

Kentucky Health Information Exchange (KHIE)

# Direct Data Entry for Case Reports: Acute Hepatitis A

User Guide

February 2023



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## **Document Control Information**

## **Document Information**

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## 1 Introduction

#### Overview

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

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

#### Supported Web Browsers

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

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

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

#### **Mobile Device Considerations**

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



#### Accessing the ePartnerViewer

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

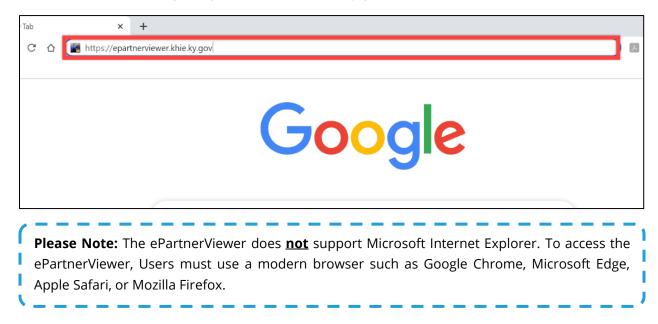
- 1. Users must be part of an organization with a signed Participation Agreement with KHIE.
- 2. Users are required to have a Kentucky Online Gateway (KOG) account.
- 3. Users are required to complete Multi-Factor Authentication (MFA).

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

## 2 Logging into ePartnerViewer

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

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





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

	Sign in with your Kentucky Online Gateway (KOG) Account (UAT) Email Address	
	Next	
	Create New Account Resend Account Verification Email	
	English 🖌 Help	

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

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	****	
COLUMN TWO IS NOT	Verify with your password	A
	(8) khie_SIT_TEST_44@mailinator.com	and the second
	Password	and the second
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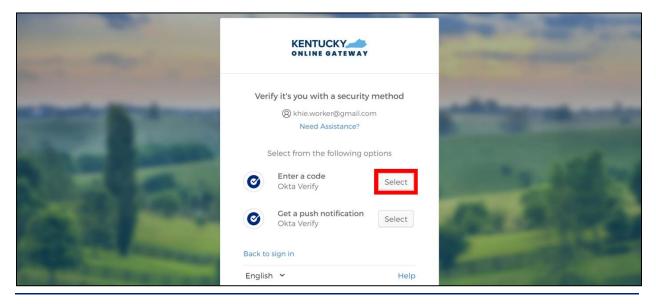
- 4. **Multi-Factor Authentication**. After logging into KOG and verifying your password, you are automatically navigated to the **Verify it's you with a security method** screen. You will be asked to complete Multi-Factor Authentication (MFA) using Okta Verify. Users have two (2) options for completing Okta Verify for MFA:
  - Use a security code from the Okta Verify app.
  - Use the push notification from the Okta Verify app.

State Britsman	Verify it's you with a security method (2) khie.worker@gmail.com Need Assistance?	- and the second
	Select from the following options           Image: Select from the following options	
	Get a push notification         Select           Okta Verify         Select	See a second
the second second second	Back to sign in English Y Help	

#### Security Code from Okta Verify App

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

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



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

435 at 1018 1	1:25	µ   1-Mode ♥. 6:05 PM + 11	1:25
	S sso.uat.kog.ky.gov	3 Touch ID for "Okta Verify" Welf your deterty to continue. Cancel	so.uat.kog.ky.gov He user lignal.com 797 518 4 Launch Daihboard 2

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

Statement of the second se		
	Enter a code	
States and States	Ø khie.user@gmail.com Need Assistance?	Contraction of the local division of the loc
	Enter code from Okta Verify app	
2460 March	797518	ADA ADDING
and the second	Verify	and the second
THE REAL PROPERTY AND INCOME.	Verify with something else	
	Back to sign in	And a second

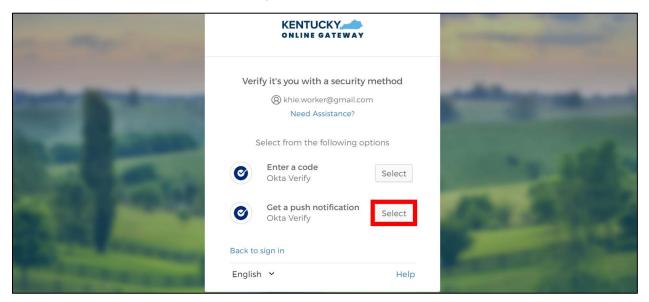
**Please Note:** Once you enter the code from the Okta Verify app, you are automatically navigated to the **Terms and Conditions of Use** screen. For more information, please review the *Terms and Conditions of Use and Logging In* sub-section of this chapter.



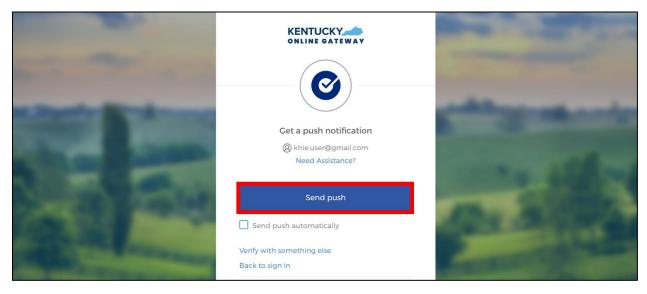
#### Push Notification from Okta Verify App

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

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

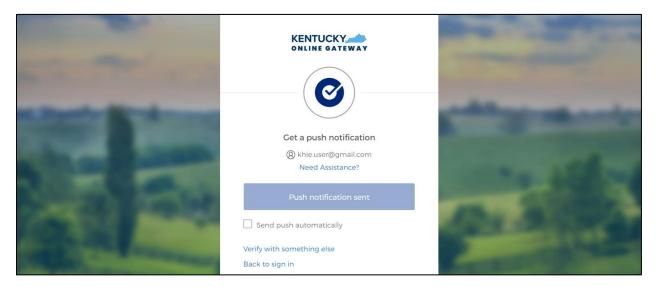


2. The Get a push notification screen displays. Click Send Push.

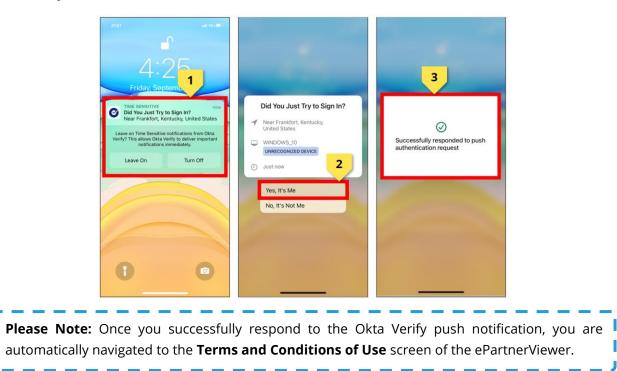


**Please Note:** Once the push notification has been successfully sent to the Okta Verify app, the **Get a push notification** screen of the ePartnerViewer displays a grayed out **Push notification sent** button.





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





#### Terms and Conditions of Use and Logging In

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

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

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

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

Terms and Conditions	You are part of the below mentioned organization.
<ul> <li>I accept the following terms and conditions of the Kentucky Health Information Exchange (KHIE):</li> <li>I am a healthcare provider currently treating a patient.</li> <li>I am currently bound by a Health Information Exchange Participation Agreement with the Division of Health Information or have a current relationship as an authorized user of a participating provider of the Division of Health Information.</li> <li>I understand that data available on KHIE is only that information available according to state and federal law.</li> </ul>	Please click on proceed to continue. KHIE Smoke Test Organization Proceed to Portal Cancel
<ul> <li>HIV medical procedures and test.</li> <li>Diagnosis codes associated with alcohol abuse and drug treatment program records and NDC codes of drugs associated with the treatment of those patients.</li> <li>I understand that all data available on KHIE WILL NOT include HIV medical procedures and tests, regardless of source.</li> <li>Select 'I accept' to accept the usage terms and conditions.</li> </ul>	
✓ Accepted	

**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**.

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## 3 Understanding the Case Report Entry Dropdown Menu

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

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

KĤIE	ePartnerViewer	Support	📢 Announcements 2 🔺 Adv	risories 🚹 😫 🔫	
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -	
Home				Case Report Forms	>
Announcement:	eHealth Summit			Case Report Entry User Summary	y
		•••		Manage User Preferences	>

#### 1. Types of Case Reports:

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

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

#### Sexually Transmitted Disease (STD) Case Report:

Designed for Users to enter STD case reports.

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

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

Designed for Users to enter MDRO case reports.

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





#### **Other Reportable Conditions Case Report:**

Designed for Users to enter Other Reportable Conditions case reports.

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

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry +
A Home				Case Report Forms
Announcement: Test				COVID-19
Announcement: Test				Sexually Transmitted Diseases
				Multi-drug Resistant Organism
		myDASHBOARD		Other Reportable Conditions
QUICK SEARCH				Hepatitis Case Report Forms

- 2. Types of Hepatitis Case Reports:
- Perinatal Hepatitis Case Report:
  - Designed for Users to enter Perinatal Hepatitis case reports.

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

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

#### Child Hepatitis Case Report:

Designed for Users to enter Child Hepatitis case reports.

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

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#### Acute Hepatitis Case Reports:

Designed for Users to choose between the two (2) types of Acute Hepatitis case reports.

Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry •	Case Report Entry -
😭 Home				Case Report Forms
Advisory: NEWLY CREATED ALERT				COVID-19
Advisory: NewLT CREATED ALERT		••••		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
		myDASHBOARD		Other Reportable Conditions
QUICK SEARCH				Hepatitis Case Report Forms
				Perinatal Hepatitis
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Child Hepatitis
				Acute Hepatitis Case Report Forms

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#### Deloitte. Direct Data Entry for Acute Hepatitis A Case Reports



- 3. Types of Acute Hepatitis Case Reports:
  - Acute Hepatitis A Case Report:
    - Designed for Users to enter Acute Hepatitis A case reports.

#### Acute Hepatitis C Case Report:

Designed for Users to enter Acute Hepatitis C case reports.

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

KHIE   ePartnerView	wer		🗷 Support 📢 Annour	ncements 🏮 🌲 Advisories 🌒 😫 SIT_TEST 44 *
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry ~	Case Report Entry -
A Home				Case Report Forms
Advisory: Updated Active advisory on 10/7/2022 7:58	-52 AM			COVID-19
Advisory: Opdated Active advisory on 10/7/2022 7.56	.55 AM	•••		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
		myDASHBOARD		Other Reportable Conditions
QUICK SEARCH				Hepatitis Case Report Forms
				Perinatal Hepatitis
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Child Hepatitis
				Acute Hepatitis Case Report Forms
BOOKMARKED PATIENTS 3		EVENT NOTIFICATIONS	(PAST 72 HOURS)	Hepatitis A
📕 ARHJOHN, JIM		There is no data	o be displayed	Hepatitis C
ABRAHAM, ALEXANDERS				
CVVUVIXJDNDTL, QHONARTRFZCHQDQFHSO				
TOWNSEND, ERIC				
WAYNE, ROBERT				
> VIEW ALL BOOKMARKED PATIENTS		₿ REFRESH > VIEW	ALL NOTIFICATIONS	

**Please Note**: The Acute Hepatitis B case report and the *Direct Data Entry for Case Reports: Acute* Hepatitis B User Guide will be available after 3/31/2023.

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#### 4. Case Report Entry User Summary:

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- 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".

<b>KÂJE</b> Patient Search	ePartnerViewer	Support Support	📢 Announcements 2 🌲 Au Lab Data Entry 🗸	dvisories 1 😫 -	
Home				Case Report Forms	>
Announcement:	Provider Assistance Program deadline extensi	on		Case Report Entry User Summar	у
		•••		Manage User Preferences	>

#### 5. Manage User Preferences:

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

KĤIE	ePartner\	/iewer 🔤	🛿 Support 🛛 📢 Ann	ouncen	nents 2 🌲 Ad	dvisories 1 🕘 🔹
Patient Search	Bookmarked Pati	ents Event Notific	cations	Lab [	Data Entry <del>-</del>	Case Report Entry 🕶
🖀 Home						Case Report Forms
Announcement: el	Health Summit					Case Report Entry User Summary
			•			Manage User Preferences
					Create Attend	ing Physician/Clinician Details
		myDASH	BOARD		View & Edit A	ttending Physician/Clinician Details
QUICK SEARCH					Create Persor	n Completing Form Details
First	Las	t	Date Of	_	View & Edit Pe	erson Completing Form Details
Name	Nar	ne	Birth	mm	Create Order	ng Provider/Clinician Details
			_		View & Edit O	rdering Provider/Clinician Details
BOOKMARKED PA	ATIENTS	EVENT	NOTIFICATIONS	(PAST	72 HOURS)	i



## 4 Manage User Preferences

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

<b>KĤIE</b> ePar	nents 🤰 🔺 Alerts 🅦 🤤 🔹			
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry ▼
A Home				Case Report Forms
Announcement: eHealth Summi	1			Case Report Entry User Summary
		•••		Manage User Preferences
		myDASHBOARD		

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

<b>KĤIE</b>   ePartne	erViewer		🔤 Support 📢 Ann	iouncements 💈 🔺 Alerts 🚹 🔮 🔹
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry 🕶	Case Report Entry -
Home				Case Report Forms
Announcement: eHealth Summit				Case Report Entry User Summary
				Manage User Preferences
				Create Interviewer Information Details
		myDASHBOARD		View & Edit Interviewer Information Details
QUICK SEARCH				Create Attending Physician/Clinician Details
				View & Edit Attending Physician/Clinician Details
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Create Person Completing Form Details
				View & Edit Person Completing Form Details
BOOKMARKED PATIENTS	6	EVENT NOTIFICATIONS	(PAST 72 HOURS)	0

~



- 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.

Prefix       Last Name*         First Name*       Last Name*         Suffix		ATTENDING PHYSICIAN/CLINICIAN
belect     ✓       II     Address 2       III     Unit, Suite, Building, etc.       IV     State*       Ir     Select	Dr. x V	
Jr Select V	Şelect   ♥ II	
(XXX) XXX-XXXX name@domain.com	Jr Sr	Select V

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

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

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

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



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

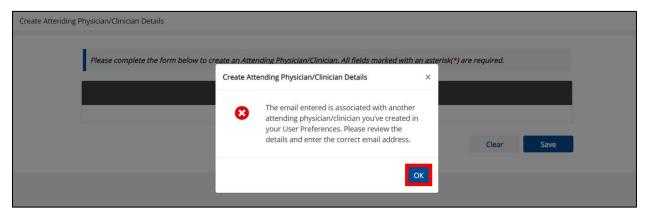
Phone* (XXX) XXX-XXXX	Email* name@domain.com
	ed in the <i>Phone</i> and <i>Email</i> fields is not entered in the displays that prevents you from proceeding to the next

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

ATTI	ENDING PHYSICIAN/CLINICIAN		
Prefix			
Dr. ×   ~			
First Name*	Last Name*		
Frank	Costanza		
Suffix			
Sr × v			
Address 1*	Address 2		
1 First Street	1A		
City*	State*		Zip Code*
Lexington	KY	×   ~	40123
Phone*	Email*		
(111) 111-1111	frank@email.com		
			Clear Sav
ease Note: If you enter an email anysician/Clinician and click <b>Save</b> , a p Present of the second state of	op-up displays with an error <i>another physician/clinician</i>	r message that n you've create	t states:
afaran and Dlama was investigated to the state	and anatana the ananana and anar - 1		
references. Please review the details ar	nd enter the correct email ada	ll ess.	







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

Create Attending Physician/Clinician Details			
Please complete the form below to cr	eate an Attending Physician/Clinician. All fields marked with	h an aste	erisk(*) are required.
	Create Attending Physician/Clinician Details	×	
	Attending Physician/Clinician details saved successfully		
	I	ОК	Clear Save

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

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

KĤIE	ePartnerViewer	<b>a</b> s	🖙 Support 📢 Announcements 🔉 🌲 Alerts 🕦 😫						
Patient Search	n Bookmarked Patients	Event Notifications Lab	Data Entry -	Case Report Entry -					
Home > View	Home > View & Edit Attending Physician/Clinician Details								
• VIEW &	♥ VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS								
SHOWING 2 ITEMS	showing 2 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						
	First Back	1 Next Last		Maximum 5 🕶 entries per page					





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

Patient Sea	rch Bookr	Update Attending Physician/Clin	ician Details	×	÷	Case Report Entry *
🖀 Home > 🕔	/iew & Edit Attending Physician/Clinici	Prefix Dr. X V				
	EDIT ATTENDING	First Name*	Last Name*			
UTEW C	KEDIT ATTENDING	Frank	Costanza			
SHOWING 2 ITEMS		Suffix Sr X V				
ACTIONS	NAME	31			IE NUMBER	\$
	-	Address 1*	Address 2			
	Dr. Frank Costanza, Sr	1 First Street	1A		111-1111	
	Ms. Helen Seinfeld	City*	State*	Zip Code*	789-1011	
		Lexington	КY ×   ~	40123		
		Phone*	Email*			Maximum 5 👻 entries per page
		(111) 111-1111	frank@email.com			
				_		
			Cancel	Save		

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

SHOWING 2 ITEMS		Update Attending Physician/Clinician Details	×		
ACTIONS	NAME	Attending Physician/Clinician details updated successfully		٠	PHONE NUMBER \$
	Dr. Frank Costanza, Sr		ĸ		(111) 111-1111
	Ms. Helen Seinfeld	ОК			(456) 789-1011

#### **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.

KÎLIE	ePartnerViewer	2	Support 📢 Announcements 2	🔺 Alerts 🅦 🤮 🔹				
Patient Search	Bookmarked Patients	Event Notifications Lat	o Data Entry -	Case Report Entry -				
Home > View 8	Edit Attending Physician/Clinician Details							
• VIEW & E	♥ VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS							
SHOWING 2 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					
	First Back	Next Last		Maximum 5 🕶 entries per page				



15. The Delete Attending Physician/Clinician Information Details pop-up displays. To delete the Physician/Clinician, click **OK**. Click **Cancel** if you do not want to delete the Physician/Clinician.

● VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS								<b>T</b> APPLY FILTER
SHOWING 1 ITEMS		Delete Attending Physician/Clinic	cian ×	-				
ACTIONS	NAME				\$	PHONE NUMBER		٠
	Dr. Frank Costanza, Sr	Are you sure?				(111) 111-1111		
		Fin	OK				Maximum 5	✓ entries per page

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.

