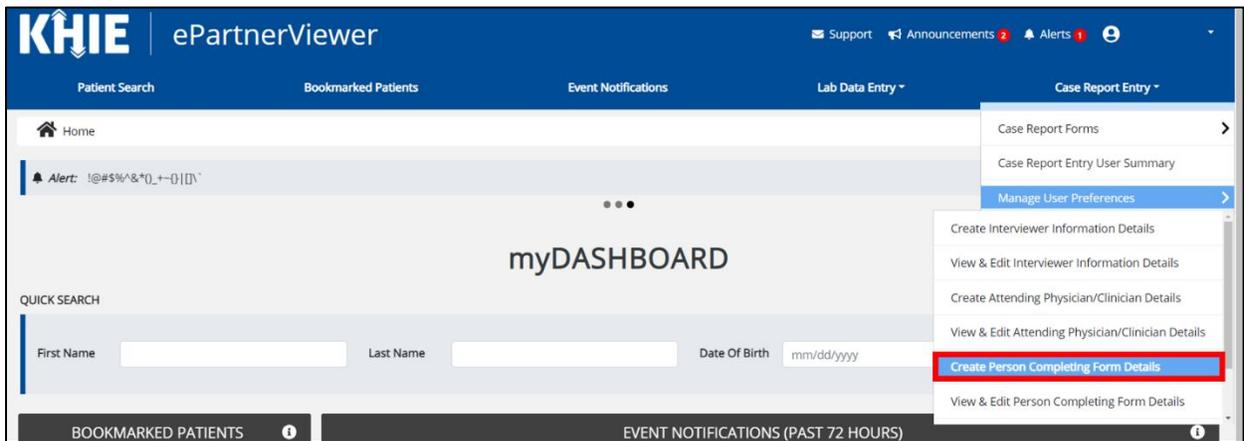
The pagination controls and 'Maximum 5 entries per page' text are also present at the bottom.

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.

First Name* Last Name*

Suffix
Select...
II
III
IV
Jr
Sr

Address 2
Unit, Suite, Building, etc.

State* Zip Code*

Email*

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

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

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

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

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

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

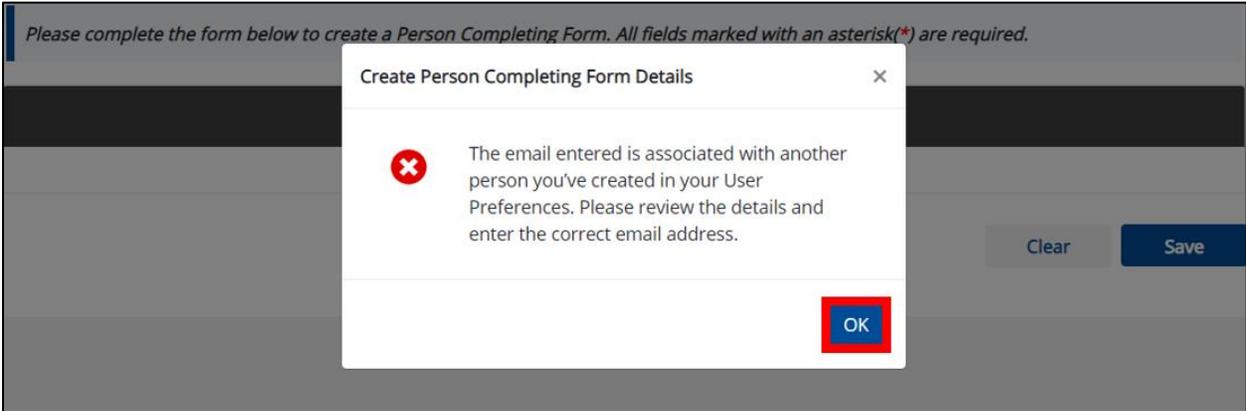
Please Note: If the information entered in the *Phone* and *Email* fields is not entered in the appropriate format, an error message displays that prevents you from proceeding to the next page until the format error is fixed.

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

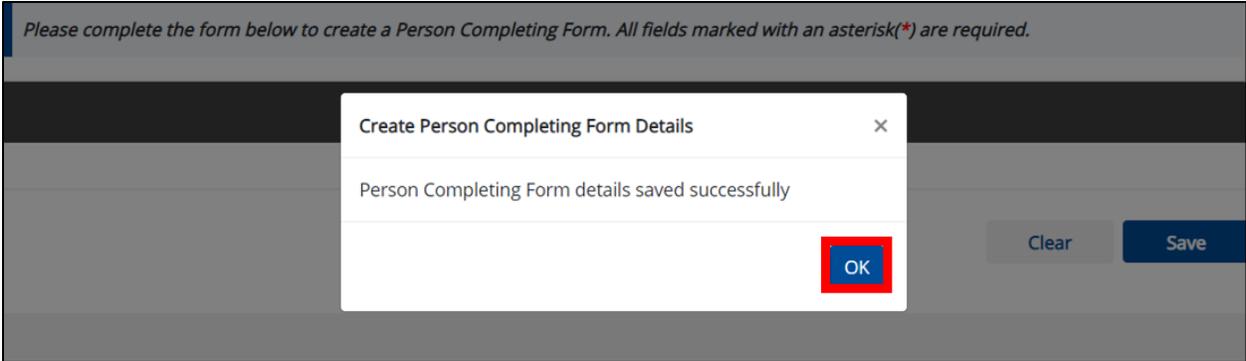
PERSON COMPLETING FORM

Prefix Mr. x v		
First Name* Arthur	Last Name* Vandelay	
Suffix II x v		
Address 1* 22 Second Avenue	Address 2 Unit, Suite, Building, etc.	
City* Lexington	State* KY x v	Zip Code* 40222-
Phone* (222) 222-2222	Email* arthur@email.com	

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.

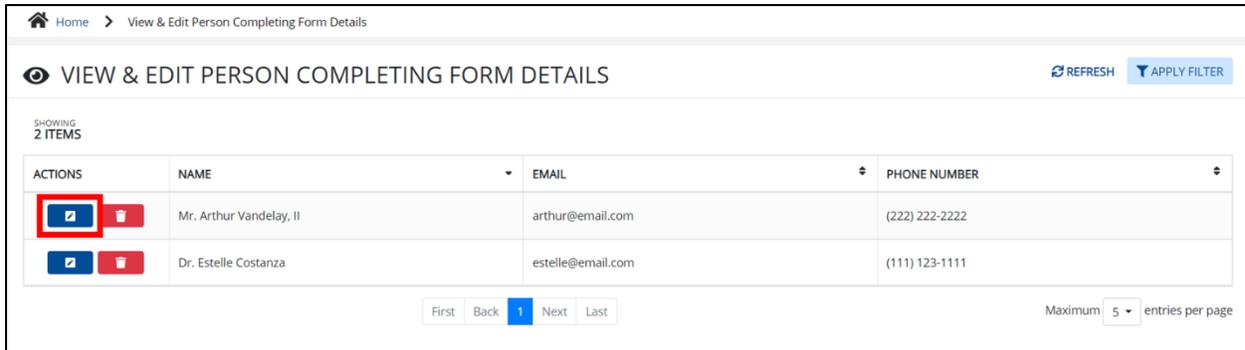


10. The *Create Person Completing Form Details* pop-up window displays. Click **OK** to proceed to the **View & Edit Person Completing Form Details** screen.

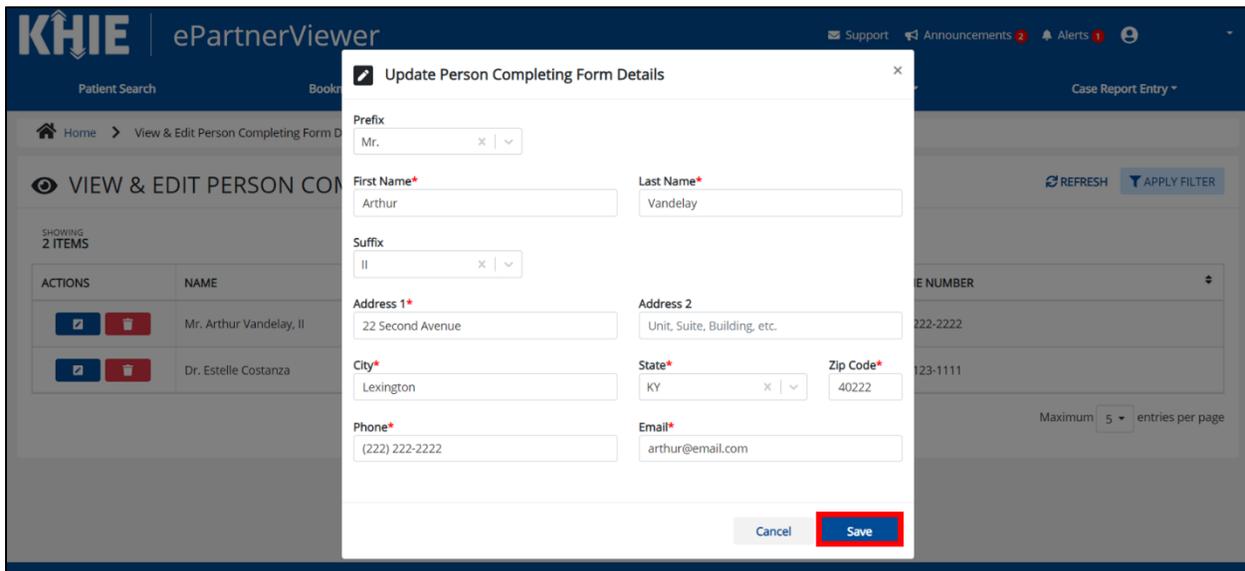


View & Edit Person Completing Form Details

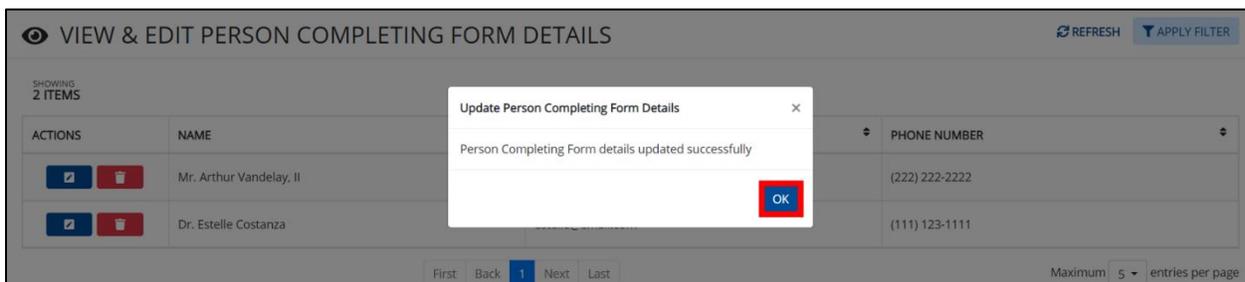
11. The **View & Edit Person Completing Form Details** screen displays. To edit details, click the **Edit** icon located next to the appropriate person.



