RESOURCE AND PATIENT MANAGEMENT SYSTEM

RADIOLOGY/ NUCLEAR MEDICINE (RA)

User Manual

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PREFACE

The Radiology package supports administrative functions related to processing patients for radiological examinations. It automates tedious tasks previously performed manually, providing increased efficiency, accuracy, and completeness in the data entry and tracking of radiology exams. Exam results are readily available online to a broad range of authorized users throughout the facility.

Some of the highlights of the Radiology package features include:

- Online patient registration for exams
- Automatic printing of flash cards and jacket labels
- Transcription of patient radiological reports
- Daily activity log, exam status reports, incomplete/delinquent exam reports, and unverified/unreleased exam reports
- Workload reports generated by various criteria such as personnel, film usage, exam area, and ward
- Reports by procedures, diagnostic codes, and radiologists for quality improvement
- Online physician verification of radiological exam reports through electronic signatures
- Full integration with the Patient Care Component
- Procedures identified with CPT codes to facilitate billing

This software application will work in conjunction with the existing Resource and Patient Management (RPMS) applications and the distribution of the package will be IHS-wide.

SECURITY

This package does not impose any additional legal requirements on the user, nor does it relieve the use of any legal requirements. Names and social security numbers used in the examples are fictitious.

This package requires access and verify codes to access the system. These can be obtained from your supervisor or site manager. In addition, security keys are assigned with your access codes. They are required to perform certain options in the Patient Registration application. Some options within the application are “locked”, i.e., the user is unable to access the option without the appropriate security key.

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1.0 Introduction

1.1 Package Overview

The RPMS Radiology / Nuclear Medicine package is a comprehensive software package, designed to assist with the functions related to processing patients for imaging examinations. The Radiology / Nuclear Medicine package automates the entire range of diagnostic functions performed in imaging departments, including request entries by clinical staff, registration of patients for exams, processing of exams, recording of reports/results, verification of reports online, displaying/printing results for clinical staff, automatic tracking of requests/exams/reports, and generation of management statistics/reports, both recurring and ad hoc. The Radiology / Nuclear Medicine package automates many tedious tasks previously performed manually, providing faster, more efficient and accurate data entry and more timely results reporting.

The Radiology / Nuclear Medicine package is fully integrated with VA FileMan and provides certain patient demographic information supplied by the Patient Information Management System (PIMS) package. It also interacts with other RPMS packages to allow personnel to see patient medication histories, contrast media reactions, and laboratory test results that may influence the nature of an examination. Request entry has been incorporated in two ways: functionality within this package and an interface with the OERR package, allowing online requesting of exams and viewing of reports. Information regarding each examination is stored by the system and may be compiled to produce a variety of reports necessary in carrying out daily business and for use by management in analyzing the workload. Information required to generate AMIS reports and resource allocation reports is also collected. The Radiology / Nuclear Medicine package supports the HL7 (Health Level 7) protocol. This allows the exchange of information concerning exam registration, cancellation, completion, and results (specifically reports and impressions) between the RPMS system and clients within or outside of RPMS.

Other related documents will also be of value in using this package. The Radiology / Nuclear Medicine radiology supervisor's guide, technical manual, and Installation guide provide the site manager, the package coordinator, and other technical personnel with information necessary for installation and maintenance of the package.

1.2 Release Notes

The Radiology/Nuclear Medicine package is designed to assist with the functions related to processing patients for imaging examinations. The types of imaging exams supported are General Radiology, Nuclear Medicine, CT Scan, Magnetic Resonance

Imaging, Angio/Neuro/Interventional, Ultrasound, Vascular Lab, Cardiology Studies, and Mammography.

One of the most significant enhancements to this version is a single combined report for a set of related procedures. This is a "printset" mechanism for entering a single report for all descendent cases registered from a parent order. (For more detailed information on parent procedures, see Procedure Enter/Edit in the radiology supervisor's guide. Also, see the radiology supervisor's guide for more information on Parent/Descendent Exams and Printsets.) The ability to report separately for each procedure ordered under a single parent procedure still exists.

Numerous other large and small enhancements have been added to this version, including:

- Online verification "STAT" category
- Ability to select and print multiple reports in "Select Report to Print by Patient"

The Radiology/Nuclear Medicine package:

- Allows for the initialization and maintenance of device specifications, timeout parameters, and other site manager functions
- Provides the ability to establish site specific division, imaging location, and examination status parameters
- Provides the ability to enter and edit examinations
- Compiles information stored by the system into a variety of reports necessary to carry out daily business and for use by management in analyzing workload. These include daily, functional workload, personnel, and other special reports (e.g. AMIS).
- Allows the grouping of results reports into distribution/routing queues which distribute reports to hospital locations
- Allows for the online pre-verification by residents of transcribed reports
- Allows for the online verification of transcribed reports
- Provides for the registration and return of outside films
- Provides the ability to view patient demographic and examination data
- Provides the ability to establish site specific division, imaging location, and examination status parameters

- Allows the creation of orderable items to be utilized through the OERR package
- Provides the ability to print jacket labels, worksheets, and flash cards
- Integrates with VA FileMan and captures certain patient demographic information supplied by the PIMS package.
- Interfaces with the OERR package to support request entry and processing
- Interfaces with the Patient Care Component (PCC) package for the purpose of crediting outpatient imaging workload
- Interfaces with the Scheduling package for the purpose of capturing clinic stop codes and ambulatory procedures
- Interfaces with the Allergy/Adverse Reaction package for the purpose of capturing and displaying contrast media allergies and reactions.
- Allows the exchange of information concerning results (specifically reports and impressions) between the RPMS system and non-RPMS applications through the HL7 interface
- Provides mechanisms whereby personnel working in a given imaging department can enter, view, and report data separately from other imaging departments within the hospital
- Interfaces with the Health Summary package to print and display relevant medical histories

Note: The sample sessions in this manual may not be the same as sessions at your facility. This is due to variations in site parameters and changes due to software patches after release. For sessions that are likely to be significantly different from one site to another, sample sessions are not included in this manual.

2.0 Orientation

2.1 How to Work with the System

Is this Chapter for You?
If you are just learning to use RPMS software, this chapter will introduce you to a small but important part of the RPMS world—signing on, entering data, and getting out. You do not have to be a computer expert or know a lot of technical terms to use RPMS software, but you do have to follow instructions. And, in general, you need to be curious, flexible, and patient. This chapter will help you to get started. If you are an experienced RPMS user, this chapter can function as a reference.

How Does RPMS Work?
RPMS software packages are "menu driven." A menu is a screen display that lists all of the choices (options) available. You will see only the menus, options, and functions, which you have security clearance to use. Once you have made a selection, the software can display another menu or submenu or you might be asked to answer questions that allow the computer to perform tasks.

2.2 How to Sign-on

The procedure for establishing a link to the computer involves access and verify codes. These codes are assigned by the site manager. Contact your supervisor if you need these codes. For security reasons, the access code and verify code are not displayed on the terminal screen when you type them in. Please do not write your code down or reveal it to others. For security reasons, you will periodically be required to change your verify code.

After you have successfully entered your access and verify codes, the sign-on banner shows the date and time when you last signed on. The banner also shows whether or not the account had any unsuccessful attempts at logon. Rad/Nuc Med staff and residents will also see a displayed message telling them how many reports are awaiting review, if any.

1. Turn on your computer.

2. Press the Return key on the keyboard. A blinking cursor will appear on the terminal and you will see the access code and verify code prompts like this:

```
ACCESS CODE:
VERIFY CODE:
```

3. Type your access and verify codes at the appropriate prompts, following each entry by pressing the Return key. When you have successfully signed on, the banners, described above, will be displayed.

2.3 How to Exit an Option

In most cases, you will continue through an option to a normal ending. At times however, you might want to exit the option before the natural end of the option. To exit an option, type a caret (^), also referred to as an up hat or circumflex (Shift + 6 on most keyboards). You can use the caret at almost any prompt to terminate the line of questioning and return to the previous level in the routine. You can completely exit the system by typing the caret at all prompts that appear until you return to the access/verify code prompts.

2.4 How to Enter Data

To indicate that you have completed an entry, you must press the Return key (or the Enter key on some keyboards) after each response that you type. In many cases, you need only enter the first few letters (called shortcut synonyms) of an option or field, and the computer fills in the rest. Shortcut synonyms can help increase speed and accuracy.

If a prompt has no default response (see page 6 for more details), and you want to bypass the question, press the Return key and the computer will go on to the next question. You will be allowed to bypass a question only if the information is not required by the system. If the prompt has a default response, pressing the Return key is the same as typing the default response.

Some typists use the lower case L for the number 1 and the letter O for zero. Please keep in mind that, with this software, the number 1 and the letter l are not interchangeable. Also, the number 0 and the letter O are not interchangeable.

2.5 How to Obtain Help

If you need assistance while interacting with the software, type one or two question marks to view the online help.

? Typing a single question mark at a prompt will provide a brief help message.

?? Typing two question marks will provide a more detailed help message.

For example, two question marks entered at any procedure code prompt will display all available procedure code selections, but may cause a long wait because it is searching through a large file.

2.6 Responding to Prompts

When the computer prompts you with a question, typically a colon (:) will follow. Several types of prompts may be used including yes/no, select, and default prompts. Prompts usually ask for information that is later stored as a field in a file, like the basic prompt shown below:

```
DATE OF BIRTH:
```

This type of prompt is waiting for you to type a value; in this case, a date like March 3, 1960. Do not forget to complete your entry by pressing the Return key.

Select Prompt

If the answer to the prompt is a choice of several alternatives, the question can appear prefixed with the word Select, as below:

```
Select PATIENT NAME:
```

Yes/No Prompt

If the question requires either a yes or no response (in which case simply Y or N, upper or lower case, is acceptable), the question will usually be followed by a question mark rather than a colon.

```
ARE YOU SURE?
```

Sometimes, the text of the question will include, within parentheses, the different allowable responses that you can make to that question:

```
ARE YOU SURE (Y/N)?
```

Default Prompt

Sometimes the question that the computer is asking has a standard expected answer. This is known as the default response. In order to save you the trouble of typing the most probable answer, the computer provides the answer followed with a double slash //. You either type nothing (also known as a null response) and press the Return key to accept the default response as your answer, or you can type a different response:

```
IS IT OKAY TO DELETE? NO//
```

One-Many-All Selector Prompts

Within the Radiology/Nuclear Medicine package you will often be given the opportunity to select one or more items from a list. Typical examples of items selected are imaging locations, imaging types, and divisions. Various workload reports allow supervisors to select multiple staff or resident names, transcriptionist names, wards, clinics, etc. The Abnormal Exam Report now allows for a selection of diagnostic codes. Transcriptionists can choose one or more divisions and imaging types for report entry. Exam status tracking allows selection of only the desired

imaging locations. Sometimes, the prompt appears with a default of All. If you take the All default you will be selecting all possible items that you have access to, given your set of computer privileges as set up by your site manager and/or radiology supervisor(s). If you choose an item, but then decide you do not want it included, you can type a minus sign - followed by the item name to de-select it. (e.g., -Mammography to delete mammography from your list of selections).

Sometimes, it will save time if you use the wildcard method of selecting. For example, if you are selecting from a list of hospital locations, and you want all the locations that start with the characters 2N, you can type 2N*. The wildcard feature is case sensitive, so you will have to type your wildcard characters in uppercase if the items you wish to find are in uppercase, and lowercase if the items are in lowercase. In the sample below, RR* is a wildcard response used to select all imaging locations starting with the letters RR (e.g., RR A&D and RR Rapid).

```
Select Imaging Location: All// ??

      Select a IMAGING LOCATIONS LOCATION from the displayed list.
      To deselect a LOCATION type a minus sign (-)
      in front of it, e.g., -LOCATION.
      Use an asterisk (*) to do a wildcard selection, e.g.,
      enter LOCATION* to select all entries that begin
      with the text 'LOCATION'. Wildcard selection is
      case sensitive.

Choose from:
      FILE ROOM               (GENERAL RADIOLOGY-523)
      1ST FLOOR RECEPTION     (GENERAL RADIOLOGY-523)
      RECEPTION 2ND FLOOR     (GENERAL RADIOLOGY-523)
      SPECIAL PROCEDURES      (ANGIO/NEURO/INTERVENTIONAL-523)
      ULTRASOUND              (ULTRASOUND-523)
      VAOPC LOWELL            (GENERAL RADIOLOGY-523BY)
      MRI                     (MAGNETIC RESONANCE IMAGING-523)
      2ND FLOOR RECEPTION     (GENERAL RADIOLOGY-523)
      RR A&D                  (GENERAL RADIOLOGY-523)
      RR RAPID                (GENERAL RADIOLOGY-523)
      RR CT                   (CT SCAN-523)
      RR ULTRA                (GENERAL RADIOLOGY-523)
      MICU/SICU BOARD         (GENERAL RADIOLOGY-523)
      RR ICU                  (GENERAL RADIOLOGY-523)
      RR OPC                  (GENERAL RADIOLOGY-523)
      RR BATCH                (GENERAL RADIOLOGY-523)
      A&D RADIOLOGY           (GENERAL RADIOLOGY-523)
      RR SPECIAL              (GENERAL RADIOLOGY-523)
      RR MRI                  (GENERAL RADIOLOGY-523)
      OPC RADIOLOGY           (GENERAL RADIOLOGY-523BZ)
      VAMC BOSTON             (GENERAL RADIOLOGY-523BZ)
      MAMMOGRAPHY             (MAMMOGRAPHY-523)
      CTG                     (CT SCAN-523)
      GI SUITE                (GENERAL RADIOLOGY-523)
      NUCLEAR MEDICINE        (NUCLEAR MEDICINE-523)


Select Imaging Location: All// OPC RADIOLOGY    (GENERAL RADIOLOGY-523BZ)

Another one (Select/De-Select): VAMC BOSTON     (GENERAL RADIOLOGY-523BZ)

Another one (Select/De-Select): RR*

Another one (Select/De-Select): -RR MRI         (GENERAL RADIOLOGY-523)

Another one (Select/De-Select): ?

      Select a IMAGING LOCATIONS LOCATION from the displayed list.
      To deselect a LOCATION type a minus sign (-)
      in front of it, e.g., -LOCATION.
      Use an asterisk (*) to do a wildcard selection, e.g.,
      enter LOCATION* to select all entries that begin
      with the text 'LOCATION'. Wildcard selection is
      case sensitive.

You have already selected:
      OPC RADIOLOGY           (GENERAL RADIOLOGY-523BZ)
      RR A&D                  (GENERAL RADIOLOGY-523)
      RR BATCH                (GENERAL RADIOLOGY-523)
```

```
      RR CT                    (CT SCAN-523)
      RR ICU                   (GENERAL RADIOLOGY-523)
      RR OPC                   (GENERAL RADIOLOGY-523)
      RR RAPID                 (GENERAL RADIOLOGY-523)
      RR SPECIAL               (GENERAL RADIOLOGY-523)
      RR ULTRA                 (GENERAL RADIOLOGY-523)
      VAMC BOSTON              (GENERAL RADIOLOGY-523BZ)

Answer with IMAGING LOCATIONS, or TYPE OF IMAGING
Do you want the entire IMAGING LOCATIONS List? N (No)

Another one (Select/De-Select): <RET>
```

Figure 2-1: Using the All Selector and Wildcards

2.7 Printsets

Printsets are sets of procedures that are done together and reported once. The single report applies to all the cases in a printset. In almost all screens where a patient's list of registered procedures is displayed, printsets will appear on contiguous lines, with no other cases in between, and will be marked with a plus sign (+) or a period (.) . The plus sign (+) indicates the beginning of a list of cases in a printset and each case in the set appearing under the first case has a period (.) to its left.

```
  Case No. Procedure                  Exam Date Status of Exam   Imaging Loc
  -------- -------------              --------  ---------------  -----------
1  217     CHEST 2 VIEWS PA&LAT       08/18/97  WAITING FOR EXAM 2ND FLOOR R
2 +73    i CT HEAD W/O CONT           08/17/97  EXAMINED         CTG
3  74    i CT ORBIT SELLA P FOS OR TE 08/17/97  EXAMINED         CTG
4  3520    MRI SPINE - LUMBAR W/O CON 06/23/95  COMPLETE         MRI
```

> **Note**: A lowercase "i" in front of the procedure indicates that the site has the Rad/Nuc Med Imaging/Multimedia package interface running and that images were collected for those exams.

On labels, headers, and footers, a plus sign (+) will appear next to data where a single value prints, but more values may exist because multiple procedures are involved.

2.8 Invalid Responses

The computer software checks each answer immediately after it is entered. Whenever the computer determines that an answer is invalid for any reason, it beeps, displays two spaces and two questions marks (??), and repeats the question on a new line.

2.9 Learn-As-You-Go (LAYGO)

RPMS software checks your answers against an internally stored table of valid answers. If your answer is not stored in this table but the Learn-As-You-Go (LAYGO) mode is allowed, the computer adds your response as one of those valid answers. If LAYGO mode is allowed, then an example dialogue goes something like this:

```
ARE YOU ADDING A NEW CLINIC?
```

If you respond with a Y (or YES, yes, or y), the software adds the new clinic in its validation table and accepts the answer. If anything other than a Yes answer is entered, the unfamiliar answer will be invalidated and the prompt will be repeated.

2.10 How to Enter Dates and Times

When prompted for a date, use the following answer formats. Note that the response is not case sensitive; upper or lower case input is acceptable:

Dates:

- Jan 20 1957, 20 Jan 57, 1/20/57, or 012057
- T (for Today), T+1 (for tomorrow), T+2, T+7, etc.
- T-1 (for Yesterday), T-3W (for 3 Weeks ago), etc.
- If the year is omitted, the computer uses the Current Year.

Time:

- If only the time is entered, the current date is assumed.
- Follow the date with a time, such as Jan 20@10, T@10AM, 10:30, etc.
- You may enter a time, such as Noon, Midnight or Now.

The year portion of the date can be left off; normally the system will assume current year. Occasionally, the software will allow you to type a time-of-day in connection with a date, for example, 4:00 P.M. on July 20, 1994. To do this, type the date in one of the above forms followed by an at sign (@), followed by the time. For example, you might type:

```
20 JUL 94@4PM
```

In this mode, you can enter time either as military (four digit) time, hour AM/PM, hour:minute:second AM/PM, or type Now for the current date/time. The colon (:) can

be omitted. AM/PM can also be omitted if the time being entered is between 6 A.M. and 6 P.M. Thus, today at 3:30 P.M. can be entered as:

```
T@330
```

Use Mid as a response to mean 12:00 A.M. (midnight) and Noon as a response to mean 12:00 P.M. for time associated with dates:

```
T+3W@MID
```

2.11 Making Corrections

When you want to delete an answer previously entered without substituting any other answer, type an at sign (@) as a response to that prompt. This leaves the answer blank.

```
DATE OF BIRTH: May 21, 1946//@
```

In this example, the date on file has been erased and now there is no answer to the "Date of Birth" prompt; it is null.

The system will ask you to confirm that you really intend to delete the information. This question is a safety feature, giving you a chance to change your mind without re-editing later.

```
ARE YOU SURE?
```

Note: You may not be able to delete a response if the information is required.

2.12 Spacebar Recall Feature

When using this software, you might want to answer a prompt with a code meaning *the same as before*. For prompts that ask you to select one of several existing entries, the computer is capable of remembering what your last response was the last time you answered the same prompt. This feature is called spacebar recall and employs the Spacebar and Return key. Different hardware and software configurations support this feature to different degrees.

You generally can repeat information you entered the last time you responded to a particular prompt by typing a space and pressing the Return key. For example, you might wish to do a series of procedures for one patient. Each time (after the first) you are asked for the patient's name, you can type a space and press the Return key and the computer will enter the same patient. The example below assumes that the user entered 5East at the last "Select Ward:" prompt.

```
Select WARD: <space><return> 5EAST
```

2.13 Printing Reports

Frequently, when you have finished entering data, you will be asked if you wish to print the record, file, or report. You can display the report on your terminal screen or produce a paper copy. You will be prompted to type a device name of the printer you want to use. If you do not know the device name of the printer, you can type a question mark for a list of printers. In some cases the device you will use has already been decided for you and you will not be asked where you want to print. If you need assistance in determining the device name, ask your radiology supervisor or site manager.

Right Margin

Sometimes you will be asked to specify the right margin of the report. You will not be asked this in all cases as the information might be preset for the device you specify and a default answer provided. Nevertheless, your choices are simple.

Generally, 80 is used for standard size paper or for displaying on the terminal screen; 132 is used for wider paper.

```
DEVICE: Right Margin: 80//
```

Display the Report on the Terminal Screen

Display is the word used to indicate data printed to a terminal screen rather than on paper. At the “Device:” prompt, if you want to view a report on your screen, press the return key. Normally, if you do not specify a device name, the information will print on your screen. After the screen fills with the first page of the report, you will be prompted to press the return key to continue with the next screen of data. The process is repeated at the bottom of every screen. You can exit the option at any time by typing a caret (^).

```
Press <RET> to continue, or '^' to quit
```

Queue Report to a Printer

Queuing a time-consuming print job or other task uses computer time more efficiently and frees your terminal immediately so you can continue to work rather than making you wait until the information prints before you can use your terminal. If you want to queue your output to run in the background, type the letter Q at the “Device:” prompt. Next, you will be prompted to type a device name of the printer you want to use. Finally, type the date and time you would like the report to print.

```
DEVICE: Type the letter Q to queue the print job.
QUEUE TO PRINT ON: Type the device name or number.
Requested Start Time: NOW// Press the Return key or type a time here using the date
and time formats discussed in section 2.10 (e.g., Now+1 for one hour from now).
```

2.14 How to Stop Printing (Long Documents)

All reports that consume a significant amount of printing time are now stoppable through the Stop Task action of the TaskMan User option under the User's Toolbox menu. The enhanced report logic checks for a stop flag during processing that is done before printing begins and during printing. Report tasks from this software will have Rad/Nuc Med as the first words in their description. Below is an example of prompts and user responses on how to discontinue printing.

```
Select Rad/Nuc Med Total System Menu Option: TBOX User's Toolbox

      Display User Characteristics
      Edit User Characteristics
      Electronic Signature code Edit
      Menu Templates ...
      Spooler Menu ...
      Switch UCI
      TaskMan User
      User Help

Select User's Toolbox Option: TaskMan User

Select TASK: ??

Please wait while I find your tasks...searching...finished!

1: (Task #35624) DQ^XQ83, MICRO UPDATING XUTL. No device. POC,POC.
From 12/13/96 at 14:32, By you. Completed 12/13/96 at 14:32.
------------------------------------------------------------------------------
2: (Task #36693) DQ^XQ83, MICRO UPDATING XUTL. No device. POC,POC.
From 01/14/97 at 8:52, By you. Completed 01/14/97 at 8:53.
------------------------------------------------------------------------------
3: (Task #36745) DQ^XQ83, MICRO UPDATING XUTL. No device. POC,POC.
From 01/15/97 at 14:11, By you. Completed 01/15/97 at 14:11.
------------------------------------------------------------------------------
4: (Task #37008) DQ^XQ83, MICRO UPDATING XUTL. No device. POC,POC.
From 01/24/97 at 10:14, By you. Completed 01/24/97 at 10:14.
------------------------------------------------------------------------------
5: (Task #37174) DQ^XQ83, MICRO UPDATING XUTL. No device. POC,POC.
From 01/31/97 at 16:17, By you. Completed 01/31/97 at 16:17.
------------------------------------------------------------------------------
6: (Task #37388) START^RADLQ1 Rad/Nuc Med START^RADLQ1. Device LINE. POC,POC.
From 02/07/97 at 16:30, By you. Waiting for device _LTA1707:
------------------------------------------------------------------------------

Press RETURN to continue or '^' to exit: ^

Select TASK: 37388 START^RADLQ1
      Taskman User Option
      Display status.
      Stop task.
      Edit task.
      Print task.
      List own tasks.
      Select another task.

      Select Action (Task # 37388): Stop Stop task.

Task unscheduled and stopped.
```

Figure 2-2: Discontinuing Printing through TaskMan

3.0 Using the Package

3.1 Package Management

This package utilizes electronic signature codes for those functions that require sign-off approval; i.e., physician sign-off on dictated reports. The electronic signature code is a code of 6-20 characters that, upon being entered into the system, identifies you specifically to the system. It is similar to your access and verify codes and the same security measures should be observed in protecting it. It should never be written down or given to anyone else to use. The site manager, as well as your supervisor, should be notified immediately should you suspect that someone else is using your code. Electronic signature codes are assigned through the Edit Electronic Signature Code option of Kernel. IRM Service will assign this option to appropriate users requiring an electronic signature code. Each user has only one electronic signature code that can be used across all applications that require an electronic signature.

The package makes use of Current Procedural Terminology (CPT) codes that are American Medical Association (AMA) copyrighted. Its use is governed by the terms of the agreement between the IHS and the AMA.

3.2 Sign-On Message

When signing onto the system, a message may appear that states how many reports are waiting to be verified. It differentiates between reports for staff awaiting verification and reports for residents waiting for pre-verification. An example of each is shown below.

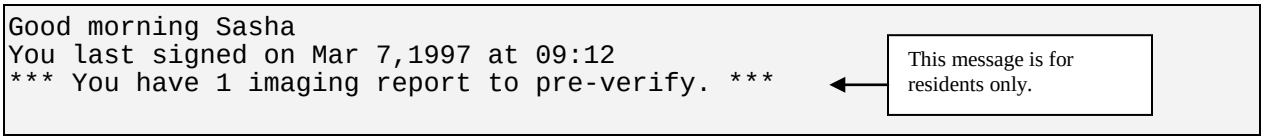


Figure 3-1: Resident Sign-on Message

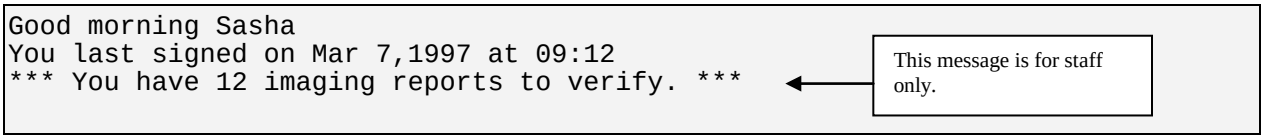


Figure 3-2: Staff Sign-on Message

3.3 Package Maintenance

The radiology supervisor should be assigned the Rad/Nuc Med Total System Menu (RA OVERALL), the RA ALLOC key, and RA MGR key. There are many options within the submenus of the Supervisor menu [RA SUPERVISOR] that help maintain

the system. Among these are system and file setup options that are discussed in depth in the radiology supervisor's guide. The rest of the options under the Supervisor Menu may be used by radiology supervisors and other supervisors to take care of day-to-day maintenance issues and are discussed in this manual.

The Site Manager menu [RA SITEMANAGER] should be assigned to the appropriate personnel by the site manager and will not appear on the Total System menu. Refer to the technical manual for a detailed explanation of these options.

3.4 Switch Locations

This option is listed first to show the user how to select a new location without logging out and logging back into the package. This option appears on several menus. It is meant to be a timesaving convenience to users.

When the package is first set up, the radiology supervisor assigns imaging locations to users through the Personnel Classification menu (see the radiology supervisor's guide). This determines which imaging locations users are allowed to select when they first sign on to the Radiology/Nuclear Medicine package.

The imaging location selected determines the default division, imaging location, imaging type, label printers and report printer during the user's interactive session. It will determine, in some cases, which data the user can access during the session because data is often "screened" by imaging type. For instance, a user signed on to an imaging location of the "Nuclear Medicine" imaging type would not be able to edit exams of a "General Radiology" imaging type.

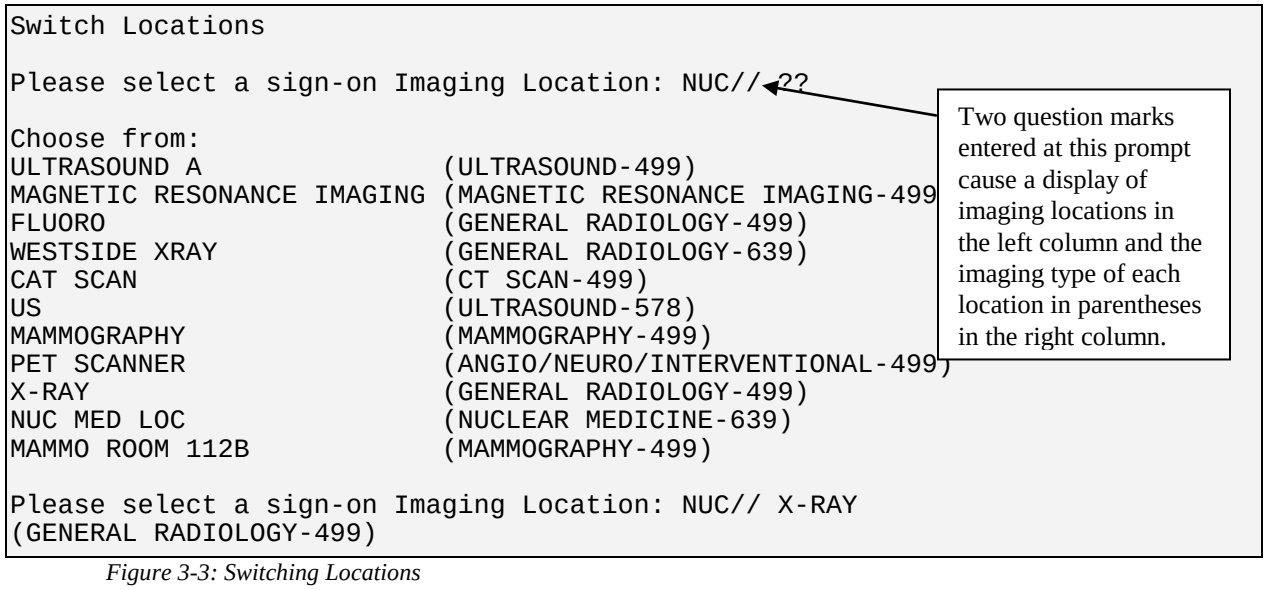


Figure 3-3: Switching Locations

A screen will then appear, outlining the parameters associated with the selected location.

```
--------------------------------------------------------------------------------
Welcome, you are signed on with the following parameters:
                                                 Printer Defaults
Version : 5.0                                    ----------------
Division : HINES CIO FIELD OFFI    Flash Card :  P-DOT MATRIX BACK
Location : X-RAY                                 1 card/exam
Img. Type: GENERAL RADIOLOGY      Jacket Label:  P-DOT MATRIX BACK
User : BEAMERS,TENA                              1 labels/visit
                                       Report :  P-DOT MATRIX BACK
--------------------------------------------------------------------------------
```

Figure 3-4: Location Parameters Screen

4.0 Exam Entry/Edit Menu

4.1 Add Exams to Last Visit

This function allows you to add more procedures to a patient's last visit. (The Register Patient for Exams option (section 4.9) will not allow you to add more procedures to an existing visit.) Use this option when a physician decides, after performing a procedure, that the patient needs additional testing during the same visit.

You are allowed to add exams to the last visit only, and only if the visit was on the current or previous day. However, if you hold the RA MGR security key, you may add examinations to any past visit, including exam sets and printsets, unless results have already been entered. Exam sets are defined by the radiology supervisor when parent and descendent exams are set up. Refer to the radiology supervisor's guide for an explanation of parent/descendent exam setup and use.

You are only allowed to add examinations to visits at your current sign-on imaging location. If the last visit for the selected patient did not take place at your current sign-on imaging location, the following message will be displayed:

```
Last visit date is for location 'NUC MED LOC'.
Your current location is defined as: 'ULTRASOUND A'.
You must log into the 'NUC MED LOC' location to add exams to the last visit.
```

If there are existing unregistered requests, you will first be given the option to choose from the existing requests. If the desired exam is not present on the list, you may create a new one after the list is displayed and you do not select one. If there are no requests available to select (generally this would mean that all imaging orders for the patient have already been registered), you will be asked if you want to request an exam for the patient. If you choose a request where the procedure's imaging type does not match the imaging type of your current sign-on location, you will not be allowed to add the procedure. Depending on how the parameters are set at your site, you may be asked to type your Access Code after you have entered the information for the new examination.

```
Add Exams to Last Visit

Select Patient:     ZMOUSE,MINNIE      NO       NSC VETERAN       06-05-96
000004444
                          PRIM. CARE: SMITH,JOHN J MD TEL 4418; 5021
                          ALT. PRIM. CARE: WELBY,MARCUS MD TEL 4418

********** Patient Demographics **********

Name         :  ZMOUSE,MINNIE
Pt ID        :  000-00-4444
Date of Birth:  JUN 5,1896 (101)
Veteran      :  Yes                    Eligibility : NSC
Sex          :  FEMALE
Narrative    :  This is a real dummy
Other Allergies:
       'V' denotes verified allergy       'N' denotes non-verified allergy
          YES(V)               PTSD(V)


Case # Last 5 Procedures/New Orders  Exam Date   Status of Exam  Imaging Loc.
------ ----------------------------  ---------   --------------  ------------
262     WRIST 2 VIEWS                AUG 18,1997 WAITING FOR    2ND FLOOR RE
899     ECHOGRAM ABDOMEN COMPLETE    JUN 25,1997 CANCELLED      ULTRASOUND
897     CHEST 2 VIEWS PA&LAT         JUN 25,1997 WAITING FOR    RAD-3
2833    CHEST 2 VIEWS PA&LAT         MAY 2,1997  CANCELLED      RAD-3
3350 +  TUMOR LOCALIZATION (GALLIUM  APR 19,1997 CANCELLED      NUCLEAR MEDI
        WRIST 2 VIEWS                Ord 10/10/95
        SHOULDER 1 VIEW              Ord 2/19/97
        CT ABDOMEN W&W/O CONT        Ord 6/13/95
        BONE IMAGING, TOMOGRAPHIC (S Ord 7/18/95
        MAMMOGRAM BILAT              Ord 10/3/95
        CHEST 2 VIEWS PA&LAT         Ord 10/27/95
        ABDOMEN 1 VIEW               Ord 12/12/95
        CT THORACIC SPINE W/O CONT   Ord 12/12/95
        SPINE SI JOINTS 3 OR MORE VI Ord 5/16/96

Last Visit Date/Time: AUG 18,1997 11:39


Case No.     Procedure      Status
--------     ---------      ------
  262        WRIST 2 VIEWS  WAITING FOR EXAM

Do you wish to add exams to this visit? No// Yes


**** Requested Exams for ZMOUSE,MINNIE **** 9                  Requests
  St Urgency  Procedure Desired                    Requester    Req'g Loc
  -- -------  ------------------------------------ ------------ -------------
1  h ROUTINE  SHOULDER 1 VIEW 02/19                STAFF,MARY    CONTINUING
2  h ROUTINE  ABDOMEN 1 VIEW 12/12                 STAFF,MARY    RADIOLOGY-U
3  h ROUTINE  CT THORACIC SPINE W/O CONT 12/12     STAFF,M. EL   LOWELL OP1
4  s ROUTINE  CHEST 2 VIEWS PA&LAT 10/27           STAFF,KEN     IM ALEX
5  h ROUTINE  WRIST 2 VIEWS 10/10                  STAFF,MARY    RADIOLOGY-U
6  h ROUTINE  MAMMOGRAM BILAT 10/03                STAFF,GARY    RADIOLOGY-B
7  h ROUTINE  BONE IMAGING, TOMOGRAPHIC (SP 07/18 STAFF,M. EL   RADIOLOGY-M
8  h ROUTINE  CT ABDOMEN W&W/O CONT 06/13          STAFF,MARY    RADIOLOGY-U
9  h ROUTINE  HIP 1 VIEW 04/22                     STAFF,JIM     C PRIMARY T
```

If there are no open requests for imaging exams for this patient, or if the procedure you want to register was not ordered, the system will automatically give you the opportunity to enter a request.

```
Select Request(s) 1-9 or '^' to Exit: Exit// 1

       Procedure: SHOULDER 1 VIEW
     ...will now register ZMOUSE,MINNIE with the next case number...

     Case Number: 264
     ----------------
     PROCEDURE: SHOULDER 1 VIEW// <RET>     (RAD Detailed) CPT:73020
     Select MODIFIERS: <RET>
     CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
     PRINCIPAL CLINIC: CONTINUING CARE-RN 7000// <RET>     7000

          ...all needed flash cards and exam labels queued to print on BAR88
PRT.
    Task #: 6567354
          ...all film jacket labels queued to print on D129.
    Task #: 6567355
```

Figure 4-1: Adding Exams to Last Visit

4.2 Cancel an Exam

This function allows the user to cancel a registered exam on record if a results report has not already been filed for that exam. An exam is often cancelled if, at the last minute, the patient cannot have the exam performed. For example, the patient may become too ill while waiting to have the procedure performed. Through this option, you can only cancel exams that have not been performed.

To cancel an exam:

1. Select the Cancel an Exam option.

2. Type the case number at the "Enter Case Number:" prompt. You can also enter the patient's name or last initial + last 4 digits of SSN, or any other common RPMS method of patient look-up.

3. Type Y or N at the "Do you wish to cancel this exam? No//" prompt.

4. Type the date and time that the status change was requested at the "Status Change Date/Time:" prompt. This question is useful if data entry is done at a later date/time than the actual processing of exams.

> **Note**: This question may not appear on your system depending on system parameters.

5. Type the number that corresponds to the reason for the cancellation at the "Reason for Cancellation:" prompt. If you need to see a list of options, type two question marks (??) at the prompt. The reasons for cancellation may be different from the one shown in the example in Figure 4-2.

6. Type Y or N at the "Do you want to cancel the request associated with this exam? No//" prompt. If you type Y, the request will also be cancelled and the request status updated to Discontinued as long as there are no other registered exams based on this order. (This might happen if the ordered procedure was designated as a parent procedure.) If you type N, the request status will be updated to HOLD as long as no other registered exams are based on the order, and may be selected for reregistration at a future date.

When all descendents of a parent procedure are cancelled, the user will be prompted to cancel the associated request. If an exam with radiopharmaceuticals is cancelled, the system will ask if you want to delete the radiopharmaceutical data from the case to prevent its being counted in the radiopharmaceutical usage reports. If the radiopharmaceutical was not drawn or administered, it is appropriate to delete the data.

```
Enter Case Number: 681

Choice Case No. Procedure            Name               Pt ID
------ -------- -------------------- ------------------ -----
   1    681     ARTHROGRAM KNEE S&I  MILLER,FRANK       9747

Do you wish to cancel this exam? NO// Y
     ...exam status backed down to 'CANCELLED'
     STATUS CHANGE DATE/TIME: APR 11,1997@14:41// <RET>

REASON FOR CANCELLATION: ??
   This is the reason this exam was cancelled.

Choose from:
   1      ANESTHESIA CONSULT NEEDED         Synonym: ANES
   6      CONFLICT OF EXAMINATIONS          Synonym: CON
   7      DUPLICATE REQUESTS                Synonym: DUP
   8      INADEQUATE CLINICAL HISTORY       Synonym: INAD
   11     OTHER CANCEL REASON               Synonym: OTH
   13     PATIENT CONSENT DENIED            Synonym: PCD
   14     PATIENT EXPIRED                   Synonym: EXP
   17     REQUESTING PHYSICIAN CANCELLED    Synonym: REQ
   19     WRONG EXAM REQUESTED              Synonym: WRN
   20     EXAM CANCELLED                    Synonym: CAN

REASON FOR CANCELLATION: 17 REQUESTING PHYSICIAN
CANCELLED Synonym: REQ
...cancellation complete.

Do you want to cancel the request associated with this exam? No// Y (Yes)
        ...request status updated to discontinued.
```

Figure 4-2: Canceling an Exam

If a request is cancelled, the Rad/Nuc Med Request Cancelled mail bulletin will be sent to members of the mail group usually named RA Request Cancelled. If it is placed on Hold, a similar bulletin, Rad/Nuc Med Request Held, is sent.

A sample mail bulletin sent to members of the RA Request Cancelled or other mail group set up by the site manager to receive the Rad/Nuc Med Request Cancelled bulletin is included below:

```
Subj: Imaging Request Cancelled (837-73-9747) [#12481] 11 Apr 97 14:41
      9 Lines
From: POSTMASTER (Sender: ORBY,SKIP) in 'IN' basket. Page 1
-------------------------------------------------------------------------------

The request for exam with the following identification was cancelled:
         1) Patient :                PATIENT,FRANK
         2) Patient SSN :            000-00-9747
         3) Procedure :              ARTHROGRAM KNEE S&I
         4) Date Desired :           APR 10, 1997
         5) Requesting Physician :   PROVIDER,GREGORY J
         6) Requesting Location :    X-RAY
         7) Reason :                 EXAM DELETED
         8) User :                   ORBY,SKIP

Select MESSAGE Action: IGNORE (in IN basket)// <RET> Ignored
```

Figure 4-3: Sample RAD/NUC MED REQUEST CANCELLED Mail Bulletin

4.3 Case No. Exam Edit

This function allows the user to edit exams for patients by selecting either the case number or the patient's name. Only active cases may be chosen. If the case number does not exist or is inactive, the system will indicate so with an error message.

> **Note**: A registered case that is not yet in a Complete status is considered active.

Once an exam is edited and in the Complete status, the associated request will display the Complete status. Reprinted requests will show the procedure ordered and the procedure(s) registered.

When an exam's status progresses to Complete, The Radiology/Nuclear Medicine system sends exam data to the Patient Care Component (PCC) package. PCC checks for required data, then passes that data to the Scheduling package. The following data is required for crediting:

- Detailed Procedure with a Valid CPT Code
- Primary Interpreting Staff or Primary Interpreting Resident
- Patient
- Exam Date/Time
- DSS ID

- Requesting Location

If all required data is not available or if PCC cannot credit the exam, a bulletin (Rad/Nuc Med Credit Failure) will be generated and sent to members of the associated mail group. The bulletin tells the recipient which case and procedure caused the crediting failure. If PCC rejected the procedure, the bulletin will include whatever information PCC sends to the Rad/Nuc Med package.

Once an exam attains a status of Complete, only holders of the RA MGR security key are allowed to edit the exam, and the long case number must be entered to retrieve the case. Imaging departments must make sure that cases are routinely processed to a Complete status. Otherwise, the case numbers will increment until the maximum number is reached (99,999) and the system will not allow users to register any more cases.

It should be noted that the radiology supervisor can use the Procedure Enter/Edit option to set up default film sizes and amounts for procedures. If this is done, these sizes and amounts used are automatically entered into the film size and number used fields. That means that the technician editing the case will have to make a point of manually deleting and re-editing these fields if the film size and number used for a specific case are not the same as the standard film size and number used entered in the procedure parameters by the radiology supervisor. See the radiology supervisor's guide for more information about procedure setup using the Procedure Enter/Edit option. The radiology supervisor's guide also contains a chart showing every possible data field that can appear in the Case Edits and Status Tracking options and includes which conditions cause the fields to be prompted.

Case Edit Fields

Procedure: You will only be able to select active procedures from the Rad/Nuc Med Procedures file (#71) for the current imaging type.

> **Note**: If contrast media is used with the procedure and the patient had a previous reaction to the media, you will be asked to "OK" the use of it.

You may type any of the following to select your procedure:

- Name of procedure
- CPT Code
- Site specific synonym for the procedure

If the procedure is changed for a case using radiopharmaceuticals, a message will appear telling you to review the radiopharmaceutical data previously entered. This

field appears during case edits and during status tracking if the "Ask" parameter is set to yes.

Category of Exam: You are required to type one of the following:

- I Inpatient
- O Outpatient
- C Contract
- S Sharing
- E Employee
- R Research

During Registration, Category of Exam is automatically filled in as:

- Inpatient if the patient is on a ward
- The category on the order if there is no ward
- The Usual Category if no order category exists

This field may be edited during registration or during case editing. An inpatient may have a Contract, Sharing, or Research category of exam if the exam procedure is not directly related with the patient's hospital stay. Data in this field is used to compile workload statistics and various management reports. This field may be edited during registration and case edits.

Ward: This field only appears during registration if the patient is an inpatient at the time of the exam, and only appears during case edits if it is already populated. It is the patient's location at the time the exam was performed. It is automatically entered by the system during registration. If the appropriate report distribution queue is active, the report for this exam will automatically be placed in the queue for this clinic, or in the current ward if the patient is admitted before the report is verified.

Service: This field only appears during registration for inpatient exams, and only appears during case edits if it is already populated. It is automatically entered by the system during registration.

Bedsection: This field only appears during registration for inpatient exams, and only appears during case edits if it is already populated. It is automatically entered by the system during registration.

Principal Clinic: This field only appears during registration if the category of exam is outpatient or employee and only appears during case edits if it is already populated. It

is the principal clinic that referred the patient to Radiology/Nuclear Medicine for the exam and is automatically entered by the system during registration. If the appropriate report distribution queue is active, the report for this exam will automatically be placed in the queue for this clinic, or in the current ward if the patient is admitted before the report is verified.

Contract/Sharing Source: This field is automatically entered during registration if a Contract or Sharing source was entered on the exam request. It only appears in case edits if the category of exam is contract or sharing or if it is already populated. It is the contract/sharing source that referred the patient to Radiology/Nuclear Medicine for the exam.

Research Source: This field is automatically entered during registration if a research source was entered on the exam request. It only appears in case edits if the category of exam is research or if it is already populated. It is the research source that referred the patient to Radiology/Nuclear Medicine for the exam.

Barium Used: It should be noted that the system automatically answers the "Barium Used?" and "Contrast Media Used?" prompts under certain conditions. If the procedure's AMIS category is one that always uses contrast media, the "Contrast Media Used?" prompt will be set to yes. The AMIS categories that always use contrast media are:

- 10 Genitourinary
- 11 Cholecystogram, Oral
- 12 Cholangiogram
- 14 Bronchogram
- 16 Angiogram, Cath-cerebral
- 17 Angiogram, Cath-visceral
- 18 Angiogram, Cath-peripheral
- 19 Venogram
- 20 Myelogram

Procedures in some AMIS categories may or may not use contrast media. In this case, you will have the opportunity to answer the "Contrast Media Used?" prompt. The AMIS categories that sometimes use contrast media are:

- 4 Cardiac Series

- 15 Digital Subtraction Angiography
- 21 Computed Tomography
- 22 Interventional Radiography

The system assumes that procedures in all other AMIS categories do not use contrast media, so no prompt appears. The use of Barium is assumed for all procedures whose AMIS category is 9—Gastrointestinal Exams. In these cases, the "Barium Used?" prompt will automatically be set to yes.