2 ITEMS		Delete Att	ending Physician/Clinician Details	×			
ACTIONS	NAME	0	This attending physician/clinician information is being used in one of the case reports that is		PHONE N	NUMBER	+
	Ms. Helen Seinfeld		s being used in one of the case reports that is still in progress. To delete this attending physician/clinician, please ensure that this		(456) 785	9-1011	
	Dr. Frank Costanza, Sr		attending physician/clinician is not being used in any case report that is in progress.		(111) 111	1-1111	



#### Filter Attending Physician/Clinician Details

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

<b>Î Î Î</b>	ePartnerViewer		🖬 Support 🛛 📢 Announcements 🤒	🜲 Alerts 🚹 😫
Patient Sea	arch Bookmarked Patien	nts Event Notifications	Lab Data Entry 🕶	Case Report Entry +
👫 Home 🖒 🕅	View & Edit Attending Physician/Clinician Details			
VIEW 8	& EDIT ATTENDING PHYSIC	IAN/CLINICIAN DETAILS		
SHOWING 2 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	
		First Back 1 Next Last		Maximum 5 - entries per p

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

KĤIE	ePartnerViewer	2	Support 📢 Announcements 2 🔺 Alerts 1 🤤 🔹					
Patient Search	Bookmarked Patients	Event Notifications Lat	) Data Entry • Case Report Entry •					
Home > View 8	& Edit Attending Physician/Clinician Details							
• VIEW & EI	VIEW & EDIT ATTENDING PHYSICIAN/CLINICIAN DETAILS							
SHOWING 2 ITEMS								
ACTIONS	NAME Enter NAME	EMAIL Enter EMAIL	PHONE NUMBER Enter PHONE NUMBER					
	Dr. Frank Costanza, Sr	frank@email.com	(111) 111-1111					
	Ms. Helen Seinfeld	helen@email.com	(456) 789-1011					
	First Back	1 Next Last	Maximum 5 • entries per page					





#### **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.

KHIE ePartnerViewer			Support 📢 Announceme	nts 2 🔺 Alerts 1 🤤 🔹
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry *
A Home				Case Report Forms
Announcement: eHealth Summit				Case Report Entry User Summary Manage User Preferences
	0 • 0			

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

KĤIE	ePartnerView	er		🖂 Support 🛛 📢 Anno	puncements 2 🔺 Alerts 1 🔮 🔹
Patient Search	Bookma	rked Patients E	vent Notifications	Lab Data Entry -	Case Report Entry +
Home					Case Report Forms
<b>▲</b> Alert: !@#\$%^&*()_+	⊷010\`				Case Report Entry User Summary
			•••		Manage User Preferences
					Create Interviewer Information Details
		myD	ASHBOARD		View & Edit Interviewer Information Details
QUICK SEARCH					Create Attending Physician/Clinician Details
					View & Edit Attending Physician/Clinician Details
First Name		Last Name	Date Of Birth	mm/dd/yyyy	Create Person Completing Form Details
					View & Edit Person Completing Form Details
BOOKMARKE	D PATIENTS		EVENT NOTIFICATIONS (	PAST 72 HOURS)	() ()

- 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.

Prefix   Mr.   X   First Name*   Last Name*   Suffix   Suffix   II   Address 2   II   Unit, Suite, Building, etc.   IV   Jr   Sr	Please complete the form below to create a P	erson Completing Form. A	ll fields marked with an asterisk(*) are red	quired.
Mr. × ✓ First Name* Suffix Select II II IV Jr Sr Email* Last Name* Last		PERSON COMP	LETING FORM	
Suffix  \$elect  ↓   Select  ↓   State* Zip Code*  ↓  ↓  ↓  ↓  ↓  ↓  ↓  ↓  ↓  ↓  ↓  ↓  ↓				
belect   II   III   III   IV   Jr   Sr	First Name*		Last Name*	
III Unit, Suite, Building, etc. IV Jr Sr Email* Unit, Suite, Building, etc. Zip Code* Zip Code* Email*				
Jr Select V	II III			
Email*	IV Jr			
(XXX) XXX-XXXX name@domain.com			Email* name@domain.com	

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Direct Data Entry for Acute Hepatitis A Case Reports



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

First Name*	Last Name*	

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

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

#### 8. Enter the **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.

\_ \_ \_ \_ \_ \_ \_

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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

PERSO	ON COMPLETING FORM		
Prefix			
Mr. ×   ~			
First Name*	Last Name*		
Arthur	Vandelay		
Suffix			
II ×   ×			
Address 1*	Address 2		
22 Second Avenue	Unit, Suite, Building, etc	-	
City*	State*		Zip Code*
Lexington	КҮ	x   ~	40222-
Phone*	Email*		
(222) 222-2222	arthur@email.com		
			Clear Save



**Please Note:** If you enter an email address that is already associated with another Person Completing Form and click **Save**, a pop-up displays with an error message that states: *The email entered is associated with another person you've created in your User Preferences. Please review the details and enter the correct email address.* 

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

Please complete the form below to create a Person Completing Form. All fields marked with an as	terisk(*,	) are required.	
Create Person Completing Form Details	×		
The email entered is associated with another person you've created in your User Preferences. Please review the details and			
enter the correct email address.	_	Clear	Save
	ОК		

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

Please complete the form below to create a Person Completing Form. All fields marked with an asterisk(*) are required.						
	Create Person Completing Form Details	×				
	Person Completing Form details saved successfully					
		ОК		Clear	Save	



#### **View & Edit Person Completing Form Details**

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

Home View & Edit Person Completing Form Details							
• VIEW 8	EDIT PERSON COMPLETI	NG FORM	DETAILS	<b><i>R</i>EFRESH T</b> APPLY FILTER			
SHOWING 2 ITEMS							
ACTIONS	NAME	•	EMAIL	♥ PHONE NUMBER			
	Mr. Arthur Vandelay, II		arthur@email.com	(222) 222-2222			
	Dr. Estelle Costanza		estelle@email.com	(111) 123-1111			
		First Back 1	Next Last	Maximum 5 🕶 entries per page			

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

<b>KHIE</b> ePartnerVie	wer	1	🖾 Support 🛛 🗬		🌲 Alerts 🚹	θ.
Patient Search Bool	r Update Person Completing Form I	Details	×		Case Rej	port Entry +
Home > View & Edit Person Completing Form	Prefix Mr. ×   ~					
VIEW & EDIT PERSON CO	First Name*	Last Name* Vandelay			<b>C</b> REFRESH	<b>T</b> APPLY FILTER
SHOWING 2 ITEMS	Suffix II × V					
ACTIONS NAME				E NUMBER		\$
Mr. Arthur Vandelay, Il	Address 1* 22 Second Avenue	Address 2 Unit, Suite, Building, etc.		222-2222		
Dr. Estelle Costanza	City* Lexington	State*	<b>Zip Code*</b> 40222	123-1111		
	Phone* (222) 222-2222	Email* arthur@email.com			Maximum 5	<ul> <li>entries per page</li> </ul>
		Cancel	Save			

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

• VIEW &	REFRESH TAPPLY FILTER					
SHOWING 2 ITEMS		Update Person Completing Form Details	×			
ACTIONS	NAME	Person Completing Form details updated successfully		÷	PHONE NUMBER	٥
	Mr. Arthur Vandelay, II		ок		(222) 222-2222	
	Dr. Estelle Costanza		UK		(111) 123-1111	
	First Back 1 Next Last Maximum 5 - entries per page					



#### **Delete Person Completing the Form Details**

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

VIEW & ED						
SHOWING 2 ITEMS						
ACTIONS	NAME	EMAIL \$	PHONE NUMBER \$			
	Mr. Arthur Vandelay, Il	arthur@email.com	(222) 222-2222			
	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111			

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

• VIEW &						
2 ITEMS Delete Person Completing Form Details ×						
ACTIONS	NAME	Are you sure?	- 1	٠	PHONE NUMBER	\$
	Mr. Arthur Vandelay, II				(222) 222-2222	
	Dr. Estelle Costanza	Cancel			(111) 123-1111	

**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 inprogress. 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 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.

SHOWING 2 ITEMS		Delete Pe	rson Completing Form Details	×			
ACTIONS	NAME	0	This person information is being used in one		¢	PHONE NUMBER	÷
	Mr. Arthur Vandelay, II	Ű	of the case reports that is still in progress. To delete this person, please ensure that this person is not being used in any case report			(222) 222-2222	
	Dr. Estelle Costanza		that is in progress.			(111) 123-1111	
	1	ir.	C	К			Maximum 5 • entries per page

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#### Filter Person Creating Form Details

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

Patient Sear	rch Bookmarked Patients	Event Notifications	Lab Data Entry - Case Report	t Entry <del>*</del>
🕈 Home 💙 V	/iew & Edit Person Completing Form Details			
VIEW 8	EDIT PERSON COMPLETING	FORM DETAILS		<b>Y</b> APPLY FILTE
2 ITEMS	NAME	€ EMAIL	PHONE NUMBER	
	NAME Dr. Estelle Costanza	EMAIL     estelle@email.com	<ul> <li>PHONE NUMBER</li> <li>(111) 123-1111</li> </ul>	

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

Ø VIEW & E	DIT PERSON COMPLETING FORM	DETAILS	
SHOWING 2 ITEMS			
ACTIONS	NAME Enter Name 🗢	EMAIL Enter Email 🕈	PHONE NUMBER         Enter Phone Number
	Dr. Estelle Costanza	estelle@email.com	(111) 123-1111
	Mr. Arthur Vandelay, II	arthur@email.com	(222) 222-2222
	First Back	Next Last	Maximum 5 🗸 entries per page



## 5 Basic Features in the Case Report Entry Form

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

#### Side Navigation Bar & Pagination

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

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

ACUTE HEPATITIS A CASE REPORT FORM	Section 2 of 8
Please provide laboratory information related to this case	e.
	LABORATORY INFORMATION
Patient Information	Does the patient have a lab test?*
Laboratory Information	Yes No
Applicable Symptoms	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for
Exposure Information	that test.
Hospitalization, ICU & Death Information	
Vaccination History	Hepatitis Marker Select
Additional Comments	Results
Review & Submit	Select v
	If applicable, please enter the viral load:
	Laboratory Name:
	ALT
	AST
	Bilirubin
	Add Bilirubin
	Save Previous Next



#### Save Feature

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

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



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

Clinical Course	Ø	Patient ID (MRN)	Save Changes? ×	
Applicable Symptoms	$\odot$	SR04011960	There's information on this screen that has not been saved.	
Medical Conditions	$\odot$	First Name*	Do you want to save it?	Last Name*
Exposure Information	$\odot$	Susan	No - Discard Yes - Save	Ross
Hospitalization, ICU & Death Information	$\odot$	Suffix		

#### **Case Report Entry Icons**

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

#### Icon Descriptions:

lcon	Name	Description
Section 8 of 10	Progress Bar	Indicates the percentage of completion.
	Lock	Indicates the sections that are not yet accessible; Users must enter all the required fields on the current screen and click <b>Next</b> to unlock the next screen.
$\bigotimes$	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 Acute Hepatitis A Case Report has multiple screens with conditional questions. Based on the answer selected for conditional questions, certain subsequent fields on the screen will be enabled or grayed out and disabled.

• For example, if you select **No** to the conditional question at the top of the **Laboratory Information** screen of the Acute Hepatitis A Case Report, the subsequent fields will be grayed out and disabled.

ACUTE HEPATITIS A CASE REPOR	T FORM	Section 2 of 8
Please provide laboratory information relate	ed to this case	h.
		LABORATORY INFORMATION
Patient Information	0	Does the patient have a lab test?*
Laboratory Information		Yes No
Applicable Symptoms	۵	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for
Exposure Information	<b>A</b>	that test.
Hospitalization, ICU & Death Information	۵	
Vaccination History	<b>a</b>	Hepatitis Marker
Additional Comments		Results
Review & Submit	۵	Select
		If applicable, please enter the viral load: $oldsymbol{\Theta}$
		Test Result Date Specimen Collection Date mm/dd/yyyy Unknown mm/dd/yyyy Unknown
		Laboratory Name:

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

		LABORATORY INFORMATION
Patient Information	Ø	Does the patient have a lab test?*
Laboratory Information		Yes No
Applicable Symptoms	<b>a</b>	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for
Exposure Information	<b>a</b>	that test.
Hospitalization, ICU & Death Information	<b>a</b>	
Vaccination History	<b>a</b>	Hepatitis Marker* Select
Additional Comments	<b>a</b>	Results*
Review & Submit	<b>a</b>	Select V
		If applicable, please enter the viral load: 📀
		Test Result Date* Specimen Collection Date*
		Laboratory Name:*
		Add Hepatitis Marker

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

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

ACUTE HEPATITIS A CASE REPORT F	RM	Section 3 of 8
Please select applicable symptoms that the patient	experienced during illness.	
	APPLICABLE SYMPTOMS	
Patient Information	Were symptoms present during the course of illness?*	
Laboratory Information	⊘ Yes No Unknown	
Applicable Symptoms		
Exposure Information	Onset Date      mm/dd/yyyy     Duknown	
Hospitalization, ICU & Death Information	<b>A</b>	
Vaccination History	If symptomatic, which of the following did the patient experience during their illness? Fever	
Additional Comments	Yes No Unknown	
Review & Submit	If yes, please enter the highest temperature: @	
	Diarrhea (>3 loose stools/24lrr period) Yes No Unknown If yes, please enter # of days of diarrhea: @	
	Abdominal pain Yes <b>No</b> Unknown	
	Anorexia Yes No Unknown	
	Arthralgia Yes No Unknown	
	Clay Colored Stools Ves No Unknown	
	Dark urine Yes No Unknown	

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

	APPLICABLE SYMPTOMS
Patient Information	Were symptoms present during the course of illness?*     Yes No Unknown
Laboratory Information	
Applicable Symptoms	Onset Date @
Exposure Information	mm/dd/yyyy 👔 🗋 Unknown
Hospitalization, ICU & Death Information	<u>۵</u>
Vaccination History	If symptomatic, which of the following did the patient experience during their illness?     Fever
Additional Comments	Ves No Unknown
Review & Submit	If yes, please enter the highest temperature: 🚱
	Diarrhea (>3 losse stools/24hr period)   Yes No   Unknown   Abdominal pain   Yes No   Unknown   Anorexia   Yes No   Unknown

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

ACUTE HEPATITIS A CASE REPORT FORM		Section 3 of 8
Please select applicable symptoms that the patient experienced	during illness.	
	APPLICABLE SYMPTOMS	
Patient Information	Were symptoms present during the course of illness?*	
Laboratory Information	Yes No Unknown	
Applicable Symptoms		
Exposure Information	Onset Date*  mm//dd/yyyy Unknown	
Hospitalization, ICU & Death Information	mm/dd/yyyyr	
Vaccination History	If symptomatic, which of the following did the patient experience during their it	liness?
Additional Comments	Fever* Yes No Unknown	
Review & Submit	If yes, please enter the highest temperature:	
	Diarrhea (>3 loose stools/24hr period)*	
	Yes No Unknown	
	if yes, please enter # of days of diarrhea: 😡	
	Abdominal pain* Yes No Unknown	
	Anorexia*	
	Yes No Unknown	
	Arthraigia*	
	Yes No Unknown	
	Clay Colored Stools*	
	Yes No Unknown	
	Dark urine*	
	Yes No Unknown	
	Elevated ALT > 200* Yes No Unknown	
	Elevated Bilirubin > 3.0* Yes No Unknown	
	Fatigue* Yes No Unknown	
	Headache* Yes No Unknown	
	Jaundice*	
	Yes No Unknown	
	Malaise*	
	Yes No Unknown	
	Muscle aches (myalgia)*	
	Yes No Unknown	
	Nausea*	
	Yes No Unknown	
	Vomiting*	
	Yes No Unknown	
	Did the patient have any other symptoms?*	
	Yes No Unknown If yes, please specify: @	
	e here keepen alaanala da	



## 6 Affiliation/Organization Conditional Question

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

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

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

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

Patient ID (MRN) 🚱	Affiliation/Organization 🚱	
	Select	
Person Completing Form	Affiliation/Organization 🚱	If other, please specify: 🚱
Select	Select	
Select Attending Physician/Clinician	Select Affiliation/Organization 🚱	If other, please specify: 🔞

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

## **Deloitte.** Direct Data Entry for Acute Hepatitis A Case Reports



#### 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 <u>one</u> *Affiliation/Organization* field is enabled. You must complete the Affiliation/Organization field that corresponds to the Patient ID (MRN). The *Affiliation/Organization* fields for the Person Completing Form and the Attending Physician/Clinician are disabled.
- 1. Select the **Affiliation/Organization** for the Patient ID (MRN) from the dropdown menu.

Yes No			
Patient ID (MRN)* 😧	Affiliation/Organization* 😧		
	Select		
Person Completing Form*	Affiliation/Organization 🚱	lfo	ther, please specify: 🔞
Select	✓ Select		
Select Attending Physician/Clinician*	Affiliation/Organization 🚱		ther, please specify: 😡

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

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

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#### Affiliation/Organization Conditional Answer: No

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

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

Yes No				
Patient ID (MRN)* 🚱		Affiliation/Organization* <b>@</b>		
		Select		
Person Completing Form*		Affiliation/Organization* 😧	If other, please specify: 🔞	
Select	~	Select	~	
Attending Physician/Clinician*		Affiliation/Organization* 😧	lf other, please specify: 🚱	
Select	$\sim$	Select	✓	

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

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

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

Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Mr. Arthur Vandelay, II (arthur@email.com) $~ imes~~$	Select 🗸 🗸	
	, i.e.i, itotiatittaa itoj iteettai iteataitej eee 🔺	
Attending Physician/Clinician*	eICR Onboarding Regression	lf other, please specify: 🔞
Select ~	Hilton Hospital	
	King's Daughters Medical Center	
Prefix	Murray-Calloway County Hospital	
Select 🗸	Test Medical Center	
First Name*	University Of Kentucky Chandler Medical Center	Last Name*
	Other	
Suffix	Date of Birth*	

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Deloitte.