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.

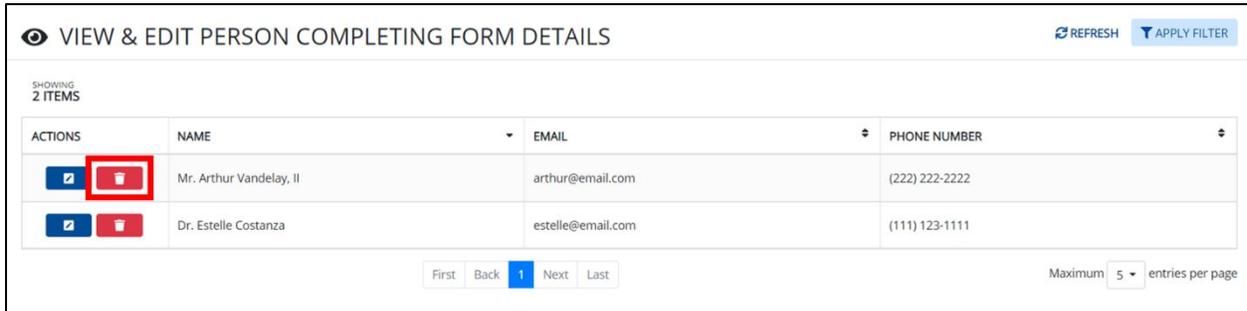


13. Once the update is successfully saved, a pop-up message displays. To proceed, click **OK**.

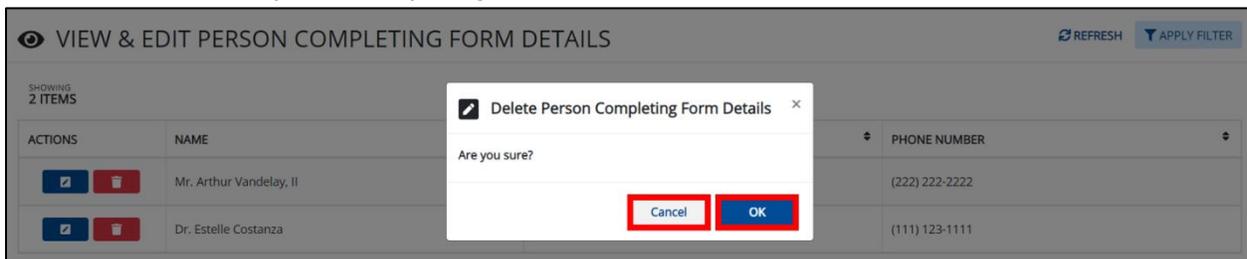


Delete Person Completing the Form Details

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



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.

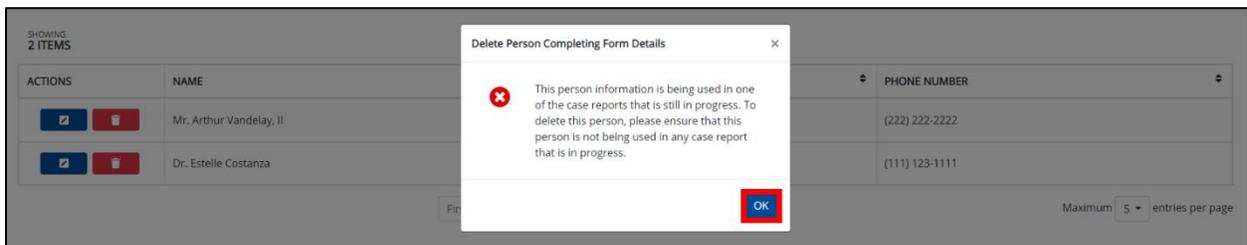


Please Note: You can delete a person on the **View & Edit Person Completing Form Details** screen as long as that person has not been selected for use in a case report that is still in progress.

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.

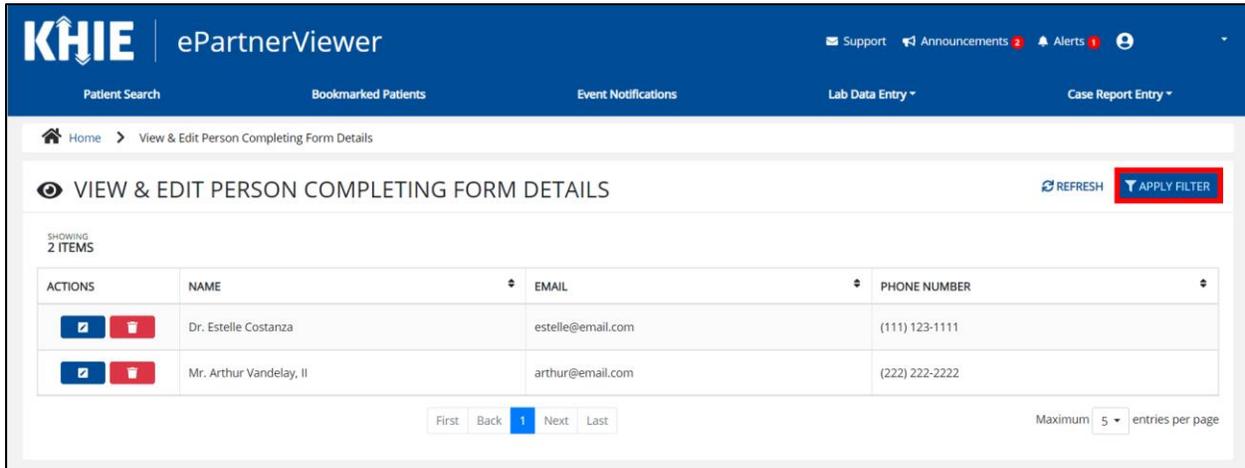
To close out of the pop-up and proceed, click **OK**.

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.

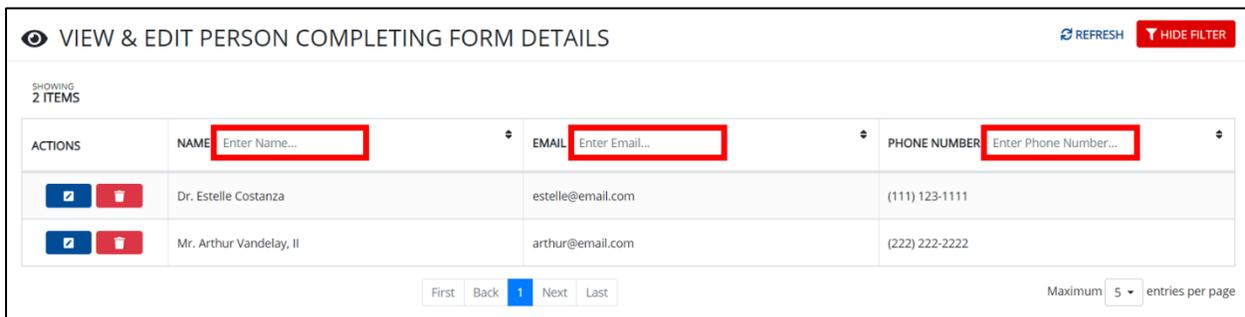


Filter Person Creating Form Details

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



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.



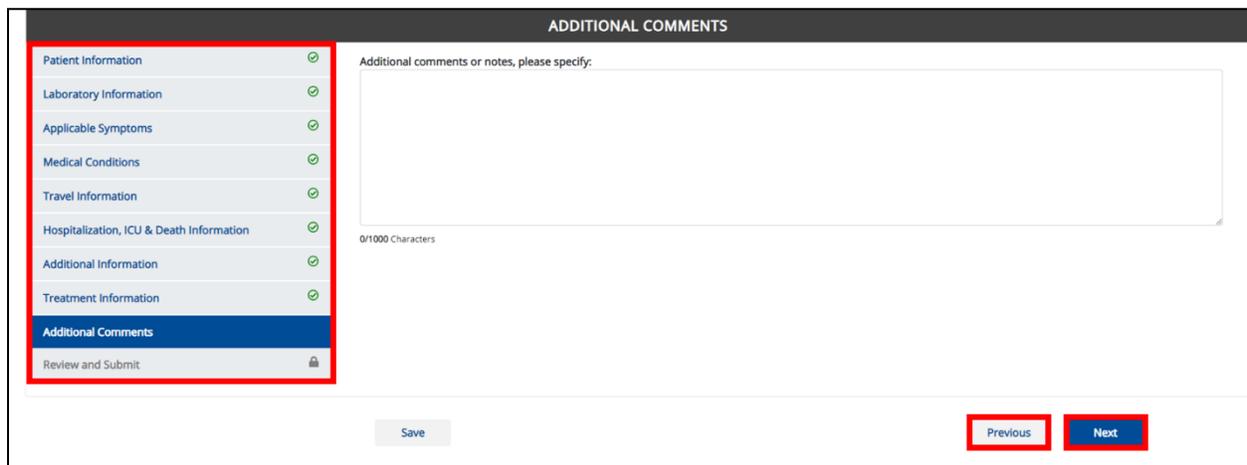
5 Basic Features of the Case Report Entry Form

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

Side Navigation Bar & Pagination

On the left side of the Case Report, tabs located in the **Side Navigation Bar** provide Users the ability to go to the different screens within a Case Report. You can also use the pagination buttons to move to the next screen or to any previous screen.