Requesting Physician: The Requesting Physician is the person who requested the exam. The entry may not be a physician; a nurse might request the exam. This data is automatically entered during registration and can be edited while in the case edits option.

Complication: This field points to the Complication Types file (#78.1) and is used to indicate if this patient experienced any complication during the exam procedure (e.g., Reaction to Contrast Medium). If a reaction to the contrast medium did occur, then the system triggers the addition of contrast media as an allergen in the Adverse Reaction Tracking (ART) package without leaving the Radiology/Nuclear Medicine option. This field only appears in case edits.

Complication Text: This field is used to give a brief explanation (4-100 characters) of the exam complication. The text entered will appear on the Complications Report, and under the Comment caption in the detailed exam view of the Profile of Rad/Nuc Med Exams. It is only asked during Case Edits when a complication has been entered.

Primary Camera/Equip/Rm: This field points to the Camera/Equip/Rm file (#78.6) for the name of the primary camera/equipment/room where the imaging exam was performed. Usually there is only one camera/equipment/room per procedure. Depending on the requirements set up in the Examination Status file (#72), it may be necessary for this field to be filled in before the exam status can be considered complete. This field appears during case edits if the division parameter contains a yes, and appears in status tracking if the "Ask" examination status parameter is set to yes.

Film Size: This field points to the Film Sizes file (#78.4) and indicates the size of the film used during the Rad/Nuc Med exam. You may also enter film sizes that have been wasted during the exam. This data is automatically entered during registration if it has been associated with the procedure registered. It is asked in case edits and it is asked in status tracking if the "Ask" examination status parameter is set to yes. The following sample list of selectable film sizes shows a set of seven entries followed by the same seven entries repeated with a "W-" preceding the names. The "W-" is a convention used to indicate wasted film. Wasted film sizes as well as used film sizes may be entered at the same Film Size prompt.

If a “W-” precedes the name, the system will count those as wasted films on the wasted film report.

- 10X12 CR10 DUPONT AFC
- 10X12 CR10 DUPONT DAYLIGHT
- 10X12 CRONEX VIF
- 10X12 SPF KODAK
- 11X14 NMB-1 KODAK
- 14X14 CR10 DUPONT
- 14X14 SPF KODAK
- W-10X12 CR10 DUPONT AFC
- W-10X12 CR10 DUPONT DAYLIGHT
- W-10X12 CRONEX VIF
- W-10X12 SPF KODAK
- W-11X14 NMB-1 KODAK
- W-14X14 CR10 DUPONT
- W-14X14 SPF KODAK

Amount: This field contains the amount of film (a number between 0 and 999) used or wasted during the Rad/Nuc Med exam. The amount represents either the number of that film size or the number of cine feet of that film size. On the film usage report, these two amounts are distinguished from each other. This data is automatically entered during registration if it has been associated with the procedure registered. It is asked in case edits and it is asked in status tracking if the "Ask" examination status parameter is set to yes.

Status Change Date/Time: This field contains the date and the time that the exam status was changed. Depending on how the division parameters are set up for “Ask Exam Status Time,” this field may or may not be filled in. If the parameter is set to yes, then the system prompts you to type a date/time of status change. The date and time of each status change is automatically entered after each status change if the division parameter contains a no. It is asked in status tracking if the "Ask" examination status parameter is set to yes.

Modifiers: This field points to the Procedure Modifiers file (#71.2) to give details and further describe this exam. Modifier examples include: Left, Right, Bilateral, Operating Room, and Portable. This data is automatically copied to the case during registration if it was entered as part of the request. It is also asked in the case edits option. Special modifiers affecting AMIS counts (i.e., portable, bilateral, and operating room) are not allowed for series-type procedures.

Technologist: This multiple field points to the New Person file (#200) and indicates the technologist(s) who performed this exam. It appears in diagnostic code edit and case edits, and it also appears in status tracking if the "Ask" examination status parameter is set to yes.

Med Administered: If any medications were administered to the patient during this exam, they may be recorded here. If medications are associated with a procedure during system setup, the system will enter them automatically when the procedure is registered. This field also appears in both the case edits option and the status tracking option if the procedure parameter for this data contains a yes. However, if the "Ask" status tracking parameter is set to no, then it is not asked in the status tracking option. Medications are not a factor in status updating.

Med Dose: This is a free text field. Type the dose and unit of measure for the medication administered. This field appears in both case edits and status tracking if the procedure parameter for this data is set to yes. However, if the "Ask" examination status parameter is set to no, this field will not appear in the status tracking option.

Date/Time Med Administered: This is the date and time the dosage was administered. It only appears in case edits if the field is already populated and appears in status tracking only if both the parameter for the procedure and the "Ask" parameter for the status are set to yes.

Person Who Administered Med: This is the name of the radiology/nuclear medicine clinician who administered the medication to the patient. The clinician entered must have one of the following:

- any Rad/Nuc Med classification other than Clerk, the ORES or ORELSE key
- or Pharmacy authorization to write medication orders with no inactive date

This field only appears in the Case Edits option if the field is already populated and appears in the status tracking option only if both the parameter for the procedure and the "Ask" parameter for the status are set to yes.

Radiopharmaceuticals: If this is a nuclear medicine procedure and radiopharmaceutical(s) are associated with the procedure, they will be automatically entered by the system when the case is registered. Radiopharmaceuticals may be deleted or added during case editing if the prompt is not suppressed by the procedure

parameter. This is also true for the status tracking option; if the "Ask" parameter is set to yes, the data will be available for edit. Certain radiopharmaceutical data entry is mandatory for printing dosage tickets to meet NRC standards. The fields needed for NRC standards are indicated below.

The following prompts may appear if a radiopharmaceutical is entered for the case. All existing radiopharmaceutical data entered for the case will be displayed prior to editing.

Prescribed Dose by MD Override: *(NRC required)* This prompt requests the dosage (in mCi) of the radiopharmaceutical as prescribed by an MD. It must be a value between .0001 and 99999.9999. The data in this field is printed on dosage tickets to meet NRC standards. This prompt will only appear (in the case edit and status tracking options) if the Radiopharm RX parameter prompt is set to Yes.

Prescribing Physician: This prompt requests the name of the physician who prescribed the radiopharmaceutical. It is not a required field. This prompt only appears in the case edits option if the procedure parameter prompt for Radiopharm Rx is set to yes and only appears in the status tracking option if:

- The Radiopharm Rx procedure parameter prompt is set to yes
- If it is not already entered

Activity Drawn: *(NRC required)* This prompt requests the amount of radiopharmaceutical activity drawn to be administered to the patient. Type an activity drawn between .0001 and 99999.9999. The unit of measure is mCi. If the radiology supervisor has entered a radiopharmaceutical range for the procedure, the high, low, and usual dose will be displayed above the prompt and user response is checked to see if it falls within the high/low range. The activity drawn is only prompted for in case edits if the field is already populated and in status tracking only if the "Ask" examination status parameter is set to yes. This field is necessary to meet NRC requirements for dosage tickets.

Date/Time Drawn: This prompt requests the date/time the radiopharmaceutical was drawn. The date/time drawn may precede the exam date/time by as much as seven days. This information is only asked for in case edits if the field is already populated and in status tracking if the "Ask" examination status parameter is set to yes.

Person Who Measured Dose: *(NRC required)* This prompt requests the name of the clinician who measured the radiopharmaceutical drawn. This person must have a Rad/Nuc Med personnel classification other than Clerk. Entering the name of the person who measured the dose is necessary to meet NRC requirements for dosage tickets. The name of the person who measured the dose is only prompted for in case edits if the field is already populated and in status tracking if the "Ask" examination status parameter is set to yes.

Dose Administered: This prompt requests the radiopharmaceutical dosage actually administered to the patient. Type a dosage between .0001 and 99999.9999 that is the same or less than the dosage drawn (if a dosage drawn value was entered at the dosage drawn prompt). The unit of measure is mCi. If the radiology supervisor has entered a radiopharmaceutical range for the procedure, the high, low, and usual dose will be displayed above the prompt and the user response is checked to see if it falls within the high/low range. If the dose administered does not fall within the predetermined range, a warning message will be displayed. This data is prompted for in case edits and status tracking if the "Ask" examination status parameter is set to yes. Dose administered is also printed on dosage tickets.

Date/Time Dose Administered: This prompt requests the date/time the radiopharmaceutical was administered. The date/time drawn is presented as the default response if a date/time value was entered in the Date/Time Drawn field. It is asked in case edits and it is asked in status tracking if the "Ask" examination status parameter is set to yes.

Person Who Administered Dose: This prompt requests the name of the individual who administered the dose. This individual must have a Rad/Nuc Med personnel classification other than Clerk. This prompt will only appear (in the case edit and status tracking options) if the "Ask" examination status parameter is set to yes.

Witness to Dose Administration: This prompt requests the name of the person who witnessed the radiopharmaceutical administration. This field is not required. This prompt will only appear (in the case edit and status tracking options) if the “Radiopharm Rx” procedure parameter prompt is set to yes.

Once the witness’s name is entered, future status tracking edits for this procedure will not ask for it again, but the name can be edited at a later time through the case edit options.

Route of Administration: This prompt requests the route of radiopharmaceutical administration. This prompt will only appear in case edits if it has been previously populated. This prompt will appear in status tracking if the “Ask” examination status parameter is set to yes

Site of Administration: This prompt requests the site of administration for the radiopharmaceutical. It only appears if a route of administration is entered in the previous prompt. This prompt will only appear for case edits if it has already been populated. This prompt will only appear for status tracking if the "Ask" examination status parameter is set to yes and there are predefined sites for the route.

Site of Admin Text: This prompt requests additional notes regarding the site of administration. Type any text (3-45 characters in length) you wish to include.

This prompt will only appear for case edits if it has already been populated. This prompt will only appear for status tracking if the "Ask" examination status parameter is set to yes and the route of administration for the case is configured to prompt for a free text site of administration.

Lot No.: *(NRC required)* This prompt requests the lot number for the radiopharmaceutical. The lot number can be the number of the batch, vial, syringe, or kit. The lot number is printed on the dosage tickets to meet NRC requirements.

Lot Number Guidelines:

- The lot for the number must be active
- The expiration date must be the same or later than the Date/Time Dose Administered (or the date/time of the exam if there is no entry for the date/time the dose was administered)
- The lot radiopharmaceutical must match the exam's radiopharmaceutical

Typing a new lot number (LAYGO) into the Lot Number file is allowed. This prompt only appears for case edits if already populated and for status tracking if the examination status "Ask" parameter is set to yes.

Volume: This prompt requests the volume of the radiopharmaceutical administered. The units of measure will either be "c" for caplets or "m" for milliliters. The number must be in the range of 1-99999.99. This prompt only appears for case edits if it has already been populated and for status tracking if the "Ask" examination status parameter is set to yes.

Form: Possible radiopharmaceutical forms are:

- Liquid (all injections)
- Gas (e.g., xenon, krypton)
- Aerosol (e.g., DTPA aerosol)
- Solid (pill) (e.g., I-123 or I-131 pill, schilling test)
- Solid (other) (e.g., radioactive egg for gastric emptying time)

This prompt only appears for case edits if it has already been populated and for status tracking if the "Ask" examination status parameter is set to yes.

Cases in a printset (i.e., a set of procedures defined as descendants of a parent and requiring a single report) must each be edited individually even though a single report will be entered to apply to all of them. Individual edits of printset cases allow you to enter different technicians, complications, etc., for each case. Individual edits of printset cases also makes sure that crediting is done properly for each case.

4.4 Diagnostic Code and Interpreter Edit by Case No.

This function allows the user to enter a diagnostic code, the primary and secondary interpreting residents, and staff physicians for any case number. If this information has already been entered for a particular case, then this function allows the user to review and update the information. If the case is part of a printset, then this option **cannot** be used; instead, the interpreter(s) and diagnostic code(s) must be entered in Report Entry/Edit and will apply to all cases in the printset.

> **Advanced Use**: Users with the RA MGR key may also edit exams with the Complete status as long as the associated report has not yet been verified.

Depending on the requirements set up by the radiology supervisor in the Examination Status file, it may be necessary for certain fields to be filled in before the exam status can be considered Complete. If the exam status is updated to Complete, the associated request will also be updated.

When an exam's status progresses to Complete, Radiology/Nuclear Medicine sends exam data to the Patient Care Component (PCC) package. PCC checks for required data, then passes that data to the Scheduling Package. The following data is required for crediting:

- Detailed Procedure with a Valid CPT Code
- Primary Interpreting Staff or Primary Interpreting Resident
- Patient
- Exam Date/Time
- DSS ID
- Requesting Location

If all required data is not available, a bulletin (Rad/Nuc Med Credit Failure) will be generated and sent to members of the associated mail group (set up by the site manager). The bulletin tells the recipient which case and procedure caused the crediting failure and can provide useful information for determining the cause of the credit failure.

Diagnostic Code Fields

Primary Interpreting Staff: This prompt requests the name of the staff member who interpreted the images. This prompt only appears during diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field should be entered during report editing instead.) Only the names of staff

members with access to one or more imaging locations allotted for the exam's imaging type will be available for selection.

Depending on the requirements set up in the examination status file (#72), this prompt may need to be answered before the exam can be moved to a complete status.

Secondary Interpreting Staff: This prompt can be used to enter the name(s) of other staff members who participated in the image interpretation. This prompt only appears during diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this data can be entered during report editing instead.) Only the names of staff members with access to one or more imaging locations allotted for the exam's imaging type will be available for selection.

Primary Interpreting Resident: This prompt requests the name of the primary interpreting resident who read the exam's images. If interpreting staff is required to review this resident's results, the Primary Interpreting Staff prompt must also be answered. Only the names of residents with access to one or more imaging locations allotted for the exam's imaging type will be available for selection. This prompt only appears during diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field should be entered during report editing instead.)

Depending on the requirements set up in the examination status file (#72), this prompt may need to be answered before the exam can be moved to a complete status.

Secondary Interpreting Resident: This prompt can be used to enter the name(s) of other resident(s), in addition to the primary interpreting resident, who interpreted the images of this exam. Only the names of residents with access to one or more imaging locations allotted for the exam's imaging type will be available for selection. This prompt only appears during diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field can be entered during report editing instead.)

Primary Diagnostic Code: This field is used at facilities that decide to enter diagnostic codes for exams, as designated in the Examination Status file parameters. It points to the Diagnostic Codes file (#78.3) to indicate the primary diagnostic code associated with this exam. If filled in, this field can be used in the search criteria for database searches. For example, the database can be searched for all "normal" chest procedures performed during a specific time period. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field can be entered during report editing.) Depending on the requirements set up in the examination status file (#72), it may be necessary for this field to be filled before the exam status can be considered complete.

Secondary Diagnostic Code: If the primary diagnostic code is entered, the system will also prompt for secondary diagnostic codes. This multiple field is used to indicate

additional diagnostic codes associated with this exam. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field can be entered during report editing.)

Technologist: This multiple field points to the New Person file (#200) and indicates the technologists who performed this exam. It appears in Diagnostic Code Edit and Case Edits, and it also appears in Status Tracking if the Examination Status "Ask" parameter is set to YES.

```
Diagnostic Code and Interpreter Edit by Case No.

Enter Case Number: 250


Choice Case No.    Procedure                Name                Pt ID
------ --------    ---------                -----------------   ------
   1   092396-250  TOE(S) 2 OR MORE VIEWS   ZZMOUSE,MICKEY      3432


     PRIMARY DIAGNOSTIC CODE: NORMAL
     Select SECONDARY DIAGNOSTIC CODE: <RET>
     PRIMARY INTERPRETING RESIDENT: ?
       Enter the name of the Primary Resident who interpreted the images for
       this exam.
     Personnel must be classified as Interpreting Resident.

     PRIMARY INTERPRETING RESIDENT: PROVIDER,JENNIFER JA 114
     Select SECONDARY INTERPRET'G RESIDENT: <RET>
     PRIMARY INTERPRETING STAFF: ?
       Enter the name of the primary staff who interpreted these images.
       Personnel must be classified as Interpreting Staff Physician.

     PRIMARY INTERPRETING STAFF: PROVIDER,MIKE art 525B/114
     Select SECONDARY INTERPRETING STAFF: PROVIDER,ARTHUR M aB 114
     Select SECONDARY INTERPRETING STAFF: <RET>
       ...exam status remains 'EXAMINED'.
```

Figure 4-4: Entering Diagnostic Code and Editing Interpreter by Case No.

Notes:

- Staff and residents must have access to at least one imaging location with the same imaging type as the exam to be selectable when you enter primary and secondary staff and residents.

- Once a diagnostic code is selected as the primary diagnostic code, it cannot be selected again as the secondary diagnostic code, and vice versa.

The system tries to credit procedures when the case status goes to Complete. Failure to credit triggers a bulletin if your IRM has a receiving mail group set up. Failure to credit can be because of missing or invalid rad/nuc med data, factors preventing PCE from crediting, or problems preventing Scheduling software from storing or transmitting credit data.

4.5 Edit Exam by Patient

This function can be used to edit active exams for a patient. It is identical to the Case No. Exam Edit function except that examinations are selected by patient name rather than case number.

See the Case No. Exam Edit (EDT) section (4.3) for information about fields edited.

4.6 Enter Last Past Visit Before RPMS

This option allows the user to enter the last visit to the department for a patient. **It is only useful when a new facility comes online.**

Many file rooms are divided by date. By entering the last exam date, it will allow the file room clerk to look up the patient's last visit by using the Display Patient Demographics option on the Patient Profile Menu. This will enable the clerk to find the date of a patient's last visit and go directly to the appropriate file room area.

You will first be prompted to select a patient. If you select a patient who is in the Patient file #2, but not in the Rad/Nuc Med Patient file #70, you must first type the name into the Rad/Nuc Med Patient file through this option. If the patient is not in the Patient file #2, PIMS must first enter the patient in file #2.

If the patient's record has a Sensitive status, a warning message will be displayed and you will be asked if you wish to continue processing the record. If you proceed, a bulletin will be sent to the station security office notifying him/her that a sensitive record has been accessed.

If the patient's last visit date has already been logged, a message will be displayed. Otherwise, you will be prompted to type the date of the patient's last visit.

```
Select Patient:   PATIENT,PETER E   04-18-14
241670575         NSC VETERAN

   Are you adding 'PATIENT,PETER E' as
     a new RAD/NUC MED PATIENT (the 304TH)? Y (Yes)

Last Exam Date before RPMS: TODAY (MAR 28, 1995) (MAR
28, 1995@00:01)
```

Figure 4-5: Entering Last Past Visit Before RPMS

4.7 Exam Status Display

This function allows the user to view the status of exams for selected imaging locations within the user's current sign-on imaging type. Only exam statuses configured into the system by the radiology supervisor will appear in the display. For

example, exams with a status of Waiting for Exam may appear on the screen, but exams with a status of Transcribed may not, depending on the exam status parameters established by the radiology supervisor. Refer to the radiology supervisor's guide for more information on examination status parameters.

The exam list screens will be displayed by status. On each page, exams will be listed in chronological order by exam date. Items included in the exam display are the current date/time, status on display, division, location(s), case number, exam date, patient name, procedure, and camera/equipment/room. If the exam date is the current date, only the exam time will be displayed.

To display exam statuses:

1. Select the Exam Status Display option.

2. Press the Return key at the "Enter Return to continue or '^' to exit:" prompt.

```
     Current Division: MESCALERO HO
     Current Imaging Type: ULTRASOUND

Enter RETURN to continue or '^' to exit: <RET>

 Exam Status Tracking Module           Division: MESCALERO HO
 Date    : 05/16/02  1:04 PM           Status  : EXAMINED
 Locations: ULTRASOUND

 Case #   Date      Patient               Procedure                  Equip/Rm
 ------   ----      -------               ---------                  -------
 28       04/04/02  PATIENT,DANIEL       U/S KNEE                  US ROOM

Enter Status, (N)ext status, '^' to Stop: NEXT//
```

Figure 4-6: Displaying Exam Status

3. Press the Return key to continue to the next page or type a caret (^) to stop displaying the exam status and return to the last menu.

4.8 Indicate No Purging of an Exam/report

This option allows the user to indicate that the data for a specific exam and its associated report cannot be purged. If the No-Purge indicator has been turned on for an exam, the data will not be purged once it is beyond the retention days specified by the site manager. (See the technical manual for an explanation of the data purge functionality of this system.)

You will first be prompted to type a case number. You may also type a patient's name at this prompt. If a patient's name is entered, all active cases for that patient will be displayed and you will be prompted to choose one.

Only active cases (registered cases that are not in a Complete status) may be selected. For example, if case No. 100 for a certain patient is in a Complete status (i.e., currently inactive) and you type 100 at the "Enter Case Number:" prompt, the system may find a more recent, active case No. 100 which has been assigned to a different patient and case than you intended.

> **Advanced Use**: Users with the RA MGR security key may select exams with a status of Complete by typing the patient's name rather than the case number at the Enter Case Number: prompt.

Next, you will be asked whether you wish to flag the selected case with a No Purge indicator. A No Purge entry will retain all the data on the computer. An Ok To Purge entry will allow some of the exam data to be deleted when the site manager runs the next purge. Deleted data will include the activity log, status tracking times, clinical history, and report text.

```
Indicate No Purging of an Exam/report
Enter Case Number: PATIENT,FRANK
06-12-25 000009747    NO    NSC    VETERAN

**** Case Lookup by Patient ****

Patient's Name: PATIENT,FRANK 000-00-9747          Run Date: MAR 28,1995

   Case No.   Procedure            Exam Date     Status of Exam   Imaging Loc
   --------   -------------        ---------     ---------------- ---------
1  286        ABDOMEN 1 VIEW       01/28/95      EXAMINED         X-RAY
2  67         FOREARM 2 VIEWS      11/04/94      CANCELLED        X-RAY
3  280        ARTHROGRAM KNEE S&I  11/04/94      CANCELLED        X-RAY
4  34         FOREARM 2 VIEWS      11/04/94      CANCELLED        X-RAY
5  300        ABDOMEN 1 VIEW       10/21/94      COMPLETE         X-RAY
6  301        CHEST STEREO PA      10/21/94      COMPLETE         X-RAY
7  302        BONE AGE             10/21/94      COMPLETE         X-RAY

Type '^' to STOP, or
CHOOSE FROM 1-7: 5

PREVENT PURGE: N NO PURGE
Select REASON FOR NOT PURGING: ??
    This field indicates why the examination should not be purged.
    Choose from:
       A Agent Orange Exposure
       C Cancer/Tumor Registry
       E Employee
       M Mammography
       P Persian Gulf War
       R Radiation Exposure
       T Teaching

Select REASON FOR NOT PURGING: T (Teaching)
Select REASON FOR NOT PURGING: <RET>
  ...exam status remains 'EXAMINED'.
```

Figure 4-7: Indicating No Purging Of An Exam/Report

4.9 Register Patient for Exams

This function allows the user to register a patient for one or more procedures. You may register a patient by selecting an existing request or by initiating a new request. Only requests in the Hold, Pending, or Scheduled statuses are valid choices. If a request is not available, the user will be prompted to request an exam and the ordering process is the same as described in the Requesting an Exam section (9.9).

You may register a parent procedure set for a detailed procedure order. At the time of registration, at the Select a Request prompt, the software will allow replacement of a single selected Detailed, Series, or Broad procedure request with a parent printset procedure by doing the following:

1. Type PN at the prompt where P indicates that you want to trigger the parent-printset registration feature and "n" is the request number. The request must NOT be a parent. Only one request may be chosen. You will then see a prompt for a parent procedure.

2. Type the name of a parent procedure of the same imaging type as the requested procedure. The parent must be predefined as a printset. (The list of requests displayed to choose from will have "+" in front of printset parent procedures.

3. Then, proceed to register the predefined descendant(s) OR, discard "^" its descendant(s) and register any descendants that you choose when it asks for more procedures to add. After the replacement printset is registered, all outstanding potentially duplicate orders to any just registered will be displayed as a reminder that these may have to be cancelled.

A patient can be registered for a procedure only if the patient has been entered in both the main PIMS patient file #2 and the Rad/Nuc Med patient file #70. If a patient is already entered in the main patient file, you may enter him/her in the Rad/Nuc Med Patient file through this option at the "Select Patient:" prompt. If the patient does not exist in file #2, then PIMS must first enter the patient. (At most facilities, this is done before any other service sees the patient because patients are first registered in PIMS.)

Registering without an Existing Request

If you are registering a patient without an existing request in the Radiology system, you will first be prompted fill out the request for the exam. To do so, you can either exit out of the Register Patient for Exams option and use the Request an Exam option (section 9.9) to first fill out a request, or you can continue with the Register Patient for Exams option, as the system will automatically prompt you for the request information before allowing you to continue registering the patient exam. Essentially, the Register Patient for Exams option will temporarily run the Request an Exam option (section 9.9) to make the combined request/ registration process easier for you.

Registering from an Existing Request

When an exam is registered using an existing request, there will be information carried over from the request record to the exam record. You will be given the opportunity to edit the default information, which includes procedure, modifiers, category of exam, and principal clinic of outpatient. Procedure modifiers available for selection are screened by imaging type, so if a modifier that you need is not available for selection, the radiology supervisor should refer to the Procedure Modifier Entry option in the radiology supervisor's guide. Registering a request changes the request status to Active.

If the patient is an inpatient, the standard default mode of transport will be Wheel Chair. If the patient is an outpatient, the standard default mode of transport will be Ambulatory. However, if Portable is entered as a modifier, the standard default mode of transport will be Portable regardless of the patient category.

When an exam is registered, the system assigns a case number; this number is a sequential number that is calculated by the system. When a case is processed to the Complete status, its case number becomes available for reuse.

> **Caution**: Normally, a case number can only be assigned to one active case at a time. However, consider the following scenario: A case is completed, so the case number is reused and assigned to a second case during registration. The completed case is then unverified causing the case to be reopened and active once more. This means that the same case number is now associated with two active cases. Although this does not happen often, users should be aware that it could happen. If this happens, you will have to use the exam dates and patient names to discern between the two cases.

Imaging departments must make sure that cases are routinely processed to a Complete status. Otherwise, the case numbers will increment until the maximum number is reached, and the system will not allow registration of any more cases.

If the exam request that you select for registration is a "parent" procedure (i.e., a set of procedures called "descendents" associated with a predefined parent procedure), several procedures will automatically appear in sequence. You may choose to register or discard each one. After the entire set of descendents is processed, you will be asked if there are any more procedures to add to the exam set. If you later find that an additional procedure was done, you cannot reenter the Register Patient for Exam option to add it to the same exam set, but you may use the registration option to add the procedure under a new exam date/time that is a few minutes later or earlier than the exam date/time under which the original exam set was registered. Or, if no report data has been entered, you can use the Add Exam to Last Visit option (section 4.1) to add the procedure to the existing exam set.

The advantages of using predefined parent procedures are:

- Instead of requiring the ordering clinician to order multiple procedures for a study, a single parent procedure can be ordered.
- The registration process is less prone to error and less time-consuming because the procedures are a predefined set and appear automatically.
- Predefined descendant procedures can be registered or discarded, allowing the registration of procedures you select.
- If the parent is set up as a printset, one report covers all set members.

Due to many of the processing requirements imposed on this software, all procedures registered under a single exam date/time must be of the same imaging type. In other words, the system will prevent users from registering a Nuclear Medicine procedure and a General Radiology procedure under exactly the same exam date/time. (The radiology supervisor assigns imaging types to procedures through the Procedure Enter/Edit option, so a procedure's imaging type at one hospital may be different than its imaging type at another hospital.) If you select multiple procedure requests of different imaging types to register, the system will automatically process the procedures by imaging type, asking for a different imaging location and exam date/time for each new imaging type.

> **Caution**: It is possible, but not usually necessary or advisable, to select an imaging location whose imaging type does not match the imaging type of the procedure being registered and change the procedure to one of the imaging types of the location. This feature was left unrestricted to allow registration of a correct procedure when the requesting physician has erroneously ordered a procedure of the wrong imaging type. However, this feature should be used rarely and judiciously; educating the requesting physician is a better solution and generally advised.

Descendents of a parent procedure will always be of the same imaging type so that they can be registered under the same exam date/time.

When a location change is required because of registration of multiple orders with a combination of imaging types, if you type "^" at the procedure prompt, the procedure will be bypassed and left as an open request. The registration option will have to be used again to register this request, and the case number will be discarded and recycled for future use.

The example in Figure 4-8 shows the registration of a single procedure and a parent procedure. These examples illustrate four advance features.

```
Register Patient for Exams
```

The user happens to be signed onto an inactive imaging location. The system detects this and gives the user an opportunity to switch locations, since cases cannot be registered to inactive locations.

```
     Your current Imaging Location: 'RECEPTION 2ND FLOOR' is inactive.
If you wish to register this patient for an exam, locations must be switched.

Do you wish to switch locations at this time? Yes// YES

Please select a sign-on Imaging Location: FILE ROOM (GENERAL RADIOLOGY-523)
------------------------------------------------------------------------------
Welcome, you are signed on with the following parameters:

                                  Printer Defaults
Version  : 5.0T9                  ----------------
Division : BOSTON, MA             Flash Card  : BAR88 PRT RADIOLOGYRECEPTION2
Location : FILE ROOM                            1 card/exam
Img. Type: GENERAL RADIOLOGY      Jacket Label: D129 (D2-150) RADIOLOGY FILE
User     : HEIER,CINDY A                        2 labels/visit
                                  Report      : D73 D2-149
------------------------------------------------------------------------------

Select Patient: ZZMOUSE,MINNIE         NO         NSC VETERAN       06-05-96
000004444
                           PRIM. CARE: PROVIDER,JOHN J MD TEL 4418; 5021
                           ALT. PRIM. CARE: PROVIDER,MARCUS MD TEL 4418

           *********** Patient Demographics ***********

Name           : ZZMOUSE,MINNIE
Pt ID          : 000-00-4444
Date of Birth  : JUN 5,1896 (101)
Veteran        : Yes                        Eligibility : NSC
Sex            : FEMALE
Narrative      : This is a real dummy
Other Allergies:
'V' denotes verified allergy 'N' denotes non-verified allergy

       YES(V)                      PTSD(V)


Case # Last 5 Procedures/New Orders Exam Date   Status of Exam Imaging Loc.
------ ---------------------------- ---------   -------------- ------------
262    WRIST 2 VIEWS                AUG 18,1997 WAITING FOR    2ND FLOOR RE
264    SHOULDER 1 VIEW              AUG 18,1997 WAITING FOR    2ND FLOOR RE
899    ECHOGRAM ABDOMEN COMPLETE    JUN 25,1997 CANCELLED      ULTRASOUND
897    CHEST 2 VIEWS PA&LAT         JUN 25,1997 WAITING FOR    GI SUITE
2833   CHEST 2 VIEWS PA&LAT         MAY 2,1997  CANCELLED       MEG
       WRIST 2 VIEWS                Ord 10/10/95
Enter RETURN to continue or '^' to exit: <RET>

Case # Last 5 Procedures/New Orders Exam Date   Status of Exam Imaging Loc.
------ ---------------------------- ---------   -------------- ------------
       CT ABDOMEN W&W/O CONT        Ord 6/13/95
       BONE IMAGING, TOMOGRAPHIC (S Ord 7/18/95
       MAMMOGRAM BILAT              Ord 10/3/95
       CHEST 2 VIEWS PA&LAT         Ord 10/27/95
```

```
       ABDOMEN 1 VIEW               Ord 12/12/95
       CT THORACIC SPINE W/O CONT   Ord 12/12/95
       SPINE SI JOINTS 3 OR MORE VI Ord 5/16/96

Imaging Exam Date/Time: NOW// <RET> (AUG 18, 1997@14:06)


**** Requested Exams for ZZMOUSE,MINNIE ****         9 Requests

  St Urgency Procedure                      Desired   Requester   Req'g Loc
  -- ------- ------------------------------ --------- ----------- -----------
1 h  STAT    +CHEST CT                      04/18     USER,M. EL C MHC MEDIC
2 h  ROUTINE ABDOMEN 1 VIEW                 12/12     USER,MARY  RADIOLOGY-U
3 h  ROUTINE CT THORACIC SPINE W/O CONT     12/12     USER,M. EL LOWELL DIET
4 s  ROUTINE CHEST 2 VIEWS PA&LAT           10/27     USER,KEN  IM ALEX
5 h  ROUTINE WRIST 2 VIEWS                  10/10     USER,MARY  RADIOLOGY-U
6 h  ROUTINE MAMMOGRAM BILAT                10/03     USER,GREG  RADIOLOGY-B
7 h  ROUTINE BONE IMAGING, TOMOGRAPHIC (SP 07/18     USER,M. EL RADIOLOGY-M
8 h  ROUTINE CT ABDOMEN W&W/O CONT          06/13     USER,MARY  RADIOLOGY-U
9 h  ROUTINE HIP 1 VIEW                     04/22     USER,JIM C PRIMARY T

(Use Pn to replace request 'n' with a Printset procedure.)
Select Request(s) 1-9 or '^' to Exit: Exit// 1

          Parent procedure: CHEST CT
```

When the system detects that the imaging type of the requested procedure is different than the current sign-on imaging type, it prompts for a new sign-on location.

```
        Current Imaging Type: GENERAL RADIOLOGY
        Procedure Imaging Type: CT SCAN

You must switch to a location of CT SCAN imaging type.

Please select a sign-on Imaging Location: CTG 523 (CT SCAN-523)
------------------------------------------------------------------------------
Welcome, you are signed on with the following parameters:
                                Printer Defaults
Version  : 5.0T9                ----------------
Division : BOSTON, MA           Flash Card  : P-CTSCAN RADIOLOGY, CT SCAN E
Location : CTG                                1 card/exam
Img. Type: CT SCAN              Jacket Label: D129 (D2-150) RADIOLOGY FILE
User     : HELLER,CINDY A                     1 labels/visit
                                Report      : D73 D2-149
------------------------------------------------------------------------------
```

Registration of parent-descendent exams is shown.

```
     Descendent procedure: CT THORAX W/O CONT
 ...will now register ZZMOUSE,MINNIE with the next case number... (AUG 18, 19
97@14:06)

     Case Number: 306
     ----------------
     PROCEDURE: CT THORAX W/O CONT// <RET>   (CT       Detailed) CPT:71250
     Select MODIFIERS: RIGHT// <RET>
     CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
     PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>   7428 USER,DAVID
```

```
Register next descendent exam (CT ABDOMEN W/O CONT)
for ZZMOUSE,MINNIE? Yes// <RET> YES

     Descendent procedure: CT ABDOMEN W/O CONT
 ...will now register ZZMOUSE,MINNIE with the next case number...

     Case Number: 307
     ----------------
     PROCEDURE: CT ABDOMEN W/O CONT// <RET> (CT       Detailed)
     CPT:74150
     Select MODIFIERS: RIGHT// <RET>
     CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
     PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>     7428
USER DAVID

Register another descendent exam for ZZMOUSE,MINNIE (Y/N)? YES
...will now register ZZMOUSE,MINNIE with the next case number...

     Case Number: 308
     ----------------
     PROCEDURE: ??
       This field points to the 'RAD/NUC MED PROCEDURES' file (#71) to
       indicate the Imaging procedure associated with this case number.

        ALLOWABLE WAYS TO ENTER THE IMAGING PROCEDURE FOR
        THIS CASE NUMBER:
        ------------------------------------------------------------------
           -Name of procedure
           -CPT Code
           -Site specific synonym

Choose from:
    CONSULTATION OF OUTSIDE CT FILMS WITH REPORT      (CT    Detailed)
CPT:76140
 CT ABDOMEN W/CONT                                  (CT    Detailed)  CPT:74160
 CT ABDOMEN W/O CONT                                (CT    Detailed)  CPT:74150
 CT CERVICAL SPINE W/CONT                           (CT    Detailed)  CPT:72126
 CT CERVICAL SPINE W/O CONT                         (CT    Detailed)  CPT:72125
 CT GUIDANCE FOR CYST ASPIRATION S&I                (CT    Detailed)  CPT:76365
 CT GUIDANCE FOR NEEDLE BIOPSY S&I                  (CT    Detailed)  CPT:76360
 CT HEAD W/IV CONT                                  (CT    Detailed)  CPT:70460
 CT HEAD W/O CONT                                   (CT    Detailed)  CPT:70450
 CT LOWER EXTREMITY W&W/O CONT                      (CT    Detailed)  CPT:73702
 CT LOWER EXTREMITY W/CONT                          (CT    Detailed)  CPT:73701
 CT LOWER EXTREMITY W/O CONT                        (CT    Detailed)  CPT:73700
 CT LUMBAR SPINE W/CONT                             (CT    Detailed)  CPT:72132
 CT LUMBAR SPINE W/O CONT                           (CT    Detailed)  CPT:72131
 CT MAXILLOFACIAL W/CONT                            (CT    Detailed)  CPT:70487
 CT MAXILLOFACIAL W/O CONT                          (CT    Detailed)  CPT:70486
 CT NECK SOFT TISSUE W/CONT                         (CT    Detailed)  CPT:70491
 CT NECK SOFT TISSUE W/O CONT                       (CT    Detailed)  CPT:70490
 CT ORBIT SELLA P FOS OR TEMP BONE W/CONT           (CT    Detailed)  CPT:70481
 CT ORBIT SELLA P FOS OR TEMP BONE W/O CONT         (CT    Detailed)  CPT:70480
 CT PELVIS W/CONT                                   (CT    Detailed)  CPT:72193
^
   PROCEDURE: CT HEAD W/IV CONT                     (CT    Detailed)  CPT:70460
      Select MODIFIERS: <RET>
      CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
      PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET> 7428 FLOURNOY,
DAVID
```

```
Register another descendent exam for ZZMOUSE,MINNIE (Y/N)? NO


 ...all needed flash cards and exam labels queued to print on P-CTSCAN.
Task #: 6571875
     ...all film jacket labels queued to print on D129.
Task #: 6571876


Select Patient: ZZMOUSE,MINNIE          NO         NSC VETERAN       06-05-96
000004444
                           PRIM. CARE: USER,JOHN J MD TEL 4418; 5021
                           ALT. PRIM. CARE: USER,MARCUS MD TEL 4418

           *********** Patient Demographics ***********

Name           : ZZMOUSE,MINNIE
Pt ID          : 000-00-4444
Date of Birth  : JUN 5,1896 (101)
Veteran        : Yes                       Eligibility : NSC
Sex            : FEMALE
Narrative      : This is a real dummy
Other Allergies:
'V' denotes verified allergy 'N' denotes non-verified allergy

       YES(V)                      PTSD(V)

Case # Last 5 Procedures/New Orders Exam Date   Status of Exam Imaging Loc.
------ ---------------------------- ---------   -------------- ------------
306    + CT THORAX W/O CONT         AUG 18,1997 WAITING FOR    CTG
307 .  CT ABDOMEN W/O CONT          AUG 18,1997 WAITING FOR    CTG
308 .  CT HEAD W/IV CONT            AUG 18,1997 WAITING FOR    CTG
262    WRIST 2 VIEWS                AUG 18,1997 WAITING FOR    2ND FLOOR RE
264    SHOULDER 1 VIEW              AUG 18,1997 WAITING FOR    2ND FLOOR RE
       WRIST 2 VIEWS                Ord 10/10/95

Enter RETURN to continue or '^' to exit: <RET>


Case # Last 5 Procedures/New Orders Exam Date   Status of Exam Imaging Loc.
------ ---------------------------- ---------   -------------- ------------
       CT ABDOMEN W&W/O CONT        Ord 6/13/95
       BONE IMAGING, TOMOGRAPHIC (S Ord 7/18/95
       MAMMOGRAM BILAT              Ord 10/3/95
       CHEST 2 VIEWS PA&LAT         Ord 10/27/95
       ABDOMEN 1 VIEW               Ord 12/12/95
       CT THORACIC SPINE W/O CONT   Ord 12/12/95
      SPINE SI JOINTS 3 OR MORE VI  Ord 5/16/96

Imaging Exam Date/Time: NOW// <RET> (AUG 18, 1997@14:07)
```

The session shows how to use a request for a 'detailed' procedure, but change it to register a parent procedure's descendents.

```
**** Requested Exams for ZZMOUSE,MINNIE ****         9 Requests

  St Urgency Procedure                    Desired   Requester   Req'g Loc
```

```
  -- ------- ---------------------------- --------- ---------- -----------
1 h  ROUTINE ABDOMEN 1 VIEW                12/12     USER,MARY  RADIOLOGY-U
2 h  ROUTINE CT THORACIC SPINE W/O CONT    12/12     USER,M. EL LOWELL DIET
3 s  ROUTINE CHEST 2 VIEWS PA&LAT          10/27     USER,KEN  IM ALEX
4 h  ROUTINE WRIST 2 VIEWS                 10/10     USER,MARY  RADIOLOGY-U
5 h  ROUTINE MAMMOGRAM BILAT               10/03     USER,GREG  RADIOLOGY-B
6 h  ROUTINE BONE IMAGING, TOMOGRAPHIC (SP 07/18     USER,M. EL RADIOLOGY-M
7 h  ROUTINE CT ABDOMEN W&W/O CONT         06/13     USER,MARY  RADIOLOGY-U
8 h  ROUTINE HIP 1 VIEW                    04/22     USER,JIM C PRIMARY T

(Use Pn to replace request 'n' with a Printset procedure.)
Select Request(s) 1-8 or '^' to Exit: Exit// P1

Current procedure for this order is ABDOMEN 1 VIEW

     You may replace this with a Printset Parent Procedure
     of the same imaging type.

Select Printset Parent Procedure : ??
     Choose from:
          BARIUM SWALLOW                          (RAD         Parent )
          MYELOMA SURVEY                          (RAD         Parent )
          PHARYNX                                 (RAD         Parent )
          UGI                                     (RAD         Parent )
          UGI SBFT                                (RAD         Parent )

Select Printset Parent Procedure : BARIUM SWALLOW     (RAD          Parent )

        Parent procedure: BARIUM SWALLOW

          Current Imaging Type: CT SCAN
        Procedure Imaging Type: GENERAL RADIOLOGY

You must switch to a location of GENERAL RADIOLOGY imaging type.

Please select a sign-on Imaging Location: FILE ROOM (GENERAL RADIOLOGY-523)

-------------------------------------------------------------------------------
Welcome, you are signed on with the following parameters:

                                  Printer Defaults
Version  : 5.0T9                  ----------------
Division : BOSTON, MA             Flash Card  : BAR88 PRT RADIOLOGYRECEPTION2
Location : FILE ROOM                            1 card/exam
Img. Type: GENERAL RADIOLOGY      Jacket Label: D129 (D2-150) RADIOLOGY FILE
User     : USER,CINDY A                      2 labels/visit
                                               Report : D73 D2-149
-------------------------------------------------------------------------------

    Descendent procedure: ESOPHAGUS RAPID SEQUENCE FILMS
 ...will now register ZZMOUSE,MINNIE with the next case number... (AUG 18, 19
97@14:07)


     Case Number: 310
     ----------------
     PROCEDURE: ESOPHAGUS RAPID SEQUENCE FILMS// <RET>    (RAD    Detailed)
     CPT:74230
     Select MODIFIERS: <RET>
     CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
```

```
     PRINCIPAL CLINIC: RADIOLOGY-UGI 4710// <RET> 4710

Register next descendent exam (ESOPHAGUS PHARYNX/CERVICAL)
for ZZMOUSE,MINNIE? Yes// YES

    Descendent procedure: ESOPHAGUS PHARYNX/CERVICAL
 ...will now register ZZMOUSE,MINNIE with the next case number...

     Case Number: 311
     ----------------
     PROCEDURE: ESOPHAGUS PHARYNX/CERVICAL// <RET> (RAD Detailed) CPT:74210
     Select MODIFIERS: <RET>
     CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
     PRINCIPAL CLINIC: RADIOLOGY-UGI 4710// <RET> 4710

Register another descendent exam for ZZMOUSE,MINNIE (Y/N)? NO

     ...all needed flash cards and exam labels queued to print on BAR88 PRT.
Task #: 6571917

      ...all film jacket labels queued to print on D129.
Task #: 6571918
```

Figure 4-8: Registering Patient for Exams

4.10 Status Tracking of Exams

This function allows the user to view the status of exams for selected imaging locations within the user's current sign-on imaging type. Only exam statuses configured into the system by the radiology supervisor will appear in the display. For example, exams with a status of Waiting for Exam may appear on the screen, but exams with a status of Transcribed may not, depending on the exam status parameters established by the radiology supervisor. Refer to the radiology supervisor's guide for more information on examination status parameters.

For more information on displaying exam status, see section 4.7.

4.11 View Exam by Case No.

This function allows the user to examine a case by viewing all the vital information about the case. Selection can be made by case number or patient name. After selecting a case and viewing the information, you will be given the opportunity to view the activity log, status tracking log, and exam report text, if applicable, for that case.

The activity log shows the date/time any action took place on the examination and/or report, what that action was and the computer user responsible for that action. The status tracking log shows the various examination statuses, the date/time it acquired that status, elapsed time between statuses and cumulative time the case has been active. The exam report text shows the patient's name, exam date, procedure, case

number, requesting physician, resident and staff interpreting physicians, exam modifiers, clinical history, report text, status and impression.