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

Yes No Patient ID (MRN)* 🕑	Affiliation/Organization* 🚱		Please select the organization of the person completing this form (if it is not listed the
CK08101955	Test Medical Center	x   ~	Affiliation/Organization dropdown).
Person Completing Form*	Affiliation/Organization* 😧		If other, please specify:* @
Mr. Arthur Vandelay, II (arthur@em 🗙 🗸	Other	×   ~	

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

atient ID (MRN)* 🚱	Affiliation/Organization* 😧	
CK08101955	Test Medical Center X V	
erson Completing Form*	Affiliation/Organization of the	If other, please specify: <b>* 0</b>
Mr. Arthur Vandelay, II (arthur@em 🛛 🗙		Test Hospital
ttending Physician/Clinician*	Affiliation/Organization* @	If other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@emai 🗙	Select 🗸	
	Afzal, Mohammad MD, Internal Medicine, LLC	
<b>refix</b> Select	eICR Onboarding Regression	
irst Name*	Hilton Hospital	
	King's Daughters Medical Center	Last Name*
	Murray-Calloway County Hospital	
uffix	Test Medical Center	
Select	University Of Kentucky Chandler Medical	
atient Sex*	Ethnicity*	Race*

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Dr. Frank Costanza, Sr (frank@emai... 🗙 🔍

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 $\times ~|~ \sim$ 

Other



### 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?* 

SK05051960 Person Completing Form*	Test Medical Center	×   ~		
Person Completing Form*				
	Affiliation/Organization* 🚱		If other, please specify:* 😧	
Mr. Arthur Vandelay, II (arthur@email.com) $~ imes~~$	Other	$\times \mid  \checkmark$	Test Hospital	
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: 🕜	
Dr. Frank Costanza, Sr (frank@email.com) $ \times \   \ \sim$	Test Medical Center	x   ~		
s the Affiliation/Organization same for Patient ID (MR	N), Person Completing Form and Attending Physi	cian/Clinician	7*	
Yes No				
SK05051960	Affiliation/Organization* 🚱 Test Medical Center	x v		
Person Completing Form*	Affiliation/Organization 🕑		If other, please specify: 🔞	
Mr. Arthur Vandelay, II (arthur@email.com) 🗙 🗸 🗸	Test Medical Center			
Attending Physician/Clinician*	Affiliation/Organization 🚱		If other, please specify: 😧	
Dr. Frank Costanza, Sr (frank@email.com) $~~ imes~~$	Test Medical Center			
Is the Affiliation/Organization same Yes No Patient ID (MRN)* SK05051960	e for Patient ID (MRN), Person Cor t Information	mpleting	×	/Clinic
A	All selections for the "Affiliation/ be reset. Are you sure you want	-	ition" will	
Person Completing For	selection?		-	
Person Completing For Mr. Arthur Vandelay,	selection?		×	

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



### Change Affiliation/Organization Conditional Answer: No to Yes

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

Patient IN (MRN)* S	Affiliation/Organization* 😧		
SK05051960	Test Medical Center	×   ~	
Person Completing Form*	Affiliation/Organization* 😧		lf other, please specify:* 🚱
Mr. Arthur Vandelay, II (arthur@email.com) $  imes                     $	Other	×   ~	Test Hospital
Attending Physician/Clinician*	Affiliation/Organization* 😧		lf other, please specify: 🚱
Dr. Frank Costanza, Sr (frank@email.com) × v	Test Medical Center	x   ~ ]	

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

Applicable Symptoms	<u> </u>	Is the Affiliation/Organization same for Patient ID (MRN), Person Completing Form and Attending Physician/Clinician?*
Medical Conditions	۵	Yes No
Travel Information	<b>A</b>	Patient ID (MRN)*
Hospitalization, ICU & Death Information	<b>A</b>	SK05051960 All selections for the "Affiliation/Organization" will
Additional Information	<b>A</b>	Person Completing For selection? If other, please specify:* •
Treatment Information	4	Mr. Arthur Vandelay.
Additional Comments	۸	Attending Physician/Cli If other, please specify:  Dr. Frank Costanza, Sr (transcormatizon) + 1 est Medical Center + 2 + 2
Review and Submit	-	

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

There are errors. Please make a selection for all required fields.				
		PATIENT INF	ORMATION	
Patient Information		Disease/Organism* 😧	Date of Diagnosis*	
Laboratory Information	۵	Chlamydia X V	07/23/2021	Unknown
Applicable Symptoms	_		Denne Constation Francisco d'Autor d'an Dhuaisian (Clini	
Medical Conditions	_	Yes No	), Person Completing Form and Attending Physician/Clini	lan/*
Travel Information	<b>A</b>	Patient ID (MRN)* 🕑	Affiliation/Organization* 😧	
Hospitalization, ICU & Death Information	۵	SK05051960	Select 🗸	
Additional Information	۵		Please Enter Affiliation/Organization	
Treatment Information	<b>A</b>	Person Completing Form* Mr. Arthur Vandelay, II (arthur@email.com) ×   >	Affiliation/Organization 🚱	If other, please specify: 🚱
Additional Comments	_	Attending Physician/Clinician*	Affiliation/Organization 😧	If other, please specify: 🚱
Review and Submit	<b>A</b>	Dr. Frank Costanza, Sr (frank@email.com) $ \times  \lor$	Select V	

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

Is the Affiliation/Organization same for Patient ID (MRN Yes No	۱), Person Completing Form and Attending Physician/Clinic	lian?*
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
SK05051960	Select 🗸 🗸	
	Afzal, Mohammad MD, Internal Medicine, LLC	
Person Completing Form*	eICR Onboarding Regression	If other, please specify: 🔞
Mr. Arthur Vandelay, II (arthur@email.com) $~ imes~~$	Hilton Hospital	
Attending Physician/Clinician*	King's Daughters Medical Center	lf other, please specify: 🔞
Dr. Frank Costanza, Sr (frank@email.com) 🛛 🗙 🛛 🗸	Murray-Calloway County Hospital	
	Test Medical Center	
Prefix	University Of Kentucky Chandler Medical Center	
Ms. × V	oniversity of Kentucky chandler Medical Center	

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

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



### Change Affiliation/Organization Conditional Answer: Yes to No

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

atient ID (MRN)* a	Affiliation/Organization* 😧		
SK05051960	Test Medical Center	x   ~ ]	
Person Completing Form*	Affiliation/Organization 🚱		lf other, please specify: 🚱
Mr. Arthur Vandelay, II (arthur@email.com) X	Test Medical Center		
	Test Medical Center Affiliation/Organization		If other, please specify: 🚱

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

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

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

Patient ID (MRN)* 🚱	Affiliation/Organization* 😧		
CK08101955	Select	$\sim$	
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify	/: 🕲
Dr. Estelle Costanza (estelle@email $ imes$   $ imes$	Select	~	
Dr. Estelle Costanza (estelle@email ×   ~	Select Affiliation/Organization* 😧	✓ If other, please specify	/: <b>@</b>

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

Is the Affiliation/Organization same for Patient ID Yes No	(MRN), Person Comp organization where the Patient ID (MRN) was assigned to the patient.	ician?*
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	_
SR05051960	Şelect 🗸	
Person Completing Form*	Afzal, Mohammad MD, Internal Medicine, LLC	If other, please specify: 🕢
Select	✓ elCR Onboarding Regression	
Attending Physician/Clinician*	Hilton Hospital	If other, please specify: 🔞
Select	<ul> <li>King's Daughters Medical Center</li> </ul>	
	Murray-Calloway County Hospital	
Prefix	Test Medical Center	
Select	Vulue volume vol	

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

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

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

Person Completing Form*	Affiliation/Organization* 🚱		If other, please specify:* 😧
Mr. Arthur Vandelay, II (arthur@em 🗙 🗸 🗸	Other	×   ~	
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify: <b>* </b>

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# 7 Tips for Manually Entering Case Report Data

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

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

<i>Please complete the form below. All fields marked with asterisk(*) are required.</i>					
		P	ATIENT INF	ORMATION	
Patient Information		Interviewer Name*		Affiliation/Organization*	
SARS CoV-2 Testing	<b>a</b>	Select	~	Select	~,

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

Please complete the form belo	w. All fields mai	rked with asterisk/*) are required An MRN or Medical Reco Number is an Organizati specific, unique Identification Number		MATION		
Patient Information		assigned to a patient by Internet healthcare organization	If Aff	filiation/Organization*		
SARS CoV-2 Testing	<b>a</b>	Dr. your organization does n use an MRN, you MUS create a way to unique		Fest Medical Center		x   ~
Clinical Course	<b>A</b>	identify your Patient.		efix		
Applicable Symptoms	<b>A</b>			Select	~	

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

City	State	КҮ	x   ~
Zip Code	County	Şelect	•
		Adair	Î
Phone Number	Email Address	Allen	
		Anderson	
		Ballard	
		Barren	t
		Bath	
nteractive	HealthInteractive HIE	Bell	<b>,</b> /ersi

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

City	State	AR	$x \mid v$
Zip Code	County	Out Of System State	x   ~

- 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.

/	dmi	ssior	n Da	te*				Discharge Date*	
I	mm	n/dd/	уууу	/				Unknown     mm/dd/yyyy	•
Ī	4	Jun	Jur	ne 20 ~	<b>21</b>	1 🗸			
	Su	Мо	Tu	We	Th	Fr	Sa	this illness?*	
	30	31	1	2	3	4	5	Unknown	
	6	7	8	9	10	11	12	death:	
	13	14	15	16	17	18	19		
	20	21	22	23	24	25	26	🛗 🔲 Unknown	
	27	28	29	30	1	2	3		

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

Admission Date*			Discharge Date*	
mm/dd/yyyy	曲	🗸 Unknown	06/20/2021	🛗 🗌 Unknown



## 8 Acute Hepatitis A Case Report Form

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

- 1. To enter Acute Hepatitis A 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 **Hepatitis Case Report Forms** from the dropdown menu.

KHIE   ePartner	Viewer		Support 📢 Ann	ouncements 🔹 🌲 Advisories 🌢 😧 SIT_TEST 44 *
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry -
Home				Case Report Forms
Advisory: NEWLY CREATED ALERT				COVID-19
Aurisory. New Created Alexi		••••		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
		myDASHBOARD		Other Reportable Conditions
QUICK SEARCH				Hepatitis Case Report Forms
				Perinatal Hepatitis
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Child Hepatitis
				Acute Hepatitis Case Report Forms
BOOKMARKED PATIENTS	0	EVENT NOTIFICATION	NS (PAST 72 HOURS)	6
ARHJOHN, JIM		There is no dat.	a to be displayed	
ABRAHAM, ALEXANDERS				
CVVUVIXJDNDTL, QHONARTRFZCHQDQFHSO				
TOWNSEND, ERIC				

3. Click Acute Hepatitis Case Report Forms. Select Hepatitis A from the sub-dropdown menu.

KHIE   ePartnerView	wer	🛎 Support 📢 Announcements 🧿 🔺 Advisories 🕢 😝 ST_TEST 44 *		
Patient Search	Bookmarked Patients	Event Notifications	Lab Data Entry -	Case Report Entry +
🖀 Home				Case Report Forms
Announcement: announcement 6				COVID-19
A Announcement. announcement o		• • • •		Sexually Transmitted Diseases
				Multi-drug Resistant Organism
		myDASHBOARD		Other Reportable Conditions
QUICK SEARCH				Hepatitis Case Report Forms
				Perinatal Hepatitis
First Name	Last Name	Date Of Birth	mm/dd/yyyy	Child Hepatitis
				Acute Hepatitis Case Report Forms
BOOKMARKED PATIENTS		EVENT NOTIFICATIO	NS (PAST 72 HOURS)	Hepatitis A
ARHJOHN, JIM		There is no da	ta to be displayed	Hepatitis C
ABRAHAM, ALEXANDERS				
CVVUVIXJDNDTL, QHONARTRFZCHQDQFHSO				
TOWNSEND, ERIC				
WAYNE, ROBERT				
ttps://epartnerviewer.test.khie.healthinteractive.net/acute-hepatitis-a-case-report/			W ALL NOTIFICATIONS	

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## 9 Patient Information

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

ACUTE HEPATITIS A CASE REPORT	T FORM	Section 1 of 8	
Please complete the form below. All fields ma	arked with an asterisk(*) are required.		
		PATIENT INFORMATION	
Patient Information	Disease/Organism*	Date of Diagnosis*	
Laboratory Information	Hepatitis A	~ mm/dd/yyyy	iii Unknown
Applicable Symptoms			
Exposure Information	Yes No	for Patient ID (MRN), Person Completing Form, and Attendi	ng Physician/Clinician /*
Hospitalization, ICU & Death Information	Patient ID (MRN)	Affiliation/Organization 🚱	
Vaccination History	<b>▲</b>	Select	
Additional Comments	Person Completing Form	Affiliation/Organization @	If other, please specify: 🚱
Review & Submit	Select	<ul> <li>✓ Select</li> </ul>	
	Attending Physician/Clinician	Affiliation/Organization 🚱	If other, please specify: 🔞

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

		PATIENT INF	ORMATION		
tient Information	Disease/Organism* Hepatitis A	~	Date of Diagnosis* mm/dd/yyyy	<b>a</b>	Unknown
	A				
	Is the Affiliation/Organization same	for Patient ID (MRN	I), Person Completing Form, and Att	ending Physician/Clini	cian?*
spitalization, ICU & Death Information	Patient ID (MRN) @		Affiliation/Organization 🔞		
cination History			Select		
ditional Comments	Person Completing Form		Affiliation/Organization 🚱		If other, please specify: 🔞
view & Submit	Select		Select		
iew of Submit	Attending Physician/Clinician		Affiliation/Organization 🙆		If other, please specify: 🚱
	Select		Select		
	Prefix				
	Select	~			
	First Name*		Middle Name		Last Name*
	Suffix		Date of Birth*		
	Select	~	mm/dd/yyyy	Ê	
	Patient Sex*		Ethnicity*		Race*
	Select	~	Select	~	Select 🗸 🗸
	Address 1*			<b>ress 2</b> nit, Suite, Building, etc.	
	City*		State	e* lect	Zip Code*
	Countral		Phone* 😧		feed
	County* Select		(XXX) XXX-XXXX		Email name@domain.com

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	Addres	\$2	
	Unit, S	Suite, Building, etc.	
City*	State*		Zip Code*
	Select		
County*	Phone* 😧	Email	
Select 🗸	(XOX) XXX-XXXX	name@dor	nain.com
Is the patient currently pregnant?			
Yes No Unknown			
If yes, please enter the due date (EDC): 🚱			
mm/dd/yyyy 🏥 🗍	Unknown		
Prior Hepatitis A Diagnosis*			
Yes No Unknown			
If yes, please enter the date of diagnosis 😡	U la las suus		
mm/dd/yyyy	Unknown		
	PATIENT INFORM		
Patient Information Disease/Or Laboratory Information	rganism* 🚱 Date	e of Diagnosis* m/dd/yyyy	Unknown
Select	rganism* 🚱 Date		Unknown
aboratory information	rganism* 🛛 Date	n/dd/yyyy	
Laboratory Information	rganism*❷ Date I ✓ I ✓ IIII d to enter the details	associated with th	e Person Completing Form
Aboratory Information	d to enter the details	associated with th g Acute Hepatitis A	e <i>Person Completing Form</i> case report information.
Aboratory Information	nganism* @ Date Date Date Date mician prior to enterin d to ase Report withing Date	associated with th g Acute Hepatitis A thout previously e	e <i>Person Completing Form</i> case report information. ntering these details, the
Aboratory Information	nganism* @ Date Date Date Date Date Markowski and State Date Markowski and State Date Markowski Date Markowski and State Date Markowski and State Date	associated with th g Acute Hepatitis A thout previously e	e <i>Person Completing Form</i> case report information. ntering these details, the
Please Note: You are required and the Attending Physician/Clin If you access the Acute Hepat Patient Information screen is	d to enter the details nician prior to enterin itis A Case Report wi disabled and display	associated with th g Acute Hepatitis A thout previously e s an error message	e <i>Person Completing Form</i> case report information. ntering these details, the e.
Please Note: You are required and the Attending Physician/Clin If you access the Acute Hepat Patient Information screen is You must click the hyperlink as	d to enter the details nician prior to enterin itis A Case Report wi disabled and display	associated with the g Acute Hepatitis A thout previously e s an error message	e <i>Person Completing Form</i> case report information. ntering these details, the e. <b>Form</b> and the <b>Attending</b>
Please Note: You are required and the Attending Physician/Clini If you access the Acute Hepat Patient Information screen is You must click the hyperlink as Physician/Clinician located in	nganism* @ Date and to enter the details <i>nician</i> prior to enterin, itis A Case Report wi is disabled and display ssociated with the <b>Pe</b> in the error message	associated with the g Acute Hepatitis A thout previously e s an error message erson Completing panner to navigate	e <i>Person Completing Form</i> case report information. ntering these details, the e. <b>Form</b> and the <b>Attending</b> e to the appropriate <b>User</b>
Please Note: You are required and the <i>Attending Physician/Clin</i> If you access the Acute Hepat Patient Information screen is You must click the hyperlink as	nganism* ad to enter the details <i>nician</i> prior to enterin, itis A Case Report wi is disabled and display ssociated with the <b>Pe</b> in the error message ate the <i>Person Comp</i>	associated with the g Acute Hepatitis A thout previously e s an error message erson Completing banner to navigate leting Form and At	e <i>Person Completing Form</i> case report information. ntering these details, the e. <b>Form</b> and the <b>Attending</b> e to the appropriate <b>User</b>

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

Disease/Organism*		Date of Diagnosis*	
Hepatitis A	~	mm/dd/yyyy	🛗 🗌 Unknown



Г



٦

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

Yes No			
Patient ID (MRN) 🚱	Affiliation/Organization	0	
	Select		
Person Completing Form	Affiliation/Organization	0	lf other, please specify: 🚱
Select 🗸	Select		
Attending Physician/Clinician	Affiliation/Organization	0	If other, please specify: 😧
Select V	Select		

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

Patient ID (MRN)* ②       Affiliation/Organization* ③         Select       Select         Affiliation/Organization ③       If other, please specify: ④         Affiliation/Organization ④       If other, please specify: ④         Attending Physician/Clinician*       Affiliation/Organization ④         Select       If other, please specify: ④	Is the Affiliation/Organization same for P Yes No	Patient ID (MRN	I), Person Completing Form and Attending	, Physician/Clinicia	n?*
Person Completing Form*       Affiliation/Organization @       If other, please specify: @         Select       Select       If other, please specify: @         Attending Physician/Clinician*       Affiliation/Organization @       If other, please specify: @	Patient ID (MRN)* 😧				
Attending Physician/Clinician* Affiliation/Organization @ If other, please specify: @	Person Completing Form*				If other, please specify: 🚱
	Select	~	Select		
Solert Solert	Attending Physician/Clinician*		Affiliation/Organization 🕝		If other, please specify: 🔞
Selection Select	Select	~	Select		

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

Yes No				
Patient ID (MRN)* 😧		Affiliation/Organization* 😧		
		Select		
Person Completing Form*		Affiliation/Organization* 😧	If other, please specify: 🕑	
Select	~	Select	×	
Attending Physician/Clinician*		Affiliation/Organization* 😧	lf other, please specify: 🚱	
Select	~	Select	✓	



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

Patient ID (MRN)* 😧	Affiliation/Organization* 😧	
	Select	

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

Patient ID (MRN)* 😧	Affiliation/Organization* 😧	
CK08101955	Şelect ✓	
Person Completing Form*	Afzal, Mohammad MD, Internal Medicine, LLC	lf other, please specify: 😡
Attending Physician/Clinician* Select	elCR Onboarding Regression Hilton Hospital King's Daughters Medical Center	If other, please specify: 😡
Prefix Select v	Murray-Calloway County Hospital Test Medical Center University Of Kentucky Chandler Medical	

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

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

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

Is the Affiliation/Organization same for Pa	tient ID (MRN), Person Completing Form and Attendir	ng Physician/Clinician?*
Patient ID (MRN)* 😧	Affiliation/Organization* 😧	
CK08101955	Test Medical Center ×	<b>~</b>
Person Completing Form*	Affiliation/Organization 🚱	If other, please specify: 😡
Select	✓ Test Medical Center ×	
Dr. Estalla Castanza (astalla Qamail sam)	Affiliation/Organization @	If other, please specify: 🚱
Dr. Estelle Costanza (estelle@email.com)	Anniation/Organization	li otilei, please specily.