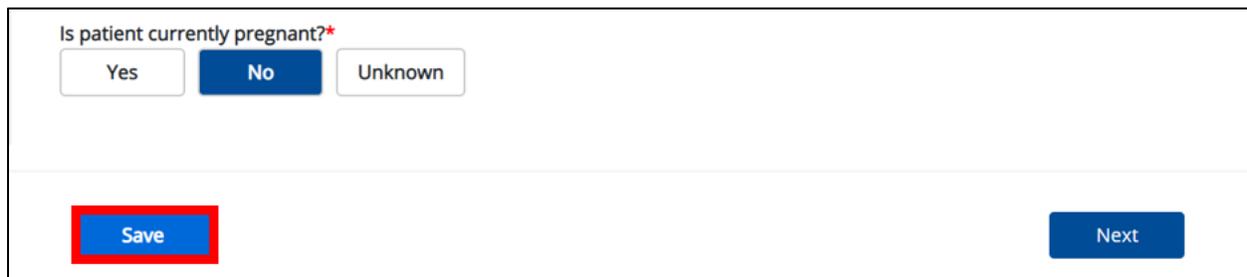
1. Using the side navigation bar, you can navigate to any previously completed screen. Click the **hyperlink** of a previously completed screen to navigate to that specific screen.
2. Click **Previous** to go to the previous screen.
3. When all required fields have been completed on the current screen, click **Next** to proceed to the next screen.



Save Feature

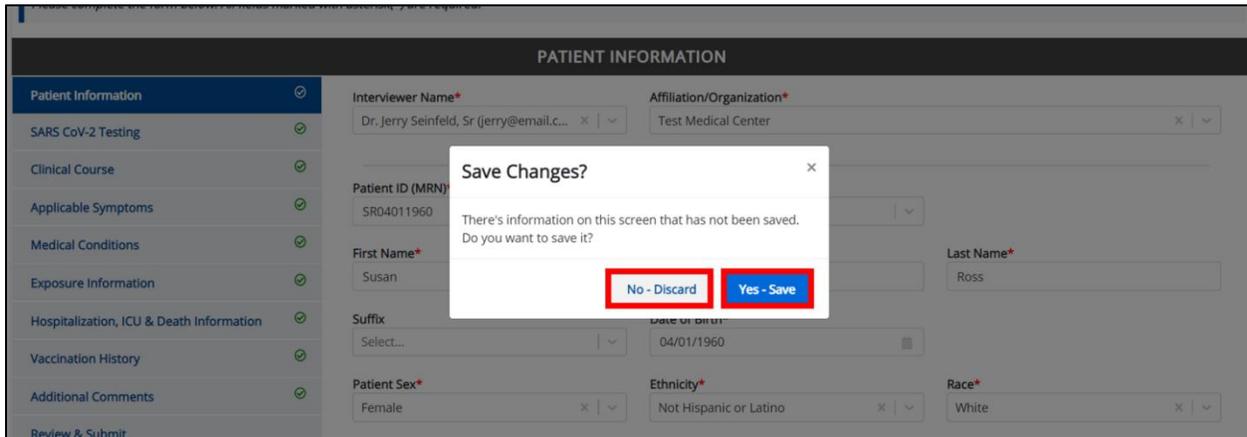
The **Save** feature allows Users to complete the case report in multiple sessions. You must **save** the information you have entered in order to return later to the place you left off previously.

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



2. If you click on a previously completed screen on the side navigation bar, the *Save Changes* pop-up will display. You have the option to save or discard the changes on the current screen before navigating to another screen.

- If you click **Yes – Save** and all the required fields are entered on the current screen, you will navigate to the intended screen. (If you have not completed all required fields on the current screen, you will not be allowed to save the data.) To navigate to the desired screen, you must first complete all required fields on the current screen.
- If you click **No – Discard**, you will navigate to the intended screen without saving any changes on the current screen. This means that none of the data entered on the current screen will be saved.



Case Report Entry Icons

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

Icon Descriptions:

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

Conditional Questions

Conditional Questions are those questions that are asked based on your responses to the previous questions. The Sexually Transmitted Diseases (STD) Case Report has multiple screens with conditional questions. Based on the answer selected for conditional questions, certain subsequent fields on the screen will be enabled or grayed out and disabled.

- For example, if you select **No** or **Unknown** to the conditional question at the top of the **Laboratory Information** screen of the STD Case Report, the subsequent fields will be grayed out and disabled.

The screenshot shows the 'LABORATORY INFORMATION' screen. On the left is a navigation menu with 'Laboratory Information' selected. The main content area has a conditional question: 'Does the patient have a lab test?*' with three buttons: 'Yes', 'No', and 'Unknown'. The 'No' button is highlighted with a red box. Below this question, the 'Laboratory Information' section is visible but all fields (Laboratory Name, Test Name, Filler Order/Accession Number, Specimen Source, Test Result) are grayed out and disabled.

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

The screenshot shows the 'LABORATORY INFORMATION' screen. The conditional question 'Does the patient have a lab test?*' has the 'Yes' button highlighted with a red box. The subsequent fields in the 'Laboratory Information' section (Laboratory Name, Test Name, Filler Order/Accession Number, Specimen Source, Test Result) are now active and highlighted with a red border.

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

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

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

MEDICAL CONDITIONS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

Yes No Unknown

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

Neurologic impairment

Yes No Unknown

If yes, please specify:

Vision impairment

Yes No Unknown

If yes, please specify:

Substance abuse or misuse

Yes No Unknown

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

Immunosuppressive condition

Yes No Unknown

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

MEDICAL CONDITIONS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

Yes No Unknown

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

Neurologic impairment

Yes No Unknown

If yes, please specify:

Vision impairment

Yes No Unknown

If yes, please specify:

Substance abuse or misuse

Yes No Unknown

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

Immunosuppressive condition

Yes No Unknown

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

MEDICAL CONDITIONS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

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

Neurologic impairment*

If yes, please specify: ?

Vision impairment*

If yes, please specify: ?

Substance abuse or misuse*

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

Immunosuppressive condition*

If yes, please specify: ?

6 Affiliation/Organization Conditional Question

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

This applies to the conditional Affiliation/Organization question on the **Patient Information** screen: ***Is the Affiliation/Organization the same for Patient ID (MRN), Person completing Form, and Attending Physician/Clinician?***

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

The screenshot shows the 'PATIENT INFORMATION' form. At the top, there are two fields: 'Disease/Organism*' with a dropdown menu showing 'Chlamydia' and 'Date of Diagnosis*' with a date picker showing '07/23/2021' and an 'Unknown' checkbox. Below these is a red-bordered box containing the conditional question: 'Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*' with 'Yes' and 'No' buttons. Below the box are three rows of fields: 'Patient ID (MRN)', 'Person Completing Form', and 'Attending Physician/Clinician'. Each row has an 'Affiliation/Organization' dropdown menu and an 'If other, please specify:' text area.

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

Affiliation/Organization Conditional Answer: Yes

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

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

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

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

Yes No

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization

If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization

If other, please specify:

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

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

Yes No

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization

If other, please specify:

Attending Physician/Clinician*

Affiliation/Organization

If other, please specify:

Affiliation/Organization Conditional Answer: No

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

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

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

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

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

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

Yes No

Patient ID (MRN)* Affiliation/Organization*

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

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

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

3. Select the **Affiliation/Organization** for the Attending Physician/Clinician from the dropdown menu.

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

Yes No

Patient ID (MRN)* Affiliation/Organization*

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

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

Prefix

First Name*

Suffix

Patient Sex* **Ethnicity*** **Race***

Please select the organization of the physician attending the patient.

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

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

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

Affiliation/Organization Validation

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

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

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

Yes **No**

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

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

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

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

Yes **No**

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

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

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

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

Yes **No**

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

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

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

Patient Information

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

Yes **No**

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

Change Affiliation/Organization Conditional Answer: No to Yes

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

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

Yes **No**

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

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

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

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

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

Yes **No**

Patient ID (MRN)* SK05051960

Person Completing Form* Mr. Arthur Vandelay,

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:

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:

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

The screenshot shows a form with the following fields and options:

- 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)
- Prefix: Ms.
- Affiliation/Organization*: A dropdown menu is open, showing a list of options: "select...", "Afzal, Mohammad MD, Internal Medicine, LLC", "eICR Onboarding Regression", "Hilton Hospital", "King's Daughters Medical Center", "Murray-Calloway County Hospital", "Test Medical Center" (highlighted), and "University Of Kentucky Chandler Medical Center".
- Two "If other, please specify:" fields are present on the right side of the dropdown menu.

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

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

The screenshot shows the same form as above, but with the following changes:

- The dropdown menu for Affiliation/Organization* is now closed and displays "Test Medical Center".
- The Affiliation/Organization* field for the Person Completing Form* is now populated with "Test Medical Center" and is disabled.
- The Affiliation/Organization* field for the Attending Physician/Clinician* is now populated with "Test Medical Center" and is disabled.
- The "If other, please specify:" fields are now empty.

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.

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

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.

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

Is the Affiliation/Organization same for Patient ID (MRN), Person Comp Please select the organization where the Patient ID (MRN) was assigned to the patient. Physician/Clinician?*

Yes No

Patient ID (MRN)*

Person Completing Form*

Attending Physician/Clinician*

Prefix

Affiliation/Organization*

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

If other, please specify:

If other, please specify:

4. Select the **Affiliation/Organization** for the Person Completing Form from the dropdown menu.
5. Select the **Affiliation/Organization** for the Attending Physician/Clinician from the dropdown menu.