The following sample shows a case that is part of a printset. All of the case information is specific to the individual procedure, but the report displayed includes all procedures that are part of the printset.

```
View Exam by Case No.

Enter Case Number: PATIENT,JOE
RILL      11-12-47      000998888       YES      SC     VETERAN       WR/

                **** Case Lookup by Patient ****

Patient's Name: PATIENT,JOE        000-99-8888        Run Date: AUG 18,1997

   Case No. Procedure                    Exam Date Status of Exam  Imaging Loc
   -------- ---------------------------- -------- ---------------- -----------
1  +578     THALLIUM SCAN (SPECT)        07/24/97  COMPLETE        NUCLEAR MED
2  .580     PROVISION OF RADIONUCLID     07/24/97  COMPLETE        NUCLEAR MED
3  .582     COMPUTER MANIPULATION <      07/24/97  COMPLETE        NUCLEAR MED
4  .583     INTRODUCTION OF NEEDLE O     07/24/97  COMPLETE        NUCLEAR MED
5   319     FOOT-3 VIEWS (ROUTINE)       04/13/95  COMPLETE        XRAY
6   321     SPINE CERVICAL MIN 4 VIEWS   04/13/95  COMPLETE        XRAY
7   252     CHEST 2 VIEWS PA&LAT (ROUT   11/06/91  COMPLETE        XRAY
8   258     CT HEAD W&WO CONT            11/01/91  COMPLETE        XRAY
9   164     CHEST 2 VIEWS PA&LAT         04/17/90  COMPLETE        XRAY

Type '^' to STOP, or
CHOOSE FROM 1-9: 1

================================================================================
Name          : PATIENT,JOE    000-99-8888
Division      : WHITE RIVER JUNCTION Category     : OUTPATIENT
Location      : NUCLEAR MEDICINE     Ward         :
Exam Date     : JUL 24,1997 08:11    Service      :
Case No.      : 578                  Bedsection   :
Clinic        : 10 EKG-MISC
--------------------------------------------------------------------------------
Registered    : THALLIUM SCAN (SPECT)
Requested     : THALLIUM SCAN
Requesting Phy: PROVIDER,MARCUS      Exam Status  : COMPLETE
Int'g Resident:                      Report Status: VERIFIED
Pre-Verified  : NO                   Cam/Equip/Rm :
Int'g Staff   : USER,LEONARD         Diagnosis    :
Technologist  : TECH,RICK           Complication :
                                     Films        : NUC (NucMed Kodak EC-1)-1

---------------------------------Exam Modifiers---------------------------------
Description : None
-----------------------------Radiopharmaceuticals-------------------------------

Rpharm: TL-201 THALLOUS CHLORIDE     Activity Drawn: 3.35 mCi
Drawn: JUL 24, 1997@08:06            Measured By: PROVIDER,RICK
Dose Adm'd: 3.35 mCi                 Date Adm'd: JUL 24, 1997@08:06
Adm'd By: PROVIDER,RICK              Route: INTRAVENOUS
Site: RIGHT ANTECUBITAL FOSSA        Lot #: T20372
Volume: 1.83 ml                      Form: Liquid

================================================================================
Do you wish to display all personnel involved? No// YES

                        *** Imaging Personnel ***
--------------------------------------------------------------------------------
Primary Int'g Resident:
Primary Int'g Staff : PROVIDER,LEONARD
Pre-Verifier:
```

```
Verifier : PROVIDER,LEONARD 081197@09:31
Secondary Interpreting Resident         Secondary Interpreting Staff
-------------------------------         ----------------------------
None                                    None

Technologist(s)                         Transcriptionist
---------------                         ----------------
TECH,RICK                            TYPESWELL,AUDREY


Do you wish to display activity log? No// Y

                        *** Exam Activity Log ***
Date/Time                     Action                        Computer User
---------                     ------                        -------------
JUL 24,1997 08:11             EXAM ENTRY                    HINESLEY,RICK
JUL 25,1997 09:51             EXAM STATUS TRACKING          HINESLEY,RICK

                      *** Report Activity Log ***
Date/Time                     Action                        Computer User
---------                     ------                        -------------
AUG 8,1997 21:30              INITIAL REPORT TRANSCRIPTION  TYPESWELL,AUDREY
AUG 11,1997 09:31             VERIFIED                      NIMOY,LEONARD
================================================================================

Do you wish to display status tracking log? No// Y

                      *** Status Tracking Log ***
                                          Elapsed Time      Cumulative Time
Status                Date/Time           (DD:HH:MM)        (DD:HH:MM)
------                ---------           ------------      ---------------
REGISTERED FOR EXAM   JUL 24,1997 08:11   01:01:40          01:01:40
EXAMINED              JUL 25,1997 09:51   14:11:41          15:13:21
TRANSCRIBED           AUG 8,1997  21:32   02:12:00          17:25:21
COMPLETE              AUG 11,1997 09:32
================================================================================

Do you wish to display exam report text? No// Y

VETERAN,JOE (000-99-8888)               Case No.        : 072497-578 @08:11
THALLIUM SCAN (SPECT)                   Transcriptionist: TYPESWELL,AUDREY
Req. Phys : WEL PROVIDER BY,MARCUS             Pre-verified    : NO
Staff Phys: PROVIDER,LEONARD (P)
Residents :
================================================================================

THALLIUM SCAN (SPECT)
     Exam modifiers : None
     Radiopharmaceutical: TL-201 THALLOUS CHLORIDE, 3.35 mCi
     Adm'd on JUL 24, 1997@08:06 by HINESLEY,RICK
     Route INTRAVENOUS Site RIGHT ANTECUBITAL FOSSA
PROVISION OF RADIONUCLIDE;DIAGNOSTIC
     Exam modifiers : None
COMPUTER MANIPULATION < 30 MIN.
     Exam modifiers : None
INTRODUCTION OF NEEDLE OR INTRACATHETER,VEIN
     Exam modifiers : None

Clinical History:
EXERTIONAL ANGINA (NEW SINCE BEGINNING OF 6/97) WITH MULTIPLE RISK FACTORS
```

```
Report:                                          Status: VERIFIED
MYOCARDIAL PERFUSION SCAN: Stress protocol was utilized with the patient
achieving a maximum heart rate of 150 at a level of 13 mets. There is an
area of probable decreased activity in the inferior segment of the left
ventricle on both the immediate post-exercise and delayed images. No
significant re-perfusion into this area is noted on the delayed study.

Impression:
Probable inferior myocardial infarction. No definite ischemia identified.

Primary Diagnostic Code:
```

Figure 4-9: View Exam By Case No.

5.0 Films Reporting Menu

5.1 Batch Reports Menu

5.1.1 Add/Remove Report From Batch

This option allows the user to remove reports from or add reports to an active batch he or she created. Users may not remove reports from or add reports to a batch created by another user.

Once a batch is deleted, you will no longer be able to access that batch.

If you type a report number not contained in the selected batch, that report will be added to the batch. Entry of an "at sign" (@) will delete the specified report from a batch.

```
Select Batch: PATIENT, PHIL 3/7/97 03-07-97 PROVIDER,TENA
Select REPORT: 010397-411 PATIENT,GEORGI
Select REPORT: <RET>
```

Figure 5-1: Adding a report to a batch

```
Select Batch: PATIENT, PHIL 3/7/97 03-07-97 PROVIDER,TENA
Select REPORT: 010397-411// @
SURE YOU WANT TO DELETE THE ENTIRE REPORT? Y (Yes)
Select REPORT: <RET>
```

Figure 5-2: Removing a report from a batch

5.1.2 Create a Batch

This option is used to create a new batch of results reports. When you create a batch, you are designating a name by which a group of individual reports can be referenced.

You should use this option if you wish to print several different reports to the same device. By placing all of the reports in a batch, you will only have to run the Print a Batch of Reports option once instead of printing each report separately.

You can also use this option to batch all the reports for a particular interpreting physician. Then, when the physician wishes to verify his or her reports, he/she will only need to call up the batch name (usually his or her last name) instead of each report individually. More than one transcriptionist may enter batches with the same name, but a user is only allowed to remove reports from and add reports to batches he or she created. The Add/Remove Report from Batch option is used to place reports in batches.

The Report Entry/Edit option has built-in functionality for creating and adding reports to batches.

Note: The system requires that new batch names be entered in uppercase. Existing batch names may be retrieved in either case.

```
Select Batch: 4/3/95 TEST REPORTS
Are you adding '4/3/95 TEST REPORTS' as a new
REPORT BATCHES? Y (Yes)
```

Figure 5-3: Creating a batch

5.1.3 Delete Printed Batches

This option allows the user to delete batches after they are no longer needed. The batch must have been created by the current user.

> **Advanced Use**: The Delete Printed Batches option prevents a user from deleting a batch created by another user. The Delete Printed Batches by Date option under the Supervisor menu allows supervisors to delete printed batches belonging to any user.

This option should be used to free up batch names so they can be reused. For instance, after a batch is verified by the interpreting physician and printed, deleting the batch will enable the batch name (usually the interpreting physician's last name) to be used again.

Once a batch is deleted you are no longer able to access that batch. In addition, you will not be able to use the Add/Remove Report from Batch option to add more reports to the batch. To add reports again, you will have to create a new batch (through the Report Entry/Edit (section 5.6) or the Create a Batch options) with the same name and then add reports to it.

After you select a batch for deletion, the system will display the date/time the batch was created, the name of the user who created the batch, and the date the batch was last printed (if any). Only batches which have been printed at least once are shown as choices.

> **Advanced use**: Refer to the Supervisor menu for another option that allows supervisors to delete printed batches regardless of who created them.

```
Delete Printed Batches
Select Batch Name: 2/22/95 JONES
                          <Batch Created>: APR 3,1995@11:29
                          <Batch Printed>: APR 3,1995@12:45

Another one (Select/De-Select): ??

    Select a REPORT BATCHES BATCH NAME from the displayed
    list.
    To deselect a BATCH NAME type a minus sign (-)
    in front of it, e.g. -BATCH NAME.
    Use an asterisk (*) to do a wildcard selection, e.g.,
    enter BATCH NAME* to select all entries that begin
    with the text 'BATCH NAME'. Wildcard selection is
    case sensitive.

You have already selected:
2/22/95 JONES                       <Batch Created>: APR 3,1995@11:29
                                    <Batch Printed>: APR 3, 1995@12:45

Choose from:
MARCH 6 REPORTS                     <Batch Created>: MAR 6,1995@11:59
                                    <Batch Printed>: MAR 6,1995@12:03
TRACKER 3/24/95                     <Batch Created>: MAR 24,1995@15:10
                                    <Batch Printed>: APR 3,1995@09:56

Another one (Select/De-Select): <RET>
                                                                  Date:
APR 3,1995
                                                                  Page: 1

                   <<< Report Batches To Be Deleted >>>
*************************************************************************
1] 2/22/95 JONES                  <Batch Created>: APR 3,1995@11:29
                                  <Batch Printed>:

Do you wish to delete all the above Report Batches? YES
      Beginning the interactive deletion process.
      <Deleting>.
      Deletion process has successfully completed.
```

Note that the selector prompt also allows you to enter ALL to select all batches, and -* or - ALL to deselect all previously selected items.

Figure 5-4: Deleting Printed Batches

5.1.4 List Reports in a Batch

This function allows the user to get a listing of all the reports that are presently in a batch. Any active batch can be selected, regardless of the creator.

If you enter a user's name, all the allowable batches for that user are displayed for selection.

The following information is displayed for the specified batch: batch name, date created, date last printed, and the name of the user who created the batch.

The following information is then listed for each report in the batch: case number, exam date, patient, and the name of the interpreting physician. An asterisk(*) is placed next to the report if the report has been previously printed.

```
Select Batch: PATIENT,MOE REPORTS            03-06-95
TAYLOR,SARA
DEVICE: HOME// <RET>      RIGHT MARGIN: 80// <RET>
```

Figure 5-5: Listing Reports in a Batch (Setup)

```
Batch: PATIENT,MOE REPORTS  Date Created: MAR 6,1995 12:57     TRACKER,FRANK
                            Last Printed: MAR 6,1995 13:05

* indicates the report has been printed from batch
================================================================================
Case No.   Exam Date        Patient                    Interpreting Phys.
--------   ---------        -------                    ------------------
* 137      MAR 6,1995       PATIENT,MOE                 PROVIDER,E.
* 138      MAR 6,1995       PATIENT,MOE                 PROVIDER,E.
```

Figure 5-6: Listing Reports in a Batch (Sample Report)

5.1.5 Print a Batch of Reports

This function allows the user to obtain a hardcopy of all the reports in a given batch. Only active batches may be selected. This output can also be produced during the Report Entry/Edit function, assuming the user has specified a batch at the beginning of that option. After the last case has been entered the user will be given the option of printing the entire batch. See the Report Entry/Edit section (5.6) for more details.

If you entered a user's name, all the allowable batches for that user are displayed for selection. The following information is displayed for the selected batch: batch name, date the batch was created, date the batch was last printed and the name of the user who created the batch.

Depending on how the device specifications are set for your imaging location, you may be prompted for a device.

```
Select Batch: DOE 3/24/95         03-24-95
PROVIDER,JOE

Batch: DOE 3/24/95         Date Created: MAR 24,1995 15:10 PROVIDER,JOE
Are you sure? No// Y
QUEUE TO PRINT ON
DEVICE: LINE COMP. ROOM    RIGHT MARGIN: 132// <RET>
Requested Start Time: NOW// <RET> (APR 03,
1995@09:56:42)
     Request Queued. Task #: 11620
```

Figure 5-7: Printing a Batch of Reports

5.1.6 Verify Batch

Only holders of the RA VERIFY security key may access this option.

This option allows the user to verify every report in a batch without having to type each case number. However, the user must indicate whether to verify each report one at a time. This option would most likely be used to verify results reports after the printed reports generated through the Print a Batch of Reports option have been reviewed and signed off.

Only active batches may be selected. You may select a batch by its batch name or the name of the user who created it. If a user name is entered at this prompt, all active batches created by that user will be displayed for selection.

Each report within the batch with a status other than Verified will be individually displayed and the user will be able to change the report status. Once all the reports in a batch have been verified, the user has the option of deleting the batch.

If any diagnostic code for the selected exam is defined by the radiology supervisor as a code that should generate an abnormal alert (via the Diagnostic Code Enter/Edit option), the attending and requesting physicians and any teams associated with the patient through the OE/RR software will be notified. Please be aware that receiving alerts depends on a variety of factors, including whether or not the appropriate clinicians' names are being entered into the PIMS system as primary and attending physicians in the OE/RR package as members of a team, whether the personal preference flags for the various alerts are turned on in the OE/RR package for each individual, and whether the potential recipients are actually logging into the system on a regular basis.

```
Select Batch: PATIENT,MOE REPORTS               03-06-95
USER,SARA

Batch: PATIENT,MOE REPORTS     Date Created: MAR 6,1995 12:57      USER,SARA
                                  Last Printed: MAR 6,1995 13:05

Is this the batch you want to verify? No// Y
---------------------------------------------------------------------------
Report for case no. 137 for HOWARD,MOE

Select one of the following:
      V VERIFIED
      R RELEASED/NOT VERIFIED
      PD PROBLEM DRAFT
      D DRAFT

REPORT STATUS: D// VERIFIED
VERIFYING PHYSICIAN: PROVIDER,M.         MEG
PRIMARY DIAGNOSTIC CODE: NORMAL// <RET>
     Select SECONDARY DIAGNOSTIC CODE: <RET>

---------------------------------------------------------------------------
Report for case no. 138 for PATIENT,MOE

Select one of the following:
      V VERIFIED
      R RELEASED/NOT VERIFIED
      PD PROBLEM DRAFT
      D DRAFT

REPORT STATUS: D// VERIFIED
VERIFYING PHYSICIAN: PROVIDER,M.// <RET>
PRIMARY DIAGNOSTIC CODE: NORMAL// <RET>
      Select SECONDARY DIAGNOSTIC CODE: <RET>
---------------------------------------------------------------------------
Can this batch now be deleted? No// Y
    ...deletion complete.
         Status updates queued!
```

Note that the RELEASED/NOT VERIFIED status will not appear as a selection unless division parameters allow it. Refer to the radiology supervisor's guide for more information.

Figure 5-8: Verifying a Batch

5.2 Display a Rad/Nuc Med Report

This option allows the user to display a Verified or Released/Not Verified imaging results report at the terminal. (Not all hospitals use the Released/Not Verified status; see the radiology supervisor's guide for more information.) Draft reports cannot be displayed since this option may be available to users outside of the Rad/Nuc Med system. This option's report output format is specially tailored for screen display by omitting footer information and blank lines.

You will first be prompted to select a Rad/Nuc Med patient. If the patient selected has more than one examination on file, a list will display with the following information for each report: case number, procedure, exam date, status of the report, and imaging location of the exam. You will be prompted to choose one of the displayed cases. More than one can be selected, delimited by commas, or a range can be selected by

typing the first and last exam numbers, separated by a hyphen. After reviewing a report, you will be given the opportunity to view the case again or continue to review other reports (if more than one was selected initially).

The report display includes exam modifiers (includes all procedures in a set), pharmaceuticals when used, radiopharmaceuticals when used, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents. The report headers are determined by the radiology supervisor when imaging location parameters are set up. If the "Imaging Locations parameter Print DX Codes in Report?" prompt is set to yes, all primary and secondary diagnostic codes will also print in the report. (See the radiology supervisor's guide for more information about imaging location setup and flash card formats.) If the selected case is part of a printset, the report will include the procedures and modifiers for all cases in the set. The displayed report does not include the headers and footers that would be printed on a hard copy.

Reports are filed through the Report Entry/Edit option of the Films Reporting menu, see section 5.6 for more information.

5.3 Distribution Queue Menu

5.3.1 Activity Logs

This option allows the user to generate a report which contains the activity logs for the various distribution queues. This log is used to determine when reports were requested, by whom, and the number of reports printed since the last purge date.

You will be prompted to select a routing queue. The routing queue distributes reports by location. These queues are set by the ADPAC or supervisor through the Reports Distribution Edit option. Ward Reports will show as a default routing queue. You may choose one of the following:

- Clinic Reports
- File Room
- Medical Records
- Other Than Ward or Clinic
- Requesting Physician
- Ward Reports

The report is printed in reverse chronological order for the selected distribution queue and contains the following information: log date/time, activity (print or reprint), user who requested the report, any additional comments (entered by the system) and the quantity printed.

The report will calculate all activity from the date the last data purge was run by the site manager. Log entries may be purged according to how the site parameters are set. However, the system will automatically retain data for the last 90 days and purging will not be allowed for this time period.

```
Prompt/User Response    Discussion

Activity Logs

Select Routing Queue: WARD REPORTS// ??

Choose from:
   CLINIC REPORTS
   FILE ROOM
   MEDICAL RECORDS
   OTHER THAN WARD OR CLINIC
   REQUESTING PHYSICIAN
   WARD REPORTS

Select Routing Queue: WARD REPORTS// <RET>
DEVICE: HOME// <RET>     RIGHT MARGIN: 80// <RET>


WARD REPORTS Distribution Activity Log                              Page: 1
Run Date: MAR 11,1997  09:38

Log Date            Activity  User                Comment               Qty
--------            --------  ----                -------               ---
FEB  1,1996  14:20  RE-PRINT  USER,GREG                                  12
JAN 29,1996  12:09  PRINT     USER,GREG           1N                    8
AUG 31,1995  10:38  PRINT     USER,GREG                                 46
```

Figure 5-9 -: Activity Log Queue

5.3.2 Clinic Distribution List

This option is used to produce a listing of verified reports by clinic for a specified date range. You may also generate this report to include data for all clinics. This option does not print the results reports themselves, it just prints a list of reports. Reports are automatically entered into the distribution queues at the time they are verified.

You will be prompted to type one or more clinic names. You will also be able to choose whether to list the previously printed reports or unprinted reports for the selected clinic(s). If you choose to list printed reports, you are then prompted to type a date range for the listing. The list prints alphabetically by patient name. If a listing is run for unprinted reports, the output generated will include the date/time the report is run, date/case number, patient name, patient ID, date/time the report was verified, and the clinic that requested the procedure.

If the listing is generated for previously printed reports the information provided will include the date/time the report is run, date/case number, patient name, patient ID, date report was printed, user who printed the report, and the clinic that requested the procedure.

Note: Only outpatients will be listed on this report. If the patient was an outpatient when the exam was requested but an inpatient when the report was initially printed, the report would appear on the ward distribution list.

The output from this option can be very long, so you may want to queue it to a printer instead of tying up your terminal for an extended period time.

```
Clinic Distribution List
Select Clinic: ALL
Another one (Select/De-Select): <RET>
Printed/Unprinted Report Selection
----------------------------------
Choose one of the following:
PRINTED
UNPRINTED
Report Selection: UNPRINTED// printed PRINTED
**** Date Range Selection ****
Beginning DATE : 4/1/95 (APR 01, 1995)
Ending DATE : t (APR 05, 1995)
DEVICE: <RET> MY DESK  RIGHT MARGIN: 80// <RET>
```

One, many, all clinics may be selected.

When **Printed** is selected, all reports that were initially printed within this date range will appear on this list. When **Unprinted** is selected, you are not prompted for a date range selection. Instead, all reports that have not been initially printed will appear on this list.

Figure 5-10: Viewing the Clinic Distribution List (Setup)

```
Printed Reports by Clinic APR 5,1995 10:51 PAGE 1
Day/Case   Patient          BID  Date Printed   Printed By     Ward/Clinic
------------------------------------------------------------------------------
021194-92  PATIENT,ANN        8476 04/05/95@10:33 TRACKER,FRANK  EMERGENCY
101293-13  PATIENT,ALAN K.    1556 04/05/95@10:33 CEBEL,GREG     EMERGENCY
011194-33  PATIENT,BILL.      1026 04/05/95@10:33 TRACKER,FRANK  EMERGENCY
011094-30  PATIENT,BILL.      1026 04/05/95@10:33 TRACKER,FRANK  GENERAL MEDICI
010794-36  PATIENT,BILL.      1026 04/05/95@10:33 TRACKER,FRANK  GENERAL MEDICI
010594-35  PATIENT,BILL.      1026 04/05/95@10:33 TRACKER,FRANK  GENERAL MEDICI
030994-4   PATIENT,VITO       3953 04/05/95@10:33 CEBEL,GREG     GENERAL MEDICI
040395-309 PATIENT,VERNON     0623 04/05/95@10:33 CEBEL,GREG     EAR NOSE & THR
062394-64  PATIENT,LARRY      8243 04/05/95@10:33 JONES,THOM     EAR NOSE & THR
062394-63  PATIENT,LARRY      8243 04/05/95@10:33 JONES,THOM     MAGNETIC RESON
062394-58  PATIENT,LARRY      8243 04/05/95@10:33 JONES,THOM     MAGNETIC RESON
062394-57  PATIENT,LARRY      8243 04/05/95@10:33 JONES,THOM     MAGNETIC RESON
040194-74  PATIENT,RALPH      8277 04/05/95@10:33 TAYLOR,SAR     MAGNETIC RESON
110193-25  PATIENT,RALPH      8277 04/05/95@10:33 TAYLOR,SAR     MAGNETIC RESON
031894-284 PATIENT,RALPH      8277 04/05/95@10:33 TAYLOR,SAR     ULTRASOUND
040494-81  PATIENT,RALPH      8277 04/05/95@10:33 TAYLOR,SAR     ULTRASOUND
032294-15  PATIENT,RALPH      8277 04/05/95@10:33 TAYLOR,SAR     ULTRASOUND
040494-20  PATIENT,RALPH      8277 04/05/95@10:33 TAYLOR,SAR     ULTRASOUND
```

Figure 5-11: Viewing the Clinic Distribution List (Sample Report)

5.3.3 Individual Ward

This option prints either:

- All verified reports not previously printed from the distribution queue of imaging studies of a specified imaging type for all patients on specified ward(s), or

- Reprints of verified reports previously printed from the distribution queue of imaging studies of a specified imaging type, done between two specified dates, for all patients on specified ward(s).

Reports are automatically entered in the distribution queues at the time they are verified.

You will be prompted to select one or more wards or divisions and one or more imaging types. You are then asked to select a sorting sequence, either by terminal digits, patient SSN, or patient name. You can also choose between listing reprints of previously printed reports or listing new reports. If you choose to list reprints of reports, you are then prompted to type a date range for the listing.

The report printout will include exam modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name. The report headers and footers are determined by the radiology supervisor when the imaging location parameters are set up. If the “Imaging Locations parameter Print DX Codes in Report?” prompt has been set to yes, all primary and secondary diagnostic codes will also print in the report. (See the radiology supervisor’s guide for more information about imaging location setup and flash card formats.) The total number of reports printed will also be provided.

This output must be queued to a printer.

```
Division Selection:
-------------------
   Requesting Division: HINES CIO FIELD OFFICE// <RET>
IL    CIOFO    499

Select Imaging Type: All// <RET>

Another one (Select/De-Select): <RET>

Sort Sequence Selection:
------------------------
    Choose one of the following:
         Terminal Digits
         SSN
         Patient

    Select Sequence: Patient// <RET>

Print/Reprint Reports Selection:
--------------------------------
    Choose one of the following:
         UNPRINTED
         REPRINT

    Enter Response: UNPRINTED// REPRINT

Date Range Selection:
---------------------
    Beginning DATE/TIME of Initial Print : T@1201AM//1/1/97@1201AM (JAN 01,
1997@ 00:01)

    Ending DATE/TIME of Initial Print : NOW// <RET> (MAR 12, 1997@11:07)

Select Ward: 1S

Another one (Select/De-select): <RET>

QUEUE TO PRINT ON
DEVICE: (Enter a device at this prompt)

Requested Start Time: NOW// <RET> (MAR 12, 1997@11:07:24)
     Request Queued. Task #: 11734
```

You may choose one or more imaging types by selecting one at a time, or you may enter ALL to include all imaging types.

You may choose more than one ward. Wild card characters may be used (i.e., 1E* to mean all wards starting with the characters 1E). To de-select a ward, enter a minus sign followed by the ward (i.e., -1S). This prompt is case sensitive.

Figure 5-12: Printing an Individual Ward's Reports

5.3.4 Print By Routing Queue

This option allows the user to print the reports for the respective distribution queues. For instance, if you want to print all results reports for all inpatients on the hospital wards, you would use this option.

The user is prompted for the routing queue, division, one or more imaging types, sort sequence (Terminal Digits, SSN, Patient), whether or not to sort by patient location before your chosen sort sequence, and choice of unprinted or reprint reports. If you

choose to print reprints, you are then prompted to type a date range for the listing. The reports are then printed (preceded and followed by a queue banner). The report printout will include exam modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name.

The report headers and footers are determined by the radiology supervisor when the imaging location parameters are set up. If the “Imaging Locations parameter Print DX Codes in Report?” prompt was set to yes, all primary and secondary diagnostic codes will also print in the report. (See the radiology supervisor’s guide for more information about imaging location setup and flash card, label, header and footer formats.) The total number of reports printed is shown at the end of the entire set of reports.

This output must be queued to a printer.

```
Select Routing Queue: WARD REPORTS// <RET>

Division Selection:
-------------------
Requesting Division: TEST CIO FIELD OFFICE// <RET>
IL      CIOFO      499


Select Imaging Type: All// <RET>

Another one (Select/De-Select): <RET>

Sort Sequence Selection:
------------------------
    Choose one of the following:
         Terminal Digits
         SSN
         Patient
    Select Sequence: Patient// <RET>


First Sort Selection:
---------------------
    Sort by patient location before Patient? Yes// <RET>

Print/Reprint Reports Selection:
--------------------------------
    Choose one of the following:
          UNPRINTED
          REPRINT
    Enter Response: UNPRINTED// ??

Enter one of the following:
         'UNPRINTED'     to print verified reports that have not been printed
         'REPRINT'       to reprint previously printed reports
          ^              to stop.

    Enter Response: UNPRINTED// REPRINT

Date Range Selection:
---------------------
  Beginning DATE/TIME of Initial Print : T@1201AM//1/1/97@1201AM (JAN 01,
1997@ 00:01)

Ending DATE/TIME of Initial Print : NOW// <RET> (MAR 12, 1997@11:07)

QUEUE TO PRINT ON
DEVICE: LINE COMP. ROOM              RIGHT MARGIN: 132// <RET>

Requested Start Time: NOW// <RET> (MAR 12, 1997@11:07:24)
    Request Queued. Task #: 11735
```

You may choose one, several, or all imaging types.

Note: The terminal digit sort uses the last two digits of the patient's SSN.

If you answer NO here, the reports will be sorted only by your sort sequence selection. If you answer YES, they will be sorted by patient location first, then your sort sequence selection.

Figure 5-13: Printing Reports By Routing Queue

5.3.5 Report's Print Status

This option allows the user to inquire about the print status of a specific report. The print status can only be checked for verified reports. This option should be used to determine if and when a report had been printed.

You may select the report by date/case number or by patient's name. If you select the report by patient's name, a list of that patient's verified reports will be displayed for selection.

The inquiry lists the report's day/case #, patient name and ID number, procedure, date verified, routing queue, date printed, who it was printed by, and the patient's ward/clinic.

```
Report's Print Status

Select Report: DEMO,WILLIAM      11-15-19      449719629       SC
VETERAN
     1     071594-64   DEMO,WILLIAM      RADIONUCLIDE THERAPY, HYPERTHYROIDISM
     2     091494-198  DEMO,WILLIAM      BONE AGE
     3     080494-165  DEMO,WILLIAM      RIBS UNILAT+CHEST 3 OR MORE VIEWS

CHOOSE 1-3: 3    080494-165
```

Figure 5-14: Checking a Report's Print Status (Setup)

```
------------------------------------------------------------------------------
Report      : 080494-165           Patient   : DEMO,WILLIAM      449-71-9629
Procedure   : RIBS UNILAT+CHEST 3  Verified  : APR 5,1995 10:18

Routing Queue       Date Printed       Printed By       Ward/Clinic
-------------       ------------       ----------       -----------
WARD REPORTS        APR 5,1995  10:20  WOOD,JANE        1S
FILE ROOM                                               1S
MEDICAL RECORDS                                         1S

==============================================================================
```

Figure 5-15: Checking a Report's Print Status (Sample Report)

NOTE: Reports can be periodically purged from the distribution queue after they are printed, so older printed reports may not be displayed.

5.3.6 Single Clinic

This option prints either:

- All verified reports not previously printed from the distribution queue of imaging studies of a specified imaging type for all patients in specified clinic(s), or

- Reprints of verified reports previous printed from the distribution queue of imaging studies of a specified imaging type, done between two specified dates, for all patients in specified clinic(s).

Reports are automatically entered in distribution queues at the time they are verified.

Only outpatient reports will be printed through this option. If the patient was an outpatient when the report was requested but an inpatient when the report was printed, the report would have to be printed though the Individual Ward option.

The user is prompted for one or more clinic(s), division, imaging type, and sort sequence (terminal digits, SSN, patient name). You can also choose between unprinted or reprint reports. If you choose to reprint reports, you are then prompted to type a date range for the listing.

The reports are then printed (preceded and followed by the queue banner). The report printout will include exam modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name. The report headings and footings are determined by the radiology supervisor when the imaging location parameters are set up. If the radiology supervisor has answered Yes to the Imaging Locations parameter Print DX Codes in Report?, all primary and secondary diagnostic codes will also print in the report. (See the radiology supervisor’s guide for more information about imaging location setup and flash card, label, header and footer formats.) The total number of reports printed is shown at the end of the entire set of reports.

This output must be queued to a printer.

```
Division Selection:
-------------------
   Requesting Division: HINES CIO FIELD OFFICE// <RET>      IL CIOFO      499


Select Imaging Type: ALL // <RET>

Another one (Select/De-Select):

Sort Sequence Selection:
------------------------
    Choose one of the following:
         Terminal Digits
         SSN
         Patient
    Select Sequence: Patient// <RET>

Print/Reprint Reports Selection:
--------------------------------
    Choose one of the following:
         UNPRINTED
         REPRINT
    Enter Response: UNPRINTED// <RET>

Select Clinic: ER EMERGENCY ROOM

Another one (Select/De-Select):

QUEUE TO PRINT ON
DEVICE: HOME// DEV-LASER (10)-PORT      RIGHT MARGIN: 80// <RET>

Requested Start Time: NOW// <RET> (MAR 13, 1997@14:40:40)
    Request Queued. Task #: 38489
```

The clinic selection prompts allow you to choose more than one clinic, or de-select clinics. Enter "?" for online help.

Figure 5-16: Printing a Single Clinic's Reports

5.3.7 Unprinted Reports List

This option is used to produce a list of verified results reports that have not yet been printed from the Distribution Queue. It does not print the reports; it just shows a list of reports.

The output is generated in alphabetical order by patient name and contains the following information: day/case number of the report, patient name and ID, date the procedure report was verified, ward/clinic, and routing queue (determines to whom the report is distributed).

Since this report can be quite lengthy, it is recommended that it be queued to a printer.

```
Unprinted Reports List APR 10,1995 09:12 PAGE 1
Day/Case
           Patient         BID
                                  Date Verified   Ward/Clinic   Routing Queue
------------------------------------------------------------------------------
032795-23 PATIENT,CHESTER     03/27/95         BILLINGS B   CLINIC REPORT
032795-23 PATIENT,CHESTER     03/27/95         BILLINGS B   MEDICAL RECOR
033094-62 PATIENT,EUGENE      06/10/94         NUCLEAR ME   CLINIC REPORT
033094-62 PATIENT,EUGENE      06/10/94         NUCLEAR ME   MEDICAL RECOR
111593-26 PATIENT,RALPH       04/26/94         1N           WARD REPORTS
111593-26 PATIENT,RALPH       04/26/94         1N           FILE ROOM
111593-26 PATIENT,RALPH       04/26/94         1N           MEDICAL RECOR
082694-31 PATIENT,MOE         08/26/94         BILLINGS B   CLINIC REPORT
082694-31 PATIENT,MOE         08/26/94         BILLINGS B   MEDICAL RECOR
090494-25 PATIENT,HARPO       09/04/94         DENTAL       CLINIC REPORT
090494-25 PATIENT,HARPO       09/04/94         DENTAL       MEDICAL RECOR
071594-58 PATIENT,CHIP        07/26/94         NUCLEAR ME   CLINIC REPORT
071594-58 PATIENT,CHIP        07/26/94         NUCLEAR ME   MEDICAL RECOR
012794-54 PATIENT,ANN         06/10/94         EMERGENCY    CLINIC REPORT
012794-54 PATIENT,ANN         06/10/94         EMERGENCY    MEDICAL RECOR
051394-8  PATIENT,ANN         06/10/94                      MEDICAL RECOR
051394-8  PATIENT,ANN         06/10/94                      OTHER THAN WA
021194-92 PATIENT,ANN         04/26/94         EMERGENCY    MEDICAL RECOR
```

Figure 5-17: Viewing the Unprinted Reports List (Sample Report)

5.3.8 Ward Distribution List

This option allows the user to generate a report that contains information about the reports in the ward distribution queue. The report can be generated for all wards or a selected ward. This option does not print the results reports themselves; it just prints a list of reports.

- You will be prompted to type one or more ward names. One, many, or all may be selected.
- You will also be able to choose whether to list previously printed reports or unprinted reports for the selected ward(s). When Printed is selected, all reports that were initially printed within this date range will appear on this list. When Unprinted is selected, you are not prompted for a date range selection. Instead, all reports that have not been initially printed will appear on this list.
- If you choose to list printed reports, you are then prompted to type a date range for the listing.

The sort order of this report is: division, ward, and patient name. If run for unprinted reports, the output generated will include the date/time the report is run, date/case number, patient name and ID, date/time the report was verified, and ward. If the listing is generated for previously printed reports the information will include the date/time the report is run, date/case number, patient name and ID, date report was printed, user who printed the report, and ward.

Only inpatients will be listed on this report. If the patient was an outpatient when the report was requested, but an inpatient when the report was printed, the report will appear under this option.

```
Ward Distribution List

Select Ward: ALL

Printed/Unprinted Report Selection
----------------------------------
    Choose one of the following:
         PRINTED
         UNPRINTED

Report Selection: UNPRINTED// PRINTED

**** Date Range Selection ****
   Beginning DATE : 3/1/95 (MAR 01, 1995)
   Ending DATE    : 3/31/95 (MAR 31, 1995)

DEVICE: <RET> MY DESK RIGHT MARGIN: 80// <RET>
```

Figure 5-18: Viewing the Ward Distribution List (Setup)

```
Printed Reports by Ward                    APR 10,1995 09:24           PAGE 1

Day/Case   Patient         BID   Date Printed    Printed By       Ward/Clinic
-------------------------------------------------------------------------------
012695-95  PATIENT,KONRAD  7512  03/07/95@12:56  CLERK,BOB        1N
012695-94  PATIENT,KONRAD  7512  03/07/95@12:56  CLERK,BOB        1N
012695-92  PATIENT,KONRAD  7512  03/07/95@12:56  CLERK,BOB        1N
011394-46  PATIENT,LARAY   4944  03/07/95@12:56  CLERK,MILLIE     1N
013095-1   PATIENT,HERMAN  7575  03/07/95@12:56  CLERK,BERNIE     1N
012595-82  PATIENT,HERMAN  7575  03/07/95@12:56  CLERK,BERNIE     1N
012595-83  PATIENT,HERMAN  7575  03/07/95@12:56  CLERK,BERNIE     1N
012595-87  PATIENT,HERMAN  7575  03/07/95@12:56  CLERK,BERNIE     1N
012595-72  PATIENT,HERMAN  7575  03/07/95@12:56  CLERK,BERNIE     1N
041194-166 PATIENT,SHELBY  5441  03/07/95@12:56  CLERK,MILLIE     1S
041194-167 PATIENT,JAMES H 1941  03/07/95@12:56  CLERK,MILLIE     1S
020295-47  PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
021395-4   PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
011895-131 PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
101994-224 PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
020894-90  PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
022894-71  PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
020394-72  PATIENT,RALPH   8277  03/07/95@12:56  CLERK,RUDY       215E
```

Figure 5-19: Viewing the Ward Distribution List (Sample Report)

5.4 Draft Report (Reprint)

This option should only be given to those users in the department who need to reprint draft reports. Since access to unverified results reports is usually not advisable, caution should be exercised in determining who should be assigned this option. For example, the transcriptionist should have access to this option, but ward clerks should

not. Instead, the ward clerks could be given access to the Select Report to Print by Patient option that prints only verified or released/not verified reports.

Reports that the user can select to be printed through this option will have a status of Draft or Problem Draft.

You will first be prompted to select a patient name. If the patient selected has more than one examination report on file, these reports will be listed and you will be prompted to choose one or more. The only other prompt in this option is for a device on which to print the output.

```
Select Patient:    PATIENT,JULES          03-23-20
231680695        NO       NSC       VETERAN

                          **** Patient's Exams ****
Patient's Name: PATIENT,JULES      000-00-0695        Run Date: MAR 14,1997

   Case No. Procedure                   Exam Date   Status of Report Imaging
Loc
   -------- ------------                --------   ---------------- ----------
-
1  311      ARTHROGRAM WRIST S&I        04/03/95    DRAFT            X-RAY
2  235      CT HEAD W/IV CONT           01/20/95    VERIFIED         X-RAY
3  236      SKULL 4 OR MORE VIEWS       01/20/95    VERIFIED         X-RAY
4  237      NECK SOFT TISSUE            01/20/95    VERIFIED         X-RAY
5  238      STEREOTACTIC LOCALIZATION   01/20/95    VERIFIED         X-RAY
6  239      NECK SOFT TISSUE            01/20/95    VERIFIED         X-RAY
7  240      FOREARM 2 VIEWS             01/20/95    DRAFT            X-RAY
8  227      ANKLE 2 VIEWS               01/19/95    None             X-RAY
9  228      FOOT 2 VIEWS                01/19/95    None             X-RAY

Type '^' to STOP, or
CHOOSE FROM 1-9: 9

DEVICE: HOME// <RET> SET HOST
```

Figure 5-20: Reprinting a Draft Report

5.5 On-line Verifying of Reports

This option allows the interpreting physician to verify reports on-line. An electronic signature code is required to use this option. The user must also be assigned the RA VERIFY security key. If the user does not own the RA VERIFY key, this option will not appear. The classification of a user as Staff or Resident is done by the radiology supervisor through the Personnel Classification menu of this package.

A results report is associated with an interpreting resident or staff member under several options in the Exam Entry/Edit menu or the Report Entry/Edit option. Several site-configurable parameters play a part in determining the behavior of this option. See the radiology supervisor’s guide for a complete description of personnel classification and division parameter setup.

The system first prompts for an electronic signature code to make sure that you are a valid user. Electronic signature codes are assigned through the Electronic Signature code Edit [XUSESIG] Kernel option.

An interpreting staff physician may verify reports associated with his or her name. Additionally, if your "Allow verifying of others" personnel parameter is set to yes, you will see the "Select Interpreting Physician:" prompt, where you can type the name of another physician and will be able to verify reports associated with that physician. If the "Allow Verifying By Residents" division parameter is set to yes and your "Allow Verifying Of Others" personnel parameter is set to yes, a resident may also verify reports associated with interpreting physicians.

If the "Allow Verifying By Residents" division parameter is set to no, residents will not be allowed to use this option at all. Similarly, if the "Allow Verifying by Residents" field is set to yes, and the "Allow Verifying Of Others" field is set to no, residents will not be allowed to verify other physicians' reports. (See the troubleshooting section of the radiology supervisor's guide for a more complete discussion of the effects of various combinations of the setup parameters.)

The interpreting physician can review reports by one of seven categories:

- Reports pre-verified by an interpreting resident (which always have a status of Draft or Released/Not Verified)
- Reports that are not pre-verified but that have a status of Released/Not Verified
- Reports with a status of Draft
- Reports with a status of Problem Draft
- All reports
- The user enters a list of selections
- Reports for STAT exams

If another physician happens to be editing a report included in your selection category, he or she can change the status of the report before you see it. If this happens, you will see a message telling you which patient, report, and interpreting physician were involved. Once verified, the legal signature may be printed in the header or footer of the report if the radiology supervisor has added this field to the footer. This option, at the request of many users, does not prohibit verification of reports without an impression, even if an impression is required by the division site parameter in this package. However, an exam will not progress to the Complete status unless an impression has been entered. **For legal purposes, it is strongly recommended that an impression always be entered for every report.**

After each report is displayed, you are given seven choices:

- Print
- Edit
- Return to the top of the report
- Status and print

- Continue on to change the report status and enter diagnostic code(s)
- Edit the status then print the report
- Stop processing

After every reedit of the report, you will get these same choices. If you edit or print the report, the system will return to the "Continue:" prompt. If you select the "continue" or "status and print" option, you will then be asked if the status of the report should change. There are four status types available for your selection.

VERIFIED - The report has been verified by an RA VERIFY key holder who is usually the interpreting physician. This report can be viewed by appropriate users outside the imaging department (e.g., ward clerks, nurses, and physicians).

RELEASED/NOT VERIFIED - The report could be displayed outside the imaging department even though a radiologist has not verified it. Entry of this status is only allowed if the "Allow Released/Not Verified" parameter of the Rad/Nuc Med Division file is set to yes. You may use the Display Report or Select Report to Print options to view or print reports with this status (if this status is allowed at your facility).

DRAFT - The report can only be displayed in the imaging department.

PROBLEM DRAFT - The report is only available for display in the imaging department. A statement to the interpreting physician describing the reason for this status will be shown.

The system will not allow you to verify a report without the completed impression text and will assign it PROBLEM DRAFT status. If you have chosen the Status and Print option, a "Device:" prompt will appear after you are finished editing the status. You may then print a report in any status or convert the report to an email message using P-MESSAGE or FAX if your site has established them as legitimate devices.

Next, you will see prompts for a primary diagnostic code. A prompt for a secondary diagnostic code will only appear if a primary diagnostic code has been entered. If the diagnostic code you select has been designated by the radiology supervisor to generate an abnormal alert message, the requesting physician will be notified. For additional details on diagnostic code setup, please refer to the radiology supervisor's guide. If you select a case that is part of a printset, the report applies to all cases in the printset. Printsets are displayed on most exam display screens with a plus sign (+) in front of the first case and a period (.) in front of the remaining cases in the set. Exam display screens that sort exams by a field other than exam date/time cannot display plus sign (+) and period (.) characters because the members of a printset do not appear in contiguous lines. An example would be Exam Profile (selected sort) when sorted by procedure.

If distribution queues are used at the hospital, then verification of a report is the event that triggers the report's entry into the appropriate distribution queue(s). If your radiology supervisor has configured auto-email to requesting physician, verification of a report will trigger an email message to the requesting physician containing the entire report as it would be printed.

After reviewing all reports in the selected category, you may choose another category and continue without retyping an electronic signature code. If only one case of another category remains present at the end, the system will automatically ask if you wish to verify it.

Report entry can be done through vendor-supplied voice recognition units via an HL7 interface provided partially by this package and partially by the vendor. Setup of this interface must be done by the site manager, who should refer to the technical manual for more information.

5.6 Report Entry/Edit

This function is one of the most important in the Radiology/Nuclear Medicine package, since it allows users to enter and edit reports for registered exams. Transcriptionists usually use this option after the report is dictated or written by the interpreting physician. Some of the data collected through this option is used for the output generated by the Transcriptionist Report option.

A report will be available to all appropriate users of the system (outside of the imaging department) only after the report has been verified or, in facilities that allow it, after the report has been given a Released/Not Verified status. If a report has already been verified, the system will not allow you to edit it unless it is first unverified.

If you have access to multiple imaging locations of different imaging types, you will first be asked to select division(s) and imaging type(s). The system will allow report entry only for cases whose division and imaging types are among those selected.

> **Tip**: Transcriptionists may be given the RA ALLOC key so that they can access all reports regardless of imaging type or division.

This option will detect if you have an electronic signature and are a staff or resident with the RA VERIFY key. If you meet these criteria, a prompt for electronic signature will appear and any verified reports will have the electronic signature affixed.

Batching Reports
If the division parameters have been set to allow batching of reports, you will be given the option of placing the reports in a batch. At this time, you will be prompted to select a batch.

You may choose an existing batch or create a new one by typing in a batch name other than that of a current batch. Usually, the batch name contains the name or initials of the interpreting physician who dictated the reports and often the batch creation date. Please note that a batch name must be at least three characters long and must not contain any lowercase letters.

If you choose to print the reports in a batch, you have the option of placing each individual report into the batch when you are finished editing it. After you have entered/edited all desired reports, you will be asked if you wish to print the entire batch.

Next you will be prompted to type a case number. If you are unsure of the case number, you can type a patient identifier (i.e., name, SSN, last initial and last 4 digits of SSN, etc.) to see a list of all active case numbers for that patient. You must choose the case for which you wish to enter a report. If you choose a case that is part of a printset (i.e., displayed with "+" or "." in front of the procedure) the report will apply to all cases in the printset.

Copying Other Reports
Once you have entered the case number, the exact sequence of prompts displayed will depend upon how the Division parameters are set at your facility. If the Division parameters are set to allow copying of reports, you will be prompted to select a report to copy. If you wish to copy the report text and impression of an already-existing report, (verified or not) you respond by typing either the day-case number of a known report or a patient name to produce a report selection list, then select a report whose information you wish to incorporate into the newly created report. Note that the clinical history section will not be copied from the other report and will remain unchanged. It is also important to note that any text you might already have in the report will be replaced with the text from the copied report. That is, if you have already entered text for a given report and select a report to copy with this option, whatever text you previously entered will be erased.