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**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

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

Person Completing Form*	 Affiliation/Organization* 😧		If other, please specify: 🚱
Select	 Select	~	

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

Please complete the form below. All fields marked w	Manage User Preferences		×		
	<i>Please complete the form below to co asterisk(*) are required.</i>	reate a Person Completing Form. All fields marked with an			
Patient Information	PERSON	I COMPLETING FORM			
Laboratory Information	Prefix			] Unknown	
Applicable Symptoms	Select V			cian/Clinician?*	
Medical Conditions	First Name*	Last Name*			
Travel Information					
Hospitalization, ICU & Death Information	Suffix				
Additional Information				If other, please specify: 🚱	
Treatment Information	H	Address 2 Unit, Suite, Building, etc.			
Additional Comments				If other, please specify: 🚱	
Review and Submit	Jr	Select Zip Code*			
	Sr	Email*			
	(XXX) XXX-XXXX	name@domain.com			
				Last Name*	_
		Cancel Save			

10. Enter the First Name and Last Name of the Person Completing the Form.

Mr.	X   ~		
First Name*		Last Name*	
Suffix			
П	×   ~		

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

Address 1*	Address 2	
	Unit, Suite, Building, etc.	
City*	State*	Zip Code*
	Select	$\sim$

12. Enter the Phone Number and Email Address.

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

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

Please complete the form below. All fields marked w	asterisk(*) are required.	a Person Completing Form. All fields marked with an	
	PERSON C	OMPLETING FORM	
Patient Information	Prefix Mr. × V		
Laboratory Information			Unknown
Applicable Symptoms	First Name* Marty	Last Name* Craine	
Medical Conditions	Suffix		cian/Clinician?*
Travel Information	Sr ×   ~		
Hospitalization, ICU & Death Information	Address 1*	Address 2	
Additional Information	123 Cheers Street	Unit, Suite, Building, etc.	If other, please specify: 🕢
Treatment Information	City* Lexington	State*         Zip Code*           KY         X         V         40123-	
Additional Comments	Phone*	Email*	If other, please specify: 🕑
Review and Submit	(555) 123-3210	marty@email.com	
		Cancel Save	Last Name*

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

Travel Information		Patient ID (MRN)* 🚱	Affiliation/Organization* 🚱	
Hospitalization, ICU & Death Information	-		Select	~
		Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Additional Information	<b></b>	Select 🗸 🗸	Select	
Treatment Information	<b>A</b>	Dr. Estelle Costanza	Affiliation/Organization* 😧	If other, please specify: 🔞
Additional Comments	<b>A</b>	(estelle@email.com)	Select	
Review and Submit		Mr. Arthur Vandelay, II (arthur@email.com)		
		Mr. Marty Craine, Sr (marty@email.com)		
		First Name*	Middle Name	Last Name*

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

Patient ID (MRN)* 😧	Affiliation/Organization	
CK08101955	Test Medical organization of the person X v completing this form.	
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify: 🔞
Mr. Marty Craine, Sr (marty@email $ imes$   $ imes$	Select 🗸	
Attending Physician/Clinician *	One	If other, please specify: 🔞
Select ~	Hilton Hospital	
	King's Daughters Medical Center	
Prefix	Murray-Calloway County Hospital	
Select ~	Test Medical Center	
First Name*	University Of Kentucky Chandler Medical Center	Last Name*
	Other	
Suffix	Date of Birth*	
lease Note: The Affiliation/Or	ganization field that applies to the	Person Completing Form is on
	the conditional question: Is the	

• 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*.

Yes No Patient ID (MRN)* 🕑	Affiliation/Organization*	Please enter the organization of the person completing this form (if it is not listed in the
CK08101955	Test Medical Center	Affiliation/Organization     dropdown).
Person Completing Form*	Affiliation/Organization* 😧	If other, please specify:* 🚱
Mr. Marty Craine, Sr (marty@email 🗙 🛛 🗸	Other	× [ ~
Attending Physician/Clinician*	Affiliation/Organization* 😧	If other, please specify: 🚱
Select V	Select	



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

Attending Physician/Clinician*	Affiliation/Organization*	If other, please specify: 🚱		
Select 🗸	Select	•		
Dr. Frank Costanza, Sr (frank@email.com)				
Ms. Helen Seinfeld (helen@email.com)				
First Name*	Middle Name	Last Name*		
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**

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

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

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

	Manage User Prefe	rences	×	
Patient Information		m below to create an Attending Physician/Clinician. All fields marke	d	Unknown
Laboratory Information	with an asterisk(*) are r	equired.		,
Applicable Symptoms	AT	TENDING PHYSICIAN/CLINICIAN		cian/Clinician?*
Medical Conditions	Prefix			
Travel Information	Select			
Hospitalization, ICU & Death Information	First Name*	Last Name*		
Additional Information	<b>A</b>			If other, please specify:* 😧 Test Hospital
Treatment Information	Suffix	_		
Additional Comments	Select	~		If other, please specify: 😧
Review and Submit	Address 1*	Address 2 Unit, Suite, Building, etc.		
	City*	State* Zip Code		
	Phone*	Email*		Last Name*
	(XXXX) XXXX-XXXXX	name@domain.com		
		Cancel Sa	/e	Race*

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Direct Data Entry for Acute Hepatitis A Case Reports



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

First Name*	Last Name*	

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

Address 2		
Unit, Suite, Building, etc.		
State*		Zip Code*
Select	~	
	Unit, Suite, Building, etc. State*	Unit, Suite, Building, etc. State*

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

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

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

	ATTEN	IDING PHYSICIAN/CLINICIAN		
Patient Information	Prefix			
Laboratory Information	□ Dr. × ∨			Unknown
Applicable Symptoms	First Name*	Last Name*		
Medical Conditions	Fraiser	Crane		cian/Clinician?*
Travel Information	Suffix Select			
Hospitalization, ICU & Death Information	Address 1*	Address 2		
Additional Information	123 Cheers Street	Unit, Suite, Building, etc.		If other, please specify: 😧
Treatment Information	City*	State*	Zip Code*	
Additional Comments	Lexington	KY X V	40123-	If other, please specify: 🚱
Review and Submit	A Phone*	Email*		
	(555) 555-4321	fraisercrane@email.com		
		Cancel	Save	Last Name*

24. 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.

Additional Comments       jelect       Select         Review and Submit       Dr. Fraiser Crane (fraisercrane@email.com)       Dr. Fraiser Crane (fraisercrane@email.com)         Dr. Fraik Costanza, Sr (frank@email.com)       Middle Name       Last Name*	Treatment information	-	Attending Physician/Clinician *		Affiliation/Organization* 🚱		lf other, please specify: 🔞	_
Review and Submit     (fraisercrane@email.com)       Dr. Frank Costanza, Sr (frank@email.com)     Middle Name       Ms. Helen Seinfeld     Middle Name	Additional Comments	•	Şelect	~	Select	~		J
(frank@email.com) Ms. Helen Seinfeld Middle Name Last Name*	Review and Submit							_
			(frank@email.com) Ms. Helen Seinfeld		Middle Name		Last Name*	

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

Attending Physician/Clinician*	Affiliation/Organization* 😧	lf other, please specify: 🚱
Dr. Fraiser Crane (fraisercra 🗙 🗸 🗸	Select 🛛 🗸 🗸	
	Twenty One	•
Prefix	Hilton Hospital	
Select V	King's Daughters Medical Center	
First Name*	Murray-Calloway County Hospital Test Medical Center	Last Name*
Select	University Of Kentucky Chandler Medical Center Other	
	<b>Vo</b> to the conditional question:	the Attending Physician/Clinician is Is the Affiliation/Organization same Sician/Clinician?

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

Person Completing Form*	Affiliation/Organization* 🕄		If other, please specify:* 😧
Mr. Marty Craine, Sr (marty 🗙 🗸 🗸	Other	×   ~	Test Hospital
Attending Physician/Clinician*	Affiliation/Organization* 😧		If other, please specify:* 😧
Dr. Fraiser Crane (fraisercra $ imes$   $ imes$	Other	×   ~	
	Mr. Marty Craine, Sr (marty × ×	Mr. Marty Craine, Sr (marty × )       Other         Attending Physician/Clinician *       Affiliation/Organization* @	Mr. Marty Craine, Sr (marty × )       Other       × )         Attending Physician/Clinician *       Affiliation/Organization* @

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

Select	$ $ $\sim$				
First Name*		Middle Name		Last Name*	
Suffix		Date of Birth*			
Select		mm/dd/yyyy	曲		

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

Last Name*

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

Suffix	Date	of Birth*		
Select	l v mm	n/dd/yyyy		
Please Note: If th	e patient is either u	under one year o	ld or more than <sup>•</sup>	100 years old, a notification
pop-up will displa	ay to confirm the c	orrect birth year	has been enter	ed or selected. You cannot
proceed to the ne	ext page until updat	ting or confirmin	g the patient's bi	rth year.

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

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

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

uffix		Date of Birth*			
Select	~	01/01/1970	<b>**</b>		
atient Sex*		Ethnicity*		Race*	

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

	U	Unit, Suite, Building, etc.		
City*	Sta	te*	Zip Code	
County*	Phone* 😧	Email		
Select	~ (XXX) XXX-XXXX	name@do	omain.com	



J

- 32. Enter the patient's **Phone Number**.
- 33. If available, enter the patient's **Email Address**.

123 First Avenue	Please enter patient's		tc.	
City*	phone number. If patier phone number is not available, please enter t	State*		Zip Code*
Lexington	provider's/interviewer		×   ~	40509-
County*	phone number.		Email	
County	Flolle		Email	
Fayette	× V (XXX) XXX-XXXX		name@domain.com	

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

the patien	t currently preg	nant?*
Yes	No	Unknown
f yes, please	enter the due o	late (EDC): 😮
mm/dd/yy	/Y	time Unknow

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

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

Is the patient curren Yes If yes, please enter t mm/dd/yyyy	due date, if known or select dy preg the 'Unknown' checkbox if the estimated due date is not known. the due date (EDC):* ? Unknown
	or <b>Unknown</b> is selected for the <i>Is the patient currently pregnant?</i> field, the lisabled: <i>If yes, please enter the due date (EDC)</i> .
Is the patient curren	ily pregnant?* No Unknown



35. Select the **appropriate answer** to *Prior Hepatitis A Diagnosis*.

Prior Hepatitis A Diagnosis*	nown	
If yes, please enter the date of diagno		*
mm/dd/yyyy	iii Unknown	

 If Yes is selected for the Prior Hepatitis A Diagnosis field, the subsequent field is enabled. Enter the Date of Diagnosis in the subsequent field. If the date of diagnosis is unknown, click the Unknown checkbox.

If yes, please enter the date of diagnosis* @   Please Note: If No or Unknown is selected for the Prior Hepatitis A Diagnosis field, the subsequent field is disabled: If yes, please enter the date of diagnosis.   Prior Hepatitis A Diagnosis*   Prior Hepatitis A Diagnosis*   Yes   No   Unknown   If yes, please enter the date of diagnosis @	Yes No	Please select 'Unknown' if this information is not available.
field is disabled: <i>If yes, please enter the date of diagnosis</i> .		
field is disabled: <i>If yes, please enter the date of diagnosis</i> .		
field is disabled: <i>If yes, please enter the date of diagnosis</i> .		
field is disabled: <i>If yes, please enter the date of diagnosis</i> .	Please Note: If No	or <b>Unknown</b> is selected for the Prior Henatitis A Diagnosis field, the subsequent
Prior Hepatitis A Diagnosis* Yes No Unknown If yes, please enter the date of diagnosis @		,
Yes     No     Unknown       If yes, please enter the date of diagnosis @	neia is alsablea. Ij j	
Yes     No     Unknown       If yes, please enter the date of diagnosis @		
If yes, please enter the date of diagnosis 🚱		Linknown
mm/dd/yyyy III Onkhown	mm/dd/yyyy	International Unknown

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

County*	Phone* 😧	Email
Fayette	× V (555) 123-0000	name@domain.com
Is the patient currently pregnant?		
Yes No Unkn	own	
If yes, please enter the due date (EDC):	0	
mm/dd/yyyy	iii Unknown	
Yes No Unkn If yes, please enter the date of diagnos	is* 0	
mm/dd/yyyy	🛗 🗹 Unknown	
Save		Next



# 10 Laboratory Information

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

LABORATORY INFORMATION				
Patient Information	Does the patient have a lab test?*			
Laboratory Information	Yes No			
Applicable Symptoms	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for			
Exposure Information	that test.			
Hospitalization, ICU & Death Information				
Vaccination History	Hepatitis Marker Select			
Additional Comments	Results			
Review & Submit	Select v			
	If applicable, please enter the viral load:			

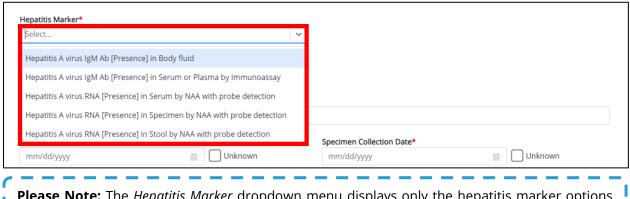
2. If **Yes** is selected, the subsequent lab-related fields on the screen are enabled. You must enter details for a lab test.

		LABORATORY INFORMATION
Patient Information	${\boldsymbol{ \oslash}}$	Does the patient have a lab test?*
Laboratory Information		Yes No
Applicable Symptoms	<b>A</b>	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for
Exposure Information	<b>A</b>	that test.
Hospitalization, ICU & Death Information	<b>A</b>	
Vaccination History	<b>A</b>	Hepatitis Marker* Select
Additional Comments	<b>A</b>	Results*
Review & Submit	<b>A</b>	Select V
		If applicable, please enter the viral load:
		Add Hepatitis Marker
Please Note: If No	or <b>U</b>	<b>nknown</b> is selected, all the subsequent fields on the screen are disabled.





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



**Please Note:** The *Hepatitis Marker* dropdown menu displays only the hepatitis marker options that apply to the selected Acute Hepatitis Case Report.