Patient ID (MRN)*

Affiliation/Organization*

Person Completing Form*

Affiliation/Organization*

Attending Physician/Clinician*

Affiliation/Organization*

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

Prefix

First Name*

Suffix

Patient Sex*

Ethnicity*

Race*

Last Name*

If other, please specify:

If other, please specify:

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

Person Completing Form*

Affiliation/Organization*

If other, please specify:*

Attending Physician/Clinician*

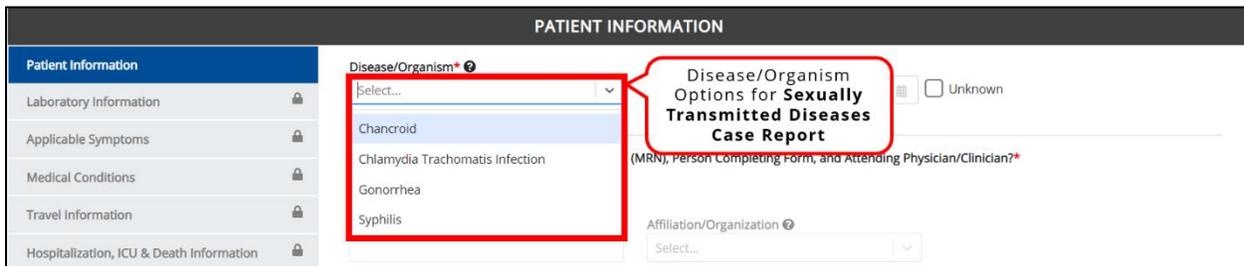
Affiliation/Organization*

If other, please specify:*

7 Dynamic Functions based on Disease/Organism

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

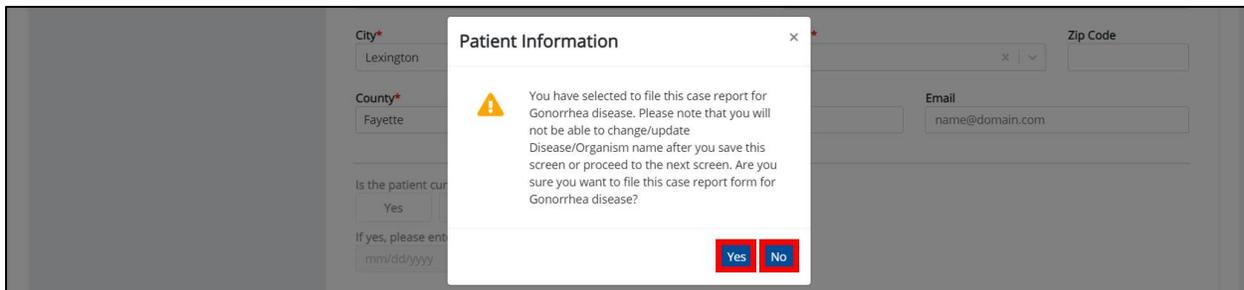
Once the Disease/Organism selection is saved on the **Patient Information** screen, the subsequent dynamic screens are customized to display only the information that applies to the selected Disease/Organism.



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:

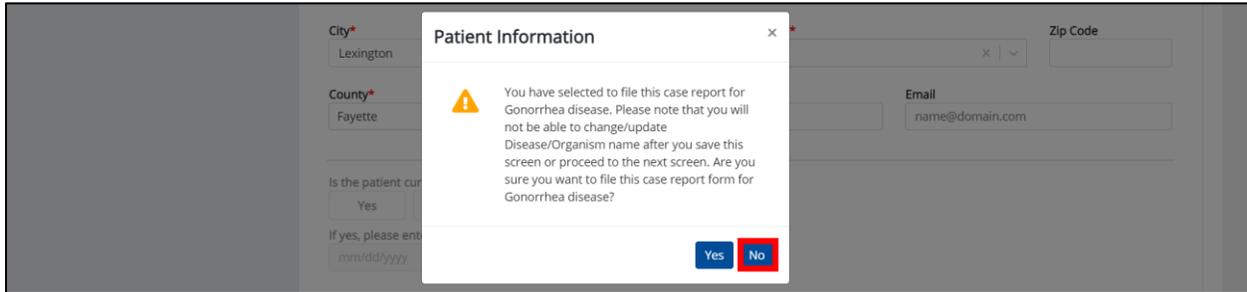
You have selected to file this case report for [selected disease]. Please note that you will not be able to change/update Disease/Organism name after you save this screen or proceed to the next screen. Are you sure you want to file this case report for [selected disease]?



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.

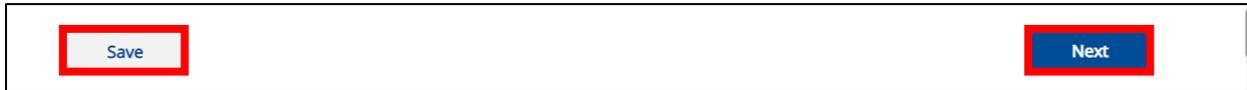
1. Upon clicking **Save** or **Next** at the bottom of the **Patient Information** screen, the Disease/Organism Pop-Up displays.
2. To change the selected Disease/Organism, click **No**.



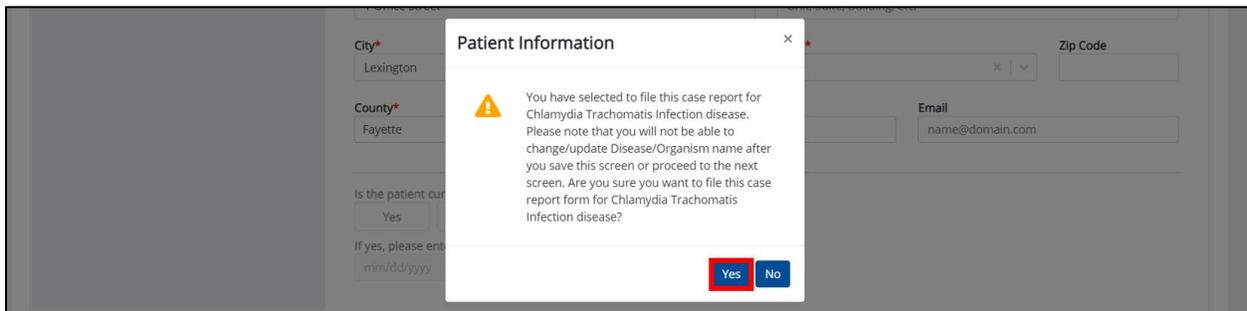
3. Select a different **Disease/Organism** from the dropdown menu.



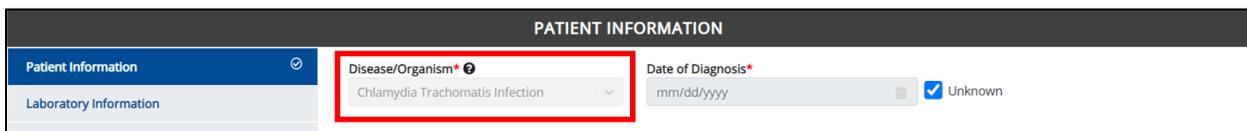
4. Once the Disease/Organism selection is complete, click **Save** to save the change or click **Next** at the bottom of the **Patient Information** screen.



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



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.



8 Dynamic Screens for STD Case Report

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

Laboratory Information: Dynamic Screen

On the **Laboratory Information** screen, the *Test Name* dropdown menu displays only the test name options that apply to the Disease/Organism selected on the **Patient Information** screen.

Hospitalization, ICU & Death Information
Additional Information
Treatment Information
Additional Comments
Review and Submit

Test Name*
Select...
Haemophilus ducreyi culture
Haemophilus ducreyi DNA by NAA
Other

Test Names for Chancroid

Hospitalization, ICU & Death Information
Additional Information
Treatment Information
Additional Comments
Review and Submit

Test Name*
Select...
Chlamydia trachomatis Ag
Chlamydia trachomatis culture
Chlamydia trachomatis DNA by NAA with probe detection
Chlamydia trachomatis rRNA by NAA with probe detection
Chlamydia trachomatis+Neisseria gonorrhoeae DNA by Probe and target amplification method
Other
If other, please specify:

Test Names for Chlamydia Trachomatis Infection

Hospitalization, ICU & Death Information
Additional Information
Treatment Information
Additional Comments
Review and Submit

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

Test Names for Gonorrhea

Hospitalization, ICU & Death Information
Additional Information
Treatment Information
Additional Comments
Review and Submit

Test Name*
Select...
Reagin Ab in Serum by RPR
Reagin Ab in Serum by VDRL
Treponema pallidum Ab in Body fluid
Treponema pallidum Ab in Cerebral spinal fluid
Treponema pallidum Ab in Serum by Agglutination
Treponema pallidum Ab in Serum by Immunoassay
Treponema pallidum Ab in Serum by Immunoblot

Test Names for Syphilis

Applicable Symptoms: Dynamic Screen

The **Applicable Symptoms** screen displays common fields for **all** of the Sexually Transmitted Diseases selected as the Disease/Organism. The **Applicable Symptoms** screen displays additional symptoms that apply to the selected Disease/Organism.

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

APPLICABLE SYMPTOMS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Were symptoms present during the course of illness?*

Onset Date* Unknown

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

Rash*

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

If other, please specify:

Fever*

If yes, please enter the highest temperature:

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

If yes, please enter # of days of diarrhea:

Did the patient have any other symptoms?*

If yes, please specify:

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

If yes, please enter # of days of diarrhea:

Painful Ulcer(s)*

Tender Inguinal lymphadenopathy*

Did the patient have any other symptoms?*

Applicable Symptoms for Chancroid

If yes, please enter # of days of diarrhea:

Cervical Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Discharge from Eye*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Discharge from Throat*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Dysuria*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Pain in Urethra*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Rectal Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Urethral Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Vaginal Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Did the patient have any other symptoms?*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>

Applicable Symptoms for **Chlamydia Trachomatis Infection**

Cervical Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Discharge from Eye*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Discharge from Throat*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Dysuria*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Inflammation of Pelvic Area*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Pain in Urethra*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Rectal Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Urethral Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Vaginal Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Did the patient have any other symptoms?*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>

Applicable Symptoms for **Gonorrhea**

Alopecia*

Chancre, Sore or Lesion*

Condylomata lata of penis*

Condylomata lata of perianal skin*

Condylomata lata of vulva*

Inguinal lymphadenopathy*

Rash of secondary syphilis*

Uveitis*

Applicable Symptoms for Syphilis

Additional Information: Dynamic Screen

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

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 7 of 10

Please select any additional information that pertains to this case.