> **Advanced Tip**: When entering the report to copy, you may type a day-case number or a patient. The patient can be specified by SSN, name, last initial and last four digits of SSN, or any other standard RPMS method of patient look-up. Although you can choose an active case to copy, you cannot specify just its case number as you ordinarily do with active cases. Rather, you must specify its date/case number in MMDDYY-case# format (e.g., 012095-240). If you specify a 4-digit case number, the computer will assume you

are referring to the last 4 digits of the patient's SSN. If you type "022595", the computer will search for all cases registered for Feb. 25, 1995. If you type "022" the computer will search for all cases done on Feb 20 - Feb 29 of any year. (This is applicable whenever you have to specify a date-case number, such as in the Unverified Reports option.)

Interpreting Physician(s)

Next you will be prompted to type the name of the primary interpreting resident. This is optional, since there is probably not a resident reading for every case, and some sites may not have residents at all. If you select a primary interpreting resident, you will also be asked to type a Secondary Interpreting Resident (also optional). You may type the name of more than one secondary interpreting resident if you wish. However, there can be only one Primary Interpreting Resident. When asked to select a resident, you may type the name of anyone classified as a "resident" through the Classification Enter/Edit option of this package (see the radiology supervisor's guide).

The next prompt is for the attending primary interpreting staff (attending). After you enter the name of a primary interpreting staff member, you have the option of entering the name(s) of one or more secondary interpreting staff members. In order for someone to be a valid entry for one of these prompts, they must be classified as "staff" through the Classification Enter/Edit option of this package (see the radiology supervisor's guide).

Standard Reports

The Standard Report feature may or may not be available to you, depending on your division parameter setup. A standard report is a predefined generic report (or part of a report) that may be copied into your current report. This eliminates the need to type the same text repeatedly into many different reports. One example of a standard report is a complete "normal" dictation (report text and impression) for a simple study, such as a chest x-ray. Another use for a standard report is to insert the standard preliminary paragraph(s) for a more complex study (such as a CT or Nuclear scan) which describes how the procedure was done or how the images were obtained. Once the text of a standard report is copied into the active report you are working on, the text may be edited to meet the specific needs of the case; the text of the standard report does not have to be identical to the final text you want for it to be useful.

Unlike copying an existing report that replaces the current report text entirely, more than one standard report may be appended to your active report. This is generally useful if the standard report text consists of a single paragraph. This allows you to select from many individual paragraphs without storing a large number of standard reports for every possible variation of a multi-paragraph report. (For more information about creating and modifying standard reports, see the Standard Reports Entry/Edit section of the radiology supervisor's guide.)

After selecting a standard report to copy into your current report, you will be asked to verify that you want to copy the standard report text into your current report.

> **Warning**: If you have any already typed text in your report, copying a standard report will replace it. This does not apply to standard report text previously entered during a single instance of using the Report Entry/Edit option.

You will then be asked if you want to add an additional standard report. This is the one exception to the rule that existing text will be erased. However, the second (and subsequent) standard reports must be added during a single instance of using the Report Entry/Edit option. If you enter one standard report, exit this option, then use this option and enter a second standard report, the first standard report (and any other text you may have entered) will be erased and replaced by the text of the new standard report.

> **Note**: For legal purposes, it is strongly recommended that an impression be entered for every report.

If the report is being entered for a set of exams in a printset, the following data will only be entered once and will apply to every case in the set:

- Report text
- Impression
- Diagnostic codes
- Primary and secondary residents and staff
- Verifier
- Reported date
- Status

A standard or copied report will also apply to all cases in the set. Since the diagnostic codes, residents, and staff apply to all cases, the system will no longer allow entry of this data through the Case Edits, Status Tracking, Diagnostic Code, or Interpreter Edit options. The reporting options must be used instead.

If distribution queues are used at the hospital, verification of a report is the event that triggers the report's entry into the appropriate distribution queue(s).

> **Note**: Report entry can be done through vendor-supplied voice recognition units with an HL7 interface provided partially by this

package and partially by the vendor. Setup of this interface must be done by the site manager, who should refer to the technical manual for more information.

Since the behavior and appearance of this option varies greatly between sites, no sample is provided.

5.7 Resident On-Line Pre-Verification

This option allows interpreting residents to pre-verify their reports. This is useful when the policies of the hospital require a staff member to review and verify reports written by residents. Reports that are pre-verified by residents will appear under the On-line Verify option for staff members' review when they choose the Pre-Verified category.

A user must be classified as Resident by the ADPAC through the Classification Enter/Edit to access this option, and must have a valid electronic signature code.

Resident On-Line Pre-Verification first asks if you want to review all the reports. If not, it presents a list of reports and asks for a selection. One or more reports can be selected. After viewing the report, you may choose from the following: continue processing, print, edit, go back to the top of the report, status and print, or stop processing. The report will re-display if it has been edited.

You will then be asked if the status of the report should change. You may select one of the following statuses:

Released/Not Verified - The report can be displayed outside the imaging department even though it has not been verified by the radiologist. A report/case is tied to an imaging location, which in turn, is associated with a division. Entry of this status is only allowed if the "Allow Released/Not Verified" parameter of this [i]Imaging Locations file is set to YES. You may use the Display a Rad/Nuc Med Report or Select Report to Print options to view reports with this status.

Problem Draft - The report is only available for display in the Imaging department. A statement to the interpreting physician describing the Reason for this status will be shown. If left in this status, the system will not prompt for pre-verification.

Draft - The report can only be displayed in the Imaging department.

If you have chosen Status and Print you will be given a Device prompt after editing the status. You may then print a report in any status, or convert the report to an e-mail message using P-Message or Fax if your IRM supports these devices.

[i] Corrected file, from Rad/Nuc Med Division to Imaging Locations.

If the interpreting resident answers Yes to the question, Want to Pre-Verify This Report?, then the resident's encrypted electronic signature, electronic signature code, and the date and time will be affixed on the report. Electronic signature codes are assigned through the Kernel option, Electronic Signature code Edit [XUSESIG]. Users requiring an electronic signature code should be given this option.

Next you will see prompts for primary and secondary diagnostic codes. The prompt for secondary diagnostic code will only appear if you have entered a primary diagnostic code. If the diagnostic code that you select has been designated by the ADPAC to generate an abnormal alert message, the requesting physician will be notified at the time the report is verified. For additional details on diagnostic code set-up, please refer to the ADPAC Guide.

If the report being reviewed and pre-verified through this option applies to multiple cases (i.e., a printset), then all data entered and pre-verified will apply to every case in the set. The information displayed on the screen will also reflect all the cases and procedures involved.

Finally, you will be prompted for Primary Interpreting Staff and Secondary Interpreting Staff.

Note: If there is a technologist comment, it is shown in the body of the report. Any comment greater than two lines contains a "(more...)" at the end of the second line. To view the entire comment, use the option View Exam by Case No., Exam Profile (selected sort), or Profile of Rad/Nuc Med Exams and enter Yes to "Do you wish to display activity log?".

5.8 Select Report to Print by Patient

This option allows the user to print results reports. If the report has not been filed, then a warning message is displayed. This option is often used to print a duplicate report (if more than one copy is needed) or to reprint a report that has been lost. Only reports with a Verified status can be printed through this option. The report produced by this option is formatted for a printer, not the screen.

If the patient that you select has more than one report on file, a list will be displayed so that one or more may be selected.

The report printout will include parents and their descendents when defined as a printset, exam modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name. The report headers and footers are determined by the radiology supervisor when the imaging location parameters are set up. If the Imaging Locations “Print DX Codes in Report?” parameter has been set to

yes, all primary and secondary diagnostic codes will also print in the report. (See the radiology supervisor's guide for more information about imaging location setup and flash card, label, and header and footer formats.)

If the report is for a printset, then each procedure in the set will print on the report. Each procedure's modifiers, case number, and exam status will also print.

A notation will appear to the right of the verifying physician's name to indicate that he or she verified the report. If the report was verified by a physician whose name was not entered as a primary or secondary staff or resident, the verifier's name will appear at the end of the report under the Verified By caption. The title of each physician appears to the right of the name.

The title is taken from the Signature Block Title field of the New Person file (#200). To change your title on this report, use the Electronic Signature Code Edit [XUSESIG] Kernel option. Whatever you type as your signature block title will print on this report.

If the physician verified his or her own report through an option other than Online Verification (section 5.5), the wording next to the verifier's name will be "Verifier, no e-sig". If a transcriptionist or someone other than the verifier changed the report status to verified, the wording will be "Verified by transcriptionist for Dr. xxx." If an electronic signature is affixed to the report (i.e., it was verified through Online Verification), the wording will be "Verifier".

This report should be directed or queued to a printer.

```
Select Report to Print by Patient


Select Patient: PATIENT,JULES 03-23-20 000000695 NO NSC VETERAN

                            **** Patient's Exams ****
Patient's Name: PATIENT,JULES    000-00-0695            Run Date: MAR 17,1997

   Case No. Procedure                    Exam Date   Status of Report Imaging
Loc
   -------- -------------                ---------   ---------------- ----------
-
1  311      ARTHROGRAM WRIST S&I         04/03/95    VERIFIED         X-RAY
2  235      CT HEAD W/IV CONT            01/20/95    VERIFIED         X-RAY
3  236      SKULL 4 OR MORE VIEWS        01/20/95    VERIFIED         X-RAY
4  237      NECK SOFT TISSUE             01/20/95    VERIFIED         X-RAY
5  238      STEREOTACTIC LOCALIZATION    01/20/95    VERIFIED         X-RAY
6  239      NECK SOFT TISSUE             01/20/95    VERIFIED         X-RAY
7  240      FOREARM 2 VIEWS              01/20/95    DRAFT            X-RAY
8  227      ANKLE 2 VIEWS                01/19/95    None             X-RAY
9  228      FOOT 2 VIEWS                 01/19/95    None             X-RAY
10 229      NON-INVAS.,LOW EXT. VEIN W   01/19/95    None             X-RAY
11 230      TOE(S) 2 OR MORE VIEWS       01/19/95    None             X-RAY
12 231      BONE AGE                     01/19/95    None             X-RAY


Type '^' to STOP, or
CHOOSE FROM 1-12: 1,3

DEVICE: HOME// <RET> SET HOST
```

One or more reports may be chosen. Selections should be separated by commas, and ranges should be separated by hyphens.

Figure 5-21: Selecting a Report to Print (By Patient)

5.9 Verify Report Only

This function allows the user to verify a report without having to edit all of the report fields required by the Report Entry/Edit option. This function is often used when a report has been edited but the report status has not been updated to reflect the Verified status. If interpreting physicians at the hospital do not use the Verify Online option to verify reports, transcriptionists can use this option to verify reports that have been reviewed and manually signed by staff and/or residents. Only holders of the RA Verify security key can access this option.

Only cases with reports that are not yet verified may be selected. If a patient's name (or other patient identifier such as SSN, last initial and last 4 digits of SSN, etc.) is entered, all cases for that patient will be displayed for selection.

The current report status will be displayed, and you will be prompted to change the status. If you change the status to Verified, you will be asked to type the name of the verifying physician. Any physician classified as "staff" or "resident" with verification privileges can be selected.

Next you will see a prompt for the primary diagnostic code. A prompt for secondary diagnostic codes will only appear if you enter a primary diagnostic code first. You may only choose one primary diagnostic code, but you may choose multiple secondary diagnostic codes. If the diagnostic code you select has been designated by the radiology supervisor to generate an abnormal alert message, the requesting physician will be notified. For additional details on diagnostic code setup, please refer to the radiology supervisor's guide.

If the exam status moves to Complete as a result of verifying the report, credit information will be sent to PCC.

If Distribution Queues are used at the hospital, then verification of a report is the event that triggers the report's entry into the appropriate distribution queue(s).

Report entry can be done through vendor-supplied voice recognition units with an HL7 interface provided partially by this package and partially by the vendor. Setup of this interface must be done by the site manager, who should refer to the technical manual for more information.

> **NOTE**: This option was designed for transcriptionists in facilities where physician on-line verifying is not done. If a physician uses this option to verify his or her own report, no electronic signature will be affixed to the report and the printed report will show the physician's name as (verifier entered by transcription).

The system will not allow you to verify a report without the impression text being complete and will file it with a Problem Draft status.

```
Select Rad/Nuc Med Division: All// <RET>
Another one (Select/De-Select): <RET>

Select Imaging Type: All// <RET>
Another one (Select/De-Select): <RET>

Enter Case Number: PATIENT,RALPH       05-15-84
321448277       NO        SHARING AGREEMENT
              **** Case Lookup by Patient ****
Patient's Name: PATIENT,RALPH      000-00-8277        Run Date: MAR 19,1997

   Case No. Procedure                  Exam Date Status of Report Imaging Loc
   -------- -------------              --------- ---------------- -----------
1   624     CARDIAC CATH LEFT SIDE S&I 03/04/97  VERIFIED         X-RAY
2   608     SPINE CERVICAL MIN 2 VIEWS 02/24/97  VERIFIED         X-RAY
3   612     CHEST 2 VIEWS PA&LAT       02/13/97  VERIFIED         WESTSIDE XR
4   613     ABDOMEN 2 VIEWS            02/13/97  VERIFIED         WESTSIDE XR
5   614     ANGIO CAROTID CEREBRAL BIL 02/13/97  None             WESTSIDE XR
6  +402     ANKLE 2 VIEWS              01/28/97  None             X-RAY
7  .420     FOOT 2 VIEWS               01/28/97  None             X-RAY
8  .423     TOE(S) 2 OR MORE VIEWS     01/28/97  None             X-RAY
9   392     THYROID SCAN               01/15/97  None             NUC MED LOC
10  343     ULTRASONIC GUID FOR RX FIE 01/15/97  None             US
11 +415     BONE IMAGING, MULTIPLE ARE 01/06/97  DRAFT            NUC MED LOC

Type '^' to STOP, or
CHOOSE FROM 1-11: 11

Select one of the following:
     V      VERIFIED
     R      RELEASED/NOT VERIFIED
     PD     PROBLEM DRAFT
     D      DRAFT

REPORT STATUS: R// VERIFIED
VERIFYING PHYSICIAN: BEAMERS,TENA// <RET>
PRIMARY DIAGNOSTIC CODE: NORMAL// <RET>
   Select SECONDARY DIAGNOSTIC CODE: <RET>

       Status update queued!
```

Figure 5-22: Verifying Reports Only

6.0 Management Reports Menu

6.1 Daily Management Reports

These reports should be generated daily. These reports are designed to help manage the system and notify hospital staff of any exams that may require special attention.

- Abnormal Exam Report
- Complication Report
- Daily Log Report
- Delinquent Outside Film Report for Outpatients
- Delinquent Status Report
- Examination Statistics
- Incomplete Exam Report
- Log of Scheduled Requests by Procedure
- Radiopharmaceutical Usage Report
- Unverified Reports

Note: Data on most management reports is separated by imaging type. Only the imaging types used at your facility will be selectable. The radiology supervisor may activate new imaging types at any time, but if the date range selected for a given report includes dates earlier than the date of activation of a new imaging type, the older data will still show under the old imaging type. For example, if ultrasound procedures were previously lumped in with the General Radiology imaging type, and the Ultrasound imaging type was activated in October of the year, all ultrasound exams completed before October will still be reported on the General Radiology page(s) of the report.

6.1.1 Abnormal Exam Report

This option, usually used by Radiology/Nuclear Medicine supervisors, radiology supervisors, or other management personnel, allows the user to print a listing of reported examinations that have a diagnostic code indicating that special action

should be taken. Only those exams for which a Primary or Secondary Diagnostic Code has been entered and that have a "Print on Abnormal Report" field is set to yes in the diagnostic codes file will be included on this report.

This report is compiled from the primary and secondary diagnostic code examination data entered through the Diagnostic Code and Interpreter Edit by Case No. and Status Tracking of Exams options under the Exam Entry/Edit menu or the Report Entry/Edit option under the Films Reporting menu.

If the user has access to more than one Radiology/Nuclear Medicine division, a prompt will appear requesting a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting for a selection. The same process occurs with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. One, many, or all diagnostic codes may be selected.

The "Print only those exams not yet printed?" prompt allows the user to decide whether he or she wishes to include all abnormal exams or just those that have not appeared on any previous listing of this report. If the exam appeared on a previous listing of this report, the Diagnostic Print Date field of the Rad/Nuc Med Patient file exam record will contain the date printed.

The user must also select a date range. The date range refers to the exam date/time entered at the time of exam registration and only exams within the selected date range will be included.

The sort order of this report is:

- Division
- Imaging Type
- Diagnostic Code

If an exam has an abnormal primary diagnostic code and one or more abnormal secondary diagnostic codes, the exam will appear under all applicable diagnostic codes (i.e., multiple times) on this report with a notation to indicate primary or secondary. Negative reporting is done for all selected imaging types within selected divisions if no exams meeting the specifications are found. If exam records have a missing or invalid division or imaging type, they will be bypassed.

For each diagnostic code, the report shows the patient name, ward/clinic, requesting physician, case number, procedure, and exam date/time. An asterisk precedes the exam if it has shown up on a previously printed Abnormal Exam Report. (P) or (S) indicates the abnormal diagnostic code was Primary or Secondary.

The following example sorts by a single division and all imaging types. Your selections may be different according to your needs.

```
Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): NUCLEAR MEDICINE

Another one (Select/De-Select): <RET>

Select Diagnostic Codes: All// <RET>
Another one (Select/De-Select): <RET>

Print only those exams not yet printed? Yes// NO

              **** Date Range Selection ****
    Beginning DATE : T-100 (MAY 10, 1997)
    Ending DATE    : T-95 (MAY 15, 1997)

DEVICE: HOME//
```

If this report had already been run for the dates you want, and you want all Abnormal exams, you need to enter NO at this prompt to get all. Otherwise, the reports will print "*No Abnormal Exams*".

Figure 6-1: Printing the Abnormal Exam Report (Setup)

```
               <<<< ABNORMAL DIAGNOSTIC REPORT >>>>       Print Date: 8/18/97
        (P=Primary Dx, S=Secondary Dx / '*' represents reprint)

Patient Name                              Ward/Clinic     Requesting Physician
                     Procedure                                  Exam Date
================================================================================
                           Division: WHITE RIVER JUNCTION, VT.
                      Imaging Type: GENERAL RADIOLOGY
                  Diagnostic Code: ABNORMALITY, ATTN. NEEDED
                  ----------------
*BLYNCHROY,JAMES ARNOLD -9990           (P) 1-WT          ZELLA,HELEN H.
Case #: 210          CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 13,1997@10:21
*COLDWELL,FREDERICK J.  -8888           (P) SDP 2-NORTH   LEMOY,LEONARD
Case #: 390          CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 13,1997@08:05
*TIBMAN,HENRY WALLACE   -4442           (P) ER            METTZINGER,JOANNE E.
Case #: 888          KNEE 2 VIEWS (ROUTINE)                  MAY 10,1997@11:58

                  Diagnostic Code: ABNORMALITY, PHYSICIAN NOTIFIED
                  ----------------
*POLTER,MARK ANTHONY   -2222            (P) 1-WT          SMITH,DENNIS
Case #: 345          ANGIO RENAL UNILAT SELECT:S&I           MAY 13,1997@12:00
*SALIZAR,JOHN          -3333            (P) ER            DAVIS,TRUDY
Case #: 898          CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 14,1997@14:46

                  Diagnostic Code: POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED
                  ----------------
*HALLINGWORTH, EDWIN   -3223            (P) ER            YU,JUDITH
Case #: 987          CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 13,1997@11:46
```

Figure 6-2: Printing the Abnormal Exam Report (Sample Report)

Note that the same case could appear two or more times on the same report if more than one diagnostic code entered for the case is flagged as abnormal.

6.1.2 Complication Report

This option allows the user (usually a supervisor or manager) to generate a listing of patient examinations in which complications occurred. To be included on this report,

an exam must have data in either the Complication field or the Complication Text field of the Rad/Nuc Med Patient file.

This report is compiled from the examination data entered through the Exam Entry/Edit Menu. If the user has access to more than one Radiology/Nuclear Medicine division, a prompt appear and request a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting him or her for a selection. The same process occurs with imaging type. An imaging type selection prompt will only appear if the user has access to more than one imaging type. An exam date range must also be selected. Only exams with an Exam Date within the selected date range will be included.

Sort order of the report is division, imaging type, patient name, exam date, and case number. Negative reporting is included for each selected imaging type within division. If "No Complication" is entered at the "Complication" question during exam edit, it will not appear in this report.

Totals are printed for each imaging type within division. If more than one imaging type occurs within a division, a division total will print. If more than one division was selected, a total for all divisions will print. The first total line shows the number of exams with complications, total number of exams, and percent of total with complications. The second total line shows number of exams with contrast media complication, total number of exams using contrast media, and percent of total contrast media exams with contrast media complication. In order for the exam to be counted as a contrast media exam, the Contrast Media Used field of the exam record in the Rad/Nuc Med Patient file must contain "Yes". In order for the exam to be counted as a contrast media complication, the Complication field of the same file must point to a complication in the Complication Types file whose "Contrast Medium Reaction" field was set to "Yes" by the radiology supervisor.

For each exam, the patient name, patient ID, exam date/time, procedure, complication, requesting physician, interpreting resident, interpreting staff, and reaction description (if available) will print.

The following example sorts by a single division and imaging type. Your selections may be different according to your needs. **Note**: The abbreviation "C.M." stands for "Contrast Media".

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE     IL     CIOFO     499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// ?
     Select an IMAGING TYPE TYPE OF IMAGING from the displayed list.
     To deselect a TYPE OF IMAGING type a minus sign (-) in front of it, e.g.,
-TYPE
     OF IMAGING.
     Use an asterisk (*) to do a wildcard selection, e.g., enter TYPE OF
IMAGING* to
     select all entries that begin with the text 'TYPE OF IMAGING'. Wildcard
selection
     is case sensitive.

Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION

Choose from:
     ANGIO/NEURO/INTERVENTIONAL
     CT SCAN
     GENERAL RADIOLOGY
     MAGNETIC RESONANCE IMAGING
     NUCLEAR MEDICINE
     ULTRASOUND

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
     Beginning DATE : 1/1/95 (JAN 1, 1995)
     Ending DATE    : T      (FEB 27, 1995)

DEVICE: (Printer Name or "Q")
```

Figure 6-3: Printing the Complication Report (Setup)

Sample Report:

```
       Division: HINES CIO FIELD OFFICE                    Page: 1
   Imaging Type: GENERAL RADIOLOGY                         Date: Feb 27, 1995
         Period: JAN 1,1995 to FEB 27,1995.
------------------------------------------------------------------------------
Name/Pt-Id                        Date/Time          Procedure/Complication
                Personnel
------------------------------------------------------------------------------
HAYES,RANDY                       2/13/95            ABDOMEN 1 VIEW
321-44-8277                       12:41 PM           CONTRAST REACTION
                Physician: HAINES,CATHY
                Interpreting Res. : HELLER,CINDY
                Interpreting Stf. : BRUG,NEIL
Description: Patient experienced fast heartbeat, flushing.
==============================================================================
Complications: 1       Exams: 252       % Complications: 0.40
Contrast Media Complications: 1         C.M. Exams: 1    % C.M. Comp.: 100.00

Division: HINES CIO FIELD OFICE
Complications: 1       Exams: 252       % Complications: 0.40
Contrast Media Complications: 1         C.M. Exams: 1    % C.M. Comp.: 100.00
```

Figure 6-4: Printing the Complication Report (Sample Report)

6.1.3 Daily Log Report

This option generates an informational report for all examination activity on a particular date. This report always covers a 24-hour period.

This report is compiled from the examination data entered through the Exam Entry/Edit Menu. If the user has access to more than one radiology/nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. Imaging locations may be selected individually. An exam date must also be selected. The default response is T-1 or yesterday. Only exams whose Exam Date field contains a day that matches the selected day will be included.

The sort order of the report is:
- Division
- Imaging Type
- Patient name
- Exam date
- Case number

If the division or imaging type is missing from an exam record, the exam will appear under Unknown. (This should not happen under normal circumstances.)

Totals are printed for each selected imaging type and division. If more than one imaging type occurs within a division, a division total will also print. If more than one division was included, a grand total for all divisions will print.

For each exam, the following items will print:
- Patient name
- Patient ID
- Ward/clinic
- Procedure
- Exam status
- Case number
- Exam time
- A “yes/no” notation indicating whether the report was entered yet

The following example was sorted by all divisions and imaging types. Your selections may be different.

```
Select Imaging Location: All// XRAY          (GENERAL RADIOLOGY-405)
Another one (Select/De-Select): <RET>

Select Log Date: T-1// <RET> (AUG 17, 1997)

DEVICE: HOME// (Enter a device at this prompt)
```

Figure 6-5: Printing the Daily Log Report (Setup)

Note that even if there is no data to report, a page will print telling you that there were no studies for that imaging type. Each selected imaging type within a division is therefore accounted for.

The sample shown below uses an 80-column format. This report can also be printed on a 132-column device that produces one line per exam, which is preferable.

```
              Daily Log Report For: Aug 17, 1997           Page: 1
Division         : WHITE RIVER JUNCTION, VT.               Date: Aug 18, 1997
Imaging Location : XRAY (GENERAL RADIOLOGY)

Name                   Pt ID              Ward/Clinic     Procedure
        Exam Status           Case #           Time           Reported
------------------------------------------------------------------------------
BAYER,JOSEPH           111-22-3333        1-NO             CHEST SINGLE VIEW
        TRANSCRIBED    9                       11:28 AM       Yes
CRYER,DARLENE          999-88-7777        1-NO S           ANGIO VISCERAL SELE
        EXAMINED       18                       8:53 AM       No
FREY,DARBY             000-55-7777        1-NO S           TRANSCATH INFUSION
        EXAMINED       2                        9:00 AM       No

        Imaging Location Total 'XRAY': 3
        Imaging Type Total 'GENERAL RADIOLOGY': 3
        Division Total 'WHITE RIVER JUNCTION, VT.': 3
```

Figure 6-6: Printing the Daily Log Report (Sample Report)

6.1.4 Delinquent Outside Film Report for Outpatients

This function allows the user to obtain a report of all the patients who have outside films registered with a “Needed Back” date less than the date the user specifies. This report reflects data entered through the Outside Films Registry menu.

> **NOTE**: It is suggested that the Record Tracking software be used instead of the Outside Films Registry functionality within this package.

Outside films are considered films that belong to private physicians, hospitals, institutions, etc., on loan to the facility. This option helps file room staff return outside films to their owners.

Outside films for inpatients are not shown on this report because it is assumed that the department would not want to send back films for patients still receiving care at the facility.

The report is in chronological order and shows patient name, patient ID, date film is needed back, whether or not there is an OK by the supervisor needed before returning the film, the source of the film, and any remarks.

This report can take a long time to process and it is recommended that you queue the report rather than tying up their terminals for a long time.

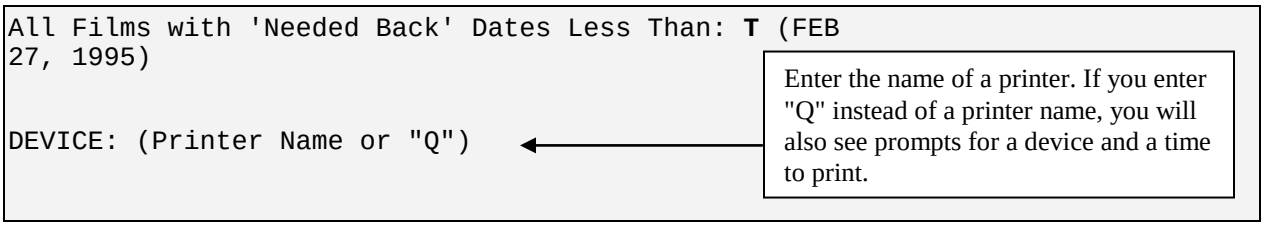


Figure 6-7: Delinquent Outside Film Report Setup

```
IMAGING SERVICE DELINQUENT OUTSIDE FILM REPORT FOR OUTPATIENTS
                                                FEB 27,1995 09:05      PAGE 1
PATIENT                      PT ID                        NEEDED BACK
--------------------------------------------------------------------------------
ZRIOT,CONE                   195-86-0001                  FEB 8,1994
'OK' NEEDED:
SOURCE   : MEMORIAL HOSPITAL
REMARKS  : Several wrist views
--------------------------------------------------------------------------------
ZRIOT,CONE                   195-86-0001                  FEB 13,1994
'OK' NEEDED:
SOURCE   : GOOD SAMARITAN HOSPITAL
REMARKS  : ANKLE
--------------------------------------------------------------------------------
SHAW,RAYMOND E               945-85-4480                  FEB 14,1994
'OK' NEEDED:
SOURCE   : HARRIS HOSPITAL
REMARKS  : Chest X-Ray
--------------------------------------------------------------------------------
```

Figure 6-8: Delinquent Outside Film Report (Sample Report)

6.1.5 Delinquent Status Report

This option allows the user (usually a supervisor or manager) to generate a listing of examination reports with a delinquent status. The only statuses considered to be delinquent are those designated by the radiology supervisor through the “Delinquent Status Report?” question in the Exam Status Entry/Edit option.

This report is compiled from the examination data entered through the Exam Entry/Edit menu. If the user has access to more than one Radiology/nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If

the user has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. An exam date range must also be selected. After selecting whether to include inpatient, outpatient, or both there is a selection to sort by patient or exam date. A screen display prior to device selection shows all exam statuses to be included for each imaging type selected.

Exams that fall within the specified date range and meet the other selection criteria will be included in the report. The program decides whether or not to include an exam based on imaging type by looking at the imaging type of the exam status. Exams which have a CANCELLED status (any status in the Examination Status file with an Order of zero) and a Complete status (any status in the Examination Status file with an Order of 9) will never be included in the report even if these statuses have a YES in the Delinquent Status Report? field on the Examination Status file 72. (For more information on setting the Examination Status parameters, see the radiology supervisor's guide.)

For each delinquent exam, the following will print: patient name, patient ID, exam date, case number, procedure, exam status, ward/clinic, yes/no to indicate if report text was entered, and yes/no to indicate if report was verified. Imaging type and division totals are also printed. A page will print for each even if the total is zero, so that all imaging types will be accounted for.

```
Select Rad/Nuc Med Division: All// BOSTON, MA      MA         523
Another one (Select/De-Select): LOWELL OPC, MA     MA VAMC    523BY
Another one (Select/De-Select): <RET>

Select Imaging Type: All// MAGNETIC RESONANCE IMAGING
Another one (Select/De-Select): MAMMOGRAPHY
Another one (Select/De-Select): <RET>

Delinquent Status Report
The entries printed for this report will be based only on exams that are in
one of the following statuses:

          MAGNETIC RESONANCE IMAGING
          --------------------------
              WAITING FOR EXAM
              EXAMINED

          MAMMOGRAPHY
          -----------
              EXAMINED
              TRANSCRIBED

**** Date Range Selection ****
Beginning DATE : T (AUG 18, 1997)
Ending DATE    : T (AUG 18, 1997)

Select one of the following:
      I     INPATIENT
      O     OUTPATIENT
      B     BOTH
Report to include: BOTH

Now that you have selected BOTH do you want to sort by Patient or Date ?
   Select one of the following:
         P     PATIENT
         D     DATE
   Enter response: PATIENT

DEVICE: HOME// (Enter a device at this prompt)
```

Figure 6-9: Printing the Delinquent Status Report (Setup)

```
Delinquent Status Report
Division: BOSTON, MA                                          Page: 1
Imaging Type: MAGNETIC RESONANCE IMAGING                      Date: Aug 18, 1997
================================================================================
Patient Name     Case #       Pt ID        Date      Ward/Clinic     Verified
  Procedure            Exam Status  Rpt Text    Interp. Phys.    Tech
================================================================================
PATIENT,HENRY H.   111          333-22-1111  08/18/97  13C             No
  MRI BRAIN + BRAIN ST EXAMINED      No         GALES,M          FROG,KERMIT
--------------------------------------------------------------------------------
PATIENT,WALTER R. 333          000-11-0000  08/18/97  6CN             No
MULTIPLANAR MRI COMP   EXAMINED      No         Unknown          HARPER,MARY
--------------------------------------------------------------------------------
   *** OUTPATIENT ***        *** OUTPATIENT ***        *** OUTPATIENT ***
PATIENT,HARVEY     221          111-99-4444  08/18/97  C SURG ORTHO MO No
MRI LOWER EXTREMITY    EXAMINED      No         GALES,M          FROG,KERMIT
--------------------------------------------------------------------------------
PATIENT,JOHN R.  502          444-00-1111  08/18/97  RADIOLOGY-WEST  No
MRI SPINAL CANAL CER   EXAMINED      No         Unknown          FROG,KERMIT
--------------------------------------------------------------------------------
Imaging Type Total 'MAGNETIC RESONANCE IMAGING': 4
```

Figure 6-10: Printing the Delinquent Status Report (Sample Report)

6.1.6 Examination Statistics

This option allows the user to generate a report that contains statistics for examinations performed within a specified date range. The report can be printed by imaging location (which includes location, division and total statistics), by imaging type (which includes imaging type, division and total statistics) by division (which includes division and total statistics), or by total (which includes only total statistics).

Regardless of detail level selected, if the user has access to more than one radiology/nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. An exam date range must also be selected.

Exams that fall within the specified date range and meet the other selection criteria will be included in the report.

The report contains each registered exam date followed by the number of visits, the number of exams, the number of completed exams, and the number of examinations in each corresponding exam category. Patient categories are determined by the contents of the Category of Exam field on the exam record in the Rad/Nuc Med Patient file #70. This field is automatically set to Inpatient or Outpatient by the system, but can be edited to change it to another category when placing orders as long as the category selected does not conflict with PIMS data about the patient's inpatient or outpatient status. (A related data item is the Usual Category which the system looks

at when determining the category of a given exam; Usual Category is editable through the Update Patient Record option, but editing this will not change the category of a single given case after the system has automatically determined it during registration.) If this field is blank (a sign of data corruption) the exam would not be included on this report. Exam category headings are abbreviations of the following fields:

- Contract
- Employee
- Inpatient
- Outpatient
- Research
- Sharing

Since the program needs to know whether or not an exam is complete to accurately report numbers under the Complete EXAMS column, if an exam's imaging type does not have a corresponding Complete status entered in the Examination Status file #72 (a status with the Order field set to 9), the exam will not be counted. See the radiology supervisor's guide for information that the radiology supervisor needs to set up the examination status file parameters.

Sort order of the report is division, imaging type, imaging location, and date. Totals are printed, depending on detail level chosen, by location, imaging type, division, and grand total.

The following example sorts by a single division and imaging type. Your selections may be different according to your needs.

```
Select one of the following:
     L     Location
     I     Imaging Type
     D     Division
     T     Totals Only

Enter Report Detail Needed: Location// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE     IL     CIOFO     499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
Beginning DATE : T-100 (NOV 19, 1994)
Ending DATE    : T (FEB 27, 1995)
```

```
DEVICE: HOME// <RET> (Printer Name or "Q")
```

Figure 6-11: Printing the Examination Statistics Report (Setup)

```
             >>>>> EXAMINATION STATISTICS <<<<<                  Page: 1
Division: HINES CIO FIELD OFFFICE          Location: FLUORO
Run Date: Feb 27, 1995                     Imaging Type: GENERAL RADIOLOGY
               For Period: Nov 19, 1994 to Feb 27, 1995.

                        COMPLETE --------------EXAM CATEGORY------------
DATE         VISITS EXAMS  EXAMS     CON    EMP    INP    OUT    RES    SHA
-------------------------------------------------------------------------------
Jan 18, 1995      1      2      0      0      0      2      0      0      0
             ------ ------ ------ ------ ------ ------ ------ ------ ------
TOTAL             1      2      0      0      0      2      0      0      0
```

Figure 6-12: Printing the Examination Statistics Report (Sample Report)

The last page of this report is a summary for all divisions selected. Summary page headings will contain no division, location, or imaging type.

6.1.7 Incomplete Exam Report

This option allows the user (usually a supervisor, radiology supervisor, or other managerial personnel) to generate a list of all exams that have not been completed. This report is the same as the delinquent status report, except for the way it determines whether to include an exam based on its status. For this report, all exams except those with a Complete or CANCELLED status are included. Refer to the Delinquent Status Report for an explanation of the report logic.

The following example sorts by a single division and imaging type. Your selections may be different according to your needs.

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE     IL      CIOFO      499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

       Incomplete Exam Report
  **** Date Range Selection ****
Beginning DATE : T-100 (JAN 12, 1997)
Ending DATE    : T (APR 22, 1997)

Select one of the following:
     I INPATIENT
     O OUTPATIENT
     B BOTH

Report to include: BOTH

   Now that you have selected BOTH do you
   want to sort by Patient or Date ?
   Select one of the following:
```

```
        P PATIENT
        D DATE
   Enter response: PATIENT

DEVICE: <RET> HOME (Printer Name or "Q")
```

Figure 6-13: Printing the Incomplete Exam Report (Setup)

```
Division: HINES CIO FIELD OFFICE                          Page: 1
Imaging Type: GENERAL RADIOLOGY                           Date: Apr 22, 1997
================================================================================
Patient Name     Case #       Pt ID        Date      Ward/Clinic     Verified
  Procedure            Exam Status  Rpt Text    Interp. Phys.    Tech
================================================================================
PATIENT,ANN        427          422-45-8476  01/28/97  1S              No
ANKLE 2 VIEWS          WAITING FOR  No          Unknown          Unknown
--------------------------------------------------------------------------------
PATIENT,ANN        428          422-45-8476  01/28/97  1S              No
FOOT 2 VIEWS           WAITING FOR  No          Unknown          Unknown
--------------------------------------------------------------------------------
PATIENT,ANN        429          422-45-8476  01/28/97  1S              No
TOE(S) 2 OR MORE VIE   WAITING FOR  No          Unknown          Unknown
--------------------------------------------------------------------------------
PATIENT,ANN        430          422-45-8476  01/28/97  1S              No
ANKLE 2 VIEWS          WAITING FOR  No          Unknown          Unknown
--------------------------------------------------------------------------------
PATIENT,ANN        431          422-45-8476  01/28/97  1S              No
FOOT 2 VIEWS           WAITING FOR  No          Unknown          Unknown
--------------------------------------------------------------------------------
```

Figure 6-14: Printing the Incomplete Exam Report (Sample Report)

6.1.8 Log of Scheduled Requests by Procedure

This option allows the user to generate a list of scheduled requests called Scheduled Request Log by Imaging Location, Procedure. The list includes the procedure, patient name, social security number, patient location, scheduled time of examination, and urgency information.

> **NOTE**: Scheduling a patient through the PIMS package does **not** schedule the patient in the Radiology/Nuclear Medicine package. To schedule a patient in the Radiology/Nuclear Medicine package, use the Schedule a Request option.

A sign-on location is asked if the user does not already have one defined. A starting and ending date range is required. If the user has access to more than one imaging location within the sign-on imaging type, a prompt will appear asking for a selection of one, many, or all imaging locations. If the user can access only one imaging location within the sign-on imaging type, the system will default to that location and no prompt will appear. If both the starting and ending dates selected are in the past, "no shows only?" prompt will appear. A display of user-selected choices will appear and the user will have the opportunity to change his or her selections.

The sort order of the report is: imaging location, scheduled day, AMIS category of procedure, scheduled time, CPT code of procedure. Each imaging location will begin on a separate page.

Only orders with a scheduled date (field #23 of the Rad/Nuc Med Orders file #75.1) within the date range selected will be included. Orders with an Imaging Location (field 20 of file 75.1) selected and orders with no imaging location will be included. Requests with no data in the Imaging Location field will print under UNKNOWN regardless of the selected locations. (The Imaging Location field contains the location entered by a requesting clinician when they see the "Submit request to" prompt during order placement, and the "Submit request to:" question is only asked if the Rad/Nuc Med Division file #79 parameter in field #.121 Ask Imaging Location is set to yes.)

If no scheduled requests fall within the selected date range for a given imaging location, a page will print stating that there are no scheduled requests for that location. If no-shows are included, only requests that are in a SCHEDULED status (i.e., not yet registered, since registration would have moved the order to an ACTIVE status) with a past scheduled date will be included. Each imaging location's report will start on a new page.

The report prints patient location. If the requesting location is different than the current location, the requesting location also prints. Current patient location is determined by data in PIMS files as well as the Requesting Location field #22 of the Rad/Nuc Med Order file #75.1.

```
Starting Scheduled Date: 1/1/95 (JAN 1, 1995)
Ending Scheduled Date: T (FEB 27, 1995)

Select Imaging Location(s): X-RAY (GENERAL
RADIOLOGY)
Another one (Select/De-Select): <RET>

Scheduled requests to be included on this report are:
Starting Schedule date:  Nov 19, 1994
Ending Schedule date:    Feb 27, 1995 11:59 pm
Locations: X-RAY

SELECTION CRITERIA OK? YES// <RET>

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-15: Printing the Log Of Scheduled Requests By Procedure (Setup)

```
Scheduled Request Log by Imaging Location, Procedure      Page: 1
     Includes requests scheduled from JAN 1,1995 to FEB 27,1995 23:59
Run Date: FEB 27,1995 09:14     Imaging Location: UNKNOWN

Patient       Procedure             Pt ID  Pt Loc     Sched. Date     Urgency
------------------------------------------------------------------------------
==============================================================================
PATIENT,HARRY    CHEST STEREO PA       2873   X-RAY      2/21/95@07:24
ROUTINE
```

Figure 6-16: Printing the Log Of Scheduled Requests By Procedure (Sample Report)

6.1.9 Radiopharmaceutical Usage Report

This option allows the user to generate a report showing radiopharmaceutical usage. It asks for a selection of one, many or all divisions, imaging types (only if both imaging types that use radiopharmaceuticals are activated), radiopharmaceuticals, and an exam date range. Selectable imaging types are based on those types that use radiopharmaceuticals, and the user's location access. If individual radiopharmaceuticals are selected, a notation will appear on the report to explain that not all radiopharmaceuticals are included.

The default date range is the previous 24 hour day. Users can choose to sort date/time before radiopharmaceutical. The status of the exam is NOT a factor in determining whether a case is included on this report. If a measured and/or administered radiopharmaceutical dosage is entered, the case will be included.

Sort order if radiopharmaceutical is selected as primary sort:

- Division
- Imaging type
- Radiopharmaceutical
- Exam date/time
- Patient
- Case number

Sort order if exam date/time is selected as primary sort:

- Division
- Imaging type
- Exam date/time
- Radiopharmaceutical
- Patient
- Case number

Detailed reports or summaries only can be printed. The report is designed for a 132 column page. If an administered dosage falls outside of the high/low dose range, an asterisk (*) prints next to it. If a radiopharmaceutical is currently inactive but has

DX200, DX201, or DX202, it will be included on the report if used during the exam date range. Since a case may have more than one radiopharmaceutical, total number of unique cases may be less than total number of radiopharmaceuticals reported.

```
Radiopharmaceutical Usage Report
Do you wish only the summary report? No//   NO

Select Rad/Nuc Med Division: All// ?

     Select a RAD/NUC MED DIVISION DIVISION from the displayed list.
     To deselect a DIVISION type a minus sign (-)
     in front of it, e.g.,  -DIVISION.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter DIVISION* to select all entries that begin
     with the text 'DIVISION'.  Wildcard selection is
     case sensitive.

 Answer with RAD/NUC MED DIVISION
Choose from:
   HINES CIO FIELD OFFICE
   CHICAGO (WESTSIDE)
   SATELLITE HINES

Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE      IL  CIOFO  499

Another one (Select/De-Select): <RET>

Select Imaging Type: All// ?

     Select a IMAGING TYPE TYPE OF IMAGING from the displayed list.
     To deselect a TYPE OF IMAGING type a minus sign (-)
     in front of it, e.g.,  -TYPE OF IMAGING.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter TYPE OF IMAGING* to select all entries that begin
     with the text 'TYPE OF IMAGING'.  Wildcard selection is
     case sensitive.

 Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION
Choose from:
   CARDIOLOGY STUDIES (NUC MED)
   NUCLEAR MEDICINE

Select Imaging Type: All// NUCLEAR MEDICINE

Another one (Select/De-Select): <RET>

Do you wish to include all Radiopharms ? Yes// <RET>  YES

**** Date Range Selection ****

   Beginning DATE : T-1//T-90  (MAY 21, 1997)

   Ending    DATE : T-1@24:00// <RET> (AUG 18, 1997@24:00)

Sort Exam Date/Time before Radiopharm ? : NO// <RET>

     ***                                                  ***
     *** This report requires a 132 column output device ***
     ***                                                  ***

DEVICE: HOME// (This report requires 132 columns)
```

Figure 6-17: Printing the Radiopharmaceutical Usage Report (Setup)

```
>> Radiopharmaceutical Usage Report <<<         Run Date: AUG 19,1997  10:11
Page: 1

Division: HINES CIO FIELD OFFICE             Imaging Type: NUCLEAR MEDICINE
For period: May 21, 1997 to Aug 18, 1997@24:00

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn  Dose
Adm'd    Low       High   Procedure       Who Adm'd
-------------------------------------------------------------------------------
-------------------------------------------------
080697-706@1211 PATIENT,ERNE  000-00-3328 THALLIUM 201      3.3000    3.3000
3.0000    3.6300  THALLIUM SCAN
080697-709@1233 PATIENT,KARL  000-00-0889 THALLIUM 201      3.3000    3.3000
3.0000    3.6300  THALLIUM SCAN
061897-558@1406 PATIENT,RALPH 000-00-8277 THALLIUM 201      3.3000    3.3000
3.0000    3.6300  THALLIUM SCAN
080797-718@0807 PATIENT,RALPH 000-00-8277 THALLIUM 201      3.3000    3.3000
3.0000    3.6300  THALLIUM SCAN
080797-721@0902 PATIENT,RALPH 000-00-8277 SESTAMIBI TC-99   8.0000    8.0000
8.0000   10.0000  MYOCARDIAL PERF PROVIDER,RICK
072597-703@1245 PATIENT,SERGI 000-00-7958 Tc99m MEDRONATE  19.6000   19.6000
18.0000   22.0000  BONE IMAGING   PROVIDER,GREG
070997-700@0907 PATIENT,HANS  000-00-9318 SULFUR COLLOID    4.0000    4.0000
3.0000    6.0000  LIVER SCAN     PROVIDER,GREG
070997-701@0932 PATIENT,RICH  000-00-6827 SULFUR COLLOID    4.5000    4.5000
3.0000    6.0000  LIVER SCAN     PROVIDER,GREG
080797-719@0807 PATIENT,RALPH 000-00-8277 Tc-99m MACROAGG   3.0000    3.0000
3.0000    6.0000  LUNG PERFUSION  PROVIDER,RICK
```

Figure 6-18: Radiopharmaceutical Usage Report (Sample Report)

```
>>> Radiopharmaceutical Usage Report <<<         Run Date: AUG 19,1997  10:11
Page: 2
                                                    (Imaging Summary)
Division: HINES CIO FIELD OFFICE             Imaging Type: NUCLEAR MEDICINE
For period: May 21, 1997 to Aug 18, 1997@24:00
Radiopharm                          Total Drawn    Total Adm'd   No. cases
(%)        No. outside range
-------------------------------------------------------------------------------
-------------------------------------------------
SESTAMIBI TC-99M                      8.0000         8.0000          1
11.11
SULFUR COLLOID TC-99M                 8.5000         8.5000          2
22.22
Tc-99m MACROAGGREATED ALBUMIN         3.0000         3.0000          1
11.11
Tc99m MEDRONATE                      19.6000        19.6000          1
11.11
THALLIUM 201                         13.2000        13.2000          4
44.44

NUCLEAR MEDICINE's Total number of unique cases: 9

Note: A case may have more than 1 radiopharm, so total no. unique cases may be
less than total no. radiopharms listed.
```

Figure 6-19: Radiopharmaceutical Usage Report – Imaging Summary (Sample Report)

6.1.10 Unverified Reports

This option allows the user to generate a listing of results reports that are not verified. This report is divided into two sections. The first section shows the total number of unverified reports for each interpreting staff physician. The second section shows the total number of unverified reports for each interpreting resident physician.

If the user has access to more than one radiology/nuclear medicine division, a prompt will appear and the user must select one or more divisions to report on. If the user has access to only one division, the system will default to that division rather than prompting the user. The same process occurs with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type.

This report includes all report statuses except VERIFIED. If the division or imaging type field of the exam record is missing or corrupted, the record will be bypassed.

The sort order for this report is:

- Division
- Imaging type
- Staff/ resident/ unknown
- Physician's name
- Date report entered

The Primary Interpreting Resident and Primary Interpreting Staff fields in the Rad/Nuc Med Patient file #70 determine who is responsible for the report. If a Primary Resident is entered, then the report is counted toward the resident, even if a Primary Interpreting Staff is also entered. If no Primary Resident is entered but a Primary Interpreting Staff is entered, then the report is counted towards that Interpreting Staff member. If neither is entered, the report is counted towards UNKNOWN.

If there are no unverified reports for a given division and imaging type combination, then the message "No Unverified Reports" appears.

The "Exam Date, Itemized List" option and the "Staff, Itemized List" option each provide one line per report. Only exams with a report are included. The "Exam Date, Itemized List" option sorts the unverified reports by division, exam date/time, patient, and case. It is useful for case turn-around and completion since the oldest cases appear first. The "Staff, Itemized List" option sorts the unverified reports by staff, exam date/time, patient, and case. If a report exists but no staff member's name is entered, it will appear as Staff Unknown. Separate pages print for each staff member, so the report can be handed out to staff members for their review and follow-up.

The detailed format includes report-aging breakout, report age totals by category (resident and staff) and individual physician. This format includes very detailed information, such as transcription date, patient ID, report status, pre-verification date,

exam date/time, order's desired date, procedure, other staff and residents, and a division summary. The division summary is suppressed to prevent redundancy if only one imaging type prints for a division.

The first sample shows an itemized list by exam date. If a 132-column device is used, it would be formatted differently and easier to read.

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE    IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// <RET>
Another one (Select/De-Select): <RET>

Select one of the following:
     b Brief
     d Detailed
     e Exam Date, Itemized List
     s Staff, Itemized List

Enter response: b// Exam Date, Itemized List

This report requires a 132 column output device.

(The date range refers to DATE EXAM REGISTERED)

**** Date Range Selection ****
Beginning DATE : T-60 (JUN 20, 1997)
Ending DATE    : T (AUG 19, 1997)

DEVICE: HOME// (Enter a device at this prompt)
```

Figure 6-20: Printing the Unverified Reports List (Setup)

```
                 UNVERIFIED IMAGING REPORTS BY DIVISION
Division: HINES CIO FIELD OFFICE
          Aug 19, 1997     Page: 1

       Exam         Report
Patient                Patient ID         Exam Date   Case  Procedure
       Status       Entered     Pri.    Int'g Staff
------------------------------------------------------------------------------
PATIENT,FRANK W           463-27-7311        7/22/97     702   CARDIOLOGY TEST
       WAITING      8/8/97      STAFF,TENA
PATIENT,HEINRICH           331-59-2115        8/7/97      722   ABDOMEN 1 VIEW
       WAITING      8/7/97      Unknown
```

Figure 6-21: Printing the Unverified Reports List (Sample Report)

6.2 Functional Area Workload Reports

These options provide the user (usually a supervisor or manager) with the ability to generate workload reports for clinics, ptf bedsections, radiology/nuclear medicine service, sharing agreement/contracts, and wards.

- Clinic Report

- PTF Bedsection Report
- Service Report
- Sharing Agreement/Contract Report
- Ward Report

All of the reports listed above have similar prompts, formats, data retrieval logic, and reporting logic. Sample prompts and formats are shown on the page with the individual report. The selection criteria prompts, data retrieval logic, reporting logic, and report format for all the workload reports are described in detail in the General Information about Workload Reports section (section 6.5).

6.2.1 Clinic Report

This option allows the user (usually a supervisor or manager) to generate a clinic workload report. This is one of a series of workload reports that have similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section of this manual, which can be found in section (section 6.5).

The following example selects a complete report and sorts by All for Division, Imaging Type, and Clinic. Your selections may be different according to your needs.

```
Do you wish only the summary report? No// <RET>

Select Rad/Nuc Med Division: All// <RET>
Another one (Select/De-Select): <RET>

Select Imaging Type: All// <RET>
Another one (Select/De-Select): <RET>

Do you wish to include all Clinics? Yes// <RET>

**** Date Range Selection ****
Beginning DATE : T-100 (NOV 19, 1994)
Ending DATE    : T (FEB 27, 1995)

     The entries printed for this report will be based only
     on exams that are in one of the following statuses:
     Enter RETURN to continue or '^' to exit: <RET>

     ANGIO/NEURO/INTERVENTIONAL
     ----------------------------
         WAITING FOR EXAM
         EXAMINED
         COMPLETE

     CT SCAN
     -------
         WAITING FOR EXAM
         EXAMINED
         COMPLETE

     GENERAL RADIOLOGY
     -----------------
         WAITING FOR EXAM
         EXAMINED
         TRANSCRIBED
         COMPLETE

     MAGNETIC RESONANCE IMAGING
     --------------------------
         WAITING FOR EXAM
         EXAMINED
         COMPLETE

     MAMMOGRAPHY
     -----------
         WAITING FOR EXAM
         COMPLETE

     NUCLEAR MEDICINE
     ----------------
        WAITING FOR EXAM
        EXAMINED
         TRANSCRIBED
         COMPLETE

     ULTRASOUND
      ----------
         WAITING FOR EXAM
         EXAMINED
         COMPLETE
```

Statuses included depend on the parameters entered by the radiology supervisor (see radiology supervisor's guide).

```
DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-22: Printing the Clinic Report (Setup)

The following example report starts with the first division (Hines CIO field Office) and imaging type (General Radiology). This report prints a different page for each clinic with the clinic totals. Then it summarizes the imaging type with totals for each clinic in the imaging type and totals for the imaging type. The last page of this report contains totals for each clinic for all imaging types in the division and totals for the division.

```
            >>> Clinic Workload Report <<<                          Page: 1
           Division: HINES CIO FIELD OFFICE
       Imaging Type: GENERAL RADIOLOGY        For period: Nov 20, 1994 to
           Run Date: FEB 28,1995 14:05                    Feb 28, 1995

                           -------Examinations------
                                                                 % of       % of
Procedure                       Inpt  Opt  Res  Other  Total  Exams  WWU  WWU
-------------------------------------------------------------------------------
             Clinic: DENTAL
STEREOTACTIC LOCALIZATION HE     0    2    0      0      2  100.0  10   100.0

Clinic Total                     0    2    0      0      2         10
-------------------------------------------------------------------------------
```

Figure 6-23: Printing the Clinic Report (Sample Report)

6.2.2 PTF Bedsection Report

This option generates a listing of PTF bedsection workloads. The bedsections used to sort the report are those stored in the Bedsection field of the exam record if the patient is an inpatient at the time the exam is registered.

The bedsection is determined by the system based on data in PIMS files. At the time a patient is registered for an imaging exam, the Bedsection field of the Examinations subfile of the Rad/Nuc Med Patient file is calculated as follows:

1. If the patient is an inpatient, Rad/Nuc Med programs call a standard PIMS data retrieval program to find out the patient's treating specialty as of the date/time of the exam.

2. The program finds this treating specialty in the Treating Specialty file (field 2 of file 45.7) and retrieves its Specialty.

3. The specialty is looked up in the Specialty file #42.4. The Name field of this file is entered automatically in the Bedsection field #19 of the Rad/Nuc Med Patient's exam record.

This is one of a series of workload reports that has similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about

Workload Reports section of this manual (section 6.5) for a full description of this report.

The following example selects a full report and sorts by a single Division and all Imaging Types and PTF Bedsections. Your selections may be different according to your needs.

```
Do you wish only the summary report? No// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD
   OFFICE   IL   CIOFO   499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// <RET.

Another one (Select/De-Select): <RET>

Do you wish to include all PTF Bedsections? Yes//
<RET>
   **** Date Range Selection ****
        Beginning DATE : T-100 (NOV 19, 1994)
        Ending DATE    : T (FEB 27, 1995)

          The entries printed for this report will be based only
          on exams that are in one of the following statuses:
    Enter RETURN to continue or '^' to exit: <RET>

        ANGIO/NEURO/INTERVENTIONAL
        ----------------------------
             WAITING FOR EXAM
             EXAMINED
             COMPLETE

        CT SCAN
        -------
             WAITING FOR EXAM
             EXAMINED
             COMPLETE

        GENERAL RADIOLOGY
        -----------------
             WAITING FOR EXAM
             EXAMINED
             COMPLETE

        MAGNETIC RESONANCE IMAGING
        --------------------------
             WAITING FOR EXAM
             EXAMINED
             COMPLETE

        MAMMOGRAPHY
        -----------
             WAITING FOR EXAM
             COMPLETE

        NUCLEAR MEDICINE
        ----------------
             WAITING FOR EXAM
             EXAMINED
             COMPLETE

        ULTRASOUND
        ----------
             WAITING FOR EXAM
             EXAMINED
             COMPLETE
```

```
DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-24: Printing the PTF Bedsection Report (Setup)

```
            >>> PTF Bedsection Workload Report <<<                  Page: 1
           Division: HINES CIO FIELD OFICE
       Imaging Type: GENERAL RADIOLOGY        For period: Nov 21, 1994 to
           Run Date: MAR 1,1995 08:45                     Mar 01, 1995

                          -------Examinations------
                                                                  % of      % of
Procedure                      Inpt  Opt  Res  Other  Total  Exams  WWU  WWU
-------------------------------------------------------------------------------
PTF Bedsection: GENERAL(ACUTE MEDICINE)
NECK SOFT TISSUE                  4    0    0      0      4    9.8   12   5.5
SKULL 4 OR MORE VIEWS             7    0    0      0      7   17.1   21   9.7
CHEST STEREO PA                   3    0    0      0      3    7.3    3   1.4
CHEST 4 VIEWS                     2    0    0      0      2    4.9    4   1.8
ABDOMEN 1 VIEW                    1    0    0      0      1    2.4    2   0.9
SPINE LUMBOSACRAL MIN 2 VIEW      2    0    0      0      2    4.9    6   2.8
UPPER GI + SMALL BOWEL            2    0    0      0      2    4.9   12   5.5
ANGIO CAROTID CEREBRAL SELEC      1    0    0      0      1    2.4   15   6.9
ANGIOGRAM,CATH - CEREBRAL         2    0    0      0      2    4.9   30  13.8
CT HEAD W/IV CONT                 9    0    0      0      9   22.0   72  33.2
STEREOTACTIC LOCALIZATION HE      6    0    0      0      6   14.6   30  13.8
PTF Bedsection Total             39    0    0      0     41        207
-------------------------------------------------------------------------------
```

Figure 6-25: Printing the PTF Bedsection Report (Sample Report)

6.2.3 Service Report

This option allows the user (usually a supervisor or manager) to generate a listing of Radiology/Nuclear Medicine service workloads. The service data is stored in the Service field of the exam record and is determined by the system at the time an exam is registered based on data in PIMS files about the patient's hospital location.

The service report is one of a series of workload reports that has similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section of this manual (section 6.5) for a full description of this report.

The following example is sorted by a single division, two imaging types, and all Services. Your selections may be different according to your needs.

```
Do you wish only the summary report? No// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): CT SCAN
Another one (Select/De-Select): <RET>

Do you wish to include all Services? Yes// <RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 19, 1994)
     Ending DATE : T (FEB 27, 1995)

         The entries printed for this report will be based only
         on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

     CT SCAN
     -------
         WAITING FOR EXAM
         EXAMINED
         TRANSCRIBED
         COMPLETE

     GENERAL RADIOLOGY
     -----------------
         WAITING FOR EXAM
         EXAMINED
         COMPLETE

DEVICE: HOME// (Printer Name or "Q")
```

If you answer no you will be asked to choose one or more individual services.

Figure 6-26: Printing the Service Workload Report (Setup)

```
            >>> Service Workload Report <<<                          Page: 2
           Division: HINES CIO FIELD OFICE
Imaging Type: General Radiology                For period: Nov 21, 1994 to
           Run Date: MAR 1,1995 09:06                      Mar 01, 1995

                          -------Examinations------
                                                                  % of       % of
Procedure                      Inpt  Opt  Res  Other  Total  Exams  WWU  WWU
-------------------------------------------------------------------------------
           Service: MEDICAL
NECK SOFT TISSUE                  4    0    0      0      4    9.8   12   5.5
SKULL 4 OR MORE VIEWS             7    0    0      0      7   17.1   21   9.7
CHEST STEREO PA                   3    0    0      0      3    7.3    3   1.4
CHEST 4 VIEWS                     2    0    0      0      2    4.9    4   1.8
ABDOMEN 1 VIEW                    1    0    0      0      1    2.4    2   0.9
SPINE LUMBOSACRAL MIN 2 VIEW      2    0    0      0      2    4.9    6   2.8
UPPER GI + SMALL BOWEL            2    0    0      0      2    4.9   12   5.5
ANGIO CAROTID CEREBRAL SELEC      1    0    0      0      1    2.4   15   6.9
ANGIOGRAM,CATH - CEREBRAL         2    0    0      0      2    4.9   30  13.8
CT HEAD W/IV CONT                 9    0    0      0      9   22.0   72  33.2
ARTHROGRAM ANKLE S&I              1    0    0      0      1    2.4    5   2.3
ARTHROGRAM TM JOINT CONT S&I      1    0    0      0      1    2.4    5   2.3
STEREOTACTIC LOCALIZATION HE      6    0    0      0      6   14.6   30  13.8
Service Total                    41    0    0      0     41         217
```

Figure 6-27: Printing the Service Workload Report (Sample Report)

6.2.4 Sharing Agreement/Contract Report

This option allows the user (usually a supervisor or manager) to generate a sharing/contract workload report. To be included in this report, an exam's Category of Exam field must be set to Contract or Sharing, and the Contract/Sharing Source field must contain a valid contract or sharing source.

This data can be entered at the time the exam is requested or after the exam is registered. This report is one of a series of workload reports that have similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section of this manual (section 6.5) for a full description of this report.

The following is an example of the first page of a report sorted by one division, one imaging type, and one sharing agreement/contract. Your report may be different according to your selections.

```
Sharing/Contract Workload Report:
---------------------------------

Do you wish only the summary report? No// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE
IL   CIOFO   499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include all Sharing/Contracts? Yes// NO
Select Sharing/Contract: ?
     Select a CONTRACT/SHARING AGREEMENTS AGREEMENT NAME from the displayed
list.
     To deselect an AGREEMENT NAME type a minus sign (-)
     in front of it, e.g., -AGREEMENT NAME.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter AGREEMENT NAME* to select all entries that begin
     with the text 'AGREEMENT NAME'. Wildcard selection is
     case sensitive.

    Answer with CONTRACT/SHARING AGREEMENTS AGREEMENT NAME
    Choose from:
        CONTRACTOR LFL
        MEMORIAL HOSPITAL
        UNIVERSITY HOSPITAL
        MEDICARE

Select Sharing/Contract: MEMORIAL HOSPITAL
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
Beginning DATE : T-100 (NOV 20, 1994)
Ending DATE : T (FEB 28, 1995)

The entries printed for this report will be based only
on exams that are in one of the following statuses:

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-28: Printing the Sharing Agreement/Contract Report (Setup)

```
            >>> Sharing/Contract Workload Report <<<                Page: 1
           Division: HINES CIO FIELD OFICE
Imaging Type: General Radiology               For period: Nov 20, 1994 to
           Run Date: FEB 28,1995 13:58                    Feb 28, 1995

                          -------Examinations------
                                                          % of       % of
Procedure                     Inpt  Opt  Res  Other  Total  Exams  WWU  WWU
-------------------------------------------------------------------------------
          Sharing/Contract: MEMORIAL HOSPITAL
SPINE SI JOINTS 1 OR 2 VIEWS     0    0    0      1      1  100.0    3  100.0
Sharing/Contract Total           0    0    0      1      1           3
-------------------------------------------------------------------------------
```

Figure 6-29: Printing the Sharing Agreement/Contract Report (Sample Report)

6.2.5 Ward Report

This option allows the user (usually a supervisor, radiology supervisor, or other managerial personnel) to generate a ward workload listing. The wards are stored in the Ward field of the exam record. This field is determined by the system for inpatients at the time an exam is ordered. Data in PIMS files is used to determine the ward location of the patient. The system considers the requesting ward and patient's ward location the same. For the purposes of this workload report, the requesting ward is used rather than the ward at the time the study was done or at the time the report was entered.

This report is part of a workload report series that have similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section of this manual (section 6.5) for a full description of this report.

The following is an example of a summary report sorting by one division, all imaging types, and all wards. Your selections may be different according to your needs.

```
Do you wish only the summary report? No// YES

Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// <RET>
Another one (Select/De-Select): <RET>

Do you wish to include all Wards? Yes// <RET>

**** Date Range Selection ****
Beginning DATE : T-100 (NOV 20, 1994)
Ending DATE : T (FEB 28, 1995)

        The entries printed for this report will be based only
        on exams that are in one of the following statuses:
        Enter RETURN to continue or '^' to exit:

     ANGIO/NEURO/INTERVENTIONAL
     ----------------------------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

     CT SCAN
     -------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

     MAGNETIC RESONANCE IMAGING
     --------------------------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

     MAMMOGRAPHY
     -----------
        WAITING FOR EXAM
        COMPLETE

     ULTRASOUND
     ----------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-30: Printing the Ward Workload Report (Setup)

Sample Report:

```
            >>> Ward Workload Report <<<                              Page: 1
           Division: HINES CIO FIELD OFFICE
Imaging Type: CT SCAN                          For period: Nov 20, 1994 to
           Run Date: FEB 28,1995 14:00                     Feb 28, 1995

                          -------Examinations------
                                                          % of       % of
Ward                           Inpt  Opt  Res  Other  Total  Exams  WWU  WWU
-------------------------------------------------------------------------------
         (Imaging Type Summary)
-------------------------------------------------------------------------------
Imaging Type Total:               0    0    0      0      0           0

# of Wards selected: ALL
```

Figure 6-31: Printing the Ward Workload Report (Sample Report)

6.3 Personnel Workload Reports

6.3.1 Physician Report

This option allows the user (usually a supervisor or manager) to generate a requesting MD workload report of examinations and work associated with exams requested by referring physicians. The physicians used in this report are stored in the Requesting Physician field of the exam file.

This report is one of a workload report series that have similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports (section 6.5) for a full description of this report.

```
Do you wish only the summary report? NO// <RET>
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include all Requesting M.D.s? Yes// NO
Select Requesting M.D.: WELBY,MARCUS
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
Beginning DATE : T-100 (JAN 01, 1997)
Ending DATE    : T (APR 11, 1997)

       The entries printed for this report will be based only
       on exams that are in one of the following statuses:

       Enter RETURN to continue or '^' to exit: <RET>

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        TRANSCRIBED
        COMPLETE

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-32: Printing the Requesting Provider Report (Setup)

```
          >>> Requesting M.D. Workload Report <<<                    Page: 1
            Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                For period: JAN 1,1997 to
            Run Date: APR 11,1997 15:01                    APR 11,1997
                                        Examinations                Percent
Procedure (CPT)                      In     Out     Total           Exams
-------------------------------------------------------------------------
         Requesting M.D.: WELBY,MARCUS
COLON BARIUM ENEMA (74270)            0       2         2           100.0

-------------------------------------------------------------------------
Requesting M.D. Total                 0       2         2

Enter RETURN to continue or '^' to exit:
```

Figure 6-33: Printing the Requesting Provider Report (Sample Report)

6.3.2 Radiopharmaceutical Administration Report

This report asks for a selection of one, many, or all divisions, imaging types (only if both imaging types that use radiopharmaceuticals are activated), radiopharmaceuticals, and an exam date range. Selectable imaging types are based on those types that use radiopharmaceuticals, and the user's location access. If individual technologists are selected, a notation will appear on the report to explain that not all technologists are included.

The default date range is the previous 24-hour day. Users can choose to sort date/time before technologist. The status of the exam is NOT a factor in determining whether a case is included in this report. If a measured and/or administered radiopharmaceutical dosage is entered, the case will be included.

Sort order if Radiopharmaceutical is selected as primary sort:

- Division
- Imaging type
- Radiopharmaceutical
- Exam date/time
- Patient
- Case number

Sort order if exam date/time is selected as primary sort:

- Division
- Imaging type
- Exam date/time
- Radiopharmaceutical
- Patient
- Case number

Detailed reports or summaries only can be printed. The report is designed for a 132-column page. If an administered dosage falls outside of the high/low dose range, an asterisk (*) prints next to it. If a radiopharmaceutical is currently inactive, but has DX200, DX201, or DX202, it will be included in the report if used during the exam date range. Since a case may have more than one radiopharmaceutical, the total number of unique cases may be less than the total number of radiopharmaceuticals reported.

```
Radiopharmaceutical Administration Report

Do you wish only the summary report? No// <RET>  NO

Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE      IL  CIOFO  499

Another one (Select/De-Select): <RET>

Select Imaging Type: All// ?

     Select a IMAGING TYPE TYPE OF IMAGING from the displayed list.
     To deselect a TYPE OF IMAGING type a minus sign (-)
     in front of it, e.g.,  -TYPE OF IMAGING.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter TYPE OF IMAGING* to select all entries that begin
     with the text 'TYPE OF IMAGING'.  Wildcard selection is
     case sensitive.

 Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION
Choose from:
   CARDIOLOGY STUDIES (NUC MED)
   NUCLEAR MEDICINE


Select Imaging Type: All// <RET>

Another one (Select/De-Select): <RET>

Do you wish to include all who administered dose ? Yes// <RET>  YES

**** Date Range Selection ****

   Beginning DATE : T-1//T-90  (MAY 21, 1997)

   Ending    DATE : T-1@24:00// <RET> (AUG 18, 1997@24:00)

Sort Exam Date/Time before Who Admin Dose ? : NO// <RET>

     ***                                                  ***
     *** This report requires a 132 column output device ***
     ***                                                  ***

DEVICE: HOME// (Enter a device that prints 132 columns)
```

Figure 6-34: Radiopharmaceutical Administration Report (Setup)

```
                                    >>> Radiopharmaceutical Administration
Report <<<    Run Date: AUG 19,1997  11:18   Page: 1

Division: HINES CIO FIELD OFFICE        Imaging Type: CARDIOLOGY STUDIES (NUC
MED)  For period: May 21, 1997 to Aug 18, 1997@24:00

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn Dose
Adm'd    Low       High   Procedure       Who Adm'd
-------------------------------------------------------------------------------
-------------------------------------------------
072297-702@1528 PATIENT,FRANK W  000-00-7311 PERCHLORACAP 25    7.0000
5.0000    0.0000    0.0000 CARDIOLOGY TEST PROVIDER,JOAN
```

Figure 6-35: Radiopharmaceutical Administration Report – Cardiology Studies (Sample Report)

```
                                    >>> Radiopharmaceutical Administration
Report <<<    Run Date: AUG 19,1997  11:18   Page: 2

Division: HINES CIO FIELD OFFICE             Imaging Type: NUCLEAR MEDICINE
For period: May 21, 1997 to Aug 18, 1997@24:00

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn Dose
Adm'd   Low       High   Procedure         Who Adm'd
-------------------------------------------------------------------------------
--------------------------------------------------
080697-709@1233 PATIENT,KARL F   000-00-0889 SESTAMIBI TC-99 600.0000
600.0000  250.0000  500.0000 THYROID IMAGING    PROVIDER,STEVE *
070997-700@0907 PATIENT,HANS     000-00-9318 SULFUR COLLOID    0.0000
10.0000   10.0000   15.0000 RADIONUCLIDE TH    PROVIDER,GREG
070997-701@0932 PATIENT,RICHARD 000-00-6827 SULFUR COLLOID   12.0000   12.0000
10.0000   15.0000 RADIONUCLIDE TH    CEBEL,GREG
072597-703@1245 PATIENT,SERGI    000-00-7958 SODIUM PERTECHN  12.0000
12.0000    0.0000   15.0000 THYROID IMAGING    PROVIDER,GREG
080797-718@0807 PATIENT,RALPH    000-00-8277 Tc-99m DTPA       0.6000
0.6000    0.5000    1.5000 LUNG AEROSOL SC    PROVIDER,RICK
080797-719@0807 PATIENT,RALPH    000-00-8277 Tc-99m MACROAGG   3.0000
3.0000    3.0000    6.0000 LUNG PERFUSION     PROVIDER,RICK
080797-721@0902 PATIENT,RALPH    000-00-8277 SESTAMIBI TC-99   8.0000
8.0000    8.0000   10.0000 MYOCARDIAL PERF    PROVIDER,RICK
```

Figure 6-36: Radiopharmaceutical Administration Report – Nuclear Medicine (Sample Report)

```
                                    >>> Radiopharmaceutical Administration
Report <<<    Run Date: AUG 19,1997  11:18   Page: 3
                                                  (Imaging Summary)
Division: HINES CIO FIELD OFFICE        Imaging Type: CARDIOLOGY STUDIES (NUC
MED)  For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                     Total Drawn    Total Adm'd   No. cases
(%)        No. outside range
-------------------------------------------------------------------------------
--------------------------------------------------
PROVIDER,JOAN                         7.0000         5.0000          1
100.00

CARDIOLOGY STUDIES (NUC MED)'s Total number of unique cases: 1

Notes: A case may have more than 1 radiopharm, so total no. unique cases may
be less than total no. radiopharms listed.
     * denotes administered dosage outside of normal range.
```

Figure 6-37: Radiopharmaceutical Administration Report – Cardiology Imaging Summary (Sample Report)

```
                                    >>> Radiopharmaceutical Administration
Report <<<    Run Date: AUG 19,1997  11:18   Page: 4
                                                    (Imaging Summary)
Division: HINES CIO FIELD OFFICE                Imaging Type: NUCLEAR MEDICINE
For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                      Total Drawn    Total Adm'd   No. cases
(%)        No. outside range
-------------------------------------------------------------------------------
-------------------------------------------------
PROVIDER,STEVE                        600.0000       600.0000         1
14.29             1
PROVIDER,GREGORY J                     24.0000        34.0000          3
42.86
PROVIDER,RICK                          11.6000        11.6000          3
42.86

NUCLEAR MEDICINE's Total number of unique cases: 7

Notes: A case may have more than 1 radiopharm, so total no. unique cases may
be less than total no. radiopharms listed.
     * denotes administered dosage outside of normal range.
```

Figure 6-38: Radiopharmaceutical Administration Report – Nuclear Medicine Imaging Summary (Sample Report)

```
                                    >>> Radiopharmaceutical Administration
Report <<<     Run Date: AUG 19,1997  11:18   Page: 5
                                                    (Division Summary)
Division: HINES CIO FIELD OFFICE
For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                      Total Drawn    Total Adm'd   No. cases
(%)        No. outside range
-------------------------------------------------------------------------------
-------------------------------------------------
PROVIDER,STEVE                        600.0000       600.0000         1
12.50             1
PROVIDER,GREGORY J                     24.0000        34.0000          3
37.50
PROVIDER,RICK                          11.6000        11.6000          3
37.50
PROVIDER,JOAN                          7.0000         5.0000           1
12.50

HINES CIO FIELD OFFICE's Total number of unique cases: 8

Notes: A case may have more than 1 radiopharm, so total no. unique cases may
be less than total no. radiopharms listed.
     * denotes administered dosage outside of normal range.
```

Figure 6-39: Radiopharmaceutical Administration Report – Division Summary (Sample Report)

6.3.3 Resident Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of exams and work associated with interpreting resident physicians. The residents for this report are stored in the Primary Interpreting Resident field and Secondary Interpreting Resident multiple field of the exam record. The user can choose to include only the Primary Interpreting Resident. If Primary and

Secondary Residents are included, more than one resident can be associated with a single exam, so totals do not correspond to the sum of the separate totals.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section 6.5 entitled General Information about Workload Reports at the end of the Management Reports Menu chapter for a full description of this report.

```
Prompt/User Response     Discussion
Interpreting Resident Workload Report:
----------------------------------

Do you wish only the summary report? NO// <RET>

Count Resident when entered as 'secondary' resident interpreter? Yes// ?

Answer 'Yes' if both Primary and Secondary Resident personnel will be included
in this report.  Answer 'No' if only Primary Resident personnel will be
included in this report.  Input a '^' to exit without a report.

Count Resident when entered as 'secondary' resident interpreter? Yes// <RET>  YES

Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE      IL  CIOFO  499

Another one (Select/De-Select): <RET>

Select Imaging Type: All// RAD    GENERAL RADIOLOGY

Another one (Select/De-Select): <RET>

Do you wish to include all Interpreting Residents? Yes// <RET>  YES

In this example, all residents will be included.

**** Date Range Selection ****

   Beginning DATE : T-100  (MAY 11, 1997)

   Ending    DATE : T  (AUG 19, 1997)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

DEVICE: HOME//   (Enter a device at this prompt)
```

Figure 6-40: Printing Resident Workload Report (Setup)

```
         >>> Interpreting Resident Workload Report <<<              Page: 1

    Division: DEMO CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                      For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                   AUG 19,1997

                                          Examinations    Percent
  Procedure (CPT)                       In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Resident: PROVIDER,DONALD
ABDOMEN 1 VIEW              (74000)        1      0      1   25.0
SPINE SI JOINTS 1 OR 2 VIEW (72200)        0      1      1   25.0
ANKLE 2 VIEWS               (73600)        0      1      1   25.0
ANGIO CAROTID CEREBRAL SELE (75660)        0      1      1   25.0
-------------------------------------------------------------------------------

  Interpreting Resident Total               1      3      4
```

Figure 6-41: Resident Workload Report (Sample Report)

```
         >>> Interpreting Resident Workload Report <<<              Page: 7

    Division: DEMO CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                      For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                   AUG 19,1997

                                          Examinations    Percent
  Procedure (CPT)                       In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Resident: UNKNOWN
SKULL 4 OR MORE VIEWS       (70260)        0      2      2    2.1
ABDOMEN MIN 3 VIEWS+CHEST   (74022)        0      1      1    1.1
CHEST APICAL LORDOTIC       (71021)        0      4      4    4.2
CHEST STEREO PA             (71015)        2      2      4    4.2
CHEST 4 VIEWS               (71030)        0      5      5    5.3
CHEST INCLUDE FLUORO        (71034)        0      3      3    3.2
ABDOMEN 1 VIEW              (74000)        1     13     14   14.7
ABDOMEN 2 VIEWS             (74010)        0      5      5    5.3
SPINE CERVICAL MIN 2 VIEWS  (72040)        0      1      1    1.1
SPINE SI JOINTS 1 OR 2 VIEW (72200)        0      1      1    1.1
ACROMIOCLAVICULAR J BILAT   (73050)        0      2      2    2.1
```

Figure 6-42: Resident Workload Report (Sample Report)

```
     >>> Interpreting Resident Workload Report <<<              Page: 11

    Division: DEMO CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                      For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                  AUG 19,1997

                                              Examinations    Percent
  Interpreting Resident                     In    Out  Total   Exams
-------------------------------------------------------------------------------
          (Imaging Type Summary)
PROVIDER,DONALD                              1      3     4      2.9
PROVIDER,BART                                0      5     5      3.6
PROVIDER,JOAN                                0      3     3      2.2
PROVIDER,DOCTOR                              1      5     6      4.4
PROVIDER,DOCTOR                              0      7     7      5.1
PROVIDER,FRED                                4     13    17     12.4
UNKNOWN                                     11     84    95     69.3
-------------------------------------------------------------------------------

  Imaging Type Total                         17    120    137

  NOTE: Since a procedure can be performed by more than one Interpreting
        Resident, the total number of exams by division and imaging type
        is likely to be higher than the other workload reports.
        Both Primary and Secondary Interpreting Resident are included in
        this report.

   # of Residents selected: ALL
```

Figure 6-43: Resident Workload Report with Totals (Sample Report)

6.3.4 Staff Report

This option allows the user (usually a supervisor or manager) to generate an interpreting staff workload report to view examinations and work associated with interpreting staff physicians. The staff names used for this report are stored in the Primary Interpreting Staff field and the Secondary Interpreting Staff multiple field of the exam record. The user can choose to only include the primary interpreting staff. If primary and secondary staff are included, more than one interpreting staff can be associated with a single exam, and totals will not correspond to the sum of the separate totals.

This report is one of a workload report series with similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section (section 6.5) for a full description of this report.

```
Do you wish only the summary report? NO// <RET>

Count Staff when entered as 'secondary' staff interpreter? Yes// ?
     Answer 'Yes' if both Primary and Secondary Staff personnel will be
included
     in this report. Answer 'No' if only Primary Staff personnel will be
     included in this report. Input a '^' to exit without a report.

Count Staff when entered as 'secondary' staff interpreter? Yes// NO

Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// NUCLEAR MEDICINE
Another one (Select/De-Select): <RET>

Do you wish to include all Primary Interpreting Staff? Yes// <RET> YES

**** Date Range Selection ****
     Beginning DATE : T-90 (MAY 21, 1997)
    Ending DATE   : T (AUG 19, 1997)

      The entries printed for this report will be based only
      on exams that are in one of the following statuses:
      Enter RETURN to continue or '^' to exit: <RET>

     NUCLEAR MEDICINE
     ----------------
        WAITING FOR EXAM
        EXAMINED
        TRANSCRIBED
        COMPLETE

DEVICE: HOME// (Enter a device at this prompt)
```

Figure 6-44: Printing the Staff Radiologist Report (Setup)

```
          >>> Interpreting Staff Workload Report <<<                 Page: 1
            Division: HINES CIO FIELD OFFICE
Imaging Type: NUCLEAR MEDICINE                    For period: MAY 21,1997 to
            Run Date: AUG 19,1997 11:55                         AUG 19,1997

                                        Examinations                Percent
Procedure (CPT)                      In     Out     Total           Exams
-------------------------------------------------------------------------------
         Interpreting Staff: PROVIDER,CINDY
LUNG AEROSOL SCAN, MULTIPLE (78587)   0       1         1           33.3
LUNG PERFUSION, PARTICULATE (78580)   0       1         1           33.3
PROVISION OF DIAGNOSTIC RAD (78990)   0       1         1           33.3
-------------------------------------------------------------------------------
Interpreting Staff Total               0       3         3
```

Figure 6-45: Printing the Staff Radiologist Report (Sample Report)

6.3.5 Technologist Report

This option allows the user (usually a supervisor or manager) to generate a workload report for technologists. The technologists for this report are stored in the

Technologist multiple field of the exam record. Since more than one technologist can be associated with a single exam, totals may not correspond to the sum of the separate totals.

This report is one of a workload report series with similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section (section 6.5) for a full description of this report.

```
Do you wish only the summary report? NO// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include all Technologists? Yes//<RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

          The entries printed for this report will be based only
          on exams that are in one of the following statuses:
          Enter RETURN to continue or '^' to exit: <RET>

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

DEVICE: (Printer Name or "Q")
```

Figure 6-46: Printing the Technologist Report (Setup)

```
     >>> Technologist Workload Report <<<                          Page: 1
            Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                 For period: Nov 21, 1994 to
            Run Date: FEB 28,1995 14:00                        Feb 28, 1995

                                      Examinations   Percent         Percent
Procedure (CPT)                     In   Out   Total   Exams    WWU      WWU
-------------------------------------------------------------------------------
          Technologist: PROVIDER,STEVE
NECK SOFT TISSUE(70360)              0     2      2     13.3      6      9.1
SKULL 4 OR MORE VIEWS(70260)         0     1      1      6.7      3      4.5
CHEST STEREO PA(71015)               0     2      2     13.3      2      3.0
ABDOMEN 1 VIEW(74000)                1     1      2     13.3      4      6.1
FOREARM 2 VIEWS(73090)               0     1      1      6.7      2      3.0
CHOLANGIOGRAM IV(74310)              0     1      1      6.7     10     15.2
CT HEAD W/IV CONT(70460)             1     1      2     13.3     16     24.2
CT MAXILLOFACIAL W&W/O CONT(70488)   0     1      1      6.7      8     12.1
STEREOTACTIC LOCALIZATION HEAD(70022) 2    1      3     20.0     15     22.7
-------------------------------------------------------------------------------
Technologist Total                   4    11     15             66
```

Figure 6-47: Printing the Technologist Report (Sample Report)

6.3.6 Transcription Report

This option allows you to print an imaging transcription report showing the number of lines and reports that each transcriptionist transcribed for a specified date range.

Only one transcriptionist may be associated with an exam. The number of lines counted is always the current number of lines in the report. So, if lines have been added, changed, or deleted, only the final number of lines at the time the report is run will be counted. The report does not reflect changes made by subsequent transcriptionists. All workloads will be credited to the initial transcriptionist for each report. The total character count is divided by 75 to produce the line count.

This report is one of a workload report series with similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section of this manual (section 6.5) for a full description of this report.

```
>>> IMAGING TRANSCRIPTIONIST WORKLOAD REPORT <<<
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFICE   IL   CIOFO   499
Another one (Select/De-Select): <RET>

Do you wish to include all Transcriptionists? Yes// <RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-48: Setting Up the Transcription Report

```
              >>> IMAGING TRANSCRIPTION REPORT <<<                    PAGE: 1
                Division: HINES CIO FIELD OFFICE
              Date Range: NOV 21,1994 - MAR 1,1995

# of Transcriptionists selected: ALL

RADIOLOGY/NUCLEAR MEDICINE PERSONNEL     NUMBER OF LINES    NUMBER OF REPORTS
================================================================================
STAFF,MARY                                        76                  38
STAFF,JOHN                                        2                   1
STAFF,SANDY                                       25                  9
STAFF,STEPHEN                                     2                   1
STAFF,MANDY                                       56                  14
STAFF,FRANK                                       39                  14
```

Figure 6-49: Sample Transcription Report

6.4 Special Reports

6.4.1 AMIS Code Dump by Patient

This option allows the user (usually a supervisor or manager) to generate a listing of patients who have an examination associated with a specified AMIS code within a designated time frame.

The listing is printed chronologically by examination date. The following information is shown in the report: patient name, patient ID, procedure, exam date and time, and ward/clinic that ordered that exam. At the bottom of the report is the total number of examinations for the specified AMIS category and a breakdown of the total into inpatient and outpatient examinations. The report also indicates which procedures have been counted as multiple or zero exams.

First you will be asked to select one AMIS category. Next you will be asked if you want to include all procedures within the selected AMIS category. If you want to select a subset of procedures, type No and you will be prompted for one or more of the procedures that are associated with the specified AMIS code. Two question marks (??) entered at any of these prompts will produce online help and a list of valid responses.

Although the report will print on an 80-column or 132-column device, it is easier to read if it is printed on a 132-column device.

Exams must meet certain criteria to be included in the report:

- First, the exam date/time must fall within the date range selected. The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. (This is determined during the Examination Status Entry/Edit setup when the radiology supervisor answers the AMIS Report question.) The division on the exam record must be one of the

divisions you selected or your default division (if a division selection prompt didn't appear).

- The procedures included on the report must be among those you selected with one exception: If AMIS category 25 (Operating Room) or 26 (Portable) was selected, then all exams that meet the other criteria, regardless of the AMIS code of the procedure performed, will be further checked for exam modifier types of "portable" or "operating room." Therefore, if an ankle x-ray with AMIS code 8 is performed, and a modifier of the "operating room" type was entered for the exam, then that exam will show up in this report when AMIS category 25 is selected AND when AMIS category 8 is selected.

Exam Counts

If the exam in the ankle x-ray example above has no other multipliers or bilateral modifiers, it will count as 1 exam. If an exam's procedure has an AMIS weight multiplier of 3 for the selected AMIS category in the Rad/Nuc Med Procedure file, it will be counted as 3 exams. If a procedure's AMIS weight multiplier is 1 or blank, but the procedure's Bilateral field is set to YES for the selected AMIS category, it would count as 2. If a bilateral type of modifier is entered during exam ordering or editing, it also would count as 2 exams. If both conditions are true, the count will still be 2.

It is possible for an exam to get a count of zero if the AMIS weight multiplier on the procedure for the selected AMIS code is set to zero. Only procedures designated by VACO as having an AMIS weight of zero should be set to zero.

The category of exam on the exam record is used to determine whether the exam count is added to inpatient totals or outpatient totals. If the category of exam is inpatient, the exam will be added to the inpatient totals. If the category of exam is anything else (outpatient, research, employee, contract, sharing), the exam will be added to the outpatient totals.

Totals are separated by division, and a grand total will also print.

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499

Another one (Select/De-Select): <RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

Select MAJOR RAD/NUC MED AMIS CODES DESCRIPTION: ??
     Choose from:
          1 SKULL,INC.SINUS,MASTOID,JAW,ETC
          2 CHEST-SINGLE VIEW
          3 CHEST MULTIPLE VIEW
          4 CARDIAC SERIES
          5 ABDOMEN-KUB
          6 OBSTRUCTIVE SERIES
          7 SKELETAL-SPINE & SACROILIAC
          8 SKELETAL-BONE & JOINTS
          9 GASTROINTESTINAL
         10 GENITOURINARY
         11 CHOLECYSTOGRAM,ORAL
         12 CHOLANGIOGRAM
         13 LAMINOGRAM
         14 BRONCHOGRAM
         15 DIGITAL SUBTRACTION ANGIOGRAPHY
         16 ANGIOGRAM,CATH- CEREBRAL
         17 ANGIOGRAM,CATH- VISCERAL
         18 ANGIOGRAM,CATH- PERIPHERAL
         19 VENOGRAM
         20 MYELOGRAM
         21 COMPUTED TOMOGRAPHY
'^' TO STOP: ^

Select MAJOR RAD/NUC MED AMIS CODES DESCRIPTION: ABDOMEN-KUB

Do you wish to include all Procedures? Yes// <RET>

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-50: Printing the AMIS Code Dump By Patient Report (Setup)

```
      >>>>> AMIS Code Dump by Patient <<<<<                          Page: 1
Patient List for AMIS Category 5 - ABDOMEN-KUB
                                            For Period: NOV 21,1994 to
Run Date: MAR 1,1995 10:58                              MAR 1,1995
Division: HINES CIO FIELD OFFICE
# of Procedures Selected: All

Patient Name   Pt ID        Procedure       Exam Date         Ward/Clinic
------------   -----        ---------       -----------   -----------
PATIENT,CHICO   819-19-7536  ABDOMEN 2 VIEWS NOV 28,1994 13:46 EMERGENCY ROOM
PATIENT,HENRY   793-13-3012  ABDOMEN 1 VIEW  DEC 2,1994 15:05  EMERGENCY ROOM
PATIENT,FRANK   512-99-2785  ABDOMEN 1 VIEW  DEC 8,1994 10:22  X-RAY STOP
PATIENT,MICHAEL 232-32-3230  ABDOMEN 1 VIEW  JAN 12,1995 09:40 X-RAY STOP
PATIENT,ROBERT  123-98-7123 +ABDOMEN 1 VIEW  JAN 23,1995 15:23 EMERGENCY ROOM
PATIENT,RALPH   321-44-827   ABDOMEN 1 VIEW  FEB 13,1995 12:41 1N
PATIENT,PAUL    194-56-3594  ABDOMEN 1 VIEW  FEB 22,1995 15:34 GENERALMEDICINE

Total=8 Inpatient=1 Outpatient=7

+ counts as multiple exams
- counts as zero exams
```

Figure 6-51: Printing the AMIS Code Dump By Patient Report (Sample Report)

6.4.2 AMIS Report

This option allows the user (usually a supervisor or manager) to generate an overall workload report based on examinations performed within a specified date range. The report contains the AMIS category number and name, and counts are listed for inpatient examination statistics, outpatient examination statistics, total examination statistics, percent of total examination statistics, weighted work unit statistics, and film usage.

A separate page prints for each division with AMIS codes listed in numerical order. An all-division page will print if more than one division is included.

If you have access to more than one Radiology/Nuclear Medicine division, you will be prompted for one or more divisions to include in the report. If you have access to only one division, the system will automatically select that division for you and you will not see a division prompt. You will be prompted for a date range, and only data from examination dates within the range you specify will be included.

Exams must meet certain criteria to be included in the report:

- The exam date/time must fall within the date range selected.
- The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. (This is determined during system setup when the radiology supervisor answers the AMIS Report question during Examination Status Entry/Edit.)

- The division on the exam record must be one of divisions you selected or your default division (if a division selection did not appear).

- The procedure on the exam record must have an AMIS code.

- If the procedure's CPT code is the same as that of another procedure on the same visit (i.e., same exam date/time), the exam is bypassed. If more than one procedure done during a visit does not have a CPT code, only the first procedure without a CPT will be counted and the rest (without a CPT) will be bypassed.

The exam counts are determined as follows:

- If the Ward on the exam record contains a valid ward, the exam is counted as an inpatient exam. Otherwise, it is assumed to be outpatient. One count per exam is added to the division visits and totals visits. The number of each film size used (including wasted film) is added to the appropriate total for division, inpatient or outpatient, film or cine total, and grand total. If the film is cine, the Cine Runs total is incremented by 1.