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

Hepatitis Marker*				
Hepatitis A virus IgM Ab [Presence] in Body fluid	x   ~			
Results*				
Select	~			
Negative				
Positive				
Undetermined/Inconclusive		Specimen Collection Date*		
mm/dd/yyyy 🗰 🗍 Unkn	lown	mm/dd/yyyy	曲	Unknown

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

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

est Result Date*	Specimen Collection Date*
mm/dd/yyyy 🛗 🗌 Unknown	mm/dd/yyyy 🛗 🗌 Unknown





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

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

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

Test Result Date*	_	Specimen Collection Date*	
07/23/2021	Unknown	07/26/2021	🛗 🗌 Unknown
Invalid Test Result Date	_	Invalid Specimen Collection Date	

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

Laboratory Name:*		

### **Adding Multiple Hepatitis Markers**

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

Laboratory Name:*	
Test Lab	
Add Hepatitis Marker	
ALT	
Add ALT	
AST	
+ Add AST	
Bilirubin	

•



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

Laboratory Name:*			
Test Lab			
			Ē.
lepatitis Marker*			
Select		~	
Results*			
Select			
Select			
f applicable, please enter the vira	al load: 😧		
		Consistent Collection Datat	
Fest Result Date*		Specimen Collection Date*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	iii Unknown
aboratory Name*			
Laboratory Name:*			

### Adding ALT

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

🔂 Add Hepa	titis Marker		
ALT			
🔂 Add ALT			

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

ALT	
Results:*	Units/Liter
Reference:*	Units/Liter
Test Result Date*	Specimen Collection Date* mm/dd/yyyy
Laboratory Name:*	



### Adding AST

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

🔂 Add ALT				
AST				
🕒 Add AST				
Bilirubin				
🔂 Add Bilirubin				
Save		Previous	Next	*

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

🛨 Add ALT	
AST	
Results:*	
	Units/Liter
Reference:*	
	Units/Liter
Test Result Date*	Specimen Collection Date*
mm/dd/yyyy 🗰 🗌 Unknown	mm/dd/yyyy 🛗 🗌 Unknown
Laboratory Name:*	
Add AST	_
	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~
Bilirubin	



### Adding Bilirubin

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

Laboratory Name:* Test Lab				
🛨 Add AST				
Bilirubin				
🕀 Add Bilirubin				
Save		Previous	Next	

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

Bilirubin	
Results:*	mg/dL
Reference:*	mg/dL
Test Result Date* mm/dd/yyyy   Unknown	Specimen Collection Date*         mm/dd/yyyy         Imm/dd/yyyy
Laboratory Name:*	
🔂 Add Bilirubin	
Save	Previous Next



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

ACUTE HEPATITIS A CASE REPORT FO	RM Section 2 of 8
Please provide laboratory information related to t	s case.
	LABORATORY INFORMATION
Patient Information	Does the patient have a lab test?*
Laboratory Information	Yes No
Applicable Symptoms	If yes, at least one Hepatitis Marker test is required. If you choose to enter additional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields for that test.
Exposure Information	A
Hospitalization, ICU & Death Information	Hepatitis Marker*
Vaccination History	Hepatitis A virus IgM Ab (Presence) in Body fluid x 🗸
Additional Comments	Results*
Review & Submit	Positive X V
	If applicable, please enter the viral load: 🛛
	Test Result Date* Specimen Collection Date*
	01/18/2023     Unknown     01/16/2023     Unknown
	Laboratory Name:*
	Testiab
	Add Hepatitis Marker
	ALT
	S Add ALT
	AST
	S Add AST
	Bilirubin
	C Add Billrubin
	Save Previous Next



# **11** Applicable Symptoms

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

CUTE HEPATITIS A CASE REPOR	T FORM Section 3 of 8
Please select applicable symptoms that the p	atient experienced during illness.
	APPLICABLE SYMPTOMS
Patient Information	Were symptoms present during the course of illness?*
Laboratory Information	Ves No Unknown
Applicable Symptoms	
Exposure Information	Onset Date      mm/dd/yyyy     III Unknown
Hospitalization, ICU & Death Information	<u> </u>
Vaccination History	If symptomatic, which of the following did the patient experience during their illness?     Fever
Additional Comments	Yes No Unknown
Review & Submit	If yes, please enter the highest temperature:
	Diarrhea (>3 loose stools/24hr period) Yes No Unknown If yes, please enter # of days of diarrhea: Abdominal pain Yes No Unknown Anorexia
	Yes No Unknown

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

CUTE HEPATITIS A CASE REPORT F	ORM		Section 3 of 8
Please select applicable symptoms that the patient	nt experienced during illness.		
			APPLICABLE SYMPTOMS
Patient Information			g the course of illness?*
Laboratory Information	⊘ Yes	No	Unknown
Applicable Symptoms	Onset Date*	D	
posure Information	mm/dd/yy		Unknown
ospitalization, ICU & Death Information	<b>A</b>		llowing did the patient experience during their illness?
ccination History	Fever*	auc, which of the fo	nowing nie nie baneur exherience om ing niei innesst
lditional Comments	A Yes	No	Unknown
eview & Submit	If yes, please	e enter the highest	temperature: 😡
	Diarrhea (>3 Yes	loose stools/24hr No	period)* Unknown
	lf yes, please	e enter # of days of	í diarrhea: 😡
	Abdominal p	in <b>*</b>	
	Yes	No	Unknown
	Anorexia*		
	Yes	No	Unknown
	Arthralgia*		
	Yes	No	Unknown
	Clay Colored Yes	d Stools*	Unknown
	Pes Dark urine*	NO	UTRITOWIT
	Yes	No	Unknown

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

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

								APPLICABLE SYMPTOMS			
W	Were symptoms present during the course of illness?*  Please select 'Unknown' if onset date information is not available.										
			e*	_		Ê		Unknown			
ſ	⊲ Su	_	Jary	~	2023 202 Th	3 🗸	Sa	wing did the patient experience during their illness?			
	1	2	3	4	5	6	7	Unknown			
	8	9	10	11	12	13	14	mperature: @			
	15	16	17	18	19	20	21	niperature. 🥪			
	22	23	24	25	26	27	28				
	29	30	31	1	2	3	4	eriod)*			
		res			IN	0	Л	Unknown			

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

ever*											
Yes	No	-	Jnknown								

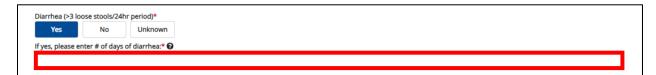
• If **Yes** is selected, the subsequent field is enabled. Enter the **patient's highest temperature** in the subsequent textbox: *If yes, please specify*.

Fever*     Please enter 'Unknown' if the highest temperature is       Yes     No	
If yes, please enter the highest temperature:* 🚱	



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

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



- 6. If the patient is symptomatic for *Acute Hepatitis A*, select the **appropriate answers** for the following fields to indicate the symptoms the patient experienced during illness:
  - Abdominal pain
  - Anorexia
  - Arthralgia
  - Clay Colored Stools
  - Dark Urine
  - Elevated ALT > 200
  - Elevated Bilirubin > 3.0

- Fatigue
- Headache
- Jaundice
- Malaise
- Muscle aches (myalgia)
- Nausea
- Vomiting

bdominal pa	in*		Fatigue*		
Yes	No	Unknown	Yes	No	Unknown
Anorexia*			Headache*		
Yes	No	Unknown	Yes	No	Unknown
Arthralgia*			Jaundice*		
Yes	No	Unknown	Yes	No	Unknown
Clay Colored S	Stools*		Malaise*		
Yes	No	Unknown	Yes	No	Unknown
Dark urine*			Muscle aches (	myalgia)*	
Yes	No	Unknown	Yes	No	Unknown
Elevated ALT >	> 200*		Nausea*		
Yes	No	Unknown	Yes	No	Unknown
Elevated Biliru	ubin > 3.0*		Vomiting*		
Yes	No	Unknown	Yes	No	Unknown

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

Did the patien	t have any oth	er symptoms?*
Yes	No	Unknown
If yes, please s	specify: 🛿	

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

Did the patient	have any othe	er symptoms?*
Yes	No	Unknown
lf yes, please sp	ecify: <b>* </b>	

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

Patient Information	0	Were symptoms present during the course of illness?*
Laboratory Information	0	Yes No Unknown
Applicable Symptoms		0
Exposure Information	<b>a</b>	Onset Date*  O1/03/2023
Hospitalization, ICU & Death Information	<b>a</b>	
Vaccination History	<b>a</b>	If symptomatic, which of the following did the patient experience during their illness? Fever*
Additional Comments	<b>a</b>	Yes No Unknown
Review & Submit	<b>a</b>	If yes, please enter the highest temperature:* 🛛
		Diarrhea (-3 loose stools/24hr period)*   Yes   No   Unknown   Abdominal pain*   Yes   No   Unknown   Anorexia*   Yes   No   Unknown   Arthralgia*   Yes   No   Unknown   Jaundice*   Yes   No   Unknown   Jaundice*   Yes   No   Unknown   Malaise*   Yes   No   Unknown   Muscle aches (myalgia)*   Yes   No   Unknown   Muscle aches (myalgia)*   Yes   No   Unknown   Dig   No   Unknown   Dig   Yes   No   Unknown   Muscle aches (myalgia)*   Yes   No   Unknown   Muscle aches (myalgia)*   Yes   No   Unknown   Muscle aches (myalgia)*   Yes   No   Unknown
		Save Previous Next



## 12 Exposure Information

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

ACUTE HEPATITIS A CASE REPORT	DRM Section 4 of 8
Please select the information that the patient	exposed to prior to illness.
	EXPOSURE INFORMATION
Patient Information	O Did the patient have any of the following exposures in the past 6 months?*
Laboratory Information	O Yes No Unknown
Applicable Symptoms	0
Exposure Information	Domestic travel (outside state of normal residence) Yes No Unknown
Hospitalization, ICU & Death Information	A If yes, please specify state:
Vaccination History	A Select.
Additional Comments	Date of Departure @     Date of Arrival @       mm/dd/yyyy     Unknown     mm/dd/yyyy
Review & Submit	Add Domestic Travel
	International travel       Yes     No     Unknown       If yes, please specify country:     Select     Y
	Date of Departure  Date of Arrival  Date of Arrival  Unknown mm/dd/yyyy
	Add International Travel      Cruise or vessel travel as passenger or crew member      Yes No Unknown      If yes, please specify cruise ship:      Date of Arrival      Date of Arrival
	mm/dd/yyyy 🟥 🗌 Unknown
	Add Cruise or Vessel Travel

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

		EXPOSURE INFORMATION	
Patient Information	0	Did the patient have any of the following exposures in the past 6 months?*	
Laboratory Information	Ø	Yes No Unknown	
Applicable Symptoms	0	Domestic travel (outside state of normal residence)*	
Exposure Information		Yes No Unknown	
Hospitalization, ICU & Death Information	<b>a</b>	If yes, please specify state: Select	
Vaccination History	_	Date of Departure  Date of Arrival  Date of Arrival	
Additional Comments	۵	mm/dd/yyyy 📋 🗌 Unknown	
Review & Submit	<b>A</b>	Add Domestic Travel	
		International travel*         Yes       No         If yes, please specify country:         Select         Date of Departure @         mm/dd/yyyy       Imm/dd/yyyy         Imm/dd/yyyy       Imm/dd/yyyy         Add International Travel	

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

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

nany female sex partners did the patient have? ct	
ct	

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

Yes	No	Unknown				
f yes, please s	pecify state:					
Select						
Date of Depart	ure 🕜			Date of Arrival 🔞		
mm/dd/yyyy			Unknown	mm/dd/yyyy	Unknown	

- If **Yes** is selected for the *Domestic travel (outside state of normal residence)* field, the subsequent fields are enabled:
- Select the **state that the patient traveled to** from the subsequent dropdown menu: *If yes, please specify state.*
- Enter the **Date of Departure** and the **Date of Arrival** in the appropriate fields.

Domestic travel (outside state of norma Yes No Unknow				
If yes, please specify state:*				
Select				$\sim$
Date of Departure* 😧		Date of Arrival* 😧		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
Add Domestic Travel				





#### **Adding Multiple Domestic Travel Details**

4. You can click **Add Domestic Travel** to log the dates of travel for multiple domestic trips. This means that you can enter additional states that the patient has traveled to in the past 6 months.

f yes, please specify state:*				
CO				×
Date of Departure* 🚱		Date of Arrival* 😧		
12/24/2022	iii Unknown	01/01/2023	🛗 🗌 Unkr	nown

• To delete an additional domestic travel section, click the **Trash Bin Icon** located at the top right.

wn			
			× v
	Date of Arrival* 😧		
🛗 🗌 Unknown	01/01/2023	🛗 🗌 Unknown	
		L	
	Date of Arrival* 😧		
🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
	Unknown	Date of Arrival*  Date of Arrival*	Date of Arrival*  Unknown Unknown Unknown Date of Arrival*

5. Select the **appropriate answer** for the field: *International travel*.

AR			>	K   ~
Date of Departure* 😧		Date of Arrival* 😧		
11/24/2022	iii Unknown	11/26/2022	🛗 🗌 Unknown	
Add Domestic Travel				
	-			
Yes No Unknow	wn			
nternational travel* Yes No Unknow f yes, please specify country:	wn			
Yes No Unknow	wn			
Yes No Unknow	wn	Date of Arrival 🚱		

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- If **Yes** is selected for the *International travel* field, the subsequent fields are enabled:
- Select the **country that the patient traveled to** from the subsequent dropdown menu: *If yes, please specify country.*
- Enter the **Date of Departure** and the **Date of Arrival** in the appropriate fields.

Yes No Unknown			
If yes, please specify country:* Select			~
Date of Departure* 😧 mm/dd/yyyy	🛗 🗌 Unknown	Date of Arrival* 😧	📋 🗌 Unknown
Add International Travel			

#### **Adding Multiple International Travel Details**

 You can click Add International Travel to log the dates of travel for multiple international trips. This means that you can enter additional countries that the patient has traveled to in the past 6 months.

International travel*				
Yes No Unknow	n			
If yes, please specify country:*				
AUSTRALIA				×   ~
Date of Departure* 😧		Date of Arrival* 😧		
10/03/2022	🛗 🗌 Unknown	10/10/2022	🛗 🗌 Unknown	
Add International Travel				

• To delete an additional domestic travel section, click the **Trash Bin Icon** located at the top right.

International travel*				
Yes No Unknown				
If yes, please specify country:*				
AUSTRALIA				$\times \mid \cdot $
Date of Departure* 😧		Date of Arrival* 😮		
10/03/2022	🛗 🗌 Unknown	10/10/2022	🛗 🗌 Unknown	
International Travel Details				
If yes, please specify country:*				
GREECE				× v
Date of Departure* 😧		Date of Arrival* 😧		
09/19/2022	🛗 🗌 Unknown	09/23/2022	🛗 🗌 Unknown	
Add International Travel				

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7. Select the **appropriate answer** for the field: *Cruise or vessel travel as passenger or crew member*.

🛗 🗌 Unknown

- If **Yes** is selected for the *Cruise or vessel travel as passenger or crew member* field, the subsequent fields are enabled:
- Enter the **name of the cruise ship or vessel** in the subsequent textbox field: *If yes, please specify cruise ship*.
- Enter the **Date of Departure** and the **Date of Arrival** in the appropriate fields.

Cruise or vesse Yes		er or crew member* Jnknown		
If yes, please sp	ecify cruise ship:*	0		
Date of Departs mm/dd/yyyy	ure* 😧	🗰 🗌 Unknown	Date of Arrival* 😧 mm/dd/yyyy	🗰 🗌 Unknown
🕂 Add Cruise	or Vessel Travel			

#### Adding Multiple Cruise or Vessel Travel Details

8. You can click **Add Cruise or Vessel Travel** to log the dates of travel for multiple cruise or vessel trips. This means that you can enter additional cruises or vessels where the patient traveled as a passenger or crew member in the past 6 months.

Yes	No	Unknown			
lf yes, please sp	becify cruise s	ship:* 🚱			
Carnival Liber	rty				
Date of Depart	ure* 😧			Date of Arrival* 😧	
08/22/2022		÷	Unknown	08/29/2022	🛗 🗌 Unknow

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To delete an additional cruise or vessel travel section, click the **Trash Bin Icon** located at the top right.

Yes No Unk			
f yes, please specify cruise ship:* 😧			
Carnival Liberty			
Date of Departure* 😧		Date of Arrival* 😧	
08/22/2022	🖮 🗍 Unknown	08/29/2022	🛗 🗌 Unknown
Cruise or Vessel Travel Details			
Cruise or Vessel Travel Details If yes, please specify cruise ship:* <b>@</b>		Date of Arrival* 🙆	

9. Select the **appropriate answer** for the field: *Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)*?

es	No	Unknown	hcare setting, grocery store	
ease sp	ecify workpla	ace setting: 🛿		

• If **Yes** is selected for the *Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)* field, the subsequent field is enabled. Enter the **name of the workplace setting** in the subsequent textbox: *If yes, please specify the name of workplace setting*.

Is the workplace	critical infras	structure (e.g., healt	hcare setting, grocery store	2)*		
Yes	No	Unknown				
f yes, please spe	cify workplac	ce setting:* 😧				
		J J				

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

/es No Unkn	own	•
place specify the pursing assis	ted living or long term care facility	r 0
se specify the nursing, assis	ted living or long-term care facility	/: 🕝



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



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

ool/daycare*		
Yes	No	Unknown
ves, please spe	cify the nam	ne of the school/

• If **Yes** is selected for the *School/daycare* field, the subsequent field is enabled. Enter the **name of the school/daycare** in the subsequent textbox: *If yes, please specify the name of the school/daycare*.

Yes No Unknown If yes, please specify the name of the school/daycare:* @
fives please specify the name of the school/daycare * <b>Q</b>
jea prease speen june nume of the sensor augenter 🗸

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

Correctional fac	:ility*	
Yes	No	Unknown
f yes, please sp	ecify name of	f correctional fac

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

Yes No Unkn information of correctional facility is not available.	
yes, please specify name of correctional facility:* 😧	





13. Select the **appropriate answer** for the field: *Other congregate settings*.

No Unknown		
specify the name of the other congregate s	setting:	0

• If **Yes** is selected for the *Other congregate settings* field, the subsequent field is enabled. Enter the **name of the congregate setting** in the subsequent textbox: *If yes, please specify the name of the other congregate setting*.

Yes No es, please specify the nam	Unknown				
es, please specify the nam					
	me of the other con	ongregate setting:* 🚱			

14. Select the **appropriate answer** for the field: *Known contact with same diagnosis or similar symptoms*.

Yes	No	Unknown			
s, please s	pecify the relat	tionship: 🔞			

- If **Yes** is selected for the *Known contact with same diagnosis or similar symptoms* field, the subsequent fields are enabled:
- Enter the **patient's relationship to the contact** in the subsequent textbox: *If yes, please specify the relationship*.
- Enter the **contact's first and last name and contact information (e.g., Phone Number, Email Address)** in the subsequent textbox: *If yes, please enter the name and contact information*.

If yes, please specify the rela	ationship:* 😧		 					 
If yes, please enter the name	e and contact inf	ormation:* 🚱						
First Name, Last Name, Ph	ione Number, Em	ail Address, etc.						



15. Select the **appropriate answer** for the field: *Incarceration*.

Inc	arceration*			
	Yes	No	Unknown	
f y	es, please sp	ecify: 🔞		
V	es, please pr	ovide the h	nistory of incarcer	erati

- If **Yes** is selected for the *Incarceration* field, the subsequent fields are enabled:
- Enter the **patient's incarceration details** in the subsequent textbox: *If yes, please specify*.
- Enter the **patient's history of incarceration** in the subsequent textbox: *If yes, please provide the history of incarceration*.

Incarceration*	
If yes, please specify:* <b>@</b>	
If yes, please provide the history of incarceration:* 🕑	

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

Foreign Born*			
Yes	No	Unknown	
f yes, please s	pecify country	r: 😧	
C all a set			

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

Foreign Born* Please select 'Unknown' if Yes of birth is not available. If yes, please specify country:* ?	
Select	~
AFGHANISTAN	
ALBANIA	
ALGERIA	
AMERICAN SAMOA	
ANDORRA	
ANGOLA	
ANGUILLA	



17. Select the **appropriate answer** for the field: *IV Drug Use*.

Drug Use*		
Yes No	Un	nknown
es, please specify de	uils: 🕜	

• If **Yes** is selected for the *IV Drug Use* field, the subsequent field is enabled. Enter the **patient's IV drug use details** in the subsequent textbox: *If yes, please specify details*.