ADDITIONAL INFORMATION

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

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

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

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

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

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

Treatment Information: Dynamic Screen

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

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

- Azithromycin 1000 MG
- Ceftriaxone
- Ciprofloxacin 500 MG
- Erythromycin 500 MG
- Other
- Unknown

Additional Information ⓘ

Duration* ⓘ

Medications for **Chancroid**

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

- Azithromycin 1000 MG
- Doxycycline hyclate 100 MG Oral Tablet
- Erythromycin 500 MG
- Levofloxacin 500 MG
- Ofloxacin 300 MG
- Other
- Unknown

Additional Information ⓘ

Duration* ⓘ

Medications for **Chlamydia Trachomatis Infection**

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

- 100 ML gentamicin 1.2 MG/ML Injection
- Azithromycin 1000 MG
- Azithromycin 250 MG Oral Tablet
- Azithromycin 500 MG Oral Tablet
- Cefixime 400 MG [Suprax]
- Ceftriaxone 1000 MG
- Ceftriaxone 2000 MG

Additional Information ⓘ

Duration* ⓘ

Medications for **Gonorrhea**

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

Medication*

Select...

- Aqueous crystalline penicillin G
- Benzathine Penicillin G
- Bicillin L-A
- Doxycycline
- Other
- Unknown

Additional Information ⓘ

Duration* ⓘ

Medications for **Syphilis**

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

9 Tips for Manually Entering Case Report Data

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

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

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

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

City [] State KY [x] [v]
Zip Code [] County Select... [v]
Phone Number [] Email Address []

Adair
Allen
Anderson
Ballard
Barren
Bath
Bell

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

City [] State AR [x] [v]
Zip Code [] County Out Of System State [x] [v]

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

Admission Date* [mm/dd/yyyy] [calendar icon] Unknown
Discharge Date* [mm/dd/yyyy] [calendar icon] Unknown

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

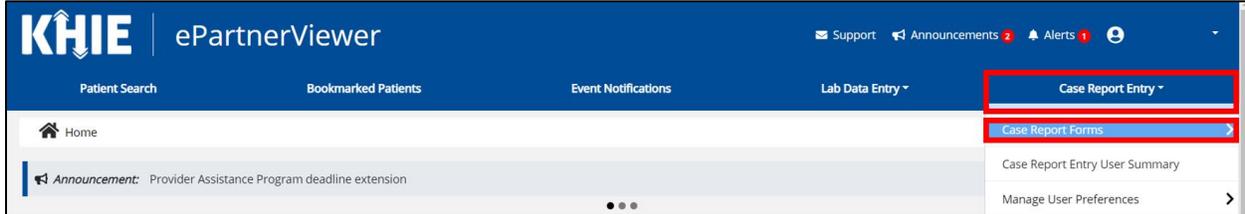
- If the date is unknown, you have the option to click the **Unknown checkbox**.

Admission Date* [mm/dd/yyyy] [calendar icon] Unknown
Discharge Date* [06/20/2021] [calendar icon] Unknown

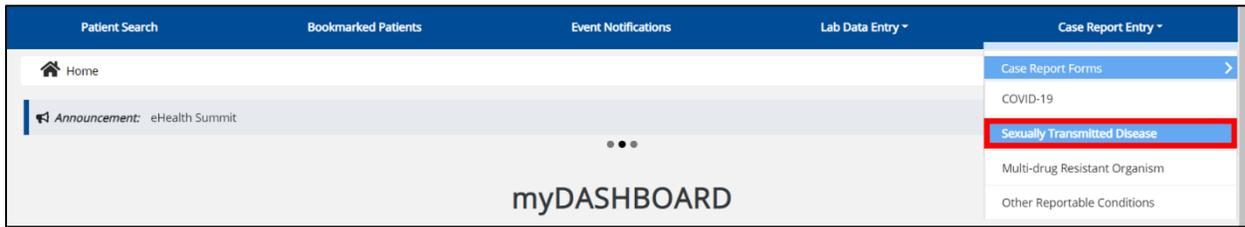
10 Sexually Transmitted Diseases Case Report Form

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

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



2. Select **Sexually Transmitted Disease** from the dropdown menu.



11 Patient Information

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 1 of 10

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

PATIENT INFORMATION

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

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 1 of 10

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

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

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

If you access the STD Case Report without previously entering these details, the **Patient Information** screen is disabled and displays an error message.

You must click the hyperlink associated with the **Person Completing Form** and the **Attending Physician/Clinician** located in the error message banner to navigate to the appropriate **User Preferences** screens and create the *Person Completing Form* and *Attending Physician/Clinician* before entering STD Case Report details.

Home > Sexually Transmitted Diseases Case Report Form

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 1 of 10

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

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

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

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

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?*

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

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

Yes No

Patient ID (MRN)*

Affiliation/Organization*

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

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

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

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

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:

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

If other, please specify:

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

Yes No

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.

Patient ID (MRN)* Affiliation/Organization*

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

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

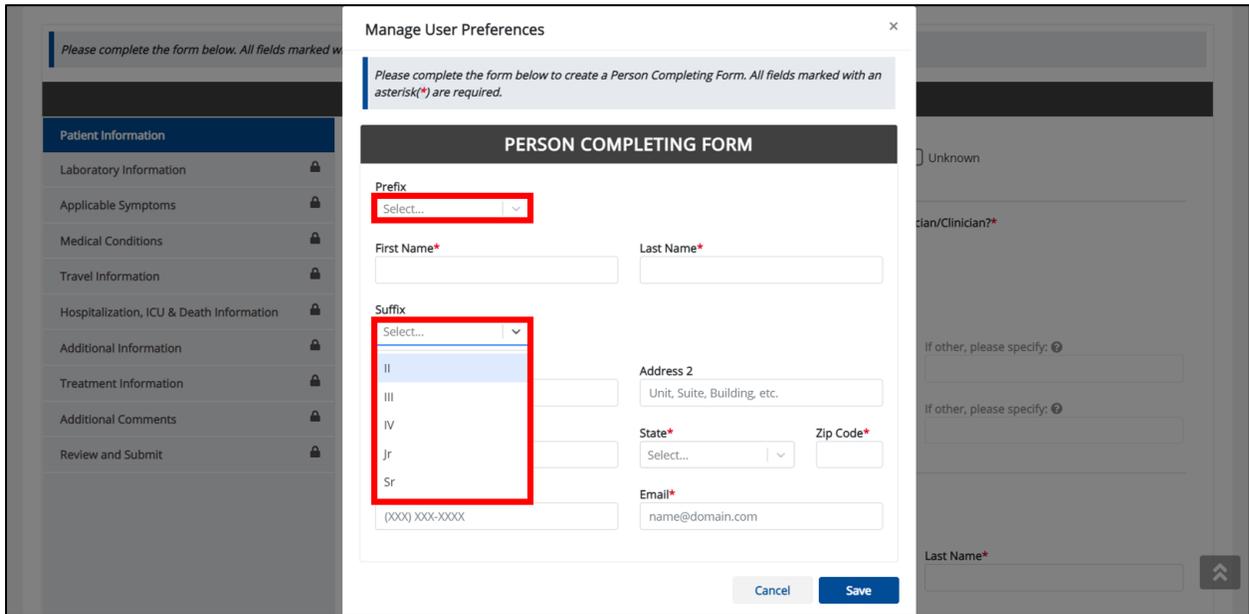
7. From the dropdown menu, select the name of the **Person Completing Form**.

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

Person Completing Form Hyperlink

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

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



- 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	
<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"/>

- 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. Select the **new name of the Person Completing Form** from the dropdown menu.

16. If applicable, select the **Affiliation/Organization** that applies to the person completing the form.

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

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

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**.

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

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

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

- Enter the Attending Physician/Clinician’s **Phone Number** and **Email Address**.

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

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

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

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

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

Please Note: Additional information on the Affiliation/Organization section of the **Patient Information** screen is covered in *Section 6 Affiliation/Organization Conditional Question.*

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

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

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

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

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

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

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

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

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

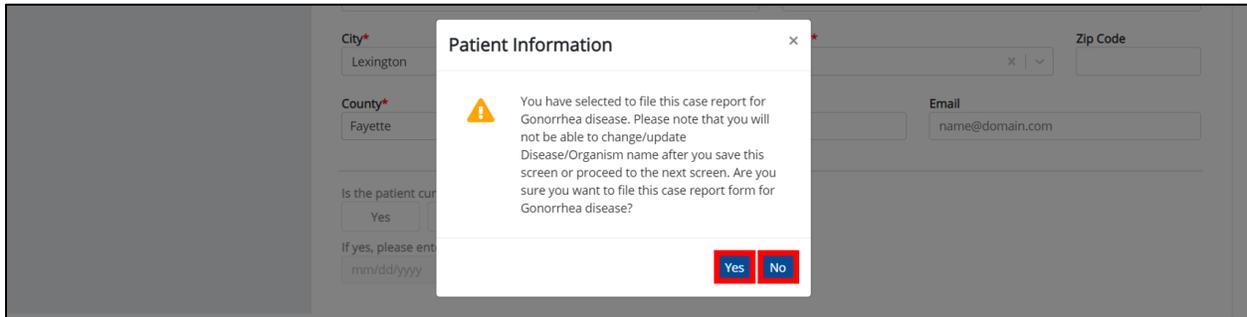
Please Note: The field *Is the patient currently pregnant?* is enabled only when you select **Female** from the *Patient Sex* dropdown menu on the **Patient Information** screen.

If **Yes** is selected, the subsequent field is enabled. You must enter the **estimated due date (EDC)** in the subsequent field: *If yes, please enter the due date (EDC)*. If the due date is unknown, click the **Unknown checkbox**.

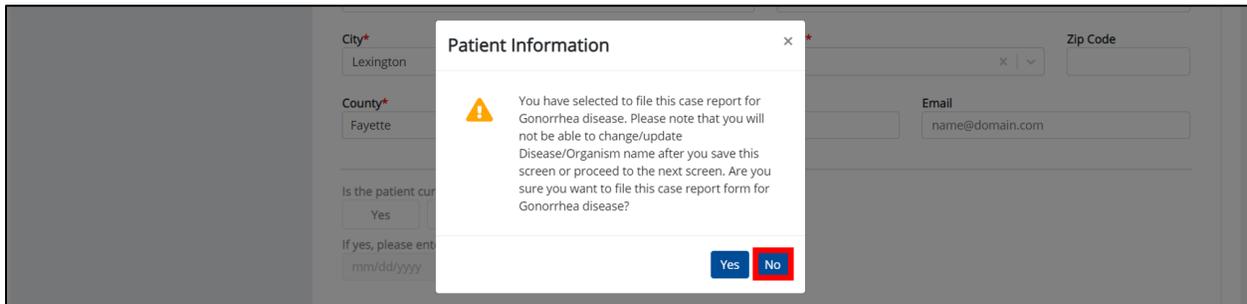
34. When the **Patient Information** screen has been completed, click **Save** to save your progress or **Next** to proceed to the **Laboratory Information** screen.