- The Patient Visits total includes one count for each exam date/time. If multiple cases are registered under one date/time, the count will be one for that visit. The Average Exams Per Visit total shows the average cases registered per each exam date/time.

- For each exam, the inpatient and outpatient examination totals for the appropriate AMIS code(s) are incremented by the number in the AMIS Weight Multiplier field in the Procedure file (the weight multiplier in most cases is 1). For each exam, the inpatient and outpatient weighted work units are incremented by the product of the AMIS Weight Multiplier and the number in the Weight field of the Major Rad/Nuc Med AMIS Codes file. If the AMIS Weight Multiplier is 1, it will be doubled before these calculations are done (if the exam is considered bilateral).

There are many cases where characteristics of the exam or procedure affect the exam counts. The program may turn on “flags” signaling that an exam is BILATERAL, PORTABLE, or done in an OPERATING ROOM. The appropriate flag is turned on if any of the exam modifiers are of the bilateral, portable, or operating room modifier type. A flag will also be turned on if AMIS code 25 (Operating Room) or AMIS code 26 (Portable) has been assigned to the procedure, or if there is a YES in the Bilateral field of the procedure for the selected AMIS code. If the OPERATING ROOM flag is set, counts are added to AMIS Code 25 as well as to the AMIS code of the procedure. If the PORTABLE flag is set, counts are added to AMIS code 26 as well as to the AMIS code of the procedure. The counts added will be identical to those added to the procedure's AMIS code, described in the last paragraph.

A MYELOGRAM flag will be set if the procedure's AMIS code is 20. A COMPUTED TOMOGRAPHY-HEAD flag is set if the AMIS code is 21 and CT Head or Body field of the procedure is set to “head.” A COMPUTED

TOMOGRAPHY-BODY flag is set if the AMIS code is 21 and the CT Head or Body field of the procedure is set to “body”. If a procedure has both AMIS codes 20 and 21 or more than one of each code, counts will only be applied once. However, if a computed tomography head and a computed tomography body are on the same procedure, counts will be added for each.

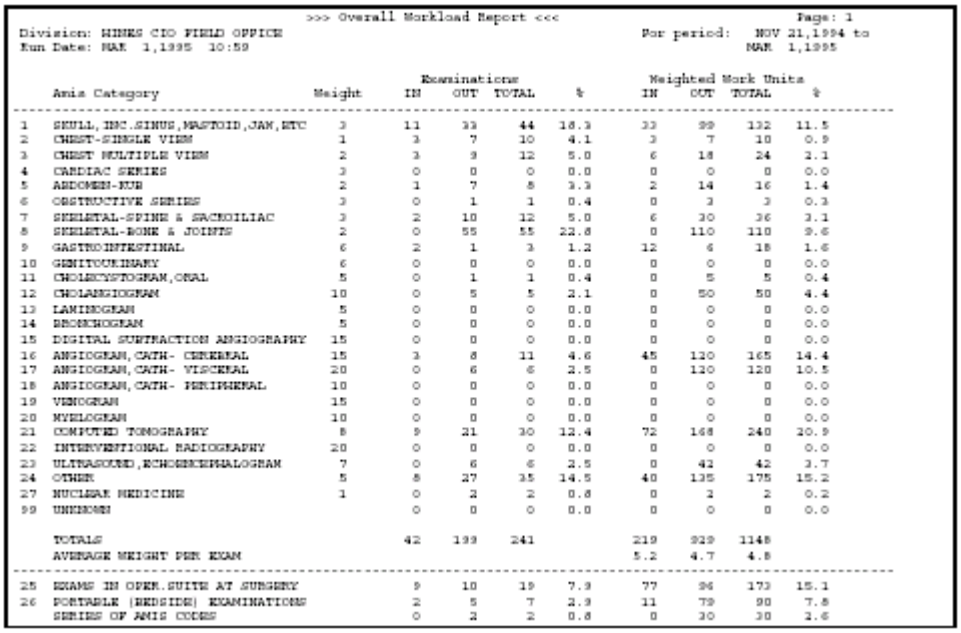
A SERIES flag is turned on if the procedure has been assigned more than one AMIS code. If the SERIES flag is on, counts are added to the Series of AMIS Codes total as well as to each AMIS code total. The counts added will be identical to those added to the procedure's AMIS code, described above.

The operating room, portable, and series totals appear at the end of the report.

Note: This report should be queued to a printer that supports 132 columns.

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

     The entries printed for this report will be based only
     on exams that are in one of the following statuses:
     Enter RETURN to continue or '^' to exit: <RET>

     ANGIO/NEURO/INTERVENTIONAL
     --------------------------
        EXAMINED
        COMPLETE

     CARDIOLOGY STUDIES (NUC MED)
     ----------------------------
        EXAMINED
        COMPLETE

     CT SCAN
     -------
        EXAMINED
        TRANSCRIBED
        COMPLETE

     GENERAL RADIOLOGY
     -----------------
        EXAMINED
        TRANSCRIBED
        COMPLETE

     MAGNETIC RESONANCE IMAGING
     --------------------------
        EXAMINED
        COMPLETE

     MAMMOGRAPHY
     -----------
        COMPLETE

     ULTRASOUND
     ----------
        EXAMINED
        TRANSCRIBED
        COMPLETE

     VASCULAR LAB
     ------------
        CALLED FOR EXAM
        EXAMINED
        ALL DONE

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-52: Printing the AMIS Report (Setup)

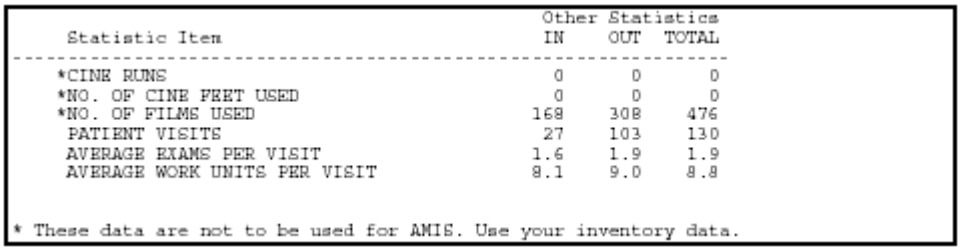


>>> Overall Workload Report <<< Page: 1

Division: HINES CIO FIELD OFFICE For period: NOV 21,1994 to
Run Date: MAR 1,1995 10:59 MAR 1,1995

	Amis Category	Weight	Examinations IN	OUT	TOTAL	%	Weighted Work Units IN	OUT	TOTAL	%
1	SKULL,INC.SINUS,MASTOID,JAW,ETC	3	11	33	44	18.3	33	99	132	11.5
2	CHEST-SINGLE VIEW	1	3	7	10	4.1	3	7	10	0.9
3	CHEST MULTIPLE VIEW	2	3	9	12	5.0	6	18	24	2.1
4	CARDIAC SERIES	3	0	0	0	0.0	0	0	0	0.0
5	ABDOMEN-KUB	2	1	7	8	3.3	2	14	16	1.4
6	OBSTRUCTIVE SERIES	3	0	1	1	0.4	0	3	3	0.3
7	SKELETAL-SPINE & SACROILIAC	3	2	10	12	5.0	6	30	36	3.1
8	SKELETAL-BONE & JOINTS	2	0	55	55	22.8	0	110	110	9.6
9	GASTROINTESTINAL	6	2	1	3	1.2	12	6	18	1.6
10	GENITOURINARY	6	0	0	0	0.0	0	0	0	0.0
11	CHOLECYSTOGRAM,ORAL	5	0	1	1	0.4	0	5	5	0.4
12	CHOLANGIOGRAM	10	0	5	5	2.1	0	50	50	4.4
13	LAMINOGRAM	5	0	0	0	0.0	0	0	0	0.0
14	BRONCHOGRAM	5	0	0	0	0.0	0	0	0	0.0
15	DIGITAL SUBTRACTION ANGIOGRAPHY	15	0	0	0	0.0	0	0	0	0.0
16	ANGIOGRAM,CATH- CEREBRAL	15	3	8	11	4.6	45	120	165	14.4
17	ANGIOGRAM,CATH- VISCERAL	20	0	6	6	2.5	0	120	120	10.5
18	ANGIOGRAM,CATH- PERIPHERAL	10	0	0	0	0.0	0	0	0	0.0
19	VENOGRAM	15	0	0	0	0.0	0	0	0	0.0
20	MYELOGRAM	10	0	0	0	0.0	0	0	0	0.0
21	COMPUTED TOMOGRAPHY	8	9	21	30	12.4	72	168	240	20.9
22	INTERVENTIONAL RADIOGRAPHY	20	0	0	0	0.0	0	0	0	0.0
23	ULTRASOUND,ECHOENCEPHALOGRAM	7	0	6	6	2.5	0	42	42	3.7
24	OTHER	5	8	27	35	14.5	40	135	175	15.2
27	NUCLEAR MEDICINE	1	0	2	2	0.8	0	2	2	0.2
99	UNKNOWN		0	0	0	0.0	0	0	0	0.0
	TOTALS		42	199	241		219	929	1148	
	AVERAGE WEIGHT PER EXAM						5.2	4.7	4.8	
25	EXAMS IN OPER.SUITE AT SURGERY		9	10	19	7.9	77	96	173	15.1
26	PORTABLE (BEDSIDE) EXAMINATIONS		2	5	7	2.9	11	79	90	7.8
	SERIES OF AMIS CODES		0	2	2	0.8	0	30	30	2.6

Figure 6-53: Printing the Overall Workload Report (Sample Report)



Statistic Item	Other Statistics IN	OUT	TOTAL
*CINE RUNS	0	0	0
*NO. OF CINE FEET USED	0	0	0
*NO. OF FILMS USED	168	308	476
PATIENT VISITS	27	103	130
AVERAGE EXAMS PER VISIT	1.6	1.9	1.9
AVERAGE WORK UNITS PER VISIT	8.1	9.0	8.8

* These data are not to be used for AMIS. Use your inventory data.

Figure 6-54: Printing the Overall Workload Report (Sample Report)

6.4.3 Camera/Equip/Rm Report

This option allows the user (usually a supervisor or manager) to generate a workload report for cameras/equipment/rooms. The report contains the following information:

- Procedure
- Number of examinations performed
- Percent of total exams performed
- Associated weighted work units
- Percent of total weighted work units

The cameras, equipment, and rooms in the report are stored in the Primary Camera/Equip/Rm field of the exam record.

This report is one of a workload report series with similar selection criteria, report output, data retrieval logic, and reporting logic. See the General Information about Workload Reports section (section 6.5) for a full description of this report.

```
Do you wish only the summary report? NO// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include all Camera/Equip/Rooms? Yes//<RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (APR 20, 1997)
     Ending DATE    : T (JUL 29, 1997)

     The entries printed for this report will be based only
     on exams that are in one of the following statuses:
     Enter RETURN to continue or '^' to exit: <RET>

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        TRANSCRIBED
        COMPLETE

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-55: Printing the Camera/Equipment/Room Report (Setup)

```
      >>> Camera/Equip/Room Workload Report <<<                    Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                For period: APR 20,1997 to
    Run Date: JUL 29,1997 15:10                            JUL 29,1997

                                     Examinations   Percent         Percent
Procedure (CPT)                    In   Out   Total   Exams    WWU      WWU
-------------------------------------------------------------------------------
-------
          Camera/Equip/Room: CAMERA 1 - Triple Head SPECT S
ARTHROGRAM SHOULDER S&I (73040)     0     1       1   100.0      5    100.0
-------------------------------------------------------------------------------
Camera/Equip/Room Total             0     1       1              5

Enter RETURN to continue or '^' to exit: <RET>
```

Figure 6-56: Printing the Camera/Equipment/Room Report (Sample Report)

6.4.4 Cost Distribution Report

This option produces a report of exam workload by cost distribution center to assist the department in preparing their cost distribution report (CDR).

This report is compiled from the examination data entered through the Exam Entry/Edit menu. If the user has access to more than one radiology/nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting for a selection. The same process occurs with imaging type. A prompt for selection of one or more imaging types will only appear if the user has access to more than one imaging type. The user must also select a date range.

If the exam date of a case is within the date range selected, the case may be included on the report as long as the exam was not cancelled, the division and category of exam data on the exam are not missing or invalid, and the cost center can be determined using the steps described below.

There are four category headings on the report: inpatient, outpatient, and research each have their own heading. contract, sharing, and employee are reported under "Other."

Inpatient Method of Determining Cost Center
If the category of exam is Inpatient, Research, Contract, or Sharing, the Ward field of the Rad/Nuc Med Patient file is used to find a Specialty (in the Ward Location file) for that ward. The name of that specialty is used as the cost center for the exam and its CDR account number (in the Specialty file) is used as the cost center number.

Outpatient Method of Determining Cost Center
If the category of exam is Outpatient or Employee, the Principal Clinic field of the Rad/Nuc Med Patient file is used to find the Stop Code for that location in the Hospital Location file. The Stop Code Name is used on the report as the Cost Center name. The stop code's Cost Distribution Center (in Clinic Stop file) appears on the report as the cost distribution center number.

If a cost center has not been determined at this point, the Requesting Location field of the Rad/Nuc Med Patient file is used to determine the cost center. The system determines if the requesting location is an Inpatient or Outpatient location by looking at its Type in the Hospital Location file (W for ward, C for clinic). If neither, the record is bypassed. If the requesting location is a ward, the Inpatient method is used to find the cost center. If the requesting location is a clinic, the Outpatient method is used.

If the cost center still has not been determined (i.e., all the above pathways failed due to one or more fields in the database not entered or invalid), the exam is bypassed.

Although the cost center names have already been calculated at this point, the program unconditionally resets the names of four cost centers:

Cost Center 1110 changes to "GENERAL MEDICINE"

Cost Center 1111 changes to "NEUROLOGY"

Cost Center 1210 changes to "GENERAL SURGERY"

Cost Center 1310 changes to "ACUTE AND LONG TERM PSYCHIATRY"

All other cost centers retain the name acquired during the previous steps.

If any AMIS code for the procedure has a YES in the Bilateral field of the AMIS subfile of the Procedure file #71, a MULTIPLIER flag is turned on.

One count is added to the appropriate exam category and cost center totals. If the MULTIPLIER flag is on, one additional count is added to the totals.

A summary will print at the end of each imaging type listings. A division summary prints if more than one imaging type for the division is included on the report. If only one imaging type is included for a division, no division summary is printed because the imaging type summary already includes all of the division summary totals.

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499

Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-57: Printing the Cost Distribution Report (Setup)

Sample Report:

```
          >>>>> COST DISTRIBUTION REPORT <<<<<                      Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                  For Period: 11/21/94 to
    Run Date: MAR 01, 1995@11:00:33                          03/01/95

                                                                      % of
Procedure                           Inpt    Opt    Res    Oth    Total   Exams
-------------------------------------------------------------------------------
          Cost Distribution Center: 1110.00 GENERAL MEDICINE
BONE AGE                               3      0      0      0        3    27.3
CHEST 4 VIEWS                          2      0      0      0        2    18.2
CT HEAD W/IV CONT                      2      0      0      0        2    18.2
SKULL 4 OR MORE VIEWS                  1      0      0      0        1     9.1
SPINE LUMBOSACRAL MIN 2 VIEWS          2      0      0      0        2    18.2
STEREOTACTIC LOCALIZATION HEAD         1      0      0      0        1     9.1

                    Total             11      0      0      0       11   100.0
                  Percent            100.0  0.0    0.0    0.0
```

Figure 6-58: Printing the Cost Distribution Report (Sample Report)

6.4.5 Detailed Procedure Report

This option allows the user (usually a supervisor, radiology supervisor, or other managerial personnel) to generate a detailed procedure workload report. The report consists of the following information for each AMIS category:

- Procedure
- Number of inpatient and outpatient examinations
- Total number of examinations
- Percent of exams
- Weighted work units
- Percent of weighted work units

This report is compiled from the examination data entered through the Exam Entry/Edit Menu. If the user has access to more than one Radiology/Nuclear Medicine division, a prompt will request a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting the user for a selection. The same process occurs with imaging type. A prompt for selection of one or more imaging types will only appear if the person has access to more than one imaging type. The user must also select a date range.

Since the output can be lengthy, you may wish to run this report during off-peak hours.

If the case's exam date is within the date range selected, the case will be included on the report as long as the procedure has been assigned an AMIS code and the exam's division and imaging type are among those selected. The current status of the exam must be specified in the Examination Status parameters as a status to include on this report. (This is determined during system setup when the radiology supervisor answers the Detailed Procedure Report question during the Examination Status Entry/Edit setup.)

Examination Counts

If the Ward field of the exam record contains a valid ward, the exam is counted under the Inpatient heading. In all other cases it is counted under the Outpatient heading.

For each exam, the inpatient and outpatient examination totals for the appropriate AMIS code(s) are incremented by the number in the AMIS Weight Multiplier field in the Procedure file (the weight multiplier in most cases is 1). For each exam, weighted work units are the product of the AMIS Weight Multiplier and the number in the Weight field of the Major Rad/Nuc Med AMIS Codes file. If the AMIS Weight Multiplier is 1 and the exam is considered bilateral, the weight multiplier will be doubled before these calculations are done.

There are many cases where characteristics of the exam or procedure affect the exam counts. The system may turn on flags signaling that an exam is bilateral, portable, or done in an operating room. The appropriate flag is turned on if any of the exam modifiers are of the bilateral, portable, or operating room modifier type. A flag will also be turned on if AMIS code 25 (Operating Room) or AMIS code 26 (Portable) has been assigned to the procedure or if there is a YES in the Bilateral field of the procedure for the selected AMIS code. If the Operating Room flag is set, counts are added to AMIS Code 25 as well as to the AMIS code of the procedure. If the Portable flag is set, counts are added to AMIS code 26 as well as to the AMIS code of the procedure. The counts added will be identical to those added to the procedure's AMIS code, described in the last paragraph.

A Series flag is turned on if the procedure has been assigned more than one AMIS code. If the Series flag is on, counts are added to the Series of AMIS Codes total as well as to each AMIS code total. The counts added will be identical to those added to the procedure's AMIS code, as described in the last paragraph.

The operating room, portable, and series totals appear at the end of the report in the division summary.

```
Select Rad/Nuc Med Division: All// HINES INFORMATION
SYSTEMS CTR ILLINOIS ISC 499
Another one (Select/De-Select): <RET>

Select one IMAGING TYPE: GENERAL RADIOLOGY

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

     The entries printed for this report will be based only
     on exams that are in one of the following statuses:
     Enter RETURN to continue or '^' to exit:

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        COMPLETE

DEVICE: (Printer Name or "Q")
```

This prompt differs from the Imaging Type selection prompt in other options. Note that only **one** Imaging Type can be selected.

Figure 6-59: Printing the Detailed Procedure Report (Setup)

```
           >>>>> Detailed Procedure Workload Report <<<<<            Page: 1

    Division: HINES INFORMATION SYSTEMS CTR
Imaging Type: GENERAL RADIOLOGY                  For period: NOV 21,1994 to
    Run Date: MAR 1,1995 11:01                               MAR 1,1995

                                      Examinations   Percent         Percent
Procedure                           In   Out   Total   Exams    WWU      WWU
-------------------------------------------------------------------------------
-------
          Amis: 1 SKULL,INC.SINUS,MASTOID,JAW,ETC
BONE SURV COMP (INCL APPENDIC        0     1       1     1.9      3      1.9
NECK SOFT TISSUE                     4    24      28    51.9     84     51.9
SKULL 4 OR MORE VIEWS                7    18      25    46.3     75     46.3

AMIS CATEGORY TOTALS                11    43      54            162
```

Figure 6-60: Printing the Detailed Procedure Report (Sample Report)

6.4.6 Film Usage Report

This option allows the user (usually a supervisor or manager) to generate a record of film usage according to film size. The report shows procedure, number of films used, number of exams, average number of films used per exam and percentage of films used for a given procedure. This listing may be generated as a detailed or summary report. The film sizes in the report are stored in the Film Size and Amount subfields of the exam record.

The user will be asked if he or she wants to print a summary only. A summary report groups all examinations together by film size for each imaging type and division. A detailed report gives information for each individual procedure performed within the

film size. This report is compiled from the film size data entered through the Exam Entry/Edit menu.

If the user has access to more than one radiology/nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting the user for a division selection. The same process occurs with imaging type. A prompt for selection of one or more imaging types will only appear if the user has access to more than one imaging type. The user must also select an exam date range. If you only want to include a limited number of film sizes on the report, type No at the "Do you wish to include all films?" prompt. A "Select film:" prompt will appear and allow you to select specific film sizes.

Before the report prints, a list of exam statuses to be included in the report will be displayed. The exam statuses may be different for each imaging type selected. This is determined during system setup when the radiology supervisor answers the Film Usage Report question during Examination Status Entry/Edit. See the radiology supervisor's guide for more information on exam status parameter setup.

Since this function's output can be lengthy, you may wish to run this report during off-peak hours.

If the exam date of a case is within the date range selected and the exam's division and imaging type are among those selected, the case will be included in the report. The current status of the exam must also be specified in the Examination Status parameters as a status to include in this report. If, during exam edit/entry, a film size was entered for an exam but no amount was entered, nothing will be added to the totals.

The exam counts are doubled if the exam is considered bilateral. An exam is bilateral if any exam modifiers are of the bilateral modifier type, or if the Bilateral field of the procedure's AMIS subrecord is set to Yes. If the AMIS Weight Multiplier field of the procedure's AMIS subrecord is set to a number greater than 1, this number will be used, and the bilateral modifiers will have no effect. An exam with more than one AMIS code will only be counted as one exam regardless of whether it is bilateral.

Film counts are not affected by multipliers or bilateral modifiers; they are determined by the numbers entered during exam editing. Wasted film types are bypassed. If the film is a cine type, its statistics are included under the Cine film size page that reports number of cine feet. Cine is included in a line on the summary page, but not in the totals. Only AMIS codes 1-24 and 27 are used in summing totals for each procedure.

The sort order of the report is:

- Division number
- Imaging type

- Film size
- AMIS category
- Procedure

There is a notation at the end of the summary page that serves as a reminder of the number of film sizes selected to include on the report.

```
Do you wish only the summary report? NO// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include all Films? Yes// <RET>

**** Date Range Selection ****
     Beginning DATE : T-100 (NOV 21, 1994)
     Ending DATE    : T (MAR 01, 1995)

     The entries printed for this report will be based only
     on exams that are in one of the following statuses:

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        TRANSCRIBED
        COMPLETE

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-61: Printing the Film Usage Report (Setup)

```
                >>>>> Film Usage Report <<<<<                      Page: 1

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY              For period: NOV 21,1994 to
    Run Date: MAR 1,1995 11:02                           MAR 1,1995

                                  Number      Number     Films     Percentage
                                    of          of        per          Films
Procedure(CPT)                    Films       Exams     Exam           Used
-------------------------------------------------------------------------------
          Film Size: 10X12
SKULL 4 OR MORE VIEWS(70260)         10           2       5.0            6.7
CHEST STEREO PA(71015)               24           5       4.8           16.0
CHEST 4 VIEWS(71030)                  8           2       4.0            5.3
ABDOMEN 1 VIEW(74000)                10           3       3.3            6.7
SPINE LUMBOSACRAL MIN 2 VIEWS(72100)  2           1       2.0            1.3
ANKLE 2 VIEWS(73600)                 18           9       2.0           12.0
FOREARM 2 VIEWS(73090)                2           1       2.0            1.3
UPPER GI + SMALL BOWEL(74245)        10           2       5.0            6.7

Film Usage Total                     84          25       3.4
```

Figure 6-62: Printing the Film Usage Report (Sample Report)

6.4.7 Procedure/CPT Statistics Report

This report will generate statistics on the number of each procedure performed for a specified date range. The statistics are not affected by modifiers or AMIS weights. This report includes cost figures based on procedure costs entered by the Rad/Nuc Med radiology supervisor.

If the user has access to more than one radiology/nuclear medicine division, a prompt will appear and ask for a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting for a selection. The same process applies to imaging type too. A prompt for selection of one or more imaging types will appear only if the user has access to more than one imaging type. One, many, or all procedures may be selected for inclusion on the report. The user must also select a date range. Selection criteria include a choice of Inpatient, Outpatient, or Both. If the both option is selected, separate pages will still print for inpatient and outpatient, with inpatient pages printing first.

To be included in the report, an exam must have:

- An exam date that falls within the selected date range
- A Division field that contains one of the divisions selected
- An Imaging Type field that contains one of the imaging types selected

If the exam passes all these criteria, a count of one (1) is added to the procedure total. Cancelled exams may or may not be included depending on the user's selection criteria. If the Ward field of the exam record contains a valid ward in the Ward

Location file, the exam is assumed to be an inpatient exam. If there is no CPT assigned to a procedure, the exam is bypassed.

The sort order for this report is:

- Division number
- Imaging type
- CPT code

The report has no division summary page. There is a page or section for each imaging type within each division for each patient category (inpatient or outpatient).

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include cancelled cases? Yes// <RET>  YES

Do you wish to include all Procedures? Yes// <RET>  YES

**** Date Range Selection ****
     Beginning DATE : T-100 (APR 22, 1997)
     Ending DATE    : T (JUL 31, 1997)

     Select one of the following:
        I INPATIENT
        O OUTPATIENT
        B BOTH
Report to include: BOTH// <RET>

DEVICE: HOME// (Printer Name or "Q")
```

Figure 6-63:Printing the Procedure/CPT Statistics Report (Setup)

```
         >>>>> PROCEDURE/CPT STATISTICS REPORT (INPATIENT) <<<<<      Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                      For period: 04/22/97 to
    Run Date: JUL 31,1997 15:12                                  07/31/97
    # of Procedures selected: All                   Cancelled Exams: included

CPT    PROCEDURE                          # DONE   (%)   $UNIT   $TOTAL   (%)
================================================================================
71015  CHEST STEREO PA                      2   20    10.00   20.00     6
71022  CHEST OBLIQUE PROJECTIONS            1   10    20.00   20.00     6
74000  ABDOMEN 1 VIEW                       3   30    10.00   30.00     9
74249  UPPER GI AIR CONT W/SMALL BOWEL      1   10    40.00   40.00    12
75660  ANGIO CAROTID CEREBRAL SELECT EXT UNIL  2   20    90.00  180.00    52
76091  MAMMOGRAM BILAT                      1   10    50.00   50.00    15

Total for this imaging type -->            10               340.00
```

Figure 6-64: Printing the Procedure/CPT Statistics Report (Sample Report)

6.4.8 Status Time Report

This option allows the user (usually a supervisor or manager) to generate a status tracking statistics report. For each status change within each division, the report lists the original status, the updated status, minimum time to make the status change, maximum time to make the status change, and the average time to make the status change for an associated procedure. This report would be used to track the progress of examinations from status to status, to determine where processing delays are occurring, and to see that exams are moving through the system in a timely fashion.

One, many, or all divisions to which the user has access may be selected. Due to the potentially large report size, only one imaging type may be selected at a time. The user must also select a date range. This report should be queued to a device.

The times in this output are rounded off; seconds are dropped and only whole minutes are used.

```
Select Rad/Nuc Med Division: All// HINES CIO FIELD
OFICE IL CIOFO 499
Another one (Select/De-Select): <RET>

Select IMAGING TYPE: GENERAL RADIOLOGY

**** Date Range Selection ****
     Beginning DATE : T-100 (DEC 24, 1996)
     Ending DATE    : T (APR 03, 1997)

DEVICE: HOME// (Printer Name or "Q")
```

You may only select one Imaging Type.

Figure 6-65: Printing the Status Time Report (Setup)

```
              ** Status Tracking Statistics Report **                Page: 1
                          Procedure Detail

  Run Date: 04/03/97                    For Period: 12/24/96 - 04/03/97
  --------                              ----------
  Division: HINES CIO FIELD OFFICE   Imaging Type: GENERAL RADIOLOGY
  --------                           ------------
           From: WAITING FOR EXAM
           To : COMPLETE

                                    Minimum    Maximum    Average
                                      Time       Time       Time     Number of
Procedure (CPT)                   (DD:HH:MM) (DD:HH:MM) (DD:HH:MM) Procedures
---------------                   ---------- ---------- ---------- ----------

STEREOTACTIC LOCALIZATION(70022) 01:01:19    01:01:19   01:01:19           1
SKULL 4 OR MORE VIEWS(70260)     01:01:19    01:01:19   01:01:19           1
NECK SOFT TISSUE(70360)          01:01:19    01:01:19   01:01:19           1
CT HEAD W/IV CONT(70460)         01:01:19    01:01:19   01:01:19           1
CHEST STEREO PA(71015)           00:00:03    00:00:03   00:00:03           1
```

Figure 6-66: Printing the Status Time Report (Sample Report)

Note: Exam statuses can move backwards. This happens if data is deleted or if a report is unverified.

6.4.9 Wasted Film Report

This option allows the user to generate a record of wasted film according to size, imaging type, and division. This report calculates the number of all films used, the number of films wasted, and the percentage wasted.

If the user has access to more than one radiology/nuclear medicine division, a prompt will appear asking for a selection of one or more divisions. If the user has access to only one division, the system will default to that division rather than prompting the user for a selection. The same process occurs with imaging type selection. A prompt for selection of one or more imaging types will only appear if the person has access to more than one imaging type. The user must also select a date range.

Before the report prints, a list of exam statuses to be included on the report will be displayed. The exam statuses may be different for each imaging type selected. This is determined during system setup when the radiology supervisor answers the Film Usage Report question during Examination Status Entry/Edit. See the radiology supervisor's guide for more information on setting up the exam status parameter.

Since the output can be lengthy, you may wish to run this report during off-peak hours.

If the exam date of a case is within the date range selected and the exam's division and imaging type are among those selected, the case may be included on the report. The current status of the exam must also be specified in the Examination Status parameters as a status to include on this report. If, during exam edit/entry, a wasted film size was entered for an exam but no amount was entered, nothing will be added to the totals.

Each film size entered on the exam record is checked. If the film size has been deleted from the Film Size file the exam is bypassed. If the film size is a wasted type, the number used is added to the total for that wasted film size. The used films are also tracked so that a percentage wasted can be calculated. The units of wasted film are separate and not included in the units of used film. The calculation for percentage wasted is: number wasted/(number used + number wasted) x 100.

In order for this report to be valid, each film size must have a wasted film entry set up in the Film Sizes file that points to the analogous unwasted film size. Refer to the radiology supervisor's guide for more information about setting up Film Sizes correctly so that this report is valid.

```
Do you wish to generate a summary report only? No// <RET>

Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE IL CIOFO
499
Another one (Select/De-Select): <RET>

Select Imaging Type: All// GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

     The entries printed for this report will be based only
     on exams that are in one of the following statuses:

     GENERAL RADIOLOGY
     -----------------
        WAITING FOR EXAM
        EXAMINED
        TRANSCRIBED
        COMPLETE

Enter the start date for the search: Mar 01, 1995// T-100 (NOV 21, 1994)
Enter the ending date for the search: NOV 21,1994// T (MAR 01, 1995)

DEVICE: HOME// <RET> SET HOST
```

Figure 6-67: Printing the Wasted Film Report (Setup)

```
                >>>>> Wasted Film Report <<<<<                      Page: 1

     Division: HINES CIO FIELD OFICE          For Period: NOV 22,1994 to
     Imaging Type: GENERAL RADIOLOGY                      MAR 2,1995.
     Run Date: Mar 02, 1995@13:32:31

                                      Units       Units          Percentage
                                      Of Used     Of Wasted      Of Wasted
Film Size                             Films       Films          Film
-------------------------------------------------------------------------
W-10X12                               150         9              5.7
          Subtotals:                  150         9              5.7
-------------------------------------------------------------------------

* Cine data not included in totals.
```

Figure 6-68: Printing the Wasted Film Report (Sample Report)

6.5 General Information About Workload Reports

For most workload reports that are sortable/selectable for one-many-all division(s) and imaging type(s), the division totals page will only print if there are more than one imaging types in the division. If there is only one imaging type in the division, the imaging type total page should be used for the division total.

The following reports calculate workload counts (i.e., exam counts, patient visit counts, and weighted work units) in a similar way:

Functional Area Workload Reports **Personnel Workload Reports**

Clinic Report	Physician Report
PTF Bedsection Report	Resident Report
Service Report	Staff Report
Sharing Agreement/Contract Report	Technologist Report
Ward Report	Transcription Report

Special Reports

Camera/Equip/Rm Report

Selection Criteria

Before the report is printed, you will be asked to specify the following selection criteria.

- You may choose to print the summary report only. The summary consists of a page for each imaging type selected within each division selected and a division summary.

- If you have access to more than one division (determined by the radiology supervisor who enters the imaging locations you have access to), you will see a prompt to select Rad/Nuc Med Divisions. The default is All, which prints all divisions to which you have access. If you do not see this prompt, it means that you only have access to one division and the report will default to that division. After selecting a division, you will be prompted for another division at the "Another one (Select/De-Select):" prompt. At this prompt you may also deselect a previously chosen division by typing its name preceded by a minus sign (i.e., -Western Division).

- If you have access to more than one imaging type (determined by the radiology supervisor who enters the imaging types you have access to) you will see a prompt to select the Imaging Type. The default is All, which prints all imaging types to which you have access. If you do not see this prompt, it means that you only have access to one imaging type and the report will default to that imaging type. After selecting an imaging type, you will be prompted for another imaging type at the "Another one (Select/De-Select):" prompt. At this prompt you may also de-select a previously chosen imaging type by typing its name preceded by a minus sign (i.e., -Ultrasound).

- The next prompt will ask if you wish to include all of the residents, wards, transcriptionists, etc. For example, if you are running the clinic report and want to include only one or a few selected clinics, you can answer no to this prompt and you will be asked which individual clinic(s) to include.

- Beginning and ending date range prompts appear next. The date range applies to the exam date. The reports will retrieve data for exams having a date within the range you select.

After the selection prompts are answered, a list of exam statuses will be displayed to let you know which statuses are included in the report. The statuses included are predetermined by the radiology supervisor who answers a question for each report for each status within each imaging type to specify whether exams of that status should be included in the report. Refer to the Examination Status Entry/Edit section of the radiology supervisor's guide for more information on setting up exam status parameters.

Data retrieval criteria

An exam will be included in the report if it meets the following criteria:

- The exam date must fall within the date range selected.

- The status of the exam at the time the report is run must be marked to be included in the report. This is done during system setup by the radiology supervisor when the Examination Status questions are answered. There is a Examination Status field for each workload report except the transcription report, which is not affected by exam status. For more information about status setup, refer to the radiology supervisor's guide.

- The exam's division must be one of the divisions selected or the default division of the user (if no division selection prompt appeared).

- The imaging type of the exam status must be one of the imaging types selected or the default imaging type of the user (if no imaging type selection prompt appeared).

- The procedure on the exam record must be valid. The only way this requirement would not be met is if there is a data corruption problem or broken pointer, which theoretically should not happen. If it does, it means someone completely deleted a procedure from the Rad/Nuc Med Procedure file.

- There must be an AMIS code associated with the procedure (AMIS codes are usually entered by the radiology supervisor using the Procedure Enter/Edit option; refer to the radiology supervisor's guide for more information about the Procedure Enter/Edit option).

- If the exam's category is Sharing/Contract, the Sharing/Contract source must be valid. An invalid Sharing Contract source would not happen unless an entry in the Contract/Sharing Agreements file (#34) has been inadvertently deleted.

Reporting Logic

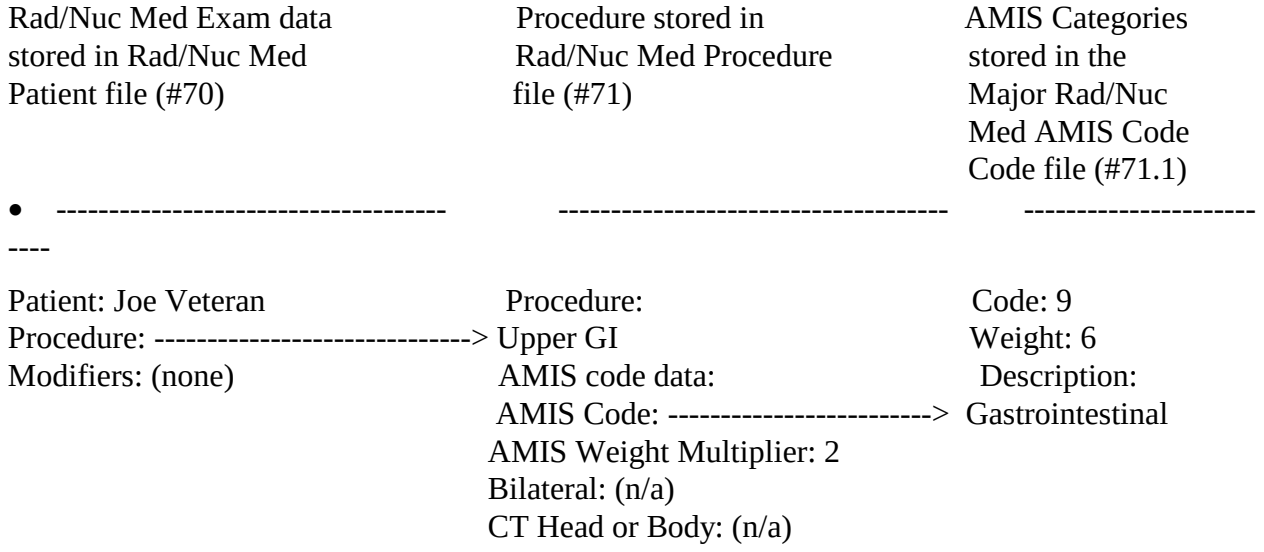
The program uses the Category of Exam field of the exam record to determine whether to count the exam under Inpatient, Outpatient, Research, or Other. The Personnel reports only print Inpatient and Outpatient. If there is a valid ward in the exam's Ward field, it will be counted under Inpatient. All other cases will be counted under Outpatient regardless of the contents of the Category of Exam field.

The functional area reports print Inpatient, Outpatient, Research, and All Other, based on whether the Category of Exam field contains Inpatient, Outpatient, Research or some other value. The report headings are abbreviated to In, Out, Res, and Other.

The Functional Area reports, the Camera/Equip/Rm Report, and the Technologist Workload Report show weighted work units (WWU). WWUs do not apply to the other Personnel reports. The AMIS Weight Multiplier Field of the Rad/Nuc Med Procedures file contains a number (0-99) to indicate to the various workload report programs how many times to multiply the weighted work units associated with the AMIS code. The Weight for each AMIS code is stored in the Weight field of the Major Rad/Nuc Med AMIS Code file.

Most multipliers will be 1. However, there are some that are greater than 1. For example, the Upper GI and Small Bowel procedure may have the AMIS code 9 (Gastrointestinal), which has a weight of 6 and an AMIS Weight Multiplier of 2. Therefore, on the workload reports, the site will get credit for 12 WWUs each time it is performed. If there are multiple AMIS codes for the procedure, each AMIS Weight Multiplier is multiplied by the AMIS Weight and then the results are summed.

Depicted below is a sample of the exam/procedure/AMIS file relationship. Using this sample, the WWUs for the exam would be 12, and the exam would count as 2 exams.



In the above example, the calculation for WWUs would be: 6 x 2 = 12 because Weight x AMIS Weight Multiplier = WWU

The bilateral modifier has special meaning and can cause increased counts. If the AMIS Weight Multiplier is one (1), "bilateral" affects the WWUs by multiplying the AMIS Weight Multiplier by 2 only when the AMIS weight multiplier is 1. The result is multiplied by the AMIS code's weight. If the procedure in the sample above had been bilateral, the WWUs would not have been affected because the AMIS Weight Multiplier is greater than 1. The exam counts are printed under the In, Out, Res, and Other headings on the report. WWUs are printed under the WWU heading.

If more than one AMIS code exists for the procedure, the appropriate exam category count is incremented by one. If only one AMIS code exists for the procedure, the count is incremented by the AMIS Weight Multiplier.

Cases with more than one technologist, resident, or staff member will be incremented accordingly, with a message warning that the total number of exams and weighted work units will be higher in these personnel reports than in the other workload reports.

Report Output

The report is sorted first by division number, then alphabetically by imaging type, and then alphabetically by topic (clinic, ward, resident, etc.). If there are exams that fit the selection criteria, but the topic sort field is missing, they will be printed under Unknown on the report for that topic. For example, if no residents were entered on the exam but the exam fits the selection criteria, it will be included under the Unknown heading on the Resident Workload Report.

The report headings show the date range selected, run date, division, imaging type, report title, and page numbers.

If a full report is selected, one page prints for each topic within the imaging type. However, if there are no exams for any clinics within a selected imaging type, only an imaging type summary sheet will print showing totals of zero. A division summary prints for each division selected. The detailed pages print one line for every procedure. The imaging type and division summaries print one line for each topic. Division summaries print a list of imaging types at the bottom of the page. Division summaries also print the number of topics selected at the bottom of the page to remind you that you may have selected only certain residents, staff, clinics, wards, etc. If only one imaging type within a division was selected, only the imaging type summary will print for that division (this is because the division summary would be identical to the imaging type summary in this case, and you can use the imaging type summary as the division summary).

If the summary only was selected, a page prints for each imaging type selected within each division selected, as well as a division summary. Summary pages for all workload reports show the selected divisions and imaging types in the body of the report rather than in the headings. (This was done because in some cases the list of divisions and imaging types can be lengthy and would not fit into the limited space of a page heading.)

The Transcriptionist Report is an exception. It prints one line per transcriptionist, one page per division, showing a total number of lines and reports transcribed. The notation showing whether you selected only certain transcriptionists or all transcriptionists appears in the report heading.

7.0 Outside Films Registry Menu

7.1 Add Films to Registry

This function allows the user to add new films to the existing outside films registry. This registry tracks films received from outside sources (e.g., private or other VA hospitals). If the selected patient is not in the Rad/Nuc Med Patient file, he or she can be added through this option.

A single patient may have more than one outside film registered at the same time. Through this option, you can add a new entry to those already in the registry. The Edit Registry option (section 7.3) should be used to make changes in existing entries.

The registry includes the registration date, the date to be returned to the source, the source of the films, and remarks.

```
Select Patient: PATIENT,BERTRAM 10-27-45 894416023 NO NSC VETERAN
     ...OK? Yes// <RET> (Yes)

   Patient is currently an inpatient.

Select OUTSIDE FILMS REGISTER DATE: JUN 15,1994// TODAY MAR 31, 1995
Are you adding 'MAR 31, 1995' as a new OUTSIDE FILMS REGISTER DATE (the 3RD
for this RAD/NUC MED PATIENT)? Y (Yes)

OUTSIDE FILMS REGISTER DATE REMARKS: CHEST - 2 VIEWS
NEEDED BACK DATE: APRIL 30, 1995 (APR 30, 1995)

SOURCE OF FILMS: COUNTY HOSPITAL
REMARKS: CHEST - 2 VIEWS// <RET>
```

Figure 7-1: Adding Films to Registry

7.2 Delinquent Outside Film Report for Outpatients

This function allows the user to obtain a report of all the patients who have outside films registered with a "Needed Back" date less than the date the user specifies. This report reflects data entered through the Outside Films Registry menu.

For more information on Delinquent Outside Film Reports, see section 6.1.4.

7.3 Edit Registry

This function allows users to edit information pertaining to a specific outside film that has been registered. Only patients currently entered in the Rad/Nuc Med patient file can be selected through this option.

A single patient may have more than one outside film registered at once. This option can be used to edit an existing entry. New outside film register dates should be added through the Add Films to Registry option (section 7.1).

The registry includes the registration date, the date to be returned to the source, the source of the films, and a remarks field. You may edit any of these fields through this option.

This option is also used to enter a date on which the films were actually returned to the source. If the entry has been flagged through the Flag Film To Need OK Before Return option (section 7.4), supervisory approval is needed before the films can be returned.

```
Select Patient: PATIENT,THOMAS 10-06-20
787140368 NO NSC VETERAN
Select OUTSIDE FILMS REGISTER DATE: MAR 3, 1997 MAR 03, 1997
    Are you adding 'MAR 03, 1997' as a new OUTSIDE FILMS REGISTER DATE (the
1ST for this RAD/NUC MED PATIENT)? No // Y (Yes)

OUTSIDE FILMS REGISTER DATE REMARKS: Need to review.

RETURNED DATE: MAR 8 (MAR 08, 1997)
NEEDED BACK DATE: MAR 8 (MAR 08, 1997)

SOURCE OF FILMS: COUNTY HOSPITAL
REMARKS: Need to review.// <RET>
```

Figure 7-2: Editing the Registry

7.4 Flag Film To Need 'OK' Before Return

This option is used to flag entries in the films registry for supervisory approval before being returned to the outside source. An example would be films that need to be retained for treatment and reference.

Only patients currently entered in the Rad/Nuc Med Patient file can be selected. A patient may have more than one outside film registered at once and one or more of these can be flagged.

If an entry is flagged as needing an OK before return, you will be asked if the supervisor has authorized the return of the borrowed films in the Edit Registry option (section 7.3). A film that has already been returned cannot be flagged.

The Add Films to Registry option (section 7.1) should be used, instead of this option to add new outside film dates, to ensure the completeness of data.

```
Select Patient: PATIENT,BERTRAM 10-27-45 894416023 NO NSC VETERAN
Select OUTSIDE FILMS REGISTER DATE: MAR 31,1995// <RET>
ASK FOR 'OK' BEFORE RETURNING?: Y YES
```

Figure 7-3: 6.6.4 Flagging Film To Need OK Before Return

7.5 Outside Films Profile

This function allows users to see if films from other hospitals or institutions have been registered for this patient. Both returned and unreturned films are listed in the profile. If they have been returned, then the date returned is given.

You will be prompted for a patient's name and the device on which to print the profile. The profile will include registration dates, returned dates, the source, remarks, and an indication showing whether supervisory approval is/was needed before returning the films.