V Drug Use* Yes	No Unknown		
If yes, please specify	r details:* 😧		 

18. Select the **appropriate answer** for the field: *Other Illicit Drug Use*.

Illicit Drug use*		
es No		Unknown
please specify det	ails: 🚱	

• If **Yes** is selected for the *Other Illicit Drug Use* field, the subsequent field is enabled. Enter the **patient's other illicit drug use details** in the subsequent textbox: *If yes, please specify details*.

Other Illicit Drug use* Yes No Unknown	
If yes, please specify details:* 😧	 

19. Select the **appropriate answer** for the field: *Recent Sexual Contact*.

Rec	cent Sexu	al Contac	t*		
	Yes		No	Unkn	wn
lf y	es, pleas	e specify r	number	of sexual	partner
Se	elect				
Wh	at is the	sexual pre	eferenc	e of the pa	tient?
Se	elect				
Но	w many i	male sex p	artner	s did the p	atient h
Se	elect				
Но	w many f	female sex	( partne	ers did the	patien
Se	elect				



- If **Yes** is selected for the *Recent Sexual Contact* field, the subsequent fields are enabled:
- Select the **number of sexual partners** from the subsequent dropdown menu: *If yes, please specify number of sexual partners*.

Recent Sexual Contact*	
Yes No Unknown If yes, please specify number of sexual partners:*	
Select	×
10	
11	
12	
13	
14	
15	
15+	

• Select the **patient's sexual preference** from the subsequent dropdown menu: *What is the sexual preference of the patient?* 

~

- Select the **number of male sexual partners** from the subsequent dropdown menu: *How many male sex partners did the patient have?*
- Select the **number of female sexual partners** from the subsequent dropdown menu: *How many female sex partners did the patient have?*

How many male sex partners did the patient have?* 0	×	
How many female sex partners did the patient have?*		
Select		~
0		
1		
2		
3		
4		
5		
6		
Save	Пеноцу	_

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

parcore	in outbreak?*	
Yes	No	Unknown
yes, please s	pecify the nam	ne of the outbre

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

Yes		the details of outbreak is		
Tes	No	the details of outbreak is not available.		
lf yes, please speci	fy the name of	f the outbreak:* 😧		

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

Other Illicit Drug use*	
Yes No Unknown	
lf yes, please specify details: 🚱	
Recent Sexual Contact*	
Yes No Unknown	
If yes, please specify number of sexual partners:*	
5	X   ~
What is the sexual preference of the patient?*	
Heterosexual	x   ~
How many male sex partners did the patient have?*	
0	x   ~
How many female sex partners did the patient have?*	
5	×   ~
Is this part of an outbreak?* Yes No Unknown	
If yes, please specify the name of the outbreak:* 🚱	
Unknown	
Save	Previous Next

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# 13 Hospitalization, ICU & Death Information

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

ACUTE HEPATITIS A CASE REPORT F	ORM		Section 5 of 8	
Please select any applicable hospitalization, ICU	and death information related to this case.			
	HOSPITA	ALIZATION, ICU & DEATH INFORM	ATION	
Patient Information		_		
Laboratory Information	⊘ Yes No Unkno	wn		
Applicable Symptoms		0		
Exposure Information	If yes, please specify the hospital name:	U		
Hospitalization, ICU & Death Information	Admission Date		Discharge Date	
Vaccination History	mm/dd/yyyy	1 Unknown		iii Unknown
Additional Comments	<b>A</b>		Still hospitalized	
Review & Submit	Was the patient admitted to an intensiv Yes No Unkno			
	Admission Date to ICU mm/dd/yyyy	Unknown	Discharge Date from ICU mm/dd/yyyy	Unknown
	Did the patient die as a result of this illn Yes No Unkno If yes, please provide the date of death Date of Death mm/dd/yyyy	wn		

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

		HOSPITALIZATION, ICU & I	DEATH INFORMATION	
Patient Information	${igodot}$	Was the patient hospitalized?*		
Laboratory Information	$\odot$	Yes No Unknown		
Applicable Symptoms	$\odot$	If yes, please specify the hospital name:* 🛿		
Exposure Information	$\odot$	ir yes, please specify the nospital name:~ 🖉		
Hospitalization, ICU & Death Information		Admission Date*	Discharge Date*	
Vaccination History	<b>A</b>	mm/dd/yyyy 🌐 🗌	Unknown mm/dd/yyyyy	iii Unknown
Additional Comments	<b>A</b>		Still hospitalized	
Review & Submit	<b>A</b>	Was the patient admitted to an intensive care unit (ICU)?*		
		Yes No Unknown		
		Admission Date to ICU	Discharge Date from ICU	
		mm/dd/yyyy 🗰 🗌	Unknown mm/dd/yyyy	time Unknown
		Did the patient die as a result of this illness?*		
		Yes No Unknown		

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

Was the patient hospitalized?





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

Yes       No       Please enter the name of the hospital where the patient is/was hospitalized.         If yes, please specify the hospital name:* @	

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

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

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

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

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

Admission Date*			Discharge Date*	
10/01/2021		🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
			Still hospitalized	
(		nsive care unit (ICU)?*		
Yes	NoUn	known		
Admission Date t	o ICU		Discharge Date from ICU	
mm/dd/yyyy		iii Unknown	mm/dd/yyyy	Unknown
Did the nationt di	ie as a result of this	illness?		
Did the patient di		known		
Yes	No Un	known		
Yes	No Un			
Yes If yes, please prov				
Yes				

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

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

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

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

There are errors. Please make a selection t	for all requ			alization, ICL ation	l & Death	×	
Patient Information	Ø	Was the patient F	0		pital discharge cannot be date of hospital admission.		
Laboratory Information	Ø	Yes				ОК	
Applicable Symptoms	Ø		ST 82			UK	
Medical Conditions	Ø	If yes, please specify Test Hospital	the hosp	oital name:* 🥝			
Exposure Information	0	Admission Date*				Disch	harge Date*
Hospitalization, ICU & Death Information		10/01/2021 Invalid Admission Date		節	Unknown	09/	/30/2021
Vaccination History	-						Still hospitalized d Discharge Date

There are errors. Please make a s	election for	all required fields.
		HOSPITALIZATION, ICU & DEATH INFORMATION
Patient Information	$\odot$	Was the patient hospitalized?*
Laboratory Information	$\odot$	Yes No Unknown
Applicable Symptoms	$\odot$	If yes, please specify the hospital name:* 🖗
Medical Conditions	$\odot$	Test Hospital
Exposure Information	$\odot$	Admission Date* Discharge Date*
Hospitalization, ICU & Death Information		10/01/2021     Unknown     09/30/2021     Unknown       Invalid Admission Date     Still hospitalized
Vaccination History	<b>a</b>	Invalid Discharge Date

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

Yes	No	Unknown			
mission Dat	e to ICU			Discharge Date from ICU	
nm/dd/yyyy		曲 🗍 U	Inknown	mm/dd/yyyy	Unknown



•



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

Admission Date to ICU* Discha	charge Date from ICU*	
mm/dd/yyyy 🛗 🗌 Unknown	nm/dd/yyyy 🗰 🗌 Unknown	n

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

id th	ne patient di	e as a res	ult of this illness?*	
	Yes	No	Unknown	
	, please prov of Death	/ide the d	ate of death:	
mm	/dd/yyyy			Unknown

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

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

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

		HOSPITALI	ZATION, ICU & DEATH INFOR	RMATION	
Patient Information	${igodot}$	Was the patient hospitalized?*			
Laboratory Information	$\oslash$	Yes No Un	known		
Applicable Symptoms	$\odot$	If yes, please specify the hospital nar	me** <b>Ø</b>		
Exposure Information	$\oslash$	General Hospital			
Hospitalization, ICU & Death Information		Admission Date*		Discharge Date*	
Vaccination History	_	12/30/2022	🗰 🗌 Unknown	01/02/2023	🗰 🗌 Unknown
Additional Comments	_			Still hospitalized	
Review & Submit	•	Admission Date to ICU mm/dd/yyyy Did the patient die as a result of this	known	Discharge Date from ICU mm/dd/yyyy	Unknown
		If yes, please provide the date of dea Date of Death mm/dd/yyyy			
		Save			Previous Next

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# 14 Vaccination History

1. On the **Vaccination History** screen, select the **appropriate answer** for the conditional question at the top: *Has the patient ever received a Hepatitis A vaccine*?

CUTE HEPATITIS A CASE REPORT	ORM s	ection 6 of 8
Please provide the vaccination history of the p	ient related to this case.	
	VACCINATION HISTORY	
Patient Information	Has the patient ever received a Hepatitis A vaccine?*	
Laboratory Information	Yes No Unknown Refused	
Applicable Symptoms	0	
Exposure Information	Vaccine Details  If yes, please provide vaccine name:	
Hospitalization, ICU & Death Information	Select	
Vaccination History	If other, please specify: 🚱	
Additional Comments	If yes, please enter the number of doses: @	
Review & Submit	Select	
	If yes, please specify the date administered:  Date Administered (1st dose) mm/dd/yyyy Date Administered (3rd dose) mm/dd/yyyy	Date Administered (2nd dose)     Unknown       mm/dd/yyyy     Unknown       Date Administered (4th dose)     Unknown

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

	VACCINATION HISTORY	
Patient Information	Has the patient ever received a Hepatitis A vaccine?*	
Laboratory Information	Yes No Unknown Refused	
Applicable Symptoms	Vaccine Details	
Exposure Information		
Hospitalization, ICU & Death Information	Select	~
Vaccination History	If other, please specify: 🚱	
Additional Comments	▲ If yes, please enter the number of doses:* ●	
Review & Submit	Select	v ]
	If yes, please specify the date administered: 🕢	
	Date Administered (1st dose) Date Administered (2nd dose)	
	mm/dd/yyyy 🗰 🗍 Unknown mm/dd/yyyy 📸 🗍 Unknown	'n
	Date Administered (3rd dose) Date Administered (4th dose)	
	mm/dd/yyyy 📸 🗍 Unknown mm/dd/yyyy 📸 🗍 Unknow	'n
	🔂 Add Vaccine	

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





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

If yes, please provide vaccine name:* 😧		
Şelect		~
hepatitis A and hepatitis B vaccine		
hepatitis A and hepatitis B vaccine, pediatric/adolescent (non-US)		
Hepatitis A vaccine, adult dosage		
Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule		
Hepatitis A vaccine, unspecified formulation		
Other		
Date Administered (3rd dose)	Date Administered (4th dose)	

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

If yes, please provide vaccine name:* 😧	
Other	x   ~
If other, please specify:* 😧	
lines along anter the number of degree O	

4. Select the **number of doses that the patient received for the selected vaccine** from the dropdown menu: *If yes, please enter the number of doses.* 

Hepatitis A vaccine, adult docage Please select the number of	×   ~
other, please specify:      doses that the patient received for the selected vaccine.	
Select	~
1	
2	
3	

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

If yes, please enter the number of the numbe	mber of doses:* 🚱		x   ~
If yes, please specify the d	ate administered: 🚱		
Date Administered (1st do	se)*	Date Administered (2nd c	lose)
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	Unknown
Date Administered (3rd do	ose)	Date Administered (4th d	ose)
mm/dd/yyyy	tim Unknown	mm/dd/yyyy	🛗 🗌 Unknown

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

f yes, please enter the nu	es, please enter the number of doses:* 🚱			
2			>	
If yes, please specify the d	ate administered: 😧			
Date Administered (1st do	se)*	Date Administered (2nd d	lose)*	
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
Date Administered (3rd do	ose)	Date Administered (4th do	ose)	
mm/dd/yyyy	Unknown	mm/dd/yyyy	🛱 🗌 Unknown	

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

3					
lf yes, please specify the d	ate administered: 😧				
Date Administered (1st do	se)*	Date Administered (2nd d	ose)*		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown		
Date Administered (3rd do	se)*	Date Administered (4th de	ose)		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	💼 🗌 Unknown		

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

f yes, please specify the da Date Administered (1st dos		Date Administered (2nd d	ose)*
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown
Date Administered (3rd dos	se)*	Date Administered (4th do	ose)*
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown

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### **Adding Multiple Vaccines**

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

yes, please provide vaccine name:*	0			
Hepatitis A vaccine, adult dosage				$\times \mid \cdot$
other, please specify: 🔞				
yes, please enter the number of dos	es:* 😧			
1				$\times \mid \cdot$
yes, please specify the date adminis	tered: 😧			
ate Administered (1st dose)*		Date Administered (2nd dose)		
12/30/2022	🛗 🗌 Unknown	mm/dd/yyyy	🛗 🗌 Unknown	
ate Administered (3rd dose)		Date Administered (4th dose)		
mm/dd/yyyy	🛗 🗌 Unknown	mm/dd/yyyy	🗰 🗌 Unknown	

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

If yes, please provide vaccine na	me:* 😯					
Select						$\sim$
lf other, please specify: 🚱						
If yes, please enter the number of	of doses:	* 0				
Select						$\sim$
If yes, please specify the date ad	minister	ed: 🕜				
Date Administered (1st dose)			Date Administered (2nd dose	)		
mm/dd/yyyy		Unknown	mm/dd/yyyy		Unknown	
Date Administered (3rd dose)			Date Administered (4th dose)			
mm/dd/yyyy		Unknown	mm/dd/yyyy		Unknown	

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

,	VACCINATION HISTORY			
Has the patient ever received a Hepati Yes No Unkn				
Vaccine Details				
If yes, please provide vaccine name:*	9			
Hepatitis A vaccine, adult dosage				×   ~
If other, please specify: 🔞				
If yes, please enter the number of dose 1 If yes, please specify the date administ Date Administered (1st dose)* 12/30/2022		Date Administered (2nd dose) mm/dd/yyyy	🛗 🗌 Unkno	x   ~
Date Administered (3rd dose)	time Unknown	Date Administered (4th dose)	🚔 🗌 Unkno	
mm/dd/yyyy  Add Vaccine	Unknown	mm/dd/yyyy	Unkno	****
Save		Р	Previous Next	

## **15** Additional Comments

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

ACUTE HEPATITIS A CASE REPORT	FORM	Section 7 of 8
Please add any additional comments related t	to this case.	
		ADDITIONAL COMMENTS
Patient Information	0	Additional comments or notes, please specify:
Laboratory Information	$\odot$	
Applicable Symptoms	$\odot$	
Exposure Information	$\odot$	
Hospitalization, ICU & Death Information	${\boldsymbol{ \oslash}}$	
Vaccination History	${\boldsymbol{\oslash}}$	0/1000 Characters
Additional Comments		
Review & Submit	<b>A</b>	
		Save Previous Next

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## 16 Review and Submit

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

#### **Print or Download Functionality**

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

CUTE HEPATITIS A CASE REPORT	FORM		Section 8 of 8	
Please review your information before submi	itting.			
		REVIEW &	SUBMIT	
Patient Information	0			
Laboratory Information	0			Print 🛃 Download
Applicable Symptoms	$\odot$	Patient Information		0
Exposure Information	0	ratent mornation		v
Hospitalization, ICU & Death Information	0	Disease/Organism Hepatitis A	Date of Diagnosis 2023/01/19	
Vaccination History	0	Is the Affiliation/Organization same for Patient ID (MR Yes	N), Person Completing Form, and Attending Physician/Clinician	an?
Additional Comments	0	Patient ID (MRN)	Affiliation/Organization	
Review & Submit		CK01011970	Hilton Hospital	
		Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital	
		Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com)	Affiliation/Organization Hilton Hospital	
		First Name Cosmo	Last Name Kramer	
		Date of Birth 1970/01/01		
		Patient Sex Male	Ethnicity Not Hispanic or Latino	Race

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

Patient Information			Destination	- Convertientie		
Disease/Organism Hepablis A			Destination			
Date of Diagnosis 01/19/2023			Pages	All	*	
Is the Affiliation/Organization same for Patient Physician/Clinician? Yes	ID (MRN), Person Completing Form, and Atten	ding	Copies	1		
Patient ID (MRN) CK01011970			Color	Color		
Affiliation/Organization Hilton Hospital						
Person Completing Form Mr. Arthur Vandelay (arthur vandelay@email.com)			More settings		, ir	nt 🛃 Download
Affiliation/Organization Hilton Hospital						
Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com)						0
Affiliation/Organization Hibon Hospital					-	
First Name Cosmo	Last Name Kramer					
Date of Birth 01/01/1970						
Patient Sex Male	Ethnicity Not Hispanic or Latino					
Race White						
123 First Avenue						
Lexington	State KY					
40509						
Fayette	Phone (555) 123-0000					
Yes						
If yes, please enter the date of diagnosis Urknown						
Laboratory Information				Print	Cancel	
Design Car		Fabricity	•	0		
Patient Sex Male		Not Hispanic or Latino		White		
	<section-header><section-header><text><text><text><text><text><text><text><text><text><text><text><text><text><text><text></text></text></text></text></text></text></text></text></text></text></text></text></text></text></text></section-header></section-header>	<section-header><text><text><text><text><text><text><text><text><text><text><text><text><text></text></text></text></text></text></text></text></text></text></text></text></text></text></section-header>	<section-header>         Name         Base         Base      &lt;</section-header>	Discast Organization     Pages       Discast Organization same for Patient D (1988), Person Completing Form, and Attending Pages     Pages       Discast Organization same for Patient D (1988), Person Completing Form, and Attending Pages     Pages       Discast Organization Network Organizatio Netw	Bestandor Specific Register Specific	Biseascinguistic   Matterial Rill   Biseascinguistic   Restrict Biseascinguistic <tr< td=""></tr<>

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

REVIEW & SUBMIT								
Patient Information	0							
Laboratory Information	$\odot$			Print 🛃 Download				
Applicable Symptoms	$\odot$	Patient Information		0				
Exposure Information	$\odot$			•				
Hospitalization, ICU & Death Information	$\odot$	Disease/Organism Hepatitis A	Date of Diagnosis 2023/01/19					
Vaccination History	Ø	Is the Affiliation/Organization same for Yes	?					
Additional Comments	$\oslash$	Patient ID (MRN)	Affiliation/Organization					
Review & Submit		CK01011970 Person Completing Form	Hilton Hospital					

- 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.