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

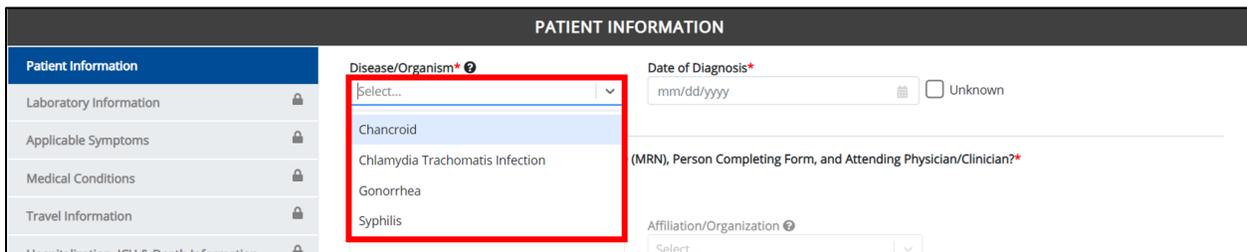
To save the selected Disease/Organism and proceed to the **Laboratory Information** page, click **Yes**. To change the selected Disease/Organism, click **No**.



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



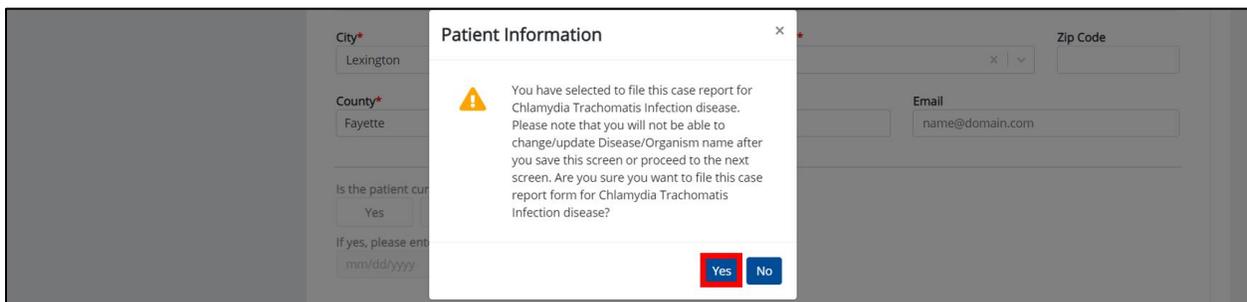
36. If changing the selection, select a different **Disease/Organism** from the dropdown menu.



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



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



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

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

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

12 Laboratory Information

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 2 of 10

Please provide laboratory information related to this case.

LABORATORY INFORMATION

Patient Information ✔	Does the patient have a lab test?* <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Laboratory Information	
Applicable Symptoms 🔒	
Medical Conditions 🔒	
Travel Information 🔒	
Hospitalization, ICU & Death Information 🔒	
Additional Information 🔒	
Treatment Information 🔒	
Additional Comments 🔒	
Review and Submit 🔒	

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

LABORATORY INFORMATION

Patient Information ✔	Does the patient have a lab test?* <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Laboratory Information	
Applicable Symptoms 🔒	
Medical Conditions 🔒	
Travel Information 🔒	
Hospitalization, ICU & Death Information 🔒	
Additional Information 🔒	
Treatment Information 🔒	
Additional Comments 🔒	
Review and Submit 🔒	

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

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

Laboratory Information

Laboratory Name*

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

Test Name*

Select...

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

If other, please specify: ?

Please Note: The *Test Name* dropdown menu displays only the test name options that apply to the Disease/Organism selected on the **Patient Information** screen.

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

Test Name*

Please enter the test name/description if it is not listed in the Test Name dropdown list.

Other

If other, please specify: *

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

If other, please specify: *

Please enter filler order number or accession number.

Filler Order/Accession Number ?

Please Note: The Filler Order Number or Lab Accession Number is typically utilized by laboratories and generally refers to the number assigned to a lab sample when it is checked in. If your organization does not log the receipt of specimens, you should create a system to uniquely track the specimen when you check it in.

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

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

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

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

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

7. If applicable, enter the **Test Result Date**.
8. Enter the **Specimen Collection Date**.

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.

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

Adding Multiple Tests

10. You can also click **Add Test** to log the details for multiple lab tests. This means that you can easily enter additional lab test results on the same patient.

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

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

Specimen Source*

Blood arterial x | v

If other, please specify: ?

Test Result*

Positive x | v

If other, please specify: ?

Test Result Date* Unknown **Specimen Collection Date*** Unknown

Additional Information ?

Lab Test Details

16/300 Characters

[+ Add Test](#)

[Save](#) [Previous](#) [Next](#)

13 Applicable Symptoms

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 3 of 10

Please select applicable symptoms that the patient experienced during illness.

APPLICABLE SYMPTOMS

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

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date Unknown

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

Rash

Yes No Unknown

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

If other, please specify:

Fever

Yes No Unknown

If yes, please enter the highest temperature:

Diarrhea (>3 loose stools/24hr period)

Yes No Unknown

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

APPLICABLE SYMPTOMS

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

Were symptoms present during the course of illness?*

Yes No Unknown

Onset Date Unknown

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

Rash*

Yes No Unknown

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

If other, please specify:

Fever*

Yes No Unknown

If yes, please enter the highest temperature:

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

Yes No Unknown

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

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

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

Were symptoms present during the course of illness?*

Yes No Unknown

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

Onset Date* ?

mm/dd/yyyy Unknown

July 2021

July 2021

Su Mo Tu We Th Fr Sa

27 28 29 30 1 2 3

4 5 6 7 8 9 10

11 12 13 14 15 16 17

18 19 20 21 22 23 24

25 26 27 28 29 30 31

Unknown

How did the patient experience during their illness?

Unknown

on the body (select all that apply): ?

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

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

Rash*

Yes No Unknown

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

Select...

If other, please specify: ?

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

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

Rash*

Yes No Unknown

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

Leg x Torso x

Face

Feet

Hands

Penis

Rectum

Vagina

Other

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

4. Select the **appropriate answer** for the *Fever* field.

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

5. Select the **appropriate answer** for the *Diarrhea (>3 loose stools/24hr period)* field.

- If **Yes** is selected for the *Diarrhea (>3 loose stools/24hr period)* field, the subsequent field is enabled. Enter **the number of days of diarrhea** in the subsequent textbox: *If yes, please enter the # of days of diarrhea.*

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

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

If yes, please enter # of days of diarrhea:

Painful Ulcer(s)*

Tender Inguinal lymphadenopathy*

Did the patient have any other symptoms?*

Applicable Symptoms for **Chancroid**

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

If yes, please enter # of days of diarrhea:

Cervical Discharge*

Discharge from Eye*

Discharge from Throat*

Dysuria*

Pain in Urethra*

Rectal Discharge*

Urethral Discharge*

Vaginal Discharge*

Did the patient have any other symptoms?*

Applicable Symptoms for **Chlamydia Trachomatis Infection**

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

Cervical Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Discharge from Eye*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Discharge from Throat*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Dysuria*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Inflammation of Pelvic Area*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Pain in Urethra*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Rectal Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Urethral Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Vaginal Discharge*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>

Applicable Symptoms for **Gonorrhea**

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

Alopecia*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Chancre, Sore or Lesion*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Condylomata lata of penis*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Condylomata lata of perianal skin*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Condylomata lata of vulva*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Inguinal lymphadenopathy*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Rash of secondary syphilis*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>
Uveitis*	<input type="button" value="Yes"/>	<input type="button" value="No"/>	<input type="button" value="Unknown"/>

Applicable Symptoms for **Syphilis**

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

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

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

14 Medical Conditions

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 4 of 10

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

MEDICAL CONDITIONS

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

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

Yes No Unknown

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

Neurologic impairment

Yes No Unknown

If yes, please specify:

Vision impairment

Yes No Unknown

If yes, please specify:

Substance abuse or misuse

Yes No Unknown

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

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

MEDICAL CONDITIONS

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

Yes No Unknown

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

Neurologic impairment*

Yes No Unknown

If yes, please specify:

Vision impairment*

Yes No Unknown

If yes, please specify:

Substance abuse or misuse*

Yes No Unknown

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

Immunosuppressive condition*

Yes No Unknown

If yes, please specify:

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

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

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

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

Neurologic impairment*

Yes No Unknown

If yes, please specify: ?

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

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

Neurologic impairment*

Yes No Unknown

If yes, please specify: *

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

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

Vision impairment*

Yes No Unknown

If yes, please specify: ?

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

Vision impairment*

Yes No Unknown

If yes, please specify: *

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

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

Substance abuse or misuse*

Yes No Unknown

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

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

Substance abuse or misuse*

Yes No Unknown

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

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

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

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

Immunosuppressive condition*

Yes No Unknown

If yes, please specify:

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

Immunosuppressive condition*

Yes No Unknown

If yes, please specify:*

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

MEDICAL CONDITIONS

Patient Information

Laboratory Information

Applicable Symptoms

Medical Conditions

Travel Information

Hospitalization, ICU & Death Information

Additional Information

Treatment Information

Additional Comments

Review and Submit

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

Yes No Unknown

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

Neurologic impairment*

Yes No Unknown

If yes, please specify:

Vision impairment*

Yes No Unknown

If yes, please specify:

Substance abuse or misuse*

Yes No Unknown

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

Unknown

Immunosuppressive condition*

Yes No Unknown

If yes, please specify:

Save Previous **Next**

15 Travel Information

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

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

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

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

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

- If **Yes** is selected for the *Domestic travel (outside state of normal residence)* field, the subsequent *If yes, please specify state(s)* field is enabled. From the multi-select dropdown menu, select the **state(s) the patient traveled.**

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

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

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 5 of 10

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

TRAVEL INFORMATION

Patient Information	✔	Does the patient have a travel history within the last 12 months?*
Laboratory Information	✔	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Applicable Symptoms	✔	
Medical Conditions	✔	Domestic travel (outside state of normal residence)*
Travel Information		<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Hospitalization, ICU & Death Information	🔒	If yes, please specify state(s):* ?
Additional Information	🔒	<input type="text" value="CA x CO x"/>
Treatment Information	🔒	International travel*
Additional Comments	🔒	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/>
Review and Submit	🔒	If yes, please specify country(s):* ?
		<input type="text" value="CANADA x MEXICO x"/>

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?*

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 6 of 10

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

HOSPITALIZATION, ICU & DEATH INFORMATION

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

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

HOSPITALIZATION, ICU & DEATH INFORMATION

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

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

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

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

- 4. Enter the patient’s hospitalization **Admission Date**.