```
Select Patient: PATIENT,BERTRAM 10-27-45 894416023 NO NSC VETERAN
DEVICE: HOME// <RET> SET HOST
```

Figure 7-4: Setting Up the Outside Films Profile

```
***** Outside Films Profile *****
--------------------------------------------------------------------------------
Registered: 09/21/94           Returned : still on file      'OK' Needed: No
Source    : COUNTY HOSPITAL
Remarks   : CHEST - 2 VIEWS
--------------------------------------------------------------------------------
Registered: 06/15/94           Returned : still on file      'OK' Needed: No
Source    : COUNTY HOSPITAL
Remarks   : BROKEN HIP, LEFT
--------------------------------------------------------------------------------
Registered: 03/31/95           Returned : still on file      'OK' Needed: Yes
Source    : COUNTY HOSPITAL
Remarks   : CHEST - 2 VIEWS
--------------------------------------------------------------------------------
```

Figure 7-5: Outside Films Profile Report

8.0 Patient Profile Menu

8.1 Detailed Request Display

This option allows users to see detailed information on a requested examination for a particular patient.

For more information on Detailed Request Display, see section 9.2

8.2 Display Patient Demographics

This option allows the user to see demographics and limited clinical data for a selected patient. Some of the data will be displayed even if the patient has no registered examinations filed. Any or all of the following information may be listed:

- name
- address
- patient ID
- date of birth
- age
- veteran (yes or no)
- eligibility
- exam category (inpatient, outpatient, contract, sharing, employee, research)
- sex
- narrative (special remark)
- currently an inpatient
- ward
- service
- bedsection
- contrast medium reaction
- other allergies
- PENDING orders for imaging exams
- case #, procedure, exam date, and status of up to the last 5 imaging exams

- message stating an exam has been performed using contrast material within the last {#} days
- any number of special messages; i.e., patient died, or the record accessed is a sensitive record

Sometimes one, two, or three asterisks will appear at the left of the case number. The explanations are as follows:

* Barium Used field on case is set to "yes"

** Cholecystogram AMIS code 11 is assigned to the procedure

*** Contrast Media used field on case is set to "yes"

```
Select PATIENT NAME: PATIENT,FRED    03-15-21      914159230     NO     NSC
VETERAN

 *********** Patient Demographics ***********

Name         : PATIENT,FRED               Address: 555 DIXON
Pt ID        : 000-00-9230                         BOONETOWNE, IL 55555
Date of Birth: MAR 15,1924
Age          : 72
Veteran      : Yes                         Currently is an inpatient.
Eligibility  : NSC                            Ward         : 1N
Exam Category: OUTPATIENT                     Service      : MEDICINE
Sex          : MALE                           Bedsection   : GENERAL (ACUTE
MEDICINE)
Phone Number : 222-0755

  Contrast Medium Reaction: No
  Other Allergies:
       'V' denotes verified allergy         'N' denotes non-verified allergy

Case #    Last 5 Procedures/New Orders    Exam Date    Status of Exam
Imaging Loc.
------    ----------------------------    ---------    --------------    -----
-------
133       ABDOMEN 1 VIEW                  MAR 18,1995  WAITING FOR
ULTRASOUND
139       ECHOGRAM ABDOMEN COMPLETE       MAR 18,1995  WAITING FOR
ULTRASOUND
140     i CHEST 1 VIEW                    MAR 18,1995  EXAMINED          X-RAY

Press <RETURN> key to continue.
```

Figure 8-1: Displaying Patient Demographics

8.3 Exam Profile (selected sort)

This option enables the user to list a patient's exam profile. It initially displays a list of exams that can be sorted by procedure or exam date, and asks for a single exam selection. Once a single exam has been selected and displayed, the user will have the opportunity to select various other displays, including exam activity log, status change log, and results report.

The initial list of exams shows case number, procedure, exam date, exam status, and imaging location of the exam. The single exam display shows most exam data entered into the system. The activity log shows which menu options were used to take action on the exam, and the status tracking log shows when status changes occurred, how much time elapsed between status changes, and total elapsed time from when the exam was registered to the last status change. The report text is the actual procedure report.

```
Select Patient:   PATIENT,ANN      01-05-32      0000008476
NO    EMPLOYEE

Sort by one of the following:
          P ==> Procedure
          D ==> Date of Exam

                            Procedure// <RET>

Do you wish to look for a specific procedure? Yes// <RET>

Select Procedure: ACUTE GI BLOOD LOSS IMAGING (NM Detailed) CPT:782

DEVICE: HOME// <RET> SET HOST
```

Figure 8-2: Displaying an Exam Profile (Setup)

```
Profile for  PATIENT,ANN  000-00-8476            Run Date: JUL 30,1997

                 **** Registered Exams Profile *****
   Case No. Procedure                  Exam Date Status of Exam  Imaging Loc
   -------- -------------              --------- ------------    -----------
1     31    ACUTE GI BLOOD LOSS IMAGIN  05/19/97  CALLED FOR EXAM  NUC

CHOOSE FROM 1-1: 1
================================================================================
Name        : PATIENT,ANN    000-00-8476
Division    : HINES CIO FIELD OFFI     Category     : INPATIENT
Location    : NUC                      Ward         : 1S
Exam Date   : MAY 19,1997 11:43        Service      : MEDICAL
Case No.    : 31                       Bedsection   : GENERAL(ACUTE MEDICINE)
                                       Clinic       :
--------------------------------------------------------------------------------
Procedure     : ACUTE GI BLOOD LOSS IMAGING
Requesting Phy: PROVIDER,CATHY          Exam Status  : CALLED FOR EXAM
Int'g Resident: REDIDENT,JERY           Report Status: VERIFIED
Pre-Verified  : NO                      Cam/Equip/Rm : NUC2
Int'g Staff   : STAFF,STEVEN            Diagnosis    : MINOR ABNORMALITY
Technologist  : TECH,RICK               Complication : NO COMPLICATION
                                        Films : 11X14 - 1
---------------------------------Exam Modifiers---------------------------------
Description : None
----------------------------------Medications-----------------------------------
Med: LIDOCAINE 0.5% W/EPI INJ MDV

Med: ASPIRIN 325MG TAB                Dose Adm'd: 1 TAB

Enter RETURN to continue or '^' to exit: <RET>

----------------------------------Medications-----------------------------------
Adm'd By: PROVIDER,CATHY               Date Adm'd: MAY 19, 1997@11:46

------------------------------Radiopharmaceuticals------------------------------
Rpharm: SULFUR COLLOID TC-99M         Dose (MD Override): 1 mCi
Prescriber: PROVIDER,CATHY            Activity Drawn: 1 mCi
Drawn: MAY 19, 1997@11:47             Measured By: PROVIDER,CATHY
Dose Adm'd: 1 mCi                     Date Adm'd: MAY 19, 1997@11:47
Adm'd By: PROVIDER,CATHY              Witness: PROVIDER,TENA
Lot #: 789

Rpharm: PERCHLORACAP 250MG CAPS       Activity Drawn: 250 mCi
Drawn: MAY 19, 1997@11:48             Measured By: PROVIDER,CATHY
Dose Adm'd: 250 mCi
================================================================================
Do you wish to display all personnel involved? No// <RET> NO

Do you wish to display activity log? No// Y

                       *** Exam Activity Log ***
Date/Time            Action                          Computer User
---------            ------                          -------------
MAY 19,1997 11:45    EXAM ENTRY                      PROVIDER,CATHY
MAY 19,1997 11:45    EXAM STATUS TRACKING            PROVIDER,CATHY
MAY 19,1997 14:10    EDIT BY CASE NO.                PROVIDER,CATHY

                     *** Report Activity Log ***
Date/Time            Action                          Computer User
```

```
---------             ------                          -------------
JUN 16,1997 14:12     INITIAL REPORT TRANSCRIPTION    PROVIDER,CATHY
JUN 16,1997 14:14     VERIFIED                        PROVIDER,CATHY
================================================================================

Do you wish to display status tracking log? No// Y

                       *** Status Tracking Log ***
                                                  Elapsed Time   Cumulative Time
Status                      Date/Time              (DD:HH:MM)       (DD:HH:MM)
------                      ---------             ------------   ---------------
WAITING FOR EXAM            MAY 19,1997 11:45       00:00:00         00:00:00
CALLED FOR EXAM             MAY 19,1997 11:45
================================================================================

Do you wish to display exam report text? No// N
```

Figure 8-3: Displaying an Exam Profile (Sample Report)

8.4 Outside Films Profile

This function allows users to see if films from other hospitals or institutions have been registered for this patient. Both returned and unreturned films are listed in the profile. If they have been returned, then the Date Returned is given.

You will be prompted for a patient's name and the device on which to print the profile.

The profile will include registration dates, returned dates, the source, remarks, and an indication showing whether supervisory approval is needed before returning the films.

```
Prompt/User Response    Discussion

Outside Films Profile


Select Patient: POTTS,BERTRAM          10-27-45     894416023   NO   NSC VETERAN
DEVICE: HOME//  <RET>  SET HOST
```

Figure 8-4: Outside Films Profile

```
               *****  Outside Films Profile  *****
------------------------------------------------------------------------------
-
Registered: 09/21/94          Returned : still on file      'OK' Needed: No
Source    : COUNTY HOSPITAL
Remarks   : CHEST - 2 VIEWS
------------------------------------------------------------------------------
-
Registered: 06/15/94          Returned : still on file      'OK' Needed: No
Source    : COUNTY HOSPITAL
Remarks   : BROKEN HIP, LEFT
------------------------------------------------------------------------------
-
Registered: 03/31/95          Returned : still on file      'OK' Needed: Yes
Source    : COUNTY HOSPITAL
Remarks   : CHEST - 2 VIEWS
------------------------------------------------------------------------------
```

Figure 8-5: Outside Films Profile (Sample Report)

8.5 Profile of Rad/Nuc Med Exams

This option enables users to see a quick list of the patient's registered exams. The exams are presented in reverse chronological order. A specific exam can be selected from the list. When an exam is selected, a very detailed display of the exam is displayed.

The user will be prompted to select a patient. If the selected patient has radiology records (films) on file within the Record Tracking system, information relevant to these records will be displayed.

If the patient has more than one registered radiology exam, a list will be displayed showing the case number, procedure, exam date, exam status, and imaging location of the exam. The user may then select one exam for detailed display. The remaining output is the same as in the Exam Profile (section 8.3).

If the Record Tracking system is not used at your site, the `No 'RADIOLOGY/NUCLEAR MEDICINE' records on file` message will appear on screen. If Record Tracking is used at used at your facility, information regarding the location of the patient's folders will appear.

```
Select Patient:    PATIENT,ANN    01-05-32    422458476    NO    EMPLOYEE

                 **** RADIOLOGY/NUCLEAR MEDICINE Profile ****
================================================================================
Name      : PATIENT,ANN (422-45-8476)             Page: 1
Birth Date: JAN 05, 1900         Ward: 1S       Run Date: JUL 30, 1997@10:00
================================================================================

No 'RADIOLOGY/NUCLEAR MEDICINE' records on file.

========================== Exam Procedure Profile ==========================
  Case No. Procedure                  Exam Date Status of Exam   Imaging Loc
  -------- ------------               --------- ---------------- -----------
1   94     BONE IMAGING, WHOLE BODY   05/19/97  WAITING FOR EXAM  NUC
2   31     ACUTE GI BLOOD LOSS IMAGIN 05/19/97  CALLED FOR EXAM   NUC
3   103    UPPER GI AIR CONT W/SMALL  05/13/97  WAITING FOR EXAM  X-RAY
4   203    CHEST OBLIQUE PROJECTIONS  05/13/97  CANCELLED         X-RAY
5   280    THYROID UPTAKE, MULTIPLE D 04/23/97  CALLED FOR EXAM   NUC
6  +430    ANKLE 2 VIEWS              01/28/97  CANCELLED         X-RAY
7   431    FOOT 2 VIEWS               01/28/97  CANCELLED         X-RAY
8   432    TOE(S) 2 OR MORE VIEWS     01/28/97  CANCELLED         X-RAY

Type '^' to STOP, or
CHOOSE FROM 1-8: 2
================================================================================
Name      : PATIENT,ANN    000-45-8476
Division  : HINES CIO FIELD OFFI     Category     : INPATIENT
Location  : NUC                      Ward         : 1S
Exam Date : MAY 19,1997 11:43        Service      : MEDICAL
Case No.  : 31                       Bedsection   : GENERAL(ACUTE MEDICINE)
                                     Clinic       :
--------------------------------------------------------------------------------
Procedure     : ACUTE GI BLOOD LOSS IMAGING
Requesting Phy: PROVIDER,CATHY       Exam Status  : CALLED FOR EXAM
Int'g Resident: RESIDENT,JERY        Report Status: VERIFIED
Pre-Verified  : NO                   Cam/Equip/Rm : NUC2
Int'g Staff   : STAFF,STEVEN         Diagnosis    : MINOR ABNORMALITY
Technologist  : TECH,RICK            Complication : NO COMPLICATION
                                     Films        : 11X14 - 1
---------------------------------Exam Modifiers---------------------------------
Description : None

---------------------------------Medications------------------------------------
Med: LIDOCAINE 0.5% W/EPI INJ MDV

Med: ASPIRIN 325MG TAB               Dose Adm'd: 1 TAB

Enter RETURN to continue or '^' to exit:

---------------------------------Medications------------------------------------
Adm'd By: WILLIAM,CATHY Date Adm'd: MAY 19, 1997@11:46

-----------------------------Radiopharmaceuticals-------------------------------
Rpharm: SULFUR COLLOID TC-99M        Dose (MD Override): 1 mCi
Prescriber: PROVIDER,CATHY           Activity Drawn: 1 mCi
Drawn: MAY 19, 1997@11:47            Measured By: PROVIDER,CATHY
Dose Adm'd: 1 mCi                    Date Adm'd: MAY 19, 1997@11:47
Adm'd By: PROVIDER,CATHY             Witness: PROVIDER,TENA
Lot #: 789
```

```
Rpharm: PERCHLORACAP 250MG CAPS      Activity Drawn: 250 mCi
Drawn: MAY 19, 1997@11:48            Measured By: PROVIDER,CATHY
Dose Adm'd: 250 mCi
===============================================================================
Do you wish to display all personnel involved? No// <RET> NO
Do you wish to display activity log? No// Y

                      *** Exam Activity Log ***

Date/Time          Action                          Computer User
---------          ------                          -------------
MAY 19,1997 11:45  EXAM ENTRY                      PROVIDER,CATHY
MAY 19,1997 11:45  EXAM STATUS TRACKING            PROVIDER,CATHY
MAY 19,1997 14:10  EDIT BY CASE NO.                PROVIDER,CATHY

*** Report Activity Log ***
Date/Time          Action                          Computer User
---------          ------                          -------------
JUN 16,1997 14:12  INITIAL REPORT TRANSCRIPTION    PROVIDER,CATHY
JUN 16,1997 14:14  VERIFIED                        PROVIDER,CATHY

===============================================================================
Do you wish to display status tracking log? No// Y

                   *** Status Tracking Log ***
                                        Elapsed Time    Cumulative Time
Status             Date/Time             (DD:HH:MM)       (DD:HH:MM)
------             ---------            ------------    ---------------
WAITING FOR EXAM   MAY 19,1997 11:45     00:00:00         00:00:00
CALLED FOR EXAM    MAY 19,1997 11:45
===============================================================================

Do you wish to display exam report text? No// N
```

Figure 8-6: Viewing the Profile of Rad/Nuc Med Exams

9.0 Radiology/Nuclear Med Order Entry Menu

9.1 Cancel a Request

This option allows users to cancel an exam request. When an exam is cancelled, a reason must be entered for the cancellation.

When a request is cancelled, it is placed in the DISCONTINUED status. Only requests that have not been acted upon by Radiology/Nuclear Medicine may be cancelled. These include requests in a PENDING or a HOLD status.

You will first be prompted to select a patient. In the event that another user is editing orders for the selected patient, a message asking that you try again later will appear. If no one else is working on orders for the patient you selected, a list of requests for the patient will be displayed, including the request status, urgency, procedure, request date, requester, and patient location.

Once you select a request to cancel, you will be asked for a cancellation reason. If a reason is not entered, the request is not cancelled.

When you cancel a request, the RAD/NUC MED REQUEST CANCELLED MailMan bulletin is sent to members of the RA REQUEST CANCELLED mail group or other mail group set up by your site manager to receive this bulletin. Printouts of cancelled requests include the name of the person who cancelled the request.

```
Select PATIENT NAME:  PATIENT,ANN    01-05-32    422458476    NO    EMPLOYEE

                  **** Requested Exams for PATIENT,ANN ****        8 Requests
  St Urgency Procedure                      Desired Requester     Req'g Loc
  -- ------- ------------------------------ ------- -----------   -----------
1 p  ROUTINE ABDOMEN 1 VIEW                 09/05   PROVIDER,CINDY  1S
2 p  ROUTINE ANGIO CAROTID CEREBRAL SELECT  09/04   PROVIDER,CINDY  1S
3 p  ROUTINE ANGIO CAROTID CEREBRAL UNILAT  09/04   PROVIDER ELLER,CINDY  1S
4 p  ROUTINE BRAIN IMAGING, PLANAR ONLY     06/28   PROVIDER,CINDY  EMERGENCY R

Select Request(s) 1-4 to Cancel or '^' to Exit: Exit// 2

Select CANCEL REASON: ??

Choose from:
     1   ANESTHESIA CONSULT NEEDED            Synonym: ANES
     6   CONFLICT OF EXAMINATIONS             Synonym: CON
     7   DUPLICATE REQUESTS                   Synonym: DUP
     8   INADEQUATE CLINICAL HISTORY          Synonym: INAD
    11   OTHER CANCEL REASON                  Synonym: OTH
    13   PATIENT CONSENT DENIED               Synonym: PCD

Select CANCEL REASON: 8 INADEQUATE CLINICAL HISTORY Synonym: INAD
   ...will now 'CANCEL' selected request(s)...
      ...ANGIO CAROTID CEREBRAL SELECT EXT UNILAT S&I cancelled...

   Task 39174: cancellation queued to print on device P-DOT MATRIX BACK
```

Figure 9-1: Canceling an Exam Request

9.2 Detailed Request Display

This option allows users to see detailed information on a requested examination for a particular patient.

After you have selected a patient, you must make a selection from a list of available requests showing request status, urgency, procedure, desired date, requester, and requesting location. Possible statuses for requests are: UNRELEASED, PENDING, SCHEDULED, ACTIVE (i.e., registered and in process), HOLD, Complete, and DISCONTINUED. Possible request urgencies are Stat, Urgent, and Routine.

The following information about the selected request is displayed when available: the procedure requested, procedure(s) registered if different from request, request status, requester, patient location and room-bed if available, who entered the request, desired date, transportation mode, isolation precautions, and imaging location the request was submitted to (if available).

If the request was cancelled (i.e., the current status of the request is DISCONTINUED) or placed on hold, the reason will be displayed, if available. It should be noted that requests cancelled through OE/RR will not have a reason for cancellation because OE/RR does not require users to type a reason. If the requested

exam has been registered, the exam status will also be displayed, and case numbers will appear beside the registered procedure names and their CPT codes.

If information has been recorded in the status tracking log for the request, the user will also have the option to view the log. The tracking log display includes the date/time of the change, the new status, the computer user who made the change, and the reason (where applicable). The system will only keep this tracking log if the "track request" status changes prompt is set to yes when the radiology supervisor sets up the division parameters. (See the radiology supervisor's guide for additional information on setting up division parameters.)

> **Note:** The sample shown below is a request for a parent procedure, displayed after the descendents are registered.

```
Select PATIENT NAME:     ZMOUSE,MINNIE       NO    NSC     VETERAN      06-0
5-96   000004444

                                PRIM. CARE: CARLISLE,JIM J MD TEL 2222; 2221
                                ALT. PRIM. CARE: CROSSMAN,KEN E. MD TEL 2223

Select Rad/Nuc Med Location: All// <RET>
Another one (Select/De-Select): <RET>

Imaging Location(s) included: 1ST FLOOR RECEPTION      2ND FLOOR RECEPTION
                              A&D RADIOLOGY      ADMINISTRATOR      CTG

Enter RETURN to continue or '^' to exit: <RET>

**** Requested Exams for ZMOUSE,MINNIE ****          127 Requests
  St Urgency Procedure                      Desired Requester   Req'g Loc
  -- ------- ------------------------------ ------- ----------- -----------
1 dc ROUTINE CHEST 2 VIEWS PA&LAT           06/24   PROVIDER,MART  10CN
2 dc ROUTINE CHEST 2 VIEWS PA&LAT           06/17   PROVIDER,KEN  10CN
3 dc ROUTINE CHEST 2 VIEWS PA&LAT           06/13   PROVIDER,MART  11D/MICU
4 dc ROUTINE +CHEST CT                      05/22   PROVIDER,M. EL  WOMEN VETER
5 dc ROUTINE ECHOGRAM ABDOMEN COMPLETE      04/20   PROVIDER,M. EL  CAUSEWAY-IV
6    ROUTINE +GALLIUM TUMOR                 04/19   PROVIDER,M. EL  C ADULT DAY

Select Request(s) 1-6 to Display or '^' to Exit: Continue// 6
```

Figure 9-2: Viewing a Detailed Request Display

```
                        **** Detailed Display ****
Name:   ZMOUSE,MINNIE     (000-00-4444)         Date of Birth: JUN 5,1896
------------------------------------------------------------------------------
Requested:         GALLIUM TUMOR                                (NM Parent )
Registered:   3350 TUMOR LOCALIZATION (GALLIUM SCAN),  (  (NM Detailed 78803)
              3351 PROVISION OF DIAGNOSTIC RADIONUCLIDE   (NM Detailed 78990)
              3352 COMPUTER MANIPULATION > 30 MIN.       (NM Detailed 78891)

Current Status:       ACTIVE
Requestor:            DOCTOR,M. DR
Tel/Page/Dig Page:    5181 / 465-9710 / 465 9710
Patient Location:     C ADULT DAY NEURO 52
Entered:              Apr 19, 1997 12:15 pm by MANEY,M. DR

Desired Date:         Apr 19, 1997
Transport:            AMBULATORY
Clinical History:     Internal bleeding, pain

Request Submitted to: UNKNOWN

Do you wish to display request status tracking log? NO// YES

*** Status Tracking Log ***
Date/Time         Status       User        Reason
----------------- ------------ ----------- ---------------------------------
04/19/97 12:15 PM PENDING      USER,M. EL
04/19/97 12:17 PM ACTIVE       USER,TIM
```

Figure 9-3: Detailed Request Display (sample report)

9.3 Hold a Request

This option enables users to place a requested exam in the HOLD status. The user will be asked to select a reason from the Rad/Nuc Med Reason file (#75.2). Only requests with a status of pending or scheduled may be placed on HOLD.

The user will be prompted to select a patient. In the event that another person is editing orders for the selected patient, a message asking the user to try again later will appear. If no one else is working on orders for the selected patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, request date, requester, and patient location.

Once the user selects a request, he or she will be asked for a reason for putting the request on HOLD. If a reason is not entered, the request will not be placed on HOLD.

When the request status is changed to HOLD, the RAD/NUC MED REQUEST HELD mail bulletin will be automatically sent to all members of the RA REQUEST HELD mail group, or other mail group set up by your IRM to receive this bulletin.

```
Select PATIENT NAME: PATIENT,VERNON   07-06-46   412760624  YES   SC   VETERAN

              **** Requested Exams for PATIENT,VERNON ****         3 Requests
  St Urgency Procedure                     Desired Requester    Req'g Loc
  -- ------- ----------------------------- ------- -----------  -----------
1 s  ROUTINE ARTHROGRAM SHOULDER S&I       04/03   PROVIDER,MA  EMERGENCY R
2 s  ROUTINE ARTHROGRAM WRIST S&I          04/03   PROVIDER,MA  EMERGENCY R
3 p  ROUTINE ANOTHER PARENT PROCEDURE      01/20   PROVIDER,MA  X-RAY STOP

Select Request(s) 1-3 to Hold or '^' to Exit: Exit// 1

Select HOLD REASON: ??

Choose from:
     1      ANESTHESIA CONSULT NEEDED        Synonym: ANES
     2      AWAITING C.A.T. EXAM RESULTS     Synonym: CAT
     3      AWAITING NUC. MED. RESULTS       Synonym: NUC
     4      AWAITING ULTRASOUND RESULTS      Synonym: US
     5      CARDIOLOGY CONSULT NEEDED        Synonym: CARD
     9      MEDICAL CONSULT NEEDED           Synonym: MED
    10      NEUROLOGY CONSULT NEEDED         Synonym: NEUR
    12      OTHER HOLD REASON                Synonym: OHR
    15      PATIENT TOO ILL FOR STUDY        Synonym: ILL
    16      REPEAT PATIENT PREP              Synonym: REP
    18      SURGERY CONSULT NEEDED           Synonym: SUR
    20      EXAM CANCELLED                   Synonym: CAN
    21      EXAM DELETED                     Synonym: DEL
    26      EQUIPMENT FAILURE                Synonym: EQF
    27      PATIENT ATE                      Synonym: ATE

Select HOLD REASON: 18 SURGERY CONSULT NEEDED Synonym: SUR
   ...will now 'HOLD' selected request(s)...
      ...ARTHROGRAM SHOULDER S&I held...

Select PATIENT NAME: <RET>
```

Figure 9-4: Holding A Request

9.4 Log of Scheduled Requests by Procedure

This option allows the user to generate a list of SCHEDULED requests sorted by procedure.

See section 6.1.8 for more information on this option.

9.5 Pending/Hold Rad/Nuc Med Request Log

This option will print a Log of Pending Requests or Log of Hold Requests listing, depending on user selections. This log is used to determine which requests have not yet been acted upon. The report output will display desired date, patient name, last 4 digits of patient ID number, procedure, patient location, date ordered, and the requesting location if it is different from the patient's current location.

The selection criteria include a choice of printing the HOLD or the PENDING requests, a selection of one or more of the imaging locations accessible by the user, and a date range selection (which is applied to the desired date).

The report is sorted chronologically by Desired Date/time. Output for each imaging location starts on a new page.

Requests will not appear in the report if no Desired Date (field #21 of the Rad/Nuc Med Order file #75.1) has been entered, if the Request Entered Date/Time (field #16 of file #75.1) is blank, if the procedure is missing or invalid due to data corruption, or if the desired date of the request is not within the selected date range. If there is no imaging location on the request, it will print under the UNKNOWN imaging location heading. This will identify orders that have not been submitted to an imaging location because the division parameter, Ask Imaging Location (in field #.121 of the Rad/Nuc Med Division file #79), is set to NO.

```
This option will generate a list of requests for a selected date
range with the status of 'PENDING' or 'HOLD'

Select one of the following:
        H HOLD
        P PENDING

Select REQUEST STATUS: P// <RET> ENDING

Select Imaging Location(s): X-RAY         (GENERAL RADIOLOGY)
Another one (Select/De-Select): <RET>

**** Date Range Selection ****
Beginning DATE : 4/1/95 (APR 01, 1995)
Ending DATE    : T (APR 03, 1995)

DEVICE: HOME// <RET> SET HOST
```

Figure 9-5:Viewing the Pending/Hold Rad/Nuc Med Request Log (Setup)

```
                        LOG OF PENDING REQUESTS
             Includes requests scheduled from 4/1/95 to 4/3/95
IMAGING LOCATION: X-RAY                              Run Date: APR 3,1995 13:13

PATIENT NAME           PROCEDURE                PT LOC             DATE ORDERED
================================================================================
               Desired Date (Time optional): APR 01, 1995
               ------------------------------------------
PATIENT,MICHAEL -3230   ABDOMEN 1 VIEW           EMERGENCY ROOM  MAR 31, 1995

               Desired Date (Time optional): APR 03, 1995
               ------------------------------------------
PATIENT,BARNEY -7203  BONE AGE                 MAMMOGRAPHY       APR 03, 1995
PATIENT,BARNEY -7203  ARTHROGRAM WRIST S&I      MAMMOGRAPHY       APR 03, 1995
PATIENT,CALVIN -2877  BONE AGE                 DISCHARGED        APR 03, 1995
                    Requesting Location: 1N

Enter RETURN to continue or '^' to exit: <RET>

                        LOG OF PENDING REQUESTS
             Includes requests scheduled from 4/1/95 to 4/3/95
IMAGING LOCATION: X-RAY                              Run Date: APR 3,1995 13:13

PATIENT NAME           PROCEDURE                PT LOC             DATE ORDERED
================================================================================
PATIENT,VERNON -0624   ARTHROGRAM SHOULDER S&I EMERGENCY ROOM    APR 03, 1995
PATIENT,VERNON -0624   ARTHROGRAM WRIST S&I    EMERGENCY ROOM    APR 03, 1995
```

Figure 9-6: Viewing the Pending/Hold Rad/Nuc Med Request Log (Sample Report)

9.6 Print Rad/Nuc Med Requests by Date

This option enables the user to print requests of a selected status for a specific range of date/times. The requests are printed by urgency, beginning with STAT and ending with ROUTINE.

If your division parameter ASK IMAGING LOCATION is set to yes, you will first be asked to select an imaging location. You may select one location or all locations.

You will be asked to choose one of the request statuses. When shown on various display screens, each status may be indicated by a lowercase abbreviation that is shown below in parentheses.

ALL CURRENT ORDERS—all requests with a status of HOLD, PENDING, ACTIVE, OR SCHEDULED.

DISCONTINUED (dc)—same as cancelled. Action on the request has been terminated.

Complete (c)—exam has been performed and the exam status is Complete (or whichever status has an order number of 9 for the appropriate imaging type of the exam).

HOLD (h)—a request is put on HOLD when the procedure cannot be performed as scheduled but will probably be performed at another time.

PENDING (p)—the request has been entered but the imaging department has taken no action (such as scheduling or registering an exam).

REQUEST ACTIVE ( )—the exam has been registered and is currently being processed by the imaging department.

SCHEDULED (s)—the imaging department has accepted the request and scheduled the procedure using the Schedule a Request option.

Note: Scheduling a patient through the PIMS package does NOT change the request status to scheduled.

Next, you will be asked to specify the date used. You must specify whether the program should look at the date the request was entered or the desired date of the request when it chooses the requests to include.

The date range selection that you make next will be used to retrieve print requests. Depending on how you answered the last prompt, the date range will be applied to either the date the request was entered or the desired date on the request.

You will also be asked whether you want to print a health summary with the requests. Health summaries will only print if the procedure requested has a health summary format assigned for printout. (See the radiology supervisor's guide for more information on procedure setup.)

The request form may include some or all of the following data:

- Patient name and ID
- Date of birth
- Age
- Urgency
- Transportation mode
- Patient location
- Phone extension of requesting location and room-bed (for current inpatients)
- Procedure
- Procedure message
- Modifiers
- Current request status
- Exam status if the exam was registered

- Requester
- Primary and attending physician at time of order and current
- Date/time ordered
- Desired date
- Clinical history
- Pregnancy information
- Isolation
- Pre-op
- Approving physician
- Bar-coded SSN
- Portable notation

There is also a worksheet section on the form for date performed, case number, technologist initials, interpreting physician initials, number/size of films used, and comments. The output should be queued to a printer.

```
Select IMAGING LOCATION: X-RAY (GENERAL RADIOLOGY)

Request Status Selection
------------------------
Choose one of the following:
     Discontinued
     Complete
     Hold
     Pending
     Request Active
     Scheduled
     All Current Orders

Select Status: Pending// <RET>

Date Criteria Selection
-----------------------
Select one of the following:
     E      ENTRY DATE OF REQUEST
     D      DESIRED DATE FOR EXAM

Date criteria to use for choosing requests to print: E// <RET> NTRY DATE OF
REQUEST

**** Date Range Selection ****
Beginning DATE : 2/1/97 (FEB 01, 1997)
Ending DATE    : T (APR 08, 1997)

Print HEALTH SUMMARY for each patient? NO

DEVICE: HOME// (Enter printer name)

>> Rad/Nuc Med Consultation for X-RAY <<                  APR 8,1997 16:07
===============================================================================
Name          :  POPITZ,JOHN                 Urgency    :  ROUTINE
Pt ID Num     :  914-73-4594                 Transport  :  AMBULATORY
Date of Birth:  DEC 2,1934                   Patient Loc:  RAD 101
Age           :  62                          Phone Ext  :
===============================================================================
Requested: FOREARM 2 VIEWS (RAD Detailed) CPT: 73090

Request Status: PENDING (p)

Requester:            CEBE,GREGORY B
Tel/Page/Dig Page: (708) 786-5904 / (708) 786-5904 / (708) 786-5904
Attend Phy Current:   UNKNOWN
Prim Phy Current:     UNKNOWN
Date/Time Ordered:    FEB 12,1997 10:48 by PROVIDER,GREGORY B
Date Desired:         FEB 12,1997
Clinical History:

>> Rad/Nuc Med Consultation for X-RAY <<                  APR 8,1997 16:07
===============================================================================
Name          :  PATIENT,JOHN                 Urgency    :  ROUTINE
Pt ID Num     :  914-73-4594                 Transport  :  AMBULATORY
Date of Birth:  DEC 2,1934                   Patient Loc:  RAD 101
Age           :  62                          Phone Ext  :
===============================================================================
Clinical History:
     Rule out fractures.
```

```
--------------------------------------------------------------------------------
Date Performed: _____________________________ Case No.: _____________________
Technologist Initials: _____________________
                                              Number/Size Films: _____________
Interpreting Phys. Initials: _____________                       _____________
                                                                 _____________
Comments:
```

Figure 9-7: Printing the Rad/Nuc Med Requests By Date

Note: If the request printer and its setup support barcode printing, the patient's bar-coded SSN will also print on this form on the right above clinical history.

9.7 Print Selected Requests by Patient

This option enables the user to print or reprint a request for a selected patient.

After you type the patient's name, all of the requested exams for that patient will be displayed and you will be prompted to select one or more. You may print requests in any status, including DISCONTINUED.

The request form may include some or all of the following data:

- Patient name and ID
- Date of birth
- Age
- Urgency
- Transportation mode
- Patient location
- Phone extension of requesting location and room-bed (for current inpatients)
- Procedure
- Procedure message
- Modifiers
- Current request status
- Exam status if the exam was registered
- Requester
- Primary and attending physician at time of order and current
- Date/time ordered
- Desired date
- Clinical history
- Pregnancy information
- Isolation
- Pre-op

- Approving physician
- Bar-coded SSN
- Portable notation

There is also a worksheet section on the form for date performed, case number, technologist initials, interpreting physician initials, number/size of films used, and comments.

If the Rad/Nuc Med Procedure parameters for the procedure ordered specify a health summary format to be used when requests print, a health summary for the patient will also print. (See the radiology supervisor's guide for information on procedure setup.)

The output should be queued to a printer.

```
Select PATIENT NAME: PATIENT,DARWIN  12-24-30   111111111 YES SC      VETERAN
                                  PRIM. CARE: WANDERLY,SUSAN S TEL 1555

                 **** Requested Exams for DELIEAS,DARWIN ****      9 Requests
  St Urgency Procedure                      Desired Requester      Req'g Loc
  -- ------- ------------------------------ ------- -----------    -----------
1 p  ROUTINE CHEST 2 VIEWS PA&LAT           10/27   PROVIDER S      SURGERY 1
2 p  ROUTINE CHEST 2 VIEWS PA&LAT           10/09   PROVIDER S      SURGERY 1
3 c  ROUTINE +ABDOMINAL CT                  09/09   PROVIDER 4B/OBS
4 c  ROUTINE +AORTIC RUNOFF                 09/08   PROVIDER,SARA S VASCULAR
5 c  ROUTINE ECHOGRAPHY,SOFT TISSUES OF HE 08/27   PROVIDER S      SURGERY 1
6 c  ROUTINE CHEST 2 VIEWS PA&LAT           08/27   PROVIDER,SARA S AMBULATOR
7 c  ROUTINE ECHOGRAM ABDOMEN COMPLETE      05/08   PROVIDER,SA C   IM PC VAN
8 h  ROUTINE CHEST 2 VIEWS PA&LAT           08/14   PROVIDER,BE     PULMONARY-A
9 c  ROUTINE CHEST SINGLE VIEW              04/08   PROVIDER,AN     11B/CCU

Select Request(s) 1-11 to Print or '^' to Exit: Exit// 4

Do you wish to generate a Health Summary Report? No// <RET> NO

DEVICE: HOME// <RET>


     >> Rad/Nuc Med Consultation for UNKNOWN <<             OCT 16,1997 16:45
================================================================================
Name         : PATIENT,DARWIN             Urgency    : ROUTINE
Pt ID Num    : 111-11-1111                Transport  : AMBULATORY
Date of Birth: DEC 24,1930                Patient Loc: S VASCULAR LAB 4TH F
Age          : 66                         Phone Ext  : 3333/3334
================================================================================
Requested:          AORTIC RUNOFF                          (ANI Parent )
Registered:    267 ANGIO EXTREMITY BILAT S&I               (ANI Detailed 75716)
               268 INTRODUCTION OF CATHETER, AORTA         (ANI Detailed 36200)
               269 AORTO ABD TRANS L W/SERIAL FILMS S&I    (ANI Detailed 75625)
               270 X-RAY EXAM OF ABDOMEN 1 VIEW, POST A    (ANI Detailed 74000)
               349 SUBTRACTION IN CONJUNCTION W CONT ST    (ANI Detailed 76350)

Procedure Message:
     -ALL REQUISITIONS MUST CONTAIN CLINICAL HISTORIES THAT COMPLY WITH ACR
      STANDARDS: INDICATIONS FOR THIS ANGIOGRAM
     -Diagnosis and evaluation of atherosclerotic vascular disease,
     -including aneurysms, emboli, occlusive disease, and thrombosis.
     -Diagnosis and evaluation of other primary vascular abnormalities,
     -including vascular malformations, vasculitis, entrapment syndrome,
     -thoracic outlet syndrome, etc.
     -Diagnosis and evaluation of vascular trauma
     -Diagnosis and evaluation of tumors
     -Preoperative planning for reconstructive surgery
     -Evaluation of surgical bypass grafts and dialysis grafts and fistulas

Request Status: COMPLETE (c)

Requester:              PROVIDER,SARATHAN K
  Tel/Page/Dig Page:  /   /   532-6022
Attend Phy Current:     UNKNOWN
Prim Phy Current:       UNKNOWN
Date/Time Ordered:      Aug 27, 1997 12:29 pm by PROVIDER,SARATHAN K
Date Desired:           Sep 08, 1997

Clinical History:
```

```
     pt with severe lifestyle limiting claudication on right, please help
     evaluation and possible angioplasty

VA Form 519a-ADP
```

Figure 9-8: Printing Selected Requests by Patient (Worksheets)

9.8 Rad/Nuc Med Procedure Information Look-Up

This option allows the user to view procedure information as requested. The display includes procedure, procedure type, imaging type, CPT and all procedure messages, and educational description. You will be prompted to select an imaging type and asked whether or not you want to include inactive procedures. When prompted to select a Rad/Nuc Med procedure, you may select one or all procedures. If you did not select to include inactive procedure, inactive Procedures will not be included.

```
Select an Imaging Type: RAD GENERAL RADIOLOGY RAD

Select a Rad/Nuc Med Procedure: CHOLANGIOGRAM OPERATIVE       (RAD Detailed)
CP T:74300
Another one (Select/De-Select): <RET>

Select a Device: HOME// (Enter a device at this prompt)
```

Figure 9-9: Looking Up Rad/Nuc Med Procedure Information (Setup)

```
              Radiology/Nuclear Medicine Procedure Information

Run Date/Time: Aug 19, 1997 1:37 pm                                  Page: 1
------------------------------------------------------------------------------
CHOLANGIOGRAM OPERATIVE              (RAD Detailed)              CPT:74300

Guidelines for Work-up of Emergency Interventional Procedures
Requested On Call

Emergency Transhepatic Cholangiogram and/or Biliary Drainage
     1.   What is the clinical history? Mental status?
     2.   Has the patient had an ultrasound or CT to look for obstruction?
     3.   Is the patient febrile? What is the WBC? Is the patient on
          antibiotics - if so, what, for how long?
     4.   Is that patient allergic to any medications or contrast?
     5.   Has the patient had prior surgery pertinent to the area of
          interest? Is there ascites?
     6.   What are the pertinent labs, including CBC, PT, PTT, platelets,
          BUN, creatinine, bilirubin, SGOT, SGPT, alk phos, EKG (read
          by MD)?
     7.   If there is a coagulopathy, is the hematology team seeing the
          patient?
     8.   If the patient is on the medical wards, have the surgeons been
          consulted? Did the surgical resident discuss the case with the
          staff surgeon on call? Did the staff surgeon agree that the
          procedure should be performed?
     9.   Permit for percutaneous biliary cholangiogram and drainage
          signed.
    10.   Pre-angiography orders: IV in arm, NPO.
    11.   Patient must be on IV antibiotics, preferably 24 hours prior to
          the procedure.
```

Figure 9-10: Looking Up Rad/Nuc Med Procedure Information (Sample Output)

9.9 Request an Exam

This option enables the user to request one or more procedures for a patient. Once the request has been entered into the Radiology/ Nuclear Medicine system, it is assigned a pending status.

You will first be prompted to select a patient. If another user is editing the selected patient's file, you will see a message asking that you try again later.

After you have a patient, you will be prompted for the patient location and the name of the person requesting order. If the patient is an inpatient, you will see a default response showing the patient's current ward according to the PIMS package. The name of the person requesting the order will default to the current user's name.

The system will display the last five registered procedures (including cancelled exams but not including cancelled requests), all imaging requests not yet registered or cancelled (i.e., PENDING, SCHEDULED, UNRELEASED), and the dates that they were ordered.

To promote efficiency in the ordering process, the radiology supervisor can create up to 40 Common Procedures for each imaging type. (See the radiology supervisor's guide for information about common procedures setup.) If common procedures have been set up by the radiology supervisor, they will also be displayed on the selection screen.

Next you will be prompted for a procedure. Only active procedures (procedures without an inactivation date or whose inactivation date is before the current date) may be selected. If the division "Detailed Procedure Required?" parameter is set to yes, procedures of the broad type will not be selectable either. Detailed, series, and parent procedures are always selectable, regardless of this parameter setting. (See the radiology supervisor's guide for more information about division parameter setup and the Procedure Enter/Edit option.) You may then choose one of the common procedures (if displayed) or any other valid procedure even though it does not appear on the common list.

You will then be prompted for modifiers and a clinical history. A procedure can be further defined through the Modifier field and several modifiers may be entered for one procedure. The clinical history should state why the exam is being requested (i.e., conditions to rule out, conditions to confirm, past history relevant to this exam, and any additional helpful information, such as pertinent lab values or dates of pertinent trauma, surgery, or procedures). The AMIS special modifiers (portable, bilateral, and operating room) are not selectable for series-type procedures, as they would make the AMIS reports inaccurate.

At the procedure prompt, the user can make multiple procedure choices by typing a comma between selections. The user can select procedures by common procedure number, CPT code, procedure name, or synonym. (See the radiology supervisor's guide for more information about using the Procedure Enter/Edit option for assigning CPTs and synonyms.)

Depending on how the radiology supervisor has set up procedure messages, you may see a message providing special instructions that you must follow when this procedure is ordered. (See the radiology supervisor's guide for additional information regarding procedure message setup.)

You will be asked to include modifiers, the desired date, and a clinical history in all circumstances. Default information is automatically entered in some fields (e.g., patient category, urgency, mode of transport, isolation, and pre-op). If the facility is running OE/RR 3.0 or higher, the facility's radiology supervisor may set up a feature where specified imaging service personnel will receive an alert when a STAT or URGENT request is entered.

If the specified patient is an inpatient, the standard default mode of transport will be wheel chair and the standard default mode of transport for outpatients will be ambulatory. However, if portable is entered as a modifier, the standard default mode

of transport will be portable regardless of the patient category. You will be given the opportunity to edit the default information. If you choose multiple procedures, the data you type for the first procedure will be automatically entered for the following procedures. If anything needs to be changed, you will have to edit it.

If the request is for a female patient who could be pregnant, you will also see a "Pregnant:" prompt. This prompt will accept a response of No, Yes, or Unknown. The response to this prompt will appear in the pregnancy status notation of the printed request form.

If the division "Ask Imaging Location?" parameter is set to yes, you will need to select an imaging location where the request form will be printed at the "SUBMIT REQUEST TO:" prompt. Only imaging locations whose imaging type matches the imaging type of the selected procedure can be chosen. If the site manager has defined a printer for request printout through the IRM menu of this package, a request form will print on that printer. (See the technical manual for information about setting up printers for imaging locations.)

Figure 9-11 is an example of requesting an exam for a patient.

```
Select PATIENT NAME: PATIENT,VERNON      07-06-46      412760624     YES    SC
VETERAN

Patient Location: GENERAL MEDICINE
Person Requesting Order: PROVIDER,BART

Case # Last 5 Procedures/New Orders Exam Date   Status of Exam Imaging Loc.
------ --------------------------- ---------   -------------- ------------
335    CHOLANGIOGRAM IV            APR 12,1995 CANCELLED      X-RAY
       ARTHROGRAM WRIST S&I        APR 3,1995  COMPLETE       X-RAY
       ANKLE 2 VIEWS               APR 3,1995  COMPLETE       X-RAY
       CT HEAD W/IV CONT           JAN 19,1995 COMPLETE       X-RAY
       SKULL 4 OR MORE VIEWS       JAN 19,1995 COMPLETE       X-RAY
       ARTHROGRAM SHOULDER S&I                 Ord 4/9/97     X-RAY
       ARTHROGRAM WRIST S&I                    Ord 4/9/97     X-RAY
       ARTHROGRAM SHOULDER S&I                 Ord 4/9/97     X-RAY

Press <RETURN> key to continue. <RET>

Select one of the following imaging types:
     GENERAL RADIOLOGY
     NUCLEAR MEDICINE
     ULTRASOUND
     CT SCAN
     ANGIO/NEURO/INTERVENTIONAL
     CARDIOLOGY STUDIES (NUC MED)

Select IMAGING TYPE: NUCLEAR MEDICINE

COMMON RADIOLOGY/NUCLEAR MEDICINE PROCEDURES (NUCLEAR MEDICINE)
---------------------------------------------------------------
1) ACUTE GI BLOOD LOSS IMAGING       7) GALLIUM SCAN FOR INFECTIOUS/INFL
2) BRAIN IMAGING, PLANAR ONLY        8) BONE SCAN PARENT
3) RADIONUCLIDE THERAPY, THYROID SU  9) THYROID SCAN
4) KIDNEY FUNCTION STUDY (RENOGRAM) 10) MUGA SCAN PARENT (3 CHILDREN)
5) STEVE'S TEST PROCEDURE           11) V/Q SCAN PARENT (3 CHILDREN)
6) BONE SCAN                        12) BONE MARROW IMAGING

Select Procedure (1-12): or enter '?' for help: 1

Processing procedure: ACUTE GI BLOOD LOSS IMAGING

NOTE: The following special requirements apply to this procedure: ACUTE GI
BLOOD LOSS IMAGING

CALL DR. SMITH BEFORE ORDERING THIS PROCEDURE

This test is designed to LOCATE the site of KNOWN GI bleeding, NOT to
determine whether there IS GI bleeding.