			REVIEW &	SUBMIT			
Patient Information	0					_	
Laboratory Information	$\odot$					Print Print	Download
Applicable Symptoms	$\odot$	Patient Informa					0
Exposure Information	$\odot$		Download PDF	×			
Hospitalization, ICU & Death Information	$\odot$	Disease/Organism Hepatitis A	Downloaded successfully				
Vaccination History	$\odot$	Is the Affiliation/O Yes		ОК	d Attending Physician/Clinician?		
Additional Comments	$\odot$	Patient ID (MRN)		Anniauon/Organization			
Review & Submit		СК01011970		Hilton Hospital			
		Person Completing Mr. Arthur Vandela	; <b>Form</b> ıy (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital			
		Attending Physiciar Dr. Frasier Crane (f	n <b>/Clinician</b> rasier.crane@email.com)	Affiliation/Organization Hilton Hospital			
		First Name Cosmo		Last Name Kramer			
		Date of Birth 1970/01/01					
		Patient Sex		Ethnicity	Race		
Acute Hepatitis Apdf							Show all

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

≡	Acute Hepatitis A Case Report For	n.pdf	1 / 6   - 100% +   🗄 👌		± ē :
		* *	Patient Information		
			Disease/Organism Hepatitis A Date of Diagnosis 01/19/2023		
	i Maria Milana Milana Milana Milana Milana Milana		Is the Affiliation/Organization same for Patient ID (M Physician/Clinician? Yes	RN), Person Completing Form, and Attending	
	No. of Concession, Name		Patient ID (MRN) CK01011970		
	9 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Affiliation/Organization Hilton Hospital		
	2		Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)		
			Affiliation/Organization Hilton Hospital		
			Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com)		
			Affiliation/Organization Hilton Hospital		
	international and a second sec		First Name Cosmo	Last Name Kramer	
	3		Date of Birth 01/01/1970		
			Patient Sex	Ethnicity	

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

		nerier a.	SUBMIT		
Patient Information	0			-	
Laboratory Information	0			Print	Downloa
Applicable Symptoms	0	Patient Information			۵
Exposure Information	0				-
Hospitalization, ICU & Death Information	$\otimes$	Disease/Organism Hepatitis A	Date of Diagnosis 2023/01/19		
Vaccination History	$\odot$	Is the Affiliation/Organization same for Patient ID (MR Yes	N), Person Completing Form, and Attending Physician/Clinician?		
Additional Comments	Ø	Patient ID (MRN) CK01011970	Affiliation/Organization Hilton Hospital		
Review & Submit		Person Completing Form	Affiliation/Organization		
		Mr. Arthur Vandelay (arthur.vandelay@email.com) Attending Physician/Clinician	Hilton Hospital Affiliation/Organization Hilton Hospital		
		Dr. Frasier Crane (frasier.crane@email.com)			
int leferation	Ø				
tient Information	0			Print	📩 Downioa
boratory Information	$\oslash$			Print	L Downloa
poratory Information	0			Print	L Downloa
poratory Information plicable Symptoms posure Information	© ©	REVIEW & SU		Print	L Downioa
poratory Information	0	REVIEW & SU		Print	Downloa
poratory Information plicable Symptoms posure Information	© ©	REVIEW & SU Patient Information Laboratory Information		Print	•
boratory Information plicable Symptoms posure Information spitalization, ICU & Death Information	0	REVIEW & SU Patient Information		Print	٢
poratory Information plicable Symptoms posure Information spitalization, ICU & Death Information scination History	© © © ©	REVIEW & SU Patient Information Laboratory Information Does the patient have a lab test? Yes Hepatitis Marker		Print	•
poratory Information plicable Symptoms posure Information spitalization, ICU & Death Information ccination History ditional Comments	© © © ©	REVIEW & SU         Patient Information         Laboratory Information         Does the patient have a lab test?         Yes		Print	٢

3. Review the *Patient Information* section.

		REVI	EW & SUBMIT			
Patient Information	0					10
Laboratory Information	0				Print	Download
Applicable Symptoms	0	Patient Information				0
Exposure Information	0	Fatencintomation				•
Hospitalization, ICU & Death Information	0	Disease/Organism Hepatitis A	Date of Diagnosis 2023/01/19			
Vaccination History	0	Is the Affiliation/Organization same for Patient ID (MRN), Pers Yes	on Completing Form, and Attending Physician/Clinician?			
Additional Comments	0	Patient ID (MRN)	Affiliation/Organization			
Review & Submit		CK01011970	Hilton Hospital			
		Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital			
		Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com)	Affiliation/Organization Hilton Hospital			
		First Name Cosmo	Last Name Kramer			
		Date of Birth 1970/01/01				
		Patient Sex Male	Ethnicity Not Hispanic or Latino	Race White		
		Address 1 123 First Avenue				
		City Lexington	State KY	<b>Zip Code</b> 40509		
		County Fayette	Phone (555) 123-0000			
		Prior Hepatitis A Diagnosis Yes				
		If yes, please enter the date of diagnosis Unknown				
		Laboratory Information				٥





4. Review the *Laboratory Information* section.

Patient Information	⊘
Laboratory Information	۵
Does the patient have a lab test? Yes	
Hepatitis Marker Hepatitis A virus IgM Ab [Presence] in Body fluid	
Results Positive	
Test Result Date         Specimen Collection Date           2023/01/18         2023/01/16	
Laboratory Name: Test Lab	
Applicable Symptoms	0

5. Review the *Applicable Symptoms* section.

Laboratory Information	
Applicable Symptoms	
Were symptoms present during the course of illness? Yes	
Onset Date 2023/01/03	
if symptomatic, which of the following did the patient experience during their illness?	
Fever Yes	
If yes, please enter the highest temperature: 101	
Diarrhea (>3 loose stools/24hr period) Yes	
f yes, please enter # of days of diarrhea: 1	
Abdominal pain Yes	
Anorexia No	
Arthraigia No	
Clay Colored Stools Yes	
Dark urine Yes	
Elevated ALT > 200 No	
Elevated Billirubin > 3.0 No	
Fatigue Yes	
Headache No	





6. Review the *Exposure Information* section.

Did the patient have any of the following exposures in the past 6 months? Yes		
Domestic travel (outside state of normal residence) Yes		
Domestic Travel Details		
If yes, please specify state: CO		
Date of Departure 2022/12/24	Date of Arrival 2023/01/01	
Domestic Travel Details		
If yes, please specify state: AR		
Date of Departure 2022/11/25	Date of Arrival 2023/01/28	
International travel Yes		
International Travel Details		
If yes, please specify country: AUSTRALIA		
Date of Departure 2022/10/03	Date of Arrival 2022/10/10	
International Travel Details		
If yes, please specify country: GREECE		
Date of Departure 2022/09/19	Date of Arrival 2022/09/29	
Cruise or vessel travel as passenger or crew member Yes		

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

Hospitalization, ICU & Death Information		٥
Was the patient hospitalized? Yes		
If yes, please specify the hospital name: General Hospital		
Admission Date 2022/12/30	Discharge Date 2023/01/02	
Was the patient admitted to an intensive care unit (ICU)? No		
Did the patient die as a result of this illness? No		

8. If applicable, review the Vaccination History section.

<u>Vaccination History</u>	۵
Has the patient ever received a Hepatitis A vaccine? Yes	٦
Vaccine Details	
If yes, please provide vaccine name: Hepatitis A vaccine, adult dosage	
If yes, please enter the number of doses: 1	
If yes, please specify the date administered:	
Date Administered (1st dose) 2022/12/30	

Direct Data Entry for Case Reports: Acute Hepatitis A User Guide





9. Review the Additional Comments section.

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

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

- 10. 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.

REVIEW & SUBMIT						
Patient Information	$\oslash$					
Laboratory Information	$\oslash$		🖶 Print 🛃 Dowr	nload		
Applicable Symptoms	$\oslash$	Patient Information		0		
Exposure Information	$\odot$	radent mornadon		-		
Hospitalization, ICU & Death Information	0	Disease/Organism Hepatitis A	Date of Diagnosis 2023/01/01			
Vaccination History	$\oslash$	Is the Affiliation/Organization same Yes	or Patient ID (MRN), Person Completing Form, and Attending Physician/Clinician?			
Additional Comments	Ø	Patient ID (MRN) CK01011970	Affiliation/Organization Hilton Hospital			
Review & Submit		Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital			

11. 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.

CUTE HEPATITIS A CASE REPORT FORM							Sec	tion	1 of	f8
Please complete the form below. All	fields marked	with an asterisk(*) are required.								
		PATIENT INFO	RM	ATI	ON					
Patient Information	⊘	Disease/Organism*	Date	ofD	Diagno	osis*	9			
Laboratory Information	Ø	Hepatitis A 🛛 🗸 🗸	01,	/03/2	2022	_	_	_	_	iii Unknown
Applicable Symptoms	$\otimes$		4	Jar	<b>Janu</b> nuary		022 2022	~	Þ	
Exposure Information	$\otimes$	Is the Affiliation/Organization same for Patient ID (I Yes No	Su	Mo 27	Tu 28		Th 30			nd Attending Physician/Clinician?*
Hospitalization, ICU & Death	$\odot$	Patient ID (MRN)* 🚱	26 2	3	4	5		7		
Information	formation	СК01011970	9	10	11	12	13	14	15	x v
Vaccination History	$\odot$		16	17	18	19	20	21	22	
	$\odot$	Person Completing Form*	23	24	25	26	27	28	29	
Additional Comments	0	Mr. Arthur Vandelay (arthur.vande 🛛 🗸 🗸	30	31	1	2	3	4	5	
Review & Submit		Attending Physician/Clinician*	Affili	atior	n/Org	aniza	ation	0		If other, please specify: 🚱
		Dr. Frasier Crane (frasier.crane@e × v	Hilt	ton H	lospit	al				

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

ACUTE HEPATITIS A CASE R	EPORT FO	RM		Section 1 of 8	
Please complete the form below. All	fields marked v	vith an asterisk(*) are required.			
			PATIENT INFORMATION		
Patient Information	Ø	Disease/Organism*	Date of Diagnos	iis*	
Laboratory Information	$\odot$	Hepatitis A	01/03/2022		Unknown
Applicable Symptoms	$\odot$	Save Cha	anges?	×	
Exposure Information	$\odot$	Is the Affiliation/	-		Physician/Clinician?*
Hospitalization, ICU & Death	$\odot$	Patient ID (MRN Do you want	mation on this screen that has not b to save it?	een saved.	
Information		СК01011970	No. Physical Distance	×   ~	
Vaccination History	$\odot$	Person Complet	No - Discard	Yes - Save	If other, please specify: 🕜
Additional Comments	$\odot$	Mr. Arthur Vandelay (arthur.va	ande ×   ~ Hilton Hospita	I × I ×	
Review & Submit		Attending Physician/Clinician*	Affiliation/Orga	nization 🕑	If other, please specify: 🔞
		Dr. Frasier Crane (frasier.cran	e@e ×   ~ Hilton Hospita		

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

CUTE HEPATITIS A CASE R	EPORT FOR	М	Section 8 of 8	
Please review your information befo	ore submitting.			
		REV	EW & SUBMIT	
Patient Information	$\otimes$			_
Laboratory Information	$\otimes$			🖶 Print 🛃 Download
Applicable Symptoms	$\otimes$	Patient Information		0
Exposure Information	$\otimes$			•
Hospitalization, ICU & Death Information	$\otimes$	Disease/Organism Hepatitis A	Date of Diagnosis 2022/01/03	
Vaccination History	Ø	Is the Affiliation/Organization same for Yes	Patient ID (MRN), Person Completing Form, and Attending Physician/Clin	ician?
Additional Comments	$\odot$	Patient ID (MRN) CK01011970	Affiliation/Organization Hilton Hospital	
Review & Submit		Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital	

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

Additional Comments	$\diamond$
Additional comments or notes, please specify: Patient Notes	
Previous Submit	2





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



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

Admissi 06/15/21	Case Report Entry ×	rge Date 2021
Additic	Case Report Entry Saved Successfully	0
Addition Patient I	ок	
Please Note: Clicking OK wh	en the case report entry has b	een submitted successfully will
	he Case Report Entry User Sum	-

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

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



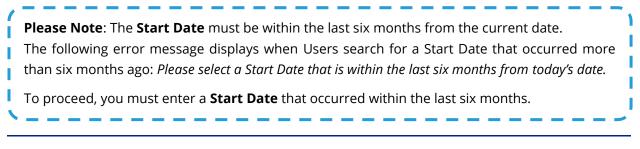
# 17 Case Report User Entry Summary

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

(ÎLIE	ePartr	nerViewer					a	Support	🛱 Announcem	ents 🟮 🌲 Advisories	I SIT_TEST 44 *
Patient Se	earch	Bookma	arked Patients		Event Notificati	ons	Lab D	ata Entry +		Case Re	oort Entry *
🖀 Home ゝ 🤇	Case Report Entry User	r Summary									
			CASE R	EPORT	ENTRY	USER SU	JMMARY	/			
LAST UPDAT	ED DATE RANGE		Start Date	02/01/2023	#		End Date 02/01/2	2023	<b>#</b>		2 Retrieve Data
SHOWING 2 ITEMS											<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE +	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX \$	STATUS 🗘	LAST UPDATED	SUBMISSION DATE +
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC аааааааааааааааааааааа	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM

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

			CASE I	REPORT	ENT	RYL	JSER SU	MMARY	7			
LAST UPDA	TED DATE RANGE		Start Date	01/01/2023	÷		E	and Date 02/01/2	023			₿ Retrieve Data
SHOWING 2 ITEMS				January 2	2023 🗸							<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE 🗘	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION		5 6 7 12 13 14	ие ≑	LAST NAME 🗘	DATE OF BIRTH	PATIENT SEX 🗘	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	22 23 24 25	19         20         21           26         27         28           2         3         4		Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:2 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC	TC506449MRP I	Josephine	2	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM





	CASE REPORT ENTRY U	SER SUMMARY	
LAST UPDATED DATE RANGE	Start Date 12/01/2020 💼	End Date 07/29/2021	🔁 Retrieve Data
Please select a Start Date that is within the last six m	onths from today's date.		

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

LAST UPDA	TED DATE RANGE		Start Date 0	1/01/2023	<b></b>	E	nd Date 02/01/2	023			
SHOWING 32 ITEMS											<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX 🗘	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaa aa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaa aa	TC506409MR NPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
Continue Delete	Acute Hepatitis A	Hepatitis A	DDE SMOKE TEST SIT NONCOVID	TC506405MR N	Oswald	Webb	1998/01/01	Male	In Progress	2023/01/27 7:44 AM	
Continue Delete	MDRO	Candida auris, colonization/screeni ng	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa	dafsf	sdfsdfds	fdsfsdfsd	2023/01/01	Male	In Progress	2023/01/27 7:43 AM	

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

LAST UPD	ATED DATE RANGE		Start Date	1/01/2023	-	F	nd Date 02/01/2	2023			C Retrieve Data
SHOWING 32 ITEMS											THIDE FILTER
	REPORT TYPE +	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME 🗘	LAST NAME	DATE OF BIRTH	PATIENT SEX \$	STATUS 🗘	LAST UPDATED	SUBMISSION DATE
ACTIONS	Enter Report Tyj	Enter Disease/ Or	Enter Affiliation/ (	Enter Patie	Enter First Name	Enter Last Na	Enter Date O	All 🗸	Enter St	All 🗸	All
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	СК01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:2 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaa aa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaa aa	TC506409MR NPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
Continue	Acute Hepatitis A	Hepatitis A	DDE SMOKE TEST SIT NONCOVID	TC506405MR N	Oswald	Webb	1998/01/01	Male	In Progress	2023/01/27 7:44 AM	

Direct Data Entry for Case Reports: Acute Hepatitis A User Guide



#### **Review Previously Submitted Case Reports**

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

LAST UPD	ATED DATE RAN	GE	Start Date	01/01/2023	<b></b>	Er	nd Date 02/01/	2023	<b> </b>		C Retrieve Data
SHOWING 32 ITEMS											APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION +	PATIENT MRN 🗘	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH \$	PATIENT SEX \$	STATUS \$	LAST UPDATED	SUBMISSION DATE
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaa aa aa	TC506449M RPI	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
View	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaa aa aa	TC506409M RNPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
Continue Delete	Acute Hepatitis A	Hepatitis A	DDE SMOKE TEST SIT NONCOVID	TC506405M RN	Oswald	Webb	1998/01/01	Male	In Progress	2023/01/27 7:44 AM	

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

Patient Se				Entry
lome <b>&gt;</b>	Patient Information			•
	Disease/Organism Hepatitis A	Date of Diagnosis 2022/01/03		
	Is the Affiliation/Organization same for Patient ID (MRN Yes	I), Person Completing Form, and Attending Pl	hysician/Clinician?	
ST UPDA	Patient ID (MRN) CK01011970	Affiliation/Organization Hilton Hospital		Retriev
NG EMS	Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital		PPLYF
	Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com)	Affiliation/Organization Hilton Hospital		JBMIS
ONS	First Name Cosmo	Last Name Kramer		ATE
View Copy	Date of Birth 1970/01/01			123/02 ):29 AM
View	Patient Sex Male	Ethnicity Not Hispanic or Latino	Race White	123/02 40 AM
Сору	Address 1			

Direct Data Entry for Case Reports: Acute Hepatitis A User Guide



#### Copy Previously Submitted Case Reports

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

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

			CASE RE	PORT	ENTRY L	JSER SI	JMMAI	RY			
LAST UPI	DATED DATE RAN	GE	Start Date	01/01/2023		Er	nd Date 02/01/	2023	<b>m</b>	I	2 Retrieve Data
HOWING											<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM \$	AFFILIATION/ ORGANIZATION *	PATIENT MRN \$	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH \$	PATIENT SEX \$	STATUS	LAST UPDATED	SUBMISSION DATE +
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaa aa aa	TC506449M RPI	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM
View Copy	Acute Hepatitis A	Hepatitis A	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaa aa aa	TC506409M RNPI	Melody	Cummings	1991/01/17	Female	Complete	2023/01/30 4:45 AM	2023/01/30 4:45 AM
Continue Delete	Acute Hepatitis A	Hepatitis A	DDE SMOKE TEST SIT NONCOVID	TC506405M RN	Oswald	Webb	1998/01/01	Male	In Progress	2023/01/27 7:44 AM	



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

- Disease/Organism
- Patient ID (MRN)
- Affiliation/Organization
- Prefix
- Suffix