- 5. Enter the patient’s hospitalization **Discharge Date**.

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

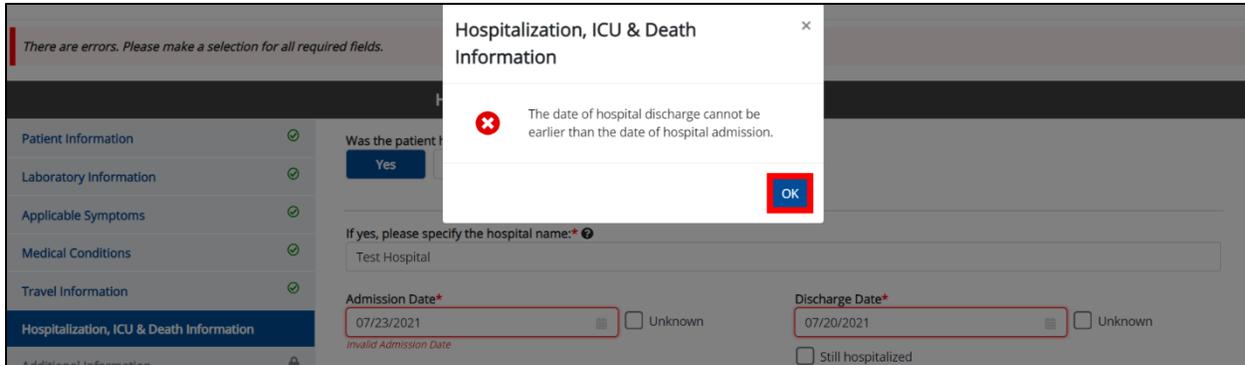
- If the **Still Hospitalized** checkbox is selected, the subsequent death-related field is disabled: *Did the patient die as a result of this illness?*

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

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

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

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



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



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



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



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

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

17 Additional Information

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

Additional Information for Chancroid or Chlamydia

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

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 7 of 10

Please select any additional information that pertains to this case.

ADDITIONAL INFORMATION

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

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

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

Save Previous Next

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

Additional Information for Gonorrhea

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

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

ADDITIONAL INFORMATION

Patient Information	✔
Laboratory Information	✔
Applicable Symptoms	✔

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

Yes No Unknown

Please select the resistance:

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

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

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

Yes No Unknown

Please select the resistance:

Select...

- Cephalosporine
- Penicillin
- Tetracycline
- Other

Additional Information on the **resistance of Gonorrhea**

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

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

Additional Information for Syphilis

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

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

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

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

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

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

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

18 Treatment Information

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

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

TREATMENT INFORMATION

Is the patient undergoing any treatment for this disease?*

Treatment Information

Treatment Date*
mm/dd/yyyy Unknown

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

Frequency*
Select... **Duration*** ?
If the frequency is other, please specify: ?

Additional Information ?

0/300 Characters

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

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

Treatment Date*
mm/dd/yyyy Unknown

July 2021
Su Mo Tu We Th Fr Sa
27 28 29 30 1 2 3
4 5 6 7 8 9 10
11 12 13 14 15 16 17
18 19 20 21 22 23 24
25 26 27 28 29 30 31

Duration* ?

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

Medication*
select...
Azithromycin 1000 MG
Erythromycin 500 MG
Ofloxacin 300 MG
Other
Unknown

Duration* ?

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

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

Medication*
Other x | v
If other, please specify:*
|

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

Frequency*
Select... v
Daily
Every 4 hours
Every 6 hours
Every 8 hours
Every 12 hours
Four times a day-QID
Once

Duration* ?
|
|
|

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

Frequency*
Other x | v
Please enter 'Unknown' if the frequency is not known.
If the frequency is other, please specify:* ?
|

Duration* ?
|

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

Medication*
Azithromycin 1000 MG x | v
If other, please specify:
|

Frequency*
Daily x | v
If the frequency is other, please specify: ?
|

Duration* ?
|

Please enter the duration of the medication. Ex. free fill for # of Days, free fill for # of Weeks etc. Or, enter 'Unknown' if the duration is not known.

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

Adding Multiple Treatments

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

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

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

19 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 and Submit** screen.

20 Review and Submit

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

Print or Download Functionality

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 10 of 10

Please review your information before submitting.

REVIEW & SUBMIT

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

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

SEXUALLY TRANSMITTED DISEASES CASE REPORT FORM Section 10 of 10

Please review your information before submitting.

REVIEW & SUBMIT

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

Destination: SecurePrintUS

Pages: All

Copies: 1

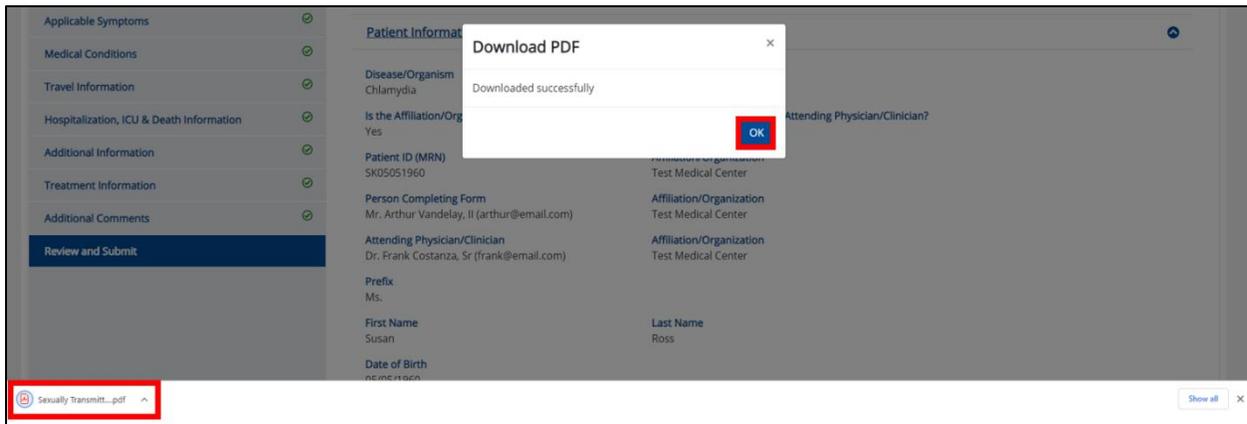
Color: Color

More settings: [v]

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

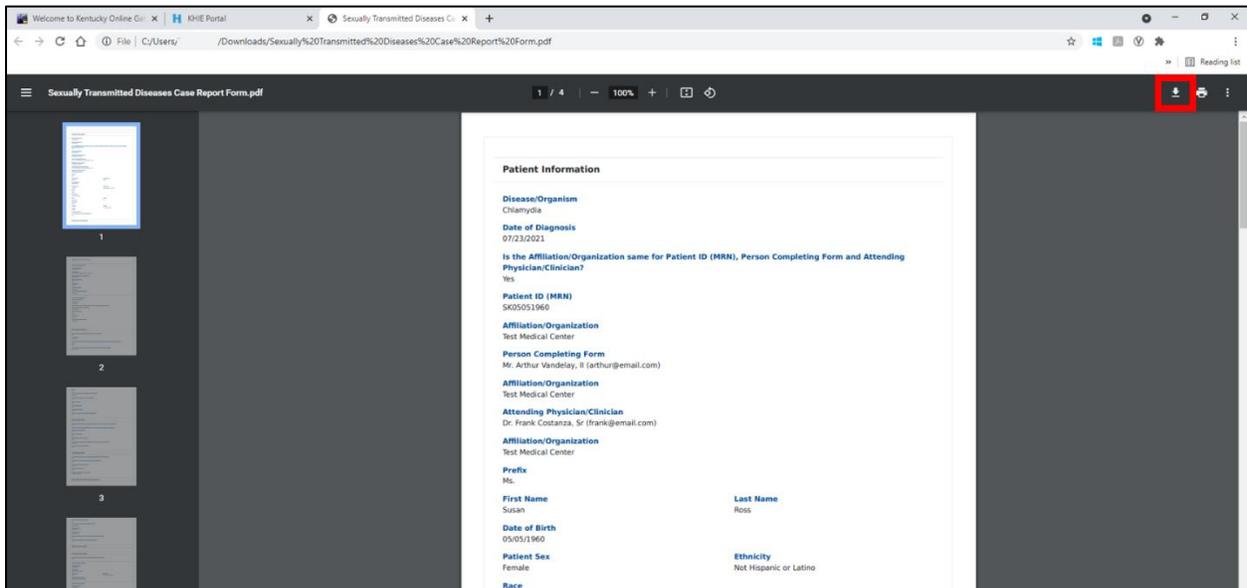


- Once the download is complete, a pop-up will display. Click **OK** to close out of the pop-up.
- To view the downloaded case report, click the **PDF** icon at the bottom left.



- 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.



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

REVIEW & SUBMIT

Print Download

Patient Information

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

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

Patient ID (MRN): SK05051960	Affiliation/Organization: Test Medical Center
Person Completing Form: Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization: Test Medical Center
Attending Physician/Clinician: Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization: Test Medical Center

Prefix: Ms.