Select MODIFIERS: ASAP
Select MODIFIERS: <RET>
DATE DESIRED (Not guaranteed): TODAY// <RET>      (APR 09, 1997)

     Enter clin hist relevant to procedure, problems to rule out/confirm.

Enter RETURN to continue or '^' to exit:
CLINICAL HISTORY FOR EXAM

==[ WRAP ]==[ INSERT ]=========< Clin Hist/Reason >=======[ <PF1>H=Help ]====
```

```
Enter patient's clinical history here
<======T=======T=======T=======T======T======T======T======T=======T=>=====T
--------------------------------------------------------------------------------
         Patient: PATIENT,VERNON
       Procedure: ACUTE GI BLOOD LOSS IMAGING
       Modifiers: ASAP
        Category: OUTPATIENT             Mode of Transport: AMBULATORY
    Desired Date: Apr 09, 1997         Isolation Procedures: NO
 Request Urgency: ROUTINE              Scheduled for Pre-op: NO
Request Location: GENERAL MEDICINE

Clinical History:
Enter patient's clinical history here.
-------------------------------------------------------------
-
Do you want to change any of the above? NO// <RET>

SUBMIT REQUEST TO: ??
This field points to the 'IMAGING LOCATIONS' file
(#79.1) to indicate the name of the imaging location
within the hospital division where the rad/nuc med exam is
to be performed.

Choose from:
     NUC                                              (NUCLE
     NUC MED LOC                                      (NUCLEAR MEDICINE-639)

SUBMIT REQUEST TO: NUC MED LOC (NUCLEAR MEDICINE-639)
    ...request has been submitted to P-DOT MATRIX BACK.
 Task #: 39212
```

Only imaging locations pre-defined (by the radiology supervisor) to have the same imaging type as the procedure requested will be selectable. If there is only one imaging location with an imaging type that matches the procedure, the system will

Figure 9-11: Requesting An Exam For A Patient

9.10 Schedule a Request

This option enables the user to schedule requested examinations for a specific date/time. An order must already have been requested through the Request an Exam option (section 9.9). Only requests with a status of HOLD or PENDING are eligible for scheduling.

The user will first be asked to select a patient. If another user is editing orders for the selected patient, the user may see a message asking that he or she try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, desired date, requester, and patient location.

Selection prompts will ask the user to enter the request that should be scheduled and to type the date and time the procedure should be scheduled for.

> **NOTE**: Scheduling in the Radiology/Nuclear Medicine package is accomplished through this option. Scheduling in the PIMS package is a completely separate function. Neither interacts with the other. PIMS scheduling is used at many hospitals in addition to

Radiology/Nuclear Medicine scheduling because it is helpful in arranging transportation, charts, etc.

```
Select PATIENT NAME: PATIENT,VERNON    07-06-46    412760624    SC    VETERAN
      **** Requested Exams for PATIENT,VERNON ****                 3 Requests

  St Urgency Procedure                      Desired Requester    Req'g Loc
  -- ------- ------------------------------ ------- -----------  -----------
1 p  ROUTINE ARTHROGRAM SHOULDER S&I        04/03   PROVIDER,MA  EMERGENCY R
2 p  ROUTINE ARTHROGRAM WRIST S&I           04/03   PROVIDER,MA  EMERGENCY R
3 p  ROUTINE ANOTHER PARENT PROCEDURE       01/20   PROVIDER,MA  X-RAY STOP

Select Request(s) 1-3 to Schedule or '^' to Exit: Exit// 1,2

Schedule Request Date/Time: ??
     Examples of Valid Dates:
       JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
       T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
       T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
     If the year is omitted, the computer assumes a date in the FUTURE.
     If only the time is entered, the current date is assumed.
     Follow the date with a time, such as JAN 20@10, T@10AM, 10:30, etc.
     You may enter a time, such as NOON, MIDNIGHT or NOW.

Schedule Request Date/Time: T@2:30PM (APR 03, 1995@14:30)
Select PATIENT NAME: <RET>
```

Figure 9-12: Scheduling A Request

9.11 Ward/Clinic Scheduled Request Log

This option enables the user to generate a list of scheduled requests for patients on a selected ward or clinic. The list includes the following information: patient name, patient ID, scheduled date, procedure, and imaging location if the request was submitted to a specific imaging location. If the “Ask Imaging Location:” parameter (field #.121 of the Rad/Nuc Med Division file #79) is set to yes, the system will prompt you for the imaging location when the order is created. If the parameter field is set to no, the imaging location will not be captured and will not appear on this report.

Selection criteria includes the name of the ward or clinic and a date range. Radiology/Nuclear Medicine orders with a scheduled date (field #23 of the Rad/Nuc Med Order file #75.1) that falls within the selected date range will be included.

Only Rad/Nuc Med requests that have been ordered and scheduled through the Schedule a Request option are included on this report. Scheduled appointments entered only through PIMS do not appear on this report.

At the time the order is placed, the requesting location is assumed to be the patient's location. If the current patient location (based on PIMS data) changed since the time the order was placed, the scheduled exam will print on the report for both the old and

the new location each with a notation referencing the other location. If the requesting location is an inpatient location but the patient is no longer an inpatient, the notation simply says DISCHARGED.

The report prints in chronological order by scheduled date/time.

```
Select Ward/Clinic: ER EMERGENCY ROOM

Starting Imaging Exam Scheduled Date: T (APR 03, 1995)
Ending Imaging Exam Scheduled Date:   T (APR 03, 1995)

DEVICE: HOME// <RET> MY DESK RIGHT MARGIN: 80// <RET>
```

Figure 9-13: Printing the Ward/Clinic Scheduled Request Log (Setup)

```
                    >>> RADIOLOGY/NUCLEAR MEDICINE <<<

Scheduled Request Log for EMERGENCY ROOM                          Page: 1
        Schedule dates from APR 3,1995 to APR 3,1995 23:59
Run Date: APR 3,1995 13:20

Patient             Pt ID Sched. Date   Procedure             Imaging Loc
------------------- ----- ------------ --------------------- --------------
PATIENT,VERNON         0624  4/3/95@14:30  ARTHROGRAM WRIST S&I  X-RAY

Press RETURN to continue...
```

Figure 9-14: Printing the Ward/Clinic Scheduled Request Log (Sample Report)

10.0 Supervisor Menu

10.1 Radiology HL7 Menu (HL7)

This menu is used to manage HL7 messages created and received by the Radiology/Nuclear Medicine V. 5.0 package.

10.1.1 Rad/Nuc Med HL7 Voice Reporting Errors (ERR)

This option displays HL7 messages received from Voice Recognition Reporting Tools (MedSpeak, PowerScribe, TalkStation, etc.) which have been rejected by RPMS Radiology. These messages are stored in the HL7 Message Exceptions file #79.3.

Further options are available to allow the list to be printed and individual messages can be resent and/or deleted.

Prompt/User Response	Discussion
Rad/Nuc Med HL7 Voice Reporting Exception List	This report allows printing by selected Voice Reporting Application, Date and Radiology User.
Select Voice Reporting Application: ALL// **RA-C**LIENT-TCP Another one (Select/De-Select): **RA-T**ALKLINK-TCP Another one (Select/De-Select): **<RET>**	Enter the name of a Voice Reporting Application (File #771) or press the <RET> key to select all applications.
Exception starting date/time: **JAN1** (JAN 01, 1999)	Enter a date to begin reporting from.
Exception ending date/time: NOW// **<RET>** (JUN 11, 1999@12:18:26)	Enter the most recent date/time to report on or press the <RET> key to accept the default of now.
Select Radiology User: ALL// **USER**,CAMERON Another one (Select/De-Select): **<RET>**	Individual users can be selected for reporting. (Entries associated with unknown users will always be displayed). Alternatively, press the <RET> key to display all users.

```
HL7 Voice Reporting Errors    Jun 11, 1999 12:18:38              Page:  1 of
1

     Date        Time      Patient                      Case#  User

     HL7 Voice Reporting Application: MEDSPEAK

1.   MAR 12,1999 11:17:20  NAMEB,PATIENT              1111   TAYLOR,CAMERON
     Error: Event Protocol Pointer (field #773,8) missing

2.   MAR 23,1999 14:53:16  Not known                  ?????  Not Known
     Error: Missing Exam Date and/or Case Number

3.   MAR 23,1999 15:08:38  NAMEA,PATIENT              1      Not Known
     Error: Invalid Provider Name

     HL7 Voice Reporting Application: TALKSTATION

4.   MAR 16,1999 13:45:28  NAMEC,PATIENT              2022   TAYLOR,CAMERON
     Error: Case Number Invalid
 Enter ?? for more actions
PL  Print Exceptions List FS  First Screen          UP  Prev HL7 Exception
RS  Resend HL7 Message    NS  Next Screen           DN  Next HL7 Exception
DE  Delete HL7 Exception  LS  Last Screen           Q   Quit
Select Action: Next Screen//
```

Figure 10-1: HL7 Voice Reporting Errors

Prompt/User Response	Discussion
Select Action: Next Screen// **<RET>**	List Manager will display the next page of HL7 Exceptions in the center screen.
Select Action: Next Screen// **LS**	List Manager will jump to the last screen of entries in the file.
Select Action: Quit// **FS**	List Manager will re-display the first screen of entries shown above.
Select Action: Next Screen// **<↓>**	Scroll down through each entry individually.
Select Action: Next Screen// **<↑>**	Scroll back up through each entry individually.
Select Action: Next Screen// **PL** Select Device: (enter a printer) Do you want your output QUEUED? NO// **Y** (YES)	The entire list will be sent to a printer. (Each Sending Application will start on a separate page). Print immediately or request the job to start later.

```
Requested Start Time: NOW// <RET>
     Request Queued, Task #: 81303
```

```
================================================================================

 HL7 Voice Reporting Errors                                          Page: 1
 (MEDSPEAK - RADIOLOGY/NUCLEAR MEDICINE)        Printed: JUN 11, 1999  14:03

================================================================================

 Exception Date:   MAR 12,1999 at 11:17:20       User: TAYLOR,CAMERON
 Patient Name:     NAMEB,PATIENT                 Case: 1111
 Reason Rejected:  Event Protocol Pointer (field #773,8) missing

 Exception Date:   MAR 23,1999 at 14:53:16       User: Not Known
 Patient Name:     Not known                     Case: ?????
 Reason Rejected:  Missing Exam Date and/or Case Number

 Exception Date:   MAR 23,1999 at 15:08:38       User: Not Known
 Patient Name:     NAMEA,PATIENT                 Case: 1
 Reason Rejected:  Invalid Provider Name


================================================================================
 HL7 Voice Reporting Errors                                          Page: 2
 (TALKSTATION - RADIOLOGY/NUCLEAR MEDICINE)     Printed: JUN 11, 1999  14:03

================================================================================

 Exception Date:   MAR 16,1999 at 13:45:28       User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT1                 Case: 2022
 Reason Rejected:  Case Number Invalid

 Exception Date:   MAR 19,1999 at 15:12:25       User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT2                 Case: 2098
 Reason Rejected:  Missing Exam Date

 Exception Date:   MAR 23,1999 at 14:38:57       User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT3                 Case: 1111
 Reason Rejected:  Invalid Procedure

 Exception Date:   MAR 23,1999 at 15:07:53       User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT4                 Case: 22
 Reason Rejected:  Invalid Diagnostic Code

 Exception Date:   APR  5,1999 at 15:37:09       User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT3                 Case: 278
 Reason Rejected:  Report already on file

 Exception Date:   APR  6,1999 at 14:39:14       User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT3                 Case: 278
 Reason Rejected:  Report already on file
```

Figure 10-2: HL7 Voice Reporting Errors (Sample Report)

Prompt/User Response	Discussion
Select Action: Next Screen// **RS** Select HL7 Exception (1-34) :**9** Re-sending Message #3749...	To re-send a message from the list, Select an entry from the list. Once re-sent it cannot be re-selected. A message similar to "Message Re-submitted on JUN 11, 1999@14:15:51" is displayed instead of the rejection reason.
Select Action: Next Screen// **DE** Select HL7 Exception (1-34) :**10** Deleting Exception...	To permanently delete an exception report entry, select an entry from the list. Once deleted it cannot be re-selected. A message similar to "Reported Exception Deleted on JUN 11, 1999@14:22:40" is displayed instead of the rejection reason.

10.1.2 Resend Radiology HL7 Message (RS)

There are many reasons why an HL7 message may not reach its attempted destination. This option allows you to re-send HL7 messages for such cases. The option will prompt for a Radiology case and will then build a new HL7 message in the hope that it will reach the subscribing applications this time.

Prompt/User Response	Discussion
Enter Case Number: **120400-111**	Enter an active case number, or a completed case as "MMDDYY-999", or a patient's name, or a patient's 9 digit SSN, or the first character of the patient's last name and the last four digits of the patient's SSN.
Choice Case No. Procedure Name Pt ID 1 120400-111 ABDOMEN FOR FETAL AGE 1 V PATIENT,TEST 9999 ========== Re-Broadcast the 'EXAM REGISTERED' HL7 message for this case??? YES// **y** YES	A confirmation prompt is displayed. Enter "Y" to Continue or "N" to cancel. The prompt will either read: EXAM REGISTERED, EXAM CANCELLED, or REPORT VERIFIED depending on the current exam and report status.

10.2 Access Uncorrected Reports

This option enables the user to view uncorrected reports on a selected patient. Uncorrected reports are the report contents saved prior to amendment. The report shows case number, procedure, exam date, status of exam, date/time report was retained, social security number, age of patient, physicians, patient location, imaging location, and service. There may be more than one uncorrected report for a single exam.

```
Select Patient: ANVIOLI,DAVID J.     NO      NSC      VETERAN     07-03-30
555-55-5555

            **** Patient's Exams ****

Patient's Name: ANVIOLI,DAVID J.   555-55-5555          Run Date: AUG 19,1997

Case No.  Procedure              Exam Date    Status of Exam      Imaging Loc
-------    -------------          ---------    ----------------    -----------
1  +234      i CT THORAX W/O CONT     08/05/97     COMPLETE            CTG

Type '^' to STOP, or
CHOOSE FROM 1-1: 1

DEVICE: HOME// (Enter a device at this prompt)
```

Figure 10-3: Accessing Uncorrected Reports (Setup)

```
             *** Uncorrected Reports for: PATIENT,DAVID J. ***
   Run Date: Aug 19, 1997                                          Page: 1
------------------------------------------------------------------------------
Date/Time Uncorrected Report retained: Aug 06, 1997 12:27:15 pm

ANVIOLI,DAVID J. 555-55-5555     67 yr. old male      Case: 080597-234@13:42
Req Phys: PROVIDER,SUSAN                Pat Loc: 9CM/080697@12:27
Att Phys: PROVIDER,DENIS                Img Loc: CTG
Pri Phys: PROVIDER,SUSAN                Service: MEDICINE

Report Unverified by: ANDERSON,MICHAEL E, M.D.

CT THORAX W/O CONT
     Exam Modifiers : None

Clinical History:
     67 yo male w/ newly dx'd sq cell lung ca...? chest wall spread
     and mets.
```

Figure 10-4: Accessing Uncorrected Reports (Sample Report)

10.3 Delete a Report

This function enables users assigned the RA MGR security key to delete a report. This option should be used rarely and with extreme caution; deleting a report should only be done to correct problems that cannot be corrected in any other way. For example, this option might be necessary is when a transcriptionist enters a report on a wrong patient, discovers it, and asks the supervisor to delete it before it is verified.

You will be prompted for a day-case number of the report you wish to delete. You may also type a patient name at this prompt to see all eligible reports for that patient.

If a report for a printset is deleted, all exams in the set will reflect the changed exam status and none of them will have reports.

When this function is executed, a bulletin is sent to the members of the RADIOLOGY REPORT DELETION mail or other group set up by IRM to receive the RAD/NUC MED REPORT DELETION bulletin.

```
Select Report Day-Case#: PATIENT,HOMER    08-27-00    000948704    NO
NSC    VETERAN
   1       031895-143         PATIENT,HOMER          ABDOMEN 1 VIEW
   2       010897-427         PATIENT,HOMER         +BONE IMAGING, WHOLE BODY
CHOOSE 1-2: 2 010897-427

Do you wish to delete this report? NO// Y
      ...report deletion complete.

   ...will now designate exam status as 'EXAMINED'... for case no. 427
      ...exam status backed down.
Credit deleted for this Visit.
```

Figure 10-5: Deleting a Report

10.4 Delete Printed Batches By Date

This option enables users to delete batches. The option purges all records up to a user-defined date. This purges records by date printed, not by the users who created the batch. This option can only be accessed by those users who hold the RA MGR key.

All batches prior to the date you select will be purged from the Report Batches file #74.2. After you select a date, the system will inform you how many batches will be deleted and ask if you want to queue the job to be completed at a later time.

Note: If you type Y to include unprinted batches, batches without data in the Date Printed field will also be displayed.

```
     All batches up to the date you enter will be purged
     from the Report Batches file #74.2.

Purge report batches printed before: APR 10,1995//4/1/95 (APR 01, 1995)

Want to include unprinted batches created before APR 1,1995? No// <RET> NO

The following Report Batches have been selected to be purged:
   Batch: MARK                       Date Created: JUN 13, 1994@12:48
   User: USER,MARK                   Date Printed: MAR 22, 1995@08:54

   Batch: TEST BATCH                 Date Created: SEP 28, 1994@10:37
   User: USER,CINDY                  Date Printed: SEP 28, 1994

   Batch: MARCH 6 REPORTS            Date Created: MAR 06, 1995@11:59
   User: USER,FRANK                  Date Printed: MAR 06, 1995@12:03

   Batch: GREG'S TEST                Date Created: MAR 09, 1995
   User: USER,GREGORY J              Date Printed: MAR 09, 1995@10:00

      'APR 1,1995', are you sure?

Enter Yes or No: YES
    There are 4 batches selected to be deleted.
    Do you wish to task this job off to be completed
    at a later time?

Enter Yes or No: YES
Requested Start Time: NOW// <RET> (APR 10, 1995@09:34:57)
```

Figure 10-6: Deleting Printed Batches by Date

10.5 Exam Deletion

This function enables users with the RA MGR security key to delete exams from the system. This function should only be used to correct problems that cannot be corrected in any other way. Deletion of an exam means permanent, non-retrievable deletion of exam data. This differs from the Cancel an Exam option where the exam data remains accessible to the user. Users should seriously consider using the Cancel an Exam option using the Exam Deletion option. This option would be useful if a clerk registers an exam for the wrong patient and the clerk asks the supervisor to delete it before any additional action is taken.

When this function is executed, the RAD/NUC MED EXAM DELETED mail bulletin is sent to members of the RADIOLOGY EXAM DELETED mail group (or other mail group setup by IRM,) to notify them of the exam deletion.

If the exam has an associated report, deletion is prohibited. The report must be deleted first before the exam can be deleted.

Once the examination has been deleted, the user will be prompted to answer yes or no to cancel the request associated with the exam. If the user types yes, the request will also be cancelled and the request status updated to CANCELLED. If the user types

no, the request status will be updated to HOLD, and the request may be selected for registration at a future date. If the request applies to a parent procedure for which other descendent procedures are registered, the user will not be allowed to place the request on hold or cancel (i.e., DISCONTINUE) the request.

Note: An exam with a Complete status cannot be deleted.

```
Enter Case Number: PATIENT,LEOPOLD
              01-22-20    000328575    YES    SC    VETERAN

                   **** Case Lookup by Patient ****

Patient's Name: DILG,LEOPOLD 688-32-8575             Run Date: AUG 19,1997
   Case No. Procedure                  Exam Date Status of Exam   Imaging Loc
   -------- -------------              --------- ---------------- -----------
1  583      BONE AGE                   08/31/95  WAITING FOR EXAM X-RAY
2  558      CHEST STEREO PA            08/31/95  COMPLETE         X-RAY
3  559      ANGIO CAROTID CEREBRAL UNI 08/31/95  WAITING FOR EXAM X-RAY
4  582      ANGIO CAROTID CEREBRAL SEL 08/31/95  WAITING FOR EXAM X-RAY
5  552      CHEST STEREO PA            08/31/95  WAITING FOR EXAM X-RAY
6  553      ANGIO CAROTID CEREBRAL UNI 08/31/95  WAITING FOR EXAM X-RAY
7  376      RADIONUCLIDE THERAPY, THYR 04/27/95  COMPLETE         NUC MED LOC
8  153      ECHOGRAM ABDOMEN COMPLETE  03/21/95  WAITING FOR EXAM ULTRASOUND
9  196    i BONE AGE                   12/08/94  COMPLETE         X-RAY
10 217      CHOLANGIOGRAM IV           12/08/94  CANCELLED        X-RAY
11 218      SPINE CERVICAL MIN 2 VIEWS 12/08/94  COMPLETE         X-RAY
12   1      ARTHROGRAM KNEE CP         06/08/94  COMPLETE         X-RAY
13  22      CHEST STEREO PA            06/08/94  COMPLETE         X-RAY
14  78      ULTRASONIC GUID FOR RX FIE 04/04/94  COMPLETE         ULTRASOUND

Type '^' to STOP, or
CHOOSE FROM 1-14: 6

Do you wish to delete this exam? NO// Y
Do you want to cancel the request associated with this exam? No// N (No)

HOLD DESCRIPTION:
No existing text
Edit? NO// YES

=[ WRAP ]==[ INSERT ]=========< HOLD DESCRIPTION >========[ <PF1>H=Help ]====
Patient called and postponed.
<=====T======T======T=======T=======T=======T=======T=======T=======T=>=====T

   ...request status updated to hold.
...exam status backed down to 'CANCELLED'
   ...deletion of exam complete.
```

Figure 10-7: Deleting Exams

10.6 Inquire to File Entries

This option is used to display all the data for one or a small number of specified entries in a file. This is useful for a quick look at an entry. Use the Print File Entries option for larger numbers of entries. This option is the same as using the VA FileMan

Inquire to File Entries option, so it is necessary that the user be assigned all of the appropriate file access codes by IRM.

The user will be prompted for a file name and then, one by one, the entries in the file he or she wishes to view.

Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, you may refer to the FileMan 22 user manual.

10.7 List Exams with Inactive/Invalid Statuses

This option will list all exams that are linked to an exam status that is invalid. An exam status is inactive/invalid if the value in the Order field is null. This could happen if the radiology supervisor deactivates the status while some exams are still in that status.

The report generated through this option lists the exam status, imaging type, and for each exam with the invalid status, the patient name and SSN, exam date, case number, and procedure. The Case Edits option or the Status Tracking option can be used to update to valid statuses.

```
DEVICE: HOME// <RET> SET HOST

                                                                    Page 1
                                                          Date: APR 11,1997
                          Exams with Inactive/Invalid Statuses
================================================================================
Exam Status: EXAMINED                          Imaging Type: ULTRASOUND
***********                                    ************
Patient: ABLKCBFV,ALAN K.                      SSN: 119-11-1556
Exam Date: JUN 21,1994@15:31                   Case #: 48
Reported: Yes                                  Report Status: DRAFT
Procedure: ULTRASOUND ABDOMEN

Patient: CORLEONE,VITO                         SSN: 625-34-3953
Exam Date: MAR 9,1994@13:44                    Case #: 7
Reported: Yes                                  Report Status: VERIFIED
Procedure: ECHOGRAM ABDOMEN COMPLETE
Patient: JORDAN,MICHAEL                        SSN: 232-32-3230
Exam Date: JAN 12,1995@10:14                   Case #: 29
Reported: Yes                                  Report Status: VERIFIED
Procedure: ECHOGRAM ABDOMEN COMPLETE

Enter RETURN to continue or '^' to exit:
```

Figure 10-8: Listing Exams With Inactive/Invalid Statuses

10.8 Maintenance Files Print Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.1 Complication Type List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.2 Diagnostic Code List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.3 Examination Status List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.4 Film Sizes List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.5 Label/Header/Footer Format List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.6 Major AMIS Code List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.7 Modifier List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.8 Nuclear Medicine List Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.8.1 Lot (Radiopharmaceutical) Number List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.8.2 Route of Administration List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.8.3 Site of Administration List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.8.4 Vendor/Source (Radiopharmaceutical) List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9 Procedure File Listings

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.1 Active Procedure List (Long)

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.2 Active Procedure List (Short)

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.3 Alpha Listing of Active Procedures

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.4 Barcoded Procedure List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.5 Inactive Procedure List (Long)

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.6 Invalid CPT/Stop Code List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.7 List of Inactive Procedures (Short)

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.8 Parent Procedure List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.9 Procedure Message List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.9.10 Series of Procedures List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.10 Report Distribution Lists

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.11 Sharing Agreement/Contract List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.8.12 Standard Reports Print

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Maintenance Files Print Menu section of the radiology supervisor's guide for more information.

10.9 Mass Override Exam Status

This function enables users with the RA MGR security key to override one or more statuses of exams to Complete. This option can be used to clean up old exams that were never completed and are still assigned a case number, allowing case numbers to be recycled and reused. However, it is preferable to use exam status tracking or case editing options to move an exam to a Complete status if work was performed. The Mass Override Exam Status option will not attempt to do any automatic stop code or procedure crediting, so if the procedures being overridden to complete represent actual work done, data for reimbursement will have to be entered manually into the PCC package.

Exams with a Complete or Cancelled status will not be updated through this option. Only exams whose imaging type is the same as the supervisor's sign-on imaging type will be updated.

The user is asked to select the statuses to override and is then asked for a cutoff date. The cutoff date must be at least 60 days prior to the current date. A printed report is generated of all the exams whose status is overridden to Complete. The report should be queued to a printer. Due to the volume of records that may be affected by this option, it is recommended that this option be run during off hours.

Data displayed on the report will include cutoff date, date report is run, patient name, exam date, case number, and the status before the override. The report is sorted by status.

```
Your sign-on imaging type is GENERAL RADIOLOGY, so only
exams of imaging type GENERAL RADIOLOGY will be changed
to complete.

Are you sure you want to proceed? YES

Select EXAMINATION STATUS: EXAMINED    GENERAL
RADIOLOGY
              ...OK? Yes// <RET> (Yes)

Select EXAMINATION STATUS: <RET>
Enter a cutoff date that is at least sixty days prior to
today.

Enter a date: T-60 FEB 10, 1997
QUEUE TO PRINT ON
DEVICE: HOME// Select a printer <RET>
```

Figure 10-9: Mass Override of an Exam Status (Setup)

```
Requested Start Time: NOW// <RET> (FEB 10, 1997@04:42:13)
      Output Queued. Task #: 39392

                              Cutoff Date for this Report is : FEB 10, 1997
                                    Date Report was Run: Apr 11, 1997

Patient Name         Exam Date            Case #       Status Before Override
PATIENT,HARRY          MAY 20, 1996@10:17    212          EXAMINED
PATIENT,RAYMOND E.     JUL 16, 1996@08:59    261          EXAMINED
PATIENT,FLAVIUS        MAY 22, 1996@14:50    232          EXAMINED
```

Figure 10-10: Mass Override of an Exam Status (Sample Report)

10.10 Override a Single Exam's Status to 'complete'

This function enables users with the RA MGR security key to override the status of any exam to Complete. The only exceptions to this function are exams that are already Complete or those that have been CANCELLED. This option can be used to update an old exam that was never completed and is still assigned a case number. This will allow case numbers to be recycled and reused. However, it is preferable to use exam status tracking or case editing options to move an exam to the Complete status if work was performed.

The Override a Single Exam Status to Complete option will not attempt to do any automatic stop code or procedure crediting, so if the procedures being overridden to complete represent actual work done, data for reimbursement will have to be entered manually into the PCC package.

You will be prompted for the case number of the exam whose status you wish to override. The case number, patient name, patient ID, procedure, exam date, technologist, and physician will be displayed for the selected case.

If you do not know the case number, you may type the patient name to see a list of exams on file and be prompted for a selection.

You will be prompted for the status change date and time; the current date/time will appear as the default.

```
Enter Case Number: PATIENT,LEOPOLD   01-22-20   000328575   YES   SC   VETERAN

                  **** Case Lookup by Patient ****

Patient's Name: DILG,LEOPOLD 688-32-8575              Run Date: APR 10,1995
  Case No. Procedure                   Exam Date Status of Exam   Imaging Loc
  -------- ------------                --------- ---------------- -----------
1 151      ABDOMEN 1 VIEW              03/21/95  WAITING FOR EXAM X-RAY
2 196      BONE AGE                    12/08/94  COMPLETE         X-RAY
3 217      CHOLANGIOGRAM IV            12/08/94  WAITING FOR EXAM X-RAY
4 218      SPINE CERVICAL MIN 2 VIEWS  12/08/94  WAITING FOR EXAM X-RAY
5 1        ARTHROGRAM KNEE CP          06/08/94  COMPLETE         X-RAY
6 22       CHEST STEREO PA             06/08/94  COMPLETE         X-RAY

Type '^' to STOP, or
CHOOSE FROM 1-6: 1
------------------------------------------------------------------------------
Name     : PATIENT,LEOPOLD               Pt ID       : 688-32-8575
Case No. : 151                           Procedure   : ABDOMEN 1 VIEW
Exam Date: MAR 21,1995 11:00             Technologist:
------------------------------------------------------------------------------
Are you sure? No// Y
   ...will now attempt override...
      STATUS CHANGE DATE/TIME: APR 10,1995@09:40//
         ...exam status is now 'COMPLETE'.

   ...will now designate request status as 'COMPLETE'...
      ...request status successfully updated.
```

Figure 10-11: Overriding a Single Exam's Status to Complete

10.11 Print File Entries

This option is used to print a report from a file, where a number of entries will be listed in a columnar format. Each column can be individually controlled for format, tabulation, justification, etc. The Print File Entries option is often used to generate ad hoc reports.

This option is the same as using the FileMan Print File Entries option, so it is necessary that the user be assigned all appropriate file access codes by IRM. This FileMan utility is extremely powerful and can interpret a large set of instructions about entry retrieval and print formatting.

Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, you may refer to the FileMan user manual.

10.12 Rad/Nuc Med Personnel Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Rad/ Nuc Med Personnel Menu section of the radiology supervisor's guide for more information.

10.12.1 Classification Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Rad/ Nuc Med Personnel Menu section of the radiology supervisor's guide for more information.

10.12.2 Clerical List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Rad/ Nuc Med Personnel Menu section of the radiology supervisor's guide for more information.

10.12.3 Interpreting Resident List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Rad/ Nuc Med Personnel Menu section of the radiology supervisor's guide for more information.

10.12.4 Interpreting Staff List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Rad/ Nuc Med Personnel Menu section of the radiology supervisor's guide for more information.

10.12.5 Technologist List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Rad/ Nuc Med Personnel Menu section of the radiology supervisor's guide for more information.

10.13 Search File Entries

This option is used to search file fields for specific data. It enables the user to specify the search logic for multiple fields and obtain a more specific set of entries than the Inquire to File Entries or Print File Entries options.

This option is the same as using the VA FileMan Search File Entries option, so it is necessary that the user be assigned all appropriate file access codes by IRM. This FileMan utility is extremely powerful but can be an intensive computer resource drain. This option should be used with care and during off-peak hours, especially if the file being searched contains a large number of entries.

Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, please refer to the FileMan user manual.

10.14 Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description in the Use of the Software section (section 3.4).

10.15 System Definition Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.15.1 Camera/Equip/Rm Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.15.2 Division Parameter Set-up

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.15.3 List of Cameras/Equip/Rms

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.15.4 Location Parameter List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.15.5 Location Parameter Set-up

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.15.6 Print Division Parameter List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the System Definition Menu section of the radiology supervisor's guide for more information.

10.16 Unverify a Report for Amendment

This function enables users with the RA MGR security key to change a report status to a status other than VERIFIED. Since a verified report cannot be edited, the report status must be changed before any corrections can be made. This option should be used sparingly. If this option is being used frequently, it usually means that procedures for reviewing reports before verifying them are inadequate.

You will first be prompted for a report date/case number. Only reports with a status of VERIFIED can be selected. If you type a patient name, you will be prompted to select from a list of eligible reports.

After you have selected a report, the valid status choices are DRAFT, PROBLEM DRAFT, VERIFIED, and, if available, RELEASED/NOT VERIFIED.

The RAD/NUC MED REPORT UNVERIFIED MailMan bulletin will be sent to members of the RADIOLOGY REPORT UNVERIFIED mail group or other mail group set up by IRM each time a report is unverified through this option. The entire contents of the report prior to unverification are copied for permanent retention and are accessible through the Access Uncorrected Reports option (section 0).

NOTE: If the report status is changed to the PROBLEM DRAFT status, the user will be prompted for a problem statement.

```
Select RAD/NUC MED REPORTS DAY-CASE#: PATIENT,BRIAN
12-01-50    000345463    NO    NSC    VETERAN

     1     013194-10     EQUATOL,BRIAN ANGIO CAROTID CEREBRAL UNILAT S&I
     2     013194-47     EQUATOL,BRIAN ARTHROGRAM KNEE CP

CHOOSE 1-2: 1 013194-10

Select one of the following:
     V VERIFIED
     R RELEASED/NOT VERIFIED
     PD PROBLEM DRAFT
     D DRAFT
REPORT STATUS: V// D <RET> RAFT

...will now designate exam status as 'WAITING FOR EXAM'...
   ...exam status successfully updated.
```

Figure 10-12: Unverifying A Report For Amendment (Setup)

```
Subj: Imaging Report Unverified (613-34-5463) [#12475] 10 Apr 95 09:43
    10 Lines
From: POSTMASTER (Sender: HELLER,CINDY) in 'IN' basket.      Page 1
-------------------------------------------------------------------------------
The following verified radiology report has been unverified:
               1) Patient                 : EQUATOL,BRIAN
               2) SSN                     : 613-34-5463
               3) Case Number             : 013194-10
               4) Exam Date               : JAN 31, 1994@11:09
               5) Desired Date            : JAN 28, 1994
               6) New Status              : DRAFT
               7) Requesting Physician    : PROVIDER,SUSAN
               8) Procedure : ANGIO CAROTID CEREBRAL UNILAT S&I
               9) Imaging Loc : X-RAY

Select MESSAGE Action: IGNORE (in IN basket)// <RET> Ignored
```

Figure 10-13: Unverifying A Report For Amendment (Sample Bulletin)

10.17 Update Exam Status

This option is used to update the status of an examination. In most cases, an examination's status will be automatically updated when the required information for the next status has been entered. Occasionally, an exam will not have the correct status. This could occur if the status requirements are changed by the radiology supervisor. (See the radiology supervisor's guide for information about setting up the Examination Status parameter.)

Through this option, the system evaluates a specified examination's data against the current exam status requirements. If necessary, the status of the specified examination will be updated. If the selected examination still does not meet the requirements of the next status, no change will be made; a message will be displayed on screen to inform you whether or not a change has been made.

You will first be prompted for a case number. If you type a patient's name, you can choose from a list of the patient's cases.

When an exam moves from one status to the next, the system will automatically attempt to pass the stop codes and procedures associated with the exam to the Scheduling package. This information is used to determine workload reimbursement.

```
Enter Case Number: 608
Choice    Case No.    Procedure                  Name              Pt ID
------    --------    ---------                  ----------------- ------
1         032097-608  BONE AGE                   PATIENT,EVARISTE    0154
2         022497-608  SPINE CERVICAL MIN 2 VIEW  PATIENT,RALPH        8277

CHOOSE FROM 1-2: 2
Case No.: 608 Procedure: SPINE CERVICAL MIN 2 VIEWS Name: HEUER,RALPH
  ...will now designate exam status as 'COMPLETE'... for case no. 608
     ...exam status successfully updated.
```

Figure 10-14: Updating Exam Status

10.18 Utility Files Maintenance Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.1 Complication Type Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.2 Diagnostic Code Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.3 Examination Status Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.4 Film Type Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.5 Label/Header/Footer Formatter

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.6 Major AMIS Code Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.7 Nuclear Medicine Setup Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.7.1 Lot (Radiopharmaceutical) Number Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.7.2 Route of Administration Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.7.3 Site of Administration Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.7.4 Vendor/Source (Radiopharmaceutical) Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.8 Order Entry Procedure Display Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.8.1 Common Procedure Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.8.2 Create OE/RR Protocol from Common Procedure

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.8.3 Display Common Procedure List

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.9 Procedure Edit Menu

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.9.1 Cost of Procedure Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.9.2 Procedure Enter/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.9.3 Procedure Message Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.9.4 Procedure Modifier Entry

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.10 Reason Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.11 Reports Distribution Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.12 Sharing Agreement/Contract Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.13 Standard Reports Entry/Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

10.18.14 Valid Imaging Stop Codes Edit

This option is primarily used by the radiology supervisor and is therefore covered in the radiology supervisor's guide.

See the Utility Files Maintenance Menu section of the radiology supervisor's guide for more information.

11.0 Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description in the Use of the Software section (section 3.4).

12.0 Update Patient Record

This function enables the user to update certain fields of information in an existing Rad/Nuc Med patient record. Only patients in the Rad/Nuc Med Patient file may be selected. This option is used if, after initial registration, data in these categories has changed and needs to be revised. Normally, these fields are edited only once.

You will be given the opportunity to enter/edit the usual category of the patient, the narrative for the patient, and whether the patient is allergic to contrast media.

If the selected patient is an inpatient, the patient category on exam records will override to "inpatient" regardless of what is entered for usual category through this option.

The narrative entered through this option will be displayed when the Display Patient Demographics, Request an Exam, and Register Patient for Exams options are used.

The contrast allergy question invokes an interface to the Adverse Reaction Tracking package if you answer yes or change an existing yes answer to no. The contrast media allergy data is stored in the Adverse Reaction Tracking package, not in the Radiology/Nuclear Medicine package.

```
Select Patient: PATIENT,FRANK H   06-21-19   512992785    NO    NSC    VETERAN
         ...OK? Yes// <RET> (Yes)

USUAL CATEGORY: ??
   This field contains a default value used during the exam registration
   process to indicate the category of exam for this Radiology/Nuclear
   Medicine patient. Available categories are: 'O' for OUTPATIENT, 'C' for
   CONTRACT, 'S' for SHARING, 'R' for RESEARCH, and 'E' for EMPLOYEE.

   Choose from:
       O OUTPATIENT
       C CONTRACT
       S SHARING
       R RESEARCH
       E EMPLOYEE
USUAL CATEGORY: O OUTPATIENT

NARRATIVE: ??
   This field may contain a brief note (up to 250 characters) about
   this Radiology/Nuclear Medicine patient. It may describe the personality
   or any unusual characteristic to identify this Radiology/Nuclear Medicine
    patient.
NARRATIVE: Aggressive, independent, stubborn
CONTRAST MEDIUM ALLERGY: NO// <RET>
```

Figure 12-1: Updating a Patient Record

13.0 User Utility Menu

13.1 Duplicate Dosage Ticket

This function enables the user to print additional dosage tickets for exams where radiopharmaceuticals have been entered.

The user will first be prompted for a case number. If the user types a patient's name at this prompt, all exam cases for that patient will be displayed for selection. The user may also type two question marks (??) and get a list of all active cases. Only cases with a Nuclear Medicine or Cardiology Studies imaging type will be displayed.

```
Enter Case Number: PATIENT,EDGAR A  08-23-00   00181787   NO   NSC     VETERAN

                    **** Case Lookup by Patient ****
Patient's Name: PATIENT,EDGAR ALLEN 000-18-1787         Run Date: OCT 28,1997
   Case No. Procedure                  Exam Date Status of Exam   Imaging Loc
   -------- -------------              --------- ---------------- -----------
1 +24       BONE SCAN, WHOLE BODY      09/08/97  COMPLETE         NUCLEAR MED
2 .25       BONE SCAN, MULTIPLE AREAS  09/08/97  COMPLETE         NUCLEAR MED
3 .26     ..PROVISION OF RADIONUCLID   09/08/97  COMPLETE         NUCLEAR MED

Type '^' to STOP, or
CHOOSE FROM 1-3: 1
DEVICE: HOME// <RET> SET HOST
```

Figure 13-1: Creating a Duplicate Dosage Ticket (Setup)

```
         Radiopharmaceutical Dose Computation and Measurement Record
                         Printed: Oct 28, 1997 2:22 pm

Case                     : 24@Sep 08, 1997 8:43 am

Patient                  : PATIENT,EDGAR ALLEN
Patient ID               : 000-18-1787
Study                    : BONE SCAN, WHOLE BODY

Radiopharmaceutical      : Tc99m MEDRONATE
Form                     : Liquid
Lot No.                  : 6138P
Kit No.                  :
Lot Expiration Date      : APR 01, 1999

Date/Time of Measurement: SEP 08, 1997@08:31
Dose Prescribed          : Low: 18 mCi   High: 22 mCi
Activity Drawn           : 21.2 mCi
Dose Administered        : 21.2 mCi
Time of Administration   : SEP 08, 1997@08:31
Signature of Person Measuring Dose: _____________________________________________
```

Figure 13-2: Creating a Duplicate Dosage Ticket (Sample Ticket)

13.2 Duplicate Flash Card

This function enables the user to print additional flash cards or exam labels for a previously registered exam. Usually, flash cards and exam labels are set up by the radiology supervisor to print at the time an exam is registered. The user can print up to 20 additional flash cards or exam labels at one time. This option may be needed if a printer malfunctions during the original printing of a label set.

You will first be prompted for a case number. If you type a patient's name at this prompt, all exam cases for the patient will be displayed.

The format of the flash card and exam label is determined by the imaging location the user is signed in to. If the system detects that the exam was registered in a location other than your default imaging location, the system will give you an opportunity to switch to the appropriate location. However, if you choose not to switch, the labels will still print but in the format assigned to your default imaging location. (See the radiology supervisor's guide for information on setting up the imaging location parameter.)

You will then be prompted for the number of flash cards and exam labels you wishes to print (0-20). If a flash card printer has not been defined by IRM (through the Device Specifications for Imaging Locations option), you will be prompted for a device. This print job should be queued to a printer.

```
Enter Case Number: PATIENT,HARRY  08-17-00 000262873    NO    NSC    VETERAN

                           **** Case Lookup by Patient ****
Patient's Name: LIME,HARRY 00-26-2873
Run Date: MAR 31,1995

  Case No. Procedure                  Exam Date Status of Exam    Imaging Loc
  -------- -------------              --------- ----------------  -----------
1  45      CHEST 4 VIEWS              01/24/95  COMPLETE          X-RAY
2  83      SKULL 4 OR MORE VIEWS      01/17/95  CANCELLED         X-RAY
3  84      NECK SOFT TISSUE           01/17/95  EXAMINED          X-RAY
4  85      STEREOTACTIC LOCALIZATION  01/17/95  WAITING FOR EXAM  X-RAY
5  86      NECK SOFT TISSUE           01/17/95  WAITING FOR EXAM  X-RAY
6  30      SPINE CERVICAL MIN 4 VIEWS 11/04/94  CANCELLED         X-RAY
7  19      SPINE CERVICAL MIN 2 VIEWS 11/04/94  CANCELLED         X-RAY
8  65      BONE AGE                   10/12/94  EXAMINED          X-RAY
9  54      ANGIO CORONARY BILAT INJ S 10/12/94  CANCELLED         X-RAY
10 48      CHEST STEREO PA            10/12/94  CANCELLED         X-RAY
11 26      ABDOMEN 1 VIEW             10/12/94  COMPLETE          X-RAY

CHOOSE FROM 1-11: 1

How many flash cards? 1// <RET>
How many exam labels? 1// <RET>

QUEUE TO PRINT ON
DEVICE: P-DOT MATRIX BACK// <RET> BY DON BERRY'S DESK
Duplicates queued to print on P-DOT MATRIX BACK. Task #: 11575
```

Figure 13-3: Duplicating a Flash Card

13.3 Jacket Labels

This option is used to print film jacket labels for a Rad/Nuc Med patient. Additional jacket labels would be required for patients with multiple volumes of films.

You will first be prompted for the name of a Rad/Nuc Med patient. Only patients registered in the Rad/Nuc Med Patient file can be selected. You will then be asked how many jacket labels you need to print (0-20).

If a jacket label printer has not been defined by IRM (through the Device Specifications for Imaging Locations option), you will also be prompted for a device. This print job should be queued to a printer.

```
Select Patient: PATIENT,JOHN L 08-03-00 000161668 NO NSC VETERAN
How many jacket labels? 1// <RET>
Duplicates queued to print on P-DOT 10 LINESAPAGE. Task #: 39436
```

Figure 13-4: Printing Additional Jacket Labels

13.4 Print Worksheets

This function enables the user to print any number of worksheets. These worksheets are used by imaging departments that do not have enough terminals to capture exam status in a real-time mode. These worksheets should accompany the exam requisition as it proceeds through the department. As the exam status changes, the appropriate entries on the worksheet should be made.

The data captured on the sheets should then be entered in a batch mode when terminals are available later in the day. The worksheets should be printed on a 132-column device. The worksheet cannot be displayed on a terminal. It must be sent to a printer.

```
          *** RADIOLOGY/NUCLEAR MEDICINE WORKSHEETS ***

Enter the number of worksheets needed: 1

    NOTE: This output should be sent to a printer that
    supports 132 columns.

DEVICE: HOME// LINE COMP. ROOM RIGHT MARGIN: 132//<RET>

DO YOU WANT YOUR OUTPUT QUEUED? NO// Y (YES)

Requested Start Time: NOW// <RET> (MAR 31,
1995@15:43:59)
     Request Queued. Task #: 11574
```

Figure 13-5: Printing Worksheets

13.5 Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description in the Use of the Software section (section 3.4).

13.6 Test Label Printer

This function enables the user to test a label printer by printing a test label in the default format. This option should be used to check the alignment of a device before printing actual labels.

```
DEVICE: HOME// <RET> MY DESK          RIGHT MARGIN: 80// <RET>

Patient Name:PATIENT,JOHN                  SSN:000-38-3342          AGE:35
RAD LOC:SECOND FLOOR C-WING                DATE OF EXAM:DEC 13,1984 14:30
PROCEDURE:1A - SKULL                       REPORT STATUS:RELEASED/NOT VERIFIED
LAST VISIT:Oct 12,1984 13:30               DX CODE:NORMAL
THIS IS A FLASH CARD FORMAT
Attend Phy At Order:DOE,JOE                Prim Phy At Order:DOE,JOE
Request Entered: Jan 21, 1994 10:30 CASE: 543
Patient Location: EENT CLINIC 51D/060894@13:35
```

Figure 13-6: Testing Label Printer

14.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Service Center by:

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