- First Name
- Middle Name
- Last Name
- Date of Birth
- Patient Sex

TE HEPATITIS A CASE REPORT FO	DRM	Sec	tion 1 of 8		
ease complete the form below. All fields marked	with an asterisk(*) are required.				
	PATIENT	INFORMATION			
tient Information	Disease/Organism*	Date of Diagnosis*		_	
boratory Information	A Hepatitis A	v 01/03/2022	≡ (	Unknown	
plicable Symptoms	A				
posure Information	Is the Affiliation/Organization same for Patient ID     Yes No	(MRN), Person Completing Form,	and Attending Physician/Clini	cian?*	
spitalization, ICU & Death Information	Patient ID (MRN)* @	Affiliation/Organization*	9		
cination History	▲ CK01011970	Hilton Hospital	×		
ditional Comments	Person Completing Form*	Affiliation/Organization @		If other, please specify: 😡	
	Mr. Arthur Vandelay (arthur.vandelay@e ×				
view & Submit	Attending Physician/Clinician*	Affiliation/Organization @		If other, please specify: 😡	
	Dr. Frasier Crane (frasier.crane@email.c ×				
	Prefix				
	Select				
	First Name*	Middle Name		Last Name*	
	Cosmo			Kramer	
	Suffix	Date of Birth*			
	Select	~ 01/01/1970			
	Patient Sex*	Ethnicity*		Race*	
	Male	✓ Not Hispanic or Latino	x   ~	White	×
	Address 1* 123 First Avenue		Address 2 Unit, Suite, Building, etc.		
	125 Hist Avenue		Unit, Suite, Building, etc.		
	City*		State*		Zip Code*
	Lexington		KY	×   ~	40509-
	County*	Phone* 🕢		Email	
	Fayette ×	<ul><li>(555) 123-0000</li></ul>		name@domain.com	
	Is the patient currently pregnant? Yes No Unknown If yes, please enter the due date (EDC): @				
	mm/dd/yyyy	Unknown			
	Prior Hepatitis A Diagnosis*           Yes         No         Unknown           If yes, please enter the date of diagnosis* @				

Direct Data Entry for Case Reports: Acute Hepatitis A User Guide



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

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

Lexington       KY       X   v         County*       Phone* @       Email         Fayette       X   v       (555) 123-0000       name@domain.com         Is the patient currently pregnant?       Yes       No       Unknown         If yes, please enter the due date (EDQ: @       Email       Email		PATIENT II	NFORMATION			
Applicable Symptoms  Spoure Information  Applicable Symptoms  Spoure Information  Applicable Symptoms  State Affliation/Organization same for Patient ID (MRM), Person Completing Form, and Attending Physician/Clinician*  Vo  Patient ID (MRM)*  Affliation/Organization same for Patient ID (MRM), Person Completing Form, and Attending Physician/Clinician*  Necenses  Additional Comments  Review & Submit   Perfox  Select  Prefix Select  Prefix Select  Prefix Select  Prefix Select  Prefix Select  Prefix Select  Address 1*  Address 1*  Address 2  Address 1*  Address 1*  Address 2  Cly*  Select  Prone*  Courte  Select  Prefix Select	Disease	/Organism*	Date of Diagnosis*			
Juicule symptons is the Affiliation/Organization same for Patient ID (MAN), Person Completing Form, and Attending Physician/Clinician**  ver & Submit	n 🔒 Hepati	itis A 🗸 🗸 🗸	01/03/2022	<b></b>	Unknown	
is the Affiliation/Organization same for Patient DU (MRN). Person Completing Form, and Attending Physician/Clinician <sup>2+</sup> is the Affiliation/Organization same for Patient DU (MRN). Person Completing Form, and Attending Physician/Clinician <sup>2+</sup> is the Affiliation/Organization same for Patient DU (MRN). Person Completing Form, and Attending Physician/Clinician <sup>2+</sup> inter & Submit         Patient DU (MRN) <sup>2</sup> ●         Affiliation/Organization @         If the Assubmit         Preson Completing Form         If the Assubmit         Preson Completing Form         Affiliation/Organization @         If the Assubmit         If	<b>A</b>					
pipelilation, ICU & Death Information	Δ		MRN), Person Completing Form,	and Attending Physician/Clin	ician?*	
Patenti Univery   Attaction History   Attaction (History)   Attaction (History)   Attaction (Point Andelsy)   Print   Select   Print   Select   Point Sex*   Male   Address 1*   Address 2*   Piontel *   Y*   Y*   Y*   Y*   Y*   Y*   Y* <tr< td=""><td></td><td>5 No</td><td></td><td></td><td></td><td></td></tr<>		5 No				
Attornatory   Richard Comments   Interding Physician/Clinician*   Interding Physician/Clinician*   Dr. Fraster Crane (fraster.crane@email.cx)   Affiation/Organization @ Hitton Hospital If other, please specify: @	Patient			0		
wr. & Submit     Mr. Arthur Vandelay (arthur vandelay@e	CK010	11970	Hilton Hospital			
Attending Physician/Clinician*   Attending Physician/Clinician*   Dr. Frasier Crane (frasier.crane@email.c × )     Prefix   Select   First Name*   Cosmo   Suffix   Date of Birth*   Select   Patient Sex*   Middle Name   Last Name*   Cosmo   Suffix   Date of Birth*   Select   Patient Sex*   Male   Vinit, Suite, Building, etc.   City*   Example   County*   Phore*@   Enail   Fayette   Vision   It the patient currently pregnant?   Vision   Vision   Vision   Vision   Vision   Vision   Vision   Vision   Vision				•	If other, please specify: @	
Dr. Frasier Crane@email.c	Ar. Ar	thur Vandelay (arthur.vandelay@e 🛛 🗸	Hilton Hospital			
Prefix   Select   First Name*   Cosmo   Suffix   Select   Date of Birth*   Select   Ot/01/1970   Patient Sex*   Ethnicity*   Race*   Male   Vite     Address 1*   Address 2   123 First Avenue   Unit, Suite, Building, etc.   City*   Lexington   KY   Fayette   Yes   No   Unknown   If yet, please enter the due date (EDC); •				)	If other, please specify: 🚱	
Select   First Name*   Cosmo   Suffix   Suffix   Date of Birth*   01/01/1970    Patient Sex*	Dr. Fra	isier Crane (frasier.crane@email.c ×   ~	Hilton Hospital			
First Name* Middle Name Last Name*   Cosmo Kramer   Suffix Date of Birth*   Select 01/01/1970   Patient Sex* Ethnicity*   Male Ithispanic or Latino   Xddress 1* Address 2   123 First Avenue Unit, Suite, Building, etc.   City* State*   Lexington Kr/   Fayette Ithis Site, Building, etc.   Fayette Ithis Site, Building, etc.   Is the patient currently pregnant? Ithis Site, Building, etc.   Yes No   Unknown Hyes, please enter the due date (EDC): @	Prefix					
Cosmo Kramer   Suffix Date of Birth*   Select 01/01/1370   Patient Sex* Ethnicity*   Male Ithispanic or Latino   Xddress 1* Address 2   123 First Avenue Unit, Suite, Building, etc.   City* State*   Lexington KY   Fayette >   Fayette >   Ves No   Unknown If yes, please enter the due date (EDC): @	Select.					
Suffix   Select   Patient Sex*   Male   Image: Select   Patient Sex*   Ethnicity*   Race*   Male   Image: Select   Address 1*   Address 2   123 First Avenue   Unit, Suite, Building, etc.   City*   Lexington   Fayette   Fayette   Yes   No   Unknown   Hyes, please enter the due date (EDC); @	First Na	me*	Middle Name		Last Name*	
Select © 1/01/1970   Patient Sex* Ethnicity*   Male Not Hispanic or Latino   Xddress 1* Address 2   123 First Avenue Unit, Suite, Building, etc.   City* State*   Lexington KY   Fayette ×<	Cosmo	D			Kramer	
Patient Sex*       Ethnicky*       Race*         Male       Not Hispanic or Latino       X   v       White         Address 1*       Address 2       Unit, Suite, Building, etc.       Itis, Suite, Building, etc.         City*       State*       2         Lexington       KY       X   v       Itis         Fayette       X   v       [555) 123.0000       name@domain.com         Is the patient currently pregnant?       Yes       No       Unknown         If yes, please enter the due date (EDC): @       Email       No	Suffix		Date of Birth*			
Male   Address 1*   Address 2   123 First Avenue   Unit, Suite, Building, etc.   City*   State*   Lexington   KY   X × v   Fayette   KY   State   Email   Fayette   Ves   No   Unknown   If yes, please enter the due date (EDC); •	Select.	~	01/01/1970			
Address 1*       Address 2         123 First Avenue       Unit, Suite, Building, etc.         City*       State*         Lexington       KY         County*       Phone* @         Fayette       X \vee         Is the patient currently pregnant?       (55) 123-0000         Yes       No         Unknown       If yes, please enter the due date (EDC): @	Patient	Sex*	Ethnicity*		Race*	
123 First Avenue     Unit, Suite, Building, etc.       City*     State*       Lexington     X       County*     Phone* @       Fayette     X       State     (555) 123-0000       Is the patient currently pregnant?       Yes     No       Unknown       If yes, please enter the due date (EDC); @	Male	×	Not Hispanic or Latino	x   ~	White	×
Lexington     KY     X     V       County*     Phone* @     Email       Fayette     X     V       Is the patient currently pregnant?     (555) 123-0000     name@domain.com       If yes, please enter the due date (EDC): @     If yes, please enter the due date (EDC): @	123 Fi	rst Avenue		Unit, Suite, Building, etc		
County*     Phone* @     Email       Fayette     X     V     (555) 123-0000     name@domain.com       Is the patient currently pregnant?     Yes     No     Unknown       If yes, please enter the due date (EDC); @     Image: Content of the second sec	City*			State*		Zip Code*
Fayette     ×     ✓     (555) 123-0000     name@domain.com       Is the patient currently pregnant?     Yes     No     Unknown       If yes, please enter the due date (EDC): •     •     •	Lexing	,ton		KY	×   ~	40509-
Is the patient currently pregnant? Yes No Unknown If yes, please enter the due date (EDC): •	County*	•	Phone* 🕢		Email	
Yes No Unknown If yes, please enter the due date (EDC): •	Fayette	e ×   ~	(555) 123-0000		name@domain.com	
If yes, please enter the due date (EDC): 😡	Is the pa	atient currently pregnant?				
	Ye	s No Unknown				
mm/dd/yyyy 💼 🛄 Unknown	mm/d	d/yyyy 📾	Unknown			
Prior Hepatitis A Diagnosis*						
Yes No Unknown						
If yes, please enter the date of diagnosis*  mm/dd/yyyy Unknown			Vnknown			
			-			
Save		Save				Next
	9					
	1					





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

County*	Phone* 😧	Email
Fayette	× v (555) 123-0000	name@domain.com
Is the patient currently pregnant?		
Yes No U	Jnknown	
If yes, please enter the due date (E	EDC): 🔞	
mm/dd/yyyy	Unknown	
	Unknown	
Prior Hepatitis A Diagnosis*	Jnknown	
Prior Hepatitis A Diagnosis* Yes No U	Jnknown	
Prior Hepatitis A Diagnosis*	Jnknown	
Prior Hepatitis A Diagnosis* Yes No U If yes, please enter the date of diag	Jnknown Ignosis @	
Prior Hepatitis A Diagnosis* Yes No U f yes, please enter the date of diag	Jnknown Ignosis @	
Prior Hepatitis A Diagnosis* Yes No U If yes, please enter the date of diag	Jnknown Ignosis @	
Prior Hepatitis A Diagnosis* Yes No U If yes, please enter the date of diag	Jnknown Ignosis @	Next

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

UTE HEPATITIS A CASE REPORT FORM		Section 2 of 8	
Please provide laboratory information related to this case.			
	LABORATORY	INFORMATION	
Patient Information	Does the patient have a lab test?*		
Laboratory Information	Yes No		
Applicable Symptoms	If yes, at least one Hepatitis Marker test is required. If you choose to enter a	dditional test results such as ALT, AST, or Bilirubin, please ensure you complete all fields fo	that test.
Exposure Information	▲		
Hospitalization, ICU & Death Information	Hepatitis Marker*		
Vaccination History	Hepatitis A virus IgM Ab (Presence) in Body fluid	x   ~	
Additional Comments	Results*		
Review & Submit	Positive	x   ~	
	if applicable, please enter the viral load: 🛛		
	Test Result Date*	Specimen Collection Date* Unknown 01/16/2023	Unknown
	Laboratory Name:*		
	Test Lab		
	Add Hepatitis Marker		
	ALT		
	• Add ALT		
	AST		
	Add AST		
	Bilirubin		
	Add Bilirubin		
	Save		Previous Next

L .



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

		REVIEW &	SUBMIT			
Patient Information	${\boldsymbol{ \oslash}}$				_	
Laboratory Information	${\boldsymbol{ \oslash}}$				🖶 Print	Download
Applicable Symptoms	${\boldsymbol{ \oslash}}$	Patient Information				0
Exposure Information	${\boldsymbol{ \oslash}}$					•
Hospitalization, ICU & Death Information	${\boldsymbol{\oslash}}$	Disease/Organism Hepatitis A	Date of Diagnosis 2022/01/03			
Vaccination History	$\oslash$	Is the Affiliation/Organization same for Patient ID (MRN), Per Yes	son Completing Form, and Attending Physician/Clinician?			
Additional Comments	$\oslash$	Patient ID (MRN)	Affiliation/Organization			
Review & Submit		СК01011970	Hilton Hospital			
		Person Completing Form Mr. Arthur Vandelay (arthur.vandelay@email.com)	Affiliation/Organization Hilton Hospital			
		Attending Physician/Clinician Dr. Frasier Crane (frasier.crane@email.com)	Affiliation/Organization Hilton Hospital			
		First Name Cosmo	Last Name Kramer			
		Date of Birth 1970/01/01				
		Patient Sex Male	Ethnicity Not Hispanic or Latino	Race White		
		Address 1 123 First Avenue				
		City Lexington	State KY	<b>Zip Code</b> 40509		
		County Fayette Prior Hepatitis A Diagnosis	Phone (555) 123-0000			
		No				
Please Note: In the Diagnosis field from		nple edit above, the Use to <b>No</b> .	r changed the selection	for the <i>Pri</i>	or Hepa	titis A

If **No** or **Unknown** is selected for the Prior Hepatitis A Diagnosis field, the subsequent field is disabled: *If yes, please enter the date of diagnosis.* 

\_\_\_\_\_

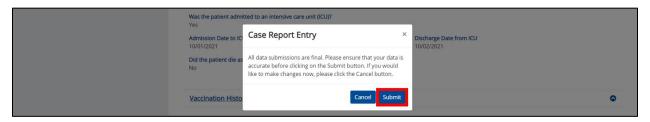
7. After verifying the information is accurate and/or the appropriate changes have been made, you must click **Submit** to submit the Acute Hepatitis A Case Report Entry.

Vaccination History	۵
Additional Comments	٥
Additional comments or notes, please specify: Additional Patient Notes	
Previous	Submit
<b>Please Note:</b> The new case report is <u>not</u> a continuation of the previously sub- for the patient.	mitted case report
	/





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



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

Was the p Yes	atient admitted to an intensive care unit (iCO)?		
Admission 10/01/202	Date to IC Case Report Entry	× Discharge Date from ICU 10/02/2021	
Did the pa No	tient die as Case Report Entry Saved Successfully		
Vaccinat	ion Histo	ок	0
<b>Please Note</b> : Clicking <b>OK</b> wh automatically navigate you to t	•	-	uccessfully will

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

Patient	Search	Bookma	rked Patients		Event Notifications		Lab D	ata Entry -		Case Rep	ort Entry -
😭 Home 🖒	Case Report Entry Use	Summary									
			CASE R	EPORT	ENTRY L	JSER SU	MMARY	,			
LAST UPDA	TED DATE RANGE		Start Date 0	2/01/2023	<b>#</b>	E	nd Date 02/01/2	023 (			₿ Retrieve Dat
SHOWING 3 ITEMS											<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION	PATIENT MRN	FIRST NAME	LAST NAME	DATE OF BIRTH	PATIENT SEX \$	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 5:26 PM	2023/02/01 5:26 PM
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:2 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaa aa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM



#### Continue In-Progress Case Reports

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

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

Patient Search Bookmarked Patients				Event Notifications		Lab D	ab Data Entry • Case F			port Entry -	
🖌 Home 🖒	Case Report Entry User	Summary									
			CASE R	EPORT	ENTRY L	JSER SU	MMARY	,			
LAST UPDA	TED DATE RANGE		Start Date	2/01/2023	*	E	nd Date 02/01/2	023			2 Retrieve Data
SHOWING 3 ITEMS											<b>T</b> APPLY FILTER
ACTIONS	REPORT TYPE 🗘	DISEASE/ ORGANISM	AFFILIATION/ ORGANIZATION ÷	PATIENT MRN	FIRST NAME	LAST NAME 🗘	DATE OF BIRTH	PATIENT SEX \$	STATUS 🕈	LAST UPDATED	SUBMISSION DATE
Continue Delete	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	In Progress	2023/02/01 5:15 PM	
View Copy	Acute Hepatitis A	Hepatitis A	Hilton Hospital	CK01011970	Cosmo	Kramer	1970/01/01	Male	Complete	2023/02/01 10:29 AM	2023/02/01 10:29 AM
View Copy	Acute Hepatitis C	Hepatitis C	Afzal, Mohammad MD, Internal Medicine, LLC aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa	TC506449MRP I	Josephine	Erickson	1965/02/02	Female	Complete	2023/02/01 6:40 AM	2023/02/01 6:40 AM

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

KHIE   ePartnerV	iewei	r	🗷 Support 📢 Ar	nnouncements 🌒 🌲 Advisories 🍓 😫 SIT_TEST 44 *	
Patient Search		narked Patients	Event Notifications	Lab Data Entry -	Case Report Entry -
Home > Acute Hepatitis A Case Report Fo	orm				
ACUTE HEPATITIS A CASE REPOR	f form			Section 7 of 8	
Please add any additional comments related	to this case.				
			ADDITIONAL COMMENTS		
Patient Information	$\otimes$	Additional comments or n	otes, please specify:		
Laboratory Information	$\oslash$	Patient details			
Applicable Symptoms	Ø				
Exposure Information	Ø				
Hospitalization, ICU & Death Information	Ø				
Vaccination History	Ø	15/1000 Characters			h
Additional Comments					
Review & Submit					
		Save			Previous Next

Direct Data Entry for Case Reports: Acute Hepatitis A User Guide Page 109 of 110





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