REVIEW & SUBMIT

Print Download

Patient Information

Laboratory Information

Does the patient have a lab test? Yes

Laboratory Information

Laboratory Name: Test Laboratory

Test Name: Chlamydia sp Ag [Presence] in Urethra

4. Review the *Patient Information* section.

Patient Information

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

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

Patient ID (MRN): SK05051960	Affiliation/Organization: Test Medical Center
Person Completing Form: Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization: Test Medical Center
Attending Physician/Clinician: Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization: Test Medical Center

Prefix: Ms.

First Name: Susan	Last Name: Ross
-------------------	-----------------

Date of Birth: 05/05/1960

Patient Sex: Female	Ethnicity: Not Hispanic or Latino	Race: Other
---------------------	-----------------------------------	-------------

Address 1: 55 Fifth Avenue

City: Lexington	State: KY	Zip Code: 40555
-----------------	-----------	-----------------

County: Fayette	Phone: (555) 555-0000	Email: susan@email.com
-----------------	-----------------------	------------------------

Is the patient currently pregnant? No

5. Review the *Laboratory Information* section.

Laboratory Information

Does the patient have a lab test?
Yes

Laboratory Information

Laboratory Name
Test Laboratory

Test Name
Chlamydia sp Ag [Presence] in Urethra

Filler Order/Accession Number
SR07232021

Specimen Source
Urine

Test Result
Positive

Test Result Date 07/26/2021 **Specimen Collection Date** 07/23/2021

Laboratory Information

Laboratory Name
Laboratory 2

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

Filler Order/Accession Number
SR07262021

Specimen Source
Stool

Test Result

6. Review the *Applicable Symptoms* section.

Additional Information ✓

Treatment Information ✓

Additional Comments ✓

Review and Submit

Applicable Symptoms

Were symptoms present during the course of illness?
Yes

Onset Date
Unknown

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

Rash
Yes

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

Fever
Yes

If yes, please enter the highest temperature:
Unknown

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

Pain in urethra
Yes

Rectal Discharge
No

Urethral Discharge
Yes

Did the patient have any other symptoms?
No

7. Review the *Medical Conditions* section.

Additional Comments ✔

Review and Submit

Medical Conditions ⬆

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

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

Neurologic impairment
No

Vision impairment
No

Substance abuse or misuse
Yes

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

Immunosuppressive condition
No

8. Review the *Travel Information* section.

Travel Information ⬆

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

Domestic travel (outside state of normal residence)
Yes

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

International travel
Yes

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

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

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

Hospitalization, ICU & Death Information ⬆

Was the patient hospitalized?
Yes

If yes, please specify the hospital name:
Test Hospital

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

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

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

Additional Information ⬆

Treatment Information ⬆

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

11. Review the *Treatment Information* section.

12. Review the *Additional Comments* section.

Click Hyperlinks to Edit

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

14. Once the appropriate edits have been made, click the **Review and Submit** tab on the side navigation bar to navigate back to the **Review and Submit** screen.

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

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

REVIEW & SUBMIT

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

Print
 Download

Patient Information

Disease/Organism Chlamydia	Date of Diagnosis 07/23/2021	
Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician? Yes		
Patient ID (MRN) SK05051960	Affiliation/Organization Test Medical Center	
Person Completing Form Mr. Arthur Vandelay, II (arthur@email.com)	Affiliation/Organization Test Medical Center	
Attending Physician/Clinician Dr. Frank Costanza, Sr (frank@email.com)	Affiliation/Organization Test Medical Center	
Prefix Ms.		
First Name Susan	Middle Name Marie	Last Name Ross
Date of Birth 05/05/1960		

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

Additional Comments

Additional comments or notes, please specify:
Additional Comments

Previous
Submit
↑

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

Treatment Information

Treatment Date
06/28/2021

Medication
Unknown

Frequency
Daily

Case Report Entry
×

All data submissions are final. Please ensure that your data is accurate before clicking on the Submit button. If you would like to make changes now, please click the Cancel button.

Cancel
Submit

Duration
Unknown

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

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

Treatment Information

Treatment Date
06/28/2021

Medication
Unknown

Frequency
Daily

Case Report Entry
×

Case Report Entry Saved Successfully

OK

Duration
Unknown

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

Congratulations! You have submitted the Sexually Transmitted Disease (STD) Case Report using KHIE's Direct Data Entry Functionality.

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

21 Case Report User Entry Summary

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

The screenshot shows the 'CASE REPORT ENTRY USER SUMMARY' interface. At the top, there are navigation tabs: Patient Search, Bookmarked Patients, Event Notifications, Lab Data Entry, and Case Report Entry. Below the title, there is a filter section for 'LAST UPDATED DATE RANGE' with 'Start Date' and 'End Date' both set to 07/29/2021. A 'Retrieve Data' button is visible. Below the filter, it says 'SHOWING 1 ITEMS' and 'APPLY FILTER'. The main table has columns for ACTIONS, REPORT TYPE, AFFILIATION/OR GANIZATION, PATIENT MRN, FIRST NAME, LAST NAME, DATE OF BIRTH, PATIENT SEX, STATUS, LAST UPDATED, and SUBMISSION DATE. The first row shows a 'View' button, MDRO report type, Test Medical Center affiliation, CK08101955 MRN, Cosmo Kramer patient, 08/10/1955 birth date, Male sex, Complete status, and 07/29/2021 4:05 PM last updated and submission dates. Navigation buttons (First, Back, 1, Next, Last) and a 'Maximum 5 entries per page' dropdown are at the bottom.

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 is similar to the previous one but shows a calendar pop-up for July 2021. The 'Start Date' and 'End Date' fields are highlighted with red boxes and contain 07/26/2021 and 07/29/2021 respectively. The calendar shows the dates from the 27th to the 31st of July, with the 26th, 27th, 28th, and 29th highlighted in blue. The 'Retrieve Data' button is also highlighted with a red box.

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

This screenshot shows the result after clicking 'Retrieve Data'. The 'Start Date' and 'End Date' fields are now 07/27/2021 and 07/29/2021. The 'Retrieve Data' button is highlighted with a red box. The table below shows the same patient information as before, but the 'LAST UPDATED' and 'SUBMISSION DATE' are now 07/29/2021 4:05 PM.

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

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

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date End Date [Retrieve Data](#)

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

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

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date End Date [Retrieve Data](#)

SHOWING 3 ITEMS [APPLY FILTER](#)

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

First Back **1** Next Last Maximum 5 entries per page

- The Filter fields display. You can search by entering the **Report Type, Affiliation/Organization, Patient MRN, First Name, Last Name, Date of Birth, Patient Sex, Status, Last Updated Date,** and/or **Submission Date** in the corresponding Filter fields.

CASE REPORT ENTRY USER SUMMARY

LAST UPDATED DATE RANGE Start Date End Date [Retrieve Data](#)

SHOWING 3 ITEMS [HIDE FILTER](#)

ACTIONS	REPORT TYPE	AFFILIATION/OR ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
	<input type="text" value="Enter Report"/>	<input type="text" value="Enter Affiliatic"/>	<input type="text" value="Enter Patient"/>	<input type="text" value="Enter First Na"/>	<input type="text" value="Enter Last"/>	<input type="text" value="Enter Date Of Bir"/>	<input type="text" value="All"/>	<input type="text" value="Enter Statu"/>	<input type="text" value="All"/>	<input type="text" value="All"/>
View	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
Continue	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
View	STD	Test Medical Center	SK05051960	Susan	Ross	05/05/1960	Female	Complete	07/28/2021 7:00 PM	07/28/2021 7:00 PM

First Back **1** Next Last Maximum 5 entries per page

Review Previously Submitted Case Reports

- 6. 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		07/26/2021		End Date		07/29/2021		Retrieve Data		
SHOWING 3 ITEMS										
APPLY FILTER										
ACTIONS	REPORT TYPE	AFFILIATION/OR GANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX	STATUS	LAST UPDATED	SUBMISSION DATE
View	MDRO	Test Medical Center	CK08101955	Cosmo	Kramer	08/10/1955	Male	Complete	07/29/2021 4:05 PM	07/29/2021 4:05 PM
Continue	Other Conditions	Test Medical Center	DM02151980	Daphne	Moon	02/15/1980	Female	In Progress	07/29/2021 11:27 AM	
View	STD	Test Medical Center	SK05051960	Susan	Ross	05/05/1960	Female	Complete	07/28/2021 7:00 PM	07/28/2021 7:00 PM

First Back 1 Next Last Maximum 5 entries per page

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

Case Report Details

Print **Download**

Patient Information

MDRO Type
Candida auris, clinical

Organism Name
Infection caused by Candida auris

Date of Diagnosis
07/23/2021

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

Patient ID (MRN)
CK08101955

Affiliation/Organization
Test Medical Center

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

Affiliation/Organization
Other

If other, please specify:
Test Hospital

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

Affiliation/Organization
Test Medical Center

First Name
Cosmo

Middle Name
Newman

Last Name
Kramer

Suffix
III

Date of Birth
08/10/1955

Patient Sex

Ethnicity

Race

OK

Continue In-Progress Case Reports

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

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

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

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

Section 8 of 10

Please provide any treatment information related to this case.

TREATMENT INFORMATION

<ul style="list-style-type: none"> <li style="border-bottom: 1px solid #ccc; padding: 5px;">Patient Information ✔ <li style="border-bottom: 1px solid #ccc; padding: 5px;">Laboratory Information ✔ <li style="border-bottom: 1px solid #ccc; padding: 5px;">Applicable Symptoms ✔ <li style="border-bottom: 1px solid #ccc; padding: 5px;">Medical Conditions ✔ <li style="border-bottom: 1px solid #ccc; padding: 5px;">Travel Information ✔ <li style="border-bottom: 1px solid #ccc; padding: 5px;">Hospitalization, ICU & Death Information ✔ <li style="border-bottom: 1px solid #ccc; padding: 5px;">Additional Information ✔ <li style="background-color: #0056b3; color: white; padding: 5px;">Treatment Information 	<p>Is the patient undergoing any treatment for this disease?*</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Unknown"/></p> <p>Treatment Information</p> <p>Treatment Date</p> <p>mm/dd/yyyy <input type="text"/> <input type="checkbox"/> Unknown</p> <p>Medication</p> <p>Select... <input type="text"/></p> <p>If other, please specify: <input type="text"/></p>
--	---

22 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.

